Baltimore County Department of Health

2021 Community Health Improvement Plan

Approved Board of Health Date: 10222021

Healthy people living, working and playing in Baltimore County

CREDITS & ACKNOWLEDGEMENTS

This Community Health Improvement Plan (CHIP) version 2 represents the work of partners involved in version 1 from the Local Health Improvement Coalition (LHIC) over the last two years. The Baltimore County Department of Health (BCDH) would specifically like to thank members of the 2020 Triennial Community Health Needs Assessment (CHNA) Collaborative for its work on the most recent CHNA informing this new CHIP. The Triennial CHNA Collaborative consisted of population health representatives from the hospital systems in Baltimore County, Baltimore City, ourHealth Officer, Deputy Health Officer and the Chief of Quality Improvement. This group will become a subcommittee of the LHIC. In addition, the Age-Friendly Baltimore County initiative from the Department of Aging was instrumental in accessing many focus groups for the CHNA qualitative data. The LHIC is the final approver of the new CHIP, as well as the Board of Health, and their input is essential.

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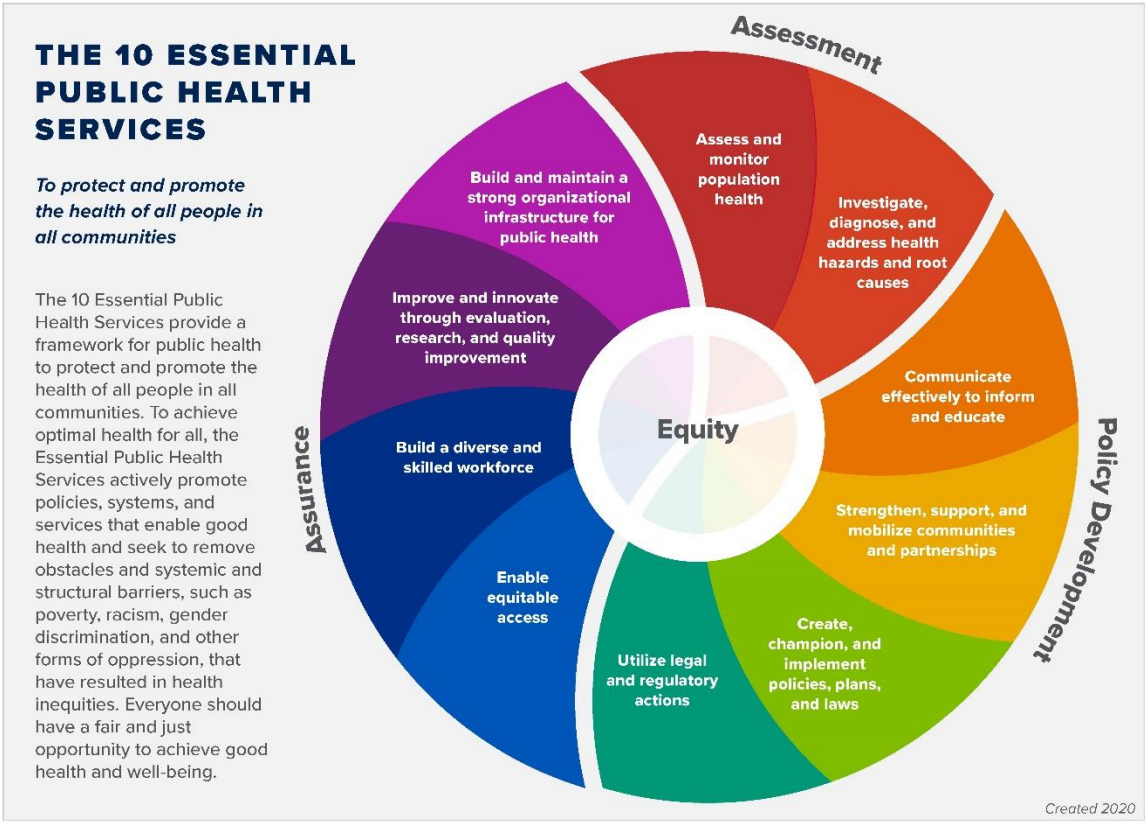
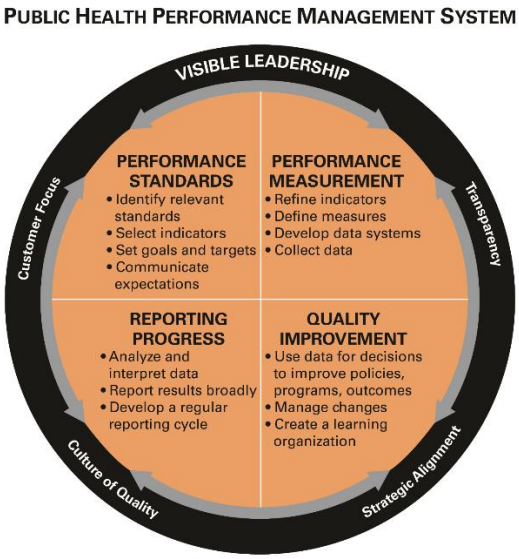
EXECUTIVE SUMMARY

Leveraging its recently updated Community Health Needs Assessment (CHNA), BCDH relied on the work of the Triennial CHNA Committee to work to identify the top three areas from the qualitiative and quantitative data. The work built on the 2017 Mobilizing for Action Through Planning and Partnerships (MAPP) assessments and CHIP Version 1. The group met monthly and worked with a consultant to analyze the data.

The Triennial CHNA group presented implementation plans at the LHIC meeting in July to determine common next steps. In August the group met and determined to focus efforts on the essential service of Communicate Effectively to Inform and Educate from the revised 2020 10 Essential Services form the Centers for Disease Control.



Using the Public Health Foundation Public Health Performance Management System framework, Performance Standards were chosen, indicators were selected and refined, and measures were developed that would allow data to be collected.



Through the work of Triennial CHNA Committee, the following priority need areas were established, which are similar to the two of the CHIP Version 1 results:

Priority Health Need Areas

- Behavioral Health, including Mental Health and Substance Use Disorders
- Physical Health
- Health Disparities

The CHIP will inform the Health Department Strategic Plan performance measures so that alignment is achieved.

BCDH encourages residents and community groups to join the CHIP process as it continues its new action phase. For more information, please contact Laura Culbertson at 410-887-3729 or lculbertson@baltimorecountymd.gov. By working together on priority need areas, community members will help realize the vision to have healthy people living, working and playing in Baltimore County.

PART 1 | BACKGROUND INFORMATION

Background

To further illustrate its commitment to the health and well-being of the community, the Collaborative completed this assessment to understand and document the greatest health needs currently faced by its residents. BCDH, Northwest Hospital of LifeBridge Health, Sheppard Pratt, GBMC, UM SJMC, and MedStar Franklin Square make up the Collaborative, and representatives from each of these organizations worked together as the CHNA Steering Committee to guide the development of this CHNA. These organizations provided the focus group and survey data that are further analyzed in this report. In addition, MedStar Franklin Square provided some existing data from their FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting that are utilized in this report. The CHNA process examines the overall health needs of the residents of Baltimore County and allows the county to continuously evaluate how best to improve and promote the health of the community. While each of these organizations has historically assessed the health needs of the community and responded accordingly, this CHNA is a more formal and collaborative approach by community partners to proactively work together to identify and respond to the needs of Baltimore County residents.

Process Overview

A significant amount of information has been reviewed during this planning process, and the CHNA Steering Committee has been careful to ensure that a variety of sources were used to deliver a truly comprehensive report. Assessment methods included both existing (secondary) data as well as new (primary) data that were collected directly from the community throughout this process. It is also important to note that, although unique to Baltimore County, the sources and methodologies used to develop this report comply with the current standards and measures of the Public Health Accreditation Board (PHAB) and IRS requirements for nonprofit hospital organizations.

The purpose of this study is to better understand, quantify, and articulate the health needs of Baltimore County residents. Key objectives of this CHNA include:

- Identify the health needs of Baltimore County residents.
- Understand racial and geographic health disparities that exist in Baltimore County.
- Understand the challenges residents face when trying to maintain and/or improve their health.
- Understand where underserved populations turn for services needed to maintain and/or improve their health.
- Understand what is needed to help residents maintain and/or improve their health.
- Prioritize the needs of the community and clarify/focus on the highest priorities.

PART 2 | SUMMARY of CHNA

Summary Findings: Baltimore County Priority Health Need Areas

To achieve the study objectives, both new and existing data were collected and reviewed. New data included information from internet-based surveys and focus groups; various local organizations, community members, and health service providers within Baltimore County participated. Existing data included information regarding the demographics, health and healthcare resources, behavioral health, disease trends, and county rankings of Baltimore County. The data collection and analysis process began in June 2020 and continued through to the development of this document.

Given the size of Baltimore County, both in geography and population, significant variations in demographics and health needs exist within the county. At the same time, consistent needs are present across the whole county and thus serve as the foundation for determining priority health needs at the county level. This document will discuss the priority health need areas for Baltimore County, as well as how the severity of those needs might vary across racial and geographic sub-groups based on the information obtained and analyzed during this process.

Through the prioritization process discussed in this document, the CHNA Steering Committee identified Baltimore County's priority health need areas from a list of over 100 potential health needs. Please note that the final priority need areas were not ranked in any hierarchical order of importance and all will be addressed by the Collaborative and the Local Health Improvement Coalition (LHIC). After analysis of all relevant data and discussions with the CHNA Steering Committee, the following three focus areas have been identified as county-wide priorities for the 2020-2021 CHNA:

Priority Health Need Areas

- Behavioral Health, including Mental Health and Substance Use Disorders
- Physical Health
- Health Disparities

It is important to note that health, healthcare, and associated community needs rarely exist in a vacuum. Instead, they are very much interrelated with each other, with improvements in one driving advancements within another. As such, although it was necessary for this process to separate the various areas for purposes of measuring need, the interrelationship should be acknowledged as improvement initiatives are considered going forward.

Further, many health needs are the result of underlying societal and socioeconomic factors. Many studies show that factors such as income, education, and the physical environment affect the health status of individuals and communities. This CHNA acknowledges that linkage and focuses on identifying and documenting the greatest health needs as they present themselves today. As strategic and health improvement plans are developed to address these needs, it is clear that the Collaborative's goal is to work with other community organizations to address more systemic factors that have the potential for long-term improvements to the population's health.

PART 3 | CHIP PLANNING PROCESS

The Collaborative shared information as part of the CHNA and its commitment to developing a joint CHIP. This was presented at a LHIC meeting in 2021.

Baltimore County Department of Health

BCDH's FY2021 Community Health Improvement Plan (CHIP) addresses the following priority areas: access to care, behavioral health, and chronic disease. Due to challenges related to the COVID-19 pandemic, some planned action items have not yet been conducted. However, BCDH has successfully increased access to care through expanded use of bilingual staff and enhanced cultural competencies in surveys and focus groups. To address behavioral health concerns, BCDH has held Narcan trainings (including virtual trainings) and provided access to Narcan kits, developed new peer case manager positions, and tracked the number of clients placed in behavioral health treatment programs. As part of its strategy related to chronic disease, BCDH and the Fetal and Infant Mortality Community Action Team (FIMR CAT) have conducted case reviews to promote healthy pregnancies and birth outcomes.

Northwest Hospital of LifeBridge Health

Northwest Hospital's 2018-2020 implementation plan addressed the following priority areas: chronic disease, health education/knowledge of available resources, medical insurance, workforce development, and its relationship with Chase Brexton Primary Care. To address these respective issues, the Office of Community Health Improvement has implemented the Diabetes Wellness Series, continued the Changing Hearts Program, increased staff to expand reach into surrounding communities, trained staff to assist patients with navigating and applying for Medicaid health insurance, utilized Sinai Hospital of Baltimore's vocational services and workforce readiness program (VSP) for training and workforce development services, and strengthened existing partnerships with Chase Brexton to increase access for patients needing behavioral health services.

Sheppard Pratt

Sheppard Pratt's 2019 Implementation Plan addresses priority areas related to behavioral health including mental health and substance use disorders. Sheppard Pratt Leadership met to determine which identified needs fall within its purview to impact as a behavioral health provider and to discuss which of the organization's programs could be expanded upon to meet community needs more effectively. The system has taken steps to serve the community by expanding access to its urgent psychiatric care clinic, improving care coordination with local health system partnerships, implementing mental health training programs for providers, developing a hub-and-spoke opioid treatment program, and advocating for policy change to better support community behavioral health.

Greater Baltimore Medical Center Healthcare

GBMC's 2020-2022 implementation plan addresses the following priority areas: behavioral health/substance use disorders, access to care, and obesity. To address issues related to behavioral health/substance use disorders, GBMC expanded Mental Health First Aid Training and continues to support the GBMC Sexual Assault Forensic Examination (SAFE) Program. Relative to access to care, GBMC has facilitated connections to meet the needs of underserved populations through the Elder Medical Care program, the Complex Care Clinic, and the Moveable Feast program. To reduce risk factors contributing to obesity, GBMC has encouraged community weight loss as a means of diabetes prevention and partnered with Hungry Harvest for Produce in a SNAP initiative.

University of Maryland St. Joseph Medical Center

UM SJMC's FY2020-2022 implementation plan addresses the following priority areas: access to care, chronic health conditions, cancer, fall prevention, and mental health and substance abuse. Although the COVID-19 pandemic created challenges related to care access, UM SJMC formed new partnerships with local schools and community organizations to distribute needed resources including COVID-19 wellness kits, vaccine education and registration support, and flyers for programs and resources. UM SJMC also successfully transitioned many programs to virtual offerings and the St. Clare Medical Outreach team continued serving underserved communities through telehealth visits.

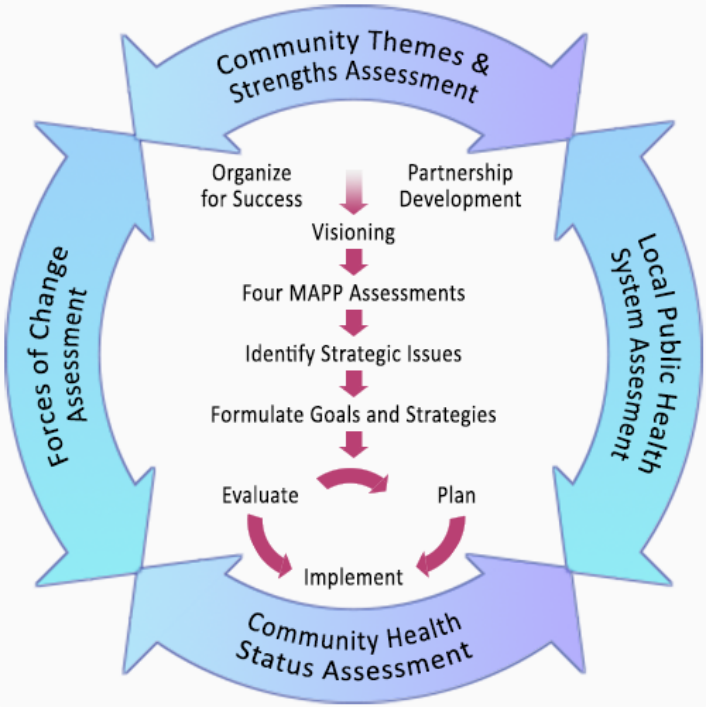
To address chronic health conditions, UM SJMC adopted the National Diabetes Prevention Program and partnered with the Baltimore County Department of Health to plan and deliver education about the dangers of vaping to local schools and youth organizations. UM SJMC also opened the Wellness and Support Center to provide a variety of support services for cancer survivors. Programs focused on fall prevention have also been expanded through the adoption of the "Tai Ji Quan: Moving for Better Balance" program which has also been offered virtually throughout the pandemic. The University of Maryland Health System has led several webinar series on mental health and health literacy topics that have been shared widely across system hospitals.

MedStar Franklin Square Medical Center

MedStar Franklin Square's 2018 implementation plan addresses the following priority areas: health and wellness, access to care and services, and social determinants of health. The hospital conducts many programs and support groups related to chronic disease including its Living Well Chronic Disease Self-Management Program, a Diabetes Prevention Program, a Smoking Cessation Program, and a Stroke Support group. To address behavioral health issues, MedStar Franklin Square has implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategy in emergency department and primary care settings and embedded Peer Recovery Coaches on hospital care teams. Relative to maternal and child health, the hospital has supported and coordinated the Healthy Babies Collaborative. To better provide access to care and services, MedStar Franklin Square has included mental health services as part of its primary care model and conducted social needs screenings and support linkages as part of care delivery. It has partnered with outside organizations to address social determinants of health related to transportation and employment, including implementing the MedStar Health UBER program, conducting the PHWSDA program, and conducting the Rx for Success Pipeline Summer Internship Program for underserved high school students.

Areas of overlap and joint population health planning were identified. The MAPP process Evaluate Plan and Implement continues with the new CHIP 2021. The impact of social determinants of health, disparities and stigma was a discussion in terms of the new goals and intervention strategies for the Collaborative.

MAPP PROCESS SUMMARY



The Collaborative met monthly to determine the Goals and Intervention Strategies for the priority areas. After approval and agreement, the LHIC presentation included both the process and the goals and action steps.

PRIORITY AREA 1: Chronic Disease

GOAL: Refer clients to lifestyle change programs to promote physical activity using culturally competent communications.

The Chronic Disease priority area includes low birth weight, obesity, diabetes and hypertension. It includes both prevention and management of chronic disease. Referrals to case management programs also would help to connect clients to resources and provide support to decrease stress.

Action Steps	Target Date	Lead Person or Organization	Process Measures or Progress Notes
1. Develop system to track referrals to	12/1/2021	Laura Culbertson HD	• How much: # quarterly data

different programs			reports submitted to the HD by partners
2. Develop and conduct focus groups in AA and Hispanic community	3/1/2022	Health Equity and chronic disease staff HD and partners	• How well: # of people that attend focus groups
3. Develop resource directory for lifestyle programs	4/1/2022	Laura Culbertson HD	• How Many: # of resources collected in a directory

PRIORITY AREA 2: Behavioral Health and Substance Use Disorder

GOAL: Inform clients of resources and referrals to programs that stabilize their conditions.

The CHNA Collaborative discussed the fact that substance use disorder and mental health issues are interrelated. The partners have committed to improving access to treatment, sponsoring groups on managing chronic pain, and connecting with mental health organizations. The use of peers has expanded form the last CHIP in 2020.

Action Steps	Target Date	Lead Person or Organization	Process Measures or Progress Notes
1. Develop system to track referrals to different programs	12/1/2021	Laura Culbertson HD	• How much: # quarterly data reports submitted to the HD by partners
2. Develop and conduct focus groups in community	3/1/2022	Health Equity staff HD and partners	• How well: # of focus groups
3. Develop resource directory for	4/1/2022	Laura Culbertson HD	• How Many: # of resources collected in a directory

behavioral health			

PRIORITY AREA 3: Health Disparities

GOAL: Connect with groups in the community experiencing health disparities.

Action Steps	Target Date	Lead Person or Organization	Process Measures or Progress Notes
1. Promote enrollment in health insurance	3/1/2022	Laura Culbertson HD	• How much: # of persons enrolled in health insurance
2. Conduct focus groups for identified health disparities	3/1/2022	Health Equity and chronic disease staff HD and partners	• How well: # bilingual resources created
3. Develop resource directory that is accessible to all languages	4/1/2022	Laura Culbertson HD	• How Many: # of resources collected in a directory in 3 languages

PART 4 | MONITORING AND EVALUATION

As the strategies and action steps result in programs with the measureable outcomes included, the Performance Management system includes reporting progress. Implementing programming to address the Priority Need areas will be added to the Strategic Plans in the BCDH. In this format, the CHIP will be directly linked to the Strategic Planning dynamic and

continuous process. Data from the Strategic Plans are collected quarterly and reviewed by the Performance Management Council. In reporting out progress, there will be opportunities to work both within the Health Improvement Coalition, the Board of Health, and the Office of QI.

Review Cycle and LHIC Responsibilities

The CHIP will be reviewed in its entirety annually and include data review of the goals, lessons learned, and revisions to the goals, objectives and/or action plans. Twice per year, according to a pre-determined schedule , the designated lead person for each of the Action Plans will complete a progress reporting tool to present to the LHIC (Appendix A). Any barriers or issues with the data collection will be reviewed.

After the annual review, a presentation to the Board of Health will take place that allows for a discussion of the Health Department's direction and population health initiatives. The Board of Health will approve any changes to the CHIP at that time.

Appendix A

CHIP Action Plan Progress Report LHIC Priority x MONTH Goal: Objective: Intrevention Strategy:				
Action Step	Target Date	Process Measure	Progress Report	Plan