Howard County's Local Health Improvement Coalition:
2012-2014 Local Health Improvement Action Plan

Submitted to:

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Howard County's Local Health Improvement Coalition:
2012-2014 Local Health Improvement Action Plan

1. Local Health Planning Coalition Description

See *Appendix A: Health Planning and Coalition Description*

2. Local Health Data Profile- Local Health Disparities and SHIP Data

The Howard County Local Health Improvement Coalition (LHIC) is responsible for guiding local health planning specifically as it relates to addressing health disparities and inequities in the local community. Local health data available from SHIP and other sources, despite their limitations (e.g., limited availability of data for Asian or Hispanic populations), demonstrate health disparities that require local attention and action.

Table 1 presents selected SHIP objectives for Howard County. In 2010, Blacks in Howard County had higher rates than the County baseline and than Whites (and Asians, for those indicators where data for Asians are available) for emergency department visits for diabetes, asthma, and hypertension. Racial/ethnic disparities also exist for the percentage of adults who were at a healthy weight (i.e., not obese/overweight) based on 2006-2008 BRFSS data, in which Asians demonstrated the highest proportion of healthy weights for adults (52.8%), followed by Whites (42.7%) and Blacks (28.4%). Blacks and Whites demonstrate a higher cancer mortality burden compared to Asians. It is also important to note data related to chronic disease mortality, morbidity, and risk factors that are *not* available at this time, including: mortality rates for heart disease among Hispanics and Asians; obesity/overweight prevalence among Hispanics; tobacco use among Hispanics; and the cancer death rate for Hispanics.

Table 1. Selected SHIP Objectives: Howard County Baseline vs. Racial/Ethnic Disparities

Obj. #	Objective Name	Objective Description	County Baseline	County Disparities
27	Reduce diabetes-related emergency department visits	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	142.1	White--103.1 Black--360.6
17	Reduce hospital emergency department visits from asthma	Rate of ED visits for asthma per 10,000 population (HSCRC 2010)	50.5	White--30.0 Black--130.3 Asian--21.4 Hispanic--62.2
28	Reduce hypertension-related emergency department visits	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	117.4	White--79.0 Black--312.8
30	Increase the proportion of	Percentage of	41.5%	White/NH--42.7%

	adults who are at a healthy weight	adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)		Black--28.4% Asian--52.8%
25	Reduce deaths from heart disease	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	169.6	White--170.1 Black--165.6
26	Reduce the overall cancer death rate	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	161.2	White--199.0 Black--181.9 Asian--100.7
32	Reduce tobacco use by adults	Percentage of adults who currently smoke (BRFSS 2008-2010)	7.2%	White/NH--8.1% Black--7.4% Asian--5.1%
39	Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines	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)	7.2%	White/NH--4.1% Black--12.8%

Source: DHMH, *Howard County Disparities*, Maryland SHIP, October 28, 2011

Addressing health disparities and implementing policies and programs to achieve greater health equity in Howard County is particularly important because of the increasing racial, ethnic, and linguistic diversity of the local population. The foreign-born population in Howard County has grown over the past decade. Data from 2006-2008 American Community Survey indicate that there are approximately 41,888 foreign-born individuals residing in the county. Of these, 55% are U.S. citizens. The number of county residents that speak a language other than English at home was 54,143 in 2009, representing 21% of the population age five and older.[1] Over the past decade, the Howard County Health Department has been spending significantly more on translation and interpretation services to account for increasing demand for services among the non-English speaking population. HCHD clinics and Healthy Howard's Door to Healthcare report serving a client population that collectively speaks a total of over 20 languages other than English. The significant numbers of undocumented County residents presents particular challenges to all organizations that deliver services to this population, whether they are publicly-funded agencies or private nonprofits.

[1] U.S. Census Bureau, 2009 American Community Survey 1-Year Estimates.

Additional areas of need flagged in the State Health Improvement Process (SHIP), include the proportion of children and adolescents receiving Medicaid who receive dental care, life expectancy at birth, the percentage of adults who have had a flu shot in the last year, and the percentage of children who enter kindergarten ready to learn.[2]

3. Local Health Context

Overview

Howard County is a relatively affluent, educated, and healthy community inhabited by 287, 085 residents. The county population increased 15% from 2000-2010. According to the 2010 Census, the age distribution of the Howard County population is similar to that of the state population. The racial/ethnic distribution in Howard County is 58% White, 18% Black, 14% Asian, and 6% Hispanic. From 2000-2010, Howard County's African American population grew by 39% and the County's Hispanic population increased by 123%.[3] Howard County's mortality and morbidity indicators are overall positive compared to most Maryland jurisdictions. Compared to other areas in the state, Howard County demonstrates a relatively low prevalence of chronic disease risk factors including physical inactivity, smoking, high blood pressure, and diabetes. However this is only part of the story.

Understanding Local Health Needs

Comparing Howard County to other Maryland jurisdictions does not offer a complete picture of the health needs and challenges faced here, particularly in the areas of chronic disease risk factor prevalence, chronic disease burden, and health disparities. Compared to state and national data on chronic disease risk factors, Howard County residents demonstrate a relatively low prevalence of physical inactivity, smoking, high blood pressure, and diabetes, which are all risk factors for chronic disease. However, despite their relatively low prevalence of these risk factors, Howard County residents are not immune to chronic disease risks. For example, Howard County residents have a higher risk of high cholesterol (41% vs. 37% State vs. 37% national). In addition, the percentage of Howard County adults who are overweight (35%) is equivalent to State and national rates (both 36%). Finally, while the percentage of Howard County adults who are obese (22%) is lower than the State and national data (26% and 27%, respectively), obesity prevalence is not as low as might be expected given the relatively high level of physical activity and relatively low levels of other risk factors previously discussed.[4]

The Howard County population also experiences a significant burden of chronic disease on par with statewide data. Statewide, 63.7% of deaths in Maryland are caused by chronic disease – heart disease, stroke, cancer, chronic obstructive pulmonary disease (COPD), and diabetes. The proportion of deaths due to chronic disease in Howard County is 60%, which represents the leading cause of death in Howard County.[5] Based on 2009 data from the Maryland Behavioral Risk Factor Surveillance Survey (BRFSS), cancer is the most prevalent chronic disease among Howard County residents, followed by diabetes, angina, heart attack, and stroke. In other words, the burden of chronic disease

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[2] State Health Improvement Process (SHIP), Maryland Department of Health and Mental Hygiene, *SHIP Profile: Howard County.* Available at: http://eh.dhmh.md.gov/ship/SHIP_Profile_Howard.pdf.
[3] 2010 U.S. Census Report. U.S. Census Bureau
[4] Maryland Department of Health and Mental Hygiene. *Burden of Chronic Disease: Howard County*. 2011.
[5] Maryland Department of Health and Mental Hygiene. *Burden of Chronic Disease: Howard County*. 2011.

is comparable to that across the state, despite the relatively healthy state of the County's population as compared to the State on other health indicators and outcomes.

Another important factor in assessing the specific local health needs in Howard County is an understanding of the demographics of the population served by the Howard County Health Department, which often have a higher proportion of Black and Hispanic clients and a lower proportion of White and Asian clients compared to the general population of the County. For example, the Howard County WIC program had a total enrollment of 4,935 women, infants and children as of December 2011. Of these, 34% were White, 29% Black, 23% Hispanic, and 9% Asian.[6] In the HCHD family planning clinic, 45% of women seen in FY10 self-identified as having limited English proficiency (LEP) and 52% of family planning clients were Hispanic. Howard County's family planning program has also experienced an increase in the number of foreign-born Asian clients from countries such as Burma, China, and Korea. In FY09, 15% of Asian family planning clients requested an interpreter.

A strong and overarching theme throughout all LHIC discussions to date has been the significant need for increased local capacity to deliver culturally-competent health services, navigators, and "connector" organizations to connect the uninsured, underinsured, and/or foreign-born and LES populations to health care and services.

<u>Funding Landscape</u>

At the same time that local population demographics are shifting and demand for public and community-based services is increasing, state funding for local public health has been cut significantly. During the 2011 Maryland General Assembly legislative session, state funding cuts to core public health funding were made permanent with the elimination of the population-based formula approach used since 1997, and Howard County took a 48% funding cut. Other substantial cuts have been made to other funding sources including chronic disease prevention, tobacco prevention and cessation (cut by 71%), substance abuse services, and cancer control. As a result, services have been cut or eliminated, positions have been eliminated or held vacant, and all available budget efficiencies have been exhausted.

In January 2012, HCHD applied to DHMH to receive a 5-year Community Transformation Grant award for work in the areas of childhood obesity prevention, tobacco prevention, and chronic disease prevention. Integrated into this proposal was additional departmental capacity to support the ongoing work of the LHIC over the coming years through a new Chronic Disease Prevention Coordinator whose scope of the work will include ensuring internal coordination among HCHD programs and coordination between HCHD and the LHIC member organizations. The CTG proposal was very well-aligned with the priorities of the Local Health Improvement Coalition, and almost all LHIC member organizations provided letters of support for the HCHD proposal.

<u>Responding to the Need for Better Local Disparities Data</u>

In 2011, a consortium of public and private partners (Howard County General Hospital, Horizon Foundation, the Columbia Association, and the Howard County Health Department) came together to discuss local health data needs. As a result, these organizations are collaborating on the development and implementation of a Biannual Health Survey to be administered four times starting in 2012-2013. We are currently working with our vendor, OpinionWorks, on designing the survey instrument, which will include questions that allow the collection of local health data and disparities data currently

[6] Howard County Health Department, WIC Program data, January 30, 2012.

unavailable to the LHIC, policymakers, and funders. In places on the Action Plan where "Obtain Local Measure" is indicated, the 2012 Biannual Health Survey will serve as the source for such data.

4. Local Health Improvement Priorities 2012-2014

Howard County Local Health Improvement Coalition has set three top priorities as the main focus of its work aimed to reduce disparities and improve outcomes. These priorities were chosen with consideration of the following criteria:

- High levels of disparities related to this health outcome.
- Improving this issue would affect large populations.
- Addressing the priority can improve a number of different health outcomes.
- There is a high cost and long-term impact of not addressing the issue.
- Organizations in the LHIC can make change happen related to the priority.
- Results can be quantified.

PRIMARY OUTCOMES: Disparities will be reduced and outcomes will improve in the three key priority areas. Specifically:

1. Access to health care will be increased and delays in accessing medical care will be reduced.
2. More people will achieve a healthy weight
3. Behavioral health services are available and fewer behavioral health emergencies occur.

RELATED OUTCOMES:

- Improve collaboration and shared vision between key stakeholders and systems – the hospital, school system, health department, nonprofit community, etc.
- Increase funding for addressing health disparities and improving health outcomes.
- Health and wellness services will be more accessible and appropriate for people of different cultures, language ability, and immigration status.
- Ensure local data is available on health disparities and their causes, including issues of race and ethnicity, undocumented status, income level, gender, and other factors.
- Raise awareness among residents of health disparities and their causes.
- Health access will be inclusive of services for mental health, substance abuse, and will meet the needs of people with disabilities.
- Develop and adopt new policies to improve health equity.
- Coordinate and publicize existing health, health education, and wellness services in Howard County.

OVERARCHING LHIC STRATEGIES TO ADDRESS DISPARITIES

- Include more people and organizations affected by disparities in the LHIC and other efforts to reduce disparities.
- Outreach and gather data on heath needs of specific populations including diversity in terms of income level, gender, race, ethnicity, language, and immigration status, as well as other characteristic such as veterans and military families, commuters, and farmers. Address gaps in data on health outcomes for Hispanic and Asian populations.
- Reach out to faith-based communities and nonprofit human services organizations.
- Devote more resources for language access.
- Ensure strategies are culturally and age appropriate.

PRIORITY #1: Increase access to health care.

Background: People having access to health care is fundamental to achieving improvement in nearly all health outcomes. Significant disparities in access exist in Howard County related to different racial groups and immigration status.

Measure

1a) Reduce the proportion of people who reported there was a time in the last 12 months they could not afford to see a doctor (obtain medical care, dental care, or prescriptions).

Data Sources and Definitions:

- BRFSS: Percentage of people who, in the last 12 months, have had a time when they could not afford to see a doctor (Source: SHIP)

Baseline Data

1a) The baseline data for this measure are:

County: 7.2%
African American: 12.8%
Hispanic: Not Available
White: 4.1%
Asian: Not Available

Goals

1a) By March 1, 2014, Howard County will achieve the following outcomes:

County: 5.8% (20% reduction)
African American: 7.2 % (55% reduction)
Hispanic: Obtain a local measure
White: 3.2 % (20% reduction)
Asian: Obtain a local measure

Strategies

A. Identify and reduce barriers to access to existing services such as lack of knowledge/information, language barriers, transportation and barriers for specific populations such as seniors, low-income residents, etc.
B. Collaborate among service providers to educate and share knowledge of available services and market the availability of services to communities affected by disparities.
C. Increase access to care for people who are not eligible for subsidized health care but aren't able to afford full coverage by providing funding for more services that are low-cost or free. Expand hours of operation to make them more accessible.
D. Enroll people who are eligible for existing programs. Current programs at DSS and Healthy Howard enroll people but do not have resources to meet growing demand or to do outreach.
E. Develop a County hotline for people who are uninsured or who are insured but need help connecting to the care they need.
F. Assess healthcare access through school enrollment and refer uninsured to a hotline for coverage.
G. Create greater access to care for undocumented immigrants.

H. Open access and eligibility for services at urgent care centers, inclusive of behavioral health services.
I. Promote preventive care for all populations by exploring standards and policies to ensure people have a medical home.

PRIORITY #2: Enable people of all ages to achieve and maintain a healthy weight through healthy eating and physical activity.

Background: Obesity prevention has been selected as a local health priority area because of its potential to improve a variety of important health outcomes that affect County residents and demonstrate health disparities, including diabetes, hypertension, heart disease, stroke, cancer and behavioral health problems. Healthy eating and active living not only improves health status, it is a wellness goal that when achieved enhances the quality of life and ability to be productive participants in society (students, employees, etc.) for individuals, families, and communities.

Measures

2a) Percentage of adults who are at a healthy weight (i.e., not overweight or obese) based on their Body Mass Index (BMI).

Data Sources and Definitions:

- Behavioral Risk Factor Surveillance Survey (BRFSS). Body Mass Index (BMI) determined through self-reported height and weight that is less than 25.0 kg/m^2. (Source: SHIP)

2b) Proportion of adolescents who are at a healthy weight (i.e., not obese) based on their Body Mass Index (BMI). Obese children have a BMI that is equal to or above 95% percentile for their age and height.

Data Sources and Definitions:

- Maryland Youth Tobacco Survey: The percentage of children who are obese are adolescents ages 12 to 19 attending public school who have a Body Mass Index (BMI) (determined through self-reported height and weight) equal to or above the 95th percentile for age and gender. (Source: SHIP)

2c) Proportion of children ages 2-14 who are at a healthy weight (i.e., not obese) based on their Body Mass Index (BMI). Obese children have a BMI that is equal to or above 95% percentile for their age and gender.

Data Sources and Definitions:

- WIC client data: BMIs for children ages 2-5 based on age and gender (Source: HCHD)
- FitnessGram data for 4th-8th grade students (Source: HCPSS)
- Healthy Childcare: BMIs for children ages 2-5 as a percentile for their age and gender (Source: Healthy Howard)

Baseline Data

2a) The baseline data for this measure are:

County: 41.5%
African American: 28.4%

Hispanic: Not Available
White: 42.7%
Asian: 52.8%

2b) The baseline data for this measure are:
County: 92.0%
African American: Not Available
Hispanic: Not Available
White: Not Available
Asian: Not Available

2c) To be determined by LHIC Obesity Prevention Working Group.

Goals for 2014

2a) By March 1, 2014, Howard County will achieve the following outcomes for this measure:
County: 50% (Increase of 20%)
African American: 40% (Increase of 40%)
Hispanic: Obtain a Local Measure
White: Obtain a Local Measure
Asian: Obtain a Local Measure

2b) By March 1, 2014, Howard County will achieve the following outcomes for this measure:
County: 96% (Increase of 43%)
African American: Obtain a Local Measure
Hispanic: Obtain a Local Measure
White: Obtain a Local Measure
Asian: Obtain a Local Measure

2c) By March 1, 2014, Howard County will achieve the following outcomes for this measure:
To be determined by LHIC Obesity Prevention Working Group.

Strategies:

A. Bring together and coordinate efforts among a wide group of players that have a stake in promoting healthy weight, including schools, parents, employers, faith-based organizations, health care providers, interest groups (such as associations focused on heart disease or diabetes), nonprofit organizations that provide nutritional support (such as food banks) and others.
B. Develop awareness campaigns and marketing messages such as the First Lady's "Let's Move" initiative. Create incentives for people and communities to participate, such as community targets for BMI.
C. Work with and educate health care providers, including Medicaid and CHIP providers, to include age-appropriate BMI screening and counseling as part of regular health check-ups.
D. Create a repository of resources for referrals for individuals and groups working on achieving a healthy weight.
E. Improve access to opportunities for physical activity by people with disabilities.
F. Help establish and revise wellness policies (schools, government offices, workplaces) to emphasize opportunities and incentives for physical activity and good nutrition. Look to new technology platform implemented by HCPSS for healthy workplace incentives.

G. Increase outreach and connections between mental health and eating behaviors.
H. Expand health coaching such as that offered by Healthy Howard to enable populations affected by disparities to gain access to health coaches and physical trainers.
I. Increase physical activity at schools through trained recess monitors and well-trained physical education teachers and ensure adequate time for physical activity.
J. Increase access to healthy food by expansion of programs like the SHARE program (boxes of groceries), food pantries, Community Action Council Garden, School Breakfast and First Class Breakfast programs, after-school supper program, summer food programs, senior nutrition programs, and adding EBT machines to enable people to buy food from farmers markets with food stamps.

PRIORITY #3: Expand access to behavioral health resources and reduce behavioral health emergencies.

Background: Access to behavioral health resources (including mental health and addictions) was identified as a significant gap in the county, especially for youth. Good behavioral health is related to a number of other important health outcomes, and may impact a person's ability to access the healthcare that they need.

Measure

3a) Rate of Emergency Department (ED) visits for a behavioral health condition per 100,000.

Data Sources and Definitions:

- HSCRC Emergency Department diagnostic code data (SHIP)

Baseline

3a) The baseline data for this measure are:

County: 806.7 ED visits per 100,000
African American: 1219.4
Hispanic: 442.3
White: 808.9
Asian: 233.1

Goal

3a) By March 1, 2014, Howard County will achieve the following outcomes for this measure

County: 645 ED visits per 100,000 (20% reduction)
African American: 806 ED visits per 100,000 (35% reduction)
Hispanic: 354 (20% reduction)
White: 645 (20% reduction)
Asian: 186 ED (20% reduction)

Strategies

A. Analyze SHIP data in collaboration with Howard County General Hospital to gain understanding of distribution of ICD codes for behavioral health ED visits.
B. Incorporate behavioral health assessments into preventive care, primary care and other assessments/screenings.
C. Promote emotional wellness as part of overall health.

D. Educate physicians, including pediatricians, to identify behavioral health issues.
E. Create an easy-access referral system, including a hotline number, to define eligibility for services and help people gain access to them.
F. Create a single point of entry for mental health and substance use issues.
G. Learn more about how behavioral health issues affect different populations and where disparities exist.
H. Analyze gaps and funding resources.
I. Identify and address administrative barriers to care.
J. Review capabilities of urgent care centers keep a current directory of services, and increase capacity of urgent care centers to include behavioral health services.
K. Educate the public about behavioral health issues, how to identify when friends or family may be having issues, and where to go for help. Incorporate into the school health curriculum.
L. Review behavioral health data and ensure all ages, including youth and seniors, have access to behavioral health services.

5. Local Health Planning Resources and Sustainability

Howard County's Local Health Improvement Coalition (LHIC) includes 50 actively engaged and dedicated stakeholders from across Howard County representing a variety of key agencies, organizations, and communities affected by health disparities. The LHIC has begun its work to improve health equity in the Howard County community by undertaking a transparent, inclusive local health improvement process that continuously engages diverse stakeholders, provides a more clear understanding of the prevalence and causes of local health disparities, and develops an action plan to improve local health outcomes in alignment with the State Health Improvement Process (SHIP).

The Coalition is accountable to the State for a 2-year Local Health Improvement Action Plan and will take immediate steps toward achieving its vision. The LHIC is committed to working within the County over the long term as it recognizes that achieving health equity will take time and perseverance. At the March 12 meeting, the LHIC will set a 2012-2013 meeting schedule for the full group and three working groups (one per priority area). In addition, the Health Department will immediately incorporate the LHIC measures into a new section of its "HealthStat" report, an internal performance measurement tool used in monthly meetings to track and evaluate progress in departmental programs and initiatives.

The Health Department will continue to provide high-level support for the LHIC's work in the areas of planning, communications, data collection and analysis, project management, and resource development. Potential funding sources to sustain and evaluate the outcomes of the Local Health Improvement Action Plan include the Maryland Community Health Resources Commission (CHRC) and Community Transformation Grant funding through the Department of Health and Mental Hygiene. Additional funding may be sought from in partnership with LHIC member organizations.

6. Timeline and Methods for the Community Health Needs Assessment (Optional)

Howard County General Hospital is a key member of the LHIC and reports that the goal is to complete the Community Health Needs Assessment by Fall 2012. Both the CHNA and Implementation Strategy will be completed by June 30, 2013.

Appendix A :
Health Planning and Coalition Description

Health Coalition and Planning Description

1st Funding Round Deadline – November 1, 2011
2nd Funding Round Deadline – December 31, 2011

1. **Jurisdiction/Region Name** Howard 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)

      LHIC Chair: Dr. Peter Beilenson, Health Officer
      Howard County Health Department
      7178 Columbia Gateway Drive
      Columbia, MD 21046
      (410) 313-6363
      pbeilenson@howardcountymd.gov

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

      LHIP Director: Nancy Lewin, MPH
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      LHIC Staff: Colleen Nester
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      Cnester@howardcountymd.gov

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

   Attached as separate document.

4. **Local Health Action Planning Coalition Structure (committees, workgroups and chairs)**

   Full Coalition: As of 12/31/11=39 members; as of 3/1/12 = 50 members
   Working Group: 17 volunteer members from the Full LHIC

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

VISION
All residents of Howard County will have access to health care and health outcomes will be equitable for all.

MISSION
Howard County's Local Health Improvement Coalition works to achieve health equity in Howard County and to identify and reduce health disparities.

EXPECTED 2- YEAR GOALS/OUTCOMES

a) Improve collaboration and shared vision between key stakeholders and systems – the hospital, school system, health department, nonprofit community, etc.

b) Increase funding for addressing health disparities and improving health outcomes.

c) Health and wellness services will be more accessible and appropriate for people of different cultures, language ability, and immigration status.

d) Ensure local data is available on health disparities and their causes, including issues of race and ethnicity, undocumented status, income level, gender, and other factors.

e) Raise awareness among residents of health disparities and their causes.

f) Health access will be inclusive of services for mental health, substance abuse, and will meet the needs of people with disabilities.

g) Develop and adopt new policies to improve health equity.

h) Coordinate and publicize existing health, health education, and wellness services in Howard County.

VALUES

- Evidence-based
- All stakeholders have a voice
- Inclusive of Howard County's diverse community
- Collaboration
- Transparency

ABOUT HOWARD COUNTY LOCAL HEALTH IMPROVEMENT COALITION

Howard County's Local Health Improvement Coalition (HCLHIC) includes more than 40 stakeholders from across Howard County. The HCLHIC works to improve health equity in the Howard County community by undertaking a transparent, inclusive local health improvement process that engages diverse stakeholders, provides a more clear understanding of the prevalence and causes of local

health disparities, and develops an action plan to improve local health outcomes in alignment with the State Health Improvement Process (SHIP).

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

   Webpage: http://www.howardcountymd.gov/DisplayPrimary.aspx?id=6442463227
   Meeting Schedule:

December 12, 2011:	10:00AM-12:00PM
January 9, 2012:	10:00AM-12:00PM
February 13, 2012:	10:00AM-2:00PM
March 12, 2012:	10:00AM-12:00PM

7. **Documents (Optional) –Local/Regional Community Health Assessments, Plans and other related documents as available for posting on the SHIP website.**

Submitted by Nancy Lewin - nlewin@howardcountymd.gov and (410) 313-6360

Finalized: December 21, 2011
Revise: March 1, 2012

Local Health Improvement Coalition: Howard County

Revised 3/1/12

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