

Fort Washington Medical Center

2020-2022 Community Health Needs Assessment Implementation Strategy

Adopted June 30, 2019



Implementation Strategy Development & Adoption

As a requirement of the Patient Protection and Affordable Care Act, not-for-profit hospitals such as Fort Washington Medical Center (FWMC), must participate in a Community Health Needs Assessment (CHNA) every three (3) years. The most recent health assessment was conducted by the Prince George's County Health Department in 2019. While the CHNA data is inclusive of Prince George's County, FWMC is focused specifically on the health needs of individuals living in the service areas of Fort Washington (20744), Oxon Hill (20745), Temple Hills (20748), and Accokeek (20607). FWMC serves 14.6 percent (133,101) of the residents in Prince George's County (912,756), and its largest population is African American, and then Hispanic and white.

Based on the results of the CHNA, the Executive team developed an implementation strategy, which identifies initiatives FWMC is undertaking to improve disparities for the communities it serves.

Use the following link to access the Prince George's County 2019 joint Community Health Needs Assessment. Participating hospitals include, Doctors Community Health System, MedStar Southern Maryland Hospital Center, University of Maryland Capital Regional Health, Prince George's County Health Department, and Prince George's Healthcare Actional Coalition Leadership. https://www.fortwashingtonmc.org/wp-content/uploads/2019/06/FINAL_-2019-Prince-Georges-CHNA.pdf

The following factors were considered in completing the prioritization process.

Incidence and Prevalence	<ul style="list-style-type: none">• Is the problem affecting a large proportion of community members?
Presence and Magnitude of Disparities	<ul style="list-style-type: none">• Are some populations disproportionately burdened?
Change over Time	<ul style="list-style-type: none">• Has the need improved, worsened, or seen no change in recent years?
Community Input	<ul style="list-style-type: none">• Based on input from the community, what are the most significant areas of need as identified by the community?
Existing Resources, Expertise, and Partnerships	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Are there relevant outcome measures? Will it be possible to make an impact?

2019 CHNA Prince George's County Health Care Priorities

Completion of the 2019 CHNA revealed four (4) health care priorities for Prince George's County. Data below show areas that have worsened since the previous Assessment in 2016. The data below is the most updated data released by the health department.

Priority 1: Social Determinants of Health

Resident to Provider Ratios increased for primary care and mental health providers

- In 2013, 1 primary care provider for every 1,860 residents; in 2015, 1 primary care provider for every 1,910 residents
- In 2015, 1 mental health provider for every 860 residents; in 2017, 1 mental health provider for every 890 residents

High School Graduation Rate for Hispanic students decreased: from 67.4% (2015) to 65.9% (2017); Hispanic students have a much lower graduation rate compared to other races and ethnicities

Fair Market Rental Pricing increased substantially: for an efficiency unit, rental pricing increased from \$1,167 (2015) to \$1,504 (2018)

- The median income for a renter in the county is \$53,774 (2018), which falls short of the median income needed for an efficiency unit by more than \$6,000 (\$60,160 estimated income needed)

Priority 2: Behavioral Health

Adults with Poor Mental Health Days have increased:

- 3-7 Poor Mental Health Days increased from 9.8% (2014) to 10.8% (2017)
- 8-29 Poor Mental Health Days increased from 7.7% (2014) to 8.8% (2017)
- 30 Poor Mental Health Days increased from 3.2% (2014) to 3.9% (2017)

High School Students Who Seriously Considered Suicide increased: from 14.7% (2014) to 17.7% (2016)

- Disparity: 21.7% of White Non-Hispanic (NH) students reported seriously considering suicide, followed by students of Other Races (20.4%).

High School Students Bullied on School Property increased: from 12.1 % (2014) to 14.5% (2016)

- Disparity: More White NH students reported being bullied (24.8%)

Total Behavioral Health ED Visits increased by 23%: from 6,842 (2014) to 8,420 (2017) for residents going to Maryland hospitals

Drug-Related Mortality Rate increased: from 6.4 deaths per 100,000 (2012-2014) to 12.2 (2015-2017)

- Disparity: White NH residents have the highest mortality rate at 32.1 per 100,00 (2015-2017)

High School Students Who Used Prescription Drugs without a Doctor's Prescription increased: from 13.9% (2014) to residents (2014) to 15.6% (2017)

Priority 3: Obesity and Metabolic Syndrome

Adult Obesity Prevalence has increased: from 34.2 (2014) to 42.8% (2017)

- Disparity: Black, NH residents have the highest prevalence at 46.7%

High School Student Obesity and Overweight Prevalence have increased: from 15.1% (2014) to 16.4% (2016) for obesity, and 17.4% (2014) to 19.1% (2016) for overweight; overall, one in three high school students are overweight or obese in the county

- Disparity: Hispanic students were more likely to be obese or overweight

Diabetes Prevalence has increased: from 11.5% (2014) to 12.3% (2017)

- Disparity: Hispanic residents had a higher prevalence at 16.7%

Stroke Mortality Rate has increased: from 37.8 deaths per 100,000 (2012-2014) to 41.6 (2015-2017)

- Disparity: Black NH residents have the highest mortality rate at 44.2 per 100,00

Hypertension Emergency Department Visit Rate has increased: from 261.7 visits per 100,000 residents (2014) to 351.2 visits (2017) (ED visits include all Maryland hospitals); the ED visit rate increased for those ages 40 to 64 years from 377.3 (2014) to 433.9 (2017), and for residents ages 65 and over from 670.2 (2014) to 885.8 (2017)

Priority 4: Cancer

Screening for Breast and Prostate Cancer has declined: from 83.7% of women 50+ with a mammogram in past 2 years (2014) to 82.3% (2016); from 49% of men 40+ with a PSA in the past two years to 41.4% (2016)

- Disparity: White, NH residents are less likely to be screened compared to Black, NH residents

Female Breast Cancer Incidence has increased: from 116.1 new cases per 100,000 women (2007-2011) to 121.7 (2010-2014)

- Disparity: Black women have a higher Incidence Rate (126.4) compared to White women (105.0)

Female Breast Cancer Mortality has increased: from 25.6 deaths per 100,000 women (2012-2014) to 25.8 (2015-2017)

- Disparity: Black women have a higher Mortality Rate (28.2) compared to White women (22.4)

Prostate Cancer Mortality has increased: from 26.0 deaths per 100,000 men (2012-2014) to 27.9 (2015-2017)

- Disparity: Black men have a Mortality Rate (36.3) twice that of White men (16.5)

Source: Prince George's County 2019 Community Health Assessment Resident and Community Expert Surveys

Significant Community Health Needs Identified

The CHNA identified heart disease, diabetes, stroke, and hypertension as underlying health indicators for the FWMC service areas. Secondary countywide health indicators that also affect the FWMC service areas are breast cancer, prostate cancer, HIV, STI's, senior health, and asthma. To develop the hospital-specific prioritizations, FWMC assessed whether they align with the overall priorities of the county, prior improvements and outcomes, existing programs and services, and opportunities for collaborations.

Additionally, FWMC examined its SocioNeeds Index, which ranks zip codes from 0 (low need) to 100 (high need) – as well as its service area profile. The service area profile, which identifies income, demographics, diagnosis, and education – found that Oxon Hill, one of its four service areas has: (1) more families below the poverty line; (2) more residents without a high school degree; (3) more unemployed; and (4) a substantially lower median household income compared to the county. Oxon Hill's SocioNeeds Index is 72.4, well above the country's average, which is 50.

Considering that FWMC serves 14.6 percent (133,101) of the residents in Prince George's County (912,756), and based on the CHNA results, Service Area Profile, and the ability to sufficiently address care and close disparity gaps, FWMC will focus on the following health needs priorities (in no particular order).

- Access to Care
- Community Engagement
- Infectious Diseases (HIV/HEP C)
- Mental Health
- Obesity (Diabetes, heart diseases, stroke)
- Telehealth

Implementation Strategy Overview: Health Education/Prevention/Awareness

Goal: To educate, increase awareness, and provide accessible resources to prevent and/or manage (preventable) illnesses such as chronic diseases.

Objectives:

- Increase engagement with organizations that can help fill the gaps in access to care, i.e. transportation and civic groups.
- Create programs/methodologies that will increase access to care.
- Increase community outreach activities by specifically targeting deficient/disparity areas.
- Convert community outreach residents into healthy patients.

Strategy 1: Mental Health Evaluation & Referral Program

- a. Work with county experts to develop and implement a mental health referral program.
- b. Partner with area organizations, physicians, physician groups, etc., to provide mental health service referrals based on evaluations initially conducted by FWMC.

Potential Partners: Adventist Behavioral Health and Wellness, Urban Behavioral Associates, and Prince George's County Health Department

Strategy 2: [Telemedicine Program](#)

- a. Telemental health services are provided through a partnership with Adventist Healthcare. Behavioral health patients often present in crisis to the FWMC emergency department. These patients are assessed and placed in facilities as needed via this program service.
- b. Other consult services are being considered.

Potential Partners: Adventist Behavioral Health and Wellness, Urban Behavioral Associates, and Prince George's County Health Department

Strategy 3: [Community Survey](#)

- a. Survey residents within the FWMC service areas to glean what programs and community services are demonstrating impact; i.e. are they positively impacting quality of life.

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. Participate in community health events that specifically target deficient demographics.
- 2. Distribute impactful, evidenced-based educational materials via print and online.
- 3. Distribute health care equipment, i.e. glucometers, blood pressure cuffs, tele-health cameras, and monitors – things considered costly for some demographics.
- 4. Provide counseling services.
- 5. Leverage Public Relations/ media platforms.

Measures of Success:

- 1. Establish benchmarks.
- 2. Provide quarterly quantitative measurements.
- 3. Provide quarterly cost of implementation and management.
- 4. Review and implement, when necessary, alternative courses of action.
- 5. Provide reports of rationale for deficiencies and/or improvements.

Plan of Action & Monitoring Progress

AREA OF NEED	ACTION	EVALUATION
Infectious Diseases (HIV & HCV Awareness & Reduction)	Patients have access to free testing/screening through FWMC Emergency Department; participate in targeted community health fairs that address priority needs; program outreach through online and print marketing	# of individuals screened through the ED # of individuals screened through community events # of positive HIV /HCV patients identified along with linkage to care
Access to Care	Patients have an additional way to seek immediate treatment through the FWMC/NOW primary care/urgent care facility; recruitment of highly qualified nurses and doctors; pursuit of HSCRC nursing grants; management of Gilead HIV grant; management of TLC Transition Grant; host quarterly CME educational series for affiliated physicians on access concerns, health disparities and wellness; and referral partnerships with area physicians who can provide specialty services	# of total re-admission rates # of patients screened # of patients diagnosed with chronic conditions # of positive HIV /HCV patients identified along with linkage to care # of CME opportunities offered # of providers who utilize CME opportunities offered by FWMC
Wellness Program	Patients have access to a free Diabetes Education Program managed by registered dietitians, and certified diabetes educator; community walking program, free yoga and Zumba classes for the community; host one (1) event per month specific to Diabetes and nutrition; weight loss and exercise challenge programs provided to staff and	# of classes held # of participants in the Diabetes Education Program, which is measured through physician referrals and class sign-in sheets. Lab values are obtained by a health care provider and are then shared with the CDE every 3-4 months or so, who evaluates if progress has been made. Blood Pressure control is tracked through the AHA database. The

Plan of Action & Monitoring Progress

AREA OF NEED	ACTION	EVALUATION
	<p>community</p> <p>The diabetes educator will continue to work collaboratively with health care providers within the community and community centers. Assist those within the community in practicing the 7 Self-Care-Core Behaviors and Goals to achieve and maintain normal hemoglobin A1c and cholesterol levels. Partner with the American Heart Association to assist individuals with maintaining good blood pressure control. Provide the community with appropriate resources through the collaboration of the CDE with pharmaceutical companies to provide glucometers and educational materials along with the local pharmacies to assist those in need of low cost diabetes medications.</p>	<p>CDE has access to the information and can follow-up with physicians and participants regarding progress and modifications that may need to occur. The tracking of glucometers and low cost medication cards will be done through documentation of the number of glucometers given on a monthly basis along with the number of medication assistance cards given.</p>
<p>Mental Health (Increased awareness of mental health)</p>	<p>Conduct staff training; development of referral program and evaluation/screening program; continue psych program and partner with psychiatry.</p>	<p># of people screened through ED # of in-patients who also receive psych evaluations # of Psych consults # of referrals and transfers</p>
<p>Care Transition</p>	<p>Partner with Totally Linking Care collaborative, a population health and transitional care program anchored by 7 community hospitals including FMWC, community health workers,</p>	<p># of patients enrolling in TLC program prior to discharge, thus reducing hospital readmissions; # of patients enrolled in program to address specific health and social needs; # of engaged pharmacist to ensure</p>

Plan of Action & Monitoring Progress		
AREA OF NEED	ACTION	EVALUATION
	medical devices and community partners; and medication management and patient navigation	patient medication therapy management; and provide resources and follow-up once patients are discharged

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

Through community collaborations, FWMC’s will continue focusing on community health initiatives that provide health equity, eliminate care disparities, and engage community health workers, in order to advance health care in the county and improve outcomes. There are priority areas FMWC is not sufficiently able to address.

1. **Social Determinants of Health** – FWMC currently does not provide programs and services that directly address all of the social determinants of health identified in the CHNA. For example, FWMC does not have programs that address, employment, housing, and access to food. The hospital does provide counseling for patients without insurance and access to Medicare and other programs. In addition, provides community outreach that promotes access to care through its free Wellness Program and building healthy communities.
2. **Cancer Care** – FWMC currently provides cancer care as part of the services offered including mammography, general surgery, and routine acute care. The hospital does not have a comprehensive cancer care program and it is currently cost prohibitive to develop one. The current cancer outreach includes providing preventative information to civic groups, and faith-based entities via presentations, demonstrations, and educational material.

A Nexus Health Company

FWMC

FORT WASHINGTON MEDICAL CENTER



Mission: Our mission is to ensure high quality, compassionate and responsive health care services dedicated to advancing the health of our community customers.

Vision: We aim to be recognized as a superior, innovative health care system exhibiting excellence in patient care and safety, illness prevention, and the wellness needs of our communities.

2018 At-A-Glance

400	Employees
7,180	Inpatient Patient Days
2,064	Admissions
3.48	Average Length of Stay
53.2	Occupancy Percentage
66.2	Adjusted Occupancy Percentage
1,690	Inpatient & Outpatient Surgeries
1,417	Observation Visits
37,912	Emergency Room Visits
29,766	Ancillary Services

Safety and Quality Achievements

Healthgrades five-star commendation in orthopedics for treatment of hip fractures

Healthgrades five-star commendation in cardiac for treatment of heart failure

Healthgrades Patient Safety Excellence Award™

Healthgrades five-star commendation for gallbladder removal surgery

Health Quality Innovators Award for prevention of falls

Fort Washington Medical Center is a community-based, not-for-profit, acute care hospital in Prince George's County, Maryland serving patients in the Fort Washington, Oxon Hill, Temple Hills, and Accokeek areas, as well as parts of southeast Washington, DC. We provide general inpatient services including adult medical and surgical care, ambulatory surgical services, laboratory, radiology and diagnostic services, as well as gastrointestinal, orthopedic, plastic, rehabilitation, and respiratory therapy. Specialty services include gynecology, neurology, urology, and ophthalmology. Two prominent community-based programs include at no cost, an outpatient Diabetes Education Program and an Infectious Diseases Program (HIV and Hepatitis C testing/education).