

## Allegany County Health Planning Coalition Local Health Action Plan FY 2015-2017

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:

1. Access and Socio-economics (children in poverty, primary care access, adult dental access, health literacy, homelessness)
2. Healthy Lifestyles and Wellbeing (smoking, physical inactivity, domestic violence, fall-related injury and death, healthy weight)
3. Disease Management (behavioral health, diabetes, heart disease, hypertension, asthma)

Each priority area includes goals, link to the State Health Improvement Process (SHIP), 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 2014, Phase 2 is January-June 2015, Phase 3 is July-December 2015, Phase 4 is January-June 2016, Phase 5 is July-December 2016, Phase 6 is January-June 2017, 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  
CASA = Court Appointed Special Advocates  
CHF = Congestive Heart Failure  
CHW = Community Health Worker  
CMA = Cumberland Ministerial Association  
CUW = County United Way  
DOD = Department of Defense  
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  
MHCE = Make Healthy Choices Easy  
MHSO = Mental Health System's Office  
PCP = Primary Care Provider  
TSCHC = Tri-State Community Health Center  
UM = University of Maryland  
WMd = Western Maryland  
WMHS = Western Maryland Health System

**The following pages include the data tables with results for each priority area followed by a summary of highlights and challenges. The FY17 update of the supporting strategies can be found at the end of the document.**

**Access and Socioeconomics**

GOAL	SHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	FY15	FY16	FY17	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
A: Improve access to appropriate care	Reduce percent of individuals unable to afford to see a doctor	1. Enhance Community Health Worker Program by increasing linkages to needed community services	Between July 1, 2014 and June 30, 2017, community health workers will provide 6,000 resource referrals for high-risk patients. <b>MET</b>  Between July 1, 2014 and June 30, 2017, community health worker clients will make 1,500 healthy lifestyle improvements. <b>MET</b>	ACHD, MHSO WMHS, AHR, TSCHC, AHEC	2374	3692	2538 (does not include inpatient CHW)	Decrease percent of children under age 18 living in households with incomes below the federal poverty level	24%	24%	<b>27%</b>
		2. Reduce transportation barriers	Between July 1, 2014 and June 30, 2017, the HRDC Mobility Management Program will provide low-income residents with 6,000 rides (one way) to health and human service appointments. <b>MET</b>	HRDC, ACHD, WMHS, TSCHC, Transport Comm.	602	982	520	Decrease FTE needs for PCPs and MH providers	4.8 PCP 3.8 MH	4.0 PCP 3.0 MH	<b>5.1 PCPC 4.2 MH</b> Next rept by Jy'17
		3. Educate community on when to use ED, Urgent Care, PCP (Is it Safe to Wait?)	By July 1, 2015, reach at least 800 people with an education campaign on when to use primary care, urgent care, and the emergency room. <b>MET</b>	Coalition, WMHS, Dental CHW	1000	Done	Done	Decrease ratio of people per dentist	1766:1	1473:1	<b>1580:1</b>
		4. Address health inequities and literacy to increase patient understanding and decision making.	Between July 1, 2014 and June 30, 2017, train at least 600 health/social service professionals on cultural competency, health literacy, and/or social determinants of health. <b>MET</b>	WMHS, ACHD, AHEC, TSCHC, Providers, Allegany Radio	463	591	577	Decrease percent of adults who self-report not having been to a dentist or dental hygienist in the past year	32.13%	28.9%	no update
B: Enhance early childhood development	Reduce child maltreatment  Increase access to healthy food	1. Establish home visiting program for high risk families	Between July 1, 2014 and June 30, 2017, the Healthy Families Allegany County Program will provide home visiting services to at least 30 high-risk families. <b>MET</b>	ACHD,LMB, YMCA, DSS, Bd of Ed, HRDC	10	33	38	Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless	492	320	<b>347</b>
		2. Assess food needs and refer to appropriate organizations for food security	By July 1, 2015, at least 3 new food resources will be offered in the community. <b>MET</b>  By July 1, 2017, at least 6 organizations will be using the food security assessment. <b>UNMET</b>	CHWs, CUW, DSS, WMHS, ACHD, CMA, Providers, Assoc. Ch., WMd Foodbank	3	4	4	Decrease the percent of adults who report missing appointments due to problems finding transportation	25%	20%	<b>16%</b>
Supporting Strategies: <ul style="list-style-type: none"> <li>Mountain Health Alliance- efforts to increase dental access especially for adults, as well as provider recruitment and rural medical education.</li> <li>Housing initiatives of the Homeless Resource Board and various Housing Authorities</li> <li>Early Childhood Advisory Council- various projects to improve school readiness, recently received grant support</li> <li>Appalachian Mountain Maryland Innovative Readiness Training (DOD)-10 day event from August 13-22 providing dental, vision, pain management, medical assessment and veterinary services at the Allegany County Fairgrounds</li> <li>Mental Health First Aid Trainings- Trainings to reduce stigma associated with mental health and to improve community response to those in need of support until professional help arrives</li> <li>Bridges to Opportunity – a community effort to address all causes of poverty. The Getting Ahead class assists community members to transition out of poverty.</li> </ul>								Decrease the number of level 1 and 2 visits to the ED	17,519	6,000	<b>7746</b>

**LOCAL HEALTH ACTION PLAN- 3 Year Summary FY15-17**

**Priority #1: Access and Socioeconomics**

**Goals**

A: Improve access to appropriate care

B: Enhance early childhood development

- 7 of the 8 SMART Objectives for this priority were met. The only objective that was not met was getting six organizations to use the food security assessment
- Of the 7 outcome metrics, 1 reached target, 3 were trending in the right direction but fell short of the target, and 1 metric went in the wrong direction (% children living in poverty). 2 of the outcome metrics are awaiting update.

**Highlights:**

- Decrease the number of level 1 and 2 visits to the ED from baseline of 17,519 to 7, 746 in fiscal year 2017
- Residents that reported missing appointments due to transportation declined from 26% to 16%
- Appalachian Mountain Innovative Readiness Training (DOD) held in August 2014 with 93 servicemen from 15 military units and 282 volunteers donating 3,264 hours to provide medical, dental and vision services to 1,102 patients
- *What's the Right Choice When You Need Medical Care?* created and distributed by Coalition partners
- *Healthy Families* program established and provided home visiting services to 38 high risk families
- CHWs provided 8604 resource referrals over three years (not including inpatient community health workers)
- Mobility Management Program grew tremendously, providing 6,534 rides in FY15, 10, 214 in FY16, and 14,755 in FY17.
- Mountain Health Alliance (MHA) with Allegany County Health Department Dental Clinic and Hyndman Area Health Center have begun a denture program
- Local rapid rehousing program implemented in July 2014, through County United Way support has continued.
- 508 people completed training in Mental Health First Aid and 1631 participated in cultural competency, health literacy and/or social determinants of health
- 50 investigators graduated Getting Ahead and 17% of graduates since December 2015 have increased stability
- Programs such as the Double Bucks, Food Drops, and fresh produce at the Western Maryland Food Bank increased food resources in the community

**Challenges:**

- There is a need for more coordination of transportation in order to meet the growing demand.
- Loss of permanent supported housing beds through the Continuum of Care in FY 17 and again in FY 18.
- Poverty levels and provider availability continue to impact healthcare access.
- Recent report showed 38% of children entering Kindergarten in Allegany County are ready to learn. There is a 24 point achievement gap between children from low-income households and their counterparts from mid to upper income households.
- There is a need to engage more agencies and providers in food security assessments.

**Healthy Lifestyles and Wellbeing**

GOAL	SHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	FY15	FY16	FY17	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
A: Increase healthy choices, including availability and affordability	Increase the percent of adults who are at a healthy weight	1. Review, propose and implement policy and environmental changes to make healthy choices easier	Between July 1, 2014 and June 30, 2017, at least 6 policy and environmental changes will be implemented. <b>MET</b>	ACHD, WMHS, MHCE, Housing Authority	2	10	9	Decrease percent of adults who smoke	24%	23%	17%
			2. Support behavior change with use of motivational interviewing and low cost, accessible programs such as 95210, Tai Chi, Everybody Walk, Quitline, Smart Moves.	ACHD, WMHS, MHCE, CHWs, AHEC	2768	5845	5940	Decrease percent of adults that report no leisure time physical activity	32%	30%	28%
	Reduce the percent of children that are considered obese	By June 30, 2017, at least 30% of low-cost, accessible healthy lifestyle programs will measure behavior change. <b>MET</b>	ACHD, WMHS, MHCE, CHWs, AHEC	12	60	58	Decrease percent of elementary children who are in the 95 <sup>th</sup> percentile or higher for body mass index	20%	13.6%	19.3%	
	Reduce the percent of adults who are current smokers			Decrease number of domestic violence crimes per 100,000 population	unavailable	600	608.6				
B: Provide violence intervention programs	Reduce domestic violence	1. Increase awareness of domestic violence and determine gaps in service. (Reference Access/SE-Action B1)	Between July 1, 2014 and June 30, 2017, at least 10 domestic violence education and awareness efforts will be conducted. <b>MET</b>	DSS, WMHS, FVC, FCRC, Child Abuse Task Force, Jane's Place, CASA	7	9	6	Decrease number of domestic violence crimes per 100,000 population	unavailable	600	608.6
		2. Promote development of positive, non-abusive relationships for improved health.	Between July 1, 2014 and June 30, 2017, a least 200 residents will participate in new initiatives to promote development of positive, non-abusive relationships. <b>MET</b>	Coalition, Agencies awarded grants	91	233	N/A				
Supporting Strategies: <ul style="list-style-type: none"> <li>Tobacco assessment tools (4P's Plus and cessation programs) by Allegany County Health Department and partners</li> <li>Tracking BMI of elementary school students via school health nurses</li> <li>School Based Violence Reduction efforts with Board of Education, Health Department and other partners</li> </ul>											

**LOCAL HEALTH ACTION PLAN- 3 Year Summary FY15-17**

**Priority #2: Healthy Lifestyles and Wellbeing**

**Goals**

A: Increase healthy choices, including availability and affordability

B: Provide violence intervention programs

- 5 of the 5 SMART Objectives for this priority were met.
- Of the 4 outcome metrics, 2 reached target, 1 was trending in the right direction but fell short of the target, and 1 metric went in the wrong direction (% children 95<sup>th</sup> percentile for obesity).

**Highlights:**

- 21 policy and environmental changes were implemented, including Red, Yellow, Green at WMHS, Tobacco Free –Housing Authority, Healthy Checkouts, Product Placements, Walkability, and healthier menu options.
- 14,553 residents participated in healthy lifestyle programs including Change to Win, Smart Moves, Family Fit and Fun, Healthy Worksite Challenge, Coaching, Mile Movers, and more. The number of participants and the percent of programs measuring behavior change increased over the three years.
- 22 domestic violence education and awareness efforts were conducted through partnerships in the three years, including two forums, video created by youth, a billboard contest and hotline promotion.
- In FY 17, of the 462- 4 P's Assessments, 23% of pregnant women are using tobacco , 85% that cut back on cigarette use
- Mental Health Enhancement was instituted in the Allegany County Public Schools. Provide 30 hours per week for mental health enhancement which involves licensed workers/certified nurses being available in all of the schools for consultation, questions, updates, etc. from school staff.

**Challenges:**

- 19.3% of elementary age children are in the 95<sup>th</sup> percentile or higher for body mass index and the percentage is increasing
- Community mini-grants were not focused or long enough to track results.

**Disease Management**

GOAL	SHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	FY15	FY16	FY17	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
A: Provide disease management targeting individuals with multiple conditions, in conjunction with primary care providers	Reduce diabetes-related emergency department visits	1. Support coordination of disease management programs, especially those for diabetes, heart disease and asthma.	Between July 1, 2014 and June 30, 2017, at least 3 cross-agency disease management initiatives will be implemented. <b>UNMET</b>	WMHS, ACHD, TSCHC, YMCA, HRDC, UM Extension	2	2	2	Decrease rate of behavioral health-related ED visits per 100,000 population (Note: includes mental health and addictions)	7517.9	4794	<b>6216.5*</b>  <b>Mh-4722.9</b> <b>SA1493.6</b>
			Between July 1, 2014 and June 30, 2017, at least 200 people will participate in chronic disease self-management programs. <b>MET</b>	WMHS, ACHD, TSCHC, AHEC, YMCA, HRDC, UM Extension	137	209	121	Decrease rate of diabetes-related ED visits per 100,000 population	379.6	192.1	<b>241.4</b>
	2. Implement educational interventions to focus on self-management of chronic diseases.						Decrease age-adjusted death rate from heart disease per 100,000 population	256.8	236.8	<b>253.2</b>	
B: Increase availability of behavioral health services	Reduce emergency visits related to behavioral health	1. Establish a behavioral health learning collaborative	By July 1, 2015, a behavioral health learning collaborative will be established with at least 20 providers participating. <b>MET</b>	MHSO, Behavioral Health Providers, AHEC	32	N/A	N/A	Decrease rate of ED visits for hypertension per 100,000 population	225.1	214.4	<b>279.1</b>
		2. Implement screening process for depression and anxiety including referral source for Providers when needed.	Between July 1, 2014 and June 30, 2017, primary care providers will be screening for anxiety/ depression and at least 20 referrals will be made to behavioral health urgent care. <b>MET</b>  Between November 1, 2015 and June 30, 2017, 75% of patients in participating practices will be screened for behavioral health needs. <b>MET</b>	WMHS, ACHD, TSCHC, Private Providers, MHSO	23  0	39  100% WMHS practices	89 (63 kept)  98% of adult pts at WMHS practices	Decrease rate of ED visits for asthma per 100,000 population	68.9	55.6	<b>61.8</b>
Supporting Strategies:											
<ul style="list-style-type: none"> <li>• Prescriber education, prescription drug use screening, and enhanced coordination is being overseen by the Overdose Prevention Task Force.</li> <li>• Center for Clinical Resources of WMHS focuses on Diabetes, CHF, COPD, anticoagulation, and may be expanding to kidney disease.</li> </ul>											

**LOCAL HEALTH ACTION PLAN- 3 Year Summary FY15-17**

**Priority #3: Disease Management**

**Goal**

A: Provide disease management targeting individuals with multiple conditions, in conjunction with primary care providers

B: Increase availability of behavioral health services

- 4 of the 5 SMART Objectives for this priority were met. The only objective that was not met was cross-agency disease management
- Of the 5 outcome metrics, 0 reached target, 4 were trending in the right direction but fell short of the target, and 1 metric went in the wrong direction (rate of ED visits for hypertension).

**Highlights:**

- Chronic Disease Self Management Program continues to be offered in community. National Diabetes Prevention Program established at YMCA in collaboration with several partners.
- 467 people participated in chronic disease self- management programs
- 32 providers participated in a behavioral health learning collaborative
- Screening for depression/anxiety has increased in primary care practices and referrals to behavioral health urgent care have tripled from 23 in FY15 to 89 in FY17.
- Several trainings and outreach efforts held for providers and public on Heroin & Opioid Epidemic including PDMP training, Prescribe Change, radio spots, billboards and more.
- Center for Clinical Resources encounters continue to increase, going from 13,907 in FY16 to 17,359 (office and phone) encounters in FY17

**Challenges:**

- Emergency department visits for hypertension are at 279.1 per 100,000 population and the rate has increased steadily since 2010
- 18.7 drug-induced deaths per 100,000 population caused by illicit or prescription drugs and deaths are rising
- Additional cross agency collaboration on disease management is needed.

## Support strategies underway in the community which contribute to achievement of Local Health Action Plan (FY17 final report)

**Mountain Health Alliance**- Efforts to increase dental access especially for adults, as well as provider recruitment and rural medical education.

### Provider recruitment and retention (AHEC West)

- Two Physician Assistant students now employed in Allegany County
- Provided 43 clinical rotations for Medical, Nurse Practitioner, and Physician Assistant students, as well as three medical residents and communicated the benefits of rural practice once their residencies or other educational requirements were fulfilled

### Efforts to increase dental access especially for adults

- Mountain Health Alliance (MHA) received 20 referrals and assisted 19 individuals to care with emergent dental needs. Of those 19 individuals, 12 were enrolled in the denture program.
- Oral health outreach and education was provided to 80 individuals at Federal Correctional Institute.
- The Oral Health Community Health Worker continues to refer individuals to Allegany College of Maryland Dental Hygiene Clinic for routine care as well as refer individuals to Hyndman Area Health Center through the sliding fee application for low-cost routine dental care and treatment.
- MHA purchased the equipment and supplies needed to make Benchmark Dentures for the Allegany County Health Department’s dental clinic.
- MHA set up an agreement with Allegany County Health Department Dental Clinic and Hyndman Area Health Center for patients enrolled in the denture program to receive dentures at greatly reduced rates. The 12 individuals enrolled in the denture program have their dentures.

<b>Dental Services (including denture)</b>	
Total Value:	\$31,193.00
Total Billed:	\$9,228.92
Total Donated:	\$21,964.08
Donated Rate:	70%

<b>Denture Services Only</b>	
Total Value:	\$23,230.00
Total Billed:	\$5,570.00
Total Donated:	\$17,480.00
Donated Rate:	75%

**Housing initiatives** of the Homeless Resource Board and various Housing Authorities. (Courtney)

<b>Homeless Total (PIT Count)</b>	<b>2012</b>	<b>2013</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
living outdoors / in car	12	11	19	34	28
in hotel / motel	21	9	27	5	8
w/family_friends	200	134	80	44	121
Total Individuals	233	154	126	83	157

<b>At Risk of Becoming Homeless Total (PIT Survey)</b>					
incarcerated or in hospital	5	4	4	0	1
has eviction notice	39	0	13	0	8
Total Individuals	44	4	17	0	9

<b>Receiving Homeless Services (HIC count)</b>					
Transitional Housing	45	44	41	34	33



Emergency Shelter	51	20	36	50	55
Rapid Rehousing	7	0	17	16	23
Perm Supportive Hsg	82	99	88	74	32
Shelter + Care	30	35	30	34	38
Total Individuals	215	198	212	208	181
<b>Unduplicated Total</b>	<b>492</b>	<b>356</b>	<b>355</b>	<b>291</b>	<b>347</b>

- Local rapid rehousing program implemented in July 2014, through County United Way support has continued. The program provides individuals and families that are either homeless or at-risk for homelessness \$200 per month in housing support for up to 10 months; followed by an additional \$100 for the next 10 months. Ten families are currently receiving assistance through the program. Funding through County United Way has been received to continue the program in FY18.
- The Section 8 Housing Voucher Program -Currently 161 households are being served through the County Program and 395 through the City of Cumberland’s Program. The County waitlist increased to 211 households and 527 for the City. Average wait time to receive a voucher is 730 days for a County resident and 1095 days for a City of Cumberland resident. Despite media reports no new housing vouchers were issued to our area or statewide. Further, the local residency preference remains in place. An individual must reside in Allegany County or the City of Cumberland for a period of 1 year before they will be added to the local waitlist. The local waitlist must be fully exhausted before people on the waitlist from outside the area are eligible for a voucher- regardless of when they apply.
- HRDC received 8 new VASH Vouchers effective April 1, 2017, which brings the total number of available VASH vouchers for the County to 23. Total VASH vouchers currently in use: 19.
- The Cold Weather Shelter, funded through the support of County United Way, area churches, and the Western Maryland Health System’s Employee fund served 26 individuals (494 bednights) thru January 2017. The new Executive Director has chosen to only open the CWS on nights when temperatures drop below 30 degrees. Alternate locations for a CWS are being actively pursued for FY18 and funds for FY17 granted through County United Way have been deferred.
- Planning Allegany County’s HUD FY17 Continuum of Care application is underway. The 2017 Point In Time Survey and Housing Inventory Count has been submitted to date.

**Early Childhood Advisory Council-** various projects to improve school readiness, recently received grant support. Recent report showed 38% ready to learn. There is a 24 point achievement gap between children from low-income households and their counterparts from mid to upper income households. Snapshot of the report is attached

**Appalachian Mountain MD Innovative Readiness Training (DOD)-**10 day event from August 13-22 providing dental, vision, pain management, medical assessment and veterinary services at the Allegany County Fairgrounds **(Done)**

**Mental Health First Aid Trainings-** Trainings to reduce stigma associated with mental health and to improve community response to those in need of support until professional help arrives

- InFY17 there were 20 classes held with 214 completers, of which 5 were youth focused with 71people

**Bridges to Opportunity:**

- 27 Getting Ahead graduates in FY
- 7 investigators completed the Investigations into Economic Class at FSU and 7 more completed at ACM
- 4 Poverty Simulations were held to increase awareness of poverty, reaching 171 participants and over 25 volunteer staffers
- 31 volunteers have been trained to serve as Resource Partners encouraging graduates on the path to self sufficiency
- Piloted placement of a Resource Coordinator a few hours a week, on-site at a local employer to help with social issues that might make an employee quit. In 8 months, assisted 32 unique individuals with 49 problems, and an 88% retention rate
- Completed survey process with KFH Group and held forum to evaluate resources and strategies for addressing identified transportation needs in Allegany County. Began investigation of One Call, One Click system and Ride Sharing options.
- Sent child care surveys to employers in two industrial parks. Focused on shortage of infant care, off hour care, and cost of care.
- Began creation of a searchable database for registered (inspected) rental properties in Cumberland, and supported several landlord/tenant education programs.
- Completed training process with community partners that included use of self sufficiency matrix, agreed to collaborate on shared tool and development of a referral network.
- 17% of graduates since December 2015 have increased stability and decreased monthly debt. 11% of graduates also report increased transportation resources.

**Tobacco assessment tools** (4P's Plus and cessation programs) by Allegany County Health Department and partners. **(Chris)**

- 462- 4 P's Assessments, 23% of pregnant women are using tobacco , 85% that cut back on cigarette use
- 1 program offered with nicotine replacement - ACHD
- 153 people participated in cessation program,34 people quit through cessation program and 66 repeated cessation program
- There were no pregnant women referred to the cessation program

**Tracking BMI of elementary school students via school health nurses.**

	2014-15	2015-16	2016-17
Underweight (<5%ile)	2.5%(92)	3.1% (125)	3.2% (136)
Healthy Weight (5-84%ile)	63.5% (2355)	61.8% (2500)	60.7% (2557)
Overweight (85-94%ile)	15.2% (562)	15.8% (639)	15.6%(657)
Obese (95%ile & over)	18.8% (697)	19.3% (782)	20.5%(864)
Total # students	3706	4046	4214

**School Based Violence Reduction efforts with Board of Education, Health Department and other partners.**

- We have licensed workers/certified nurses in all of the schools in Allegany County.
- We provide 30 hours per week for mental health enhancement which involves our staff being available for consultation, questions, updates, etc. from school staff.
- Utilization rates of the mental health enhancement times have remained steady and consistently utilized by school staff

**Prescriber education, prescription drug use screening, and enhanced coordination is being overseen by the Overdose Prevention Task Force.)**

- Training held at WMHS for prescribers and providers provided by DEA on Heroin & Opioid Epidemic in March 2017. Very well attended over 150.
- The OMPP grant is awarded for FY 18 . We will be reaching out to prescribers and providers with more media messages and materials regarding opioid prescriptions.
- We had the PDMP training in Aug 2016 partnered with WMHS
- New section was added to the Prescribe Change Website specific to Prescribers
- Several opportunities with radio Dave Norman Show July 2016 radio spots, billboards informing the public to do safe storage and to utilize the drop-off to sites for expired or unused medications.
- Presented at Frostburg State Symposium Obstacles and Opportunities in Appalachian Sept 2016
- Presented at AC Drug Abuse In Western MD Sept 2016

**Center for Clinical Resources** of WMHS focuses on Diabetes, CHF, COPD, anticoagulation, and may be expanding to kidney disease.

- 1778 referrals in FY17
- 100 Telephone avoided ER visits COPD, DM, and CHF in FY17
- 17,359 office and phone encounters COPD, DM, CHF in FY17
- % no shows vs scheduled: COPD is 18.7%,CHF is 6.2%, DM is 10.3%