UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

BEHAVIORAL HEALTH

Outcome:

1. Reduced emergency room visits and inpatient admissions for behavioral health patients while providing comprehensive behavioral health services that will serve the entire County; and provide the Community an easy-to-access alternative to the hospital emergency room for behavioral health (mental illness and substance use) crises.
2. Improved Behavioral Health in the Harford County community.
3. Increased knowledge and awareness for University of Maryland Upper Chesapeake Health (UMUCH) Team Members on substance abuse and the resources available in the community.

Goals:

1. The Klein Family Harford Crisis Center (KFHCC) will be a Behavioral Health hub for the County, providing a trauma-informed continuum of care including: A 24/7 Behavioral Health Crisis Warmline/Hotline, a Behavioral Health Urgent Care Center for triage, assessment and referral, Outpatient therapy/psychiatry and Residential Crisis Beds (approximate length of stay of 3 days). The need for additional services, such as Intensive Case Management for guests accessing care at the KFHCC, local emergency departments, or through local community stakeholders will be explored in order to further stabilize the assessment/treatment initially received through the KFHCC.
2. To provide an educational, clinical, and management program that works to prevent or improve behavioral health issues in the Harford County community.
3. To provide education and support to UMUCH team members in relationship to substance abuse.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care The KFHCC will be recognized as the County's Behavioral Health hub (i.e., first stop for assessment, intervention, and linkage to necessary community resources.)	Provide at least 3 podcasts each year on topics related to behavioral health/substance use and the impact trauma has on individuals and families. Participation in community stakeholder meetings to inform of KFHCC service provision and performance:	LEAD: UMUCH Behavioral Health (UMUCH BH) Harford County Mobile Crisis Team Office on Mental Health Local law enforcement agencies Behavioral Health providers across Harford County	A reduction of behavioral health visits to UMUCH Emergency Departments. A reduction of behavioral health admissions from the Bel Air area to the Harford Memorial Hospital Behavioral Health Unit.	Ongoing

	• Mental Health Addiction Advisory Council/Local Health Coalition – Behavioral Health Workgroup/Harford County Opioid Intervention Team Meeting • All (Behavioral Health) Providers Meeting • Crisis Response Provider Meeting • Office on Mental Health Board Meetings • Police Commission Meeting • QPR (Question, Persuade, Refer) /Suicide Prevention Workgroup • Involuntary Commitment Stakeholders Meeting • Law Enforcement Assisted Diversion Operational Workgroup		A decrease in length of stay on the behavioral health inpatient unit through the use of step-down services at the KFHCC.	
Consider expanding Collaborative Care model of care into 1-2 more practices. (This evidence-based model of care provides integrated behavioral health and physical health care within the primary care physician's office.)	Through the use of telehealth, collaborative care clinical staff could increase the ability to service more individuals in need of behavioral health and psychiatric care within the primary care physicians office.	LEAD: UMUCH BH UMUCH affiliated Primary Care physician practices	Number of patients accessing behavioral health care through collaborative care model, decreasing stigma associated with access behavioral health care.	Ongoing

UMUCH Leadership Role in guiding the County towards becoming Trauma-Informed	Development of the Harford County Trauma Institute's Trauma-Informed Care Steering Committee Creation of an action plan that addresses Awareness, Treatment/Intervention and Prevention efforts for the County re: Trauma-Informed Care. Use of Peers with lived experience (mental health and/or substance use) in the ED's and KFHCC	LEAD: UMUCH BH Office on Mental Health Law Enforcement agencies State's Attorney's Office Harford County Public Schools (HCPS) Harford County Health Department (HCHD) Office of Drug Control Policy Department of Social Services Department of Juvenile Services Parole and Probation Local Behavioral Health Providers Local Business Owners/Managers	Enhanced awareness re: impact of trauma on an individual's physical and mental health Improved and increased linkages to behavioral health services Increased use of mobile crisis services and KFHCC vs. law enforcement for behavioral health crises with the goal of decreasing hospitalizations and emergency petitions and appropriate linkage to care/community resources	May: Steering Committee established December: Action Plan created Work will be ongoing
	Care Transformation Organization (CTO) Program: screens patients and their families for behavioral health issues and makes the appropriate referrals. Promotion of existing resources and encouraging at risk populations to engage.	LEAD: CTO Healthy Harford (HH) UMUCH Community Outreach and Health Improvement (CO/HI) HCHD Care Coordination Plus (CC+) Program County mental health and substance use disorder agencies and organizations HCPS	Medicare patients linked with CTO affiliated primary care providers have access to social work services for behavioral health coordination and counseling support services. There are 14 PCP practices in Harford County that participate with the CTO program.	Ongoing
Support Groups and Self-Management KFHCC	 Behavioral Health Support Group for Families/Friends	 LEAD: UMUCH BH Various community agencies	 Number of attendees and participation rate	 Ongoing

	AA/NA meetings on site at KFHCC	Peer Recovery Coaches and AA/NA community	Increased opportunity for the community to associate recovery and support with the KFHCC Decrease stigma/anxiety re: participating in a 12-Step meeting for Residential crisis Bed guests	Start date: TBD: Held Monthly Start date TBD: Weekly
Support Groups and Self-Management Community	Evidence based classes: Chronic Pain Self-Management Program (CPSMP)	LEAD: UMUCH CO/HI KHFCC Harford County physicians Harford County Public Libraries (HCPL) MAC, Inc. - Maintaining Active Citizens – Agency on Aging	Number of completers for program Completer survey results	Ongoing
Education	Provide educational classes specific to behavioral health: • Mental Health First Aid • QPR • How nutrition affects depression and anxiety • Linkages between diabetes and depression	LEAD: UMUCH BH HH UMUCH Diabetes and Endocrine Center HCHD HCG	Increased and improved education regarding preventing and coping with mental illness.	Ongoing
	Educate patients a families on local mental health resources for Women and Children	LEAD: UMUCH W&C KFHCC HCHD In-Patient Pediatric Department	Decreased number of in-patient mental health admissions for Women and Children	7/2021 – 6/2023

		Family Birth Place (FBP) and other department which for women Local providers		
Transition of Care	CTO affiliated PCP practices work with Medicare patients in the community to ensure that they are linked to necessary services to reduce or eliminate future avoidable Emergency Department (ED) visits, inpatient stays and hospital readmissions.	LEAD: CTO HH HCHD HCG Mental Health providers Department of Human Services (DHS) KFHCC HC Office on Aging (HC OOA) UMUCH Foundation	Reduced or eliminate future avoidable ED visits, inpatient stays and hospital admissions. Improved patient outcomes.	Ongoing
Policy	Work with the Harford County Sheriff's Office to provide crisis management assistance as part of their Crisis Intervention and Crisis Negotiation Teams.	LEAD: UMUCH Behavioral Health HH HCG HCSO	De-escalated mental health crisis situations.	Ongoing
	Support legislation that improves access to mental health and mental health crisis care	LEAD: HH	Preserve Telehealth Act – parity reimbursement Healing MD's Trauma Act-ACEs Thomas Bloom Raskin Act – mental health check in's	

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS

Outcome:

1. Improved care coordination and continuity of care for identified high risk, rising risk and high ED utilizers through navigation services insuring these patients receive the right care in the right setting.
2. Decreased avoidable ED utilization for identified high risk.
3. Improved general wellness in Harford County with a reduction on chronic disease burden.
4. Improved education and awareness of prevention and wellness through community programming, health screenings, and vaccinations.

Goals:

1. To reduce the number of avoidable ED and observation visits and inpatient admissions of individuals in our community.
2. To provide a comprehensive plan, including educational, clinical, and policy components that addresses the chronic disease burden, injury prevention and quality of life issues in the Harford County community.
3. To increase the number of community members that participate in the offered wellness screenings and health education programs.
4. To develop new partnerships with businesses and community organizations and physicians' offices to engage and refer community members who are in need of programs and screenings.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	Medicare patients linked with CTO affiliated primary care providers have access to case management staff who provide psycho/social and clinical support for high utilizer patients post discharge and via referral.	LEAD: UMUCH CCC UMUCH CTO/WATCH HCHD Harford County Housing HC OOA Community Action Agency (CAA) HHC Providers	Reduced or eliminate future avoidable ED visits, inpatient stays and hospital readmission. Improved patient outcomes.	Ongoing
	Comprehensive CARE Center (CCC): Transition Nurse Navigators, RN Case Managers, Social Workers, and Pharmacist – Ensures continuity of care through education, disease management, medication	LEAD: CCC CTO Program HH Primary Care Physicians (PCP) Pulmonologist Cardiologist Other identified specialists HCHD	Decreased number of avoidable ED visits and inpatient admissions. Increased patient access to needed services.	Ongoing

	and symptom review, and coordinate care with appropriate community resources including arrangement of transportation. CCC patients are assessed for needed services such as palliative care, Advance Directive and Maryland Medical Orders for Life-sustaining Treatment (MOLST) forms. The CCC has worked to address early onset of COVID symptoms but creating a Monoclonal Antibody Infusion site for COVID pts	HC OOA Home Health Agencies Skilled Nursing Facilities Faith Based Community CAA	Reduced admission, symptoms and mortality of COVID pts by receiving MAB infusion.	
Support Groups and Self-Management	CHF Shoprite Store Tour- Provides enhanced education on dietary needs and challenges to patients with CHF in our community. The CCC holds a COVID Support Group 1x/month (may look to expand as need arises)	LEAD: CCC Klein's Shoprite LEAD: CCC	Increased number of CHF individuals participating in nutrition education specific to their disease. Address mental health and provide support to COVID pts in the community.	Ongoing
	Chronic Disease Self-Management Program (CDSMP)	LEAD: UMUCH CO/HI CCC HH HCHD HCPL Faith based community HC OOA	Increased knowledge of the individual's' chronic condition. Improved ability to self-manage the individual's chronic condition.	Ongoing

		MAC, Inc. - Maintaining Active Citizens – Agency on Aging	Improved utilization of needed health care services.	
Education	Provide chronic disease, medication, and durable medical equipment education. Provide education and access process to community programs, resources, and community outreach screenings throughout the County. Provide community health and wellness education, healthy lifestyle education, health screenings, and outreach throughout the County.	LEAD: CCC UMUCH CO/HI UMUCH Heart and Vascular institute UMUCH Stroke Center UM Cooperative Extension HH HCHD HCPS/Private HCG Faith Based Community Community Based Organizations Local Businesses Local Municipalities Bel Air Aberdeen Havre de Grace HC OOA TasteWise Kids Aberdeen Proving Group (APG)	Increased number of community residents educated on health and wellness. Improved health and wellness with a reduction of chronic disease in the residents of Harford County.	Ongoing
Policy	Work with local partners to create a more walkable, bikeable community.	LEAD: HH HCG Department of Planning and Zoning Baltimore Metropolitan Council (BMC) Local municipalities Bike Harford Chesapeake Spokes, Bike Maryland, Harford Traffic Safety Advisory Board	Improved health outcomes through improved physical activity, and improved social determinants of health through greater access to opportunities due to improved transportation options.	Ongoing
	Create and sustain access to Community gardens.	LEAD: HH UM Cooperative Extension Community Based Organizations United Way Chosen HCPS	Improved access to fresh produce.	

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: TOBACCO USE PREVENTION

Outcome:

1. Decreased number of Harford County adults and youth using tobacco and nicotine products.
2. Increased education and awareness of the harmful effects of tobacco and nicotine product usage.

Goals:

1. To decrease the Harford County adult smoking rate (20.6) to be equal to or less than the Maryland rate (13.1). 2011-2019 BRFSS
2. To decrease the youth electronic vapor product use percentage (29.3) to be equal to or less than the Maryland percentage (23.0). 2014 -2018 YRBSS
3. To improve knowledge and awareness to Harford County residents about the dangers of tobacco and nicotine usage.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	Provide tobacco cessation information to Harford County residents through Maryland Health Matters, UMUCH and HH website and social media, HealthLink Call Center, and Kaufman Cancer Center (KCC).	LEAD: KCC UMUCH CO/HI CTO Program HH HCHD HC OOA Faith Based communities	Increased number of enrolled Harford County residents in Smoking Treatment classes. Decreased number of Harford County residents both adults and youth using tobacco and nicotine products.	Ongoing
Support Groups and Self-Management	Tobacco Treatment Programs: KCC will offer 4 six-week educational class series led by a certified Tobacco Cessation expert. These free classes are open to the community at large. We are currently evaluating best practices for tobacco cessation to engage more participants.	LEAD: Cancer LifeNet (CLN) UMUCH CO/HI Greta S. Brand & Associates, Inc. HCHD Community Physician Practices	Increased number of enrolled Harford County residents in Smoking Treatment classes. Decreased number of Harford County residents both adults and youth using tobacco and nicotine products.	Ongoing

Education	Provide education on smoking, tobacco use, and vaping at health events, business, schools and the faith-based community throughout the County.	LEAD: UMUCH CO/HI HCHD HCPS KCC Faith Based communities Local Businesses Local Municipalities APG	Decreased number of Harford County residents both adults and youth using tobacco and nicotine products.	Ongoing

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: CANCER

Outcome:

1. By 2025, reduce the age-adjusted cancer incidence & mortality rates consistent with reduction goal for Maryland's Incidence & Mortality & High Burden Cancer Targets (pg. 65-71; Maryland Comprehensive Cancer Control Plan 2020-2025)
2. Improved education and awareness of cancer prevention and wellness through community programming, cancer screenings, and vaccinations.
3. Reduce cancer disparities through education and awareness programs targeted to disadvantaged populations.

Goals:

1. To provide services to any resident of Harford County impacted by cancer to assure timely access to time care; navigation throughout the health care system during, pre-diagnosis, diagnosis, treatment, and transitional survivorship, long-term survivorship, and transition to end-of-life care as indicated through the CLN Program at the KCC.
2. To increase participation at community cancer screenings.
3. To improve Harford County resident's knowledge and awareness of life styles that can reduce certain kinds of cancer.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	Offer nurse navigation, dietician and social work services to assist all Harford County residents, with a diagnoses of cancer, free of charge with obtaining access to care for clinical services, diagnostic procedures, treatment and distress management due to their cancer, regardless of where they plan to receive their treatment.	LEAD: KCC Community-based Physicians CTO Program HH HCHD HC OOA American Cancer Society (ACS) Red Devils (503c)	1700 Harford County individuals will be served annually	Ongoing
Access to Care	Provide annual cancer screenings (skin, adolescent melanoma, lung, colorectal, and oral head and neck).	LEAD: KCC UMUCH CO/HI HCPS HCHD Maryland Cancer Collaborative ACS	Offer 120-150 site-specific screening events/year. Offer walk in mammograms 50-60 days/year	ongoing

	Provide education and access to underserved populations to increase awareness.	HC OOA Religious Affiliations Community Based physicians	Increased number of African American women in the BCCP by 30%	
Transportation Coordination & Assistance	Provide limited funding for those who do not have access to public transportation, MA transportation services, or when timely arrangement with Harford Transit or MA Transportation services is a barrier to patients receiving timely treatment. Provide free taxi and Harford Transit vouchers for buses as needed for those in financial need to assure access to care. CLN Social Worker & Program Assistant coordinates scheduling of patients receiving care at the KCC	LEAD: KCC CLN UMUCH Foundation (503c) UM UCMC shuttle service Harford County MA Transportation Services Harford Transit The Red Devils (503c) Kelly's Dream Foundation (503c) Taxi cab companies	600 rides coordinated annually. 95% of scheduled appointments for individuals requiring transportation assistance will be met.	Ongoing
Transition of Care--	Provide coordinated care for patients in our community admitted to other acute care facilities and sub-acute care facilities to assure continuation of cancer treatment and minimize patients need for hospitalization and ED care.	LEAD: KCC CLN Sub-acute Care facilities	100% of patients from sub-acute facilities requiring cancer therapies will have access to the care as indicated.	Ongoing
	Provide coordinated care for patients in our community admitted to Hospice Care at home or in the hospice facility.	LEAD: KCC CLN Hooper House Community Hospice Agencies	Increased in patient days in hospice by 20% (>3 days)	Ongoing

Clinical Care/Pathways	Follow national evidence-based guidelines for each cancer disease site.	LEAD: KCC	Survey and Accreditation by: • Commission on Cancer Accreditation • National Accreditation Program for Breast Center Patient satisfaction Survey scores	 2023 2022 Ongoing
Support Groups and Self-Management—	Provide monthly support group meetings for the patient populations listed below. These programs are open to community regardless of where the patient is receiving treatment. The purpose of these groups are to provide expert speakers, education and support. • Blood Cancer Support Group • Breast Cancer Support Group • CLIMB—Children's Support Group • Head & Neck Cancer Support Group • Prostate Cancer Support Group • Healing Through Support Sponsor yearly free celebratory cancer survivor event – virtual format or on-site. Provide Cancer Thriving & Surviving Program - a six-week evidence	LEAD: KCC CLN Leukemia & Lymphoma Society Children's Treehouse Foundation ACS LEAD: CLN UMUCH CO/HI LEAD: CLN UMUCH CO/HI	Offer 70-80 group sessions annually increasing support for current cancer patients and their families as well as survivors and their families. 100-200 on-site 50-100 virtually 24 sessions/year	Ongoing Annually Ongoing

	based chronic disease management program for cancer survivors and their caregivers.	MAC, Inc. - Maintaining Active Citizens – Agency on Aging		
Exercise and Wellness programs	Provide programming that promotes exercise, Yoga, meditation, nutrition education, wellness, etc. for patients undergoing and recovering from cancer treatment.	LEAD: KCC CLN Various contracted and volunteer individuals	Offer 150-200 classes/session annually	Ongoing
Integrative Therapies	Provide services to assist patients undergoing cancer treatment with reducing distress and managing their wellness with the goal of overall wellbeing. • Meditation Classes • Mindfulness-based stress reduction classes • Yoga Classes • Master Gardening Classes for relaxation and wellness • Massage Therapy - check with Patsy about CLN plan	LEAD: CLN Various contracted and individuals	Increased number of health and wellness resources for patients undergoing current cancer treatment.	Ongoing
	Provide a free acupuncture clinic in which doctorate student interns, under the supervision of faculty from MUIH will provide free evidence-based acupuncture care to	LEAD: KCC CLN Maryland University of Integrative Health (MUIH)	Increased number of health and wellness resources for patients undergoing current cancer treatment.	Ongoing

	support patients in their distress—emotionally, symptom and side effect management. This clinic will be operational 2 or 3 days per week and provide approximately 15-20 treatments per week.			
Education	Reduce disparities Provide culturally sensitive cancer screening education to disadvantaged populations to increase awareness regarding cancer prevention and risk. Targeting: Breast, Colorectal, Cervical and Lung cancers.	LEAD: KCC Breast & Cervical Screening Program CLN UMUCH CO/HI HCHD Religious Affiliations	12-20 offers annually	Ongoing

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: STROKE

Outcome:

1. The University of Maryland Upper Chesapeake Health includes two MIEMSS (Maryland Institute of Emergency Medical Services) Certified Primary Stroke Centers: Upper Chesapeake Medical Center and Harford Memorial Hospital. This designation reflects our commitment to meeting the emergent needs of Stroke patients by providing high quality, evidence-based care to the residents of Harford County and all neighboring communities.
2. Through our Stroke Community Benefits program, we are able to address the many health and socio-economic issues affecting Harford County residents by partnering with many community agencies, organizations and non-profits to provide significant community education and support in addressing cardiovascular disease.
3. Our goals for our Stroke Community Benefits program includes education on Stroke Risk Assessments and ways our community can prevent a Stroke. It also includes education on how to identify if someone is having a Stroke using the BE FAST acronym. Finally, it focuses on education surrounding the "Time is Brain" concept and the need to call "911" at the very first sign of Stroke symptoms. These educational objectives support our goal of decreasing the morbidity and mortality of Stroke in our community.

Goals:

1. Conduct Stroke Risk Assessments that identify an individual's Stroke Risk factors.
2. Teach individuals how to modify their identified Stroke Risk factors.
3. Teach community members of all ages how to identify signs of Stroke using the BE FAST acronym.
4. Increase the number of patients having Stoke like symptoms who arrive via EMS versus private vehicle.
5. Decrease the amount of time from "Last Known Normal" to Arrival at Hospital.

Key Strategies	Actions	Partners Internal/External	Outcomes	Timeline
Access to Care	Community Stroke Screening	LEAD: UMUCH Stroke Center UMUCH CO/HI Faith based community HCHD Community groups/organizations EMS/ Local Fire Departments Health Fairs	Minimum Ten Events per year. Record number of contacts at each event.	

		HCPS		
Transition of Care	Conduct regular Stroke updates with EMS providers.	LEAD: UMUCH Stroke Center Harford County EMS	EMS time on scene ten minutes or less. All stroke patients will be scored (Cincinnati score/LAMS score)	Ongoing
Clinical Care/Pathways	Review and implement appropriate clinical guidelines in Upper Chesapeake Medical Center and Harford Memorial Hospital based on American Heart Association / American Stroke Association recommendations in concert with state MIEMSS requirements.	LEAD: UMUCH Stroke Center University of Maryland Stroke Coordinator's Collaborative	Achieve door to tPA Alteplase administration within 45 minute of arrival for 75% of eligible patients.	Ongoing
Support Groups and Self-Management	Monthly Stroke Survivors Support Group "Stroke Club"	LEAD: UMUCH Stroke Center American Stroke Association	Record number of participants monthly.	Ongoing – The third Wednesday of every month.
Education	Community based stroke education sessions held at Upper Chesapeake Medical Center or a central Community location. Stroke Coordinator will participate in various radio/in-person Stroke presentations.	LEAD: UMUCH Stroke Center UMUCH CO/HI Faith based community HCHD Community groups/organizations	Three scheduled events held annually. Record number of participants at each event.	Annually

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: DIABETES

Outcome:

1. Improved health of persons in Harford County with diabetes.
2. Reduced hospitalization/ED visits/30 day readmissions for uninsured diabetes patients that are without resources.
3. Stabilize the rate of diabetes through diabetes prevention efforts by increasing knowledge and awareness of healthy lifestyle behavior of Harford County persons with diabetes and chronic illness, through participation in evidence-based programs.
4. Reduced severe hypoglycemia events resulting in injury or death to self or community member.
5. Target minority populations with high risk for diabetes to prevent diabetes with an orientation towards health equity.

Goals:

1. To provide evidence-based chronic disease and diabetes self-management classes for community residents with diabetes and their caregivers.
2. To decrease incidences of hypoglycemia thus reducing risks to patient and community.
3. To increase the diabetes' community's knowledge and survival skills through the provision of education and classes, supplies, individual patient information sessions, and health fairs.
4. To increase access to diabetic supplies (blood glucose monitoring supplies and medications) for patients who are uninsured or who are without resources through working with the Diabetes educators and Care Center social worker.
5. To reduce avoidable ED visits and hospital admissions related to diabetes.
6. To increase the engagement of high-risk minority populations in diabetes prevention and diabetes self-management.

Key Strategies	Actions	Partners Internal/External	Outcomes	Timeline
Access to Care Care and monitoring of glucose levels will be provided at no charge to the patient once they are identified as having unrecognized Hypoglycemia, nocturnal hypoglycemia or frequent episodes of hypoglycemia.	Patient with diabetes referred to diabetes center educator following episodes of hypoglycemia. Diabetes educator applies continuous glucose monitor (CGM) for patient to wear for one week. Patient returns for download of sensor. If nocturnal hypoglycemia, unrecognized hypoglycemia or frequent hypoglycemia (>5%) of hours wearing sensor, is identified in CGM	LEAD: UMUCH Diabetes Center Endocrinologists PCP Diabetes Inpatient Consultants Hospitalists High Risk Case Managers	Reduction in hypoglycemia to >5% of hours that sensor is worn	Ongoing process – timeline for process: Patient to be contacted within 24 business day hours of notification. Patient to be seen by educator within one week of identification.

	download, educator will adjust dosing of insulin or oral hypoglycemic medication, and continue to have patient wear CGM. Patient will continue to be seen and wear sensor every 2 weeks until hypoglycemia is under 5% of hours work.			Follow-up visits every 1-2 weeks ongoing until goal is met.
	Provide countywide Diabetes Risk Assessments and HbA1c screenings.	LEAD: UMUCH CO/HI UMUCH Diabetes Center CTO Program HH HC OOA Faith Based community Local Businesses	Increased numbers of people having diabetes risk assessments performed. Increased early detection of diabetes. Increased education and awareness of signs and symptoms of diabetes.	Ongoing
	Provide follow-up phone calls to diabetic high risk patients after discharge from in-patient stay, to diabetic patients who have been identified during their in-patient stay as a high-risk patient in need of further education and support.	LEAD: UMUCH Diabetes and Endocrine Center CCC Inpatient and care center case managers, diabetes center, care center Inpatient Transitional Nurse Navigator (TNN) CTO Program	Success rate in reaching patients by phone Increased communication and support for those identified patients.	Ongoing following identification
	Provide patients at risk for unrecognized hypoglycemia a referral to a continuous glucose monitoring company. Provide education regarding safety when hypoglycemia is unrecognized and information regarding continuous glucose monitoring for home use.	LEAD: UMUCH Diabetes and Endocrine Center Diabetic Educators Dexcom Medtronic Abbott pharmaceuticals	Reduction of hypoglycemia based on CGM report. Increased patient self-reporting of safety measures being followed. Documented patient utilization of home CGM.	Ongoing As needed

Support Groups and Self-Management	Provide access to diabetes support groups at local Senior Centers. Provide evidence based chronic disease and diabetes self-management program to Harford County residents with diabetes and/or patients referred to Community Outreach for this program. Provide diabetes support at UMUCH Diabetes and Endocrine Center Provide CDC evidence based Diabetes Prevention Program for Harford County residents at risk for diabetes. Partnered with the Diabetes Center to hold Diabetes Support Group led by Diabetic Nurse Educators	LEAD: UMUCH CO/HI UMUCH Diabetes and Endocrine Center UMUCH Diabetes Inpatient Consultants Hospital inpatient TNN's CCC CTO Program LEAD: UMUCH Diabetes and Endocrine Center	Improved ability for patients to better manage their disease process and reduce their HbA1c. Increased individual knowledge and awareness of their diabetes disease process. Reduced avoidable ED visits and inpatient admissions. Decreased participant weight by 5 to 7% Increased physical activity to 150 minutes per week. Reduced HbA1c. Increased number of DM pts participating in diabetic education specific to their disease.	Ongoing
Education	Provide diabetes education and Diabetes Risk Assessments to community residents, community organizations and community partners.	LEAD: UMUCH CO/HI HH CTO Program UMUCH Departments Welcome One Homeless Shelter Lion's Club HC OOA Community Organizations Community Clinical Specialists (Podiatry and Vision)	Improved ability for patients to better manage their disease process and reduce their HbA1c. Increased individual knowledge and awareness of their diabetes disease process. Reduced avoidable ED visits and inpatient admissions.	Ongoing

Hypoglycemia education Continuous Glucose Monitor (CGM) for home use recommendation	Diabetes center educators to provide education regarding safety when hypoglycemia is unrecognized. Diabetes educator to provide information regarding continuous glucose monitors for home use. Diabetes educator to make referrals to CGM company.	LEAD: UMUCH Diabetes and Endocrine Center Diabetes Educators Community Physicians Endocrinologists CGM Company Dexcom Medtronic Abbott pharmaceuticals	Patient self-reporting of safety measures being followed. Reduction of hypoglycemia based on CGM report. Patient able to demonstrate that they are following safety measures by carrying treatment for low blood sugar, by wearing personal CGM or testing BG before driving.	Ongoing - At any point during the monitoring phase when hypoglycemia is less than 5%.

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY OUTREACH AND HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: HEART DISEASE

Outcome:

1. Improved cardiovascular and pulmonary health of the Harford County community.
2. Improved education and awareness of risk factors for cardiovascular disease.

Goals:

1. To provide information on risk factor reduction: smoking cessation, improved dietary choices, the importance of exercise, stress reduction and other behavior modifications that support heart health.
2. To provide education on recognizing signs of heart attack and the importance of dialing 911.
3. To provide education for work with EMS to assure efficient, effective transport of STEMI patients to the Cardiac Cath Lab.
4. To provide cardiovascular screening events for early detection of possible cardiovascular disease.
5. To offer support groups for those who have had cardiac or pulmonary events and who may or may not have partaken in our rehab programs.
6. To develop partnerships with physician offices to engage and refer at risk community members who are in need of evidence based self-management programs.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	CHF program- individuals recently diagnosed with or re-hospitalized for Congestive Heart Failure (CHF) are referred to the CCC for management of their disease including medication education and review, disease process education, appointment coordination, and identification of other needed community services. Initiated IV Lasix Program for eligible CHF individuals to reduce avoidable admissions/readmissions	PCP CTO Program CCC HH Pulmonologists Cardiologists Identified specialists HCHD HC OOA Home Health Agencies Skilled Nursing Facilities Faith Based Community CAA	Increased number of appropriate referrals to the CCC. Decreased number of avoidable ED visits and inpatient admissions.	Ongoing

	Vivify program – tele-monitoring system utilizing tablet, BP cuff, scale, and pulse ox to monitor patients' vitals at home and address change in meds if needed.			
Access to Care	Monthly STEMI Process Action Team meeting - discussion of topics related to improvement of the procedures followed to and care for the STEMI patient. Includes discussion of pre-hospital issues and involves representatives from Cecil, Harford, and Baltimore Counties EMS, as well as representatives from AMR ambulance service. Hart to Heart, and the University of Maryland Express Care ambulance services. Continue to purchase LIFENET EKG transmitters for all ambulances in Harford and Cecil counties, for sending EKGs from the scene to the ED for interpretation by a physician and early activation of the STEMI team to reduce door to balloon time. Website includes HeartAware risk assessment tool as well as information on signs of a heart attack, shopping guide for heart healthy foods and tips on preventing heart disease.	LEAD: UMUCH Cardiovascular Physicians RNs Radiation Technicians ED EMS AMR ambulance Others Hart to Heart (H2H) Ambulance Company University of Maryland ExpressCare	Improved door-to-balloon time and decreased mortality for STEMI patients and for all patients coming to the Cath Lab.	Ongoing
Transition of Care	Provide monitored cardiac rehabilitation program for newly recovering heart attack patients.	LEAD: UMUCH Cardiovascular UMUCH Cardiac and Pulmonary Rehab participants	Improved patients' physical health by maintaining an exercise regimen in a place that they feel safe. This transitional program provides	Ongoing. Started April 2, 2018.

	Provide a maintenance program for Cardiac and Pulmonary Rehab patients to provide a transitional program as patients move from their more closely monitored Rehab program to exercising on their own to maintain their health.		less team member oversight as the patients become more comfortable with exercising without having their heart or lung function monitored.	
Fund Raising Support national organizations with local ties	Coordination of efforts and Coordinate UMUCH's participation in the Greater Baltimore American Heart Association (AHA) Heart and Stroke Walk, raising funds for research and education regarding reducing heart disease risk and mortality.	LEAD: UMUCH Cardiovascular American Heart and Stroke Association	Increased funds to be used for New research that assists with improving cardiovascular health. AHA lends support to our community through provision of educational material and through research that improves CPR techniques as well as other clinical processes.	
Support Groups and Self-Management	Lung Rangers - Monthly educational and support meetings for pulmonary patients. Check, Change, Control program - In partnership with American Heart and Stroke Association, assist community members to sign up online for this program that promotes following blood pressure measurements, to be sure members know what their blood pressure is so that they can determine the need to make lifestyle changes to improve their blood pressure and/or to see their physician. Evidence based classes: CDSMP	LEAD: UMUCH Cardiovascular UMUCH CO/HI American Heart and Stroke Association	Community members are better able to cope with their disease and continue to learn about ways to improve their health. Community members become more familiar with their blood pressure levels. Will learn about blood pressure and what it means. Will learn when to address issues with physicians. Increased knowledge and awareness of appropriate blood pressure levels. Increased awareness as to when to address issues with their physicians.	Ongoing

		LEAD: UMUCH CO/HI MAC, Inc. - Maintaining Active Citizens – Agency on Aging	Increased knowledge about blood pressure and the importance of regular monitoring and maintaining their pressure at a healthy and safe level.	
Education and Screening	Provide heart disease education through targeted educational programs, risk assessments and dissemination of heart information. Flyers distributed on signs of heart attack and the importance of calling 911. Ask-a-Doc- column in the local newspaper, The Aegis. UMUCH cardiologists, vascular surgeons and pulmonologists will address clinical questions for the community. Fall seminar – Cardiac and Pulmonary Rehabilitation Team and physicians will present specific cardiac- and pulmonary- relate topics at UCMC. Red Dress Pink Ribbon event in February, in conjunction with the KACC. Provide education on topics related to health and wellness that apply to women dealing with cardiac disease, cancer or both. Cardiac and vascular screenings held periodically throughout the year	LEAD: UMUCH Cardiovascular UMUCH CO/HI UMUCH Education Department UMUCH Marketing Department EMS Physicians AHA/ASA Various faith-based organizations, Organizations looking for education and screening for members.	Improved access to care for emergent issues (heart attack) Better lifestyle choices/changes. Increased knowledge of cardiac, vascular and pulmonary issues and preventive strategies. Increase knowledge on how to address the common issues related to heart or cancer care: exercise, eating right, stress reduction and more. Early detection leads to early, more cost effective treatment. Education also provided.	Ongoing

		Support of other departments holding health fair within UMUCH (e.g.- Diabetes Fair)		
	Provide community health and wellness education addressing risk factors for cardiovascular disease. Provide community health screenings, including blood pressure, cholesterol, HbA1c, and vascular, throughout the County.	LEAD: UMUCH CO/HI HH UMUCH Diabetes and Endocrinology UMUCH Cardiovascular Center Faith-based organizations Community organizations Local businesses HC OOA APG HCHD HCPS HC Libraries	Increased awareness and early identification of cardiovascular disease. Increased early intervention and treatment of cardiovascular disease.	Ongoing

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: RESPIRATORY DISEASES

Outcome:

1. Reduced avoidable ED visits and hospital admissions/readmissions
2. Improved care coordination and continuity of care for identified high risk, rising risk and high utilizers of the ED diagnosed with respiratory diseases.
3. Improved education and awareness of signs and symptoms or respiratory distress for better management of the disease. By educating on use of Meter Dose Inhaler (MDI), the goal is to see a decrease in hospital admissions/readmission of asthma patients.

Goals:

1. To increase compliance of asthma treatment by increasing Meter Dose Inhaler (MDI) usage and decreasing nebulizer treatment use in pediatric patients.
2. To improve symptom management in patients with respiratory diseases.
3. To reduce avoidable ED visits and admission/readmissions related to respiratory diseases.
4. To improve care coordination for high utilizers with respiratory diseases.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	Chronic Obstructed Pulmonary Disease (COPD) Disease program- individuals recently diagnosed with or re-hospitalized for COPD are referred to the CCC for disease management including medication education and review, symptom management, MDI and nebulizer education, disease education, appointments coordination and identification of additional needed services in the community.	PCP Pulmonologists HCHD CTO Program HC OOA Faith based organizations Home Health Agencies Skilled Nursing Facilities CAA	Increased number of appropriate referrals to the CCC. Reduced numbers of respiratory distress incidents in patients with COPD and asthma. Decreased number of avoidable ED visits and inpatient admissions/readmissions.	Ongoing

Transition of Care	Provide Pulmonary Rehabilitation Program for patients with a diagnosis of chronic lung disease.	UMUCH Pulmonary Rehab Department Pulmonologists PCP Community Physicians	Improved patient's physical health through exercise, education and support in managing their respiratory disease.	Ongoing
Education	Provide MDI vs. Nebulizer education for patients, families, community Pediatricians, and the school system. Evidence based program: CDSMP	LEAD: FBP HCHD UMUCH ED UMUCH Pediatric Department UMUCH Respiratory Therapy Department HCPS LEAD: UMUCH CO/HI HH CCC Physicians HCHD HC OOA HC Libraries MAC, Inc. - Maintaining Active Citizens – Agency on Aging	Increased use of MDI in pediatric patients with asthma. Increased knowledge of the individual's chronic condition. Improved ability to self-manage the individual's chronic condition. Improved utilization of health care services.	Ongoing
Support Groups/Self-Management	Partnered with Pulmonary Rehab to hold Pulmonary Support Group led by respiratory therapies.	LEAD: CCC Pulmonary Rehab	Increased number of COPD patients participating in expanding their disease specific education	

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: INJURY AND PREVENTION/FALLS

Outcome:

1. Reduced rate of falls, particularly focused on seniors, throughout Harford County.

Goals:

1. To decrease rate of fall related deaths in Harford County which is currently above the state average.
2. To complete fall risk assessments in the community to screen for people with increased risk and make recommendations for appropriate follow up.
3. To educate at risk community members through the Stepping On program regarding exercise and activity that can decrease risk for falls.
4. To utilize technology to provide improved results of assessment and treatment through the portable VSR Sport and Neurocom Balance Master.
5. To provide a streamlined process and improved clinical care to patients with osteopenia and osteoporosis to decrease risk of fragility fractures with falls.
6. To provide evaluation of ED falls data, identifying fall trends for those patients.
7. To provide evidence based falls prevention programs throughout the continuum of care and in the community.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Assess Risk of Falls	Provide Community Falls Risk Screenings	LEAD: UMUCH Rehabilitation Services HC OOA Geriatric Assistance and Information Network Y of Central Maryland	Number of residents screened. Reduced number in fall statistics.	Ongoing
Screenings	Provide bone density screenings for patients with osteopenia or osteoporosis.	LEAD: UMUCH Rehabilitation Services Upper Chesapeake Orthopedic Specialty Group and University of Maryland Rehab Network at UCH UMUCH CO/HI	Number of patients seen for follow up in Osteoporosis Program	Ongoing
Support Groups and Self-Management	Provide evidence based falls prevention program: Stepping On Program.	LEAD: UMUCH CO/HI UMUCH Rehabilitation Services	Number of participants Reduced fall statistics	Ongoing

		UMUCH Pharmacy UMUCH Physical Therapy Department HCSO HC OOA MAC, Inc. - Maintaining Active Citizens – Agency on Aging		
Education	Provide evidence based education through the Stepping On Program. Provide fall risk education during Community fall risk screenings.	LEAD: UMUCH CO/HI UMUCH Rehabilitation Services UMUCH Pharmacy Harford County Sheriff Department UMUCH Physical Therapy Department HC OOA Geriatric Assistance and Information Network Y of Central Maryland MAC, Inc. - Maintaining Active Citizens – Agency on Aging	Number of participants Reduced fall statistics	Ongoing

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: INJURY AND PREVENTION/CHILD SAFETY

Outcome:

1. Improved child injury outcomes and quality of life by preventing injury or death to a child/children related to being improperly restrained in a vehicle.
2. Improved access for low or no income Harford County families in need of a child safety seat.
3. Increased number of children and adults using bike helmets.
4. Increased knowledge children have regarding bike and road safety.

Goals:

1. To increase the number of Harford County children who are properly restrained in child passenger restraint system and education to their caregivers.
2. To prevent life altering injury if a motor vehicle accident does occur.
3. To provide car seats to families who otherwise could not afford a proper child restraint for a child.
4. To increase the number of children and adults wearing properly fitted bike helmets.
5. To increase children's knowledge of road and bike safety.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Education	Increase advertising for car seat check events. Provide monthly car seat checks. Identify opportunities and provide car seat safety education in the community. Explore the possibility of adding a car seat check event each month.	LEAD: UMUCH CO/HI Maryland Kids in safety seats (K.I.S.S) H2H company Harford County Sheriff Department HCHD- WIC office Epi-Center UMUCH Security Department	Increased numbers of families scheduling a car seat safety check appointment.	ongoing
	Offer Child Passenger Technician training to those interested.	LEAD: UMUCH CO/HI K.I.S.S.	Continued offering of the car seat safety program.	ongoing

	Support current technicians in maintaining their certifications.	UMUCH Women and Children Department		
	Host bike rodeos and bike/helmet giveaways events.	LEAD: HH Jam Squad Bike Harford Chesapeake Spokes City of Aberdeen HCPS HCPL	Increased number of residents biking and using helmets. Reduced cycling head injuries. Improved physical activity, especially in low-income neighborhoods.	Ongoing
	Policy work to ensure safe roadways for all utilizers	LEAD: HH HCPNZ	Work to access and amend safe roadways for all non-vehicular travel.	

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

CHRONIC DISEASE PREVENTION AND WELLNESS: INJURY AND PREVENTION/FLU VACCINES

Outcome:
1. Increased rate of adults and children receiving annual flu vaccinations.
2. Reduced number of Harford County residents admitted to hospital for flu.

Goals:
1. To increase the number of Harford County residents, adult and children, receiving the annual flu vaccination.
2. To make annual flu vaccinations available to the high-risk seniors population.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	Provide annual flu vaccinations throughout the County at various locations with a focus on the Senior population.	LEAD: UMUCH CO/HI HC OOA HCHD Faith based community Local community partners	Increased numbers of community residents receiving the annual flu vaccination.	Annually

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

FAMILY STABILITY: SUBSTANCE ABUSE NEWBORNS

Outcome:

1. Decreased number of newborns exposed to illegal substances.
2. Decreased number of substance depended pregnant women using illegal substances.
3. Increased community treatment organizations' engagement by educating treatment facilities on the Substance Exposed Newborn (SEN) population.

Goals:

1. To work collaboratively with key stakeholders to improve outcomes for our Substance Exposed Newborn (SEN) population, as well as pregnant women who are substance dependent.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	Link pregnant patients to needed resources (i.e. Treatment Facilities, Care Coordination Programs, and DSS).	Treatment Facilities DHS HCHD UMUCH FBP OB physicians' offices	Increased number of patients utilizing treatment program resources during pregnancy.	Ongoing
Education	Provide education regarding substance exposed newborn postnatal treatment needs and experiences Outreach to treatment providers. Engage HCHD, Peer Recovery Specialists, OB Providers.	LEAD: FBP HCHD DSS OB Providers ED Case Management at UMUCH Megan's Place Office of Drug Control Policy	Decreased number of patients admitted to FBP and Special Care Nursery (SCN) with positive toxicology screens for illegal substances. Increased community knowledge related to SEN and Substance Dependent pregnant women.	4/2021-6/2023
Clinical Care/Pathways	Develop pathways for pregnant women to utilize when using illegal substances or in a MAT program.	LEAD: FBP United based Peer Recovery Coaches (Project Heart Grant)	Post-Partum mother's will actively participate in recovery/peer recovery	4/2021 – 6/2023

		OB/GYN offices UMUCH ED HCHD Local MAT UMUCH Clinical Resource Management	pregnant patients will engage with Peer Recovery.	
	Family Centered Focus with Rooming in of mother and baby.	LEAD: FBP Pediatrics Pediatric Hospitalist OT/PT/Speech	Decreased admission to SCN for withdrawal. Decreased length of stay for SEN	1/2021- 6/2023
Support Groups and Self-Management	Link patients to needed resources, i.e., Treatment Facilities, Care Coordination Programs, and DSS	LEAD: FBP Treatment facilities DSS HCHD Megan's Place	Increased number of patients utilizing treatment programs resources.	4/2021 – 6/2023

UM UPPER CHESAPEAKE HEALTH
Upper Chesapeake Medical Center / Harford Memorial Hospital

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

FAMILY STABILITY

Outcome:
Improved Family Health and Resiliency

Goals:
To create comprehensive programs and policies to improve Family Health and Resiliency.

Key Strategies	Actions	Partners Internal/External	Outcome	Timeline
Access to Care	CTO Program	LEAD: CCC UMUCH HH HCHD HC OOA	High risk Medicare patients linked with CTO affiliated PCP have access to improved health care plans and resource connection through intense care coordination.	Ongoing
	Food Access Workgroup	LEAD: HH UMUCH CO/HI CBOs HCCAA MDCS HPS HCG	Ensure family stability through addressing food insecurity through cooperative workgroup	Ongoing
Education	Provide ACEs training throughout Harford County.	LEAD: HH HCG Sheriff's Office HCPS Court Appointed Special Advocates (CASA) for Children CBO	Reduced childhood trauma, better assist adults who have issues resulting from childhood trauma.	Ongoing
	Cherish the Child, Trauma Conference	LEAD: HH HCG Community Services Core Services Office on Mental Health	Improved community education regarding trauma and its lasting effects.	Annually

	Provide Advance Directive classes, linkages, education and assistance.	LEAD: HH UMUCH Chaplain Services and Guest Services UMUCH CO/HI Community faith based entities HCPL	Increases number of people with Advance Directive to reduce family stress and burden.	Ongoing
	Provide community educational presentations related to nutrition and lifestyles and how they can improve family health and resiliency.	LEAD: HH UMUCH CO/HI CBO Faith based organizations	Improved lifestyles for improved resiliency.	Ongoing
Policy	Handle with Care policy for children who have experienced trauma return to school.	LEAD: HH HCPS HCG HC Sheriff's Office	Improved trauma response for reduced ACE scores.	Ongoing