Mary Washington Healthcare, in compliance with the Internal Revenue Service regulations related to section 501(r) of the Affordable Care Act, created the following document to provide a road map on how it will use the findings of the Rappahannock Region Health Needs Assessment to ensure it is meeting the needs of the communities it serves.

Community Health Needs Assessment Summary

Mary Washington Healthcare and the Rappahannock Area Health District launched the Rappahannock Region Community Health Needs Assessment in January 2015. The Rappahannock Region was charged with completing a Community Health Needs Assessment to identify high priority healthcare needs within the regional Mary Washington Healthcare service area. The Rappahannock Region is financially supported by Mary Washington Healthcare, the Rappahannock United Way, the Rappahannock Area Community Services Board, GEICO, Rappahannock Area Health District, Mary Washington Hospital Foundation, and Spotsylvania Regional Medical Center. The Health Communities Institute out of Stanford University was contracted to facilitate planning meetings, gather and analyze related data, and manage project timelines and schedules.

The Rappahannock Region established two committees: Advisory and Steering, The Rappahannock Region Advisory Committee comprises 40 community volunteers representing regional hospitals, health departments and insurers, private businesses, community-based organizations, and healthcare and mental health services providers. The Rappahannock Region Steering Committee includes representatives from Mary Washington Healthcare, the United Way, GEICO, the Moss Free Clinic, the University of Mary Washington, Spotsylvania Regional Medical Center, and the Rappahannock Area Health District.

Data Collection for the Rappahannock Region Community Health Needs Assessment focused on the following areas: community input, vital statistics, reasons for doctor and clinic visits, risk factors for common illness, lifestyle improvements, and localities where residents were not meeting established health targets. Some data is available only on the countywide level but still provides valuable information. Both qualitative and quantitative data were collected between April and August 2015.

Qualitative primary research:
The qualitative primary research for the 2015 Community Health Needs Assessment was conducted by key informant interviews with community leaders from public and private organizations selected for the Rappahannock Region Advisory Committee and engagement of Mary Washington Healthcare's Citizen Advisory Council, along with solicited community input.

Secondary data and information sources:
Information was obtained from a number of different sources such as the Healthy Communities Institute's Community Health Information Resource tool (CHIR), the Virginia Department of Health, the American Community Survey, the Urban Institute, Healthy People 2020, and information supplied directly from a sample of healthcare service providers within the defined community.

Prioritizing Health Needs

The Steering Committee of the Rappahannock Region reviewed and established decision-making criteria to guide their discussions regarding identification of the region's highest priority healthcare needs. The criteria that follow are not listed in order of priority:

1. Magnitude of the identified priority
2. Severity of the problem – the risk of morbidity and mortality associated with the problem
3. Alignment of the priority with the community's strengths and health priorities
4. Impact of the identified priority on vulnerable populations – health care disparity
5. Importance of the priority to the community
6. Existing resources addressing the identified priority
7. Relationship of the priority to other community issues
8. Affordability of intervention strategies
9. Potential for short-term and long-term impact on the community

The criteria yielded **The Top Three Health Priorities** identified through the Rappahannock Region Community Health Needs Assessment:

1. **Access to Health Services and Preventative Care**
2. **Behavioral Health and Behavioral Disorders**
3. **Exercise, Nutrition and Weight**

Addressing the Top Three Health Needs

Mary Washington Hospital and Stafford Hospital organized its implementation strategy around Mary Washington Healthcare's core Community Benefit objectives established for years 2019-2022. Utilizing the resources of Mary Washington Hospital and Mary Washington Healthcare's Centers of Excellence, all Top Three Health Needs will be addressed during the three-year period. The Mary Washington Hospital Implementation Strategy will target persons living in the City of Fredericksburg and the counties of southern Stafford, Spotsylvania, Caroline, King George, Westmoreland, and eastern Orange. Not all Community Benefit Programs listed in the implementation strategy will be held on the campus of Mary Washington Hospital. Promotion of activities and data collection will reflect the targeted communities described above and may result in the development of new sites based upon interest and need.

Internal and external strategies (See Note) along with related anticipated outcomes, identified community partnerships, and specific programs/activities for each Community Benefit outcome describe how the health needs are being addressed. The utilization of the Community Health Information Resource (CHIR) tool is encouraged to provide the ability to benchmark those specific diseases and conditions where a measurement or comparison is available to objectively evaluate the effectiveness of these strategies.

The implementation strategy is reviewed by the Mary Washington Healthcare Board of Trustees. Findings from formal evaluations of each Community Benefit program and continuous engagement of community

stakeholders influence modifications to the implementation strategy. The implementation strategy is approved annually by the Mary Washington Healthcare's Board of Trustees.

Note: Mary Washington Healthcare considers efforts to support its patients and Associates part of its commitment to the community. Therefore, while programs/activities that are open to the broader community (external strategies) are only reportable to the Internal Revenue Service, Mary Washington Healthcare includes internal strategies targeting only its patients and Associates in addition to reportable external strategies.

Mary Washington Healthcare Community Benefit Objectives

Create, promote, and make available educational programs to community groups. These presentations will specifically address health needs identified in the Rappahannock Region Community Health Needs Assessment.

1. Facilitate **access** to **preventative health-related** services for uninsured/underinsured, while supporting a stronger community referral process and creating **population health** programs.
    1. MWHC supports programs that are continuing to expand our understanding of the many different social, economic and environmental factors which shape our communities health, and empowering communities nationwide with the data, knowledge and tools they need to enable everyone to live the healthiest life possible. MWHC will work to help identify and address the root causes of our communities' health disparities.
    2. MWHC will focus on eliminating racial/ ethnic health disparities in maternal-fetal health for our PD 16 residents

2. Improve access to **behavioral health and behavioral disorders**, both directly and in providing support for community initiatives.

    1. Inform seniors and their caregivers of relevant issues including understanding of mental changes associated with aging, end-of-life decisions, and community resources.

    2. Support the initiatives of community outreach programs that address behavioral health in youth and young adults.

3. Increase focus on **exercise, nutrition, and weight** for improving and maintaining health.
    1. Increase diabetes education and screening opportunities targeting both pre-diabetes/diabetes populations with a focus on programming that addresses nutrition and obesity from birth through adulthood.
    2. Increase healthy food options to targeted PD 16 food deserts.
    3. Strengthen existing community partnerships to increase access to exercise programs and facilities in PD 16.

Community Benefit Objective 1: Facilitate access to health-related services for uninsured/underinsured, while supporting a stronger community referral process and population management.

Top Health Need:

Objective 1 will specifically explore ways to improve access to primary care providers in the Mary Washington Hospital community as well as develop processes to improve the coordination of care for uninsured and/or underinsured patients.

Internal Strategies:

1. Explore opportunities to partner with local primary care physicians and safety net providers to establish referral patterns for all unassigned patients being discharged from the emergency and inpatient departments at Mary Washington Hospital.
2. Provide community resources information to all identified, uninsured/underinsured MWHC patients.
3. Work with internal departments to collect Social Determinants of Health data (including language Race, Ethnicity).

External Strategies:

1. Collaborate with various community service groups and safety-net providers to streamline enrollment processes for financial assistance programs taking into consideration current criteria for various social service programs
2. Host information sessions for community groups and advocates to raise awareness of MWHC's Patient Financial Assistance Programs (PFAP).
3. Raise awareness of community resources, including education related to insurance access
4. Partner with community stakeholders to create initiatives that address the Social Determinants of Health (SDoH) to the health outcomes and reduce readmission rates.

Anticipated Primary Outcomes:

- Improve health status of patients by establishing medical homes resulting in reduced readmission rates for patients seeking primary care follow-up in emergency departments.
- Better understanding of community health-related services in the community and appropriate use of medical services
- Increased participation in **Medicaid/Medicare Expansion** products, **MWHC's Patient Financial Assistance** Programs as compared to last year.
- Increased coordination of care for uninsured/underinsured patients navigating various free or reduced-fee community services.
- Increase transition care plans for all eligible patients.

Community Benefit Tactic(s) 2019-2022

1. Develop a partnership between MWHC, key safety- net providers, willing community physicians, and other community partners that will

encourage a coordinated continuum of care for uninsured/underinsured.

2. Collaborate with The MWHC Alliance to create an intentional plan to address transitional care plans for our patients and the community.

Potential Core Evaluation Metrics

Access to Care Health Coverage

- Children without health coverage
- Adults without health coverage
- Adults without dental coverage
- Access to Services Adults who delayed care due to cost
- Population in poverty living in primary care shortage areas
- Adults without a usual primary care provider
- Avoidable hospitalizations
- Average travel distance to hospital-based birthing services

OUTCOMES TO DATE

Due to COVID-19 Pandemic this and all plans are being re-evaluated to address the needs of the pandemic.

Community Benefit Objective 2: Improve access to behavioral health services, both directly as well as in providing support for community initiatives.

Top Health Need:

Mental health and mental disorders will be addressed in Objective 2. Resources at Mary Washington Hospital and Snowden at Fredericksburg will play a critical role in addressing this objective.

Internal Strategies:

1. Increase capacity and services provided to promote access at Snowden of Fredericksburg to reduce referrals to other facilities due to the lack of beds or specialty services.
2. Continued mental health assessment and physician-requested consultations for disposition with referrals for appropriate services
3. Provide expertise and awareness about mental health and mental disorders as they address specific community mental health concerns.

External Strategies:

1. Continue community-based collaborations with such organizations as the Rappahannock Area Community Services Board, regional utilization management teams, and Mental Health of America and to improve coordination of care and increase access to behavioral health services
2. Continue to provide free mental health assessments and screenings to individuals in the community with appropriate referrals to services offered in the community.
3. Continued grant support for 24-hour Crisis Hotline with professional therapists to address immediate, behavioral health needs of community, including referrals to appropriate programs.
5. Continue to partner with Be Well Rappahannock to continue the Opioid crisis taskforce and continue to align with the initiatives.
6. Support the development of a strong mental health workforce with trainings and internships

Anticipated Primary Outcomes:

- Community members will have increased knowledge and awareness of key mental health signs and symptoms as well as a better understanding of services available.
- To have a more resilient community that can support one another through mental health trauma and substance abuse.

Potential Core Evaluation Metrics

Substance Use Disorder

- Drug Overdose Deaths
- Drug Overdose Hospitalizations
- Substance Use Disorder Hospitalizations
- Liver Disease Deaths
- Alcohol-Impaired Driving Deaths

Mental Health

- Depression
- Suicide
- Suicide attempts

OUTCOMES TO DATE

Due to COVID-19 Pandemic this and all plans are being re-evaluated to address the needs of the pandemic.

Community Benefit Objective 3: Exercise, Nutrition, and Weight Increase diabetes education and screening opportunities targeting both pre-diabetes/diabetes population with a focus on programming that addresses nutrition and obesity from birth through adulthood.

Objective 3 will address both diabetes and obesity through its strategies and programs. Resources from MWHC's Diabetes Management Program will be critical in implementing the following strategies.

Internal Strategies:

1. Provide referrals to Community Benefit programs that address diabetes and obesity prevention to/management to adult patients

2. Promotion of Health & Wellness initiatives related to nutrition and fitness for MWHC Associates

External Strategies:

1. Conduct diabetes-related health screenings in the community
2. Provide diabetes and obesity related support
3. Raise awareness and provide access to healthy food seminars, classes and town halls
4. Advocate for area-wide "health living" campaign
5. Supply educational training related to nutrition counseling for the community
6. Provide community-wide blood pressure screens

Anticipated Primary Outcomes:

- Improved understanding of nutritional needs to reduce on-set of diabetes, as measured by pre- and post-test analysis with Community Benefit program participants.
- Increased knowledge of new and healthy foods to low-income youths and their families using access to free fruits and vegetables, recipe/cooking tips and social media reminders.
- Improved self-efficacy of diabetes management, as measured by pre/post-test analysis

Community Benefit Tactics 2019-2022:

1. Continue to host "Kids for a Cure Diabetes" Summer Camp in order to promote healthy management of diabetes and provide educational resources to help children manage their health. (MWHC Diabetes Management Program and Diabetes and Obesity work group)
2. Participate in the "Balanced Living with Diabetes" program
3. Work with the area YMCA to enroll eligible patients into the YMCA LEAN and Exercise program

Potential Core Evaluation Metrics

Cardiovascular Disease

- Adults with hypertension Hospitalizations for hypertension
- Hospitalizations for stroke Deaths due to stroke
- Preventable deaths from heart disease, stroke, or hypertensive disease

Diabetes

- **Adults with diabetes**
- **Adults with pre-diabetes Hospitalizations for diabetes**

Diet, Exercise, and Weight

- Adults consuming 5+ servings of fruits and/or vegetables per day
- Physical activity
- Adult overweight and obesity

Tobacco, e-cigarettes, and Vaping Smoke tobacco

- Adults using e-cigarette or vaping delivery systems

OUTCOMES TO DATE*

Due to COVID-19 Pandemic this and all plans are being re-evaluated to address the needs of the pandemic.