Implementation Plan of Needs Identified in the Community Health Needs Assessment FY19-FY21 Progress Report

BACKGROUND:

Community Needs Assessment

In 2018-19, AGH in coordination with the local health departments, neighboring hospitals and community stakeholders, conducted a community needs assessment. The needs assessment is a primary tool used by the Hospital to determine its community benefit plan, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of our service area. The Community Health Needs Assessment (CHNA) was approved by the Hospital's Board of Trustees in May 2019.

Needs Identified

This 2019-2021 CHNA combines population health statistics, in addition to feedback gathered from the community in the form of surveys and focus groups. AGH uses Healthy Communities Institute to provide health indicator and ranking data to supplement community data provided by partners of the collaboration. When combined, findings from the data and community feedback are particularly useful in identifying priority health needs and developing action plans to meet those needs.

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes information gathered through ongoing key community groups.

Secondary Data Collection AGH partners with surrounding hospitals, health departments and state agencies to bring to together a multitude of information. This Community Health Needs Assessment, a follow-up to a similar study conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Atlantic General Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. The information as well as other surveys, research and community data are used to identify issues of greatest concern and guide resource allocation to those areas, thereby making the greatest possible impact on community health status. The needs assessment is a primary tool used by the Hospital to determine its community benefit priorities, which outlines how the Hospital will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates

components of primary data collection and secondary data analysis that focuses on the health and social needs of our service area. A sampling of resources utilized to complete the assessment is listed below. A comprehensive list is found under CHNA FY19-21 references.

- Community meetings with persons representing the broad interests of the community
- AGH Community Needs Survey
- Maryland State Health Improvement Process (SHIP) www.dhmh.maryland.gov/ship
- Tri-County Health Improvement Plan (T-CHIP)
- Healthy People 2020
- Worcester County Community Health Improvement Plan (CHIP) LHIC Local Health Improvement Coalition
- 2018 Medical Staff Development Plan
- Health Fairs
- Community Education Events
- 2018 County Health Outcomes & Roadmaps
- State of Delaware Health Needs Assessment www.dhss.delaware.gov/dhss/dph/fles/shaship.pdf
- Delaware Health and Social Services through the Delaware Health Tracker ww.delawarehealthtracker.com
- Beebe Medical Center Community Health Needs Assessment www.beebehealthcare.org/sites/default/fles/1-CHNA%20FINAL%20DRAFT_0.pdf
- US Census Bureau

The Community Health Needs Assessment survey was distributed by community outreach personnel and the Atlantic General Hospital website. Stakeholder interviews and focus groups were conducted by community outreach personnel. Community surveys represent information that is self-reported. Results from the paper surveys (286) and electronic versions (222) are found in CHNA FY19-21, Appendix G.

The top health concerns among 2018 survey respondents were prioritized as listed:

#1 Cancer
#2 Diabetes/Sugar
#3 Overweight/Obesity
#4 Smoking, drug or alcohol use
#5 Heart Disease
#6 Mental Health
#7 High Blood Pressure/Stroke
#8 Access to Healthcare / No Health Insurance
#9 Dental Health
#10 Asthma / Lung Disease
#11 Injuries
#12 Sexually transmitted disease & HIV

(Bold items addressed as priority areas in implementation plan. Italicized items not addressed as priority areas in implementation plan.)

Top Health Concern Priorities Over The (3) CHNA	2012	2015	2018
Cancer	1	1	1
Diabetes/Sugar	4	3	2
Overweight/Obesity	3	2	3
Smoking, drug or alcohol use	5	5	4
Heart Disease	2	4	5
Mental Health	7	7	6
High Blood Pressure/Stroke	6	6	7
Access to Healthcare / No Health Insurance	8	8	8
Dental Health	10	10	9
Asthma / Lung Disease	9	9	10
Injuries	11	11	11
Sexually transmitted disease & HIV	12	12	12

Prioritized Needs

Key findings from all resources were used as a framework to develop community benefit priorities. These are closely aligned with local, state, and national priority areas. The process for determining the priorities of the Community Outreach programs involves many people inside and outside the organization. The hospital's strategic initiatives are determined by the Hospital Board of Trustees, the Medical Staff and the Leadership of the hospital. Each year those long term initiatives are evaluated and updated with environmental information, such as the most recent Community Health Needs Assessment. In addition to input from those groups there are two committees that have a part in setting our priorities; they are the Community Benefits Committee and the Healthy Happenings Advisory Board. The Healthy Happenings Board is made up of hospital and community members who have a health connection in the community. Through this board we are able to keep our pulse on the needs of the community. Each department in the hospital has an appointee who sits on the Community Benefits Committee. The purpose of this committee is to oversee the Community Outreach of the hospital and comply with the government regulations regarding reporting Community Benefits. Because the committee is made of all departments the views are varied. Annual evaluations of each initiative's success are found in the HSCRC Community Benefit Report sent to the State of Maryland.

Our hospital leaders are involved on many community boards and community entities (both for profit and not-for-profit). Through these boards we are able to keep abreast of the underserved, low income and/or minority needs in the community. We are involved in the health departments throughout our service area in Maryland and Delaware and coordinate services with them to decrease duplication of services and know what services are needed to fill the gaps. Obviously working with the target areas of the state improvement initiatives influences the priorities we set. Our Population Health outreach providers are out in the community and are able to observe community needs. Through our Patient Centered Medical Home, Care Coordination models and Population Health Department, we are able to have another resource in the community that we can use for assisting us in setting priorities.

The 2019-2021 Community Benefit priorities are based on the criteria of:

- Size and severity of the problem determined by what percentage of the population is affected by risks
- Health system's ability to impact the need
- Availability of resources

They were graded as high (3), moderate (2) and low (1) to rank the priority, based on self-reported survey data and prioritized as above.

Areas of Opportunity		Ø size and severity of the problem determined by what percentage of the population is effected by risks	Ø health system's ability to impact the need	Ø availability of resources	Total
Access to Health Services	Difficulty getting a physician appointment Physician recruitment Cost of care	high	high	high	9
Cancer	Prevalence of Cancer	high	high	high	9
Diabetes	Prevalence of Diabetes Borderline/Pre-Diabetes	high	mod	high	8
Respiratory Disease	COPD Asthma diagnosis	mod	mod	high	7
Nutrition, Physical Activity & Weight	Prevalence of overweight & obesity Meeting physical activity guidelines lack of leisure time physical activity	high	mod	mod	7
Heart Disease & Stroke	Heart Disease Prevalence High Blood Pressure High blood cholesterol Overall Cardiovascular Risk	high	mod	mod	7
Behavioral Health	Mental Health, Suicide prevention Substance Abuse	high	mod	low	6
Arthritis, Osteoporosis & Chronic back conditions	Prevalence of Sciatica/Chronic Back Pain	mod	low	high	6

FY19-21 Priority Areas
Access to Health Services
Cancer
Diabetes
Respiratory Disease
Nutrition, Physical Activity & Weight
Heart Disease & Stroke
Behavioral Health
Arthritis, Osteoporosis & Chronic Back Conditions

FY19-21 CHNA IMPLEMENTATION PLAN:

Priority Area: Access to Health Services

Goal: Increase community access to comprehensive, quality health care services.

Healthy People 2020 Goal: Improve access to comprehensive, quality health care services.

Anticipated Impact:

- Reduce unnecessary healthcare costs
- Reduction in hospital admissions and readmissions
- Increase in awareness and self-management of chronic disease
- Reduce health disparities
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase number of practicing primary care providers and specialists to community

Impact Rationale: Atlantic General Hospital is the only hospital in Worcester County, a DHMH federally-designated medically-underserved area, a state-designated rural community, and a HRSA-designated Health Professional Shortage Area for primary care, mental health, and dental health. In AGH's service area, the top reasons for patients not seeking health care in our communities are cost, transportation, insurance plans or lack of insurance, appointment availability, and lack of providers. According to the Community Health Needs Assessment (CHNA) FY2019, the community rated the follow as the top barriers to access health care:

Too expensive/can't afford it	29.31%
No health insurance	23.53%
Couldn't get an appointment with my doctor	14.06%
No transportation	12.26%
Service is not available in our community	8.28%
Local doctors are not on my insurance plan	7.08%
Doctor is too far away from my home	5.48%

Action:

- Provide community health events to target minority populations
- Partner with homeless shelters and food pantries to promote wellness
- Utilize Faith-based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Educate community on financial assistance options
- Educate community on ED appropriate use

- Increase the number of practicing primary care providers and specialists to community
- Participate on Worcester County Healthy Planning Advisory Council
- Participate on Homelessness Committee and HOT
- Refer community to local agencies such as Shore Transit and Worcester County Health Department for transportation assistance
- Participate on Tri County Health Planning Council and Local Health Improvement Coalition
- Participate on AGH's Health Equity Steering Committee to promote health equity and reduce disparities
- Pilot School Based Telehealth Program
- Promote patient engagement through adult health literacy initiative

Measurement:

- AGH database
- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives
- Community Survey
- Maryland SHIP http://dhmh.maryland.gov/ship/Pages/home.aspx

Hospital Resources:

- Population Health Department
- AGH/HS
- Human Resources
- Registration/Billing Services
- Emergency Department
- Executive Care Coordination Team
- Health Equity Steering Committee

Community Resources:

- Faith-based Partnership
- Homelessness Committee
- Worcester County Healthy Planning Advisory Council
- Worcester County Health Department
- Worcester County Public Schools
- Diakonia
- Samaritan Shelter
- MD Food Bank and local pantries/soup kitchens
- Shore Transit
- Tri County Health Planning Council
- LHIC
- United Way

Priority #1 Progress: Access to Health Services

-Community Survey: Next CHNA Cycle FY22-24

-AGH database

ZIP CODES ACCOUNTING FOR 65% OF IP DISCHARGES FY20

Zip- City	IP Visits	% of total
21811-BERLIN	831	31.4%
21842-OCEAN CITY	374	14.1%
19975-SELBYVILLE	310	11.7%
19945-FRANKFORD	106	4.0%
21813-BISHOPVILLE	79	3.0%
All Other	947	35.8%
Total IP Discharges	**2,647**	**100.0%**

ED and IP Visits by Select DX groups-first 3 dx codes on account pulled

	ED	IP
FY20 AGH Visits	28,077	2,647

Number of Visits for select DX groups

DX Group % of Total ED or IP Visits

- there is some overlap-a patient may have Diabetes listed as primary and Heart Disease as secondary dx on their account. They are counted twice-once in each category. There were 6,811 total ED visits and 1,425 total IP Visits for the DX codes listed below. 1,134 visits had two or more of the DX codes listed below on their account.

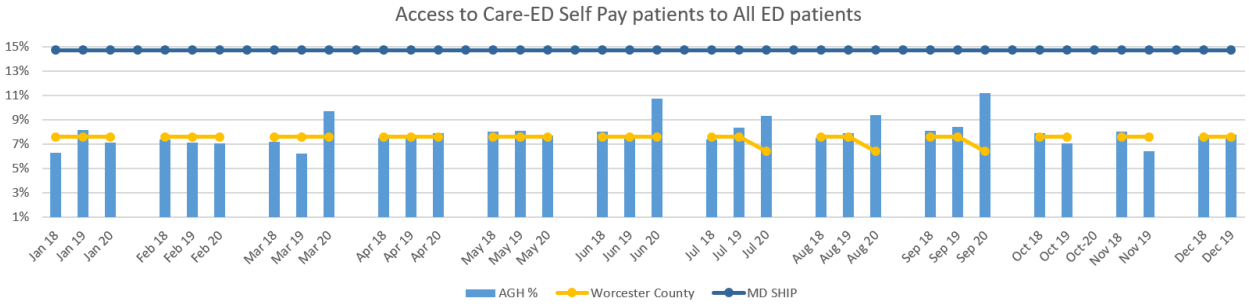
DX Group	ED	IP
Alcohol Abuse	532	53
Asthma	483	28
Cancer	247	130
COPD	353	248
Diabetes	852	241
Heart Disease	3,074	780
Mental Disorder	1,936	95
Opioid Dependency	112	18
RA	17	9
Renal Disease	117	75

DX Group	ED	IP
Alcohol Abuse	1.89%	2.00%
Asthma	1.72%	1.06%
Cancer	0.88%	4.91%
COPD	1.26%	9.37%
Diabetes	3.03%	9.10%
Heart Disease	10.95%	29.47%
Mental Disorder	6.90%	3.59%
Opioid Dependency	0.40%	0.68%
RA	0.06%	0.34%
Renal Disease	0.42%	2.83%

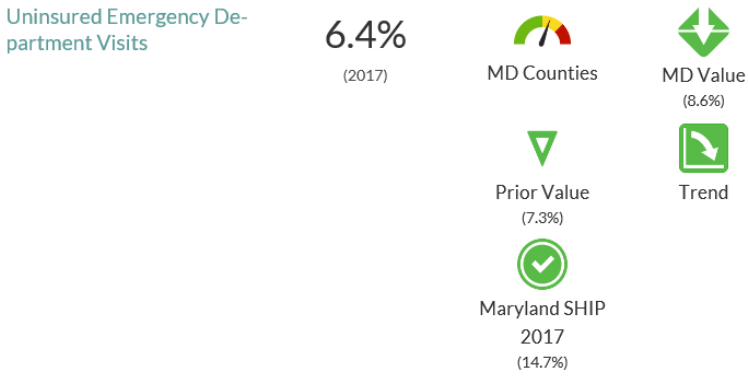
During FY19-20, AGH/AGHS has strived to address priority #1 Access to Health Services by the following: health fairs, community education events, free community screenings, flu clinics, physician recruitment, health equity initiatives, and health literacy initiatives – to name a few. Through community benefit priority areas, as defined by the HSCRC and guided by CHNA, AGH has provided to the community 45,679 staff hours, 604 volunteer hours of service, and touched 79,840 community members lives beyond the hospital walls. Programs of interest include a school based telehealth pilot

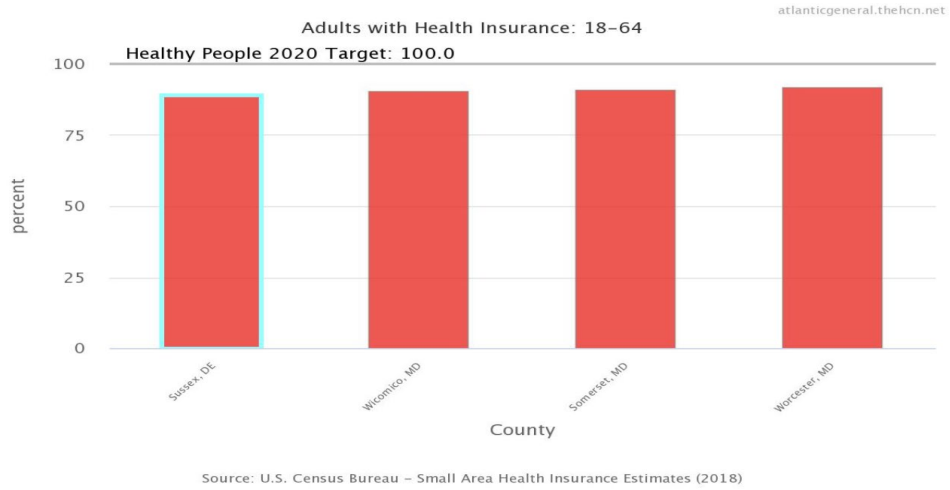
program at Pocomoke High School, our continued partnership with WCPS via the Integrated Health Literacy Program in grades 1-8 county-wide, nutrition initiatives, diabetes and pre-diabetes initiatives, virtual community education, virtual support groups, and patient portal/telehealth service expansion. Through all the challenges of Covid-19, the pandemic challenged us to take a more innovative approach to avenues to access and opportunities to reach our community.

As of April 2020, Atlantic General Health System offers telehealth visits with our primary care providers, specialists and Immediacare locations. The video visits are conducted securely through the FollowMyHealth Patient portal. This direct-to-consumer approach to telehealth promotes access to care by allowing patients to join in the virtual consult through their desktop computer, tablet or smart phone at their preferred location. Preferred location may include the comfort of their home or work location. Since the launch of our telehealth service line in the spring, AGHS providers have performed approximately 2,000 video visits. Over 52 AGHS providers provide video visits. The utilization of these video visits through AGH's FollowMyHealth Patient Portal has increased total connected patients from 10,000 in April 2020 to 13,500 as of September 2020. Additionally, these video visits have increased portal usage by 88.6% from April 2020 to September 2020.



-MD SHIP/Healthy People 2020





Source: U.S. Census Bureau – Small Area Health Insurance Estimates (2018)

Priority Area: Cancer

Goal: Decrease the incidence of *advanced* breast, lung, colon, and skin cancer in community.

Healthy People 2020 Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

Anticipated Impact:

- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for cancer related treatment
- Reduce health disparities
- Improve access and referrals to community resources resulting in better outcomes
- Increase support to patients and caregivers
- Increase participation in community cancer screenings – especially at-risk and vulnerable populations

Impact Rationale: According to Healthy People 2020, continued advances in cancer detection, research and cancer treatment have decreased cancer incidences and death rates in the United States. Despite continued advances, cancer remains a leading cause of death second to heart disease in the United States. (Healthy People 2020)

Action:

- Recruit proper professionals in community to provide for cancer related treatment
- Provide community health screenings
- Partner with local health agencies to facilitate grant application to fund cancer programs
- Improve proportion of minorities receiving colonoscopy screenings
- Improve proportion of minorities receiving LDCT screenings
- Improve proportion of minorities receiving women's preventative health services

- Increase the proportion of persons who participate in behaviors that reduce their exposure to harmful ultraviolet (UV) irradiation and avoid sunburn through melanoma education and skin cancer screenings.

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
- AGH database
- MD SHIP Measures
- Vital Statistics

Hospital Resources:

- Population Health Department
- Human Resources
- Foundation
- Women's Diagnostic Center
- Endoscopy
- Imaging
- Respiratory Therapy Department
- Regional Cancer Care Center
- AGH Cancer Committee

Community Resources:

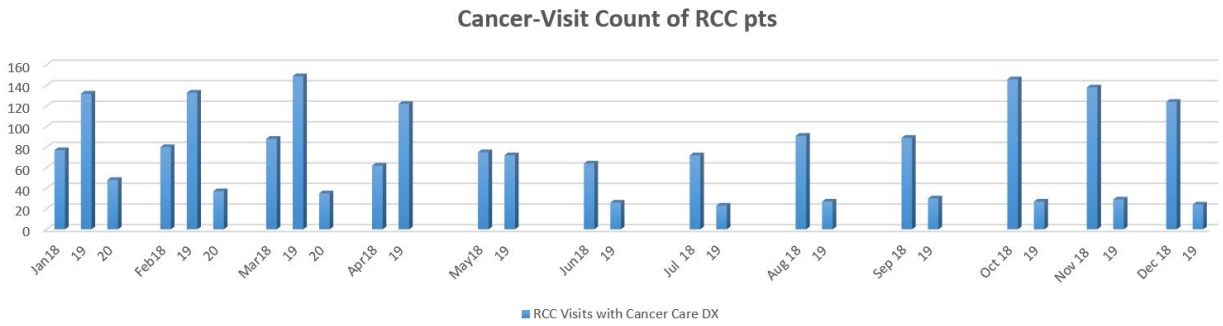
- Worcester County Health Department
- Komen Consortium
- Relay for Life
- Women Supporting Women

Priority #2 Progress: Cancer

-AGH database

CANCER ED/IP VOLUMES (First 3 Dx Codes)

FY	ED	IP	Totals
FY2019	287	189	476
FY2020	247	130	377



-MD SHIP/Healthy People 2020

County: Worcester, MD

176.1

deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2012-2016
Maintained by: Conduent Healthy Communities Institute
Last update: October 2019
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (160.3)
US Value (161.0)	Prior Value (179.7)	Trend
Maryland SHIP 2017 (147.4)	Maryland SHIP 2014 (169.2)	HP 2020 Target (161.4)

County: Sussex, DE

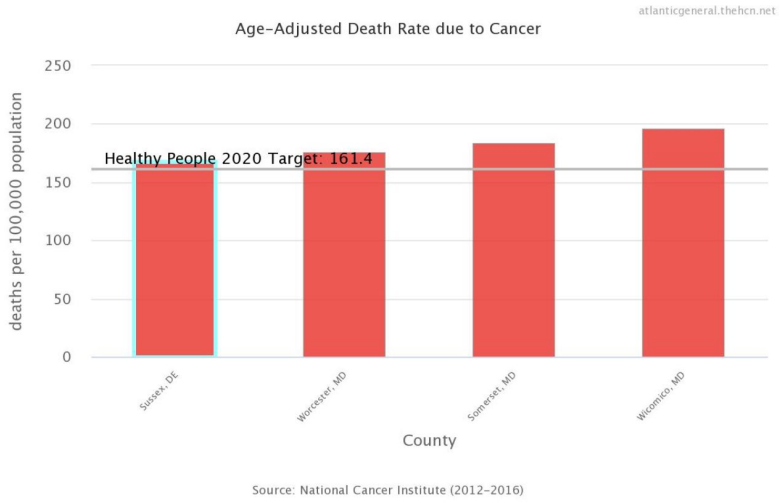
167.7

deaths/ 100,000 population

Source: National Cancer Institute
Measurement period: 2012-2016
Maintained by: Conduent Healthy Communities Institute
Last update: October 2019
Filter(s) for this location: State: Delaware

COMPARED TO

U.S. Counties	DE Value (169.6)	US Value (161.0)
Prior Value (165.9)	Trend	Maryland SHIP 2017 (147.4)
Maryland SHIP 2014 (169.2)	HP 2020 Target (161.4)	



Priority Area: Diabetes

Goal: Decrease incidence of diabetes in the community.

Healthy People 2020 Goal: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Reduce unnecessary healthcare costs
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention of diabetes and early detection
- Increase provider services in community to provide for diabetes related treatment
- Increase participation in community glucose screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale: According to the CDC National Center for Health Stats (2015), national data trends for people with Diabetes show a significant rise in diagnoses. In the U.S., Diabetes is becoming more common. Diagnoses from 1980 – 2014 increased from 5.5 million to 22 million.

	Worcester County	Maryland	Sussex County	Delaware
Diabetic Monitoring (Medicare)	88%	85%	89%	86%
Diabetes Prevalence	13%	10%	13%	11%

(County Health Rankings, 2016)

Action:

- Partner with local health agencies to facilitate grant applications to fund diabetes programs
- Provide Diabetes Support Group
- Explore Diabetes Education opportunities via telehealth
- DPP for AGH Associates
- Provide diabetes screenings in community
- Increase prevention behaviors in persons at high risk for diabetes with prediabetes
- Wellness Workshops DSMP for chronic disease self-management

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives
- Incidence of adult diabetes
- SHIP Measure
- Decrease ED visits due to acute episodes related to diabetes condition
- County Health Rankings

Hospital Resources:

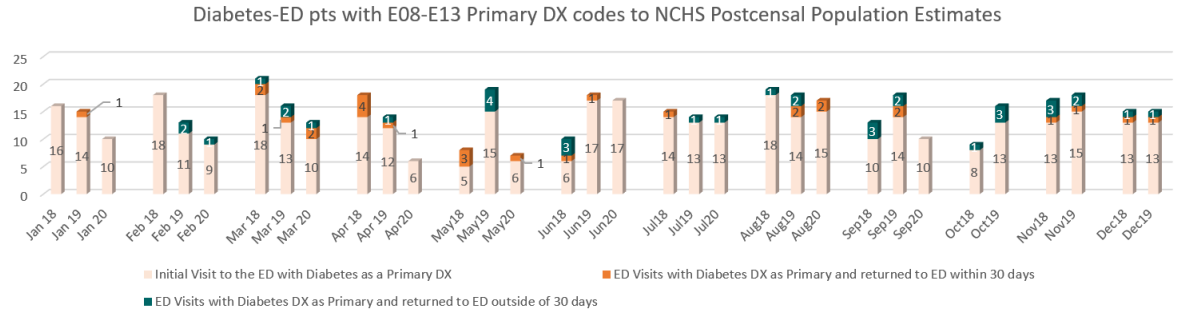
- Diabetes Outpatient Education Program
- Diabetes Support Group
- Population Health Department
- Emergency Department
- Foundation
- Endocrinology
- Outpatient Lab Services

Community Resources:

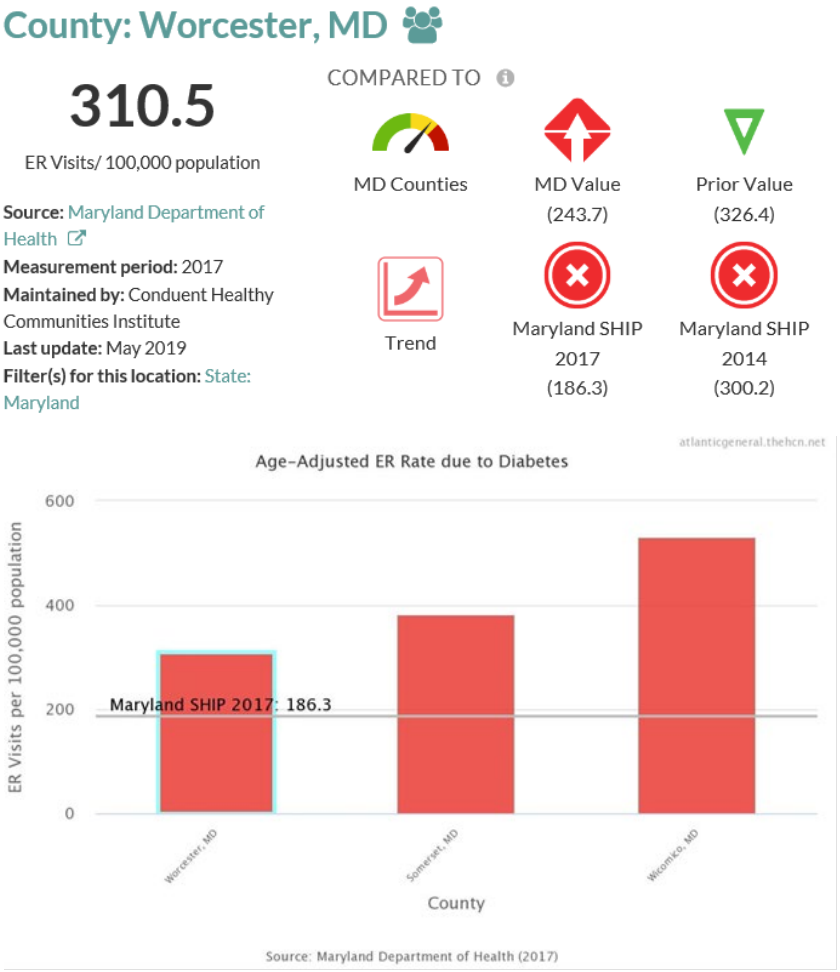
- Worcester County Health Department
- MAC, Inc.

Priority #3 Progress: Diabetes

-AGH Database



-MD SHIP/Healthy People 2020



ADULTS WITH DIABETES

County: Worcester, MD

8.0%

COMPARED TO

MD Counties

MD Value (9.6%)

US Value (10.5%)

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019
Filter(s) for this location: State: Maryland

Prior Value (12.9%)

Trend

County: Sussex, DE

12.6%

COMPARED TO

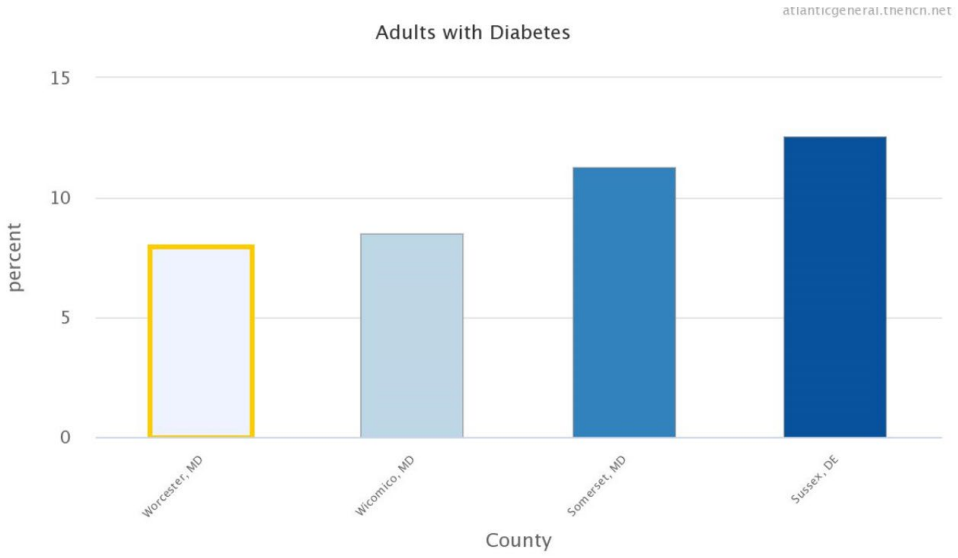
DE Value (11.3%)

US Value (10.5%)

Prior Value (13.1%)

Source: Behavioral Risk Factor Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: October 2018
Filter(s) for this location: State: Delaware

Trend



Source: Maryland Behavioral Risk Factor Surveillance System, Behavioral Risk Factor Surveillance System (2017)

Priority Area: Respiratory Disease, including Smoking

Goal: Promote community respiratory health through better prevention, detection, treatment, and education efforts.

Healthy People 2020 Goal: Promote respiratory health through better prevention, detection, treatment, and education efforts.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Decrease tobacco, e cigarettes and vaping use in Worcester County
- Increase health literacy and self-management for health conditions/healthy living
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention and early detection
- Increase provider services in community to provide for respiratory related treatment
- Increase participation in community lung/respiratory screenings – especially at-risk and vulnerable populations

Impact Rationale: According to Healthy People 2020, approximately 23 million Americans have asthma and approximately 13.6 million adults have COPD. Healthy People 2020 estimates there are an equal number of undiagnosed Americans. (Healthy People 2020)

Action:

- Recruit Pulmonologist to community
- Improve proportion of minorities receiving LDCT screenings
- Collaborate with Worcester County Health Department Prevention Department
- Reduce emergency department (ED) visits for chronic obstructive pulmonary disease (COPD) and asthma
- Provide speakers to community groups on smoking cessation
- Improve Health Literacy in middle schools related to tobacco and vaping use

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases/objectives
- Decrease ED visits due to acute episodes related to respiratory condition
- MD SHIP

Hospital Resources:

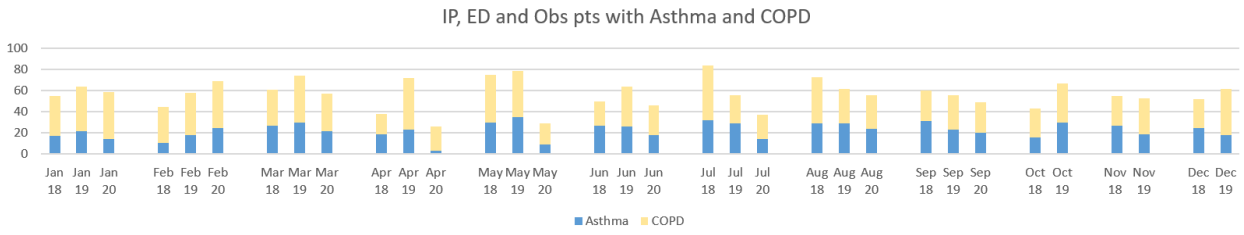
- Respiratory Therapy
- Imaging
- Emergency Department
- Population Health Department
- Human Resources
- Pulmonology

Community Resources:

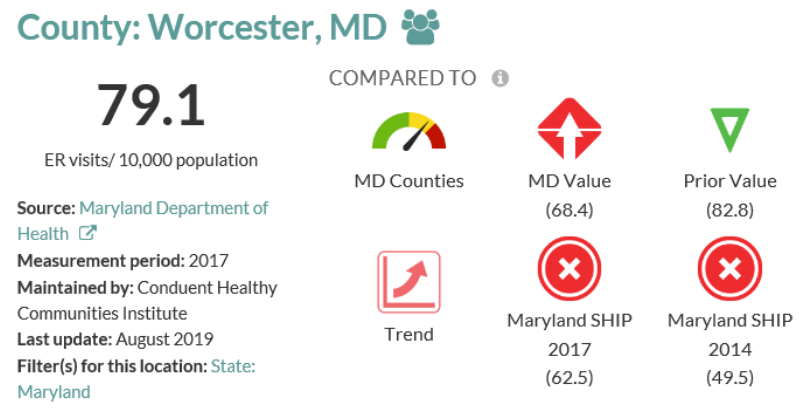
- Worcester County Health Department
- Worcester County Public Schools

Priority #4 Progress: Respiratory Disease, including Smoking

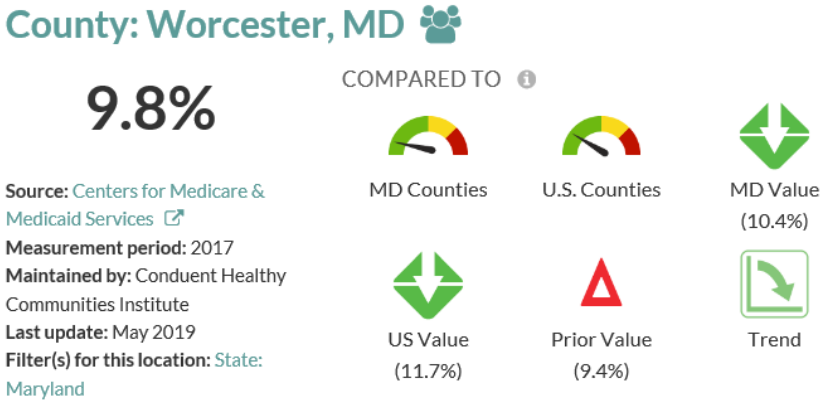
-AGH Database

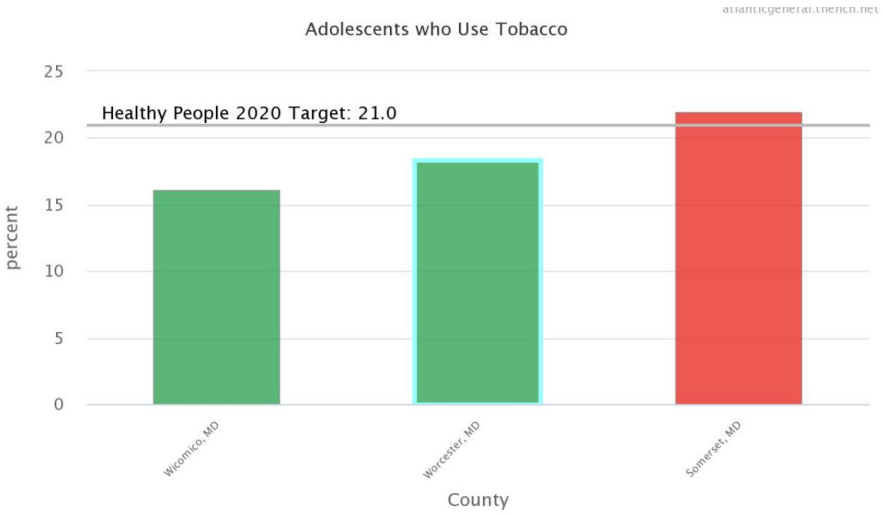


-MD SHIP/Healthy People 2020

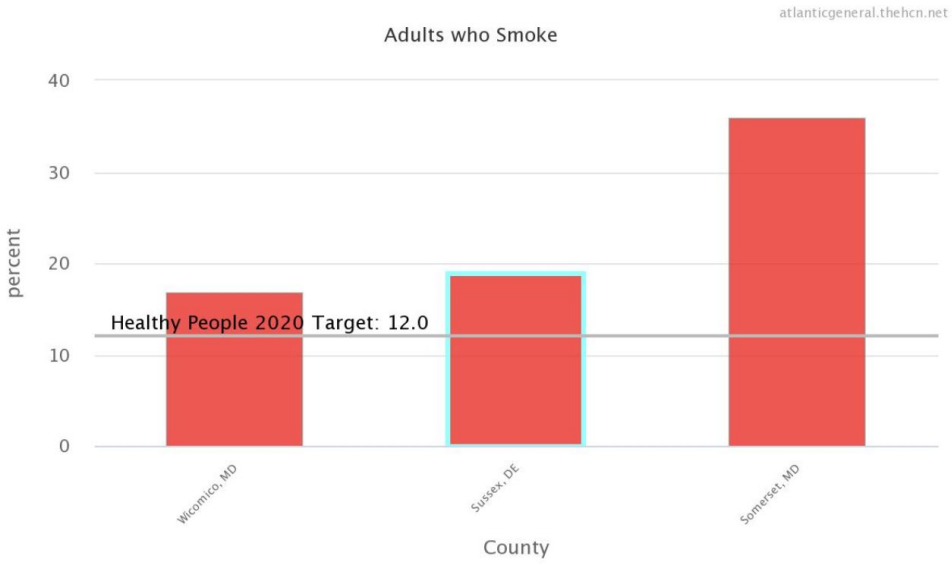


COPD: MEDICARE POPULATION





Source: Maryland Department of Health (2016)



Source: Maryland Behavioral Risk Factor Surveillance System, Behavioral Risk Factor Surveillance System (2017)

Priority Area: Nutrition, Physical Activity & Weight

Goal: Support community members in achieving a healthy weight.

Healthy People 2020 Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

Anticipated Impact:

- Increase health literacy and self-management for health conditions/healthy living
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Reduce unnecessary healthcare costs
- Reduce community obesity rate
- Increase access to healthy foods and nutritional information
- Increase awareness around importance of nutrition, exercise and healthy weight
- Increase participation in community BMI screenings – especially at-risk and vulnerable populations
- Increase awareness of community resources, programs and services
- Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs

Impact Rationale: Obesity is defined as having a Body Mass Index (BMI) that is greater than or equal to 30, while being overweight is defined as having a BMI of 25 – 29.9. Obesity has been linked to a variety of cancers and chronic illnesses including diabetes, colorectal cancer, kidney cancer, breast cancer, hypertension and cardiovascular disease (NCI, 2015).

According to the CDC National Center for Health Statistics (2015), the prevalence of obesity was slightly more than 36 percent in adults and 17 percent in youth.
•The prevalence of obesity was higher in women 38.3% than in men 34.3%. No significant difference was noted by gender among youth.
•The prevalence of obesity was higher among middle-aged and older adults than younger adults. (2013 – 2014)

	Worcester County	Maryland	Sussex County	Delaware
Adult Obesity	30%	28%	31%	29%
Physical Inactivity	27%	23%	27%	25%
Limited Access to Health Foods	4%	3%	5%	6%

(County Health Rankings, 2016)

Action:

- Improve Health Literacy in elementary and middle schools related to nutrition and exercise
- Participate in the "Just Walk" program of Worcester County
- FAB Program
- Distribution brochure to public about Farmer's Market & fresh produce preparation
- Provide Hypertension and BMI screenings in the community
- Provide speakers to community groups on nutrition
- Continue to provide education on health living topics to Faith-based Partnership and community senior centers
- Bariatric Support Group
- Participate in community events to spotlight surgical and non-surgical weight loss services

Measurement:

- Healthy People 2020 Objectives https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives
- CDC National Center for Health Statistics
- SHIP
- County Health Rankings

Hospital Resources:

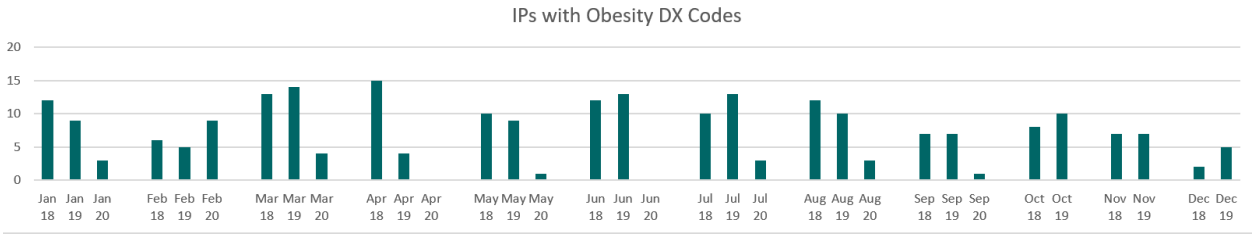
- Population Health Department
- AGHS Offices
- FAB Program and Bariatric Support Group
- Nutrition Services
- Atlantic General Bariatric Center

Community Resources:

- Faith-based Partnership
- Worcester County Public Schools
- Worcester County Health Department
- MAC, Inc.
- Community Senior Centers
- Yoga/Tai Chi Programs
- TOPS of Berlin

Priority #5 Progress: Nutrition, Physical Activity & Weight

-AGH Database



-MD SHIP/Healthy People 2020

ADULTS WHO ARE OBESE

County: Worcester, MD

39.5%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: April 2020
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (31.5%)	US Value (30.9%)
Prior Value (29.6%)	Trend	HP 2020 Target (30.5%)

County: Sussex, DE

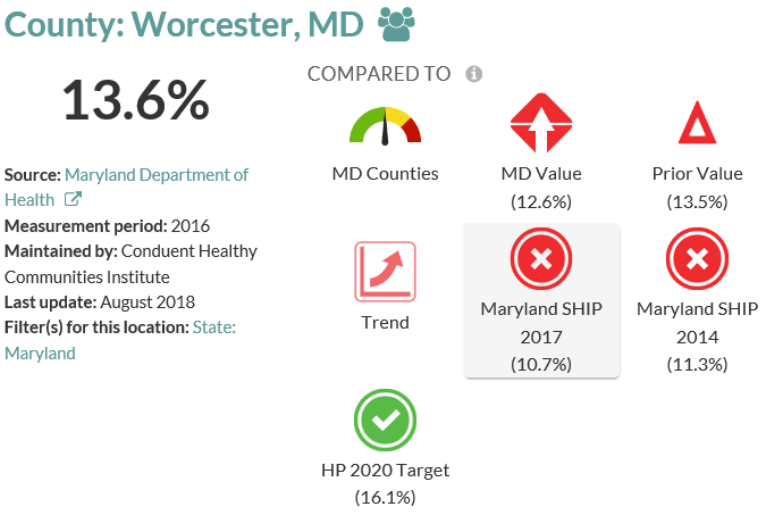
32.6%

Source: Behavioral Risk Factor Surveillance System
Measurement period: 2017
Maintained by: Conduent Healthy Communities Institute
Last update: October 2018
Filter(s) for this location: State: Delaware

COMPARED TO

DE Value (31.8%)	US Value (31.3%)	Prior Value (33.3%)
Trend	HP 2020 Target (30.5%)	

ADOLESCENTS WHO ARE OBESE



Priority Area: Heart Disease & Stroke

Goal: Improve cardiovascular health of community.

Healthy People 2020 Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.

Anticipated Impact:

- Increase care for individuals suffering from chronic conditions
- Reduce unnecessary healthcare costs
- Decrease tobacco use in Worcester County
- Increase patient engagement in self-management of chronic conditions
- Decrease hospital admissions and readmissions
- Increase awareness around importance of prevention and early detection of heart disease and hypertension
- Increase provider services in community to provide for cardiovascular related treatment
- Increase participation in community hypertension, cholesterol and carotid screenings – especially at-risk and vulnerable populations
- Increase community capacity and collaboration for shared responsibility to address unmet health needs
- Increase health literacy and self-management for health conditions/healthy living

Impact Rationale: According to the CDC Heart Disease Statistics and Maps (2015), approximately 610,000 people die of heart disease in the United States yearly. Heart disease is the leading cause death among most ethnic groups. Hypertension, high cholesterol and smoking

are key risk factors and 47 percent of Americans have at least one risk factor Heart Disease Statistics and Maps (CDC, 2015).

Action:

- Ensure proper professionals in community to provide vascular care
- Maintain AGH/HS campus and locations as tobacco free
- Increase community health screenings for high blood pressure, carotid artery and cholesterol
- Decrease readmissions to hospital for chronic disease management
- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic disease management
- Improve Health Literacy in elementary and middle schools related to heart health

Measurement:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke/objectives
- AGH database
- SHIP Measure
- County Health Rankings

Hospital Resources:

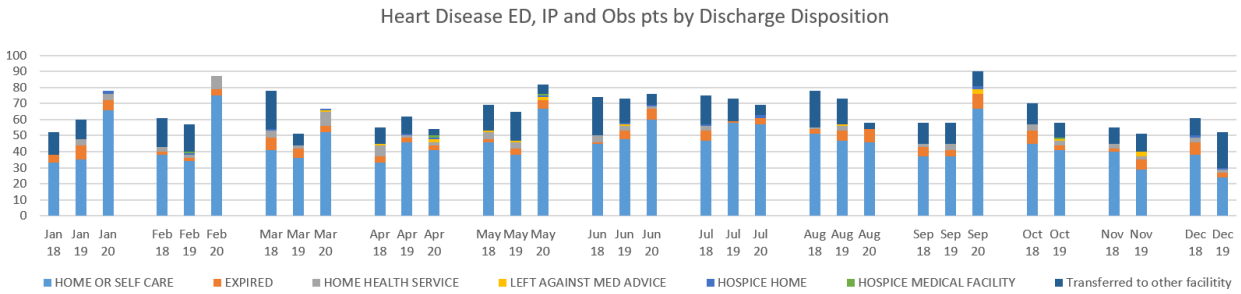
- Population Health Department
- AGH/HS
- Outpatient Lab Services
- Nutrition Services
- Human Resources
- Stroke Center

Community Resources:

- Faith-based Partnership
- MAC, Inc.
- Worcester County Health Department

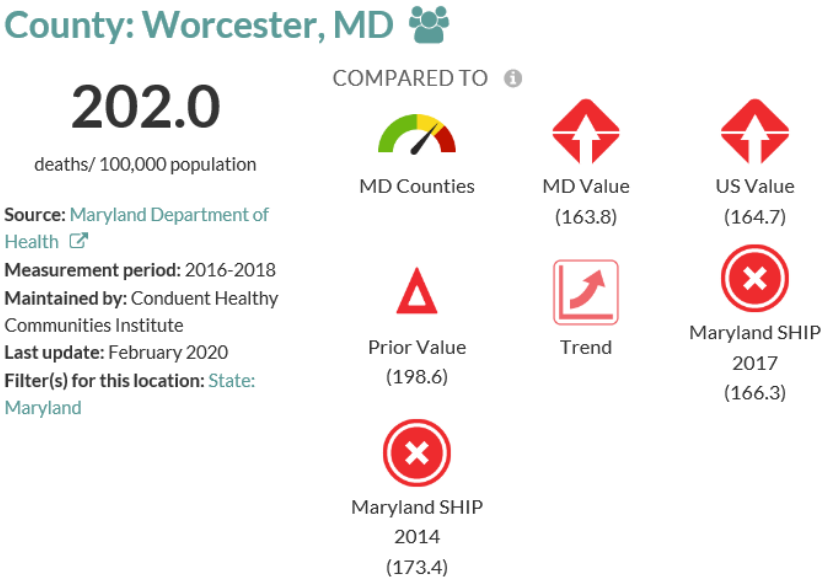
Priority #6 Progress: Heart Disease & Stroke

-AGH database



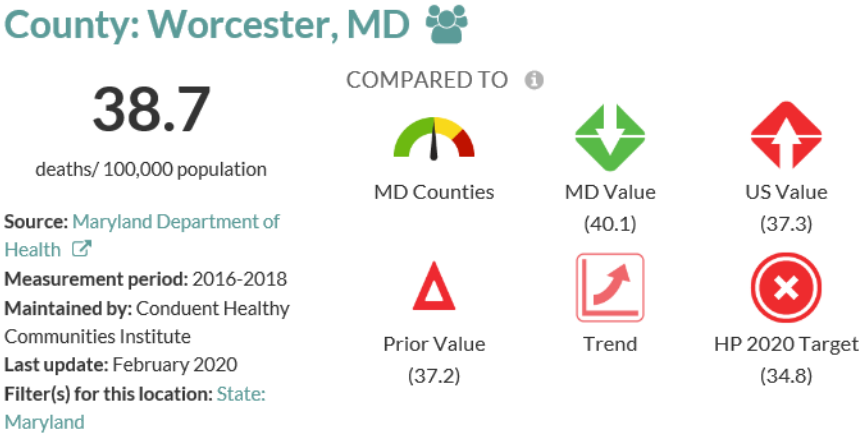
-MD SHIP/Healthy People 2020

WORCESTER COUNTY: AGE ADJUSTED DEATH RATE DUE TO HEART DISEASE



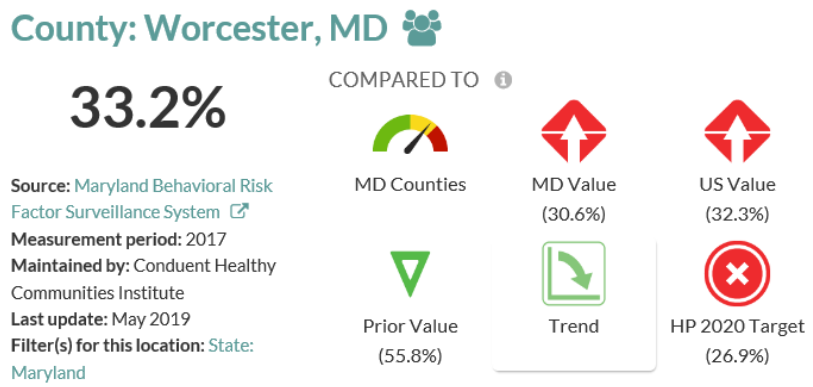
SUSSEX COUNTY: WORCESTER COUNTY: AGE ADJUSTED DEATH RATE DUE TO HEART DISEASE

WORCESTER COUNTY: AGE ADJUSTED DEATH RATE DUE TO STROKE

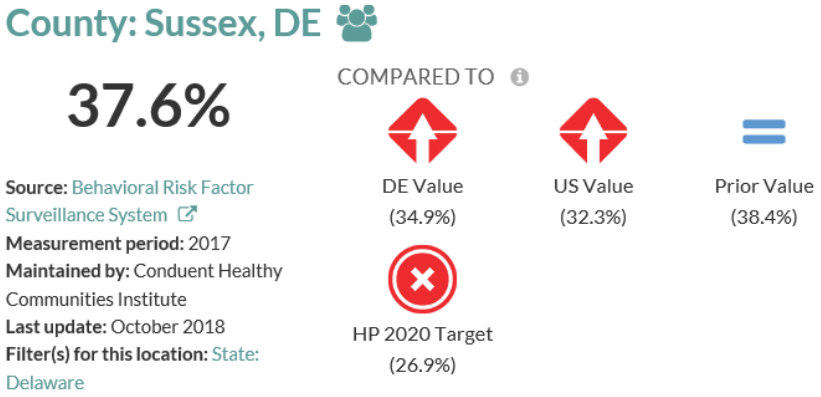


SUSSEX COUNTY: AGE ADJUSTED DEATH RATE TO STROKE

WORCESTER COUNTY: HIGH BLOOD PRESSURE PREVALENCE



SUSSEX COUNTY: HIGH BLOOD PRESSURE PREVALENCE



Priority Area: Behavioral Health

Goal: Promote and ensure local resources are in place to address behavioral health services.

Healthy People 2020 Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.
Healthy People 2020 Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Anticipated Impact:

- Increase accurate and up-to-date information and referral service
- Improve Health Literacy in elementary and middle schools related to mental health and substance use.
- Decrease opioid abuse and overdose rates in Worcester County

- Increase awareness of community resources, programs and services

- Increase and strengthen capacity and collaboration for shared responsibility to address unmet health needs
- Increase provider services in community to provide for behavioral health related treatment

Impact Rationale: According to the CDC Mental Health Surveillance (2013), mental illness affects approximately 25 percent of the U.S. population and is associated with a variety of chronic illnesses.

	Worcester County	Maryland	Sussex County	Delaware
Mental Health Providers	520:1	470:1	610:1	440:1
Poor Mental Health Days	3.5	3.4	3.5	3.7

(County Health Rankings, 2016)

According to Healthy People 2020, approximately 22 million Americans struggle with addiction to alcohol and/or drugs and approximately 95 percent are unaware they have a substance use issue. An emerging area of substance use issues includes opiate use. Teen rates of prescription drug abuse have increased over the last 5 years, including nonmedical use of drugs such as Vicodin and OxyContin. (Healthy People 2020)

	Worcester County	Maryland	Sussex County	Delaware
Drug Death Overdose	15	16	16	18
Drug Death Overdose - modeled	18.1-20.0	17.4	16.1-18.0	20.9

(County Health Rankings, 2016)

Action:

- Increase access and continue to collaborate with Sheppard Pratt telemedicine services to provide additional psychiatry professional
- Participate in community events to spotlight behavioral health services
- Engage critical response teams when a mental health crisis is discovered
- Partner with WCHD (Peer Support and Case Managers) in AGH ED
- Improve Health Literacy in middle schools related to mental and emotional health
- Recruit LSCW to the community
- Behavioral Health Integration into Primary Care

- Participate on WOW Committee
- Participate on Behavioral Health/Opioid Task Force/Pain Management Team
- Participate in Worcester County Health Department naloxone training sessions sponsored by Opiate Overdose Prevention Program
- Increase the proportion of persons who are referred for follow-up care for opioid problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)
- Evaluate and educate organization and community on appropriate prescribing practices
- Utilize Prescription Drug Maintenance Program (PDMP) via CRISP

Measurement:

- Healthy People 2020
- Behavioral Risk Factor Surveillance System
- County Health Rankings
- AGH database
- SHIP Measure

Hospital Resources:

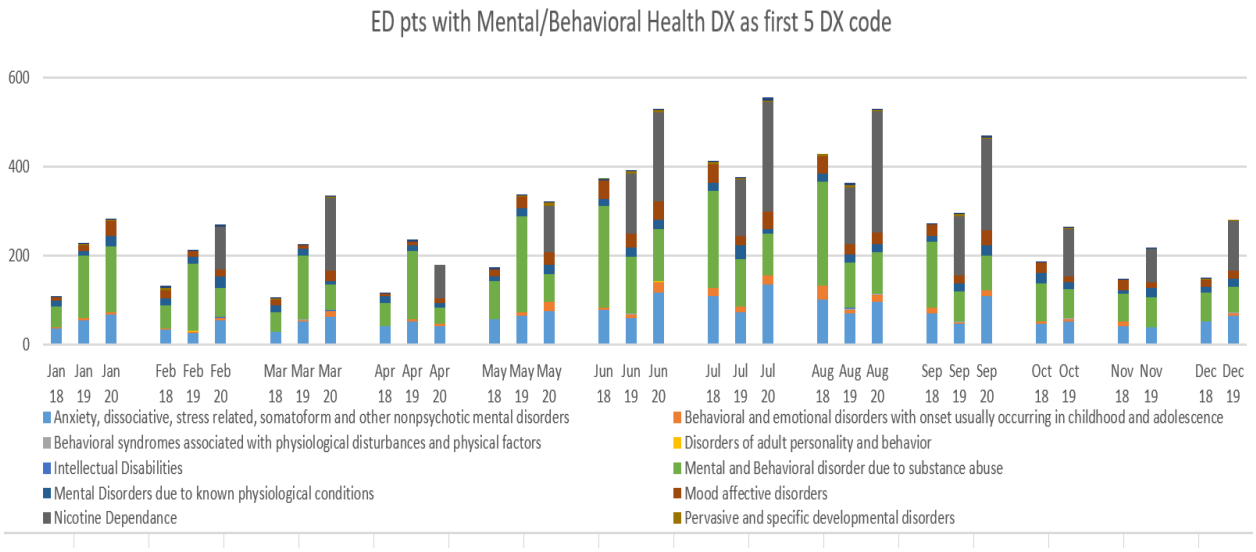
- Population Health Department
- Atlantic Health Center
- Human Resources
- Pastoral Care Services
- Bereavement Support Group
- Pain Rehabilitation Program
- AGH Pharmacy

Community Resources:

- Sheppard Pratt
- Worcester County Health Department
- Worcester Youth and Family Services
- Hudson Health Services
- NAMI Lower Shore Support Group
- Worcester County Public Schools
- WOW
- CRISP

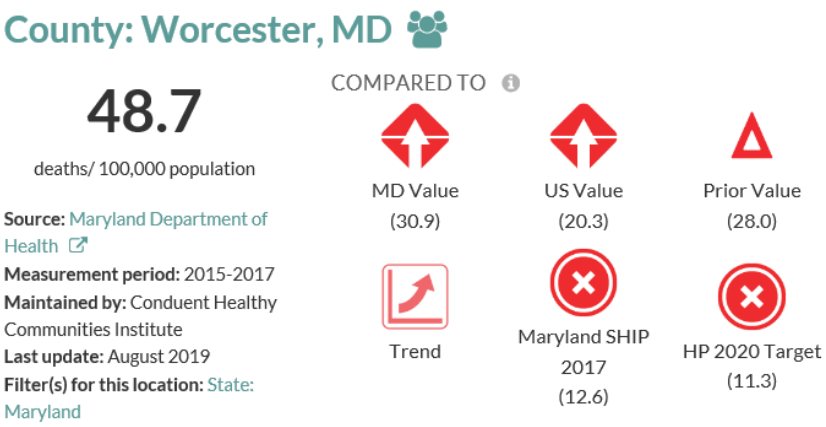
Priority #7 Progress: Behavioral Health

-AGH database

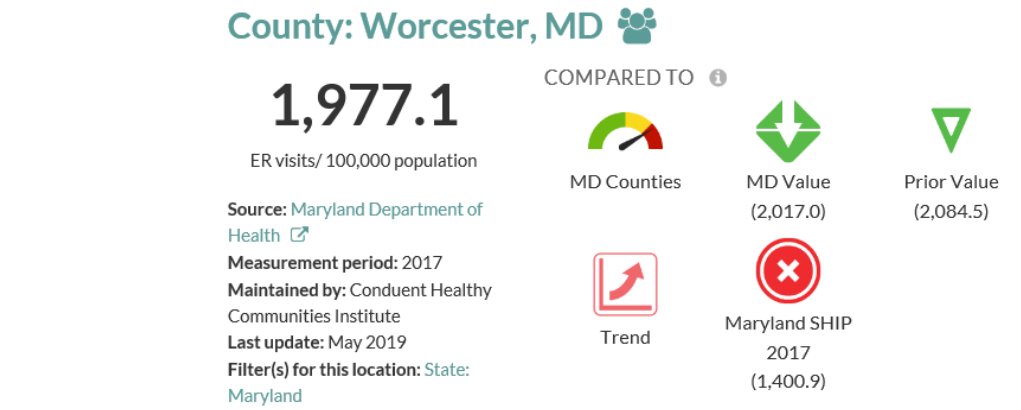


-MD SHIP/Healthy People 2020

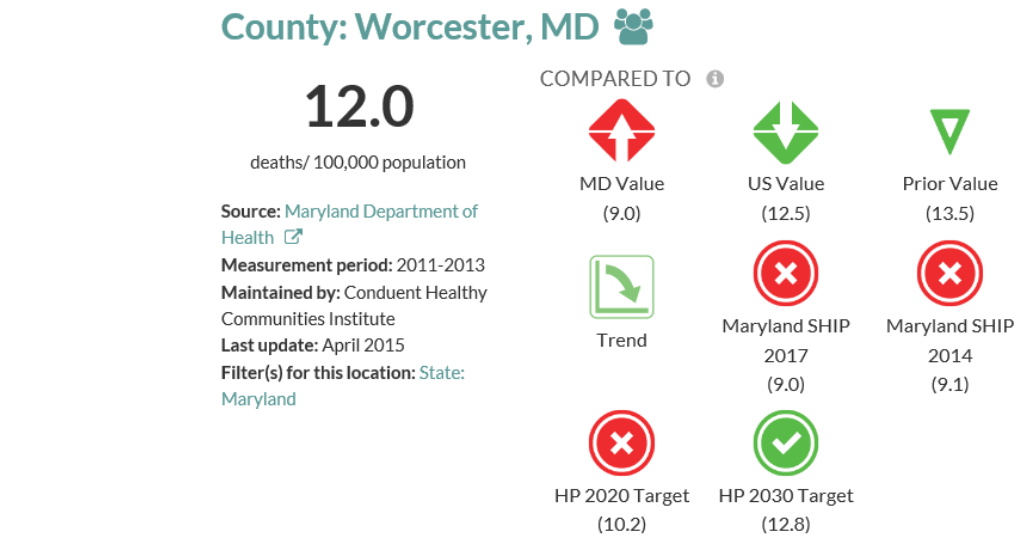
WORCESTER COUNTY: AGE ADJUSTED DEATH RATE DUE TO DRUG USE



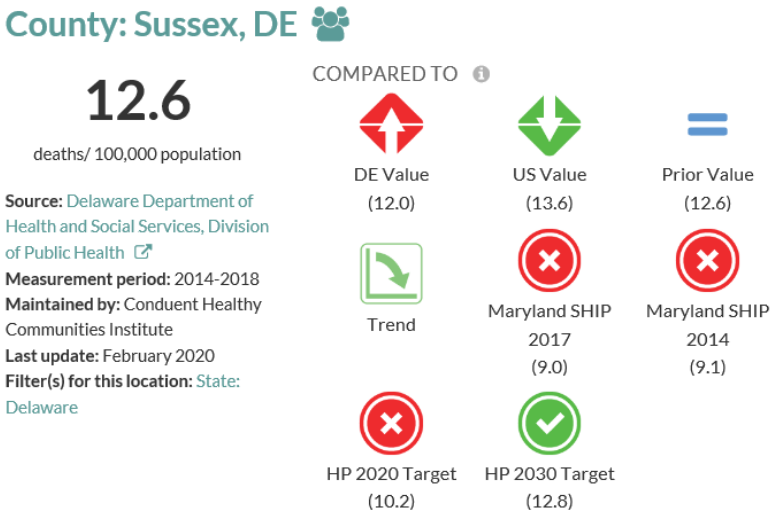
WORCESTER COUNTY: AGE ADJUSTED ER RATE DUE TO ALCOHOL/SUBSTANCE ABUSE



WORCESTER COUNTY: AGE ADJUSTED SUICIDE RATE



SUSSEX COUNTY: AGE ADJUSTED SUICIDE RATE



Priority Area: Arthritis, Osteoporosis & Chronic Back Pain

Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions in the community.

Healthy People 2020 Goal: Prevent illness and disability related to arthritis and other rheumatic conditions, osteoporosis, and chronic back conditions.

Anticipated Impact:

- Reduce unnecessary healthcare costs
- Increase provider services to community to provide for arthritis and other rheumatic conditions, osteoporosis, and chronic back condition related treatments
- Increase health literacy and self-management for chronic health conditions/healthy living

Impact Rationale: According to Healthy People 2020, arthritis, osteoporosis and chronic back pain impact quality of life, activities of daily living and ability to work. Arthritis affects one in five adults. Osteoporosis affects approximately 5.3 million adults aged 50 years and older in the United States. Also, approximately 80 percent of people in the United States experience chronic back conditions. Successful and underused interventions include weight management, physical activity and self-management. (Healthy People 2020)

According to CHNA Survey summary of findings, an area of significant need includes prevalence of sciatica and chronic back pain in the community.

Action:

- Utilize Faith Based Partnerships, to provide access to high risk populations for education about healthy lifestyles and chronic pain workshops
- Explore osteoporosis clinic program
- Utilize Women's Diagnostic Health Services, to provide access to high risk populations about healthy lifestyles and bone density screenings
- Provide educational opportunities to raise community awareness about osteopenia/osteoporosis and provide bone density screenings
- Increase accurate and up-to-date information and referral service

Measurements:

- Healthy People 2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Arthritis-Osteoporosis-and-Chronic-Back-Conditions
- CPSMP Workshop attendance
- SHIP
- County Health Ranking
- Community Survey

Hospital Resources:

- Population Health Department
- Human Resources
- Atlantic Health Center/Pain Management
- Women's Diagnostic Health Services

Community Resources:

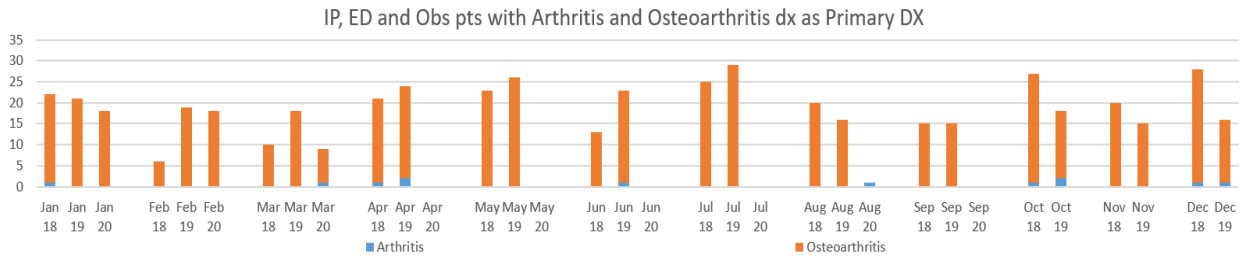
- MAC, Inc.
- Faith-based Partnership

Priority #8 Progress: Arthritis, Osteoporosis & Chronic Back Pain

-Community Survey: Next CHNA Cycle FY22-24

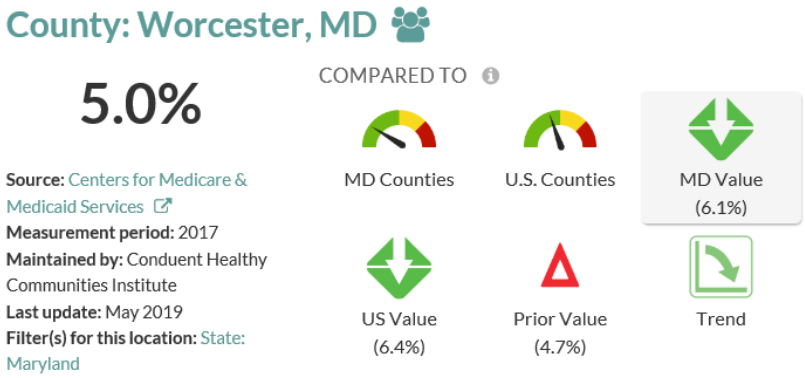
-MAC Workshop Attendance
During FY19-20, through a contract with MAC's evidence-based Living Well and Stepping on Programs, community members were provided both Chronic Pain Self-Management Workshops (CPSMP) and Stepping On Falls Prevention/Malnutrition Workshops. Through this programming, 68 persons were served with a completer rate of 88.2%.

-AGH database

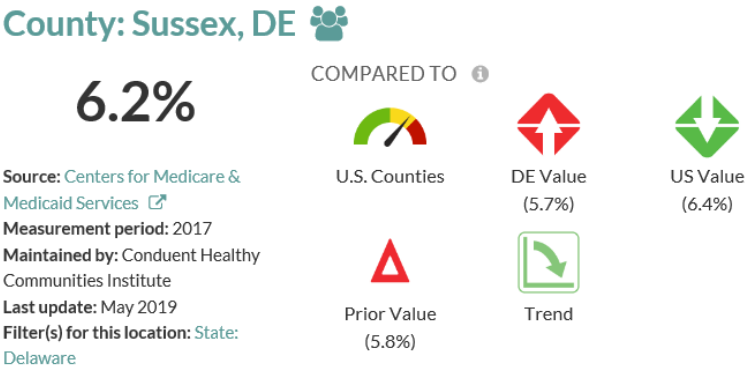


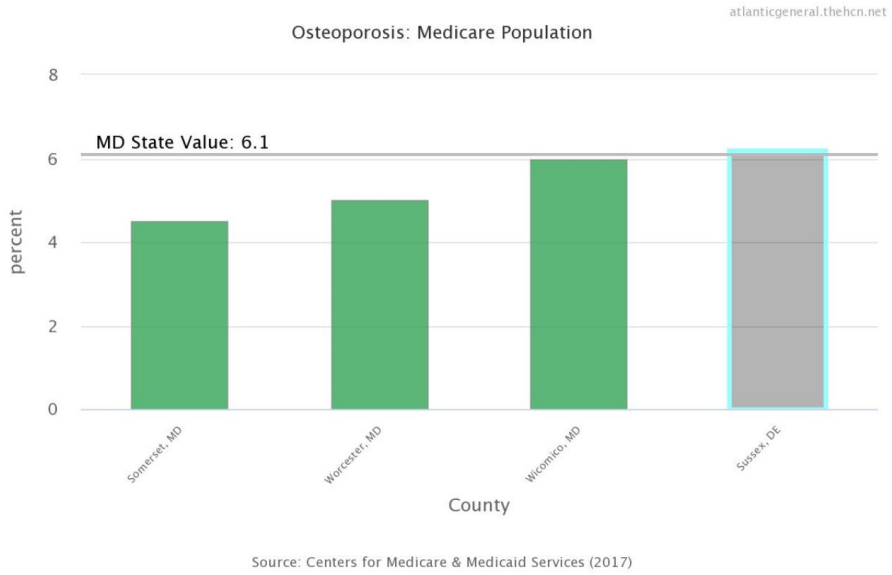
-MD SHIP/Healthy People 2020

WORCESTER COUNTY: OSTEOPOROSIS MEDICARE POPULATION

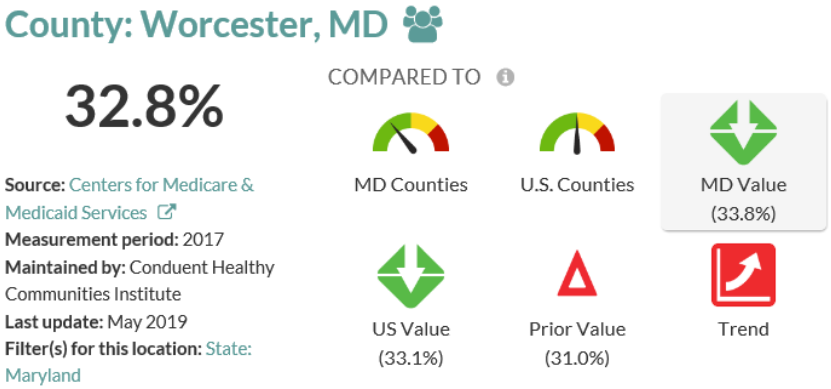


SUSSEX COUNTY: OSTEOPOROSIS MEDICARE POPULATION

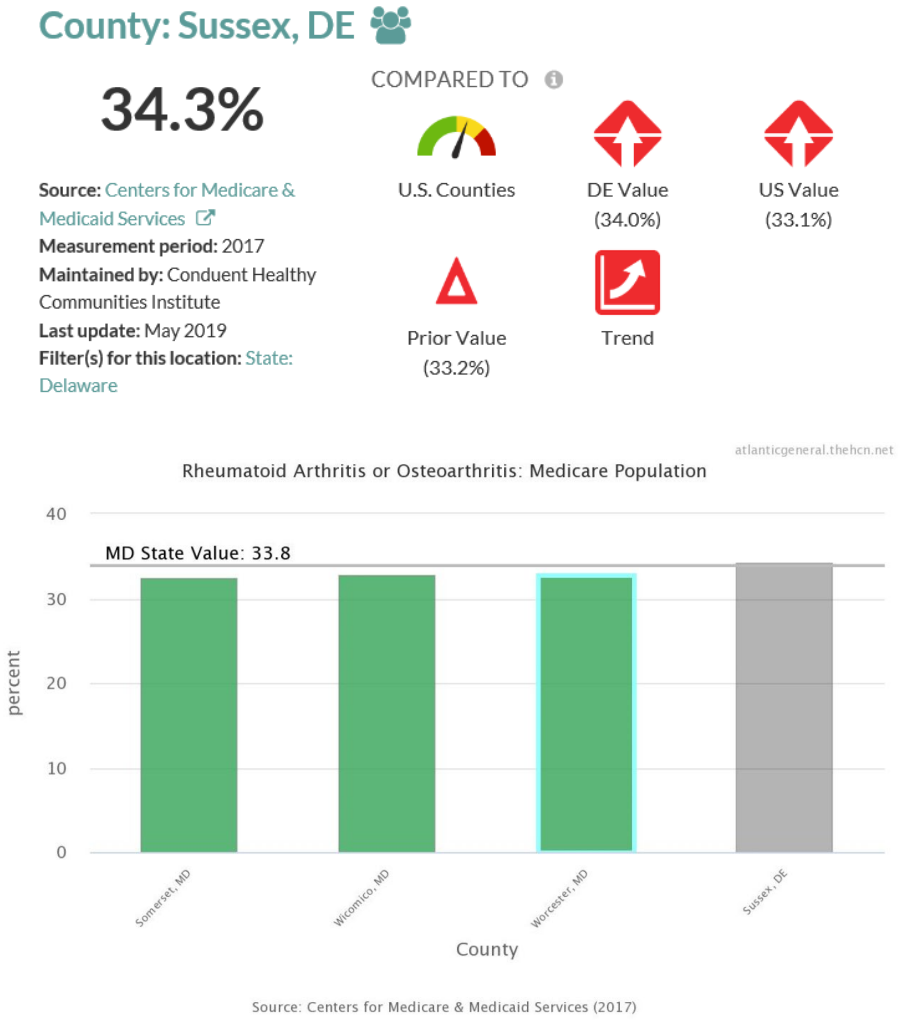




WORCESTER COUNTY: RHEUMATOID OR OTHER OSTEOARTHRITIS



SUSSEX COUNTY: RHEUMATOID OR OTHER OSTEOARTHRITIS



Other needs identified in the CHNA but not addressed in this plan

Each of the health needs listed in the Hospital's CHNA as well as Worcester County Health Department's Community Needs Assessment is important and is being addressed by numerous programs and initiatives operated by the Hospital and/or other community partners of the Hospital. Needs not addressed as a priority area in the Implementation Plan are being addressed in the community by other organizations and by organizations better situated to address the need.

Needs Not Addressed In Plan	Rationale
Dental/Oral Health	-Need addressed by Worcester County Health Department's Dental Services for pregnant women and children less than 21 years of age -Priority Area Worcester CHIP -Need addressed by Lower Shore Dental Task Force & Mission of Mercy for adult population -Need addressed by AGH ED referral to community resources -Need addressed by Chesapeake Health Services, a federally funded dental clinic for Somerset and Wicomico Counties
Injury & Violence	-Need addressed by Worcester County Health Department Programs: Child Passenger Safety Seats (refer to Worc GOLD) Injury Prevention Highway Safety Program Safe Routes to School -Need addressed by Worcester County Sheriff's Department, State Police and Municipal Law Enforcement Agencies -Need addressed by AGH Health Literacy Program
HIV & STD (<2% ea)	-Need addressed by Worcester County Health Department Communicable Disease Programs

References

CDC National Center for Health Stats (2015). Retrieved from http://www.cdc.gov/nchs/fastats

CDC Diabetes Public Health Resource (2014). Diabetes Public Health Resource (1980 – 2014). Retrieved from http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm

CDC Heart Disease Statistics and Maps (2015). Retrieved from http://www.cdc.gov/HeartDisease/facts.htm

Community Health Needs Assessment FY2019-2021

County Health Rankings (2016). Worcester County, Maryland, Sussex County, Delaware Data. Retrieved on August 25, 2016, from http://www.countyhealthrankings.org/app/

NCI (2015). National Cancer Institute: Obesity, National Institute of Health. Retrieved on August 25, 2016, from http://www.cancer.gov/about-cancer/causes-prevention/risk/obesity

Mental Health Surveillance (2013). CDC. Retrieved on August 30, 2016, from https://www.cdc.gov/mentalhealthsurveillance/

PRC Survey (2015). Professional Research Consultants, Inc.