UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Community Health Implementation Plan, FY2020-FY2022

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 2016 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 2016 CHNA.

Health Priorities FY2020-2022

The top five priorities:

1. Access to care
2. Preventable ER visits
3. Chronic Disease management
4. Mental health/substance abuse
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 — SMC at Chestertown, SMC at Dorchester, and SMC at Easton 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: 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 and populations	**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 • Eastern Shore Area Health Education Center (AHEC)
	Strategy 2: Enhance and Expand Telemedicine Opportunities	• Increase total consults • Identify and implement new consult services: Dermatology and Child/Adolescent Psychiatry currently under negotiation	University of Maryland Medical Center, University of Maryland Faculty Physicians, (FPI) University of Maryland School of Medicine (SOM)
	Strategy 3: Reduce transportation barriers and enhance awareness of available services	• Number of transportation vouchers • Resource information distribution • Participate Mid-Shore Rural Health Collaborative Transportation Workgroup	• Delmarva Community Transit (DCT) and Queen Anne's County Ride cover Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties • Rural Health Collaborative
	Strategy 4: Connect uninsured to private insurance, Medicaid, or other available coverage	• Number of insured residents	• Maryland Health Exchange

ACTIVITIES/INITIATIVE:

Recruit additional health care providers and specialists to the region. Provide subsidies 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 the number of specialties providing telehealth consultations.

Transportation- Work to mitigate transportation barriers 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 2: Preventable ER Visits			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Help patients obtain "The Right Care, at the Right Place, at the Right Time"	**Strategy 1**: Provide community health education to improve understanding of appropriate use of primary care, urgent care, and emergency department in terms of medical capability and patient needs	• Decrease in unnecessary emergency department visits • Increase health in literacy	• Payers • Community media outlets
	Strategy 2: Improve care coordination, info sharing protocols to achieve safer, more effective care	• Protocols developed • Chronic disease management	• Community providers • five county health departments • social services • EMS agencies • Aging agencies

ACTIVITIES/INITIATIVES:

Educational topics include:

- 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 seek health care services (e.g. primary care, urgent care, Emergency Department)
- How to access community resources that can help prevent and manage chronic conditions

Rural Health Collaborative: UM SRH participates as a member on the Integrating Clinical and Social Support Services Workgroup. This workgroup supports the Rural Health Collaborative in determining actions that can be taken within the five Mid-Shore counties and throughout the Mid-Shore region to better integrate clinical and social support services. The Workgroup is charged with:

- Articulating the overarching problem to be addressed
- Identifying the current status of clinical and social support services and the resources supporting those services (including the components being added by the Maryland Total Cost of Care Waiver beginning January 2019)
- Determining the optimal availability and integration of clinical and social support services
- Deciding what is feasible to achieve by 2023 to better integrate clinical and social support services and steps to take to do so
- Recommending actions for improving integration of clinical and social support services to the Care Transformation Organizations and/or the Care Managers assigned to Primary Care Providers.

HEALTH NEED 3: Chronic Disease Management			
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

ACTIVITIES/INITIATIVES EXAMPLES:

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

Engage targeted communities on healthy lifestyles: Through sponsorship or provision of:
- Community-wide education
- Store Tours
- Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol)
- Exercise Demonstrations

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.

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

HEALTH NEED 4: BEHAVIORAL HEALTH			
Goal	**Strategies**	**Metrics/What are we measuring**	**Potential Partnering/External Organizations**
Goal: Improve access and integration/ coordination of mental health and substance abuse services	**Strategy 1**: Provide individual, group, medication assisted treatment, and other mental health services, including prevention and support services	• Decrease re-hospitalization • Number of patients who accept treatment following an overdose • Number of adults who utilize services • Increase family and patient understanding of mental health treatments.	• Eastern Shore Crisis Response • Queen Anne's, Talbot, and Dorchester County Health Departments • Shore Medical Group Bridge Clinic
	Strategy 2: Expand program(s) to support ED patients waiting for	• Number of patients served by the Bridge Clinic	• Corsica River Mental Health Center

	outpatient mental health and/or substance use disorder treatment	• Number of follow-up phone calls and outreach to patients who have experienced an overdose	• Community Behavioral Health • Marshy Hope Mental Health
	Strategy 3: Improve care coordination for mental health and substance abuse co-occurring conditions through facilitation of direct hand-offs to the next level of care	• Number of patients referred between systems • Improve access by providing education regarding available resources and services	• Mid-Shore Behavioral Health System • Eastern Shore Crisis Response • Physician practices • Local Health Depts.

ACTIVITIES/INITIATIVES EXAMPLES:

Behavioral Health Bridge Clinic. The Bridge Clinic serves patients discharged from the behavioral health inpatient unit who are unable to access psychiatric care from community due to shortage of psychiatric providers.

Continue to provide: (1) medication administration assistance to complement counseling services currently being offered and to assist post discharge overdose patients; (2) injection support/education clinic to promote use of long acting psychotropic medications

The Bridge Clinics family group meeting. Community supporters of patients and in particular patients' family members receive education and support regarding mental health and treatment strategies. Assist families in maintaining positive support for their loved ones.

Education: To improve access to mental health care, programs are offered on a quarterly basis to the community providing up to date information on available mental health resources and services.

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

Education/Awareness: Cosponsor the series "Not All Wounds Are Visible": A Community Conversation. 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.

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.