MedStar Health

MedStar Franklin Square Medical Center • MedStar Georgetown University Hospital
MedStar Good Samaritan Hospital • MedStar Harbor Hospital
MedStar Montgomery Medical Center • MedStar National Rehabilitation Network
MedStar St. Mary's Hospital • MedStar Union Memorial Hospital
MedStar Washington Hospital Center

Community Health Assessment 2012

Knowledge and Compassion
Focused on You

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Executive Summary

MedStar Health conducted its first Community Health Assessments (CHA) as a system for each of the nine MedStar hospitals in fiscal year 2012 (July 1, 2011-June 30, 2012). This new systemwide effort was borne out of the need to create a more organized, formal and systematic approach to meeting the needs of underserved communities. This opportunity is especially relevant in light of growing momentum and increased scrutiny around how hospitals are making a measurable contribution to the health of the communities they serve. MedStar Health's CHAs comply with the new Internal Revenue Service (IRS) mandate requiring not-for-profit hospitals to conduct community health needs assessments once every three years.

MedStar Health's approach to the CHA is based on guidelines established by the IRS. The approach also incorporates best practice standards that have been published by nationally recognized leaders in the field, such as the Catholic Health Association,[1] the Association for Community Health Improvement[2] and the American Public Health Association.[3] The CHA allows hospitals to better understand the health needs of vulnerable or underserved populations; and subsequently, develop a plan that will guide future community benefit programming. MedStar Health hospitals will advance their work in the community by deploying community benefit resources to support a documented plan with measurable objectives.

The involvement of local residents, community partners, and stakeholders was a cornerstone of the CHA. Each hospital's assessment was led by an Advisory Task Force (ATF), which was comprised of a diverse group of individuals, including grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders and other stakeholder organizations, such as representatives from local health departments. ATF members reviewed quantitative and qualitative data and provided recommendations for the hospital's health priorities, specifically as they relate to the needs of underserved and low-income communities.

The findings from extensive data analyses were corroborated by stakeholder and community input. Heart disease was consistently identified as a priority for all of MedStar's acute hospitals. Diabetes and obesity were also high priorities for most hospitals. In addition to heart disease, diabetes and obesity, two of the acute hospitals identified unique priorities based on their needs assessment, coupled with existing goals or efforts with community partners. MedStar St. Mary's Hospital selected substance abuse to align with existing county priorities. MedStar Franklin Square Medical Center identified substance abuse and asthma due to its existing partnership with the Southeastern Network Collaborative and Baltimore County Public Schools. MedStar National Rehabilitation Hospital, MedStar's only free-standing specialty hospital, identified prevention of subsequent stroke among persons who speak Spanish as a primary language as an underserved population in the rehab community.

Each hospital identified a Community Benefit Service Area (CBSA) – a specific community or target population of focus, a very important aspect of the needs assessment. The impact of the hospitals' work in the CBSA will be tracked over time. Implementation strategies were developed and will serve as a roadmap for how the hospital will use its resources and collaborate with strategic partners to address the priorities.

Implementation strategies were endorsed by the hospital's Board of Directors and the Strategic Planning Committee of the MedStar Health Board of Directors. The MedStar Health Board of Directors approved each hospital's implementation strategy on June 20, 2012.

IRS Requirements for Tax Exempt Status:
Community Health Assessments

In 2006, the Internal Revenue Service (IRS) initiated a study that examined the community benefit reporting methodologies of more than 500 not-for-profit hospitals. There were three key findings: 1) there were discrepancies in how hospitals were defining and reporting community benefit; 2) there was no standardized approach in determining how to use community benefit resources to best meet the needs of the community; and 3) some hospitals' community benefit contributions were not commensurate with their tax exempt status.[4] These findings have informed a national argument for developing more consistent community benefit reporting expectations for all not-for-profit hospitals.

On March 23, 2010, Congress approved the Patient Protection and Affordable Care Act (PPACA). The Act included a Community Health Assessment (CHA) mandate for not-for-profit hospitals. According to the mandate, the CHA must be conducted once every three years and it must include input from persons who represent the broad interests of the community, as well as those with public health expertise. Furthermore, an implementation strategy must be developed by the hospital and approved by its Board of Directors. The implementation strategy must be publicly available within the same tax year the CHA is conducted.[5]

Systemwide Approach to the Community Health Assessment

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

Roles and Responsibilities

- *Corporate Community Health Department* - Establish a CHA methodology for all hospitals; identify strategic partners; provide expertise and technical support as needed; ensure that processes, deliverables and deadlines comply with the IRS mandate.
- *Executive Sponsor* – Serve as liaison to the senior leadership team; ensure the hospital's selected priorities are aligned with the strengths of the organization.
- *Hospital Lead* – Serve as internal resource on existing community health programs and services; facilitate and document all activities associated with the assessment.
- *Advisory Task Force* – Review quantitative data; design data collection tool and review findings; recommend the hospital's Community Benefit Service Area and community benefit health priorities. *Task force members included grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders and other stakeholder organizations, such as representatives from local health departments.*
- *Hospital Boards* – Review and endorse the hospital's Community Benefit Service Area health priorities and implementation strategy.
- *Strategic Planning Committee of the MedStar Health Board* - Review and endorse each hospital's Community Benefit Service Area, health priorities and implementation strategy.
- *MedStar Health Board of Directors*– Approve each hospital's implementation strategy.

Data Collection and Review

Advisory Task Force members analyzed quantitative and qualitative data to identify and confirm health priorities. In an effort to promote consistency in data collection and analysis among all hospitals, MedStar Health partnered with the Healthy Communities Institute (HCI) [6] and Holleran Consulting.[7]

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

HCI data were available by county or city and some measures were available by census track. If more localized data were available, the CCHD facilitated efforts to ensure they were accessible to Advisory Task Force members. *Baseline data for indicators that were not available, but deemed important by some hospitals, will be determined as a FY13 implementation action step.*

Qualitative Data

MedStar Health engaged Holleran, a public health consulting firm, to help each Advisory Task Force: 1) develop a community input tool; 2) conduct face-to-face community input sessions; 3) analyze findings and undergo a prioritization process; and 4) develop an approach to an implementation strategy.

Each ATF developed a community input survey that was disseminated to the residents and stakeholders of its CBSA. The tool included approximately 30 questions that allowed respondents to rate their perception of the level of importance around issues related to wellness and prevention, access to care and quality of life. Open-ended questions allowed them to offer suggestions on the hospital's role in addressing some of the community's most severe health issues. The majority of respondents completed the survey online. Hard copies were also available and respondents had the option to complete the survey over the phone. The survey was available in Spanish for hospitals that targeted Spanish speaking populations.

Over 900 surveys were completed systemwide. In an effort to capture a snapshot of the respondent population, demographic variables were collected for each respondent and aggregated in the hospital's final report. Variables included race, highest level of education, household annual income and health insurance status.

Face-to-face input sessions were open to residents and stakeholders of the targeted communities. Each hospital's session lasted 90 minutes. During the session, participants were asked the same questions that were included in the community input survey. However, respondents contributed their input through keypad technology, which allowed for more efficient prioritization of health concerns. The session concluded with breakout sessions that allowed participants to engage in guided conversations related to critical issues that impact the health of their community. The dialogue allowed facilitators to identify important trends and issues that would inform the hospital's approach to its implementation strategy.

In addition to face-to-face input sessions for the community at-large, another community input session was held with public health leaders in two jurisdictions where MedStar Health has more than one hospital – Baltimore City and the District of Columbia. There were 23 participants in the session held in the District of Columbia and 7 participants in the Baltimore City session. Participants included representatives from the Department of Health, federally qualified health centers, community clinics, the United Way, the Catholic Health Association, schools of public health and healthcare coalitions.

Local, State and National Health Goals

In addition to reviewing primary and secondary data, Advisory Task Force members reviewed city, state and national health goals. For example, Maryland hospital task force members reviewed the priorities outlined in Maryland's State Health Improvement Process;[8] Baltimore City task force members reviewed Healthy Baltimore 2015;[9] and all task force members reviewed Healthy People 2020[10] targets. Awareness of these targets helped task force members understand the context of national, state and local jurisdiction health goals as they prioritized health issues.

As part of the assessment, all MedStar hospitals collaborated with or received input from their local health departments. For example, Baltimore City hospital presidents had a series of meetings with the Baltimore City Health Commissioner to explore opportunities to align the city's lead health priority, heart disease, with hospital activities.

Summary of Systemwide Key Findings

Although Community Health Needs Assessments were specific to each hospital, all hospitals identified heart disease as a key health priority. All MedStar hospitals in Baltimore City and MedStar Georgetown University Hospital and MedStar Washington Hospital Center in the District of Columbia identified diabetes as a priority. Priorities were selected by quantitative data analyses and corroborated by stakeholder and community input.

Key Finding: A high prevalence of heart disease with noteworthy gender and racial disparities in some jurisdictions.

Washington Hospitals

- *District of Columbia:* The age adjusted death rate due to coronary heart disease is 184.1 per 100,000. Compared to all US counties, this figure falls within the range of the worst quartile. The rate is also significantly higher than the Healthy People 2020 target (100.8/100,000).[11] The age adjusted death due to coronary heart disease is significantly higher in Blacks/African Americans (228.1/100,000) compared to Whites (116.0/100,000).[11] It is also significantly higher in men (247.2/100,000) than women (140.3/100,000).[11]

- *St. Mary's County:* The age adjusted death rate due to heart disease is 234.4 per 100,000.[12] Compared to all Maryland counties, this figure falls within the range of the worst quartile.[12]

- *Montgomery County:* 38.7% of Montgomery County residents age 18 and older have high cholesterol. This percentage is higher than the state average and ranks within the 25th to 50th percentile of all Maryland counties. It also exceeds the Healthy People 2020 target (13.5%).[13]

Baltimore City Hospitals

- *Baltimore City:* The age adjusted death rate due to heart disease is 262.9/100,000.[12] Compared to all Maryland counties, this figures falls within the worst quartile.[12] The death rate is significantly higher in men (339.1/100,000) than women (209.9/100/000).[12]

- *Baltimore County:* 33.8% of Baltimore County residents age 18 and older have hypertension.[13] This percentage is higher than the state average and ranks among the worst quartile of all Maryland counties. It also exceeds the Healthy People 2020 target (26.9%).[13] The prevalence of hypertension is also higher in Blacks/African American (48%) than Whites (31.7%).[13]

- *Anne Arundel County:* The age adjusted death rate due to heart disease is 196.8 per 100,000. Compared to all Maryland counties, this figure falls within the range of the worst quartile.

Key Finding: A high prevalence of diabetes with noteworthy racial disparities in the District of Columbia and Baltimore City.

District of Columbia
10.9% of District of Columbia residents age 18 and older have been diagnosed with diabetes.[14] Compared to all US states, this percentage is within the worst quartile.[14] The prevalence of diabetes is significantly higher in Blacks/African Americans (17.5%) than Whites (3.6%).[14]

Baltimore City
12.9% of Baltimore City residents age 18 and over have diabetes[13] and the age adjusted death rate due to diabetes in Baltimore City is 31.9/100,000.[12] Compared to all Maryland counties, these figures rank among the worst quartile.[13] The prevalence of adults with diabetes is higher in Blacks/African Americans (15%) than Whites (9.6%) and the age adjusted death rate in Blacks/African Americans is higher (39.0/100,000) than whites (21.7/100,000).

Heart Disease Statistics

Measure	District of Columbia	St. Mary's County	Montgomery County	Baltimore City	Baltimore County	Anne Arundel County	Healthy People 2020
Age adjusted death rate due to heart disease (per 100,000)	184.1	234.4	131.0	262.9	196.6	198.8	N/A
% of adults with high blood pressure	26.1	24.0	24.5	**36.7***	**33.8***	**28.5***	26.9
% of adults with high cholesterol	**34.6***	**33.4***	**38.7***	**36.1***	**36.2***	**34.9***	13.5

**percentage exceeds Healthy People 2020 goal*

Key findings from surveys and community input sessions

Over 900 surveys were completed throughout region and nine community input sessions were conducted. The following opportunities were consistently identified across the system:

Wellness and Prevention: Respondents expressed an ongoing need for programs and services that address heart disease, overweight/obesity, diabetes and cancer. Efforts to increase awareness of existing wellness and prevention services were also suggested.

Access to Care: Respondents recommended that providers bring health services directly into the communities that need them most. Increasing the accessibility of specialty care providers for the underinsured and uninsured and enhancing access to convenient and affordable transportation for medical visits were also high priorities.

Quality of Life: Respondents suggested comprehensive efforts to improve the quality and safety of neighborhoods to promote physical activity and healthy living. Increasing access to affordable healthy foods was also identified as a need.

Community Benefit Service Areas and Priorities

Community Benefit Service Areas

Each hospital's Advisory Task Force identified a Community Benefit Service Area (CBSA) – which is defined as a geography or target population that will serve as the hospital's priority for future community benefit programming. CBSAs were determined based on the following key considerations: 1) a high density of residents who are low-income or underserved; 2) the CBSA's proximity to the hospital; and 3) an existing presence of effective programs and partnerships.

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

Common Priorities

The terminology used to depict each priority was determined by the hospital's Advisory Task Force and based on what was preferred and resonated most with the community. For example, community members preferred the term "heart disease" over "cardiovascular disease" and some hospitals selected heart disease as a priority, while others selected a risk factor for heart disease as a priority. MedStar Georgetown University Hospital will focus on the reduction of hypertension in its service area and MedStar St. Mary's Hospital will implement activities aimed to reduce the percentage of obese or overweight residents in its service area. The majority of acute hospitals identified diabetes as a priority. While the terminology may be unique, many of the educational and preventive activities for heart disease, diabetes, obesity and hypertension are interrelated.

Unique Priorities

Quantitative and qualitative findings, coupled with pre-existing partnerships allowed some hospitals to identify unique priorities. MedStar St. Mary's Hospital selected substance abuse based on quantitative data and alignment with a pre-determined county priority. MedStar Franklin Square Medical Center selected substance abuse and asthma due to a pre-existing partnership with the Southeastern Network Collaborative and Baltimore County Public Schools, respectively. MedStar National Rehabilitation Hospital identified prevention of recurrent stroke among persons who speak Spanish as a primary language as a unique and underserved population in the rehab community.

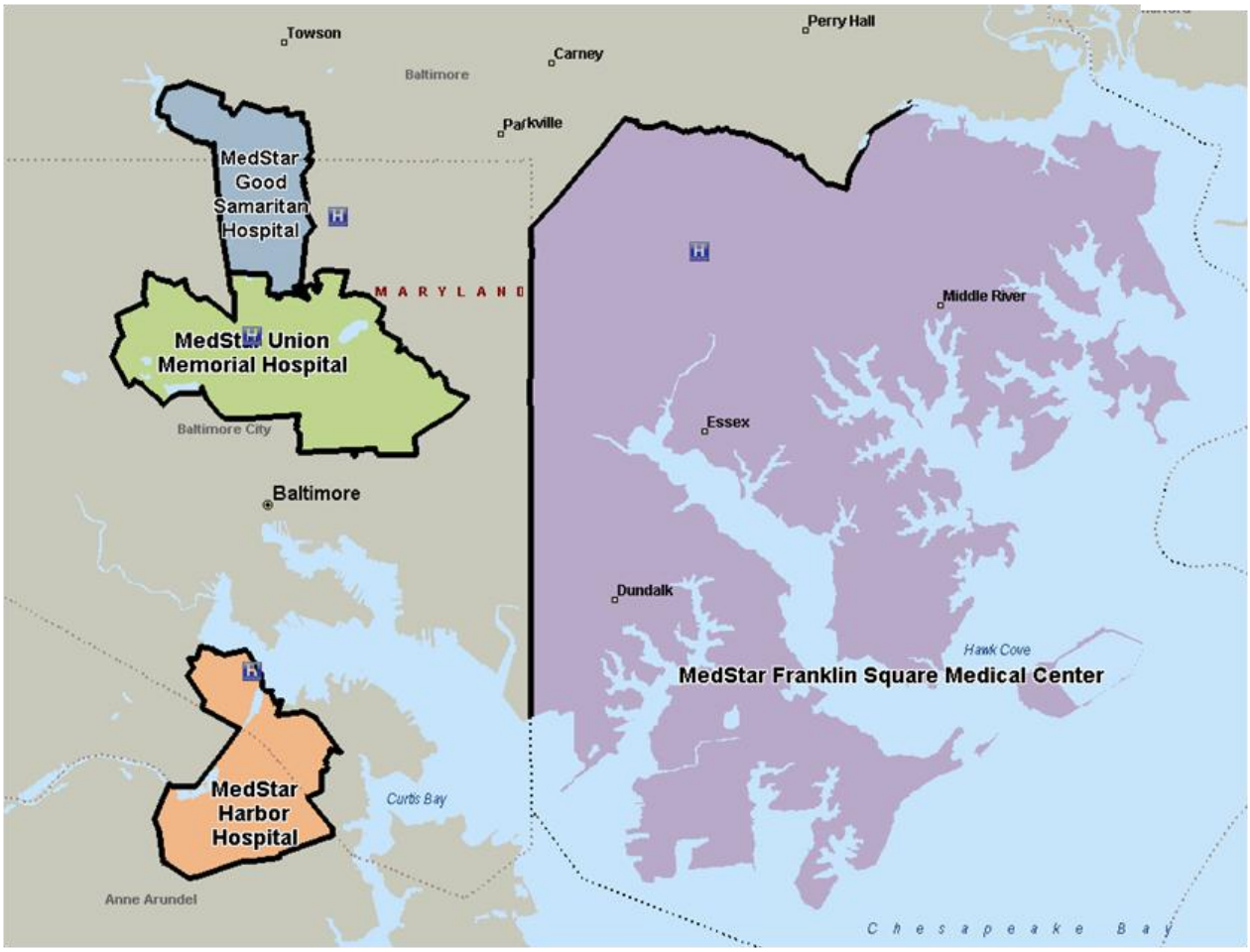
Services Provided Outside of the CBSA

MedStar hospitals have a history of contributing to the health of the region by providing services outside of their CBSAs. These programs and services address health awareness, education, early detection and prevention of disease. Hospitals will continue to maintain a presence in these areas; however, the CBSA will serve as the population of focus. Activities within the CBSA will be evaluated or refocused for more rigorous outcomes tracking. Promising practices will be piloted and evidence-based programs will be replicated in the CBSA.

Overview of Individual Hospital Community Benefit Service Areas and Health Priorities

Baltimore Hospitals

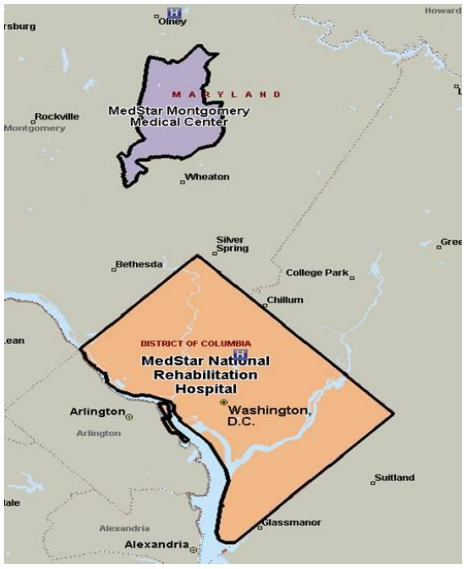
	MedStar Franklin Square Medical Center	MedStar Good Samaritan Hospital	MedStar Harbor Hospital	MedStar Union Memorial Hospital
Heart Disease	X	X	X	X
Diabetes		X	X	X
Substance Abuse	X			
Asthma	X			
Community Benefit Service Area	Southeast Baltimore County	Greater Govans	Cherry Hill / Brooklyn Park	North Central Baltimore City



Washington Hospitals

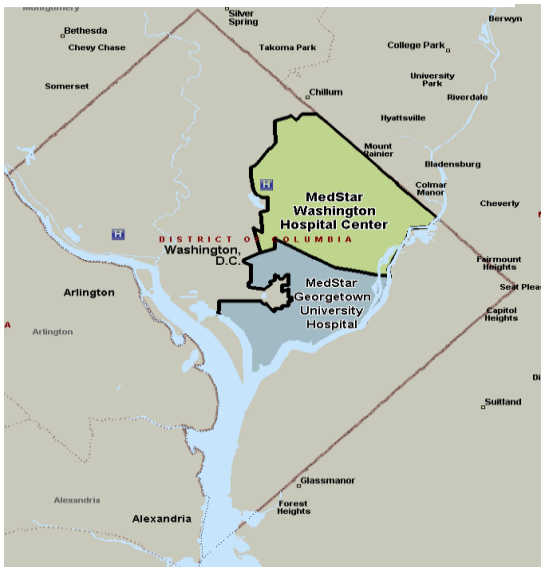
	MedStar Georgetown University Hospital	MedStar Montgomery Medical Center	MedStar National Rehabilitation Hospital	MedStar St. Mary's Hospital	MedStar Washington Hospital Center
Heart Disease	X	X		X	X
Diabetes	X			X	X
Obesity	X			X	X
Substance Abuse				X	
Stroke			X	X	
Community Benefit Service Area	Ward 6	Aspen Hill / Bel Pre	Spanish speaking stroke survivors and their caregivers	St. Mary's County with emphasis on Lexington Park	Ward 5

MedStar Montgomery Medical Center
MedStar National Rehabilitation Hospital



MedStar St. Mary's Hospital

MedStar Georgetown University Hospital
MedStar Washington Hospital Center



Implementation Strategy Approach

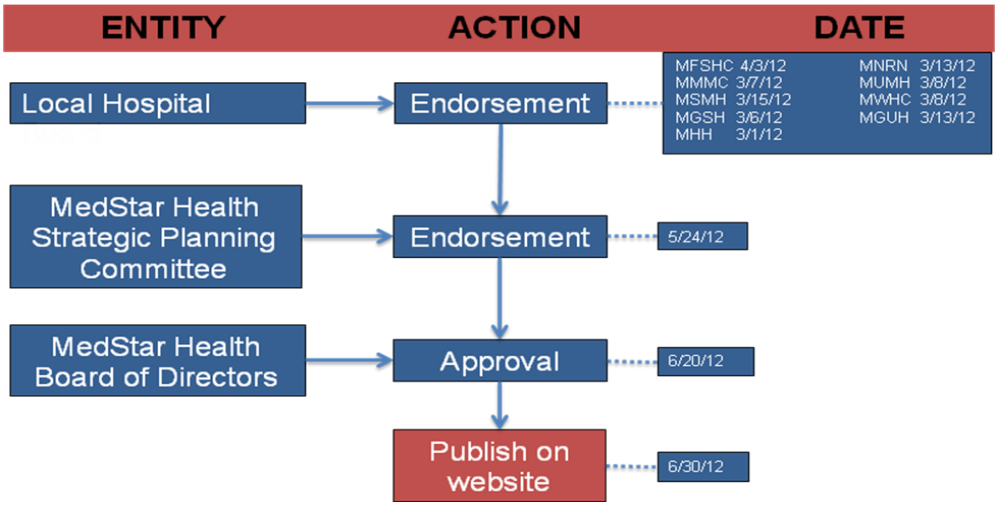
The Implementation Strategy serves as a roadmap for how community benefit resources will address the health priorities and contribute to the health of the communities served. In an effort to improve outcomes and measure progress over time, the activities are few and focused. The programming component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

- Including specific short- and long-term measurable outcomes.
- Refining or expanding existing programs and services that are aligned with health priorities.
- Sustaining, enhancing or identifying new partners.
- Focusing on the expansion of services directly into communities of need.
- Identifying and testing promising practices for replication throughout the system.
- Developing common programming to support heart disease, the system priority.
- Leveraging expertise throughout the system.
- Sharing and using existing human and operating resources to support priorities.

The activities documented in the Implementation Strategy will undergo extensive evaluation. Process evaluations will support continuous quality improvement efforts to enhance how the activity is delivered and outcome evaluations will assess for a change in knowledge, skill or health status among persons impacted. In an effort to support local and national health disparity goals, mechanisms for more robust demographic data collection will be established. Examples include but are not limited to: race/ethnicity, primary language, culture and religious affiliation.

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

IMPLEMENTATION STRATEGY ENDORSEMENT AND APPROVAL PROCESS



Institutionalizing Performance

Corporate Community Health Department (CCHD)
The CCHD Department will provide systemwide leadership to optimize the outcomes of the hospital's implementation strategy. The Department will manage the activities of a Community Benefit Workgroup, identify a common platform for tracking and measuring performance, and identify new partners and sustain relationships with existing partners who support a systemwide strategy. The Department will also work with Hospital Leads to support the execution of implementation strategies and convene groups to support the replication of evidence-based programs across the system.

- Community Benefit Workgroup
  The Community Benefit Workgroup is comprised of Hospital Leads and other internal community health associates. The workgroup convenes quarterly and meetings are designed to promote information exchange, disseminate new guidelines and performance measures, ensure consistency in documentation and data collection, and advance the knowledge, skills and abilities of individual team members.

- Tracking and Measurement
  The Corporate Community Health Department will identify, develop and implement a common platform for documenting demographics and change in knowledge, skills or health status of persons impacted. The department will provide guidelines and provide technical support to promote consistency across all hospitals.

- Partnerships
  Heart disease is a systemwide priority for MedStar Health. Activities to prevent heart disease and promote healthy living among persons with heart disease are included in each hospital's implementation strategy. The CCHD Department will lead efforts to cultivate partnerships that will expand the hospitals' capacity to contribute to the reduction of heart disease in vulnerable populations. The CCHD will also explore opportunities to expand MedStar Health's partnership with the Department of Health and Human Services as a member of the Million Hearts Campaign.

Hospital Leadership
Senior leaders who oversee the hospital's community benefit activities will support efforts to identify resources that can be allocated or reorganized to support the priorities and activities documented in the implementation strategy. Hospitals leaders will also identify and support opportunities to integrate community benefit activities with the relevant requirements of each hospital's accreditation or certification programs.

Advisory Task Force, Board Leadership and Community Updates
Annual updates on the progress of the implementation strategy will be provided to the hospital's Advisory Task Force, the Board of Directors and the MedStar Health Strategic Planning Committee. Updates will also be available to the community and stakeholders through the MedStar Health corporate website.

Resources

[1] http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx
[2] http://www.communityhlth.org/
[3] http://www.apha.org/
[4] http://www.irs.gov/pub/irs-tege/frepthospproj.pdf
[5] http://housedocs.house.gov/energycommerce/ppacacon.pdf
[6] http://www.healthycommunitiesinstitute.com/
[7] http://www.holleranconsult.com/
[8] http://dhmh.maryland.gov/ship/SitePages/Home.aspx
[9] http://www.baltimorehealth.org/healthybaltimore2015.html
[10] http://www.healthypeople.gov/2020/default.aspx
[11] http://wonder.cdc.gov/ucd-icd10.html
[12] http://www.dhmh.state.md.us/
[13] http://www.marylandbrfss.org/
[14] http://apps.nccd.cdc.gov/brfss/

For more information on MedStar Health's Community Health Assessment, please contact the Corporate Community Health Department
410-772-6693 or Jessica.Roach@medstar.net

Individual Hospital Assessments

Baltimore Hospitals

MedStar Franklin Square Medical Center
Community Health Assessment FY2012

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

MedStar Franklin Square Medical Center's (MFSMC) Community Benefit Service Area (CBSA) includes residents of zip codes 21206, 21219, 21220, 21221, 21222, 21224, and 21237. This region was selected due to the hospital's pre-existing partnership with the Baltimore County Southeast Area Network – a volunteer community organization that monitors and works to improve the health of residents in the southeastern portion of Baltimore County. Based on quantitative and qualitative findings, asthma management among children, awareness of resources concerning alcohol and substance abuse and heart health have been identified as the MedStar Franklin Square Medical Center's community benefit priorities.

2. Provide a description of the CBSA.

The total population of the seven ZIP codes that make up the MedStar Franklin Square's CBSA is 271,230. The majority of the population is white (67.0%), followed by Black/African American (26.8%), Asian (1.6%), other (1.5%), American Indian/Alaskan Native (0.7%) and Native Hawaiian/Pacific Islander (0.1%). An additional 2.4% of people identify with two or more races/ethnicities. Adults ages 18-44 account for 37.0% of the population, while those younger than 18 represent 22.8% of the population and those over the age of 65 represent 14.1%. The weighted average annual household income in Southeast Baltimore County is $47,241, as compared to $63,279 in Baltimore County as a whole (Claritas, 2011).

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

The community benefit priorities were recommended by an Advisory Task Force, which consisted of Baltimore County representatives from the Health Department, Department of Social Services, Local Management Board, Office of Planning and MedStar Franklin Square representatives from Community Outreach, Community Medicine, Senior Management, Board, Patient Advocacy, Marketing, Family Practice, and Healthcare for the Homeless.

The Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the Medical Center's operating plan, the outcomes of prior community health assessments and current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life. The Advisory Task Force invited key local partners, including area non-profit service providers and representatives from the Maryland State Department of Education**,** Baltimore County Public Schools and the Department of Aging to a community benefit planning forum to evaluate the survey results, identify priorities, and plan collaborative action steps.

In addition to quantitative and qualitative findings, the Task Force considered the hospital's strengths as well as local, regional and/or state health goals. Based on findings, the Task Force made a recommendation on the priorities, which were then approved by the MedStar Franklin Square Medical Center's President, endorsed by the MFSMC Board of Directors and the MedStar Health Board of Director's Strategic Planning Committee and approved by the MedStar Health Board of Directors.

Advisory Task Force Members

Name	Title	Organization
Janet Rafky	Sr. Dir, Patient Advocacy	MedStar Franklin Square
Tricia Isennock, MS, RN-BC, MCHES	Community Outreach Mgr.	MedStar Franklin Square
Trina Adams	AVP Marketing	MedStar Franklin Square
Nick D'Alesandro	Community Liaison	Baltimore County Social Services
Gregory Branch, MD	County Health Officer	Baltimore County Department of Health
Terri Kingeter	Sector Coordinator	Baltimore County Planning Office
Caryn Koterwas	Marketing Specialist	MedStar Franklin Square
Scott Krugman, MD	Community Medicine Service Line Director	MedStar Franklin Square
Patricia Norman	Board Member	MedStar Franklin Square
Sally Rixey. MD, MEd	FHC Chief of Family Practice	MedStar Franklin Square
Karen Robertson-Keck	VP, Human Resources	MedStar Franklin Square
Don Schlimm	Acting Executive Director	Baltimore County Local Management Board
Kelechi Uduhiri. MD, MPH, MS	Medical Director	Healthcare for the Homeless - Baltimore County
Rene Youngfellow, RN	Division Chief, Clinical Services-Center Based Services	Baltimore County Department of Health

Key Community Partners in Community Benefit Planning

Name	Title	Organization
Donna Bilz	Healthscope Director	Baltimore County Department of Aging
Wendy Freeman	PartnerSHIP Program Director	Baltimore County Department of Health
Susan Hahn	Parent Support Services	Baltimore County Public Schools
Diane Kretzschmar, RN, PNP, CCE, PN	Parish Nurse Coordinator	MedStar Franklin Square
Mike Mason	Specialist Physical Education	Maryland State Department of Education
Joanne McAuliffe	Oncology Service Line Director	MedStar Franklin Square
Karen Polite-Lamma RN, BS, BSN, CCE, MCHES	Education Specialist	MedStar Franklin Square
Laura Riley	Deputy Director, CountyRide	Baltimore County Department of Aging
Kristin Scilipoti	Health Educator	MedStar Franklin Square

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

a) Community Asthma Management	
Quantitative Evidence	• At 21.9%, the percentage of children diagnosed with asthma is higher than any surrounding county and higher than the state percentage (16.4%). This statistic translates into missed days of school, limitations on daily activities, visits to the emergency department for treatment of asthma symptoms, and hospitalizations. • MedStar Franklin Square Medical Center CY2011 Asthma Statistics: - Pediatric ED visits: 449 - Admissions: 143 - Transferred to PICU: 13 • Baltimore County Public Schools (BCPS) 2010-11 (total enrollment 104,000 students): - 13,344 students with asthma diagnosis - 4,831 students had asthma medication orders at school
Qualitative Evidence	BCPS school nurses report increased nurse visits and 911 transfers of students from school to emergency room due to asthma
Hospital Strengths	Center of Excellence for Pediatric Asthma Management
Alignment with local, regional, state or national health goals	• Healthy People 2020 Respiratory objectives RD-1 through RD-7 • Maryland State Health Improvement Plan (MD SHIP): Child Health • BCPS stats • Southeast Network: Keeping children safe and healthy
Other justification	Resource access (spacers, management plans) is limited in this area due to economic status

b) Resource Awareness - Tobacco Use and Substance Abuse Prevention/Cessation	
Quantitative Evidence	• Registration for free tobacco cessation programs at MedStar Franklin Square is frequently so low that programs are cancelled • The current adult smoking rate in Maryland is 15.2% (MD BRFSS) • The current adult smoking rate in Baltimore County is 15.6% (MD BRFSS) • Tobacco use contributes to cancer, heart disease, and respiratory diseases (including emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death
Qualitative Evidence	• 70.3% (n=243) of Community Input Survey respondents think tobacco use is a “critical” or “very critical” issue • 27.3 (n=243) of Community Input Survey respondents “don’t know” that smoking cessation, prevention, education and support programs are available in Southeast Baltimore County • 28.3 (n=243) of Community Input Survey respondents “don’t know” that substance abuse prevention, education and support programs are available in Southeast Baltimore County • Only 41.4% (n=243) of Community Input Survey respondents “agreed” or “strongly agreed” that smoking cessation, prevention, education and support programs are available; 27.3% did not know; another 6.6% did not respond • Only 38.5% (n=243) of Community Input Survey respondents “agreed” or “strongly agreed” that substance abuse, prevention, education and support programs are available; 28.3% did not know; another 8.2% did not respond
Hospital Strengths	• Marketing department • Website • Partnerships – Southeast Network, Baltimore County Tobacco Coalition • Stop Smoking Today program (73% quit rate, N=5)
Alignment with local, regional, state or national health goals	• Healthy People 2020 TU-1 through TU-20; the HP2020 target is to reduce the proportion of adults who smoke to 12% • MD SHIP: Tobacco Use • Baltimore County plan: Tobacco Coalition
Other justification	N/A

c) Senior Heart Health	
Quantitative Evidence	• There are 195.4 deaths due to heart disease per 100,000 population in Baltimore County (MD DHMH & MD VSA, 2009) • There are 239.0 deaths due to heart disease per 100,000 population in Baltimore County (HSCRC, 2010) • Heart disease is the leading cause of death in Maryland, accounting for 25% of all deaths (MD SHIP) • 36.2% of people in Baltimore County report high cholesterol (MD BRFSS, 2009) • 33.8% of people in Baltimore County report high blood pressure (MD BRFSS, 2009) • Heart disease accounts for 26.5% of all deaths in Southeast Baltimore County (Community Needs Assessment, 2008)
Qualitative Evidence	• 81.8% (n=243) of Community Input Survey respondents rated heart disease to be “critical” or “very critical” • 73.4% (n=243) of Community Input Survey respondents rated stroke to be “critical” or “very critical”
Hospital Strengths	• Recipient of highest level of recognition for quality stroke care from the American Heart Association/American Stroke Association (AHA/AMA) • Relationship with Baltimore County Department of Aging
Alignment with local, regional, state or national health goals	• Healthy People 2020 HDS-1 through HDS-5 • MD SHIP: Reduce deaths from heart disease (Chronic Disease)
Other justification	N/A

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

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner
Domestic Violence/Child Abuse	Quality of Life	Triple P (Positive Parenting Program) Child Protective Team	Baltimore County Local Management Board Child Protective Team
Obesity	Wellness & Prevention; Quality of Life	Fit Families Heart Smart Trail Mall Walking	MedStar Franklin Square Family Health Center Department of Natural Resources White Marsh Mall Eastpoint Mall Baltimore County Local Health Coalition
Diabetes	Wellness & Prevention	Diabetes support group	
Heart Disease	Wellness & Prevention; Access to Care	Blood pressure screenings Women's Health Navigator	White Marsh Mall Eastpoint Mall Target Various community sites
Cancer	Wellness & Prevention; Access to Care	Community screenings	Community sites - businesses
Stroke	Wellness & Prevention; Access to Care	Blood pressure screenings Risk screening	White Marsh Mall Eastpoint Mall Target Various community sites
Infant mortality	Wellness & Prevention	Reducing Adverse Perinatal Outcomes Sleep Safety	Blue Cross Blue Shield Baltimore County Local Health Coalition Various community sites
Homelessness	Wellness & Prevention; Access to Care	Healthcare for the Homeless – Baltimore County	Baltimore County Communities for the Homeless Baltimore County: Office of Planning, Department of Health, Department of Social Services Area shelters

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

Condition / Issue	Classification	Source	Explanation
Transportation	Access to Care	42.1% (n=243) of Community Input Survey respondents found the quality of transportation to be "fair," "poor" or "very poor"	MFSMC does not have the expertise or infrastructure to serve as a lead around this area of need
Housing	Quality of Life	53.1% (n=243) of Community Input Survey respondents found the quality of housing to be "fair," "poor" or "very poor"	MFSMC does not have the expertise or infrastructure to serve as a lead around this area of need

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

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

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

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

Resources

- Claritas, 2011
- Healthy People 2020
- US Census 2010
- Maryland State Health Improvement Plan
- Maryland Vital Statistics Administration
- Maryland Department of Health and Mental Hygiene
- Maryland Health Services Cost Review Commission
- Maryland Behavioral Risk Factor Surveillance System
- Baltimore County Local Health Coalition
- Holleran Community Input Results – MedStar Franklin Square Medical Center

Implementation Strategy

Community Need: Asthma Care
Goal Statement: Improve the quality of asthma care for children in the fifty-one BCPS schools in the Community Benefit Service Area (CBSA) through standardized asthma management plans and spacer availability.
Target Population: Children who attend Deep Creek Elementary School, Golden Ring Middle School, and Kenwood High School

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Baltimore County Public School (BCPS) RNs MedStar Franklin Square Community Asthma Team MedStar Grant Development Team MedStar Franklin Square Outpatient Pharmacy	Continue collaboration with BCPS and area school nurses through the Community Asthma Team.	Convene monthly meetings to identify challenges, opportunities and resources.	Determine number of 911 calls due to asthma in target schools	Decrease 911 calls by 10%[1] from the fifty-one BCPS schools in the Community Benefit Service Area (CBSA)	Baltimore County Public Schools Community Asthma Team	Community Asthma Team
2		Facilitate the use of a standardized, accessible management plan form for each elementary school child experiencing asthma.	Identify and implement a standardized form Identify and eliminate barriers Promote the use of a standardized form	Identify the current number of children with diagnosed asthma with completed asthma action plans in target schools	Increase by 10% the number of completed asthma action plans in targeted schools by November 2014[2]	Baltimore County Public Schools Community Asthma Team	Maryland Department of Health and Mental Hygiene Baltimore County Public Schools Community Asthma Team
3		Increase the availability of spacers for use in schools	Identify and mitigate obstacles to spacer access Identify funding source(s) for spacers Obtain and distribute spacers to schools	Obtain funding to supply ten spacers to each of the fifty-one BCPS schools in the CBSA	Provide ten spacers to each of the fifty-one BCPS schools in the CBSA by November 2014	Baltimore County Public Schools Community Asthma Team	MedStar Franklin Square Outpatient Pharmacy Baltimore County Public Schools Community Asthma Team

[1] According to the BCPS RN Director, there were 63 911 calls from BCPS schools in 2011.
[2] Baseline will be established in 2013.

Community Need: Resource Awareness
Goal Statement: Increase the awareness of the public, providers and policy makers in the Community Benefit Service Area (CBSA) about available tobacco and other substance abuse prevention, education and support programs resources.
Target Population: Adults who live and/or work in the CBSA

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar Franklin Square Community Health Education (CHE) Stop Smoking Today (smoking cessation program) Baltimore County Department of Health Tobacco Coalition American Cancer Society American Heart Association Holleran	Identify obstacles to resource awareness	Hold three community input sessions with the Southeast Network, other healthcare providers, and community members	Increased awareness of tobacco and other substance abuse resources as indicated by the re-execution of the Holleran community input survey at all the previous sites November 2014: Decrease number of "Don't Know" responses by 10%[1]	Increased number of Stop Smoking Today participants by 10%	Baltimore County Department of Health Baltimore County Department of Aging Baltimore County Office of Planning Baltimore County Public Schools Southeast Area Network	Community Outreach Manager
2		Increase publicity about tobacco and other substance abuse resources.	Utilize MedStar Franklin Square marketing opportunities to publicize smoking and substance abuse cessation prevention, education and support programs in the CBSA[2] Collaborate with Baltimore County and area resource providers in related publicity campaigns Send brochure electronically to BCDH and SEN to be distributed to all providers and clients	Determine baseline participation in One Voice Dundalk.			AVP MedStar Franklin Square Marketing

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
3		Re-execution of the Holleran community input survey at all the previous sites	Distribute surveys	At least 250 community input surveys completed by November 2014	Increase participation in One Voice Dundalk by 10%		

[1] Holleran survey, Wellness and Prevention questions 4a (27.3%, n=243) and 4g (28.3%, n=243).
[2] Include information in the MedStar Health education calendar, MedStar Franklin Square website, and distribute 20 brochures in all MedStar physician offices and facilities in CBSA.

Community Need: Senior Cardiovascular Health
Goal Statement: Improve the quality of cardiovascular health for seniors attending the seven Baltimore County Department of Aging (BCDA) Senior Centers in the Community Benefit Service Area.
Target Population: Seniors attending the seven BCDA Senior Centers in the CBSA: Ateaze, Edgemere, Essex, Fleming, Overlea-Fullerton, Rosedale, and Victory Villa

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Baltimore County Department of Aging • Senior Centers • Fitness Centers • CountyRide MedStar Franklin Square • Community Health Education • Food and Nutrition • Consumer Health Library • Pharmacy • Fitness Coordinator • Family Medicine Residency Cardiovascular Nurse American Heart Association Million Hearts Initiative	Implement Heart Smart club[1] in each targeted Senior Center: Ateaze, Edgemere, Essex, Fleming, Overlea-Fullerton, Rosedale, and Victory Villa	Recruit 10 participants at each senior center Assess each participant for baseline heart health indicators[2] Collect pertinent heart health medical information[3] from each participant Hold monthly meetings (Oct – May) to discuss hearth health topics[4] Reassess heart health indicators[2] and BRFSS questions at end of program	Determine number of blood pressures in therapeutic range Increased number of screening participants who are aware of personal blood pressure numbers by 10%[5] 10% increased awareness of blood pressure/stroke risk factors as indicated by pre- and post tests[5]	Blood pressures in therapeutic range increased by 10%[5] Decreased number of hospital/ED visits for hypertension by 10% by participants[5]	Baltimore County Department of Aging University of Maryland, Baltimore and Notre Dame of Baltimore Pharmacy students Eastpoint Mall White Marsh Mall	Health Educator Community Outreach Manager

[1] Name tentative
[2] Height, weight, blood pressure, body mass index (BMI), waist circumference, cholesterol, glucose
[3] Behavior Risk Factor Surveillance System (BRFSS) questions, current medications, any advance directives on file, emergency information, recent (within the past year) doctor/hospital/emergency department visits
[4] I.e., risk factor education, self-management techniques, resource navigation, health literacy
[5] Baseline will be established on first day of program.

MedStar Good Samaritan Hospital
Community Health Assessment FY2012

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

MedStar Good Samaritan Hospital's Community Benefit Service Area includes residents of the Govans area of Baltimore (ZIP code 21212). The area was selected due to its close proximity to the hospital, coupled with a high density of residents with low incomes. Based on quantitative and qualitative findings, primary and secondary prevention of heart disease and diabetes have been identified as the hospital's community benefit priorities.

2. Provide a description of the CBSA.

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

According to statistics from the Baltimore City 2011 Neighborhoods Health Profile, the total population in Govans is just over 10,000, the majority of which is African American (91.3%). Caucasians make up 5.7% of the population, 0.5% is Asian, 1.3% is Hispanic, and 2.5% is two or more races or other. Adults over the age of 18 years old make up three-quarters (75.6%) of the population, with seniors over age 65 years at 12.8%. Children under the age of 18 account for 24.4% of the Govans population. The median annual household income is $37,000, about the same as Baltimore City, while unemployment is 14.9%, higher than the average of Baltimore City (11.0%). Just over one-quarter (26.9%) of households are headed by a single-parent. The poverty rate is 11.6%, slightly less than that of Baltimore City (15.7%). In 2011, approximately 1,400 local families in the Govans area received assistance from CARES, a combination Food Pantry and Emergency Financial Assistance center. Over two-thirds (62.2%) of residents over 25 years of age have at most a high school. Life expectancy is 73.9, just longer than that of Baltimore City (71.8). The top causes of death are heart disease (24.9 per 10,000), cancer (19.5 per 10,000), HIV/AIDS (4.9 per 10,000), stroke (4.2 per 10,000), and diabetes (2.6 per 10,000).

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

The Community Benefit priorities were recommended by an Advisory Task Force, which consisted of local residents, a member of a local community organization, a public health professional, a local church pastor, two physicians, and hospital personnel.

The Advisory Task Force reviewed local secondary data, coupled with city, state and federal community health goals. Task Force members also reviewed the hospital's operating plan, as well as current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

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

Advisory Task Force Membership

Name	Title / Affiliation with Hospital	Name of Organization
Jennifer Wilkerson	VP Planning and Business Development	MedStar Good Samaritan
Deborah Bena, RN	Parish Nurse	MedStar Good Samaritan
Dobbin Chow, MD	Primary Care Physician	MedStar Good Samaritan
Bernadette Donnenberg, RN	Staff Nurse/local resident	MedStar Good Samaritan
Catherine Evans, PhD	Board Member	Northeast Development Alliance & Northeast Community Organization
Pastor Alvin Gwynn, Sr.	Local Pastor	Friendship Baptist Church
Karen Kansler, RN	Community Outreach Nurse	MedStar Good Samaritan
Moria Larson, MD	Physician, President of Medical Staff	MedStar Good Samaritan
Jeffrey Matton	President	MedStar Good Samaritan
Barbara Metz	Director of Social Ministry	St. Matthew Catholic Church
Rachael V. Neill	Director	CARES
Allan Noonan, MD, MPH	Director of Public Health Program Board Member	Morgan State University MedStar Good Samaritan
Kris Roeder	Director, Marketing and Public Relations	MedStar Good Samaritan

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

a) Heart Disease	
Quantitative Evidence	• Heart disease is the leading cause of death in Baltimore City (Healthy Baltimore 2015) • The age-adjusted death rate due to heart disease is 262.9 deaths per 100,000 – placing it in the "red zone" for severity and prevalence (DHMH, 2011) • The life expectancy at birth of a Govan's resident is 73.9 and heart disease accounts for 25.7% of all deaths (Baltimore City Neighborhood Profile, 2011)
Qualitative Evidence	The majority (62.5%; n=40) of Community Input Survey respondents classified the incidence of heart disease as "severe" or "very severe."
Hospital Strengths	• MedStar Good Samaritan Hospital has a cardiology program designed to diagnose and treat cardiac patients at every juncture in the clinical pathway • Cardiac and vascular services feature experienced specialists and state-of-the-art programs for the diagnosis and treatment of cardiovascular diseases • The hospital has an out-patient phase II cardiac rehabilitation program and a congestive heart failure wellness center housed in the Good Health Center. Community Outreach programs include heart health and nutrition talks, exercise programs, and health screenings, including blood pressure and cholesterol
Alignment with local, regional, state or national health goals	All local, regional, state and national health goals identify heart disease as a priority health condition. • Healthy People 2020 HDS-1 through HDS-5 • MD SHIP: Reduce deaths from heart disease
Other justification	Heart Disease is a condition that aligns with stated and documented community need, along with MedStar Good Samaritan Hospital's core competencies, both clinically and in the community outreach infrastructure

b) Diabetes	
Quantitative Evidence	• "In 2007, diabetes was the seventh leading cause of death in the United States. In 2010, an estimated 25.8 million people or 8.3% of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older. The burden of diabetes in the United States has increased with the increasing prevalence of obesity. Multiple long-term complications of diabetes can be prevented through improved patient education and self-management and provision of adequate and timely screening services and medical care." (MD BRFSS) • "From 2008, the average prevalence of diagnosed diabetes among white Marylanders was 7.5% and 12.3% among black Marylanders. Black females (12.5%) had almost double the diabetic rates of white females (6.8%). Although diabetes is widely associated with older age, the older working age population (50-64) represents the fastest growing diabetic group in Maryland. Additionally, 15.4% of diabetic Marylanders have less than a high school education and 17.1% of diabetic Marylanders earn less than $15,000 annually." (Healthy Maryland – Project 2020)
Qualitative Evidence	The majority of Community Input Survey respondents (75%; n=40) classified the incidence of diabetes as "severe" or "very severe."
Hospital Strengths	MedStar Good Samaritan Hospital has a variety of services to treat and manage diabetes. Experienced endocrinologists provide both inpatient and outpatient care to patients with diabetes The Diabetes Center, located in the Good Health Center, has a certified diabetes educator and registered dietitian that teach the skills needed to self-manage the disease. The Good Health Center also has a phase III fitness program, where doctors can refer their patients for medically supervised exercise. Community outreach nurses facilitate a six-week workshop call "Living Well…Managing Your Diabetes," which is provided to the community. This is an evidenced-based program developed by Stanford University.
Alignment with local, regional, state or national health goals	As stated above, the state of Maryland via numerous research modalities and reports, including Healthy People 2020, has identified diabetes as a significant, and growing, health problem. In particular, minorities, who make up a large portion of the Govans population, are disproportionately affected by this condition.
Other justification	Diabetes is a condition that aligns with stated and documented community need, along with MedStar Good Samaritan Hospital's core competencies both clinically and in the community outreach infrastructure.

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

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner (name and contact person)
Cancer	Access to Care	"Take a Stand for Breast Health" – grant funded program to increase number of women receiving mammograms	Komen Foundation
	Wellness & Prevention	Look Good Feel Better Program – program designed to help women who are receiving cancer treatments	American Cancer Society
	Wellness & Prevention	Annual Prostate Screening – provided by the Good Health Center	American Cancer Society
HIV	Access to Care	Under the direction of the Chief of Infectious Diseases, MedStar Good Samaritan operates a clinic that cares for 240 people living with HIV and AIDS.	Primary Care Center at MedStar Good Samaritan
Obesity	Wellness & Prevention	Good Health Center- phase III exercise program Tai' Chi Exercise Program – meditative exercise for all ages Sign Chi Do Exercise Program – meditative exercise for all ages Bring Back Balance- comprehensive exercise for all ages Senior Chair Exercise Program- comprehensive exercise program for seniors	Action in Maturity Senior Program Baltimore County Department of Aging Action in Maturity Senior Program
Stroke	Wellness & Prevention	MedStar Good Samaritan Hospital's "Know Stoke" program	Local Senior Centers

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Mental/Behavioral Illness	Wellness & Prevention	57.5% (n=40) of Community Input Survey respondents rated mental/behavioral illness to be "severe" or "very severe"	MedStar Good Samaritan has one on-campus psychiatric practice that perpetually operates near or at capacity. The MedStar Baltimore hospitals are exploring new partnerships to allow them to better meet the health needs of patients with mental/behavioral illness. At this time, the hospital does not have the infrastructure or the core competencies to effectively deliver community benefit programs around this area of need.
Substance Abuse	Quality of Life	64.7% (n=34) of Community Input Survey respondents rated substance abuse to be "severe" or "very severe"	MedStar Good Samaritan does not have services at this time to effectively deliver community benefit programs around this area of need.
Infant Mortality	Wellness & Prevention	Statistics from the 2011 Neighborhood Health Profile, Infant Mortality Rate10.6 per 1,000 live births (2005-2009).	MedStar Good Samaritan does not offer obstetrical services.
Chronic Lower Respiratory Disease (includes chronic obstructive pulmonary disease, emphysema, chronic bronchitis, and asthma)	Wellness & Prevention	The 5th cause of death in Baltimore City according to the 2011 Neighborhood Health Profile	A major risk factor of chronic lower respiratory disease is smoking. MedStar Good Samaritan Hospital will focus on smoking cessation in the Implementation Strategy related to heart disease. Although MedStar Good Samaritan will not make this a top priority, the hospital does offer a smoking cessation support group and thus is already addressing this need.

Obesity	Wellness & Prevention	• 70.0% (n=40) of Community Input Survey respondents rated obesity to be “severe” or “very severe” • Adult and childhood obesity are listed as the Maryland State Health Improvement Process goals.	MedStar Good Samaritan will focus on obesity as related to heart disease and diabetes rather than as an individual priority.
Neighborhood Safety	Quality of Life	• Only 15.0% (n=40) of Community Input Survey respondents identified the quality/availability neighborhood safety to be “good” or “excellent” • According to the following statistics there is a significant amount of crime in the neighborhood. Homicide rate is 15.9 per 10,000, domestic violence rate is 41.0 per 1,000, juvenile arrest rate is 104.6 per 1,000 (Baltimore Neighborhood Indicators Alliance from the Baltimore City Police Department)	As a local hospital, MedStar Good Samaritan does not have the infrastructure or specialized knowledge to address this as a priority, but the hospital is committed to working as a partner with local officials and community organizations to reduce the crime rate in this area.

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

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

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

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

Resources

- Baltimore City 2011 Neighborhoods Health Profile
- Healthy Baltimore 2015
- Maryland Department of Health and Mental Hygiene
- Maryland Behavioral Risk Factor Surveillance System
- Healthy Maryland – Project 2020

Implementation Strategy

Community Need: Heart Disease
Goal Statement: Increase awareness of heart disease prevention through educational programs and screening
Target Population: Low-income adults ages 18 and over who reside in the Govans area of Baltimore

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar Good Samaritan public relations department	Increase partnerships with local and faith-based organizations	Form and strengthen at least 2 partnerships with local and/or faith-based organizations Provide partnering faith-based organizations with monthly heart health bulletin and educational brochures	Form 1 new partnership and/or expand 1 existing partnership each year	Maintain and strengthen existing partnerships		Health Ministries Coordinator
2	Dietician Community Outreach Nurse Fitness Specialist Director, CARES	Conduct community education classes and workshops in partnership with CARES	Pilot one 5-week session with 20 participants Develop and implement pre- and post-educational assessments to demonstrate improvements in health behaviors	Develop the program based on pilot session results 65% of participants score higher on post assessment, demonstrating increase in knowledge and health behaviors	Scale up educational classes and workshops, holding one session each quarter 70% of participants score higher on post assessment, demonstrating increase in knowledge and health behaviors	CARES Food Pantry St. Mary's of the Assumption Church Senior Network of North Baltimore (promotional support)	Health Ministries Coordinator

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
3	MedStar Good Samaritan public relations department Local churches, health care facilities, partnering organizations, etc.	Develop communication plan to increase participation in community-based programs	Distribute 2,000 flyers to partnering organizations and health care facilities throughout the Govans area of Baltimore Promote program in "MedStar Focus On You Newsletter"	Establish a baseline number of participants	Increase participation in programs by least 5% each year		Health Ministries Coordinator Director, Marketing and Communications

Community Need: Diabetes
Goal Statement: Increase awareness of diabetes prevention and diabetes management through educational programming
Target Population: Low-income adults ages 18 and over who reside in the Govans area of Baltimore

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Diabetes educator American Diabetes Association	Conduct community education classes and workshops in partnership with CARES concerning diabetes prevention and management of disease	Pilot one 5-week session with 15 participants Develop and implement pre- and post-educational assessments to demonstrate improvements in health behaviors	Review pilot session results (i.e. pre- and post-test results; attendance) and improve and modify program as necessary 65% of participants score higher on post-assessment, demonstrating increase in knowledge and health behaviors	Scale up educational classes and workshops, holding one session each quarter 70% of participants score higher on post assessment, demonstrating increase in knowledge and health behaviors	CARES Food Pantry St. Mary's of the Assumption Church	Health Ministries Coordinator
2	"Living Well…Take Charge of Your Diabetes" education booklet and CD	Implement evidence-based program "Living Well…Take Charge of Your Diabetes," developed by Stanford University	Teach at least one 6-week workshop series At least 10 participants will complete the program	Teach at least two 6-week workshop series Maintain at least 10 participants during each series 65% of participants score higher on post assessment, demonstrating increase in knowledge and health behaviors (i.e. better self-management of diabetes and diabetes-related conditions)	Maintain two 6-week workshops Maintain at least 10 participants during each series 70% of participants score higher on post assessment, demonstrating increase in knowledge and health behaviors (i.e. better self-management of diabetes and diabetes-related conditions)	CARES Food Pantry St. Mary's of the Assumption Church Baltimore City Health Department or Baltimore County Department of Aging	Health Ministries Coordinator Community Outreach Nurse

MedStar Harbor Hospital
Community Health Assessment FY2012

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

MedStar Harbor Hospital's Community Benefit Service Area includes all residents of Baltimore City ZIP code 21225, the hospital's home zip code. In particular, the hospital will focus on the Cherry Hill community. This area was selected due to a high density of residents with low incomes, its close proximity to the hospital, as well as the opportunity to build on pre-existing programs, services, and partnerships. Based on quantitative and qualitative findings, primary and secondary prevention of heart disease and diabetes have been identified as the hospital's community benefit priorities.

2. Provide a description of the CBSA.

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

Statistics gathered in the 2000 census indicated that Cherry Hill's population fell by nearly 30 percent between 1990 and 2000. U.S. Census data from 2010 lists the current population of ZIP code 21225 at 33,545. The population of Cherry Hill in 2010, according to the Baltimore City 2011 Neighborhood Health Profile, is 8,202, and 96 percent of Cherry Hill residents are African-American, as compared with 63.6 percent of Baltimore as a whole. Approximately 53 percent of Cherry Hill households with children were headed by a single parent—again, higher than the citywide percentage of 26 percent.

Thirty-four percent of Cherry Hill residents ages 25 to 64 do not have a high school education, while less than seven percent of adults 25 and older have a bachelor's degree or more (American Community Survey, 2005 – 2009). The median household income for Cherry Hill in 2010 was $19,183, among the lowest of Baltimore neighborhoods. In fact, nearly 92 percent of families in the neighborhood, excluding married couple families, earn below the Maryland Self Sufficiency wage standard. According to the 2010 U.S. Census, 45.1 percent of Cherry Hill families live in poverty.

In terms of health care, the Cherry Hill community houses MedStar Harbor Hospital, as well as a local branch of the Family Health Centers of Baltimore, which is a Federally Qualified Health Center (FQHC) providing health care services on a sliding fee scale. In addition, Baltimore City Health Department programs operate city-wide, and various mobile services—such as a needle exchange program, violence prevention, Maternal and Infant Nursing, lead poisoning and abatement programs and others—serve the Cherry Hill area.

According to the Cherry Hill Health Profile, published by the Baltimore City Health Department in partnership with the Johns Hopkins School of Public Health in October 2008, the life expectancy at birth of a Cherry Hill resident is 65.0, as compared to 70.9 in Baltimore City as a whole and 78.1 in the United States. Heart disease accounts for 23 percent of all

deaths, and cancer accounts for 20 percent. Stroke, HIV/AIDS and homicide are less common but, when combined, cause 18 percent of deaths in this area.

High rates of type 2 diabetes and heart disease, including stroke, also occur in this community. For a variety of reasons, including the high poverty rate and low rate of health care insurance coverage, many Cherry Hill residents often use the MedStar Harbor Hospital emergency department for primary care services.

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

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

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

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

Advisory Task Force Membership

Name	Title / Affiliation with Hospital	Name of Organization
Jean F. Bunker	VP, Marketing, Community Relations & Philanthropy	MedStar Harbor Hospital
Meg Miller	Community Relations Director (former)	MedStar Harbor Hospital
Cathy McClain	Executive Director	Cherry Hill Trust
Deborah Woolley	Learn to Work and Service Learning Coordinator	Benjamin Franklin High School, Baltimore, MD
Joanne Robinson	Program Coordinator/Volunteer	Family Health Centers of Baltimore
Laurie Fetterman	Health Planner	Anne Arundel County Health Department
Nadine Braunstein, Ph.D., RD	Allied Health Program Director, Office of Collaborative Programs	Towson University
Nilda Ledesma	Manager, Quality and Case Management	MedStar Harbor Hospital
Robert Dart, M.D.	Physician, Harbor Primary Care	MedStar Harbor Hospital
Sally Seen, RN	Parish Nurse	MedStar Harbor Hospital
Tanesha Boldin	Board Member	PNC Bank
James E. Wood, M.D.	Physician, Department Chairman of Orthopaedics	MedStar Harbor Hospital
Megan Long	Community Relations and Philanthropy Specialist	MedStar Harbor Hospital

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

a) Heart Disease	
Quantitative Evidence	• Heart disease is the leading cause of death in Baltimore City (Healthy Baltimore 2015). • The age-adjusted death rate due to heart disease is 262.9 deaths per 100,000 – placing it in the "red zone" for severity and prevalence Data from the Maryland Department of Health and Mental Hygiene (MD DHMH, 2011). • Life expectancy at birth of a Cherry Hill resident is 65.0, as compared to 70.9 in Baltimore City as a whole and 78.1 in the United States (Cherry Hill Health Profile, 2008). • Heart disease accounts for 23% of all deaths in Cherry Hill (Cherry Hill Health Profile, 2008).
Qualitative Evidence	The majority (59.5%; n=37) of community input survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as "very severe."
Hospital Strengths	MedStar Harbor Hospital, as an engaged health partner, has a cardiology program designed to diagnose and treat cardiac patients at every juncture in the clinical pathway. Cardiology is a core clinical service that MedStar Harbor must provide, particularly given the health status of the hospital's community, the aging population, and the rate of recurrence when not properly managed. Of particular note is the hospital's commitment to community health education via its Heart Smart Church Program, with close to 3,000 encounters over the past four fiscal years; its seminar education series that reaches approximately 100 participants annually; and other community education tools, such as Parish Nurse Notes and LifeResource, which reach more than 55,000 area residents annually.
Alignment with local, regional, state or national health goals	All local, regional, state and national health goals, without exception, identify heart disease as a priority health condition. • Healthy People 2020 HDS-1 through HDS-5 • MD SHIP: Reduce deaths from heart disease
Other justification	Heart Disease is a condition that aligns with stated and documented community need, along with MedStar Harbor's core competencies both clinically and in the community outreach infrastructure.

b) Diabetes	
Quantitative Evidence	• "In 2007, diabetes was the seventh leading cause of death in the United States. In 2010, an estimated 25.8 million people or 8.3% of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older" (MD BRFSS). • "From 2008, the average prevalence of diagnosed diabetes among white Marylanders was 7.5% and 12.3% among black Marylanders. Black females (12.5%) had almost double the diabetic rates of white females (6.8%). Diabetes is widely associated with older age, and the older working age population (50-64) represents the fastest growing diabetic group in Maryland. Additionally, 15.4% of diabetic Marylanders have less than a high school education and 17.1% of diabetic Marylanders earn less than $15,000 annually" (Healthy Maryland – Project 2020). • At MedStar Harbor Hospital, diabetes and related conditions are top causes of inpatient admissions, as well as readmissions due to failure/inability to comply with disease management protocols.
Qualitative Evidence	The majority (58.3%; n=36) of community input survey respondents, who live and/or work in the CBSA, rated the incidence of diabetes as "very severe."
Hospital Strengths	MedStar Harbor Hospital has a strong Diabetes and Endocrine Center that provides multiple layers of clinical and educational support for the community. Experienced endocrinologists provide both inpatient and outpatient care to patients with diabetes. Experienced Certified Diabetes Educators, including a registered dietitian and registered nurse, teach the program.
Alignment with local, regional, state or national health goals	The state of Maryland has identified diabetes as a significant, and growing, health problem. In particular, minorities and elderly, who make up a large portion of MedStar Harbor's CBSA, are disproportionately affected by this condition. As the population demographic shifts, with the aging Baby Boomer population, this concerted focus on diabetes is clearly a health mandate for MedStar Harbor.
Other justification	In Fiscal Year 2011, there were 737 discharges at MedStar Harbor with diabetes as the primary condition – approximately two per day. There are significantly more when diabetes is identified as a co-morbidity.

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

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner (name and contact person)
Overweight/Obesity	Wellness & Prevention	• Dinner with the Dietitian	• Morrison Catering (based out of MedStar Harbor Hospital); Sandra Koehler, Registered Dietitian
	Wellness & Prevention	• Diabetes Seminars	• MedStar Harbor Hospital Diabetes & Endocrine Center educator
Cancer	Wellness & Prevention	• Seminars, screenings and support groups	• Coordinated internally at MedStar Harbor, but promoted via the hospital's Parish Nurse; Breast & Cervical Cancer Program; and direct mailings to the community targeted to at-risk residents

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Mental and Behavioral Illness	Wellness & Prevention	80.5% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	While MedStar Harbor, like many community hospitals, has very basic in-house support systems, most of the expertise in treating this condition is provided by other community providers. The MedStar Baltimore hospitals are exploring new partnerships to allow them to better meet the health needs of patients with mental/behavioral illness. At this time, the hospital does not have the infrastructure or the core competencies to effectively program around this disease condition. However, MedStar Harbor has a robust case management program, through which the hospital creates access to the appropriate level of outside inpatient and outpatient treatment and management programs.
Cancer	Wellness & Prevention	55.6% (n=37) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	Oncology is a clinical service that MedStar Harbor provides. In addition, the hospital has a solid infrastructure of support, through seminars, screenings, and, the Breast & Cervical Cancer Program. With those in place, and with finite resources available, the hospital determined it was best to focus its efforts on other health priorities.

Arthritis and Joint Health	Wellness & Prevention	44.4% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	Orthopaedics is a major area of clinical expertise at MedStar Harbor. The hospital offers a solid infrastructure of support, through seminars and screenings. With those in place, and with finite resources available, the hospital determined it was best to focus efforts on other health priorities.
Stroke	Wellness & Prevention	61.1% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	MedStar Harbor is certified as a primary stroke center. Through the hospital's Emergency Department and inpatient efforts, as well as other community involvement such as stroke Awareness Month activities, other groups within the hospital are forming the lead on education about stroke. In addition, many outreach efforts around heart disease, and even diabetes, will support education related to Stroke. The hospital believes this is being thoroughly covered both directly and indirectly.
Overweight/ Obesity	Wellness & Prevention	91.7% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	MedStar Harbor already has existing programming in place that specifically targets obesity/overweight. Additionally, by targeting factors that contribute to heart disease and diabetes, the hospital will indirectly address overweight/obesity.

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

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

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

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

Resources

- Healthy Baltimore 2015
- Healthy Communities Index Dashboard for Harbor Hospital
- Healthy People 2020
- Community Input Session moderated by Holleran Consulting
- Baltimore City Health Department, Neighborhood Health Profiles (21225)
- U.S. Census 2000 and U.S. Census 2010

Implementation Strategy

Community Need: Diabetes Prevention and Management
Goal Statement: To have an educated public with regard to diabetes prevention and management.
Target Population: Residents of zip code 21225 in Baltimore City, with a significant focus on the Cherry Hill community located directly west of the hospital.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Potential Partnering Organizations	Responsible Party(ies)
1	Program coordinator Diabetes educators Dietician Fitness educator Endocrinologist Parish Nurse Grant writer	Launch a diabetes "Community Smart" Program	# of modules conducted # of persons tracked and evaluated # of persons with a usual source of care Development of a brochure # of referrals to primary care providers and/or endocrinologist	Identify 2 locations in our CBSA to hold the program in FY13. Increase the number of times the program is given to 4 in FY14. Improve the ability of those with diabetes to better manage their condition. Increase patient-healthcare provider interaction for those with diabetes.	Improve health indicators of individuals with Type 2 diabetes.[1] Reduce the incidence of diabetes and diabetes related complications.[1]	MedStar Harbor Hospital Diabetes and Endocrine Center MedStar Diabetes Institute Local community health centers Local universities Churches	Director of Community Relations Director of Philanthropy

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Potential Partnering Organizations	Responsible Party(ies)
2	Program coordinator Diabetes educator Dietician Endocrinologist Parish Nurse Grant writer	Offer diabetes education seminars and screenings.	# of free diabetes education seminars and screenings # of community locations for seminars # of seminar announcements in the corporate publication, "Focused on You" # of calendar announcements to local media # of pre- and post-tests collected # of referrals to primary care providers and/or endocrinologist	Offer 6 seminars with three held in the community in FY14. Increase number of screening opportunities by 10% and hold 50% in the community.[1] Increase the number of participants in FY14 by 50 percent using FY12 as a baseline.	Improve health indicators of individuals with Type 2 diabetes.[1] Reduce the incidence of diabetes and diabetes related complications. Evaluate the success of the outreach effort through increased participation. Improved awareness and knowledge of behaviors that support heart health.[1]	MedStar Harbor Hospital Diabetes and Endocrine Center Local community health centers Local universities Churches	Director of Community Relations Director of Philanthropy (grants)

[1] Baseline will be established in FY13.

Community Need: Heart Disease Prevention and Management
Goal Statement: To have an educated public with regard to heart disease prevention and management.
Target Population: Residents of zip code 21225 in Baltimore City, with a significant focus on the Cherry Hill community located directly west of the hospital.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Potential Partnering Organizations	Responsible Party(ies)
1	Parish Nurse Church volunteer blood pressure screeners Grant writer	Introduce MedStar Harbor's Heart Smart Church Program in the CBSA	# of new partners Development of a brochure # of patients with blood pressures tracked Completion of benchmark analysis of the participant's blood pressures using FY12 data # of referrals to primary care providers and/or cardiologists for persons with high blood pressure	Increase number of participating faith-based organizations in FY14 by 50 percent from baseline year FY12.	Increase the number of participating faith-based organizations by in FY15 by 100 percent from baseline year FY12. Reduce blood pressures among those tracked.[1]	MedStar Harbor Department of Cardiology MedStar Harbor Primary Care Churches	Director of Community Relations Director of Philanthropy Parish Nurse
2	Parish Nurse Grant writer	Community blood pressure screenings	# of new sites for blood pressure screenings # of educational materials distributed # of referrals to primary care providers and/or cardiologists for documented high blood pressure # of persons and BP readings recorded by ZIP code	Conduct benchmark analysis in FY13 of the overall health by location.	Increase the number of readings by 25 percent in using FY12 as a baseline. .	Local community health centers Local businesses and community based organizations Senior centers Recreational centers Churches	Director of Community Relations Director of Philanthropy Parish Nurse

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Potential Partnering Organizations	Responsible Party(ies)
3	Cardio educator Community Relations Specialist	Offer Healthy Heart and Risky Business seminars.	# of seminars offered. # of announcements in "Focused on You" # of community locations for seminars. # # of seminar pre- and post-test collected # of referrals to primary care providers and/or cardiologists	Increase the number of seminars held in the community by 25 percent using FY12 as a baseline. Improved awareness and knowledge of behaviors that support heart health.[1] .	Improved awareness and knowledge of behaviors that support heart health.[1] Increase to 50 percent and maintain # of seminars in the community using FY12 as a baseline.	MedStar Heart Network Local community health centers Local businesses and community based organizations Senior centers Recreation centers Churches	Director of Community Relations Director of Philanthropy

[1] Baseline will be established in FY13.

MedStar Union Memorial Hospital
Community Health Assessment FY2012

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

MedStar Union Memorial Hospital's (MUMH) Community Benefit Service Area (CBSA) includes adults who reside in Baltimore City ZIP codes 21211, 21213 and 21218. The area was selected due to its close proximity to the hospital, coupled with a high density of residents with low incomes. Based on quantitative and qualitative findings, heart disease and diabetes have been identified as community benefit priorities.

2. Provide a description of the CBSA

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

According to the United States Census Bureau, there are 106,560 residents currently living within the CBSA, almost 20% of the entire population of Baltimore City. It is a relatively diverse population, with 65% African American, 28% White, 3% Asian, 2% Hispanic and 2% other. The vast majority of the population (79%) is over the age of 18. Average median household income across the CBSA is $37,142 per year.

Heart disease is the leading cause of death in Baltimore City and diabetes is the seventh. The statistics for Baltimore City mirror the state of Maryland and are expected to represent the CBSA. ZIP code level data is not available at this time.

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

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

The Advisory Task Force reviewed local secondary data, coupled with city, state and federal community health goals. Task Force members also reviewed the hospital's operating plan, as well as current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

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

Advisory Task Force Membership

Name	Title	Name of Organization
Bradley Chambers	President	MedStar Union Memorial Hospital
Jill Johnson	AVP Planning, Community & Government Relations	MedStar Union Memorial Hospital
Savas Karas	Chair – Community Relations Committee	MedStar Union Memorial Hospital
Tim Chriss	Board Member	MedStar Union Memorial Hospital
Derrick Adams	Board Member	MedStar Union Memorial Hospital
Neil MacDonald	VP Operations	MedStar Union Memorial Hospital
Mary Pat Clark	Councilwomen	Baltimore City
Jack VandenHengel	Executive Director	Shepherd's Clinic
Mario Trescone	VP Operations and Market Analysis	YMCA
Rev. James Blackburn	Reverend	Episcopal Church
Alice Ann Finnerty	Board Member	Hampden Family Center
Mary Ellen Thomsen	Resident	Roland Park Place
Ruth Ricks	Resident	Hamlet Hill
Dana DiCarlo	Resident	Charlcote Place

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

a) Heart Disease	
Quantitative Evidence	• Heart disease is the leading cause of death in Baltimore City (Healthy Baltimore 2015). • The age-adjusted death rate due to heart disease is 262.9 deaths per 100,000 – placing it in the "red zone" for severity and prevalence (DHMH, 2011).
Qualitative Evidence	The majority (76.1%; n=151) of Community Input Survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as "severe" or "very severe."
Hospital Strengths	MedStar Union Memorial Hospital has a cardiology infrastructure designed to diagnose and treat cardiac patients at every juncture in the clinical pathway.
Alignment with local, regional, state or national health goals	All local, regional, state and national health goals, without exception, identify heart disease as a priority health condition. • Healthy People 2020 HDS-1 through HDS-5 • MD SHIP: Reduce deaths from heart disease.
Other justification	Heart Disease is a condition that aligns with stated and documented community need, along with MedStar Union Memorial Hospital's core competencies, both clinically and in the community outreach infrastructure.

b) Diabetes	
Quantitative Evidence	• In 2007, diabetes was the seventh leading cause of death in the United States. In 2010, an estimated 25.8 million people or 8.3% of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older. The burden of diabetes in the United States has increased with the increasing prevalence of obesity. Multiple long-term complications of diabetes can be prevented through improved patient education and self-management and provision of adequate and timely screening services and medical care." (MD BRFSS) • "From 2008, the average prevalence of diagnosed diabetes among white Marylanders was 7.5% and 12.3% among black Marylanders. Black females (12.5%) had almost double the diabetic rates of white females (6.8%). Although diabetes is widely associated with older age, the older working age population (50-64) represents the fastest growing diabetic group in Maryland. Additionally, 15.4% of diabetic Marylanders have less than a high school education and 17.1% of diabetic Marylanders earn less than $15,000 annually." (Healthy Maryland – Project 2020)
Qualitative Evidence	The majority (84.7%; n=151) of Community Input Survey respondents, who live and/or work in the CBSA, classified the incidence of diabetes as "severe" or "very severe."
Hospital Strengths	MedStar Union Memorial Hospital has a strong Diabetes and Endocrine Center that has been designed to provide multiple layers of clinical and educational support to our community. Experienced endocrinologists and Certified Diabetes Educators provide inpatient and outpatient care and education to patients with diabetes.
Alignment with local, regional, state or national health goals	As stated above, the state of Maryland via numerous research modalities and reports, including Healthy People 2020, has identified diabetes as a significant, and growing, health problem. In particular, minorities and elderly, who make up a large portion of MedStar Union Memorial's CBSA, are disproportionately affected by this condition.
Other justification	

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

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner (name and contact person)
Arthritis and Joint Health	Wellness & Prevention	Seminars, Screenings, On-line education	Orthopedic Educator
Work Rehabilitation	Wellness & Prevention	Prevention of Work – Related health Problems	MNRH
Mental Health	Access to Care	• Provide support and tools for recovery from mental illnesses via peer support • Advocacy group for the mentally ill	Depression and Bipolar Support Alliance
Addiction	Access to Care	Dual Recovery Anonymous	Dual Recovery Anonymous
Obesity	Wellness & Prevention; Quality of Life	Healthy eating, grocery store tours, Waverly Farmers Market	MUMH Educational Staff
Smoking	Wellness & Prevention	Smoking enders	Great American Smoke-out

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Oncology	Wellness & Prevention	70.9% (n=151) of Community Input Survey respondents rated cancer as either “severe” or “very severe” within the CBSA	Due to limited resources, MUMH did not select oncology as a priority; however, the hospital does employ an oncology educator and an oncology nurse navigator who provide community-based education and screenings.
Overweight / Obesity	Wellness & Prevention	75.5% (n=151) of Community Input Survey respondents rated overweight /obesity as either “severe” or “very severe” within the CBSA	This topic will be integrated into the programming for heart disease and diabetes education.
Mental and Behavioral Health	Wellness & Prevention	71.7% (n=145) of Community Input Survey respondents rated overweight / obesity as either “severe” or “very severe” within the CBSA	MUMH does not have the expertise or infrastructure to serve as a lead around this area of need.
Arthritis and Joint Health	Wellness & Prevention	36.3% (n=22) of Community Input Survey respondents rated arthritis and joint health as either “severe” or “very severe” within the CBSA	Current educational support will continue as this topic is in line with our core competence.
Stroke	Wellness & Prevention	66.3% (n=151) of Community Input Survey respondents rated stroke as either “severe” or “very severe” within the CBSA	The hospital is certified as a primary stroke center. Many of outreach efforts around heart disease will support education related to stroke. The hospital believes this is being thoroughly covered both directly and indirectly.
Neighborhood Safety	Quality of Life	37.1% (n=151) of Community Input Survey respondents rated the quality/availability of neighborhood safety as either “poor” or “very poor” within the CBSA	The hospital will continue to partner with the community to improve safety, but it is not within MUMH’s expertise to take a lead role.

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

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

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

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

Resources

- U.S. Census 2010
- Healthy Baltimore 2015
- Maryland Department of Health and Mental Hygiene
- Maryland State Health Improvement Plan
- Healthy People 2020
- Maryland Behavior Risk Factor Surveillance System
- Healthy Maryland – Project 2020
- MedStar Union Memorial Hospital Community Input Survey (Holleran)

Implementation Strategy

Community Need: Heart disease education and awareness
Goal Statement: To increase knowledge and promote behaviors that reduce risk of heart disease.
Target Population: Adults who reside in zip codes 21218, 21211 and 21213 in Baltimore City.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Cardiac Educator Clinical Ladder Nurses Cardiac Rehabilitation Exercise Physiologist Towson University Community Health Interns	Coordinate / Facilitate Health Fairs, Education sessions, Screenings	# of educational sessions # of attendees # of Completed Evaluations # of Heart scans # of BP screenings # of Cholesterol screenings	Develop a mechanism to measure cardiac health awareness	10% increase in attendance at educational events per year Improve knowledge and awareness by 10% per year as measured by pre and post seminar testing	Towson University Baltimore City Health Department American Heart Association	VP Cardiovascular Services
2	The Shepherds Clinic Cardiac Educator	Education Sessions Screenings, Informational Material, Staff training	# of educational sessions # of attendees # of Completed Evaluations # of Heart scans # of BP screenings # of Cholesterol screenings	Increase program availability in the CBSA	Improved compliance with treatment protocol in at least 10% of the patient population Improved markers (BP, BMI, Cholesterol) in at least 25% of the patient population	The Shepherds Clinic Hamden Family Center	AVP community Relations Executive Director, Shepherds Clinic
3		Develop an educational module for all new clinic patients to improve awareness of cardiovascular risk factors, prevention and treatment.	# of persons trained	Implement new educational module for all new patients by FY14			

Community Need: Diabetes education and awareness
Goal Statement: To increase knowledge and promote behaviors that reduce risk of heart disease.
Target Population: Adults who reside in zip codes 21218, 21211 and 21213 in Baltimore City.

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Diabetes Educator Clinical Ladder Nurses Towson University Community Health Interns	Coordinate / Facilitate Health Fairs, Education sessions, Screenings	# of educational sessions # of attendees # of Completed Evaluations # of screenings	Develop a mechanism to measure awareness	10% increase in attendance at educational events per year Improve knowledge and awareness by 10% per year as measured by pre and post seminar testing	Towson University Baltimore City Health Department MedStar Diabetes Institute	AVP Community Relations
2	The Shepherds Clinic Diabetes Educator	Education Sessions (ABCs of Diabetes), Screenings, Informational Material, Staff training	# of educational sessions # of attendees # of Completed Evaluations screenings	Increase program availability in the CBSA	Improved compliance with treatment protocol in at least 25% of the patient population Improved Hemoglobin HBA1C in at least 25% of the patient population	The Shepherds Clinic MedStar Washington Hospital Center Hamden Family Center	AVP community Relations Executive Director, Shepherds Clinic
3		Develop an educational module for all new clinic patients to improve awareness of cardiovascular risk factors, prevention and treatment	# of persons trained	Implement educational module for all new patients by FY14			

Washington Hospitals

MedStar Georgetown University Hospital
Community Health Assessment FY2012

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

MedStar Georgetown University Hospital's (MGUH) Community Benefit Service Area (CBSA) includes children and adults who reside in Ward 6 of the District of Columbia. This area was selected to expand upon pre-existing primary care services in Ward 6 that are offered to underinsured, uninsured, and low-income persons. Based on qualitative and quantitative findings, primary and secondary prevention of the following conditions have been identified as the hospital's community benefit priorities:

- Obesity and overweight
- Diabetes
- Hypertension

2. Provide a description of the CBSA.

Demographics
According to Neighborhood Info DC (www.neighborhoodinfodc.org), there are 76,598 residents in the Ward 6 community, 13 percent of whom are children. This is a racially and ethnically diverse area, with 47 percent white, 42 percent African American, 5 percent Asian American/Pacific Islanders, and 4.8 percent Hispanic. Approximately 8 percent of Ward 6 residents are foreign-born.

Unemployment among Ward 6 residents is 8.4 percent and 18 percent of Ward 6 residents live below the federal poverty line. Compared to the District of Columbia, Ward 6 residents are somewhat less likely to be unemployed but as likely to live in poverty. However, the percentage of children living in poverty is slightly higher than the city average. While 29 percent of children in the District of Columbia live in poverty, 31 percent of children in Ward 6 live in poverty.

The violent crime rate in Ward 6 is 10 per 1,000 residents, lower than the average violent crime rate of 12 per 1,000 residents in the District of Columbia. The property crime rate, on the other hand, is 41 per 1,000 residents, slightly above the average of 40 per 1,000 residents in the District of Columbia.

Adult HealthData on the health status of the population at the Ward level are relatively limited. One of the most comprehensive sources is a community health needs assessment conducted by the RAND Corporation. According to the RAND report, adult residents of Ward 6 are somewhat more likely to be overweight or obese than residents in the District of Columbia (58% compared to 54.6%). When compared to the District of Columbia, more adult residents in Ward 6 have hypertension (28.2% compared to 27.1%) or have diabetes (9.2% compared to 8.1%). Infectious diseases are, on average, less common among adults in Ward 6 compared to the District of Columbia with the exception of syphilis (Government of the District of Columbia HAHSTA Annual Reports 2009 and 2010). Premature mortality due to heart disease (84 per 100,000) and hypertension (33 per 100,000) among adult residents in Ward 6 is higher than in the District of Columbia (45 per 100,000 and 26 per 100,000, respectively) (DC DOH).

Child Health

According to the DC Department of Health, the infant mortality rate in Ward 6 is 6.4 deaths per 1,000 live births, a rate that has decreased over the past decade and is now the third lowest in the District of Columbia. According to the RAND community health needs assessment, children in Ward 6 are somewhat more likely to be overweight, have limitations in activity or function, have behavioral health issues needing treatment, and have dental problems compared to children in the District of Columbia.

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute provided** quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

The CHNA was led by an Advisory Task Force, which consisted of: District of Columbia community health leaders; university-based public health professionals; and MGUH/MedStar physicians and staff members. Several of these individuals were also residents of the District of Columbia and Ward 6.

The Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals and current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool focused around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

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

Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Steve Evans, MD	Vice President, Medical Affairs and Chief Medical Officer	MedStar Georgetown University Hospital
Dennis McIntyre, MD	Associate Medical Director, Utilization and Case Management	MedStar Georgetown University Hospital
Vera Johnson	Director	Sasha Bruce Youth Work
Sam Tramel	Executive Director	DC Children's Trust Fund
Simone Singh, Ph.D.	Assistant Professor	Georgetown University Department of Health Systems Administration
Michael Stoto, Ph.D.	Professor	Georgetown University Department of Health Systems Administration
Regina Knox Woods	Vice President, Government Affairs, Washington DC Metro Area	MedStar Health
Matthew Levy, MD	Medical Director, Kids Mobile Clinic, Department of Pediatrics	MedStar Georgetown University Hospital

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

a) Obesity and Overweight	
Quantitative Evidence	Fifty-eight percent of Ward 6 residents are overweight or obese, a figure slightly higher than that of the DC population as a whole (55%) (RAND, 2003)
Qualitative Evidence	68.7% (n=131) of Community Input Survey respondents rated obesity/overweight as either "severe" or "very severe" within the CBSA
Hospital Strengths	Opportunities to provide primary prevention activities aimed at obesity and overweight are available through the MGUH Hoya Clinic and the Kids Mobile Clinic; inpatients can receive nutritional counseling and be referred to community-based counseling services.
Alignment with local, regional, state or national health goals)	Weight control and obesity initiatives for Ward 6 are closely aligned with activities proposed by the following organizations/initiatives: • US Department of Health and Human Services • Healthy People 2020 • Washington, DC Department of Health • Centers for Disease Control and Prevention (CDC)
Other justification	N.A.

b) Diabetes	
Quantitative Evidence	• The prevalence of diabetes in the US population is 8.3%; in the District of Columbia that figure is 8.1% whereas in Ward 6 it is 9.2% (National Diabetes Information Clearinghouse; RAND Corporation) • Diabetes is the leading cause of kidney failure, non-traumatic lower limb amputations, and new causes of blindness among adults in the United States.
Qualitative Evidence	61.9% (n=131) of Community Input Survey respondents rated diabetes as either "severe" or "very severe" within the CBSA
Hospital Strengths	MGUH has a robust multidisciplinary limb and wound center (plastic surgeons; podiatrists; vascular surgeons) that is capable of providing limb-sparing surgery for diabetic patients suffering from vascular insufficiency and chronic infections.
Alignment with local, regional, state or national health goals	Diabetes control initiatives for Ward 6 are closely aligned with activities proposed by the following organizations/initiatives: • US Department of Health and Human Services • Healthy People 2020 • Washington, DC Department of Health • Centers for Disease Control and Prevention (CDC)
Other justification	N.A.

c) Heart Disease / Hypertension (high blood pressure)	
Quantitative Evidence	• Hypertension, a contributor to heart disease, affects 28% of Ward 6 residents, as compared to 27% of DC residents in general • Premature mortality for heart disease in Ward 6 (84 per 100,000) is almost twice that for all residents of DC (45 per 100,000) • Premature mortality for hypertension in Ward 6 residents (33 per 100,000) is 27% higher than for all residents of DC (26 per 100,000)
Qualitative Evidence	70.3% (n=131) of Community Input Survey respondents rated hypertension as either "severe" or "very severe" within the CBSA
Hospital Strengths	Strong cardiology department with referral channel to Washington Hospital Center for cases requiring surgical intervention.
Alignment with local, regional, state or national health goals	Heart disease initiatives for Ward 6 are closely aligned with activities proposed by the following organizations/initiatives: • US Department of Health and Human Services • Healthy People 2020 • Washington, DC Department of Health • Centers for Disease Control and Prevention (CDC)
Other justification	N/A

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

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner (name and contact person)
Obesity/Overweight	Wellness & Prevention; Access to Care	Hoya Clinic: provides acute care and preventive services to homeless DC residents Kids Mobile Clinic: provides preventive services and acute care to children in select DC neighborhoods MGUH-sponsored primary care office sites	Hoya Clinic: Dr. Eileen Moore Kids Mobile Clinic: Dr. Matt Levy
Diabetes	Wellness & Prevention; Access to Care	Hoya Clinic Kids Mobile Clinic Primary care office sites	As above
Hypertension	Wellness & Prevention; Access to Care	Hoya Clinic Kids Mobile Clinic Primary care office sites	As above

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Access to a primary care physician	Wellness & Prevention; Access to Care	Only 8.4% (n=131) of Ward 6 survey respondents indicated that they "disagree" or "strongly disagree" that they are able to access a primary care physician	Did not rank among top three health care concerns
Access to a specialist	Wellness & Prevention; Access to Care	Only 16.8% (n=131) of Ward 6 survey respondents indicated that they "disagree" or "strongly disagree" that they are able to access a specialist	Did not rank among top three health care concerns
Access to a dentist	Wellness & Prevention; Access to Care	Only 21.4% (n=131) of Ward 6 survey respondents indicated that they "disagree" or "strongly disagree" that they are able to access primary care	Did not rank among top three health care concerns; not a core competency of MGUH
Access to transportation for medical appointments	Wellness & Prevention; Access to Care	Only 14.6% (n=131) of Ward 6 survey respondents indicated that they "disagree" or "strongly disagree" that they are able to access primary care	Did not rank among top three health care concerns
Availability of fresh produce and other healthy foods in the Ward 6 community	Wellness & Prevention	65.7% (n=131) of Ward 6 survey respondents felt availability of fresh produce and other health foods was fair or better	Did not rank among top three health concerns; MGUH does not have the expertise or resources to serve as a lead agency that addresses diabetes.

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

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

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

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

Resources

- Neighborhood Info DC (www.neighborhoodinfodc.org)
- RAND Analysis of the National Survey of Children's Health (2003)
- DC State Health Plan (2007): http://dchealth.dc.gov/doh/cwp/view,a,1374,q,603403.asp
- *Healthy People 2020*; http://www.healthypeople.gov/2020/default.aspx
- Data provided by Holleran from the Healthy Communities Institute
- Centers for Disease Control and Prevention; http://www.cdc.gov/
- Results of community needs assessment survey developed by Holleran and MedStar Health (n=131)

Implementation Strategy

Community Need: Obesity/Overweight Awareness and Management
Goal Statement: To reduce the prevalence and improve treatment and awareness of the effects of obesity and overweight
Target Population: All adult residents of Ward 6 in Washington, DC who have a body mass index (BMI) of 25 or greater; all children between the ages of 2-18 years who are residents of Ward 6 and have a BMI for age greater than the 90th percentile.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Advisory Task Force Staff of The HOYA Clinic Community health clinics Staff of the MGUH Kids Mobile Van Nutritional counselors Exercise counselors/physical therapists DC Department of Health TCP	Identify DC obesity and nutritional counseling programs	# of obesity and nutritional counseling programs Produce directory of services # of directories distributed Produce web-based directory	Increase overweight/obesity screening rates of Ward 6 residents Increase community awareness of links between obesity and other illnesses (e.g., diabetes; hypertension; heart disease; stroke; kidney disease; liver disease) Increase the Ward 6 community's knowledge about where to seek counseling about overweight/obesity	Increase the Ward 6 community's knowledge about where to seek counseling about overweight/obesity	The HOYA Clinic The MGUH Kids Mobile Van Georgetown University graduate students in the Health Systems Administration Department Coalition of Georgetown University medical students and nursing students DC Public Schools (Department of Education)	Associate Medical Director, Case Management and Utilization Review, MUGH Volunteer medical students/nursing students at The HOYA Clinic Professor of Medicine and Assistant Dean for Community Education and Advocacy, Georgetown University Assistant Professor of Pediatrics and Medical Director, Kids Mobile Clinic, Georgetown University
2		Identify best practices for disseminating health care-related information to Ward 6 residents	# of practices identified / # of new practices		Increase the Ward 6 community's knowledge about where to seek counseling about overweight/obesity		
3		Offer nutritional counseling for all HOYA Clinic and Kids Mobile Van patients	# of exercise and counseling services rendered at HOYA Clinic and Kids Van # of participants who are overweight or obese # of participants who report at least 30 minutes of physical activity at least five days per week		Decrease by 5% the number of patients who are classified as overweight or obese by 2015[1] Increase by 5% the number of adults seen at The HOYA Clinic who report at least 30 minutes of physical activity at least five days per week by 2015[2]		
#	**Resources**	**Activities**	**Outputs**	**Short-Term Outcomes**	**Long-Term Outcomes**	**Partnering Organizations**	**Responsible Party(ies)**

4	Advisory Task Force Staff of The HOYA Clinic Community health clinics Staff of the MGUH Kids Mobile Van Nutritional counselors Exercise counselors/physical therapists DC Department of Health	Expand the IronMed Health and Wellness Program	Enroll 30 new patients # of participants who are overweight or obese # of participants who report at least 30 minutes of physical activity at least five days per week		Decrease by 5% the number of participants who complete the IronMed Health and Wellness Program who are classified as overweight or obese by 2015[2] Increase by 5% the number of participants who complete the IronMed Health and Wellness Program who report at least 30 minutes of physical activity at least five days per week by 2015[2] At three month follow-up, maintain a 2% reduction of weight in participants completing the program	Staff of The HOYA Clinic Community health clinics Exercise counselors/physical therapists	Associate Medical Director, Case Management and Utilization Review, MUGH
5	TCP	Secure philanthropic support	Produce sponsorship letter # of letters distributed to businesses for in-kind and financial support	Solicit financial donations from five community businesses every year in support of promoting healthy eating; focus on restaurants and grocery stores	Expand existing preventive activities and increase financial independence of The HOYA Clinic.	Local grocery store chains---TBD Local restaurants---TBD	Advisory Task Force Volunteer nursing/medical students

[1] Baseline data from the 2010 HOYA Clinic patient population indicate that 18% of patients are overweight, 27% are obese and 21% are morbidly obese based on body mass index (BMI) measurements.
[2] Baseline will be established in FY13

Community Need: Diabetes Awareness and Management
Goal Statement: Reduce the prevalence and improve the medical management of persons with diabetes in Ward 6.
Target Population: All residents of Ward 6 in Washington, DC who are 18 years of age or older who have an established diagnosis of Type 1 or Type 2 diabetes mellitus.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Advisory Task Force Staff of The HOYA Clinic Nutritional counselors Exercise counselors DC Department of Health Community health clinics Volunteer endocrinologists and/or internists from MGUH and the community Podiatrists Ophthalmologists	Conduct inventory of all city-wide diabetes education programs and diabetes clinics by 9/30/2012	# of programs identified	Increase community awareness of diabetes-related educational and treatment resources	Increase community awareness of diabetes-related educational and treatment resources	The HOYA Clinic Georgetown University graduate students in the Health Systems Administration Department Coalition of Georgetown University medical students and nursing students DC Public Schools (Department of Education) MGUH and community volunteer physicians The Community Partnership for the Prevention of Homelessness DCDOH DHS	Associate Medical Director, Case Management and Utilization Review, MUGH
2		Identify national best practices to use in disseminating above information to Ward 6 residents.	# of new practices implemented	Increase community awareness of diabetes-related educational and treatment resources	Increase community awareness of diabetes-related educational and treatment resources		
3		By 12/31/12, identify two sites within Ward 6 (in addition to the HOYA Clinic) that can serve as diabetes screening, education, and referral centers	# of new partners # of Ward 6 residents without a usual source of care # of Ward 6 residents without a usual source of care with retinal or renal disease # of physician volunteers	Increase community awareness of diabetes-related educational and treatment resources	Increase community awareness of diabetes-related educational and treatment resources		
#	**Resources**	**Activities**	**Outputs**	**Short-Term Outcomes**	**Long-Term**	**Partnering**	**Responsible**

					Outcomes	Organizations	Party(ies)
4	Advisory Task Force Staff of The HOYA Clinic	Implement consistent diabetes monitoring measures at the HOYA Clinic	# of patients with diabetes	At least 30% of diabetes patients and program participants above baseline will receive a referral to a podiatrist and an ophthalmologist 30% of patients and program participants above baseline will have their Hgb A1c levels checked at least twice during their enrollment period. 100% of the patients and program participants will be offered a diabetes assessment, including screenings for retinal disease, microalbuminuria, chronic kidney disease and peripheral vascular disease 95% of patients and program participants with an identified medical home will be referred back to those providers upon discharge from the shelter or program completion. Patients may elect to continue with the program. 95% of patients and program participants without a medical home will be referred to a medical home for follow up upon discharge from the shelter or program completion	Each diabetic patient identified should have a 10% reduction per year in their Hgb A1cC levels After three years of the program's interventions, at least 90% of identified diabetic patients should have a Hgb A1c level of less than 7%.	The HOYA Clinic Georgetown University graduate students in the Health Systems Administration Department Coalition of Georgetown University medical students and nursing students DC Public Schools (Department of Education) MGUH and community volunteer physicians The Community Partnership for the Prevention of Homelessness DCDOH DHS	Professor of Medicine and Assistant Dean for Community Education and Advocacy, Georgetown University Associate Medical Director, Case Management and Utilization Review, MUGH Volunteer medical students / nursing students at The HOYA Clinic
5	Nutritional counselors Exercise counselors DC Department of Health Community health clinics Volunteer endocrinologists and/or internists from MGUH and the community Podiatrists Ophthalmologists	Expand the IronMed Health and Wellness Program	Enroll 30 patients in the IronMed Health and Wellness Program by 12/31/2012 # of program participants with diabetes				

Community Need: Heart Disease / Hypertension Awareness and Management
Goal Statement: Reduce the prevalence and improve the medical management of persons with hypertension in Ward 6.
Target Population: All residents of Ward 6 in Washington, DC who are 18 years of age or older who have hypertension.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Advisory Task Force Staff of The HOYA Clinic Community health clinics Nutritional counselors Exercise counselors DC Department of Health Volunteer internists and family physicians from MGUH and the community	Conduct inventory of all city-wide hypertension education programs by 9/30/2012	# of old programs/ # of new programs	Increase community awareness of the clinical importance of hypertension.	By 2015, decrease by 5% the percentage of patients in Ward 6 who have hypertension	The HOYA Clinic Georgetown University graduate students in the Health Systems Administration Department Coalition of Georgetown University medical students and nursing students DC Public Schools (Department of Education) MGUH and community volunteer physicians	Professor of Medicine and Assistant Dean for Community Education and Advocacy, Georgetown University
2		Identify best practices to use in disseminating above information to Ward 6 residents.	# of new practices implemented	Increase effective communication about hypertension to the Ward 6 community.			
3		By 12/31/2012 identify two sites within Ward 6 (besides The HOYA Clinic) that can serve as hypertension screening, education and referral centers	# of community health clinic partners # of hypertensive persons with no usual source of care # of persons with cardiac, renal or neurological disease # of physician volunteers	Increase hypertension screening capacity.			

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
4	Advisory Task Force Staff of The HOYA Clinic Community health clinics Nutritional counselors Exercise counselors DC Department of Health Volunteer internists and family physicians from MGUH and the community	Implement consistent hypertension monitoring measures at the HOYA Clinic	# of patients with hypertension	At least 50% of hypertensive patients above baseline will have monthly BP checks while enrolled in the program Of the general population of hypertension patients seen at HOYA Clinic, ensure that at least 95% are counseled about the importance of diet and exercise in their control of hypertension 95% of patients with an identified medical home will be referred back to those providers upon completion of the program and discharge from the Shelter. Patients may elect to continue with the program if discharged prior to completion 95% of those enrolled in the program without a medical home will be referred to a medical home for follow up after completion of the program and upon discharge from the shelter	By 2015, decrease by 5% the percentage of patients in Ward 6 who have hypertension	The HOYA Clinic Georgetown University graduate students in the Health Systems Administration Department Coalition of Georgetown University medical students and nursing students DC Public Schools (Department of Education) MGUH and community volunteer physicians	Professor of Medicine and Assistant Dean for Community Education and Advocacy, Georgetown University Associate Medical Director, Case Management and Utilization Review, MUGH Volunteer medical students / nursing students at The HOYA Clinic
5		Expand the IronMed Health and Wellness Program	Enroll 30 patients in the IronMed Health and Wellness Program by 12/31/2012 # of program participants with hypertension				

MedStar Montgomery Medical Center
Community Health Assessment FY2012

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

   MedStar Montgomery Medical Center's (MedStar Montgomery) Community Benefit Service Area includes residents in the Aspen Hill/Bel Pre neighborhood (ZIP code 20906) with a focus on persons aged 50 and older having risk factors that are linked to heart disease. This area was selected due to its close proximity to the hospital, coupled with a high density of residents with low-incomes.

   While the primary focus will be on heart disease, the other identified community needs of cancer prevention and mental/behavioral health will be considered for future programming, with greater focus to begin in FY14.

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

   The area encompassed by ZIP code 20906 has 65,043 residents, over 40% of whom are age 54 or older. The population is racially diverse, with 44.3% White, 25.5% Black/African American, 12.3% Asian and 17.9% other (Claritas, 2011). According to the Montgomery County Department of Health and Human Services, the leading cause of death for both males and females in Montgomery County as a whole is cardiovascular disease (2009).
   .
   MedStar Montgomery Medical Center selected this area as the CBSA for several reasons. First, African American and Asian male populations in have the highest prevalence of heart disease, cholesterol and high blood pressure in the Montgomery County (Maryland Department of Health and Mental Hygiene; Maryland Behavioral Risk Factor Surveillance System). As nearly 38% of the Aspen Hill/Bel Pre population consists of these two groups, it represents a high risk area where cardiovascular health education can have the greatest impact.

   Second, the hospital used the Catholic Healthcare West's Community Needs Index (CNI), which measures the severity of health disparities based on five healthcare access barriers: income, culture/language, education, insurance and housing. According to the CNI scoring methodology, a score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers. Zip code 20906 scored 3.4 out of 5 indicating pervasive socioeconomic disparities in access to healthcare services.

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

   Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

   Montgomery County Department of Health and Human Services (DHHS) provided countywide leadership to support the design of www.healthymontgomery.org, a web-based,

interactive platform that houses quantitative data based on 129 community health indicators. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process. As a financial supporter of www.healthymontgomery.org, MMMC partners with the DHHS, other hospitals in the county, and community stakeholders to develop, support and execute a countywide community health improvement strategy.

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

To determine MedStar Montgomery Medical Center's community benefit focus for FY12-FY14, the hospital formed an Advisory Task Force, which consisted of hospital personnel, community leaders and community members.

The Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, as well as current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

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

Advisory Task Force Membership

Name	Title / Affiliation with Hospital	Name of Organization
Nikki Yeager	Executive Sponsor / Vice President, Planning, Marketing and Business Development	MedStar Montgomery Medical Center
Veronica M. Everett	Lead / Community Outreach Coordinator	MedStar Montgomery Medical Center
Amy Matey	Co-Lead / Analyst	MedStar Montgomery Medical Center
Dr, Robert Larkin	Physician; Emergency Dept	Physician; Volunteer
Dr. Morton Albert	Physician; AMHC	Physician; Volunteer
Julie Bawa	Board Member	Project Officer, Public Health Analyst at US Dept of HHS
Margaret Simons	Community Member	Volunteer
Judith Thomas	Community Member	Proyecto Salud
Dr. Giuliana Centty	Board Member	Private Practice

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

a) Heart Disease	
Quantitative evidence	Heart disease is the leading cause of death in White, Latino and African American/Black men and women. (American Community Survey, U.S. Census Bureau, American Fact Finder, 2005-2009). Rates of high cholesterol have increased in the county from 30% in 2005 to 39% in 2009 (http://app.nccd.cdc.gov/cdi).
Qualitative evidence	74.2% (n=31) of Community Input Survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as "somewhat severe," "severe" or "very severe."
Hospital strengths	MedStar Montgomery Medical Center is a Certified Primary Stroke Center and Accredited Chest Pain Center, and one of only 4 recipients in the state of the 2011 Gold Performance Achievement Award, Action Registry-GWTG from the American College of Cardiology and American Heart Association.
Alignment with local, regional, state or national health goals	All local, regional, state and national health goals identify heart disease as a priority health condition. • Healthy People 2020 HDS-1 through HDS-5 • MD SHIP: Reduce deaths from heart disease
Other justification	N/A

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

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner
Behavioral / Mental Illness	Access to Care	24-hour, 365 day help line; shuttle van to transport residents to and from programs	Kent Fangboner, Director AMHC
Behavioral / Mental Illness	Wellness & Prevention; Quality of Life	Postpartum Support Group	Regina Keefe, LCSW; Ann Waller, LCSW
Cancer (Breast)	Wellness & Prevention	WHIP, Women's Health Initiative Program	Proyecto Salud/Montgomery County DHHS
Cancer	Quality of Life	Monthly support group for patients, family and friends	MedStar Montgomery Medical Center's Cancer Care Navigator
Cancer	Wellness & Prevention	Ongoing lung cancer screening program	Oncology service line, MedStar Georgetown University Hospital and MedStar Washington Hospital Center

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Mental / Behavioral Health	Quality of Life	54.9% (n=31) of Community Input Survey respondents rated mental/behavioral health as either "severe" or "very severe" within the CBSA	MedStar Montgomery Medical Center already addresses this concern through a full spectrum of programs, including a 24/7 Mental Health Help Line. MMMC provides transportation to and from programs for those in need. The hospital also hosts the county's only postpartum support group.
Substance Abuse	Wellness & Prevention	22.6% (n=31) of Community Input Survey respondents rated substance abuse as either "severe" or "very severe" within the CBSA	MedStar Montgomery Medical Center already addresses this concern through a full spectrum of programs, including a 24/7 Mental Health Help Line. and provides transportation to and from programs for those in need.
Cancer (Breast)	Wellness & Prevention	• Data shows there are 125.7 cases/100,000 females diagnosed with breast cancer in Montgomery County, which is ranked 13th for highest incidence of breast cancer out of 24 counties in state of Maryland (www.cancer.gov) • 25.8% (n=31) of Community Input Survey respondents rated cancer as either "severe" or "very severe" within the CBSA	MedStar Montgomery Medical Center is already addressing this issue through ongoing support programs. The hospital also has a partnership with Proyecto Salud through which it offers breast exams and follow-up care to underserved women.

Condition / Issue	Classification	Provide statistic and source	Explanation
Cancer (Lung)	Wellness & Prevention	• Data shows that lung cancer is the second most common cancer and the primary cause of cancer-related death in both men and women in the U.S. (http://seer.cancer.gov) • 25.8% (n=31) of Community Input Survey respondents rated cancer as either "severe" or "very severe" within the CBSA	MedStar Montgomery Medical Center has an ongoing partnership with MedStar Georgetown University Hospital and MedStar Washington Hospital Center, through which it offers lung cancer screenings and diagnosis
Diabetes	Wellness & Prevention	38.8% (n=31) of Community Input Survey respondents rated diabetes as either "severe" or "very severe" within the CBSA	MedStar Montgomery offers support groups, health education talks and programs that adequately address this issue. Additionally, MedStar Montgomery feels that by focusing on heart disease factors, we will indirectly address this health concern.
Overweight / Obesity	Wellness & Prevention; Quality of Life	48.4% (n=31) of Community Input Survey respondents rated overweight/obesity as either "severe" or "very severe" within the CBSA.	MedStar Montgomery feels that by focusing on heart disease factors, we will indirectly address this health concern as well. Additionally, the hospital currently offers Yoga, Aerobics and Tai Chi courses to community members. It also partners with elementary schools in walking groups and hosts weight loss surgery seminars.
Stroke	Wellness & Prevention	19.3% (n=31) of Community Input Survey respondents rated stroke as either "severe" or "very severe" within the CBSA	MedStar Montgomery feels that by focusing on heart disease factors, we will indirectly address this health concern.

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

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

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

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

Resources

- www.chwhealth.org
- American Community Survey, 2005-2009
- Claritas, 2011
- http://app.nccd.cdc.gov/cdi
- www.cancer.gov
- www.seer.cancer.gov

Implementation Strategy

Community Need: Heart Disease
Goal Statement: To have an educated public with regard to heart disease prevention and management and available resources
Target Population: Males and females of all ethnicities in the geographic area of 20906 / Bel Pre/Aspen Hill.

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Cardiologists Nurse practitioners Nutritionists Vascular screening technicians MedStar Montgomery Medical Center Community Outreach Coordinator	Conduct heart disease-related education programs throughout the Aspen Hill/Bell Pre region	Quarterly health information talks on heart disease-related topics focused in Aspen Hill area Place heart disease prevention advertisements/articles	Increase knowledge of heart disease-related factors based on pre/post-test results[1] Educate community on heart disease prevention with placement of two heart disease prevention ads/articles	Increase access of primary health care in Aspen Hill area[1]	Holy Cross Montgomery County DHHS Community cardiac and vascular physician groups	Community Outreach Coordinator Director of Laboratory Services Medical Director, MedStar Montgomery Medical Center Laboratory Medicine Cardiologist Nurse Practitioner, Cardiac Services Physician Assistant, Cardiac Services
2	Health Ambassadors	Develop an ambassador program	Train four health ambassadors to extend educational reach	Increase contact with community with education and support	Continued support where needed to maintain community knowledge		
3	MedStar Montgomery Medical Center Community Outreach Coordinator	Implement smoking cessation program	Offer two eight-week smoking cessation courses	Support persons wishing to quit smoking with program		American Lung Association	
#	**Resources**	**Activities**	**Outputs**	**Short-Term**	**Long-Term**	**Partnering**	**Responsible**

				Outcomes	Outcomes	Organizations	Party(ies)
4	Cardiologists Nurse practitioners Nutritionists Vascular screening technicians MedStar Montgomery Medical Center Community Outreach Coordinator Health Ambassadors	Complement health education programs with heart disease-related screenings	Three cholesterol screenings of 15 persons or more with focus on Aspen Hill area Blood pressure screenings of 15 persons at various locations within designated community benefit area Semi-annual vascular screenings	Engage 20% or more of persons screened for cholesterol to attend information talks to educate them on how to decrease high cholesterol Engage 20% or more of persons screened for blood pressure reading to return for at least one follow-up screening Engage 20% or more of persons screened for blood pressure to attend health information talk on reducing high blood pressure Increase knowledge of factors contributing to vascular blockage/heart disease	Repeating lab work/rescreen to assess cholesterol numbers of at least 30% of originally screened persons		Community Outreach Coordinator Director of Laboratory Services Medical Director, MedStar Montgomery Medical Center Laboratory Medicine Cardiologist Nurse Practitioner, Cardiac Services Physician Assistant, Cardiac Services
5		Support new community clinic opening in Aspen Hill in April 2012	Support opening of Holy Cross Clinic in Aspen Hill	Educate community on opening of clinic	Clinic can serve as a medical home for community members		

[1] Baseline will be established in 2013.

MedStar National Rehabilitation Hospital
Community Health Assessment FY2012

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

MedStar National Rehabilitation Network's Community Benefit Service Area includes Spanish speaking stroke survivors and their caregivers who reside in the District of Columbia. Based on quantitative and qualitative findings, this population was identified due to considerable growth of the Spanish speaking community in the District of Columbia, coupled with a dearth of culturally and linguistically tailored services to prevent recurrent stroke in the Spanish speaking population.

2. Provide a description of the CBSA.

According to the U.S. Census Bureau 2010 statistics, 9.1 percent of District of Columbia population is persons of Hispanic or Latino origin. The Latino population in the District has grown steadily since 1980. Ward 1 has the highest concentration of Hispanics, which account for 21 percent of the population, followed by 19 percent of the Ward 4 population. District of Columbia Department of Health (DCDOH) data indicate that Ward 4 has the highest rate of stroke mortality—at 64.1 per 100,000; Ward 1 stroke mortality rate stands at 21.2 per 100,000.

The American Stroke Association reports that about 795,000 strokes occur in American each year, more than 20 percent of which are recurrent events. Additionally, nearly 18% of annual strokes result in death (National Institute for Neurological Disorders and Stroke). Recurrent stroke is a major contributor to disability, and risk of severe disability or death increases with each stroke recurrence. The risk of a recurrent stroke is greatest right after a stroke—approximately 3 percent of stroke patients will have another stroke within 30 days of their first stroke and one-third of recurrent strokes take place within two years of the first stroke.

Stroke is the fourth-leading cause of death among Hispanics. According to the American Heart Association, some studies indicate that Hispanics have a higher rate of hemorrhagic strokes at a younger age than non-Hispanic-whites. One study found that hemorrhagic strokes occurred more commonly in Hispanics than in any other sub-group. In addition, data indicate that Spanish-speaking Hispanics are less likely to know stroke symptoms than English-speaking Hispanics, African Americans and Caucasians. Anecdotal evidence indicates that Hispanic-Latino stroke survivors and their caregivers have difficulty finding and utilizing follow-up education and support after a first stroke. This complicates recovery and increases the risk for second stroke.

Hispanics also have a different prevalence of risk factors for stroke when compared with non-Hispanic whites. Diabetes, high blood pressure, metabolic syndrome and obesity are more prevalent among Hispanics. The American Heart Association reports that 75 percent of Mexican-American men and 72 percent of women age 20 and older were overweight or obese compared to 29 percent of men and 40 percent of women in the population at large.

The National Health and Nutrition Examination Survey reported that 65 percent of Mexican-American men and 74 percent of Mexican-American women did not participate in leisure-time physical activity.

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

The Community Benefit priority was recommended by an Advisory Task Force, which includes MedStar NRH Team Members, MedStar NRH board members, former MedStar NRH patients, and representatives from the Department of Health.

The Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan as well as current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

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

Advisory Task Force Members

Name	Title	Name of Organization
Robert Hartmann	Vice President, Marketing and Strategic Development	MedStar National Rehabilitation Network
Michael Leaver	Community Relations Coordinator	MedStar National Rehabilitation Network
Cathy Ellis	Assistant Vice President, Clinical Services	MedStar National Rehabilitation Hospital
Jackie Watson, DO	Executive Director, DC Board of Medicine	MedStar National Rehabilitation Network Board Member
Joan Joyce	Manager, Therapeutic Recreation	MedStar National Rehabilitation Hospital
Jill Anderson	Assistant Vice President, Outpatient,	MedStar NRH Rehabilitation Network
Susan Groah, MD	Director of SCI Research and Director of SCI Consultations Associate Professor of Rehabilitation Medicine	MedStar National Rehabilitation Network Georgetown University
John Rockwood	President	MedStar National Rehabilitation Network
Jennifer Sheehey	Former Patient	Secretary of MedStar NRH Board of Associates
Deeona Farr	Researcher	MedStar National Rehabilitation Hospital
Timothy Strachan	Former Patient	FCC – Attorney Advisor Legal Affairs
Carol Bartlett	Manager of Care Coordination	MedStar National Rehabilitation Network

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

a) Spanish Language Healthy Living and Second Stroke Risk Reduction Education for Survivors and Caregivers	
Quantitative Evidence	• Stroke is the fourth-leading cause of death among Hispanics (American Stroke Association) • The risk of a recurrent stroke is greatest right after a stroke—approximately 3 percent of stroke patients will have another stroke within 30 days of their first stroke and one-third of recurrent strokes take place within two years of the first stroke (NINDS) • Hispanics also have a different prevalence of risk factors for stroke when compared with non-Hispanic whites (American Stroke Association) • Anecdotal evidence indicates that Hispanic-Latino stroke survivors and their have difficulty finding and utilizing follow-up education and support after a first stroke. This complicates recovery and increases the risk for second stroke.
Qualitative Evidence	While much of the Holleran Report data were neutral, indicators show a high percent of those surveyed responded "don't know" when asked to rate support/education programs for caregivers of persons with health conditions (20.8%), persons with cardiovascular disease (33.3%) and of cardiovascular disease prevention (33.3%).
Hospital Strengths	MedStar NRH has a strong stroke program with inpatient stroke accounting for 31% of annual admissions in FY2011. In 2011, 30 Hispanic patients were discharged from MedStar National Rehabilitation Hospital with stroke or stroke-like symptom conditions. That number was consistent in 2010 when MedStar NRH saw 33 Hispanics with the same diagnoses and is up from 23 in 2009. In all three years, stroke or stroke-like symptoms accounted for a disproportionate number of the Hispanic population treated at the Hospital. MedStar NRH is home to one of the Nation's largest stroke rehabilitation programs, seeing more than 600 patients per year. The Hospital also has extensive experience with support groups. It has offered the "Stroke Come Back Club," a support group for stroke survivors, their caregivers and families, for over 10 years.

Alignment with local, regional, state or national health goals	The five-year DC Chronic Care Initiative calls for increasing prevention and detection of chronic disease including stroke while the 2007 District of Columbia State Health Plan makes a call to “Reduce the mortality rate from stroke to no more than 33.2 per 100,0000 residents.” The same plan acknowledges that “minorities are less likely than whites to receive the best diagnostic tests or treatments for stroke or cancer;” while addressing health disparities in the District of Columbia. Goals of Healthy People 2020, the national health initiative, call for prevention, early detection and treatment for heart attack and stroke, and of repeat cardiovascular events.
Other justification	N/A

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

Condition / Issue	Classification	Provide statistic and source	Explanation
All physical disabilities	Quality of Life	Adaptive Sports Program The MedStar NRH Adaptive Sports Program, started in the early 1990's, is designed to engage individuals with disabilities, especially those who use wheelchairs for mobility, in exercise and physical activity, which is often neglected by this population. MedStar NRH's Adaptive Sports Program includes partnering with the BlazeSports Clubs of America, US Paralympics, Walter Reed National Military Medical Center and also features a loaner program for variety of adaptive sports chairs and equipment to pediatric patients in the Washington Metropolitan Area.	BlazeSports America **US Paralympics** Community Veterans Program Manager United States Olympic Committee 27 South Tejon Colorado Springs, CO 80903 719-866-2040 [office] **Walter Reed National Military Medical Center** Director, Paralympic Military Program United States Olympic Committee 27 South Tejon Colorado Springs, CO 80903 719-866-2043 [office]

Condition / Issue	Classification	Provide statistic and source	Explanation
Mild Traumatic Brain Injury	Wellness & Prevention	Concussion Education in Schools and the Community MedStar NRH has partnered with Children's National Medical Center, MedStar Sports Medicine, and MedStar Union Memorial Hospital to create a Concussion Education Series for the District of Columbia, Montgomery County and the greater Baltimore Area. MedStar NRH and Children's National Medical Center focus on the schools and the community in DC and Montgomery County, while the other partners focus on the Baltimore area. The goal of this series is to educate children and parents of the risks associated with an untreated concussion including permanent cognitive impairment (dementia), depression, movement disorders, seizures and other complications later in life. Through this initiative, we will help to ensure that we are not only considering the return to play, but also the successful return to the classroom.	Children's National Medical Center MedStar Sports Health Survivors and Advocates for Empowerment (SAFE), Inc 500 Indiana Avenue Northwest #4235 Washington, DC 20001

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Seating and positioning education of group home staffs/providers to prevent decubitus ulcers	Wellness & Prevention	Anecdotal evidence that providers in group homes are not educated about proper seating leading to decubitus ulcers requiring hospital stays and rehabilitation	Difficult to track and define population, high risk of not being successful because of a lack of cooperation from group homes, very small population
Diabetes prevention	Wellness & Prevention	Identified as a top priority for the District of Columbia	MedStar National Rehabilitation Hospital does not have the expertise or resources to serve as a lead agency that addresses diabetes.
Concussion Prevention for student	Wellness & Prevention	Concussion and Mild TBI in student athletes is garnering much attention in the media and within homes – evidence shows that without treatment the long-term effects can be detrimental	MedStar National Rehabilitation Hospital is currently partnering with MedStar Health and other local organizations to provide these services.

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

MedStar National Rehabilitation Hospital will institutionalize community benefit programming by following specific steps to support the objectives identified in the Implementation Strategy.

a) The support group for stroke survivors and their caregivers of Hispanic origin will be overseen by the Hospital's Stroke Team with support from the Community Relations Coordinator.
b) The Hospital will include in its on-going operating plan measures to ensure that it continues to educate and conduct outreach to underserved populations in the District of Columbia, including Hispanics. This goal aligns with national goals set forth by the Center for Accreditation of Rehabilitation Facilities (CARF) as well as the Joint Commission on Healthcare Accreditation.
c) As the only provider of Adaptive Sports Programming in the District of Columbia, MedStar NRH is fully invested in its Program and will remain so until there is no need for this program. The Hospital's commitment to this program is demonstrated by its continued investment in the program. The creation of fundraising events to support the program and the continued inclusion of Therapeutic Recreation in the Hospital's programming despite a lack of payment for these services.

The Advisory Task Force will continue its work following submission of the Community Needs Assessment to advise Hospital Leadership on steps which need to be taken to ensure timely, focused completion of the projects outlined. Decision making authority will continue to be held with Senior Leadership, directed by the Board but guided by MedStar National Rehabilitation Hospital's core missions: Patient Care, Advocacy, Rehabilitation Research, Assistive Technology and Education. Performance and timely completion of project steps will be overseen by the Community Relations Coordinator reporting to hospital leadership and the Advisory Task Force.

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

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

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

Resources

- American Heart Association. Heart Disease and Stroke Statistics 2010 Update At-a-Glance. At: http://www.americanheart.org/presenter.jhtml?identifier=1200026
- U.S. Census Bureau 2010; District of Columbia: http://quickfacts.census.gov/qfd/states/11000.html
- District of Columbia DOH, Community Health Administration: http://dchealth.dc.gov/doh/cwp/view,a,1374,q,603795.asp
- District of Columbia DOH: http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/shpda/pdf/new_2007_health_plan.pdf
- American Stroke Association; Stroke Among Hispanics: *Topics in Stroke Rehabilitation*, Winter 2003.
- National Institute for Neurological Diseases and Stroke (NINDS): http://www.ninds.nih.gov/

Implementation Strategy

Community Need: Stroke survivors and caregivers who speak Spanish as a primary language
Goal Statement: Provide Spanish language education about healthy living and reduction of risk for recurrent stroke for stroke and/or brain injury survivors and their caregivers in the District of Columbia
Target Population: Spanish-speaking adults living in the District of Columbia who have suffered from stroke[1] or care for someone who has

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar NRH team members Community partners Financial personnel/backing Transportation to MedStar NRH for Support Group attendees	Develop a pilot Spanish language psycho-education support group	Identify three primary Spanish-speaking educational support group facilitators Distribute 1,000 flyers and brochures to community-based health, religious and advocacy organizations to advertise and promote the group Hold monthly support group session with a minimum of 5 attendees at each	Increase awareness among stroke survivors of possibility and risks of recurrent stroke Develop relationships with former Hispanic patients and caregivers to provide leadership role in design and implementation of support group Increase the number of attendees at support group session by 3 each quarter	Reduced primary and secondary strokes due to awareness and action on the part of stroke survivors and their families and/or caregivers[*2]	Local Hispanic Community Centers	Manager, Care Coordination Speech Language Pathologist Community Relations Coordinator Vice President, Medical Affairs
2	Professional Spanish-language translator	Translate appropriate stroke educational patient materials into Spanish	Four to five translated stroke educational patient materials	Better understanding and awareness of materials by non-English speaking patients			Vice President, Marketing and Strategic Development

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
3		Develop pre- and post-testing instrument to measure participant learning	20 question test gauging basic stroke knowledge	60% of participants will demonstrate improvement in knowledge between pre- and post-tests	85% of participants will demonstrate improvement in knowledge between pre- and post-tests	MedStar Health	Speech Language Pathologist Manager, Care Coordination Community Relations Coordinator
4	Professional Spanish-language translator MedStar web team	Develop a Spanish language Web page with educational materials and community resource information	Develop web page framework Write web page copy Post online	Increase availability and accessibility of Spanish-language stroke health resources[3]	Increase availability and accessibility of Spanish-language stroke health resources[3]		Vice President, Marketing and Strategic Development Community Relations Coordinator
5	Professional Spanish-language translator Funding to cover cost for translating book Community partner(s) to assist with cultural competency of translation	Translate press book “A Guide to Living Well with Stroke” into Spanish	Translate book Include/tailor testimonials in book to Spanish speaking audience by including stories from former Spanish speaking patients Make books available, free of charge to Spanish speaking patients of MedStar NRH and for a nominal charge for non-patients	Increase availability and accessibility of Spanish-language stroke health resources[3]	Increase availability and accessibility of Spanish-language stroke health resources[3]		Vice President, Marketing and Strategic Development Community Relations Coordinator

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
6		Develop partnerships to help improve access to Spanish-language stroke education-support for stroke survivors and caregivers in their communities	Identify a total of 4 community partner organizations in Wards 1 and 4 Review current health educational opportunities available in the community and work with them to build cooperative programming Establish a neighborhood-based, psycho-educational support group based on the pilot and measure participant learning	Create network of resources and resource organizations around stroke and secondary stroke for Spanish-speaking populations Extended outreach and awareness among Spanish-speaking populations	Create network of resources and resource organizations around stroke and secondary stroke for Spanish-speaking populations Extended outreach and awareness among Spanish-speaking populations	Mary's Center Christ House Ayuda (Help!)	Speech Language Pathologist Manager, Care Coordination Community Relations Coordinator Vice President, Medical Affairs

[1] Stroke is defined as a stroke or mild traumatic brain injury.
[2] Current data available only addresses the number of primary strokes within the Hispanic Population. This number is disproportionally high compared to other groups in the District. Trends show that a higher number of people are likely to have a second, more serious event if they are not educated and do not seek proper follow-up care. Baseline data will be collected in FY13.
[3] Baseline data will be collected in FY13.

MedStar St. Mary's Hospital
Community Health Assessment FY2012

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

MedStar St. Mary's Hospital's Community Benefit Service Area includes the 105,000 residents of St. Mary's County, Maryland, with a focus on the Lexington Park community (ZIP code 20653). The Lexington Park community was selected due to a high density of low-income residents. Based on quantitative and qualitative findings, obesity, substance abuse (tobacco and alcohol), access to care for the uninsured, and healthcare provider shortages have been identified as the hospital's community benefit priorities.

2. Provide a description of the CBSA.

According to 2010 US census data, St. Mary's County has a population of 105,000 citizens. The population increased by 22% from the 2000 to the 2010 census, making St. Mary's one of the fastest growing jurisdictions in Maryland. St. Mary's is a federally designated rural area. The census designated place (CDP) of greatest concern to public health officials is Lexington Park, which has the greatest number of residents living at or below the federal poverty level (16.7%), with the highest percentage of minorities (32% African American and 7.4% Hispanic) living with health, social and economic inequities. Additionally, according to the 2011 County Health Ranking Report, there are an estimated 12,150 adults (15%) in St. Mary's County who are uninsured and 8.5% of resident's county-wide are living at or below the federal poverty level.

The Health Resources and Services Administration (HRSA) designated the southern portion of the county as a Health Professional Shortage Area (HPSA) and Dental and Mental Health HPSA county-wide. The county averages 1,723 citizens per one physician, more than double the state and national averages (713:1 and 631:1, respectively). As the only hospital in St. Mary's County, MedStar St. Mary's Emergency Department (ED) saw 51,624 patients in 2010 out of a total population of 105,000 residents, which represents a more than 50% increase in utilization since 2000.

Obesity is a severe issue in this jurisdiction, where 72% of adults are either overweight or obese according to the 2010 Maryland Behavioral Risk Factor Surveillance System (BRFSS). The percentage of St. Mary's County adults who report being obese is even higher within the African American population, where 45.6% of adults report a Body Mass Index (BMI) above 30, which is significantly higher than that of Caucasian adults (26%). This health inequity has been recognized by the Maryland Department of Health and Mental Hygiene (DHMH), which identified the obesity prevalence in St. Mary's County as a racial disparity. The epidemic of obesity has spread to our youth, where self-reported data from the Maryland Youth Tobacco Survey show that 16.7% of public school children over 11 years old in St. Mary's were overweight and 10.8% were obese in 2008. Direct measurements from the 2009 Maryland Pediatric Nutrition Surveillance Survey suggest that 35.1% of low-income preschoolers (2-4 years old) in St. Mary's were overweight or obese.

Major co-morbidities of obesity are also prevalent in St. Mary's County, with cancer and stroke mortality placing in the bottom quartile in both categories according to the 2010 Primary Care Needs Assessment (DHMH), which also placed a disparity designation for heart disease mortality. According to the 2009 Maryland BRFSS, 8.7% of the adults in St.

Mary's County have diabetes. Furthermore, DHMH identified diabetes prevalence as a high racial disparity condition in the county. Tobacco use is also a highly concerning issue in the eyes of local public health officials, where the percentage of adult smokers stands at 21%, one of the highest rates of usage in the state. Health inequity was also captured in the county's 2009 Community Health Needs Assessment, where 50% of low-income, minority adults self-reported tobacco use versus 13% for Caucasian adults. Moreover, lung cancer is the second leading cancer diagnosis in St. Mary's County, reflecting the high rates of tobacco use within our rural community (MedStar St. Mary's Hospital 2010 Cancer Report).

Substance abuse has also become a health priority in St. Mary's County, where 19% of adults report binge or excessive drinking in the past 30 days (County Health Ranking Report). Additionally, data from a 2010 Community Needs Assessment found a 50% smoking rate in the low income population living in the Lexington Park area.

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

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

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

Advisory Task Force Membership

Name	Title/Hospital Affiliation	Organization
Joan Gelrud	Vice President	MedStar St. Mary's Hospital
Lori Werrell	Director, Health Connections	MedStar St. Mary's Hospital
Mary Leigh Harless	Board Member	MedStar St. Mary's Hospital
Lewie Aldridge	Board Member	MedStar St. Mary's Hospital
Linda Dudderar	Board Member	MedStar St. Mary's Hospital
Tim Storch	Board Member	MedStar St. Mary's Hospital
Barbara Thompson	Board Member	MedStar St. Mary's Hospital
Paul Barber	Board Member	MedStar St. Mary's Hospital
Jane H. Sypher	Board Member	MedStar St. Mary's Hospital
Dr. A.D. Shah	Physician, Chief of Staff	MedStar St. Mary's Hospital
Dr. Harold Lee	Physician, Medical Staff Representative to Board	MedStar St. Mary's Hospital
Donald Sirk	Director of IT; Representative to Board	MedStar St. Mary's Hospital
Christine Wray	President and CEO	MedStar St. Mary's Hospital
Joan Gelrud	VP	MedStar St. Mary's Hospital
Mary Lou Watson	VP,CNO	MedStar St. Mary's Hospital
Dr. Steve Michaels	VPMA	MedStar St. Mary's Hospital
Mark Boucot	VP	MedStar St. Mary's Hospital
Ric Braam	VP,CFO	MedStar St. Mary's Hospital
Holly Meyers	Director Marketing and Public Relations	MedStar St. Mary's Hospital

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

a) Obesity – (as risk factor for Heart Disease)	
Quantitative Evidence	• 26.9% of adults are obese, which is just below state average of 27.9% (MD BRFSS, 2010) • 16.5 % of low income preschoolers are obese (MD BRFSS, 2011) • 29.5% of adults report 30 minutes of moderate physical activity for 5 days per week • St. Mary's ranked 24th out of 24 state jurisdictions for moderate physical activity
Qualitative Evidence	• Obesity was identified as the second most concerning area of need in the community input session • 77.3% (n=154) of Community Input Survey respondents rated obesity either "Severe" or "Very Severe" in the CBSA
Hospital Strengths	MedStar St. Mary's Hospital is the lead for the obesity goal defined in the 2010 Community Health Improvement Plan for St Mary's County and leads the *Fit and Healthy St Mary's* Obesity Coalition.
Alignment with local, regional, state or national health goals	Maryland State Health Improvement Plant (SHIP) St. Mary's Community Health Improvement Plan (CHIP) **NWS-8**: Increase the proportion of adults who are at a healthy weight **NWS-9**: Reduce the proportion of adults who are obese **NWS-10**: Reduce the proportion of children and adolescents who are considered obese
Other justification	Obesity is a co-morbidity to many chronic conditions. Reducing obesity may also create a reduction in the incidence and severity of other chronic conditions, such as heart disease and diabetes.

b) Access to care for the uninsured and underinsured	
Quantitative Evidence	• 12.1% of adults report that they are unable to afford to see a doctor (MD BRFSS, 2010)

	• 13.7% of adults are uninsured (Census 2010) • Southern half of county is designated as a Health Professions Shortage Area (HPSA).
Qualitative Evidence	The two areas garnering the lowest levels of agreement were "There is sufficient access to health care services for the uninsured" and "There are a sufficient number of physicians and other health care providers accepting Medicaid or other forms of medical assistance." These two items averaged ratings of 2.3 and 2.4 respectively. With respect to challenges, the overuse and misuse of the Emergency Department services was discussed at length during the community input session. While the hospital was applauded as being a safety-net provider with its Emergency Department, this over-extension of the ED is perceived as a significant challenge. More and more individuals utilize the Emergency Department at the hospital for their primary care needs, which may reduce continuity of care while driving up health care costs and reducing resources for those with emergencies. The lack of services for the un- and under-insured in the county is blamed for this use of the Emergency Department. The second most commonly noted barrier was a lack of health insurance for a number of residents in the county. For those who have some form of Medical Assistance, the barriers are just as significant. It was generally perceived that the county has medical services available, but that they are only available to those with private insurance. The residents who are supported by the public system become frustrated with too few providers and long waiting periods for appointments. There are also significant concerns within the public about how to effectively navigate this system.
Hospital Strengths	As the trusted leader in health care, MedStar St Mary's has provided the Get Connected to Health program since 2008 and will be expanding this primary care service for the uninsured to a full time practice with a mid-level clinician as a part of this community health improvement plan.
Alignment with local, regional, state or national health goals	Healthy People 2020 goal **AHS-5**: Increase the proportion of persons who have a specific source of ongoing care
Other justification	People with a usual source of care are more likely to obtain routine checkups and screenings, and are more likely to know where to go for treatment in acute

	situations. Not having a usual source of care or a usual place to go to when sick or in need of health advice can cause a delay in necessary care, leading to increased risk of complications.

c) Health Care Provider Shortage	
Quantitative Evidence	• 14.4% of adults report not having had a routine

	checkup. • The county averages 1,723 citizens per one physician, more than double the state and national averages (713:1 and 631:1, respectively) • As the only hospital in St. Mary's County, MedStar St. Mary's Emergency Department (ED) saw 51,624 patients in 2010 out of a total population of 105,000 residents, which represents a more than 50% increase in utilization since 2000. • Southern Maryland has physician-to-population ratios below the HRSA benchmark for all types of physicians.
Qualitative Evidence	The two areas garnering the lowest levels of agreement on the Community Input survey were "There is sufficient access to health care services for the uninsured" and "There are a sufficient number of physicians and other health care providers accepting Medicaid or other forms of medical assistance." These two items averaged ratings of 2.3 and 2.4, respectively.
Hospital Strengths	MedStar St. Mary's is committed to improving the physician shortage in St. Mary's County through recruitment and bringing in specialists from our sister hospitals to help meet community need, as well as working with community partners to bring an FQHC and after hours primary care services to Lexington Park.
Alignment with local, regional, state or national health goals	• Southern Maryland region has the most severe physician shortage in the state • Healthy People 2020 goals **AHS-4** - (Developmental) Increase the number of practicing primary care providers **AHS-3** - Increase the proportion of persons with a usual primary care provider
Other justification	People with a usual source for care are more likely to obtain routine checkups and screenings, and are more likely to know where to go for treatment in acute situations. Not having a usual source of care or a usual place to go to when sick or in need of health advice can cause a delay in necessary care, leading to increased risk of complications.

d) Substance Abuse	
Quantitative Evidence	• 16.9% of adults report binge drinking at least once during the 30 days prior to the survey. (Male binge

	drinking is defined as five or more drinks on one occasion, and female binge drinking is four or more drinks on one occasion) (MD BRFSS, 2010). • Percentage of alcohol related treatment admissions of residents under 21 is higher than state average as reported in (State of Maryland Automated Tracking, 2010).
Qualitative Evidence	• Community Input Survey respondents rated substance abuse the most severe issue throughout the county (average rating of 4.3). • 89.3% (n=28) of Community Input Survey respondents rated substance abuse either "Severe" or "Very Severe" in the CBSA
Hospital Strengths	Maryland Strategic Prevention Framework grant and the Prevention Services block grant recipient to implement strategies to reduce under-age drinking, binge drinking and alcohol-related crashes in youth and young adults
Alignment with local, regional, state or national health goals	**SA-2**: Increase the proportion of adolescents never using substances **SA-14**: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
Other justification	MSMH is part of a grant with Walden Sierra, Inc from the Community Health Resource Commission (CHRC) to provide primary care services to their behavioral health/substance abuse clients for the next two years

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

Condition / Issue	Classification	Name of Program	Key Partner

			/ Description of Service	
Cancer	Age-adjusted death rate due to prostate cancer	Wellness & Education	Cancer Awareness Day – twice annually June is Men's Health Month on the mobile outreach unit, with focus on prostate cancer education	Local urologist American Cancer Society
	Age-adjusted death rate due to lung cancer	Wellness & Education	Spiral CT screening for early detection of Lung Cancer	MedStar Initiative
Cardiovascular	Age-adjusted death rate due to heart disease	Wellness & Education	Free Blood Pressure Screenings Living Well with CHF STEMI initiative	Libraries, McKay's grocery stores, Senior Centers, American Legion, Ridge Market
	Age-adjusted death rate due to cerebrovascular disease (stroke)	Wellness & Education	Stroke Survivors group- monthly support group Stroke Fair – annual stroke awareness event Stroke Focus group – annually focus group event Certified Stroke Center	Rescue Squads

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

Condition / Issue	Classification	Provide statistic and source	Explanation
Transportation	Access to Care	41.8% (n=153) of Community Input Survey respondents either "disagreed" or "strongly disagreed" they have access to transportation for medical appointments	Human Services Council of St. Mary's County mobilizing resources to address this identified need.
Mental / Behavioral Illness	Access to Care	61.1% (n=154) of Community Input Survey respondents rated mental/behavioral illness as either "Severe" or "Very Severe" in the CBSA	Walden Sierra and NAMI are partners who lead
Colon Cancer Screening	Wellness & Prevention	The current prevalence of colon cancer in St. Mary's County is 64.1% (MD BRFSS)	Health Department is lead
Pap Test History	Wellness & Prevention	84.2% of women in St. Mary's County have ever had a Pap Smear Maryland Behavioral Risk Factor Surveillance System	Health Department is lead
Infant Mortality Rate	Wellness & Prevention	Current infant moratlity rate in St. Mary's County is 7.6 deaths/1,000 live births- (MD DHMH)	Health Department is lead
Mean Travel Time to Work	Quality of Life	The average commute time in St. Mary's County is 29.7 minutes (American Community Survey)	MSMH does not have the expertise or infrastructure to serve as a lead around this area of need.
Workers who drive alone to work	Quality of Life	82.1% of workers in St. Mary's County drive to work alone (American Community Survey)	MSMH does not have the expertise or infrastructure to serve as a lead around this area of need.
SNAP certified stores	Quality of Life	0.4 stores/1,000 population (USDA Food Environment Atlas)	MSMH does not have the expertise or infrastructure to serve as a lead around this area of need.
Student to Teacher ratio	Quality of Life	16.4 students/teacher (NCES)	School system is lead

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

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

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

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

Resources

- Maryland Behavioral Risk Factor Surveillance System - http://www.marylandbrfss.org/
- Maryland State Health Improvement Plan data
- Healthy people 2020 - http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx
- County Health Ranking Report - http://www.countyhealthrankings.org/maryland/st-marys
- U.S. Department of Agriculture - Food Environment Atlas
- 2010 US Census
- Health Resources and Services Administration - http://hpsafind.hrsa.gov/HPSASearch.aspx
- 2010 Primary Care Needs Assessment: Maryland Department of Health and Mental Hygiene - http://fha.maryland.gov/pdf/ohpp/PCO-NeedsAssessment.pdf
- MedStar St. Mary's Hospital 2010 Cancer Report
- MHCC Extramural Report: Maryland Physician Workforce Study - http://mhcc.maryland.gov/workforce/physician_workforce_study_20110513.pdf
- National Center for Education Statistics - http://nces.ed.gov/ccd/bat/

Implementation Strategy

Community Need: Obesity/Overweight
Goal Statement: To increase the number of individuals with a healthy body mass index (BMI)
Target Population: St. Mary's County Residents

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Coalition Chairman and members United Way MedStar St. Mary's Hospital Grants Coordinator	Lead Fit & Healthy St. Mary's Coalition (continuous)	Monthly coalition meetings with 25+ participating businesses and organizations	Implement one new program or demonstration project each year	Decrease by 5% the number of adults who report being overweight or obese by 2015[2]	Fit and Healthy St. Mary's Coalition	Director, Health Connections Fit & Healthy St. Mary's Coalition MedStar St. Mary's Grants Coordinator
2		Create demonstration projects to determine meaningful interventions for this community	Steps to a Fit and Healthy You program in various populations- general, elderly and low-income	Evaluate effectiveness and determine expansion	Increase by 5% the number of adults who report at least 30 minutes of physical activity at least 5 days a week by 2015	Community Health Advisory Committee	
3		Organize and execute the annual St. Mary's Health and Fitness Expo (annual one-day event)	Distribute letters and sponsorship information to 50 local health and fitness businesses and organizations Place advertisements in multiple print, television, and social media settings[4]	Engage 20 businesses and organizations Attract 200 community participants Raise $2,500 in sponsorships to support annual expo	Involve 3 more businesses and organizations each year Increase attendance by 50 persons each year Raise an additional $500 each year	Fit and Healthy St. Mary's Coalition	Director, Health Connections Fit & Healthy St. Mary's Coalition MedStar St. Mary's Grants Coordinator

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
4	Health Department Environmental Staff MedStar St. Mary's Hospital, Director of Health Connections Grants Coordinator Community Health Educator Nutritionist	St. Mary's Healthy Stores (CTG 2012 – 2015)	Work with Johns Hopkins Bloomberg School of Public Health Center for Human Nutrition to identify local stores	Engage one store per year to be part of this program	Decrease by 5% the number of adults who report being overweight or obese by 2015[2]	St. Mary's County Health Department MedStar St. Mary's Hospital, Health Connections Johns Hopkins Bloomberg School of Public Health Center for Human Nutrition	Health Department Director of Nursing Environmental Services Supervisor Director, Health Connections MedStar St. Mary's Grants Coordinator MedStar St. Mary's outpatient Nutritionist
		Include information about Physical Activity and Nutrition in Workplace Wellness Initiatives	Increase number of Worksites with Physical Activity and and Nutrition Guidelines	Engage 5 businesses	Increase by 5% the number of adults who report at least 30 minutes of physical activity at least 5 days a week by 2015		
5	Fit and Healthy St Mary's Coalition members	Promote a healthier physical environment for residents in St. Mary's County by advocating to local public officials and private community developers for healthy and safe community design, creation and maintenance of local parks, trails and recreation areas and through promotion of healthful and safe physical activities within the community	Develop annual policy recommendations for distribution to the Board of County Commissioners and other relevant stakeholders responsible for the physical environment of St. Mary's County Report data and information related to obesity rates within St. Mary's County to the CHAC, media and other relevant stakeholders responsible for the physical environment of St. Mary's County	Annual public communications campaign on necessary environmental strategies and policy changes to combat obesity in St. Mary's County		Fit and Healthy St Mary's Coalition members Community Health Advisory Committee (CHAC) St. Mary's Board of County Commissioners (BOCC) MedStar St. Mary's Hospital	

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
6	MedStar St. Mary's Hospital, Director of Health Connections Medstar Washington Hospital Center Support Staff Nutritionist	Implement bariatric surgery support programs with MedStar Washington Hospital Center as indicated by Bariatric Surgery Center	Hold discussions with MedStar Washington Hospital Center and Bariatric Surgery Center to discuss	Continue support group, MedFit and MNT services that meet qualifications for MedStar Washington Hospital Center and Bariatric Surgery Center	Provide all possible non-surgical pre and post surgical services at MSMH necessary to be a candidate for bariatric surgery at MWHC	MedStar St. Mary's Hospital, Health Connections MedStar Washington Hospital Center	MedStar St Mary's Hospital Vice President MedStar St Mary's Hospital Director of Health Connections

[1] As of April 2012, 28 business and organizations are member of the coalition.
[2] According to the latest figures (2010), the obesity/overweight prevalence in adults is 68.2 overweight or obese adults. When the coalition started in 2009, the prevalence was 74% (Maryland BRFSS).
[3] I.e., weight management, nutrition, exercise, heart health, diabetes
[4] I.e.,Healthy Living, Channel 10, MSMH Facebook page, Hospital website

Community Need: Childhood Obesity/Overweight
Goal Statement: To increase the number of children with a healthy body mass index (BMI)
Target Population: Title I Elementary School Children

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	St. Mary's County Public Schools Staff MedStar St. Mary's Hospital Community Health Educator University of Maryland Extension Staff	As part of Healthier US Schools Challenge (HUSSC) (CTG 2012 – 2015): Work with Title I Elementary Schools and associated Early Childhood Development Centers to achieve USDA Healthier Schools Challenge award	Meet monthly with teams from each school Assist in the production of the application	A minimum of 3 Title I Elementary Schools and associated Early Childhood Development Centers will be engaged in the HUSSC process in 2012. (Additional schools will be added to the program as interest and resources allow) A minimum of 10 centers/homes will take the quiz in the first year	A minimum of 3 Title I Elementary Schools and associated Early Childhood Development Centers will meet HUSSC standards by 2015 Increase the percentage of children with a healthy BMI (≤24) in Title I Elementary Schools and associated Early Childhood Development Centers by 3% by 2015[1] Reduce preschool obesity rate by 3% by 2015	St. Mary's County Public Schools MedStar St. Mary's Hospital University of Maryland Extension (UME)	Director, Health Connections
2		Regular participation in the School Health Council	Serve as a resource for teams				
3		Hold trainings for early care and educations centers/homes on physical activity and nutrition	Let's Move Child Care checklist quiz				

[1] Baseline will be established in 2013 using internal school data

Community Need: Substance Abuse (Tobacco use and Binge Drinking)
Goal Statement: Decrease the number of residents who use tobacco products and decrease the number of resident exposed to second-hand smoke
Target Population: St. Mary's County residents, with a particular focus on Lexington Park residents

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Health Department Community Health Educators MedStar St. Mary's Hospital Community Health Educators, Operations Specialist and Grants Coordinator Healthiest Maryland Institute	Implement a Smoke-free Workplace Program	Tobacco educator to approach businesses and explain program	Engage 10 businesses annually to implement smoke-free workplace policies and provide tobacco cessation programming and support	Reduce tobacco use by 2% in St. Mary's County by 2015	St. Mary's County Health Department MedStar St. Mary's Hospital Community Health Coalition	Health Department Director of Nursing Director, Health Connections
2		Execute annual Great American Smoke-out Event	Event in Lexington Park in November	Reduce exposure to second hand smoke among all St. Mary's County residents	Reduce exposure to second hand smoke among all St. Mary's County residents		
3		Support the local Health Department Smoking Cessation Program	Provide nurse for 10 week smoking classes	Focus on Lexington Park (low-income communities) with smoking-cessation education			
4		Institute Youth Cigar Use Awareness	Social Marketing Campaign	Increase awareness of youth cigar use	Decrease youth cigar use by 5%		
5		Advocate for Smoke-Free Outdoor Areas	Develop annual policy recommendations for distribution to the Board of County Commissioners and other relevant stakeholders responsible for the physical environment of St. Mary's County	Reduce exposure to second hand smoke among all St. Mary's County residents	Reduce exposure to second hand smoke among all St. Mary's County residents		

Community Need: Substance Abuse (Tobacco use and Binge Drinking)
Goal Statement: Decrease youth alcohol use and binge drinking in St. Mary's County
Target Population: St. Mary's County residents

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar St. Mary's Hospital, Director of Health Connections Maryland Strategic Prevention Framework Coordinator Department of Aging and Human Services, Prevention Coordinator MSPF, Local Program Evaluator University of Maryland (UMD), Program Evaluators Alcohol & Drug Abuse Administration, MSPF Program Coordinators	Build comprehensive evidence-based strategies in St. Mary's County to address the issues of underage drinking and binge drinking	Develop and lead the Community Alcohol Coalition (CAC) to implement the Maryland Strategic Prevention Framework (MSPF) process in St. Mary's County	MSPF Steps 1-3 by July 2012 1) Execute a Community Health Needs Assessment 2) Build Community Coalition Capacity 3) Develop a Strategic Plan 4) Implement the Strategic Plan The strategic plan will be created, approved and implemented by the CAC in FY'13.	Reduce the number of youth, ages 12-20, reporting past month alcohol use by 2016 Reduce the number of young persons, ages 18-25, reporting past month binge drinking by 2016	MedStar St. Mary's Hospital St. Mary's County Department of Aging and Human Services University of Maryland Maryland Alcohol & Drug Abuse Administration	Director, Health Connections MSPF Coordinator Prevention Coordinator Local Program Evaluator UMD, PhD-Lead Evaluator ADAA MSPF Program Coordinator

Community Need: Access to care for the uninsured/underinsured
Goal Statement: Goal Statement: To increase availability of services for the uninsured and underinsured in St. Mary's County.
Target Population: Uninsured/Underinsured residents

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar St Mary's, Director of Health Connections MedStar St Mary's VP MedStar St Mary's Health Connections Medical Director Nurse Practitioner Nurse Case Manager	Expand the Get Connected to Health Program to fulltime primary care practice	Implement grant with Walden Sierra Inc. Implement CareFirst grant Implement ARR strategy to reduce readmissions in vulnerable populations	Expand days of service from 1 to 4 in FY13	Patient visits increased from 600 to 2400 per year	Walden Sierra, Inc. CareFirst Health Share Community Health Advisory Committee	Director, Health Connections Medical Director, Health Connections
2	MSMH, Director of Health Connections MSMH, Operations Specialist Health Connections Health Educators	Increase outreach events in Lexington Park specific to disparities in Asthma, Diabetes and High Blood Pressure related ER visits identified in State Health Improvement Plan Increase education for Prostate Cancer targeting African American Males	Provide one outreach event to support self management education and/or screening for Asthma, Diabetes, High Blood pressure Provide 2 additional programs for prostate cancer	Increase awareness of disparities through outreach programs Implement Million Hearts campaign	Reduce disparities as measured by the Maryland SHIP data Reduce Prostate Cancer mortality in St Mary's County		Director, Health Connections

Community Need: Availability of healthcare specialists
Goal Statement: Goal Statement: To increase the number of available primary care providers and specialists in St. Mary's County.
Target Population: Citizens of St Mary's County

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar St Mary's, Director of Health Connections MedStar St Mary's VP MedStar St Mary's Health Connections Medical Director	Create Community Health Center	Work with partners to develop a clinic in the Lexington Park area Coordinate with other community specialists and mental health providers to utilize clinic for other services	Secure funding for Community Health Center	Completion and opening of Community Health Center in Lexington Park by FY15 Increase primary care access in underserved population in Lexington Park		MSMH VP Director, Health Connections
2		Recruit primary care providers to the service area	Identify the needed primary care physicians and recruit new physicians from medical training programs within MedStar	Continue to provide rural residency electives with primary care program at MFSMC	Become ACGME site for primary care rural residency slots being developed within MedStar Academic Affairs.	MedStar Health MedStar Physician Partners	MSMH Administration
3		Provide rotating sub-specialists in Pediatrics	Utilize new Outpatient Pavilion and Specialty Physicians offices to offer these services for community	Begin Peds Cardiology in Spring of 2012, expand Peds Endocrinology in Summer 2012	Bring additional specialists from Georgetown Pediatrics to the Specialty Physicians offices	MGUH Children's National Medical Center	
4		Open Wound Care Center	Utilize existing space on hospital campus to provide hyperbaric oxygen chambers and wound care center for outpatient treatment	Open Center in Summer 2012	Increase business by 5% each year		

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
5	MedStar St Mary's, Director of Health Connections MedStar St Mary's VP MedStar St Mary's Health Connections Medical Director	Explore further opportunities for specialty physicians and services affiliated through the MedStar System to initiate programs in the Specialty Physicians at St Mary's suite in the Pavilion		Ongoing discussion with sister hospitals	Expansion of service line and new physician recruited	MWHC, MGUH, MPP	

MedStar Washington Hospital Center
Community Health Assessment FY2012

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

MedStar Washington Hospital Center's (MWHC) Community Benefit Service area includes adults age 18 or older who reside in Ward 5 of the District of Columbia. This area was selected due to its close proximity to the hospital, coupled with an opportunity to build upon pre-existing programs and services in Ward 5. Based on quantitative and qualitative findings, primary and secondary prevention of heart disease, diabetes and obesity have been identified as the hospital's community benefit priorities.

2. Provide a description of the CBSA.

Ward 5 is located in the northeastern quadrant of the District of Columbia. It is the home of approximately 74,308 residents; 83% are adults age 18 and older. The majority of residents are African American (77%). Fifteen percent (15%) are white and 6.3% are Hispanic.[1]The average household income in Ward 5 ($75,559) is less than the city average ($115,016). The percent of adults without a high school diploma (19%) is greater than the city average (15%) (Neighborhood Info DC).

Heart disease is the leading cause of death in Ward 5, totaling close to 300 deaths per year (DC DOH). According to the 2009 Behavioral Risk Factor Surveillance Survey, compared to all other Wards, Ward 5 has the highest percentage of residents who have high blood pressure (38.5%). Nearly 36% of residents have high cholesterol. Diabetes rates are also highest in Ward 5; approximately 15.8% of residents have some form of diabetes. Diabetes related complications account for nearly 35 deaths annually.[3] Compared to all Wards, the percentage of residents who are overweight in Ward 5 is highest (38.1%) and nearly 31% of residents are obese (BRFSS, 2009).

Based on the 2009 Behavior Risk Factor Surveillance Survey, more than 25% of adults in Ward 5 indicate that they had not participated in any physical activities or exercise, other than their regular job, during the past month.[3] Over two-thirds (67.5%) indicate that they eat less than the recommended five servings of fruit and vegetables.[3]

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

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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

The Community Benefit priorities were recommended by an Advisory Task Force, which consisted of Ward 5 residents, ANC commissioners from Wards 4 and 5, public health professionals, hospital personnel and representatives from the Department of Health and Department of Aging.

The Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, as well as current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment survey around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to quantitative and qualitative findings, the task force considered the hospital's strengths as well as local, regional and/or state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's President, endorsed by the hospital Board of Directors and the MedStar Health Board of Director's Strategic Planning Committee and approved by the MedStar Health Board of Directors.

Advisory Task Force Membership

Name	Title / Affiliation with Hospital	Name of Organization
James P. Hill	Executive Sponsor and Senior Vice President, Administrative Services	MedStar Washington Hospital Center
Ruby Price	Lead, Community Relations	MedStar Washington Hospital Center
Mary Farmer Allen	ANC Commissioner	Ward 5C 06
Jacqueda Arguelles	Chair	Commission on Aging
Dianne Barnes	Community Leader	Ward 5C 07
Richard T. Benson, MD	Associate Director, Stroke Center	MedStar Washington Hospital Center
Craig DeAtley, PA-C	Director, Institute for Public Health Emergency Readiness	MedStar Washington Hospital Center
Brede Eschliman, MPH	Administrative Resident	MedStar Washington Hospital Center
Pat Fisher	Community Resource Specialist	Edgewood / Brookland Family Support Collaborative
Khay Bullock Henry	Manager and Health Educator, Community Relations	MedStar Washington Hospital Center
Cleopatra Jones	Executive Director and Community Empowerment Specialist	Neighbors of Seaton Place Ward 5
Grace Lewis	President	North Michigan Park Civic Association
John J. Lynch, MD	Co-Chair and Medical Director, Center for Ethics	DC Cancer Consortium MedStar Washington Hospital Center
Marshall R. Phillips, Sr.	Minister and ANC Commissioner	Greater Mount Calvary Holy Church Ward 5C 08 Edgewood Community
Dawn M. Quattlebaum	Director	Seabury Ward 5 Aging Services
Heather A. Reffett	Performance Improvement Manager, Office of the Director	DC Department of Health
Roland Roebuck	Latino Community Leader	Ward 4
Romaine Thomas	Past President and Community Activist	AARP for the District of Columbia Ward 5
Alice A. Thompson	Community Outreach Specialist, Aging and Disability Resource Center	Office of Aging, Government of the District of Columbia
John M. Thompson, Ph.D., FAAMA	Executive Director	DC Office of Aging
Tina Thompson	ANC Commissioner	Ward 4D 03

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

a) Heart Disease	
Quantitative Evidence	According to 2008 mortality statistics, heart disease is the leading cause of death in Ward 5, totaling 290 deaths. According to the 2011 Behavioral Risk Factor Surveillance System (BRFSS), 26.2% of Ward 5 respondents had not participated in any physical activities or exercise, other than their regular job, during the past month. Over two-thirds (67.5%) eat less than the recommended five servings of fruit and vegetables. Additionally, 38.5% have high blood pressure; 2.9% had a heart attack; 3.2% have heart disease; 2.7% had a stroke. Finally, 38.1% of residents are overweight and 31.1% are obese.
Qualitative Evidence	Over three-quarters (77%; n=78) of the Community Input Survey respondents rated heart disease as either "somewhat severe," "severe" or "very severe"
Hospital Strengths	MedStar Washington Hospital Center has been recognized *U.S.News & World Report* as one of the nation's leading heart centers for more than 14 years. Due to the high volume of patients served, the Hospital Center takes pride in serving as the most experienced leader in treating heart related conditions. In 2011, there were 7,725 cardiac admissions, 1,670 cardiac surgeries, 35 ventricular assist device (VAD) procedures and 10 heart transplants. The heart program remains one of the most renowned in the United States.
Alignment with local, regional, state or national health goals	The activities outlined in the implementation plan support the goals of Healthy People 2020 and the District of Columbia Department of Health's chronic disease management plan.
Other justification	Goals also support the mission of the District of Columbia Chronic Care Coalition.

b) Diabetes	
Quantitative Evidence	The 2009 Behavioral Risk Factor Surveillance System (BRFSS) health data for Ward 5 indicate that 15.8% of Ward 5 residents have diabetes – the highest percentage compared to other Wards.
Qualitative Evidence	81.4% (n=78) of Community Input Survey respondents rated diabetes as either "somewhat severe," "severe" or "very severe."
Hospital Strengths	Through its MedStar Diabetes Institute, MedStar Washington Hospital Center has a history of conducting culturally tailored diabetes prevention and diabetes management community services. The hospital also specializes in a wide range of diabetes inpatient and outpatient clinical trials. The hospital has served as a leader in designing and piloting a culturally and linguistically tailored electronic health record to improve treatment and the health status of minorities with diabetes.
Alignment with local, regional, state or national health goals	The activities outlined in the implementation plan support the goals of Healthy People 2020 and the District of Columbia Department of Health's chronic disease management plan.
Other justification	Goals also support the mission of the District of Columbia Chronic Care Coalition.

c) Obesity	
Quantitative Evidence	The 2009 Behavioral Risk Factor Surveillance system (BRFSS) health data indicate that 38.1% of Ward 5 residents are overweight (the highest compared to other Wards) and 31.1% are obese.
Qualitative Evidence	78.3% (n=78) of Community Input Survey respondents rated obesity as either "somewhat severe," "severe" or "very severe."
Hospital Strengths	MedStar Washington Hospital Center has a strong track record of offering exercise and nutrition classes in the community. Other activities include participation in the annual *NBC 4 Health and Fitness Expo* and the distribution of educational materials to support healthy weight. Support groups are offered as part of the hospital's bariatric surgery program.
Alignment with local, regional, state or national health goals	The activities outlined in the implementation plan support the goals of Healthy People 2020 and the District of Columbia Department of Health's chronic disease management plan.
Other justification	Goals also support the mission of the District of Columbia Chronic Care Coalition.

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

Condition / Issue	Category	Name of Program / Description of Service	Key Partner
Accessible health services for seniors	Access to Care	MWHC's Medical House Call Program provides primary care and support services in the home of seniors and persons with disabilities. Patients reside within a 5 mile radius of the hospital. Services are provided to more than 600 persons annually.	• DC Long Term Care Coalition • DC Office of the Aging • Little Sister's of the Poor • The Washington Home and Community Hospice • George Washington Geriatric Consortium
Youth Services (STD prevention)	Wellness & Prevention	MWHC's Teen Alliance for Prepared Parenting's mission is to prevent subsequent cases of teen pregnancy. STD education and prevention through prophylaxis is a core component of the program. Services are provider to more than 200 teens annually.	• DC Public School System • Children's Youth Investment Trust • Columbia Heights Educational Center
Cancer Education and Cancer Screening Services	Wellness & Prevention; Quality of Life	MWHC's Cancer Institute participates in approximately 15 community-based events annually. Activities include education, screening and support services for cancer survivors.	• DC Department of Health • Edgewood Terrace • Faith Based Organizations

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

Condition / Issue	Category	Provide statistic and source	Explanation
HIV/AIDS Infection	Wellness & Prevention	HIV/AIDS is one of the top ten leading causes of death in the District of Columbia. (DC DOH, Health Statistics Administration, 2008)	MWHC does not have the expertise or resources to serve as a lead agency for HIV/AIDS prevention and management. However, the hospital does provide primary care and support services that are funded by Ryan White federal dollars. The hospital does have strategic partners to ensure that the comprehensive needs of persons living with HIV/AIDS are met.
Influenza and pneumonia vaccinations for persons 65 and older	Wellness & Prevention	35.6% of Ward 5 residents report having a flu shot within the past 12 months. *(*2009 Behavioral Risk Factor Surveillance System Annual Report, DC Dept. of Health)	The Hospital Center has served as a partner in citywide efforts to improve immunization rates; however, it has not served as a lead agency. Hospital Center leadership believes a more impactful difference can be achieved by refining or enhancing existing services that are related to the hospital's core service areas. MWHC will continue to serve as a community partner to increase the percentage persons immunized.
Transportation services for seniors to medical appointments at the Hospital Center	Access to Care	Issue rose through anecdotal viewpoints of Advisory Task members; there were no quantitative findings.	As part of its commitment to improving the patient's experience, MWHC will continue to work with partners, such as Metro Access, to make access to the hospital more available, efficient and convenient for seniors.
Youth Services (crime and STD prevention)	Quality of Life	There were 928 incidences of youth arrests for violent crimes in 2008. (http://www.grahamwone.com/docs/blueprint.pdf)	MWHC has existing programs that target youth; however, MWHC does not have the expertise or resources to serve as a lead agency that addresses youth violence.

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

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

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

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

Resources

- Neighborhood Info DC: http://www.neighborhoodinfodc.org/wards/nbr_prof_wrd5.html
- DC Dept. of Health, Health Statistics Administration, 2008
- 2009 Behavioral Risk Factor Surveillance System Annual Report, DC Dept. of Health
- Ward 5 2008 Mortality Data
- Ward 5 2009 Behavioral Risk Factor Surveillance System (BRFSS) Health Data published September 2011
- Healthy Communities Institute website
- MedStar Washington Hospital Center's programs

Implementation Strategy

Community Need: Heart disease prevention and management
Goal Statement: To contribute to the reduction of heart disease among residents in Ward 5.
Target Population: African American men in Ward 5 (Hair, Heart and Health)

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Program Director	Oversee development of the Hair, Heart and Health curriculum; provide oversight of clinical and operational activities. Identify philanthropic support and supervise program manager.	Completion of curriculum; # of formal partnerships with barbers, # of grant applications	Finalize programmatic and clinical data measures for evaluation. Submit at least two grant applications in FY13	Employ programmatic and clinical procedures that can be spread to at least two additional shops by FY14	M&S Barbershop Against da Grain MedStar Heart Institute MedStar Washington Hospital Center Foundation DC Chronic Care Coalition DC Department of Health American Heart Association	Steering Committee
2	Program Manager	Oversee day-to-day clinical and administrative functions	# of patrons screened; % of patrons retained; # of site visits; # of barbers trained; # of interactions with patrons	Startup of two new shops; Train at least 8 barbers	Reduce hypertension in at least 50% of persons retained over a 12 month period		Medical Director
3	Barbers	Provide one-on-one heart health conversations with patrons	Conduct sessions each quarter[1]	Demonstrate a measurable increase in barbers' knowledge and confidence in delivering health messages[1]	Increase the number of participating barbers by 50% by FY14		Program Manager
4	Speaker's Bureau	To provide community-based heart health education		Increase the number of Speaker's Bureau volunteers with cardiovascular health expertise[1]	To improve knowledge of behaviors and dietary habits that promote heart health[1]		Community Relations Manager

[1] Baseline data will be determined in FY13

Community Need: Diabetes prevention and management
Goal Statement: To increase knowledge and promote behaviors that reduce risks of diabetes and diabetes-related complications.
Target Population: African American men and women in Ward 5 (Hair, Heart and Health)

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Program Director	Oversee development of the Hair, Heart and Health curriculum; provide oversight of clinical and operational activities. Identify philanthropic support and supervise program manager.	Completion of curriculum; # of formal partnerships with barbers, # of grant applications.	Finalize programmatic and clinical data measures for evaluation. Submit at least two grant applications in FY13.	Employ programmatic and clinical procedures that can be spread to at least two additional shops by FY14.	M&S Barbershop Against da Grain MedStar Diabetes Institute DC Chronic Care Coalition DC Department of Health American Diabetes Association	Steering Committee
2	Program Manager	Oversee day-to-day clinical and administrative functions	# of patrons screened; % of patrons retained; # of site visits; # of barbers trained; # of interactions with patrons	Startup of two new shops; Train at least 8 barbers	Reduce blood glucose in at least 50% of persons retained over a 12 month period.		Medical Director
3	Barbers	Provide one-on-one heart health conversations with patrons	Participate in events each quarter[1]	Demonstrate a measurable increase in barbers' knowledge and confidence in delivering health messages[1]	Increase the number of participating barbers by 50% by FY14.		Program Manager
4	Speaker's Bureau	To provide community-based diabetes prevention and diabetes management education.		To increase the number of Speaker's Bureau volunteers with diabetes expertise[1]	To improve knowledge of behaviors and dietary habits that reduce risks of diabetes on-set or diabetes related complications[1]		Community Relations Manager

[1] Baseline data will be determined in FY13

Community Need: Overweight / Obesity Prevention
Goal Statement: To have an educated public with regard to overweight and obesity prevention and management.
Target Population: Ward 5 Residents

	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Community Relations Manager	To oversee and evaluate the impact of all activities associated with overweight and obesity in Ward 5.	Complete monthly tracking report and establish year 1 baseline data. Include # of persons impacted, change in behavior, skill or knowledge.	Increase number of obesity-related activities conducted in Ward 5.	To improve knowledge of behaviors and dietary habits that promote healthy weight[1]	Faith Based Organizations (TBD)	AVP, Community Health
2	Fitness Consultant	To conduct free exercise and aerobics classes for community members	Teach classes each quarter[1] Enroll at least 20 participants at each session	Develop a Memorandum of Understanding with Turkey Thicket Recreational Center	To maintain or decrease weight among routine participants annually[1] To increase community awareness and expand participation by 20% each year	Turkey Thicket Recreational Center	Manager and Health Educator
3	Speaker's Bureau	To provide community-based education and lectures	Conduct at least one per quarter	Increase the number of Speaker's Bureau volunteers with obesity prevention expertise	To improve knowledge of behaviors and dietary habits that promote healthy weight[1]		Community Relations Manager

[1] Baseline data will be determined in FY13