Prince George's Hospital Center
Community Health Improvement Plan (CHIP)

Note: Olive Green shade are Dimension-wide activities; Purple shaded areas are Prince George's Hospital Center priority initiatives.

Community Health Infrastructure Development (Internally and Externally Focused)					
Goal	**Target population**	**Objective**	**Activities/Tasks**	**Measure(s)**	**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 2016 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 carry out Community Benefit strategic initiatives	• **Share 2016 Community Health Needs Assessment (CHNA)** with community partners and broader community • **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 Dimensions population health management (PHM) strategy • **Award mini-grants ($5,000 - $10,00) to community organizations** to develop capacity and/or support activities that are aligned with Community Benefit (CB) priorities	• # of times CHNA accessed from Dimensions website • # of community organizations met with to discuss PGH PHM vision and explore partnerships • # of times staff participated in TLC, LHIP and other community coalition events • Number of CBOs operating within Prince George's County • List of CBOs awarded grants and total amount awarded	• Prince George's County Health Department • Doctors Community Hospital, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center • Community-based organizations including faith-based organizations • Grantees
Promote Collaboration with Community Health Partners (Internal Focus)	• Dimensions Clinical and Administrative Staff	• Increase awareness of Dimensions' Community Benefit plans and accomplishments • Develop and encourage participation in Hospital's "Speaker's Bureau" • Align Community Benefit	• **Hire new staff and/or build capacity of current staff to develop, coordinate and track community benefit activities**, align with or integrate into population health management infrastructure • **Report Community Benefit plans and accomplishments** (orally and in writing) to staff, crosswalk to PHM accomplishments/metrics • **Present community health awards** to administrative staff	• # of internal community meetings attended where CHNA/CHIP was promoted • # of staff awards given out • # of administrative staff/clinicians included in the Speakers Bureau	

Community Health Infrastructure Development (Internally and Externally Focused)					
Goal	**Target population**	**Objective**	**Activities/Tasks**	**Measure(s)**	**Community Partners**
		strategy with Dimensions Healthcare System's Population Health Management Strategic Transformation Plan	and clinicians who have made exemplary contributions to community benefit and community health activities • **Develop, market and promote the use of Speakers Bureau** as a resource for the community	• # of Speakers Bureau events organized	

Priority Area 1: Social Determinants of Health Risk Factors					
Goal	**Target population**	**Objective**	**Activities**		
Promote Wellness, Behavior Change, and Engagement In Appropriate Care (Physical, mental, emotional, and behavioral health)	• Community at-large • Uninsured populations	• Raise awareness about health risk factors, health promotion, and wellness • Promote engagement in primary care and behavioral health services • Raise awareness about mental, emotional, and behavioral risk factors	**1) <u>Health Education and Primary Prevention Activities (overall wellness)</u>** • **Participate in health fairs** for enhanced screening, health literacy, and community education • **Promote and organize community workshops and educational sessions via speakers bureau** 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 education and awareness events** for their constituencies • **Promote employee wellness programs**: co-sponsor employee wellness forum with PGC Chamber of Commerce, featuring MGM's wellness programs.	• # of speaker bureau events focused on health promotion • # screened for pre-diabetes, diabetes, hypertension, obesity, COPD • Age-adjusted death rates from heart disease, by race/ethnicity	• Prince George's County Health Department, Health Literacy Imitative • Prince George's County School Districts • Community based organizations (churches, Prime Time Sister Circles, Nueva Vida, etc.)
Increase Physical Activity and Healthy Eating	• Community at-large • Older adults • Children	• Increase the number of children, youth, and adults who are physically active • Increase access to healthy and affordable foods • Improve nutritional quality of the food supply • Decrease the number of	**2) <u>Healthy Eating / Active Living Program</u>** • **Support walking and other physical activity groups** in schools, community-based and primary care-based settings • **Work with the Capital Area Food Bank** to implement programs that improve access to healthy food for those in the County who are most at-risk • **Support community-based organizations to promote**	• # of residents reporting engagement in physical activities • # of residents reporting access to health food options • Obesity rates for adults and children, by race/ethnicity	• Prince George's County Health Department, Healthy Eating and Active Living (HEAL) funded programs • Capital Areas Food Bank • Port Towns Community Health Partnership

Priority Area 1: Social Determinants of Health Risk Factors					
Goal	**Target population**	**Objective**	**Activities**		
		individuals and families who suffer from food insecurity	**accessible/affordable healthy food**: work with area grocers in Community Benefit Service Area (CBSA) to increase the number of healthy options on shelves		• Local grocers • Prince George's County School Districts
Promote Engagement in Patient Centered Primary Care (PCMH)	• Low income, uninsured adults and families	• Reduce the number of county residents who are uninsured • Reduce transport barriers to access primary care, attend wellness programs, obtain healthy food, etc. • Increase the number of uninsured who are linked to a primary care medical home • Reduce patients' no-show rates at Dimensions Wellness Clinics	**3) <u>Engagement in Appropriate Primary and Specialty Care Services</u>** • **Implement ED Triage Programs in the hospital EDs to ensure that patients are insured and engaged with a primary care medical home** • **Establish strong relationships with primary care providers** in CBSA • **Support or develop para-transit, voucher, and/or other transportation activities** (e.g. Health Departments transportation voucher program) to reduce the number of patients who face transportation barriers	• # of referrals to primary care medical home • # of transportation vouchers/$'s for transportation • Hospital PQI • # assisted with enrollment in Medicaid/CHIP and subsidized insurance • % uninsured in the County	• Dimensions Family Health and Wellness Centers • Gerald Family Care • Greater Baden Medical Services • Global Vision Healthcare • La Clinica • Prince George's County Health Department • Local area taxi companies, Uber
Reduce Cancer Disparities	• At-risk populations, in particular Black communities	• Have targeted outreach, education, and screening for target community • Increase the number of adults who screen positive for cancer who are referred for education, counseling and treatment • Increase the number of adults with cancer who are linked to a cancer navigator	**4) <u>Cancer Screening and Peer Support Programs</u>** • Support the development of Detailed Cancer Prevention Plan in collaboration with Dimensions Cancer Care Committee • Support access to cancer screening and treatment for target population, including low income, uninsured adults (breast, prostate, colon, and lung, cancers), including mammograms and colorectal screening. • Support or develop County-wide cancer navigators program and link patients screened positive for cancer to Cancer Patient Navigators • Provide emotional support programs through evidence-based patient and caregiver support programs	• % screened, by race/ethnicity • Cancer-related hospitalizations by race/ethnicity • Cancer-related deaths by race/ethnicity	• County Health Department, Health Literacy project • Dimensions Family and Wellness Centers • University of Maryland Medical System

Priority Area 2: Physical Health and Chronic Disease Management					
Goal	**Target population**	**Objective**	**Activities**		
Improve Chronic Disease Management	• Adults with chronic disease or complex conditions • Low income individuals	• Increase proportion of adults with chronic disease or other complex conditions who receive evidence-based screening, education, referral, and/or treatment services	**5) <u>Living Well- Diabetes Self- Management Program, Congestive Heart Failure Initiative, Pulmonary Home Initiative</u>** • Organize and support programs in Dimensions' Family Health and Wellness Centers and within other primary care clinics that screen those at-risk for various complex/chronic conditions and provide evidence-based education, prevention messages, and basic self-management support. • Provide evidenced-based counseling/coaching (including intensive self-management support) and treatment • Link those with complex or chronic conditions to appropriate specialty care services, particularly those with diabetes, hypertension, HIV/AIDS, and asthma	• # of high risk assessments • # of patients participating in chronic disease self-management/lifestyle change programs	• Prince George's County Health Department • Community-based organization, including faith-based organizations
Improve Transitional Care	• Adults discharged from the hospital with complex and/or chronic conditions • Older adults • Low income individuals	• Conduct assessment to identify condition-specific priorities and barriers to care coordination • Develop and implement enhanced care coordination plans for adults with chronic conditions who are discharged from the hospital • Promote enhanced primary care follow-up and home care services • Develop partnerships with elder services agencies to enhance linkages to services • Reduce 30 day ED/inpatient readmission	**6) <u>Care Coordination and Care Transitions Support Program</u>** • Provide intensive coordination services in the ED and inpatient settings to ensure clinical follow up, medication management, and appropriate linkages to community services (focused specifically on high-utilizers with chronic or complex conditions) • Implement Ambulatory Care Transitions Team (ACTT) and Ambulatory Care Center for Evaluation and Stabilization Models (ACCESS) • Enroll high utilizers in mobile integrated health home visiting program • Utilize HEZ community health workers for patients residing in HEZ-designate area. • Work with Elder Service Agencies and Councils on Aging to develop programs to link those discharged to needed services	• # of high utilizers assigned to care transition coordinator • # of high utilizers receiving home visits • Emergency department utilization rate by race/ethnicity • Hospital PQI	• Prince George's County Health Department HEZ CHW Care Coordination and Navigator Program • Prince George's EMS
Improve HIV/AIDS	• At-risk for HIV	• Early detection through	**7) <u>HIV/AIDS Prevention and Disease Management</u>**	• HIV new case rates by	• Hospital ED

Priority Area 2: Physical Health and Chronic Disease Management					
Goal	**Target population**	**Objective**	**Activities**		
Prevention and Disease Management	infection	screening • Education to reduce rate of new infection within target population (Black, MSM)	• Provide screening, education/counseling, and treatment services for those with HIV/AIDS, as well as HIV/HEP C and HIV/HCV co-infection • Support groups for men and women living with HIV/AIDS	race/ethnicity/ at-risk group	• Family Health and Wellness Centers • Heart to Hand, other community based organizations

Priority Area 3: Behavioral Health					
Goal	**Target population**	**Objective**	**Activities**		
Refine Behavioral Health Systems and Infrastructure	• Front- line providers within clinical and other community-based service providers	• Improve screening and identification protocols • Develop an internal behavioral health strategy • Create resource inventory of mental health and substance use providers and other resources to streamline the referral process • Reduce Hospital LOS	**8) <u>Refine Behavioral Health Infrastructure</u>** • Convene Behavioral Health Regional Coalition to coordinate improvements to behavioral health services within Prince George's County • Conduct an internal behavioral health assessment to determine gaps in capacity and to refine screening, counseling and referral services in ED, inpatient, and outpatient settings • Develop a Behavioral Health Resource Inventory • Develop transitional housing strategy for persons with complex medical and behavioral conditions, working in collaboration with Health Department, Department of Social Services (DSS), and Housing Authority of Prince George's County (HAPGC).	• # of providers using evidence-based guidelines • Hospital LOS • # of housing units available for transition from hospital to home/residential care • # of BH providers serving low income populations	• Family Health and Wellness Centers • Community-based organizations, including faith-based • FQHCs and other primary care providers • Beacon (Medicaid BH Contractor) • Prince George's County HD, DSS, and Housing Authority
Develop Behavioral Health Outreach and Education Programs in Clinical and Community-based	• Front- line providers within clinical and other community-based service providers • Community at	• Educate the public about behavioral health risk factors, behavioral health promotion, and basic wellness issues • Promote engagement in appropriate primary and specialty care	**9) <u>Health Education and Primary Prevention Activities (Behavioral Health)</u>** • Support behavioral health awareness, education and stigma reduction • Provide behavioral health education and screening in primary care settings (provider education and written materials)	• # of Mental Health First Aid Workshops conducted, # of attendees	• Family Health and Wellness Centers • Community-based organizations, including faith-based • FQHCs and other

Priority Area 3: Behavioral Health					
Goal	**Target population**	**Objective**	**Activities**		
Settings	large	• Educate service providers and educators on behavioral health first aid • Increase screening and referral activities in clinical, community, school-based, and worksite settings	• Conduct Mental Health First Aid Workshops with first responders and staff at community-based organizations		primary care providers • Prince George's EMS
Promote Behavioral Health/ Primary Care Integration	• Low income individuals and families • Immigrant population • Persons with behavioral health/mental health needs	• Increase number of adults (12+) screened for depression and linked to care (50% benchmark from UDS) • Increase number of primary care providers with behavioral health integration	**10) <u>Primary Care / Behavioral Health Integration</u>** • Work with Dimensions' Wellness Clinics and other affiliated primary care practices to implement PC/BH integration (e.g., screening, assessment, counseling, treatment) • Implement universal screenings for depression at health fairs, other screening events using PHQ 2 and PHQ 9 or other similar tools, and encourage engagement with a primary care medical home • Promote tele-psychiatry in primary care and other clinical settings	• # screened for depression • Hospital PQI • #/rate of readmissions related to behavioral health	• Family Health and Wellness Clinics • Gerald Family Care • University of Maryland Medical System
Reduce burden of Substance Use (Alcohol and PCP use)	• Adults with substance abuse/ behavioral health conditions	• Increase capacity of providers to prevent alcohol and drug use by implementing MHA provider recommendations • Reduce stigma of MH/SA issues	**11) <u>Substance Use Screening, Counseling and Referral in Clinical and Community Settings</u>** • Implement screening, counseling, and referral services (SBIRT) in Hospital ED, primary care, and other community-based settings • Provide screening, counseling, and care management services in home and community-based settings for those identified with or at-risk of substance use issues • Partner with law enforcement to conduct home visits with patients who overdose in the Hospital ED • Educate community-based providers on appropriate prescription guidelines.	• # screened • #/rate of alcohol and drug related hospitalizations by race/ethnicity • #/rate of alcohol and drug related deaths by race/ethnicity	• Public law enforcement • Doctors Community Health Center, urgent care centers • Roberta Houses (safe house for women in domestic violence situations)