



BRIDGING HEALTH EQUITY

Maryland's Two Generation Approach

December 7, 2017

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The 2-Generation Approach Strives to Harness the Family's Full Potential



Policies and programs address the needs of children and parents separately and track child and adults independently



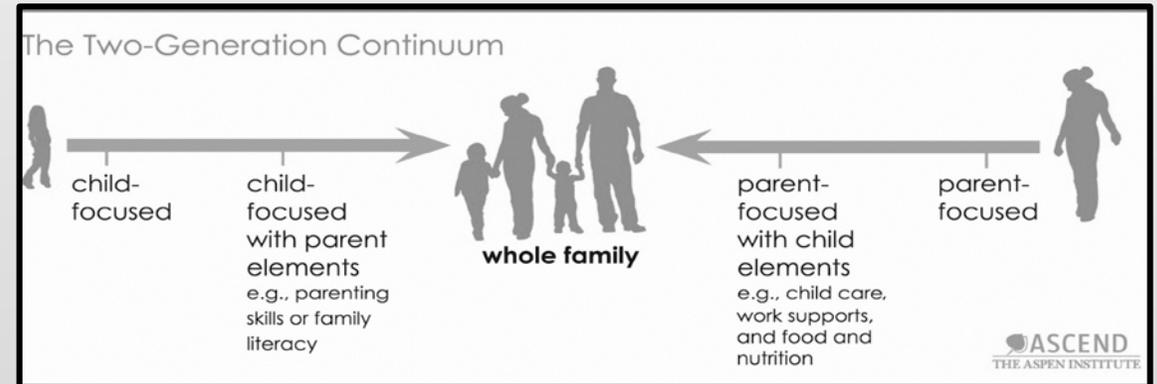
Policies and programs that address the needs of *children and their parents together* can harness the family's full potential and put the *entire family* on a path to permanent economic security.

Research shows that:

- the impact of a parent's education level and economic stability on the overall health of children
- children's education and healthy development are powerful catalysts for parents

2 Gen is a Whole Family Approach

- Whole-family approaches focus equally on services and opportunities for the parent and the child.
- Two-generation approaches track outcomes for both the parent and the child/youth.
- Programs/strategies need to break through the silos of fragmented policies in order to harness a family's full potential and put the entire family on a path to economic security.



2 Gen: Changing How We Do Business

- It is an approach not a program
- It is taking the burden of coordination off of parents and putting it on programs, systems, and policies.
- It is braiding existing early child and family support funding into 2G frame.
- It is building and sustaining processes that focus on staff relationships with families and on outcomes

2 Gen Frame

Focus on providing access to supports and services for both generations simultaneously.

- Postsecondary education
- Workforce development
- Family asset building
- Income supports for parents
- Education and developmental supports for children
- Health and mental health for children and adults
- Encouraging social capital



Maryland's Two Generation Commission

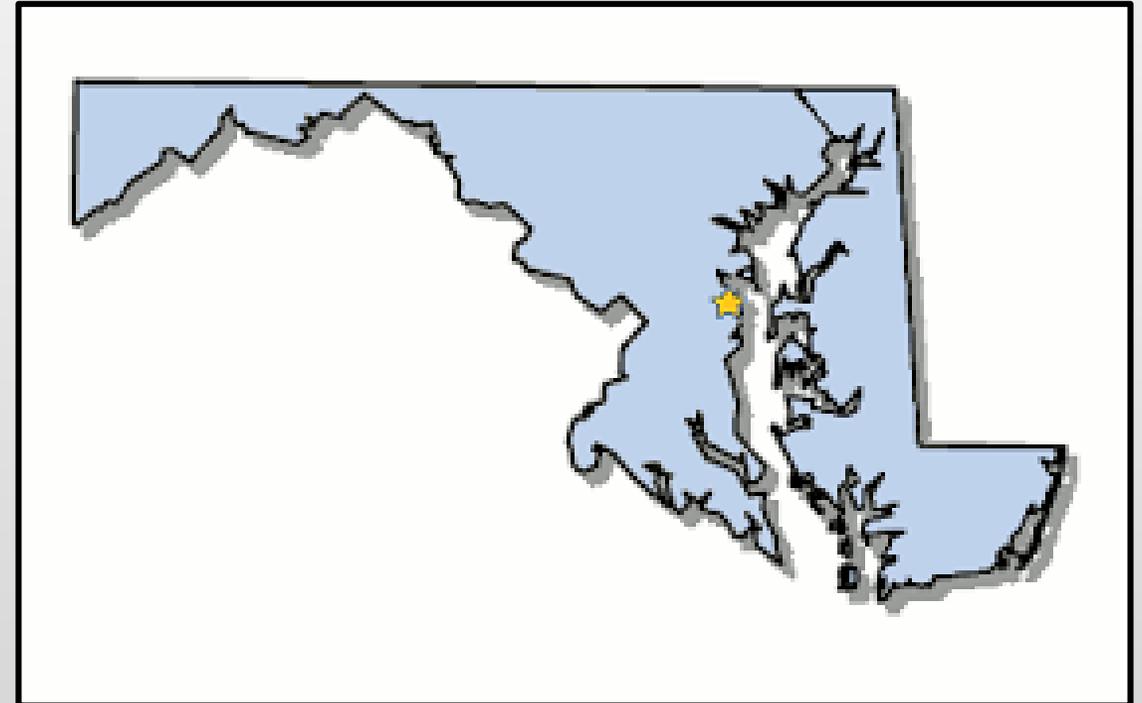
- On March 9, 2017, Governor Hogan announced the Two Generation Family Economic Security Commission (Executive Order 01.01.2017.03).
- The goal is to mitigate multigenerational poverty in Maryland.
- The Commission will
 - ✓ identify what current State services and policies can be utilized in a multigenerational approach that addresses the needs of both parents and children in low-income families.
 - ✓ develop recommendations on how the state can link programs and services that create opportunities for both parents and children, particularly in the areas of education, economic stability, and family engagement.
 - ✓ help influence what indicators are vital in identifying trends and opportunities for interventions to assist families at the earliest points possible.

Maryland Children's Cabinet

- Believes that supporting 2 gen approaches that focus on creating opportunities for and addressing the needs of both vulnerable children/youth and their parents together is a unique opportunity to advance child and family well-being.
- Seeks to establish and expand 2 gen approaches and encourages the Boards to align services across multiple organizations to provide coordinated services to children and parents together.
- Provides funding, training and technical assistance to Local Management Boards for 2 gen approaches in local jurisdictions.

Maryland's 2 Gen Momentum

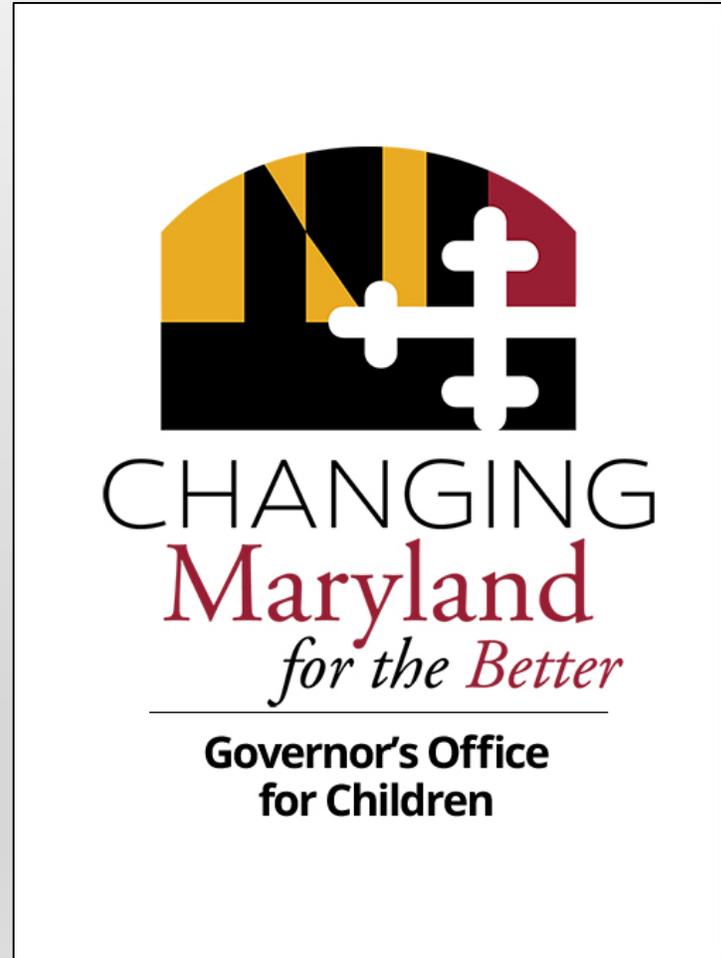
- ✓ **Two-Generation Family Economic Security Commission**
- ✓ **MD THINK**
- ✓ **Howard CAC, Allegany HRDC, GCCAC**
- ✓ **Departments of Human Resources and Labor and Licensing initiatives**
- ✓ **Children's Cabinet support of Local Management Board community initiatives**
- ✓ **Innovate+Educate/NAWB Grant to Montgomery County**



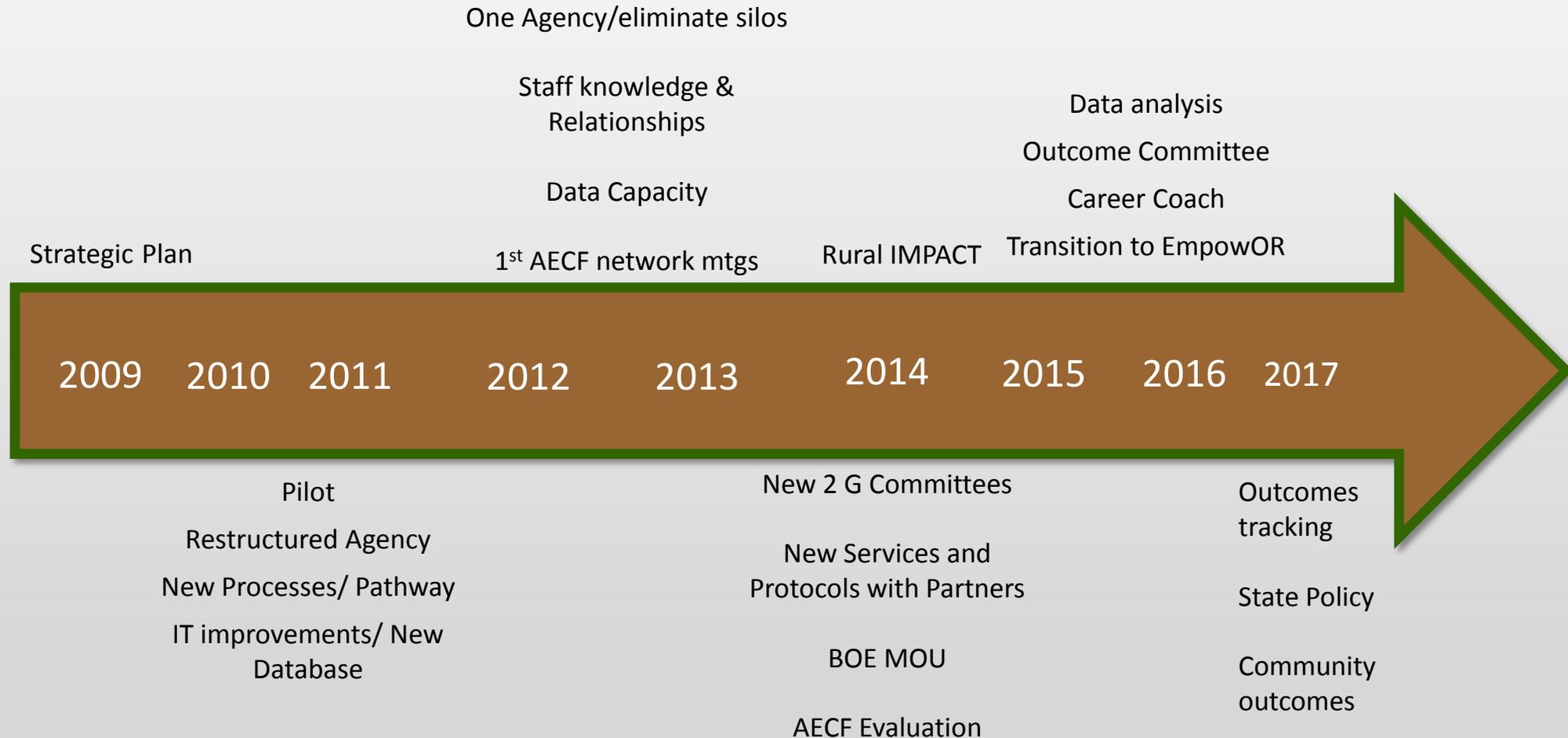
For more information about State activities:

- www.goc.state.Maryland.gov
- @marylandGOC
- www.governor.maryland.gov/ltgovernor/to-generation-commission

Poverty must not be the legacy that's handed down from generation to generation, or accepted as a way of existence.



Implementing 2G in Garrett



2G Frame

Parent centered:

- Occupational training
- Post-secondary education
- Adult Basic Education / GED
- Economic Supports
- Financial coaching
- Parenting skills
- Home visiting
- Health & Well-Being



Child centered:

- Early Head Start / Head Start
- High-quality child care
- Home visiting
- Health & Well-Being
- Developmental screenings
- School Supports

Intentionally Linked Services in Garrett

Implementing 2G



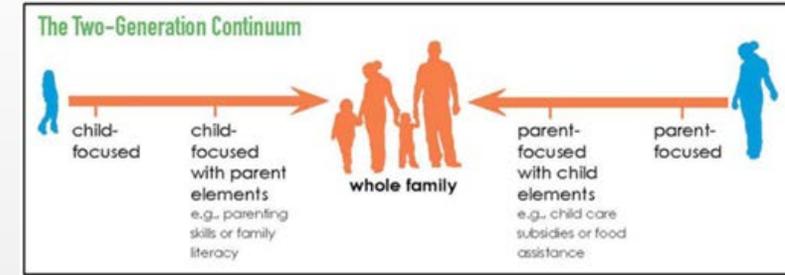
Pre-2011 GCCAC Service Delivery Model

Organizational and staffing structural changes

- ❑ **Departments organized around outcomes and strategic objectives rather than program contents.**
 - Stabilization services
 - Asset Development
 - Aging and Nutrition
 - Early Education and Family Development
 - Community and Economic Development
 - Transportation
- ❑ **Staffing Structure – Organize staff around elements leading to greater economic security and independence**
 - Position descriptions changed to reflect new GCCAC functions rather than departments or programs.
 - Went from over 80 position descriptions to 12.
 - Coordinators, contents specialists, managers, directors, support positions,
- ❑ **Supporting Staff**
 - Interdepartmental crises team
 - Regular Coordinators meetings
 - Self Sufficiency Manager position



GCCAC's 2G Model today



- How do families learn about
 - Any door/program/service/one intake
 - Presumptive eligibility
 - Bundling services that support family with their pathway plan
- From Intake to assessment to pathway plan
 - All families make an assessment of where they are using a crises to thrive scale
 - All are invited to complete an electronic pathway plan to identify goals, action steps and timelines.
 - Frontline staff transitioned from case management to coaching
- How do we coordinate contact with families
 - Based on assessment and pathway plan, families are automatically linked to supporting services via appointments or interviews
 - Any time any a service is provided or coordinator makes contact with a family, progress on the assessment and pathway plan in the data base is updated and reviewed by the family.
 - Outcomes are defined, tracked and shared with families

Crisis to Thrive Scale

Crisis to Thriving Scale: Short Form					Revised 8/14/14
5 Primary Domains					
CRISIS	VULNERABLE	SAFE	STABLE	THRIVING	
Food & Nutrition					
1. Has less than a day of food and limited ability/means to prepare or cook food	3. Consistently unable to meet basic food needs; often didn't have enough food to eat in the past 3 months	5. Eligible for partial food stamps or subsidies but not receiving them	7. Receives occasional food assistance (brown bag, commodities); not eligible for food stamps	9. Can choose to shop at store of choice, never reduces meal size or skips meals b/c of money, and sometimes has money to eat out.	
2. Has less than a day of food available and no money to purchase more	4. Without food stamps or other food subsidies, would often not have enough food to eat	6. Receives partial food stamps or subsidies to meet basic food needs	8. Can meet all basic food needs (does not skip or reduce meals b/c of lack of money) without assistance; but no extras and very little/no eating out	10. Can shop at store of choice and purchase any food items desired	
Housing					
1. Literally homeless	3. Legal threat of eviction (5-day notice, writ) or immediate foreclosure	5. Receiving temporary rent/mortgage subsidy (or has received within the last 3 months)	7. In stable housing (rent or own) that is not affordable (> 40% on housing costs)	9. Household is in safe, affordable, unsubsidized rental housing of choice	
2. In an emergency shelter or hotel	4. Transitional housing OR staying with others OR foreclosure notice	6. In stable subsidized housing	8. Household is in safe, affordable, unsubsidized housing	10. Household is in safe, affordable, home they own	
Childcare (all children in household--if childcare not available for one child or not affordable for even one of the children then answer accordingly)					
1. Childcare not available for all children in the household	3. Childcare available in unlicensed facility	5. Subsidized, safe childcare is available but not satisfied with it	7. Safe, affordable, unsubsidized childcare available but not satisfied with it	9. Safe, reliable care from family or friends and satisfied with it	
2. Childcare available but can not afford it	4. Childcare is unreliable (unreliable family or friends)	6. Subsidized, safe childcare (not including quality early childhood education like head start) available and satisfied	8. Safe, affordable, unsubsidized childcare available & satisfied with it	10. Safe quality care that includes early childhood education from licensed facility is available and affordable (including HeadStart, Early Headstart, Center based)	
Transportation (answer from perspective of household)					
1. No means of transportation and public transport not available when needed	3. Relies exclusively on transportation from friends or family	5. Has a single unreliable vehicle or vehicle(s) that needs minor repairs to run	7. Vehicle is reliable but older or unaffordable and there is no alternative	9. Has at least one reliable and affordable vehicle and back up transportation	
2. Own an inoperable vehicle and no funds to fix it	4. Has a vehicle but no insurance and/or no license	6. Has two (or more vehicles) but all vehicles are unreliable	8. No alternative transportation if primary source is unavailable.	10. Has sufficient number of reliable and affordable vehicles for family	
Financial \$ Management					
1. Not able to pay bills or past due debts	3. Paying all current bills, not paying past due debts	5. Paying current bills; paying minimum on debt	7. Paying all current bills, paying off debts most months and not saving regularly	9. Always paying all current bills and debts, NOT saving regularly	
2. Paying some bills but late/not paying others		6. Paying all current bills, following plan to pay off debts	8. Paying all current bills, paying off debts most months, saving regularly	10. Always paying all current bills and debts, and saving regularly	

Family self assessment Dimensions

- Food/nutrition
- Housing
- Childcare
- Transportation
- Financial management
- Credit
- Child Dev.
- Education/job skills
- Employment
- Health
- Energy
- Assets
- Community involvement
- Social capital
- Family

Family wellness assessment tool

Crisis to Thriving Scale: Long Form

7 Additional Domains

CRISIS	VULNERABLE	SAFE	STABLE	THRIVING
Credit Building				
1 No reasonable credit	3 No credit history	5 Have secured credit card	7 Loan on own or regular credit card with \$500 limit	9 Credit report is excellent
2 Unable to get credit from bank or credit card w/o a co-signer	4 Very limited credit history (i.e. particular store)	6 Loan paid on with co-signer or credit problems	8 Credit report is good	
Child & Youth Development				
1 Child w/ identified behavioral or developmental issues not receiving assistance	3 Child with developmental/behavioral needs receiving assistance			
2 Child not attending school or other socialization regularly	4 Child failing multiple classes or more than one child failing any classes	6 Child is failing a class	8 All children passing all courses	10 All children with GPA of 2.5 or better & or proficient
Child Development - Head Start Participant				
1 Child has identified behavioral or developmental issues not receiving assistance	3 Child with developmental/behavioral needs receiving assistance	5 Child in Head Start with proficiency of "Not Yet"	7 Child in Head Start with proficiency of "In Process"	9 Head start child with proficiency of "Proficient"
Education/Job Skills				
1 Less than 8th grade education--no GED--&/or limited reading/writing ability	3 Completed some high school--no GED	5 High school graduate or GED	7 Completed associate's degree, vocational training or certification program	9 Bachelor's Degree or high level vocational licensing (i.e. master plumber, electrician, Microsoft certified developer, etc.)
2 Less than 8th grade education--no GED	4 Seeking GED &/or in vocational training	6 Currently attending college or a certification program		10 Advanced degree or completed college and has specialized certification or employed in field of study
Energy				
1 One or more utilities shut off	3 Door hanger or shut-off imminent	5 Utility bills past due	7 Utility bills current, receives energy assistance	9 Utilities current, no energy assistance & seeking energy saving improvements
2 Home unsafe	4 Disconnect notice or needs utility deposit to connect utilities in new residence	6 Utility bills are current with history of late payments or shutoffs	8 Utilities current, receives energy assistance & seeking energy saving improvements	10 Utilities current, no history late payments, completed energy saving improvements
Family Development/Parent Engagement				
1 Abusive relationships, child domestic violence, child abuse/neglect	3 Poor parenting/relationship skills--unaware of negative family dynamics	5 Parents respond to requests for info occasionally but don't attend meetings or events	7 Parents and children engage in activities together regularly	9 Parents volunteer in child related activities and family engages in activities together
2 Little family, friends, church or community support--socially isolated	4 Marginal parenting/relationship skills (parents do not respond to requests); separated from abuser (if relevant)	6 Parents attend teacher conferences and/or other child events; little entire family interaction	8 Regular full family activities and parental relationship good	10 Good parenting/relationship skills; parents and children engaged in community/volunteer activities
Financial Education				
1 Not able to pay bills or past due debts	3 Paying all current bills, not paying past due debts	5 Paying current bills; paying minimum on debt	7 Paying all current bills, paying off debts most months and saving monthly	9 Always paying all current bills and debts, saving monthly
2 Paying some bills but late/not paying others		6 Paying all current bills, following plan to pay off debts		

Example of Child Development and Youth Development Assessment

Crises

- Child has identified behavior developmental issues and not receiving assistance (1)
- Child not attending school or other socialization. (1)

Vulnerable

- Child with developmental needs receiving assistance (3)
- Child failing multiple classes or more than one child failing any class (3)
- Seeking GED/vocational credential(4)

Safe

- One child failing one class (6)
- Child in preschool with "not yet" assessment (5)

Stable

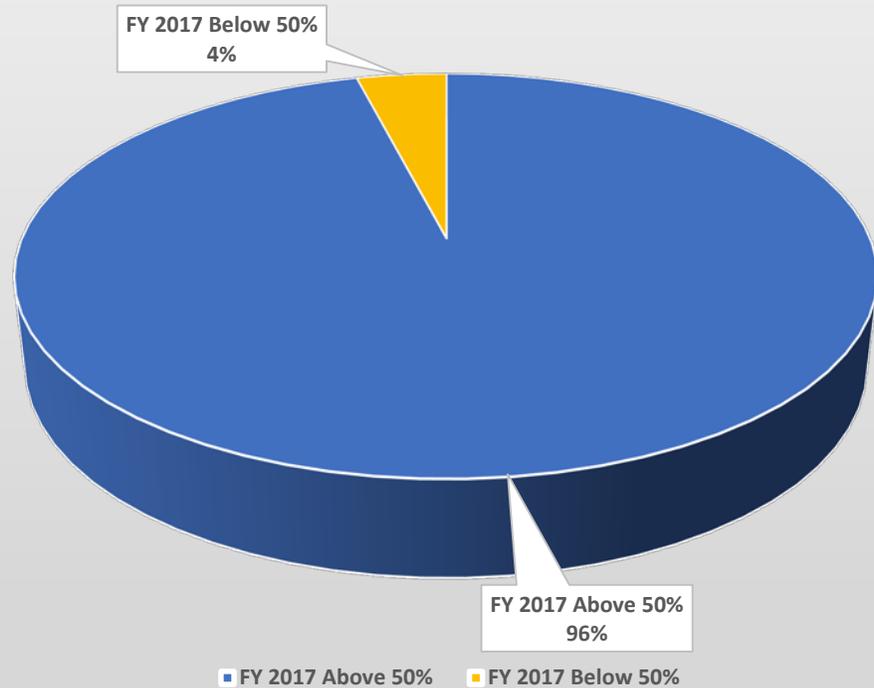
- All children passing all courses (8)
- Child in preschool has assessment of "in process" (7)

Thriving

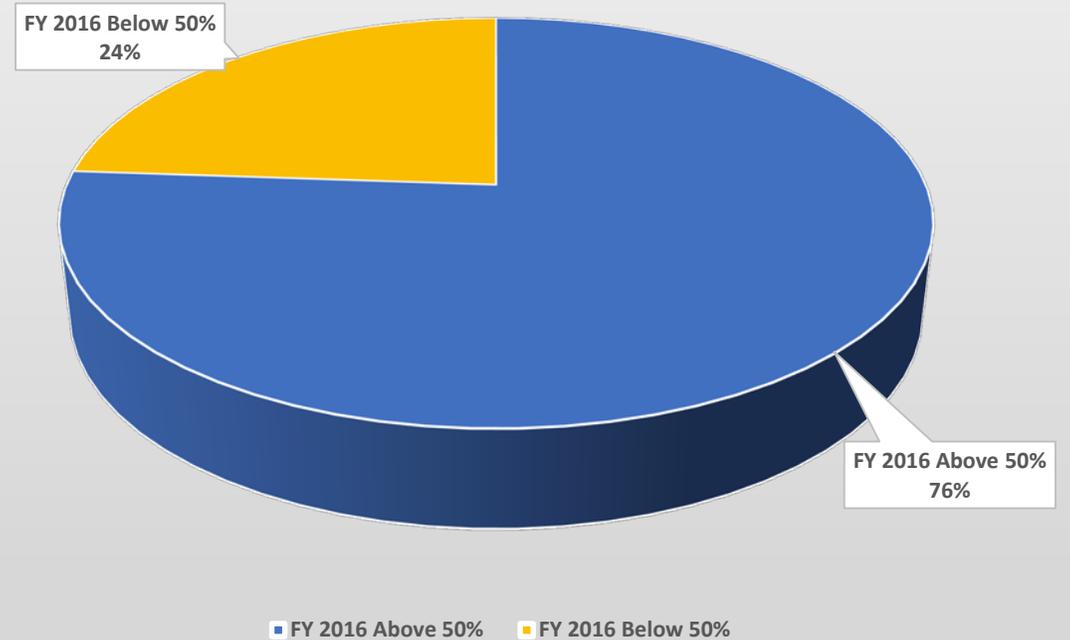
- All children with GPA of 2.5 or more (10)
- Proficient assessment for preschool children (9)

Comparing 2017 and 2015 2G family wellness scores

Family Wellness Scores FY 2017



Family Wellness Scores FY 2016



Pathway plans

- **Pathway Plan Formalizes Goals Determined by the Family**
 - Tool for bundling services that support family aspirations
 - Goals and actions based on assessment
 - Electronic form that tracks goal areas and progress

Pathway Plan for

Head of HH Last name: ██████████ First name: **Jasmine** Last 4 SSN: ██████

Plan Start Date: 1/17/2014 Plan End Date: 1/17/2015 (12 Months from start)

Is this an ABC Family Plan?
 Is this a E/HS Family Plan?
 Other Pathway Family?

Plan includes Crisis Action Steps Crisis Began: ██████████ Crisis Ended: ██████████

Current Lead Coordinator is: **Jill ██████████**

Who in your family, church, or friends can be your primary supporter/cheerleader as you work on this plan?
 Foster mother

Goal: Employment/Income Education Apply for job or promotion
 sending out application

Current Crisis to Thrive # on this Dimension: 3

Crisis to Thrive Explanation: unemployed has never worked before.

Action Step	Due Date	Who Completes (staff, client, family, friend, etc.)	Resources (what assets/community resources are available to help)	Complete
look for job postings	3/1/2014	Jasmine	news paper, job service, internet	<input checked="" type="checkbox"/>
send application	3/1/2014	Jasmine	businesses	<input checked="" type="checkbox"/>
plan for interview	3/1/2014	Jasmine	employer	<input checked="" type="checkbox"/>

Insert Action Step

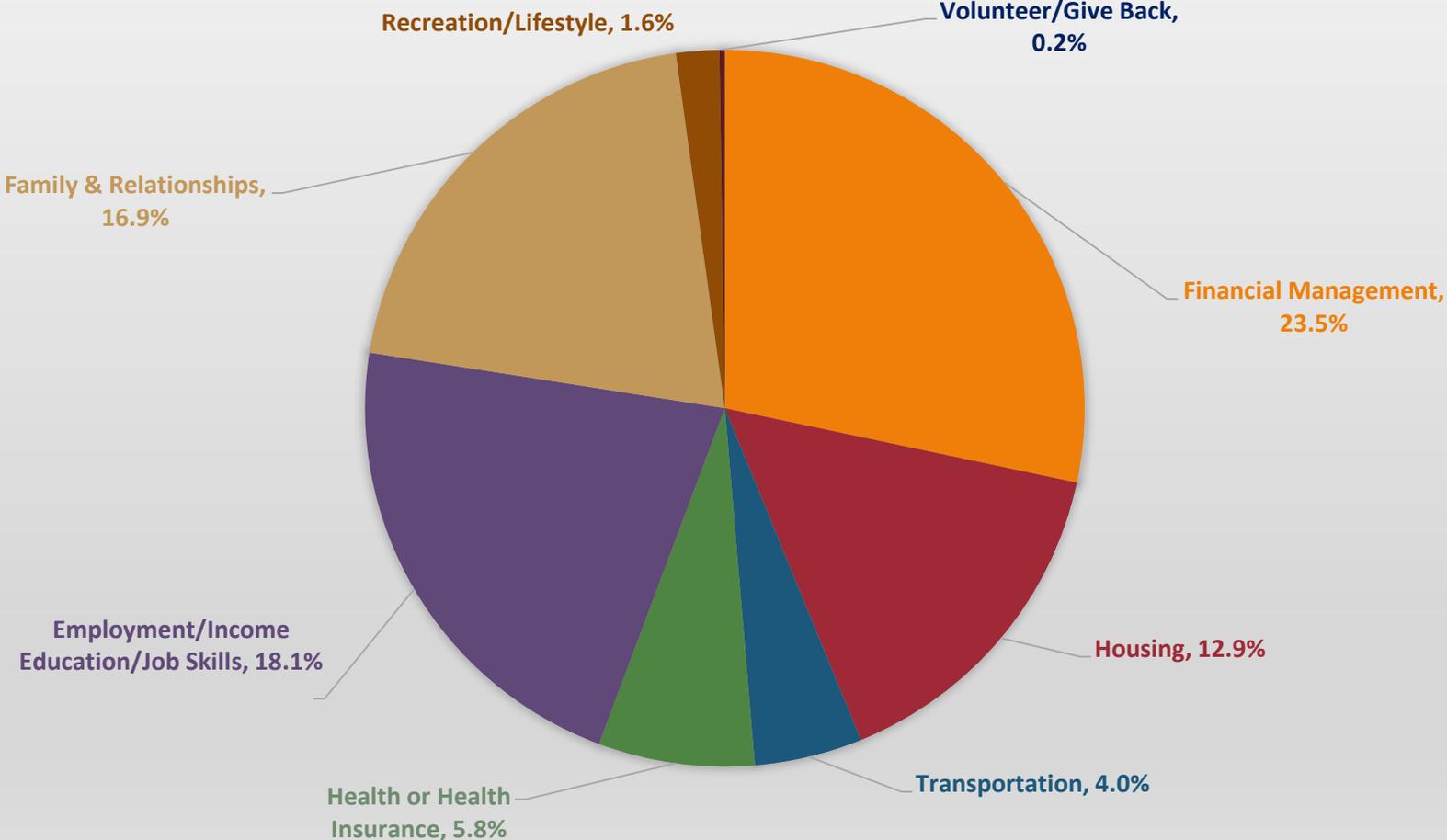
Date of Plan Review: 3/25/2014 Progress Rating: Goal has been met Defining new goal

Progress Description: Jasmine found part time work, but would still like full time employment and interested in taking the CNA class.

Crisis to thrive # on this dimension/ explanation: 7 working part time



2G family goal areas



Bundling GCCAC 2G families with support

	2015		2016
Utilized 1 Dept.	66%		42%
Utilized 2 Depts.	26%		37%
Utilized 3 Depts.	7%		18%
Utilized 4 Depts.	1%		3%
Utilized 5 Depts.			1%
Average #	1.7		3.2

Involved use of 25 separate programs with largest increase in Energy Assistance, VITA, financial education, homeless prevention and child care.



Information Systems

Data Quality Report for 7/1/2014 to 7/30/2014 Monday, July 28, 2014 Page 1

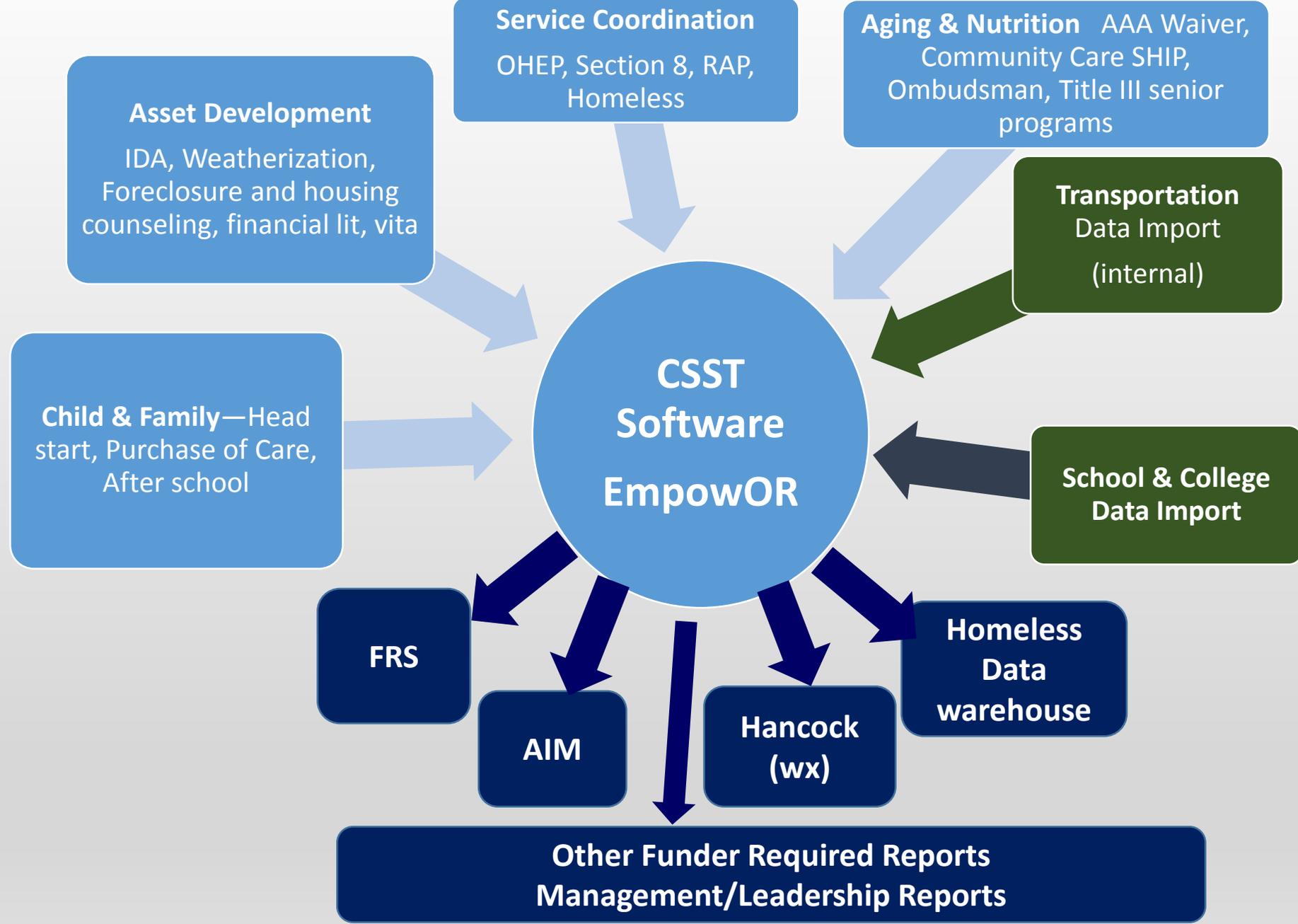
■ Has data
■ Data missing

Name	SSN	DOB	Region	Family Type	Address	City	State	Zip	County	Birth Date	Marital Status	Sex	Family Position	Race	Ethnicity	Disabled	Insured	Language	English Skill	Education Level	Housing Status	Housing Payment	Income	Family Head	US Residency	School or Job	
Gaither, Trudy, Staff, ID [5]	33																										
As, As	717/0007																										
As, As	1116/0211																										
As, Ga	1119/2010																										
As, Ga	114/1972																										
As, Wv	421/0204																										
As, Nc	727/1894																										
Co, Ai	410/2013																										
Co, Ha	430/0519																										
Co, Jh	45/2014																										
De, Le	513/2011																										
Ti, Jh	54/1985																										
Ho, Ry	83/2000																										
Le, Ill	415/2011																										
Le, Na	415/2011																										
Le, Sa	123/11907																										
Nc, Ca	228/1891																										
Nc, Ms	1114/1974																										

Count for Gaither, Trudy, Staff, ID [5] 33 2 missing data Gaither, Trudy, Staff, ID [5] 33 Total Client Count: 17

Information systems to support 2G work

- Create a single electronic point on entry for all or any combination of services from any GCCAC location.
- Create and use an agency wide input and output data base for identifying support provided and results achieved
- Measure and assess degree of economic security and independent living – Crises to Thriving Scale
- Creating systems to monitor family’s economic stability throughout the life course – linking information on children gathered by schools to information from Head Start, Early Head and Early Care Home Visiting providing an ongoing longitudinal measure using the Crisis to Thriving Scale
- Meet Needs of individual Funders

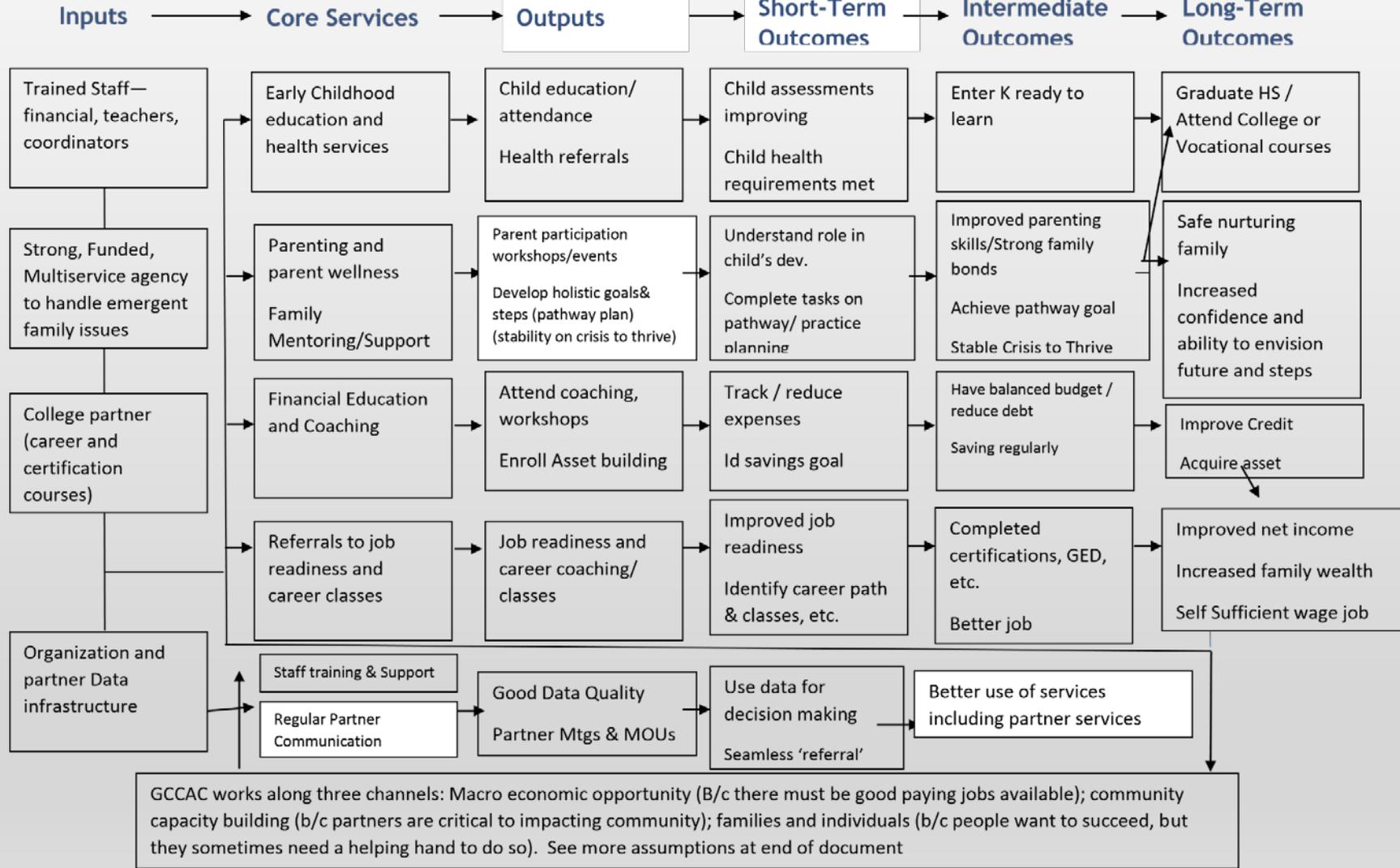


Goal: Low income families and children succeed now and thrive in the future

GCCAC Summary Logic Model*

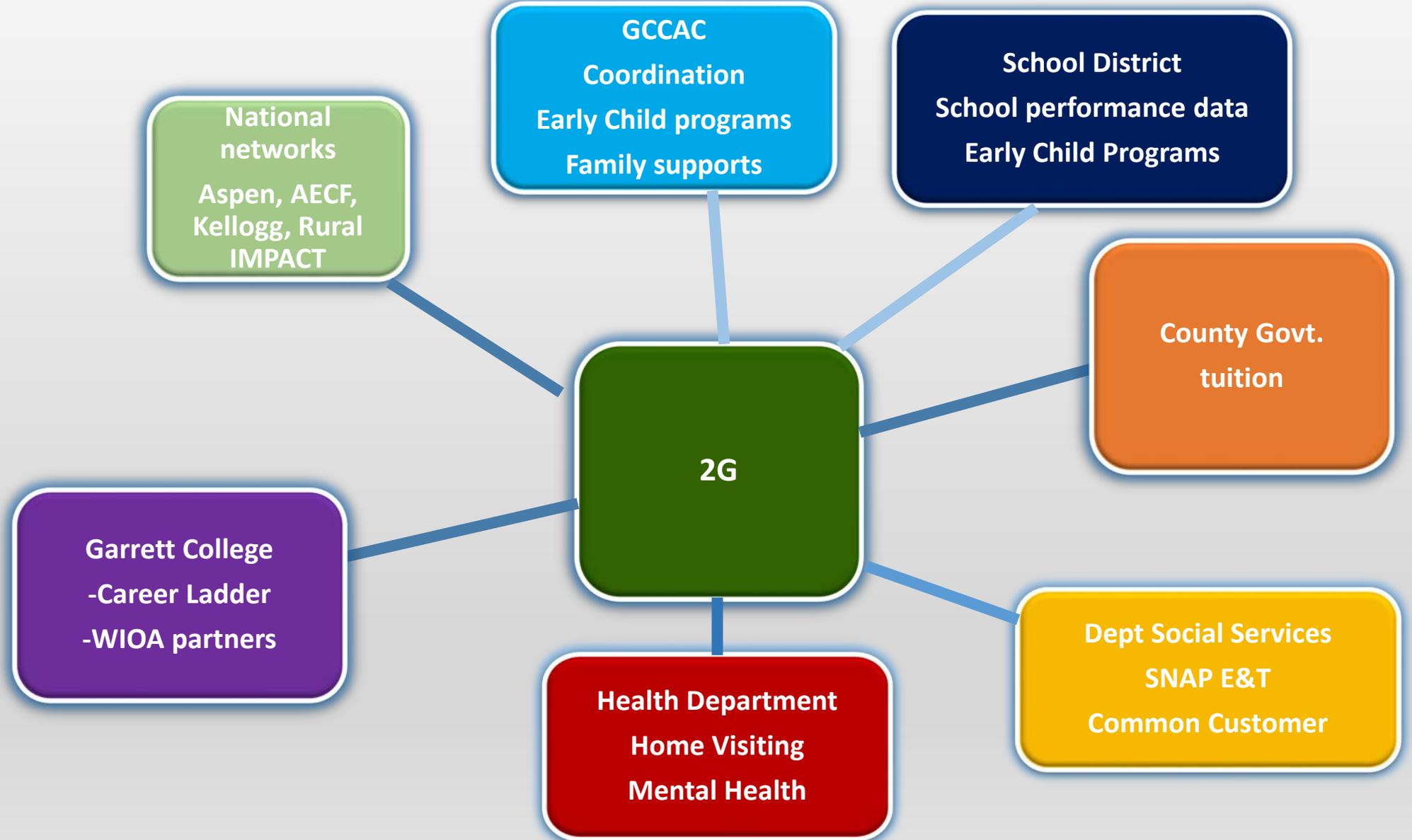
This summary model is intended as a concise diagram to be used as a higher level communication document, whereas the more detailed model following this is intended for evaluators and other interested in the specifics.

Target Population: Low income (under 130% poverty) families with children under age 5. HS/EHS Families



Theory of Change

2G Agencies and Partners



Braiding and Blending funds to support 2G

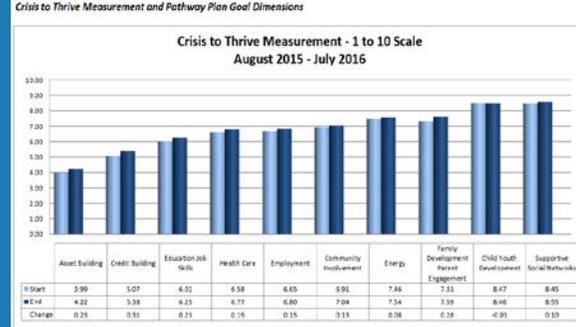
Paying Operations

- 23 Coordinators
 - *Intake, assessment, pathway plan, enrollment, services*
 - HUD (COC, Sec 8,
 - HHS (HS/EHS, LIEAP,
 - State (housing counseling, SLH, RAP)
- 5 Data quality and contract Mangers
 - *Data quality, contract reports, 2G tracking, program rules*
 - HUD, DOE, State, Foundations, HHS,
 - CSBG
- Content Specialists
 - *Specialized knowledge and training supporting 2G*
 - Usually paid by programs
- Data system
 - *One central system accessible to all sites, tracks outcomes and outputs*
 - Paid by program allocations and earned income
- Administration
 - Indirect, CSBG, Local Govt. Foundations

Paying family benefits

- Community partners
 - College tuition and occupational training
 - Health and well being
 - Career coach
 - Stabilization services
 - Home visiting
 - Early Child
- GCCAC
 - Early child and parenting skills
 - Stabilization services
 - Asset Building services
 - Gap filling
 - Coaching and coordination

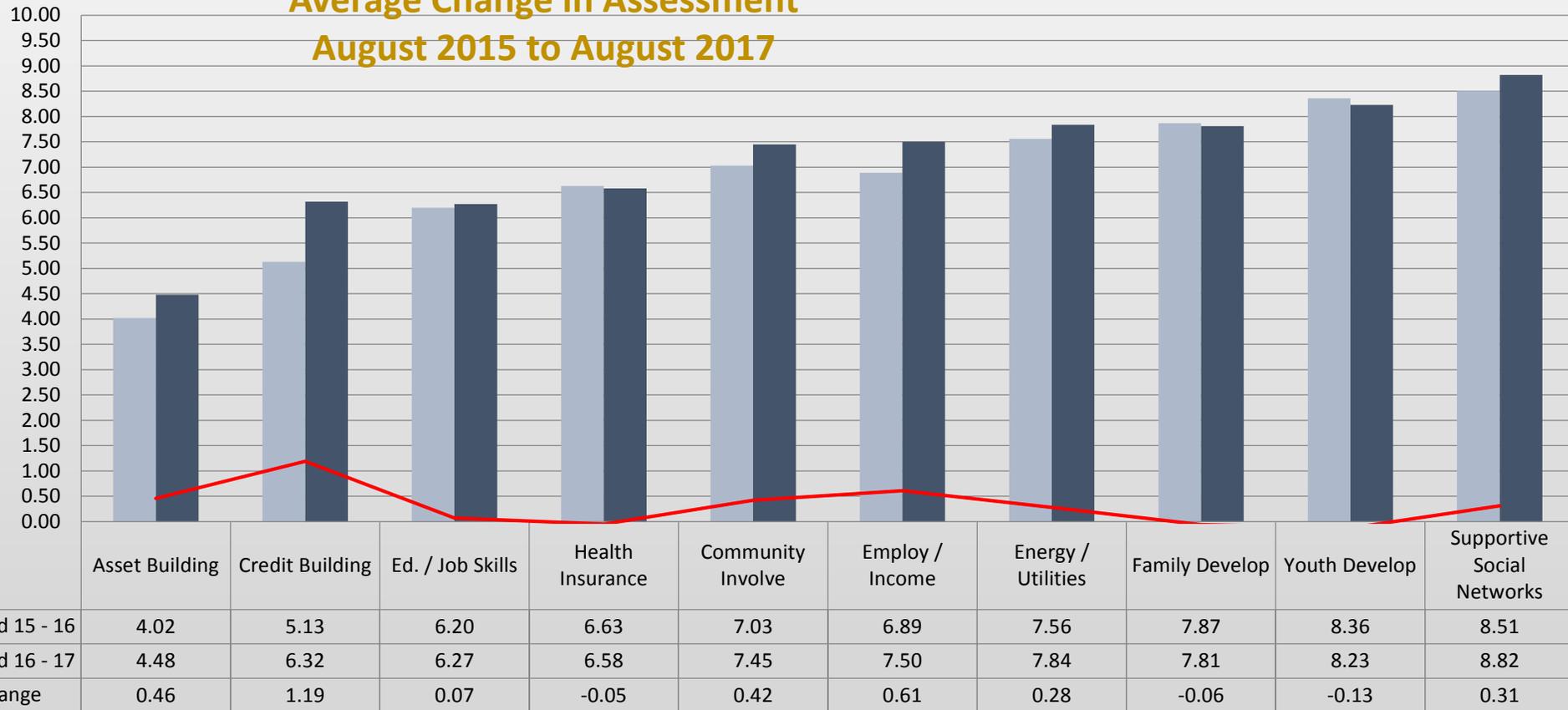
Preliminary GCCAC Outcomes



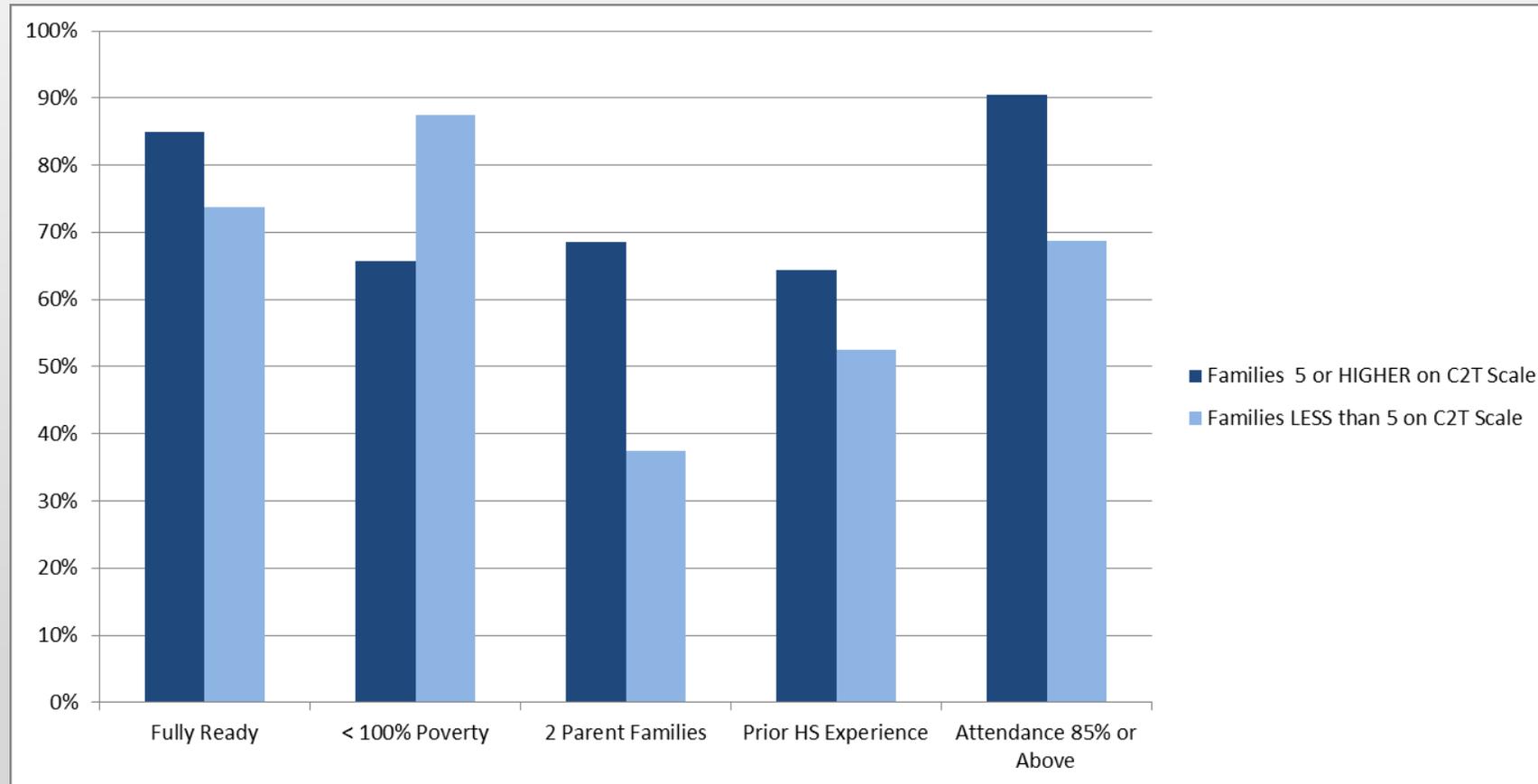
- Correlation between family interests and assessment
- Consistent pattern of improvement in all dimensions of family wellness assessment scale 2016
- Increased utilization of economic supports
- Reduction in number of repeat crises
- Net increase in number of households with incomes over 200% of poverty
- Correlation between family wellness and school readiness

Trends in Family Wellness Assessments for 2G Families

Average Change in Assessment August 2015 to August 2017



Correlating family wellness and early child progress



Using the *work sampling* school readiness assessment for all 2G children and the *Crises to Thrive* assessment scale in 2016.

How Have We Changed?

Case Management



Family Coaching

Program-Centric



Participant Focused

Referrals



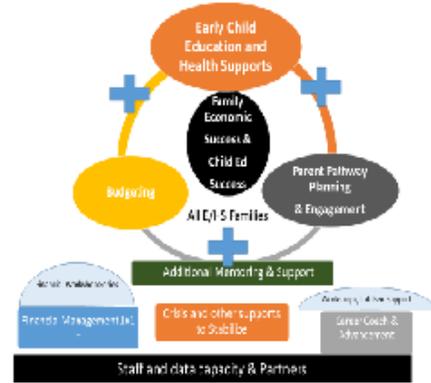
**Seamless Integration
Goal Achievement**

Head Counts



Outcomes

The 2-Generational Approach



Key DIFFERENTIATORS

- Focus on Family's perspective
- Coaching approach and cross coordination
- Pathway Plan Process and documentation acts as coordinating tool
- Joint meetings and focus on families both inside GCCAC and with partners
- On-going focus and discussions on the seamless integration
- Outcomes data and data review

Family Self-Assessment Tools & Pathway Planning

Operational Framework....

Focus activities on steps that lead to greater economic security/independence

Stabilize persons in crises

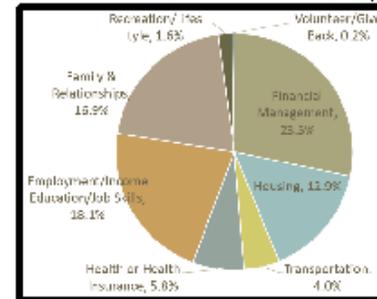
- Bundling services
- Crises intervention
- Pathway invitation

Assist each family or person create a pathway action plan

- Financial literacy and coaching
- Education and career advancement
- Acquiring assets -savings, homeownership, energy

Work to remove barriers and create opportunities

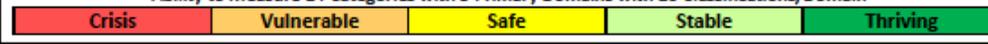
- Housing and economic development
- Workforce development
- Policy
- Municipal and community capacity



Data Quality Begins at Intake, **empowOR**, Outcomes Reporting, Presumptive Eligibility, **Community Partners**, **MOUs**, Common Customer, **Centralized Data**, **Quality Early Education**, **Corporate Culture**, **Strategic Planning**.....

Crisis to Thrive Scale

Ability to Measure 14 Categories with 5 Primary Domains with 10 Classifications/Domain



One Agency One Mission

Garrett County Community Action Committee, Inc., 104 East Center Street, Oakland, MD 21550
301.334.9431 www.garrettcac.org

- www.garrettcac.org.

Community reports and presentations

- <http://www.garrettcac.org/index.php/educationlifelonglearning/2-generation-2g>



14th Annual Health Equity Conference

DECEMBER 7, 2017

Opioid Operational Command Center

Speaker:

Clay Stamp

Executive Director, Maryland Opioid Operational Command Center

Senior Emergency Management Advisor to the Governor

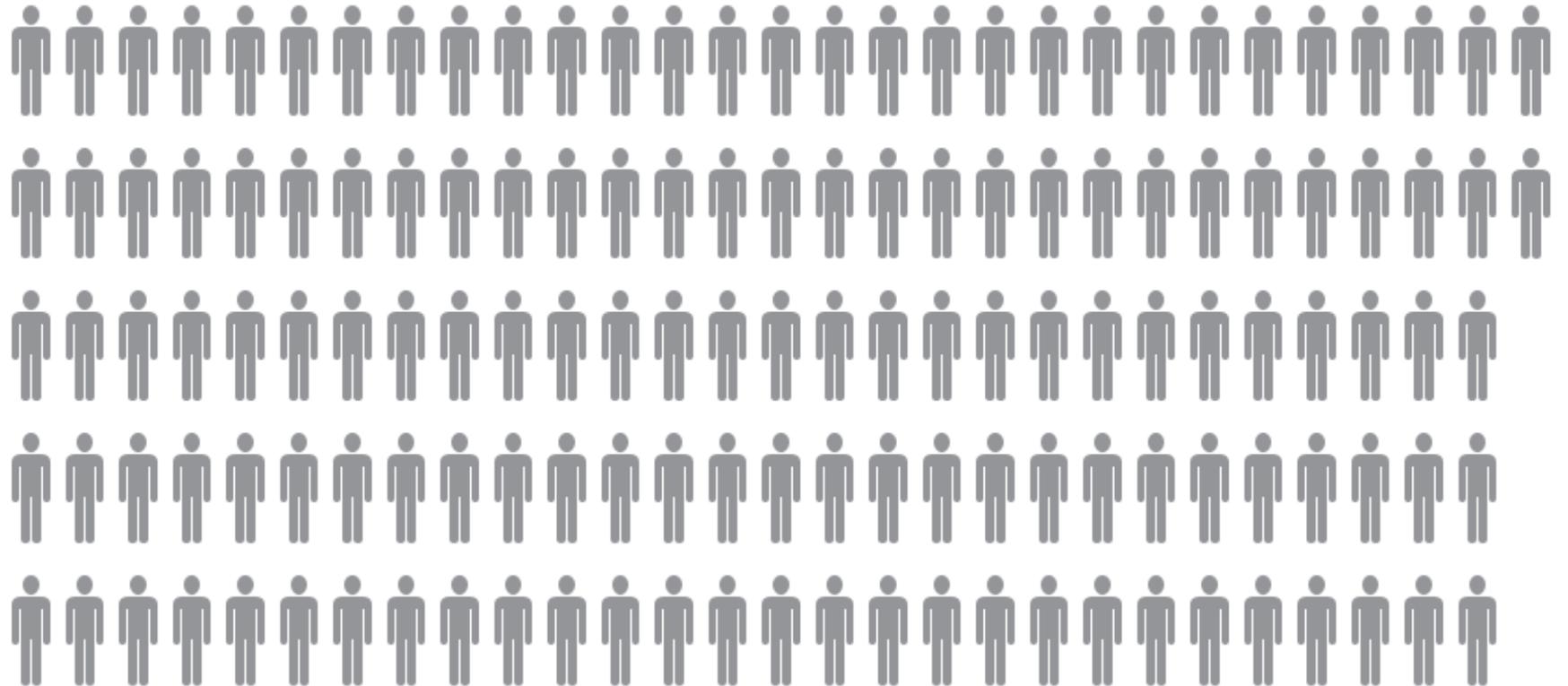
Chair of the Governor's Emergency Management Advisory Council



Nearly **6** deaths every day in Maryland



142 deaths
per day in the
United States



Hogan-Rutherford Administration Declares State of Emergency



EXECUTIVE ORDER
01.01.2017.02

Executive Order Regarding the Heroin, Opioid, and Fentanyl Overdose Crisis
Declaration of Emergency

WHEREAS, The State of Maryland is subject to an emergency as defined in Section 14-101(c) of the Public Safety Article of the Code of Maryland;

WHEREAS, Heroin and opioid abuse is an illness that threatens the well-being, productivity, livelihood, and relationships of Marylanders;

WHEREAS, Heroin and opioid use has tripled nationwide in the last 12 months, with approximately 27 million users across the country;

Empowers the OOCC to:

- Drive priorities across State agencies
- Engage communities to form local jurisdiction coordination bodies (Opioid Intervention Teams)
- Delegate emergency powers to state and local emergency management officials
- Oversee a supplemental budget of \$50 million in new funding over a five-year period

Opioid Operational Command Center

Core Functions

- ❖ Coordination and Enhancement of State Partners
- ❖ Coordination and Enhancement of Local Opioid Intervention Teams
- ❖ Facilitation of Information and Data Sharing
- ❖ Coordination of Public Communication
- ❖ Funding Oversight
- ❖ Centralized Reporting
- ❖ Operating from Common Goals and Objectives

State Agency Coordination

- Department of Health
- Governor's Office of Crime Control and Prevention
- Maryland Emergency Management Agency
- Maryland State Police
- State Department of Education
- Department of Human Services
- Department of Juvenile Services
- Department of Public Safety and Correctional Services
- Maryland Institute for Emergency Medical Services Systems
- Maryland Higher Education Commission
- Maryland Insurance Administration
- Office of the Attorney General
- Baltimore/Washington HIDTA
- Dept. of Housing & Community Development



Response Goals

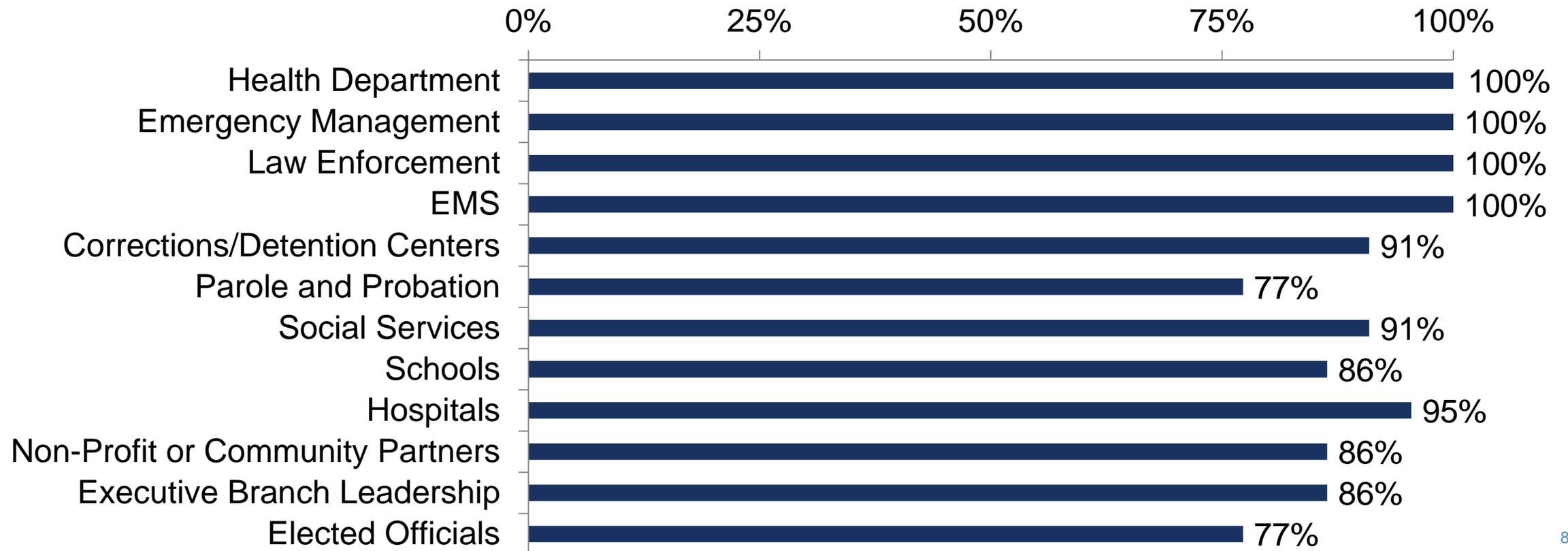
1. Prevent new cases of opioid addiction and misuse
2. Improve early identification and intervention of opioid addiction
3. Expand access to services that support recovery and prevent death and disease progression
4. Enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic

OOCC Opioid Intervention Teams

Opioid Intervention Teams (OITs), as named by executive order, are the local jurisdiction multi-agency coordination bodies that complement and integrate with the statewide opioid response

Local Jurisdiction Coordination

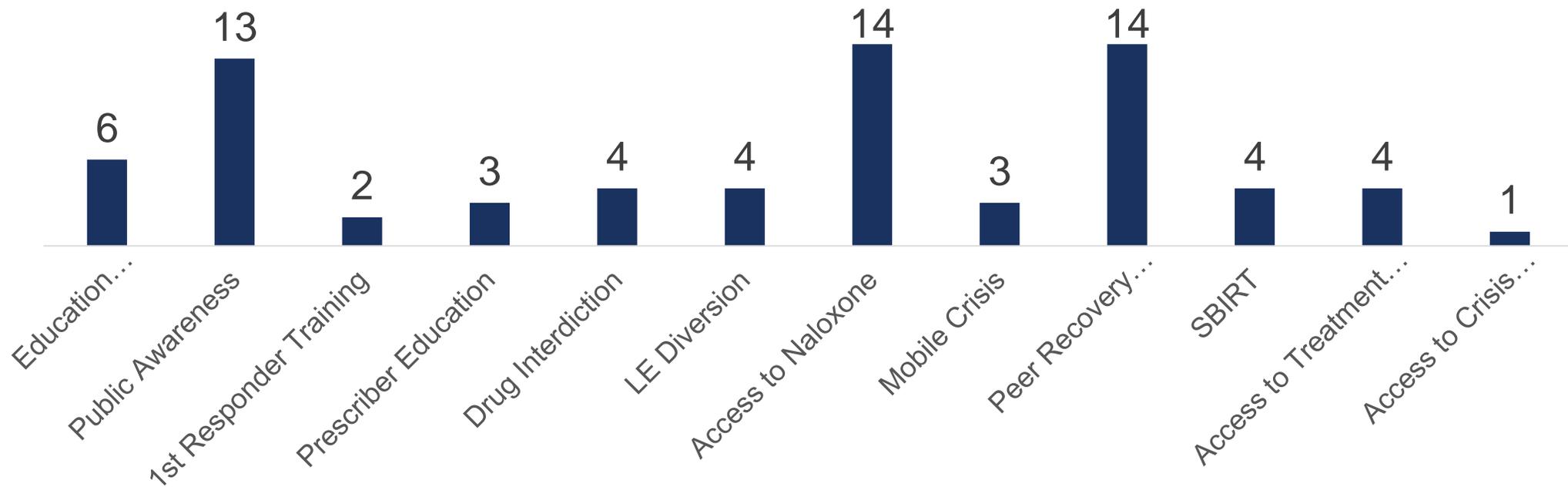
Percent of Jurisdiction OIT's that have representation from the following sectors



State-Driven Efforts

Opioid Intervention Teams

- **\$4 million** total distributed to local Opioid Intervention Teams for each jurisdiction to determine how best to fight the heroin and opioid epidemic



Final Thoughts

1. Elevate conversation and put a face to it, working to combat stigma.
2. Focus the energy around a balanced approach.
3. Make sure we are using data to drive direction and performance measures for projects.
4. Establish expectations.

THANK YOU

PREVENTION • TREATMENT • RECOVERY



Before it's **too late.**

Web:

beforeitstoolatemd.org

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facebook.com/BeforeItsTooLateMD

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[@BeforeIts2Late](https://twitter.com/BeforeIts2Late)

Collaborative Opioid Overdose Prevention Efforts In Maryland

Kathleen Rebbert-Franklin, LCSW-C
Behavioral Health Administration (BHA)
December 7, 2017

Four Statewide Goals for Opioid Epidemic

Overarching goal is to reduce the rate of overdose deaths among Marylanders

Goal 1: Prevent new cases of opioid misuse and addiction

Goal 2: Improve early identification of and intervention with opioid addiction

Goal 3: Expand access to services that support recovery and prevent death and disease progression

Goal 4: Enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic

Goal 3: Expand Access to Services that Support Recovery and Prevent Death and Disease Progression

Select Buprenorphine-Related Approaches

- 1) Increase access to and knowledge regarding buprenorphine, including changes to DATA 2000 law.
- 2) Promote integration of office based buprenorphine services with public behavioral health treatment and recovery system at local level.
- 3) Encourage Opioid Treatment Programs to provide buprenorphine.
- 4) Expand use of buprenorphine in other clinical settings including emergency rooms and outpatient mental health clinics.
- 5) Increase integration of buprenorphine, overdose education strategies, use of telemedicine, and naloxone distribution for high risk patients in multiple clinical settings in rural and underserved areas.

Goal 3: Expand Access to Services that Support Recovery and Prevent Death and Disease Progression

Priority 3.1 Improve access to and quality of evidence-based opioid addiction treatment in the community.

Key Strategy: BHA Buprenorphine Expansion-Related Projects

- **MACS (Maryland Addiction Consultation Service) (Cures Grant)**
- PCSS-MAT Implementation Program (PCSS-MIP)
- Buprenorphine prescribing via telehealth
- Outreach to PAs and NPs
- Jurisdictional buprenorphine initiatives, including induction in new crisis residential beds
- **ED Buprenorphine Induction Project (Hospital-Based Buprenorphine Initiative, HBBI)**

MACS (Maryland Addiction Consultation Service)

- Supports specialty prescribers of buprenorphine across Maryland in identification and treatment of opioid use disorders to include Physicians, Nurse Practitioners and Physician Assistants.
- Providers have access to support through free phone consultation (warm-line), training, education, resource and referral information for patients.
- Prescribers provide information or consultation request to behavioral health clinician for triage; MACS consultant will call back within 1 business day.
- Prescribers receive a written summary of call for records.
- Service went live October 16, 2017 Call 1-855-337-6227

MACS (Maryland Addiction Consultation Service)

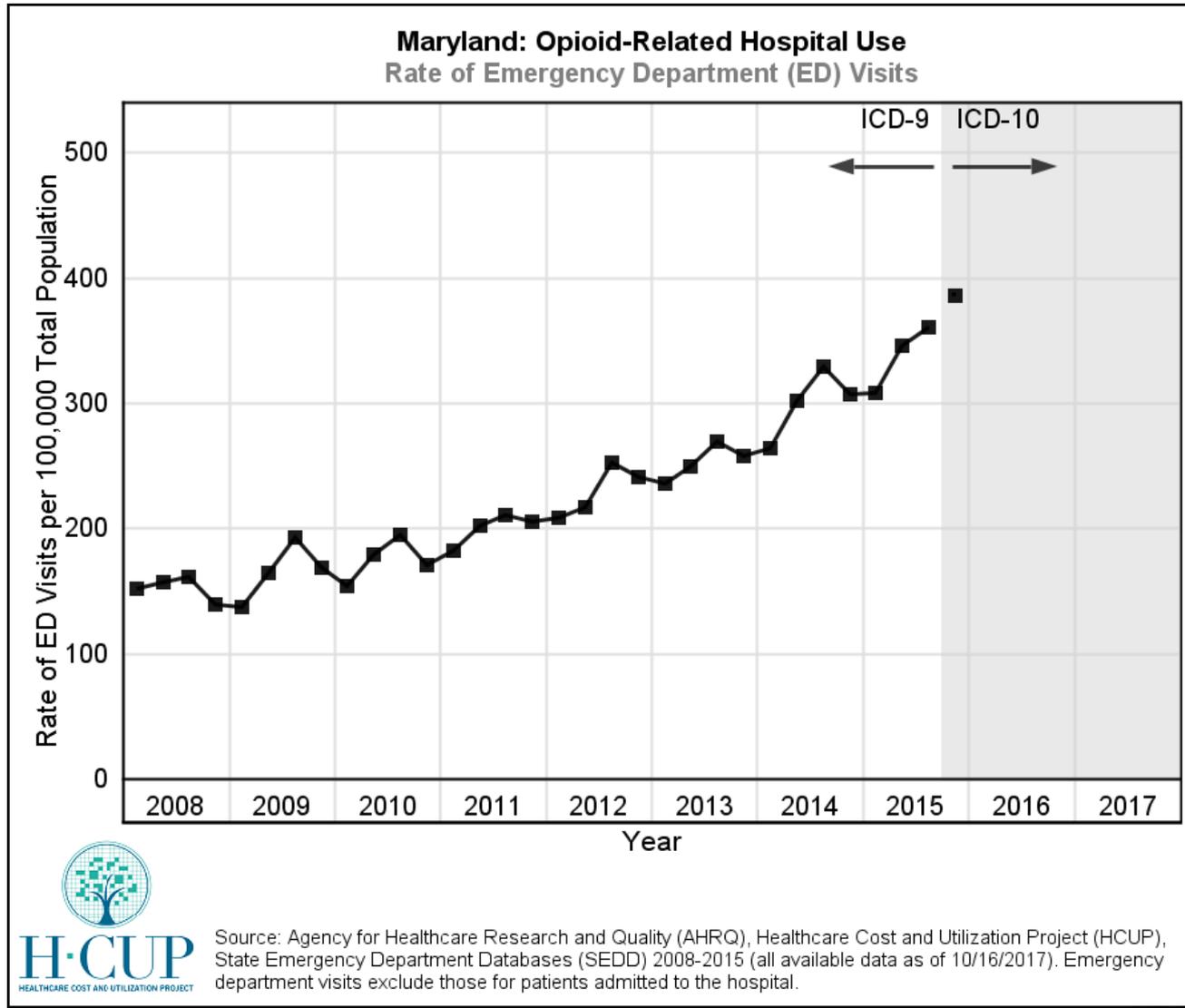
Appropriate questions for MACS ?

Any questions related to the initiation, maintenance, or discontinuation of buprenorphine for the treatment of opioid use disorders

Topics may include:

- Initiation and maintenance of buprenorphine
 - Termination of buprenorphine
 - Psychopharmacology
 - Alternative medication treatments
- Community resources and referrals

Maryland Picture: Rise in Opioid-Related Emergency Department Visits



<https://www.hcup-us.ahrq.gov/faststats/OpioidUse>

HBBI: Evidence-Based Practice

- **Observational study: Berg et al. Drug Alcohol Depend 2007**
 - 158 patients seen in Johns Hopkins adult ED with opioid withdrawal
 - 56% were given dose of injectable buprenorphine +/- symptomatic medications
 - 26% received only symptomatic medications
 - 18% received no medications
 - 8% receiving buprenorphine returned to ED w/in 30 days for drug related visit vs 17% of those receiving symptomatic treatment
 - No incidents of precipitated withdrawal or other adverse consequences
- **RCT: D'Onofrio et al. JAMA 2015**
 - 329 adults screening positive for opioid use disorder (OUD) in adult ED at Yale
 - 9% with opioid overdose
 - 34% seeking treatment for OUD
 - Randomized to one of 3 arms:
 - Referral to addiction treatment
 - Brief intervention and referral to addiction treatment
 - Buprenorphine dose and referral to primary care within 72 hours for ongoing buprenorphine
 - Primary outcome was engagement in addiction treatment at 30 days

HBBI: Evidence-Based Practice

- RCT: D'Onofrio et al. JAMA 2015 – RESULTS
 - Significantly higher proportion of patients receiving buprenorphine in ED were engaged in addiction treatment at 30 days
 - 78% in buprenorphine arm
 - 37% in referral arm
 - 45% in brief intervention and referral arm
 - Greater reductions in self-reported illicit opioid use among buprenorphine group
 - From mean 5.4 days per week to 0.9 days in buprenorphine arm
 - From mean 5.4 days per week to 2.3 days in referral arm
 - From mean 5.6 days per week to 2.4 days in brief intervention and referral arm

Hospital Based Buprenorphine Induction (HBBI) Services

Initiates buprenorphine in emergency departments for survivors of opioid overdose, and other patients with severe opioid use disorder

Collaboration between multiple partners and a growing list of hospital EDs:

- Behavioral Health Administration (BHA)
- The Mosaic group
- SBIRT Emergency Department (ED) physicians

Current Hospitals include:

- Bon Secours Hospital
- MedStar Harbor Hospital
- Mercy Hospital
- UMMS
- UM Midtown

Hospitals Planned for 2018:

- Johns Hopkins Bayview
- MedStar Franklin Square
- Medstar Good Samaritan
- Medstar Union Memorial

HBBI: Process and Clinical Protocol

Step 1- Patient is screened using SBIRT screening and identified as having OUD and motivated for treatment.

- **Clinical Protocol-** Patient referred to PRC to assesses motivation for treatment. If motivated, refers to clinical team.

Step 2- Medical team approves patient for HBBI protocol and assesses if patient is clinically able to receive buprenorphine dose in ED. Patient receives initial dose of buprenorphine.

- **Clinical Protocol-** COWS administered by nursing and MD assesses patient for exclusion criteria (Long acting opioid pain medication or pregnant), COWS of 8 or higher triggers order for buprenorphine 8 mg. Nurse administers initial dose.

Step 3- Patient is Fast Tracked to MAT provider in community for next day continued buprenorphine induction.

- **Clinical Protocol-** After receiving patient agreement and signed release, PRC arranges next day appointment at Fast Track treatment program. Patient provided discharge summary with diagnosis of OUD and indication of dose administered. PRC follows up to determine linkage to treatment and needed support.

HBBI: Fast Track Treatment Programs

Treatment programs that offer MAT using buprenorphine:

- OTP
- IOP/OP
- Primary Care
- Psychiatrist

Partner with HBBI hospital to accept patient next day

Receive discharge summary from hospital at any time of day

Use discharge summary clinical information to obtain order for Day 2 buprenorphine induction

Enroll patient in other services as indicated

HBBI: Buprenorphine Waiver Not Necessary

DEA “Three Day Rule”

- Exception to DATA 2000 Waiver
- Provides for practitioner flexibility in emergency situations to treat patients undergoing opioid withdrawal
- 72-hour exception allows for provider to dispense up to three days of medication to treat acute withdrawal symptoms while arranging for treatment
- EDs generally do not allow patients to leave with medications, thus one dose is provided in HBBI under this provision

HBBI: Buprenorphine Outcomes to Date

189 Referred to Protocol	78% of patients receive initial induction
53% patients kept next day appointment	41% retained in treatment at 30 days

Thank You! Questions?

Kathleen Rebbert-Franklin, LCSW-C
Director, Health Promotion and Prevention
Behavioral Health Administration
Maryland Department of Health
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The Drug User Health Work Group

**Kip Castner, MPS, Chief
Center for HIV/STI Integration and Capacity
Infectious Disease Prevention and Health Services Bureau
Prevention and Health Promotion Administration**

**Collaborative Opioid Overdose Prevention Efforts in Maryland
14th Annual Health Equity Conference
December 7, 2017**



MISSION AND VISION

MISSION

The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

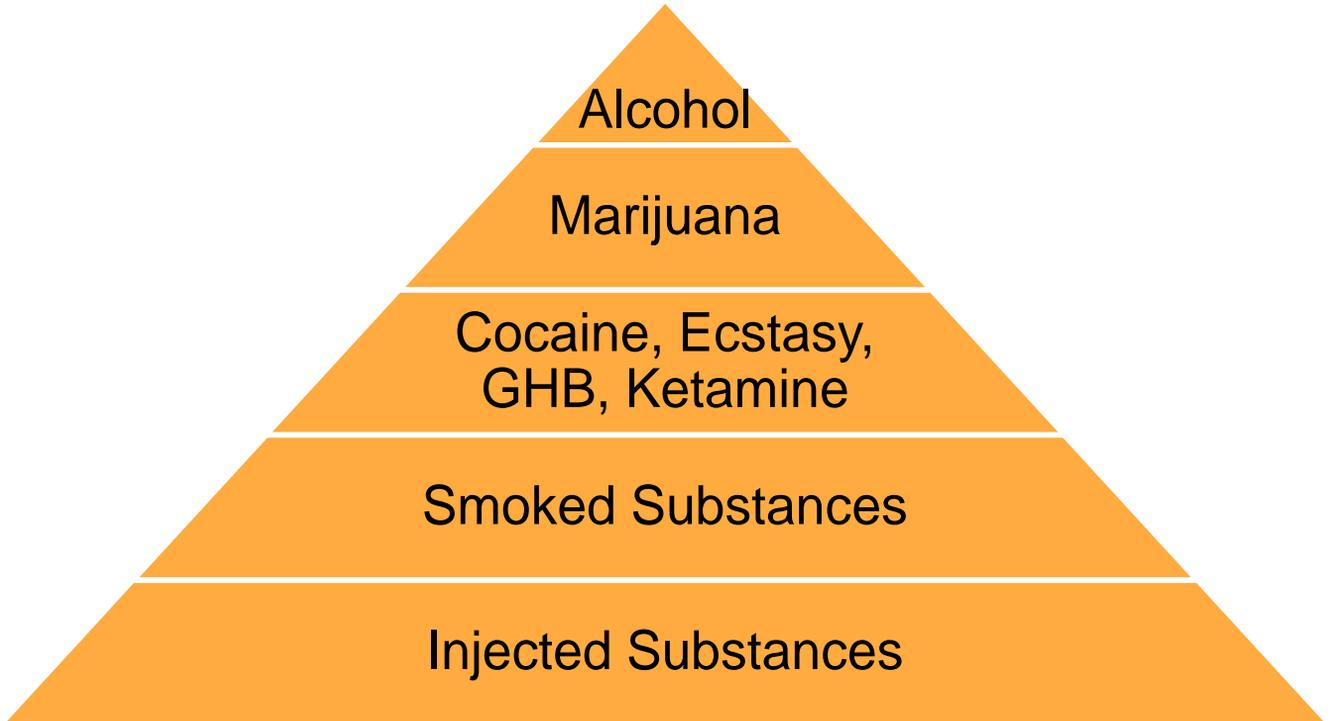


Workshop Agenda

- Substance Use Stigma
- Historical Context: Policy as a Tool
- The Drug User Health Work Group
- Other Lenses Through Which to Understand and Respond to the Opioid Crisis



Layers of Substance Use Stigma



Historical Context

- Chinese immigrants using opium (late 19th century): criminalized by municipalities and states, then federally in 1909; heroin criminalized in 1924
- Mexican immigrants using marijuana: taxed (1937), later criminalized (1970's)
- African Americans using cocaine (early 20th century): taxed (1914) and effectively outlawed
- African Americans using crack: criminalized in 1986 with sentences 100 times harsher than for cocaine; War on Drugs targeted heroin users as well
- Fair Sentencing Act of 2010 reduced ratio to 14:1



Justice?



Sentence for possession of 1 gram of crack = sentence for possession of 100 grams of cocaine

Affected Communities Distinguished



“There is one, only one, cause of the AIDS crisis—the willful refusal of homosexuals to cease indulging in the immoral, unnatural, unsanitary, unhealthy, and suicidal practice of anal intercourse, which is the primary means by which the AIDS virus is being spread through the “gay” community, and, thence, into the needles of IV drug abusers, the transfusions of hemophiliacs, and the bloodstreams of unsuspecting health workers, prostitutes, lovers, wives, children.”

-- Pat Buchanan, 1987

Affected Communities Distinguished



Get Help With (

Drug & Alcohol Treatment ▾ Detox Services ▾ Dual Diagnosis ▾ Facilities Why Us

Opioids, Restrictions on Prescriptions, and a Medical Field in Uproar

Timothy Bailor ▾ ADDICTION NEWS OPIOIDS RESEARCH ▾ No Comments



“Opioid addiction is affecting everyone – even the experts. In a quick review: You’re supposed to trust police detectives. You’re supposed to respect research scientists. You’re supposed to hold physicians in high esteem. Yet each of these professionals was caught up on the opioid addiction epidemic – **through no fault of their own.**”

Challenge

- The “new face” of heroin has opened a window of opportunity for improving and expanding the public health system for persons who use drugs, from policy changes (Syringe Services Program legalization, Safe Consumption Facilities) to dismantling stigma.
- How do we leverage the opportunity in ways that honor the wisdom of communities who have faced heroin for decades, and in ways that deepen our collective understanding of substance use?

Erin Haas: Visionary



“A Drug User Health Work Group would pool expertise from multiple parts of the Department. The objectives of the Work Group will be:

To share information about programs and projects that target people who use drugs

To share available data on the population

To enhance coordination of projects that target people who use drugs

To improve communication across parts of the Department

To identify public health system gaps in drug user health

To make recommendations for the improvement of public health and healthcare services for people who use drugs

Mission

- The mission of the Drug User Health Work Group is to improve the alignment between the needs of people who use drugs and the programs and services of the Maryland Department of Health
- The DUHWG seeks to expand the window of compassion for people affected by opioids to all people affected by substance use
- The DUHWG proposes the following frames for understanding our current crisis and designing solutions:

Adverse Childhood Experiences



Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations



CA Framework for Injection Drug User Health and Wellness

- Drug users have a right to protect their health and the health of those around them.
- All drug users should:
 - have the means by which to protect their health, including access to sterile injection equipment sufficient to meet their needs.
 - receive accurate, non-biased and non-judgmental information on illicit drugs and other substances.
 - receive the same level of care as any other individual accessing health care or social services.
 - have access to drug and alcohol treatment on demand.
- Providers should:
 - recognize the valid and valuable expertise that people who use drugs can give to designing, delivering and evaluating effective services.
 - ensure that the provision of services to drug users is not contingent upon the individual's agreement to enter drug treatment, or abstain from drug use. Service providers must not withhold appropriate treatments or services from drug users.
- Services should be provided to encourage engagement and retention in care.

Current Landscape for PWID



Public Health:
Prevention

Law Enforcement:
Arrest
Incarceration

Public Health:
Treatment

PWID = People Who Inject Drugs

Meeting People Where They Are

Stages of Change				
Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
OVERDOSE REVERSAL WITH NALOXONE	SYRINGE SERVICES PROGRAMS OVERDOSE REVERSAL WITH NALOXONE		TREATMENT ENTRY: MAT, DETOX, INTENSIVE OUTPATIENT, OP	MAT, RECOVERY SUPPORTS, AA, NA, OTHER GROUPS



Harm Reduction

Harm Reduction is a public health philosophy operationalized as a set of interventions designed to reduce the harms associated with drug use, such as:

- Infectious Disease education, testing, and linkage to prevention and care (e.g., HIV PrEP, HCV treatment)
- Wound care and education on safe injection practices
- Naloxone, condom, and syringe distribution
- Linkage to substance abuse treatment and other needed services

Reimagined Landscape for PWID



Drug User Health Work Group

- Originated in the biweekly collaboration calls between BHA Overdose Response and PHPA HIV Integration
- Began monthly meetings in April 2017
- Open to MDH employees with a passion for improving the health of persons who use drugs
- Meetings have included presentations by participants to build a shared foundation of understanding of MDH data and programs
- Meetings include brainstorming about ways to collaborate

DUHWG As A Resource

- The Drug User Health Work Group wishes to serve as a resource for others in the Department interested in exploring the promises of the Adverse Childhood Experiences, Social Determinants Of Health, Drug User Health, and Transtheoretical models for improving the design and delivery of messages and programming to persons who use drugs. This can include providing feedback from—and on behalf of—drug users on current and proposed approaches to addressing the opioid crisis.



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<https://phpa.health.maryland.gov>



MARYLAND
Department of Health



Dorchester County M.O.T.A: **Making a Difference through Community** **Conversations**

Ashyrra C. Dotson, Director of Programs
Associated Black Charities - Dorchester County



Objectives:

- ▶ To demonstrate community engagement strategies for National Minority Health Month – April 2017
- ▶ To Identify and work to address the needs of the people through community conversations
- ▶ To review the challenges and benefits of engaging community members when addressing those needs

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WHAT DID WE DO ?

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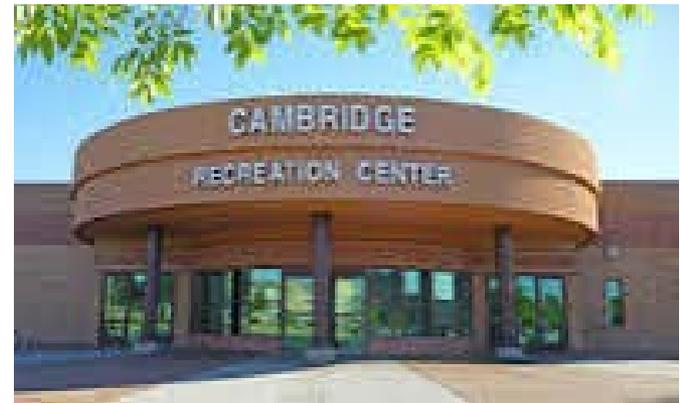


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Met our Community Members where they were:






ABC Associated Black Charities
Community Needs Survey

Please share your concerns and suggestions regarding the needs for your community. Associated Black Charities appreciate your honest opinion and thanks you for taking the time to complete this survey.

Please identify your community: Carbridge Harlick Other _____

How long have you been in this community: Years _____ Months _____

Education Level: Some high school _____ Age Range: 20-29 _____
High school graduate _____ 30-39 _____
Some college/tech school _____ 40-49 _____
Two year degree _____ 50-59 _____
Four year degree _____ 60 & up _____
Graduate _____ NA _____

Which of the following best describes your occupation:

Business Owner _____ Public/Private _____ Agency Staff _____
 Public Official _____ Clergy/Minister _____ Homemaker _____
 Educator _____ Volunteer _____ Health/Professional _____
 Truck Driver _____ Hospitality Employee _____ Student _____
 Factory Employee _____ Food Industry Employee _____ Construction Employee _____
 OTHER _____

Income Level:

Less than \$25,000 _____
 \$25,000 - \$49,999 _____
 \$50,000 - \$99,999 _____
 \$100,000 - \$149,999 _____
 \$150,000 - \$199,999 _____
 Over \$200,000 _____
 Refused _____

HEALTH

Show your 3 Greatest Health Needs:

Please indicate if you use the Health Care system in your community: Yes _____ No _____

If Yes, What is YOUR primary reason for choosing the physician or clinic you attend?

Location	Insurance coverage
Convenience hours	Reputation
Physician quality	Other _____

On a scale from 1 - 5 with 1 being not met at all and 5 being met exceptionally - How well were the following health issues in the area being met: (A - DK = Don't Know)

Availability of Family Physicians	1	2	3	4	5	DK
Government Issues - at all	1	2	3	4	5	DK
Availability of quality services	1	2	3	4	5	DK
Available transportation for health-care needs	1	2	3	4	5	DK
Availability of Women's care	1	2	3	4	5	DK
Confidence in the provider	1	2	3	4	5	DK
Emergency medical care	1	2	3	4	5	DK

Ways you would like to see improvement to Health Care in your area:

TRANSPORTATION

Show your 3 Greatest Transportation Needs:

Do you have your own source of transportation? Yes _____ No _____

If No - what sources of transportation do you use? _____

Please indicate if you use the public transportation system in your community: Yes _____ No _____

If Yes, What is YOUR primary reason for choosing to use the public transportation system?

Cost	Access to services
Honesty of Service	Other _____

On a scale from 1 - 5 with 1 being not met at all and 5 being met fully met - How well were the following transportation issues in the area being met: (A - DK = Don't Know)

Availability of public transportation services	1	2	3	4	5	DK
Convenient hours	1	2	3	4	5	DK
Quality services	1	2	3	4	5	DK
Customer pick-up & drop-off locations	1	2	3	4	5	DK
Honesty of the driver/subscribers	1	2	3	4	5	DK
Access to schedules and routes	1	2	3	4	5	DK

Ways you would like to see improvement to TRANSPORTATION in your area:

EMPLOYMENT

Show your 3 Greatest EMPLOYMENT Needs:

Are you currently employed? Yes _____ No _____

Are you employed within 12 miles of where you and your family live? Yes _____ No _____

If NO, show your reason for working more than 12 miles outside of the area where you live?

What are the main employment opportunities where you and your family live?

On a scale from 1 - 5 with 1 being not met at all and 5 being met fully met - How well were the following EMPLOYMENT needs in the area being met: (A - DK = Don't Know)

Availability of Employment Opportunities in all fields	1	2	3	4	5	DK
Variety of Management positions available to local residents	1	2	3	4	5	DK
Quality Wages	1	2	3	4	5	DK
Stipend of Employees	1	2	3	4	5	DK
Benefits to Employees	1	2	3	4	5	DK
Availability of Workers' Reinstatement Services	1	2	3	4	5	DK

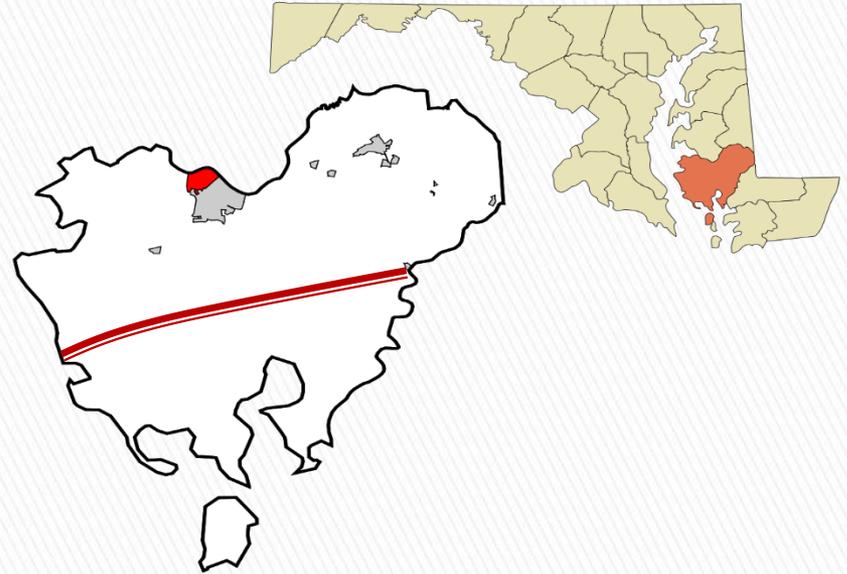
Ways you would like to see improvement to EMPLOYMENT in your area:

THANK YOU!

This survey is brought to you through a grant from the Department of Health and Mental Hygiene - Office of Minority Health and Health Disparities in Associated Black Charities.

Community Feedback:

- ▶ Lack of Adequate transportation to services if you don't own a vehicle
- ▶ No Grocery Stores without having to travel 20 - 45 miles
- ▶ Employment Opportunities quickly depleting- some factory work
- ▶ No doctors or Medical Facilities within 20-45 miles
- ▶ Public Water systems are tainted
- ▶ Safe Communities for children are needed



North Dorchester

Community Feedback:



- ▶ Lack of a viable, cost effective transportation system for this county
- ▶ Limited Medical transportation, only 1 hospital in the entire county and no birthing center in the county
- ▶ Low wages and very limited employment opportunities for degreed individuals
- ▶ Not enough safe greenspaces

South Dorchester

Compared the Information:

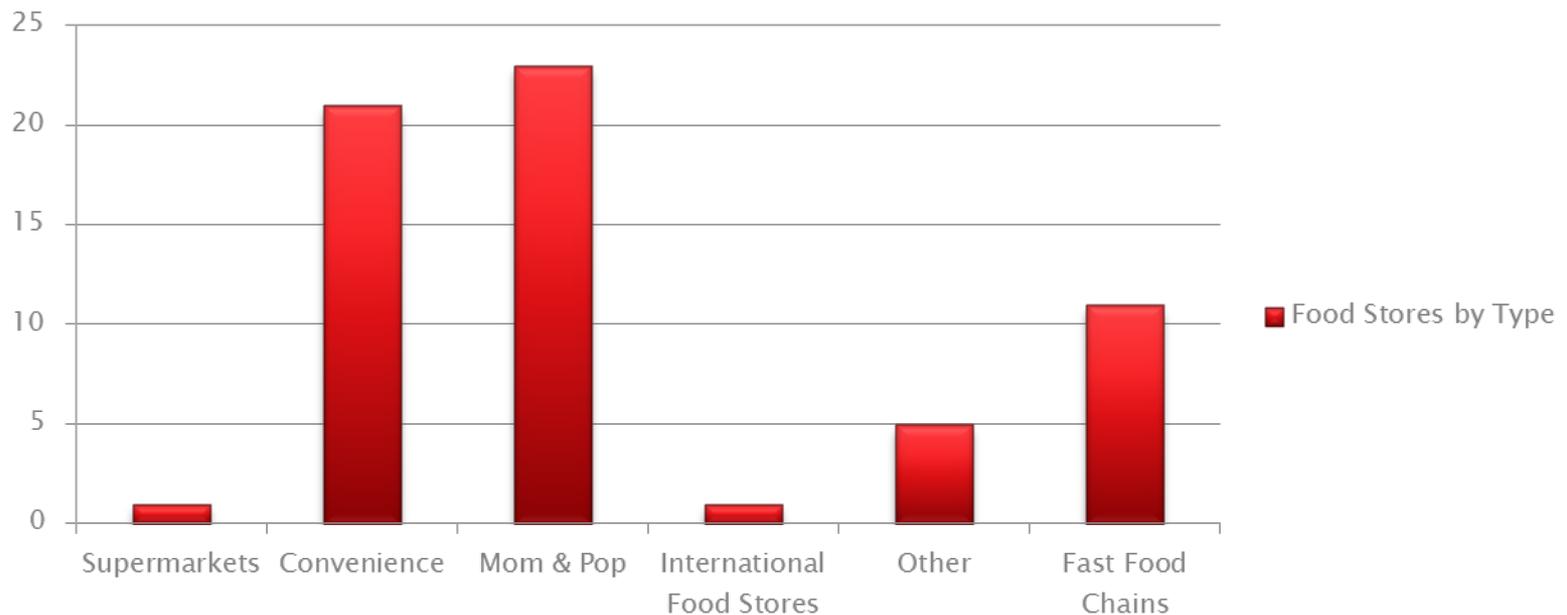


Dorchester County is extremely rural with a **population density** (People/Square mile) of **54.32** within a land mass of 540.76 square miles. This often lends to accessibility obstacles for the residents.

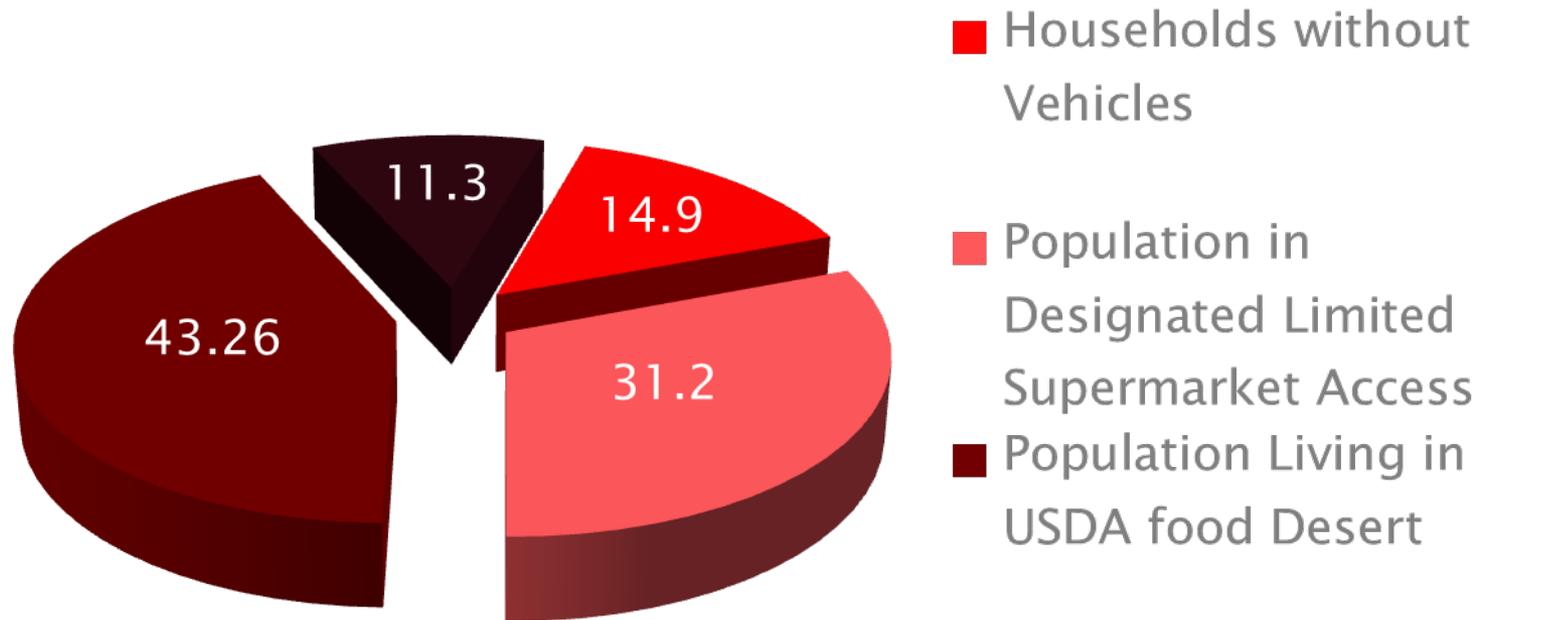
- **Limited Transportation Network**
- **Food Availability**
- **Health Disparities**

Food Availability

Dorchester County



Food Availability and Access



Transportation Networks

Dorchester County, has three (3) primary Transportation Networks readily available to the community residents:

- **Auto and Taxi Services – Total Fleet of 17 vehicles**
- Dorchester Transit – Bus Fleet of 22 buses – 21 routes operating every 45 minutes to 1 hour from 5:00 am – 6:45 pm
- **Medical Transportation – Appointment Only**

Health Access & Care Availability

Primary care provider to population ratio, by county

Caroline County: 1:2,915

Dorchester County: 1:2,437

Talbot County: 1:1,056

Worcester County: 1:2,028

Queen Anne's County: 1:2,016

Somerset County: 1:2,452

Wicomico County: 1:1,668

Kent County: 1:1,462

Maryland statewide: 1:1,647

– Source: Maryland Primary Care Office, DHMH

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THEN WHAT ?

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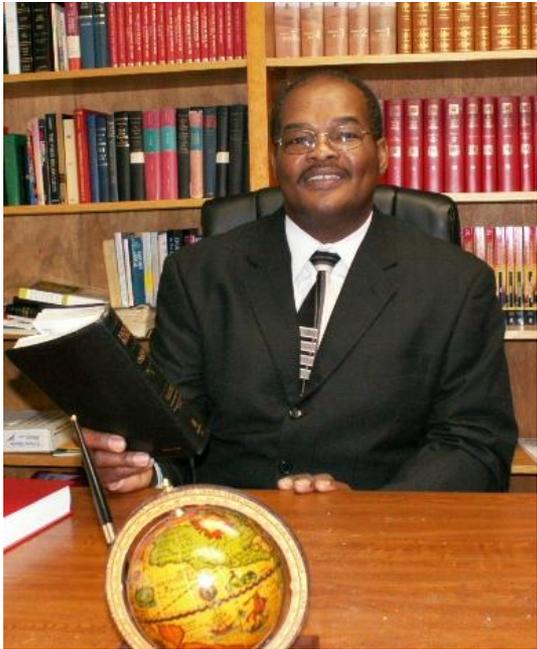
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Meeting the needs of the people:



Key Results

- ▶ Incorporated additional No Cost, Fresh Produce and Protein mobile pantries in outlying areas of the community
- ▶ Provided Transportation Vouchers for community members to access health care or services related to employment
- ▶ Partnered to increase community interest in the available transportation services
- ▶ Met with various stakeholders and community members to develop county plans which will increase access to transportation and quality health services.

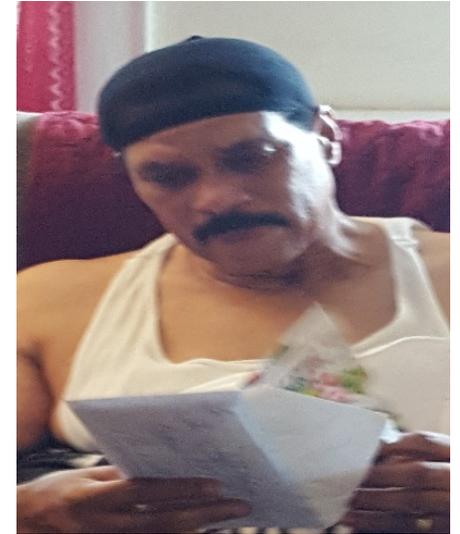
WHERE ARE WE NOW -

- Community Members who are excited about linking with CHW's and Health Care Providers as a team.
- Expanded M.O.T.A. services for community members to include:
 - Self-management training 30, 60, & 90 day follow-ups
 - Community Centered Mobile Food Pantries
 - A greater sense of TRUST within multi-cultural communities
 - HIV Education
 - No Cost Health Screenings and increased referrals for services
 - Increased Awareness among community members on the environmental Impacts that affect health and health outcomes.
- Truly culturally sensitive to all marginalized communities



Lastly -

A larger population of our Dorchester County community members who are invested and actively participating in the improvement of their health outcomes.



Telehealth in Rural Communities



Resources

DHMH - Maryland Health Equity Data

<http://dhmh.maryland.gov/mhhd/Pages/Health-Equity-Data>

*Maryland Chartbook of Minority Health And Minority Health Disparities Data
Selected Statewide and Dorchester County Data - February 15, 2011*

DHMH – Maryland Primary Care Office

<http://bhpr.hrsa.gov>



THANK YOU!

Ashyrra C. Dotson
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410 - 221 - 0795

Minority Outreach Coalition

Health

Education in support of a better community

Logistics

Performance

MOC was founded in 1999.
Has been a Minority Outreach
and Technical Assistance
(MOTA) partner since 2006

Targeting African Americans,
Hispanic/Latinos, Asian
Americans, Pacific Islander and
Native Americans residents in
the communities of St. Mary's
County, Maryland

***Bridging Health Equity Across
Communities.***

The goal of the MOC during National Minority Health Month (NMHM) was to understand the community and its health care system and identify ways the health of community residents can be improved.

Focus Areas for Discussion were, Community Health Needs, Access to Health Care providers, gaps in health insurance coverage/service and ideas to improve access to care and services in St. Mary's County.

The following Non-traditional partners were present at the community conversations meeting: (Health Connection, Order of Eastern Star, UCAC, Elks, Senior Assisted living, MedStar and the Local Health Department)



The theme, *Building Health Equity Across Communities*, meant

raising awareness about efforts across health, education, justice, housing, transportation and employment sectors to address the factors known as the social determinants of health – environmental, social and economic conditions that impact health.



The information we gathered was used to develop a health plan to serve our community by sharing with our community coalition teams, it was necessary that we establish a cross section of all community members Youth 18 to 30, Adult 30 to 50 and seniors 50 and up.

Meeting were held at community centers, Senior living centers, Masonic and elk lodge, Health connection facility. There were roughly 25 participants at each meeting and a cross section of our targeted groups in race and ethnicity with age ranging from 25 to 85 years old



WHAT WAS DISCUSSED (QUESTIONS ASKED DURING THE MEETINGS)

- 1) What do you like about living in the County?
- 2) What are some of your favorite things to do in County?
- 3) What are some things about living in the County that could be improved?
- 4) How have you noticed the community changing over the past year or so?
- 5) What community do you feel insecure in? If you feel insecure, why?
- 6) Do you walk in your community? If no, why not?
- 7) Is your community providing all your needs, what is missing?
- 8) When was the last time you, if ever did you see or meet your county commissioner?



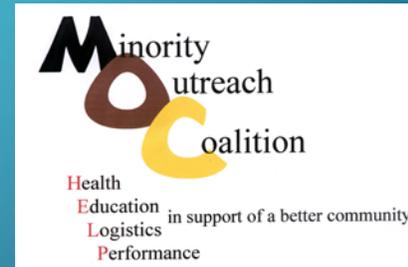
QUESTIONS ABOUT HEALTH AND ACCESS TO HEALTHCARE AND HEALTHCARE PROVIDERS IN THE COUNTY

- 1) Do you have a family doctor? How did you select your current family doctor? If you don't have one, Why don't you have one? If you do, what are some things you look for when finding one? (Is location important? Do you prefer a male or female? etc.)
- 2) How do you define "health" or what does "healthy" mean to you? Which word best describes your health? Excellent, very good, good, fair or poor.
- 3) What community resources or programs do you or your family use to maintain your health?
- 4) What are the major health concerns in your community?
- 5) What is the community doing well to address healthy living?
- 6) What can the county do to improve the health of its residents?
- 7) How do you find a specialist? (referral from a doctor? ask a friend? or see who is in your insurance network?) What are some barriers to seeing and using specialists?
- 8) What can the communities do to improve access to care and healthcare providers?



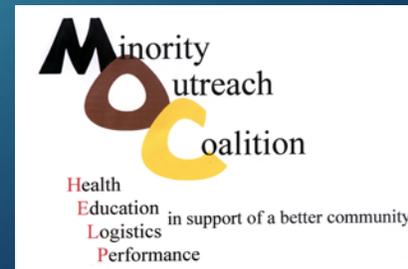
Key Outcomes of Community Conversations Meetings:

- We never see or hear from our county commissioners unless its an election year.
- Communities are not safe to walk or sit outside after sunset.
- Communities are not walk friendly. (traffic pattern/lack of sidewalks.
- Communities are poorly lit.
- Transportation is poor.
- Health care visits are long.
- Transportation to county events and parks is non-existent.
- Many Health Care Specialist are out of county and transportation is lacking.
- There is no cessation programs for youth under 18.
- Specialist referrals are out of county.



Key Outcomes Continued:

- Healthy Foods are too far from middle and low income areas.
- Care providers are mostly referred to by family or friends.
- Dental programs are too expensive for low and middle income.
- Youth have very little to do in the county and afterschool programs are hard to get to.
- Emergency and first responders services are very good.
- Scheduling appointments is difficult at the health department.
- Internet service for senior citizens is too expensive.
- Sheriff patrols not frequent enough.



Key Outcomes Continued:

- Health department visit are long.
- Hospital emergencies room is slow.
- The local newspaper only comes out twice a week.
- Job opportunity in the county is poor if you don't have a degree.
- Housing cost is high for buying or renting.
- Transportation in and outside the county needs improvement.



Lessons Learned:

- It is most important to have a good recorder to take notes.
- Notes need to be cataloged as to where they will be address and to whom they will be presented too.
- Establish a follow up date if the reply to questions need to be addressed.
- Inform the group of how their responses will be addressed.
- Have a good schedule/listing of whom they can follow up with.
- Distribute a county wide resources catalog or brochure.
- Distribute your contact information and most importantly have a list of community contacts they can seek for any help they may need.

St. Mary's County was fortunate in having establish the Healthy St. Mary's Partnership (HSMP)



MOC's six month Follow Up Findings:

After presenting these finding to various departments and agencies MOC has noticed some changes:

- Our four major coalitions meet monthly since April 2017 of the NMHM
- The five County Commissioners now schedule quarterly meeting with various groups within their Jurisdictions who invite them.
- Access to care is addressing the transportations issues and their finding should be out in mid-2018
- Behavior Health Coalition is meeting monthly and addressing more mental health issues
- Healthy Eating and Living Coalition as presented a complete street package to the county commissioners and it up for adoption.
- The Masonic lodge, Elk organization, Eastern Star and UCAC have partnered with MOC to assist with mini health fairs, and being more active at the senior assisted living centers and the homeless. The county has establish more warm centers for them to go too.
- The sheriff department has agreed to step up patrols in Lexington Park, Great Mills, Park Hall and Leonardtown.
- The Health Department is the process of reviewing their various appointment policies.
- HSMP is releasing a bi-weekly news letter now and as agreed to post partner upcoming events.
- Heath Connections will address dental issues early 2018.

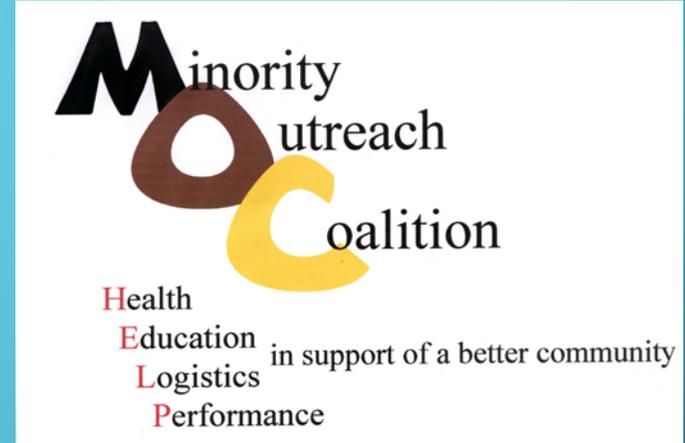


NMHM CONCERNS THAT NEED TO BE ADDRESSED

- Coalition meeting need to be scheduled in line with community attendance.
- More minorities from our target groups need to be active on boards and coalitions.
- Median Household income need to be reviewed its currently at \$86,498.00
- Health Department programs needs to be extended past 4pm
- Teens need a place to go after school and weekends
- Suicides and drug use needs more attention from community groups
- Faith Based Organizations need to be more involved outside their congregation
- Homeless and assisted living centers need a complete policy review.



Mr. Nathaniel Scroggins
MOTA Project Director
Minority Outreach Coalition
45488 Brawny Street
Great Mills, MD 20634
natscr.ns@gmail.com



MOC CAN BE CONTACTED AT MOCSTMARYS@GMAIL.COM OR 240-538-5681



Dorchester County M.O.T.A: **Making a Difference through Community** **Conversations**

Ashyrra C. Dotson, Director of Programs
Associated Black Charities - Dorchester County



Objectives:

- ▶ To demonstrate community engagement strategies for National Minority Health Month – April 2017
- ▶ To Identify and work to address the needs of the people through community conversations
- ▶ To review the challenges and benefits of engaging community members when addressing those needs

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WHAT DID WE DO ?

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Met our Community Members where they were:






ABC Associated Black Charities
 Community Needs Survey

Please share your concerns and suggestions regarding the needs for your community. Associated Black Charities appreciates your honest response and thanks you for taking the time to complete this survey.

Please identify your community: Cambridge Warwick Other

How long have you been in the community: Years Months

Education Level: Same high school Age Range: 18 - 24
 High school graduate 25 - 43
 Some college/tech school 44 - 64
 Two year degree 65 - 75
 Four year degree 76 & up
 Graduate Retired

Which of the following best describes your occupation

Business Owner <u> </u>	Public/Policy Mgr <u> </u>	Agency Staff <u> </u>
Public Official <u> </u>	Chgoy/Minister <u> </u>	Homemaker <u> </u>
Education <u> </u>	Volunteer <u> </u>	Health Professional <u> </u>
Truck Driver <u> </u>	Hospitality Employee <u> </u>	Student <u> </u>
Factory Employee <u> </u>	Food/Beverage Employee <u> </u>	Construction Employee <u> </u>
Other <u> </u>		

Income Level:

Less than \$25,000
 \$25,000 - \$49,999
 \$50,000 - \$99,999
 \$100,000 - \$149,999
 \$150,000 - \$199,999
 Over \$200,000
 Refused

HEALTH
 Share your 3 Greatest Health Needs:

Please indicate if you use the Health Care system in your community? Yes No

If Yes, What is YOUR primary reason for choosing the physician or clinic you attend?

Location	Insurance coverage
Convenient hours	Reputation
Physician quality	Other <u> </u>

On a scale from 1 - 5 with 1 being not met at all and 5 being met exceptionally - How well were the following health issues in the area being met? (i.e. - Don't Know)

Availability of Family Physicians	1	2	3	4	5	DK
Convenient hours of service	1	2	3	4	5	DK
Availability of quality services	1	2	3	4	5	DK
Available transportation for health care needs	1	2	3	4	5	DK
Availability of Women's care	1	2	3	4	5	DK
Confidence in the provider	1	2	3	4	5	DK
Emergency medical care	1	2	3	4	5	DK

Ways you would like to see improvement to Health Care in your area

TRANSPORTATION
 Share your 3 Greatest Transportation Needs:

Do you have your own source of transportation? Yes No

If No - what means of transportation do you use?

Please indicate if you use the public transportation system in your community? Yes No

If Yes, What is YOUR primary reason for choosing to use the public transportation system?

Cost	Access to services
Means of Services	Other <u> </u>

On a scale from 1 - 5 with 1 being not met at all and 5 being totally met - How well were the following transportation issues in the area being met? (i.e. - Don't Know)

Availability of public transportation services	1	2	3	4	5	DK
Convenient hours	1	2	3	4	5	DK
Quality services	1	2	3	4	5	DK
Convenient pick-up & drop-off locations	1	2	3	4	5	DK
Reliability of the driver/volunteers	1	2	3	4	5	DK
Access to suburban and routes	1	2	3	4	5	DK

Ways you would like to see improvement to TRANSPORTATION in your area

EMPLOYMENT
 Share your 3 Greatest EMPLOYMENT Needs:

Are you currently employed? Yes No

Are you employed within 12 miles of where you and your family live? Yes No

If NO, share your reason for working more than 12 miles outside of the area where you live?

What are the main employment opportunities where you and your family live?

On a scale from 1 - 5 with 1 being not met at all and 5 being totally met - How well were the following EMPLOYMENT needs in the area being met? (i.e. - Don't Know)

Availability of Employment Opportunities in all Skills	1	2	3	4	5	DK
Variety of Management positions available to local residents	1	2	3	4	5	DK
Quality of jobs	1	2	3	4	5	DK
Motivation of Employees	1	2	3	4	5	DK
Benefits to employees	1	2	3	4	5	DK
Availability of Training/mentorship services	1	2	3	4	5	DK

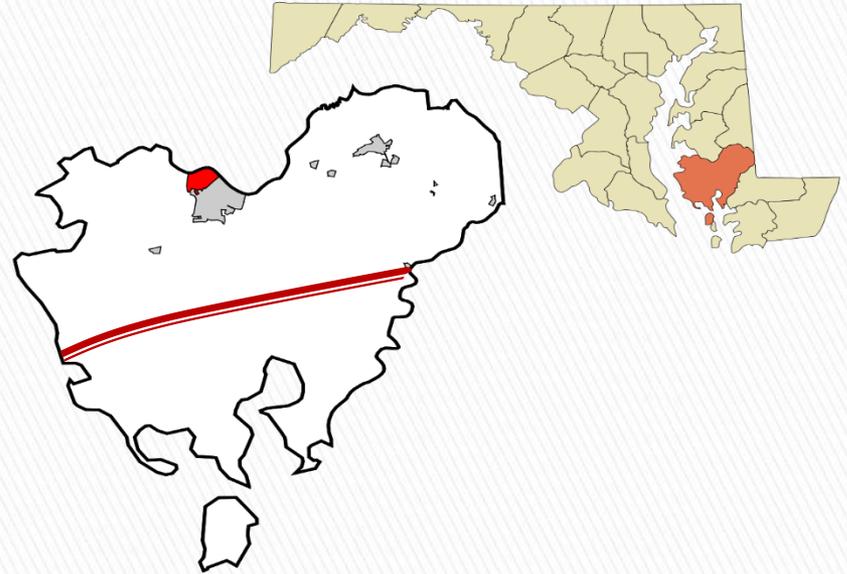
Ways you would like to see improvement to EMPLOYMENT in your area

THANK YOU!

This survey is brought to you through a grant from the Department of Health and Mental Hygiene - Office of Minority Health and Health Disparities to Associated Black Charities.

Community Feedback:

- ▶ Lack of Adequate transportation to services if you don't own a vehicle
- ▶ No Grocery Stores without having to travel 20 - 45 miles
- ▶ Employment Opportunities quickly depleting- some factory work
- ▶ No doctors or Medical Facilities within 20-45 miles
- ▶ Public Water systems are tainted
- ▶ Safe Communities for children are needed



North Dorchester

Community Feedback:



- ▶ Lack of a viable, cost effective transportation system for this county
- ▶ Limited Medical transportation, only 1 hospital in the entire county and no birthing center in the county
- ▶ Low wages and very limited employment opportunities for degreed individuals
- ▶ Not enough safe greenspaces

South Dorchester

Compared the Information:

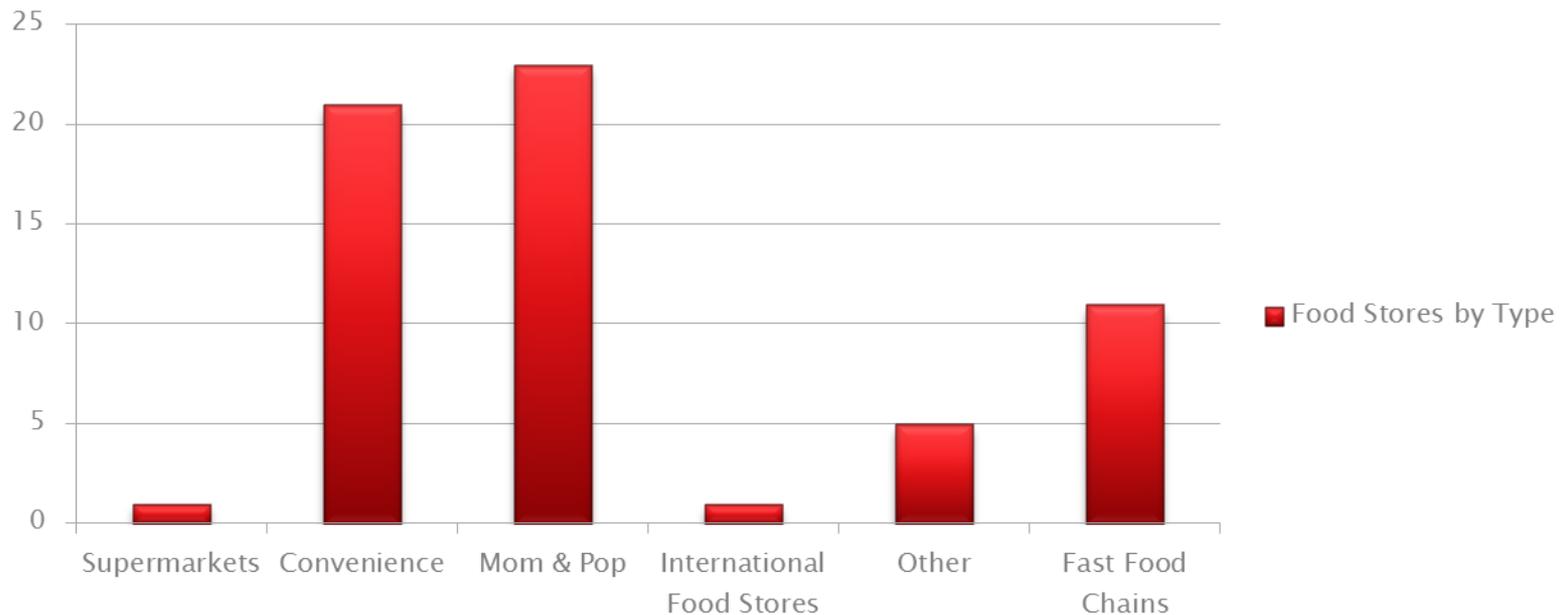


Dorchester County is extremely rural with a **population density** (People/Square mile) of **54.32** within a land mass of 540.76 square miles. This often lends to accessibility obstacles for the residents.

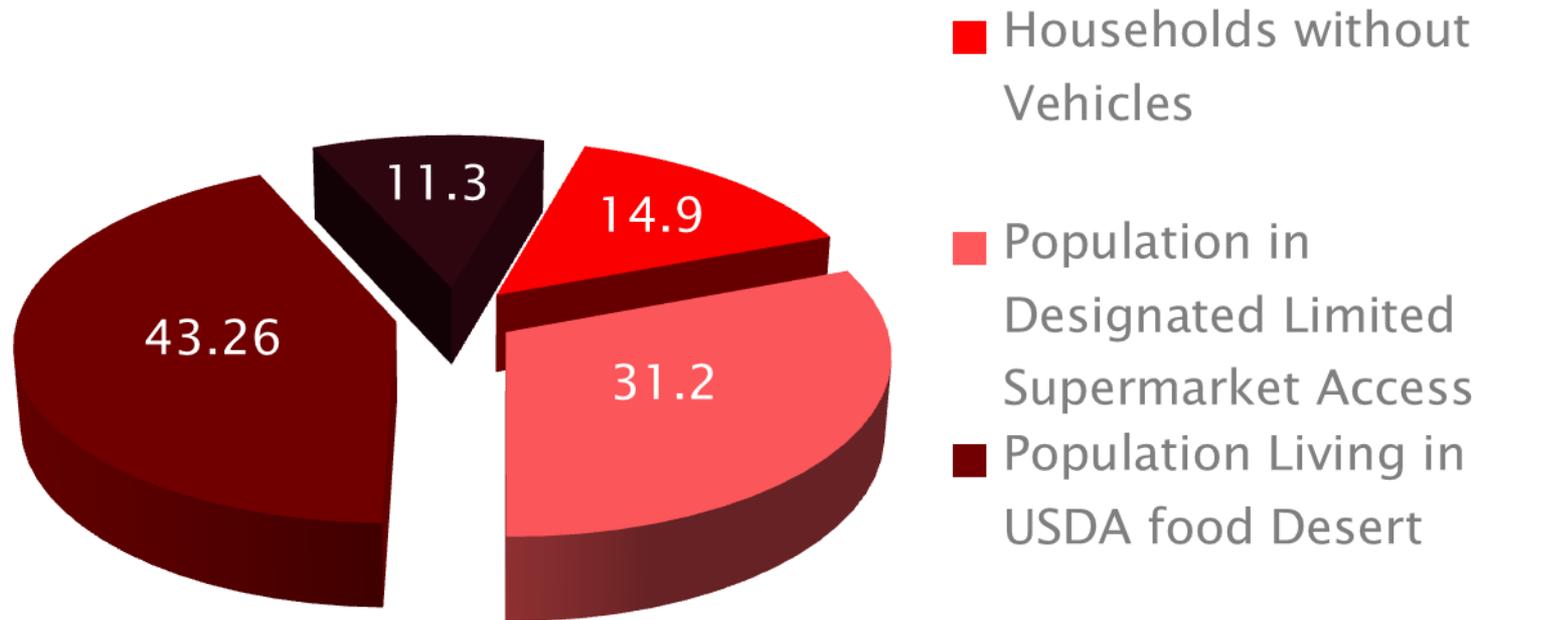
- **Limited Transportation Network**
- **Food Availability**
- **Health Disparities**

Food Availability

Dorchester County



Food Availability and Access



Transportation Networks

Dorchester County, has three (3) primary Transportation Networks readily available to the community residents:

- **Auto and Taxi Services – Total Fleet of 17 vehicles**
- Dorchester Transit – Bus Fleet of 22 buses – 21 routes operating every 45 minutes to 1 hour from 5:00 am – 6:45 pm
- **Medical Transportation – Appointment Only**

Health Access & Care Availability

Primary care provider to population ratio, by county

Caroline County: 1:2,915

Dorchester County: 1:2,437

Talbot County: 1:1,056

Worcester County: 1:2,028

Queen Anne's County: 1:2,016

Somerset County: 1:2,452

Wicomico County: 1:1,668

Kent County: 1:1,462

Maryland statewide: 1:1,647

– Source: Maryland Primary Care Office, DHMH

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THEN WHAT ?

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Meeting the needs of the people:



Key Results

- ▶ Incorporated additional No Cost, Fresh Produce and Protein mobile pantries in outlying areas of the community
- ▶ Provided Transportation Vouchers for community members to access health care or services related to employment
- ▶ Partnered to increase community interest in the available transportation services
- ▶ Met with various stakeholders and community members to develop county plans which will increase access to transportation and quality health services.

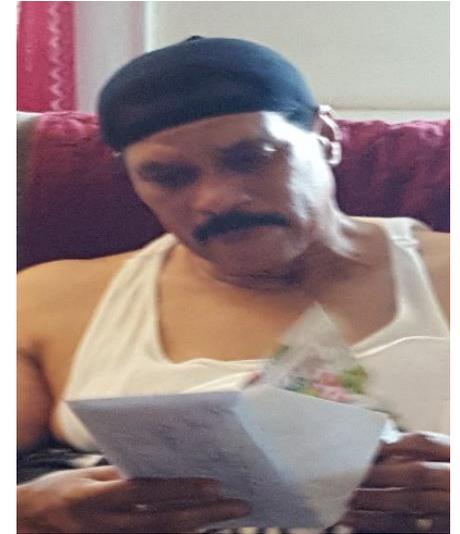
WHERE ARE WE NOW -

- Community Members who are excited about linking with CHW's and Health Care Providers as a team.
- Expanded M.O.T.A. services for community members to include:
 - Self-management training 30, 60, & 90 day follow-ups
 - Community Centered Mobile Food Pantries
 - A greater sense of TRUST within multi-cultural communities
 - HIV Education
 - No Cost Health Screenings and increased referrals for services
 - Increased Awareness among community members on the environmental Impacts that affect health and health outcomes.
- Truly culturally sensitive to all marginalized communities



Lastly –

A larger population of our Dorchester County community members who are invested and actively participating in the improvement of their health outcomes.



Telehealth in Rural Communities



Resources

DHMH - Maryland Health Equity Data

<http://dhmh.maryland.gov/mhhd/Pages/Health-Equity-Data>

*Maryland Chartbook of Minority Health And Minority Health Disparities Data
Selected Statewide and Dorchester County Data - February 15, 2011*

DHMH – Maryland Primary Care Office

<http://bhpr.hrsa.gov>



THANK YOU!

Ashyrra C. Dotson
adotson@abc-md.org
410 - 221 - 0795



**Asian American
Center of Frederick**
Enhance. Empower. Enrich

WELCOME

Health Equities – 180°

Elizabeth Chung, Executive Director
Asian American Center of Frederick

Maryland office of Minority Health and Health Disparities
14th Annual Health Equity Conference

December 7, 2017

The Mission

ENHANCE: Access to services

EMPOWER: Capacity Building

ENRICH: Cultural Diversity

Programs and Services Offered

Citizenship & Integration Services (CIS)

Preparing citizenship applications and providing weekly Civics and English (ESL) classes.

AACF Ambassador Programs

Training volunteers to serve as bridges between the community and AACF by participating in outreach events and services.

Retired & Senior Volunteer Program

Drawing on the experiences and skills of our older community members to meet critical community needs through our RSVP.

Health Programs

Advocating health equity by providing health events, information and referrals to health services.

Community Health Workers (CHWs)

Connecting individual community members to health care services, information and resources.

Interpreting & Translation Services

Improving community access to health and social services by offering interpreting services in more than 30 languages including: American Sign Language, Burmese, Chinese, French, Hindi, Korean, Russian, Spanish, Vietnamese and more.

Culture

Enriching local culture by sponsoring ethnic events and encouraging cross-cultural activities.



**Asian American
Center of Frederick**
Enhance. Empower. Enrich



The Vision

We support everyone to reach the American Dream – Equity



Targeted Population

Ethnic Minority
(recent) immigrants



Human Resources

14 FTE
500+ Volunteers
30 Consultants



Governing Board

12 members
75% minority
50% (M/F)



Financial Capital

60% contracts
25% grants,
15% donation (Est.)



National Minority Health Month 2017

BUILDING HEALTH EQUITY ACROSS COMMUNITIES

Faith Striders of Frederick, MD presents
Co-sponsored by Asian American Center of Frederick

3rd Annual 2017 *Minority* HEALTH FAIR

SATURDAY, APRIL 8 9:30AM - 2PM

Trinity United Methodist Church
705 West Patrick Street, Frederick, MD
MULTI-PURPOSE ROOM

APRIL - NATIONAL MINORITY HEALTH MONTH

FREE SCREENINGS VENDORS demonstrations

BUILDING HEALTH EQUITY ACROSS COMMUNITIES

Health Professionals COUNSELING prevention
Give-Aways & More

APRIL - NATIONAL MINORITY HEALTH MONTH

FOOD Resources nutrition WOMEN'S HEALTH

THIS IS A FREE EVENT AND ALL ARE WELCOME
For more info contact Angela Spencer (301) 514-1071 angelaospencer@gmail.com

4/8 Community - based Health Fair



BOOMERS TALK!

Navigating the Path Ahead

*Your path in life is changing... are you ready?
Do you know where to turn for answers and assistance?*

Join us for a FREE MEAL and conversation about your needs as you move forward in your life!

- ✓ Free and open to the public age 55+ and/or caregivers!
- ✓ Interpreter services available upon request.
- ✓ RSVP Enrollment

WHEN?	APRIL 27, 2017 4-6pm
WHERE?	Trinity United Methodist Church 705 W. Patrick St., Frederick, MD 21701
WHO?	Aged 55+ and/or caregivers
RSVP:	info@aacfmd.org or call: 301-694-3355 By April 25, 2017

Asian American Center of Frederick
Enhance. Empower. Embrace.

RSVP

BRIDGING HEALTH EQUITY ACROSS COMMUNITIES
NATIONAL MINORITY HEALTH MONTH 2017

Funding provided by the Maryland Office of Minority Health & Health Disparity

4/27 – Senior Health Sharing



TOWN HALL MEETING

BRIDGING HEALTH EQUITY ACROSS COMMUNITIES
NATIONAL MINORITY HEALTH MONTH 2017

The Life Center International wants to know what's on your mind concerning healthcare in Washington County. So we're holding a town hall meeting to find out what's important to you, your neighborhood and your town. It's your chance to talk to the church, local government and community organizations about some of Washington County's top medical issues and care concerns.

- ✓ Free and open to the public
- ✓ HIV testing *
- ✓ Free blood pressure screening
- ✓ Free giveaways
- ✓ Healthcare Information
- ✓ Free Food

*Please RSVP at 301-600-3388 for HIV testing appointment

THUR APR 27th
6:30 PM - 8:30 PM
Doors open at 6:00 PM

"Let's Talk Health"

The Life Center International
Transforming lives through faith, fundamentals and fellowship

† 62 E. Antietam St Hagerstown MD 21740 (240)280-0885 Phone

4/27 - Faith-based Town Hall



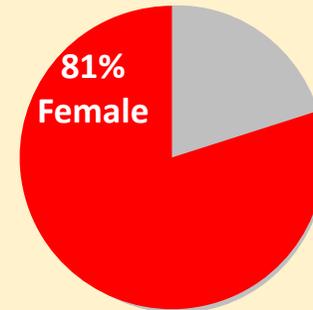
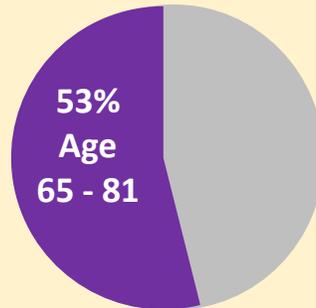
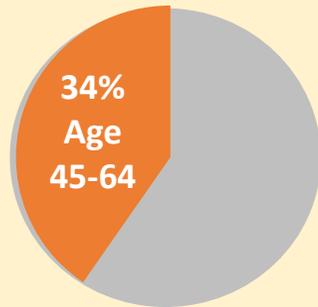
Boomers Talk: Navigating the Path Ahead

April 27, 2017

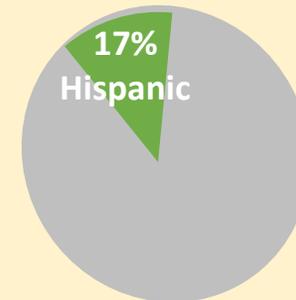
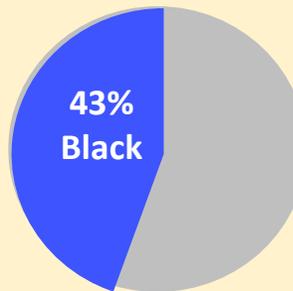
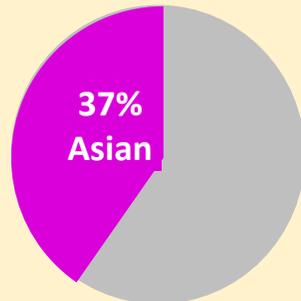
Targeted: 55+ and care givers

Goal: conversation with seniors on their health needs

Highlights
Attendees:
at least 90



Race/Ethnicity



Empowerment



Enrich
inclusiveness



Partnership



Enhance access



Collaboration



Boomers Talk – Navigating the Path Ahead



Fath Striders – 3rd Annual

Attendees – 100+

Partners – 30



Partnership



Access

Collaboration



Empowerment



Engagement



Partnership



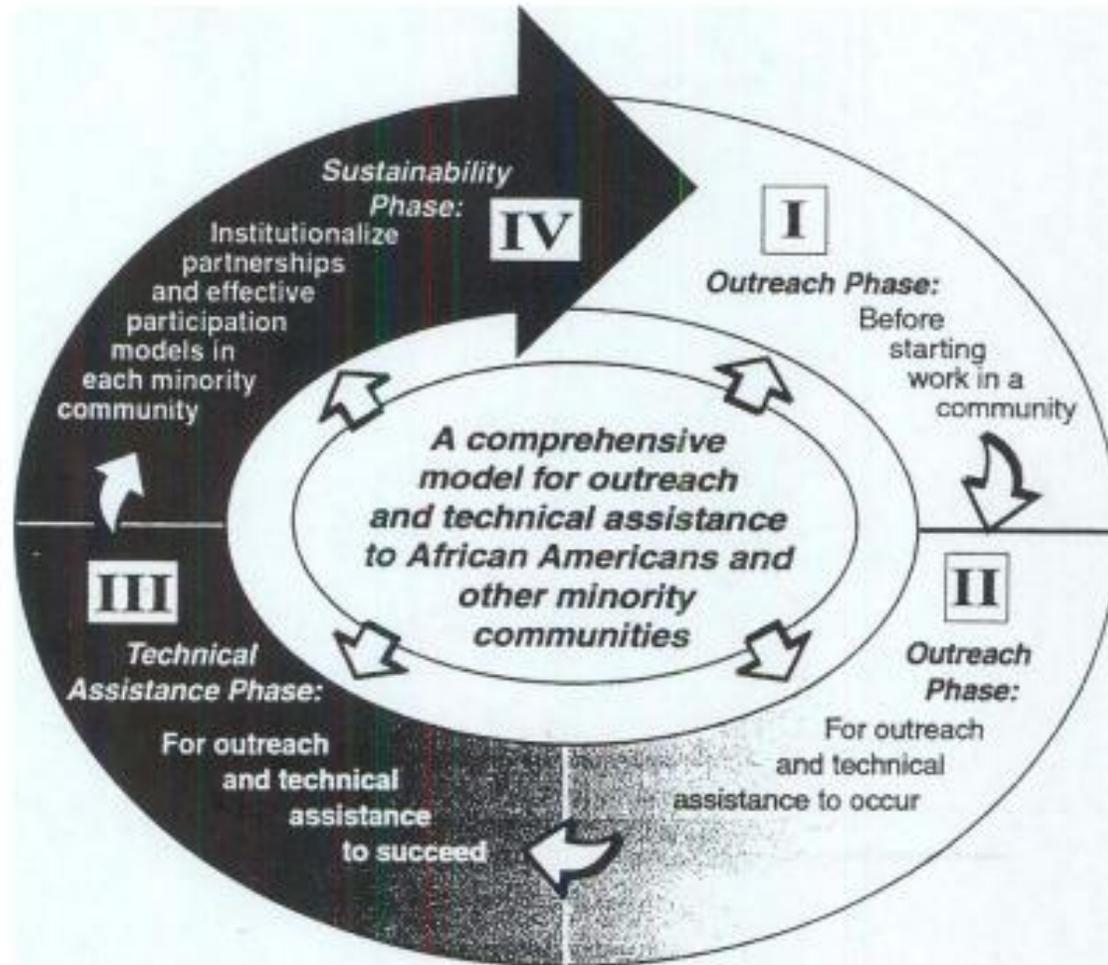
Technical Assistance



Town Hall– Washington County Maryland Health Department – Baltimore



Sustainable Minority Outreach and Technical Assistance Model. A Comprehensive Model For African-American And Other Minorities



February 2001

SMOTA Model

The process of creating the community collaborations and what engagement strategies.

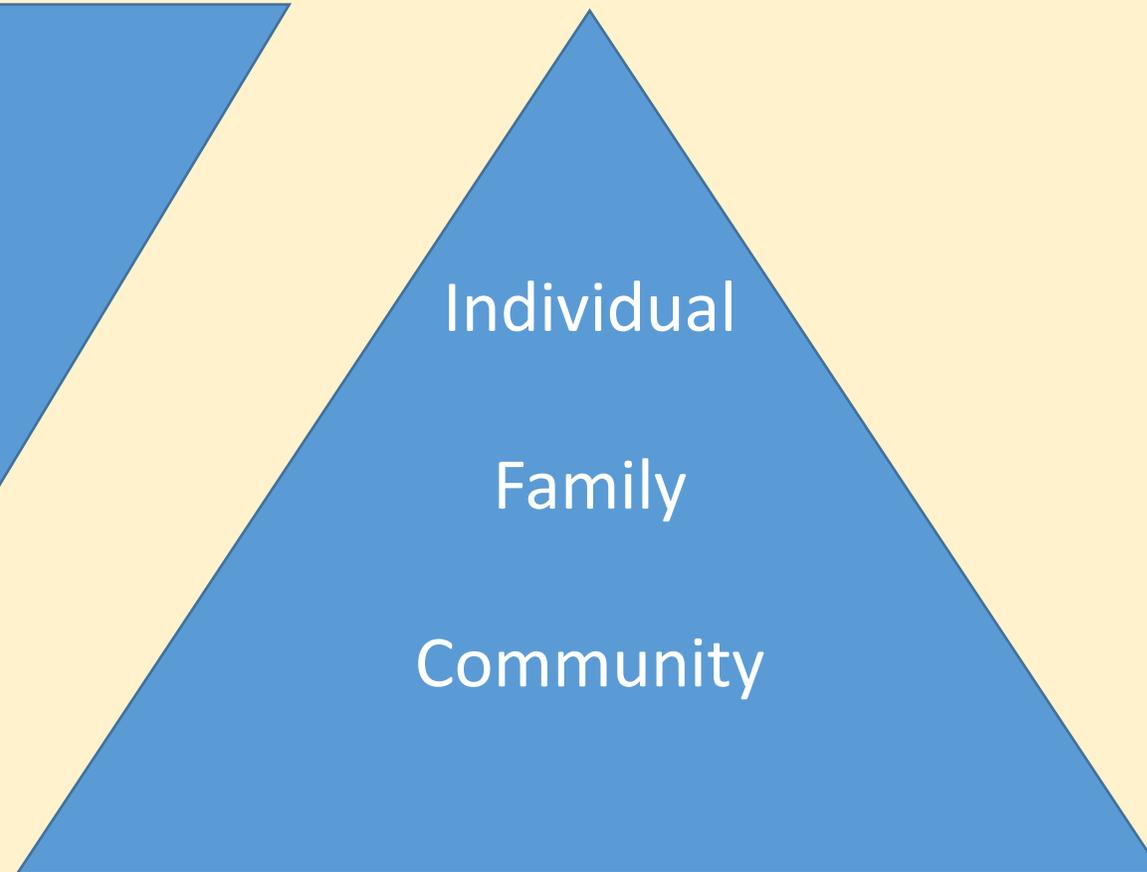
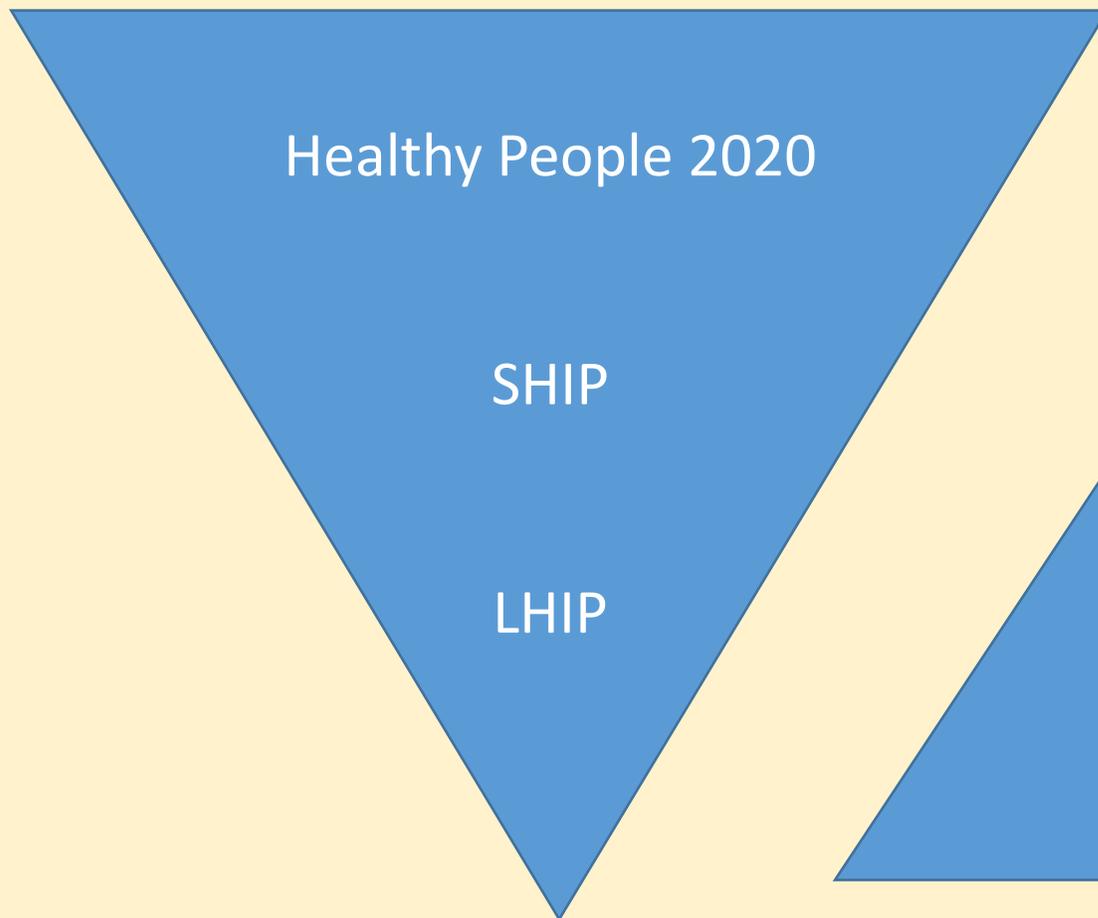
Source:

https://health.maryland.gov/mhhd/mota/SiteAssets/SMOTA_Model.pdf

Maryland's Cigarette Restitution Fund Program Sustainable Minority Outreach and Technical Assistance Model. A Comprehensive Model For African-American And Other Minorities Maryland Department of Health and Mental Hygiene

- Parris N. Glendening, Governor
- Kathleen Kennedy Townsend, Lt. Governor
- Georges C. Benjamin, MD, Secretary Carlessia A. Hussein, Dr.PH, Director CRFP Prepared by Naomi Booker & Associates February 2001

Health Equities 180°



Highlight or Take-Away from NMHM Community Conversations

Health Inequities Exist

● Race/Ethnicity, Age, Immigrant Status,
Gender/Sex Orientation

● Institution - Government, Public/Private,
Profit/Non-Profit, Corporation/Community

Current Public Health Practices

Prevention

Disease
Management

Intervention

Physical
Environment
Zoning and Land use
– community
development,
Housing, School,
Parks, Transportation

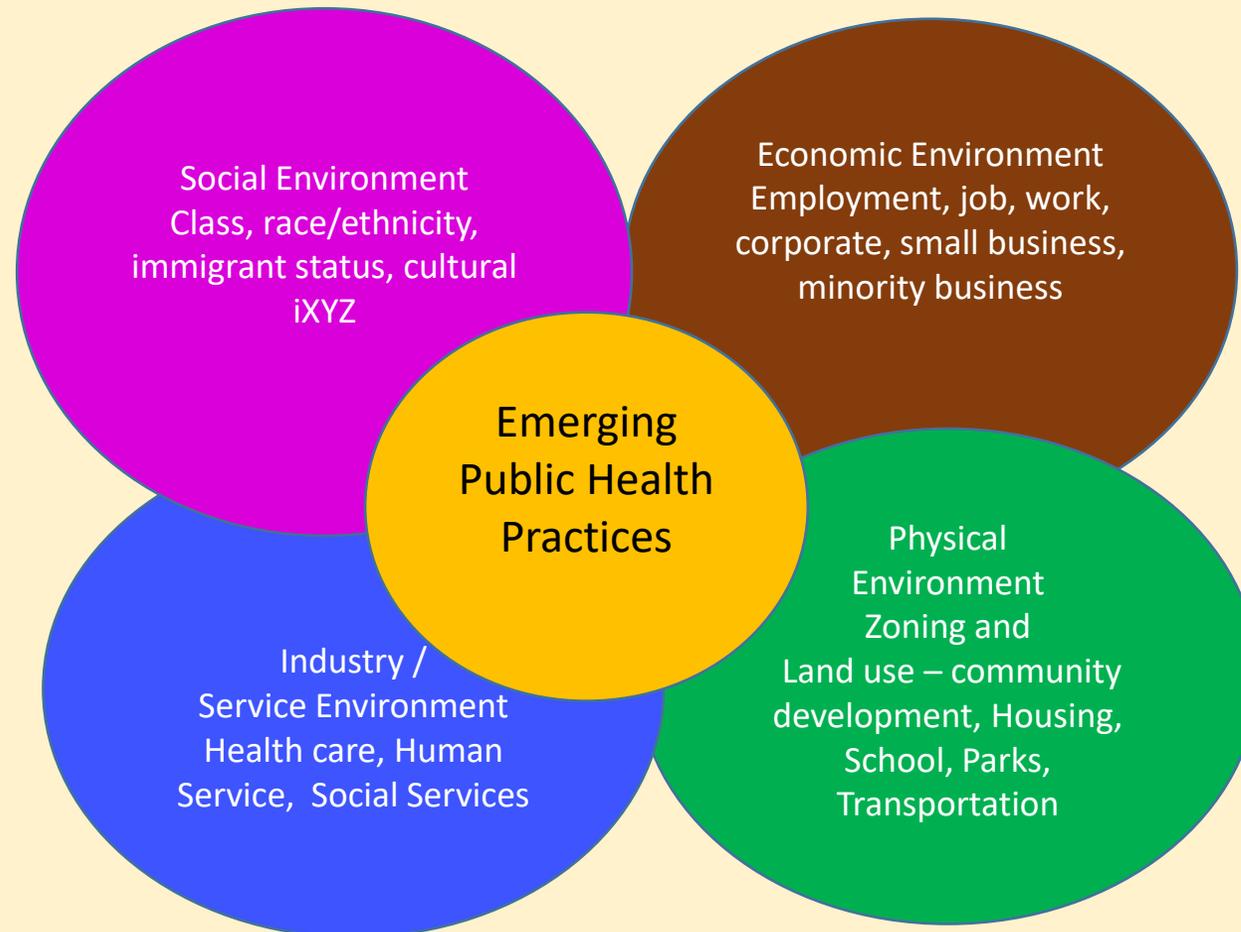
Social
Environment
Class,
race/ethnicity,
immigrant status,
cultural iXYZ

Economic
Environment
Employment, job,
work, corporate,
small business,
minority business

Industry / Service
Environment
Health care,
Human Service,
Social Services

Health Equities 180°

A change of mind set to lead optimal health for individual, family, community, state, and the nation



Lessons learned to improve Health Equities



START UP
Partnership

“Zero to One” by
Peter Thiel



SYSTEM
Collaboration

by
STAR Communities



AGENCY
Process

“SCRUM” by
J. Sutherland



#1 NEW YORK TIMES BESTSELLER

ZERO TO ONE

NOTES ON STARTUPS, OR
HOW TO BUILD THE FUTURE

Peter Thiel
WITH BLAKE MASTERS

STAR Community Rating System

Version 1.0 - October 2012



Copyrighted Material

SCRUM The Art of Doing Twice the Work in Half the Time

JEFF SUTHERLAND
Co-creator of Scrum
J. J. SUTHERLAND

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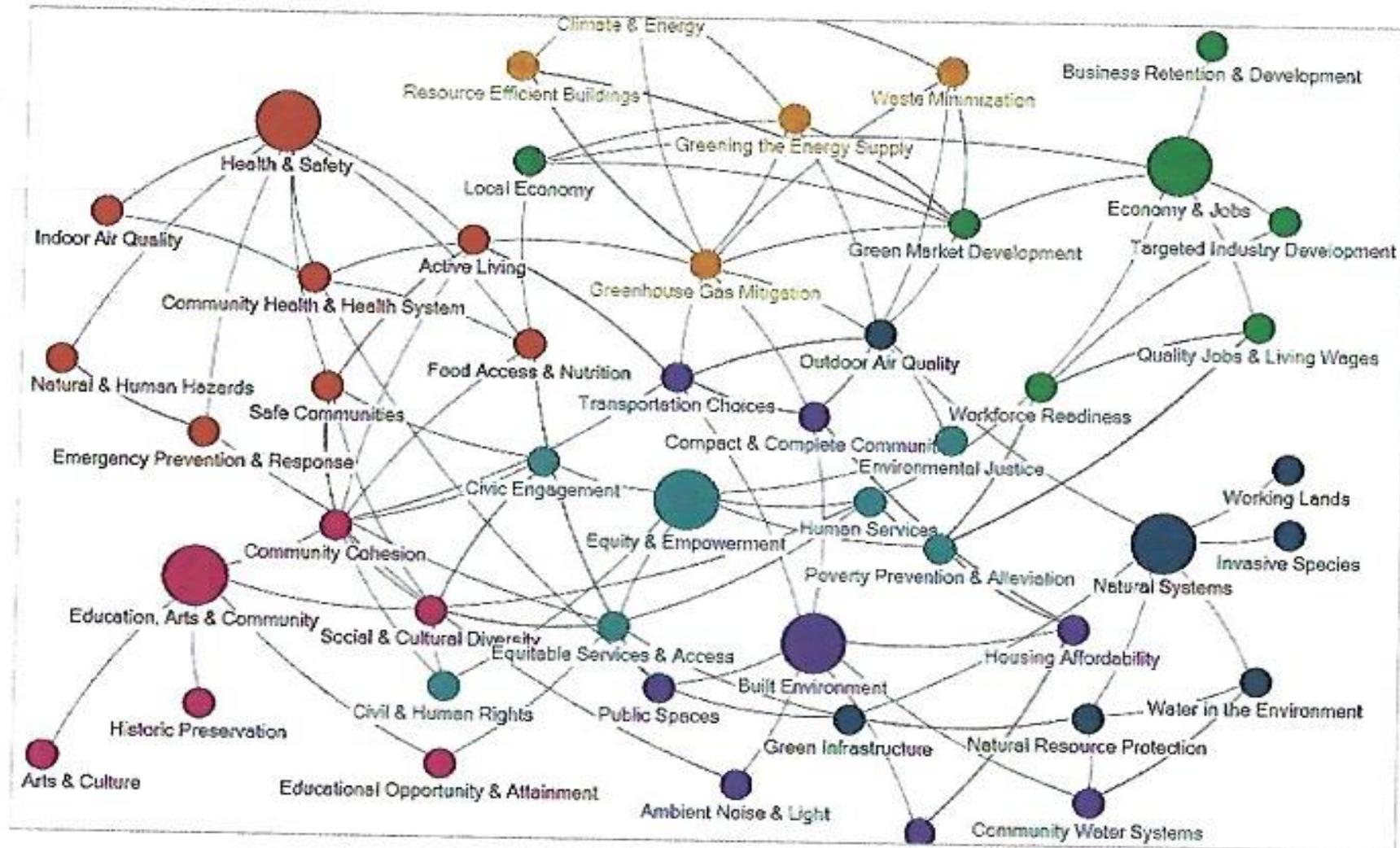
The STAR Community Rating System

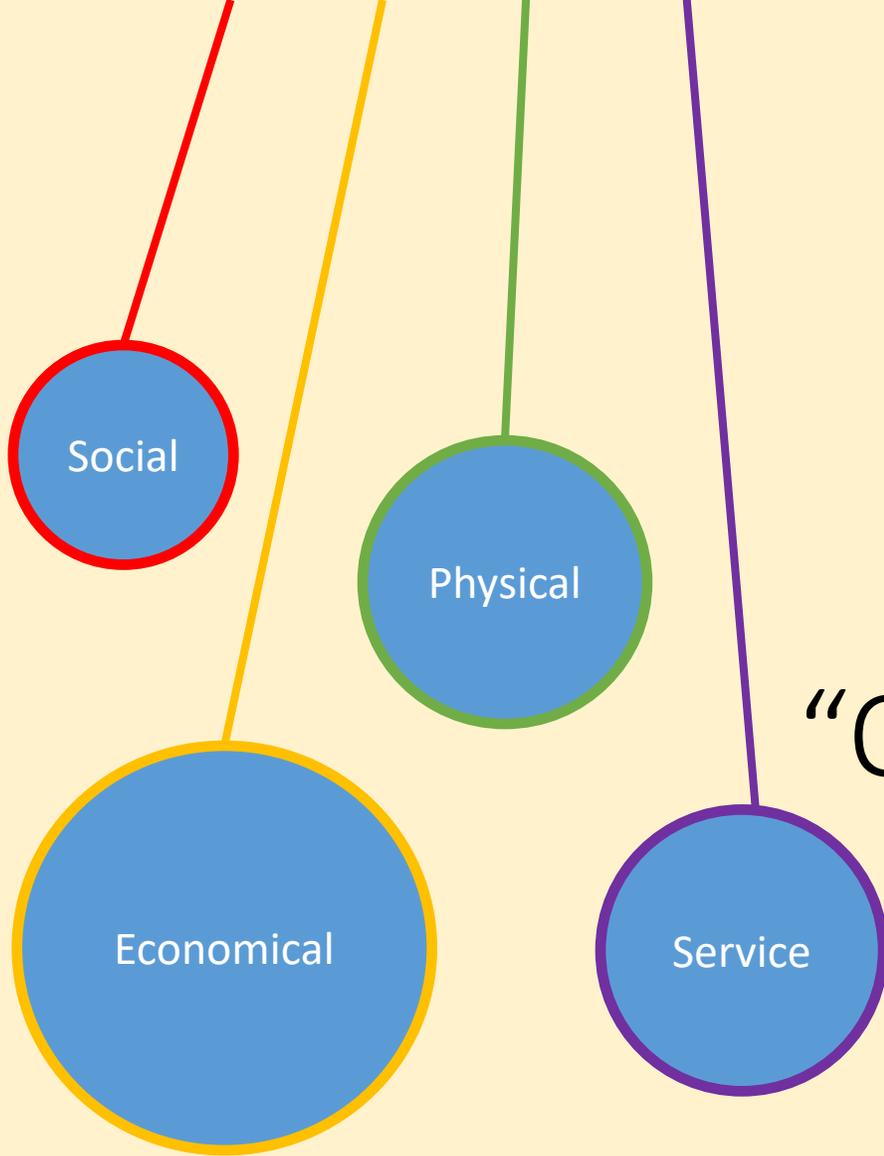
Goal Areas & Objectives are mapped and rated in the online system - helping local leaders set goals and measure progress across areas.

Built Environment	Climate & Energy	Economy & Jobs	Education, Arts & Community	Equity & Empowerment	Health & Safety	Natural Systems
Ambient Noise & Light	Climate Adaptation	Business Retention & Development	Arts & Culture	Civic Engagement	Active Living	Green Infrastructure
Community Water Systems	Greenhouse Gas Mitigation	Green Market Development	Community Cohesion	Civil & Human Rights	Community Health & Health System	Invasive Species
Compact & Complete Communities	Greening the Energy Supply	Local Economy	Educational Opportunity & Attainment	Environmental Justice	Emergency Prevention & Response	Natural Resource Protection
Housing Affordability	Industrial Sector Resource Efficiency	Quality Jobs & Living Wages	Historic Preservation	Equitable Services & Access	Food Access & Nutrition	Outdoor Air Quality
Infill & Redevelopment	Resource Efficient Buildings	Targeted Industry Development	Social & Cultural Diversity	Human Services	Indoor Air Quality	Water in the Environment
Public Spaces	Resource Efficient Public Infrastructure	Workforce Readiness		Poverty Prevention & Alleviation	Natural & Human Hazards	Working Lands
Transportation Choices	Waste Minimization				Safe Communities	

STAR CERTIFICATION PROGRAM

Collect and report data across the framework of goals and objectives





Social Justice Dr. Martin Luther King:

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane”.

谢谢

شكرا لك

Asante

Cảm ơn bạn

Danke

Gracias

고마워.

Merci

Salamat sa iyo

Thank You

