

## Allegany County Health Planning Coalition Local Health Action Plan FY 22-25

Last Updated 1.9.24

### Allegany County Health Planning Coalition

#### Local Health Action Plan: July 2022-June 2025

Based on the results of a community health needs assessment, the Allegany County Health Planning Coalition (Coalition) created the following Local Health Action Plan (LHAP) to improve health and wellbeing in Allegany County. The Coalition is charged with implementing the LHAP, measuring progress, and building on best practices already in use in the community. The LHAP addresses four priority areas:

- Transportation
- Social Determinants of Health (SDOH)
- Chronic Disease Management (CDM)
- Behavioral Health

Each priority area includes goals, SMART objectives, responsible parties, outcomes, and the current status. The LHAP is a three-year plan and progress is reviewed in twelve-month phases: Phase 1 is July 2022 – June 2023, Phase 2 is July 2023 – June 2024, Phase 3 is July 2024 – June 2025.

This LHAP is a combined effort from the *UPMC Western Maryland Community Health Needs Assessment and Community Health Strategic Plan 2022-2025* and the existing *Allegany county LHAP*. The LHIC voted in January 2023 to adopt this assessment and the plan years, so that moving forward all coalition partners will be on the same cycle.

The new LHAP was approved on July 11, 2023. The LHAP also includes supporting strategies which are underway in the community and may contribute to the achievement of LHAP goals and outcomes but are not overseen by the Coalition. The LHAP works to build upon and not duplicate existing community health improvement efforts.

### Acronyms and Abbreviations

ACHD = Allegany County Health Department  
AHEC = Area Health Education Center  
AHR = Allegany Health Right  
Assoc. Ch. = Associated Charities  
ACPS = Allegany County Public Schools  
CHW = Community Health Worker  
CMA = Cumberland Interfaith Ministerial Association  
CUW = County United Way  
DSS = Department of Social Services  
ED = Emergency Department  
FCRC = Family Crisis Resource Center  
FTE = Full-time Equivalent  
FVC = Family Violence Council  
HRDC = Human Resources Development Commission  
LHAP = Local Health Action Plan  
LHIC = Local Health Improvement Coalition  
LMB = Local Management Board  
MH = Mental Health  
MHA = Mountain Health Alliance  
MHCE = Make Healthy Choices Easy  
MPC= Maryland Physicians Care  
LBHA= Local Behavioral Health Authority  
OB= Obstetrics  
PCP = Primary Care Provider  
TSCHC = Tri-State Community Health Center  
TSWHC = Tri State Women's Health Center  
TOPS= Take Off Pounds Sensibly  
UM = University of Maryland  
UPMC WM = UPMC Western Maryland  
WMD = Western Maryland

**TRANSPORTATION**

GOAL	SMART OBJECTIVE	WHO	PHASE I July 22-June 23	PHASE II July 23- June 24	PHASE III July 24- June 25
Increase access to safe, affordable, and reliable transportation to health and human services appointments	Each year of this cycle, educate at least <u>100</u> transportation users or service providers about the transportation options for appointments and of any system changes.	<b>HRDC - Provided transportation for the following partners:</b> 1)UPMCWMM 2)ACHD 3)Center for Hope and Healing 4) Committed to Change 5)Progressive Physical Therapy 6) Devlin Manor 7) WVU Medicine	<b>HRDC</b> 4,525 clients served 12,810 transports provided		
		<b>Mountain Laurel,</b>	<i>Moving forward all partners will be on the same plan years and report data from Phase 2 on.</i>	<b>As of 7/1/23 number of Current transportation Partners:</b>	
<b>Transportation For All</b> 1) Toursim 2) Non-medical transports 3) Prescription deliveries 4) Human service transports		<b>Transportation Committee</b> 1) Allegany County Chamber of Commerce 2) Allegany County DSS	Committee meetings in progress, transportation study approved	Committee meetings in progress, transportation study approved	

**Supporting Resources**

**Transportation Committee-** Allegany County Chamber of Commerce, Allegany County Department of Social Services (Working on a transportation plan for the county with HRDC, MPC, and other stakeholders)

**Transportation Services-** HRDC Mobility Management Program- ACHD, MedTrans, Alltrans (Confirm with Wendolyn)



**CHRONIC DISEASE MANAGEMENT: OBESITY**

GOAL	SMART OBJECTIVE	WHO	PHASE I July 22-June 23	PHASE II July 23- June 24	PHASE III July 24- June 25
<p><b>UPMCWM Obesity</b>- Increase awareness of obesity prevention and management and encourage healthy behaviors.</p> <p>1) Provide education about achieving and maintaining healthy lifestyles, including methods to prevent chronic illnesses</p> <p>2) Engage in community outreach events to raise awareness about the links between obesity and chronic diseases</p> <p>3) Encourage physical activity by promoting fitness classes and events</p>	<p><b>UPMCWM</b></p> <p>Increase awareness of general community members in health coaching, outreach awareness/education, physical activity/fitness classes and targeted awareness programs in the community.</p>	<p><b>UPMCWM</b></p>	<p><b>UPMCWM 6-30-22 to 6-30-23</b></p> <p>Health Coaching- 184 Referrals</p> <p>Woman's/Girl's Expo YMCA- 88 ed/screening, healthy food demos/tasting- 60 participants</p> <p>Energize Your Life-7 classes</p> <p>Community Fitness Classes (Yoga)-152 classes/2,981 participants, (Strength/resistance)- 37 classes/272 participants</p> <p>Grocery Store Tours-9 tours, 21 participants</p> <p>Nutrition halftime question/Trivia- 26 events/613 encounters</p> <p>Diabetes cooking demo/tasting- 14 families/meal kit fix at home</p> <p>My Mini Market- 41 events/614 encounters</p> <p>Storytime in the Park- 10 events/552 encounters</p>		
		<p><b>ACHD</b> (tabulates the number of encounters reported by UPMCWM)</p>			

**Supporting Strategies**

- UPMC Western Maryland:**
- Health Coaching
  - Energize Your Life
  - Free Grocery Store Tours
  - Holiday Meal
  - Centre Street Collective Trivia
  - My Mini Markets
  - Story Time in the Park
  - Community Fitness Classes
  - Healthy Parks, Healthy People (Rocky Gap)

**Other Supporting Resources/Planned Collaborations**

Allegany County Health Department, Allegany County Public Schools, Rocky Gap State Park, Wellness Ambassadors, Allegany County Human Resources Development Commission (HRDC Senior Centers), Area Health Education Center West (AHEC West), Allegany County Public Library System, Western Maryland Food Bank, Western Maryland Food Council, Maryland Physician Care, Allegany College of Maryland, Frostburg State University, Tri-State Community Health Center, and local municipalities

**CHRONIC DISEASE MANAGEMENT: DIABETES**

GOAL	SMART OBJECTIVE	WHO	PHASE I July 22-June 23	PHASE II July 23- June 24	PHASE III July 24- June 25
<p><b>UPMCWDM Diabetes-</b> Increase awareness of diabetes prevention and management and encourage lifelong healthy behaviors.</p> <p>1) Provide diabetes education and training</p> <p>2) Leverage referring providers to increase awareness and promote participation in diabetes management programs</p> <p>3) Offer preventive screenings to identify and treat potential health problems before they develop or worsen</p> <p>4) Increase community engagement through outreach events and health fairs</p> <p>5) Offer medical nutrition therapy to support behavioral or lifestyle changes and provide individualized meal planning</p>	<p><b>UPMCWDM</b></p> <p>Educate/raise awareness of general community members about interventions, screenings, and programs available at UPMC Western Maryland, the prediabetes program and diabetes self-management program.</p>	<p><b>UPMCWDM</b></p>	<p><b>UPMCWDM 6-30-22 to 6-30-23</b> *Expand to see all in cell</p> <p>DPP-851 referrals/148 enrolled</p> <p>DSMT-416 referrals, 88 patients enrolled, 61 encounters/group DSMT, 211 encounters indiv./DSMT</p> <p>MNT-1,630 encounters</p> <p>Health Fairs/Community Education- 49 events, 3,638 encounters</p> <p>Community Fitness Classes (Yoga)-152 classes/2,981 participants, (Strength/Resistance)- 37 classes/272 participants</p> <p>Diabetes cooking demo/tasting- 14 families/meal kit fix at home</p> <p>Save-a-Lot Mkt Healthy snack demo- 3 markets/60 participants</p> <p>Woman's/Girl's Expo YMCA-88 ed/screening, healthy food demo/tasting- 60 participants</p> <p>Dr. Gammoh Chorus Call ed talk-38 attendees</p> <p>Allegany County BOE/UPMCWDM Real Well Newsletter- All 24 schools in county, QR code for programs embedded</p> <p>UPMCWDM Diabetes Awareness Day-153 encounters</p> <p>Senior Center Screenings-3 events/52 encounters</p> <p>Auxiliary/Rotary/Board Meetings/Education- 4 events/120 encounters</p> <p>Local Churches/Education/Weekly programs- 10 churches/2,302 encounters</p> <p>Local Pharmacies/Education/Pharm bags- 8 locations/1,350 encounters</p>		
	<p><b>ACHD</b></p> <p>Address health disparities as relating to DM II, by offering group support and access to DM management resources to at least 30 individuals a year.</p>	<p><b>ACHD- TOPS Program</b></p>	<p>New Program data will be entered during Phase II</p>		

**Supporting Strategies**

**UPMC Western Maryland:**  
 National Diabetes Prevention Program  
 Diabetes Self-Management Education and Training  
 Health Fairs  
 Fitness and cooking classes  
 Medical Nutrition Therapy (MNT)  
 Centre Street Collective Trivia

**Other Supporting Resources/Planned Collaborations**

UPMC Primary Care Practices, local primary care practices, Mountain Laurel Medical Center, Allegany County Human Resources Development Commission, Area Health Education Center West (AHEC West), Allegany County Health Department, and Tri-State Community Health Center

**CHRONIC DISEASE MANAGEMENT: HEART DISEASE AND STROKE**

GOAL	SMART OBJECTIVE	WHO	PHASE I July 22-June 23	PHASE II July 23- June 24	PHASE III July 24- June 25
<p><b>UPMCWM Heart Disease and Stroke-</b> Increase awareness of disease prevention and management and encourage healthy behavior.</p> <p>1) Provide chronic disease education and support in the community</p> <p>2) Continue to offer a cardiac rehabilitation program to help lower the risk of death, complications, and risk for readmission for patients who have had a cardiac event or procedure</p> <p>3) Provide interventions and screenings for community members</p> <p>4) Monitor symptoms of heart failure and connect patients with a source of support for managing chronic medical conditions, such as diabetes, anticoagulation medication, heart failure, and COPD</p>	<p><b>UPMCWM</b></p> <p>1) Increase awareness of general community members in heart healthy nutrition classes, support groups, cardiac rehabilitation</p> <p>2) Educate/raise awareness of general community members about interventions/screenings/programs available at the Center for Clinical Resources</p>	<p><b>UPMCWM</b></p>	<p><b>UPMC 6-30-22 to 6-30-23</b></p> <p>MNT-1,000 encounters</p> <p>CCR-5,621 encounters, over 2,000 encounters ed related-chronic disease mgmt</p> <p>Heart Healthy Nutrition Classes</p> <p>12 classes/41 participants</p> <p>Cardiac Rehabilitation - 41% participation rate</p> <p>Stroke Support Group</p> <p>First meeting 7-27-22/6 participants</p>		
		<p><b>ACHD</b> (tabulates the number of encounters reported by UPMC)</p>			

**Supporting Strategies**

**UPMC Western Maryland:**  
 Heart Healthy Nutrition Classes  
 Medical Nutrition Therapy (MNT)  
 Stroke Groups (i.e., Monthly Stroke Support Group)  
 Cardiac Rehabilitation Program  
 Free Screenings  
 Center for Clinical Resources (CCR)

**Other Supporting Resources/Planned Collaborations**

Allegany County Health Department, Allegany County Public Schools, Wellness Ambassadors, Allegany County Human Resources Development Commission (HRDC Senior Centers), Faith-based institutions, Area Health Education Center West (AHEC West), Heart Institute at UPMC Western Maryland, Stroke Center, and Tri-State Community Health Center

**BEHAVIORAL HEALTH: OPIOID ADDICTION AND SUBSTANCE ABUSE, ACCESS**

GOAL	SMART OBJECTIVE	WHO	PHASE I July 22-June 23	PHASE II July 23- June 24	PHASE III July 24- June 25
<p><b>UPMCWWM Opioid Addiction and Substance Abuse-</b> Increase awareness and access to substance misuse resources and interventions.</p> <ol style="list-style-type: none"> <li>1) Improve coordination and communication between service providers with embedded behavioral health specialists at primary care locations.</li> <li>2) Continue to offer a residential crisis service facility to provide support for adults with mental health illness and addictions.</li> <li>3) Increase awareness throughout the community to help reduce the stigma of addiction.</li> <li>4) Partner with local community organizations to provide education and training.</li> <li>5) Develop and support programming to address substance misuse and addiction recovery.</li> <li>6) Provide early intervention and treatment to people with substance use disorders and those at risk of developing these disorders.</li> </ol> <p><b>UPMCWWM Access-</b> Improve access to behavioral health services by increasing access points for individuals to be connected to the right level of care across the continuum.</p> <ol style="list-style-type: none"> <li>1) Embed behavioral health services into the primary care setting</li> <li>2) Offer telehealth services for behavioral health care</li> <li>3) Track and improve access to provider referrals.</li> <li>4) Provide education and training to community members on how to offer initial help to individuals with the signs and symptoms of mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care.</li> </ol>	<p><b>UPMCWWM</b> Educate/raise awareness of general adult community members about access to substance misuse resources and interventions and efforts to improve access and coordination of care for behavioral health services</p>	<p><b>UPMCWWM</b></p>	<p><b>UPMCWWM 6-30-22 to 6-30-23</b> Improve</p> <ul style="list-style-type: none"> <li>Coordination-878 opportunities</li> <li>Behavioral Health Referrals (embedded into primary care settings)-605</li> <li>Center for Hope and Healing Referrals-274</li> <li>UPMCWWM Outpatient BH Clinic- 46 referrals</li> <li>UPMCWWM Telehealth Visits-2,217</li> <li>Mental Health First Aid-59 participants</li> <li>SMART Recovery-454 participants</li> <li>Recovery Coaching-51 participants</li> <li>Collaboration with community organizations to plan suicide prevention &amp; awareness walk</li> <li>Primary Care offices screening over 90% patients (state threshold is 74%)</li> </ul>		
	<p>Annually educate/raise awareness with at risk youth by offering at least two educational resources/programs focused on substance use and/or vaping.</p>	<p><b>ACHD-Project Alert, ACPS</b></p>	<p><b>ACHD and ACPS</b> Newly added will begin reporting during Phase II</p>	<p><b>ACHD and ACPS</b> # educated/resources # of school programs</p>	
	<p>Increase awareness and educate 100 community members of available Naloxone resources each year.</p>	<p><b>ACHD, AHEC West</b></p>	<p><b>ACHD</b> Newly added will begin reporting during Phase II</p> <p><b>AHEC West</b></p> <ul style="list-style-type: none"> <li>1,971 Naloxone doses provided</li> <li>478 Fentanyl test strips provided</li> <li>133 referrals for Recovery/Treatment services provided</li> <li>362 Peers trained</li> <li>412 individuals receiving Peer Recovery Services</li> <li>177 individuals enrolled in Syringe Service Program</li> <li>776 professionals and community members educated on substance use, stigma and PurpleFest</li> <li>751 youth reached with programming in the schools/ECHO</li> </ul>	<p><b>ACHD</b> # of Naloxone doses provided from Vending Machines</p> <p><b>AHEC West</b></p> <ul style="list-style-type: none"> <li># of Naloxone doses provided</li> <li># of Fentanyl test strips provided</li> <li># of Xylazine test strips provided</li> <li># of referrals for Recovery/Treatment services provided</li> <li># of Peers trained</li> <li># of individuals receiving Peer Recovery Services</li> <li># individuals enrolled in Syringe Service Program</li> <li># of professionals and community members educated on substance use, stigma, and PurpleFest</li> <li># of youth reached with programming in the schools/ECHO</li> </ul>	

<p><b>Baltimore Crisis Response Inc</b></p> <p>1) Provide holistic and trauma-informed care and resources to individuals who may need supportive and/or crisis counseling</p> <p>2) Work closely with community partners to create a caring and collaborative ecosystem within the behavioral health arena</p> <p>3) Advocate for investments within the crisis services system and the broader mental health industry</p> <p><b>Goals:</b></p> <p>1) Promote timely access to appropriate care and services for those who require ongoing mental health or co-occurring mental health and substance use disorder services</p> <p>2) Work to divert individuals in crisis from the hospital, emergency department and criminal justice system</p> <p>3) Stabilize/maintain current placement or living arrangement</p> <p>4) Make time-limited crisis intervention services available to individuals to reduce escalation of crisis situations</p> <p>5) Relieve the immediate distress of individuals experiencing a crisis situation</p> <p>6) Reduce the risk of individuals in a crisis situation from doing harm to themselves or others</p>	<p>Provide:</p> <p>1) Mobile response for youth and adults</p> <p>2) Crisis stabilization for youth and adults to include follow-up services and resource linkage</p> <p>3) 24 hrs/day, 7 days/week service</p> <p>4) 2 teams within each county</p> <p>5) 8 weeks of follow-up services for youth and adults</p>	<p><b>Mobile Crisis Response &amp; Stabilization Services (MCRSS) Allegany &amp; Garrett counties</b></p>		<p>November 2023 - Hiring/Training underway</p>	
<p><b>Archway Station</b></p> <p><b>Assertive Community Treatment (ACT)</b> - Serving Allegany and Garrett Counties</p> <p><u>Clinical Treatment:</u> Medication management, psychotherapy, physical health (PCP &amp; dental), integrated treatment for substance abuse issues</p> <p><u>Rehabilitation:</u> Case management, crisis stabilization, transportation, coordination with legal and hospital systems</p> <p><u>Support:</u> Supported employment, self-advocacy and self-efficacy development, wellness and recovery management, supportive housing</p> <p><u>Engagement:</u> Engaging with natural supports, social skills building, wellness and recovery groups and opportunities</p>		<p><b>Archway Station</b></p>		<p>November 2023 - Hiring/Establishing referral network. Community outreach and education will follow, launch mid-2024</p>	
<b>Supporting Strategies</b>					

**UPMC Western Maryland Opioid Addiction and Substance Abuse:**

Behavioral health specialists embedded/primary care settings with office rotations

Center for Hope and Healing

Community-wide education and stigma reduction

Narcan delivery training, etc.

Self-Management and Recovery Training (SMART) Recovery Program

Screening, Brief Intervention, and Referral to Treatment (SBIRT) screenings

AHEC West Street Team

Possibility Shop

Baltimore Crisis Response Inc

**Other Supporting Resources/Planned Collaborations**

Allegany County Health Department, Archway Station, Potomac Behavioral Health, Allegany County Sheriff's Department, Maryland State Police, Cumberland City Police Department, Frostburg State University Police, Department of Social Services, Allegany County Human Resources Development Commission, Healing Allegany, local nursing homes, Frostburg State University, Allegany College of Maryland, Allegany County Drug and Alcohol Abuse Council and Overdose Prevention Task Force, Prescribe Change, Tri-State Community Health Center Maryland Physician Care, Allegany County Public Schools, Baltimore Crisis Response Inc.