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

COMMUNITY 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. To develop a Behavioral Health Crisis Center in Bel Air that will house a 24/7 Behavioral Health Crisis Hotline, a Behavioral Health Urgent Care Center for triage, assessment and referral, and Residential Crisis Beds (approximate length of stay of 3 days).
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 Development of Behavioral Health Crisis Center	Open Outpatient Behavioral Health Clinic Open Behavioral Health Urgent Care Center (up to 23 hours) Open Behavioral Health Crisis Residential Beds	Harford County Government (HCG) Harford County Mobile Crisis Team Harford County Behavioral Health Crisis Hotline Local law enforcement agencies Behavioral Health providers across Harford County	A reduction of behavioral health visits to Upper Chesapeake Health Emergency Departments. A reduction of behavioral health admissions from the Bel Air area to the Harford Memorial Hospital Behavioral Health Unit.	June: Outpatient Behavioral Health Clinic July: Mobile Crisis & Crisis Hotline December/January: Behavioral Health crisis beds
	Wellness Action Teams of Cecil and Harford County (WATCH) Program: screens patients and their families	Healthy Harford (HH) Harford County Health Department (HCHD)	Improved and increased linkages to behavioral health services for Medicare	Ongoing

	for behavioral health issues and makes the appropriate referrals.	Care Coordination Plus (CC+) Program County mental health and substance use disorder agencies and organizations	residents engaged with the WATCH program. Approximately 300 patients are engaged with the WATCH program.	
Clinical Care/Pathways	Develop clinical pathways for patients entering crisis center.	Crisis Center Team	Patient and staff satisfaction survey results	6/1/18-12/31/18
Support Groups and Self-Management In Patient Behavioral Health Unit Community	 Behavioral Health Support Group for Families/Friends Evidence based classes: Chronic Pain Self-Management Program (CPSMP)	 Various community agencies Harford County physicians Harford County Public Libraries (HCPL) Behavioral Health Crisis Center	 Number of attendees and participation rate Number of completers for program Completer survey results	 Held Monthly Ongoing
Education	Provide education to internal team and Ashley Addiction Treatment on lateral violence (abuse in workplace by one employee to another, it includes both overt and covert acts of verbal and non-verbal aggression). Provide education on co-occurring behavioral health/substance abuse issues and trauma informed care. Provide quarterly substance abuse education/events opportunities for UMUCH team members.	UMUCH team members including crisis center team Ashley Addiction Treatment Office of Drug Enforcement HCHD University of Maryland Medical System (UMMS) UMUCH Emergency Room physicians	Increased knowledge and awareness of lateral violence. Increased knowledge and awareness of co-occurring behavioral health/substance abuse issues and trauma informed care. Number of UMUCH team members attending events.	July 1, 2018 – Ongoing 1 year

		UMUCH Spirituality		
	H.O.P.E. (Heroin Overdose Prevention Effort – a mobile educational tool designed to raise awareness and inform people of the warning signs of controlled dangerous substance use and/or abuse) trailer at both hospital campuses with drug take days.	Office of Drug Enforcement Harford County Sheriff's Office (HCSO)	Number of team members touring H.O.P.E. trailer. Number of pounds of drugs collected.	Annually
	Provide educational classes specific to behavioral health: • Mental Health First Aid • Question, Persuade, Refer (QPR) • How nutrition affects depression and anxiety • Linkages between diabetes and depression	HH HCHD UM Center for Diabetes and Endocrinology at UCMC HCG	Increased and improved education regarding preventing and coping with mental illness.	Ongoing
Transition of Care	WATCH teams 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) or hospital admissions.	HH HCHD HCG Mental Health providers Department of Human Services (DHS)	Reduced avoidable future ED visits or 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.	HH HCG HCSO	De-escalated mental health crisis situations.	Ongoing
	Participate on the Substance Exposed Newborn (SEN) Taskforce to develop policies and implementation plans to link pregnant women with substance use disorder to treatment.	HH HCHD DHS HCG UMUCH OB/Gyn practices	Increased number of pregnant women with substance use disorder to initiate and maintain both prenatal and substance use treatment during pregnancy.	Ongoing

			Reduced fetal and/or neonatal deaths.	

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

PREVENTION AND WELLNESS

Outcome:

1. Improved care coordination and continuity of care for identified high risk, rising risk and high Emergency Department (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 emergency department 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	WATCH program provides psycho/social and clinical support for high utilizer Medicare patients post discharge and via referral.	UMUCH CCC HCHD Care Coordination Plus (CC+) Program Harford County Housing Harford County Office on Aging (HC OOA)	Reduced avoidable ED usage and hospital admissions.	Ongoing
	Comprehensive CARE Center (CCC): Transition Nurse Navigation and Social Worker - Ensures continuity of care through education, disease management, medication and symptom review, and coordinate care with	Primary Care physicians Pulmonologist Cardiologist Identified specialists HCHD HC OOA Home Health Agencies WATCH Program Skilled Nursing Facilities	Decreased number of avoidable ED visits and inpatient admissions	Ongoing

	appropriate community resources including arrangement of transportation. CARE Center patients are assessed for needed services such as palliative care, Advance Directive and Maryland Medical Orders for Life-sustaining Treatment (MOLST) forms.	HH Faith Based Community Community Action Agency (CAA)		
Support Groups and Self-Management	CHF Shoprite Store Tour- Provides enhanced education on dietary needs and challenges to patients with CHF in our community.	Klein's Shoprite	Increased number of CHF individuals participating in nutrition education specific to their disease.	Ongoing
	Chronic Disease Self-Management Program (CDSMP)	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. Improved utilization of health care services.	Ongoing
Education	Provide community health and wellness education, health screenings, and outreach throughout the County.	HH UMUCH Community Outreach UM Cooperative Extension HCHD HCPS/Private HCG Faith Based Community Community Based Organizations Local Businesses Local Municipalities Bel Air Aberdeen	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

		Havre de Grace HC OOA UM UCH Heart and Vascular institute UM UCH Stroke Center TasteWise Kids Aberdeen Proving Group (APG)		
Transition of Care	Project Healthy Connect – a mobile screening and care coordination clinic for at-risk populations who are screened for depression, stroke, blood pressure and diabetes.	HH UMUCH Community Outreach Community Based Organizations	Improved linkages of at-risk population to clinical and psycho/social care.	Ongoing
Policy	Work with local partners to create a more walkable, bikeable community.	HH HCG Department of Planning and Zoning Baltimore Metropolitan Council (BMC) Local municipalities County Council Bike Harford Chesapeake Spokes, Bike Maryland, Maryland Traffic Safety Taskforce	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.	HH UM Cooperative Extension Boys and Girls Clubs HCG	Improved access to fresh produce.	

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

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 (20.7) to be equal to or less than the Maryland rate (15.1). 2006-2015 BRFSS
2. To decrease the Harford County adolescent tobacco use rate (19.2) to be equal to or less than the Maryland rates (16.4). 2013-2014 YRBSS
3. To decrease the youth e-cigarette use rate (41.4) to be equal to or less than the Maryland average (37.6). 2014 YRBSS
4. 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, UM UCH website and social media, HealthLink Call Center, and Kaufman Cancer Center.	UM UCH Community Outreach HCHD Kaufman Cancer Center HH 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. The Harford County Health Department will provide nicotine replacement products to participants.	Cancer LifeNet Greta S. Brand & Associates, Inc. HCHD	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.	

Education	Provide education on smoking, tobacco use, and vaping at health events, business, schools and the faith based community throughout the County.	UM UCH Community Outreach HCHD HCPS Kaufman Cancer Center Faith Based communities Local Businesses Local Municipalities APG	Decreased number of Harford County residents both adults and youth using tobacco and nicotine products.	Ongoing
	Provide continual educational to the HealthLink Community Outreach nurses on existing programs, best practices and evidence based tobacco programs.	UM UCH Community Outreach HCHD MD Quit	Improved education provided by the HealthLink Community Outreach nurses to the residents of Harford County.	Ongoing

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

PREVENTION AND WELLNESS: CANCER

Outcome:

1. By 2020, reduce the age-adjusted cancer incidence & mortality rates consistent with reduction goal for Maryland's Incidence & Mortality & High Burden Cancer Targets (pg. 64-70; Maryland Comprehensive Cancer Control Plan 2016-2020)
2. Improved education and awareness of cancer prevention and wellness through community programming, cancer screenings, and vaccinations.

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 Cancer LifeNet Program.
2. To increase the number of age eligible children in Harford County that have received at least one HPV vaccination by to 80% by 2020. (target of Maryland Comprehensive Cancer Control Plan)
3. To increase participation at community cancer screenings.
4. 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 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. Cancer LifeNet Social Worker & Program Assistant coordinates scheduling of patients receiving care at the KCC and UM UCMC.	Community-based Physicians HH HCHD HC OOA American Cancer Society (ACS) .	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).	HCPS HCHD Kaufman Cancer Center Maryland Cancer Collaborative ACS HC OOA Claire Marie Foundation	Increased numbers of people having preventative cancer screenings performed. Increased early detection of potential cancers. Increased education and awareness of signs and symptoms of certain cancers.	ongoing
	Provide access to HPV vaccines to low income and uninsured age appropriate children (11-17) through school vaccine clinics.	UMUCH Community Outreach HCHD HCPS Kaufman Cancer Center	Increased numbers of age appropriate children receiving two doses of the HPV vaccine.	School year 2018/2019
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.	Cancer LifeNet Harford County MA Transportation Services Harford Transit The Red Devils (503c) UMUCH Foundation (503c) Kelly's Dream Foundation (503c) Taxi cab companies UM UCMC shuttle service	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 emergency department care.	Cancer LifeNet Sub-acute Care facilities	100% of patients from sub-acute facilities requiring cancer therapies will have access to the care as indicated.	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 • Look Good, Feel Better support group • Healing Through Support	Cancer LifeNet Leukemia & Lymphoma Society Children's Treehouse Foundation AMS	Increased support for current cancer patients and their families as well as their survivors and their families.	Ongoing
	Sponsor yearly free celebratory cancer survivor event.	Cancer LifeNet UM UCH Community Outreach	300-400 will attend	Annually
	Provide Cancer Thriving & Surviving Program - a six week evidence based chronic disease management program for cancer survivors and their caregivers.	Cancer LifeNet UMUCH community Outreach MAC, Inc. - Maintaining Active Citizens – Agency on Aging	Increased number of health and wellness resources for patients undergoing current cancer treatment.	Ongoing
Exercise and Wellness programs	Provide Stay Fit & Active Program - The purpose of this program is to provide a modified exercise program for patients undergoing and recovering from cancer treatment. Class held 2x/week or 100 classes	Cancer LifeNet Various contracted and volunteer individuals	Increased number of health and wellness resources for patients undergoing current cancer treatment.	Ongoing

	per year. Free and open to anyone impacted by cancer. Provide Fresh + Local = Health Cooking demonstrations with nutrition education classes - 4x per year we will have a healthy cooking demonstration provided by a MD and RD to teach the community new and healthy ways to prepare fresh fruits and vegetables to promote healthy eating. Provide Health & Wellness Coaching and Delivery of Survivorship Care Plans - Patients will have any opportunity to receive assistance of health & wellness coaches. At the end of cancer treatment, patients will also receive a written summary of their treatment along with a plan for surveillance, follow up and wellness self-care plan.			
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	Cancer LifeNet 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 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.	Maryland University of Integrative Health (MUIH)	Increased number of health and wellness resources for patients undergoing current cancer treatment.	Ongoing
Education	Provide HPV education to parents and age appropriate children regarding the need for HPV vaccination and that the vaccine prevents six types of cancer. Provide HPV education to age appropriate college students (18-26) and the importance of receiving the HPV vaccination series for cancer prevention. Provide physician pediatric, OB/GYN, and primary care physician offices with HPV vaccination information.	UMUCH Community Outreach Kaufman Cancer Center HCHD HCPS Maryland Cancer Collaborative ACS Primary Care Physicians Pediatrics OB/GYN Physicians	Increased number of age appropriate children and young adults receiving the HPV vaccination series.	Ongoing

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

PREVENTION AND WELLNESS: STROKE

Outcome:

1. Improved patient outcomes and quality of life after a stroke by reducing the elapsed time from the onset of symptoms until the patient arrives at the hospital.
2. Improved EMS provider knowledge related to stroke care.
3. Improved community education and awareness about symptom recognition and the need to immediately call 911.

Goals:

1. To improve knowledge of stroke symptom recognition using BE FAST acronym for Harford County EMS providers.
2. To decrease average time from initial 911 call to patient's arrival at the emergency department.
3. To educate the EMS providers through the use of educational sessions.
4. To improve the community's awareness and knowledge of stroke symptoms using BE FAST acronym.
5. To increase the community's awareness of the importance to utilize 911 services at the onset of stroke symptoms.
6. To increase the percentage of patients that arrive to the emergency department via EMS ambulance service and decrease the percentage of patients that arrive to the emergency department via private vehicle.
7. To conduct Stroke Risk Assessment screenings throughout the County.

Key Strategies	Actions	Partners Internal/External	Outcomes	Timeline
Access to Care	Provide countywide Stroke Risk Assessments and Blood Pressure Screenings	UM UCH Community Outreach UM UCH Stroke Center HH HC OOA Faith Based community Local Businesses	Increased numbers of people having stroke risk assessments performed. Increased early detection of stroke symptoms. Increased education and awareness of signs and symptoms of stroke.	
Clinical Care/Pathways	Implement evidence-based clinical guidelines from American Heart Association/American Stroke Association in concert with State	UM Stroke Collaborative American Stroke Association	Achieved door to tPA Alteplase administration within 45 minutes of arrival for 50% of eligible patients.	Ongoing

	MIMS requirements at both UCMC and HMH.			
Support Groups and Self-Management	Provide Stroke Survivors Support Group "Stroke Club".	UM Stroke Center	Increased support for current stroke patients and their families.	Ongoing
Education	Provide stroke education to EMS providers at UCMC First Friday's education hosted by the Emergency Department. Provide on-site stroke training sessions with EMS providers at local Harford County fire companies. Provide community stroke education sessions at UCH.	Harford County EMS Leadership and Medical Director UM Stroke Center UM UCH ED UCH Stroke Center UCH Marketing	Improved EMS response time to 10 minutes or less for stroke call. Increased number of patients transported as Priority One stroke alert within 24 hours of symptoms onset. Decreased time between 911 call and hospital arrival time. 75% of participants will have increased knowledge as indicated through pre and post tests.	Ongoing

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

PREVENTION AND WELLNESS: DIABETES

Outcome:

1. Reduced hospitalizations and ED visits for community members with diabetes.
2. Improved overall health and wellness of community members with diabetes.
3. Reduced hospitalization and ED visits for uninsured diabetes patients that are without resources.
4. Increased knowledge and awareness of healthy lifestyle behaviors for persons diagnosed with diabetes.
5. Reduced severe hypoglycemia events resulting in injury or death.

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 diabetic's knowledge and survival skills for better management of their disease.
4. To increase access to diabetic supplies for diabetic patients who are uninsured or are without resources.
5. To reduce avoidable ED visits and hospital admissions related to diabetes.

Key Strategies	Actions	Partners Internal/External	Outcomes	Timeline
Access to Care	Provide care and monitoring of glucose levels to diabetic patients identified as having unrecognized Hypoglycemia, nocturnal hypoglycemia or frequent episodes of hypoglycemia at no charge.	Endocrinologists Primary Care Physicians Diabetes Inpatient Consultants Hospitalists High Risk Case Managers	Reduced hypoglycemia events in diabetic patients being monitored through medication adjustment.	Ongoing
	Provide countywide Diabetes Risk Assessments and HbA1c screenings.	UM UCH Community Outreach UM UCH Diabetes Center 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 annual diabetes health fair	UM UCH Community Outreach HCHD Harford Primary Care HCPL HC OOA UM UCH Endocrine and Diabetes Center UM UCH Marketing HH	Increased knowledge and awareness of services available to patients with diabetes. Increased awareness and education about UM UCH Diabetic and Endocrine Center services.	Ongoing
	Provide care management to uninsured diabetic patients to assure access to diabetic medications and needed diabetic services.	CCC Diabetes Inpatient Consultants In Patient High Risk TNN's – Transitional Nurse Navigators WATCH Team	Reduced 30-day readmissions measured by High Risk TNN's.	Ongoing
Transition of Care	Provide follow-up phone calls 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.	Inpatient TNN's CCC UM UCH Diabetes Center	Increased communication and support for those identified patients.	Ongoing
	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.	UM UCH Diabetes 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
Clinical Care/Pathways	Identify in-patient diabetic patients with HgbA1c >9%, Inpatient Diabetes Consultants meet with identified patients and	Hospital inpatient TNN's CCC UM UCH Diabetes Center	TBD	Ongoing

	determine any self-management barriers.			
	Initiate Diabetes Center's hypoglycemia protocol for identified patients who require assessment and initiation of GCM.	UM UCH Diabetes Center educators Physicians	Decreased hypoglycemia events and better blood glucose control.	Patient dependent Ongoing
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 UM UCH Diabetes Endocrine Center Provide CDC evidence based Diabetes Prevention Program for Harford County residents at risk for diabetes.	UM UCH Community Outreach UM UCH Diabetes Inpatient Consultants Hospital inpatient TNN's CCC UM UCH Diabetes 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.	Ongoing
Education	Provide diabetes education and Diabetes Risk Assessments to community residents, community organizations and community partners.	UMUCH Community Outreach HH Welcome One Homeless Shelter Lion's Club HC OOA Community Organizations Community Clinical Specialists (Podiatry and Vision) UMUCH Departments	Improved ability for patients to better manage their disease process and reduce their HbA1c. Increased individual knowledge and awareness of their diabetes disease process.	Ongoing

			Reduced avoidable ED visits and inpatient admissions.	
	Provide diabetes education and survival skill programs to identified at-risk diabetic patients.	UMUCH Diabetes Center Endocrinologists Primary Care Physicians CCC	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

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

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 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.	Primary Care Physicians Pulmonologists Cardiologists Identified specialists Harford County Health Department Office on Aging Home Health Agencies WATCH Program Skilled Nursing Facilities Healthy Harford Faith Based Community Community Action Agency	Increased number of appropriate referrals to the CCC. Decreased number of avoidable ED visits and inpatient admissions.	Ongoing
Access to Care	Monthly STEMI Process Action Team meeting - discussion of topics related	Physicians RNs	Improved door-to-balloon time and decreased mortality	Ongoing

	to improvement of the procedures 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 Hart to Heart, and the University of Maryland Express Care ambulance services. 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.	Radiation Technicians Emergency Department EMS Hart to Heart (H2H) Ambulance Company University of Maryland ExpressCare	for STEMI patients and for all patients coming to the Cath Lab.	
Transition of Care	Provide monitored cardiac rehabilitation program for newly recovering heart attack patients. 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.	UMUCH Cardiac Rehab Department	Improved patients' physical health by maintaining an exercise regimen in a place that they feel safe. This transitional program provides less team member oversight as the patients become more comfortable with exercising without having their heart or lung function monitored.	Ongoing.
Fund Raising	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.	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	Heart Club - Monthly educational and support meetings for cardiac patients. 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	UMUCH Cardiovascular Center 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. Increased knowledge and awareness of appropriate blood pressure levels. Increased awareness as to when to address issues with their physicians. Increased knowledge about blood pressure and the importance of regular monitoring and maintaining their pressure at a healthy and safe level.	Ongoing
Education and Screening	Provide spring trauma symposium for Harford and Cecil County EMS personnel. Education is provided on specific diseases and/or clinical issues of interest and need so EMS is educated and remain competent and trained to manage emergencies. Provide and manage website, which includes the HeartAware risk assessment tool, as well as information on signs of a heart attack, shopping guide for heart	EMS Physicians UMUCH Cardiovascular Center AHA/ASA UMUCH Education Department UMUCH Marketing Department	Improved access to care for emergent issues (heart attack) Better lifestyle choices/changes Increased knowledge of cardiac, vascular and pulmonary issues and preventive strategies.	Ongoing

	healthy foods and tips on preventing heart disease.			
	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.	UMUCH Community Outreach Faith-based organizations Community organizations Local businesses HC OOA APG HCHD HCPS HC Libraries UMUCH Diabetes and Endocrinology UMUCH Cardiovascular Center	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

PREVENTION AND WELLNESS: RESPIRATORY DISEASES

Outcome:

1. Reduced avoidable emergency department visits and hospital admissions/readmissions
2. Improved care coordination and continuity of care for identified high risk, rising risk and high utilizers of the emergency department 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 emergency department 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.	Primary Care physicians Pulmonologists HCHD WATCH Program Office on Aging Faith based organizations Home Health Agencies Skilled Nursing Facilities Community Action Agency	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

Clinical Care/Pathways	Create Asthma treatment algorithm using Meter Dose Inhaler (MDI)	IT Pediatricians UMUCH Pediatric Department UMUCH Pediatric Educator	Decreased admissions to in-patient PEDS unit with diagnosis of asthma.	Ongoing
Transition of Care	Provide Pulmonary Rehabilitation Program for patients with a diagnoses of chronic lung disease.	UMUCH Pulmonary Rehab Department Pulmonologists Primary Care Physicians 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	HCHD UMUCH ED HCPS UMUCH Pediatric Department UMUCH Respiratory Therapy Department UMUCH Community Outreach Physicians HCHD Office on Aging HH CCC HC Libraries	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

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

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	HC OOA Geriatric Assistance and Information Network Y of Central Maryland	Number of residents screened. Reduced number in fall statistics.	Ongoing
Support Groups and Self-Management	Provide evidence based falls prevention program: Stepping On Program.	UMUCH Community Outreach UMUCH Pharmacy HCSO UMUCH Physical Therapy Department HC OOA	Number of participants Reduced fall statistics	Ongoing
Education	Provide evidence based education through the Stepping On Program.	UMUCH Community Outreach UMUCH Pharmacy	Number of participants Reduced fall statistics	Ongoing

	Provide fall risk education during Community fall risk screenings.	Harford County Sheriff Department UMUCH Physical Therapy Department Office on Aging Geriatric Assistance and Information Network Y of Central Maryland		
Evaluating data on falls	Physical Therapist in the Emergency Department at UCMC (NEW position April 2018)	Upper Chesapeake Medical Center Emergency Department and Case Management Team	Decreased rate of falls with injury.	Ongoing
Access to Care/ Pathways/ Clinical Management	Development of Osteoporosis Program to enhance follow up for bone density screenings for patients with osteopenia or osteoporosis.	Upper Chesapeake Orthopedic Specialty Group and University of Maryland Rehab Network at UCH UMUCH Community Outreach	Improved management of osteoporosis to decrease risk of fragility fractures.	Ongoing

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

PREVENTION AND WELLNESS: INJURY AND PREVENTION

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.	Maryland Kids in safety seats K.I.S.S H2H company Harford County Sheriff Department HCHD- WIC office Epi-Center UMUCH Community Outreach Department UMUCH Security Department	Increased numbers of families scheduling a car seat safety check appointment.	ongoing
	Offer Child Passenger Technician training to those interested.	K.I.S.S. UMUCH Community Outreach Department	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.	Jam Squad Bike Harford Chesapeake Spokes Harford County Sheriff's Office. HH UMUCH Community Outreach	Increased number of residents biking and using helmets. Reduced cycling head injuries. Improved physical activity, especially in low income neighborhoods.	Ongoing

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

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.	UMUCH Community Outreach 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 HEALTH AND RESILIENCY: 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.	4/2017-6/2020
Education	Provide education regarding substance exposed newborn postnatal treatment needs and experiences to treatment providers. Engage Harford County Health Department, Peer Recovery Specialists, OB Providers.	Health Department DSS OB Providers Emergency Department Case Management at UM UCH Office of Drug Control Policy	Decreased number of patients admitted to Family Birth Place (FBP) and Special Care Nursery (SCN) with positive toxicology screens for illegal substances. Increased community knowledge related to SEN and Substance Dependent pregnant women.	4/2017-6/2020

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

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN

FAMILY HEALTH AND RESILIENCY

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	Participate in Project Homeless Connect.	UMUCH Community Outreach HH HCHD UMUCH Community Based Organizations (CBO) United Way	Improved clinical care and psycho/social support for homeless and rising risk individuals and families.	Annually in January
	Project Healthy Connect	UMUCH Community Outreach HH WATCH Dresher Foundation United Way	Increased access to clinical and psycho/social services for uninsured, homeless, and marginal populations throughout the County.	2018 - 2020
	WATCH Team	UMUCH HH HCHD Office on Aging	Improved health and wellbeing of high risk and rising risk Medicare population through intense care coordination and home visiting.	Ongoing
Education	Provide ACEs training throughout Harford County.	HH HCG Sheriff's Office HCPS	Reduced childhood trauma, better assist adults who have issues resulting from childhood trauma.	Ongoing

		Court Appointed Special Advocates (CASA) for Children CBO		
	Cherish the Child, Trauma Conference	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.	HH UMUCH Chaplain Services and Guest Services Community faith based entities HCPL	Increase the 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.	HH CBO Faith based organizations	Improved lifestyles for improved resiliency.	Ongoing
Policy	Habitat for Humanity Housing Partnership	HH Susquehanna Habitat for Humanity	Improved linkages for appropriate housing and housing renovations.	Ongoing
	Handle with Care policy for children who have experienced trauma return to school.	HH HCPS HCG Sheriff's Office	Improved trauma response for reduced ACE scores.	Ongoing