Well-being.

|A state characterized by health, happiness, and prosperity|

Executive Summary

EASTERN SHORE OF VIRGINIA PLAN FOR WELL-BEING

2017 – 2020

Full plan is at www.eshealthycommunities.org

The Eastern Shore of Virginia Plan for Well-Being 2017 - 2020

Vision: By 2020 all residents of the Eastern Shore of Virginia report a growing, positive sense of health, well-being, and self-empowerment.

Mission: As a volunteer multi-sector partnership, Eastern Shore Healthy Communities' mission is to develop an accountable care community using policies, systems, and environmental change to improve the health and success of the Eastern Shore of Virginia.

PLAN FOR WELL-BEING OUTLINE

AIM I. Healthy, Connected Communities

Goal 1.1. Eastern Shore of Virginia (ESVA) Families Maintain Economic Stability

Goal 1.2. ESVA Communities Collaborate to Improve the Population's Health

AIM II. Strong Start for Children

Goal 2.1. ESVA Residents Plan their Pregnancies

Goal 2.2. ESVA Children are Prepared to Succeed in Kindergarten

Goal 2.3. The Racial Disparity on the ESVA Low Weight Live Births is Eliminated

AIM 3. Preventive Actions

Goal 3.1. ESVA Residents Follow a Healthy Diet and Live Actively

Goal 3.2. ESVA Prevents Nicotine Dependency

Goal 3.3. ESVA Residents are Protected against Vaccine-Preventable Diseases

Goal 3.4. Cancers Are Prevented or Diagnosed at the Earliest Possible Stage

Goal 3.5. ESVA Residents Have Life-Long Wellness

AIM 4. System of Health Care

Goal 4.1. ESVA has a Strong Primary Care System Linked to Behavioral Health Care, Oral Health Care, and Community Support System

Goal 4.2. ESVA's IT System Connects People, Services, and Information to Support Optimal Health Outcomes

Goal 4.3. Health Care-Associated Infections Are Prevented and Controlled on the ESVA

Achieving this Vision and Accomplishing the Plan for Well-Being Requires Intersectoral Leadership

Six Characteristics of Effective Intersectoral Leaders

1. **Balanced motivations.** A desire to create public value no matter where they work, combining their motivation to wield influence (often in government), have social impact (often in nonprofits) and generate wealth (often in business).

2. **Transferable skills.** A set of distinctive skills valued across sectors, such as quantitative analytics, strategic planning and stakeholder management.

3. **Contextual intelligence.** A deep empathy of the differences within and between sectors, especially those of language, culture and key performance indicators.

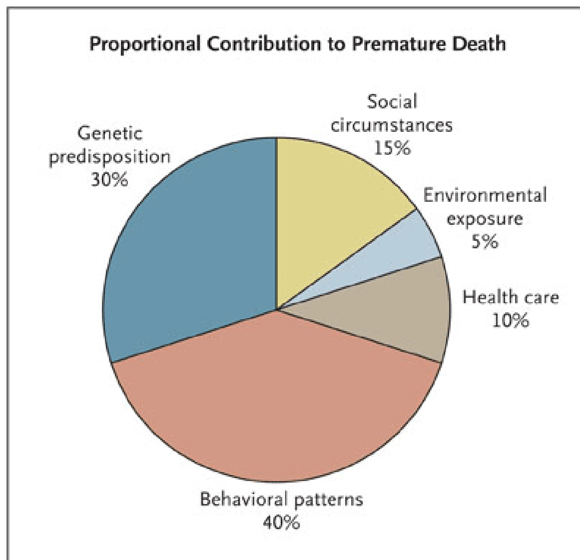
4. **Integrated networks.** A set of relationships across sectors to draw on when advancing their careers, building top teams, or convening decision-makers on a particular issue.

5. **Prepared mind.** A willingness to pursue an unconventional career that zigzags across sectors, and the financial readiness to take potential pay cuts from time to time.

6. **Intellectual thread.** Holistic subject matter expertise on a particular multi-sector issue by understanding it from the perspective of each sector.

(Lovegrove and Thomas, 2013)

And An Understanding of Where Health Comes From



AIM I. Healthy, Connected Communities

Goal 1.1. Eastern Shore of Virginia (ESVA) Families Maintain Economic Stability

Strategies

1.1.1. Provide alternative pathways to graduation and post-secondary training for disconnected youth and those with special needs

1.1.2. Develop and use early warning systems to prevent failure and help at-risk students

1.1.3. Develop school policies to assess and address physical, social, and environmental health barriers that impede learning

1.1.4. Expand training and work-linked learning opportunities for youth

1.1.5. Support opportunities for mid-career retraining

1.1.6. Provide community information clearinghouses in public libraries to improve access to information, resources, and education

1.1.7. Build affordable housing, and rehabilitate existing affordable housing to accommodate low-income families

Goal 1.2. ESVA Communities Collaborate to Improve the Population's Health

Strategies

1.2.1. Establish a collaborative health assessment and strategic health improvement planning process throughout ESVA that works in concert with state plans and include public health, health care systems, and community partners

1.2.2. Align health system community benefit programs with community health improvement plans

1.2.3. Enhance data systems and public health information technology to collect, manage, track, analyze, and report county-level data for use in health assessments

AIM II. Strong Start for Children

Goal 2.1. ESVA Residents Plan their Pregnancies

Strategies

2.1.1. Increase access to quality family planning services for all women of child-bearing age

2.1.2. Expand evidence-based programs that promote healthy relationships

2.1.3. Educate women and men about the effectiveness of contraceptive methods and increase access to the most effective methods

2.1.4. Expand access to and use of preconception health services

2.1.5. Create a system of access to pregnancy, contraception, prenatal, and parenting information resources through the public libraries

Goal 2.2. ESVA Children are Prepared to Succeed in Kindergarten

Strategies

2.2.1. Increase developmental screening for childhood milestones and delays

2.2.2. Increase enrollment of three to five year-old children in early childhood education and library programs that include quality educational components that address literacy, numeracy, cognitive development, socio-emotional development, and motor skills

2.2.3. Increase the number of providers and educators who screen for adverse childhood events (ACEs) and are trained in using a trauma-informed approach to care

2.2.4. Expand programs that help families affected by ACEs, toxic stress, domestic violence, mental illness, and substance abuse. Create safe, stable, and nurturing environments

2.2.5. Expand programs and easily accessible information resources that teach positive parenting and help parents fully engage with their children in productive ways

2.2.6. Increase opportunities for fathers to be engaged in programs and services for their children

Goal 2.3. The Racial Disparity on the ESVA Low Weight Live Births is Eliminated

Strategies

2.3.1. Form neighborhood collaboratives co-led by community members in under-resourced communities to identify obstacles and develop plans to address the root causes of health inequities

2.3.2. Eliminate early elective deliveries

2.3.3. Expand outreach to pregnant women and increase the number of group prenatal care classes

2.3.4. Expand home visiting and family support programs

AIM 3. Preventive Actions

Goal 3.1. ESVA Residents Follow a Healthy Diet and Live Actively

Strategies

3.1.1. Integrate health planning into local and regional comprehensive planning

3.1.2. Adopt community designs that support active living, including concentrated mixed use development and bicycle- and pedestrian-friendly communities

3.1.3. Expand opportunities during and after school for children to get healthy meals and the recommended amount of daily physical activity

3.1.4 Create parks, recreation facilities or open space in all neighborhoods

3.1.5. Increase access to healthy and affordable foods in all neighborhoods

3.1.5. Promote public libraries resources for health information, family development and food programs

3.1.6. Implement organizational and programmatic nutrition standards and policies

3.1.7. Expand programs and services to eliminate childhood hunger

3.1.8. Help people recognize and make healthy food and beverage choices

3.1.9. Increase the number of evidence-based employee wellness programs

Goal 3.2. ESVA Prevents Nicotine Dependency

Strategies

3.2.1. Establish smoke-free policies and social norms

3.2.2. Promote tobacco cessation and support tobacco users in quitting

3.2.3. Prevent initiation of tobacco use

3.2.4. Provide easily accessible and relevant information resources on dependency/addiction prevention

Goal 3.3. ESVA Residents are Protected against Vaccine-Preventable Diseases

Strategies

3.3.1. Use patient registries to identify patients due for vaccination and send them reminders

3.3.2. Evaluate data from the Vaccines for Children program and target outreach to providers who have the opportunity to improve vaccination rates

3.3.3. Evaluate data from the Virginia Immunization Information System to assess immunization coverage and develop targeted interventions to address gaps

3.3.4. Educate ESVA residents about the effectiveness of HPV vaccination in preventing HPV-associated cancers

3.3.5. Increase the number of adolescents who receive well visits in patient-center medical homes

3.3.6. Establish policies to ensure health-care providers receive annual influenza vaccine

Goal 3.4. Cancers Are Prevented or Diagnosed at the Earliest Possible Stage

Strategies

3.4.1. Increase tobacco prevention and cessation programs

3.4.2. Increase educational outreach efforts and resources about early cancer screening prevention benefits

3.4.3. Increase the number of providers, lay health advisors, and volunteers trained in health literacy to provide one-on-one education in medical, community, worksite, and household settings to support people in seeking recommended cancer screenings

3.4.4. Implement evidence-based strategies to reduce structural barriers to cancer screenings

3.4.5. Implement provider assessment and feedback interventions to increase cancer screenings

Goal 3.5. ESVA Residents Have Life-Long Wellness

Strategies

3.5.1. Encourage construction of safe, congregate and retirement housing for the aging population

3.5.2. Increase access to internet usage for aging residents

3.5.3. Increase the number of fitness programs that promote senior fitness

3.5.4. Develop a senior falls prevention program

3.5.5. Implement community-wide value-neutral programs to support planning in advance for future healthcare choices

3.5.6. Provide lifelong learning programs and resources that stimulate memory and personal interaction

AIM 4. System of Health Care

Goal 4.1. ESVA has a Strong Primary Care System Linked to Behavioral Health Care, Oral Health Care, and Community Support System

Strategies

4.1.1. Create an Accountable Care Community on the Eastern Shore of Virginia that includes groups of health-care providers and community partners that voluntarily coordinate high quality care to ensure patients get the right care at the right time; avoid duplication of services; and prevent medical errors

4.1.2. Improve access to comprehensive primary care in patient-centered medical homes

4.1.3. For patients with complex conditions, integrate primary care with specialty care, behavioral health care, substance abuse services, and oral health care

4.1.4. Increase the availability of community behavioral health services

4.1.5. Expand telemedicine services

4.1.6. Increase the number of providers who screen for domestic violence and refer victims to organizations that can assist them

4.1.7. Increase care coordination across providers and settings

4.1.8. Expand adoption of the community health worker model by health care organizations

4.1.9. Develop patient-centered health communications that have a positive impact on health, health care, and health equity

4.1.10. Increase the number of providers who screen for nicotine use, including smokeless tobacco and e-cigarettes, and provide or refer for cessation services

4.1.11. Promote drug-prescribing protocols in health care settings to reduce opioid prescription abuse

4.1.12. In primary care and other settings increase use of the Screening, Brief Intervention, Referral and Treatment tool (an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs)

4.1.13. Increase communicate with Eastern Shore of Virginia residents about how to avoid wasteful or unnecessary medical tests, treatments and procedures

4.1.14. Increase promotion efforts for and use of easily accessible information, resources, and programs that support personal health and well-being

Goal 4.2. ESVA's IT System Connects People, Services, and Information to Support Optimal Health Outcomes

Strategies

4.2.1. Adopt electronic health records in all clinical and care coordination settings

4.2.2. Expand the use of specific disease registries and reports (for example patients with hypertension) by medical practices and hospital to evaluate and track patient outcomes and develop targeted interventions to improve patient outcomes

4.2.3. Connect providers, hospitals, and community partners electronically to allow for Shore-wide health information exchange

4.2.4. Develop the capacity to create aggregated data reports through a Shore-wide connected electronic information data base that can be used to analyze and track population health measures

4.2.5. Enhance public and private data systems and public health information technology to collect, manage, track, analyze, and report population health data

4.2.6. Support Health Information Technology training opportunities and jobs

Goal 4.3. Health Care-Associated Infections Are Prevented and Controlled on the ESVA

Strategies

4.3.1. Create a culture of safety in health care facilities that encourages effective communication between health—care providers, patients, and family members

4.3.2. Perform hand hygiene frequently

4.3.3. Use antibiotics wisely to prevent bacteria from developing resistance to the drugs that are used to treat them

4.3.4. Implement standard precautions in the care of all patients in all health care settings all of the time

4.3.5. Use evidence-based methods to clean medical equipment and the health care environment

4.3.6. Collect, analyze, and use data to engage healthcare providers in quality improvement activities

4.3.7. Increase knowledge and practice of key prevention strategies for the various HAIs across and within healthcare settings

4.3.8. Use health information systems to reinforce clinical practices that improve patient safety

PLAN FOR WELL-BEING MEASURES

VISION

By 2020 all residents of the Eastern Shore of Virginia report a growing, positive sense of health, well-being, and self-empowerment

AIM 1 >> Healthy, Connected Communities

Goal 1.1: EASTERN SHORE OF VIRGINIA FAMILIES MAINTAIN ECONOMIC STABILITY

By 2020, the percent of ESVA high school graduates enrolled in an institute of higher education within 16 months after graduation increases in Accomack County from 45% to 47.6 % and in Northampton County from 56 % to 59.2 %.

By 2020, the percent of cost-burdened ESVA households (more than 30% of monthly income spent on housing costs) decreases by 7.5%. The percentage of Accomack County cost-burdened households reduces from 25% to 23.1%. The percentage of Northampton County cost-burdened households reduces from 31.9% to 29.5%.

By 2020, the ESVA Consumer Opportunity Profile ranking for both Accomack and Northampton counties moves up from 68th place out of 134 counties to 66th place.

By 2020, the ESVA Economic Opportunity Profile ranking for both Accomack and Northampton counties moves up from 67th place out of 134 counties to 63rd place.

Goal 1.2: EASTERN SHORE OF VIRGINIA COMMUNITIES COLLABORATE TO IMPROVE THE POPULATION'S HEALTH

By 2020, all ESVA towns and counties and a varied group of citizens representing multiple sectors participate in an on-going collaborative community health planning process

AIM 2 >> Strong Start for Children

Goal 2.1: EASTERN SHORE OF VIRGINIA RESIDENTS PLAN THEIR PREGNANCIES

By 2020, Accomack County's teen pregnancy rate decreases from 19.6% to 17.6%. Northampton County's teen pregnancy rate decreases from 24.3% to 21.9%.

Goal 2.2: EASTERN SHORE OF VIRGINIA CHILDREN ARE PREPARED TO SUCCEED IN KINDERGARTEN

By 2020, the percent of ESVA children who do not meet the PALS K benchmarks in the fall of kindergarten and require literacy interventions decreases in Accomack County from 13.4% to 12.9% and in Northampton County from 11.40% to 11.0%

By 2020, the percent of third graders on ESVA who pass the Standards of Learning third grade reading assessment increases in Accomack County from 63% to 73% and in Northampton County from 60.3% to 70.3%

Goal 2.3: THE RACIAL DISPARITY ON EASTERN SHORE OF VIRGINIA LOW WEIGHT LIVE BIRTH RATE IS ELIMINATED

By 2020, ESVA's Black Low Weight Live Birth rate equals the White Low Weight Live Birth rate. ESVA's Black Low Weight Live Birth Rate reduces 73% from 26 to 15

AIM 3 >> Preventive Actions

Goal 3.1: EASTERN SHORE OF VIRGINIA RESIDENTS FOLLOW A HEALTHY DIET AND LIVE ACTIVELY

By 2020, the percent of ESVA adults who did not participate in any physical activity during the past 30 days decreases from 38.4% to 32.6%

By 2020, the percent of ESVA adults who are overweight or obese decreases from 76.1% to 74.1%

By 2020, the percent of ESVA people who are food insecure for some part of the year decreases from 15.7% to 13.2%

Goal 3.2: VIRGINIA PREVENTS NICOTINE DEPENDENCY

By 2020, the percent of ESVA adults aged 18 years and older who report using tobacco decreases from 25.7% to 14.1%

Goal 3.3: EASTERN SHORE OF VIRGINIA RESIDENTS ARE PROTECTED AGAINST VACCINE-PREVENTABLE DISEASES

By 2020, the percent of ESVA adults who receive an annual influenza vaccine increases from 51.7% to 75.0%

By 2020, the percent of ESVA girls aged 13-17 who receive three doses of HPV vaccine increases from 17.8% to 80.0%

By 2020, the percent of ESVA boys aged 13-17 who receive three doses of HPV vaccine increases from 15.7% to 39.7%

Goal 3.4: CANCERS ARE PREVENTED OR DIAGNOSED AT THE EARLIEST STAGE POSSIBLE

By 2020, the percent of adults aged 50 to 75 years who receive colorectal cancer screenings increases from 54.4% to 66.9%

Goal 3.5: EASTERN SHORE OF VIRGINIA RESIDENTS HAVE LIFE-LONG WELLNESS

By 2020, the average years of disability-free life expectancy for Virginians increases from 66.5 years to 67.7 years

By 2020, the percent of adults in Virginia who report adverse childhood experiences decreases (metric under development)

AIM 4 >> System of Health Care

Goal 4.1: EASTERN SHORE OF VIRGINIA HAS A STRONG PRIMARY CARE SYSTEM LINKED TO BEHAVIORAL HEALTH CARE, ORAL HEALTH CARE, AND COMMUNITY SUPPORT SYSTEMS

By 2020, the percent of adults who have a regular health care provider increases from 73.3% to 89.9%

By 2020, the rate of avoidable hospital stays for ambulatory care sensitive conditions decreases in Accomack County from 717.14 to 609.57 per 100,000 persons and decreases in Northampton County from 1,140.32 to 969.27 per 100,000 persons

By 2020, the rate of adult mental health and substance use disorder hospitalizations decreases from 203.8 to 193.6 per 100,000 adults

By 2020, the percent of adults who report having one or more days of poor health that kept them from doing their usual activities decreases from 26.7% to 24.6%

Goal 4.2: EASTERN SHORE OF VIRGINIA HEALTH IT SYSTEM CONNECTS PEOPLE, SERVICES, AND INFORMATION TO SUPPORT OPTIMAL HEALTH OUTCOMES

By 2020, all ESVA health care providers have implemented a certified electronic health record.

By 2020, the number of ESVA entities connected by an electronic information exchange system, increases from 0 to 3

By 2020, Eastern Shore of Virginia Health District has electronic health records and connects to community providers through Connect Virginia

Goal 4.3: HEALTH CARE-ASSOCIATED INFECTIONS ARE PREVENTED AND CONTROLLED IN VIRGINIA

By 2020, Riverside Shore Memorial Hospital meets the state goal for prevention of hospital-onset *Clostridium difficile* infections

Ways You Can Help Create Well-Being on ESVA

Key to Numbers Below: X,X,X – Aim, Goal, Strategy

Individuals

Continue to be an ESHC partner and participate in work groups that carry out plan strategies.

Work in your faith community to encourage participation in this plan, especially those areas outlined below.

If you belong to a club, partnership, coalition whose focus is service, find places in the plan where your organization can assist and let us know.

Within your neighborhood, form a neighborhood collaborative – especially in under-resourced communities (see 2.3.1)

Look at Aim 3: its goals, strategies and measures. There's a place for you to participate in all of them.

Advocate for remedies to food insecurity: 3.1.3

Civic Leagues & Neighborhood Groups: 3.1.5

Organizationally

Education or educational support organizations (Smart Beginnings, Northampton County Education Foundation, Head Start, School Boards). Goal 1.1 all strategies. Goal 2.2.1-6; 3.1.3; 3.1.6-8; 3.2.1-4; 3.4.1

Housing. 1.1.7; 3.1.1; 3.2.1-4; 3.5.1, 4

Planning. 1.1.7; 3.1.1, 2; 3.1.4; 3.1.7; 3.2.1-4

Public Libraries. Goal 1.1.6; 3.1.6; 3.2.1-4; 3.4.1; 3.5.2, 5, 6

Information Technology. Find a way to assist with information connectivity. Goal 1.2.3; 3.5.2;

Mental Health. 2.2.1, 3, 4; 3.1.7; 3.2.1-4; 3.4.1; 4.1.1, 3-11, 13

Health (medical, public) 2.2.3, 4; 2.3.2,3,4; 3.1.7, 8, 9; 3.2,1-4 ; 3.3.1-6; 3.4.1-5; 3.5.4, 5; 4.1.1-14; 4.2.1-6.

Faith Communities. 2.2.4, 5, 6; 3.1.7-9; 3.2.1-4, 3.5.2-3; 3.5.4, 5;

Social Services. 2.2.all strategies; 2.3.3; 3.1.7, 9; 3.2,1-4; 3.4.1; 3.5.2, 5;

Businesses. Participate in 1.1.1.4-5. Support 1.1.7. Participate in 1.2.1; 2.1.3, 4, 5; 3.1.4; 3.1.7-10; 3.4.1; 3.5.2; 4.1.1,2, 13, 14

Childcare Provider. 2.2.2; 3.1.7, 8, 9;

Elected Officials. Insure all of these strategies are underway in your community. 3.1.1.2; 3.1.4; 3.1.7, 8;

Literacy Council. 3.4.3

Area Agency on Aging. 3.5.1-6, Participate in 4.1.1;