STATE OF MARYLAND
Community Health Resources Commission
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Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman – Nelson J. Sabatini, Vice Chairman – Mark Luckner, Executive Director

LHIC Grant Application Cover Sheet FY 2013-FY 2014

State Health Improvement Process: Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health

LHIC Designated Applicant Organization:

Name of Organization: Montgomery County, Maryland through the Department of Health and Human Services

Federal Identification Number (EIN): 52-6000980

Street Address: 401 Hungerford Drive

City: Rockville State: MD Zip Code: 20850 County: Montgomery

LHIC Official Authorized to Execute Grants/Contracts:

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Title: Assistant Chief Administrative Officer E-mail: kathleen.boucher@montgomerycountymd.gov

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Signature: _____ Date: 5/31/13

LHIC Project Director (if different than the official authorized to execute contracts)

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Phone: 240-777-4397 Fax: 240-777-3099

Overall LHIC Grant Funding Request: $236,672

(Range of $150,000 to $250,000 may be provided by CHRC on a competitive basis; funding requests below $150,000 will also be received and considered).

Draft February 29, 2012

Healthy Montgomery
Community Health Improvement Process
Action Plan

Mission

The mission of Healthy Montgomery is to achieve optimal health and well-being for Montgomery County, Maryland, residents. The Healthy Montgomery process is based upon an ongoing sustainable community and consensus-driven approach that identifies and addresses key priority areas that ultimately improve the health and well-being of our community.

Goals

- Improve access to health and social services;
- Achieve health equity for all residents; and
- Enhance the physical and social environment to support optimal health and well-being.

Objectives

- To identify and prioritize health needs in the County as a whole and in the diverse communities within the County;
- To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporate a wide variety of county and sub-county information resources and utilize methods appropriate to their collection, analysis and application;
- To foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and
- To coordinate resources to support the Healthy Montgomery infrastructure and improvement projects.

Background

Environmental Scan, Needs Assessment and Priority-Setting Process

The Montgomery County Community Health Improvement Process launched in June 2009 with a comprehensive scan of all existing and past planning processes. Past assessment, planning, and evaluation processes were compiled that related to health and well-being focus and social determinants of health across a multitude of sectors, populations, and communities within Montgomery County. By 2010, the focus was on establishing a core set of indicators that could be examined through a comprehensive needs assessment with approximately 100 indicators being released at the launch of the Healthy Montgomery website in February 2011.

During 2011, Healthy Montgomery staff and the Institute for Public Health Innovation (IPH*i*) consultants collected information on the health and well-being status of Montgomery County residents, along with socio-demographic information collected by Urban Institute consultants.

Healthy Montgomery staff then compiled this information into the *Healthy Montgomery Needs Assessment*, which was sent to the Healthy Montgomery Steering Committee (HMSC) in September 2011. The draft Executive Summary of the Healthy Montgomery can be found here.

In October 2011, the HMSC held a half-day retreat to choose the strategic priority areas for improvement activities.

The priority setting process utilized an online survey tool that the Steering Committee members completed prior to the retreat to enable them to independently evaluate potential priority areas by five criteria:

1. How many people in Montgomery County are affected by this issue?
2. How serious is this issue?
3. What is the level of public concern/awareness about this issue?
4. Does this issue contribute directly or indirectly to premature death?
5. Are there inequities associated with this issue? Health inequities are differences in health status, morbidity and mortality rates across populations that are systemic, avoidable, unfair, and unjust.

The survey results were compiled for each member and for the entire HMSC. The results were ranked and provided at the retreat to initiate the group process. Through multi-voting and consensus discussion, the Steering Committee narrowed the top-ranked priority areas to the following:

- Behavioral Health;
- Cancers;
- Cardiovascular Health;
- Diabetes;
- Maternal and Infant Health; and
- Obesity

Overarching Themes for Healthy Montgomery

In addition to selecting the six broad priorities for action, the HMSC selected three overarching themes (lenses) that Healthy Montgomery should address in the health and well-being action plans for each of the six priority areas. The themes are:

- Lack of access;
- Health inequities; and
- Unhealthy behaviors

The chart below summarizes the Healthy Montgomery priority areas, related Healthy Montgomery Website measures and related State Health Improvement Process (SHIP) objectives. Priority area-specific workgroups once formed in March 2012 may choose one or more of these measures/objectives for their action plans, depending on the specific improvement topic selected within the priority area.

Priority Areas	Healthy Montgomery Website Measures	SHIP Objectives
Behavioral Health	▪ Self-Reported Mental Health ▪ Age-Adjusted Death Rate Due To Suicide ▪ Self-Reported Diagnosis Of Anxiety ▪ Self-Reported Diagnosis Of Depression ▪ Youth Who Had A Major Depressive Episode ▪ Adult Social And Emotional Support ▪ Alcohol Use ▪ Alcohol Binge Drinking ▪ Non-Medical Use Of Pain Relievers ▪ Marijuana Use ▪ Illicit Drug Use	#8 Suicide Rate # 9 Decrease the rate of alcohol impaired driving fatalities #29 Reduce drug-induced deaths #34 Reduce the number of emergency department visits related to behavioral health conditions
Cancers	**Breast Cancer** ▪ Incidence Rate ▪ Age-Adjusted Death Rate Due To Breast Cancer ▪ Mammogram History **Colorectal Cancer** ▪ Incidence Rate ▪ Age-Adjusted Death Rate Due To Colorectal Cancer ▪ Screening Rate **Prostate Cancer** ▪ Incidence Rate ▪ Age-Adjusted Death Rate Due To Prostate Cancer **Cervical Cancer** ▪ Incidence Rate ▪ Age-Adjusted Death Rate Due To Cervical Cancer ▪ Pap Test **Lung And Bronchus Cancer** ▪ Incidence Rate ▪ Age-Adjusted Death Rate Due Lung Cancer ▪ Smoking ▪ Recognized Carcinogens Released Into Air	#26 Reduce the overall cancer death rate
Cardiovascular Health	▪ Age-Adjusted Death Rate Due To Heart Disease ▪ Age-Adjusted Death Rate Due To Cerebrovascular Disease (Stroke) ▪ High Cholesterol Prevalence ▪ High Blood Prevalence	#17 Increase access to healthy food #25 Reduce deaths from heart disease #28 Reduce hypertension-related emergency department visits # 30 Increase the proportion of adults who are at a healthy weight
Diabetes	▪ Age-Adjusted Death rate due to Diabetes ▪ Adults with Diabetes	#27 Reduce diabetes-related emergency department visits

Priority Areas	Healthy Montgomery Website Measures	SHIP Objectives
Maternal and Infant Health	▪ Infant mortality rate ▪ Babies with very low birth weight ▪ Babies with low birth weight ▪ Mothers who received early prenatal care ▪ Mothers who did not receive prenatal care or only received care in the 3rd trimester ▪ Teen birth rate	#2. Reduce infant death #3 Reduce low-birth weight (LBW) and very low birth weight (VLBW) babies #4 Reduce sudden unexpected infant deaths (SUIDS) #5 Increase the proportion of pregnancies that are intended # 6 Increase the proportion of pregnant women starting prenatal care in the first trimester
Obesity	▪ Adult who are obese/overweight ▪ Adult who are obese ▪ Adult engaging in moderate physical activity ▪ Fruit and vegetable consumption	#17 Increase access to healthy food # 30 Increase the proportion of adults who are at a healthy weight #31 Reduce the proportion of young children and adolescents who are obese

Action Plan Development

The six priority areas selected by the HMSC are broad and encompass a plethora of possible areas in which action can be taken. Therefore, the Steering Committee will establish workgroups, composed of individuals who are experts in the respective priority areas. Their task will be to develop, execute, and evaluate specific action plans that are designed to improve the health of the residents of Montgomery County. The workgroups will be supported by the Healthy Montgomery staff (currently less than 1.0 full-time equivalent) and IPH*i* consultants, who will provide technical assistance.

Because of limited resources to support the work groups, the Steering Committee will choose the order in which the work groups will be formed to address the priority areas at its March 5, 2012, meeting. The chart below shows the planned schedule for the implementation of the work groups.

Milestone/Deliverable	Completion Date	Responsible Parties
Select order of priority areas entering into action planning	March 2012	HMSC
Identify members of 2 initial workgroups ▪ Recruit individuals ▪ Orient members ▪ Select Work Group Chairs	 March 2012 April 2012 April 2012	Healthy Montgomery Staff
Assign staff to support workgroups ▪ Staff orientation ▪ Develop meeting schedule for all workgroup staff to meet ▪ Develop tools for staff support to report back to Project Manager	 March 2012 March 2012 April 2012	Healthy Montgomery Staff IPH*i* Staff

Milestone/Deliverable	Completion Date	Responsible Parties
Workgroups submit strategic plans ▪ IPH*i* produces tools ▪ IPH*i* presents tools and TA to groups ▪ Workgroups complete tools to finalize strategic plan ▪ Workgroups submit strategic plan to HMSC for approval	 April 2012 May 2012 August 2012 September 2012	Workgroup Chairs Workgroup members Healthy Montgomery Staff IPH*i* Staff
Workgroups submit implementation plans ▪ IPHi produces tools to compile implementation plan ▪ IPHi presents Implementation Plan tools and TA to groups ▪ Workgroups complete tools to finalize implementation plan ▪ Workgroups submit implementation plan to HMSC for approval	 July 2012 August 2012 October 2012 November 2012	Workgroup Chairs Workgroup members Healthy Montgomery Staff IPH*i* Staff
Workgroups submit evaluation plans ▪ IPHi produces Evaluation Plan tools ▪ IPHi presents Evaluation Plan tools and TA to groups ▪ Workgroups complete tools to finalize evaluation plan ▪ Workgroups submit evaluation plan to HMSC for approval	 October 2012 November 2012 December 2012 January 2013	Workgroup Chairs Workgroup members Healthy Montgomery Staff IPH*i* Staff
Action Planning Results are posted on Healthy Montgomery and Monitoring/Evaluation Begins	January 2013	Workgroup Chairs Workgroup members Healthy Montgomery Staff IPH*i* Staff

This plan will be updated as the individual action plans for each priority area are further developed and implemented.

Implementation Strategies for First Two Priority Areas (Areas of Focus)

I. Behavioral Health
II. Obesity

On March 5, 2012, the HMSC will act on a staff recommendation to adopt Behavioral Health and Obesity as the first two areas of focus for the development of workgroups to identify specific strategies and actions along with related evaluation plans to demonstrate impact on key health and well-being outcomes in each area. The specific strategic directions adopted by the initial workgroups will align with the National Prevention Strategy in its implementation approach. The following sections may be revised as needed upon final determination by the HMSC on or after March 5, 2012.

I. Behavioral Health

Mental Health and Mood Disorders
One in four adults in Montgomery County report they are not getting the social and emotional support they need. One in seven women and one in 14 men have been diagnosed with some form of an anxiety disorder, including acute stress, obsessive compulsive disorder, panic, phobia, post-traumatic stress disorder, or social anxiety. Over 40% of Montgomery County residents get inadequate sleep at night. Almost all (99%) Asian and Pacific Islander and Hispanic/Latino adults report being satisfied or very satisfied with their lives, while fewer African American/Black (88%) and White adults (94.1%) report being satisfied/very satisfied with their lives.

Substance Abuse
Substance abuse behaviors remained relatively level in 2006-2008 when compared with 2004-2006 estimates from the National Survey of Drug Use and Health, a national household survey of persons 12 years and older conducted by the U.S. DHHS Substance Abuse and Mental Health Services Administration (SAMHSA). Montgomery County is comparable to the State and the individual counties and Baltimore City in cigarette smoking, binge drinking in the past month, illicit drug use in the past month and non-medical use of prescription drugs in the past month.

Summary of Key Data Findings

- Adults, 18-44 years, reported most often having more than two days in a month when their mental health was poor, compared with adults, 45-64, and the elderly. Hispanic/Latino adults (35.8%) and White adults (20.4%) had the highest percent of adults reporting more than two days of poor mental health in a month.
- Rates of suicide among males are approximately 2.5 times higher (9.6/100,000 population) than females (4.2/100,000 population). Whites have a rate that is almost 50% higher (7.9/100,000 population) than the African American/Black population (4.3/100,000 population).
- One in 14 adolescents (12-17 years) reports experiencing a major depressive episode in the past year. The rate of depression increases with age among the non-elderly adults with one in seven adults, ages 18-44 years, and one in five adults, ages 45-64 years, report experiencing depression in the past year. Women have higher rates (18.6%) of self-reported depression than men (14.9%).
- Montgomery County has the lowest percent of persons (15.5%), 12 years and older, who reported cigarette use in the past month, use of any tobacco product in the past month and had the highest percent of people with a perceived great risk from smoking one or two packs of cigarettes a day when compared to other regions within Maryland.
- The Montgomery County prevalence for alcohol dependence and illicit drug dependence is lower than the Maryland and U.S. rates.
- Marijuana use is almost three-fold higher (15%) among Montgomery County young adults (18-25 years) than the overall Montgomery County population (5.6%).

While Montgomery County has slightly higher rates of alcohol use in the past month and marijuana use in the past year when compared to Maryland the other jurisdictions, the proportion of residents engaged in these behaviors has decreased compared to 2004-2006 estimates. Of concern is that fewer residents perceived a great risk from drinking five or more drinks once or twice a week in 2006-2008 than in 2004-2006. Nationally, alcohol consumption and binge drinking by youth, 12-20 years, decreased, but in Montgomery County in that same time period binge drinking increased slightly while alcohol consumption showed a modest decline.

Objective	2009 Baseline	2014 Target
Reduce the percent of adults that report more than two days of poor mental health in the past month. *Source: MD DHMH FHA BRFSS*	76.7% - Total 1.3 rate ratio (84.0% Black/64.2% Hispanic) 1.2 rate ratio (79.6% A/PI/64.2% Hispanic) Not Available: Asian/PI *(Data suppressed due to small sample size)*	5% reduction in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Close the disparity gap while reducing suicide deaths (Age-adjusted rate per 100,000 population). *Source: MD DHMH VSA*	7.0 – Total 2.5 rate ratio (10.3 Male/4.3 Female) 1.8 rate ratio (7.9 White/4.3 Black)	5% reduction in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Close the disparity gap while reducing the percent of adults that report ever being diagnosed with anxiety. *Source: MD DHMH FHA BRFSS*	2.0 rate ratio (13.7% Female/7.0% Male) 1.4 rate ratio (12.4% Adults 18-44 Yrs/8.7% Adults 45-64 Yrs)	5% reduction in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Close the disparity gap while reducing the percent of adults 18 years and older with self-reported diagnosis of depression. *Source: MD DHMH FHA BRFSS*	16.9% – Total 1.3 rate ratio (18.6% Female/14.7%Male) 1.8 rate ratio (20.8% Adults 45-64 Yrs/11.7% Adults 65+ Yrs)	5% reduction in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Reduce the percent of youth, 12-17 years, who had a major depressive episode in the past year *Source: SAMHSA NSDUH*	7.3 % (2006-2008)	6.9% *(5% Reduction)*
Close the disparity gap while increasing the percent of adults reporting adequate social and emotional support. *Source: MD DHMH FHA BRFSS*	81.6% – Total 0.9 rate ratio (80.9% Female/90.0% Male) 0.8 rate ratio (64.4% Black/85.1% White)	5% increase in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Reduce the percent of persons who have consumed alcohol in the past month. *Source: SAMHSA NSDUH*	58.7% – Total (2006-2008) 16.4% – 12-17 years 68.1% – 18-25 years 62.8% – 26+ years	55.7% *(5% Reduction)*
Reduce the percent of persons who had five or more drinks of alcohol on the same occasion in the month. *Source: SAMHSA NSDUH*	20.9% – Total (2006-2008) 9.8% – 12-17 years N/A – 18-25 years 19.5% – 26+ years	19.9% *(5% Reduction)*
Reduce the percent of people aged 12 or older who used marijuana in the past month *Source: SAMHSA NSDUH*	5.6% – Total (2006-2008) 6.4% – 12-17 years 15.0% – 18-25 years 2.9% – 26+ years	5.3% *(5% Reduction)*

Objective	2009 Baseline	2014 Target
Reduce the percent of people aged 12 or older who used illicit drugs in the past month. *Source: SAMHSA NSDUH*	6.7% – Total (2006-2008) 8.3% – 12-17 years 18.1% – 18-25 years 4.1% – 26+ years	6.4% *(5% Reduction)*
Reduce the percent of people aged 12 and older who used pain relievers for non-medical reasons in the past year. *Source: SAMHSA NSDUH*	3.4% – Total (2006-2008) 4.3% – 12-17 years 9.7% – 18-25 years 2.4% – 26+ years	3.2% *(5% Reduction)*

Strategies

Unhealthy Behaviors

- Support implementation and enforcement of alcohol and drug control policies.
- Educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking.
- Work with media outlets and retailers to reduce alcohol marketing to youth.
- Increase awareness on the proper storage and disposal of prescription medications.

Health Inequities

- Use data to identify populations at greatest risk and work with communities to implement policies and programs that address highest priority needs.
- Improve coordination, collaboration, and opportunities for engaging community leaders and members in prevention.
- Ensure that those in need, especially potentially vulnerable groups, are identified and referred to mental health services.
- Increase the cultural and communication competence of health care providers.
- Train and hire more qualified staff from underrepresented racial and ethnic minorities and people with disabilities.
- Enhance care coordination and quality of care (e.g., medical home models, integrated care teams).

Lack of Access

- Develop integrated care programs to address mental health, substance abuse, and other needs within primary care settings.
- Pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas.
- Enhance communication and data sharing (with patient consent) with social services networks to identify and treat those in need of mental health services.
- Ensure students have access to comprehensive health services, including mental health and counseling services.

Data/Infrastructure

- Support State efforts to implement the YRBS in local jurisdictions, including Montgomery County. County-wide data that characterize important health status, health risk and lifestyle behaviors, such as quality of life measures, overall mental and physical health and well-being, violence, stress, bullying, substance abuse, physical activity, nutrition, and sedentary behaviors, are not available for children, a group that has an increasing risk for many health and mental health conditions either during childhood or later into adulthood. The State (DHMH/MSDE) had planned to field the Youth Risk Behavior Surveillance System (YRBSS) with sampling methodology that would enable valid County level estimates biannually beginning in the fall of 2012, but those plans did not materialize. Healthy Montgomery will explore and address barriers to survey implementation.
- Support improvement in the availability local data for sub-population and vulnerable population groups in existing data sources, like the BRFSS. Health status, health risk and lifestyle behaviors, such as quality of life measures, overall mental and physical health and well-being, violence, substance abuse, physical activity, nutrition, and sedentary behaviors that increase the risk for developing mental health and chronic health conditions, such as depression, anxiety disorders, diabetes, cancer and heart disease, are difficult to measure accurately among our sub-populations, especially the Hispanic/Latino and Asian/Pacific Islander subpopulations because of survey methodology issues.
- Leverage existing population-based health data metrics (birth, death, and hospital utilization rates) to produce and post onto Healthy Montgomery neighborhood-/community-level estimates to inform policy, planning, and evaluation efforts.

Summary of Key Findings

- Men are less likely to eat five or more fruits and vegetables daily (26.1%) than females (38.1%). Younger adults, ages 18-44 (30.7%) and adults, ages 45-64 (30.0%) are less likely to get the recommended servings of fruits and vegetables than the elderly (39.7%). White adults were most likely to get five or more servings (33.6%) when compared to Asians (27.3%), African Americans/Blacks (29.1%) and Hispanic/Latinos (30.4%).
- Men are less likely to engage in at least light-to-moderate physical activity than females. Adults, 45-64 years (32.6%), are less likely to engage in at least light-to-moderate physical activity than adults, 18-44 years (34.4%), or the elderly (35.1%). Hispanic/Latino adults (39.7%) and White adults (35.2%) are more likely than Asian/Pacific Islander (25.3%) and African American/Black (29.1%) adults to engage in at least light-to-moderate physical activity.
- Men (61.0%) are more likely to be at least overweight than females (41.9%). Seven out of every ten Hispanic/Latino adults and African American/Black adults are either overweight or obese. Obesity levels are lowest among the Asian/Pacific Islander adults (2.6%) and highest among African American/Black (28%) and Hispanic/Latino adults (30%).

II. Obesity

In 2009, Montgomery County had more adults that consume five or more fruits and vegetables daily compared to all other reporting areas in Maryland. Montgomery County also has a statistically significant higher proportion of adults (48.4%) who were not overweight or obese compared with the rest of Maryland. Montgomery County has the lowest proportion of obese adults (17.5%) compared to the rest of the State (26.8%). Montgomery County is comparable (33.9%) to the Maryland average (34.1%) in the percent of adults with low to moderate physical activity on a weekly basis.

Inequities are prevalent among most key indicators for obesity. Addressing the root causes and closing the gaps in these disparities are paramount to improving outcomes in Montgomery County.

Objective	2009 Baseline	2014 Target
Close the disparity gap while reducing the percent of adults who are overweight or obese. *Source: MD DHMH FHA BRFSS*	51.6% – Total 1.5 rate ratio (61.0% Male/41.9% Female) 1.9 rate ratio (56.2% Adults 45-64 Yrs/ (29.5% Children Under 18 Yrs) 1.8 rate ratio (53.5% Seniors 65+ Yrs/29.5% Children Under 18 Yrs) 3.1 rate ratio (69.6% Black/22.1% Asian/PI) 3.1 rate ratio (67.9% Hispanic/22.1% Asian/PI)	5% reduction in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Close the disparity gap while reducing the percent of adults who are obese. *Source: MD DHMH FHA BRFSS*	17.5% – Total 10.8 rate ratio (28.0% Black/2.6% Asian/PI) 11.5 rate ratio (30.0% Hispanic/2.6% Asian/PI)	5% reduction in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Close the disparity gap while increasing the percent of adults who are engaging in at least moderate physical activity weekly. *Source: MD DHMH FHA BRFSS*	33.9% – Total 0.64 rate ratio (25.3% Asian/PI/39.7% Hispanic 0.73 rate ratio (29.1% Black/39.7% Hispanic)	5% increase in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Close the disparity gap while increasing the percent of adults who are consuming at least five servings of fruits and vegetables daily. *Source: MD DHMH FHA BRFSS*	32.1% – Total 0.75 rate ratio (27.4% Male/36.7% Female) 0.78 rate ratio (30.7% Adults 18-44 Yrs/39.6% Adults 65+ Yrs) 0.77 rate ratio (30.3% Adults 45-64 Yrs/39.6% Adults 65+ Yrs) 0.58 rate ratio (25.5% Asian/PI /44.2% Hispanic) 0.65 rate ratio (28.8% Black /44.2% Hispanic) 0.68 rate ratio (29.9% White /44.2% Hispanic)	5% increase in each rate ratio *(disparity gap eliminated when ratio equals 1.0)*
Reduce the percent of children who are obese or overweight. *Source: MD DHMH/MSDE YRBSS*	Data not collected Proxy from 2009 BRFSS: 29.5%	*To Be Determined*
Reduce the percent of children who are obese. *Source: MD DHMH/MSDE YRBSS*	Data not collected	*To Be Determined*
Increase the percent of children who are engaging in at least moderate physical activity weekly. *Source: MD DHMH/MSDE YRBSS*	Data not collected	*To Be Determined*
Increase the percent of children consuming at least five servings of fruits and vegetables daily. *Source: MD DHMH/MSDE YRBSS*	Data not collected	*To Be Determined*

Strategies

Unhealthy Behaviors

- Support community outreach and education efforts across all sectors that promote both the individual need to balance intake and expenditure of calories to manage body weight and to follow the current USDA dietary guidelines: Eat less by avoiding oversized portions; make half of the plate fruits and vegetables; make at least half of the grains whole grains; switch to fat-free or low-fat (1%) milk; choose foods with less sodium; and drink water instead of sugary drinks.
- Support local education and outreach programs across all sectors that support breastfeeding babies exclusively for the first 6 months after birth when able.
- Support local efforts to prevent food-borne illness by following key safety practices— clean (wash hands and surfaces often), separate (do not cross-contaminate), cook (cook food to proper temperatures), and chill (refrigerate promptly).

Health Inequities

- Use data to identify populations at greatest risk and work with communities to implement policies and programs that address highest priority needs.
- Improve coordination, collaboration, and opportunities for engaging community leaders and members in prevention.
- Improve privacy-protected health data collection for underserved populations to help improve programs and policies for these populations.
- Ensure that those in need, especially potentially vulnerable groups, are identified and referred to needed services.
- Increase the cultural and communication competence of health care providers.

Lack of Access

- Support Montgomery County Commission on Health efforts to ensure that foods served or sold in government facilities and government-funded programs and institutions (e.g., schools, prisons, juvenile correctional facilities) meet nutrition standards consistent with the Dietary Guidelines for Americans.
- Support policies that further increase the availability of healthy foods, including, but not limited to, healthy foods in a la carte lines, school stores, vending machines, and fundraisers.
- Support Montgomery County Public Schools in efforts to make further strides to eliminate high-calorie, low-nutrition drinks from vending machines, cafeterias, and school stores and provide greater access to water.
- Support efforts to strengthen licensing standards for early learning centers to include nutritional requirements for foods and beverages served.
- Support Montgomery County Commission on Health efforts to work with our hospitals, early learning centers, health care providers, and community-based organizations to implement breastfeeding policies and programs.
- Support Department of Recreation and other local organizations to offer opportunities for physical activity across the lifespan (e.g., aerobic and muscle strengthening exercise classes for seniors).

- Support collaboration among Montgomery County Department of Health and Human Services, Maryland-National Capitol Parks and Planning Commission, and other local organizations:
    - to conduct a comprehensive scan of current laws, regulations, and policies related to zoning regulations, incentives to zoning codes
    - to promote access to healthy food to develop an approach to attract full-service grocery stores, supermarkets, and farmers markets to underserved neighborhoods, and disincentives in zoning codes that discourage a disproportionately high availability of unhealthy foods, especially around schools.

Data/Infrastructure

- Support State efforts to implement the YRBS in local jurisdictions, including Montgomery County. County-wide data that characterize important health status, health risk and lifestyle behaviors, such as quality of life measures, overall mental and physical health and well-being, violence, stress, bullying, substance abuse, physical activity, nutrition, and sedentary behaviors, are not available for children, a group that has an increasing risk for many health and mental health conditions either during childhood or later into adulthood. The State (DHMH/MSDE) had planned to field the Youth Risk Behavior Surveillance System (YRBSS) with sampling methodology that would enable valid County level estimates biannually beginning in the fall of 2012, but those plans did not materialize. Healthy Montgomery will explore and address barriers to survey implementation.
- Support improvement in the availability local data for sub-population and vulnerable population groups in existing data sources, like the BRFSS. Health status, health risk and lifestyle behaviors, such as quality of life measures, overall mental and physical health and well-being, violence, substance abuse, physical activity, nutrition, and sedentary behaviors that increase the risk for developing mental health and chronic health conditions, such as depression, anxiety disorders, diabetes, cancer and heart disease, are difficult to measure accurately among our sub-populations, especially the Hispanic/Latino and Asian/Pacific Islander subpopulations because of survey methodology issues.
- Leverage existing population-based health data metrics (birth, death, and hospital utilization rates) to produce and post onto Healthy Montgomery neighborhood-/community-level estimates to inform policy, planning, and evaluation efforts.

State Health Improvement Process:
Supporting Local Health Improvement Coalitions to Fuel Local Action and Improve Community Health

Background Information and Summary

Montgomery County, Maryland's most populous county with nearly one million residents, is one of the nation's 336 "minority-majority" counties. County residents represent a racially, culturally, and ethnically diverse mix, including 17.2 percent African-American or Black, 13.9 percent Asian, and 17.0 percent Hispanic. More than 30 percent are foreign-born, and 35.8 percent speak a language other than English at home [Census 2010]. While this diversity brings great vitality to our community, it also challenges providers to meet varied health care and social service needs in culturally and linguistically sensitive ways. Although Montgomery County appears to have abundant health resources, unacceptable health and health care disparities persist especially for members of racial and ethnic minority groups who have low incomes. An estimated 120,000 residents are uninsured and a significant number of Montgomery County residents are Medicaid-insured. These groups include a heavier representation of racial and ethnic minorities than the general population, and bear a higher disease burden with health disparities and difficulty in accessing health care services.

The health issues of special focus for the project proposed here are *behavioral health* and *obesity*. They comprise two of the six priority areas set by Healthy Montgomery (HM), the County's Local Health Improvement Coalition (LHIC), using information gathered from health indicators and vital statistics. The Healthy Montgomery Steering Committee selected behavioral health and obesity as the first two priority areas for countywide intervention. Increases in the rates of overweight or obese residents within Montgomery County and rising utilization rates of behavioral health services were factors used to support this selection.

Currently, 56.1 percent of Montgomery County's residents are overweight or obese, a 10 percent increase since 2007. While the County's 47.7 percent of adults in 2009 who were at a healthy weight exceeded the Maryland 2014 target (35.7 percent) at baseline, obesity is an increasingly common, costly health condition and a risk factor for the leading and most preventable causes of chronic disease and death: heart disease, stroke, diabetes, and certain cancers. Specific programs that address weight loss, nutrition, and physical activity exist within the County. However, to effectively address the rising rates of obesity and its associated, preventable health conditions, greater coordination among providers and increased access to support services will be required.

In recent years, Montgomery County-operated programs have experienced a rise in requests for behavioral health services. In addition, uninsured or underinsured patients with behavioral health diagnoses (both mental health and substance abuse) represent a significant portion of "frequent fliers" – patients with repeated avoidable or non-emergent visits – in the emergency departments of Montgomery County hospitals [Primary Care Coalition, Report 2011]. Although public agencies and some safety-net medical homes provide behavioral health services, enhanced communication/integration of services would greatly improve care coordination amongst behavioral health service providers.

The proposed project will work with public agencies, hospital emergency departments, clinics and other partners to increase awareness of existing services and promote integration across programs so patients, especially low-income uninsured or underinsured patients, will have increased access to culturally appropriate, quality care. The project will establish referral systems and track patients referred from one service to another to assess how effectively health needs are being met. The proposed project will train patient navigators and outreach workers to understand and communicate about the Healthy Montgomery priority areas, with special attention to obesity and behavioral health as well as incorporate mental health training opportunities to increase capacity through the department's community outreach workers.

Proposed LHIC: Healthy Montgomery Project

The Montgomery County Local Health Improvement Coalition, Healthy Montgomery (www.healthymontgomery.org), consists of four phases that repeat every three years: information gathering; assessing needs; setting priorities/planning action; and monitoring and evaluation. Based on a core set of 100 indicators of health and social determinants of health tracked by Healthy Montgomery and additional vital statistics/demographic information, the *Healthy Montgomery Needs Assessment* was completed in September 2011. In October 2011, using the information compiled in the report, the Healthy Montgomery Steering Committee (HMSC) established the following six priority action areas: behavioral health, cancers, cardiovascular health, diabetes, maternal and infant health, and obesity. At the March 2012 meeting, the HMSC chose obesity and behavioral health as the first two priority areas for action. Throughout Montgomery County, fewer resources have been devoted to these two areas, especially for low-income, uninsured, or underinsured patients, and existing resources are not well coordinated.

The overarching aim of the project is to support and strengthen the recommendations provided by the existing Obesity and Behavioral Health Action Planning Work Groups to advance Healthy Montgomery's efforts. Ultimately, the goals involve the integration and enhancement of services and the reduction of health inequities. The project will target the *Triple Aim* goals of better population health and patient experience of care with reduced overall health care costs. It will promote referral to safety-net medical homes in the community where vulnerable patients can receive both primary health care and behavioral health care in an outpatient setting.

Behavioral Health

During the summer of 2012, the HM Behavioral Health Action Planning Work Group was established. The group is comprised of behavioral health service providers and advocates throughout Montgomery County. Throughout the course of numerous meetings over the following months, the Work Group members developed a draft action plan for review/adoption by the HMSC. If funded, the below goals and objectives will align closely with the draft Behavioral Health Action Planning Work Group action plan to improve service delivery and care coordination throughout providers within Montgomery County.

Goal 1: Connect low income patients with behavioral health conditions, who have higher utilization of the emergency department for care, with integrated medical and behavioral health care services in order to lower emergency department utilization and improve the quality of physical and behavioral health care for these patients.

Objective 1a: Refer and navigate uninsured and underinsured patients who receive a behavioral health diagnosis in the emergency department to appropriate and integrated behavioral and somatic health services.

A successful 2009-2011 emergency department diversion project led by the Primary Care Coalition in Montgomery County referred low-income, uninsured and Medicaid-insured patients discharged from emergency departments at County hospitals to safety-net medical home clinics for follow-up care and primary care. Among its findings:

- Behavioral health patients were more prevalent among the non-emergent emergency department utilizers (5.2 percent) than the safety net population in general (3.0 percent).
- Emergency department patients with behavioral health diagnosis represented a percentage of the high emergency department utilizer group ("frequent fliers").
- Emergency department patients with behavioral health diagnosis were less likely to maintain a visit to a primary care clinic after referral (15.0 percent) than patients with chronic medical conditions, such as hypertension, hyperlipidemia, diabetes (range from 22.7 percent to 42.8 percent).
- Behavioral health patients were less likely to make an avoidable emergency department visit (-41.2 percent) after successful referral to a safety-net medical home clinic, however not as significantly reduced as patients with chronic condition medical conditions (range from -67.4 percent to -79.0 percent).

The proposed HM project will build on the above emergency department diversion project to develop and test enhanced referral activities specifically designed for patients with behavioral health diagnosis. The goal is to connect these patients with appropriate services (both behavioral health and medical) in the community that will improve their health and behavioral health outcomes and lower their emergency department use.

Emergency department staff will make referrals to navigators to provide the enhanced referrals. Navigators will receive training on behavioral health conditions and motivational interviewing techniques. They will be trained in algorithms to follow based on each patient's behavioral health and medical diagnoses in order to develop an intervention plan to connect patients with appropriate services. Navigators will be trained to reach out to patients with behavioral health diagnoses, understand the resources for these patients in the community, and design specific interventions that are tailored to each patient's needs.

Additionally, the Navigators will receive supervision from behavioral health professionals who will enable them to better navigate patients with behavioral health diagnosis. Participation in this process from community partners (Montgomery County behavioral health and safety-net clinics) will be essential to patient navigation success. Some of the interventions to be tested may include making expedited or next day appointments, providing reminder calls, checking whether the patient kept the appointment, and involving active engagement from the referral clinic that encourages the patient to keep the appointment.

Objective 1b: Expand outreach with trained outreach workers to communities with a high prevalence of residents with high non-emergent emergency department utilization ("hot-spotting") and refer vulnerable patients to safety-net medical homes.

Using data from its emergency department that sees a high percentage of Montgomery County's low-income emergency department patients, Holy Cross Hospital (HCH) has mapped addresses of patients with four or more avoidable emergency department visits in a year. The "hot-spots" data show that the "frequent flier" patients reside primarily in the Georgia Avenue corridor from Silver Spring to Aspen Hill. HCH has developed, and with this grant, will expand a community outreach program called *Linking Individuals to Community Services*. The project aims to connect vulnerable persons in the "hot-spot" communities, including behavioral health patients, to the health care and community services they need. Outreach workers will refer identified patients for care in safety-net clinics near their homes. The workers will track the number of encounters; number of persons referred to each safety-net clinic; the number of persons referred to community resources or classes; the number of persons enrolled in each class; including class attendance and class completion rate.

Objective 1c: Train emergency department navigators and outreach workers, as well as outreach workers and health promoters from Montgomery County's minority health initiatives, about the six Healthy Montgomery priority areas and include training to enhance skills in providing outreach to and working with persons with behavioral health conditions.

The proposal calls for the enrollment of project navigators and outreach workers in Holy Cross Hospital's Ethnic Health Promoter (EHP) program. The program trains motivated individuals who do not have a medical background to offer effective outreach and education on health issues to vulnerable populations in the community. The six-session EHP curriculum, developed by a medical anthropologist, focuses on the six health priorities set by Healthy Montgomery: obesity, behavioral health, cancers, cardiovascular health, diabetes, and maternal and child health. It utilizes adult learning techniques and innovative teaching strategies to engage students by using props, eliciting class participation, and role-playing. Participants who meet course requirements will receive a certificate of completion.

An additional component of the proposed project involves the enrollment of project navigators, outreach workers and health promoters in the Montgomery County Mental Health Association's training course called Mental Health First Aid (MHFA). The training introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews common mental health treatments.

Once completed, the participating staff will possess the following capacities:

- Identify potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, psychosis, eating disorders, substance use disorders, and self-injury;
- Gain an understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities;

- Proficiency in a five-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care;
- Ongoing access to evidence-based professional, peer, social, and self-help resources available to help someone with a mental health problem.

The inclusion of the MHFA training is highly recommended. The proposed partnership with the Montgomery County Mental Health Association will build capacity within the County's navigators, outreach workers, health promoters; enabling the possibility of early detection and timely referral to a service provider for treatment.

Goal 2: Integrate services among differing behavioral health providers, including the MCDHHS Behavioral Health and Crisis Services (BHCS), the Montgomery Cares Behavioral Health Program (MCBHP), MedStar Montgomery's Addiction and Mental Health Center (MMMC) and Holy Cross Hospital.

- The Montgomery County BHCS provides crisis and behavioral health services to complex patients requiring psychiatric intervention or management and detoxification/addiction recovery services for patients with substance abuse problems.
- The MCBHP offers treatment for patients with behavioral health conditions (depression, anxiety, trauma, panic, etc.) that are responsive to outpatient care and assists primary care providers when they treat behavioral health patients.
- The MMMC has earned a reputation of excellence in the delivery of a broad range of care including inpatient, outpatient, crisis, community education and outreach programs.
- Holy Cross Hospital (HCH) offers a full range of inpatient, outpatient and community-based health care services, with specialized expertise in women and infant services, senior services, surgery, neuroscience and cancer.

Objective 2a: Implement *Care-2-Care*, an electronic referral and management system, in County-run BHCS sites to improve communication across providers when co-managing patients.

Care-2-Care is a stand-alone electronic case management module originally piloted to manage ongoing treatment of cancer patients. It features ways to manage case loads, assign follow-up tasks and set shared care plans for patients that can enable providers from different agencies to better serve the same patient without sharing all of the information in their respective Electronic Medical Records with each other. Currently, the MCBHP uses Care-2-Care as a case management tool to efficiently manage large numbers of patients receiving behavioral health services in three primary care safety-net clinics.

This project will implement the use of Care-2-Care as the data management system commonly used by participating partners in order to track navigation of patients who are diagnosed with a behavioral health condition in the emergency department to allow for greater integration of behavioral health services in the County and coordinated care for BHCS patients with other providers. The project will develop and implement a patient consent form to inform patients about sharing of behavioral health and medical information and obtain their agreement.

The project will develop technology upgrades that connect Care-2-Care with two Electronic Health Record systems where a connection does not exist.

Objective 2b: Develop effective systems for referrals and expedited referrals from emergency departments to behavioral health services and between participating behavioral health services (BHCS, MCBHP, AMHC and HCH).

Behavioral health organizations will review and revise referral systems to ensure that patients receive needed care in the most appropriate setting. Programs will establish and implement clear shared criteria for referrals and expedited referrals.

Behavioral health organizations will work with partnering safety-net medical homes to provide expanded behavioral health services for patients referred through this project.

Obesity Prevention

Similar to the HM Behavioral Health Action Planning Work Group, a complimentary Action Planning Work Group was established during the summer of 2012 to develop an action plan to address the rising trends of at-risk or obese Montgomery County residents. The HM Obesity Action Planning Work Group, comprised of representatives from federal government agencies, local government departments, hospitals and interested community members, has developed draft recommendations for adoption by the HMSC. Healthy Montgomery's draft Obesity Action Plan lists the below overarching goals for consideration by the HMSC:

Goal #1: Improve coordination among all public and private agencies addressing obesity prevention and reduction activities in order to foster collaboration, address gaps, reduce duplication, and increase awareness of services among providers and the public.

Goal #2: By 2014, establish a County-wide obesity prevention surveillance system (MCOPSS) based on a set of valid, reliable, comparable and timely indicators on overweight and obesity among all available ages, races, ethnicities and socio-economic status in Montgomery County.

Central to the success of the Montgomery County Obesity Prevention Action Plan is the proposed coordination of interested public/private groups, commissions and boards currently addressing obesity within Montgomery County. The establishment of one official body is recommended to truly enable coordination and collaboration to provide an effective public health response to this alarming national trend.

If awarded, the Community Health Resources Commission's (CHRC) support will enable MCDHHS to recruit term-limited assistance to manage the below items in support of the Healthy Montgomery Obesity Goal #1:

Objective I.: Establishment of the Montgomery County Obesity Prevention Partnership - a coordinating body of key community public and private partners that are integrally involved in implementing policies, programs, and services that address obesity through healthful eating and physical activity by establishing a

collaborative vision, mission and goals for reducing obesity in Montgomery County through a multi-faceted and coordinated approach.

Objective II.: Montgomery County Obesity Prevention Partnership will initiate a strategic plan to enhance obesity prevention efforts through key strategies that directly increase healthful eating and physical activity to reduce obesity using existing resources.

Objective III.: Montgomery County Obesity Prevention Partnership will develop a sustainable funding strategy to support collaborative efforts in Montgomery County through the Montgomery County Obesity Prevention Partnership, including identifying an individual or agency that supports the Montgomery County Obesity Prevention Partnership.

Objective IV.: Montgomery County Obesity Prevention Partnership will create and publicize an obesity-related website with links to county, state and national public and private agencies addressing obesity prevention and reduction. Benefits to participating organizations include sharing information, fostering collaboration and increased awareness of services. The website should identify roles and responsibilities of various organizations, available resources, initiatives, priority needs and gaps. Benefits to individuals seeking healthful eating and activities programs will be to have information in one easily accessible website.

Objective V.: Montgomery County Obesity Prevention Partnership will finalize a strategic plan for obesity reduction for distribution to stakeholders, including, but not limited to, the Montgomery County Executive, the Montgomery County Council and the Montgomery County Department of Health and Human Services (MCDHHS).

The proposed position will be dedicated to the Obesity Prevention Action Planning Work Group, assisting with the planning efforts to establish the Montgomery County Obesity Prevention Partnership. Once in place, the position will transition to staffing the Montgomery County Obesity Prevention Partnership in order to achieve the subsequent milestones listed above within the terms of the CHRC grant.

Project Partners/Capacity/ Leveraging Resources

Montgomery County Department of Health and Human Services: MCDHHS will direct and provide oversight for the project. MCDHHS is an integrated health and human services agency providing an array of supports that address the basic and critical needs of the most vulnerable children, adults and seniors in Montgomery County. Within its integrated service delivery model, MCDHHS includes Behavioral Health and Crisis Services, Public Health Services as well as three additional service areas.

Holy Cross Hospital: HCH will be responsible for the referral of patients to safety-net medical homes and to track data for project evaluation. Operating for more than 50 years in Silver Spring, HCH is a 442-bed facility and one of the largest hospitals in Maryland. HCH cares for more than 196,000 patients each year. As a not-for-profit hospital, HCH reinvests its earnings into innovative and sustainable community benefit programs to improve the health of all those served, with particular emphasis on medically underserved and vulnerable community members. HCH's emergency department serves more patients than any other Emergency Department in the County.

MedStar Montgomery Medical Center (MMMC): MMMC will refer patients to safety-net medical homes, to accept referred behavioral health patients, and to track data for project evaluation. Founded in 1918 as Montgomery General Hospital, the first acute care hospital in the County, MMMC offers an integrated healthcare delivery system with 138 beds. MMMC's state-of-the-art emergency department completed renovation and new construction in 2010. The hospital also offers an inpatient and outpatient behavioral health care as well as health and wellness classes.

Holy Cross Hospital Health Centers (HCH Clinics): HCH Clinics will accept referred patients for primary and behavioral health care and track data for project evaluation. Established by Holy Cross Hospitals, the HCH Clinics operate in three sites (Silver Spring, Gaithersburg, and Aspen Hill) to serve more than 5,800 low-income uninsured patients each year. Among all the County's safety-net clinics, the HCH Clinics serve the most medically fragile patients; including patients recently discharged from the hospital. The clinics offer integrated behavioral health services. Clinic leadership is committed to a holistic team approach to clinical care and care management.

Proyecto Salud Clinic: Proyecto Salud will accept referred patients for primary and behavioral health care and track data for project evaluation. Proyecto Salud was established in 1997 to provide linguistically and culturally sensitive health care to Spanish speaking residents of Montgomery County. Currently serving more than 5,000 patients per year in two locations (Wheaton and Olney), Proyecto Salud offers primary adult healthcare, some specialty care, behavioral and mental health, diabetes services and disease self-management training, laboratory and medications.

MCDHHS Behavioral Health and Crisis Services: BHCS will install the Care-2-Care software within its sites; facilitating the referral process between other County service providers. BHCS maintains multiple sites within Montgomery County; serving as an integral component within the County's behavioral health system of care.

Primary Care Coalition of Montgomery County, Inc. (PCC): PCC will be responsible for day-to-day project management, upgrading and training staff on use of Care-2-Care, compiling and analyzing project data, and project evaluation. The PCC administers public-private collaborations for MCDHHS, managing health care for more than 30,000 uninsured adults and children each year. With additional grant funding, PCC provides technical assistance to 12 participating safety-net clinics, including a specialty referral network, point-of-service generic

pharmacy, quality and process improvement projects, integrated behavioral health, IT support, Medicaid implementation, and preparation for health care reform.

MCDHSS Minority Health Programs/Initiatives: Healthy Montgomery will coordinate with the Minority Health Programs/Initiatives to identify navigators, outreach workers, and health promoters for inclusion in the proposed training opportunities.

Evaluation

The various project partners recognize evaluation as an important part of their work. They will collect data to assess the effectiveness of this project and use it to continually improve processes and services.

Behavioral Health

For emergency department and community referrals to outpatient services, partners will collect the following data elements:

- Number of patients referred from emergency departments to safety-net medical homes and/or behavioral health services
- Number of patients referred from the "hotspot" communities to safety-net medical homes
- Number of patients who attended an appointment ("successful referral")
- Number of patients with follow-up behavioral health or primary care appointments
- Number of emergency department visits by referred patients, after referral, including both avoidable and non-avoidable

Based on these data, the project will aim to increase the rate of successful referral for behavioral health patients from 15% of the total referred to 25% and reduce post-referral emergency department utilization by patients with successful safety-net medical home referrals by 50%.

The project will assess the training of patient navigators and outreach workers using pre- and post-training surveys of their knowledge and understanding of the Health Montgomery priority areas and of working with behavioral health patients.

To assess the increased integration of behavioral health services, the project will use pre- and post-testing of providers and staff who are trained on and use the Care-2-Care module to determine its effectiveness for coordination of patient care.

Based on criteria for expedited referrals in the project, providers and staff will track the number of expedited referrals made and the number of patients who kept expedited referral appointments.

Obesity Prevention

The requested position to support the establishment of the Montgomery County Obesity Prevention Partnership will be tasked with completing the detailed action items previously listed. Milestone dates will be assigned to each item to ensure completion by the conclusion of the grant term.

Sustainability

The systems to be developed and improved upon within the scope of this project are sustainable. Partner organizations will have greater knowledge and understanding of one another leading to better ability to sustain cooperative systems. If, as anticipated, the project demonstrates improvements in successful patient referrals from emergency departments and "hot-spot" communities to safety-net medical homes, project partners will know which referral processes work best. Navigators and outreach workers will continue to have the knowledge they gained from training together and from their additional experience working directly with vulnerable behavioral health patients.

Activities developed in hospitals to refer patients will be incorporated into the ongoing work of the emergency departments and ongoing relationships with the safety-net medical home clinics will be strengthened. All reduction of avoidable emergency department visits will result in financial savings to the hospitals, which may allow hospitals to sustain the navigator role. The effort to integrate behavioral health is sustainable because provider organizations will develop stronger relationships and understanding of one another and they will have clear criteria for patient referrals. The participating hospitals/service providers will be able to integrate activities into ongoing work.

In regards to the obesity prevention activities, sustainability is at the core of the recommendation to consolidate the various efforts within Montgomery County. The groups, with various overlapping representatives and overlapping proposals, will be best supported by merging their respective capacities to be most effective within the County. Ensuring the ongoing sustainability of the Montgomery County Obesity Prevention Partnership is an essential component of the Obesity Prevention recommendations. Healthy Montgomery will work to align with the Montgomery County Obesity Prevention Partnership to achieve official county designation as well.

MCDHHS and each partner organization in this project are committed to increasing access to health care for all county residents, with special attention to vulnerable populations. This commitment means that the organizations will continue to seek additional funding as needed and develop additional strategies to achieve the overall aims of Healthy Montgomery, Triple Aim, or the coordination of planning efforts/intervention regarding obesity prevention activities.

Project Budget Form for LHIC Grant Funding Request	
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION	
State Health Improvement Process: ***Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health***	
LHIC/Organization Name: Healthy Montgomery/MCDHHS	
Project Name: Behavioral Health and Obesity Prevention Implementation	
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
Personnel Subtotal	
Personnel Fringe (% - Rate)	
Information Technology (Care -2-Care Software)	$18,000
Equipment/Furniture	$5,180
Supplies	$2,300
Travel/Mileage/Parking	$2,200
Staff Trainings/Development	$11,000
Contractual	$188,624
Other Expenses	$5,000
Indirect Costs (no more than 10% of direct costs)	$4,368.0
Matching Funds – at least 10% of the overall CHRC grant request must be provided in matching funds	$25,000
Total Amount Requested	$236,672
Total Including Match	$261,672

HOLY CROSS HOSPITAL

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Silver Spring, MD
20910-1484
(301) 754-7000
www.holycrosshealth.org

May 31, 2013

Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, Maryland 21401

To Whom It May Concern:

Holy Cross Hospital (HCH) is one of the largest hospitals in Maryland. Founded 50 years ago by the Congregation of the Sisters of the Holy Cross, today HCH is a 442-bed, 501(c)(3) not-for-profit teaching hospital caring for more than 196,000 patients each year. Located in Silver Spring, just north of Washington, D.C., and near the Capital Beltway and Metro transportation system, HCH primarily serves residents of the state's two largest jurisdictions, Montgomery and Prince George's Counties. As a member of Trinity Health, HCH serves in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities, and to steward resources. We serve a growing, aging and diverse suburban community which is increasingly urban, and our response to community need has been a central theme since our inception.

We enthusiastically support the Montgomery County Department of Health and Human Services' application for the State Health Improvement Process: Supporting Local Health Improvement Coalitions to Fuel Local Action and Improve Community Health. To support this proposal, we can meet the $25K match in personnel to support community participants through our *Linking INdividuals to Community Services (LINCS)* program. As partners in the program, the proposed budget request is for $30,770 to expand the *LINCS* program.

LINCS was developed in fiscal year 2014, to improve the health outcomes of the community by addressing the top-ranked priority areas (behavioral health, cancers, cardiovascular health, diabetes, maternal and infant health, and obesity) that were set by *Healthy Montgomery*, the county's local health improvement coalition. Utilizing information from the *New Yorker's* "The Hot Spotters" article, we were able to use Holy Cross Hospital's ER utilization data to pinpoint "hot spots" in the community that could benefit from targeted outreach and comprehensive care management. It was found that large clusters of ER frequent flyers reside along the Georgia Avenue corridor between Wheaton and Aspen Hill. The program will focus on this area by using community navigators and an Insurance Enrollment Guide to:

- Increase access to primary care by referring uninsured/underinsured residents to safety net clinics and by referring eligible individuals to a Medicaid/Health Insurance Exchange navigator for Medicaid enrollment,
- Increase healthy behaviors by enrolling Montgomery County residents in one or more HC Health sponsored, wellness programs (e.g., Chronic Disease Self-Management, Diabetes Prevention Program, or a variety of community fitness classes) and
- Address social determinants of health by developing community cohesiveness by implementing a Neighbor-to-Neighbor program. This program will engage the residents and partner with businesses and not-for-profit organizations in the community to assist in linking participants to health services, employment services, tax assistance, affordable housing, clothing, food and other county and state resources.

We look forward to partnering with the county to expand this program and improve the health outcomes of the community by providing access, education and health resources to the underserved communities in an effort to decrease health disparities in Montgomery County. We wish you great successes in this application. If you have any further questions, I can be reached by email at friarw@holycrosshealth.org or by phone at 301-754-7161.

Thank you for your consideration,

Sincerely,

Wendy Friar, RN, MS
Vice President, Community Health