Dimensions Healthcare System

Laurel Regional Hospital

Community Health Needs Assessment
Implementation Strategy Plan
Fiscal Year 2014-2016

INTRODUCTION

Laurel Regional Hospital (LRH) is a full-service community hospital providing access to high quality healthcare services since 1978. The 166-bed facility located in Laurel, Maryland, is known for its: free standing, award-winning Wound Care and Hyperbaric Medicine Center, the only nationally accredited physical rehabilitation center in Prince George's County and Gladys Spellman Specialty Care Unit – the only specialty care program in the area within a major acute care hospital providing 24-hour physician coverage and pulmonologist-directed recovery of patients.

LRH is a member of Dimensions Healthcare System, the largest not-for-profit healthcare provider in Prince George's County, caring for more than 150,000 patients each year. The System is comprised of two hospital facilities, one emergency medical center and an ambulatory care/outpatient center. The hospital offers a comprehensive range of inpatient and outpatient medical and surgical services, as well as a variety of free health, wellness and education programs to the communities it serves. LRH continues to develop more health initiatives to promote awareness of risk and prevention associated with health conditions such as diabetes, cancer, and hypertension.

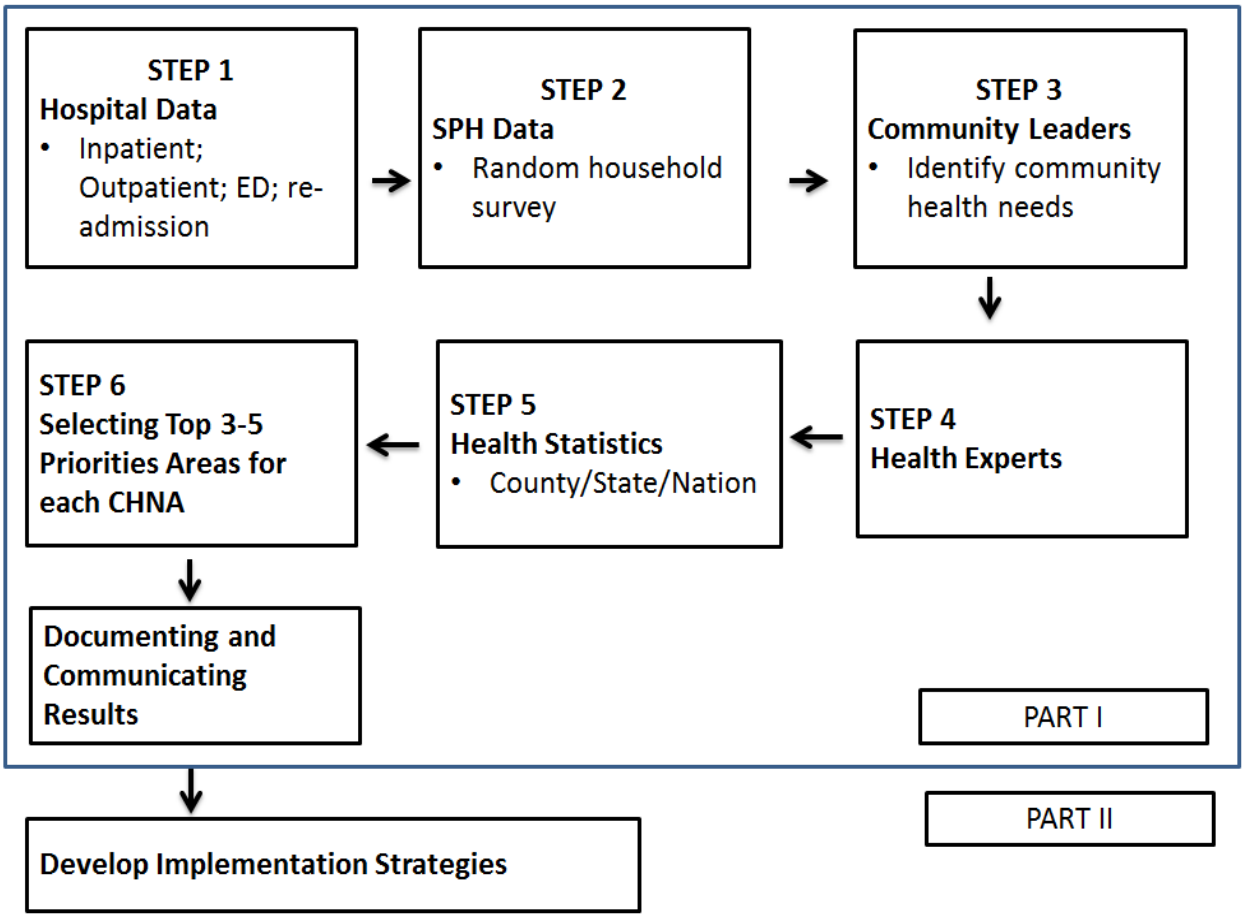
LRH endeavors to improve and adapt its current health programs into sustainable community based programs to impact the overall health and wellness of the community in a positive way. The hospital's approach to attaining this expansion and adaptation is through collaborative partnerships with state and local health agencies, as well as various community organizations. Laurel Regional Hospital, in conjunction with the University of Maryland School of Public Health (UMSPH), conducted a Community Health Needs Assessment (CHNA) in fiscal year 2013. This Implementation Strategy provides a summary of how the hospital plans to address the top community health priorities identified in the assessment for fiscal year 2014-2016.

HEALTH NEEDS IDENTIFICATION & SELECTION

Dimensions Healthcare System employed a system-wide approach inclusive of both Laurel Regional Hospital and Prince George's Hospital Center to identify and select community health needs. Community health needs assessments and implementation strategy plans (ISP) were completed for both hospitals individually with similarity due to some overlap in service area within Prince George's County. LRH identified and selected community health needs in a two-phase process. In phase one, LRH collaborated with the University of Maryland School of Public Health to identify community health needs. UMSPH conducted analyses utilizing multiple data sources to assess community needs and identify top health concerns in the LRH service area. Community needs were assessed in a series of six steps culminating in the identification of significant health needs from which to select for implementation. These steps focused on the analyses of hospital discharge data, a household survey, community leader and health expert focus groups, and compilation of existing health needs statistics. Each step yielded

information about the most frequently presented diseases within LRH's patient population, resident perception of health needs, community leader and health expert opinions, and county, state and national statistics of health needs.

LRH CHNA Six-Step Analysis Strategy



In phase two of the process, identified needs were reviewed, selected and prioritized for implementation based on prevalence of community need, existing programming, strengths, resource allocation, operational alignment and partnerships. Need selection was conducted by the Implementation Strategy Plan Task Force (ISPTF), a multidisciplinary team of health administrators with expertise in each of the areas of most concern as documented in the CHNA. Four of the areas of concern were selected as community health needs focus areas for implementation of community health improvement programs and initiatives. The community health needs focus areas are:

1) Diabetes
2) Mental Health/Wellness
3) Respiratory Health/Wellness
4) Physical Rehabilitation

Each of the four community health needs focus areas were then linked to three healthcare administration areas. They are:

1) Health Access & Primary Care
2) Disease Prevention & Management
3) Health Integration & Coordination

Community health needs focus areas and health administration areas were aligned, in part, with national, state and local health priorities. This alignment is designed to improve overall access, integration and coordination and to achieve better health outcomes across the continuum of care.

Comparison of National, State, and Local Health Priorities

Healthy People 2020 Overarching Goals	National Prevention Strategy 2011 Priority Areas	Maryland State Health Improvement Plan (SHIP) 2011 Vision Areas	Prince George's County Health Improvement Plan 2011 Priority Areas
Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.	Tobacco Free Living	Healthy Babies	Access to Health Care
Achieve health equity, eliminate disparities, and improve the health of all groups.	Preventing Drug Abuse and Excessive Alcohol Use	Healthy Social Environments	Chronic Diseases
Create social and physical environments that promote good health for all.	Healthy Eating	Safe Physical Environments	Reproductive Health
Promote quality of life, healthy development, and healthy behaviors across all life stages.	Active Living	Infectious Diseases	Infectious Diseases
	Injury and Violence Free Living	Chronic Diseases	Safe and Healthy Physical Environments
	Reproductive and Sexual Health	Health care Access	Safe and Healthy Social Environments
	Mental and Emotional Well-Being		

IMPLEMENTATION STRATEGY DEVELOPMENT

The development of the implementation strategy plan consisted of a comprehensive approach inclusive of the selected community health needs focus areas and the healthcare administration linkage. The community health needs focus areas are directly linked to each other and to the healthcare administration areas to ensure that health needs are met in the most effective manner. Many of the health challenges in the LRH service area are due to the large population of uninsured residents in Prince George's County, as well as the lack of access to and availability of needed health services, including primary care services for which there is a shortage of providers. As a result, access to and availability of preventative care and disease management tools and resources, including education, are limited. Health integration and coordination affect and are affected by healthcare affordability, accessibility and availability, particularly for underserved, vulnerable and disparate populations.

Fragmented and uncoordinated health systems have perpetuated the dysfunction of healthcare administration in the LRH service area, making effective and efficient health integration and coordination essential to meet community health needs. By acknowledging the relationship between inpatient care and community health improvement efforts, the ISPTF was able to develop a plan that will positively impact quality and safety across the continuum of care.

Building an Infrastructure for Community Health Improvement & Empowerment
Building the appropriate infrastructure is required to sustain community health improvement and empowerment efforts. This infrastructure will allow for effective administration of community health improvement and community benefit planning/implementation. The infrastructure build focuses on evidence-based community health/wellness program development and management through partnerships with community organizations. While the expansion and restructuring of current programming is a priority, the development of new programming to improve health status and outcomes through assessment, response, measurement and evaluation are also of great significance. As LRH continues to build the infrastructure to respond to selected community health needs, community/staff engagement and empowerment, and education and training are all integral components of community health improvement. Other integral components include physician recruitment and establishing health access points such as primary care offices within the community.

Partnerships for Health Promotion & Improvement
Laurel Regional Hospital recognizes the value of community collaboration through partnerships to promote and improve community health. Therefore, LRH will continue to develop and strengthen collaborative relationships with national and local health/ wellness and community organizations, including federally qualified health centers and the Prince George's County Health Department, faith based, government, and academic institutions.

Unaddressed Needs
While the total range of community health needs is important, LRH is not currently positioned to focus on top health concerns identified by the CHNA such as heart and kidney failure due to lack of resources to make the most impactful changes in these areas. These needs did not emerge as community health needs focus areas, but they as well as other chronic diseases and co-morbidities will be taken into account and incorporated into the strategic plan where appropriate. Though these needs are not presently being addressed by LRH as an area of focus, the hospital will explore opportunities to collaborate with other community and public health organizations such as the health department and federally qualified health centers to address these needs.

COMMUNITY HEALTH NEEDS FOCUS AREAS

Goals and strategies for each of the selected community health needs focus areas are documented in this section. Each goal and strategy can be linked to one or more of the healthcare administration areas to ensure effective response to needs. Metrics and methods of evaluation will be incorporated into each focus area as work plans are developed.

Focus Area: Diabetes

Goal I: **Improve the availability of diabetes self-management education and services to the community.**

Strategies:

- Enhance screenings and information offered at community health events.
- Increase frequency of education and information offerings to area churches, senior centers, and activity centers.
- Continue to offer quarterly on-site free information sessions to community to provide access to resources that are usable by residents with diabetes/pre-diabetes.

Goal II: **Engage and partner with community physicians to increase awareness of diabetes services and education availability.**

Strategies:

- Create engagement process inclusive of information package to inform and educate community physicians about diabetes services.
- Distribute program description and promotional materials to physician offices and patients with face-to-face visits to physician/practice administrator.

Goal III: **Advance quality and continuity of diabetic care through formation of outpatient care teams and group visits.**

Strategies:

- Increase the accurate/adequate coordination of care post ED visit.
- Streamline follow up appointments into outpatient clinics to improve continuity of care.
- Form outpatient care teams to include MD, RN, nutrition and diabetes educator, case manager, podiatrist and wound care RN when needed.
- Educate patients about group visits and coordinate care with outpatient care team to conduct visits.

Goal IV. Promote diabetes literacy – particularly focusing on prevention of diabetes.

Strategies:

- Partner with City of Laurel to create diabetes awareness and education for all ages, focusing on prevention, in local libraries, other public buildings. Advertise via posters newspaper, radio, etc.
- Partner with school system to incorporate nutrition and exercise education into school curriculum via newsletters, health fairs at schools, PTA meetings, and Board of Education.

Focus Area: Mental Health/Wellness

Goal I: **Improve health access to and integration /coordination of mental health services.**

Strategies:

- Improve and coordinate outpatient resources for mental health care patients.
- Partner with multiple community resources and care providers including the National Alliance on Mental Illness to increase the community's access to mental health services.
- Host a series of mental health educational workshops at local churches, synagogues, and mosques to promote mental health awareness, prevention and management.
- Provide monthly mental health screenings at LRH to screen for depression, schizophrenia, and substance abuse.
- Provide on-site community education for local elementary and high schools.
- Develop support groups for individuals to create a network of sharing information and coping with mental illness disease processes.

Goal II: **Collaborate to increase community capacity to develop and promote a public campaign addressing the skills needed to diagnose, treat and counsel young patients with mental illness**.

Strategies:

- Partner with school system and academic institutions to develop early intervention programs targeting behavioral health issues among students/young adults.
- Educate youth in local schools to provide resources/ health fair for at risk teens.

Focus Area: Respiratory Health/Wellness

Goal I: Improve quality of life of patients with COPD and Asthma in the Greater Laurel community.

Strategies:

- Provide monthly health awareness classes conducted at the hospital designed to empower patients in self-care understanding of COPD and asthma.
- Develop school-based asthma awareness and education program.

Goal II: Reduce the number of children who start smoking and reduce the number of adults in community who are actively smoking by helping them with smoking cessation.

Strategies:

- Partner with American Lung Association, American College of Chest Physicians, Local School Board, University of Maryland College Park Student groups and UMSPH to organize "Concerted Health Initiative".
- Partner with community based organizations to provide smoking cessation program at places of community gatherings such as churches, synagogues and senior centers.
- Partner with Life in Yoga and Meditation Anywhere to increase health awareness and disease prevention through mindfulness and healthy life style in the community.
- Prevent initial tobacco use among young people by targeting young people in smoking prevention efforts such as support for school-based programs in conjunction with community enforcement of youth tobacco sales restrictions.
- Enhance current smoking cessation counseling program to increase public knowledge of the resource and use of the services internally to the organization and externally to the community.

Focus Area: Physical Rehabilitation

Goal I: Increase the community's knowledge regarding the prevention of a stroke and the signs and symptoms.

Strategies:

- Develop promotional and educational materials on stroke prevention and the signs and symptoms of a stroke. Use materials from the National Stroke Association to distribute at senior centers, libraries, and community centers.
- Schedule at least two presentations to community groups about stroke prevention and stroke facts.
- Explore ways to target African American and Hispanic communities who are at higher risk; church groups or fairs.
- Link hospital website to National Stroke Association to provide access to stroke prevention and recovery information.
- Host a minimum of four one-hour seminars on total wellness and stress management at the hospital and in the community.

Goal II: Promote active living to increase the community's participation in exercise programs.

Strategies:

- Host an exercise program led by physical and/or occupational therapists at the hospital in conjunction with the Arthritis Foundation.
- Sponsor a health walk fundraiser in partnership with the American Heart Association or another health advocacy organization to provide health lifestyles information and access to health services in the community.

IMPLEMENTATION STRATEGY EXECUTION

The next phase of the ISP will focus on proper execution of the plan. This will be achieved by allocating the necessary resources, aligning strategies with operations and engaging partners. The ISPTF will be expanded into a body of internal and external advisors who will continue to build the infrastructure to fully execute the ISP, develop sustain, and monitor community health improvement initiatives and programs.