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. 31, 2019 Phase 5**	**January 1-June 30, 2020 Phase 6-** Participation levels were lower and many of the activities planned for this phase were cancelled due to the pandemic.
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, FY19-6104, **FY20-5167 MET** Each year at least 70% of participating residents will show an increase in knowledge through a pre/post test. FY18-79% FY19-100%, **FY20-NA OFI**	**102** women participated in the STEP program **272** additional women were reached through presentations, health fairs, and outreach events. Prescribe Change **3936** people reached through local events, naloxone trainings, health class presentations, trainings, and presentations Increase of knowledge- obtained at year end	**64** women participated in the STEP program Prescribe Change **793** people reached through local events, naloxone trainings, health class presentations, trainings, and presentations Pre/post Tests were not obtained in FY20.
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 FY19-623, **FY20-604 MET**	**282** women were screened (198-TSWHC & 84 WMHS)	**322** women were screened (TSWHC: 197; WMHS: 125)

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. 31, 2019 Phase 5	January 1-June 30, 2020 Phase 6
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/agencies to assess and address social determinants of health with their patients. FY18 – 6, FY19-11, **FY20-2 MET** Each year document new strategies or resources used to address identified social determinants. **Refer to Aunt Bertha for resources. OFI**	**2** partners added to Aunt Bertha (ACM and WMFB), 69 active users from partners and 205 users from the public, 3438 resource searches, 161 health related social needs assessments completed, 91 referrals made and 14% of the referrals were closed loop. **891** interventions from CHWs	65 active users from partners and 123 users from the public, **2325** resource searches, **155** health related social needs assessments completed, **146** referrals made and 35% of the referrals were closed loop. **733** Interventions for the CHWs
		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, FY19-571, **FY20-1031** **MET** Each year create a list of food interventions implemented and barriers that were overcome. **MET- OFI**	**25-30** Food Farmacy participants for weekly pick-up of 752 total boxes and bags of food **20** patients provided home meal program frozen meals at discharge. **3** returned for a second week of frozen meals (50% off) **14** visits to the Union Rescue Mission to teach healthy cooking and provide healthy snacks with an average of 65 participants per visit. **636** (avg per month 106**)** duplicated households served by Brown Bag Program; **54** unduplicated households MD Emergency Food Program SunLife Emergency Food Packs and Equipment	**27-32** Food Farmacy participants for weekly pick-up of **724** total boxes and bags of food. Delivered as of March due to pandemic **17** patients provided home meal program frozen meals at discharge. **2** returned for a second week of frozen meals (50% off) **9** visits to the Union Rescue Mission (stopped in March due to COVID) Brown Bag Program not held due to inclement weather and pandemic. **37** unduplicated households MD Emergency Food Program **25** households received food via CUW mini Grant; and **300** at Food Drop sponsored by HRDC and Salvation Army **100** participants in healthy living events and **440** emergency food packs distributed via SunLife partners Also provided microwaves and crock pots when needed. **1047** market vouchers were distributed. The on-campus location had an 80% return rate. Food system mapping-reviewed connection of food access with geography, income and transportation. Grant submitted to support next steps. Pantries met to discuss barriers and opportunities.

Heart Disease

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	July -Dec. 31, 2019 Phase 5	January 1-June 30, 2020 Phase 6
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, FY19-6 **MET** By June 30, 2020, 300 individuals at risk for hypertension will be identified and given recommended follow up action. FY18 – 196, FY19-102, FY20-NA **MET**	Chronic Disease grant was not renewed for FY 2020. Objectives **MET**	Program ended in FY19.
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, FY19-9, **FY20-5 MET** By June 30, 2020, engage 10,000 students in positive behavior changes related to healthy eating and physical activity. FY18 – 5768, FY19-1978, **FY20-2572 MET**	**342** students reached-BIBA competition to increase activity Cresaptown and John Humbird FSNE: 9 collaborating schools (Beall, Cash Valley, Georges Creek, John Humbird, Mt Savage, Northeast, South Penn, Westernport & West Side) Read For Health (nutrition literacy curriculum) PK, K & 1 - 66 classrooms Growing Healthy Habits (learning nutrition through gardening) 2nd & 3rd - 18 classrooms Refresh (monthly themes related to nutrition and linked to MD Ag) 4th & 5th - 22 classrooms, Dig In (extension to Growing Healthy Habits) after school students at South Penn & John Humbird-2,230 individual students X 6 lessons = 13,380 total contacts **Added a 5th Smarter Lunchroom** school to include Beall, Georges Creek, John Humbird, South Penn and West Side - cafeteria staff training, plus 2 recipe tastings for the entire school	FSNE- continued at 9 schools listed in prior phase Dig In (extension to Growing Healthy Habits) after school students at South Penn & John Humbird-**2,230** individual students X 1.5 lessons = 3,345 total contacts (no Jan lesson, 1 lesson in Feb, and only half of students received a lesson in March) Since 3/13, Telework outreach to students and teachers: read aloud books and physical activity videos plant science resources and videos. COVID-19 info and resource flyer distributed with school meals and learning packets WMD Healthy Living FB posts WMD Extension YouTube video channel

Access to Care and Health Literacy

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	July -Dec. 31, 2019 Phase 5	January 1-June 30, 2020 Phase 6
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, FY19-2, **FY20-6 MET**	Emergency Room education campaign re waiting Closed out HHP- awarded prizes and transition to revised plan with Wellness Ambassadors Thrive by 3-ACHD	Extended enrollment during pandemic Compiled and distributed delivery options for pharmacy Provided telehealth and on-line programs
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, FY19-1523, **FY20-396 MET-OFI- sepsis** Each year at least 70% of participants will show an increase in knowledge through a pre/post test. **OFI**	**3** education programs (see support strategies for list) 131 participants **56** completed Mental Health First Aid- see support strategies **100%** report increase in knowledge Awaiting results from MAC on CPSMP	MHA provided education (oral health, chronic disease, access to care/resources) to **70** individuals. **7** people completed Mental Health First Aid **100%** report increase in knowledge A Beat Burnout program was initiated with **101** UPMC Western Maryland employees **21** people attended Mind-Body Skills Groups. Increased resilience ranged between 1 and 42 percent, with 3 participants showing reduced resilience. **10** more people participated in introductory sessions. How Much of Yourself Do You Own?- Offered in collaboration with Human Services class at ACM, but discontinued due to COVID.

Supporting Strategies (Phase 6- January-June 2020)

Substance Abuse

AHEC West - STEP

- STEP yoga instructors transitioned and provided online learning opportunities for yoga and meditations once COVID-19 restrictions and guidelines were in place for social distancing. These were recorded so participants could access them on demand.
- In partnership with the Gilchrist Museum, community yoga was provided via Zoom each week and open to STEP participants.
- The STEP Facebook page provided the community with a vast array of wellness learning opportunities, including a trauma-sensitive yoga webinar, a "gratitude" scavenger hunt, COVID-19 community resources, and a self-care challenge. STEP also promoted the online Mind Body Skills Groups, being offered throughout the community.

WMHS- Provider Education

- Jan, 29, 2020- Hot Topics (Discuss electronic prescribing of controlled dangerous substances, Discuss Naloxone options, Describe safe drug disposal, options, and sites)
- CME- Feb. 12, 2020- Tobacco Cessation- Attended- 63
- CME- three hour video series by Dr. Cheshire: Pain Management and Opioids: Balancing Risks and Benefits; providers complete on own time

Chronic Pain Self Management Program (partnership) – on hold due to pandemic

Poverty Bridges to Opportunity

- Continue to work with numerous community partners to address the social determinants and to build resources, including food insecurity, housing, and transportation access
- Getting Ahead : 6 of 10 participants completed the four week class. Monthly graduate gatherings to answers questions and increase social networking capital attracted 28 participants.
- Getting Ahead graduate accomplishments:
    - moved out of her parent's house, got a car and was able to work for the first time in many years.
    - earned her GED and got a full-time job at a childcare facility.
    - got a job at Goodwill and has been able to maintain working even though her son passed away earlier in the year.
    - taking online classes and plans to complete her bachelor's degree (Management) in 2021.
    - working at Way Station, is trying to live healthier and is working on promoting his rap songs.
    - graduated AC in 2019 and is now attending FSU working on her sociology degree.
    - bought a house in 2019 and works at FSU.

Allegany County Board on Homeless

- 110 unduplicated households (220 individuals) received homeless services (HP, RRH, Laura's Anchor, CUW, RAP, VASH)

Heart Disease

ACHD Tobacco Control and Prevention

- 61 total cessation participants; 10 participants repeating the program; 3 quit. The WMHS Pulmonary Clinic does not track for repeat/quit, etc.
- TSWHC – 197 screened, 62 smoked before (31.4%) and 43 smoked after (21.8%)
- UPMC (WMHS) OB/GYN- 125 screened, 29 smoked before (23.2%) and 19 smoked after (15.2%)

Access to Care and Health Literacy

Mental Health First Aid

- 7 participants that included Archway staff, UPMC Western Maryland peer specialists, and UPMC Western Maryland employees.

Western Maryland Health Insurance Connector

- 1,568 residents enrolled in a Qualified Health Plan (QHP); 16,579 enrolled in Medicaid. This represents an 11% increase over the prior year.