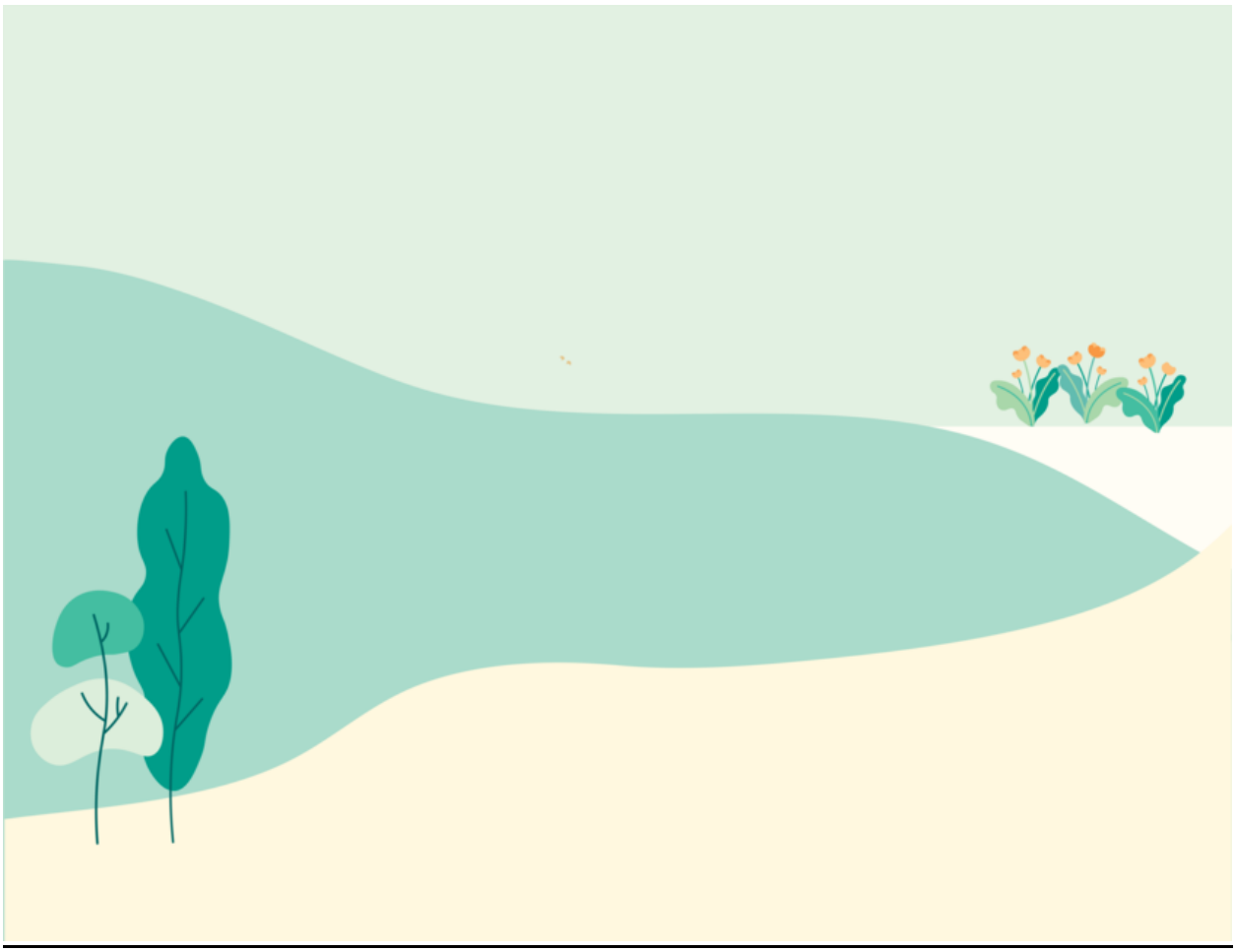

Community Health Needs Assessment

Implementation Plan

FY2022 – FY2024

Luminis Health

Executive Summary

Luminis Health is pleased to provide the FY2022 through FY2024 Community Health Needs Assessment (CHNA) and Implementation Plan. This plan is inclusive of all three hospitals in the health system: Luminis Health Anne Arundel Medical Center (LHAAMC), Luminis Health Doctor's Community Medical Center (LHDCMC), and Luminis Health McNew Family Medical Center. This report is designed to describe the process of collecting information and ascertaining the community needs, prioritizing those needs and a description of our action plan to address those needs to improve health. For the purpose of this report, the community is defined within Anne Arundel and Prince George's Counties since the majority of patient discharges reside in this area. The Board of Directors approved this plan on September 22, 2022 in accordance with IRS regulations.

About Luminis Health

In 2019, Anne Arundel Medical Center added Doctors Community Medical Center and was renamed to Luminis Health (LH), remaining a not-for-profit health system that serves communities across central Maryland, from Washington D.C. to Delaware. Luminis Health includes three hospitals with 611 licensed beds and over 80 ambulatory locations. As a major employer in central Maryland, we have more than 1770 on the medical staff, 6,500 employees and 1,400 volunteers. Our mission is to enhance the health of the people and communities we serve.

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 outlines multiple health needs in our community, county leaders have narrowed the top needs to chronic disease

(heart disease and cancer), obesity, diabetes/metabolic syndrome disease, behavioral health, and social determinants of health (SDOH). The results and correlating action plans are included in Table 1.

Table 1

Priority	Action Plans
Chronic Disease	Reduce incidence and mortality from Cancer by improving risk factors and screening rates. Reduce mortality from heart disease by providing education related to heart disease and risk factors. Improve access to cardiologists to reduce utilization.
Obesity/ Diabetes Prevention	Increase education for lifestyle risk factors to reduce obesity. Increase access to screenings and prevention programs to reduce incidence of diabetes.
Behavioral Health	Increase community awareness of programs. Increase access to behavioral health treatment for children, teens, and adults.
Social Determinants of Health (SDOH)	Create advisory councils to assist the health system to identify how to improve SDOH. Pilot and determine strategy to address food insecurity and how healthy food access can limit burden of disease (cancer, heart disease, diabetes).

CHNA Methodology and Process

Luminis Health participated in two separate CHNA processes, one for Anne Arundel County and one for Prince George's County. In both CHNA reports, the summative (quantitative) data was gathered from a variety of local, state and national sources. Qualitative data was obtained from key informant interviews, targeted population-based focus groups, and resident-household surveys. While both CHNA reports and data collection processes

were separate, each hospital participated with a diverse group of community partners to gather input including county health departments, hospital systems, public health leaders, faith based leaders, law enforcement, elected officials and business owners. While the CHNA reports are separate by county, Luminis Health has developed a comprehensive Implementation Plan that addresses the needs defined in Table 1.

Documenting and Communicating Results

The 2022–2024 Community Health Needs Assessment process fully embraced community involvement and collaboration with a broad group of community leaders, the general public, and health experts. This report will be posted on our website at (INSERT LINK).

Highlights of this report will also be documented in the Community Benefits Annual Report for FY2022-2024. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

Priorities and Implementation Planning

Luminis Health aligned its identified community health priorities with the state health priorities (SIHIS, Maryland Behavioral Health Plan), and national quality benchmarks (HEIDS). Program objectives and outcome measures will be measured annually for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. Program evaluations

will occur annually, and adjustments to programs will be as needed. All community benefits reporting will occur annually to meet state and federal reporting requirements.

Unmet Community Needs

Each CHNA report contained additional topic areas that will not be addressed within this plan. Due to resource limitations, LH will focus the majority of its efforts on the identified strategic priorities. We will periodically review the complete set of needs identified in the CHNA for future collaboration and work.

The LH identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

FY2022-FY2024 Community Health Improvement Implementation Plan

PRIORITY AREA: Chronic Disease- Cancer Heart Disease

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Reduce morbidity and mortality related to cancer.
2. Reduce morbidity and mortality related to heart disease.

Objective	**Target Population**	**Strategy**
Increase access to breast, cervical and colorectal cancer screenings.	Patients who meet screening eligibility	Identify opportunities in the care continuum to educate and schedule patients for screenings. Outreach to patients who lack access to screenings and face barriers (language, transportation, insurance).
Increase access to tobacco cessation and prevention programs.	Patients who smoke/ at risk for smoking	Continue on-going efforts to recruit patients through referral process. Identify high risk patients (behavioral health, face barriers) and enroll into programs.
Promote heart failure awareness among community and patients	Community	Increase self-assessment abilities through interactive learning experiences
Encourage participants to assume responsibility for their own health choices through development of a personal wellness plan for maximizing heart health throughout life	Community	Provide educational opportunities for patients to better understand how to implement a heart healthy diet, maintain weight, omit tobacco use, limit alcohol and drug use, get regular exercise.

Increase access to ambulatory cardiology providers to reduce readmissions, ED visits, for CHF and Afib	Heart patients	Increase providers to improve patient wait times and follow up visit adherence Improve process to schedule follow up appointments with providers.

PRIORITY AREA: Obesity/ Diabetes Prevention

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Expand Diabetes Prevention Programs across service area to reduce mean BMI, maintain HbA1c, and blood pressure monitoring in adults.
2. Expand diabetes prevention programs to non-English speaking populations.
3. Increase number of patients with access to healthy food.
4. Increase number of patients who are physically active.

Objective	**Target Population**	**Strategy**
Increase education and access to programs to improve health, reduce BMI, and reduce incidence of diabetes.	Patients and community who meet CDC diabetes prevention definitions	Expand DPP programs in English and Spanish Expand mobile van testing and screenings (HbA1c, total glucose, total cholesterol, blood pressure) Expand programs in Primary Care offices to improve HbA1c and blood pressure screenings Continue to support Prince George's County HSCRC Diabetes Catalyst Grant initiatives Expand the number of community partners to increase efforts

PRIORITY AREA: Behavioral Health

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Reduce the suicide rate and reduce the emergency department visits related to mental health

2. Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders

3. Increase the proportion of patients (Children, teens and adults) adults with behavioral health illnesses who receive treatment

Objective	**Target Population**	**Strategy**
Expand co-occurring capacity of Treatment and Prevention Programs	Staff	Provide awareness and education about programs ED continue to facilitate Naloxone distribution Partner with Sheppard Pratt to expand Collaborative Care Services in ambulatory practices
Explore new partnerships for community outreach and health promotion for mental health and substance use.	Community organizations	Provide awareness and education about programs
Improve access to Behavioral Health Care for children, teens, and adults	Patients	Expand consult service capacity for mental health and substance use within LHAAMC and LHDCMC Expand services at LHDCMC - open an inpatient psychiatric unit, Psychiatric Day Hospital, OMHC, Urgent care and residential addiction-crisis unit for adults Expand ED Evaluations at LHDCMC and offer Emergency Petition (EP) capacity Develop Child & Adolescent Outpatient Services on a regional basis to serve both Anne Arundel and Prince George's Counties

		Continue to monitor and evaluate programs and access for patients

PRIORITY AREA: Social Determinants of Health

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Increase number of patients who have access to healthy food.
2. Reduce number of patients with risk factors for disease since they have access to healthy food.

Objective	**Target Population**	**Strategy**
Establish advisory councils for each hospital to develop strategies to address SDOH in a clinical setting and in the community.	Community leaders	Pilot SDOH faith based council at LHDCMC. Develop lessons learned and implement strategies at both hospitals. *Plan to be updated FY23-FY24