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

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

| | | Community Health Infrastructure Development (Internally and Externally Focused) | | | | |
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| **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<br>• Promote use of the 2016 Community Health Needs Assessment (CNNA) findings to better target community health initiatives<br>• Support the development of effective community health programming<br>• 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<br>• **Participate in existing community coalitions** including Totally Linking Care in MD (TLC), Prince George's County Local Health Improvement Plan (LHIP)<br>• **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<br>• **Award ≥ 1 mini-grant ($5,000 - $10,00) per year to community organizations** to develop capacity and/or support activities that are aligned with Community Benefit (CB) priorities | • # of times CHNA accessed from UM Capital Website<br>• # of current PGC Coalitions UM Capital staff participate in/or lead.<br>• # of times staff participated in TLC, LHIP and other community coalition events<br>• # of community organizations met with to discuss PGHC PHM vision and explore partnerships<br>• # of grants awarded and total amount.<br>• # of hour's staff spent at coalition meetings. | • Web Analytics<br>• CBISA | • Prince George's County Health Department ( PGCHD)<br>• Doctors Community Hospital, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center<br>• Community-based organizations including faith-based organizations<br>• Grantees |

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| **Goal** | **Target population** | **Objective** | **Activities/Tasks** | **Measure(s)** | **Data Source** | **Community Partners** |
| **Promote Collaboration with Community Health Partners (Internal Focus)** | • UM Capital Clinical and Administrative Staff | • Increase awareness of UM Capital Community Benefit plans and accomplishments<br>• Develop and encourage participation in Hospital's "Speaker's Bureau"<br>• Align Community Benefit strategy with UM Capital Population Health Management Strategic Transformation Plan | • **Develop Community Health PRN pool/ hire new staff to develop, coordinate and track community benefit activities**, align with or integrate into population health management infrastructure<br>• **Lead UM Community Health Workgroup** to Report Community Benefit plans and accomplishments (orally and in writing) to staff, crosswalk to PHM accomplishments/metrics<br>• **Develop an Engagement Survey** to capture cultural norms and increase knowledge of UM Capital staff participation in community based activity, to create a bridge to possible partnerships and collaborations.<br>• **Present community health awards** to staff who demonstrate exemplary volunteer contributions to community benefit and community health activities.<br>• **Develop, market and promote the use of Speakers Bureau** as a resource/database for community education. | • # of staff hired<br>• # of internal community meetings attended where CHNA/CHIP was promoted<br>• # of Community Health workgroup meetings per year<br>• # of awards given out<br>• # of administrative staff/clinicians included in the Speakers Bureau.<br>• # of speakers bureau events organized. | • **CBISA** | |

## Priority Area 1: Social Determinants of Health Risk Factors

**Long Term Goals Support Maryland SHIP**

1. **Increase the proportion of adults with a healthy weight; PGC 31.7% ( 2014). MD Goal ( 2017) 36.6%**
2. **Reduce cancer age-adjusted mortality rate; PGC (2015-2017) 154.1/100,000. MD Goal ( 2017) 147.4/100,000**

**Long Term Goals Supporting Healthy People 2020**

1. **Reduce the proportion of adults who are obese; PGC (2013-2017) 46.7%. Target 30.5%**

| Goal | Target population | Objective | Activities | Measures | Data Source | Community Partners |
|---|---|---|---|---|---|---|
| **Promote Wellness, Behavior Change, and Engagement In Appropriate Care** | • Community at-large<br>• Uninsured/ Underinsured populations | • Raise awareness about health risk factors, health promotion, and wellness<br>• Increase the number screened who are referred for further follow-up.<br>• Promote engagement in primary care and behavioral health services.<br>• Raise awareness about mental, emotional, and behavioral risk factors | 1) **<u>Health Education and Primary Prevention Activities (overall wellness)</u>**<br>• **Participate in health fairs** for enhanced screening, health literacy, and community education<br>• **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<br>• **Work with community partners and schools to organize education and awareness events** for their constituencies<br>• **Promote employee wellness programs** in collaboration with UM Capital employee wellness committee, partnering community businesses and associations to adopt UM Capital employee wellness model ( year 2-3) | • # of health related programs aligned with SHIP priorities<br>• # of speaker bureau events focused on health promotion.<br>• # screened for pre-diabetes, diabetes, hypertension, obesity, COPD<br>• # of people linked to care for further follow-up.<br>• # of employees participating in UM Capital wellness activity. | • CBISA | • Prince George's County Health Department, Health Literacy Initative<br>• Prince George's County School Districts<br>• Community based organizations<br>• Avanath Capital Management<br>• Victoria Falls, Senior living facility.<br>• Mall at Prince George's<br>• Maryland National Capital Park & Planning Commission ( M-NCPPC) |

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| **Increase Physical Activity and Healthy Eating** | • Community at-large<br>• Older adults<br>• Children | • Increase the number of children, youth, and adults who are physically active<br>• Increase access to healthy and affordable foods<br>• Improve nutritional quality of the food supply.<br>• Decrease the number of individuals and families who suffer from food insecurity. | **2) <u>Healthy Eating / Active Living Activities</u>**<br>• **Support walking and other physical activity groups** in schools, community-based and primary care-based settings<br>• **Work with mobile food markets** to support community-based organizations to promote & improve accessible/affordable healthy foods for those in the county who are most at-risk. | • # of individuals attending Dine, Learn & Move.<br>• Pre & Post-test Knowledge increase<br>• Obesity rates for adults and children, by race/ethnicity | • Pretest/Posttest<br>• CBISA<br>• Participants reporting increased access to healthy food. (zipcode tracking) | • M-NCPPC<br>• Prince George's County Health Care Alliance<br>• Local Farmer Markets & Community Partners<br>• Local grocers |
| **Promote Engagement in Patient Centered Primary Care (PCMH)** | • Low income, uninsured adults and families | • Reduce the number of county residents who are uninsured<br>• Reduce transport barriers to access primary care, attend wellness programs, obtain healthy food, etc.<br>• Increase the number of uninsured who are linked to a primary care medical home<br>• Reduce patients' no-show rates with the UM Capital Region medical group | **3) <u>Engagement in Appropriate Primary and Specialty Care Services</u>**<br>• **Implement ED Triage Programs in the hospital EDs to ensure that patients are insured and engaged with a primary care medical home**<br>• **Establish strong relationships with primary care providers** in CBSA<br>• **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<br>• # of transportation vouchers/$'s for transportation<br>• # assisted with enrollment in Medicaid/CHIP and subsidized insurance<br>• % uninsured in the County | • AthenaNet | • UM Capital Medical Group<br>• Gerald Family Care<br>• Greater Baden Medical Services<br>• Global Vision Healthcare<br>• La Clinica<br>• Prince George's County Health Department<br>• Local area taxi companies, Uber |

| Priority Area 2: Physical Health and Chronic Disease Management | | | | | | |
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| **Long Term Goal Supporting Maryland SHIP:**<br>**1. Age- adjusted death rate from heart disease: PGC (2015-2017) 168.9/100,000. MD Goal ( 2017) 166.3/100,000**<br>**2. Reduce emergency room visit rate due to diabetes: PGC 210.4/100,000. MD Goal (2017) 186.3/100,000**<br>**3. Reduce HIV incidence rate: PGC 41.9/100,000. MD Goal ( 2017) 26.7/100,000**<br><br>**Long Term Goals Supporting Healthy People 2020**<br>**1. Reduce the proportion of adults who are obese. PGC (2013-2017) 46.7%. Target 30.5%**<br>**2. Increase the proportion of adults with a healthy weight PGC( 2014) 31.7%. Target 36.6%** | | | | | | |
| **Goal** | **Target population** | **Objective** | **Activities** | **Measure** | **Data Source** | **Community Partners** |
| **Improve Chronic Disease Management** | • Adults at risk of & living with chronic disease or complex conditions<br>• 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<br>• Increase referrals o outpatient nutrition and diabetes services.<br><br>• Increase Behavioral Change | **4.) <u>Diabetes Prevention& Management, Cardiovascular Disease & other chronic conditions.</u>**<br>• **Organize and support programs in UM Capital Region Medical Group** 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.<br>• **Support, organize & host the Stanford University Living Well** with Chronic Disease Self-Management Education Workshops.<br>• **Implement heart healthy nutrition community** class offering program.<br>• **Partner with community organizations to expand the National Diabetes Prevention Program** in Prince George's County.<br>• **Provide evidenced-based counseling/coaching** (including intensive self-management support) and treatment<br>• **Link those with complex or chronic conditions to appropriate specialty care services**, particularly those with diabetes, hypertension, asthma, pulmonary, cardiac and HIV/AIDS. | • # of patients participating in chronic disease self-management/lifestyle change programs.<br>• # of participants participating in heart healthy nutrition community classes.<br>• # of referrals for Outpatient Nutrition and Diabetes Education services<br>• # of participants in Medical Nutrition therapy and diabetes education support services.<br>• # of partners involved in DPP expansion.<br>• # of high risk assessments(Cardiac, Diabetes) | • AthenaNet<br>• CBISA<br>• Diabetes Center | • PGCHD<br>• Community-based organization, including faith-based organizations |

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| **Goal** | **Target population** | **Objective** | **Activities** | **Measure** | **Data Source** | **Community Partners** |
| **Reduce Cancer Disparities** | • At-risk populations, in particular Black communities | • Have targeted outreach, education, and screening for target community | **4) <u>Cancer Screening and Peer Support Programs</u>**<br>• **Support the development of UM Capital Cancer Service Line** Plan in collaboration with the UM Capital Cancer Care Committee<br>• **Increase UM Capital Branded Cancer Education and Resources materials**- collaboration with UM Medical Group/Cancer Committee/Women's Health)<br>• **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.<br>• **Work with community partners to provide emotional support programs** through evidence-based patient and caregiver support programs. | • % screened, by race/ethnicity<br># of patients linked to care | • AthenaNet | • Hope Connections for Cancer<br>• Breast Care for Washington<br>• University of Maryland Medical System |

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| **Goal** | **Target population** | **Objective** | **Activities** | **Measure** | **Data Source** | **Community Partners** |
| **Improve Transitional Care** | • Adults discharged from the hospital with complex and/or chronic conditions<br>• Low income individuals | • Conduct assessment to identify condition-specific priorities and barriers to care coordination<br>• Develop and implement care coordination plans for adults with chronic conditions who are discharged from the hospital<br>• Promote enhanced primary care follow-up and home care services<br>• Reduce 30 day | **5.) <u>Care Coordination and Care Transitions Support Program</u>**<br>• **Provide coordination services in the ED and inpatient settings** to ensure clinical follow up, medication management, and appropriate linkages to community services (focused specifically on readmissions and rising risk patients with chronic or complex conditions)<br>• **Implement Ambulatory Care Transitions Team** (ACTT)<br>Utilize various care coordination programs to provide community based support. | • # of patients identified by the care coordination team.<br>• # of high utilizers referred to community based care transition and disease specific education programs.<br>• Hospital PQI rate.<br>• # of Population Health Alignment meetings | • AthenaNet<br>• Care Connect<br>• Cerner | • TLC-MD<br>• Hospital to Home<br>• ICTC<br>• Prince George's EMS |

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| **Goal** | **Target population** | **Objective** | **Activities** | **Measure** | **Data Source** | **Community Partners** |
| | | ED/inpatient readmission | | | | |
| **Improve HIV/AIDS Prevention and Disease Management** | • At-risk for HIV infection<br>• Community- at Large | • Improve disease management & healthy lifestyle education for people living with HIV.<br>• Increase early detection of undiagnosed population through increased screenings.<br>• Education to reduce rate of new HIV infections with a focus on high risk populations. | **6.) <u>HIV/AIDS Prevention and Disease Management</u>**<br>• **Provide screening, education/counseling, and treatment services** for those with HIV/AIDS, as well as HIV/HEP C and co-infections.<br>• **Support for men and women living with HIV/AIDS** & co-infections<br>• **Partner with community organizations** to support the development of a comprehensive strategic HIV/AIDS plan | • HIV new case rates by race/ethnicity/ at-risk group<br>• # of linkages to care<br>• # of HIV screenings conducted in community. | • HIV/HEPC Program | • AHV<br>• Gilead<br>• Us Helping Us<br>• Heart to Hand<br>• PGCHD<br>• Access to wholistic and reproductive health living institute<br>• Other Community Based Organization's |

| Priority Area 3: Behavioral Health | | | | | | |
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| **Long Term Goal Supporting MD SHIP:**<br>1. **Age -Adjusted ER visit rate due to Mental Health: PGC 1,861.6/100,000.MDGoal ( 2017) 3,152.6**<br>***(MD SHIP goal has been met however; the Prince George's value is increasing significantly (Previous value ,2014-2016 1,539.3***<br>2. ***Age-Adjusted Death Rate due to Suicide 5.7/100,000. MD Goal ( 2017) 9.0/100,000***<br>***( MD SHIP Goal has been meet however, Suicide mortality rate for Black, NH (4.4 per 100,000 in2014; 5.0 per 100,000- in 2017)*** | | | | | | |
| **Goal** | **Target population** | **Objective** | **Activities** | **Measures** | **Data Sources** | **Community Partners** |
| **Increase Health Outreach and Education Programs in and Community-based Settings** | • Front- line providers within clinical and other community-based service providers<br>• Community at large | • Promote engagement in appropriate primary and specialty care.<br>• Educate and increase Awareness in the community of mental health.<br>• Increase screening and referral activities in school-based, and worksite settings.<br>• Increase number of adults (12+) screened for depression and linked to care. | **7.) <u>Health Education and Primary Prevention Activities (Behavioral Health)</u>**<br>• **Conduct Mental Health First Aid Workshops** with first responders and staff at community-based organizations<br>• **Provide adverse childhood experiences** (ACE's) **education and awareness** for families and children in partnership with select PG County Public Schools.<br>• **Provide behavioral health education and screening in primary care settings** (provider education and written materials)<br>• **Co-sponsor annual Mental Health Conference** annually for the community at large<br>• **Provide screenings for depression at health fairs** & other screening events using PHQ 2 and PHQ 9 or other similar tools, and encourage engagement with primary care providers. | • # of Mental Health First Aid workshops conducted<br>• # educated with MHFA<br>• # of referrals to care<br>• # attending Mental health Conference<br>• # screened for depression. | • CBISA | • Community-based organizations, including faith-based<br>• Local business partners<br>• FQHCs and other primary care providers<br>• Prince George's EMS<br>• Prince George's County Schools |

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| **Reduce burden of Substance Use (Alcohol and PCP use)** | • Adult residents of PGC with alcohol and substance abuse conditions. | • Increase identification and stop or reduce alcohol and substance abuse use of target population.<br>• Provide linkages to community care<br>• Increase community peer to peer support.<br>• Reduce stigma of MH/SA issues | • **<u>SBIRT Program- Screening, Brief Intervention and Referral for Treatment program.</u>**<br>• A new program launched in 2019; using the evidence based cost- effective SBIRT model to identify and stop or reduce alcohol and substance abuse use.<br>○ **Provide Peer recovery coaches** who will provide support and motivation to encourage patients who are seeking treatment for alcohol or drug dependency, *to include opioid use.* Coaches will also provide linkages to treatment and recovery support services.<br>○ **Overdose Survivors Outreach Project ( OSOP)** will consists of a team member who works primarily in the community to conduct outreach and engagement with overdose survivors and to address potential barriers to treatment in an effort to avoid any subsequent overdoses. | • # of persons screened<br>• # of persons linked to treatment<br>• # of community referrals made by OSOP member | • Athena Net<br>• CBISA | • PGC Fire & EMS<br>• Roberta Houses (safe house for women in domestic violence situations) |
| **Promote Behavioral Health/ Primary Care Integration** | • Low income individuals and families<br>• Immigrant population<br>• Persons with behavioral health/mental health needs | • Increase number of primary care providers with behavioral health integration | **8.) <u>Primary Care / Behavioral Health Integration</u>**<br>• Work with UM Capital Medical Group and other affiliated primary care practices to implement PC/BH integration (e.g., screening, assessment, counseling, treatment) | • Hospital PQI<br>• #/rate of readmissions related to behavioral health | • AthenaNet | • UM Capital Region Medical Group<br>• Gerald Family Care<br>• University of Maryland Medical System |

## Priority Area 4: Physical Safety

**Long Term Goals Supporting Maryland SHIP:**

1. **Reduce rate of homicides: PGC 11.6. MD Goal (2017) 9.0/100,000**

**Long Term Goal Supporting Healthy People 2020**

1. **Reduce rate of Homicides. Target 10.2/100,000**

| Goal | Target population | Objective | Activities | Measures | Data Sources | Community Partners |
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| **Reduce Accidental Deaths** | • Community-at-Large | • Reduce Injuries associated with…<br>• Increase safety awareness for motor cycle accidents, bicycle safety, helmet safety and other pedestrian and motor vehicle related incidents | **<u>10.) Injury Prevention & Awareness -</u>**<br>• **Participate in health fairs to increase education, awareness a**nd provide tips on how to increase public safety :<br>  ○ Pedestrian Safety<br>  ○ Motor vehicle crashes/ Distracted Driving<br>  ○ Injury Prevention<br>• **Increase education in schools, community centers, senior centers** and faith based institutions through the distributions of educational materials.<br>• **Support the safe development & use of bike share** programming in collaboration with Prince George's County Government and cities ( FY23).<br>• **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<br>• # of events attended where injury prevention awareness education materials where distributed<br>• # of state collaborations | • Trauma Services | • Fire & EMS<br>• PGC Schools<br>• PGC Police Department<br>• Maryland State Highway Patrol |
| | • Community at Large.<br>• Youth | • Reduce the rate of homicides to support Healthy | **<u>11.) Trauma Youth Initiative</u>**- a new program in development; promoting and educating youth, in partnership with PGC School system. | • Number of prevention or community engagement events conducted during the reporting | • Trauma Services<br>• CBISA | • PGC Police Dept/ Fire department |

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| **Promote Violence Prevention & Education** | (Middle/High School)<br>• CAP-VIP; age target 15-34 | People 2020 Target. | (capital violence prevention, stop the bleed & bullying etc)<br>• **Provide Stop the Bleed Education and Trainings**- in community settings and in partnership w/ the PGC police & Fire dept . | quarter<br>• # of primary victims served by victims' stated race(s) or ethnicit(y/ies)<br>• # of primary victims served by victims age<br>• # of primary victims served by victims stated gender.<br>• Location of residence for each new crime victim served. (primary and new secondary victims) | | • Governor's office of Crime Control and Prevention.<br>• Office of Victim Service & Justice Grants |

## Priority Area 5: Maternal & Infant Health

**Long Term Goals Support Maryland SHIP:**

1. **Increase the percentage of women receiving prenatal care in the 1st Trimester. PGC: 57.5. MD Goal 66.0/100,000**
2. **Decrease the percentage babies born at a low -birth weight. PGC 9.8% MD Goal 8%**

**Long Term Goals Supporting Healthy People 2020:**

1. **Reduce age adjusted death rates from perinatal conditions. PGC 6.9. Target 3.3/100,000**

| 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<br>• Communities with a poverty rate >16% | • Increase access to high-quality prenatal care<br>• Provide education and information on healthy pregnancies, breastfeeding, and early Infant care. | **12.) Mama & Baby Bus Program-**<br>• **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.<br><br>**13.) Participate in health fairs**<br>• **Provide education and information on UM Capital Women's health services**, programs, and activities. | • % of uninsured patients who are assisted to apply for insurance.<br>• % of patients who are screening for depression screening.<br>• % of patients who smoke, who are linked to tobacco cessation services.<br>• % of patients who receive HIV Testing and counseling<br>• % of patients who receive recommended preventive- flu vaccines, mammograms, diabetes and hypertension screenings.<br>• % of patients who receive an annual well woman visits.<br>• % of patients who are screened for domestic violence<br>• % of patients with social support needs<br>• Number of women served on MBB unity<br>• % of patients referred to dental care<br>• % of patients who return for follow-up visits<br>• % of referrals provided<br>• # of health events attended. | • AthenaNet<br>• Satisfaction Surveys | • United Communities Against Poverty/Shepard's Cove Women's Shelter<br>• Laurel Advocacy Services ( LARS)<br>• Prince George's Community College<br>• Southern Management Corporation<br>• Prince George's County Health Department<br>• Other Faith-Based & Community based |

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| **Improve Birth Outcomes** | • High-risk Women in Prince George's County<br>• Uninsured/underinsured | • Improve Birth Outcome for high-risk women in PGC<br>• Increase Exclusive Breastfeeding among Prince George's County New Mothers Up to 6 months post-partum for optima development and health of infants | **<u>14.) Maternal & Fetal Medicine Services. (MFM)</u>**<br>• **Increase awareness of MFM** services among community partners.<br>• **Increase integration of MFM** services into the care coordination of patients.<br><br>**<u>15.) Breast-Feeding Coalition</u>**<br>• **New monthly UM Capital** breastfeeding education class-once a month (1 hr class)<br>• **Expand course offerings** for community health workers; to include certified lactation consultant (CLC) training class<br>• **Develop and partner** to create county- wide recommendations on the importance of breastfeeding practices. | • # of participants attending monthly breastfeeding class<br>• # of pediatric providers in PGC receiving breastfeeding recommendation<br>• # of peer CLC's deployed<br>• % of babies born >27 wks gestation<br>• % of babies born >2500 | • Athena Net | • Greater Baden Medical Services<br>• Mary Center's<br>• CCI<br>• Access to wholistic and productive living institute |