Frederick Memorial Hospital
Community Health Needs Assessment
Implementation Strategy
FY2016-2019

Approved September 27, 2016
Introduction:

Since 1902 Frederick Memorial Hospital (FMH) has provided health care to the residents of Frederick County. As the only acute care hospital in the county and within a 25 miles radius of Frederick City, FMH’s mission is to contribute to the health and well-being of the community it serves by providing quality healthcare in a caring, cost efficient, safe and convenient manner. FMH uses a coordinated program of prevention, diagnosis and treatment, rehabilitation, and support.

In 2016 FMH conducted a Community Health Needs Assessment (CHNA) in partnership with the Frederick County Health Department to better understand the specific health needs of the community. In addition to the CHNA, FMH is required, in accordance with section 501(c)(3) of the Internal Revenue Code, to develop an Implementation Strategy that addresses the key findings brought forward in the assessment.

Strategic Priorities:

The themes throughout the CHNA presented themselves as three strategic priorities:

1) Access to Care
2) Health Care Navigation
3) Community Outreach and Health Literacy

All of the CHNA topic area and key findings below fall into one if not all of the strategic priorities listed.

Frederick County Priority Setting Summit:

On September 13, 2016 the Frederick County Health Department, with support from FMH, hosted more than 100 healthcare providers, administrators, non-profit leaders, health officials, government agency representatives and community members of Frederick County to review the findings of the CHNA.

Although we agree that all health needs are important, the goal of the summit was to prioritize the areas of focus for the community at large. The general consensus for community collaboration was to focus on addressing the social determinants of health, which ultimately impact the prevalence and severity of mental health, substance abuse, and chronic disease.

The top three priorities which received the most votes are:

• Behavioral Health
• Elderly Support
• Adverse Childhood Experiences

FMH will support a subset of those priorities as outlined in the Implementation Strategy Summary grid. The Frederick County Health Department and other community partners are actively working on their specific subsets. FMH will continue to actively support and participate in the county level work groups. The implementation strategy is intended to be a fluid document that continues to evolve as these findings are further interpreted and understood.
<table>
<thead>
<tr>
<th>Frederick County Needs Assessment Key Findings</th>
<th>Goal</th>
<th>Strategic Priority</th>
<th>Response to Community Need</th>
<th>Method of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Care</td>
<td>Improve access to adult dental care, in the right place, right setting, right time</td>
<td>Access to Care/Health Navigation</td>
<td>Refer to Monocacy Health Partners Dental clinic offered to uninsured/underinsured &gt;200% FPL, Frederick county residents age 18 and older</td>
<td># of participants treated in dental clinic</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Improved Identification and treatment of Mental Health</td>
<td>Access to Care/Health Navigation &amp; Literacy</td>
<td>Embed behavioral health specialists within primary care practices. Implement depression screening tools into practice models; implementation of a Behavioral Health Community Case Manager paired with a partnership with an organization to provide intensive community based case management.</td>
<td># patients referred to Behavioral health specialist # of patients referred to peer recovery specialist</td>
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<tr>
<td>Substance Abuse/Addiction</td>
<td>Improved Identification and treatment of Substance Abuse/Addiction</td>
<td>Access to Care/Health Navigation &amp; Literacy</td>
<td>Peer recovery specialist embedded in hospital; Incorporate Narcotics Anonymous (NA) into inpatient Behavioral Health Unit, establish community connections/support before discharge, Community outreach and education through Team COPE</td>
<td># patients seen by Peer Recovery specialist and continue on with care, # of participants in NA groups, # inpatients identified on opiate withdrawal scale to better support recovery, # of educational offerings. # of patients treated with Naroxone who did not reutilize for substance abuse within last 30, 60, 90 days.</td>
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<tr>
<td>Chronic Disease Management</td>
<td>Increase outreach, education and navigation to vulnerable communities</td>
<td>Access to Care Health Care Navigation &amp; Community Outreach</td>
<td>CARE clinic/Care Transitions program, Bridges program, Community Screenings, Community Health Worker Program, Implementation of programs and partnerships to provide intensive community based case management services to individuals in the home environment.</td>
<td># of participants engaged in care management program; # participants connected to a primary care site; Reduction in hospital utilization (ED, inpatient and readmissions); Improve health attitudes/confidence in self management</td>
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<tr>
<td>Heart Disease and Stroke</td>
<td>Increase outreach, education and navigation to vulnerable communities</td>
<td>Access to Care Health Care Navigation &amp; Community Outreach</td>
<td>CARE clinic, Bridges program, Community Health Worker Program, Pediatric Asthma Camp, Implementation of programs and partnerships to provide intensive community based care management services to individuals in the home environment.</td>
<td># of participants engaged in care management program; # participants connected to a primary care site; Reduction in hospital utilization (ED, inpatient and readmissions); Improve health attitudes/confidence in self management</td>
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<tr>
<td>Lung Disease (COPD/Pediatric Asthma)</td>
<td>Increase outreach, education and navigation to vulnerable communities</td>
<td>Access to Care Health Care Navigation &amp; Community Outreach</td>
<td>CARE Clinic, Bridges, Community Screenings and education, CHW, PreDiabetes Boot Camp and Diabetes Support Groups, FCPS partnership, evaluating other community partners.</td>
<td># patients screened in programs; # attendees at educational offerings; completion of needs assessment for pediatric population (DM prevention)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Increase outreach, education and navigation to vulnerable communities</td>
<td>Access to Care Health Care Navigation &amp; Community Outreach</td>
<td>CARE Clinic, Bridges, Community Screenings and education, CHW, PreDiabetes Boot Camp and Diabetes Support Groups, FCPS partnership, evaluating other community partners.</td>
<td># of patients referred to Lung Cancer Screening program from high risk/vulnerable demographics</td>
</tr>
<tr>
<td>Cancer</td>
<td>Increase outreach, education and navigation to vulnerable communities</td>
<td>Access to Care/Health Care Navigation</td>
<td>Lung Cancer Seminar, Lung Cancer Screening Program, Navigator lung cancer detection education and outreach in community</td>
<td># of patients referred to Lung Cancer Screening program from high risk/vulnerable demographics</td>
</tr>
</tbody>
</table>
**FMH Community Benefits Committee:**
The community benefits committee is comprised of key leaders and front line providers that review requests for FMH participation in community events, outreach and sponsorship. This committee will use the 2016 CHNA implementation strategy to guide them in decision making to allocate resources that align with the identified health needs of Frederick County.

These initiatives include participation in local health fairs and events where we provide screenings, education and navigation to resources in the community and follow up information. For example in 2016 FMH is once again a key partner with the Asian American Center of Frederick at its annual Health Fair. FMH will offer 500 flu vaccine, 300 cholesterol and glucose screenings and bone density screening. *Health Care Navigation, Health Literacy, Community Outreach*

In addition to the implementation strategy summary page, further narrative explanation of response to community needs is included below. Many of these programs were developed to address health disparities and to help us reach vulnerable populations.

**Bridges Lay Health Educator Program:**

FMH established Bridges and the Lay Health Educator (LHE) Program in response to feedback obtained during the 2012 Community Health Needs Assessment indicating that more FMH sponsored programs and seminars needed to be conducted in the community. The assessment showed that the multicultural community wanted and needed to be engaged to improve health and the overall quality of life. This focused new efforts to connect networks and build partnerships to close the gap on health disparities, decrease the incidence of chronic disease and preventable illness, and build a healthier Frederick.

The LHE Program is designed to prepare volunteers from multicultural communities to start or energize health programs in the places that they live, work, worship and gather. Instructors are drawn from the hospital’s physicians, other professional staff, nursing educators, advocacy groups and community physicians.

To date, Bridges has prepared 42 people from 24 different faith based and community service organizations who represent more than 12 countries and languages. Some of the faith and culturally based organizations serve isolated and vulnerable senior populations, while others have health ministry members who perform outreach to local low income communities.

One significant outcome is that people are reaching across racial, religious, and ethnic lines to build new bridges toward better health. Perhaps more significantly, they are now being integrated into other hospital programs that benefit from consumer involvement so that their diverse perspectives can be called upon in building the future of healthcare. *Health Care Navigation & Literacy, Community Outreach*

**Community Behavioral Health Case Management:**
The Community Behavioral Health Case Manager provides intensive community based services to individuals who have recently been hospitalized due to a mental health or substance use related crisis.
FMH also contracts services from Potomac Case Management Inc. to provide similar services to the community as the volume of the need exceeds our available resources. Both the community behavioral health case manager and Potomac Case Management work to engage individuals in the community to coordinate services and remove barriers as they relate to: access to follow-up care and treatment, medications, transportation, health insurance, employment, and overall health and wellness.

*Access to Care, Health Care Navigation, Health Literacy*

**Community Health Worker Program:**
The Community Health Worker is a front line public health worker. Their understanding of unique communities as it relates to culture, language, socio-economic status, and overall challenges the community faces around social determinates result in higher levels of trust and engagement. The Community Health Worker serves as a liaison between individuals/communities and the health and social services systems. They are navigators, advocates, educators, resource gathers, and promoters of improved self-management and independence.

The Community Health Worker Program at FMH will focus on uninsured or underserved individuals as well as those with chronic conditions, including heart failure, COPD, Diabetes, and Asthma, while also working to strengthen the health and wellness of vulnerable communities across Frederick County.

*Access to Care, Health Care Navigation, Health Literacy, Chronic Disease*

**CARE Clinic and Care Transitions Program:**

The CARE Clinic and Care Transitions Program provide comprehensive, multidisciplinary services to individuals with chronic conditions and with limited or no access to necessary healthcare services. Services provided include: health literacy education, medication management, self-management techniques/skills, care coordination and navigation as well as advocacy and navigation to remove financial barriers to care and social determinates of health.

The CARE Clinic is a stable clinic setting within the hospital, while the Care Transitions team provides the same comprehensive service in a mobile environment, in homes, community centers, or in physician practices. The design of the program was created with flexibility in mind, allowing the team to engage individuals in the most appropriate setting.

*Access to Care, Health Care Navigation, Health Literacy, Chronic Disease*

**Lung Cancer Among African American Males in Frederick County**

Research has shown that African Americans are more likely to die from lung cancer than people of any other race or ethnicity, although they are not more likely to smoke. African Americans are disproportionately affected by lung cancer. The percentage of African-American men diagnosed with lung cancer each year is at least 30% higher than among white men, even though they have similar rates of smoking as white men.
In Frederick County, the incidence of lung cancer in African Americans is 66.7 per 100,000. The death rate from lung cancer is 52.8 compared to the Maryland rate of 49.0. Cancer mortality for African Americans in Frederick County increased 60% from 2008 to 2011, and was up 19% from 2010 to 2011.

FMH is going to focus on this vulnerable population by educating African American males about lung cancer and the lung cancer screening program that is offered at the Frederick Regional Health System (FRHS). Education will be provided through community outreach programs that are offered through local churches and civic groups. This education will be provided by the thoracic nurse navigator.

The method of evaluation will be the number of referrals into the lung cancer screening program. This will be monitored by the thoracic nurse navigator. In addition to lung cancer, further analysis and interpretation of health disparities will take place for future programming and outreach.

*Access to Care, Health Care Navigation*

**Monocacy Health Partners Dental Clinic (Part of the Frederick Regional Health System):**

In efforts to reduce unnecessary health care expenditure and over utilization of high cost hospital/emergency department (ED) resources, it is necessary to explore innovative and collaborative approaches to achieve the right care, in the right place, at the right time for our community. Patients seeking access for urgent dental care has been identified as one of the primary diagnoses that could be diverted to less expensive, more appropriate care settings. Despite the local efforts towards improving access to adult dental care, ED utilization at FMH for dental diagnosis has increased over the past three years.

Monocacy Health Partners (MHP) and University of Maryland School of Dentistry (UMD) opened a dental clinic directly across the street from the FMH ED. FMH provides the facility, office staff and operational expenses.

UMD uses the dental clinic as a rotational practicum site for its students. UMD also provides faculty oversight of the students. Local dentists and oral surgeons have been recruited to UMD faculty to support oversight of the clinic.

The intent is to approach the project in two phases. It opened with three operatories, functioning five days per week, with primary focus on urgent care. The second phase will expand to six operatories that will allow restorative and preventive care in addition to urgent care. The phasing of this project will depend on funding and community support. Partners in this effort include several community non-profit organizations, such as the Frederick Community Action Agency and the Religious Coalition.

Over time, the dental clinic is expected to reduce the number of ER visits identified with a dental diagnosis. Patient and community data will be tracked in efforts to continue to meet the needs of our community.

*Access to Care, Health Care Navigation*
Adoption of Implementation Strategy

This report supports and responds to the Community Health Needs assessment conducted by FMH during this fiscal year and has been reviewed and adopted by the FMH Board of Directors.

[Signature]

E. James Reinsch
Chair of the Board of Directors
Frederick Memorial Hospital

Date: 9/30/16