

Fort Washington Medical Center
2017-2019 Community Health Needs
Assessment Implementation Strategy



Fort Washington Medical Center (FWMC) participated in the 2016 joint Community Health Needs Assessment (CHNA) with the Prince George's County Health Department. The CHNA Process was developed to 1) maximize community input, 2) learn from the community experts, 3) utilize existing data, and 4) ensure a comprehensive community prioritization process. The Prince George's County Health Department staff led the CHNA process in developing the data collection tools and analyzing the results with input from representatives from FWMC and other area hospitals.

(The Prince George's County 2016 joint community health needs assessment can be found here: <https://www.princegeorgescountymd.gov/Archive/ViewFile/Item/2884>)

The completion of the Prince George's County Community Health Needs Assessment was instrumental in obtaining community involvement and participation in order to affect and improve the community health status for communities in the primary service area for Fort Washington Medical Center including: Fort Washington (20744), Oxon Hill (20745), and Temple Hills (20748).

This assessment produced significant findings and priorities for Fort Washington Medical Center to incorporate in addressing the chronic health care needs and quality of health conditions for its primary and secondary service areas. Analysis of all quantitative and qualitative data provided for identification of five (5) critical areas of need within these primary and secondary service areas. The top priorities noted below are unmet community health challenges that our health care organization is committed to addressing and improving.

The Implementation Strategy is designed to address the "critical" health care needs of the communities serve by FWMC as identified in the CHNA. The Implementation Strategy is not intended to address every need identified for each participating hospital. The following factors were considered in completing the prioritization process.

- **Incidence and Prevalence:** Is the problem affecting a large proportion of community members?
- **Presence and Magnitude of Disparities:** Are some populations disproportionately burdened?
- **Change over Time:** Has the need improved, worsened, or seen no change in recent years?
- **Community Input:** Based on input from the community, what are the most significant areas of need as identified by the community?
- **Existing Resources, Expertise, and Partnerships:** Does FWMC have resources, existing programing, expertise, or existing/potential partnerships that can be leveraged to effectively address the need?
- **Gaps and Resources in the Community:** Are there existing resources sufficiently addressing the need or are additional resources needed? Where specifically do the gaps lie?
- **Potential for Measurable and Achievable Outcomes:** Are there relevant outcome measures? Will it be possible to make an impact?

Based on the prioritization process – which is attached – and input from the community, FWMC has elected to focus on initiatives such as: Health fairs/health education, Diabetes management and counseling, HIV and HCV screening and education, access to care, and TeleHealth by addressing conditions such as Heart Disease, Hypertension and Stroke, Diabetes, Sexually Transmitted Disease, and obesity. To be more definitive, and based on the CHNA, the following health needs have been determined as a priority by FWMC.

Identified Needs:

- 14.3%, or nearly 100,000 adults are estimated to have **asthma** (MD 2014 BRFSS)..
- 13.9% of children are estimated to have asthma (MD 2013 BRFSS).
- In 2011, 3,235 residents were diagnosed with **cancer** in the county, and the cancer incidence rate was 390.0 per 100,000 residents.
- An estimated 11.5% of adult residents (78,525) have **Diabetes** and nearly as **Pre-Diabetes**.
- One in three residents over 65 has **Diabetes**.
- All community input noted **Diabetes** as a leading issue (or the leading issue) in the county.
- **Heart Disease** is the leading mortality rate in the county, and second highest in number (24% of deaths).
- Black non-Hispanic residents have a higher ED visit rate for **Heart Disease**, but White non-Hispanic residents have a higher mortality rate.
- 418 residents were diagnosed with **HIV** in 2013, a rate of 56.2 per 100,000 residents.
- 73% of all new **HIV** cases were men.
- 37.9% of adults (252,160) are estimated to have **hypertension** in the county.
- Over 75% of the residents aged 65+ and nearly half (47.8%) of adults ages 45 to 64 are estimated to have **hypertension**.
- 10.9% of residents (74,502) reported experiencing at 8 days of poor **mental health** during the last 30 days (2014 MDFSS).
- In 2014, there were 51 suicide deaths in the county (**mental health**).
- 34.2% of adults (218,270) in the county are estimated to be **obese**, and an additional 34.1% are considered **overweight**. (2014 MD BRFSS)
- In 2013, 52.6% of adults (310,107) did not meet physical activity recommendations.
- In 2014, 14% of county residents reported binge drinking, and 14.5% indicated they chronically drink (BRFSS).
- There were 855.6 Emergency Room visits per every 100,000 county residents in 2014 for **Substance Abuse Disorders**.

Note: The information above was extracted from the 2016 Prince Georges County Community Health Needs Assessment.

Note 2: MD BRFSS – Maryland Behavioral Risk Factor Surveillance System

FWMC CHNA Priorities	Secondary Chronic CHNA challenges for FWMC
Diabetes Heart disease HIV Mental health Obesity	Alzheimer’s Disease Cancer Chronic Lower Respiratory Disease Hypertension and Stroke Infectious Disease Lead poisoning Maternal and Infant Health Nephritis Oral Health Sexually Transmitted Disease Substance Use Disorder Unintentional Injuries Violence and Domestic Violence

Implementation Strategy Overview: Health Education/Prevention

Identified Needs: Healthy Lifestyles/Improved Diet and Exercise

Goal: Improved Outreach to Primary and Secondary service areas

Objectives:

1. Address the growing need to provide additional preventative health care services to those in the community.
2. Promote and increase awareness of community programs, resources, and services to county residents.
3. To improve community awareness of the different types of available programs and geographic localities

Strategy: Prevention/Education/Awareness

Overview & Activities: Community Health fairs for local schools, community centers, community coalitions, churches and assisted living/retirement facilities

Potential Partners: Area hospitals, agencies on aging, local health department, local health improvement coalitions, faith-based organizations, colleges & universities, as well as behavioral health organizations, social services groups, advocacy organizations, community and health care organizations, Prince George’s County School system, and local government agencies such as human resources, natural resources, and environmental.

Committed Resources:

1. Hospital employee time to attend health fairs, instruct educational classes, and to screen for health issues and concerns.
2. Evidenced- based educational material for all chronic and non-chronic health matters, assortment of brochures and pamphlets.
3. Equipment such as glucometers, blood pressure cuffs, tele-health cameras, and monitors.
4. One-on-one counseling by hospital staff and physicians.
5. Promotion of the programs and activities available to patients at FWMC.

Planning for Action & Monitoring Progress

AREA OF NEED	ACTION	EVALUATION
HIV & HCV Awareness & Reduction	Testing/screening through FWMC Emergency Department	#of workshops # of individuals screened # of positive HIV patients identified; # of positive Hepatitis C patients identified
Improved access to care for county residents	Initiated primary care/urgent care facility; recruited nurses & MD's; pursued HSCRC nursing grant; secured Gilead HIV grant; TLC Transition Grant; launched a quarterly CME educational series for affiliated physicians on access concerns, health disparities & wellness	Improved screening/identification of chronic conditions; distribution of more robust patient education & support
Wellness program; nutritional health education; obesity; physical activity & healthy lifestyle	Education programs through registered dietitians; community walking program; free yoga classes for the community; one (1) event per quarter specific to Diabetes & nutrition. Weight loss & exercise challenge programs provided to staff & community (mindful mile)	Improved awareness through advanced marketing efforts; alignment with the FWMC mission and vision to ensure high quality health care services for the health and wellbeing of the community; increase the number of classes and activities offered to patients; and solicit patient feedback and ideas
Increased awareness of mental health within the communities we serve	Staff training – health care providers & staff; provide mental health screening & resources; initiated tele-psych program & recruited psychiatrist	# of people screened # of positive screens # of referrals
Totally Linking Care; Population Health & Transitional Care Program	Medical care coordination provided by a collaborative anchored by five (5) community hospitals including Fort Washington; community health workers; medical devices & community partners; medication management & patient navigation	Reduction in hospital readmissions by providing additional education before a is released ; improved patient and staff education of medication management; adoption of health behaviors; and number of patients enrolled in our programs

Additional Areas of Need That Cannot be addressed by Fort Washington Medical Center

While Fort Washington Medical Center (FWMC) has identified primary service areas (Fort Washington, Oxon Hill, and Temple Hills) as its priority areas for this Implementation Strategy period, the hospital will continue to address other areas of need through existing community health outreach programs, education, screenings, and financial contributions. Our overarching approach will be to focus on community health initiatives that provide health equity, eliminate care disparities, involve community health workers, reduce violence and improve safety, and continue to meet patient's needs and our health system needs through community collaborations in order to advance health.

- 1. Maternal/Child Health** – Fort Washington Medical Center currently does not address maternal/child health mostly due to a lack of resources and strategic imperatives. Maternal/child health needs are being filled by other healthcare organizations and systems in Virginia, DC, and parts of Maryland. Nexus – Fort Washington Medical Center has partnerships with area organizations providing these services to ensure various maternal/child health concerns are met timely.
- 2. Cancer Care** – Fort Washington Medical Center cancer outreach program currently consists of educational programs for various churches in our service area, whereby presentations, demonstrations and educational material is provided. There are opportunities for future breast care services as well as colorectal screenings for low income, uninsured/uninsured individuals 50 years and older.