Healthy Delmarva

Building a Healthier Delmarva

COMMUNITY HEALTH IMPROVEMENT PLAN

FY 2026–2028

PREPARED IN PARTNERSHIP WITH
Ascendient Healthcare Advisors

Healthy Delmarva

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COMMUNITY HEALTH IMPROVEMENT PLAN

FY2026-2028

TidalHealth, Somerset County Health Department, Wicomico County Health Department, and Atlantic General Hospital are excited to share and begin implementation of the FY2026-2028 Community Health Improvement Plan (CHIP). Over the next three years, these organizations and their community partners will drive efforts to address three priority health need areas:

Healthcare Access

Goal 1: Make healthcare more accessible by providing services that respect cultural differences, use clear language, and are easy to understand.

Goal 2: Help people use healthcare services by improving referrals, coordinating care better, and offering guidance to navigate the system.

Goal 3: Continue to build a strong healthcare system in Delmarva with enough qualified staff from diverse backgrounds and additional ways to deliver services.

Chronic Disease

Goal 1: Improve chronic disease screening and early detection.

Goal 2: Enhance chronic disease management and prevention.

Goal 3: Address risk factors through targeted prevention strategies.

Behavioral Health

Goal 1: Enhance screening, referral, and intervention processes for behavioral health.

Goal 2: Reduce stigma and increase awareness of behavioral health services among special populations.

Goal 3: Strengthen care coordination and integration across the behavioral health system.

Cross-Cutting Goal

Implement cross-cutting strategies to address system-level challenges impacting the health and wellbeing of Delmarva residents as it particularly relates to literacy and retaining and promoting community health workers.

The FY2026-2028 Community Health Improvement Plan provides a collaborative roadmap for addressing Healthcare Access, Chronic Disease, and Behavioral Health needs, along with cross-cutting initiatives addressing literacy and community health workforce development, across the Delmarva region. Through regular monitoring of performance metrics and strong partnerships, this plan will guide our efforts to improve health outcomes for all residents, particularly those facing barriers to care. The Healthy Delmarva Partnership remains committed to building a healthier community through evidence-informed and inclusive approaches that respond to emerging needs while focusing on our shared goals.

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Terminology and Record of Changes

Terminology: To ensure shared understanding of the key components of this Community Health Improvement Plan (CHIP), this section of the report describes the meaning behind key CHIP elements.

- **Action Plan**: A detailed, practical roadmap outlining the specific steps, resources, and timelines needed to address identified health issues within a community. It's a proactive, strategic approach to implementing the CHIP's goals, objectives and activities.
- **Goal:** A broad, high-level target that addresses a specific priority area identified in the CHIP. Goals are the desired outcomes that the CHIP aims to achieve for the community. They are more general than the specific objectives that outline the measurable steps to achieve those goals.
- **Objective:** A specific and measurable step toward achieving the stated goal. Objectives define how the community will measure progress towards the goals.
- **Activity:** A specific action or intervention designed to address an objective identified in the CHIP.

Record of Changes: The Healthy Delmarva Partnership reviews and updates this CHIP on a biannual basis. Any major changes to the contents of this document, including but not limited to goals, objectives, and/or activities outlined in the Appendices will be noted in this section of the report to support version control.

Date	Brief Description of CHIP Update	Responsible Party

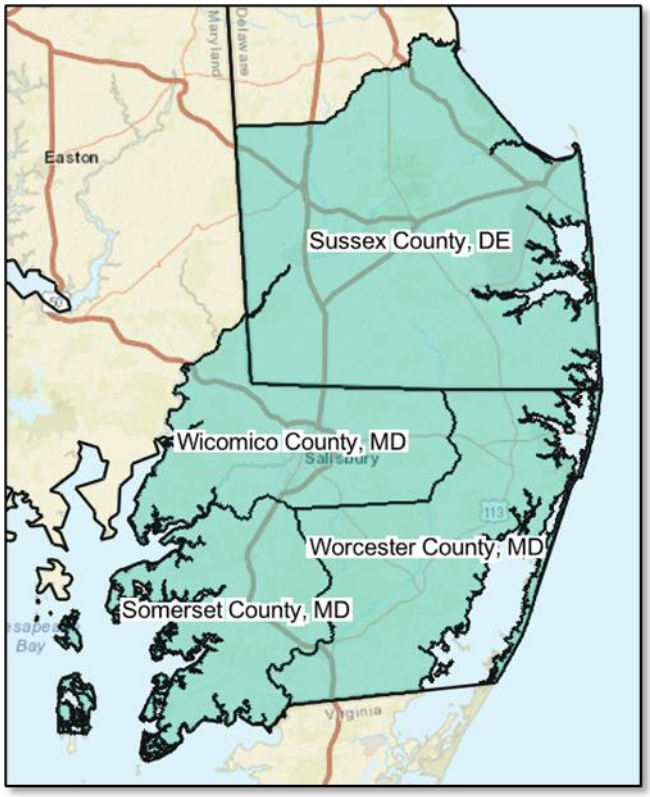
Original Date of Publication: June 2025

Anticipated Dates of Implementation: July 2025 to June 2028

Introduction

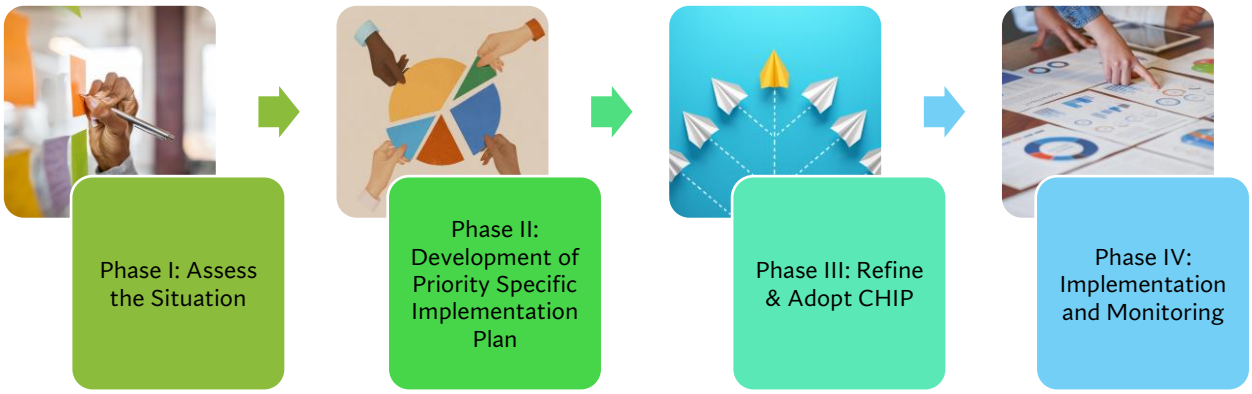
The Delmarva Region CHIP represents a collaborative effort between TidalHealth, Somerset County Health Department, Wicomico County Health Department, and Atlantic General Hospital to address the most pressing health needs across Somerset, Wicomico, and Worcester counties in Maryland, as well as Sussex County in Delaware. This comprehensive plan outlines specific community health activities, measurable goals, and targeted activities designed to improve health outcomes for the region's approximately 447,000 residents over the next three years (July 2025- June 2028).

Figure I.1: Map of Delmarva Region



The CHIP development process brought together public health professionals, community organizations, and healthcare providers to ensure the plan reflects both technical expertise and diverse community perspectives. It involved a four-phased process, demonstrated in Figure I.2 below.

Figure I.2: The Four CHIP Phases



Phase I: Assess the Situation

Phase I involved conducting a comprehensive Community Health Needs Assessment (CHNA) that integrated primary and secondary quantitative and qualitative data. The assessment included extensive secondary data analysis following the County Health Rankings[1] framework, along with primary data collection through surveys completed by over 1,200 community residents and 28 healthcare and social service providers, focus groups with 53 participants, and interviews with 9 key community leaders.

This multi-method approach ensured the selected health priorities reflected both statistical realities and community experiences. Through a Steering Committee-driven prioritization process, the Healthy Delmarva partners identified three priority health needs: Healthcare Access, Chronic Disease, and Behavioral Health. In addition to the three priority health needs, the Steering Committee highlighted the importance of Social Determinants of Health as a critical cross-cutting theme affecting all priority areas that should be considered and addressed through the CHIP process.

Figure I.3: Delmarva Region Priority Health Needs

[1] https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods/the-evolution-of-the-model

Phase II: Development of Priority-Specific Implementation Plan

Phase II began with the formation of three Action Teams, each focused on one of the priority health needs represented in Figure I.3. These teams participated in facilitated 90-minute virtual meetings to review CHNA findings and prioritize potential focus areas. Prioritization was based on feasibility and potential community impact using Strategy Grid prioritization activities.

A gap analysis was also conducted following these meetings to identify differences between the current state of health services and the desired future state, highlighting opportunities for integration across priority areas. The Action Teams developed draft goals and objectives for each priority area, which were further refined through web-based surveys to collect additional feedback from community stakeholders and Steering Committee members.

Phase III: Refine & Adopt CHIP

Phase III involved the Steering Committee reconvening to finalize the goals and objectives for each priority area. This process helped ensure goals were appropriate and that objectives were specific, measurable, and achievable within the three-year timeframe of this CHIP.

This phase resulted in three primary goals for each priority health need, each with specific objectives and designated timeframes. Cross-cutting opportunities were identified to address multiple health priorities simultaneously, maximizing the efficiency and impact of implementation efforts. The final CHIP presents a comprehensive roadmap for collaborative health improvement initiatives in the Delmarva region through 2028, with flexibility for ongoing assessment and adaptation as new challenges and opportunities emerge. The goals, objectives, and activities selected by the Steering Committee are detailed in the Appendices 1-10 of this report.

Phase IV: Implementation & Monitoring

The final phase of the CHIP process is collaborative implementation of activities geared toward achieving the plan's goals and objectives. Action plans with specific activities, timelines, resources, responsible parties, and anticipated outcomes have been developed and are included as Appendices 1-10 of this document. Progress will be tracked regularly, with opportunities for adjustment as needed to ensure the plan remains responsive to community needs. The Healthy Delmarva Partnership will coordinate implementation efforts, leveraging existing community resources and initiatives to achieve meaningful improvements in community health across all three priority areas.

By working collaboratively and leveraging existing community assets, the Healthy Delmarva Partnership aims to create meaningful improvements in healthcare access,

chronic disease prevention and management, and behavioral health services for all residents of the region.

The following pages provide further details about each phase of work, beginning with the comprehensive assessment process that laid the foundation for this plan. Each phase built upon the previous one, creating a systematic approach to identifying community health priorities and developing evidence-based strategies to address them. This methodical process ensured that the final CHIP reflects both data-driven insights and authentic community input, positioning the Healthy Delmarva Partnership to make meaningful progress on the region's most pressing health challenges over the next three years.

Phase I: Assess the Situation

Community Health Needs Assessment Overview

The CHNA and current CHIP process was guided by a dedicated Steering Committee comprised of representatives from key healthcare and public health entities in the service area. The CHNA was led by TidalHealth, Wicomico County Health Department, and Somerset County Health Department. In May 2025, a merger between TidalHealth and Atlantic General Hospital was completed, and as a result, Atlantic General Hospital joined the Healthy Delmarva Partnership for the CHIP's development. The Healthy Delmarva Partnership, with a consultant partner, Ascendient Healthcare Advisors, was responsible for overseeing all aspects of the assessment process including data collection methodologies, analysis of findings, facilitation of community engagement activities, and ultimately, the identification and prioritization of community health needs.

Primary Data: The Delmarva region's comprehensive CHNA employed a robust, multi-method approach to identify and prioritize health needs across Somerset, Wicomico, and Worcester counties in Maryland and Sussex County in Delaware. The Steering Committee collected new data from over one thousand community members and leaders through four primary data collection strategies:

Table 1.1. Primary Data Inputs for 2025 CHNA Process

Data Collection Strategy	Total Number of Participants
Community Health (Resident) Survey	1,274
Key Leader Survey	28
Community Focus Groups	53
Key Leader Interviews	9

Secondary Data: Primary data were complemented by extensive secondary data analysis using the County Health Rankings model framework, which examined indicators across categories like length of life, quality of life, clinical care, health behaviors, physical environment, and social/economic factors.

Data Integration: The strength of the 2025 CHNA is largely due to its intentional integration of primary and secondary data, creating a comprehensive understanding that reflects both statistical realities and lived community experiences. This approach allowed the Steering Committee to identify disparities, validate findings across multiple sources,

and develop contextually appropriate recommendations that address the unique needs of the region's approximately 447,012 residents.

Prioritization Process: The prioritization process for identifying the region's health priorities was collaborative, involving multiple steps that ensured both data-driven decision making and stakeholder input. This process is described in greater detail in the Healthy Delmarva CHNA which can be accessed here.

Review of Secondary Data: The Steering Committee first reviewed secondary data organized according to the County Health Rankings model framework, examining six major categories: Length of Life, Quality of Life, Clinical Care, Health Behaviors, Physical Environment, and Social and Economic Environment. For each category, the committee analyzed specific indicators and identified "high need" areas where counties performed worse than their respective state and national averages. This systematic review allowed for objective identification of statistical outliers and areas of concern.

Review of Primary Data: To accompany this quantitative analysis, the Committee then examined the rich qualitative data from primary sources. They analyzed the community health survey, key leader survey, focus groups, and key leader interviews, looking for recurring themes and alignment with the secondary data findings. This dual approach ensured health issues present in the secondary data were validated by community experience and perception.

Steering Committee Voting and Discussion: Once CHNA data were thoroughly examined, the Committee employed a structured group polling process to prioritize health needs. During this process, Committee members evaluated each potential priority area against four key factors:

1. Severity and intensity of health need based on secondary data metrics,
2. Feasibility of potential interventions to address the need,
3. Presence and extent of health disparities associated with the need, and
4. Level of importance the community placed on addressing the need, as evidenced in primary data.

This multi-dimensional evaluation approach ensured that the final priorities reflected not only significant health concerns but also areas where collaborative intervention could realistically create meaningful impact. Through this process, **Healthcare Access, Chronic Disease, and Behavioral Health** emerged as the clear priorities, with Social Determinants of Health recognized as a cross-cutting theme influencing each priority area.

The Committee did not prioritize one health need over another but rather committed to addressing each with dedicated attention and resources through the health improvement planning process over the next three years of this CHIP.

Community Assets and Resources: The Healthy Delmarva CHNA included compilation of a community resource inventory and asset mapping for select healthcare assets and resources. The community resource inventory includes a list and description of resources available across the four-county service area specific to the priority need areas identified in the CHNA. This can be accessed in the full CHNA report which is linked below.

Access the Full CHNA Report

Detailed data about the service area, priority health needs, and assets and resources available in the Delmarva region are presented in the FY2026-FY2028 CHNA. The full report is available for download at www.healthydelmarva.org

Phase II: Development of Implementation Plans

The CHIP process followed several steps for defining goals, objectives, and activities that culminated in the creation of priority-specific action plans. The action plans are included as Appendices 1-10 in this report. The process that resulted in their development is described in the sections that follow.

Process for Initial Goal Development

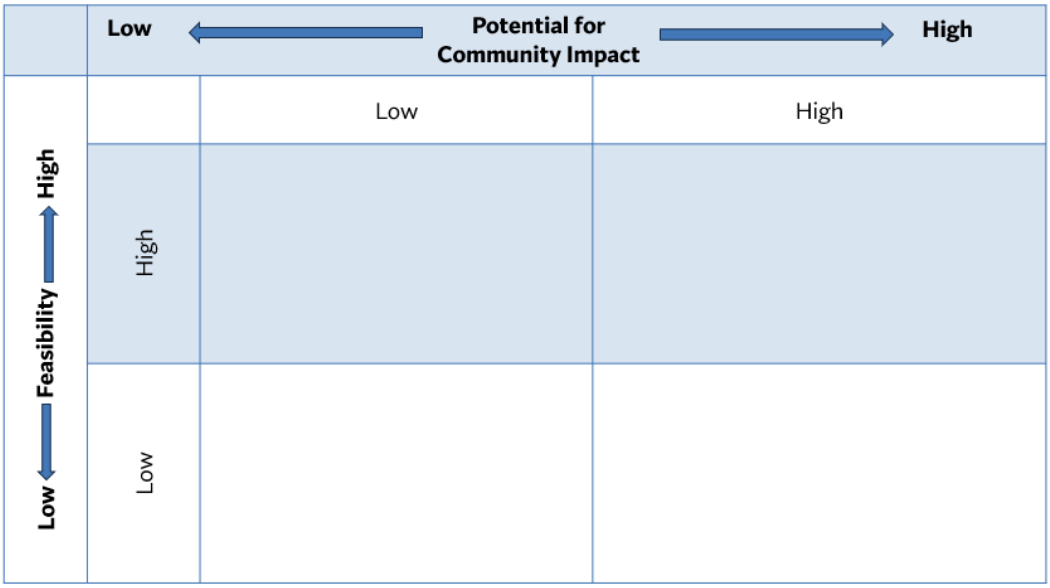
The Steering Committee and partners used a multi-phase approach to develop goals and objectives for the three priority health needs identified in the CHNA. The goal selection process was designed to maximize community input and ensure alignment with local health priorities.

The goal development process began with the formation of three Action Teams, one for each priority health need. These teams included representatives from TidalHealth, the county health departments (Somerset, Wicomico, and Worcester), the Delaware Department of Health and Social Services, community-based organizations, social service agencies, healthcare providers, and other stakeholders. A list of individuals and organizations serving on each priority health need Action Team is provided in the Acknowledgments section of this report.

In March 2025, Action Team members were provided with pre-read materials that included primary and secondary CHNA data to review ahead of a facilitated virtual meeting. During these meetings, Action Team members briefly reviewed CHNA findings, discussed the prior CHNA and CHIP's goals and objectives for the region, and discussed potential focus areas within the Action Team's respective priority health need. This process considered both feasibility and potential community impact.

Action Team members for each priority health need engaged in a Strategy Grid prioritization activity. This was facilitated over Zoom using the 'whiteboard' feature and allowed Action Team members to discuss and evaluate various aspects and factors impacting a health need area based on potential for meaningful impact and implementation feasibility. This process helped narrow the focus to issues and factors in which community partners perceived greatest ability to realistically make progress over the next three years.

Figure 2.1: Strategy Grid for Prioritization



To further refine and gather additional input from stakeholders, a web-based survey was distributed to Action Team meeting participants following the Strategy Grid prioritization activity. This survey's purpose was to collect feedback from Action Team members on the draft goals generated from the meeting and to solicit suggestions for associated objectives and strategies for the CHIP.

Healthcare Access Goal Development

Initial Discussion and Prioritization

As discussed in the previous section, the Healthcare Access Action Team evaluated potential focus areas through a matrix activity that considered both feasibility and potential community impact. Three possible goal areas emerged as priorities during the discussion:

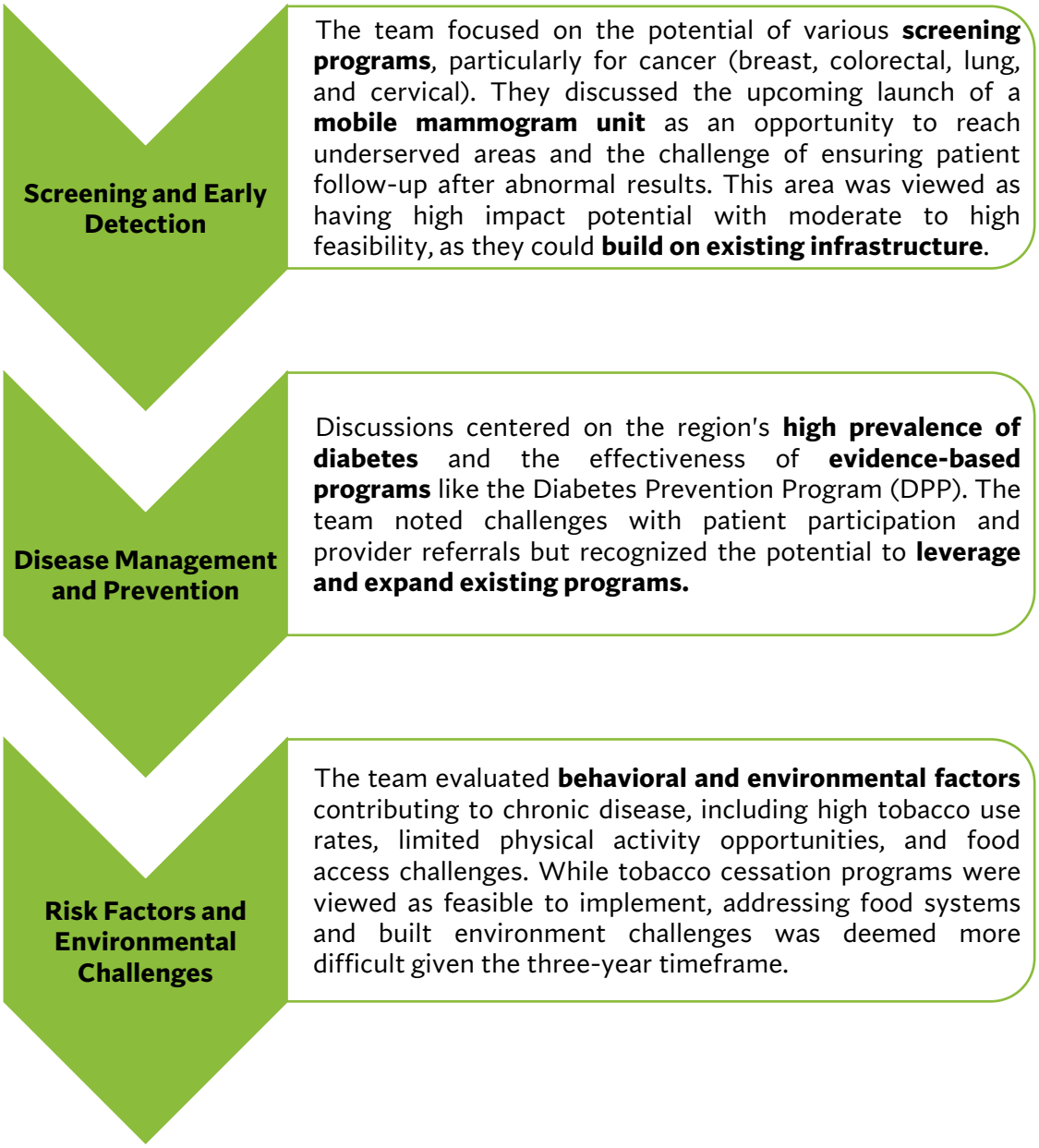
Figure 2.2: Potential Goal Areas and Discussion Topics for Healthcare Access

Chronic Disease Goal Development

Initial Discussion and Prioritization

The Chronic Disease Action Team followed the same matrix activity approach to consider feasibility and potential community impact in drafting possible CHIP goals for the chronic disease priority health need. The possible goal areas emerging from this discussion included:

Figure 2.3: Potential Goal Areas and Discussion Topics for Chronic Disease

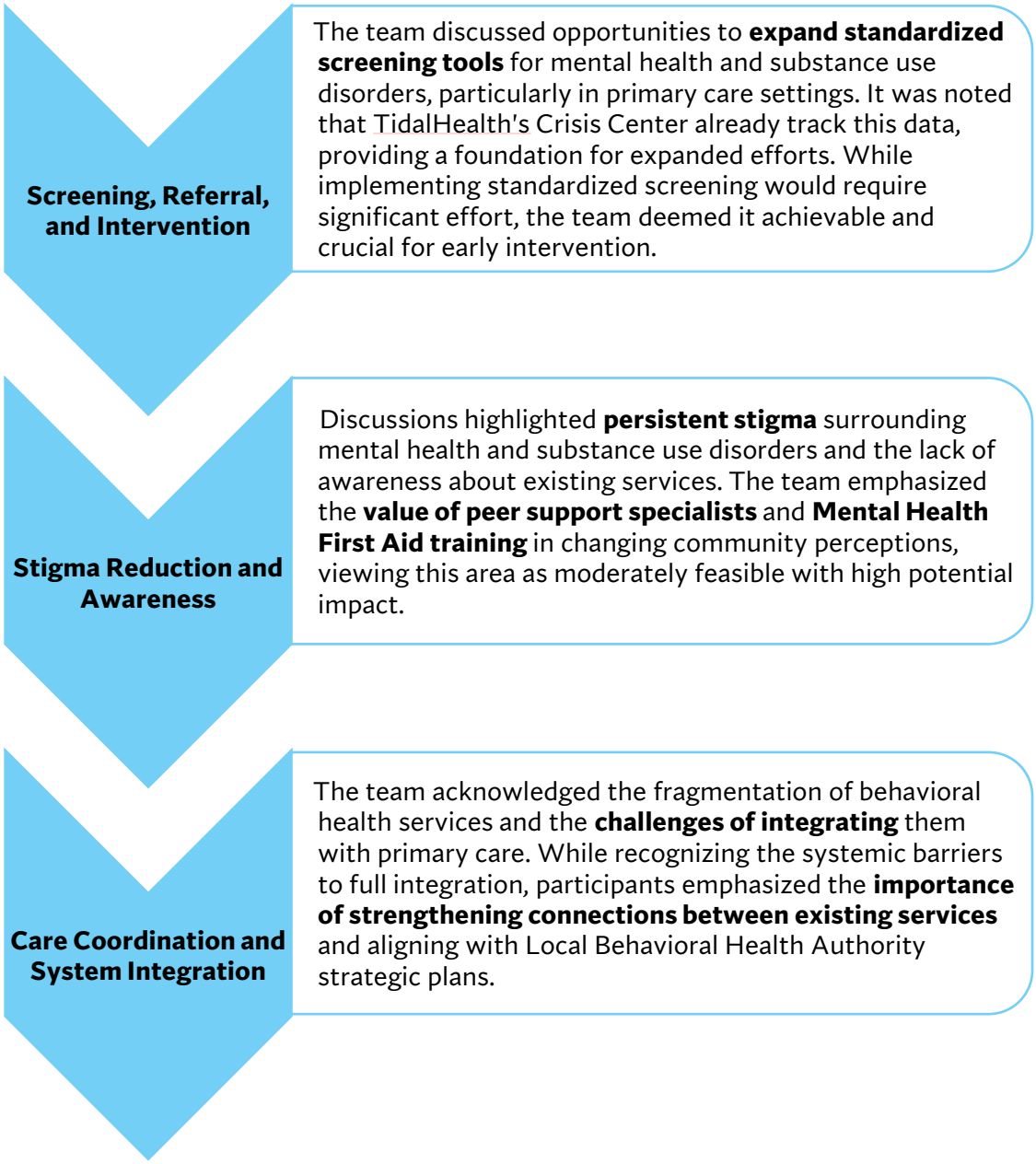


Behavioral Health Goal Development

Initial Discussion and Prioritization

The Behavioral Health Action Team identified possible goals during their matrix activity, as well. These included:

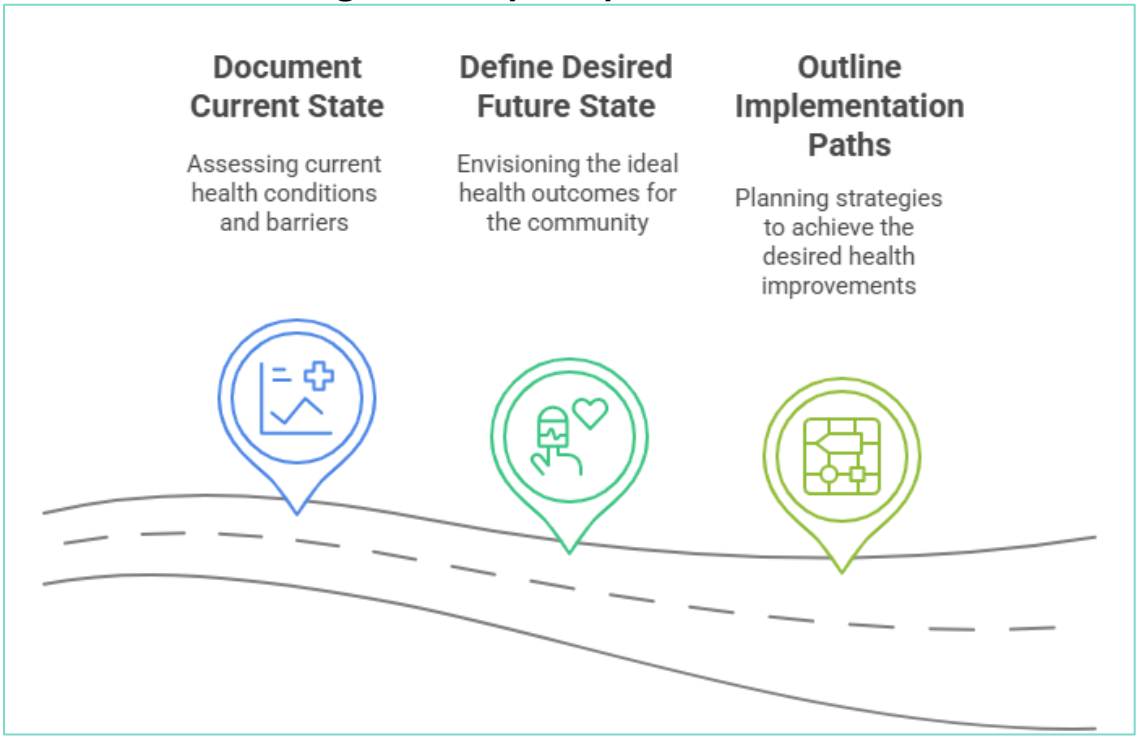
Figure 2.4: Potential Goal Areas and Discussion Topics for Behavioral Health



Gap Analysis

Gap Analysis Process Description: A gap analysis was conducted to identify the differences between the current state of health services, resources, and outcomes in the Delmarva region and the desired future state that stakeholders hope to achieve through the CHIP. This process was critical for ensuring that the CHIP addressed the most significant health needs of the community while maximizing the impact of available resources.

Figure 2.5: Gap Analysis Framework



The gap analysis examined each priority area (Healthcare Access, Chronic Disease, and Behavioral Health) by:

1. Documenting the **current state** of health conditions, services, and barriers in the Delmarva region based on data collected through the Community Health Needs Assessment.
2. Defining the **desired future state** representing what success would look like if the community's health improvement goals were achieved.
3. Outlining potential **implementation paths** that would bridge the gap between current conditions and desired outcomes.

Purpose and Value of the Gap Analysis: The gap analysis served several important purposes in the CHIP development process. These are listed and described below.

1. **Strategic Focus**: It helped stakeholders identify where the greatest needs and opportunities existed, allowing for more targeted goal-setting and planned resource allocation.
2. **Realistic Planning**: By thoroughly understanding current limitations and resources, the analysis enabled the development of achievable objectives rather than aspirational but unrealistic goals.
3. **Cross-Cutting Opportunities**: Perhaps most importantly, the gap analysis revealed opportunities for integration across the three priority areas, identifying where similar approaches could address multiple health issues simultaneously.
4. **Resource Optimization**: The analysis highlighted existing community assets and resources that could be leveraged to address identified gaps, promoting efficiency and avoiding duplication of efforts.

The cross-cutting opportunities identified through this process were particularly valuable, as they allowed for the development of collaborative strategies that could simultaneously address multiple health priorities. For example, the expansion of community health workers was identified as an approach that could improve healthcare navigation, chronic disease management, and behavioral health screening all at once.

By conducting this gap analysis, the Healthy Delmarva Partnership ensured the CHIP would be comprehensive, realistic, and strategically focused on the most impactful interventions for improving community health across the region.

Finalizing Goals, Objectives, and Activities

In early April 2025, the Steering Committee reconvened to affirm draft goals for each priority area and have deeper discussion relating to objectives, strategies, implementation considerations, lead organizations, and measurement approaches. This final step of the goal-setting process involved Steering Committee consideration of cross-cutting opportunities identified through the gap analysis and planning steps that could be applied across the three priority areas. The Steering Committee also affirmed the final set of goals and drafted objectives for each.

This meeting included review of the gap analysis to ensure that critical community health needs were adequately addressed while avoiding duplication of efforts. The Steering Committee also considered the alignment of proposed goals with existing community initiatives and resources.

The culmination of this process resulted in three primary goals for each priority health need area and multiple specific and measurable objectives to be achieved over the next three years (July 2025 – June 2028) of the CHIP's lifecycle. There was also an overarching CHIP goal with associated objectives identified that will address all three priority health needs through one cohesive and coordinated effort. All goals and objectives in this plan form the foundation of the Healthy Delmarva CHIP, providing a roadmap for collaborative health improvement efforts across the region.

Phase III: Refine & Adopt CHIP

The goals and objectives outlined in this CHIP represent a strategic roadmap for community health improvement initiatives in the Delmarva region through June 2028. While these goals and objectives provide clear direction, the Steering Committee recognizes that achieving meaningful improvements in community health requires flexibility, ongoing assessment, and adaptation as new challenges and opportunities emerge.

The tables that follow detail the specific goals and objectives for each of the three priority health need areas, as well as an overarching goal and associated objectives for addressing system-level issues in the region. Action plans with specific activities, timelines, resources, responsible parties, and anticipated outcomes have been created by the Steering Committee with input from other community partners for each objective and are included as Appendices 1-10 in this report.

Please note that throughout this section and thereafter, the **Healthy Delmarva Partnership** refers to the organizations that led the CHNA/CHIP process which include:

- TidalHealth
- Somerset County Health Department
- Wicomico County Health Department
- Atlantic General Hospital

Cross-Cutting (Overarching) Goal and Objectives

Table 3.1: Cross-Cutting Objectives for Addressing all Three Priority Health Need Areas in a Coordinated Manner

Goal #O: Implement cross-cutting strategies to address system-level challenges impacting the health and wellbeing of Delmarva residents.	
Objective O.1	By June 2028, Healthy Delmarva Partnership organizations will improve staff awareness, knowledge, understanding, and application of literacy considerations through training and implementation of improved and standardized literacy practices within their respective organizations.
Objective O.2	By June 2028, Healthy Delmarva Partnership organizations will retain and/or promote at least 80% of the current Community Health Worker workforce.

Healthcare Access Goals and Objectives

Table 3.2: Healthcare Access Implementation Plan, Goal 1

Goal #1: Make healthcare more accessible by providing services that respect cultural differences, use clear language, and are easy to understand.	
Objective 1.1	By June 2026, establish a baseline measure for bilingual healthcare providers across the region, and then increase the proportion of bilingual healthcare providers working in the region by 5% annually thereafter to better serve the healthcare needs of the Spanish-speaking and Haitian communities in the Delmarva Region.
Objective 1.2	By June 2028, at least 90% of patients/clients engaging with Healthy Delmarva Partnership organizations for medical or public health services will be provided with timely and appropriate interpretation services by a qualified interpreter.
Objective 1.3	By June 2028, healthcare provider and public health practitioner cultural competency will be improved through adherence to Culturally and Linguistically Appropriate Services (CLAS) requirements and ongoing staff training across Healthy Delmarva Partnership organizations.

Table 3.3: Healthcare Access Implementation Plan, Goal 2

Goal #2: Help people use healthcare services by improving referrals, coordinating care better, and offering guidance to navigate the system.	
Objective 2.1	By June 2026, TidalHealth and Atlantic General Hospital will integrate the findhelp referral platform into hospital Electronic Health Records to facilitate improved care coordination between health systems and community-based organizations in the Delmarva region.
Objective 2.2	By June 2027, TidalHealth will increase the number of REACH partners willing/able to receive electronic referrals for health-related social needs through the findhelp platform from 3 to 7.
Objective 2.3	By June 2028, Healthy Delmarva Partnership will increase public awareness of local, low-cost and free health-related social need resources available via the findhelp platform through marketing and outreach efforts.

Table 3.4: Healthcare Access Implementation Plan, Goal 3

Goal #3: Continue to build a strong healthcare system in Delmarva with enough qualified staff from diverse backgrounds and additional ways to deliver services.	
Objective 3.1	By June 2026, all Healthy Delmarva Partnership organizations will establish processes for hosting at least one healthcare/public health student for rural health rotations/practicum experience annually.
Objective 3.2	By June 2028, TidalHealth maintain 50% retention rates for residents completing their training through the local residency program.
Objective 3.3	Annually, Healthy Delmarva Partnership organizations will each engage in at least one local opportunity to promote medical career choices among young people in the region through organizations like Volunteens, AHEC Scholars, Junior Achievement, or others.

Chronic Disease Goals and Objectives

Table 3.5: Chronic Disease Implementation Plan, Goal 1

Goal #1: Improve chronic disease screening and early detection.	
Objective 1.1	By June 2026, the Healthy Delmarva Partnership will identify and define cancer screening disparities for breast, prostate, colorectal, and lung cancers across the region.
Objective 1.2	By June 2028, the Healthy Delmarva Partnership will maintain or improve patient adherence to recommended cancer screenings (breast, colorectal, and cervical) through improved collaboration between TidalHealth and Wicomico and Somerset county health departments.

Table 3.6: Chronic Disease Implementation Plan, Goal 2

Goal #2: Enhance chronic disease management and prevention.	
Objective 2.1	By June 2027, the Healthy Delmarva Partnership will improve consistent patient referrals to evidence-based disease prevention and management programs through streamlined processes and increased program capacities in the region.
Objective 2.2	By June 2028, the Healthy Delmarva Partnership will improve healthcare provider awareness of how to refer patients to local chronic disease support services that can better support their disease prevention and management through the findhelp platform through marketing and outreach efforts.

Table 3.7: Chronic Disease Implementation Plan, Goal 3

Goal #3: Address risk factors through targeted prevention strategies.	
Objective 3.1	By June 2028, the Healthy Delmarva Partnership will reduce tobacco use rates among adults and youth in the region.
Objective 3.2	By June 2028, the Healthy Delmarva Partnership will improve access to healthy food for those with limited access in the region.
Objective 3.3	By June 2028, the Healthy Delmarva Partnership will increase opportunities for physical activity across the region.

Behavioral Health Goals and Objectives

Table 3.8: Behavioral Health Implementation Plan, Goal 1

Goal #1: Enhance screening, referral, and intervention processes for behavioral health	
Objective 1.1	By June 2027, the Healthy Delmarva Partnership will enhance screening for substance use disorders by implementing standard screening in specific patient encounters*.
Objective 1.2	By June 2027, the Healthy Delmarva Partnership will enhance screening for mental health conditions by implementing standard screening in specific patient encounters*.

**Screenings to be implemented in TidalHealth primary care settings and WiCHD programs*

Table 3.9: Behavioral Health Implementation Plan, Goal 2

Goal #2: Reduce stigma and increase awareness of behavioral health services among special populations	
Objective 2.1	Annually, maintain or increase the peer support specialists available in the Delmarva region to support those seeking behavioral health services and support.
Objective 2.2	Annually, maintain or increase the number of people completing Mental Health First Aid training in the Delmarva region.
Objective 2.3	Annually, increase awareness about and utilization of available behavioral health programs and services in the Delmarva region among the public and behavioral health system partners through tailored marketing and outreach efforts.

Table 3.10: Behavioral Health Implementation Plan, Goal 3

Goal #3: Strengthen care coordination and integration across the behavioral health system	
Objective 3.1	By June 2028, the Healthy Delmarva Partnership will align community efforts outlined in this CHIP with the Local Behavioral Health Authority strategic plans in the three Maryland counties to ensure coordination to best address behavioral health needs in the region.

Phase IV: Implementation and Monitoring

The implementation of this CHIP will be managed and monitored by Healthy Delmarva Partnership organizations – TidalHealth, Somerset County Health Department, Wicomico County Health Department, and Atlantic General Hospital. The methods by which this plan management will be done are described in the sections that follow.

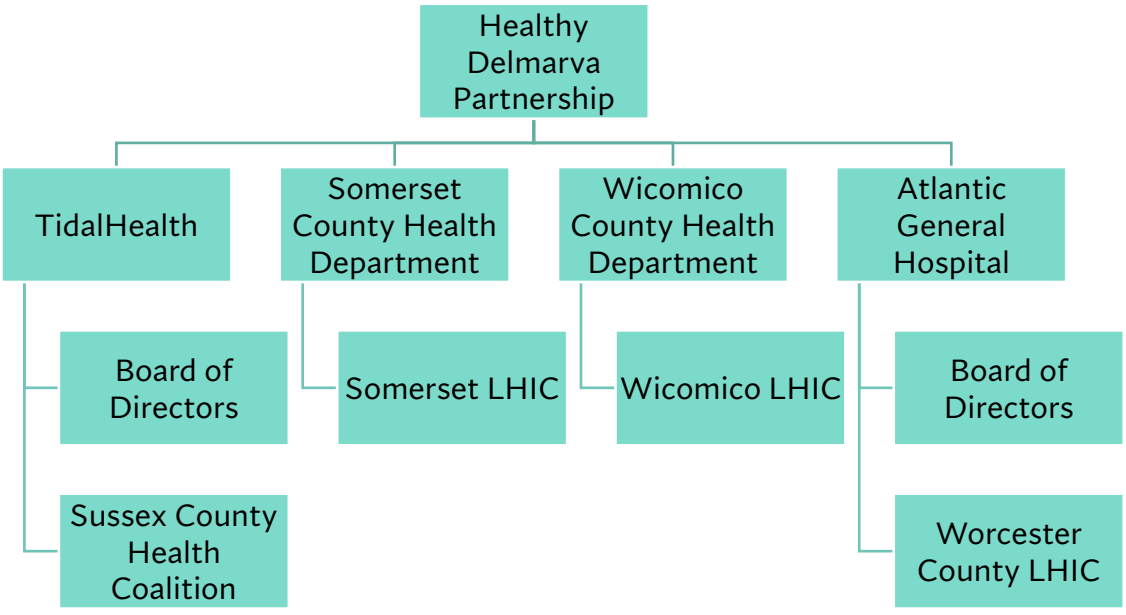
Process for Monitoring Implementation Progress

General Monitoring and Reporting: Healthy Delmarva Partnership

The implementation of the CHIP will be monitored at least biannually through a structured review process conducted by partner organizations. This monitoring will involve systematic assessment of progress on all established goals, objectives, and activities across the priority areas of Healthcare Access, Behavioral Health, and Chronic Disease. Biannual reporting on CHIP activities will occur in December and June of each year during a meeting of Partnership organizations, scheduled and hosted by TidalHealth.

During each CHIP review session, participating organizations will report on specific metrics and activities tied to each objective, documenting both quantitative data (such as number of screenings completed, referrals made, or participants enrolled in programs) and qualitative outcomes (such as narrative descriptions), as appropriate. Partner organizations will evaluate whether activities are proceeding according to planned timelines and address any implementation barriers. Modifications to the CHIP may be made during these reviews. This will be recorded in the record of changes section of this report and communicated to partners and stakeholders impacted by the changes.

Figure 4.1: Progress Monitoring and Reporting Structure for CHIP Implementation



Layers of CHIP Monitoring and Reporting: Sub-Geographies and Health Systems
Due to the multi-state, multi-county, and multi-health system nature of this CHIP, there are multiple accountability mechanisms by which progress will be tracked and reported. These layers of monitoring and reporting will occur within sub-geographies and within health systems but will 'roll-up' into an overall review process coordinated by the Healthy Delmarva Partnership. The 'roll-up' CHIP monitoring and reporting process is described in the 'General Monitoring and Reporting' section above.

TidalHealth: At least annually, TidalHealth's Population Health will provide an update on CHIP activities to senior leadership for its three hospitals – TidalHealth Peninsula Regional, TidalHealth Nanticoke, and Atlantic General Hospital.

Maryland: Local Health Improvement Coalitions (LHICs) are groups of jurisdiction level stakeholders that are often led by local health departments and can serve as informal extensions of the health department. Both Somerset County Health Department and Wicomico County Health Department have active LHICs that serve as the bodies responsible for reviewing CHIP implementation for their respective communities. Somerset and Wicomico County health departments will present progress on the CHIP activities for which they are designated leads to their LHICs at least biannually for accountability and awareness.

Delaware: Delaware does not have an equivalent to the Maryland LHIC structure, but Sussex County does have an active health coalition in which TidalHealth is a member. CHIP implementation updates will be presented to the Sussex County Health Coalition at least annually by TidalHealth to keep the community and key partner organizations apprised of ongoing activities, accomplishments, challenges, and opportunities to collaborate on CHIP implementation.

CHIP Performance Metrics

Part of the biannual review process of the CHIP will include assessment of progress toward performance metrics aligned with each of the priority health need areas. This section of the CHIP outlines a series of outcome metrics that can be discussed by partner organizations during their formal reviews to determine whether activities implemented in support of the CHIP are moving the region toward stated goals and objectives.

The metrics identified in this section of the CHIP will be reported to key stakeholders once per year by the Healthy Delmarva Partnership to document progress toward overall plan achievements over the course of the CHIP's three-year lifespan. ***The report-outs of progress on these metrics will occur following the annual June Healthy Delmarva Partnership biannual CHIP review meeting.***

Table 4.1 Cross-Cutting Priority Metrics

Metric	Source	Frequency
Number of Community Health Workers retained and/ or promoted	Eastern Shore AHEC workforce data	Annually
Number of staff trained in literacy considerations	Healthy Delmarva Partnership organizational training records	Annually

Table 4.2 Healthcare Access Metrics

Metric	Source	Frequency
Proportion of bilingual healthcare providers working in the region	TidalHealth People Department records	Annually
Percentage of patients/clients provided with timely and appropriate interpretation services	Language service tracking reports	Annually
Number of healthcare provider and public health practitioners trained in cultural competency	CLAS Committee reports, Learning Management Systems	Annually
Number of REACH partners receiving electronic referrals through findhelp platform	Findhelp platform data	Annually
Public awareness of local health-related social need resources available via findhelp	Findhelp utilization analytics	Annually
Number of healthcare/public health students hosted for rural health rotations	Partner organization records	Annually
Retention rates for residents completing training through local residency program	TidalHealth GME program data	Annually

Table 4.3 Chronic Disease Metrics

Metric	Source	Frequency
Cancer screening disparities for breast, colorectal, and lung cancers	SEER data, state cancer registries, BRFSS data	Annually
Patient adherence to follow-up care referrals following positive screening results	Epic electronic health record data	Annually
Number of patient referrals to evidence-based disease management programs	SmartSheets, Epic EHR	Annually

Metric	Source	Frequency
Tobacco use rates among adults and youth	County health department reports, BRFSS data	Annually
Number of residents with improved access to healthy food in areas with limited access	REACH grant monitoring data	Annually
Number of opportunities for physical activity across the region	Partner organization tracking	Annually

Table 4.4 Behavioral Health Metrics

Metric	Source	Frequency
Number of patients screened for substance use disorders	Epic EHR screening data (DAST-10)	Annually
Number of patients screened for mental health conditions	Epic EHR screening data (PHQ9, GAD7)	Annually
Number of peer support specialists available in the region	TidalHealth and health department staffing records	Annually
Number of people completing Mental Health First Aid training	LBHA training records	Annually
Public awareness of behavioral health services	Outreach event tracking, resource guide distribution	Annually
Alignment of CHIP activities with Local Behavioral Health Authority strategic plans	LBHA and LHIC Behavioral Health Workgroup reports	Annually

Acknowledgements

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Healthy Delmarva Steering Committee

The following individuals and organizations provided leadership and guidance throughout the assessment and planning process:

Healthy Delmarva Partnership Steering Committee Members		
Name	**Title**	**Organization**
Kathryn Fiddler	Vice President of Population Health	TidalHealth
Chris Hall	Vice President, Strategy and Business Development / Chief Business Officer	TidalHealth
Katherine Rodgers	Director of Community Health Initiatives	TidalHealth
Bobbi McDonald	Community Health Educator	TidalHealth
Danielle Weber	Health Officer	Somerset County Health Department
Andra Taylor	Director of Planning, Prevention, and Communication	Somerset County Health Department
Korey Colbert	Health Planner	Somerset County Health Department
Matthew McConaughey	Health Officer	Wicomico County Health Department
Christina Gray	Director, Division of Planning and Assessment	Wicomico County Health Department
Lisa Renegar	Health Planner	Wicomico County Health Department

Action Team Members

We also thank the following individuals who participated in the Action Team meetings for each of the three priority health need areas, who are listed on the following pages:

Healthcare Access Action Team

Name	Organization
Alyce Marzola	Atlantic General Hospital
Beth Spencer	Eastern Shore Area Health Education Center (AHEC)
Bobbi McDonald	TidalHealth
Brittany Young	Maryland Physicians Care
Bruce Wright	1st State Community Action Agency
Christina Gray	Wicomico County Health Department
Christopher Osment	Somerset County Health Department
Danielle Weber	Somerset County Health Department
Jasmine Crowson	Wicomico County Health Department
Josh Boston	Chesapeake Healthcare
Katherine Rodgers	TidalHealth
Kathryn Fiddler	TidalHealth
Kathy Mutzberg	Wicomico Department of Social Services (DSS)
Kiya Lofland	Worcester County Health Department, Lower Shore Health Insurance Assistance Program
Korey Colbert	Somerset County Health Department
Lisa Renegar	Wicomico County Health Department
Roosevelt Toussaint	Haitian Development Center of Delmarva
Tammy Griffin	Wicomico County Health Department

Chronic Disease Action Team

Name	Organization
Alyce Marzola	Atlantic General Hospital
Courtney Masterson	Quality Insights
Elizabeth Justice	Somerset County Health Department
Jackie Ward	Worcester County Health Department
Katherine Rodgers	TidalHealth
Kathy Mutzberg	Wicomico County Department of Social Services, Adult Services
Korey Colbert	Somerset County Health Department
Lisa Renegar	Wicomico County Health Department
Lois Haynie	Wicomico County Health Department Cancer Screening Program
Matthew McConaughey	Wicomico County Health Department
Nadya Julien	Tabita Medical Care, Lewes, Delaware
Natalie Andrews	Delaware Department of Public Health
Tammy Griffin	Wicomico County Health Department
Wendy Bailey	Delaware DHDPCP

Behavioral Health Action Team

Name	Organization
Amber Copeland	HealthPort
Dimitri Cavathas	HealthPort
Jackie Ward	Worcester County Health Department
Katherine Rodgers	TidalHealth
Kendall Smith	Recovery Resource Center
Lisa Brown	Transportation services provider
Lisa Renegar	Wicomico County Health Department
Michelle Hardy	Local Behavioral Health Authority (LBHA)
Mike Trader	Worcester County Health Department
Tiffany Travers	TidalHealth Crisis Center
Yvonne Harris	Somerset County Health Department

Plan Consultants

Healthy Delmarva commissioned Ascendient Healthcare Advisors (Ascendient) to support the 2025 CHNA and CHIP. Ascendient works with healthcare organizations and public health departments nationwide to complete IRS-compliant and Public Health Accreditation Board conforming community health assessments, improvement plans, and progress tracking mechanisms.

The Ascendient team members involved in the development of this report included: Brian Ackerman, MHA, Partner; Chelsey Saari, DrPH, MPH, Manager; and Kristen Lewis, MPH, Consultant. To learn more about Ascendient Healthcare Advisors, please visit their website at www.ascendient.com.

Appendix 1 | Cross-Cutting CHIP Goal Action Plans

GOAL O: Implement cross-cutting strategies to address system-level challenges impacting the health and wellbeing of Delmarva residents.

The Healthy Delmarva CHIP includes a goal focused on implementing cross-cutting strategies to address system-level issues because the three priority areas—**Healthcare Access, Behavioral Health, and Chronic Disease**—share common underlying challenges that require coordinated solutions.

Cross-cutting objectives and strategies recognize that improving community health requires more than isolated interventions within individual silos. Instead, by focusing on objectives that relate to retention and upskilling of community health workers (CHWs) and enhancing provider capacity around health literacy, the CHIP can efficiently address barriers that impact all priority areas simultaneously.

OBJECTIVE #O.1: By June 2028, Healthy Delmarva Partnership organizations will improve staff awareness, knowledge, understanding, and application of literacy considerations through training and implementation of improved and standardized literacy practices within their respective organizations.

BACKGROUND: Improving staff awareness and knowledge of health literacy considerations through standardized training is essential because many residents in the Delmarva region face challenges understanding health information, particularly those in the Haitian and Hispanic communities. Implementing improved literacy practices within partner organizations would enhance effective communication between patients and providers, ensure understanding of healthcare decisions, and reduce barriers to care for vulnerable populations who currently struggle to navigate the healthcare system.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Cultural Competency Training (TidalHealth)	Annually	Learning Management Systems	Lady Johnson/ TidalHealth	Improved cultural competency and provision of culturally competent care
Cultural Competency Training (Somerset County Health Department)	Annually	TRAIN Website	Workforce Committee/ SCHD	Improved knowledge of cultural competency and related services
Health Literacy Certification for community health workers, community health nurses, community health educator(s)	6/30/2028	Health Literacy Curriculum	Bobbi McDonald/ TidalHealth	Improved health literacy among patient populations
Continued implementation of the National CLAS[2] Standards	6/30/2028	WiCHD CLAS Committee, The Blueprint (implementation guide)	Lisa Renegar, CLAS Committee/ WiCHD	Improved quality of services and reduced health disparities among WiCHD clients

[2] Culturally and Linguistically Appropriate Services

OBJECTIVE #O.2: By June 2028, Healthy Delmarva Partnership organizations will retain and/or promote at least 80% of the current Community Health Worker workforce.

BACKGROUND: Community Health Workers (CHWs) are vital to addressing healthcare barriers in the Delmarva region by providing culturally and linguistically appropriate services to underserved populations, particularly the Haitian and Hispanic communities. Expanding and diversifying the CHW workforce would improve healthcare navigation, enhance referral processes, and strengthen community-based care coordination, ultimately reducing emergency department visits and improving health outcomes for vulnerable residents.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Create inventory of CHWs serving Delmarva region to establish baseline of current workforce	December 2025	Data from organizations employing CHWs across the region.	Eastern Shore Area Health Education Center	Inventory of CHWs currently serving the Delmarva region. Baseline number of CHWs to compare to assess retention.
Assess current CHW workforce to determine best approaches for retention strategies	March 2026	Survey tool, Survey platform, Staff time for analysis	Organizations with CHWs	Report of findings, Plan to implement retention strategies
Develop career advancement pathways for CHWs	June 2026		Eastern Shore Area Health Education Center, TidalHealth	Documented career advancement pathway for CHWs
Implement career advancement pathways program for CHWs	December 2026		Organizations with CHWs	Enrollment of CHWs in career advancement pathway program
Analyze CHW data and obtain feedback from stakeholders to determine continued needs of CHWs.	Annually	CHW workforce data for region	Local Health Improvement Coalitions (LHICs)	Report of findings
Obtain additional CHW staff to increase community outreach.	June 2026	Continue to recruit and hire to increase CHW workforce within agency	Christopher Osment/ SCHD	Increase community outreach to promote services.

Appendix 2 | Healthcare Access Goal 1 Action Plans

GOAL 1: Make healthcare more accessible by providing services that respect cultural differences, use clear language, and are easy to understand.

OBJECTIVE #1.1: By June 2026, establish a baseline measure for bilingual healthcare providers across the region, and then increase the proportion of bilingual healthcare providers working in the region by 5% annually thereafter to better serve the healthcare needs of the Spanish-speaking and Haitian communities in the Delmarva Region.

BACKGROUND: Expanding bilingual healthcare providers in the Delmarva region is crucial because language barriers significantly impact healthcare access for the growing Haitian and Hispanic communities, as identified in the community health assessment. Having providers who can communicate directly in patients' primary languages would improve patient-provider trust, enhance health literacy, and lead to better health outcomes by ensuring patients fully understand their diagnoses, treatment plans, and prevention strategies.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Target sourcing from medical schools	Ongoing	Recruiters	TidalHealth People Department	Increased providers from the Caribbean and Central America
CV Screening for language proficiency	Ongoing	Recruiters	TidalHealth People Department	Bilingual candidates are prioritized
Direct outreach to U.S. teaching programs	Ongoing	Recruiters, workforce management	TidalHealth People Department	Increased relationships with residency and fellowship programs in U.S. regions serving large multilingual communities

Community-Aligned Recruitment Marketing	Ongoing	Recruiters	TidalHealth People Department	Recruitment materials and job postings highlight the organization's commitment to diversity, equity, and inclusion, with specific messaging to attract bilingual providers who want to make an impact in underserved communities

OBJECTIVE #1.2: By June 2028, at least 90% of patients/clients engaging with Healthy Delmarva Partnership organizations for medical or public health services will be provided with timely and appropriate interpretation services by a qualified interpreter.

BACKGROUND: Offering qualified medical interpretation services in the Delmarva region is essential because language barriers were identified as significant obstacles to healthcare access, particularly for the Haitian and Hispanic communities. Establishing a reliable network of trained medical interpreters would facilitate better communication between patients with limited English proficiency and healthcare providers, ensuring accurate understanding of complex medical information and increasing trust in the healthcare system, which could ultimately lead to better health outcomes and reduced emergency department utilization.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Implement Dual Enroll Program for inpatient and outpatient areas (including ED) with focus on Spanish & Haitian-Creole	June 2027	Systemwide Language Services Coordinator; program funding $90,000 for dual-enroll employees and proficiency testing/medical interpretation coursework	Grace Conick/ TidalHealth	A functional, integrated Dual Enroll workforce that provides interpretive services for all TidalHealth locations

Recruit and retain bilingual workforce	June 2028	People Department recruiters/talent acquisition, trainers, language services coordinator, Dual Enrollment Program	Grace Conick/ TidalHealth + People Department	Increased bilingual workforce
Optimize language interpretation services by implementing department codes to track and identify areas of high need. Perform language/Propio audits to determine quality standards and assess performance	June 2027	Reporting and analytics via language interpretation platform(s)	Grace Conick/ TidalHealth	Targeted approaches to increasing access to interpretation services
Translate health information into Haitian-Creole and Spanish	June 2028	Translation services	Grace Conick/ TidalHealth Kelly Ward, CLAS Committee/ WiCHD	Increased health literacy through translation of materials available in multiple languages
Use Epic to obtain more documents in languages such as Spanish/ Haitian-Creole	June 2028	Translated materials through Epic EMR	Grace Conick/ TidalHealth	Increased health literacy through translation of materials available in multiple languages
Continue collecting customer satisfaction surveys from the LEP population to obtain feedback on language access services.	Ongoing	Customer Satisfaction Surveys	Lisa Renegar, Quality Council/ WiCHD	Customer feedback used to improve services
Translation of vital documents into Spanish, Haitian Creole and Arabic	Ongoing	Translation Services	Korey Colbert/ SCHD	Vital documents available in multiple languages
Continue providing interpretation services for Hispanic residents	Ongoing	Interpretation Services	Patricia Salem/ SCHD	Hispanic residents provided with quality interpretation services

OBJECTIVE #1.3: By June 2028, healthcare provider and public health practitioner cultural competency will be improved through adherence to Culturally and Linguistically Appropriate Services (CLAS) requirements and ongoing staff training across Healthy Delmarva Partnership organizations.

BACKGROUND: Adhering to Culturally and Linguistically Appropriate Services (CLAS) standards is vital for healthcare providers in the Delmarva region because it ensures equitable, respectful, and effective care for diverse populations, particularly the Haitian and Hispanic communities identified as having significant unmet healthcare needs. Implementation of CLAS standards would help overcome cultural and linguistic barriers that currently prevent many residents from seeking or receiving appropriate care, while also building trust between healthcare systems and historically underserved communities. The community health assessment data clearly shows disparities in healthcare access and outcomes, which CLAS-compliant care delivery could help address by creating more welcoming, responsive, and culturally competent healthcare environments.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Ensure health information, education, communications meet CLAS standards	June 2028	CLAS training and resources	Erica Courtney/ TidalHealth	More accessible health information, improved health literacy
Utilize On-Call Finder in Epic so hospital providers can reach onsite qualified bilingual staff who provide in-person interpretation services	June 2028	Epic resource	Grace Conick/ TidalHealth	Promote health equity by increased access to in-person interpreters at hospitals
Include health literacy question in SDOH assessments	June 2026	Epic, Community Health Workers	Katherine Rodgers/ TidalHealth	Increased awareness of health literacy needs and strategies to improve health literacy
Mobile integrated health services	Ongoing	Community Wellness team, EMS partnership	Tammy Walbert/ TidalHealth	Increased screening and wrap around supports through MIH program and services using cultural and linguistically appropriate standards

Mobile health screenings, outreach, and education	Ongoing	Mobile units, Community Wellness team	Katherine Rodgers/ TidalHealth	Ensure routine health outreach and screenings are provided in medically underserved areas in culturally and linguistically appropriate ways.
Implement core competency training plans for cultural competence for public health professionals	June 2026	TRAIN Learning Network	Christina Gray, Workforce Development Committee/ WiCHD	Improved staff ability to interact with and serve diverse populations; improved communication, improved customer satisfaction, and better health outcomes
Continue providing introduction to cultural competence and equal access compliance training to all new staff.	Ongoing	Staff trainers and curriculum	Lisa Renegar, CLAS Committee/ WiCHD	Improved staff knowledge; health equity promotion
Continue HECC(Health Equity CLAS Committee) training for all staff	Annually	Agency Training	Korey Colbert, HECC/ SCHD	Improve knowledge of Health Equity and improve quality of services
Continue Introduction to CLAS training to all new staff	Ongoing	Staff Training	Korey Colbert, HECC/ SCHD	Increase staff knowledge of CLAS within our agency.

Appendix 3 | Healthcare Access Goal 2 Action Plans

GOAL 2: Help people use healthcare services by improving referrals, coordinating care better, and offering guidance to navigate the system.

OBJECTIVE #2.1: By June 2026, TidalHealth and Atlantic General Hospital will integrate the findhelp referral platform into hospital Electronic Health Records (EHR) to facilitate improved care coordination between health systems and community-based organizations in the Delmarva region.

BACKGROUND: Integrating TidalHealth's EHR with the findhelp referral platform will create a seamless connection between clinical care and social services, allowing healthcare providers to more efficiently address patients' social determinants of health alongside their medical needs. This integration will enable closed-loop, bidirectional referrals between TidalHealth and community-based organizations, improving care coordination and ensuring patients will receive comprehensive support that addresses both their health and social needs.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Continue to expand SDOH screenings throughout health system	June 2026	Implement routine, SDOH assessments across healthcare system	Katherine Rodgers & Joan Vavrek/ TidalHealth	Increased use of findhelp for patient social care coordination
Operate mobile integrated health program with community health workers to effectively screen and address SDOH using findhelp	Ongoing	CHWs, findhelp	Katherine Rodgers/ TidalHealth	Increased ability to assess and address patient needs
Integrate findhelp with Epic	March 2026	Epic analysts, findhelp support	Katherine Rodgers & Joan Vavrek/ TidalHealth	Increase ability of case managers to identify and refer patients for community-based resources

Implement Compass Rose Module in Epic	March 2026	Epic analysts, findhelp support	Joan Vavrek/ TidalHealth	Ability to conduct and track closed-loop, bidirectional referrals using findhelp and Epic for improved care coordination
Collaborate with community-based organizations to claim programs and receive referrals through platform	June 2027	Community engagement team members, community partners	Katherine Rodgers/ TidalHealth	Increase # of organizations, programs, and services on findhelp
Work with community partners and CRISP to ensure data flows into CRISP	June 2027	CRISP, findhelp	Katherine Rodgers & Joan Vavrek/ TidalHealth	Increase information sharing across organizations and healthcare system related to SDOH
Increase team member utilization of findhelp	June 2027	Findhelp, Epic, Compass Rose, TidalHealth population health leadership	Katherine Rodgers & Joan Vavrek/ TidalHealth	Increased referrals and improved care coordination using findhelp

OBJECTIVE #2.2: By June 2027, TidalHealth will increase the number of REACH partners willing/able to receive electronic referrals for health-related social needs through the findhelp platform from 3 to 7.

BACKGROUND: Community-based organizations (CBOs) will be able to receive and act on electronic referrals from TidalHealth more efficiently, allowing them to better serve vulnerable populations with time-sensitive social needs. The electronic referral system will create a closed-loop process where CBOs can document outcomes and communicate back to healthcare providers, significantly improving coordination between medical and social services. This streamlined approach will ultimately help CBOs demonstrate their impact on health outcomes, potentially increasing their funding opportunities while ensuring that patients with health-related social needs won't fall through the cracks of a fragmented system.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Collaborate with community-based organizations to claim programs and receive referrals through platform	June 2026	Community Partners engaged in REACH grant	Rochelle Tyler/ TidalHealth	Improved coordination among grant partners
REACH coalition meetings	Ongoing	Meeting schedule and space	Rochelle Tyler/ TidalHealth	Maintain and increase engagement with community partners associated with the grant program

OBJECTIVE #2.3: By June 2028, Healthy Delmarva Partnership will increase public awareness of local, low-cost and free health-related social need resources available via the findhelp platform through marketing and outreach efforts.

BACKGROUND: When community members become aware of findhelp, they will be empowered to proactively address their own social determinants of health without necessarily waiting for a healthcare provider to make a referral. This increased awareness will lead to earlier interventions for social needs that impact health outcomes, ultimately helping to create a healthier community where individuals can more effectively navigate both healthcare and social service systems.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Connect findhelp to MyChart	June 2026	MyChart, findhelp	Jenny Harsin/ TidalHealth	Patients able to access findhelp via patient portal
Launch a public awareness campaign about findhelp	June 2027	Media	Katherine Rodgers/ TidalHealth	Increased public utilization of findhelp
Make findhelp prominent feature on TidalHealth.org	June 2027	Website	Laren MacMillan/ TidalHealth	Increased public awareness of findhelp
Allow patients to complete self SDOH assessments	June 2026	MyChart, self-registration and assessment in Epic	Katherine Rodgers/ TidalHealth	Increased screening and referrals for SDOH

Appendix 4 | Healthcare Access Goal 3 Action Plans

GOAL 3: Continue to build a strong healthcare system in Delmarva with enough qualified staff from diverse backgrounds and additional ways to deliver services.

OBJECTIVE #3.1: By June 2026, all Healthy Delmarva Partnership organizations will establish processes for hosting at least one healthcare/public health student for rural health rotations/practicum experience annually.

BACKGROUND: By hosting medical students for rural health rotations, students can develop cultural competence and specialized skills needed to serve diverse communities. By exposing future providers to the unique rewards and challenges of rural healthcare practice, these rotations will increase the likelihood that medical professionals will choose to practice in underserved areas of the Delmarva region after completing their training.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
TidalHealth Community Wellness to work with Graduate Medical Education to host rural health rotations in department	June 2026	GME coordinators	Betsy Kelly/ TidalHealth	Improved skills and competencies among students and residents for rural, community health
Partner with local universities to host students for rural health rotations	June 2026	Internship coordinators	Betsy Kelly/ TidalHealth	Increased internship opportunities in community health
Formalize and standardize the process for student interns	June 2026	Workforce Development Committee	Christina Gray, Workforce Development Committee/ WiCHD	Stable process agency-wide resulting in increased internship opportunities
Host medical students for rural health rotation	June 2026	Workforce Development Committee, Medical Deputy Director	Dr. Calixte/ WiCHD	Improved skills and competencies among students and residents for rural, community health

Continue to host public health program students	June 2026	Internship coordinator	Elizabeth Justice/ SCHD	Increased internship opportunities

OBJECTIVE #3.2: By June 2028, TidalHealth maintain 50% retention rates for residents completing their training through the local residency program.

BACKGROUND: Retaining residents who complete their training at TidalHealth is important because it helps address the critical healthcare workforce shortage in the Delmarva region by keeping locally-trained physicians who already understand the unique needs and challenges of serving rural and underserved communities. Residents who train at TidalHealth have developed familiarity with the patient population, healthcare infrastructure, and community resources, making them more effective providers from day one and more likely to establish long-term practices in the area. This retention strategy is particularly valuable for improving healthcare access in the region, as it reduces the costly and time-consuming cycle of continuously recruiting outside providers while building a stable workforce of physicians committed to serving the local community.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Offer stipends to retain physicians depending on specialty	Ongoing	Funding for stipends	TidalHealth	Retained physicians
Establish programs across a range of needs to increase the reputation of institutions and attract more qualified applicants	Ongoing	GME program	TidalHealth	Quality residents
Establish multiple core clinical campuses with regional medical schools developing a pipeline of potential candidates	Ongoing	GME program	TidalHealth	Increase number of residents and students who will stay local
Recruiters meet with the incoming class to start retention process earlier	Ongoing	GME program	TidalHealth	Retention rates

OBJECTIVE #3.3: Annually, Healthy Delmarva Partnership organizations will each engage in at least one local opportunity to promote medical career choices among young people in the region through organizations like Volunteens, AHEC Scholars, Junior Achievement, or others.

BACKGROUND: Promoting health career choices among young people in the Delmarva region is important because the area faces significant healthcare workforce shortages, particularly in rural and underserved communities, which directly impacts residents' access to care. By encouraging local students to pursue healthcare careers through programs like career days, internships, and partnerships with organizations like AHEC Scholars and Junior Achievement, the Healthy Delmarva Partnership can help build a pipeline of future providers who understand the unique needs and challenges of their home communities. This local talent development strategy is especially valuable because healthcare professionals who have roots in the region are more likely to return and stay to serve their communities long-term, helping to address the ongoing challenge of recruiting and retaining qualified healthcare workers in rural areas.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Talent Acquisition attend career days at schools	Ongoing	People Department recruiters	TidalHealth	More local students choosing careers in healthcare
Incorporate youth engagement strategies in Wicomico County Health Department's workforce development plan	June 30, 2028	Workforce Development Committee	Christina Gray, Workforce Development Committee/ WiCHD	More local students choosing careers in healthcare
TidalHealth partnerships with Jobs for Delaware Graduates	Ongoing	People Department	TidalHealth	Increased number of new graduates employed
Internship opportunities for high school students	Ongoing	People Department	TidalHealth	Increased number of students participating in internships, volunteer experiences

Appendix 5 | Chronic Disease Goal 1 Action Plans

GOAL 1: Improve chronic disease screening and early detection.

OBJECTIVE #1.1: By June 2026, the Healthy Delmarva Partnership will identify and define cancer screening disparities for breast, prostate, colorectal, and lung cancers across the region.

BACKGROUND: Identifying and defining cancer screening disparities is important for the Healthy Delmarva Partnership because it provides the data-driven foundation needed to understand where gaps in care exist across different populations and geographic areas in the region. By establishing baseline measurements and clearly documenting disparities in breast, colorectal, and lung cancer screening rates, the partnership can develop targeted interventions and allocate resources more effectively to address the specific needs of underserved communities. This systematic approach to identifying disparities ensures that efforts to improve cancer screening are evidence-based and focused on populations most likely to benefit, ultimately leading to earlier detection, better outcomes, and reduced cancer mortality across the Delmarva region.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Analyze data from SEER and state cancer registries alongside self-reported screening data from BRFSS and NHIS	Annual	Data registries	Cathy Stafford/ TidalHealth Christina Gray/ WiCHD	More data-driven strategies to address disparities
Implement Mobile Mammogram Program	October 2025	Epic, GIS mapping	Katherine Rodgers/ TidalHealth Lois Haynie/ WiCHD	Increased rate of women screened; increased percentage in follow-up for women needing diagnostic screening
Public awareness, education, and outreach at local health fairs and community events	Ongoing	Health educators and outreach workers; WiCHD staff	Katherine Rodgers & Cathy Stafford/ TidalHealth Lois Haynie/ WiCHD	Increased public awareness about health screenings

Provide education and outreach at local community events using the agency wellness van	Ongoing	Wellness Van	Community Health Nurse/ SCHD	Promote and educate the importance of screenings.
Continue providing funding and education for breast, cervical, and colorectal screenings	Ongoing	Funding, providers, outreach and education materials	Lois Haynie/ WiCHD	Increased knowledge about the importance of screenings, earlier detections, improved survival and reduced mortality

OBJECTIVE #1.2: By June 2028, the Healthy Delmarva Partnership will maintain or improve patient adherence to recommended cancer screenings (breast, colorectal, and cervical) through improved collaboration between TidalHealth and Wicomico and Somerset county health departments.

BACKGROUND: Improving coordination between healthcare organizations and other community-based organizations for referrals and patient adherence is essential because many health issues are influenced by social determinants like housing, food security, transportation, and social support that extend beyond traditional medical care. When healthcare providers can seamlessly connect patients to social services, community programs, and support organizations, it creates a comprehensive care network that addresses the root causes of health problems and removes barriers that prevent patients from following through with treatment recommendations. This coordinated approach leads to better patient outcomes, reduced emergency department visits, and more efficient use of community resources by ensuring patients receive the right services at the right time through streamlined referral processes.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Improve patient adherence to follow-up care referrals after positive cancer screening results by enhancing coordination between TidalHealth and local health departments.	Ongoing	Meetings	Cathy Stafford/ TidalHealth	Improved follow-up rates

Share referral tracking systems, streamline patient navigation services	June 2026	Epic	Cathy Stafford/ TidalHealth	Improved bidirectional referrals pathways
Implement joint outreach efforts to improve timely follow-up care	June 2027	Outreach opportunities	Cathy Stafford/ TidalHealth	Improved care coordination
Mobile Mammogram Program	October 2025	Care Coordination specialist, Nurse Navigator	Katherine Rodgers/ TidalHealth	CCSs and RN will coordinate follow-up for patients
Mobile Integrated Health	Ongoing	CHWs, LMSW, NPs, RNs, community paramedics	Tammy Walbert/ TidalHealth	MIH team works with medically underserved individuals in the community to ensure access to care
Smith Island Care Clinic	April – November	Clinic	Tammy Walbert/ TidalHealth	Provide routine urgent care visits to residents on Smith Island
Provide case management services to patients with positive breast, cervical, and/or colorectal cancer screenings until connected to treatment	Ongoing	WiCHD staff, providers	Lois Haynie/ WiCHD	Improved access to care, better continuity of care, reduced delays in treatment, improved health outcomes, improved survival rates
Provide follow-up services to patients with positive screenings while waiting to be connected to a provider	Ongoing	Case management, coordinator	Ben Dashiell/ SCHD	Improved communication and access to care for patients

Appendix 6 | Chronic Disease Goal 2 Action Plans

GOAL 2: Enhance chronic disease management and prevention.

OBJECTIVE #2.1: By June 2027, the Healthy Delmarva Partnership will improve consistent patient referrals to evidence-based disease prevention and management programs through streamlined processes and increased program capacities in the region.

BACKGROUND: Consistent patient referrals to disease prevention and management programs is important because it ensures equitable access to evidence-based interventions that can significantly improve health outcomes and prevent disease progression. When referral processes are standardized and reliable, patients are more likely to receive timely connections to programs like diabetes prevention, hypertension management, or smoking cessation services that can reduce their risk of complications and hospitalizations. Consistent referrals also help maximize the utilization and effectiveness of existing community health programs, creating a more integrated healthcare system where medical treatment is complemented by preventive and supportive services**.**

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
TidalHealth Medical Partners Diabetes Education Referrals	Ongoing	Epic	Linda Micai-Manning/ TidalHealth	Increased referrals from providers for patients to participate in TidalHealth Diabetes Education Educated PCPs and Care Coordinators on referral process. Created BPA for Care Coordinators to be reminded about diabetes education requirement.
Chronic Kidney Disease Referrals	Ongoing	Epic	Amanda Hottenstein/ TidalHealth	Increased referrals and participation in Chronic Kidney Disease programming

Mobile health screenings and outreach	Ongoing	Mobile health units	Katherine Rodgers/ TidalHealth	Promote healthy lifestyle programming in community
Evidence-Based Programs in partnership with MAC, Inc., YMCA, local health departments	Ongoing	Evidence-based curriculum and certified facilitators	Katherine Rodgers & Bobbi McDonald/ TidalHealth	Support healthy lifestyle programming for free in the community
Formalize referral process for Diabetes Prevention Program	June 2028	Evidence-based curriculum and certified facilitators	Tammy Griffin/ WiCHD HEALTH project & Chistopher Osment/ SCHD	Increased referrals and participation in DPP
Formalize referral process for smoking cessation program	June 2028	Evidence-based curriculum and trained facilitator	Tammy Griffin/ WiCHD	Increased referrals and participation in smoking cessation
Formalize referral process for hypertension program	June 2027	Evidence-based curriculum and trained facilitator	HEALTH project & Christopher Osment/ SCHD	Increased referral and participation for hypertension prevention program

OBJECTIVE #2.2: By June 2028, the Healthy Delmarva Partnership will improve healthcare provider awareness of how to refer patients to local chronic disease support services that can better support their disease prevention and management through the findhelp platform through marketing and outreach efforts.

BACKGROUND: Making providers aware of how to refer patients to disease prevention and management services is crucial because many patients with chronic conditions like diabetes and hypertension require comprehensive support beyond traditional medical care to effectively manage their health. When healthcare providers know how to connect patients to evidence-based programs, community resources, and support services, it creates a more coordinated care approach that can improve patient outcomes, reduce hospitalizations, and help prevent disease progression. This awareness also ensures that valuable community resources and programs don't go underutilized, maximizing the impact of available services and creating a stronger healthcare safety net for patients with chronic disease management needs.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Presentations to medical practices	Annually	Presenters	Bobbi McDonald/ TidalHealth	Increased awareness and referrals made by providers/practices
Establish electronic referral processes for diabetes education	June 2026	SmartSheets, findhelp, Epic	Susan Cottongim/ TidalHealth	Increased referrals via electronic pathways for diabetes education

Appendix 7 | Chronic Disease Goal 3 Action Plans

GOAL 3: Address risk factors through targeted prevention strategies.

OBJECTIVE #3.1: By June 2028, the Healthy Delmarva Partnership will reduce tobacco use rates among adults and youth in the region.

BACKGROUND: Reducing tobacco use is important because tobacco is a leading cause of preventable death and disease, significantly increasing the risk of cancer, heart disease, stroke, and chronic lung conditions like COPD. Beyond individual health impacts, tobacco use places a substantial burden on healthcare systems through increased medical costs and reduces quality of life for users and their families through secondhand smoke exposure. Implementing tobacco cessation programs and reducing tobacco use rates helps prevent chronic diseases before they develop, ultimately improving community health outcomes and reducing healthcare expenditures across the region.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Tobacco Cessation Coordinator from health department located in TidalHealth Pulmonary Department	June 2026	Tobacco Cessation coordinator and programming	Tammy Griffin/ WiCHD	Increased participation in evidence-based tobacco cessation programming
Expand Tobacco Cessation through Cardiac Rehab @ TidalHealth	June 2027	Tobacco cessation coordinator and programming	Chris Evans/ TidalHealth	Increased participation in evidence-based tobacco cessation programming
Promote 1-800 quit line	Ongoing	Tobacco Cessation Coordinator and programming	Tammy Griffin/ WiCHD	Increased referrals
Continue to participate and support student tobacco art project	Ongoing	Somerset County Schools and Tobacco Cessation Coordinator	Elizabeth Justice/ SCHD	Reduced tobacco use rates among youth in the community

OBJECTIVE #3.2: By June 2028, the Healthy Delmarva Partnership will improve access to healthy food for those with limited access in the region.

BACKGROUND: Increasing access to healthy food is a foundational public health strategy that prevents chronic disease, reduces disparities, and improves the health and vitality of entire communities. Some of the key strategies for addressing food insecurity through healthcare systems have included onsite food pantries and Food Is Medicine initiatives, nutrition education and counseling, and screening for food insecurity and connecting patients with resources.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Food is Medicine Programs	June 2028	Meal delivery services	Bobbi McDonald/ TidalHealth	Enrolled food insecure patients with diabetes and/or hypertension into food-is-medicine program
Food insecurity bags through Love INC and MAC, Inc.	June 2028	Meal/food bags	Katherine Rodgers/ TidalHealth	Established and maintained partnerships with community-based organizations to supply food bags for patients screened with food insecurity
Establish food insecurity program for AGH	June 2027	Community partnership, meal bags	Katherine Rodgers/ TidalHealth	Established food insecurity program to address patient food needs
REACH – increase healthy food at food pantries	June 2028	Community partnerships, grant funding	Rochelle Tyler/ TidalHealth	Increased access to healthy food in the community via food pantries
Mobile Market from Maryland Food Bank outreach	June 2026	Community health educator	Bobbi McDonald/ TidalHealth	Increased access to healthy education and healthy food
AGH Community Garden	Ongoing	Garden	Amanda Buckley/ AGH	Maintained community garden

Healthy eating demonstrations and programming	June 2026	Food, supplies for demonstrations	Bobbi McDonald/ TidalHealth	Established routine healthy eating programming in the community
Continue Somerset Garden Project	Annually	Community partnership garden	Elizabeth Justice/ SCHD	Increased health food access options in the community

OBJECTIVE #3.3: By June 2028, the Healthy Delmarva Partnership will increase opportunities for physical activity across the region.				
BACKGROUND: Increasing access to physical activity opportunities is a foundational public health strategy that yields broad and lasting benefits for individuals and communities. Some key benefits of this strategy are disease prevention, improved mental health, and longevity.				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**
REACH community health education programming	June 2028	Community Health Educator	Bobbi McDonald/ TidalHealth	Access to evidence-based programming and services that promote healthy lifestyles and physical activity
Walk with a Doc (AGH and TidalHealth)	Ongoing	Engaged providers	Bobbi McDonald, Nicole Alu/ TidalHealth Alyce Marzola/ AGH	Community participation in hospital-sponsored Walk-with-a-Doc program
Wellness Committee Activities (Burnalong, Walks)	Ongoing	Burnalong	Danielle Giddins/ TidalHealth	Increased participation in physical activity and healthy lifestyle programming throughout organization
Fitness Plus	Ongoing	Gym	Chris Evans/ TidalHealth	Increased opportunities for employees to access equipment for exercise
Support community walks and running festivals	Ongoing	Volunteers, waters, first aid	Alyce Marzola/ AGH	Hospitals and health departments provide

			Tammy Griffin/ WiCHD	support for large community walk/run events and festivals
Increase the # of walking groups throughout Wicomico County	June 2028		Tammy Griffin/ WiCHD	
Continue to host free walks in the community	Ongoing	Volunteers	Elizabeth Justice/ SCHD	Increased access to physical activity in the community
Continue to support physical activity classes offered at the local library	Ongoing	Somerset County library	Elizabeth Justice/ SCHD	Promote and increase healthy lifestyle changes for residents in the community

Appendix 8 | Behavioral Health Goal 1 Action Plans

GOAL 1: Enhance screening, referral, and intervention processes for behavioral health.

OBJECTIVE #1.1: By June 2027, the Healthy Delmarva Partnership will enhance screening for substance use disorders by implementing standard screening in specific* patient encounters.

BACKGROUND: DAST-10 screening is a validated, efficient, and effective tool for early detection, risk assessment, and management of drug use problems in health settings, ultimately improving patient outcomes and supporting public health goals.
[**Screenings to be implemented in TidalHealth primary care settings and WiCHD programs.]*

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Implement substance use screening DAST-10 for adults in primary care settings	June 2027	Screenings tools	Tiffany Travers/ TidalHealth	Improve integration between behavioral health and primary care
Mobile Integrated Health expansion including on-call providers	December 2025	Medication Assisted Treatment	Tiffany Travers & Tammy Walbert/ TidalHealth	Better care coordination and access to medication assisted treatment through SWIFT and Crisis Center
Mobile screening, outreach and education in community	December 2025	Mobile Unit, Community Wellness, Narcan	Tammy Walbert/ TidalHealth	Partner with fire department, SU, health departments, and others to promote screening in the community and access to Narcan

Develop and implement standardized SDOH screening and process	June 2027	Quality Council Members	Lisa Renegar, Quality Council/ WiCHD	Tool identified and implemented; better coordination between WiCHD programs and addiction providers

OBJECTIVE #1.2: By June 2027, the Healthy Delmarva Partnership will enhance screening for mental health conditions by implementing standard screening in specific* patient encounters.

BACKGROUND: Standardized use of PHQ-9 and GAD-7 improves the quality, efficiency, and effectiveness of mental health care by providing reliable screening, supporting early intervention, enabling ongoing monitoring, and facilitating better clinical decision-making. [**Screenings to be implemented in TidalHealth primary care settings and WiCHD programs.]*

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Implement PHQ9 and GAD7 for adults in primary care settings	June 2027	Screening tools	Tiffany Travers/ TidalHealth	Increase integration between behavioral health and primary care
Provide PHQ9 assessment through MyChart for primary care patients	June 2027	MyChart	Tiffany Travers & Jenny Harsin/ TidalHealth	Increase integration between behavioral health and primary care
PEARLS – MAC	Ongoing	Certified facilitators	Leigh Ann Eagle/ MAC	Support evidence-based program to address mild depression in the community
Develop and implement standardized SDOH screening and process	June 2027	Quality Council Members	Lisa Renegar, Quality Council/ WiCHD	Tool identified and implemented; better coordination between WiCHD programs and mental health providers

Appendix 9 | Behavioral Health Goal 2 Action Plans

GOAL 2: Reduce stigma and increase awareness of behavioral health services among special populations.

OBJECTIVE #2.1: Annually, maintain or increase the peer support specialists available in the Delmarva region to support those seeking behavioral health services and support.

BACKGROUND: Having peer support specialists in health settings is crucial for several reasons, all of which contribute to improved outcomes for individuals experiencing mental health or substance use challenges. Some of these reasons include shared lived experience and mutual understanding, reduction in hospitalization and healthcare costs, and improved quality of life and empowerment. Peer support specialists play a vital role in behavioral health by bridging gaps between clinical care and everyday recovery, fostering trust, increasing engagement, and supporting long-term wellness for individuals with mental health and substance use conditions.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Employ peer support specialists in the hospital and ambulatory settings	June 2027	Recruitment	Tiffany Travers/ TidalHealth	Peer Support Specialists employed
Maintain peer support specialists in behavioral health case management programs	Ongoing	Recruitment	Tasha Jamison/ WiCHD	Peer Support Specialist employed
Maintain peer support specialists at the Wellness and Recovery center	Ongoing	Recruitment	Shannon Frey/ SCHD	Peer support specialist employed

OBJECTIVE #2.2: Annually, maintain or increase the number of people completing Mental Health First Aid training in the Delmarva region.

BACKGROUND: Mental Health First Aid (MHFA) is a training program designed to teach individuals how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The course provides participants with the skills needed to offer initial help and support to someone who may be developing a mental health problem, experiencing a worsening of an existing condition, or going through a mental health crisis. MHFA is the equivalent of traditional first aid for mental health, empowering individuals to provide immediate support and connect those in need with appropriate care and resources.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Continue implementation of the MHFA initiative for youth and adults	June 2028	Certified Instructors and curriculum materials	Michelle Hardy/ WiCHD	Maintained and/or increased # individuals trained; improved mental health literacy, reduced stigma
Maintain/increase the number of certified MHFA instructors	Ongoing	LBHA staff	Michelle Hardy/ WiCHD	Maintained and/or increased # of MHFA Instructors

OBJECTIVE #2.3: Annually, increase awareness about and utilization of available behavioral health programs and services in the Delmarva region among the public and behavioral health system partners through tailored marketing and outreach efforts.

BACKGROUND: Making the public aware of available behavioral health resources is a critical strategy for improving the utilization of those services. Awareness campaigns and outreach efforts have several interconnected effects that directly contribute to increased engagement with behavioral health care such as reducing stigma, increasing knowledge and recognition, improving help-seeking behaviors, connecting people to resources, building community support, and encouraging earlier intervention.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result
Outreach, education, promotion of behavioral health services	Ongoing	Outreach materials	Tiffany Travers/ TidalHealth	Increased public awareness about behavioral health resources
Outreach, education, promotion of overdose prevention services, including naloxone, harm reduction, and training	Ongoing	Outreach materials, promotional materials, naloxone	Julie Willis, Jessica Taylor & Tasha Jamison/ WiCHD	Increased public awareness, reduced overdose deaths, increased access to care and support services, reduced stigma
Harm reduction vending machines	Ongoing	Vending machines	Tiffany Travers/ TidalHealth Jessica Sexauer/ WiCHD Andra Taylor/ SCHD	Work with health department partners to place harm reduction vending machines throughout the community
Continue the annual publication of the Tri-County Resource Guide for Behavioral Health	Annually	LBHA Staff	Michelle Hardy/ WiCHD	Increased awareness of behavioral health resources in the three lower shore Maryland counties.

Appendix 10 | Behavioral Health Goal 3 Action Plans

GOAL 3: Strengthen care coordination and integration across the behavioral health system.

OBJECTIVE #3.1: By June 2028, the Healthy Delmarva Partnership will align community efforts outlined in this CHIP with the Local Behavioral Health Authority strategic plans in the three Maryland counties to ensure coordination to best address behavioral health needs in the region.				
BACKGROUND: Local Behavioral Health Authorities (LBHAs) are county-level or regional agencies in Maryland responsible for overseeing the planning, management, and monitoring of the public behavioral health system within their jurisdictions. LBHAs ensure a network of providers delivers quality care to residents.				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**
Updated LBHA strategic plan established and demonstrates alignment with CHIP	March 2026	Wicomico LBHA Staff	Michelle Hardy/ WiCHD	Updated LBHA strategic plan published with alignment to CHIP
Wicomico LBHA will continue leading the LHIC Behavioral Health Workgroup	Ongoing through June 2028	Wicomico LBHA Staff	Michelle Hardy/ WiCHD	CHIP and LBHA Strategic Plan implementation reports