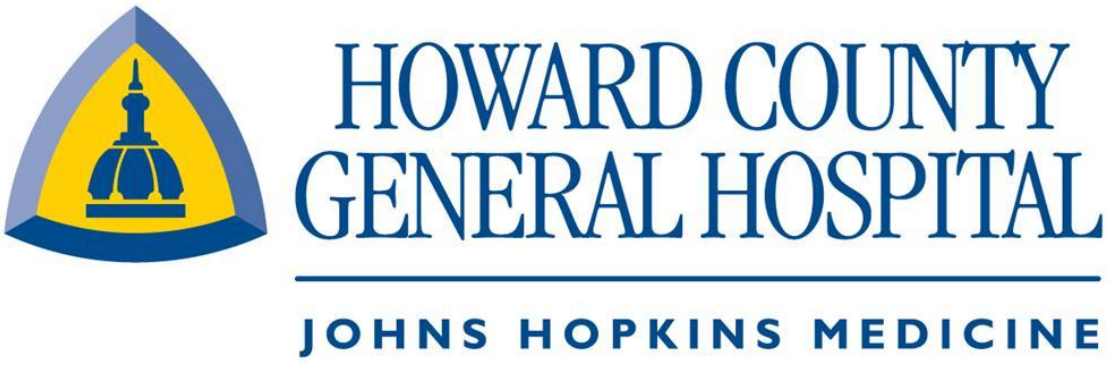
Howard County General Hospital

Community Health Needs Assessment

Fiscal Year 2013

June 2013



HOWARD COUNTY GENERAL HOSPITAL
COMMUNITY HEALTH NEEDS ASSESSMENT
AND
IMPLEMENTATION STRATEGY
FY 2013

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

Howard County General Hospital ("HCGH" or "Hospital") conducted a Community Health Needs Assessment ("CHNA") during FY 2013. The initiative was based on the IRS notice issued in July 2011 regarding hospital sponsored community health needs assessments and employed guiding principles developed by the Johns Hopkins Health System ("JHHS") Community Benefits Advisory Council.

In order to ensure broad based input of the community served by the Hospital, a CHNA Task Force was convened (**Appendix A**) which included thought leaders of local health and human service organizations, county government leadership, local business leaders and hospital trustees and management. The Task Force met three times between March and May 2013. In brief, its agendas for each meeting were the following:

1. Data dive into county health status indicators
2. Health needs prioritization
3. Partnership and action planning.

During the first meeting, a comprehensive analysis of data describing the health status of Howard County was presented by Tanvir Hussain, MD, post-doctoral fellow at the Johns Hopkins University Bloomberg School of Public Health. Data analyzed was compiled from a wide array of sources including:

- Results from a comprehensive 2012 health behaviors research study of Howard County residents underwritten by HCGH, the Howard County Health Department, The Horizon Foundation and the Columbia Association
- Local health indicators summarized on Howard Health Counts (www.howardhealthcounts.org)
- Maryland Department of Health and Mental Hygiene State Health Improvement Plan (http://dhmh.maryland.gov/ship)
- Analyses compiled by the Howard County Health Department for the 2012 Local Health Improvement Coalition ("LHIC") health needs assessment
- Proprietary data analysis companies including The Nielsen Company and Thomson Reuters

In meeting #2, the Task Force had extensive discussion about the health status information set, and identified seven highest priority health improvement opportunities. Upon further discussion, the Task Force recommended that HCGH focus its resources on the top four priorities listed below:

1. Access to care
2. Obesity

3. Behavioral Health
4. Elderly Health Improvement

Priorities determined to be beyond the scope of hospital focus during the FY 2014-2016 implementation cycle were:

- Chronic Disease Management
- Healthy Lifestyles
- Health Education

In the third meeting the Task Force discussed tactics that HCGH might pursue and potential partners with which the Hospital could collaborate to execute upon the identified community health improvement priorities. The Implementation Strategy included herein as **Appendix E.**

While community health needs assessments can identify underlying causes of good or poor health status, health providers are not in a position to affect all of the changes required to address each health need in a community. Moreover, HCGH recognizes that there are numerous organizations addressing community health needs, and in order to direct resources in a manner to drive maximum impact it must encourage other organizations that share its commitment to community health improvement to address community needs consistent with their respective missions. Therefore, HCGH will focus on its selected four priorities, but regularly work with our numerous community health providers to encourage them to address unresolved needs.

The HCGH executive management team will apportion accountability for execution of the implementation strategy and begin work on the three year plan in the summer of 2013.

II. INTRODUCTION

A. Overview of Howard County General Hospital

The Howard County General Hospital is a community hospital serving primarily Howard County Maryland as well as its adjacent communities since 1973. Its mission is to "Provide the highest quality care to improve the health of our entire community through innovation, collaboration, service excellence, diversity, and a commitment to patient safety". Since 1998 the Hospital has been a proud member of Johns Hopkins Medicine ("JHM"). The JHM mission reflects HCGH's commitment and passion for patient care, research, and the training of future health professionals. In each of these areas, the mission extends beyond the buildings and direct services to encompass the well-being of the communities we serve. As a non-profit institution, HCGH aims to fulfill both its mission of community service and its charitable, tax-exempt purpose.

Howard County General Hospital: a Member of Johns Hopkins Medicine is a comprehensive, acute-care medical center specializing in women`s and children`s services, surgery, cardiology, oncology, orthopedics, gerontology, psychiatry, emergency services, and community health education. In FY 2012 HCGH was licensed to operate 249 beds. During the same period the Hospital had 15,667 inpatient admissions and 3,333 births. The hospital served 77,488 patients in its emergency department, and provided 68,253 other outpatient visits.

This Community Health Needs Assessment ("CHNA") is based on the IRS notice issued in July 2011 regarding community health needs assessments and guiding principles developed by the Johns Hopkins Health System ("JHHS") Community Benefits Advisory Council.

B. The Community Served by HCGH

The Hospital considers its Community Benefit Service Area ("CBSA") as specific populations or communities of need to which the hospital allocates resources through its community benefits plan. The Hospital defines its CBSA using the zip codes contained within the geographic boundaries of the Howard County jurisdiction as set forth by the Maryland Department of Planning and Zoning. The combination of HCGH's status as the only acute care hospital in Howard County and the natural boundaries of the Patapsco and Patuxent rivers as well as predominant local commuting patterns for goods and services provide a level of "containment" of the local population for seeking health care and other services. Approximately 62% of HCGH's patients reside in the community, further supporting the definition of the Howard County jurisdiction as its CBSA.

Figure 1. Community Benefits Service Area (CBSA)

Howard County Zip Codes:
20701, 20723, 20759, 20763, 20777, 20794, 20833, 21029, 21036, 21042, 21043, 21044, 21045, 21046, 21075, 21076, 21104, 21163 ,21723, 21737, 21738, 21771, 21784, 21794, 21797

The following table provides a demographic description of the Hospital's CBSA as well as a profile of the community relative to various social determinates of health.

Table 1. Population by Gender, Howard County

	2012	2017 (Projected)
Total Male Population	143,945 (49.7%)	151,226 (49.6%)
Total Female Population	145,965 (50.3%)	153,954 (50.4%)

Source: *2012 The Nielsen Company, 2012 Thomson Reuters*

Table 2. Population by Age

	Howard County	USA
0-14	60,411 (21%)	20%
15-17	14,705 (5%)	4%
18-24	23,435 (8%)	10%
25-34	34,513 (12%)	14%
35-54	95,038 (33%)	28%
55-64	33,569 (12%)	11%
65+	28,239 (10%)	13%

Source: *2012 The Nielsen Company, 2012 Thomson Reuters*

Additional health status indicators for Howard County residents are included in **Appendix B.**

III. APPROACH AND METHODOLOGY

A. Building Upon Preceding Community Health Improvement Efforts

1. Healthy People 2020

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives. Based on this input, a number of new topic areas are included in the new initiative, including:

- Adolescent Health
- Blood Disorders and Blood Safety
- Dementias, including Alzheimer's Disease
- Early and Middle Childhood
- Genomics
- Global Health
- Health-Related Quality of Life and Well-Being
- Healthcare-Associated Infections,
- Lesbian, Gay, Bisexual and Transgender Health
- Older Adults
- Preparedness
- Sleep Health
- Social Determinants of Health

2. Maryland State Health Improvement Plan

Maryland has the top-rated educational system (Education Week 4/25/12) and the 4th highest per capita income (US Census Bureau Statistical Abstract 2012) in the United States, but when a national organization ranked states on the health of their people, Maryland came in 22nd

(America's Health Rankings 2011). The goal of the State Health Improvement Process (SHIP) is to provide a framework for accountability, local action, and public engagement to make progress in Maryland's health.

Accountability begins with setting measurable targets for Maryland's health in 2014 based on today's data. The SHIP includes 39 measures in 6 vision areas that represent what it means for Maryland to be healthy. 28 objectives have been identified as critical racial/ethnic health disparities measures.

Local action is critical to public health progress. Local health coalitions are forming or operating in every jurisdiction in the State (see next section). These coalitions will adopt strategies for progress on selected SHIP measures as well as on other local health priorities, including addressing local health disparities. The SHIP supports local efforts by providing local data, information on sound strategies, interactive on-line communications and a Toolkit of resources.

Public Engagement by a wide array of professionals, organizations, commentators and most importantly the public steered the development of the SHIP. The SHIP will continue to draw strength and ideas from across Maryland. The Department of Health and Mental Hygiene received more than 250 comments about the SHIP measures. (Source: http://dhmh.maryland.gov/SHIP)

3. Howard County Local Health Improvement Plan

Howard County General Hospital was an active participant in the community wide Local Health Improvement Coalition (LHIC) convened in the fall of 2011, by the Howard County Health Department (HCHD). Working closely with HCHD, HCGH participated in a three month interactive exercise convening local stakeholders in community health improvement to review current health status information and establish shared health improvement priorities. In over 12 hours coalition meetings with more than 40 community organizations and dozens of hours of off-line data analysis and meetings with individual stakeholders, HCGH helped shape the final Howard County 2012-2014 Local Health Improvement Action Plan (LHIAP). An executive summary of the LHIAP final report, included herein as **Appendix C**, focuses on three health improvement priorities:

- Increase access to health care
- Enable people of all ages to achieve and maintain a healthy weight through health eating and physical activity.
- Expand access to behavioral health resources and reduce behavioral health emergencies.

B. HCGH Community Health Needs Assessment Process

1. Community Health Needs and Community Benefits Oversight

Ultimate leadership of the CHNA process begins at the governance level with the Hospital's board of trustees, which has identified community benefit as a fundamental goal of the Hospital articulated in its mission and vision. The board charges the president/CEO to carry out a community benefit program.

Operational leadership at all levels of the organization is involved in the community benefits administration process. At the executive management level, the CNHA Administration is co-led by the Hospital's Chief Financial Officer (measurement and tracking) and Senior V.P. of Planning and Marketing (community needs assessment and planning). All members of the executive leadership team support this process through their respective divisions. While all members of middle management are responsible for tracking and reporting on community benefit initiatives within their departments, specific leadership responsibility falls to the manager of regulatory compliance (compilation) and the director of community health education (needs assessment). All executives and middle managers are responsible for delivering community benefit through service to community health and human service organizations.

Finally, numerous Hospital employees as well as members of the professional staff (i.e. physicians and allied health professionals on the medical staff) deliver community benefit through health education, health partnerships with community organizations, participation in hospital sponsored community health events (e.g. health fairs, screenings, etc.) and targeted programs.

The Community Benefits Workgroup consists of finance, community relations, and/or community wellness staff from Howard County General Hospital and across the Johns Hopkins Health System. This collaborative team is responsible for collecting and reporting community benefit activities on an annual basis to the president and chief financial officer of both HCGH and JHHS. The workgroup meets monthly to discuss data collection, community benefit planning and evaluation.

The Community Benefits Advisory Council was established to guide our community benefit efforts across HCGH. The Council is comprised of leadership from HCGH with insight into community health needs. Council representatives are responsible for developing a systematic approach to community benefits that aligns community benefits objectives with HCGH and Johns Hopkins Medicine priorities. The Council participates in quarterly meetings.

2. CHNA Task Force

In order to ensure broad based input of the community served by the Hospital, a CHNA Task Force was convened (**Appendix A**), which included thought leaders of local health and human service organizations, county government leadership, local business leaders and hospital trustees and management. The Task Force met three times between March and May 2013. In brief, its agendas for each meeting were the following:

1. Data dive into county health status indicators
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In meeting #2, the Task Force had extensive discussion about the health status information set, and identified seven highest priority health improvement opportunities. Using a multi voting process, the Task Force developed a list of recommended health improvement priorities that HCGH focus its resources upon.

In the third meeting the Task Force discussed tactics that HCGH might pursue and potential partners with which the Hospital could collaborate to execute upon the identified community health improvement priorities. From this discussion an implementation strategy was developed, with particular focus on initiatives, community partnerships, and both process and outcome metrics.

The Task Force recommendations were reviewed by both the Howard County General Hospital Executive Committee and then the full board of trustees, which voted to adopt the recommendations at its June 18, 2013 meeting.

IV. FINDINGS

A. Data Assessment

On the whole, Howard County is a relatively healthy community. Howard County was ranked the healthiest county in Maryland by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute in 2013. All Maryland counties were ranked on health outcomes and a series of health determinants (including, but not limited to, tobacco use, diet and exercise, access to and quality of care, education, employment and income, and air quality).

A comprehensive analysis of data describing the health status of Howard County was prepared by Tanvir Hussain, M.D., Johns Hopkins University post-doctoral fellow at the Bloomberg School of Public Health. Data analyzed was compiled from a wide array of sources including:

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Below is a summary of the data.

1. Demographics

Howard County overall is a socioeconomically advantaged community compared to the U.S. population. There is a large minority population: three times the national average of Asians/Pacific Islanders, and nearly twice the national average of Blacks. Hispanics are under-represented in the community relative the Maryland and the US.

Table 3. Population by Income, 2012

	Howard County	USA
<$15K	3,983 (4%)	13%
$15-25K	3,253 (3%)	11%
$25-50K	14,356 (14%)	27%
$50-75K	17,541 (17%)	20%
$75-100K	16,916 (16%)	12%
>$100K	48,650 (47%)	18%

Source: *2012 The Nielsen Company, 2012 Thomson Reuters*

The Average Household Income in Howard County in 2012 was $116,905 while the Median Household Income was $70,647. The percentage of households with incomes below the federal poverty level (2006-2010) within the county was 4.2% as compared to 13.8% for the US as a whole (*http://quickfacts.census.gov/ qfd/states/24/24027.html*)

Table 4. Population by Educational Attainment, 2012

	Howard County Age 25+	USA
Less than High School	5,473 (3%)	6%
Some High School	6,840 (4%)	9%
High School Degree	30,476 (16%)	29%
Some College/ Assoc. Degree	42,081 (22%)	29%
At least Bachelor's Degree	106,489 (56%)	28%

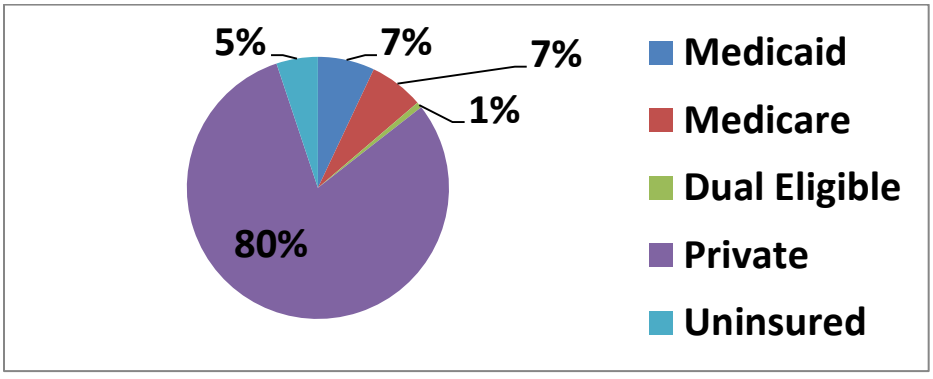
Source: *2012 The Nielsen Company, 2012 Thomson Reuters*

Table 5. Population by Race/Ethnicity, 2012

	2012	USA
White, Non-Hispanic	163,161 (56%)	63%
Black, Non-Hispanic	54,035 (19%)	12%
Hispanic	18,464 (6%)	17%
Asian & Pacific Islander	43,566 (15%)	5%
Others	10,684 (4%)	3%

Source: *2012 The Nielsen Company, 2012 Thomson Reuters*

Table 6. Howard County Insurance Coverage, 2012



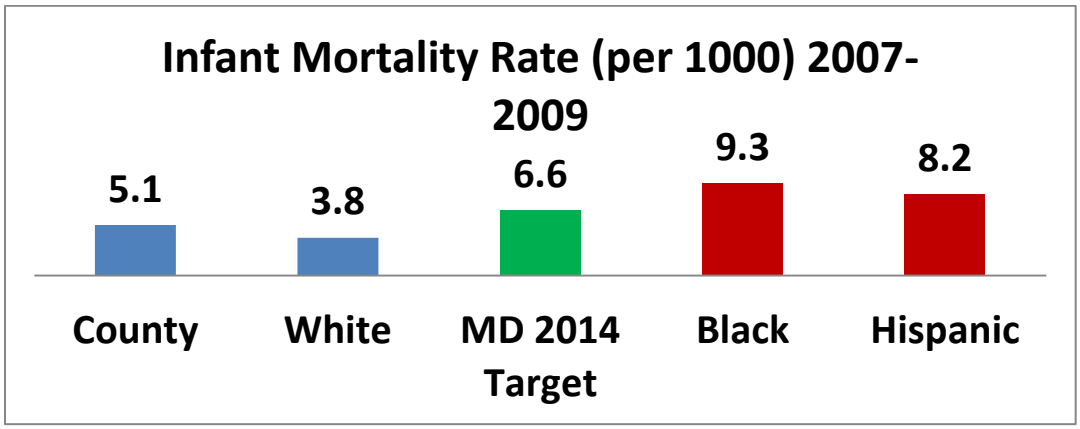
Source: *2012 The Nielsen Company, 2012 Thomson Reuters*

2. State Health Improvement Plan Indicators: Key Findings

Overall, the Howard County community compares favorably to Maryland 2014 health indicator targets. However, there are important racial disparities in care. Blacks, for example, do not reach Maryland 2014 targets on any one of the measures presented. Data on Asians/Pacific

Islanders is not available on all measures. Below are some illustrative examples. *The source of all data in Tables 7 through 12 is the Maryland State Health Improvement Plan* (http://dhmh.maryland.gov/ship).

Table 7.



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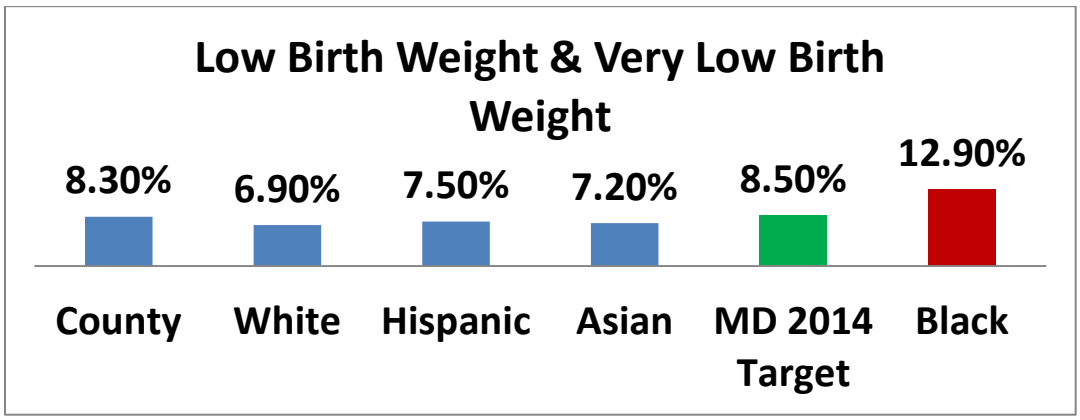

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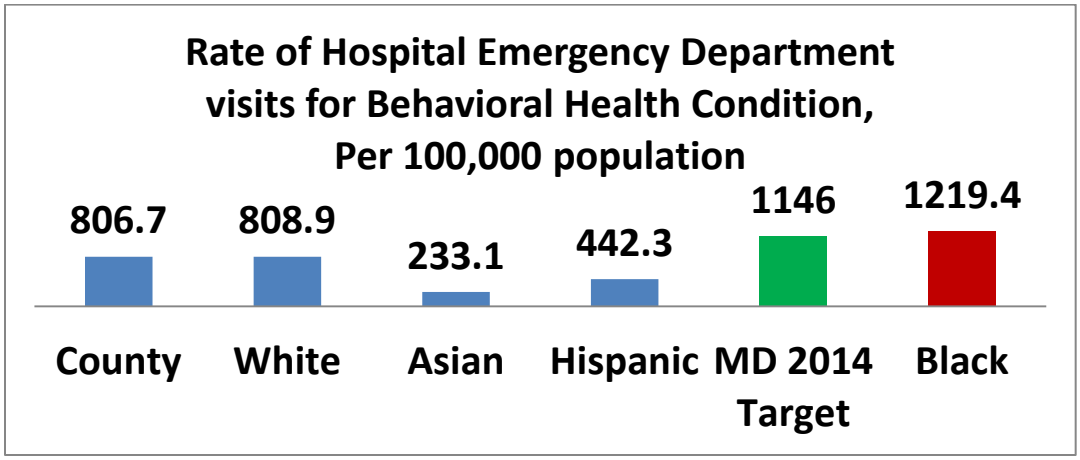

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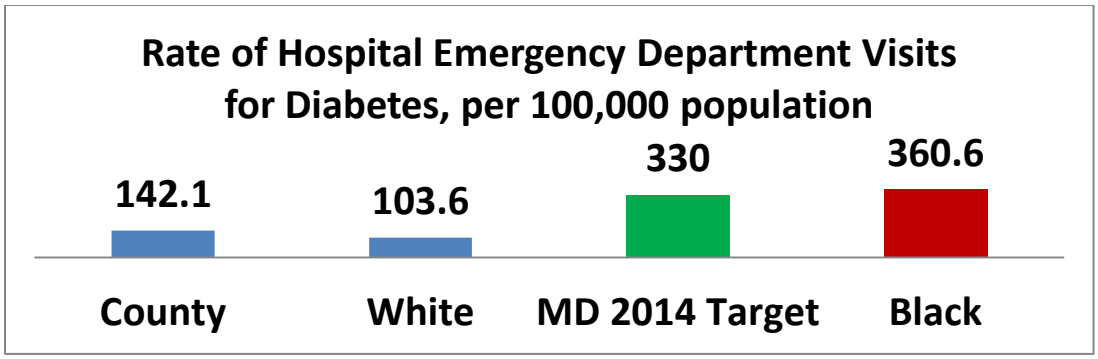

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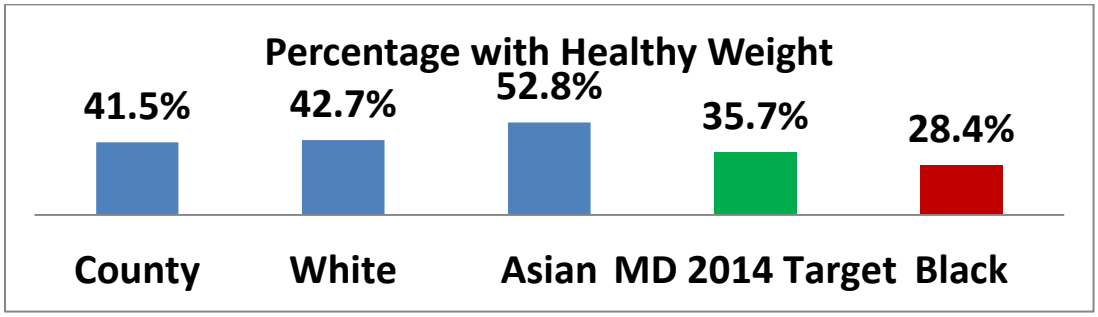

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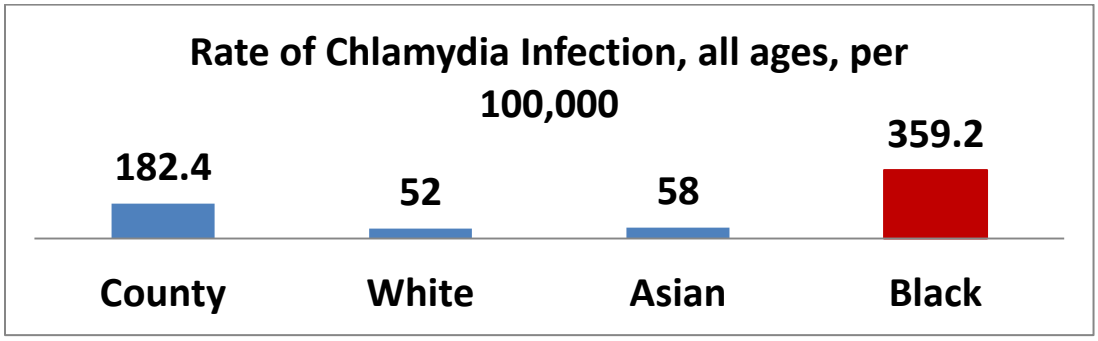


A complete comparison of Maryland State Health Improvement Plan indicators for Howard County versus the state as a whole is included in **Appendix D**.

B. Community Input: Howard County Health Assessment Survey

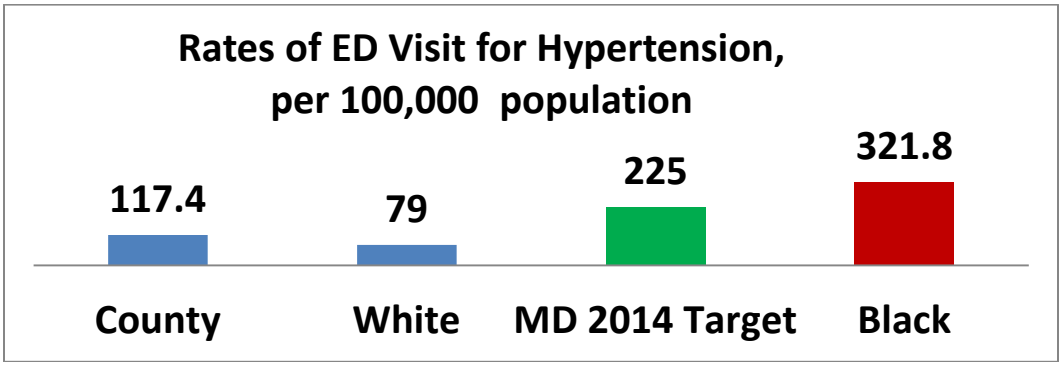
In FY 2012 HCGH, partnering with Howard County Health Department, The Horizon Foundation and The Columbia Association (collectively "The Partners"), embarked upon an ambitious long term research initiative to measure health status of the community. By pooling financial resources the Partners undertook the first bi-annual community health behaviors survey of Howard County residents, known as the Howard County Health Assessment Survey ("HCHAS"). Modeled after the Behavioral Risk Factor Surveillance System (BRFSS), the Partners developed a 15 minute telephone survey to be administered to a demographically representative sample of 2000 Howard County residents. The first of four biannual administrations of the survey was administered in the fall of 2012. Results of the survey were reported to the sponsors in November 2012. The Partners have agreed to use the findings from this survey to inform the ongoing activities of the Local Health Improvement Coalition ("LHIC") and individual organizations participating in LHIC to support individual and collaborative efforts to improve community health.

Several highlights from that survey shed additional perspective on some of the quantitative findings noted above.

Whites are more likely to report having diabetes. (HCHAS, question C6.13). However, greater number of doctor visits for African Americans. (HCHAS, question M 2.5). How do we reconcile the possible lower rates of diabetes amongst African Americans with the greater number of doctor's visits and higher ED usage for Diabetes amongst African Americans? Possibilities discussed included under-diagnoses, cost as barrier to medications, lack of a regular/primary doctor (fragmented care) and simply more severe disease

Regarding hypertension, whites report having hypertension as frequently as African Americans. (HCHAS, question C4). Yet blacks use the hospital emergency department for treatment of hypertension at a rate four times greater than that for whites.

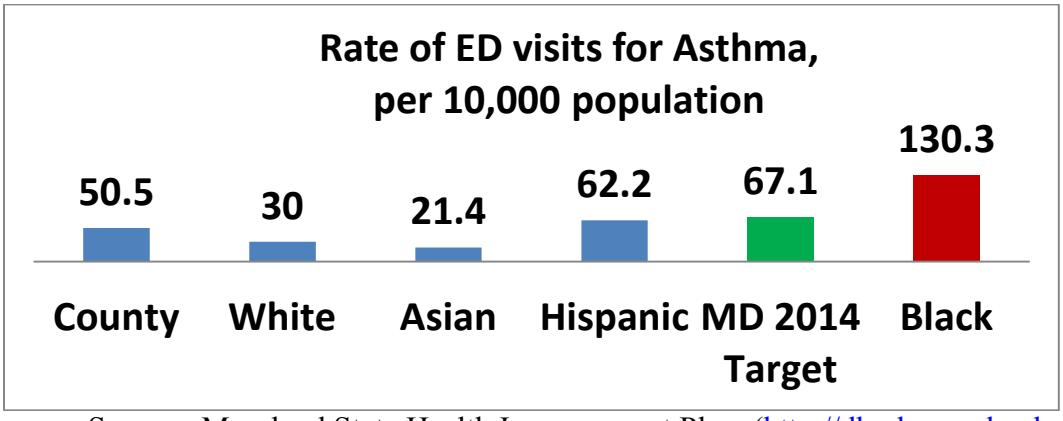
Table 13.



Source: Maryland State Health Improvement Plan, (http://dhmh.maryland.gov/ship)

Finally, for asthma Whites and Asians are more likely than Blacks to report a diagnosis of asthma (C6.4). However, blacks use the hospital emergency department twice as frequently.

Table 14.



Source: Maryland State Health Improvement Plan, (http://dhmh.maryland.gov/ship)

C. Expert Evaluation: CHNA Task Force

The data and community input as well as the findings from both the Maryland State Health Improvement Plan and Howard County Local Health Improvement Coalition were evaluated by the cross section of health and community experts comprising the CHNA Task Force. The CHNA Task Force included Hospital board of trustees' members, Hospital" leadership, Johns Hopkins faculty, and local community organization leadership. (**Appendix A)**

In seeking information about community health needs, hospital leadership consulted with the following community organizations and agencies, many which include representatives of sub-populations within the CBSA facing health disparities.

- Howard County Health Officer and Howard County Health Department Staff
- Howard County Library
- Howard County Office on Aging
- Howard County Office of Citizen Services
- Howard County Fire and Rescue Services

- Howard County Police Department
- Howard County Public School System
- Howard County Mental Health Authority
- The Horizon Foundation
- The Columbia Foundation
- Chase Brexton Health Services (Federally Qualified Community Health Center)
- National Alliance for Mentally Ill, Howard County Chapter
- Korean American Citizen's Association of Howard County
- Gilchrist Hospice Care
- Numerous private practice physicians across many specialties serving Howard County
- HCGH Community Relations Council
- Association of Community Services of Howard County
- United Way of Central Maryland, Howard County Partnership Board
- Maryland Department of Mental Hygiene
- Asian American Health Center of Howard County
- Alianza de la Comunidad
- Conexiones
- Vantage House Retirement Community
- Howard County Muslim Foundation
- Elected Officials representing Howard County, including County Executive, County Council
- People Acting Together in Howard (PATH)

D. Data Gaps Identified

Despite a wide variety of data sources (e.g. Howard Health Counts, census data, the Maryland State Health Improvement Plan, etc.), there were acknowledged limitations of the information available. Specifically, granular information about health status of certain racial and ethnic groups was cited, as was information about geographic pockets of health need.

Funders of the aforementioned Howard County Health Assessment Survey will be seeking to use this input to inform refinements to future administrations of the survey.

V. SELECTING PRIORITIES

A. Hospital Priorities

After careful evaluation and extensive discussion and debate surrounding the available data, information and expert opinion, the HCGH CHNA Task Force identified the following as the top four community health improvement priorities:

1. Access to Care: *Increase the percentage of local residents with access to affordable health care.*
2. Obesity: *Enable people of all ages to achieve and maintain a healthy weight through healthy eating and physical activity.*
3. Behavioral Health (Mental Health and Addictions): *Ensure access to affordable and quality behavioral health services for residents of all ages and decrease the number of hospital emergency visits for behavioral health issues.*
4. Elderly Health Improvement: *Improve case management services and coordinated health care for senior citizens to reduce repeat hospitalizations and increase the number of seniors living independently at home.*

Table 15. Hospital Community Health Improvement Priorities

Hospital Priority #1	Access To Care
Quantitative Reason	Disparities in emergency department usage across racial and ethnic groups are believed to be at least partially driven by lack of access to affordable primary care
Qualitative Reason	More appropriate use of primary care will relieve crowded emergency department and provide more satisfied patients.
Hospital Strengths	Strong medical staff presence serving community Commitment to charity care program; support of Healthy Howard insurance initiative
Alignment with local, regional, state, or national goals	Howard County LHIC: MD SHIP: Healthy People 2020:
Hospital Priority #2.	Obesity
Quantitative Reason	55% White, 70% African Americans report being overweight or obese (Ho Co Health Assessment Survey)
Qualitative Reason	Obesity is a major contributing factor to diabetes and hypertension, two conditions exhibiting disparities in emergency department visits
Hospital Strengths	Diabetes education program. Comprehensive wellness offerings. Links to Johns Hopkins Bariatric Services
Alignment with local, regional, state, or national goals	Howard County LHIC: MD SHIP: Healthy People 2020:
Hospital Priority #3.	Behavioral Health
Quantitative Reason	Rate of behavioral health ED visits by blacks is 50% greater than for whites and 6 times the rate for Asians.
Qualitative Reason	Increasing pediatric emergency department utilization appears preventable with better early screening and intervention
Hospital Strengths	Strong behavioral health emergency service Comprehensive 20 bed inpatient behavioral health unit that serves both voluntary and involuntary patients.
Alignment with local, regional, state, or national goals	Howard County LHIC: MD SHIP: Healthy People 2020:

Hospital Priority #4.	Elderly Health Improvement
Quantitative Reason	Local senior population (65+) projected to double in next 20 years. Senior population consumes disproportionate share of health care resources
Qualitative Reason	Coordination of care across health delivery sites holds tremendous opportunities for improving lifestyle of seniors
Hospital Strengths	Acute Care for Elderly (ACE) Unit Office on Aging Transition Care Nurse COGS Partnership AgeWell Exercise Program
Alignment with local, regional, state, or national goals	Howard County LHIC: MD SHIP: Healthy People 2020:

B. Hospital Programs/Activities that Support Other Community Health Needs

The four improvement priorities noted in the previous section are certainly not the only health improvement issues for the Howard County community. HCGH provides community benefit to improve the health of Howard County through a wide range of initiatives, programs and partnerships with organizations that share its commitment to health improvement. These initiatives broadly include:

- Community health services: free screenings, education, support groups, etc.
- Education of health professionals: nurses, therapists, clinical technicians, etc.
- Mission driven services: direct care subsidized by hospital reserves.
- Financial contributions to health, human service and community organizations that share the hospital's mission of community health improvement.
- Community building: constructing or improving upon community based infrastructure to promote improvement of healthy living. For example, the Hospital continued its support of the healthy children's play area in the Columbia Mall, a centerpiece of the Howard County community, to promote healthy habits in a fun educational manner.

Below is a sampling of selected other hospital activities that address a range of health improvement needs outside of the selected priorities.

Table 16. Hospital Programs/Activities that Support Other Community Health Needs

Health Outcome / Health Factor	Name of Program	Description of Services	Key Partners
Infant Mortality	Healthy Families Howard County	Counseling and support for at-risk first time parents	Family And Children's Services Local Children's Board

Health Outcome / Health Factor	Name of Program	Description of Services	Key Partners
Hypertension	Community Cardiovascular Project	Regular Hypertension Screening as well as ongoing health information and educational programming	20 diverse faith communities throughout Howard County
Substance Abuse Health Access (Careers)	Public Schools Partnership	Funding for chemical free proms Health Career shadowing opportunities	18 elementary, middle and high schools
Health Access	Ethnic Health Fairs	Comprehensive screenings, health information and referral targeted to emerging local immigrant populations	Korean American Citizen's Association of Howard County Asian American Health Center of Howard County Alianza de la Comunidad Conexiones Howard County Muslim Foundation

C. Health Improvement Issues Beyond the Selected Priorities: Unaddressed Identified Needs

While community health needs assessments can point out underlying causes of good or poor health status, health providers and health related organizations—primary users of information found in CHNAs—are not usually in a position to affect all of the changes required to address a health issue. For example, the ability to reduce poverty, improve educational attainment, or affect employment cannot be achieved by a health system alone. Priorities determined to be beyond the scope of hospital focus during the FY 2014-2016 implementation cycle, i.e. beyond the top four issues, included:

- Chronic Disease Management
- Healthy Lifestyles
- Health Education

The Hospital does not plan to explicitly address these health priorities. However, each of these priorities will be employed in tactics addressing priorities 1-4. Moreover, HCGH recognizes that there are numerous organizations addressing community health needs, and in order to leverage resources in a manner to drive maximum impact HCGH will collaborate with other organizations to address these issues and, where feasible, share financial or human

resources support to other organization's efforts to address community health improvement needs consistent with their respective missions.

VI. IMPLEMENTATION STRATEGY

Howard County General Hospital's board of trustees and executive leadership will ensure the Hospital's strategic and clinical goals are aligned with the four community health improvement priorities set forth in this assessment. Furthermore, HCGH leadership with promote a culture of collaboration with its numerous community partners including the Howard County Health Department, the Local Health Improvement Coalition, physicians and other health care providers in the community, to establish and nurture creative partnerships to build a healthier Howard County community.

Specific initiatives that the Hospital plans to undertake to achieve the four health improvement priorities of the CHNA are set forth in **Appendix E**.

Furthermore, HCGH will aim to influence the decision making process and prioritization of Hospital community benefit activities through ongoing monitoring and evaluation of unmet community needs over the next three years. HCGH's commitment to improving the health of its community will be evident through deliberate planning of health education, screening, and outreach to segments of our community experiencing gaps in access to health services, and providing in-kind and financial support to organizations and initiatives that share our commitment to addressing these priorities.

VII. CONCLUSION

Howard County General Hospital has invested in caring for the community it serves. HCGH has a 40 year history of dedicating health initiatives to address the needs of vulnerable populations in its community. In collaboration with local community stakeholders and other aligned organizations that have a shared vision; HCGH has and will continue to strive to meet the needs and demands of those who reside in our community. The process in which the Hospital prioritizes its efforts has become more specialized, focused and deliberate through the efforts outlined herein. The CHNA process will guide the organization to focus on barriers to accessing health care, addressing community understanding of major health concerns, considering demographic, economic and health care provider trends, addressing lack of available health services and leveraging resources to improve access to care and overall quality of life. With its partners HCGH will work diligently over the next three years to ensure that the valuable information attained from the CHNA is an integral tool to measure and evaluate how established health targets and goals are achieved. The health implementation plan will continue to be an evolving hospital strategy and process to produce the best care and services for this community.

Appendix A.

Community Health Needs Assessment Task Force Participants

Kayode Williams, M.D., MBA	Task Force Chair, HCGH Trustee
Shaukat Ashai, M.D.	Community ObGyn physician
Dee Athey	United Way of Central Maryland
Jay Blackman	Chief Operating Officer, HCGH
Evelyn Bolduc	Chair, HCGH Board of Trustees
Vic Broccolino	President and CEO, HCGH
Dayna Brown	Administrator, Ho. Co. Office on Aging
Susan Case	Director of Marketing, HCGH
Kenneth Crawford	Enterprise Foundation
Craig Cummings	Howard County Schools
Desiree De La Torre	Asst. Dir. Health Policy Planning, Johns Hopkins Medicine
Brian England	British American Auto Care, Ho. Co., Citizens Association
Debra Furr-Holden, Ph.D.	Faculty, Johns Hopkins Bloomberg School of Public Health
Hector Garcia	Howard County Foreign Information and Referral Network
Paul Gleichauf	Sr. VP, Planning, HCGH
Lou Grimmel, Jr.	Encore at Turf Valley Assisted Living
Eric Grimmel	Lorien Columbia Skilled Nursing
Nikki Highsmith Vernick	Horizon Foundation
Tanvir Hussain, M.D.	Johns Hopkins Bloomberg School of Public Health
Richard Larison	Chase Brexton Health Services
Nancy Larson	Director of Case Management, HCGH
Barbara Lawson	Non-profit consultant
David Lee	Howard County Office of Minority Affairs
David Leichtling, M.D.	Columbia Medical Practice, Family Practice
Ann B. Mech, J.D., R.N.	HCGH Trustee
Matthew Medley	Administrative Fellow, HCGH
Cindi Miller	Director of Community Health Education, HCGH
John Mangione, Jr.	Lorien Elkridge Skilled Nursing
Meredith Page	St. John's Baptist Church, PATH
David Powell	HCGH Trustee
Maura Rossman,	Howard County Health Officer
Esti Schabelman, M.D.	Emergency Physician, HCGH
Jim Young	Chief Financial Officer, HCGH

Appendix B.

Additional Health Indicators for Howard County

INDICATOR / *Source*	**MEASURE**
Percentage of uninsured people within the CBSA *2012 The Nielsen Company* *2012 Thomson Reuters*	5.1%
Percentage of Medicaid recipients within the CBSA *2012 The Nielsen Company* *2012 Thomson Reuters*	7.0%
Life Expectancy within the CBSA, by race and ethnicity where data are available *http://dhmh.maryland.gov/ship*	The Howard County Life Expectancy baseline is 81.9 years at birth. It is above the State baseline at 78.7 and the National baseline at 77.9.
Mortality Rates within the CBSA, by race and ethnicity where data are available *http://dhmh.maryland.gov/ship*	Heart Disease Deaths per 100,000: Howard County: 150.1 - White: 170 Black: 166 Maryland: 193 - White: 184 Black: 238 Cancer Deaths per 100,000: Howard County: 145.6 - White: 163 Black: 167 Maryland: 176.8 - White: 177 Black: 193 Asian: 100.7 Infant Mortality Rate per 1,000 births Howard County: 5.8 Maryland: 7.3 White: 4.2 Black: 11.8

INDICATOR / *Source*	**MEASURE**
Access to healthy food, quality of housing, and transportation within the CBSA (to the extent information is available) http://www.countyhealthrankings.org/maryland http://quickfacts.census.gov/qfd/states/24/24027.htm http://howardcountymd.gov/DisplayPrimary.aspx?id+6442460766	Limited Access to Healthy Foods: • Howard County: 2% • Maryland: 4% Quality of Housing: Home ownership rate, 2006-2010: 74% Housing units in multi –unit structures, 2006–2010: 24.8% Transportation: Scheduled bus services operated daily throughout Eastern Howard County. County provides specialized curb-to-curb for senior citizens and individuals with disabilities. Four transportation programs under county oversight: • Howard Transit (fixed route) • HT Ride (ADA complimentary and para-transit service) • Howard Commuter Solutions (ride share/vanpool) • Work on Wheels (reverse commuter service). In addition, Neighbor Ride, a local non-profit, supplements public transportation 3.7% of HH have no vehicle.
Available detail on race, ethnicity, and language with the CBSA *2012 The Nielsen Company* *2012 Thomson Reuters* *www.howardhealthcounts*	Race/Ethnicity: White Non-Hispanic: 163,161 (56.3%) Black Non-Hispanic: 54,035 (18.6%) Hispanic: 18,464 (6.4%) Asian/Pacific Islander Non- Hispanic: 43,566 (15.0%) All Others: 10,684 (3.7%) Language at Home: Only English: 79.6% Other than English: 21.4% Spanish: 4.09% Asian/PI: 7.71% Indo-European: 7.05% Other: 1.47%

Appendix C.

Howard County's Local Health Improvement Coalition: 2012-2014 Local Health Improvement Action Plan

EXECUTIVE SUMMARY

About Howard County's Local Health Improvement Coalition (LHIC)

VISION: All residents of Howard County will have access to health care and health outcomes will be equitable for all.

MISSION: Howard County's Local Health Improvement Coalition works to achieve health equity in Howard County and to identify and reduce health disparities.

VALUES:

- Evidence-based
- All stakeholders have a voice
- Inclusive of Howard County's diverse community
- Collaboration
- Transparency

Local Health Improvement Priorities 2012-2014

Howard County's LHIC has set three top priorities as the main focus of its work aimed to reduce disparities and improve outcomes.

- **PRIORITY #1: Increase access to health care.**
- **PRIORITY #2: Enable people of all ages to achieve and maintain a healthy weight through healthy eating and physical activity.**
- **PRIORITY #3: Expand access to behavioral health resources and reduce behavioral health emergencies.**

The *2012-2014 Local Health Improvement Action Plan* is based on the three priorities set by the LHIC and the corresponding measures, goals, and strategies for each priority area. The priorities were chosen with consideration of the following prioritization criteria:

- High levels of disparities related to this health outcome.
- Improving this issue would affect large populations.
- Addressing the priority can improve a number of different health outcomes.
- There is a high cost and long-term impact of not addressing the issue.
- Organizations in the LHIC can make change happen related to the priority.
- Results can be quantified.

PRIMARY OUTCOMES:

Disparities will be reduced and outcomes will improve in the three key priority areas. Specifically:

1. Access to health care will be increased and delays in accessing medical care will be reduced.
2. More people will achieve a healthy weight
3. Behavioral health services are available and fewer behavioral health emergencies occur.

RELATED OUTCOMES:

- Improve collaboration and shared vision between key stakeholders and systems – the hospital, school system, health department, nonprofit community, etc.
- Increase funding for addressing health disparities and improving health outcomes.
- Health and wellness services will be more accessible and appropriate for people of different cultures, language ability, and immigration status.
- Ensure local data is available on health disparities and their causes, including issues of race and ethnicity, undocumented status, income level, gender, and other factors.
- Raise awareness among residents of health disparities and their causes.
- Health access will be inclusive of services for mental health, substance abuse, and will meet the needs of people with disabilities.
- Develop and adopt new policies to improve health equity.
- Coordinate and publicize existing health, health education, and wellness services in Howard County.

OVERARCHING LHIC STRATEGIES TO ADDRESS DISPARITIES

- Include more people and organizations affected by disparities in the LHIC and other efforts to reduce disparities.
- Outreach and gather data on heath needs of specific populations including diversity in terms of income level, gender, race, ethnicity, language, and immigration status, as well as other characteristic such as veterans and military families, commuters, and farmers. Address gaps in data on health outcomes for Hispanic and Asian populations.
- Reach out to faith-based communities and nonprofit human services organizations.
- Devote more resources for language access.
- Ensure strategies are culturally and age appropriate.

Local Health Planning Resources and Sustainability

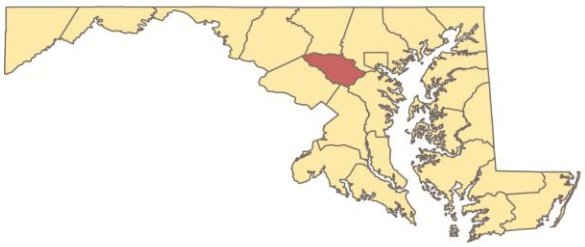
Howard County's Local Health Improvement Coalition (LHIC) includes 50 actively engaged and dedicated stakeholders from across Howard County representing a variety of key agencies, organizations, and communities affected by health disparities. Upon first convening in December 2011, the LHIC took immediate steps toward setting and achieving its vision. The LHIC began its work to improve health equity in the Howard County community by undertaking a transparent, inclusive local health improvement process that continuously engages diverse stakeholders, provides a more clear understanding of the prevalence and causes of local health disparities, and uses a 2-year action plan aligned with the State Health Improvement Process (SHIP) as the framework for improving local health outcomes. The LHIC submitted its *2012-2014 Local Health Improvement Action Plan* to the Maryland Department of Health and Mental Hygiene on March 1, 2012. With continued support and technical assistance from the Howard County Health Department, the LHIC will track and evaluate the implementation of the *2012-2014 Local Health Improvement Action Plan*. The LHIC is committed to working within the County over the long term as it recognizes that achieving health equity will take time and perseverance.

March 1, 2012

Appendix D.

Maryland State Health Improvement Plan Indicators for Howard County

HOWARD COUNTY



Howard County has some notable health strengths and other areas where an investment in targeted action could pay dividends over the upcoming years.

Good News! In terms of the 39 SHIP measures, Howard County performs best relative to the State baseline on access to healthy food, new HIV infections, and emergency department visits related to domestic violence.

Challenges – SHIP measures where Howard County does not perform as well are the proportion of children and adolescents who receive dental care, life expectancy, influenza vaccinations, and the proportion of students who enter kindergarten ready to learn.

The SHIP website provides continuously updated tools to address health challenges in the County, as well as tips and resources for individuals. The website also features news and opportunities to inform evidence based local action. We invite you to visit the website frequently and let us know how to improve it by clicking on the comment link. You can also friend us on Facebook http://www.facebook.com/MarylandSHIP or follow us on Twitter http://www.twitter.com/MarylandSHIP for regular news and resources. Click on the link at the bottom of this page or e-mail the coalition contact listed below to get involved or learn more.

Demographics	Howard	Maryland
Total Population*	287,085	5,773,552
Age, %*		
Under 5 Years	6.0%	6.3%
Under 18 Years	26.0%	23.4%
65 Years and Older	10.1%	12.3%
Race/Ethnicity, %*		
White	62.2%	58.2%
Black	17.5%	29.4%
Native American	0.3%	0.4%
Asian	14.4%	5.5%
Hispanic or Latino origin	5.8%	8.2%
Median Household Income**	$103,657	$70,017
Households in Poverty**, %	3.9%	8.6%
Pop. 25+ Without H.S. Diploma**, %	5.3%	12.1%
Pop. 25+ With Bachelor's Degree or Above**, %	58.6%	35.6%

*Sources: *U.S. Census (2010), **American Community Survey (2008-2010)*

Health Improvement Coalition Contact:

Nancy Lewin

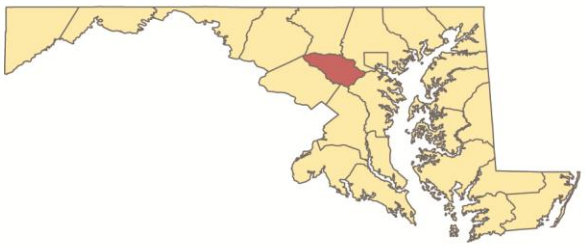
Director, Health Policy & Planning

410-313-6360

Local Health Improvement Coalition Website: http://www.howardcountymd.gov/DisplayPrimary.aspx?ID=6442463213

Minority Outreach Contact: Resources for the Foreign Born, Inc.
http://dhmh.maryland.gov/hd/mota/pdf/Resources_for_the_Foreign_Born.pdf

HOWARD COUNTY

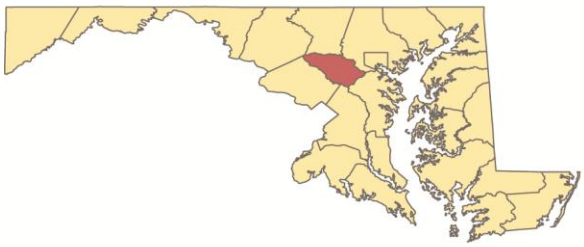


High Impact Objectives

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state baseline.

Obj #	SHIP Measure (Maryland Baseline Source)	County Baseline	Maryland Baseline	Maryland 2014 Target
High Morbidity Impact				
17	Rate of ED visits for asthma per 100,000 population (HSCRC 2010)	**505.4**	850.0	671.0
27	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	**142.1**	347.2	330.0
28	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	**117.4**	237.9	225.0
34	Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)	**806.7**	1,206.3	1,146.0
High Mortality Impact				
25	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	**169.6**	194.0	173.4
26	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	**161.2**	177.7	169.2
Multiple Impact Objectives (those objectives with a high rate of return on investment)				
3	Percentage of births that are LBW (VSA 2007-2009)	**8.3%**	9.2%	8.5%
6	Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)	**94.0%**	80.2%	84.2%
11	Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	**88.6%**	80.7%	84.7%
30	Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)	**41.5%**	34.0%	35.7%
31	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	**8.0%**	11.9%	11.3%
32	Percentage of adults who currently smoke (BRFSS 2008-2010)	**7.2%**	15.2%	13.5%
33	Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)	**20.0%**	24.8%	22.3%
36	Percentage of civilian, non- institutionalized 18-64 yr olds with any type of health insurance (BRFSS 2008-2010)	**91.9%**	86.5%	90.9%
38	Percentage of children 4-20 yrs enrolled in Medicaid that received a dental service in the past year (Medicaid CY2009)	**61.6%**	59.0%	62.0%
39	Percentage of people who reported there was a time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)	**7.2%**	12.0%	11.4%

HOWARD COUNTY



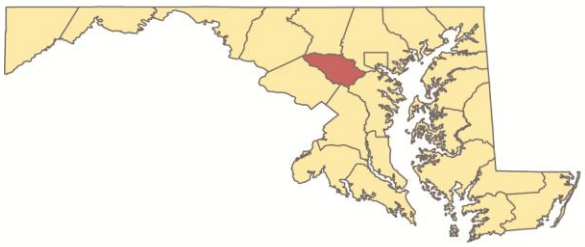
SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
38	**Percentage of children 4-20 yrs enrolled in Medicaid that received a dental service in the past year (Medicaid CY2009)**	61.6%	59.0%	N/A		62.0%	**4.4**	N/A
1	**Life expectancy at birth (VSA 2009)**	82.2	78.6	77.9		82.5	**4.6**	**5.5**
24	**Percentage of adults who have had a flu shot in last year (BRFSS 2008-2010)**	45.1%	43.0%	25.0%	White/NH-49.9% Black-33.7%	61.5%	**4.9**	**80.4**
10	**Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011)**	86.0%	81.0%	N/A		85.0%	**6.2**	N/A
36	**Percentage of civilian, non-institutionalized 18-64 yr olds with any type of health insurance (BRFSS 2008-2010)**	91.9%	86.5% ^	N/A		90.9%	**6.2**	N/A
26	**Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)**	161.2	177.7	178.4	White-162.7 Black-166.6 Asian-100.7	169.2	**9.3**	**9.6**
3	**Percentage of births that are LBW (VSA 2007-2009)**	8.3%	9.2%	8.2%	White/NH-6.9% Black-12.9% Asian- 7.2% Hispanic-7.5%	8.5%	**9.8**	**-1.2**

Cont.

HOWARD COUNTY



SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
11	**Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)**	88.6%	80.7%	74.9%		84.7%	**9.8**	**18.3**
25	**Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)**	169.6	194	190.9	White-170.1 Black-165.6	173.4	**12.6**	**11.2**
6	**Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)**	94.0%	80.2%	70.8%	White/NH-96.1% Black-90.3% Asian-93.7% Hispanic-92.1%	84.2%	**17.2**	**32.8**
33	**Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)**	20.0%	24.8%	26.0%		22.3%	**19.4**	**23.1**
30	**Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)**	41.5%	34.0%	30.8%	White/NH-42.7% Black-28.4% Asian-52.8%	35.7%	**22.1**	**34.7**
8	**Rate of suicides per 100,000 population (VSA 2007-2009)**	7.4	9.6	11.3		9.1	**22.5**	**34.1**

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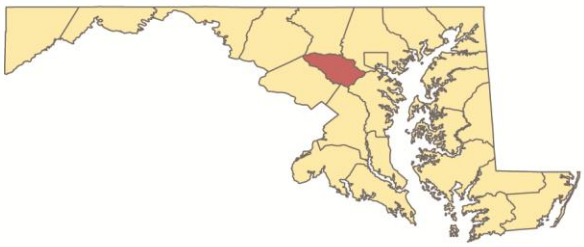
HOWARD COUNTY



SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
14	**Rate of deaths associated with falls per 100,000 population (VSA 2007-2009)**	5.3	7.3	7.0		6.9	**27.7**	**24.6**
2	**Infant Mortality Rate per 1,000 births(VSA 2007-2009)**	5.1	7.2	6.7	White/NH- 3.8 Black- 9.3 Hispanic- 8.2	6.6	**29.2**	**23.9**
31	**Percentage of youth (ages 12-19) who are obese (MYTS 2008)**	8.0%	11.9%	17.9%		11.3%	**32.8**	**55.3**
34	**Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)**	806.7	1,206.3	N/A	White- 808.9 Black- 1,219.4 Asian- 233.1 Hispanic- 442.3	1,146.0	**33.1**	N/A
39	**Percentage of people who reported time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)**	7.2%	12.0%	14.6%	White/NH- 4.1% Black- 12.8%	11.4%	**40.0**	**50.7**
17	**Rate of ED visits for asthma per 10,000 population (HSCRC 2010)**	50.5	85.0	N/A	White- 30.0 Black-130.3 Asian- 23.9 Hispanic- 62.2	67.1	**40.5**	N/A
29	**Rate of drug-induced deaths per 100,000 population (VSA 2007-2009)**	7.4	13.4	12.6		12.4	**44.5**	**40.9**

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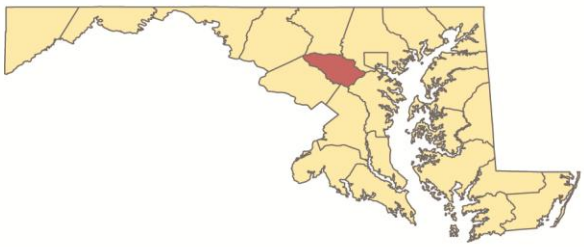
HOWARD COUNTY



SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
28	**Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)**	117.4	237.9	N/A	White- 79.0 Black- 312.8	225.0	**50.7**	N/A
32	**Percentage of adults who currently smoke (BRFSS 2008-2010)**	7.2%	15.2%	20.6%	White/NH- 8.1% Black- 7.4% Asian- 5.1%	13.5%	**52.6**	**65.0**
16	**Rate of Salmonella infections per 100,000 (IDEHA 2010)**	8.7	18.8	15.2		12.7	**53.7**	**42.8**
15	**Rate of pedestrian injuries (SHA 2007-2009)**	17.5	39.0	22.6		29.7	**55.1**	**22.5**
21	**Rate of Chlamydia infection for all ages per 100,000 (IDEHA 2009)**	182.4	416.7	N/A	White- 52.0 Black- 359.2 Asian- 58.0 (all ages)	N/A	**56.2**	N/A
27	**Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)**	142.1	347.2	N/A	White- 103.1 Black- 360.6	330.0	**59.1**	N/A
35	**Rate of hospital admissions related to dementia/ Alzheimer's per 100,000 population (HSCRC 2010)**	7.0	17.3	N/A		16.4	**59.7**	N/A
7	**Rate of indicated non-fatal child maltreatment cases reported to social services per 1,000 children under age 18 (Dept of Human Resources FY2010)**	1.8	5.0	9.4		4.8	**64.9**	**81.3**

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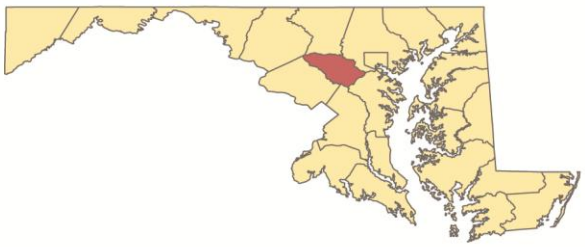
HOWARD COUNTY



SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
12	**Rate ED visits related to domestic violence/abuse per 100,000 population (HSCRC 2010)**	23.0	69.6	N/A		66.0	**67.0**	N/A
20	**Rate of new (incident) cases of HIV in persons age 13 and older per 100,000 (IDEHA 2009)**	9.5	32.0	N/A		30.4	**70.3**	N/A
18	**Percentage of census tracts with food deserts (USDA 2000)**	0.0%	5.8%	10.0%		5.5%	**100**	**100**
4	**Rate of SUIDs (in-cludes deaths attributed to Sudden Infant Death Syndrome (SIDS), Accidental Suffocation and Strangulation in Bed (ASSB) and deaths of unknown cause) per 1,000 births (VSA 2005-2009)**	***, 5 (Count only)	1.0	0.9		0.89	N/A	N/A
9	**Rate of deaths associated with fatal crashes where driver had alcohol involvement per 100 million Vehicle Miles of Travel (SHA 2009)**	***, 11 (Count only)	0.29	0.4		0.27	N/A	N/A
13	**Rate of new (incident) cases of elevated blood lead level in children under 6 per 100,000 (MDE 2009)**	***, 1 (Count only)	79.1	N/A		39.6	N/A	N/A

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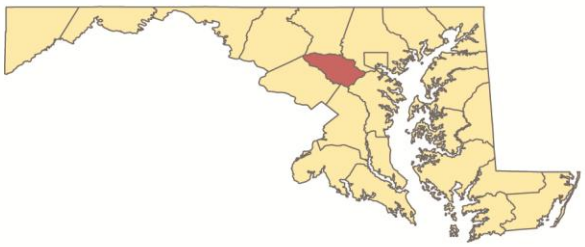
HOWARD COUNTY



SHIP Measures Ranked by Percent Difference from Maryland Baseline (Worst to Best)

Figures in RED/GREEN represent when the county baseline is WORSE/BETTER than the state and national baselines.

Obj#	SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
19	**Number of days per year the AQI exceeded 100; not all counties are measured for AQI (EPA 2008)**	N/A	8.4	11		8.0	N/A	N/A

Three-year rolling averages are presented for many of the measures as a means to display more stable data (less year-to-year variation) while showing change over time. Data details for figures found in "National Baseline" and "Maryland Baseline" columns can be found on the Maryland SHIP webpage under MEASURES at http://dhmh.maryland.gov/ship/measures.html.

* Race/ethnicity definitions based on the sources of data used. Hispanic origin can be from any race; White/NH denotes those who are both White and of Non-Hispanic origin.

***Rates based on counts less than 20 are not shown due to instability.

^ Maryland baseline value for Objective #36 - Proportion of persons with health insurance -- has been adjusted to allow for comparison with county level data.

Percent difference formula:

$$\frac{x \text{ county} - x \text{ state}}{x \text{ state}} \times 100$$

Appendix E.

Community Health Improvement Implementation Strategy

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOALS	PARTNERING ORGANIZATIONS
1	**Access to Care:**	Adults with less than high school education. Asian, African American, Hispanic	-Develop pilot initiatives aimed at increasing the percentage of county residents with access to primary care, affordable health care and access to the right level of care at the right time. -Identify local Hotspots to improve access using Camden Model.	Increase the percentage of local residents with access to affordable health care.	-Howard County Health Department -Horizon Foundation -Healthy Howard -Chase Brexton Health Services -Foreign Information Referral Network -MD Access Point -State Health Insurance Assistance Program -United Way of Central Maryland -Local Health Improvement Coalition
2	**Obesity**	-56% of Howard County population identified as obese or overweight. -Higher concentrations in Laurel and Elkridge. -Higher concentration of African Americans	-Develop and execute strategies to reduce consumption of sugary beverages -Promote LHIC obesity strategies to hospital patients, visitors, employees. -Expand dietary counseling capacity -Develop and execute pilot walking fitness program	Enable people of all ages to achieve and maintain a healthy weight through healthy eating and physical activity.	-Howard County Health Department -Horizon Foundation -Local Health Improvement Coalition (LHIC) -Local Fitness Providers (e.g. CA, YMCA, Ho Co Parks and Rec)

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOALS	PARTNERING ORGANIZATIONS
3	**Behavioral Health (Mental Health and Addictions):**	-Children (<18) -Laurel, Elkridge -Low Income	-Integrate primary care and behavioral health services. -Promote mental health screening in pediatric primary care practices	Ensure access to affordable and quality behavioral health services for residents of all ages and decrease the number of hospital emergency visits for behavioral health issues	-Chase Brexton Health Services -HCGH Primary Care medical staff -HCGH pediatricians
4	**Elderly Health Improvement**	-Seniors (>65) -Caregivers and families of seniors	-Extend person centered hospital discharge pilot. -Promote Howard Count Office on Aging (HCOA) to hospital patients, families, visitors. -collaborate with post-acute providers to connect patients with primary care, medical homes or other programs that facilitate more effective transitions of care.	Improve case management services and coordinated health care for senior citizens to reduce repeat hospitalizations and increase the number of seniors living independently at home.	-HCOA -Howard County Health Department -Coalition of Geriatric Services -Local Post acute care providers (SNF, assisted living, rehabilitation facilities)

Appendix F.

Figures and Tables

FIGURE

TABLES