

# Community Health Needs Assessment



Allegany County Health Department  
and  
UPMC Western Maryland  
(Formerly Western Maryland Health System - WMHS)

**To be Released June 2020**

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# Allegany County Community Health Needs Assessment

## Executive Summary

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act (known together as the Affordable Care Act) require non-profit hospitals to conduct a community health needs assessment and implementation strategy in conjunction with public health entities every three years. These requirements are codified as Internal Revenue Code (Section 501(r)(3)(A)). The creation, implementation and ongoing support of a health improvement plan are also required for local health department accreditation through the Public Health Accreditation Board (PHAB).

The Allegany County Health Department (ACHD) and UPMC Western Maryland (formerly Western Maryland Health System -WMHS) co-chair the Allegany County Health Planning Coalition and lead the community health needs assessment process through the Local Health Action Plan (LHAP) Workgroup. The mission of the Allegany County Health Planning Coalition is 'Healthy Lifestyles through collaborative partnerships, evidence-based practices and personal commitments'. Over the years, various community stakeholders have partnered to improve the health of our community. Through the assessment and planning process the Coalition creates a unified plan to collectively address the community needs that impact health.

Prior CHNAs were completed in 2011, 2014 and 2017. The assessment being completed in fiscal year 2020 will be the fourth cycle and build upon improvements made and lessons learned in prior cycles. The community health needs assessment is used to develop a Local Health Action Plan, also referred to as the implementation strategy. The process includes engaging partners in shared priorities, defining target populations, aligning policies and programs, utilizing evidence-based practices and ensuring accountability with identified metrics.

Each CHNA cycle has related to State and National efforts, including the State Health Improvement Process (SHIP) and Healthy People 2020. The County Health Ranking Model created by the University of Wisconsin and Robert Wood Johnson Foundation helps guide the local framework by showing the impact of behavior and socioeconomic factors on health status.

After reviewing the results from prior community health needs assessment cycles, updating secondary data sources, and gathering input through a community survey, a community forum was held. The forum was open to the public and community organizations. A broad spectrum of community partners participated in the event. During the forum data were presented, participants ranked the needs using an assessment tool created by Kanawha County, WV, and aggregate totals were compiled to draft a priority list. Participants discussed the findings, existing community resources, and gap areas. There was consensus on the following three priority areas:

1. Transportation
2. Social Determinants of Health
3. Prevention-Youth Risk Reduction

The supporting strategies already in existence to address these priorities were reviewed along with evidence-based practices. For each priority area the following were created: goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The Local Health Action Plan will be reviewed for approval by the UPMC Western Maryland Board of Directors and the Allegany County Health Planning Coalition before both the needs assessment and action plan are made available to the public before June 30, 2020.

## Defined Community Demographics: Allegany County

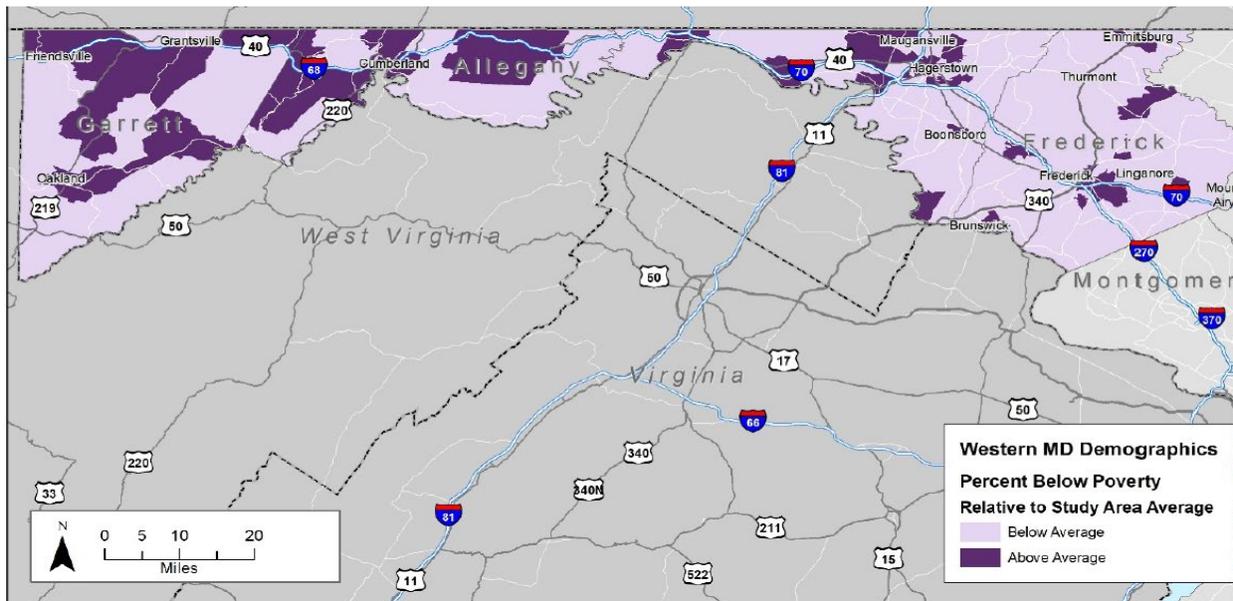
Allegany County, Maryland is the defined community for this CHNA. It is located in rural Western Maryland and has a population of 71,977 (ACS, 5yr. est. 2014-18). As part of the Appalachian region, the county has a larger elderly population, less racial diversity, and lower household incomes and education levels than the state of Maryland as a whole.

In Allegany County, 19.6% of the population is age 65 and older (compared to 14.6% in Maryland) and 17.5% of the county population is under age 18 (compared to 22.4% in Maryland). In Allegany County, 89% of the population is white, 9.6% is black, and 1.8% is Hispanic or Latino. Only 4% of residents speak a language other than English at home compared to 18.4% in Maryland (ACS, 5yr. est. 2014-18).

The median household income in Allegany County is \$42,564, well below the state median of \$80,711 and the national median of \$60,336 (SAIPE 2017). The unemployment rate in Allegany County is 4.4% compared to 3.8% in Maryland (ACS, 5yr. est. 2014-18), and the percent of single parent households continues to rise, to current level of 36% (CHR, 2020).

Socioeconomic factors contribute to poor health outcomes in Allegany County. According to the American Community Survey (ACS, 5yr. est. 2014-18), the percent of county residents living below the federal poverty level is 16.4% compared to 9.4% in Maryland and 14.1% in USA. The percent of children under age 18 living in poverty in Allegany County is 23%, which is decreased since the last cycle. Based on the United Way ALICE (Asset Limited, Income Constrained, Employed) Project, another 25% of Allegany County residents had incomes above the federal poverty level but not high enough to afford a basic household budget including housing, child care, food, transportation, and health care.

The map below shows the Relative Density of Below Poverty Populations (WMD Coordinated Public Transit and Human Services Transportation Plan, 2019).



Allegany County has a high school graduation rate of 90% but the county continues to have low numbers of adults age 25 and over with a bachelor's degree or higher (18.3% compared to 39.6% in Maryland). In addition, 11.3% of Allegany County residents age 16 and over are illiterate.

There were no significant demographic changes found in Allegany County since the last community health needs assessment. However, according to Maryland Vital Statistics 2018 report, the life expectancy for black residents in the county decreased from 80.4 to 75.5 and the mortality rate for non-Hispanic blacks increased from 302.5 to 465.2. These data points will require further investigation and discussion with the impacted population. Meetings have been set up with NAACP to start the discussion.

**Process and Methods to Conduct CHNA**

Prior CHNA and Progress to Date

There was no written input received on the prior CHNA or implementation strategy. However, through the process and methods utilized to conduct the CHNA and local plan, input was received from public health entities, medically underserved, low income and minority populations, and other representatives of the community.

The first step was to review the successes and remaining opportunities in the current cycle. Based on outcome data, the following areas showed some improvement:

- Heart Disease Death Rate
- Mental Health Provider Ratio
- Dental Provider Rati
- Mental Health Visits to the ED
- Homelessness at Point In Time
- Food Index
- Child Maltreatment Rate

Opportunities for improvement continued in the following areas and were used to direct further investigation.

- Drug Induced Deaths
- Substance Exposed Newborns
- Children Living in Poverty
- Transportation
- Hypertension- ED Visits
- Level 1 & 2 ED Visits
- PCP Ratio
- Sepsis (# Inpatient Discharges)
- Domestic Violence Crimes

In addition to looking at the current cycle, we compared the priority areas over the last three cycles. The table below lists the identified priorities from each cycle.

2011		2014	2017
Tobacco Cessation (especially during pregnancy)		Access and Socioeconomics (children in poverty, primary care access, adult dental access, health literacy, homelessness)	Substance Abuse
Obesity			Poverty
Access to Care and Providers			
Emotional and Mental Health (suicide rate / depression)			
Substance Abuse (alcohol and drugs)		Healthy Lifestyles and Wellbeing (smoking, physical inactivity, domestic violence, fall-related injury and death, healthy weight)	
Screening and Prevention (diabetes, hypertension, cancer)			
Heart Disease and Stroke			Heart Disease
Health Literacy			
Healthy Start (prenatal care)		Disease Management (behavioral health, diabetes, heart disease, hypertension, asthma)	
Dental			
Cancer			Access to Care and Health Literacy
Immunizations (flu)			
Chronic Respiratory Disease			

Throughout each three-year cycle, progress on the Local Health Action Plan was monitored and its impact on the identified outcome measures was evaluated. The next table shows the key measures and the changes seen over time.

### Comparison of Progress Made and Continued Challenges from 2011-2019

Measures/Source	2011	2014	2017	Latest	+ or -
Percentage of children (under age 18) living in poverty (CHR)	19%	26%	27%	23%	
ED visits for hypertension primary diagnosis per 100,000 population (SHIP)	225.1	231.6	279.1	453.3	-
Drug induced death rate per 100,000 population which illicit or prescription drugs are underlying cause (SHIP)	14.2	17.0	18.7	52.6	-
Age-adjusted mortality rate from heart disease (per 100,000 population (SHIP)	256.8	259.8	253.2	230.6	+
% elementary public-school students with BMI at 95 <sup>th</sup> percentile or above (ACPS-Elementary BMI)	20% (799)	17% (699)	20.5% (864)	21.2% (872)	-
% Adults report smoking (CHR)	26%	24%	17%**	16%	+
% of uninsured residents (CHR)	15%	12%	8%	6%	+
Rate of behavioral health related ED visits per 100,000 population (SHIP)	7517.9	6846.8	4723	NA	?
Average number of poor mental health days in last 30 days (CHR)	4.2	3.8	4.1	4.3	-
Average number of poor physical health days in last 30 days (CHR)	4.5	4.5	4.0	3.8	+
% of respondents missing medical appointments due to transportation (local survey)	25%	23%	16%	19%	
Number of level 1 and 2 visits to the ED (WMHS- Meditech)	15,501	8219	6476	7345	-
Population to Primary Care Provider Ratio (CHR)	1023	1698	1620	1900	-
Sepsis-number of inpatient discharges with primary diagnosis (WMHS)	1050 fy16	1123 fy17	692 fy18	863 fy19	
Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless (PIT)	492	356	304	200	+
Ratio of people per dentist (CHR)	1766 (2013)	1638	1580	1400	+

\*\*Data not comparable to prior years due to change in definition or method

### Secondary Data Sources

After reviewing progress and areas for improvement in both prior and the current Local Health Action Plan, a variety of secondary data sources were compiled and reviewed by the LHAP Workgroup. The Workgroup includes representatives from the hospital, health department, community action agency and area health education center. Each of these representatives was tasked with pulling sources available to them and sharing them for review.

The metrics and sources included:

Maryland's State Health Improvement Process (SHIP)  
Community Commons  
Allegany County Youth Risk Behavioral Survey (YRBS)  
American Community Survey  
Allegany County Public School BMI data  
Community Needs Index  
State Cancer Profile  
WMHS Dental ED Visits  
Drug and Alcohol Related Deaths- BHA, MDH  
Top 10 reasons WMHS ED visits and Admissions

County Health Ranking  
US News Civic Ranking  
Kids Count  
Healthy People 2020  
Opportunity Nation  
Feeding America  
Local Transportation Survey  
MD College Survey  
Homeless Data-HRDC  
WMHS Dimensional Insight

Needs trending in the wrong direction or off target compared to the state or nation were compiled for review by the Allegany County Health Planning Coalition. The County Health Ranking data from 2010-2019 were reviewed and compared over time when valid. Data points were eliminated from continued review if the sample size was too small, need appeared stable, or issue was represented by another metric. The data table specifying why each measure is a concern can be found in the Appendix.

The Coalition was asked for missing elements and/or corrections. Updated YRBS data was desired but unavailable until after the community forum. Information from the American College Health Assessment was obtained via Frostburg State University regarding vaping use by college students and shared at the forum.

Updated YRBS (2018) data for Allegany County became available after priorities were identified and the first draft plan was compiled. These data were reviewed by members of the LHAP Workgroup and then shared with the Coalition at the March meeting. The data supported selection of Prevention-Youth Risk Reduction priority and several of the YRBS metrics will be utilized as outcome measures in the local health action plan.

#### Community Input (Primary Data)

Two surveys were conducted in order to obtain input from a broader spectrum of the community, including low income, medically underserved, and minority populations. Coalition members were engaged in the survey design, distribution and review.

The transportation survey was a paper survey collected at the UPMC Western Maryland Emergency Department, Tri State Community Health Center- Cumberland Primary Care, and the Allegany County Health Department Clinics throughout July 2019. These locations were utilized this year and every other year we conducted this survey based on the target population they serve. A total of 599 responses were received this round and 19% of the respondents reported missed appointments because of problems finding transportation. This was a three percent increase since 2017. 14% of the respondents reported lack of transportation regularly impacted their ability to get to grocery store and 6% noted challenges getting to the food pantry.

Survey monkey was utilized to conduct the other survey, online and in a paper version for those without computer access. The survey link was shared on hospital and health department websites and posted by many other Coalition members. Paper copies were distributed to lower wage employees without easy access to computers, at community outreach events and to participants in Getting Ahead classes. The questions were developed based on utilization of survey results in the last CHNA cycle. One question was multiple choice with the option to check all that apply and to add others. The second question was ranking of defined categories, and the third major question was open ended.

The survey questions were as follows:

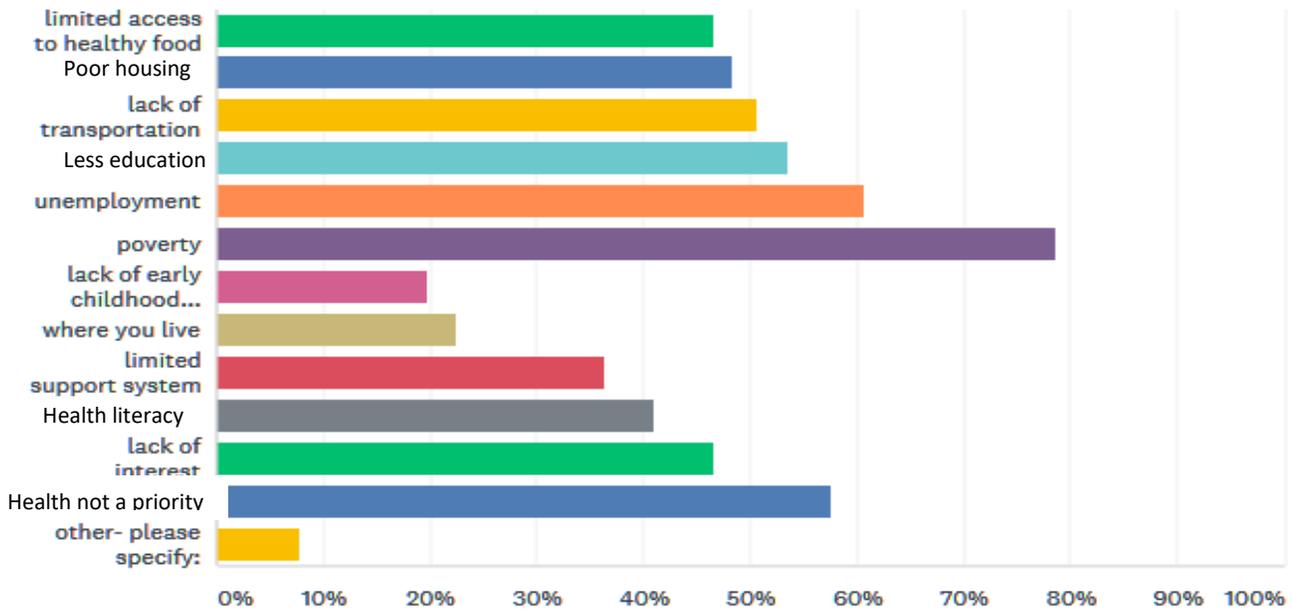
- What are the causes of poor health in our community?
- How would you rank the importance of these four categories for improving health?
  - Prevention -Activities to avoid development of disease or disability such as: medical and dental check-ups, youth programs, social involvement, coaching, vaccines, access to health insurance, tobacco cessation, and education on healthy eating, sleep, physical activity
  - Screening -Methods to identify diseases and risks in the earliest stages, before the onset of signs and symptom such as: mammogram, blood pressure, cholesterol, PSA, eye exams, risk assessments for substance use, physical and mental health issues, and social needs assessment
  - Treatment -Services provided to help with a disease or disability such as self-management workshops, social activities, medication management, counseling, dialysis, chemotherapy, drug and alcohol treatment, holistic therapy, and physical/occupational therapy
  - Recovery -Efforts to increase the ability to cope such as housing, job training, social engagement, support groups, childcare, NA and AA meetings, and community education
- What services/resources are needed in our community?

Survey responses were received from 745 individuals. Respondents were also asked to provide Residence, Age, and Level of Education. A summary of the responses follows.

### What are the causes of poor health in our community? Please check al...



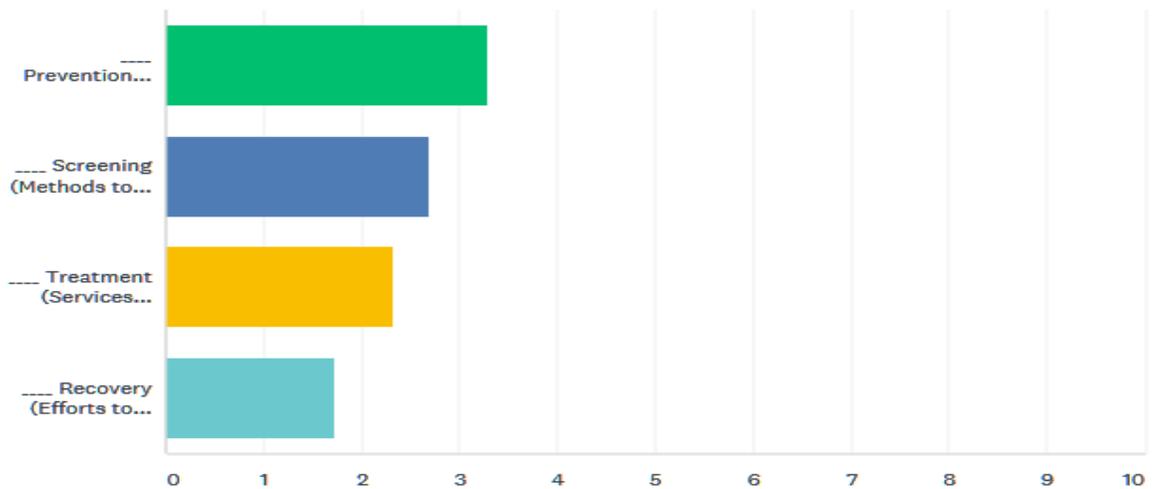
Answered: 745 Skipped: 0



Seventy-eight percent of respondents felt poverty causes poor health in our community, followed by unemployment at 60% and 58% selecting health not being seen as a priority.

### How would you rank the importance of these four categories for impr...

Answered: 745 Skipped: 0

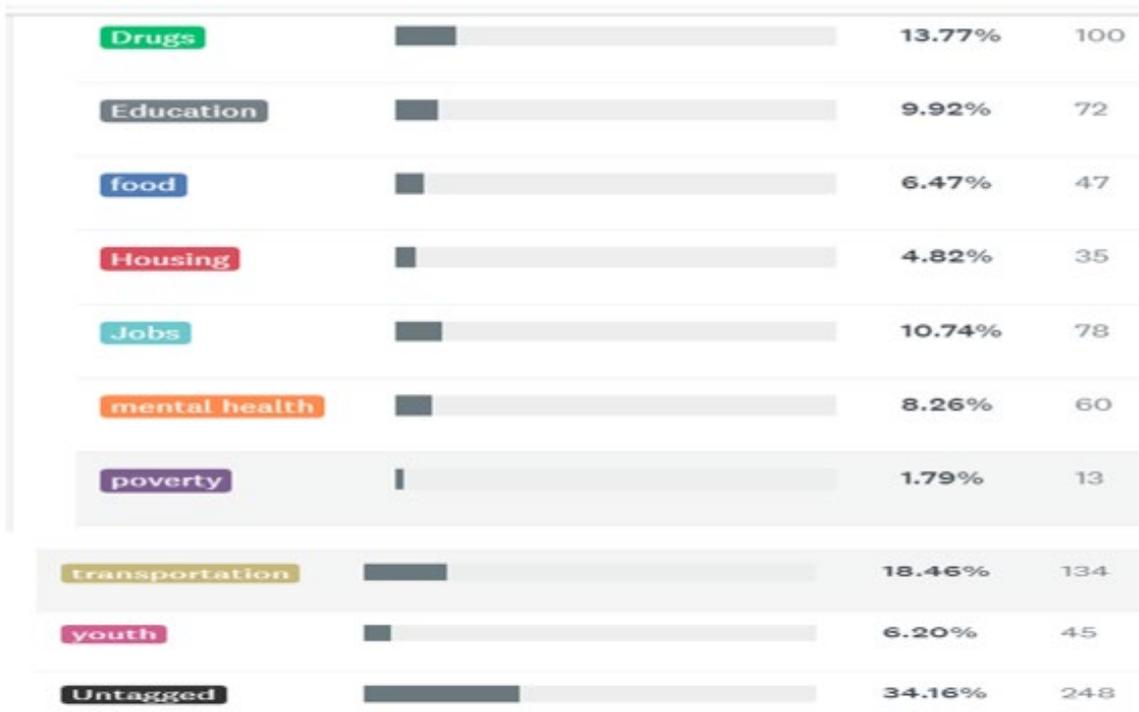


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Key words were tagged in the open-ended responses and the tally of such can be found below.

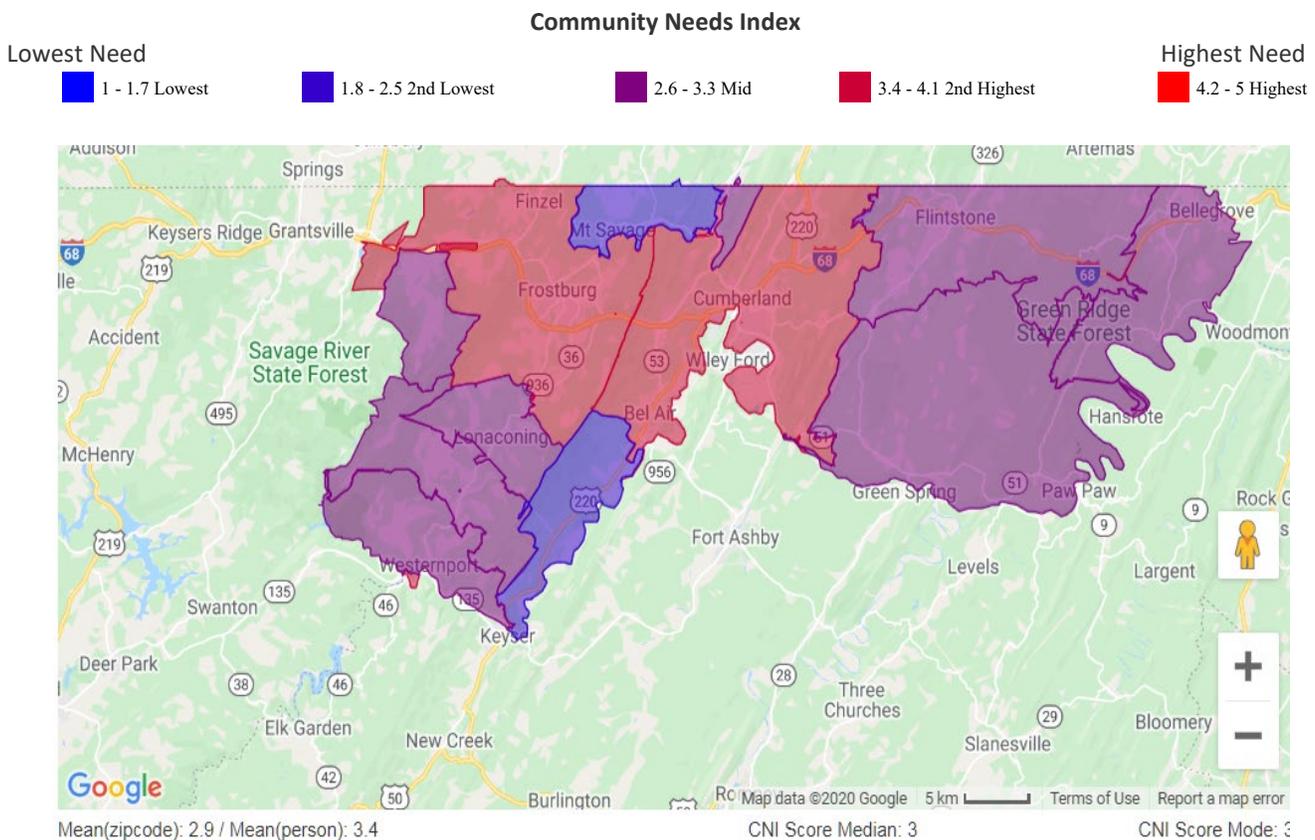
## Services & Resources Needed in Community



There were no new resource or service needs identified through the community survey. The responses reinforced needs already noted.

Thirty nine percent of the respondents reported Cumberland as their place of residence and 18% noted a Frostburg residence. The remaining 43% were distributed through various locations in the county. Age distribution of respondents was in a bell curve with 25% being the largest age bracket (age 45-54). The level of education reported by respondents did not reflect the education level of the community overall. An exceeding number of college graduates responded to the survey. After doing a separation of the respondents by education level, there did not seem to be significant differences in the overall outcome.

To identify the highest overall need based on geography we looked at the Community Needs Index. The map below shows the Community Needs Index for Allegany County with the highest overall need in shades of red. The CNI scores for various zip codes are listed below the map



Zip Code	CNI Score	Population	City	County	State
21502	3.6	42311	Cumberland	Allegany	Maryland
21521	3.2	1159	Barton	Allegany	Maryland
21529	3	517	Ellerslie	Allegany	Maryland
21530	3	1493	Flintstone	Allegany	Maryland
21532	3.4	15752	Frostburg	Allegany	Maryland
21539	3	2709	Lonaconing	Allegany	Maryland
21540	3.4	88	Luke	Allegany	Maryland
21545	2.2	2000	Mount Savage	Allegany	Maryland
21555	2.6	1777	Oldtown	Allegany	Maryland
21557	2.4	1791	Rawlings	Allegany	Maryland
21562	2.8	2779	Westernport	Allegany	Maryland
21766	2.6	656	Little Orleans	Allegany	Maryland

All community survey respondents that requested results were sent the summary and invited to participate in a community forum. If unable to attend the forum we invited respondents to submit written or verbal comments.

## Identification of Priorities

### Community Forum: Ranking Priorities – Criteria and Process

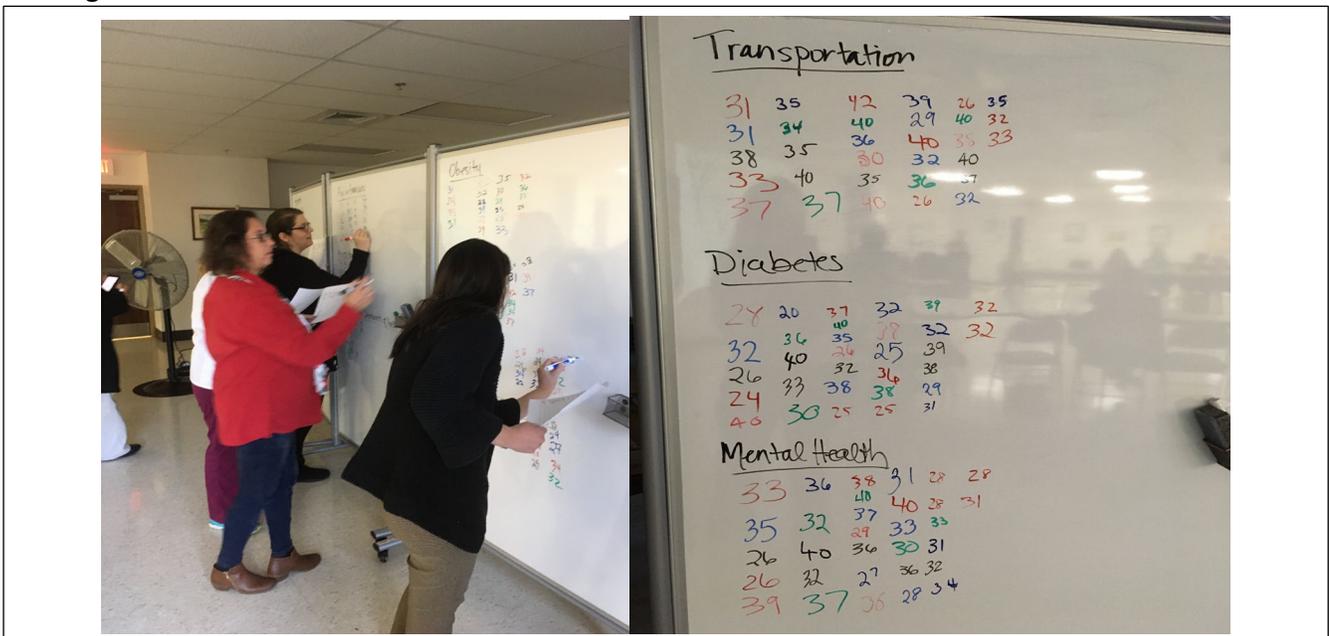
The data and survey results noted previously in this report were presented at a Community Forum on December 5, 2019. A total of 33 coalition partners, affiliates and members of the public participated. The presentation included a review of the following:

- Demographics
- Success and Opportunities for Improvement within Current Cycle
- Comparisons from 2011-2020
- County Health Ranking Trends
- Community Survey Results
- Next Steps

Based on discussions at prior Coalition and Workgroup meetings, there was a more focused assessment of need related to: transportation, diabetes, mental health, hypertension, access to care, poverty & social determinants of health, obesity, substance use, sepsis, and sexually transmitted infection. An assessment tool created by Kanawha County, WV was used to have participants score each of the need areas on a scale of 1-7 (with 7 being completely agree) regarding the following criteria:

- Problem is greater in Allegany County compared to State or region
- We can create an improvement in the quality of life by addressing this problem
- We can make progress on this problem in the short term (3 years)
- The progress we make over the 3 years can be sustained long term
- We can do something about this problem with existing leadership and resources
- We can reduce long term cost to the community by addressing this problem

After the participants rated the needs individually, their total scores for each need were collected. A total ranking score for each need was then calculated.



Participants discussed the needs in order of the total ranking scores. The priority areas were examined more closely regarding the criteria in the assessment tool, and existing community resources were noted. The table below provides a snapshot of the initial results and preferred actions.

Priorities	Total Ranking Score	Priority Order	Selected Yes or No	Notes
<b>Transportation</b>	1089	1	yes	All agreed transportation was the top priority.
<b>Diabetes</b>	1008	6	no	State Plan will involve action focused on diabetes and Coalition will be engaged in creation of local diabetes plan. Action for other priorities will also impact diabetes.
<b>Mental Health</b>	1022	5	*Prevention	There was a desire to focus on mental health resources for youth and prevention with services supporting resilience.
<b>Hypertension</b>	837	10	No	It was felt that BP screenings, care of comorbidities, and Living with Hypertension workshops would address this need.
<b>Access to Care</b>	1070	2	no	The group agreed that access to care will be addressed by other root causes (SDOH).
<b>Poverty and SDOH</b> (food insecurity, housing, etc.)	1061	3	yes	All agreed poverty is a significant need. Focus on addressing the SDOH was recommended. Aspects noted: childcare, education, jobs, poverty, food and/or housing
<b>Obesity</b> (includes physical inactivity)	990	7	*Prevention	Majority felt obesity will be impacted by action for other priorities. Agreed to merge it with other prevention efforts targeting youth (healthy living)
<b>Substance Use</b> (opioids, alcohol, and tobacco)	1027	4	*Prevention	With the numerous community initiatives already underway related to substance use, the group felt the Coalition could do more with prevention, especially vaping.
<b>Sepsis</b>	916	9	no	WMHS has a committee that focuses on sepsis and can share updates and education with partners as appropriate. No additional action recommended.
<b>Sexually Transmitted Infection</b>	932	8	no	ACHD STI Clinic noted as resource for the small numbers. Will explore Title X services for county but not as part of action plan.

The consensus at the close of the Forum was to develop a plan focused on the following priorities.

- Transportation
- Social Determinants of Health
- Prevention- Youth Risk Reduction

An offer was made to email a copy of the presentation slides to participants upon request. Copies of the data tables from which the presentation were compiled will be posted on the Coalition website as part of this report.

### Needs not Addressed and Why

Through the Community Health Needs Assessment process, there were some community needs identified which will not be included in the Local Health Action Plan. The Coalition felt that many of these community needs were already being addressed by or planned to be addressed by other partnerships in the community. Some of these efforts are noted as a supporting strategy in the Local Health Action Plan. The reasons needs are not addressed in the LHAP are explained below.

- Diabetes: With the recent release of a Diabetes Action Plan by the State and several grant opportunities, there are efforts underway and being planned to address this need. In addition to the Center for Clinical Resources with diabetes as a focus area, there are self-management programs for both individuals with diabetes and people with prediabetes. There are also two grants underway that bring partners together to impact diabetes (Bridging the Gap-Merck, and SunLife Financial). These grants have produced positive outcomes. During this CHNA cycle, the county will need to create a local diabetes action plan that supports the State plan. The Coalition will oversee the local diabetes action plan, but it will be kept separate from the LHAP.
- Hypertension: Though not an identified priority in the plan, hypertension will be addressed through blood pressure screenings that are offered by the health system and various other partners. High blood pressure is also addressed as a risk factor in many education programs and is the focus of a workshop called Living With Hypertension. This workshop will be offered at least annually in the area.
- Access to Care: It was decided by the Coalition that access to care will be addressed indirectly by other root causes, including transportation and other social determinants of health.
- Sepsis: Though Septicemia continues to be the top inpatient discharge by APRDRG, the number has decreased since its peak in FY17. It is important to maintain a focus on sepsis so that the numbers do not increase. UPMC Western Maryland has a sepsis committee that will focus on this area and will share education with partners as appropriate.
- Sexually Transmitted Infections: Though the number of chlamydia cases per 100,000 population have a negative trend, the percentage of change has been negative in the last two years. The rate of gonorrhea cases has had a 36.7% increase in the last two years, but the number of cases is low (41). Substance abuse was felt to be a major contributing factor for the increase in STI, and the services available through ACHD STI Clinic could address the need. It was noted that there is no longer Title X Family Planning in the county, and this should be explored.

Obesity and substance abuse will be addressed as part of the Prevention-Youth Risk Reduction priority area and include healthy living. The Social Determinants of Health priority will address the root cause of poverty. Though food, housing, childcare, education and employment were all mentioned at the Forum, the Coalition agreed to start with a focus on food and home/community safety, then proceed to the other areas as feasible in later years.

### Priorities into Plan

Results from the Community Forum were reviewed at the following Coalition meeting and additional clarification was obtained. A compilation of the discussions at the Coalition meeting were reviewed by the Workgroup. The Local Health Action Plan Workgroup was then tasked with drafting a plan based on these priorities and discussion of community capacity, feasibility, impact, existing resources, and root causes.

It was agreed that SHIP metrics would be incorporated as outcome measures where appropriate. For each priority area the focus was defined, and potential outcome measures identified. Connections to County United Way's Strategy Map were also discussed.

For transportation, it was felt that the Coalition could help with education of options and changes, as well as address the reverse transport options including delivery services, telemonitoring and more. Outcomes would link to the primary transportation survey and look at not only % of missed appointments but also % unable to get groceries.

For social determinants of health, it was agreed to focus on increasing access to healthy food sources. There was some concern about the food insecurity outcome and whether it addressed only the income side of access. Additional review revealed that the metric also includes ability to provide balanced meals. Though housing was an important issue, the group was uncertain about what role the Coalition can play. It was also known that a comprehensive housing survey is underway in the county and next steps might best be decided after hearing the results. The final decision was to focus on home and community safety including security and fire. Additional input will be requested from the Coalition.

For prevention youth risk reduction, the group proposed education regarding stigma and prevention. It was also suggested to offer mind body skills groups and opportunities to connect youth outside of school. Select YRBS data were recommended as outcome metrics for the plan.

To address the changes in mortality and life expectancy seen in the non-Hispanic Black population, discussions were scheduled with the local NAACP. An infographic of Non-Hispanic Black Health Disparities in Maryland was circulated and will be shared at the NAACP meeting along with the data from the CHNA.

In February, a draft plan was shared with the Population Health Council at UPMC Western Maryland and a few edits were recommended; mainly adding to the responsible parties. Through April, the draft plan will continue to be revised by the Coalition and Workgroup. Once the Coalition approves the plan it processed through UPMC Western Maryland Population Health Council and Strategic Planning to the WMHS Board of Directors for input and approval by June 2020. A final draft of the plan can be found in the Appendix and the approved plan will be posted to the Coalition website. Implementation will occur starting July 1, 2020 and extend through June 30, 2023.

## **Collaborative Plan of Action**

### Available Resources to Address Needs

Strong partnerships exist in Allegany County to address community health needs. Organizations are working together to implement a variety of strategies. UPMC Western Maryland (previously Western Maryland Health System) provides a continuum of care. Service includes acute care, a Center for Clinical Resources focused on the individuals with multiple chronic conditions, community health and wellness, clinical prevention, care coordination, home care, Community Health Workers, and provider recruitment. With a focus on value-based care it has a vested interest in population health and prevention. UPMC Western Maryland and several community partners participate in the Regional Transformation Grant with Trivergent Health Alliance. During the last three years this effort has increased the regional focus on complex care and behavioral health case management.

The Allegany County Health Department provides screening and prevention programs, care coordination, WIC, inpatient and outpatient behavioral health services, mental health care management, dental services, public health emergency preparedness, and food and water protection. The health department continues to host the

*Prescribe Change* campaign with a mission to create awareness and educate the citizens of Allegany County about the growing crisis of opioid prescription drugs, and heroin misuse and abuse in our community. In addition to this community outreach, ACHD offers provider education regarding the Prescription Drug Monitoring Program.

In addition to the lead agencies, there are a variety of organizations that collaborate to build resources and improve the overall health of Allegany County. The Maryland Area Health Education Center West (AHEC West) facilitates continuing education and training for health professionals, supports clinical education, facilitates interprofessional experiences, provides community health workers and is a partner of Maryland Health Connection. The Human Resources Development Commission (HRDC) a community action agency provides services for all ages and targets low income populations. HRDC oversees Head Start and the Senior Centers, as well as several assistance programs (transportation, energy assistance, food, etc.). Allegany College of Maryland and Frostburg State University train local health care providers in nursing, psychology, dental hygiene, respiratory therapy, and other areas and support continuing education for health care professionals. The Coalition engages two federally qualified health centers, a few healthcare providers, numerous non-profits, managed care organizations, and other entities providing direct care or addressing the social determinants of health.

The Allegany County Health Planning Coalition continues to build upon the various workgroups that come together to address specific needs in the community. Examples include: Tobacco Free Coalition, Opioid and Overdose Prevention Task Force, Transportation Committee and Bridges to Opportunity. Launched in 2014, *Bridges to Opportunity* is a community initiative to reduce poverty by helping individuals and the community 'get ahead' through relationships and resources. Through outreach and poverty simulations, Bridges to Opportunity has brought together people from various classes to discuss identified barriers and potential strategies to address the social determinants of health.

The Allegany County Health Planning Coalition has pursued and received several grants collectively. With funding from the Maryland Community Health Resources Commission, the Coalition launched Healthy Allegany which included Community Health Worker training and community outreach, a mobility manager and transportation vouchers, cultural competency trainings, as well as efforts to strengthen the Coalition. A comprehensive community resource guide was compiled in 2013 and annual updates were made until the online resource directory replaced it in 2019 (Path2Help.com). In addition to this public facing directory, several of the partners are connected to the expanded online platform- Aunt Bertha and can use it for closed loop referrals.

The Memorandum of Understanding (MOU) was updated this year as part of this CHNA cycle. We continue to insure representation from the following sectors of the community: media, housing, law enforcement, economic development, physical and behavioral health providers, and case management. Some members are more engaged than others. The Coalition continues to reach out to new community members to represent additional sectors and populations. As of January 2020, there are 52 agencies/organizations signed on to support the Coalition mission of healthy lifestyles through collaborative partnerships, evidence-based practices and personal commitments. The Coalition Membership can be found in the Appendix.

As we develop a plan to address the new priorities, we are also identifying available resources. When appropriate the Coalition will guide action with partners, and other times the Coalition will monitor existing resources as a supporting strategy in the plan.



The following are some of the strategic objectives for 2018-2020 in the UPMC Western Maryland Strategic Plan that have a connection to the Coalition's Local Health Action Plan.

- Improve health status and social determinants of health
- Expand pre-hospitalization and post-acute care services to reduce utilization
- Transform care delivery models

One example of this process is UPMC Western Maryland utilizing the findings from Aunt Bertha (on-line closed loop referral network), Voice of Customer, secondary data, and the community survey to identify food insecurity and transportation as significant needs in our community. Realizing that the health system cannot combat these needs alone, we applied a ecosystems approach to clarify the needs and processes, align stakeholders and build strategies to address social needs in a complex system. We are leading an initiative with community partners to map the existing food resources, streamline the intake process, identify gaps and opportunities for increased efficiency in the food system, and to establish a collective approach to address food insecurity. Through the local health action planning process additional strategies will be defined for addressing the priority needs.

Alignment of activities and investments to improve population health is essential. Through common measures the impact of collaborative efforts can be evaluated. With the UPMC Western Maryland Director of Community Wellness serving as co-chair of the Local Health Improvement Coalition, and coordinator of the hospital's community benefit reporting the process is coordinated. Progress on strategies in the Local Health Action Plan will be tracked and reported to the HSCRC and IRS as required, noting the specific role of UPMC Western Maryland.

#### Hospital Role

In addition to the role UPMC Western Maryland plays in coordination of the CHNA and implementation strategy with the Allegany County Health Planning Coalition, it takes on responsibility for numerous activities within the plan. UPMC Western Maryland currently plays a significant role in addressing social determinants of health and will continue to do so in the next CHNA cycle. It also has an interest in prevention and improving population health.

The following is a list of the roles and functions that UPMC Western Maryland will assume with the new plan.

#### Transportation:

- Facilitate the Transportation Committee advocating for improved coordination of services
- Partner in Mobility Management and fund additional transportation support for patients
- Provide transportation education
- Maintain relationships with numerous transportation providers to help patients with access
- Guide exploration of delivery services and reverse transportation options

#### Social Determinants of Health:

- Oversee the workgroups creating food systems maps and solutions
- Support establishment of more healthy food sources in the community
- Coordinate development of education and assessment process to improve home and community safety
- Assist with locating funds to support needed resources to address safety issues
- Continue to serve as the anchor institution for Bridges to Opportunity and strive to build resources
- Host Aunt Bertha and Path2Help and engage Community Health Workers and Care Coordination in addressing social needs of patients

#### Prevention- Youth Risk Reduction:

- Implement mind body skills groups and workshops collaboratively via ACM
- Share in the schools the expertise of respiratory staff regarding vaping
- Organize cross sector forums on risk behaviors and prevention strategies
- Identify and implement a program to increase healthy choices which will reduce obesity

UPMC Western Maryland will also communicate with NAACP and County United Way to insure integration of efforts.

#### Summary of Plan Development and Approval Process

As stated in the County Health Ranking process, “evidence of effectiveness is one of many factors to consider when choosing a strategy to solve a community health challenge. Community ‘fit,’ readiness, priorities, capacity, and resources are also important considerations.” Starting with the Community Forum and several of the Coalition and Workgroup meetings that followed, existing strategies and recommended practices to address the priority needs were explored.

The LHAP Workgroup compiled the various data points and information noted throughout this report and identified best practices both underway in the community and those which may contribute to achievement of the goals and address the priority needs. For each objective a lead partner is identified and assumes responsibility to implement and monitor activities with the key partners.

Progress reports are given at least every six months and the outcomes are reviewed annually. As issues arise or innovative solutions are identified, the LHAP Workgroup reviews the information and presents it to the Coalition for discussion and decision. At least one a year, the Allegany County Health Planning Coalition updates the data in the Community Health Needs Assessment, incorporates new or changing needs, and alters the Local Health Action Plan as appropriate.

A final draft of the Local Health Action Plan is included in the Appendix. By June 30, 2020, the approved Plan will be posted to the Allegany County Health Planning Coalition website at [www.alleganyhealthplanningcoalition.com](http://www.alleganyhealthplanningcoalition.com). For questions, please contact one of the Allegany County Health Planning Coalition Co-Chairs, Jenelle Mayer at 301-759-5001 or Nancy Forlifer at 240-964-8422.

# Appendix

Allegany County Health Planning Coalition  
Community Health Needs Assessment FY20  
**Measures for Review**

Measures	Allegany Co	Why is this measure a concern?	Source
Sexually Transmitted Infections Chlamydia cases / Population * 100,000	336.4	<ul style="list-style-type: none"> <li>Continuing Increase in County (236, 262,325.6, 336.4)</li> <li>See trend chart</li> <li>Chlamydia rate 24.7% increase between 2018 and 2019 (20 cases)</li> </ul>	County Health Ranking 2019
Substance exposed newborns	16.8% of deliveries	<ul style="list-style-type: none"> <li>About the same number of cases at WMHS</li> <li>161 substance exposed newborns of which 40 were dependent</li> </ul>	WMHS CY18
Physically Active Adults (self-report 150/75 minutes.wk)	46.1%	<ul style="list-style-type: none"> <li>(2011 -52.2%,41.2%-2014, 46.1%-2017)</li> <li>Below state and nation levels</li> <li>Adult obesity rate is getting worse</li> <li>CHR 27% of adults physically inactive compared to 21% MD</li> </ul>	SHIP
Child Maltreatment rate- Number of total indicated findings for physical and sexual abuse, mental injury-abuse, neglect, and mental injury-neglect among children, rate per 1000 >18yrs	19.6	<ul style="list-style-type: none"> <li>Baseline was 23.3, last year 21.1 and now 19.6</li> <li>Does anecdotal data reflect the same?</li> </ul>	SHIP
Domestic Violence- Number of domestic violence crimes per 100,000	653.5	<ul style="list-style-type: none"> <li>Increasing after dropping a couple years (719.5, 608.6, 610,653.5)</li> </ul>	SHIP
ED visits for diabetes primary diagnosis per 100,000 population	286.1	<ul style="list-style-type: none"> <li>Trending in wrong direction-2010 (185.2) 2017-286.1</li> <li>Above State at 243.7</li> </ul>	SHIP (2017)
ED visits for mental health related diagnosis per 100,000 population	3309.6	<ul style="list-style-type: none"> <li>Decrease from last year (2320.6, 4722.9, 3309.6) still above baseline</li> <li>Current measure does not include addiction related visits</li> </ul>	SHIP
Teen Birth rate -ages 15-19 years (per 1,000 population)	23.5	<ul style="list-style-type: none"> <li>Trending downward in County (31.8 – 2010)</li> <li>Above MD at 14.2</li> </ul>	SHIP (2017)
% students ever using e-vapor products	27.1% middle school 55.4% high school	<ul style="list-style-type: none"> <li>Above state in use of e-vapor products</li> <li>More than double the Healthy People target (21%) in high school</li> <li>Increased since last local survey-18.4% middle school 48.7% high school</li> </ul>	YBRS2018 SHIP
% FSU students have tried e-cigs at least once	23.1%	<ul style="list-style-type: none"> <li>MD Survey adds that 28% of alcohol or marijuana users indicate using e-cigs in last 30 days.</li> </ul>	2019 American College Health Asst.
% FSU students using e-cigs in last 30 days	14%	<ul style="list-style-type: none"> <li>51% of past year marijuana users indicate using e-cigs as method to consume THC</li> </ul>	2019 Md College Survey
Alcohol Impaired Driving Deaths - Percentage of driving deaths with alcohol involvement	48%	<ul style="list-style-type: none"> <li>Negative Trend in County (29,34,44. 39,56,48)</li> <li>MD 30% and top performers in US 13%</li> </ul>	County Health Ranking

Measures	Allegheny Co	Why is this measure a concern?	Source
Food insecurity -% population who lack access to adequate food	13.0%	<ul style="list-style-type: none"> <li>29.8% County population without access to large grocery store, (MD, US and Peer Groups- 22%)</li> <li>MD 11% food insecure, of this group 69% below SNAP threshold</li> <li>Percentage of population who are low-income and do not live close to a grocery store 13% in county and 3% for MD</li> <li>With 10 as best Food Environment Index, County score has improved from 6.4 to 7.3, still below state at 9.1</li> </ul>	County Health Ranking 2019 US News Civic Ranking
Sepsis-number of inpatient discharges with primary diagnosis	863	<ul style="list-style-type: none"> <li>Septicemia was top reason for inpatient discharges in FY19</li> <li>Had decreased to 692 last year, now going back up, still below baseline 1050</li> </ul>	WMHS FY19
Diabetes Prevalence-Percentage of adults aged 20 and above with diagnosed diabetes.	15%	<ul style="list-style-type: none"> <li>MD-11% and top US performers 9%</li> </ul>	County Health Ranking 2019
Adult Obesity (over age 20, BMI 30 and over	38%	<ul style="list-style-type: none"> <li>MD- 30% and top US performers 26%</li> </ul>	County Health Ranking 2019
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	15%	<ul style="list-style-type: none"> <li>MD at 17% and top US performers at 9%</li> <li>Majority due to cost, 14% of county population (3606 households) spends more than 50% of income on housing, MD 15% and top US at 7%</li> <li>69% homeownership in county, MD at 67%</li> </ul>	County Health Ranking 2019
Primary Care Doctor Availability/100K pop.	52.7%	<ul style="list-style-type: none"> <li>MD-87.7%, US-75.6%, Peer Group 58.3%</li> <li>Reflects the PCP ratio in County Health Rankings</li> </ul>	US News Civic Ranking
Deaths of Despair	46.7%	<ul style="list-style-type: none"> <li>MD-32%, US 36% and Peer Group 42.1%</li> <li>Poor Mental Health days increase in County (4.3) compared to 3.5 in MD, 3.8 in US and 4.2 in Peer Group</li> </ul>	US News Civic Ranking
Percentage of students entering Kindergarten ready to learn	39%	<ul style="list-style-type: none"> <li>45% MD</li> </ul>	SHIP 2017
Age adjusted Cancer mortality rate	164.8	<ul style="list-style-type: none"> <li>Above MD at 154.5 and MD is above the US rate</li> </ul>	SHIP (2015-17)

## Assessment and Ranking Tool

Scale: 1=Completely Disagree 2=Strongly Disagree 3=Disagree 4=Neither Agree nor Disagree 5=Agree 6=Strongly Agree 7=Completely Agree	Problem is greater in Allegany County compared to state or region	We can create an improvement in the quality of life by addressing this problem	We can make progress on this problem in the short term (3 years)	The progress we make over the 3 years can be sustained long term	We can do something about this problem with existing leadership and resources	We can reduce long-term cost to the community by addressing this problem	TOTAL
Transportation							
Diabetes							
Mental Health							
Hypertension							
Access to Care							
Poverty and SDOH (food insecurity, housing, etc.)							
Obesity (includes physical inactivity)							
Substance Use (opioids, alcohol, and tobacco)							
Sepsis							
Sexually Transmitted Infection							

Source: Kanawha County

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 three priority areas:

Transportation

Social Determinants of Health

Prevention- Youth Risk Reduction

Each priority area includes goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The LHAP is a three-year plan and progress is reviewed in six-month phases: Phase 1 is July-December 2020, Phase 2 is January-June 2021, Phase 3 is July-December 2021, Phase 4 is January-June 2022, Phase 5 is July-December 2022, Phase 6 is January-June 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

Bd of Ed = Board of Education

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

LMB = Local Management Board

MH = Mental Health

MHA = Mountain Health Alliance

MHCE = Make Healthy Choices Easy

MHSO = Mental Health System's Office

OB= Obstetrics

PCP = Primary Care Provider

TSCHC = Tri-State Community Health Center

TSWHC =Tri State Women's Health Center

UM = University of Maryland

WMd = Western Maryland

WMHS = Western Maryland Health System now UPMC Western Maryland

**Transportation**

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Increase access to safe, affordable and reliable transportation	<p>Each year of this cycle educate at least <u>100</u> transportation users or service providers about the transportation options and system changes.</p> <p>Each year of this cycle identify existing transportation alternatives (including delivery services and reverse transport options) and seek at least one new option to reduce the transportation barrier.</p>	<p><b>Transportation Committee</b>, UPMC WMd                      Mobility Mgmt.- HRDC                      Med Trans- NEMT ACHD or Statewide vendor, All Trans-County Transit Taxi (Crown, Yellow, QCity)                      County Medical Transport, Bay Runner                      Garrett Transit                      Mineral County - Logisticare, PVTA                      CUW, Communities for Life, Service Providers</p>	<p>Reduce % of respondents missing medical appointments due to transportation</p> <p>Reduce % of respondents not getting to grocery store</p>	<p>25</p> <p>14 grocery 6 foodbank</p>	<p>10</p> <p>12 total</p>	<p>19</p> <p>14 grocery 6 foodbank</p>

**Supporting Strategies**

Transportation Committee-

- One Call One Click-shared system (Trip Master- CTS Software) for scheduling and tracking rides
- Linking of dispatch services
- Streamline the rules across services Planned coordination of transports to outlying areas
- Coordination of rides during off hours cross agency
- Collaborate on grants for transportation
- Increased education for users and staff assisting people with transportation
- Establishment of Express Loops with certain days and routes- use geo- mapping of historic use rides

**Social Determinants of Health**

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Increase access to healthy foods and local food sources	Utilize information obtained through food system mapping to identify and establish 5 sites per cycle year where healthy food choices or local food sources will be increased.	Bridges to Opportunity-poverty SunLife Partners- Aramark, WMFC, food bank, ACM, AHEC, As. Ch, HRDC, <b>UPMC W MD.</b> , UM Ext., FSU, ACHD, Funders-CareFirst, Singer, etc.	% population who lack access to adequate food (CHR)	12	9	13
Improve home and community safety (fire, security, safety)	Each year of cycle provide education and assessment process focused on improving home and community safety for 100 or more people.  By June 2023, assess and assist 100 individuals with home or community safety need	Cumberland Housing Authority and Alliance, HRDC, ACHD, Law Enforcement and Fire Dept. Home Care and CHW, FSU, AHEC <b>Committee-</b> Brittany, Julie, Heather, Allison	Reduce # of poor mental health days (CHR)	4.7	3.8	4.7

**Supporting Strategies**

SunLife Partners- Food Insecurity- Systems mapping and identification of key strategies to overcome the gaps and increase efficiency  
 WMHS- Food Farmacy

County United Way -Safe, Affordable Housing: Everyone deserves home with basic amenities- space, heat/cooling, water/sewer, secure roof and safe entry  
 Bridges to Opportunity- Home sharing

## Prevention- Risk Reduction Youth

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Improve the mental and physical health of youth through prevention and risk reduction focused on substance use (vaping), mental health (resilience), and healthy living (obesity-nutrition and physical activity).	By June 2023, engage 500 or more youth in mind body skills groups and targeted prevention programs in the community  Each cycle year host at least 3 cross sector forums regarding identified risk behaviors of youth and potential prevention strategies for our community (such as-stigma-Distorted Perception, vaping-Don Swogger, family needs and trauma informed care- Family First).	ACHD and Frostburg Coalition- Vaping-Don Swogger ACPS, ACHD, LMB, DJS- Youth Mental Health <b>ACM- CMBM- healthy living</b> <b>UPMC W MD--</b> Wellness and Resp. Dept healthy living AHEC Families First Family Junction, 4H UMExt- MDROTA.org	% students ever using e-vapor products YRBS -2018	27.1 ms 55.4 hs	25.1 ms 53.4 hs	27.1 ms 55.4 hs
			% students ever seriously thought about killing self YRBS	22.3 ms 20.5 hs	21.3 ms 19 hs	22.3 ms 20.5 hs
			% students not physically active 60 min. 5 or more days/wk. YRBS	41.9 ms 72.9 hs	39 ms 49 hs	41.9 ms 72.9 hs
			% elementary public school students with BMI at 95 <sup>th</sup> percentile or above	20	13.6	21.2

**Supporting Strategies**

ACPS- Vaping addressed in all school levels

LMB-Trauma Educational series and FFT Multisystemic Therapy (DJS)

County United Way- Impact Grant- Strategy Map

- Prevent ACEs from contributing to life-long outcomes for current and future generations
- Provide trauma-informed care and accessible evidence-based treatments from trained and knowledgeable specialists
- Ensure a continuum of services exist to meet behavioral health needs

**Other Supporting Strategies**

Eliminate Health Disparities – NAACP, County United Way,

**Allegany County Health Planning Coalition Membership List**

Name of Organization/Group	Sector	Contact
Allegany County Health Department	Public Health	Jenelle Mayer (Health Officer) Jennifer Corder (Medical Director) Brenda Caldwell (Preparedness/Website) Lynn Kane (Accreditation) Tricia Evix (WIC/Nutrition) Paula McKenzie (Cancer) Lisa Beardsley (MedTrans) Margaret Wright Catherine Parish Leann Frank Trish Tichnell
Western Maryland Health System	Non-profit Hospital	Nancy Forlifer (Director Community Wellness) Jo Wilson (VP Population Health) Ben Kosewski
Tri-State Community Health Center	FQHC	Mandy Blackburn (Site Manager) Susan Walter (CEO) Sheila DeShong (COO) Ashley Barnes (Case Mgr.-Women's Health)
AHEC West	Non-profit Health Education	Susan Stewart (Exec. Director)
Allegany Human Resource Development Comm.	Community Action	Wendolyn McKenzie
County United Way	Community Development	Michele Walker Juli McCoy
Allegany Board of Education	Education	Kim Green (Administration) Tracey Leonard (Health & PE)
Allegany Radio	Media	Annette Wolford Patrick Sullivan
Cumberland Housing Alliance	Housing	Jaime Thomas Steve Kesner (CEO)
Allegany Chamber of Commerce	Economic Development	Stu Czapski (Executive Director)
Chapman & Associates	Medical Provider	Cathy Chapman (CRNP)
Mountain Laurel Medical Center	FQHC	Sandra Moore Jonathan Dayton

Name of Organization/Group	Sector	Contact
Pressley Ridge	BH Provider	Mary Beth DeMartino (Executive Director)
Allegany County Sheriff's Office	Law Enforcement	Craig Robertson (Sheriff)
Office of Consumer Advocate	Behavioral Health	Margaret Paul (Executive Director)
Salvation Army	Non-profit	Ronnette Smith (Administration) Karen Wells (Social Worker)
YMCA	Non-profit	Julie O'Neal (CEO)
Western MD Food Bank	Non-profit- Food	Amy Moyer (Executive Director)
Local Management Board	Non-profit	Renee Kniseley (Executive Director)
Cumberland Area Interfaith Ministerial Association	Faith Based	Rebecca Vardiman (President)
Aetna	MCO	Sarah Bush
NAACP	Non-profit	Carmen Jackson (President)
University of MD Extension	Higher Education	Lisa McCoy
Maryland Physicians Care	MCO	Shannon Jones Christie Staubs
Priority Partners	MCO	Lisa Moran
Allegany College of Maryland	Higher Education	Kathy Condor
Allegany Transit	County- Transportation	Elizabeth Robison-Harper
Friends Aware	Non-profit- Human Service	Robert Godfrey
Allegany County Dept. Social Services	County Social Service	Courtney Thomas (Director) Kim Truly
Associated Charities	Non-profit- Prescription & Emergency Svs	Deanna Clark (Executive Director)
----	Pharmacies	Bill McKay
Drug Abuse Alcohol Council	Coordinating Entity	Kathy Dudley
Tobacco Free Coalition	Prevention Coordinating Entity	Kathy Dudley
Family Junction	Non-profit	Melanie McDonald
Frostburg State University	Higher Education	Doug Brown (PA Medicine)
Board of Health	County Govt.	Jacob Shade

Name of Organization/Group	Sector	Contact
Park and Recreation Department	City Govt.	Diane Johnson
Mental Health Advisory Board	Coordinating Entity	Becki Clark
Family Crisis Resource Center	Non-profit	Sarah Kaiser
Tri County Council	Regional Coord. transportation	Ryan Davis
Dental Society	Dental Profession	Dorian Birkholz Diane Romaine
Opioid and Overdose Prevention Task Force	Coordinating Entity	Becky Meyers
Western Maryland Food Council	Coordinating Entity	Dan Fiscus
Mountain Health Alliance	Coordinating Entity	Catie Wampole
Western Maryland Health Connection	Insurance	David Stewart Carol Morgan
Homeless Resource Board	Coordinating Entity	David Nedved
Workforce Development	Workforce, Govt.	Matt Shipway
Jane's Place	Child Protection, Non-profit	Marlene Oleksak Alexis Jackson
Archway Station	Non-profit	Jim Raley
SurgCenter of Western Maryland, LLC	Provider	Raghu Reddy
Apples for Children	Childcare	Heather Glass
Horowitz Center for Health Literacy, University of MD	Health Literacy	Anna Shao, MPH, CHES
Community Trust Foundation	Funder	Leah Shaffer