Community Health Needs Assessment

CalvertHealth *Implementation Strategy* 2024-2027

EXCEPTIONAL CARE FOR A *Lifetime*

CalvertHealth

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Message from the President and CEO

Community Members, Partners and Stakeholders,

As the CEO of Calvert Health System, it is with great pride and responsibility that I share with you our Community Health Needs Assessment Implementation Strategy Report. This report reflects our unwavering commitment to our mission: improving the health and well-being of those we serve.

Our vision is to be the trusted healthcare leader in our region, a vision that drives every decision, initiative and partnership we undertake. This strategy is not just a document—it's a roadmap that guides us toward creating a healthier community through collaboration, innovation, and compassion.

As we embark on our 2024-2028 strategic plan, we are setting ambitious goals to advance healthcare delivery, enhance patient experience and foster community wellness. This plan outlines our commitment to expanding access to care, integrating cutting-edge technology and strengthening partnerships with local organizations. By focusing on these strategic priorities, we aim to build a healthcare system that is responsive to the evolving needs of our community. The needs identified in this report reflect the voices and concerns of our community. Addressing these needs requires a collective effort, and we are incredibly fortunate to have the support and collaboration of our community partners – many of whom are listed on the following page. Together, we have made significant strides in tackling some of our region's most pressing health challenges, and I am confident that together, we will continue to make a meaningful impact.

We are grateful for your partnership and trust. Your contributions are invaluable as we work toward our shared goal of removing barriers to care and enhancing quality of life for our entire community.

Thank you for your continued support, and I look forward to what we will achieve together in the coming years.

Sincerely,

Jeremy S. Bradford, MBA
President & CEO
Calvert Health System

Acknowledgements

The success of the Calvert Community Health Needs Assessment Implementation Strategy highlights the collaborative efforts of numerous organizations, healthcare systems, community-based organizations (CBOs), and individuals involved in its development. Together, we have created strategies to achieve significant, lasting positive changes and identify key health objectives. The foundational work established through this collaboration will lead to improved health outcomes and greater community well-being.

Thank you to the dedicated individuals from the following local organizations who gave generously of their time and expertise to help guide the development of the work plans for Calvert County 2024-2027.

- Calvert County Department of Public Safety
- Calvert Alliance Against Substance Abuse, Inc.
- Calvert County Family Network
- Calvert County Farmers Market Association
- Calvert County Government
- Calvert County Health Department
- Calvert County Office on Aging
- Calvert County Parks & Recreation
- Calvert County Public Schools
- Calvert County Sheriff's Office
- Calvert County Veterans Affairs Committee
- Calvert County Local Behavioral Health Authority (LBHA)
- Community Health Improvement Round Table (CHIR)
- Subcommittees of CHIR (Diabetes, Cancer and Tobacco, Behavioral Health ,and Health Ministry)
- Department of Economic Development of Calvert County Government
- Farming 4 Hunger
- HIPPY/Healthy Families/PAT
- Solomons Mission Center

Many of the organizations listed above participate in the Community Health Improvement Roundtable. We are grateful for their commitment to excellence and dedication to our community.

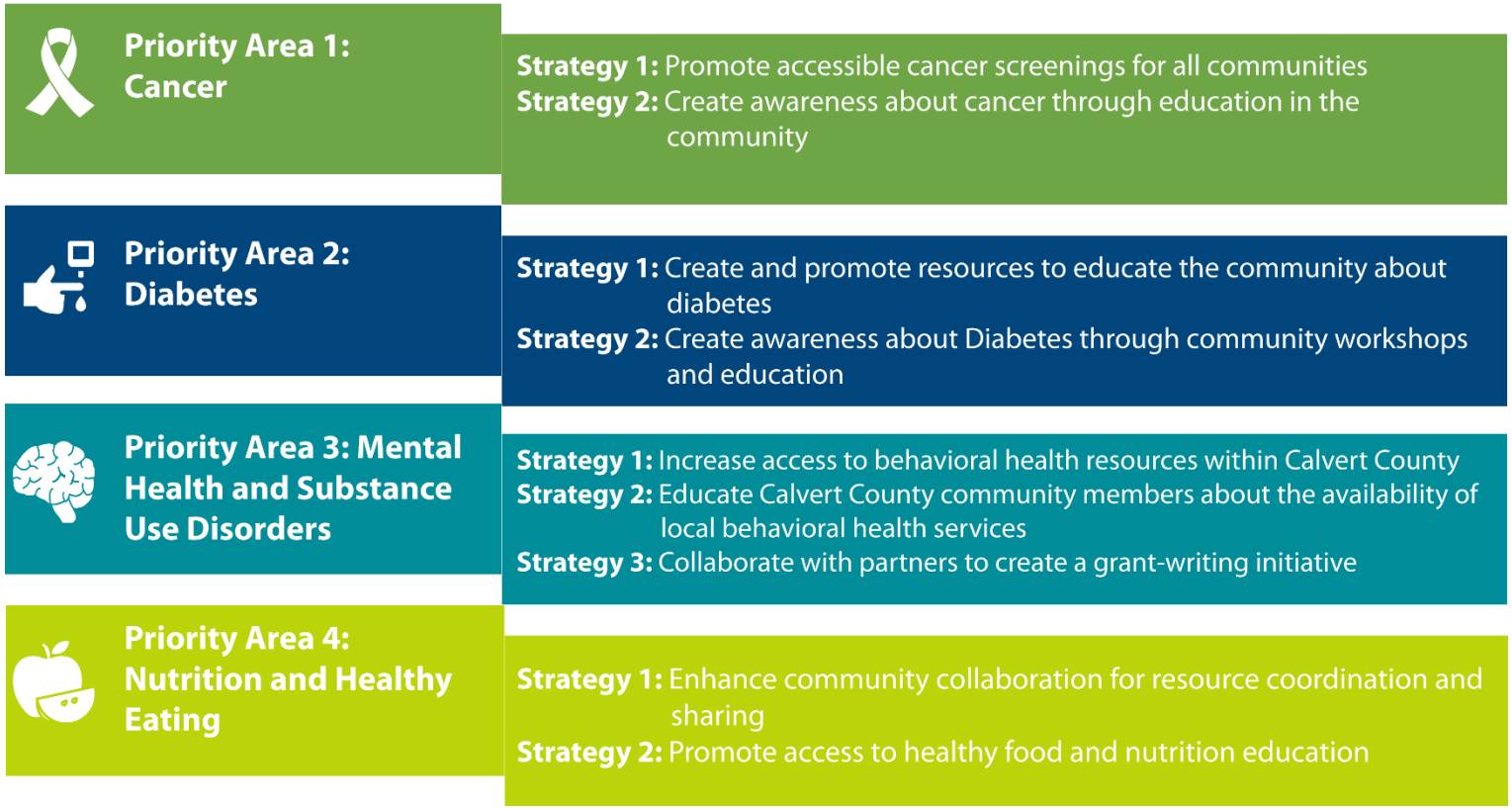
Consultants

CalvertHealth commissioned Conduent Healthy Communities Institute (HCI) to support facilitation and development of the Implementation Strategy for CalvertHealth 2024-2027. Conduent collaborates with clients across the nation to drive improved community outcomes by providing expert guidance for assessing community needs, developing strategies, and implementing evaluation and monitoring processes. Consultants for this project included Era Chaudhry, MPH, MBA, Public Health Consultant and Eileen Aguilar, MPH, Public Health Consultant. To learn more about Conduent HCI, visit conduent.com/community-health.

Executive Summary

CalvertHealth is pleased to share the 2024-2027 Implementation Strategy (IS) which follows the development of the 2023 Community Health Needs Assessment (CHNA). In accordance with the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the CalvertHealth Board of Directors on November 28, 2023.

This report summarizes the plans for CalvertHealth to develop and collaborate on community benefit programs that address the priority health areas identified in the 2023 CHNA. These include:



Purpose and Context

The purpose of this Implementation Strategy (IS) report is to identify the goals, objectives and strategies that CalvertHealth will use to address the five health priorities identified in the most recent CHNA: (1) Cancer; (2) Diabetes; (3) Mental Health and Mental Disorders; (4) Substance Use Disorders; and (5) Nutrition and Healthy Eating. To streamline implementation planning, it was decided to merge the Mental Health, Mental Disorders, and Substance Use Disorders priority areas into one, as the workgroup participants were the same and their efforts are interconnected.

This report includes:

- An overview of the 5 health needs identified and prioritized in the most recent CHNA
- A description of the process and methods used to design the implementation strategy plan
- Strategies designed to address each health need
- A framework describing key actions, responsible persons, process measures and anticipated outcomes for each strategy

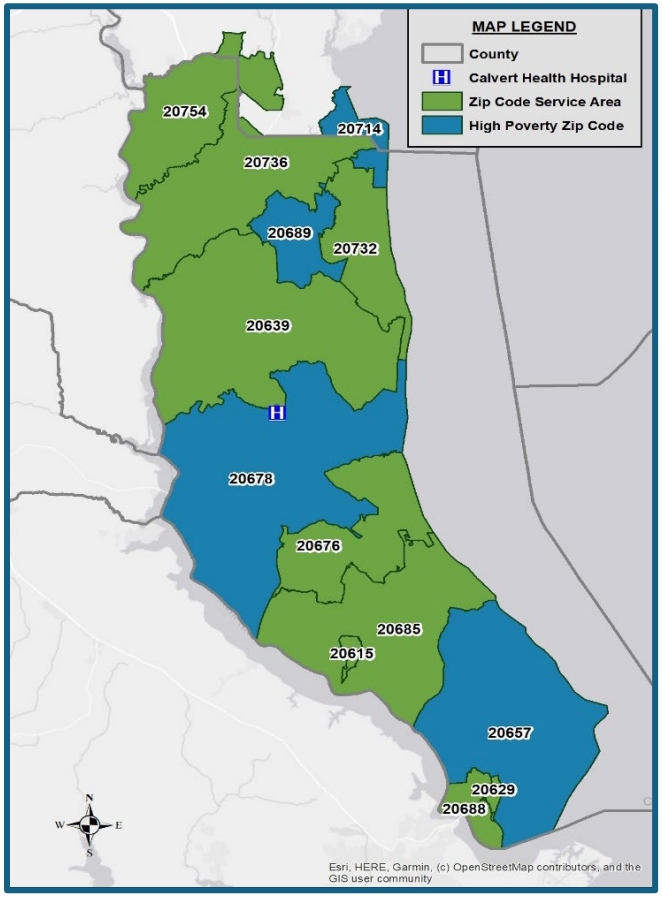
The CalvertHealth IS has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r). It requires hospital facilities owned and operated by an organization, described in Code section 501(c)(3), to conduct a CHNA at least once every three years and adopt an IS to meet the community health needs identified through the CHNA.

This report is intended to satisfy each of the applicable requirements set forth in final regulations released in December 2014 and also meet community health improvement plan requirements for Public Health Accreditation.

This IS describes the planned response by CalvertHealth and its collaborative partners to the needs identified in the 2023 CHNA. The IS was approved by the board of directors and applies to tax years July 2024 through June 2027.

The 2024 implementation plans for CalvertHealth were thoughtfully developed to leverage current community resources, while also working collaboratively across multiple sectors to engage new community partners. A series of in-person and virtual workshops were conducted to identify the goals, objectives and strategies documented in this plan. An overarching goal was developed for each health need, ensuring alignment and consistency across collaborative partner organizations. These plans will guide CalvertHealth and its collaborative partners' health improvement efforts from 2024 to 2027.

Description of the Community Served



In this document, the "community served" is defined as the resident population within the hospital's service area. The service area for CalvertHealth is defined as the geographical boundary of Calvert County, Maryland. CalvertHealth Medical Center is the only hospital in Calvert County with health care locations in Prince Frederick, Dunkirk, Solomons, and Twin Beaches. Although Calvert County is relatively close to Washington D.C., the long and narrow geography of the peninsula results in a rural atmosphere with transportation challenges for residents. Calvert County has a population of 94,444. The age distribution of Calvert County skews older. The racial makeup of Calvert County is somewhat homogenous, with 74.0% of the population identifying as White. Black or African American (12.3%) community members represent the second largest proportion of all races in Calvert County. Families living in North Beach, Sunderland, Chesapeake Beach, Prince Frederick, and Lusby have the highest poverty rates. Additional details describing the Calvert County community, including demographics and social and economic determinants of health, can be found in the CHNA report on the HealthyCalvert.org website at healthycalvert.org/content/sites/calverthospital/CHNA/2023/CalvertHealth_FY_2023-2025_CHNA_Report_Final.pdf.

Community Health Needs Assessment Findings

CalvertHealth conducted its 2023 Community Health Needs Assessment (CHNA) between April and November 2023. The purpose of the CHNA was to identify and prioritize the significant health needs of the community.

Methods of Identifying Community Needs

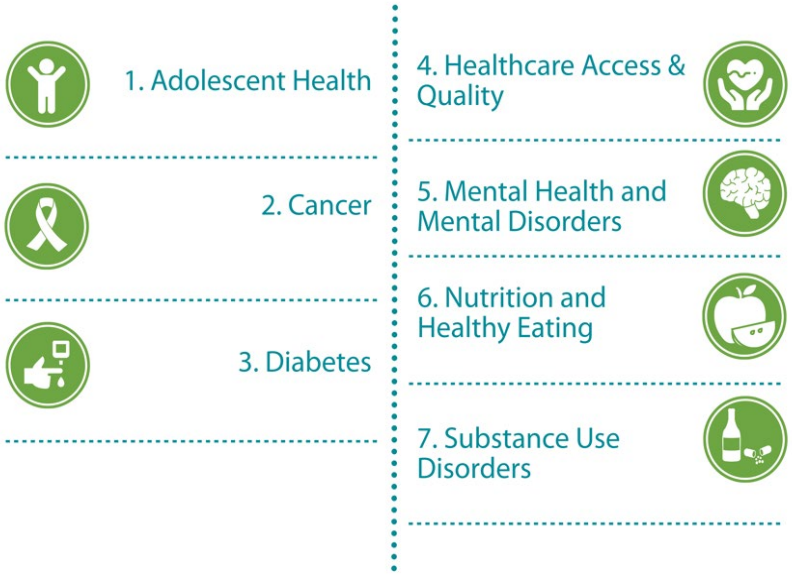
Conduent Healthy Communities Institute (HCI) analyzed primary and secondary data for the CHNA. Secondary data collected by state and national sources used in the assessment consisted of community health indicators. Primary data collected by Conduent HCI included an online survey and key informant interviews with community stakeholders. Each type of data was analyzed using standardized methodology and findings were organized by health topic. Findings from both primary and secondary data sources were analyzed and combined to identify the significant health needs for the community served by CalvertHealth.

Summary of Findings

Health needs were determined to be significant if they met the following criteria: a secondary data score of 1.40 or higher, high frequency of discussion of the within or across interviews, and identification as a priority issue by 20% or more of survey respondents. Based on these criteria, seven health needs emerged as significant.

Figure 2 illustrates the seven significant health needs, listed in alphabetical order, which were included for prioritization based on the findings of all forms of data collected for the CalvertHealth 2023 CHNA.

FIGURE 2. CALVERTHEALTH SIGNIFICANT HEALTH NEEDS



To better target activities to address the most pressing health needs in the community, CalvertHealth and community leaders participated in a presentation of data, facilitated by HCI, on significant health needs.

Determining Health Priority Areas

An invitation to participate in the Calvert County data synthesis presentation and prioritization activity was sent out in the weeks preceding the meeting held on Wednesday, August 9, 2023. A total of 18 individuals representing CalvertHealth , Calvert County Health Department, as well as community-based organizations, and nonprofits attended the virtual meeting. In the meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses leading to the significant health needs. From there, participants were given time to access an online link and assign a score to each of the significant health needs based on how well they met the criteria set forth by the public health department and hospital.

The criteria for prioritization included:

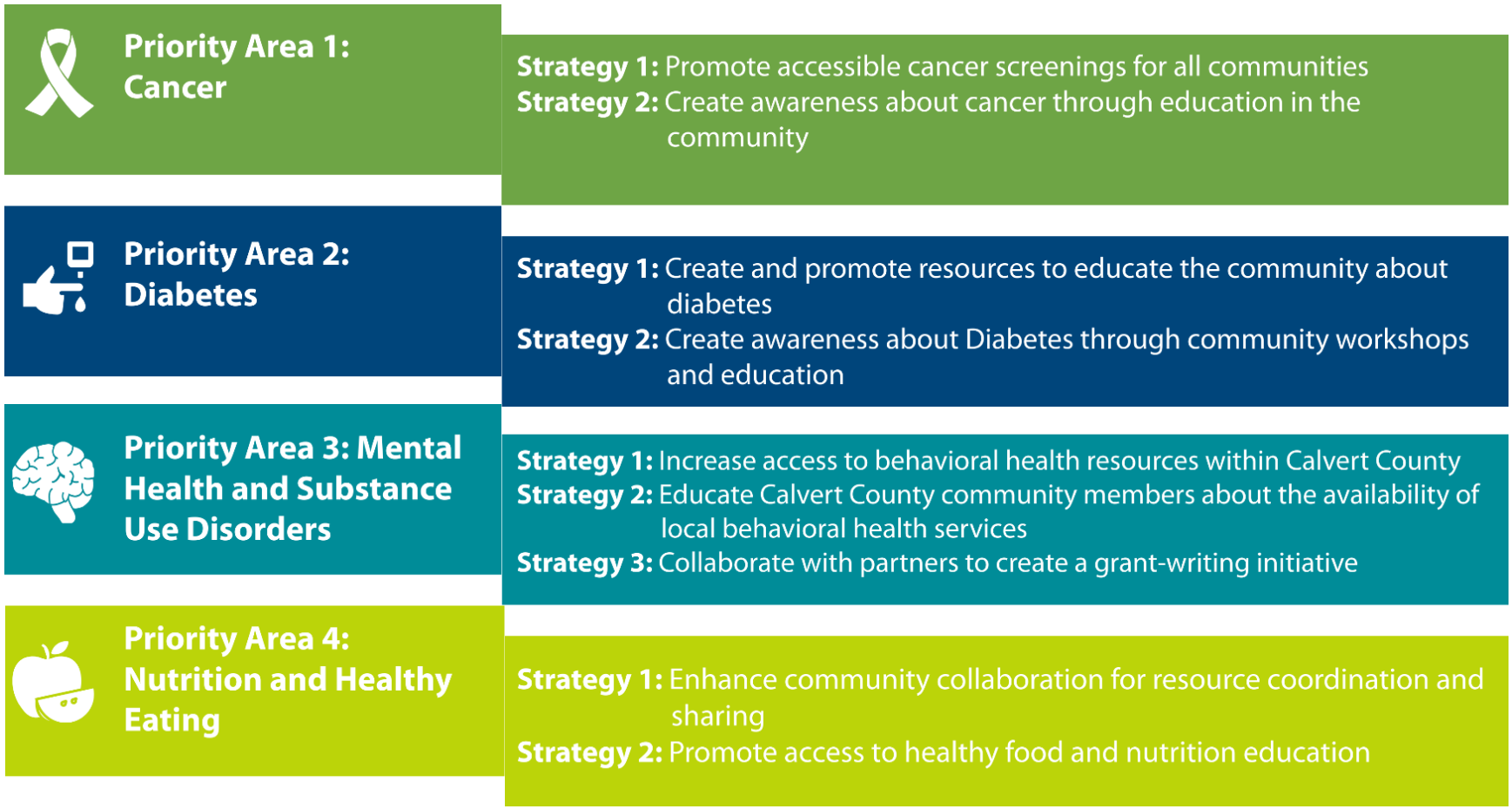
- **Magnitude of the Issue**
  How many people in the community are or will be impacted? How does the identified need impact health and quality of life? Has the need changed over time?
- **Ability to Impact**
  Can actionable and measurable goals be defined to address health needs? Are those goals achievable in a reasonable period? Does the hospital or health system have the expertise or resources to address the identified health need? Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?

Participants assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. Numerical scores for the two criteria were then combined and averaged to produce an aggregate score and ranking for each health topic.

Prioritization Results

Following the prioritization session, CalvertHealth and the Calvert County Health Department brought together a decision-making team that reviewed and discussed the scoring results of the prioritized significant community needs and identified five overall priority areas to be considered for integration into the Implementation Strategy process. These included *Cancer*, *Diabetes*, *Mental Health and Mental Disorders*, *Nutrition and Healthy Eating*, and *Substance Use Disorders* (Figure 3). To streamline implementation planning, CalvertHealth decided to merge the *Mental Health and Mental Disorders*, and *Substance Use Disorders* priority areas, as the workgroup participants were the same and their efforts are interconnected.

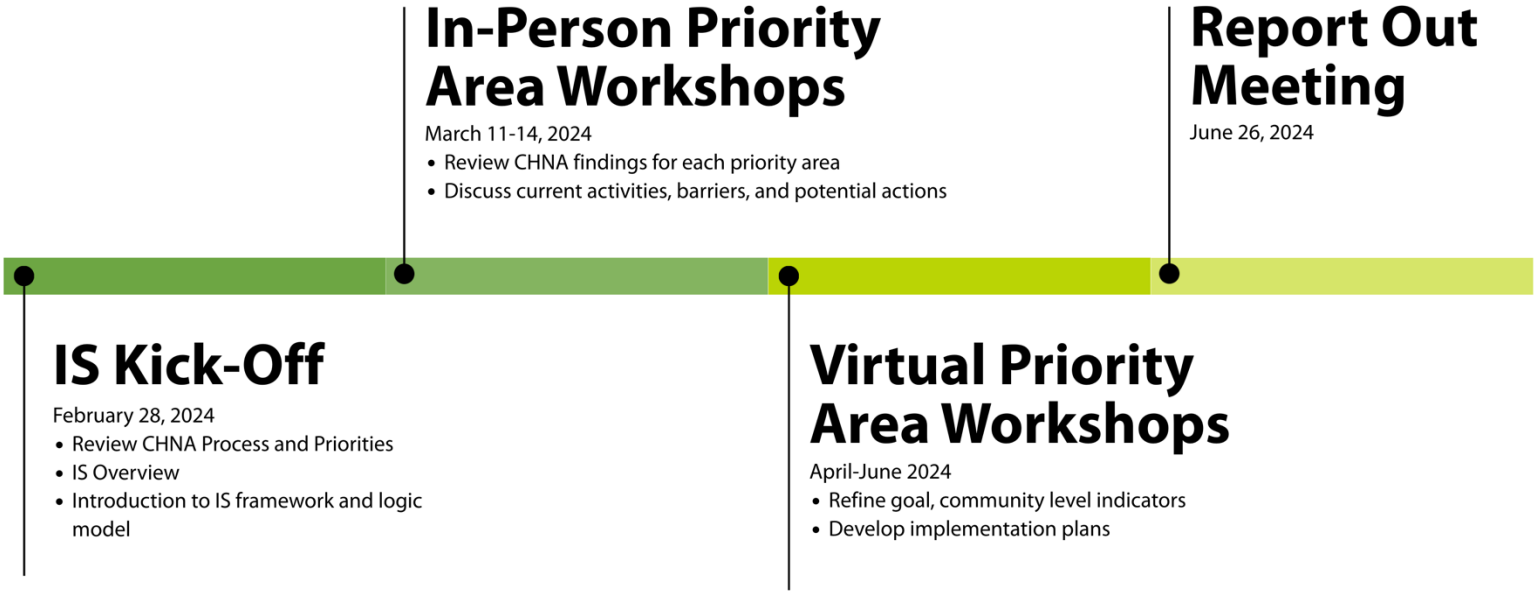
FIGURE 3. CALVERTHEALTH STRATEGIES FOR PRIORITY AREAS



2024-2027 Implementation Strategy (IS)

This section presents strategies, objectives, and activities that CalvertHealth and its partners intends to deliver, support, and/or collaborate on to address significant prioritized community health needs over the next three years, including resources for and anticipated impacts of these activities. Planned activities are consistent with current needs and CalvertHealth's mission, vision, and strategic initiatives. CalvertHealth may amend the plan as circumstances warrant, such as changes in community needs or resources to address them. Following the identification of the four priority health needs, CalvertHealth and its partners began subsequent work on implementation planning with the following goals:

Planning Process



The IS planning process started with a Kick-Off on February 28, 2024, and continued with a series of in-person and virtual workshops. Participants included community partners, providers, and subject matter experts knowledgeable about community needs and services for the priority area. On June 26, 2024, a report-out meeting was held to share the summary of the overall plans with all stakeholders.

Planning Workshops

Conduent Healthy Communities Institute (HCI) facilitated a series of in-person and virtual workshops with work groups for each priority area. Participants included community partners, providers, and subject matter experts knowledgeable about community needs and services for the priority area.

The first in-person workshop took place over a two-and-a-half-hour meeting. Before the first workshop, participants received Pre-Workshop Worksheets and a list of evidence-based resources to prepare them for the conversation. During the workshop, Conduent HCI facilitated a group discussion on the questions below. The conversation was captured using Miro Board, a collaborative digital board (see Figure 4 for example). Participants discussed:

- Changes they would like to see based on findings from the Community Health Needs Assessment (CHNA) to inform the group's goals and community-level indicators to track progress
- Existing programs, activities and resources addressing the priority area
- Common barriers blocking improvement in the area
- Potential actions that the group could commit to that can inform the work group's strategies

FIGURE 4. MENTAL HEALTH AND SUBSTANCE DISORDERS MIRO BOARD

After the initial in-person workshop, follow-up virtual sessions were held to refine the draft overarching goal, and community-level indicators, and develop implementation plans for each priority area. Collaborative online tools including Miro Board, Google Jamboard, and shared Google documents were used to encourage engagement and interaction in the development of the plan during the virtual meetings.

Plan Implementation and Progress Tracking

The work plans outline the strategies that work groups will implement for each priority area. The following components are outlined: 1) broad overarching goals and community-level indicators to track long-term progress; 2) strategies with measurable shorter-term objectives; and 3) specific activities, timelines, and lead organizations or individuals responsible. Priority area work groups will meet regularly to implement activities and track progress. The work plans will be regularly reviewed and revised to reflect evolving community needs, assets, and activities.

Priority Areas and Plans

Priority Area 1: Cancer

Cancer emerged as a critical health priority in CalvertHealth's community health needs assessment process. Calvert County's age-adjusted death rates due to various cancers including breast cancer, lung cancer, and colorectal cancer were higher than state and national values. High cancer rates and their impact on overall health and well-being were expressed by community members as a concern in key informant interviews. More detail about community input and data findings related to *Cancer* is available starting on page 46 of the CalvertHealth CHNA report.

Assets and Resources: Calvert County has a range of existing resources that were discussed during the planning workshops that support cancer prevention and treatment including, but not limited to:

- The Survivorship Program is designed to support individuals who have completed cancer treatment.
- Breast and Skin Cancer screenings to increase accessibility and awareness of cancer prevention and early detection.
- Collaboration with local Parks and Recreation departments to promote community activities that encourage physical fitness and overall well-being. It aims to integrate health awareness into everyday recreational activities.
- Cancer screenings by Calvert County Health Department are offered to individuals with lower incomes or who lack health insurance. This initiative ensures that high-quality cancer detection services are accessible to underserved populations, helping to reduce health disparities.
- Tobacco, marijuana and vaping shows and health fairs in schools to increase the awareness among younger population related to risks associated.
- CalvertHealth and Duke Health has established a comprehensive partnership aimed at enhancing cancer treatment resources. This collaboration focuses on providing state-of-the-art care and support for cancer patients.

Priority Area 1: Cancer

Underlying Barriers: Some underlying barriers related to cancer prevention and treatment that were discussed during the planning workshops include:

- **Time Constraints:** Residents of Calvert County often face significant time constraints due to busy schedules, making it difficult to prioritize health screenings and annual exams. This delay in early detection and treatment can negatively impact cancer outcomes.
- **Proactive and Preventative Conversations with Providers:** There is a need for more proactive and preventative conversations between residents and healthcare providers. Many individuals may not engage in annual exams and regular check-ups due to a lack of awareness or encouragement from their healthcare providers.
- **Lack of Transportation and Longer Commutes:** Transportation poses a significant barrier for many residents. Longer commute times and unreliable transportation can delay timely access to medical care and healthcare facilities.
- **Financial Barriers and Funding:** Financial constraints are a critical barrier to cancer care. The cost of medical care, including screenings, treatments, and follow-up appointments, can be prohibitive. Increased funding and financial support are necessary to make cancer care more accessible and affordable for all residents.

Priority Area 1: Cancer

Community Level Indicators: Cancer

The following indicators from the 2023 Community Health Needs Assessment (CHNA) were identified to help track long-term progress towards the goal:

- **Decrease in Age-adjusted death rates due to Breast Cancer:** 25.6 deaths/100,000 females
- **Decrease in Age-adjusted death rates due to Cancer**: 166.2 deaths/100,000 population
- **Decrease in Melanoma Incidence Rates:** 35.3 cases/100,000 population
- **Decrease in Age-adjusted death rates due to Lung Cancer:** 38.6 deaths/100,000 population

Priority Area 1: Cancer

Overarching Goal: Improve access to screening and prevention initiative programs for Calvert County community members, especially communities experiencing disparities in care.

Strategy 1: Promote accessible cancer screenings for all communities					
Objective 1.1: By end of fiscal year 2026, increase the number of screenings targeting underserved populations.					
Measurement: Establish the baseline of the number of screenings in year 1					
Activity	**Process Measures**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Collect demographic information and share across agencies as available and monitor participation trends for underserved and uninsured populations.	Establish the baseline information in year 1	CalvertHealth Community Wellness, Calvert County Health Department	X		
Gather data on low-dose CT screenings.	Establish the baseline information in year 1	CalvertHealth Community Wellness, Calvert County Health Department	X	X	X

Priority Area 1: Cancer

Activity	Process Measures	Lead/Collaborators/Expert	Year 1	Year 2	Year 3
Update the current document (created by the Cancer and Tobacco subcommittee and approved by the cancer accreditation team) on current screening practices to increase understanding of screening rates.	Establish the baseline information in year 1	Cancer and Tobacco Coalition	X		
Disseminate the standard document on all available cancer screenings across outreach workers and provider types.	#of organizations/ providers and outreach workers that receive the document	Cancer and Tobacco Coalition	X	X	X
Work with community/faith-based partners to increase the community's knowledge about cancer screenings.	# of meetings with community/faith partners	Health Ministry Network	X	X	X
Recruit medical providers to provide cancer screenings on the Mobile Health Unit or community organizations.	# of cancer screening events in the Mobile Health Unit or the community	CalvertHealth Community Wellness with Cancer Committee	X	X	X

Priority Area 1: Cancer

Identified community partners/opportunities for collaboration: Office on Aging, Calvert County Parks and Recreation, Library, Primary Care Practices
Target population(s): underserved and uninsured population (collect demographic information as available and monitor participation trends)

Priority Area 1: Cancer

Strategy 2: Create awareness about cancer through education in the community					
Objective 2.1: By end of fiscal year 2026, increase communication and outreach about programs and activities related to cancer in Calvert County.					
Measurement: Establish the baseline of the number of communication and outreach programs/activities happening in Calvert County in year 1.					
Activity	**Process Measures**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Create a survey to evaluate current cancer support groups to maximize effectiveness and identify opportunities for improvement	# of surveys	Director Oncology Clinical Services Director Oncology Clinical Services (CalvertHealth), Manager (CalvertHealth Community Wellness)	X		
Create a document for cancer patients and families that provides information on support groups and programs in the community for patients and caregivers	Increased support group participation by 10%	Health Ministry Network	X	X	X

Priority Area 1: Cancer

Activity	Process Measures	Lead/Collaborators/Expert	Year 1	Year 2	Year 3
Promote educational awareness and resources through advertising via different social media platforms	# of social media posts # of updates on the websites # of articles in the magazine	Director Oncology Clinical Services (CalvertHealth), Manager Community Wellness (CalvertHealth Community Wellness), (CalvertHealth Marketing)	X	X	X
Explore new and innovative ideas for sharing and promoting events for cancer education/outreach programs	# of events for cancer education/outreach programs	Supervisor Health Promotions Director Health Equity (Calvert County Health Department), Manager Community Wellness (CalvertHealth,	X	X	X
Increase awareness of HPV risk factors and promote awareness of vaccines	# of vaccines given for HPV # of educational activities	Health Officer (Calvert County Health Department)	X	X	X
Identified community partners/opportunities for collaboration: Office on Aging, Public School System					

Priority Area 1: Cancer

Target population(s): All race/ethnicity and ages

Priority Area 2: Diabetes

Diabetes is increasingly becoming a major health concern in Calvert County, as evidenced by the significant upward trend in hospitalization rates. More than one in five community members identified Diabetes as one of the critical priority health areas in Calvert Health's community health needs assessment process. Additionally, the key informants have raised concerns about the community's limited awareness of healthy lifestyle choices and proper nutrition. This lack of knowledge is perceived as a contributing factor to the diabetes surge in the county. More detail about community input and data findings related to *Diabetes* is available starting page 48 of CalvertHealth CHNA report.

Assets and Resources: Calvert County has a range of existing resources that were discussed during the planning workshops that support the prevention and management of diabetes including, but not limited to:

- **Educational Programs and Workshops**
  - Diabetes and Nutrition Education Classes: Cooking demonstrations provided by the Smile Food Pantry.
  - Community Health Round Table: Discussions on various health topics.
  - Certified Educators Workshops/Classes: Education for healthcare professionals.
  - Primary Care Practice Training: Education for Medical Assistants and Technicians.
  - Lunch and Learns: Informative sessions during lunch breaks.
- **School and Community Programs**
  - Calvert Schools' Child Nutrition Program: Nutritional education and meal planning for children.
  - Weight Watchers Program: Affordable meal planning and weight management.
- **Support and Management Programs**
  - Meals on Wheels: Meal delivery service for those in need.
  - Living Well with Diabetes: Support and education for managing diabetes.
  - Diabetes Self-Management Certification Program: Certification for effective diabetes management.

Priority Area 2: Diabetes

- **Events**
    - Diabetes Expo: An event focused on diabetes awareness and education.

Underlying Barriers: Some underlying barriers related to the prevention and management of diabetes that were discussed during the planning workshops include:

- **Access to Medications**
    - Limited Types of Medications: Some individuals may have access to a limited range of diabetes medications.
    - Cost: Many individuals cannot afford diabetes medications.
    - Availability: Medications are sometimes not available through pharmaceutical channels.
    - Communication Gaps: There is often communication gaps between providers and patients when medications are not ready.
- **Community Awareness and Education**
    - Lack of Awareness: There is a significant lack of awareness in the community about diabetes programs and resources.
    - Educational Gaps: Certain parts of the community have gaps in diabetes education.
    - Marketing Strategies: Improved marketing strategies are needed to provide education about community programs and resources.
- **Cultural and Social Barriers**
    - Cultural Norms:" Cultural norms and systems may make healthier food choices less accessible for some communities.
    - Stigma: There is a stigma that individuals with diabetes, particularly the older population, did something wrong to cause their condition.

Priority Area 2: Diabetes

- **Support Systems**
  - Case Managers: There are not enough case managers to help the older population gain access to diabetes medications and navigate prescriptions.
  - Health Workers: Availability of health workers is limited.
- **Nutritional and Lifestyle Support**
  - Nutritional Services: Some individuals are not being referred to nutritional services, and other health concerns are not being addressed.
  - Healthier Restaurants: There is a need for more support for healthier restaurant options.
- **Information and Communication**
  - Hospitalization: If individuals are not hospitalized, they often lack information about obtaining medications.
  - Technology Barriers: Many individuals cannot access the internet due to a lack of technology or knowledge about it.

Priority Area 2: Diabetes

Community Level Indicators: Diabetes

The following indicators from the 2023 Community Health Needs Assessment (CHNA) were identified to help track long-term progress towards the goal:

- **Decrease in Age-Adjusted ER Rate due to Diabetes:** 273.6 ER visits per 100,000 population
- **Decrease in Age-Adjusted Hospitalization Rate due to Diabetes:** 19.6 Hospitalizations per 10,000 population 18+ years
- **Decrease in Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes**: 9.1 Hospitalizations per 10,000 population 18+ years
- **Decrease in Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes**: 7.8 Hospitalizations per 10,000 population 18+ years
- **Decrease in Age-Adjusted Hospitalization Rate due to Type 2 Diabetes:** 12.7 Hospitalizations per 10,000 population 18+ years
- **Decrease in Diabetes:** Medicare Population: 28%
- **Decrease in the adults with Diabetes:** 12%
- **Decrease in Adults who are Overweight or Obese:** 68.1%

Priority Area 2: Diabetes

Overarching Goal: To prevent diabetes and improve health and well-being among Calvert County community members affected by diabetes.

Strategy 1: Create and promote resources to educate the community about diabetes					
Objective 1.1: By end of fiscal year 2026, increase educational materials related to diabetes that are culturally inclusive (in Spanish and languages other than English) and for people with impaired vision.					
Measurement: Establish the baseline of the number of materials in year 1					
Activity	**Process Measures**	**Lead/Collaborators/Experts**	**Year 1**	**Year 2**	**Year 3**
Evaluate current resources that are inclusive and culturally appropriate	# of available resources that are available and being used by community organizations	CHIR diabetes subcommittee	X		
Culturally inclusive resources to be reviewed by compliance with Health Literacy Standards (plain language)	# of resources that are reviewed	CHIR diabetes subcommittee	X	X	
Create diabetes educational materials that are accessible for people with impaired vision by using larger fonts, audio resources, etc.	# of educational materials created for people with impaired vision	CHIR diabetes subcommittee, Calvert County Office on Aging		X	X

Priority Area 2: Diabetes

Identified community partners/opportunities for collaboration: University of Maryland Extension/ Horowitz Center, Calvert County Health Department Diversity and Equity					
Target population(s): Hispanic population, people with impaired vision					
Objective 1.2: By end of fiscal year 2026, implement a communication plan, involving Calvert County community partners, to create and distribute education and resources related to Diabetes					
Measurement: Establish a communication plan by year 3					
Activity	**Process Measures**	**Lead/Collaborators/Experts**	**Year 1**	**Year 2**	**Year 3**
Create a workgroup to develop an education and communication plan	Not applicable	CHIR diabetes subcommittee	X		
Assemble information on all the available resources in the community	# of resources available	CHIR diabetes subcommittee	X		
Create a survey to gather community input on their knowledge of available current resources	# of surveys completed	CHIR diabetes subcommittee	X		
Develop a mailer to promote diabetes programs/resources/healthycalvert.org to all county residents	# of mailers created	CHIR diabetes subcommittee	X	X	

Priority Area 2: Diabetes

Activity	Process Measures	Lead/Collaborators/Experts	Year 1	Year 2	Year 3
Create a comprehensive plan to educate and provide resources to the healthcare community	# of resources provided to healthcare community	CHIR diabetes subcommittee	X	X	X
Identified community partners/opportunities for collaboration: Marketing and communication representatives from different agencies, primary care practitioners, pediatricians, endocrinologists					
Target population(s): All individuals with diabetes, with a particular emphasis on those with Type 2 Diabetes.					

Priority Area 2: Diabetes

Strategy 2: Create awareness about Diabetes through community workshops and education					
Objective 2.1: By 2026, increase the number of community-based education sessions related to Diabetes education in Calvert County.					
Measurement: Establish the baseline of the number of education sessions provided in year 1					
Activity	**Process Measures**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Evaluate Diabetes subcommittee members and participation and recruit	Establish the baseline information in year 1	CHIR diabetes subcommittee	X		
Evaluate the structure of the diabetes subcommittee and set expectations	Establish the baseline information in year 1	CHIR diabetes subcommittee	X		
Identify gaps in educational offerings for diabetes awareness through survey	Survey to gather information on education gaps.	CHIR diabetes subcommittee	X	X	

Priority Area 2: Diabetes

Activity	Process Measures	Lead/Collaborators/Expert	Year 1	Year 2	Year 3
Work with community partners to add workshops/educational offerings to fill in the gaps/needs as identified	# of workshops/educational offerings provided	CHIR diabetes subcommittee		X	X
Establish joint ventures in delivering workshops and education	# of workshops delivered as a joint venture	CHIR diabetes subcommittee	X	X	X
Objective 2.2: By 2026, increase the number of new onsets with diabetes who get formal diabetes education.					
Measurement: Establish the baseline of the number of participants in year 1					
Activity	**Measurement**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Create a marketing plan to promote educational programs and classes	Establish the baseline information in year 1	CHIR diabetes subcommittee	X	X	

Priority Area 2: Diabetes

Activity	Measurement	Lead/Collaborators/Expert	Year 1	Year 2	Year 3
Collect and report participation in workshops and education programs (all agencies)	# of participants in attendance at workshops (submitted by agencies)	CHIR diabetes subcommittee		X	X
Identified community partners/opportunities for collaboration: Partners In Accountable Care Collaboration And Transitions Committee					
Target population(s): All individuals with diabetes with a particular emphasis on those with Type 2 Diabetes.					

Priority Area 3: Mental Health and Substance Use Disorders

Mental health and substance use disorders have been identified as critical health priorities in Calvert County, significantly impacting the well-being of its residents. Age-adjusted death rates due to suicide in Calvert County is comparatively higher than the state and national values. In addition, age-adjusted death rates due to drug and opioid involved overdose are higher in Calvert county compared to state and national values. Community members expressed concerns about the shortage of behavioral health practitioners and the need for more mental health and behavioral health services. The majority of survey respondents identified mental health as the most important health problem, highlighting concerns for school-aged children, individuals with low income, and older adults. Substance use disorders are also a significant concern, with survey respondents identifying alcohol and substance misuse as major health issues. More detail about community input and data findings related to *Mental Health and Substance Use Disorders* is available starting on page 50 of the CalvertHealth CHNA report.

Assets and Resources: Calvert County has a range of existing resources that were discussed during the planning workshops that address mental health and substance use disorders including, but not limited to:

- **Mobile Crisis Unit:** Services provide immediate crisis intervention for individuals aged 13 and up.
- **Inpatient Services:** Inpatient care for individuals aged 13 and up dealing with mental health and substance use disorders.
- **Public Events and Resources:**
    - Support Services: Various public events provide resources and support services.
    - Adolescent Safe House: After-school programs aimed at providing a safe environment for adolescents.
- **Licensed Facilities and Outpatient Services:** Licensed facilities offering opioid and outpatient services.
- **Peer-Related Programs**
    - Transition Services: Programs aimed at helping individuals transition back into the community.

  - Harm Reduction Program: Focuses on unsheltered populations, providing food, tents, and other resources.
- **Libraries:** Libraries in the county serve as resource hubs for information and support.
- **Parks and Recreation:** Various services and programs offered by Parks and Rec. that includes initiatives like "Farming for Hunger" and "Rec on the Go" to address transportation barriers.
- **Mental Health App:** Agency support program addressing Post-Traumatic Stress Disorder (PTSD) concerns among younger responders.
- **Safe Nights Program for** unsheltered populations**.** Some individuals face difficulties adhering to program rules, limiting their ability to take advantage of services.

Underlying Barriers: Some underlying barriers related to addressing mental health and substance use disorders that were discussed during the planning workshops include:

- **Provider Challenges:** Lack of incentives and low salaries for mental health and substance use disorder providers.
- **Coordination and Funding:**
  - Difficulty identifying who needs what and coordinating roles among grant writers and service providers.
  - Need for collaboration to secure and utilize funding effectively.
- **Community and Faith-Based Support:**
  - Churches and spiritual organizations could use more grant funding for programs.
  - Importance of spiritual and faith-based initiatives in providing purpose and support.
- **Collaboration and Resource Utilization:**
  - Existing resources are underutilized due to a lack of collaboration and communication among community-based organizations.
  - Working together rather than in silos is crucial for maximizing impact.

Priority Area 3: Mental Health and Substance Use Disorders

- **Housing and Homelessness:**
  - Insufficient homeless shelter capacity.
  - Lack of affordable housing particularly for the homeless and senior populations.
  - Funding needed for housing and food access.
- **Connectivity and Communication:**
  - Lack of connectivity and communication contributes to isolation to older adults in the county.
  - Need to build relationships within the community to improve access to services and reduce stigma.
- **Youth and Education:**
  - Younger population self-medicating due to stress, with inadequate resources for schools, teachers, and administrators.
  - Schools need more support to handle the increasing mental health challenges among students.
- **Funding and Participation:**
  - More funding is needed to address various challenges.
  - Family and youth peer support programs lack sufficient participation.

Priority Area 3: Mental Health and Substance Use Disorders

Community Level Indicators: Mental Health and Substance Use Disorders

The following indicators from the 2023 Community Health Needs Assessment (CHNA) were identified to help track long-term progress towards the goal:

- **Decrease in Age-Adjusted Death Rate due to Suicide:** 16.5 deaths/100,000 population
- **Decrease in Age-Adjusted Hospitalization Rate due to Adolescent suicide and intentional Self-inflicted injury:** 23.7 hospitalizations/10,000 population aged 10-17
- **Decrease in Age-Adjusted Hospitalization Rate due to Adult suicide and intentional Self-inflicted injury:** 43.8 hospitalizations/10,000 population 18+ years
- **Decrease in Age-Adjusted Death Rate due to Drug Use:** 36.9 deaths/100,000 population
- **Decrease in 8th-grade students that drank alcohol in the past 30-days:** 10.5%
- **Decrease in 8th-grade students that have used an electronic vapor product in the past 30 days:** 13.4%
- **Decrease in 7th-grade students that used prescription pain medicine without a doctor's prescription or differently than prescribed:** 6.9%
- **Decrease in Liquor Store Density:** 25.6 stores/100,000 population

Priority Area 3: Mental Health and Substance Use Disorders

Overarching Goal for Mental Health: Develop a holistic approach to mental health and well-being that addresses the diverse needs of all community members in Calvert County.

Overarching Goal for Substance Use Disorders: Promote a holistic approach to prevention, treatment, and recovery for Substance Use Disorders and utilization of resources available across Calvert County.

Strategy 1: Increase access to behavioral health resources within Calvert County.					
Objective 1.1: By end of fiscal year 2026, increase utilization of local resources among Calvert County community members.					
Measurement: Baseline to be established in year 1					
Activity	**Process Measures**	**Lead/Collaborators/Experts**	**Year 1**	**Year 2**	**Year 3**
Create a survey to understand better why there is underutilization of MH and SUD services and why attendance is low at events/services	# of surveys distributed	LBHA, Calvert County Govt, Veterans Affairs Commission, Harm Reduction	X		
Create and deploy a plan to identify existing collaboratives, focus, and meeting frequency	Baseline data developed in Year 1 will be used	Senior Behavioral Health Coordinator (LBHA), Associate VP Ancillary Services (CalvertHealth)	X	X	X

Priority Area 3: Mental Health and Substance Use Disorders

Activity	Process Measures	Lead/Collaborators/Experts	Year 1	Year 2	Year 3
Create a system to identify existing key activities/events of local collaboratives working on behavioral health	Establish the baseline information in year 1	Senior Behavioral Health Coordinator (LBHA), Associate VP Ancillary Services (CalvertHealth)	X	X	X
Create a system for sharing key activities of local collaboratives working on behavioral health	Establish the baseline information in year 1	Senior Behavioral Health Coordinator (LBHA), Associate VP Ancillary Services (CalvertHealth)	X	X	X
Implement a plan to engage existing collaboratives and meet regularly to share information	Establish the baseline information in year 1	Senior Behavioral Health Coordinator (LBHA), Associate VP Ancillary Services (CalvertHealth)	X	X	X
Restructure of (CHIR) and subcommittees to foster diverse and inclusive community representation and collaboration of effort	Establish the baseline information in year 1	CHIR Steering committee	X		

Priority Area 3: Mental Health and Substance Use Disorders

Activity	Process Measures	Lead/Collaborators/Experts	Year 1	Year 2	Year 3
Identify emerging wrap-around services for all diverse groups in Calvert County	Establish the baseline information in year 1	LBHA advisory council, Director Community Resources (Calvert County Government), Director(LBHA)	X	X	
Have wrap-around services for all diverse groups in Calvert County	Establish the baseline information in year 1				X
Identified community partners/opportunities for collaboration: Faith-based organizations, Behavioral Health Collaboration Outreach					
Target population(s): Older population, diverse population					

Priority Area 3: Mental Health and Substance Use Disorders

Strategy 2: Educate Calvert County community members about the availability of local behavioral health services					
Objective 2.1: By end of fiscal year 2026, decrease in inpatient hospitalization / ER utilization for behavioral health reasons.					
Measurement: Baseline to be established in year 1 (Crisis utilization data and ED utilization data)					
Activity	**Process Measures**	**Lead/Collaborators/Experts**	**Year 1**	**Year 2**	**Year 3**
Collaboration work groups to get the word out on where the resources are and how to access them- central website, HealthyCalvert, HOPE4Calvert, Calvet County Local Behavorial Health Autority pageOur Calvert	Tracking Google Analytics for online resource pages. # of provider meetings (to educate and update the community on resources)	Director Community Resources (Calvert County Government), Behavioral Health Communications & Outreach subcommittee, Provider Meeting, and Local Behavioral Health Advisory Council	X	X	X
Create, deploy, monitor, and analyze a survey for tracking awareness of Behavioral Health services	# of surveys created pre and post-survey results	LBHA, Director Community Resources (Calvert County Government), Chairman (Veterans Affairs Commission), Supervisor, Peer Recovery & Harm Reduction (Calvert County Health Department)	X	X	X

Priority Area 3: Mental Health and Substance Use Disorders

Activity	Process Measures	Lead/Collaborators/Experts	Year 1	Year 2	Year 3
Create a universal post-event survey and deploy it to measure attitudes toward receiving behavioral health services	#of surveys deployed for each event versus number in attendance	LBHA, Community Wellness (CalvertHealth)	X	X	X
CHIR membership and steering committee restructure and refocus	# of new partners joined the committee # of participation from various agencies	Co-Chairs CHIR	X	X	X
Crosswalk crisis utilization data and ED utilization data as a measurement	Decrease ED utilization	LBHA	X	X	X
Identified community partners/opportunities for collaboration: Cornerstone, Avenues, public and private Schools					
Target population(s): Calvert County community members of all race/ethnicity and ages					

Priority Area 3: Mental Health and Substance Use Disorders

Strategy 3: Collaborate with partners to create a grant-writing initiative					
Objective 3.1: By end of fiscal year 2026, create a collaborative grant-writing initiative.					
Measurement: Number of joint grants submitted and letters of support					
Activity	**Process Measures**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Ensure that members of CHIR regularly attend the county grant collaborative meeting	Report back through meeting minutes	CHIR Steering Committee	X	X	X
Standing agenda items at CHIR meetings to discuss upcoming health-specific grant opportunities, identify partners, review the status of current grants	Establish the baseline information in year 1	CHIR and LBHAC and Provider Meetings	X	X	X
Utilize resources through Non-profit institutes for education about the grant process and awareness about grant opportunities	# of resources identified # of resources utilized # of educational opportunities utilized	Director Community Resources (Calvert County Government	X	X	X
Identified community partners/opportunities for collaboration: Grant writer collaborative, Non-profit Institute, Governor grant office					
Target population(s): Calvert County community members of all race/ethnicity and ages					

Priority Area 4: Nutrition and Healthy Eating

People who eat too many unhealthy foods are at increased risk for health problems such as obesity, heart disease, and diabetes. Promotion of nutrition and healthy eating emerged as a critical priority in CalvertHealth's community health needs assessment process. Community members identified childhood and adolescent obesity as a concern, indicating high cost of healthy food, lack of affordable options, and insufficient nutrition education in schools are significant barriers. Community members indicated concern for the following populations: Black/African Americans, individuals with lower socioeconomic status, people experiencing homelessness, and those relying on food pantries. In addition, community input suggested that the communities of North Beach, Prince Frederick, Lusby, and St. Leonard's may be more impacted by poor nutrition. More detail about community input and data findings related to *Nutrition and Healthy Eating* is available starting on page 52 of the CalvertHealth CHNA report.

Assets and Resources: Calvert County has a range of existing resources that were discussed during the planning workshops that support nutrition and healthy eating including, but not limited to:

- **Health and Wellness Programs:**
  - Conducting virtual prediabetes/diabetes classes.
  - Weight-loss programs for coaching and healthy guidance.
- **Nutrition and Food Access Programs:**
  - Supplemental Nutrition Assistance Program Education (SNAP Ed) programs offering nutrition education for low-income populations.
  - Partnership between SNAP Ed and local farmers.
  - Meals on Wheels program.
  - Social Determinants of Health (SDOH) grant enhancing food pantry services and expanding SNAP benefits.
  - Eating Together program with suggested donations.

Priority Area 4: Nutrition and Healthy Eating

- **Economic development programs through Parks and Recreation**

Underlying Barriers: Some underlying barriers blocking improvement of nutrition and healthy eating that were discussed during the planning workshops include:

- **Infrastructure and Accessibility:**
  - Lack of safe routes and walkability.
  - Insufficient transportation for accessing farmers' markets and grocery stores, especially for the aging population.
  - High rent costs for stores, indoor fitness centers, and local businesses.
- **Economic Barriers:**
  - Affordability issues, with fast food being cheaper than healthy options.
  - Financial constraints preventing the purchase of healthy foods.
  - High costs and insurance barriers for weight loss programs and surgeries.
  - Lack of funding and grants for prevention programs.
- **Education and Communication:**
  - Lack of education on nutrition and healthy eating.
  - Inadequate communication among organizations to promote available resources.
  - Need for culturally appropriate education on healthy eating.
- **Technology and Aging Population:**
  - Older adults may have limited access to technology and virtual meetings.
- **Convenience and Awareness:**
  - Barriers to convenient access to healthy food, exercise, and transportation.
  - Need for increased awareness of available resources.

Priority Area 4: Nutrition and Healthy Eating

- **Social and Cultural Factors:**
  - Social stigma around using food assistance programs.
  - Cultural preferences for familiar foods, which may be less healthy.
  - Difficulty in changing cultural habits and promoting healthier options at events.
  - Social barriers, with younger people avoiding places frequented by older populations.
- **Resource Limitations:**
  - Lack of storage options for healthy foods for the people experiencing homelessness and those living on boats.
  - Shortage of dietitians and affordable access to nutritionists.
  - Financial barriers limiting access to healthy options.

Priority Area 4: Nutrition and Healthy Eating

Community Level Indicators: Nutrition and Healthy Eating

The following indicators from the 2023 Community Health Needs Assessment (CHNA) were identified to help track long-term progress towards the goal:

- **Increase in Adults with Healthy Weight:** 32.9%
- **Increase in Access to Exercise Opportunities:** 81.8%
- **Increase in Adults Engaging in Regular Physical Activity:** 49.9%
- **Decrease in Adults Who are Obese:** 34.1%
- **Decrease in Adults who are Overweight or Obese:** 68.1%
- **Decrease in Child Food insecurity Rate:** 4.0%

Priority Area 4: Nutrition and Healthy Eating

Overarching Goal: Improve health by promoting healthy lifestyle choices and making nutritious food options accessible for all Calvert County community members.

Strategy 1: Enhance community collaboration for resource coordination and sharing					
Objective 1.1: By end of fiscal year 2026, increase the participation of Calvert County community members at community events.					
Measurement: Establish baseline in year 1					
Activity	**Process Measures**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Partner with CHIR to collaborate and identify community partners at the table	Establish the baseline information in year 1	CHIR steering committee, Interagency Council	X	X	
Create a marketing plan for rolling out HealthyCalvert.org to the broader community and promote the use of it	# of promotional activities	CHIR, Interagency Council, Calvert County Government Community Resources CalvertHealth	X	X	X
Continue to support Farmer's markets and money-match programs to address food insecurity	$ matched and redeemed at CalvertHealth Tuesday market, # new enrollees	Calvert Farmers Market Association, Market vendors Lifestyles of Maryland, Transportation partners Office on Aging	Increase by 2%	Increase by 2%	Increase by 2%

Priority Area 4: Nutrition and Healthy Eating

Activity	Process Measures	Lead/Collaborators/Expert	Year 1	Year 2	Year 3
Partner with churches to host healthy lifestyle or healthy eating presentations or programs for church and community members	# of events hosted with churches Establish baseline in year 1	Health Ministry members Other faith communities that may not be part of the Health Ministry Solomons Mission Center Registered Dietitian (Office on Aging) Health Department	X	X	X
Explore ways to collaborate and support the school system with plans for nutrition and healthy eating	# of educational activities offered on healthy eating offered at schools	CHIR roundtable, Calvert County Public Schools	X	X	X
Foster ways for the nutrition and healthy eating implementation group to stay engaged and active	# of meetings/year	CHIR	X	X	X
Identified community partners/opportunities for collaboration: Schools, Churches, Food pantries, Farmers Market Associations, dieticians from representative agencies, Bariatric support services					
Target population(s): High-needs zip codes 20714 (North Beach), 20678 (Prince Frederick), 20657 (Lusby)					

Priority Area 4: Nutrition and Healthy Eating

Strategy 2: Promote access to healthy food and nutrition education					
Objective 2.1: By end of fiscal year 2026, increase access to healthy food and nutrition education.					
Measurement: Establish baseline in year 1					
Activity	**Measurement**	**Lead/Collaborators/Expert**	**Year 1**	**Year 2**	**Year 3**
Increase # of farmers in the community who accept EBT/SNAP and partner with Market Match	# of farmers participated	Senior Behavioral Health Coordinator (LBHA), , SNAP-ed, Dept of Agriculture		X	X
Work with local farmers to have more fresh produce available at grab-and-go summer food pick-up places Calvert HS, Southern MS, Windy Hill MS	# of farmers participated # of families who participated	Coordinator - Calvert County Family Network), Solomons Mission Center	X	X	X
Increase the redemption rate of Farmer's Market vouchers	Percentage increase by 10%	Registered Dietitian (Office on Aging), Farmers Market Association, Community Wellness (CalvertHealth)	X	X	X
Offer free cooking demonstrations in additional locations within targeted zip codes	# of demonstrations given # of participants	Calvert County Health Department	X	X	X

Priority Area 4: Nutrition and Healthy Eating

Activity	Process Measures	Lead/Collaborators/Expert	Year 1	Year 2	Year 3
Continue to expand education and awareness of healthy eating through the farmer's market	# of guests joining the farmer's market # of recipe cards created by community wellness department	Calvert County Farmers Market Association, Calvert County Agriculture, Community Wellness (CalvertHealth)			
Build capacity community gardens in targeted areas - Food Pantries, East John Youth Center, Farming 4 Hunger, University of Maryland Extension	# of gardens # of people served	Solomons Mission Center), Coordinator (Calvert County Family Network),	X	X	
Create a networking plan in conjunction with community partners to promote and advertise community gardens	Establish the baseline information in year 1	Solomons Mission Center, Coordinator (Calvert County Family Network),	X	X	X
Identified community partners/opportunities for collaboration: Schools, Farming 4 Hunger, Food Pantries					
Target population(s): High-needs zip codes 20714 (North Beach), 20678 (Prince Frederick), 20657 (Lusby)					

CalvertHealth Implementation Strategy

2024-2027

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CalvertHealth