2025

MONTGOMERY COUNTY REGIONAL COLLABORATIVE **COMMUNITY HEALTH IMPLEMENTATION PLAN**

Adventist HealthCare

DHHS Montgomery County Department of Health and Human Services

healthy montgomery

HOLY CROSS HEALTH A Member of Trinity Health

MedStar Health

SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE

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WELCOME AND OVERVIEW OF REPORT

The 2025 Montgomery County Community Health Improvement Plan (CHIP) was developed through a collaboration among Adventist HealthCare (Adventist HealthCare Rehabilitation, Adventist HealthCare Shady Grove Medical Center, and Adventist HealthCare White Oak Medical Center), Holy Cross Health (Holy Cross Hospital and Holy Cross Germantown Hospital), MedStar Health (MedStar Montgomery Medical Center) and Johns Hopkins Medicine (Suburban Hospital), collectively known as the Montgomery County Hospital Collaborative (MCHC), and Healthy Montgomery, the Local Health Improvement Coalition[1] LHIC) representing Montgomery County, Maryland. Healthy Montgomery brings together government agencies, minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers and other stakeholders to achieve optimal health and well-being for all Montgomery County residents. Each of the healthcare systems have actively participated in Healthy Montgomery and the Healthy Montgomery Steering Committee (HMSC) since 2009. An overview of HMSC, including its purpose, function, and oversight of the CHIP process is in Appendix I. Similarly, an overview of the MCHC can be found in Appendix II.

Better together is not simply an aspiration but an intention. This collaboration deliberately focused on a community-centered and inclusive approach to identifying how to address the identified health needs. That is, it considers the diversity of our service area, both geographically and across the various populations and is anchored in the Mobilizing Action through Planning and Partnership, or MAPP process. The MAPP process includes a wide variety of voices, experiences, and perspectives to ensure that the most vulnerable populations are represented in the health improvement strategies of the improvement plan. The three areas of focus in this CHIP were identified and prioritized through a rigorous and inclusive needs assessment process that included hundreds of voices across Montgomery County in 2023 and 2025. This feedback was analyzed in conjunction with a wide range of current data from the local, state, and national level.

While Healthy Montgomery and the Montgomery County Hospital Collaborative set out to identify the most pressing health needs in our county at different periods, this report represents the deliberate collaboration with a shared mission: improve health for those living in Montgomery County. This report is built through many years of experience; Healthy Montgomery has existed since 2009 and has issued three improvement plans and MCHC has issued a total of 16 CHIPs (referred to as CHNA Implementation Strategies on hospital websites) among the four systems since the enactment of the Affordable Care Act in 2010.

It is with great pride and enthusiasm that we invite you to engage with this Community Health Needs Assessment Improvement Plan. Each section, including Appendix III, will further detail the history and background of the collaborators, the rigorous needs assessment process engaged in to identify the prioritized health needs, and the inclusive MAPP process that leveraged a variety of Health Priority Action Team perspectives to ultimately design a roadmap to health improvement.

SECTION 1.

INTRODUCTION

While Healthy Montgomery and the hospital health systems have historically operated as separate but connected entities, their work has always been closely aligned. Healthy Montgomery, the county's Local Health Improvement Coalition, has provided the framework for countywide data collection, needs assessment, and priority setting. The hospitals, through MCHC, have brought their collective resources, expertise, and community benefit strategies to the table.

Although the county and hospitals previously conducted separate CHNAs, the identified priorities consistently mirrored one another, underscoring a shared understanding of Montgomery County's most pressing health issues. This long-standing alignment created a strong foundation for deeper collaboration. By joining together, Healthy Montgomery and the MCHC are now able to move from parallel planning to fully integrated action.

The result is the first joint Community Health Improvement Plan (CHIP), a coordinated roadmap for improving health outcomes, reducing disparities, and advancing equity across the county. This joint CHIP reflects the collective strengths of both entities while ensuring that resources are deployed strategically, roles are clear, and every identified need is addressed through a unified, countywide approach.

JOINT CHIP: STRATEGIC FOCUS WITH FLEXIBILITY

This joint CHIP reflects a deliberate shift in approach. In the past, partners tended to showcase a broad set of shared priorities and describe how each entity was working with them. While comprehensive, this approach stretched resources thin and limited measurable progress. The evolved CHIP emphasizes strategic focus and role clarity, while also recognizing that each partner brings unique assets that can be applied creatively across traditional boundaries.

- Hospitals will leverage their clinical expertise and community benefit resources while also addressing social determinants of health (such as food insecurity, housing stability, and language access). As major employers and anchor institutions, hospitals will also use their economic, hiring, and purchasing power to influence policy, systems, and environmental (PSE) strategies that advance equity and create healthier communities.
- County agencies will continue to lead public health infrastructure, policy, and systems-level change. In addition, the County plays a vital role in addressing social determinants of health (SDOH) directly through its health and human services programs, connecting residents to essential supports, and ensuring that equity is embedded in service delivery. The County's capacity to strategically invest in programs that reduce health disparities and enhance community well-being through public financing is a critical mechanism for advancing health equity across the population.
- Nonprofit and community partners will address social and environmental determinants of health through direct services, advocacy, and grassroots engagement, while also collaborating with hospitals and county agencies to integrate health promotion and prevention into nontraditional settings.

Together, these complementary and overlapping roles ensure that all identified needs are addressed in ways that maximize each entity's strengths, while leaving space for innovation and cross-sector action. By clarifying leadership roles *and* embracing flexibility, the joint CHIP creates a roadmap for measurable progress across the full spectrum of community health priorities, while maintaining a unified vision of improved health and well-being for all Montgomery County residents.

SECTION 2.

OVERVIEW OF THE COMMUNITY SERVED

For this joint improvement strategy, Montgomery County DHHS and the Montgomery County Hospital Collaborative have aligned their service areas to reflect the communities both entities serve. DHHS brings a countywide perspective, ensuring that the needs of all Montgomery County residents are represented, while MCHC hospitals focus on the 38 zip codes where patient care is most concentrated, spanning most of Montgomery County and portions of northern Prince George's County. By combining these perspectives, this improvement strategy reflects the full scope of community health needs across the county while also acknowledging critical areas of hospital engagement beyond county borders.

Together, these areas represent more than 1.2 million residents living in densely populated urban, suburban, and rural neighborhoods. Montgomery County is the most diverse county in Maryland

with more than half of residents identifying as people of color[2] and over 40 percent speaking a language other than English at home[3]. Immigrant populations, including large communities from El Salvador, Ethiopia, China, and India, contribute to the county's rich cultural fabric while also creating distinct health access and communication challenges[4]. The median age in Montgomery County is 40 years old[5], reflecting a mix of younger families and an aging population[6]. By 2040, one in five residents in Montgomery County will be 65 or older, significantly increasing demand for chronic disease management, caregiver support, and aging services.

The MCHC service area extends beyond Montgomery County into northern Prince George's County, where hospitals serve thousands of additional residents. This area is similarly diverse, with higher proportions of Black/African American and Hispanic/Latino residents compared to the state overall, and a significant percentage of residents with limited English proficiency.

Across the combined service area, the vibrant cultural diversity is a source of strength but also highlights inequities in access, language, and social supports. The joint strategy intentionally reflects both the countywide public health perspective and the hospital-centered service patterns, ensuring that efforts are comprehensive, coordinated, and responsive to the communities most affected by health disparities.

UNDERSTANDING COMMUNITY NEEDS THROUGH AN EQUITY LENS

The combined service area of Montgomery County and northern Prince George's County is home to a richly diverse population, but this diversity also brings complex challenges. Within this region, certain groups face disproportionate barriers to health and well-being due to systemic inequities, social determinants of health, and limited access to resources. To ensure that the joint improvement strategy is both inclusive and effective, it is essential to identify and address the needs of populations experiencing vulnerabilities, those most at risk for poor health outcomes and least likely to benefit from traditional health systems without targeted support.

POPULATIONS WITH LOW-INCOME STATUS

Low-income status and poverty remain significant drivers of poor health outcomes due to their correlation with adverse conditions such as substandard housing, homelessness, food insecurity, inadequate childcare, limited access to health care, unsafe neighborhoods, and under-resourced schools. Coronavirus disease (COVID-19) exacerbated these inequities, with inflation and economic instability disproportionately impacting low-income communities[7]. Approximately 20.2%, or 253,967 individuals, within the MCHC CBSA, live in households with incomes below 200% of the Federal Poverty Level (FPL). Poverty creates barriers to access, including essential health services, healthy food, and other necessities contributing to poor health status[8].

MINORITY GROUPS

Racial and ethnic minority populations continue to experience disproportionately higher rates of

illness and death across various health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts. As noted by Dr. Joia Crear-Perry, "racism, not race, causes health disparities"[9]. This perspective highlights the role of systemic racism as a key driver of health inequities rather than genetic differences. In the CBSA, approximately 54.7% of the population is Non-Hispanic, Non-White, and 24.0% are Hispanic.

Ongoing national debates over affirmative action policies and restrictions on healthcare access for immigrants pose new threats to achieving health equity[10,11].

UNINSURED POPULATIONS

Lack of health insurance remains a significant barrier to achieving optimal health outcomes. People without insurance coverage face obstacles in accessing timely care, often postponing or forgoing medical attention altogether. This leads to chronic conditions remaining undiagnosed or poorly managed, increasing morbidity and mortality rates. In the CBSA, 9.1% of the total civilian non-institutionalized population are without health insurance coverage, which is higher than the state average of 6.2%. Although Maryland has relatively lower uninsured rates, there are still several factors complicating efforts to reduce them, most notably immigrant status[12].

PEOPLE WITH DISABILITIES

In Montgomery County, 8.7 percent of residents reported a disabilit[13]. The likelihood of having a disability varied by age, from 3.3 percent of people under 18 years old, to 6.7 percent of people 18 to 64 years old, and to 23.8 percent of those 65 and over[14]. About one quarter of residents aged 65 or older have a disability - a rate that rises to 37 percent among older adult residents living in poverty[15]. The unemployment rate is higher for those who have a disability. In 2018, the unemployment rate for those 18-64 years old who reported a disability was over three times that of those who did not report a disability (11.1 percent compared to 3.5 percent)[16]. Families with a member who is disabled are nearly two to three times more likely to be food insecure than those without[17].

OLDER ADULTS

The U.S population will be older and more racially and ethnically diverse in the decades to come[18]. This is also true for Montgomery County, as the 65 and older population is forecast to reach 20 percent of the total population in 2040[19]. According to the 2021 ACS one-year estimates, Asian residents make up the largest minority group among County residents age 60 or older[20]. Additionally, 36.6 percent of residents who are age 60 and older speak a language other than English at home, with 18.1 percent of residents age 60 or older speaking English less than "very well.[21]" Almost eight percent of the county's older adults live in poverty, with 3.5 percent of older adults living between 100 and 150 percent of the poverty line[22].

MATERNAL AND INFANT POPULATIONS

The well-being of mothers, infants, and children remains a critical indicator of community health. Access to quality preconception, prenatal, postnatal, and interconception care can significantly reduce the risk of maternal and infant mortality. However, recent reports indicate that maternal

mortality rates are rising nationally, particularly among Black women who experience disproportionately higher risks of severe maternal morbidity.

Locally, the MCHC CBSA continues to experience notable disparities in maternal and child health. Between 2017 and 2019, approximately 7.2 percent of births in the CBSA involved late or no prenatal care, which is higher than the national average of 6.1 percent. Additionally, the infant mortality rate for the CBSA between 2015 and 2021 was 5.6 per 1,000 live births, with Prince George's County experiencing a higher rate of 7.4 per 1,000 live births compared to 5.0 per 1,000 live births in Montgomery County. Low birth weight also remains a concern, with the CBSA average at 7.9 percent, although this is lower than the state average of 8.7 percent and the national average of 8.3 percent. Non- Hispanic Black populations continue to have the highest rates of low birth weight, at 11.6 percent in Prince George's County and 9.6 percent in Montgomery County.

These disparities indicate that significant work remains to be done to improve maternal and child health equity. Effective strategies must address systemic inequities, enhance access to culturally competent care, and prioritize outreach to populations experiencing the highest disparities[23].

Teen birth rates at 10.6 per 1,000 persons in the 15-19 age group compares favorably to the state average of 13.3 and the national average of 16.6.

YOUTH

Twenty-three percent of the population in Montgomery County are below 18 years of age[24]. The leading causes of death for ages 5- to 17-yearold residents is accidents (16.2 percent) and the leading cause of hospitalization for this age group is mental health (53.9 percent)[25]. Disparities exist in the younger residents including in those experiencing poverty and in adolescent birth rate. In 2016-2020, an estimated 7.9 percent of children under 18 were below the poverty level[26]. Children living in poverty are more likely to be Non-Hispanic Black (14.1 percent), Hispanic or Latino (11.7 percent), and Asian (5.6 percent), then Non-Hispanic white (2 percent)[27]. The adolescent birth rate has been declining over the past ten years, however the birth rate has consistently been higher in the Hispanic population (31 per 1,000) as compared with the Non-Hispanic White population (1.5 per 1,000)[28].

LGBTQ+

LGBTQ+ is an abbreviation for lesbian, gay, bisexual, transgender, queer, and/or questioning. The 'plus' is used to signify all the gender identities and sexual orientations that are not specifically covered by the other five initials. The umbrella acronym LGBTQ+ groups together comprise distinct populations, to include subpopulations based on race, ethnicity, socioeconomic status, age, and other factors, with their own concerns and considerations.

Although county-level data is limited for this population, the County is working to address social issues and unforeseen barriers faced by this community. Health disparities exist between LGBTQ+ people and non-LGBTQ+ people. LGBTQ+ youth are disproportionately at risk for substance use disorder, risky sexual behaviors, bullying and harassment in schools, and violence[29]. Young Black

gay and bisexual men and transgender women are at significantly higher risk of acquiring HIV/AIDS[30].

SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUITIES

While Montgomery County is ranked among the healthiest counties in Maryland, social determinants of health contribute to racial and ethnic inequities across zip codes in the county[31]. For example, residents in Bethesda, Chevy Chase, and Potomac have greater length of life compared to those living in Montgomery Village, Silver Spring, and Poolesville[32]. In order to assess potential racial and social inequities in the county, Montgomery Planning Department developed the Equity Focus Areas Analysis tool to identify areas that have high concentrations of lower-income households, people of color, and individuals who may speak English less than very well[33]. These communities may not have the same access to resources or opportunities as other populations, and by developing this data-driven tool to identify and map these areas in the county, they can better understand existing conditions and direct planning efforts. Approximately 25 percent of the county population is living in an Equity Focus Area, areas primarily concentrated along the I-270 Corridor, the Route 29 Corridor and the eastern part of Down County. Compared to the county overall, the population in Equity Focus areas are younger, have lower educational attainment and are more likely to be Hispanic[34].

FOOD INSECURITY

Food insecurity is the state of being without consistent, reliable access to enough affordable, nutritious food. As with unemployment, food insecurity rose in Montgomery County due to the COVID-19 pandemic. In 2021, food insecurity affected 30 percent of Montgomery County residents[35]. Nearly 13.9 percent of the county's children are estimated to be food insecure, representing 33,000 children[36]. Food insecurity is estimated to be most prominent in certain areas in East County, Silver Spring, Aspen Hill, Wheaton, Gaithersburg, and Germantown[37]. Additionally, during the 2021-2022 school year, more than one third (39.5 percent) of Montgomery County Public Schools' students received free and reduced-price meals[38]. To end food insecurity for county youth, the County created the Office of Food Systems Resilience. The office will serve as a liaison to the County government and help bolster food access in the county.

HOUSING

The Point-in-Time survey is a "snapshot" count of those experiencing homelessness on a single night during the last two weeks of January. The County aims to end homelessness for all populations by 2025[39]. Lack of affordable housing, in addition to poverty and unemployment, can contribute to homelessness. According to a 2020 Montgomery County Housing Needs Assessment, the income needed to afford the median-priced home is rising faster than the median household income. In 2018, the household income required to afford the median home was $125,621, which is above the 2018 median household income of $108,188[40]. There is demand for housing across all income levels, with a particularly growing need for affordably priced housing[41].

HEALTH NEEDS OF THE COMMUNITY

Both CHNAs conducted used a systematic data collection and analysis process to identify key health needs and issues that persist in our community. In addition to leveraging the highest quality data available from private and public sources, qualitative input was gathered and analyzed from a broad and diverse group of stakeholders through surveys and community conversations.

PRIORITIZATION PROCESS

The hospitals of the MCHC and Montgomery County DHHS carefully reviewed the results of the most recent CHNAs. In response to these findings, each organization employed a structured, evidence-based process to identify and prioritize the most pressing health needs. While their approaches differed, they were complementary, and together provide a robust foundation for a shared improvement strategy that reflects community voice, stakeholder expertise, and available resources.

HOW MCHC IDENTIFIED TOP PRIORITIES

A fundamental component of a community health needs assessment, as described by the Catholic Health Association, is the prioritization of identified needs. To achieve this goal, MCHC engaged local public health leaders, service providers, and community advocates to participate in a priority-setting process. Three criteria were applied to prioritize needs from the primary and secondary data analysis:

- Severity: The seriousness or urgency of the issue within the community.
- Feasibility: The likelihood that meaningful progress could be achieved in the next three years.
- Outcome: The potential to positively impact the greatest number of people. Using these criteria, along with their professional expertise and lived experience, stakeholders identified nine health factors as the most pressing unmet needs for Montgomery County.

HOW DHHS IDENTIFIED TOP PRIORITIES

The Montgomery County Department of Health and Human Services applied the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework to guide its priority-setting process. MAPP 2.0 is a structured, community-driven model that brings together diverse partners to review local data, elevate resident input, and assess system capacity in a coordinated way. It emphasizes cross-sector collaboration and ensures the community's voice remains central throughout.

As part of the prioritization step, DHHS convened stakeholders and residents to review findings from surveys, focus groups, and secondary data. Participants applied agreed-upon criteria to weigh each issue, including:

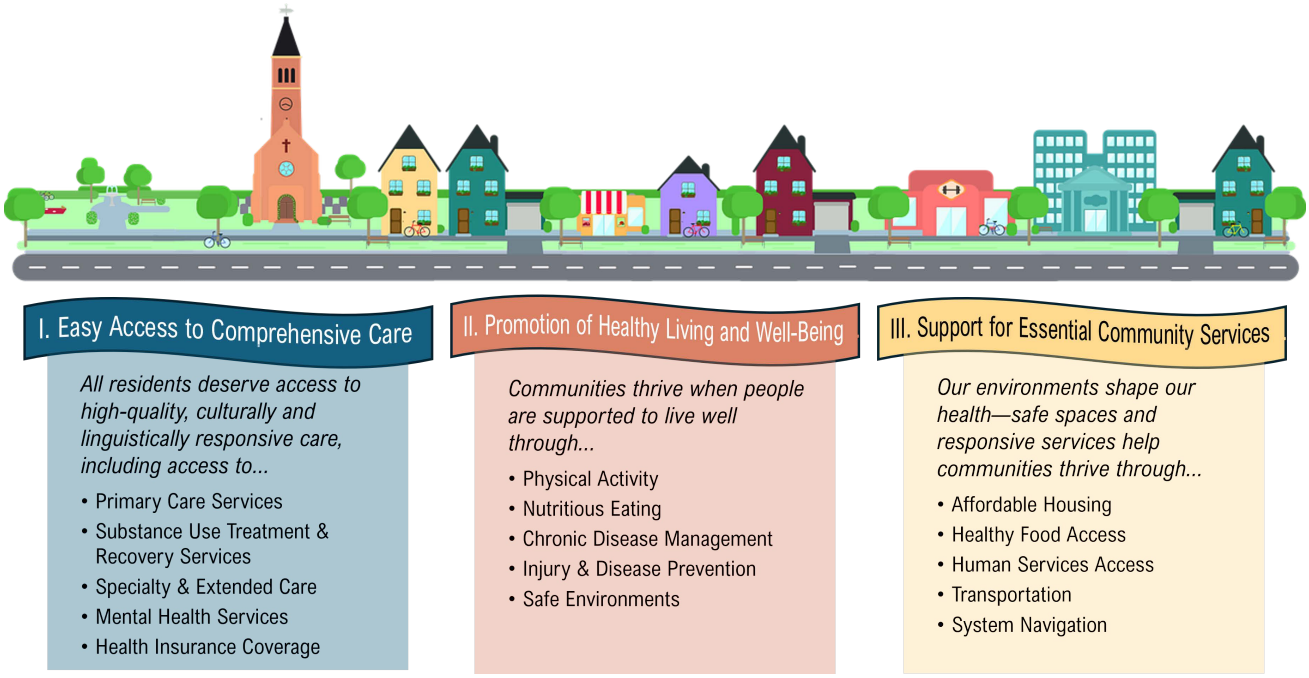
- Magnitude and Severity: The size and seriousness of the issue in Montgomery County.

- Disparities: The degree to which certain populations are disproportionately affected.
- Feasibility and Resources: The likelihood of making progress with existing assets, partnerships, and capacity.
- Community Readiness: The level of community support and momentum to address the issue.
- Alignment: Consistency with state and national public health priorities.
- Through this transparent and participatory process, DHHS identified a focused set of priorities that balance data-driven evidence with the lived experiences of residents.

A UNIFIED FOUNDATION

Although MCHC and DHHS used different methods, both processes were grounded in data, community voice, and stakeholder expertise. Taken together, the results provide a unified picture of the health challenges facing Montgomery County and surrounding areas. By aligning their distinct yet complementary approaches, the partners established shared priorities (see Figure 1) that reflect the diverse needs of the service area and are actionable within both the local health system and public health infrastructure.

Figure 1. Priorities of the Montgomery County Hospital Collaborative and the Montgomery County Department of Health and Human Services



These shared priorities not only highlight the most urgent health challenges facing the identified service area but also point toward opportunities for meaningful and measurable change. By grounding the priorities in both data and community voice, MCHC and DHHS have created a clear roadmap for collective action. The next section, Needs Into Action, outlines how these priorities will be translated into strategies, programs, and partnerships that advance health equity and improve outcomes.

SECTION 3.

NEEDS INTO ACTION

After identifying and prioritizing the most pressing health needs, outlined in Figure 1, MCHC, DHHS, and Healthy Montgomery moved from analysis to action together through the Community Health Improvement Plan. The CHIP is the countywide roadmap, jointly developed and implemented, that translates needs assessment findings into shared goals, objectives, and strategies. It is the mechanism the county uses to put needs into action, ensuring that hospitals, public health, and community partners are working in alignment.

HOW THE COUNTY CONTRIBUTES

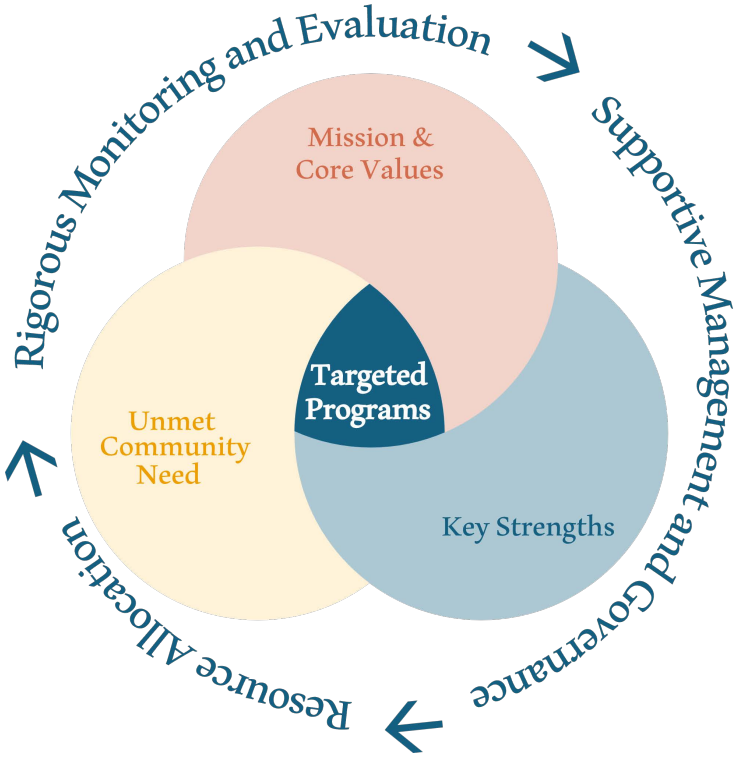
The County plays a pivotal role in shaping public health strategies by leveraging its Department of Health and Human Services. Through Healthy Montgomery, which serves as the county's Local

Health Improvement Coalition, DHHS brings together a wide range of stakeholders - including residents, healthcare providers, nonprofits, and government agencies - to gather broad community input. This inclusive approach ensures that health initiatives reflect the diverse needs and perspectives of the population. DHHS also applies state and national public health frameworks, such as those from the CDC or Maryland Department of Health, to guide evidence-based decision-making. Additionally, the County integrates social determinants of health - factors like housing, education, income, and access to nutritious food - into its planning processes. This holistic view helps identify root causes of health disparities and supports the development of targeted interventions that promote equity and long-term wellness.

HOW HOSPITALS CONTRIBUTE

Hospitals contribute meaningfully to community health by developing targeted programs and initiatives that are strategically informed by the findings of their CHNAs. These assessments provide a data-driven understanding of the most pressing health challenges facing local populations, including gaps in access, disparities, and emerging trends. Hospitals use this information to design responses that align with their clinical strengths, mission commitments, and available resources, ensuring that each initiative is both practical and purpose-driven (see Figure 2). This strategic alignment allows hospitals to focus their efforts where they can make the greatest impact. By grounding their work in both community input and institutional capacity, hospitals not only address immediate health concerns but also contribute to broader, long-term improvements in population health. Their efforts, when integrated into countywide public health strategies, help create a more coordinated and effective system of care that reaches beyond hospital walls.

Figure 2. How Hospitals Address Unmet Community Need



HOW NONPROFIT AND COMMUNITY PARTNERS CONTRIBUTE

Community partners play a vital role in improving community health by actively participating in the development and execution of the Community Health Improvement Plan alongside DHHS and MCHC. Their involvement ensures that the plan reflects the lived experiences, needs, and priorities of diverse populations, fostering trust and collaboration. By contributing resources, expertise, and outreach capabilities, these partners help bridge gaps in care, promote health equity, and enhance access to preventive services. Their engagement also strengthens the sustainability of health initiatives by aligning efforts across sectors and reinforcing a shared commitment to long-term community well-being.

SHARED FRAMEWORKS

The CHIP is anchored in both Healthy People 2030 (HP2030) and the Maryland State Health Improvement Process (SHIP) 2024. HP2030 provides national objectives and benchmarks for health improvement, while SHIP 2024 establishes Maryland-specific targets and indicators for advancing health equity. Together, these frameworks offer common language, evidence-based direction, and measurable benchmarks that guide collective action.

TRANSFORMING COMMUNITY HEALTH

Together, MCHC, DHHS, Healthy Montgomery, and community partners are well positioned to respond to both existing and emerging needs. To address unmet needs, partners will focus downstream through prevention, education, and disease management programs, while also working upstream through policy, systems, and environmental change strategies that optimize wellness, advance equity, and eliminate disparities. This work addresses both individual social needs and broader community conditions, with three key focus areas:

- Clinical Care: Delivery of efficient, people-centered health care services that reduce outcome disparities and address the social needs of patients.
- Community Engagement: Expanding access to wrap-around and community-based services, and ensuring that patients, residents, and employees are connected to supports they can use.
- Community Transformation: Policy, systems, and environmental changes that strengthen neighborhoods through community building, economic revitalization, housing, and other social determinants of health.

PRIORITY-SETTING THROUGH HPATS

In 2025, Health Priority Action Teams (HPATs) brought together partners and residents to examine the county's most pressing needs. Using an impact-and-feasibility framework, HPAT members identified strategies and sequenced them into immediate, next, and longer-term actions. This process informed the CHIP, which lays out the shared goals, SMARTIE objectives, and strategies that guide countywide action.

FROM PLAN TO IMPROVEMENT

The workplans that follow operationalize the CHIP. They demonstrate how hospitals, DHHS, Healthy Montgomery, and community partners align strategies with shared countywide goals and objectives. Each workplan identifies responsibilities, partners, timelines, and measures of success, creating a roadmap for moving needs into coordinated action.

WORKING TOGETHER FOR IMPACT

This is a countywide strategy, not a siloed effort. Cross-cutting approaches, such as coordinated community health worker networks, mobile and hub-based services, common referral pathways, and shared training programs, ensure that progress in one area strengthens another. The following pages outline the major activities that will be implemented to address the unmet needs identified in the Community Health Needs Assessments of DHHS and the MCHC, organized by priority and key focus area. Detailed workplans expand on these activities, with objectives derived from HP2030, SHIP 2024, and measures designed for accountability and impact. Because this is a living document, strategies will be updated and evaluated at least annually, and more often as emerging needs arise. In this way, MCHC, DHHS, Healthy Montgomery, and community partners remain responsive to changing conditions while sustaining alignment with countywide goals.

SECTION 4.

IMPLEMENTATION STRATEGIES

The following implementation strategies translate shared priorities into actionable, measurable initiatives designed to improve health and well-being across Montgomery County. Organized by Community Health Improvement Plan priority areas and focus topics, these strategies outline the specific activities that partners will undertake to address identified needs, advance health equity, and strengthen systems of care. Each strategy reflects a commitment to collaboration, evidence-informed practice, and accountability, with clearly defined goals, timelines, responsible organizations, and performance measures. Together, these strategies serve as the practical blueprint for coordinated action—connecting planning to implementation and ensuring progress toward sustained, countywide impact.

Community Health Improvement Plan

Priority 1: Easy Access to Comprehensive Care

Overarching Goal 1: Improve system coordination and integration to eliminate gaps and reduce barriers

Priority 1a: Increase Access to Primary Care Services

Goal 1: Enhance care delivery models to meet the needs of different populations

Background: Access to primary care remains limited for many in our region, especially among low-income, immigrant, and older adult populations. Barriers such as transportation, language, and lack of culturally responsive care contribute to fragmented services and overuse of emergency departments. Enhancing care delivery models—like mobile clinics, telehealth, and community health workers—can better meet diverse needs and improve access, continuity, and equity in primary care.

CHNA Impact	Actual	Target*
Increase the proportion of people with a usual primary care provider* (Source: Maryland Office of Population Health improvement; MD SHIP data)	MC: 85.5% PGC: 83.1%	83.7%
Increase percent of mothers receiving early and adequate prenatal care* (Source: Vital Statistics Admin, Jurisdictional Data)	MC: 67.4% PGC: 55.3%	58.2%
Increase the proportion of females who get screened for breast cancer* (Mammography use among women aged 50-74: Age-Adjusted) (Source: CDC Places)	MC: 80.2% PGC: 80.7%	80.4%

Objective 1.1: By December 2030, increase the proportion of residents who report having a usual primary care provider from the current progress to date of 82.2% to the target of 83.7%, as measured by the Office of Population Health Improvement data. This will be achieved through community-based outreach, partnerships with local clinics and FQHCs, and culturally responsive engagement strategies that prioritize inclusive access for historically underserved populations, including Black, Latino, immigrant, and rural residents.

Key Metric: % population with usual primary care provider (Office of Population Health, SHIP Data)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
1.1.1 Provide financial and in-kind support to primary care community clinics and organizations	Adventist HealthCare MedStar Montgomery Suburban Hospital	✖	✖	✖	**Process Measures:** # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided. **Focus Location:** MCHC CBSA **Focus Population:** Refugees, low-income, and uninsured/underinsured populations	CASA de Maryland, MobileMed, Mercy, Mary's Center, Kaseman Clinic, CCI, American Diversity Group; Aspen Hill Holy Cross Clinic, Olney Proyecto Salud Clinic; Proyecto Salud, & Catholic Charities	Staffing Grant Funding Infrastructure Medical Supplies & Equipment Technology & Data Systems Training & Capacity Building Community Engagement Resources Evaluation & Reporting Tools
1.1.2 Connect uninsured and underinsured patients to primary care by operating safety-net health centers and primary care practices in geographically accessible and medically underserved areas to ensure continuity of care and establish a medical home for families.	Holy Cross Health	✖	✖	✖	**Metrics:** # encounters, #patient visits, clinical measures #Montgomery Perinatal Progam patients linked to health centers **Focus Location**: MC Equity Focus Areas, MCHC CBSA, Health Professional Shortage Area, Medically Underserved Area **Focus Population:** low-income, uninsured/underinsured/insured populations, pregnant women, infants	Montgomery Perinatal Program (formerly, the Maternity Partnership Program), Montgomery Cares, MedStar Health, Primary Care Coalition, EveryMind, Lighthouse for the Blind, Montgomery Cares & Montgomery County Dept. of Health, Kingdom Cares	Staffing & Facility Operations Medical Equipment & Supplies Health IT Infrastructure Referral/Scheduling Infrastructure Community Outreach & Navigation Transportation & Accessibility Services Partnership Development Evaluation & Quality Improvement
1.1.3 Identify and refer individuals with unmet health needs to primary care and wraparound services through targeted outreach and screenings.	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** # of encounters, # of enrolled clients, % screening rate, # of referrals **Focus Location:** Montgomery County, MC Equity Focus Areas, PGC District 1, MCHC CBSA **Focus Population:** low income, uninsured/underinsured populations	Montgomery Cares, Catholic Charities, MD Minority Outreach and Technical Assistance program, MC DHHS, Primary Care Coalition, Cross Community	Staffing & Facility Operations Medical Equipment & Supplies Health IT Infrastructure Referral/Scheduling Infrastructure Community Outreach & Navigation Transportation & Accessibility Services Partnership Development Evaluation & Quality Improvement

Objective 1.2: By December 2030, increase early and adequate prenatal care among pregnant residents from 53.0% to 58.2%, using inclusive outreach, culturally responsive education, and support services, with a focus on Black, Latino, immigrant, and uninsured populations.

Key Metric: % mothers receiving early and adequate prenatal care (Vital Statistics Admin, Jurisdictional Data)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
1.2.1 Provide home-based case management services to high risk pregnant and parenting families through the Montgomery Perinatal Program.	DHHS	✘	✘	✘	**Metrics:** # of encounters, # of enrolled clients, % screening rate, # of referrals **Focus Location:** Montgomery County **Focus Population:** High risk, low-income Montgomery County pregnant women.	Maryland Department of Health, Holy Cross Hospitals,Adventist Hospital Systems, Medstar Montgomery Hospital, SMILE, Babies Born Healthy, Mary's Center, Community Clinic Inc. (CCI)	Staffing & Facility Operations Medical Equipment & Supplies Health IT Infrastructure Referral/scheduling infrastructure Community Outreach & Navigation Transportation & Accessibility Services Partnership Development Evaluation & Quality Improvement Program Participation Incentives
1.2.2 Provide care coordination services through the Babies Born Healthy and SMILE program to help high risk pregnant women connect with resources to help them stay healthy through their pregnancy and ensure they receive prenatal care.	DHHS	✘	✘	✘	**Metrics:** # of encounters, # of enrolled clients, % screening rate, # of referrals **Focus Location:** Montgomery County **Focus Population:** High risk Montgomery County Black/African American pregnant women.	Montgomery Perinatal Program, Maryland Department of Health, African American Health Program.	Staffing & Facility Operations Medical Equipment & Supplies Health IT Infrastructure Referral/scheduling infrastructure Community Outreach & Navigation Transportation & Accessibility Services Partnership Development Evaluation & Quality Improvement Program Participation Incentives
1.2.3 Provide perinatal health services to improve birth outcomes and improve health during the first years of life, with an increased focus on healthy birth outcomes for women of color (morbidity and mortality)	Adventist Health Care Holy Cross Health	✘	✘	✘	**Metrics:** # of encounters, pre/posttests, participant surveys, # of Maternity Partnership admissions, % Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries. # of women served, # of teenage deliveries, pregnancy loss and infant mortality rate, trimester that pre-natal care was initiated, % of babies born with a low birth weight **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations, pregnant families, uninsured women	Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS Maternity Partnership Montgomery County Department of Health and Human Services; Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS Maternity Partnership	Staffing & Facility Operations Medical Equipment & Supplies Health IT Infrastructure Referral/scheduling infrastructure Community Outreach & Navigation Transportation & Accessibility Services

Objective 1.3: By December 2030, increase breast cancer screening among women aged 50–74 from 49.6% to 80.4% through mobile services, outreach, and support for uninsured and underinsured women, with a focus on equity for Black, Latina, immigrant, and low-income residents.

Key Metric: % of females who get screened for breast cancer (CDC Places)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
1.3.1 Provide access to mammogram services for uninsured patients	Holy Cross Health	✘	✘	✘	**Metrics:** # of encounters, % eligible health center patients health center patients receiving referrals, # of mammograms, # navigated to care and cycle time from diagnosis to treatment, # enrolled in state breast and cervical cancer program **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations	Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Kevin J. Sexton Fund, Primary Care Coalition	Staffing & Facility Operations Medical Equipment & Supplies Health IT Infrastructure Referral/scheduling infrastructure Community Outreach & Navigation Transportation & Accessibility Services

Priority 1b: Mental Health and Substance Use Treatment & Recovery Services

Goal 2: Expand Access to, and utilization of, behavioral health services.

Background: Many residents face persistent barriers—such as transportation, language, and affordability—that limit access to behavioral health services, highlighting the need to expand availability and encourage utilization of culturally responsive, community-based mental health care.

CHNA Impact	Actual	Target
Decrease mental health related ER visits per 100,000 population* (Source: Healthy Montgomery Core Measures)	MC: 2,312.1 PGC: 1,955.6	2,446.69 per 100,000
Decrease percentage of adults with poor mental health (Source: Trinity Data Hub)	MC: 12.7% PGC: 13.3%	9.7%
Decrease percentage of high school students feeling sad or hopeless (Source: YRBS HS Summary)	MC: 32.2% PGC: 38.3%	32.0%
Decrease age-adjusted suicide mortality rates per 100,000 population (Source: Trinity Data Hub)	CBSA: 7.3	13.9

Objective 2.1: By December 2030, reduce mental health-related emergency department visits from 1,756.41 to 1,446.69 per 100,000 through expanded behavioral health services and equitable outreach to youth, communities of color, and uninsured residents.

Key Metric: # of ER visits per 100,000 population (MD SHIP, Healthy Montgomery Core Measures)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
2.1.1 Deliver Addiction Treatment services for adolescents and adults with substance abuse disorder	Suburban Hospital	✘	✘	✘	**Metrics:** Phase 1 completion, school attendance, behavior, #encounters, # classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** Montgomery County **Focus Population:** Adolescents & Adults with Substance abuse	Montgomery County DHHS	Clinical Staffing & Facility Operations Medical & Therapeutic Supplies Behavioral Health IT Systems Training & Certification Programs Community Outreach & Engagement Transportation & Accessibility Support Evaluation & Quality Improvement Tools
2.1.2 Provide virtual and in-person case management services for patients with a behavioral health diagnosis.	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital	✘	✘	✘	**Metrics:** # of participants served & readmission rate **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Patients with behavioral health diagnosis.	Mindoula Health ACT Team	Contractual Services Technology Integration Staff Coordination Training & Onboarding (referral workflows) Patient Engagement Tools Evaluation & Reporting Systems

Objective 2.2: Increase the proportion of children, adolescents, and adults with mental health problems who receive the mental health services they need in Montgomery and Prince George's Counties by December 2030, with a focus on equity by prioritizing outreach and service expansion in under-resourced communities, including Black, Latino, and immigrant populations.

Key Metric: # of linkages to treatment (Reported by DHHS and Hospital Partners)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
2.2.1 Collaborate with community organizations, community partners, and health systems to effect change at a systems level, such as training physicians to address mental health needs of patients, to improve behavioral health outcomes	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✘	✘	✘	**Metrics:** % of total BH ED encounters for high utilizer BH patients (30+ encounters/year), total ED encounters for high utilizer patients, total ED charges for BH high utilizer patients, # of trainings held, # of participants, % of behavioral health teleconsultation participants reporting increase in confidence working with behavioral health conditions **Focus Location:** Montgomery County **Focus Population:** Adults, Primary Care Physicians in our Clinically Integrated Network	Nexus Montgomery, County Agencies, Community Representatives, Cornerstone Montgomery, Sheppard Pratt, DHHS, MCFRS, and the Local Behavioral Health Authority, Clinically Integrated Network (CIN) of Physician Practices	Training & Education Programs Clinical Integration Support Partnership Coordination Technology & Data Infrastructure Outreach & Engagement Materials Evaluation & Reporting Tools Consulting & Facilitation Services
2.2.2 Implement a behavioral health care team at clinical care sites and/or provide behavioral health screenings with connections to treatment.	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✘	✘	✘	**Metrics:** # of screenings, # of positive screenings, # brief interventions, # referrals to treatment, # of linkages to treatment **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Broader community, patients with substance abuse	Philanthropic/Foundation, Caron, Recovery Centers of America (RCA), Avery Road Treatment Center, Shumaker House, Mountain Manor, Massie Unit, Lawrence Court, Delphi, MD Addiction Centers, Salvation Army, Helping Up Mission, Grass Roots, Kolmac Clinic, MedStar Outpatient Addiction Services, Suburban Outpatient Addiction Services. Community Care Delivery Existing/Potential Partners: Montgomery Cares, Primary Care Coalition, Maryland Dept. of Health, Montgomery County DHHS, Mosaic Group, Kevin J. Sexton Fund	Clinical Staffing Behavioral Health Screening Tools Referral & Care Coordination Systems Health IT Integration Training & Education Patient Engagement Materials Facility Operations Evaluation & Quality Improvement Tools
2.2.3 Provide grant funding and sponsorships to organizations addressing access to mental health services.	Adventist HealthCare MedStar Montgomery Suburban Hospital	✘	✘	✘	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	CentrePointe Counseling, Montgomery County Coalition for the Homeless (MCCH), Identity, Inc., EveryMind, Inc., Cornerstone Montgomery, Story Tapestries, Community Clinic Inc. (CCI): EveryMind, Inc., Parent Encouragement Program, Cornerstone Montgomery, National Alliance on Mental Illness	Funding Infrastructure Organizational Partnerships Staff & Technical Support Operational Support
2.2.4 Provide inpatient mental healthcare services as well as an assited living facility for adults with chronic and severe mental illness.	Adventist HealthCare	✘	✘	✘	**Metrics:** # of patients served, participation in therapy and wellness programs **Focus Location:** Montgomery County & Prince George's County **Focus Population: :** Adolescent (12+), adults and seniors with severe mental health symptoms (inpatient); adults with chronic and severe mental illness who are unable to live independently (assisted living).	NAMI, Alcoholics Anonymous, Tree of Hope, MedStar , Suburban Hospital, Local Behavioral Health Authority (ALF)	Staffing Training/capacity building Referral/scheduling infrastructure Technology infrastructure Residential support infrastructure Case management services Medication management systems Transportation services Communicatons/outreach materials Accessibility services Family engagement services Community/partner engagement support Monitoring/evaluation

2.2.5 Outpatient and partial hospitalization programs	Adventist HealthCare Suburban Hospital	✘	✘	✘	**Metrics:** # of patients served, # of group therapy sessions, family engagement sessions **Focus Location:** Montgomery County **Focus Population:** Adults with behavioral health conditions who do not require 24-hour inpatient care (PHP) and children, teens, adults and seniors (Outpatient)	Bloom, Compass, JSSA, Newport	Staffing Training/capacity building Referral/scheduling infrastructure Technology infrastructure Communicatons/outreach materials Accessibility services Family engagement services Community/partner engagement support Monitoring/evaluation

Objective 2.3: December 2030, increase mental health awareness and reduce stigma through culturally responsive education and outreach events annually, prioritizing inclusive engagement of youth, communities of color, and underserved populations to promote healthy behaviors and improve outcomes.

Key Metric: # culturally responsive education and outreach events (Reported by DHHS and Hospital Partners)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
2.3.1 Provide or collaborate with community organziations to implement mental health and wellness workshops, educational events, and support groups in the community.	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✘	✘	✘	**Metrics:** # of workshops and support groups held, # of participants, % of participants who had an increase in knowledge and self-efficacy **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents & adults, Latino/Hispanic Families	Charles E. Smith Life Communities; AHC Outpatient Wellness Center (OWC), EveryMind, Inc., Montgomery County Area Agency on Aging, GROWS, MedStar Outpatient Wellness Clinic, Mary's Center, Office of Community Partnerships, Montgomery County Community Engagement Cluster	Staffing Training/capacity building Referral/scheduling infrastructure Technology infrastructure Communicatons/outreach materials Translation/interpretation services Accessibility services Community/partner engagement support Monitoring/evaluation
2.3.2 Provide students with hands-on learning and experience with behavioral health professionals through behavioral health internships and medical rotations.	Adventist HealthCare Suburban Hospital	✘	✘	✘	**Metrics:** # of students hosted, # of staff hours **Focus Location:** Montgomery County **Focus Population:** Students at any collegian level (bachelors, masters, doctorate programs)	Howard University, George Washington University, University of Maryland, Washington Adventist University, Towson University, Georgetown University	Staffing Training/capacity building Internship program infrastructure Technology infrastructure Communications/outreach materials Student/partner engagement support Monitoring/evaluation
2.3.3 Train lay persons, such as faith/community leaders and CHWs, to be first responders for someone within their congregation/community experiencing a mental health or substance use challenge or crisis	Holy Cross Health	✘	✘	✘	**Metrics:** Total # of faith leaders trained, # of faith leaders trained in FCN/HM network **Focus Location:** MC Equity Focus Areas & Prince George's County **Focus Population:** Faith-based organizations	Faith-based Organizations, Maryland Department of Health, EveryMind, Mental Health Association of Maryland, Faith Community Partners	Training Personnel Curriculum Development Participant Support Training Supplies Venue & Logistics Translation & Accessibility Services Evaluation Tools Partnership Coordination

Priority 1c: Specialty & Extended Care

Goal 3: Reduce Barriers to Care

Background: Many residents face challenges accessing specialty and extended care services due to transportation, language, and financial barriers—highlighting the need to reduce systemic obstacles and improve equitable access across the full continuum of care.

CHNA Impact	Actual	Target
Health Professional Shortage Area (HRSA) score.	MC Primary Care: 5 MC Dental: 3 MC Mental Health: 3	No Target
Percentage of community health survey respondents that indicate transportation to health care is a barrier	CBSA: 39%	No Target

Objective 3.1: December 2030, reduce the percentage of adults who report being unable to see a doctor through inclusive outreach, financial assistance programs, and partnerships with community health providers, prioritizing engagement with uninsured, low-income, and immigrant populations.

Key Metric: % of Adults Who Report Being Unable to See a Doctor Due to Cost (BRFSS)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
3.1.1 Provide access to specialty care, such as mammogram services, cardiology and endocrinology, for uninsured patients	Adventist Healthcare Holy Cross Health Suburban Hospital	✘	✘	✘	**Metrics:** # of encounters, % eligible health center patients receiving specialty care referrals, #patients navigated to Project Access, # of mammograms, # enrolled in state breast and cervical cancer program **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations	Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Kevin J. Sexton Fund, Primary Care Coalition, MobileMedical, Inc. Montgomery County Dept. of Health Brem Foundation	Staffing Diagnostic services Enrollment support Referral/scheduling infrastructure Patient navigation tools Technology infrastructure Communicatons/outreach materials Community/partner engagement support Monitoring/evaluation
3.1.2 Provide evening and weekend hours at safety net health centers and primary care sites	Holy Cross Health Suburban Hospital	✘	✘	✘	**Metrics:** #patient visits on evenings and weekends, #days open on evening and weekends **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations	MedStar Health, Primary Care Coalition, EveryMind, Lighthouse for the Blind, Mobile Medical, Inc., Montgomery Cares & Montgomery County Dept. of Health	Staffing Referral/scheduling infrastructure Technology infrastructure Facility operations Supplies/equipment Transportation coordination Communications/outreach materials Monitoring/evaluation
3.1.3 Provide perinatal health services to improve birth outcomes and improve health during the first years of life, with an increased focus on healthy birth outcomes for women of color (morbidity and mortality)	Adventist HealthCare Holy Cross Health DHHS	✘	✘	✘	**Metrics:** # of encounters, pre/posttests, participant surveys, # of Montgomery County Perinatal Program admissions, % Montgomery County Perinatal Partnership patients receiving early prenatal care, and percent low-birth weight deliveries. # of women served, # of teenage deliveries, pregnancy loss and infant mortality rate, trimester that pre-natal care was initiated, % of babies born with a low birth weight **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations, pregnant families, uninsured women	Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County Department of Health and Human Services; Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS, Montgomery County Perinatal Program	Staffing Enrollment support Referral/scheduling infrastructure Patient navigation tools Screening & assessment tools Technology infrastructure Communicatons/outreach materials Community/partner engagement support Monitoring/evaluation

Priority 1d: Health Insurance Coverage

Goal 4: Increase the proportion of people with health insurance

Background: Many residents remain uninsured due to barriers such as income, immigration status, and lack of awareness—highlighting the need to increase health insurance coverage through inclusive outreach, enrollment support, and equitable access to affordable plans.

CHNA Impact	Actual	Target
Increase the proportion of people with health insurance (Source: Trinity Data Hub)	CBSA: 91.1%	92.1%
Percentage of insured population receiving Medicaid (Source: Trinity Data Hub)	CBSA: 19.1%	No Target

Objective 4.1: By December 2030, increase health insurance coverage among residents from 91.1% to 92.1% through targeted enrollment support and inclusive outreach, prioritizing uninsured Black, Latino, immigrant, and low-income communities.

Key Metric: % people with health insurance (American Community Survey)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
4.1.1 Advocate for policy, systems, and environmental changes addressing insurance reform and the needs of the uninsured population	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburan Hospital	✖	✖	✖	**Metrics:** activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County DHHS, Montgomery Cares, MD Hospital Association	Staffing Training/capacity building Advocacy/data collection infrastructure Communications/outreach materials Strategic planning support Community/partner engagement support Monitoring/evaluation
4.1.2 Provide financial and in-kind support to community clinics and community organizations addressing lack of insurance and/or insurance enrollment	Adventist HealthCare MedStar Montgomery Suburan Hospital	✖	✖	✖	**Metrics:** # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided **Focus Location:** MCHC CBSA **Focus Population:** refugees, low income, and uninsured/underinsured populations	CASA de Maryland, Mobile Medical, Inc., Mercy, Mary's Center, Kaseman Clinic, CCI, American Diversity Group; Aspen Hill Holy Cross Clinic, Olney Proyecto Salud Clinic, Catholic Charities	Staffing Training/capacity building Clinical support services Grantmaking infrastructure Technology infrastructure Data/quality improvement tools Communications/outreach materials Community/partner engagement tools Monitoring/evaluation
4.1.3 Provide support to uninsured patients, colleagues and community members by assisting with enrollment to publicly funded programs	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburan Hospital DHHS	✖	✖	✖	**Metrics:** # of participants, #colleagues assessed, #Colleages identified as uninsured, #linked to resources, Charity care expenses, #insured **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations	Montgomery County DHHS, Meduit, DeCorm	Staffing Enrollment support Training/capacity building Referral/scheduling infrastructure Technology infrastructure Communications/outreach materials Accessibility services Community/partner engagement tools Monitoring/evaluation

Implementation Plan FY2025-FY2028

Priority 2: Promotion of Healthy Living and Well-Being

Overarching Goal 2: Enhance primary prevention of chronic disease

Priority 2a: Physical Activity & Nutritious Eating

Goal 5: Reduce overweight and obesity by helping people eat healthy and get physical activity.

Background: High rates of overweight and obesity are driven by limited access to affordable healthy food, safe spaces for physical activity, and culturally relevant wellness resources—highlighting the need to support healthier eating and active living through inclusive, community-based strategies.

CHNA Impact	Actual	Target
Percentage of adults who are obese (Source: Maryland Behavior Risk Factor Surveillance System)	CBSA: 27.7%	36.0%
Reduce the proportion of children and adolescents who are obese or overweight (Source: YRBS, HS (overweight plus obese)	MC: 28.2% PGC: 39.0%	14.5%

Objective 5.1: By December 2030, reduce the percentage of adults reporting no leisure-time physical activity through inclusive fitness programs and wellness outreach, prioritizing older adults, low-income families, and communities of color.

Key Metric: % of residents aged 20 years and older with no reported leisure-time physical activity (BRFSS)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
5.1.1 Implement and/or partner with organizations and community centers to provide physical and social activity programs for older adults aged 55+	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital	✘	✘	✘	**Metrics:** # participants # of encounters, # programs offered; # of classes offered, pre/post assessments, participant surveys **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Prince George's County **Focus Population:** Adults aged 55+	Montgomery County HOC and Recreation Department, Maryland Department on Aging, Kaiser Permanente of the Mid-Atlantic States, MoCo Department of Recreation, Maryland National Capital Park and Planning Commission, Faith-Based and Community-based Organizations, Retirement Communities, Faith-based organizations	Staff time Program materials Facility access Evaluation tools Community engagement supports
5.1.2 Address obesity through a three-pronged approach: education, improved nutrition, and increased physical activity (Dine, Learn & Move).	Suburban Hospital	✘	✘	✘	**Metrics:** # of participants, pre/post evaluation **Focus Location:** Prince George's County **Focus Population:** Adults 18+	Maryland National Capital Park and Planning Commission Department of Parks and Recreation Prince George's County, University of Maryland Capital Region Health, Price George's County Health Department.	Staff time Educational materials Nutrition and fitness program supplies Evaluation tools

5.1.3 Provide funding to organizations addressing access to physical activities services through community contributions.	Adventist HealthCare Suburban Hospital	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** Physical and Mental Differences Adults (special needs), General Pop	Spirit Club, Main Street, American Heart Association, YMCA	Community grant allocations Staff coordination Partnership development Program monitoring and reporting tools
Objective 5.2: By December 2030, reduce adult obesity (BMI ≥ 30) from 71.1% to 40.9% through inclusive nutrition and physical activity programs, prioritizing access to healthy food, safe spaces, and culturally responsive education for low-income and communities of color.							
Key Metric: % of adults who are overweight or obese (Trinity Data Hub)							
Activity	**Organization(s) Implementing Activities**	**Implementation Period**			**Process Measures/ Location/Population**	**Existing and Potential Partners**	**Required Resources**
		Year 1	**Year 2**	**Year 3**			
5.2.1 Expand or implement evidence-based/informed programs addressing obesity in children, adolescents	Holy Cross Health	✖	✖	✖	**Metrics:** Quarterly reports on number of encounters, pre/posttests, participant surveys, weight loss, # Kids Fit participants, BMI **Focus Location:** MC Equity Focus Areas **Focus Population:** Children/adolescents	Montgomery County Housing Partnership, Boys and Girls Club, Kingdom Fellowship AME	Program staff and facilitators Educational and fitness materials Data collection and evaluation tools Outreach and engagement supports
5.2.2 Implement evidence-based or evidence-informed diabetes prevention programming (English and Spanish)	Holy Cross Health Suburban Hospital	✖	✖	✖	**Metrics:** #DPP, #RTH, and #EWI-DP cohorts offered by qualified providers; # referrals **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Montgomery Cares, MD DHHS Office of Minority Health and Health Disparities	Program coordination and staffing Bilingual educational materials Community outreach and engagement tools Referral tracking systems Evaluation and reporting supports
5.2.3 Provide diabetes care management, education, and/or nutrition counseling for or in the community.	Holy Cross Health Suburban Hospital	✖	✖	✖	**Metrics:** Health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults, high-risk patients	Community Care Delivery Existing/Potential Partners: Montgomery County DHHS, Montgomery Cares, Kevin J. Sexton Fund	Care coordination staff Health education materials Nutrition counseling tools Referral systems and tracking Community engagement and outreach supports

Priority 2b: Chronic Disease Prevention & Management

Goal 6: Enhance screening, treatment and care for chronic illness

Background: Chronic illnesses remain a leading cause of poor health outcomes, often worsened by delayed diagnosis and inconsistent management—highlighting the need to enhance screening, treatment, and coordinated care to improve quality of life and reduce preventable complications.

CHNA Impact	Actual	Target
Diabetes mortality rate per 100,000 population (Source: Healthy Montgomery Core Measures)	MC: 13.8 PGC: 31.4	13.7 per 100,000
Heart disease mortality rate per 100,000 population (Source: Healthy Montgomery Core Measures)	MC: 92.7 PGC: 139.9	78.6 per 100,000
Cerebrovascular disease (including stroke) mortality rate per 100,000 population (Source: Maryland Vital Statistics)	MC: 35.9 PGC: 44.7	33.4 per 100,000

Objective 6.1: By December 2030, increase participation in diabetes education and self-management programs among adults, with focused outreach to Black, Latino, immigrant, and low-income communities through bilingual care management and culturally responsive services.

Key Metric: Diabetes mortality rate (Healthy Montgomery Core Measures)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
6.1.1 Provide diabetes care management, education and/or nutrition counseling	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** Health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults, high-risk patients	Community Care Delivery Existing/Potential Partners: Montgomery County DHHS, Montgomery Cares, Kevin J. Sexton Fund	Clinical staff and care coordinators Health education and nutrition materials Referral systems and tracking tools Community engagement and outreach supports Program evaluation and reporting infrastructure
6.1.2 Implement or expand diabetes self-management and prevention programming (English and Spanish)	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** #DSMP and #DSMES cohorts offered by qualified providers; # of participants # referrals **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Nexus Montgomery, Adventist Health, Medstar Montgomery, Holy Cross and Suburban, Montgomery County DHHS, Healthy Montgomery, Montgomery Cares, BRMDP	Program facilitators and bilingual educators (English and Spanish) curriculum materials and toolkits Referral and tracking systems Community outreach and engagement supports Evaluation and reporting infrastructure

Objective 6.2: By December 2030, increase participation in chronic disease self-management programs among adults, with targeted outreach to Black, Latino, and immigrant communities to ensure equitable access and engagement.							
Key Metric: Heart disease mortality rate and cerebrovascular mortality rate (Healthy Montgomery Core Measures)							
Activity	**Organization(s) Implementing Activities**	**Implementation Period**			**Process Measures/ Location/Population**	**Existing and Potential Partners**	**Required Resources**
		Year 1	**Year 2**	**Year 3**			
6.2.1 Provide healthy lifestyle education programs, wellness activities, workshops, and support groups	Adventist HealthCare MedStar Montgomery Suburban Hospital	✖	✖	✖	**Metrics:** # of encounters, person served, classes/workshops held, etc. **Focus Location:** Montgomery County & Prince George's County **Focus Population:** Adults and older adults	Montgomery County Department of Recreation, Faith Communities, Montgomery County non-profits	Program facilitators and wellness educators Educational and activity materials Outreach and engagement supports Evaluation and reporting tools
6.2.2 Implement evidence-based programs for chronic disease self-management	Adventist HealthCare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** Quarterly reports on encounters, attendance/completion rate, number of safety-net SMP referrals, pre/posttests, self-efficacy survey **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Older Adults	Evidence-based Programs and Initiatives Existing/Potential Partners: Montgomery County DHHS, HQI	Program facilitators and trainers Curriculum and evaluation tools Referral systems and tracking infrastructure Outreach and engagement supports Reporting and data analysis tools

Priority 2c: Injury & Safe Environments

Goal 7: Reduce the rate of violence, injuries, and associated harms.

Background: High rates of violence and injury are driven by community safety concerns—including crime, gang activity, intimate partner violence, and firearm-related harms—underscoring the need to promote safe environments and prevent violence through collaborative, equity-focused strategies.

CHNA Impact	Actual	Target
Firearm Mortality Rate per 100,000 (Source: 2023 CHNA)	MC: 10.4 PGC: 11.6	10.7
Firearm-related hospitalizations per 100,000 (Source: 2023 CHNA)	MC: 3.3 PGC: 3.0	No Target
Homicide deaths per 100,000 (Source: 2023 CHNA)	MC: 2.0 PGC: 11.7	5.5
Reported violent crime offenses per 100,000 (Source: 2023 CHNA)	MC: 421.46 PGC: 474.5	No Target

Objective 7.1: By December 2030, reduce the age-adjusted rate of intimate partner violence-related emergency department visits in Montgomery County from 35.9 per 100,000 to a target rate to be determined, through trauma-informed outreach, survivor-centered services, and partnerships with culturally responsive community organizations, prioritizing support for Black, Latino, immigrant, and low-income populations.

Key Metric: Age-adjusted rate of IPV-related ED visits per 100,000 residents (MD SHIP)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
7.1.1 Provide 24/7 crisis services that provides assessment and referrals for domestic violence.	DHHS	✖	✖	✖	**Metrics:** Programmatic reports on encouters, center usage, and referrals. **Focus Location:** Montgomery County **Focus Population:** All Montgomery County residents of all ages	Montgomery County Crisis Center, Trauma Services, DHHS, Montgomery County Police Department, Shady Grove Adventist Hospital - emergency room and forensic unit	24/7 crisis staffing and clinical coverage to include crisis hotline operations, Training and certification in trauma-informed and culturally responsive crisis intervention, Interpreter services and multilingual communication tools, Inter-agency collaborative meetings, Transportation resources for emergency relocation, Public awareness and outreach materials to ensure county residents know how to access crisis services
7.1.2 Provide crisis intervention services through the Trauma Services Program that offers shelter, on-going support, counseling and advocacy services to victims of partner-related domestic abuse and their families.	DHHS	✖	✖	✖	**Metrics:** Programmatic reports on encouters, center usage, and referrals. **Focus Location:** Montgomery County **Focus Population:** All Montgomery County residents of all ages	Trauma Services, Department of Health and Human Services (DHHS), Montgomery County Police Department (MCPD) – Domestic Violence Unit, State's Attorney's Office – Domestic Violence Unit, District and Circuit Courts (Protective Order process), House of Ruth Legal Clinic, Montgomery County Child Welfare Services (CWS) and Adult Protective Services (APS), Montgomery County Animal Services (for pet safety support during relocation), Maryland Network Against Domestic Violence (MNADV)	Immediate access to services, Transportation assistance, Emergency clothing, food, and supplies for shelter residents, Staff development – trauma-informed and culturally and linguistically appropriate, Outreach materials and media partnerships to increase awareness of available services

7.1.3 Provide crisis intervention services through the Trauma Services Program that offers information, referrals, advocacy, on-going support, counseling, and compensation services for victims of crime.	DHHS	✖	✖	✖	**Metrics:** Programmatic reports on encouters, center usage, and referrals. **Focus Location:** Montgomery County **Focus Population:** Montgomery County residents who are survivors of domestic violence and their dependents	Trauma Services, Department of Health and Human Services (DHHS), Montgomery County Police Department (all districts), Maryland Criminal Injuries Compensation Board (CICB), State's Attorney's Office Victim/Witness Unit, Shady Grove Adventist Hospital – emergency room and Forensic Unit, Maryland Coalition Against Sexual Assault, Montgomery College and MCPS for outreach and prevention initiatives	Immediate access to services, Transportation assistance, Emergency clothing, food, and supplies, Staff development – trauma-informed and culturally and linguistically appropriate, Outreach materials and media partnerships to increase awareness of available services

Implementation Plan FY2025-FY2028

Priority 3: Support for Essential Community Services

Overarching Goal 3: Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.

Priority 3a: Affordable Housing

Goal 9: Reduce Housing Cost Burden

Background: Access to affordable housing remains a significant social determinant of health, with many residents—especially low-income, immigrant, and uninsured families—facing cost burdens that limit their ability to meet other essential needs and maintain overall well-being.

CHNA Impact	Actual	Target
Percentage of homes sold in that were affordable on the median teacher's salary. (Source: MD SHIP). Affordable housing is defined as housing that costs less than 30% of household income	MC: 37.3% PGC: 62.8%	No Target

Objective 9.1: By December 2030, increase the percentage of residents and families who buy homes sold at affordable price, affordable housing defined as housing that costs less than 30% of household income, from 20.7% to % to be determined, as measured by MD SHIP. This will be accomplished through advocacy, expanded access to affordable housing units, rental assistance programs, financial literacy workshops, and partnerships with housing developers and local agencies.

Key Metric: % of homes sold at affordable price (MD SHIP)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
9.1.1 Advocate for policy, systems, and environmental changes addressing the housing cost burden	Adventist Healthcare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** Activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County Council, Community-based organizations, faith-based organizations, Montgomery County Coalition for the Homeless, Nexus Montgomery, A Wider Circle	Personnel & Expertise Operational Support Partnership Development Advocacy Infrastructure
9.1.2 Coordinate care and link patients, colleagues and community members to social services.	Adventist Healthcare Holy Cross Health MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** # of screenings, Number of patients/community members with coordination plans, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	Personnel & Expertise Technology & Tools Operational Support Community Parnterships
9.1.3 Provide financial support to community organizations addressing housing cost burden through the community health funding.	Adventist Healthcare Suburban Hospital MedStar Montgomery	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** Low-income, uninsured, underinsured	Montgomery County Coalition for the Homeless, Seabury Resources for Aging	Funding Infrastructure Organizational Partnerships Staff & Technical Support Operational Support

Priority 3b: Healthy Food Access

Goal 10: Promote equitable access to nutrition and social services through integrated clinical practices, community partnerships, and capacity-building initiatives.

CHNA Impact	Actual	Target
Decrease percent of households that are food insecure (Source: Trinity Data Hub)	MC: 8.9% PGC: 7.4%	6.0%
Decrease percent of minority groups that are food insecure (Source: USDA)	BLK: 18.0% HSP: 16.9%	6.0%
Increase the proportion of households who receive SNAP benefits (Source: Trinity Data Hub)	CBSA: 7.8%	No Target

Objective 10.1: By December 2030, reduce household food insecurity through social needs screening in clinical settings, SNAP support, and funding for community-based nutrition programs, with targeted outreach to low-income and immigrant families.

Key Metric: Percentage of households experiencing food insecurity (MD SHIP)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
10.1.1 Screen safety net health center and primary care patients for social needs and refer patients who screen positive to community resources	Holy Cross Health	✘	✘	✘	**Metrics:** # of patients screened, # of patients referred to resources **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** low-income, uninsured/underinsured	Montgomery Cares	Personnel & Expertise Technology & Tools Community Partnerships Operational Support
10.1.2 Coordinate care and link patients, colleagues and community members to social services	Adventist HealthCare Holy Cross MedStar Montgomery Suburban Hospital	✘	✘	✘	**Metrics:** # of patients/community members with coordination plans in FindHelp, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	Personnel & Expertise Technology & Systems Community Parnterships Operational Support

10.1.3 Train Community Health Workers on SNAP education and enrollment	Holy Cross Health	✖	✖	✖	**Metrics:** # of CHWs trained, #participants enrolled **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** low-income, uninsured/underinsured	Montgomery County Food Council, Cross Community	Personnel & Expertise Training Infrastructure Community Partnerships Operational Support
10.1.4 Provide grant funding and sponsorships to organizations addressing access to food insecurity and hunger.	Adventist HealthCare MedStar Montgomery Suburban Hospital DHHS	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	Community Health and Empowerment through Education and Research (CHEER), Food & Friends, Nourish Now, Feed the Fridge, Crossroads Community Food Network, Institute for Public Health Innovation, The Shepherd's Table, Manna Food Center, United Way, Montgomery County Office of Food System Resilience Nourishing Bethesda Funding recipients may vary from year to year	Funding Infrastructure Organizational Partnerships Staff & Technical Support Operational Support
10.1.5 Support efforts to increase Montgomery County family's access to fresh and shelf-stable food	DHHS	✖	✖	✖	**Metrics:** support efforts provided **Focus Location:** Montgomery County **Focus Population:** Montgomery County households that have at least one child under the age of 18 who is not eligible to receive SNAP benefits and has a post-tax income below 400% of the Federal Poverty Level.	Montgomery County Office of Food System Resilience, DHHS, Instacart Health, the Montgomery County Food Council.	Montgomery County Office of Food System Resilience operating budget funds.

Objective 10.2: By December 2030, increase access to foods that support healthy dietary patterns through education and expanded availability of affordable, culturally relevant options, with targeted outreach to low-income, immigrant, and communities of color.

Key Metric: Percentage of households experiencing food insecurity (MD SHIP)

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
10.2.1 Increase availability and access to healthy and/or culturally appropriate food	Adventist HealthCare Holy Cross MedStar Montgomery Suburban Hospital	✖	✖	✖	**Metrics:** # of individuals served through food access programs, # of culturally appropriate food initiatives implemented **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Montgomery College, Montgomery County Master Gardeners, Montgomery County Food Council, Montgomery County Ag Reserve, Boys and Girls Club, Food and Friends, Manna Food Center, One Acre Farms	Personnel & Expertise Infrastructure & Tools Community Partnerships Operational Support

10.2.2 Increase food literacy	Adventist HealthCare Holy Cross MedStar Montgomery Suburban Hospital	✘	✘	✘	**Metrics:** #encounters, #classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Montgomery College, MoCo Food Council, UMD Extension, Boys and Girls Club, Manna	Personnel & Expertise Educational Infrastructure Community Partnerships Operational Support

Priority 3c: Transportation

Goal 11: Improve and promote transportation infrastructure across Montgomery County

CHNA Impact	Actual	Target
Increase percent of population living in a census block within a quarter of a mile to a fixed transit stop (Source: 2023 CHNA)	54.90%	No Target
Decrease percent of community health survey respondents that indicate transportation to health care is a barrier (Source: 2023 CHNA)	4.5%	No Target

Objective 11.1: By December 2030, increase the number of trips to work made by mass transit from 8.5% to 9% as measured by the American Community Survey (5 year).

Activity	Organization(s) Implementing Activities	Implementation Period			Process Measures/ Location/Population	Existing and Potential Partners	Required Resources
		Year 1	Year 2	Year 3			
11.1.1 - Offer free bus fare to all Montgomery County residents.	Montgomery County DOT	✘	✘	✘	**Metrics:** # of daily riders through Ride On **Focus Location:** Montgomery County **Focus Population:** Montgomery County	Montgomery County DOT	Resources for this strategy are being considered.
11.1.2 - Increase new services to unserved areas that are not presently served by Ride On/Metro.	Montgomery County DOT	✘	✘	✘	**Metrics:** # of daily riders through Ride On **Focus Location:** Ag reserves **Focus Population:** Ag reserves	Montgomery County DOT	Resources for this strategy are being considered.

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APPENDICES

APPENDIX I HMSC OVERVIEW, PURPOSE, FUNCTION, OVERSIGHT OF CHIP

In June 2008, DHHS and the Montgomery County Collaboration Council for Children, Youth and Families sponsored a meeting that brought together organizations in the county that provide services to improve the health and well-being of Montgomery County residents. The purpose of the meeting was to evaluate how the local public health system delivers essential public health services to the community. Attendees collectively assessed how well the ten essential public health functions are carried out in the county and identified several areas needing improvement. Montgomery County initiated Healthy Montgomery to address these needs. Today, Healthy Montgomery is designated as the Local Health Improvement Coalition (LHIC) for Montgomery County. Every county in the state of Maryland has an LHIC, which was initiated with the publication of the State Health Improvement Plan (SHIP) in 2012. This statewide effort focuses on improving population health outcomes and measures in every jurisdiction on identified population health metrics.

Healthy Montgomery works to improve the health and well-being of Montgomery County residents by:

- Improving access to health and social services;
- Achieving health equity for all residents; and
- Enhancing the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors. Healthy Montgomery objectives are:
  - To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporates a wide variety of county and sub-county information resources and utilizes methods appropriate to their collection, analysis, and application;
  - To identify and prioritize health needs in the County as a whole and in the diverse communities within Montgomery County;
  - To foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and to coordinate and leverage resources to support the community health improvement process infrastructure and improvement projects.

Healthy Montgomery is guided by the Healthy Montgomery Steering Committee which is comprised of community stakeholders who represent various sectors and communities in Montgomery County.

PURPOSE

The purpose of Healthy Montgomery is to provide ongoing sustainable and community-driven approaches that identify and address key priority areas for the health and well-being of Montgomery County community members. The Healthy Montgomery Steering Committee provides insights into community needs and offers strategies to address those needs.

FUNCTION

Healthy Montgomery's process is based upon nationally recognized community health improvement process models such as the National Association of County and City Health Officials' planning initiative and Mobilizing for Action through Planning and Partnerships. The community health improvement process is based on five phases.

- Phase 1: Compile quantitative data, qualitative data, community resources, and strategies
- Phase 2: Develop a comprehensive community health needs assessment
- Phase 3: Set health priorities and develop action plans to address identified priorities
- Phase 4: Plan for action
- Phase 5: Implement, monitor, evaluate, and preplan for the next cycle

APPENDIX II MONTGOMERY COUNTY HOSPITAL COLLABORATIVE (MCHC)

Montgomery County's hospitals have long been engaged in the county's community health improvement process, participating in Healthy Montgomery's Steering Committee and providing financial support to sustain its infrastructure since its launch in 2009. Recognizing the value of working together to address shared community health priorities and avoid duplication of effort, the community benefit leaders from each of the four health systems (six hospitals came together in 2015 to form the Montgomery County Hospital Collaborative (MCHC).

PURPOSE

The collaborative was created to align hospital community benefit strategies, leverage collective resources, and strengthen the impact of hospital-led initiatives on the health and well-being of Montgomery County residents. Using a population health approach and the principles of the Triple Aim, the MCHC focuses on:

- Improving community health outcomes and advancing health equity;
- Stewarding hospital resources by coordinating efforts and reducing duplication;
- Analyzing programs collectively to identify and address service gaps; and
- Demonstrating measurable community impact through shared metrics.

FUNCTION

The Montgomery County Hospital Collaborative brings together community benefit leaders from all six county hospitals in a non-hierarchical, rotating leadership structure. Members meet bimonthly to align strategies, share data, and track progress, with support from Healthy Montgomery Staff. Key functions include:

- Identifying and prioritizing health needs using shared CHNA data;
- Advising on hospital community benefit investments;
- Partnering with community organizations to expand impact; and
- Developing and monitoring shared metrics for collective impact.

Each hospital contributes equally to sustain the collaborative, supporting Health Montgomery's infrastructure and advancing countywide health improvement.

PROGRESS TOWARD JOINT PLANNING

In 2022, the MCHC developed its first joint Community Health Needs Assessment (CHNA) and joint Improvement Strategy. This marked a significant milestone demonstrating the hospitals' ability to not only align priorities but also produce a single plan for collective action. The 2025 CHNA builds on this foundation, incorporating lessons learned, new data sources, and enhanced methodologies.

APPENDIX III CHIP FOUNDATIONS

FOUNDATIONS AND PURPOSE

This plan details the health improvement priorities for Montgomery County from 2025-2028 in addition to the specific goals and strategies that will be used to work to improve them.

WHY IS THIS NEEDED?

- All health departments in Maryland are required to complete a Community Health Improvement Plan (CHIP).
- The IRS requires non-profit hospitals to complete community health needs assessments at least every three years, which will create national linkages for partnering on community health in Montgomery County.
- It is a requirement of the Public Health Accreditation Board (PHAB), through which Montgomery County Department of Health and Human Services is accredited.
- Assessment is a core function of public health. Through evaluating health data and working with community partners, both Healthy Montgomery and the Montgomery County Hospital Collaborative can develop effective strategic plans to improve the overall health of the community.
- Successful partnerships with community members allow for an ongoing planning process with the ability to identify and address emerging health needs in Montgomery County.

MAPP

Mobilizing for Action through Planning and Partnerships (MAPP) is the framework utilized for completing the Community Health Improvement Process. MAPP was developed by the National Association of County and City Health Officials (NACCHO). According to NACCHO, "MAPP is a community-driven strategic planning process for improving community health which is facilitated by public health leaders. This interactive process helps improve efficiency and effectiveness of local public health systems by guiding participants through different phases of the model." Utilization of the MAPP model, depicted in Figure 3, provided a process to work through the stages of collaboration needed for the Community Health Improvement Plan (CHIP).

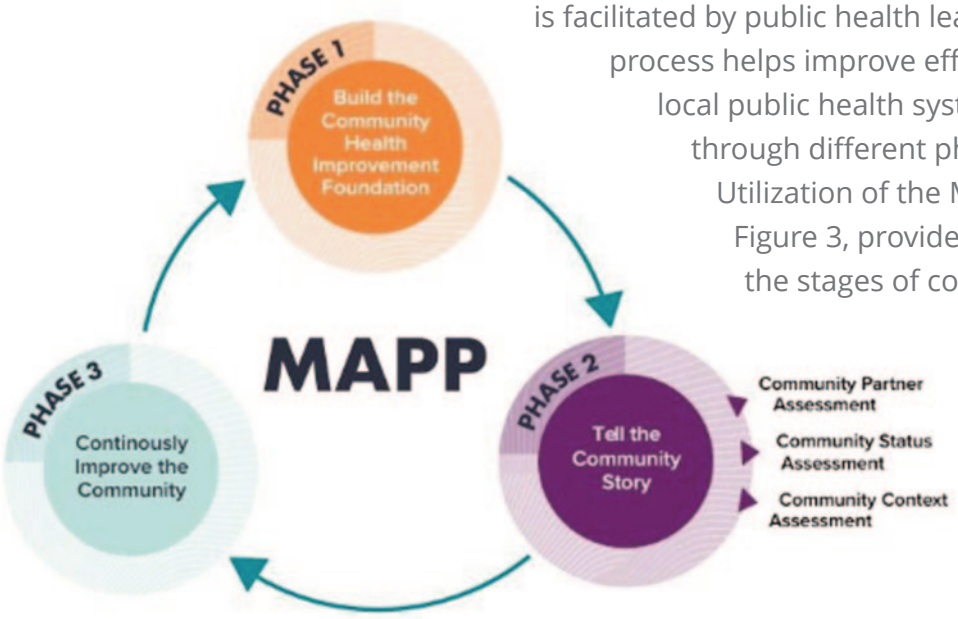


Figure 3. Mobilizing for Action through Planning and Partnerships model.

MAPP is an adaptable framework. To provide guidance and recommendations on how to follow MAPP, a MAPP Subcommittee was developed under Healthy Montgomery.

HUMAN-CENTERED DESIGN

According to the Interaction Design Foundation, human-centered design is a practice that puts people at the center of a development process, in which we seek to understand and solve root problems. This is accomplished by understanding that everything is a complex system with interconnected parts.

Harvard Business School defines human-centered design as, "...a problem-solving technique that puts real people at the center of the development process, enabling you to create products and services that resonate and are tailored to your audience's needs."

Montgomery County found the concept of human-centered design essential in ensuring that the Community Health Improvement Plan (CHIP) is a fully owned and invested community process. Using the idea of human-centered design, community members were invited to participate in the health prioritization process and in selecting strategies to address health needs in the CHIP. The MAPP Subcommittee was also responsible for incorporating Human-Centered Design into the CHIP process.

MARYLAND SHIP

Building a Healthier Maryland is Maryland Department of Health's State Health Improvement Plan (SHIP). The SHIP identifies the State's top health priorities and lays out associated goals and objectives for improved health outcomes over five years. The SHIP aligns with the State Health Equity Plan (SHEP), as required by Maryland's participation in the States Advancing All-Payer Equity Approaches and Development (AHEAD) Model, the total cost of care model from the Centers for Medicare and Medicaid Services.

Maryland's State Health Improvement Plan (SHIP) is a long-term systematic plan that addresses issues identified in the State Health Assessment (SHA). Development of the plan utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process. The five health priority areas in the SHIP are Chronic Disease, Access to Care, Women's Health, Violence, and Behavioral Health.

Montgomery County is tasked with identifying one SHIP objective for local Improvement.

CHNA OVERVIEW

Conducting a comprehensive Community Health Needs Assessment (CHNA) to identify significant health needs is vital to improving health outcomes, disparities, and equity in Montgomery County. The data in the CHNA is what informs the Community Health Improvement Plan's health priorities. The CHNA is compiled with data and insights from the following:

- Community members who provided their opinions on health, well-being, and access to resources in a survey or a group discussion.
- Community members that represent the racial and ethnic communities of Montgomery County

who participated in group discussions:

- Asian American and Pacific Islander Community
- Black/African American/African Diaspora Community
- Hispanic or Latino Community
- Community members that are in the following populations that participated in group discussions:
- Agricultural Reserves Community
- Community Members with Disabilities
- Immigrant Community
- Older Adults' Community
- Uninsured, Low-Income Community
- Youth Community
- LGBTQ+ Community

- Interviews with individuals from various community organizations.
- Survey data from local public and private dental offices and clinics that provide oral health services.
- Data from local, state, and national sources for comparison.

This research gives a comprehensive view of Montgomery County's health – where the county is succeeding and where it needs to improve. The assessment reveals differences in health and well-being among communities and populations in the county. From this research, eighteen significant health needs were identified using the priorities and emerging themes. The significant health needs are listed in alphabetical order.

- Access to Behavioral Health, and Substance Use Disorder Services
- Access to Human Services' Needs, Such as Education, Income, Housing, Employment, Food, and Personal Social Services
- Access to Parks, Public Spaces, Wellness, and Recreation
- Access to Quality Dental Health Services
- Access to Quality Primary Care Health Services
- Access to Specialty and Extended Care
- Access to Technology
- Access to Transportation
- Active Living and Healthy and Nutritious Eating
- Cultural and Language Competence
- Environmental Health
- Health and Human Services' System Navigation

- Injury and Disease Prevention and Management
- Maternal and Early Childhood Health
- Pedestrian Safety
- Safe and Violence-Free Environment
- Social Associations and Community Connectiveness
- Waste Management

The 2023 Montgomery County Community Health Needs Assessment can be viewed online[42].

CHIP PROCESS

Using results and identified significant health needs from the CHNA, health priorities were selected using a multi-step approach. The process was as follows:

- The CHNA Advisory Committee conducted a prioritization process called multi-voting technique in January 2023.
- In April 2024, online prioritization surveys and community health info sessions were conducted to have Montgomery County residents prioritize the significant health needs.
- The MAPP Subcommittee reviewed results from each prioritization process and recommended 3 health priorities to be addressed in the Community Health Improvement Plan (CHIP). This was completed using criteria from MAPP 2.0:
  - Relevance of the issue to community members.
  - Magnitude/severity of the issue.
  - Urgency to solve the issue.
  - Impact of the issue on communities impacted by inequities.
  - Availability and feasibility of solutions and strategies to address the issue.
- Trending health concerns (e.g., COVID-19, mental health, obesity, and access to healthcare).
- Availability of resources (time, funding, staffing, equipment) to address the issue.
- Opportunity to apply upstream strategies to address the issue.
- Social, political, historical, and cultural context of the issue.

The health priority diagram below was created and presented to the Healthy Montgomery Steering Committee in November 2024. The health priorities of Easy Access to Comprehensive Healthcare, Support for Essential Community Services, and Promotion of Healthy Living and Wellbeing for All were voted on and approved by the Steering Committee in December 2024.

A Health Priority Action Team (HPATs) was formed for each of the CHNA priority areas. These teams comprised leaders with decision-making influencing across a wide array of sectors in each priority domain. In spring 2025 and each HPAT completed a series of facilitated strategic planning sessions to understand the root causes of the health needs and identify strategies to address them.

I. Easy Access to Comprehensive Care

All residents deserve access to high-quality, culturally and linguistically responsive care, including access to...

- Primary Care Services
- Substance Use Treatment & Recovery Services
- Specialty & Extended Care
- Mental Health Services
- Health Insurance Coverage

II. Promotion of Healthy Living and Well-Being

Communities thrive when people are supported to live well through...

- Physical Activity
- Nutritious Eating
- Chronic Disease Management
- Injury & Disease Prevention
- Safe Environments

III. Support for Essential Community Services

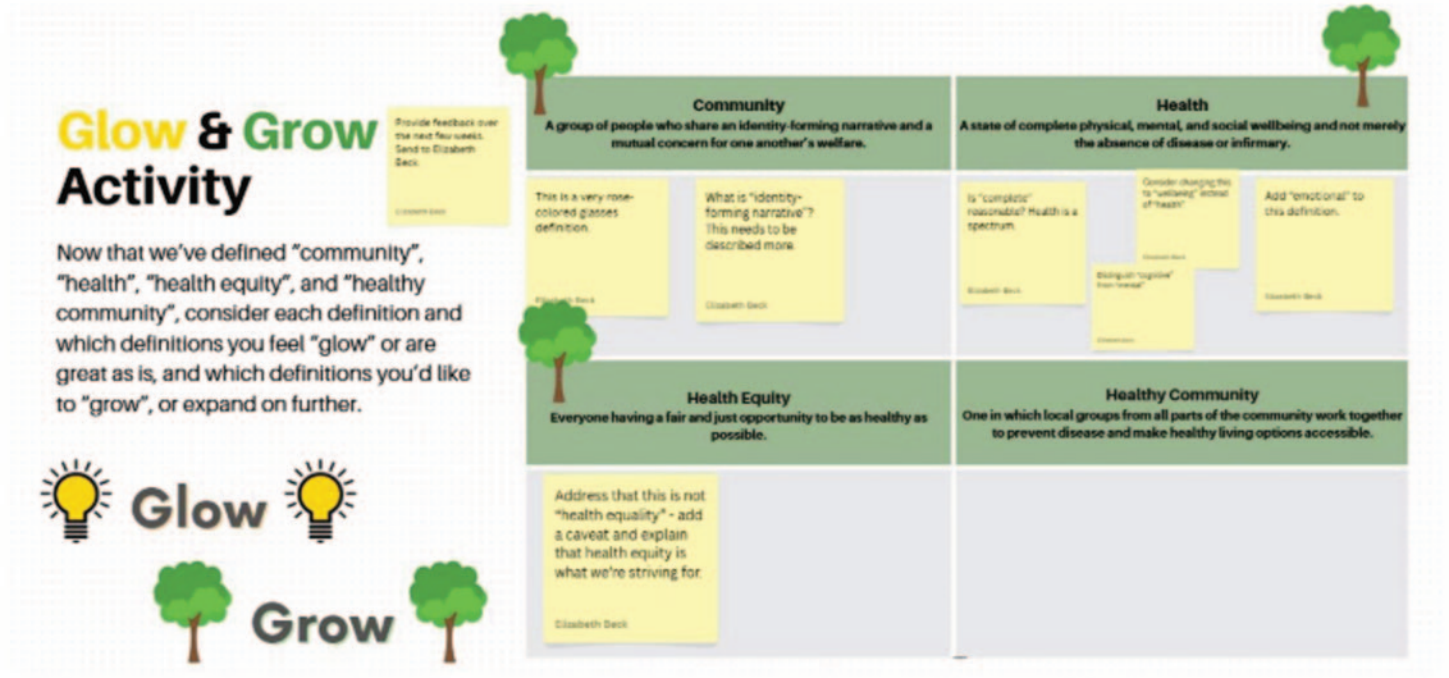
Our environments shape our health—safe spaces and responsive services help communities thrive through...

- Affordable Housing
- Healthy Food Access
- Human Services Access
- Transportation
- System Navigation

From this process, the Community Health Improvement Plan (CHIP) was developed. The CHIP provides the goals, objectives and strategies to improve health and well-being in the community.

OVERVIEW OF DEFINITIONS

During the March 2025 Health Priority Action Team Kickoff Meeting, participants reviewed definitions of "Community", "Health", "Health Equity", and "Healthy Community" and then engaged in a "Glow and Grow" activity". The goal of this exercise was to encourage members to begin thinking of what their ideal vision was for the community when it came to health, and to indicate if certain definitions "glowed", meaning they were great as is, or if they needed to "grow", and needed further expanding. An image of the activity can be seen below.



Updated definitions based on responses from the activity are:

COMMUNITY

A group of people who live in the same geographical place and share a mutual concern for one another's welfare.

HEALTH

A state of physical, cognitive, emotional, and social wellbeing and not merely the absence of disease or infirmary.

HEALTH EQUITY

Everyone having a fair and just opportunity to be as healthy as possible.

HEALTHY COMMUNITY

One in which local groups from all parts of the community work together to prevent disease and make healthy living options accessible.

OVERSIGHT OF CHIP

The Community Health Improvement Plan (CHIP) will be monitored and evaluated annually. Each health priority has a dedicated workgroup to complete the strategies outlined in the workplans in this plan.

Adventist HealthCare

DHHS Montgomery County Department of Health and Human Services

healthy montgomery

HC HOLY CROSS HEALTH
A Member of Trinity Health

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