

MARYLAND FORWARD

Governor's Forum on Children and Health



January 10, 2011
Coppin State University

Table of Contents

Forum Overview

Purpose of the Event

Introduction

Governor's Strategic Policy Goals on Children and Health

Framing Questions and Themes for the Day

Forum Recommendations

Ending Childhood Hunger

Health Information Technology

Substance Abuse Treatment

Infant Mortality Reduction

HIV

Lead Poisoning Prevention

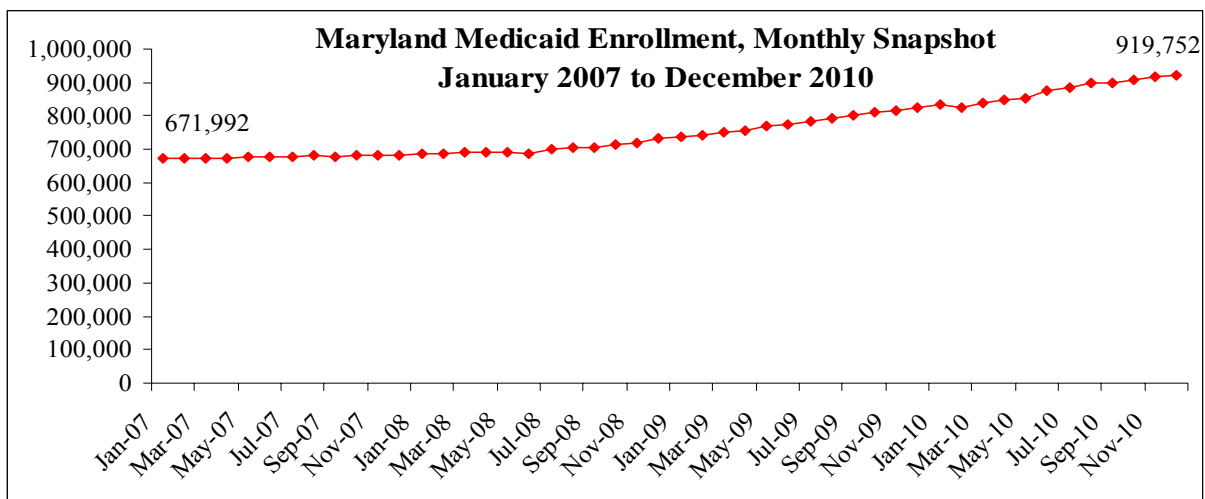
Conclusion

Purpose of the Event

On January 10, 2011, Governor Martin O'Malley convened the *Maryland Forward Forum on Children and Health* at Coppin State University, the fourth of five transition forums. Approximately 400 leaders from health and human services sectors were present including private sector, academic, and local, state and federal government representatives. This report summarizes the discussions and recommendations from that day.

Introduction

According to the Maryland Health Care Commission's (MHCC) latest report on health insurance coverage, 14.5 percent, or 720,000, of the State's population under age 65 was uninsured in 2008–2009.¹ The 2008-2009 uninsured percentage is below the national average of 18 percent and statistically unchanged from 2007-2008. Indeed, at a time when the economic recession forced other states to cut Medicaid enrollment, Maryland was able to expand enrollment to working families, in part through the Working Families and Small Business Health Coverage Act. The new law, which took effect in July 2008, extended Medicaid coverage to parents and caretaker relatives with low family incomes, and subsidized insurance premiums for workers and eligible relatives in small, low-wage businesses. From January 2007 to December 2010, Maryland has added almost 250,000 individuals to the Medicaid rolls, 118,000 of which are children.



However, the recession forced many Marylanders out of their jobs and into the ranks of the uninsured, and more work is necessary to reduce the 720,000 Marylanders who still lack coverage. The difficulty is compounded by the State's budget gap. The federal Patient Protection and Affordable Care Act (ACA) is intended to reform the health care system by making it illegal for insurance companies to deny coverage to individuals with pre-existing conditions, and encouraging employers to provide health insurance. The Governor established, by executive order, the Maryland Health Care Reform Coordinating Council (HCRCC) to evaluate the federal health reform legislation and identify decision points to be considered by the state. The HCRCC's Interim Report found that full ACA implementation will reduce Maryland's

¹ http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_2009_20110120.pdf

700,000 uninsured by more than half, to just below 7%.² Before the forum began, outgoing DHMH Secretary Jim Colmers presented the HCRCC's recommendations for implementing health care reform in Maryland. Each breakout session at the forum was asked to consider the potential impact of the new health reform law on the population and health issue that was being discussed.



Governor's Strategic Policy Goals on Children and Health

Governor O'Malley ran for office in 2006 with a commitment to make government work again for the people of our State. Upon taking office, the Governor instituted StateStat, a system of performance-based management, to make our State government more accountable and efficient. In 2008, the Governor created the Delivery Unit as an extension of StateStat to implement cross-agency initiatives and effectively align State and federal resources. Working with the Executive Agencies and StateStat, the Delivery Unit oversees the Governor's 15 strategic policy goals, broadly categorized into four key areas – skills, security, sustainability, and health.

This structure of centrally coordinated policy implementation and accountability has propelled Maryland's progress towards attainment of the strategic policy goals and has set the course for governmental efficiency and innovative reform. Discussion relating to the following four strategic goals was a central focus of the Children and Health Forum:

- **End Childhood Hunger in Maryland by 2015**
- **Establish Best in the Nation Statewide Health Information Exchange and Electronic Health Records Adoption by End 2012**
- **Reduce Infant Mortality in Maryland by 10% by End 2012**
- **Expand Access to Substance Abuse Services in Maryland by 25% by End 2012**

Framing Questions and Themes for the Day

Each breakout session was framed by relevant portions of the following cross-cutting questions:

1. What are the top three things that the State should do in each of the following areas:
 - a. Reducing infant mortality statewide
 - b. Increasing the number of summer meals, breakfast, and supper served in Maryland
 - c. Decreasing barriers to accessing food programs

² Health Care Reform Coordinating Council. (2010, July). *Interim report*. Retrieved from <http://healthreform.maryland.gov/interimreport.html>.

- d. Expanding access to substance abuse services in Maryland by 25% by 2012
 - e. Increasing adoption and implementation of electronic health records (EHRs) by hospitals
 - f. Increasing number of health providers connected to the State's Health Information Exchange
 - g. Recruiting 1,000 primary care providers to transition to EHR by 2014
 - h. Reducing new HIV infections
 - i. Increasing Access to Care and improve health outcomes for people living with HIV
 - j. Reducing HIV-related disparities and health inequities
 - k. Mitigating the harmful effects of lead on children's growth and development
2. What State programs are helpful to your agency, commission, hospital, or organization? How can these programs be enhanced?
 3. Are there any State programs that are not helpful to agency, commission, hospital, or organization? Should these programs be eliminated or reformed?
 4. Can you identify any untapped resources or partnerships?
 5. How can we best align the resources of state government to enhance service delivery or achieve economies of scale?

Forum Recommendations

Breakout Session One: Childhood Hunger

Related Goal: End Childhood Hunger in Maryland by 2015

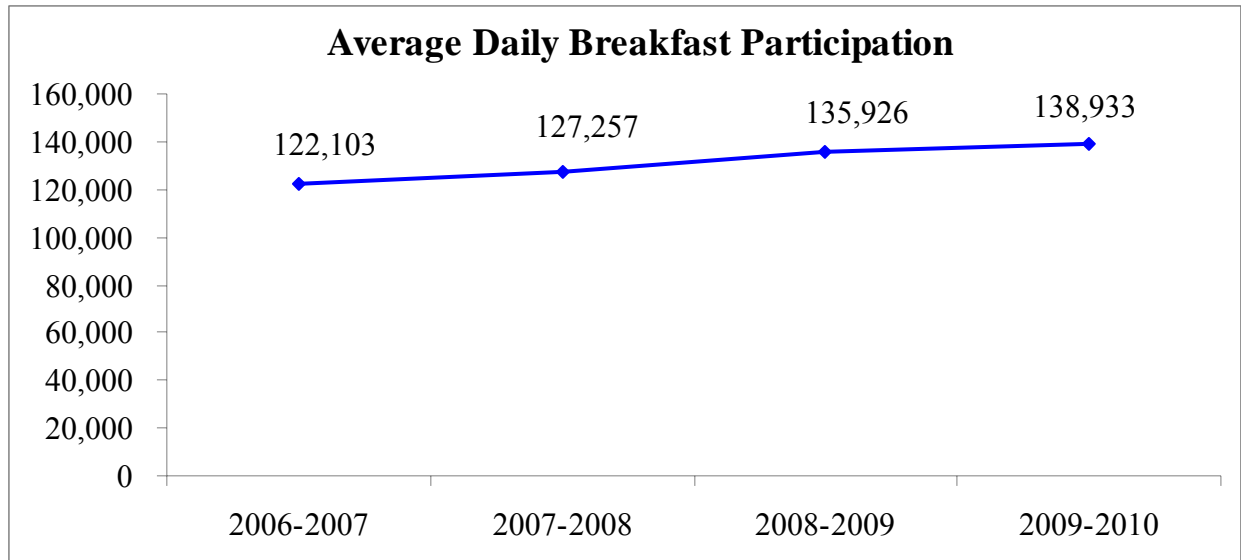
Food security—access by all people at all times to enough food for an active, healthy life—is a health, wellness, and quality of life issue. According to a recent survey by Share Our Strength, 65% of America's teachers regularly see kids who come to school hungry because they aren't getting enough to eat at home.³ In Maryland in 2007-2009, 14.3 percent of households with children were food-insecure. This was below the national average of 19.4 percent for those years. These represented 106,000 households each year and about 210,000 children lived in these food-insecure households.⁴ Food-insecure households have difficulty at some time during the year providing enough food for all their members due to a lack of resources. Parents in food-insecure households often forgo paying bills or sacrifice their own nutrition so that their children may eat. Children in food-insecure homes perform poorly in school and are at a disadvantage compared to other children.

Ending childhood hunger in Maryland by 2015 is one of the Administration's 15 policy goals.

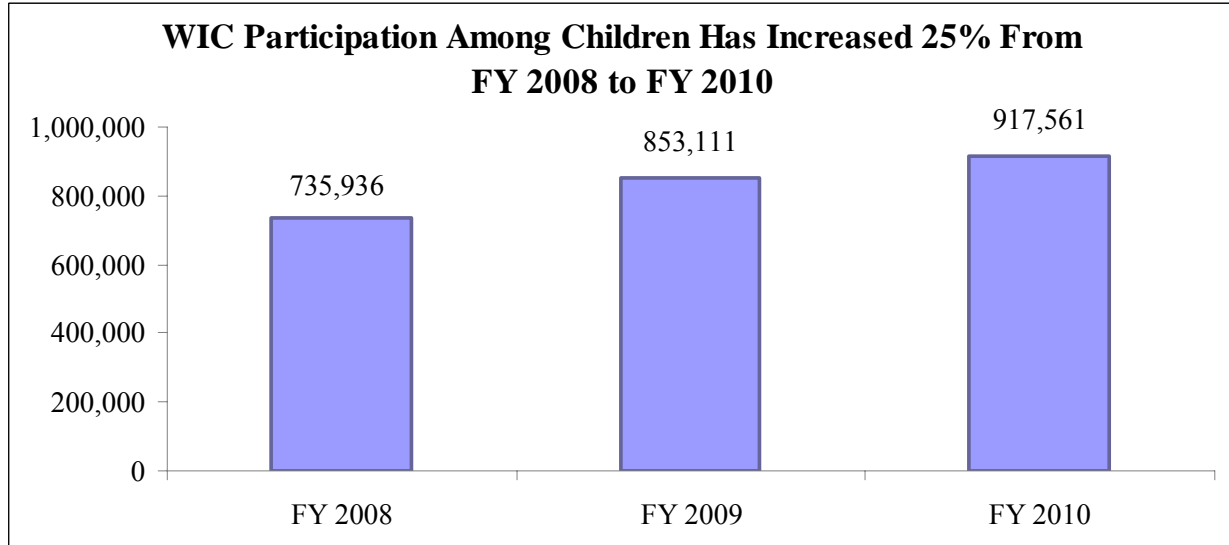
- From CY 2007 to CY 2010, there was a 27 percent increase in meals served through the Summer Food Service Program.
- From the 2006-2007 school year to the 2009-2010 school year, there has been a 13 percent increase in average daily participation in the School Breakfast program.

³ <http://www.strength.org/teachers/>

⁴ <http://www.ers.usda.gov/briefing/foodsecurity/data/mapdata2009.xls>



- The average number of children served daily through the At-Risk Afterschool Meals Program has increased by 2,438 from October 2009—the year that the program started in Maryland—to October 2010—the most recent month for which data are available.
- The number of children participating in WIC increased 25 percent from FY 2008 (735,936) to FY 2010 (917,561), as shown in the chart below.



The key strategies driving goal attainment are:

- Ensure that all eligible families have access to, and are taking advantage of, the Food Supplement Program in Maryland;
- Provide all school children in Maryland with access to a healthy breakfast;
- Expand summer meals programs so that they are within reach of all children in need;

- Expand access to nutritious food through the Women, Infants, and Children (WIC), Child and Adult Care Food, and At-Risk Afterschool Supper Programs.

Following are recommendations that were presented and discussed by stakeholders at the Governor's Forum on Children and Health:

- DHMH, DHR and GOC should disseminate information to potentially eligible individuals
 - DHMH and GOC should distribute information on hunger programs in locations where eligible persons will see them. Examples include posters in DSS waiting rooms, convenience stores, and televised information. A Maryland Food Finder website could also be developed, and 211 can be expanded. As an example of web-based assistance, EdLine in Montgomery County exists for school work, and it can be used to give service information as well.
 - Information (posters, websites and hotlines) should be available in multiple languages.
 - The state could partner with athletes and celebrities to be the "face" of childhood hunger.
 - Within schools, teachers can be advised of tactful ways to reach out to students who are not being served. PTAs should be encouraged to get more involved so that parents know about programs and services as well.
- The relevant agencies should involve professionals in outreach
- Professionals should advise potentially eligible individuals of hunger programs available to students. For example, ESOL teachers can give information about school lunch programs to students to take back to their parents. Pediatricians can notify children and parents of programs and services during physical examinations.
- Programs should find a way to continue food service during inclement weather.
- Health care providers should share information on food programs with one another.
- Service providers and nonprofits should partner to share information about available resources. For example, non-profit networks in Montgomery County meet to discuss services monthly, and a Food Policy Council comprised of non-profits and providers exists in Baltimore. These models could be replicated elsewhere in the state.
- The state should work toward making automatic eligibility determination the norm.
 - Local Education Agencies (LEAs), Departments of Social Services (DSS), and Local Health Departments (LHDs) should work to determine eligibility for all programs when an individual enrolls in one program. Examples can include direct certification in which the Maryland State Department of Education (MSDE) provides LEAs with an electronic file of children enrolled in both SNAP and TANF every other month and LEAs match the list with their rolls, and "reverse" direct certification, in which LEAs share lists of students receiving free and reduced lunch with DHR.
 - During the 2009-2010 school year 85 percent of school age SNAP participants in Maryland were directly certified for free school meals. This was a fifteen percent increase in school-age SNAP participants who were directly certified for free school meals from SY 2008-2009.¹ The national direct certification rate in SY 2009-2010 was 75 percent.
 - An evaluation of matching software in Montgomery County revealed that the software identified additional students who were not directly certified by the traditional Montgomery County Public School process. Purchasing the software could reduce the number of manpower hours required for manual certification, thus expanding resources.
 - Currently, five LEAs are participating in a "reverse" certification process with DHR. The five LEAs are:
 - Cecil County

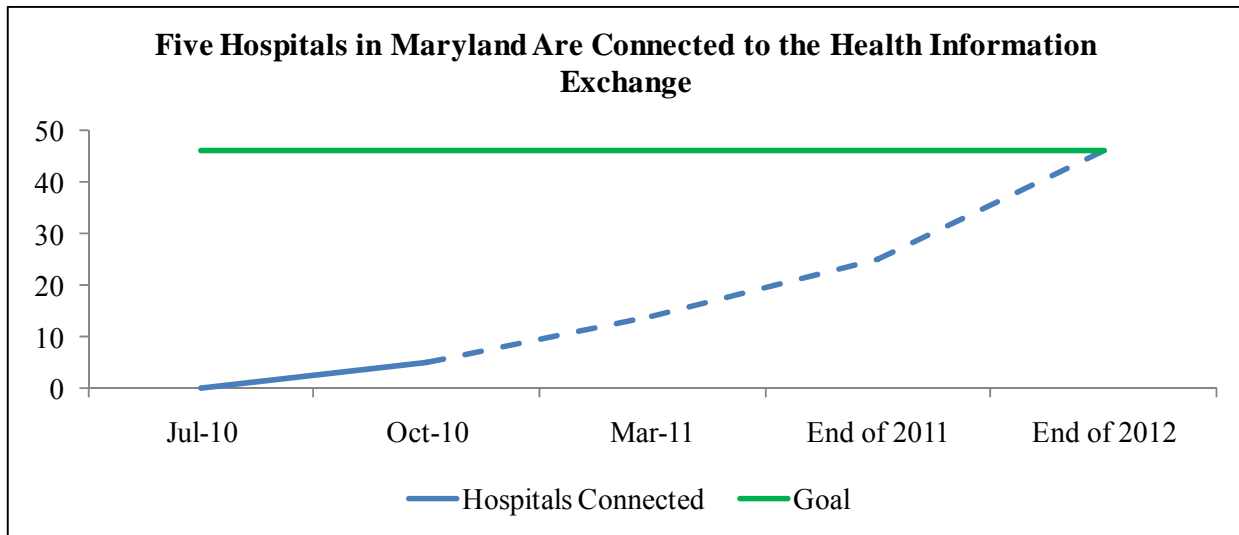
- Garrett County
 - Howard County
 - Prince George's
 - Washington County
- Pending the results, the reverse certification could be expanded to other LEAs.
- The state should seek private funding to support the administrative costs of federal nutrition programs.

Breakout Session Two: Health IT

Related Goal: Establish Best in the Nation Statewide Health Information Exchange and Electronic Health Records Adoption by End 2012

Maryland has prioritized the advancement of health information technology (health IT) to assure that clinicians have the right information available at the time and place of care to improve treatment, prevent errors, and reduce health care costs. Toward the goal of establishing best in the nation statewide health information exchange (HIE) and electronic health records (HER) adoption by the end of 2012, Maryland was one of the first three states in the nation to have its State Health IT Plan approved by the National Coordinator for Health Information Technology. Strategies toward statewide adoption include connecting acute care hospitals, nursing homes, and physician practices to the exchange, as well as incentivizing providers who adopt EHR.

- Five out of 46 hospitals are connected (11%).
- 20 other hospitals are currently establishing connections and 9 will be connected within the next 45 days, resulting in 30% attainment.
- All 46 acute care hospitals in Maryland have signed a letter of intent to connect to the statewide exchange.



Following are of recommendations that were presented and discussed by stakeholders at the Governor’s Forum on Children and Health:

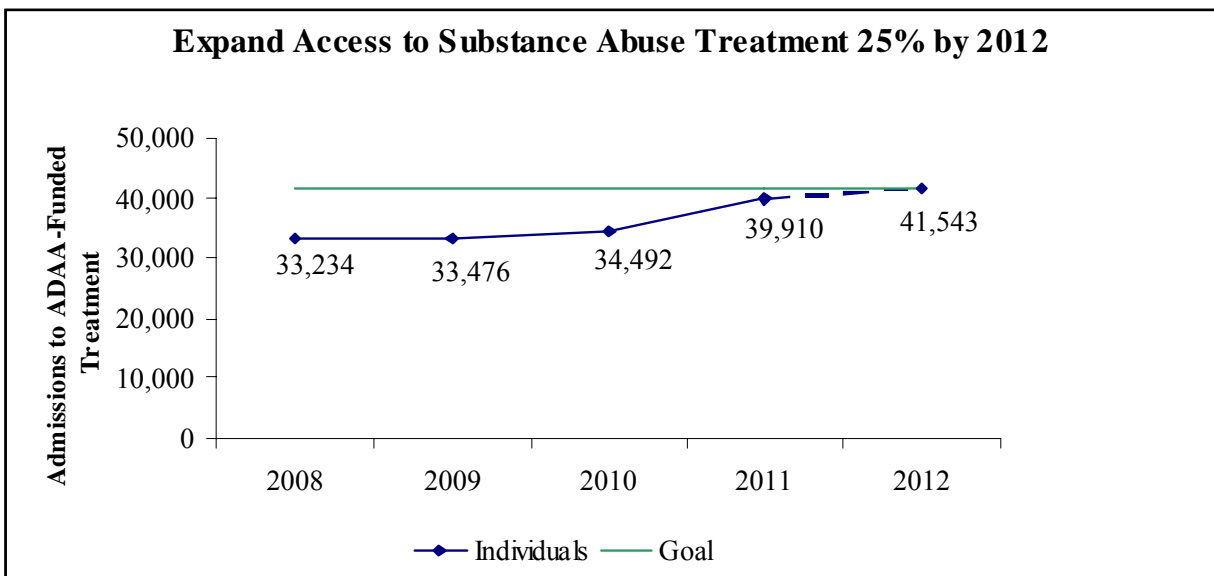
- The state should require organizations that exchange electronic health information to be subject to policies adopted by the MHCC.

- The state should expand telemedicine, focusing on developing a telemedicine reimbursement policy.
- Government and research institutions should consider CRISP as a partner to research clinical effectiveness and population health. Enabling this requires new policies from the MHCC.
- The state should leverage the academic institutions to promote HIT workforce expansion, with a special focus on workforce retention and MBE development.
- The state should use the HSCRC capital investment program to assist in HIE sustainability.
- The state should simplify the Connection Experience. This includes connecting to patients; connections between providers and hospitals; and providers and payers including CMS. The State should also consider recommending to ONC that connecting to the Statewide HIE is a prerequisite to meeting Meaningful Use.
- MHCC should finalize regulations that delineate the incentives to physicians who adopt of electronic health records.

Breakout Session Three: Substance Abuse

Related Goal: Expand access to substance abuse services in Maryland by 25% by 2012

- Overall, the number of individuals receiving ADAA-funded treatment has increased 3% since FY 2007, from 33,387 to 34,512.



The key strategies driving goal attainment are:

- Expand Buprenorphine service to 2,000 individuals by the end of FY 2011;
- Maximize federal funding by redirecting payment for substance abuse outpatient care from State-funded grants to Medicaid;
- Re-engineer the existing system of care to mandate expanded access to treatment for those who need it; and
- Expand the treatment delivery system by developing a Recovery Oriented Systems of Care model in Maryland.

Following are recommendations that were presented and discussed by stakeholders at the Governor’s Forum on Children and Health:

- Identify individuals who need substance abuse services
 - The state should encourage primary care providers and ERs to use the Screening, Brief Intervention, and Referral to Treatment (SBIRT) public health model of early intervention and treatment.
 - DHMH should partner with non-profits and other organizations to bring treatment and assessment into communities. Individuals in recovery could be hired to locate and reach out to addicts who may not seek treatment. Assessments should occur in locations where people already are, such as schools and juvenile probation facilities.
 - The Governor could convene a substance abuse task force to look at barriers to services and answer the question, how do we engage people in a healthcare system that they were alienated from for a long time? The study could include legal, physical, financial, and emotional barriers.
 - The state should expand data capture so that a comprehensive, complete picture can be produced of those coming in contact with the substance abuse service delivery system. This could include looking at waiting lists and how to decrease them, and counting the children of parents in treatment to share with the Department of Juvenile Service (DJS). The data could be used for early intervention to prevent substance abuse in children, and co-occurring disorders in the future.
- DHMH should identify and use effective substance abuse service delivery models and settings
 - Maryland has started slowly down the Recovery Oriented System of Care road.
 - The state should encourage utilization of community-based services offered by providers.
- The state could incentivize those who pursue an education in substance abuse treatment. One way could be to encourage state universities and community colleges to offer a minor in substance abuse treatment that would automatically qualify those individuals successfully completing this coursework for trainee status. Trainees then can work while continuing their training.
- The state should adequately fund substance abuse outreach, engagement, treatment, and recovery services
 - The Governor could sponsor and sign legislation to raise taxes on alcohol, including a provision that the increased tax revenue would be used to fund substance abuse services.
 - The state should encourage a comprehensive funding model so that all relevant agencies contribute funding to some aspect of substance abuse treatment.

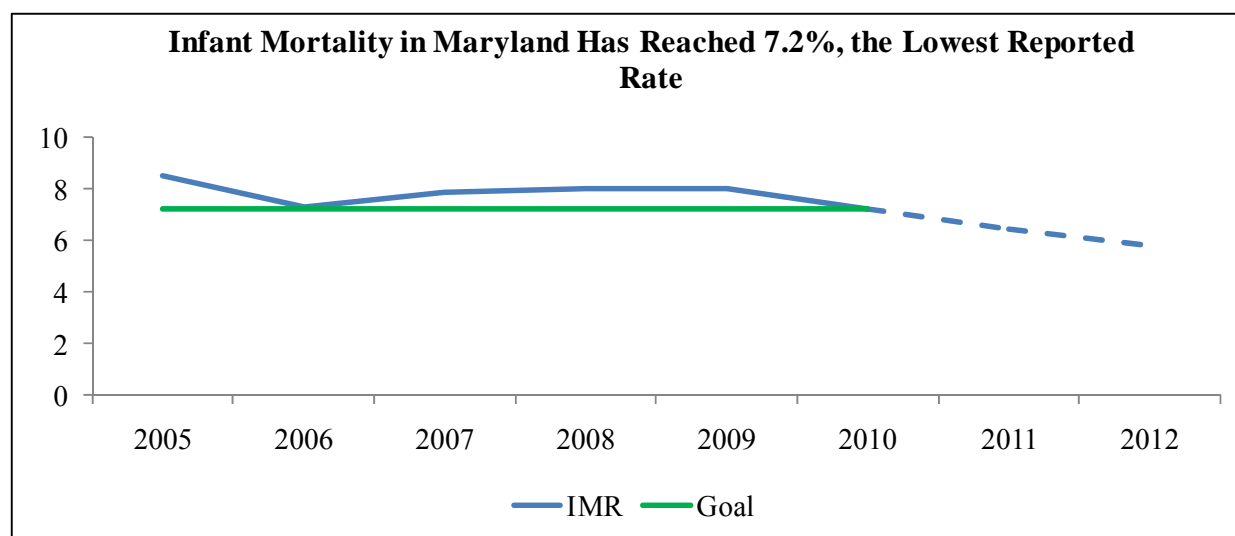
Breakout Session Four: Infant Mortality

Related Goal: Reduce Infant Mortality in Maryland by 10% by End 2012

Reducing infant mortality in Maryland by 10% by the end of 2012 is one of the Administrations' 15 policy goals. Guided by research that links improved birth outcomes with early prenatal care, the Administration has emphasized access to care as a critical strategy in reducing infant mortality. Strategies include:

- Require admission within one business day of the request for all pregnant women that present themselves to a behavioral health or disabilities programs.
- Mandate use of evidence-based practices for pregnant women and women of child-bearing age.
- Assist with the training of community obstetrician-gynecologists regarding substance abuse, mental and developmental disabilities services.
- Support behavioral health programs identified for implementation to combat infant mortality.

As a result, Maryland's overall infant mortality rate (IMR) declined from 8 deaths per 1,000 in 2008 to 7.2 per 1,000 in 2009. This represents not only the early attainment of the Administration's 10 percent by 2012 reduction goal, but also the lowest recorded rate of infant mortality in ten years. However, the infant mortality rate among blacks in Maryland increased.



Following are recommendations that were presented and discussed by stakeholders at the Governor's Forum on Children and Health:

- DHMH should train front line workers so that they are familiar with community resources and available services at the point of healthcare delivery.
- The state should encourage flexibility of funding so local health departments have more discretion in how to deliver results within established programs.
- The state should collaborate and coordinate with WIC to resolve issues with the federal government. For example, loosening federal restrictions would allow local health care facilities to fully interact with families.
- DHMH should disseminate best practices along with information regarding funding sources and state, federal and local programs to practitioners and payers.
- Use local health implementation plans as a vehicle to push out best practices and programs. Hold payers, including MCO's, accountable in regards to promoting the best practices.
- Facilitate discharge plans to ensure that families, especially those with premature babies, receive proper care management after births.
- State support for breast feeding could counteract efforts by formula vendors to inundate new mothers with free formula.
- The state should coordinate prenatal care messaging with the availability of services. Be sure that all messaging and programs have a "life course" message.
- The Stop Smoking marketing campaign can be used as a model for an effective marketing campaign Baltimore City's B-more for Healthy Babies is a good example of consistent messaging.
- High-risk families need face-to-face contact to deliver and reinforce messaging. Community Health Ambassadors are already out in communities but are only speaking on specific issues. Ambassadors could be trained to speak about issues related to infant mortality, such as safe sleep and breast feeding.
- The state could engage faith-based communities to help carry out public health messages.

Breakout Session Five: HIV

In July 2010, the President presented a National HIV/AIDS Strategy (NHAS) which contained three main goals:

- Reduce new HIV infections
- Increase Access to Care and improve health outcomes for people living with HIV
- Reduce HIV-related disparities and health inequities

Maryland is working to align its HIV prevention and care planning and program activities with the NHAS. The various planning group members and other stakeholders in the HIV breakout session were active participants and partners in this process. Following are the recommendations for achieving the goals of the NHAS that were presented and discussed by stakeholders at the Governor's Forum on Children and Health:

- DHMH should encourage early diagnosis through the use of incentives to providers and required third party reimbursement for HIV testing.
- DHMH should utilize health information technology for better data collection and analysis to improve health outcomes and define and reduce health disparities.
- Financial performance-based incentives can be granted for improvement of health outcomes detected by the data.
- The state should ensure that health care reform financing is used to decrease fragmentation and improve coordination and collaboration of prevention and treatment.
- MSDE should include as mandatory curriculum a comprehensive health care literacy course, including sexual education, beginning in grade school.
- The state should promote partnerships between business, education and faith-based communities to facilitate early diagnosis of HIV/AIDS. Those partnerships can be used to promote health literacy and awareness of HIV/AIDS to increase early diagnosis and retention in care.
- The state should enhance engagement of state agencies in coordinated implementation to accomplish National HIV/AIDS Strategy Goals.



Breakout Session Six: Lead Poisoning Prevention

In 2011, Maryland has allocated \$6.4 million to lead poisoning prevention broken down as follows:

MDE \$3,865,346
DHMH \$1,395,348
DHCD \$1,170,000

In 2009, the State tested 107,416 children under the age of six. Statewide, 553 children had a blood lead level (BLL) at 10µg/dL or higher. There has been a 98% reduction in the percentage of children with a BLL of 10µg/dL for the years 1993 to 2009 due to a 1994 law that required owners of rental units built before 1950 to register with the state and remove traces of lead to reduce risks of young tenants picking up lead paint dust. Lead paint has been banned in Baltimore since 1950, but the ban was not statewide until 1978. The State faces other challenges, specifically 553 children statewide with an elevated BBL. Further, in November, the CDC published that they recommend the lead exposure level be reduced to 5 micrograms. If this standard was applied to the children that have been tested in MD, the number of people considered to be above levels would increase nearly tenfold. Following are recommendations to prevent lead poisoning in Maryland that were presented and discussed by stakeholders at the Governor's Forum on Children and Health:

- Educate contractors, health care providers, and new parents.
 - Aviation gasoline still has lead; more than 3 million children live near airports in the U.S.
- Implement uniform standards of testing.
 - Lead-dust testing is the known best-practice; this should be recommended and adopted across agencies statewide. Lead inspection should also be a part of the home inspection process. Inspectors should be properly trained and should enforce the property laws. Every jurisdiction should use a uniform standard for how the house should be treated, and how it should be certified.
- The legislature should expand Maryland's lead law to include owner-occupied homes and dwellings built before 1978.
 - Educate non-affected properties during purchase of home by making it part of the inspection of the house at the time of sale for rentals or private homes.
 - Educate day care operators and foster care houses
- The state should increase funding to MDE for and encourage the agency to follow through with enforcement.
 - The Environmental Protection Agency issued a regulation in April requiring contractors to take precautions against spreading lead-paint dust when renovating, repairing or painting homes, schools and day care facilities built before 1978. Any contractor doing such work is supposed to be certified by the EPA as having been trained in lead-safe practices. Any contractor that does not meet standards should not be allowed to retain a license.
- The state should work to get Medicaid to reimburse for mitigation that reduces risk of lead poisoning (under the 1115 waiver).
 - Maryland should look at national efforts.
 - The state should leverage money from medical and private insurance for intervention and elimination of lead.
- The legislature should revisit tax credits for people who invest in lead hazard control and mitigation efforts.
- Integrate lead poisoning efforts with green and healthy home efforts that are being implemented around the country to reduce lead poisoning, while also reducing allergens and other risks to human health.
 - The "healthy homes" umbrella is a much easier marketing tool that allows for funding for lead that people would otherwise be less inclined to believe impact them. Families need the fastest, most efficient means to solve their problems. We can make it easier for them

by combining programs, cross-training workforce to identify/mitigate all aspects of the healthy homes initiative. Certified curriculum for community health workers and anyone that deals with lead poisoning identification and mitigation.

- Target the Universities; develop a course specific to the health field
- Develop a database for rental properties
- Expand the federal lead law to other products, not just those for children's intended use.

Conclusion

Governor Martin O'Malley's theme for the second term is Maryland Forward, a constant reminder of the Governor's commitment to advance the Administration's goals. The Administration will accomplish these goals by continuing to make government work better through setting goals, fiscal responsibility, changing course when necessary and measuring progress. The purpose of the Maryland Forward Forum on Children and Health was to generate more ideas for how the State can meet the health needs of Marylanders. The Administration will consider the idea recommended by Marylanders when shaping its policy agenda for the next four years. State initiatives as well as implementation of the federal health care law will move Maryland forward toward achieving our articulated health goals.



ⁱ <http://www.fns.usda.gov/ora/MENU/Published/CNP/FILES/DirectCert2010.pdf>