Access and Socioeconomics

GOAL	SHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	WHEN	PHASE 4	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. **Fy15-2374** Between July 1, 2014 and June 30, 2017, community health worker clients will make 1,500 healthy lifestyle improvements. **Fy15-602**	ACHD, MHSO WMHS, AHR, TSCHC, AHEC	Phase 1-6	CHWs provided **1095** resource referrals **fy16-3398** CHW clients made **380** lifestyle improvements **Fy16-982**	Decrease percent of children under age 18 living in households with incomes below 200% of the federal poverty level	24%	24%	**23%**
		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 to health and human service appointments. **Fy15-3919**	HRDC, ACHD, WMHS, TSCHC, Transportation Committee	Ongoing	Mobility Management Program provided **3281** rides **Fy16-5989**	Decrease FTE needs for PCPs and MH providers	4.8 PCP 3.8 MH	4.0 PCP 3.0 MH	**5.1 PCPC** **4.2 MH** 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. **Fy15-1000**	Coalition, WMHS, Dental CHW	Phase 1-2	1,000 people reached with educational campaign	Decrease ratio of people per dentist	1766:1	1473:1	1490:1
		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. **Fy15-463**	WMHS, ACHD, AHEC, TSCHC, Providers, CHWs, Allegany Radio,	Phase 1-6	**128** professionals trained **Fy16-591**	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. **Fy15-10**	ACHD,LMB, YMCA, DSS, Bd of Ed, HRDC	Phase 1-6	Home visiting program assisted **23** families **Fy16-33**	Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless	492	320	291
		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. **Fy15-3** By July 1, 2017, at least 6 organizations will be using the food security assessment. **Fy15-3**	CHWs, CUW, DSS, WMHS, ACHD, CMA, Providers, Assoc. Ch., WMd Foodbank	Phase 1-5	4 new food resources offered in the community **fy16-4** 3 organizations using food security assessment **fy16-3 (same 3 as fy15)**	Decrease the percent of adults who report missing appointments due to problems finding transportation	25%	20%	**23%** July survey
Supporting Strategies: • Mountain Health Alliance- efforts to increase dental access especially for adults, as well as provider recruitment and rural medical education. • Housing initiatives of the Homeless Resource Board and various Housing Authorities • Early Childhood Advisory Council- various projects to improve school readiness, recently received grant support • 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 • 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 • Bridges to Opportunity – a community effort to address all causes of poverty. The Getting Ahead class assists community members to transition out of poverty.							Decrease the number of level 1 and 2 visits to the ED	15,501	6,000	**8219**

Healthy Lifestyles and Wellbeing

GOAL	SHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	WHEN	PHASE 4	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
A: Increase healthy choices, including availability and affordability	Increase the percent of adults who are at a healthy weight Reduce the percent of children that are considered obese Reduce the percent of adults who are current smokers	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. **Fy15-2**	ACHD, WMHS, MHCE, Housing Authority	Ongoing	**6** policy and environmental changes implemented **Fy16-10**	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.	Between July 1, 2014 and June 30, 2017, at least 6,000 residents will participate in low-cost, accessible healthy lifestyle programs. **Fy15-2768** By June 30, 2017, at least 30% of low-cost, accessible healthy lifestyle programs will measure behavior change. **Fy15-12**	ACHD, WMHS, MHCE, CHWs, AHEC	Ongoing	**2158** residents participated in healthy lifestyle programs **fy16-5845** Approximately **60%** of healthy lifestyle programs measure behavior change	Decrease percent of adults that report no leisure time physical activity Decrease percent of elementary children who are in the 95th percentile or higher for body mass index	32% 20%	30% 13.6%	**29%** **19.3%**
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. **Fy15-7**	DSS, WMHS, FVC, FCRC, Child Abuse Task Force, Jane's Place, CASA	Ongoing	**2** education and awareness efforts conducted **fy16- 9**	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. **Fy15-91**	Coalition, Agencies awarded grants	Phase 2, 4, 6	**142** residents participated in initiatives to promote positive relationships **fy16- 233**				
Supporting Strategies: • Tobacco assessment tools (4P's Plus and cessation programs) by Allegany County Health Department and partners • Tracking BMI of elementary school students via school health nurses • School Based Violence Reduction efforts with Board of Education, Health Department and other partners										

Disease Management

GOAL	SHIP AREA	STRATEGY	SMART OBJECTIVE	WHO	WHEN	PHASE 4	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 Reduce hypertension-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. **Fy15-2**	WMHS, ACHD, TSCHC, YMCA, HRDC, UM Extension	Ongoing	2 cross-agency disease management initiatives implemented **Fy16-2 (same 2 as fy15)**	Decrease rate of behavioral health-related ED visits per 100,000 population (Note: includes mental health and addictions)	7517.9	4794	**6216.5*** **Mh-4722.9 SA1493.6**
		2. Implement educational interventions to focus on self-management of chronic diseases.	Between July 1, 2014 and June 30, 2017, at least 200 people will participate in chronic disease self-management programs. **Fy15-137**	WMHS, ACHD, TSCHC, AHEC, YMCA, HRDC, UM Extension	Ongoing	**72** people participated in chronic disease self-management programs **Fy16-209**	Decrease rate of diabetes-related ED visits per 100,000 population	379.6	192.1	**241.4***
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. **Fy15-32**	MHSO, Behavioral Health Providers, AHEC	Phase 1-2	Collaborative established with 32 providers participating **fy16-32 (same 32 as fy15)**	Decrease age-adjusted death rate from heart disease per 100,000 population	256.8	236.8	**253.2***
		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. **Fy15-23** Between November 1, 2015 and June 30, 2017, 75% of patients in participating practices will be screened for behavioral health needs. **Fy15-0**	WMHS, ACHD, TSCHC, Private Providers, MHSO	Phase 1-6	No new anxiety/ depression screening. 23 patients referred to behavioral health urgent care **(same 23 as fy15)** **100%** of WMHS practices and **Medicare% of ACO** practices annually screen for BH needs	Decrease rate of ED visits for hypertension per 100,000 population Decrease rate of ED visits for asthma per 100,000 population	225.1 68.9	214.4 55.6	**279.1** **61.8**
Supporting Strategies: • Prescriber education, prescription drug use screening, and enhanced coordination is being overseen by the Overdose Prevention Task Force. • Center for Clinical Resources of WMHS focuses on Diabetes, CHF, COPD, anticoagulation, and may be expanding to kidney disease.										

*Better than baseline but have not improved since prior year

Support strategies underway in the community which contribute to achievement of Local Health Action Plan

January-June 2016 (Will combine the phase 3 and 4 for the fy16 final report)

Mountain Health Alliance- efforts to increase dental access especially for adults, as well as provider recruitment and rural medical education. (**Kimi-Scott**)

- Established relationship with West Virginia University School of Dentistry in order to better serve dental clients with more extensive dental and oral health needs.
- Advocated for preceptor tax credit for nurse practitioners and physicians in Maryland willing to mentor professional students.
- Orchestrated visit of five AHEC pipeline Exploring Careers in Health Occupations students to West Virginia University's Rural Health Interest Day.
- Facilitated program at the Western Maryland Health System by Dr. Jay Perman, President of the University of Maryland Baltimore professional schools, entitled Interprofessionalism in Health Care Delivery and Education.
- Met with professors at West Virginia University's Extension Service regarding the creation of an Appalachian specific cultural competency and poverty training and continuing education program that MHA will own and provide for MHA Network members and other health care providers in the community.
- The behavioral health CHW received 26 referrals and have active caseload of 17. Oral health CHW had 41 referrals.

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

- 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. Eight families are currently receiving assistance through the program.
- The Section 8 Housing Voucher Program -Currently 153 households are being served through the County Program and 363 through the City of Cumberland's Program. The County waitlist increased to 125 households and 401 for the City. Average wait time to receive a voucher is 260 days for a County resident and 800 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 15 new VASH Vouchers effective July 1, 2015. All vouchers were issued and units were leased up by September 30, 2015. This brings the total number of available VASH vouchers for the County to 18. Total VASH vouchers currently in use: 16
- The Cold Weather Shelter, funded through the support of County United Way, area churches, and the Western Maryland Health System's Employee fund served 49 individuals (387 bednights) during 2016.
- Allegany County's HUD Continuum of Care application was funded in the amount of $699,622. Two programs were not funded but all clients currently served by the programs were placed in other housing.
- Planning for the FY17 CoC application is already underway with the application to be submitted in September 2016.

Early Childhood Advisory Council- various projects to improve school readiness, recently received grant support (**Jenn)**

- Council continues to meet. There was a question about the need for support.
- Supportive of Imagination Library for 5 years and with assistance of Board of Education will be able to track the readiness and academic performance of the first group of book recipients .

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 **(Lesa)**

- MHSO-From Apr- Jun 2016 there were 36 trained in MHFA, 30 core/adult and 6 youth

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

- 159 people participated in cessation program, 13 people quit through cessation program and 24 repeated cessation program
- 208 4 P's Assessments -25.5% of pregnant women are using tobacco , 86% that cut back on cigarette use
- 3 of referred women to cessation program and 1 of women participated in cessation
- 1 program offered with nicotine replacement - ACHD
- 98 people participated in cessation program, 21 people quit through cessation program and 24 repeated cessation program

Tracking BMI of elementary school students via school health nurses.

	2014-15	2015-16
Underweight (<5%ile)	2.5%(92)	3.1% (125)
Healthy Weight (5-84%ile)	63.5% (2355)	61.8% (2500)
Overweight (85-94%ile)	15.2% (562)	15.8% (639)
Obese (95%ile & over)	18.8% (697)	19.3% (782)
Total # students	3706	4046

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

- 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 continue to increase each year.

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

- The Need Assessment for the Opioid Misuse Prevention Project (OMPP), Grant was approved in March 2016 . We worked on the Strategic Plan for FY 16 which was approved in April 2016.
- We were able to have several media campaigns, i.e., billboards, radio spots and PSA's during the few months left in FY 16. Magnets with all medication disposal sites were also designed. The magnets are currently being delivered to all pharmacies in the county to be placed in prescriptions.
- The Center for Disease Control and Prevention released new guidelines for prescribing opioids in March 2016. We are working on developing packets to be disseminated to prescribers in the county to help educate and create awareness of these new recommendations.
- Two training opportunities are in the initial stages of being planned with partnership of WMHS for the Prescription Drug Monitoring Program and Heroin Epidemic.
- The OMPP Grant was awarded again for FY 17. Plans are currently being established for those initiatives that will be addressed during FY 17.

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

- 937 referrals between Jan-June
- 99 Telephone avoided ER visits COPD, DB and CHF
- 9078 office and phone encounters COPD, DB, CHF
- YTD % checked out vs scheduled COPD(62.2%), DB (60%), CHF (75.5%)