DOCTOR'S COMMUNITY MEDICAL CENTER
COMMUNITY HEALTH IMPROVEMENT PLAN FY2019-FY2021

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Executive Summary

DCMC is dedicated to continuously helping area residents maintain and improve their overall health. Our fiscal years 2020 and 2021 Community Health Needs Assessment (CHNA) and Community Health Improvement Plans (CHIP) outlines how we will address specific high-priority healthcare concerns in Prince George's County.

This report relies on data from the Prince George's County 2019 Community Health Assessment. Prepared by the Prince George's County Health Department, this information was the result of a collaboration with the Prince George's Healthcare Action Coalition and a core team of leaders from four area hospitals: DCMC, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center and University of Maryland Prince George's Hospital Center.

This diverse team envisioned a system "to serve all with quality services." To gain important insights, it conducted community surveys, community expert profiles and key informant interviews. It also gathered secondary demographic and population descriptions including socioeconomic indicators. Consequently, it identified multiple health need priorities: social determinants of health, behavioral health (mental health and substance use), obesity and metabolic syndrome (diabetes, heart disease and hypertension), and cancer.

During fiscal years 2020 and 2021, DCMC will develop and implement targeted strategies to contribute to the improvement Prince Georgians' health by focusing on obesity/metabolic syndrome (and diseases caused my metabolic syndrome such as diabetes, heart disease, and hypertention), cancer, and behavioral health. DCMC will collaborate with community partners to address the health priorities.

Table 2: FY2019-FY2021 Community Health Priorities

Health Priority	Action Plan
Metabolic Syndrome Prevention	Expand diabetes prevention programs via CDC partnership; increase partner participation, develop health education materials; continue/ expand screenings and services provided by the Wellmobile clinic to provide free screenings to vulnerable residents.
Cancer	Continue to provide and expand free education, screenings and support programs for breast, cervical, and colorectal cancers, programs targeted to uninsured and under-insured men and women. Initiate tobacco cessation program.
Behavioral health	In collaboration with Prince George's County government, initiate planning for behavioral health programs to provide enhanced services that address needs through the DCMC emergency department and the community. Develop and Implement in-patient, out-patient, and urgent care programs

About Doctors Community Medical Center

DCMC was founded in 1975 by physicians who were committed to delivering accessible, high-quality and comprehensive health care to area residents. Since that time, our non-profit organization has grown into a network of care. On 37.7 acres in Lanham, we have multiple buildings including our 206-bed hospital and 130-bed short-term-stay / long-term-care facility. To deliver care close to where people live, work and play, we also have ambulatory services offices conveniently located in Bowie, Camp Springs, Crofton, District Heights, Hyattsville, Lanham, Laurel, Riverdale and Temple Hills.

In fiscal year 2018, our compassionate healthcare team included 1,604 employees and 616 medical staff professionals. We also had 360 volunteers who donated 26,830 hours of support. Our mission is rooted in our tradition of being dedicated to caring for the health of the community. We have earned numerous recognitions including U.S. News & World Report's high performing hospital in colon cancer surgery and heart failure, Medicare's highest-ranking hospital in Prince George's County with a four-star quality rating, Maryland Institute for Emergency Medical System's Primary Stroke Center designation and many others. In addition, we provided over $13million annually in community benefit programs.

Prince George's County is the second largest jurisdiction in Maryland with 912,756 residents as reported in 2017, which represents an increase of 110,000 since 2000. The race and ethnicity composition of the community is 62.0 percent black, non-Hispanic; 18.5 percent Hispanic; 12.6 percent white, non-Hispanic; 4.0 percent Asian, non-Hispanic; and 2.0 percent other, non-Hispanic.

Table 1: Demographics

Demographics	Prince George's County	Maryland	U.S.
Median Household Income	$81,240	$80,776	$60,336
Poverty	8.4%	9.3%	13.4%
Education (25 Years and Older) with at Least a High School Education			
High School Graduate	26.9%	24.5%	27.1%
Some College, No Degree	21.8%	18.9%	20.4%
Associate Degree	6.4%	6.8%	8.5%
Bachelor's degree	18.1%	21.3%	19.7%
Graduate or Professional Degree	14.0%	18.3%	12.3%

Our community represents a diverse population. Yet, good health is still not attainable for most residents.

Community Health Needs Assessment

Process and Methodology

Our health needs assessment and implementation plan were developed using local, state and national data presented in the Prince George's County's Community Health Assessment. The Prince George's County Health Department spearheaded the initiative for the county. Some of the secondary data sources included in the report are the Maryland Health Services Cost Review Commission, Maryland Vital Statistics Annual Reports, Maryland Department of Health's Annual Cancer Report, Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention's CDC Sonder Online Database, Centers for Medicare and Medicaid Services, National Vital Statistics Report, Maryland State Health Improvement Plan (SHIP), and the Prince George's County Health Department. Additional data points were from the U.S. Census Bureau, Maryland Report Card, United States Department of Agriculture, County Health Rankings and National Low Income Housing.

Table 3: Qualitative Data

Categories	Methods	Respondents
Key Informants – local government, hospital systems, patient advocates, faith-based organizations, public school system, local politicians, academia, public safety, safety net providers, state government, physician providers, private industry, local philanthropy and special populations	Telephone interviews, 30 – 75 minutes	28 potential / 14 interviewees
Community Experts – providers, community-based organizations, local governments and population representatives	Email surveys	270 potential / 83 responses
Resident Survey – diverse county population with surveys available in English, Spanish and French	Online and printed surveys	218 responses

Prioritizing Health Needs

There was an impactful response to the qualitative data collection process. In combination with the quantitative data analysis, it was determined that numerous health and social needs impact the health of Prince George's County residents. Therefore, the Prince George's County Department of Health held a prioritization discussion with the hospital systems in the county. During the discussion, all the hospital systems represented agreed that the work they started in 2016 is not yet complete, and the data and community input are reflective of this. The stakeholders therefore agreed to maintain the four main priority areas during the next three years: social determinants of health, behavioral health, obesity and metabolic syndrome, and cancer. Furthermore, DCMC leadership determined that the needs should support a strategic framework, maximize resources, and have an impact. Therefore, we prioritized obesity/metabolic syndrome, cancer, and behavioral health as our health priorities with an

emphasis on developing innovative outreach strategies and developing community partnerships (as recommended by the PGDOH CHNA).

Implementation Strategy

Obesity and Metabolic Syndrome, Diabetes Prevention, Heart Health/ Hypertension Control

Obesity, poor nutrition, and sedentary lifestyle are risk factors for obesity and related metabolic syndromes such as diabetes, heart disease, and hypertension. Diabetes is the fifth leading cause of death in the county with the black, non-Hispanic, emergency rate being double that of white, non-Hispanics. The mortality rate is highest among black, non-Hispanics. The diabetes prevalence in Prince George's County is higher that the state. Heart disease is the number one underlying cause death in the county with black, non-Hispanics. More than two-thirds of residents ages 65 and over have hypertension. These health conditions are viewed as significant by county residents that have long term consequences.

Objectives	Actions	Metrics
Improve education for residents related to obesity and diabetes prevention, proper nutrition, physical activity, and other disease prevention strategies.	1. Implement Diabetes Prevention Program in accordance with CDC guidelines (Initiate Cohort 1 and 2 during FY2020 and Cohort 3 in FY2021).	1. Number of classes held, number of participants, weight Lost, number of physical activity minutes logged
	2. Expand partnerships to expand chronic disease management programs a. Partner with local grocery stores to provide "talk and teach" programs that educate customers about how to select healthier dietary options b. Engage with PGHAC's subcommittee on Healthy lifestyle to promote programs c. Partner with faith-based organizations to support programs about chronic diseases, self-management / prevention tips and treatment options	2. Number of grocery stores, number of faith based organizations, number of referrals to programs, number of participants reached
	3. Develop educational materials in English and Spanish targeting internal and external audiences (FY 2021) including print/video.	3. Number of educational materials developed, number of individuals viewing educational materials

Objectives	Actions	Metrics
Provide support for individuals who have diabetes	1. Integrate with mobile health clinic to track pre-diabetics and diabetics to receive education and screenings 2. Develop support group for residents with diabetes	• Number of patients reached and monitor of symptoms • Number of meetings, number of participants
Expand mobile health clinic's diabetes screening process: • Education • Medication education • Follow-up instructions for patients' primary care providers • Follow-up calls to participants with unfavorable glucose results to encourage management	1. Develop modified framework and processes (FY 2020) 2. Develop promotional tactics in English and Spanish targeting internal and external audiences (FY 2021) 3. Evaluate program and trends (FY 2021)	• Approved framework and processes • Produced materials/forms • Number of screenings

Cancer Screenings and Supportive Care

Cancer remains the leading cause of death in Prince George's for Black residents and the second cause of death for all residents. There is still significant disparity for Black residents with regard to cancer, despite health screenings.

Objectives	Actions	Metrics
To enhance and sustain a community-based continuum that will increase utilization of breast screening by uninsured and underserved women.	Expand breast and cervical cancer screenings to more than 850 women over the next 3 years.	• Number of health talks • Number of community partners • Number of free mammograms and pap smears
Reduce disparity in colorectal cancer deaths by improving access to screening, diagnosis and treatment.	Expand free colorectal cancer screenings to more than 300 uninsured and underinsured residents.	• Number of health talks • Number of residents screened for colorectal cancer
Reduce incidence of tobacco related cancers.	Provide group or 20 individual counseling sessions for tobacco cessation and refer clients to MD Quitline.	• Number of patients enrolled in tobacco cessation • Number of referrals to MD Quitline

Behavioral Health

The hospitals, public safety, and criminal justice system in the County see many residents needing behavioral health services and treatment. Yet, the county lacks adequate resources needed to address residents with significant behavioral health issues. Furthermore, stigma around behavioral health continues to be an ongoing challenge in the county.

Objectives	Actions	Metrics
For the next year, develop a plan to address behavioral health needs in a variety of settings and along the continuum from moderate to urgent.	Review and assess the plan, including resources, opportunities and barriers to implement: • In-patient behavioral health unit • Partial hospitalization program • Intensive outpatient program • Outpatient medication management and therapy • Enhanced hospital Emergency Department consultation • Development of a Walk-In/Urgent Care Center • Residential Crisis Service (RCS)	• Number of Meetings • Plan Progression • Resources Identified • Barriers addressed • Number of community partners

Conclusion:

The Prince George's County Department of Health made additional recommendations in the CHNA 2019 that we will consider as we develop our Implementation Plan. Specifically, residents need additional information about existing programs and services - and how to navigate them. More outreach and education is needed community-level to be culturally sensitive and reach residents. As part of our integration work with Luminis Health, we will be proactively engaging additional outreach staff to provide education and meet more residents. Additional educational materials, in multiple medias, will be developed in English and Spanish. Last, our partnerships will expand to include more faith based organizations, non-profits, workplaces, and social service agencies.