Allegany County Health Planning Coalition
Local Health Action Plan FY 2017-20

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:

Substance Abuse Poverty Heart Disease Access to Care and Health Literacy

Each priority area includes goals, link to the State Health Improvement Process (SHIP) and/or PHIP, strategies, SMART objectives, responsible parties, timelines, current progress toward the SMART objective, and outcomes including baseline, target, and current status. The LHAP is a three-year plan and implementation is divided into six-month phases: Phase 1 is July-December 2017, Phase 2 is January-June 2018, Phase 3 is July-December 2018, Phase 4 is January-June 2019, Phase 5 is July-December 2019, Phase 6 is January-June 2020, and Ongoing indicates that implementation will occur over all six phases. 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.

Substance Abuse

GOAL	SHIP/PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec. 2018 Phase 3	Jan-June 30, 2019 Phase 4	FY19
Increase understanding of opioid use and related consequences	SHIP- Access to Health Care PHIP- Substance Use	Support multi-component community education about the impact of opioid use (such as impact on oral health and addictions)	Between July 1, 2017 and June 30, 2020, partners in the Coalition will reach 10,000 residents through community education regarding the impact of opioid use and available resources for prevention and treatment. FY18 - 7,621 Each year at least 70% of participating residents will show an increase in knowledge through a pre/post test. FY18-79%	**2996** residents reached through Prescribe Change education. **796** people were reached through STEP and its various components. **100%** (12 out of 12) in the 10 week STEP program felt more educated to make decisions about their overall health care. No pre/post test results from Prescribe change for this phase.	**722** women reached through STEP and its various components. Prescribe Change **1590** people reached through local events, naloxone trainings, health class presentations, trainings, and presentations **100%** (12 out of 12) in the 10 week STEP program felt more educated to make decisions about their overall health care.	**6104** **100%**- STEP Met objectives
Increase early identification of pregnant women using substances	SHIP- Healthy Beginnings PHIP- Substance use	Expand use of evidence based 4Ps program in OB practices in county	By June 30, 2018, train staff and implement the use of 4Ps program in 80% or more of area's OB practices. **MET** By June 30, 2020, identify 100 at risk women through the 4P screening and provide a brief intervention. **FY18 - 716**	**331** women were screened	**292** women were screened	**623** **67.7%** positive screens and **47%** brief intervention Met objectives

Note: Outcome Measure- Heroin related deaths – 2014 baseline and current is 2016, from BHA,DHMH report on Drug and Alcohol Related Deaths in Maryland. Target based on 25% reduction.

Poverty

GOAL	SHIP/PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec. 2018 Phase 3	Jan-June 30, 2019 Phase 4	FY19
Increase collaboration to address the social determinants of health	SHIP- Healthy Communities PHIP-Chronic Disease Mgmt. & Prevention	Engage providers and institutions in assessing for and addressing social determinants of health (such as housing and income)	Between July 1, 2017 and June 30, 2020, collaborate with at least 10 practices to assess and address social determinants of health with their patients. FY18 - 6 Each year document new strategies or resources used to address identified social determinants.	Practices engaged with assessment of SDOH have not changed during this phase. The number of referrals to CHWs based on these assessments continues to rise. Aunt Bertha was launched and SDOH assessment tool accepted for the Care Transformation Organization.	**5** partners with 215 users can assess with Aunt Bertha and 228 unduplicated consumers searched resources 1904 resources have been searched. 220 health related social needs assessments have been completed. 19 users have referred for a total of 32 referrals. 19% of the referrals were closed loop. **945** social needs met or addressed by CHW at WMHS	**11*** Revise measure?
		Implement food interventions to address chronic disease, poverty and outlying geographic areas	Between July 1, 2017 and June 30, 2020, assist 500 residents overcome barriers to accessing healthy food on a budget or in food deserts. FY18 - 378 Each year create a list of food interventions implemented and barriers that were overcome.	**92** households served by Brown Bag Program; **250** Groceries to Go; **18** households MD Emergency Food Program **39** patients Home Meal Program and **7** return patients for discount purchase of more meals; **25** participants in Food Farmacy; **55** people on average at Union Rescue Nutrition outreach Partners collaborated on grant proposal to MD CHRC for food insecurity& obesity project.	25 Food Farmacy participants for weekly pick-up of 592 total boxes & bags of food **22** patients provided Home Meal Program frozen meals at discharge **5** patients returned for a second week of frozen meals. (4 were 50% off and 1 free –obtained Pt. Assistance funds) Increased numbers of participants at the Union Rescue Mission- visit weekly for average of **65** people 463 (avg per month 92**)** duplicated households served by Brown Bag Program; **33** unduplicated households MD Emergency Food Program	**571** Met objectives

Heart Disease

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec. 2018 Phase 3	Jan-June 30, 2019 Phase 4	FY19
Increase early identification and treatment of hypertension	SHIP-Quality Preventive Care PHIP-Chronic Disease Mgmt. & Prevention	Identify hypertensive individuals through non-traditional settings such as dentist, pharmacies, and worksites, and utilize consistent message regarding follow up actions	By June 30, 2020, have at least 30 non-traditional settings incorporate blood pressure screening with standard follow up actions recommended. **FY18 - 26** By June 30, 2020, 300 individuals at risk for hypertension will be identified and given recommended follow up action. **FY18 - 196**	**2** sites provided blood pressure screenings with recommended follow up action, number served not reported	**4** non-traditional sites provided BP screening with recommended followup. **102** people were identified with potential hypertension.	**6** sites Met objective **102** Just below objective target
Reduce obesity levels of elementary age children	SHIP-Quality Preventive Care PHIP-Chronic Disease Mgmt. & Prevention	Identify and implement strategies to support and supplement the school wellness policy aimed at elementary school	Between July 1, 2017 and June 30, 2020, implement at least 12 strategies to increase engagement of elementary students in healthy eating and physical activity. **FY18 - 7** By June 30, 2020, engage 10,000 students in positive behavior changes related to healthy eating and physical activity. **FY18 - 5768**	**5** strategies through FSNE-Read for Health- 67 classrooms; Growing Healthy Habits 13 classrooms; Refresh- 22 classrooms; Smarter Lunchroom 4 schools with school wide tasting at 2 schools; Nutrition activity at Fair # students reached via FSNE not reported; **235** students engaged in physical activity in afterschool programs	**4** strategies added. Same number of classrooms for Read For Health, Growing Healthy Habits and Refresh. 4 Smarter Lunchroom schools (Beall, Georges Creek, John Humbird and South Penn) - 4 school-wide tastings at each site this year. 200 youth from summer programs attended Youth Days at the Fair Cresaptown and John Humbird Schools received grant to connect BIBA software to playground equipment linking screen time for children with movement. Awaiting data for pilot. Middle School After School did mindfulness and physical movement. 72 students attended each month, with a total of 578 encounters.	**9** strategies Met objective **1978** In total, FSNE reached 1906 individual students this school year X 6 lessons = 11,436 total contacts. Unmet objective

					Screen Time survey - 81 organizations and 234 individuals responded. Aware screen time impacts their lives but reported lower than average use.	

Access to Care and Health Literacy

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec. 2018 Phase 3	Jan-June 30, 2019 Phase 4	FY19
Increase Access to Care	SHIP-Access to Health Care PHIP- Mental Health	Promote availability of health resources and how to access care (including provider access, support teams, insurance coverage and education)	Each year of the three year cycle, identify and promote at least 5 ways to improve access to care in the appropriate setting. **FY18 - 5**	No new strategy to improve access to care in the appropriate setting was noted this phase	**2** efforts to improve access to care in appropriate setting- Hometown Healthy Partnership to engage residents in health and wellbeing where they are in the community and whatever stage of readiness. ACT pilot- care team to follow patients from admission to post discharge	2 Unmet objective
Enhance understanding of health information	SHIP-Access to Health Care PHIP- Mental Health	Improve health literacy for sepsis, oral health, child maltreatment/family violence and mental health	Between July 1, 2017 and June 30, 2020, provide education that is understandable on sepsis, oral health, child maltreatment/family violence and mental health. **FY18 - 364** Each year at least 70% of participants will show an increase in knowledge through a pre/post test.	**1** education programs on sepsis, oral health, child maltreatment/family violence and mental health were reported this phase Oral Health education provided to 65 individuals through AHEC and others at Mission of Mercy Mental Health First Aid- see support strategies	**5** education programs (see support strategies for list) Oral Health education provided to **1,277** individuals through AHEC West community health worker presentations and outreach. Mental Health First Aid- see support strategies **100%** report increase in knowledge.	**6** programs 1523+ people MHFA only pre/post and it had 100% increase Opportunity for improvement

Supporting Strategies Jan- June 2019

Substance Abuse

AHEC West - STEP

- Approximately 70% of 10 week STEP participants disclosed they "had experienced" or "were experiencing" chronic pain. Over the course of a 10-week session, the STEP program transitioned participants from self-reported "poor" health ratings to improved health ratings, including some who moved from low ratings to "excellent" status.
- STEP Jr. launched in the fall of 2018 as a pilot program and attracted over 50 students (unduplicated). Over 90% of the students noted in their pre-survey that they needed yoga and mindfulness to deal with either stress; anxiety; depression, and pain, emotional and/or physical. At the close of the first session in fall 2018, 97% reported STEP Jr. helped in at least one area. Stress – 40%; Anxiety – 27%; Emotional pain – 18%; Physical pain – 12%
- A combined 132 participants took part in six STEP Yoga programs held in schools.
- Presentation -STEP, Yoga, and Mindfulness to BACHS Healthcare clients. A combined 590 participants participated in 10 outreach presentations focused on mindfulness, stress reduction and self care. Through another nine outreach events, 586 people were reached.

WMHS- Provider Education (*list for goal)

- Jan 16- Hot Topics (Discuss CRISP, Discuss the state-wide Health Information Exchange, New Opioid Risk Assessment Tool)
- Feb 26*- Early Sepsis in Neonates
- Mar 13*- Cultural Competency
- Apr 23*- OCD
- May 22- Exploring local data from Chesapeake Regional Information System for our Patients (CRISP): Trends in local benzodiazepine prescribing and dispensing
- Jun 17*- Clear Communication about Health as a Community Value and Everyday Practice
- Jun 25- Autism
- Jun 27*- Aggression Management

Poverty

Bridges to Opportunity

- Continue to work with numerous community partners to address the social determinants and to build resources, including child care workforce, housing, and transportation access
- Getting Ahead classes have a new format to better reach those who are ready to get ahead. Part 1 is a four-week class covering the basic concepts and resources. Part 2 is an eight-week class similar to the current class which takes participants deeper into learning how to build resources and identifying community needs. Part 3 provides support for individualized action plans and Part 4 is the monthly gathering for all graduates and resource partners to continue building relationships and resources.
- 15 more individuals graduated Getting Ahead, 6 completed the 4 week phase one and 81 people participated in at least one session. Continued monthly Getting Ahead Graduate gathering to answers to questions and increase social capital 41 people have participated.
- Poverty Simulations aimed at providing a "real life" understanding of what those living in instability face on a day-to-day basis were held (FSU, AC) with 148 people attended.
- R Rules facilitated at all ACPS middle schools and Project Restart at Eckhart. 143 students started the curriculum through the After- School Program in Allegany County Schools and Burlington UM Family Services in West Virginia. 75 students finished the program for a completion rate of 52.4%. Students demonstrated knowledge of mental models, frozen, formal and informal language and practiced appropriately using the adult, parent and child voices. Students were even able to recall difficult concepts such as relevance, rigor and rebellion.
- In total, there were 785 encounters with Getting Ahead, 355 with R Rules and 298 with Bridges to Opportunity presentations.
- Updates from graduates include the following successes: overcame the Cliff Effect and no longer dependent on agency assistance; worked with our partners to complete the needed driving hours and obtain driver's license; started own business, bought a car and is completing childcare classes; and bought a house and will purchase his car in July.

Allegany County Board on Homeless

- 39 unduplicated households (88 individuals) received homeless services (HP, RRH, Laura's Anchor, CUW, RAP, VASH)

Heart Disease

ACHD Tobacco Control and Prevention Kathy

88 total cessation participants, 11 participants repeating the program, and 9 quit

ACHD began partnering with the WMHS Pulmonary Clinic in February; out of the total 88 participants they account for 57. They do not tally those who repeat/quit, etc., so their numbers are not reflected in that data.

Access to Care and Health Literacy

Mental Health First Aid

- 7 trained including Allegany College staff, Archway staff, and WMHS Peer Specialists. Peer Specialist are now required to have MHFA

Mountain Health Alliance:

- AHEC West began facilitating the Diabetes Prevention Program, and facilitated Chronic Disease Self-Management Program
- MHA began planning to implement Chronic Pain Self-Management Program, master trainer received certification to facilitate lay leader training and workshops during this period.

Western Maryland Health Insurance Connector

- QHP enrollments in Allegany County went from 1119 in 2018 to 1358 in 2019, a 21% change