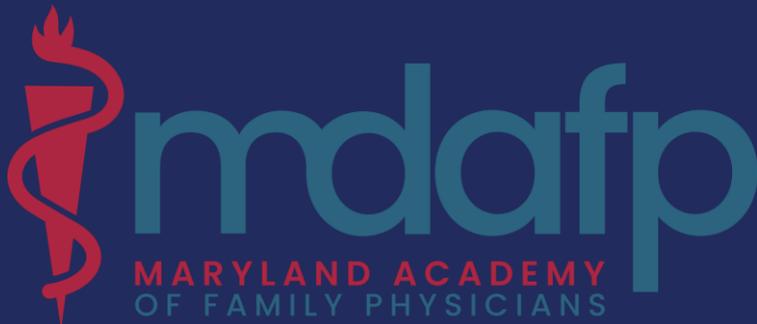


The Warm Handoff: *Linking Primary Care, Patients, and Local Health Departments*

January 20, 2026 – 7 pm

Speakers:

Kisha Davis, MD, MPH, FAAFP, *Health Officer, Montgomery County*
Barbara A. Brookmyer, MD, MPH, *Health Officer, Frederick County*
Meena G. Brewster, MD, MPH, FAAFP, *Health Officer, St. Mary's County*



mdhealthofficers.org

Objectives

1. Know where to find contact information for LHDs in your catchment area
2. Describe the LHO's Chief Strategist role in and for the community
3. Develop ways to identify resources in your community of relevance to your patients
4. Formulate a plan on how to collaborate and coordinate with the LHD(s) in your catchment area
5. Consider ways to get involved in your local community
6. Examine how to connect and integrate primary care and public health to achieve shared health outcomes
7. Provide feedback to LHOs about primary care, patient referrals, and areas of potential collaboration

CME Accreditation: Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

The MDAFP-MACHO Project

In late 2024 MDAFP approached MACHO about ways to make primary care and public health seamless for Maryland residents.

MDAFP & MACHO Are Working Together To:

- Strengthen relationships between Family Physicians and LHOs/LHDs
- Support health equity and SDoH integration
- Build practical pathways for collaboration

Selected projects:

- ✓ Survey of MDAFP member top issues
- ✓ Monthly articles for MDAFP newsletter
- ✓ Quarterly webinars
- ✓ Contacts for LHDs for services on MDAFP website

Public Health 101: LHOs, LHDs, & MACHO



PUBLIC HEALTH



DISEASE PREVENTION



HAND WASHING



COMMUNITY HEALTH



MEDICAL SERVICES



HEALTH MONITORING



OCCUPATIONAL SAFETY



HEALTH PROTECTION



FAMILY HEALTHCARE



HEALTH AWARENESS



HEALTH LIFESTYLE



UNIVERSAL HEALTHCARE



EDUCATION



HYGIENE



TELEMEDICINE



EPIDEMIOLOGY



SOCIAL MEDICINE



NUTRITION



VACCINATION



CHECKUP



HEALTH EQUITY



FIRST AID



HOSPITAL



PRIMARY CARE

What is Public Health?

Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.

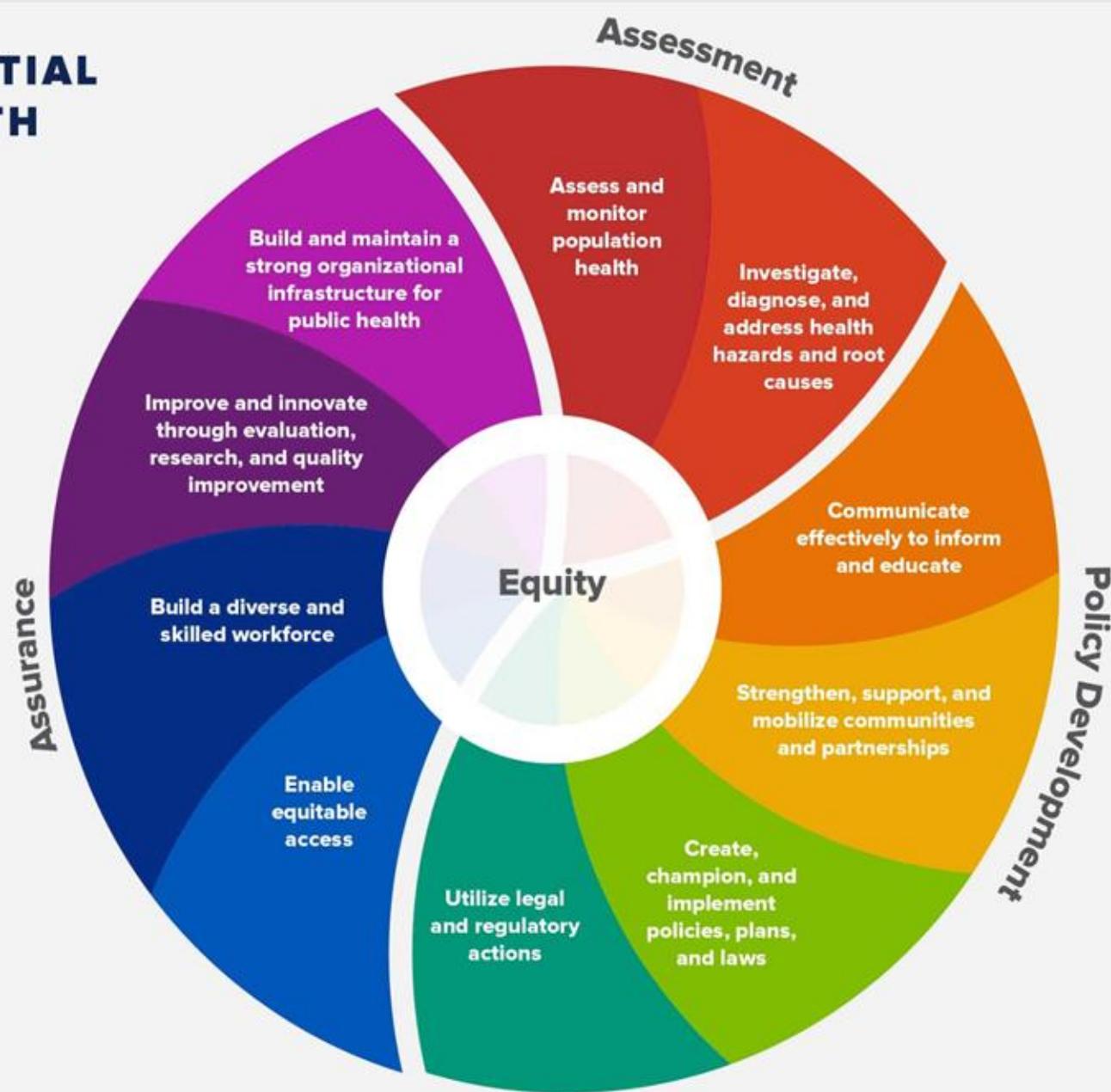
(The Future of Public Health, IOM, 1988)

PH
frame
-work
used
by
LHDs
→

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.



What is a Local Health Department (LHD)?

A government agency responsible for protecting and improving the health of its specific community by preventing disease, promoting healthy behaviors, and responding to health threats and emergencies.

The services and programs a LHD delivers in its community differ within a state and across the nation and are based on needs assessments, gaps, community-identified priorities, funding sources, and other factors.

LHDs serve as the frontline for public health, directly interacting with residents and addressing community-specific health concerns.

IN MD – there are 24 LHDs, 1 in each jurisdiction, each led by a Local Health Officer (LHO). They have shared governance with the state health dept. and their counties.

Your LHD is *Your* Community Health Partner

What Do LHDs Do?

- **ASSESS** data to determine and monitor community health priorities
- **Build PARTNERSHIPS** across a community to address public health issues
- Implement **PROGRAMS** to address community health problems
- Recommend or administer **POLICIES** that have an impact on public health
- Monitor or improve the **SYSTEM** (the way things are done)
- Improve and protect the **ENVIRONMENT** that affects health
- **COMMUNICATE** information to empower healthier decisions
- **PREPARE** for and **RESPOND** to health-related emergencies
- Advance **HEALTH EQUITY** by addressing social determinants of health

Common Local Public Health Focus Areas

- Chronic Disease Prevention & Control
- Infectious Disease Prevention & Outbreak Control
- Emergency Preparedness & Response
- Environmental Health
- Access to Health Care
- Vital Records
- Behavioral Health (mental health & substance use prevention/control)
- Maternal Child Health
- Violence, Injury & Trauma Prevention
- Special focus areas based on community gaps and needs

Advance Health Equity

Sample of Services Provided by MD LHDs

ALL	NEARLY ALL	SOME
Chief Health Strategist	Family Planning Clinics	Early Care Programs
Immunizations	Environmental Health - MDE	Dental Clinics
Communicable Disease Surveillance	Oral Health Outreach	Residential Services
Adult Evaluation Services	Behavioral Health Care System Oversight (LBHA)	Behavioral Health Treatment
Cancer Control Programs	Medical Transportation	Home Health
Tobacco Control and Prevention	Birth and Death Certificates	School Based Health Clinics
Emergency Preparedness	Violence and Injury Prevention	Laboratory Services
Drug and Alcohol Prevention	Fatality Reviews	Harm Reduction Programs (syringe services, naloxone distribution, etc.)
Rabies Control	Medicaid Enrollment	Child Safety Seat
Environmental Health MDH	Chronic Disease Education	After School Programs

LHD Activities Specific to Access to Care

System Oversight

- Monitor access to health care challenges
- Work with clinical partners to resolve local gaps in health care services
- Facilitate/approve referrals for specific clinical services (e.g., behavioral health)
- Support community emergency response capabilities of local health care providers/institutions

Direct Clinical Services

- Reproductive health & family planning
- Vaccines
- Primary care
- Infectious disease (e.g., TB, hepatitis, HIV)
- School-based health centers
- Behavioral health crisis walk-in and mobile response
- Outpatient, crisis and residential behavioral health treatment
- Oral health/dentistry
- Home health care
- Wound care
- Tobacco cessation counseling
- Mobile clinics

Remove Barriers to Healthcare Access

- Transportation to medical appointments
- Health insurance eligibility and enrollment
- Community health workers
- Care coordination & patient navigators
- Support/administer school health services
- Support/administer health services in jails
- Home visiting programs (e.g., MCH)
- Community-clinical linkages

Health Officers as Chief Health Strategists

LHOs serve as decision-makers in their communities to:

- Engage multi-sector collaboration to examine gaps & needs in the community
- Examine upstream factors such as economic stability, education, housing, & transportation
- Leverage & interpret data for actionable, data driven decision making
- Ensure true community representation & involvement in data collection, decision-making, & implementation
- Leverage, blend, & braid funding to support long term, community-level work
- Drive policy change

LHOs and their LHDs work with hospitals, community members, and other partners to conduct the following assessments and plans and align common objectives and measures:

- **Community Health Assessments (CHAs)**
- **Community Health Implementation Plans (CHIPs)**
- **Local Health Department Strategic Plans**

NEW

AHEAD model shared measures

MACHO

Maryland Association of County Health Officers

Mission: to promote, protect, and improve the health and well-being of all Maryland residents through an effective statewide system of local public health departments

- 24 local Health Officers/Chief Health Strategists for the State's 24 local public health departments
- Collective voice for local public health in Maryland
- Coordinate with internal/external groups to address the distinct public health needs in each community

Contact: Ruth Maiorana, Executive Director, rmaiora1@jhu.edu

The Primary Care–Public Health Warm Handoff

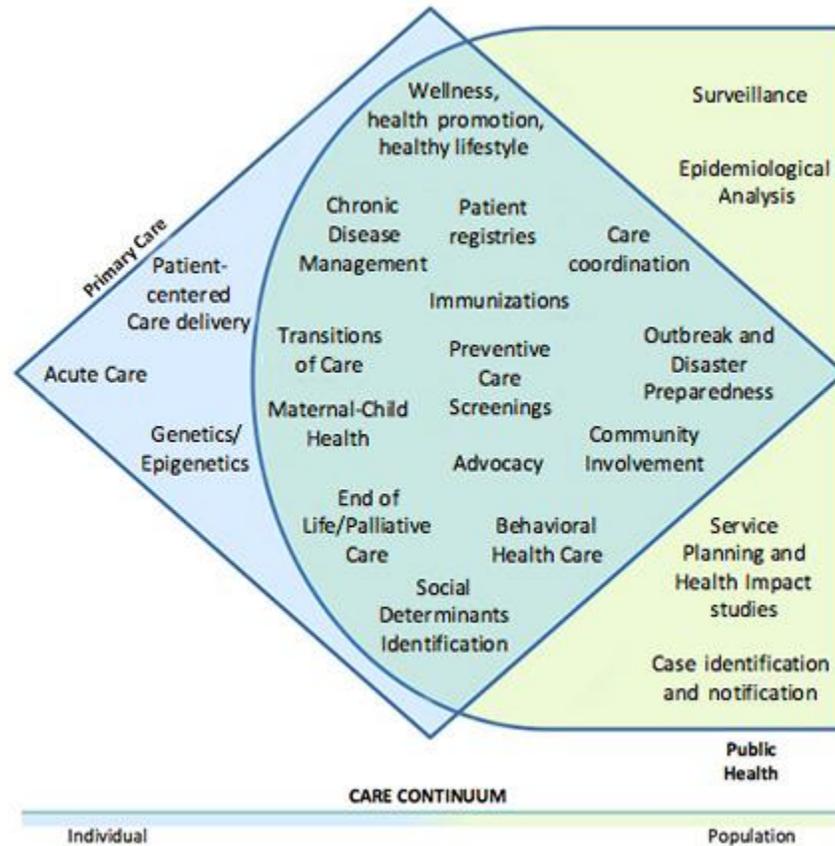


Fig. 2: Primary Care and Public Health Care Continuum
From the AAFP Integration of Primary Care and Public Health (Position Paper)
<https://www.aafp.org/about/policies/all/integration-primary-care.html>

Dr. Kisha Davis, Health Officer, Montgomery County

- The Warm Handoff
- Why Primary Care & Public Health Must Integrate
- Montgomery County Example

The Warm Handoff

Moving beyond referrals → real connections

A bi-directional partnership between clinics and LHDs

Designed to improve patient outcomes & equity





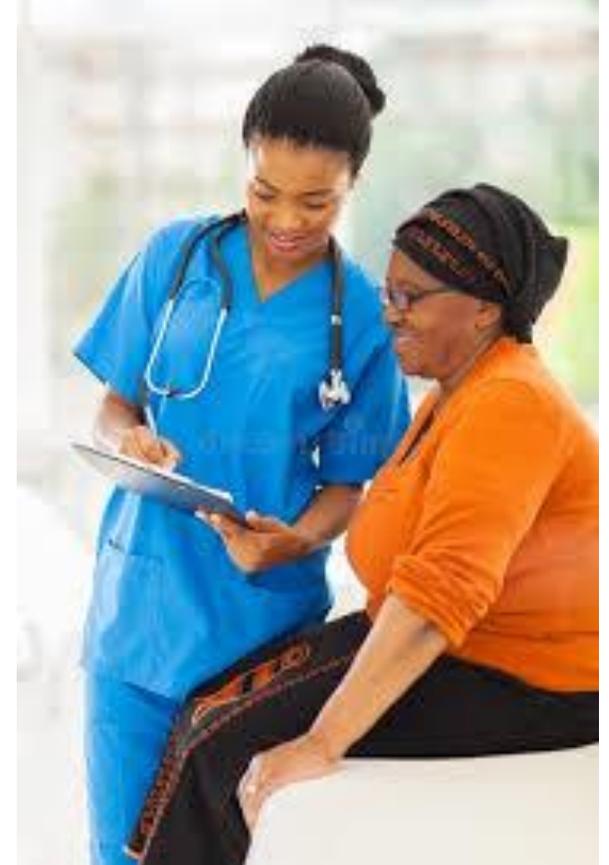
Why The Warm Handoff Matters

- ❖ Patients' needs don't stop at the exam room
- ❖ Social, economic & structural barriers affect outcomes
- ❖ Strong partnerships save time & improve care

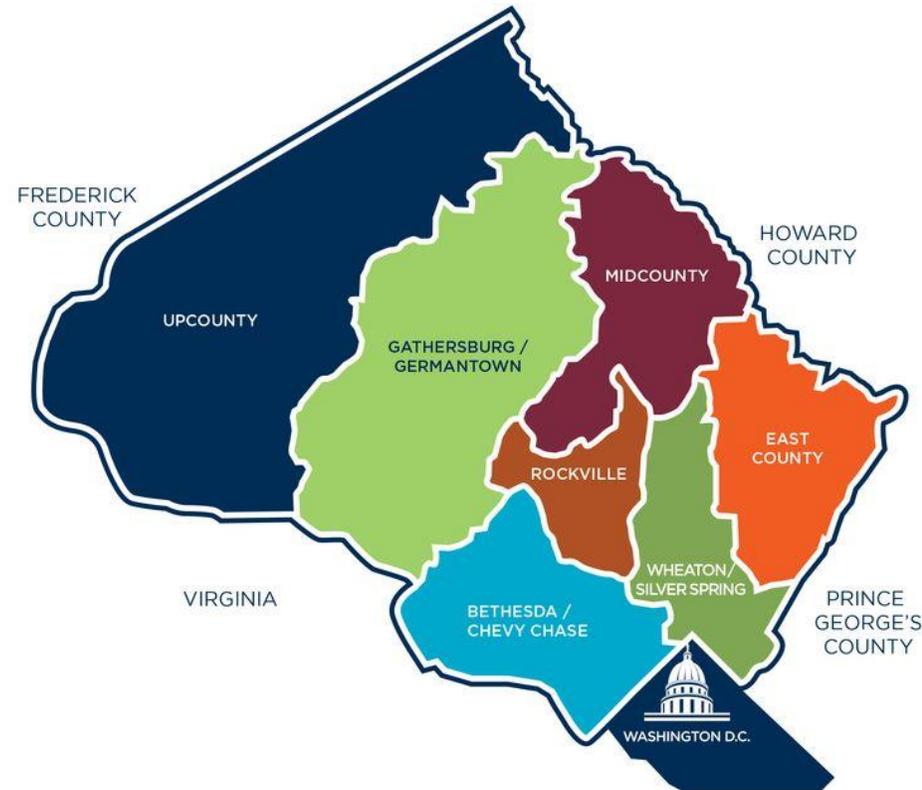
What a Warm Handoff Looks Like

- ❑ Direct connection, not just a resource list
- ❑ Follow-up + feedback loop
- ❑ Shared accountability by primary care & public health

*Health is shaped in exam rooms
and
in neighborhoods*



Warm Handoff In Action: Montgomery County Example





The DHHS Mobile Health Clinic Ribbon Cutting

- The Mobile Unit was delivered to the County end of April 2025.
- The Ribbon Cutting took place Thursday, May 29th hosted by WUMCO Help, Inc in Poolesville Maryland

Dr. Barbara Brookmyer, Health Officer, Frederick County

- SDoH in Primary Care: National Framing
- What FPs are Saying (AAFP data)
- How LHDs Support Screening, Referral, & CHWs

What Family Physicians Are Saying

- 83% want to address SDoH – 80% lack time
- 78% want to partner – 64% lack staffing
- 75% want to advocate – 56% lack solutions

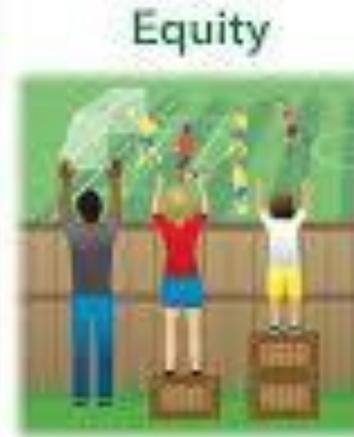
Source: AAFP's Health Equity: Leading the Change -<https://www.aafp.org/credit-reporting/cmecenter/details?activityId=107166> – Striving for Health Equity and Addressing SDoH

Health Equity Requires System Change

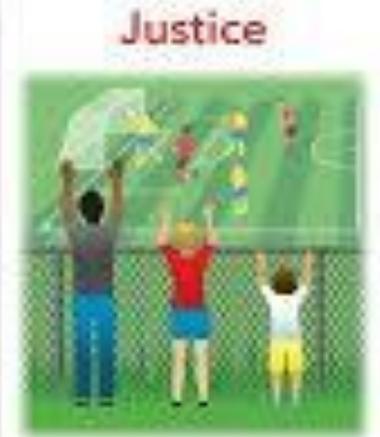
- Poverty, racism, access, and education drive inequities
- Not [just] individual behavior
- Structural problems need structural solutions



The assumption is that everyone benefits from the same supports. This is equal treatment.



Everyone gets the supports they need (this is the concept of "affirmative action"), thus producing equity.



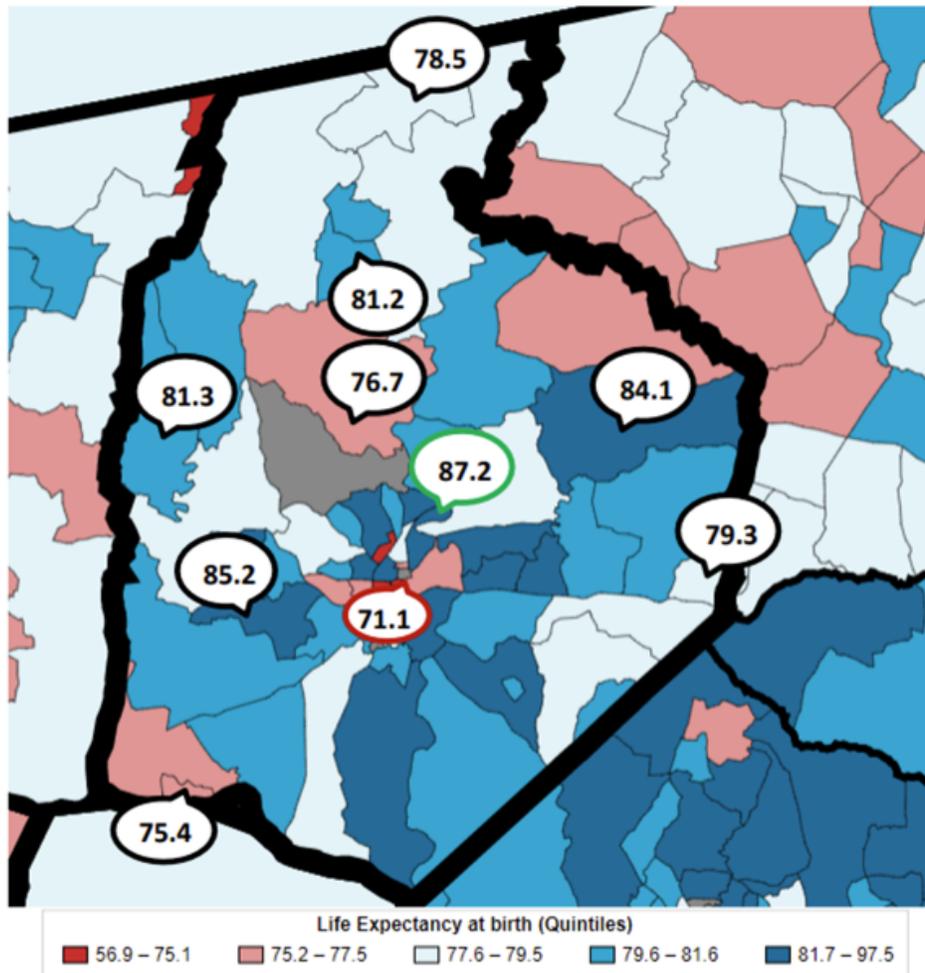
All 3 can see the game without supports or accommodations because the cause(s) of the inequity was addressed. The systemic barrier has been removed.

Our Options

It's not just the
choices we make,
but also, the
options we have.



Life Expectancy in Frederick County



- The highest life expectancy in Frederick County is **87.2** years in Walkersville.
- The lowest life expectancy in Frederick County is **71.1** years in the city of Frederick in the area of South Bentz and West South streets.
- Maryland state average life expectancy is **79.6** years.

Tejada-Vera B, Bastian B, Arias E, Escobedo LA., Salant B, Life Expectancy Estimates by U.S. Census Tract, 2010-2015. National Center for Health Statistics. 2020.

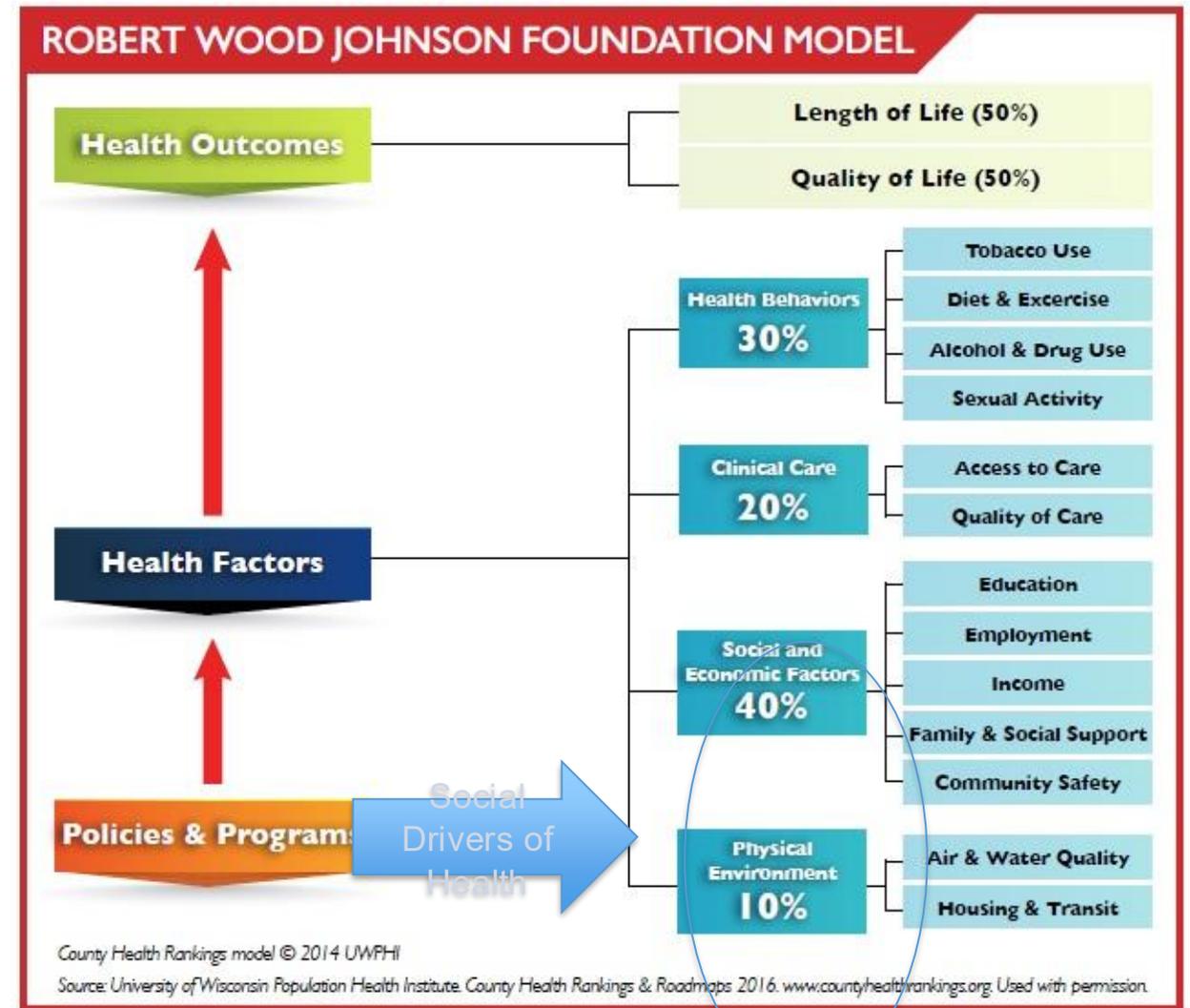
<https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html>

8

What Makes a County Healthy?

Health in All Policies (HiAP) approach!

- Counties shape SDOH: housing, transit, recreation, environment
- Embed health in decision-making across agencies
- Examples: safer streets, housing-health partnerships



Advancing Health Equity: Address SDoH

LHDs collaborate with partners to provide:

- Youth mentoring
- Health literacy
- Financial coaching
- Policies supporting economic stability
- Housing supports (education, assistance, financial relief)
- Legal support (e.g., expungement)
- Employment support services
- Jail diversion programs
- Built environment policies
- Violence prevention and interruption
- Education supports

Social Determinants of Health



Social Determinants of Health
Copyright-free

 Healthy People 2030

AAFP's The EveryONE Project & SDoH Screening

The EveryONE Project | AAFP

- Many practices are already screening
- Need support for referral + navigation
- LHDs help close the loop

The EveryONE Project

Neighborhood Navigator

The EveryONE Project offers you screening tools to identify patients' social needs and address health equity in your practice. The Neighborhood Navigator is the next step for you to improve social determinants of health among your patients.

Use this interactive tool at the point of care to connect patients with supportive resources in their neighborhoods. It lists more than 40,000 social services by zip code.

Find Services in Your Community



Food



Housing



Transportation



Employment aid



Legal aid



Financial

<https://www.aafp.org/family-physician/patient-care/the-everyone-project/neighborhood-navigator.html>

LHDs as Allies in Your Workflow

English

Cost help starts here.

FOOD HOUSING GOODS TRANSIT HEALTH MONEY CARE EDUCATION WORK LEGAL

↑

2,606 programs
in the Frederick, MD 21702 area

Choose from the categories above and browse local programs

The EveryONE Project™
Advancing health equity
in every community

This curated database of resources is provided by **Neighborhood Navigator**.

- CHWs/Navigators
- Universal screening & referral integration
- Resource coalitions & databases

frederick, md (21702) / food / meals (18)

Personal Filters

Map Satellite

Wegmans

Costco Wholesale

Google Keyboard shortcuts Map data ©2026 Google Terms

Sending Referrals to Resources Through



- ❖ [CRISP_SDOH_Provider_Flyer.pdf](#) – how-to flyer
- ❖ How-to video – [Send a Referral in CRISP – YouTube](#)



The screenshot shows the CRISP web portal interface. On the left is a navigation menu with options like 'Search Programs', 'MyDirectives for Clinicians', 'Snapshot Staging', 'InContext', and 'Reports Role Manager'. The main content area is titled 'Search Area' and contains a search form with fields for 'Search Resources' (containing 'food'), 'Address, City, or Zip' (containing '21029'), and 'Search Radius (In Miles)' (containing '15'). A 'Create Referral for Program' button is circled in red. Below the search form, it says 'Showing results for Search Terms: 'food' in radius '15' around address '21029' Found: 108 Results'. A table of results is displayed with columns for Source, Organization Name, Program Name, Contact, and Program Description.

Source	Organization Name	Program Name	Contact	Program Description
<input checked="" type="checkbox"/>	HIE Directory	Hungry Harvest	HarvestRx Online Grocery Store	333-333-3335
<input type="checkbox"/>	HIE Directory	St. Mary's County Health Department	Nurse Family Partnership (NFP)	301-475-6778

- ✓ You can easily send electronic referrals to community-based organizations via CRISP via In-Context or from the CRISP Web-based portal.
- ✓ Connected to Maryland 2-1-1 system

Why Evaluation & Feedback Matter – What's *AHEAD*

- Track screening → referral → resolution
- Inform practice improvement
- Strengthen community partnerships

Measures by AHEAD Primary Care Program

Target Population	Measure Domain	Measure Title	Data Source	PC AHEAD	MDPCP	Medicaid
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Claims	X	X	X
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Claims	X	X	X
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Claims			X
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Claims			X
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan (CDF-CF and AD): Ages 12 to 64	eQMs through CRISP	X	X	X
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CDC-HbA1c Poor Control)	eQMs through CRISP	X	X	X
Adults	Chronic Conditions	Controlling High Blood Pressure (CBP)	eQMs through CRISP		X	X
Adults	Prevention & Wellness	Colorectal Cancer Screening	eQMs through CRISP	X		X

9

Warm Handoff in Action: Frederick County Example

- Need identified in clinic
- LHD navigates to community support
- Feedback loop to provider

☐ **Infants & Toddlers Program**

by Frederick County Health Department

✔ Reviewed on: 11/20/2025

Frederick County Health Department provides early intervention services that support young children with developmental needs and their families. All children receive individualized service...

📌 **Main Services:** daily life skills , parenting education , understand disability , early childhood intervention , in-home support , one-on-one support

👤 **Serving:** children, all disabilities, developmental disability, families, with children

Next Steps:

Call 301-600-1612 or get a referral from <https://health.frederickcountymd.gov/269/infants-toddlers-program> to apply.

📍 4.53 miles (serves your local area)

350 Montevue Lane, Frederick, MD 21702

🕒 Open Now : 8:00 AM - 5:00 PM EST ▼

MORE INFO ▼

★
SAVE

➦
SHARE

☰
NOTES

✎
SUGGEST

➔ SEE NEXT STEPS

Take the Next Step to Connect ✕

😊 **Best way to connect!**

Call [301-600-1612](tel:3016001612) to get services.

OR: Get a referral from <https://health.frederickcountymd.gov/269/Infants-Toddlers-Program> to apply.

Helping someone else?

LOG A REFERRAL

AAFP's Neighborhood Navigator and Maryland's CRISP Referral Tools

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The screenshot shows the CRISP (Connecting Providers with Technology to Improve Patient Care) interface. The top navigation bar includes the CRISP logo, user information (NAUREEN ELAHI), and a LOGOUT button. A search bar for 'Search Applications & Reports' is visible. The main content area is titled 'Referral Program Selection' and contains a 'Back to Program Selection' button. Below this is a 'Referral Confirmation Page' with a thank-you message and referral details: 'Thank you for using the SharedServices-Referral service! Below is the referral information you submitted. You can keep a copy for your records. *HarvestRx Online Grocery Store* Confirmation Number: 3d851393-d0e8-415a-997d-420d292cfd79 Date: 2024-05-31 09:39 AM'. A 'Patient Information' section displays fields for First Name (GILBERT), Middle Name, Last Name (GRAPE), Date of Birth (01/01/1984), HomeAddress1 (4145 EARL C ADKINS DR), and HomeAddress2. A sidebar on the left lists various reports and applications like 'Search Programs', 'MyDirectives for Clinicians', 'Snapshot Staging', 'InContext', 'Reports Role Manager', 'PopHealth', and 'DC VAC'.

Silos



to



Systems

LHD partnerships:

- ✓ extend your reach
- ✓ help you better meet your patients' whole person needs
- ✓ save time & improve care
- ✓ align shared/common objectives & measures
- ✓ make community health improvement a team sport

Dr. Meena Brewster, Health Officer, St. Mary's County

- Identifying Community Resources
- How to Find & Work With Your LHD(s)
- Practical Collaboration Workflows

Who is Your LHD? How to Reach Them

Who is Your LHD?

- Every county in MD has one
- Different structure, same mission
- Your gateway to community resources

How to Reach Your LHD

- MDH LHD Directory
- County Government Websites
- MACHO and MDAFP websites

See the MDAFP November 25, 2025 newsletter article titled, [Local PH in MD: Programs for your Patients](#) by MACHO

Community Resources & Referrals

Food, housing, transportation, legal, employment

Faith-based, grassroots organizations

Navigation and follow up

Feedback to clinicians

LHDs curate trusted partners

What are key medical/non-medical priorities in your practices?

How to Start Working With Your LHD

In the Office

Identify a shared priority

Start small, build trust

Create simple workflows

Beyond Clinic

Advisory boards, coalitions

Policy, advocacy

Practice champions

CALL TO ACTION

Learn your LHD contacts

Identify one opportunity to collaborate

Be a champion in your practice



Primary Care & Public Health - Together

We care about the same people

We see the world in much the same way

We care about the people who tend to fall
through the cracks

Primary Care

+

Public Health

= Stronger

Communities

Turning Connection Into Action: Discussion



Resources

MACHO

<https://mdhealthofficers.org/about-2/#target-members>

About LHDs, public health, current LHOs, links to LHD websites

MDAFP

<https://www.mdafp.org/membership/resources-and-toolkits/health-department-resources-dashboard>

MDAFP's LHD Resources Dashboard (MDAFP-MACHO project)