Community Health Needs Assessment Implementation Plan

FY2019-FY2021

Approved, Board of Trustees

May 21, 2019

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EXECUTIVE SUMMARY

Anne Arundel Medical Center (AAMC) is pleased to provide the FY2019 through FY2021 Community Health Needs Assessment (CHNA) and Implementation plan. This report is designed to describe the process of collecting information and ascertaining the community needs, prioritizing those needs and a description of AAMC's action plan to address those needs to improve health. For the purpose of this report, the community is defined as Anne Arundel County since the majority of patient discharges reside in this area. The Board of Directors approved this plan on (INSERT DATE) in accordance with IRS regulations.

Key Findings: The CHNA data was compiled from secondary data sources and qualitative information obtained from key informant interviews and several focus groups of diverse community members. It outlined over 50 health needs in the Anne Arundel County community. While a singular entity or hospital does not have the capacity or resources to address all of the needs, AAMC intends to collaborate with partners and address many of the needs to better the health of the community. AAMC's senior leadership and select patient advisors prioritized the 50 needs and selected 4 health needs. The results and correlating action plans are included in Table 1.

Table 1

Priority	Action Plans
Senior Health	**Build age-friendly programs around the 4Ms (Medication, Mentation, Mobility, what Matters), with additional focus in ambulatory care settings**
Youth Behavioral Health/ In-Crisis	**Engage community stakeholder to identify gaps in services and implement programs to increase education on risk and warning signs for mental health for adults and adolescents.**
Social Determinants of Health	**Create a systemic screening process for patients to address social determinants of health. Engage community partners to expand referrals.**
Assessing Needs in Prince George's & Queen Anne's Counties	**Year 1 – Integrate and participate in Prince George's County and Eastern shore health department(s) community coalitions.** **Year 2 – Select 1 health need from findings from Year 1 and develop and focused implementation plan.**

INTRODUCTION

During Fiscal Year 2019, AAMC conducted its third three-year Community Health Needs Assessment (CHNA) in collaboration with University of Maryland, Baltimore Washington Medical Center (UMBWMC), the Anne Arundel County Department of Health (AADOH), the Anne Arundel County Mental Health Agency, and the Anne Arundel County Partnership for Children, Youth and Families pursuant to the requirements of Section501® of the Internal Revenue Code ("Section 501(r)"). The FY2019 CHNA covers the fiscal years 2019, 2020 and 2021. The CHNA findings and corresponding Implementation Plan was approved by Board in INSERT DATE, also required by Section 501(r), and made available on the hospital website.

The report outlined more than 50 health needs with input from secondary data analysis and community input (focus groups and key informant interviews). One hospital, alone, does not have the resources necessary to address the fifty needs identified in the CHNA. Collaboration with community partners (county and city governments, local non-profits, faith based organizations, employer groups, payor groups, etc.) will be paramount to improving health and addressing the needs of county residents. AAMC is committed to improving the health of the patients we serve, and as a result, the priorities and plan outlined in this report represent what our leadership has determined we can impact. This will provide part of the foundation in which to allocate resources for the next three years.

ABOUT ANNE ARUNDEL MEDICAL CENTER

We are a regional health system headquartered in Annapolis, Md., serving an area of more than one million people. Founded in 1902, AAMC includes a not-for-profit hospital, a medical group, imaging services, a substance use treatment center, and other health enterprises. In addition to a 57-acre Annapolis campus, AAMC has outpatient pavilions across Anne Arundel County, and physician practices on the Eastern shore and in Prince George's County. A new mental health hospital, the McNew Family Hospital, will open in the Spring, 2020. With more than 1,200 medical staff members, 4,800 employees and 900 volunteers, AAMC consistently receives awards for quality, patient satisfaction and innovation.

AAMC's mission is *to enhance the health of the people it serves. It is also guided by its core principles of compassion, trust, dedication, quality, innovation, diversity and collaboration.* That means that the care that AAMC provides is centered on the patient. We operate beyond the walls of the hospital and serve a broad geography and diverse population of patients. Our work builds on partnerships, relationships and connectivity. We hold shared accountability among patients, physicians, hospital, employees and community. We are driven by standards based on evidence and outcomes while remaining viable, cost-effective, and responsible.

In FY2016, AAMC engaged in a multi-year project to reduce health disparity and create a culture of health equity for providers and employees, patients, families and the community we serve. The program is multi-dimensional and includes improving language access for better communication between provider and patient, on-going cultural competency education for physicians and staff, and identifying programs that narrow disparity and foster equity. Our work will continue to focus on strengthening a system of equity, recruiting and hiring a diverse workforce, improved training for staff and physicians, and using a health equity lens as we approach health needs of the community.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND METHODOLOGY

The summative (quantitative) data contained in this needs assessment was gathered from a variety of local, state and national sources. Population and socio-economic statistics were compiled using data from the United States (U.S.) Census Bureau's Population Estimates Program and the American Community Survey 1-Year and 5 Year Estimates. These data should be considered less reliable due to the gap of eight years since the last full census. All data here are based on census estimates. Birth and death data files were obtained from the Maryland Department of Health and Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the Maryland Health Services Cost Review Commission for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare and Medicaid Services,

National Vital Statistics Reports and County Health Rankings, and a variety of local databases. The specific data sources are listed throughout the report.

The FY2019 CHNA draws on qualitative data gathered from 26 key informants and 11 focus groups. Focus group areas included emergency department personnel, low income youth, behavioral health providers, Hispanic residents, advocates, domestic violence victims and a host of others representing a total of 185 participants. Key informants included law-makers, hospital CEOs, and leaders from health department, police, schools, faith organizations, and community residents – representing 26 individuals. A full list of focus groups and key informants can be found in the CHNA (NOTE WEBSITE).

PRIORITIZING COMMUNITY HEALTH NEEDS

We followed provided an unbiased process to narrow more than 50 community health needs to 4. While many of the needs overlap or are needs we currently address, it is important to prioritize needs to support a strategic framework, maximize resources, and have an impact. First, a visual model (infographic—Appendix A) of the CHNA was developed to condense the document into a workable tool. Executive council, service line leaders, and patient advisors were convened to review the model and review the findings of the CHNA. The Council was asked to rank their top needs. These recommendations were collected and present to the Population Health Task Force. The task force included executive leaders and ambulatory leaders who were charged with developing a robust and focused implementation plan.
The task force re-validated the recommendations from the Executive Council and reviewed/ included additional focus areas for consideration. Approximately 8-10 community needs were discussed. Members of the Population Health Task Force further narrowed and ranked the needs based on the following criteria:

- Community importance
- AAMC's ability to impact change
- Need aligns with AAMC's strategic priorities
- Impact on vulnerable populations or disparity

The following list includes the prioritized needs as determined above.

1. Somatic Health: Senior Health (inclusive of chronic conditions, dementia, mental health, polypharmacy, and loneliness/social isolation)
2. Social Determinants: Strengthen partnerships to address social determinants
3. Behavioral Health: Youth Crisis Intervention/Youth Suicide
4. Expand Community Needs into primary service including Prince George's and Queen Anne's Counties.

IMPLEMENTATION STRATEGY

See the following for a detailed plan.

SOMATIC HEALTH: SENIOR HEALTH

Individuals over the age of 65 are on the rise in our community. Furthermore, chronic diseases account for 75% of all healthcare spending,[i] and almost 90% of seniors have at least one chronic condition, with a quarter of them having four or more.[ii] With the outsized impact senior citizens have on healthcare utilization and spending, addressing their unique characteristics and needs plays a vital role not only in controlling costs but in providing the best care possible to this patient population. As an *Age-Friendly Health System*, AAMC is committed to meeting the needs of the elderly population – in the acute care setting, in the outpatient setting and in the community at large.

Objectives	Actions	Metrics	Community Partners
Reduce harmful medication interactions	Pilot and expand Beers Criteria Alarm in AAMC practices to warn prescribers about interactions and inform patients	Establish baseline for Beers Criteria assessment and set goal for Year 2, 3	• Anne Arundel County Department of Aging & Disabilities • Skilled Nursing Facilities
Improve mobility	Increase mobility screening via "Timed up and Go" programs and refer patients to physical therapy	Establish baseline for Timed Up and Go assessment and set goal for Year 2, 3	
Increase the number of patients with "What Matters" conversations with providers	Educate providers and increase What Matters screenings to increase the number of documented conversations about patient goals Implement Wellness visits into AAMC practices	Increase the number of patients with documented patient goals in patient medical record (including end of life wishes and documents) Increase the number of patients with a Wellness visit on the Eastern shore.	
Reduce social isolation	Implement social isolation screening tool; increase the number of programs patients are referred to for home visits and interaction	Establish screening tool, establish baseline for social isolation and set goal for Year 3	
Increase awareness of link between chronic disease and dementia.	Explore the connection between Type 2 Diabetes and vascular dementia.	Establish screening tool, establish baseline and set goal for Year 3	

BEHAVIORAL HEALTH: YOUTH CRISIS & SUICIDE

Between 2012 and 2016, suicide was the second leading cause of death for 10-24 year olds in Anne Arundel County[iii]. During this period, Anne Arundel County has also seen a 97% increase in female youth suicide attempts in just six years (2011- 348, 2016 – 433)[iv]. The number of crisis interventions for social and emotional problems has more than doubled since 2013[v]. Anne Arundel County high school students report higher rates of feeling sad or hopeless and seriously considering attempting suicide compared to the state of Maryland[vi].

Objectives	Actions	Metrics	Community Partners
Engage Community stakeholders to identify barriers related to gaps in screening, access to care, continuity of treatment, community resources Increase education and awareness about risk factors for mental health/ crisis in youth among adults and youth Expand outreach and grassroots programs in schools	Implement programs that address gaps related to screening, access to care	Increase the number of programs implemented; increase the number of individuals referred to care	• Anne Arundel County Public Schools Anne Arundel County Mental Health Agency • American Academy for Pediatrics • National Alliance on Mental Illness National Foundation for Suicide Prevention • Student led grassroots awareness and advocacy groups(e.g., Our Minds Matter, Burgers and Bands, Ellie's Bus)
	Implement programs for adult Mental Health First Aid training and Youth and Adult Resiliency program.	Increase the number of individuals trained in mental health and resiliency	
	Collaborate with Anne Arundel County Public Schools and the Department of Health to educate staff and suicide prevention, screening and resources.	Increase the number of Anne Arundel County Public Schools staff trained in mental health; increase the number of students referred for programs.	
	Collaborate with Anne Arundel County Public Schools and pediatricians to implement programs and campaigns to raise awareness and reduce stigma around mental health and youth.	Improve screening and referral process for youth accessing mental health care.	
	Implement Intensive Outpatient Psychiatric (IOP)	Increase the number of youth in care	

SOCIAL DETERMINANTS OF HEALTH: STRENGTHENING PARTNERSHIPS

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes.[vii] These conditions are known as social determinants of health (SDOH). Many factors determine the state of a person's overall wellness. The social determinants of health include income level, especially for those who live in poverty, access to healthy food, emotional stability, the cleanliness and safety of the environment, and access to health services. Although Anne Arundel County has a high standard of living overall, there are pockets of poverty and health access issues found in areas of high population density in North County, Annapolis, and in some of the rural areas of South County. Transportation, affordable housing, childcare, and access to healthy food remain as needs for county residents.[1]

Objectives	Actions	Metrics	Community Partners
Create a systemic screening process for patients to address social determinants of health. Engage community partners to expand referrals.	Implement systematic screening/ screening tool of social determinants of health in all AAMC primary Care Practices (FY19)	Increase the number of patients who are screened for social determinants of health.	• 211/ United Way • Other local resources such as Department of Aging and Disabilities, Department of Health, Department of Social Services, etc.)
	Develop and implement a multi-layered referral process (FY20)	Increase the number of referrals to community resources.	
	Develop and communicate a comprehensive resource list, including partnerships and programs (e.g., UWCM 211) (FY20)	Establish and communicate resource list.	
	Provide education to physicians, medical assistants, patient panel coordinators, etc. (FY20)	Increase the number of providers and staff educated about social determinants of health to increase screenings referrals to services	
	Identify top 2-3 SDOH needs that impact patient care and develop partnerships and plans to address SDOH, including resource allocation (FY20-21)	Determine resource allocation expense (community benefit) to address needs.	

EXPANSION INTO GEOGRAPHIC SERVICE AREA

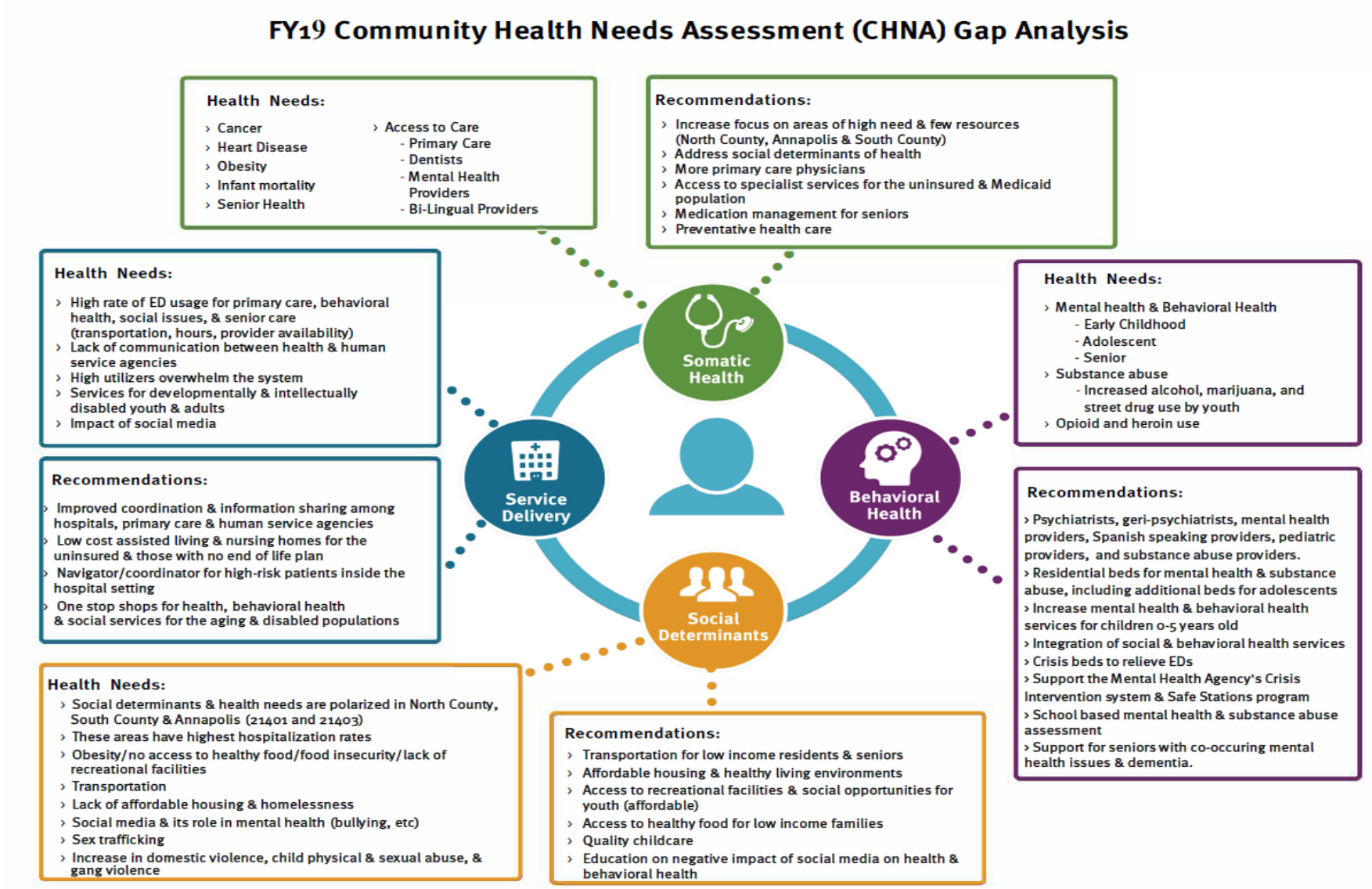
AAMC serves a growing number patients and residents in areas of Prince George's and Queen Anne's Counties. It is imperative that the Implementation Plan address the health needs in those communities. For example, Prince George's County is home to more than 900,000 diverse residents and includes urban, suburban, and rural areas. In contrast, Queen Anne's County is one of the twenty-four counties in Maryland with a rural designation. The populations are unique and diverse across the counties and we are committed to providing the right care in the right place.

Objectives	Actions	Metrics	Partners
Focus on integration and full participation with the Prince George's County and Eastern Shore health departments and community coalitions. Select one category of need specific to each geography and develop a focused plan to impact needs.	Attend community coalition meetings to determine outcomes of FY19-FY20 CHNA	Increase the number of meetings attended and partners identified. Outcome measures are to be determined based on plan.	• AAMC practices and providers in Prince George's County and Eastern Shore Counties • Prince George's County Department of Health • Prince George's County Public Schools • Prince George's County Department of Aging and Disabilities • City of Bowie • Chamber(s) of Commerce • Queen Anne's County Department of Community Services • Queen Anne's County on Aging – Maryland Access Point • Rural Health Collaborative
	Align partnerships in geographic areas to establish strategic plans to address needs		
	Develop plans and identify actions, resources and outcome metrics for FY20, 21		

FINAL NOTES

The implementation plan will be incorporated into the strategic planning process for the next three years to ensure that adequate resources are allocated to the projects. Activities will be monitored and the progress will be communicated. A copy of this report and a complete report of the CHNA can be found on our website at www.aahs.org

Appendix A


FY19 Community Health Needs Assessment (CHNA) Gap Analysis
Health Needs:
› Cancer
› Heart Disease
› Obesity
› Infant mortality
› Senior Health
› Access to Care
- Primary Care
- Dentists
- Mental Health Providers
- Bi-Lingual Providers
Recommendations:
› Increase focus on areas of high need & few resources (North County, Annapolis & South County)
› Address social determinants of health
› More primary care physicians
› Access to specialist services for the uninsured & Medicaid population
› Medication management for seniors
› Preventative health care
Health Needs:
› High rate of ED usage for primary care, behavioral health, social issues, & senior care (transportation, hours, provider availability)
› Lack of communication between health & human service agencies
› High utilizers overwhelm the system
› Services for developmentally & intellectually disabled youth & adults
› Impact of social media
Recommendations:
› Improved coordination & information sharing among hospitals, primary care & human service agencies
› Low cost assisted living & nursing homes for the uninsured & those with no end of life plan
› Navigator/coordinator for high-risk patients inside the hospital setting
› One stop shops for health, behavioral health & social services for the aging & disabled populations
Somatic Health
Service Delivery
Behavioral Health
Social Determinants
Health Needs:
› Mental health & Behavioral Health
- Early Childhood
- Adolescent
- Senior
› Substance abuse
- Increased alcohol, marijuana, and street drug use by youth
› Opioid and heroin use
Recommendations:
› Psychiatrists, geri-psychiatrists, mental health providers, Spanish speaking providers, pediatric providers, and substance abuse providers.
› Residential beds for mental health & substance abuse, including additional beds for adolescents
› Increase mental health & behavioral health services for children 0-5 years old
› Integration of social & behavioral health services
› Crisis beds to relieve EDs
› Support the Mental Health Agency's Crisis Intervention system & Safe Stations program
› School based mental health & substance abuse assessment
› Support for seniors with co-occuring mental health issues & dementia.
Health Needs:
› Social determinants & health needs are polarized in North County, South County & Annapolis (21401 and 21403)
› These areas have highest hospitalization rates
› Obesity/no access to healthy food/food insecurity/lack of recreational facilities
› Transportation
› Lack of affordable housing & homelessness
› Social media & its role in mental health (bullying, etc)
› Sex trafficking
› Increase in domestic violence, child physical & sexual abuse, & gang violence
Recommendations:
› Transportation for low income residents & seniors
› Affordable housing & healthy living environments
› Access to recreational facilities & social opportunities for youth (affordable)
› Access to healthy food for low income families
› Quality childcare
› Education on negative impact of social media on health & behavioral health

References

[i] Healthy Aging Facts: National Council on Aging.

[ii] *The Future of Home Health Care: A Strategic Framework for Optimizing Value.* Home Health Care Management and Practice Journal. October 5, 2016.

[iii] Anne Arundel County Department of Health. 2018, March. Trends in youth suicide in Anne Arundel County 2012-2016. Found at https://www.aahealth.org/wp-content/uploads/2018/07/YouthSuicideReport2012-2016.pdf

[iv] Anne Arundel County Department of Health. 2014, September. Youth Suicide; an assessment of youth suicide behavior in Anne Arundel County 2008-2012. Found at https://www.aahealth.org/youth-suicide-report-september-2014/

[v] Anne Arundel County Department of Health. 2018, March. Trends in youth suicide in Anne Arundel County 2012-2016. Found at https://www.aahealth.org/wp-content/uploads/2018/07/YouthSuicideReport2012-2016.pdf

[vi] Maryland Department of Health. 2014. Maryland youth risk behavior survey high school summary tables, Anne Arundel County. Found at https://phpa.health.maryland.gov/ccdpc/Reports/Documents/2014YRBSReports/YRBS0HighSchoolSummaryByCounty.pdf

[vii] http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health