2019 – 2022
Implementation Strategy Plan
for TidalHealth Peninsula Regional

Community Health Improvement Plan
for Somerset County Health Department and Wicomico County Health Department

Fiscal Year 2022 Plan Update

Public Health
Prevent. Promote. Protect.
Somerset County
Health Department

Public Health
Prevent. Promote. Protect.
Wicomico County
Health Department

TidalHealth™

2019 – 2022 Implementation Strategy Plan
for TidalHealth Peninsula Regional
and
Community Health Improvement Plan
for Somerset County Health Department and
Wicomico County Health Department

Fiscal Year 2022 Plan Update

The 2019 – 2022 plan has been updated for Fiscal Year 2022 (July 1, 2021 – June 30, 2022).

- Several program activities and evaluation measures have been updated.
- A summary of FY20 and FY21 progress is provided in Appendices A and B.
- The document reflects the name change of Peninsula Regional Medical Center (PRMC) to TidalHealth Peninsula Regional. In January 2020, PRMC was re-branded to reflect the merge with McCready Health in Crisfield and Nanticoke Memorial in Seaford.
- The internal team staff members identified for TidalHealth Peninsula Regional, Somerset County Health Department, and Wicomico County Health Department has been updated to reflect staff changes.

Introduction

TidalHealth Peninsula Regional, in partnership with Somerset County Health Department (SCHD), and Wicomico County Health Department (WiCHD) is pleased to share their Implementation Strategy Plan, which follows the development of the 2019 Community Health Needs Assessment (CHNA). In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the TidalHealth Peninsula Regional Board of Directors on November 7, 2019. This document also serves as the Community Health Improvement Plan for the health departments and was approved by the Somerset Local Health Improvement Coalition (LHIC) on November 12, 2019, and approved by the Wicomico LHIC on December 6, 2019.

After a thorough review of the health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address using our resources, expertise, and community partners.

The following are the prioritized health needs that will be addressed:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Lung, Skin)

Each priority area selected, will also address access to care when possible and appropriate.

This Implementation Strategy summarizes the plans for TidalHealth Peninsula Regional, SCHD, and WiCHD to develop and/or collaborate on community benefit programs that address the prioritized health needs identified in the 2019 CHNA.

TidalHealth Peninsula Regional provides additional support for community benefit activities in the community that lay outside the scope of the programs and activities outlined in this Implementation Strategy. However, those additional activities will not be explored in detail in this document.

Additionally, this document includes the significant health needs that the partnership will not be addressing and why.

TidalHealth Peninsula Regional, SCHD, and WiCHD

TidalHealth Peninsula Regional is the 8th largest hospital in Maryland with 288 acute care beds, and the region's largest, most advanced tertiary care facility, which has been meeting the healthcare needs of

Delmarva Peninsula residents since 1897. Its 3,300 physicians, staff, and volunteers provide safe, compassionate, and affordable care designed to exceed the expectations of the nearly 500,000 patients who rely on the Medical Center team each year for inpatient, outpatient, diagnostic, sub-acute and emergency/trauma services. It is the region's oldest healthcare institution with the most experienced team of healthcare professionals. It also infuses over $500 million annually into its regional economy, and is the recipient of over 125 national awards, recognitions, and certifications in the past half-decade for the care it offers patients and the outcomes they experience.

Somerset County Health Department's (SCHD) mission is "Dedicated to serving the Public by preventing illness, promoting wellness and protecting the health of our community." The Health Department continues to evolve with the changes in the healthcare system and is currently in the planning stage of the Public Health Accreditation process.

Wicomico County Health Department's (WiCHD) mission is "To maximize the health and wellness of all members of the community through collaborative efforts." The public health department, accredited by the Public Health Accreditation Board on March 8, 2016, has expanded over the years to meet changing needs of the community and continually works toward protecting the health and environment of the people of Wicomico County.

TidalHealth Peninsula Regional, SCHD, and WiCHD service areas are jointly defined by Somerset, Wicomico, and Worcester counties in the state of Maryland. These three counties are referred to as the Tri-County Service Area. Additionally, the service area includes the 43 zip codes and associated census places and census tracts within those three counties.

Community Health Needs Assessment

In December 2018, TidalHealth Peninsula Regional, SCHD, and WiCHD published their 2019 Community Health Needs Assessment (CHNA). The CHNA Report provides an overview of significant health needs in the Tri-County Service Area. This CHNA report was developed to provide an overview of the health needs in the Tri-County Service Area, including Somerset, Wicomico, and Worcester counties in Maryland. TidalHealth Peninsula Regional, SCHD, and WiCHD partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the Tri-County Service Area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data, or data that has been previously collected, is the TidalHealth Creating Healthy Communities platform, a publicly available data platform that is embedded on the main TidalHealth Peninsula Regional website. That platform can be found here: https://www.tidalhealth.org/community-outreach-partners/community-health-research-data/creating-healthy-communities.

Priorities

On October 24, 2018, TidalHealth Peninsula Regional, SCHD and WiCHD came together to prioritize the significant health needs in a session facilitated by Conduent HCI consultants. Using a prioritization matrix, participants voted on the most critical needs while considering the following criteria:

- Importance of problem to the community
- Alignment with Maryland SHIP 2017 objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

The following three topics were selected as the top priorities:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Skin)

Each priority area selected, will also address access to care when possible and appropriate.

No one organization can address all the health needs identified in its community. TidalHealth Peninsula Regional, SCHD, and WiCHD are committed to serving the community by adhering to their mission, and using their skills, expertise, and resources to provide a range of community

benefit programs. This Implementation Strategy does not include specific plans to address other significant health needs including: Older Adults & Aging, and Oral Health.

These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. TidalHealth Peninsula Regional, SCHD, and WiCHD have other programs in these areas, but they are not the focus of this report.

Implementation Strategy Design Process

In April 2018, TidalHealth Peninsula Regional contracted with Conduent HCI to facilitate the Implementation Strategy process. TidalHealth Peninsula Regional, SCHD, and WiCHD assembled an internal team and created an inventory of existing programs in the chosen priority areas. Conduent HCI reviewed the inventory for those with an evidence base and those most applicable for community benefit. Conduent HCI also conducted research into additional evidence-based programs for consideration by the internal team. As a result, TidalHealth Peninsula Regional, SCHD, and WiCHD are committed to a portfolio of new and existing programs to create positive change for the prioritized health needs of their community.

TidalHealth Peninsula Regional, SCHD, and WiCHD Internal Team

Stakeholder	Organization/Title
Chris Hall	TidalHealth, Vice President, Strategy & Business Development
Kathryn Fiddler	TidalHealth, Vice President, Population Health Management
Henry Nyce	TidalHealth, Manager, Planning and Business Development
Logan Becker	TidalHealth, Planning Analyst
Allie O'Leary	TidalHealth, Population Health Data Analyst
Kat Rodgers	TidalHealth, Director, Community Health Initiatives
Lori Brewster	WiCHD Health Officer
Lisa Renegar	WiCHD, Health Planner, Office of Planning
Danielle Weber	SCHD Health Officer
Sharon Lynch	SCHD, Preventive Services & Communications Supervisor

Priority Areas

Behavioral Health

Goal 1: Address behavioral issues in the Tri-County Service Area by reducing the instances of opioid-related deaths.

Strategies:

- Collaboratively address the opioid crisis in the Tri-County Service Area with an emphasis on prevention, treatment, resources, and enforcement.
- Provide peer support for people who have overdosed or sought help for opioid addiction issues.

Goal 2: Address behavioral health issues in the Tri-County Service Area by prioritizing programs and services for seniors suffering with minor to major depression.

Strategies:

- Address depression in adults 50 years or older through skill building, problem solving, and socialization activities.

Objectives and Anticipated Impact for Goal 1:

- Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year.
    - **Evaluation Measures for Somerset County Opioid United Team**
        - # of individuals exposed to opioid related messaging through an advertising "campaign." Target - 7,000
        - # of individuals attending community events held in schools. Target - 600
        - # of individuals attending educational/training events held in the community. Target - 1500
        - # of additional officer hours dedicated to opioid related calls and initiative. Target - 480
        - % of overdose cases shared by Law Enforcement with the Health Department. Target - 100%
        - # of individuals referred to Peer Recovery Support Specialists (PRSS) from Law Enforcement. Target – 30
        - # of resource cards given to Law Enforcement Officers to disseminate to overdose patients, families, friends, and the community. 2000
        - # of individuals referred to PRSS from Emergency Department. Target – 20
        - # of individuals referred to PRSS from Law Enforcement. Target – 30.

        - # of individuals referred to treatment by PRSS. Target -25.
        - # of Individuals referred to treatment by PRSS who were admitted to treatment. Target - 15
    - **Evaluation Measures for Wicomico County Opioid Intervention Team**
        - # of OIT meetings held. Target- 25
        - # of community events where Opioid Coordinator was present and providing education to the community. Target- 10
        - # of Local Overdose Fatality Review Team (LOFRT) meetings attended- Target-10
        - # of individuals who attend CE (continuing education) trainings planned by OIT Coordinator- Target- 100
        - # of individuals exposed to messaging via tv, radio, or social media – Target- 60,000
        - # of times the OIT Educational Trailer is deployed in FY21 Target-10
        - # of Medication Disposal Bags provided to community members. Target-150
        - #of individuals provided education via OIT trailer- Target- 500
        - # of first responders who attended dinner and received education- Target-75

- Utilizing the Community Outreach Addictions Team (C.O.A.T.), contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues.
    - **Evaluation Measures**
        - # of contact attempts
        - # of opioid users contacted
        - # linked to treatment
        - % of those who receive treatment and remain in recovery for 6 months and beyond
- # supported through navigation services (increase access to insurance, primary care physicians, and social service benefits)Reduce avoidable or preventable Emergency Department (ED) Utilization
    - **Evaluation Measures for SWIFT**
        - # of patients served
        - Pre/Post analysis of hospital utilization for recipients of SWIFT

Objectives and Anticipated Impact for Goal 2:

- Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%
    - **Evaluation Measures**
        - # of community members enrolled
        - % of enrollees with reduction in level of depression maintained over 12 months

        - % of enrollees achieving remission of depression symptoms for at least 6 months
        -
- Increase Access to Care for Smith Island.
    - **Evaluation Measures for Smith Island:**
        - # patients served
        - # Medication refills
        - # of telehealth visits
        - # Office visits
        - # labs
        - # community BP
        - Pre/Post analysis of ED utilization for residents of Smith Island.

Recommended Policy Change:

- Align and integrate prevention and treatment efforts among public and private agencies.
- Design communications that help people understand detection, management, and decreased stigma of mental illness and their associated risk factors.

TidalHealth Peninsula Regional Resource Contributions:

- TidalHealth Peninsula Regional staff
- Data Collection
- Vehicles/Transportation
- Phone Service
- Staff training and materials as needed

Alignment Opportunities:

- TidalHealth Peninsula Regional as part of a regional partnership with Atlantic General Hospital in Worcester County, Worcester County Health Department, and SCHD and WiCHD are collaborating with the Maryland Health Service Cost Review Commission to develop a regional approach to behavioral health. The planning for the crisis stabilization center began in fiscal 2021. A 23-hour center will be located in Salisbury and an additional site will be located in Berlin with limited hours.
- The health departments and hospitals are also collaborating on a "Hub and Spoke" grant focusing on primary care offices that assist patients in initiating medication assisted treatment. This grant award continues through September 2024. WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health. Increasing access to care will be addressed in the priority areas.

Programs to Address Behavioral Health

1. **Community Outreach Addictions Team (C.O.A.T.)**

TidalHealth Peninsula Regional and WiCHD will build off the successful efforts that were included for this program in their 2016 Implementation Strategy Plan

Activities:

- Train peer support specialists
- Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues
- Provide connections to resources including treatment options
- Provide peer outreach to high risk areas of the community
- Maintain ongoing communications about metrics between TidalHealth Peninsula Regional and C.O.A.T. team
- Evaluate expansion to Somerset County
- Collaborate with TidalHealth Peninsula Regional to meet with any patient, 24/7, who has overdosed; C.O.A.T. will address barriers to treatment, such as insurance, transportation, etc.

Program Owner:

- Wicomico County Health Department

Program Collaborators:

- TidalHealth Peninsula Regional
- Somerset County Health Department
- Hudson Health Services, Inc.
- Lower Shore Clinic, Inc.
- Wicomico County Sheriff's Department
- Tri-County community Primary Care Physicians
- Law Enforcement
- EMS
- Office of the State's Attorney General
- Numerous other community providers assist with resources and access to program services

2. Wicomico County Opioid Intervention Team and Somerset County Opioid United Team

Activities:

- Bring awareness, education, and resources to the community to work toward reducing the stigma associated with addiction and substance use disorders.
- Provide OIT partners and stakeholders with continuing education opportunities, which include Harm Reduction focused trainings, with the ability to obtain continuing education credits.
- Target awareness activities and campaigns for the community, which will include a community event.

- Participation in drug awareness coalitions and other community meetings that seek to address the opioid epidemic.
- Provide education to the general community via the OIT educational trailer. This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use.
- Coordinate and host first responder dinner to help address compassion fatigue among the first responder population.
- Work with community partners to coordinate the Go Purple Substance Misuse Awareness Campaign

Program Owners:

- Wicomico County Health Department
- Somerset County Health Department

Program Collaborators:

- TidalHealth Peninsula Regional
- Wicomico County Health Department
- Somerset County Health Department
- Wicomico County Executive's Office
- Wicomico County Department of Emergency Services
- Wicomico County State's Attorney
- Wicomico County Sheriff's Office
- Maryland State Police Barrack E
- Fruitland Police Department
- Salisbury Police Department
- Natural Resource Police
- Pittsville Police Department
- Delmar Police Department
- Hudson Health Services, Inc.
- Maryland Coalition of Families
- Clarion Call Restoration Ministries
- MAC, Inc.
- Peninsula Addictions and Mental Health
- J. David Collins and Associates
- Second Wind, Inc.
- Focus Point Behavioral Health
- United Way of the Lower Eastern Shore
- SonRise Church 8
- Recovery Resource Center
- City of Salisbury Fire Department
- High Intensity Drug Trafficking Area (HIDTA) Program
- Eastern Shore Psychological Center
- Wor-Wic Community College
- Salisbury University

- Wicomico County Public Schools/Board of Education
- BNJ Health Services
- St. James AME Methodist Church
- Department of Social Services
- Department of Parole and Probation
- Sante Group/Mobile Crisis
- Life Crisis Center
- Community Behavioral Health
- Deer's Head Hospital Center
- Comcast Spotlight
- Lower Shore Clinic, Inc.
- DKH Recovery House
- Somerset County Emergency Services
- Crisfield Police Department
- Somerset County Sheriff's Office
- McCready Health
- Somerset County Department of Social Services
- Princess Anne Police Department
- Department Parole & Probation
- Crisfield Drug Free Community
- University of Maryland Eastern Shore
- Somerset Circuit Court
- Somerset Recovery Court
- Somerset County Public Schools

3. **Program to Encourage Active and Rewarding Lives (PEARLS)**

Activities:

- Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members
- Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one visits at locations convenient for the community member being served

Program Owner:

- TidalHealth Peninsula Regional

Program Collaborators:

- MAC, Inc.

4. **SWIFT**

Activities:

- SWIFT–a mobile integrated health team makes home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. The team provides physical, mental, and safety assessments, and screens for social determinants of health. Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in-home providers, financial and social resources, as well as other community resources as necessary.
- Update for FY2022 – The SWIFT program is expanding to a wider radius in Wicomico County outside of Salisbury. Additionally, an expanded model for SWIFT launched August 2021 in which a TidalHealth nurse practitioner and fire department paramedic respond in real time to low acuity 911 calls.
- TidalHealth is partnering with Salisbury University to distribute Narcan and provide Narcan training through the Community Wellness and SWIFT programs.

Program Owner:

- TidalHealth Peninsula Regional Program

Collaborators:

- City of Salisbury
- Wicomico County Health Department

5. Smith Island Primary Care and Telemedicine Access
Activities:

- TidalHealth provides primary care in person and via telemedicine to residents of Smith Island. A nurse practitioner and/or physician, pharmacist and other health care providers and educators travel to the island by boat throughout the year. A medical assistant is a resident of the island and provides health outreach and education as well as coordinates in person and telemedicine visits with the providers.

Diabetes

Goal: Improve health of people with diabetes or pre-diabetes in the Tri-County Service Area.

Strategies:

- Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County Service Area.
- Expand access to diabetes screening, education, and resources throughout the TriCounty Service Area through the TidalHealth mobile Community Wellness program.
- Provide a free evidenced-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset counties.

Objectives and Anticipated Impact:

- By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year.
    - **Evaluation Measures:**
        - # of 6-week classes
        - # of people reached
        - Class completion rate
        - % knowledge change

- By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program, which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.
    - **Evaluation Measures:**
        - # of screenings provided
        - Number of A1C's checked
        - # of community members referred for diabetes education
        - # of community members referred to their PCP

- Starting in September 2019 and ending in December 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; demonstrated behavior change and improved health status
    - **Evaluation Measures:**
        - % of adults with weight loss of at least 5% of their baseline body weight
        - % knowledge change
        - % reporting improved health status
        - # of adults enrolled in SCALE program
        - # of adults diagnosed as overweight or obese
        - # of adults diagnosed as overweight or obese with improved BMI or weight loss
        - # of adults with an increase in healthy lifestyle choices.

Recommended Policy Changes:

- Increase access to fresh fruits and vegetables through community-based initiatives.
- Increase active time in early childcare care sites and schools including physical education.

TidalHealth Peninsula Regional System Resource Contributions:

- Staff
- Data
- Marketing materials
- Training materials
- Mobile van

- Phone service
- Staff training and materials as needed

Alignment Opportunities:
- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health.

Programs to Address Diabetes

1. **Chronic Disease Self-Management (CDSM) Classes**

TidalHealth Peninsula Regional will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan

Activities:
- Target and identify patients who have diabetes and their caregivers through self-referral or provider referral
- Train Community Peer Trainers and TidalHealth Peninsula Regional Community Health Workers to conduct classes
- Offer classes in English, Spanish and American Sign Language
- Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages, based on availability of peer trainers in these languages
- Offer 6-week classes at least weekly
- Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers
- Partner with MAC, Inc. to collect data on pre and post A1C values
- Connect with the statewide Health Information Exchange to make referrals between providers office and Mac, Inc for all CDSM classes

Program Owners:
- MAC, Inc.

Program Collaborators:
- TidalHealth Peninsula Regional

2. **TidalHealth Community Wellness Program expansion**

TidalHealth Peninsula Regional and WiCHD will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan

Activities:
- Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care services.
- Provide screenings for diabetes (other screenings provided as well).

- Identify need for and make referrals to community resources for health education programs.
- Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up.
- Track rate of successful PCP follow up for all referrals.
- Identify barriers to accessing PCP follow up and work towards future solutions.
- Connect individuals with additional social and economic needs to a community health worker to address SDOH and self-management education.

Program Owners:

- TidalHealth Peninsula Regional

Program Collaborators:

- Wicomico, Somerset and Worcester County Health Departments
- HOPE
- HALO
- Salisbury Urban Ministries
- St. James AME
- St. Peter's Lutheran
- Resource and Recovery Center
- Atlantic Club
- Marion Pharmacy
- MAC, Inc
- National Kidney Foundation
- Wicomico County Schools
- Maryland Food Bank
- Various other community and faith-based organizations

3. Sustainable Change and Lifestyle Enhancement (SCALE)

Activities:

- Target outreach to overweight women of child bearing age (up to age 55) and overweight children ages 7 – 17
- Offer education and activities to encourage healthier eating and physical activity
- Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food

Program Owners:

- Wicomico County Health Department
- Somerset County Health Department

Program Collaborators:

- TidalHealth Peninsula Regional
- YMCA

- University of Maryland Eastern Shore
- Wicomico County Detention Center
- HOPE
- Community Health Providers

Cancer

Goal: Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer in the Tri-County Area.

Strategies:

- Partner with WiCHD and SCHD to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

Objectives and Anticipated Impact:

- Working in partnership with the WiCHD and SCHD offer additional cancer prevention programs and screening options for underserved community members, and connect those that need it to treatment
- Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities
    - **Evaluation Measures:**
        - # of individuals reached with cancer screening
        - # of individuals reached with prevention education
        - # of screenings conducted
        - % follow up post positive screening
        - # of patients connected to treatment
        - # events participated in

Recommended Policy Changes:

- Design culturally competent communications that help people understand the importance of screening for early detection
- Engage communities with health disparities to modify risky behaviors and to access resources for prevention

TidalHealth Peninsula Regional System Resource Contributions:
Providers for screening

Programs in Support of the Strategies

1. **TidalHealth Community Wellness Program and Cancer Institute**

Activities

- Increase knowledge in terms of cancer prevention and healthy lifestyle (American Cancer Society handout, etc.)
- Skin cancer screening
- Education
- Referral for cancer screenings

Program Owner:

- TidalHealth Peninsula Regional

Program Collaborators:

- Wicomico County Health Department
- Somerset County Health Department

Alignment Opportunities

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

APPENDIX A

FY 2020 Progress in Addressing Priority Areas				
BEHAVIORAL HEALTH PRIORITY AREA **Goal:** Address behavioral issues in the Tri-County Service Area by reducing the instances of opioid related deaths **Goal:** Address behavioral issues in the Tri-County Service Area by targeting seniors suffering with minor to major depression **Strategies:** • Collaboratively address the opioid crisis in the Tri-County Service Area with an emphasis on prevention, treatment, resources, and enforcement • Provide peer support for people who have overdosed or sought help for opioid addiction issues • Address depression in adults 50 years or older through skill building, problem solving, and socialization activities				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2020 Evaluation Data**
WiCHD	C.O.A.T.	• Train peer support specialists • Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues • Provide connections to resources including treatment options • Provide peer outreach to high risk areas of the community • Maintain ongoing communications about metrics between PRMC and C.O.A.T. team •Evaluate expansion to Somerset County	**Contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues** • of contact attempts • # of opioid users contacted • # linked to treatment • % of those who receive treatment and remain in recovery for 6 months and beyond • # supported through navigation services (increase access to insurance, primary care physicians, and social service benefits)	• 1,413 Contact Attempts • 240 served* • 119 linked to treatment* •6 month follow-up data to be reported in FY21** •260 Navigation Services * * *Data for the categories marked, do not include data from July 1, 2019 - December 31, 2019 due to a change in data collection and data operationalization.* ***This measure assesses progress of individuals served the prior fiscal year. Data collection began January 2020. Six months of data will be reported in the FY21 report.*

SCHD WiCHD	Opioid Teams	• Bring awareness, education, and resources to the community to work toward eliminating opioid abuse • Target awareness activities and campaigns to the community and schools • Participation in drug awareness coalitions • Narcan training for community members • Develop and implement an OIT educational trailer for parents, guardians, and adults This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use • Coordinate and host first responder dinner to help address compassion fatigue • Work with community partners to coordinate the Go Purple Awareness Campaign	**Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year** • Monthly data from ED visits on opioid overdoses collected and reported to the count • # of individuals Narcan trained • # of individuals exposed to educational messaging • # of prescription drug deactivation bags distributed in the community • # of educational/training events • # of OIT meetings held • # of informational campaigns • # of schools with Go Purple Clubs • # of school based educational Go Purple events	Data is for Somerset and Wicomico Counties • 131 ED visits • 140 Salisbury Fire Dept. Overdose Calls • 319 Narcan Trained • 333,930 exposed to educational messaging • 350 deactivation bags distributed • 66 educational/training events • 37 meetings held • 14 informational campaigns • 8 Go Purple School Clubs • 26 School Go Purple Events
Tidal Health (contracts with MAC)	PEARLS	• Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members • Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one	**Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%** • # of community members enrolled • % of enrollees with reduction in level of depression maintained over 12 months	• 128 participants enrolled • 38 Active (in-person) • 17 Active (completed and follow-up) • 1 Active (screened out) • 34 Inactive (completed) • 39 Disenrolled or dropped out • 79% enrollees achieved reduction in level of depression • 65% of enrollees achieved remission of depressive symptoms for at least 6 months

		visits at locations convenient for the community member being served	• % of enrollees achieving remission of depression symptoms for at least 6 months	
Tidal Health	ER Utilization Reduction & Access Improvement Wagner Wellness Van; SWIFT; and Smith Island Telemedicine	• Mobile unit conducts home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. •The team provides physical, mental, and safety assessments, and screens for social determinants of health. •Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in-home providers, financial and social resources, as well as other community resources as necessary.	**Reduce emergency department utilization of high end users as well as increase access for Smith Island** • # of patients • # refills • # telehealth visits (office, lab and community) • # SWIFT patients served	Smith Island Telemedicine: • Total patients: 184 • Medication refills: 18 • Telehealth visits: 46 • Office: 32 • Lab: 14 • Community BP: 27 SWIFT: • 112 SWIFT Patients served
DIABETES PRIORITY AREA **Goal:** Improve health of people with diabetes or pre-diabetes in the Tri-County Service Area **Strategies:** • Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County Service Area • Expand access to diabetes screening, education, and resources throughout the Tri-County Service Area with the Wagner Wellness Van mobile clinic services • Provide a free evidenced-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset Counties				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2020 Evaluation Data**

Tidal Health (contracts with MAC)	CDSM Classes	• Target and identify patients who have diabetes and their caregivers through self-referral or provider referral • Train Community Peer Trainers and PRMC Community Health Workers to conduct classes • Offer classes in English, Spanish and American Sign Language • Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages, based on availability of peer trainers in these languages. • Offer 6-week classes at least weekly • Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers • Partner with MAC, Inc. to collect data on pre and post A1C values • Connect with the Statewide Health Information Exchange to make referrals between providers and MAC, Inc. for all CDSM classes	**By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year** • # of 6-week classes • # of people reached • Class completion rate • % knowledge change	• 14 workshops completed • 105 people reached • 71% completion rate
Tidal Health	Wagner Wellness Van Expansion	• Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care ser Provide screenings for	**By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program,**	• 690 screenings • 138 outings • Screening events: 37 • 1,097 patients reached • 150 Diabetes Screenings

		diabetes (other screenings provided as well) • Identify need for and make referrals to community resources for health education programs • Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up • Track rate of successful PCP follow up for all referrals • Identify barriers to accessing PCP follow up and work towards future solutions	**which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.** • # of screenings provided • Number of A1C's checked • # of community members referred for diabetes education • # of community members referred to their PCP	• 9 A1cs • 7 referred to PCP **Please note that every patient seen in outreach is offered the pre-diabetes risk assessment. If their score is 5 or above, they are given education by the nurses. If the score is very high (8 or above), they are given education, referred to PCP, and/or finger stick glucose or A1c is performe*d.
SCHD WiCHD	SCALE	• Target outreach to overweight women of child bearing age (up to age 55) and overweight children ages 7 – 17 • Offer education and activities to encourage healthier eating and physical activity • Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food	**Starting in September 2019 and ending in June 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; 20% of adults participants will report a drop-in hemoglobin A1C by 0.2 point or more; 20% of adult participants will report a decrease in blood pressure (diastolic and systolic) by 5 points or more; demonstrated behavior change and improved health status** • % of adults with weight loss of at least 5% of their baseline body weight • % of adults with a drop in A1C levels by 0.2 point or more. • % of adults reporting decrease in blood pressure by 5 points or more • % knowledge change • % reporting improved health status	Data is for Somerset and Wicomico Counties • 50 adults enrolled • 22 Somerset • 28 Wicomico • 18 adults completed program • 11 Somerset • 7 Wicomico • 10 children enrolled • 1 Somerset • 9 Wicomico • 1 child completed program (Somerset) • 26% reported weight loss of at least 5% of body weight • 26% Somerset • 0% Wicomico • % unknown for drop in A1C levels • % unknown for decrease in blood pressure • % adults demonstrated behavior change • 100% Somerset • unknown Wicomico • % unknown for improved health status

CANCER PRIORITY AREA

Goal: Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer in the Tri-County Area.

Strategies:

- Partner with WiCHD and SCHD to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2020 Evaluation Data**
Tidal Health	Wagner Wellness Van Expansion	• Clinical breast exams • Skin cancer screening • Education • Referral for cancer screenings	**Working in partnership with the WiCHD and SCHD offer additional cancer prevention programs and screening options for low income community members, and connect those that need it to treatment** **Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities** • # of screenings conducted • % follow up post positive screening • # of patients connected to treatment • % knowledge increase of cancer prevention	Two cancer screening events in the tri-county area. 1) Westover event to reach Haitian/Creole population. Partnered with Somerset Health Department by having the BCCP booth next to TidalHealth. There were trust issues at first with not wanting to do the breast exam on the van, but we worked through that and were able to connect them that day with BCCP. 2) Salisbury – Primarily Hispanic population. We had hoped to do an oral cancer screening event on the van, but have not been able to do this because of COVID. We are focusing/prioritizing communities/populations in Somerset County with our cancer screening efforts because of the disproportionately high prevalence of cancer. We have resumed lung cancer screenings at the hospital and would like to outreach to the community about this service. We typically have skin cancer screening events four times a year, but these have been on hold because of COVID. As we start to get the van back out into the communities, we are hoping to resume these screenings.

APPENDIX B

FY 2021 Progress in Addressing Priority Areas				
BEHAVIORAL HEALTH PRIORITY AREA **Goal:** Address behavioral issues in the Tri-County Service Area by reducing the instances of opioid related deaths **Goal:** Address behavioral issues in the Tri-County Service Area by targeting seniors suffering with minor to major depression **Strategies:** • Collaboratively address the opioid crisis in the Tri-County Service Area with an emphasis on prevention, treatment, resources, and enforcement • Provide peer support for people who have overdosed or sought help for opioid addiction issues • Address depression in adults 50 years or older through skill building, problem solving, and socialization activities				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2021 Evaluation Data**
WiCHD	C.O.A.T.	• Train peer support specialists • Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues • Provide connections to resources including treatment options • Provide peer outreach to high risk areas of the community • Maintain ongoing communications about metrics between PRMC and C.O.A.T. team •Evaluate expansion to Somerset County	**Contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues** • of contact attempts • # of opioid users contacted • # linked to treatment • % of those who receive treatment and remain in recovery for 6 months and beyond • # supported through navigation services (increase access to insurance, primary care physicians, and social service benefits)	• 421 served • 176 served with history of Opioid Disorder • 236 Wicomico Residents linked to treatment • 42 non-residents linked to treatment •Attempted contact with 234 for 6 month follow-up. Made contact with 56. Of those contacted, 45 or 80.3% remained in recovery. • 261 Navigation Services provided to 171 individuals

SCHD WiCHD	Opioid Teams	• Bring awareness, education, and resources to the community to work toward eliminating opioid abuse • Target awareness activities and campaigns to the community and schools • Participation in drug awareness coalitions • Narcan training for community members • Develop and implement an OIT educational trailer for parents, guardians, and adults This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use • Coordinate and host first responder dinner to help address compassion fatigue • Work with community partners to coordinate the Go Purple Awareness Campaign	**Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year.** *Evaluation Measures for Somerset County Opioid United Team (SCOUT):* • # of individuals exposed to opioid related messaging through an advertising "campaign." Target - 7,000 • # of individuals attending community events held in schools. Target - 600 • # of individuals attending educational/training events held in the community. Target - 1500 • # of additional officer hours dedicated to opioid related calls and initiative. Target - 480 • % of overdose cases shared by Law Enforcement with the Health Department. Target - 100% *Evaluation Measures for Wicomico County Opioid Intervention Team (OIT)*: • # of OIT meetings held. Target- 25 • # of community events where Opioid Coordinator was present and providing education to the community. Target- 10 • # of Local Overdose Fatality Review Team (LOFRT) meetings attended- Target- 10 • # of individuals who attend CE (continuing education) trainings planned by OIT Coordinator- Target- 100 • # of individuals exposed to messaging via tv, radio, or social media – Target- 60,000	***Somerset County Opioid United Team (SCOUT):*** • 306,389 individuals exposed to opioid related messaging (Shore Birds stadium 50,000 fans, Clear Channel Billboard 106,389 impressions, The Voice radio station 150,000 listeners.) • Due to COVID-19 no community events at schools were held in FY21 • Due to COVID-19 no education/training events were held in the community in FY21. However, bags were provided that advertised Somerset OIT grant with educational information to the increasing food pantries that popped up due to COVID-19. • 368.75 additional officer hours dedicated to opioid related calls and initiatives were funded by this grant. • 100 overdose cases shared by Law Enforcement with the Health Department. ***Wicomico County Opioid Intervention Team (OIT)*:** • 15 OIT Meetings held. COVID-19 impacted the # of meetings held. • 16 community events were held. 14 of these were Narcan trainings. • 11 Local Overdose Fatality Review Team meetings held. • 70 individuals attended CE trainings. • 76,103 post reaches were made via Facebook, 15,000 resource mailers were sent to residences in Wicomico County which included SUD resources, and 76.11k impressions were made by utilizing digital advertising. • OIT trailer was only deployed at 1 event in FY21 due to COVID restrictions. • 60 Medication bags provided. • 100 provided education via OIT trailer. Efforts impacted by COVID-19.

			• # of times the OIT Educational Trailer is deployed in FY21 Target-10 • # of Medication Disposal Bags provided to community members. Target- 150 • #of individuals provided education via OIT trailer- Target- 500 • # of first responders who attended dinner and received education- Target-75	• Appreciation dinner not held due to COVID-19. 24 appreciation baskets sent to each local agency in lieu of dinner.
Tidal Health (contracts with MAC)	PEARLS	• Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members • Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one visits at locations convenient for the community member being served	**Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%** • # of community members enrolled • % of enrollees with reduction in level of depression maintained over 12 months • % of enrollees achieving remission of depression symptoms for at least 6 months	• 143 enrolled • 141 screened • 71 with 6 or more sessions • 51% total remission of depressive symptoms • 59% achieved a response
Tidal Health	ER Utilization Reduction & Access Improvement Wagner Wellness Van; SWIFT; and Smith Island Telemedicine	• Mobile unit conducts home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. •The team provides physical, mental, and safety assessments, and screens for social determinants of health.	**Reduce emergency department utilization of high end users as well as increase access for Smith Island** *Evaluation Measures for Smith Island Telemedicine:* • # patients served • # Medication refills • # of telehealth visits • # Office visits • # labs • # community BP *Evaluation Measures for SWIFT*	• Labs 126 • Telehealth 32 • Office 68 • Med refill 42 • Bp 48 • COVID-19 test 55 (most were health department issued) • Flu shots 58 • Pneumonia 3

		•Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in-home providers, financial and social resources, as well as other community resources as necessary.	• # patients served	

DIABETES PRIORITY AREA
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- Expand access to diabetes screening, education, and resources throughout the Tri-County Service Area with the Wagner Wellness Van mobile clinic services
- Provide a free evidenced-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset Counties

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		languages, based on availability of peer trainers in these languages • Offer 6-week classes at least weekly • Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers • Partner with MAC, Inc. to collect data on pre and post A1C values • Connect with the statewide Health Information Exchange to make referrals between providers office and Mac, Inc for all CDSM classes		
Tidal Health	Wagner Wellness Van Expansion	• Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care ser Provide screenings for diabetes (other screenings provided as well) • Identify need for and make referrals to community resources for health education programs • Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up • Track rate of successful PCP follow up for all referrals	**By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program, which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.** • # of screenings provided • Number of A1C's checked • # of community members referred for diabetes education	• No A1cs were done due to licensing constraints during the pandemic emergency. We did refer 11 people to their PCP for elevated blood pressures during this time.

		• Identify barriers to accessing PCP follow up and work towards future solutions	• # of community members referred to their PCP	
SCHD WiCHD	SCALE	• Target outreach to overweight women of child bearing age (up to age 55) and overweight children ages 7 – 17 • Offer education and activities to encourage healthier eating and physical activity • Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food	**Starting in September 2019 and ending in June 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; 20% of adults participants will report a drop-in hemoglobin A1C by 0.2 point or more; 20% of adult participants will report a decrease in blood pressure (diastolic and systolic) by 5 points or more; demonstrated behavior change and improved health status** • % of adults with weight loss of at least 5% of their baseline body weight • % knowledge change • % reporting improved health status • # of adults enrolled in SCALE program • # of adults diagnosed as overweight or obese • # of adults diagnosed as overweight or obese with improved BMI or weight loss • # of adults with an increase in healthy lifestyle choices.	*Due to COVID-19, the grant has been extended to December 2021. Both counties held classes virtually due to COVID-19. ***Somerset County Classes:*** • 14 Adults enrolled • 57% reported at least 5% weight loss from baseline • 100% demonstrated knowledge change • 85% reported improved health status • 10 individuals diagnosed as overweight or obese; 2 had improved BMI after class • 9 individuals had increase in healthy lifestyle choices ***Wicomico County Classes:*** • 8 Adults enrolled • 95% reported at least 5% weight loss from baseline • 100% demonstrated knowledge change • 50% reported improved health status • 7 individuals diagnosed as overweight or obese; 7 had improved BMI after class

CANCER PRIORITY AREA

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