UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Implementation Plan, FY2023-FY2025

The Community Health Implementation Plan (CHIP) is a list of specific goals and strategies that demonstrate how UM SRH plans to address the most significant needs identified in the CHNA while also being aligned with UMMS community health improvement initiatives and national, state and local public health priorities.

Our Annual Operating Plan, which is derived from our strategic plan, includes community benefit and population health improvement activities.

Based on qualitative and quantitative data collected and analyzed during the CHNA process, UM SRH's Implementation Plan remains committed to the goals and strategies identified in the FY2020-FY2022 CNHA. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain the same as reported in the previous CHNA.

Health Priorities FY2023-2025

The top five priorities:

1. Mental health/substance abuse
2. Access to care
3. Chronic Disease management
4. Preventive/wellness programs
5. Cancer

Overarching theme for addressing health priorities:

1. Reduce barriers to care
2. Improve care coordination
3. Focus on health outreach and education

UM SRH is engaged in numerous programs addressing the identified needs of the Mid-Shore. The UM SRH hospitals work to strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships.

The CHIP items which follow provide action plan strategies and examples of ongoing initiatives that address the identified needs. Strategies emphasize clinical and community partnership development and improved coordination of care. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

HEALTH NEED 1: BEHAVIORAL HEALTH			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access and integration/ coordination of intensive mental health and substance abuse services	**Strategy 1**: Provide access to acute inpatient and Intensive Outpatient services for mental health and substance use disorders including prevention and support services	• Number of referrals to the Intensive Outpatient programs. Both the mental health and Substance abuse programs • Number of adults admitted to inpatient services	• All Mid-Shore Mental Health Agencies • Local Health Departments • Local Emergency and Primary Care practices
	Strategy 2: Expand program(s) to support Primary Care patients waiting for outpatient mental health and/or substance use disorder treatment	• Number of referrals from primary care providers • Length of time to first mental health or substance abuse appointment • Number of Primary Care sites with co-located mental health services • Develop Urgent Care Services	• Community Behavioral Health • Local Mid-Shore Community Mental Health partners
	Strategy 3: Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of "direct hand-offs" in Emergency Departments and Primary Care Offices to the next level of care	• Number of patients referred between systems • Number of Inpatient readmissions • Number of Emergency room visits	• Local Emergency Departments • Primary Care Practices • Local Health Departments • Corsica River Behavioral Health • Community Behavioral Health • ACT Team
Opioids- Improve overdose mortality Statewide Integrated Health Improvement Strategy (SIHIS) goal	**Strategy 4:** • Expand screening, brief intervention, and referral to treatment (SBIRT) and buprenorphine induction in the Emergency Department and Substance Abuse IOP. • Distribute Naloxone to patients who receive treatment in the emergency department (ED) for a non-fatal overdose. • Connect with Regional Partnership on plans to expand behavioral health crisis infrastructure in the community	• Number of patients screened who presented to ED • Number/% of overdose patients presenting to the ED with intensive community peer support • Number of medication initiated encounter for opioid-using patients presenting to the ED • Number of patients linked to treatment after community peer engagement • Number of patients linked to MOUD induction in the ED to MOUD treatment same or next day after discharge	• Regional Opioid Taskforce • All Mid-Shore Local Addiction Authorities

EXAMPLE INITIATIVES:

Maryland Department of Health -Reverse the Cycle (RTC) program

Comprehensive hospital substance use response program RTC includes:

- Universal screening and peer intervention
- Overdose survivors outreach
- Medication initiation

Co-Location of Mental Health Services in Primary Care Clinics

"Warm handoff" to community resources from the inpatient unit

- Care Connections
- Community Behavioral Health
- Lower Shore ASCT team

Regional Opioid Task Force: The task force — which includes representatives of county health departments and emergency services, and emergency and behavioral health physicians and nurses, and hospital officials — is led by Dr. Walter Atha, regional director of emergency medicine for UM Shore Regional Health, and Dorchester County Health Officer Roger Harrell. The task force is working to coordinate and standardize the medical community's response among Mid-Shore counties tackling the heroin and opioid epidemic

HEALTH NEED 2: ACCESS TO CARE			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access to care for medically underserved and vulnerable groups of all ages	**Strategy 1**: Increase capacity by addressing the recruitment, retention, accessibility, competency of providers	• Medical Staff assessment-identify shortages • Provide/fund physician subsidies to meet identified community needs • Establish physician/resident training programs	• University of Maryland School of Medicine and UMMC • AHEC • Choptank FQHC
	Strategy 2: Enhance and Expand Telemedicine Opportunities	• Increase total consults • Identify and implement new consult services: Neurology subspecialties	• Within SRH and its physicians • University of Maryland Medical Center and UM SOM/FPI
	Strategy 3: Reduce transportation barriers and enhance awareness of available services	• Number of transportation vouchers • Resource information distribution	• DCT and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties
	Strategy 4: Connect uninsured to private insurance, Medicaid, or other available coverage	• Number of insured residents	• County Medicaid offices through SRH Case Management

EXAMPLE INITIATIVES:

Recruit additional health care providers and specialists to the region to address access barriers identified by the community. Provide subsidies as a means to increase the availability of health care providers in order to best meet identified patient and community needs related to the availability of health care services.

Telehealth services Expand existing programs to outlying facilities as much as possible, increase both the number of specialties providing telehealth consultations and the number of telehealth consultations.

Transportation- Work to mitigate transportation barrier by assisting/arranging transportation for patients to travel to medical appointments

Uninsured/underinsured care -Inform patients and family members of UM SRH Financial Assistance Policy, assist with application for financial assistance, and provide financial assistance to eligible patients. Work with patients to determine eligibility for medical assistance, e.g. Medicaid, and other social services.

HEALTH NEED 3: Chronic Disease			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Prevent, detect, and manage chronic diseases	**Strategy 1**: Work with community organizations, congregational networks, and individuals to improve care, management and prevention of chronic diseases	• Number of health education/outreach encounters provided to community-based organizations and churches • Number of participants in health events and number of screenings performed • Number of outreach programs	• Health Departments • Faith based organizations • Homeports • Department(s) of Aging • YMCA • Area Schools
	Strategy 2: Screen for barriers/social needs of patients with chronic conditions during transitions to improve ability of patient to manage condition	• Increased transition support available to patients with chronic disease • Number of patients connected to services addressing social needs	• Home care providers • Faith based organizations • Department(s) of Social Services • Pharmacies • Meals on Wheels • Mobile Integrated Community Health
	Strategy 3: Provide specialized health information, "physician to physician" education regarding diabetes treatment and management.	• Number of provider outreach education sessions for primary care offices and medical staff	• Community providers

INITIATIVES:

Outreach: Education, screenings and support groups offered on the following topics/conditions: high blood pressure and heart disease; diabetes; cancer, stroke; hospice services and palliative care; obesity, exercise and nutrition; depression and anxiety

Chronic Disease: To address chronic disease-related emergency department visits, The Transitional Nurse Navigator (TNN) Program provides continued care coordination for high-risk patients from the beginning of their hospital stay through up to 30-days after discharge. The scope of the discharge planning process has been expanded to include the broader, holistic needs of patients. Caseworkers and transitional nurse navigators help patients anticipate what their care needs will be in their home environment, connect with the patient's primary care provider to ensure proper follow-up, and provide links to needed community resources offering services such as transportation, home care, meals, home technologies and social support.

Food Distribution: Through grant funding, support Maryland Food Bank, Eastern Shore Mobile Pantry

Physician Outreach: Provide education to community physicians who manage patients with complex chronic conditions

HEALTH NEED 4: Preventive/wellness programs			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Health Promotion and Wellness Services strives to support inclusive, accessible, and diverse health and wellness opportunities.	**Strategy 1**: • Provide classes, program, speakers, events to improve health & wellness • Expand diabetes/pre-diabetes educational classes- State Diabetes Action Plan • Develop an annual calendar of events, screening and support groups sponsored by UM SRH, and community partners • Support Upper Shore Aging education programs for seniors and caregivers • Provide education specialist(s) needed to support wellness programing	• Number of classes offered • Number of attendees who participate	• Health Departments • Upper Shore Aging • YMCA • U of Md Extension
	Strategy 2: Health Literacy • Promote monthly "Community Conversation" - discussion with UMMS experts to learn more about a health topic and how to avoid/manage a medical condition. • Promote existing public library programs that enhance learning	• Number of events offered • Number of attendees	• University of Maryland Medical System • Local Libraries

	Strategy 3: Improve care coordination, info sharing protocols to achieve safer, more effective care	• Protocols developed • Educational materials standardized across setting. • % of educational materials available in Spanish	Health Departments

EXAMPLE INITIATIVES:

Education/Awareness: Cosponsor the series "Not All Wounds Are Visible": *A Community Conversation* and "Let's Talk About Health". The community events are facilitated by University of Maryland Medical System and the University of Maryland, Baltimore– to help community members engage with experts and gain valuable tools on how to lead a healthy life - mentally and physically.

Educational topics include:

Diabetes, Stroke, Heart Education Programs

- Education Series
- Support Groups
- Radio Broadcasts
- Heart Wellness Newsletter and Presentations
- Stroke Education/Presentations

- How to understand Medicare, Medicaid and commercial health insurance plan benefits (e.g. copays, coinsurance, in and out of network providers)
- How to choose where to see health care services (e.g. primary care, urgent care, Emergency Department)
- How to access community resources that can help prevent and manage chronic conditions

HEALTH NEED 5: Cancer			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Reduce cancer mortality rate	**Strategy 1**: Provide increased and improved screening and prevention services for breast, skin, prostate and colorectal cancer and evaluate adding cervical screening.	• Number of health education/outreach encounters provided to community • Number of participants in health events and number of screenings performed • Number of outreach programs	• University of Maryland Medical Center • County Health Departments • Specialty practices
	Strategy 2: Continue to educate the community about Lung Cancer Screening Program and support programming to reduce use of tobacco products	• Earlier detection of lung cancer • Improve survival rates • Work with Talbot County HD to develop a formal pathway for smoking cessation.	• County Health Departments • Community Providers

ACTIVITIES/INITIATIVES:

WELLNESS FOR WOMEN ACCESS TO CARE PROGRAM

The program serves as a point of access into care for age and risk specific mammography screening, clinical breast exam, and genetic testing for breast cancer.

Offers **no cost mammograms** to eligible women: those under the age of 40 and over 65 who have no insurance. Those women needing further diagnostic tests or who need treatment for breast cancer are enrolled in the State of Maryland Diagnosis and Treatment Program through the case manager.

LUNG CANCER EARLY SCREENING PROGRAM

The low dose computed tomography (LDCT) screening program promotes earlier detection of lung cancer. Eligible patients are the high-risk groups which include those who have smoked a pack of cigarettes daily for two or three decades, who are currently smokers, or those who quit smoking less than 15 years ago to have them screening for lung cancer. Earlier detection promotes better treatment and survival rates.

ANNUAL PROSTATE SCREENING

Public screening for males who are $\geq$ 40 years of age for a baseline screening, African American men, men with a family history of disease, and males > 55-74 for yearly screening.