UM - Capital Region Health
Community Health Improvement Plan (CHIP)- 2022

Note: Olive Green shade are UM Capital wide activities; Purple shaded areas are priority initiatives.

			Community Health Infrastructure Development (Internally and Externally Focused)			
Goal	**Target population**	**Objective**	**Activities/Tasks**	**Measure(s)**	**Data Source**	**Community Partners**
Promote Collaboration with Community Health Partners (External Focus)	• Community Partners	• Maintain collaboration with the Health Department and other community health stakeholders • Promote use of the 2023 Community Health Needs Assessment (CNNA) findings to better target community health initiatives • Support the development of effective community health programming • Build a network of non-profit community based organizations (CBOs) in Prince George's County that can help to	• **Participate in existing community coalitions** including Totally Linking Care in MD (TLC), Prince George's County Local Health Improvement Plan (LHIP) • **Identify and develop formal, substantive collaborations with 3-4 community partners** on activities tied to community health priorities and UM Capital population health management (PHM) strategy	• # of current PGC Coalitions UM Capital staff participate in/or lead. • # of hours staff participated in TLC, LHIP and other community coalition events	• CBISA	• Prince George's County Health Department (PGCHD) • Doctors Community Hospital, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center • Community-based organizations including faith-based organizations

Community Health Infrastructure Development (Internally and Externally Focused)						
Goal	Target population	Objective	Activities/Tasks	Measure(s)	Data Source	Community Partners
		carry out Community Benefit strategic initiatives				
Promote Collaboration with Community Health Partners (Internal Focus)		• Increase awareness of UM Capital Community Benefit plans and accomplishments • Develop and encourage participation in Health Wellness lecture series.	• **Develop, market and promote the use of health & wellness lecture series** as a resource/database for community education. • **Collaborate with UM Capital's Community Advisory Council's to** promote awareness and enhance programmatic health and wellness activities.	• # of administrative staff/clinicians included in the Health wellness lectures series. • # of health & wellness events organized.	• **CBISA**	

Priority Area 1: Social Determinants of Health Risk Factors

Long Term Goals Supporting Maryland Statewide Integrated Health Improvement Strategy:
Total Population Health

Long Term Goals Supporting Healthy People 2030: Health Care Access & Quality.
Increase to comprehensive, high-quality health care services.

Goal	Target population	Objective	Activities	Measures	Data Source	Community Partners
Promote Wellness, Behavior Change, and Engagement In Appropriate Care	• Community at-large • Uninsured/ Underinsured populations	• Raise awareness about health risk factors, health promotion, and wellness • Increase the number screened who are referred for further follow-up. • Promote engagement in primary care and behavioral health services. • Raise awareness about mental, emotional, and behavioral risk factors	**1) Health Education and Primary Prevention Activities (overall wellness)** • **Participate in health fairs** for enhanced screening, health literacy, and community education. • **Promote and organize community workshops and educational sessions via health & wellness lecture series** on key health issues with the goal of educating the public and engaging participants in appropriate primary care and specialty care services. • **Work with community partners and schools to organize health education and awareness events** for their populations.	• # of health & wellness lectures focused on health promotion. • # of people linked to care for further follow-up. • # of chronic disease screenings • # of health fairs	• CBISA • Epic	• Prince George's County Health Department • Prince George's County School Districts • Community based organizations • Faith-based institutions • Avanath Capital Management • Maryland National Capital Park & Planning Commission (M-NCPPC)

Priority Area 2: Physical Health and Chronic Disease Management

Long Term Goal Supporting Maryland HSCRC Statewide Integrated Health Improvement Strategy (SIHIS): Total Population Health Diabetes.
Reduce the mean BMI for adult Maryland Residents

Long Term Goals Supporting Healthy People 2030: Preventive Care.
Help people get recommended preventive health care services.

Goal	Target population	Objective	Activities	Measure	Data Source	Community Partners
Increase Physical Activity and Healthy Eating	• Community at-large • Older adults • Children	• Increase the number of children, youth, and adults who are physically active.	2) **Healthy Eating / Active Living Activities** • **Work with community partners to support the Dine, Learn & Move** educational demonstration and lecture series. • **Organize Senior Dining & lecture series** at UM Capital Region facility locations	• # of individuals attending Dine, Learn & Move. • # of individuals attending Senior Dining lecture. • Pre/post knowledge increase	• CBISA • Pretest/Posttest	• M-NCPPC • Community based-advocacy agencies
Improve Chronic Disease Management	• Adults at risk of & living with chronic disease or complex conditions • Low income	• Increase Behavioral Change of adults with or at-risk for developing chronic diseases and other complex conditions. • Increase the number of eligble people completing CDC recognized type 2 diabetes prevention program	3.) **Diabetes Prevention& Management, Cardiovascular Disease & other chronic conditions.** • **Implement and partner with community organizations to conduct National Diabetes Prevention Program** to support health lifestyle change for community members who are pre-diabetic. • **Support, organize & host the Stanford University Living Well** with Chronic Disease Self-Management Education Workshops.	• # of patients participating in chronic disease self-management/lifestyle change programs. • Percentage of DPP participants who lost at least 5% of body weight. • Percentage of DPP participants who reached at least 150 minutes of physical activity each week.	• CBISA	• PGCHD • Community-based organizations, including faith-based organizations
Reduce Cancer Disparities	• At-risk populations, in particular	• Have targeted outreach,	3) **Cancer Screening and Peer Support Programs**	• # of health lectures conducted • # of screenings conducted	• CBISA	• Hope Connections for Cancer

	Black communities	education, and screening for target community	• **Support the development of UM Capital Cancer Service Line** – collaboration with service line for education and awareness workshops. • **Support access to cancer screening** and treatment for target population, including low income, uninsured adults (breast, prostate, colon, and lung cancers). • **Work with community partners to provide emotional support programs** through evidence-based patient and caregiver support programs.			• Breast Care for Washington • University of Maryland Medical System
Improve HIV/AIDS Prevention and Disease Management	• At-risk for HIV infection • Community- at Large	• Improve disease management & healthy lifestyle education for people living with HIV. • Increase early detection of undiagnosed population through increased screenings. • Education to reduce rate of new HIV infections with a focus on high risk populations.	**4.) HIV/AIDS Prevention and Disease Management** • **Provide screening, education/counseling, and treatment services** for those with HIV/AIDS, as well as HIV/HEP C and co-infections. • **Support for men and women living with HIV/AIDS** & co-infections • **Partner with community organizations** to support the development of a comprehensive strategic HIV/AIDS plan	• # of linkages to care • # of HIV screenings conducted in community.	• HIV/HEPC Program	• AHV • Gilead • Us Helping Us • Heart to Hand • PGCHD • Access to wholistic and reproductive health living institute • Other Community Based Organization's

Priority Area 3: Behavioral Health

Long Term Goal Supporting Healthy People 2030: Mental Health & Mental Disorders.
Improve mental health

Goal	Target population	Objective	Activities	Measures	Data Sources	Community Partners
Increase Health Outreach and Education Programs in and Community-based Settings	• Community at large	• Promote engagement in appropriate primary and specialty care. • Educate and increase Awareness in the community of mental health.	5.) <u>**Health Education and Primary Prevention Activities (Behavioral Health)**</u> • **Conduct Mental Health First Aid Workshops** with first responders and staff at community-based organizations • **Support the Let's Talk UMMS Community Health seminar series,** supporting the mental health and health literacy needs of the community	• # of Mental Health First Aid workshops conducted • # educated with MHFA • # attending UMMS Let's Talk Community Health Seminar Series	• CBISA	• Community-based organizations, including faith-based • Local business partners • Prince George's EMS • Prince George's County Schools

Priority Area 4: Physical Safety

Long Term Goal Supporting Healthy People 2030: Healthy Behaviors.
Prevent Violence and related injuries and deaths.

Goal	Target population	Objective	Activities	Measures	Data Sources	Community Partners

Reduce Accidental Deaths	• Community-at-Large	• Reduce Injuries associated with…
		 • Increase safety awareness for motor cycle accidents, bicycle safety, helmet safety and other pedestrian and motor vehicle related incidents
			10.) Injury Prevention & Awareness -
			 • **Participate in health fairs to increase education, awareness a**nd provide tips on how to increase public safety :
			     o Pedestrian & road safety
			     o Motor vehicle crashes/ Distracted Driving
			     o Injury Prevention
			
			 • **Increase education in schools, community centers, senior centers** and faith based institutions through the distributions of educational materials.
			 • **Provide Stop the Bleed education and trainings-** in community settings and in partnership w/ the PGC Police & Fire Department
				• # of people who have been trained on stop the bleed
				 • # of events attended where injury prevention awareness education materials where distributed
				 • # of state collaborations
					• CBISA	• Fire & EMS
						 • PGC Schools
						 • PGC Police Department
						 • Maryland State Highway Patrol
						 • MD, DC & VA , local and State Trauma Centers.

Promote Violence Prevention & Education	• Community at Large. •	• Provide Trauma informed medical/forensic examinations, crisis response and therapeutic care to	**12.) Domestic Violence & Sexual Assault Center** • **Provide case management support** to assist vulnerable population's secure housing support, professional and therapy counseling.	• # of peopled reached	• CBISA • Crisis Counselor Reports • Phone/Therapist Logs	• PGC Police Dept/ Fire department • Governor's office of Crime

| | | survivors of sexual and domestic violence and exploitation. | **Support victim advocacy** in court preceding's. **Provide onsite and 24/7 hotline** crisis intervention **Deploy crisis response** for medical and forensic examinations for domestic and sexual assault victims. | | | Control and Prevention.
• Office of Victim Service & Justice Grants |

Priority Area 5: Maternal & Infant Health						

Long Term Goals Supporting Healthy People 2030: Pregnancy & Childbirth.
Prevent pregnancy complications and maternal deaths and improve women's health before, during and after pregnancy

Goal	Target population	Objective	Activities	Measures	Data Sources	Community Partners
(Improve Education & Access to Prenatal Care)	• Uninsured/underinsured women primarily living in Prince George's County	• Increase access to high-quality prenatal care • Provide education and information on healthy pregnancies, breastfeeding, and early Infant care.	**12.) Mama & Baby Bus Program-** • **The Mama & Baby Mobile Unit serves as a healthcare access point** for under-insured, uninsured and under-served women and children. The Mama & Baby Mobile Unit provides basic, uncomplicated maternal and child health services through partnerships with local community based organizations, shelters, food pantries, faith institutions, schools and institutions of higher learning. • Supportive Pregnancy Program • Doula Program • Post-partum support group	• # of patients seen • # patients referred to care • # Preventive screenings conducted. • # of support group meetings	• EPIC • Satisfaction Surveys	• United Communities Against Poverty/Shepard's Cove Women's Shelter • Laurel Advocacy Services (LARS) • Prince George's Community College • Southern Management Corporation • Prince George's County Health Department • Other Faith-Based & Community based organization

Improve Birth Outcomes	• High-risk Women in Prince George's County • Uninsured/underinsured	• Improve Birth Outcome for high-risk women in PGC • Increase Exclusive Breastfeeding among Prince George's County New Mothers Up to 6 months post-partum for optima development and health of infants	**13.) Breast-Feeding Coalition** • **New monthly UM Capital** breastfeeding education class-once a month (1 hr class) • **Expand course offerings** for community health workers; to include certified lactation consultant (CLC) training class • **Develop and partner** to create county- wide recommendations on the importance of breastfeeding practices.		• Athena Net	• Greater Baden Medical Services • Mary Center's • CCI • Access to wholistic and productive living institute