State Health Improvement Process:

Supporting Local Health Improvement Coalitions to Fuel Local Action and Improve Community Health

June 26, 2013

Background

Montgomery County is the most populous county in Maryland, characterized by diversity and the variety of resources available to residents. However, there are significant disparities in socio-economic circumstances and health status among the County's nearly one million residents.

-More than 50 percent of residents represent racial or ethnic minority groups; establishing Montgomery County as a minority-majority county.

-More than 30 percent of residents are foreign-born and 35.8 percent speak a language other than English at home.

-There are 120,000 people who currently lack health insurance and a significant number of residents are Medicaid-insured.

- It is estimated that after the implementation of the Patient Protection and Affordable Care Act as many as 60,000 Montgomery County residents will remain uninsured.

Local Health Improvement Coalition: Healthy Montgomery
(www.healthymontgomery.org)

Montgomery County's Local Health Improvement Process is conducted in multiple phases that repeat every three years.

Following the completion of the Healthy Montgomery (HM) Needs Assessment in September 2011, the Healthy Montgomery Steering Committee established the following six priority areas:
- Behavioral Health
- Diabetes
- Cancers
- Cardiovascular Health
- Maternal and Child Health
- Obesity

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Project Priorities

Recognizing the significance of health disparities among Montgomery County residents, the HM Steering Committee considers race, ethnicity, income and access to health services in reviewing and analyzing data. It also considers the distribution of existing resources.

Among the HM six priorities, **Behavioral Health** and **Obesity** were selected as the first two issue areas for intervention.

Project Aim: Support the recommendations of the Behavioral Health and Obesity Work Groups by enhancing and integrating services that address health inequities related to behavioral health conditions and obesity.

Project Framework: Establish Triple Aim metrics that demonstrate improved population health, better quality care and reduced costs.

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Proposal Partners

- Montgomery County Department of Health and Human Services
    - Behavioral Health and Crisis Services

    - Minority Health Initiatives

- Holy Cross Hospital and Health Centers

- MedStar Montgomery Medical Center

- Proyecto Salud Clinic

- Primary Care Coalition of Montgomery County, Inc.

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Behavioral Health

Goal 1: Connect low-income patients with behavioral health conditions and a high frequency of Emergency Department (ED) utilization with integrated medical and behavioral health care services to decrease ED utilization and improve health status.

Objective 1a.
Refer and navigate uninsured and underinsured patients with behavioral health diagnoses from the ED to integrated somatic and behavioral health services.

Objective 1b.
Expand outreach efforts with specially trained community   outreach workers in *hot-spot* areas where residents have high rates of avoidable ED visits to facilitate linkages to safety-net clinics.

Objective 1c.
Train ED navigators and community outreach workers on the Healthy Montgomery issue areas and provide specialized training to enhance the skills required to work effectively with people with behavioral health conditions.

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Behavioral Health (continued)

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.

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.

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

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## Behavioral Health (continued)

Holy Cross Hospital - Linking Individuals to Community Services (LINCS): A public health initiative that addresses high healthcare utilization and one or more of the needs identified in Montgomery County's most recent Community Health Needs Assessment (CHNA) including diabetes, obesity and health disparities.

The plan will:
- Demonstrate the participation of a multi-sector team.

- Use decision support to identify ED and hospitalization data that supports the issues identified in the CHNA and to be addressed in the plan.

- Use the 'Hot Spotters' model to identify and target specific areas of concern in the community.

- Use evidence-based models and tools for monitoring the success of the plan with quantifiable metrics.

Hot Spotters' Model

Map 1 – CBM Population with 4 for more Visits
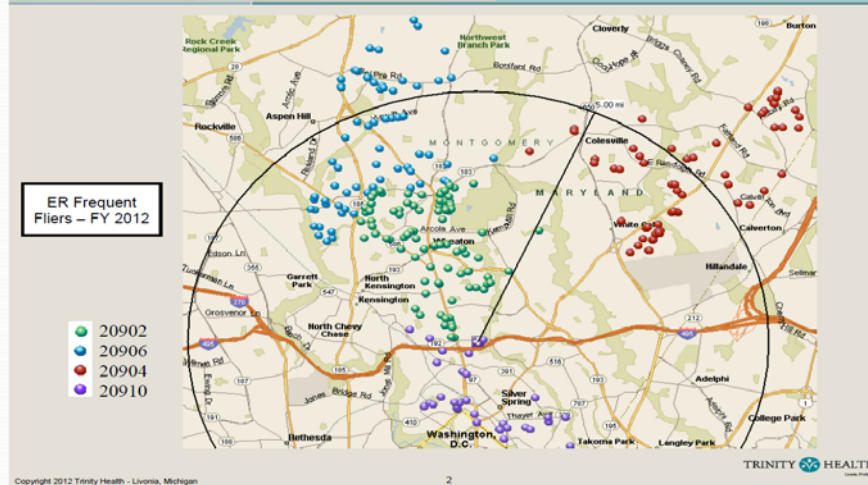
Obesity Prevention

Obesity is an increasingly common, costly health condition . It is also a risk factor for the leading and most preventable causes of chronic disease and death: heart disease, stroke, diabetes, and certain cancers.

In Montgomery County, 56.1 percent of residents are overweight or obese; a 10 percent increase since 2007.

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.

Obesity Prevention (continued)

Goal 1: Establish the Montgomery County Obesity Prevention Partnership to improve coordination among public and private agencies addressing obesity prevention and reduction activities to foster collaboration, address gaps, reduce duplication and increase provider and public awareness.

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

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Obesity Prevention (continued)

Current State   ### Future State

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Evaluation

Behavioral Health

- Collection and analysis of the five data elements listed within the proposal (page 9).

- Increase the rate of successful referrals for behavioral health patients to 25 percent.

- Reduction of post-referral ED utilization by patients with successful safety-net medical home referrals by 50 percent.

Obesity Prevention

- Unification of the various groups addressing the rising rates of obesity within Montgomery County.

- Achievement of the HM objectives listed within the proposal (pages 6-7).

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Sustainability

Behavioral Health

- Initial training and IT costs associated with the pilot project
are fixed.

- Ongoing support for the requested positions will be realized via cost-savings generated by the anticipated operational efficiencies.

Obesity Prevention

- Ongoing support of the County's integrated obesity prevention efforts will be absorbed within HM. Staffing assistance is needed to coordinate with the existing boards, committees and commissions leading to the establishment of a single obesity prevention body.

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