Adventist HealthCare
Shady Grove Medical Center

2017-2019 Community Health Needs Assessment Implementation Strategy

Adopted May 15, 2017

Adventist HealthCare

Implementation Strategy Development & Adoption

Adventist HealthCare Shady Grove Medical Center's 2017-2019 Community Health Needs Assessment (CHNA) was reviewed and approved by the Adventist HealthCare Board of Trustees in November of 2016. Based on the findings, as well as input from the community, Shady Grove Medical Center's Presidents Council prioritized the needs identified in the CHNA in order to guide the development of an Implementation Strategy. The following factors were considered in completing the prioritization process:

- **Incidence and Prevalence**: How big of a problem is the need in the community?
- **Presence and Magnitude of Disparities**: Are some populations disproportionately burdened?
- **Change over Time**: Has the need improved, worsened, or seen no change in recent years?
- **Alignment with County Priority Areas**: Is the health area aligned with Montgomery County's priority areas?
- **Community Input**: Based on the primary survey data, Healthy Montgomery Community Conversations, and input from the Center for Health Equity and Wellness Advisory Board, what are the most significant areas of need as identified by the community?
- **Existing Resources, Expertise, and Partnerships**: Does the hospital have resources, existing programing, expertise, or existing/potential partnerships that can be leveraged to effectively address the need?
- **Gaps and Resources in the Community**: Are there existing resources sufficiently addressing the need or are additional resources needed? Where specifically do the gaps lie?
- **Potential for Measurable and Achievable Outcomes**: Are there relevant outcome measures? Will it be possible to make an impact?

The final prioritized list of needs for Shady Grove Medical Center's 2017-2019 Community Health Needs Assessment is as follows:

1. Diabetes
2. Breast Cancer
3. Colorectal Cancer
4. Maternal/Child Health
5. Cardiovascular Health
6. Prostate Cancer
7. Flu
8. Housing
9. Obesity
10. Behavioral health
11. Cervical Cancer
12. Lung Cancer
13. Food Access
14. Education
15. Asthma
16. Thyroid Cancer
17. HIV

Based on the prioritization process, Shady Grove Medical Center has elected to focus new initiatives on diabetes, in particular for the uninsured/underinsured populations.

Implementation Strategy Overview: Diabetes

Identified Need

The Shady Grove Medical Center primary service area, Montgomery County, is ranked in the top half of all counties in Maryland for percentage of adults with diabetes, age-adjusted death rates due to diabetes, age-adjusted emergency room (ER) and hospitalization rates due to diabetes, and overall ER rates due to diabetes.[1,2,3] Furthermore, there has been an increase in the overall presence of diagnosed diabetes cases in the Medicare population.[4] Among those suffering from diabetes, Blacks and American Indians/Alaskan Natives are most likely to suffer from complications resulting in hospitalizations and ER visits.[5] Oftentimes, such complications from diabetes result from an individual's inability to properly self-manage his/her diabetes. Access to healthy food and knowledge about healthy eating habits are crucial for preventing and managing diabetes. In Montgomery County, 66.70% of adults report consuming less than 5 servings of fruits and vegetables each day.[6] Additionally the rate of Montgomery County residents experiencing food insecurity is 7%.[7]

Goal

Increase access to diabetes education and care for uninsured and underinsured patients and community members.

Strategy 1: Connecting High Risk Diabetes Patients with Primary Care Providers

Overview & Activities

In order to increase access to care and support patients with diabetes along the care continuum, a direct referral process will be put into place with local safety net clinics, beginning with Mercy Clinic. In order to ease the burden, a process will be put into place to electronically facilitate the scheduling of an initial eligibility appointment, as is required to become a clinic patient.

Objectives

- Increase referrals for patients with diabetes who do not have primary care providers
- Increase primary care connections for patients (i.e. patient referrals that followed through with their appointments and were enrolled as patients)

Collaborative Partners

- Mercy Clinic

Committed Resources

- Staff time for development and implementation of electronic referral functionality, patient identification, patient referral, and evaluation

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[1] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2014].

[2] Department of Health and Mental Hygiene (2014). *Age-Adjusted Death Rate Due to Diabetes per 100,000 Population.* Retrieved May 4, 2017 from http://dhmh.maryland.gov/Pages/Index.aspx

[3] Department of Health and Mental Hygiene (2014). *ER Rate Due to Diabetes per 100,000 Population.* Retrieved May 4, 2017 from http://dhmh.maryland.gov/Pages/Index.aspx

[4] Centers for Medicare and Medicaid Services (2014). *Percentage of Medicare Population Treated for Diabetes.* Retrieved May 4, 2017 from https://www.cms.gov/

[5] Montgomery County Health Department. (2014). *Healthy Montgomery.* Retrieved from http://www.healthymontgomery.org/

[6] Community Commons (2013). *Community Commons Community Health Needs Assessment.* Retrieved from http://assessment.communitycommons.org/CHNA/report?page=3&id=404

[7] Feeding America. (2016). Food insecurity in Maryland. Retrieved from: http://map.feedingamerica.org/county/2014/overall/maryland

Strategy 2: Providing American Association of Diabetes Educators (AADE) Accredited Diabetes Self-Management Education (DSME) for Uninsured/Underinsured Populations

Overview & Activities

DSME classes will be offered outside of the hospital and will be open to community members, including those that are uninsured/underinsured at little to no cost. The DSME class is a comprehensive education and training program to help diabetics manage all aspects of their health. Topics covered include:

- Blood glucose testing
- Preventing short and long term complications
- Medication guidance
- Food/eating education and guidance
- Foot care
- Physical activity recommendations
- Goal setting, coping, and stress management
- Resources for ongoing support and assistance

Objectives

- Increase access to diabetes self-management education for uninsured/underinsured patients and community members
- Increase participant knowledge and self-efficacy compared to baseline
- Decrease in participant A1C compared to baseline

Collaborative Partners

- Adventist HealthCare Medical Group Practices

Committed Resources

- RN Certified Diabetes Educator (CDE) staff time for class planning, instruction, and evaluation
- Funds and staff time for class organization and administration including participant registration
- Funds for class location space rental

Strategy 3: Increasing Access to Fresh Fruits and Vegetables for Low-Income Patients

Overview & Activities

In order to increase access to healthy foods including fresh fruits and vegetables, Shady Grove Medical Center is partnering with Hungry Harvest to provide food deliveries for low-income individuals. To be eligible, participants must be at or below 250% of the poverty level. Participants receive bi-weekly food deliveries for 90 days.

Objective

- Increase fruit and vegetable consumption among participants

Collaborative Partners

- Hungry Harvest

Committed Resources

- Staff time for program administration as well as participant identification, assessment of eligibility, and enrollment
- Funds for 90 days of bi-weekly Hungry Harvest food deliveries for up to 250 participants annually

Strategy 4: Cooking Classes for Individuals with Diabetes

Overview & Activities

Designed specifically for individuals with diabetes, Shady Grove Medical Center is offering cooking classes with Adventist HealthCare's Executive Systems chef. At each class, participants learn how to prepare delicious and healthy meals that are quick and easy to make, and receive:

- Food samples
- Healthy recipes
- Carbohydrate counting and nutrition information
- Q&A and advice from a certified diabetes educator

Objective

- Increase participant knowledge and self-efficacy in managing their diabetes by maintaining a healthy diet

Committed Resources

- Staff time for class planning, preparation, and implementation as well as registration, including a chef and RN Certified Diabetes Educator
- Funds for class materials including educational handouts, food, and cooking supplies

Other Areas of Need Addressed by Shady Grove Medical Center

While Shady Grove Medical Center (SGMC) has identified diabetes as its priority area for this Implementation Strategy period, the hospital will continue to address other areas of need through existing community health outreach programs, education, screenings, and financial contributions.

In addition to the action items listed in the table below, SGMC as a part of Adventist HealthCare is committed to providing financial support to improve the health and wellbeing of our community through the Community Partnership Fund. The Adventist HealthCare Community Partnership fund provides funding for 501(c)(3) non-profit organizations whose activities align with our mission and the following funding objectives:

- **HEALTH AND WELLNESS:** Support community health services, education, and prevention and wellness programs
- **PARTNERSHIPS:** Leverage partnerships to address socioeconomic disadvantages that affect health
- **CAPACITY BUILDING:** Improve community health through collaborative partnerships, economic and workforce development, and advocacy

When reviewing applications, the priorities for the Community Partnership Fund include:

- Activities that address a priority area of need identified in our hospitals' Community Health Needs Assessments
- Activities that target populations in Adventist HealthCare's service area that are socially and economically disadvantaged or medically underserved
- Activities that align with Adventist HealthCare's community-based mission
- Activities that have a measurable impact on the community being served

Area of Need	Action	Evaluation
Cancer	**Cancer Overall:** SGMC's cancer outreach team works with community organizations such as housing units, community center, and faith based organizations to provide cancer education. This may include presentations, demonstrations, and screenings such as carbon monoxide. Cancer support groups and classes are also offered. Groups include cooking classes, Look Good Feel Better, and fitness and meditation classes. **Breast:** Through SGMC's breast cancer screening program, hundreds of low income, uninsured/underinsured women receive free breast cancer screening services annually. **Colorectal:** Through a partnership with the Montgomery County Cancer Crusade, SGMC provides contract management and referral services to increase access to free colorectal cancer screenings for low income, uninsured/underinsured individuals 50 years and over.	**Cancer Overall:** • Number of classes and support groups held • Number of education sessions • Number of screenings • Number of participants (classes, support groups, education sessions, screenings) **Breast:** • Number of screenings • Average days between screening and diagnostic mammogram **Colorectal:** • Number of colorectal screening referrals
Maternal/Child Health	SGMC offers free support groups and resources for parents and families. • **Breastfeeding Education, Support, and Togetherness (BEST):** Weekly support group for breastfeeding moms and their babies. A lactation consultant is present at each session for breastfeeding information, support, and assistance. • **Discovering Motherhood:** Weekly support group for moms, both new and experienced. • **Warm Line:** Free over the phone breastfeeding assistance and support from a certified lactation consultant. The warm line is open 7 days a week/365 days a year. • **Perinatal Loss Group:** A six week support program for families that have experienced the loss of a baby during pregnancy or infancy. The program is led by a registered nurse/doula who is an	**Breastfeeding Education, Support, and Togetherness (BEST):** • Number of support groups held • Number of encounters • Breastfeeding rates (exclusively breastfeeding, breastfeeding and supplementing, not breastfeeding) • Participant satisfaction **Discovering Motherhood:** • Number of support groups held • Number of encounters **Warm Line:** • Number of calls • Number of encounters • Number of persons served **Perinatal Loss Group:** • Number of sessions held • Number of encounters

	experienced bereavement specialist for perinatal and infant death.	
Cardiovascular Health	**Cardiovascular Outreach:** SGMC provides free screenings, health education, and lectures in the community around cardiovascular health. Regular blood pressure screenings and education are provided at several community locations. Additional screenings, education, and lectures are provided at health fairs and locations such as senior centers, low-income housing units, and community centers. Screenings offered include blood pressure, body mass index, body fat percentage, and waist to hip ratio.	**Cardiovascular Outreach:** • Number of events (screenings, lectures, health fairs, etc.) • Number of screenings • Number of encounters • Screening results and geography
Flu	SGMC provides both education and clinics in the community during flu season. • **Flu Clinics:** SGMC provides low cost flu shot clinics throughout the county to children, adults, and senior centers at various locations including community centers, senior centers, faith-based organizations, and low-income housing units, among others. • **Education and Outreach:** SGMC also provides health education on cold and flu prevention to community members at many of the locations listed above.	**Flu Clinics:** • Number of clinics • Number of vaccinations administered • Number of each type of vaccination administered **Education and Outreach:** • Number of lectures/health education sessions provided • Number of encounters
Obesity	SGMC provides outreach, education, and screenings around obesity, nutrition, and active living. • **Screenings and Education**: Screenings, education, and lectures are provided in the community. Screenings include BMI, body fat percentage, and waist to hip ratio. • **Nutrition and Cooking Classes**: Two free cooking classes are offered to the community. One of these classes is more geared toward those with, or recovering from cancer, while the other has	**Screenings and Education**: • Number of events (screenings, lectures, health fairs, etc.) • Number of screenings • Number of encounters **Nutrition and Cooking Classes**: • Number of cooking classes • Number of encounters

	more of a focus on individuals with diabetes.	
Social Determinants of Health: Food Access	As described in the Implementation Strategy above, SGMC partners with Hungry Harvest to increase access to fresh fruits and vegetables for individuals at or below 250% of the poverty level. *See Implementation Strategy above for additional details*	*See Implementation Strategy above for additional details*

Other Areas of Need Not Directly Addressed by Shady Grove Medical Center

SGMC does not directly address the areas of need included in the table below through ongoing education or programing. However, these areas may be addressed through the Adventist HealthCare Community Partnership Fund which aims to provide funding for community organizations working to address needs identified in our community health needs assessment.

Area of Need	Rationale
Behavioral Health	SGMC does not directly address behavioral health due to a lack of expertise and resources. Behavioral health is being addressed by other organizations in the community including Adventist HealthCare Behavioral Health and Wellness Services, a specialty care hospital part of the Adventist HealthCare system. SGMC also participates in the Nexus Montgomery Regional Partnership along with the other five hospitals operating in Montgomery County as well as community organizations such as the Primary Care Coalition. The aim of the partnership is to improve the health status of those most at risk of avoidable hospital use, including those with severe behavioral health conditions.
Asthma	SGMC does not currently provide community outreach and educational programs specific to asthma due to limited financial resources, expertise, and a focus on areas that were identified as higher priority during the CHNA prioritization process.
HIV	SGMC does not currently provide community outreach and educational programs specific to HIV/AIDS due to limited financial resources, expertise, and a focus on areas that were identified as higher priority during the CHNA prioritization process.
Social Determinants of Health: Housing and Education	SGMC does not currently provide community outreach and educational programs specific to housing and education due to limited financial resources, expertise, and a focus on areas that were identified as higher priority during the CHNA prioritization process.