2023 – 2025

Community Health Improvement Plan Strategies and Indicators

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Executive summary: Ideas into action

TidalHealth, Somerset County Health Department (SCHD) and Wicomico County Health Department (WiCHD) worked collaboratively to develop this Community Health Improvement Plan and Implementation Strategy in response to the 2022 Community Health Needs Assessment. The collaborative approach reduces duplication of resources and provides a more comprehensive approach to addressing health improvement. For purposes of this report, the three leading organizations: TidalHealth, SCHD, and WiCHD will collectively be referred to as “the Partnership.”

A community health improvement plan (or CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. Health and other governmental education and human service agencies, in collaboration with community partners, use this plan to set priorities, coordinate and target resources. At the heart of this plan are the fundamental goals and actions that will enable communities to improve health and environment, implement policies to support healthy lifestyles, increase access to health services, and strengthen safety net systems that foster more effective and equitable delivery of health services.

Conduent HCI worked with the Partnership as a leadership committee to create a joint framework that serves both the needs of nonprofit hospital and health department partners, as well as the entire service area encompassing the Lower Eastern Shore of Maryland and Sussex County, Delaware.

2022 Maryland Statewide Integrated Health Improvement Strategy (SIHIS)

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of health care quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed-upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. As a result of the collaboration with CMMI, the State entered into a Memorandum of Understanding (MOU) that required Maryland to provide a proposal for the Statewide Integrated Health Improvement Strategy (SIHIS) to CMMI by December 31, 2020. The SIHIS aligns statewide efforts across three domains that are interrelated and, if addressed successfully, have the potential to make significant improvement in not just Maryland's healthcare system, but in the health outcomes of Marylanders.

The top health priorities identified for the Maryland SIHIS were:

1. Hospital Quality
2. Care Transformation Across the System
3. Total Population Health Diabetes
4. Total Population Health Opioid Use Disorder
5. Total Population Health Maternal and Child Health

The interconnectedness of Maryland's greatest health challenges, along with the overall consistency of health priorities identified in the CHNA assessment, indicates many opportunities for collaboration between a wide variety of partners at and between the state and local level, including physical and behavioral health organizations and sectors beyond health. It is our hope that this framework will serve as a foundation for such collaboration.

To view the full 2021 Statewide Integrated Health Improvement Strategy, please visit:

https://hscrc.maryland.gov/Documents/Modernization/Statewide Integrated Health Improvement Strategy/SIHIS 2021 Annual Report FINAL w appendix.pdf

2022 Delaware Statewide Integrated Health Improvement Plan (SHIP)

The State Health Assessment (SHA), State Health Improvement Plan (SHIP), and the Division of Public Health's organizational strategic plan are prerequisites for State Health Departments that pursue National Public Health Accreditation Board Accreditation (PHAB).

The State Health Department's SHIP addresses the needs of all citizens in the state. The SHIP is a long-term, systematic plan to address issues identified in the SHA. The purpose of the SHIP is to describe how the health department and the community it serves will work together to improve the health of the population in their jurisdiction. The community, stakeholders, and partners can use a solid SHIP to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.

The Evidence-based and Promising Strategies across SHIP priority areas for 2020 include:

- Chronic Disease
- Maternal and Child Health
- Substance Use Disorder
- Mental Health

Hospital Internal Revenue Services (IRS) Requirements

Certain hospitals as set forth in the Section 501(r) regulations are required to complete a CHNA and corresponding implementation strategy at least once every three years in accordance with regulations promulgated by the Internal Revenue Service pursuant to the Patient Protection and Affordable Care Act (ACA), 2010. The partnership collaborating on this CHIP framework adopted the most recent CHNA in April 2022 in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements.

Public Health Accreditation Board (PHAB) Accreditation Requirements

PHAB accreditation is a process that supports health departments to improve and strengthen quality, accountability and performance. WiCHD has been PHAB accredited since 2016; SCHD is currently working towards initial PHAB accreditation. To receive and maintain PHAB accreditation, health departments, along with their partners must have a comprehensive approach to assessing community health. The assessment results are then used to develop and implement a community health improvement plan (CHIP) to address the highest health needs identified. The CHIP provides guidance to the health departments, its partners, and stakeholders for improving the health of the population within the jurisdiction.

Identifying and Prioritizing Needs

The Partnership reviewed and discussed the scoring results of the prioritized significant community needs and identified three priority areas for subsequent implementation planning. These three priority areas are:

1. Access and Health Equity
2. Behavioral Health
3. Chronic Disease and Wellness

To better target activities to address the most pressing health needs in the Partnership worked collaboratively to participate in two virtual working sessions along with weekly collaborative sessions facilitated by Conduent HCI. A central piece of these virtual exercises was a nontraditional approach to building consensus around the activities that would feed into Goals, Objectives and Strategies. Within Public Health and Healthcare, there has been deep conversation to center equity in the discussion and considerations for building long-term strategies that support the communities served. Having organizations working together and seeing successful outcomes based on their investment is central to scalable solutions and targeted action within the communities served. The Partnership used two different strategies to develop the final framework, The Aligning Health Systems, and the Results Based Accountability Framework.

Aligning Health Systems Framework

The Robert Wood Johnson Foundation along with its partners developed a collaborative framework that addressed sectors that traditionally work closely together, however do not usually align directly in their operations, or how they approach complex community issues. Public Health, Health Care and Social Services, within this context, need strong emphasis around coordination beyond singular project based collaborative work, and instead focuses on these sectors to work together in new ways to improve the health and well-being of the communities they all serve. The Partnership used this framework to align on the highest levels around big long-term goals.

Monitoring Plan Progress

This community health improvement plan (CHIP) is a three-year action plan. The CHIP is a living document, that will continue to evolve after the initial release. For example, strategies may need revision or new strategies may be added based on a completed objective. Somerset and Wicomico Counties each have a Local Health Improvement Coalition (LHIC). Members of the two LHICs are jurisdictional-level stakeholders and community partners, who are charged with providing input and guidance on the community health needs assessment and oversight and monitoring of the CHIP.

Once implemented, the LHICs will evaluate the CHIP on an ongoing basis to track the status of the effort or results of the actions taken to implement CHIP strategies. The LHICs will be responsible for tracking and collecting data. The Partnership will make amendments to the CHIP objectives and strategies when applicable and will prepare progress reports on an annual basis.

Access and Health Equity

Creating a culture of health for whole communities

Alignment Indicator(s): Adults with health insurance, adults unable to afford to see a doctor, primary provider rates

Goal 1.1: Increase equitable access to healthcare		
Objective(s)	**Strategies (Program Owner)**	**Performance Measures**
1. By June 2025, increase insurance coverage for populations with disparities in health coverage. **Wicomico:** Increase coverage for Hispanic residents of Wicomico County to 75% (2020 baseline = 65.3%). **Somerset:** Maintain coverage rate for Hispanic residents of Somerset County at 90% (2020 baseline = 90%). **Sussex:** Maintain percentage of adults with health insurance at 90%.	• Outreach to uninsured and underinsured groups to increase health insurance enrollment (Lower Shore Health Insurance Assistance Program – Worcester County Health Department). • Outreach and MCHIP assistance especially for Hispanic residents. (WiCHD) • Continue the work that is currently being done in the migrant program and integrating our Community Health Workers into healthcare facilities. (SCHD) • Screen patients for health insurance coverage and refer to health insurance assistance programs and navigators (TidalHealth) • Refer children without health insurance at School-Based Wellness Centers to Community Health Worker (TidalHealth)	• Percentage of Hispanic residents with health insurance for Wicomico and Somerset Counties • Number of outreach activities conducted to promote health insurance coverage among uninsured and underinsured populations

Goal 1.1: Increase equitable access to healthcare (continued)		
Objective(s)	**Strategies (Program Owner)**	**Performance Measures**
2. By June 2025, establish a process to determine the insurance coverage percentage for the Haitian population. **Wicomico:** Process created and piloted by June 2025.	• Work with LHIC partners to develop and pilot process. (WiCHD)	• Documented process • Results of pilot of implemented process
3. By December 2023, implement best practices and standardization of social determinants of health screening and closed-loop, bidirectional referrals across multiple sectors and community-based partners. **Service area:** Adopt a screening tool and referral platform.	• Conduct an environmental scan of community-based partners to assess who is currently utilizing SDOH screenings (TidalHealth). • Increase adoption and use of social care service and resource referral platform among community-based organizations i.e. findhelp. (TidalHealth)	• Documented process and identified tool. • Establish baseline of adopters of identified tool(s) and increase CBOs using the tool for screening and referrals.
4. By June 2025, expand the diversity of the community health worker workforce within health systems, public health and adjacent sectors. **Service area:** Establish baseline of CHWs in each of the counties.	• Determine baseline measure of Community Health Workers (CHWs), including the number of bilingual CHWs. (LHICs) • Increase access to funding to support certification training and salaries for Community Health Worker (CHW) positions at local health care, public health, and community-based organizations serving marginalized or disadvantaged populations by collaborating on grants and alternative payment agreements with Medicaid MCOs (TidalHealth) • Establish a regional association for CHWs to support workforce development (ESAHEC)	• Baseline of CHWs across community-based originations. • Number of new CHWs hired overall • Number of new bilingual CHWs hired • Number of CHWs certified • Establishment of regional CHW association

Goal 1.2: Provide education and promote awareness of health equity, including policy recommendations		
Objective(s)	**Strategies (Program Owner)**	**Performance Measures**
1. By June 2024, develop and adopt Health Equity Framework(s) among key partner organizations.	• Participate in health equity learning collaboratives and adopt Institute of Healthcare Improvement's Health Equity framework (TidalHealth) • Establish a subcommittee in the LHIC to be tasked with Health Equity (Wicomico LHIC)	• Outcomes of health equity project aims as identified by TidalHealth • Health Equity Sub-Committee established
2. By June 2025, local health coalitions present at least one policy recommendation related to health equity.	• Conduct an environmental scan for community organizations to assess health literacy polices and resources in place (Somerset and Wicomico LHICs) • Create action plan to address gaps identified in the environmental scan. (Somerset and Wicomico LHICs)	• Documented scan completed • Completed action plan
3. June 2024, increase engagement of diverse community members in the local health improvement coalitions in Somerset and Wicomico counties. **Wicomico and Somerset:** Recruit at least 2 LHIC members annually.	• Complete analysis of LHIC membership annually and recruit new members based on gaps identified (SCHD and WiCHD) • Promote LHIC to diverse groups such as Lower Shore Vulnerable Populations Task Force to increase engagement and membership among underrepresented groups. (SCHD and WiCHD)	• Analysis report of LHIC membership • Number of new LHIC members overall • Number of new LHIC members by sector • Number of outreach presentations of the LHIC

Behavioral Health

Reducing trauma and improving access

Alignment indicator(s): Frequent mental distress, poor mental health days, self-reported mental health, death rate due to drug use

Goal 2: Improve behavioral health through prevention, treatment, and recovery		
Objective(s)	**Strategies (Program Owner)**	**Performance Measures**
1. By June 2025, reduce the rate of suicide deaths in the service area. **Wicomico:** Reduce rate to 9.0 per 100,000 (Baseline: 11.7 in 2020). **Sussex:** Reduce rate to 10 per 100,000 (Baseline 11.9 in 2020)	• Increase the number of persons trained in Mental Health First Aid (WiCHD) • Implement the Talk Saves Lives Program (WiCHD). • Educate the community about 988 suicide and crisis line (WiCHD) • Increase access to treatment and prevention services including the Crisis Stabilization Center (TidalHealth) • ACT (Lower Shore Clinic) • Conduct PHQ 2 and 9 surveys in primary care settings (TidalHealth) • Support Sussex County Health Coalition on suicide prevention strategies	• Persons trained in Mental Health First Aid • Percentage of PHQ 2 and 9 screenings (Goal: 90 percent)

Goal 2: Improve behavioral health through prevention, treatment, and recovery (continued)		
Objective(s)	**Strategies (Program Owner)**	**Performance Measures**
2. **By June 2025, reduce and prevent opioid misuse and overdoses.** **Wicomico:** Reduce deaths by 40% (Baseline: 39 in 2020). **Somerset:** Reduce deaths by 25% (Baseline is 13 in 2020) **Sussex:** Reduce Age-adjusted drug and opioid-involved overdose death rates per 1,000 from 46.6 to 44.6.	• Expand access to Narcan/ Naloxone and training in the community (WiCHD) • Continue linking individuals to treatment via Community Outreach Addiction Team (COAT) services. (WiCHD) • Increase access to treatment and prevention services including the Crisis Stabilization Center (TidalHealth) • Provide and promote use of Narcan/Naloxone upon discharge when prescribed opioid medication (TidalHealth). • Provide and promote use of Narcan/Naloxone in community (TidalHealth) • Support regional Go Purple campaigns	• Number of Narcan trainings to those with social experience and their family members. (WiCHD, TidalHealth) • Percentage of COAT contacts (including non-residents) successfully linked to treatment. • Percentage of COAT clients remaining in recovery for at least six months.
3. **By June 2025, strengthen the integrated behavioral health-primary care model among local healthcare providers.** **Wicomico:** Academic Detailing Target = 12 visits Hub and Spoke Target = 15 individuals served through care coordination. Target: 1,000 referrals to TidalHealth behavioral health therapist annually Goal: 90 percent patients screened for PHQ 2/9 (TidalHealth)	• Increase referrals to behavioral health therapist among TidalHealth Medical Partners primary care practices. • Increase PHQ 2 and 9 screenings at TidalHealth Medical Partners primary care practices (TidalHealth) • Hub and Spoke Program will support community prescribers to expand care for more patients with opioid use disorder. (WiCHD) • Academic Detailing visits to healthcare providers for best practices in prescribing opioids. (WiCHD)	• Number of referrals to TidalHealth behavioral health therapist (Goal: 1,000 referrals annually) • Percentage of PHQ 2 and 9 screenings (Goal: 90 percent) • Number of individuals receiving care coordination through the Hub and Spoke Program. • Number of academic detailing visits

Goal 2: Improve behavioral health through prevention, treatment, and recovery (continued)		
Objective(s)	**Strategies (Program Owner)**	**Performance Measures**
4. **By June 2025, decrease the proportion of adults reporting excessive poor mental health days.** **Wicomico:** reduce the proportion of adults reporting poor mental health for 14 or more days each month to 12%. (Baseline: 15.3%; MD BRFSS) **Sussex:** Reduce to 10% (Baseline 11.9% in 2020)	• Expand the PEARLS program (TidalHealth/MAC) • Assertive Community Treatment (ACT) (Lower Shore Clinic) • Increase referrals to behavioral health (TidalHealth)	• Number of people completing PEARLS Program

Chronic Disease and Wellness

Well-being in all aspects of life

Healthy 2030 Alignment Indicator(s):

Goal 3.1: Reduce the prevalence and mortality rates of chronic diseases in the Partnership area		
Objective(s)	Strategies (Program Owner)	Performance Measures
1. **By June 2025, reduce the prevalence of diabetes among adults in the service area.** **Wicomico:** Reduce prevalence to 8.0% (Baseline: 10.9% in 2020). **Sussex:** Reduce prevalence to 13% (Baseline: 15.7% in 2020)	• Facilitate at least two Diabetes Prevention Program (DPP) cohorts per fiscal year. (WiCHD). • Strengthen referral process between primary and providers and DPP providers. (WiCHD) • Increase access to the National Diabetes Prevention Program by providing it in community settings. (WiCHD) • Facilitate at least three Diabetes Prevention Program groups per fiscal year. (SCHD) • Maintain the current referral process and relationship with Chesapeake Healthcare (CHC). Also try to connect with other providers to receive additional referrals. (WiCHD) • Increase referrals from TidalHealth primary care providers – utilize CRISP DPP report to identify potential patients for referrals (TidalHealth)	• Number of DPP cohorts • Number of health care providers referring to the DPP (5) • Number of individuals referred to DPP programs to reduce risk factors for type 2 diabetes (25) • Number of cohorts launched • Number of DPP participants enrolled; number of participants retained by session 4 (30)

Goal 3.1: Reduce the prevalence and mortality rates of chronic diseases in the Partnership area (continued)		
Objective(s)	Strategies (Program Owner)	Performance Measures
1. (continued)	• Engage at least 2 healthcare providers to refer participants to DPP (SCHD) • Provide the National DPP lifestyle change program with at least two cohorts to at least 30 new participants	
2. **By June 2025, reduce the rate of hospital ED visits, admissions and readmissions for diabetes and hypertension among adults.** Based on Maryland CRISP data provided in 2019: 5% reduction in average hospital encounters for hypertension (rate: 470/1000) 5% reduction in average hospital encounters for diabetes (rate: 8/1000)	• Operate a mobile integrated health program (SWIFT) (TidalHealth and Salisbury Fire Department) • Provide Remote Patient Monitoring to high-risk patients with chronic conditions such as diabetes, CHF, COPD (TidalHealth) • Provide health screening, outreach, and education in the community including diabetes risk assessments and blood pressure checks. (TidalHealth)	• Number of patients served by SWIFT • Pre/Post utilization of SWIFT patients • Number of people served by RPM program and pre/post data • Number of screenings and outreach activities via mobile clinic
3. **By June 2025, increase the proportion of adults who get evidence-based preventative health care including screenings.** **Wicomico:** Increase adults receiving recent routine checkup to 90% (Baseline: 81.2% in 2020). **Somerset:** Increase adults receiving recent routine checkup to 85% (Baseline: 76.9%) **Sussex:** Increase awareness and uptake of recommended prostate cancer screenings.	• Complete at least 25 colorectal screenings a year. (WiCHD) • Complete at least 12 colorectal screenings per year. (SCHD) • Launch an awareness and outreach campaign to increase acceptance and uptake of prostate cancer screenings (TidalHealth)	• Number of colorectal screenings completed • Number of outreach events and people reached

Goal 3.2: Promote and support healthy lifestyles and wellness in the service area to reduce risk of chronic disease		
Objective(s)	Strategies (Program Owner)	Performance Measures
1. By 2025, decrease the proportion of people with overweight or obesity. **Wicomico:** Reduce prevalence to 8.0% (Baseline: 10.9% in 2020). **Somerset:** Reduce prevalence to 13% (Baseline: 15.7% in 2020)	• Promote and expand participation in Chronic Disease Self-Management and Healthy Lifestyle programming. (TidalHealth and MAC) • Increase participation in Healthy Lifestyle community challenges (WiCHD). • Promote and expand walking initiatives (WiCHD) • Promote use of community gardens as a source for healthy, free produce. (WiCHD) • Implement a social marketing campaign promoting healthy lifestyles (WiCHD) • Collaborate with Sussex County Health Coalition and participate in the Let's Get Healthy Sussex campaign (TidalHealth.	• Number of participants in healthy lifestyle programing • Completion rate in healthy lifestyle programming • Participation in walking initiatives • Use of community gardens • Reach of social marketing campaigns
2. By 2025, increase the proportion of residents achieving the recommended physical activity level (150 minutes per week of moderate activity or vigorous equivalent). **Wicomico:** Increase proportion of residents with recommended physical activity level to at least 55% (Baseline: 50.5% in 2019). **Somerset:** Increase proportion of residents with recommended physical activity level to at least 45% (Baseline: 39.2% in 2019)	• Promote and increase participation in walking initiatives. (WiCHD) (SCHD) • Increase and promote physical activity programs through the local YMCAs. (YMCA) • Increase and promote physical activity programs through MAC, Inc. for older adults. (MAC, Inc.) • Collaborate with Sussex County Health Coalition and participate in the Let's Get Healthy Sussex campaign.	• Number of participants in the physical activity programs at the YMCA and MAC • The number of participants in the walking initiatives

References:

Author Organization Aligning Systems for Health. (2020, November 30). *A theory of change for aligning health care, public health, and social services in the time of COVID-19*. RWJF Alignment. Retrieved September 30, 2022, from https://www.alignforhealth.org/resource/a-theory-of-change-for-aligning-health-care-public-health-and-social-services-in-the-time-of-covid-19/

Author Organization Northeastern University. (2020, March 23). *Aligning Health Care and social services: Recommendations for effective engagement*. RWJF Alignment. Retrieved September 30, 2022, from https://www.alignforhealth.org/resource/aligning-health-care-and-social-services-recommendations-for-effective-engagement/

Author Organization ReThink Health. (2020, June 23). *Doing business differently, together: The story of rethink health ventures*. RWJF Alignment. Retrieved September 30, 2022, from https://www.alignforhealth.org/resource/doing-business-differently-together-the-story-of-rethink-health-ventures/

Delaware SHIP. (n.d.). *Delaware State Health Improvement Plan*. Delaware SHIP. Retrieved September 28, 2022, from https://delawareship.org/

Friedman, M. (2022, June 16). *Results-based accountability — overview and guide*. Clear Impact. Retrieved October 3, 2022, from https://clearimpact.com/results-based-accountability/

Public Health Accreditation Board. (2022, August 4). Retrieved October 1, 2022, from https://phaboard.org/about/

RWJF's approach: Alignment. RWJF Alignment. (2021, May 4). Retrieved September 21, 2022, from https://www.alignforhealth.org/framework/

Statewide Integrated Health Improvement Strategy. The Maryland Health Services Cost Review Commission. (n.d.). Retrieved September 21, 2022, from https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx

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