Allegany County Health Planning Coalition
Local Health Action Plan FY 2017-2020

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 2017
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 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.	3,099 reached through Prescribe Change education. 764 lbs. of medication was collected at permanent drop-off and mini-take back events. 97.3% Town Hall and Faith Based Symposium residents stated that they now know more about opioids than they did prior to the event.
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. By June 30, 2020, identify 100 at risk women through the 4P screening and provide a brief intervention.	WMHS OB/GYN Practice was trained on 4P's assessment tool on 9/14/17. 284 pregnant women were assessed through Tri-State Women's Health Center & WMHS OB/GYN Practice. Results on assessment are not available yet.

Poverty

GOAL	SHIP/PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec 2017
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 (ie 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.	2 practices collaborated with to assess and address social determinants of health via Community Health Workers at WMHS 2 new resources used to address SDOH- Apple Orchard distribution with WMFB, churches and other organizations, Vision Van

		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.	Though distribution of prepared meals targeting specific chronic diseases and outreach by a Veggie Van to outlying areas are planned, they have not yet been implemented.

Heart Disease

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec 2017
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. By June 30, 2020, 300 individuals at risk for hypertension will be identified and given recommended follow up action.	11 non-traditional settings (ex. pharmacy, dentist office) incorporating blood pressure screening with standard follow up actions recommended 104 individuals at risk for hypertension identified and given recommended follow up action (data from 5 dental practices)
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 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.	3 strategies to increase engagement of elementary students in healthy eating and physical activity (Library Summer Reading Program Presentation, Healthy School Challenge, School Wellness & Nutrition Committee) 50 elementary students engaged in positive behavior changes related to healthy eating and physical activity

Access to Care and Health Literacy

GOAL	SHIP /PHIP AREA	STRATEGY	SMART OBJECTIVE	July-Dec 2017
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.	3 improvements to access care in appropriate setting (ACHD Dental Project – CHRC, MHA renewal, and Merck- Bridging the Gap)
Enhance understanding of health information	SHIP-Access to Health Care PHIP- MH	Improve health literacy for sepsis, oral health, child maltreatment,family violence & 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.	Planning stage for educational programs and materials.

Supporting Strategies

Substance Abuse

AHEC West and WMHS- Provider Education

- Promoted STEP program at 4 public housing sites to recruit participants. Shared information on what an opioid is; national statistics; who is affected/at-risk; pain management alternatives.
- Developed brochure on the benefits of Yoga and opioid misuse prevention education
- Conducted 2 radio interviews; participated in a community panel at local community opioid training

Community Strengthening (NAACP initiated)

Poverty

Bridges to Opportunity

- Recognized 3 year initiative- determine to focus on institutional and community changes
- 6 more Getting Ahead graduates
- Continue to problem solve in housing, child care, transportation and education

Board of the Homeless

Heart Disease

AHEC West

- CHWs are providing hypertension training to providers and non-clinical staff in the region.
- CDSMP workshops provided in the community to residents.

ACHD Tobacco Control and Prevention

- 47 individuals sought cessation services through MDQUIT line
- 43 individuals participated in the ACHD cessation program
- 3,973 individuals were reached outreach efforts
- 11 individuals in ACHD program were had repeated the program
- 2 pregnant women participated in the ACHD cessation program

Access to Care and Health Literacy

Mountain Health Alliance- Allegany Health Right and AHEC

- Outreach and education specific to oral and behavioral health, health insurance, health literacy are being provided at health fairs, community venues (senior centers, job centers, etc) and CHW training.

Mental Health First Aid

- Classes continue to be held in community. Added programs for staff of Archway, ACM students in Human Services and Criminal Justice.