STATE OF MARYLAND
Community Health Resources Commission
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Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor
John A. Hurson, Chairman – Nelson J. Sabatini, Vice Chairman – Mark Luckner, Executive Director

LHIC Grant Application Cover Sheet FY 2013-FY 2014

State Health Improvement Process: Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health

LHIC Designated Applicant Organization:

Name of Organization: Allegany County Health Department

Federal Identification Number (EIN): 52 - 204 6033

Street Address: 12501 Willowbrook Road

City: Cumberland State: _____ Zip Code: 21502 County: Allegany

LHIC Official Authorized to Execute Grants/Contracts:

Name: Sue Raver, M.D.; M.P.H.

Title: Health Officer E-mail: sue.raver@maryland.gov

Phone: 301- 759-5001 Fax: 301-777-5674

Signature: Sue Raver Date: 5/21/2013

LHIC Project Director (if different than the official authorized to execute contracts)

Name: _____

Title: _____ E-mail: _____

Phone: _____ Fax: _____

Overall LHIC Grant Funding Request:

(Range of $150,000 to $250,000 may be provided by CHRC on a <u>competitive</u> basis; funding requests below $150,000 will also be received and considered).

ALLEGANY COUNTY HEALTH PLANNING COALITION

Local Health Action Plan

2-12-13

Priority #1: *Tobacco* *(ACHD lead)*

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Tobacco use by Adults	23.8%	*	21.8%	13.5%	Not available	SHIP #32
Tobacco use by Youths	27.5%	*	25.5%	22.3%	Not available	SHIP #33
Tobacco Use during Pregnancy	38% (3 yr avg '08-10)	37.2% (3 yr avg'10-12)	36%	19.7 (MD Baseline)	⬆	Pre-Natal Risk Assess

*Updates pending based on changes to the Behavioral Risk Factor Surveillance Survey.
County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.

Strategies:

A. Pregnant women - Assess and refer to cessation services

B. Decrease tobacco use among youth and adults.

Actions

Strategy A: Screen pregnant women for tobacco use provide brief intervention to help them quit and offer cessation services			
ACTION	**WHO**	**WHEN**	**MEASURES**
1. Implement the 4 P's Plus Assessment Tool	ACHD Prevention Program, Tri-State Women's Health Center, OB Providers, Tobacco Free Coalition	Phase 1-3	# pregnant women who receive an assessment-A % using tobacco-A # of referred women -A # women participated in cessation-A
2. Education and media campaign on the health risks associated with second-hand smoke and third hand smoke	ACHD, OB Providers, WMHS Child Birth Classes, LMB, Family Junction, Tobacco Free Coalition, March of Dimes, Comm. Tran Grant	Phase 2-3	# persons receiving education-A* % above baseline from previous year-A
ACTION	**WHO**	**WHEN**	**MEASURES**
1. Provide increase access to free / low cost tobacco cessation with nicotine replacement and education services	ACHD, WMHS, Primary Care Providers, BOE, Tobacco Free Coalition, Worksites, Quitline	Phase 2-4	# Programs offered with nicotine replacement-A* # Persons who participate-A* # who quit, # who repeat cessation-A*

2. Mass Media Campaign to promote awareness of dangers of second hand smoke and available cessation services --- Red Ribbon Week Great American Smoke Out Social media to target youth	ACHD,WMHS ACM,FSU Media venues Parish Nurses, Respiratory students, Neighborhood Assn., CTG, AHR, Cumb. RAB, Tobacco Free Coalition	Phase2-3	# Persons reached via campaign-A* *#youth educated about danger of cigar use and industry marketing-A* *# adults educated about danger of cigar use and industry marketing-A*
3. Develop policies restricting the sale of tobacco to those under 18 and limiting smoking in public areas (Ex. Parks, schools, campuses, worksites, licensed child care sites, multi-unit housing)	Allegany College, ACHD, FSU, WMHS, CTG Tobacco Free Coalition, BOE, LE – Bureau of Police, Neighborhood Assn., Cumb. RAB	Phase 2-4	Policies implemented to reduce tobacco use and to create tobacco free environments-A *#people educated about smoke free multiunit housing-A* *#partners trained to support smoke free multiunit housing & outdoor areas-A* *# people educated about benefits of smoke free outdoor areas-A* *# new smoke free outdoor area policies enacted-A*
4. Promote cessation quit-line (health care providers, behavioral center providers, social media, etc.)	ACHD, WMHS, PC providers, Mental health and addictions centers, AHR, Tobacco Free Coalition	Phase 1-3	# persons who call the quit-line (Above the previous year baseline)-A

Priority # 2: *Obesity* (WMHS lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	SOURCE
% of Adults who are at a healthy weight	28.4%	*	30.1%	35.7	Not available	#30 - SHIP
% of elementary age children who were in the 95th percentile or higher	20%	20% 2011-12	13.6%	11.3%	⇔	2010-11 School Year data – Allegany County Public Schools

*Updates pending based on changes to the Behavioral Risk Factor Surveillance Survey.
County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.

Strategies:

A. Activate policy & environmental changes to increase physical activities
B. Promote available and accessible healthful food and beverage choices

Actions:

Strategy A: Activate policy & environmental changes to increase physical activities			
ACTIONS	WHO	WHEN	MEASURES
1. Increase use and ease of access to trails and sidewalks (evidence-based action for-social support-walking)	City and County Government, Bicycling groups, Parks & Recreation Departments, ACHD Make Healthy Choices Easy(MHC),WMHS, Life Fit. Mgmt.	Phase 3-5	# of facilities per 100,000 population-W # efforts to increase use of local trails-W*
2. Increase the amount of physical activity in a school setting and behavioral intervention to reduce screen time (Project Fit)	BOE Board of Health MHC, WMHS, ACHD Homeschool-S. Witt , YMCA	Phase 2-5	# new physical activity opportunities offered in schools –W* *#school wellness committee/school health council meetings-A* *# of partnerships with Title 1 schools-A* *#students enrolled in Title 1 schools-A* *# of improved physical activity standards in local school wellness policy-A*
3. Increase worksite assessment of employee health and adoption of policies to promote physical activity (access to facility, encourage walking, sponsor community facility or charity walk)	MHC, Chamber, Parks & Recreation, Rotary Club, WMHS,	Phase 3-5	# policies and # worksites-W* % no leisure time physical activity-W *#worksite wellness strategies implemented-W** *# employees reached through the partner worksites-W** *# businesses recruited for Healthiest Maryland Businesses-W**

Strategy B: Promote increase choice of and access to healthful food and beverage choices			
ACTIONS	WHO	WHEN	MEASURES
1. Promote healthier food and beverage choices in community & schools and implement product placement of nutritious products for improving healthier selections	WMHS,BOE MHC, Chamber, Parish Nurses, School Athletic Associations, ACHD	Phase 1,3,5	# worksites outreached to that decrease unhealthy choices-W* # healthy choice efforts and #changes made-W*
2. Implement campaigns to provide nutrition information about healthy choices and link to physical activity; (Support 95210 Campaign, labeling, calorie on menu, nutrition workshops for the underserved)	Making Health Choices Easy Coalition WMHS, YMCA BOE, Scouts, Restaurants, Chamber of Commerce, CTG, LFM, ACHD, UM Extension	Phase 1-6	# added or improved labeling-W* % fruit & vegetable consumption-W *#child care providers programs trained-A* *# children served by trained providers/programs-a* *# of improved nutrition standards in local school wellness policy-A* *#new worksite wellness strategies implemented-W** *# partnerships with worksites to further worksite wellness implementation-W** *# employees reached in these worksites(#on staff)-W**
3. Advocate for primary care provider screening of obesity and referral to counseling (technology options)	PCP, WMHS, AHEC-dietetic caucus, MHC	Phase 1-2	# PCP practices utilizing the resource materials-W
4. Educate and promote safe breastfeeding (baby friendly hospital, worksite support, community acceptance, medication/food impact)	MHC, Chamber, PN, ACHD-WIC, WMHS, providers	Phase 1-3	% of breastfed babies and duration of breastfeeding-W # worksites assisted with breast feeding support-W*

Priority #3: *Access* (WMHS lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	SOURCE
% Persons (under 65)with health insurance (SHIP changed baseline & goal)	85.8%	87.3%	92.3	93.6%	⬆	#36 SHIP
FTE Needs of PCP and MH providers	**	4.8PCP 3.8MH	5.8 PCP 4.8 MH	**	⬆	WMHS Physician Needs Analysis
% Individuals report missing medical appointments due to transportation	25%	No update	20%	N/A	Not available	Local Survey

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.
** Baseline information not available, goal is based on projected need.

Strategies:

A. Increase access to health care services by maintaining or increasing enrollment in public & safety net programs, increasing provider availability and addressing the transportation barrier
B. Provide dental care for un/underinsured adults

Actions

Strategy A: Increase access to health care services by maintaining or increasing enrollment in public & safety net programs, increasing provider availability and addressing the transportation barrier			
ACTIONS	WHO	WHEN	MEASURES
1. Promote enrollment in programs offered by State and safety net alternatives when an individual is not eligible	ACHD-ACCU, Workgroup on Access to Care, WMHS, Tri-State CHC, AHR, Health Care Providers, Health Insurance Exchange	Phase 2-3, 6	# served via safety net and # enrolled in MA , PAC, Family Planning-W* # enrollees in health insurance exchange program-A
2. Recruit PCP and MH providers to meet the identified community need	Garrett Allegany Workforce Development Network, Workgroup on Access Care, WMHS, Tri-State CHC, AHEC, Mental Health Advisory Board	Phase 1-3	# providers (PCP & MH)-W
3. Collaborate to identify mechanism for addressing transportation barrier	Workgroup on Access Care, Transportation Advisory Board,	Phase 2-3	% reporting transportation as reason for missing medical appt-W*

Strategy B: Provide dental care for un/underinsured adults			
ACTION	WHO	WHEN	MEASURES
1. Link under/uninsured adults with cost effective dental care versus the emergency dept. (MOM, AHR, Health Insurance Exchange …)	ACHD, MHA, ACM, AHR, AHEC, Dental Society, DHMH, WMHS, Wash. Co. Health Dept.	Phase 1-3,6	# adults using ED for dental care-W # provided dental care with expanded services-A*
2. Establish dental clinic to provide care to uninsured adults	MHA- Mineral Co HD, FQHCs-Hyndman and TSCHC, AHR	Phase 2-3	Operating dental clinic-W # adults served-W

Priority #4: *Emotional & Mental Health* (WMHS lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Rate of behavioral health related admissions to ED per 100,000 population (SHIP changed baseline & goal-now includes sub. abuse)	7517.9	6846.8	7253.3	5028.3	⬆	SHIP #34
Poor Mental Health Days-Average # reported in past 30 days age adjusted	4.2	3.9	3.5	3.3	⬆	Un. Of Wisconsin-County Health Ranking

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.

Strategies:

A. To integrate mental health and physical health including more depression screening
B. Facilitate opportunities for social connectedness

Actions:

Strategy A: To integrate mental health and physical health including more depression screening			
ACTION	WHO	WHEN	MEASURES
1. Continue to screen for depression as part of all history and physicals at WMRMC	WMHS	Phase 1,6	# new patients referred for mental health services-W
2. Develop mechanisms for integrating mental health services in offices for physical health	WMHS, PCP, ACHD, Home Care, CSA-MHSO, TSCHC, DSS	Phase 4-5	# mental health services available at physical health sites-W* #depression screenings documented in ECW-W #Outreaches to providers-A*

Strategy B: Facilitate opportunities for social connectedness			
ACTION	WHO	WHEN	MEASURES
1. Promote development of positive, non-abusive relationships for improved health (positive parenting, anti-bullying, mentor programs, visitation of elderly, developmental assets, Community Health Workers)	Family Junction WMHS ACHD, MHC, HRDC, BOEd, Big B Big S, Cumb. Ministerial, Sal. Army, YMCA, AHEC, MH Adv. Bd.	Phase 2-3, 4-5	# Coalition sponsored programs offered-W* # participants in program, increasing over time-W*
2. Community education about depression, bipolar disorder, abuse and neglect and available resources to help (Mental Health 1st Aid)	Family Junction WMHS ACHD, MHC, HRDC, Bd of Ed, Big B Big S, Cumb. Ministerial, DSS,AHEC, MHSO, Mental Health Advisory Board	Phase 2-5	# trained-W* # educational materials distributed-W*
3. Promote support of families with faith-based groups through outreach, visitation and other social events	Ministerial Association, Parish Nurses Sal. Army	Phase 6	# individuals registered in programs-W
4. Promote integrative wellness in the community through educational opportunities (physicians and complementary providers)	Community Wellness Coalition	Phase 1-3	#events-W

Priority #5: *Substance Abuse – Alcohol & Drugs* (ACHD lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	SOURCE
Reduce Drug-induced Deaths(Deaths per 100,000 population) Changed baseline	13.3	13.8	12.3	12.4	⬇	SHIP #29 –
% Alcohol-related crashes	6.4	6.2	5.4	--	⬆	(MCTSA/SHA)

**MCTSA (Maryland Center for Traffic Safety Analysis) / SHA (State Highway Administration)
County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.

Strategies:

A. Provide education on controlled substance prescriptions including screening, treatment and monitoring as well as, misuse, storage and disposal.
B. Enforce laws and promote programs to prevent excessive alcohol consumption

Actions:

Strategy A: Provide education on controlled substance prescriptions including screening, treatment and monitoring as well as, misuse, storage and disposal.			
ACTIONS	WHO	WHEN	MEASURES
1. Develop an education program for prescribers to address screening (ex. SBIRT), prescription drug monitoring, safe (controlled substance)prescription practices, and treatment options	AHEC, Allegany Health Right, Assoc.Charities WMHS, Pharmacies, ACHD, Medical & Dental Societies, Drug Al. Council,TSCHC	Phase 1-3	# providers trained-A* # Educational opportunities-A
2. Develop a public educational campaign in tandem with the prescriber training to address safe use, storage and disposal of prescription drugs and identification of abuse and available treatment resources	ACHD, WMHS, AHEC Pharmacies, DAAC	Phase 1-3	# participants in education program-A*
3. Create a system for safe disposal of prescription drugs for the community and reduce illegal sales of prescription drugs in the community	ACHD, WMHS, Pharmacy Association, Neighborhood Assn., DAAC, Local Law Enf.	Phase 1-2	# containers collected by programs for safe disposal of prescription drugs -A
Strategy B: Enforce laws and promote programs to prevent excessive alcohol consumption			
ACTIONS	WHO	WHEN	MEASURES
1. Conduct compliance checks at alcohol retailers to restrict sales to minors	ACHD, Drug & Alcohol Council, Law Enf,	Phase3 & 5,6	# retailers in compliance-A # compliance checks-A
2. Provide information on the dangers of binge drinking at area schools	ACHD, WMHS, Drug & Alcohol Abuse Council, FSU, ACM, Students, Bd of Ed, Parent Groups (Parent Hosts Lose the Most)	Phase 2 & 4	# students reached-A
3. Offer breathalyzer at large community events serving alcohol	Law enforcement, event organizers	Phase 1-3	# events where this is offered-A # persons who obtain the test-A #who fail the test-A # DUI overall -A

Priority #6: *Screening* *(WMHS lead))*

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Rate of ED visits for hypertension per 100,000 (SHIP changed baseline & goal-Md residents only)	225.1	231.6	214.4	202.4	⬇	SHIP #28
Rate of ED visits for diabetes per 100,000 (SHIP changed baseline & goal-Md residents only)	379.6	385.6	363.8	300.2	⬇	SHIP #27

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal

Strategies:

A. Improve delivery of clinical prevention services consistent with USPSTF recommendations
B. Support self management programs for diabetes and other chronic diseases as needed

Actions

Strategy A: Improve delivery of clinical prevention services consistent with USPSTF recommendations			
ACTION	WHO	WHEN	MEASURES
1. Implement a education campaign for both providers and consumers regarding consistent screening	Medical staff, ACHD, WMHS, ACS, Providers; Tristate CHC,AHEC	Phase 1-2	ECW-# screened for blood pressure-W #providers willing to share recommended screenings-W # consumers educated on recommended screening-W*
2.Promote STI screening among the high risk and minority populations	Medical staff, ACHD, WMHS, ACS, Providers, Tristate CHC	Phase **6**	# STI Cases-A #STI Screenings-A
Strategy B: Support self management programs for diabetes and other chronic diseases as needed			
ACTION	WHO	WHEN	MEASURES
1. Promote and expand diabetes self management program at WMHS	WMHS, Providers, ACHD-WIC, Parish Nurses, Comm Partners, TSCHC, AHEC	Phase2-3	# participants in program, increasing over time-W # low income persons (MA & FAP)assisted-W
2. Identify other self management programs that are feasible in the area	WMHS, ACHD, AHEC, Tristate CHC	Phase 2-3, 4-5	# initiated programs-W

Priority #7: *Heart Disease & Stroke* (WMHS lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Age adjusted death rate per 100,000 population from heart disease	256.8	259.8	236.8	173.4	⇩	SHIP #25

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal

Strategies:

A. Support evidence based practices that will impact the rate of heart disease deaths

NOTE: The following actions found under other priority areas will help with achievement of this goal:

- Tobacco cessation
- Screening for lipid and blood pressure
- Promotion of healthy eating and physical activity

Actions

Strategy A: Support evidence based practices that will impact the rate of heart disease deaths			
ACTION	WHO	WHEN	MEASURES
1. Maintain & develop primary, secondary and tertiary prevention strategies for heart disease (aspirin, CHF clinic, cardiac rehab, etc)	WMHS , EMS	Phase 6	# participants completing the various prevention strategies-W
2. Promote Getting Healthier Together initiative throughout the community	WMHS, ACHD, TSCHC, Bd of Ed, AHEC, MHC	Phase 2-4	# reached through initiative-W*
3. Increase awareness of heart attack signs and when to call 911	WMHS, EMS, media, Parish Nurses, AHEC, TriState CHC	Phase 2-3	#private vehicles and # EMS arrivals to ED for heart attack and Door to Balloon (D2B) time for each-W

Priority #8: *Health Literacy* (WMHS lead)

Baseline and Goal for 2014:

	County Baseline	MD Baseline	Local 2014 Goal	Source
Reduce by 10% the never/sometimes responses regarding providers offering help to remember to take medicines	58%	N/A	48%	Consumer Survey 2012
Reduce by 10% the never/sometimes responses regarding offer to help to complete a form	65%	N/A	55%	Consumer Survey 2012

Strategies:

B. Reduce barriers of health literacy with the Agency for Healthcare Research and Quality (AHRQ) model

NOTE: This priority overlaps with all the other priorities and should be considered in development of materials and processes.

Actions

Strategy A: Reduce barriers of health literacy with the AHRQ model			
ACTION	WHO	WHEN	MEASURES
1. Assess health literacy needs of consumers and appropriate response by provider	WMHS, AHEC,TSCHC, ACHD	Phase 2-3, 4-5	Results of consumer survey-W
2. Implement identified strategies to address health literacy	WMHS, ACHD, AHEC,	Phase 6	#strategies implemented-W*

Priority #9: *Healthy Start* (*ACHD lead*)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Infant Mortality Rate per 1000 births (SHIP changed data baseline)	14 count only	12 count only	7.8	6.6	⬆	Local data from Kids Count (2006-2011) Update-SHIP #2

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal

Strategies:

A. Promote breastfeeding (see Obesity)
B. Increase babies given a healthy start by screening and counseling pregnant women regarding creation of a safe environment, tobacco & alcohol misuse, as well as promoting healthy eating and physical activity

NOTE: The following actions found under other priority areas will help with achievement of this goal:

- Tobacco Cessation
- Promotion of breastfeeding-obesity
- Screening
- Promotion of healthy eating and physical activity

Strategy B: Increase babies given a healthy start by screening and counseling pregnant women regarding creation of a safe environment, tobacco & alcohol misuse, as well as promoting healthy eating and physical activity			
ACTION	WHO	WHEN	MEASURES
1. Create and distribute information to prevent unintentional injury of infants	WMHS, ACHD, providers, Family Junction, WIC, Child Case Fatality Review, FIMR	Phase 4-5,6	# recipients of the information-A* # fact sheets developed and # topics addressed-A

Priority #10: *Dental* *(ACHD lead)*

Baseline and Goal for 2014: Refer to Access Priority for Goal and Strategies

Note: The following actions currently exist in the community and/or are included under other priorities.

Actions

- Maintain Water fluoridation [exists in % of area water supplies] in public water systems
- Maintain and increase Sealant delivery [occurs] in the schools
- Implementation appropriate actions in the MD Oral Health Plan 2011-2015
- Dental care is available to children in area. Dental care for adults, especially the uninsured is addressed under the Access Priority. **PHASE 6**

Priority #11: *Cancer* (ACHD lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Age adjusted mortality rate per 100,000 population from cancer	190.2	184.4	181.7	169.2	⇧	SHIP #26

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal

Strategies:

A. Increase screening rates for breast, cervical, ~~ovarian,~~ and colon cancer

Actions

Strategy A: Increase screening rates for breast, cervical, ~~ovarian~~, and colon cancer			
ACTION	WHO	WHEN	MEASURES
1. Establish a reminder and recall system to support recommended cancer screening	ACHD, AHEC,WMHS, media, providers, TSCHC	Phase 3-5	Screening rates (E-Clinical Works)-W # screenings for breast, cervical and colon cancer-A
2. Advocacy for screening of at risk populations (age and minority)	ACHD, Access Workgroup	Phase 1-2	# screened from at risk population-A

Priority #12: *Immunizations* (ACHD Lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Percentage of children &adults who get vaccinated annually against seasonal flu (SHIP change to include children)	35.5	*	50.5	65.6	Not available	SHIP #24

*Updates pending based on changes to the Behavioral Risk Factor Surveillance Survey.
County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.

Strategies:

A. To increase immunization rate with continued education and policy changes

Actions

Strategy A: To increase immunization rate with continued education and policy changes			
ACTION	WHO	WHEN	MEASURES
1. Pursue mandatory vaccination of healthcare providers in area, except for declinations due to medical or religious reasons	WMHS, ACHD, TSCHC, AHEC, PCPs, Dental Society, Pharmacies	Phase 2-3	Vaccination rate-A*
2. Create consistent source to educate community about immunizations	WMHS, PCP, ACHD, Home Care, AHEC, Medical & Dental Society, Pharmacies	Phase 4-5	# users of source-A # educational opportunities-A # immunization records checked-A

Priority #13: *Chronic Respiratory Disease* (WMHS lead)

Baseline and Goal for 2014:

	County Baseline	County Update	County 2014 Goal	MD 2014 Goal	STATUS	Source
Rate of ED visits for asthma per 100,000 population (SHIP changed baseline & goal-Md residents only)	68.9	61.6	55.6	49.5	⬆	SHIP #17

County 2014 Goals are based on the % difference between the state baseline and the state 2014 goal.

Strategies:

A. Implement an educational campaign regarding chronic respiratory diseases

Actions

Strategy A: Implement an educational campaign regarding chronic respiratory diseases			
ACTION	WHO	WHEN	MEASURES
1. Implement COPD Awareness campaign (NHLBI)	WMHS , Better Br Club, Pul Rehab, TSCHC, Adult Eval Review Svs.	Phase 3-5	# reached-W* # educational opportunities-W
2. Educate and support individuals in identifying triggers and controls for asthma	WMHS, Better Br Club, Pul Rehab, Pediatricians PCP, Home Care ,TSCHC, School Health Nurses, AHEC, AERS	Phase 2-5	# individuals educated about triggers & controls-W

Project Narrative

Healthy Allegany has been designed by the Allegany County Health Planning Coalition (the Coalition) to achieve the following goals:

- Provide culturally sensitive Community Health Worker services to link medical and social services and improve health outcomes for high-risk populations;
- Strengthen and align community resources to address social determinants of health;
- Improve provider engagement through provider trainings about poverty, cultural competency, social determinants, and patient engagement as well as tools to help meet the needs of area residents; and
- Strengthen the capacity of the Allegany County Health Planning Coalition to facilitate interconnected systems of care to improve the health of our community.

Community Health Needs and Interventions

The Community Health Needs Assessment and Local Health Action Plan (LHAP) adopted by the Coalition serve as the foundation for the identified needs in Allegany County. Allegany County is a rural county of 74,012 (U.S. Census, 2012) with health needs that extend beyond the available community health resources. Many of the county's health needs are rooted in social determinants including poverty, low education levels, and cultural barriers between patients and providers.

According to the Behavioral Risk Factor Surveillance System (2008-2010), Allegany County has the highest rate of diabetes of any jurisdiction in the State. 14.8% of the population in the county has been diagnosed as diabetic compared to 9.2% in Maryland. There are 385.6 emergency department (ED) visits for diabetes per 100,000 population in Allegany County compared to 314.6 in the State. As indicated in the LHAP, the Coalition is working to decrease ED visits for diabetes through diabetes self-management programs (LHAP Priority 6). Healthy Allegany will involve the provision of these evidence-based diabetes self-management services in non-traditional settings such as low-income housing units. Grant funding will support Community Health Workers (CHWs) that will identify residents at risk for diabetes, link residents to the evidence-based diabetes self-management program at Western Maryland Health System (WMHS), and assist diabetes patients in making lifestyle choices that will help them manage their disease. CHWs have proven effective in promoting the use of primary and follow-up care for preventing disease and managing chronic conditions including diabetes, asthma, and hypertension (Centers for Disease Control and Prevention, 2011).

The LHAP identifies mental/emotional health as a priority area, with the goals of decreasing behavioral health related ED admissions and poor mental health days (LHAP Priority 4). In Allegany County, behavioral health ED visits are well above the State average (6,846.8 per 100,000 in Allegany, 5,521.7 in Maryland), and severe depression is the sixth leading cause of admission to the WMHS (fiscal year 2011). To address these issues, the Coalition is working to facilitate opportunities for social connectedness, educate the community about depression and other behavioral health issues and the resources available to help, increase screening and referrals for depression, and integrate mental health services into physical health provider sites. CHWs are identified as a LHAP strategy to develop positive relationships that promote health. Grant funding will support CHWs trained to identify the warning signs of depression, link community members with behavioral health resources, and ensure that behavioral health patients

are complying with treatment regimens. Physical health service providers will also receive information on social service and behavioral health resources in the community so they can refer patients as needed, further integrating the physical and behavioral health sectors. WMHS will provide mini-grants to local organizations for initiatives that enhance social connectedness.

Heart disease and stroke are leading causes of death in the community, and hypertension is a key risk factor. The LHAP set goals to decrease ED visits due to hypertension and the death rate due to heart disease (LHAP Priorities 6 and 7). Allegany County has an age-adjusted death rate from heart disease of 259.8 per 100,000 residents (Vital Statistics, 2008-2010), one of the three worst rates in the State. ED visits for hypertension are also above the state average (231.6 per 100,000 in Allegany, 222.2 in Maryland). The U.S. Preventive Services Task Force (USPSTF) recommends blood pressure screening as an evidence-based strategy to identify adults at increased risk for cardiovascular disease. USPSTF also indicates that treatment of high blood pressure in adults substantially decreases the incidence of cardiovascular events. CHWs will screen for high blood pressure, link patients to treatment with area providers, ensure that residents are taking prescribed medication for hypertension, and assist community members in making lifestyle choices that decrease risk for heart disease.

Chronic respiratory diseases are also a priority in Allegany County (LHAP Priority 13). According to Maryland Vital Statistics (2009-2011), the age-adjusted death rate for chronic lower respiratory disease is 50.7 per 100,000 in the county compared to 35.3 per 100,000 in Maryland. In addition, ED visits due to asthma are above the State average (61.6 per 100,000 in Allegany County and 59.1 in Maryland). The LHAP includes strategies to increase chronic obstructive pulmonary disease (COPD) awareness as well as educate and support individuals in identifying triggers and controls for asthma. CHWs will play an important role in identifying warning signs of respiratory disease, linking residents to tobacco cessation services, assisting residents in avoiding asthma triggers, and ensuring that patients have the health care services they need to control their asthma and prevent respiratory emergencies. When CHWs performed similar duties in a Boston study, asthma ED visits were reduced by 60% (AHRQ, 2013).

Social determinants including income, education, built environment, housing, food access, and transportation contribute to poor health outcomes in Allegany County. According to the U.S Census (2007-2011), 14.9% of county residents are living below the poverty line compared to 9.0% of Maryland residents. The median household income is $39,408 in Allegany County while it is $72,419 in the state. Scientific evidence shows a direct correlation between lower income and higher rates of premature mortality (CDC, 2012). Education levels in Allegany County are also well below the State average; 15.9% of Allegany County residents ages 25 and over have a bachelor's degree compared to 36.1% of Marylanders (U.S. Census, 2007-2011). And the County Health Rankings indicate that 11% of Allegany County residents are illiterate. Education and income are correlated with health status and represent significant cultural challenges to overcome in Allegany County.

Allegany County is in the Appalachian region and reflects the Appalachian culture. Core values include a strong sense of community, self-reliance, religious affiliation, and trustworthiness. Cultural norms include a distrust of outsiders and formalized medical systems. These characteristics often lead to delayed care. In addition to communicating health information in a way that is understood by residents with a low education level, trusting relationships need to be developed between patient and provider. Addressing barriers to health literacy is a priority

included in the LHAP (LHAP Priority 8). Grant funding will support CHWs from low-income, high need areas in Allegany County that will serve as trusted advisors for community members. Funding will also support health literacy assessments for health facilities and training for health and human service providers on poverty, cultural competency, social determinants of health, and patient engagement.

Inadequate access to healthy foods; lack of safe, stable housing; inability to afford prescription medications; and transportation barriers are all detrimental to health. Because so many Allegany County residents are living at or near the poverty line, meeting these needs is a challenge. 25% of the census tracts in Allegany County are classified as food deserts by the U.S. Department of Agriculture, and housing assistance has decreased due to a loss of Federal Emergency Management Agency funds and recent changes to the utilities assistance program. *Healthy People 2020*, the science-based 10-year agenda for improving the nation's health recognizes that addressing social determinants is vital to improving health. To improve health outcomes, *Healthy People 2020* indicates that we must address socioeconomic conditions, transportation options, and resources to meet daily needs (e.g., safe housing, local food markets). By partnering with Associated Charities, a portion of the grant funding will be used to provide support services to address social determinants of health. Services will include emergency food, housing assistance, utilities assistance, and prescription assistance for residents in need. In addition, CHWs will link residents to resources to address social determinants and health care providers will be educated on community resources so they can help meet the social needs of patients.

Despite the availability of a public bus system and van transport for Medical Assistance, 25% of the respondents to a community survey reported missing health and human service appointments due to lack of transportation. Better coordination of funds and resources are needed to fill transportation gaps in Allegany County. Research shows that patients in rural areas who have access to transportation (car, ride from family/friend, or public transit) have more checkups and chronic care visits per year than those without access to transportation (Journal of Rural Health, 2005). The LHAP identifies addressing transportation barriers as a key element to increase access to health care services (LHAP Priority 3). Grant funds will be used to support a coordinated transportation voucher system with oversight from a mobility manager at the Human Resources Development Commission (HRDC).

Leveraging Community Resources and Facilitating Partnerships

Healthy Allegany will leverage community resources, build upon the strong partnerships that already exist in the county, and create new partnerships to improve health outcomes. The Allegany County Health Planning Coalition is led by eight partner agencies who will work together to implement grant activities: Allegany County Health Department (ACHD), WMHS, HRDC, Tri State Community Health Center (TSCHC), Western Maryland Area Health Education Center, Allegany County Board of Education, Allegany Health Right, and the County United Way.

Grant efforts will build upon existing resources in Allegany County including:

- Diabetes self-management program at WMHS,
- Mental health services provided through WMHS and ACHD,
- Low- or no-cost health services at the federally-qualified health center (TSCHC),
- Support services system at Associated Charities to address social determinants of health,

- Workgroup that is currently assessing transportation needs and developing strategies to meet them,
- WMHS data systems that will allow the Coalition to identify areas of high need and high health care utilization, and
- Services and outreach efforts provided by community organizations.

Partners outside of the Coalition will be vital to the success of LHAP initiatives. Health care providers will participate in trainings on cultural competency, patient engagement, and social determinants of health, and use the tools provided to refer patients to community resources that will address social needs. Associated Charities will be responsible for facilitating assistance to address social determinants of health (food, housing, utilities). Allegany Transit and Express Medical Transport will partner with HRDC on the coordinated transportation voucher system. The following community organizations will assist in identifying CHWs, promote outreach and support for LHAP activities, receive referrals from CHWs, and be invited to participate in cultural competency and health literacy training: Salvation Army, Housing Authority of the City of Cumberland, Neighborhood Association, YMCA, Western Maryland Food Bank, Local Management Board, Cumberland Ministerial Association, Parish Nursing Program, Community Unity in Action, Carver Community Center, NAACP, University of Maryland Extension, Fort Recovery, Office of Consumer Advocates, Chamber of Commerce, Allegany County Department of Economic and Community Development, Friends Aware, Allegany County Department of Social Services. All partners will utilize their current expertise and assets as appropriate to support the improvement of health outcomes in Allegany County.

Maintaining Coalition Activities and Preparing for CIMH

The activities of the Coalition are currently supported with funding from the Western Maryland Health System (WMHS), Allegany County Health Department (ACHD), several state, federal and private grants, and in-kind support from various partners. Both staff from ACHD and WMHS will continue to play key roles in the implementation of the Local Health Action Plan and the facilitation of activities within their organization. Over the grant year, the Coalition will explore development of a 501(c)3 with a framework similar to Partnership for Healthier Carroll County, in which a community-led non-profit is supported by both the hospital and health department, but the coalition is not a direct service provider. By becoming an established, more formal entity, the Coalition will be able to serve as a conduit for various funding streams and be recognized for community linkages and local health planning.

The activities in Healthy Allegany reflect many of the concepts in the Community Integrated Medical Home (CIMH) model, including community health workers, data analysis, social determinants, and strengthened local coalitions. Healthy Allegany will be able to assess the use of CHWs at various practice sites including a federally qualified health center, disease management clinics for high utilizers, and the Mental Health Systems Office. By extending the CHW training to community organizations, there will be increased awareness of available resources, referral processes, health literacy, cultural competency, and chronic disease management. Engaging multiple stakeholders will also increase community readiness for a future CIMH initiative.

Currently WMHS uses inpatient and ED data to identify high utilizers and has begun mapping hot spots. Healthy Allegany will use the data to locate CHW and additional resources in the areas

of greatest need. Through the grant period, use of new data sources and processes for sharing of data will be explored. In addition, the Coalition will look for the State launch of the system with Trilogy, expanded interfaces with CRISP, and increasing reports from the meaningful use data.

Addressing social determinants and linking the medical and social aspects of care, will lead to improvements in quality of care, patient compliance and population health. These efforts will be sustained due to more efficient medical and social care processes and coordination across the continuum. At the end of the grant period, Healthy Allegany will have established a referral process that will continue to grow between Community Health Workers, Case Managers and Primary Care Providers.

By continuing to break down barriers between institutions and opening the lines of communication between medical and social providers, Healthy Allegany will assist in building a more interconnected local system that will enable future participation in the CIMH initiative. Increasing trust and understanding of community needs and resources, will prepare medical and social providers for the team-based approach of CIMH. These enhanced relationships will also help as the Maryland *Model Design Proposal to the Center for Medicare and Medicaid Innovation* evolves. During Healthy Allegany, efforts will be made to learn from the Maryland Learning Collaborative resources and other models being implemented in Maryland via the Health Enterprise Zones and Patient Centered Medical Homes.

Cost savings will be realized by linking individuals with appropriate care in lower cost settings and reducing ED visits. Health outcomes will be improved by increasing access to understandable health information and services, use of evidence based practices, and consideration of environmental and lifestyle factors to health. Healthy Allegany will seek to integrate the community with efforts of WMHS as a total patient revenue (TPR) hospital having several outpatient clinics focused on chronic diseases and high utilizers. Integrated efforts to address population health across the continuum will result in process efficiencies and better health outcomes which can be reinvested into population health.

The Post-CHRC funding Sustainability Plan following this project narrative will detail how the Coalition will sustain the actions supported by CHRC funds after the grant ends.

Goals, Measures, Outcomes & Strategies

Goal 1: Provide culturally sensitive Community Health Worker services to link medical and social services and improve health outcomes for high-risk populations

To overcome the cultural barriers that prevent individuals from seeking necessary medical care and maintaining a healthy lifestyle, Community Health Workers (CHWs) will be recruited from high risk neighborhoods with help from organizations that serve that target population. Though a few organizations have community outreach workers to assist clients, there is currently no coordinated system in Allegany County. Realizing the potential of a CHW and their place in the changing healthcare system, the Coalition has identified agencies interested in testing their use with the intent of hiring them if successful. Three candidates will be interviewed and selected as CHWs. They will be asked to commit to a term of service in exchange for payment during their training hours. After the grant period, CHWs will be hired by Tri-State Community Health Center, the Western MD Health System and the Mental Health Systems Office (MHSO) at the Allegany County Health Department. The CHW training will be free and also promoted to

community agencies for current staff interested in system improvements and future implementation of CIMH. The program will seek to train at least 15 individuals.

The Western Maryland Area Health Education Center (AHEC) researched several national models and selected the CHW Curriculum developed by the Texas East AHEC. This evidence based curriculum is a 160 hours and includes cultural competency and health literacy. It also covers key roles for the CHW and provides the tools and strategies to link individuals with the medical care and needed community services. Participants will learn how to support healthy lifestyle choices, how to spot "red flags" for hypertension, diabetes, depression and respiratory disease (Asthma and COPD), and who to contact for support. The vetted curriculum will include resources for addressing social determinants, referral lists, and protocols for confidential documentation and tracking of services. After successfully completing the training, the CHWs will be assigned to their high risk neighborhood and report to the Project Coordinator, housed at ACHD.

Each CHW will work 32 hours to maintain an average caseload of 4-6 clients per week. The CHW will be expected to complete an intake for each individual and track every interaction. A patient checklist will assess: healthy living (tobacco use, activity level, and nutrition), primary care access and usage, chronic disease management, and social needs. Based on the checklist, CHWs will identify areas of concern, complete appropriate screenings, and work with the patient to develop an action plan. In addition to baseline assessment of need, CHWs will utilize the checklist to monitor progress and assess improvement in compliance over the year.

The CHWs will serve as trusted advisors for the clients whom they serve. These trained CHWs will communicate in ways that residents can understand and they are trusted enough to ask questions. Because they live within the community, they can provide support and help residents navigate through their medical and social needs. CHWs will use an established referral process to link patients with primary care providers, specialists, social services, and community resources. The CHW will augment the outreach for Maryland Health Connection by connecting those in need with the Navigators and Assisters.

The CHW training will be evaluated and if successful may serve as a model for statewide certification and recognition as a Workforce Investment Board training program so that displaced workers can get the training paid for with local WIB funds. Healthy Allegany will test several strategies for enhancing communication between the community and medical providers, all with the aim of achieving optimum health outcomes and reflecting the cultural sensitivities of individuals from high-risk groups, especially frequent users.

Outcome: 150 high risk individuals are assisted with addressing barriers to health and engaged by qualified CHWs in improving their access, satisfaction and overall health outcomes

Goal 2: Strengthen and align community resources to address social determinants of health

Healthy Allegany will link medical providers and community resources to support patient-centered care that meets both medical and social needs. A comprehensive list of community resources will be compiled and distributed to health care providers in Allegany County. This list will include information on available services for food, housing, transportation, health insurance, and social supports. Having this information on hand will help medical providers link patients to

resources to meet their social needs. Community health workers will also use the resource guide to help remove barriers that keep individuals from living a healthy lifestyle and accessing the care they need. In addition, a food security checklist will be incorporated into the intake process at health care facilities to identify residents experiencing food insecurity and connect them with appropriate resources (ex. SNAP, WIC, food pantry). Currently, no comprehensive resource guide is available for health care providers in Allegany County and very few providers are assessing food security at intake.

To meet the transportation needs of Allegany County residents, a coordinated transportation voucher system will be created with oversight from a Mobility Manager at the Human Resources Development Coalition (HRDC). The system will be based on the work that has already been done by the transportation workgroup analyzing transportation issues in the community and proposing solutions. The Mobility Manager will work in conjunction with CHWs and Maryland Access Point, which provides referral resources for seniors and people with disabilities. Residents will use the transportation voucher system to attend health and human service appointments, and community organizations will be asked to promote use of the service. In a baseline assessment, 25% of residents said transportation was a barrier to attending health and human service appointments and the transportation voucher system will create a coordinated system to help remove this barrier.

Healthy Allegany will include funding for support services for low-income residents to address social determinants of health including emergency food, housing assistance, utilities assistance, and prescription assistance. Support services will be provided through Associated Charities which has an established, organized system for addressing emergency needs and strong relationships in the community. Funding will provide emergency assistance for approximately 100 additional residents based on per individual estimates from Associated Charities.

Community Health Workers that have been trained in health literacy will assess local health care facilities. A health literacy checklist will be used to identify areas for improvement and assist facilities in taking steps to address health literacy issues. An introductory health literacy training was offered to area health care providers this year, but facilities have not taken part in health literacy assessments. Health literacy assessments will encourage health care facilities to make practice and policy changes that result in increased patient compliance and improved communication between patients and providers.

To increase access to health care services for underserved populations, disease management programs will be offered in nontraditional settings. Clinical staff from the evidence-based diabetes self-management program at the Western Maryland Health System (WMHS) will provide diabetes management services in areas of high need such as low-income housing units and senior centers. Currently, these services are not being offered outside of the clinic. In these nontraditional settings, outreach, screening, and disease management education will also be provided for depression, hypertension, and chronic respiratory diseases including asthma and chronic obstructive pulmonary disease (COPD).

Healthy Allegany will include policy and environmental changes to promote health. Through partnerships with worksites, child care settings, and schools, policies and practices will be implemented to promote healthy eating, physical activity, and tobacco-free living. This will be done in close collaboration with the Community Transformation Grant efforts and will change

the environment in the county to make it easier for residents to make healthy choices. CHWs will help engage neighborhoods in environmental and policy changes to promote health. Community organizations will have the opportunity to apply for mini-grants to fund projects that enhance social connectedness for community residents.

Outcome: 50 health care providers linking patients to community resources to meet their social needs and 200 low-income residents served by new resources to address social determinants of health (transportation, emergency assistance).

Goal 3: Improve provider engagement through provider trainings about poverty, cultural competency, social determinants, and patient engagement as well as tools to help meet the needs of area residents

Provider training and participation is essential to establishing and maintaining a link between the Community Health Workers (CHWs) and the primary care providers in the community. Two training sessions throughout the grant year will be funded and organized by the Western Maryland Health System (WMHS). Medical professionals and identified case managers will be provided training and resources to increase their cultural competency and ability to address social determinants that impact health. Providers will be trained on poverty, cultural competency, social determinants, and patient engagement. The Cultural Competency and Health Literacy Primer, compiled through the Office of Minority Health and Health Disparities, will provide guidance for these trainings. Many area providers are not native to Allegany County or the Appalachian culture so it is essential to educate them on the characteristics and behaviors of their patient population so they can better understand and serve their patients' needs. WMHS recently held health literacy training for providers and had fifty participants.

Medical providers will identify a contact person that the CHWs can collaborate with to best serve the needs of their patients. Several practices currently have case managers making it easier to establish a direct point of contact. By establishing a point of contact for medical providers, groundwork for long-term communication and sustainability is established beyond the grant period. At the trainings and throughout the grant period, tools and consistent education materials will be created via the Coalition and shared with the identified contacts. In addition, providers will be given the opportunity to recognize both CHWs and patients for following through and engaging in healthy living.

Through improved provider engagement and training in social determinants, patient satisfaction will increase. A pre-post patient satisfaction survey will be conducted by the CHWs.

Outcome: 50 providers will link to the CHWs and utilize Healthy Allegany tools and resources to improve collaboration and engagement between providers and patient population

Goal 4: Strengthen the capacity of the Allegany County Health Planning Coalition to facilitate interconnected systems of care to improve the health of our community.

In 2011, the ACHD and WMHS partnered to conduct the community health needs assessment and to develop the Local Health Action Plan (LHAP). Over 35 community groups and independent residents have been involved in the development and implementation of the LHAP to date. Implementation of the LHAP is overseen by the Allegany County Health Planning Coalition (the Coalition) which is jointly chaired by the ACHD and the WMHS. The Coalition's

mission is "Healthy Lifestyles through collaborative partnerships, evidence-based practices and personal commitments". The Coalition also provides oversight for the implementation of the Community Health Resources Commission (CHRC) and Community Transformation grants. The Coalition will provide governance of Healthy Allegany and ACHD will be the fiscal agent.

Currently the Coalition is led by 8 partner agencies and there are several coalitions and workgroups in the community that address specific issues and are involved in implementation of parts of the Local Health Action Plan. As part of Healthy Allegany we will increase the engagement of these stakeholders and recruit new Coalition members to include physicians, case managers, and non-traditional partners such as housing, economic development, law enforcement.

Members of the Coalition successfully completed a community health needs assessment using over 40 data sources and input from various sectors in the community. This information was analyzed and used to compile the LHAP with 13 identified priorities and associated measures from which we monitor progress. With the availability of additional data resources through the State and other entities, the Coalition will be able to streamline the process, seek to share more data sources and use hot spot mapping to identify the location and needs of high utilizers, develop collaborative plans and evaluate their impact on cost, care and satisfaction. Through Healthy Allegany the Coalition will continue to assess the availability of population health measures (such as those endorsed by the National Quality Forum) from claims data and other sources.

Over the last two years, the Coalition has collaborated to develop educational materials and joint outreach campaigns, branding them with the Coalition logo. However, with various funding sources and multiple agency requirements this has been a time consuming and challenging process. By strengthening the coalition, these barriers can be overcome. Through Healthy Allegany, the Coalition will develop educational tools, a referral process, and community resource lists to help link the Community Health Workers, community and medical providers. As described earlier, these resources will be designed so that they are understandable and are intended to increase referrals to less costly preventive and disease management services in the community.

Discussions have begun about coordination of care across the continuum, and various agencies have collaborated to address the needs of our community. There is still a need for building more bridges between the community and medical care system and between all of the providers and the population of individuals. The Coalition will facilitate a series of discussions with consumers, providers, and hospital and health department representatives regarding integration of efforts and resources to improve community health. Participants will examine how to improve engagement of various partners in shared data analysis, interconnected and patient-centered care, and development of innovative solutions to improve population health. In addition to discussing the strategies of Healthy Allegany, the participants will review the Coalition's vision, mission and plan. With input from participants, an organizational structure for the Coalition's continued shared work will be identified, including governance, ongoing staff support, funding and required agreements for data sharing and collaboration.

During the grant period for Healthy Allegany, the Coalition will test several strategies for use in the CIMH model and will strengthen its capacity to align resources with the areas of greatest

need. By actively engaging partners from various sectors in the community with implementation of a streamlined action plan that addresses needs identified through enhanced data analysis, the Coalition will have a greater impact on the quality of care, associated costs and population health. Through trainings, establishment of a referral process for community resources, and development of user friendly materials, the Coalition will increase access to patient-centered care that bridges from the primary care office into the community. With increased alignment between the LHAP and medical service delivery in our community, the Coalition will seek to establish itself as the recognized coordinator of local health planning.

Outcome: Community-led coalition with at least 1.0 FTE and $25,000, supported by the WMHS and ACHD, recognized as the leader for engaging various partners in: shared data analysis, interconnected and patient-centered care, and development of innovative solutions to improve population health.

Evaluation

Evaluation data will be reported every other month to the Coalition. The report will address progress toward achieving the LHAP objectives and Healthy Allegany measures. The Project Coordinator, while situated at the health department, reports to the Coalition, and will coordinate all evaluation activities for Healthy Allegany. The Project Coordinator will facilitate implementation of the action plan, conduct evaluation, report on progress and achievements, and pursue opportunities to ensure sustainability of Healthy Allegany. The Project Coordinator will ensure that patient confidentiality is maintained in the process. The Coalition is committed to participating in the ongoing evaluation of the grant program and will comply with reporting requirements. The Project Coordinator and ACHD will oversee fiscal matters and report every other month to the Coalition on Healthy Allegany.

Evaluation will consist of monitoring progression of the performance measures in an effort to achieve the quantifiable outcome measures under each core goal. The table that follows lists the performance measures have been selected to demonstrate progress throughout the grant period while the outcome measures are more long term.

Goal 1: Provide culturally sensitive Community Health Worker services to link medical and social services and improve health outcomes for high-risk populations	
Performance Measures	• # recruited and hired as CHW • # successfully completed CHW Training with appropriate skills • # served per CHW • # encounters by type: lifestyle, access, disease specific, red flags, and social determinants • improved compliance rates as demonstrated by pre-post assessment of lifestyle, access, disease specific, red flags, and social determinants • % Increased patient satisfaction (pre-post survey) • # ED visits and hospital readmissions for individuals in hot spot areas
Outcome: 150 high risk individuals are assisted with addressing barriers to health and engaged by qualified CHWs in improving their access, satisfaction and overall health outcomes	
Goal 2: Strengthen and align community resources to address social determinants of health	
Performance Measures	• # assisted with transportation • # individuals receiving emergency assistance • # health care facilities assessed for health literacy • # patients receiving disease management education in nontraditional settings • # policy and environmental changes to promote health
Outcome: 50 health care providers linking patients to community resources to meet their social needs and 200 low-income residents served by new resources to address social determinants of health (transportation, emergency assistance).	
Goal 3: Improve provider engagement through provider trainings about poverty, cultural competency, social determinants, and patient engagement as well as tools to help meet the needs of area residents	
Performance Measures	• # providers trained • # of medical offices with identified point of contact for CHW • # providers using comprehensive resource guide • # providers using food security checklist at intake
Outcome: 50 providers will link to the CHWs and utilize Healthy Allegany tools and resources to improve collaboration and engagement between providers and patient population	
Goal 4: Strengthen the capacity of the Allegany County Health Planning Coalition to facilitate interconnected systems of care to improve the health of our community.	
Performance Measures	• # new and active Coalition members to include physicians, case managers, and non-traditional partners such as housing, economic development, law enforcement. • # data sharing and hot spot mapping events to identify the needs of high utilizers, develop collaborative plans and evaluate their impact on cost, care and satisfaction. • # shared tools, resources and processes developed and supported in order to increase engagement and access to patient-centered, less costly preventive and disease management services in the community. • # participants in a series of community-wide discussions with consumers, providers, and hospital & health department representatives regarding integration of efforts and resources to improve community health. • Documented commitment from ACHD, WMHS and # of community and medical providers to an identified organizational structure for the Coalition's continued shared work, including governance, ongoing staff support, funding and required agreements for data sharing and collaboration
Outcome: Community-led coalition with at least 1.0 FTE and $25,000, supported by the WMHS and ACHD, recognized as the leader for engaging various partners in: shared data analysis, interconnected & patient-centered care, and development of innovative solutions to improve population health.	

Addressing Unmet Needs, Disparities and Affordable Care Act

Healthy Allegany will use several strategies to address the unmet needs of low-income, uninsured, and underinsured populations. The following strategies will be implemented and have been outlined in detail in the Goals section of this proposal:

- Train and engage Community Health Workers to provide culturally sensitive support and bridge clinical care with community resources
- Educate providers to increase their ability to address poverty, cultural competency, social determinants and patient engagement
- Address social determinants of health as part of a system of care that connects medical and social needs
- Strengthen the Coalition to build a more interconnected local system that will improve the health of our community and enable future participation in the CIMH initiative

Healthy Allegany will reduce health disparities in the region and advance the overall concept of health equity in the community. Local data is collected and reviewed to help identify the areas of highest need in the community. The Western Maryland Health System gathers data and maps the high utilizers of the Emergency Department and Hospital Readmissions. This mapping data will help Healthy Allegany determine where the Community Health Workers will focus their efforts to help those with the greatest need. By addressing disparities, Healthy Allegany will help reduce health care costs and better serve the patients' needs.

Healthy Allegany will assist with the implementation of the Affordable Care Act by expanding access to residents who will become eligible for health insurance in 2014. The CHW will augment the outreach for Maryland Health Connection by connecting those in need with the Navigators and Assisters. Navigators and Assisters will be housed with several Coalition members that have partnered with Healthy Howard (Connector Entity for Western Region) to connect people with the expanded Medical Assistance and Qualified Health Plans. Once gaining coverage, individuals will be assisted by the CHWs in accessing the needed care. Coalition members have facilitated access to care through public and safety net programs for over 10 years and will continue to collaborate and work together to help successfully implement the Affordable Care Act in Allegany County.

Post- CHRC Funding Sustainability Plan

Healthy Allegany plans to build momentum for community-wide change by maximizing currently available assets and organizing resources to address existing gaps. Sustainability of actions initially supported with CHRC funding will include: 1) the pledges of three community agencies to hire Community Health Workers (CHWs), 2) tested curricula for both CHW and provider training, 3) justification for additional grant support of transportation and social determinants and 4) a confirmed organizational structure to continue Coalition work.

The CHW training has potential to become an eligible Workforce Investment Board (WIB) training program so displaced workers could get the training paid for with local WIB funds. By extending the program to community organizations, there will be improved understanding of available resources, referral processes, health literacy, cultural competency, and the targeted diseases. The three agencies hiring the CHWs, post CHRC funding, are active members of the Coalition. These agencies will take on oversight of the CHWs, previously done by the Project Coordinator, and will continue to provide feedback on their performance. With the prospect of CIMH and CHW, this low cost extender may become reimbursable by Medical Assistance and other funders in the future. It is also feasible to sustain this training by offering it through community colleges for a fee.

Integral to Healthy Allegany is a network of care which teaches community residents how to navigate and utilize the available resources to improve their health and quality of life. An important component of the network will be resource identification and linkages that remain beyond the grant period. The Coalition and its partners will maintain the resource lists, offer provider trainings, and continue evaluation and sustainability efforts post CHRC funding. Relationships enhanced through Healthy Allegany will become a foundation for future efforts with CIMH and the Maryland Model Design Proposal for Medicare and Medicaid Innovation.

By addressing social determinants and linking medical and social aspects of care, improvements will be made in quality of care, patient compliance, and population health. These efforts will continue to be sustained due to more efficient processes and coordination across the continuum of care. Linking individuals with appropriate care in lower cost settings and reducing ED visit will result in cost savings. As a Total Patient Revenue (TPR) hospital, WMHS will continue to focus on improving quality care through preventative initiatives as well as lowering costs which will align with the efforts of sustaining Healthy Allegany. The Coalition is also seeking grant funding from state and federal funds to sustain transportation collaboration initiatives among several agencies throughout the community.

Currently, the Coalition is seeking innovative ways to serve the needs of the community. Data sharing and analysis of high utilizer data will help determine resource allocation and programs. The Coalition is exploring the development of a 501(c)3 framework. By the end of the grant period the plan is to be a community-led coalition with at least 1.0 FTE and $25,000, supported by the WMHS and ACHD, recognized as the leader for engaging various partners in: shared data analysis, interconnected and patient-centered care, and development of innovative solutions to improve population health.

Project Budget

Project Budget Form for LHIC Grant Funding Request	
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION	
State Health Improvement Process: Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health	
LHIC/Organization Name:	Allegany County Health Planning Coalition/ Allegany County Health Department
Project Name:	Healthy Allegany
Budget Request for CHRC Grant Funding	**Amount of Request**
Personnel Salary	
.5 FTE Project Coordinator	$25,000
2.5 FTE Community Health Workers	$57,200
Personnel Subtotal	$82,200
Personnel Fringe (8%-Rate)	$6,576
Equipment/Furniture	$3,000
Supplies	$2,400
Travel/Mileage/Parking	$4,000
Staff Trainings/Development	$0
Contractual	$80,000
Other Expenses	$0
Indirect Costs (no more than 10% of direct costs)	$6,872
Matching Funds- at least 10% of the overall CHRC grant request must be provided in matching funds	$21,000
Total:	Grant Request: $185,048 Total with match:$206,048

Budget Justification

- Personnel Salary: .5FTE for Project Coordinator ($25,000) and 2.5 FTE for the Community Health Workers (5200hours X $11 per hour=$57,200)
- Personnel Fringe: The fringe benefit rate for these positions at ACHD is 8%, for a total of $6,576.
- Equipment/Furniture: 3 laptop computers with software for the Community Health Workers (3x$1000).
- Supplies: Telephones, blood pressure monitors, scales, and other supplies for the community health workers ($800 @ X 3CHW =$2400)
- Travel/Mileage/Parking: Local travel by Community Health Workers (est.46 miles per wk. x 52wks x 3 at a rate of $0.555 per mile=est.$4000).
- Staff Trainings/Development: No grant funds requested.
- Contractual
    - Western Maryland Area Health Education Center- Staff time (salary/fringe) to coordinate and teach the 160 hour CHW Training ($18,500), instructional materials, books, supplies and computer lab fee ($6,000), and CPR ($500).
    - Associated Charities: $10,000 for the purpose of addressing barriers to health and care, including prescription assistance, utilities and housing assistance, food support and transportation. These funds will be disbursed through an established process at Associated Charities.
    - HRDC: .5FTE Mobility Manager ($20,000 plus 45% fringe=$29,000) and $16,000 for transportation vouchers to support gaps in service.
- Other Expenses: No grant funds requested.
- Indirect Costs: 7% of grant request before match and without pass through funds ($6,872)
- Matching Funds: WMHS $15,000 for provider training, healthy living incentives, mini-grants and printing. ACHD $3000 for printing and WMAHEC $3,000 for CHW curriculum. Total of $21,000 over 10% of grant request.
- Total Grant Request: $185,048 and with matching funds $206,048

Allegany County Health Department

"Promoting Health and Preventing Disease"

Sue V. Raver, M.D., M.P.H., Health Officer
12501-12503 Willowbrook Road, SE
P.O. Box 1745
Cumberland, MD 21501-1745

Equal Opportunity Employer
301-759-5000 Phone
301-777-5674 Fax
www.alleganyhealthdept.com

May 10, 2013

Mark Luckner, Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner:

The Allegany County Health Department is committed to providing $3,000 towards the local match for the projects proposed by the Allegany County Health Planning Coalition. It is our understanding that these funds will be used for the various printing expenses associated with the project.

In addition to these matching funds, we will continue to support the local health improvement coalition with the in-kind contributions of staff time and leadership.

Sincerely,

Sue Raver MD

Sue Raver, MD
Health Officer

Western Maryland Health System

May 17, 2013

Mark Luckner
Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner:

The Western Maryland Health System is committed to providing $15,000 towards the local match for the projects proposed by the Allegany County Health Planning Coalition. It is our understanding that these funds will be used to:

- support provider training focused on cultural competency, health literacy, and addressing social determinants;
- offer mini-grants to local organizations for community-driven projects that promote healthy lifestyles;
- provide support materials and incentives to motivate Community Health Workers and the individuals they assist in making healthier choices.

In addition to these matching funds, we will continue to support the local health improvement coalition with the in-kind contributions of staff time and leadership.

Sincerely,

Barry P. Ronan
President and CEO

WESTERN MARYLAND
AHEC

Western Maryland Area Health Education Center
39 Baltimore Street
Suite 201
Cumberland, Maryland 21502
Phone 301-777-9150 • Fax 301-777-2649

May 10, 2013

Mark Luckner, Executive Director
Maryland Community Health Resources Commission
45 Calvert Street, Room 336
Annapolis, MD 21401

Dear Mr. Luckner:

The Western Maryland Area Health Education Center is committed to providing $3,000 towards the local match for the projects proposed by the Allegany County Health Planning Coalition. It is our understanding that these funds will be used to purchase the Community Health Worker curriculum.

In addition to these matching funds, we will continue to support the local health improvement coalition with the in-kind contributions of staff time and leadership.

Sincerely,

Susan Stewart

Susan Stewart
Executive Director