COMMUNITY BENEFIT NARRATIVE REPORT

FISCAL YEAR 2011

Holy Cross Hospital
1500 Forest Glen Rd
Silver Spring, MD 20910

Submitted December 15, 2011

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, and (3) hospital community benefit administration.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. ***Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.***

Table I General Hospital Demographics and Characteristics

FY11 Bed Designation:	448		
FY11 Inpatient Admissions:	33,210		
FY10 Primary Service Area ZIP Codes: (see figure 1)	20904 20906 20902 20910 20901 20903 20853	20877 20783 20705 20874 20912 20878 20706	20895 20774 20707 20852 20886 20708 20770
All other Maryland Hospitals Sharing FY10 Primary Service Area:	Adventist Rehabilitation Hospital of Maryland – 20706, 20774, 20783, 20852, 20853, 20874, 20877, 20878, 20886, 20895, 20901, 20902, 20903, 20904, 20906, 20910, 20912, 20706, 20770, 20774 Doctor's Community Hospital – 20706, 20770, 20774 Laurel Regional Hospital – 20705, 20706, 20707, 20708, 20770, 20783, 20904 Montgomery General Hospital – 20853, 20904, 20906 Prince George's Hospital Center – 20706, 20774 Shady Grove Adventist – 20852, 20874, 20877, 20878, 20886 Suburban - 20852, 20878, 20895, 20902, 20906 Washington Adventist - 20705, 20706, 20783, 20901, 20902, 20903, 20904, 20906, 20910, 20912		
Percentage of Uninsured Patients, by county:	Montgomery County: 11.5% Prince George's County: 14.8%		
Percentage of Patients who are Medicaid Recipients, by county	Montgomery County: 7.1% Prince George's County: 7.0%		

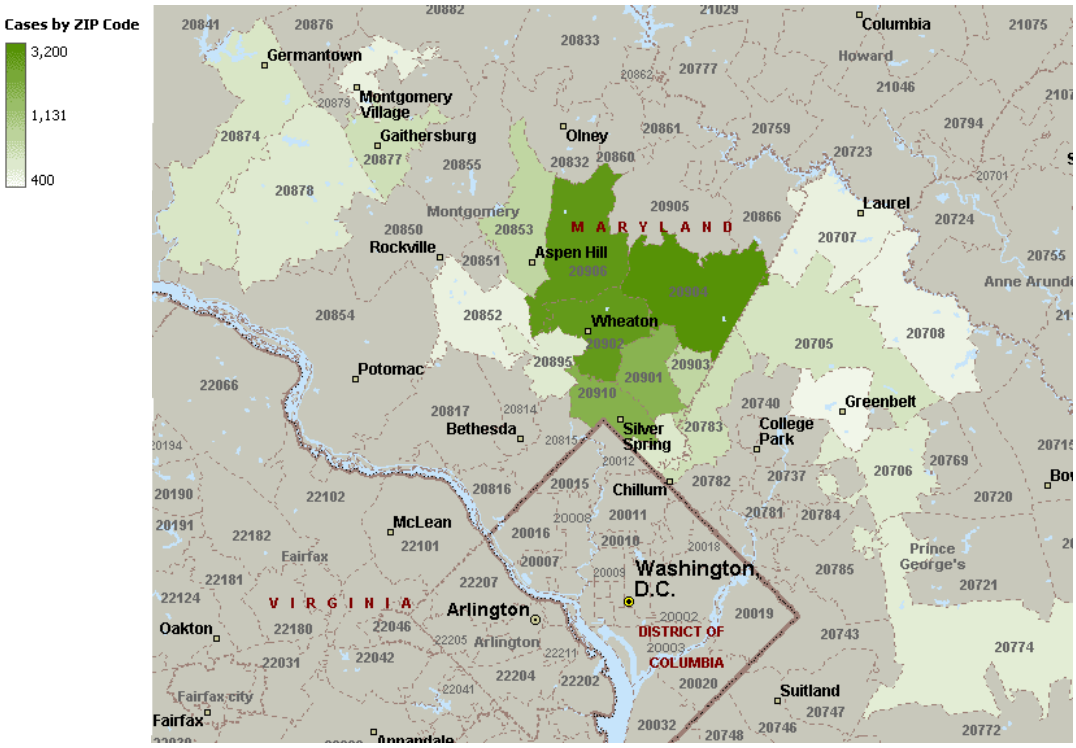


Figure 1. FY10 Primary Service Area (ZIP codes with 60% of discharges).

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents. An estimated 1.6 million people make up our four market area or our *Community Benefit Service Area* (CBSA). We draw 83 percent of our discharges from a defined market area with four sub-areas within Montgomery and Prince George's Counties (see figure 2). Seventeen percent of our discharges come from outside this four-market area. When considering both inpatients and outpatients, we draw 69 percent from Montgomery County.

Figure 2. HCH Four market area represents our Community Benefit Service

Our CBSA has an average household income of $103,384, (more than 50 percent higher than the US average) and is one of the most culturally and ethnically diverse areas in the nation. During the last two decades the minority population has grown considerably and the minorities have become the majority. [1] Today, within our CBSA, 37 percent of residents are non-Hispanic Whites compared to 64 percent of the total United States population (see Table II).

[1] Carol Morello and Dan Keating, "Minorities are majority population in Montgomery County," *The Washington Post,* February 10, 2011 (from http://www.washingtonpost.com/wp-dyn/content/article/2011/02/09/AR2011020904310.html).

The last two decades also brought a shift in the areas foreign-born population, many of whom speak English less than "very well." The foreign-born population of Montgomery County increased from 12 percent in 1980 to more than 30 percent.[2] Forty-six percent of those who are foreign-born speak English less than "very well" (Maryland Department of Planning, Planning Data Services, 2007). In Prince George's County, the gain in the foreign-born population as a percent of total population gain from 2000-2007 was the highest in the state at 199.9 percent compared to a state average of 70.7 percent. More than 18 percent of the county's residents are foreign-born, of which 42 percent speak English less than "very well" (Maryland Department of Planning, Planning Data Services, 2009). The highest rates of linguistic isolation are among Latino Americans and Asian Americans.

At median income of $94,420 and $69,947 in Montgomery County and Prince George's County, respectively, our CBSA is relatively affluent compared to the U.S. median income of $50,221. However, disparities exist. For example, minority populations in Montgomery County average lower median income than the income level determined for self-sufficiency (see Table II). The presence of disparities and inequities is an underlying theme of our community health needs assessment. Despite income levels in Prince George's County about equal to the county's self-sufficiency income level, life expectancy is lower and mortality rates are higher in Prince George's County.

The highest population density is concentrated near our hospital in Silver Spring, especially on the southern border between Montgomery and Prince George's Counties and in Gaithersburg. Areas to the immediate south and east of Holy Cross Hospital have the lowest median income in the area, and Silver Spring and Gaithersburg are next. Areas in Silver Spring and Gaithersburg have the highest percentages of residents who speak English less than very well.

For many health conditions and negative health behaviors, minorities, especially non-Hispanic blacks, bear a disproportionate burden of disease, injury, death, and disability when compared to their white counterparts (CDC, 2005) and are more likely to be without health insurance than non-Hispanic whites. Minorities also make up a disproportionate number of persons unable to afford health care when needed (Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities, 2006).

Along with its growth, the area is also rapidly aging. We face similar dramatic demographic change with the coming unprecedented aging of our county. As the senior population increases in Montgomery and Prince George's Counties, the need for senior health services also increases. It is estimated that by the year 2030 the 60+ population in Montgomery and Prince George's Counties will increase by 142 percent (316,495) and 162 percent (236,973), respectively (Maryland Department of Planning Population Projections, 2008). Currently, the two counties also have the second and third highest percentage of senior minorities in the state with 24.4 percent residing in Prince George's County and 15.7 percent in Montgomery County.

[2] Neal Peirce, "Outreach to immigrants: A suburb's exciting new way," *The Washington Post,* May 17, 2009 (http://www.postwritersgroup.com/archives/peir090517.htm).

b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Some statistics may be accessed from the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), and the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/).

Table II Significant Demographic Characteristics and Social Determinants

Community Benefit Service Area (CBSA) Target Population (target population, by sex, race, and average age):

	CBSA Area
2011 Total Population	1,583,062
Total Male Population	766,942
Total Female Population	816,120
Females, Child Bearing Age (15-44)	322,937

RACE/ETHNICITY

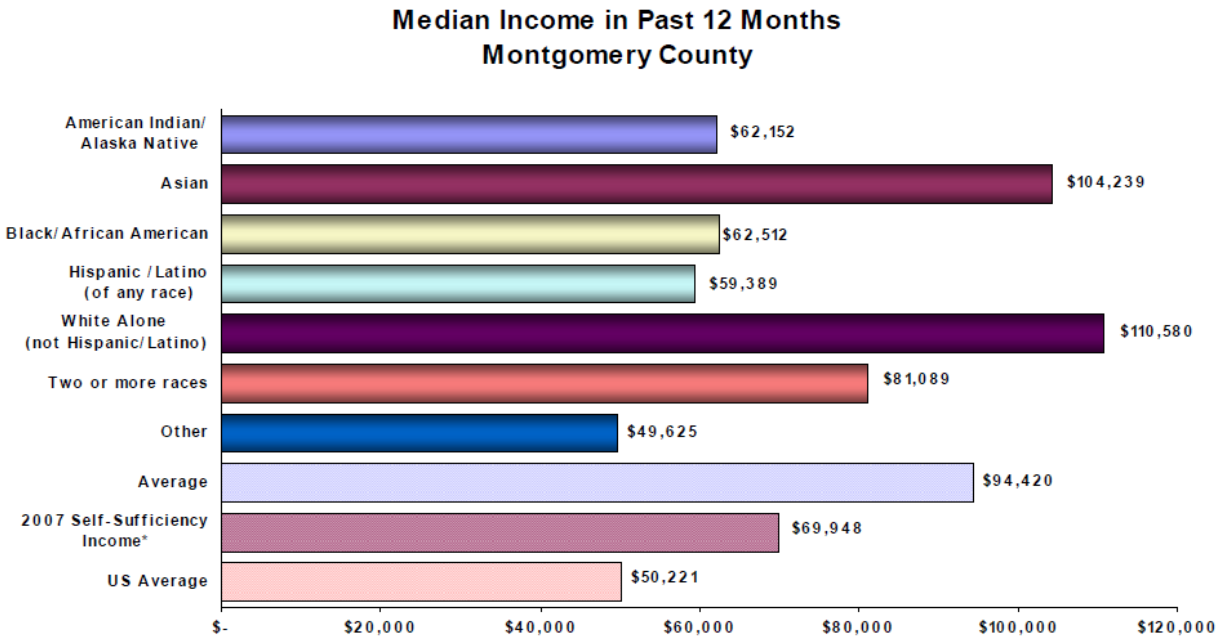
	Race/Ethnicity Distribution		
Race/Ethnicity	**2011 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	586,664	37.1%	64.2%
Black Non-Hispanic	521,654	33.0%	12.1%
Hispanic	268,432	17.0%	16.1%
Asian & Pacific Is. Non-Hispanic	159,262	10.1%	4.6%
All Others	47,050	3.0%	3.0%
Total	**1,583,062**	**100.0%**	**100.0%**

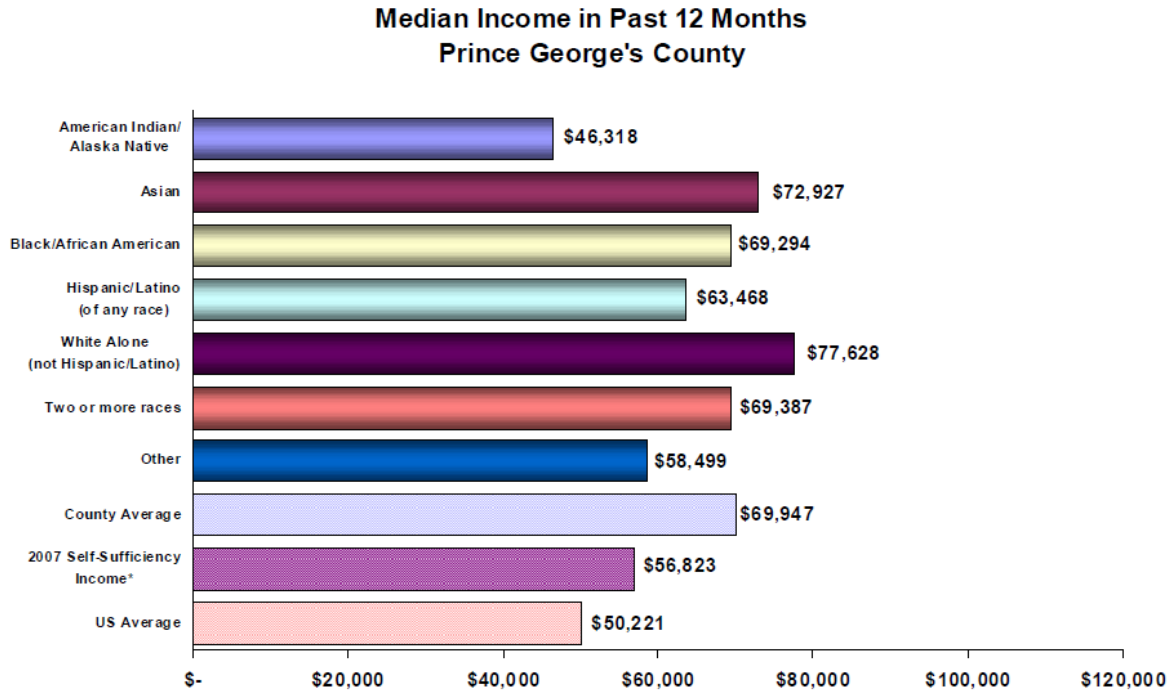
POPULATION DISTRIBUTION

	Age Distribution		
Age Group	**2011 Pop**	**% of Total**	**USA 2011 % of Total**
0-14	324,831	20.5%	20.2%
15-17	66,893	4.2%	4.2%
18-24	145,140	9.2%	9.7%
25-34	208,897	13.2%	13.3%
35-54	466,572	29.5%	27.6%
55-64	186,862	11.8%	11.7%
65+	183,867	11.6%	13.3%
Total	**1,583,062**	**100.0%**	**100.0%**

Median Household Income within the CBSA :

AVERAGE HOUSEHOLD INCOME	
CBSA Area	**USA**
$103,384	$67,529





Household Income by race for Montgomery and Prince George's County.
*Income for two adults, one preschool and one school age child
Source: U.S. Census Bureau, 2009 ACS

Percentage of households with incomes below the federal poverty guidelines within the CBSA: >25K = 10.4%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2011 Household Income	HH Count	% of Total	USA % of Total
<$15K	32,438	5.6%	12.9%
$15-25K	27,883	4.8%	10.8%
$25-50K	105,853	18.3%	26.6%
$50-75K	109,824	19.0%	19.5%
$75-100K	88,160	15.2%	11.9%
Over $100K	214,073	37.0%	18.3%
Total	**578,231**	**100.0%**	**100.0%**

Please estimate the percentage of uninsured people by county within the CBSA

Uninsured by County

Race/Ethnicity	Montgomery County	Prince George's County	Maryland	USA
Average, All Races	**11.5%**	**14.8%**	**11.1%**	**15.1%**
American Indian/Alaska Native	11.4%	25.9%	20.0%	29.2%
Asian	12.6%	17.5%	14.3%	14.8%
Black/African American	15.2%	11.3%	12.7%	18.1%
Hispanic/Latino (of any race)	32.8%	41.2%	33.6%	31.0%
White Alone (not Hispanic/Latino)	3.9%	7.2%	7.3%	10.7%
Two or more races	7.1%	12.9%	9.6%	14.5%
Other	40.0%	48.4%	39.7%	34.1%

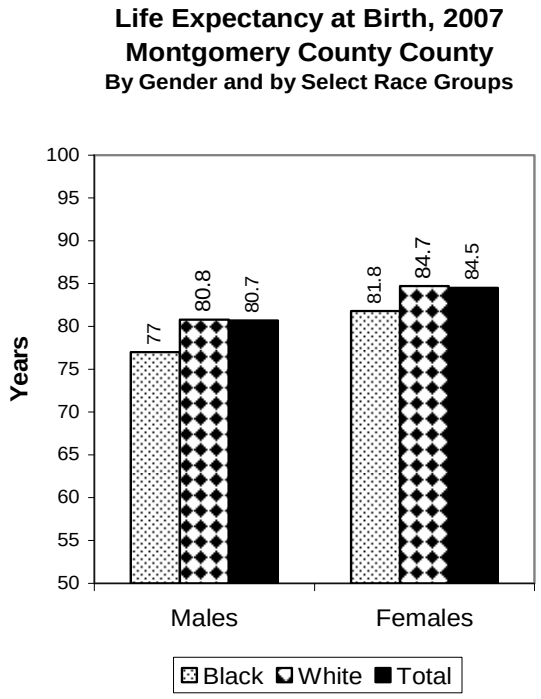
Source: U.S. Census Bureau, 2009 American Community Survey

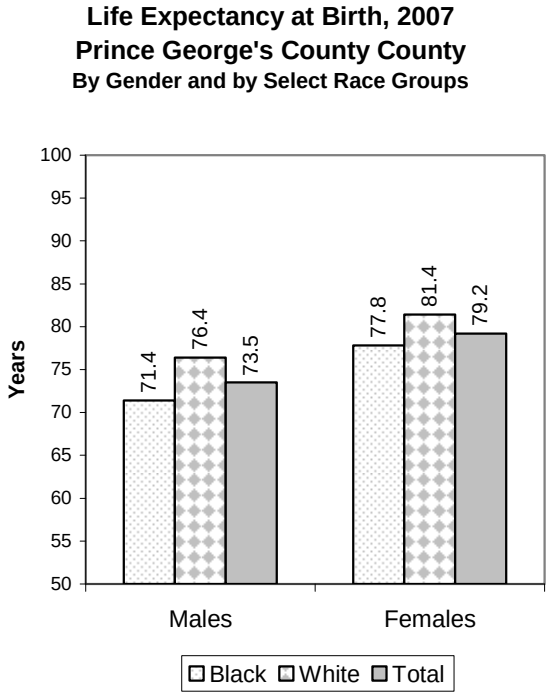
Percentage of Medicaid recipients by county within the CBSA:

Montgomery County: 9.8% (95,130 recipients)
Prince George's County: 12.1% (104,446 recipients)

Source:
Medicaid data from Health Services Cost Review Commission, 2011; Population Data from U.S. Census Bureau, 2009 American Community Survey

Life expectancy by county within the CBSA:





Source: Institute for Health Metrics and Evaluation, University of Washington, 2011

Mortality Rates/100,000 by county within the CBSA:

Montgomery County

All Cause Death Rate: 524.9

Males: All races, ethnicities, and ages combined

Cause	Rank	Rate
Diseases of the Heart	1	167.2
Malignant Neoplasms	2	151.7
Major Non-Cardiac Vascular Diseases	3	40.1
Accidents	4	24.1
Influenza and Pneumonia	5	19.1

Females: All races, ethnicities, and ages combined

Cause	Rank	Rate
Malignant Neoplasms	1	111.8
Diseases of the Heart	2	99.7
Major Non-Cardiac Vascular Diseases	3	40.1
Chronic Lower Respiratory Disease	4	22.8
Alzheimer's Disease	5	14.4

Prince George's County

All Cause Death Rate: 777.3

Males: All races, ethnicities, and ages combined

Cause	Rank	Rate
Diseases of the Heart	1	277.7
Malignant Neoplasms	2	215.9
Major Non-Cardiac Vascular Diseases	3	56.2
Accidents	4	34.3
Diabetes Mellitus	5	31.5

Females: All races, ethnicities, and ages combined

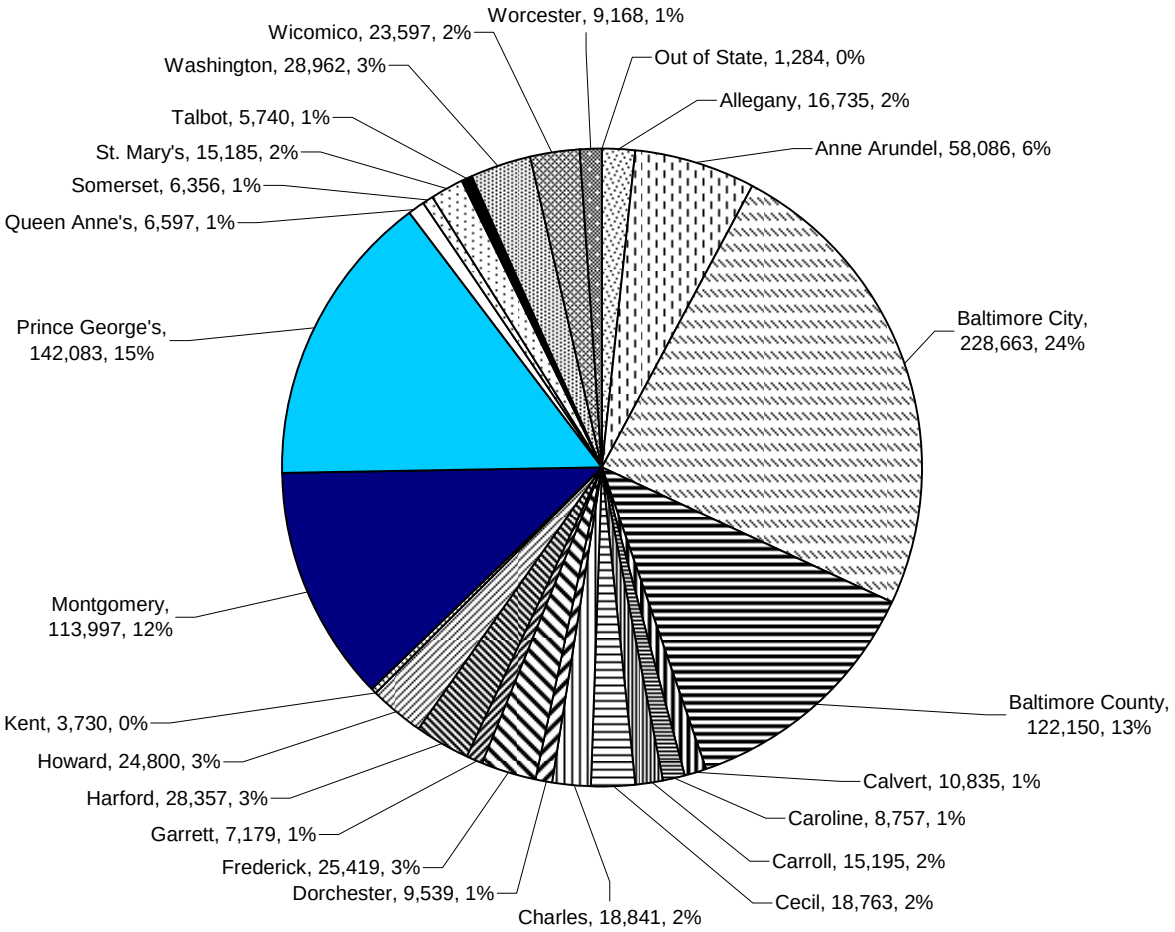
Cause	Rank	Rate
Diseases of the Heart	1	181.2
Malignant Neoplasms	2	144.3
Major Non-Cardiac Vascular Diseases	3	45.8
Diabetes Mellitus	4	27.9
Chronic Lower Respiratory Disease	5	26.5

Source: Maryland Family Health Administration, Maryland Assessment Tool for Community Health, 2009

Access to healthy food, quality of housing, and transportation by county within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	(See Table II Supplement)
Other: See Table II Supplements A and B below.	

Table II Supplement A

FY11 Average Number of All Medicaid Eligible Persons Per Month by County
Per Month Average for the State = 949,589



Source: Maryland Medicaid eHealth Statistics, Maryland Department of Health and Mental Hygiene, 2011

Table II Supplement B
CDC COUNTY HEALTH RANKING DATA GRID

Measures	Montgomery County	Prince Georoge's County	Maryland	US Benchmark/ Target	Source
HEALTH OUTCOMES					
MORTALITY					
Years of potential life lost/100,000 pop.	4,094	8,374	7,537	5,564	National Center for Health Statistics (NCHS)
MORBIDITY					
% Adults reporting fair or poor health	9%	12%	13%	10%	Behavior Risk Factor Serveillance System (BRFSS)
Avg. physically unhealthy days/month	2.7	3	3.2	2.6	BRFSS
Avg. mentally unhealthy days/month	2.6	3	3.3	2.3	BRFSS
% Live births with low birth weight <2500g	8.0%	10.5%	9.1%	6.0%	NCHS
HEALTH FACTORS					
HEALTH BEHAVIORS					
Tobacco: % Adults reporting currently smoking	10%	16%	18%	15%	BRFSS
Diet & Exercise: % Adults reporting obesity (BMI > 30)	19%	32%	27%	25%	National Center for Disease Prevention & Health Promotion (CDC)
Alcohol Use: %Adults reporting binge drinking	13%	10%	15%	8%	BRFSS
Motor-vehicle related mortality/100,000 pop.	7	17	13	12	NCHS
Hi-Risk Sexual Behavior: Births/1,000 teen females, ages 15-19	20	38	34	22	NCHS
New Chlamydia cases/100,000 pop.	207	638	439	83	NCHS
Access to Care: % Adults 18-64 without insurance	17%	22	17	13	Small Area Health Insurance Estimates
Quality of Care: discharges for ambulatory care sensitive conditons/1,000 Medicare en	44	62	70	52	Medicare/Dartmouth Institute
% Diabetic Medicare enrollees receiving HbA1c test	83%	76%	81%	89%	Medicare/Dartmouth Institute
% Chronically ill Medicare enrollees admitted to hospice in last 6 mos. of life	27%	23%	28%	35%	Medicare/Dartmouth Institute
SOCIOECONOMIC FACTORS					
Education: % high school students graduating in 4 yrs	85%	70%	80%	92%	National Center for Education Statistics
% Population age 25+ with 4-year college degree or higher	56%	30%	35%	34%	Census/American Community Survey (ACS)
Employment: % Population age 16+ unemployed & looking for work	5.3%	6.9%	7.0%	5.3%	Bureau of Labor Statistics
Income: % Children (<age 18) living in poverty	7%	8%	10%	11%	Small Area Income & Poverty Estimates
Gini coefficient of household income inequality (multiplied by 100)	44	38	44	38	Census/ACS
Family & Social Support: % Adults reporting not getting social/emotional support	19%	24%	21%	14%	BRFSS
% Households that are single-parent households	22%	40%	32%	20%	Census/ACS
PHYSICAL ENVIRONMENT					
Air Quality: # Days air quality was unhealthy due to fine particulate matter	0	4	4	0	Environmental Protection Agency (EPA)/CDC
# Days that air quality was unhealthy due to ozone	10	29	16	0	EPA/CDC
BUILT ENVIRONMENT					
% Zip Code in county with healthy food outlet	74%	91%	62%	92%	Zip Code Business Patterns
Liquor stores/10,000 pop.	12	18	20	n/a	County Business Patterns
Recreation Facilities/100,000 pop.	15	8	12	17	County Business Patterns

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment;
(2) With whom the hospital has worked;
(3) How the hospital took into account input from community members and public health experts;
(4) A description of the community served; and
(5) A description of the health needs identified through the assessment process.

Examples of sources of data available to develop a community health needs assessment include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health improvement plan (http://dhmh.maryland.gov/ship/);
(2) Local Health Departments;
(3) County Health Rankings (http://www.countyhealthrankings.org);
(4) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(5) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(6) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(7) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(8) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(9) For baseline information, a Community health needs assessment developed by the state or local health department, or a collaborative community health needs assessment involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(10) Survey of community residents
(11) Use of data or statistics compiled by county, state, or federal governments; and
(12) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers.

1. ***Identification of Community Health Needs:***
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

Community Health Needs Assessment Background

Holy Cross Hospital identifies unmet community health care needs in our community in a variety of ways. We use a range of available needs assessments and reports to identify unmet health care needs. Each year since 2005, we have invited input and obtained advice from a group of external participants to review our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority needs and the direction to take for the next year. We also solicited guidance on long-term strategies during 2010 when we developed our fiscal 2011-2014 strategic plan.

External group participants include the public health officer and the department director of Montgomery County Department of Health and Human Services, a variety of individuals from local and state governmental agencies, and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations. These participants are experts in a range of areas including public health, minority populations and disparities in health care, social determinants of health, health and social services. The group's input helps to ensure that we have identified and responded to the most pressing community health care needs.

On an ongoing basis, we participate in a variety of coalitions, commissions, committees, boards, partnerships and panels. Our ethnic health promoters and community outreach workers spend time in the community as community participants and bring back first-hand knowledge of community needs.

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The Affordable Care Act), which puts in place comprehensive health insurance reforms that will enhance the quality of health care for all Americans. In an effort to enhance the quality of health care, the Affordable Care Act will also require non-profit hospitals to complete a community health needs assessment every three years. Building on our efforts since 2005 to obtain external input, Holy Cross Hospital collaborated with Montgomery County Department of Health and Human Services (MCDHHS) and other community partners (including all other hospitals located in Montgomery County) to develop and participate in a formal county-wide process to identify and address key priority areas that would improve the health and well-being of Montgomery County.

Healthy Montgomery: The Montgomery County Healthy Montgomery Community Health Improvement Process was initiated to address the need of all organizations to have valid, reliable, and user-friendly data related to health and the social determinants of health and to coordinate efforts of public and private organizations, like Holy Cross Hospital, to identify and address health and health-related issues in Montgomery County.

In 2010, Holy Cross Hospital and the other three hospital systems in Montgomery County each gave $25,000, for a total of $100,000, in grants to the Urban Institute to provide support for the

development of *Healthy Montgomery*. This included coordinating the environmental scan, which looked at all the existing sources of data (e.g., vital statistics, Maryland Department of Health and Mental Hygiene) and needs assessments and improvement plans from organizations in the county (many of these documents are now available through the *Healthy Montgomery* Website), support of the effort to select the 100 indicators to include in the *Healthy Montgomery* Website, preparation of indicators and maps that show the social determinants of health for the county as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the Needs Assessment document.

In 2011, Holy Cross Hospital and the four other individual hospitals each gave $25,000, for a total of $125,000, in grants to the Institute for Public Health Innovation. These funds continue to support the *Healthy Montgomery* Steering Committee meetings, preparation and presentation of all of the community conversations, preparation of the Needs Assessment Report (quantitative data and information from the community conversations), support for the Steering Committee in determining selection criteria that will be used to choose the priorities for community health improvement, and support for the priority selection process.

At this time, Prince George's County does not have a similar county-wide data program so Holy Cross Hospital used the data sources found in *Healthy Montgomery* to extract data that was specific to Prince George's County so that health information could be analyzed for both counties. The Center for Disease and Control County Health Rankings Data was also analyzed. As the needs assessment process evolves in Prince George's County, we will incorporate this information in our ongoing analysis and response.

Healthy Montgomery

Healthy Montgomery builds on past and current efforts, including environmental scans, comprehensive needs assessments, community health-related work, and relevant information from the healthcare provider organizations in the county. In addition to numerous quantitative data sources, Community Conversations were held with groups of residents to solicit their ideas about health and well being in their communities and in the county as a whole. These conversations provided views of diverse subpopulations on the issues they find critical.

The health improvement process has four objectives: (1) To identify and prioritize health needs in the county as a whole and in the diverse communities within the county; (2) To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporate a wide variety of county and sub-county information resources and utilize methods appropriate to their collection, analysis and application; (3) To foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and (4) To coordinate and leverage resources to support the *Healthy Montgomery* infrastructure and improvement projects.

Healthy Montgomery is under the leadership of the Healthy Montgomery Steering Committee, which includes planners, policy makers, health and social service providers (including Holy Cross Hospital) and community members. It is an ongoing process that includes periodic needs assessment, development and implementation of improvement plans and monitoring of the resulting achievements. The process is dynamic, thus giving the county and its community partners the ability to monitor and act on the changing conditions affecting the health and well-being of county residents. The material presented in this document is based on Montgomery County's Community Health Needs Assessment conducted during 2009-2011.

Community Needs Index

For each ZIP code in the United States, the Community Needs Index aggregates five socioeconomic indicators/barriers to health care access that are known to contribute to health disparities related to income, education, culture/language, insurance and housing. We use the Community Needs Index to identify communities of high need and direct a range of community health and faith-based community outreach efforts to these areas (www.chwhealth.org/cni).

Other Available Data

As available, we also use a range of other specific needs assessments and reports to identify unmet needs, especially for ethnic and racial groups, those with limited English proficiency, seniors, and women and children. Our work is built on past available needs assessments, and we use these documents as reference tools, including the following key resources:

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014;
- Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012;
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008.

We review our own internal patient data and review purchased and publicly available data and analyses on the market, demographics and health service utilization.

Data Gaps Identified

Where available, the most current and up-to-date data was used to determine the health needs of the community. Although the data set available is rich with information, not surprisingly, data gaps exist.

- Data such as health insurance coverage and cancer screening, and certain incidence and mortality rates are not available by geographic areas within Montgomery or Prince George's Counties.
- Data is not available on all topics to evaluate health needs within each race/ethnicity by age-gender specific subgroups.
- Diabetes prevalence is not available for children, a group that has had an increasing risk for type 2 diabetes in recent years due to increasing overweight/obesity rates.

- Health risk behaviors that increase the risk for developing chronic diseases, like diabetes, are difficult to measure accurately in subpopulations, especially the Hispanic/Latino populations, due to BRFSS methodology issues.
- County-wide data that characterize health risk and lifestyle behaviors like nutrition, exercise, and sedentary behaviors are not available for children.
- Analysis of linked birth-death records would provide detailed information about characteristics and risk factors that contribute to fetal and infant losses in Montgomery and Prince George's Counties among those populations that could be at elevated risk for poor birth outcomes.
- An ongoing source of Pregnancy Risk Assessment Monitoring System (PRAMS) data at the county level at least every three years would improve policy and planning efforts in maternal, fetal and infant health.
- Data is not as available in Prince George's County when compared to Montgomery County.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

In 2011, the following external participants were consulted and provided input and advice on our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority needs and the direction to take for the next year:

- Uma S. Ahluwalia, Director, Montgomery County Department of Health and Human Services
- Ronald Bialek, President and CEO, Public Health Foundation; Member, Montgomery County Commission on Health
- Becky Boeckman, Director, Pastoral Care, First United Methodist Church
- Steven Galen, President and CEO, Primary Care Coalition
- Rose Marie Martinez, Sc.D., Director, Institute of Medicine; Member, Montgomery County Commission on Health
- Cesar Palacios, Executive Director, Proyecto Salud
- Angela M. Pickwick, Dean of Health Sciences, Montgomery College, Takoma Park Campus
- Douglas Propheter, CEO, Workforce Solutions Group of Montgomery County and Montgomery Works
- Wayne L. Swann, Swann Enterprises; Member, Montgomery County Commission on Health
- Richard Takamoto, Executive Director, Research Administration, Kaiser Permanente; Member, Montgomery County Commission on Health
- Ulder J. Tillman, M.D., Montgomery County Health Officer and Chief of Public Health Services

3. When was the most recent needs identification process or community health needs assessment completed?

Provide date here. 10/27/2011

The *Healthy Montgomery* Community Health Improvement Process was launched in 2009, priorities were identified in late 2011 and an action plan will be developed in 2012. Holy Cross Hospital used preliminary information from *Healthy Montgomery*, as it became available, during February – October 2011. The Holy Cross Hospital Board of Trustees accepted the Community Health Needs Assessment on October 27, 2011.

4. ***Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?***
_X_ Yes, during Fiscal 2012
___ No

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

See attached PDF

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Does your hospital have a CB strategic plan?

_X_ Yes
___ No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. _X_ CEO
2. _X_ CFO
3. _X_ Other (Senior Vice President, Corporate Development; Vice President, Mission Services, Vice President, Community Health; Vice President, Strategic Planning; Vice President, Revenue Cycle Management; Executive Director, Community Care Delivery)

ii. Clinical Leadership

1. _X_ Physician (Medical Director, Community Care Delivery)

2. _X_ Nurse (Senior Vice President Operations; Chief Nurse Officer; Senior Director, Women's and Children's Services; Directors, HCH Health Centers at Silver Spring and Gaithersburg)
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. _X_ Individual (Manager, Community Benefit - 1.0 FTE)
2. ___Committee
3. _X_ Other (Senior Market Analyst, Planning)

The CEO Review Committee on Community Benefit meets quarterly made up of all individuals listed above and here. Community Benefit Operations is administered by the Manager, Community Benefit with oversight by the Vice President, Community Health and the Senior Vice President, Corporate Development who serves as Chief Community Benefit Officer.

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet _X_ yes _____ no
Narrative _X_ yes _____ no

In addition, it undergoes an external audit as part of the audited financials

d. Does the hospital's Board review and approve the completed FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet _X_ yes ___ no
Narrative _X_ yes* ___ no

*The Board of Trustees receives the substance of the HSCRC report through its review of the annual IRS Form 990 Schedule H. In addition, the Board of Trustees annually approves the community benefit plan and the community health needs assessment prior to the December deadline for the HSCRC narrative report.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).

<u>For example</u>: for each major initiative where data is available, provide the following:

a. ***Identified need: This includes the community needs identified in your most recent community health needs assessment.***

b. ***Name of Initiative: insert name of initiative.***

c. ***Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)***

d. ***Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?***

e. ***Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.***

f. ***Date of Evaluation: When were the outcomes of the initiative evaluated?***

g. ***Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).***

h. ***Continuation of Initiative: Will the initiative be continued based on the outcome?***

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
High breast cancer incidence and death rates; with disproportionate results between races and between counties	Komen- Community Assisted Mammogram Program (K-CAMP) Komen Foundation Community Collaboration to Battle Breast Cancer (KFCC-BBC)	- To reduce disparities in breast health care among low-income, medically underserved, uninsured women and men from targeted racial and ethnic populations. - To provide high quality, culturally competent outreach and education to 30,000 individuals over three years. - To provide early detection of breast cancer by screening 2,250 individuals over three years. - To provide high quality, culturally competent and comprehensive breast health care navigation and case management services to an estimated 450 uninsured or underinsured women from targeted racial and ethnic populations over three years.	Multi-Year CY2010-2012	Community Clinics Inc. Community Ministries of Rockville's Mansfield Kaseman Clinic Diagnostic Medical Imaging, PA Holy Cross Health Centers, Silver Spring and Gaithersburg People's Community Wellness Center Proyecto Salud, Wheaton Montgomery County African American Health Program, and Asian American Health Initiative CASA of Maryland Inc. Community Ministries of Rockville	FY2011	K-CAMP: 21,715 educated 834 mammograms (544 screening; 290 diagnostic) 167 breast ultrasounds 77 breast surgeon consultations 57 biopsies 3 surgeries 4 breast cancer diagnoses Approximately 100 abnormal breast screening cases navigated KFCC-BBC: 5,500 educated 157 mammograms (124 screening; 33 diagnostic) 28 breast ultrasounds 10 breast surgeon consultations 7 biopsies 1 surgery 4 breast cancer diagnoses Approximately 60 abnormal breast screening cases navigated	Yes

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Seniors are disproportionately affected by chronic disease and the numbers of seniors in our community is growing rapidly.	Senior Fit	To provide age appropriate exercise classes to minimize symptoms of chronic disease and improve strength, flexibility and endurance and encourage self-management.	In operation since 1995	Holy Cross Hospital, Kaiser Permanente of the Mid-Atlantic States, Montgomery County Dept. of Recreation, Maryland National Capital Park and Planning Commission and local churches	Participants are assessed twice a year in the spring and fall using the evidence-based Rikli and Jones Senior Fit Test	The Rikli and Jones Test measures upper body strength (arm curl), lower body strength (chair stand), speed and agility (8-foot up and go) and upper body flexibility (back scratch). A matched data sample of 326 seniors (251 women and 75 men, age range 60-94 years), comparing the two FY10 fitness assessments (March and Oct. 2010), found an increase in those that performed "above standard" on three of the four tests. In addition, the number of participants who scored "below standard" decreased on all four tests which demonstrate an improvement in the functional ability of the group.	Senior Fit has an active enrollment of 2,990 participants at 21 sites. In FY2011, 714 new participants joined the program. It is an award-winning, low cost and highly effective community benefit program that is expected to expand in the future to meet the growing need for wellness programs for older adults in our area.

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Fourth leading cause of death in Prince George's County Ninth leading cause of death in Montgomery County	Diabetes Prevention Program	This program to prevents or delays the onset of diabetes for at risk individuals with blood glucose levels higher than normal but not yet diabetic. One program is conducted in Spanish at New Hampshire Estates Elementary School (NHE). The other program is conducted in English at Holy Cross Hospital (HCH).	Multi-year, in operation since 2008	New Hampshire Estates Elementary School, HCH Foundation	FY2011	One program is held at New Hampshire Estates Elementary School (NHE) and is conducted in Spanish. The second program is held at Holy Cross Hospital (HCH) and is conducted in English. In FY11 there were 87 total participants with an age range of 19-91; 66 in the HCH program (74% Female, 26% Male; 36% African American, 36% White, 25% Asian- Pacific Islander, 3% Hispanic) and 21 in the NHE program (100% Hispanic). Sixty-seven percent of participants reside in a geographic location with a community need index of 3.0 or greater (indicating socio-economic barriers). To complete the program, participants were required to attend a minimum of 8 out of 12 classes or 75% of classes. Thirty-nine (44.8%) total participants completed the program; 29 (43.9%) in the HCH program and 10 (47.6%) in the NHE program. The FY11 evaluation analyzed matched data for lab results (fasting glucose; HbA1c; total, HDL and LDL cholesterol, and triglycerides), percent weight loss and minutes of physical activity. 12-week Program - HCH • Fasting blood glucose at 12 weeks showed three conversions from the pre-diabetes range into the normal range and one conversion from the pre-diabetes range into the diabetes range (n=15) • HbA1c at 12 weeks showed three conversions out of the diabetes or pre-diabetes range and into the normal range and one conversion from the pre-diabetes range into the diabetes range (n=13) • Total Cholesterol results at 12 weeks showed one transition from high to borderline and two transitions from normal to borderline (n=15) • HDL Cholesterol results showed that three people transitioned into the at-risk category at 12 weeks (n=15) • LDL Cholesterol results showed that four transitions out the of LDL goal into less optimal categories (2 into near optimal and 2 into borderline); and one transition from the LDL high category into the borderline category at 12 weeks (n=15) • Triglyceride results showed one transition from high to normal at 12 weeks (n=15) • Weight loss of 5-7% of body weight occurred in 13 (31%) participants (n=42) • A total of 14 (78%) participants exercised for at least 150 minutes per week (n=18) 15-week Program - NHE • Fasting Blood Glucose at 15 weeks showed three conversions from the pre-diabetes range into the normal range and zero from the pre-diabetes range into the diabetes range (n=10) • HbA1c at 15 weeks showed now change from pre-program results (n=5) • Total Cholesterol results at 15 weeks showed that two people transitioned out of the borderline range into the normal range (n=10) • HDL Cholesterol results showed that two people transitioned out of the at-risk range at 15 weeks and into the normal or borderline range (n=10) • At 15 weeks, one transition into the Very High LDL range from the High range and one transition from the Borderline High range into the Near Optimal range (n=10) • Triglyceride results showed one transition from normal to borderline at 15 weeks (n=9) • Weight loss of 5-7% of body weight occurred in 2 (40%) participants (n=5) • A total of 2 (100%) participants exercised for at least 150 minutes per week (n=2)	Yes

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
More than 50% of Montgomery County residents and more than 65% of Prince George's County residents are overweight or obese.	Kid's Fit	Since 2005, Holy Cross Hospital in partnership with the Housing Opportunities Commission of Montgomery County has offered *Kid's Fit,* a free fitness and wellness class for children who live in low-income communities in Montgomery County. *Kid's Fit* classes meet twice a week at Housing Opportunities Commission sites. In 2008, Holy Cross established a partnership with the Silver Spring Boys and Girls Club and added a class at this facility, increasing the total number of sites to five and expanding the number of unduplicated participants to 108.	Kid's Fit began operation in 1995.	Program partners include Holy Cross Hospital, the Housing Opportunities Commission of Montgomery County and the Silver Spring Boys and Girls Club.	The evidence-based President's Challenge Fitness Test is administered twice a year in the winter and spring to evaluate the participants' upper body strength, abdominal strength, speed and agility and hamstring flexibility.	During the past three years scores on the shuttle run (speed/agility) have been low compared to norms at all sites. In 2010 we selected one site to provide additional cardiovascular training and implemented a half-mile time trial. Although scores for the boys remained consistent, scores for the girls showed an improvement of 20%. We plan to replicate this activity at other sites. Beyond the lessons learned on healthy food choices and the importance of exercise we have seen an overall improvement in confidence and fair play learned from the *Kid's Fit* activities. In 2010, 363 classes were held with 4,662 encounters.	Kid's Fit has an active enrollment of 108 participants at 5 sites. The program is funded by Holy Cross Hospital and is provided free of charge to participants. We anticipate that the program will continue and possibly expand in the future.

Initiative 5.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Chronic Diseases are the leading causes of death and disability in Montgomery and Prince George's Counties	Chronic Disease Self-Management Program	The Stanford University Chronic Disease Self-Mgt. Program (CDSMP) is a low-cost, evidence-based program with a proven track record in improving exercise compliance, symptom management, communication skills and self-reported overall health.	Holy Cross Hospital has offered CDSMP workshops since 2007.	Holy Cross Hospital, Montgomery County Dept. of Health and Human Services, Maryland Dept. on Aging, Holy Cross Hospital Foundation	Participants are required to fill out a workshop survey at the first session of the six-week workshop that includes demographic data and history of chronic illness.	In FY11, eight workshops were held for 138 participants. Chronic illnesses represented in the classes included arthritis, diabetes, heart disease, hypertension, kidney disease and multiple sclerosis.	We anticipate that this program will continue to expand and to be more closely aligned with our health centers and our readmissions program.

2. Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not?

Healthy Montgomery, the health improvement process for Montgomery County organized a steering committee of representatives from county government agencies, county commissions, non-profit organizations, local health providers, and hospitals. The steering committee used data collected from 100 indicators to determine the most pressing needs of the county. These data are organized into 13 categories: access to health services; cancer; diabetes; exercise, nutrition and weight (obesity); heart disease and stroke; maternal, fetal and infant health; family planning; immunizations and infections disease; mental health and mental disorders; respiratory diseases; substance abuse and illicit drug use; wellness and lifestyle; and prevention and safety.

The Healthy Montgomery steering committee conducted a priority setting process and identified six priority community needs based on three lenses, unhealthy behaviors, lack of access and health inequities; six categories emerged as top priorities. The top priorities selected are behavioral health, cancers, cardiovascular disease, diabetes, maternal and infant health, and obesity. We took this information and juxtaposed our strengths with the identified needs and incorporated five of the six top priorities into our community benefit plan and chose to add access to health services as a top priority for hospital programming. The top priorities of the hospital are access to health services, cancer, diabetes, obesity, heart disease and stroke, and maternal and infant health.

We recognize that we cannot pursue all of the identified health needs and that choices need to be made. We made choices using a rigorous process to ensure that documented unmet community health needs intersect with our mission commitments and key clinical strengths (see figure 10). At this time, behavioral health has not been incorporated into our community benefit plan because it is not a key clinical strength of the hospital and we do not have the infrastructure needed to sustain programs that would make an impact in this area. However, although we currently cannot sustain programs aimed to improve the mental health of the county, Holy Cross will continue to participate in the ongoing needs assessment process to determine how we can play a role in improving outcomes in this area.

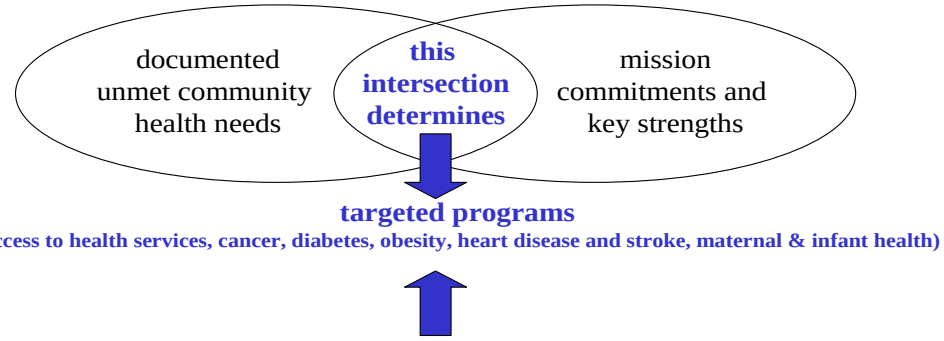


Figure 10. HCH's approach to meeting community health needs aligned with the strengths of the hospital.

V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Providing care for uninsured patients is challenging for many of the independent medical staff members, especially by "on call" specialty physicians in the emergency center who feel the liability and financial burden of caring for these patients is too great.

Inpatient specialty care is provided by specialty physicians, hospitalists, and other professional staff that provide care in the following specialties: Neurology, cardiology, pulmonary, orthopedics, dermatology, infectious disease, oncology, hematology, medical imaging, laboratory, infusion center, anesthesiology, presurgical testing, surgery, obstetrics, gynecology, physical therapy, home care, hospice, patient education, pharmacy, sleep lab, electrocardiogram, and pain management. Gaps will occur when the ratio of uninsured patients to insured patients threatens sustainability.

Uninsured outpatients have access to hospital services but are in need of outside resources for most of their specialty care. Both of the Holy Cross Hospital Health Centers, the only clinics in the county operated by a hospital, are fortunate to have experienced, full-time physicians that are able to treat and manage many of the patients requiring specialty care. The Holy Cross Hospital Health Centers are able to provide specialty care in neurology, orthopedics, hematology, ophthalmology, and otorhinolaryngology on-site, on a limited basis. These specialists can accommodate the immediate needs of the health centers. Nurses also report having a difficult time referring patients for urology.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

In order to meet the needs of the uninsured/underinsured population, Holy Cross Hospital has approximately 100 physician contracts for the provision of on-call clinical services as needed. These services are provided on a 24-hour/7-day a week basis, operate on a negative margin and are frequently used by the uninsured/underinsured population. If subsidies were discontinued, the following services would not be available and patients would need to be transported to other facilities or have unmet needs:

Category One: Hospital-based physician subsidies with which the hospital has an exclusive contract and/or subsidy in order to retain services that represent a community benefit

- We provide a $400,458 subsidy to anesthesiology to bring in a third (or more) anesthesiologist in off hours. This is required in part because of our very large maternity partnership program that serves uninsured, pregnant women and our very busy emergency department that drives off-hours demand for specialty care, disproportionately by uninsured patients.

Category Two: Non-Resident house staff and hospitalists

- The hospital contracts/employs non-resident house staff and hospitalists to provide inpatient services, including night coverage to admit and cover the uninsured/underinsured population. In FY10, Holy Cross Hospital provided a net benefit of $927,574.
- The hospital contracts/employs pediatric hospitalists to meet the inpatient need of uninsured/underinsured infants and children. In FY10, Holy Cross Hospital provided a net benefit of $1,310,276.

Category Three: Coverage of Emergency Department call

- The hospital contracts with individual physicians and physician groups to ensure the needs of the uninsured/underinsured population are met by providing subsidies for the coverage of emergency department calls. In FY10, Holy Cross Hospital provided a net benefit of $1,677,330 to ensure emergency coverage in the following areas:
    - General Surgery, Orthopedic Surgery, Neurology/Stroke Care, Neurosurgery, ENT, Oral Surgery, Interventional Cardiology, Plastic Surgery, Urology, Ophthalmology, Vascular Surgery, Thoracic Surgery, Psychiatry and Anesthesiology

Category Four: Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

- No additional subsidies provided beyond those described above, however, all hospital based contracted physicians and on-call physicians follow the hospital's charity care policy.

Category Five: Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- No subsidies provided

VI. APPENDICES

To Be Attached as Appendices:

1. ***Describe your Charity Care policy:***
    a. ***Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy. (label appendix I)***

For example, state whether the hospital:

- ***posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;***
- ***provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;***
- ***provides a copy of the policy, or summary thereof, and financial assistance contact information to patients with discharge materials;***
- ***includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or***
- ***discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.***

Charity Care Policy Description

All Holy Cross Hospital registration, financial counseling and customer service staff members are trained to be familiar with the availability of financial assistance and the criteria for such assistance.

In addition:

- The financial assistance application and information about the program are prominently displayed in all registration areas, the emergency center and each cashier's office. The information available is offered in both English and Spanish, the predominant languages in our patient population at Holy Cross Hospital.
- Material describing the financial assistance program and an application are to be given or sent to all patients who request this information.
- Staff is responsible for being particularly alert to those who are registered as self-pay patients and provide them with information on how to contact a financial counselor or provide them financial assistance information. All financial assistance applicants are screened for eligibility for federal, state or other local programs before financial assistance is offered.
- All financial counselors are bilingual (English/Spanish).
- The financial assistance application is accessible through the hospital's external website
- Notice of financial assistance availability is indicated on all hospital billing statements
- Holy Cross Hospital uses Ethnic Health Promoters that inform community members about our financial assistance policy on a one-on-one basis or in group settings where people gather in the community (e.g., hair salons, churches, community centers).
- A written notice is published annually in local newspapers in English and Spanish to advise the public of our financial assistance policy.

The Holy Cross Hospital financial assistance policy provides systematic and equitable clinical services to those who have medical need and lack adequate resources to pay for services. In FY11, Holy Cross Hospital provided $19.2 million in financial assistance. Individuals who are uninsured are able to obtain primary health care services at two Holy Cross Hospital health centers located in Silver Spring and Gaithersburg, Maryland. The health centers provide a convenient option for uninsured residents in need of high quality, discounted medical care. In FY11, health center visits increased 28 percent from 16,705 in FY10 to 21,349 and exceeding our target of 18,000 by 18 percent. Financial assistance also increased 17 percent from $16.4 million to $19.2 million and exceeded our budget of $12.8 million. We plan to open a third health center in the Aspen Hill area in 2011 to accommodate the increase in patient visits at both Gaithersburg and Silver Spring Health Centers.

b. Include a copy of your hospital's charity care policy (label appendix II).

HOLY CROSS HOSPITAL

Patient Financial Assistance

Purpose

It is part of the Holy Cross Hospital mission to make medically necessary care available to those in our community who are in need regardless of their ability to pay. The Hospital maintains a formal financial assistance program to equitably and efficiently provide access for those who cannot pay. Since all care has associated cost, any "free" or "discounted" service provided through this program results in that cost being passed on to other patients and their payers. Holy Cross Hospital therefore has a dual responsibility to cover those in need while ensuring that the cost of care is not unfairly transferred to individuals, third party payers and the community in general.

It is the purpose of this policy to:

- Ensure a consistent, efficient and equitable process to provide free or reduced-cost medically necessary services to patients who reside in the state of Maryland or who present with an urgent, emergent or life-threatening condition and do not have the ability to pay.
- Ensure regulatory agencies and the community at large that the hospital documents the financial assistance provided to these patients so that their eligibility for the assistance is appropriately demonstrated.
- Protect a stated level of each patient's assets when determining their eligibility for financial assistance under this policy.
- Provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance under this policy.

Applies to HCH

- Financial counseling and revenue cycle staff
- Hospital contracted physicians

Policy Overview

The Holy Cross Hospital financial assistance policy applies in those cases where patients do not have sufficient income or assets to pay for their care and fulfill their obligation as patients to cooperate with and avail themselves of all programs for medical coverage (including Medicare, Medicaid, commercial insurances, workers compensation, and other state and local programs). The Hospital's financial assistance policy is comprised of the following programs - each of which may have its own application and documentation requirements.

- **Scheduled Financial Assistance Program:** Holy Cross makes available financial assistance to eligible patients who have a current or anticipated need for inpatient or outpatient medical care. This assistance requires completion of a full application and provision of supporting documentation. Once approved, such financial assistance remains in effect for a period of six months after the determination unless the patient's financial circumstances change or they become eligible for coverage through insurance or available public programs during this time.

- **Presumptive Financial Assistance Program:** Holy Cross makes available presumptive financial assistance to eligible patients as follows:

    - Patients, unless otherwise eligible for Medicaid or CHIP, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
        - Households with children in the free or reduced lunch program;
        - Supplemental Nutritional Assistance Program (SNAP);
        - Low-income-household energy assistance program;
        - Primary Adult Care Program (PAC) until such time as inpatient benefits are added to the PAC benefit package;
        - Women, Infants and Children (WIC)

    - Services provided within Holy Cross Health Centers and the Obstetrics and Gynecology Clinic as well as for select outpatient services provided at the Hospital. In some cases both the eligibility and documentation requirements will reflect the processes and policies of county or other public programs for financial assistance. This assistance is based on the same financial assistance eligibility schedule,

Policy Overview (continued)

but normally requires a less extensive documentation process. Should a patient who is granted presumptive status for routine outpatient care have a need for more substantial services or inpatient services, more extensive documentation will be required, and a redetermination of eligibility will be made.

- **Medical Financial Hardship Program:** Holy Cross also makes available financial assistance to eligible or "medically indigent" patients who demonstrate a financial hardship as a result of medical debt. This program requires a more extensive documentation process. Reduced-cost financial assistance will remain in effect during the 12-month period after the date the reduced-cost medically necessary care was initially received and will apply to the patient or any immediate family member of the patient living in the same household when seeking subsequent care at Holy Cross Hospital.

If a patient meets the eligibility requirements of more than one of the programs listed above, the Hospital shall apply the reduction in charges that is most favorable to the patient. If reduced-cost care is approved for a patient, the maximum patient payment for care will not exceed the charge minus the hospital mark-up.

The documentation requirements and processes used for each financial assistance program are listed in the financial assistance and billing and collection procedures maintained by the Revenue Cycle Management division.

Within two business days of the receipt of a completed application for financial assistance, medical assistance or both, a determination of probable eligibility will be made.

Covered Services

The financial assistance policy applies only to hospital charges for medically necessary patient services that are rendered at facilities operated solely by Holy Cross Hospital; i.e., inpatient, outpatient, emergency center, clinic, and Health Center. It does not apply to services that are operated by a "joint venture" or "affiliate" of the hospital. Hospital contracted physicians (Emergency Center, Anesthesia, Pathology, Radiology, Hospitalists, Intensivists and Neonatalogists are contracted) also honor scheduled financial assistance determinations made by the hospital. Financial assistance is only applicable when a patient takes advantage of the most appropriate cost effective setting to obtain their care.

Provision of services specifically for the uninsured: In the event that Holy Cross provides a more cost effective setting for needed services

(such as the Obstetrics and Gynecology Clinic or the Health Centers for uninsured patients), in cooperation with community groups or contracted physicians, specific financial assistance and payment terms apply that may differ from the general Holy Cross Hospital financial assistance program. In these heavily discounted programs, patients are expected to make the minimum co-payments that are required regardless of the level of charity care for which the patient would otherwise be eligible. Those minimum obligations are not then eligible to be further reduced via the scheduled financial assistance policy.

Services Not Covered

Services not covered by this financial assistance policy are:

1) Private physician services or charges from facilities in which Holy Cross Hospital has less than full ownership.
2) Cosmetic, convenience, and/or other Hospital services, which are not medically necessary. Medical necessity will be determined by the SVP of Medical Affairs after consultation with the patient's physician and must be determined prior to the provision of any non-emergent service.
3) Services for patients who do not cooperate fully to obtain coverage for their services from County, State, Federal, or other assistance programs for which Holy Cross believes they are eligible.

Patient Eligibility Requirements

Holy Cross provides assistance to Maryland residents and patients who present with an urgent, emergent or life-threatening condition whose income is less than 300% of the federal poverty level and whose monetary assets (assets that are convertible to cash excluding up to $150,000 in equity in their primary residence, personal tools used in their trade or business, and deferred retirement plan assets) do not exceed $10,000 as an individual or $25,000 within a family. Holy Cross will also provide assistance to patients with family income up to 500% of the federal poverty level that demonstrate a financial hardship as a result of incurring hospital medical debt that exceeds 25% of family income over a 12-month period.

Any individual may make a request to reconsider the level of reduced-cost care approved or denial of free or reduced-cost care by the Hospital for the individual. In such cases, requests are to be made to the financial counseling manager who will consider the total financial circumstances of the individual including outstanding balances owed to the Hospital, debt and medical requirements as well as the individual's income and assets. The financial counseling manager will assemble the patient's request and documentation and present it to the financial assistance exception committee (comprised of the Vice President, Mission Services, the Chief Financial Officer, and the Senior Vice President, Corporate

Development) for consideration.

In any case where the patient's statements to obtain financial assistance are determined to be materially false, all financial assistance that was based on the false statements or documents will be rescinded, and any balances due will be processed through the normal collection processes.

The scheduled financial assistance program provides free medically necessary care to those most in need – patients who have income equal to or less than 200% of the federal poverty level. It also provides for a 60% reduction in charges for those whose income is between 201% and 250% of the poverty level, and 30% assistance from 251% to 300% of the federal poverty level. For those patients who demonstrate a medical financial hardship, a minimum of 30% assistance may be provided from 301% to 500% of the federal poverty level. The Hospital's schedule of financial assistance will change according to the annual update of federal poverty levels published in the HHS Federal Register.

Continuing financial obligation of the patient: Patients who receive partial financial assistance have been determined to be capable of making some payment for their care. Unless a specific patient financial assistance exception request is made and approved, or hospital management formally adopts a procedure that exempts collection processes for particular services, patients are expected to pay the amount of the reduced balance. In cases other than the above, any patient who fails to pay their reduced share of the account in question will have that account processed through our normal collection procedures, including the use of outside agencies and credit reporting. However, the hospital will not pursue a judgment against anyone who has legitimately qualified for any scheduled level of Holy Cross Hospital financial assistance. Payment plans are also made available to uninsured patients with family income between 200% and 500% of the federal poverty level that request assistance.

Notice of Financial Assistance

The financial assistance program is publicized to patients of Holy Cross Hospital to whom it may apply. The information will be made available via the following methodologies:

1) Notice of the availability of financial assistance will be prominently displayed in all hospital registration areas, the emergency center, health centers, and each cashier's office in the predominant languages represented by our patient population. The financial assistance application and the Hospital patient information sheet are also accessible on the hospital's external website.
2) Notice of financial assistance availability is indicated on all hospital billing statements along with a reference to the external website and

phone number where inquires can be made.
3) All self-pay patients are advised of the existence of the financial assistance program during the pre-registration and registration process.
4) Information regarding eligibility and applications for financial assistance will be mailed to any patient who requests it at any time – including after referral to collection agencies.
5) A notice will be published each year in a newspaper of wide circulation in the primary service area of the hospital.

References

- Trinity Health. "Billing, Collection and Support for Patients with Payment Obligations", Trinity Health system policy 6-11-1, revised January 24, 2007.
- Federal Poverty Guidelines, HHS Federal Register

Questions and more information

Contact the financial counseling department at extension 7195 or the financial counseling manager at extension 7155 with questions and for more information.

Policy Modifications

The Holy Cross Hospital Board of Trustees must approve modifications to this policy. In addition, this policy will be presented to the Board for review and approval every two years.

Revision History

- Originating Department: Administration
- Original Date: April 9, 2009
- Latest Revision Date: September 29, 2011
- Effective: November 1, 2011

Approval

Name	Title	Date
Julie D. Keese	VP, Revenue Cycle Management	
Sr. Rachel Callahan, CSC	VP, Mission Services	
Roseanne Pajka	SVP, Corporate Development	
Anne Gillis	Acting CFO & VP of Finance	
Kevin J. Sexton	President and CEO	
Board of Trustees		10/27/11

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2. Attach the hospital's mission, vision, and value statement(s) (label appendix III).

Holy Cross Hospital Mission, Vision and Value Statement

Our Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us.

Our Core Values

- Respect
- Social justice
- Compassion
- Care of the poor and underserved
- Excellence

Our Role

Holy Cross Hospital in Silver Spring, Maryland, exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area.

Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

HOLY CROSS HOSPITAL

Holy Cross Hospital of Silver Spring, Maryland
Community Health Needs Assessment
Accepted by the Holy Cross Hospital Board of Trustees on October 27, 2011

Contents

Introduction

Overview of Holy Cross Hospital

Holy Cross Hospital is a community teaching hospital, a Maryland not-for-profit corporation and a member of Trinity Health, one of the nation's largest Catholic health care systems. Our medical staff has approximately 1,200 physicians and our workforce includes 3,200 people, 70 percent of whom are minorities. Holy Cross Hospital is the only organization to receive the Workplace Excellence award each year since 1999 from the greater Washington, D.C., Alliance for Workplace Excellence.

Our main hospital facility has approximately 700,000 square feet of space with 455 adult, pediatric and neonatal intensive care licensed beds and an on-site obstetrics/gynecology outpatient clinic for uninsured women. Beyond our campus, we provide service at multiple locations, including two safety net community health centers for uninsured adults and a vital aging center for seniors. We have established geographic presence at 21 sites that host our senior exercise program and in 60 churches through our faith community nurse program.

Annually, Holy Cross has approximately 33,000 discharges, one of the highest volumes of any hospital in Maryland. We also provide 163,000 outpatient visits. These include 87,000 visits to the emergency center and more than 30,000 visits to our clinics for uninsured patients. In our service area of 1.5 million people, our inpatient market share is 23 percent—higher than any other hospital. We emphasize meeting local community needs with services for which location is important (e.g., senior care, obstetrics and emergency) and broader community needs with more complex services (e.g., cancer, high risk obstetrics and neonatology, minimally invasive surgery and neurosciences). We reached 260,000 encounters through our community benefit outreach programs last year.

Holy Cross Hospital's overall approach to community benefit is to target the intersection of documented unmet community health needs and our organization's key strengths and mission commitments. We take prudent risks in developing innovative ideas and implementing responsive programs. We emphasize prenatal and primary health care services, health promotion, and chronic disease prevention and management, especially for vulnerable and underserved women, seniors, and racial, ethnic and linguistic minorities. We are evolving to link our community-based services more explicitly with our clinical services to help build the continuum of care.

We fully integrate our commitment to community service into our management and governance structures as well as our strategic and operational plans, and we are rigorous in monitoring and evaluating our progress. We seek and nurture relationships with a broad range of collaborative partners to build community and organizational capacity. We strive to sustain an effective community benefit ministry.

The overarching goal of Holy Cross Hospital's community benefit ministry is to respond to identified community health needs, increase access and improve health status, especially for the most vulnerable and underserved individuals and families in our community, and to be a leader and serve as an example to others in community service.

The hospital is committed to a program of community benefit through our mission and role statement to be the most trusted provider of health care services, with special emphasis on access for vulnerable and underserved populations (especially, women; children; seniors; and racial, ethnic, and linguistic minorities) and improvements in health status.

Our commitment is evidenced by our established and improved explicit financial assistance and billing and collection policies and procedures, and we encourage physician and employee participation in providing services to address the needs of poor and underserved individuals and families. Key elements of our financial assistance policy are active communication, comprehensive coverage of services provided by the hospital and hospital-based physicians, and a six-month period of eligibility. We work to assess eligibility for public programs and provide enrollment support.

We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community benefit activities, which are integrated into our multi-year strategic and annual operating planning processes.

Three strategic community benefit themes, which emerged from the fiscal 2011-2014 strategic planning process, frame selected annual initiatives. They are: 1) Play a lead role in building a better system of care for those without insurance and with limited access to health care; 2) Target at risk populations for special outreach and care coordination, and 3) Demonstrate value of community-based programs, processes and outcomes and maintain our leadership position in community benefit.

As a faith-based, tax-exempt organization, we embrace our responsibility to reinvest our earnings in our programs and facility to serve the community and to provide community benefit. We enthusiastically support more transparency in public reporting.

The Congregation of the Sisters of the Holy Cross founded the hospital in 1963 in cooperation with a community group and local physicians. Responding to community need was a central theme at that time and it remains so today. In addition, the spirit of partnership and inclusion that led to the hospital's creation remains a commitment today that is embedded in our mission and operations.

During fiscal 2011, Holy Cross received State approval to establish what will be the first new hospital in Montgomery County in 35 years when it opens in 2014. The final decision mentioned our strong record in access to care for the indigent and broader community benefits.

The Community We Serve

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents. An estimated 1.5 million people make up our four market area, of which 62% are minorities. Our 12 ZIP code core market includes 339,489 people, of which 61% are minorities (see Figure 1).

Race	Four Market Area (1.5 Million)	Core Market (339,489)
White-Non-Hispanic	586,451 (38.4%)	131,225 (38.7%)
Black Non-Hispanic	502,823 (32.9%)	84,163 (24.8%)
Asian/Pacific Islander	151,230 (9.9%)	41,308 (12.2%)
Hispanic	241,125 (15.8%)	71,004 (20.9%)
All Others	45,893 (3.0%)	11,789 (3.5%)

Figure 1. Demographic breakdown of HCH market area by race

We draw 83 percent of our discharges from a defined market area with four sub-areas within Montgomery and Prince George's Counties (see Figure 2). Seventeen percent of our discharges come from outside this four-market area. Our core market is defined as 12 contiguous ZIP Codes in Montgomery County from which we draw 42 percent of our discharges. We draw 69 percent of our inpatient and outpatients from Montgomery County.

Figure 2. HCH Four market area

HCH Percent Distribution of Patient Discharges

- **Core (42%)**
- **Northern Prince George's (14%)**
- **Prince George's Referral (11%)**
- **Montgomery Referral (16%)**

The community we serve is one of the most culturally and ethnically diverse in the nation, having experienced a demographic shift and a pace of change that comes with being a "gateway suburb." Montgomery County is one of only 336 "majority-minority" counties in the country. During the last two decades, the county's foreign-born population increased from 12 percent in 1980 to more than 30 percent.[1] Immigrants from all over the world bring a great vitality to our community; at the same time, they challenge the hospital and other local community service providers to understand and meet their varied needs.

Montgomery County, Maryland's most populous jurisdiction, with a population of 971,777, has a median household income of $94,420 compared to the statewide median household income of $69,272 (see figure 3). The county's income level is positively correlated to its level of education; more than half of the county's residents (56.3%) hold a bachelor's degree or higher compared to 35.7% statewide (U.S. Census Bureau, 2009 American Community Survey).

Due to the large number of federal agencies and contractors, the area generally enjoys low unemployment. However, relatively greater rates of unemployment are experienced among the African American and Latino American populations. During the last two decades, minorities have become the majority – today 49 percent of the county's residents are non-Hispanic whites, down from 60 percent in 2000 and 72 percent a decade before that (Morella & Keating, 2011).[2] Despite its relative wealth in terms of income, education and support for public services, more than 123,000 adults are uninsured (SAHIE, 2007).

Fluency in English is very important when navigating the health care system as well as finding employment. In Montgomery County, the highest rates of linguistic isolation are among Latino Americans and Asian Americans. Forty-six percent of those who are foreign-born speak English less than "very well" (Maryland Department of Planning, Planning Data Services, 2007).

Prince George's County also experienced a large influx of foreign-born residents during the last two decades. The county's foreign-born population as a percent of total population gain from 2000-2007 was the highest in the state at 199.9 percent compared to a state average of 70.7 percent. More than 18 percent of the county's residents are foreign-born, of which 42 percent speak English less than "very well" (Maryland Department of Planning, Planning Data Services, 2009).

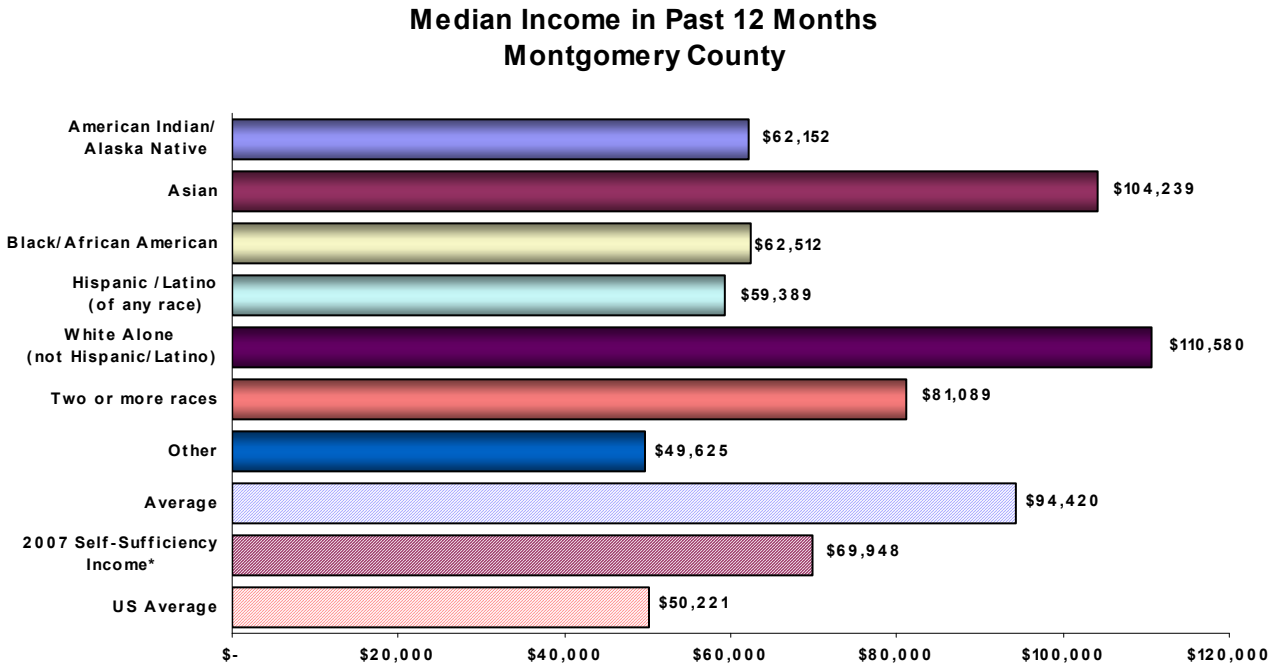
Prince George's County, like Montgomery County, is one of the states most populous jurisdictions with a population of more than 863,420 residents and a median household income of $69,947, slightly higher than the state average (see figure 3). Less than one

[1] Neal Peirce, "Outreach to immigrants: A suburb's exciting new way," *The Washington Post* May 17, 2009, from http://www.postwritersgroup.com/archives/peir090517.htm.

[2] Carol Morello and Dan Keating, "Minorities are majority population in Montgomery County," *The Washington Post*, February 10, 2011 (from http://www.washingtonpost.com/wp-dyn/content/article/2011/02/09/AR2011020904310.html).

third (29.2 percent) of the county's residents hold a bachelor's degree or higher (U.S. Census Bureau, 2009 American Community Survey) and over 149,000 individuals are uninsured (SAHIE, 2007).

Despite the relative affluence of our local community, disparities exist. For example, in Montgomery County, key minority populations average lower median income than the income level determined for self-sufficiency. In Prince George's County, relatively high income levels do not help lower the African American infant mortality rate. Pressing community health needs exist that will be described in this document.



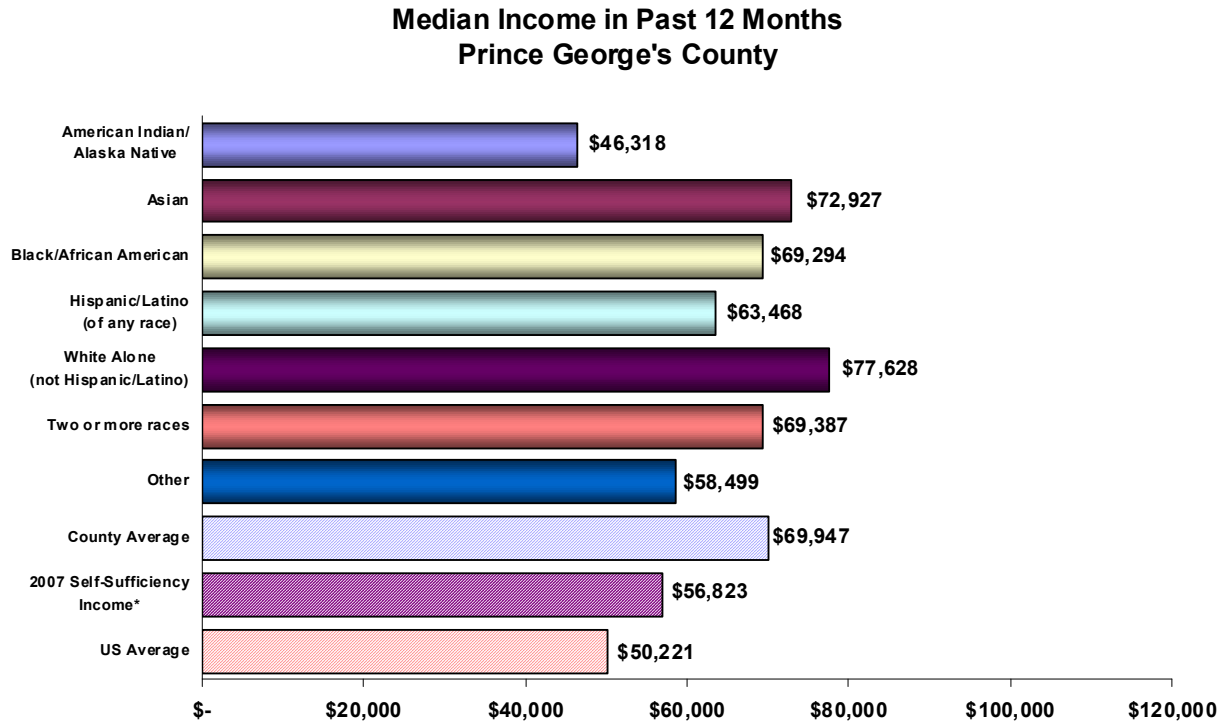


Figure 3. Household Income by race for Montgomery and Prince George's County. Source: U.S. Census Bureau, 2009 ACS
*Income for two adults, one preschooler and one school age child

Approach/Methodology

Community Health Needs Assessment Background

Holy Cross Hospital identifies unmet community health care needs in our community in a variety of ways. We use a range of available needs assessments and reports to identify unmet health care needs. Each year since 2005, we have invited input and obtained advice from a group of external participants to review our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority needs and the direction to take for the next year. We also solicited guidance on long-term strategies during the year we developed our fiscal 2011-2014 strategic plan.

External group participants include the public health officer and the department director of Montgomery County Department of Health and Human Services, a variety of individuals from local and state governmental agencies, and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations. These participants are experts in a range of areas including public health, minority populations and disparities in health care, social determinants of health, health and social services. The group's input helps to ensure that we have identified and responded to the most pressing community health care needs.

On an ongoing basis, we participate in a variety of coalitions, commissions, committees, partnerships and panels. Our ethnic health promoters and community outreach workers spend time in the community as community participants and bring back first-hand knowledge of community needs.

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The Affordable Care Act), which puts in place comprehensive health insurance reforms that will enhance the quality of health care for all Americans. In an effort to enhance the quality of health care, the Affordable Care Act will also require non-profit hospitals to complete a community health needs assessment every three years. Building on our efforts since 2005 to obtain external input, Holy Cross Hospital collaborated with Montgomery County Department of Health and Human Services (DHHS) and other community partners (including all other hospitals located in Montgomery County) to develop and participate in a formal county-wide process to identify and address key priority areas that would improve the health and well-being of Montgomery County.

Healthy Montgomery: The Montgomery County Healthy Montgomery Community Health Improvement Process was initiated to address the need of all organizations to have valid, reliable, and user-friendly data related to health and the social determinants of health and to coordinate efforts of public and private organizations, like Holy Cross Hospital, to identify and address health and health-related issues in Montgomery County.

In 2010, Holy Cross Hospital and the other three hospital systems in Montgomery County each gave $25,000, for a total of $100,000, in grants to the Urban Institute to

provide support for the *Healthy Montgomery* work. This included coordinating the environmental scan, which looked at all the existing sources of data (e.g., vital statistics, Department of Health and Mental Hygiene) and needs assessments and improvement plans from organizations in County (many of these documents are now available through the *Healthy Montgomery* Website), support of the effort to select the 100 indicators to include in the *Healthy Montgomery* Website, preparation of indicators and maps that show the social determinants of health for the County as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the Needs Assessment document.

In 2011, Holy Cross Hospital and the four other individual hospitals each gave $25,000, for a total of $125,000, in grants to the Institute for Public Health Innovation. These funds continue to support the Healthy Montgomery Steering Committee meetings, preparation and presentation of all of the community conversations, preparation of the Needs Assessment Report (quantitative data and information from the community conversations), support of the Steering Committee in determining selection criteria that will be used to choose the priorities for community health improvement, and support for the priority selection process.

Prince George's County does not have a similar county-wide data program so Holy Cross Hospital used the data sources found in *Healthy Montgomery* to extract data that was specific to Prince George's County so that health information could be analyzed for both counties (see Attachment A). The Center for Disease and Control County Health Rankings Data and the top 60% ZIP codes by volume in fiscal 2011 were also analyzed (see Attachment B).

Healthy Montgomery

Healthy Montgomery builds on past and current efforts, including environmental scans, comprehensive needs assessments, community health-related work, and relevant information from the healthcare provider organizations in the County. In addition to numerous quantitative data sources, Community Conversations were held with groups of residents to solicit their ideas about health and well being in their communities and in the county as a whole. These conversations provided views of diverse subpopulations on the issues they find critical.

The health improvement process has four objectives: (1) To identify and prioritize health needs in the County as a whole and in the diverse communities within the County; (2) To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporate a wide variety of county and sub-county information resources and utilize methods appropriate to their collection, analysis and application; (3) To foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and (4) To coordinate and leverage resources to support the *Healthy Montgomery* infrastructure and improvement projects.

Healthy Montgomery is under the leadership of the Healthy Montgomery Steering Committee, which includes planners, policy makers, health and social service providers and community members (see Attachment C). It is an ongoing process that includes periodic needs assessment, development and implementation of improvement plans and monitoring of the resulting achievements. The process is dynamic, thus giving the County and its community partners the ability to monitor and act on the changing conditions affecting the health and well-being of County residents. The material presented in this document is based on Montgomery County's Community Health Needs Assessment conducted during 2009-2012.

Community Needs Index

The Community Needs Index identifies the severity of health disparities for every ZIP code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations (Catholic Healthcare West, 2011). For each ZIP code in the United States, the Community Needs Index aggregates five socioeconomic indicators/barriers to health care access that are known to contribute to health disparities related to income, education, culture/language, insurance and housing. We use the Community Needs Index to identify communities of high need and direct a range of community health and faith-based community outreach efforts to these areas (see Attachment D).

Other Available Data

As available, we also use a range of other specific needs assessments and reports to identify unmet needs, especially for ethnic, racial, and linguistic minorities, seniors, and women and children. Our work is built on past available needs assessments, and we use these documents as reference tools, including the following key resources that became available more recently:

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014;
- Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012;
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008.

We review our own internal patient data and review purchased and publicly available data and analyses on the market, demographics and health service utilization.

Data Gaps Identified

Where available, the most current and up-to-date data was used to determine the health needs of the community. Although the data set available is rich with information, not surprisingly, data gaps exist.

- Data such as health insurance coverage data and cancer screening, incidence and mortality rates are not available by geographic areas within Montgomery or Prince George's Counties.
- Data is not available on all topics to evaluate health needs within each race/ethnicity by age-gender specific subgroups.
- Diabetes prevalence is not available for children, a group that has had an increasing risk for type 2 diabetes in recent years due to increasing overweight/obesity rates.
- Health risk behaviors that increase the risk for developing chronic diseases, like diabetes, are difficult to measure accurately in subpopulations, especially the Hispanic/Latino populations, due to BRFSS methodology issues.
- County-wide data that characterize health risk and lifestyle behaviors like nutrition, exercise, and sedentary behaviors are not available for children.
- Analysis of linked birth-death records would provide detailed information about characteristics and risk factors that contribute to fetal and infant losses in Montgomery and Prince George's Counties among those populations that could be at elevated risk for poor birth outcomes.
- An ongoing source of Pregnancy Risk Assessment Monitoring System (PRAMS) data at the county level at least every three years would improve policy and planning efforts in maternal, fetal and infant health.
- Data is not as available in Prince George's County when compared to Montgomery County.

Findings

Access to Care

Despite the median income of both Montgomery County and Prince George's County being well above the national average, many residents are without health insurance. Barriers like lack of health insurance and the high cost of medical care decrease access to quality health care and can lead to unmet health needs. This includes delays in receiving appropriate care, inability to get preventive services, and potentially preventable hospitalizations thus increasing mortality and morbidity (HHS, 2010).

Approximately 10% of Montgomery County residents and 15% of Prince George's County residents were without health insurance; however, racial disparities exist in both counties (see figure 4). Hispanics are more than 5 times as likely to be without health insurance in Montgomery County and more than 2.5 times as likely in Prince George's County when compared to their white counterparts. Almost 65% of the Montgomery County uninsured population and almost 60% of the Prince George's County uninsured population come from households with combined incomes of less than $75,000 annually.

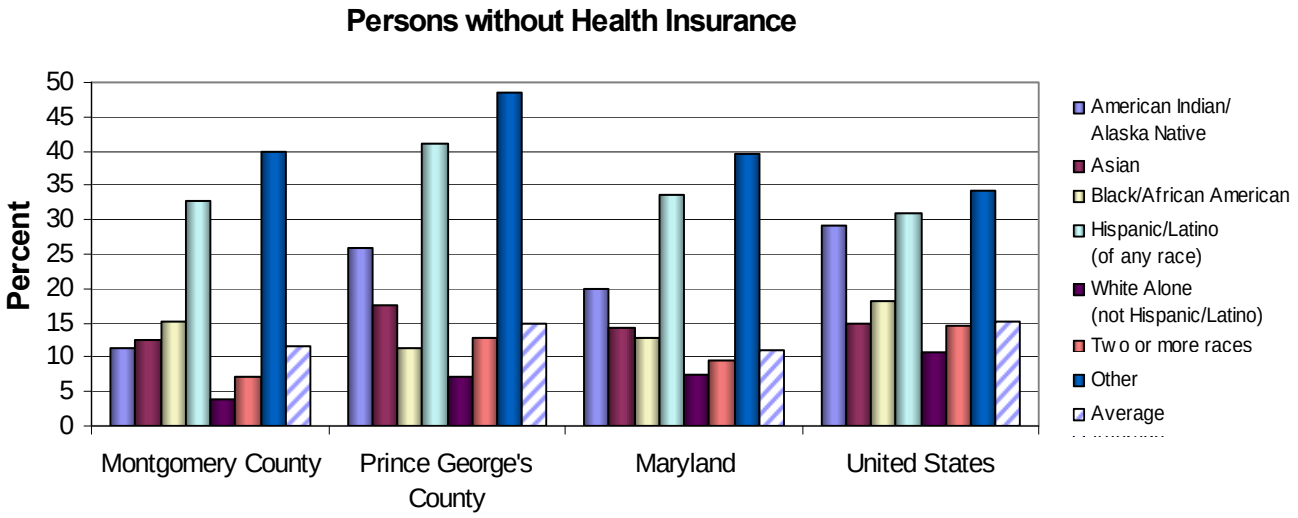


Figure 4. Comparison of racial breakdown of uninsured persons between Montgomery County, Prince George's County, the state of Maryland, and the United States. Source: Source: U.S. Census Bureau, 2009 American Community Survey.

Montgomery County has the largest number of non-citizen residents (64,000) with no health insurance among all the jurisdictions in Maryland (38 percent of the State's 170,000 non-citizen residents with no health insurance (Healthy Montgomery, 2011).

In addition to high rates of uninsured, one in every five adults (18-44 years), one in every four Hispanic/Latino adults, one in every six African American/Black adults, and one in every six adult males living in Montgomery County reported they were unable to see a doctor in the past year because they could not afford it (Healthy Montgomery, 2011).

Almost all Community Conversation groups ranked affordable/accessible health care as a priority. Concerns about poverty, employment, income and transportation created anxiety about health care access.

Disease Incidence and Prevalence

Cancer

Incidence and death rates for all cancers have been declining due to advances in research, detection and treatment, yet, cancer remains a leading cause of death in the United States (U.S. Department of Health and Human Services, 2010). It is also the second leading cause of death for both Montgomery and Prince George's County residents (Vital Statistics, 2009) and is the top leading cause of death among Montgomery County Asians and Pacific Islanders. The burden of battling cancers within our community varies; with disparities clearly present (DHHS, 2011).

For example, in Montgomery County almost 19% more white women are diagnosed with breast cancer each year when compared to African American/Black women,

however, 50% more African American/Black women in the county die from breast cancer when compared to white women. The incidence and death rates between counties also shows disproportionate results. Montgomery County has a 10.5 % higher incidence rate of breast cancer when compared to Prince George's County, however, the death rate for Prince George's County is 40% higher when compared to Montgomery County (see Figure 5).

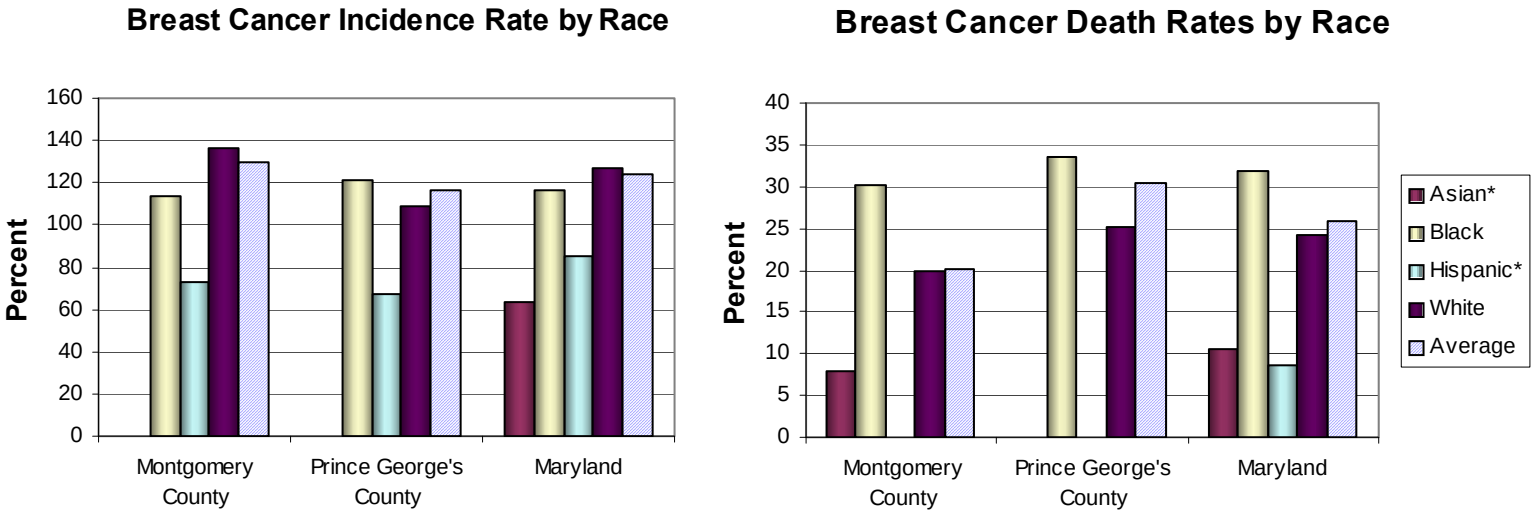


Figure 5. Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat.

Colorectal cancer, cervical cancer, lung cancer and prostate cancer also show health disparities in screening, incidence or death rates. Hispanic/Latino women are diagnosed with cervical cancer about twice as often as other women. Colorectal cancer screening is low among all men with African Americans/Blacks having the lowest screening rates. African Americans/Black men are also most likely to be diagnosed with or die from colorectal cancer when compared to the rates of Whites, Asians or Pacific Islanders and Hispanic/Latinos. Lung and bronchus cancer incidence is higher among men than women, with White and African American/Black residents twice as likely as Asians or Pacific Islanders to be diagnosed. African American/Black men are almost 50% more likely to be diagnosed with prostate cancer and twice as likely to die from the disease as White men (DHHS, 2011).

Heart Disease and Stroke

Together, heart disease and stroke are among the most widespread and costly health problems facing the Nation today, they are also among the most preventable (U.S. Department of Health and Human Services, 2010). In Montgomery County and Prince George's County heart disease is the leading cause of death and stroke is the third leading cause of death. Heart disease is the leading cause of death for African American/Black, Hispanic/Latino and White residents and is the second leading cause of

death among Asian and Pacific Islander residents. African American/Black residents die from stroke at a rate that is 15% (34.4 deaths per 100,000 population) higher than White residents (29.8 per 100,000 population) and more than double the rate experienced by Hispanic/Latino residents (14.5 per 100,000 population).

Men are disproportionately affected by heart disease mortality with a death rate that is more than 50% higher than it is for women. (167.5 deaths per 100,000 population vs. 106.2 per 100,000 population, respectively). African Americans/Blacks are also disproportionately affected by heart disease mortality. The mortality rate for African Americans/Blacks (159.5 per 100,000 population) is three times the rate Hispanic/Latino residents (53.9 per 100,000 population) and more than double the Asians and Pacific Islanders rate (71.7 per 100,000 population).

Diabetes

Diabetes Mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death (CDC, 2008) It is the ninth leading cause of death in Montgomery County and the fourth leading cause of death in Prince George's County (Maryland Vital Statistics, 2009). Diabetes can lower life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. It is also the leading cause of kidney failure, lower limb amputations and adult-onset blindness (U.S. Department of Health and Human Services, 2010).

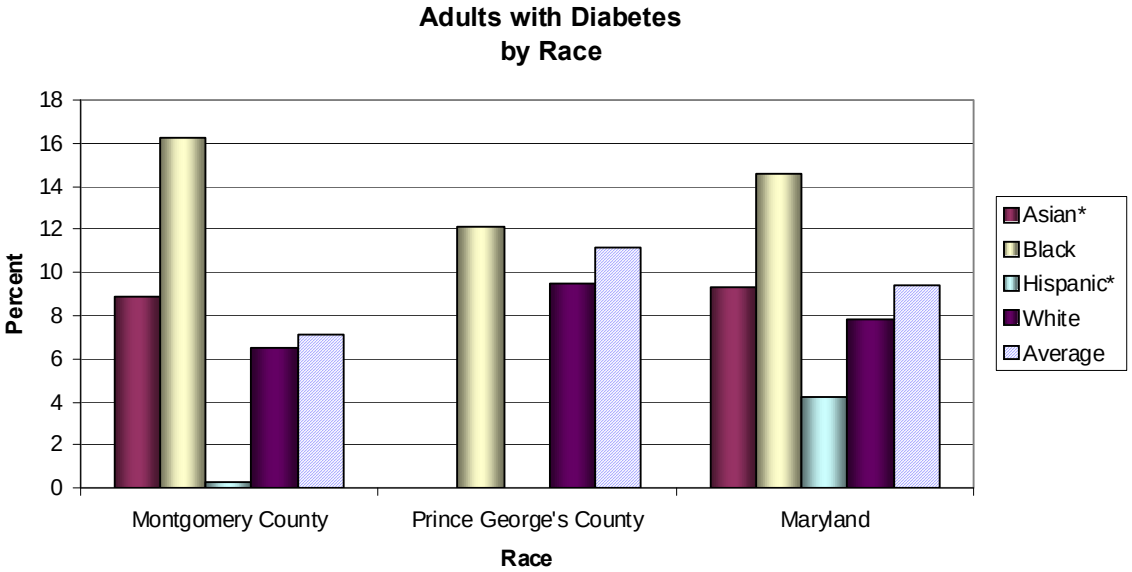


Figure 6. Source: Maryland Behavioral Risk Factor Surveillance System, 2009
*Data from sample sizes of <50 are statistically unstable and are not displayed.

Further analysis of Montgomery County data reveals that it is the fourth leading cause of death among African Americans/Blacks, fifth leading cause of death among Hispanics/Latinos, and sixth leading cause of death among Asians and Pacific Islanders (DHHS, 2011). African American/Blacks also die from diabetes more often when

compared to the overall county (see Figure 6). The mortality rate (28.8/100,000) for African American/Black residents is more than twice the overall county rate (12.7/100,000). Among African American/Black women, diabetes is the third leading cause of death. The overall mortality rate for Prince George's County is 31.4/100,000.

Obesity

During the past twenty years, obesity rates have increased in the United States; doubling for adults and tripling for children (see Figure 7). More than 50% of Montgomery County residents and more than 65% of Prince George's County residents are overweight or obese. Obesity affects all populations, regardless of age, sex, race, ethnicity and socioeconomic status (U.S. Department of Health and Human Services, 2010), however, disparities do exist and rates are affected by race/ethnicity, sex and age.

Prevalence of Obesity among Maryland Adults by Jurisdiction

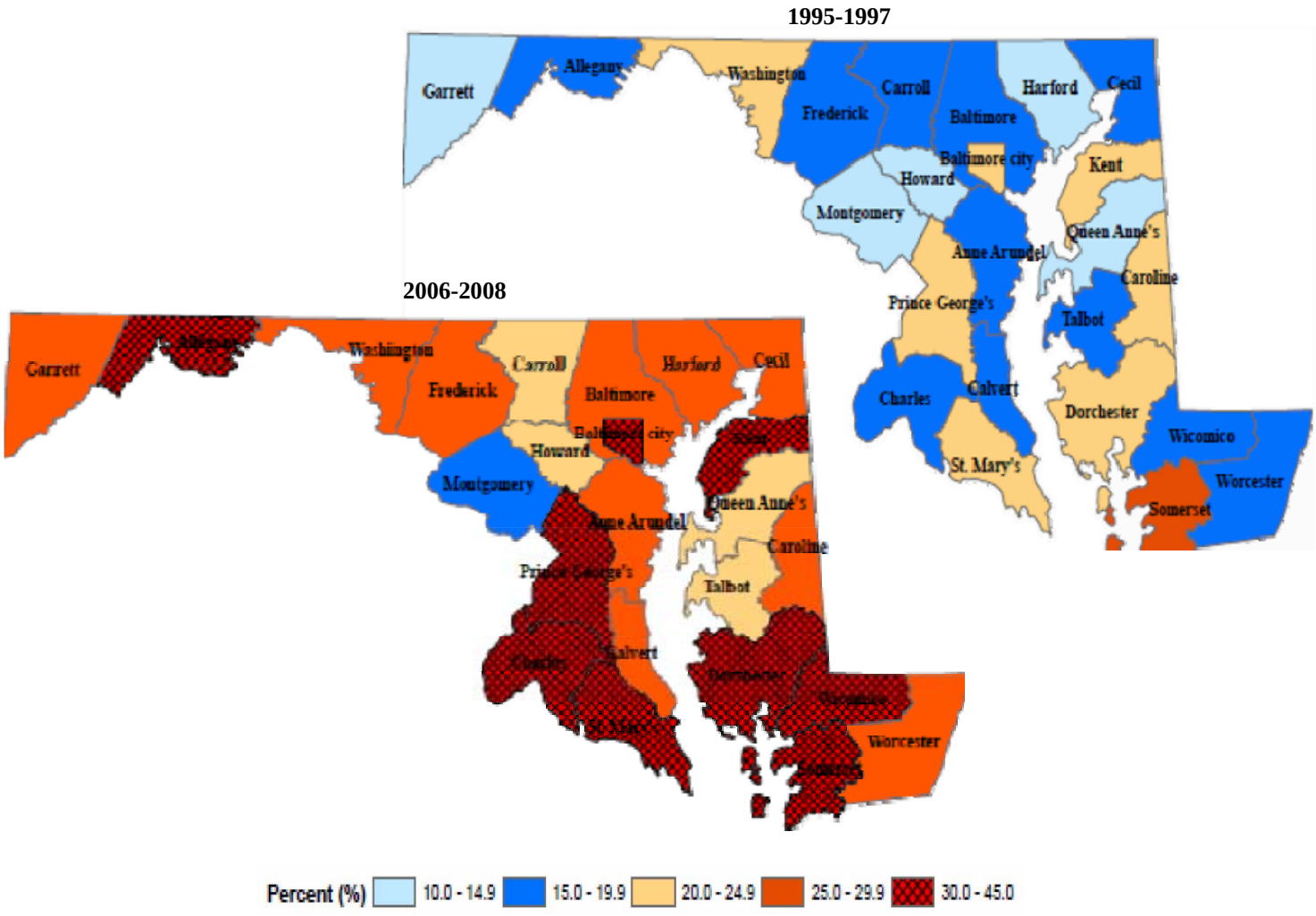


Figure 7. Maryland Department of Health and Mental Hygiene, Maryland Behavioral Risk Factor Surveillance System, BRFSS-1995-2008 Cumulative Results, Retrieved from: www.marylandbrfss.org

Men (61%) are more likely to be at least overweight. Seven out of every ten Hispanic/Latino adults and African American/Black adults are either overweight or obese. Obesity levels (BMI at or above 30.0 see figure 8) are lowest among the Asian/Pacific Islander adults (2.6%) and highest among African American/Black (28%) and Hispanic/Latino adults (30%). Men and adults aged 45-64 are also less likely to engage in 30 minutes of moderate activity for 30 minutes or more per day. Hispanic/Latino adults (39.7%) and White adults (35.2%) are more likely than Asian/Pacific Islander (25.3%) and African American/Black (29.1%) adults to engage in at least light-to-moderate physical activity.

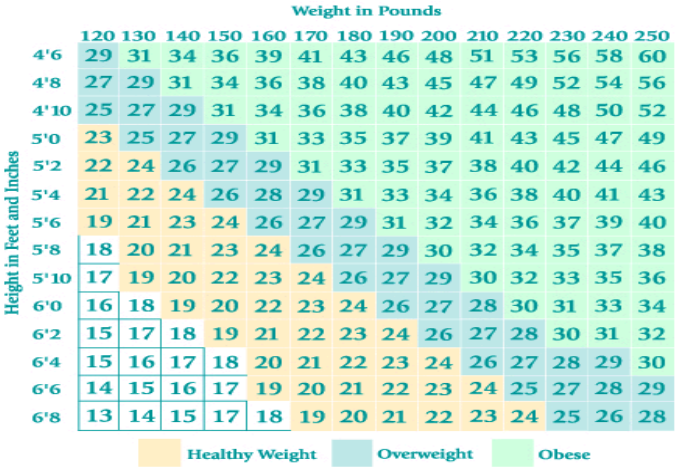


Figure 8. Body Mass Index chart .

Population-Based Health

Minorities

The highest population density between both counties is concentrated near our hospital in Silver Spring, especially on the southern border between Montgomery and Prince George's Counties and in Gaithersburg. Areas to the immediate south and east of Holy Cross Hospital have the lowest median income in the area, and Silver Spring and Gaithersburg are next. Areas in Silver Spring and Gaithersburg have the highest percentages of residents who speak English less than very well.

Demographic analysis further reveals that areas close to Holy Cross Hospital have a large number of persons who are poor, of childbearing age, elderly, racially and ethnically diverse, and have limited English proficiency (see figure 9).

For many health conditions and negative health behaviors, minorities, especially non-Hispanic blacks, bear a disproportionate burden of disease, injury, death, and disability when compared to their white counterparts (CDC, 2005) and are more likely to be without health insurance than non-Hispanic whites. Minorities also make up a disproportionate number of persons unable to afford health care when needed

(Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities, 2006).

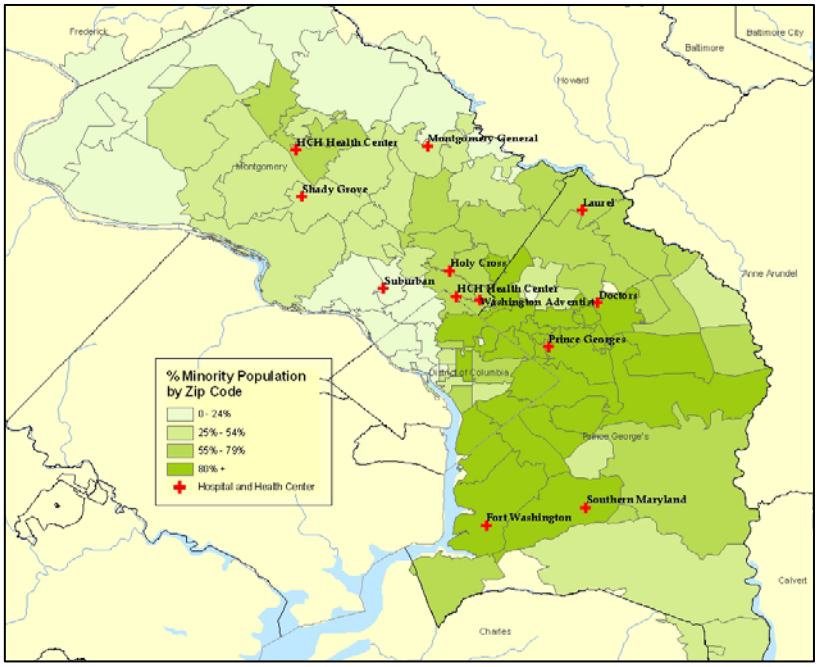
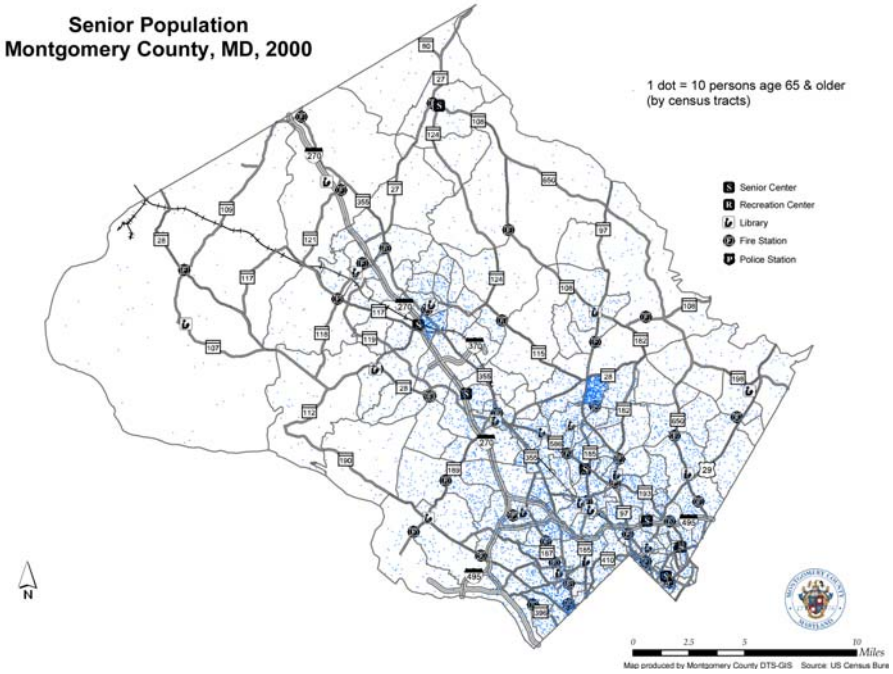


Figure 9. Percentage of Population of Holy Cross Hospital market area that is Minority, including Hispanic ethnicity (Thomson Reuters, 2010).

Seniors

Montgomery County is also rapidly aging (see figure 10). We face dramatic demographic change with the coming unprecedented aging of the county. The population age 65 and older will grow 4.1 percent per year over the next 10 years, eight times faster than the population under age 65 (.5 percent). As a result, the percent of the population age 65 and older will increase from 13 percent to 18 percent (Maryland Department of Planning, Planning Data Services, 2009).

As the senior population increases in Montgomery and Prince George's Counties, the need for senior health services also increases. It is estimated that by the year 2030 the 60+ population in Montgomery and Prince George's Counties will increase by 142% (316,495) and 162% (236,973), respectively (Maryland Department of Planning Population Projections, 2008). Currently, the two counties also have the second and third highest percentage of senior minorities in the state with 24.4 percent residing in Prince George's County and 15.7 percent in Montgomery County.



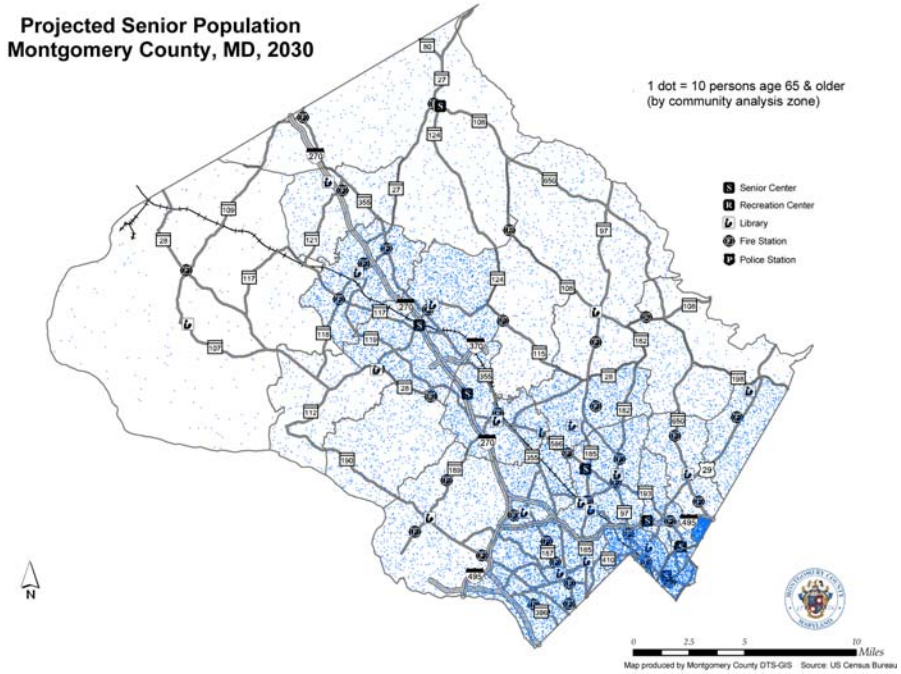


Figure 10. Thirty-year senior population growth of Montgomery County. Source: US Census Bureau

More than 37 million older adults (60 percent of the population aged 65+) will manage more than one chronic condition by 2030 (U.S. Department of Health and Human Services, 2010). Older adults are at high risk for developing chronic illnesses and related disabilities and experience disproportionate rates of heart disease, cancer, diabetes, congestive heart failure, arthritis and dementia (including Alzheimer's).

For example, one out of every two Montgomery County senior residents, 65 years and older, has hypertension. African American /Black adult residents are approximately one and a half times more likely (39.9%) than White residents (24.6%), twice as likely as Asian/Pacific Islander residents (17.1%) and three times more likely than Hispanic/Latino residents (14.4%) to experience high blood pressure.

Rates of high cholesterol have increased in Montgomery County from 30% in 2005 to 39% in 2009 and more than half of seniors have high cholesterol levels, which is a major risk factor for heart disease. Older adults also experience higher death rates from preventable diseases such as pneumonia and influenza.

Vaccination rates for pneumonia and influenza are lower among younger seniors aged 65-74 than for those 85 years and older (DHHS, 2011). Senior men are less likely to be vaccinated compared to senior women. Deaths due to either influenza or pneumonia occur mostly among seniors, 65 years and older and death rates are higher among men. White senior adults experience 45% higher rates of death than Asian/Pacific Islander seniors and 10% higher rates than African American/Black seniors.

Women and Children

The health and well-being of women, infants and children determines the health of the next generation and can help predict future public health challenges for families, communities and the health care system (U.S. Department of Health and Human Services, 2010).

The rates of low-birth-weight (LBW) and very low-birth-weight (VLBW) births in Montgomery and Prince George's County are highest among African American/Black births. Although Montgomery County met the Healthy People 2020 LBW target of 7.8% in 2007, the percent of LBW births increased in 2009 to 8.2%. The percent of VLBW births remained at 1.4%, which equals the Healthy People 2020 target.

Montgomery County has an infant death rate that is comparable to the median value (5.5 deaths per 1,000 live births) of all 24 Maryland jurisdictions. While the overall County infant mortality rate meets the Healthy People 2020 target of 6.0 per 1,000 live births, the African American/Black infant mortality rate is almost double the county rate at 10.7 deaths per 1,000 live births.

Teen mothers and mothers under 25 years of age are most likely not to have entered care within their first trimester. In Montgomery County, only 67% of Hispanic/Latino mothers and 76.2% of African American/Black mothers entered care in their first trimester in 2009, both below the Healthy People 2020 target of 77.9%.

Teen mothers and mothers under 25 years of age are most likely to enter prenatal care late or get no prenatal care. In 2009 about 7% of Hispanic/Latino mothers and African American/Black mothers had no prenatal care or entered care in their last trimester. The percent of mothers who received late or no prenatal care increased in 2009 for the first time in the past four years.

Response to findings

Unaddressed Identified Needs

Eight other topic areas (family planning, immunizations and infectious diseases, mental health care and prevention, prevention and safety, respiratory diseases, substance abuse, illicit drug use, and wellness and lifestyle) were identified for data collection, review and priority setting.

One of these (mental health care and prevention) has emerged as an area for more attention by the county. Holy Cross will continue to participate in the ongoing needs assessment process to determine how we can play a role in improving outcomes in this area.

Mental Health and Mental Disorders

One in four adults in Montgomery County report they are not getting the social and emotional support they need. One in seven women and one in 14 men have been diagnosed with some form of an anxiety disorder, including acute stress, obsessive compulsive disorder, panic, phobia, post-traumatic stress disorder, or social anxiety. Over 40% of Montgomery County residents get inadequate sleep at night. Almost all (99%) Asian and Pacific Islander and Hispanic/Latino adults report being satisfied or very satisfied with their lives, while fewer African American/Black (88%) and White adults (94.1%) report being satisfied/very satisfied with their lives.

Community Benefit Plan

As the County's Community Health Improvement Process evolves, priorities will be determined, and with this information, Holy Cross Hospital will address unmet needs within the context of our overall approach, mission commitments and key clinical strengths and within the overall goals of *Healthy Montgomery*.

Key findings from all data sources, including data provided by *Healthy Montgomery*, our external review group (see Attachment E) and hospital available data were reviewed and the most pressing needs (see Attachment F) were incorporated into our annual community benefit plan (see Attachment G for highlights). The community benefit plan reflects Holy Cross Hospital's overall approach to community benefit by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of the organization (see figure 11) to help build the continuum of care. We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community benefit

activities, which are integrated into our multi-year strategic and annual operating planning processes.

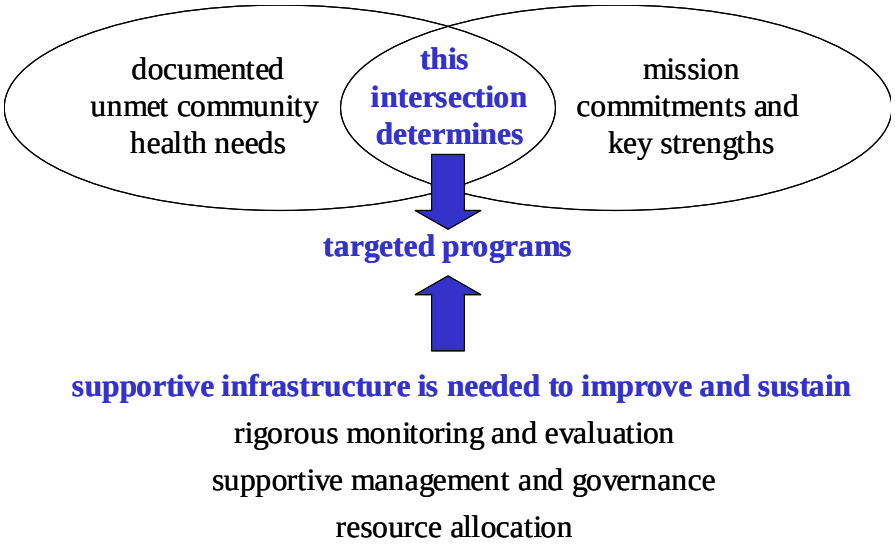


Figure 11. How HCH aligns targeted programs with the mission and strengths of the hospital and unmet community needs

The fiscal 2011-2014 strategic planning process developed three strategic community benefit themes that frame selected annual initiatives. They are: 1) Play a lead role in building a better system of care for those without insurance and with limited access to health care; 2) Target at risk populations for special outreach and care coordination, and 3) Demonstrate value of community-based programs, processes and outcomes and maintain our leadership position in community benefit.

Holy Cross Hospital's Community Benefit Implementation Strategy is presented in a separate document.

HOLY CROSS HOSPITAL

Attachment A

Community Health Needs Assessment Data

Montgomery County, Prince George's County and Maryland

Indicator	Green	Yellow Range	Red	Average/ Comparison	Montgomery County	PG County	State
Access to Health Services							
Adults Unable to Afford to See a Doctor	≤ 12.3%	12.4-16.8%	≥ 16.9%		14.4%	17.9%	13.0%
Adults who have had a Routine Checkup	≥ 87.1%	87.0-84.8%	≤ 84.7%		87.2%	90.9%	87.5%
Persons with Private Health Insurance Only				64.8	68.6		
Persons with Public and Private Health Insurance				11.2	9.7		
Persons with Public Health Insurance Only				12.9	10.2		
Persons without Health Insurance				11.1	11.5	14.8	11.1
Cancer							
Age-Adjusted Death Rate due to Breast Cancer cases/100,000 population	≤ 25.3	25.4-29.6	≥ 29.7		20.2	30.3	25.8
Age-Adjusted Death Rate due to Colorectal Cancer deaths/100,000 population	≤ 19.6	19.7-22.0	≥ 22.1		12.2	21.0	18.6
Age-Adjusted Death Rate due to Lung Cancer deaths/100,000 population	≤ 60.1	60.2-66.2	≥ 66.3		30.6	49.5	53.8
Age-Adjusted Death Rate due to Prostate Cancer deaths/100,000 males	≤ 19.7	19.8-24.4	≥ 24.5		19.7	37.7	27.5
Breast Cancer Incidence Rate cases/100,000 females	≤ 122.2	122.3-129.9	≥ 131		129.6	116.7	123.8
Cervical Cancer Incidence Rate cases/100,000 females	≤ 7.8	7.9-8.5	≥ 8.6		8.0	7.0	7.6
Colon Cancer Screening	≥ 70.6%	70.5-66.2%	≤ 66.1%		72.1%	73.9%	71.3%
Colorectal Cancer Incidence Rate cases/100,000 population	≤ 50.4	50.5-53.0	≥ 53.1		38.1	46.9	46.9
Lung and Bronchus Cancer Incidence Rate (cases/100,000 population)	≤ 75.6	75.7-83.5	≥ 83.6		42.6	54.4	67.6
Mammogram History	≥ 81.1%	81.0-76.9%	≤ 76.8%		82.6%	81.7%	80.5%
Pap Test History	≥ 83.5%	83.4-79.8	≤ 79.7%		87.4%	82.2%	84.1%
Prostate Cancer Incidence Rate cases/100,000 males	≤ 152.4	152.5-167.7	≥ 167.8		158.2	178.8	159.4
Diabetes							
Adults with Diabetes	≤ 10.0%	10.1-10.9%	≥ 11.0%		7.1%	10.9%	9.4%
Age-Adjusted Death Rate due to Diabetes deaths/100,000 population	≤ 20.6	20.7-26.6	≥ 26.7		12.7	31.4	21.9
Exercise, Nutrition, & Weight							
Adult Fruit and Vegetable Consumption	≥ 25.2%	25.1-23.3	≤ 23.2%		32.1%	30.1%	27.6%
Adults Engaging in Moderate Physical Activity	≥ 35.1%	35.0-31.2%	≤ 31.1%		33.9%	28.3%	34.1%
Adults who are Obese	≤ 27.5%	27.6-33.2%	≥ 33.3%		17.5%	33.8%	26.8%
Adults who are Overweight or Obese	≤ 67.7%	67.8-69.6%	≥ 69.7%		51.6%	67.9%	62.9%
Family Planning							
All-Age Birth Rate live births/1,000 females aged 15-44				63.5	69.7	66.2	63.5
Teen Birth Rate live births/1,000 females aged 15-44	≤ 31.1	31.2-36.3	≥ 36.4		20.3	35.4	31.2
Heart Disease & Stroke							
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	≤ 41.0	41.1-44.5	≥ 44.6		29.7		
Age-Adjusted Death Rate due to Heart Disease deaths/100,000 population	≤ 209.2	209.3-230.4	≥ 230.4		131.0	225.4	197.8
High Blood Pressure Prevalence	≤ 31.1	31.2-34.7	≥ 34.8		24.5	34.2	30.1
High Cholesterol Prevalence	≤ 38.6	38.7-40.6	≥ 40.7		38.7	34.7	37.4
Immunizations & Infectious Diseases							
Age-Adjusted Death Rate due to HIV				5.8	1.6	8.8	6.8
Age-Adjusted Death Rate due to Influenza and Pneumonia	≤ 17.9	18.0-18.3	≥ 18.4		17.8	15.5	17.7
Chlamydia Incidence Rate	≤ 266.5	266.6-372.7	≥ 372.8		198.2	626.0	416.7
Gonorrhea Incidence Rate	≤ 48.5	48.6-90.2	≥ 90.3		31.1	171.1	112.2
Influenza Vaccination Rate 65+	≥ 73.8	73.7-66.1	≤ 66.0		77.6	66.1	71.5
Pneumonia Vaccination Rate 65+	≥ 68.5	68.4-64.5	≤ 64.6		73.4	65.8	68.9
Syphilis Incidence Rate	≤ 1.4	1.5-2.5	≥ 2.6		2.1	8.5	5.5
Maternal, Fetal & Infant Health							
Babies with Low Birth Weight	≤ 7.7%	7.8-8.6%	≥ 8.7%		8.2%	11.2	10.0
Babies with Very Low Birth Weight	≤ 1.6%	1.7-1.9%	≥ 2.0%		1.4%	2.4	1.8
Infant Mortality Rate	≤ 5.5	5.6-7.3	≥ 7.4		5.5	8.7	7.2
Maryland Mothers who did Not Receive Prenatal Care or Only Received Care in the 3rd Trimester				4.6%	4.6%		
Mothers who Received Early Prenatal Care				80.2%	81.0%	65.6	80.1
Mental Health & Mental Disorders							
Age-Adjusted Death Rate due to Suicide death rate per 100,000 population				8.9	7.0		
Self-Reported Diagnosis of Anxiety	≤ 11.1	11.2-15.2	≥ 15.3		10.6	8.7	12.4
Self-Reported Diagnosis of Depression	≤ 16.0%	16.1-18.8%	≥ 18.9%		16.8%	12.1%	15.9%
Self-Reported Mental Health	≥ 78.0%	77.9-75.2%	≤ 75.1%		76.7%	80.0%	76.9%
Social and Emotional Support	≥ 80.9%	80.8-78.2%	≤ 78.1%		78.0%	77.5%	78.0%
Youth who had a Major Depressive Episode				7.5%	7.3%	7.50%	7.50%
Prevention & Safety							
Age-Adjusted Death Rate due to Unintentional Injuries death rate per 100,000	≤ 28.9	29.0-32.7	≥ 32.8		17.7		
Respiratory Diseases							
Adults with Asthma	≤ 12.5%	12.6-16.1%	≥ 16.2%		12.4%	13.8%	13.9%
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases deaths/100,000 population	≤ 41.6	41.7-46.7	≥ 46.8		21.2		
Substance Abuse							
Alcohol Use				54.7%	58.7%	47.3%	54.7%
Binge Alcohol Use				21.6%	20.9%	18.1%	21.7%
Cigarette Smoking				21.8%	15.5%	18.8%	21.8%
Illicit Drug Use							
Marijuana Use				4.9%	5.6%	4.5%	493.0%
Nonmedical Use of Pain Relievers				3.9%	3.4%	3.1%	3.9%
Wellness & Lifestyle							
Self-Reported General Health Assessment	≥ 86.3%	86.2-80.1%	≤ 80.0%		89.3%	89.7%	87.1%
Self-Reported Life Satisfaction	≥ 94.3%	94.2-93.0%	≤ 92.9%		94.6%	96.0%	94.1%
Self-Reported Physical Health	≥ 76.0%	75.9-72.9%	≤ 73.0%		76.2%	81.6%	76.7%

HOLY CROSS HOSPITAL

Attachment B; Other Data

CDC COUNTY HEALTH RANKING DATA GRID (c) 2010 Trinity Health Novi, Michigan. All Rights Reserved.					
Measures	**Montgomery County**	**Prince Georoge's County**	**Maryland**	**US Benchmark/ Target**	**Source**
HEALTH OUTCOMES					
MORTALITY					
Years of potential life lost/100,000 pop.	4,094	8,374	7,537	5,564	National Center for Health Statistics (NCHS)
MORBIDITY					
% Adults reporting fair or poor health	9%	12%	13%	10%	Behavior Risk Factor Serveillance System (BRFSS)
Avg. physically unhealthy days/month	2.7	3	3.2	2.6	BRFSS
Avg. mentally unhealthy days/month	2.6	3	3.3	2.3	BRFSS
% Live births with low birth weight <2500g	8.0%	10.5%	9.1%	6.0%	NCHS
HEALTH FACTORS					
HEALTH BEHAVIORS					
Tobacco: % Adults reporting currently smoking	10%	16%	18%	15%	BRFSS
Diet & Exercise: % Adults reporting obesity (BMI > 30)	19%	32%	27%	25%	National Center for Disease Prevention & Health Promotion (CDC)
Alcohol Use: %Adults reporting binge drinking	13%	10%	15%	8%	BRFSS
Motor-vehicle related mortality/100,000 pop.	7	17	13	12	NCHS
Hi-Risk Sexual Behavior: Births/1,000 teen females, ages 15-19	20	38	34	22	NCHS
New Chlamydia cases/100,000 pop.	207	638	439	83	NCHS
Access to Care: % Adults 18-64 without insurance	17%	22	17	13	Small Area Health Insurance Estimates
Quality of Care: discharges for ambulatory care sensitive conditons/1,000 Medicare en	44	62	70	52	Medicare/Dartmouth Institute
% Diabetic Medicare enrollees receiving HbA1c test	83%	76%	81%	89%	Medicare/Dartmouth Institute
% Chronically ill Medicare enrollees admitted to hospice in last 6 mos. of life	27%	23%	28%	35%	Medicare/Dartmouth Institute
SOCIOECONOMIC FACTORS					
Education: % high school students graduating in 4 yrs	85%	70%	80%	92%	National Center for Education Statistics
% Population age 25+ with 4-year college degree or higher	56%	30%	35%	34%	Census/American Community Survey (ACS)
Employment: % Population age 16+ unemployed & looking for work	5.3%	6.9%	7.0%	5.3%	Bureau of Labor Statistics
Income: % Children (<age 18) living in poverty	7%	8%	10%	11%	Small Area Income & Poverty Estimates
Gini coefficient of household income inequality (multiplied by 100)	44	38	44	38	Census/ACS
Family & Social Support: % Adults reporting not getting social/emotional support	19%	24%	21%	14%	BRFSS
% Households that are single-parent households	22%	40%	32%	20%	Census/ACS
PHYSICAL ENVIRONMENT					
Air Quality: # Days air quality was unhealthy due to fine particulate matter	0	4	4	0	Environmental Protection Agency (EPA)/CDC
# Days that air quality was unhealthy due to ozone	10	29	16	0	EPA/CDC
BUILT ENVIRONMENT					
% Zip Code in county with healthy food outlet	74%	91%	62%	92%	Zip Code Business Patterns
Liquor stores/10,000 pop.	12	18	20	n/a	County Business Patterns
Recreation Facilities/100,000 pop.	15	8	12	17	County Business Patterns

HOLY CROSS HOSPITAL

Top 60% ZIP Codes by Volume for Holy Cross Hospital in FY11

Market Area	ZIP Code and City	Total Cases
Core Market	20904 - Silver Spring	3,192
Core Market	20902 - Silver Spring	2,735
Core Market	20906 - Silver Spring	2,733
Core Market	20910 - Silver Spring	1,875
Core Market	20901 - Silver Spring	1,703
Core Market	20903 - Silver Spring	849
Core Market	20853 - Rockville	730
Core Market	20895 - Kensington	608
Montgomery Referral	20877 - Gaithersburg	680
Montgomery Referral	20874 - Germantown	646
Montgomery Referral	20878 - Gaithersburg	626
Montgomery Referral	20852 - Rockville	533
Montgomery Referral	20886 - Montgomery Village	530
Montgomery Referral	20850 - Rockville	508
Northern Prince George's	20783 - Hyattsville	844
Northern Prince George's	20705 - Beltsville	678
Northern Prince George's	20707 - Laurel	615
Northern Prince George's	20708 - Laurel	592
Northern Prince George's	20912 - Takoma Park	570
Northern Prince George's	20706 - Lanham	516
Prince George's Referral	20774 - Upper Marlboro	597
All Market Areas	Total of Top 60% ZIP Codes	22,360

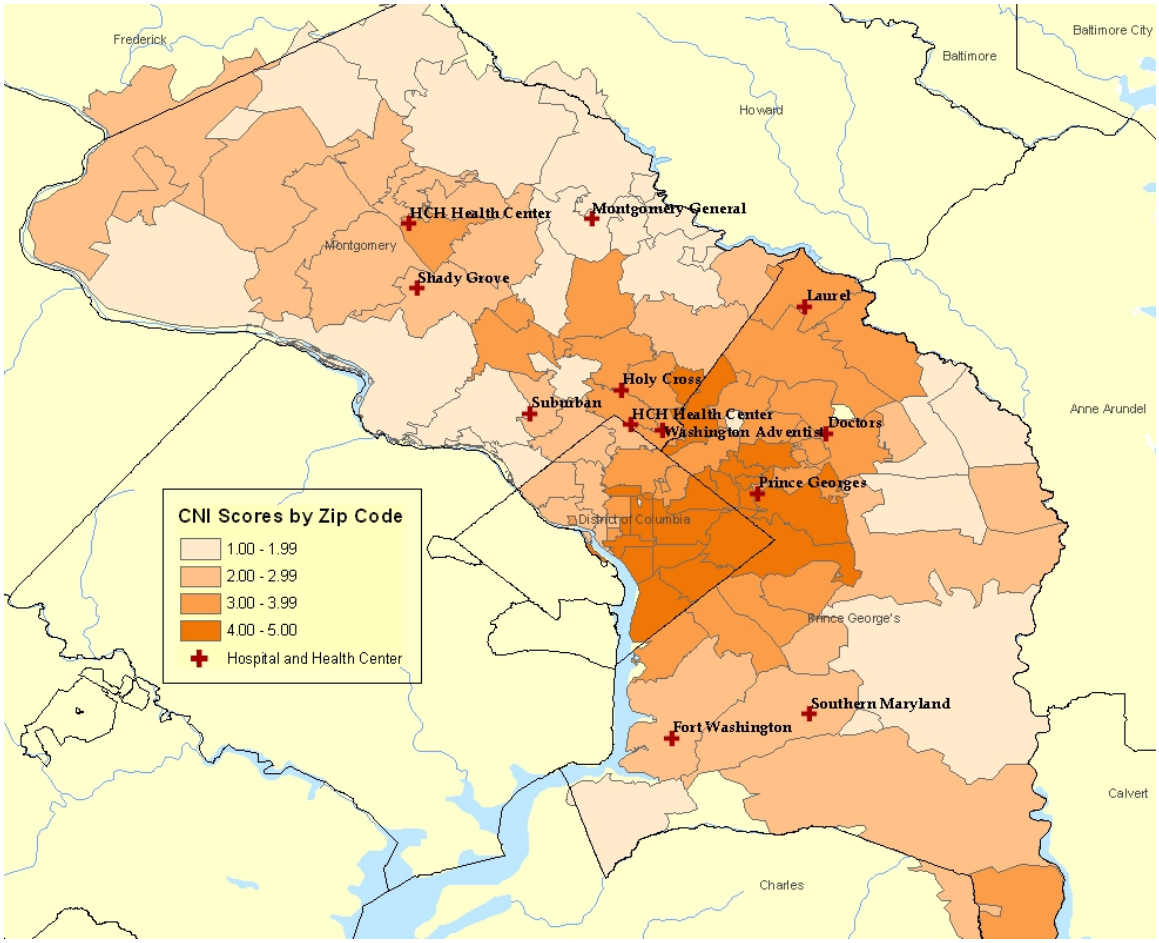
Attachment C

The Healthy Montgomery Steering Committee, Chaired by Councilmember George Leventhal
May 2011

	Last Name	First Name	Title	Organization	Healthy Montgomery Affiliation
1	Ahluwalia	Uma	Director	Montgomery County Department of Health and Human Services	Montgomery County DHHS
2	Blackburn	Frankie	Senior Advisor	IMPACT Silver Spring	Impact Silver Spring
3	Duell	Tammy	Director, Medical Adult Day Care Program	Holy Cross Hospital	Commission on Aging
4	Friedman	Sharon	Executive Director	Mental Health Association of Montgomery County	Mental Health Association of Montgomery County
5	Garvey	Carol	Principal	Garvey Associates	Montgomery County Collaboration Council for Children, Youth and Families
6	Harr	Thomas	Executive Director	Family Services, Inc.	Family Services, Inc.
7	Harris-Muller	Carrie	Chief Administrative Officer	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Kaiser Permanente
8	Knight-Major	Lorrie	Member	Commission on Veterans Affairs	Commission on Veterans Affairs
9	Korper	Sam	Senior Advisor, Aging Studies	Westat	Commission on Health* **Ron Bialek, PHF, will be rep COH starting in June 2011*
10	Leventhal	George	Councilmember	Montgomery County Council	HHS Committee, Montgomery County Council
11	Miers	John G.	Member	Commission on People with Disabilities	Commission on People with Disabilities
12	Pajka	Roseanne	Senior Vice President, Corporate Development	Holy Cross Hospital	Holy Cross Hospital
13	Palacios	Cesar	Executive Director	Proyecto Salud Health Center	Latino Health Initiative
14	Sanfuentes	Monique	Director, Community Health and Wellness	Suburban Hospital	Suburban Hospital
15	Stoto	Michael	Professor of Health Systems Administration and Population Health	Georgetown University School of Nursing and Health Studies	Academia
16	Warner	Tim	Community Liaison to the African American and Faith Communities	Office of Community Partnerships, Montgomery County	Office of Community Partnerships
17	Widerlite	Paula	Vice President, System Strategy and Chief Development Officer	Adventist HealthCare System	Adventist HealthCare System
18	Young	Celia	Chair	Mental Health Advisory Committee	Mental Health Advisory Committee
19	Young	Susan	Chair, Health Committee	Montgomery County Council of Parent-Teacher Association	Montgomery County Council of Parent-Teacher Associations
20	Zalewski	Sharon	Vice President	Primary Care Coalition of Montgomery County	Primary Care Coalition of Montgomery County
21	Miller	Beatrice	Clinical Director	NurseFinders, Inc.	African American Health Program
22	Zorich	Pamela	Demographer	Montgomery County Regional Office, Research and Technology Center	Montgomery County Planning Department
23	Yeager	Nikki	Director of Marketing, Planning and Business Development	Montgomery General Hospital	Montgomery General Hospital
24	Lee	Sunmin	Assitant Professor	School of Public Health, University of Maryland	Asian American Health Initiative
25	Shubert	Tina	Recreation Specialist	Montgomery County Department of Recreation	Montgomery Recreation Department
26	*VACANT*				Homeless Issues

Attachment D

2009 Community Needs Index
Montgomery and Prince George's County
(5=highest need (darkest areas); 1=lowest need (lightest areas))



Source: Thomson Reuters

Montgomery County Community Need Index by ZIP Code

ZIP Code	CNI Score	Population	City
20816	1.6	15354	Bethesda
20818	1.6	1743	Cabin John
20812	1.6	230	Glen Echo
20912	3.8	25018	Takoma Park
20815	2.4	28969	Chevy Chase Section Five
20910	3.4	37009	Silver Spring
20817	1.8	34103	Potomac
20814	2.6	26244	Bethesda
20903	4.2	19443	Silver Spring
20895	1.8	18803	Kensington
20902	3.6	45359	Wheaton-Glenmont
20901	3.2	34833	Silver Spring
20852	3.2	38239	North Bethesda
20854	1.6	52752	Travilah
20904	2.8	54336	Colesville
20851	3.4	14788	Rockville
20850	2.8	42290	Rockville
20853	1.8	27665	Aspen Hill
20906	3.4	62255	Aspen Hill
20866	2.4	12630	Burtonsville
20868	1.6	546	Burtonsville
20878	2.4	61730	Gaithersburg
20837	1.6	6246	Montgomery County
20877	3.6	34011	Gaithersburg
20905	1.8	18223	Fairland
20860	1.8	1863	Ashton-Sandy Spring
20839	2.8	444	Montgomery County
20861	1.8	1841	Ashton-Sandy Spring
20832	1.6	25645	Olney
20855	2	16563	Redland
20862	1.6	491	Montgomery County
20886	2.6	30578	Montgomery Village
20879	2.4	25632	Gaithersburg
20874	2.4	57294	Germantown
20841	2	4949	Montgomery County
20838	1.8	226	Barnesville
20876	2.4	23754	Clarksburg
20833	1.6	8167	Montgomery County
20882	1.6	15048	Damascus
20871	1.6	6847	Montgomery County
20842	2	2025	Montgomery County
20872	1.8	12422	Damascus

Prince George's County Community Need Index by ZIP Code

ZIP Code	CNI Score	Population	City
20608	3.4	785	Eagle Harbor
20607	1.8	8444	Accokeek
20613	2.6	10437	Brandywine
20623	1.8	2982	Prince George's County
20744	2	50201	Friendly
20735	2	35654	Clinton
20762	2.6	6642	Andrews AFB
20745	3.8	27152	Forest Heights
20772	1.8	41127	Greater Upper Marlboro
20748	3.2	37809	Marlow Heights
20746	3.6	28813	Suitland-Silver Hill
20747	3.8	39102	District Heights
20743	4	40226	Prince George's County
20785	4	39790	Prince George's County
20774	2	40914	Greater Upper Marlboro
20712	4.2	9049	Mount Rainier
20721	1.8	26841	Woodmore
20722	4.2	5148	Colmar Manor
20781	4	10370	Prince George's County
20710	4.4	7756	Bladensburg
20716	2.4	20511	Prince George's County
20782	3.8	27902	Chillum
20784	3.8	26823	Prince George's County
20737	4.2	19788	Riverdale Park
20706	3.2	36214	Glenarden
20769	2	5567	Glenn Dale
20740	3.6	33680	College Park
20783	4.2	42838	Adelphi
20770	3.2	23292	Greenbelt
20720	1.8	19058	Bowie
20715	1.6	23411	Bowie
20705	3.2	22604	Beltsville
20708	3.2	25319	Prince George's County
20707	3	26522	Prince George's County

Attachment E

FY2011 External Review Committee
June 13, 2011

Participants:

- Uma S. Ahluwalia, Director, Montgomery County Department of Health and Human Services
- Ronald Bialek, President and CEO, Public Health Foundation; Member, Montgomery County Commission on Health
- Becky Boeckman, Director, Pastoral Care, First United Methodist Church
- Steven Galen, President and CEO, Primary Care Coalition
- Rose Marie Martinez, Sc.D., Director, Institute of Medicine; Member, Montgomery County Commission on Health
- Cesar Palacios, Executive Director, Proyecto Salud
- Angela M. Pickwick, Dean of Health Sciences, Montgomery College, Takoma Park Campus
- Douglas Propheter, CEO, Workforce Solutions Group of Montgomery County and Montgomery Works
- Wayne L. Swann, Swann Enterprises; Member, Montgomery County Commission on Health
- Richard Takamoto, Executive Director, Research Administration, Kaiser Permanente; Member, Montgomery County Commission on Health
- Ulder J. Tillman, M.D., Montgomery County Health Officer and Chief of Public Health Services

Key Highlights from Meeting:

- Develop and/or nurture partnerships to leverage resources and work toward mutual goals; articulate range of partnerships in community benefit plan
- Continue to evolve health care to broader definition of health; integrate logic models in programs, incorporate the population/public heath side with the clinical side of the hospital, consider Triple Aim (patient experience, cost, public health)
- Incorporate findings from Montgomery County's Community Health Needs Assessment
- Address program sustainability
- Use students as interns in planning, implementing and evaluating programs
- Think beyond the clinical aspect of workforce development; look into other areas such as accounting, laundry, engineering, dietary, etc.
- Engage medical staff

Attachment F

Identified Community Health Needs	
Access to Care	• Lack of health insurance • Lack of Primary Care Physician/Medical Home • Inability to afford to see a doctor
Disease	
- *Cancer*	• Second leading cause of death • High breast cancer incidence and death rates • High Prostate cancer death rates among African American/Black men
- *Heart Disease and Stroke*	• First and third leading cause of death, respectively • Increasing cholesterol rates
- *Diabetes*	• Fourth leading cause of death in Prince George's • Seventh leading cause of death in Montgomery • Increases risk of heart disease
- *Obesity*	• More than half of Montgomery and Prince George's county residents are overweight or obese
Population-Based Health	
- *Minorities*	• Disproportionate burden of disease, including cancer, heart disease, stroke, diabetes, and obesity
- *Seniors*	• Disproportionately affected by chronic disease • Influenza/Pneumonia vaccination
- *Women and Children*	• High infant mortality rate of African Americans/Blacks • High low-birth weight and very low-birth weight rates • Percent of no prenatal care or late prenatal care disproportionate among minorities

Attachment G

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

Community	Holy Cross Hospital			
Healthy Montgomery Needs Assessment Topic Area and Key Finding	**Mission**	**Strategic Priority**	**Response to Community Need**	**Method of Evaluation**
Access to Health Services 1/10 residents, 1/3 Latino residents, have no health insurance	Access for underserved, vulnerable		Community Care Delivery: Operate two health centers for uninsured adults and build and equip third center in Aspen Hill during 2012	Number of visits compared to budget; diabetes and heart failure indicators toward best practice
Cancer Leading cause of death; 50% more African American/Black women die from breast cancer than White women	Outreach that improves health status and access for underserved, vulnerable	Cancer; Women and children	Minority and Community Outreach Program: Mammogram Assistance Program: breast education; self examination; screening; mammograms; navigation; biopsy; ultrasound; surgery	# of mammograms; # of breast cancers found; decrease in breast cancer incidence (or increase due to increased screening) and mortality rates
Diabetes Leading cause of death for African American/Black women; disparities	Outreach that improves health status and access for underserved, vulnerable		Health centers in Silver Spring and Gaithersburg; Diabetes Prevention Program; Chronic disease self management program	# of visits; progress on 10 diabetes indicators; # pre-diabetics advancing to diabetics; reduction in hospital admissions and readmissions
Heart Disease and Stroke Leading cause of death; Half of seniors have high cholesterol levels	Outreach that improves health status and access for underserved, vulnerable	Seniors	Community Fitness Program: Senior Fit; Health centers in Silver Spring and Gaithersburg	Semi-annual fitness assessments; progress on 10 heart failure indicators
Exercise, Nutrition and Weight 50%+ in county are overweight or obese	Outreach that improves health status and access for underserved, vulnerable		Community Fitness Program: Kids Fit	Semi-annual fitness assessments
Maternal, Fetal and Infant Health Opportunities to improve maternity care processes and outcomes within subpopulations	Access for underserved, vulnerable	Women and children	Ob/gyn clinic; Maternity Partnership program; perinatal community education classes; home care follow up for babies discharged from neonatal intensive care unit	# of admissions to Maternity Partnership; % low birth weight; reduction in infant mortality

HOLY CROSS HOSPITAL

Holy Cross Hospital's Community Benefit Plan
Approved by the Holy Cross Hospital Board of Trustees on October 27, 2011

I. Community Benefit Implementation Strategy
A. Multi-Year Community Benefit "Strategic Action" Plan

Overall Goal and Approach to Community Benefit

The overarching goal of Holy Cross Hospital's community benefit ministry is to respond to identified community health needs, increase access and improve health status, especially for the most vulnerable and underserved individuals and families in our community, and to be a leader and serve as an example to others in community service.

Holy Cross Hospital's overall approach to community benefit is to target the intersection of documented unmet community health needs and our organization's key strengths and mission commitments. We take prudent risks in developing innovative ideas and implementing responsive programs. We emphasize prenatal and primary health care services, targeted health screening and promotion, and chronic disease prevention and management, especially for vulnerable and underserved women, seniors, and racial, ethnic and linguistic minorities. We are evolving to link our community-based services more explicitly with our clinical services to help build the continuum of care.

We fully integrate our commitment to community service into our management and governance structures as well as our strategic and operational plans, and we are rigorous in monitoring and evaluating our progress. We seek and nurture relationships with a broad range of collaborative partners to build community and organizational capacity. We strive to sustain an effective community benefit ministry.

Commitment

Holy Cross Hospital's community benefit ministry is rooted in our identity as a Catholic health care provider. Our commitment is evidenced by:

- Written statements (e.g., Purposes for which Holy Cross Hospital is organized as stated in Articles of Restatement and Amendment, mission and role statement; community benefit plan; annual operating targets for community benefit)
- Organizational structures (e.g., the community benefit ministry officer and vice president mission services are senior executives with direct reports to the CEO; the CEO Review Committee on Community Benefit is interdivisional)
- Policies (e.g., financial assistance policy; comprehensive coverage by hospital and hospital-based physicians; billing and collection policy)
- Allocation of institutional resources (e.g., $39.5 million in fiscal 2011 using state and federal mandated reporting guidelines).

We have established and improved explicit financial assistance and billing and collection policies and procedures, and we encourage physician and employee participation in providing services to address the needs of poor and underserved individuals and families.

Key elements of our financial assistance policy are active communication, comprehensive coverage of services provided by the hospital and hospital-based physicians, and a six-month period of eligibility. We work to assess eligibility for public programs and provide enrollment support.

We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community benefit activities, which are integrated into our multi-year strategic and annual operating planning processes.

Three strategic community benefit themes, which emerged from the fiscal 2011-2014 strategic planning process, frame selected annual initiatives. They are: 1) Play a lead role in building a better system of care for those without insurance and with limited access to health care; 2) Target at risk populations for special outreach and care coordination, and 3) Demonstrate value of community-based programs, processes and outcomes and maintain our leadership position in community benefit.

As a faith-based, tax-exempt organization, we embrace our responsibility to reinvest our earnings in our programs and facility to serve the community and to provide community benefit. We enthusiastically support more transparency in public reporting.

The Congregation of the Sisters of the Holy Cross founded the hospital in 1963 in cooperation with a community group and local physicians. Responding to community need was a central theme at that time and it remains so today. In addition, the spirit of partnership and inclusion that led to the hospital's creation remains a commitment today that is embedded in our mission and operations.

Description of the Community We Serve

Holy Cross drew 69 percent of its patients (inpatients and outpatients) from Montgomery County in fiscal 2010, and therefore, we focus most heavily on meeting the needs in this community.

Montgomery County is Maryland's most populous jurisdiction with more than 900,000 residents. Although it is one of the nation's most affluent counties in terms of income and education, 110,000 adults are uninsured.

The community we serve is one of the most culturally and ethnically diverse in the nation, having experienced during the last two decades a demographic shift and a pace of change that comes with being a "gateway suburb" for the largest influx of immigrants to the United States in more than 100 years. Montgomery County is one of only 336 "majority-minority" counties in the country. It has the largest number of non-citizen residents (64,000) with no health insurance among all the jurisdictions in Maryland (38 percent of the State's 170,000 non-citizen residents with no health insurance).

Thirty percent of Montgomery County's population is foreign-born. Immigrants from all over the world bring a great vitality to our community; at the same time, they challenge

the hospital and other local community service providers to understand and meet their varied needs.

Fluency in English is very important when navigating the health care system as well as finding employment. In our community, the highest rates of linguistic isolation are among Latino Americans and Asian Americans. Forty-two percent of those who are foreign-born speak English less than "very well."

Due to the large number of federal agencies and contractors, the area generally enjoys low unemployment. Relatively greater rates of unemployment are experienced among the African American and Latino American populations.

Montgomery County is also rapidly aging. We face similar dramatic demographic change with the coming unprecedented aging of our county. The population age 65 and older will grow 4.1 percent per year over the next 10 years, eight times faster than the population under age 65 (.5 percent). As a result, the percent of the population age 65 and older will increase from 13 percent to 18 percent.

Holy Cross Hospital also serves a portion of Prince George's County, with nearly 20 percent of patients residing there. We will continue to conduct data analysis and pursue collaborative relationships to help us understand the community better.

Identification of Unmet Community Health Needs: Data Collection and Community Health Needs Assessment

Holy Cross Hospital identifies unmet community health care needs in our community in a variety of ways. We use a range of available written needs assessments and reports to identify unmet health care needs. Beginning in 2009, we have participated in the ongoing countywide Healthy Montgomery: Community Health Improvement Process, which is described below and in our separate Community Health Needs Assessment document.

External review – community feedback. Beginning in 2005 for fiscal 2006, we have invited input and obtained advice on an annual basis from a group of 5-11 external participants, including the public health officer as well as the director of Montgomery County Department of Health and Human Services, and a variety of individuals from other local and state governmental agencies and commissions, community-based organizations, foundations, churches, colleges, coalitions, and associations. These participants are experts in a range of areas including public health, minority populations, disparities in care, social determinants of health, health and social services.

Each year, this external group reviews our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority needs and the direction to take for the following year. We periodically invite the group's insight into our strategic planning process, as we did in fiscal 2010 for the fiscal 2011-2014 strategic planning period. The group's input helps to ensure that we have identified and respond to the most pressing community health care needs. Fiscal 2012 is the seventh consecutive year we have invited and received such input. (See appendix for history of

our utilization of community feedback, including public health experts, in crafting and modifying our community benefit plans.)

Federal law now requires that a hospital's community needs assessment "takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and is made widely available to the public." Additionally, the law requires hospitals to conduct a community health needs assessment once every three years and to adopt an implementation strategy to meet the community health needs identified through such assessments. We believe we have already met the requirements of the law with respect to community benefit when they are required of us in fiscal 2013.

Participation. We participate in our local health department's periodic planning processes, including strategic planning (the County's last strategic plan was 2006-2011) and the Healthy Montgomery: Community Health Improvement Process (2009-present). The hospital is a participant and financial supporter of Healthy Montgomery, a multi-year, county-wide process consisting of information gathering, needs assessment, priority setting, and monitoring and evaluation.

Healthy Montgomery was launched in June 2009 with funding from Holy Cross Hospital and each of the other three hospital systems (each $25,000; total $100,000) to support initial work including coordination of the environmental scan, which looked at all the existing sources of data, needs assessments and improvement plans from organizations in the County. Holy Cross Hospital relied on many of these assessments during the past decade since our first community benefit plan was approved by the hospital's board of trustees in 2001. In addition, the funding supported the county-wide effort to select 100 indicators to be included in the Healthy Montgomery website, preparation of indicators and maps that show the social determinants of health for the county as a whole and for Public Use Microdata areas (PUMAs) that will be included in the County's Needs Assessment document.

In fiscal 2011, Healthy Montgomery was supported by Holy Cross Hospital and the other four hospitals in the county (each $25,000; total $125,000) to support the Steering Committee meetings, preparation and presentation of all of the community conversations, preparation of the Needs Assessment Report (quantitative data and information from the community conversations), support of the Steering Committee in determining selection criteria that will be used to choose the priorities for community health improvement, and support for the priority selection process.

On an ongoing basis, we participate in a variety of coalitions, commissions, committees, partnerships and panels.

Our ethnic health promoters and community outreach workers spend time in the community as community participants and bring back first-hand knowledge of community needs.

Data analysis. As available, we use a range of specific needs assessments and reports to identify unmet needs, especially for ethnic, racial, and linguistic minorities, seniors, and women and children. Our past work over the years since 2001 has been built on available needs assessments, and we use these documents as reference tools, including the following key resources that became available more recently:

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014;
- Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012;
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008.

During 2011, the quantitative and qualitative results of the county-wide Healthy Montgomery: Community Health Improvement Process became available. As a result, we have added a new document, our Community Health Needs Assessment, to our community benefit materials that includes a vast amount of information.

In addition, we review our own internal patient data and review purchased and publicly available data and analyses on the market, demographics and health service utilization.

We use the "Community Needs Index" methodology to identify communities of high need and direct a range of community health and faith community outreach efforts to these areas. For each ZIP code in the United States, the Community Needs Index aggregates five socioeconomic indicators/barriers to health care access that are known to contribute to health disparity related to income, education, culture, insurance and housing. For example, we used the Community Needs Index to help us locate our second health center in Gaithersburg and our soon-to-be-built health center in Aspen Hill. They are located in the third and six most needy ZIP codes in Montgomery County.

Identification of Unmet Community Health Needs: Findings and Priority Setting Process

Community Health Needs Assessment. The complete set of findings of the Healthy Montgomery Community Health Improvement Process can be found in the County's written reports, which were released in draft form in September 2011. A subset of the findings are described separately in Holy Cross Hospital's Community Health Needs Assessment document. As the priorities emerge from the Healthy Montgomery process, we will incorporate them into our plans. We expect the county-wide priorities to be chosen in November 2011, with action planning targeted for completion by April 2012.

The field of community health now places more emphasis on the contribution of social forces to individual health, with a movement away from conceptualizing health in terms of the absence of specific diseases in favor of a wellness approach. There is growing awareness of the critical role that can be played by linguistic sensitivity and cultural competence in reducing disparities in health care. This broader perspective of social complexity informs county priorities.

External Review. The external review held in June 2011 at Holy Cross Hospital had a fiscal 2012 focus, and participants advised us on several areas of focus, which are

detailed in a separate appendix document. (See History of Utilizing Community Feedback.) We will follow up on these suggestions during the next year, including:

- Develop and/or nurture partnerships to leverage resources and work toward mutual goals
- Continue to evolve health care to a broader definition of health
- Incorporate findings from Montgomery County's Community Health Needs Assessment
- Address program sustainability
- Use student interns
- Think beyond the clinical aspect of workforce development
- Engage the medical staff.

Other written needs assessments to identify needs of racial and ethnic populations. High level identified needs show some similar and different needs.

African American. The African American Health Program of the Department of Health and Human Services identified key health disparities in its Strategic Plan 2009-2014: infant mortality, diabetes, HIV/AIDS and cancer. The County has also identified hypertension, arthritis, asthma, allergies, and depression as health conditions/problems for African Americans, along with the effects of smoking.

African and Caribbean Immigrants. Key health conditions/problems identified in this population are hypertension, allergies, malaria, arthritis and diabetes.

Latino Americans. Health conditions/problems identified by the County for Latinos are: asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, liver disease, tuberculosis, diabetes, depression, anxiety, and post-traumatic stress disorder (family isolation, war in country of origin), and acculturation linked to poorer health.

Asian-Americans. The Asian American Health Initiative identified the top three health concerns as cardiovascular disease related conditions, diabetes, and mental health. Weight concerns, cancer, arthritis, smoking, osteoporosis and hepatitis B followed next.

Response to Unmet Community Health Needs

Demographic and socioeconomic analysis reveals particular areas that have a large number of people who are poor, of child-bearing age, elderly, racially and ethnically diverse, and of limited English speaking ability. We focus our community benefit activities on the most vulnerable and underserved individuals and families, including women/children, seniors and racial, ethnic and linguistic minorities.

To select outreach priorities, Holy Cross links community healthcare needs to our mission and strategic priorities. We developed a set of principles to help determine our highest priorities and guide our decision-making about community benefit:

- Be the Montgomery County leader and a state/national model
- Take prudent risks and ensure sound financial stewardship and sustainability

- Be focused on the primary service area (which includes areas close to the hospital in Montgomery and Prince George's Counties)
- Meet Holy Cross Hospital's strategic focus and identified community need
  - Women/children (particularly infant mortality and obesity)
  - Seniors (particularly cardiovascular disease, diabetes, and obesity)
  - Cancer (particularly breast cancer)
- Meet Holy Cross Hospital's overall commitment to access to care and identified community need
  - Access, especially for vulnerable and underserved populations (racial and ethnic population subgroups; uninsured residents; primary care access, especially for chronic conditions including diabetes and heart failure)
  - Outreach to targeted populations (especially for cancer prevention in African American, African/Caribbean American, Latino American, Asian American, Native American populations)
  - Demonstrated improvements in health status (reduction in infant mortality; reduction in percentage of children and adults with obesity; reduction in rate of breast cancer deaths; reduction in preventable hospital admissions for chronic disease)
  - Ongoing learning and sharing of new knowledge (public education)
- Have measurable outcomes and be integrated with planning and budgeting
- Reflect partnership.

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

Community	**Holy Cross Hospital**			
Healthy Montgomery Needs Assessment Topic Area and Key Finding	**Mission**	**Strategic Priority**	**Response to Community Need**	**Method of Evaluation**
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Cancer Leading cause of death; 50% more African American/Black women die from breast cancer than White women	Outreach that improves health status and access for underserved, vulnerable	Cancer; Women and children	Minority and Community Outreach Program: Mammogram Assistance Program: breast education; self examination; screening; mammograms; navigation; biopsy; ultrasound; surgery	# of mammograms; # of breast cancers found; decrease in breast cancer incidence (or increase due to increased screening) and mortality rates

Community (cont.)	Holy Cross Hospital (cont.)			
Healthy Montgomery Needs Assessment Topic Area and Key Finding	**Mission**	**Strategic Priority**	**Response to Community Need**	**Method of Evaluation**
Diabetes Leading cause of death for African American/Black women; disparities	Outreach that improves health status and access for underserved, vulnerable		Health centers in Silver Spring and Gaithersburg; Diabetes Prevention Program; Chronic disease self management program	# of visits; progress on 10 diabetes indicators; # pre-diabetics advancing to diabetics; reduction in hospital admissions and readmissions
Heart Disease and Stroke Leading cause of death; Half of seniors have high cholesterol levels	Outreach that improves health status and access for underserved, vulnerable	Seniors	Community Fitness Program: Senior Fit; Health centers in Silver Spring and Gaithersburg	Semi-annual fitness assessments; progress on 10 heart failure indicators
Exercise, Nutrition and Weight 50%+ in county are overweight or obese	Outreach that improves health status and access for underserved, vulnerable		Community Fitness Program: Kids Fit	Semi-annual fitness assessments
Maternal, Fetal and Infant Health Opportunities to improve maternity care processes and outcomes within subpopulations	Access for underserved, vulnerable	Women and children	Ob/gyn clinic; Maternity Partnership program; perinatal community education classes; home care follow up for babies discharged from neonatal intensive care unit	# of admissions to Maternity Partnership; % low birth weight; reduction in infant mortality

Other Unmet Community Health Needs

Eight other topic areas were identified by the Community Health Needs Assessment process for data collection, review and priority setting: family planning, immunizations & infectious diseases, mental health & mental disorders, prevention & safety, respiratory diseases, substance abuse, illicit drug use, and wellness & lifestyle.

While we will focus the majority of our efforts on the identified needs outlined in the table above that are obvious for Holy Cross Hospital to address, we will review the complete set of priorities defined by the county-wide Community Health Needs

Assessment process as they emerge to determine our response and make any adjustments in our plans. In addition, we will seek the advice of our external review group as we determine our fiscal 2013 plans.

Monitoring and Evaluation
Holy Cross has developed specific methods for monitoring and evaluating progress toward community benefit objectives.

The hospital's annual operating plan has specific organizational targets for key elements of community benefit. The annual hospital budgeting process also includes designated operating expenditures for several departments dedicated to community benefit: community health, faith community nursing, perinatal education, obstetrics/gynecology clinic, the health centers in Silver Spring and Gaithersburg, senior source, and medical adult day care.

The department of community health leads the development of the community benefit plan, including the development and analysis of the community health needs assessment. The interdepartmental CEO Review Committee on Community Benefit provides guidance and expectations, including the annual implementation work plan, and monitors progress toward goals and targets on a quarterly basis. The senior management team also reviews progress quarterly as part of the operating plan review.

The Mission and Strategy Committee of the Board of Trustees provides governance oversight for the strategic plan, the master facility plan, the human resources plan, and the community benefit plan. The full board of trustees annually approves the community benefit plan including the annual implementation work plan.

A set of overall community benefit performance indicators selected by the Mission and Strategy Committee are shared with the full board on a quarterly basis including financial assistance; number of new admissions to Maternity Partnership Program; number of high risk deliveries in Maternity Partnership program; number of visits to the health centers; two sets of specific chronic disease clinical process and outcomes indicators for diabetes and heart failure for health center patients. We will review this information and refine going forward as determined by the Mission and Strategy Committee.

Many of our community health programs are evidence-based and include outcome measurement and evaluation. For example:

- *Health Living and Disease Prevention*
  - *Senior Fit.* Semi-annual fitness assessments of key indicators are measured using four tests: lower body strength through the "chair stand;" speed and agility through the "8-Foot Up and Go" test; upper body strength through arm curls, and upper body flexibility through the "back scratch."
  - *Kids Fit.* Semi-annual fitness assessments of key indicators are measured using the President's Challenge tool: upper body strength through "right angle

push ups; abdominal strength through curl ups; speed and agility through shuttle run, and lower back/hamstring flexibility through sit and reach

- *Chronic Disease*
  - *Stanford University's Chronic Disease Self-Management Program.* Seven indicators are collected and reviewed at the completion of each workshop: identifying strategies for living with a chronic condition; managing symptoms; establishing supportive relationships; creating an action plan; coping with fatigue, pain and frustration; and the motivation related to exercising and making healthy food choices.
  - *Diabetes Prevention Program.* Data is collected on gender, age and race and assessments are made based on key indicators including weight gain/loss, number of minutes exercised per week, and lab results (HbA1c, fasting glucose levels, cholesterol, LDL levels, HDL levels, and triglyceride levels).
  - *Diabetes and heart failure in health center patients*. Data is collected on 10 diabetes indicators and 11 heart failure indicators and compared across Trinity Health clinics.

Periodically, the hospital reviews community benefit programming. We recently reviewed programs against an "evaluation matrix" with relevant criteria to help with decisions to expand, maintain or harvest the programming, including tie to overall organizational community benefit goal and local community needs assessment priority; cost of program; number of individuals served; impact measures. The matrix helps us determine the success and continuation of the program. We intend to juxtapose this information with the county's emerging identified priorities.

With respect to making our community benefit plan available to the public, we have distributed our community benefit plan widely for many years and provided past copies to the Catholic Health Association for posting on its website. We also widely distribute our annual community benefit report, including posting on our website. We provided a detailed narrative response to the supplemental questions on our Form 990 Schedule H submission to the Internal Revenue Service and as part of our submission to the Health Services Cost Review Commission in Maryland, which is posted on the State of Maryland's website. We will post our community health needs assessment and our implementation plan on www.holycrosshealth.org