ORIGINAL

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Annapolis, MD 21401, Room 336
Office (410) 260-6290 Fax No. (410) 626-0304

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: Harford County Health Department

Federal Identification Number (EIN): _____

Street Address: 120 Hays Street

City: Bel Air State: MD Zip Code: 21014 County: Harford

LHIC Official Authorized to Execute Grants/Contracts:

Name: Russell Moy, MD MPH

Title: Deputy Health Officer E-mail: Russell.moy@maryland.gov

Phone: 410-877-1011 Fax: _____

Signature: [signature] Date: June 3, 2013

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

Name: MaryJo Beach RN

Title: Director, Administrative Care Coordination E-mail: Maryjo.beach@maryland.gov

Phone: 410-273-5626 Fax: 410-272-5467

Overall LHIC Grant Funding Request:

(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).

Harford County Health Department - *Developing Community-wide Coordinated Comprehensive Care and Improved Mental Health Care in Harford County.*

Program Need:

On the surface, Harford County seems to be a community with relatively minimal risk for negative health outcomes. It has a high median income, a 91% high school graduation rate, a respectable low rate of years of potential life lost, and a large percentage of insured residents. In fact, for the 15 selected medical and social indicators for Maryland Communities at Risk determined by the Department of Health and Mental Hygiene (DHMH), Center for Maternal-Child Health, Harford County is considered relatively low risk. And yet there are persistent areas of high negative health outcomes that are particularly striking, especially when broken down by race and geographic location.

Harford County has a minority population of approximately 18%; 13% of which is African American. While not a predominant percentage of the overall population, Harford County minorities suffer disproportionally from negative health outcomes. According to a 2009 report from the DHMH Office on Minority Health, Harford County ranks in the bottom 50% of counties for minority health disparities. This report also states that in 2009 African Americans in Harford County had a higher mortality rates for all-cause mortality as well as for the top four causes of death. [1]. In particular, minority populations suffer disproportionally from heart disease and diabetes, both high risk conditions which can contribute to negative pregnancy outcomes. The rate for diabetes was reported as two times higher for African Americans and 1.5 times higher for Latinos compared to Whites. In addition, while Harford County's total infant mortality rate in 2010 was 5.5 infant deaths/1,000 births, the County's African American infant mortality rate was 11.2/1,000. This rate was higher than the state average of 6.7/1,000 and particularly higher than the County's White infant mortality rate of 3.5/1,000 – a racial disparity of 3.2 to 1.

According to DHMH State Health Improvement Plan (SHIP) data, Harford County has a worse rating than the state average for: suicide rate, air quality, adult seasonal influenza vaccine rate, heart disease mortality, cancer mortality, drug-induced deaths, adult and youth tobacco use, behavioral health and Alzheimer's admissions to the emergency room, and Dental care for children and adolescents. This is supported by our Local Health Improvement Plan that focuses on obesity (heart disease/cancer), tobacco use, and behavioral health (substance abuse/mental health).

The issues regarding behavioral health are of particular concern as the effects of this public health issue are manifesting in ways that will affect not only the present quality of life in the community, but the life of residents for generations to come. This includes the growing number

[1] Maryland Chartbook of Minority Health and Minority Health Disparities Data, 2nd Edition (December 2009)

of children born with drugs and alcohol in their system, an increase in crime, a rise in behavioral health admissions to the emergency departments, and a higher than the state average suicide rate.

A large majority of safety net services such as sliding scale fee primary care, family planning, substance abuse, and mental health are located in and/or provide service for a client base that draws heavily from the high poverty areas of Aberdeen and Edgewood. Yet according to Emergency department records from Upper Chesapeake Health (UCH), our local hospital system, a full 40% of all emergency department patients come from the Aberdeen and Edgewood communities. Such high utilization of emergency room services is a clear indication of inadequate primary care. What we are finding is that only a small percentage of the total eligible populations from those areas are engaged in all the necessary care they need, and although there is a strong cross referral program to link clients to different services within the community, there are often unanticipated barriers accessing those services, resulting in a lack of follow through and less than optimal health outcomes. In other words, although many people may enter the system of care and be linked to multiple services through our no-wrong-door referral service, there is questionable follow through with services beyond the point of initial contact within the system. Our proposal is to create an integrated partnership between the Harford County Health Department (HCHD) and Upper Chesapeake Health (UCH) to actively care coordinate high risk patients to ensure all necessary somatic, environmental, and social services are received.

The Project:

The overarching purpose of this proposal is to improve overall health outcomes for high risk residents by providing comprehensive coordinated care and preventative mental health services to decrease unnecessary utilization of the emergency departments which are traditionally poor providers of primary and mental health care. While there is an established strong cross referral program in the county between primary, specialty care, mental health, substance abuse and social services such as WIC, tobacco cessation, and housing and domestic abuse programs, there is little or no care coordination across services to ensure that all services are being utilized to their full potential. This project will capitalize on the successful Comprehensive Women's Health Care Services program funded by the MCHRC and expand that service model to other entry points in the system utilized by high risk clients. Expanding this model takes the no-wrong-door approach a step further and provides targeted coordinated care management for all high risk clients to assure they will receive all necessary services both within the HCHD, UCH, and the community. In addition, over 50% of all suicide victims are said to have visited their primary care practitioner within one month of attempting suicide, the LHIC Behavioral Health Workgroup strongly suggests offering suicide screening and prevention training to local primary care providers, as well as hiring a mental health consultant for 4.5 hours a week to serve as a call-in resource for Practitioner mental health consultation and bridge prescription assistance as patients wait to be linked to a mental health care provider.

In order to accomplish this, three FTE clinical nurse social workers will be hired to case manage clients that enter the safety net service continuum from a number of different departments within the HCHD and Upper Chesapeake Health. This includes not only the emergency department, but also the maternity ward, outpatient services, and primary care, as well as WIC, substance abuse, HIV clinic, family planning, and Health Care for the Homeless among others. The project will be directed out of the Care Coordination unit of the Harford County Health Department which has a long history of community care coordination and community services support for high risk populations, but staff will rotate between offices in the HCHD, UCH HealthLink Primary Care Clinic, and other service agencies that service our target population.

Project goals already initiated through Comprehensive Women's Health Services Grant:

- Assessment of current level of care coordination services currently being provided in the HCHD family planning program.
- Identifying gaps in care coordination services that should be ideally provided.
- Establishing new relationships and strengthening existing relationships with key service partners in the community so that risk-appropriate referrals may be facilitated for clients in need.

Expanded goals under this new project:

- Expanding assessment and gaps analysis to other Health Department programs.
- House Care Coordinators in different locations within the community to ensure collaborative relationships with service providers and establish a trusted presence with target client population.
- Establishing a protocol that would screen all uninsured clients for Medicaid eligibility and assist with applications, or connect them with Health Insurance Exchange Navigators and Assistors.
- Develop a protocol of offerings that assures comprehensive services to all clients, including screening and referral for WIC nutrition services, substance abuse and mental health services, domestic violence prevention, tobacco cessation, literacy training, weight management, diabetes counseling, and other preventive services. Include consent form protocol so that clients are actively aware that other programs will be following up with them for services.
- Follow up with all clients who receive expanded services and referrals to make sure that no one is lost to care.
- Assess barriers to care and assist clients in navigating those barriers.
- Work with emergency department Patient Navigators and Behavioral Health Navigators to track high risk clients to monitor their emergency department usage and identify reasons for use, redirecting inappropriate use to more suitable venues for improved health care management.

- Collaborate with Hospitalists to ensuring that high risk users are properly following their discharge plans and are linked to the appropriate services.
- Establish quarterly "green room" meetings of representative service providers/institutions where high risk client cases and emergency room Super-users' files are examined and managed across the continuum of care.
- Emphasize stabilization of social and physical environment of high risk clients for improved health outcomes i.e. Coordination with Susquehanna Workforce for employment opportunities, Habitat for Humanity for improved home conditions (asthma/allergens, fall risks) , Meals on Wheels for food access, Harford Family House for emergency housing, etc.
- Collaboratively implement strategies to improve access to services for those who experience barriers.
- Develop fast track and walk-in protocols for identified high risk clients across the continuum.
- Provide suicide prevention training to all primary care providers and implement a community wide suicide screening protocol.
- Establish a care intervention for suicide risks to include a mental health consultant to serve as an on-call resource for high risk clients.
- Maintain a system for tracking and evaluation purposes to continuously improve programmatic processes.

The target population for this project is low income residents of Harford County that are in need of coordinated care due to challenging medical and social unmet needs, emergency department Super-users, and high risk populations such as parents of newborns born with drug or alcohol in their systems or patients with a history of mental illness. A number of statistical data sets have demonstrated that an alarming number of people in-need in Harford County are simply not engaged in care. According to the Alan Guttmacher Institute's Contraceptive Needs and Services, 8,040 (4,500 under 250% FPL, and 3,540 under age 20) women in Harford County are in need of contraceptive services, yet the Maryland Center for Maternal and Child Health FY2010 Reproductive Health Data Reports only 2,744 unduplicated clients in Harford County received services, *leaving a gap of unmet need estimated to be as high as 5,296 or 66% of women in need of services.* The Harford Maryland WIC program reports that only 64.5% of all eligible women and children access WIC services, leaving a gap of 35.5% of those in need who do not receive food and nutrition services. Of the estimated 20,000 uninsured in Harford County (Small Area Health Insurance Estimates, US Census Bureau and CDC, 2006-2010) only approximately 1,500 are enrolled in the Upper Chesapeake HealthLink Primary Care Clinic, the only primary care provider for the uninsured in our community. Through the efforts of the Affordable Care Act, many more people will soon have access to health services. If we do not establish systems now, however, which engage people in-need with necessary services across a

spectrum of services, community health outcomes many not necessarily improve simply with improved primary care access alone.

Evaluation:

Goal 1: Link all clients enrolled in coordinated care to a health care via Medicaid, the Health Insurance Exchange or the HealthLink Primary Care Clinic for uninsured patients.

Objective 1: By June 2013, screen and educate 100% of care coordination clients for insurance eligibility, and provide assistance with enrollment.

Objective 2: Case manage 100% clients to ensure linkage with a medical home, report quarterly beginning October 2013.

Goal 2: Engage low income high risk Harford County residents, with particular attention to minority populations, in care coordination program to improve health outcomes through comprehensive coordinated medical, social, and environmental services.

Objective 1: Establish protocols between 5 community service organizations such as Habitat for Humanity, Harford Family House (emergency family housing), Sexual Assault Resource Center (SARC), Community Action Agency (emergency services), Harford Food Bank, etc. for fast tracking of high risk clients in the Care Coordination program.

Objective 2: Develop and launch by September 2013 a community outreach program that incorporates at least 3 non-traditional but evidence based outreach methods to communicate the services of the Care Coordination program to the public i.e. website, social media, direct texting, etc.

Objective 3: Each annum starting in September 2013 increase the number of clients engaged in coordinated care by 10% through community outreach efforts.

Goal 3: Improve community mental health services through increased primary care provider training, and access to mental health consultation.

Objective 1: By March 2014 conduct a suicide prevention training open to all primary care providers and distribute toolbox of mental health resources in the community.

Objective 2: By January 2014 establish a mental health consultation resource available for conferring on patient care, bridge medication management, and patient stabilization to avoid unnecessary hospital admissions for low risk patients.

The success of this program will be based on a variety of factors including achievement of stated objectives and work plan outlines, and statistical analysis of diagnostic and referral information. The Care Coordinator project manager will prepare semi-annual reports detailing achievement of benchmarks, interim outcome results, and process measures, and communicate relevant information with collaborating agencies and departments.

Current in-house information technology is adequate for the project requirements, and the Health Department will not need new information infrastructure. The Harford County Health Department currently utilized the PatTrac software program to track client information and link merge information gathered in different Health Department departments for one comprehensive unified report per person. Via this system the HCHD is able to track client demographics, insurance information and services provided. Upper Chesapeake Health utilizes a different medical software system and the programs are not compatible. As such, for the time being, patient information will need to be communicated on a case by case basis within the confines of HIPPA laws. The intent is to create a protocol that allows patients to grant consent to a community care coordination team that spans across service providers, integrating information across data systems as necessary.

Data to be Collected

Measurement	Method(s) of Measurement
Diagnosis and Demographics	• Number of clients • Number of clients by age, race/ethnicity, insurance status, zip code. • Service provided • Types of Referrals made • Type Education received • Number and percent of Medicaid clients accessing services
Treatment	• Number of new clients • Number of clients referred from emergency department • Number of clients referred for mental health as primary reason • Number of consultations with mental health consultants, by providers, by patients. • Number of outreach activities

Access	• Catalogue of contacts per client • Track enrollment in Medicaid or other insurance plan • Catalogue of number and percent of patients referred to which community programs • Average number of days between referral and actual appointment date • Number and percent of patients with missed appointments by appointment type and reason
Resource utilization	• Track rate of visits to the emergency department within 2 years.

A critical aspect of evaluation is insuring that our primary goal of linking patients to medical care through enrollment in insurance programs as per the Affordable Care Act, improve health outcomes through coordinating access to medical care with necessary social, and environmental services, and providing increased access to bridge mental health care through better community training and improved resources. Every six months, qualitative and quantitative data will be compiled and analyzed. The Project Director will conduct periodic assessments of the program, review findings, and make adjustments as warranted. The goal is to ensure that the goals and objectives of the project are being met, to keep the work plan on schedule, and to monitor program sustainability efforts.

Sustainability:

The sustainability of this project comes from the idea that through care coordination more people will be screened for Medicaid eligibility and linked with either Medicaid or another form of insurance through the Health Insurance Exchange. Patient care will then be reimbursable for the services received. Care coordination and mental health services are also billable items under Medical Assistance. Cost savings will be realized through directing people towards preventative primary care as opposed to episodic emergency room visits; addressing underlying causes for poor health outcomes such as unsanitary or unsafe home conditions, homelessness, weight management, domestic violence, poor nutrition, etc.; as well as creating a primary care delivery system that is better trained to access and deter suicide and other mental health issues. Providing primary care providers with access to mental health consultation will also help decrease unnecessary emergency department visits. On-call mental health consultation can also provide an alternative place for emergency department Behavioral Health Patient Navigators to link low risk patients and avoid costly hospital admissions.

Key Personnel:

Project Administrator - Deputy Health Officer, Harford County Health Department – Russell W. Moy, M.D. M.P.H. Dr. Moy, a Board Certified physician in Obstetrics and Gynecology, is

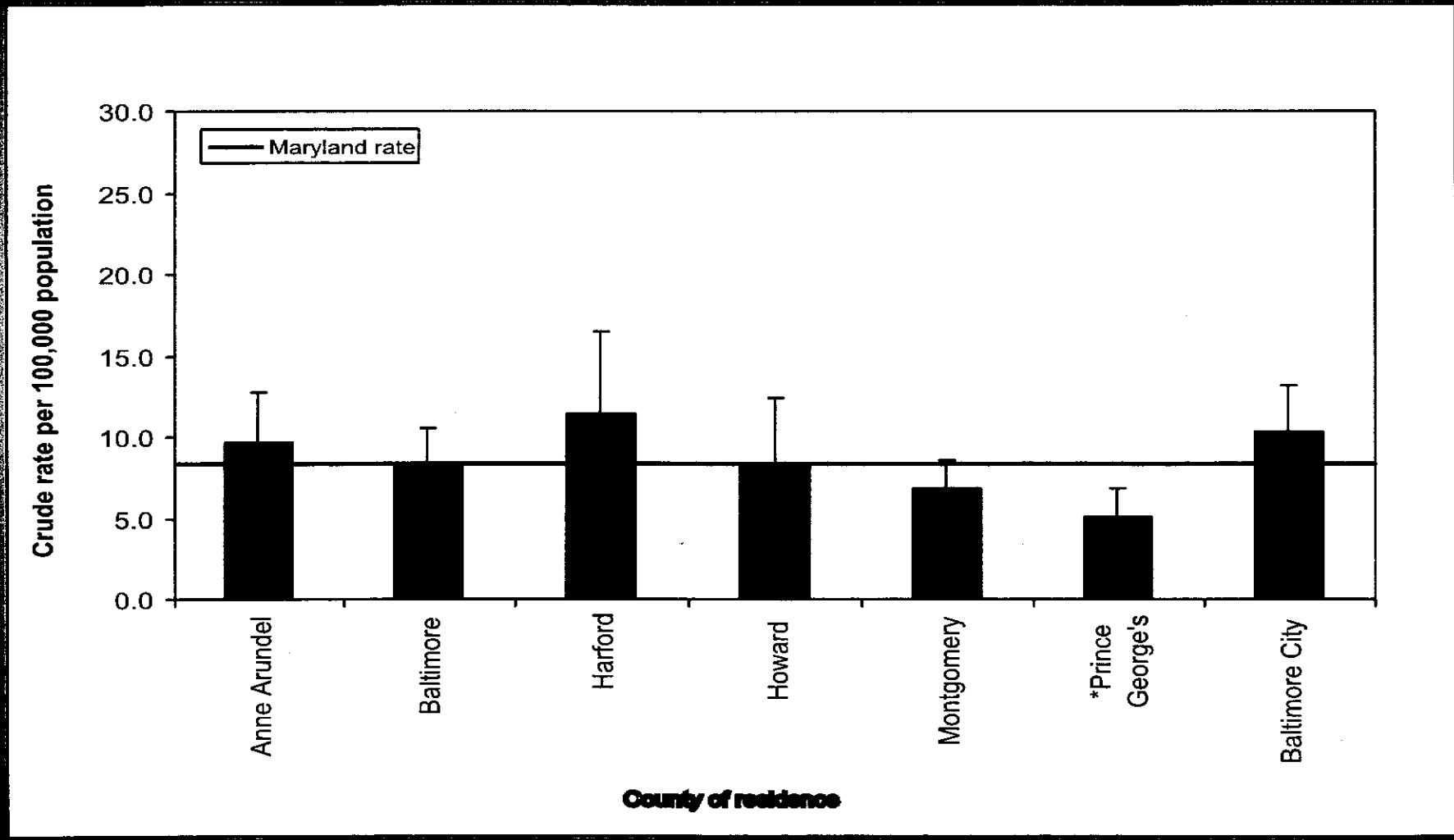
responsible for the medical and clinical oversight of local public health programs for the Harford County Health Department. Dr. Moy is the former Director, Family Health Administration, for the Maryland Department of Health and Mental Hygiene where he provided programmatic and clinical oversight of a broad array of statewide public health programs, including maternal and child health; family planning and reproductive health; genetics and children with special health care needs; WIC; cancer surveillance and control; tobacco use prevention; chronic disease and injury prevention; oral health; public health data, policy and planning; and chronic rehabilitative care. In addition he was responsible for administrative oversight of over 200 central office personnel and public health programs with an aggregate annual budget of over $200 million, and for governing body oversight of two chronic rehabilitative facilities with an aggregate annual budget of over $40 million.

Project Director – Mary Jo Beach, RN, Program Director, Administrative Care Coordination Unit. The Administrative Care Coordination Unit (ACCU) is the local arm of the Department of Health and Mental Hygiene (DHMH) and the Maryland Medicaid Program. ACCU answers questions about HealthChoice, the Maryland Children's Health Program, choosing an MCO, choosing a doctor, Medical Assistance benefits, and helps with accessing care. ACCU assists in locating mental health services, substance abuse treatment services, dental services, specialty providers and care coordination services for medical assistance recipients.

Ms. Beach will provide overall program direction and vision and will determine what issues need to be brought forth to executive leadership, namely the Health Officer and the Deputy Health Officer. She will be the direct supervisor of the yet-to-be hired Registered Nurse Care Coordinators, and will oversee program reporting, outreach and education strategies, financial operations, data collection and management. She will act as liaison to the FQHC, West Cecil Health Center, Upper Chesapeake HealthLink Primary Care Clinic, SARC, Core Services - Mental Health Agency as well as other departments within the HD, to ensure successful execution of this program.

Community Health Nurse II (TBA) – The Community Health Nurse II will be responsible for assessing the care coordination services currently being provided in the HCHD; identifying gaps in care coordination between programs, and developing/strengthening referral relationships within the community to facilitate access referrals so clients will have access to all risk-appropriate services. As part of case managed coordinated care, this person will review client medical records and link to them to appropriate community services, develop a protocol of offerings that assures expanded comprehensive services to all clients, including screening and referral for Medicaid eligibility, WIC nutrition services, substance abuse and mental health services, domestic violence prevention, smoking cessation, weight management and other prevention services, and follow up with all clients who receive expanded services and referrals, ensuring that no one is lost to care. As part of the community outreach component, the program will employ both traditional and non-traditional avenues (including social media) for communicating with and reaching out to stakeholders and clients. Other duties include

maintaining a data system for tracking and evaluation purposes in order to continuously improve programmatic processes.


30.0
25.0
20.0
15.0
10.0
5.0
0.0
Maryland rate
Crude rate per 100,000 population
Anne Arundel
Baltimore
Harford
Howard
Montgomery
*Prince George's
Baltimore City
County of residence

Circumstances

There were known circumstances in 98.1% of the [illegible] known circumstances,

- 39% of the victims had a history of mental health treatment.
- 214 (46.3%) victims had a current mental health problem, with only 118 (25.5%) being currently treated for their mental health problem.
- Even though 65.7% of the females had a current mental health problem, only 36.7% received mental health treatment currently

- The suicide rate among Whites was 2.4 times that of Blacks (10.6 vs. 4.4 per 100,000, respectively).
- 75% of the suicides occurred in the House, apartment (incl. drive way, porch, yard).
- Firearms were used in the majority of suicide deaths (43.9%)

PubMed

Display Settings: Abstract

Psychiatr Hung. 2012;27(2):72-81.

Prevention of depression-related suicides in primary care.

Rihmer Z, Gonda X.

Department of Clinical and Theoretical Mental **Health**, Semmelweis University, Budapest, Hungary. rihmerz@kut.sote.hu

Abstract

Suicide attempt and completed suicide are rare events in the community, but they are quite common among psychiatric patients who contact their GPs before the suicide event. The current prevalence of unipolar and bipolar major depressive episode in general **practice** is around ten percent but unfortunately about half of these cases remain unrecognized, untreated or mistreated. Major depressive episode is the most common current psychiatric **diagnosis** among suicide victims and attempters (56-87%) and successful acute and long-term treatment of depression significantly reduces the risk of suicidal behaviour even in this high-risk population. As over half of all suicide victims contact their GPs within four weeks before their death, **primary care** doctors play an important role in suicide prediction and prevention. Five large-scale community **studies** demonstrate that education of GPs and other medical professionals on the **diagnosis** and appropriate pharmacotherapy of depression, particularly in combination with psycho-social interventions and public education improve the identification and treatment of depression and reduces the rate of completed and attempted suicide in the areas served by trained doctors.

PMID:22700618[PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms, Substances

LinkOut - more resources

Budget Justification:

Personnel Salary – Community Health Nurse II, 3 FTE. Community Health Nurses will be home based in the Administrative Care Coordination Unit, but will float among different HCHD divisions such as WIC, Addiction Services, HIV, Health Care for the Homeless, Clinical Care, etc., to meet clients where they are. They will also retain regular hours at the Upper Chesapeake HealthLink Primary Care Clinic, as well as other to be determined partnering agencies, in order to develop interconnected working relationships and facilitate cooperative care coordination.

Contractual- $3,500 for suicide prevention training course for primary care providers. $24,500 for psychiatric mental health on-call consultant. $120 per hour, 4 hours a week, for 50 weeks.

Matching funds - $24,900 in-kind from Upper Chesapeake HealthLink. Office space and support, cooperative assistance of Minority Health Outreach Coordinator, emergency department Patient Navigators and Behavioral Health Patient Navigators, and services of Spanish language Interpreter as necessary.

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:	Harford County Health Department
Project Name:	*Developing Community-wide Coordinated Comprehensive Care and Improved Mental Health Care in Harford County.*
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
% FTE – Title Care Coordinator, Community Health Nurse II	42,928
% FTE – Title Care Coordinator, Community Health Nurse II	42,928
% FTE – Title Care Coordinator, Community Health Nurse II	42,928
Personnel Subtotal	128,784
Personnel Fringe (% - Rate)	30,916 @ =92,748
Equipment/Furniture	
Supplies	
Travel/Mileage/Parking	
Staff Trainings/Development	
Contractual	3,500 + 24,968
Other Expenses	
Indirect Costs (no more than 10% of direct costs)	
Matching Funds – at least 10% of the overall CHRC grant request must be provided in matching funds	24,900
Total	**274,900**

HealthLink
A SERVICE OF UPPER CHESAPEAKE HEALTH

Swan Creek Village Center
2027 Pulaski Highway, Suite 215
Havre de Grace, Maryland
21078

800-515-0044

May 29, 1013

Mark Luckner, Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 306
Annapolis, Maryland 21401

RE: *Developing Community-wide Coordinated Comprehensive Care and Improved Mental Health Care in Harford County.*

Dear Mr. Luckner:

As part of the overall community effort to improve health care outcomes for our most vulnerable citizens, the Upper Chesapeake HealthLink Primary Care Clinic is pleased to write a letter of support for the *Developing Community-wide Coordinated Comprehensive Care and Improved Mental Health Care in Harford County* program.

The Upper Chesapeake HealthLink Primary Care Clinic is the only Harford County sliding scale fee primary care clinic dedicated to serving low and moderate income adults, up to 300% of the Federal Poverty Level. Our goal is to improve the health care status of underserved, uninsured and underinsured members of the community for improved health outcomes. While our clinic offers primary care services, access to specialty care through a Specialty Care Network of providers willing to provide probono or reduced care cost to our clients, diabetes education, and mental health counseling, are patients are cross referred to the Harford County Health Department for a number of complementary services such as family planning, mammogram and colorectal screenings, addiction services, WIC and others. While cross referrals are imperative, providing comprehensive care coordination for our at-risk clients would produce improved health outcomes and ensure that no one would be lost to care.

Through this grant initiative, the Upper Chesapeake HealthLink Primary Care Clinic is committed to being part of the care coordination team and will provide in-kind support to the total of $24,900 for onsite office space and support services to the Care Coordinators, as well as

the cooperative services of our emergency department Patient Navigators, and HealthLink staff, including the Minority Outreach Coordinator and Spanish Language Interpreter.

Sincerely,

Vickie Ensor Bands, MSA, MSN, RN

Vickie Ensor Bands, MSA, MSA, RN
Director Community Outreach
Executive Director HealthLink Primary Care Clinic
Upper Chesapeake Health

HARFORD COUNTY LOCAL HEALTH ACTION PLAN – Revised 5/12/2013

[redacted]

Priority #1: Obesity

Baseline and Goal for 2014:

	County Baseline	Maryland Baseline	County 2014 Target	Maryland 2014 Target
Percentage of adults who are at a healthy weight, not overweight or obese (BRFSS 2008-2010)	36.6%	34%	38%	35.7%
Percentage of youth (ages 12-19) who are obese (MYTS 2008)	9.7%	11.9%	9%	11.3%

Strategies:

A. Increase access to healthy foods
B. Enhance the built environment to support active living
C. Create a 'Community of Wellness' through community engagement
D. Increase physical activity and healthy eating in schools
E. Increase physical activity and healthy eating in early child care settings

Strategy A. Increase access to healthy foods

Actions	Responsible parties	Timeline	Measures	Status
1. Conduct a study of food deserts in Harford County.	Obesity Task Force Access to Healthy Food Subcommittee (AHF) and Harford County Government, Department of Community Services	May 2012	Food desert study	Department of Community Services completed assessment, April, 2012
2. Create a map highlighting access to food in Harford County to determine underserved areas.	AHF and Harford County Government, Department of Community Services (DCS)	December 2012	Completed map highlighting: # of supermarkets, # of	Completed April, 2012 as part of the food desert study.

Actions	Responsible parties	Timeline	Measures	Status
			food pantries, # soup kitchens # of farmers markets/coops	
3. Strategize how community based organizations such as food pantries can operate in underserved areas.	AHF, LHIC members, Department of Community Services	July 2013	Access to Food Community Needs Assessment	Department of Community Services conducted a community café, July 18, 2012
4. Determine ways to familiarize families that receive public assistance and seniors on fixed income to access healthy foods via the farmers markets.	AHF, Farmer's markets, Department of Social Services, senior centers	December 2014	# of community outreach efforts # of SNAP participants accessing food at farmers markets.	Harford County Office on Aging offers a $10 produce to go box for seniors at the Activity Centers.
5. Review local bus routes and ensure linkages between low income residential areas and supermarkets.	AHF and DCS	December 2013	Percentage of people in low income areas that have public transportation access to supermarkets.	Completed April, 2012 as part of the food desert study.
[redacted]	AHF, Healthy Harford, Community Engagement Subcommittee (CE), Chamber of Commerce	December 2014	Number of restaurants providing calorie menu labeling Number of restaurants identifying healthy options on their menus.	Healthy Howard information gathering meeting held June, 2012. Active Healthy Restaurant Designation workgroup, guidelines established, partnership with HCC established for manager food handling class, initial contacts with select restaurants. Meeting to partner with Economic Development scheduled.

Actions	Responsible parties	Timeline	Measures	Status
				Meeting held with Laurrapin March 27, 2013.
[redacted]	AHF, CE, Healthy Harford	December 2014	Number of website hits	Healthy Harford marketing plan to be completed June 2013. Current Ongoing promotional efforts in effect.
8. Utilize schools (and PTA's as a central way to reach families) to teach meal planning and ways to exercise outside of the school day.	AHF, School Wellness Workgroup (SWW)	December 2014	Number of schools participating, number of families reached	School wellness programs piloted at 3 elementary schools in 2012-2013 school year.
9. Look into opportunities to offer additional fresh fruit & vegetable tastings at more elementary schools in Harford County.	AHF, School Wellness Workgroup (SWW)	December 2014	Number of schools participating, number of children reached	Being accomplished through the cafeteria lead at Edgewood Elementary through Taste Test Tuesdays. University of Maryland Extension visits William Paca/Old Post once per month and does tastings through their ReFresh program.
10. Explore opportunities for targeted educational outreach on healthy eating including recipe cards at food pantries and healthy meal planning for church groups	AHF, CE, food pantries, faith based groups	December 2014	Number of outreach activities conducted	Eating Out Guides have been distributed to church groups, and Healthy Harford is presently engaged in helping some churches

Actions	Responsible parties	Timeline	Measures	Status
				establish community gardens.

Strategy B. Enhance the built environment to support active living

Actions	Responsible Parties	Timeline	Measure	Status
1. Work with leadership in the Planning and Zoning Department (PZD) to have a representative from the Obesity Task Force (OTF) or workgroup member appointed by the County Executive to sit on the Bike and Pedestrian Advisory Board.	Planning and Zoning Department (PZD), OTF chairs.	February 2012	Representative appointed	Member appointed to board January, 2012
2. Complete a Bike and Pedestrian Master Plan that outlines strategies to improve bikability and walkability in Harford County, present to County Council.	Planning and Zoning Bike and Pedestrian Advisory Board	February 2013	Bike and Pedestrian Master Plan	Open comment period held in winter, 2013. Presented to County Council February 19. Public hearing to be held spring, 2013.
3. Launch a web-based interactive map that overlays bike routes with bus routes to encourage multi-modal transportation.	Built Environment Subcommittee (BE), Harford Transit, Planning and Zoning, Healthy Harford	December 2013	Number of people utilizing service to meet their transportation needs.	Was concluded at state level that most cyclists still use paper maps. Such a map is put out by the state. Harford County will purchase 8 additional large buses in 2013. All will have front bike racks. Largest increase in ridership is students and seniors.
4. Encourage multi-modal and "active" transportation, particularly in low socio-economic status areas, through targeted	BE, Minority CBOs, Health Department, Harford County Sustainability Office,	December 2014	Number of people utilizing multi-modal means of transportation.	Health Department purchased 36 bike racks which were installed at

Actions	Responsible Parties	Timeline	Measure	Status
outreach and education concerning available resources (potential examples - Quick Response (QR) bus schedules, bike racks on buses, interactive web based bus/bike maps, safe riding classes and mentors, bike racks, helmet giveaways).	Sheriff's Office, Public Libraries, Parks and Rec., Healthy Harford (HH), Harford Transit			government buildings, Parks and Recreation sites and schools in the fall, 2012. Sheriff's Office held a bike rodeo and Health Department sponsored a helmet giveaway at Healthy Harford Day on October 13, 2012. Helmet giveaways were also included in Family Wellness Nights at three pilot schools. Healthy Harford is presently working with LASOS to arrange a helmet fitting and giveaway for their population, especially adults that commute to work via bike. Health Department participated in Bike to Work Day May 17, 2013
[redacted]	PZD, BE, Bike/Ped Advisory Board, Health Department, Dept. of Public Works	December 2014	Number of pieces of information disseminated	Street Smart to be funded through Community

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]	(DPW), Sheriff's Office.			Transformation Grant Harford meeting held February 21, 2013. Media campaign to be implemented August 26, 2013.
[redacted]	BE, Community Engagement Subcommittee (CE), Tobacco Workgroup (TW), HH, PZD, Sustainability Office, DCS	December 2014	Healthy Workplace Designation program strategies	Healthy Work Place Designation program has been slated for 2014.
7. Encourage changes that emphasize active movement (examples – visible, well-lit staircases in buildings, more sidewalks as opposed to parking spaces, path connections between retail, residential, and workplaces).	BE, PZD, Department of Inspections, Licenses and Permits	December 2014	Number of strategies implemented	Encouragement and plans for such changes have been included in current government documents such as the OTF to County Council, the Bike and Pedestrian Master Plan, and the Parks and Rec. Land Use plan.
8. Encourage development of walking paths for use during work/school day as well as promoting community activity and recreation.	BE, Parks and Rec., Healthy Harford Designation programs	December 2014	Number of walking paths established	School wellness pilot programs exploring temporary signage for walking paths. Pedometers purchased to encourage walking by school staff. Encouragement for

Actions	Responsible Parties	Timeline	Measure	Status
				paths is also included in the above mentioned government documents.
9. Incorporate goals for recreation facilities to serve citizens of all ages and physical abilities in to the 2012 Land Preservation, Parks and Recreation Plan. This plan should promote physical activity for individuals and families as well as team sports.	BE, Parks and Recreation, County Government	December 2014	2012 Land Preservation Parks and Recreation Plan	Draft Plan finalized and published at harfordcountymd.gov winter, 2013. Presently open for public review and comments.
10. In cooperation with the School Wellness Workgroup, encourage students to walk, bike or otherwise "actively commute" to and from school whenever possible. Show support through annual Walk to School Day (Oct.) and Bike to School Day (May).	BE, Sustainability Office, Sheriff's Office, SWW, CE, school staff	December 2014	Active Transport guidance	Sustainability Office will work with 3 HCPS pilot schools in 2012-2013 (Red Pump Elementary, Southampton Middle and Joppatowne High) to encourage walking and biking to school. Red Pump participating in National Bike to School, May 8, 2013.

Strategy C. Create a 'Community of Wellness' through community engagement

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]	Community Engagement Subcommittee (CE), Healthy Harford, Health Department, Upper Chesapeake Health, marketing specialist, schools, businesses, CBOs.	December 2014	Number of health promotion messages disseminated Number of people aware of the health risk associated with obesity	Healthy Harford marketing plan to be developed spring, 2013

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]				
2. Build community support for the new Master Plan, Land Use plan, and Bicycle and Pedestrian Master Plan in achieving the goals of a more walkable/bike able community.	CE, Built Environment (BE) Subcommittee, PZD, Healthy Harford, Media Specialist.	December 2013	Number of outreach efforts	Support and encouragement for community input through social media, e-mail blast and the Healthy Harford website.
[redacted]	CE, BE, Access to Healthy Foods (AHF), Tobacco Workgroup (TW), Healthy Harford, Chamber of Commerce, Harford County Public Library	December 2014	Number of organizations designated. Number of strategies implemented.	Sub-group of CE actively meeting regarding Restaurant and Family Designation programs (meeting held with Library on 2/20/13)
[redacted]	CE, HCHD Health Educator, Media Specialist, Healthy Harford, Upper Chesapeake Health	December 2014	Number of participating physician practices Number of patients receiving obesity consultations	Sub-group of CE actively meeting to develop Dining with Doc meeting to engage and educate pediatricians regarding talking to their patients about obesity.
5. Provide regular updates regarding LHIC and the Obesity Task Force to elected officials and policy makers to keep them abreast of work and encourage them to promote healthy eating and physical activity in their districts.	CE chair, County Council, City Councils	December 2014	Summary of e-mails, reports to County Council	Members of the CEW and the OTF Co-Chair meet every two weeks with County Council OTF Co-Chair to discuss progress.
[redacted]	Harford County Government, Health	December 2014	Sustainability plan developed	Members of the CEW and the OTF Co-Chair

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]	Department, Upper Chesapeake Health			meet every two weeks with County Council OTF Co-Chair to draft sustainability plan.
[redacted]	Community Transformation Grant Coordinator (CTGC), CE, Harford County Health Department (HCHD) Health Educator, Chamber of Commerce, Healthy Harford,	December 2014	Number of businesses recruited for Healthiest Maryland Business	Health Department staff attended the Million Hearts Campaign Symposium in February, 2013. One focus was on the Healthiest MD Business effort.
[redacted]	CTGC, Harford County Health Department, Healthy Harford, Upper Chesapeake Health, Chamber of Commerce, Rotary Club, Businesses	December 2014	Number of new worksites supporting Asheville-like pharmacist model Number of employees reached at these worksites	

Strategy D. Increase physical activity and healthy eating in schools

Actions	Responsible Parties	Timeline	Measure	Status
1. As part of the Local Health Improvement Plan, recruit members of the Local Health Improvement Coalition (LHIC) to sit on the School Wellness workgroup (SWW)	Health Officer as LHIC lead, Obesity Task Force (OTF), and School Wellness Chair	October 2012	Schedule of meetings	School Wellness Workgroup made up of Health Department staff as well as HCPS administrative and school representatives participating in the Community Transformation Grant
2. Conduct meeting for members of SWW to familiarize group with the	SWW chair, HCPS Wellness Policy Committee	March 2013	Number of school wellness council	Participating members of the SWW are up to

Actions	Responsible Parties	Timeline	Measure	Status
Harford County Public School (HCPS), School Wellness Policy, amendments made in 2009, and implementation in 2011. Introduce Wellness Policy Committee who is responsible for implementation of the School Wellness Policy.			meetings	date with the SWP. The SWP and its amendments are posted on the HH website.
3. Three elementary schools will receive targeted school wellness enhancements: William Paca, Edgewood, and Havre de Grace. SWW chair will meet with principals to discuss proposed enhancements and work toward plan for wellness enactments	CTG Coordinator (CTGC), SWW, Healthy Harford, HCPS Coordinator of Physical Activity, HCPS Nurse Coordinator, and school principals	September 2012	Number of school partnerships with Number of students enrolled in participating schools	School wellness implementation began August, 2012
4. As per recommendations from the National Assoc. for Sports and Physical Education, increase the total number of physical activity opportunities during the day.	CTGC, SWW, Healthy Harford, HCPS Coordinator of Physical Activity, HCPS Nurse Coordinator, and school principals	June 2013	Physical activity break changes	The Supervisor of Elementary and Middle School Physical Education and Health has introduced curriculum changes that encourage movement at least every two hours as per NASPE guidance.
5. As per evidenced based Shape Up Somerville (SUS) program, switch recess to before lunch for calmer children and increased consumption of milk, fruits, and vegetables. Hand washing stations will be required so students can wash hands before eating.	CTGC, SWW, Healthy Harford, HCPS Coordinator of Physical Activity, and school principals	June 2013	Recess changes implemented	This initiative was introduced at select schools in spring of 2012, but met with some resistance. It was reintroduced in some elementary schools in 2013. Final feedback has not been received.

Actions	Responsible Parties	Timeline	Measure	Status
6. Build and utilize recess carts, one at each school, filled with hoops, balls, jump ropes, etc. to enhance recess and encourage active play. Equipment will be replaced as necessary.	CTGC, SWW, Healthy Harford, HCPS Coordinator of Physical Activity, and school principals	December 2012	Recess changes implemented	Recess carts purchased or updated for 3 pilot schools in spring, 2012.
7. Provide training sessions to provide hands on training in encouraging active play. These teachers will then function as Recess Coaches to encourage physical activity on the playground.	CTGC, SWW, Healthy Harford, HCPS Nurse, and school principals	June 2013	Recess changes implemented, training notes	Introduced into teacher development for 2012-2013 school year.
[redacted]	CTGC, SWW, CE, Healthy Harford, HCPS Nurse Coordinator, and school staff	December 2014	Number of schools participating in Healthy School Program	The guidance for Healthy Schools Designation includes 150 minutes of PE class, which is not available to schools in HC due to space/scheduling constraints.
9. Explore opportunity to engage parents and promote the importance of healthy eating and active living - keeping parents up to date on changes in the school and how they can support these changes at home (importance of not using food as a reward, encouraging non food related fundraisers, and offering healthier food options at after school events).	CTGC, SWW, Community Engagement Subcommittee (CE), Healthy Harford, Public Schools, Media Specialist	December 2014	Number of outreach initiatives, messages	Student, staff and family wellness initiatives offered over the course of school year 2012-2013 including winter school wellness nights.
[redacted]	CTGC, SWW, Healthy Harford, HCPS Nurse Coordinator, and school staff, CE	December 2014	Unified Media Plan	Healthy Harford marketing plan to be completed spring, 2013

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]				
11. Engage staff at targeted schools to design and implement a Staff Wellness program focusing on healthy eating and active living, as directed in the School Wellness Policy, to encourage a culture of wellness, and model positive behavior.	CTGC, SWW, Healthy Harford, HCPS Nurse Coordinator, and school staff	December 2014	Staff Wellness Program plan	Staff provided school wellness feedback through pre-survey and offered free health screenings by HealthLink August/September, 2012. Cultural changes at many schools have already taken effect. HCPS now offers health screenings to all of their employees.
12. Analyze data from selected schools to monitor school wellness progress	CTGC, SWW, HCPS data services, Superintendent	December 2014	Wellness data, school wellness survey data	Pre-surveys of staff, families and students conducted fall, 2012
[redacted]	CTGC, SWW	December 2014	Number of physical activity practices include in local school wellness policy	
[redacted]	CTGC, SWW	December 2014	Number of improved nutrition standards included in the local school wellness policy	

Strategy E. Increase physical activity and healthy eating in child care

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]	CTGC, Healthy Harford, Child Care Resource and Referral Center, Child Care Centers	December 2014	Number of child care providers/programs trained Number of children	Child Care Links Resource Center will provide a training to child care providers in

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]			served by trained providers/programs	April, 2013 which incorporates both physical activity and healthy eating. Attending providers will receive curriculum materials.
2. Encourage early care and education settings regulated by MSDE to implement Caring for our Children: National Health & Safety Performance Standards for Early Care and Education Programs (3rd Ed.) physical activity and screen time standards	CTGC, Healthy Harford, Child Care Resource and Referral Center, Child Care Centers	December 2014	Number of child care providers/programs trained Number of children served by trained providers/programs	This resource was shared with Child Care Links Resource Center Fall, 2012.
[redacted]	CTGC, Healthy Harford, Child Care Resource and Referral Center, Child Care Centers	December 2014	Number of child care providers/programs trained Number of children served by trained providers/programs	Completion of the Let's Move Checklist quiz will be incorporated into the physical activity and nutrition training that will be offered by Child Care Links in April, 2013.

Priority #2: Tobacco

Baseline and Goal for 2014:

	County Baseline	Maryland Baseline	County 2014 Target	Maryland 2014 Target
Percentage of adults that currently smoke (BRFSS 2008-2010)	20.3%	15.2%	18.6%	13.5%
Percentage of high school students (9-12) that have used any tobacco	26.8%	24.8%	24.8%	22.3%

product in the past 30 days (MYTS 2010)				

Strategies:

A. Raise awareness of the tobacco issue and gain community support
B. Encourage workplaces to adopt tobacco free campuses, create policy level change
C. Smoke-free multi-unit housing
D. Youth cigar use awareness

Strategy A. Raise awareness of the tobacco issue and gain community support

Actions	Responsible Parties	Timeline	Measure	Status
1. Participate in community events to educate the public regarding the negative effects of high rate of tobacco usage in Harford County on the health and well-being of our community.	TW, Healthy Harford, HCHD Tobacco Health Educator, municipal employees, Upper Chesapeake Health	December 2014	Number of community events	Harford County Health Department Tobacco Cessation Program Specialist and School and Community Tobacco Education Specialist are involved in a number of events. Examples: Provided CDC's Tobacco Free Sports Playbook to all 22 Rec Councils, August 2012; Participated in three school family wellness nights winter 2013.
2. Promote smoking cessation programs as well as access to low/no cost cessation assistance medication.	TW, Healthy Harford, HCHD Tobacco Health Educator, Minority Outreach Technical Assistance grantee (MOTA)	December 2014	Number of outreach efforts	HCHD Tobacco specialists share information about smoking cessation at

Actions	Responsible Parties	Timeline	Measure	Status
				outreach events. Information will be shared with members of the Continuum of Care on March 19, 2013 as part of a Harford Roundtable meeting.
[redacted]	TW, Community Engagement Subcommittee (CE), Healthy Harford, HCHD Tobacco Health Educator, Media Specialist, municipalities	December 2013	Number of people reached by campaign	Campaign to be conducted through a variety of mediums, spring 2013. CTG funding will support creation of second hand smoke-specific advertising.

Strategy B. Encourage workplaces to adopt tobacco free campuses, create policy level change

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]	TW, CE, Harford County Health Department (HCHD) Tobacco Education Specialist (TES), Healthy Harford, Media Specialist	December 2012	Healthy Harford Workplace Designation Program	Healthy Workplace Designation Program slated for 2014.
2. Engage and educate local workplaces, including municipalities, as to importance of tobacco free campuses and Smoke Free Outdoor Areas (SFOA) to the health and well-being of the community.	TW, HCHD Tobacco Health Educator, CBO, Municipal leaders	June 2013	Schedule of meetings, number of people educated (face to face) about benefits of SFOA	Representatives of County Council, Havre de Grace, Aberdeen and Bel Air have been engaged in discussions around smoke free areas. Regional Tobacco Meeting held

Actions	Responsible Parties	Timeline	Measure	Status
				January 10, 2013. Meeting held with Havre de Grace Authority on February 12, 2013. Presentation on "Tobacco and Affordable Housing" given to Continuum of Care members on March 29, 2013.
[redacted]	TW, CTGC, Harford County Health Department	December 2014	Number of partners trained to support SFOA	
[redacted]	TW, CTGC, Harford County Health Department, Department of Community Services, Municipalities	December 2014	Number of new SFOA policies enacted	County property, hospital campuses, and community college are all smoke free. Presently in discussions with municipalities listed above. Meeting held with Department of Community Services January 18, 2013
[redacted]	Harford County Health Department Community Health Education (HCHD-CHE)	December 2014	Number of available cessation classes, number of participants	
[redacted]	Harford County Health	December	Outreach specialist	

Actions	Responsible Parties	Timeline	Measure	Status
[redacted]	Department Community Health Education (HCHD-CHE)	2014	recruited	
[redacted]	TW, HCHD Health Educator, Media Specialist, Healthy Harford, Upper Chesapeake Health	December 2014	Number of participating physician practices Number of patients receiving tobacco consultations	HCHD does some under its Cigarette Restitution Fund (CRF) grant
8. Reach out to members of County Council, as the Board of Health, to educate them regarding the importance of the policy change; data statistics on youth smoking rates, public health implications, success of policy change in other counties, etc.	TW, HCHD-CHE, Healthy Harford	June 2013	Number of County Council members interested in public health initiative.	County Council member Dick Slutzsky has been recruited to sit on the Tobacco Workgroup and actively attends.
[redacted]	TW, Harford County Health Department, Community Health Education (HCHD-CHE), MWI	December 2012	Comparative research on adoption and implementation of policy in other jurisdictions.	Research has been conducted. Tobacco Workgroup hosted Rita Vera of the MD Legal Resource Center in February, 2013 and is interested in this policy change. Regular legislative updates are received from her office.

Strategy C. Smoke-free multi-unit housing

Actions	Responsible Parties	Timeline	Measure	Status
1. Engage in community outreach regarding the benefits of smoke-free multi-unit housing (SFMUH)	TW, CTGC, Harford County Health Department	December 2014	Number of people educated (face to face) about benefits of	Meeting held with Havre de Grace Authority on February

Actions	Responsible Parties	Timeline	Measure	Status
			SFMUH	12, 2013. Presentation on "Tobacco and Affordable Housing" given to Continuum of Care (Harford Roundtable) members on March 29, 2013
[redacted]	TW, CTGC, Harford County Health Department	December 2014	Number of partners trained to support SFMUH	
[redacted]	TW, Community Transformation Grant Coordinator (CTGC), Harford County Health Department, Department of Community Services	December 2014	Number of new SFMUH policies enacted	HCHD staff and Tobacco Workgroup Chair met with representatives of Community Services January 18, 2013. Health Department's representative on the Development Advisory Committee (DAC) has added a component on smoke-free housing to their comments for plans related to new multi-unit housing.

Strategy D. Youth cigar use awareness

Actions	Responsible Parties	Timeline	Measure	Status
1. Share information with youth about	TW, CTGC, Harford County	December	Number of youth	Health Department

Actions	Responsible Parties	Timeline	Measure	Status
the danger of cigar use and industry marketing	Health Department Health Educators, Upper Chesapeake Health	2014	educated (face to face) about the danger of cigar use and industry marketing	School and Community Tobacco Education Specialist educates over 7,000 youth per year about the dangers of tobacco, including cigar use. Upper Chesapeake Health's "Smoking Out the Truth Program" includes information about cigar use.
2. Share information with adults about the danger of cigar use and industry marketing	TW, CTGC, Harford County Health Department Health Educators, Upper Chesapeake Health	December 2014	Number of adults educated (face to face) about the danger of cigar use and industry marketing	Upper Chesapeake Health's "Smoking Out the Truth Program" includes information about cigar use.

Priority #3: Behavioral Health Integration

Strategies

A. Develop mechanisms to integrate substance abuse and mental health treatment programs
B. Improve delivery and awareness of behavioral health services

Baseline and Goals for 2014:

	County Baseline	Maryland Baseline	County 2014 Target	Maryland 2014 Target
Rate of suicides per 100,000 population (VSA 2007-2009)	11.7	9.6	11.2	9.1%
Rate of drug- induced deaths per 100,000	14.9	13.4	13.9	12.4%

population (VSA 2007-2009)				
Reduce the number of emergency department visits related to behavioral health conditions (HSCRC 2010)	1,243.7	1,206.3	1,183.4	1,146.0

Strategy A. Develop mechanisms to integrate substance abuse and mental health treatment programs

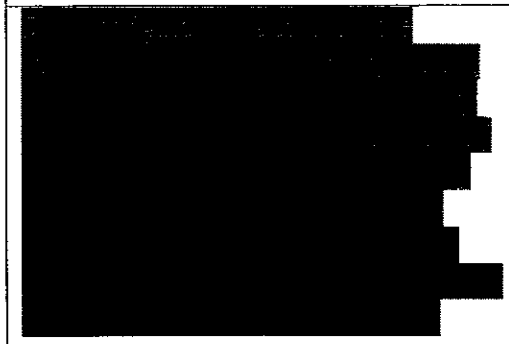
Actions	Responsible Parties	Timeline	Measure	Status
1. As part of the Local Health Improvement Plan, recruit members of the Local Health Improvement Coalition to sit on the Behavioral Health Workgroup (BHW).	Health Officer as LHIC lead and BHW chair	January 2012	Meeting minutes and presentations.	Coalition with representation from the Harford County School Board, District Court, Sheriff's Office, Social Services, County Government, Faith-based, Upper Chesapeake Health, treatment providers, and mental health leadership established in February, 2012.
2. Explore ways to reduce Emergency Department visits for behavioral health conditions.	BHW, Upper Chesapeake Health, Office on Mental Health (OMH), Health Department Division of Addictions, local providers	December 2013	Reduced ED visits for behavioral health	Focus group held 6/27/12 with Upper Chesapeake Health and Harford Memorial Hospital Emergency Department Staff to explore behavioral health encounters in the emergency department. OMH, local providers and ED staff meet on a quarterly basis.

[redacted]	BHW chair, HCHD Addictions Division, Office on Mental Health (OMH), local providers	June 2013	Number of providers trained, number of presentations held	Health Department to sponsor trainings for addiction and mental health providers winter/spring of 2013.
[redacted]	BHW chair, HCHD Addictions Division, OMH, local practices	December 2014	Number of providers adopting the use of screenings	Subcommittee formed in fall 2013 to investigate opportunities. Meeting held with UCH/Harford Memorial psychiatric staff on March 26, 2013 to discuss potential referral process.
[redacted]	BHW chair, HCHD Addictions Division, OMH, local providers	December 2014	Number of clients supported through these resources	Health Department Division of Addictions Peer Specialist to work with individuals at SPIN (Mental Health Drop-in Center for adults) Van purchased to facilitate transportation between SPIN and Division of Addictions to promote substance abuse treatment Behavioral Health Integration Conference will be held June 11, 2013.

Strategy B. Improve delivery and awareness of behavioral health services

Actions	Responsible Parties	Timeline	Measures	Status
1. Utilize technology to promote behavioral health wellness.	HCHD, Office on Mental Health-Core Service Agency, Department of Community Services Office of Drug Control Policy (ODCP), Harford County Health Department (HCHD)	December 2012	Decreased appointment no-show rate, increased medication compliance rate	Teen Diversion text message pilot program for appointment and medication reminders to be implemented in school year 2012-2013.
2. Increase community education on behavioral health - warning signs, treatment options and promoting wellness (potential ideas: Public Health Matters cable network show, Partner with HealthLink to distribute information, utilize social media).	HCHD, Office on Mental Health-Core Service Agency, ODCP, Upper Chesapeake Health community addiction and mental health providers.	December 2014	170 parents participated in youth behavior survey. Number of individuals reached through outreach efforts	Online survey developed to query parents about youth tobacco, substance abuse and mental health use/treatment. Results compiled July, 2012. Survey results along with warning signs and resource information disseminated among parents, schools and provider agencies fall, 2012.
3. Raise community awareness around prescription drug use, treatment and monitoring as well as misuse, storage and disposal.	HCHD, Office on Mental Health-Core Service Agency, ODCP, Drug Enforcement Administration, community addiction and mental health providers.	December 2014	Meeting minutes, presentations, number of pounds of unused medication turned in to take-back events	Prescription Drug Task Force established in Fall, 2011. Partnership with the Office of Drug Control Policy (ODCP), Health Department, the District Court of Maryland, and local law enforcement agencies.

				Bi-monthly task force meetings are currently being held. Quarterly drug take-back events have been scheduled throughout the county. Magnets detailing proper storage/disposal procedures for medications were ordered and are being disseminated. Presentations to pharmacists and physicians. ODCP has partnered with health educators at APG to bring similar education to the military base. ODCP's Harford County Symposium – Drug Prevention, Intervention and Treatment – "Just What the Doctor Ordered" 6/26/13
4. Increase education on prescription	Harford County Public Schools,	December	Number of	ODCP presentations on

drugs and behavioral health within schools (potential ideas: support distribution of ODCP's youth-targeted Drinking and Driving DVD; explore possibility of a youth-produced behavioral health-focused DVD to be shared in schools; investigate ways to work with school counselors on detection of early psychosis)	local private schools, HCHD Health Education Workers, ODCP	2012	presentations, number of students reached	refusal skills and substance abuse, including prescription drugs -All 9th grade classes - spring -All 8th graders at Bel Air Middle -Meets with health teachers each fall -Presented for the first time at the Center for Educational Opportunity, fall 2012 (only high school without a PTA)
	HCHD, Office on Mental Health-Core Service Agency, community providers, faith-based community, SPIN Adult Drop-in Center	December 2014	Action Plan and results.	HCHD and County Government (FACE-IT) co-sponsored a Recovery Festival, September 22, 2012 at Aberdeen Festival Park. Mental Health Town Hall Event focused on "Resiliency: Building a Path to Recovery for Children and Adolescents" – 5/2/13