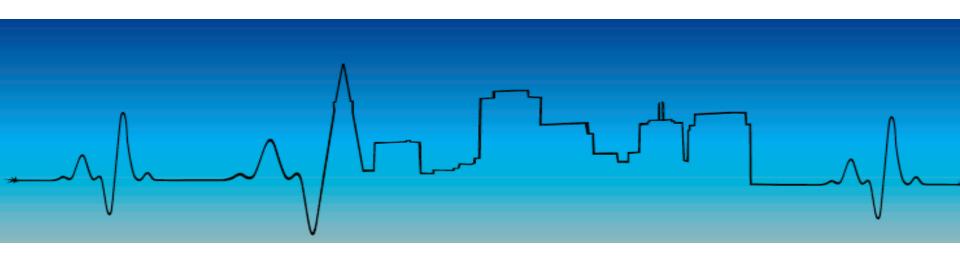
# Community Health Needs Assessment



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### What Does Our County Look Like?

- Population: ~ 100,000
- Race: 87% white; 7% AA; 6% other
- Avg hh income: \$80k (avg hh size: 2)
- 60% of UHCC patients come from North East & Elkton
- Items that cause disparities/access to care issues:
  - Unemployment (10%)
  - Poverty (6.5%)
  - Medicaid (15%)
  - Uninsured (10%)
  - No high school diploma (12.5%)
- **Poll**: Where do you think most of the disparity causing items are concentrated?

## How Can We Assess the Needs of the Community?

- Collect and analyze data
  - Meet with stakeholders
  - ID gaps & challenges
- Select priorities
  - Top 3 (Resp. Health, Heart Disease, Obesity)
- Plan for action
  - Engage community partners in strategic steps
- Monitor progress
  - Share data & progress
- Document & disseminate results

### **How Are We Making Impact?**

#### Respiratory Health

 Partnering with HD to connect patients and community to smoking cessation resources

#### Heart Disease

- Partnering with HD, AA churches, schools, & paramedics to address hypertension in the community
- Partnering with area health fairs to provide stroke risk assessments

#### Obesity

 Promoting nutrition & physical activity to adults and children through the schools and other local partners

## What Other Programs Can We Model?

- Hair, Heart, & Health
  - MedStar Health program that promotes heart health in barber shops in DC and Baltimore



## What Can We Do with the Information?

- By assessing and identifying community health needs we can:
  - Increase access to care
  - Improve patient self-management
  - Reduce preventable ED visits
  - Enhance (targeted) population health
  - Show transformative difference in our community

## Why is All of This Important?

### The CHNA can help:

- Link hospital and community partners to identified community assets
- Build on hospital-community-public health partnerships to enhance prevention
- Target efforts around most costly health needs



### Thank You!



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