HCLHIC FY 2017 Updates and FY 18-20 Strategic Plan

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Health Officer , Howard County Health Department, HCLHIC Co-Chair

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HOWARD COUNTY HEALTH DEPARTMENT

Howard County LHIC
Local Health Improvement Coalition

Purpose

- GOAL: Provide an overview of insurance enrollment and access in Howard County, a preview of the 2018 Maryland Legislative Session, training on NAMI's "Say it Out Loud" anti-stigma campaign and review the 2018-2020 HCLHIC Strategic Action Plan.

- OBJECTIVES:

A. Insurance Enrollment and Access in Howard County
B. 2018 Legislative Session
C. "Say it Out Loud" Anti-Stigma Campaign
D. Delegate's Report/ 2018-2020 Strategic Action Plan

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Approval of Minutes
and
Member Announcements

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2018 Maryland Legislative Session Update

Mellissa Sager, J.D., Staff Attorney,

Legal Resource Center for Public Health Policy

University of Maryland Carey School of Law

HOWARD COUNTY HEALTH DEPARTMENT

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Access to Care in Howard County

Traci Kodeck, CEO

HealthCare Access Maryland

Shanika M. Cooper, MHS-PC

Director Bureau of Access to Healthcare

Howard County Health Department

HealthCare Access MARYLAND
COVERAGE. CARE. CONNECTIONS.

HealthCare Access Maryland

Howard County
Local Health Improvement Coalition (LHIC)

Traci Kodeck, MPH, *CEO*
Lynell Medley, RN, *VP, Programs*
Karen Stone, MPP, *Director, Performance Improvement*

Mission and Vision

Mission

We are making Maryland healthier by connecting residents to insurance and care, educating the community about healthier living, and advocating a more equitable health care system.

Vision

We envision Maryland as a place where all people have equal access to health care and where there are no disparities in health outcomes based on income or race. HealthCare Access Maryland will be a state and national leader in reforming the health care system.

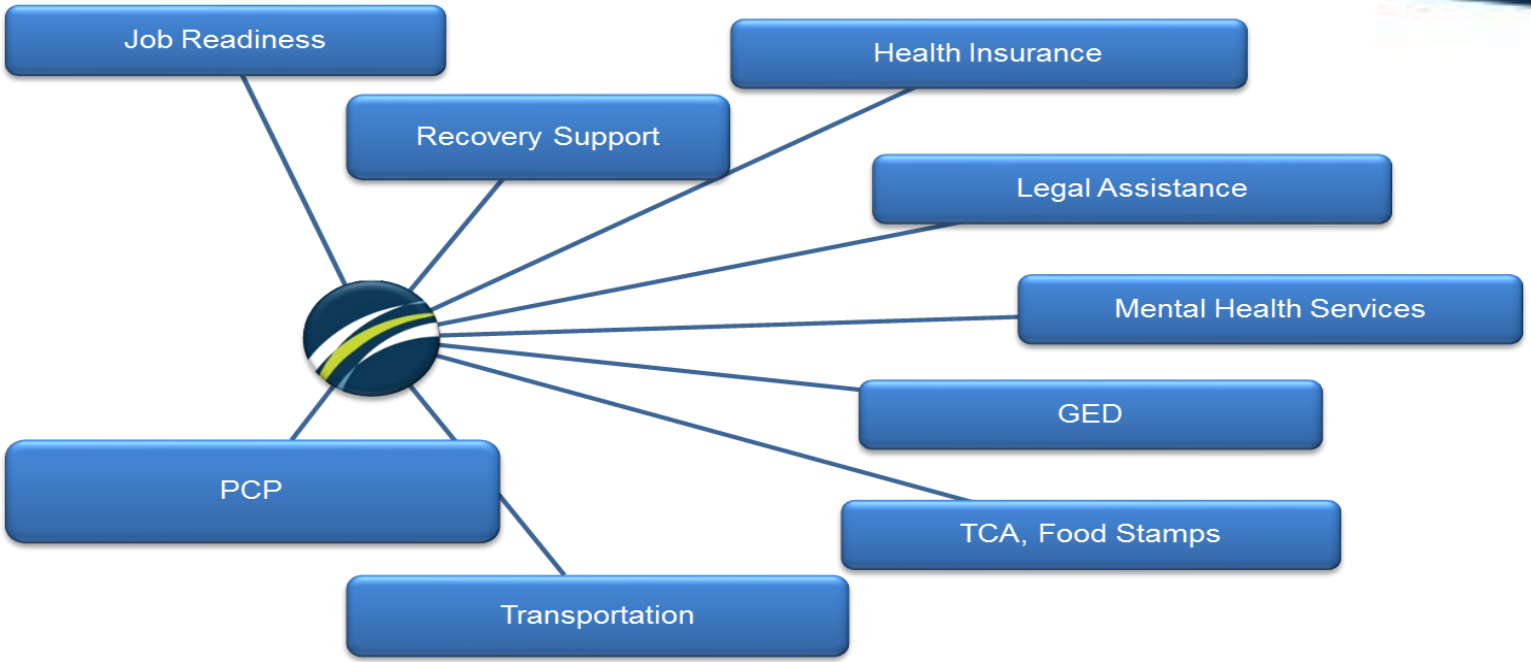
HCAM's History

- 501-C3 established in 1997
- Overseen by a committed, diverse board of directors
- HCAM plays a critical role in strengthening Maryland's health care delivery system
- Funding from both Public and Private Sector
- 200 Total Employees/ $18M Budget
- Serve 145,000 people per year
- Experienced and Tenured Management Team/Staff
- Experience with health insurance enrollment and system navigation
- Care coordination focused on social determinants of health

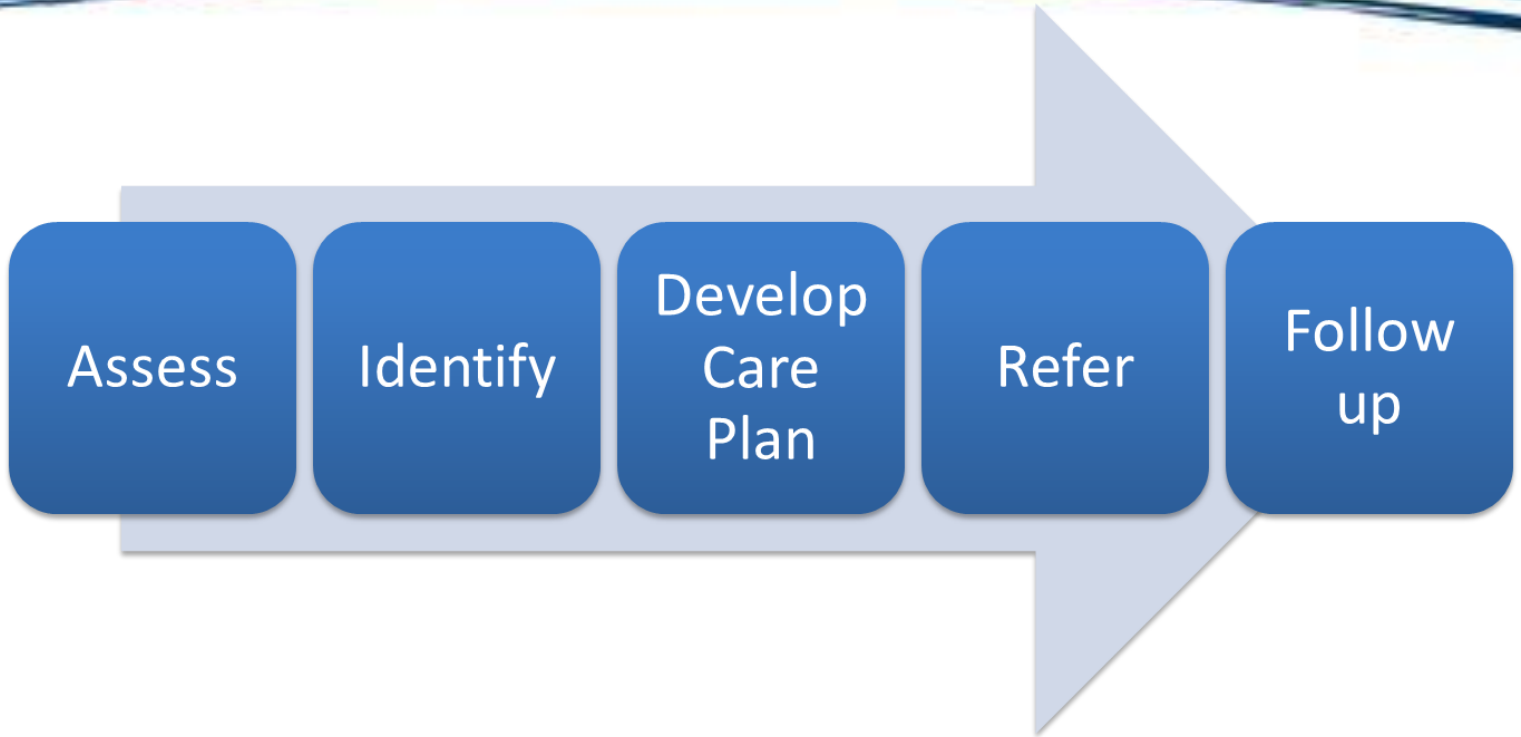
Core Services

- Eligibility/Enrollment
- System Navigation
- Case Management/Care Coordination
- Public Policy and Advocacy

Social Determinants of Health



Our Model



Programs

- Connector: Baltimore City/County, AA County, Howard, Carroll, Frederick
- Eligibility Unit for Baltimore City LHD
- Behavioral Health Outreach Programs
  - Care Coordination (State, MDRN, BBI, Pregnant Women)
  - Information and Referral Line
- Care Coordination Program (ACCU)
  - Managed Care Organizations/PCP/OB providers
- Baltimore City Foster Care: MATCH
- Population Health Programs
  - 911/Operation Care
  - Hospitals : St. Agnes and West Baltimore Collaborative: University of Maryland, Midtown, Bon Secours and St. Agnes

eClinical Works and CRISP

- eClinical Works (eCW) EMR implemented across HCAM programs between June 2015 – March 2016
  - Ability to capture medical data and link to case management data
- Current work with CRISP to track utilization of patients in our readmission programs (Population Health)
  - Real time notification of utilization for specific HCAM populations
- Currently interfacing with partner EMRs with Care Alert capability through CRISP
- Future work with CRISP to share care plans with partner EMRs
  - Coordination of care across provider types/ partners

Community Stakeholders/Partners*

- Local Health Department
- Local Department of DSS
- Hospital Partners
- Community Action Centers
- Housing/Shelters
- Federally Qualified Health Centers
- Managed Care Organizations
- Food Pantry's
- Religious Community partners
- Behavioral Health Facilities including outpatient and inpatient
- MedChi
- Foundations

*represents the larger partner entities and is not complete

Client Impact #1

The client is a 56 year old woman who often came to the ED for non-emergency reasons, such as a stomach ache. The Coordinator met with her in the ED and the client agreed to program services. Her goals were to obtain a new PCP and a home aide.

After initial enrollment, the client was unresponsive to follow up.

The coordinator was able to reestablish contact and the client now has a new PCP, receives pain management, and has a therapist. HCAM is in the process of obtaining a home aide. The client has been compliant with her appointments so far.

Prior to enrollment, the client visited Sinai's ED 14 times within a 4-month period. Since development of a care plan, the client has returned to the ED only once.

Client Impact #2

A 42 year-old female who was identified as a high volume EMS caller was referred to the Operation Care 911 program. The staff was able to learn that the client was calling 911 because she was depressed, facing eviction, facing homelessness, had lost her father and her son to recent deaths, suffering from somatic illnesses, and was without a sustainable income source at the time of referral.

Through active engagement with the Operation Care 911 case manager, she was connected to community resources to help her become self-sufficient. She was enrolled in a 12 week work study program offered by My Sisters Place, and at the end of the work study program she was able to secure employment with the Second Chance Program. In addition, the case manager assisted her with obtaining the appropriate working attire required by her employer. She has maintained her employment with this agency, and is currently making plans to secure housing for herself and her 12 year-old daughter.

At the conclusion of the program enrollment and the 90 days after case closure, the client has sustained a 911 call volume of zero.

Celebrating 20 Years

Thank You!

Traci Kodeck, MPH CEO
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https://one.bidpal.net/hcam20th/welcome

HOWARD COUNTY HEALTH DEPARTMENT

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Local Health Improvement Coalition

Bureau of Access to Healthcare

Shanika M. Cooper, MHS-PC

Director Bureau of Access to Healthcare

Howard County Health Department

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Bureau of Access to Healthcare

- Bridge the gap between healthcare professionals, the community, and other bureaus within the Howard County Health Department

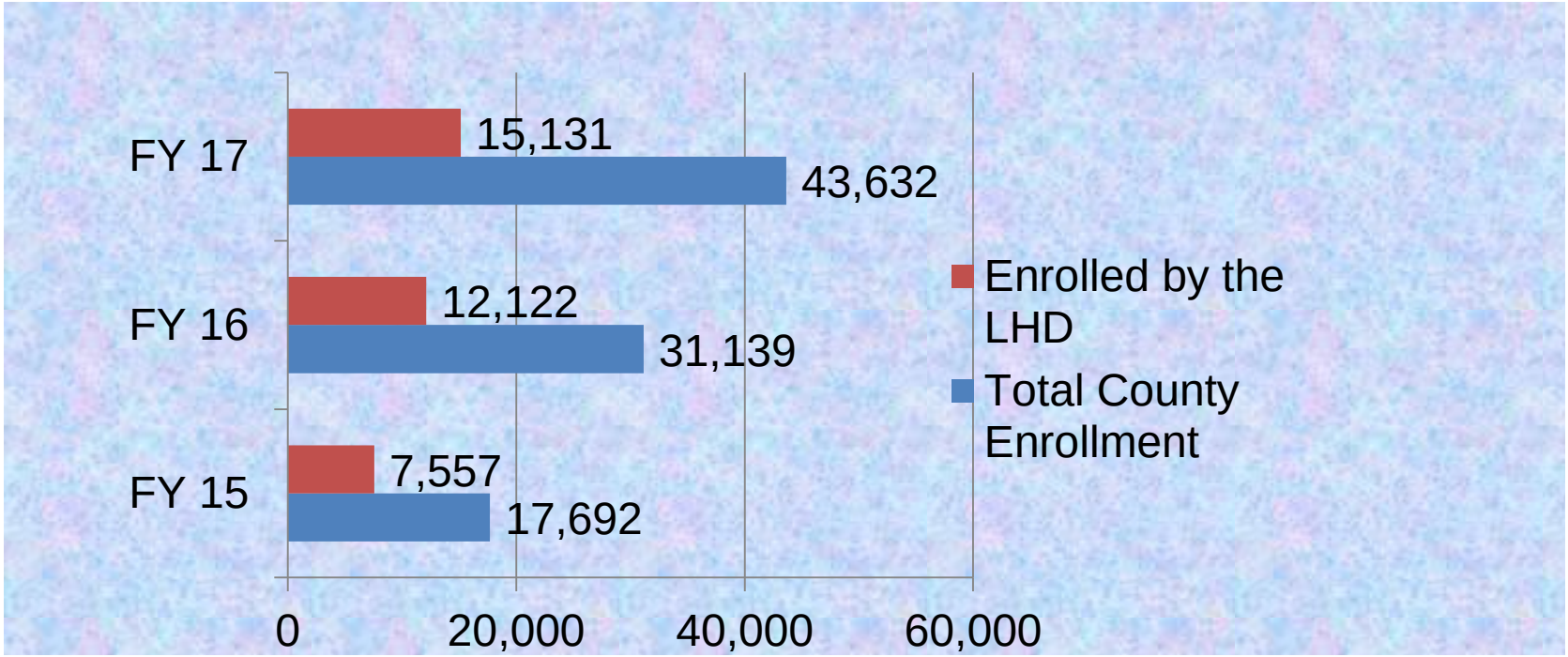
  - Maryland Children's Health Program (MCHP)

  - Administrative Care Coordination (ACC)

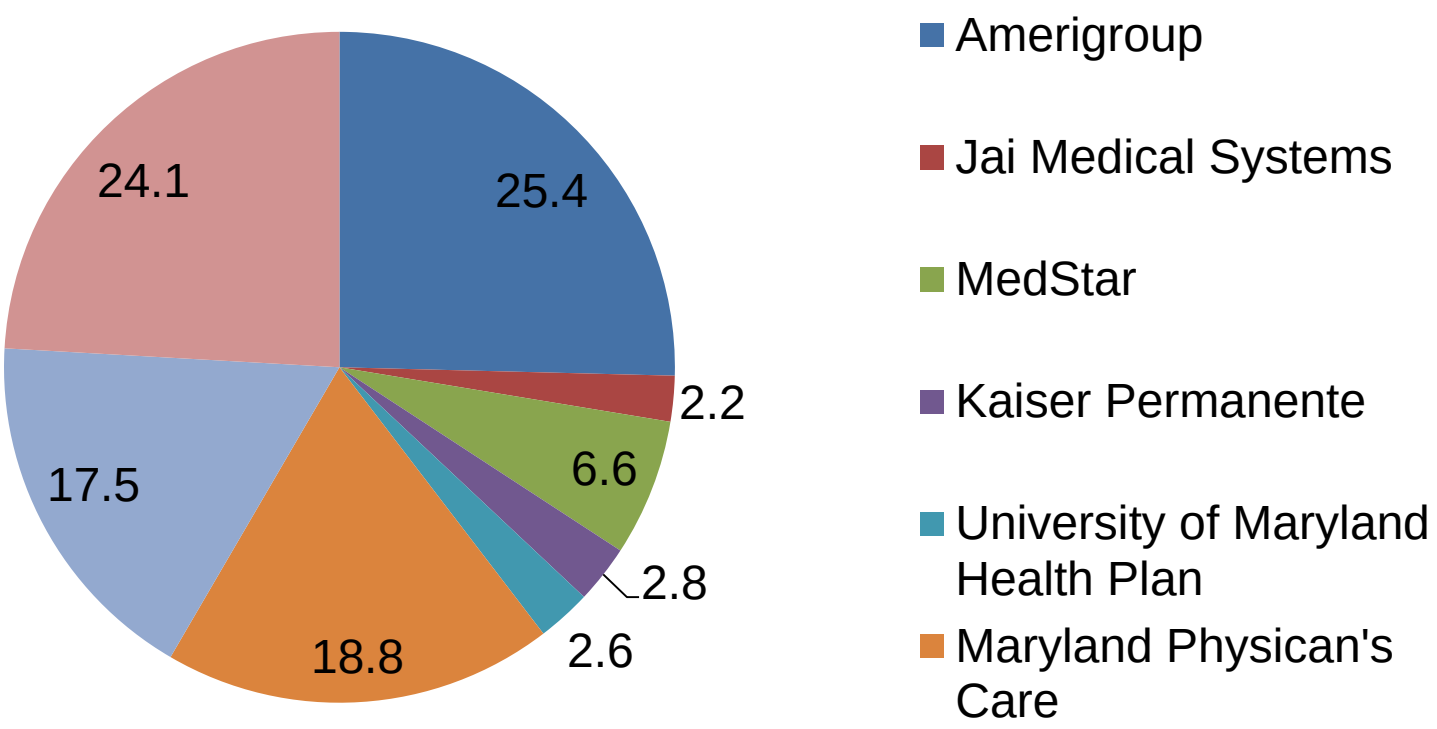
  - Non-emergency Medical Transportation Program (NEMTP)

You may be eligible for Medicaid if your annual income is up to approximately:					
If your household size is this	Adults	Children (MCHP)	Children (MCHP Premium)		Pregnant Women
1	$16,643	$25,447	$31,838	$38,833	N/A
2	$22,411	$34,266	$42,874	$52,293	$42,874
3	$28,180	$43,086	$53,909	$65,752	$53,909
4	$33,948	$51,906	$64,944	$79,212	$64,944
5	$39,716	$60,726	$75,979	$92,672	$75,979
6	$45,485	$69,546	$87,014	$106,131	$87,014
7	$51,253	$78,365	$98,050	$119,591	$98,050
8	$57,022	$87,185	$109,085	$133,050	$109,085

Howard County Medicaid Enrollment



Managed Care Organization Market Share



Administrative Care Coordination

- Gives assistance with the utilization of the Health choice program, assists client with Medicaid client dispute resolution, and provides a link between the client, medical provider, and the MCO

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Non-Emergency Medical Transportation Program

- Provides transportation services for Howard County Medicaid recipients who need medical care and have no transportation available.

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Bureau Initiative

- Emphasize primary and preventive care

- Improve the quality of health care and patient outcomes across health care settings within Howard County

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7th Inning Stretch

Healthy Meeting Stretch Break

Photo Credit: http://bleacherreport.com/articles/1446337-nfl-spreadshredder-week-15-new-look-ravens-to-upset-old-friend-broncos

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Say It Out Loud Anti-Stigma Campaign

Alikah Adair

NAMI Howard County

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Delegate Reports

Access to Care Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

Howard County LHIC
Local Health Improvement Coalition

FY 2018-2020 Priority 1: Reduce Emergency Department visits for diabetes, hypertension, and asthma in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 1.1a** Provide referral/linkage to diabetes/hypertension/asthma education and services through community partnerships and evidenced-based programs for priority populations
- ❑ **Goal 1.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media on disease prevention and awareness for priority populations
- ❑ **Goal 1.2a** Convene HCLHIC member organizations in a collaborative advisory capacity to coordinate evidenced-based CDSM and DPP programming and services for priority populations to ensure reach throughout Howard County

Expected Outcomes:

- Increased availability and completion of CDSM, DPP, Hypertension and Asthma-related evidenced-based programs for HC priority populations
- Increased HCLHIC partner engagement in Diabetes, Hypertension, Asthma, and appropriate uses of primary, urgent, telemedical, and emergency care awareness campaigns

Immediate Needs:

- Organizational data sharing to establish baseline

Access to Care Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

Howard County LHIC
Local Health Improvement Coalition

FY 2018-2020 Priority 2: Increase the number of Howard County children and adults who access dental care annually.

FY 2018-2020 Goals:

- ❑ **Goal 2.1a** Provide referral/linkage to dental care and oral health education through community partnerships and evidenced-based programs for priority populations
- ❑ **Goal 2.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media on disease prevention and oral health awareness for priority populations
- ❑ **Goal 2.2a** Convene HCLHIC member organizations in a collaborative advisory capacity to increase the number of dental providers offering free/low cost dental services for priority populations.

Expected Outcomes:

- Increased availability of and completed referrals to free/low cost clinical dental services for adults and children
- Increased HCLHIC partner engagement in coordinated oral health and low cost dental providers awareness campaigns
- Increased dental insurance coverage rate in Howard County

Immediate Needs:

- Organizational data sharing to establish baseline

Behavioral Health Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

Howard County LHIC
Local Health Improvement Coalition

FY 2018-2020 Priority 1: Reduce Emergency Department visits related to mental health conditions in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 1.1a** Provide referral/linkage for mental health conditions-related education and services through community partnerships and evidenced-based programs for priority populations
- ❑ **Goal 1.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media to reduce stigma about prevention and treatment of mental health conditions for priority populations

Expected Outcomes:

- Increased availability of stigma reduction programs and educational symposia/CE opportunities related to mental illness for providers, care professionals and community members
- Increased HCLHIC partner engagement in stigma reduction and appropriate uses of emergency care and crisis intervention services awareness campaigns

Immediate Needs:

- Organizational data sharing to establish baseline

Behavioral Health Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

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FY 2018-2020 Priority 2: Reduce Emergency Department visits for addiction-related conditions in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 2.1a** Provide referral/linkage for addictions-related education and services through community partnerships and evidenced-based programs for priority populations
- ❑ **Goal 2.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media to reduce stigma about prevention and treatment of addictions-related conditions among priority populations

Expected Outcomes:

- Increased availability of stigma reduction programs and educational symposia/CE opportunities related to addictions for providers, care professionals and community members
- Increased HCLHIC partner engagement in stigma reduction and appropriate uses of emergency care and crisis intervention services awareness campaigns

Immediate Needs:

- Organizational data sharing to establish baseline

Behavioral Health Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

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FY 2018-2020 Priority 3: Reduce suicide rates in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 3.1a** Provide referral/linkage for suicide prevention education and services through community partnerships and evidence-based programs for priority populations
- ❑ **Goal 3.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media to reduce stigma about suicide prevention among priority populations

Expected Outcomes:

- Increased availability of stigma reduction programs and educational symposia/CE opportunities related to suicide prevention for providers, care professionals and community members
- Increased HCLHIC partner engagement in stigma reduction and appropriate uses of emergency care and crisis intervention services awareness campaigns

Immediate Needs:

- Organizational data sharing to establish baseline

Healthy Aging Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

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FY 2018-2020 Priority 1: Reduce Alzheimer's and dementia-related emergencies in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 1.1a** Provide referral/linkage to brain health education, future and advanced care planning for healthy aging and aging-related services through community partnerships and outreach programs for priority populations
- ❑ **Goal 1.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media on brain health education, future and advanced care planning for healthy aging and aging-related services for priority populations
- ❑ **Goal 1.2a** Convene HCLHIC member organizations in a collaborative advisory capacity to coordinate integration of brain health education, future and advanced care planning for healthy aging and aging-related services to ensure reach throughout Howard County

Expected Outcomes:

- Increased availability and completion of evidenced-based programs for HC priority populations
- Increased availability of educational symposia/CE opportunities for providers, care professionals, community members, and caregivers
- Increased integration of healthy aging and aging related services and education into standard operations/communications
- Increased HCLHIC partner engagement in future planning awareness campaigns

Immediate Needs:

- Organizational data sharing to establish baseline

Healthy Aging Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

Howard County LHIC
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FY 2018-2020 Priority 2: Reduce fall-related deaths in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 2.1a** Provide referral/linkage to falls prevention, adaptive device resources and awareness services through community partnerships and evidence-based programs for priority populations
- ❑ **Goal 2.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media on falls prevention, adaptive device resources and awareness services for priority populations

Expected Outcomes:

- Increased availability and completion of evidenced-based programs for HC priority populations
- Increased availability of educational symposia/CE opportunities for providers, care professionals, community members, and caregivers
- Increased integrations of falls preventions services and education into standard operations/communications
- Increased HCLHIC partner engagement in falls prevention awareness campaigns

Immediate Needs:

- Organizational data sharing to establish baseline

Healthy Weight Work Group Report

HOWARD COUNTY HEALTH DEPARTMENT

Howard County LHIC
Local Health Improvement Coalition

FY 2018-2020 Priority 1: Reduce obesity in Howard County.

FY 2018-2020 Goals:

- ❑ **Goal 1.1a** Provide referral/linkage for free/low-cost resources for physical activity through community partnerships and evidence-based programs for priority populations
- ❑ **Goal 1.1b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media for physical activity to educate priority populations
- ❑ **Goal 1.2a** Provide referral/linkage for free/low-cost nutrition education and services through community partnerships and evident-based programs for priority populations
- ❑ **Goal 1.2b** Engage HCLHIC member organizations in coordinated communication efforts through social, print and other media for nutrition to educate priority populations

Expected Outcomes:

- Increased availability of evidenced-based physical activity and nutrition programs for HC priority populations
- Increased HCLHIC partner engagement in awareness campaigns around sugary/sweetened beverages, point of decision markers to promote physical activity, and walking/biking safety

Immediate Needs:

- Organizational data sharing to establish baseline

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2018 Full HCLHIC Quarterly Meeting Dates

January 25, 2018 8:30 am - 10:30 am (Susquehanna) *Tentative location

April 26, 2018 8:30 am - 10:30 am (Susquehanna) *Tentative location

June 28, 2018 8:30 am - 10:30 am (Susquehanna) *Tentative location