

# 2012 STATE OF MARYLAND HEALTH IMPROVEMENT PROCESS (SHIP) & Local Health Improvement Plan (LHIP)

## A. Methodology

In the fall of 2011, the Maryland Department of Health and Mental Hygiene launched a state-wide effort to standardize a health improvement process within their system of local county health departments. The effort at the state level is known as the State Health Improvement Process (SHIP) and the Local Health Improvement Plan (LHIP) at the county level. The initiative received strong support from the Office of the Governor as a valuable asset to existing goals of improving the health of Marylanders and thus impacting the spiraling costs of health care consumption. Hospital members of The Maryland Hospital Association agreed to lend their support and pledged hospital participation which in some areas included significant financial support to establish the state-wide web-based reporting system associated with the SHIP.

In areas where hospital/health department collaborations on health improvement activities were already up and running, the value of that collaborative relationship was recognized and no additional cash support was requested. Because of the existing strong and effective relationship between CHC and CCHD in creating The Partnership for a Healthier Carroll County, Inc. we were not required to advance the \$25,000 per hospital that some contributed.

The Partnership's Board of Directors configuration met all of the representative requirements proposed by the SHIP for the "Community Coalition" required to lead the LHIP in our county. Originally, it was thought that the SHIP process and CHNA process could be almost seamless so this seemed like an easy solution and The Partnership Board agreed to serve; however, as the SHIP evolved it became apparent that they would have to be managed as parallel projects because of the SHIP connection to state funding through a state grant application process. This essentially doubled our workload as we conducted both the CHNA and the SHIP simultaneously.

To start and standardize, the SHIP identified 6 common "Vision Areas" for each county with 39 High Impact objectives. They provided per county baseline and comparative state-wide performance measures for each. A county profile document including a brief demographic

summary was prepared by each local coalition (attached). This is very valuable adjunct information in our CHNA process as well.

After thorough data analysis, our coalition identified 5 major priority areas which needed attention in order to meet HP 2020 improvement targets.

Those 5 areas are:


- Addictions and Behavioral Health
- Oral Health
- Tobacco
- Nutrition-Obesity and Salmonella
- Heart Disease and Cancer


## **B. Results Summary**

Pages have been established on The Partnership's website [www.HealthyCarroll.org](http://www.HealthyCarroll.org) regarding the SHIP-LHIP including meeting minutes and other information required since it is required to have public participation and therefore an open process.

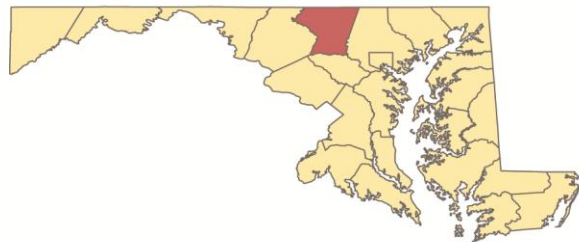
## **C. Inclusions**

- i. SHIP Vision Areas & Objectives
- ii. Carroll County SHIP Profile - December 2011
- iii. Carroll County Local Health Improvement Process 2012-2014 - March 2012
- iv. Carroll County LHIP Review and Update - June 2012

Vision Area	SHIP Objectives
 <p data-bbox="350 478 521 506">Healthy Babies</p>	<p data-bbox="626 239 938 266">1. Increase Life Expectancy</p> <p data-bbox="626 275 906 302">2. Reduce infant deaths</p> <p data-bbox="626 310 1287 369">3. Reduce low birth weight (LBW) &amp; very low birth weight (VLBW)</p> <p data-bbox="626 378 1230 405">4. Reduce sudden unexpected infant deaths (SUIDs)</p> <p data-bbox="626 413 1317 441">5. Increase the proportion of pregnancies that are intended</p> <p data-bbox="626 449 1260 508">6. Increase the proportion of pregnant women starting prenatal care in the first trimester</p>
 <p data-bbox="350 720 521 779">Healthy Social Environments</p>	<p data-bbox="626 522 979 550">7. Reduce child maltreatment</p> <p data-bbox="626 558 943 585">8. Reduce the suicide rate</p> <p data-bbox="626 594 1287 621">9. Decrease the rate of alcohol-impaired driving fatalities</p> <p data-bbox="626 630 1198 688">10. Increase the proportion of students who enter kindergarten ready to learn</p> <p data-bbox="626 697 1317 756">11. Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade</p> <p data-bbox="626 764 984 791">12. Reduce domestic violence</p>
 <p data-bbox="277 1035 594 1062">Safe Physical Environments</p>	<p data-bbox="626 806 1097 833">13. Reduce blood lead levels in children</p> <p data-bbox="626 842 995 869">14. Decrease fall-related deaths</p> <p data-bbox="626 877 1174 905">15. Reduce pedestrian injuries on public roads</p> <p data-bbox="626 913 1317 940">16. Reduce Salmonella infections transmitted through food</p> <p data-bbox="626 949 1268 1008">17. Reduce hospital emergency department visits from asthma</p> <p data-bbox="626 1016 1044 1043">18. Increase access to healthy food</p> <p data-bbox="626 1052 1292 1110">19. Reduce the number of days the Air Quality Index (AQI) exceeds 100</p>
 <p data-bbox="334 1356 537 1383">Infectious Disease</p>	<p data-bbox="626 1117 1206 1176">20. Reduce new HIV infections among adults and adolescents</p> <p data-bbox="626 1184 1325 1243">21. Reduce Chlamydia trachomatis infections among young people</p> <p data-bbox="626 1251 1308 1310">22. Increase treatment completion rate among tuberculosis patients</p> <p data-bbox="626 1318 1341 1377">23. Increase vaccination coverage for recommended vaccines among young children</p> <p data-bbox="626 1386 1300 1444">24. Increase the percentage of people vaccinated annually against seasonal influenza</p>
 <p data-bbox="342 1749 529 1776">Chronic Disease</p>	<p data-bbox="626 1446 1065 1474">25. Reduce deaths from heart disease</p> <p data-bbox="626 1482 1092 1509">26. Reduce the overall cancer death rate</p> <p data-bbox="626 1518 1292 1545">27. Reduce diabetes-related emergency department visits</p> <p data-bbox="626 1554 1341 1581">28. Reduce hypertension-related emergency department visits</p> <p data-bbox="626 1589 1011 1617">29. Reduce drug-induced deaths</p> <p data-bbox="626 1625 1292 1684">30. Increase the proportion of adults who are at a healthy weight</p> <p data-bbox="626 1692 1308 1751">31. Reduce the proportion of children and adolescents who are considered obese</p> <p data-bbox="626 1759 1333 1787">32. Reduce the proportion of adults who are current smokers</p> <p data-bbox="626 1795 1284 1854">33. Reduce the proportion of youths who use any kind of tobacco product</p>

	34. Reduce the number of emergency department visits related to behavioral health conditions.
	35. Reduce the proportion of hospitalizations related to Alzheimer's disease and other dementias
	36. Increase the proportion of persons with health insurance
	37. Increase the proportion of adolescents who have an annual wellness checkup
	38. Increase the proportion of children and adolescents who receive dental care
<p>Healthcare Access</p>	39. Reduce the proportion of individuals who are unable to afford to see a doctor

# CARROLL COUNTY



Carroll County has some notable health strengths and other areas where an investment in targeted action could pay dividends over the upcoming years.

**Good News!** In terms of the 39 SHIP measures, Carroll County performs best relative to the State baseline on new HIV infections, Chlamydia infections and pedestrian injuries on public roads.

**Challenges** – The top five SHIP measures where Carroll County performs worse than the State baseline are hospitalizations related to Alzheimer’s disease and other dementias, adult smoking, emergency department visits related to behavioral health conditions, suicide, and the proportion of children who receive dental care.

The SHIP website provides continuously updated tools to address health challenges in the County, as well as tips and resources for individuals. The website also features news and opportunities to inform evidence based local action. We invite you to visit the website frequently and let us know how to improve it by clicking on the comment link. You can also friend us on Facebook <http://www.facebook.com/MarylandSHIP> or follow us on Twitter <http://www.twitter.com/MarylandSHIP> for regular news and resources. Click on the link at the bottom of this page or e-mail the coalition contact listed below to get involved or learn more.

Demographics	Carroll	Maryland
Total Population*	167,134	5,773,552
Age*, %		
Under 5 Years	5.4%	6.3%
Under 18 Years	24.7%	23.4%
65 Years and Older	13.0%	12.3%
Race/Ethnicity*, %		
White	92.9%	58.2%
Black	3.2%	29.4%
Native American	0.2%	0.4%
Asian	1.4%	5.5%
Hispanic or Latino origin	2.6%	8.2%
Median Household Income**	\$79,703	\$70,017
Households in Poverty**, %	6.3%	8.6%
Pop. 25+ Without H.S. Diploma**, %	9.8%	12.1%
Pop. 25+ With Bachelor’s Degree or Above**, %	31.8%	35.6%

Sources: \*U.S. Census (2010), \*\*American Community Survey (2008-2010)

## Health Improvement Coalition Contact:

Barb Rodgers

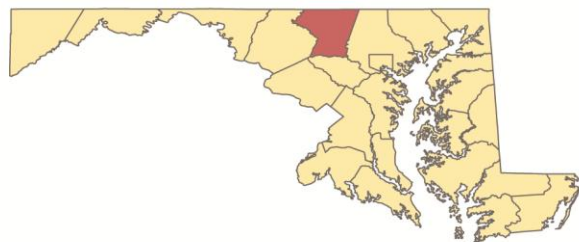
Dir. Health Planning & Community Improvement  
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[brodgers@dhmh.state.md.us](mailto:brodgers@dhmh.state.md.us)



**Local Health Improvement Coalition Website:** <http://www.healthycarroll.org>

# CARROLL COUNTY

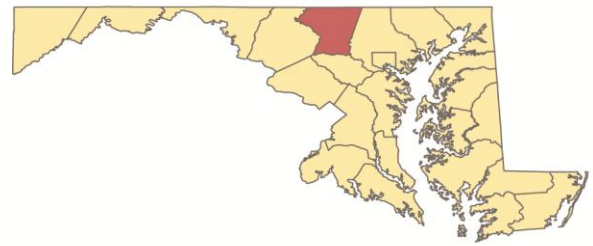


## High Impact Objectives

Figures in **RED**/**GREEN** represent when the county baseline is **WORSE**/**BETTER** than the state baseline.

Obj #	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	Maryland 2014 Target
<b>High Morbidity Impact</b>				
17	Rate of ED visits for asthma per 100,000 population (HSCRC 2010)	<b>381.0</b>	850.0	671.0
27	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	<b>227.4</b>	347.2	330.0
28	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	<b>123.3</b>	237.9	225.0
34	Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)	<b>1,364.8</b>	1,206.3	1,146.0
<b>High Mortality Impact</b>				
25	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	<b>192.1</b>	194.0	173.4
26	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	<b>182.1</b>	177.7	169.2
<b>Multiple Impact Objectives (those objectives with a high rate of return on investment)</b>				
3	Percentage of births that are LBW (VSA 2007-2009)	<b>6.8%</b>	9.2%	8.5%
6	Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)	<b>90.5%</b>	80.2%	84.2%
11	Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	<b>90.3%</b>	80.7%	84.7%
30	Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)	<b>34.6%</b>	34.0%	35.7%
31	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	<b>9.1%</b>	11.9%	11.3%
32	Percentage of adults who currently smoke (BRFSS 2008-2010)	<b>20.3%</b>	15.2%	13.5%
33	Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)	<b>23.1%</b>	24.8%	22.3%
36	Percentage of civilian, non- institutionalized 18-64 yr olds with any type of health insurance (BRFSS 2008-2010)	<b>90.7%</b>	86.5%	90.9%
38	Percentage of children 4-20 yrs enrolled in Medicaid that received a dental service in the past year (Medicaid CY2009)	<b>52.5%</b>	59.0%	62.0%
39	Percentage of people who reported there was a time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)	<b>8.7%</b>	12.0%	11.4%

# CARROLL COUNTY



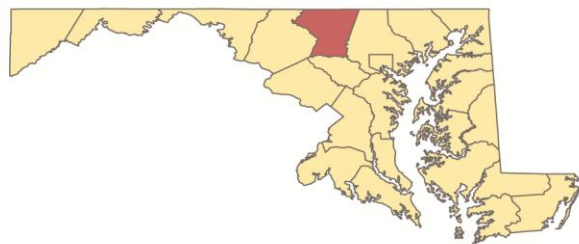
## SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in **RED**/**GREEN** represent when the county baseline is **WORSE**/**BETTER** than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
35	Rate of hospital admissions related to dementia/ Alzheimer's per 100,000 population (HSCRC 2010)	29.3	17.3	N/A		16.4	<b>-69.5</b>	N/A
32	Percentage of adults who currently smoke (BRFSS 2008-2010)	20.3%	15.2%	20.6%	White/NH-18.9%	13.5%	<b>-33.6</b>	<b>1.5</b>
34	Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)	1,364.8	1,206.3	N/A	White-1,359.5 Black-2,306.8	1,146.0	<b>-13.1</b>	N/A
8	Rate of suicides per 100,000 population (VSA 2007-2009)	10.8	9.6	11.3		9.1	<b>-12.5</b>	<b>4.4</b>
38	Percentage of children 4-20 yrs enrolled in Medicaid that received a dental service in the past year (Medicaid CY2009)	52.5%	59.0%	N/A		62.0%	<b>-11.0</b>	N/A
24	Percentage of adults who have had a flu shot in last year (BRFSS 2008-2010)	40.7%	43.0%	25.0%	White/NH-43.8%	61.5%	<b>-5.3</b>	<b>62.8</b>
26	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	182.1	177.7	178.4	White-181.4 Black-148.5	169.2	<b>-2.5</b>	<b>-2.1</b>

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# CARROLL COUNTY



## SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

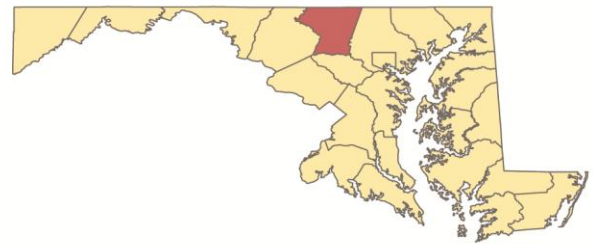
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Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
25	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	192.1	194.0	190.9	White-187.9 Black-210.0	173.4	1.0	-0.6
1	Life expectancy at birth (VSA 2009)	79.6	78.6	77.9		82.5	1.3	2.2
30	Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)	34.6%	34.0%	30.8%	White/NH-34.1%	35.7%	1.8	12.3
29	Rate of drug-induced deaths per 100,000 population (VSA 2007-2009)	13.2	13.4	12.6		12.4	1.8	-4.4
36	Percentage of civilian, non-institutionalized 18-64 yr olds with any type of health insurance (BRFSS 2008-2010)	90.7%	86.5% ^	N/A		90.9%	4.9	N/A
33	Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)	23.1%	24.8%	26.0%		22.3%	6.9	11.2
16	Rate of Salmonella infections per 100,000 (IDEHA 2010)	16.8	18.8	15.2		12.7	10.6	-10.5

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# CARROLL COUNTY



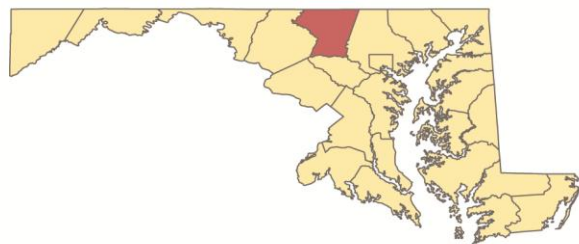
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11	Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	90.3%	80.7%	74.9%		84.7%	11.9	20.6
6	Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)	90.5%	80.2%	70.8%	White/NH- 91.5% Black- 82.6% Asian- 92.7% Hispanic- 71.1%	84.2%	12.8	27.8
10	Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011)	95.0%	81.0%	N/A		85.0%	17.3	N/A
14	Rate of deaths associated with falls per 100,000 population (VSA 2007-2009)	5.9	7.3	7.0		6.9	19.3	15.8
31	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	9.1%	11.9%	17.9%		11.3%	23.5	49.2
12	Rate ED visits related to domestic violence/abuse per 100,000 population (HSCRC 2010)	52.1	69.6	N/A		66.0	25.2	N/A
3	Percentage of births that are LBW (VSA 2007-2009)	6.8%	9.2%	8.2%	White/NH- 6.7% Black- 9.9% Asian- 7.3% Hispanic- 7.9%	8.5%	26.1	17.1

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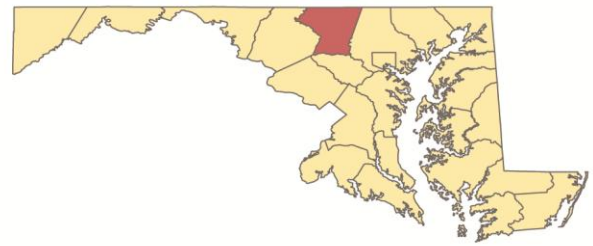
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Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
39	Percentage of people who reported there was a time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)	8.7%	12.0%	14.6%	White/NH-8.2%	11.4%	<b>27.5</b>	<b>40.4</b>
27	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	234.5	347.2	N/A	White-228.6 Black-562.6	330.0	<b>34.5</b>	N/A
7	Rate of indicated non-fatal child maltreatment cases reported to social services per 1,000 children under age 18 (Dept of Human Resources FY2010)	3.2	5.0	9.4		4.8	<b>35.5</b>	<b>65.7</b>
19	Number of days per year the AQI exceeded 100; not all counties are measured for AQI (EPA 2008)	5.0	8.4	11.0		8.0	<b>40.5</b>	<b>54.5</b>
2	Infant Mortality Rate per 1,000 births(VSA 2007-2009)	4.2	7.2	6.7	White/NH-3.8	6.6	<b>41.7</b>	<b>37.3</b>
18	Percentage of census tracts with food deserts (USDA 2000)	3.2%	5.8%	10.0%		5.5%	<b>44.8</b>	<b>68.0</b>
28	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	123.3	237.9	N/A	White-117.2 Black-375.1	225.0	<b>48.2</b>	N/A

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# CARROLL COUNTY



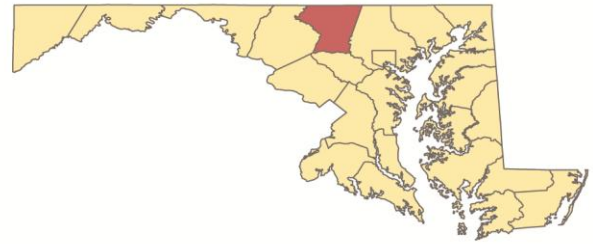
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17	Rate of ED visits for asthma per 10,000 population (HSCRC 2010)	38.1	85.0	N/A	White-36.1 Black-84.4	67.1	<b>55.2</b>	N/A
15	Rate of pedestrian injuries (SHA 2007-2009)	16.3	39.0	22.6		29.7	<b>58.2</b>	<b>27.9</b>
21	Rate of Chlamydia infection for all ages per 100,000 (IDEHA 2009)	91.1	416.7	N/A	White-35.3 Black-140.7 (all ages)	N/A	<b>78.1</b>	N/A
20	Rate of new (incident) cases of HIV in persons age 13 and older per 100,000 (IDEHA 2009)	5.7	32.0	N/A		30.4	<b>82.2</b>	N/A
4	Rate of SUIDs (includes deaths attributed to Sudden Infant Death Syndrome (SIDS), Accidental Suffocation and Strangulation in Bed (ASSB) and deaths of unknown cause) per 1,000 births (VSA 2005-2009)	***, 6 (Count only)	1.0	0.9		0.89	N/A	N/A
9	Rate of deaths associated with fatal crashes where driver had alcohol involvement per 100 million Vehicle Miles of Travel (SHA 2009)	***, 4 (Count only)	0.29	0.4		0.27	N/A	N/A

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# CARROLL COUNTY



## SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in **RED**/**GREEN** represent when the county baseline is **WORSE**/**BETTER** than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
13	Rate of new (incident) cases of elevated blood lead level in children under 6 per 100,000 (MDE 2009)	***, 6 (Count only)	79.1	N/A		39.6	N/A	N/A

Three-year rolling averages are presented for many of the measures as a means to display more stable data (less year-to-year variation) while showing change over time. Data details for figures found in "National Baseline" and "Maryland Baseline" columns can be found on the Maryland SHIP webpage under MEASURES at <http://dhmh.maryland.gov/ship/measures.html>.

\* Race/ethnicity definitions based on the sources of data used. Hispanic origin can be from any race; White/NH denotes those who are both White and of Non-Hispanic origin.

\*\*\*Rates based on counts less than 20 are not shown due to instability.

^ Maryland baseline value for Objective #36 - Proportion of persons with health insurance -- has been adjusted to allow for comparison with county level data.

Percent difference formula:

$$\frac{x_{\text{county}} - x_{\text{state}}}{x_{\text{state}}} \times 100$$



# Carroll County Local Health Improvement Coalition/Plan – Review & Update

The Partnership for a Healthier Carroll County  
Board of Directors' Meeting – June 6, 2012



## Local Health Improvement Process/Plan

1. Establish a local health improvement coalition (LHIC)
2. Involve the public in open meeting opportunities
3. Review the 39 state objectives specific to Carroll County
4. Review the county data associated with these objectives
5. Develop action plans
6. Submit plan March 1, 2012 to qualify and receive Pre-Qualification Letter from Department of Health and Mental Hygiene (DHMH) for funding
7. Submit proposal for funding to Community Health Resources Commission by March 15, 2012
8. Awarded base funding of \$25,000
9. Next steps



## 1. Establish a LHIC

- At the October Board meeting, the Board of Directors of the Partnership voted to serve as the LHIC
- At the February Board meeting, the Community Health Needs Assessment Subcommittee was tasked with approving the Local Health Improvement Plan/Process due March 1 to DHMH
- The Local Health Improvement Team (LHIT) followed the State Health Improvement Process



## 2. Involve the public

- Develop web based information about the process ([www.HealthyCarroll.org](http://www.HealthyCarroll.org))
- Invite the public to the LHIT monthly meetings through news releases
- Link to the State Health Improvement Process website





### 3. Review 39 State Objectives

- Divide LHIT into six workgroups, one for each Vision Area of the state health improvement plan framework
- Each workgroup had members with expertise in the vision area
- Vision areas were Healthy Babies, Healthy Social Environments, Safe Physical Environments, Infectious Disease, Chronic Disease, and Health Care Access
- Narrowed 39 to top 10 objectives



## 4. Review County Data

- Compared county, state and national baselines
- Created data conclusion for each objective
- Analyzed special situations that effected data
- Identified resources in the county to address the objective
- Proposed resources needed to address objective
- Developed recommendations for action



## 5. Develop Action Plans

- Narrow 10 objectives to 5 priorities
- Create goals/strategies for each priority
- Propose actions and partners
- Set Time Frame of July 2012 – June 2014
- Identify evaluation measures
- Vote to prioritize the top 5 2012-2014 Priorities – 1. Addictions and Behavioral Health, 2. Oral Health, 3. Tobacco, 4. Nutrition – Obesity/ Salmonella and 5. Heart Disease/Cancer
- Submit plan to CHNA Subcommittee with the addition of “proposed” partners for approval



## 6. DHMH Pre-qualification letter

- Submit plan to DHMH by March 1, 2012 to receive letter
- Plan sections include – LHIC information, local health data profile, local health context, health improvement priorities, baseline/goal and strategies/actions, local health planning resources and sustainability, and timeline and method for community health needs assessment



## 7. Submit Proposal for funding

- Receive Community Health Resources Commission (CHRC) Funding announcement February
- Select priority one for CHRC funding at February 28<sup>th</sup> LHIT meeting
- Submit proposal for funding on March 15, 2012



## 8. Base Funding - Behavioral Health

- Selected objectives:
  - Reduce the suicide rate
  - Reduce the number of emergency department visits related to behavioral health conditions
- Selected action:
  - Implement a model of urgent care services with an Outpatient Mental Health Clinic



## 9. Next Steps

- Received approval for funding from CHRC around mid-April – Base \$25,000
- Implement action plan selected for 2012-13
- Collect evaluation measures for 2012-13
- Comply with CHRC grant guidelines
- Determine future direction of CHRC funding for April 2013



## The Local Health Improvement Team:

- Barbara Rodgers, Director of Health Planning - Chair
- Tricia Supik, CEO - Partnership for a Healthier Carroll County (PHCC)
- Meghan Tew, Community Health Improvement - PHCC
- Larry Leitch, Health Officer
- Dr. Elizabeth Ruff, Deputy Health Officer
- Shannon Barnes, Fiscal Chief
- Cindy Bosley and Carol Ann Bauman - Nursing
- Sue Doyle - Addictions
- Darlene Flaherty - Nutrition
- Sarah Hawkins – Core Service Agency
- Ed Singer – Environmental Health
- Kim Spangler - Health Education

Beginning with the August 2012 Access to Health Care Leadership Team meeting, the LHIT meeting will be held following the August, October, December, February, April, and June Access meeting. This will allow members of the Access Team to participate in the LHIT.





# Meeting Schedule

## PHCC Board Meeting dates - Bold indicates LHIC meetings

Feb	<b>April</b>
June	August
<b>October</b>	December

## Access to Health Care Meetings - Bold Indicates LHIT meetings

January	<b>February</b>
March	<b>April</b>
May-WOOW	<b>June</b>
July	<b>August</b>
September	<b>October</b>
November	<b>December</b>

# Carroll County Local Health Improvement Process 2012-2014



## Proposed Priorities:

**Addictions and Behavioral Health**

**Oral Health**

**Tobacco**

**Nutrition – Obesity and Salmonella**

**Heart Disease and Cancer**

**March 1, 2012**

## Introduction

**State Health Improvement Process (SHIP)** The State of Maryland Department of Health and Mental Hygiene (DHMH) introduced the State Health Improvement Process (SHIP) in 2011. The SHIP aligns with a small subset of objectives from the Center for Disease Control and Prevention's Healthy People 2020, a science-based effort for improving the health of all Americans. The objectives were selected after reviewing recent state, local, and national plans and indicators; consulting with state officials; meeting with health and community leaders to discuss health outcome factors where the state ranks worse than its neighbors; and considering the input of public feedback. The chosen objectives focus on the factors that are most critical for achieving the SHIP's goals of health equity and improving the health of Maryland residents. The objectives will also measure whether implemented actions are successful in meeting the goals.

**The Local Health Improvement Process (LHIP)** In recognizing that local energy and local leadership are critical for progress in public health, the SHIP requested each jurisdiction in Maryland to prioritize objectives for their respective communities. The Local Health Improvement Process (LHIP) in each county is designed to identify, develop, and implement measures for inclusion with the larger health improvement process. Carroll County, under the direction of the health officer, complied with the SHIP request for local involvement and established a Local Health Improvement Coalition (LHIC), comprised of key stakeholders in the community committed to improving the health and well being of the residents.

**Local Health Improvement Coalition (LHIC)** The function of the Local Health Improvement Coalition (LHIC) is performed by the Board of Directors of the Partnerships for a Healthier Carroll County, Inc. (PHCC), whose members are well qualified for this role by experience, skills, and their backgrounds of community involvement. The LHIC submits the Local Health Improvement Process document to the SHIP. LHIC also collaborates with the PHCC Strategic Planning Committee and Carroll Hospital Center (CHC) Community Benefit Committee to determine and analyze health needs and propose recommendations for community health improvement. More information about the LHIC is included in the LHIC Description Form which is Section 1 of this document. Also working with the LHIC/Partnership Board of Directors on the LHIP is the Local Health Improvement Team (LHIT).

**Local Health Improvement Team** The Local Health Improvement Team (LHIT) is comprised of staff from PHCC and senior staff from the Carroll County Health Department (CCHD). Programs represented from the health department include: Addictions, Behavioral/Mental Health, Environmental Health, Fiscal, Health Education, Nursing, Nutrition, Oral Health and Tobacco and Cancer (Cigarette Restitution Fund). Based on data profiles and contextual data for each indicator, the LHIT identified ten indicators for five areas and developed a proposed action plan for each area. The LHIT recommendations are then reviewed and approved by the LHIC.

## ***Proposed Carroll County Local Health Improvement Process (CCLHIP)***

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Priority, Baseline and Goal, Strategies, and Actions**
- Section 5: Local Health Planning Resources and Sustainability**
- Section 6: Timeline and Method for the Community Health Needs  
Assessment**

**Section 1:  
Local Health Improvement  
Coalition Description Form**

## Section 1. Local Health Coalition and Planning Description

1. Jurisdiction/Region Name: Carroll County

2. Local Health Action Planning Coalition Leadership and Contact Information

a. Local/Regional Public Health Coalition Leader (Health Officer Name, Title, Address, Telephone, e-mail address)

Larry Leitch, Health Officer, Carroll County Health Dept.

290 S. Center St. Westminster, MD 21157 (410)876-4972

[leitchl@dhhm.state.md.us](mailto:leitchl@dhhm.state.md.us)

b. If applicable, Other (Name, Title, Organization, Telephone, e-mail address)

N/A

3. Local Health Action Planning Coalition Membership (names, titles, organizations)

The Partnership for a Healthier Carroll County, Inc. (PHCC) Board of Directors will serve as the Carroll County Local Health Improvement Coalition (CCLHIC or LHIC) for Carroll County's Local Health Improvement Process (LHIP)

Rationale:

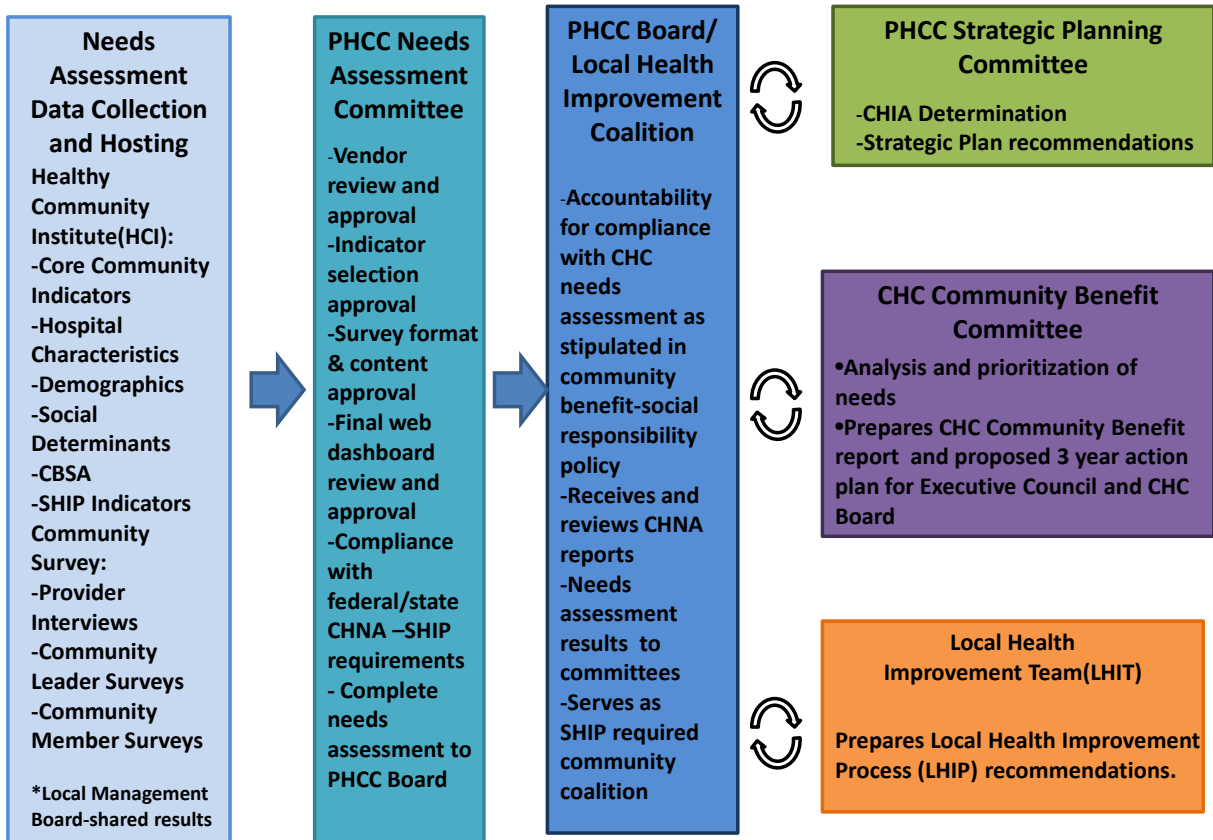
The Partnership achieves health improvement progress through leadership collaboratives and action teams (previously called work groups) formed around the Core Health Improvement Areas. Core Health Improvement Areas were identified through community health needs assessments. Experts and interested parties from each Area were invited to be on Leadership Teams. Leadership Teams identify indicators of health (known as Healthy Carroll Vital Signs) to measure progress in their areas. The Leadership Teams then establish objectives and action plans for improving indicator data. Leadership Teams often form sub-groups known as Action Teams in order to better manage specific action plans. Annual reporting, review, and recognition of progress takes place at our community health forum, We're on Our Way.

**The Partnership for a Healthier Carroll County, Inc. Board of Directors who will be serving as Carroll County's Local Health Improvement Coalition (LHIC):**

- Alva Baker, MD, McDaniel College
- Sue Doyle, Carroll County Health Department
- Lorraine Fulton, EdD, Gerstell Academy
- Abby Gruber, Carroll County Parks and Recreation
- George Hardinger, Carroll County Detention Center
- David Hogue, M&T Bank
- **Larry Leitch, Carroll County Health Department, Chairperson of Local Health Improvement Coalition**
- Sally Long, Carroll Community College (Vice-Chairperson of PHCC Board of Directors)
- David Louder, MD, Carroll Hospital Center
- Rosemary Murphey , Citizen/DHMH (Chairperson PHCC Board of Directors)
- Jonathan O'Neal, Carroll County Public Schools
- Arthur Riley, Carroll Drugs Inc.
- Barbara Rodgers, Carroll County Health Department
- John Sernulka, Carroll Hospital Center
- Patricia Supik, Carroll Hospital Center
- Robert Wack, MD, Westminster City Council
- Lynn Wheeler, Carroll County Public Library (Past-Chairperson of PHCC Board of Directors)

4. Local Health Improvement Coalition Structure

**Community Benefit Plan and Local Health Improvement Process**



**4. Health Planning Coalition Vision and Mission Statement**

**Our Vision**

The Carroll County Health Improvement Coalition will mobilize support to achieve better health in Carroll County.

**Our Mission**

The Carroll County Health Improvement Coalition will improve the health of all residents with particular attention to communities and sub-groups with health disparities by providing a health improvement framework with support for local action and linked to the State Health Improvement Process



**Activities/Schedules – Local Health Improvement Coalition meeting dates and schedules (include link to local websites for public meeting schedules to be posted on the SHIP website)**

The Carroll County’s Local Health Improvement Coalition (LHIC) meetings will be a portion of The Partnership for a Healthier Carroll County Board Meetings two times per year and will be open to the public. These meetings are held on the 1<sup>st</sup> Wednesdays of every other month in the Carroll Hospital Center Board Room. A meeting was held December 9, 2011 and the next CCLHIC meeting will be on April 4, 2012 at 9 a.m.

As a subcommittee of the LHIC, the Local Health Improvement Team meetings will also be opened to the public and a meeting schedule will be posted on The Partnership and Health Department websites. The committee meets at least monthly. Committee Meetings have been held on October 31, November 18, November 28(December’s Meeting), and January 9<sup>th</sup>. The next meeting will be held February 27<sup>th</sup> at 9 a.m. in the multi-purpose room of the Carroll County Health Department to review the final Action Plan document. Future meetings will be posted on [www.HealthyCarroll.org](http://www.HealthyCarroll.org) on the Community Health Needs Assessment page.

**Documents– Local/Regional Community Health Assessments, Plans and other related documents**

The following documents are posted in the [Healthy Carroll Vital Signs](#) section on [www.HealthyCarroll.org](http://www.HealthyCarroll.org):

County Health Rankings 2010 (pdf)

Dashboard 2009 /2010 (pdf)

Elder Health Needs Assessment/ 2009 (pdf)

Healthy Carroll Vital Signs II - 2008 (pdf)

Healthy Carroll Vital Signs - 2006 (pdf)

Strength & Needs Assessment 2006 (pdf)

Community Assessment Data Update 2003 (pdf)

Healthy Indicators 2002 (pdf)

Carroll Commuter Survey 2001 (pdf)

Submitted by: Barb Rodgers at [brodgers@dhmh.state.md.us](mailto:brodgers@dhmh.state.md.us) 443-375-7286.

**Section 2:**  
**Local Health Data Profiles**

## Section 2: Local Health Data Profiles - Inventory of local data including SHIP measures.

From the 39 State Health Indicators, the following 10 priority objectives were selected for Carroll County.

### Additions and Behavioral Health:

County Obj.	Maryland SHIP Indicator	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/ Ethnicity	Maryland by Racial/ Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County/ Maryland vs. County
1	Reduce the suicide rate (SHIP #8)	Rate of suicides per 100,000 pop - VSA 2010	10.8	11.3	9.6	n/a	White 12.0 Black 5.3	10.2/9.1	<b>4.52</b> <b>/-11.77</b>
2	Reduce drug-induced deaths (SHIP #29)	Rate of drug-induced deaths per 100,000 population (VSA 2007-2009)	13.2	12.6	13.4	n/a	White - 14.8 Black - 12.6	11.3/ 12.4	<b>-4.32/1.63</b>
3`	Reduce the number of emergency department visits related to behavioral health conditions (SHIP #34)	Rate of ED visits for a behavioral health condition Per 100,000 pop (HSCRC 2010)	1364.8	n/a	1206.3	White – 1359.5 Black – 2306.8	White – 1168.1 Black – 1527.4 Asian – 214.3 Hispanic – 861.6	n/a/ 1146	<b>n/a/</b> <b>-12.33</b>

## Local Health Data Profiles – cont’d

### Salmonella:

County Obj.	Maryland SHIP Indicator	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/ Ethnicity	Maryland by Racial/ Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County/ Maryland vs. County
4	Reduce salmonella infections transmitted through food (SHIP #16)	Rate of Salmonella infections per 100,000 IDEHA 2010	16.8	15.2	18.8			11.4/ 12.7	<b>-10.0/</b> <b>11.24</b>

### Heart Disease:

County Obj.	Maryland SHIP Indicator	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/ Ethnicity	Maryland by Racial/Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County/ Maryland vs. County
5	Reduce deaths from heart disease (SHIP #25)	Rate of heart disease deaths per 100,000 population (age adjusted) VSA 2007-2009	192.1	190.1	194	White – 187.9 Black – 210.0	White - 184.3 Black – 238.3	152.7/ 173.4	<b>-0.63/0.98</b>

### Cancer:

County Obj.	Maryland SHIP Objective	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/ Ethnicity	Maryland by Racial/ Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County and Maryland vs. County
6	Reduce overall cancer rate (SHIP #26)	Rate of cancer deaths per 100,000 population (age adjusted) VSA 2007-2009	182.1	178.1	177.7	White - 181.4 Black - 148.5	White – 176.6 Black - 193.0	160.6/ 169.2	<b>-2.05/-2.45</b>

Local Health Data Profiles – cont'd

Obesity:

County Obj.	Maryland SHIP Indicator	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/Ethnicity	Maryland by Racial/Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County/ Maryland vs. County
7	Reduce the proportion of young children and adolescents who are obese (SHIP# 31)	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	9.1%	17.9%	11.9%	N/A	White 8.8% Black – 15.8% Asian – 8.4% Hispanic – 15.0%	16.1%/11.3%	65.19/ 26.67

Tobacco:

County Obj.	Maryland SHIP Indicator	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/Ethnicity	Maryland by Racial/Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County/ Maryland vs. County
8	Reduce tobacco use by adults (SHIP #32)	Percentage of adults who currently smoke (BRFSS 2008-2010)	20.3%	20.6%	15.2%	White/non-Hispanic 18.9%	White/NH – 15.0% Black – 17.8% Asian – 4.4% Hispanic – 7.8%	12%/13.5%	1.47/ -28.73
9	Reduce the proportion of youth who use any kind of tobacco product (SHIP #33)	Percentage of high school students (9-12 grade) that have used any tobacco products in the past 30 days ( MYTS 2010)	23.1%	26%	24.8%		White – 24.7% Black – 24.2% Asian/Native Hawaiian/other Pac. Isl. – 18.6% Hispanic – 29.8%	21%/22.3%	11.81/ 7.10

Local Health Data Profiles – cont’d

Oral Health:

County Obj.	Maryland SHIP Indicator	County Baseline description	County Baseline	National Baseline	MD Baseline	County by Racial/ Ethnicity	Maryland by Racial/ Ethnicity	Healthy People 2020/ MD 2014 Target	%difference National vs. County and Maryland vs. County
10	Increase the proportion of the children and adolescents who receive dental care (SHIP #38)	Percentage of children 4-20 yrs enrolled in Medicaid that received dental service in the past year (Medicaid)	52.5%	N/A	59.0%	n/a	n/a	n/a	<b>-11.66</b>

## **Section 3: Local Health Context**

**3. Local Health Context** - Brief description of existing health related conditions, initiatives and other contextual factors that are related to the priority objectives.

**Addictions and Behavioral Health**

<b>Data Conclusion for County Objective 1: Reduce the Suicide rate</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Better than National -Worse than State -FY 11 data not on chart will show a 240% increase in suicide rate over FY 2010	-An increase in prescription drug abuse rates (1800% over ten years) -Loss of connection to school system (28,000 students) due to loss of safe and drug free school program	-Formation of Prevention and Early Intervention Work group with Mental Health and Substance Abuse Focus of Behavioral Health & Addiction Advisory Council -Garrett Lee Smith Suicide Prevention Grant allows school system to contract with Youth Service Bureau for assessments -"Finding Kind" the video used as a model for Bullying Interventions	-Loss of Garrett Lee Smith Suicide Grant after this year - estimated need \$10,000 yearly to maintain efforts -Expand Mental Health First Aide training to beyond professionals- estimated \$10,000 yearly -Expansion of prevention efforts by re-establishment of a Safe and Drug Free Schools Program and re-establish connection with students- estimated need \$80,000 yearly -Expansion of Crisis Services- estimated need \$42,000 yearly.	-Charge Prevention & Intervention Work group with the formation of the Strategic Plan  -Develop Cross System Community Involvement
<b>Data Conclusion for County Objective 2: Reduce drug-induced deaths</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Higher than National -On par with State Level -1800% increase in Prescription Drug Abuse in Carroll County over the past ten years	-Data may be skewed by the fact a death may not be listed as an overdose.	-Partnership for a Healthier Carroll County and CCHD sent educational information to all County physicians and dentists -Behavioral Health and Addictions Advisory Council -Hampstead Police Department -Carroll County Government Prescription Take Back Program -CCHD Environmental Health	-Increase prevention efforts at all levels: Professional, children, adult and community providers -Prescription Drug Monitoring Program becomes effective this year	Combine this objective with objective 1 to reduce the number of drug induced deaths.



**Local Health Context – cont’d**

**Addictions and Behavioral Health**

<p><b>Data Conclusion for County Obj. 3: Reduce the number of emergency department visits related to behavioral health conditions.</b></p>	<p><b>Special situation or consideration effecting data</b></p>	<p><b>Resources currently in the county to address the objective</b></p>	<p><b>Proposed resources needed to address the objective</b></p>	<p><b>Recommendations for action</b></p>
<p>-Significantly higher than MD Data per Carroll Hospital Center -CHC has the highest one day BH admission rate in the state.</p>	<p>-Are we sure that the data is for only those Carroll residents or is this anyone who is seen in the CHC ER – CHC has a high rate of out of county and out of state behavioral health emergency department visits -Lack of a crisis continuum in Carroll – No urgent crisis, No mobile crisis, no ACT, no Crisis beds, no walk-in Crisis Clinic</p>	<p>-Currently have request for proposals that will address operation of four crisis beds for the explicit purpose of “prevention of inpatient admission” -Proposal from Community Provider for Urgent Care visits</p>	<p>-Funding is the reason for lack of action on development of a continuum of Crisis services in Carroll because the size of the county and the level of need we often do not qualify -ACT \$450,000 one-time only funds needed to become operational and reach fidelity -Urgent Care Visits - \$18,000 yearly -Walk-in Crisis Clinic – TBD -Crisis Beds to Prevent inpatient admissions - \$200,000 yearly</p>	<p>-Examine existing resources and reallocate funding -Development of a Cross Systems Plan -Advocate for CHC participation – they benefit in assisting in the development of Crisis Continuum -Look for grant opportunities</p>

**Local Health Context – cont’d**

**Salmonella**

<b>Data Conclusion for County Objective 4: Reduce salmonella infections transmitted through food.</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Lower than Maryland baseline -Higher than Health People 2020 and Maryland 2014 Target, and National Baseline	-These cases are primarily individual and not associated with outbreaks or licensed food service establishments -Higher rates reported may be indicative of a population with better access to health care and more likely to seek health care for this type of illness	-Carroll County Health Department (CCHD), Bureau of Environmental Health food service facility licensing and inspection program -Limited CCHD outreach and education through publications, news articles and in person -Outreach by Maryland Cooperative Extension Service -Web based information from FSA, USDA, and CCHD	-Maintain current level of activity through CCHD food service licensing and inspection program -Staffing and educational materials to identify and reach target audiences - This staffing could be CCHD based or within organizations in the community	-Monitor funding levels of food service licensing and inspection program and look for opportunities to maintain or enhance current program - Outreach efforts could be combined with objective 7 to talk about what foods are healthy and how to prepare them safely

**Heart Disease**

<b>Data Conclusion For County Obj. 5: Reduce deaths from heart disease.</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-County baseline better than MD baseline but worse than national baseline	-Data obtained from VSA should be accurate	-CHC provides blood pressure screening -Some heart health educational and screening events -Partnership Leadership Teams – Heart Health and Prevention and Wellness Teams	-Funding would be needed	-May want to consider the federal program ABCS in primary care model

**Local Health Context-cont'd**

**Cancer**

<b>Data Conclusion For County Obj. 6: Reduce the overall cancer rate.</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Higher than National and Maryland -Need a lot of improvement to reach 2020 goal	-DHMH Cancer survey shows different numbers with Carroll being lower than Maryland rate and having the 3 <sup>rd</sup> lowest cancer rate in the State	-Cigarette Restitution Fund Program - Breast and Cervical Cancer Program -Carroll Hospital Cancer Program	-Funding would be needed	-Promote all cancer screenings

**Obesity**

<b>Data Conclusion for County Obj. 7: Reduce the proportion of young children and adolescents who are obese.</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Based on the MYTS data, the Carroll County baseline data is 9.1% of youth ages <b>12-19</b> who are obese -Lower than Maryland, National, Healthy people 2020 and the Maryland 2014 target	-Maryland has no data on children from 5-12 - Pediatric Surveillance Data and MYTS limited data self reported heights and weights -Data either not consistently collected -Unable to access from private physicians	-Possibility of a Transformation Grant that would require at least two interventions in each of 3 Title 1 schools dealing with reducing obesity and/or tobacco use -Partnership for a Healthier Carroll County Kaiser Permanente Grant -Begin to look at methods for collection of data on heights and weights from physician's offices -CHC Registered Dietitians address issue if referred by M.D. -Recreation Councils, organized sports and fitness activities, etc. exist for youth, many cost money to participate -WIC addresses through 5 <sup>th</sup> birthday. (7.2% of 2-5yrs.obese July 11)	-Need to get accurate data about the extent of the problem  -Review evidence based interventions to address the problem.  -Nutrition programs to educate parents/children Increased opportunities for physical activity for families and children	Committee wanted to consider this for action, especially as it related to Transformation grant. National evidence suggests this continues to be a problem, and more health issues/chronic diseases are being linked to childhood obesity

**Local Health Context – cont’d**

**Tobacco**

<b>Data Conclusion for County Obj. 8: Reduce tobacco use by adults.</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Lower than National -Higher than MD rate -Need a lot of improvement to reach 2020 goal	-DHMH started using a new data set which increased the numbers 2008(old data set) – 12%; 2010(new data set) – 21.2%	-CRFP cessation program reaches 300 people per year	-Additional funding and identification of additional locations for programs	-More advertising, less expensive way to supply nicotine replacement therapy and Chantix

<b>Data Conclusion for County Obj. 9: Reduce the proportion of youth who use any kind of tobacco products</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Lower than National MD rate -Close to Healthy People 2020 goal	-Many new products on the market targeting young smokers Polytobacco users	-CRFP has a small prevention component	-Increase knowledge of new products among adults, esp. parents, teachers, and others who work with youth	-Educate general population regarding new tobacco products -More required programs in schools to educate youth -Change laws regarding cigars

**Local Health Context – cont’d**

**Oral Health**

<b>Data Conclusion for County Objective 10: Increase the proportion of the children and adolescents who receive dental care</b>	<b>Special situation or consideration effecting data</b>	<b>Resources currently in the county to address the objective</b>	<b>Proposed resources needed to address the objective</b>	<b>Recommendations for action</b>
-Worse than the state	-The trend for Carroll County has improved from 23% to 52.5 % since 2001 -Reimbursement rates have improved greatly over the past five years	-Pediatric dental clinic -Some private dentists have started to accept Medical Assistance (MA)	-Funding for operatory and education to dentists about MA	-Additional operatory in the clinic -Encourage more private dentists to take MA

**Section 4:**  
**Local Health Improvement Priorities 2012-2014**  
**Priority, Baseline/Goal, Strategies, Actions**

## Section 4: Proposed Local Health Improvement Priorities 2012-2014

### Priority 1: Addictions and Behavioral Health

**Goal #1:** Reduce the suicide rate in Carroll County by June 30, 2014.

(MD 2014 Target: 9.1 per 100,000/MD Baseline: 9.6 per 100,000/Carroll County Baseline: 10.8 per 100,000)

#### Strategies:

- 1.1. Expand Mental Health First Aid Training to the community with a focus on law enforcement and education personnel
- 1.2. Re-establish the Safe and Drug Free Schools Coordinator Position
- 1.3. Expand Crisis Services

#### Proposed Action Plan

Action	Proposed Partners	Time Frame	Measures
1.1.1 Expand Mental Health First Aid Training	Prevention and Intervention Workgroup of the Behavioral Health and Addictions Advisory Council Core Service Agency Schools Youth Service Bureau The Partnership for a Healthier Carroll County	July 2012 – June 2014	1.1.1 Number of professionals trained
1.2.1 Funding identified for Safe and Drug-Free Schools Program	Prevention and Intervention Workgroup of the Behavioral Health and Addictions Advisory Council Core Service Agency Schools Youth Services Bureau The Partnership for a Healthier Carroll County	July 2012 – June 2014	1.2.1 Re-established Safe and Drug- Free Schools Program
1.3.1. Expand Crisis Services	Prevention and Intervention Workgroup of the Behavioral Health and Addictions Advisory Council Core Service Agency Schools Youth Services Bureau The Partnership for a Healthier Carroll County	July 2012 – June 2014	1.3.1 Creation of the Strategic Plan and develop cross system community involvement

**Addictions and Behavioral Health cont'd**

**Goal #2:** Reduce drug-related deaths in Carroll County by June 30, 2014.

(Healthy People 2020: 11.3 per 100,000/MD 2014 Target: 12.3 per 100,000/ Carroll County Baseline: 13.2 per 100,000)

**Strategies:**

- 2.1. Increase prevention of prescription abuse efforts among professionals, children, adults and community providers.
- 2.2. Promote Prescription Drug Monitoring Program.

**Proposed Action Plan**

Action	Proposed Partners	Time Frame	Measures
2.1.1 Increase prevention of prescription abuse efforts among professionals, children, adults and community providers	Prevention and Intervention Workgroup of the Behavioral Health and Addictions Advisory Council Schools Youth Services Bureau Hampstead Police Department and other law enforcement agencies Carroll County Government -Take Back Program Carroll County Health Department - Environmental Health The Partnership for a Healthier Carroll County	July 2012 – June 2014	2.1.1. Number of participants educated about prescription abuse prevention
2.1.2. Increased participation in drug take back programs	Same as above	July 2012 – June 2014	2.1.2. Number of prescriptions received in the take back programs
2.2.1. Prescription Drug Monitoring Program	Same as above	July 2012 – June 2014	2.2.1. Implementation of a prescription drug monitoring program



## Addictions and Behavioral Health cont'd

**Goal #3:** Reduce the number of emergency department visits related to behavioral health conditions by June 30, 2014. (MD Baseline: 1206.3/Carroll County Baseline: 1364.8)

### Strategies:

- 3.1. Develop continuum of crisis services in Carroll County
- 3.2. Develop urgent care capacity at local Outpatient Mental Health Clinic

### Proposed Action Plan

Action	Proposed Partners	Time Frame	Measures
3.1.1 Identification of funding including existing resources and reallocation of funding to operate four crisis beds	Carroll Hospital Center (CHC) Core Service Agency (CSA)	July 2012 – June 2014	3.1.1. Number of Crisis Beds that exist
3.2.1. Identification of a community provider for urgent care services.	Carroll Hospital Center (CHC) Core Service Agency (CSA)	July 2012 – June 2014	3.2.1. Number of providers for urgent care services

## Priority 2: Oral Health

**Goal #1:** Increase the proportion of children and adolescents who receive dental care by June 30, 2014. (MD Baseline: 59.0%/Carroll County Baseline: 52.5%)

### Strategies:

- 1.1. Open new primary clinic with three dental operatories at Access Carroll, Inc.
- 1.2. Open third operatory in the pediatric dental clinic at the Carroll County Health Department
- 1.3. Increase participation of private dentist in the provision of dental services to medical assistance eligible children.

### Proposed Action Plan

Actions	Proposed Partner	Time Frame	Measures
1.1.1 Assist Access Carroll in opening new dental clinic.	Access Carroll Carroll County Health Department - Pediatric Dental Clinic and Referring Agencies Partnership for a Healthier Carroll County	December 2012 – June 2014	1.1.1. Access Carroll dental services open
1.1.2. Refer patients ages 15-20 with Medical Assistance to Access Carroll.	Access Carroll Carroll County Health Department - Pediatric Dental Clinic and Referring Agencies Partnership for a Healthier Carroll County	December 2012 – June 2014	1.1.2. Number of patients 15-20 years of age seen at Access Carroll for dental care
1.2.1. Increase caseload by opening third operatory.	Carroll County Health Department Referring Agencies	July 2012 – June 2013	1.2.1. Number of patients seen at Carroll County Health Department
1.3.1. Educate private dentists about medical assistance dental programs	Maryland Office of Oral Health, Maryland Healthy Smiles Program Carroll County Dental Society - Private dentists Carroll County Health Department	July 2012 – June 2014	1.3.1. Number of providers who join Maryland Healthy Smiles.

### Priority 3: Tobacco

**Goal #1:** Reduce tobacco use by adults by June 30, 2014.

(MD Baseline: 15.2%/Carroll County Baseline: 20.3%)

**Strategies:**

- 1.1. Identify new sites to provide smoking cessation programs to reach “hard to reach” populations.
- 1.2. Increase advertising venues for smoking cessation; including social networking, Patch.com etc.
- 1.3. Offer daytime walk in clinic for tobacco cessation.

**Proposed Action Plan**

Action	Proposed Partners	Time Frame	Measures
1.1.1. Identify “hard to reach” populations	Cigarette Restitution Fund Program  Members of the Tobacco Coalition  Private medical and dental providers	July 2012- June 2014	1.1.1. Number of cessation programs and number of participants in them
1.1.2. Identify additional locations for “hard to reach” populations	Same as above	July 2012- June 2014	1.1.2. Number of new locations
1.2.1. Use more advertising for cessation programs	Cigarette Restitution Fund Program  Members of the Tobacco Coalition  Private medical and dental providers  Partnership for a Healthier Carroll County	July 2012- June 2014	1.2.1. Number of types of advertising
1.3.1. Increase the number of day time walk-in clinics	Same as above	July 2012- June 2014	1.3.1. Number of programs that provide replacement therapy

**Tobacco – cont’d**

**Goal #2:** Reduce the portion of youth who use any kind of tobacco product by June 30, 2014.  
 (Healthy People 2020: 21%/MD 2014 Target: 22.3%/Carroll County Baseline: 23.1%)

**Strategies:**

- 2.1. Increase knowledge of new products among adults; especially parents, teachers, and others who work with youth.
- 2.2. Liaison with University of Maryland Tobacco Law Center to support legislation regarding the sale and placement of cigars.

**Proposed Action Plan**

<b>Action</b>	<b>Proposed Partners</b>	<b>Time Frame</b>	<b>Measures</b>
2.1.1. Educate population that works with youth regarding new tobacco products	Carroll County Health Department - Cigarette Restitution Program Parents/ Schools Community groups that work with youth University of Maryland Law Center Partnership for a Healthier Carroll County	July 2012 – June 2014	2.1.1. Number of participants educated about tobacco
2.2.1. Change laws regarding cigars.	Carroll County Health Department - Cigarette Restitution Program Parents/ Schools Community groups that work with youth University of Maryland Law Center Partnership for a Healthier Carroll County	July 2012 – June 2014	2.2.1. Laws changed regarding the sale and placement of cigars

## Priority 4: Nutrition – Childhood Obesity and Salmonella

**Goal #1:** There is no reliable source of data available to determine if Carroll County is meeting baseline or target objectives for childhood obesity for children ages 0-12. For children ages 12-19 in Carroll County, 9.1 % are obese according to the Maryland Youth Tobacco Survey compared to 17.9% in the Nation, 11.9% in Maryland. Anecdotally there appears to be a problem with childhood obesity in Carroll County. The first step in the process would be developing reliable data to determine where we stand in relation to the established targets. If data shows that anecdotal observations are accurate, we would want to reduce the portion of young children and adolescents who are obese by June 30, 2014. (Carroll County Baseline: 9.1% MD Target for 2014 11.3% /Healthy People 2020 16.1%)

### Strategies:

- 1.1. Gather raw statistical height/weight data for school-age children through various community sites such as doctor offices and schools
- 1.2. Establish a free cold drinking water program through the school system in cafeterias as an alternative to high calorie drinks

### Proposed Action Plan

Action	Proposed Partners	Time Frame	Measures
1.1.1. Identify target population and source of data	Schools Parents Private doctor offices Partnership for a Healthier Carroll County	July 2012 – June 2014	1.1.1. Number of populations and sources identified
1.1.2. Develop the method of data collection and compile and analyze data	Schools Parents Private doctor offices Partnership for a Healthier Carroll County	July 2012 – June 2014	1.1.2. Existence of a data collection method
1.1.3. Collect county specific anonymous height/weight data	Schools Parents Private doctor offices Partnership for a Healthier Carroll County	July 2012 – June 2014	1.1.3. Amount of data collected
1.2.1. Provide free cold drinking water in school cafeterias as an alternative to high calorie drinks	Schools Parents Partnership for a Healthier Carroll County	July 2012 – June 2014	1.2.1. Number of school cafeterias participating in the program

**Nutrition – cont’d**

**Goal #2:**

Reduce salmonella infections transmitted through food by June 30, 2014.

(Health People 2020: 11.4 per 100,000/MD 2014 Target: 12.7 per 100,000/Carroll County Baseline: 16.8 per 100,000)

**Strategies:**

2.1. Conduct outreach and education on nutritional, health, and safe foods in conjunction with the school system and group day care facilities

**Proposed Action Plan**

Action	Proposed Partners	Time Frame	Measures
2.1.1. Educate targeted youth on nutritious food	Schools Childcare providers Parents Carroll County Health Department – Nutrition and Environmental Health Programs Partnership for a Healthier Carroll County	July 2012- June 2014	2.1.1.Number of educated children about nutritious food
2.1.2. Educate targeted youth and their families about safe food (food-borne illness)	Same as above	July 2012- June 2014	2.1.2. Number of children and parents educated about safe food
2.1.3. Work with teachers in the schools and operators of child care facilities to implement an educational and outreach program within their curriculum	Schools Childcare providers Parents Carroll County Health Department – Nutrition and Environmental Health Programs Partnership for a Healthier Carroll County	July 2012- June 2014	2.1.3. Number of teachers and facilities that implement curriculum

## Priority 5: Heart Disease and Cancer

**Goal #1:** Reduce deaths from heart disease by June 30, 2014.

(MD 2014: 173.4 per 100,000 /National Baseline: 190.9 per 100,000/Carroll County Baseline: 192.1 per 100,000)

### Strategies:

1.1 County-wide Wellness Challenge – organized/planned opportunities to participate in healthy eating, exercise and health screenings - for families and worksites

### Proposed Action Plan

Action	Proposed Partners	Time Frame	Measures
1.1.1. Research Wellness Challenge models	The Partnership for a Healthier Carroll County Carroll County Health Department – Nursing and Health Education	July 2012 – June 2013	1.1.1. Wellness Challenge Model identified
1.1.2. Identify funding to hire program coordinator	Same as above	July 2012 – June 2013	1.1.2. Funding and Staff acquired
1.1.3. Implement Pilot region	Same as above	July 2012 – June 2013	1.1.3. Pilot implemented
1.1.4. Implement Wellness Challenge for families and worksites	Same as above plus Agencies that provide health promotion activities	July 2013 – June 2014	1.1.4. Number of people participating with improvement in participants' health indicators including: blood pressure, cholesterol, tobacco use, health screenings, increased physical activity, attends health education programs about healthy food preparation, substance and addiction abuse prevention
1.1.5. Develop a youth component to prevent childhood obesity	Same as above plus Agencies that provide health promotion activities	July 2013 – June 2014	1.1.5 Number of youth participants

**Cancer and Heart Disease – cont’d**

**Goal #2:** Reduce overall cancer rate by June 30, 2014.

(Healthy People 2020: 160.6 per 100,000/MD Baseline: 177.7 per 100,000/Carroll County Baseline: 182.1 per 100,000)

**Strategies:**

2.1 Promote cancer screening based on cancer screening guidelines

Proposed Action Plan

Action	Proposed Partners	Time Frame	Measures
2.1.1. Implement cancer screening promotional programs	Carroll County Health Department - Cigarette Restitution Fund Program(CRFP);  Cancer Coalition Members through (CRFP)  American Cancer Society, and other Cancer related community groups	July 2012- June 2014	2.1.1. Numbers of participants in cancer screening programs



**Section 5:**  
**Local Health Planning Resources**  
**and Sustainability**

**Section 5: Plan for continued local coalition planning and direct and in-kind support.**

The Local Health Planning Coalition, which is also The Partnership for a Healthier Carroll County Inc. Board of Directors, currently receives support from Carroll Hospital Center, Carroll County Health Department and all members of The Partnership for a Healthier Carroll County Board of Directors. This sustainability is in the form of both direct and in-kind support.

**Section 6:**  
**Timeline and Methods**  
**Community Health Needs Assessment**

## Section 6: Needs Assessment Time Frame and Activities



December 2011-January 2012	January 2012-February 2012	February 2012-April 2012	April 2012	April 2012-June 2012	June 2012 and Ongoing	Ongoing
<ul style="list-style-type: none"> <li>• Consultation and Orientation with Healthy Communities Institute (HCI) for website database development</li> <li>• Consultation, orientation and introduction of Holleran Consulting for community member and key informant surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Development of core indicator list for inclusion in website</li> <li>• Identification of secondary data sources</li> <li>• Review of sample surveys</li> <li>• Selection of survey questions and survey design</li> </ul>	<ul style="list-style-type: none"> <li>• Finalization of Survey Design</li> <li>• Collection of community input</li> <li>• Database embedding in HealthyCarroll.org</li> <li>• Addition of local content and site training</li> <li>• Submission of Local Health Improvement Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Review of HDU database with key stakeholders</li> <li>• Addition of any more local content</li> <li>• Start of licensing period</li> </ul>	<ul style="list-style-type: none"> <li>• Reports available on website for dissemination to partners</li> <li>• Reports developed by Holleran Consulting from community and key informant surveys</li> <li>• Configuration of secondary data</li> </ul>	<ul style="list-style-type: none"> <li>• Creation of Executive report</li> <li>• Reporting data given to Carroll Hospital Center, Carroll County Health Department, PHCC Board of Directors</li> </ul>	<ul style="list-style-type: none"> <li>• Planning by key partners for Community Health Improvement</li> </ul>

