# Local Health Action Plan – Washington County
## 1st Funding Round Deadline December 1, 2011
## 2nd Funding Round Deadline March 1, 2012

## 1. Local Health Planning Coalition Description

(See "Health Planning and Coalition Description" form – Washington County)

## 2. Local Health Data Profile

SHIP measures: Washington County Profile (provided by DHMH) – Appendix A

Washington County disparity measures (provided by DHMH) – Appendix B

Strategic Community Impact Plan (SCIP) – Appendix C – SCIP document

Summary of available data – Appendix D – WCHIC Data Source List

## 3. Local Health Context

The Washington County Health Improvement Coalition's (WCHIC) vision and mission statements mirror the Washington County Health Department's (WCHD) statement and are supported by the Coalition's priorities and objectives. The vision statement is to have "A healthy community for all". The mission statement is to "Promote healthy behaviors, prevent disease and injury, and safeguard the environment".

The priorities identified through the local planning process are not new and were not developed over night. The Washington County Community Foundation and the United Way of Washington County spearheaded a two-year strategic community planning effort beginning in the spring of 2010 that culminated in the publishing of the Strategic Community Impact Plan (SCIP) in the fall of 2011. A Steering Committee oversaw the planning effort with the Impact Council monitoring the work of eleven focus groups: Education, Jobs and Economic Development, Transportation, Family Safety and Security, Health and Well-Being, Older Adults, Disability, Self-Sufficiency, Public Safety, Arts, Culture and Tourism, and Civic Engagement. The focus groups reviewed available data, identified gaps, developed goals, strategies and improvement objectives. The Impact Council will monitor the work of the focus groups over the next several years and will assess the community impact of SCIP.

Since the summer of 2011, Meritus Health and the WCHD have been discussing the importance of facilitating a comprehensive community health needs assessment, including a community-wide survey, since one has not been conducted in the County for approximately ten years. The importance of the needs assessment was also highlighted in the SCIP document as Goal #42: Facilitate a Needs Assessment bringing together data from health and human services to support coordinated program development and delivery.

The County has many other coalition groups that are also focusing their efforts on the top issues in the community. The WCHIC will work very closely with these groups to build upon existing efforts, minimize duplications, and implement a coordinated health improvement plan. The Coalition will also seek to work other identified community partners to build upon their efforts and minimize duplications.

Current Coalitions/Initiatives:

- **Nutrition and Physical Activity (NAPA) Coalition**
  - Partners: Hagerstown YMCA, Washington County Head Start, Washington County Commission on Aging, Food Resources, Inc., Maryland Cooperative Extension, Hagerstown Community College Fitness Center, Cumberland Valley Cycling Club, Washington County Health Department, Department of Social Services, Meritus Health, Parish Nurses, Towson University, United Way, Washington County Housing Authority, Tri-State Health Center, Washington County Board of Education, and the Discovery Station

- **Living Well Coalition**
  - Partners: Washington County Health Department, Meritus Health, Department of Social Services, Hagerstown Community College, and Commission on Aging

- **Washington County Cancer Coalition**
  - Partners: Walnut Street Community Health Center, International Corporate Training and Marketing, American Cancer Society, Washington County Health Department, Maryland Physician's Care, Med Bank, Communidad Latina, Hospice of Washington County, Washington County Head Start, PNC Bank, community representatives, Brothers United Who Dare to Care, Meritus Health, and Komen.

- **Washington County Tobacco Coalition**
  - Partners: Hagerstown Police Department, Girl Scouts, Hagerstown Community College, Community Action Council, American Cancer Society, Teens Have Choices, Boys and Girls Club, community representatives, Brothers United Who Dare to Care, Memorial Recreation, Washington County Public Schools – student government, Girls Inc., Hagerstown Suns, Tri-State Community Health Center, Washington County Health Department, and Sheriff's Department

- **Strategic Community Impact Plan - Health and Well-Being Focus Group**
  - Partners: American Red Cross, Tri-state Community Health Center, Teens Have Choices, Meritus Health, Washington County Health Department, Community Free Clinic, YMCA, Mental Health

Center, Hospice, Walnut Street Community Health Center, area physicians, Parish Nurses, Mental Health Center – Core Service Agency, John Marsh Cancer Center, area dentist, Brooklane, and American Cancer Society

- **Strategic Community Impact Plan - Family Safety and Security Focus Group**
    - Partners: Mason Dixon Boy Scout Council, retired minister, Washington County Health Department, community members, Teens Have Choices, Brooklane, Department of Social Services, Community Action Council, Girls Inc., Western Maryland Consortium, QCI Behavioral Health, Citizens Assisting and Sheltering the Abused (CASA), and Parish Nurses

- **Strategic Community Impact Plan - Impact Council**
    - Partners: Washington County Board of Education, Communidad Latina, Chamber of Commerce, Head Start, Citi Corp, Greater Hagerstown Committee, Washington County Health Department, Teens Have Choices, community representatives, Boys and Girls Club, Girls Inc., Western Maryland Consortium, Community Free Clinic, Dept. of Social Services, Emergency Management, Washington County government, United Way, Community Foundation, League of Women Voters, Arts Council, Sheriff's Department, Hub Labels, and 211

- **Mountain Health Alliance**
    - Partners: Western Maryland Area Health Education Center, Allegany Health Right, Inc., Workgroup on Access to Care, Allegany Health Department, Mineral County Health Department, Mineral County Family Resource Network, Healthy Mineral County Coalition, Washington County Health Department, and Tri-State Community Health Center

- **Local Alcohol and Drug Abuse Council**
    - Partners: Washington County Health Department, Washington County government, Washington County Board of Education, State's Attorney's Office, Office of the Public Defender, Department of Social Services, Circuit Court for Washington County, Washington County Mental Health Authority, Department of Juvenile Services, community representatives, and community provider representative

- **Washington County Local Health Disparities Coalition**
    - Partners: YMCA, Meritus Health, Brothers Who Care, Senator Mikulski's office, Minority Outreach and Technical Assistance (MOTA), Washington County Free Library, Hispanic Association of Hagerstown, Maryland Physician's Care, community

representatives, Walnut Street Community Health Center, Hagerstown Community College, and Washington County Health Department

- **Community Anti-Drug (CAD) Coalition of Washington County**
  - Partners: Hagerstown Police Department, Sheriff's Department, Smithsburg Police Department, Boonsboro Police Department, Hancock Police Department, Maryland State Police, Boys & Girls Club, CSAFE, Kaplan College, Hagerstown Community College, Washington County Public Schools, Juvenile Drug Court, Department of Juvenile Services, Liquor Board, Maryland State Beverage Association, Youth Court, Hagerstown Suns, Washington County Health Department, Teens Have Choices, Mental Health Authority, community members, and St. Maria Goretti High School

Other community partners include:

- Local Management Board
- School Health Council
- Safe Kids
- C-Safe
- Hagerstown Area Religion Council (HARC)
- Parish Nurse Program
- Neighborhood 1st groups in City of Hagerstown
- Western Maryland Area Health Education Center (AHEC)
- United Way of Washington County
- Community Foundation of Washington County

## 4. Local Health Improvement Priorities 2012-2015

### Priority #1 – Access to Care

The importance of the needs assessment was also highlighted in the SCIP document as Goal #42: Facilitate a Needs Assessment bringing together data from health and human services to support coordinated program development and delivery. Goal #23 in SCIP document also addresses access to care: Decrease personal barriers that prevent residents from accessing quality health care services (medical, mental, dental, specialty care, and prescriptions).

Goal: Decrease barriers that prevent residents from accessing quality health care services

| Strategy I<br>Gather data to identify gaps and barriers related to access to health care | | | |
|---|---|---|---|
| Actions | Lead Organization/Partners | Timeline/Milestones | Success Measures |
| Conduct a comprehensive community health needs assessment (CHNA) | WCHD, Meritus Health | *Please see #6 in this document related to specific timeline for CHNA | Report by Fall 2012 |
| Facilitate focus groups with identified populations such as African Americans and Latinos | WCHD, Meritus Health, SCIP Impact Council, WCHIC partners, Communidad Latina, Local Health Disparities Coalition | Collaborate with partners<br>Advertise focus groups<br>Recruit facilitators by May 2012<br>Conduct focus groups | # of meetings<br><br># of attendees<br><br>Summary reports from groups |
| Review final CHNA report | WCHIC | Fall 2012 | Gaps and barriers identified |
| Prioritize gaps and barriers | WCHIC | Fall 2012 | Prioritization exercise completed |
| Develop an Action Plan | WCHIC | January 2013 | Plan completed |

## Priority #2 – Deaths from Heart Disease

Much of the burden of heart disease and stroke could be eliminated by decreasing major risk factors such as high blood pressure, high cholesterol, tobacco use, diabetes, physical activity and poor nutrition.

The SCIP document contains Goal #24: Decrease the obesity rate in children and adults by increasing physical activity and healthy eating. SCIP also contains the following improvement objective: Decrease smokeless tobacco and cigarette use in 12th graders by 3% and in adults by 5% in the next five years (by 2016).

According to the SHIP Baseline Data, Washington County's rate of hypertension-related emergency department visits for African-Americans is 353.8 compared to the County baseline of 170.3 and the State baseline of 237.9.

Goal: Reduce deaths from heart disease by 5% by 2015

| Strategy I<br>Decrease tobacco use | | | |
|---|---|---|---|
| Actions | Lead Organization/Partners | Timeline/Milestones | Success Measures |
| Provide Stop Smoking For Life (SSFL) community cessation program | WCHD, Tobacco Coalition | Ongoing | # of participants<br><br>Amount of time tobacco-free (quit rate) |
| Utilize Maryland Quitline (calling, making referrals, etc.) | WCHD, all community partners, community members | Ongoing | # of callers<br><br>Amount of time tobacco-free (quit rate) |

| Strategy 2<br>Increase physical activity | | | |
|---|---|---|---|
| Actions | Lead Organization/Partners | Timeline/Milestones | Success Measures |
| Complete asset mapping activity to identify resources, gaps, and improve communication and collaboration | WCHD, Meritus Health, WCHIC, SCIP Impact Council, NAPA, area gyms/fitness clubs | Fall 2012 | # of resources identified<br>#of existing partnerships identified<br># of potential partnerships identified<br># of gaps identified |
| Review final CHNA report | WCHIC | Fall 2012 | Barriers identified |
| Prioritize identified barriers to physical activity | WCHIC | Fall 2012 | Prioritization exercise completed |
| Develop an Action Plan | WCHIC | January 2013 | Plan completed |

| Strategy 3<br>Increase healthy eating | | | |
|---|---|---|---|
| Actions | Lead Organization/Partners | Timeline/Milestones | Success Measures |
| Complete asset mapping activity to identify resources, gaps, and improve communication and | WCHD, Meritus Health, WCHIC, SCIP Impact Council, | Fall 2012 | # of resources identified<br>#of existing |

| collaboration | NAPA, area gyms/fitness clubs, Washington County Public Schools | | partnerships identified<br># of potential partnerships identified<br># of gaps identified |
|---|---|---|---|
| Review final CHNA report | WCHIC | Fall 2012 | Barriers identified |
| Prioritize barriers to healthy eating | WCHIC | Fall 2012 | Prioritization exercise completed |
| Develop an Action Plan | WCHIC | January 2013 | Plan completed |

| Strategy 4<br>Improve blood pressure rates and reduce hypertension-related emergency department visits among African-Americans | | | |
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| Actions | Lead Organization/Partners | Timeline/Milestones | Success Measures |
| Build upon existing partnerships with faith-based community in Jonathon Street Community targeting African-Americans | Meritus Health, WCHD, WCHIC, Local Health Disparities Council, HARC | Ongoing | # of participants<br><br># of BP screenings |
| Offer blood pressure screenings, information and referrals in more African-American communities in the County | Meritus Health, WCHD, WCHIC, Local Health Disparities Council, HARC | By Spring 2013 | # of participants<br><br># of BP screenings<br><br># of referrals to community providers |
| Develop a chronic disease case management model focusing on information, referral and targeted case management services | WCHD, Meritus Health, WCHIC, Diabetes Education Center, Local Health Disparities Coalition, HARC | Spring of 2013 | Lit review<br><br>Asset mapping<br><br>Best practices review |
| Seek funding for implementation of the chronic disease case management program | WCHD, Meritus Health, WCHIC, Local Health Disparities Coalition, HARC | Fall of 2014 | Funding secured |
| Implement a chronic disease case management program | WCHD, Meritus Health, WCHIC, Local Health Disparities Coalition, HARC | Spring 2015 | Implementation of program |

Priority #3 – Diabetes Related Emergency Department Visits

WCHIC chose diabetes related emergency department visits as the third of three top priorities for strategic action planning due in part to the direct relationship to obesity, impact on premature morbidity and mortality, the disparity between the county's rates of morbidity and mortality, significant racial disparity, and the potential of addressing the issue with evidence-based strategies.

According to the Centers for Disease Control and Prevention, the prevalence of diagnosed diabetes among adults has continued to increase since 1997. It is the seventh-leading cause of death in the United States. Washington County has the highest death rate from diabetes in Maryland. From 2007 through 2009, Washington County had an age-adjusted death rate of 36.4 deaths from diabetes per 100,000 people in the population, according to the 2009 Maryland Vital Statistics Report. That's about 67 percent higher than the state rate of 21.8. According to the Maryland Vital Statistics Administration, Washington County ranks ninth in Maryland for adults diagnosed with diabetes.

Diabetes is associated with long-term complications that affect almost every part of the body. Complications include: heart disease and stroke, high blood pressure and complications of pregnancy. Heart disease and stroke account for an estimated 65% of deaths in people with diabetes. Approximately 7% of adults with diabetes have blood pressure greater than 130/80 or use a prescription medication to control their blood pressure.

Goal: Reduce the rate of diabetes-related emergency department visits with specific focus on African-Americans from by 10% by 2015

| Strategy I<br>Improve diabetes outcomes with diabetes case management and self-management training programs | | | |
|---|---|---|---|
| Actions | Lead Organization/Partners | Timeline/Milestones | Success Measures |
| Complete asset mapping activity to identify resources, gaps, and improve communication and collaboration | WCHD, Meritus Health, WCHIC, SCIP Impact Council | Fall 2012 | # of resources identified<br>#of existing partnerships identified<br># of potential partnerships identified<br># of gaps identified |
| Identify persons with diabetes who have used emergency department services in past years | WCHD, Meritus Health, Local Health Disparities Coalition, SCIP Impact | Spring 2013 | # of persons identified |

| | | | |
|---|---|---|---|
| and target them for diabetes education and case management | Council, patients, EMS | | # of participants in education/case management programs |
| Identify providers' offices and/or practices and target them and their patients for diabetes education and case management (work with providers to educate them on resources available to patients) | WCHD, Meritus Health, area providers, patients | Spring 2013 | # of providers identified<br><br># of providers that collaborate with education and case management programs |
| Review CHNA final report | WCHIC | Fall 2012 | Report reviewed |
| Facilitate diabetes support groups | WCHD, Housing Authority, Meritus Health, WCHIC | Ongoing | # of participants<br><br># of groups held |
| Provide chronic disease/diabetes self-management programs to community members | WCHD, Diabetes Education Center, Meritus Health | Ongoing | # of participants |
| Develop a community based chronic disease case management model focusing on information, referral and targeted case management services | WCHD, Meritus Health, WCHIC, Diabetes Education Center | Spring of 2013 | Lit review<br><br>Asset mapping<br><br>Best practices review |
| Seek funding for implementation of the chronic disease case management program | WCHD, Meritus Health, WCHIC | Fall of 2014 | Funding secured |
| Implement a community based chronic disease case management program | WCHD, Meritus Health, WCHIC | Spring 2015 | Implementation of program |

**5. Local Health Planning Resources and Sustainability**

As a not for profit hospital, Meritus Medical Center, Inc. directed $21.3 million in resources during FY2011 to help meet community needs and improve the health of the residents who live here. Meritus Medical Center, Inc. has provided financial support for the WCHIC start-up and is providing both in-kind dollars and personnel to complete the comprehensive community health needs assessment. The ability to sustain community health improvement strategies will be partially dependent upon the strategic and purposeful allocation of future community benefit resources.

The Washington County Health Department will continue to devote staff time to coordinate with Meritus Health and Department of Health and Mental Hygiene in conducting a Community Health Needs Assessment and to implement the local health improvement plan.

Both entities will seek funding opportunities for financing implementation projects cited in the local plan. WCHIC will continue to work with the Community Foundation and the United Way to align our priorities, minimize duplication of effort, and seek funding opportunities that will assist us in furthering our goals.

**6. Timeline and Methods for the Community Health Needs Assessment**

The process of completing a comprehensive community health needs assessment was begun in earnest in 2011. The Meritus Community Health Needs Assessment steering committee reviewed and built upon the initial community health needs that were identified in the 2012-2016 Strategic Community Impact Plan. A process to gather demographic and secondary data for the purpose of assessing health needs was completed. During the review of the State Health Improvement Plan it was determined that a larger community coalition would be established to partner in conducting the needs assessment. The Washington County Health Improvement Coalition was formed and held a Community Health Summit for the purpose of reviewing the SHIP objectives with key stakeholders to obtain input from providers and the public. Using the ranked SHIP objectives, SCIP needs and analysis of secondary data it was determined that a randomized sample of the region's residents will be surveyed to obtain primary data and input in the assessment of needs. In addition, focus groups will be conducted to address health disparities in issues that include access to care, cardiovascular disease, diabetes and obesity.

Goal:

To complete a comprehensive assessment of the health status and healthcare access needs of residents living in the Washington County region

Objectives:

1. Identify the current health status of regional residents to include baseline data for benchmarking and assessment
2. Assess whether existing services meet the community's health needs and are accessible
3. Identify the availability of treatment to meet needs, service gaps and areas of duplication
4. Evaluate and direct Meritus Health's community benefit and strategic planning
5. Enhance strategic planning for Washington County Health Department's services and allocation of resources

6. Access Meritus Healthcare Foundation grant program to identify funding opportunities that address solutions to current and emerging regional health issues

Timeline:

| | | |
|---|---|---|
| March 2012 | - | Apply for funding from CHRC and complete RFP |
| April 2012 | - | Secure vendor and develop needs assessment survey |
| May 2012 | - | Conduct needs assessment survey and facilitate focus groups |
| June 2012 | - | Complete analysis of primary and secondary data |
| July 2012 | - | Publish community health needs assessment with action plan to address identified needs |