



Cecil County Community Health Improvement
Plan (CHIP) FY 2017-2019
Presentation to Cecil County Community Health
Advisory Committee 7.21.16

Daniel Coulter, MPH: daniel.coulter@maryland.gov

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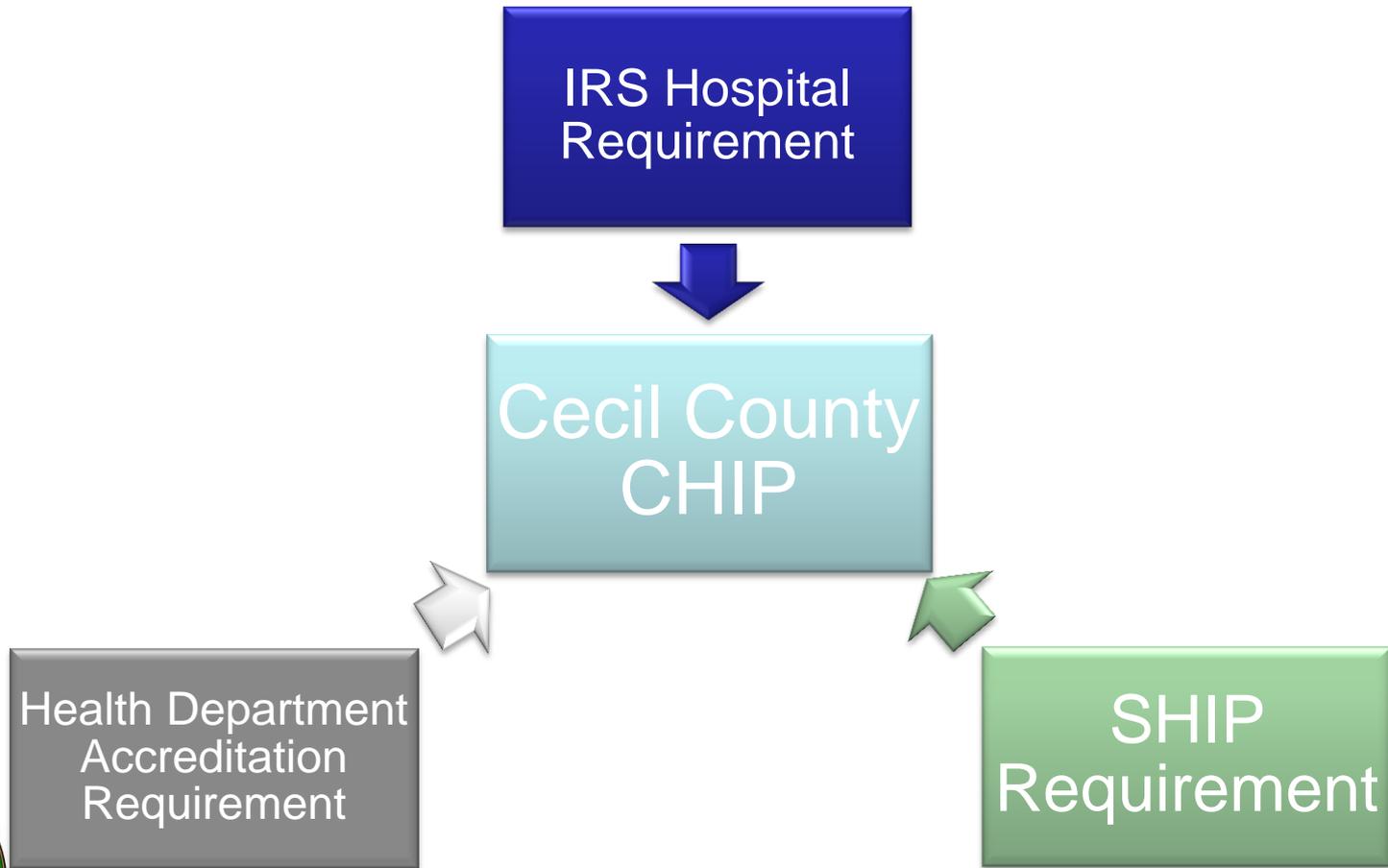
Community Health Improvement Plan (CHIP) Overview

- Developed by Cecil County Health Dept (CCHD) and Union Hospital (UHCC) in collaboration with CHAC membership.
- Long-term, systematic effort to address public health problems identified through the Community Health Needs Assessment (CHNA).
- The CHIP allows partners to focus on a limited number of health issues and leverage resources for a larger collective impact.



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Alignment of Community Health Improvement Efforts



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Process to Develop the CHIP

- January 21, 2016 CHAC Meeting:
 - Selection of Health Priorities
 - Attendees presented with CHNA findings and asked to vote on their top 3 priorities based on: size, seriousness, trends, equity, interventions, feasibility, value, consequences of inaction, social determinant/root cause.
 - Selection of Specific Health Needs for Each Priority
 - Participants divided into 3 groups based on expertise and/or interest and were asked to use the above criteria to select 1 to 3 health needs for each health priority.



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Process to Develop the CHIP

- March 16, 2016 CHAC Meeting-
 - A second meeting was held to develop work plans including goals, objectives, strategies and responsible parties to address each health priority.
 - Participants again broke into work groups by expertise and/or interest.
 - Following the meeting, work group moderators wrote up draft work plans and requested feedback from the groups.
- Additional meetings and discussions between participants in the three work groups resulted in the development of the work plans.



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FY 2017- 2019 CHIP Priorities

- Priority 1: Behavioral Health
 - Illicit drug use and problem alcohol use
 - Mental health
 - Access to behavioral health services
- Priority 2: Chronic Disease
 - Diabetes
 - Heart disease and stroke
 - Respiratory and lung disease
- Priority 3: Determinants of Health
 - Poverty
 - Homelessness



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Priority 1: Behavioral Health Goals and Objectives

- Goal 1.1: Reduce the prevalence of substance use disorders in Cecil County.
 - Objective 1.1.1: By June 30, 2019, reduce the drug-induced death rate by 5%.
 - Baseline: 26.5 deaths per 100,000 population; Source: SHIP Measure, Maryland DHMH VSA
 - Objective 1.1.2: By June 30, 2019, reduce the percentage of youth in grades 9-12 reporting the use of alcohol on one or more of the past 30 days to no more than 33.8%.
 - Baseline: 37.5% in 2013; Source: 2013 Maryland YRBS



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Objective 1.1.1 Strategies

- Continue to provide Narcan training to law enforcement officers and the public.
- Provide education at pharmacies and physicians' offices on prescription drug abuse and Narcan Training.
- Advocate for the development of more treatment options for adults and adolescents in the county.
- Partner with providers to increase the utilization of existing services.
- Work with the school system to reach at-risk adolescents.
- Increase participation in prevention and education programs such as My Family Matters and Strengthening Families.
- Provide incentives for attending programs.
- Promote the creation of educational messages focusing on prevention.
- Implement recommendations of Cecil County's Local Overdose Fatality Review Team (LOFRT).



Objective 1.1.2 Strategies

- Partner with Maryland Strategic Prevention Framework 2 (MSPF2) to implement strategies identified through a needs assessment.
- Continue to support and expand Life Skills training in Cecil County Public Schools.



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Priority 1: Behavioral Health Goals and Objectives

- Goal 1.2: Improve the mental health and well-being of Cecil County residents.
 - Objective 1.2.1: By June 30, 2019, reduce the percentage of youth in grades 9-12 who felt sad or hopeless almost every day for two weeks or more during the past 12 months to no more than 24.8%.
 - Baseline: 27.5% in 2013; Source: 2013 Maryland YRBS
 - Objective 1.2.2: By June 30, 2019, decrease the suicide rate in Cecil County by 5%.
 - Baseline: 15.1 deaths per 100,000 population in 2011-2013; Source: SHIP Measure, Maryland DHMH VSA.



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Objective 1.2.1 Strategies

- Promote depression screening during wellness checkups.
- Research programming to promote the health and well-being of youth.
- Promote Behavioral Health Integration in Pediatric Primary Care (B-HIPP).



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Objective 1.2.2 Strategies

- Promote the availability of crisis and suicide hotlines.
- Continue to support, promote the utilization of, and expand mobile crisis services in Cecil County.
- Promote regular screening for depression during primary care provider visits.
- Promote Mental Health First Aid (MHFA) training.



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Priority 1: Behavioral Health Goals and Objectives

- Goal 1.3: Improve access to behavioral health services in Cecil County.
 - Objective 1.3.1: By June 30, 2019, decrease the rate of emergency department visits related to mental health conditions by 10% and emergency department visits related to substance use disorders by 5%.
 - Baseline- Mental Health Conditions: 5501.6 ED visits per 100,000 population in 2014
 - Baseline-Substance Use Disorders: 2165.7 ED visits per 100,000 population in 2014.
 - Source: SHIP Measures. Maryland HSCRC Research Level Statewide Outpatient Data Files.



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Objective 1.3.1 Strategies

- Provide education to reduce the stigma surrounding behavioral health disorders.
- Increase awareness of behavioral health resources and services in the community.
- Continue to support outreach efforts to enroll uninsured residents in health insurance/ Medical Assistance.
- Reduce the health impact of violence and trauma by integrating trauma-informed care throughout the health care and behavioral health systems.
- Expand options for inpatient and outpatient behavioral health treatment for Cecil County residents.
- Partner in the development of a regional crisis center.
- Promote a system of care that integrates somatic and behavioral health care.
- Continue to hold monthly ER Diversion meetings.



Priority 2: Chronic Disease Goals and Objectives

- Goal 2.1: Reduce the morbidity of diabetes in Cecil County.
 - Objective 2.1.1: By June 30, 2019, increase physician practice sites making referrals to chronic disease self-management programs by 2 sites.
 - Baseline: 0 sites
 - Objective 2.1.2: By June 30, 2019, increase the number of sites hosting chronic disease self-management programs by 5 sites.
 - Baseline: 7 sites in 2015; Source: Living Well Programs
 - Objective 2.1.3: By June 30, 2019, create 1 county-wide walking program.



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Objective 2.1.1 and 2.1.2 Strategies

- Engage 2 physician practice sites to participate in the chronic disease self-management programs
- Track the number of referrals made by the 2 physician practice sites.
- Engage 5 additional sites to host chronic disease self-management programs.



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Objective 2.1.3 Strategies

- Using the Delaware Walking Program as a model, create and implement a walking program that tracks the number of participating individuals, testimonials received, and total miles walked.
- If successful, create a plan for future walking programs (if not successful, indicate in annual reporting and provide lessons learned).



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Priority 2: Chronic Disease Goals and Objectives

- Goal 2.2: Reduce mortality from lung cancer in Cecil County.
 - Objective 2.2.1: By June 30, 2017, increase the number of individuals receiving low-dose lung CT screenings by 5%, in order to increase awareness for lung cancer prevention.
 - Baseline: 108 persons screened from Calendar Year 2015 – Calendar Year 2016 (as of June 29, 2016); Source: Union Hospital Lung Health Program.
 - Objective 2.2.2: By June 30, 2019, reduce the prevalence of tobacco use among adolescents by 5% and cigarette smoking among adults by 5%.
 - Baseline-Adolescents: 24.6% in 2013
 - Baseline-Adults: 12.4% in 2014.



Sources: Maryland SHIP Measures. 2013 Maryland YRBS. Maryland BRFSS

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Objective 2.2.1 Strategies

- Advertise and promote the low-dose lung CT screening program in the community.
- Support recommendations of the Union Hospital Cancer Program's community outreach plan for low-dose lung CT screenings.



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Objective 2.2.2 Strategies

- Promote community smoking cessation and prevention resources to youth-serving organizations.
- Educate adults about community-based and state-based smoking cessation and prevention resources.
- Support recommendations of the Cecil County Tobacco Task Force.



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Priority 2: Chronic Disease Goals and Objectives

- Goal 2.3: Reduce morbidity and mortality of heart disease and stroke in Cecil County.
 - Objective 2.3.1: By June 30, 2019, reduce high blood pressure among adults by 5%, in order to reduce the incidence of stroke in Cecil County.
 - Baseline: 30.1% in 2006-2012; Source: Maryland BRFSS
 - Objective 2.3.2: By June 30, 2019, increase the percentage of students who eat vegetables one or more times per day by 5%, in order to reduce the incidence of heart disease in Cecil County.
 - Baseline: 58.0% in 2013; Source: Maryland YRBS
 - Objective 2.3.3: By June 30, 2019, implement a wellness program for one local small business.



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Objective 2.3.1 Strategies

- Educate and support health care providers on how to write prescriptions for physical activity.
- Provide a community-wide campaign to target reducing sodium intake (also supports healthy eating for youth).
- Support recommendations from the Union Hospital Stroke Program for stroke prevention in the community.



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Objective 2.3.2 Strategies

- Partner with schools, day cares, and the Head Start program to provide education to staff and community members on nutrition for youth.
- Support the transition from the school year to the summer by working with summer food program providers to increase access to and awareness of summer food programs in the community.
- Advocate for the incorporation of healthy foods into school lessons.
- Utilize a local newspapers to provide helpful tips, recipes, and/or news stories on healthy lifestyle choices as they pertain to the CHIP objectives (refer to Delaware Health column).



Objective 2.3.3 Strategies

- Implement a wellness program that provides wellness challenges for employees to participate in.
- Require the partnering small business to provide prizes/awards for its staff that wins the challenges.



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Priority 3: Determinants of Health

Goals and Objectives

- Goal 3.1: Reduce the burden of poverty in Cecil County to improve the overall health of Cecil County residents.
 - Objective 3.1.1: By October 30, 2016, research existing and new or innovative anti-poverty programs/ initiatives for implementation in Cecil County.



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Objective 3.1.1 Strategies

- Get information on the anti-poverty program recently presented at the BHA Child/Adolescent Conference.
- Identify & research existing anti-poverty programs in the county.
- Collect information from faith-based anti-poverty initiatives.
- Investigate Carroll County's program model.
- Review all options as a group.



Priority 3: Determinants of Health

Goals and Objectives

- 3.2: Reduce the prevalence of homelessness in Cecil County to improve the overall health of the community and its residents.
 - 3.2.1: By June 30, 2018, expand services and interventions for homeless individuals/families to decrease prevalence of homelessness in Cecil County by 10%. Services/interventions will be based on three tiers, including: 1) emergency/immediate assistance, 2) intermediate/short-term assistance, and 3) longer-term assistance geared toward those experiencing chronic homelessness.



- Baseline: 191 Homeless individuals counted in 2015; Source: Point in Time Homeless Survey

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Objective 3.2.1 Strategies

- All tiers: implement a county-wide coordinated assessment system for efficient linkage to services and housing options for all.
- All tiers: participate in technical assistance from HUD to develop a by-name list to end veteran homelessness.
- All tiers: seek funding for or develop case management/housing search services whose sole eligibility criteria is that of being homeless.
- Explore the possibility of a multidisciplinary meeting to review those at risk of homelessness or those with complex housing needs.
- Tier 1: create the availability of 24-hour resource assistance to people experiencing homelessness, including emergency shelter during extreme weather events.
- Tier 1: establish liaisons between law enforcement and provider agencies.
- Tier 2: establish a community furniture bank to assist those transitioning from homelessness back into stable housing.



CHIP Reporting Responsibilities

- **Behavioral Health**

- Goal 1.1- DAAC
- Goal 1.2- MHCSA Advisory Council
- Goal 1.2 - DAAC & MHCSA Advisory Council

- **Chronic Disease**

- Goal 2.1- Healthy Lifestyles Task Force
- Goal 2.2 Objective 1- Cancer Task Force
- Goal 2.2 Objective 2- Tobacco Task Force
- Goal 2.3- Healthy Lifestyles Task Force

- **Determinants of Health**

- Goals 3.1 & 3.2- CCIACH Determinants of Health Subcommittees



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Process for Tracking and Updating the CHIP

- Quarterly Progress Reports- Submitted to Maryland DHMH
 - Task forces should submit updates to CHAC chairpersons
- Semi-annual Task Force Reports at CHAC meetings
- Annual CHIP Progress Report
 - Updates to the CHIP will occur annually based on annual progress reports developed by CCHD and UHCC.



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Important Links

- For more information on CHAC and to access meeting materials:
<http://www.cecilcountyhealth.org/ccdhxx/ccdhAdvisoryComm.htm>
- To read the Community Health Needs Assessment:
<http://www.cecilcountyhealth.org/ccdhxx/pdf/Cecil%20County%20Community%20Health%20Needs%20Assessment%20FY%202015-2016.pdf>
- To read the Community Health Improvement Plan:
<http://www.cecilcountyhealth.org/ccdhxx/pdf/Cecil%20County%20Community%20Health%20Improvement%20Plan%20FY%202017-2019.pdf>
- For more information on UHCC Community Benefit:
<https://www.uhcc.com/about-us/community-benefit/>
- For information on how Cecil County is doing on SHIP measures:
<http://cecil.md.networkofcare.org/ph/>



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