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
WMd = Western Maryland
WMHS = Western Maryland Health System

Substance Abuse

GOAL	SHIP/PHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	WHEN	CURRENT STATUS	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. Each year at least 70% of participating residents will show an increase in knowledge through a pre/post test.	ACHD, MHSO WMHS, AHEC, Prescribe Change, Drug & Alcohol Abuse Council, **Opioid & Overdose Prevention Task Force**, Priority Partners, TSCHC, Frostburg Comm. Coalition, Chamber of C.	Phase 1-6		Decrease drug induced death rate per 100,000 population Heroin related deaths Decrease infant mortality rate per 1,000 live births Decrease % of deliveries that are substance exposed newborns	14.2 3 6.8 17%	11.3 26 6.5 10%	18.7 34 9.1 15.4%
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.	**ACHD**, WMHS, OB Providers, TSWHC	Phase1-6					
Supporting Strategies: • Prescribe Change • AHEC West and WMHS- Provider Education • Community Strengthening (NAACP initiated)										

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	WHEN	CURRENT STATUS	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. Each year document new strategies or resources used to address identified social determinants.	TSCHC, PCP, **WMHS**, Housing, Transportation, HRDC, Bridges to Opportunity, Board of Homeless, CUW, AHEC West, Assoc Ch, DSS	Phase 1-6		Decrease percent of children under age 18 living in households with incomes below the federal poverty level Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless Decrease the percent of adults who report missing appointments due to problems finding transportation Improve Food Environment Index 1 to 10, 10 best	26% 492 25% 6.4	20% 290 10% 8	23% 291 16% 6.4
		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. Each year create a list of food interventions implemented and barriers that were overcome.	**Food Council**, ACHD, WMHS, HRDC, CMA, MHCE, Assoc Ch, DSS, UM Ext.	Phase 1-6					
Supporting Strategies: • Bridges to Opportunity • Board of the Homeless										

Heart Disease

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	WHEN	CURRENT STATUS	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. By June 30, 2020, 300 individuals at risk for hypertension will be identified and given recommended follow up action.	Cardiologists, Worksites, **ACHD**, WMHS, Pharmacy, Dentists, AHEC, AHR, Assoc Ch.	Phase 1-6		Decrease age-adjusted death rate from heart disease per 100,000 population Decrease rate of ED visits for hypertension per 100,000 population	256.8 225.1	236.8 214.4	253.2 **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. By June 30, 2020, engage 500 students in positive behavior changes related to healthy eating and physical activity .	WMHS, ACHD, MHCE, YMCA, , Bd of Ed, **School Health Council**	Phase 1-6		Decrease percent of elementary children who are in the 95th percentile or higher for body mass index	20%	13.6%	19.3%
Supporting Strategies: • 1422 – Chronic Disease Grant • Tobacco Control and Prevention										

Access to Care and Health Literacy

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	WHEN	CURRENT STATUS	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.	WMHS, ACHD. AHEC, Connector Entity, AHR, MHA, Assoc Ch., DSS, **Workgroup on Access to Care**	Phase 1-6		Decrease ratio of people per PCP Decrease ratio of people per MH Decrease ratio of people per dentist Decrease the number of level 1 and 2 visits to the ED Decrease ED visits for mental health related diagnosis per 100,000 population Sepsis-number of inpatient discharges with primary diagnosis Decrease number of domestic violence crimes per 100,000 population Reduce Child Maltreatment rate	1698:1 903:1 1766:1 15,501 2320.6 567 719.5 23.3	1200:1 450:1 1473.1 6000 3500 450 500 19	1600:1 500:1 1490.1 8219 4722.9 567 608.6 23.3
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. Each year at least 70% of participants will show an increase in knowledge through a pre/post test.	WMHS, ACHD. **AHEC**, AHR, MHA,FCRC, FVC, MHSO, HRDC, LMB, DSS	Phase 1-6					
Supporting Strategies: • Mountain Health Alliance- Allegany Health Right and AHEC • Mental Health First Aid										