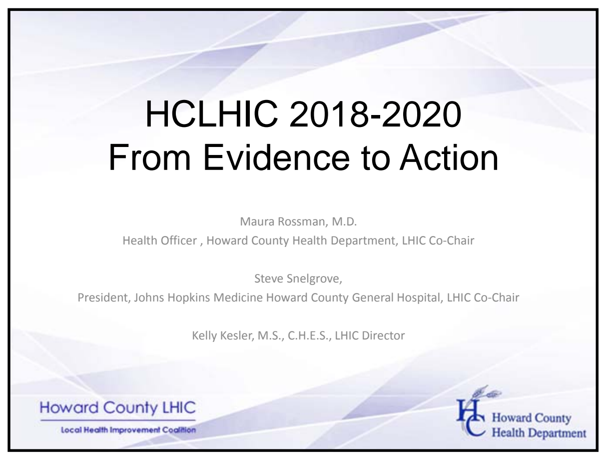
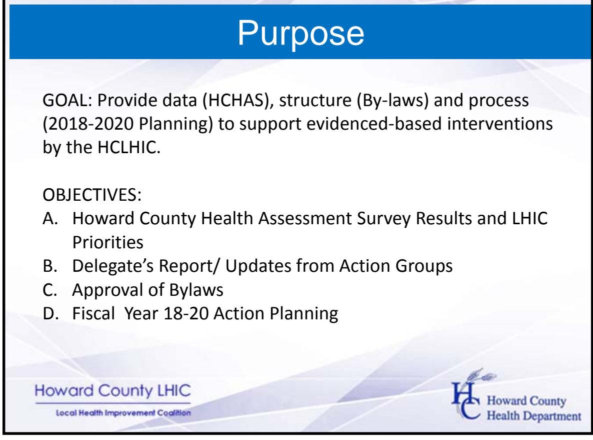

HCLHIC 2018-2020
From Evidence to Action
Maura Rossman, M.D.
Health Officer , Howard County Health Department, LHIC Co-Chair
Steve Snelgrove,
President, Johns Hopkins Medicine Howard County General Hospital, LHIC Co-Chair
Kelly Kesler, M.S., C.H.E.S., LHIC Director
Howard County LHIC
Local Health Improvement Coalition
Howard County
Health Department


Purpose
GOAL: Provide data (HCHAS), structure (By-laws) and process (2018-2020 Planning) to support evidenced-based interventions by the HCLHIC.
OBJECTIVES:
A. Howard County Health Assessment Survey Results and LHIC Priorities
B. Delegate's Report/ Updates from Action Groups
C. Approval of Bylaws
D. Fiscal Year 18-20 Action Planning
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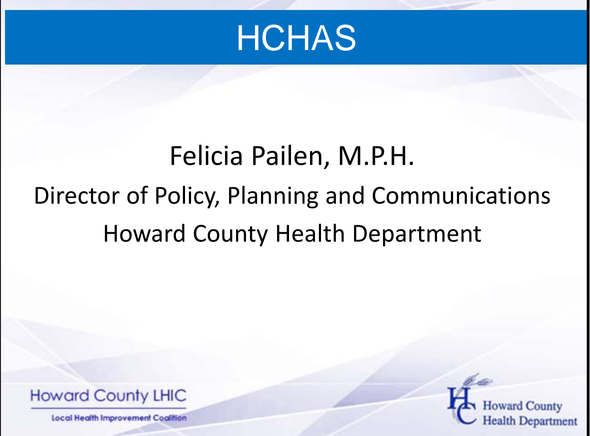
HCHAS
Felicia Pailen, M.P.H.
Director of Policy, Planning and Communications
Howard County Health Department
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Local Health Improvement Coalition
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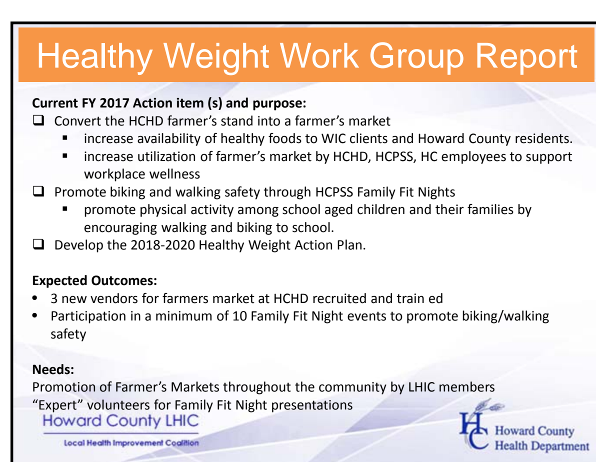
Healthy Weight Work Group Report
Current FY 2017 Action item (s) and purpose:
Convert the HCHD farmer's stand into a farmer's market
increase availability of healthy foods to WIC clients and Howard County residents.
increase utilization of farmer's market by HCHD, HCPSS, HC employees to support workplace wellness
Promote biking and walking safety through HCPSS Family Fit Nights
promote physical activity among school aged children and their families by encouraging walking and biking to school.
Develop the 2018-2020 Healthy Weight Action Plan.
Expected Outcomes:
3 new vendors for farmers market at HCHD recruited and train ed
Participation in a minimum of 10 Family Fit Night events to promote biking/walking safety
Needs:
Promotion of Farmer's Markets throughout the community by LHIC members
"Expert" volunteers for Family Fit Night presentations
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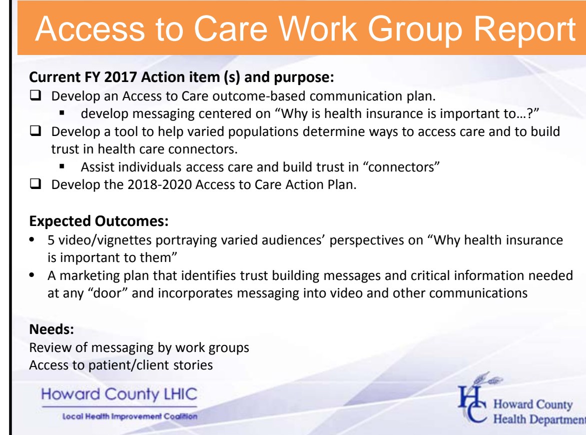
Access to Care Work Group Report
Current FY 2017 Action item (s) and purpose:
Develop an Access to Care outcome-based communication plan.
develop messaging centered on "Why is health insurance is important to…?"
Develop a tool to help varied populations determine ways to access care and to build trust in health care connectors.
Assist individuals access care and build trust in "connectors"
Develop the 2018-2020 Access to Care Action Plan.
Expected Outcomes:
5 video/vignettes portraying varied audiences' perspectives on "Why health insurance is important to them"
A marketing plan that identifies trust building messages and critical information needed at any "door" and incorporates messaging into video and other communications
Needs:
Review of messaging by work groups
Access to patient/client stories
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Healthy Aging Work Group Report
Current FY 2017 Action item (s) and purpose:
Develop recommendations for future planning among aging populations and their caregivers (Healthy Aging White Paper).
Identify key areas and evidenced based practices for promoting personal planning for the future for the aging population and their caregivers.
Develop resource referral tool (s) and a planning for the future checklist
Provide resource tool(s) for the aging population and their caregivers to aide in identifying areas of importance while planning for the future and provide referral to key connector resources.
Establish educational sessions on future planning topics in collaboration with the Commission on Aging, Office on Aging and Independence and other collaborating partners.
Offer community education in partnership with, and consistent with, HCLHIC member initiatives that promote strategies for future planning.
Develop the 2018-2020 Healthy Aging Action Plan.
Expected Outcomes:
Quick reference resource referral tool, website resource, and planning for the future checklist developed and provided to HCLHIC members
Planning for the Future educational session held in May.
Needs:
Promotion of educational events and utilization of resource tool and planning checklist as appropriate
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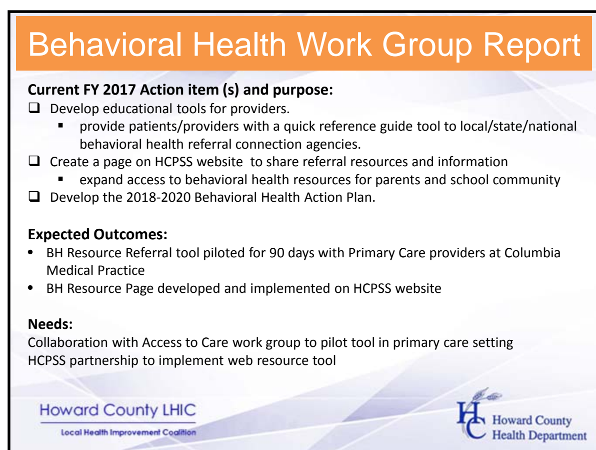
Behavioral Health Work Group Report
Current FY 2017 Action item (s) and purpose:
Develop educational tools for providers.
provide patients/providers with a quick reference guide tool to local/state/national behavioral health referral connection agencies.
Create a page on HCPSS website to share referral resources and information
expand access to behavioral health resources for parents and school community
Develop the 2018-2020 Behavioral Health Action Plan.
Expected Outcomes:
BH Resource Referral tool piloted for 90 days with Primary Care providers at Columbia Medical Practice
BH Resource Page developed and implemented on HCPSS website
Needs:
Collaboration with Access to Care work group to pilot tool in primary care setting
HCPSS partnership to implement web resource tool
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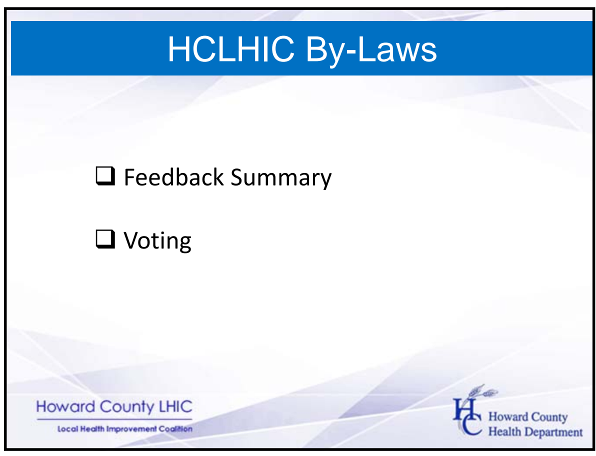
HCLHIC By-Laws
Feedback Summary
Voting
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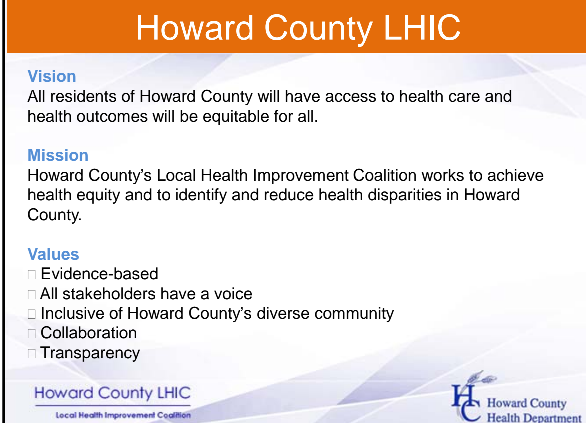
Howard County LHIC
Vision
All residents of Howard County will have access to health care and health outcomes will be equitable for all.
Mission
Howard County's Local Health Improvement Coalition works to achieve health equity and to identify and reduce health disparities in Howard County.
Values
Evidence-based
All stakeholders have a voice
Inclusive of Howard County's diverse community
Collaboration
Transparency
Howard County LHIC
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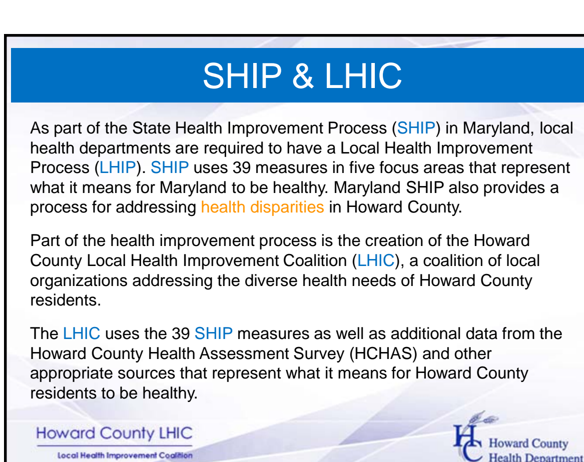
SHIP & LHIC
As part of the State Health Improvement Process (SHIP) in Maryland, local health departments are required to have a Local Health Improvement Process (LHIP). SHIP uses 39 measures in five focus areas that represent what it means for Maryland to be healthy. Maryland SHIP also provides a process for addressing health disparities in Howard County.
Part of the health improvement process is the creation of the Howard County Local Health Improvement Coalition (LHIC), a coalition of local organizations addressing the diverse health needs of Howard County residents.
The LHIC uses the 39 SHIP measures as well as additional data from the Howard County Health Assessment Survey (HCHAS) and other appropriate sources that represent what it means for Howard County residents to be healthy.
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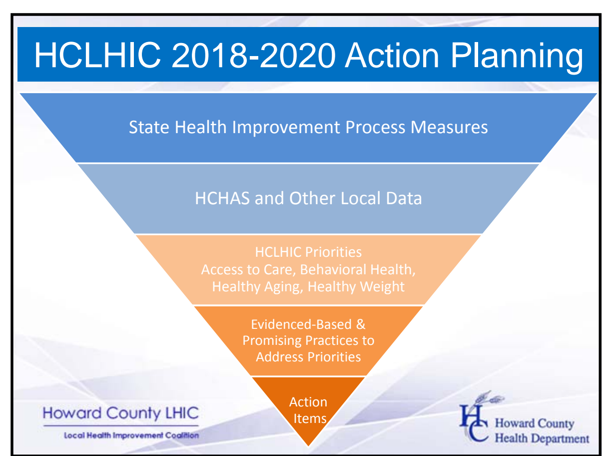
HCLHIC 2018-2020 Action Planning
State Health Improvement Process Measures
HCHAS and Other Local Data
HCLHIC Priorities
Access to Care, Behavioral Health, Healthy Aging, Healthy Weight
Evidenced-Based & Promising Practices to Address Priorities
Action Items
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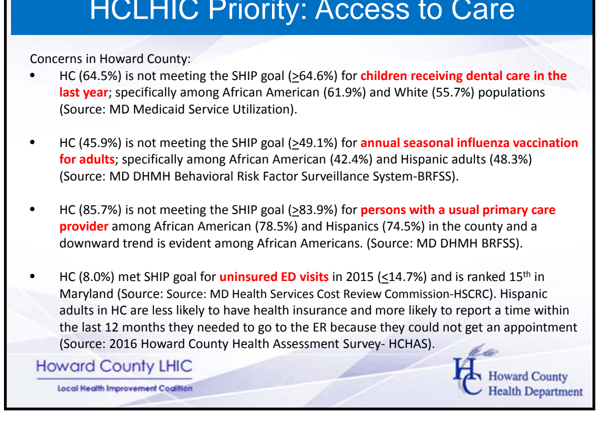
HCLHIC Priority: Access to Care
Concerns in Howard County:
HC (64.5%) is not meeting the SHIP goal (≥64.6%) for children receiving dental care in the last year; specifically among African American (61.9%) and White (55.7%) populations (Source: MD Medicaid Service Utilization).
HC (45.9%) is not meeting the SHIP goal (≥49.1%) for annual seasonal influenza vaccination for adults; specifically among African American (42.4%) and Hispanic adults (48.3%) (Source: MD DHMH Behavioral Risk Factor Surveillance System-BRFSS).
HC (85.7%) is not meeting the SHIP goal (≥83.9%) for persons with a usual primary care provider among African American (78.5%) and Hispanics (74.5%) in the county and a downward trend is evident among African Americans. (Source: MD DHMH BRFSS).
HC (8.0%) met SHIP goal for uninsured ED visits in 2015 (≤14.7%) and is ranked 15th in Maryland (Source: Source: MD Health Services Cost Review Commission-HSCRC). Hispanic adults in HC are less likely to have health insurance and more likely to report a time within the last 12 months they needed to go to the ER because they could not get an appointment (Source: 2016 Howard County Health Assessment Survey- HCHAS).
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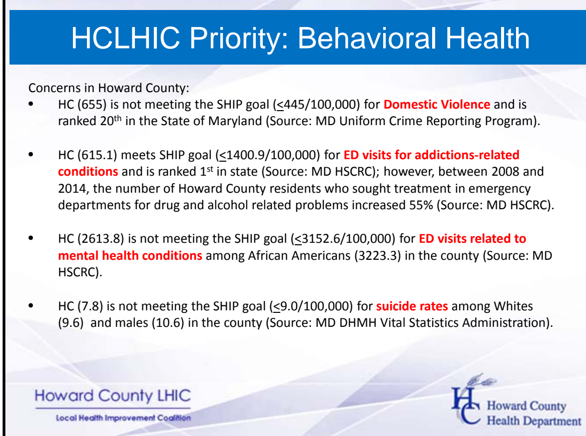
How is the concern being addressed? Best Practices

Dental Care in Children	Seasonal Influenza Vaccinations	Adults with a usual Primary Care Provider	Uninsured ED visits
Collaboration with Maternal Child Health Programs	Increase community demand (client reminders and recall systems, manual outreach and tracking, client or community-wide education, client incentives, etc.)	Broaden Access to Primary Care Services (Medical Health Homes; Alternative Primary Care Sites)	Case Management-CHWs; Patient Navigators
School-Based Dental Sealant Programs	Enhance access to vaccination services (expanded access in healthcare settings, home visits, and reduced client out-of-pocket costs).	Deliver primary care and preventive services to individuals where they live	Individualized Care Planning (especially targeting "super-users" and behavioral health)
Culturally competent and linguistically appropriate oral health education	Engage vaccination providers (e.g. provider assessment and feedback, provider education, and provider reminder systems).	Increase use of primary care resources through shared medical appointments	Information Sharing



How is the concern being addressed? Best Practices

Domestic Violence	ED Visits for Addictions-Related Conditions	ED Visits Related to Mental Health Conditions	Suicide Rate
Increase domestic violence service providers' access to information on effective interventions to better serve victims of domestic violence and their children.	Explore effective programs for older adults that address mental health and/or addiction issues.	Psychiatry consultations live or via telemedicine.	Build community receptivity, capacity, and competence to implement evidence-based approaches to the prevention of suicidal behavior.
Engaging men and boys in violence prevention	Ensure handling of individuals with drug-seeking behavior in the ED includes the use of prescription drug monitoring programs.	ED psychiatric case management.	Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
Encouraging bystander intervention	Review opioid alternatives to pain management; and safeguard prescription opioids against diversion.	Develop statewide patient dashboards. To help EDs match boarded patients to available inpatient beds more quickly.	Develop collaborations between ED and others to provide alternatives to ED care and hospitalization when appropriate, and promote rapid follow-up after discharge.

Behavioral Health Work Group 2018-2020 Action Planning

2018-2020 Planning Team:

- HCLHIC Staff
  - Kelly Kesler
  - HCLHIC Coordinator
- Delegates
  - Beverly Francis-Gibson
  - Roe Rodgers-Bonacorsy
- Work Group Representatives
  - Lisa Cooper-Lucas- Delta Sigma Theta Sorority, Inc.
  - Joan Webb-Scornaienchi- HC Drug Free
  - Debra Dunn- Chase Brexton

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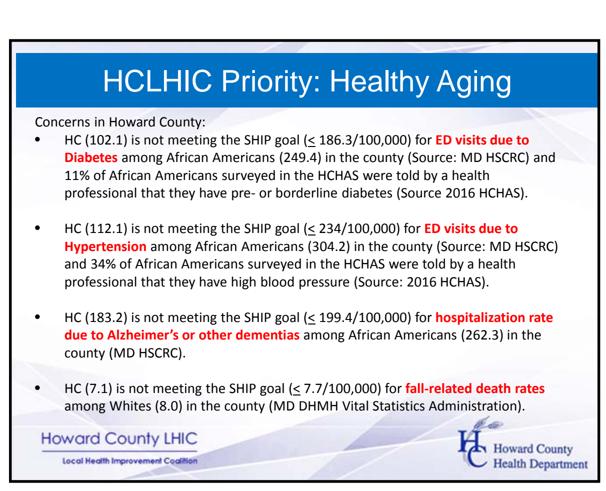

How is the concern being addressed? Best Practices

ED Visit Rate Due to Diabetes	ED Visit Rate Due to Hypertension	Hospitalization Rate Due to Alzheimer's or Other Dementias	Fall-Related Death Rate
Implement diabetes self-management education (DSME) interventions implemented in community gathering places.	Promote self-measured blood pressure monitoring interventions combined with additional support such as patient counseling, education, or web-based support.	Ensure availability of high-quality, culturally responsive information for those diagnosed with dementia and their caregivers.	Support and stimulate the implementation, dissemination, and sustainability of evidence-based falls prevention programs for older adults and adults with disabilities.
Engage CHWs in diabetes prevention in underserved communities.	Implement team-based care to improve the proportion of patients with controlled blood pressure.	Implement a range of effective caregiver support strategies to better address the multiple needs of informal caregivers.	Implement a multifactorial falls risk assessment and management program for those with a history of falls.
Implement combined diet and physical activity promotion programs for people at increased risk of type 2 diabetes.	Engage CHWs to prevent (CVD) such as education, outreach, enrollment, and acting as information agents to increase self-reported health behaviors.	Improve public and professional awareness and understanding of dementia.	Implement exercise programs targeted to a general population of older adults.

Healthy Aging 2018-2020 Action Planning

2018-2020 Planning Team:

- HCLHIC Staff
  - Kelly Kesler
  - Rhonda Jenkins
- Delegates
  - Courtney Barkley
  - Renee Bitner
- Work Group Representatives
  - Bruce Fulton- Neighbor Ride
  - Peggy Hoffman- Howard County Office on Aging and Independence
  - Sharonlee Vogel- Howard County Commission on Aging

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HCLHIC Priority: Healthy Weight

Concerns in Howard County:

- HC (50.7%) is barely meeting the SHIP goal (> 50.4%) for **increasing physical activity** and is not meeting the SHIP goal among Hispanics (31.1%) and females (46.7%) in the county. HC is ranked 8th in Maryland for this SHIP measure (Source: MD BRFSS).
- HC (7.5%) is not meeting the SHIP goal (<10.7%) for **adolescents who have obesity** among African Americans (12.5%) in the county and barely met the goal for males (10.5%). The number of adolescents who have obesity is trending upward (up from 5.9% in 2013) (Source: MD BRFSS).
- HC (36.7%) is not meeting the SHIP goal (> 36.6%) for **adults who are not overweight or obese** among African Americans (15.8%) in the county (Source: MD BRFSS) and 32% of all those surveyed in the HCHAS were advised by a doctor in the last 5 years to lose weight (Source: 2016 HCHAS).
- HC (35.8) is not meeting the SHIP goal (< 62.5/100,000) for **ED visit rate due to Asthma** among African Americans (86.5) in the county (Source: MD HSCRC) and 20% of those surveyed in the HCHAS had a child in the household had asthma (2016 HCHAS).

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How is the concern being addressed? Best Practices

Increase Physical Activity	Children and Adolescents who are Obese	Adults who are a Healthy Weight	ED Visits Due to Asthma
Utilize Point-of-decision prompts to encourage remind people who want to become more active about an immediate opportunity to do so.	Promote behavioral interventions to reduce recreational sedentary screen time among children aged 13 years and younger.	Implement technology-supported coaching or counseling to help clients lose weight and/or maintain weight loss.	Implement community asthma initiatives to improve health outcomes and reduce disparities among children with asthma
Support and implement design and land use policies and practices that support physical activity to increase physical activity.	Implement childcare food and beverage policies and environments	Implement worksite programs to improve diet or physical activity and reduce weight among employees.	ED-directed educational interventions (targeting either adult patients or providers) as effective strategies to increase office follow-up visits with a primary care provider after asthma exacerbations.
Engage social support interventions in community settings to increase physical activity and improve physical fitness among adults.	Create of or enhanc access to places for physical activity combined with informational outreach activities	Refer obese patients to programs that offer intensive counseling and behavioral interventions for optimal weight loss.	Increase patient and clinician adherence to the National Asthma Education and Prevention Program guidelines.

Healthy Weight 2018-2020 Action Planning

2018-2020 Planning Team:

- HCLHIC Staff
  - Kelly Kesler
  - Rhonda Jenkins
- Delegates
  - Barbara Wasserman
  - Kayla Kavoukas
- Work Group Representatives
  - Alexandra York- Maryland University of Integrative Health
  - Shawni Paraska- Columbia Association
  - Mike Senisi- HCPSS

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