MID-SHORE LOCAL HEALTH IMPROVEMENT COALITION MEETING
September 09, 2013

Present:	Cathleen Bilodeau	Carolyn Brooks	Iris Carter	Joseph Ciatola
	Ida Dacey	Tracy Curry	Ashyrra Dotson	Jake Frego
	Gary Fry	Janet Fountain	Michelle Hammond	Roger Harrell
	Holly Ireland	Paula Lowry	Kathleen McGrath	Wanda Molock
	Chad Morris	Rebecca Rice	Leland Spencer	
	Mary Ann Thompson	Matthew Peters	Mary Walker	Linda Walls
	Kathy Wright			

I. WELCOME:

Dr. Spencer welcomed everyone to the meeting, and a round of self-introductions was conducted.

II. MEETING OBJECTIVE FOCUS:

Review regional data on behavioral health in preparation for strategic planning.

III. DR. SPENCER'S INTRODUCTION AND ANNOUNCEMENTS:

Today we will look at some regional data on Behavioral Health and then Linda Walls will begin strategic planning. At next month's meeting we will continue the strategic planning process.

Dr. Spencer shared the mission and goals of the Mid-Shore Local Health Improvement Coalition, to include: Assessing health outcome data to establish regional health priorities in coordination with SHIP, ongoing strategic planning to address health priorities, and leveraging community partnerships and or funding sources to assist with implementation. In addition, he shared the current priorities: adolescent and adult obesity, adolescent smoking, diabetic ED visits, behavioral health: prevention of unintentional drug overdose deaths, opioid prevention plan, suicide prevention , behavioral health ED visits, and for early next year, looking at cancer deaths (example: the Eastern Shore prostate cancer rates are 10-25% above the national rate).

Dr. Spencer shared a PowerPoint presentation on current suicide data:

- Behavioral Health
  -objective 8: Reduce the suicide rate.
  - Reduce the number of ED visits
- National Perspective
  CDC MMWR May 3, 2013 released that suicide deaths have surpassed MVA deaths
  - National study to investigate trends from 1999 to 2010
    - Substantial increase in suicides between ages 35-64
    - Increase in all 4 geographic regions
    - Men 27%, women 32% increase
    - Major shift in methods
- Graph showing the change in suicide rates among selected age groups
  - Age and experience + resiliency over 35, under 65.

    - In 2010, there was a nearly 50% jump in the 50-54 age group, as well as the 35-64 age group.
    - In 1999, Whites and American Indian/Native Alaskan groups were the highest.
    - In 2010, these groups increased tremendously; minorities basically stayed the same.
- Methods
    - In 1999- firearm, overdose, hanging.
    - In 2000- firearms decrease, overdose stayed the same, but hangings increased from 17%-23% across this time frame.
- DHMH website data shows that Kent County has highest suicide rate; for Whites, Dorchester County is highest, then Kent County.
- BRFSS data: Q: How often do you get the emotional support that you need? A: Never: Kent, Dorchester, Somerset, Caroline.
- The suicide death rate in MD and on the Mid-Shore is highest for the 45-54 age group.
- The overall approach has to be comprehensive because it affects all age groups.
- Suicide by firearm for the 35-64 age group (as of 2010): On the Mid-Shore is 54%; in the US, is 48%, and in MD is 45%.
- National Perspective
    - The 2012 Surgeon General's report calls for a National Strategy for Suicide Prevention to address:
        - The lack of social support
        - The lack of community connectedness
        - The lack of access to mental health and preventive health services
        - The prevalence of stigma and barriers associated with seeking help

Dr. Joe Ciatola shared that for EMS there has been a significant increase in suicide attempts. He asked if this presentation captures attempts as well as completions; Dr. Spencer responded that this presentation documents completions only. Dr. Ciatola shared that the EMS software, EMEDS can compile data on suicide attempts and several of the prevalent methods.

- Contributing factors for the rise in suicide rates among middle-aged adults
    - Economic downturn
    - Cohort effort- baby boomer generation had high rates of suicides during adolescent which may contribute to higher risk of suicides in middle age (culture of tolerance).
    - Increase in prescription opioid addiction contributing to increased risk for suicide
    - Lack of research to explain differences across racial population's; middle aged Whites and American Indians/Alaskan Natives are 3-4 x more likely to commit suicide then Blacks, Hispanics, or Asians, even when controlling for mental illness.

Objective 34: Reduce ED visits related to Behavioral Health conditions

- The incidence may be underreported because the graph does not factor in those who go out of state for medical care- it only shows MD hospitals.

  Holly Ireland shared that there are lower suicide rates for Blacks, but higher rates of

seeking behavioral health service. This data comes from, the first diagnosis the doctor writes for the discharge information; however there could be secondary reasons too.

- All 5 counties on the Mid-Shore saw increases in mental health-related ED visit rates from 2008-2010.
- Caroline public schools have a behavioral health concern in that students are being dismissed from school with instructions to take them to ER; Somerset County is the same.
- Upper Shore closed in 2010 but mobile crisis opened simultaneously.
- Not all counties have behavioral specialist care, but the need is great for this service.
- BRFSS data: Q: Have you ever been told you have a depressive disorder? A: YES: Cecil, Kent, Queen Anne's, Caroline, Dorchester, Somerset counties all had very high rates.

STRATEGIC ACTION PLAN

1. Surveillance
   a. Suicides: need information such as history of substance abuse, mental health diagnosis, treatment history, SES, or other stressors that might have contributed to increased risk (suicide mortality review team)
   b. Mental health ED visits: hospital surveillance to identify trends and define at-risk populations.
2. Identify gaps in current system of care
3. Plan interventions- reduce factors that increase risk, increase factors that promote resiliency:
   a. Augment existing services
   b. Implement new services
4. Sustainability Plan

Dr. Spencer shared that, "planning is important so we have something to move forward on when money comes available."

IV. MEMBER UPDATES AND ANNOUNCEMENTS:

The state and country-affordable care act: Jake Frego is a major player for Mid-Shore counties. Dr. Spencer asked Jake to give a status update:

Jake Frego: AHEC navigators for the area start training next Monday for the healthcare exchange; October 1 is the target start date. Choptank will retain 3 assistors. Jake offered his appreciation for the Health Department and medical directors for making space available for the navigators to sit and do their work- it provides the springboard as we move forward. He also shared that he is looking forward to the kickoff next Monday.

Holly Ireland- Event tomorrow night- September 10th – The International Suicide Prevention Awareness Candlelight Vigil- held in each county in the Mid-Shore area; the event begins at 7:45pm with speakers: survivors of attempts or suicide survivors of those who completed the act. Crisis services information, providers, trained professionals, etc. will be in attendance as well. The locations are as follows:

Talbot County-Thompson Park

Dorchester County: Long Wharf Park

Queen Anne's County: Court House Square
Caroline County-Courthouse greens
Kent County: Fountain Park
Candles are provided for attendees. There are vigils held throughout the world on this day; suicide impacts almost everyone at some point; most individuals have fleeting thoughts of suicide at one time or another.

V. LINDA WALLS- RESULTS ACCOUNTABILITY

- Local management board used it first- but it has also been used by social services, churches, the mental health field and others.
- Results accountability starts with:
  1. Desired result?
  2. Headline indicators
  3. What is the story behind the headline indicators? This comes from local information; studies (local); it should not be our own assumptions
  - Impact with mental health insurance coverage
  - Gaps in network
  4. Who are the partners (with a role to play to change things)?
  5. What works? To get to desired results, not assumptions, what does the evidence say/what are the best practices or proven approaches? This needs to be steeped in literature and steeped in success
  - mental health first aid
  6. What are 3-5 strategies we can implement and are actionable (low to no cost) if funding already identified strategies in advance of funding opportunity?
  - timeline
  - lead agency
  - estimated cost
- This needs to use common sense, common ground and common language.
- Does this allow for innovation? Yes it does, but there are always best practices involved.
- Desired results: suggestions specific to the data today
  - Significant reduction in behavioral health visits to the ED-10-15% in the first year
- Integrated system of care where prevention, screening and intervention in behavioral health are common practice across the lifespan.
- What is the data? What is the data really saying about what and where the issues are?
- Have an eastern shore population who view behavioral health as essential to overall health.

HEADLINE INDICATORS

- Differences between Whites and Blacks, for example: Queen Anne's County.
- White well-to-do/White overall
- Opioid use over the last 2 years- prescription and illicit
- Age change in suicides
- Why the higher rate on the Easter Shore?
- Shifts in suicide methods
- Data on attempts
- Delaware data- who goes to Delaware since it does not show in our data, only MD.

Will ask for EMEDS gross data at region 4 meeting next week

VI. NEXT COALITION MEETING:

The next coalition meeting will take place on Monday, 21 October 2013 at 12:30 pm, at the Queen Anne's County Health Department. Lunch will be provided, beginning at noon.

VII. ADJOURNMENT

The meeting adjourned at 2:00 pm.