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:

1. Substance Abuse
2. Poverty
3. Heart Disease
4. 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.

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
W MD = Western Maryland
WMHS = Western Maryland Health System- as of 2/2020 UPMC Western Maryland

Substance Abuse

GOAL	SHIP/PHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	FY18	FY19	FY20	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	LATEST AVAILABLE
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. **Total: 18,892 MET** Each year at least 70% of participating residents will show an increase in knowledge through a pre/posttest. **Total Avg. 60% OFI**	ACHD, MHSO WMHS, AHEC, Prescribe Change, Drug & Alcohol Abuse Council, **Opioid & Overdose Prevention Task Force**, Priority Partners, TSCHC, Frostburg Comm. Coalition, Chamber of C.	7,621 79%	6104 100%	5167 NC	Decrease drug induced death rate per 100,000 population (SHIP 15-17) Heroin related deaths (2018 BHA, MDH) Decrease infant mortality rate per 1,000 live births (SHIP, 2017)	14.2 3 6.8	11.3 26 6.5	52.6 15 <5 too small to report
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. **Total: 1943 MET**	**ACHD**, WMHS, OB Providers, TSWHC	>80% 716	>80% 623	>80% 604	Decrease % of deliveries that are substance exposed newborns (UPMC Western Maryland, CY19)	17%	10%	18%
Supporting Strategies: • Prescribe Change- initiative designed 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 • STEP-Stretching to EmPower is a program that educates, motivates and strengthens women, arming them intellectually, psychologically and physically against the risks and ravages of opioid misuse. • AHEC West and WMHS- Provider Education targeted for prescribers and other healthcare providers.											

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	WHO	FY18	FY19	FY20	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	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. **Total: 19 MET** Each year document new strategies or resources used to address identified social determinants. **Refer to Aunt Bertha for resources. OFI**	TSCHC, PCP, **WMHS**, Housing, Transportation, HRDC, Bridges to Opportunity, Board of Homeless, CUW, AHEC West, Assoc Ch, DSS	6	11	2	Decrease percent of children under age 18 living in households with incomes below the federal poverty level (CHR,2020) Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless (PIT, FY20) Decrease the percent of adults who report missing appointments due to problems finding transportation (local survey, Jy19) Improve Food Environment Index 1 to 10, 10 best (CHR, 2020)	26% 492 25% 6.4	20% 290 10% 8	21% 251 19% 7.2
		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. **Total: 1980 MET** Each year create a list of food interventions implemented and barriers that were overcome. **MET- OFI**	**Food Council**, ACHD, WMHS, HRDC, CMA, MHCE, Assoc Ch, DSS, UM Ext.	378	571	1031				
Supporting Strategies: • Bridges to Opportunity- a community effort to address all causes of poverty. The Getting Ahead class assists community members to transition out of poverty. • The Allegany County Local Homelessness Coalition (formerly the Board on Homelessness) connects consumers, advocates, community-based organizations, faith communities, government, businesses and the general public in efforts to end homelessness.The community board works to increase education and awareness of homelessness, mitigate barriers to housing and mainstream supports, and works to increase available resources for homeless and individuals/families at-risk for homelessness.											

Heart Disease

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	FY18	FY19	FY20	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	CURRENT STATUS
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 incorporated 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. **Total:300 MET**	Cardiologists, Worksites, **ACHD**, WMHS, Pharmacy, Dentists, AHEC, AHR, Assoc Ch.	26 196	6 104	NA NA	Decrease age-adjusted death rate from heart disease per 100,000 population (SHIP 2015-17) Decrease rate of ED visits for hypertension per 100,000 population (SHIP, 2017)	256.8 225.1	236.8 214.4	230.6 453.3
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. **Total: 21 MET** By June 30, 2020, engage 10,000 students in positive behavior changes related to healthy eating and physical activity. **Total: 10,318 MET**	WMHS, ACHD, MHCE, YMCA, Bd of Ed, **School Health Council**	7 5768	9 1978	5 2572	Decrease percent of elementary children who are in the 95th percentile or higher for body mass index (ACPS & ACHD, 2019-20)	20%	13.6%	21%
Supporting Strategies: • 1422 – Chronic Disease Grant- focused on chronic disease prevention, especially hypertension. • Tobacco Control and Prevention-ACHD led efforts with cessation and tobacco use prevention including education, outreach, and surveillance.											

Access to Care and Health Literacy

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	FY18	FY19	FY20	OUTCOMES (included SHIP Measures)	BASELINE	TARGET	CURRENT STATUS
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. **Total: 13 MET**	WMHS, ACHD. AHEC, Connector Entity, AHR, MHA, Assoc Ch., DSS, **Workgroup on Access to Care**	5	2	6	Decrease ratio of people per PCP (CHR,2020)	1698:1	1200:1	1880:1
								Decrease ratio of people per MH (CHR,2020)	903:1	450:1	330:1
								Decrease ratio of people per dentist (CHR,2020)	1766:1	1473.1	1290:1
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. **Total: 2283 MET-OFI- sepsis** Each year at least 70% of participants will show an increase in knowledge through a pre/posttest. **OFI**	WMHS, ACHD. **AHEC**, AHR, MHA, FCRC, FVC, MHSO, HRDC, LMB, DSS	364 NC	1523 NC	396 NC	Decrease the number of level 1 and 2 visits to the ED (UPMC WM Meditech, FY20)	15,501	6000	6502
								Decrease ED visits for mental health related diagnosis per 100,000 population (SHIP, 2017)	2320.6	3500	3309.6
								Sepsis-number of inpatient discharges with primary diagnosis (UPMC WM FY20)	567	450	942
								Decrease number of domestic violence crimes per 100,000 population (SHIP, 2017)	719.5	500	653.5
								Reduce Child Maltreatment rate (SHIP, 2017)	23.3	19	19.6

Supporting Strategies:

- Mountain Health Alliance-regional network focused on health education, CHW and outreach.
- Western Maryland Health Insurance Connector (AHEC West)- region's connector entity for qualified health plans and Medical Assistance.
- Mental Health First Aid- evidence based program to reduce stigma associated with mental health and to improve community response to those in need of
  support until professional help arrives

Priority #1: **Substance Abuse**
Goals
Increase understanding of opioid use and related consequences
Increase early identification of pregnant women using substances

Objectives and Outcome Status:

- 3 out of 4 objectives were met.
  - 18,892 residents were reached through community education regarding the impact of opioid use and available resources for prevention and treatment
  - 1,943 at risk women were identified through the 4P screening and provided a brief intervention. Over 80% of the providers in county are engaged with 4P.
  - An opportunity for improvement exists with evaluation of programs. Pre/post tests were done consistently as planned.
- Though the drug induced death rate increased significantly since the baseline, it is believed that if more current data was available the number may not be as high. The number of heroin related deaths seem to level off over the years.
- Infant mortality rate decreased and the percentage of deliveries at UPMC Western Maryland that are substance exposed increased slightly since the baseline.

Highlights:

- Prescribe Change was originally projected to reach 500 people and in the end reached over 18,000.
- STEP efforts included: outreach to public housing, education on pain management alternatives, yoga, mindful breathing and yoga stretching at several elementary schools, partnership with Health Quality Innovators and pharmacist to provide personalized medication reviews to STEP participants, and "Teddy Bear Drive" 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. Even during the pandemic, STEP offered programs via Zoom and Facebook. 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. STEP Jr. launched in the fall of 2018 as a pilot program and helped participants deal with Stress, Anxiety, Emotional pain, and Physical pain.
- Naloxone training was offered throughout the community.
- Jennifer Corder, MD presented on the CDC Guidelines and Checklist for Prescribing Opioids for Chronic Pain. A local Resource Guide for Non-Opioid Treatment of Chronic Pain and Pocket Guide: Tobacco, Alcohol, & Other Substance Use, SBIRT were distributed to providers.
- UPMC Western Maryland's OB/GYN practice was trained and began implementation in this cycle.
- Since implementing the 4P's Plus program, Allegany County has administered a total of 4,363 screens. There was a total of 2,699 positive screens, or 68.6% of the total number of prenatal screens. A total of 2,508 referrals were offered and 500 (19.9%) of those were accepted.
- DSS secured grant funding to hire two Peer Support Staff to model recovery, provide teaching skills and support clients to lead a meaningful life with their families and within the community while working towards recovery and reunification with their children. Peer Support Staff engage with clients and families which are actively participating in In-Home and Out of Home services.

Challenges:

- In year one, pre/post tests showed an increase of knowledge in well over 70% of participants, but over time assessment of knowledge declined.
- During the first 18 months of this cycle there was a focus on opioid education and more comprehensive services. This resulted in improved outcomes, however in the final year the need started to increase again.
- Maintaining sustained efforts and valuable metrics.

***Priority #2*: Poverty**
Goal
Increase collaboration to address the social determinants of health

Objectives and Outcome Status:
- 3 out of 4 objectives were met.
  - 19 practices/agencies collaborate to assess and address social determinants of health with their patients.
  - 1980 residents were assisted in accessing healthy food.
  - New strategies and interventions were offered. There is an opportunity to improve collective documentation regarding the social determinants of health and available resources.
- Since the baseline, the number of homeless in the county and the percentage of children living in poverty has reduced.
- Progress has been seen in transportation and food security. However, SDOH continue to be a priority need.

Highlights:
- Community Health Workers expanded their reach through the practices and increased the number of social needs addressed over the 3-year cycle.
- Aunt Bertha and Path2Help were launched providing an on-line resource directory, social needs assessments and referral network. There are over 1900 resources, 151 agency users, 652 public users, and 300 completed social needs assessments. Partners include AC DSS, AHEC West, HRDC, Local Management Board, Allegany College of Md., Associated Charities, and EMS.
- Numerous resources and strategies were initiated to address social determinants of health, including driver's license education support, childcare training pilot, vision van, monthly support for Getting Ahead graduates, and poverty simulations.
- 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 was piloted at Washington Middle School. Based on results, the program author was contracted to train 18 additional facilitators and grant funds were awarded from the Community Trust Foundation to expand the program.
- Food interventions included: apple orchard distribution through the Western Md. Food Bank and area churches, diabetic discharge meals, Food Farmacy, Veggie Van, food assessment of inpatients, Groceries to Go , Emergency Food and Brown Bag Program, Nutrition Outreach at Union Rescue Mission, and farmers market vouchers.
- During pandemic, County United Way provided a grant for food, and HRDC & Salvation Army partnered on a food drop. DSS and Associated Charities worked with the Maryland Food Bank to distribute food via a drive thru pantry.
- With grant funds from SunLife Financial, UPMC Western Maryland, Western Maryland Food Council, Western Maryland Food Bank, AHEC West, Human Resource Development Commission, Allegany College of Maryland, Associated Charities, and area food pantries worked to address food insecurity and related health care needs of obesity and diabetes. In addition to compiling maps and creating a resource database of food access in the county, this program engaged 100 people in healthy living events, distributed 440 emergency food packs and several microwaves and crock pots when people had no available cooking equipment.

Challenges:
- Full engagement with Aunt Bertha as a referral system has been slow. At the end of FY20, there were 84 closed loop referrals and 100 claimed programs.
- The pandemic impacted the need and availability of resources. Some programs and services had to be put on hold.
- Identifying a lead agency for transportation and collaborating to use resources effectively.

Priority #3: **Heart Disease**
Goals
Increase early identification and treatment of hypertension
Reduce obesity levels of elementary age children

Objectives and Outcome Status:

- 4 out of 4 objectives were met.
  - 32 non-traditional settings incorporated blood pressure screening with standard follow up actions and identified 300 at-risk individuals.
  - 21 strategies were implemented to increase engagement of elementary students in healthy eating and physical activity.
  - 10,318 students were engaged in positive behavior changes related to healthy eating and physical activity.
- Though the death rate for heart disease declined, the rate of ED visits for hypertension significantly increased.
- The percent of elementary children who are in the 95th percentile or higher for body mass index seems to have leveled off during this timeframe but is not moving toward the target.

Highlights:

- Six pharmacies, five dental practices incorporated blood pressure screening and standard follow up actions. Businesses were given blood pressure monitors for use by employees.
- Strategies to increase engagement in healthy eating and physical activity included: Library Summer Reading Program, Healthy School Challenge, School Well and Nutrition Committee, Family Fun and Literary nights, Stress Buster Fair at ACM, Arts in the Outdoors at Evergreen, Middle School Afterschool Program and Youth Day at fair.
- Through the School Wellness and Nutrition Committee, and with support from MD Hunger Solutions, Community Eligibility Provision (CEP) a federal meal funding option that allows high poverty schools to provide free breakfast and lunch to all students was researched and as a result, ACPS plans to implement CEP at 4 schools in the upcoming school year.
- FSNE program offered the following programs in the schools: Read for Health, Growing Healthy Habits, Smarter Lunchroom, Refresh, Dig In, various nutrition activities and tastings at fairs and YouTube.
- Screen Time survey - 81 organizations and 234 individuals responded. Aware screen time impacts their lives but reported lower than average use.
- Cresaptown and John Humbird Schools received grant to connect BIBA software to playground equipment linking screen time for children with movement.
- The WMHS Pulmonary Clinic had staff trained in tobacco cessation and in partnership with ACHD have increased the number engaged in cessation.
- Through the OB/GYN practices, cessation efforts showed results (TSWHC – 197 screened, 62 smoked before (31.4%) and 43 smoked after (21.8%) and UPMC (WMHS) OB/GYN- 125 screened, 29 smoked before (23.2%) and 19 smoked after (15.2%).

Challenges:

- The grant supporting the blood pressure initiative was ended.
- There appears to be an opportunity to expand the number of CEP schools.
- Engagement in behavior change programs is a challenge, as is the demonstration of impact.

Priority #4: **Access to Care and Health Literacy**
Goals
Increase Access to Care
Enhance understanding of health information

Objectives and Outcome Status:

- 2 out of 3 objectives were met.
  - 13 ways to improve access to care in the appropriate setting were identified and promoted.
  - 2283 people participated in education on sepsis, oral health, child maltreatment/family violence and/or mental health. However, the change in knowledge and understandability was not assessed as planned.
- The ratio of providers (primary care, dental and mental health) improved and the number of level 1 and 2 ED visits (visits more appropriate for urgent care) is less than half of the baseline.
- There was a decrease in the child maltreatment rate and number of domestic violence crimes since the baseline.
- The number of inpatient discharges with primary diagnosis of sepsis had declined but over the last two years has increased closer to the baseline.

Highlights:

- Strategies for improving access to care included: ACHD Dental Project with support from Md. Community Health Resources Commission, Mountain Health Alliance renewal, Bridging the Gap for diabetes with Merck grant, Hometown Healthy Partnership, Connector Entity at hot spots, ACT pilot care team, Diabetes Prevention Program (DPP) via AHEC, Chronic Pain Self-Management Program, Allegany Speaks, ER education campaign, delivery option list, Thrive by 3 and telehealth.
- Education programs covered oral health, sepsis, Mental Health First Aid, cultural competency and health literacy. Written materials were created to show the connection between oral health and chronic diseases. To address mental health needs several programs were offered- mind body skills groups, *How Much of Yourself Do You Own?,* and resilience.
- In the final year, 1,568 residents enrolled in a Qualified Health Plan (QHP); 16,579 enrolled in Medicaid. This represents an 11% increase over the prior year.
- There was a Mission of Mercy event held to provide access to dental care.

Challenges:

- Evaluation of increased knowledge and understanding needs to be increased.
- Health literacy remains an area for improvement.
- Sepsis education from health system needs to be shared through community.