

FY 2018 ANNUAL REPORT

July 1, 2017 – June 30, 2018



*“Working Better Together
to Improve
Health Outcomes”*

FOCUS AREAS:

- ◆ Maternal & Child Health
- ◆ Diabetes
- ◆ Sexual Health
- ◆ Cardiovascular Health
- ◆ Mental Health
- ◆ Cancer
- ◆ Oral Health



Montgomery County, Maryland
Department of Health and Human Services
Office of Community Affairs
African American Health Program



Prepared by *McFarland & Associates, Inc.*



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INTRODUCTION

During FY 2018 the African American Health Program (AAHP), implemented by McFarland & Associates, Inc. (McFarland) continued to improve health outcomes for Blacks in Montgomery County through the delivery of health education, awareness, health screenings and self-management educational classes conducted throughout the County. Health and wellness services targeted cancer, diabetes, hypertension and heart disease, child and maternal health (infant mortality), sexually transmitted infections/HIV, and oral health. These are major problems that continue to account for shorter life spans and lives that are affected by avoidable health conditions among Blacks in Montgomery County.



In 2018, AAHP staff and volunteers skillfully engaged key stakeholders and broadened AAHP's reach into target areas by conducting health awareness education and screening services in more neighborhoods and communities where Black people live, work, worship, or play within Montgomery County. "In 2017, the Department of Health and Human Services (DHHS) of Montgomery County, Maryland commissioned the Health Disparity Hot Spot Identification Initiative (HDHSII) to identify geographic hot spots within the

County where severe racial disparities in health outcomes exist and where services for the Black populations that show high prevalence and incidence of disease that are greatest."¹ The preliminary findings of this report revealed a stark contrast between health outcomes for Blacks and Whites in Montgomery County across the six focus areas addressed by AAHP. The final research will be used by AAHP as a guide to gain more precision in targeting health promotion services.

Prior to the formal identification of zip code areas, AAHP anecdotally selected areas in Montgomery County where large pockets of Black residents lived and where fewer health promotion and wellness services exist. The preliminary findings of the HDHSII gave credence to the anecdotal findings and suggested a need to expand across certain zip code areas. Consequently, these areas were a focal point for many of AAHP's FY 2018 outreach efforts designed to reduce disparities in health outcomes for Blacks in Montgomery County by building new community partnerships to increase health education, awareness and screening services.

This Annual Report documents program highlights, achievements, and measurable outcomes directly related to AAHP's efforts to reduce disparate rates of chronic disease, infant mortality, and other health focus areas in the target population.

¹ Nanda J, Guy-McFarland A, Joice S, McFarland G (2018). Health Disparities Among Blacks in Montgomery County, Maryland: The Health Disparity Hot Spot Identification Initiative (HDHSII).

PROGRAM HIGHLIGHTS

In FY 2018, AAHP continued to improve the health of Blacks in Montgomery County by:

- Providing education and information about key health issues;
- Conducting screening and outreach activities;
- Improving personal self-care management;
- Increasing health literacy to empower participants to understand and manage their health by increasing collaboration with healthcare providers; and
- Expanding methods for evaluating program success.

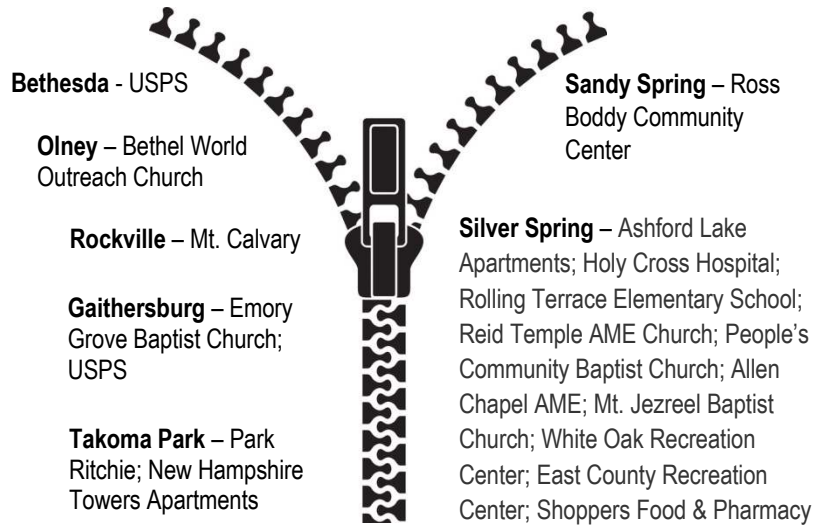
In FY 2018, McFarland extended its use of technology to reach more County residents and manage programs and services. The use of computer software was expanded to identify and obtain a wider range of community resources to address health and social determinants that are essential to wellness. During 2018 AAHP increased the use of Healthify, a software solution to locate and access community resources to improve the health of participants in the maternal and child health focus area; Office 365 Sharepoint, a Microsoft platform designed to collect demographic, patient profile data, and record information about services provided during each encounter with AAHP principals; and mobile apps that included Microsoft Health Vault and Omron® Wellness applications to record store and share personal health information. These software tools provided new means for increasing access to participants' personal information and ensuring that the information was current. For the first-time hundreds of AAHP participants had their blood pressure read using the technology.

Another key highlight of FY 2018 was our increased responsiveness to the mental health needs of participants using online platforms. “Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, and cancer. Mental illness is associated with a lower use of medical care, reduced adherence to treatment therapies for chronic diseases and higher risks of adverse health outcomes. Mental health includes a much wider range of issues that needed to be addressed to reduce health disparities. In addition to the SMILE program’s mental health assessment pre and post-delivery, an anonymous on-line assessment tool was implemented that avoids the stigma of responding to questions by strangers. The tool directs participants to resources after taking the assessment for those whose lives are becoming overwhelming.



In FY 2018, AAHP also encouraged a change in behaviors by expanding the use of social media to reach residents of all ages. AAHP developed the “Know Your Status in MOCO,” a new street outreach program where residents gather such as post offices, community centers, libraries, churches, and other locations to distribute health information, conduct health screenings and offer health related counsel. For example, the most prominent location was in downtown Silver Spring near the Civic Center.

Figure 2. Community Engagement Locations



Disparate health outcomes in Black people in Montgomery County stem from a complex mix of social, physical and economic factors that contribute to disparities. To reduce disparities, the AAHP deployed staff that included a social worker, community health workers and nurses who worked in concert to offer a wide range of services to reach more individuals and families across focus areas. AAHP staff completed training in diabetes, mental health, CPR/AED, HIV, and other areas to also enhance their skills. This enabled staff to provide expert advice about the importance of monitoring one’s glucose levels, blood pressure, and sexual health status, and other biometric measures. By working as a well-coordinated team, collective efforts were used to better address social determinants including mental health, homelessness, unemployment, domestic violence and cultural and linguistic barrier for those who either did not speak English or for whom English was a second language.

In 2018 AAHP completed the required prerequisites needed to offer training, education and awareness services for male and female inmates at the County’s Correctional Facility in Boyd, Maryland. Much of the initial efforts focused on meeting with correctional staff to develop class content and complete requirements for program implementation at the detention facility. In preparation for the initiation of training, two staff members completed a three-day comprehensive training program at Johns Hopkins University on the prevention of HIV/AIDS and sexually transmitted diseases. The formal training curriculum was adopted as a foundation for the program content and training methods for When I Get Out (WIGO). This training was modified to ensure compliance with national standards and appropriate to fit the needs of inmates.

Another highlight of FY 2018 was the inaugural launch of a SMILE conference, held at the Silver Spring Civic Center on September 30, 2017. The AAHP Executive Coalition and AAHP Executive Committee spearheaded this event. The conference theme was *Health Literacy: What Black*

Women Need to Know. AAHP staff coordinated weekly planning sessions, and helped recruit participants and panelists, and manage conference logistics.



In December 2017, AAHP was recognized for the exemplary health promotion leadership of AAHP for addressing disparate health outcomes in Montgomery County. The agency was also issued a citation for outstanding work in eliminating health disparities in Montgomery County. Throughout FY 2018, AAHP received numerous community commendations for its health promotion work to reduce health disparities in the County.

Although we value the accolades and recognition, our greatest satisfaction comes from clients who report dramatic reductions in their personal health risk and who are eager to tell others their success stories. In recognition of the many successes shown during the year, AAHP began selecting program participants who were recognized as AAHP's Champions of the Month. Some of these testimonies are included in the testimonial section at the end of this report.

Community Engagement

During 2018 AAHP placed more emphasis on community engagement to strengthen relationships throughout the County. Community engagement is “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people.”² Community engagement strategies were critical to nurturing relationships with churches and



other faith groups, beauty and barber salons, shops, colleges, healthcare providers, apartment complexes, community centers and other settings where residents gather, live and play.

In addition, AAHP hosted a foreign delegation of 15 government officials from China's Anhui Province who were interested in discovering more about efforts in the County to prevent health disparities and avoid preventable diseases. Participants included professors of varied disciplines and universities in China who were interested in learning more about the use of technology by AAHP to promote health and wellness. This event provided both AAHP staff and visitors with an opportunity to discuss mutual challenges and opportunities to promote health in the County and in China where the number of physicians to residents is extremely large.

During the year, AAHP partnered with numerous churches and apartment complex managers to host AAHP community health education and screening events. In FY 2018, AAHP also increased its impact by promoting self-care through health education and promotional lectures and workshops supplemented by or collaborated with pre-established health ministries.

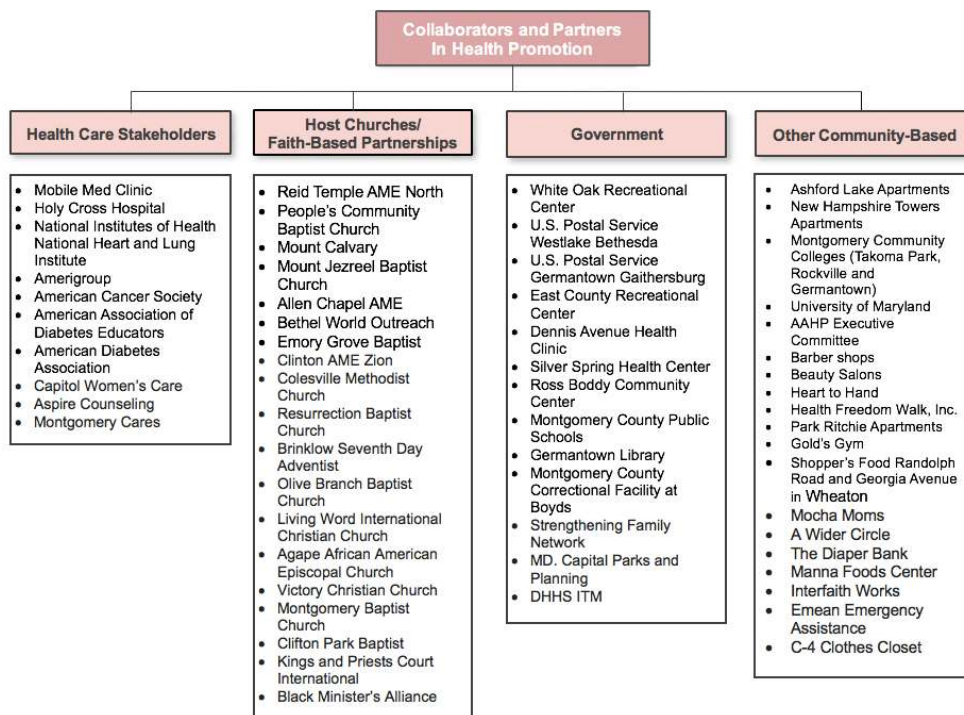
² Best Practices in Community Engagement: Tip Sheet, Office of Adolescent Health, May 2011.

Many of AAHP’s program services leveraged relationships with volunteers, community stakeholders and known providers to engage members of the target population through presentations at community events. For example, a partnership with Heart to Hand, a non-profit group with an HIV testing van allowed both AAHP and Heart to Hand to use their mobile van to conduct more HIV tests in more communities and neighborhoods than would otherwise be possible by working alone.

During FY2018, AAHP established a special partnership with the National Institutes of Health (NIH) National Heart, Lung, and Blood Institute (NHLBI). This partnership allowed AAHP to receive large quantities of health promotion materials and tools to increase the awareness and knowledge about high blood pressure and heart disease and the influence of these factors on health and wellness. NHLBI provided AAHP with culturally appropriate printed and digital materials such as tip sheets, fact sheets, etc. on lung and cardiovascular diseases. In addition, they have offered training resources connected with a National Training Initiative titled, *With Every Heartbeat is Life*. This training manual emphasizes cultural competency and tools to improve the skills of community health workers in reducing heart-related health risks.

Figure 3 is a pictorial depiction of the robust partnerships established by AAHP to support its community engagement objectives. These partnerships are invaluable to the effort to reduce health disparities in Blacks in Montgomery County.

Figure 3. Collaborators and Partners in Health Promotion



In April 2018, another key collaboration, the Annual AAHP Community Day Celebration, highlighted the historic partnership among the AAHP Executive Committee, AAHP, and organizations and agencies throughout Montgomery County that promote health equity. Almost 100 people participated in this event in Takoma Park. Notable participants included the County Executive, members of the County Council, the director of the Montgomery County Department of Health and Human Services, the County’s Health Officer, the County’s Offices on Aging and Human Rights, and leadership of various offices. The event focused on the importance of movement in promoting health. The theme was *Making Obesity Virtually Extinct* (M.O.V.E.). The planning and execution of Community Day demonstrated the shared commitment of County residents and community leaders to reduce health disparities. Together, these groups participated in events focused on health and nutrition education, health screening, and exercise.

In June, AAHP continued its annual partnership with Health Freedom, Inc. to co-host the 14th Annual Health Freedom Celebration Walk. This initiative celebrates the concept of walking for freedom as a memorial to Harriet Tubman and other former slaves who walked to freedom. Formed at least six weeks prior to the Health Freedom Celebration Walk, the Circle of Friends walking groups promote physical activity and incorporate learning about the history of the Underground Railroad. The Health Freedom Celebration Walk was held at the Woodlawn Manor Cultural Park in Sandy Spring on Saturday, June 9. In addition to the 2.75-mile trek, participants enjoyed historical reenactments and festive opening and closing ceremonies. Approximately 100 persons participated.



FOCUS AREAS



Health (The SMILE Program)

The longest and most sustained program of AAHP, Starting More Infants Living Equally healthy (SMILE) experienced stable participations rates after experiencing a brief decline during staff changes. The AAHP SMILE registered nurses continued to provide in-home case management for pregnant women 28 weeks or less along, through delivery, and post-partum services to the infant through age one.

Focus Areas: Maternal and Child



The cross-training staff module AAHP introduced in FY 2017 yielded good outcomes in FY 2018 during the transition of staff. Without interruption of service, community health workers and the social worker assisted in the care management of mothers during this transition, which enabled the program to thrive throughout change. Similarly, all AAHP staff participated in actively recruiting new mothers for the SMILE program and expanding services to reduce stress and other factors that promote healthy birth outcomes. AAHP

also recruited SMILE participants during diabetes education and outreach activities and during HIV/STI encounters with potential clients or referral sources.

AAHP's Chronic Disease Wellness program has always enjoyed wide community support. In FY 2018, AAHP continued to help start or strengthen prevention aims of groups that proactively formed their own wellness programs with AAHP's support. Sometimes health and fitness were easier sells in the community than convincing mothers that the free interventions offered by AAHP SMILE would be helpful to them during their pregnancies and in the first year of the birth of their children. However, new efforts to expand AAHP partnerships with the SMILE program included working with Reid Temple AME North, which hosted a baby shower to collect supplies for SMILE mothers. Additionally, Mocha Moms joined AAHP staff to rearrange the storage area needed to contain the large amount of donations raised through Reid Temple's efforts. This focus on the SMILE program drew attention to the needs of SMILE mothers and children and created additional recruitment opportunities for AAHP.

The annual average monthly SMILE program enrollment in FY 2018, was 92 which recorded a 5% increase over the previous year. This was an amazing accomplishment, given the challenges of managing more complex cases involving pregnant women whose circumstances included more cases influenced by being homeless, obesity, unemployment, mental health, food insecurity and domestic violence. Despite these difficulties the total caseload for all mothers and children increased in every month during the fiscal year except for the months of September and October when the total number of cases either remained the same as the previous month or decreased by only two cases. AAHP is pleased that only two of the 78 births during the year were low birth weight deliveries. The fiscal year ending in June recorded (100) the highest number of cases enrolled in the past two years. In summary, what the data on program performance shows is that almost all mothers remained enrolled in the program during pregnancy and experienced positive birth outcomes. These same mothers also chose to remain in the program for a year after the birth of their infants. The Performance Dashboard (**Table 1**) shows the distribution and profiles of mothers enrolled in the SMILE program at the end of FY 2018, and also shows that healthy birth outcomes averaged 96.83% during FY 2018.

Table 1. SMILE Performance Dashboard for FY 2018

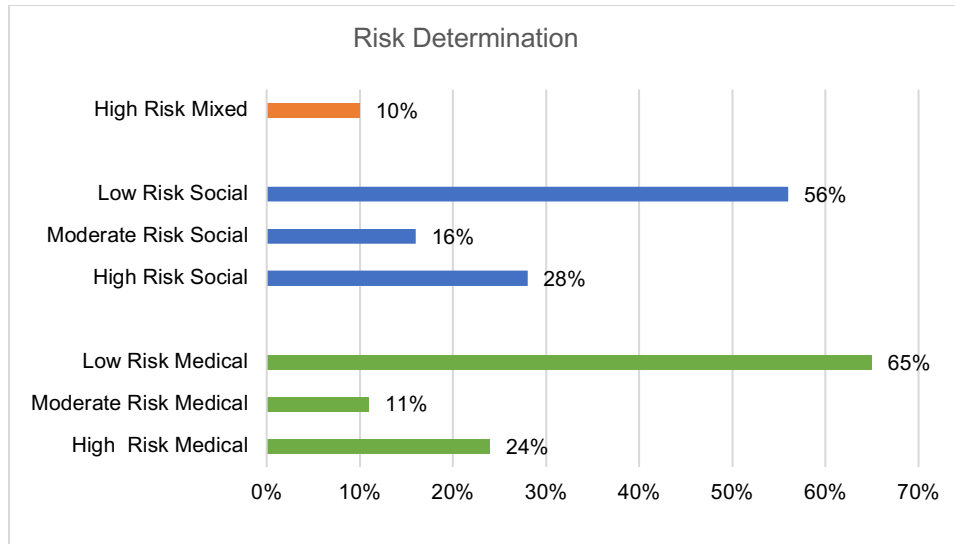
PROFILES AND SERVICES	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
A) Currently Active Moms	92	96	94	90	94	97	92	85	86	90	91	100
Prenatal (still pregnant)	50	44	41	34	25	22	23	20	22	24	25	27
Postpartum (Moms who have delivered)	42	52	53	56	69	75	69	65	64	66	66	73
B) All infants	44	53	55	57	71	77	73	71	68	67	68	75
Single births	40	49	51	53	65	71	63	63	64	65	64	71
Multiples	4	4	4	4	6	6	10	8	4	2	4	4
Case Load (A+B)	136	149	149	147	165	174	165	156	154	157	159	175
Mom's Ethnicity												

PROFILES AND SERVICES	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
African American Clients	37	36	34	30	29	31	25	23	22	23	26	28
African Clients	48	52	53	53	58	59	57	52	56	59	59	67
African Caribbean Clients	7	8	7	7	7	7	10	10	8	8	6	5
REFERRALS												
Prenatal Referrals	2	10	12	14	18	7	9	5	9	10	13	16
Other Prenatal Referrals	9	5	2	0	0	0	0	0	0	3	0	0
Total Prenatal Referrals	11	15	14	14	18	7	9	5	9	13	13	16
NEW ENROLLMENTS												
Prenatal Moms Newly Enrolled during the Month	9	9	5	2	7	3	4	3	7	9	7	9
Post-Partum Moms Newly Enrolled during the Month	2	8	3	7	4	4	2	1	0	2	1	2
Infants Newly Enrolled during the Month	7	13	5	7	9	4	6	3	4	6	7	5
All New enrollments, for the Month	18	30	13	16	20	11	12	7	11	17	15	16
DELIVERIES												
Term Deliveries	7	13	4	7	7	6	5	3	3	6	7	6
Preterm Deliveries	0	0	0	0	2	0	1	0	1	0	0	0
Total Deliveries	7	13	4	7	9	6	6	3	4	6	7	6
BIRTH OUTCOMES												
Healthy Birth Weight (% of Total Deliveries)	100 %	100 %	100 %	100 %	89%	100 %	100 %	100 %	75%	100 %	98%	100 %
Low Birth Weight	0	0	0	0	1	0	0	0	1	0	0	0
Very Low Birth Weight	0	0	0	0		0	0	0	0	0	0	0

Maternal and child health are affected by social and medical risk factors. To assess and appropriately triage SMILE mothers, AAHP uses a risk analysis that ranks risks to determine interventions. The standard assessment protocol defines risks by high, medium and low. High-risk³ classifications are at greater risks for poor pregnancy outcomes and infant mortality. High-risk clients also demand a more intensive intervention. To better track and manage caseloads, AAHP placed more emphasis on individualized medical and social risk assessments and used these assessments as a basis for coordinating a wider range of services to address the social and medical needs of each mother. These assessments and determinations took on added importance as the organization received more referrals that evidenced either high-risk medical or high-risk social issues or combined high social and medical risks. The chart in **Figure 4** shows the distribution and profiles of mothers enrolled in the SMILE program at the end of FY 2018.

Figure 4. Pregnancy Risk Assessment

³ See Appendix A for definition of high risk, medium risk, and normal.



June 2018 recorded the highest overall caseload in a single month during FY 2018. The caseload included 27 prenatal and 73 post-partum women. Nine (9) prenatal cases enrolled during the month. Ninety-four percent (94%) of mothers with babies three-months-old or younger breastfed their babies. Six (6) healthy babies were born into the program, and all births were at term, and within normal weight. Five (5) infants were discharged. The percent of high social risk cases decreased from 14% in May to 12% in June. However, the management of two cases intensified greatly because of related complex mental and social problems confronting each case. These two cases were referred for Intensive Team Meetings (ITMs).

In FY 2017, AAHP worked with DHHS staff to use Intensive Team Meetings to assess and address the complex myriad of complex human service issues faced by pregnant mother and their families. The fifty percent (50%) increase in FY 2018 in the use of the ITM brought together resources that are scattered throughout the County under one roof in a facilitated meeting format to jointly focus on the needs of a mother, children or family. These County resources can include child welfare, housing, mental health professionals and others. ITMs aim to ensure that each child and family receives comprehensive services.

During FY 2018, AAHP conducted classes on birthing and breastfeeding at the White Oak Recreation Center. These sessions helped a total of seventy-three expectant mothers and fathers increase their knowledge about healthy birth and post-partum outcomes. The Fall and Spring classes covered labor and delivery, postpartum and newborn care, breathing and relaxation comfort measures during labor, and emotional wellbeing and self-care. AAHP nurses also covered information about how moms and dads can work together to promote a healthy and supportive family.



➤ **Focus Areas: Diabetes and Heart Health (Chronic Disease Wellness Program)**



AAHP continued its partnership with Healing Our Village (HOV) to provide culturally competent chronic disease prevention and management interventions to Blacks in Montgomery County. In January, AAHP received formal accreditation from the American Association of Diabetes Educators and the American Diabetes Association and recognition as a certified Diabetes Program Provider.

In collaboration with HOV, AAHP created program-specific educational materials, referral forms,

demographic forms, and culturally sensitive teaching aids to address diabetes, hypertension, and heart health in the target population. The objectives of the Chronic Disease Wellness component remain consistent with the previous year's objectives to:

- Develop, implement, and expand feedback reports on hypertension and diabetes measures, including hypertension patient visit adherence and more specific measures to drive Quality Improvement performance
- Provide interventions to “high risk” diabetic and hypertension patients in the target population
- Screen and enroll County residents with hypertension into a Hypertension/Diabetes (Chronic Disease) Wellness and Self-Management Program
- Conduct patient screenings using a depression survey (PHQ 9) for diagnosing, monitoring and measuring the severity of depression using DSMIV diagnostic criteria
- Refer and follow up participants screened for hypertension or elevated glucose, and who do not have a Primary care physician, refer to a physician in the County
- Provide at least three follow-up visits and interventions to participants
- Follow-up on all individuals screened with elevated values and referred to AAHP's Chronic Disease Wellness Program

Participation rates in FY 2018 increased by roughly 20% over FY 2017. One thousand three hundred ninety-one (1,391) persons participated in the Chronic Disease Wellness program in FY 2018. During the program year, AAHP began a new collaborative relationship with Shoppers Food & Pharmacy located in zip code hot spot 20902 to increase knowledge about how to adopt healthier behavioral choices through good nutrition, exercise, and self-care. AAHP and Shoppers Food & Pharmacy also jointly demonstrated the effectiveness of changing one's lifestyle to reduce the risk of hypertension, heart disease, stroke, and diabetes. The collaboration included health screenings, lectures, demonstrations on food preparation, and tastings inside the store.



During FY 2018, AAHP conducted **1,391** blood glucose, blood pressure and BMI screenings at community outreach events presented in **Table 2**.

Table 2. Chronic Disease Program Snapshot

1391	Blood Pressure Screenings
257	Glucose Screenings
141	Hemoglobin A1C Screenings
156	Counseled and Supported for self-management of clients with Diabetes/Hypertension
73	Community Outreach Events
88	Individuals given Glucose meters and supplies and instructed on how to use, as well as log books to track
72	Individuals given BP monitors and instructed on how to test as well as log books to track
26	Individuals successfully referred, tracked, and followed up into a medical home and primary care physician
19	Medication recommendation made, 11 accepted, 5 lost to follow-up due to non-attendance
58	Individuals screened for mental health using (PHQ9)

Nutrition: Food is Medicine

AAHP has a robust and ongoing Food and Nutrition component of its Chronic Disease Wellness program. Nutrition classes were led by Robina Barlow, AAHP’s nutritionist, who discussed how to adopt a plant-based diet and conducted food demonstrations. These classes are critical to improving health and wellness among program participants. Each month had a specific food and nutrition focus. Some of the class topics in FY 2018 included the following:

- Class 1: How Foods Fight Diabetes: Fueling Up on Low-Fat, High-Fiber Foods
- Class 2: The Power of Your Plate and Grocery Cart
- Class 3: Understanding Type 2 Diabetes

One participant was close to going on dialysis. By adopting a plant-based diet, she moved out of the immediate danger zone and had improved kidney functioning.



Each class included a discussion on how food and nutrition impact health and various chronic diseases as well as personal experiences about diet and lifestyle challenges and successes from the previous week. Class participants shared their health challenges and asked questions about food selections, preparations, and shopping. Each week’s class included a short video of 5 to 20 minutes about health, nutrition or diabetes. The topics covered, and foods samples prepared included the following:

1. How Foods Fight Diabetes, Good-Enough-for-Guests Green Salad, Yes-You-Can Black Bean Chili, Sweet Potatoes or Toasted Brown Rice, Chocolate Cherry Nirvana Smoothie

2. The Power of Your Plate and Grocery Cart. A cooking demonstration and samples of some plant-based staples
3. Understanding Type 2 Diabetes, Very Primo Pasta Broccoli Salad, Steamed Kale with “Parmesan Cheese”, Gingered Melon

In addition to the recipes listed above, the second class featured samples of many foods, including various plant-based milks, quinoa salad, veggies, dips, whole grain baguettes, whole grain and sprouted cereal, and fruit.

A participant shared that he reduced his A1C by half by applying what he learned through AAHP.

During FY 2018, the number of class participants whose health and well-being considerably improved was very encouraging. Recent classes and individual testimonies show high levels of satisfaction as well. Testimonial accounts of improvements and behavioral change are captured later in this report.

Table 3. Chronic Disease Management Program FY 2018

Participants	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	FY 2018
Male	40	39	77	18	46	3	48	26	48	53	42	42	482
Female	53	47	140	52	99	21	67	67	104	123	94	42	909
Total	93	86	217	70	145	24	115	93	152	176	136	84	1,391
% African American	95%	92.5%	95.6%	94%	94%	94%	94%	94%	94%	94%	89%	90%	93%
Diabetes													
Pre-diabetes cases	1	2	2	0	12	3	18	11	9	51	5	2	116
Diabetes cases	16	41	21	8	7	5	9	11	8	13	18	7	141
Hypertension													
Pre-hypertension cases	0	10	6	6	17	1	37	14	20	43	25	16	195
Hypertension cases	23	23	13	13	32	6	40	45	27	56	44	34	356
Uncontrolled hypertension	1	2	3	1	1	0	3	3	2	12	7	2	37
Total	93	86	217	70	145	24	115	93	152	176	136	84	1,391
Elevated	41	55	45	28	69	15	107	84	66	175	99	61	845
% Elevated	44%	64%	21%	40%	48%	63%	93%	90%	43%	99%	73%	73%	61%

The Chronic Disease Management Program was very successful in improving health indicators for participants.

- 85% of participants in the Diabetes and Cardiovascular Health Program had a positive health or behavior change
- 80% of participants in the Diabetes and Cardiovascular Health Program had improved A1C levels at 3-month follow-up
- 90% of participants in the Diabetes and Cardiovascular Health Program learned to read food labels
- 90% of participants in the Diabetes and Cardiovascular Health Program learned to inspect their feet daily

- 100% of participants in the Diabetes and Cardiovascular Health Program learned to take, record, and monitor their own blood pressure
- 70% of participants with an elevated blood pressure showed improvement over 3 to 6 months
- 80% of clients in the Diabetes and Cardiovascular Health Program had improvement in nutrition and fitness behaviors over 3 to 6 months
- 90% of participants in the Diabetes and Cardiovascular Health Program were screened utilizing an approved mental health screening tool

As important, the participants have become supportive of each other providing information on successful strategies and encouragement.

➤ **Focus Area: Sexual Health (HIV/STIs)**



“HIV transmission cannot be eliminated if individuals do not know their HIV status (i.e., whether they are HIV positive or HIV negative). An HIV test is the only way to determine if a person is living with the virus. Once an individual knows s/he is living with HIV, safer behaviors may be practiced reducing or eliminating the likelihood of transmission.”⁴ In the third quarter of FY 2018, three more AAHP staff were certified by the State of Maryland to conduct HIV counseling and testing. A total of four staff are now certified to conduct testing and provide pre and

post-test counseling. Currently, AAHP is expanded community outreach to areas identified in the HDHSII report to better address the rising spread of Sexually Transmitted Infections (STIs) in Montgomery County.

During FY 2018, AAHP launched a new initiative called *Know Your Status* to reach more County residents with education on sexual health and HIV/AIDS prevention. AAHP conducted 33% more HIV tests in FY 2018 than in FY 2017. Clients tested were counseled and referred for STI testing as appropriate. Table 4 provides a breakdown of the HIV testing in FY 2018.

Table 4. FY 2018 HIV Testing

	Male	Female	Total
African Americans	190	167	357
All Others	35	24	59
Total	225	191	416

⁴ <https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/HivTesting.html>. August 2018.

During April 2018, two members of the staff completed orientation and background clearance procedures required to begin offering prevention and education services at the County’s Detention Center in Clarksburg. In June, AAHP’s Clinical Director and the HIV Navigator initiated the “When I Get Out” (WIGO) program to provide disease prevention and health promotion education to the incarcerated population of the Montgomery County Correctional Facility at Boyds. Twenty female inmates participated in the first session. The general prevention topics covered included oral health and healthy sexual practices to guard against HIV and other common STIs such as trichomoniasis, chlamydia, gonorrhea, syphilis, and herpes. The session was well-received. Male inmates will receive the same education session in July 2018. These sessions repeat on the first and second Fridays of each month. AAHP staff distributed a variety of health materials to the participants. AAHP will conduct sexual health education outreach with inmates on an ongoing basis.

➤ **Focus Area: Men’s Health – Brother 2 Brother (B2B)**

In FY 2018, AAHP increased emphasis on recruiting more Black men into health screenings, educational seminars and classes to increase their understanding about the importance of health and wellness. Historically Black men have the shortest life expectancies and suffer more avoidable illness than other ethnic groups in the County. To attract more men to program screenings and services AAHP began new efforts to fill this gap in services in 2017 to deliberately target men with the health promotion efforts of AAHP. B2B provides a platform to address men’s health issues in comfortable settings led by men who bring expertise in key topic areas regarding men’s health and reached 382 black males in FY 2018.



Topics like prostate cancer, colon cancer, diabetes, obesity and cardiovascular disease in Black men have been the focus of the conversations. As in 2017, the sessions remain exclusively for males and individual experiences and questions are encouraged in environments that are safe and non-judgmental. Four hundred and thirty-five brochures were distributed that had detailed information including the need to have prostate screenings.

In December 2017, the B2B program achieved the highest levels of participation for a single event at the People’s Community Baptist Church. The theme of the program was ***From Health Disparity to Health Prosperity: Transforming our Health***. AAHP engaged closely with church leadership to promote this event, which led to the largest number of B2B participants since its inception on the first snow day of winter, with more than 100 Black men attending. Significantly, 30 Black male high school students attended the program, which represented a new milestone for youth participation.

Mount Jezreel Baptist Church in Silver Spring continued to be a valuable partner in hosting B2B sessions. On June 16, 2018, B2B brought together 50 Black men at Mount Jezreel Baptist Church for “Getting Through the Storm,” a conversation about emotional resiliency. For the first time ever, a B2B Talk included a comedian who brought laughter and lightheartedness to balance out the serious dialogue on stress and mental health. AAHP’s mission to help Black men live healthier

lives was also integrated into a stirring sermon about health delivered by a guest minister. This event also included the full range of free health screenings.



200 MEN PARTICIPATED IN B2B DURING FY 2018*

*30 of the 100 participants in December 2017 were high school-aged males.

➤ Focus Area: Mental Health

Because the mental health status of participants across AAHP focus areas are an important determinant of the overall health of Black Montgomery County residents, AAHP expanded its outreach and education in mental health.



To address this problem, in December 2017, McFarland began offering mental health screening through online self-assessments that include working with a new online subscription service to provide additional mental health screening tools that measure depression in adults and adolescents, anxiety, psychosis, eating disorders, substance use, and bi-polar disorders. This new asset enables County residents to use validated and reliable tools to assess their mental health in privacy and when indicated, appropriate resources are identified to meet their needs. One of the advantages of online approaches is that it allows the individual to avoid much of the stigma associated with mental illness. The anonymous self-assessment is an application on the AAHP website at <http://screening.mentalhealthscreening.org/aahtmoutgomery>.

Although the testing is anonymous, AAHP collects basic demographic information on the overall number of residents who used the system along with other pertinent data on age, gender, ethnicity, the severity of their illness and their intentions to seek help with mental health problems. Since adding this app, AAHP has screened 380 individuals in FY 2018. During 2018 most participants who engaged in mental health screening were females between the ages of 18-44 for depression and generalized anxiety. Mental health screening was offered using online and in-person resources appropriate to their specific mental health concerns.

As noted above, data show that depression and generalized anxiety were conditions screened for most frequently, and females accounted for almost eight out of 10 tests. However, by the end of the fiscal year, AAHP also saw a slight increase in the number of males who were screened, at 21%. Interestingly, almost 25% of screens were for adolescents who were found to show signs of depression. This result may mean that more adolescents are being screened or perhaps these are adults who are concerned about the behavior of adolescents they know. Most persons screened described themselves as Black or African American (80%).

SMILE clients are screened pre and post-delivery on a standard mental health tool and post-partum depression is discussed. To support the growing demand for mental health assessments and referrals, AAHP hired another social worker who will continue to enhance its focus on improving the mental health status of the target population.

➤ **Focus Areas: Cancer and Oral Health**



Given the high number of cancer deaths African Americans in Montgomery County, in February, AAHP expanded participation with the American Cancer Society and Cancer Coach for YOU. This expertise is aiding in preventing and managing social and psychological problems related to cancer. AAHP also created an alliance with Amerigroup, a firm that provides a wide range of mobile healthcare testing services free of charge and reestablished communication with the African Women’s Cancer Awareness Association.

AAHP promotes good oral health by providing oral health information and supplies, including oral health kits, at community events and health fairs. AAHP also initiated a partnership with Dr. Joseph Latta, a dentist who brings to each lecture more than four decades of providing dental care to residents of the County. Throughout the year Dr. Latta conducted 8 lectures about the importance of oral health to 97 individuals as a cross-cutting health issue that impacts almost every aspect of disease prevention and wellness. His lectures are designed to encourage every resident to establish a regimen of regular dental health visits.

➤ **Social Media Health Promotion**

AAHP recognizes social media as an effective and efficient tool for health education efforts; constituent engagement; and promotion of AAHP’s events, programs, and services. In FY18, AAHP continued to nurture and leverage social media to reduce health disparities that impact Blacks in Montgomery County.

AAHP’s social media distributes health information from trusted sources such as the Centers for Disease Control and Prevention and the Mayo Clinic, and government-based partners such as the Montgomery County Department of Health and Human Services and the Office of Minority Health. AAHP’s social media channels also post repurposed content from AAHP’s website and monthly newsletter. All content adheres to AAHP branding guidelines and social media best practices appropriate for each channel.





❖ Social Media Highlights

On July 12, 2017, in observance of Minority Mental Health Month, AAHP participated in a Twitter chat hosted by the National Institute on Minority Health and Health Disparities (NIMHD). During this hour-long event, AAHP tweeted answers to questions posed by NIMHD on community mental health. AAHP’s tweets expressed AAHP’s outlook on promoting mental health care among Blacks in Montgomery County. By contributing to an active social media conversation, AAHP’s social media metrics reflected increased engagement and visibility within the health services community.

AAHP Community Day 2018’s theme was M.O.V.E. (Make Obesity Virtually Extinct). Marketing efforts centered on the groundbreaking movie *Black Panther* to take advantage of a unique cultural moment that celebrated “Black excellence” and united Black people from across the African diaspora. Social media posts for Community Day included such hashtags as #LiveFromWakanda and #WakandaInMoCo, which helped build interest and engagement. AAHP broadcasted on Facebook Live for Community Day’s Opening Ceremonies featuring a special drumming performance by Jabari Exum, *Black Panther*’s fight scene drummer.

At the beginning of 2018, AAHP expanded its social media efforts with the addition of an AAHP Instagram account, which features photos and videos that showcase AAHP’s events and activities. As an extension of AAHP’s marketing efforts, AAHP’s Instagram account expanded AAHP’s social media reach and is expected to capture a younger audience as it grows.

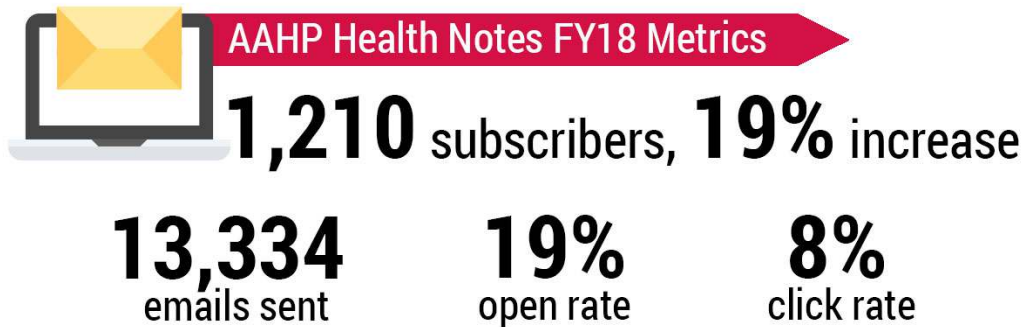


AAHP also works to meet people "where they are" by going to churches, gyms, barbershops, etc. to provide resources and services. #MinorityMH



AAHP Health Notes

AAHP’s monthly newsletter, Health Notes, continued to deliver pertinent health information to its growing list of subscribers. Articles in Health Notes include features based on monthly health observances; health tips, news, and information on health issues that disproportionately affect Blacks; ads for AAHP events and programs; and recurring features of selected video, recipes, and staff. Health Notes added 195 new subscribers in FY18, and metrics for clicks and opens increased as well. Health Notes continued to be published on AAHP’s website each month.



➤ **Conclusion and Testimonials**

At AAHP we undertake every task with the understanding that every life is precious, and our continuing commitment is to do everything that we can to give every infant a good start and every youth and adult participant a healthier life. We do this by helping each mother take control of her health by knowing the benefits of healthier living on birth outcome. We also do this by ensuring that every participant in either of our focus areas knows their individual worth and the importance of their own proactive self-health management practices. We are pleased that in FY 2018 we continued counseling, education, screening and information dissemination about how to promote behavioral change that conformed to the individual needs of Blacks in Montgomery County.

While we take seriously our role in saving lives and helping our neighbors to enjoy the benefits of improving their health, it is the personal stories that convey a human touch to our work. Presented below are just a sample of what our participants have told us about how we made a difference in their lives.

➤ **May 2018 Health Champion**

May's Health Champion was Mr. H. Mr. H. had been with the program for a short time and had made a huge impact on his health status while also advocating for the health of others and the program. Since enrolling in the Chronic Disease Management class, Mr. H. lost over 30 pounds and lowered his blood pressure by more than 15 systolic blood pressure points. He credits the Chronic Disease program for providing him with the "education and support to change his life around completely." Mr. H. has adopted new healthy food habits and blood pressure monitoring routines. He continues to be a huge advocate for the program whether it is bringing friends to the class or spreading the word at different events about how much of an impact the program has made on improving his life.

➤ **June 2018 Health Champion**

June's Health Champion was Ms. PB, a Black woman who has been working with AAHP for more than a year. Ms. PB was introduced to AAHP's services after consultations with AAHP principals at a health screening event at her church. Ms. PB had a keen interest in improving her health and had reached a roadblock. Since she began her screenings and adopting a plan that includes a vegan diet, Ms. PB has gone from 10% kidney function and Stage 4 kidney disease to kidney function of 48% and reduced her status from Stage 4 CKD to Stage 2 CKD. Ms. PB now only must see her nephrologist every six months rather than every month, and she has become named "a miracle patient." Ms. PB credits the chronic disease program with providing her with "an education and support network to turn her life around completely." Ms. PB is always eager to share her successes and suggestions and plans to continue attending weekly and bringing friends because "the program has added so much to [her] life." Ms. PB brought a friend to every class in June.

➤ **Testimonials**

One person shared that over the few months since attending classes, she has gone from obese to overweight, while another participant reported that she had lost 14 lbs. Another participant noted that she was close to going on dialysis, however, by adopting a plant-based diet, she has moved out of the immediate danger zone and does not need to see her nephrologist for six months because of improved kidney functioning. Another participant shared that her husband lost several inches from his waist and lost 30 lbs. since coming to the class. Another participant shared that he had reduced his A1C by half. All in all, the testimonies were strong and compelling.

THANK YOU SO MUCH for an AWESOME presentation yesterday. That was one of the BEST (if not THE Best) Prayer Breakfast that we have ever had to date. It was extremely informative, substantive, and participative. We will be in touch with you to work out a date for us to host another Brother to Brother event.



Sample Testimonial March 2018 Monthly Report

“I worked for class last night, and I have to tell you, it was amazing! There were 12 people in the room, 2 were clinic patients I sent over, and one was a woman from Reid Temple who approached me with a hug and said I saved her life. She is a cancer survivor and hospitalized for most of 2 1/2 years with sepsis and complications. She said I did her screening at Reid and begged/guilted her into

Diabetes Reboot. After that, she said she would come to class but on the day probably would have brushed us off had not Dr. Myers called and asked her to come. That personal touch got her there in Jan 2017, and she has been coming since. She went vegan, and her doctors are amazed. She feels good! And on Monday, her doctor took her vegan paperwork out of her hands and copied the sheets for him/her self!!! All of her docs are amazed.”

We are certain that the future of AAHP will continue an upward trajectory of improved health outcomes for our target population as we expand our outreach and community engagement strategies to more locations where Black people live, work, worship and play in Montgomery County.

APPENDIX A: MATERNAL HEALTH RISK DEFINITIONS

High Risk

- Advanced Maternal Age: Advanced maternal age includes women at the ages of 35 years and above, which increases the risk of unfavorable outcomes including baby born with Down's Syndrome
- Teen pregnancy or adolescent: This category has a significant high rate of preterm birth, low birth weight, miscarriages, and even death.
- Overall health status
- History of miscarriage, still birth and other pregnancy complications
- Primigravida
- History of gestational diabetes and /or pre-eclampsia
- In addition to other social determinants
- Positive tests in communicable and non-communicable diseases.

Medium Risk

- Within normal range or expected maternal age, with presence of various social determinants which can lead to unfavorable outcomes or a lack of lack of supporting system which can create a poor supporting environment and elevate the level of stress that parent is facing.

Low (Normal) Risk

- Overall health within normal limits
- Under prenatal care
- Good support system