# Community Health Needs Assessment


Allegany County Health Department
and
UPMC Western Maryland
(Formerly Western Maryland Health System - WMHS)

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**Allegany County Community Health Needs Assessment**

**Executive Summary**

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act (known together as the Affordable Care Act) require non-profit hospitals to conduct a community health needs assessment and implementation strategy in conjunction with public health entities every three years. These requirements are codified as Internal Revenue Code (Section 501(r)(3)(A). The creation, implementation and ongoing support of a health improvement plan are also required for local health department accreditation through the Public Health Accreditation Board (PHAB).

The Allegany County Health Department (ACHD) and UPMC Western Maryland (formerly Western Maryland Health System -WMHS) co-chair the Allegany County Health Planning Coalition and lead the community health needs assessment process through the Local Health Action Plan (LHAP) Workgroup. The mission of the Allegany County Health Planning Coalition is 'Healthy Lifestyles through collaborative partnerships, evidence-based practices and personal commitments'. Over the years, various community stakeholders have partnered to improve the health of our community. Through the assessment and planning process the Coalition creates a unified plan to collectively address the community needs that impact health.

Prior CHNAs were completed in 2011, 2014 and 2017. The assessment being completed in fiscal year 2020 will be the fourth cycle and build upon improvements made and lessons learned in prior cycles. The community health needs assessment is used to develop a Local Health Action Plan, also referred to as the implementation strategy. The process includes engaging partners in shared priorities, defining target populations, aligning policies and programs, utilizing evidence-based practices and ensuring accountability with identified metrics.

Each CHNA cycle has related to State and National efforts, including the State Health Improvement Process (SHIP) and Healthy People 2020. The County Health Ranking Model created by the University of Wisconsin and Robert Wood Johnson Foundation helps guide the local framework by showing the impact of behavior and socioeconomic factors on health status.

After reviewing the results from prior community health needs assessment cycles, updating secondary data sources, and gathering input through a community survey, a community forum was held. The forum was open to the public and community organizations. A broad spectrum of community partners participated in the event. During the forum data were presented, participants ranked the needs using an assessment tool created by Kanawha County, WV, and aggregate totals were compiled to draft a priority list. Participants discussed the findings, existing community resources, and gap areas. There was consensus on the following three priority areas:

1. Transportation
2. Social Determinants of Health
3. Prevention-Youth Risk Reduction

The supporting strategies already in existence to address these priorities were reviewed along with evidence-based practices. For each priority area the following were created: goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The Local Health Action Plan will be reviewed for approval by the WMHS Board of Directors and the Allegany County Health Planning Coalition before both the needs assessment and action plan are made available to the public before June 30, 2020.

**Defined Community Demographics: Allegany County**

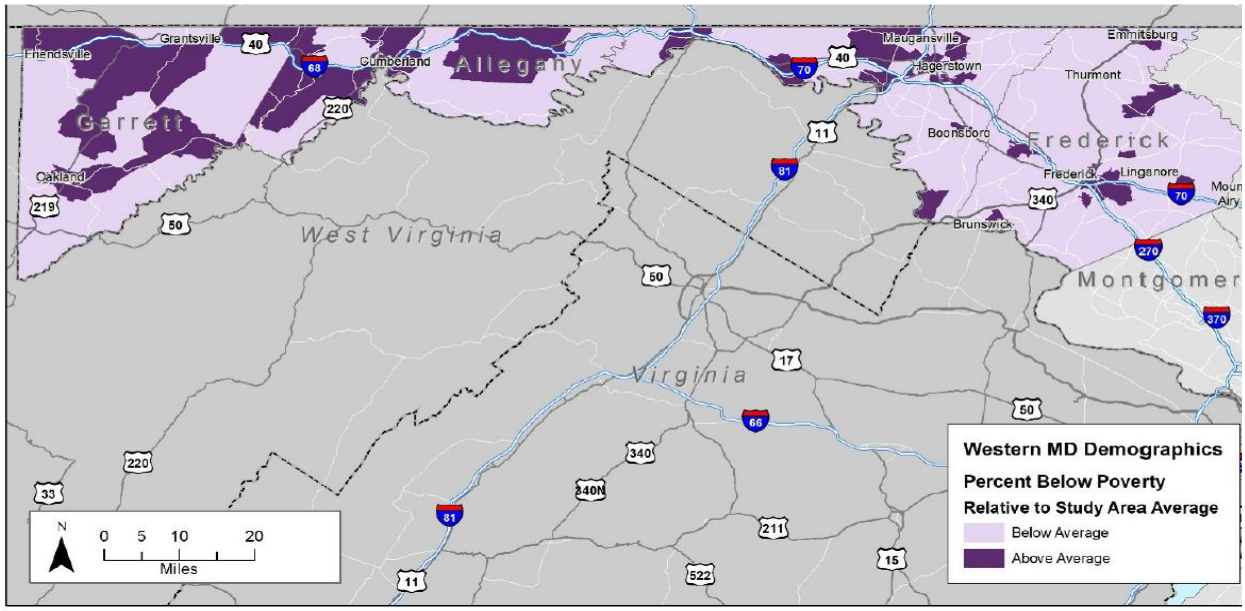
Allegany County, Maryland is the defined community for this CHNA. It is located in rural Western Maryland and has a population of 71,977 (ACS, 5yr. est. 2014-18). As part of the Appalachian region, the county has a larger elderly population, less racial diversity, and lower household incomes and education levels than the state of Maryland as a whole.

In Allegany County, 19.6% of the population is age 65 and older (compared to 14.6% in Maryland) and 17.5% of the county population is under age 18 (compared to 22.4% in Maryland). In Allegany County, 89% of the population is white, 9.6% is black, and 1.8% is Hispanic or Latino. Only 4% of residents speak a language other than English at home compared to 18.4% in Maryland (ACS, 5yr. est. 2014-18).

The median household income in Allegany County is $42,564, well below the state median of $80,711 and the national median of $60,336 (SAIPE 2017). The unemployment rate in Allegany County is 4.4% compared to 3.8% in Maryland (ACS, 5yr. est. 2014-18), and the percent of single parent households continues to rise, to current level of 36% (CHR, 2020).

Socioeconomic factors contribute to poor health outcomes in Allegany County. According to the American Community Survey (ACS, 5yr. est. 2014-18), the percent of county residents living below the federal poverty level is 16.4% compared to 9.4% in Maryland and 14.1% in USA. The percent of children under age 18 living in poverty in Allegany County is 23%, which is decreased since the last cycle. Based on the United Way ALICE (Asset Limited, Income Constrained, Employed) Project, another 25% of Allegany County residents had incomes above the federal poverty level but not high enough to afford a basic household budget including housing, child care, food, transportation, and health care.

The map below shows the Relative Density of Below Poverty Populations (WMD Coordinated Public Transit and Human Services Transportation Plan, 2019).




Allegany County has a high school graduation rate of 90% but the county continues to have low numbers of adults age 25 and over with a bachelor's degree or higher (18.3% compared to 39.6% in Maryland). In addition, 11.3% of Allegany County residents age 16 and over are illiterate.

There were no significant demographic changes found in Allegany County since the last community health needs assessment. However, according to Maryland Vital Statistics 2018 report, the life expectancy for black residents in the county decreased from 80.4 to 75.5 and the mortality rate for non-Hispanic blacks increased from 302.5 to 465.2. These data points will require further investigation and discussion with the impacted population. Meetings have been set up with NAACP to start the discussion.

**Process and Methods to Conduct CHNA**

Prior CHNA and Progress to Date

There was no written input received on the prior CHNA or implementation strategy. However, through the process and methods utilized to conduct the CHNA and local plan, input was received from public health entities, medically underserved, low income and minority populations, and other representatives of the community.

The first step was to review the successes and remaining opportunities in the current cycle. Based on outcome data, the following areas showed some improvement:

- Heart Disease Death Rate
- Mental Health Provider Ratio
- Dental Provider Rati
- Mental Health Visits to the ED
- Homelessness at Point In Time
- Food Index
- Child Maltreatment Rate

Opportunities for improvement continued in the following areas and were used to direct further investigation.

- Drug Induced Deaths
- Substance Exposed Newborns
- Children Living in Poverty
- Transportation
- Hypertension- ED Visits
- Level 1 & 2 ED Visits
- PCP Ratio
- Sepsis (# Inpatient Discharges)
- Domestic Violence Crimes

In addition to looking at the current cycle, we compared the priority areas over the last three cycles. The table below lists the identified priorities from each cycle.

<table>
<tr><th>2011</th><th></th><th>2014</th><th>2017</th></tr>
<tr><td>Tobacco Cessation (especially during pregnancy)</td><td></td><td rowspan="5">Access and Socioeconomics (children in poverty, primary care access, adult dental access, health literacy, homelessness)</td><td>Substance Abuse</td></tr>
<tr><td>Obesity</td><td></td><td rowspan="5">Poverty</td></tr>
<tr><td>Access to Care and Providers</td><td></td></tr>
<tr><td>Emotional and Mental Health (suicide rate / depression)</td><td></td></tr>
<tr><td>Substance Abuse (alcohol and drugs)</td><td></td></tr>
<tr><td>Screening and Prevention (diabetes, hypertension, cancer)</td><td></td><td rowspan="4">Healthy Lifestyles and Wellbeing (smoking, physical inactivity, domestic violence, fall-related injury and death, healthy weight)</td></tr>
<tr><td>Heart Disease and Stroke</td><td></td><td rowspan="3">Heart Disease</td></tr>
<tr><td>Health Literacy</td><td></td></tr>
<tr><td>Healthy Start (prenatal care)</td><td></td></tr>
<tr><td>Dental</td><td></td><td rowspan="4">Disease Management (behavioral health, diabetes, heart disease, hypertension, asthma)</td><td rowspan="4">Access to Care and Health Literacy</td></tr>
<tr><td>Cancer</td><td></td></tr>
<tr><td>Immunizations (flu)</td><td></td></tr>
<tr><td>Chronic Respiratory Disease</td><td></td></tr>
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Throughout each three-year cycle, progress on the Local Health Action Plan was monitored and its impact on the identified outcome measures was evaluated. The next table shows the key measures and the changes seen over time.

**Comparison of Progress Made and Continued Challenges from 2011-2019**

| Measures/Source | 2011 | 2014 | 2017 | Latest | + or - |
|---|---|---|---|---|---|
| Percentage of children (under age 18) living in poverty (CHR) | 19% | 26% | 27% | 23% | |
| ED visits for hypertension primary diagnosis per 100,000 population (SHIP) | 225.1 | 231.6 | 279.1 | 453.3 | - |
| Drug induced death rate per 100,000 population which illicit or prescription drugs are underlying cause (SHIP) | 14.2 | 17.0 | 18.7 | 52.6 | - |
| Age-adjusted mortality rate from heart disease (per 100,000 population (SHIP) | 256.8 | 259.8 | 253.2 | 230.6 | + |
| % elementary public-school students with BMI at 95th percentile or above (ACPS-Elementary BMI) | 20% (799) | 17% (699) | 20.5% (864) | 21.2% (872) | - |
| % Adults report smoking (CHR) | 26% | 24% | 17%** | 16% | + |
| % of uninsured residents (CHR) | 15% | 12% | 8% | 6% | + |
| Rate of behavioral health related ED visits per 100,000 population (SHIP) | 7517.9 | 6846.8 | 4723 | NA | ? |
| Average number of poor mental health days in last 30 days (CHR) | 4.2 | 3.8 | 4.1 | 4.3 | - |
| Average number of poor physical health days in last 30 days (CHR) | 4.5 | 4.5 | 4.0 | 3.8 | + |
| % of respondents missing medical appointments due to transportation (local survey) | 25% | 23% | 16% | 19% | |
| Number of level 1 and 2 visits to the ED (WMHS- Meditech) | 15,501 | 8219 | 6476 | 7345 | - |
| Population to Primary Care Provider Ratio (CHR) | 1023 | 1698 | 1620 | 1900 | - |
| Sepsis-number of inpatient discharges with primary diagnosis (WMHS) | 1050 fy16 | 1123 fy17 | 692 fy18 | 863 fy19 | |
| Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless (PIT) | 492 | 356 | 304 | 200 | + |
| Ratio of people per dentist (CHR) | 1766 (2013) | 1638 | 1580 | 1400 | + |

**Data not comparable to prior years due to change in definition or method

Secondary Data Sources

After reviewing progress and areas for improvement in both prior and the current Local Health Action Plan, a variety of secondary data sources were compiled and reviewed by the LHAP Workgroup. The Workgroup includes representatives from the hospital, health department, community action agency and area health education center. Each of these representatives was tasked with pulling sources available to them and sharing them for review.

The metrics and sources included:

- Maryland's State Health Improvement Process (SHIP)
- Community Commons
- Allegany County Youth Risk Behavioral Survey (YRBS)
- American Community Survey
- Allegany County Public School BMI data
- Community Needs Index
- State Cancer Profile
- WMHS Dental ED Visits
- Drug and Alcohol Related Deaths- BHA, MDH
- Top 10 reasons WMHS ED visits and Admissions
- County Health Ranking
- US News Civic Ranking
- Kids Count
- Healthy People 2020
- Opportunity Nation
- Feeding America
- Local Transportation Survey
- MD College Survey
- Homeless Data-HRDC
- WMHS Dimensional Insight

Needs trending in the wrong direction or off target compared to the state or nation were compiled for review by the Allegany County Health Planning Coalition. The County Health Ranking data from 2010-2019 were reviewed and compared over time when valid. Data points were eliminated from continued review if the sample size was too small, need appeared stable, or issue was represented by another metric. The data table specifying why each measure is a concern can be found in the Appendix.

The Coalition was asked for missing elements and/or corrections. Updated YRBS data was desired but unavailable until after the community forum. Information from the American College Health Assessment was obtained via Frostburg State University regarding vaping use by college students and shared at the forum.

Updated YRBS (2018) data for Allegany County became available after priorities were identified and the first draft plan was compiled. These data were reviewed by members of the LHAP Workgroup and then shared with the Coalition at the March meeting. The data supported selection of Prevention-Youth Risk Reduction priority and several of the YRBS metrics will be utilized as outcome measures in the local health action plan.

<u>Community Input (Primary Data)</u>

Two surveys were conducted in order to obtain input from a broader spectrum of the community, including low income, medically underserved, and minority populations. Coalition members were engaged in the survey design, distribution and review.

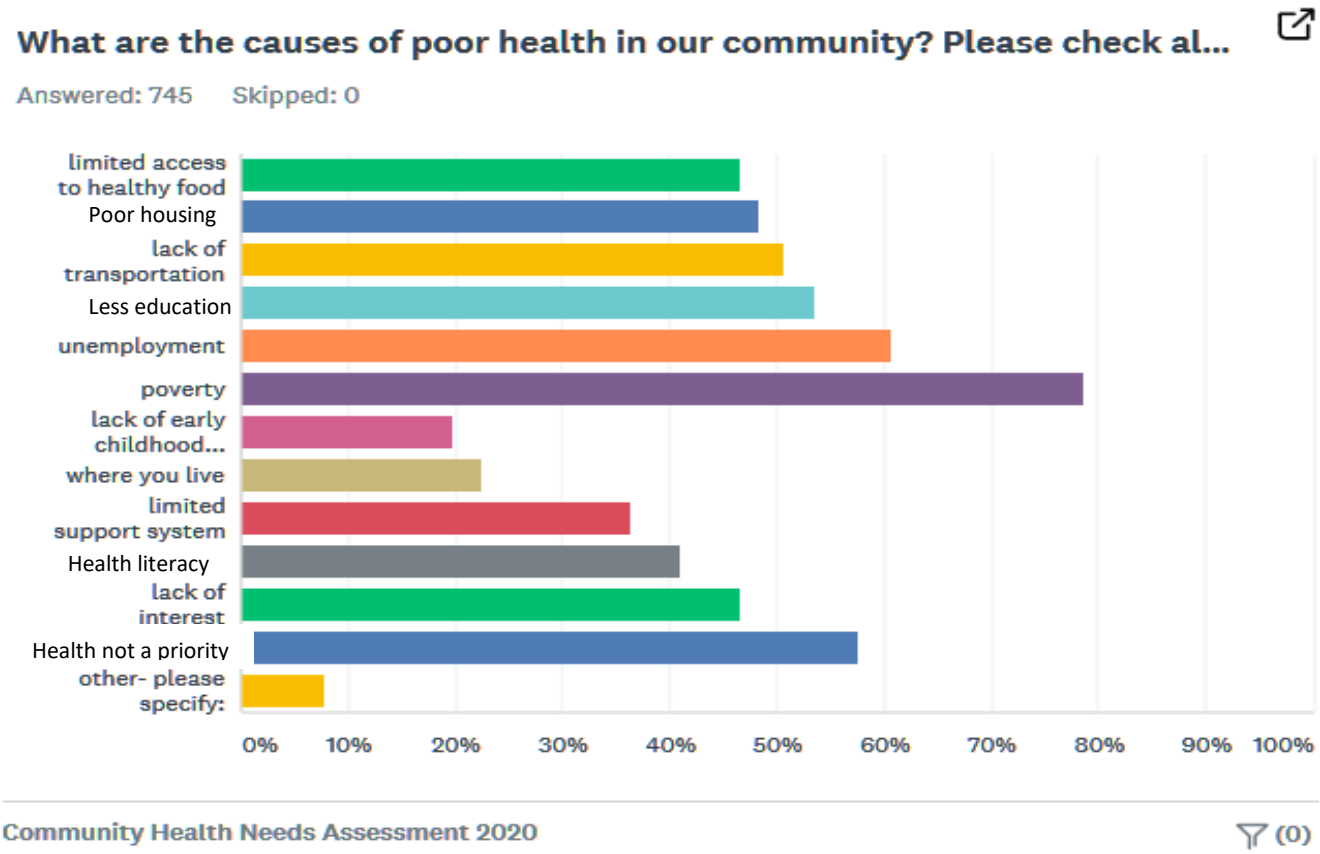
The transportation survey was a paper survey collected at the UPMC Western Maryland Emergency Department, Tri State Community Health Center- Cumberland Primary Care, and the Allegany County Health Department Clinics throughout July 2019. These locations were utilized this year and every other year we conducted this survey based on the target population they serve. A total of 599 responses were received this round and 19% of the respondents reported missed appointments because of problems finding transportation. This was a three percent increase since 2017. 14% of the respondents reported lack of transportation regularly impacted their ability to get to grocery store and 6% noted challenges getting to the food pantry.

Survey monkey was utilized to conduct the other survey, online and in a paper version for those without computer access. The survey link was shared on hospital and health department websites and posted by many other Coalition members. Paper copies were distributed to lower wage employees without easy access to computers, at community outreach events and to participants in Getting Ahead classes. The questions were developed based on utilization of survey results in the last CHNA cycle. One question was multiple choice with the option to check all that apply and to add others. The second question was ranking of defined categories, and the third major question was open ended.

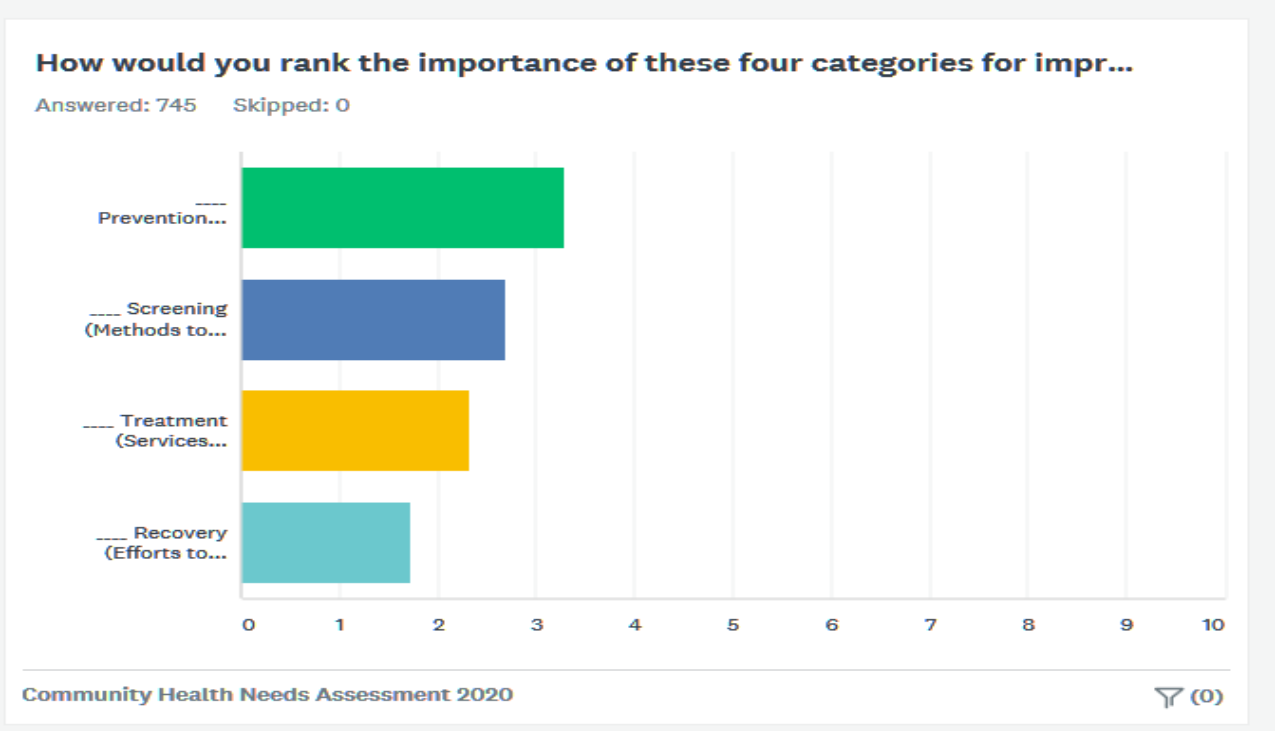
The survey questions were as follows:

- What are the causes of poor health in our community?
- How would you rank the importance of these four categories for improving health?
    - Prevention -Activities to avoid development of disease or disability such as: medical and dental check-ups, youth programs, social involvement, coaching, vaccines, access to health insurance, tobacco cessation, and education on healthy eating, sleep, physical activity
    - Screening -Methods to identify diseases and risks in the earliest stages, before the onset of signs and symptom such as: mammogram, blood pressure, cholesterol, PSA, eye exams, risk assessments for substance use, physical and mental health issues, and social needs assessment
    - Treatment -Services provided to help with a disease or disability such as self-management workshops, social activities, medication management, counseling, dialysis, chemotherapy, drug and alcohol treatment, holistic therapy, and physical/occupational therapy
    - Recovery -Efforts to increase the ability to cope such as housing, job training, social engagement, support groups, childcare, NA and AA meetings, and community education
- What services/resources are needed in our community?

Survey responses were received from 745 individuals. Respondents were also asked to provide Residence, Age, and Level of Education. A summary of the responses follows.




Seventy-eight percent of respondents felt poverty causes poor health in our community, followed by unemployment at 60% and 58% selecting health not being seen as a priority.

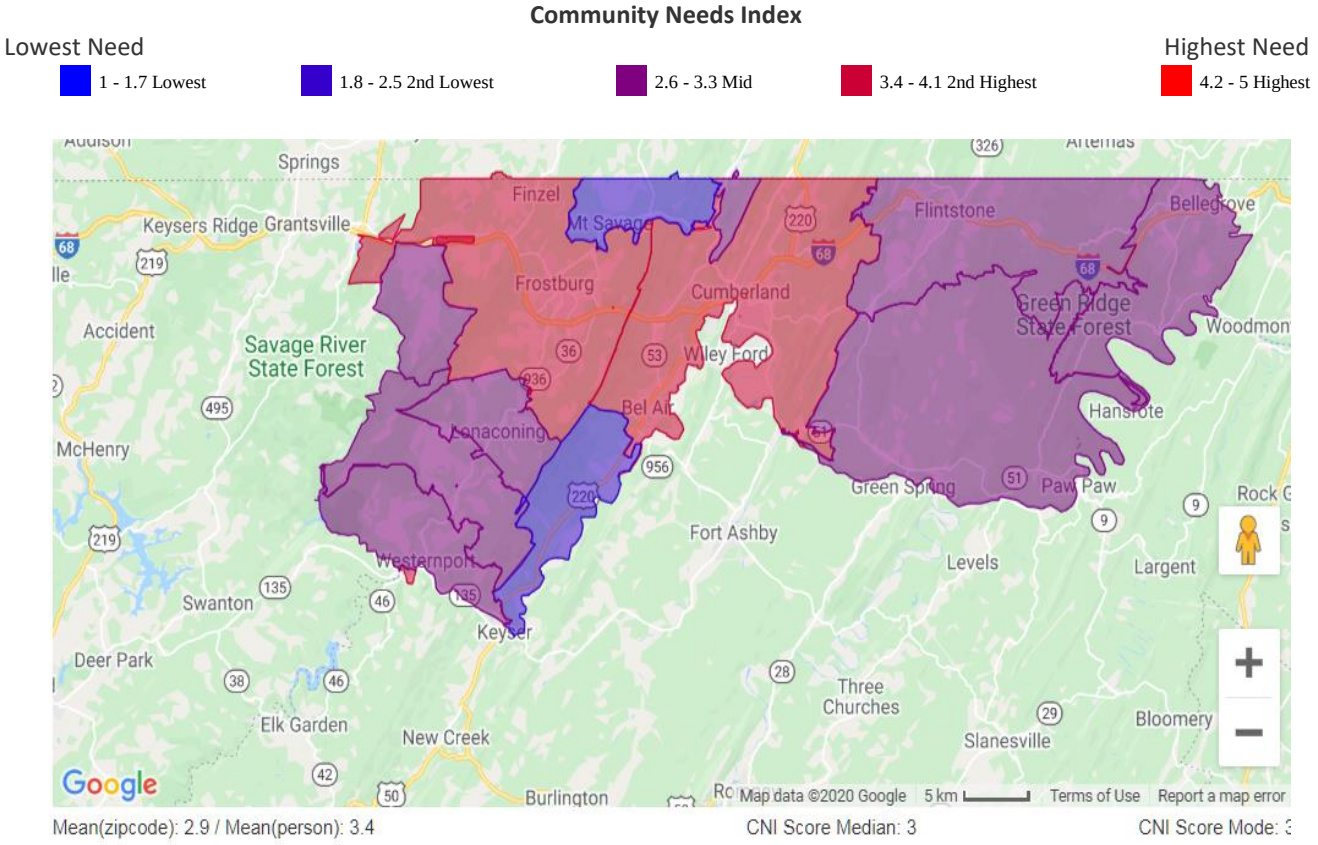



Key words were tagged in the open-ended responses and the tally of such can be found below.


There were no new resource or service needs identified through the community survey. The responses reinforced needs already noted.

Thirty nine percent of the respondents reported Cumberland as their place of residence and 18% noted a Frostburg residence. The remaining 43% were distributed through various locations in the county. Age distribution of respondents was in a bell curve with 25% being the largest age bracket (age 45-54). The level of education reported by respondents did not reflect the education level of the community overall. An exceeding number of college graduates responded to the survey. After doing a separation of the respondents by education level, there did not seem to be significant differences in the overall outcome.

To identify the highest overall need based on geography we looked at the Community Needs Index. The map below shows the Community Needs Index for Allegany County with the highest overall need in shades of red. The CNI scores for various zip codes are listed below the map




Mean(zipcode): 2.9 / Mean(person): 3.4 CNI Score Median: 3 CNI Score Mode: 3

| Zip Code | CNI Score | Population | City | County | State |
|---|---|---|---|---|---|
| 21502 | 3.6 | 42311 | Cumberland | Allegany | Maryland |
| 21521 | 3.2 | 1159 | Barton | Allegany | Maryland |
| 21529 | 3 | 517 | Ellerslie | Allegany | Maryland |
| 21530 | 3 | 1493 | Flintstone | Allegany | Maryland |
| 21532 | 3.4 | 15752 | Frostburg | Allegany | Maryland |
| 21539 | 3 | 2709 | Lonaconing | Allegany | Maryland |
| 21540 | 3.4 | 88 | Luke | Allegany | Maryland |
| 21545 | 2.2 | 2000 | Mount Savage | Allegany | Maryland |
| 21555 | 2.6 | 1777 | Oldtown | Allegany | Maryland |
| 21557 | 2.4 | 1791 | Rawlings | Allegany | Maryland |
| 21562 | 2.8 | 2779 | Westernport | Allegany | Maryland |
| 21766 | 2.6 | 656 | Little Orleans | Allegany | Maryland |

All community survey respondents that requested results were sent the summary and invited to participate in a community forum. If unable to attend the forum we invited respondents to submit written or verbal comments.

**Identification of Priorities**

Community Forum: Ranking Priorities – Criteria and Process

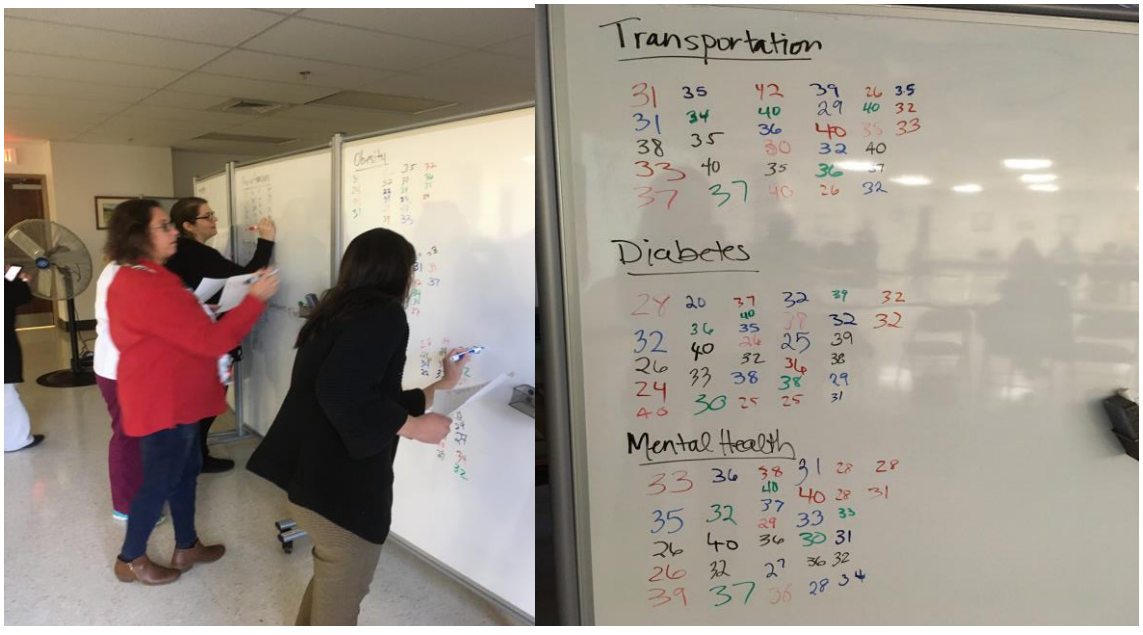
The data and survey results noted previously in this report were presented at a Community Forum on December 5, 2019. A total of 33 coalition partners, affiliates and members of the public participated. The presentation included a review of the following:

- Demographics
- Success and Opportunities for Improvement within Current Cycle
- Comparisons from 2011-2020
- County Health Ranking Trends
- Community Survey Results
- Next Steps

Based on discussions at prior Coalition and Workgroup meetings, there was a more focused assessment of need related to: transportation, diabetes, mental health, hypertension, access to care, poverty & social determinants of health, obesity, substance use, sepsis, and sexually transmitted infection. An assessment tool created by Kanawha County, WV was used to have participants score each of the need areas on a scale of 1-7 (with 7 being completely agree) regarding the following criteria:

- Problem is greater in Allegany County compared to State or region
- We can create an improvement in the quality of life by addressing this problem
- We can make progress on this problem in the short term (3 years)
- The progress we make over the 3 years can be sustained long term
- We can do something about this problem with existing leadership and resources
- We can reduce long term cost to the community by addressing this problem

After the participants rated the needs individually, their total scores for each need were collected. A total ranking score for each need was then calculated.



Participants discussed the needs in order of the total ranking scores. The priority areas were examined more closely regarding the criteria in the assessment tool, and existing community resources were noted. The table below provides a snapshot of the initial results and preferred actions.

| Priorities | Total Ranking Score | Priority Order | Selected Yes or No | Notes |
|---|---|---|---|---|
| **Transportation** | 1089 | 1 | yes | All agreed transportation was the top priority. |
| **Diabetes** | 1008 | 6 | no | State Plan will involve action focused on diabetes and Coalition will be engaged in creation of local diabetes plan. Action for other priorities will also impact diabetes. |
| **Mental Health** | 1022 | 5 | *Prevention | There was a desire to focus on mental health resources for youth and prevention with services supporting resilience. |
| **Hypertension** | 837 | 10 | No | It was felt that BP screenings, care of comorbidities, and Living with Hypertension workshops would address this need. |
| **Access to Care** | 1070 | 2 | no | The group agreed that access to care will be addressed by other root causes (SDOH). |
| **Poverty and SDOH** (food insecurity, housing, etc.) | 1061 | 3 | yes | All agreed poverty is a significant need. Focus on addressing the SDOH was recommended. Aspects noted: childcare, education, jobs, poverty, food and/or housing |
| **Obesity** (includes physical inactivity) | 990 | 7 | *Prevention | Majority felt obesity will be impacted by action for other priorities. Agreed to merge it with other prevention efforts targeting youth (healthy living) |
| **Substance Use** (opioids, alcohol, and tobacco) | 1027 | 4 | *Prevention | With the numerous community initiatives already underway related to substance use, the group felt the Coalition could do more with prevention, especially vaping. |
| **Sepsis** | 916 | 9 | no | WMHS has a committee that focuses on sepsis and can share updates and education with partners as appropriate. No additional action recommended. |
| **Sexually Transmitted Infection** | 932 | 8 | no | ACHD STI Clinic noted as resource for the small numbers. Will explore Title X services for county but not as part of action plan. |

The consensus at the close of the Forum was to develop a plan focused on the following priorities.

- Transportation
- Social Determinants of Health
- Prevention- Youth Risk Reduction

An offer was made to email a copy of the presentation slides to participants upon request. Copies of the data tables from which the presentation were compiled will be posted on the Coalition website as part of this report.

Needs not Addressed and Why

Through the Community Health Needs Assessment process, there were some community needs identified which will not be included in the Local Health Action Plan. The Coalition felt that many of these community needs were already being addressed by or planned to be addressed by other partnerships in the community. Some of these efforts are noted as a supporting strategy in the Local Health Action Plan. The reasons needs are not addressed in the LHAP are explained below.

- Diabetes: With the recent release of a Diabetes Action Plan by the State and several grant opportunities, there are efforts underway and being planned to address this need. In addition to the Center for Clinical Resources with diabetes as a focus area, there are self-management programs for both individuals with diabetes and people with prediabetes. There are also two grants underway that bring partners together to impact diabetes (Bridging the Gap-Merck, and SunLife Financial). These grants have produced positive outcomes. During this CHNA cycle, the county will need to create a local diabetes action plan that supports the State plan. The Coalition will oversee the local diabetes action plan, but it will be kept separate from the LHAP.

- Hypertension: Though not an identified priority in the plan, hypertension will be addressed through blood pressure screenings that are offered by the health system and various other partners. High blood pressure is also addressed as a risk factor in many education programs and is the focus of a workshop called Living With Hypertension. This workshop will be offered at least annually in the area.

- Access to Care: It was decided by the Coalition that access to care will be addressed indirectly by other root causes, including transportation and other social determinants of health.

- Sepsis; Though Septicemia continues to be the top inpatient discharge by APRDRG, the number has decreased since its peak in FY17. It is important to maintain a focus on sepsis so that the numbers do not increase. UPMC Western Maryland has a sepsis committee that will focus on this area and will share education with partners as appropriate.

- Sexually Transmitted Infections: Though the number of chlamydia cases per 100,000 population have a negative trend, the percentage of change has been negative in the last two years. The rate of gonorrhea cases has had a 36.7% increase in the last two years, but the number of cases is low (41). Substance abuse was felt to be a major contributing factor for the increase in STI, and the services available through ACHD STI Clinic could address the need. It was noted that there is no longer Title X Family Planning in the county, and this should be explored.

Obesity and substance abuse will be addressed as part of the Prevention-Youth Risk Reduction priority area and include healthy living. The Social Determinants of Health priority will address the root cause of poverty. Though food, housing, childcare, education and employment were all mentioned at the Forum, the Coalition agreed to start with a focus on food and home/community safety, then proceed to the other areas as feasible in later years.

Priorities into Plan

Results from the Community Forum were reviewed at the following Coalition meeting and additional clarification was obtained. A compilation of the discussions at the Coalition meeting were reviewed by the Workgroup. The Local Health Action Plan Workgroup was then tasked with drafting a plan based on these priorities and discussion of community capacity, feasibility, impact, existing resources, and root causes.

It was agreed that SHIP metrics would be incorporated as outcome measures where appropriate. For each priority area the focus was defined, and potential outcome measures identified. Connections to County United Way's Strategy Map were also discussed.

For transportation, it was felt that the Coalition could help with education of options and changes, as well as address the reverse transport options including delivery services, telemonitoring and more. Outcomes would link to the primary transportation survey and look at not only % of missed appointments but also % unable to get groceries.

For social determinants of health, it was agreed to focus on increasing access to healthy food sources. There was some concern about the food insecurity outcome and whether it addressed only the income side of access. Additional review revealed that the metric also includes ability to provide balanced meals. Though housing was an important issue, the group was uncertain about what role the Coalition can play. It was also known that a comprehensive housing survey is underway in the county and next steps might best be decided after hearing the results. The final decision was to focus on home and community safety including security and fire. Additional input will be requested from the Coalition.

For prevention youth risk reduction, the group proposed education regarding stigma and prevention. It was also suggested to offer mind body skills groups and opportunities to connect youth outside of school. Select YRBS data were recommended as outcome metrics for the plan.

To address the changes in mortality and life expectancy seen in the non-Hispanic Black population, discussions were scheduled with the local NAACP. An infographic of Non-Hispanic Black Health Disparities in Maryland was circulated and will be shared at the NAACP meeting along with the data from the CHNA.

In February, a draft plan was shared with the Population Health Council at UPMC Western Maryland and a few edits were recommended; mainly adding to the responsible parties. Through April, the draft plan will continue to be revised by the Coalition and Workgroup. Once the Coalition approves the plan it processed through UPMC Western Maryland Population Health Council and Strategic Planning to the WMHS Board of Directors for input and approval by June 2020. A final draft of the plan can be found in the Appendix and the approved plan will be posted to the Coalition website. Implementation will occur starting July 1, 2020 and extend through June 30, 2023.

**Collaborative Plan of Action**

<u>Available Resources to Address Needs</u>

Strong partnerships exist in Allegany County to address community health needs. Organizations are working together to implement a variety of strategies. UPMC Western Maryland (previously Western Maryland Health System) provides a continuum of care. Service includes acute care, a Center for Clinical Resources focused on the individuals with multiple chronic conditions, community health and wellness, clinical prevention, care coordination, home care, Community Health Workers, and provider recruitment. With a focus on value-based care it has a vested interest in population health and prevention. UPMC Western Maryland and several community partners participate in the Regional Transformation Grant with Trivergent Health Alliance. During the last three years this effort has increased the regional focus on complex care and behavioral health case management.

The Allegany County Health Department provides screening and prevention programs, care coordination, WIC, inpatient and outpatient behavioral health services, mental health care management, dental services, public health emergency preparedness, and food and water protection. The health department continues to host the

*Prescribe Change* campaign with a mission to create awareness and educate the citizens of Allegany County about the growing crisis of opioid prescription drugs, and heroin misuse and abuse in our community. In addition to this community outreach, ACHD offers provider education regarding the Prescription Drug Monitoring Program.

In addition to the lead agencies, there are a variety of organizations that collaborate to build resources and improve the overall health of Allegany County. The Maryland Area Health Education Center West (AHEC West) facilitates continuing education and training for health professionals, supports clinical education, facilitates interprofessional experiences, provides community health workers and is a partner of Maryland Health Connection. The Human Resources Development Commission (HRDC) a community action agency provides services for all ages and targets low income populations. HRDC oversees Head Start and the Senior Centers, as well as several assistance programs (transportation, energy assistance, food, etc.). Allegany College of Maryland and Frostburg State University train local health care providers in nursing, psychology, dental hygiene, respiratory therapy, and other areas and support continuing education for health care professionals. The Coalition engages two federally qualified health centers, a few healthcare providers, numerous non-profits, managed care organizations, and other entities providing direct care or addressing the social determinants of health.

The Allegany County Health Planning Coalition continues to build upon the various workgroups that come together to address specific needs in the community. Examples include: Tobacco Free Coalition, Opioid and Overdose Prevention Task Force, Transportation Committee and Bridges to Opportunity. Launched in 2014, *Bridges to Opportunity* is a community initiative to reduce poverty by helping individuals and the community 'get ahead' through relationships and resources. Through outreach and poverty simulations, Bridges to Opportunity has brought together people from various classes to discuss identified barriers and potential strategies to address the social determinants of health.

The Allegany County Health Planning Coalition has pursued and received several grants collectively. With funding from the Maryland Community Health Resources Commission, the Coalition launched Healthy Allegany which included Community Health Worker training and community outreach, a mobility manager and transportation vouchers, cultural competency trainings, as well as efforts to strengthen the Coalition. A comprehensive community resource guide was compiled in 2013 and annual updates were made until the online resource directory replaced it in 2019 (Path2Help.com). In addition to this public facing directory, several of the partners are connected to the expanded online platform- Aunt Bertha and can use it for closed loop referrals.

The Memorandum of Understanding (MOU) was updated this year as part of this CHNA cycle. We continue to insure representation from the following sectors of the community: media, housing, law enforcement, economic development, physical and behavioral health providers, and case management. Some members are more engaged than others. The Coalition continues to reach out to new community members to represent additional sectors and populations. As of January 2020, there are 52 agencies/organizations signed on to support the Coalition mission of healthy lifestyles through collaborative partnerships, evidence-based practices and personal commitments. The Coalition Membership can be found in the Appendix.

As we develop a plan to address the new priorities, we are also identifying available resources. When appropriate the Coalition will guide action with partners, and other times the Coalition will monitor existing resources as a supporting strategy in the plan.

The following are the assets identified to date:

- The Transportation Committee was reactivated this year and involves numerous partners. It was determined their efforts will be a supporting strategy in the plan. The Committee will also be asked for input on the education component in the plan.

- Through efforts to address poverty, the community has increased food resources to include: Groceries to Go, Brown Bag Program, Emergency Food Packs, Discharge Meal Program, Food Farmacy, Veggie Van, and school nutrition programs by UM Extension.

- Several initiatives are underway or in the planning stage which will support the Prevention and Youth Risk Reduction priority. Allegany College of Maryland received a grant from the Maryland Opioid Operational Command Center to bring training from the Center for Mind-Body Medicine to our community. The grant will fund the CMBM Professional & Advanced training for 150 participants. Upon completion of the Advanced Training, participants are committed to facilitate Mind-Body Skills group and information workshops in the community. The goal is to reach 2,000 individuals with the groups and workshops. Several of these groups will target youth.

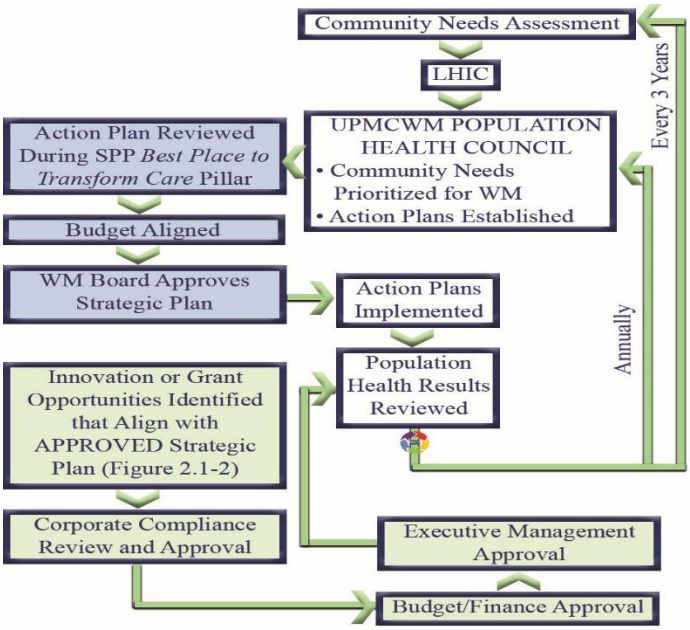
- The Local Management Board has spearheaded efforts to expand training in Trauma Informed Care and has applied to get staff trained in Family Functional Therapy. These are both supporting strategies to the plan.

- The County United Way Impact Grant Strategy Map includes many of the same priorities as the LHAP. As they progress with grant selection and implementation, we will be able to identify potential connections.

- The NAACP is a member of the Coalition. With the negative changes in the mortality rate and life expectancy for black residents, it is anticipated that this group will be engaged more in developing strategies.

Link to Community Benefit

In addition to collaborating with public health entities on the Community Health Needs Assessment, hospitals are encouraged to align their community benefit operation in some way with the implementation strategies selected to address priority needs. UPMC Western Maryland does this by sharing the data collected as part of the Community Health Needs Assessment with its Population Health Council.




Community Support Process

The Population Health Council reviews the findings to identify key opportunities for involvement of UPMC Western Maryland internally and with the Local Health Improvement Coalition (LHIC) regarding the community. As a cycle of learning, these opportunities are then considered in the strategic planning process. Once priorities, plans and metrics are approved and aligned with the budget process, the CHNA and implementation plan are presented to the Board for approval, then implemented, tracked and measured.

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The following are some of the strategic objectives for 2018-2020 in the UPMC Western Maryland Strategic Plan that have a connection to the Coalition's Local Health Action Plan.

- Improve health status and social determinants of health
- Expand pre-hospitalization and post-acute care services to reduce utilization
- Transform care delivery models

One example of this process is UPMC Western Maryland utilizing the findings from Aunt Bertha (on-line closed loop referral network), Voice of Customer, secondary data, and the community survey to identify food insecurity and transportation as significant needs in our community. Realizing that the health system cannot combat these needs alone, we applied a ecosystems approach to clarify the needs and processes, align stakeholders and build strategies to address social needs in a complex system. We are leading an initiative with community partners to map the existing food resources, streamline the intake process, identify gaps and opportunities for increased efficiency in the food system, and to establish a collective approach to address food insecurity. Through the local health action planning process additional strategies will be defined for addressing the priority needs.

Alignment of activities and investments to improve population health is essential. Through common measures the impact of collaborative efforts can be evaluated. With the UPMC Western Maryland Director of Community Wellness serving as co-chair of the Local Health Improvement Coalition, and coordinator of the hospital's community benefit reporting the process is coordinated. Progress on strategies in the Local Health Action Plan will be tracked and reported to the HSCRC and IRS as required, noting the specific role of UPMC Western Maryland.

<u>Hospital Role</u>

In addition to the role UPMC Western Maryland plays in coordination of the CHNA and implementation strategy with the Allegany County Health Planning Coalition, it takes on responsibility for numerous activities within the plan. UPMC Western Maryland currently plays a significant role in addressing social determinants of health and will continue to do so in the next CHNA cycle. It also has an interest in prevention and improving population health.

The following is a list of the roles and functions that UPMC Western Maryland will assume with the new plan.

Transportation:

- Facilitate the Transportation Committee advocating for improved coordination of services
- Partner in Mobility Management and fund additional transportation support for patients
- Provide transportation education
- Maintain relationships with numerous transportation providers to help patients with access
- Guide exploration of delivery services and reverse transportation options

Social Determinants of Health:

- Oversee the workgroups creating food systems maps and solutions
- Support establishment of more healthy food sources in the community
- Coordinate development of education and assessment process to improve home and community safety
- Assist with locating funds to support needed resources to address safety issues
- Continue to serve as the anchor institution for Bridges to Opportunity and strive to build resources
- Host Aunt Bertha and Path2Help and engage Community Health Workers and Care Coordination in addressing social needs of patients



Prevention- Youth Risk Reduction:

- Implement mind body skills groups and workshops collaboratively via ACM
- Share in the schools the expertise of respiratory staff regarding vaping
- Organize cross sector forums on risk behaviors and prevention strategies
- Identify and implement a program to increase healthy choices which will reduce obesity

UPMC Western Maryland will also communicate with NAACP and County United Way to insure integration of efforts.

Summary of Plan Development and Approval Process

As stated in the County Health Ranking process, "evidence of effectiveness is one of many factors to consider when choosing a strategy to solve a community health challenge. Community 'fit,' readiness, priorities, capacity, and resources are also important considerations." Starting with the Community Forum and several of the Coalition and Workgroup meetings that followed, existing strategies and recommended practices to address the priority needs were explored.

The LHAP Workgroup compiled the various data points and information noted throughout this report and identified best practices both underway in the community and those which may contribute to achievement of the goals and address the priority needs. For each objective a lead partner is identified and assumes responsibility to implement and monitor activities with the key partners.

Progress reports are given at least every six months and the outcomes are reviewed annually. As issues arise or innovative solutions are identified, the LHAP Workgroup reviews the information and presents it to the Coalition for discussion and decision. At least one a year, the Allegany County Health Planning Coalition updates the data in the Community Health Needs Assessment, incorporates new or changing needs, and alters the Local Health Action Plan as appropriate.

A final draft of the Local Health Action Plan is included in the Appendix. By June 30, 2020, the approved Plan will be posted to the Allegany County Health Planning Coalition website at www.alleganyhealthplanningcoalition.com. For questions, please contact one of the Allegany County Health Planning Coalition Co-Chairs, Jenelle Mayer at 301-759-5001 or Nancy Forlifer at 240-964-8422.

# Appendix

Allegany County Health Planning Coalition
Community Health Needs Assessment FY20
**Measures for Review**

| Measures | Allegany Co | Why is this measure a concern? | Source |
|---|---|---|---|
| Sexually Transmitted Infections Chlamydia cases / Population * 100,000 | 336.4 | • Continuing Increase in County (236, 262,325.6, 336.4)<br>• See trend chart<br>• Chlamydia rate 24.7% increase between 2018 and 2019 (20 cases) | County Health Ranking 2019 |
| Substance exposed newborns | 16.8% of deliveries | • About the same number of cases at WMHS<br>• 161 substance exposed newborns of which 40 were dependent | WMHS CY18 |
| Physically Active Adults (self-report 150/75 minutes.wk) | 46.1% | • (2011 -52.2%,41.2%-2014, 46.1%-2017)<br>• Below state and nation levels<br>• Adult obesity rate is getting worse<br>• CHR 27% of adults physically inactive compared to 21% MD | SHIP |
| Child Maltreatment rate- Number of total indicated findings for physical and sexual abuse, mental injury-abuse, neglect, and mental injury-neglect among children, rate per 1000 >18yrs | 19.6 | • Baseline was 23.3, last year 21.1 and now 19.6<br>• Does anecdotal data reflect the same? | SHIP |
| Domestic Violence- Number of domestic violence crimes per 100,000 | 653.5 | • Increasing after dropping a couple years (719.5, 608.6, 610,653.5) | SHIP |
| ED visits for diabetes primary diagnosis per 100,000 population | 286.1 | • Trending in wrong direction-2010 (185.2) 2017-286.1<br>• Above State at 243.7 | SHIP (2017) |
| ED visits for mental health related diagnosis per 100,000 population | 3309.6 | • Decrease from last year (2320.6, 4722.9, 3309.6) still above baseline<br>• Current measure does not include addiction related visits | SHIP |
| Teen Birth rate -ages 15-19 years (per 1,000 population | 23.5 | • Trending downward in County (31.8 – 2010)<br>• Above MD at 14.2 | SHIP (2017) |
| % students ever using e-vapor products | 27.1% middle school<br>55.4% high school | • Above state in use of e-vapor products<br>• More than double the Healthy People target (21%) in high school<br>• Increased since last local survey-18.4% middle school 48.7% high school | YBRS2018<br>SHIP |
| % FSU students have tried e-cigs at least once<br><br>% FSU students using e-cigs in last 30 days | 23.1%<br><br>14% | • MD Survey adds that 28% of alcohol or marijuana users indicate using e-cigs in last 30 days.<br>• 51% of past year marijuana users indicate using e-cigs as method to consume THC | 2019 American College Health Asst.<br><br>2019 Md College Survey |
| Alcohol Impaired Driving Deaths - Percentage of driving deaths with alcohol involvement | 48% | • Negative Trend in County (29,34,44. 39,56,48)<br>• MD 30% and top performers in US 13% | County Health Ranking |

| Measures | Allegany Co | Why is this measure a concern? | Source |
|---|---|---|---|
| Food insecurity -% population who lack access to adequate food | 13.0% | • 29.8% County population without access to large grocery store, (MD, US and Peer Groups- 22%)<br>• MD 11% food insecure, of this group 69% below SNAP threshold<br>• Percentage of population who are low-income and do not live close to a grocery store 13% in county and 3% for MD<br>• With 10 as best Food Environment Index, County score has improved from 6.4 to 7.3, still below state at 9.1 | County Health Ranking 2019 US News Civic Ranking |
| Sepsis-number of inpatient discharges with primary diagnosis | 863 | • Septicemia was top reason for inpatient discharges in FY19<br>• Had decreased to 692 last year, now going back up, still below baseline 1050 | WMHS FY19 |
| Diabetes Prevalence-Percentage of adults aged 20 and above with diagnosed diabetes. | 15% | • MD-11% and top US performers 9% | County Health Ranking 2019 |
| Adult Obesity (over age 20, BMI 30 and over | 38% | • MD- 30% and top US performers 26% | County Health Ranking 2019 |
| Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 15% | • MD at 17% and top US performers at 9%<br>• Majority due to cost, 14% of county population (3606 households) spends more than 50% of income on housing, MD 15% and top US at 7%<br>• 69% homeownership in county, MD at 67% | County Health Ranking 2019 |
| Primary Care Doctor Availability/100K pop. | 52.7% | • MD-87.7%, US-75.6%, Peer Group 58.3%<br>• Reflects the PCP ratio in County Health Rankings | US News Civic Ranking |
| Deaths of Despair | 46.7% | • MD-32%, US 36% and Peer Group 42.1%<br>• Poor Mental Health days increase in County (4.3) compared to 3.5 in MD, 3.8 in US and 4.2 in Peer Group | US News Civic Ranking |
| Percentage of students entering Kindergarten ready to learn | 39% | • 45% MD | SHIP 2017 |
| Age adjusted Cancer mortality rate | 164.8 | • Above MD at 154.5 and MD is above the US rate | SHIP (2015-17) |

**Assessment and Ranking Tool**

| Scale:<br>1=Completely Disagree<br>2=Strongly Disagree<br>3=Disagree<br>4=Neither Agree nor Disagree<br>5=Agree<br>6=Strongly Agree<br>7=Completely Agree | Problem is greater in Allegany County compared to state or region | We can create an improvement in the quality of life by addressing this problem | We can make progress on this problem in the short term (3 years) | The progress we make over the 3 years can be sustained long term | We can do something about this problem with existing leadership and resources | We can reduce long-term cost to the community by addressing this problem | TOTAL |
|---|---|---|---|---|---|---|---|
| Transportation | | | | | | | |
| Diabetes | | | | | | | |
| Mental Health | | | | | | | |
| Hypertension | | | | | | | |
| Access to Care | | | | | | | |
| Poverty and SDOH (food insecurity, housing, etc.) | | | | | | | |
| Obesity (includes physical inactivity) | | | | | | | |
| Substance Use (opioids, alcohol, and tobacco) | | | | | | | |
| Sepsis | | | | | | | |
| Sexually Transmitted Infection | | | | | | | |

Source: Kanawha County

Based on the results of a community health needs assessment, the Allegany County Health Planning Coalition (Coalition) created the following Local Health Action Plan (LHAP) to improve health and wellbeing in Allegany County. The Coalition is charged with implementing the LHAP, measuring progress, and building on best practices already in use in the community. The LHAP addresses three priority areas:

Transportation

Social Determinants of Health

Prevention- Youth Risk Reduction

Each priority area includes goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The LHAP is a three-year plan and progress is reviewed in six-month phases: Phase 1 is July-December 2020, Phase 2 is January-June 2021, Phase 3 is July-December 2021, Phase 4 is January-June 2022, Phase 5 is July-December 2022, Phase 6 is January-June 2023. The LHAP also includes supporting strategies which are underway in the community and may contribute to the achievement of LHAP goals and outcomes but are not overseen by the Coalition. The LHAP works to build upon, and not duplicate, existing community health improvement efforts.

*Acronyms and Abbreviations*

ACHD = Allegany County Health Department
AHEC = Area Health Education Center
AHR = Allegany Health Right
Assoc. Ch. = Associated Charities
Bd of Ed = Board of Education
CHW = Community Health Worker
CMA = Cumberland Interfaith Ministerial Association
CUW = County United Way
DSS = Department of Social Services
ED = Emergency Department
FCRC = Family Crisis Resource Center
FTE = Full-time Equivalent
FVC = Family Violence Council
HRDC = Human Resources Development Commission
LMB = Local Management Board
MH = Mental Health
MHA = Mountain Health Alliance
MHCE = Make Healthy Choices Easy
MHSO = Mental Health System's Office
OB= Obstetrics
PCP = Primary Care Provider
TSCHC = Tri-State Community Health Center
TSWHC =Tri State Women's Health Center
UM = University of Maryland
WMd = Western Maryland
WMHS = Western Maryland Health System now UPMC Western Maryland

**Transportation**

| GOAL | SMART OBJECTIVE | WHO | OUTCOMES | BASELINE | TARGET | CURRENT STATUS |
|---|---|---|---|---|---|---|
| Increase access to safe, affordable and reliable transportation | Each year of this cycle educate at least 100 transportation users or service providers about the transportation options and system changes.<br><br>Each year of this cycle identify existing transportation alternatives (including delivery services and reverse transport options) and seek at least one new option to reduce the transportation barrier. | **Transportation Committee,** UPMC WMd<br>Mobility Mgmt.- HRDC<br>Med Trans- NEMT<br>ACHD or Statewide vendor, All Trans-<br>County Transit<br>Taxi (Crown, Yellow, QCity)<br>County Medical Transport,<br>Bay Runner<br>Garrett Transit<br>Mineral County - Logisticare, PVTA<br>CUW, Communities for Life, Service Providers | Reduce % of respondents missing medical appointments due to transportation<br><br>Reduce % of respondents not getting to grocery store | 25<br><br>14 grocery<br>6 foodbank | 10<br><br>12 total | 19<br><br>14 grocery<br>6 foodbank |

**Supporting Strategies**

Transportation Committee-

- One Call One Click-shared system (Trip Master- CTS Software) for scheduling and tracking rides
- Linking of dispatch services
- Streamline the rules across services Planned coordination of transports to outlying areas
- Coordination of rides during off hours cross agency
- Collaborate on grants for transportation
- Increased education for users and staff assisting people with transportation
- Establishment of Express Loops with certain days and routes- use geo- mapping of historic use rides

**Social Determinants of Health**

| GOAL | SMART OBJECTIVE | WHO | OUTCOMES | BASELINE | TARGET | CURRENT STATUS |
|---|---|---|---|---|---|---|
| Increase access to healthy foods and local food sources | Utilize information obtained through food system mapping to identify and establish 5 sites per cycle year where healthy food choices or local food sources will be increased. | Bridges to Opportunity-poverty SunLife Partners- Aramark, WMFC, food bank, ACM, AHEC, As. Ch, HRDC, **UPMC W MD**., UM Ext., FSU, ACHD, Funders-CareFirst, Singer, etc. | % population who lack access to adequate food (CHR) | 12 | 9 | 13 |
| Improve home and community safety (fire, security, safety) | Each year of cycle provide education and assessment process focused on improving home and community safety for 100 or more people.<br><br>By June 2023, assess and assist 100 individuals with home or community safety need | Cumberland Housing Authority and Alliance, HRDC, ACHD, Law Enforcement and Fire Dept. Home Care and CHW, FSU, AHEC **Committee-** Brittany, Julie, Heather, Allison | Reduce # of poor mental health days (CHR) | 4.7 | 3.8 | 4.7 |

**Supporting Strategies**

SunLife Partners- Food Insecurity- Systems mapping and identification of key strategies to overcome the gaps and increase efficiency
WMHS- Food Farmacy

County United Way -Safe, Affordable Housing: Everyone deserves home with basic amenities- space, heat/cooling, water/sewer, secure roof and safe entry
Bridges to Opportunity- Home sharing

**Prevention- Risk Reduction Youth**

| GOAL | SMART OBJECTIVE | WHO | OUTCOMES | BASELINE | TARGET | CURRENT STATUS |
|---|---|---|---|---|---|---|
| Improve the mental and physical health of youth through prevention and risk reduction focused on substance use (vaping), mental health (resilience), and healthy living (obesity-nutrition and physical activity). | By June 2023, engage 500 or more youth in mind body skills groups and targeted prevention programs in the community<br><br>Each cycle year host at least 3 cross sector forums regarding identified risk behaviors of youth and potential prevention strategies for our community (such as-stigma-Distorted Perception, vaping-Don Swogger, family needs and trauma informed care- Family First). | ACHD and Frostburg Coalition- Vaping-Don Swogger<br>ACPS, ACHD, LMB, DJS- Youth Mental Health<br>**ACM**- CMBM-healthy living<br>**UPMC W MD**--Wellness and Resp. Dept healthy living<br>AHEC<br>Families First<br>Family Junction, 4H<br>UMExt- MDROTA.org | % students ever using e-vapor products YRBS -2018<br><br>% students ever seriously thought about killing self YRBS<br><br>% students not physically active 60 min. 5 or more days/wk. YRBS<br><br>% elementary public school students with BMI at 95th percentile or above | 27.1 ms<br>55.4 hs<br><br>22.3 ms<br>20.5 hs<br><br>41.9 ms<br>72.9 hs<br><br>20 | 25.1 ms<br>53.4 hs<br><br>21.3 ms<br>19 hs<br><br>39 ms<br>49 hs<br><br>13.6 | 27.1 ms<br>55.4 hs<br><br>22.3 ms<br>20.5 hs<br><br>41.9 ms<br>72.9 hs<br><br>21.2 |

**Supporting Strategies**

ACPS- Vaping addressed in all school levels

LMB-Trauma Educational series and FFT Multisystemic Therapy (DJS)

County United Way- Impact Grant- Strategy Map

- Prevent ACEs from contributing to life-long outcomes for current and future generations
- Provide trauma-informed care and accessible evidence-based treatments from trained and knowledgeable specialists
- Ensure a continuum of services exist to meet behavioral health needs

**Other Supporting Strategies**



Eliminate Health Disparities – NAACP, County United Way,

**Allegany County Health Planning Coalition Membership List**

| Name of Organization/Group | Sector | Contact |
|---|---|---|
| Allegany County Health Department | Public Health | Jenelle Mayer (Health Officer)<br>Jennifer Corder (Medical Director)<br>Brenda Caldwell (Preparedness/Website)<br>Lynn Kane (Accreditation)<br>Tricia Evix (WIC/Nutrition)<br>Paula McKenzie (Cancer)<br>Lisa Beardsley (MedTrans)<br>Margaret Wright<br>Catherine Parish<br>Leann Frank<br>Trish Tichnell |
| Western Maryland Health System | Non-profit Hospital | Nancy Forlifer (Director Community Wellness)<br>Jo Wilson (VP Population Health)<br>Ben Kosewski |
| Tri-State Community Health Center | FQHC | Mandy Blackburn (Site Manager)<br>Susan Walter (CEO)<br>Sheila DeShong (COO)<br>Ashley Barnes (Case Mgr.-Women's Health) |
| AHEC West | Non-profit<br>Health Education | Susan Stewart (Exec. Director) |
| Allegany Human Resource Development Comm. | Community Action | Wendolyn McKenzie |
| County United Way | Community<br>Development | Michele Walker<br>Juli McCoy |
| Allegany Board of Education | Education | Kim Green (Administration)<br>Tracey Leonard (Health & PE) |
| Allegany Radio | Media | Annette Wolford<br>Patrick Sullivan |
| Cumberland Housing Alliance | Housing | Jaime Thomas<br>Steve Kesner (CEO) |
| Allegany Chamber of Commerce | Economic<br>Development | Stu Czapski (Executive Director) |
| Chapman & Associates | Medical Provider | Cathy Chapman (CRNP) |
| Mountain Laurel Medical Center | FQHC | Sandra Moore<br>Jonathan Dayton |

| Name of Organization/Group | Sector | Contact |
|---|---|---|
| Pressley Ridge | BH Provider | Mary Beth DeMartino (Executive Director) |
| Allegany County Sheriff's Office | Law Enforcement | Craig Robertson (Sheriff) |
| Office of Consumer Advocate | Behavioral Health | Margaret Paul (Executive Director) |
| Salvation Army | Non-profit | Ronnette Smith (Administration)<br>Karen Wells (Social Worker) |
| YMCA | Non-profit | Julie O'Neal (CEO) |
| Western MD Food Bank | Non-profit- Food | Amy Moyer (Executive Director) |
| Local Management Board | Non-profit | Renee Kniseley (Executive Director) |
| Cumberland Area Interfaith Ministerial Association | Faith Based | Rebecca Vardiman (President) |
| Aetna | MCO | Sarah Bush |
| NAACP | Non-profit | Carmen Jackson (President) |
| University of MD Extension | Higher Education | Lisa McCoy |
| Maryland Physicians Care | MCO | Shannon Jones<br>Christie Staubs |
| Priority Partners | MCO | Lisa Moran |
| Allegany College of Maryland | Higher Education | Kathy Condor |
| Allegany Transit | County-Transportation | Elizabeth Robison-Harper |
| Friends Aware | Non-profit- Human Service | Robert Godfrey |
| Allegany County Dept. Social Services | County Social Service | Courtney Thomas (Director)<br>Kim Truly |
| Associated Charities | Non-profit-Prescription & Emergency Svs | Deanna Clark (Executive Director) |
| ---- | Pharmacies | Bill McKay |
| Drug Abuse Alcohol Council | Coordinating Entity | Kathy Dudley |
| Tobacco Free Coalition | Prevention Coordinating Entity | Kathy Dudley |
| Family Junction | Non-profit | Melanie McDonald |
| Frostburg State University | Higher Education | Doug Brown (PA Medicine) |
| Board of Health | County Govt. | Jacob Shade |

| Name of Organization/Group | Sector | Contact |
|---|---|---|
| Park and Recreation Department | City Govt. | Diane Johnson |
| Mental Health Advisory Board | Coordinating Entity | Becki Clark |
| Family Crisis Resource Center | Non-profit | Sarah Kaiser |
| Tri County Council | Regional Coor. transportation | Ryan Davis |
| Dental Society | Dental Profession | Dorian Birkholz<br>Diane Romaine |
| Opioid and Overdose Prevention Task Force | Coordinating Entity | Becky Meyers |
| Western Maryland Food Council | Coordinating Entity | Dan Fiscus |
| Mountain Health Alliance | Coordinating Entity | Catie Wampole |
| Western Maryland Health Connection | Insurance | David Stewart<br>Carol Morgan |
| Homeless Resource Board | Coordinating Entity | David Nedved |
| Workforce Development | Workforce, Govt. | Matt Shipway |
| Jane's Place | Child Protection, Non-profit | Shannon Frankenberry<br>Alexis Jackson |
| Archway Station | Non-profit | Jim Raley |
| SurgCenter of Western Maryland, LLC | Provider | Raghu Reddy |
| Apples for Children | Childcare | Heather Glass |
| Hororwitz Center for Health Literacy, University of MD | Health Literacy | Anna Shao, MPH, CHES |
| Community Trust Foundation | Funder | Leah Shaffer |