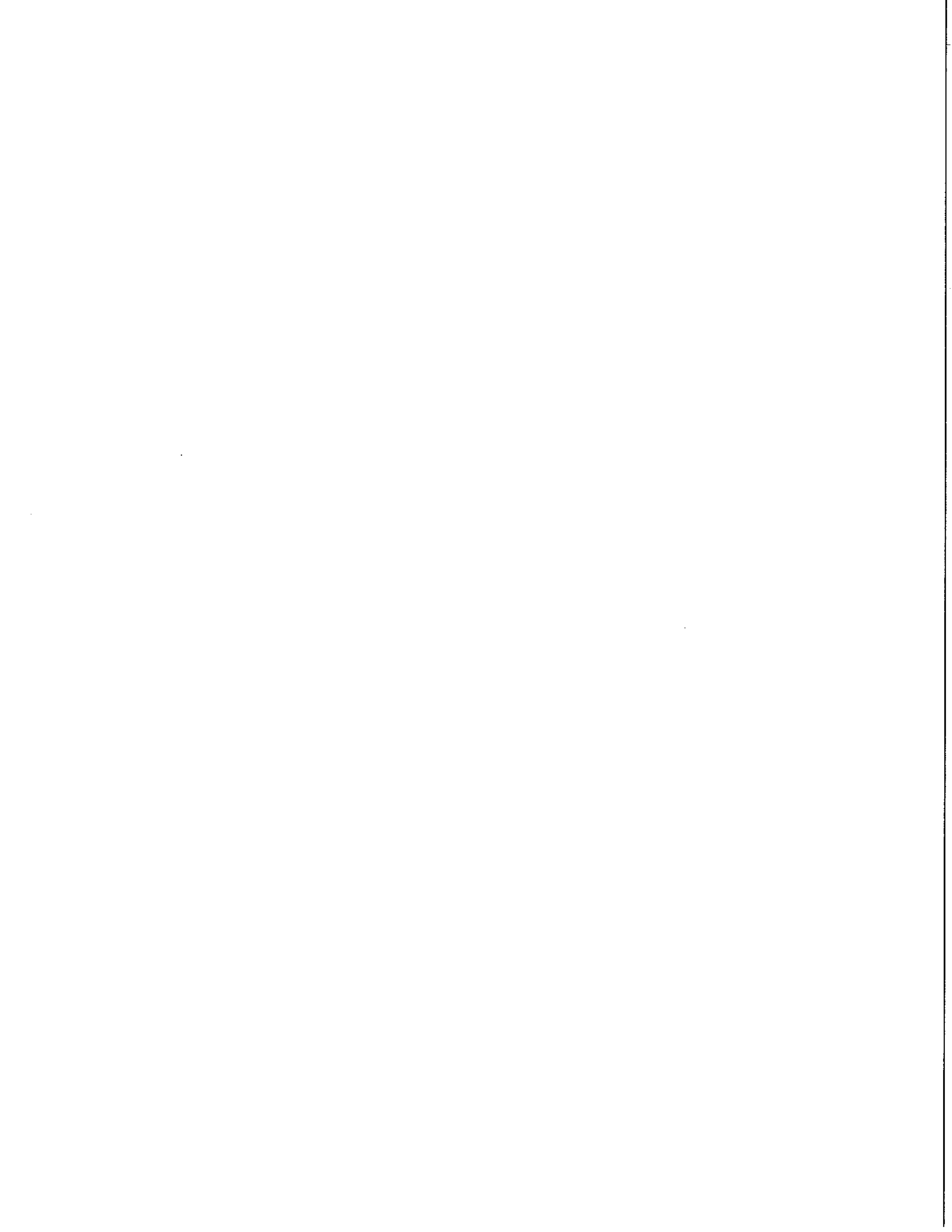
APPENDIX I



LHIC Action Plan Tracking Tool – 2012-2014 Summary - Access to Care

Priority

1a) Reduce proportion of people who reported there was a time in the last 12 months they could not afford to see a doctor.

Goals

	County	African American	Hispanic	White	Asian	
Baseline	7.2%	12.8%	*	4.1%	*	
2014 Goal	5.8%	7.2%	*	3.2%	*	
Measure (Data Source)	SHIP #39 (BRFSS)	SHIP #39 (BRFSS)	SHIP #39 (BRFSS)	SHIP #39 (BRFSS)	SHIP #39 (BRFSS)	
2014 SHIP	7.6%	8.3%	*	6.6%	*	Note: 2014 SHIP data for Howard County uses aggregate BRFSS data for 2011-2013.
2014 HCHAS	5.7%	8.0%	1.6%	5.0%	7.9%	Note: Small sample sizes for subgroups may make data unreliable. Hispanic: 42; Other: 79; Asian: 174.

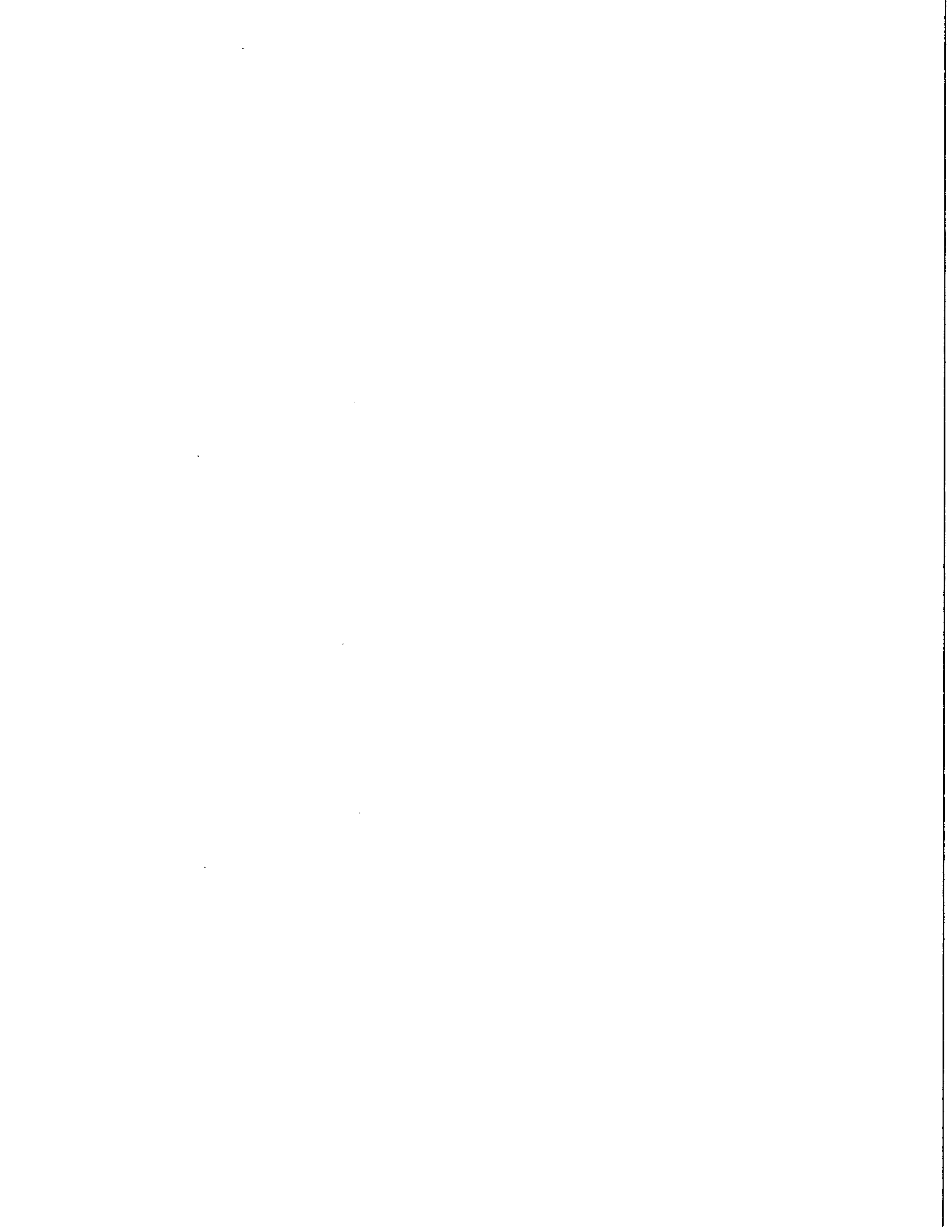
LHIC Action Plan Tracking Tool – 2012-2014 Summary - Access to Care

Strategies	Action Steps
1A. 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.	1. Health Literacy program (Door w/University of MD Extension, MHBE.) - Western Region. The Door to HealthCare Western Region is working with the University of Maryland Extension, MHBE, and the Maryland Women's Coalition for Health Care Reform on "My Smart Choice Health Insurance© Consumer Workbook" and other materials that will help people get and use health insurance. Materials were created by the University of MD Extension and University of Delaware Extension. Healthy Howard is member of the Maryland Rural Health Association and works closely with the Association on outreach to the rural community. HHI also works with Health Care for All, creating partnerships to avoid duplication of effort.
	2. Healthy Howard's Prenatal Coordination Program provided services, including transportation for prenatal care, for undocumented Latina women. The program ran from December 2012 to December 2014 and served a total of 108 Latina women.
	3. Through a grant from the Horizon Foundation, MARTTI (My Accessible Real Time Trusted Interpreter) was piloted with Chase Brexton, Healthy Howard, and HCGH. • MARTTI provided interpretation for 39 languages, including American Sign Language • The top five most commonly interpreted languages were Spanish (46%); Korean (16%); Chin (11%); Mandarin (7%); and, American Sign Language (5%)
	4. Healthy Howard's Re-entry Health Services Program started 10/2012 and has served a total of 353 clients. In partnership with the Laurel Multi Service Center, the program created a community office to serve clients who have been released from incarceration.
	5. The Horizon Foundation met with Health Care for the Homeless to see if they could offer services to the Day Resource Center (pre-ACA). As a FQHC, they would need to apply for an expansion/scope of work. Follow up conversations were not continued (post ACA).
	6. Healthy Howard established the Door to HealthCare Western Region program in 2013 to connect residents of the 6 Western Region counties to health insurance. From 10.1.13 through 3.15.14, the program enrolled 43,199 persons in affordable health care (Medical Assistance: 33,084, Qualified Health Plans: 10,115). In Open Enrollment 1 in Howard County, there were a total of 13,824 persons enrolled in affordable health care (Medical Assistance: 9,259, Qualified Health Plans: 4,565). In Open Enrollment 2, as of January 4, 2015, 9,131 Howard County residents had enrolled in Medical Assistance or a Qualified Health Plan.

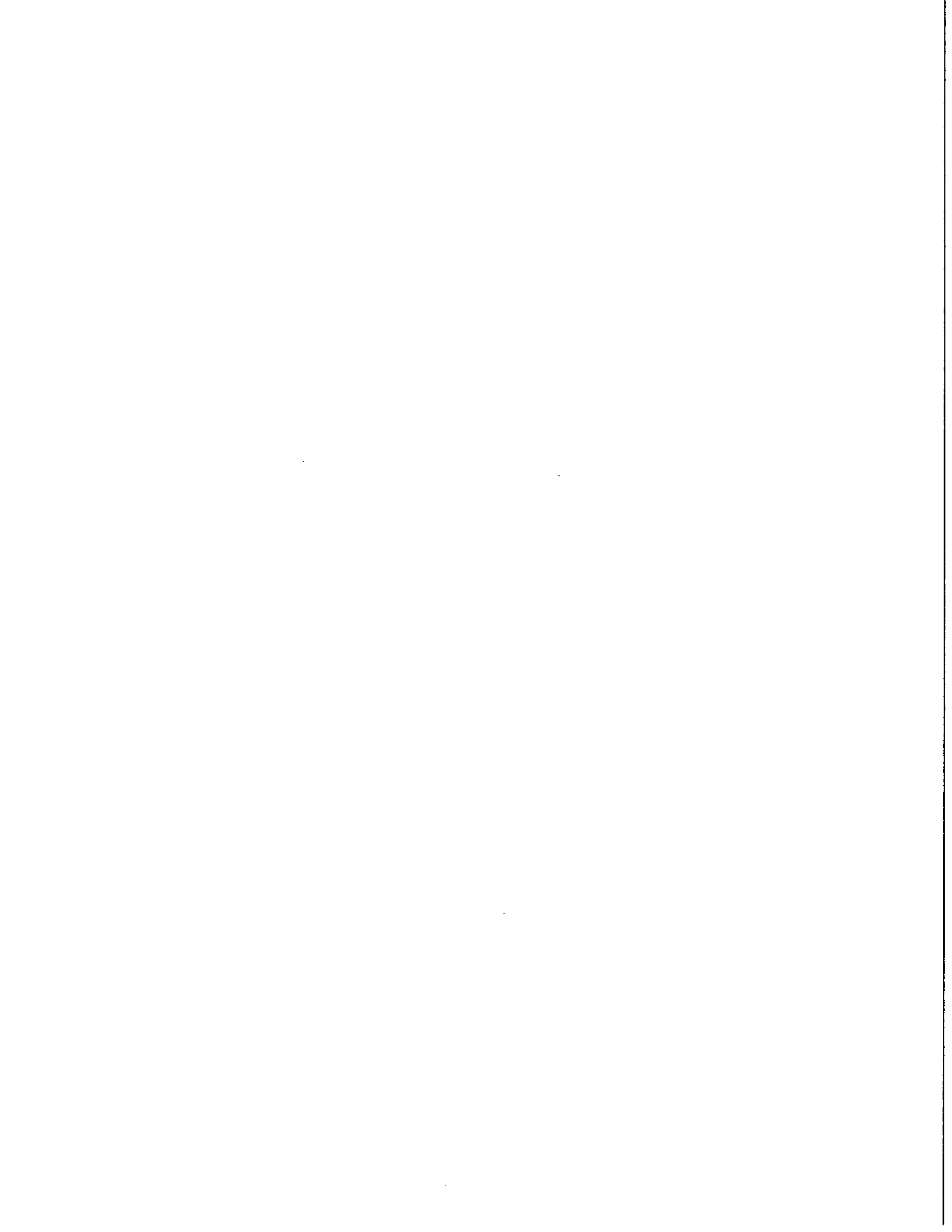
	7. The Door to HealthCare is building strong partnerships to connect people to care. Primary partners include: Korean Resource Center, Grassroots, Maryland Benefit Services (BDT), Chase Brexton. Other partners: Office of Aging, SHIP (State Health Insurance Assistance Program), HCPSS, Howard County General Hospital, FIRN, Workforce Development, Office of Citizenship Services, Housing, Office of Tourism, Howard County Family Child Care Association, MD University of Integrative Health, ACS, Howard County Library System, OFA (Organizing for America), African American Community Round Table, Parks and Rec, Horizon, Community Action Council, North Laurel Multi Service Center.
	8. The Door to HealthCare staff participated in trainings, conferences, and other events in order to provide the highest quality service to customers. Conferences included: Community Outreach Summit (6/2/13)- More than 300 participants and stakeholders attended a Community Outreach Summit, which provided background information on the state's Connector program. Each Connector Entity gave a short talk about its region's strategies around education and enrollment and staff gathered great ideas from the other Connector Organizations. Maryland Hospital Association Conference (6/7/13) - Connector Entities met with the hospital representatives from their regions. Discussions included how to design the program for the Western Region and involve those organizations that may not be receiving funding from MHBE through HHI, but are certainly partners and stakeholders. Healthy Howard made a presentation to the Ethnic Roundtable on the ACA and referring people to the Door to HealthCare.
1B. Collaborate among service providers to educate and share knowledge of available services and market the availability of services to communities affected by disparities.	1. The Healthy Howard Health Plan served nearly 2,000 Howard County residents between 2009 and 2013. When it ended on 12/31/14, the Plan had 721 active members. Staff conducted extensive outreach to active Plan members including sending out a series of letters with information about Open Enrollment and making follow-up calls about members' insurance status. Close to 65% (473) of Plan members either responded to a follow-up call, met with a navigator at Chase, or received enrollment assistance at the Door to HealthCare. 338 members reported they had active insurance (data collected at the end of March 2014).
	2. Door to HealthCare trainings and conferences (See 1A.8)
	3. Healthy Howard started the Community Care Team in 2014 to work with frequently hospitalized Howard County residents. In the first year, the team worked with more than 100 individuals to link them to resources, increase access to primary care services, and decrease hospitalizations.

	4. "Hot Spotting; Using Data to Pinpoint Community Health Care Access Needs" by R. M. Krieg, Horizon Foundation Annual Meeting (6/4/13) - Hot Spotting data from Howard County General Hospital from 2012, analyzed by Camden Coalition, and used to identify target population for Community Care Team project.
	5. "Health Care Reform and Nonprofits: A New Prescription" (5/21/2013) - Conference held in Howard County in partnership with the Women's National Health Network targeting organizations working with people who would be eligible under the ACA and discussing possibilities for billing/reimbursements.
1C. 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.	1. The Kaiser Bridge Plan partnership was designed to help those who cannot afford health care coverage due to an unexpected change in job status or income and for individuals who would not be eligible for any other public or private health care program. In 2013, a total of 157 Howard County residents were enrolled in the Bridge program. To comply with the ACA, a new charity care plan was designed to replace the Bridge program. This new plan is known as the Kaiser Permanente Community Health Access Program or CHAP and was launched in January 2014. This program enables Kaiser to retain Bridge Plan members and has full benefits (primary/specialty care, dental, hospitalization, pharmacy and optical). Anyone enrolled in this program qualifies for the Medical Financial Assistance program (no co-pays for services received in a Kaiser facility).
	2. Healthy Howard Health Plan Hardship Fund. This fund helped Plan members who were unable to afford services within the health plan.
	3. Healthy Howard Health Plan. See 1B.1.
	4. Prenatal Coordination program. See 1A.2.
1D. 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.	1. The Door to HealthCare held five community forums in September of 2013, one in each District. More than 29 presentations were given to the community at large and to organizations. Between June 2013 and October 2014, the Door held more than 250 events to disseminate information on how to get affordable health care through the ACA.
	2. The Door to HealthCare uses its website (www.doortohealthcare.org), Facebook, and Twitter to promote programs and events.

	3. Connector Program volunteer corp. HHI created a volunteer program and worked closely with OFA (Organizing for America). Twice a week, OFA volunteers were at two libraries and gave out literature and captured information from individuals with specific questions. Created a partnership with Workforce Development to give individuals looking for jobs the opportunity to gain experience in the call center. Three individuals would come three times a week to answer calls, give information, and schedule individuals to enroll.
	6. Community Care Team program. See 1B.3.
1E. Develop a County hotline for people who are uninsured or who are insured but need help connecting to the care they need.	This action was addressed through a network of referral services: Door to HealthCare, CAC, 211, Maryland Health Connection Call Center. Consensus was that we did not need to develop a hotline but rather refer individuals to exisiting services. We wanted to push 211 as the go-to number, however without marketing dollars those efforts were not successfully accomplished. 211 was in talks with the state to become the go-to number as well. We wanted to coordinate with the state LHIC to ensure we were all pushing the same number.
1F. Assess healthcare access through school enrollment and refer uninsured to a hotline for coverage.	Door to HealthCare outreach, education, and mobile enrollment connnector program strategy included communications via the public school system. Information was also distributed via E-newsletters and back to school nights.
1G. Create greater access to care for undocumented immigrants.	1. Prenatal Coordination program. See 1A.2.
	2. Kaiser Bridge Plan partnership. See 1C.1.
	3. Healthy Howard's Administrative Care Coordination Unit (ACCU) provides Medicaid and MCHP enrollment, WIC information and applications, and transportation for medical appointments. The ACCU closed 1,295 cases from July 2014 - December 2014.
1H. Open access and eligibility for services at urgent care centers, inclusive of behavioral health services.	In 2013, the Behavioral Health work group did a project reaching out to urgent care centers. They found no centers interested in incorporating behavioral health services.
1I. Promote preventive care for all populations by exploring standards and policies to ensure people have a medical home.	Healthy Howard created a Community Integrated Medical Home Program (CIMH) that incorporates a Community Care Team (CCT) and a Patient Centered Medical Home (PCMH) program. The CCT provides a 90-day intervention for patients who are frequently hospitalized, connecting those patients to a primary care provider (medical home) and other community resources and providing in-home medication reconciliation and chronic disease education. The PCMH program works with primary care providers to help them become more patient-centered and to integrate the CCT into the practices for better support to mutual patients. There are plans to expand both programs in 2015.



APPENDIX II



LHIC Action Plan Tracking Tool – 2012-2014 Summary - Healthy Weight

Strategies	Action Steps

Priority

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

Goals

	County	African American	Hispanic	White	Asian	
Baseline	41.5%	28.4%		42.7%	52.8%	
Goal 2014	50.0%	40.0%		51.0%	63.0%	
Measure (Data Source)	SHIP #30 (BRFSS)					
2014 HCHAS	44.1%	38.8%	46.8%	40.9%	63.8%	Note: Small sample sizes for subgroups may make data unreliable. Hispanic: 42; Other: 79; Asian: 174.

2b) Decrease the proportion of adolescents 12-19 who are 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.

Goals

	County	African American	Hispanic	White	Asian	
Baseline	8.0%					
Goal 2014	4.0%					
Measure (Data Source)	SHIP #31 (MYTS)					
2013 MD YRBS	5.9%	8.1%	6.6%	5.4%	3.6%	

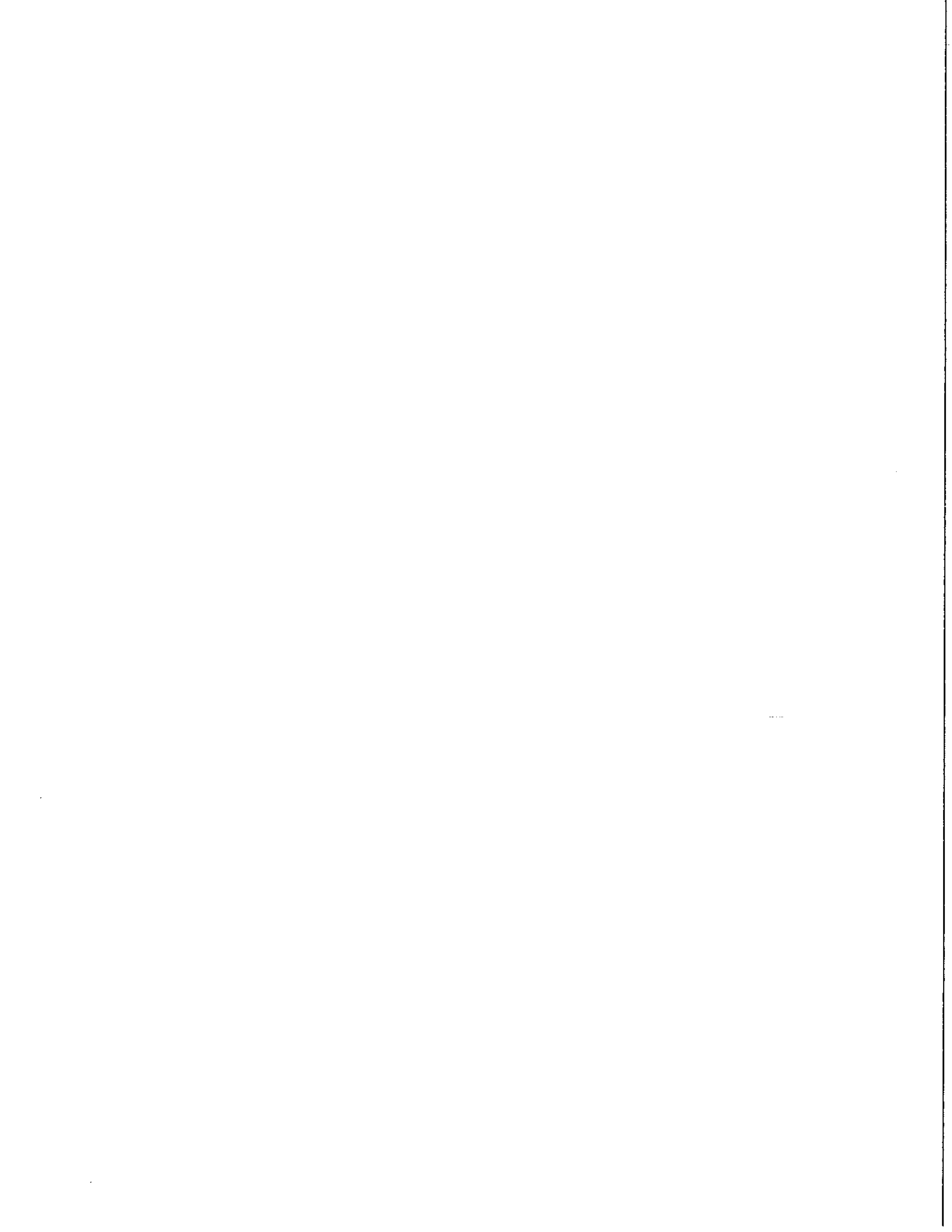
Priority

LHIC Action Plan Tracking Tool – 2012-2014 Summary - Healthy Weight

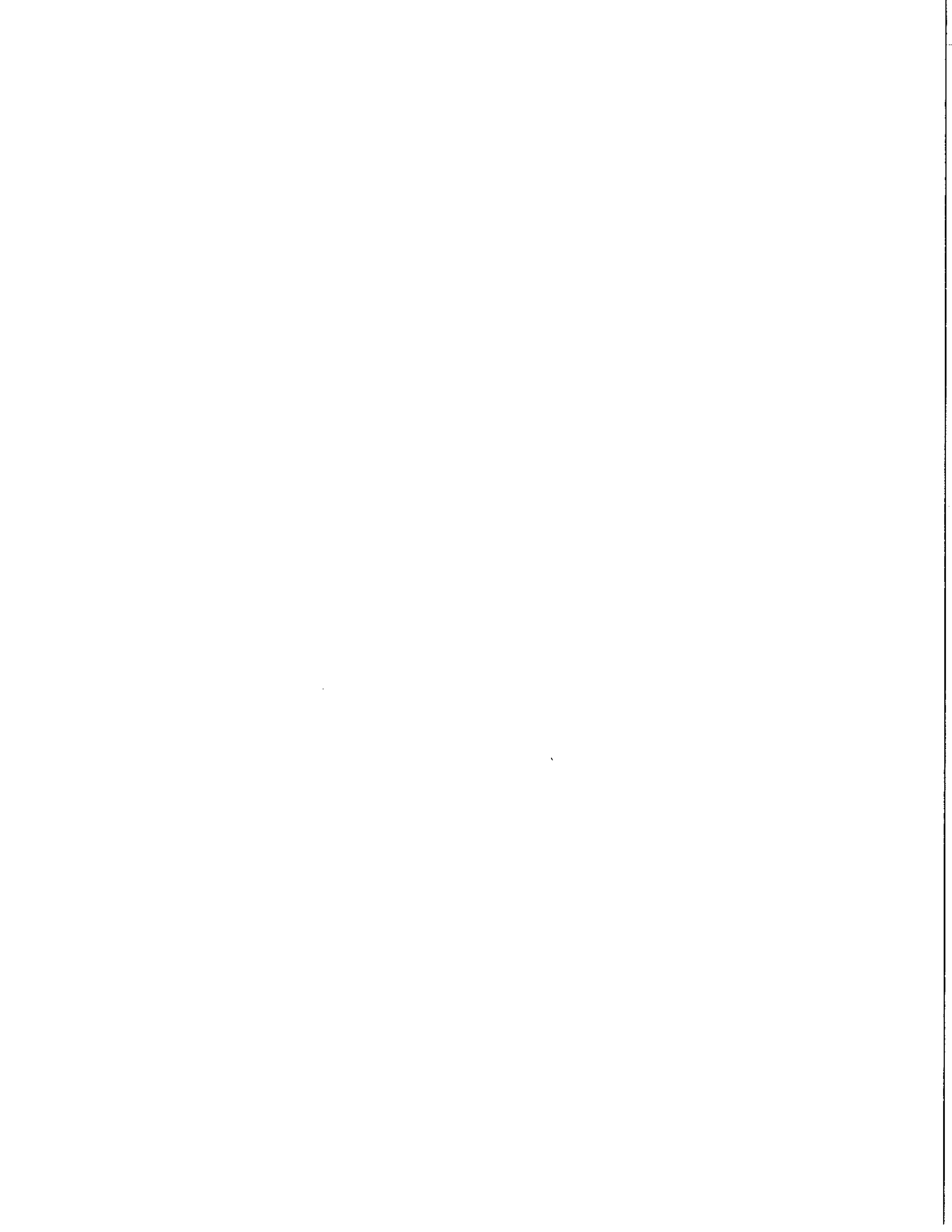
Strategies	Action Steps
2A. Bring together and coordinate efforts among a wide group of players that have a stake in promoting healthy weight, including schools, parents, employers, faith-based organizations, health care providers, interest groups (such as associations focused on heart disease or diabetes), nonprofit organizations that provide nutritional support (such as food banks) and others.	The LHIC Healthy Weight Work Group convenes stakeholders from most of these areas. The group continually recruits representatives from new organizations to provide a complete picture of needs and services in Howard County.
2B. Develop awareness campaigns and marketing messages such as the First Lady's "Let's Move" initiative. Create incentives for people and communities to participate.	Most participating organizations have initiatives in this area: We Promote Health conducts Boot Camp in the park. Horizon launched Hoco Unsweetened in Dec 2012. Horizon working with doctors, nurses, dentists, marketing better beverage finder, collecting data. Healthy Howard conducted Healthy Child Care program, including BMI screenings. LHIC staff promote these programs through the bi-weekly LHIC Digest.
2C. 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.	Healthy Howard, MDAAP, and Horizon collaborated on the Childhood Obesity Prevention Project, which worked with healthcare providers, dentists and hygienists to create and distribute a Childhood Obesity Prevention Toolkit and educate providers on its use.
2D. Create a repository of resources for referrals for individuals and groups working on achieving a healthy weight.	This action was deferred until 2015 - the first Resource Guides were printed in June, 2015.
2E. Improve access to opportunities for physical activity by people with disabilities.	There was some research done in this area, but otherwise no activity.

LHIC Action Plan Tracking Tool – 2012-2014 Summary - Healthy Weight

2F. 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.	Provided representatives for the committee to revise the Howard County Public School System's Wellness Through Nutrition and Physical Activity Policy 990. Healthy Howard's Healthiest Maryland Businesses Regional Coordinator works with businesses to design and implement wellness policies. Healthy Howard's Healthy Schools program provided assistance to schools implementing wellness committees.
2G. Increase outreach and connections between mental health and eating behaviors.	No action in this area.
2H. 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.	No action in this area.
2I. Increase physical activity at schools through trained recess monitors and well-trained physical education teachers and ensure adequate time for physical activity.	The HCPSS Wellness Through Nutrition and Physical Activity Policy 990 addresses these issues.
2J. 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.	Healthy Howard's Heal Zone conducted a summer food program. The Roving Radish is a new program that delivers fresh meal kits to residents, with discounted prices for low-income families.



Appendix III



LHIC Action Plan Tracking Tool – 2012-2014 Summary - Behavioral Health

Priority							
3a) Reduce rate of Emergency Department (ED) visits for a behavioral health condition per 100,000.							
Goals							
	County	African American	Hispanic	White	Asian		
Baseline	806.7	1219.4	442.3	808.9	233.1	The SHIP measure changed after the 2012-2014 Action Plan was developed.	
Goal 2014	645	806	354	645	186	Baseline and goal no longer apply.	
Measure (Data Source)	SHIP #34 (HSCRC)	SHIP #34 (HSCRC)	SHIP #34 (HSCRC)	SHIP #34 (HSCRC)	SHIP #34 (HSCRC)		

Strategies	Actions	Date completed
3A. Analyze SHIP data in collaboration with Howard County General Hospital to gain understanding of distribution of ICD codes for behavioral health ED visits.	The work group twice reviewed HSCRC data provided by HCGH, in 2013 and 2014. The group created a presentation regarding hospital inpatient and ED use for behavioral health for the Howard County Behavioral Health Task Force which was convened in October 2014.	Sep-14
3B. Incorporate behavioral health assessments into preventive care, primary care and other assessments/screenings.	This was discussed within the work group.	On-going
3C. Promote emotional wellness as part of overall health.	The Mental Health Authority promotes "is emotional wellness part of your overall fitness plan?" NAMI HC conducted an educational forum on ways of coping with mental illness - holistic wellness, stress management, exercise.	On-going
3D. Educate physicians, including pediatricians, to identify behavioral health issues.	MDAAP held a CME event on behavioral health for pediatricians. Topics included Autism Spectrum Disorders, Anxiety and Depression, and Psychopharmacology. Approximately 90 providers from throughout Maryland attended.	Sep-14
3E. Create an easy-access referral system, including a hotline number, to define eligibility for services and help people gain access to them.	See 3H for a description of the Continuum of Care. The group is also investigating Network of Care and 211 to determine their capacity for behavioral health referrals for Howard County residents.	On-going

LHIC Action Plan Tracking Tool – 2012-2014 Summary - Behavioral Health

3F. Create a single point of entry for mental health and substance use issues.	There was no activity on this strategy.	
3G. Learn more about how behavioral health issues affect different populations and where disparities exist.	The Howard County Health Assessment Survey was modified to include additional questions on behavioral health.	Jul-14
3H. Analyze gaps and funding resources.	The work group is compiling a database of behavioral health resources in the county. LHIC staff are reaching out to providers to get detailed information about their programs and assembling the information into a behavioral health care continuum. The group anticipates providing this information to the Behavioral Health Task Force as they work to identify gaps in services. One gap that was identified was a lack of ability to follow up with frequent utilizers of the ED who are at-risk for suicide. MHA, in partnership with Grassroots, developed a program to follow individuals who have been to the ED for behavioral health reasons 3 or more times in the last 6 months. A Grassroots staff person will maintain contact with the individual and help get him/her into appropriate community-based care. This program uses an evidence-based SAMHSA model and is expected to begin operating in the 3rd quarter of FY15.	On-going
3I. Identify and address administrative barriers to care.		
3J. Review capabilities of urgent care centers keep a current directory of services, and increase capacity of urgent care centers to include behavioral health services.	The work group conducted an outreach effort to urgent care centers to assess their capacity to address behavioral health needs. Very few centers responded to the group's requests for information.	2013
3K. 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.	The Mental Health Authority has conducted Mental Health First Aid training. On Our Own of Howard County conducted an eCPR (Emotional CPR) workshop to train 12 individuals to respond to someone in emotional crisis in an empowering way. On Our Own also hosted a showing of The Anonymous People for 35 people to raise awareness about recovery. The County also developed Stand Up HoCo, an anti-bullying initiative that allows anyone to report an incident of bullying on-line. Incidents go into a database monitored by the Local Children's Board and are referred to the appropriate agency.	2014
3L. Review behavioral health data and ensure all ages, including youth and seniors, have access to behavioral health services.	See 3A and 3G.	