Adventist HealthCare
Washington Adventist Hospital

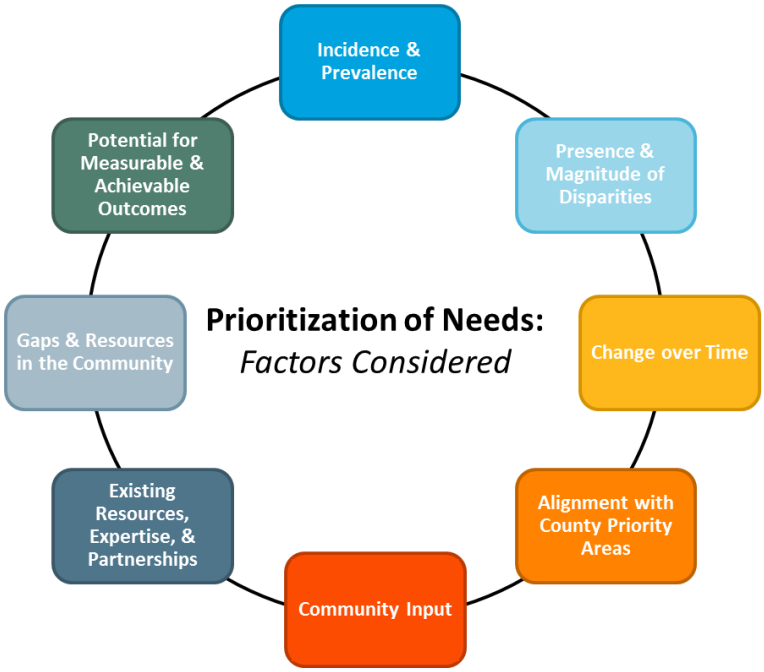
2017-2019 Community Health Needs Assessment Implementation Strategy

Adopted May 15, 2017

Adventist HealthCare

Implementation Strategy Development & Adoption

Adventist HealthCare Washington Adventist Hospital'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, Washington Adventist Hospital'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 Washington Adventist Hospital's 2017-2019 Community Health Needs Assessment is as follows:

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

Based on the prioritization process, Washington Adventist Hospital has elected to focus new initiatives on chronic disease by addressing cross-cutting factors such as nutrition, physical activity, and food access.

Implementation Strategy Overview: Chronic Disease

Identified Need

- Primary data collected as part of Adventist HealthCare Washington Adventist Hospital's CHNA ranked obesity and diabetes in the top 10 among 26 identified community health concerns. Obesity was ranked 2nd, while diabetes was ranked 4th. Additionally, access to affordable nutritious food was identified as both a health concern and a needed resource in the community.
- In Montgomery County, 20.3% of adults are obese and 57.4% are overweight or obese. In Prince George's County, 34.2% of adults are obese and 68.3% are overweight or obese. State Health Improvement Process (SHIP) targets are unmet for obesity in both counties. In both counties the groups most disproportionately affected are 45-64 year olds as well as Blacks and Hispanics.
- Among adolescents, in Montgomery County 7.5% are obese while 15.1% are obese in Prince George's County. SHIP targets in Prince George's County are unmet. Similar to the adult populations, among adolescents the most disproportionately affected groups are Blacks and Hispanics.
- In Montgomery and Prince George's Counties, only 29.6% and 32.4% of adults, respectively, consume 5 or more servings of fruits and vegetables each day.
- 7% of the population in Montgomery County and 15.5% of the population in Prince George's County experienced food insecurity in 2015.
- In Montgomery and Prince George's Counties, only 52.8% and 47.4% of adults, respectively, engage in regular physical activity. Rates are lowest among Hispanics, 25.5% in Montgomery County and 33.6% in Prince George's County.
- 7% of adults in Montgomery County and 11.5% of adults in Prince George's County have been diagnosed with diabetes.
- ER rates due to diabetes meet SHIP targets overall for both counties, however, Blacks do not meet the targets in either county – experiencing ER rates 2 times that of whites in Prince George's County and 4 times that of whites in Montgomery County.

Goal

Increase knowledge of, and access to, skills and resources around nutrition and physical activity to better prevent and manage chronic disease.

Strategy 1: Long Branch Healthy Food Access Program (LBHFAP)

Overview & Activities

Starting in the spring of 2017, the Long Branch Healthy Food Access Program will serve low-income, food insecure residents of the Takoma Park and Long Branch communities who have uncontrolled diabetes. The aim of the LBHFAP is to improve the health status of 250 residents who are low income (250% of the poverty level and below) and diabetic (HbA1c > 7) by December 2019. For each participant, there will be 3 months of active intervention followed by 9 months of maintenance. During the active intervention, community health workers (CHWs) work with participants to develop a tailored food access and healthy living plan, assess eligibility for assistance programs such as SNAP and WIC, enroll interested participants in Manna's nutrition education program, and provide referrals to PCPs if participants do not already have one. Participants also receive weekly food deliveries from Hungry Harvest and Manna for three months. At 12 months, CHWs reach out once again to provide additional support and follow-up.

Objectives

- Increase the percentage of program participants who consume five or more servings of fruits and vegetables daily
- Improve health outcomes among program participants; specifically see decreases in HbA1c, BMI and weight
- Improve participant self-care and engagement in managing diabetes
- Reduce food insecurity among program participants

Collaborative Partners

- Community Health and Empowerment through Education and Research (CHEER)
- Manna Food Center
- Crossroads Community Food Network
- MobileMed
- Primary Care Coalition of Montgomery County

Committed Resources

- Staff time for: training of CHWs; participant identification, assessment of eligibility, and program enrollment; provision of baseline assessments such as A1C; and program administration and evaluation in collaboration with program partners
- Financial support which includes: 900 packages of fresh food deliveries; funds for equipment, supplies and software for participant data tracking; and funds for incentives such as transportation and child care to enable participants to take part in educational programming, meet with the CHWs, and facilitate food pickups and deliveries

Strategy 2: Addressing Chronic Disease through the Promotion of Healthy Eating and Physical Activity in Partnership with the Faith Community

Overview & Activities

Adventist HealthCare has developed an extensive and diverse faith community network in addition to leading a Faith Community Nurse Network. Utilizing these partnerships, Washington Adventist Hospital will offer 6-week workshops to promote healthy eating and physical activity. Each workshop will be interactive and include a mix of lectures, demonstrations, and discussions. Incentives and challenges will be incorporated to encourage regular attendance and bolster participant engagement.

Objectives

- Increase participant knowledge compared to baseline regarding nutrition, healthy eating practices, and physical activity
- Increase participant self-efficacy in engaging in healthy eating practices and incorporating physical activity into their lifestyle
- Increase participant fruit and vegetable consumption
- Increase participants engaging in moderate physical activity
- Improvements in participant biometric data compared to baseline including decreases in blood pressure, body fat percentage, BMI, weight, and waist to hip ratio

Collaborative Partners

- Adventist HealthCare Faith Community Network *(exact organizations TBD)*
- Adventist HealthCare Faith Community Nurse Network

Committed Resources

- Staff time for planning, implementing, and evaluating the workshops
- Staff time and funding for workshop materials and incentives

Other Areas of Need Addressed by Washington Adventist Hospital

While Washington Adventist Hospital (WAH) has identified obesity 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, WAH 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:** WAH'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. Look Good Feel Better is also offered at WAH. **Breast:** Through WAH'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, WAH 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 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	WAH offers free support groups and resources for parents and families. • **Hecho de Pecho:** Monthly group providing support and education for breastfeeding moms and their babies. Mothers are able to bring additional family members, children, and support people. The group is conducted in Spanish and a lactation consultant is present at each session for breastfeeding information, support, and assistance. • **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.	**Hecho de Pecho:** • Number of support groups held • Number of encounters **Warm Line:** • Number of calls • Number of encounters • Number of persons served
Cardiovascular Health	**Cardiovascular Outreach:** WAH 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	WAH provides both education and clinics in the community during flu season. • **Flu Clinics:** WAH provides free and 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:** WAH 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

Diabetes & Obesity	In addition to the initiatives described in the implementation strategy above, WAH provides outreach, education, and screenings around diabetes, obesity, active living, and healthy eating. • **Screenings and Education**: Screenings, education, and lectures are provided in the community. Screenings include BMI, body fat percentage, and waist to hip ratio. • **Diabetes Self-Management Classes**: The Stanford Diabetes Self-Management Program, an evidence based 6 week community based program is offered for free in both English and Spanish. • **Zumba Classes:** Free Zumba classes offered outdoors in the community.	**Screenings and Education**: • Number of events (screenings, lectures, health fairs, etc.) • Number of screenings • Number of encounters **Diabetes Self-Management**: • Number of workshops • Number of encounters and persons served • Knowledge change • Behavior change **Zumba Classes:** • Number of classes • Number of encounters

Other Areas of Need Not Directly Addressed by Washington Adventist Hospital

WAH 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	WAH does not directly address behavioral health due to a lack of 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. WAH 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	WAH 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	WAH 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	WAH 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.