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	Jan-Jun 2018 Phase 2	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	CURRENT STATUS
Increase understanding of opioid use and related consequences	SHIP-Access to Health Care PHIP-Substance Use	1. 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 500 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.	**4,522** reached through Prescribe Change education. **12** completed STEP. **79%** showed increased knowledge. **92%** of STEP participants increase awareness of alternative care options	Decrease drug induced death rate per 100,000 population (SHIP 2014-16 & C3I) Heroin related deaths (2017-BHA, MDH) Decrease infant mortality rate per 1,000 live births (SHIP,2016)	14.2 3 6.8	11.3 26 6.5	18.7 37.6 34 14 9.1 8.1
Increase early identification of pregnant women using substances	SHIP- Healthy Beginnings PHIP-Substance use	2. 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. By June 30, 2020, identify 100 at risk women through the 4P screening and provide a brief intervention. **FY18 - 716**	**Objective Met:** WMHS OB/GYN and Tri-State Women's Health utilize. Only one practice not using 4P's. **432** women were screened	Decrease % of deliveries that are substance exposed newborns (WMHS, 2017)	17%	10%	15.4% 15%

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	Jan-Jun 2018 Phase 2	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	CURRENT STATUS
Increase collaboration to address the social determinants of health	SHIP- Healthy Communities PHIP-Chronic Disease Mgmt. & Prevention	3. 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.	4 practices helped by CC/CHW (2 WMHS, Chapman, TSCHC) Adapted version of Arizona Self Sufficiency Matrix used by WMHS Care Coor., CHWs and BH Case Mgr. and AHEC West CHWs. Food Assessment done with WMHS Inpatients to determine discharge needs. Drivers license education support, Groups formed to create Child Care Pilot.	Decrease percent of children under age 18 living in households with incomes below the federal poverty level (CHR, 2018) Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless (PIT, FY18) Decrease the percent of adults who report missing appointments due to problems finding transportation (local survey) Improve Food Environment Index 1 to 10, 10 best (CHR, 2018)	26% 492 25% 6.4	20% 290 10% 8	23% 22% 291 304 16% Resurvey-Jy2019 6.4 7.1
		4. 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.	**250** Groceries to Go low income and elderly Allegany County residents with food boxes of nutritious USDA foods **34** households served by Md. Emergency Food Program, and **50** households through Brown Bag Program **12** Home Meal program, **10** Food Farmacy, **22** Veggie Van-URM (**Total- 378**) HRDC's Aging and Disabilities Department 2018 in partnership with MDOA and USDA - My Groceries to Go! Food Program. Space for food was challenge overcome with county facility support. HRDC's Department of Housing and Community Resources Maryland Emergency Food Program; and the Brown Bag Program. WMHS Home Meal Program for Discharge, Food Farmacy and Veggie Van- Barriers include manpower to pack boxes, transportation and communication regarding potential participants			

Heart Disease

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	Jan-Jun 2018 Phase 2	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	CURRENT STATUS
Increase early identification and treatment of hypertension	SHIP-Quality Preventive Care PHIP-Chronic Disease Mgmt. & Prevention	5. 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**	**5** dental practices and **6** pharmacies provide hypertension screenings and provide recommended follow up action. **4** businesses provided with blood pressure cuffs to allow their employees to monitor their own BP. **92** individuals that were screened for, had hypertension and were referred to primary care	Decrease age-adjusted death rate from heart disease per 100,000 population (SHIP, 2014-16) Decrease rate of ED visits for hypertension per 100,000 population (SHIP, 2014)	256.8 225.1	236.8 214.4	253.2 246.7 279.1 279.1
Reduce obesity levels of elementary age children	SHIP-Quality Preventive Care PHIP-Chronic Disease Mgmt. & Prevention	6. 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 5 strategies to increase engagement of elementary students in healthy eating and physical activity. **FY18 - 7** By June 30, 2020, engage 500 students in positive behavior changes related to healthy eating and physical activity. **FY18 - 5768**	**4** strategies implemented to increase engagement of elementary students in healthy eating and physical activity. (Family Fun & Literacy Nights, Stress Buster Fair at ACM, Arts In the Outdoors-Evergreen). Community Eligibility Provision was approved for 4 schools. 16 of 22 schools participated in Healthy School Challenge. **218** students were reached in targeted events and **5500** students were reached through Healthy School Challenge.	Decrease percent of elementary children who are in the 95th percentile or higher for body mass index (ACPS &ACHD, 2017-18)	20%	13.6%	19.3% 21.5%

Access to Care and Health Literacy

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	Jan-Jun 2018 Phase 2	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	CURRENT STATUS
Increase Access to Care	SHIP-Access to Health Care PHIP- Mental Health	7. 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**	**2** ways to improve access: Connector entity collaborating with WMHS at hot spot clinics, self sufficiency matrix asks about insurance coverage and PCP so referrals can be made when needed.	Decrease ratio of people per PCP (CHR-2018) Decrease ratio of people per MH (CHR-2018) Decrease ratio of people per dentist (CHR-2018) Decrease the number of level 1 and 2 visits to the ED (WMHS- Meditech FY18)	1698:1 903:1 1766:1 15,501	1200:1 450:1 1473.1 6000	1600:1 1650:1 500:1 410:1 1490.1 1500:1 8219 6476
Enhance understanding of health information	SHIP-Access to Health Care PHIP- Mental Health	8. 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.	3 programs on Sepsis- Screening & Guidelines (151 attended) WMHS 361 individuals were educated on oral health through outreach (AHEC) Created education materials for community members supporting link between diabetes, hypertension, heart disease and oral health care. No pre/post tests.	Decrease ED visits for mental health related diagnosis per 100,000 population (SHIP-2014) Sepsis-number of inpatient discharges with primary diagnosis (WMHS, FY16) Decrease number of domestic violence crimes per 100,000 population (SHIP,2016) Reduce Child Maltreatment rate (SHIP, 2016)	2320.6 ~~567~~ 1050fy16 719.5 23.3	3500 450 500 19	4722.9 4722.9 ~~567~~ 1123fy17 692fy18 608.6 610 23.3 21.1

Supporting Strategies FY18

Substance Abuse

AHEC West - STEP

- Promoted STEP program at 4 public housing sites to recruit participants. Shared information on what an opioid is; national statistics; who is affected/at-risk; pain management alternatives.
- Outreach included HRDC Senior Nutrition, Health and Wellness Fair, Stressbuster Fair at Allegany College of Maryland , Community Baby Shower, HOPE station, ECHO 101 & 201, and Frostburg Public Housing
- Developed brochure on the benefits of Yoga and opioid misuse prevention education
- Offered mindful breathing and yoga stretching at several elementary schools.
- STEP Yoga instructor completed *addictions yoga training*.
- Conducted 2 radio interviews; participated in a community panel at local community opioid training
- Partnered with Health Quality Innovators and the Blue Bag Initiative along with a Trivergent pharmacist to provide personalized medication reviews to STEP participants.
- Participated in National Wellness Institute "Empowered Health Consciousness & Prescription Drugs: The Wellness Alternative" train the trainer online course, with plans of implementation into the STEP program.
- Initiated a "Teddy Bear Drive" through STEP for opioid abuse awareness and collected over 1400 for local law enforcement and first responders to have on hand to give to children on the scene of an opioid or other adverse drug-related event.

Community Strengthening (NAACP initiated)

WMHS- Provider Education

- Distributed to all providers (section on pain mgmt)
- Distributed annual education booklet with section on pain management and resources to providers:
    - Pocket Guide: Tobacco, Alcohol, & Other Substance Use, SBIRT
    - Local Resource Guide for Non-Opioid Treatment of Chronic Pain
- Jan 10- Hot Topics- New pain Mgmt Standards from JC
- Jan 17- CME- Pelvic Pain and Mgmt- Dr. Gonzalez
- Jan 24- CME- Utilizing the CDC Guidelines and Checklist for Prescribing Opioids for Chronic Pain; local alternatives for pain mgmt- Dr. Corder
- Jan 24- mailed to providers (resources from 1-24 CME program):
    - Chronic Pain Mgmt Modalities
    - Chronic Pain Mgmt Reference List
    - Checklist for Prescribing Opioids for Chronic Pain
    - Article: Mgmt of Chronic Pain in the Aftermath of the Opioid Backlash
    - Primary Care of Patients with Chronic Pain
    - CDC Opioid Prescribing APP
    - Calculating Total Daily Dose of Opioids for Safer Dosage
    - Prescribing Change: Allegany County
- March 28- CME- Utilizing SBIRT (Screening, Brief Intervention, & Referral to Treatment) for Individuals Who Misuse Substances- Dr. Corder
- April 4- CME- The Opioid Epidemic: What's New and Mgmt Options- Dr. Treisman
- April 11- Hot Topics- reviewed the new pain management standards from the Joint Commission, the statutory requirements related to PDMP and upcoming deadlines, new pain committee plan, and the High risk assessment pain tool
- April 20- HIV, HPV, Hep C & Opioid Epidemic and Options in MD- various speakers from JHH
- April 24- Pediatric Addictions and Treatment Options
- May 23- Non-Pharmacologic Management for Chronic Pain

Poverty

Bridges to Opportunity

- Recognized 3 year initiative- determine to focus on institutional and community changes
- Continue to problem solve in housing, child care, transportation and education
- During these phases, Getting Ahead classes ended producing 22 more Getting Ahead graduates
- Initiated a monthly Getting Ahead gathering to discuss barriers identified by the graduates and to increase social capital through networking. 32 people have participated in first two months.
- Poverty Simulations aimed at providing a "real life" understanding of what those living in instability face on a day-to-day basis were held (WMHS, FSU, ACPS and DSS) with 315 people attended. The poverty simulation with middle and high school students was held with the ACPS Student Council. Students shared feedback including one teen speaking about how the simulation represented her life.
- R Rules program was piloted at Washington Middle School with 17 participants. Based on results, the program author, Betti Souther, was contracted to train 18 additional facilitators and grant funds were awarded from the Community Trust Foundation to expand the program next year.
- In response to challenges identified by Getting Ahead graduates regarding getting a driver's license, an FSU social work class researched the issue and shared promising models for consideration, and a scholarship was established at ACM for graduates wishing to take the driver's license course.
- With support from the Maryland Behavioral Health Administration, we did training for BH providers on the Bridges concepts and exploring institutional changes to help individuals increase stability and resources.
- Facilitated progression of Bridges initiative to the next phase focused more on problem solving, linking with existing institutions and engaging resource partners and workgroup members with the graduates.

Allegany County Board on Homeless:

- Coordinated Entry began in January resulting in a list of potential clients needing assistance with shelter/housing.
- Enhanced partnerships with the Union Rescue Mission for shelter and food needs; the ACHD to provide counseling services to clients receiving rental assistance; and Archway for housing services and case management.

Heart Disease

AHEC West

- CHWs are providing hypertension training to providers and non-clinical staff in the region.
- CDSMP workshops provided in the community to residents.

ACHD Tobacco Control and Prevention

- 47 individuals sought cessation services through MDQUIT line
- 105 individuals participated in the ACHD cessation program with 6 quitting smoking. 22 were participants repeating the program.
- 3,973 individuals were reached through outreach efforts
- 2 pregnant women participated in the ACHD cessation program
- Under the Tobacco Education and Enforcement Grant for FY17 there were 96 educational visits to tobacco vendors completed by the Allegany County Health staff. The Allegany County Sheriff's Department conducted 202 enforcement/ compliance checks in the county and there were 13 businesses that were cited for selling tobacco to minors.

Access to Care and Health Literacy

Mountain Health Alliance- Allegany Health Right and AHEC

- Outreach and education specific to oral and behavioral health, chronic disease, health insurance, and health literacy are being provided at health fairs, community venues (senior centers, job centers, etc.) and CHW training.

Mental Health First Aid

- Classes continue to be held in community. Added programs for staff of Archway, ACM students in Human Services and Criminal Justice.
- 7 Mental Health First Aid trainings were held with 88 participants, doubling the number from the prior year. One class was held for the health professions students graduating from the Career Center.