STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Annapolis, MD 21401, Room 336

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor

John A. Hurson, Chairman – Mark Luckner, Executive Director

LHIC Grant Application Cover Sheet FY 2012-FY2014

State Health Improvement Process:
Supporting Local Health Improvement Coalitions (LHICs)
To Fuel Local Action and Improve Community Health

LHIC Designated Applicant Organization:

Name of Organization: Cecil County Health Department for Cecil County Community Health Advisory Committee (Cecil's LHIC)

Federal Identification Number (EIN): 52-2046029

Street Address: 401 Bow Street

City: Elkton State: MD Zip Code: 21921 County: Cecil

LHIC Official Authorized to Execute Grants/Contracts:

Name: Stephanie Garrity, M.S.

Title: Health Officer, Cecil County Health Department and Co-chair of LHIC E-mail: stephanie.garrity@maryland.gov

Phone: 410-996-5115 or 5550 Fax: 410-996-5179

Signature: Stephanie Garrity Date: May 30, 2013

LHIC Project Director (if different than the official authorized to execute contracts)

Name: same as above

Title: E-mail:

Overall LHIC Grant Funding Request: $189,659

(Range of $150,000 to $250,000 may be provided by CHRC, on a competitive basis; funding requests below $150,000 will also be received and considered).

(2) The LHIC Local Health Action Plan:

Cecil County's Health Improvement Plan is attached at the end of this proposal (Attachment 1). Cecil's LHIC requests funding for two projects: 1) Community Case Management Program Pilot ($89,659); and 2) Mobile Crisis Response ($100,000). Total - $189, 659.

Funding for the Community Case Management Program Pilot ($89,659) will support a community nurse case manager who, in Year 1 of the pilot, will work with Union Hospital-readmitted patients with certain chronic conditions (COPD/ respiratory diseases, heart failure/ heart disease and diabetes) to reduce future hospital readmissions. These chronic conditions were identified via the hospital's strategic planning and community benefits processes. In Year 2 of the pilot, the targeted chronic conditions will expand to include readmissions for behavioral health issues. This is consistent with Priority #2 in Cecil County's Local Health Improvement Plan: Mental/Behavioral Health-Access to Treatment. The primary goal under this priority is to increase access to mental/behavioral health treatment services in Cecil County with an objective to decrease the rate of emergency department visits related to behavioral health conditions.

Funding for Mobile Crisis Response ($100,000) will support the presence of a 24/7 behavioral health mobile crisis service within the county, consistent with Priority #2 in Cecil County's Local Health Improvement Plan: Mental/Behavioral Health-Access to Treatment. The two primary goals under this priority are as follows: 1) increase access to mental/behavioral health treatment services in Cecil County, and 2) increase the number of providers in Cecil County.

In addition, both of these projects address two of the three "Specific Types of Projects" that MCHRC is looking to support: 1) " projects that will support specific population health/community health interventions and reflect the main goals of the LHIC and its local health improvement plan"; and 2) "projects that will facilitate the integration of public health, social services, and other community health resources with the health care delivery system to address social determinants of health."

Also, both projects help Cecil County "set the stage" in anticipation of its participation in the State's plan to develop a "community-integrated medical home" (CIMH) model of care – integrating patient-centered medical care (Cecil County has several of these practices currently via a pilot with MHCC) with community-based resources. Both projects will give the LHIC enhanced capacity to better integrate community health with medical care. The Cecil County community has embraced this impending change in health care delivery – three community members are serving on the CIMH development workgroups.

Additionally, Union Hospital and Cecil County Health Department established the Cecil Community Health Care Center (CCHCC) in January 2011 to connect uninsured patients to needed primary care services with a goal of reducing over-utilization of the emergency department for non-urgent, routine medical care. The hospital and the Health Department continue to monitor emergency department and primary care utilization – preliminary reports look promising.

The CCHCC operates in space provided inside the Health Department. Patients are referred by either nurse case managers in Union Hospital's emergency department or by staff from the Health Department. A wide range of pediatric and adult primary care services are offered. Patients must make an appointment. Union Hospital provides physicians, as well as clinical and non-clinical staff that serve as greeters, floaters and exit interviewers. All volunteer their time. The Health Department provides eligibility assessors (good practice for us, as the Health Department will serve as assisters and the hospital's billing arm – Triangle Health Alliance -will serve as navigators as Maryland's Health Benefit Exchange rolls out in October 2013), EMR administrators, a clinic manager and nurse case managers. The CCHCC is governed by a committee of staff and providers from both Union Hospital and the Health Department.

Finally, Union Hospital adopted HSCRC's Total Patient Revenue (TPR) methodology in 2011. TPR assures a certain amount of revenue each year, independent of the number of patients treated and the amount of services provided to these patients. The hospital, therefore, has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care.

(3) Project Narrative:

Community Case Management Program Pilot

Funding for the Community Case Management Program Pilot ($89,659) will support a community nurse case manager who, in Year 1 of the pilot, will work with Union Hospital-readmitted patients with certain chronic conditions (COPD/ respiratory diseases, heart failure/ heart disease and diabetes) to reduce further hospital readmissions. These chronic conditions were identified via the hospital's strategic planning and community benefits processes. In Year 2 of the pilot, the targeted chronic conditions will expand to include readmissions for behavioral health issues.

Data from the Maryland State Health Improvement Plan (SHIP), updated in 2012, reflect the presence of significant chronic disease issues among residents of Cecil County:

- 236 emergency department visits for hypertension per 100,000 Cecil County population compared to 222 visits per 100,000 population in the State of Maryland;
- 289 emergency department visits for diabetes per 100,000 Cecil County population in 2012 vs. 275 visits per 100,000 Cecil County population in 2011; and
- 50 emergency department visits for asthma per 10,000 Cecil County population in 2012 vs. 53 visits per 10,000 Cecil County population in 2011 (we want to keep the momentum going – MD SHIP 2014 target is 49.5).

Recent information from senior management at Union Hospital reinforces what the data show:

- 50% of annual Union Hospital re-admissions have some behavioral health history;
- 80% of annual hospital admissions come through the emergency department; and

- 20-25 readmissions per month are for COPD/ respiratory diseases, heart failure/ heart disease and diabetes.

(source: May 30, 2013 interview with Union Hospital Senior Vice President and CFO, Laurie Beyer.)

To meet the needs of this community, it is essential that we find ways to connect the individual to community-based and financial resources to better manage their health. Our current process for connecting patients to resources appears to be largely hospital driven--- patients become sick and then come to the hospital emergency department for care and/or connection to free or low cost community resources. A large percent of these clients have multiple chronic health conditions and deal with complex and often confusing medical treatments when they return to their homes and thus may be readmitted to the hospital within 30 days of discharge. Community case managers are one resource that can be activated to meet these needs. Case management is a collaborative process for assessment, planning, facilitation, and advocacy for options and services to meet the patient's health needs and goals through communication and linkage to available resources to promote quality and cost-effective outcomes. Community case managers assist with the coordination of services and implementation of disease management strategies which could lead to earlier identification of health issues, earlier connection to community resources, greater awareness of alternatives to hospital-based care, and strategies to better self-management of their chronic diseases in the home or outpatient environment – all outside the walls of the hospital.

Current hospital data through CRISP demonstrate that a number of patients are readmitted to the hospital with a diagnosis of COPD/ respiratory diseases, heart failure/ heart disease and diabetes. Many of these individuals have issues with limited access to care due to financial and social barriers, communicating information across providers, fulfilling medication instructions, follow up with providers and identifying what to do when their conditions worsens. A number of patients reporting to the hospital to receive care lack insurance or means to finance their healthcare. Continuity, multi-disciplinary communication of the plan of care and clear management of disease process is limited. With the Community Case Management Program pilot, it is believed that these patients will be better able to manage their healthcare needs without hospitalization and will be better able to connect to existing community resources.

Part of the reason people use the emergency department and the hospital as a gateway to service connection is the lack of knowledge about appropriate disease management, inability to connect to services independent of hospital support, and lack of awareness of alternatives to emergency department and hospital based care. By initiating community case management at the time of transition from hospital to home, it is our hope that we will be in a position to partner with patients and their families to identify health need deficits, connect the patient /family to community based resources, and reduce overall health care expenditures of the identified patient population through better use of resources.

In June 2013, the Community Case Management Program pilot, a partnership with the Cecil County Health Department and Union Hospital of Cecil County, will be implemented to provide better management of the needs of chronically ill patients in Cecil County. This is a voluntary program and there will be no cost to the patient. The program will mirror the evidence-based "Project Re-Engineered Discharge (RED)" conducted by Brian Jack, MD at Boston

Univeristy Medical Center with funding from AHRQ. More about the research can be found at http://www.bu.edu/fammed/projectred/index.html.

The goal of this new collaborative effort is to provide program components that focus patients, families and caregivers to better self manage their disease processes in an outpatient setting and to avoid a health crisis requiring hospital readmission. This will be accomplished through a patient centered plan of care over a 4 -6 week time frame, which will address medication adherence, continued health care provider support, education on disease "red flags" (disease crisis signals which may alert to the need for community intervention or a return to the hospital) and establishing a personal health record. The time from discharge and return to home or alternative settings is a challenging time for patients and families as they try to assimilate the changes in the new medical plan received from the hospital, connect to primary care services for follow up, and incorporate the recommended changes in medical care with activities of daily life. The Community Case Management Program pilot is intended to be a patient centered transition plan that provides support and guidance to patients and their families as they "bridge the gaps" and assure proper healthcare provider follow up and establish better strategies to self manage his/her chronic disease(s). The Community Case Management Program pilot will facilitate information sharing among providers and utilize data provided by CRISP to evaluate the program's outcome measures and address quality improvement efforts so that patients enrolled in the program will attain their patient centered plan of care.

The community case manager will work very closely with Union's complex case manager, using her discharge plan and an initial introduction to the patient and family to begin the post discharge process. The community case manager's first visit with the patient will occur pre-discharge from the hospital, where the patient will be offered and can sign up for the post-discharge service. Expectations are set, information is received from the hospital team, and post-discharge care providers are identified and secured. Visit #2 will occur immediately after discharge. This visit, and hopefully all future visits, will be at the patient's home. At this visit, a physical assessment is completed, discharge instructions are reviewed, goals are established, and disease education, including "red flags", occurs. Visit #3 happens about one week later - another physical assessment is completed and "red flag" disease education is reviewed. If needed, patient behavior modification will be attempted. During Visit #4, about one week later, the community case manager conducts another physical assessment, reinforces the "red flags" with the patient and family, revisits goals and modifies same as needed, and follows up with the primary care provider and any other community agencies providing services. It is hoped that Visit #5 will be the final visit. The community case manager would re-cap the patient's accomplishments, identify any further work that needs to be done, review "red flags" and community resources, and complete the patient's personal health record.

Community case managers will promote health literacy by being the bridge between physicians and patients, encouraging questions between the two entities, advocating on behalf of the patient if necessary, and emphasizing the overall importance of a strong physician-patient relationship. Case managers will be given access to phone and in-person interpreting services and will have a mechanism for document translation for speakers of other languages. Necessary transportation for patients to medical appointments that is ADA compliant will be provided.

Goals of a successful Community Case Manager Program pilot will:

- Improve quality of care transitions from hospital to home;
- Further advance patient-centered care vs. disease-focused care by providing educational opportunities and coordination of client focused care with primary care and specialist;
- Improve chronic disease self management for patients with CHF, COPD, and diabetes in Year 1 of pilot;
- Provide focused disease education and knowledge of disease management strategies to reduce complications of disease. Teach patient identification of disease "red flags" and strategies to manage symptoms and/or connect with appropriate health services/providers;
- Perform post discharge evaluation and facilitation of communication between patients/families and primary care providers/specialists, and the Community Case Management Program pilot staff;
- Reduce hospital readmissions within a 30 day window for identified chronic diseases;
- Empower patients to better navigate the healthcare system and make better decisions about healthcare management;
- Connect patients and families to health and community services to optimize disease management;
- Work with patients and families as they identify and meet health management goals; and
- Establish a patient-developed personal health record and be able to communicate with providers effectively about their plan of care.

Union Hospital and Cecil County Health Department make no distinction in the delivery of services provided to individuals and their families based upon race, color, sex, age, disability, religion, national origin, or any other classification prohibited by law. Services are provided based upon identified needs not based upon an individual's ability to pay or the organizational economics.

The Health Department has some experience with the community care model for disease management. Currently, the Health Department receives a Patient Navigator Program grant from DHMH to fund a nurse case manager help primary care practices better engage those patients who are in need of cancer screening or treatment to get further testing or treatment. The data management system used for the Patient Navigator Program will be used for the Community Case Management Program pilot. Information tracked for the pilot using this data management system will be integrated into the patient's EMR. Also, the Health Department has a successful partnership with Cecil County Department of Senior Services in providing chronic disease self-management classes using the evidence-based Stanford University model. Program outcomes have been noteworthy and there are plans to include appropriate Community Case Management Program pilot patients in future classes, as funding permits.

Evaluation

Using two community case managers for the pilot, one funded by Union Hospital and one funded by MCHRC, we expect to document the following impact after one year of service implementation:

- 95% of first/second visits with readmitted patients made within two days of discharge, with 75% of those contacts a home visit;
- 75% of patients referred will complete the Community Case Management Program pilot;
- 5% reduction of inappropriate hospital readmissions within a 30 day post-discharge window for Community Case Management Program pilot patients;
- 75% of enrolled patient readmissions will be determined as appropriate per " red flag" guidelines;
- Each enrolled patient will access at least two community and/or provider resources (clinic, primary care, home health, etc) that contribute to the successful accomplishment of the patient's health care plan and goals;
- 75% of enrolled patients will be able to establish a personal health record; and
- 75% of patients/ family who complete the program would recommend the program to others.

Mobile Crisis Response

Data from the Maryland State Health Improvement Plan (SHIP) reflect the presence of significant behavioral health issues among residents of Cecil County. The most recent SHIP data ranks Cecil County number two in the state for suicides (12.6 per 100,000), drug-induced deaths (21.8 per 100,000) *and* drug & alcohol related intoxication deaths (24 per 100,000). The county is number three in the state for emergency department visits where a behavioral health issue is a primary reason for presentation or a co-morbid health issue - behavioral health visits to the Emergency Department in 2011 were at an all time high (8934 visits per 100,000 population). Also, the 2012 national County Health Rankings lists Cecil County as 22 of 24 Maryland counties in the number of poor mental health days reported (1=best and 24=worst).

These issues are compounded by the challenge of timely access to behavioral health treatment, which has long been an issue for Cecil County residents, demonstrated by a consistent wait time of 2-3 months for a standard outpatient psychiatric visit and a limited number of mental health or substance abuse providers in the area in general. Within the county, community behavioral health services are available through one outpatient mental health clinic (OMHC), one group practice, one federally qualified health center (FQHC), the Cecil County Health Department (2 hours/week of telepsychiatry availability), and a handful of practitioners in private practice. In FY 2014, with additional funds from Cecil County Government, telepsychiatry availability will increase to 4 hours/week.

In 2010, after the closure of a regional state hospital, the Mental Hygiene Administration put funding into a regional mobile crisis service covering eight counties on the Eastern Shore. The contracted provider of the service is Affiliated Santé Group which currently responds from three sites in the region, including an office in Chestertown, Salisbury, and most recently Cambridge. This state funding also provided for a 24/7 information, referral, and crisis line run by Mid-Shore Core Service Agency, which serves as the call triage site and dispatch mechanism for crisis teams. Mobile crisis teams are available 10am to midnight seven days a week.

While the mobile crisis services has had some success in responding to the Cecil County community as it is currently structured, the average response/arrival time for the mobile crisis team is 70 minutes. For this reason, the service has limited use in terms of being a resource for

entities such as law enforcement personnel or the public school system, and in some cases, for residents who are assessed as being unable to wait safely that long for a response. In FY2012, Cecil County residents made 200 calls to the information and crisis line, accounting for 17% of the calls; Cecil County was the second highest user among the eight counties served. There were 45 mobile dispatches during the same time period. As of April 30th, this fiscal year (FY2013), there have been 54 dispatches to Cecil County demonstrating an increase from the previous year. It is believed that as the service becomes more accessible, its use will increase, and more people will be connected to on-going treatment and in a more timely manner.

With funding already committed by Cecil County Government for FY14 ($200,000) and with funds from MCHRC ($100,000), Affiliated Santé will be able to provide 24/7 mobile crisis response from a site in Cecil County to Cecil County residents.

Evaluation

In expanding the existing mobile crisis service to a site in Cecil County, we expect to document the following impact after one year of service implementation:

- double the number of individuals served in Cecil County annually from 45 to 90 via mobile dispatches;
- decrease response time to the site of crisis from an average of 70 minutes to an average of 35 minutes;
- increase utilization by local law enforcement agencies;
- increase utilization by the public school system;
- reduce emergency department admissions for primary behavioral health reasons;
- increase the number of individuals who were connected to an outpatient care provider via mobile team or crisis line and show rate for outpatient appointments; and
- increase the number of mobile dispatches resulting in diversion from emergency department services.

Note that by developing an additional response site in Cecil County, the entire Eastern Shore region benefits as the area served is then decreased for all response sites, improving response time and availability across the region.

(4) Post-CHRC Funding Sustainability Plan:

Community Case Manager Program Pilot

Union Hospital has committed to fund one case manager for FY 2014. If significant reductions in readmissions are demonstrated in Year 1 of the pilot, then Union Hospital will continue to fund two community case managers in the out years. Also, incentives built in to the federal Affordable Care Act may encourage physicians to incorporate case management into their practices thereby continuing this service without the need for grant funds.

Mobile Crisis Response

Recognizing the increased need for behavioral health services in the County, Cecil County Government has included $200,000 for mobile crisis response in the Health Department's budget for FY 2014. Should mobile crisis response expansion in Cecil County

decrease the rate of emergency department visits for behavioral health conditions in FY 2014, then the Health Department will request an additional $100,000 from the County for FY 2015 and beyond.

(5) Project Budget:

The LHIC requests funding for two projects: 1) Community Case Management Program Pilot ($89,659); and 2) Mobile Crisis Response ($100,000). Total - $189,659. Budget pages follow.

Project Budget Form for LHIC Grant	
MARYLAND COMMUNITY HEALTH RESOURCES	
State Health Improvement Process: ***Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health***	
LHIC/Organization Name:	Cecil County Health Department for LHIC
Project Name:	Community Case Management Program Pilot/Mobile Crisis Response
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
% FTE - Title 100% Community Health Nurse	$ 52,282
% FTE - Title	
% FTE - Title	
Personnel Subtotal	
Personnel Fringe (% - Rate) 30%	$ 15,685
Equipment/Furniture	$ 1,850
Supplies	
Travel/Mileage/Parking	$ 1,500
Staff Trainings/Development	$ 500
Contractual - Mobile Crisis Response Expansion	$100,000
Other Expenses - Telephone	$ 600
Indirect Costs (no more than 10% of direct costs)	$ 17,242
Matching Funds – at least 10% of the overall CHRC grant request	$ 19,000
Total	$208,659

CECIL COUNTY HEALTH DEPARTMENT
BUDGET JUSTIFICATION

PERSONNEL	**$**	**52,282**
100% - Community Health Nurse II (CHN II) - Case Manager/Care Coordinator	$	52,282
FRINGE COSTS	**$**	**15,685**
EQUIPMENT / FURNITURE	**$**	**1,850**
Laptop computer for CHN II	$	1,500
VPN Token for CHN II	$	150
Cell Phone for CHN II @ $200	$	200
TRAVEL/MILEAGE/PARKING	**$**	**1,500**
CHN II travel @ $1,500 per year (includes transportation assistance for patient appointments if barriers exist.)	$	1,500
CONTRACTUAL	**$**	**100,000**
Mobile Crisis Program Expansion - Santé, Inc. - Expand Crisis treatment program to improve response times and increase ability to respond	$	100,000
STAFF TRAINING/DEVELOPMENT	$	500
Cultural Competency and Diversity Training for CHN II	$	500
OTHER EXPENSES	**$**	**600**

Cell Phone expense @ $50/month for CHN II	$	600
INDIRECT COSTS @ 10%	**$**	**17,242**
SUBTOTAL - CECIL COUNTY HEALTH DEPARTMENT GRANT REQUEST:	**$**	**189,659**
MATCHING FUNDS:	**$**	**19,000**
Cash Match from Cecil County Health Department (See Attachment 2 for letter of commitment)	$	19,000
GRANT TOTAL:	**$**	**208,659**

(6) Key Staff:

LHIC Project Director

Stephanie Garrity, MS
Health Officer – Cecil County Health Department
Co-chair - LHIC
Ms. Garrity oversees an annual Health Department budget of $10M, ensures the appropriate and results-oriented expenditure of public and private public health funds, formulates partnerships to address the county's health problems, and strategically positions resources to address the changing public health landscape in the wake of health care reform and public health accreditation. She will be responsible for the overall management of the grant and will complete an evaluation of the grant's effectiveness in meeting/exceeding performance measures. She will have help, however, from the experts listed below.

Community Case Management Program Pilot

Mary Ellen Rapposelli, RN, BSN, MSN
Director, Health Promotion Division – Cecil County Health Department
Ms. Rapposelli manages cancer control and cardiovascular risk reduction programs, Community Transformation Grant activities, health education and community outreach, Cigarette Restitution Fund and oral health programs, and other risk reduction activities. Total budget responsibility - $1,300,000 in federal, state, local and private foundation funds. Ms. Rapposelli will supervise the community case manager paid for with Union Hospital funds and, if funded by MCHRC, the second community case manager.

Kristin Heiner, RN, BSN, MSHA
Director of Case Management – Union Hospital of Cecil County

Ms. Heiner directs and coordinates the care delivery services of the Case Management Department at Union Hospital and provides leadership and direction to the following multidisciplinary teams and work groups: Readmissions; Observation Management; Utilization Management; and community-based Continuity of Care. Ms. Heiner will serve as the hospital's complex case management liaison with the Health Department's community case managers and Ms. Rapposelli.

Mobile Crisis Response

Gwen Parrack, MSW

Director, Special Populations Services Division - Cecil County Health Department

Ms. Parrack manages the Mental Health Core Service Agency, Developmental Disabilities Program, Adult Evaluation and Review Services, and the Medical Assistance Personal Care Program. Total budget responsibility - $1,760,000 in federal, state, and local funds and fee collection. Ms. Parrack will manage the sub-contract with Affiliated Santé.

Carol Masden, LCSW-C

Director, Eastern Shore Mobile Crisis – Affiliated Santé Group

Ms. Masden manages the Eastern Shore Mobile Crisis team, insuring rapid team response, team member training, quality assurance, community outreach, and data management for the eight Eastern Shore counties catchment area. Ms. Masden will hire staff for the Cecil County site and ensure quality mobile crisis response.

Attachment 1 - Cecil County Health Priorities Action Plan

Priority #1: Substance Abuse—Prescription Drugs/ Pain Management			
Goal 1: Reduce the incidence of abuse of prescription drugs			
Objectives	Action Steps	Collaborate With	Completed By When?
1. Increase and enhance research and data analysis on prescription drug abuse and its applications.	1.1: Charge the Alcohol and Drug Council with the task of investigating issues of health care providers who are identified as potential sources of over-prescribed medications or who disregard common prescription drug protocol to prevent haphazard prescribing.	-Alcohol and Drug Council -Substance abuse subcommittee of Alcohol and Drug Council -Law enforcement -Pharmacies -Methadone clinic -Attorneys -Maryland Department of Health and Mental Hygiene (DHMH) -Drug Enforcement Administration (DEA) -Court System -Municipalities	End of FY 2013
	1.2: Research different methodologies used by other communities to tackle prescription drug abuse.		
	1.3: Research how enforcement agencies handle oversight for physicians who violate prescribing laws.		
	1.4: Research which laws regulate prescribing by physicians.		
	1.5: Analyze physicians in the community that consistently see patients who require copious amounts of drugs prescribed. 1.5a: Look for loitering patients in parking lots. 1.5b: Look for repeat patients that have been turned away or patients that return within 30 days without ailments.		
	1.6: Promote Nuisance laws enforcement		
	1.7: Research which pharmaceutical companies provide incentives to providers to encourage narcotic/regulated drug prescribing. 1.7a: What are the laws that govern this incentivizing? 1.7b: Is there opportunity to determine if these laws are being violated? 1.7c: What drugs are being promoted by pharmaceutical companies and how often?		
	1.8: Research the available areas for drug disposal in Cecil County. 1.8a: Determine if ordinances exist and analyze if certain organizations or physician offices are in direct violation of these laws. 1.8b: Provide training for security officers.		

	1.8c: Post disposal information on applicable community organization websites. 1.8d: Propose to increase the number of disposal facilities in Cecil County. 1.8e: Survey a population (Hollingsworth Manor) on how they dispose of their household medications/pain		
	1.9: Conduct a study on what generics are available as substitutes for regulated/hard narcotics prescribed for pain management. 1.9a: Measure accessibility. 1.9b: Measure availability.		
2) Increase education for health professionals and community members on the effects of prescription drug abuse in Cecil County.	2.1: Provide training for staff in physician offices on appropriate prescribing practices and inappropriate use of opioids. 2.1a: The training for staff should be required. 2.1b: Training for physicians should be strongly encouraged.	-Union Hospital -Cecil County Health Department -Law Enforcement -Alcohol and Drug Council -Maryland State Police -Cecil County Government	End of FY 2013
	2.2: Increase training and education for the proper storage and disposal of medications.		
	2.3: Screen for the potential for overdose and provide overdose prevention kits as appropriate.	Cecil County Health Department Alcohol and Drug Recovery Center	By January 2013
3) Increase the pursuit of and enhance the measures to which we pursue funding	3.1: Support funding of prescription drug/pain medication programs through state tax payer funds, restitution funds. 3.1a: As opposed to federally funded programs.	-Community Advocates -Federal and state legislative representatives -Grassroots organizations	End of FY 2013
	3.2: Draft letters to state/local representatives informing them of our position on this issue and how we intend to solve the problem.		

for the prevention and alleviation of prescription drug abuse in Cecil County.	3.2a: Meant to garner legislative support and include said support in grant applications.	-Private funders -Cecil County Health Department -Union Hospital's grant steering committee -Cecil County Government	

Goal 2: Expand resources for the use of alternative pain management methods.

Objectives	Action Steps	Collaborate With	Completed By When?
1) Investigate alternative methods of treating pain.	1.1: Investigate having a local pain management center to treat chronic pain	-Area alternative treatment providers -Others	End of FY 2013
	1.2: Encourage the use of alternative practitioners.		
	1.3: Investigate the availability of alternative practitioners.		
	1.4: Advocate to reduce barriers that coverage of alternative methods of pain management may cause. 1.4a: Find out what insurances cover in this field of treatment 1.4b: Are there coverage period restrictions (is coverage only for one or two months)? 1.4c: What would be out-of-pocket costs for patients seeking these alternative treatment methods?		

Priority #2: Mental/Behavioral Health—Access to Treatment

Goal 1: Increase access to mental/behavioral health treatment services in Cecil County.

Objectives	Action Steps	Collaborate With	Completed By When?
1) Increase transportation to mental/	1.1: Apply for funding for buses/vehicles.	-Any organization	On an ongoing basis, first round
	1.2: Train drivers/certify drivers.		

	behavioral health services/ providers.	1.3: Collaborate with other transportation organizations to provide transit vouchers to patients without insurance.		by end of FY 2013
2)	Increase funding for mental/ behavioral health programs, services and providers.	2.1: Research funding sources and apply for grants. 2.2: Collaborate with other local organizations to share/match funding for mental/behavioral health recruiting efforts.	-Local agencies -Local community organizations -Cecil County Health Department -Union Hospital -Others	Funding should be sought on an ongoing basis, perhaps applied for 3-4 times per year
3)	Decrease rate of Emergency Department visits related to behavioral health conditions	3.1: Provide training for law enforcement in "on scene" behavioral health intervention. 3.2: Provide referrals through the Emergency Department for behavioral health.	-Union Hospital -Law Enforcement -Cecil County Health Department	End of FY 2013
4)	Provide education and promote mental/behavioral health awareness.	4.1: Have coalition meetings involving mental/behavioral health providers only to discuss issues in the county with services, treatment needs, problem cases, need for resource collaboration or allocation. 4.2: Review the Core Services Agency's mental health needs assessment and apply appropriate parts of the mental health plan to each organization/provider's strategic plan for FY 2013.	-Upper Bay Counseling -Behavioral Health Unit at Union Hospital -Counselors, psychiatrists and psychologists	On an ongoing basis, first round by end of FY 2013
5)	Improve mental/behavioral health literacy in Cecil County.	5.1: Increase patient-provider or provider-support system dialogue by incorporating: 5.1a: Question checklists 5.1b: Discharge plans 5.1c: Medication regimens 5.1d: Direction repeats 5.1e: Peer-to-peer counseling training for family members/trusted friends 5.1f: Support groups.	-Care Coordinators -Case Managers -Health Educators -Counselors	End of FY 2013

	5.2: Counselor Pilot Project – provide doctors' offices with counselors to screen for patients' behavioral health problems and risk for child maltreatment		
6) Improve school based counseling services.	6.1: Make counseling services available to all Cecil County public and private schools to increase access to care for all students in the county.	-Upper Bay Counseling -Union Hospital -Area psychologists and psychiatrists -Cecil County Public Schools -Private Schools -Staffing agencies	End of FY 2014
	6.2: Implement mandatory trainings for mental/behavioral health professionals serving schools and: 6.2a: Emphasize updating parents on student progress (per the Family Educational Rights and Privacy Act (FERPA) 6.2b: Improve professional manner and organizational skills aligned with providing services to youth 6.2c: Address practitioners' time management skills 6.2d: Implement either an "on-call" system or a system that brings in relief providers/substitutes for providers out or overworked.		
7) Decrease racial and ethnic disparities for access to mental/behavioral health treatment services.	7.1: Increase minority awareness about mobile crisis unit, West Cecil Health Center, and other mental health service providers in the county	-Mobile Crisis -Health Educators -Cecil County Health Department -Union Hospital -Primary Care Doctors -Faith-based Organizations	End of FY 2013
	7.2: Decrease the number of steps required to attain mental health care for minorities		
	7.3: Increase patient-provider or provider-system dialogue		
	7.4: Increase referrals for behavioral health by having mental health screenings done in primary care settings and emergency rooms		
	7.5: Provide education through minority faith-based organizations		

Goal #2: Increase the number of mental health providers in Cecil County.

Objectives	Action Steps	Collaborate With	Completed By When?
1) Increase funding for	1.1: Research funding sources and apply for grants.	-Local agencies -Local community	End of FY 2013

	recruitment and retention of mental/ behavioral	1.2: Collaborate with other local organizations to share/match funding for mental/behavioral health recruiting efforts.	organizations -Cecil County Health Department -Union Hospital	

health providers in the county.		-Other	
2) Increase provider recruitment efforts in the county.	2.1: Conduct a needs assessment that identifies the number of providers available in the county. 2.1a: Breakout specialties that may need increased recruiting efforts for mental/behavioral providers. 1. Telepsychiatry 2. Pediatric counseling 3. Substance abuse counseling/treatment 4. Suicide 2.2: Collaborate with alternative treatment sources, like faith-based counseling to increase the number of providers available in the county.	-Local agencies -Local community organizations -Cecil County Health Department -Union Hospital -Other	End of FY 2013
3) Increase retention efforts in the county.	3.1: Provide better provider incentives – examples: benefits, loan forgiveness, multiple medical facility privileges (encourages regionalization of services and there is less duplication of services).	-Local agencies -Local community organizations -Cecil County Health Department -Union Hospital -Other	End of FY 2013

Priority #3: Substance Abuse Prevention

Goal #1: Increase community awareness of the potential root causes of substance abuse in Cecil County.

Objectives	Action Steps	Collaborate With	Completed By When?
1) Improve research and data analysis related to local communities and the	1.1: Secure additional data surrounding local substance abuse data from: 1.1a: Union Hospital 1.1b: Police stations 1.1c: Cecil County Health Department 1.1d: Parole and probation programs	-Cecil County Health Department -Union Hospital -Alcohol and Drug Council and Council Subcommittee	End of FY 2013

prevalence of substance abuse in Cecil County.	1.1e: Drug courts 1.1f: Social services 1.1g: School systems 1.1h: Treatment program 1.1i: Department of Juvenile Services		
2) Analyze data to draw conclusions to make recommendations on how to prevent substance abuse in the county.	2.1: Local Health Improvement Process (LHIP) Staff will gather and analyze data to present before the Alcohol and Drug Council.	-Cecil County Health Department -Union Hospital -Alcohol and Drug Council and Council Subcommittee	End of FY 2013
Goal #2: Increase public action to reduce substance abuse in Cecil County.			
Objectives	**Action Steps**	**Collaborate With**	**Completed By When?**
1) Assess existing educational programming to address the prevention of substance abuse in communities in Cecil County.	1.1: Evaluate programming for effectiveness and make recommendations for public information and use. 1.2: Work with other community organizations to implement a media campaign that educates the community and gets them involved in prevention situations.	-Alcohol and Drug Council and Council Subcommittee -Local Management Board -Cecil County Health Department -Union Hospital	End of FY 2013

Priority #4: Child Abuse

Goal #1: Decrease the incidence of child abuse in Cecil County.

Objectives	Action Steps	Collaborate With	Completed By When?
1) Increase the availability of promotional opportunities to help educate Cecil County parents on issues of child development, discipline, parenting skills etc.	1.1: In 2012, participate in local cable franchise agreement negotiations to advocate for local access/community channels 1.2: Develop print educational resource materials (i.e. workbooks/brochures) for parents 1.3: Develop video public service announcements 1.4: Distribute "time-out" tips for parents via phone apps, mail-outs, school lunch menus 1.5: Create mail-outs. 1.6: Utilize social media—Twitter, Facebook, YouTube, etc.	-Department of Social Services -Cecil County Health Department -Police Departments -Cecil County Department of Emergency Services -Cecil County Public and Private Schools	End of FY 2013
2) Increase public awareness of and access to crisis hotlines, "warm" lines and other telephone resources that can help parents in crisis	2.1: By 2013, identify existing hotline and "warm" line resources in Cecil County and Determine their effectiveness 2.2: Ensure crisis hotline and "warm" line groups have updated information on available services in Cecil County 2.3: Identify ways to promote the use of crisis hotlines and "warm" lines to families in crisis 2.3a: Promote hotline/ "warm" line numbers on billboards and other outdoor advertising.	-Department of Social Services -Cecil County Health Department -Police Departments -Cecil County Department of Emergency Services	End of FY 2013
3) Increase the amount of trained staff for child abuse services in the county.	3.1: Recruit staff from local colleges and universities.	-Department of Social Services -Cecil County Health Department	End of FY 2013

4) Increase the capacity and availability of in-home counseling and family intervention services	4.1: Recruit more social work staff from local colleges and universities. 4.2: Increase the numbers of medical providers who can identify possible abuse & who offer education opportunities for parents 4.3: Increase the numbers of public and private school based health centers	-Department of Social Services -Cecil County Health Department	End of FY 2013
5) Improve retention measures to support strategic points of patient intake for child abuse services offered in Cecil County.	5.1: Provide education on child abuse at the high school level to promote interest in college-level degrees and increase the pool of available Child Abuse professionals.	-Department of Social Services -Cecil County Health Department	End of FY 2013
6) Educate parents about child abuse and the importance of its prevention.	6.1: In educational materials or classes, emphasize the importance of the stages of child development and the impact/influence their environment can have on this development. 6.2: Develop interactive courses that initiate and evaluate the parents' use of proper, safe and healthy disciplinary action for children. 6.3: Develop interactive courses that highlight appropriate parenting skills.	-Department of Social Services -Cecil County Health Department -Union Hospital -Cecil County Public and Private Schools	End of FY 2013
7) Facilitate the physician-patient dialogue around child abuse.	7.1: Promote a one-on-one dialogue between the patient and the physician by encouraging the physician to spend 5-10 extra minutes in a question and answer session with the patient. 7.2: Create a question checklist for patients to bring with them to the doctor's visit. 7.3: Promote the "bring-a-buddy" system where spouses, guardians or other support people are included in the dialogue process.	-Department of Social Services -Cecil County Health Department -Union Hospital -Cecil County Public and Private Schools	End of FY 2013

	7.4: Work with OB/GYNS to educate pregnant parents		
8) Increase overall awareness in the community about child abuse prevalence.	8.1: Utilize the schools to assess the staff's understanding of the warning signs of child abuse. 8.2: Post procedure protocol (make more accessible and viewable for the public) for how to handle child abuse situations in schools; OR 8.3: Create a reaction system protocol for how to handle parents and other problem situations involving the identification of child abuse.	-Department of Social Services -Cecil County Health Department -Union Hospital -Cecil County Public and Private Schools	End of FY 2013
9) Promote faith center outreach.	9.1: Assess the availability of faith-based child abuse programming in Cecil County and make a resource list. 9.2: Once a resource list is created, make sure that it is made widely available/accessible to the public; also, make sure it is updated every 6 months to 1 year.	-Department of Social Services -Cecil County Health Department -Union Hospital -Cecil County Public and Private Schools	End of FY 2013

Priority #5: Childhood Obesity—Physical Activity

Goal #1: Improve nutrition and increase physical activity for youth (children) in Cecil County to reduce the prevalence and incidence of childhood obesity.

Objectives	Action Steps	Collaborate With	Completed By When?
1) Increase awareness of available youth-oriented physical activities and youth-oriented nutritious foods available in the county.	1.1: Promote awareness of available physical activity and age-appropriate nutritious programs and activities in the county by posting resources on agency websites, newsletters, and postings in or around Town Parks, at the Library, through social media and other internet sources. 1.2: Display signage, send email blasts, send text messages, and provide quick phone reminder messages about local availability of physical activities and good sources of nutrition in the County. 1.2a: Bulletin boards in grocery stores. 1.2b: Bulletin boards, screen savers at the Library. 1.2c: Set-up tables in lobbies of Union Hospital, Cecil County Health Department, churches, health fairs, YMCA, sporting	-Project Crossroads -Department of Social Services -Cecil County Public Schools -Parks and Recreation -Cecil County Government -County Library -Cecil County Health Department -Media Outlets	End of FY 2013

	events, etc.	-Parents	
	1.3: Change the food culture and environment to focus on identifying and eating good portion sizes, as well as participating in at least 30 minutes of physical activity daily. 1.3a: Develop and implement a campaign led by youth in each community to move forward with these initiatives (using peer role modeling may be a more effective awareness promotion tool).		
2) Increase motivation for youth to participate appropriate amounts of physical activity and eating healthy on a daily basis.	2.1: Provide education opportunities for new and future parents.	-Cecil County Public Schools -Cecil County Health Department -Union Hospital -Other medical providers -Community organizations (Judy Center, county library, grocery and retail stores, faith communities) -Local Media Outlets -University of Maryland Cooperative Extension	End of FY 2013
	2.2: Supplement elementary and middle school curricula with hands-on/interactive nutritious activities.		
	2.3: Supplement elementary and middle school curricula with lessons geared toward adding 10-15 minutes outdoor time to increase physical activity among youth at school.		
	2.4: Promote after-school sports, sports clubs, and/or community service work that involves teaching good nutrition and physical activity measures to other youth in the community.		
	2.5: Increase communication about the availability of physical activities and youth-oriented nutrition through social media sites and other internet usage.		
	2.6: Display signage, send email blasts, send text messages, and provide quick phone reminder messages about local availability of physical activities and good sources of nutrition in the County. 2.6a: Bulletin boards in grocery stores. 2.6b: Bulletin boards, screen savers at the Library. 2.6c: Set-up tables in lobbies of Union Hospital, CCHD, churches, health fairs, YMCA, sporting events, etc.		
3) Increase youth's access to physical activities and nutritious foods in each	3.1: Make nutritious foods available to youth at home and away from home through projects like a community garden, partnerships with farmers' co-ops, and the promotion of buying/using locally grown foods in cafeterias.	-Cecil County Public Schools -Cecil County Health Department -Union Hospital -Other medical	End of FY 2013
	3.2: Increase communication about the availability of physical activities and youth-oriented nutrition through social media sites and		End of FY 2013

community in Cecil County.	other internet usage.	providers	
	3.3: Display signage, send email blasts, send text messages, and provide quick phone reminder messages about local availability of physical activities and good sources of nutrition in the County. 3.3a: Bulletin boards in grocery stores. 3.3b: Bulletin boards, screen savers at the Library. 3.3c: Set-up tables in lobbies of Union Hospital, Cecil County Health Department, churches, health fairs, YMCA, sporting events, etc.	-Community organizations (Judy Center, county library, grocery and retail stores, faith communities) -Local Media Outlets -University of Maryland Cooperative Extension	End of FY 2013

ATTACHMENT 2

CECIL COUNTY HEALTH DEPARTMENT
STEPHANIE GARRITY M.S., HEALTH OFFICER
JOHN M. BYERS HEALTH CENTER • 401 BOW STREET • ELKTON, MD 21921
WWW.CECILCOUNTYHEALTH.ORG

May 30, 2013

Mr. Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner,

The Cecil County Health Department is committed to provide a $19,000 cash match for the Supporting Local Health Improvement Coalitions to Fuel Local Action and Improve Community Health proposal.

Please let us know if you have any questions or need additional information. Thank you.

Sincerely,

Laurie Humphries
Acting Director
Administrative Services