Suburban Hospital
Fiscal Year 2017
Community Benefit Report

JOHNS HOPKINS
MEDICINE

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Johns Hopkins Health System

Fiscal Year 2017 Community Benefit Report Narrative

Suburban Hospital

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I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

HOSPITAL INFORMATION:

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The Hospital provides all major services except obstetrics. One of nine regional trauma centers in Maryland, the Hospital is the state-designated level II trauma center for Montgomery County with a fully equipped, elevated helipad. Every year, more than 40,000 patients are treated at Suburban Hospital's busy Emergency/Shock Trauma Center.

The Hospital's major services include a comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; Cardiac Surgery Program, providing cardiac surgery, elective and emergency angioplasty as well as inpatient diagnostic and rehabilitation services; orthopedics with joint replacement and physical rehabilitation; behavioral health; neurosciences including a designation as a Primary Stroke Center and a 24/7 stroke team; and senior care programs. In addition, Suburban Hospital provides services including the NIH-Suburban MRI Center; state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; and a free physician referral service (Suburban On-Call). Suburban Hospital is one of two hospitals in Montgomery County to achieve the Gold Seal of Approval™ by The Joint Commission for its joint replacement program.

1. Primary Service Area.

The PSA is defined as the Maryland postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period (FY17) where the discharges from each zip code are ordered from largest to smallest number of discharges. This information was provided by the Health Services Cost Review Commission (HSCRC).

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients by county:	Percentage of Hospital's Patients who are Medicaid Recipients:	Percentage of Hospital's Patients who are Medicare beneficiaries:
222	13,794	20814, 20815, 20817, 20850, 20852, 20853, 20854, 20878, 20895,	Suburban Hospital, (20814) Adventist Rehabilitation Hospital of MD, (20850)	Montgomery County 74.0%; Prince George's 8.3%; Anne Arundel 0.6%; Howard County 0.6%; Frederick County 10%;	7.46% of Hospital's Patients are Medicaid Recipients; based on total inpatient/out	47.63% of Hospital's Patients are Medicare beneficiaries; based on total inpatient/out patient

		20902, 20904, 20906, 20910	Shady Grove Adventist Hospital, (20850) Holy Cross Hospital, (20910)	Baltimore City 0.5%; Baltimore County 0.5%; Other Maryland Counties 1.0%; Washington D.C. 4.1%; Fairfax County, VA 1.9%, All Other Virginia Counties 2.2%; Other Out of State Counties 4.7%[1]	patient discharges in FY17[2]	discharges in FY17[3]

2. Community Benefit Service Area.

 a. Description of Community Benefit Service Area.

Suburban Hospital considers its Community Benefit Service Area (CBSA) as specific populations or communities of need to which the Hospital allocates resources through its community benefits plan and does not limit its community services to the primary service area. To determine the Hospital's CBSA, data from Inpatient Records, Emergency Department (ED) Visits, and Community Health Improvement Initiatives and Wellness Activities were aggregated and defined by the geographic area contained within the following fifteen zip codes: 20814, 20815, 20817, 20850, 20851, 20852, 20853, 20854, 20874, 20877, 20878, 20895, 20902, 20906, and 20910. Zip codes (20877-Gaithersburg and 20874-Germantown) were identified and included in the Hospital's CBSA due to an increase in patient and charity care cases and community health and wellness activities.

Within the CBSA, Suburban Hospital focuses on certain target populations such as uninsured individuals and households, underinsured and low-income individuals and households, ethnically diverse populations, underserved seniors and at-risk youth. Although some of the zip codes selected for Suburban Hospital's CBSA are not immediately adjacent to Suburban Hospital, the Hospital does treat 38.4 % of patients from the Silver Spring, Gaithersburg and Germantown areas (20902, 20906, 20910, 20878 and 20874) which is a 1.7% increase from Fiscal year 2016's percentages of 35.3%. Furthermore, Suburban Hospital substantially supports safety net clinics and free health prevention and chronic disease programs in those designated areas.

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[1] Suburban Hospital discharge data

[2] Suburban Hospital discharge data

[3] Suburban Hospital discharge data

In addition to the Primary and Community Benefit Service areas, the Hospital provides both in-kind and financial contributions to expand awareness of cardiovascular diseases and chronic disease management to neighboring counties including Prince George's, Calvert, and St. Mary's, which represent more racially and ethnically diverse and rural communities than the primary service area. In Prince George's county, specifically, 289 community health improvement activities, reaching 4,439 community members living in zip codes 20706, 20722, 20740, 20747, 20782, 20783 during FY17.

- **Geographic boundary** (city, zip codes, or county)

    - Charity care/bad debt: Of all hospital visits at Suburban, approximately $3,137,583; supported services in charity care and $5,774,331 was allocated to bad debt during FY17. Within the CBSA zip codes, 1,691 patients' accounts had charity adjustments of $1,604,808.

    - ED patient origin: The CBSA area accounted for 32,855 visits to Suburban Hospital, representing 69% of all FY17 ED visits.

    - Medically underserved: Suburban Hospital provides both financial and in-kind support to MobileMed Inc., one of the largest safety net clinics in Montgomery Cares network, to expand access to primary care services within the Hospital's CBSA identified zip codes: (20814, 20817, 20854, 20852 and 20874).

    - Ethnic minorities: The CBSA includes a population which is 46.9% White, non-Hispanic; 14.0%, Black non-Hispanic; 19.7% Hispanic; 16.0% Asian and Pacific Islander non-Hispanic; 3.4% All others.

    - Health disparities: 2.58% of the population is uninsured within the hospital's CBSA.

- **Outreach approach** (hospital's principal function or specialty areas of focus, e.g., Burn Center)

Suburban Hospital's health improvement and outreach approach connects the hospital, community partners, local stakeholders and other resources with identified health needs. Building a healthy community goes beyond providing health care. Suburban Hospital not only aligns health priorities with the areas of greatest identified need, but also considers where the Hospital's resources will generate the greatest impact. The Hospital approaches this through the utilization of collective impact, a framework by which a group of stakeholders tackle complex issues. A single person or group cannot solve deeply entrenched problems, such as obesity, the opioid epidemic, escalating healthcare costs and high hospital readmission rates. Collective impact is not simply about collaboration. It brings together multiple entities from various sectors to align individual agendas into a shared, well-defined and measureable goal. This approach supports positive health outcomes both within the hospital and in the community.

According to the Centers for Disease Control, heart disease continues to be the leading cause of death among African American/Blacks, white, non-Hispanics and Hispanics in the United States. Within Suburban Hospital's CBSA, the age-adjusted death rate due to coronary artery disease correlates to those in the United States with the African American/black population having a higher age-adjusted death rate due to heart disease of 156.8 compared to the overall rate of 108.1 in Montgomery County. In the state

of Maryland, the overall rate of heart disease deaths is 169.4.[4] With that in mind, Suburban Hospital supports programs to reduce the gap in disparities within its CBSA. One example is through the Hospital's funding of four HeartWell clinics in Suburban's targeted CBSA. The goal of the clinics is to establish access to needed cardiovascular specialty care to vulnerable residents in the community. For the past fifteen years, consistent health improvement initiatives such as HeartWell have provided thousands of seniors who have suffered heart attacks or advanced cardiovascular illness access to free cardiovascular health education, disease management, exercise, and nutrition classes. Under the care of three HeartWell nurses, individuals have the opportunity to visit four local senior centers throughout the county several days a week to receive ongoing follow-up care and support, thereby better managing their chronic disease and avoiding possible hospital re-admissions. In recent years, HeartWell has expanded its efforts to reach community members who are pre-diabetic or living with diabetes as the HeartWell nurses facilitate Diabetes Support and Continuing Education meetings at four locations including: 20906 (Wheaton/Glenmont), 20878 (Gaithersburg), 20901 (Silver Spring) and 20814 (Bethesda).

- **Target population** (uninsured, elderly, HIV, cardiovascular disease, diabetes)

While Suburban Hospital's health improvement initiatives are targeted to the needs of various areas of our community, a Community Advisory Board and Visioning team was established in 1998. Composed of several public and private health officials along with other outside organization leaders, the team identified four specific target areas of need: 1.) A focus on health access of minority populations; 2.) underserved seniors; 3.) at-risk youth; and 4.) management of chronic diseases including diabetes for the under/uninsured. Today, almost twenty years later, similar health priorities and areas of targeted focus serve as guiding principles for community health improvement. For instance, our area has a rapidly growing senior population; inside Suburban Hospital's CBSA, 28.8% of the population is over the age of 55.[5] In fact, Montgomery County has one of the longest life expectancy rates in the country: 83.5 years for women and 79.3 years for men.[6]

As the community grows older, the need to care for the elderly in specific ways is expanding. For that reason the Hospital earned the NICHE (Nurses Improving Care for Health system Elders) Progressive Implementation designation from The Hartford Institute for Geriatric Nursing at the New York University College of Nursing. NICHE is the only national geriatric initiative designed to improve the care of older hospitalized adults. This designation represents Suburban's on-going, high-level dedication to geriatric medical care and preeminence in the implementation and quality of system-wide interventions and initiatives. With this prestigious designation, Suburban Hospital acknowledges the many distinct issues that older patients face, such as hearing and vision loss and gait and balance challenges, and has incorporated best practices in place to provide expert, patient-centered care for these individuals. Examples of this initiative include hospital-wide education programs to help sensitize staff to the specific needs of older adults, and environmental design changes to enhance function and comfort.

Additionally, the Community Health and Wellness Division conducts hundreds of community health improvement programs, screenings, classes and seminars within the Hospital's CBSA each year reaching populations from school age children to active seniors. Further detail of these partnerships and health initiatives are highlighted throughout the report.

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[4] Maryland State Improvement Process (SHIP), 2013-2015, http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship25

[5] 2017 Truven Health Analytics Inc.

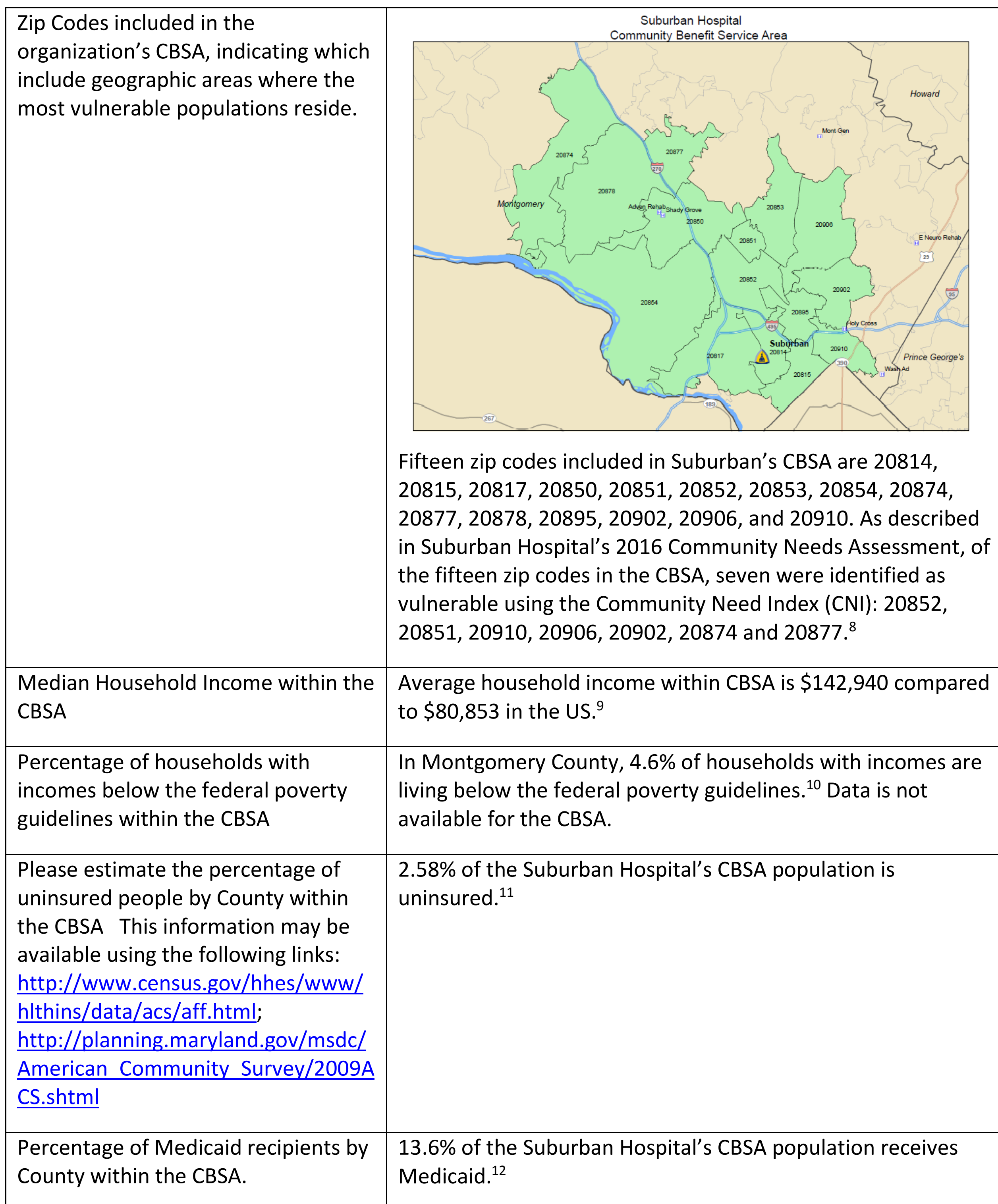
[6] Institute for Health Metrics Evaluation, www.healthmetricsandevaluation.org, 2014

b. Demographics.

Table II

Community Benefit Service Area (CBSA) Target Population (# of people in target population, by sex, race, ethnicity, and average age)[7]	Total population within the CBSA: 651,984 <u>Sex:</u> Male: 313,256/48.05% Female: 338,728/51.95% <u>Race/Ethnicity:</u> White, non-Hispanic: 305,629/46.9% Black, non-Hispanic: 91,589/14.0% Hispanic: 128,519/19.7% Asian and Pacific Islander non-Hispanic: 104,347/16.0% All others: 21,900/3.4% <u>Age:</u> 0-14: 122,900/18.9% 15-17: 24,278/3.7% 18-24: 50,282/7.7% 25-34: 84,686/13.0% 35-54: 182,358/28.0% 55-64: 85,229/13.1% 65+: 102,251/15.7%

[7] 2017 Truven Health Analytics Inc.



Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	Fifteen zip codes included in Suburban's CBSA are 20814, 20815, 20817, 20850, 20851, 20852, 20853, 20854, 20874, 20877, 20878, 20895, 20902, 20906, and 20910. As described in Suburban Hospital's 2016 Community Needs Assessment, of the fifteen zip codes in the CBSA, seven were identified as vulnerable using the Community Need Index (CNI): 20852, 20851, 20910, 20906, 20902, 20874 and 20877.[8]
Median Household Income within the CBSA	Average household income within CBSA is $142,940 compared to $80,853 in the US.[9]
Percentage of households with incomes below the federal poverty guidelines within the CBSA	In Montgomery County, 4.6% of households with incomes are living below the federal poverty guidelines.[10] Data is not available for the CBSA.
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	2.58% of the Suburban Hospital's CBSA population is uninsured.[11]
Percentage of Medicaid recipients by County within the CBSA.	13.6% of the Suburban Hospital's CBSA population receives Medicaid.[12]

[8] Truven Health Analytics Inc. and Dignity Health
[9] 2017 Truven Health Analytics Inc.
[10] www.healthymontgomery.org
[11] 2017 Truven Health Analytics Inc.
[12] 2017 Truven Health Analytics Inc.

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	The life expectancy is 84.6[13] years at birth in Montgomery County, which is higher than the life expectancy in Maryland (79.5)[14] and the projected National Baseline (78.8).[15] Compared with other counties in Maryland, Montgomery County has a higher life expectancy. Data for Suburban Hospital's CBSA is not available at this time. The life expectancy in Montgomery County for White, non-Hispanic (84.4) individuals is slightly higher than Black, non-Hispanic (82.7).[16]
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Within Suburban Hospital's CBSA, the infant mortality rate for all Races is 4.7 per 1,000 live births; among Caucasians is 3.7 per 1,000 live births and among African Americans is 10.5 per 1,000 live births and among Hispanics is 4.2 per 1,000 live births.[17] The infant mortality rate for all Races in Montgomery County, is 5.3 per 1,000 live births; among Caucasians is 2.2 per 1,000 live births and among African Americans is 8.1 per 1,000 live births and among Hispanics is 7.5 per 1,000 live births.[18] Age-Adjusted Death Rate due to Heart Disease within Suburban Hospital's CBSA is 108.1 deaths/100,000 population.[19] Age-Adjusted Death Rate due to Heart Disease by Race/Ethnicity within Suburban Hospital's CBSA:[20] – 156.8/100,000 Black – 112.0/100,000 White – 54.8/100,000 Hispanic

[13] Maryland DHMH Vital Statistics Annual Report, 2015, 68 https://health.maryland.gov/vsa/Documents/15annual.pdf
[14] Maryland DHMH Vital Statistics Annual Report, 2015, 3 https://health.maryland.gov/vsa/Documents/15annual.pdf
[15] National Vital Statistics Report, Final data for 2015, http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf
[16] Maryland DHMH Vital Statistics Annual Report, 68 2015, https://health.maryland.gov/vsa/Documents/15annual.pdf
[17] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2008-2012 and 2010-2014 Results."
[18] Maryland Vital Statistics, Infant Mortality in Maryland, 2015, 121 https://health.maryland.gov/vsa/Documents/15annual.pdf
[19] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[20] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."

	– 64.0/100,000 Asian/Pacific Islander Age-Adjusted Death Rate due to Heart Disease in Montgomery County is 107.5 deaths/100,000 population.[21] Age-Adjusted Death Rate due to Heart Disease by Race/Ethnicity in Montgomery County:[22] – 127.8/100,000 Black – 110.0/100,000 White – 55.7/100,000 Hispanic – 59.8/100,000 Asian/Pacific Islander Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) within Suburban Hospital's CBSA is 25.3 deaths/100,000 population.[23] Age-Adjusted Death Rate due to Cerebrovascular Disease by Race/Ethnicity within Suburban Hospital's CBSA:[24] – 31.7/100,000 Black – 25.2/100,000 White – 18.9/100,000 Hispanic – 21.7/100,000 Asian/Pacific Islander Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) is 24.5 deaths/100,000 population in Montgomery County.[25] – 27.5/100,000 Black – 23.7/100,000 White – 19.7/100,000 Hispanic – 23.2 /100,000 Asian/Pacific Islander

[21] Healthy Montgomery, www.healthymontgomery.org
[22] Healthy Montgomery, www.healthymontgomery.org
[23]Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[24] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[25] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."

	Age-Adjusted Death Rate due to Colorectal Cancer in Montgomery County is 9.3 deaths/100,000 population.[26] Age-Adjusted Death Rate due to Colorectal Cancer by Race/Ethnicity in Montgomery County: – 9.2/100,00 White, Non-Hispanic – 12.3/100,000 Black – 7.1/100,000 Hispanic – 9.2/100,000 Asian/Pacific Islander[27] Age-Adjusted Death Rate due to Prostate Cancer for men in Montgomery County is 15.2 deaths/100,000 males.[28] Age-adjusted Death Rate due to Prostate Cancer by Race/Ethnicity in Montgomery County: – 15.3/100,000 White, Non-Hispanic – 26.2/100,000 Black – No data Hispanic – 5.8/100,000 Asian/Pacific Islander[29] Age-Adjusted Death Rate due to Breast Cancer for women in Montgomery County is 17.3 deaths/100,000 females.[30] Age-adjusted Death Rate due to Breast Cancer by Race/Ethnicity in Montgomery County:[31] – 19.0/100,000 White, Non-Hispanic – 22.0/100,000 Black – 8.4/100,000 Hispanic – 8.8/100,000 Asian/Pacific Islander

[26] National Cancer Institute, Death Rate Report for Maryland by County, Colon & Rectum, 2010-2014 https://statecancerprofiles.cancer.gov/deathrates/index.php
[27] National Cancer Institute, Death Rate Report for Maryland by County, Colon & Rectum, 2010-2014 https://statecancerprofiles.cancer.gov/deathrates/index.php
[28] National Cancer Institute, Death Rate Report for Maryland by County, Prostate, 2010-2014 https://statecancerprofiles.cancer.gov/deathrates/index.php
[29] National Cancer Institute, Death Rate Report for Maryland by County, Prostate, 2010-2014 https://statecancerprofiles.cancer.gov/deathrates/index.php
[30] National Cancer Institute, Death Rate Report for Maryland by County, Breast, 2010-2014, https://statecancerprofiles.cancer.gov/deathrates/index.php
[31] National Cancer Institute, Death Rate Report for Maryland by County, Breast, 2010-2014, https://statecancerprofiles.cancer.gov/deathrates/index.php

	Within its CBSA, Suburban Hospital has several community initiatives and programs to prevent and decrease these four chronic disease rates.
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status 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 SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	1% of Montgomery County residents are low- income and do not live close to a grocery store compared to 3% of residents who live in the state. 26% of children enrolled in Montgomery County public schools are eligible for free lunch compared to 36% of children in Maryland. [32] Within the CBSA, there are several grocery stores, produce stands and farmers markets enabling residents to choose healthier food options. In Montgomery County, most grocery stores along with several farmers markets, including the FRESHFARM Market in Silver Spring, MD 20910[33] and the Rockville Farmers Market in Rockville, MD 20850, accept food stamps.[34] 45.8% of Montgomery County Public School students now or have in the past received Free and Reduced Meals (FARMs).[35] 6.3% of Montgomery county residents experienced food insecurity at some point during the year.[36] 13.3% of children (under 18 years of age) are living in households that experienced food insecurity at some point during the year.[37]
Transportation	Suburban Hospital and its outpatient facility are accessible to public transportation. The Ride-On bus system is the primary public transportation system and serves Montgomery County.[38] In addition, Washington Metro stations are located near the Hospital at the National Institutes of Health campus and in downtown Bethesda, a 30-minute walk to the hospital. Limited bike lanes are also available.[39] The Capital Bike Share program installed 19 docks of bicycles near Suburban Hospital and NIH as part of the Montgomery County Bike Share program in 2014. Located on the corner of Old Georgetown Road and Southwick Street, one block from the Hospital, the Capital Bike Share Program encourages community members to ride to work and other activities as a

[32] County Health Rankings, http://www.countyhealthrankings.org/
[33] Fresh Farm Markets, https://freshfarm.org/index.html
[34] Maryland Farmers Market Association, www.marylandfma.org/
[35] Montgomery County Public Schools, 2016-2017, www.montgomeryschoolsmd.org/departments/regulatoryaccountability/glance/currentyear/schools/county.pdf
[36] http://map.feedingamerica.org/county/2015/overall/maryland/county/montgomery
[37] http://www.feedingamerica.org/research/map-the-meal-gap/2015/MMG_AllCounties_CDs_CFI_2015_1/MD_AllCounties_CDs_CFI_2015.pdf
[38] Montgomery County Department of Transportation, www.montgomerycountymd.gov/dot-transit/index.html
[39] Washington Metropolitan Area Transit Authority, www.wmata.com

	way to save money, increase travel flexibility while increasing their activity level. [40] Montgomery County includes over 100 miles of park trails for both hikers and bikers. For example, the 11-mile Capital Crescent Trail begins in Silver Spring, MD, east of the Rock Creek Trestle and curves westward and south through Bethesda, MD into Washington, D.C., to end in the heart of historic Georgetown. It covers a large portion of Suburban's CBSA and affords the opportunity for residents to stay active and healthy.[41]
Education Attainment in Montgomery County[42] People 25+ with a Bachelor's Degree or Higher by Race/Ethnicity[43]	Population 25 years and over: 698,595 Less than 9th grade: 5.0% 9th to 12th grade, no diploma: 3.9% High school graduate (includes equivalency): 14.0% Some college, no degree: 14.3% Associate's degree: 5.0% Bachelor's degree: 26.6% Graduate or professional degree: 31.3% American Indian or Alaska Native: 28.4% Asian: 66.9% Black or African American: 42.1% Hispanic or Latino: 25.8% Native Hawaiian or Other Pacific Islander: 43.4% Other: 14.3% Two or more Races: 50.1% White, Non-Hispanic: 70.4% Overall: 57.9%
Exposure to environmental factors that negatively affect health status by County within the CBSA	According to the American Lung Association, the Ozone Grade is a C based on the annual number of high ozone days in Montgomery County although the county earned an A grade based on Annual Particle.[44] According to the Environmental Protection Agency (EPA), 112 pounds of reported and recognized carcinogens were released into the air in 2016 which is an increase from 98 pounds reported in 2015. However, the total net pounds of reported amount of PBT (Persistent, Bioaccumulative, and Toxic Chemicals) released into the environment decreased from 1,192 in 2015 to 1,127 in 2016.[45]

[40] Montgomery Bike Share, www.montgomerycountymd.gov/bikeshare/
[41] Trail Link, www.traillink.com
[42] American Community Survey 5-Year Estimates, 2011-2015, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_5YR_S1501&prodType=table
[43] American Community Survey 5-Year Estimates, 2011-2015, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_5YR_S1501&prodType=table
[44] http://www.lung.org/our-initiatives/healthy-air/sota/city-rankings/states/maryland/montgomery.html
[45] U.S. Environmental Protection Agency, www.epa.gov

	0% of people get water from public water systems that have received at least one health-based violation in the reporting period.[46]
Available detail on race, ethnicity, and language within the CBSA	39.6% of Montgomery County residents speak a language other than English at home. 32.6% are Foreign-born persons living in Montgomery County.[47]
Minority owned businesses in Montgomery County[48]	32.4%: Women owned 12.4%: Black 12.1%: Asian 10.0%: Hispanic 0.7%: American Indian- and Alaska Native 0.1%: Native Hawaiian and Other Pacific Islander
Economic Development	Jacqueline Schultz, Suburban Hospital President, served as a board member of the Montgomery County Chamber of Commerce during FY17. Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region is a board member of the Bethesda Chevy Chase Chamber of Commerce in FY17. The Hospital supports the BCC Chamber in several events supporting economic growth in Montgomery County. According to the Montgomery County Department of Economic Development, Suburban Hospital is one of the leading employers of Montgomery County, employing over 1,700 residents throughout Metropolitan Washington area. The Minority, Female and Disabled Owned Business Program within the Department of Procurement of Montgomery County provides services to more than 80,000 small and minority businesses located in Montgomery County by creating initiatives and forming partnerships with community organizations, business groups, private enterprises, and other public agencies.[49]

II. COMMUNITY HEALTH NEEDS ASSESSMENT

[46] County Health Rankings & Roadmaps, www.countyrankings.org
[47] https://www.census.gov/quickfacts/fact/table/montgomerycountymaryland/SBO020212#viewtop
[48] US Census, Quick Facts, 2010, www.census.gov
[49] Montgomery County Economic Development, https://thinkmoco.com/

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

___✓ Yes
____ No

Suburban Hospital published its second Community Health Needs Assessment (CHNA) report on **June 1, 2016**.

Suburban's 2016 CHNA process included a three-tiered approach: 1) reviewing available local, state, and national data sets for core health indicators for Montgomery County; 2) conducting a community health survey to assess the needs and insights of residents in high priority zip codes from the Hospital's Community Benefit Service Area (CBSA); and, 3) engaging health experts and stakeholders to advise on the direction of the needs assessment. Results from primary and secondary data, Suburban's medical area of expertise, and county, state, and national health priorities were taken into consideration to identify the top five health needs for Suburban's community. After multiple prioritization discussions with stakeholders, the following main focus areas emerged for Suburban's 2016 Community Health Needs Assessment (presented below in no specific order):

- Behavioral health
- Cardiovascular health
- Diabetes
- Obesity
- Cancer

The Hospital's first assessment was conducted in 2013 and identified the same conditions as its health priorities. The 2013 CHNA also included maternal and infant health as health priority but was eliminated in 2016 after consideration that while it aligned with county health priorities, it was not consistent with the Hospital's medical specialties, or its primary and secondary data, or health improvement programming. Suburban Hospital will continue to build upon existing programs addressing these five health areas and will work thoughtfully and diligently with partners over the next two years (2018-2019) to ensure that the valuable information attained from the CHNA process continues to be utilized for monitoring and evaluating established health targets and goals.

Suburban Hospital's 2016 Community Health Needs Assessment is available online to the community via:
http://www.hopkinsmedicine.org/suburban_hospital/_documents/community_health/CHNA_2016.pdf

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4 of Narrative Instructions?

___✓ Yes Enter date approved by governing body here: **September 29, 2016**
____ No

Suburban Hospital's approved health improvement plan connects hospital, community partners, local stakeholders and other resources with identified health needs. Suburban Hospital not only

aligns health priorities with the areas of greatest identified need, but also considers where the Hospital's resources will generate the greatest impact. As such, the implementation plan includes an evaluation component to measure each health outcome identified in the plan. Over the next three years, Suburban Hospital will focus its health improvement efforts to specific populations or communities of need to which the hospital allocates resources, identified in the report as the Community Benefit Service Area (CBSA). Striving to reduce rate of disease and improve health quality associated with the five priorities, the Hospital has established health initiatives, programs and partnerships associated with each priority and is included in the Hospital's implementation plan, serving the community's needs.

- **Cardiovascular Health** – alignment with National Heart Lung and Blood Institute (NHLBI) and Suburban Hospital cardiac surgery program which features an accredited open heart program; MobileMed/NIH Heart Clinic at Suburban Hospital; Latino Health Initiative; 4 HeartWell clinics throughout Montgomery County; American Heart Association.
- **Diabetes** – alignment with National Institutes of Diabetes and Digestive Kidney Diseases (NIDDK), MobileMed/NIH Endocrine Clinic at Suburban Hospital; various support groups at Montgomery County Department of Parks and Recreation centers; Diabetes education in partnership with Sibley Memorial Hospital; Fine-Tuning Your Diabetes, and Pre-Diabetes Action classes at Suburban Hospital.
- **Obesity** – partnership with Girls on the Run; various Senior Shape Exercise classes held Montgomery County Department of Parks and Recreation centers; Weight Management classes at Suburban Hospital, BCC-YMCA Turkey Chase.
- **Cancer** – alignment with National Cancer Institute (NCI); Montgomery County Cancer Coalition (MCCC); MD Comprehensive Cancer Control Plan, cancer-related support groups and symposia at Suburban; AVON Breast Cancer Crusade, Komen for the Cure; *Check It Out;* American Lung Association;
- **Behavioral Health** – Hospital understands current challenges with identifying and treating patients to appropriate referral services in Montgomery County; alignment with NAMI, Addiction Treatment Center at Suburban; support groups at Suburban Hospital, YMCA/PEP Parenting programs, partnership with the Scotland Community of Potomac, MD.

If you answered yes to this question, provide the link to the document here.

Suburban Hospital's Implementation Plan in response to the 2016 Community Health Needs Assessment can be accessed via:

http://www.hopkinsmedicine.org/suburban_hospital/_documents/community_health/CHNA_2016_Implementation_Strategy_Report.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. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

___✓___Yes
___No

If yes, please provide a description of how the CB **planning** fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Suburban Hospital's Community Benefit strategic plan is incorporated into the Hospital's strategic plan to ensure a collective approach to building quality relationships with community partners in addressing the health needs of the community. Three community health improvement goals were included in Suburban Hospital's FY 17 strategic plan: 1.) Advance community health education through the implementation of a new or expanded existing health clinics to meet a specific, identified community need; 2.) Increase access to quality diabetes management and treatment for residents living in Suburban's CBSA; 3.) Improve positive mental health outcomes by conducting deliberate interventions that foster social and emotional support. These goals were measured and reported quarterly as part of the hospital's overall operation performance scorecard.

By the end of FY 17, the three goals were achieved. Included among the performance measures used to evaluate goal attainment were the integration of health improvement programs, an increase in access to care and the expansion of health promotion programs and interventions targeting diverse populations. One example of integrating health improvement programs into an established model is the Fine Tune Diabetes (FTD) initiative, which contributed to achieving the first two strategic goals. Recognizing a need for further diabetes education for our patients, Suburban Hospital designed the FTD Initiative, which enrolls hospital in-patients with diabetes in a specially designed small group class called Fine Tune Your Diabetes (FTYD). The FTYD class provides a behavioral-based disease self-management program that serves people living with diabetes (either newly diagnosed or those with pre-existing condition) and their care partners. The class is aimed to ease the often difficult transition from hospital-to-home by meeting a patient's immediate need through Specific, Measurable, Achievable, Reasonable and Timely (SMART) goal setting. Through the MobileMed/NIH Endocrine Clinic at Suburban Hospital, a referral system was established enabling clinic patients to be linked to the FTYD and other health education classes at Suburban Hospital. The FTD initiative also enabled increased access to quality diabetes management programs for residents living within Suburban's CBSA. By the end of FY17, not only was there a connection between FTYD and hospital and safety-net clinic patients, but the FTD classes reached full capacity.

In order to improve positive mental health outcomes by conducting deliberate interventions that foster social and emotional support for our families, Suburban Hospital supported several events throughout the year such as: The YMCA/PEP Parenting Education seminars, titled "Helping Children to Manage the Challenges of Separation and Divorce" and "Finding Balance with Kids in a Tech-Savvy World," which educated parents on issues affecting their children; the Adopt a Family Holiday Initiative, which involved hospital departments adopting underserved residents in Montgomery County during the holiday season; and the #JustGirls workshops in partnership with Scotland Community. The #JustGirls workshops were designed for the preteen girls living in the Scotland Community in Potomac, MD, with the goal of creating a positive atmosphere. Meeting once a month, staff from the Hospital's Community Health and Wellness division lead interactive workshop which include several themes such as: nutrition, healthy body image, physical exercise and safety. Furthermore, the "11 Things You Need To Know" workshop dealt with the challenges facing young girls as they grow up; the "Growing Connections" workshop provided guidance for making lasting friends; and the "Pieces of Me" workshop focused on self-esteem.

Other initiatives include the Village Ambassador Alliance to support "Aging in Place" and Stop-the-Bleed® emergency preparedness community training. Specifically, Suburban Hospital's Trauma Department and Community Health and Wellness Division launched the Stop-the-Bleed® training in early FY17. Stop-the-Bleed® is a free hands on training program, designed by the American College of Surgeons Committee on Trauma, to teach individuals with little or no medical training bleeding control techniques using their hands, dressings and tourniquets.

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 describe the role each plays in the planning process (additional positions may be added as necessary)

In working with the Montgomery County Department of Health and Human Services and addressing the needs set by Healthy Montgomery, Suburban Hospital's Board of Trustees, President and CEO, and the organization's operations leadership team work thoroughly to ensure that the hospital's strategic and clinical goals are aligned with unmet community needs though the planning, monitoring and evaluation of its community benefit activities.

In addition, nursing leadership, community physicians, health partnership advisory boards, local government and business agencies, and other not-for-profit organizations continue to influence the decision making process and prioritization of Suburban Hospital's community benefit activities.

1. Senior Leadership✓:
   I. Jacqueline Schultz, R.N., M.S.N., C.N.A.A., President
   II. Marty Basso, Senior Vice President of Finance and Treasurer, Community Division, National Capital Region and Chief Financial Officer, Sibley Memorial Hospital and Suburban Hospital
   III. Queenie C. Plater, Vice President of Human Resources, Community Division, National Capital Region
   IV. June Marlin Falb, Vice President of Development
   V. Joseph Linstrom, Vice President of Operations
   VI. David Simpkins, Vice President of Marketing and Communications, Community Division, National Capital Region
   VII. Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region
   VIII. Jason Cole, Senior Director of IT
   IX. Brian Ebbitt, Chief of Staff, Administration
   X. Tom Stewart, Senior Director of Ambulatory Care/ Physician Services
   XI. Sunil Vasudevan, Senior Director of Finance
   XII. Leslie Ford Weber, Director, Campus, Government and Community Affairs, Montgomery County

Senior Leadership plays a crucial role as active members of the Hospital's Community Benefit Advisory Council by providing feedback and recommendations to the council on Hospital community benefit reporting and population health initiatives. In addition, several members of senior leadership contribute community benefit hours to the Hospital's annual report. Below are a few examples:

- Jacqueline Schultz, President, represented the Hospital by serving on the Montgomery Cares Program Advisory Board whose goal is to advise the community leaders on matters relating to the County's uninsured residents in FY17.
- Marty Basso, Senior Vice President of Finance and Treasurer, Community Division, National Capital Region and Chief Financial Officer, Sibley Memorial Hospital and Suburban Hospital oversees that community benefit dollars are properly reported.
- Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region, represents the Hospital at the Greater Bethesda Chamber of Commerce.
- Jason Cole, Senior Director of IT, oversees the Hospital "Recycle My Computer" program which donates used hospital computers to community organizations which serve vulnerable communities.
- Leslie Ford Weber, Director, Montgomery County, Campus, Government and Community Affairs, represented the Hospital on the Montgomery County Chamber of Commerce and the Montgomery Workforce Development Board. Ms. Weber also works with the Hospital's leadership and Board of Trustees in approving community contributions which align with the Hospital's health priorities in supporting non-for-profit organizations including the YMCA Bethesda-Chevy Chase, Girls on the Run Montgomery County and A Wider Circle to name a few. In FY17, Suburban Hospital donated $328,347.31 of in-kind and cash donations.
- Brian Ebbitt, Chief of Staff, Administration, serves on Suburban's Community Benefit Advisory Council and leads Suburban's strategic planning process. Brian provides continuous counsel on the incorporation and alignment of community health improvement in the organization's strategic goal-setting process.

2. Clinical Leadership✓:
    i. Physicians: Eric Dobkin, M.D., Vice President of Medical Affairs; Diane Colgan, M.D., Board Chair of Medical Staff; Dominique Foulkes M.D., Medical Director of the Shaw Family Pediatric Emergency Center, Mihail Zilbermint, MD, Director, Endocrinology, Diabetes and Metabolism Care at Suburban Hospital, Johns Hopkins Community Physicians
    ii. Nurses: LeighAnn Sidone, Vice President and Chief Nursing Officer
    iii. Social Workers: Janice Torre, Director, Care Coordination
    iv. Other(s): Matthew Tovornik, Division Director, Orthopedic & Neurosurgery Service Lines and Rehabilitation; Beth Kane-Davidson, Director of Addiction Treatment Center; Shawn Donnelly, Department Director, Managed Care and Patient Access; Rev. Barbara McKenzie, Director of Pastoral Care; C. LuLu Fulda, R.D., L.D.N., C.N.S.C., Clinical Nutrition Manager

Equally valuable, clinical leadership plays an important role in the community benefit process by working closely with the Community Health and Wellness Division on community health initiatives such as health education programs and specialty clinics. In addition, members of clinical leadership are also involved in contributing community benefit health improvement initiatives on a regular basis. Below are a few examples:

- Dr. Diane Colgan, Board Chair of Medical Staff, serves on the Hospital's CBAC and provides a physician perspective to population health.
- Dr. Dominique Foulkes, volunteers her time providing health tips on the Girls on the Run Montgomery County website, escorts local Girl Scout troops on tours of the Shaw Family Pediatric Emergency Center and attends the annual Bethesda Chevy Chase YMCA Healthy Kids Day.
- Mihail Zilbermint, MD, Director, Endocrinology, Diabetes and Metabolism Care at Suburban Hospital, Johns Hopkins Community Physicians chairs the Hospital's Glucose Steering Committee

whose goal is to improve diabetes management for patients and provides support to the staff of Community Health and Wellness on health improvement programming involving diabetes prevention and management.

- Matthew Tovornik, Division Director, Orthopedic & Neurosurgery Service Lines and Rehabilitation, offers a variety of free or low cost balance, fall prevention and joint health education classes and seminars at the local senior community centers so that seniors improve their balance and prevent falls.
- Beth Kane-Davidson, Director, Addiction Treatment Center, travels throughout the Montgomery County high schools to caution teens and parents on the dangers of substance abuse while offering a forum for open dialogue.
- Shawn Donnelly, Department Director, Managed Care and Patient Access and his team volunteers their time by registering clinic patients for the MobileMed/NIH Heart Clinic and MobileMed/NIH Endocrine Clinic at Suburban Hospital.
- C. LuLu Fulda, R.D., L.D.N., C.N.S.C., Clinical Nutrition Manager and her team of registered and licensed hospital dietitians donate their time and expertise at the MobileMed/NIH Endocrine clinic by educating diabetic patients on practical approaches to managing their diabetes through proper nutrition and food choices.

3. Population Health Leadership and Staff✓:

   i. Patricia M.C. Brown, Senior VP, Managed Care and Population Health, Johns Hopkins Medicine
   ii. Janice Torre, Director, Care Coordination, Suburban Hospital
   iii. Margie Hackett, R.N., B.S.N., B.C. in Geriatrics, C.H-G.C.N., Transition Guide Nurse, Readmissions Initiative, Care Coordination Department, Suburban Hospital
   iv. Monique L. Sanfuentes, M.A., Administrative Director, Community Affairs & Population Health, Community Health and Wellness, Suburban Hospital

Describe the role of population health leaders and staff in the community benefit process.

For the staff of Care Coordination and Community Health and Wellness, population health is a natural extension of the synergistic efforts occurring within the hospital and throughout the community. In order to address the need to keep our vulnerable senior community members healthy and out of the hospital, Community Health and Wellness and Care Coordination Transition Guide Nurses combine efforts to better serve our community. Examples of collaboration efforts include the Care Partner Initiative and the Village Ambassador Alliance.

In the Care Partner Initiative, an evidence-based strategy useful in the prevention of hospitalizations and readmissions, the Community Health and Wellness division and Care Coordination transition guide nurses work to improve readmissions outcomes and medication management for our at risk senior patients. Hospital transition guide nurses (TGN) work hand in hand with patients and their Care Partners to bridge the gap between hospital and community with the goal of improved quality of life. In examining hospital data, it was determined that the largest readmission rates were associated with those patients from the Adult Medical Unit. The Care Partner initiative is an instrumental and effective resource to assist patients in meeting the daily challenges that can impact their health and recovery. In order to measure improved readmission outcomes and better medication management, a community health nurse works with the patient and a voluntary Care Partner to provide education on the specific

and potential needs of the patient in advance of discharge to home. Examples include help with medications, follow up with medical appointments and care in the community, transportation, and meals. Encouraged to be present at the time of discharge instruction to be best prepared, Care Partners play a vital role in ensuring a safe, successful transition from hospital to home and across the continuum of care. Patients and their Care Partners are contacted by the TGN after discharge to continue this effort and receive additional hospital support. This initiative engages and supports patients in managing their healthcare from hospital to home.

Through the Washington Area Village Exchange in Montgomery County, Community Health and Wellness is able to link residents to community health improvement programming while Care Coordination bridges the gap in the discharge planning process for patients who live in the villages. This fiscal year kicked off the Village Ambassador Alliance, which brings together leaders representing their local villages. The first two gatherings featured relationship building with the hospital, learning about what each Village offers for their members, an explanation of community and patient resources offered by the hospital, and an assessment of the assets and needs of each party. As a result of learning about each other, successive forums have been able to address specific interests of the villages, such as learning about the role of a hospitalist, the clinical decision unit, and what to expect prior to a hospital admission. Care Coordination, Community Health and Wellness and a Village Ambassador were able to successfully locate and connect a recently-discharged patient with their Village, providing an added layer of support for the patient after their recovery. This included rehab before coming home to heal. It is these open lines of communication and trust that help both parties live out their missions of helping adults successfully age in place.

4. Community Benefit Operations✓

The Community Health and Wellness (CHW) Division consists of five public health professionals who oversee 2,613 community health improvement programs, screenings, classes, seminars and activities serving 69,489 individuals throughout Montgomery County as well as Prince George's, Calvert and St. Mary's Counties. The Community Health and Wellness Division is also responsible for the Hospital's Community Benefit Report and the Community Health Needs Assessment. Individuals manage the Community Benefit process by collecting, reporting and analyzing data and composing the narrative to the HSCRC. By working directly with Healthy Montgomery to complete the Hospital's Community Health Needs Assessment, the Division also administers supplemental community feedback surveys, analyzing its results and composes the assessment and implementation plan during the three year cycle and submits the plan to the IRS. Furthermore, the Division works collaboratively with the Montgomery County Health and Human Services Department, other Montgomery County Hospitals, coalitions, community partners and leaders to ensure common goals are established to best leverage and provide resources to our county's most vulnerable residents.

Staff from the Finance department work alongside the Community Health and Wellness Division and are responsible for calculating the dollars attributed to the Community Benefit report.

i. Individuals✓:

- Monique L. Sanfuentes, M.A., Administrative Director, Community Affairs & Population Health, Community Health and Wellness; (1 FTE)
- Eleni Antzoulatos, M.P.H., Supervisor, Community Health and Wellness Operations, Community Health and Wellness; (1 FTE)

- Sara Demetriou, B.S., Coordinator, Health Initiatives and Community Partnerships, Community Health and Wellness; (1 FTE)
- Brian Ebbitt, M.B.A., B.S., Chief of Staff, Administration; (1 FTE)
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury; (1 FTE)
- Kate McGrail, M.P.H., Program Manager, Health Outcomes and Evaluation, Community Health and Wellness; (1 FTE)
- Patricia Rios, M.P.H., Manager, Community Health Improvement, Community Health and Wellness; (1 FTE)
- Sunil Vasudevan, M.S., M.E., Senior Director, Finance and Treasury, Finance and Treasury; (1 FTE)

– Monique L. Sanfuentes, Administrative Director, Community Affairs & Population Health, oversees the community health improvement processes and the community benefit and works collaboratively with senior, clinical, and community leadership to make certain that the Hospital's health priorities and initiatives are being met. She oversees all aspects of the hospital's community benefit operations which includes: financial contributions, health partnerships, community initiatives, strategic affiliations and collaboration with health coalitions, health improvement activities, wellness programs and corporate projects. She has an active role in the Hospital's population health process by working directly with staff of Care Coordination and Readmission Initiative. She is also serves on the Board of Managers for Nexus Montgomery.

– Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness, is responsible for producing Suburban Hospital's Community Benefit Report by collecting, evaluating and reporting data received from hospital staff using CBISA software. She also coordinates the data content for the Community Benefit narrative, which is submitted to the HSCRC. In addition, she oversees many Health Promotion and Community Wellness initiatives at Suburban Hospital through the healthy lifestyle programs known as WellWorks, which offers nutrition, safety, healthy lifestyle and fitness classes to community members and Worksite Wellness initiatives, which help local businesses, encompass healthy lifestyle practices within the workplace. Antzoulatos arranges Suburban Hospital's health and wellness seminars and special events, including the Annual Women's and Men's Health Symposia, alongside the physician liaison, communications and service line administrators.

– Sara Demetriou, Coordinator, Health Initiatives and Community Partnerships, coordinates and evaluates Health Initiatives and Community Partnerships throughout Montgomery County working closely with both adolescents and older adult population. Exercise programs like Senior Shape encourage residents 50 and over to build strength, flexibility and improve balance. In addition, Demetriou's oversight of ongoing blood pressure screenings conducted at various senior centers affords community members access to ongoing monitoring and links to other needed medical services. Throughout the academic school year, Demetriou leads the coordination and programing of the Medical Exploring Program in partnership with the Boy Scouts of America to provide a unique hands-on learning experience to high school students interested in pursuing careers in science and medicine. Furthermore, she collaborates closely with the local chapter of Hadassah to operate the *Check It Out* program which delivers breast cancer awareness and education to 11th and 12th grade female students. She also spends a portion of her time engaging hospital colleagues to contribute and participate in organization wide initiatives that support the United Way as well as the Adopt-A-Family Program. All of these programs contribute to the Hospital's Community Benefit operations.

- Brian Ebbitt is Suburban Hospital's Chief of Staff and serves on Suburban's Community Benefit Advisory Council. Ebbitt leads Suburban's strategic planning process. In addition to providing direction on the incorporation and alignment of community health improvement in the organization's strategic goal-setting process, Ebbitt ensures support of the Hospital's cardiovascular outreach to southern Maryland priority areas.
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury, works in coordination with Community Health and Wellness Division, compiling and completing the financial data into the Community Benefit data collection sheet submitted to the HSCRC.
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness, leads health improvement efforts specifically related to cardiovascular, diabetes, and stroke prevention for the Hospital's community benefit service area as well as in Prince George's, Calvert and St. Mary's counties. In this capacity, McGrail coordinates the planning, organization, development and implementation of community education programs, health partnerships, and blood pressure and cholesterol screenings. As program manager of health outcomes and evaluation, McGrail also leads the implementation planning process, which guides the work of the community health and wellness division and measures the impact of its programs on identified health needs.
- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness spearheads the Hospital's community health needs assessment and implementation processes as she works diligently with County health improvement team to provide feedback and recommendations on the community health improvement plan. She also leads diabetes education efforts for the community, and serves as a liaison for ethnic and multicultural populations. She works closely with safety net clinics and local health coalitions that increase access to chronic disease treatment and prevention for Montgomery County's uninsured and underserved residents. Specific efforts include screening and education for colorectal cancer, hypertension and stroke, as well as nutritional counseling. Rios is also responsible for overseeing the hospital's quarterly blood drive, and is the primary contact for public health internships and volunteering.
- Sunil Vasudevan, Senior Director, Finance and Treasury, supervises and ensures that the completion of the Community Benefit data collection sheet has met the Maryland Health Services Cost Review Commission's (HSCRC) standards and guidelines. Vasudevan supports the management of Suburban Hospital in monitoring the performance metrics/goals to achieve operational targets and utilizes internal and external information to report to health care regulatory agencies.

ii. Committee (please list members):

JHHS Community Health Improvement Strategy Council✓:

The Johns Hopkins Health System Community Health Improvement Strategy Council (CHISC) is responsible for collecting and reporting community benefit activities to the president of JHHS and each hospital president and chief financial officer, the HSCRC and IRS annually. The Council meets monthly to discuss data collection, infrastructure of community benefit planning and evaluation.

The Johns Hopkins Hospital

- Sherry Fluke, Senior Financial Analyst, Govt. & Community Affairs (GCA)
- Sudanah Gray, Budget Analyst, GCA
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
- William Wang, Associate Director, Strategic Initiatives, GCA

Johns Hopkins Bayview Medical Center

- Patricia A. Carroll, Manager, Community Relations
- Kimberly Moeller, Director, Financial Analysis and Special Projects
- Selwyn Ray, Director, Community Relations JHBMC, Health and Wellness

Howard County General Hospital

- Elizabeth Edsall-Kromm, Vice President, Population Health and Advancement
- Laura Hand, Director, Strategic Planning
- Fran Moll, Manager, Regulatory Compliance
- Scott Ryan, Senior Revenue Analyst

Suburban Hospital

- Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness
- Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness
- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
- Monique Sanfuentes, Administrative Director, Community Affairs and Population Health, Community Health and Wellness
- Sunil Vasudevan, Senior Director of Finance and Treasury, Finance and Treasury

Sibley Memorial Hospital

- Marti Bailey, Director, Sibley Senior Association and Community Health
- Courtney Coffey, Community Health Program Manager
- Angel Fernandez, Financial Analyst
- Marissa McKeever, Director, Government and Community Affairs
- Honora Precourt, Community Program Coordinator

Johns Hopkins All Children's Hospital

- Jill Pucillo, Accounting Manager
- Alizza Punzalan-Randle, Community Engagement Manager

Johns Hopkins Health System

- Christopher Davis, Senior Director, Tax Compliance
- Bonnie Hatami, Senior Tax Accountant
- Sandra Johnson, Vice President, Revenue Cycle Management
- Anne Langley, Senior Director, Health Policy Planning and Community Engagement

iii. Suburban Hospital Community Benefit Advisory Council✓:

Suburban Hospital's Community Benefit Advisory Council (CBAC) is comprised of a diverse group of local business, not-for-profit executives and community advocacy leaders. Chartered by the Hospital's Board of Trustees and chaired by a trustee, the Advisory Council exists to guide and participate in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital.

- Norman Jenkins, Founder and CEO of Capstone Development, LLC. (Chairman)
- Mark Bergel, Ph.D., Founder and Executive Director, A Wider Circle
- Belle Brooks O'Brien, Community Advocate
- Crystal Carr Townsend, President, Healthcare Initiative Foundation
- Betsy Carrier, Treasurer, Bradley Hills Village
- Eva Cohen, President, Bradley Hills Village
- Diane Colgan, M.D., Community Physician and Medical Staff Chair for Suburban Hospital
- Ken Hartman, Regional Services Director, Bethesda Chevy Chase Regional Services Center
- Carla P Larrick, Vice President of Operations, YMCA of Metropolitan Washington
- Elizabeth McGlynn, Executive Director, Girls on the Run Montgomery County
- Stacy C. Murchison, Chief Marketing Officer, Chevy Chase Trust
- Carmen Ortiz Larsen, President of AQUAS, Incorporated
- Michael Prather, officer, Montgomery County Police Department
- Brandy B. Sanders, Chief Human Resources Officer - SVP, Human Resources, Total Wine and More
- Michael Smith, M.D., Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter
- Anastasia Snelling, Ph.D., Professor and Department Chair, Health Studies American University
- Dana Stroman, officer, Montgomery County Police Department
- Michael K. Yuen, CPA, Aronson, LLC

Suburban Staff

- Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury
- Adrienne Gude, Major Gifts Manager, Suburban Hospital Foundation
- Brian Ebbitt, Chief of Staff, Administration
- Monique Sanfuentes, Administrative Director, Community Affairs and Population Health, Community Health and Wellness
- Jacqueline Schultz, President
- Leslie Ford Weber, Director, Campus, Government and Community Affairs, Montgomery County

iv. Patient and Family Advisors ✓:

The Patient and Family Advisory Council (PFAC) brings together patient and family advisors and Suburban Hospital clinical, administrative, and executive staff to foster a culture of patient- and family-centered care. The PFAC works to help transform Suburban to a model of care that engages patients and their families as equal partners in care, exchanging information with them in useful and understandable ways, and encouraging and supporting their involvement in health care.

- Karin Bertozzi
- Stephen Bokat*
- Sarah Cuneo
- Elsie Durland
- Howard Gilson
- June Graff
- Joel Hirschhorn
- Jean Hochron
- Barbara Kahl
- Deborah Kovach
- Barrie Kydd
- Toby Levin
- Kathleen McGuiness
- Carol McLeod
- Belle O'Brien
- Vicki Stearn
- Sarah Steinberg
- Sahiba Zubairi
- Mark Zweig

Staff Advisors

- Diane Colgan, M.D., Medical Staff Chair
- Joanne Crowley, M.S.N., R.N., O.N.C., Nursing Director, Orthopaedics, Neuro-and Adult Surgery Unity
- Eunice D'Augostine, M.S.N., R.N., Nursing Director, Adult Medical
- Kris Hakanson, Director, Patient and Family Experience
- Brian Ebbitt, Chief of Staff, Administration
- Kimberley Kelly, M.S.N., R.N., C.C.R.N.-K, Nursing Director, Critical Care
- Joseph H. Linstrom, Vice President, Operations
- Amir Nader, M.D., Progressive Cardiac Care Unit, Medical Director
- Jennifer Raynor, Director, Pharmacy
- Atul Rohatgi, M.D., Assistant Medical Director, Hospitalist Group
- Jacqueline Schultz, President
- LeighAnn Sidone, M.S.N., R.N., O.C.N., C.E.N.P., Vice President and Chief Nursing Officer*

*co-chairperson

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

Spreadsheet__✓___Yes _____No

Narrative __✓___Yes _____No

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

The Community Benefit report is reviewed in detail by Suburban Hospital Executive Leadership, the Community Benefit Advisory Council (CBAC), and the Planning and Finance Departments which includes a one on one with the CFO. Specifically, weeks before submitting the report, Johns Hopkins Health System hospitals meet for a formal review with the System's President and executive vice president of Johns Hopkins Medicine, Mr. Ronald Peterson. In addition, community benefit is integrated into the system's strategic plan and is reviewed quarterly with members of Management Communication Forum and the Hospital's Leadership Clinical Operations Team. The Johns Hopkins Health System's Executive Vice President, the Hospital's President and CFO all review and sign off the on the narrative and data collection before it is submitted to the HSCRC. The report is vetted though the Community Benefit Advisory Council chaired by Mr. Norman Jenkins and the Hospital's Board of Trustees chaired by Mr. Howard Gleckman.

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

Spreadsheet__✓___Yes_____No
Narrative __✓___Yes _____No

If no, please explain why.

Led by its chairman, Mr. Howard Gleckman, the Hospital's Board of Trustees dedicates time at a board meeting to review and approve the Community Benefit Report. In addition to the Hospital's Board reviewing and approving the complete Community Benefit Report, the FY17 community benefit deliverables are also reviewed in detail by the CEO and CFO of the Johns Hopkins Health System prior to submission to the HSCRC. Notably, Mr. Gleckman is a Resident Fellow at the Urban Institute and has been covering healthcare as well as tax and budget issues as a journalist for over three decades. Consequently of his professional experience, he has been engaged in the Community Benefit and Health Improvement Process at Suburban Hospital.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

__✓___Yes _______No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

Integrating both the hospital's implementation and internal strategic goals, the Transformation plan is aligned with the objective of providing a guided healthcare system to our most vulnerable patients and communities. Deliberately applying a collective impact approach, Community Health and Wellness and Care Coordination guides and supports the following population health objectives:

- The Hospital will support its Transition Guide Nurses whose goal is to ensure a seamless transition and better manage patients' complex needs from hospital to home through the Care Partner Initiative.
- The Hospital will initiate a re-admissions reduction strategy by supporting a Village Alliance Model to support "Aging in Place" within Suburban's CBSA zip codes.
- The Hospital will utilize data analytics to identify vulnerable communities in Suburban CBSA zip codes to support and integrate population health-specific interventions with the goal of reducing health inequities as outlined by Community Health Improvement Report.
- The Hospital will integrate population health interventions aimed at reducing health inequities and partner with Safety Net Clinics in Montgomery County to increase access of care to underserved populations and provide a continuum of care in chronic disease management interventions.
- The Hospital will leverage current stakeholder resources to identify and address gaps within population-specific behavioral health disparities and seek to improve access to urgent care mental health services through Healthy Montgomery and by partnering with Safety Net Clinics.

Furthermore, Suburban Hospital is a founding member of NexusMontgomery, a unique and formal health transformation collaborative of all six hospitals in Montgomery County, Maryland, focused on achieving quality community health improvement via enhancing patient care, improving population health and lowering total health care costs for seniors.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

__✓___ Other hospital organizations
__✓___ Local Health Department
__✓___ Local health improvement coalitions (LHICs)
__✓___ Schools
__✓___ Behavioral health organizations
__✓___ Faith based community organizations
__✓___ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

The Healthy Montgomery community health improvement process is a community-based effort to improve the health and well-being of Montgomery County residents. 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. The community health improvement process includes data collection, identification of areas for improvement, priority-setting, strategic planning, implementation planning, and collaborative efforts to address the priority needs in Montgomery County and evaluate the success of the improvement efforts.

Organization	Name of Key Collaborator	Title	Collaboration Description
Montgomery County Council	Mr. George Leventhal	Councilmember	Co-chair of Healthy Montgomery
Mana Food Center	Ms. Jackie DeCarlo	Executive Director	Co-chair of Healthy Montgomery
Montgomery County Department of Health and Human Services	Ms. Uma Ahluwalia	Director	Steering Committee Member, Healthy Montgomery
AmeriGroup	Ms. Marcia Alphonso	Network Consultant	Steering Committee Member, Healthy Montgomery
Montgomery County Public Schools	Dr. Jonathan Brice	Associate Superintendent	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Health and Human Services	Dr. Raymond Crowel	Chief, Behavioral Health and Crisis Services	Steering Committee Member, Healthy Montgomery
Maryland General Assembly	Delegate Bonnie Cullison	Member of the House of Delegates	Steering Committee Member, Healthy Montgomery
Kaiser Permanente	Ms. Tanya Edelin	Director, Reporting and Compliance, Community Benefit	Steering Committee Member, Healthy Montgomery
Primary Care Coalition of Montgomery County	Ms. Leslie Graham	President and Chief Executive Officer	Steering Committee Member, Healthy Montgomery

Montgomery County Department of Health and Human Services	Dr. Travis Gayles	County Health Officer and Chief of Public Health Services (Acting)	Steering Committee Member, Healthy Montgomery
Public Health Foundation	Dr. Michelle Hawkins	Commission on Health	Steering Committee Member, Healthy Montgomery
Montgomery County Collaboration Council for Children, Youth, and Families	Ms. April Kaplan	Executive Director	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Planning	Ms. Amy Lindsey	Senior Planner	Steering Committee Member, Healthy Montgomery
Adventist Healthcare	Dr. Marilyn Dabady Lynk	Executive Director	Steering Committee Member, Healthy Montgomery
Medstar Montgomery Medical Center	Ms. Dairy Marroquin	Community Outreach Coordinator	Steering Committee Member, Healthy Montgomery
Holy Cross Hospital	Ms. Kimberley McBride	Community Benefit Officer	Steering Committee Member, Healthy Montgomery
Ronald D. Paul Companies	Ms. Kathy McCallum	Controller	Steering Committee Member, Healthy Montgomery
Carefirst Blue Cross Blue Shield African American Health Program	Ms. Beatrice Miller	Senior Regional Care Coordinator Member	Steering Committee Member, Healthy Montgomery
Montgomery Parks	Ms. Rachel Newhouse	Park Planner Coordinator	Steering Committee Member, Healthy Montgomery
Asian American Health Initiative	Dr. Nguyen Nguyen	Member	Steering Committee Member, Healthy Montgomery

Montgomery County Department of Transportation	Mr. Samuel Oji	Senior Planning Specialist	Steering Committee Member, Healthy Montgomery
Proyecto Salud Health Center Latino Health Initiative	Dr. Cesar Palacios	Executive Director Member	Steering Committee Member, Healthy Montgomery
Montgomery County Recreation Department	Dr. Joanne Roberts	Program Manager	Steering Committee Member, Healthy Montgomery
Suburban Hospital	Ms. Monique Sanfuentes	Administrative Director, Community Affairs & Population Health	Steering Committee Member, Healthy Montgomery
Georgetown University School of Nursing and Health Studies	Dr. Michael Stoto	Professor	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Health and Human Services	Dr. Ulder J. Tillman	Officer and Chief, Public Health Services	Steering Committee Member, Healthy Montgomery
Department of Housing and Community Affairs	Ms. Myriam Torrico	Community Program Manager	Steering Committee Member, Health Montgomery

Suburban Hospital's Community Benefit Advisory Council (CBAC) is comprised of a diverse group of local business, non-for-profit executives and community advocacy leaders. Chartered by the Hospital's Board of Trustees and chaired by a trustee, the Advisory Council exists to guide and participate in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital. Working directly with the Community Health and Wellness Division, members of CBAC provide governance in the direction and implementation process of the Hospital's Community Needs Assessment and Community Benefit Report.

Capstone Development, LLC	Mr. Norman Jenkins	Founder and CEO	Chairman of Suburban Hospital's Community Benefit Advisory Council; facilitates the Advisory meetings; Suburban Hospital Board of Trustees.
A Wider Circle	Dr. Mark Bergel, Ph.D.,	Founder and Executive Director	Member of Suburban Hospital's Community Benefit Advisory Council;

			offers unique community perspective as his organization works with the underserved population.
Community Advocate	Ms. Belle Brooks O'Brien	Resident of Montgomery County	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital Board of Trustees
Healthcare Initiative Foundation	Ms. Crystal Carr Townsend	President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Betsy Carrier	Treasurer	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Eva Cohen	President	Member of Suburban Hospital's Community Benefit Advisory Council
Community Physician	Dr. Diane Colgan	Medical Staff Chair for Suburban Hospital	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital Board of Trustees
Bethesda Chevy Chase Regional Services Center	Mr. Ken Hartman	Regional Services Director	Member of Suburban Hospital's Community Benefit Advisory Council; host facility for many CHW programs.
YMCA of Metropolitan Washington	Ms. Carla P Larrick	Vice President of Operations	Member of Suburban Hospital's Community Benefit Advisory Council
Girls on the Run, Montgomery County	Ms. Elizabeth McGlynn	Executive Director	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital

			supports GOTR as it official health sponsor providing financial support, training for coaches and health education at bi-annual races.
Chevy Chase Trust	Ms. Stacy C. Murchison	Chief Marketing Officer	Member of Suburban Hospital's Community Benefit Advisory Council
AQUAS, Incorporated	Ms. Carmen Ortiz Larsen	President	Member of Suburban Hospital's Community Benefit Advisory Council
Montgomery County Police Department	Mr. Michael Prather	Officer	Member of Suburban Hospital's Community Benefit Advisory Council; Partners with CHW to bring safety information to the Hospital's CBSA community.
Total Wine and More	Brandy B. Sanders	Chief Human Resources Officer - SVP, Human Resources	Member of Suburban Hospital's Community Benefit Advisory Council
Community Physician	Dr. Michael Smith	Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter	Member of Suburban Hospital's Community Benefit Advisory Council; Partners with CHW in bringing health education to Alpha Phi Alpha Montgomery County Chapter
American University	Dr. Anastasia Snelling	Professor and Department Chair, Health Studies	Member of Suburban Hospital's Community Benefit Advisory Council

Montgomery County Police Department	Ms. Dana Stroman	Officer	Member of Suburban Hospital's Community Benefit Advisory Council; Partners with CHW to bring safety information to the Hospital's CBSA community.
Aronson, LLC	Mr. Michael K. Yuen	Certified Public Accountant	Member of Suburban Hospital's Community Benefit Advisory Council

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars? If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

____Yes _✓_No

Montgomery County is unique in that there are six hospitals located within a short distance of one another to serve community healthcare needs. For this reason, there was a deliberate decision to not have the hospitals serve as co-chairs and to focus on impartial stakeholders to lead in this role. For example, one co-chair of the County's LHIC is Council Member George Leventhal. However, Suburban Hospital is a committed and consistent steering committee lead of the County's LHIC, Healthy Montgomery (Monique Sanfuentes), Behavioral Health Task Force (BHTF) (Beth Kane-Davidson, Addiction Treatment Center), Healthy Montgomery Chronic Disease Cluster (CDC) (Sara Demetriou and Kate McGrail) and the Healthy Montgomery Measurement & Evaluation Subcommittee (Patricia Rios and Eleni Antzoulatos). In addition, Suburban Hospital also provides supplemental in-kind support for Healthy Montgomery by providing light meals at one of the bi-quarterly meetings.

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

_✓_Yes _____No

Yes, Ms. Monique L. Sanfuentes is a member of the Healthy Montgomery Steering Committee and attends the committee's bi-quarterly meetings.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Suburban Hospital recognizes the community's unmet or potential health needs by participating in community coalitions, partnerships, advisory groups, boards, panels, committees, and serving on local County commissions and working with public health officials at the Montgomery County Department of Health and Human Services (MCDHHS). In FY17, Suburban Hospital delivered $21,607,689.39 in community benefit contributions and conducted 2,613 community health improvement programs,

screenings, classes, seminars and activities serving 69,489 individuals; of which 12,251 are a high-risk population defined as being homeless, employment or insurance status, from an immigrant community, vulnerable children or the elderly. Minorities in Montgomery County are one of the fastest growing populations representing 53.1% of Suburban Hospital's CBSA and as a result the Hospital targets programs within those groups to reduce health disparities. (See Exhibit 1)

In 1998, a Community Outreach Vision was established through a community health advisory council comprising health department officials and local community stakeholders. The council approved the following target areas of need: 1.) Access to Care, 2.) Management and Prevention of Chronic Disease, 3.) Underserved Seniors, and 4.) Vulnerable Youth. The Healthy Montgomery needs health assessment validated that the Community Outreach vision established nineteen years ago is still relevant today.

Suburban Hospital continues to work to distinguish health priorities and generate solutions to address the growing challenges of preventing chronic disease, increasing access to care, and building safe and healthy communities in its Community Benefit Service Area.

Below is an example of community benefit activities that met major community needs in FY17.

- Nurses at four HeartWell clinics - located in Silver Spring, Gaithersburg, Wheaton and Chevy Chase - cared for an average of 519 patients per month, totaling 6,228 preventive clinic visits. The encounters include free blood pressure screenings, one-on-one counseling, disease prevention and management sessions, small and large group educational programs.

- Montgomery Cares patients have received access to expert care from cardiologists, specialty diagnostic screenings, and open heart surgery since the inauguration of the MobileMed/NIH Heart Clinic at Suburban Hospital in 2007, totaling over 4,000 patient visits. In FY17, there were 414 encounters, with 297 unduplicated patients at the MobileMed/NIH Heart Clinic.

- More than 1,800 patients have access to the specialty care of endocrine diseases through the MobileMed/NIH Endocrine Clinic at Suburban Hospital that was established in July 2010. In FY17, there were 322 encounters with 133 unduplicated patients at the MobileMed/NIH Endocrine Clinic.

- The Suburban Hospital Heart Center is dedicated to advancing the understanding and importance of heart care by addressing the most vulnerable populations' cardiovascular health needs through education and outreach. In FY17, cardiovascular outreach in Southern Maryland, engaging 4,952 individuals through 347 health improvement activities to improve healthy lifestyles of residents in Prince George's, Calvert, and St. Mary's counties.

- Medical Exploring and Job Shadowing resulted in 21 educational events for 801 students interested in pursuing careers in medicine.

- The Safe Sitter course at Suburban has produced 997, 11-13 year - old graduates who learned safety essentials of babysitting in 2017.

- 219 monthly blood pressure screenings conducted at area mall-walking programs and community centers contributed to assisting nearly 3,000 individuals to know their numbers and take better charge of their health in Montgomery and Prince George's counties.

- 1,141 Senior Shape classes taught by certified exercise instructors built flexibility, strength, and healthy hearts for thousands of seniors across Montgomery and Prince George's counties.

- Staff from Suburban Hospital coordinated, supported and contributed to 61 health education seminars and awareness events throughout Montgomery County, reaching over 3,677 people, including vulnerable seniors, youth and minority groups. These events are free, open to the public and advertised through the Hospital's newsletter and social media. Topics ranged from: *"Caring for the Skin You're In"* and *"Recipe for a Happy Tummy"* to *"Aging in Place"* and *"Colorectal Cancer education."*

- Since 2003, Suburban has hosted 25 YMCA parenting workshops that educated 1,905 families on issues facing parents today, from "*More Joy and Less Stress: Parenting with Courage and Uncommon Sense*" to "*Helping Children to Manage the Challenges of Separation and Divorce*."

- Since its inception seven years ago, the *Knots for Shots* health initiative program has provided uninsured and homeless county residents with a free hat, scarf or blanket in exchange for getting a flu shot and in doing so reaching out to close to 1,000 residents in Montgomery County who would otherwise not seek the vaccination.

- Suburban Hospital joined the nationwide campaign to empower individuals to act quickly and save lives by launching Stop-the-Bleed® - a free training designed by the American College of Surgeons Committee on Trauma. During the two-hour workshop, individuals with little or no medical training learn bleeding control techniques using their hands, dressings and tourniquets. Approximately 200 community members were trained in FY17.

1. **Table III, Initiative 1.MobileMed/NIH Heart Clinic at Suburban Hospital**

Identified Need	Cardiovascular Disease; Access to specialty care. In Montgomery County, the age adjusted rate for heart disease is 107.5 deaths per 100,000[50] while in Suburban Hospital's CBSA, the age adjusted death rate is 108.1 per 100,000.[51] In addition, 6.5% of residents in Montgomery County do not have any type of health insurance coverage.[52] Suburban Hospital's 2016 Community Health Needs Assessment identified cardiovascular disease as one of its five priorities.
Hospital Initiative	MobileMed/NIH Heart Clinic at Suburban Hospital

[50]Healthy Montgomery, www.healthymontgomery.org
[51] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results
[52] American Community Survey, 2016

Total Number of People within Target Population	The age adjusted rate in Montgomery County is 107.5 deaths per 100,000[53] population while in Suburban Hospital's CBSA, the age adjusted death rate is 108.1 per 100,000.[54] In addition, 6.5% of residents in Montgomery County do not have any type of health insurance coverage.[55]
Total Number of People Reached by Initiative	In FY17, there were 414 encounters, with 297 unduplicated patients who attend the MobileMed/NIH Heart Clinic at Suburban Hospital.
Primary Objective	The MobileMed/NIH Heart clinic at Suburban Hospital seeks to reduce the number of deaths associated with coronary heart disease in Montgomery County. A Cardiovascular clinic is held one night a week at Suburban Hospital where uninsured individuals have access to cardiac care, diagnostic tests, surgery and rehabilitation when needed, at little or no cost. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients and managing associated risk factors with coronary heart disease.
Single or Multi-Year Initiative Time Period	Multi-Year; From July 1, 2016 to June 30, 2017, the clinic is opened every Thursday night from 3:30pm-8:00pm in the NIH Heart Center at Suburban Hospital. The clinic has been opened since October 2007.
Key Collaborators in Delivery	Suburban Hospital, MobileMed, Inc., the National Institute of Heart, Lung and Blood (NHLBI), Community Cardiologists. Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Heart, Lung and Blood and MobileMed-volunteer their time to staff the cardiovascular clinic.
Impact/Outcome of Hospital Initiative	The clinic was evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Number of racial and ethnic patients served. Outcomes for FY17: – In FY17, there were 414 encounters, with 297 unduplicated patients. The top five diagnosis (ICD-10 codes): I10 Essential (primary) hypertension (26.5% of encounters), I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris (3.4% of encounters), I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (2.7% of encounters), R00.2 Palpitations (3.4% of encounters), R07.9 Chest pain, unspecified (5.6% of encounters). – Compared to FY16, there was nearly a 9% increase in the number of patients treated for hypertension (101 in FY 16 vs. 110 in FY17). – The racial breakdown of clinic patients was as follows: 24.6% Black or African American, 8.8% Asian, 15.8% White, non-Hispanic, 44.1% Other

[53]Healthy Montgomery, www.healthymontgomery.org
[54] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results
[55] American Community Survey, 2016

	Race, 0.7% American Indian or Pacific Islander, 6.0% Unreported/Refused to Report.
Evaluation of Outcome (Include process and impact measures)	The MobileMed/NIH Heart clinic at Suburban Hospital has been in operation since 2007. Over the 10-year period, the clinic has had over 4,000 encounters and served more than 3,000 uninsured patients in need of cardiovascular specialty care. These are individuals that would have not received cardiovascular specialty care. During this same period, we have provided more than 10 open-heart surgeries. Each year, the clinic measures its success by whether the number of patients it serves increases (short-term goal); whether effective treatment of the different conditions that put the patients at risk for cardiovascular disease is reduced (mid-term goal); and by improving their quality of life while reducing their risk from pre-mature coronary heart disease mortality (long-term goal).
Continuation of Initiative	Yes, The MobileMed/NIH Heart Clinic is in its tenth year and continues to expand. Since the clinic is volunteer-based, one of the challenges has been to recruit enough nurses to support the clinic on a weekly basis. One of the ways to meet this challenge has been to increase recruitment efforts throughout the Hospital through an internal communication publication. The mechanism for which the clinic has been successful is through the collaborative process between Suburban Hospital, MobileMed and NHLBI while leveraging resources. For example, the Hospital donates the space and supplies and services to the clinic while NHLBI physicians from donate their time and MobileMed refers the patients to the clinic. This has served as a mechanism for success as it builds on strengthens of each partner.

Expense A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $233,806.00	B. Direct offsetting revenue from Restricted Grants

Table III, Initiative 2. MobileMed/NIH Endocrine Clinic at Suburban Hospital

Identified Need	Diabetes, Access to specialty care. Suburban Hospital's 2016 Community Health Needs Assessment identified diabetes as one of its five priorities. The age-adjusted hospitalization rate due to diabetes is 11.6 per 10,000 population aged 18 years and older.[56] Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[57] 6.5% of residents in Montgomery County do not have any type of health insurance coverage.[58]

[56] The Maryland Health Services Cost Review Commission, 2009-2011.
[57] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2009-2013 Results."
[58] American Community Survey, 2016

Hospital Initiative	Mobile Med/NIH Endocrine Clinic at Suburban Hospital
Total Number of People within Target Population	The age-adjusted hospitalization rate due to uncontrolled diabetes is 0.9 per 10,000 population aged 18 years and older.[59] Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[60]
Total Number of People Reached by Initiative	In FY17, there were 322 encounters with 133 unduplicated patients at the MobileMed/NIH Endocrine Clinic.
Primary Objective	The MobileMed/NIH Endocrine clinic at Suburban Hospital seeks to reduce the number of deaths in Montgomery County associated from complications from endocrine diseases including diabetes. An Endocrine clinic is held one night a week at Suburban Hospital where uninsured individuals have access to the specialty care of endocrine conditions and diseases, from diagnostic tests, examinations, and one-on-one consultation with a Suburban Hospital Registered Dietitian, at little or no cost. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients and managing associated risk factors with endocrine diseases. The objective of clinic is twofold- 1.) Increase access of specialty care to patients who would not otherwise receive care and 2.) Reduce the incidence of complications due to endocrine diseases including diabetes.
Single or Multi-Year Initiative Time Period	Multi- Year; From July 1, 2016 to June 30, 2017, the clinic operates every Thursday night from 4:00 pm-7:30 pm at the Johns Hopkins Health Care and Surgery Center in Bethesda, MD. The clinic has been opened since July 2010.
Key Collaborators in Delivery	Suburban Hospital, MobileMed. Inc., and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Diabetes and Digestive and Kidney Diseases and MobileMed-volunteer their time to staff the endocrine clinic.
Impact/Outcome of Hospital Initiative	The clinic is evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Improved health status of patients. – Number of racial and ethnic patients served. Outcomes for FY17: – In FY17, there were 322 encounters with 133 unduplicated patients. – The clinic continues to see improvements in Hemoglobin A1C (HbA1C) among diabetic patients, as nearly two-thirds of patients lowered their A1C in FY17. The clinic continues to demonstrate effective diabetes care. Despite the complexity of the cases, over 60% of diabetic patients seen are now under good control (A1C<7) and/or have shown improvement. The average A1C result among these patients is 8.2 in FY17.

[59] The Maryland Health Services Cost Review Commission, 2009-2011.
[60] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2009-2013 Results."

	– Of those 322 encounters, the top five diagnosis (ICD-10 codes) are: E11.9 Diabetes mellitus without mention of complications (17.7% of encounters), E11.65 Type 2 diabetes mellitus with hyperglycemia (17.4% of encounters), E11.8 Type 2 diabetes mellitus with unspecified complications (5.6% of encounters), E05.00 Thyrotoxicosis with diffuse goiter thyrotoxic crisis or storm (3.11% of encounters) and E03.9 Hypothyroidism, unspecified (4.0% of encounters). – The racial breakdown of clinic patients was as follows: 34.6% Black or African American, 6.8% Asian, 13.5% White, 39.8% Other Race, 0.8% American Indian, 4.5% Unreported/Refused to Report.
Evaluation of Outcome (Include process and impact measures)	The MobileMed/NIH Endocrine clinic at Suburban Hospital has been in operation since 2010. During the seven-year period, the clinic has served over 1,800 uninsured patients in need of endocrine specialty care who would have otherwise not been seen. During this same period, we have seen an improvement of Hemoglobin A1C. Each year, the clinic measures its success by continued improvement of Hemoglobin A1C among diabetic patients (short-term goal); access to quality diabetes management and treatment for at-risk residents (mid-term goal); and by improving patient's quality of life while reducing their risk from complications from diabetes morbidity (long-term goal).
Continuation of Initiative	One of the challenges of the clinic has been the high turnover of clinic administrator, the person responsible for calling patients and registering them for the clinic. However, this continues to be a priority and funding has been identified to secure a person for this role. A focus for FY18 is to provide diabetes self-management education for patients with diabetes. In FY17, the MobileMed/NIH Endocrine clinic celebrated its seventh year of operation. The clinic will continue to operate and bridge the gap in access to specialty care.

Expense C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	C. Total Cost of Initiative $10,804.00	D. Direct offsetting revenue from Restricted Grants

Table III, Initiative 3. Senior Shape Exercise Program

Identified Need	Cardiovascular Health, Obesity, Behavioral Health. Suburban Hospital's 2017 Community Health Needs Assessment identified cardiovascular, obesity and behavioral health as three of its priorities. Heart disease continues to be the leading cause of death in Montgomery County as the age adjusted rate in Montgomery County is 107.5 deaths/100,000

	population[61] while in Suburban Hospital's CBSA, the age adjusted rate is 108.1 deaths per 100,000.[62]
Hospital Initiative	Senior Shape Exercise Program
Total Number of People within Target Population	Heart disease continues to be the leading cause of death in Montgomery County as the age adjusted rate is 107.5deaths per 100,000[63] while in Suburban Hospital's CBSA, the age adjusted rate is 108.1 deaths per 100,000.[64]
Total Number of People Reached by Initiative	494 Montgomery County residents were enrolled in the Senior Shape classes during FY17.
Primary Objective	The Senior Shape Program provides active seniors a safe, low to high impact exercise regimen that focuses on strength and weight training, balance, flexibility, stretching and aerobic activity for optimal cardiovascular benefits and stamina. Held in senior and community centers in Montgomery and Prince George's Counties, fitness assessments are performed every six months during their class period to measure the participant's balance, strength, flexibility and endurance. The goal of Senior Shape Program is to increase physical activity and fitness among the senior population by creating access to age-specific exercise programs.
Single or Multi-Year Initiative Time Period	Senior Shape classes are held on an ongoing basis, occurring from July 1, 2016 to June 30, 2017; Multiple exercise classes were held either once or twice a week at ten different senior centers in Montgomery and Prince George's Counties. Bi-annual fitness assessment designed to test the Senior Shape member's balance, strength; flexibility and endurance were held during class time.
Key Collaborators in Delivery	Suburban Hospital Community Health and Wellness Division, Montgomery County Department of Recreation (Holiday Park Senior Center, Margaret Schweinhaut Senior Center, Benjamin Gaither Center, Clara Barton Community Center, Potomac Community Center, North Potomac Community Center, Jane E. Lawton Community Center, Wisconsin Place Community Center) Bethesda Regional Service Center, and Parks and Recreation of Prince George's County (Gwendolyn Britt Community Center).
Impact/Outcome of Hospital Initiative	Suburban Hospital holds a bi-annual fitness assessment designed to test the Senior Shape member's balance, strength, flexibility and endurance against national data through 4 exercises twice a year, during class time. The fitness assessments were held at 6 of the 10 community centers in Montgomery and Prince George's counties. The assessment included the Chair Sit and Reach, Arm Curl, 2 Minute Step in Place and the Chair Stand.

[61]Healthy Montgomery, www.healthymontgomery.org
[62] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results
[63]Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[64] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results

Based on the fitness assessment results, all of the seniors either met or exceeded the national average for their age range. When comparing the average results between genders from November to May, the average number of Chair Stands and Arm Curls increased while the average number of Chair Sit and Reaches decreased. Regarding the 2 Minute Step in Place, the averages between males and females was the same but decreased by one step between the assessments. Please see below information for specifics.

Senior Shape participants in FY17= 494

Number of sessions held in FY17 = 1,216

Locations= 9 in Montgomery County & 1 in Prince George's Count

Fitness Assessment Results from November 2016:

Test	Average Females	Average National Standard Females	Average Males	Average National Standard Males
Chair Stand (# of stands in 30 seconds)	**16**	**4 - 17**	**16**	**7 - 12**
Arm Curl (# of reps in 30 seconds)	**19**	**8 - 19**	**19**	**10 - 22**
2 Minute Step in Place (# of steps in a 2 minute time period)	**114**	**44 - 107**	**114**	**52 – 116**
Chair Sit & Reach (inches +/-)	**0.9**	**-4.5 - 5.0**	**0.9**	**-6.5 - 4.0**

Fitness Assessment Results from May 2017:

Test	Average Females	Average National Standard Females	Average Males	Average National Standard Males
Chair Stand	**17**	**4 - 17**	**17**	**7 - 12**

(# of stands in 30 seconds)				
Arm Curl (# of reps in 30 seconds)	**22**	**8 - 19**	**22**	**10 - 22**
2 Minute Step in Place (# of steps in a 2 minute time period)	**113**	**44 - 107**	**113**	**52 - 116**
Chair Sit & Reach (inches +/-)	**0.48**	**-4.5 - 5.0**	**0.49**	**-6.5 - 4.0**

Aside from the bi-annual fitness assessments, a brief qualitative survey was distributed in June 2017 to gather feedback on the experiences and health impact the program has had on the Senior Shape members. In addition, Suburban Hospital collaborated with the other Montgomery County hospitals and added 3 quantitative questions related to their number of hospital stays and possible readmissions. Due to the format of the survey and the software used, the members were not required to complete a response for each question. The questions and results from this survey as it relates to their health are as follows:

1. **Please rate your Senior Shape experience in regard to how it has impacted your life and daily activities.**
   a. *It has increased my range of motion.*
      4-strongly disagreed
      1-disagreed
      19-neither agreed or disagreed
      42-agreed
      64-strongly agreed
      6-N/A

   b. *It has improved my quality of life.*
      4-strongly disagreed
      0-disagreed
      15-neither agreed or disagreed
      48-agreed
      63-strongly agreed
      5-N/A

   c. *My level of strength and flexibility has increased since I started the program.*
      4-strongly disagreed
      1-disagreed
      16-neither agreed or disagreed

	48-agreed 61-strongly agreed 5-N/A d. *The class has improved my health and wellbeing.* 5-strongly disagreed 0-disagreed 9-neither agreed or disagreed 42-agreed 73-strongly agreed 6-N/A 2. **I have noticed improvements or have been able to maintain healthy levels of the following health measures**: a. *Blood Pressure:* 1-strongly disagreed 1-disagreed 42-neither agreed or disagreed 42-agreed 21-strongly agreed 24-N/A b. *Cholesterol:* 1-strongly disagreed 1-disagreed 46-neither agreed or disagreed 37-agreed 21-strongly agreed 24-N/A *c. Glucose and HbA1c (blood sugar:* 1-strongly disagreed 2-disagreed 43-neither agreed or disagreed 34-agreed 19-strongly agreed 29-N/A *d. Body Weight:* 2-strongly disagreed 3-Strongly disagree 3-disagreed 38-neither agreed or disagreed 50-agreed 33-strongly agreed 6-N/A The 3 additional questions included in collaboration with the Montgomery County hospitals are as follows: 1. **In the past 12 months, how many times did you go to a hospital emergency room for treatment for yourself?**

	a. None/0 - 127 Responses b. Once - 21 Responses c. Twice - 7 Responses d. 3x - 1 Response e. 4x - 0 Responses 2. **How many different times were you admitted to a hospital overnight or longer in the past 12 months?** a. None/0 - 156 Responses b. Once - 2 Responses c. Twice - 0 Responses d. 3x - 1 Response e. 4x - 0 Responses 3. **How many total nights did you spend in the hospital in the past 12 months?** a. None/0 - 147 Responses b. Once - 5 Responses c. Twice - 5 Responses d. 3x - 2 Response e. 4x - 1 Responses
Evaluation of Outcome (Include process and impact measures)	The Senior Shape Program classes are designed to improve the cardiovascular health and overall fitness of the participants. The results from the fitness assessment show that they are meeting or, in many cases, exceeding what is considered normal for their age range and therefore meeting the national fitness standard (short-term); increase participant's cardiovascular endurance (mid-term); and improving participant's quality of life while reducing their risk of coronary heart disease and risk factors associated with heart disease and obesity (long-term). Based on the responses from the qualitative survey, most of the respondents have noticed favorable and positive impacts on their health due on their participation in Senior Shape. Furthermore, most of the Senior Shape member responses stated they experienced no hospital stays or readmissions in the past 12 months. Therefore, the Senior Shape members have been maintaining or improving cardiovascular health and overall fitness levels.
Continuation of Initiative	Senior Shape classes are scheduled through 2018 with Fitness Assessments slated for November 2017 and May 2018. The first Senior Shape class began in 2001, best practice models continue to replicate and we are on schedule to operate indefinitely. Challenge of program has been inconsistent follow up of some Senior Shape participants in the fitness assessments.

Expense	E. Total Cost of Initiative	F. Direct offsetting revenue from Restricted Grants
E. Total Cost of Initiative for Current Fiscal Year F. What amount is Restricted Grants/Direct offsetting revenue	$78,667.00	$27,153.00

Table III, Initiative 4.Freedom from Smoking® Class

Identified Need	Cancer. Suburban Hospital's 2016 Community Health Needs Assessment identified cancer as the second leading cause of deaths in Montgomery County. Lung cancer continues to be the leading cause of cancer deaths in both men and women. While age-adjusted death rates due to lung cancer, in Montgomery County, has declined to 24.8 per 100,000[65], the disease affects racial ethnic group disproportionally. In blacks, the age-adjusted death rate due to lung cancer is 27.2/100,000- higher than the County average. Cigarette smoking is related to cancer of the lung, blood, colon, rectum, cervix, and others.[66] In 2014, 7.9% of the adult population reported smoking cigarettes.[67]
Hospital Initiative	Freedom From Smoking®
Total Number of People within Target Population	In Montgomery County, in a given month, 13.4% of people aged 12 or older reported smoking cigarettes.[68] Among the adult population 7.9% smoke cigarettes; however, there is a higher incidence rate among Asians (11.8%) and Blacks (13.6%) who currently smoke: than Hispanics (5.2%) and Whites (6.2%).[69]
Total Number of People Reached by Initiative	In FY17, the Freedom From Smoking® class was highlighted in Suburban's quarterly newsletter "New Directions." The newsletter is mailed to 270,000 homes in Montgomery County. Additionally, the class was advertised to the over 1,200 employees at Suburban Hospital. A total of 14 people registered to participate in the program.
Primary Objective	The primary objective of the program is to help reduce the prevalence of cigarette smoking among the adult population. This goal is achieved by educating the public about the availability of and promoting the use of Freedom From Smoking® class. Smoking cessation has been shown to decrease the risk of developing smoking-related cancers. Freedom From Smoking® (FFS) is an evidence-based cessation program utilizing psychological and pharmacological principles and methods in order to help people quit smoking. FFS consists of eight sessions, taught face-to-face by a certified facilitator. The small group format allows smokers to work through the challenges of quitting both individually and as part of a group. The end-goal is to help smokers gain control over their behavior and transition into a smoke-free lifestyle.
Single or Multi-Year Initiative Time Period	The Freedom From Smoking® (FFS) has been offered at Suburban Hospital since 2014. The 8 class, seven-week series is offered every quarter at Suburban Hospital and will continue to be offered to community members, patients and hospital employees. In FY17, the FFS class was offered:

[65] National Cancer Institute, State Cancer Profiles, Death Rate Report for Maryland by County, Lung & Bronchus, https://statecancerprofiles.cancer.gov/deathrates, 2010-2014
[66] National Cancer Institute, State Cancer Profiles, Death Rate Report for Maryland by County, Lung & Bronchus, https://statecancerprofiles.cancer.gov/deathrates, 2009-2013
[67] Maryland Behavioral Risk Factor Surveillance System, http://www.marylandbrfss.org/, 2014
[68] National Survey on Drug Use and Health, https://nsduhweb.rti.org/, 2012-2014,
[69] Maryland Behavioral Risk Factor Surveillance System, http://www.marylandbrfss.org/, 2014

	Summer-8/3/2016-9/14/2016 Fall-10/11/2016-11/22/2016 & 11/8/2016-12/20/2016 Winter-2/7/2017-3/21/2017 Spring- 4/11/2017-5/23/2017 & 5/31/2017-7/19/2017	
Key Collaborators in Delivery	Key partners and collaborations include the: American Lung Association, Montgomery County Cancer Crusade, Montgomery County Tobacco Coalition, and Suburban Hospital's Community Health & Wellness Department, Respiratory Therapy Department, and Cancer Program.	
Impact/Outcome of Hospital Initiative	In FY17, six classes (each 7-week, 8-sessions) were offered to the community and 3 classes were held. In FY17, 50% of registered participants completed the program and were smoke-free. The average number of relapses was equal to 1.5.	
Evaluation of Outcome (Include process and impact measures)	Smoking cessation has been shown to decrease the risk of developing smoking-related cancers. To objective of the program is to help people stop smoking. At 1-week after the program completion, 43% of those who completed the program remained smoke free (short-term evaluation). The smoke-free rate remained steady at 3-month and 6-month post program participation (mid-term evaluation). Long term evaluation metrics will look at the number of program participants who stay smoke-free 1 year after program participation thereby helping increase the total number of adults who are smoke-free in Montgomery County, MD.	
Continuation of Initiative	Quitting smoking is hard. People who stop smoking will often attempt to quit several times. However, the FFS class has been proven the gold standard for smoking cessation classes and has helped many people quit. Therefore, Suburban Hospital will continue to offer the FFS to the community. In FY17, Suburban Hospital worked towards increasing visibility of the FFS and increasing program participation as additional classes were added. In addition, a Suburban Hospital employee initiative started in FY17 where employees were able to take the FFS class for free and would receive a $20 credit added to their paycheck upon completion of the program. The program experienced again a low participation rate.	
Expense Total Cost of Initiative for Current Fiscal Year What amount is Restricted Grants/Direct offsetting revenue	Total Cost of Initiative $1,954.88	Direct offsetting revenue from Restricted Grants $250.00

Table III, Initiative 5 Check It Out Program

Identified Need	Cancer. Suburban Hospital's 2016 Community Health Needs Assessment identified cancer as the second leading cause of deaths in Montgomery County. According to the National Cancer Institute, the age-adjusted death rate due to breast cancer is 17.3 per 100,000 in Montgomery County.[70] Within Suburban's CBSA, the age-adjusted death rate is slightly higher at 18.4 per 100,000. Furthermore, the age-adjusted death rate among African American is 27.1 compared to 19.5 in Caucasians within Suburban's CBSA.[71] If detected early, breast cancer is highly treatable.
Hospital Initiative	*Check It Out* Program
Total Number of People within Target Population	According to the National Cancer Institute, the age-adjusted death rate is 17.3 per 100,000 in Montgomery County.[72] Within Suburban's CBSA, the age-adjusted death rate is slightly higher at 18.4 per 100,000. Furthermore, the age-adjusted death rate among African American is 27.1 compared to 19.5 in Caucasians within Suburban's CBSA.[73]
Total Number of People Reached by Initiative	2,124 of high school 11th and 12th grade young women from 11 Public and Private schools in Montgomery County attended the Check It Out program in FY17.
Primary Objective	The *Check It Out* program is a free breast health awareness program where a Suburban Hospital Cancer Program nurse addresses Montgomery County 11th and 12th grade young women on the importance of breast self-examination during one class period of school. In addition to the clinical speaker, a breast cancer survivor, usually a member of the school facility shares her story with breast cancer with the young women, encouraging them to regularly perform self-breast health exams.
Single or Multi-Year Initiative Time Period	The *Check It Out* program is offered every two years from January to April. In FY17, it occurred from January 2017 to April 2017.
Key Collaborators in Delivery	Suburban Hospital Cancer Program and Community Health and Wellness Division, the Greater Washington Chapter of Hadassah and Montgomery County Public Schools, and local private high schools.
Impact/Outcome of Hospital Initiative	At every *Check It Out* session, participants are given a knowledge based evaluation which includes on thirteen questions- 10 based on knowledge and 3 based on their confidence level. Outcomes from the FY17 evaluations included: 1.) When asked if all breast lumps are cancer: 98.88% answered false, that all breast lumps are not cancerous. 2.) When asked if an injury to the breast causes cancer: 98.64% answered false, that an injury to the breast does not cause cancer.

[70] National Cancer Institute, www.nci.gov, 2010-2014

[71] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."

[72] National Cancer Institute, www.nci.gov, 2010-2014

[73] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."

	3.) When asked if younger women develop breast cancer as often as older women: 91.99% answered false, while young women could develop breast cancer, it occurs more frequently in older women. 4.) When asked if large-breasted women have a greater chance of developing breast cancer than small-breasted women: 97.64% answered false, that the chance of a women developing breast cancer does not depend on the size of her breasts. 5.) When asked if women should consider having mammograms at age 40-50: 95.99% answered true, that women should begin to have mammograms between the ages of 40-50. 6.) 95.36% answered correctly that monthly breast self-examinations are an important tool for early detection. 7.) 92.24% answered correctly that a woman should perform a breast self-examination 7 to 10 days after her period 8.) When asked if exercising 3 to 5 hours a week can help reduce the risk of breast cancer: 96.85% answered true, that exercise does reduce the risk of breast cancer. 9.) When asked if a woman is pregnant, she does not need to perform a breast self-examination: 93.43% answered false, as women can still get breast cancer even when pregnant. 10.) When asked if only women develop breast cancer: 95.21% answered false as men can also develop breast cancer. 11.) When asked if the program help you understand the importance of Breast self-examination as a regular health habit? 100% answered Yes 12.) When asked did the presence of a breast cancer survivor add to the learning experience? 99.00% answered Yes 13.) When asked if they learned anything from the question/answer session, 95.00% of the students answered Yes.	
Evaluation of Outcome (Include process and impact measures)	No Baseline data was collected because a behavioral objective approach evaluation model was used to assess goal attainment. Every two years, the Check It Out program measures its success by the number of students it is able to reach (short-term goal); increase awareness of breast self-examinations among the young women who attend the program (mid-term goal); and by improving the student's quality of life while reducing their risk from breast cancer mortality (long-term goal).	
Continuation of Initiative	Challenges with the *Check It Out* Program include the schools declining or not following up to schedule the program, limited amount of time allocated to program; Hospital increase its communication with schools and seeking out support of school administration for support of program.	
Expense G. Total Cost of Initiative for Current Fiscal Year H. What amount is Restricted Grants/Direct offsetting revenue	G. Total Cost of Initiative $3,901.00	H. Direct offsetting revenue from Restricted Grants $2,149.00

Table III, Initiative 6.Fine Tuning Your Diabetes

Identified Need	Suburban Hospital's 2016 Community Health Needs Assessment identified diabetes as one of its five health priorities. Furthermore, in Montgomery County, 7.4% of the adult population has diabetes.[74] The age-adjusted hospitalization rate due to diabetes is 11.6 per 10,000 population aged 18 years and older.[75] Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[76] In FY17, Suburban Hospital had 2,592 in-patients that had diabetes.
Hospital Initiative	Fine Tune Diabetes Initiative
Total Number of People within Target Population	The age-adjusted hospitalization rate due to diabetes is 11.6 per 10,000 population aged 18 years and older.[77] Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[78] Hospital admission records for FY17 presents a total 2,592 in-patients with diabetes.
Total Number of People Reached by Initiative	Between July 1, 2016 and June 30, 2017, a total of 330 Suburban Hospital in-patients were identified and connected to the Fine Tune Diabetes initiative.
Primary Objective	Recognizing that diabetes care doesn't stop when patients leave the hospital, Suburban Hospital designed the Fine Tune Diabetes (FTD) Initiative, which includes a system to enroll in-patients with diabetes to a specially designed small group class called *Fine Tune Your Diabetes (FTYD)*. The FTYD class provides a behavioral based disease self-management program that serves people living with diabetes (either newly diagnosed or those with pre-existing condition) and their care partners. The class is aimed to ease the often difficult transition from hospital-to-home by meeting a patient's immediate need through Specific, Measurable, Achievable, Reasonable and Timely (SMART) goal setting. The initiative's unique feature is its focus on reducing patient barriers by creating a smooth transition to an outpatient education program. During a patient's hospital stay, hospital clinical staff initiative a conversation with the patient about the benefits of the class and later "prescribe" the class as part of the post-discharge treatment. The class is provided at no cost to the patient. Patients have the option to reject or accept enrollment into the class. The Fine Tune Diabetes Initiative has the following main objectives: 1. Link patients with diabetes to an outpatient diabetes education and self-management program 2. Introduce the American Association for Diabetes Association (AADE) 7 self-care behaviors and stablish related SMART goals 3. Reduce ED/Hospital readmission due to diabetes

[74] Maryland Behavioral Risk Factor Surveillance System, http://www.marylandbrfss.org/, 2014
[75] The Maryland Health Services Cost Review Commission, 2009-2011.
[76] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2009-2013 Results."
[77] The Maryland Health Services Cost Review Commission, 2009-2011.
[78] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2009-2013 Results."

<table>
<tr><td>Single or Multi-Year Initiative Time Period</td><td>Multi- Year; The Fine Tune Diabetes initiative was launched on May 2016 and is currently in its second year of operation. The Fine Tune Your Diabetes classes are offered twice a month at Suburban Hospital.</td></tr>
<tr><td>Key Collaborators in Delivery</td><td>The FTD initiative is a multi-disciplinary approach aimed to improve patient health outcomes and to ensure patients are connected to resources from beginning-to-end. Successful implementation of the initiative requires strong collaboration among all members of the patient healthcare team. The process starts with the physician or nurse, who identify the patient and connects him/her to the outpatient FTYD class. The Administrative Service Representative (ASR) receives the order from the provider and proceeds to schedule the patient via an online system to an upcoming FTYD class. Instructions for the class are entered on the discharge planning instructions by the nurse and/or ASR. Suburban's community health and wellness team receive the list of scheduled patients and provide reminder calls for the upcoming class. At the FTYD class, diabetes educators, dietitians and pharmacists are present to provide 1:1 coaching on the SMART self-management goal. The diabetes educators' follow-up with the patient one-month post class participation to track goal status.</td></tr>
<tr><td>Impact/Outcome of Hospital Initiative</td><td>In FY17, Year 01, 12% (n=330) of patients with diabetes were identified and connected to the FTD initiative. From the total of patients that were enrolled in the initiative, 21% (70 patients) attended the FTYD outpatient class and stablished a SMART self-management diabetes goal. 54% of the SMART goals focused on healthy eating, 22% on being active and the remaining 24% focused on other American Association for Diabetes Association (AADE) 7 self-care behaviors such as monitoring, reducing risk and medication management.</td></tr>
<tr><td>Evaluation of Outcome (Include process and impact measures)</td><td>The goal of the Fine-Tune Diabetes Initiative is to improve a patient's diabetes through support and education. The following impact measures were developed and tracked for the FTD initiative:

<table>
<tr><th colspan="3">Outcomes Measures</th></tr>
<tr><th>Short</th><th>Medium</th><th>Long</th></tr>
<tr><td>Deliver enrollment process in-services for hospital staff

Train ASR on class registration system

Identify and enroll 10% of in-patients with diabetes to the FTYD class.</td><td>Have a least 50% of enrolled patients attend class.

Increase enrolled patient's knowledge and self-efficacy.

Work with class patients to set one diabetes self-management SMART goal (based on AADE 7 self-care behaviors)</td><td>Patient SMART Goal Achievement (50%)

Improved patient quality of life</td></tr>
</table>
A total of 330 patients participated in the FTD initiative, which accounts for over 10% of the target population. Class attrition rate for the program was</td></tr>
</table>

	calculated at 78%, higher than expected. However, as program continues to grow, attrition rate has been dropping. The goal for Year 02 is to lower attrition rate to 65%. 53% of patients enrolled reached their SMART Goal. Patients were encouraged to bring a care partner to the FTYD class. Educators found that patients with a care partner were more likely to achieve their SMART goal.	
Continuation of Initiative	The FTD initiative was designed as a response to ease the often difficult transition from hospital-to-home by meeting a patient's immediate need for diabetes management support. The FTD initiative has been positively received by patients, their care partners and hospital staff. This initiative will continue and will evolve to better serve the target population. Two changes that are projected for Year 02 include (1.) modification to the hours of when the FTYD classes are offered and (2.) adding as an impact measure readmission rates for patients enrolled in the FTD initiative.	
Expense A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $31,673.00	B. Direct offsetting revenue from Restricted Grants $0

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

The Healthy Montgomery steering committee established six official health priorities to be tracked, measured and evaluated based on health inequities, lack of access, and unhealthy behaviors over the next three years. One of those health priorities includes Maternal and Child Health. Suburban Hospital may not be in a position to affect all of the changes required to address this health priority given that the hospital does not have an obstetrics designation or deliver babies. One reason for not seeking this designation is due to the fact that there are several other community hospitals within 5-10 miles of our Bethesda location that have reputable obstetrics programs. While Suburban Hospital may not be able to directly address this health priority, the Hospital does indirectly support Maternal and Child Health initiatives through funding and programming of several other organizations, which promote the health and well-being of children and their families. Notably, Suburban Hospital supports the YMCA Youth and Family Services by hosting parenting seminars at the hospital twice a year. Proceeds from the seminars go directly to the YMCA and support its programming available to the community's families. Suburban physicians and nurses also participate in the Annual YMCA Bethesda Chevy Chase *Healthy Kids Day* where staff facilitates interactive safety activity "Pick your Poison" and takes blood pressure for parents and children. In addition, Suburban Hospital provides financial support to safety net clinics in Montgomery County who treat specific patients requiring obstetric or pediatric care. The Hospital is also the official health sponsor of *Girls on the Run* Montgomery County providing discounted CPR and 1st aid training classes to the coaches, purchasing shoes and healthy snacks for students from Title I schools and providing health tips on *Girls on the Run* Montgomery County website. In addition, the Hospital also provides indirect support to OASIS Montgomery's *CATCH Healthy Habits* program sponsored through an Amerigroup Foundation grant. *CATCH Healthy Habits* engages senior adults as mentors to teach children grades K-5 about healthy eating and active living in Montgomery and Prince George's Counties.

Furthermore, the Shaw Family Pediatric Emergency Center at Suburban Hospital provides children of all ages with quality care in a kid-friendly, family-centered environment ensuring around-the-clock pediatric expertise and promotes continuity of care. Recognizing the unique medical needs of our youngest patients, a team of board-certified pediatricians and specially trained pediatric nurses treat everything from sore throats to playground injuries and broken bones to complex illnesses and offers a full range of ancillary care, including radiology and laboratory services. The Center also offers support for children who are undergoing outpatient procedures.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

As of 2010, Montgomery County had the highest number of individuals age 60+ of any Maryland jurisdiction and the third highest percentage of minority seniors. With this expanding senior population, Suburban Hospital is working collaboratively with the other five Montgomery County hospitals to reduce readmissions and improve the health and well-being of the county's senior population. One of the ways that Suburban Hospital directs its efforts toward the State's initiatives for improvement in population health is through the collaboration of NexusMontgomery, a community-based care management

program to enhance the health and well-being of seniors, age 65 and up and improve the rate of preventable hospital utilization.

Through a six-month grant awarded by Maryland's Health Services Cost Review Commission (HSCRC), NexusMontgomery ties to the goals of Maryland's new all-payer model and to achieve the Triple Aim of enhancing patient care, improving population health and lowering total health care costs for seniors. It is a cooperative partnership comprised of Holy Cross Health, Suburban Hospital, MedStar Montgomery, Adventist Healthcare, the Montgomery County Department of Health and Human Services, 23 subsidized senior living communities, physicians, and community social service resources and other providers. The Primary Care Coalition of Montgomery County serves as the neutral convener and project manager. Expertise on related subject matter is provided by Discern Health (payment modeling), MedChi (physician perspective), and LifeSpan (senior care perspective).

The goal of NexusMontgomery is to better identify residents in senior living communities who are chronically ill and/or at risk for avoidable utilization of health care services, provide care coordination and referral in partnership with individuals' primary care physicians, and supplement individual services with community-based case management and health promotion programs. Since the inception of Nexus Montgomery, four goals have been developed.

In addition, the Care Partner (Health Buddy) Initiative, modeled after Johns Hopkins Bayview Medical Center' Bridge to Home and Health Buddy Program, is a collaborative effort between the Hospital's Transition Guide nurses and Community Health and Wellness Division by bridging the gap between the Hospital and community. Piloted on May 4, 2015, and administered on the Adult Medical Unit by a HeartWell nurse provider dedicated 20 hours per week of clinical effort introducing the program to patients. Patients enroll in the initiative voluntarily. The nurse provider works with the patient and the Care Partner to provide education on the specific needs and potential needs of the patient when they discharge home. These may include help with medications; follow up with medical care in the community, transportation and meals to name a few. The Care Partner is encouraged to be present at the time of discharge instructors to be best prepared for their role and plays a vital role in ensuring a safe, successful transition from hospital to home and across the continuum of care. Patients and their Care Partner are contacted after discharge to continue this effort and provide support. The Care Partner initiative is an evidence-based strategy useful in the prevention of hospitalizations and readmissions. The initiative engages and supports patients in managing their healthcare. The Care Partner becomes a resource to assist patients in meeting the challenges they may face on a day-to-day basis that are impacting their health.

The outcomes from the pilot program demonstrated that the Care Partner Initiative was effective in reducing the number of readmissions during the five month time period. Those patients who were seen by a nurse were readmitted to the hospital at a rate of 13.56% compared to those who did not see a nurse at 16.28%. In addition, the readmissions rate rose to 17.74% after the pilot program ended. As a result of the success from the pilot program, the Care Partner Initiative restarted in FY17 with additional staff been employed to implement the program, working on the Adult Medical and Acute Medicals Units where our vulnerable patients are cared for during their hospital stay. Starting in mid-January through June, of the 312 patients enrolled in the program, 35 patients were readmitted to the hospital. The readmission rate of 11.2% for this program compared to the overall readmission rate of 14.4% at Suburban. Of those 37 patients who decline participation of the Care Partner Initiative, eleven patients were readmitted within 30 days of being discharged.

VI. 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.

Suburban Hospital is concerned about patient access to care, which is endangered by an identified shortage of physicians in Montgomery County practicing in primary care and in several specialties. Studies have found shortages in Primary Care, Dermatology, Hematology/Oncology, Psychiatry, Anesthesiology, Emergency Medicine, Thoracic Surgery, and Vascular Surgery. Maryland also has only a borderline supply of orthopedic surgeons. Committed to expanding not only access to primary care for the uninsured, Suburban Hospital collaborates with local health partners like Montgomery Cares, Project Access, Primary Care Coalition, Catholic Charities, Mobile Medical Care, Clinica Proyecto Salud, NHLBI, NIDDK, community cardiologists and orthopedic surgeons to provide much needed specialty care, especially for those who suffer from chronic disease. A few examples of how Suburban Hospital and its partners are working to narrow the gap in availability of these specialty services are outlined below:

Since 2007, the MobileMed/NIH Heart Clinic at Suburban Hospital has provided expert care to more than 4,000 patients to date and has conducted multiple open-heart surgeries at no cost to those patients who are in urgent need of these specialty care and inpatient services. Mobile Medical Care, Inc., the National Heart, Lung and Blood Institute and Suburban Hospital have operated a specialty cardiac clinic on-site to provide access to care and alleviate the gap in specialty providers for cardiac patients. Referred from safety net clinics in the County operated by MobileMed, Clinica Proyecto Salud and the Holy Cross Hospital Health Centers, each patient is seen by a Suburban cardiologist and clinical staff from the NIH. In addition to coordinating the cardiologists and nurses who volunteer at the clinic, the Hospital absorbs the costs associated with free cardiovascular specialty diagnostic screenings and open-heart surgery for patients who require advanced care.

Based on the best practice model of the MobileMed/NIH Heart Clinic, Suburban Hospital, MobileMed Inc. and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) established a free endocrine clinic providing lifestyle and chronic disease management for people with endocrine diseases. For seven years, staff from Suburban Hospital, NIDDK and MobileMed have volunteered their time once a week by providing diagnostic tests, laboratory services and free medical examinations and have treated nearly 2,000 patients. In addition, Endocrine clinic patients have the opportunity to meet one-on-one with Suburban Hospital Registered Dietitians for free nutrition consultations to review individual nutrition plans and examine challenges with dietary restraints.

Suburban Hospital provides financial support to several other safety net clinics in Montgomery County including Mary's Center to support its primary care initiatives at their Montgomery County locations. In addition, the Hospital provides in kind support to established safety net clinics –MobileMed and Clinica Proyecto Salud in providing diagnostics and laboratory testing for its patients. Suburban Hospital provides specialized care to the patients of Catholic Charities of Washington DC through a referral agreement at no cost.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	As a state-designated regional trauma center for Montgomery County and the surrounding Washington DC Metropolitan area, Suburban Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital. Physicians from Bethesda Emergency Associates staff the Hospital's busy Emergency Department, treating 46,939 life-threating and non-life-threatening patients in FY17 including approximately 1,500 trauma patients. In FY17, the Hospital contributed $876,985.86 in Trauma On Call Coverage and $225,966.00 in Emergency Room Coverage.
Non-Resident House Staff and Hospitalists	The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician. In addition, Suburban Hospital Cardiac surgery program provides specialty cardiac care with three cardiothoracic surgeons. In total, the Hospital supported $5,149,725.97 for these hospital-based physicians. With the rising costs of healthcare for patients living with diabetes, the Hospital recognizes the need for specialty care and offers a diabetes management service for inpatients who are diabetic or at risk of developing diabetes. Directed by Dr. Mihail Zilbermint, director of Endocrinology, Diabetes, and Metabolism Care at Suburban Hospital, the goal of the service is to improve the care of patients living with diabetes and decrease length of stay.
Coverage of Emergency Department Call	See above under Hospital Based Physicians
Physician Provision of Financial Assistance	Suburban Hospital supports the efforts of community physicians who are willing to provide a sliding scale fee for patients unable to pay for service on an as needed basis. In addition, Suburban Hospital supports partnership efforts between community physicians and organizations such as the Primary Care Coalition and Catholic Charities of the Archdiocese of Washington.
Physician Recruitment to Meet Community Need	Since diabetes was one of the top twenty conditions among readmissions at Suburban Hospital in FY16, Endocrinology, Diabetes, and Metabolism Care at Suburban Hospital was established and overseen by Dr. Mihail Zilbermint.

Other – (provide detail of any subsidy not listed above – add more rows if needed)	ENT On Call OB/GYN On Call Behavioral Health On Call Urology On Call Cardiology On Call Gastroenterology Anesthesiology On Call Ophthalmology On Call Stroke On Call Vascular On Call General Surgery Ortho and Spine Surgery

VII. APPENDICES

APPENDIX I: FINANCIAL ASSISTANCE POLICY DESCRIPTION

FINANCIAL ASSISTANCE POLICY DESCRIPTION

Description of 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 financial assistance policy.

Suburban Hospital maintains accessibility to all services regardless of an individual's ability to pay. The Hospital policy on charity care is to provide necessary emergency medical care to all persons regardless of their ability to pay and consider for charity care those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/or inability to pay. Free care, sliding fee scales and extended payment plans are offered to eligible patients. Approval for charity care, sliding fee scales or payment plans is based on submission of a financial assistance application available upon request at each of our registration points of entry, via mail, or our website, www.suburbanhospital.org.

The Patient Access Department provides patients registered for emergency, outpatient, or inpatient care a copy of our Financial Assistance Information Sheet. Signs are posted in English and Spanish explaining the availability of financial assistance and where to call for assistance. The signs are located in the Emergency, Pediatrics, Cath Lab, and Financial Counseling Departments, as well as at the main registration desk. A financial assistance application is given to every self-pay patient with instructions on how to apply and who to contact for assistance. The same information is provided to all other patients upon request. This information is also available in Spanish as well as many other languages.

Suburban Hospital's Financial Counselors and Social Workers are trained to answer patients' questions about financial assistance and provide linkage to other community assistance resources prior to discharge. Registration and Patient Financial Services staff members are trained to answer questions regarding financial assistance and who to contact to apply. The Patient Access Department has Medicaid Specialists onsite to assist patients in applying for Maryland Medical Assistance. All uninsured patients are screened for Medicaid upon admission and provided with information and referral for financial assistance. In addition, since implementation of the Affordable Care Act, Suburban Hospital now has access to Certified Application Counselors available to assist patients who have questions about eligibility requirements for the Maryland Health Insurance Exchange. These Certified Application Counselors provide information and assist patients with initiation of online health exchange plan enrollment when requested.

APPENDIX II: DESCRIPTION OF CHANGES TO HOSPITAL'S FINANCIAL ASSISTANCE POLICY HAS CHANGED SINCE THE AFFORDABLE CARE ACT'S HEALTH CARE COVERAGE EXPANSION OPTION BECAME ON EFFECTIVE ON JANUARY 1, 2014

Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option become effective on January 1, 2014.

The Johns Hopkins Health System expanded its definition of Medical Debt to include copayments, co-insurance and deductibles of patients who purchased insurance through a Qualified Health Plan. JHHS defines a Qualified Health Plan as:

Under the Affordable Care Act, starting in 2015, an insurance plan that is certified by the Health Insurance marketplace, provides essential health benefits, follows established limits on cost sharing (like deductibles, co-payments, and out-of-pocket maximum amount, and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Notice of financial assistance availability was posted on the Hospital's website and mentioned during oral communications. Suburban Hospital's policy was changed to state this is being done. This change was in response to IRS regulation changes.

Previously patients had to apply for Medical Assistance as a prerequisite for financial assistance. Suburban Hospital policy now requires that the patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements.

For Medical Hardship

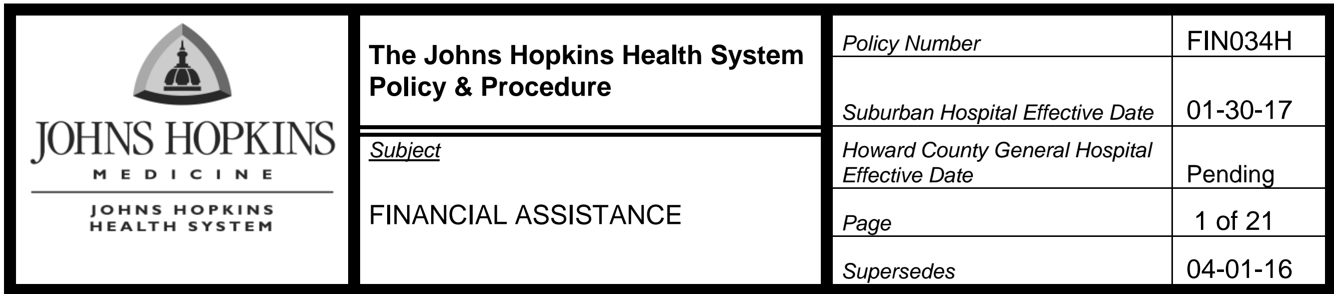
Medical Debt is defined as out-of-pocket expenses for medical costs for Medically Necessary Care billed by Suburban Hospital, the out-of-pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

Suburban Hospital's Financial Assistance Policy was also changed to add an Appendix and language advising that the Appendix list physicians that provide emergency and medically necessary care at the hospital and whether the doctor is covered under the hospital's financial assistance policy. The Appendix is updated quarterly and posted on the hospital website. The policy and the website instruct patients to direct any questions they may have concerning whether a specific doctor has a financial assistance policy separate and apart from the hospital's policy. This change is in response to IRS regulation changes.

Presumptive Financial Assistance Eligibility

In February 2017, Suburban Hospital's financial assistance policy was updated further to expand presumptive eligibility to include partial financial assistance based on the federal poverty guidelines. Previously, patients received presumptive financial assistance only if they were at a level of the federal poverty guidelines to receive 100% assistance.

APPENDIX III: FINANCIAL ASSISTANCE POLICY



JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034H
		Suburban Hospital Effective Date	01-30-17
	Subject	Howard County General Hospital Effective Date	Pending
	FINANCIAL ASSISTANCE	Page	1 of 21
		Supersedes	04-01-16

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: Howard County General Hospital (HCGH) and Suburban Hospital (SH).

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted so long as other requirements are met.

FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CARE NOTICE:
Attached as EXHIBIT D is a list of physicians that provide emergency and medically necessary care as defined in this policy at HCGH and SH. The lists indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician's office to determine if the physician offers financial assistance and if so what the physician's financial assistance policy provides.

Definitions

Medical Debt — Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the JHHS hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing)

Liquid Assets — Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash.

Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.

Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Medically Necessary Care	Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each marketplace in which it is sold.

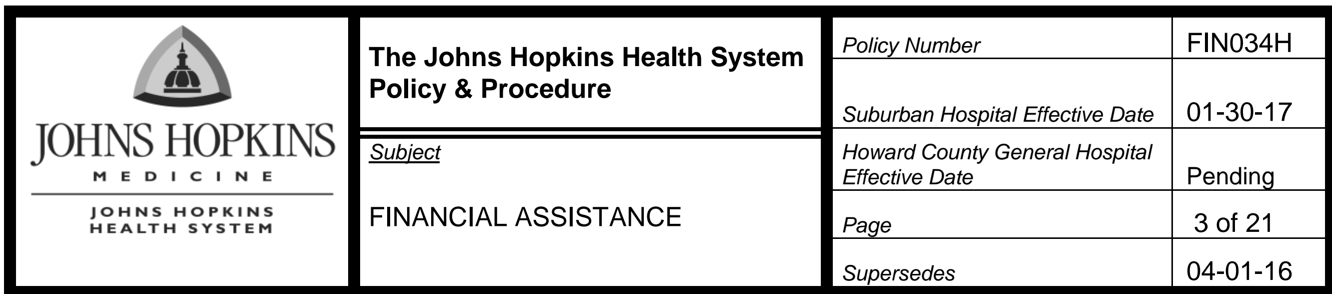
PROCEDURES

1. An evaluation for Financial Assistance can begin in a number of ways:

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.



3. Designated staff may meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, as defined by Medicaid regulations. To help applicants complete the process, a statement of conditional approval will be provided that will list the paperwork required for a final determination of eligibility.

   b. Applications received will be sent to the JHHS Patient Financial Services Department for review; a written determination of probable eligibility will be issued to the patient.

   c. At HCGH, complete applications with all supporting documentation submitted at the hospital are approved via the appropriate signature authority process. Once approved and signed off on, the approved applications will be sent to the JHHS Patient Financial Services Department's to mail patient a written determination of eligibility.

4. To determine final eligibility, the following criteria must be met:

   a. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

   b. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:

   a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).

   b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

   c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

   d. A Medical Assistance Notice of Determination (if applicable).

   e. Proof of disability income (if applicable).

   f. Reasonable proof of other declared expenses.

   g. Non-U.S. citizens must complete the Financial Assistance Application (Exhibit A). In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S.

Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO (HCGH) or Director of PFS and/or CFO (SH) to determine if additional information is necessary.

h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles for medical costs billed by a JHHS hospital unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines. At HCGH, the Financial Counselor will forward to Director, Revenue Cycle for review and final eligibility based upon JHMI guidelines.

   a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments for reconsideration to the CFO (HCGH) or Director PFS and CFO (SH) for final evaluation and decision.

   b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will have a final determination made no later than 30 days from the date the application was considered complete. The Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will base their determination of financial need on JHHS guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

8. Services provided to patients registered as Voluntary Self Pay do not qualify for Financial Assistance.

9. A department operating programs under a grant or other outside governing authority (i.e.: Psychiatry Program) may continue to use a government-sponsored application process and associated income scale.

10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient makes a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information

provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is either a partial or a 100% write-off of the account balance dependent upon income and FPL amounts. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patient's representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

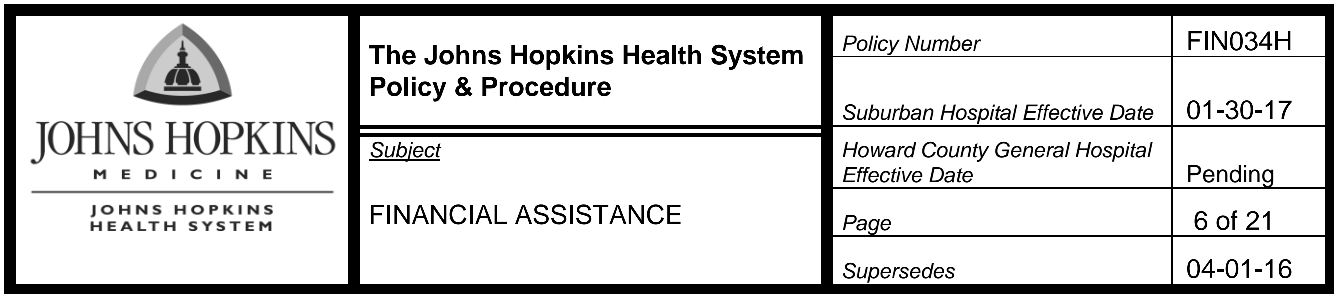
13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.

15. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.

16. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

17. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.



REFERENCE[1]

JHHS Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

RESPONSIBILITIES - HCGH, SH

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, send to Patient Financial Services Department's for determination of probable eligibility. Review preliminary application (Exhibit A), Patient Profile Questionnaire (Exhibit B) and Medical Financial Hardship Application (Exhibit C), if submitted, to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.

[1] NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

CFO (HCGH, SH)
Director of Revenue Cycle (HCGH)
Director, PFS (SH)

REVIEW CYCLE

Two (2) years

APPROVAL

____ ____________________
Sr. VP of Finance/Treasurer & CFO for JHH and JHHS Date

APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.

2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.

3. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

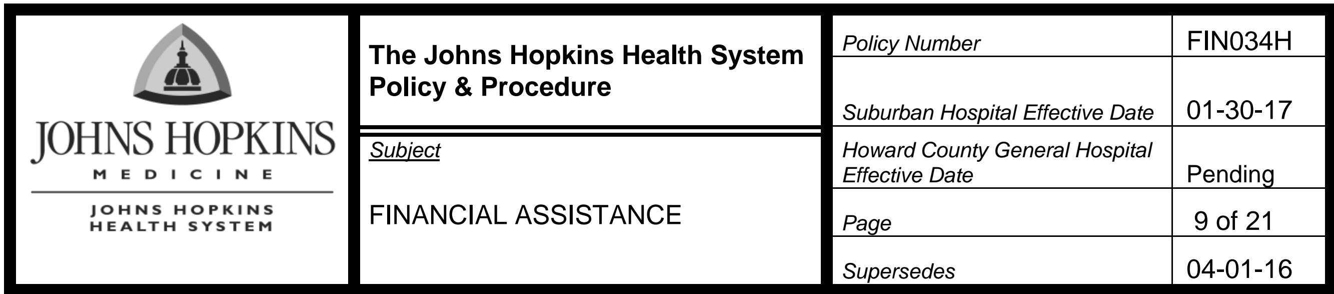
4. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior-year tax return;
   (b) Current pay stubs;
   (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
   (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
   (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.

5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife, same sex married couples) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.

7. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.

8. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.



9. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination.

10. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

11. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application (Exhibit A) will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.

12. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exceptions
The Vice President, Finance/CFO may make exceptions according to individual circumstances.

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF
FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,540**	$ 25,894	$ 28,248	$ 30,602	$ 32,956	$ 35,310
2	**$ 31,860**	$ 35,046	$ 38,232	$ 41,418	$ 44,604	$ 47,790
3	**$ 40,180**	$ 44,198	$ 48,216	$ 52,234	$ 56,252	$ 60,270
4	**$ 48,500**	$ 53,350	$ 58,200	$ 63,050	$ 67,900	$ 72,750
5	**$ 56,820**	$ 62,502	$ 68,184	$ 73,866	$ 79,548	$ 85,230
6	**$ 65,140**	$ 71,654	$ 78,168	$ 84,682	$ 91,196	$ 97,710
7	**$ 73,460**	$ 80,806	$ 88,152	$ 95,498	$ 102,844	$ 110,190
8*	**$ 81,780**	$ 89,958	$ 98,136	$ 106,314	$ 114,492	$ 122,670
**amt for each member	$8,120	$8,932	$9,744	$10,556	$11,368	$12,180
Allowance to Give:	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines
**For family units with more than eight (8) members

EXAMPLE:	Annual Family Income	$54,000
	# of Persons in Family	4
	Applicable Poverty Income Level	$47,700
	Upper Limits of Income for Allowance Range	$57,240 (60% range)

($54,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

Appendix A-1

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is either a partial or a 100% write-off of the account balance dependent upon income and FPL levels. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- active enrollees of the Chase Brexton Health Center (See Appendix C) (applicable for HCGH patients)
- Participation in Women, Infants and Children Programs (WIC)*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility *
- Households with children in the free or reduced lunch program*
- Low-income household energy assistance program participation*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- patients referred to Suburban Hospital by organizations which have partnered with Suburban (See Appendix E)
- Patient is deceased with no known estate
- Health Department moms – For non-emergent outpatient visits not covered by medical assistance
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- Patients returned by SRT as not meeting disability criteria but who meet the financial requirements for Medical Assistance

*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:
1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance are met.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for Medically Necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.

Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost Medically Necessary Care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

5. Patient is not eligible for any of the following:
   - Medical Assistance
   - Other forms of assistance available through JHM affiliates

6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.

7. The affiliate has the right to request patient to file updated supporting documentation.

8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.

9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:

- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the JHHS treating facility where the application was made.
- Liquid Assets (leaving a residual of $10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

Exceptions

The Vice President, Finance/CFO or designee may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.

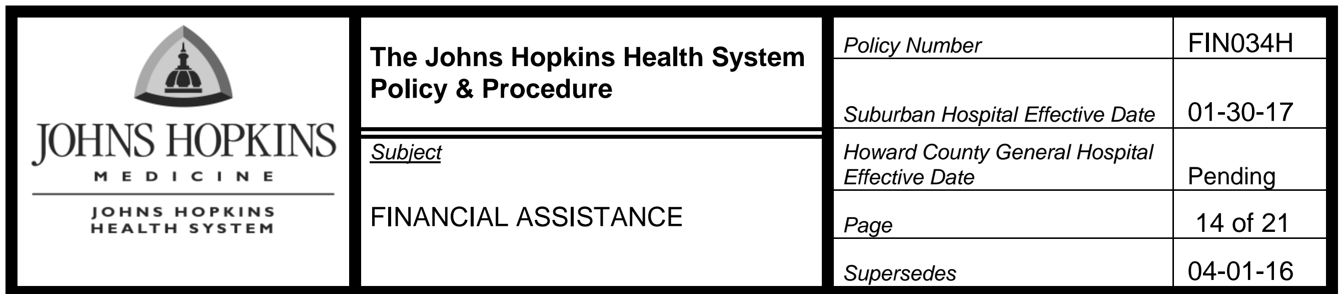
2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES **Effective 2/1/15**			
# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	**$ 35,310**	$ 47,080	$ 58,850
2	**$ 47,790**	$ 63,720	$ 79,650
3	**$ 60,270**	$ 80,360	$ 100,450
4	**$ 72,750**	$ 97,000	$ 121,250
5	**$ 85,230**	$ 113,640	$ 142,050
6	**$ 97,710**	$ 130,280	$ 162,850
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Allowance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,480 for each additional person at 300% of FPL, $16,640 at 400% at FPL; and $20,800 at 500% of FPL.



APPENDIX C (HCGH only)
FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are uninsured or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.

This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for Chase Brexton Health Services. It is the policy of HCGH to accept patients previously screened by Chase Brexton for financial assistance. Patients will not have to apply for assistance but will need to notify HCGH of their participation in this program.

Inpatient/Outpatient cases
All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of FAR.PENDIN, FARB20, FARN40, FARN50, FARN70 FARN80, and FAR100 is assigned to the case and the claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released. The insurance code assignment is based on the level of charity care the patient has qualified for.

Insurance listed as:	Charity Care	Patient to pay:
FAR.PENDIN	Pending Verification	
FARB20	20% of charges	80% of charges
FARN40	40% of charges	60% of charges
FARN50	50% of charges	50% of charges
FARN70	70% of charges	30% of charges
FARN80	80% of charges	20% of charges
FAR100	100% of charges	0% of charges

PROCEDURE

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of FAR.PENDIN into Meditech if the patient hasn't been seen within the last 6 months. If the patient is in the system with a service date within the last 6 months and the patient was already identified as a Chase Brexton patient that met a certain level of charity care the registrar can allow the insurance code of (FARB20, FARN40 etc,) to be pulled forward.

2. The Sr. Financial Counselor receives a daily report with all patients registered with a FAR code.

3. The Sr. Financial Counselor will review all patients on the report daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for.

4. The Sr. Financial Counselor is responsible for updating the insurance code to reflect the proper level of charity care and collecting the patient balance (if any).

5. The Sr. Financial Counselor is responsible for entering a form and through date into Meditech that the patient is eligible to receive this level of charity care.

6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.

APPENDIX D (Suburban Hospital only)
FINANCIAL ASSISTANCE FOR MONTGOMERY COUNTY AND LOCALLY BASED PROGRAMS FOR LOW INCOME UNINSURED PATIENTS

Purpose

Suburban Hospital is partnered with several Montgomery County, MD and locally based programs that offer primary care services and/or connection to local specialty and hospital based care. Based on agreements with these partnered programs, Suburban Hospital provides access to inpatient and outpatient care to patients who would not otherwise be able to access or afford medically necessary care.

Policy

Suburban Hospital shall accept charity referrals for medical necessary care from the following providers: Catholic Charities, Mary’s Center, Mobile Med, Inc., Montgomery County Cancer Crusade, NIH Children’s Inn, Primary Care Coalition, Project Access, and Proyecto Salud. Care is provided to such patients based on meeting eligibility requirements for one of the aforementioned local programs.
Patients must provide a program generated referral for care as proof of their enrollment in one of the above programs to qualify for presumptive approval for 100% free care. Suburban Hospital shall base acceptance of such referrals on the referring programs’ enrollment of patients using their income based eligibility requirements which for these designated programs is at or below a maximum of 250% of the federal poverty guidelines.

Procedure

1. When a patient is scheduled and/or presents for services at SH, the patient must provide a referral form from one of the above programs as proof of enrollment.
2. Once the referral form is received, the Scheduler or Registrar will apply to the account a designated insurance mnemonic for the referring partnered program.
3. If no referral form is received by the patient, the account will be registered as self pay. The patient has 30 days to produce a referral or proof of enrollment in one of the partnered programs. An additional 30 days will be allowed upon request from the patient.
4. A Financial Counselor and/or Registrar will check the real time eligibility or Maryland EVS System to verify enrollment in Maryland Medicaid. If enrolled, Medicaid will prevail and free care presumptive approval will not apply.
5. Each hospital account with a designated insurance mnemonic for one of the partnered programs will be subject to final review for the existence of a program referral prior to application of the program driven charity adjustment. Presumptive approval for 100% free care applies to a single episode of care (account) only.

Exhibit A

Howard County General Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name ____
First Middle Last

Social Security Number ______-____-______ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address ____ Phone _______________

____

____ _______________
City State Zip code Country

Employer Name ____ Phone _______________

Work Address ____

____
City State Zip code

Household members:

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? ________________
If yes, what was the determination? ____

Do you receive any type of state or county assistance? Yes No

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	______________
Retirement/pension benefits	______________
Social security benefits	______________
Public assistance benefits	______________
Disability benefits	______________
Unemployment benefits	______________
Veterans benefits	______________
Alimony	______________
Rental property income	______________
Strike benefits	______________
Military allotment	______________
Farm or self employment	______________
Other income source	______________
Total	______________

II. Liquid Assets

	Current Balance
Checking account	______________
Savings account	______________
Stocks, bonds, CD, or money market	______________
Other accounts	______________
Total	______________

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance ______________		Approximate value ______________
Automobile	Make __________	Year ______	Approximate value ______________
Additional vehicle	Make __________	Year ______	Approximate value ______________
Additional vehicle	Make __________	Year ______	Approximate value ______________
Other property			Approximate value ______________
		Total	______________

IV. Monthly Expenses

	Amount
Rent or Mortgage	______________
Utilities	______________
Car payment(s)	______________
Credit card(s)	______________
Car insurance	______________
Health insurance	______________
Other medical expenses	______________
Other expenses	______________
Total	______________

Do you have any other unpaid medical bills? Yes No

For what service? ____

If you have arranged a payment plan, what is the monthly payment? ______________________

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

______________________________________ ______________________

Applicant signature Date

____

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: ____

PATIENT NAME: ____

PATIENT ADDRESS: ____
(Include Zip Code)

MEDICAL RECORD #:_______________________________________

1. What is the patient's age? _______

2. Is the patient a U.S. citizen or permanent resident? Yes or No

3. Is patient pregnant? Yes or No

4. Does patient have children under 21 years of age living at home? Yes or No

5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No

6. Is patient currently receiving SSI or SSDI benefits? Yes or No

7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

   Family Size:

   Individual: $2,500.00

   Two people: $3,000.00

   For each additional family member, add $100.00

   (Example: For a family of four, if you have total liquid assets of less than $3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
   If not a Maryland resident, in what state does patient reside? ________

9. Is patient homeless? Yes or No

10. Does patient participate in WIC? Yes or No

11. Does patient receive Food Stamps? Yes or No

12. Does patient currently have:
    - Medical Assistance Pharmacy Only Yes or No
    - QMB coverage/ SLMB coverage Yes or No
    - PAC coverage Yes or No

13. Is patient employed? Yes or No
    If no, date became unemployed. ________
    Eligible for COBRA health insurance coverage? Yes or No

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: ____

PATIENT NAME: ____

PATIENT ADDRESS: ____
(Include Zip Code)

MEDICAL RECORD #:____

Date: ____

Family Income for twelve (12) calendar months preceding date of this application: __________________

Medical Debt incurred at The Johns Hopkins Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of service	Amount owed
_________________	________________________
_________________	________________________
_________________	________________________
_________________	________________________

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

_____________________________________ Date: _____________________
Applicant's signature

____
Relationship to Patient

For Internal Use: Reviewed By:
____________________________________Date:______________

Income: ________________ 25% of income=_____________________

Medical Debt: ______________________Percentage of Allowance: _____________

Reduction: ________________________

Balance Due: ______________________

Monthly Payment Amount:__________________ Length of Payment Plan:__________month

APPENDIX IV: PATIENT INFORMATION SHEET

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION SHEET

Billing Rights and Obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought in to the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial Assistance

If you are unable to pay for medical care, you **may qualify for Free or Reduced-Cost Medically Necessary Care** if you:

- Have no other insurance options
- Have been denied medical assistance or fail to meet all eligibility requirements
- Meet specific financial criteria

If you do not qualify for Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill.

Call: 855-662-3017

With questions concerning:

- Your hospital bill
- Your rights and obligations with regard to your hospital bill
- Your rights and obligations with regard to reduced-cost medically necessary care due to financial hardship
- How to apply for free and reduced-cost care
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills

For information about Maryland Medical Assistance

Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.

APPENDIX V: MISSION, VISION, AND VALUE STATEMENT

MISSION

Improving health with skill and compassion.

VISION

As a member of Johns Hopkins Medicine, Suburban Hospital will foster the development of an integrated and innovative system of care that provides state of the art clinical care supported by a strong base of medical research and education.

VALUE STATEMENT

Suburban Hospital is a community-based hospital serving Montgomery County and the surrounding area since 1943. We are a not-for-profit healthcare provider guided by the needs of our patients and community. On June 30, 2009, Suburban Hospital became a member of Johns Hopkins Medicine. The designated trauma center for Montgomery County, Suburban Hospital is affiliated with many local healthcare organizations, including the National Institutes of Health. It is committed to continuous improvement and appropriate use of resources, and creates an environment that encourages the success and fulfillment of our physicians, staff, and volunteers.

Suburban Hospital will set the standard for excellence in healthcare in the Washington metropolitan region. Through our affiliations, we aspire to provide world-class patient care, technology, and clinical research.

VALUES

- Compassion
- Excellence
- Integrity
- Teamwork
- Accountability

APPENDIX VI: COMMUNITY BENEFIT SERVICE AREA (CBSA) DEMOGRAPHICS

Suburban Hospital

Community Benefit Service Area

FY 2017 Q1-Q3

Source: HSCRC, DCHA, VHA

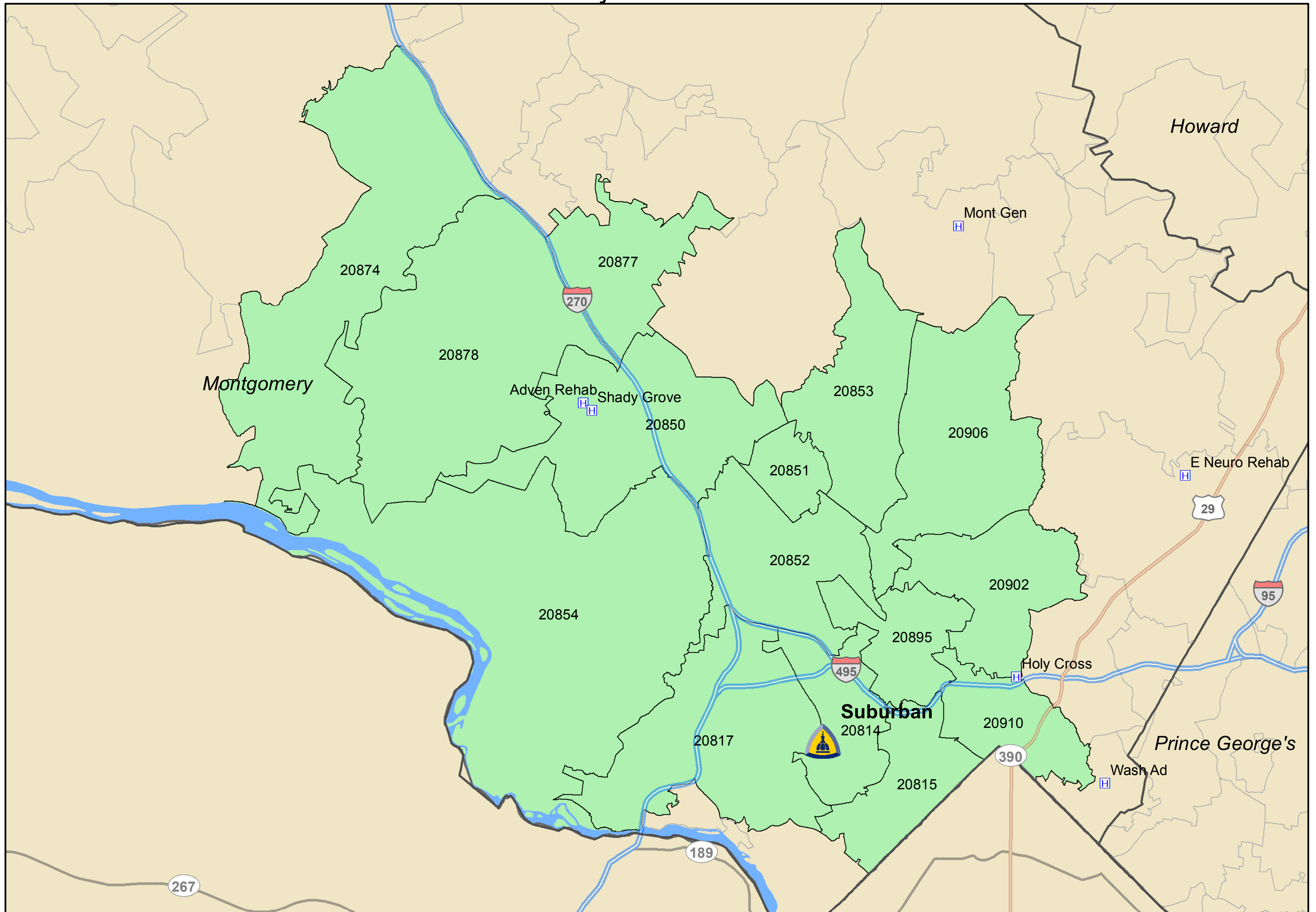
Includes Newborns

Zip Code	Zip City	JHSH Discharges	JHSH Market Share	All Hospital Discharges*	JHSH % of Zip**
20852	Rockville	1,081	37.2%	2,904	10.5%
20854	Potomac	825	34.9%	2,363	8.0%
20817	Bethesda	752	41.3%	1,819	7.3%
20814	Bethesda	727	47.3%	1,538	7.0%
20815	Chevy Chase	562	32.6%	1,724	5.4%
20906	Silver Spring	401	7.2%	5,586	3.9%
20895	Kensington	361	32.1%	1,125	3.5%
20850	Rockville	345	12.5%	2,759	3.3%
20902	Silver Spring	345	9.6%	3,600	3.3%
20878	Gaithersburg	249	7.9%	3,165	2.4%
20853	Rockville	232	11.0%	2,100	2.2%
20910	Silver Spring	214	8.3%	2,578	2.1%
20874	Germantown	200	5.4%	3,695	1.9%
20851	Rockville	173	16.7%	1,034	1.7%
20877	Gaithersburg	125	4.6%	2,736	1.2%
Total		6,592	17.0%	38,726	63.9%

*Includes Maryland, DC, and Northern VA Hospitals (Source: HSCRC, DC Hospital Assocation (DCHA), and Virginia Hospital Association (VHA))

**Note: Suburban Hospital had 10,318 discharges in FY 2017 Q1-Q3

Suburban Hospital
Community Benefit Service Area



2017 Insurance Coverage Estimates by ZIP Code Reform
Area: Suburban FY2017 CB SA
Ranked by ZIP Code(Asc)

		2017 Reform Population								
ZIP Code	ZIP City	Total	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private - Direct	Private - ESI	Private - Exchange	Uninsured
20814	Bethesda	30,600	2,664	935	3,687	595	2,184	19,160	667	707
20815	Chevy Chase	30,982	2,008	784	4,803	759	2,201	19,358	494	575
20817	Bethesda	37,059	2,188	823	4,922	775	2,758	24,399	530	663
20850	Rockville	53,475	5,481	1,885	5,658	921	3,732	33,059	1,301	1,437
20851	Rockville	14,609	1,277	496	1,050	178	1,108	9,822	354	324
20852	Rockville	48,499	5,148	1,862	5,608	908	3,311	29,121	1,256	1,285
20853	Rockville	30,691	1,984	844	3,541	568	2,301	20,354	548	549
20854	Potomac	51,604	2,613	935	7,321	1,147	3,926	34,206	623	834
20874	Germantown	63,457	6,873	2,671	3,353	603	4,673	41,843	1,747	1,695
20877	Gaithersburg	37,365	5,816	1,963	3,073	508	2,348	20,936	1,303	1,419
20878	Gaithersburg	67,494	5,189	2,113	5,441	914	5,168	45,915	1,372	1,381
20895	Kensington	20,612	1,890	721	2,401	386	1,435	12,835	432	512
20902	Silver Spring	53,545	6,515	2,451	4,362	724	3,650	32,697	1,546	1,599
20906	Silver Spring	69,191	9,103	3,043	10,654	1,690	4,119	36,263	1,938	2,380
20910	Silver Spring	42,801	6,241	2,157	3,468	586	2,811	24,644	1,403	1,491
Total		651,984	64,990	23,684	69,343	11,263	45,726	404,613	15,515	16,851

Demographics Expert 2.7
2017 Demographic Snapshot
Area: Suburban FY2017 CB SA
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	597,686	308,745,538
2017 Total Population	651,984	325,139,271
2022 Total Population	687,147	337,393,057
% Change 2017 - 2022	5.4%	3.8%
Average Household Income	$142,940	$80,853

	2017	2022	% Change
Total Male Population	313,256	330,606	5.5%
Total Female Population	338,728	356,541	5.3%
Females, Child Bearing Age (15-44)	126,117	127,739	1.3%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	**2017**	**% of Total**	**2022**	**% of Total**	**USA 2017 % of Total**
0-14	122,900	18.9%	125,900	18.3%	18.8%
15-17	24,278	3.7%	26,809	3.9%	3.9%
18-24	50,282	7.7%	56,559	8.2%	9.8%
25-34	84,686	13.0%	79,100	11.5%	13.4%
35-54	182,358	28.0%	185,566	27.0%	25.7%
55-64	85,229	13.1%	91,464	13.3%	12.9%
65+	102,251	15.7%	121,749	17.7%	15.5%
Total	**651,984**	**100.0%**	**687,147**	**100.0%**	**100.0%**

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2017 Household Income	**HH Count**	**% of Total**	**USA % of Total**
<$15K	13,935	5.6%	11.8%
$15-25K	10,975	4.4%	10.1%
$25-50K	32,092	12.9%	22.9%
$50-75K	36,789	14.8%	17.4%
$75-100K	30,637	12.3%	12.1%
Over $100K	124,013	49.9%	25.7%
Total	**248,441**	**100.0%**	**100.0%**

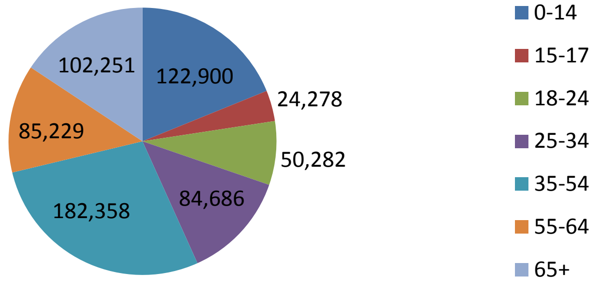
EDUCATION LEVEL

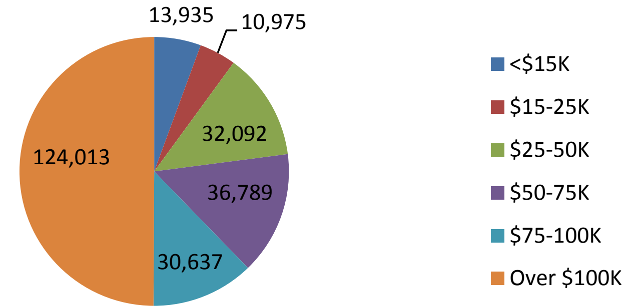
	Education Level Distribution		
2017 Adult Education Level	**Pop Age 25+**	**% of Total**	**USA % of Total**
Less than High School	22,481	4.9%	5.8%
Some High School	16,117	3.5%	7.7%
High School Degree	58,239	12.8%	27.8%
Some College/Assoc. Degree	81,077	17.8%	29.1%
Bachelor's Degree or Greater	276,610	60.9%	29.6%
Total	**454,524**	**100.0%**	**100.0%**

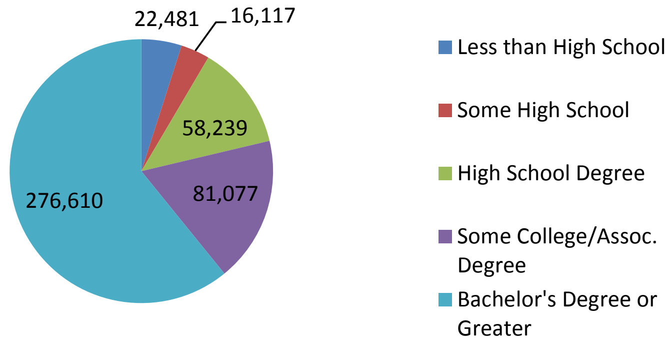
RACE/ETHNICITY

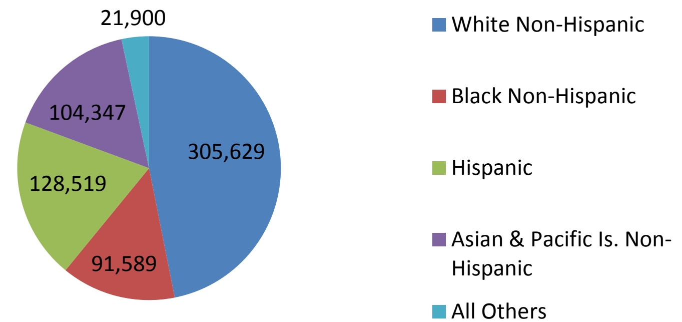
	Race/Ethnicity Distribution		
Race/Ethnicity	**2017 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	305,629	46.9%	60.8%
Black Non-Hispanic	91,589	14.0%	12.4%
Hispanic	128,519	19.7%	18.0%
Asian & Pacific Is. Non-Hispanic	104,347	16.0%	5.7%
All Others	21,900	3.4%	3.2%
Total	**651,984**	**100.0%**	**100.0%**

2017 Demographic Snapshot Charts
Area: Suburban FY2017 CB SA
Level of Geography: ZIP Code









APPENDIX VII: SUBURBAN HOSPITAL FY 2017 CBSA DEFINITION

FY 2017 Suburban Hospital Community Benefit Service Area Definition

Zip Code	City
20906	SILVER SPRING
20902	SILVER SPRING
20878	GAITHERSBURG
20852	ROCKVILLE
20910	SILVER SPRING
20854	POTOMAC
20850	ROCKVILLE
20853	ROCKVILLE
20895	KENSINGTON
20851	ROCKVILLE
20814	BETHESDA
20815	CHEVY CHASE
20817	BETHESDA
20877	GAITHERSBURG
20874	GERMANTOWN

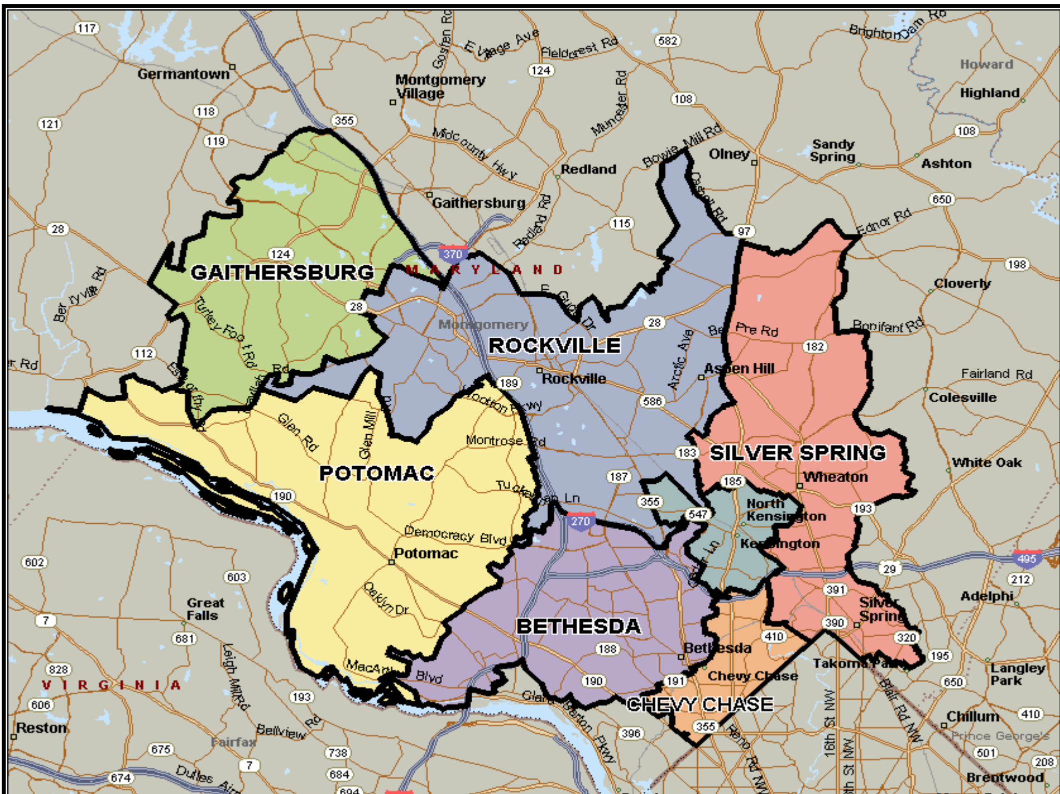
<u>Criteria used to define the Suburban Hospital Community Benefit Service Area (SH CBSA):</u>

The SH CBSA is defined as the geographic region that includes zip codes that are common to the following:

a) The top 20 zip codes from which Suburban Hospital ED visits originate*
b) The Top 20 zip codes from which Suburban Hospital FY17 inpatients originate*
c) The top 25 zip codes for Suburban Hospital Charity Care cases*
d) The Top 10 zip codes for Suburban Hospital Community Benefit Actitivites**

*As defined by indicated residence of the recipient

** As defined by the total number of Suburban Hospital programs in the indicated zip code



APPENDIX VIII: SUBURBAN HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT 2016

COMMUNITY HEALTH NEEDS ASSESSMENT

2016

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

Suburban Hospital

Community Health Needs Assessment

2016

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2 EXECUTIVE SUMMARY

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County, MD and the surrounding area since 1943. Suburban Hospital's mission is to improve health with skill and compassion. The following values are its cornerstones: communication, integrity, teamwork, accountability and compassion. Suburban Hospital prides itself on the various major services offered to patients, as well as the community benefit services, programs and initiatives that extend beyond the hospital walls. The hospital serves a community that is diverse in racial and ethnic background, culture, life stage and socioeconomic status. While Montgomery County is home to some of the most affluent communities in our nation. However, even with great resources, Montgomery County faces unique access to care challenges because of several social and economic disparities. There are approximately 1,016,677 residents living in Montgomery County, of which 47.0% are White non-Hispanics, 17.0% are Black non-Hispanics, 18.3% Hispanic/Latino and 14.0 % Asian/Pacific Islander. The per capita income for White non-Hispanic is $67,181 whereas for Hispanics/Latinos it is only $23,393. The premature death rate in Montgomery County is approximately 3,500 per 100,000 population (age-adjusted) compared to the state average of 6,400 years of potential life lost before age 75. Approximately 7.9% of county residents smoke, 57.4% are overweight or obese, 18% of adults 20 years and older report no physical activity, and 15% partake in excessive or binge drinking. In Montgomery County, 14.8% of residents rely on public health coverage, and 6.9% live below the federal poverty line. The high school graduation rate is 89.7%. Unemployment has decreased over the past three years to 4.4%, and 16.7% of adults report inadequate social and emotional support.

The average infant mortality rate in Montgomery County is 4.8 per 1,000 live births. Among Black non-Hispanics that number increases to 8.3 compared to 3.5 for their White non-Hispanic counterparts. The average life expectancy of an individual living in Montgomery County is 84.3 years; however, it is 82.4 years for Black non-Hispanics compared to 84.3 years for White non-Hispanic. In Montgomery County, the leading causes of death for all races are heart disease, cancer and stroke. Nearly 100,000 residents do not have health insurance, which is equivalent to 9.7% of the total population. Additionally, 10.4 % of adult residents reported not being able to financially afford to see a doctor in the past year with Hispanics/Latinos reporting the highest financial barriers (19.5%).

Mandated by the Internal Revenue Service (IRS) to conduct a Community Health Needs Assessment (CHNA) every three years and to develop an implementation strategy, Suburban Hospital executed this process with a three-tiered approach: 1) reviewing available local, state, and national datasets for core health indicators for Montgomery County; 2) engaging health experts and stakeholders to advise on the direction of the needs assessment; and 3) conducting a community health survey to assess the needs and insights of residents in high priority zip codes from Suburban's Community Benefit Service Area (CBSA).

Suburban Hospital surveyed 427 Montgomery County residents in the seven zip codes that were determined to be part of its Community Benefit Service Area high-need zip codes in order to gain a more comprehensive understanding of the community's health needs. Community members were surveyed with a questionnaire on issues related to their biggest perceived health concern; barriers to health; healthy lifestyle behaviors such as fruit and vegetable consumption, tobacco use, alcohol consumption, seatbelt use and stress management; and self-reported health status.

Community members identified five major health issues in the county today: overweight/obesity, heart disease, cancer, high blood pressure and diabetes. These findings aligned almost identically to the major health priorities of

Healthy Montgomery (Montgomery County's formal Community Health Improvement Process). Respondents said that 'cost' was the most significant barrier to receiving the health care they or others need (28%), followed by lack of health insurance (18%), lack of time (17%), and lack of information (11%). The community was asked to assess their personal health behaviors. Physical activity level was found to be low among respondents, where only 36% reported always engaging in at least 20-30 minutes of moderate physical activity at least five days a week. Fruit and vegetable consumption was also assessed and 27% of the community reported always eating at least five servings every day compared to 7% who said never. Overall, 82% of respondents never used tobacco products, 70% never consume more than five alcoholic drinks a week, 92% always wear a seatbelt while traveling in a vehicle, and 31% are always or often able to manage and control their stress. When asked to rate their own health status, 20% said they have excellent health and 55% said they have good health. While only 11% of respondents did not see a need to change their health behavior, 67% felt at risk of developing a disease.

Results from primary and secondary data, Suburban's medical area of expertise, county, state, and national health priorities were taken into consideration to identify the five the top five health needs for Suburban's community. After multiple prioritization discussions with stakeholders, the following main focus areas emerged for Suburban's 2016 Community Health Needs Assessment: obesity, cancer, diabetes, cardiovascular, and behavioral health. During the first assessment, conducted in 2013, these same conditions were identified as health priorities for Suburban Hospital. Suburban Hospital will continue to build upon existing programs addressing these five health areas and will work diligently with partners over the next three years to ensure that the valuable information attained from the CHNA is an integral tool for monitoring and evaluation of established health targets and goals.

3 INTRODUCTION

About the Federal Requirements

Under Section 501(c) (3) of the Internal Revenue Code, nonprofit hospitals may qualify for tax-exempt status if they meet certain federal requirements. The 2010 Patient Protection and Affordable Care Act (ACA) added four basic requirements to the Code. One of the additional requirements for tax-exempt status is the provision of a community health needs assessment (CHNA) every three years and an implementation strategy to meet the identified health needs.[1]

The purpose of a community health needs assessment is to identify the most important health issues surrounding the hospital using scientifically valid health indicators and comparative information. The assessment also identifies priority health issues where better integration of public health and healthcare can improve access, quality, and cost effectiveness of services to residents surrounding the hospital.

This report represents Suburban Hospital's efforts to share information that can lead to improved health status and quality of care available to our residents, while building upon and strengthening the community's existing infrastructure of services and providers.

Background on Healthy Montgomery

Healthy Montgomery, launched in June 2009 and initiated by the Montgomery County Department of Health and Human Services, is the County's formal Community Health Improvement Process (CHIP). Healthy Montgomery aims to improve access to health and social services, achieve health equity, and support optimal health and well-being for Montgomery County residents through a dynamic ongoing process that allows stakeholders to monitor and act on conditions affecting the health and well-being of its residents.

Healthy Montgomery is governed by a Steering Committee composed of members from the public health system, such as county government and public health officials, advocacy groups, academic institutions, minority health programs/initiatives, and members of health care provider organizations. Suburban Hospital is a permanent steering committee member, providing recommendations and technical expertise to help advance periodic county-wide needs assessments, identification and prioritization of health needs, leverage of population-based data and information, and the research and adoption of best-practice strategies for health improvement. In addition, since 2010, Suburban Hospital has contributed $25,000 annually to support an ongoing health improvement process and infrastructure. **See Appendix A for a list of Healthy Montgomery Steering Committee Members.**

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[1] Internal Revenue Bulletin: 2015-5; https://www.irs.gov/irb/2015-5_IRB/ar08.html

Overview of Suburban Hospital

Suburban Hospital is located in Montgomery County, MD, one of the most affluent counties in the United States. Montgomery County is adjacent to Washington, D.C., and is also bordered by the Maryland counties of Frederick, Carroll, Howard and Prince George's, and the Commonwealth of Virginia.

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The hospital provides all major services except obstetrics. One of nine regional trauma centers in Maryland, the hospital is the state-designated level II trauma center for Montgomery County with a fully equipped, elevated helipad. Suburban Hospital's busy Emergency/Shock Trauma Center treats more than 40,000 patients a year.

The hospital's major services include: a comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; The NIH Heart Center at Suburban Hospital, providing cardiac surgery, elective and emergency angioplasty as well as inpatient diagnostic and rehabilitation services; orthopedics with joint replacement and physical rehabilitation; behavioral health; neurosciences including a designation as a Primary Stroke Center and a 24/7 stroke team; pediatrics and senior care programs.

Other services provided include: the NIH-Suburban MRI Center; state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; and a free physician referral service (Suburban On-Call). Suburban Hospital is the only hospital in Montgomery County to achieve the Gold Seal of Approval™ by The Joint Commission for its joint replacement program.

During fiscal year 2015, Suburban Hospital was licensed to operate 220 acute care beds, and had 13,861 inpatient admissions.

4 THE COMMUNITY WE SERVE

Suburban Hospital's Definition of Community Served by Hospital Facility

A PSA or primary service area is defined as the postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period. This information is provided by the Maryland Health Services Cost Review Commission (HSCRC). Suburban's Hospital's PSA includes the following zip codes: 20852, 20814, 20854, 20817, 20815, 20850, 20906, 20895, 20902, 20878, and 20874.

Suburban Hospital considers its Community Benefit Service Area (CBSA) as specific populations or communities of need to which the Hospital allocates resources through its community benefits plan. Within the CBSA, Suburban Hospital focuses on certain target populations such as uninsured individuals and households, underinsured and low-income individuals and households, ethnically diverse populations, underserved seniors and at-risk youth.

To determine the Hospital's CBSA, data from Inpatient Records, Emergency Department (ED) Visits, and Community Health Improvement Initiatives and Wellness Activities were aggregated and defined by the geographic area

contained within the following sixteen zip codes: 20814, 20817, 20852, 20854, 20815, 20850, 20895, 20906, 20902, 20878, 20853, 20910, 20851, 20877 and 20874. Suburban's CBSA extends beyond its primary service area. **See Figure 1**.

Figure 1. Suburban Hospital Community Benefit Service Area (CBSA) Zip Codes.

Demographic Profile of Community Served

This section provides an overview of the demographics of Suburban Hospital's CBSA, with comparison to county, state, and national data as a reference where available. All data are sourced from Healthy Montgomery, Data Montgomery, and the US Census unless otherwise indicated.

Population

Montgomery County is home to 1,016,677 people.[2] Suburban CBSA residents makes up nearly 63% of the total population. The population in the CBSA is growing at a faster pace than the county, state, and national level.

[2] 2015 County Health Ranking

Between 2010 and 2015, the population size in the CBSA grew by 6.4%. Both in the CBSA and at the County level, females make up 52% of the population.[3]

Table 1. Population Growth & Average Household Income

	SH CBSA[3]	Montgomery County	Maryland	USA
2010 Total Population	598,189	971,777	5,773,552	308,745,538
2015 Total Population	638,821	1,016,677	5,928,814	319,459,991
% Change 2010-2015	6.4%	4.4%	2.6%	3.4%
Average Household Income	$138,765	$97,873	$72,482	$74,165

Source: County Health Rankings & Truven Health Analytics, Inc.

Economic Characteristics

In Montgomery County, the average household size is 2.70 persons and the average family size is 3.22 persons.[4] To live in Montgomery County, without any private or public financial assistance, a family of three (one adult, one preschooler, and one school-aged child) requires an annual income of $77,933.[5] The average household income in the CBSA is $138,765 compared to $97,873 in the County.[3] While the per capita income for the county is $49,038, looking at specific racial/ethnic groups reveals great disparities. For example, the per capita income for White non-Hispanic ($67,181) is almost three times that of Hispanics/Latinos ($23,393).[5] **See Figure 2.**

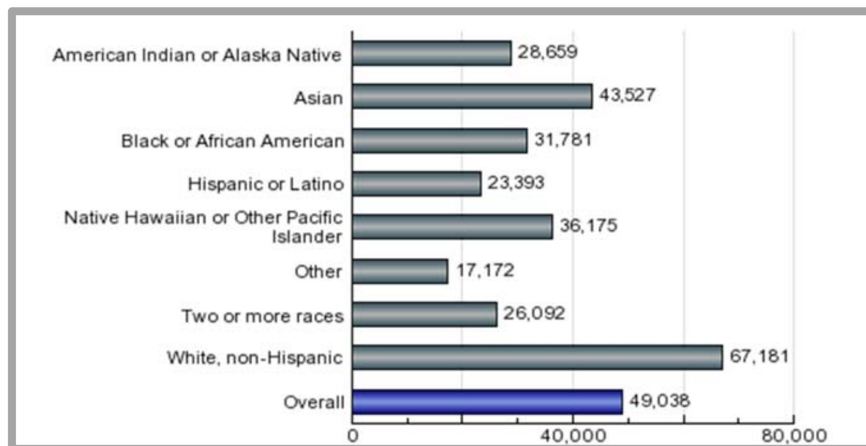


Figure 2. Per Capita Income by Race/Ethnicity

Source: Healthy Montgomery (2010-2014)

[3] (Truven Health Analytics, 2015)

[4] (US Census Bureau FactFinder, 1)

[5] (Healthy Montgomery, 2010-2014)

At the County level, 6.9% of the total population and 4.5% of families live below the federal poverty line.[5] Poverty affects Montgomery County residents disproportionately. Black non-Hispanics (11.5%) and Hispanics/Latinos (11.4%) have the highest rates of poverty in the County. The least impoverished groups are White non-Hispanics (3.6%) and American Indian/Alaska Natives (4.4%).[6]

In the County, 51.5% of renters spend 30.0% or more of their household income on rent leaving minimal resources for other expenses, such as food, transportation, health, and savings (2010-2014).[5] Although the unemployment rate for Maryland remains at 5.8%, in Montgomery County it has decreased from 5.6% to 4.4% since 2013.[2]

Age

The premature death rate in Montgomery County is approximately 3,500 per 100,000 population (age-adjusted) compared to the state, with 6,400 years of potential life lost before age 75.[2] While infant mortality rates at the County level have decreased to 4.8 per 1,000 live births, the rate for White non-Hispanics has increased to 3.5 from 2.9 between 2011 and 2014. Hispanics/Latinos (7.8/1,000) and Black non-Hispanics have the highest (8.3/1,000).[7,5]

The average life expectancy in Montgomery County is 84.3 years at birth, which is higher than the Maryland baseline (79.6). The life expectancy for White non-Hispanics (84.3) is longer than Black non-Hispanics (82.4).[8] The median age in Montgomery County is estimated to be 38.5 years, where 23.5% of the population is under the age of 18, and 13.7% are 65 years of age or older.[4] The current and projected age distribution within Suburban's CBSA is similar to the County level (**See Table 2**).

Table 2. Suburban's CBSA Population Age Distribution

	Age Distribution				
Age Group	2015	% of Total	2020	% of Total	USA 2015 % of Total
0-14	119,379	18.7%	122,463	18.1%	19.1%
15-17	23,838	3.7%	25,964	3.8%	4.0%
18-24	48,925	7.7%	55,633	8.2%	9.9%
25-34	85,180	13.3%	78,386	11.6%	13.3%
35-54	182,077	28.6%	185,765	27.5%	26.3%
55-64	83,568	13.1%	91,893	13.6%	12.7%
65+	95,854	15.0%	115,821	17.1%	14.7%
Total	**638,821**	**100%**	**675,925**	**100%**	**100.0%**

Source: Truven Analytics Inc.

[6] ("Healthy Montgomery: Community Dashboard", n.d.)

[7] (Montgomery Maryland State Health Improvement Process, 2014)

[8] (Maryland Vital Statistics Annual Report, 2013)

Ethnic/Racial Diversity

Montgomery County prides itself on its racial diversity and cultural richness. The County's population is 47.0% White non-Hispanic, 17.3% Black non-Hispanic, and 14.9% Asian.[4] Montgomery County has the largest population of Hispanics/Latinos (18.3%) in Maryland.[2] Foreign-born residents account for 32.4% of the population in Montgomery County. It is not surprising to find that 39.3% of county residents speak a language other than English at home.[4] The most common spoken languages, aside from English (60.7%), include Spanish (15.7%), other Indo-European (10.1%), and Asian and Pacific Islander languages (9.4%).[4] **Table 3** represents the racial/ethnicity distribution at the CBSA level, which mirrors County level information.

Table 3. Suburban Hospital CBSA Race/Ethnicity Distribution

Race/Ethnicity	2015 Pop	% of Total	USA % of Total
White non-Hispanic	312,333	48.9%	61.8%
Black non-Hispanics	86,654	13.6%	12.3%
Hispanic/Latino	121,084	19.0%	17.6%
Asian & Pacific Is. Non-Hispanic	97,898	15.3%	5.3%
All Others	20,852	3.3%	3.1%
Total	**638,821**	**100%**	**100%**

Source: Truven Health Analytics Inc. 2015

Education

Montgomery County has a high percentage (57.1%) of residents over 25 years of age who hold a Bachelor's Degree or higher. Asians (65%) and White non-Hispanics (69%) are the races/ethnicities in Montgomery County with the greatest attainment of Bachelor's Degrees or higher, while Hispanics/Latinos have the lowest rate (24.6%).[5] A college degree is important for obtaining high paying jobs and having access to healthcare services.

Within Suburban's CBSA, the percentage of individuals holding higher education degrees is slightly higher than the County. However, a closer look at the individual zip codes in the CBSA highlights zip code 20877 (Gaithersburg) as having the lowest (34.3%) and 20817 (Potomac) having the highest rate of individuals with a Bachelor's Degree.[6] **See figure 3** for a comparison of college degree attainment across the CBSA zip codes.

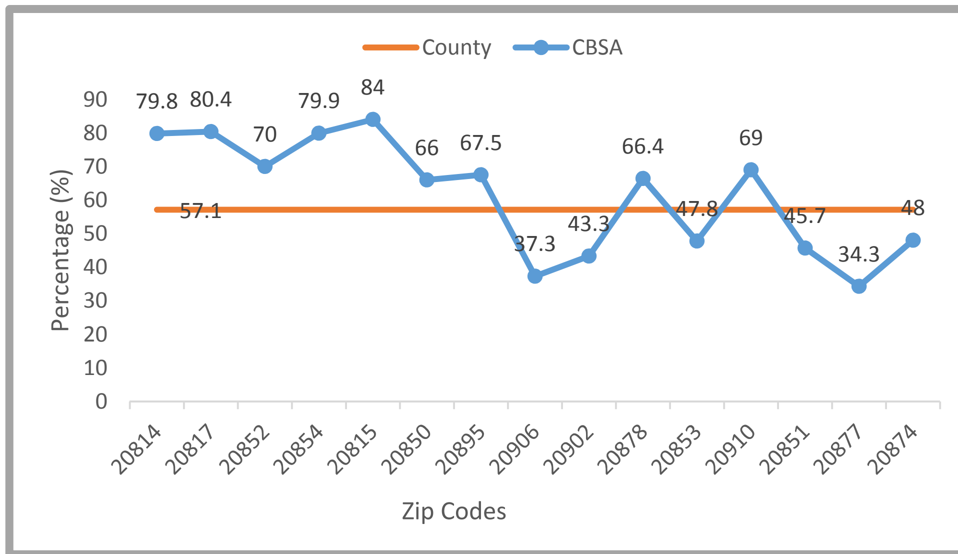


Figure 3. Percentage of people age 25 and over with a Bachelor's Degree

Healthcare Access

Whereas 87.2% of the population in Montgomery County is insured, 14.8% of residents rely on public health coverage. A closer look at the uninsured population (9.7%) reveals that an individual in the 18-34 age group is most likely to be uninsured (19.3%) followed by the 35-64 age group (10.9%). These numbers, however, have decreased in the past three years.[5]

Uninsured individuals make up 3.61% of Suburban's total CBSA population, less than the County average. Within Suburban's CBSA, individuals living in zip code 20854 (Potomac) are most likely to be insured. In comparison, residents in 20906 (Silver Spring) and 20877 (Gaithersburg) have the highest percentage of uninsured residents in Suburban's CBSA, with rates of 6.14% and 5.22% respectively.[3] **See Appendix B for 2015 Insurance Coverage Estimates for Suburban Hospital's CBSA.**

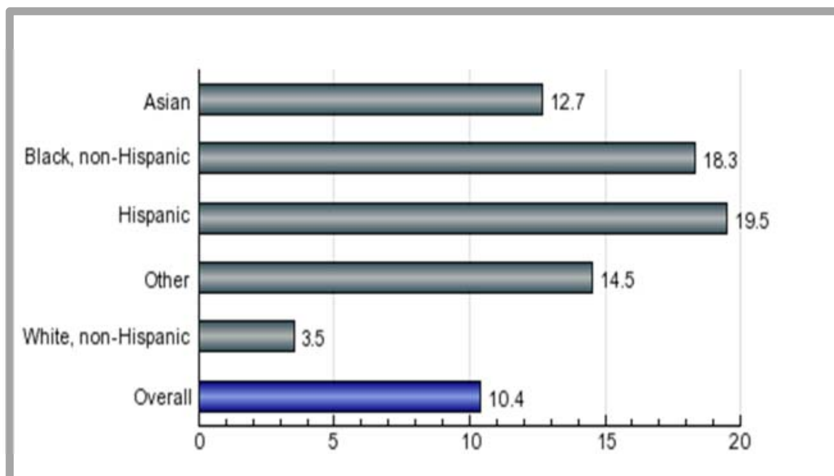


Figure 4. Adults Unable to Afford to See a Doctor by Race/Ethnicity

Source: Healthy Montgomery, 2014

People who do not have insurance and are unable to afford to see a doctor may not receive proper and timely medical services when needed. In 2014, 10.4% of the adult population in Montgomery County reported being unable to see a doctor in the past 12 months. This number decreased by 3% since 2011.[5] When accessing care, there is a significant variation among the racial/ethnic groups. In Montgomery County, Hispanics/Latinos (19.5%) and Black non-Hispanics (18.3%) continue to be the major race/ethnic groups most affected by the inability to afford to see a doctor.[5] **See Figure 4**.

5 SUBURBAN HOSPITAL'S APPROACH TO COMMUNITY HEALTH NEEDS ASSESSMENT

To effectively identify and prioritize health needs for Montgomery County residents, Suburban Hospital implemented a three-part process to execute its Community Health Needs Assessment: (1) Engage health experts and key stakeholders, (2) review secondary datasets for core health indicators, and (3) collect primary data via a community health survey. Through this methodology, Suburban ensured optimum collaboration and leverage of resources, reduction of redundancies and support of an ongoing health improvement process and infrastructure.

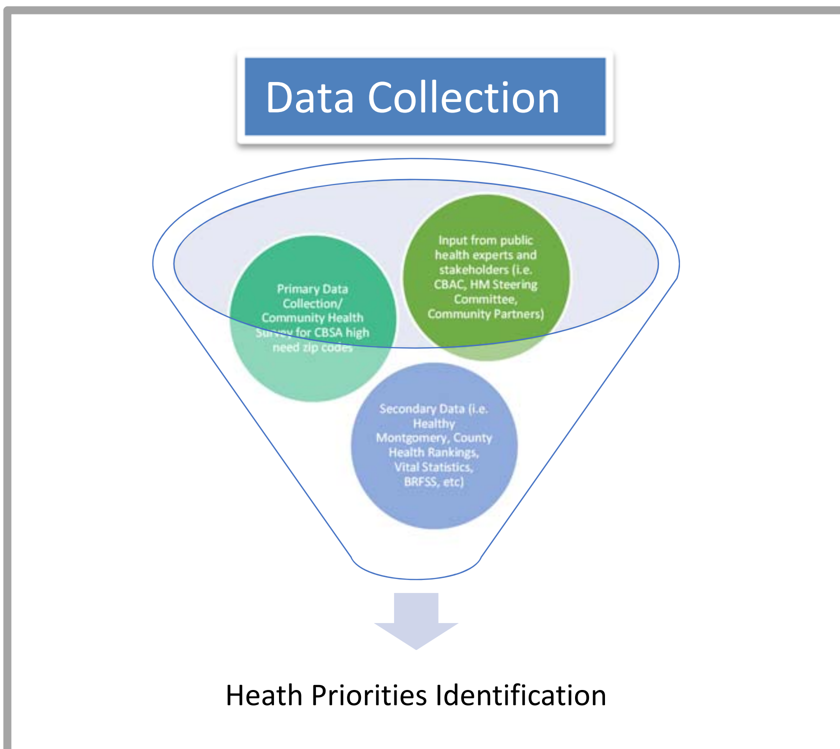


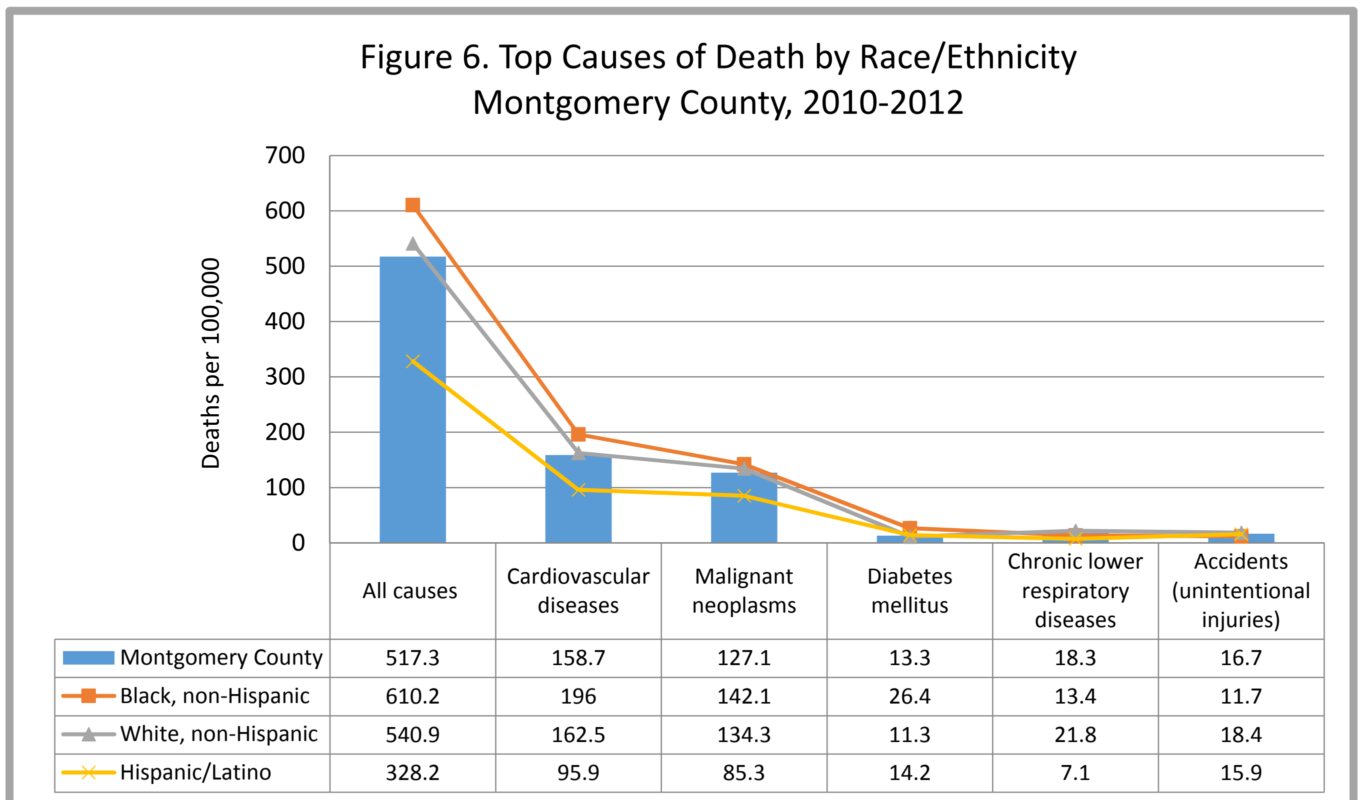
Figure 5. Suburban Hospital's Data Assessment Process.

Health Outcomes

Top Leading Causes of Death in Montgomery County

The chances of pre-mature death in Montgomery County (3,500 per 100,000) is low compared to the state of Maryland (6,400 per 100,000) and that of all the other counties that make up the state.[2] Most recent data for Montgomery County reports 517.3 total deaths per 100,000 population. Cardiovascular disease (158.7 per 100,000) continues to be the leading cause of death for Montgomery County residents, followed by malignant neoplasms (127.1 per 100,000), and chronic lower respiratory diseases (18.3 per 100,000).[9] **See Appendix C for a list of the top ten causes of death in Montgomery County**.

Data Montgomery, the County's portal to direct access to a variety of datasets, reveals that cardiovascular diseases and malignant neoplasms (cancer) were the top two main causes of mortality in Montgomery County for White non-Hispanics, Black non-Hispanics, and Hispanic/Latinos between 2012-2012. Differences in disease prevalence are seen outside these top two conditions, where the third leading cause of death for Black non-Hispanics is diabetes (26.4 per 100,000), accidents for Hispanics/Latinos (15.9 per 100,000), and chronic lower respiratory disease for White non-Hispanics (21.8 per 100,000).[9] See Figure 6.



	All causes	Cardiovascular diseases	Malignant neoplasms	Diabetes mellitus	Chronic lower respiratory diseases	Accidents (unintentional injuries)
Montgomery County	517.3	158.7	127.1	13.3	18.3	16.7
Black, non-Hispanic	610.2	196	142.1	26.4	13.4	11.7
White, non-Hispanic	540.9	162.5	134.3	11.3	21.8	18.4
Hispanic/Latino	328.2	95.9	85.3	14.2	7.1	15.9

Source: Data Montgomery

[9] (Population Health Measures: Age-Adjusted Mortality Rates, n.d.)

Cardiovascular disease

Cardiovascular disease, or CVD, is not a single disease, it is but an umbrella term for multiple conditions that involve narrowing or blockage of the blood vessels of the heart, the brain, and the circulatory system. CVD is the leading cause of death in Maryland and the US. CVD can affect both men and women, without regard to ethnicity, race or socioeconomic status. Most forms of CVD include coronary heart disease and cerebrovascular disease. There are several risk factors associated with CVD. Some of these are: diabetes, hypertension, high cholesterol, obesity, smoking, alcohol use, poor diet and inactivity. Due to the complexity of this disease, it can incur higher health care costs.

Coronary heart disease is also known as heart disease. Over the years, the age-adjusted death rate due to heart disease has slowly decreased in Montgomery County. In fact, the mortality rate in Montgomery County (108.0 deaths per 100,000) is lower than the state of Maryland (172.8 death per 100,000).[9,10] Although this condition is not gender specific, men are more likely to die from heart disease than women. When comparing different races and ethnicities, Black non-Hispanics have the highest number of deaths associated with this health condition.[9] **See Figure 7.**

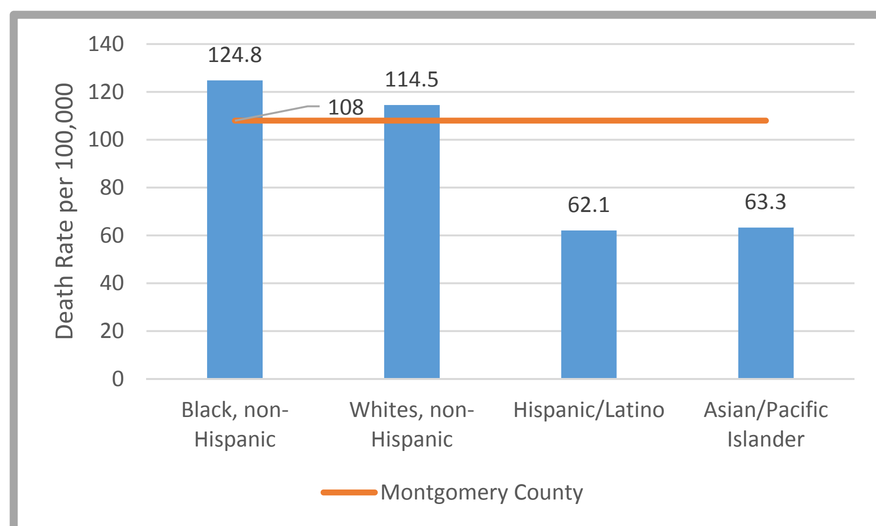


Figure 7. Age-Adjusted Death Rate per 100,000 due to Heart Disease by Race/Ethnicity.

Source: National Center for Health Statistics, 2011-2013

Cerebrovascular disease or stroke is the brain's equivalent of a heart attack. The age-adjusted death rate due to stroke in Montgomery County is 25.6 deaths per 100,000 population. Cerebrovascular death rates tend to be slightly higher for Black non-Hispanics (27.3 per 100,000) than for White non-Hispanics (25.0 per 100,000). Hispanics/Latinos (20.7 per 100,000) have the lowest rate of deaths attributed to cerebrovascular disease.[10]

Hypertension, or high blood pressure, and high cholesterol are two modifiable risk factors that place individuals at significant risk of developing stroke, heart disease, and other chronic conditions. As of 2013, 38.1% of Montgomery County residents were reported to have high cholesterol. High cholesterol is more common among those 65 and over (55.3%), followed by 45-64 years (44.8%), and 18-44 years (21.6%) age groups.[6] High blood pressure is present

[10] (National Center for Health Statistics, 2011-2013)

in 27.7% of County residents. Although 61.1% of those with high blood pressure are age 65 and over, this condition is also present in younger age groups: 18-44 years (9.0%) and 45-64 years (34.1%).[5] Males are more likely than women to suffer from higher cholesterol and hypertension.

Malignant Neoplasms (Cancer)

Malignant neoplasms, or cancer, is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled, it can result in death. A person's risk for developing cancer can be lowered by avoiding certain risk factors such as tobacco use, lack of physical activity, and high-fat/low fiber diets. In addition, prevention or delayed onset of cancer can be achieved through screening methods that allow early detection and removal of precancerous growths, thereby improving health outcomes. Early detection methods are currently available for specific cancers.

Cancer ranks as the second leading cause of death in Montgomery County for both men and women. The baseline for age-adjusted cancer rates is less in Montgomery County (127.1 per 100,000) than in Maryland (160.9 per 100,000) and the National rate (163.2).[10] According to Data Montgomery, cancer related deaths are more common in Black non-Hispanics (142.1 per 100,000) than other racial/ethnic minorities.[9] Men are more likely to die of cancer (142.7 per 100,000) than women (110.9 per 100,000).[5]

Table 4. Montgomery County Age-Adjusted Death Rate due to Specific Cancer Type

Cancer Type	Rate per 100,000
Breast	18.8
Colorectal	9.7
Lung	25.9
Prostate	16.7

Source: Healthy Montgomery, 2008-2012

When looking at specific types of cancers, there are disparities among the various racial/ethnic groups. Breast cancer is the leading cause of cancer deaths among women. However, Black non-Hispanic women die more frequently from breast cancer than any other racial group. Recent Montgomery County data show that 27.1 per 100,000 Black non-Hispanic women died of breast cancer compared to 18.4 per 100,000 White non-Hispanic women. Hispanics/Latinas (7.4 per 100,000) and Asian and Pacific Islander (8.4 per 100,000) women have the lowest mortality rate from breast cancer.[5]

Colorectal cancer ranks fourth in cancer related deaths. The age-adjusted death rate due to colorectal cancer in Montgomery County is 9.7 deaths per 100,000 population. More men (11.3 per 100,000) than women (8.6 per 100,000) die from this disease, even though both groups get screened at almost equal rates. In Montgomery County, more Black non-Hispanics (13.2 per 100,000) die from colorectal cancer than White non-Hispanics (9.1 per 100,000) and Asian/Pacific Islanders (9.7 per 100,000). Hispanics/Latinos (7.5 per 100,000) have the lowest reported death rate in the County for this cancer. [6]

Prostate cancer is the most common type of cancer in men. The age-adjusted death rate due to prostate cancer is 16.7 deaths per 100,000 males. Prostate cancer claims more Black non-Hispanics (28.1 per 100,000) lives than

colorectal cancer and is more common in this group than in White non-Hispanic men (16.7 per 100,000). County level data is unavailable for the Hispanic and Asian/Pacific Islander population.[6]

At the national level and in Montgomery County, lung cancer claims more lives than any other cancer. Although the mortality rate due to lung cancer among men has reached a plateau, the rate in women continues to rise. Lung cancer mortality is high for both Black non-Hispanics (30.9 per 100,000) and White non-Hispanic (26.5 per 100,000). According to available data, Asian/Pacific Islanders have an age-adjusted death rate of 18.2 per 100,000 due to lung cancer while Hispanics/Latinos have the lowest rate (11.1 per 100,000) compared to all other groups.[6]

Chronic Lower Respiratory Diseases

Chronic lower respiratory diseases (CLRD) refers to a group of conditions that affect the lungs. Currently, 6.8 million of adults in the US suffer from a type of CLRD. In Montgomery County, the age-adjusted death rate for CLRD is 18.3 per 100,000 – a decrease from previous years.[9] The most deadly CLRD is chronic obstructive pulmonary disease (COPD) which makes it difficult for an individual to breathe. Asthma, chronic bronchitis, and emphysema are the most common forms of COPD. Asthma accounted for 34.3 per 10,000 emergency room visits in 2011 and the age-adjusted hospitalization rate was 8.4 per 10,000 (2009-2011). [5]

COPD is more common among those 65 and older. Cigarette smoking has been identified as the main cause of COPD, but other factors such as air pollutants, genetics, and respiratory infections can contribute to the development of COPD.[11] In 2004, the healthcare expenditure for COPD reached over $20 billion. The average annual age-adjusted hospitalization rate due to COPD is 9.1 per 100,000 in Montgomery County (2009-2011).[5]

See Appendix C for mortality and morbidity rates by race and ethnicity for Montgomery County's leading causes of death.

Healthy Montgomery Core Measures Set

In 2013, through a multi-sectorial collaborative of local data experts, Healthy Montgomery identified a set of 37 community indicators that would represent the six health priority areas identified through the 2011 county-wide community health needs assessments. The six health priorities were: behavioral health, obesity, cancer, cardiovascular health, diabetes, and maternal and infant health. The 37 core indicators aim to capture key social determinant measures, help highlight areas of disparities and inequities, include metrics that are part of the Maryland State Health Improvement Process, Robert Wood Johnson's County Health ranking, and the national Healthy People 2020 Benchmarks. Furthermore, the 37 core measures presented in **Figure 6** allows planners, policy makers, and community members to establish common benchmarks and tracks progress towards important health and quality of life indicators.[6]

The 37 core indicators and their corresponding datasets are monitored and publicly available through Montgomery County's population-based database at www.healthymontgomery.org. The 37 core indicators serve as a systematic and quantitative source for comparing severity and improvement across the identified health priorities for Montgomery County. With the assistance of Montgomery County Department of Health and Human Services

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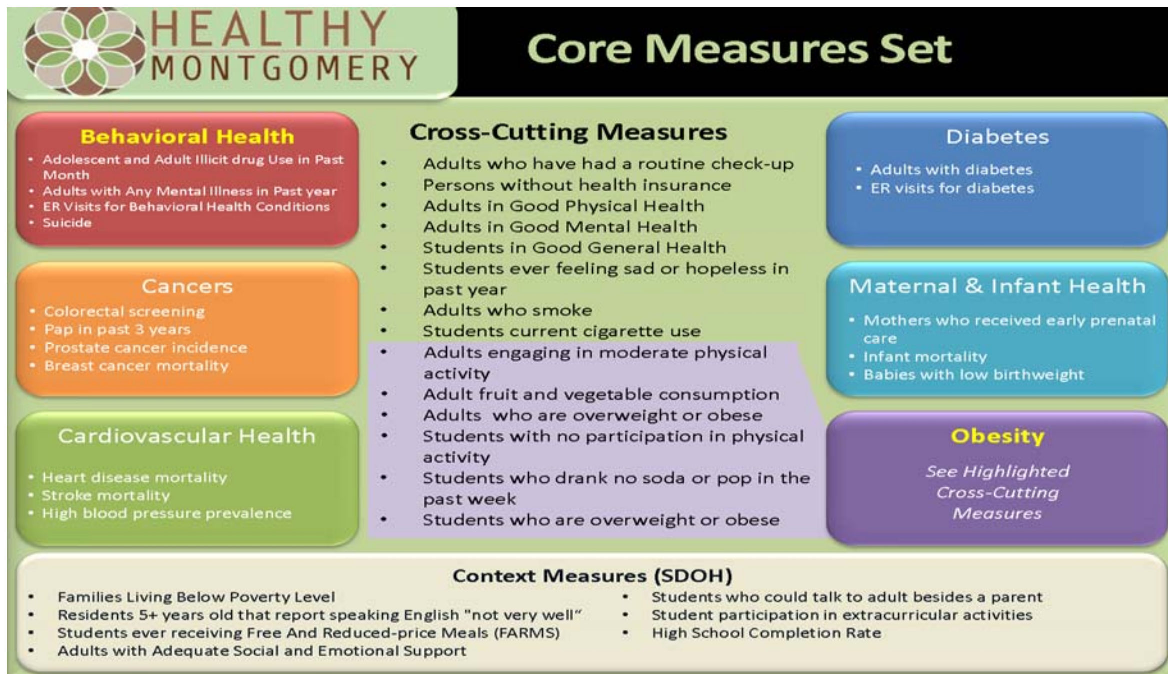
[11] (Centers for Disease Control and Prevention, 2015)

(DHHS), key core measures were analyzed and processed for all six Montgomery County hospitals' community benefit service areas, including Suburban Hospital. Therefore, these indicators and their available datasets were adopted as a source for secondary data for Suburban's CHNA. **See Appendix D for an analysis of Core Measure Indicators for Suburban Hospital's CBSA.**

Figure 8. Healthy Montgomery Core Measure Indicators



Data Gaps/Limitations Identified

The Healthy Montgomery website was utilized as the main data resource for gathering quantitative data for Montgomery County residents. Where appropriate, census and state databases were also accessed to supplement needed data for the health indicators mentioned in this report. Despite the search for various resources, there were specific limitations and availability of information on particular racial/ethnic groups. Currently, baseline data for variables aimed to measure social determinants of health are not all-inclusive, limiting group comparison analysis. Furthermore, data at the local level is needed to be able to assess and evaluate health outcomes for specific communities within Suburban's Community Benefit Service Area zip codes.

Top Inpatient Diagnoses at Suburban Hospital

All Patients Refined Diagnosis Related Groups (APR-DRG) is a classification system that categorizes patients according to their reason for hospital admission, severity of illness and risk of mortality. It helps to monitor the

quality of care and the utilization of services in a hospital setting.[12] Suburban Hospital's top causes of hospitalizations, based on APR-DRG, for the past three years are reported in **Table 5**.

Suburban Hospital is distinguished as a Certified Stroke Center and Level II Trauma Center, as well as a Center of Excellence for cardiac care, orthopedics and joint replacement surgery, neurosciences and oncology. The most common reasons for hospitalizations at Suburban is a reflection of the causes of morbidity in users and Suburban's area of medical expertise.

Table 5. Top APR-DRG Inpatient Diagnosis at Suburban Hospital

APRDRG	APR-DRG Description	2013	2014	2015
302	KNEE JOINT REPLACEMENT	780	864	1049
720	SEPTICEMIA & DISSEMINATED INFECTIONS	592	745	920
301	HIP JOINT REPLACEMENT	526	597	755
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	572	518	539
753	BIPOLAR DISORDERS	462	455	458
194	HEART FAILURE	359	337	377
139	OTHER PNEUMONIA	354	290	336
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	251	272	321
308	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	219	234	260
775	ALCOHOL ABUSE & DEPENDENCE	266	251	242

Source: Suburban Hospital, EPIC 2016

6 COMMUNITY INPUT

While secondary data (from sources such as Healthy Montgomery, County Health Rankings, Warehouse Indicators, Data Montgomery, and the MD Vital Statistics Report) provide a macroscopic view of the causes of morbidity and mortality in populations, Suburban Hospital prioritized the need to understand what the unmet health needs are in communities of greatest need within Suburban's Community Benefit Service Area zip codes through primary data analysis. This process included the development and distributions of a community health survey tool that allowed the collection of direct input from community members residing in Suburban's Community Benefit Service Area (CBSA) high need zip codes. **See Appendix E: Community Health Survey Tool.**

Survey Sample Population Calculation

In 2004, Dignity Health and Truven Health Institute developed the Community Need Index, or CNI, to assist in identifying areas that have greater need than others. CNI scores range from 1 to 5, with the higher the score

[12] (Shafrin, 2012)

reflecting the higher the need. CNI scores are calculated using socioeconomic barriers to health, such as income, cultural, education, insurance and housing. [13]

Suburban understands the importance of prioritizing and effectively distributing hospital resources to communities of greatest need. Suburban's 15 CBSA zip codes were rated using the CNI score system. Seven of the total CBSA zip codes (listed in **Table 6**) were identified to have a CNI score of 2.5 or greater.

Table 6. Suburban's CBSA top CNI score

City	Zip Code	CNI Score	Population Size
North Bethesda	20852	2.6	45,984
Germantown	20874	2.6	61,341
Rockville	20851	3.0	14,815
Silver Spring	20910	3.2	41,070
Wheaton-Glenmont	20902	3.6	51,468
Aspen Hill	20906	3.6	66,892
Gaithersburg	20877	3.8	36,133

To understand the greatest needs and barriers facing the residents of these seven zip codes a quantitative and qualitative community health survey tool was developed. The objective of this survey was to gather community input and perspectives on the following topics:

- Biggest issues or concerns in the community
- Trends relative to demographics, the economy, the health care provider community, and community health status
- Problems people face in obtaining health care and/or social services
- Services lacking in the community
- Barriers and services related to chronic health conditions
- Perceived health risks and benefits
- Recommendations for improving access to care and the health of the community

[13] (Truven Health Analytics)

Survey Data Collection

The population was sampled randomly, which afforded the best opportunity to gain valuable opinions of residents living in the identified seven zip codes. The survey was distributed throughout diverse locations, such as shopping centers, day laborer sites, public libraries, train and bus stops, food restaurant chains, senior centers, patient waiting room areas at safety-net clinics, and large community events. A team of interviewers was assembled to distribute the self-administered questionnaire and to assist respondents with questions.

The survey distribution period started in March 2015 and reached completion in June of 2015. A total of 427 surveys were collected from more than 25 different locations and utilized for data analysis. While the county-wide health needs assessment process "Healthy Montgomery" provides a picture of the health status of Montgomery County residents at-large, the findings from the survey results served as a primary source of information for behaviors, needs, and opinions about various health and community issues directly affecting Suburban Hospital's seven vulnerable CBSAs.

Health Survey Results

Suburban Hospital community benefit programs target populations residing in 15 specific zip codes in Montgomery County. The 15 Community Benefit Service Area (CBSA) zip codes were rated using the Community Needs Index (CNI) score to determine those communities with the highest need. Seven zip-codes in Suburban's CBSA were identified to have the highest need, with a CNI score of 2.5 or higher. Residents from these seven zip codes were surveyed to understand barriers and drivers to health. The survey results presented serve as an information guide for the behaviors, needs, and opinions about various issues directly affecting those residents in the top seven CBSA zip codes.

Survey Demographics

The survey sample size for specific zip codes was dependent on the population size for that particular zip code. Zip code 20874 had the largest population size while 20851 had the smallest among all seven zip codes. The respondent distribution across the seven zip codes is represented in **Figure 9**.

Survey participation was evenly distributed among females (50%) and males (49%). Respondents reported English (67%) as their preferred language for communication, followed by Spanish (28%), and other (5%) languages such as French, Portuguese, Farsi, and Chinese.

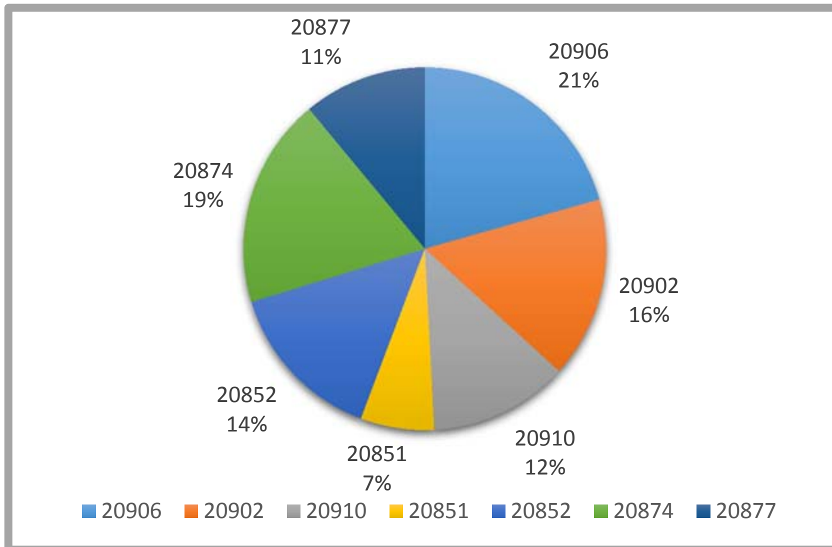


Figure 9: Survey Response by Zip Code

Montgomery County is one of the most diverse counties in the country. The level of diversity was evident at the zip code level, where 74% of respondents were found to be ethnically and racially diverse (**See Figure 10**). Nearly 70% of respondents were under the age of 50 years old.

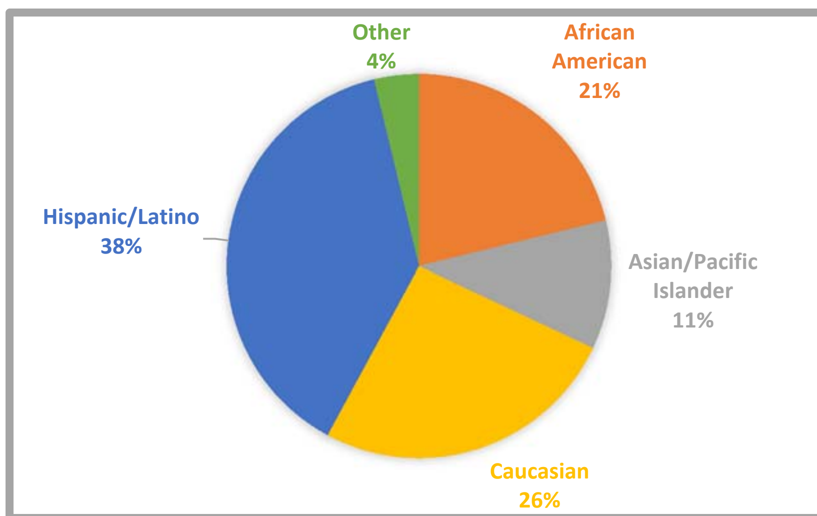


Figure 10. Survey Respondents Race & Ethnicity Distribution

Higher education level attainment has long been linked to better health. According to the Robert Woods Johnson Foundation, college graduates can expect to live five years longer than those who have not completed high school. Furthermore, research shows that adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime.

The percentage of high school graduates in Montgomery County has slowly increased over the years. Although 89.7% of students graduate from high school, Montgomery County has not reached the 2017 Maryland goal of

95%.[5,14] A Bachelor's degree is correlated with a better life. While 57.4% of residents in Montgomery County hold a Bachelor's degree, American Indians/Alaska Natives (25.7%) and Hispanics/Latinos (25.1%) are reported to have the lowest percent of individuals holding a bachelor's or higher degrees when compared to other racial/ethnic groups.[5] These percentages have increased over the years. Among the sampled population, only 38% of survey respondents reported having a Bachelor's degree or higher (**Figure 11**).

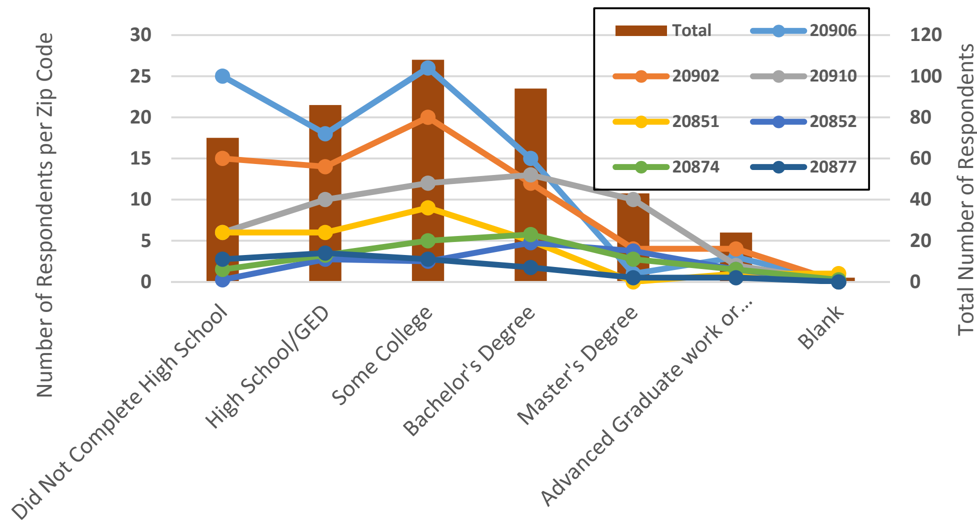


Figure 11: Survey Respondents Highest Level of Education Completed

Health Behaviors

The American Academy of Family Physicians suggests that to improve health, individuals should (among other things) exercise regularly, eat a healthy diet, avoid any form of tobacco, drink alcohol in moderation (if at all) and use a seatbelt when riding in a vehicle.[15] These behaviors have been identified as modifiable risk factors that can improve an individual's health outcome.

Physical Activity. Physical activity has been linked with reducing many serious health conditions including obesity, heart disease, diabetes, colon cancer, and hypertension while improving mood and promoting healthy sleeping patterns. [6] Approximately 52.7% of adults in the County engage in regular physical activity, while 18% report physical inactivity.[2,6]

The 2008 Guidelines for Physical Activity for Americans define moderate physical activity as engaging in 150 minutes of aerobic exercise a week plus two or more days of strength training exercises. Survey respondents were asked how often they engage in moderate physical activity (at least 2.5 hours per week) outside of work. Exercise frequency was common among respondents. Thirty-six percent reported "always" exercising the recommended

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[14] (Montgomery Maryland State Health Improvement Process, 2014)

[15] (America's Health Ranking Report, 2012)

amount, 52% “often” and/or “occasionally,” and 12% “never.” Altogether 64% of the sampled population does not always obtain the recommended amount of exercise. **See Figure 12.**

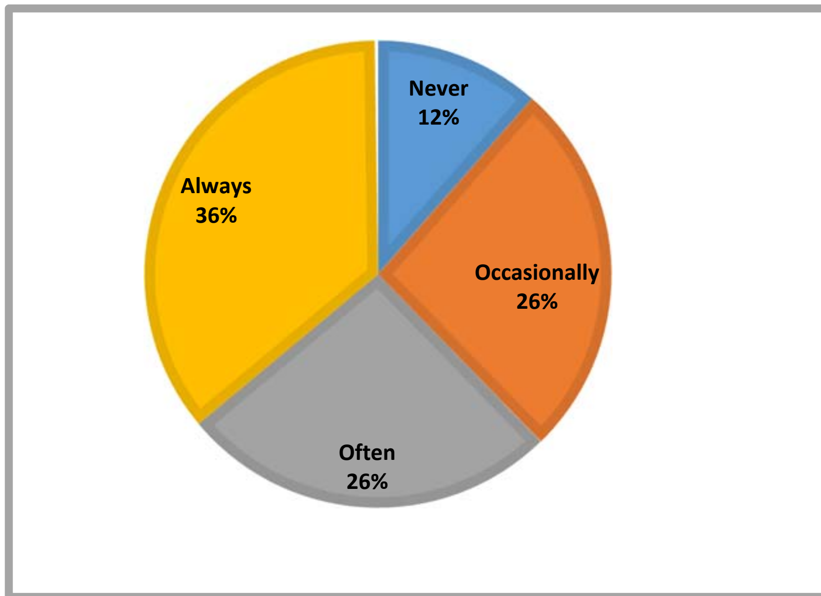


Figure 12. Survey Respondents Exercise Frequency.

Fruit and Vegetable Consumption. Only 29.6% of adults in Montgomery County consume the recommended five or more servings of fruits and vegetables a day according to the Behavioral Risk Factor Surveillance System (BRFSS).[6] In order to maintain a healthy weight and prevent chronic disease, numerous studies have shown that consuming vegetables and fruits in large quantities and varieties can decrease the risk of disease.

Survey respondents were asked to assess their frequency of fruits and vegetables consumption. One serving of fruit/vegetable is approximately equal to one-half cup. While 93% of respondents were found to consume fruits and vegetables, the frequency of consumption was not optimal. Consistent with the entire County, less than 30% of respondents were found to always consume the recommended portion and quantity of fruits and vegetables. **See Figure 13.**

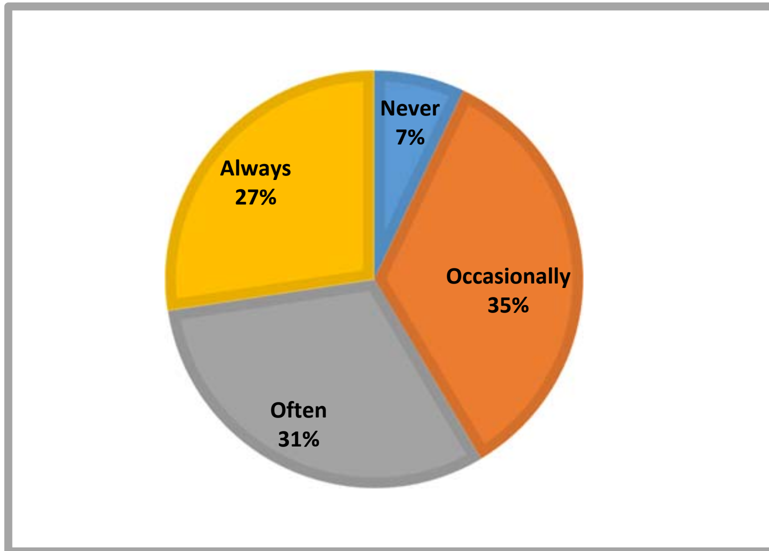


Figure 13. Survey Respondents Fruit and Vegetable Consumption

Tobacco. In Montgomery County, 7.9 % of the adult population currently smokes or smokes most days (2014).[14] Usage of tobacco products is linked with poor health outcomes, including pre-mature death. Respondents were asked how often they use tobacco products such as cigarettes, smokeless tobacco, cigars, and pipes. **Figure 14** demonstrates that 82% of respondents do not use tobacco products while 18% reported using some form of tobacco products- almost 2.5 times as many in the general county population).

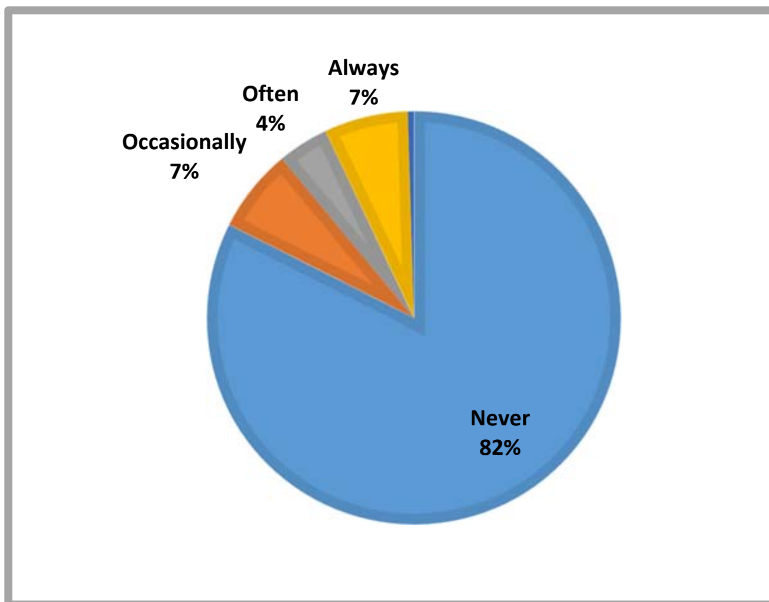


Figure 14. Survey Respondents Tobacco Use

Alcohol Consumption. Excessive drinking, defined as consumption of five or more alcoholic beverages at one occasion, is a serious problem and can lead to deadly consequences. A recommended moderate consumption of alcohol is equal to one drink a day for women and up to two drinks for men. Generally, anything greater than

moderate drinking can be harmful to one's health**.** The rate at the County level (15%) for excessive drinking is lower than the State (17%).[2] When asked if they consume more than five alcoholic drinks a week (beer, liquor, wine), 70% of respondents self-reported never exceeding this quantity. However, the rate of consumption was found to be twice as high as the overall County. **See Figure 15.**

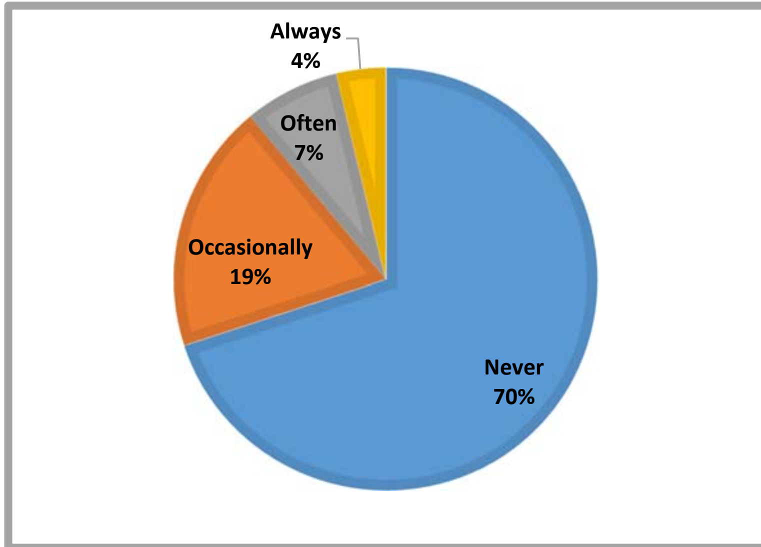


Figure 15. Survey Respondents Alcohol Consumption

Seatbelt Usage. The County's age-adjusted death rate due to motor vehicle collisions is 6.4 per 100,000 population.[6] Statistics demonstrate that seatbelt use helps save lives and prevent serious injury. When assessing seatbelt usage while traveling in a vehicle, more than 90% of respondents were found to wear their seatbelt at all times. The small percentage of participants that selected "never" as a response were individuals that used public transportation as their only source of transportation. Seatbelts are not made available in public buses or subways serving the Montgomery County area. **See Figure 16.**

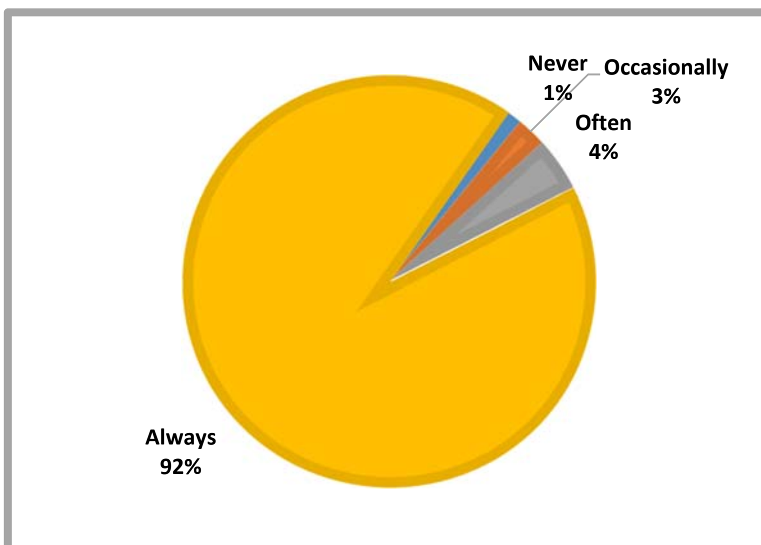


Figure 16. Survey Respondents Seatbelt Use

Stress Management. High levels of stress can lead to serious health problems. Effective stress management can reduce these negative impacts. Among those surveyed, 94% of respondents were found to be able to manage and control their stress. However, only 30% of individuals reported being able to manage their stress all the time, compared to those who are able to manage it often (49%) and occasionally (15%). **See Figure 17.**

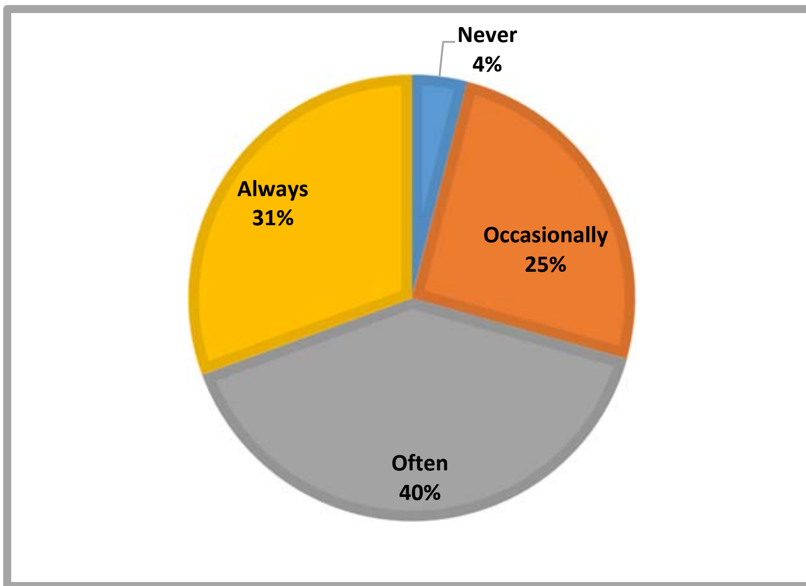


Figure 17. Survey Respondents Stress Management

Self-Reported Areas of Behavior Modification. A person's perceived health benefit serves as an indicator of a person's willingness to adapt secondary prevention behaviors and an assessment of how valuable the adaptation of a new behavior is to the person in decreasing their risk for developing a disease.[16] To assess perceived health benefit, respondents were asked to select an area of their health that needed the most improvement. Close to 90% of respondents indicated that they needed to improve certain health behaviors, with 35% indicating that physical activity was their top-rated area for behavior modification. Healthy eating and stress management were also listed as areas needing attention. **See Figure 18.**

[16] Jones and Bartlett Publishers. Health Belief Model, Chapter 4

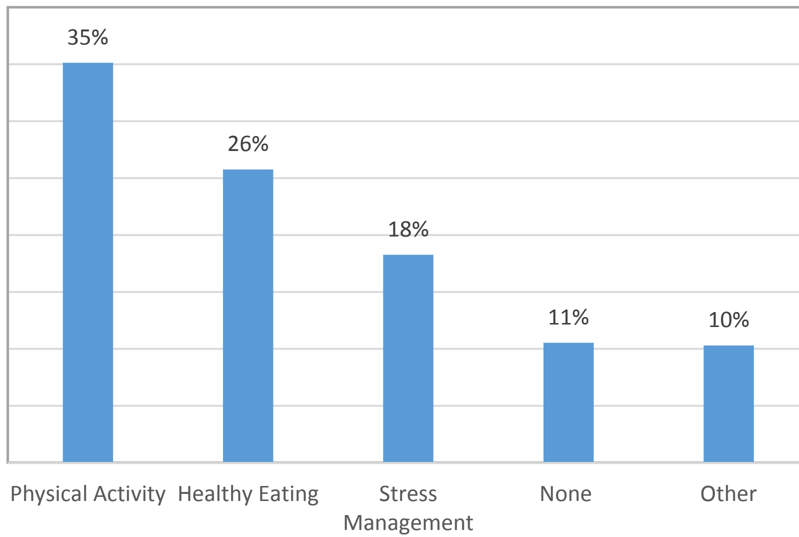


Figure 18. Self-Reported Areas of Behavior Modification by Survey Respondents

Health Priorities

Respondents were asked to rate their top five health concerns. Participants were given 13 different options to choose from, plus an option to write an open response. **Figure 19** presents the top five health concerns for the sample population, which are: diabetes/sugar (32%), high blood pressure/stroke (31%), cancer (26%), heart disease (25%), and overweight/obesity (20%).

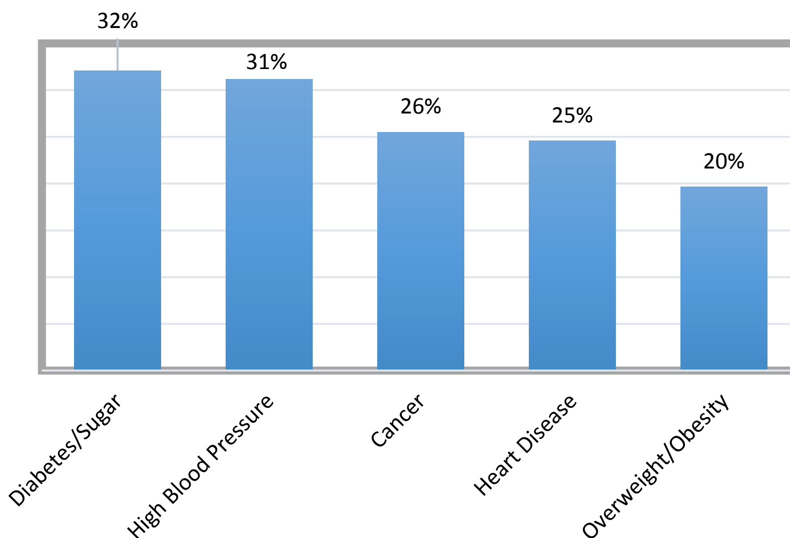


Figure 19: Top Five Health Concerns among Survey Respondents

Perceived risk is used to assess the likelihood to adopt a positive behavior to decrease one's risk. Participants were asked to assess their risk for developing a health condition. Sixty-five percent of respondents felt at risk for developing a health condition while 33% did not feel any risk. Diabetes (18%) was at the top of the list, followed by cancer (14%) and heart disease (14%). **See Figure 20.**

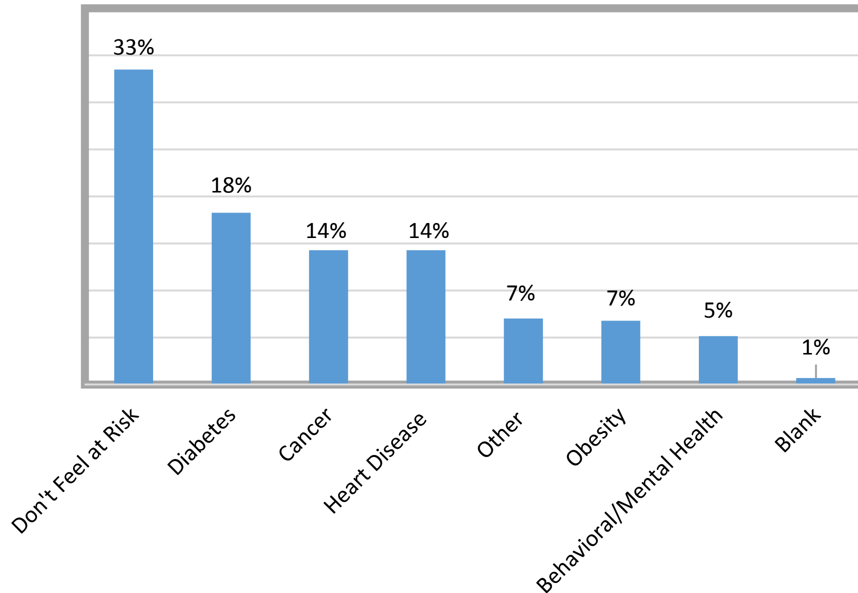


Figure 20. Perceived Health Risk among Survey Respondents

Self-Reported Health Status. Self-reported health status is a strong prognostic indicator for subsequent mortality, and in particular, for responses that fall in the fair and/or poor category. The majority of surveyed individuals reported to either have good (55%) or fair (22%) health status. A small percentage (4%) reported having fair or poor health status. At the County level, 10% of the adult population reported poor or fair health status.[2] **See Figure 21.**

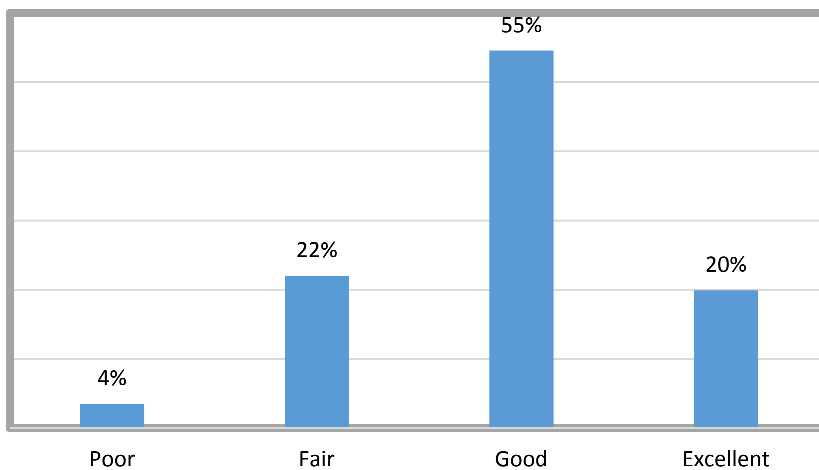


Figure 21. Survey Respondents Health Status

Health Barriers

Respondents were asked to share the barriers keeping them from getting the health care they need. Participants were given 10 different options to choose from plus an option to write an open response. **Figure 22** presents the top five barriers to health as reported by respondents. Cost (28%) was found to be the single most important barrier to health followed by lack of health insurance (18%), time (17%), and information (11%). However, 42% of participants stated they had no barriers preventing them from getting the care they need.

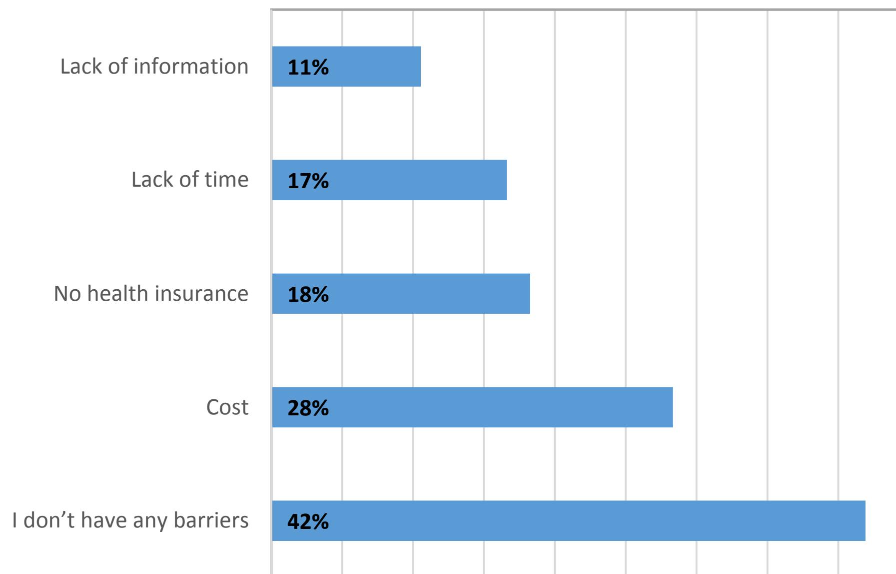


Figure 22. Survey Respondents Top Barriers to Better Health

7 SELECTING PRIORITIES

Identified Health Priorities

Suburban hospital began its priority setting process by identifying the main health issues affecting the community. The public health data previously presented was reviewed and used to assess the magnitude of top health problems in Montgomery County (i.e. causes of morbidity and mortality). The results from the community surveys helped to assess what common health conditions were of most importance to vulnerable residents in Suburban's CBSA. These findings were compared with Suburban's areas of medical expertise and current health improvement programs. Due to Suburban's active participation in the County's health improvement process -Healthy Montgomery- the County-wide six health priorities were also taken into consideration in the priority identification process. The outcome is a comprehensive list containing the top 10 health issues for Montgomery County, particularly Suburban Hospital's community benefit service area. **See Table 7. Health Needs Facing Suburban's Community.**

Table 7. Health Needs Facing Suburban's Community

	Primary Data (Community Input & Inpatient Diagnosis)	Secondary Data (County, National, & state Datasets)	Suburban Hospital's Medical Specialties	Suburban Hospital's Health Improvement Programs Programming	Healthy Montgomery Health Priorities
Cardiovascular diseases	√	√	√	√	√
Cancer	√	√	√	√	√
Diabetes mellitus	√	√		√	√
Chronic Lower Respiratory Diseases (CLRD)	√				
Accidents (unintentional injuries)	√		√		
Obesity		√		√	√
Behavioral Health	√	√	√	√	√
Maternal & Infant Health					√
Hypertension		√		√	
Dental		√			

Health Priority Setting

Suburban Hospital engaged in prioritization activities and discussions to align identified preliminary health needs with County-wide goals that would have a positive impact on the health of Montgomery County residents. The process included leading community conversations with key stakeholders to not only share findings from the multiple datasets, but also to include and align recommendations. Key stakeholders included member's from Suburban Hospital's Health Advisory Council, the United Way Regional Advisory Council, and Suburban's Patient and Family Education Committee.

In 2011, Suburban Hospital identified the need to establish an Advisory Council that would guide and participate in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital. In June 2012, the hospital held its first Community Benefit Advisory Council (CBAC) meeting. Chartered by the hospital's Board of Trustees and chaired by a trustee, the Advisory Council is comprised of a diverse group of local businesses, non-for-profit executives and community advocacy leaders who represent the perspective of the County's medically underserved, low-income and racially/ethnically diverse populations. The Council represents diverse sectors of the Suburban Hospital service area and acts as a liaison between the community and the hospital to identify health improvement opportunities and needs.

The Council played a critical role in the development of the community health needs assessment process, particularly in the prioritization process. Their role included providing a voice and insight into the needs of the community, and analyzing needs assessment data and community assets. In addition to the expertise contributed by the Council, Suburban Hospital's Community Health and Wellness (CHW) Department served as a key player in shaping the CHNA process by integrating public health knowledge, principles and expertise. The CHW Department acted as a public

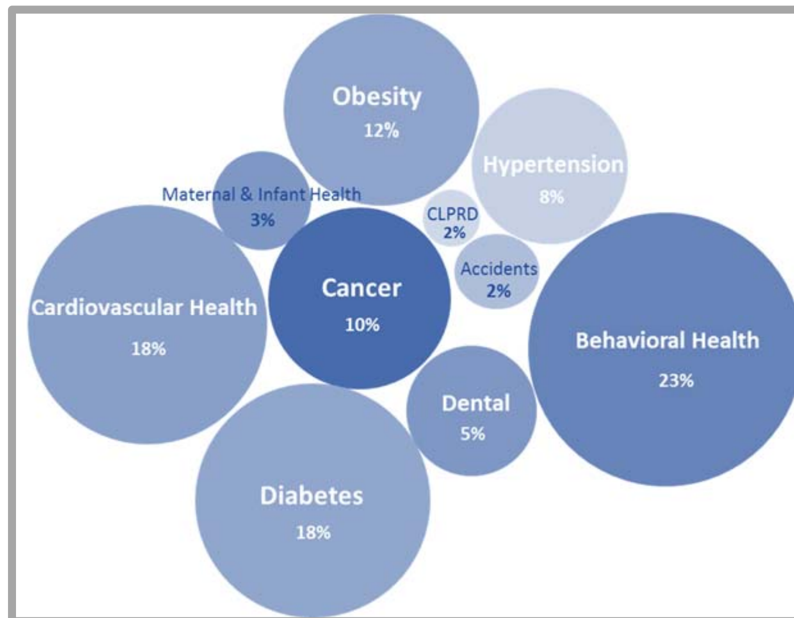
health resource and guide, due in part to the educational background of the staff, and the strong relationships built in the community and firsthand knowledge of the major health concerns, barriers and needs.

The Montgomery County United Way Regional Council (MCUWRC) consists of volunteers from business, public, and nonprofit sectors in the County. Regional Council members serve as representatives of their community by providing advice about unique situations and needs. Moreover, the Council oversees the allocation of the United Way's Community Impact Fund grant for Montgomery County.

The Patient and Family Education Committee serves in an advisory capacity and as a resource for the staff of Suburban Hospital. The committee is responsible for the development of facility-wide patient and family education goals and plans and performs the following functions: assists in identifying facility-wide patient education needs and establishing priorities, reviews patient education materials (print, audiovisual, etc.) for quality and suitability for Suburban's patient population, and advises departments on how to obtain or develop educationally sound patient education materials. (**See Appendix G: Community Benefit Advisory Council, Montgomery County United Way Regional council, and Patient and Family Education Committee members)**

As prominent members of Montgomery County, members of the CBAC, MCURC, and Patient and Family Education Committee participated in the health need prioritization process, which involved extensive discussion and a vote to help rank essential health issues in the community. The results from the voting process is represented in **Figure 23**.

Figure 23. Ranking of Identified health Needs



Health Priority Validation and Consensus

The structured priority setting process, led by numerous discussions based on recent health data, guided community stakeholders to the identification of five health priorities for Montgomery County. The five official health priorities to be tracked, measured and evaluated over the next three years are presented below in no particular order:

- Cardiovascular Disease
- Cancer
- Diabetes
- Behavioral Health
- Obesity

These five health priorities overlap or align with national, state, and local priorities (see Table 8) as well as Suburban's 2013 CHNA findings. This relationship affords Suburban Hospital the ability to parallel its community health improvement efforts to existing actions in order to decrease health inequities, lack of access and unhealthy behaviors.

Table 8. Comparison of Federal, State, and Local Health Priorities

Healthy People 2020: Leading Health Indicators	Maryland State Health Improvement Plan 2017 (SHIP)	Healthy Montgomery 2013
Mental Health, Substance Abuse, & Tobacco	Healthy Communities	Behavioral Health
Access to Health Services, Clinical Preventive Services	Access to Health Care	Cancer
Nutrition, Physical Activity, and Obesity	Qualitative Preventive Care	Obesity
Maternal, Infant, and Child Health	Healthy Beginnings	Maternal and Child Health
Social Determinants	Healthy Living	Diabetes
Environmental Quality, Injury & Violence		Cardiovascular Health
Oral Health, Reproductive and Sexual Health		

Source: US Department of Health and Human Services, MD Department of Health and Mental Hygiene, and Healthy Montgomery, 2016

8 IMPLEMENTATION STRATEGY

Addressed Needs and Implementation Plan

In working with the Montgomery County Department of Health and Human Services and addressing shared health priorities, Suburban Hospital's Board of Trustees, President and CEO, and the organization's operations executive and leadership team will work thoroughly to ensure that the hospital's strategic and clinical goals are aligned with these five official health priorities: **behavioral health, obesity, diabetes, cancer, and cardiovascular health**. See Table 9.

Furthermore, Suburban Hospital will aim to influence the decision making process and prioritization of Suburban Hospital's community benefit activities through the planning, monitoring and evaluation of unmet community needs over the next three years. Suburban Hospital's commitment to improving the health and well-being of the community will be demonstrated through the deliberate planning of health education initiatives and screenings; providing financial and in-kind support to community clinics and programming of wellness activities that directly align with our 2016 needs assessment and identified social determinants of health. Collaboration with several key partnerships, coalition committees, non-profit organizations, corporations, institutes and county government will be instrumental in leveraging resources to ensure that all stakeholders are engaged. Suburban Hospital's annual *Community Benefit* report and the *2016 Implementation Strategy* report, both available through Suburban Hospital's website, will serve to guide and document progress for the identified five health priorities over the next three years.

Table 9. Suburban Hospital's Top 5 Health Priorities

↓ A decrease in rate since 2013 CHNA report
↑ An increase in rate since 2013 CHNA report

Hospital Priority	Behavioral Health
Quantitative Reason	– ↑ 1791.7 per 100,000 population have used a hospital ED for a behavioral health condition (2014)[14] – ↓ 16.7% of Montgomery County residents report not having adequate social and emotional support (2010) [6] – ↑ 80.4% of residents self-reported experiencing two or fewer days of poor mental health in the past month (2014)[6] – The average number of mentally unhealthy days reported over a 30-day period is 2.6 (2006-2012) [14] – ↓ 15.0% of Montgomery County adult residents use alcohol in excess and 7.9% smoke (2020-2012)[2,6]
Qualitative Reason	– Suburban Hospital's Advisory Council unanimously voted mental health as a top health priority for Montgomery County – 5 % of Community Input Survey respondents reported mental health problems to be a top health concern for them – Only 31% of Community Input Survey respondents reported being able to "Always" manage their stress

Hospital Initiatives	– Suburban Hospital provides multiple comprehensive Behavioral Health Services for individuals with emotional problems, mental illness and addictive diseases, as well as some services designed to foster mental health – Suburban Hospital offers support groups to help community members manage mental stress associated with chronic and acute health conditions – Suburban Hospital's comprehensive community health improvement programs foster social support, particularly among the senior population, due to the continuous encounters with the same population
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Mental Health & Mental Disorders – Maryland State Health Improvement Plan 2017: Qualitative Preventive Care Measures (2 of 39 indicators) – Montgomery County Healthy Montgomery Health Priority: Behavioral Health
Hospital Priority	**Obesity**
Quantitative Reason	– ↑ 57.4% of adults in Montgomery County are obese or overweight (2013)[14] – ↓ 7.1% of children's and adolescents in Montgomery County are reported to be obese and only 52.7% of adults report getting the recommended amount of physical activity (2013)[6,14] – The food environment index (factors that contribute to a healthy food environment) for Montgomery County is 9.2 out of 10 (2015) [2]
Qualitative Reason	– 20% of Community Input Survey respondents reported overweight/obesity to be a top health concern for them – 27% of Community Input Survey respondents reported "Always" consuming five servings of fruits and vegetables – 36% of Community Input Survey respondents reported "Always" engaging in moderate physical activity outside of work at least 20 to 30 minutes for a minimum of 5 days per week
Hospital Initiatives	– Suburban Hospital's longstanding partnership with Sodexho links nutrition services, by registered dieticians, to communities outside the walls of the hospital – Suburban Hospital collaborates and leverages resources with local organizations to offer free seminars, cooking demos, walking programs, fitness programs, cooking classes to help improve community members' nutrition and exercise level – Suburban Hospital offers specialized weight and chronic disease management programs and services – Suburban Hospital supports Community Supported Agriculture (CSA) programs providing staff and their families the opportunity to purchase local fruits and vegetables on hospital property
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Nutrition & Weight Status – Maryland State Health Improvement Plan 2017: Healthy Living Measures (2 of 39)

	– Montgomery County Healthy Montgomery Health Priority: Obesity
Hospital Priority	**Diabetes**
Quantitative Reason	– ↑ 7.1% of adults in Montgomery County have diabetes (2014)[5] – ↓ The rate of ED visits for diabetes is 95.0 per 100,000 population (2014)[5] – ↑ The age-adjusted death rate due to diabetes is 13.3 per 100,000 population (2010-2012)[5] – ↑ 86% of diabetic Medicare enrollees received HbA1c screening[2] compared to 89% which is the national benchmark (2015)[2] – ↓ 9.7% of adults in Montgomery County do not have health insurance and 10.4% of adults could not afford to see a doctor in a 12-month period (2014)[6]
Qualitative Reason	– 22% of Community Input Survey respondents reported diabetes to be a top health concern for them – 18% of Community Input Survey respondents reported "lack of health insurance" as a barrier to health for themselves and/or others – 28% of Community Input Survey respondents reported cost as a barriers to health for themselves and/or others
Hospital Initiatives	– Suburban Hospital's one-of-its kind specialty care clinic held in partnership with Mobile Medical Care, Inc. and the National Institutes of Health offers comprehensive endocrine-related treatment at low or free cost to the uninsured population – A long-standing partnership with a safety-net clinic, Proyecto Salud, provides uninsured individuals with quality diabetes management services and outpatient education – Two regional symposia featuring breakthroughs in treatment – Support Group for patients with diabetes – Quarterly pre-diabetes classes – Hospital Glucose Steering Committee & Diabetes Nursing Champions
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Diabetes – Maryland State Health Improvement Plan 2017: Qualitative Preventive Care Measures (1 of 39 indicators) – Montgomery County Healthy Montgomery Health Priority: Diabetes
Hospital Priority	**Cancer**
Quantitative Reason	– ↓ The death rate due to cancer is 127.1 per 100,000 (2011-2013) [6] – ↑ The age-adjusted death rate per 100,000 females due to breast cancer is 18.8 (2008-2012)[6] – ↓ The age-adjusted death rate per 100,000 population due to colorectal cancer is 9.7 (2008-2012)[6] – ↓ The age-adjusted incidence rate for prostate cancer is 137.0 cases per 100,000 males (2008-2012)[6]

	– ↓ 79.5% of women aged 50 and over who have had a mammogram in the past two years (2014)[6] – ↓ 10.4% of adults could not afford to see a doctor in a 12-month period (2014)[6]
Qualitative Reason	– 26% of Community Input Survey respondents reported Cancer to be a top health concern for them – 18% of Community Input Survey respondents reported access to health services to be a top health concern for them
Hospital Initiatives	– Suburban Hospital has historical partnerships with organizations to deliver free cancer awareness programs, early prevention and service programs for prostate, colorectal, skin, and breast cancer – Suburban's Cancer Center is affiliated with the Bethesda-based National Cancer Institute, offering patients access to extraordinary treatment options and clinical research trials – Cancer-focused patient navigators and support groups
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Cancer – Maryland State Health Improvement Plan 2017: Qualitative Preventive Care Measures (1 of 39 of indicators) – Montgomery County Healthy Montgomery Health Priority: Cancer
Hospital Priority	**Cardiovascular Health**
Quantitative Reason	– ↓ The age-adjusted death rate due to heart disease in Montgomery County is 108.0 per 100,000 deaths (2012-2014)[6] – ↑ 141.0 per 100,000 ED visits in Montgomery County hospitals were due to hypertension (2014)[6] – ↑ 27.7% of the adult population in Montgomery County has hypertension and 53.5% of Medicare recipients were treated for hypertension (2013)[6] – ↑ 38.1% of adults who have had their blood cholesterol checked have been told that it was high (2013)[6]
Qualitative Reason	– 25% of Community Input Survey respondents reported heart disease to be a top health concern for them – 31% of Community Input Survey respondents reported hypertension/stroke to be a top health concern for them – 64% of Community Input Survey respondents reported not "always" engaging in the recommended amount of physical activity.
Hospital Initiatives	– Through collaboration with the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health and Johns Hopkins Medicine, Suburban Hospital's Heart Center offers state-of-the-art cardiac surgery, angioplasty, cardiac diagnostics and rehabilitation – Suburban's HeartWell Program offers free cardiovascular health education, disease management, and nutrition classes at local senior centers throughout the county – Through partnerships with Montgomery County Departments of Recreation and Senior Services, Suburban Hospital offers fitness exercise programs to the community

	– Suburban Hospital has a comprehensive health and wellness program available, including blood pressure and cholesterol screenings, educational seminars, and free exercise programs that promote a healthy cardiovascular system – One-of-its kind specialty care clinic held in partnership with Mobile Medical Care, Inc. and the National Institutes of Health, Suburban Hospital offers comprehensive cardiovascular treatment services including diagnostic to open heart-surgery to uninsured Montgomery County residents at low or free cost
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Heart Disease and Stroke – Maryland State Health Improvement Plan 2017: Quality Preventive Care Measures (3 of 39 indicators) – Montgomery County Healthy Montgomery Health Priority: Cardiovascular Health

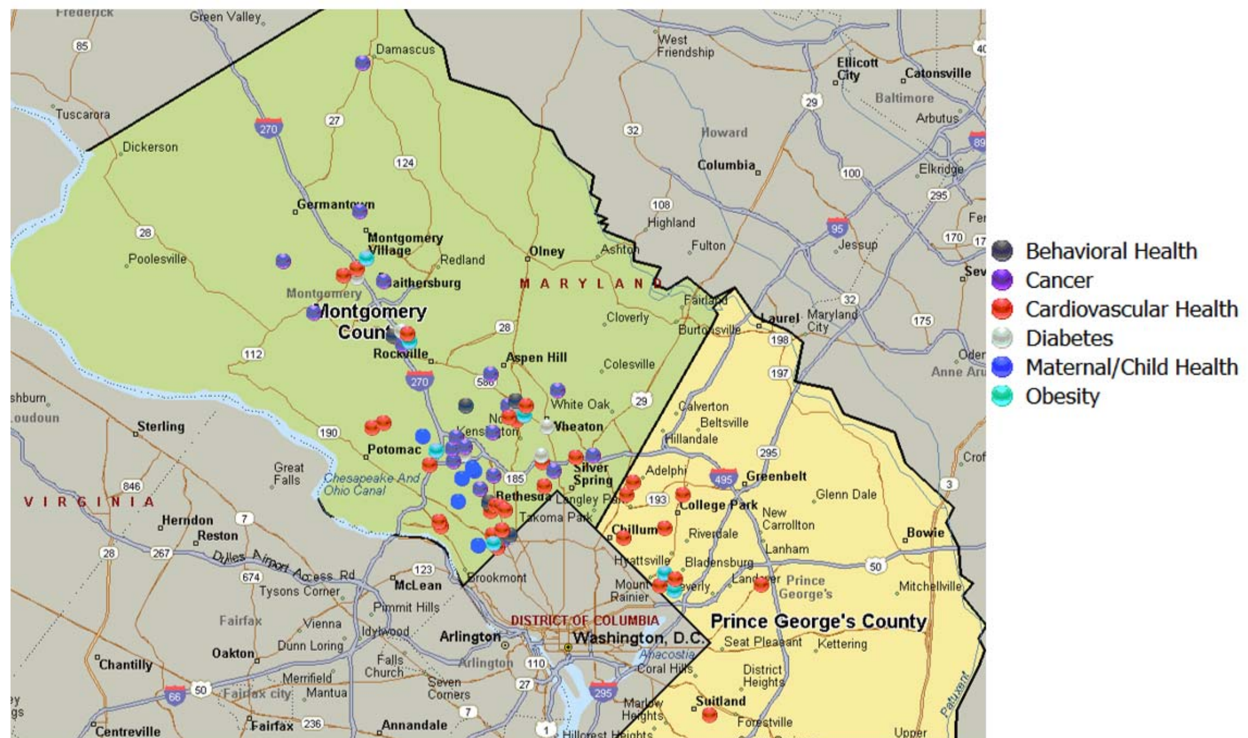
Unaddressed Identified Needs

Suburban Hospital recognizes the importance of supporting needs that are outside the identified five health priorities through innovative leverage of resources with community partners in order to improve health outcomes for Montgomery County residents. As such, Suburban Hospital will continue to work directly - and contingent upon resource availability - with several community centers, organizations, institutes, and corporations, including the AARP, A Wider Circle, Alpha Phi Alpha Fraternity, American Heart Association, American Red Cross, and Bethesda Cares to name a few, to support undressed needs and social determinants of health affecting vulnerable populations.

The Healthy Montgomery Steering Committee established six official health priorities to be tracked, measured and evaluated based on health inequities, lack of access, and unhealthy behaviors over the next three years. One of these health priorities includes Maternal and Child Health. Suburban Hospital is not in a position to affect all of the changes required to address this health priority given that the hospital does not have an obstetrics designation or deliver babies. The reason for not seeking this designation is due to the fact that there are several other community hospitals within 5-10 miles of our Bethesda location that have an obstetrics program. While Suburban Hospital may not be able to directly address this health priority, the hospital does and will be able to indirectly support Maternal and Child Health initiatives through funding and programming of several other organizations that promote the health and well-being of children and their families. For example, Suburban Hospital supports the YMCA Youth and Family Services by hosting parenting seminars at the hospital twice a year. Proceeds from the seminars go directly to the YMCA and support its programming available to the community's families. In addition, Suburban Hospital provides financial support to safety net clinics in Montgomery County that treat patients requiring obstetric or pediatric care. The Hospital is also the official health sponsor of Girls on the Run Montgomery County. Girls On the Run is an organization dedicated to inspire girls to be healthy and confident using running and an experience-based curriculum. The Hospital provides discounted CPR and First Aid training classes to the coaches, purchasing shoes and healthy snacks for students from Title I schools, and providing health tips on Girls on the Run Montgomery County website. The Hospital also provides indirect support to OASIS Montgomery's CATCH Healthy Habits program sponsored through an Amerigroup Foundation grant. CATCH Healthy Habits engages senior adults as mentors to teach children grades K-5 about healthy eating and active living in Montgomery and Prince George's Counties.

Community Assets

Suburban's long-standing commitment to health equity has promoted the design and implementation of best-practice models pertaining to obesity, diabetes, cardiovascular health, cancer, and behavioral health. Suburban Hospital has been addressing these five focus areas for many years and has established programing in Montgomery and Prince George's Counties. In the area of cardiovascular health, for example, Suburban Hospital has 35 recognized sites providing services ranging from blood pressure screenings to health education sessions to provision of specialty care. Figure 24 provides a snapshot, by health need, of the various locations where Suburban Hospital's health improvement programs are held across the County. Health priority specific asset maps for Suburban Hospital sponsored programs is made available in **Appendix H**.



As part of the county-wide community health needs assessment conducted by Healthy Montgomery, the six hospital systems (Shady Grove Adventist, Holy Cross, Holy Cross Germantown, MedStar Montgomery, Suburban, and Washington Adventist) gathered information about existing community resources. **Appendix I** is a compilation resources, programs, funding etc. related to the identified Healthy Montgomery priority issue areas.

9 SUBURBAN HOSPITAL 2013 COMMUNITY HEALTH NEEDS ASSESSMENT EVALUATION

Suburban's initial Community Health Needs Assessment (CHNA) 2013 and Implementation Strategy (IS) were made publicly available through the hospital website on June 1, 2013. A statement accompanied the release of the report soliciting community stakeholder's feedback. Since it was published, the report has been referenced and used a guide internally and externally by various organizations, including Suburban's Cancer Program, Alpha Phi Alpha Fraternity, Healthy Montgomery, and Montgomery County's Senior Connection. To date, no input has been received regarding the content of the 2013 CHNA or the IS.

Health Improvement Measures

We measure progress in the areas of access, health inequities and unhealthy behaviors to assess our progress and generate solutions that promote safe and healthy communities. Suburban Hospital routinely monitors and evaluates the impact of community health improvement efforts in Suburban's Community Benefit Service Area. Program outcomes are shared with the County and State governing bodies, community partners, and program beneficiaries to share knowledge and engage stakeholders. Recently released results for key Suburban Hospital best-practice initiatives are presented in **Table 10**.

Table 10. 2013 Health Priorities Program Outcomes

CARDIOVASCULAR DISEASE	
Identified Need	Cardiovascular Disease; Access to specialty care. Heart disease continues to be the leading cause of death in Montgomery County as the age-adjusted rate in Montgomery County is 108.0 deaths per 100,000 [6] while in Suburban Hospital's CBSA, the age adjusted death rate is 111.7 per 100,000.[17] In addition, 9.7% of residents in Montgomery County do not have any type of health insurance coverage.[7]
Hospital Initiative	MobileMed/NIH Heart Clinic at Suburban Hospital
Primary Objective	The MobileMed/NIH Heart clinic at Suburban Hospital seeks to reduce the number of deaths associated with coronary heart disease in Montgomery County. A Cardiovascular clinic is held one night a week at Suburban Hospital where uninsured individuals have access to cardiac care, diagnostic tests, surgery and rehabilitation when needed, at little or no cost. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients and managing associated risk factors with coronary heart disease.
Initiative Time Period	Multi-Year; From July 1, 2014 to June 30, 2015, the clinic is opened every Thursday night from 3:30pm-8:00pm in the NIH Heart Center at Suburban Hospital. The clinic has been opened since October 2007.

[17] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2009-2013 Results."

Key Collaborators in Delivery	Suburban Hospital, MobileMed, Inc., the National Institute of Heart, Lung and Blood (NHLBI), community cardiologists. Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Heart, Lung and Blood and MobileMed-volunteer their time to staff the cardiovascular clinic.
Impact/Outcome of Hospital Initiative	The clinic is evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Number of racial and ethnic patients served. Outcomes for FY 15: – In FY 15, there were 502 encounters, with 317 unduplicated patients. The top five conditions treated were: Hypertension (21% of encounters), Unspecified Chest Pain (9%), Coronary Atherosclerosis of Native Coronary Artery (8%), Other Chest pain (7%), and Unspecified Essential Hypertension (6%). The racial breakdown of clinic patients was as follows: 27% Black non-Hispanics, 14% Asian, 14% White non-Hispanic, 35% Other Race, 9% Unreported/Refused to Report, 0.6% Native Hawaiian or Other Pacific Islander. Out of the 317 patients who were treated, 45% reported their Ethnicity as Hispanic/Latino, 3% refused to report. – In comparison to FY14, there was nearly a three-fold increase in the number of patients treated for hypertension (28 in FY 14 vs. 68 in FY 15)
Evaluation of Outcome	The MobileMed/NIH Heart clinic at Suburban Hospital has been in operation since 2007. Over the 8-year period, the clinic has served 3,200 uninsured patients in need of cardiovascular specialty care. These are individuals that would have not received cardiovascular specialty care. During this same period, Suburban has provided more than 10 open-heart surgeries. Each year, the clinic measures its success by the number of patients it serves (short-term goal); effective treatment of the different conditions that put the patients at risk for cardiovascular disease (mid-term goal); and by improving their quality of life while reducing their risk from pre-mature coronary heart disease mortality (long-term goal).
DIABETES	
Identified Need	Diabetes; Access to specialty care. The Montgomery County average age-adjusted ER visit rate due to uncontrolled diabetes is 0.4 per 10,000 population aged 18 years and older. Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[17] Nearly 10% of residents in Montgomery County do not have any type of health insurance coverage.[6]
Hospital Initiative	Mobile Med/NIH Endocrine Clinic at Suburban Hospital
Primary Objective	The MobileMed/NIH Endocrine clinic at Suburban Hospital seeks to reduce the number of deaths in Montgomery County associated from complications from endocrine diseases including diabetes. The endocrine clinic is held one night a week at Suburban Hospital where uninsured individuals have access to the specialty care of endocrine conditions and diseases, including diagnostic tests, examinations, and one-on-one consultation with a Suburban Hospital Registered Dietitian, at little or no cost. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients and managing associated risk factors with endocrine diseases.

	The objective of clinic is two-fold: 1.) Increase access of specialty care to patients who would not otherwise receive care; and 2.) Reduce the incidence of complications due to endocrine diseases including diabetes.
Initiative Time Period	Multi- Year; From July 1, 2014 to June 30, 2015, the clinic was open every Thursday night from 4:00 pm-7:30 pm at the Johns Hopkins Health Care and Surgery Center in Bethesda, MD. The clinic has been open since July 2011.
Key Collaborators in Delivery	Suburban Hospital, MobileMed., Inc., and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Diabetes and Digestive and Kidney Diseases and MobileMed-volunteer their time to staff the endocrine clinic.
Impact/Outcome of Hospital Initiative	The clinic is evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Improved health status of patients. – Number of racial and ethnic patients served. Outcomes: – In FY 15, there were 157 unduplicated patients; with 364 encounters. – The clinic continues to see improvements in Hemoglobin A1C (HbA1C) among diabetic patients, as patient's results remain stable or improved slightly in FY 15. The last report number averaged a drop from 8.9% to 7.8% (1.1 point decrease) – Of those 364 encounters, the top five diagnosis are: diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (22.88% of encounters); goiter (8.50%); thyrotoxicosis (6.54%); diabetes with unspecified complication, type II or unspecified type, uncontrolled (6.54%), and hypothyroidism (5.88%). – The racial breakdown of clinic patients was 33% Black non-Hispanics, 12% Asian, 19% White non-Hispanic, 31% other race, 4% unreported/refused to report. – Of the 157 patients who were treated, 43% reported their ethnicity as Hispanic/Latino.
Evaluation of Outcome	The MobileMed/NIH Endocrine clinic at Suburban Hospital has been in operation since 2010. During the 5-year period, the clinic has served 1,500 uninsured patients in need of endocrine specialty care who would have otherwise not been seen. During this same period, there was an improvement of Hemoglobin A1C. Each year, the clinic measures its success by continued improvement of Hemoglobin A1C among diabetic patients (short-term goal); access to quality diabetes management and treatment for at-risk residents (mid-term goal); and by improving patient's quality of life while reducing their risk from complications from diabetes morbidity (long-term goal).
OBESITY AND BEHAVIORAL HEALTH	
Identified Need	Cardiovascular Health, Obesity, Behavioral Health. Heart disease continues to be the leading cause of death in Montgomery County as the age adjusted rate in Montgomery County is 108.0 deaths per 100,000 [6] while in Suburban Hospital's CBSA, the age adjusted rate is 111.7 deaths per 100,000.[17] Twenty-five percent of people over the age of 65 live alone. People who live alone are vulnerable to social

	isolation and lack of access to care.[6] Exactly 57.4% of adults in Montgomery County are either overweight or obese according to their Body Mass Index.
Hospital Initiative	Senior Shape Exercise Program
Primary Objective	The Senior Shape Program provides active seniors a safe, low to high impact exercise regimen that focuses on strength and weight training, balance, flexibility, stretching and aerobic activity for optimal cardiovascular benefits and stamina. Held in senior and community centers in Montgomery and Prince George's Counties, fitness assessments are performed bi-annually in order to measure the participant's balance, strength, flexibility and endurance. The goal of Senior Shape Program is to increase physical activity and fitness among the senior population by creating access to age-specific exercise programs and providing social support.
Key Collaborators in Delivery	Suburban Hospital Community Health and Wellness department, Montgomery County Department of Recreation (Holiday Park Senior Center, Margaret Schweinhaut Senior Center, Gaithersburg Upcounty Senior Center, Clara Barton Community Center, Potomac Community Center, Jane E. Lawton Community Center, Wisconsin Place Community Center), Bethesda Regional Services Center, and Parks and Recreation of Prince George's County (Gwendolyn Britt Community Center).
Impact/Outcome of Hospital Initiative	Suburban Hospital holds a bi-annual fitness assessment designed to test the Senior Shape members' balance, strength, flexibility and endurance against national data using 4 exercises. These exercises, held at the nine community centers in Montgomery and Prince George's Counties include the back scratch, arm curl, 8-foot up-and-go, and chair stand. Based on the fitness assessment results, all of the seniors either met or exceeded the national average for their age range. Please see below information for specifics. **Outcomes of Fitness Assessment:** Program participants= 500 Number of sessions held in FY 15 =1,100 Locations= 8 in Montgomery County & 1 in Prince George's County FY 15 program participant fitness assessment results:

Test	Average Females	Average National Standard Females	Average Males	Average National Standard Males
Chair Stand (# of stands in 30 seconds):	15.73	7-14	15.02	11-16
Arm Curl (# of reps in 30 seconds):	20.17	10-17	21.60	13-19
2-minute step in place	101.57	63-95	111.52	74-104
Chair Sit & Reach (inches +/-)	+1.47	-4.5-5.0	-0.30	-6.5-4.0

Evaluation of Outcome	The Senior Shape Program classes are designed to improve the cardiovascular health and overall fitness of the participants. The results from the fitness assessment show that they are meeting or, in many cases, exceeding what is considered normal for their age range and therefore meeting the national fitness standard (short-term); increase participant's cardiovascular endurance (mid-term); and improving participant's quality of life while reducing their risk of coronary heart disease and risk factors associated with heart disease and obesity.

CANCER	
Identified Need	Cancer. According to Healthy Montgomery, the age-adjusted death rate for breast cancer is 18.8 per 100,000 in Montgomery County (2008-2012)[6] Within Suburban's CBSA, the age-adjusted death rate is slightly higher at 18.9 per 100,000. Furthermore, the age-adjusted death rate among Black non-Hispanics is 30.4 compared to 19.9 in White non-Hispanics within Suburban's CBSA.[17] If detected early, breast cancer is highly treatable.
Hospital Initiative	*Check It Out* Program
Primary Objective	The Check It Out program is a free breast health awareness program where a Suburban Hospital Cancer Program nurse addresses to 11th and 12th grade young women in Montgomery County during one class period of school about the importance of breast health. In addition to the nurse, a breast cancer survivor, usually a member of the school facility, shares her story about her diagnosis and treatment with the young women, encouraging them to regularly perform self-breast health exams.
Initiative Time Period	The *Check It Out* program is offered every two years from January to April. In FY 15, it occurred from January 2015 to April 2015.
Key Collaborators in Delivery	Suburban Hospital Cancer Program and Community Health and Wellness Division, the Greater Washington Chapter of Hadassah, Montgomery County Public Schools, and local private high schools.
Impact/Outcome of Hospital Initiative	At every *Check It Out* session, participants were given a knowledge based evaluation which included twelve questions- 10 based on knowledge and 2 to assess their confidence level. Specifically, participants were asked: 1.) *Are all breast lumps cancer?* 99.50% answered correctly, that all breast lumps are not cancerous. 2.) *Does an injury to the breast cause cancer?* 98.20% answered correctly, that an injury to the breast does not cause cancer. 3.) Do *younger women develop breast cancer as often as older women?* 89.40% answered correctly, while young women could develop breast cancer, it occurs more frequently in older women. 4.) *Do large-breasted women have a greater chance of developing breast cancer than small-breasted women?* 97.40% answered correctly, that the chance of a women developing breast cancer does not depend on the size of her breasts. 5.) *Should women begin having mammograms at age 20?* 73.00% answered correctly, that women should begin to have mammograms after the age of 40. 6.) *Are breast self-exams (BSE) important for cancer detection?* 98.40% answered correctly that monthly breast self-examinations are an important tool for early detection. 7.) *When is the best time for a woman for perform a BSE?* 96.10% answered correctly that a woman should perform a breast self-examination 7 to 10 days after her period 8.) *If exercising 3 to 5 hours a week can help reduce the risk of breast cancer?* 97.90% answered correctly, that exercise does reduce the risk of breast cancer. 9.) *Can a woman is pregnant, is she still at risk for breast cancer*? 96.10% answered correctly, women can still get breast cancer even when pregnant.

	10.) *Does breast cancer only develop in women?* 98.10% answered correctly, men can also develop breast cancer 11.) *Did Check It Out help them understand the importance of breast self-examination as a regular health habit?* 98.40% answered Yes 12.) *Did the presence of a breast cancer survivor add to the learning experience?* 95.60% answered Yes
Evaluation of Outcome	Every two years, the Check It Out program measures its success by the number of students it is able to reach (short-term goal); increase awareness of breast awareness among the young women who attend the program (mid-term goal); and by improving the student's quality of life while reducing their risk from breast cancer mortality (long-term goal).

10 CONCLUSION

Suburban Hospital is committed to and invested in caring for the community it serves. Suburban has a long history of dedicating health initiatives to address the needs of vulnerable populations such as the under- and uninsured, low-income, racially and ethnically diverse, underserved seniors and at-risk youth. In collaboration with local community stakeholders and other aligned organizations with a shared vision, Suburban has always strived to meet the needs and demands of those who reside in Montgomery County and beyond. Along with the establishment of the Healthy Montgomery Community Health Needs Assessment and specific supporting data collected from Suburban Hospital's community benefit service area, the process which the hospital prioritizes its efforts are more specialized, focused and deliberate to meet the identified community health needs, which include five established health priorities. The CHNA process has afforded Suburban Hospital the opportunity to sharpen the community health improvement lens, which will guide the organization to a specific focus on barriers to accessing health care, addressing community perceptions of major health concerns, considering demographic, economic and health care provider trends, addressing lack of available health services and leveraging resources to improve access to care and overall quality of life. Suburban Hospital and its partners will continue to work diligently over the next three years to ensure that the valuable information attained from the CHNA is an integral tool to measure and evaluate how established health targets and goals are achieved. The health implementation plan will continue to be an evolving hospital strategy and process to produce the best care and services for optimal health and quality of life for all.

11 APPENDICES

Appendix A. List of Healthy Montgomery Steering Committee Members

Organization	Name of Key Collaborator	Title	Collaboration Description
Montgomery County Council	Mr. George Leventhal	Councilmember	Co-chair of Healthy Montgomery
ICF International	Ms. Sharan London	Vice President	Co-chair of Healthy Montgomery
Montgomery County Department of Health and Human Services	Ms. Uma Ahluwalia	Director	Steering Committee Member, Healthy Montgomery
Public Health Foundation	Mr. Ron Bialek	President	Steering Committee Member, Healthy Montgomery
MedStar Montgomery Medical Center	Ms. Gina Cook	Marketing, Communications Manager	Steering Committee Member, Healthy Montgomery
Maryland General Assembly	Delegate Bonnie Cullison	Member of the House of Delegates	Steering Committee Member, Healthy Montgomery
Kaiser Permanente	Ms. Tanya Edelin	Senior Project Manager for Community Benefit	Steering Committee Member, Healthy Montgomery
Garvey Associates	Dr. Carol Garvey	Principal	Steering Committee Member, Healthy Montgomery
Primary Care Coalition of Montgomery County	Ms. Leslie Graham	President and Chief Executive Officer	Steering Committee Member, Healthy Montgomery
Family Services, Inc.	Mr. Thomas Harr	Executive Director	Steering Committee Member, Healthy Montgomery
Asian American Health Initiative	Ms. Karen Ho Chaves	Member	Steering Committee Member, Healthy Montgomery
Commission on Veterans Affairs	Ms. Lorrie Knight-Major	Member	Steering Committee Member, Healthy Montgomery
Commission on Aging	Dr. Samuel P. Korper	Member	Steering Committee Member, Healthy Montgomery

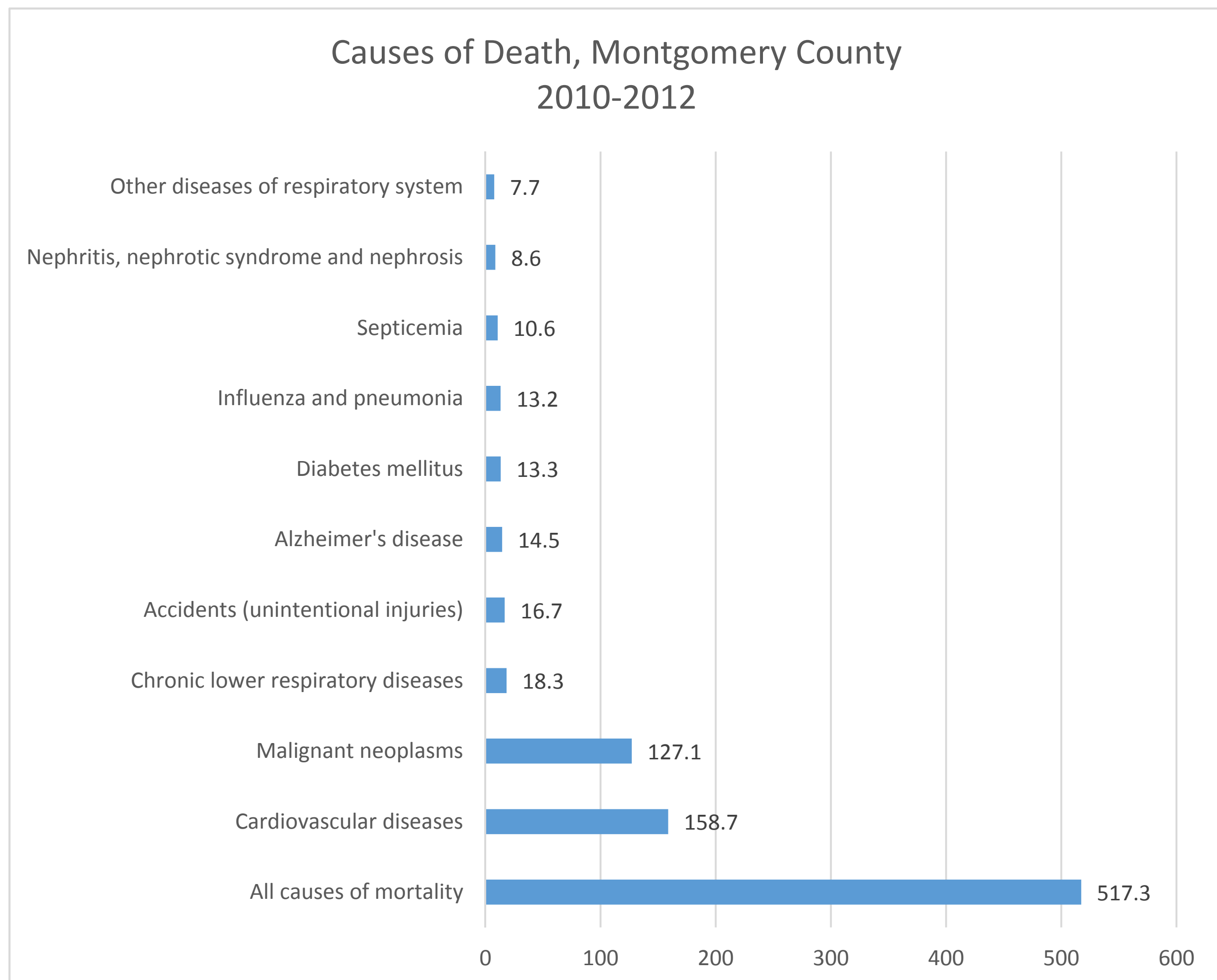
Montgomery County Department of Planning	Ms. Amy Lindsey	Senior Planner	Steering Committee Member, Healthy Montgomery
Holy Cross Hospital	Ms. Kimberley McBride	Community Benefit Officer	Steering Committee Member, Healthy Montgomery
Ronald D. Paul Companies	Ms. Kathy McCallum	Controller	Steering Committee Member, Healthy Montgomery
Carefirst Blue Cross Blue Shield/African American Health Program	Ms. Beatrice Miller	Senior Regional Care Coordinator/Member	Steering Committee Member, Healthy Montgomery
Commission on People with Disabilities	Dr. Seth Morgan, MD	Member	Steering Committee Member, Healthy Montgomery
Asian American Health Initiative	Dr. Nguyen Nguyen	Member	Steering Committee Member, Healthy Montgomery
Clinica Proyecto Salud / Latino Health Initiative	Dr. Cesar Palacios	Executive Director/ Member	Steering Committee Member, Healthy Montgomery
Montgomery County Recreation Department	Dr. Joanne Roberts	Program Member	Steering Committee Member, Healthy Montgomery
Suburban Hospital	Ms. Monique L. Sanfuentes	Director, Community Health and Wellness	Steering Committee Member, Healthy Montgomery
Georgetown University School of Nursing and Health Studies	Dr. Michael Soto	Professor	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Health and Human Services	Dr. Ulder J. Tillman	Officer and Chief, Public Health Services	Steering Committee Member, Healthy Montgomery
Adventist Health Care	Dr. Deidre Washington	Research Associate, Center for Health Equity & Wellness	Steering Committee Member, Health Montgomery
Commission on Veterans Affairs	Ms. Marie Wood	Member	Steering Committee Member, Health Montgomery
Montgomery County Public Schools	Dr. Andrew Zuckerman	Chief of Staff	Steering Committee Member, Healthy Montgomery

Appendix B. 2015 Insurance Coverage Estimates for Suburban Hospital's CBSA

2015 Insurance Coverage Estimates
Area: Suburban_FY2015_CB_SA
Ranked by ZIP Code(Asc)

ZIP Code	ZIP City	2015 Adjusted Population								
		Total	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private - Direct	Private - ESI	Private - Exchange	Uninsured
20814	Bethesda	29,349	2,455	1,145	3,495	531	1,543	18,789	464	926
20815	Chevy Chase	30,814	1,965	943	4,738	704	1,640	19,646	402	776
20817	Bethesda	36,685	1,935	1,016	4,793	709	2,074	24,931	453	773
20850	Rockville	52,497	4,786	2,337	5,393	830	2,742	33,782	861	1,767
20851	Rockville	14,556	1,292	665	997	160	803	9,895	266	478
20852	Rockville	46,769	4,604	2,213	5,495	835	2,343	28,795	805	1,678
20853	Rockville	30,499	3,178	1,423	3,478	524	1,528	18,681	497	1,191
20854	Potomac	51,401	2,236	1,152	7,059	1,041	2,985	35,431	575	922
20874	Germantown	62,031	5,434	3,067	2,971	514	3,480	43,436	1,161	1,968
20877	Gaithersburg	36,644	6,464	2,696	2,954	460	1,551	19,525	748	2,247
20878	Gaithersburg	65,168	4,450	2,649	4,907	783	3,729	45,942	1,050	1,659
20895	Kensington	20,683	2,014	1,013	2,364	358	1,036	12,833	325	740
20902	Silver Spring	52,020	6,406	3,108	4,185	655	2,555	31,844	987	2,279
20906	Silver Spring	67,761	9,720	4,004	10,118	1,515	2,845	34,876	1,142	3,542
20910	Silver Spring	41,944	6,156	2,718	3,253	521	1,949	24,417	811	2,118
Total		638,821	63,096	30,148	66,200	10,140	32,803	402,823	10,546	23,064

Appendix C. Top Ten Causes of Mortality in Montgomery County



Appendix D. Mortality and Morbidity Rates by Race and Ethnicity for Montgomery County's Leading Causes of Death.

Health Indicator	Blacks, non-Hispanic	Whites, non-	Hispanic or Latino	Asian/Pacific Islander	CBSA	MoCo	Definition
Cardiovascular Disease+	196	162.5	95.9			158.7	Age-Adjusted Death Rate per 1000,000 (2010-2012)
Heart Disease*	124.8	114.5	62.1	63.3	111.7	108.0	Age-Adjusted Death Rate per 100,000 (2011-2013)
Cerebrovascular Disease*	27.3	25.0	20.7	24.1	26.3	25.6	Age-Adjusted Death Rate per 100,000 (2011-2013)
Cancer+	142.1	134.3	85.3	88.4		127.1	Age-Adjusted Death Rate per 1000,000 (2010-2012)
Colorecal Cancer	13.2	9.1	7.5	9.7		9.7	Age-Adjusted Death Rate (2008-2012)
Prostate Cancer	28.1	16.7				16.7	Age-Adjusted Death Rate (2008-2012)
Breast Cancer	27.1	18.4	7.4	8.4		18.8	Age-Adjusted Death Rate (2008-2012)
Lung Cancer	30.9	26.5	11.1	18.2		25.9	Age-Adjusted Death Rate (2008-2012)
Adults with Diabetes (%)	7.6	7.2	2.9	9.3		7.0	Percentage of Adults who have ever been diagnosed with diabetes (2014)
ER Rate Due to Long-Term Complications	16.6	4.3		2.3		5.6	ER Visits/10,000 populations 18+ years n(2009-2011)
Diabetes Mellitus+	26.4	11.3	14.2			13.3	Age-Adjusted Death Rate per 100,000 (2011-2013)
Chronic lower respiratory disease+	13.4	21.8	7.1			18.3	Age-adjusted deaths per 100,000 (2010-2012)
Hospitalization due to Pediatric Asthma	21.5	6.4		8.4		12.3	Age-Adjusted per 10,000 populationn under 18 years (2009-2011)
Hospitalization Rate due to COPD	14.5	9.1			2.9	9.1	Age-Adjusted per 10,000 population 18+ years (2009-2011)
Accidents (Unintentional Injuries)+	11.7	18.4	15.9			16.7	Age-Adjusted per 10,000 population 18+ years (2010-2012)
Motor Vehicle Traffic*	5.2	3.6	6.6			4.1	Age-Adjusted Death Rate per 100,000 (2011-2013)
Falls deaths, unintentional*		8.5				7.4	Age-Adjusted Death Rate per 100,000 (2011-2013)
Poisoning deaths*	4.9	8.3				5.9	Age-Adjusted Death Rate per 100,000 (2011-2013)
Firearms-related deaths*	4.5	4.2				3.7	Age-Adjusted Death Rate per 100,000 (2011-2013)

Source
*Health Indicators Warehouse
Healthy Montgomery
+Data Montgomery

Appendix E. Core Measure Indicators for Suburban Hospital's CBSA

Behavioral Health	Measure	Source
Adolescent and adult illicit drug use <30 days	Percent of people aged 12 or older who used an illicit drug a month preceding survey	NSDUH
Adults with any mental illness <1yr	Percent of adults who had any mental illness in the past year	NSDUH
ER visits for behavioral health conditionals	Age Adjusted Rate-Per American Community Survey 100,000 Population	HSCRC ER
Suicide	Age Adjusted Rate-Per American Community Survey 100,000 Population	VSA Deaths
Cancers		
Colorectal Screening	Percentage of adults aged 50 and over who have had a blood stool test within the past two years	BRFSS
Pap in past 3 years	Percentage of women aged 18 and over who have had a Pap smear in the past three	BRFSS
Prostate cancer incidence	Age-Adjusted incidence rate for prostate cancer in cases per 100,000 males	NCI
Breast cancer mortality	Age Adjusted Rate- Per American Community Survey 100,000 Population	VSA Deaths
Cardiovascular Health		
Heart disease mortality	Age Adjusted Rate- Per American Community Survey 100,000 Population	VSA Deaths
Stroke mortality	Age Adjusted Rate- Per American Community Survey 100,000 Population	VSA Deaths
High blood pressure prevalance	Percentage of adults who have been told they have high blood pressure (above 140/90 mm Hg)	BRFSS
Diabetes		
Adults with diabetes	Percentage of adults who have ever been diagnosed with diabetes	BRFSS
ER visits for diabetes	Emergency room visit rate due to diabetes per 100,000 population	SHIP
Age-Adjusted Rate due to diabetes	Average annual age-adjusted emergency room visit rate due to diabetes per 10,000 population aged 18 years and older	HSCRC ER
Maternal & Infant Health		
Mother's who received early prenatal care	Percent of births to women with prenatal care beginning in the first trimester	VSA Births
Infant mortality	Crude Rate- Deaths Per 1,000 Live Births	VSA Deaths
Babies with low birth birthweight	Percent of births in which the newborn weighed less than 2,500 grams (5 pounds, 8	VSA Births
Obesity		
Adults engaging in moderate physical activity	Percentage of adults who participate in at least 150 minutes of aerobic physical activity per week	BRFSS
Adults fruit and vegetable consumption	Percentage of adults who eat fruits and vegetables five or more times per day	BRFSS
Adults who are overweight or obese	Percentage of adults who are overweight or obese according to the Body Mass Index (BMI)	BRFSS
Students with no partcipation in physicial activity	Percentage of high school students who were not physically active for at least 60 minutes on one day the past seven days	YRBS
Students who drank no soda or pop in the past week	Percentage of high school students who did not drink a can, bottle, or glass of soda or pop during the past seven days	YRBS
Students who are overweight or obese	Percentage of high school students who are overweight or obese according to BMI	YRBS
Cross-Cutting Measures		
Adults who have had a routine check-up	Percentage of adults that report having visited a doctor for a routine checkup within the last two years	BRFSS
Persons without health insurance	Percentage of people who do not have any type of health insurance coverage	ACS
Adults in good physical health	Percentage of adults who stated that they experienced two or fewer days of poor physical health in the past month	BRFSS
Adults in good mental health	Percentage of adults who stated that they experienced two or fewer days of poor mental health in the past month	BRFSS
Students in good general health	Percentage of high school students who described their health in general as "very good" or "excellent"	YRBS
Students ever feeling sad or hopeless in the past year	Percentage of high school students who felt so sad or hopeless almost every day for at least two consecutive weeks that they stopped doing some usual activities during the past 12 months	YRBS
Adults who smoke	Percentage of current smokers (smoked at least 100 cigarrettes in their lifetime and currently smoke)	BRFSS
Students current cigarette use	Percentage of high school students who smoked cigarettes on one or more of the past 30 days	YRBS

Context Measures (SDOH)

Families living below poverty level %	Percentage of families living below the federal poverty level	ACS
Residents 5+years old that report speaking English "not very well"	Percentage of the population aged 5 years and over who report speaking English less than "very well"	ACS
Students ever reveiving free and reduced-price meals (FARMS)	Percentage of students who now or in the past have received free or reduced price school lunches	MCPS
Adults with adequate social and emotional support	Percentage of adults who report they usually or always get the social and emotional support they need	BRFSS
Students who could talk to adult besides a parent	Percentage of high school students who would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting	YRBS
Students participation in extracurricular activities	Percentage of high school students who participate in any extracurricular activities at school	YRBS
High School Completion Rate	Percentage of people aged 25 years and over who have completed a high school degree or the equivalent	ACS

Sources:

Maryland Healthcare Services and Cost Review Commission annual emergency room outpatient discharges (HSCRC ER)
Maryland Department of Health & Mental Hygiene (DHMH), Vital Statistics Administration Annual Birth Files, Montgomery County (VSA Births)
Maryland Department of Health & Mental Hygiene (DHMH), Vital Statistics Administration Annual Death Files, Montgomery County (VSA Births)
National Survey on Drug Use and Health (NSDUH)
National Cancer Institute (NCI)
Maryland Behavioral Risk Factor Surveillance System (BRFSS)
Maryland Youth Risk Behavior Survey (YRBS)
American Community Survey (ACS)
Montgomery County Public Schools (MCPS)
Maryland State Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/SitePages/Home.aspx
Healthy Montgomery http://www.healthymontgomery.org/
State Cancer Profiles http://statecancerprofiles.cancer.gov/
http://www.dartmouthatlas.org/data/table.aspx?ind=198
Community Commons sessment.communitycommons.org
Health Indicators Warehouse http://www.healthindicators.gov/

	State	County	CBSA	HP 2020 Goal	MD 2017 Goal
Behavioral Health					
Adolescent and adult illicit drug use <30 days	7.56	7		16.6	
Adults with any mental illness <1yr	17.4	17.9			
ER visits for behavioral health conditions	3442.6	1791.7	778.2		3152.6
Suicide	9	7.3	7.2	10.2	9
Cancers					
Colorectal Screening	16.5	23.1		70.5	
Pap in past 3 years	79.8	83		93	
Prostate cancer incidence	141.1	137			
Breast cancer mortality	23.7	18.8	**18.9**	20.7	
Cardiovascular Health					
Heart disease mortality	172.8	108.0	111.7	152.7	166.3
Stroke mortality	36.8	25.6	26.3	34.8	
High blood pressure prevalance	28	27.7		26.9	
Diabetes					
Adults with diabetes	10.1	7.1		7.2	
ER visits for diabetes	204	95.0	**583.3**		186.3
Age-Adjusted Death Rate due to diabetes		13.3			
Maternal & Infant Health					
Mother's who received early prenatal care (%)	66.6	63.1	73.1	77.9	66.9
Infant mortality	6.6	4.7	4.6	6	6.3
Babies with low birthweight (%)	8.6	7.5	**7.6**	7.8	8
Obesity					
Adults engaging in moderate physical activity		52.7		47.9	50.4
Adults fruit and vegetable consumption		29.6			
Adults who are overweight or obese	64.9	57.4			
Students with no partcipation in physicial activity (teens)	18	16.5			
Students who drank no soda or pop in the past week	28.4	33			
Teens who are overweight or obese	25.8	20			

	State	County	CBSA	HP 2020 Goal	MD 2017 Goal
Cross-Cutting Measures					
Adults who have had a routine check-up	89.3	86.2			
Persons without health insurance	7.9	9.7		0	
Adults in good physical health	77.6	79.4		79.8	
Adults in good mental health	76.7	77.8		80.1	
Students in good general health	49.9	52.3			
Students ever feeling sad or hopeless in the past year	27	26.9			
Adults who smoke	14.6	7.9		12	15.5
Students current cigarette use (teens)	11.9	8.5			
Context Measures (Social Determinants Of Health)					
Families living below poverty level %	6.9	4.5			
Residents 5+years old that report speaking English "not very well"	6.3	15.1			
Students ever receiving free and reduced-price meals (FARMS)		43.3			
support		83.3			
Students who could talk to adult besides a parent	77.3	73.9		83.2	
Students participation in extracurricular activities	67.4	72.1			
High School Completion Rate (%)	89	89.7			

Appendix F. Community Health Survey Tool (English)

Code #: ___________

Community Health Survey

Your health and wellbeing is our passion. Help us prioritize your needs by participating in this confidential survey (also available online via www.suburbanhospital.org).

1. What is your home zip code? _________
2. What language do you prefer to speak? ______________
3. What is the highest level of education you have completed?
   - ☐ Did Not Complete High School
   - ☐ High School/GED
   - ☐ Some College
   - ☐ Bachelor's Degree
   - ☐ Master's Degree
   - ☐ Advanced Graduate work or Ph.D.
4. What is your gender?
   - ☐ Male
   - ☐ Female
5. What is your age?
   - ☐ Under 19 years
   - ☐ 20-30 years
   - ☐ 31-40 years
   - ☐ 41-50 years
   - ☐ 51-60 years
   - ☐ 61-70 years
   - ☐ 71-80 years
   - ☐ 81-90 years
   - ☐ Older than 91 years
6. What is your race/ethnicity?
   - ☐ African American
   - ☐ Asian/Pacific Islander
   - ☐ Caucasian
   - ☐ Hispanic/Latino
   - ☐ Other: ____________________________
7. Which health condition do you feel you are most at risk of developing? Please select ONLY **one**.
   - ☐ Cancer
   - ☐ Obesity
   - ☐ Heart Disease
   - ☐ Diabetes
   - ☐ Behavioral/Mental Health
   - ☐ Other:_______________
   - ☐ I don't feel at risk of developing any health conditions
8. What health concern(s) do YOU have? Please check **no more than five**.
   - ☐ Heart Disease
   - ☐ Cancer
   - ☐ Diabetes/Sugar
   - ☐ Asthma/Lung Disease
   - ☐ Smoking/Drug and Alcohol Use
   - ☐ Mental Health Issues (depression, anxiety, etc.)
   - ☐ High Blood Pressure
   - ☐ Other
   - ☐ Stroke
   - ☐ Traffic Accidents
   - ☐ Maternal/Child Health
   - ☐ Overweight/Obesity
   - ☐ Access to Health Care
   - ☐ No Health Insurance
   - ☐ Environmental Health
   - ☐ Dental
   - ☐ None

   If you checked "Other," please explain:

   ____

Please turn the page over ➔

9. What barriers are keeping you from getting the health care YOU need? Please check **all** that apply.

☐ No health insurance
☐ Cost
☐ No transportation
☐ Lack of information
☐ Difficulty getting an appointment with my doctor
☐ Lack of time
☐ Language
☐ Child care
☐ I have health insurance, but local doctors are not on my insurance plan
☐ I don't have any barriers
☐ Other

If you checked "Other", please explain:

____

10. Please circle the number which best identifies your response to the following statements.

In the past month, I have:	Never	Occasionally	Often	Always
a. Been physically active outside of work for at least 2.5 hours a week (i.e. very brisk walking).	1	2	3	4
b. Eaten at least five servings of fruits and vegetables every day (1 serving = 1/2 cup).	1	2	3	4
c. Used tobacco products (cigarettes, cigars, smokeless tobacco, e-cigarettes, and pipes).	1	2	3	4
d. Consumed more than 5 alcoholic drinks a week (1 drink= 12 fl oz of beer, 1.5 fl oz shot "hard liquor", 5 fl oz of wine).	1	2	3	4
e. Worn a seat belt when traveling in a vehicle.	1	2	3	4
f. Been able to manage and control my stress.	1	2	3	4

11. Which area of your health do you think you need to improve the most? Please select ONLY **one**.

☐ Physical activity
☐ Healthy eating
☐ Smoking/tobacco use
☐ Alcohol consumption
☐ Driving safety
☐ Stress management
☐ None

12. How would you rate your current health status?

☐ Excellent
☐ Good
☐ Fair
☐ Poor

Thank you for completing the survey.

Office Use Only:

Date: __________ Location: ____________ Zip Code: ___________ Surveyor: ____________

Appendix G. Community Benefit Advisory Council

Organization	Name	Title	Description
Capstone Development, LLC	Mr. Norman Jenkins	Founder and CEO	Chairman of Suburban Hospital's Community Benefit Advisory Council; facilitates the Advisory meetings.
A Wider Circle	Dr. Mark Bergel, Ph.D.,	Founder and Executive Director	Member of Suburban Hospital's Community Benefit Advisory Council; offers unique community perspective as his organization works with the underserved population.
Community Advocate	Ms. Belle Brooks O'Brien	Resident of Montgomery County	Member of Suburban Hospital's Community Benefit Advisory Council
Healthcare Initiative Foundation	Ms. Crystal Carr Townsend	President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Betsy Carrier Ms. Eva Cohen	Treasurer President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Eva Cohen	co-President and chair	Member of Suburban Hospital's Community Benefit Advisory Council
Community Physician	Dr. Diane Colgan	Medical Staff Chair for Suburban Hospital	Member of Suburban Hospital's Community Benefit Advisory Council
Bethesda Chevy Chase Regional Services Center	Mr. Ken Hartman	Regional Services Director	Member of Suburban Hospital's Community Benefit Advisory Council; provides a facility to many CHW programs.
YMCA of Metropolitan Washington	Ms. Carla P Larrick	Vice President of Operations	Member of Suburban Hospital's Community Benefit Advisory Council
Girls on the Run	Ms. Elizabeth McGlynn	Executive Director	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital supports GOTR as it official health sponsor providing financial support, training for coaches and health education at bi-annual races.

AQUAS, Incorporated	Ms. Carmen Ortiz Larsen	President	Member of Suburban Hospital’s Community Benefit Advisory Council
Montgomery County Police Department	Mr. Michael Prather	Officer	Member of Suburban Hospital’s Community Benefit Advisory Council; Partners with CHW to bring safety information to the Hospital’s CBSA community.
Community Physician	Dr. Michael Smith	Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter	Member of Suburban Hospital’s Community Benefit Advisory Council; Partners with CHW in bringing health education to Alpha Phi Alpha Montgomery County Chapter
Montgomery County Police Department	Ms. Dana Stroman	Officer	Member of Suburban Hospital’s Community Benefit Advisory Council; Partners with CHW to bring safety information to the Hospital’s CBSA community.
Association of Community Cancer Centers	Ms. Lisa Townsend	Marketing Manager	Member of Suburban Hospital’s Community Benefit Advisory Council
Aronson, LLC	Mr. Michael K. Yuen	Certified Public Accountant	Member of Suburban Hospital’s Community Benefit Advisory Council

Appendix G. Montgomery County United Way Regional Council Members

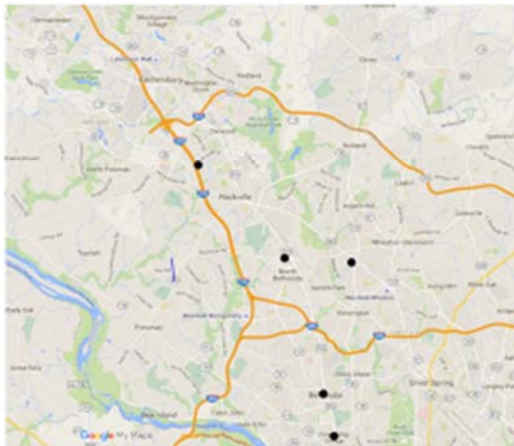
Randy R. Schools, Council Chair, Nominating Chair	Bill Carey
President	Director of Membership and Community Relations
Recreation-Welfare Association	Strathmore Hall Foundation, Inc.
NIH-NOAA	5301 Tuckerman Lane
9000 Wisconsin Avenue	North Bethesda, MD 20852
Bethesda, MD 20892	**Office:** 301-581-5135
Office: 301-251-1743	**Email:** bcarey@strathmore.org
Email: schoolsr@ors.od.nih.gov	
Rudy Oswald, Community Impact Chair	**Lawrence Cooper**
Retired	General Counsel : DC Office of Cable TV, Film, & Entertainment
11804 Devilwood Dr.	District of Columbia Government
Potomac, MD 20854	1899 9th Street, NE,
Home: 301-340-7569	Washington, DC 20018
Email: rudyosw@verizon.net	(Bethesda Resident)
	Office: (202) 671-0066
	Email: lncooper@verizon.net
Michele M. Hamilton	**Torrie Cooke**
Retired from US Government Accountability Office (GAO)	Detective
10003 Stoneybrook Drive	Montgomery County Police Department
Kensington, MD 20895	18512 Office Park Drive
Home: 301-585-5521	Montgomery Village, MD 20886
Email: mhcager@aol.com	**Cell:** 240-793-1462
	Email: tcooke35@verizon.net
Jay Wilson	**Tony Marciante**
Sr Staff Accountant	Chef Proprietor & CSO
9520 Ament Street	Chef Tony's
Silver Spring, MD 20910	4926 St. Elmo Avenue
Cell: 404-295-5451	Bethesda, MD 20817
Email: jlwilson82@gmail.com	**Office:** 301-654-3737
	Email: alltonysmail@gmail.com
Patricia Rios	**Frank Gangi**
Supervisor, Community Health Improvement	Friendship Heights Store
Surburban Hospital	Nordstrom (Bethesda resident also)
8600 Old Georgetown Road	5333 Wisconsin Avenue,
Bethesda, MD 20814	Washington DC 20015
Office: (301) 896-2849	**Office:** 202.697.4100
Email: PRios@jhu.edu	**Email:** frank.gangi@nordstrom.com

Appendix G. Suburban Hospital Patient and Family Education Committee members

Name	Suburban Hospital Title
Atul Rohatgi MD	Hospitalist
Barbara Kohl PFAC	Community Member
Barbara Olivier	Manager, Patient Access
Cathy Clark	Nursing Supervisor, Nursing Education
Charlotte Savarino	Nurse, Pediatrics
Debbie Kovach PFAC	Community Member
Debra Scheinberg	Manager, Marketing & Communications
Jacky Schultz	EVP & COO, Administration
Judy Holloway	Coordinator, Quality Management
June Graft PFAC	Community Member
Karen Carlson	Director, OR Minor
Kathrine Carongoy	Nurse, Adult Surgical
Kristina Kepner	Nurse, Nursing Education
Leighann Sidone	VP CNO, Administration
Matilde Hazeley-Muhongi	Nurse, Intensive Care Unit
Norma Bent	Director, Care Coordination
Pamela Fogan	Director, Volunteer Services
Pamela Gurian	Nurse, PACU
Patricia Rios	Supervisor, Community Health & Wellness
Quentin Simeone	Coordinator, Clinical Support
Sarah Rassmussen	Eppic Informatics, MIS
Shawn Donnelly	Director, Managed Care
Steve Bokat PFAC	Community Member
Teresa MCCannon	Nurse Educator, Nursing Education
Toby Levin PFAC	Community Member

Appendix H. Suburban Hospital Program & Services Asset Map

Behavioral Health



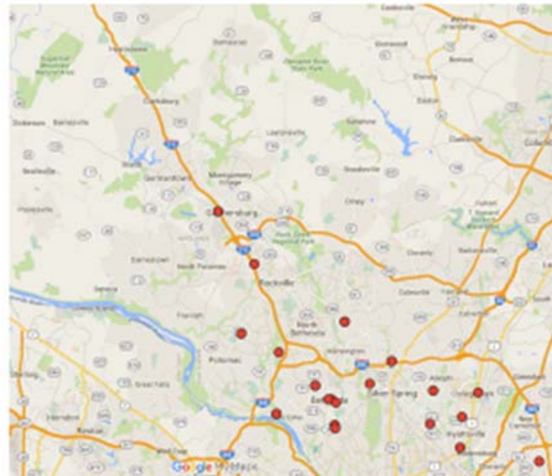
5 sites

- Support groups (host & facilitate)
    - Nutrition
    - Bipolar disorders
    - Stroke
    - Diabetes
    - Cancer
    - Respiratory
- Health education seminars
- Addiction treatment center (includes outreach)
- Mindfulness Meditation classes

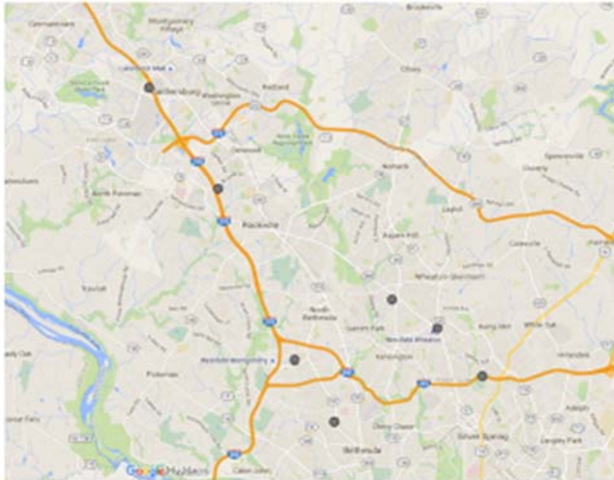
Cardiovascular Health

35 sites

- HeartWell Clinics
- Blood pressure screenings
- Cholesterol screenings
- MobileMed/NIH Heart Clinic
- Dine & Learn
- Physical activity classes
    - Senior Shape
    - Mall walking
    - Tai Chi
- Health education seminars and symposia
- Health fairs
- CPR classes
- Financial support for safety net clinics



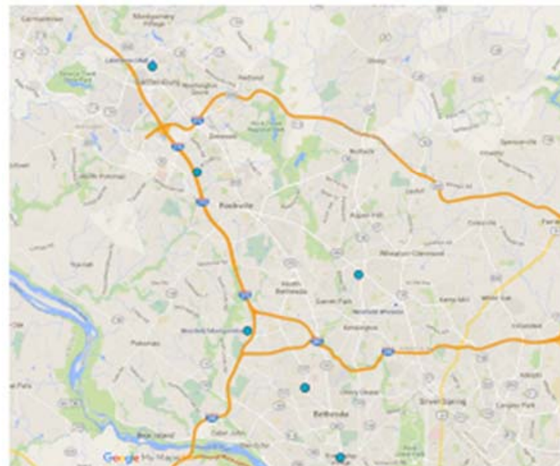
Diabetes



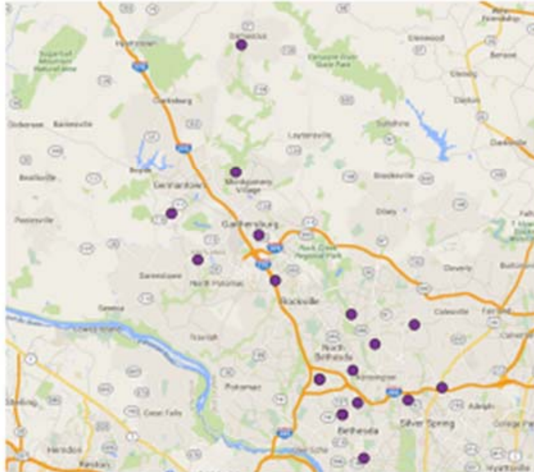
7 sites
- Pre-diabetes and diabetes management classes
- Support groups
- Nutrition counseling
- MobileMed/NIH Endocrine Clinic
- Health education seminars
- Diabetes symposium
- Financial support for safety net clinics
- Support of Protecyo Salud diabetes school

Obesity

9 sites
- Dine & Learn
- Senior Shape
- Physical activity
  - Girls on the Run
  - Fun runs
- Nutrition counseling
- Nutrition classes & seminars
- Cooking demonstrations



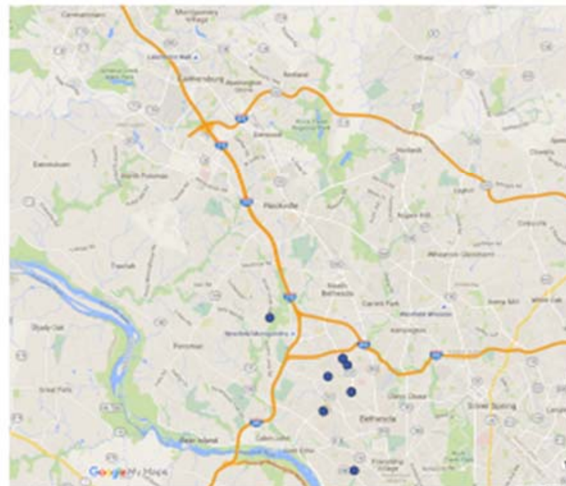
Cancer



24 sites
- Screenings (skin, head, neck)
- Free pap smears for Proyecto Salud patients
- Patient navigators
- Symposia
  - Breast
  - Prostate
- Survivor support groups
- Colorectal awareness day
- Health education seminars & classes
  - Check it Out (breast & testicular)
  - Yoga
  - Look Good, Feel Better

Maternal and Child Health

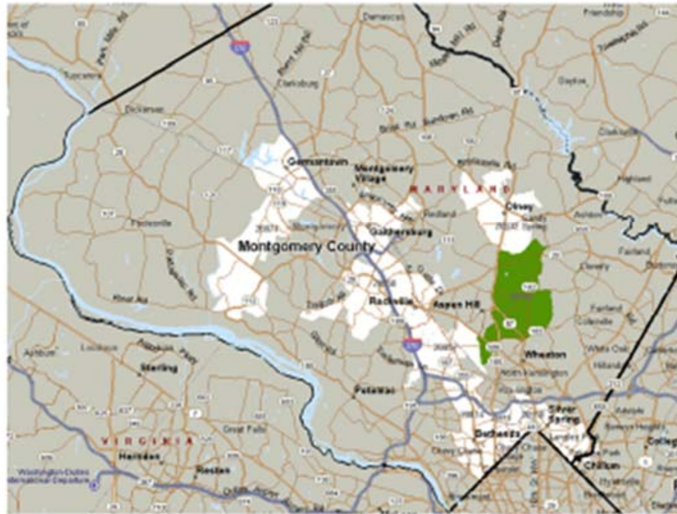
9 sites
- Safe Sitter
- Adopt-a-Family
- Parenting seminars
- Survival guide for first-time grandparents
- The Gabriel Project & Knots for Shots



Appendix I. Asset Map for Montgomery County

Behavioral Health

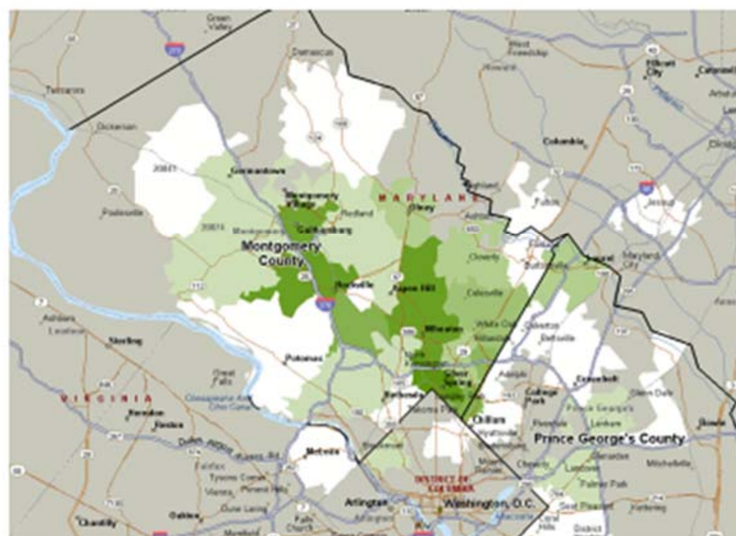
Gradient shading based on number of programs in ZIP code; darker the shading, higher number of programs



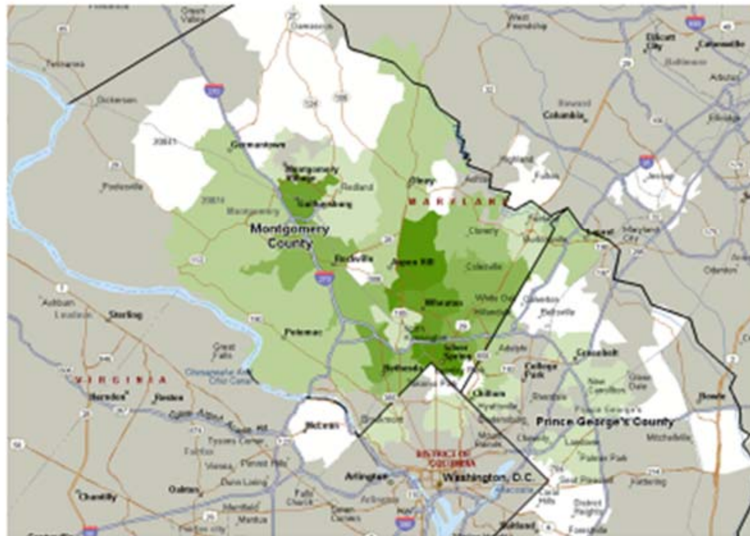
Obesity

Maternal and Infant Health

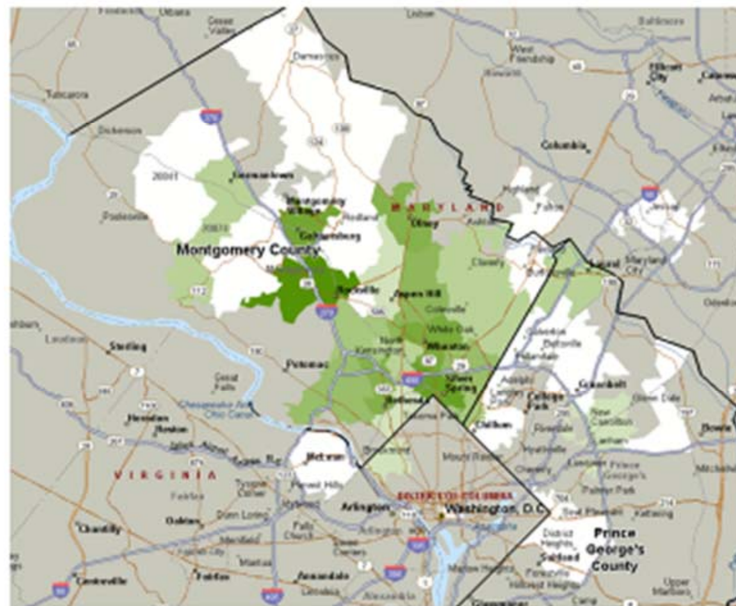
Diabetes



Cardiovascular



Cancer



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APPENDIX IX: COMMUNITY HEALTH NEEDS ASSESSMENT 2016 IMPLEMENTATION STRATEGY

Suburban Hospital

Implementation Strategy

In response to the

Community Health Needs Assessment

Fiscal Year 2016

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

SUBURBAN HOSPITAL
COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY
FY 2016

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Introduction

A. Overview of Suburban Hospital

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The Hospital provides all major services except obstetrics. One of nine regional trauma centers in Maryland, the Hospital is the state-designated level II trauma center for Montgomery County with a fully equipped, elevated helipad. Suburban Hospital's busy Emergency/Shock Trauma Center treats more than 45,000 patients a year.

The Hospital's major services include a comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; a cardiac center providing cardiac surgery, elective and emergency angioplasty as well as inpatient diagnostic and rehabilitation services; orthopedics with joint replacement and physical rehabilitation; behavioral health; neurosciences including a designation as a Primary Stroke Center and a 24/7 stroke team; pediatrics and senior care programs.

Suburban Hospital is the only hospital in Montgomery County to achieve the Gold Seal of Approval™ by The Joint Commission for its joint replacement program. Other services provided include a state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; and a free physician referral service (Suburban On-Call). During fiscal year 2015, Suburban Hospital was licensed to operate 220 acute care beds and had 13,861 inpatient admissions.

B. Community Health Needs Assessment

Under Section 501(c) (3) of the Internal Revenue Code, nonprofit hospitals may qualify for tax-exempt status if they meet certain federal requirements. The 2010 Patient Protection and Affordable Care Act (ACA) added four basic requirements to the Code. One of the additional requirements for tax-exempt status is the provision of a community health needs assessment (CHNA) once every three years and an implementation strategy to meet the identified health needs. (Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals, 2010)

In Fiscal Year 2016, Suburban Hospital conducted a community health needs assessment to identify the most important health issues surrounding the hospital using scientifically valid health indicators and comparative information. The assessment helped to identify priority health issues affecting Montgomery County as a whole and specifically residents' of Suburban Hospital's Community Benefit Service Area (CBSA). Suburban Hospital's Community Health Needs Assessment FY 2016 is available to the public via SuburbanHospital.org. This report describes Suburban Hospital's implementation strategy for addressing the identified health needs in the community in order to improve health status and quality of care available to our residents, while building upon and strengthening the community's existing infrastructure of services and providers.

Suburban Hospital Health Priorities

As a result of using similar data sources and integrating historical partners / stakeholders in setting local health priorities over the years, the summary of key data findings conducted by the Montgomery County health improvement process, referred to as Healthy Montgomery, are similar, if not identical to health inequities identified by Suburban Hospital through community member surveying, discussions with community members, and hospital data. This relationship easily affords Suburban Hospital the ability to align its community health improvement efforts to five of the six priorities identified by the Healthy Montgomery Steering Committee in order to decrease health inequities, lack of access, and unhealthy behaviors. The five official health priorities to be addressed, tracked, and evaluated over the next three years are presented below in no particular order:

- Behavioral Health
- Cancer
- Cardiovascular Health
- Diabetes
- Obesity

The Community We Serve

Suburban Hospital is located in Montgomery County, one of the most affluent counties in the United States. Montgomery County is adjacent to the nation's capital, Washington, D.C., and is also bordered by the Maryland counties of Carroll, Frederick, Howard and Prince George's, and the Commonwealth of Virginia.

A close review of service utilization led to the identification of Suburban Hospital's primary service area (PSA). The PSA is defined as the Maryland postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period after the discharges from each zip code are ordered from largest to smallest number of discharges. This information was provided by the Maryland Health Services Cost Review Commission (HSCRC).

As part of the PSA definition process, Suburban Hospital began to look at specific populations or communities of need to which the Hospital allocates resources through its community benefit plan. This in-depth process required an analysis of data from the Hospital's Inpatient Records, Emergency Department (ED) Visits, and Community Health Improvement Initiatives and Wellness Activities. The product was a geographic area, identified as Suburban Hospital's Community Benefit Service Area (CBSA) and contains the following fifteen zip codes: 20814, 20817, 20852, 20854, 20815, 20850, 20895, 20906, 20902, 20878, 20853, 20910, 20851, 20874, and 20877. A close look revealed that Suburban Hospital's CBSA has increased by two zip codes (20874 and 20877) from fiscal year 2013 and is not limited to the primary service area.

Addressed Needs and Implementation Strategy

Suburban Hospital's CHNA taskforce conducted an analysis of current Suburban Hospital's community benefit activities, while also taking into consideration Suburban Hospital's major services of excellence, and found present efforts to be aligned, in some capacity, with the five health priorities mentioned above. Because the Hospital does not have an obstetrics designation or deliver babies, Suburban Hospital does not include Maternal and Child Health initiatives as an identified health priority, the sixth Healthy Montgomery priority. Suburban Hospital does, however, indirectly support Maternal and Child Health initiatives through funding and programming of several other organizations which promote the health and well-being of children and their families.

Suburban Hospital's approved health improvement plan connects hospital, community partners, local stakeholders and other resources with identified health needs. Suburban Hospital not only aligns health priorities with the areas of greatest identified need, but also considers where the Hospital's resources will

generate the greatest impact. As such, the implementation plan includes an evaluation component to measure each health outcome identified in the plan. Over the next three years, Suburban Hospital will focus its health improvement efforts to specific populations or communities of need to which the hospital allocates resources, identified above as the Community Benefit Service Area (CBSA). Within the CBSA, Suburban Hospital will focus on certain target populations such as uninsured individuals and households, underinsured and low-income individuals and households, ethnically diverse populations, underserved seniors, or at-risk youth.

Community Health Need: BEHAVIORAL HEALTH					
Target Population: CBSA residents					
Goal: Improve behavioral health through prevention and linkage to appropriate services *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*

PROMOTION OF HEALTHY BEHAVIORS	By June 2019, improve positive behavioral health outcomes by conducting deliberate interventions that foster social and emotional support	Increase the proportion of seniors that participate in educational and community-based programs, e.g. reduce isolation
		
		Provide on-going tools and resources that improve family functioning and positive parenting
			• Support groups
			• Senior fitness programs
			  ○ Tai Chi
			  ○ Pilates
			  ○ Senior Shape
			  ○ Mall Walking
			• Village Ambassador Alliance
			
			• Parenting seminars
				• Referrals to programs
				• Attendance in programs
					• Montgomery County Department of Recreation Senior Centers
					• AARP
					• OASIS
					• Montgomery County Stroke Association Bethesda-Chevy Chase YMCA
					• Bethesda-Chevy Chase Youth & Family Services
					• Parenting Encouragement Program (PEP)
					• Johns Hopkins University Press
					• WAVE

ACCESS TO HEALTHCARE SERVICES	By June 2019, increase knowledge of behavioral health resources in Montgomery County and facilitate access to available services and resources	Link patients in need of behavioral health services to appropriate community resources	• Suburban On-Call • Behavioral inpatient and outpatient services ○ Support Groups • Mindoula / Magellan Care Coordination Services	• Established alliances • Readmission rates	• National Alliance on Mental Illness of Montgomery County • Alcoholics Anonymous • Narcotics Anonymous • Healthy Montgomery

Community Health Need: OBESITY					
Target Population: CBSA residents					
Goal: Reduce obesity rates through promotion of healthy lifestyles *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*

PROMOTION OF HEALTHY BEHAVIORS	By June 2019, increase awareness of risk factors associated with obesity	Deliver structured and deliberate educational messages and promote existing services that support healthy eating and physical activity	Promote and provide, in coordination with public and private agencies, affordable, structured on-going programs to increase knowledge and utilization of available obesity reduction and prevention services, including:
			• Health seminars
			• Cooking demonstrations
			• Fitness classes
			  ○ Senior Shape
			  ○ Tai Chi
			  ○ Pilates
			  ○ Mall walking
			• HeartWell clinics
			  ○ Know Your Numbers
			• Nutrition counseling
			  ○ Healthy Weigh
			  ○ Healthy Choices
			  ○ Nutrition One on One
				• Individuals' perceived self-efficacy with regards to weight loss and healthy behavior modifications
				• Class attendance rates
					• Montgomery County Department of Recreation Senior Centers
					• Lakeforest Mall
					• Friendship Heights Village Center
					• Girls on the Run of Montgomery County
					• Scotland Health Partnership
					• Bethesda-Chevy Chase YMCA
					• Rotary Club

			Collaborate with and support organizations that promote healthy eating and physical activity in children and youth (including: • Girls on the Run • #JustGirls • Turkey Chase		
		Assess individuals' risk factors for obesity through screenings and health assessments	Provide on-going health screenings: • BMI	Metrics for increased health risk, approved by American Heart Association and/or Centers for Disease Control and Prevention	

Community Health Need: CANCER					
Target Population: CBSA residents					
Goal: Increase cancer prevention and survivorship rates *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*
PROMOTION OF HEALTHY BEHAVIORS (1 of 2)	By June 2019, increase awareness of cancer risk factors	Deliver on-going, structured educational messages and promote existing services that support healthy behaviors.	• Check It Out • Community seminars and symposiums • Smoking cessation programs	Assess individuals' self-efficacy with regards to management healthy behaviors	• Greater Washington Chapter of Hadassah • Montgomery County Public Schools • Lymphoma & Leukemia Foundation • Susan G. Komen Foundation • Montgomery County Cancer Crusade
PROMOTION OF HEALTHY BEHAVIORS (2 of 2)	By June 2019, increase awareness of existing cancer prevention resources at community level	Partner with public and private organizations that serve communities at high risk of cancer to educate them on the existing free or low-cost cancer prevention and screening resources available in the community	• Suburban Hospital Cancer Program • Walk and Talk	Referrals to programs	• Project Access • Catholic Charities • Proyecto Salud • Alpha Phi Alpha, Inc. fraternity • Montgomery County Cancer Crusade • Sidney J. Malawer Memorial Foundation

					• Mobile Medical Care, Inc.
ACCESS TO HEALTHCARE SERVICES (1 of 2)	By June 2019, increase access to cancer prevention and early detection services	Leverage resources to link and/or deliver free or low-cost early detection prevention screening and treatment programs	Provide on-going health screenings and testing: • Skin • Prostate • Colorectal • Breast • Head & neck • Cervical • Lung	• Number of patients served • Resources allocated to serving patients	• Project Access • Catholic Charities • Proyecto Salud • Alpha Phi Alpha, Inc. fraternity • Montgomery County Cancer Crusade • Sidney J. Malawer Memorial Foundation • Mobile Medical Care, Inc.
ACCESS TO HEALTHCARE SERVICES (2 of 2)	By June 2019, increase availability of support systems for those diagnosed with cancer, survivors, and family/ caretakers	Provide cancer-specific patient navigation services, deliver information, knowledge, support, and guidance needed to manage a cancer diagnosis and treatment Design wellness classes and programs for cancer patients, caretakers, and survivors to reduce stress and anxiety around dealing	• Nurse patient navigators • Look Good, Feel Better • Exercise programs for cancer survivors • Cancer-specific support groups	Referral to programs	• American Cancer Society • Leukemia & Lymphoma Society • Primary Care Coalition • Montgomery County Cancer Crusade • Whole Foods

Community Health Need: DIABETES					
Target Population: CBSA residents					
Goal: Reduce diabetes prevalence and associated health complications *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*
PROMOTION OF HEALTHY BEHAVIORS	By June 2019, increase awareness of risk factors associated with diabetes	Deliver structured educational messages and promote existing services that support: • Healthy eating and physical activity • Diabetes self-management, including Fine Tuning initiative	Provide affordable, on-going health seminars, cooking demonstrations, fitness classes, support groups, counseling services, and on-site nutrition services	Assess individuals' self-efficacy with regards to management of diabetes	• Montgomery County Department of Recreation Senior Centers • Sodexo • Sibley Memorial Hospital • African American Health Program
ACCESS TO HEALTHCARE SERVICES	By June 2019, increase access to quality endocrine specialty care, management, and treatment for uninsured CBSA residents	Provide free or low-cost access to: • Endocrinologists • Specialty state-of-the-art diagnostic screenings • Treatment • Rehabilitation	Partner with public and private organizations to deliver quality specialty cardiovascular and endocrine medical treatment: • MobileMed / NIH Endocrine Clinic • Project Access • Catholic Charities	Number of patients served Resources allocated to serving patients	• Mobile Medical Care, Inc. • National Institutes of Health • Primary Care Coalition • Montgomery Cares safety net clinics

BUILDING BRIDGES WITHIN THE COMMUNITY	By June 2019, increase collaboration with community partners to implement/support collective impact	Advocate for collective impact	Participate in Montgomery County Community Health Improvement Process (Healthy Montgomery)	• Align reporting metrics for health priorities across all Montgomery County hospitals • Implement evidence-based strategies to integrate health literacy and equity into care and services provided	• Healthy Montgomery Steering Committee members • Montgomery County hospital working group

Community Health Need: CARDIOVASCULAR HEALTH					
Target Population: CBSA residents					
Goal: Improve cardiovascular health through prevention strategies *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*

PROMOTION OF HEALTHY BEHAVIORS	By June 2019, increase awareness of behavior change associated with cardiovascular disease	By June 2019, increase awareness of risk factors associated with cardiovascular disease
		
		Assess individuals' risk factors for chronic diseases through screenings and health assessments
			Provide affordable, on-going programs and services:
			• Health seminars
			• Cooking demonstrations
			• Fitness classes
			  ○ Senior Shape
			  ○ Pilates for Senior
			  ○ Tai Chi
			  ○ Mall walking
			• Screenings
			  ○ Body composition
			  ○ Blood pressure
			  ○ Varicose vein
			  ○ Cholesterol
			• On-site nutrition services
			• Heart Smart Classes
			• HeartWell in Action
			
			Provide on-going health screenings:
			• Blood pressure
			• TC/HDL cholesterol
			• Fitness assessments
				Individual's perceived self-efficacy with regards to management of chronic diseases
				
				Metrics for increased health risk, approved by American Heart Association and/or Centers for Disease Control and Prevention
					• Montgomery County Department of Recreation Senior Centers
					  ○ Clara Barton Community Center
					  ○ Friendship Heights Village Center
					  ○ Benjamin Gaither Center
					  ○ Holiday Park Senior Center
					  ○ Jane E. Lawton Community Center
					  ○ Margaret Schweinhaut Senior Center
					  ○ Potomac Community Center
					  ○ Rockville Senior Center
					• Bethesda Regional Service Center

					• Johns Hopkins University Montgomery County Campus • Lakeforest Mall • Sibley Memorial Hospital • OASIS at Macy's Home Store • Wisconsin Place Apartments • Montgomery County Public Schools • Girls on the Run of Montgomery County • Sodexo
ACCESS TO HEALTHCARE SERVICES (1 of 2)	By June 2019, increase access to quality cardiovascular specialty care, management, and treatment for uninsured CBSA residents	Provide free or low-cost access to: • Cardiologists • Specialty state-of-the-art diagnostic screenings • Treatment • Rehabilitation	Partner with public and private organizations to deliver quality specialty cardiovascular and endocrine medical treatment: • MobileMed / NIH Heart Clinic • Project Access • Catholic Charities	• Number of patients served • Resources allocated to serving patients	• Mobile Medical Care, Inc. • National Institutes of Health • Primary Care Coalition • Montgomery Cares safety net clinics
ACCESS TO HEALTHCARE SERVICES (2 of 2)	By June 2019, reduce frequency of hospital admissions/re-admissions due to cardiovascular disease	Connect individuals to existing programs and services at both the hospital and throughout the community, including regular counseling and disease prevention and	HeartWell Clinics Re-Admission Initiative	• Referrals made to Suburban or community programs • Unadjusted Medicare 30-day readmission rate	• HeartWell Clinics • Montgomery County Department of Recreation Senior Centers

		management education sessions			• Skilled nursing facilities
BUILDING BRIDGES WITHIN THE COMMUNITY	By June 2019, increase collaboration with community partners to implement/support collective impact	Advocate for collective impact	Participate in Montgomery County Community Health Improvement Process (Healthy Montgomery)	• Align reporting metrics for health priorities across all Montgomery County hospitals • Implement evidence-based strategies to integrate health literacy and equity into care and services provided	• Healthy Montgomery Steering Committee members • Montgomery County hospital work group

APPENDIX X: SUBURBAN HOSPITAL FY 2017 STRATEGIC PLAN

Johns Hopkins Medicine
FY17 Strategic Objectives

Johns Hopkins Community Division
Affiliate: Suburban Hospital

	GOAL	METRIC	O	√ -	√	√ +	SUBURBAN HOSPITAL Fiscal Year End STATUS UPDATE - SCORE
	Advance community health education through Implementation of a new or expanded existing clinic to meet a specific identified community need	Community Needs	Community needs not identified and no progress towards implementation / expansion of clinic	Community needs identified with plans to implement / expand a clinic	Community needs identified and at least one new clinic implemented or expanded	Community needs identified with expansion / implementation of more than one clinic or integration with SOM program.	1. Established a system to link clinic NIH/MobileMed Endocrine Clinic-patients to diabetes, exercise, and nutrition education classes at Suburban Hospital: 2. Increase capacity with established safety net clinics i.e. MobileMed, Proyecto Salud and Mary's Center for Laboratory/Diagnostics; 3. Strategic chronic disease management interventions, coordination of care and behavioral health services among Mary's Center Montgomery County locations; 4. Continuum of Care of Cardiac Rehab services for NIH/MobileMed Heart Clinic Patients
	Advance community health education through Implementation of a new or expanded existing clinic to meet a specific identified community need	Leverage current NCR resources to enhance diabetes education, programs and support groups.	Model exists, but no progress.	One quality diabetes component leveraged.	Two quality diabetes components leveraged.	Three quality components leveraged for diabetes management model.	1. In collaboration with Montgomery County Hospitals developing a system to connect safety-net clinic patients to the evidence-based stanford chronic disease management program; 2. Fine-Tune Diabetes classes have (Diabetes self-management education and support) reached full implementation, offered bi-monthly at Suburban Hospital. Provider referral to class averages 20 patients per class, are now at full capacity; 4. A new partnership established with JDRF Diabetes Foundation and Suburban to offer Type I diabetes support group meetings in Bethesda. Monthly sessions are being held at Suburban; 5. Quarterly two session pre-diabetes courses offered is partnership with Sibley Memorial Hospital. Taught by Suburban Hospital registered dietitian and Sibley Hospital certified diabetes educator. Classes registrations continue to reach full capacity.
	Advance community health education through Implementation of a new or expanded existing clinic to meet a specific identified community need	Provide tools and resources that improve family functioning, positive parenting and healthy behaviors among vulnerable populations.	No additional tools or resources provided.	One intervention for seniors implemented.	One Intervention targeted to seniors and one intervention targeted to parents.	Multiple interventions targeting an age, language and population specific community.	1. YMCA/PEP Parenting Education seminars-"Helping Children to Manage the Challenges of Separation and Divorce" and "Finding Balance with Kids in a Tech-Savvy World"; 2. #JustGirls workshops in partnership with Scotland Community. Workshops include: '11 Things You Need To Know', 'Growing Connections', and 'Pieces of Me'. 3. Adopt a Family Holiday Initiative; 4. Establish Village Ambassador Alliance to support "Aging in Place"; In partnership with Trauma Team, establish "Stop the Bleed" community training

EXHIBIT 1: SUBURBAN HOSPITAL FY 2017 COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)

Community Health & Wellness Department- Southern MD Initiatives

Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Prince George's County						
Ongoing Cardiac Initiatives & Partnership Programs						
Twice Weekly	Senior Shape Exercise Class at Gwendolyn Britt Senior Activity Center	20722	104	23	2,392	2,272
Once a Week	Tai Chi Class at Gwendolyn Britt Senior Activity Center	20722	50	9	450	428
	Section Subtotal		**154**	**32**	**2,842**	**2,700**
Screenings						
Twice Monthly - Mondays	Blood Pressure Screenings at Glenarden Senior Nutrition Center	20706	24	6	144	144
Twice Monthly - Tuesdays	Blood Pressure Screenings at Gwendolyn Britt Senior Activity Center	20722	24	18	432	432
Twice Monthly - Tuesdays	Blood Pressure Screenings at PG Plaza Community Center	20782	24	10	240	240
Once a month- Thursdays	Blood Pressure Screenings at Spellman House Apts in partnership with Capital Area Food Bank	20740	12	15	180	180
Once a month- Wednesdays	Blood Pressure Screening at Langley Park Senior Activity Center	20783	12	11	132	132
September 20, 2016	Gwendolyn Britt Senior Shape Fitness Health Assessment (pre-test)	20722	1	29	29	29
February 21, 2017	Gwendolyn Britt Senior Shape Fitness Health Assessment (post-test)	20722	1	26	26	26
	Section Subtotal		**98**	**115**	**1,183**	**1,183**
Worksite Wellness						
09/22/16	Cholesterol screening at Capital Cadillac TC/HDL Screening in Greenbelt, MD	20770	1	11	11	6
	Section Subtotal		**1**	**11**	**11**	**6**
Presentations/Seminars						
July 2016	Take as Directed (Langley Park Senior Activity Center)	20783	1	5	5	3
September 2016	Active Aging Week: Zero to Thirty in 14 Days (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	15	15	14
October 2016	Feeling Great When You Vaccinate (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	25	25	21
November 2016	I Survived a Heart Attack: Lessons from a Survivor (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	27	27	24
January 2017	Oh, I See How it Is! (eye screening at Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	25	25	22
February 2017	Act F.A.S.T. with Stroke Awareness (Gwendolyn Britt Senior Activity Center)	20722	1	9	9	9
April 2017	Rockin' the Spice Rack (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	25	25	24
May 2017	May is for Mmmm (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	15	15	14
June 2017	What's On Your Plate: Nutrition Needs after 50 (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	20	20	16
July 2016	Suitland and Rollingcrest-Chillum Dine & Learn: Grill & Chill - Food Safety	20782, 20747	2	39	39	39
August 2016	Suitland and Rollingcrest-Chillum Dine & Learn: What's in Your Drink?	20782, 20747	2	28	28	28
September 2016	Suitland and Rollingcrest-Chillum Dine & Learn: Superfood Spotlight - Beans	20782, 20747	2	19	19	19
October 2016	Suitland Dine & Learn: The Lowdown on the Glycemic Index	20747	1	18	18	18
November 2016	Suitland Dine & Learn: Eat Healthy and Be Merry: Balance, Variety, and Moderation	20747	1	9	9	9
January 2017	Suitland Dine & Learn: Early Start for the New Year	20747	1	12	12	12
February 2017	Suitland Dine & Learn: Be a Healthier Valentine	20747	1	10	10	10
March 2017	Suitland Dine & Learn: Put Your Best Fork Forward	20747	1	21	21	21
April 2017	Suitland Dine & Learn: Smart Snacking	20747	1	19	19	19
May 2017	Suitland Dine & Learn: Healthing Cooking without the Pressure	20747	1	14	14	14
June 2017	Suitland Dine & Learn: Keepin' it Fresh at the Farmers' Market	20747	1	18	18	18
	Section Subtotal		**30**	**373**	**373**	**354**
Meetings/Conference Calls						
Monthly	Prince George's Healthcare Action Coalition (PGHAC) Chronic Disease Work Group Meeting	20774	4	6	24	22
September 2016	Suitland Dine & Learn Planning Conference Calls	20747	2	3	6	5
	Section Subtotal		**6**	***9***	***30***	***27***
	Prince George's County Total		**289**	**540**	**4,439**	**4,269**

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)
Community Health & Wellness Department- Southern MD Initiatives

Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Calvert County						
Screenings						
Monthly	Blood Pressure at Our Lady Star of the Sea Catholic Church, Solomons, MD	20688	12	11	132	8
Monthly	Blood Pressure at Middleham/St. Peter's Parish, Lusby, MD and SMILE	20657	12	12	144	66
Monthly	Blood Pressure at Waters Memorial United Methodist Church, St. Leonard, MD	20685	7	9	63	1
Monthly	Blood Pressure at Calvary Bible Church, Lusby, MD	20657	12	9	86	12
	Section Subtotal		**43**	**41**	**425**	**87**
Health Fair						
September 10, 2016	Cholesterol screening at Middleham/St. Peter's Parish, Lusby, MD	20657	1	24	24	12
	Section Subtotal		**1**	**24**	**24**	**12**
Meetings/Conference Calls						
Monthly	Calvert County Health Ministry Meetings	20678	10	6	60	0
	Section Subtotal		**10**	**6**	**60**	**0**
	Calvert County Total		**54**	**71**	**509**	**99**
St. Mary's County						
Ongoing Cardiac Initiatives & Partnership Programs						
	MedStar St. Mary's Hospital's Congestive Heart Failure Program and Partnership: BP monitors and Bathroom Scales	20650	0	0	0	0
	Section Subtotal		**0**	**0**	**0**	**0**
Meetings/Conference Calls						
	St. Mary's CHF Program - request for new eqipment & program measurement	20650	4	1	4	0
	Section Subtotal		**4**	**1**	**4**	**0**
	Saint Mary's County Total		**4**	**1**	**4**	**0**
	SOUTHERN MARYLAND INITIATIVES TOTAL		**347**	**612**	**4,952**	**4,368**

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)

Community Health & Wellness Department- Health Partnerships

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
COMMUNITY OUTREACH HEALTH PARTNERSHIPS							
Medical Exploring Crew 1984							
	9/12/2016	Medical Exploring Open House	20814	1	130	130	
	10/10/2016	Medical Exploring Program Kick-Off	20814	1	71	71	
	10/24/2016	Tour of ER/Trauma Bay & Helipad with Dr. Westerband	20814	1	65	65	
	varies	Suturing with Dr. Rotello	20814	2	31	62	
	11/21/2016	Advancing to Medical School and Beyond	20814	1	41	41	
	12/12/2016	Holiday Mixer/Adopt a Family	20814	1	32	32	
	1/20/2017	U.S Pharmacopeial Convention Field Trip	20852	1	32	32	
	1/27/2017	NIH National Library of Medicine Tour	20892	1	32	32	
	1/30/2017	Otolaryngology	20814	1	40	40	
	2/13/2017	Oncology	20814	1	47	47	
	2/27/2017	Psychiatry	20814	1	45	45	
	3/13/2017	Pathology	20814	1	38	38	
	4/7/2017	National Institute of Standards and Technology	20899	1	20	20	
	4/24/2017	B-CC Rescue Squad	20814	1	29	29	
	5/8/2017	Cardiothoracic Surgery	20814	1	41	41	
	5/12/2017	Physician Assistant and End of Year Celebration	20814	1	44	44	
	varies	CPR/AED training	20814	3	10	30	
	6/8/2017	Organizational Planning Meeting for 2017-2018	20814	1	2	2	
		Subtotal		***21***	***750***	***801***	***0***
Scotland Health Partnership							
	8/2/2016	National Night Out at Scotland	20854	1	150	150	150
	10/6/2016	Knots for Shots at Scotland: Flu Vaccination Initiative	20854	1	11	11	11
	7/27/2016	#JustGirls Social Club/ Masterchef	20854	1	4	4	4
	8/24/2016	#JustGirls Social Club/ Growing Connections	20854	1	7	7	7
	9/28/2016	#JustGirls Social Club/ Entrepreneurs for Young Savers	20854	1	9	9	9
	10/26/2016	#JustGirls Social Club/ Pieces of Me	20854	1	9	9	9
	1/25/2017	#JustGirls Social Club/Thinking Towards the Future	20854	1	7	7	7
	3/29/2017	#JustGirls Social Club/Safe Sitter fundamentals	20854	1	6	6	6
	4/26/2017	#JustGirls Social Club/Safe Sitter fundamentals	20854	1	2	2	2
	5/31/2017	#JustGirls Social Club/Mindfulness Magic	20854	1	8	8	8
		Subtotal		***10***	***213***	***213***	***213***
Support Groups							
	Monthly	Montgomery County Stroke Association Support Group	20814	11	5	55	11
	Monthly	JDRF Type 1 Support Group	20814	7	4	29	0
		Subtotal		***18***	***9***	***84***	***11***
Suburban Hospital Auxiliary							
	Various	Board Meetings	20814	4	5	20	0
	5/4/2017	Auxiliary Final Celebration	20854	1	29	29	0
		Subtotal		***5***	***34***	***49***	***0***

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)
Community Health & Wellness Department- Health Partnerships

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
American Red Cross Blood Drive							
	Various	Donor Table Recruitment*	20814	5	75	375	n/a
	9/15/2016	Fall Blood Drive*	20814	1	44	44	n/a
	11/29/2016	Winter Blood Drive*	20814	1	42	42	n/a
	2/22/2017	Spring Blood Drive*	20814	1	52	52	n/a
	5/10/2017	Summer Blood Drive*	20814	1	40	40	n/a
		Subtotal		***9***	***253***	***553***	***0***
Safe Sitter Program							
	Various	North Bethesda Middle School	20817	12	15	180	
	Various	Pyle Middle School	20817	24	16	384	
	Various	Westland Middle School	20816	12	13	156	
	Various	St Jane de Chantal	20814	8	10	80	
	Various	Suburban Hospital	20814	11	15	165	
	Various	The Norwood School	20817	4	8	32	
		Subtotal		***71***	***77***	***997***	***0***
OSHER Education Program*							
	4/4/2017	Osher-Medicine: Advances in Health Research and Treatment with Dr. Dr. Edward Healy	20850	1	90	90	90
	4/11/2017	Osher-Medicine: Advances in Health Research and Treatment with Jonathan Gilbert, L.Ac.	20850	1	50	50	50
	4/18/2017	Osher- Medicine: Advances in Health Research and Treatment with Dr. Kenneth Pienta	20850	1	90	90	90
	4/25/2017	Osher- Medicine: Advances in Health Research and Treatment with Dr. Taylor Banks	20850	1	90	90	90
	5/2/2017	Osher- Medicine: Advances in Health Research and Treatment with Dr. Joseph O'Brien	20850	1	90	90	90
	5/9/2017	Osher- Medicine: Advances in Health Research and Treatment with Dr. Greg Kumkumian	20850	1	90	90	90
		Subtotal		***6***	***500***	***500***	***500***
Girls on the Run-Montgomery County							
	various	Heartsaver AED/CPR	20814	6	6	36	
	11/13/2016	Girls on the Run 5K*	20817	1	500	500	250
	5/21/2017	Girls On the Run 5K*	20817	1	500	500	250
		Subtotal		***8***	***1006***	***1036***	***500***
Stop the Bleed: Save-A-life (NEW)							
	Various	Planning Meetings	20814	6	4	24	0
	Various	Leader Trainings	20814	2	15	30	0
	Various	Community Classes	20814	5	15	75	0
		Subtotal		***13***	***34***	***129***	***0***
Hospital Tours							
	3/16/2017	Girls Scout Tour of Pediatric Department	20814	1	12	12	0
	5/11/2017	Girls Scout Tour of Pediatric Department	20814	1	12	12	0
	6/9/2017	Girls Scout Tour of Pediatric Department	20814	1	12	12	0
		Subtotal		***3***	***36***	***36***	***0***

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)

Community Health & Wellness Department- Health Partnerships

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
SCHOOL PARTNERSHIPS							
Ashburton Elementary School Partnership*							
	12/20/2016	Ashburton Chorus Visit	20814	1	150	150	150
	varies	Ashburton Adopt-A-Family Holiday Initiative	20814	1	45	45	45
	4/4/2017	Ashburton Elementary Health Fair	20817	1	40	40	-
		Subtotal		***3***	***235***	***235***	***195***
Bradley Hills Elementary School Partnership*							
	10/24/2016	Bradley Hills Elementary School Halloween Card Delivery	20814	1	12	12	0
	2/13/2017	Bradley Hills Elementary School Valentine's Day Card Delivery	20814	1	10	10	
		Subtotal		**2**	**22**	**22**	**0**
Check It Out Breast Cancer Awareness Program- Montgomery County Public Schools*							
	1/25/2017	CIO- Academy of the Holy Cross High School	20902	1	225	225	
	1/31/2017	CIO- Montgomery Blair High School	20901	1	365	365	
	2/2/2017	CIO- Winston Churchill High School	20854	1	329	329	
	2/6/2017	CIO- Watkins Mill High School	20879	1	256	256	
	2/7/2017	CIO- Melvin J. Berman Hebrew Academy High School	20901	1	45	45	
	2/9/2017	CIO- John F. Kennedy High School	20902	1	204	204	
	2/17/2017	CIO- James Hubert Blake High School	20905	1	30	30	
	2/21/2017	CIO- Northwest High School	20874	1	340	340	
	3/6/2017	CIO- Yeshiva of Greater Washington	20910	1	35	35	
	3/7/2017	CIO- Thomas Sprigg Wootton High School	20850	1	295	295	
	4/21/2017	CIO- Paint Branch High School	20866	1	379	379	
		Subtotal		**11**	**2503**	**2503**	**0**
Bethesda Chevy Chase High School*							
	12/8/2016	Bethesda Chamber of Commerce and BCC High School Career Partnership Day	20814	1	8	8	0
		Subtotal		**1**	**8**	**8**	**0**
Green Acres Elementary							
	2/10/2017	Nutrition education presentation	20852	1	24	24	0
		Subtotal		**1**	**24**	**24**	**0**

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)

Community Health & Wellness Department- Health Partnerships

Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Montgomery County Recreation- Senior Shape Program						
	Clara Barton Community Center	20818				
	Aerobics/Strength/Stretch (Monday & Wednesday)		100	54	5,400	540
	Aerobics/Strength/Stretch (Tuesday & Thursday)		100	33	3,300	330
	Weight Training		50	29	1,450	145
	Potomac Community Center	20854				
	Advanced Aerobics		50	25	1,250	125
	Aerobics/Strength/Stretch		99	68	6,732	673
	Bethesda Regional Service Center	20814				
	Aerobics/Strength/Stretch		51	24	1,224	122
	Weight Training		51	42	2,142	214
	Benjamin Gaither Center (formally known as Gaithersburg Senior Center)	20878				
	Weight Training		52	22	1,144	114
	Flexible Strength		52	11	572	57
	Stability Ball		52	9	468	46
	Margaret Schweinhaut Senior Center	20901				
	Weight Training~33		51	34	1,734	173
	Stability Ball		51	9	459	45
	Holiday Park Senior Center	20906				
	Stability Ball~12		51	12	612	61
	Advanced Weight Training		51	19	969	96
	Weight Training		51	22	1,122	112
	Jane E. Lawton Community Center	20815				
	Weight Training		50	52	2,600	260
	Wisconsin Place Community Center	20815				
	Advanced Aerobics		49	19	931	93
	North Potomac Community Center	*20850*				
	Aerobics/Strength/Stretch		25	10	250	25
7/30/2015	Senior Shape Lunch and Learn*	20816	1	130	130	
	Subtotal		***1,037***	***624***	***32,489***	***3,231***
	Health Partnership Initiatives Total		**1,216**	**6,292**	**39,643**	**4,650**

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)

Community Health & Wellness Department- Health Initiatives

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
WellWorks Signature Programs							
Monthly Blood Pressure Screenings							
	3rd Wednesday	Clara Barton Community Center	20818	11	20	220	22
	Last Monday	Lakeview House Senior Living	20817	10	6	60	60
	2nd Tuesday	Coffield Community Center	20910	11	10	110	11
	2nd Wednesday	Bethesda Regional Service Center	20814	12	15	180	18
	2nd Tuesday	Potomac Community Center	20854	11	8	88	88
	4th Friday	Waverly House Senior Living	20814	5	6	30	30
	1st Wednesday	The Oaks at Olde Towne Senior Living	20877	11	6	66	66
		Subtotal		**71**	**71**	**754**	**295**
Weekly Mall Walking							
	Wednesdays	"Rise n Shine" Lakeforest Mall (Wednesdays)	20877	52	15	780	156
Diabetes Lite Program							
	Monthly	Glucose Steering Committee Meetings*	20814	8	7	56	0
	Various	Diabetes Continuum Education & Support Group Meetings @ SH*	20814	10	6	60	0
	5/18/2017	Diabetes Symposium at Suburban Hospital	20814	1	52	52	0
	Various	Pre-Diabetes Class: Laying the Foundation	20814	4	13	52	0
	Various	Pre-Diabetes Class: What Should I Eat?	20814	4	11	44	0
		Subtotal		**27**	**89**	**264**	**0**
Worksite Wellness Programs							
	8/9/2016	Worksite Wellness BP Screening at Healthy Directions	20817	1	16	16	-
	9/20/2016	Nuclear Regulatory Commission Health Fair	20852	1	45	45	10
	9/30/2016	Dine & Learn Healthy cooking demo at Total Wine & More	20817	1	30	30	0
	10/5/2016	Mindful Meditation at Total Wine & More	20817	1	30	30	0
	10/28/2016	Aromatherapy at Total Wine & More	20817	1	30	30	0
	11/15/2016	Mindful Meditation at Total Wine & More	20817	1	30	30	0
	3/4/2017	Nutrition Seminar at Congressional Country Club for members	20817	1	14	14	
	3/13/2017	March to Wellness health fair at Total Wine & More	20817	1	50	50	0
	3/28/2017	One on One Nutrition Counseling at Congressional Country Club	20817	3	1	3	
	4/10/2017	Cholesterol Screening at Sport Chevrolet in Silver Spring, MD	20904	1	41	41	21
	4/11/2017	Cholesterol Screening at Sport Honda in Silver Spring, MD	20904	1	41	41	21
	4/12/2017	TC/HDL Cholesterol screening at Sport Honda Service Center in Silver Spring, MD	20910	1	12	12	6
	4/13/2017	Lose the Clutter, Lose the Stress, Find Time for Yourself at Total Wine & More	20817	1	30	30	0
	4/27/2017	City of Rockville, Employee Health Fair- Smoking Cessation Education	20850	1	40	40	40
	5/2/2017	Worksite Wellness Fair at American Society of Healthsystem Pharmacists (ASHP)	20814	1	35	35	0
	5/24/2017	Stretch & Relax Chair Yoga at Total Wine & More	20817	1	30	30	0
		Subtotal		**18**	**475**	**477**	**98**
WellWorks Health & Safety							
		CPR for Friends & Family	20814	4	5	20	
		First Aid Basic and Adult CPR	20814	0	0	0	
		Heartsaver AED Adult CPR	20814	3	5	15	
		Community CPR	20814	3	6	18	
		Survival Guide for First Time Grandparents	20817	4	6	24	
	6/17/2017	Heartsaver AED Adult CPR at Friendship Heights Village Center	20815	1	4	4	
		Subtotal		**15**	**26**	**81**	**0**
WellWorks Nutrition & Weight Management							
		Nutrition Counseling	20814	188	1	188	
		Healthy Choices	20814	20	4	80	
		Healthy Weigh	20814	24	6	144	
		Healthy Cooking Classes at Suburban Hospital	20814	2	10	20	
		Subtotal		**234**	**21**	**432**	**0**

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Community Health & Wellness Department- Health Initiatives

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
WellWorks Signature Programs							
WellWorks Health Assessments							
		Cholesterol Screening	20814	0	0	0	
		Subtotal		**0**	**0**	**0**	**0**
WellWorks Healthy Lifestyle Programs							
		Learn to Understand Your Anger	20814	1	7	7	
		Learn to Manage Your Anger	20814	2	4	8	
		Let's Beat Procrastination	20814	1	6	6	
		Simplify Your Life	20814	2	5	10	
		Mindfulness Meditation	20814	36	11	396	
		Freedom From Smoking	20814	24	5	120	0
		American Lung Association Better Breathers Club	20814	4	6	24	
		Subtotal		**70**	**44**	**571**	**0**
WellWorks Fitness Programs							
		Tai Chi for Seniors at Bethesda Regional Service Center	20814	42	10	420	
		Tai Chi for residents at Maplewood Park Place	20814	50	9	450	
		Balancing Act	20906	8	12	96	
		Pilates for Seniors	20814	48	18	864	
		Pilates for Seniors for residents at Brighton Gardens of Friendship Heights	20815	50	15	750	
		Subtotal		**198**	**64**	**2580**	**0**
		WellWorks Initiatives Total		**685**	**805**	**5,939**	**549**

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)
Community Health & Wellness Department

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population	CBISA
Community Seminars & Special Events*								
July								
	7/19/2016	Utilizing Your Farmers Market with Rhoda Brandes at Holiday Park Senior Center	20906	1	29	29	5	
	7/28/2016	Managing Your Medications with Pharmacy Residents at Rockville Senior Center Seminar	20850	1	18	18		
August								
	8/7/2016	5th Annual Latino Health Fair	20902	1	328	328	328	
	8/25/2016	Nutrition After 50 with Rhonda Brandes at Rockville Senior Center Seminar	20850	1	30	30		
September								
	9/6/2016	Stay Firm on Your Feet with Pat Dirkse, PT at Holiday Park Senior Center	20906	1	56	56		
	9/17/2016	Georgia Avenue Baptist Church Health Fair	20906	1	50	50	34	
	9/21/2016	2nd Annual Emergency Preparedness Fair at JHU Shady Grove	20850	1	250	250	50	
	9/22/2016	Best Foot Forward Seminar with Dr. Danielle Venegonia at Rockville Senior Center	20850	1	29	29		
	9/22/2016	Jump for Joint Replacement at Friendship Heights Village Center with Kevin Woodward, PA	20815	1	11	11	0	
	9/27/2016	Hispanic Heritage Monthly Program/Symposium @ Unplugged	20902	1	46	46	46	
October								
	10/5/2016	Best Foot Forward seminar with Dr. Danielle Venegonia at Friendship Heights Village Center	20815	1	17	17	0	
	10/13/216	United Way Kick Off	20814	1	250	250		
	10/13/2016	YMCA Parenting Seminar: Helping Children to Manage the Challenges of Separation and Divorce	20814	1	6	6		
	10/13/2016	Sustainability Series with Bethesda Green: Cool Commuting seminar	20814	1	6	6		
	10/13/2016	Rockville Senior Center Abuelitas Session	20850	1	12	12	12	
	10/22/2016	Colesville United Methodist Health Fair	20906	1	50	50	50	
	10/27/2016	Take a Deep Breathe to Health seminar with Rene Davenport at Rockville Senior Center	20850	1	20	20		
November								
	11/1/2016	Film Screening and Panel Discussion of Being Mortal in partnership with JSSA	20814	1	127	127		
	11/4/2016	Nutrition After 50 with Rhonda Brandes for a Women's Club	20814	1	20	20	0	
	11/9/2016	Keeping the Beat seminar at Friendship Heights Village Center with Dr. Erich Wedam	20815	1	14	14		
	11/10/2016	Rockville Senior Center Abuelitas Session	20850	1	15	15	15	
	11/17/2016	Homeless Resource Fair	20877	1	75	75	75	
	11/17/2016	Great American SmokeOut	20814	1	40	40	0	
	11/17/2016	How We Can Cope with Greif during the Holidays with JSSA at Rockville Senior Center Seminar	20850	1	6	6		
	11/22/2016	Shady Grove Nursing School Community Health Improvement Presentation	20850	1	45	45	0	
	11/24/2016	34th Annual Turkey Chase	20814	1	10000	10000	0	
December								
	12/8/2016	Minority Legislative Breakfast	20814	1	25	25	-	
	12/9/2016	United Way Inter-Entity Basketball Tournament	20815	1	200	200	-	
	12/14/2016	How We Can Cope with Greif during the Holidays with JSSA at Friendship Heights Village Center	20815	1	3	3	0	
January								
	1/11/2017	Managing Your Medications seminar at Friendship Heights Village Center with Pharmacy Residents	20815	1	3	3	0	
	1/24/2017	Nutrition after 50 seminar at Holiday Park Senior Center	20906	1	30	30	10	
	1/26/2017	Demystifying Your Thyroid with Shabina Ahmed, MD at Rockville Senior Center	20850	1	48	48		
February								
	2/3/2017	Wear Red Day	20814	2	15	30	0	
	2/8/2017	A Better Body at Any Age seminar at Friendship Heights Village Center with Jeanmarie Gallagher	20815	1	10	10	0	
	2/9/2017	Heart Health event at Suburban	20814	1	500	500	100	
	2/14/2017	Rotary Heart Luncheon with Dr. Edward Healy	20816	1	60	60	0	
	2/21/2017	Keeping Your Eyes Healthy: How to Prevent and Reverse Eye Conditions seminar at Holiday Park Senior Center	20906	1	50	50	10	
	2/22/2017	15th Annual Women's Health Symposium at Chevy Chase Club with Dr. Philip Corcoran and Dr. Jennifer Lawton	20815	1	95	95	10	
	2/23/2017	Jump for Joint Replacement with Kevin Woodward, PA at Rockville Senior Center Seminar	20850	1	22	22		
March								
	3/2/2017	YMCA/PEP Parenting Seminar: Finding Balance with Kids in a Tech-Savy World	20814	1	21	21		
	3/8/2017	Optimizing Quality of Life with Palliative Care Dr. Steven Wilks at Friendship Heights Village Center	20815	1	13	13	0	
	3/9/2017	Wear Blue Day for Colorectal Cancer	20814	3	15	30	0	
	3/22/2017	Colorectal Cancer Education Table	20814	1	50	50	0	
	3/23/2017	Listen Up! With David Bianchi, MD - Rockville Senior Center Seminar	20850	1	25	25		
	3/31/2017	Think F.A.S.T. seminar at Holiday Park Senior Center with Mary Jo Rucker from NIH Stroke Center at Suburban Hospital	20906	1	31	31	10	

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Community Health & Wellness Department

Date		Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population	CBISA
Community Seminars & Special Events*								
April								
	4/5/2017	The Big Event	20812	1	150	150	0	
	4/13/2017	What is a Hospitalist? Seminar at Friendship Heights Village Center	20815	1	7	7	0	
	4/24 & 4/25/2017	JHU-Montgomery County Bread Baking Event	20850	2	125	250	40	
	4/25/2017	Diabetes Management seminar with Cynthia Tucker at Holiday Park Senior Center	20906	1	10	10	10	
	4/22/2017	Highland Elementary School Fair	20906	1	25	25	25	
	4/27/2017	Advance Care Planning seminar with MOCO Hospice at Rockville Senior Center	20850	1	12	12		
	4/29/2017	YMCA Healthy Kids Day	20814	1	50	50	50	
May								
	5/5/2017	Charles E. Smith Symposium: Mental Health Crisis in a Geriatric Population: Strategies for Clinicians and Caregivers	20852	1	200	200	-	
	5/6/2017	Move More Festival	20850	1	50	50	40	
	5/10/217	Pressure Points: The Latest on Blood Pressure with Dr. Hayder Hashim at Friendship Heights Village Center	20815	1	12	12		
	5/23/2017	Healthy Habits for a Healthier You with Alzheimer's Association at Holiday Park Senior Center	20906	1	20	20	20	
	5/24/2017	Rockville Senior Center Annual Health Fair	20850	1	150	150	150	
	5/25/2017	Tipping the Scale to Health with Jill Johnson- Rockville Senior Center Seminar	20850	1	9	9		
June								
	6/14/2017	Tipping the Scale to Health with Jill Johnson at Friendship Heights Village Center	20815	1	15	15	0	
	6/14/2017	14th Annual Men's Health Symposium at Kenwood Golf and Country Club with Dr. Hayder Hashim and Dr. Bashir Zikria	20814	1	57	57		
	6/22/2017	Caring for the Skin You're In with Shane O'Neil, PA- Rockville Senior Center Seminar	20850	1	30	30		
	6/27/2017	Making Healthy Food Choices with Jill Johnson at JFGH	20852	1	34	34		

	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Special Events Total	***66***	***13,722***	***13,877***	***1,090***

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)

Community Health & Wellness Department- Partnerships

		Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Activities						
	Community Benefit Operations					
	Suburban Hospital Community Benefit Advisory Council	20814	3	22	66	0
	Subtotal		***3***	***22***	***66***	***0***
	Community Health and Wellness State & County Health Initiatives					
	CHIP Community Health Improvement Process (Healthy Montgomery)		6	25	150	
	Healthy Montgomery Hospital Workgroup Meeting		5	9	45	
	Healthy Montgomery Monitoring & Evaluation Workgroup		2	5	10	0
	Healthy Montgomery-Diabetes Hospital Workgroup		2	10	20	
	Subtotal		***15***	***49***	***205***	***0***
	Partnership Meetings held at Suburban					
	Annual Mobile Med Meeting at Suburban Hospital	20814	1	75	75	
	Subtotal		***1***	***75***	***75***	***0***
	Village Partnerships					
	Bannockburn Village	20817	0			
	Bethesda Metro	20814	0			
	Bradley Hills Village	20817	0			
	Burning Tree Village	20817	0			
	Chevy Chase Village	20815	1	40	40	
	Farmland Village	20852	1	50	50	
	Little Falls Village	20816	0			
	Maplewood Village	20814	0			
	Potomac Village	20854	0			
	Rockville Village	20850	0			
	Village of Kensington	20895	2	1	2	
	Wyngate Village	20817	0			
	Subtotal		***4***	***91***	***92***	***0***

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)
Community Health & Wellness Department- Partnerships

		Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
	FY2017 Coalition/Partnerships/Affiliations Meetings					
	American Red Cross		2	2	4	0
	A Wider Circle Adopt-A-Family Holiday Initiative		1	49	49	49
	AHCN Advisory Council/Catholic Charities of Washington, DC Meetings		3	10	30	
1/16/2017	Alpha Phi Alpha MLK Breakfast	20852	1	20	20	
	American Lung Association	20814	6	5	30	0
4/27/2017	Lung Expo 2017	21244	1	150	150	25
	BCC Chamber of Commerce	20814	2	50	100	
	BCC-YMCA Board	20814	6	25	150	
	Bethesda Chevy Chase Rotary Club Meetings and Community Development events	20816	6	50	300	
	Cancer Disparities Taskforce*	20910	4	12	48	40
	CASA of MD*	20901	1	8	8	8
	Diabetes Hospital Sub-Workgroup *	20906	4	5	20	0
	Charles E. Smith Life Communities Symposium Planning	20852	4	10	40	
	Girls on the Run-Montgomery County Partnership Initiative	20852	1	1	1	
	Health Quality Innovators*	20814	2	2	4	0
	Mansfield Kaseman Health Clinic					
	Meetings	20850	2	5	10	10
	Health Promoters Training	20850	1	10	10	10
	Latino Health Initiative	20910	5	10	55	55
	Leadership Montgomery		1	200	200	0
	Mobile Medical Care, Inc.					
	Transition of Care Meetings	20814	5	5	25	0
	Mobile Med/NIH Heart Clinic at Suburban Hospital	20814	51	15	765	765
	MobileMed/NIH Endocrine Clinic at Suburban Hospital	20817	51	12	612	612
	Montgomery County Tobacco Coalition	20852	1	10	10	0
	Montgomery County Cancer Crusade	20852	7	8	56	10
	Montgomery County Chamber of Commerce	20850	2	50	100	
	Montgomery County Senior Sub-cabinet group-Health and Wellness Advisory Committee	20906	2	15	30	0
	Nexus Montgomery		20	20	400	
	Primary Care Coalition		20	20	400	
	Safe Kids Coalition	20906	4	8	24	0
	Scotland Community Partnership- National Night Out Planning Meetings	20854	1	10	10	10
	Sunrise Corporation		4	10	40	

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Community Health & Wellness Department- Partnerships

		Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
	United Way National Capital Region					
	United Way Awareness Tables	20814	5	100	500	0
	United Way Ticket Sales	20814	3	17	51	0
	United Way MoCo Regional Council	20852	3	4	12	0
	United Way JH Conference Calls	20814	6	8	48	0
	United Way Planning Meetings	20814	19	4	76	0
various	Village Ambassador Alliance	20814	3	17	52	0
	Village to Village Network Initiative (WAVE)		1	50	50	
	Washington Metropolitan OASIS	20817	15	10	150	
	Subtotal		***276***	***1017***	***4640***	***1594***
	Partnership Subtotal		***299***	***1254***	***5078***	***1594***
List of Total Partnerships, Coalitions and Affiliations						
	A Wider Circle					
	Alpha Phi Alpha Fraternity					
	American Heart Association					
	American Lung Association					
	American Red Cross					
	Archdioceses Healthcare Network/Catholic Charities of Washington DC					
	Ashburton Elementary School					
	BCC YMCA					
	Bethesda Cares					
	Bethesda Chevy Chase Rotary Club					
	Bethesda-Chevy Chase Chamber of Commerce					
	Boy Scouts of America					
	Cancer Disparities Taskforce*					
	CASA of MD*					
	Charles E. Smith Life Communities					
	Girls on the Run of Montgomery County					
	Go4Life, National Institute on Aging*					
	Jewish Social Service Agency					
	Health Quality Innovators*					
	Mansfield Kaseman Health Clinic*					
	Kaiser Permanente					
	Latino Health Initiative					
	Leadership Montgomery					
	MobileMed Inc.					
	Montgomery Cares					
	Montgomery County Cancer Coalition					
	Montgomery County Chamber of Commerce					

Suburban Hospital Community Benefit Report - FY 2017 (July 1, 2016 - June 30, 2017)
Community Health & Wellness Department- Partnerships

		Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
	Montgomery County Department of Health and Human Services					
	Montgomery County Department of Parks and Recreation					
	Montgomery County Housing Opportunity Commission					
	Montgomery County Office on Aging					
	Montgomery County Public Schools					
	Montgomery County Stroke Association					
	Montgomery Hospice					
	National Institutes of Health- National Heart Lung and Blood Institute					
	National Institutes of Health-National Institute of Diabetes and Digestive and Kidney Diseases					
	Primary Care Coalition					
	Project Access					
	Proyecto Salud Clinic					
	Safe Kids Coalition					
	Safe Sitter, Inc.					
	Scotland Community Partnership					
	Sunrise at Fox Hills					
	Tobacco Free Coalition					
	University of Maryland School of Nursing*					
	University of Maryland School of Public Health*					
	United Way National Capital Region					
	United Way Regional Council- Montgomery County					
	Village to Village Network Initiative					
	Washington Metropolitan OASIS					
	Wellness Corporate Solution*					
	YMCA Youth and Family Services.					

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Community Health & Wellness Department- Partnerships

		QTY	Financial ($)	Total $
Community Donations/ Community Contributions				
	Equipment Donation to Safe Kids Montgomery County Coalition	100	$2.93	$5.86
	Food Expenses for Cooking Demos at Gwendolyn Britt & Langley Park Senior Activity Centers Health Seminar Series	1	$150.00	$150.00
	Food Expenses for Suitland Dine and Learn Program	11	$50.00	$550.00
	Food for Latino Health Symposium	46	$1,400.00	$1,400.00
	Food and Advertisin for the Women's Health Symposium	1	$7,473.00	$7,473.00
	Advertising for the Men's Health Symposium	1	$240.00	$240.00
	Food and Advertising for Diabetes Symposium	1	$2,395.00	$2,395.00
	Hispanic Chamber of Commence Leadership Breakfast	1	$50.00	$50.00
	Instructor Fees for Free Senior Shape Class at Gwendolyn Britt in Prince George's County (July-Oct. 2016)	33	$45.00	$1,485.00
	Instructor Fees for Free Senior Shape Class at Gwendolyn Britt in Prince George's County (Nov. 2016-June 2017)	67	$55.00	$3,685.00
	Instructor Fees for Free Tai Chi Class at Gwendolyn Britt Senior Activity Center in Prince George's County	50	$45.00	$2,250.00
	Instructor Fees for Gwendolyn Britt & Langley Park Senior Activity Centers Health Seminar Series	0	$0.00	$0.00
	Instructor Fees For Rollingcrest Dine and Learn Program	3	$150.00	$450.00
	Instructors for Girls on the Run CPR and 1st aid classes	3	$87.50	$262.50
	Healthy Snacks and Shoes for Girls on the Run	1	$4,399.70	$4,399.70
	Instructors for Senior Shape Classes in Montgomery County	1	$74,685.00	$74,685.00
	Sponsorship for 33rd YMCA Turkey Chase	1	$2,500.00	$2,500.00
	Validation Parking Stickers for Mobile Med/NIH Endocrine Clinic	305	$1,984.97	$1,984.97
	Mary's Center	1	$5,000.00	$5,000.00
	Scotland Flu Clinics	11	$275.00	$275.00
	TOTAL	***638***	***$ 100,988.10***	***$ 108,966.03***