VOLUME 1, ISSUE 3

GARRETT COUNTY HEALTH DEPARTMENT

COMMUNITY HEALTH IMPROVEMENT PLAN

GARRETT COUNTY

2020

Garrett County, a healthier place to live, work, and play!

TABLE OF CONTENTS

WELCOME!

Garrett County, a healthier place to live, work, and play!

Congratulations! Our community has crafted the very first digitally responsive Community Health Improvement Plan. Creating a vision for our county and incrementally measuring our progress toward the goals we set together has created a true culture of collaboration in Garrett County. The Robert Wood Johnson Foundation recognized our efforts and has awarded Garrett County as one of the culture of health prize winners for 2017. Way to go, Garrett County!

What does this mean for you? As a community, we are addressing social risk factors that determine health in a systematic and collaborative way, ultimately leading to better health outcomes for the citizens of Garrett County.

"Our goal is to foster innovation to improve health outcomes in Garrett County."

- Bob Stephens M.S., Health Officer

This innovative new approach in public health engages the community utilizing the digital platform found at mygarrettcounty.com, which has achieved unprecedented success and dramatically increased equity!

This plan reflects your ideas, concerns, and solutions. Community feedback on such a large scale has informed measure development and prioritization, marking an important step toward ensuring that measures reflect what is most important in the daily lives of our community stakeholders.

Shelley Argabrite M.A.

Garrett County Strategic Health Planner, Author
Garrett County Health Department

Johnathon Corbin

Public Affairs Specialist/Informatician
Garrett County Health Department

HOW IT WORKS

A Data-Driven Approach to Population Health

While Garrett County, Maryland has a long established record of excellence in collaboration, the innovative and transformational community health improvement planning processes found at mygarrettcounty.com, and summarized in this document, demonstrates our greatest commitment yet toward measuring the improvements in local health outcomes for stakeholders in our community.

This innovative process originated out of the need to increase representation, improve stakeholder engagement, and create opportunities for equity to flourish. This journey began through analysis of the Garrett County 2016 Community Health Assessment, which identified four broad focus areas for our community, based on the data collected: **behavioral health** (including substance related disorders and mental health), **chronic diseases** (prioritizing modifiable risk factors, such as physical activity, nutrition, and tobacco use), **access to care and community linkages**, and **maternal, child, and adolescent health** (later revised to incorporate comprehensive family health, regardless of familial structure). While these focus areas initially guided our framework for mygarrettcounty.com, many additional community-driven insights, especially within the domain of the **social determinants of health** (also referred to as social risk factors), emerged through open and transparent digital discussions, and have gained popularity as matters of importance that are actively addressed with measurable strategies in this version of the Community Health Improvement Plan.

This transformational process offers a beacon of hope for our community's most vulnerable residents as it seeks to engage nontraditional, multisectoral partners at an unprecedented scale and works toward establishing baselines for the most vital programs, initiatives, and systems changes that ensure healthy, thriving communities.

Furthermore, this plan is the first-of-its-kind to be driven by hyper local data, collected and reported within and by our community, that is timely, actionable, specialized, attributable, and collective to ensure validity and understand interoperational connectivity. This transformational approach is the most comprehensive pivot toward data-driven decision making that our community has ever employed, and offers incalculable opportunities for collaborative strategies that seek to not only improve, but transform health outcomes for all who live, work, and play in Garrett County, Maryland.

PROJECT TIMELINE

Oct. '16	Innovative Health Planning Collaborative Developed
Nov. '16	Initial BETA Launch of the Garrett County Planning Tool (GCPT) to Primary Stakeholders
Dec. '16	Widespread Community Launch of GCPT
Feb. '17	Peak Growth Phase as Nontraditional Community Stakeholders are Onboarded
June '17	Measurement Framework Process Begins and the GCPT Achieves National Status as Innovative Practice with Funding from PHNCI & RWJF
Sep. '17	Rural Data Infrastructure Planning
March '18	CHIP Dash Launched and Document Published
April '18	Integrated Population Health Implementation

INNOVATION VISION

The *BIG* Picture

The Garrett County Planning Tool, found at mygarrettcounty.com, was created with the intention to guide our community as we built a local, data-informed vision from our current needs by meaningfully and transparently engaging all residents.

This vision becomes actionable through the planning tool framework providing the platform for the creation of a comprehensive and responsive Community Health Improvement Plan.

Demonstrating high performance through accountability and credibility is an especially important element for health departments initially seeking or maintaining public health accreditation and is essential to sustaining a robust public health system that is responsive to the needs of all residents.

"Culture of Health Prize communities have inspired hope across the country."

- Richard Besser .MD., RWJF Presesident and CEO

This framework guides stakeholders through the process of creating a measurement framework to ensure that the strategies they implement to improve health in our community have metrics that specifically align with desirable population health outcomes identified as strategic priorities through our Community Health Assessment. The ultimate goal being that the specific strategies, measured as ***hyper local data***, become the primary method of program attribution.

Meaningful, transparent measurements establish unprecedented levels of accountability and commitment by community agencies and stakeholders to work collectively toward eliminating health disparities and develop equity, while propelling Garrett County toward transforming into the healthiest community to live, work, and play in the state of Maryland.

THINGS YOU NEED TO KNOW

This Community Health Improvement Plan (CHIP) is unlike any other our community has ever had access to in the past. This plan is living, and constantly being revised, updated, and worked on at mygarrettcounty.com, where anyone who lives, works, or plays in Garrett County has an opportunity to participate in the planning and implementation processes.

Due to the dynamic nature of this CHIP, ***snapshots*** are taken quarterly for comparison of performance measures over time, and to correlate our collective efforts in working toward improved health outcomes for Garrett County.

"While other plans may be static documents that don't change for several years, this CHIP is an innovative step toward creating living processes that ensure the best outcomes for all of our community's stakeholders. The more successful our planning processes are, the more likely this document is to change and grow over time as we work to make Garrett County the healthiest community in the state of Maryland."

- Shelley Argabrite M.A., Strategic Health Planner

Every strategy that the CHIP measures lives in a group on my mygarrettcounty.com, where transparent, collaborative planning occurs. This innovative process is open 24/7 to make it easy for people to participate at their convenience and improves community engagement. After all, community improvement initiatives are most successful when we're able to work together. So merge your passions with our purpose, and join groups today to make Garrett County a healthier place to live, work, and play tomorrow!

STRATEGIES TO IMPROVE HEALTH

The following strategies have been proposed for the first time ever in the transparent workspace on mygarrettcounty.com, working with a variety of multisectoral partners in efforts to drastically change health outcomes in Garrett County through the highest degree of collaboration that we've ever been able to measure.

You may notice in future iterations of this plan that data points may change and strategies may be improved as we work to become more responsive to the community. While this printed plan is a convenient carry along, we encourage everyone to utilize the digital edition at mygarrettcounty.com to always have access to the most up-to-date information, and have plentiful opportunities to participate in the implementation and refinement of these strategies, or propose new ones as health priorities change and evolve over time. We'll see you on mygarrettcounty.com, and look forward to improved health outcomes in 2020!

JOIN US!

PARTICIPATE IN THE DISCUSSION ONLINE AT **MYGARRETTCOUNTY.COM**

Access to Quality Behavioral Health Treatment and Support Services.

Public Group 17 days ago

Leave Group

GROUP ADMINS

Behavioral Health Authority

Access to Quality Behavioral Health Treatment and Support Services.

https://mygarrettcounty.com/groups/behavioral-health-authority/access-to-behavioral-health-services-and-quality-of-care-throughout-the-continuum-of-care/

Snapshot Generated: 2019-02-14

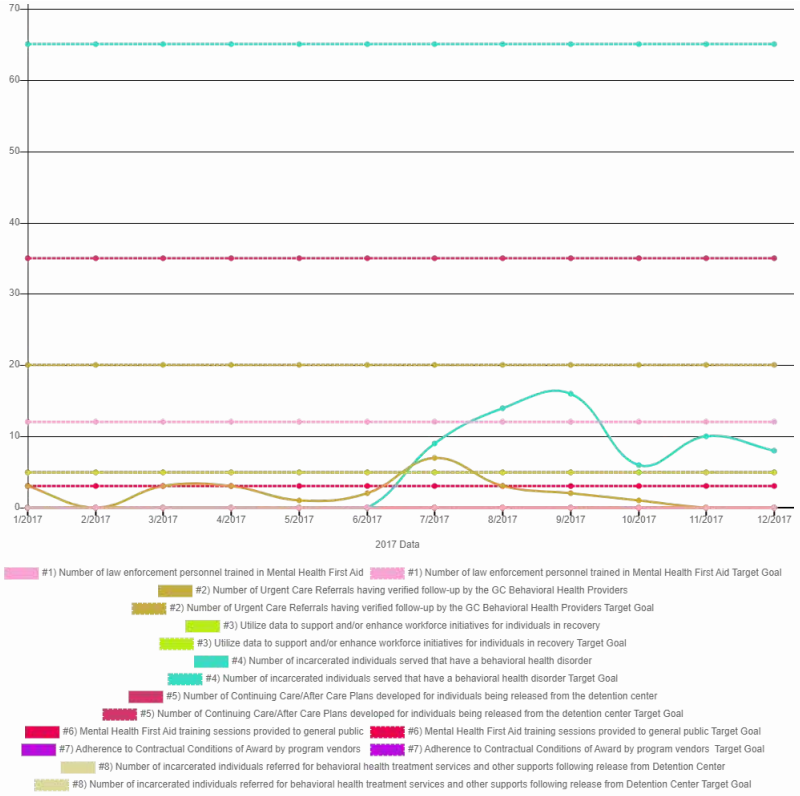
Narrative: There is one CARF accredited comprehensive mental health and substance abuse service provider located at the Garrett County Center for Behavioral Health to serve county residents. Individuals served consist of children, adolescents, adults, couples and families that are facing complex issues. The staff is comprised of psychiatrists, social workers, nurses, licensed substance abuse and mental health counselors and recovery coaches, all dedicated to helping those in need. Garrett County has two additional CARF Accredited Behavioral Health Treatment providers: Garrett County Lighthouse, Inc., which provides Adult Psychiatric Rehabilitation Program services; and Appalachian Parent Association, providing Behavioral Health Supported Employment services.

Strategy Description: As behavioral health providers increase, a multifaceted approach toward achieving the goal of access to quality behavioral health treatment and support services will be accomplished through: enhanced crisis response services and community based suicide prevention, supporting the expansion of accredited behavioral health providers in Garrett County, and support cost-effective, coordinated and recovery oriented services to individuals incarcerated in the local detention center, community supervision programs, and juvenile services.

Level of Change: Systems

Primary Focus Area: Behavioral Health: including Substance Abuse and Mental Health

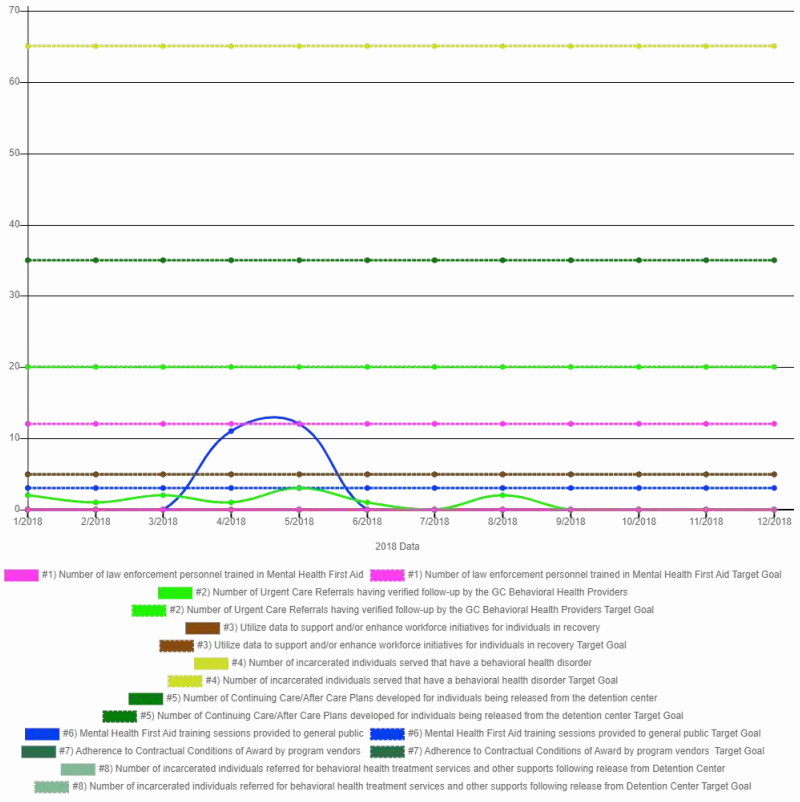
Estimated Implementation Date: 2017-07-01 | **Estimated Completion Date:** 2020-12-31



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
#1) Number of law enforcement	12	Active	Garrett County Behavioral Health Authority/Local Management Board Staff;	0	0	0	0	0	0	0	0	0	0	0	0

personnel trained in Mental Health First Aid			Garrett County Office of the Sheriff; Maryland State Police, McHenry Barrack; Oakland City Police; Department of Natural Resources Police												
#2) Number of Urgent Care Referrals having verified follow-up by the GC Behavioral Health Providers	20	Active	Garrett Regional Medical Center; Garrett County Center for Behavioral Health	3	0	3	3	1	2	7	3	2	1	0	0
#3) Utilize data to support and/or enhance workforce initiatives for individuals in recovery	5	Archived	MyGarrettCounty.com; Garrett County Local Management Board; Garrett County Behavioral Health Authority; Garrett County Health Department; Garrett County Community Action, Inc.; Garrett County Department of Juvenile Services; Garrett County Department of Social Services; Garrett County Drug Free Communities Coalition; Garrett County Mental Health Advisory Committee												
#4) Number of incarcerated individuals served that have a behavioral health disorder	65	Active	Garrett County Detention Center Medical Staff; Garrett County Center for Behavioral Health Clinical Staff; Garrett County Behavioral Health Authority	0	0	0	0	0	0	9	14	16	6	10	8
#5) Number of Continuing Care/After Care Plans developed for individuals being released from the detention center	35	Archived	Garrett County Detention Center; Garrett County Center for Behavioral Health Clinical Staff and Peer Recovery Specialists												
#6) Mental Health First Aid training sessions provided to general public	3	Active	Garrett County Behavioral Health Providers							0	0	0	0	0	0
#7) Adherence to Contractual Conditions of Award by program vendors	5	Active	Contract Vendors; Garrett County Behavioral Health Authority Staff												
#8) Number of incarcerated individuals referred for behavioral health treatment services and other supports following release from Detention Center		Active													



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#1) Number of law enforcement personnel trained in Mental Health First Aid	12	Active	Garrett County Behavioral Health Authority/Local Management Board Staff; Garrett County Office of the Sheriff; Maryland State Police, McHenry Barrack; Oakland City Police; Department of Natural Resources Police	0	0	0	0	0	0	0	0	0	0	0	0
#2) Number of Urgent Care Referrals having verified follow-up by the GC Behavioral Health Providers	20	Active	Garrett Regional Medical Center; Garrett County Center for Behavioral Health	2	1	2	1	3	1	0	2	0	0	0	0
#3) Utilize data to support and/or enhance workforce initiatives for individuals in recovery	5	Archived	MyGarrettCounty.com; Garrett County Local Management Board; Garrett County Behavioral Health Authority; Garrett County Health Department; Garrett County Community Action, Inc.; Garrett County Department of Juvenile Services; Garrett County Department of Social Services; Garrett County Drug Free Communities Coalition; Garrett County Mental Health Advisory Committee												

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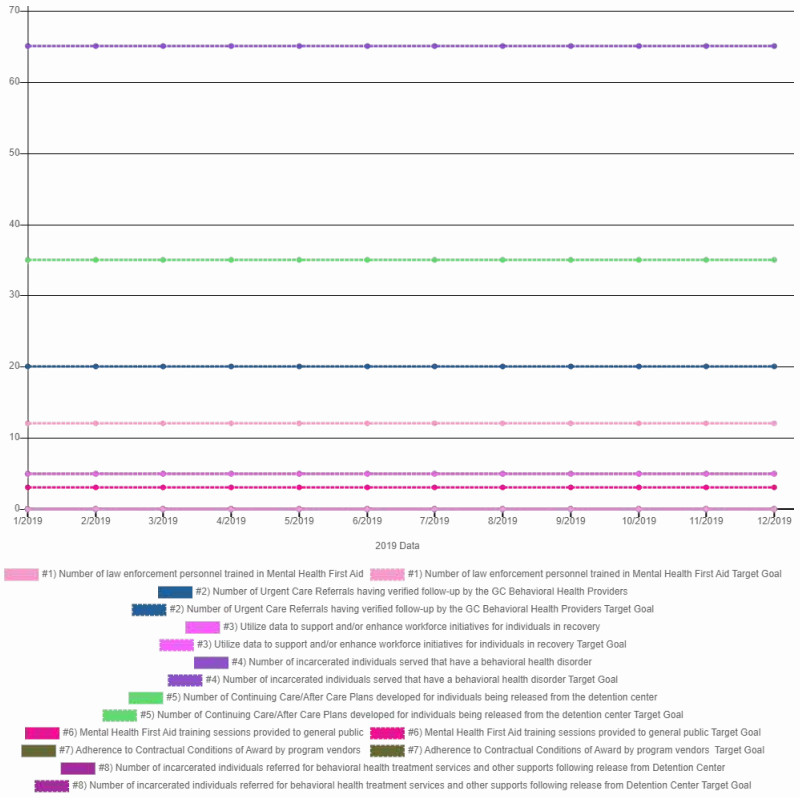
#6) Mental Health First Aid training sessions provided to general public	3	Active	Garrett County Behavioral Health Providers	0	0	0	11	12	0	0					
#7) Adherence to Contractual Conditions of Award by program vendors	5	Active	Contract Vendors; Garrett County Behavioral Health Authority Staff												
#8) Number of incarcerated individuals referred for behavioral health treatment services and other supports following release from Detention Center		Active													



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#7) Adherence to Contractual	5	Active	Contract Vendors; Garrett County Behavioral Health Authority Staff												

Conditions of Award by program vendors																	
#8) Number of incarcerated individuals referred for behavioral health treatment services and other supports following release from Detention Center		Active															

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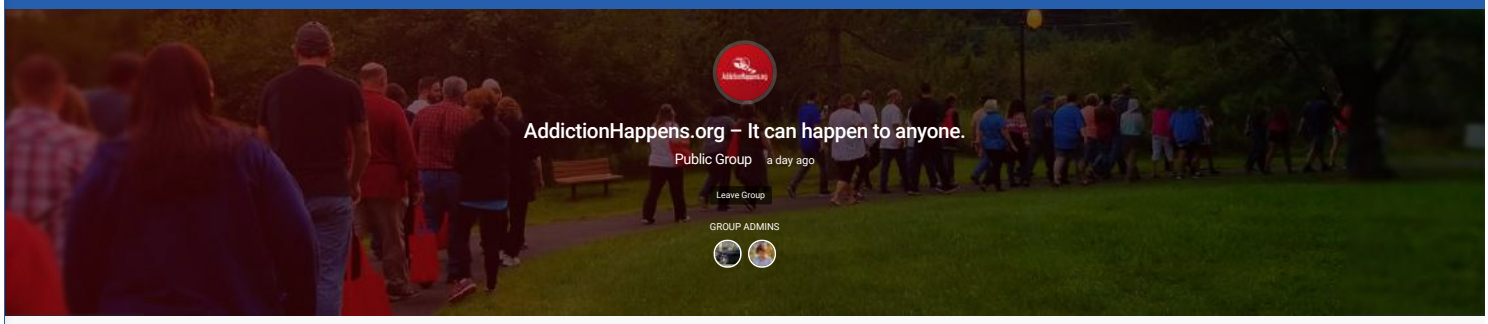
#8) Number of incarcerated individuals referred for behavioral health treatment services and other supports following release from Detention Center		Active													

Contributing Community Participants:

Joseph Burger / Gillian Shreve / Jodi Kulak / ANNIE MAY SHORT / Thomas J. Killian Jr. / Amanda Oliverio / jessica howard / Chris Baker / Cameron Pollock / Sandra / Carrie Hook / Dave Dayhoff / Diana Boller / Christy Lambert / Lauren / Mary Johnson / Rose M Clark / Jessica / Christine / Matthew Friend / Lindsey Bernal / Candace Jones / Jennifer Brenneman / Les McDaniel / Heather Cooper / Brittany Hamilton / Heather Hanline / Claire Ninde / Cindy Mankamyer / Charles Wilt / Maria Friend / Jennifer Lee-Steckman / Anita Rhodes / Jillian Kelly / John Corbin / Alicia Cignatta / Deanna Artice / janice winebrenner / Elaine Hinebaugh / Kendra McLaughlin / Jennifer Corder / Jennifer Loughry / Sandy Miller / LaRena M. Naylor / Ann Bristow / Tabitha Moyer / Susan Mills / Les McDaniel / Teresa Friend / Kathaleen Skipper / Craig Umbel / Sadie Liller / HEATHER BERG / Fred Polce /

Generated by the Universal Community Planning Tool (UCPT).

Flag this group as inappropriate



Drug Prevention

AddictionHappens.org – It can happen to anyone.

https://mygarrettcounty.com/groups/opioid-intervention-team/addictionhappens-org-it-can-happen-to-anyone/

Snapshot Generated: 2019-02-14

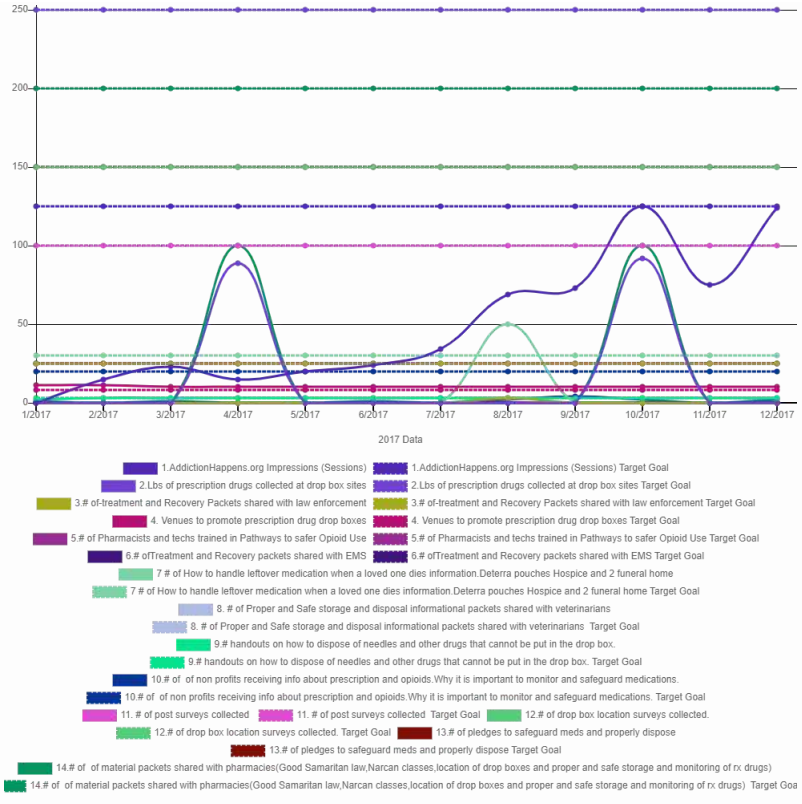
Narrative: The Garrett County Health Department leads an initiative to help prevent drug misuse/abuse. We promote education and awareness of treatment and recovery support services in all Garrett County Communities. #addictionhappens.org - It can happen to anyone. Let's Stand Together!

Strategy Description: Maintain and expand partnerships with community individuals, businesses, health care providers, law enforcement, education, clergy, and organizations; Provided supportive opportunities to engage family and friends of individuals involved with drug misuse and abuse; Utilize educational material and provide methods promoting safe storage and disposal of medications; Inform residents of Garrett County of available treatment and recovery resources

Level of Change: Systems

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2017-01-01 | **Estimated Completion Date:** 2020-06-30



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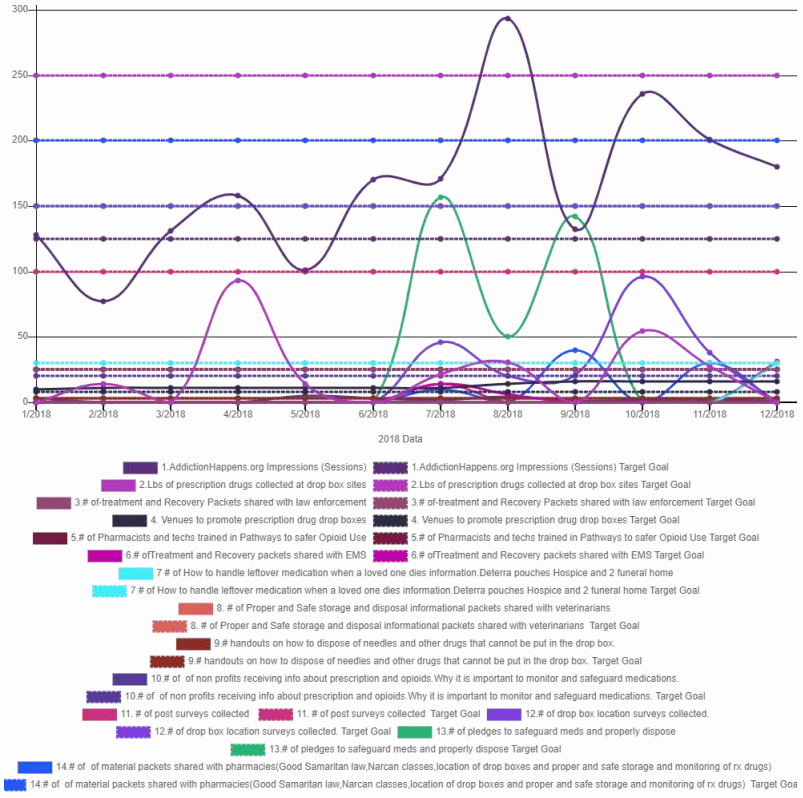
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
1.AddictionHappens.org Impressions (Sessions)	125	Active	John Corbin	0	15	23	15	20	24	34	69	73	125	75	124
2.Lbs of prescription drugs collected at drop box sites	250	Active	Sadie Liller				88.75						92		

3.# of-treatment and Recovery Packets shared with law enforcement	25	Active	Sadie Liller								3				
4. Venues to promote prescription drug drop boxes	8	Active	Sadie Liller	11	11	10	10	10	10	10	10	10	10	10	10
5.# of Pharmacists and techs trained in Pathways to safer Opioid Use	25	Active	Sadie Liller												
6.# ofTreatment and Recovery packets shared with EMS	25	Active	Sadie Liller												
7 # of How to handle leftover medication when a loved one dies information.Deterra pouches Hospice and 2 funeral home	30	Active	Sadie Liller								50				
8. # of Proper and Safe storage and disposal informational packets shared with veterinarians	25	Active	Sadie Liller												
9.# handouts on how to dispose of needles and other drugs that cannot be put in the drop box.	3	Active	Sadie Liller	2	3	3	3	3	3	3	3	3	3	3	3
10.# of of non profits receiving info about prescription and opioids.Why it is important to monitor and safeguard medications.	20	Active	Sadie Liller	1		1			1		2	4	2		2
11. # of post surveys collected	100	Active	Sadie Liller												
12.# of drop box location surveys collected.	150	Active	Sadie Liller												
13.# of pledges to safeguard meds and properly dispose	150	Active	Sadie Liller												
14.# of of material packets shared with pharmacies(Good Samaritan law,Narcan classes,location of drop boxes and proper and safe storage and monitoring of rx drugs)	200	Active	Sadie Liller				100						100		



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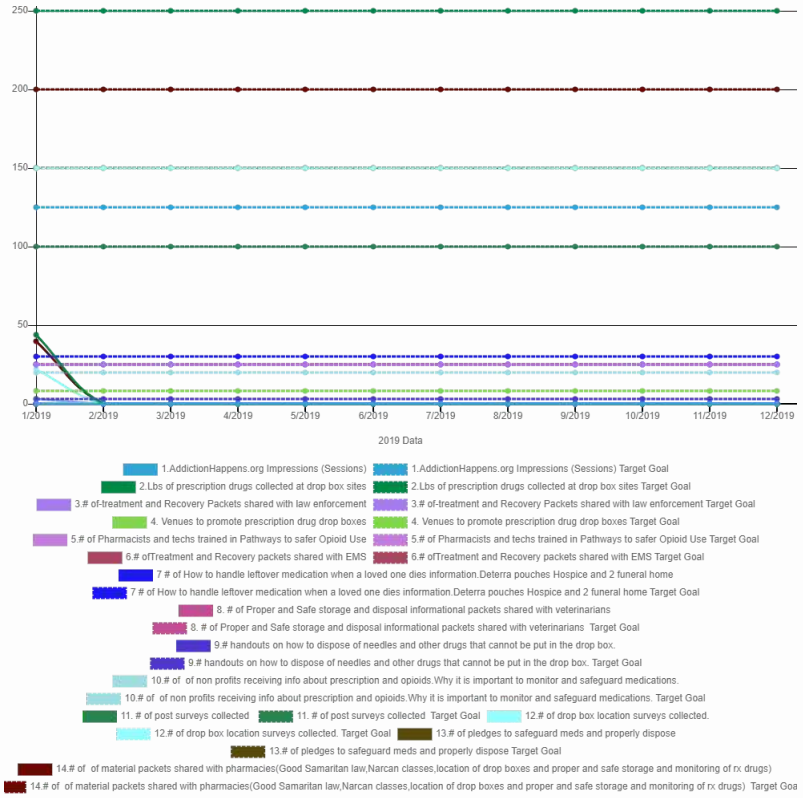
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
1.AddictionHappens.org Impressions (Sessions)	125	Active	John Corbin	128	77	131	158	101	170	171	293	132	236	201	180
2.Lbs of prescription drugs collected at drop box sites	250	Active	Sadie Liller		14		93	14	0	21.25	30.5		54.78	27.45	
3.# of-treatment and Recovery Packets shared with law enforcement	25	Active	Sadie Liller						0	0					
4. Venues to promote prescription drug drop boxes	8	Active	Sadie Liller	10	11	11	11	11	11	11	14	16	16	16	16
5.# of Pharmacists and techs trained in Pathways to safer Opioid Use	25	Active	Sadie Liller						0.04						
6.# ofTreatment and Recovery packets shared with EMS	25	Active	Sadie Liller							14	6				
7 # of How to handle leftover medication when a loved one dies information.Deterra pouches Hospice and 2 funeral home	30	Active	Sadie Liller												30
8. # of Proper and Safe storage and disposal informational packets shared with veterinarians	25	Active	Sadie Liller												
9.# handouts on how to dispose of needles and other drugs that cannot be put in the drop box.	3	Active	Sadie Liller	3	3	3	3	3	3	3	3	3	3	3	3
10.# of of non profits receiving info about prescription and opioids.Why it is important to monitor and safeguard medications.	20	Active	Sadie Liller	3				5	3	2	4	1	2	2	1
11. # of post surveys collected	100	Active	Sadie Liller							14					31
12.# of drop box location surveys collected.	150	Active	Sadie Liller							46	20	21	96	38	
13.# of pledges to safeguard meds and properly dispose	150	Active	Sadie Liller							157	50	142			

14.# of of material packets shared with pharmacies(Good Samaritan law,Narcan classes,location of drop boxes and proper and safe storage and monitoring of rx drugs)	200	Active	Sadie Liller							10		40		30		



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1.AddictionHappens.org Impressions (Sessions)	125	Active	John Corbin												
2.Lbs of prescription drugs collected at drop box sites	250	Active	Sadie Liller	44											
3.# of-treatment and Recovery Packets shared with law enforcement	25	Active	Sadie Liller												
4. Venues to promote prescription drug drop boxes	8	Active	Sadie Liller												
5.# of Pharmacists and techs trained in Pathways to safer Opioid Use	25	Active	Sadie Liller												
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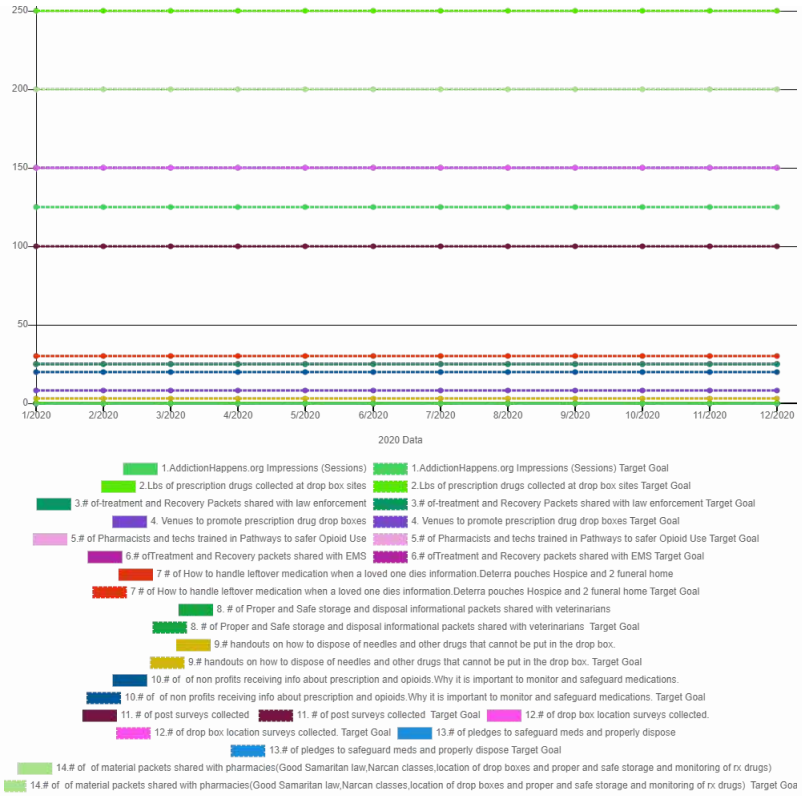
10.# of of non profits receiving info about prescription and opioids.Why it is important to monitor and safeguard medications.	20	Active	Sadie Liller	3											
11. # of post surveys collected	100	Active	Sadie Liller												
12.# of drop box location surveys collected.	150	Active	Sadie Liller	22											
13.# of pledges to safeguard meds and properly dispose	150	Active	Sadie Liller												
14.# of of material packets shared with pharmacies(Good Samaritan law,Narcan classes,location of drop boxes and proper and safe storage and monitoring of rx drugs)	200	Active	Sadie Liller	40											



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10.# of of non profits receiving info about prescription and opioids.Why it is important to monitor and safeguard medications.	20	Active	Sadie Liller												
11. # of post surveys collected	100	Active	Sadie Liller												
12.# of drop box location surveys collected.	150	Active	Sadie Liller												
13.# of pledges to safeguard meds and properly dispose	150	Active	Sadie Liller												
14.# of of material packets shared with pharmacies(Good Samaritan law,Narcan classes,location of drop boxes and proper and safe storage and monitoring of rx drugs)	200	Active	Sadie Liller												

Data Narrative:

Measure 1. shows how many people have accessed our media campaign website that has information about proper and safe disposal methods as well as the permanent drop off locations that someone can dispose of their unneeded opioids. **Measure 2.** shows the poundage of prescription drugs that are collected at the 3 permanent drop box sites throughout the year. **Measure 3.** Treatment and recovery informational packets shared with law enforcement to be given to a person with Substance Use Disorder. **Measure 4.** is the different ways we get our messages out to the public. such as radio,billboards,poster, pens, magnets etc... **Measure 5.** is to train Pharmacists and Pharmacy Techs in evidence based program Pathways to safer Opioid Use. So them may have an informed discussion with a patient that has been prescribed an opioid. **Measure 6.** is for treatment and recovery informational packets that are shared with EMS for a person and family member who refuse transport to the hospital after an overdose. **Measure 7.** Information about why it is important to safeguard and dispose of unwanted prescription medication, drop box locations and a Deterra Drug Deacativation pouch to be given to clients at funeral home and to Hospice. **Measure 8.**Proper and safe storage and disposal information with a Deterra Drug Deactivation Pouch to be given to pet owners who are prescribed an prescription drug. **Measure 9.** Information on the side of the permanent prescription drug drop box for people to pick up with information on how to dispose of needles and other substances that cannot be put in the permanent prescription drop box. **Measure 10.** Nonprofits will receive information about why it is important to safeguard prescription medications and how to safely dispose of them with information about the permanent prescription drug drop off locations and how to obtain a Deterra Deactivation pouch. **Measure 11.** is the number of post surveys collected that will show the number of people who will change how they monitor/safeguard medications in the home and the number of people who will change how they dispose of medications.Also the number of people who will feel comfortable to share how to safely dispose of prescription medications and why it is important. **Measure 12.** is the number of surveys collected to measure how many people are aware that GC has 3 prescription drop boxes. Do they know where they are and how did they find out about them. **Measure 13.**Pledges collected to safely store prescription medications and to get rid of them when no longer needed either by using one of the permanent locations,Deterra Deactivation pouch or with wet kitty litter or coffee grounds. **Measure 14.** The number of material packets shared with pharmacies to be given to a person who has been prescribed an opioid for the first time.This packet contains information about opioids,treatment and recovery information,permanent prescription drug drop box locations.

Contributing Community Participants:

Christy Thomas / Savannah Turner / faith friend / Brian X. Murray / Shannon Baker / Gillian Shreve / Joseph M Casey / Charee Reckner / Amy Ritchie / Richard Kerns / Melissa Clark / Kendra McLaughlin / servant / Jodi Kulak / ANNIE MAY SHORT / Jackie Stein / jessica howard / Chris Baker / Sandra / Carrie Hook / Dave Dayhoff / Diana Boller / Christy Lambert / Kate / Mary Johnson / Ashlee Boyd / Jessica / Amanda Oliverio / Sabrina Tasker / Charles Wilt / Christy / Christine / Anita Rhodes / Mike / Rose M Clark / Lindsey Bernal / Miriam Sincell Burton / Reckenberger / Steve Putnam / Heather Hanline / Sandy Miller / Carol Bass / christy thomas / Sharon Custer / Suzette Merrick / Kristen Walker / Diane Lee / Amy Barnhouse / Karen Matthews /

Beth Brenneman / Chris Duckworth / Mark Stutzman / Andy / Bev Rasel / Shelley Argabrite / Brenda Sisler / Candace Jones / Shelley Menear / Linda Costello / Daphne Gooding / Bob Stephens / Fred Polce / Ed Kight / Alicia Cignatta / Jennifer Loughry / HEATHER BERG / Teresa Friend / John Corbin / Sadie Liller /

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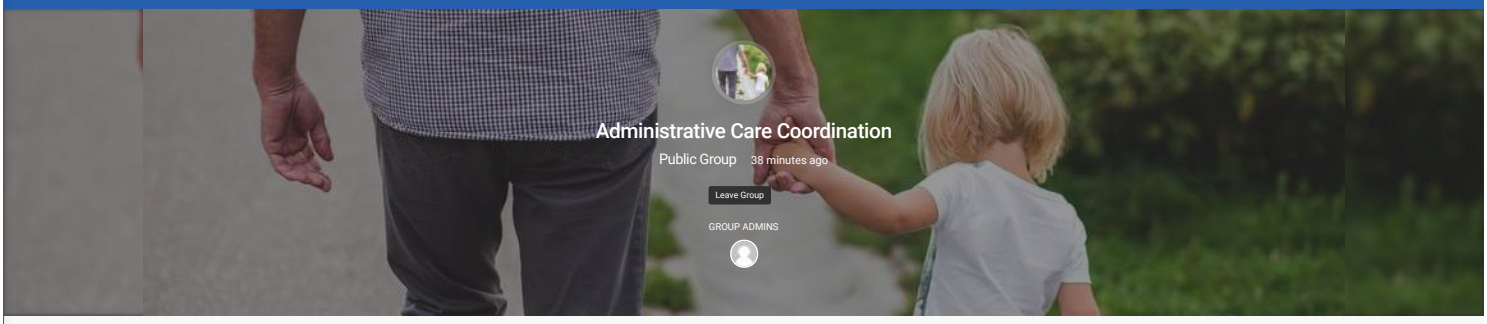


Access to Care for Maryland Medical Assistance recipients

Administrative Care Coordination

https://mygarrettcounty.com/groups/administrative-care-coordination/

Snapshot Generated: 2019-02-14

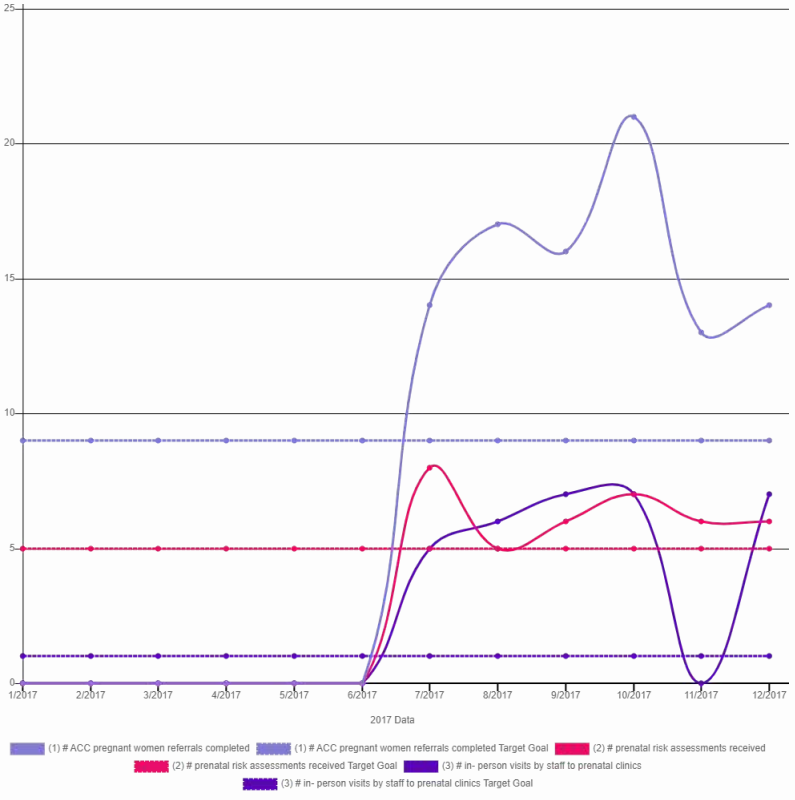
Narrative:

Strategy Description: Referrals are received from Maryland Department of Health's medical assistance application process (this can not be influenced by the program) and prenatal clinics. 2)Prenatal risk assessments are received from four prenatal clinics, strategies to increase the number of assessments include: a) provider education by physcially visiting the prenatal clinics (at least quarterly), contacting them by phone (weekly)

Level of Change: Programs

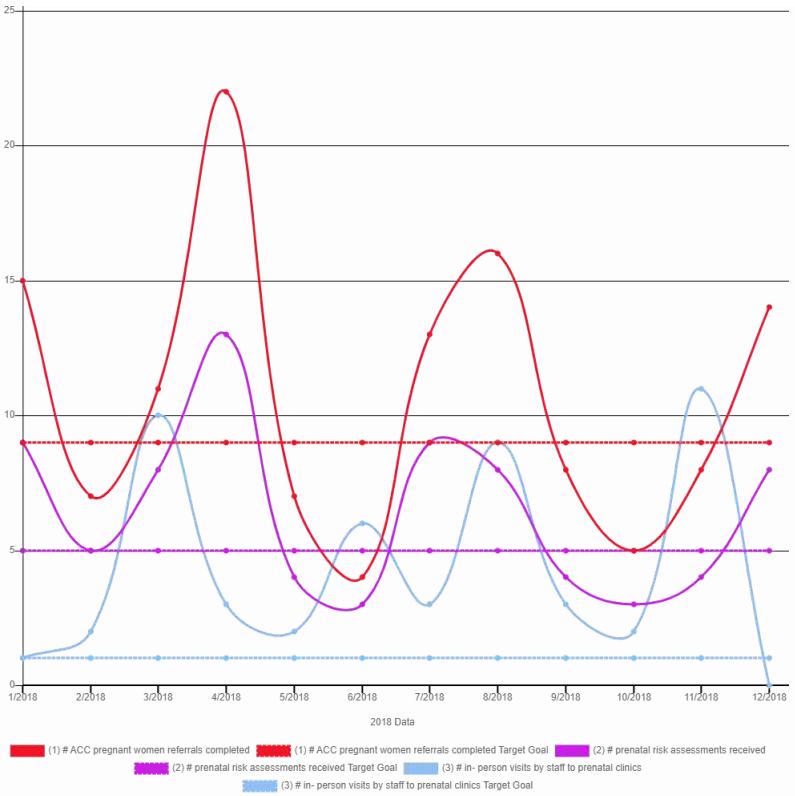
Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2017-01-02 | **Estimated Completion Date:** 2018-01-01



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
(1) # ACC pregnant women referrals completed	9	Active								14	17	16	21	13	14
(2) # prenatal risk assessments received	5	Active								8	5	6	7	6	6
(3) # in- person visits by staff to prenatal clinics	1	Active								5	6	7	7	0	7



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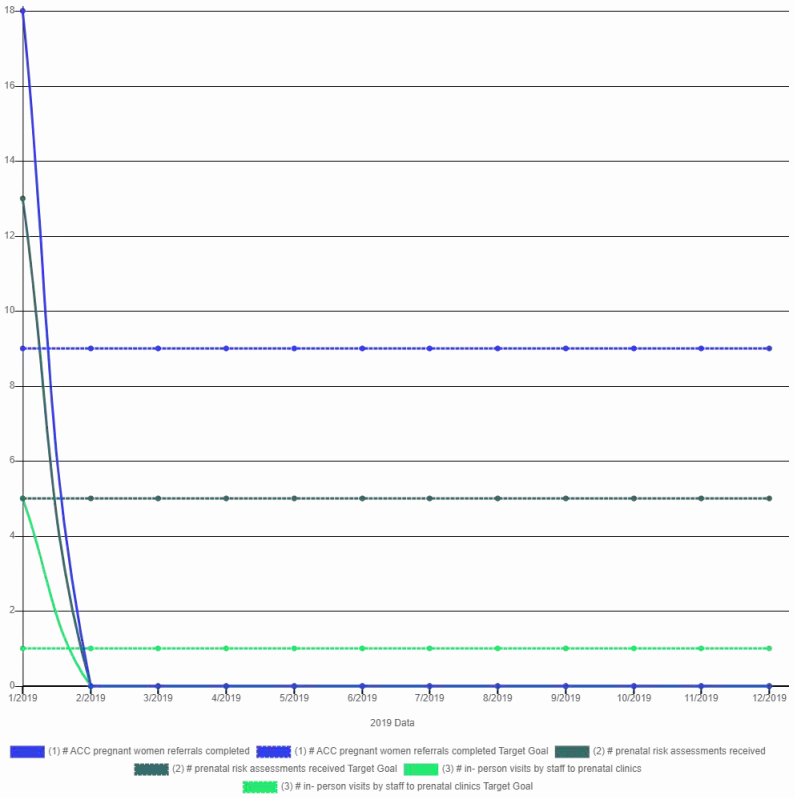
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
(1) # ACC pregnant women referrals completed	9	Active		15	7	11	22	7	4	13	16	8	5	8	14
(2) # prenatal risk assessments received	5	Active		9	5	8	13	4	3	9	8	4	3	4	8
(3) # in- person visits by staff to prenatal clinics	1	Active		1	2	10	3	2	6	3	9	3	2	11	0



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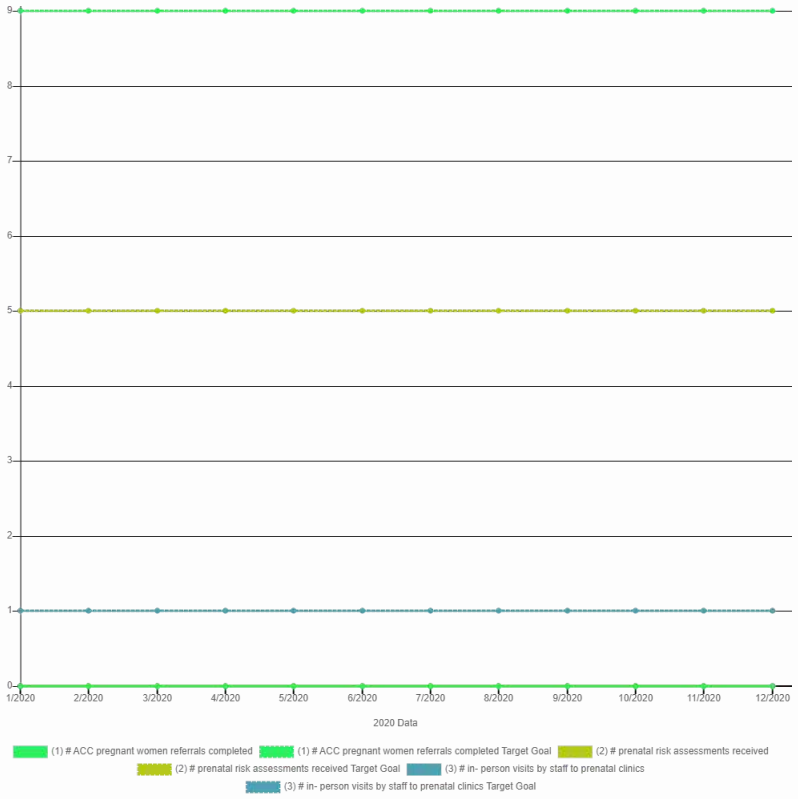
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
(1) # ACC pregnant women referrals completed	9	Active		18											
(2) # prenatal risk assessments received	5	Active		13											

(3) # in- person visits by staff to prenatal clinics	1	Active		5											



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
(1) # ACC pregnant women referrals completed	9	Active													
(2) # prenatal risk assessments received	5	Active													
(3) # in- person visits by staff to prenatal clinics	1	Active													

Data Narrative:

(1) The number of pregnant women referrals completed is the actual number of women who were able to be contacted via telephone call or home visit and prenatal information was successfully provided to them. This number reflects only those women who were referred and are enrolled in Medical Assistance or Managed Care Organization (MCO) coverage. (2) Maryland Prenatal Risk Assessment (MPRA) are the forms utilized by prenatal clinics to make referrals to Administrative Care Coordination Unit (ACCU). The forms provide demographic information so the client may be contacted. This statistic only includes the number of MPRA's received on women who were already enrolled in or eligible to be enrolled in Medical Assistance or a Managed Care Organization (MCO). Not all offices provide MPRA's to the ACCU. For example, if a pregnant women seeks prenatal care in West Virginia, the office is not required to provide a MPRA. (3) There are currently four prenatal clinics that ACCU staff visit for the purpose of outreach. These clinics include Cornerstone Family Medicine, Wellspring Family Medicine, WMHS OB/GYN, and Tri-State Womens Health. This statistic reflects the number of times the clinic receives outreach through an ACCU Coordinator per month.

Contributing Community Participants:

Brian X. Murray / Michelle Ross / Chris Baker / Cameron Pollock / Jim Keough / Mary Johnson / Jessica / Christine / Lindsey Bernal / Kara Taylor / Jennifer Lee-Steckman / sharon rounds / Alicia Cignatta / Shelley Argabrite / Tiffany Fratz / John Corbin /

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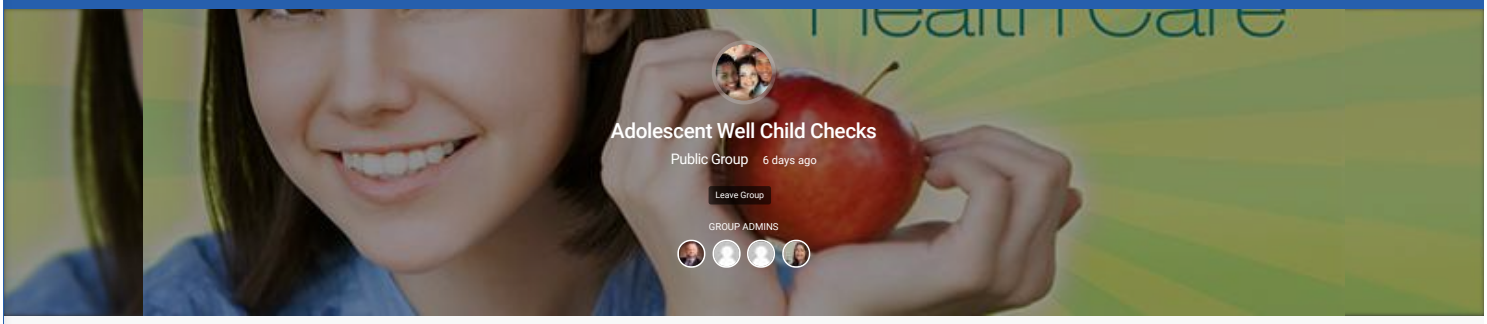


Family Health

Adolescent Well Child Checks

https://mygarrettcounty.com/groups/increase-adolescent-well-child-checks/

Snapshot Generated: 2019-02-14

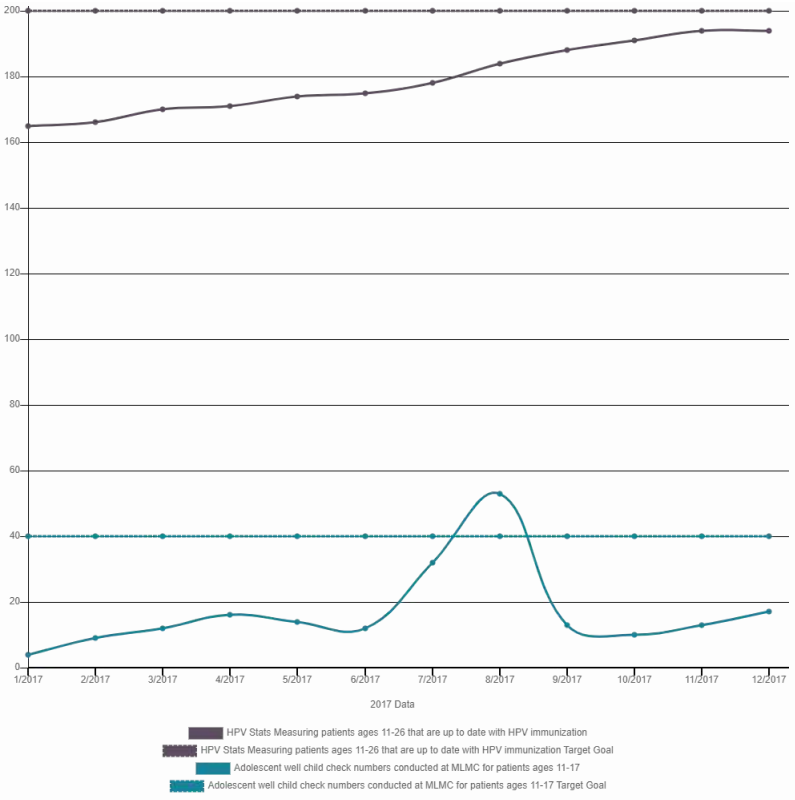
Narrative: When adolescents do come in for a well child visit, it's the perfect opportunity to get the patient caught up on their immunizations. Recently, we have begun tracking statistics for HPV vaccines.

Strategy Description: Attempt to administer HPV vaccine while the adolescent is in for the well child check in addition to well child checks.

Level of Change: Systems

Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2017-01-02 | **Estimated Completion Date:** 2020-12-31



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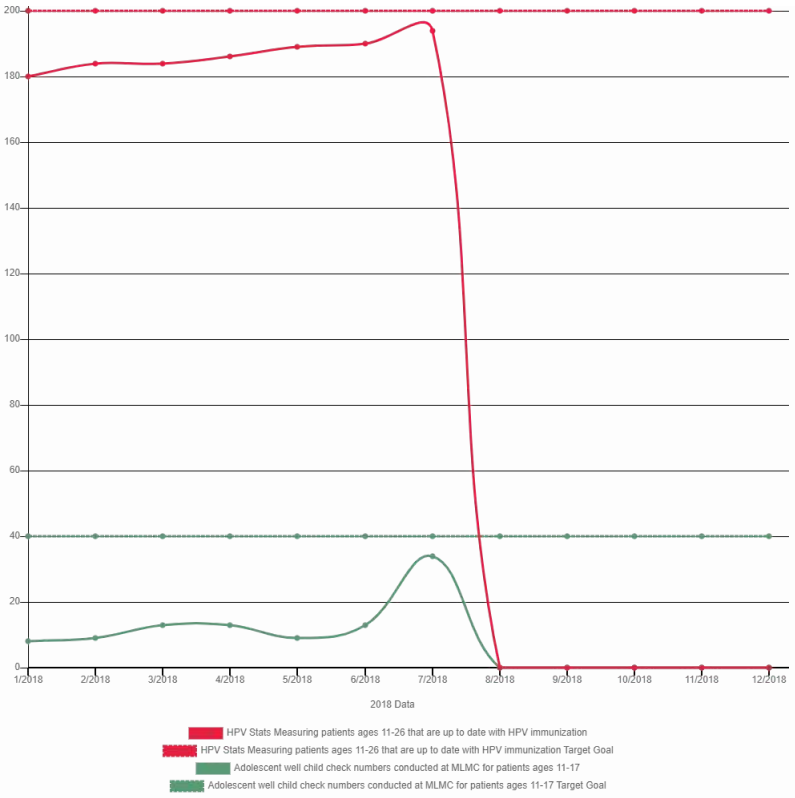
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
HPV Stats Measuring patients ages 11-26 that are up to date with HPV immunization	200	Active		165	166	170	171	174	175	178	184	188	191	194	194
Adolescent well child check numbers conducted at MLMC for patients ages 11-17	40	Active		4	9	12	16	14	12	32	53	13	10	13	17



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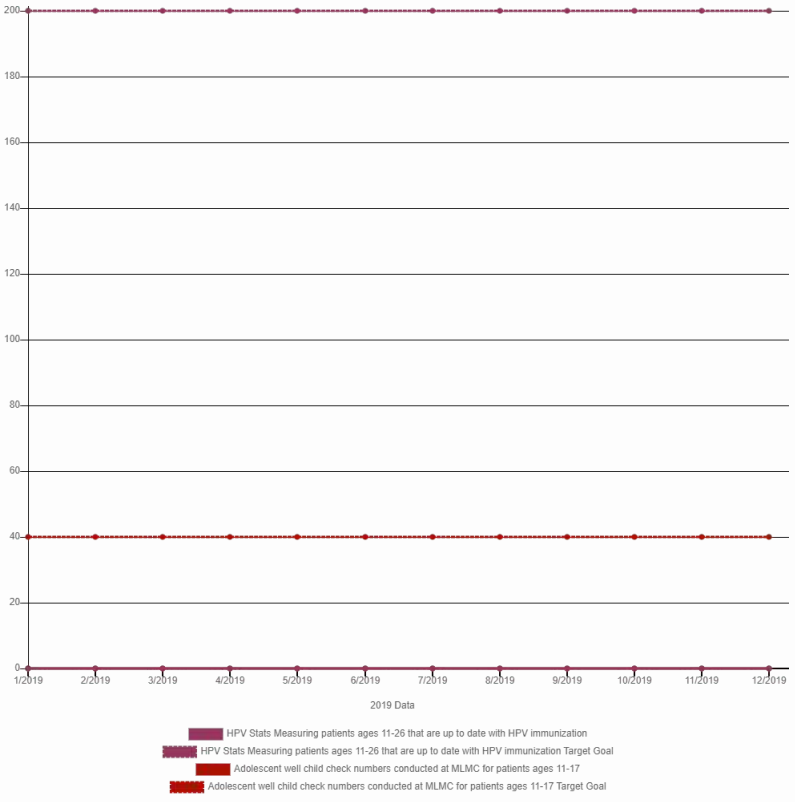
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
HPV Stats Measuring patients ages 11-26 that are up to date with HPV immunization	200	Active		180	184	184	186	189	190	194					
Adolescent well child check numbers conducted at MLMC for patients ages 11-17	40	Active		8	9	13	13	9	13	34					



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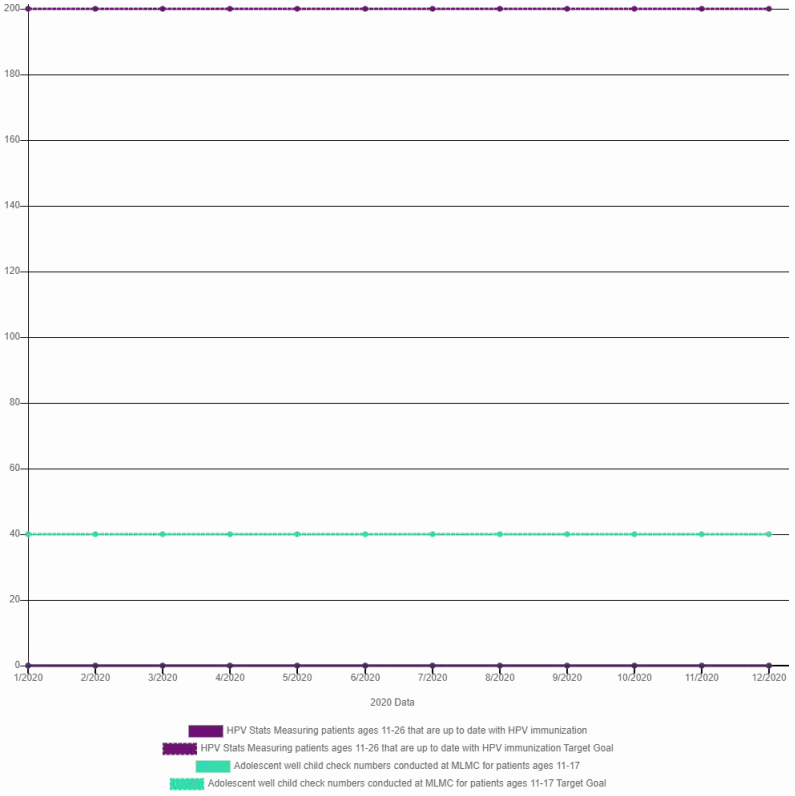
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
HPV Stats Measuring patients ages 11-26 that are up to date with HPV immunization	200	Active													
Adolescent well child check numbers conducted at MLMC for patients ages 11-17	40	Active													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
HPV Stats Measuring patients ages 11-26 that are up to date with HPV immunization	200	Active													
Adolescent well child check numbers conducted at MLMC for patients ages 11-17	40	Active													

Research: Currently, Garrett County ranks last in the state for Adolesent Well Child Checks according to the Maryland State Health Improvement Process, http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship37 Data source: Maryland Medicaid Service Utilization: Beginning in 2015 the age range was increased to include adolescents aged 12 - 21 years, as a result, data reported for 2015 and onward cannot be trended with previous years of data.

Contributing Community Participants:

Susan Mills / Beth Brenneman / Dr. Robert Phares / William pope / jessica howard / Amy Ritchie / Venessa Stacy / Chris Baker / Carrie Hook / Sandy Miller / Christine / Jennifer Corder / Jennifer Lee-Steckman / Lindsey Bernal / Karl Schwalm / Cindy Mankamyer / Alicia Cignatta / Teresa Friend / Bev Tucker / Jodi Roberson / Hannah / Shelley Argabrite / John Corbin / HEATHER BERG / Laura Schroyer / Heather Cooper / Charles Wilt /

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Adult Evaluation and Review Services: AERS

Private Group 14 minutes ago

Leave Group

GROUP ADMINS

Evaluation Services for functionally disabled and/or older adults

Adult Evaluation and Review Services: AERS

https://mygarrettcounty.com/groups/h2h/adult-evaluation-and-review-services-aers/

Snapshot Generated: 2019-02-14

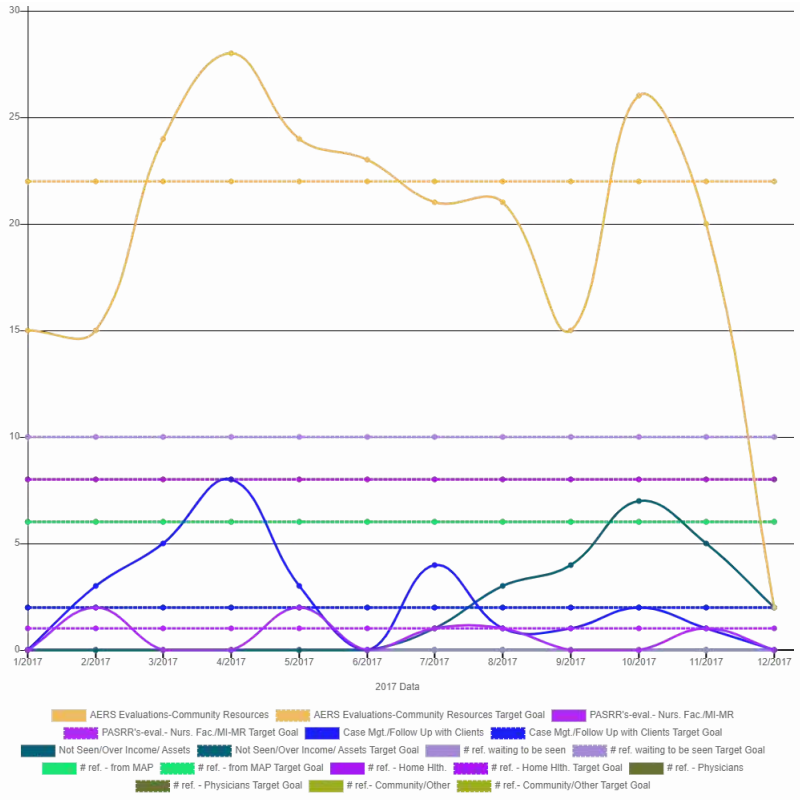
Narrative:

Strategy Description: Strengthen relationships with community referrel sources to increase participation from the community.

Level of Change: Programs

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2017-01-02 | **Estimated Completion Date:** 2017-12-29



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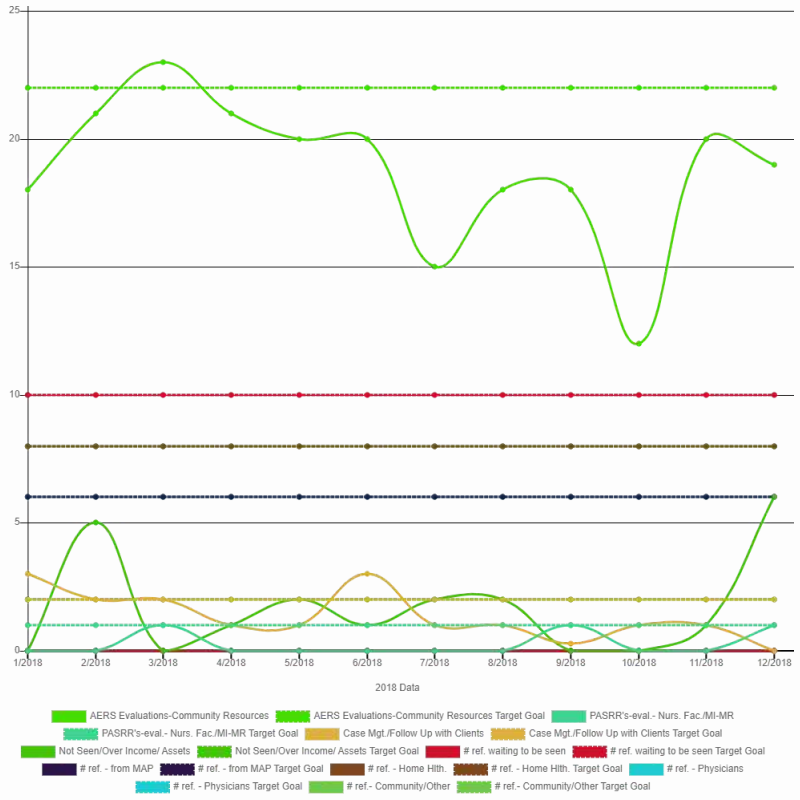
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
AERS Evaluations-Community Resources	22	Active	Kathy Skipper, GCHD AERS	15	15	24	28	24	23	21	21	15	26	20	2
PASRR's-eval.- Nurs. Fac./MI-MR	1	Active	Kathy Skipper, GCHD AERS	0	2	0	0	2	0	1	1	0	0	1	0
Case Mgt./Follow Up with Clients	2	Active	Kathy Skipper, GCHD AERS	0	3	5	8	3	0	4	1	1	2	1	0
Not Seen/Over Income/ Assets	2	Active	Kathy Skipper, GCHD AERS	0	0	0	0	0	0	1	3	4	7	5	2

# ref. waiting to be seen	10	Active													
# ref. - from MAP	6	Active													
# ref. - Home Hlth.	8	Active													
# ref. - Physicians	6	Active													
# ref.- Community/Other	8	Active													



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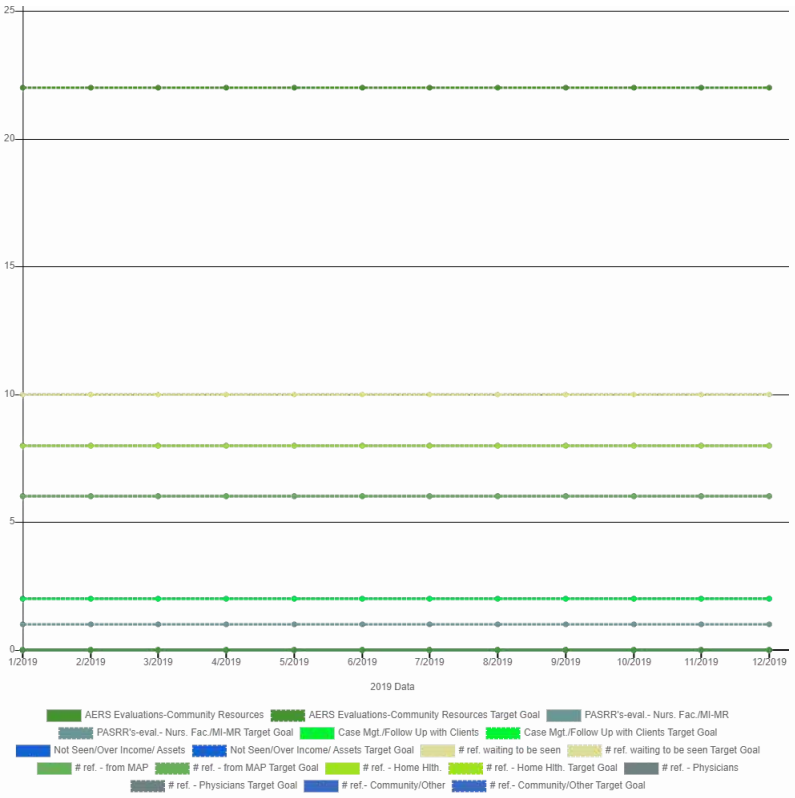
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
AERS Evaluations-Community Resources	22	Active	Kathy Skipper, GCHD AERS	18	21	23	21	20	20	15	18	18	12	20	19
PASRR's-eval.- Nurs. Fac./MI-MR	1	Active	Kathy Skipper, GCHD AERS	0	0	1	0	0	0	0	0	1	0	0	1
Case Mgt./Follow Up with Clients	2	Active	Kathy Skipper, GCHD AERS	3	2	2	1	1	3	1	1	00.27	1	1	0
Not Seen/Over Income/ Assets	2	Active	Kathy Skipper, GCHD AERS	0	5	0	1	2	1	2	2	0	0	1	6
# ref. waiting to be seen	10	Active													
# ref. - from MAP	6	Active													
# ref. - Home Hlth.	8	Active													
# ref. - Physicians	6	Active													
# ref.- Community/Other	8	Active													



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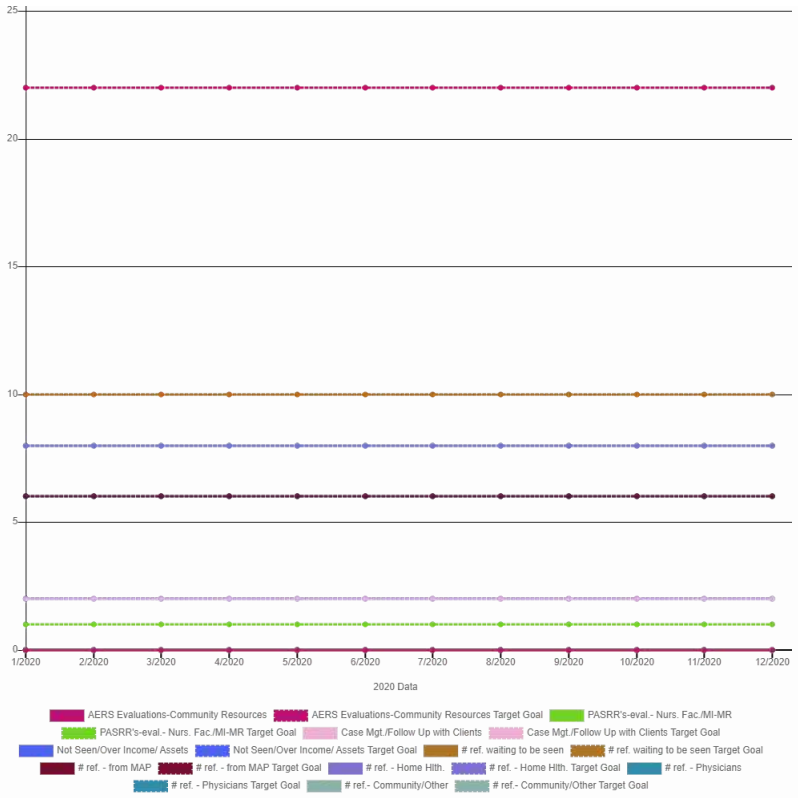
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
AERS Evaluations-Community Resources	22	Active	Kathy Skipper, GCHD AERS												
PASRR's-eval.- Nurs. Fac./MI-MR	1	Active	Kathy Skipper, GCHD AERS												
Case Mgt./Follow Up with Clients	2	Active	Kathy Skipper, GCHD AERS												
Not Seen/Over Income/ Assets	2	Active	Kathy Skipper, GCHD AERS												
# ref. waiting to be seen	10	Active													
# ref. - from MAP	6	Active													
# ref. - Home Hlth.	8	Active													
# ref. - Physicians	6	Active													
# ref.- Community/Other	8	Active													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
AERS Evaluations-Community Resources	22	Active	Kathy Skipper, GCHD AERS												
PASRR's-eval.- Nurs. Fac./MI-MR	1	Active	Kathy Skipper, GCHD AERS												
Case Mgt./Follow Up with Clients	2	Active	Kathy Skipper, GCHD AERS												
Not Seen/Over Income/ Assets	2	Active	Kathy Skipper, GCHD AERS												
# ref. waiting to be seen	10	Active													
# ref. - from MAP	6	Active													
# ref. - Home Hlth.	8	Active													
# ref. - Physicians	6	Active													
# ref.- Community/Other	8	Active													

Data Narrative:

Line 2, 3 and 4 is just for our internal tracking and we have no control over increases/or decreases in these categories.

Contributing Community Participants:

Tiffany Fratz / Carol Bass / Teresa Friend / Jennifer Lee-Steckman / Kathaleen Skipper / John Corbin / Shelley Argabrite /

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Behavioral Health Authority

Behavioral Health Authority

https://mygarrettcounty.com/groups/behavioral-health-authority/

Snapshot Generated: 2019-02-14

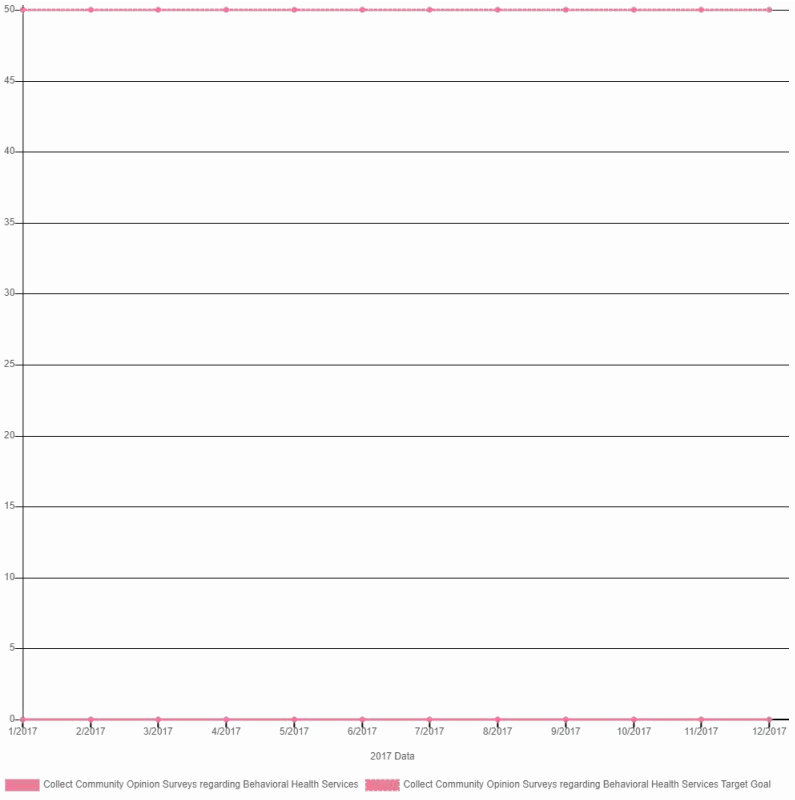
Narrative: The Garrett County Behavioral Health Authority has responsibilities of leadership, direction, management, and education for publicly funded behavioral health services in Garrett County. Although there are multiple goals undertaken through the work of the Garrett County Behavioral Health Authority, local community needs assessments and focus group sessions have indicated that residents of the county are sometimes unaware of the type of services available for individuals who are experiencing emergency mental health and/or addiction issues or have long term mental health and/or addiction issues. This action group keeps a pulse on community input regarding behavioral health issues. The Garrett County Behavioral Health Plan of Operations for Fiscal Year 2019, is available for review, in the Uploads.

Strategy Description: Although there are multiple goals undertaken through the work of the Garrett County Behavioral Health Authority, local community needs assessments and focus group sessions have indicated that residents of the county are sometimes unaware of the type of services available for individuals who are experiencing emergency mental health and/or addiction issues or have long term mental health and/or addiction issues. The Garrett County Behavioral Health Plan of Operations for Fiscal Year 2019, is available for review, in the Uploads.

Level of Change: Systems

Primary Focus Area: Behavioral Health: including Substance Abuse and Mental Health

Estimated Implementation Date: | Estimated Completion Date:



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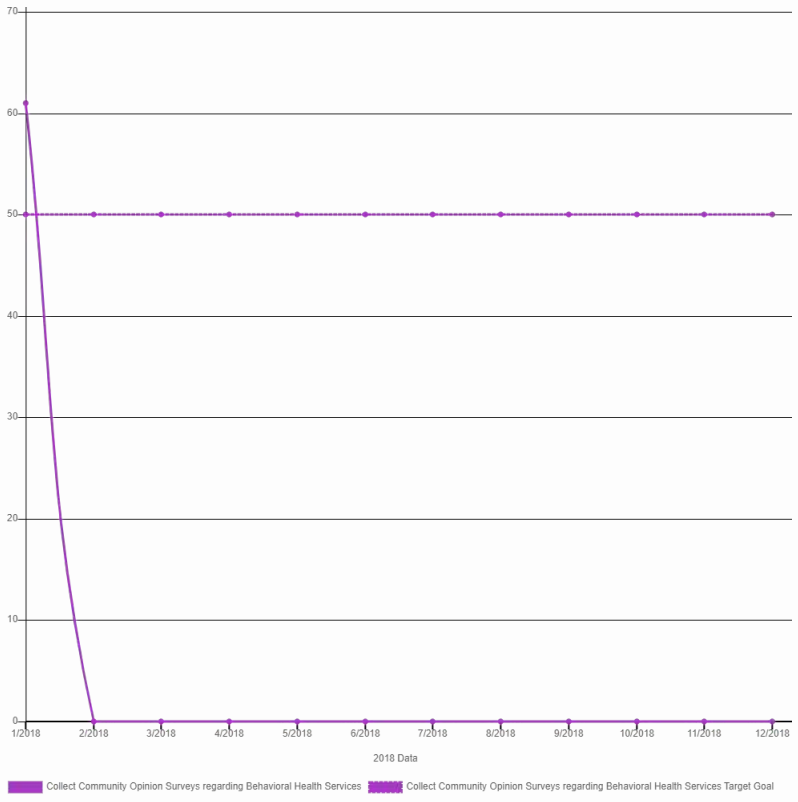
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017

Collect Community Opinion Surveys regarding Behavioral Health Services	50	Active	Garrett County Behavioral Health Authority/Local Management Board; Garrett County Population Health, Innovation and Infomatics Unit; General Public; County and State Organizations; Public Behavioral Health Providers; Recipients of Treatment Services	0	0	0	0	0	0	0	0	0	0	0	0



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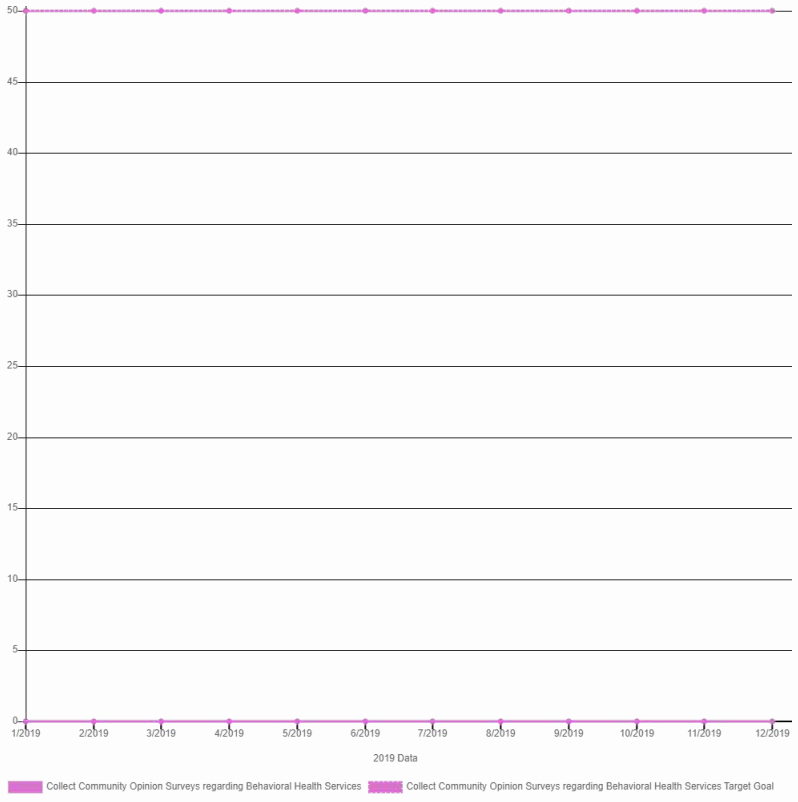
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Collect Community Opinion Surveys regarding Behavioral Health Services	50	Active	Garrett County Behavioral Health Authority/Local Management Board; Garrett County Population Health, Innovation and Infomatics Unit; General Public; County and State Organizations; Public Behavioral Health Providers; Recipients of Treatment Services	61											



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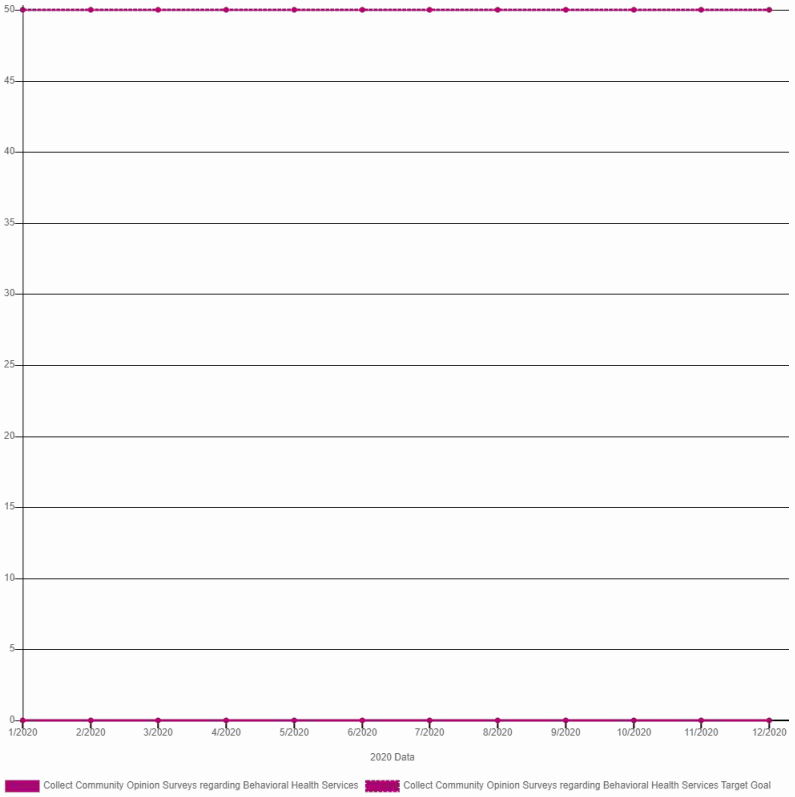
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Collect Community Opinion Surveys regarding Behavioral Health Services	50	Active	Garrett County Behavioral Health Authority/Local Management Board; Garrett County Population Health, Innovation and Infomatics Unit; General Public; County and State Organizations; Public Behavioral Health Providers; Recipients of Treatment Services												



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Collect Community Opinion Surveys regarding Behavioral Health Services	50	Active	Garrett County Behavioral Health Authority/Local Management Board; Garrett County Population Health, Innovation and Infomatics Unit; General Public; County and State Organizations; Public Behavioral Health Providers; Recipients of Treatment Services												

Contributing Community Participants:

Gillian Shreve / John Corbin / Fred Polce / Shelley Argabrite /

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Blood Pressure Monitoring

Public Group 2 days ago

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GROUP ADMINS

Blood Pressure Monitoring

Blood Pressure Monitoring

https://mygarrettcounty.com/groups/blood-pressure-monitoring/

Snapshot Generated: 2019-02-14

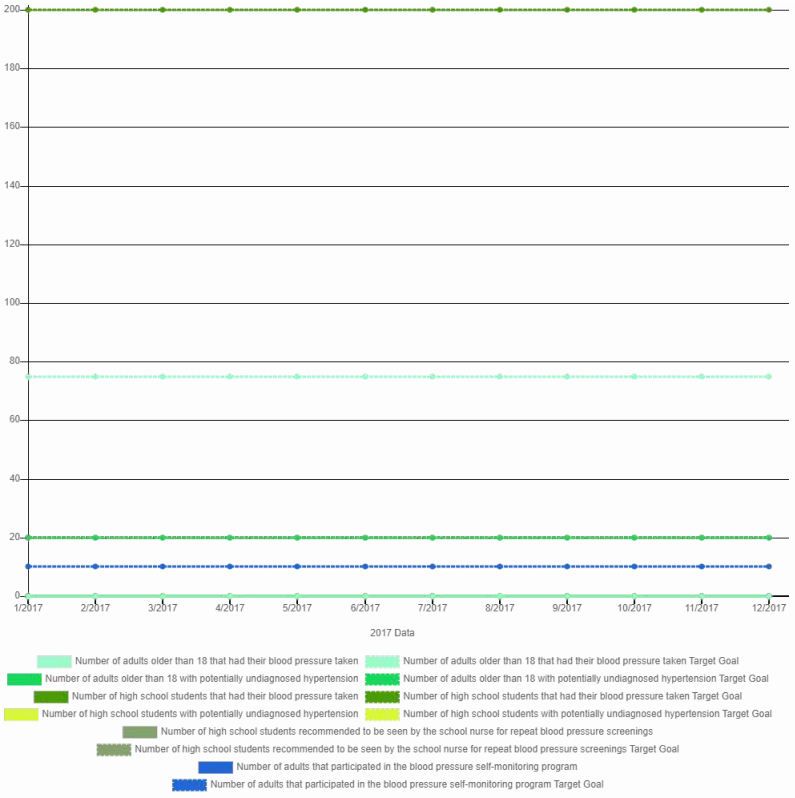
Narrative: Health professionals at various facilities throughout the county are monitoring blood pressures of patients/clients and students who may normally only have their blood pressure taken at a doctor's visit. The prevalence of heart disease in Garrett County is high and residents of all ages need to know their risks and how to prevent a cardiovascular event. The goal is to get those already diagnosed with high blood pressure to take their medication and make lifestyle changes as prescribed, and to identify those with undiagnosed hypertension.

Strategy Description: Blood pressure monitors have been distributed to various health professionals within the health department, First Choice Physical Therapy, GRMC Diabetes Educator and five dental practices. A loaner program has been established at all locations except the dental practices in which patients will have an opportunity to self monitor and report the results to the health professional who provided the monitor. If patient's blood pressure is consistently elevated a referral will be sent to the patient's physician.

Level of Change: Programs

Primary Focus Area: Chronic Diseases and their common risk factors: lack of physical activity, poor nutrition, and tobacco use

Estimated Implementation Date: 2018-10-25 | **Estimated Completion Date:** 2018-10-25



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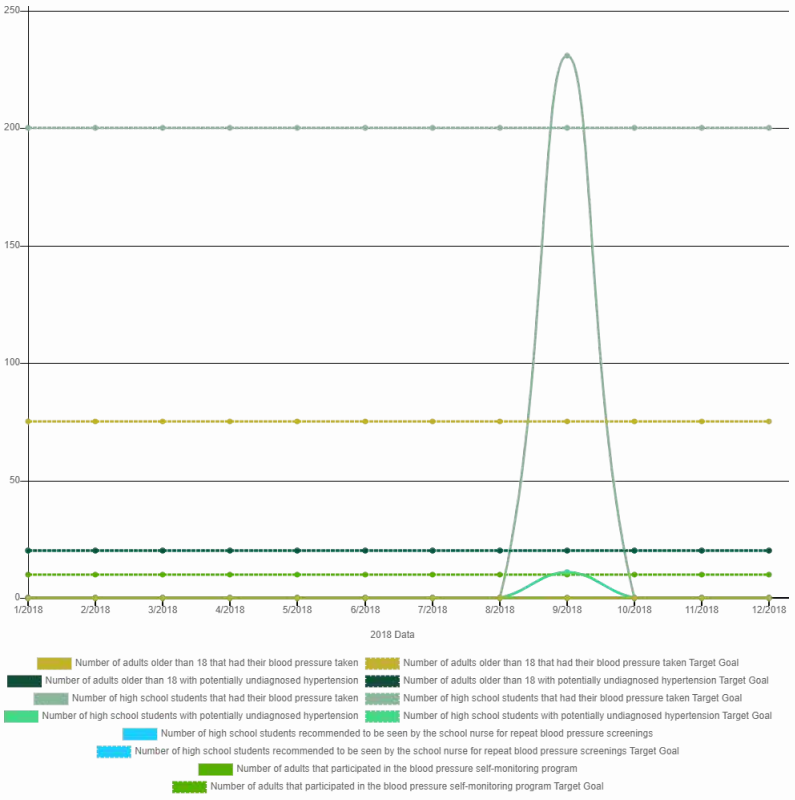
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Number of adults older than 18 that had their blood pressure taken	75	Active	Amy Ritchie, Outreach Team, & Betty Anderson												
Number of adults older than 18 with potentially undiagnosed	20	Active	Amy Ritchie, Outreach Team & Betty Anderson												

hypertension															
Number of high school students that had their blood pressure taken	200	Active	Amy Ritchie, Outreach Team & Bety Anderson												
Number of high school students with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson												
Number of high school students recommended to be seen by the school nurse for repeat blood pressure screenings	20	Active	Amy Ritchie, Outreach Team, Health Teachers, School Nurses & Betty Anderson												
Number of adults that participated in the blood pressure self-monitoring program	10	Active	Amy Ritchie, Outreach Team & Betty Anderson												



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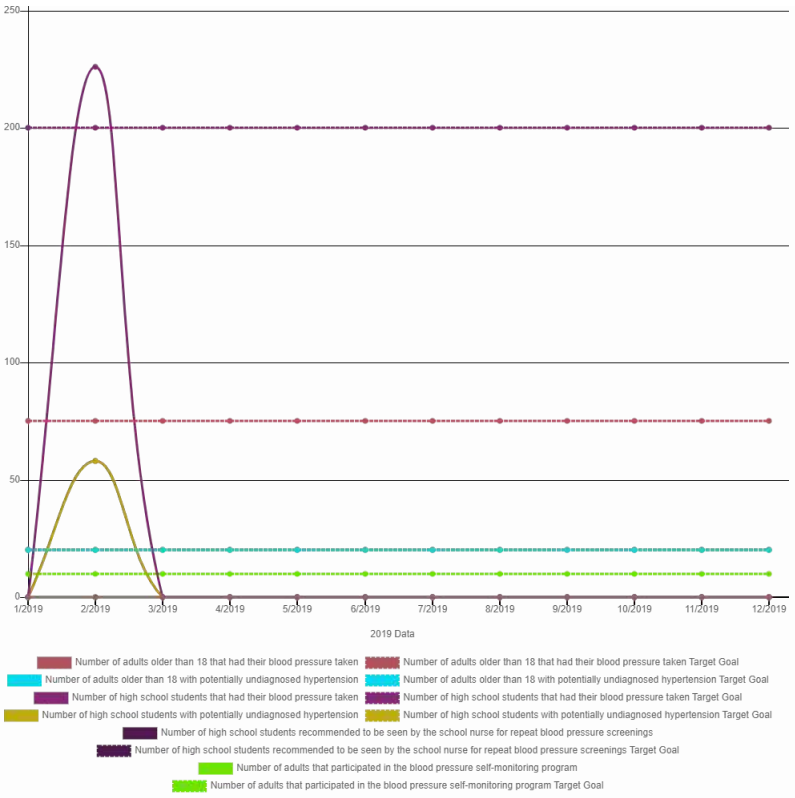
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Number of adults older than 18 that had their blood pressure taken	75	Active	Amy Ritchie, Outreach Team, & Betty Anderson												
Number of adults older than 18 with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson												
Number of high school students that had their blood pressure taken	200	Active	Amy Ritchie, Outreach Team & Bety Anderson									231			
Number of high school students with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson									11			
Number of high school students recommended to be seen by the school nurse for repeat blood pressure screenings	20	Active	Amy Ritchie, Outreach Team, Health Teachers, School Nurses & Betty Anderson									11			
Number of adults that participated in the blood pressure self-monitoring program	10	Active	Amy Ritchie, Outreach Team & Betty Anderson												



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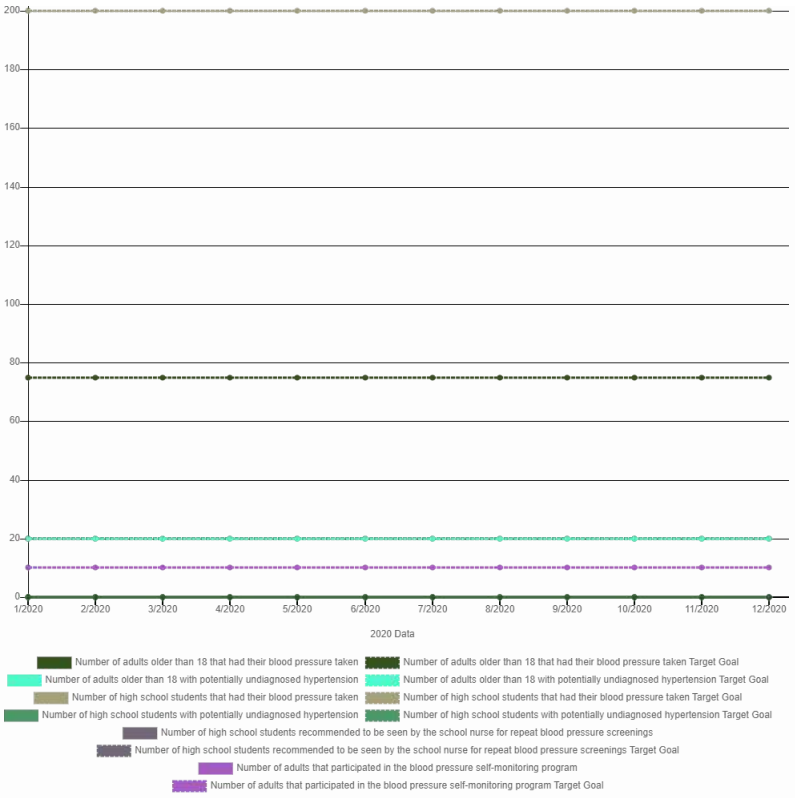
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Number of adults older than 18 that had their blood pressure taken	75	Active	Amy Ritchie, Outreach Team, & Betty Anderson												
Number of adults older than 18 with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson												
Number of high school students that had their blood pressure taken	200	Active	Amy Ritchie, Outreach Team & Bety Anderson		226										
Number of high school students with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson		58										
Number of high school students recommended to be seen by the school nurse for repeat blood pressure screenings	20	Active	Amy Ritchie, Outreach Team, Health Teachers, School Nurses & Betty Anderson		58										
Number of adults that participated in the blood pressure self-monitoring program	10	Active	Amy Ritchie, Outreach Team & Betty Anderson												



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Number of adults older than 18 that had their blood pressure taken	75	Active	Amy Ritchie, Outreach Team, & Betty Anderson												
Number of adults older than 18 with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson												
Number of high school students that had their blood pressure taken	200	Active	Amy Ritchie, Outreach Team & Bety Anderson												
Number of high school students with potentially undiagnosed hypertension	20	Active	Amy Ritchie, Outreach Team & Betty Anderson												
Number of high school students recommended to be seen by the school nurse for repeat blood pressure screenings	20	Active	Amy Ritchie, Outreach Team, Health Teachers, School Nurses & Betty Anderson												
Number of adults that participated in the blood pressure self-monitoring program	10	Active	Amy Ritchie, Outreach Team & Betty Anderson												

Data Narrative:

The Health Department provided blood pressure monitors through a blood pressure grant from the Maryland Department of Health to various health professionals in the county along with data collecting forms. Health Department staff will compile the data monthly from 10/1/18-3/31/19. Students attending Northern and Southern High Schools have their blood pressure taken at the beginning and the end of the semester as part of the fitness assessment for students enrolled in 9th Grade Health and Weight Lifting classes.

Research: Data is being collected monthly from 10/1/18-3/31/19

Contributing Community Participants:

Joseph Burger / John Corbin / Brian X. Murray / Amy Ritchie /

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Community First Choice/Community Options Waiver

Public Group 21 minutes ago

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GROUP ADMINS

Aging In Place

Community First Choice/Community Options Waiver

https://mygarrettcounty.com/groups/community-first-choicecommunity-options-waiver/

Snapshot Generated: 2019-02-14

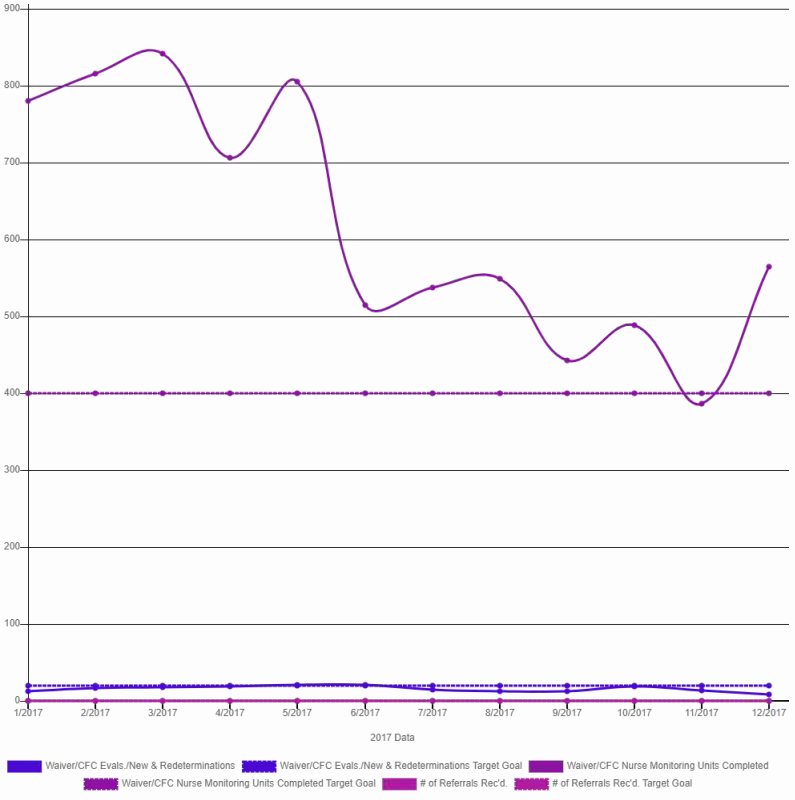
Narrative:

Strategy Description: Provide medically compromised individuals who would normally require nursing home care, to be able to stay in their homes with help. This is done by providing an in home aide, meals, emergency response buttons, medical equipment, case management by a Supports Planner and nurse monitoring of the caregivers. Client must meet medical and financial criteria in order to qualify for assistance. The financial criteria is that client must have Medicaid.

Level of Change: Programs

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2017-07-01 | **Estimated Completion Date:** 2018-06-30



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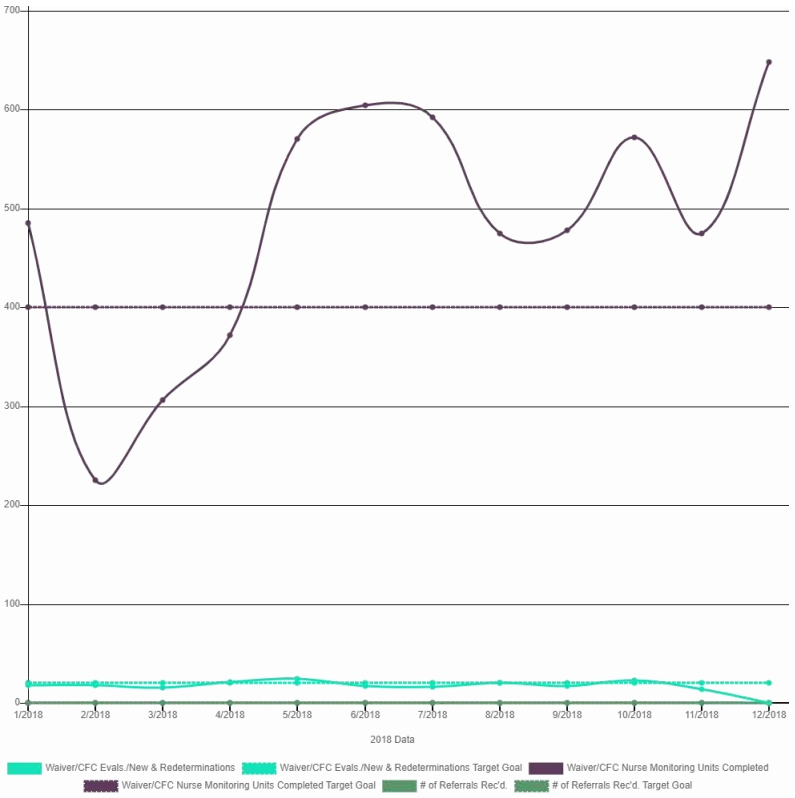
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Waiver/CFC Evals./New & Redeterminations	20	Active	Kathy Skipper, GCHD AERS	12	17	18	19	21	21	15	13	13	19	14	8
Waiver/CFC Nurse Monitoring Units Completed	400	Active	Kathy Skipper, GCHD AERS	780	816	842	706	805	515	537	549	443	489	386	565
# of Referrals Rec'd.		Active													



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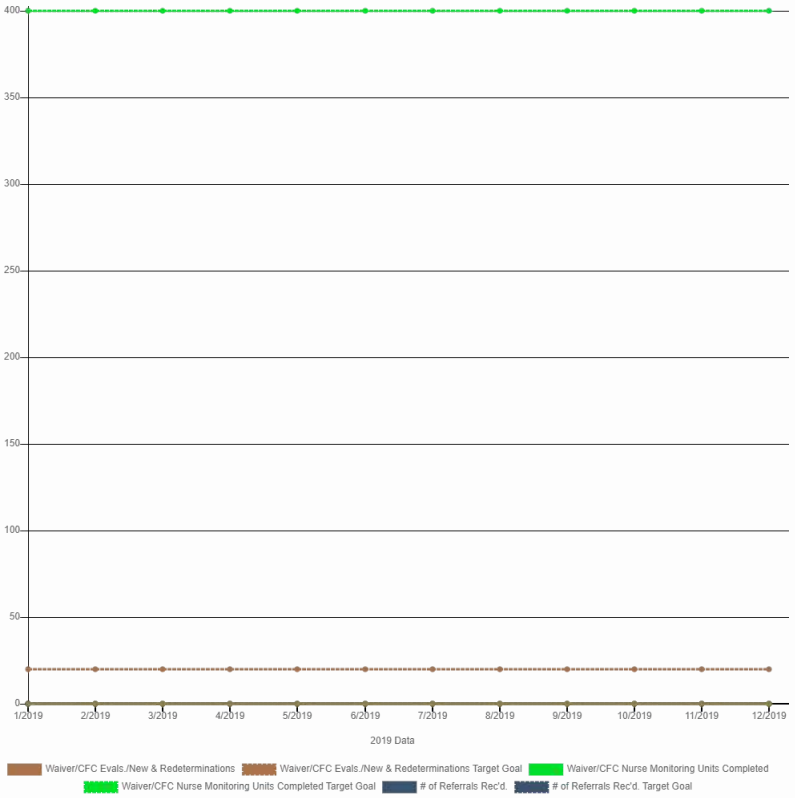
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Waiver/CFC Evals./New & Redeterminations	20	Active	Kathy Skipper, GCHD AERS	18	18	15	21	24	17	16	20	17	23	14	0.09
Waiver/CFC Nurse Monitoring Units Completed	400	Active	Kathy Skipper, GCHD AERS	485	225	306	372	570	604	592	475	478	572	475	648
# of Referrals Rec'd.		Active													



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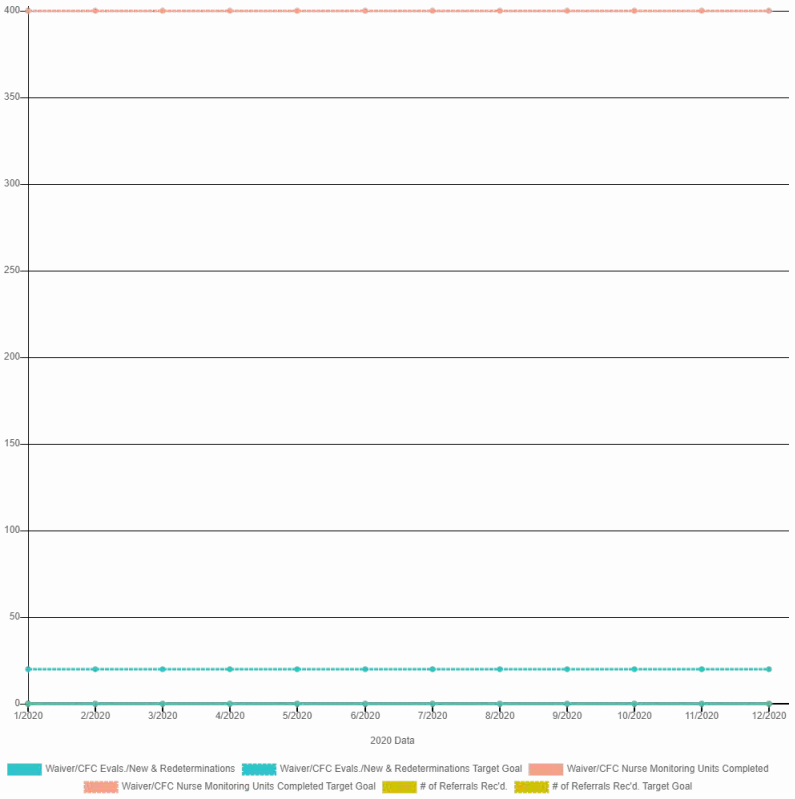
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Waiver/CFC Evals./New & Redeterminations	20	Active	Kathy Skipper, GCHD AERS												
Waiver/CFC Nurse Monitoring Units Completed	400	Active	Kathy Skipper, GCHD AERS												

# of Referrals Rec'd.		Active														



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Waiver/CFC Evals./New & Redeterminations	20	Active	Kathy Skipper, GCHD AERS												
Waiver/CFC Nurse Monitoring Units Completed	400	Active	Kathy Skipper, GCHD AERS												
# of Referrals Rec'd.		Active													

Contributing Community Participants:

Jenny / Susie / Patrick / Mary Johnson / Christine / Lindsey Bernal / Jennifer Lee-Steckman / Teresa Friend / John Corbin / Kathaleen Skipper /

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Coordinated Behavioral Health

Public Group 44 minutes ago

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GROUP ADMINS

Coordinated Behavioral Health

Coordinated Behavioral Health

https://mygarrettcounty.com/groups/behavioral-health-authority/coordinated-behavioral-health/

Snapshot Generated: 2019-02-14

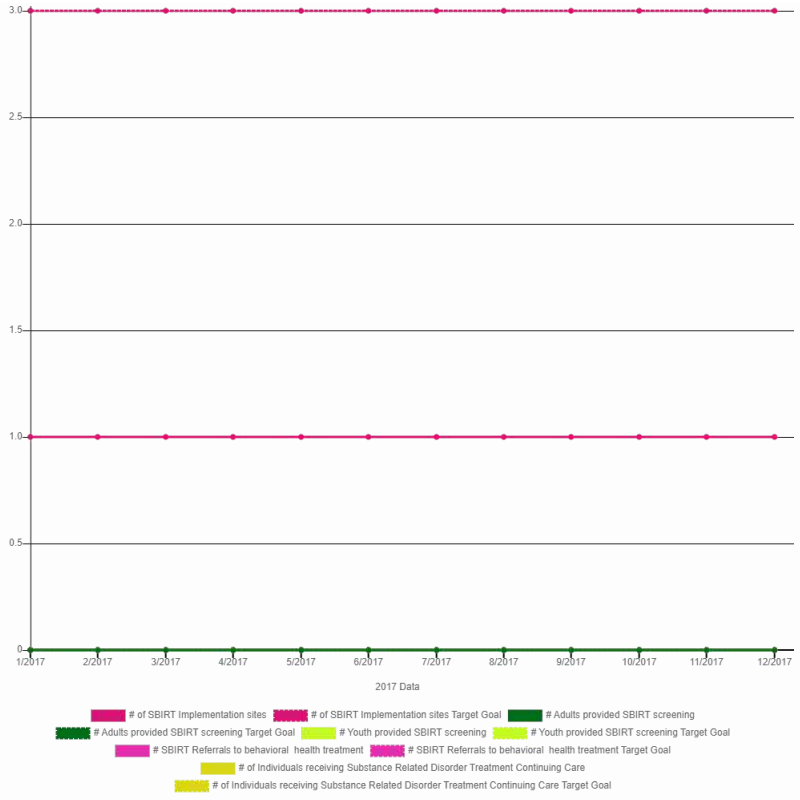
Narrative:

Strategy Description: Develop, implement, and evaluate screening, prevention, and early intervention services. SBIRT information promoted through www.mygarrettcounty.com; Number of Implementation sites Number of Adults Screened Number of Youth Screened Number of Referrals to Behavioral Health treatment Facilitate online training developed and implemented for providers and practitioners; Number of Mental Health First Aid training sessions provided to general public and lay professionals; Enhance and sustain a comprehensive approach to discourage youth substance use. Implement data driven, evidenced based prevention and early intervention initiatives targeted for youth. Number of Evidenced Based strategies implemented; Number of General Public individuals involved in DFCC Action Teams and/or planned prevention education events; Number of youth attending scheduled prevention events Promote Community Awareness of commercial and social access to tobacco, alcohol, and other drugs Number of alcohol compliance checks Number of tobacco compliance checks Number of Training for Intervention Procedures (TIPs) server and conscession training. Increase Behavioral Health Recovery Rates for Adolescents and Adults Number of in-person or telephonic collaborations with Primary Care Physicians and other Somatice Health Care providers during course of behavioral health treatment; Number of Outcome Management System Interviews showing improvement form previous interview. Assure that transportation in accessible to individuals in the Maryland Public Behavioral Health System

Level of Change: Systems

Primary Focus Area: Behavioral Health: including Substance Abuse and Mental Health

Estimated Implementation Date: 2017-07-01 | **Estimated Completion Date:** 2018-07-02



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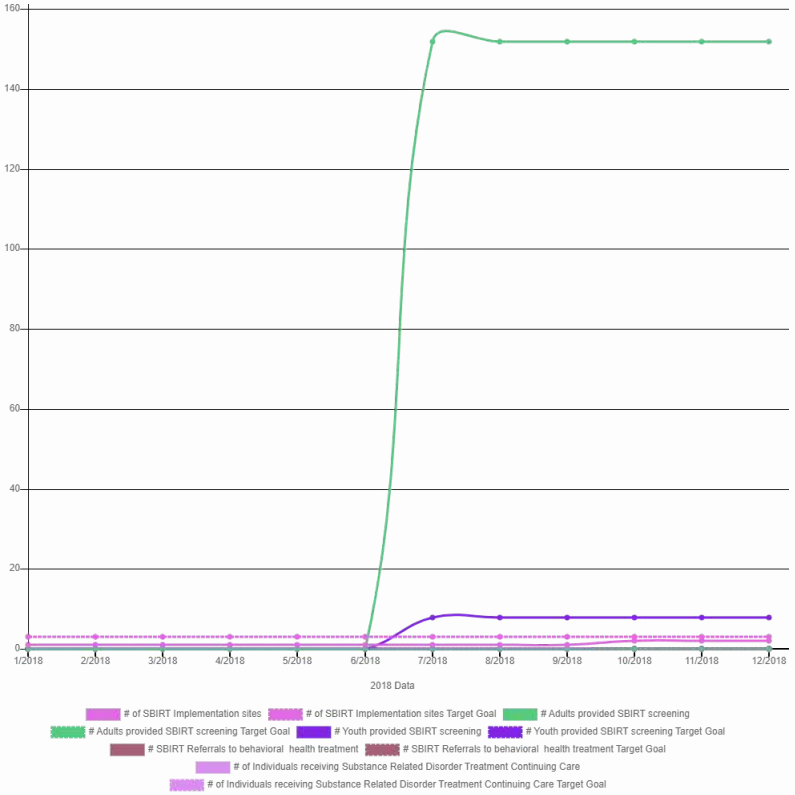
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017

# of SBIRT Implementation sites	3	Active	Mountain Laurel Medical Center; Garrett Regional Medical Center; Garrett County Health Department	1	1	1	1	1	1	1	1	1	1	1	1
# Adults provided SBIRT screening		Active		0	0	0	0	0	0	0	0	0	0	0	0
# Youth provided SBIRT screening		Active													0
# SBIRT Referrals to behavioral health treatment		Active		0	0	0	0	0	0	0	0	0	0	0	0
# of Individuals receiving Substance Related Disorder Treatment Continuing Care		Active													



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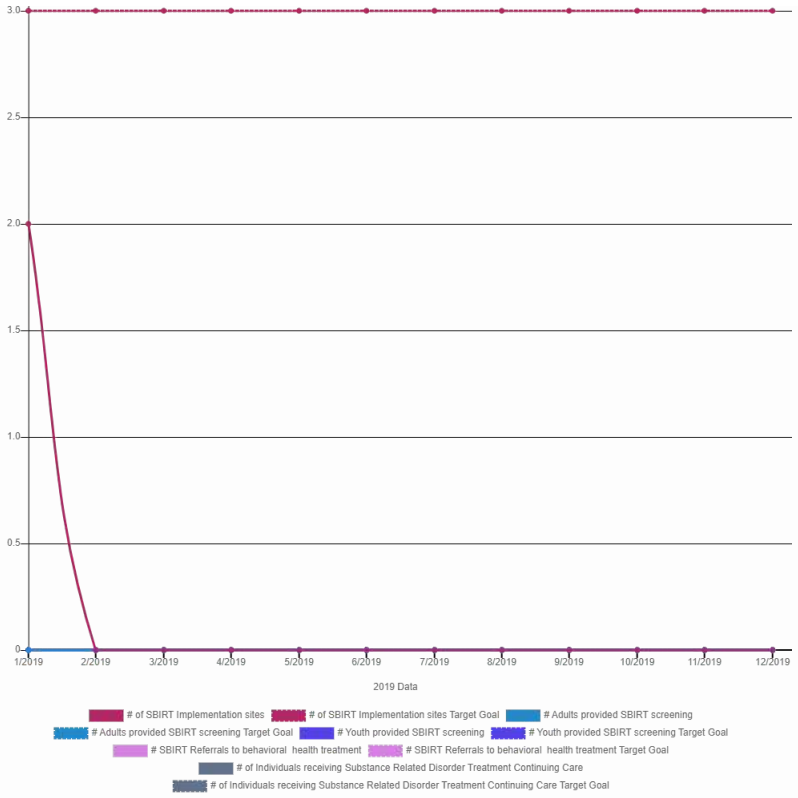
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
# of SBIRT Implementation sites	3	Active	Mountain Laurel Medical Center; Garrett Regional Medical Center; Garrett County Health Department	1	1	1	1	1	1	1	1	1	2	2	2
# Adults provided SBIRT screening		Active		0	0	0	0	0	0	151.73	151.73	151.73	151.73	151.73	151.73
# Youth provided SBIRT screening		Active		0	0	0	0	0	0	7.73	7.73	7.73	7.73	7.73	7.73
# SBIRT Referrals to behavioral health treatment		Active		0	0	0	0	0	0	0	0	0	0	0	0
# of Individuals receiving Substance Related Disorder Treatment Continuing Care		Active													



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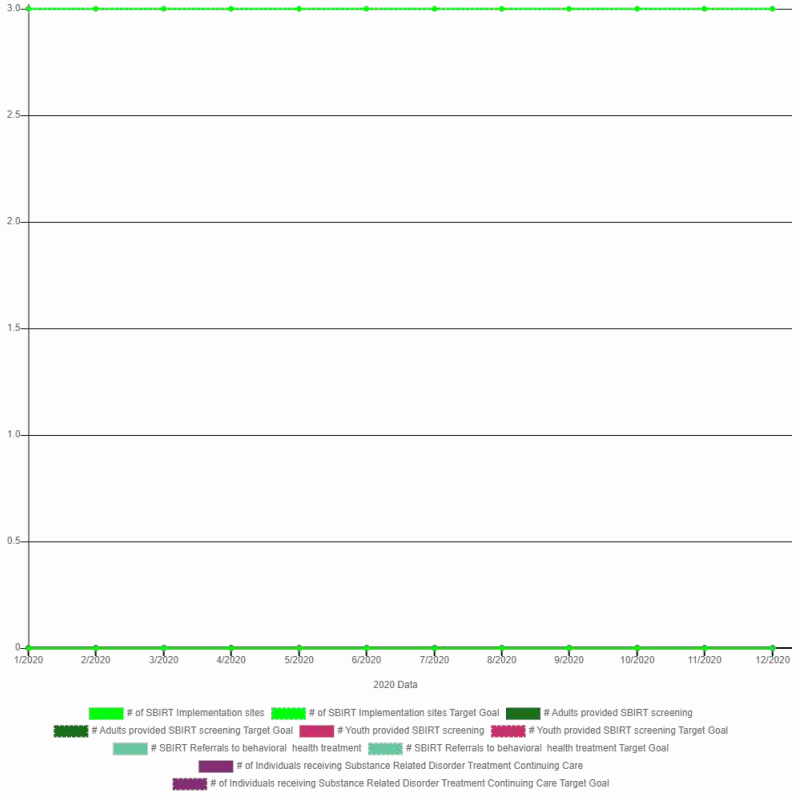
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
# of SBIRT Implementation sites	3	Active	Mountain Laurel Medical Center; Garrett Regional Medical Center; Garrett County Health Department	2											
# Adults provided SBIRT screening		Active													
# Youth provided SBIRT screening		Active													
# SBIRT Referrals to behavioral health treatment		Active													
# of Individuals receiving Substance Related Disorder Treatment Continuing Care		Active													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
# of SBIRT Implementation sites	3	Active	Mountain Laurel Medical Center; Garrett Regional Medical Center; Garrett County Health Department												
# Adults provided SBIRT screening		Active													
# Youth provided SBIRT screening		Active													
# SBIRT Referrals to behavioral health treatment		Active													
# of Individuals receiving Substance Related Disorder Treatment Continuing Care		Active													

Data Narrative:

- SBIRT (Screening, Brief Intervention, Referral, Treatment) is a process involving a screening tool for substance use and referral to treatment. This group is attempting to gather baseline information. We're looking for clinical stakeholders who have the opportunity to conduct SBIRT and those willing to share the data to report to the Garrett County Behavioral Health Plan authored by the Behavioral Health Authority. The Mental Health Advisory Committee and the Drug Free Communities Colation provide input for the plan.
- Data collection efforts focus on the number of SBIRT completed, and how many are referred for treatment.
- Mountain Laurel Medical Center was able to provide data for the number of SBIRT completed from July 1, 2018 through December 17, 2018 for both Adults (Ages 18+) and Youth (ages 12-17). However, their system has not been configured to track the number of SBIRT leading to referral for Behavioral Health services.
- Number of SBIRT for Adults is represented in a monthly average, based on total of 1138 (Monthly Average of 151.73)
- Number of SBIRT for Youth is represented in a monthly average, based on total of 58 (Monthly Average of 7.73)

Research: http://www.annfammed.org/content/16/4/346.full https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warmhandoff-quickstartfull.pdf How to Partner with Primary Care: A Guide for Behavioral Health Providers Integrating primary care into a behavioral health practice is a big step with implications affecting every aspect of your organization. For a seamless merge, involve all stakeholders from both clinics in key decisions. The most effective healthcare practices also make customer service the main priority. Careful planning will yield improved service delivery and better health outcomes for the people you serve. Strategic Planning • Vision and mission. Start with clearly defined goals. Make sure your expectations align with your partner's before the planning process begins. • Scope. Identify potential clients, the services you will offer, and the clinical tools required. • Operations. Choose an operational model that meets the needs of your community and partnership. • Location. Arrange your physical space so that behavioral health and primary care staff can interact easily. This proximity will promote teamwork and "hallway consults." • One reception area. Simplify the customer experience by creating one reception area for both behavioral health and primary care services. • Flexible scheduling. Offering open access and same-day scheduling, if possible, can increase convenience for people needing services and improve engagement. • Legal and regulatory matters. An attorney can help you understand the legal and regulatory requirements of integrating your services with a primary care provider. Obtain appropriate liability insurance coverage, too. • Financial. Prepare a detailed account of billing codes and which partner will bill for which services. • Marketing. Create a short-term and long-term plan for promoting and expanding your services. Close Teamwork • Partner buy-in. Include your primary care partner in all aspects of planning to limit unnecessary modifications later. • Collaboration. Create implementation teams with staff from both organizations to promote face-to-face interaction from the beginning. • Cooperation. Solicit input from clinical and administrative staff on process mapping and workflow. • Communication. Set up weekly treatment team meetings for all behavioral health and primary care staff members so they can pool their expertise to discuss treatment challenges. • Referrals. Introduce the people you serve to the primary care professional you are recommending. A warm, personal handoff increases the likelihood a person will follow through. • Assessment. Develop a method to track and measure your clinical, financial, and operational outcomes. • Celebrate. You are ready to unveil your enhanced services! Celebrate this milestone with those who helped to make it happen. This will reenergize and strengthen team relationships. To find out more about integration, contact the SAMHSA-HRSA Center for Integrated Health Solutions web: www.integration.samhsa.gov; email: integration@thenationalcouncil.org; phone: 202-684-7457.

Contributing Community Participants:

Joseph Burger / Jennifer Corder / Gillian Shreve / Brian X. Murray / Patrick / Jodi Kulak / ANNIE MAY SHORT / Thomas J. Killian Jr. / jessica howard / Chris Baker / Cameron Pollock / Carrie Hook / Diana Boller / Christy Lambert / Lauren / Mary Johnson / Jessica / Christy / Christine / Rose M Clark / John Corbin / Lindsey Bernal / Charles Wilt / Jessica / Ed Kight / Alicia Cignatta / Les McDaniel / Teresa Friend / Anita Rhodes / Bob Stephens / Fred Polce / Shelley Argabrite /

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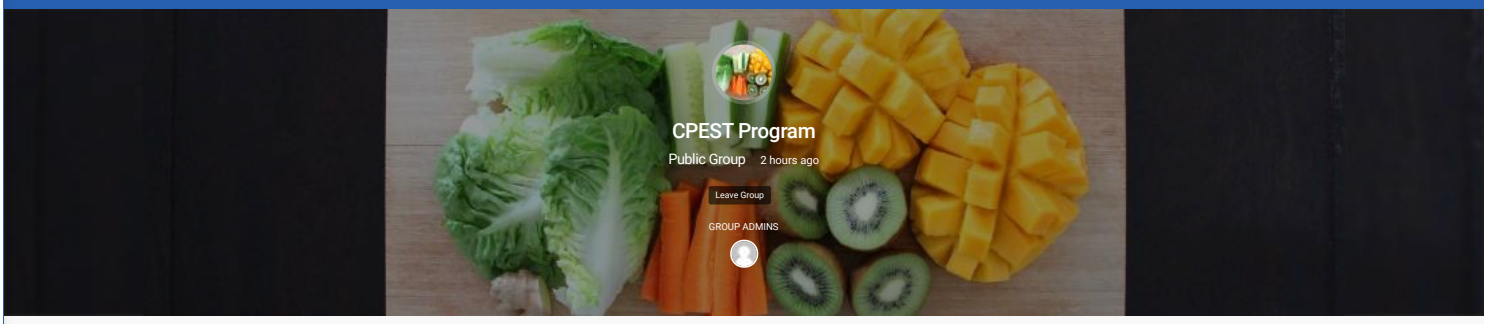


Cancer Program

CPEST Program

https://mygarrettcounty.com/groups/cpest-program-1268928979/

Snapshot Generated: 2019-02-14

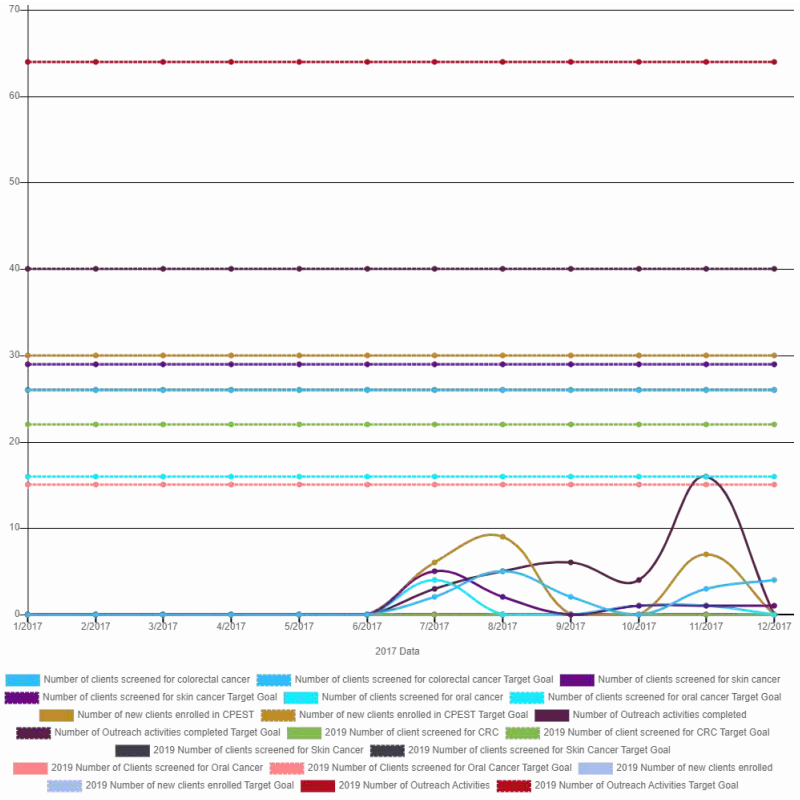
Narrative: The Maryland Cigarette Restitution Fund (CRF) was established in 2000 by the Maryland General Assembly to reduce the cancer incidence and mortality in Maryland. The legislation required the establishment of a local public health component to coordinate efforts in each jurisdiction. The local public health component of the CRF is the Cancer Prevention, Education, Screening, and Treatment Program

Strategy Description: CPEST Program will offer cancer screening services for skin, oral, and colorectal cancers. Program information and education will be promoted by Garrett County Health Department Outreach Program in the community and to local health care providers.

Level of Change: Programs

Primary Focus Area: Chronic Diseases and their common risk factors: lack of physical activity, poor nutrition, and tobacco use

Estimated Implementation Date: 2000-01-01 | **Estimated Completion Date:**



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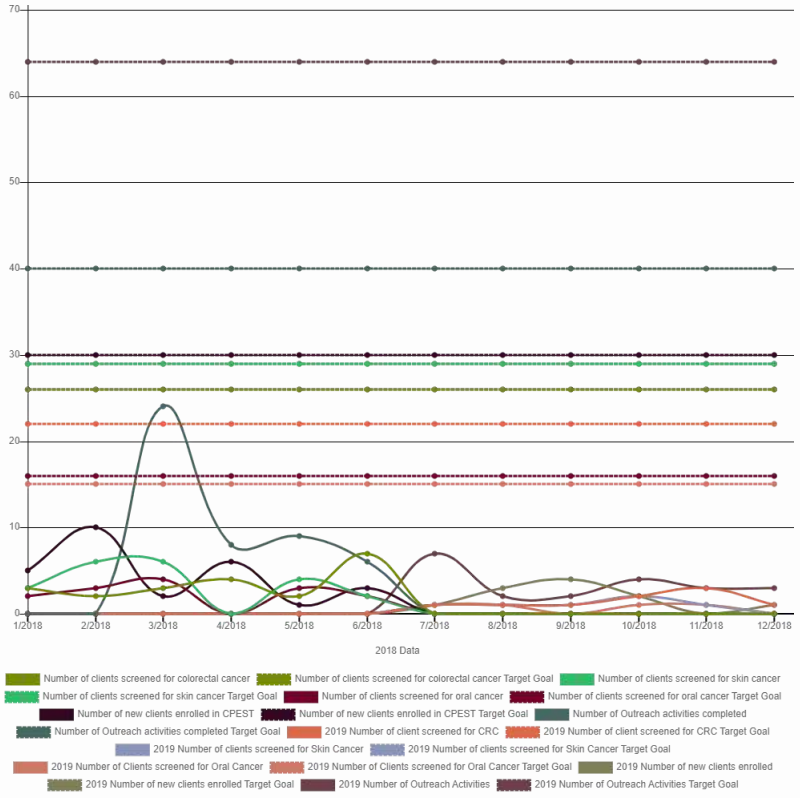
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Number of clients screened for colorectal cancer	26	Archived								2	5	2	0	3	4
Number of clients screened for skin cancer	29	Archived								5	2	0	1	1	1
Number of clients screened for oral cancer	16	Archived								4	0	0	1	1	0

Number of new clients enrolled in CPEST	30	Archived								6	9	0	0	7	0
Number of Outreach activities completed	40	Archived								3	5	6	4	16	0
2019 Number of client screened for CRC	22	Active													
2019 Number of clients screened for Skin Cancer	26	Active													
2019 Number of Clients screened for Oral Cancer	15	Active													
2019 Number of new clients enrolled	29	Active													
2019 Number of Outreach Activities	64	Active													



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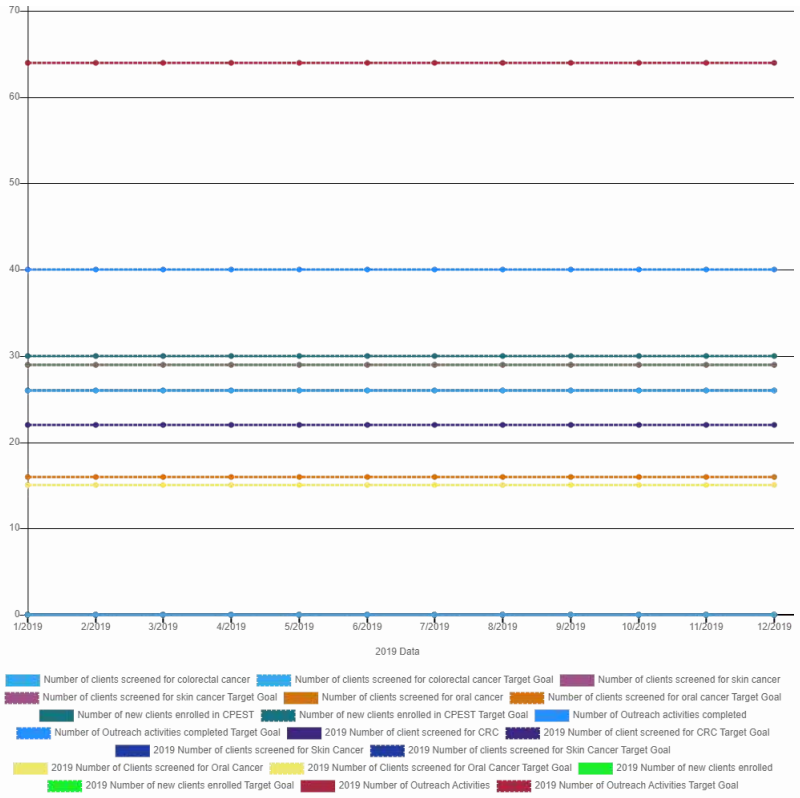
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Number of clients screened for colorectal cancer	26	Archived		3	2	3	4	2	7						
Number of clients screened for skin cancer	29	Archived		3	6	6	0	4	2						
Number of clients screened for oral cancer	16	Archived		2	3	4	0	3	2						
Number of new clients enrolled in CPEST	30	Archived		5	10	2	6	1	3						
Number of Outreach activities completed	40	Archived		0	0	24	8	9	6						
2019 Number of client screened for CRC	22	Active								1	1	1	2	3	1
2019 Number of clients screened for Skin Cancer	26	Active								1	1	1	2	1	0
2019 Number of Clients screened for Oral Cancer	15	Active								1	1	0	1	1	0
2019 Number of new clients enrolled	29	Active								1	3	4	2	0	1
2019 Number of Outreach Activities	64	Active								7	2	2	4	3	3



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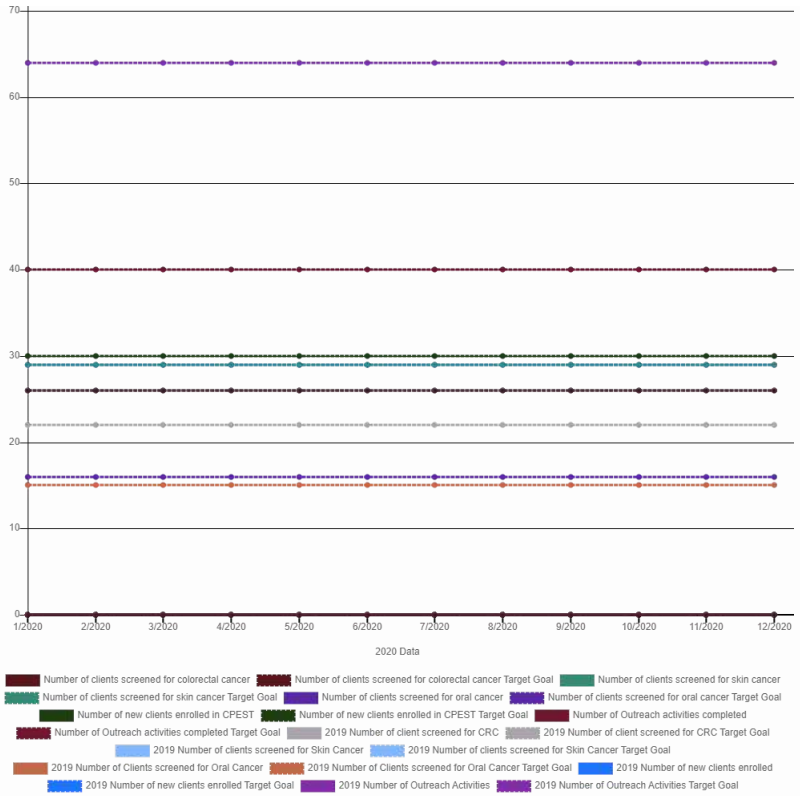

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2019 Number of Outreach Activities	64	Active													

Contributing Community Participants:

Chris Baker / HEATHER BERG / Christine / John Corbin / Lindsey Bernal / Kara Taylor / Christa / Cindy Mankamyer / Sharon Custer / Tiffany Fratz / Jennifer Lee-Steckman / Caroline Evans / Judy Sines /

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Early Care Immunizations

Public Group an hour ago

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GROUP ADMINS

Navigation Navigation

Immunizations through Early Care Programs at the Garrett County Health Department

Early Care Immunizations

https://mygarrettcounty.com/groups/early-care-immunizations/

Snapshot Generated: 2019-02-14

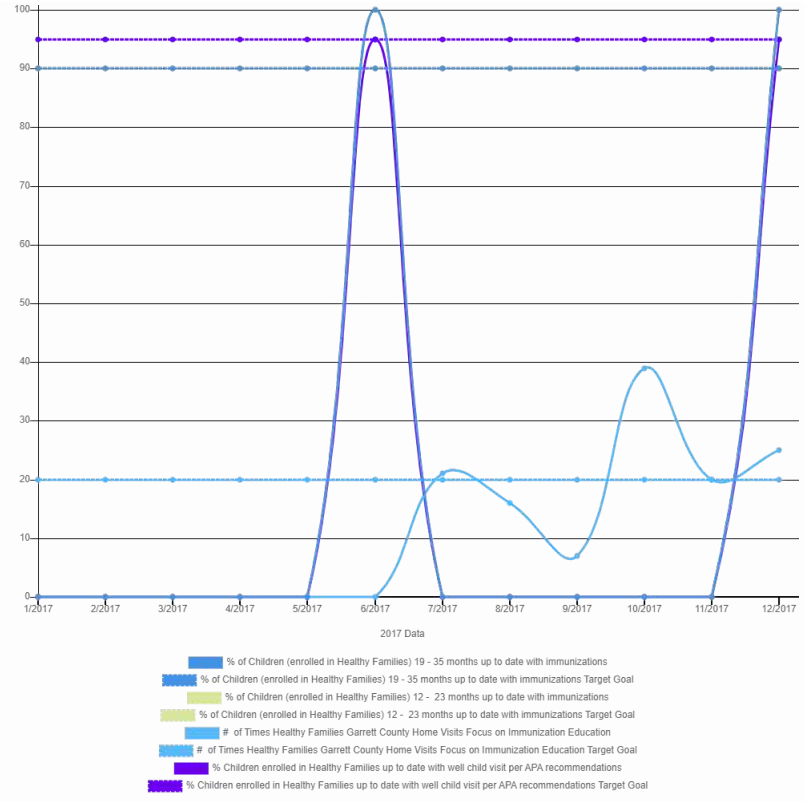
Narrative:

Strategy Description: The Community Preventive Services Task Force recommends home visits to increase childhood immunization rates. The recommendation is based on strong evidence of home visitatation providing effectiveness in increasing vaccination rates as a result of home visitors completing activites that include home visitors assessing clients' vaccination status, discussing the importance of recommended vaccinations, and referring to primary care providers (The Community Guide, 2016). In addition to the above activites, Healthy Families Garrett County provides assistance to families by arranging or providing transportation to medical appointments for immunizations as needed. The program also provides verbal and written vaccine education to families, provides immunization tracking books to families and collaborates with providers, along with families as needed, to discuss and schedule necessary appointments. Healthy Families Garrett County collects data on the following measures to evaluate effectivenss of home vistitation services in increasing immunization rates for children enrolled in program services: % of Enrolled Healthy Families children up-to-date with immunizations between 19 and 35 months % of Enrolled Healthy Families children between 12 and 23 months up-to-date with immunizations required for 6 months of age; and children 23 months up-to-date with immunizations required for 18 months of age # of families enrolled in Healthy Families provided education on immunizations (education incudes information on the importance of immunizations, the America Academy of Pediatrices recommended immunization schedule, what to expect when receiving immunizations, child care after immunizations, tracking immunizations received, etc.) % of Children enrolled in Healthy Families up to date with well child visits per the American Academy of Pediatrics recommendations

Level of Change: Programs

Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2000-07-01 | **Estimated Completion Date:** 2018-06-30



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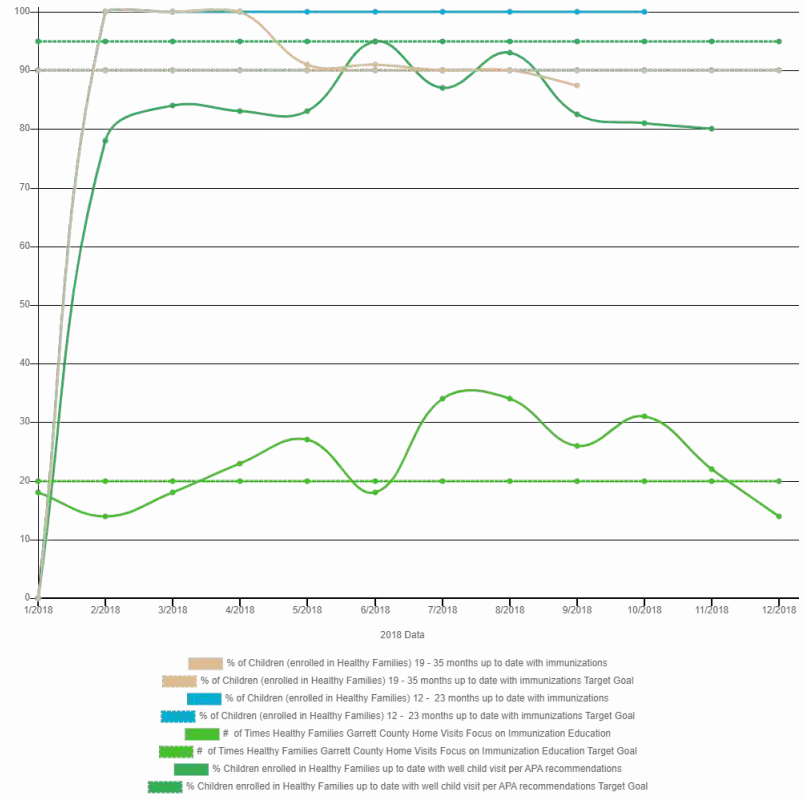
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017

% of Children (enrolled in Healthy Families) 19 - 35 months up to date with immunizations	90	Active							100						100
% of Children (enrolled in Healthy Families) 12 - 23 months up to date with immunizations	90	Active							100						100
# of Times Healthy Families Garrett County Home Visits Focus on Immunization Education	20	Active								21	16	7	39	20	25
% Children enrolled in Healthy Families up to date with well child visit per APA recommendations	95	Active							95						95



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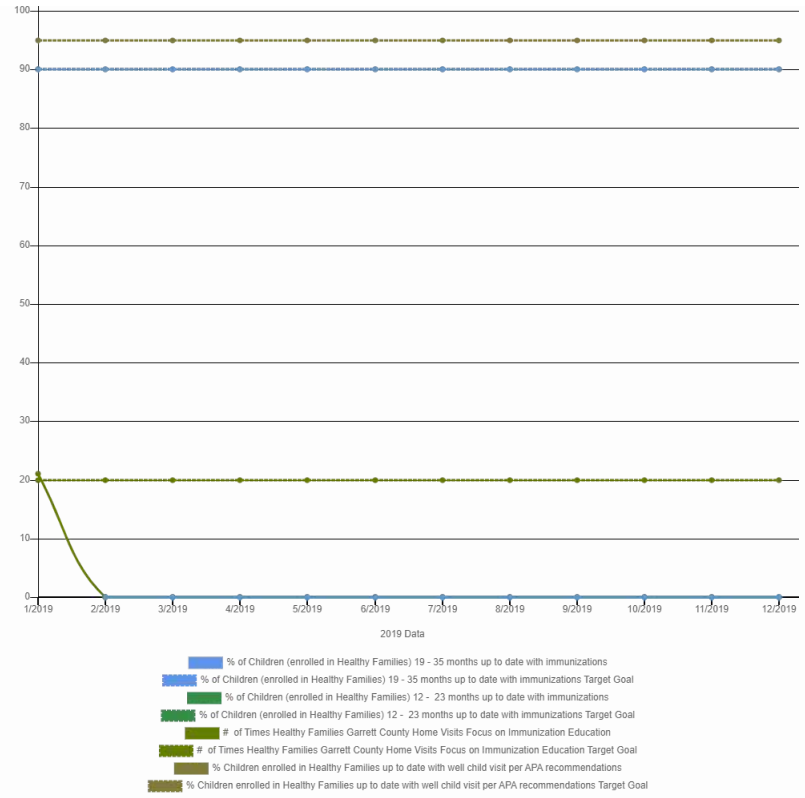
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
% of Children (enrolled in Healthy Families) 19 - 35 months up to date with immunizations	90	Active			100	100	100	91	91	90	90	87.5	86%	86%	89%
% of Children (enrolled in Healthy Families) 12 - 23 months up to date with immunizations	90	Active			100	100	100	100	100	100	100	100	100	100%	100%
# of Times Healthy Families Garrett County Home Visits Focus on Immunization Education	20	Active		18	14	18	23	27	18	34	34	26	31	22	14
% Children enrolled in Healthy Families up to date with well child visit per APA recommendations	95	Active			78	84	83	83	95	87	93	82.5	81	80	100%



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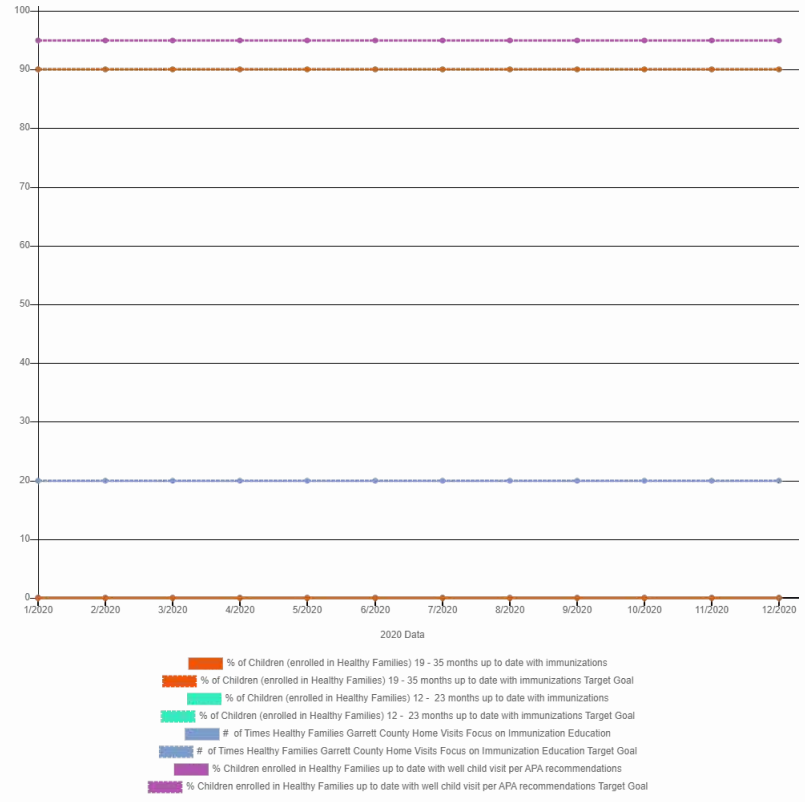
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
% of Children (enrolled in Healthy Families) 19 - 35 months up to date with immunizations	90	Active		89%											
% of Children (enrolled in Healthy Families) 12 - 23 months up to date with immunizations	90	Active		100%											
# of Times Healthy Families Garrett County Home Visits Focus on Immunization Education	20	Active		21											
% Children enrolled in Healthy Families up to date with well child visit per APA recommendations	95	Active		95%											



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% of Children (enrolled in Healthy Families) 12 - 23 months up to date with immunizations	90	Active												
# of Times Healthy Families Garrett County Home Visits Focus on Immunization Education	20	Active												
% Children enrolled in Healthy Families up to date with well child visit per APA recommendations	95	Active												

Contributing Community Participants:

servant / Erin Marsh / Jennifer VanPelt / Christine / Lindsey Bernal / Brittany Hamilton / Natasha / Alisha Plessinger / Charles Wilt / Karen Matthews / Kathy Powell / joanne roberts / Teresa Friend / Debra House / bonnie paugh / Marcia Ashby / Marilyn Kight / Theresa Cavalier / Bev Tucker / bonnie tichnell / kristina wadidii / Maria Friend / John Corbin / linda welch RN.BSN / Debbie Durben / Karen Keefer / Tracy Savage / Jodi Roberson / Michelle Ford / Debra / Katie Welch / Christinia Kemper / Melina Manley / Kimberly Hawes / Cindy Mankamyer / Kara Taylor / HEATHER BERG / Earleen Beckman /

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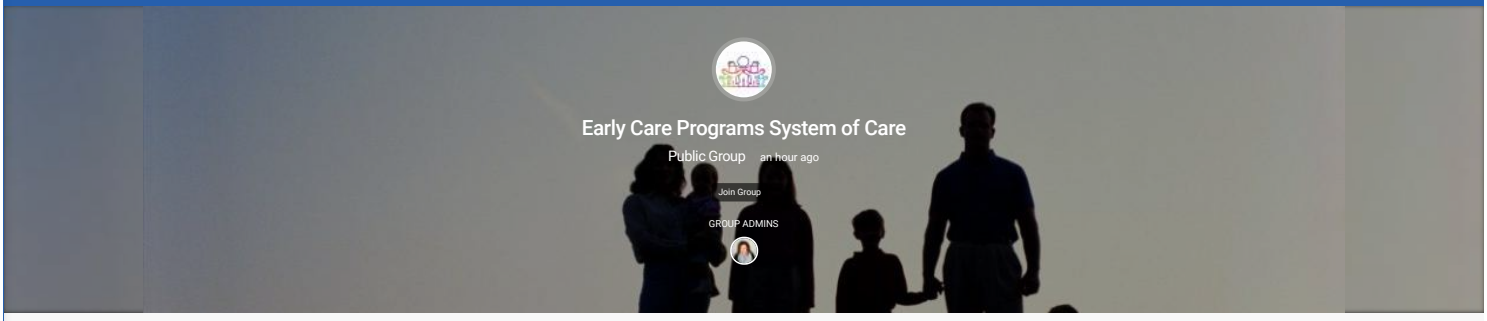


Early Care Programs System of Care

Early Care Programs System of Care

https://mygarrettcounty.com/groups/early-care-programs-system-of-care/

Snapshot Generated: 2019-02-14

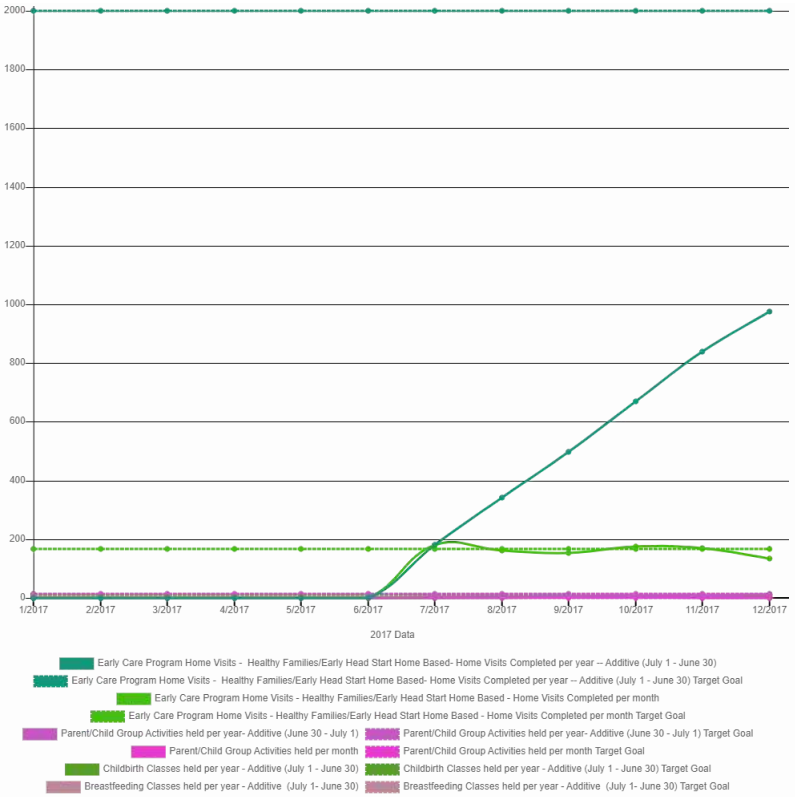
Narrative: Early Care Programs System of Care offers voluntary home visiting services that empower parents, at no cost, to give their child the best beginning in life! Early Care Programs offers Healthy Families Garrett County home visiting, Early Head Start Home Based home visiting, help to families in setting future goals & provides support in meeting those goals, childbirth and breastfeeding classes, and parent/child group activities.

Strategy Description: How Early Care Systems of Care can empower parents during the most important stages of learning (birth to three): Answers questions about pregnancy, nutrition, and childbirth. Links families with community resources. Teaches methods to soothe a crying baby. Offers breastfeeding support. Offers childbirth and breastfeeding classes. Provides developmental screenings. Invites caregivers and children to group activities such as Pizza N Play, Parent Groups, and Stroller Walks. Provides information on infant care, nutrition, child development, health, safety, and many more topics. Helps families set goals for the future & assist families in reaching them. Supports families to achieve advanced education and job readiness goals. Offers Free Warm Line services- Friendly, call-in telephone information & support (301-334-7720 or 301-895-3111).

Level of Change: Programs

Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2018-07-01 | **Estimated Completion Date:** 2018-06-30



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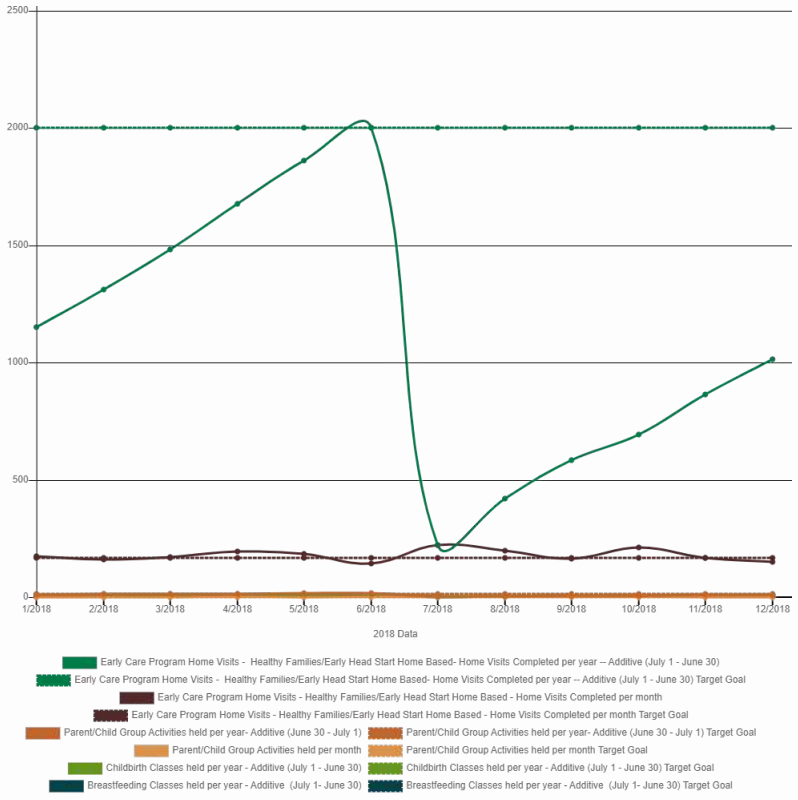
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Early Care Program Home Visits - Healthy Families/Early Head Start Home Based- Home Visits	2000	Active	Early Care Programs							180	342	496	670	840	975

Completed per year -- Additive (July 1 - June 30)			Database													
Early Care Program Home Visits - Healthy Families/Early Head Start Home Based - Home Visits Completed per month	166	Active	Early Care Program Database							180	162	154	174	170	135
Parent/Child Group Activities held per year- Additive (June 30 - July 1)	15	Active	Early Care Program							2	4	6	8	9	10
Parent/Child Group Activities held per month	1	Active	Early Care Program							2	2	2	2	1	1
Childbirth Classes held per year - Additive (July 1 - June 30)	11	Active	Early Care Program							1	2	3	4	5	6
Breastfeeding Classes held per year - Additive (July 1- June 30)	10	Active	Early Care Program							0	1	2	3	4	5



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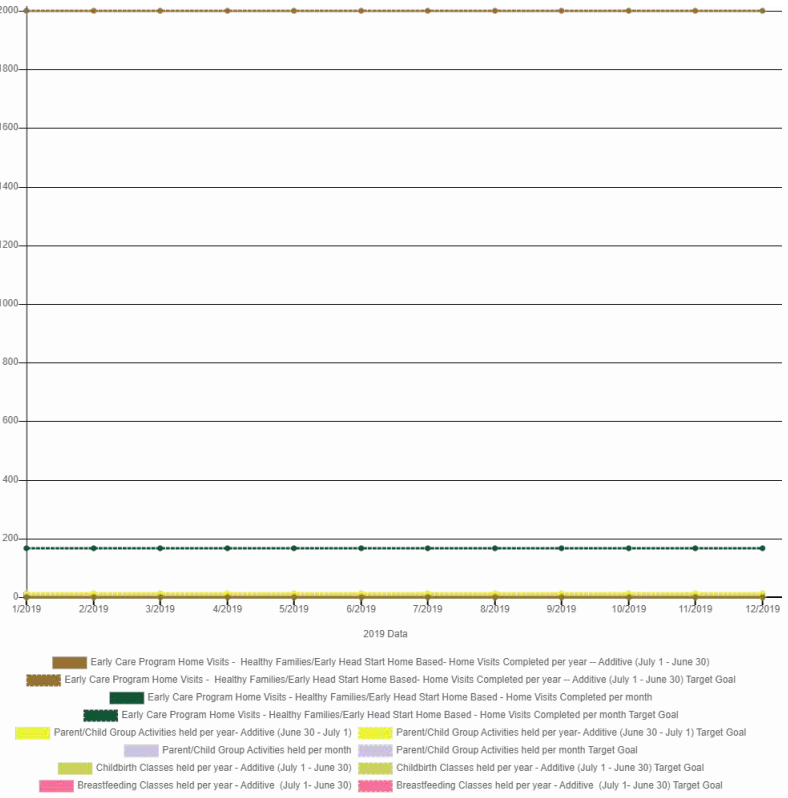
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Early Care Program Home Visits - Healthy Families/Early Head Start Home Based- Home Visits Completed per year -- Additive (July 1 - June 30)	2000	Active	Early Care Programs Database	1150	1311	1481	1676	1861	2003	223	420	583	695	864	1013
Early Care Program Home Visits - Healthy Families/Early Head Start Home Based - Home Visits Completed per month	166	Active	Early Care Program Database	175	161	170	195	185	142	223	197	163	212	169	149
Parent/Child Group Activities held per year- Additive (June 30 - July 1)	15	Active	Early Care Program	11	13	13	15	16	18	2	4	6	8	9	10
Parent/Child Group Activities held per month	1	Active	Early Care Program	1	1	1	2	1	2	2	2	2	2	1	1
Childbirth Classes held per year - Additive (July 1 - June 30)	11	Active	Early Care Program	7	8	9	10	11	12	1	2	3	4	5	6
Breastfeeding Classes held per year - Additive (July 1- June 30)	10	Active	Early Care Program	6	7	8	9	10	11	1	2	3	4	5	6



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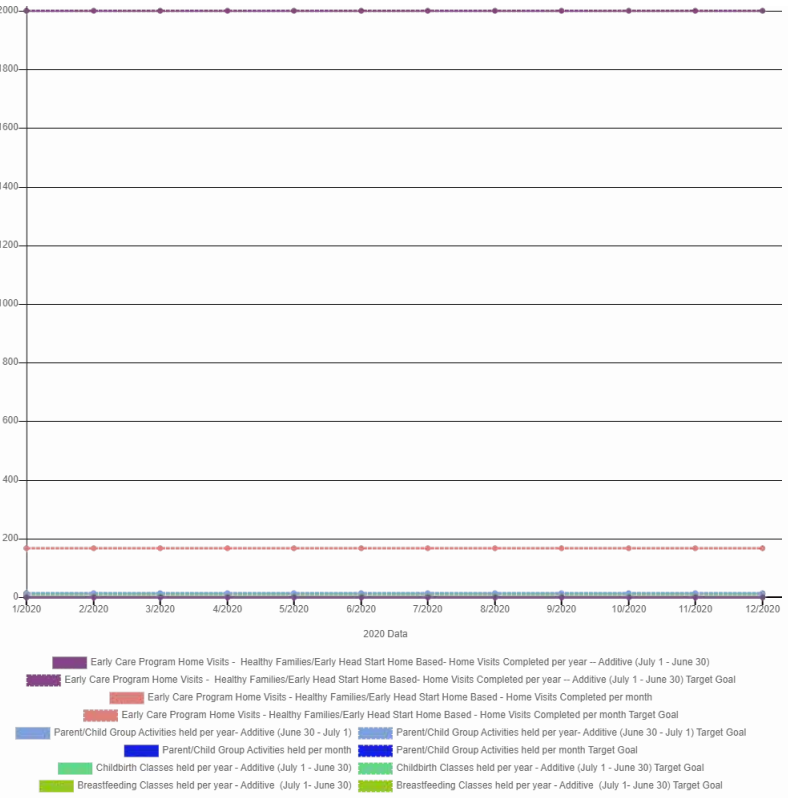

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Data Narrative:

Regrading annual (yearly) target goals, data collection begins on July 1 and ends on June 30th. Every July 1 begins with new data collection. Home visit data collected on unduplicated number of home visits completed within Early Care Program services.

Research: http://www.healthyfamiliesamerica.org/; https://eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-programs

Contributing Community Participants:

Jenny / Virgie / Patrick / William pope / Erin Marsh / jessica howard / Carrie Hook / Lauren / Mary Johnson / Jennifer VanPelt / bonnie paugh / Katie Welch / Maria Friend /

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Food Resource Asset Map – GC Food Insecurity Workgroup – Western Maryland Food Council

Public Group 17 days ago

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GROUP ADMINS

Food Insecurities

Food Resource Asset Map – GC Food Insecurity Workgroup – Western Maryland Food Council

https://mygarrettcounty.com/groups/social-determinants-of-health/

Snapshot Generated: 2019-02-14

Narrative:

In Garrett County the Food Insecurity Workgroup uses a collaborative approach to better meet the nutritional needs for our most vulnerable residents and is a part of the regional Western Maryland Food Council. The Food Council works on issues related to food, from production at the farm to nutrition at the table. Assessment efforts will be tracked with the intent to gain more understanding of the need for food resources in the county.

Strategy Description:

Create a list of all locations where free/reduced price foods are available throughout the county.

1. Research churches, food pantries, soup kitchens, etc.

2. Log those locations/dates/times available in a Google Sheet here:

https://docs.google.com/spreadsheets/d/1ee-ol1c-_07xuz-T5HRtDyMVbpYToHT7S7mzogVSyL8/edit?usp=sharing

3. Prepare the data into a user-friendly format (print and web-based)

4. Disseminate the information

   a. GarrettGuide

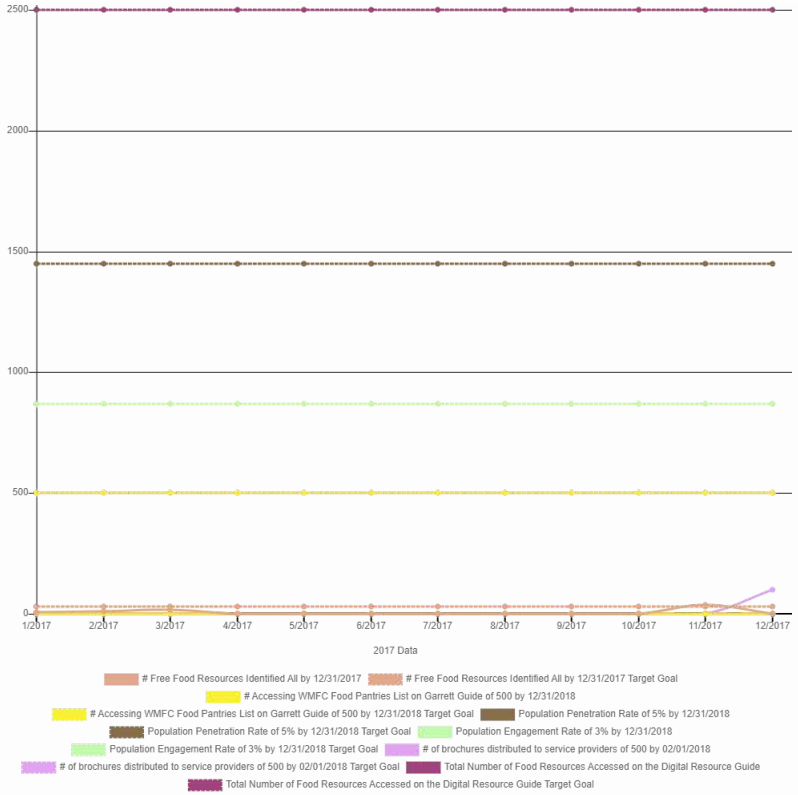
   b. Social Media

   c. Handouts to service providers

Level of Change: Systems

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2017-01-01 | **Estimated Completion Date:** 2020-12-31



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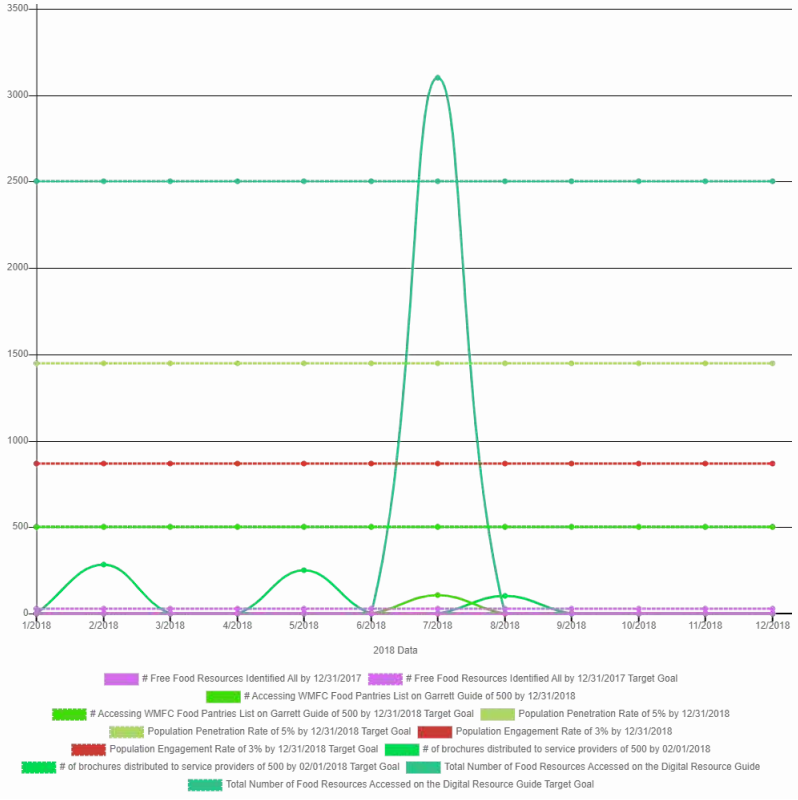
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
# Free Food Resources Identified All by 12/31/2017	30	Active		6	10	15								37	
# Accessing WMFC Food Pantries List on Garrett Guide of 500 by 12/31/2018	500	Active	John Corbin, via Garrett Guide analytics												
Population Penetration Rate of 5% by 12/31/2018	1450	Archived	John Corbin, via Garrett Guide												
Population Engagement Rate of 3% by 12/31/2018	870	Archived	John Corbin, via (Garrett Guide)												
# of brochures distributed to service providers of 500 by 02/01/2018	500	Active													100
Total Number of Food Resources Accessed on the Digital Resource Guide	2500	Active													



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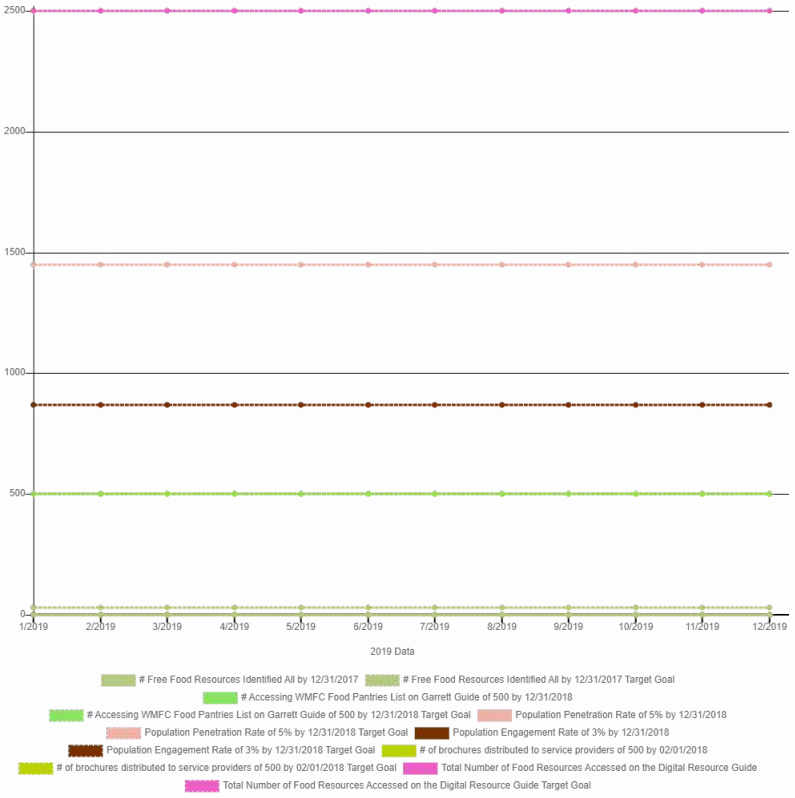
# Free Food Resources Identified All by 12/31/2017	30	Active													
# Accessing WMFC Food Pantries List on Garrett Guide of 500 by 12/31/2018	500	Active	John Corbin, via Garrett Guide analytics							107					
Population Penetration Rate of 5% by 12/31/2018	1450	Archived	John Corbin, via Garrett Guide												
Population Engagement Rate of 3% by 12/31/2018	870	Archived	John Corbin, via (Garrett Guide)												
# of brochures distributed to service providers of 500 by 02/01/2018	500	Active			284			250			100				
Total Number of Food Resources Accessed on the Digital Resource Guide	2500	Active								3102					



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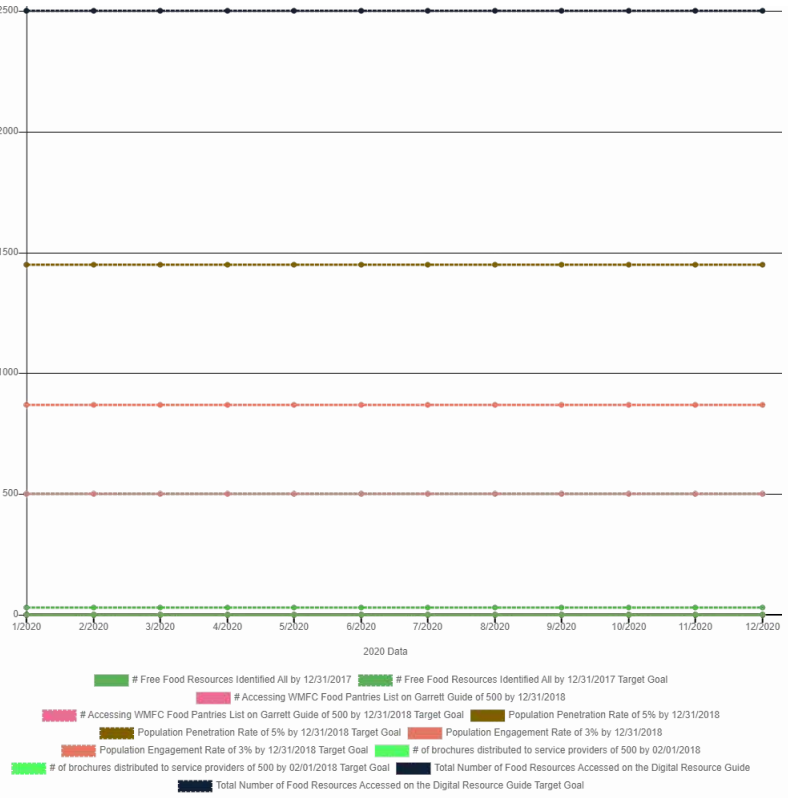
Total Number of Food Resources Accessed on the Digital Resource Guide	2500	Active													



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# of brochures distributed to service providers of 500 by 02/01/2018	500	Active													
Total Number of Food Resources Accessed on the Digital Resource Guide	2500	Active													

Data Narrative:

8.2018 Population Penetration and Engagement Rates have been archived as there are no further mechanisms in place at this time to further drill down on conversion metrics (i.e.; number of source referrals).

The brochure continues to be disseminated by various agencies and individuals. It is available online and via hard copy at the Health Department, Courthouse, Hospital, Community Action, Senior Centers, Judy Center, University of Maryland Extension Garrett Office, Garrett College, and others.

Contributing Community Participants:

Joseph Burger / Kendra McLaughlin / Kathaleen Skipper / Jennifer Corder / Lisa McCoy / Jacob Israel Hannah / Jessica Cooper / Roberta Cvetnick / Carol Bass / Susan Mills / Teresa Friend / Kay Schroeder / Willie Lantz / Amy Ritchie / Scott Germain / Katie Welch / Cynthia Jackson / John Corbin / Heather Cooper / Cheryl DeBerry / Shelley Argabrite /

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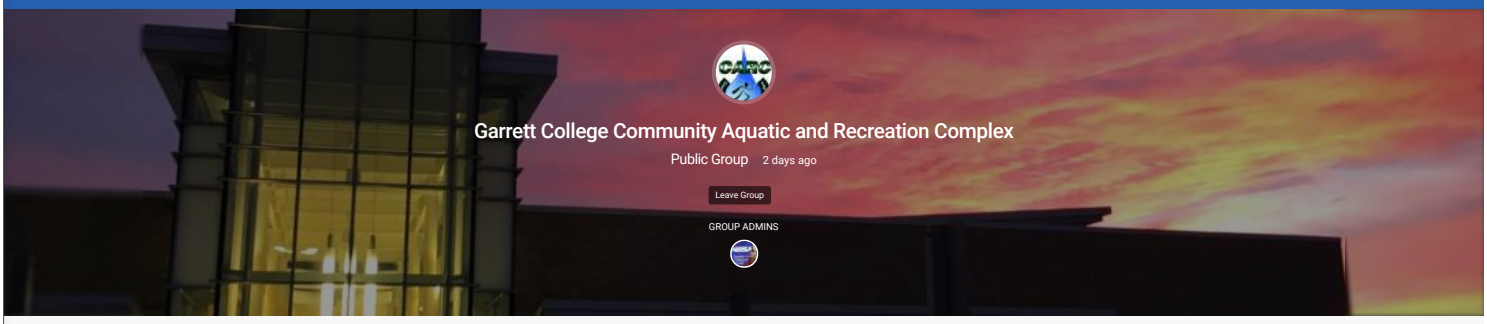

Garrett College Community Aquatic and Recreation Complex

Public Group 2 days ago

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GROUP ADMINS

Physical Activity: CARC

Garrett College Community Aquatic and Recreation Complex

https://mygarrettcounty.com/groups/garrett-college-community-aquatic-and-recreation-complex/

Snapshot Generated: 2019-02-14

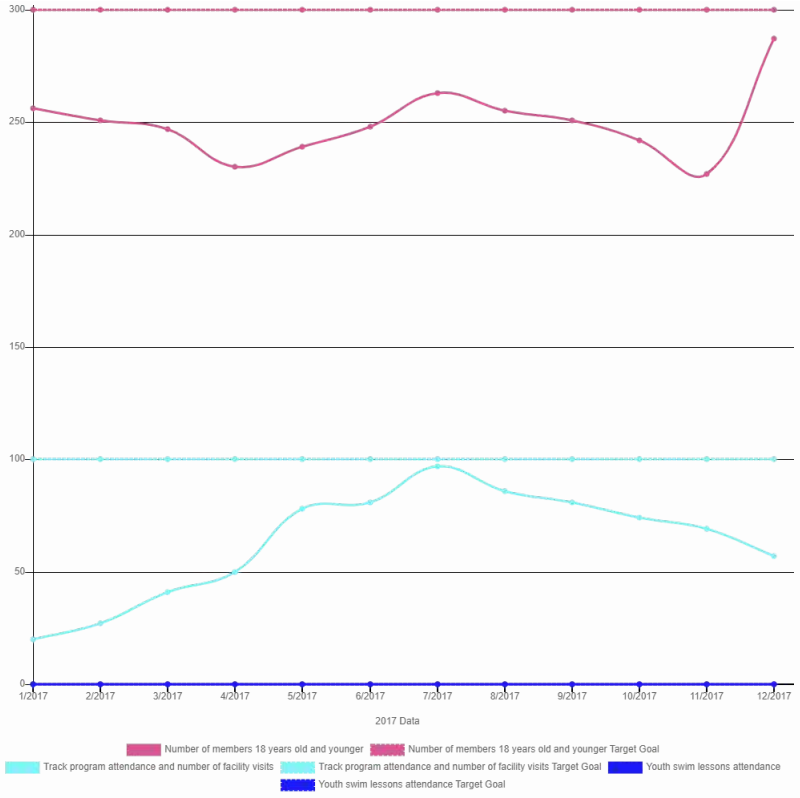
Narrative: A plan is in place for targeting the youth population of Garrett County to increase the use of the facility. The application of this goal will be realized through new programming, summer camps, target marketing, and collaboration with other organizations. Update 8/1/2018: The goals remains the same and work continues to reach these numbers. There has been changes to programming to keep what works and eliminate what does not. Summer camps and swim lessons are providing the biggest increase in youth numbers. Camps are seasonal and do not provide stable numbers. Swim lessons are the priority goal for the upcoming fiscal year.

Strategy Description: We targeting our youth population for increased use of the facility. The application of this goal will promote new programs, summer camps, target marketing, and collaboration with other outside organizations. After almost two years of data collect, we will now focus on pool based programming. Aquatic's programming appears to have the greatest appeal to current youth members and attracting potential youth members.

Level of Change: Programs

Primary Focus Area: Chronic Diseases and their common risk factors: lack of physical activity, poor nutrition, and tobacco use

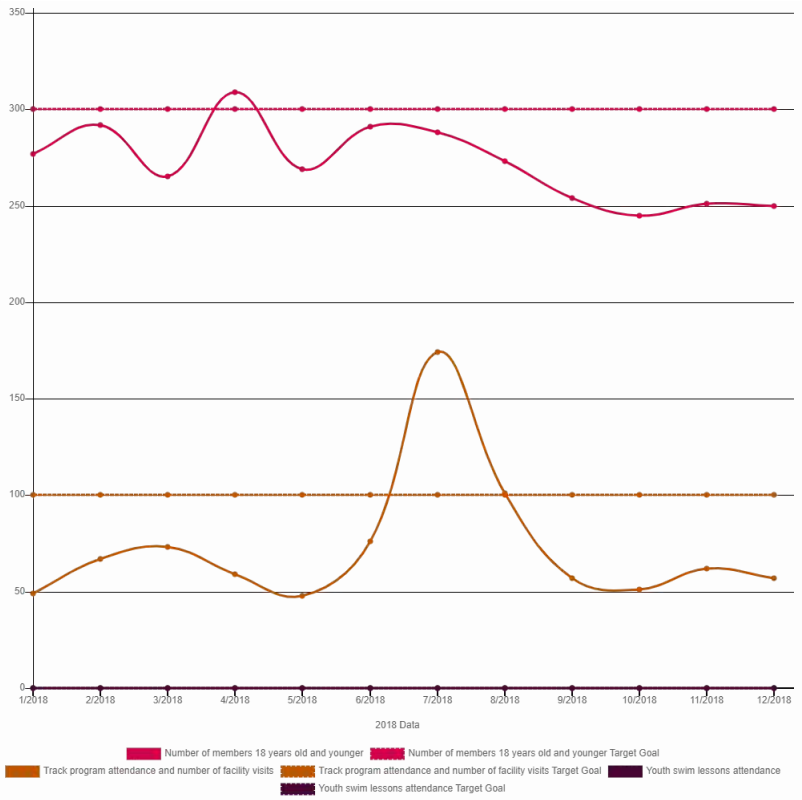
Estimated Implementation Date: 2016-11-01 | **Estimated Completion Date:** 2020-12-31



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Number of members 18 years old and younger	300	Active		256	251	247	230	239	248	263	255	251	242	227	287
Track program attendance and number of facility visits	100	Active		20	27	41	50	78	81	97	86	81	74	69	57

Youth swim lessons attendance		Active													



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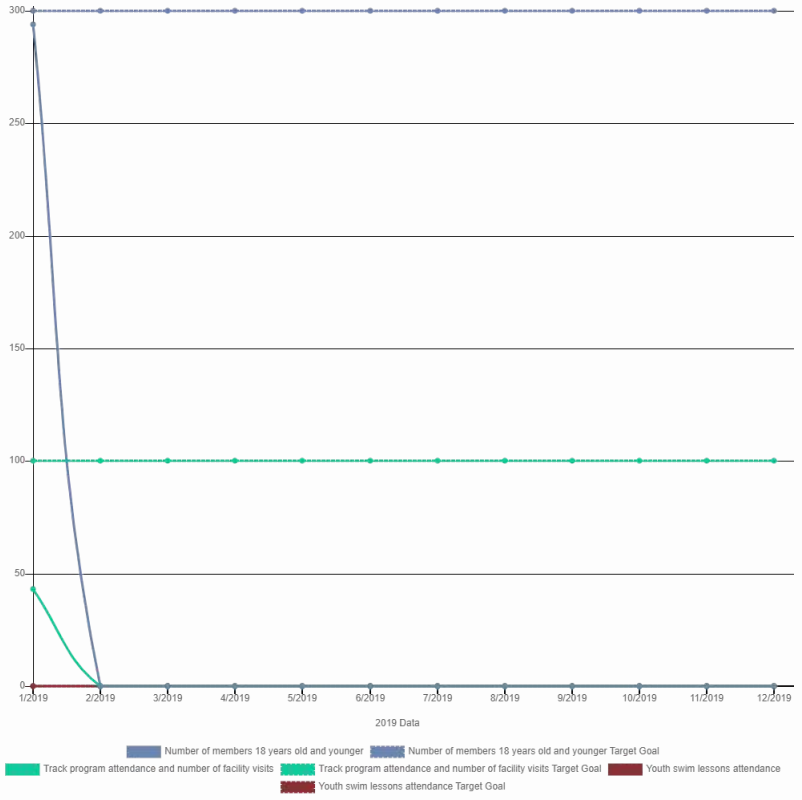
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Number of members 18 years old and younger	300	Active		277	292	265	309	269	291	288	273	254	245	251	250
Track program attendance and number of facility visits	100	Active		49	67	73	59	48	76	174	101	57	51	62	57
Youth swim lessons attendance		Active													



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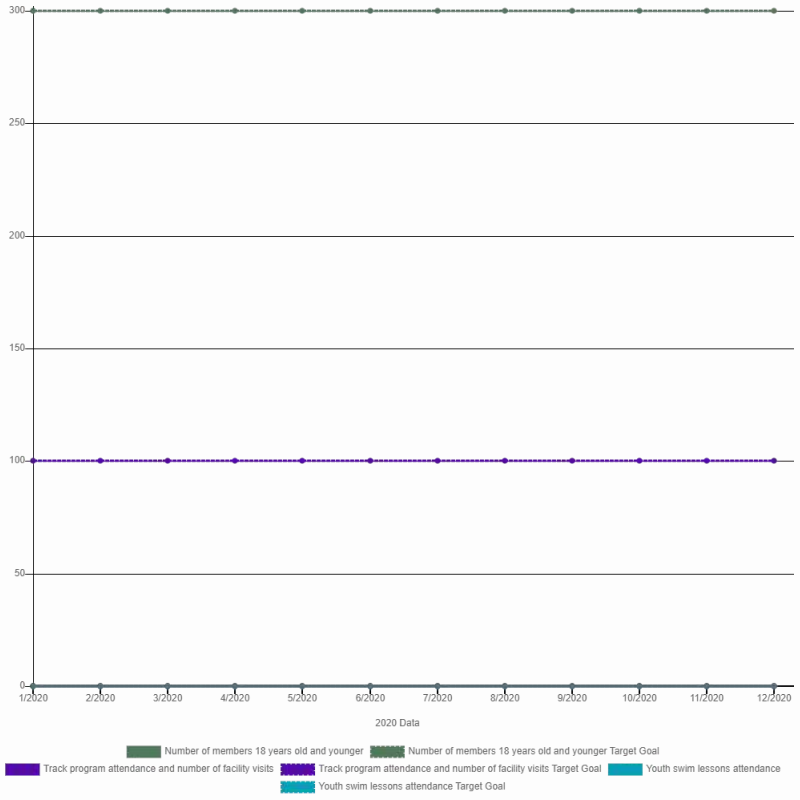
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019

Number of members 18 years old and younger	300	Active		294											
Track program attendance and number of facility visits	100	Active		43											
Youth swim lessons attendance		Active													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Number of members 18 years old and younger	300	Active													
Track program attendance and number of facility visits	100	Active													
Youth swim lessons attendance		Active													

Contributing Community Participants:

Rose M Clark / Brian X. Murray / Chris Baker / Christy Lambert / Jessica / Christine / Deborah Carpenter / Lindsey Bernal / Candace Jones / Ed Kight / Alicia Cignatta / Rebekah Stuckey / Teresa Friend / Heather Cooper / Bev Tucker / Lori Lewis / Debra / Christinia Kemper / Daphne Gooding / Melina Manley / Shelley Argabrite / Christie Reckart / Kimberly Hawes / Rich Midcap / mark geiger / Kristin Spiker / HEATHER BERG / Maney Gale / Brittany Hamilton / Cindy Sharon / John Corbin / Steve Putnam /

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Garrett County Breast and Cervical Cancer Screening Programs

Public Group 2 months ago

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GROUP ADMINS

Navigation Navigation

Cancer Screening

Garrett County Breast and Cervical Cancer Screening Programs

https://mygarrettcounty.com/groups/garrett-county-breast-and-cervical-cancer-screening-programs/

Snapshot Generated: 2019-02-14

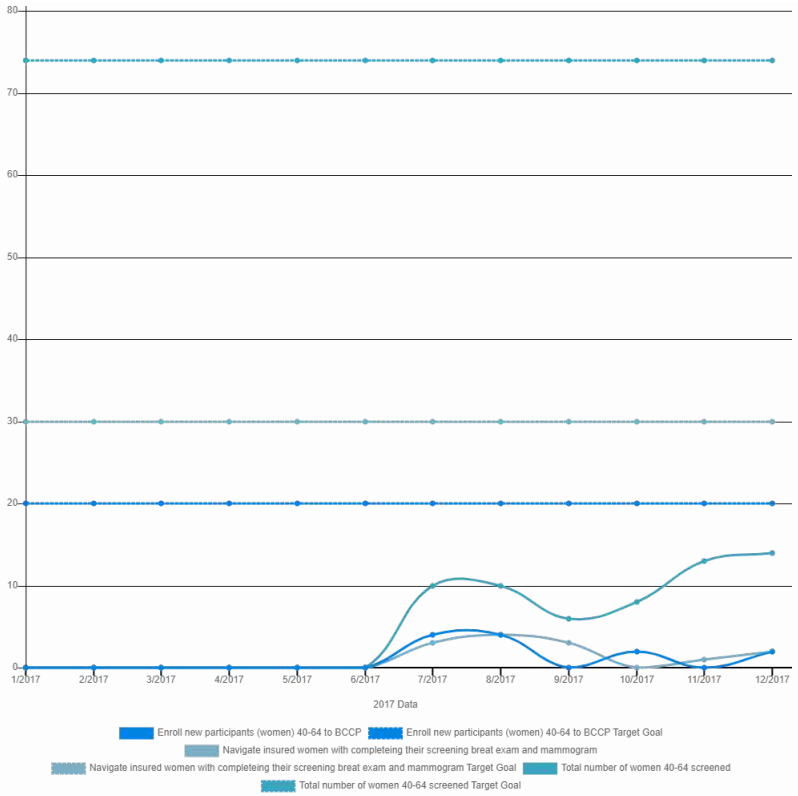
Narrative: Garrett County Breast and Cervical Cancer Screening Program Available to Garrett County women, either uninsured or insured, between the ages of 40-64 years.

Strategy Description:

Level of Change: Systems

Primary Focus Area: Chronic Diseases and their common risk factors: lack of physical activity, poor nutrition, and tobacco use

Estimated Implementation Date: | Estimated Completion Date:



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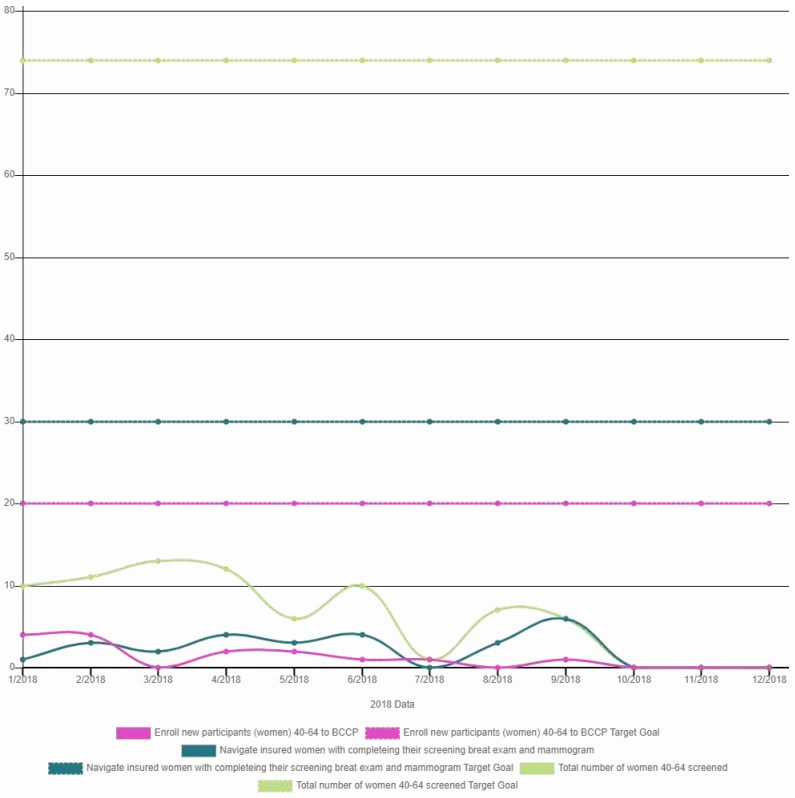
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Enroll new participants (women) 40-64 to BCCP	20	Active	Caroline Evans							4	4	0	2	0	2
Navigate insured women with completeing their screening breat exam and mammogram	30	Active	Caroline Evans							3	4	3	0	1	2
Total number of women 40-64 screened	74	Active	Caroline Evans							10	10	6	8	13	14



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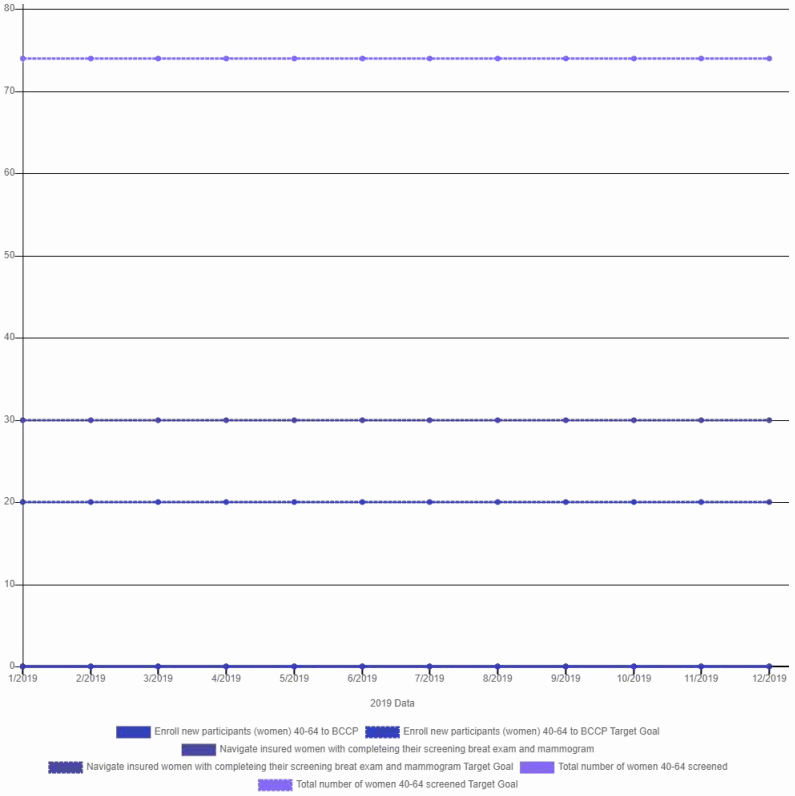
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Enroll new participants (women) 40-64 to BCCP	20	Active	Caroline Evans	4	4	0	2	2	1	1	0	1	0		
Navigate insured women with completeing their screening breat exam and mammogram	30	Active	Caroline Evans	1	3	2	4	3	4	0	3	6			
Total number of women 40-64 screened	74	Active	Caroline Evans	10	11	13	12	6	10	1	7	6			



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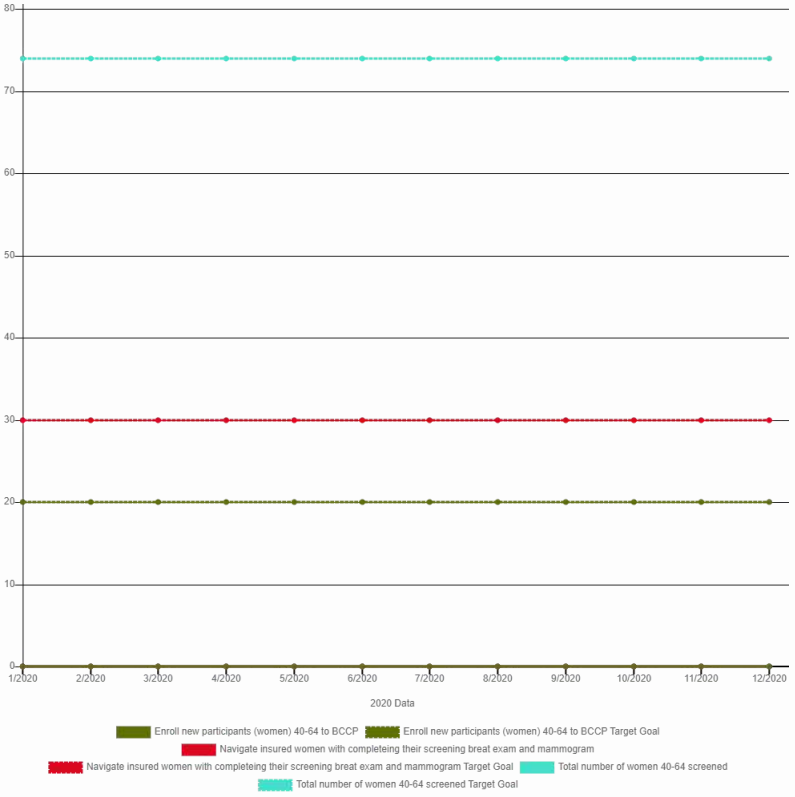
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Enroll new participants (women) 40-64 to BCCP	20	Active	Caroline Evans												
Navigate insured women with completeing their screening breat exam and mammogram	30	Active	Caroline Evans												

Total number of women 40-64 screened	74	Active	Caroline Evans													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Enroll new participants (women) 40-64 to BCCP	20	Active	Caroline Evans												
Navigate insured women with completeing their screening breat exam and mammogram	30	Active	Caroline Evans												
Total number of women 40-64 screened	74	Active	Caroline Evans												

Contributing Community Participants:

Jenny / Sbroadwater / Jim Keough / Lauren / Jessica / Christine / Lindsey Bernal / Sharon Custer / Kristen Walker / Sandy Miller / HEATHER BERG / Kara Taylor / Jennifer Lee-Steckman / Caroline Evans / Linda Costello / Jennifer Corder / Teresa Friend / John Corbin /

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Garrett County Medbank Program

Public Group 17 days ago

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GROUP ADMINS

Help with Rx's

Garrett County Medbank Program

https://mygarrettcounty.com/groups/garrett-county-medbank-program/

Snapshot Generated: 2019-02-14

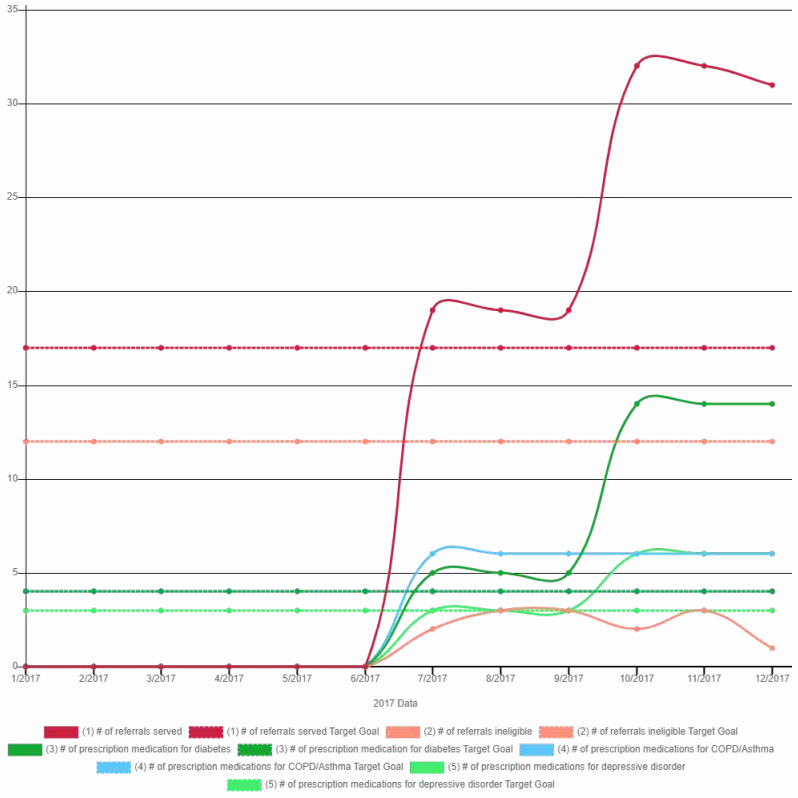
Narrative: The Garrett County Medbank Program provides access to prescription medications to medically needy, financially eligible residents of Garrett County. Individuals must reside within Garrett County, have no prescription coverage through private or public insurance, and meet financial guidelines.

Strategy Description: Referrals to the Medbank Program can be made by anyone and are made by contacting the Garrett County Health Department Medbank Program. Individuals must reside within Garrett County, have no prescription coverage through private or public insurance, and meet financial guidelines. Individuals must be willing to provide the following proofs for eligibility verification: Social Security Numbers Income Proof (including current year income tax info) for all members of household Medication(s) and Dosage(s) Denial Letters for Medicaid (if appropriate) Health Insurance Information Financial eligibility guidelines as well as medication availability are estabblished by each Pharmaceutical Company.

Level of Change: Programs

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: | **Estimated Completion Date:**



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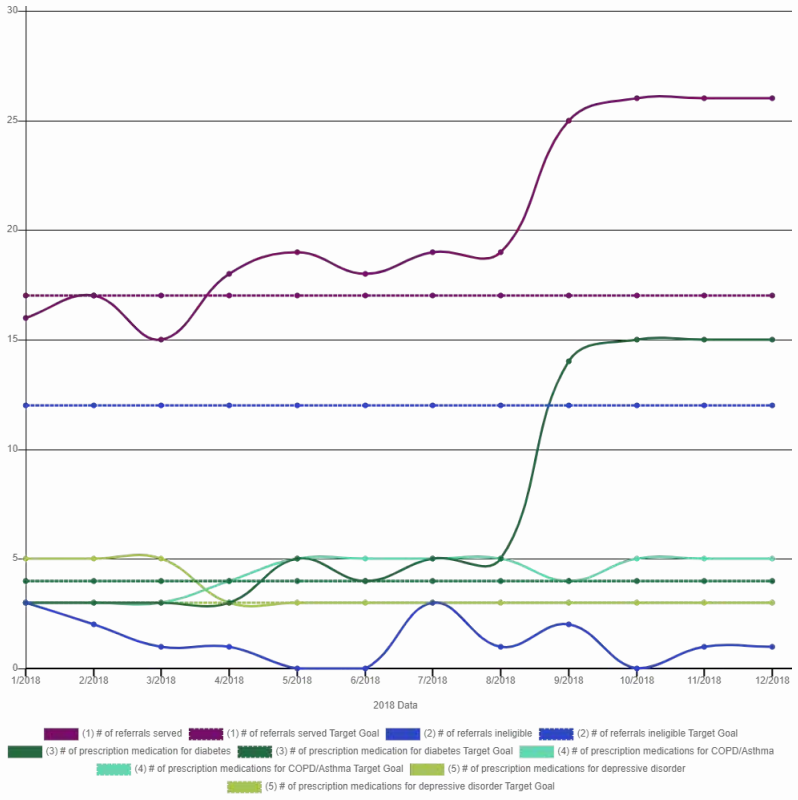
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
(1) # of referrals served	17	Active								19	19	19	32	32	31
(2) # of referrals ineligible	12	Active								2	3	3	2	3	1

(3) # of prescription medication for diabetes	4	Active								5	5	5	14	14	14
(4) # of prescription medications for COPD/Asthma	4	Active								6	6	6	6	6	6
(5) # of prescription medications for depressive disorder	3	Active								3	3	3	6	6	6



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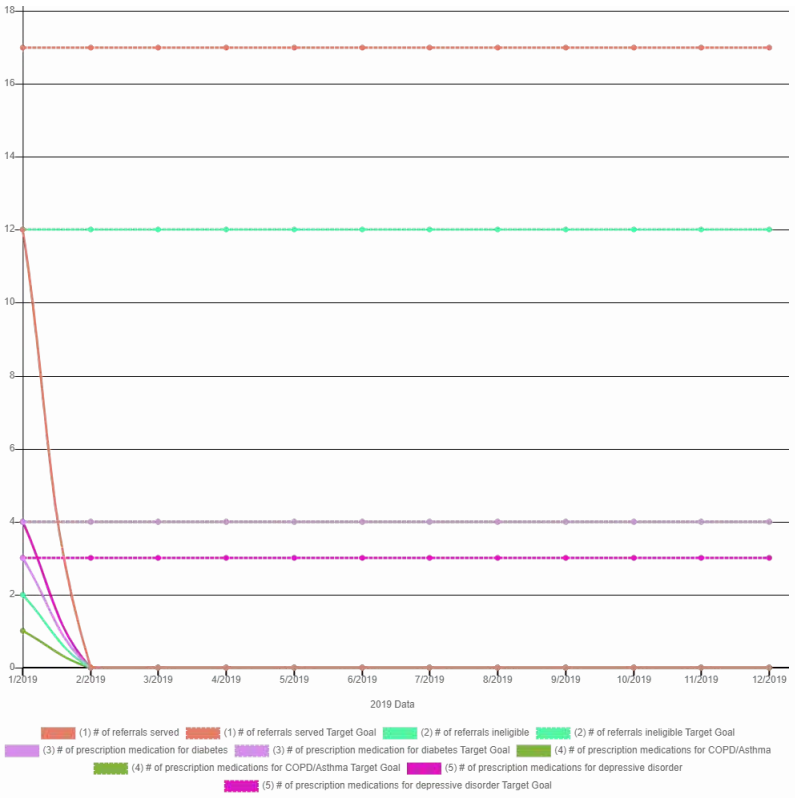
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
(1) # of referrals served	17	Active		16	17	15	18	19	18	19	19	25	26	26	26
(2) # of referrals ineligible	12	Active		3	2	1	1	0	0	3	1	2	0	1	1
(3) # of prescription medication for diabetes	4	Active		3	3	3	3	5	4	5	5	14	15	15	15
(4) # of prescription medications for COPD/Asthma	4	Active		3	3	3	4	5	5	5	5	4	5	5	5
(5) # of prescription medications for depressive disorder	3	Active		5	5	5	3	3	3	3	3	3	3	3	3



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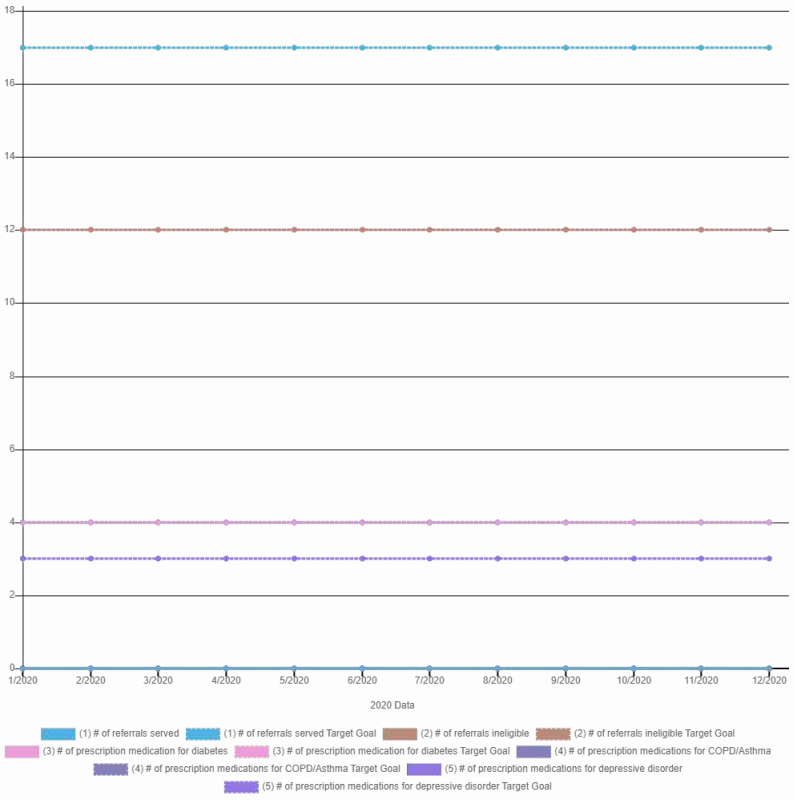
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
(1) # of referrals served	17	Active		12											
(2) # of referrals ineligible	12	Active		2											
(3) # of prescription medication for diabetes	4	Active		3											
(4) # of prescription medications for COPD/Asthma	4	Active		1											
(5) # of prescription medications for depressive disorder	3	Active		4											



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020

(1) # of referrals served	17	Active													
(2) # of referrals ineligible	12	Active													
(3) # of prescription medication for diabetes	4	Active													
(4) # of prescription medications for COPD/Asthma	4	Active													
(5) # of prescription medications for depressive disorder	3	Active													

Data Narrative:

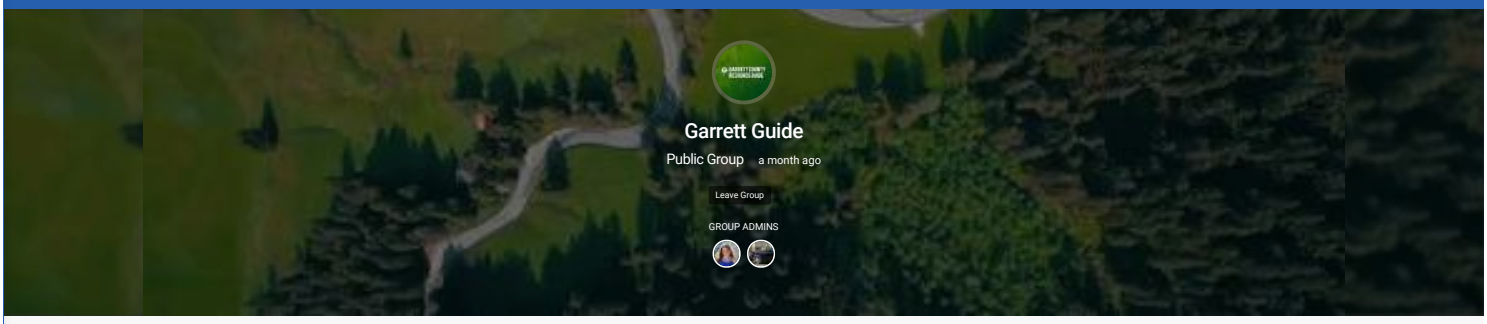
(1) The number of referrals served is the actual number of individuals currently being served by the Medbank program. This means the referral was received, processed, and medication has been approved for the client. Number of referrals served typically decreases in January, as individuals who are in the Medicare Part D coverage gap become ineligible for the pharmaceutical in January. During the month of January, clients must use their Medicare Part D coverage to obtain their medications. (2) The number of ineligible individuals is the number of individuals per month who were referred to Medbank but were ineligible to participate. Reasons of ineligibility may include the medication not being offered by the pharmaceutical company, overscale in income/assets, insured with a copay situation, or individual does not meet all eligibility guidelines. If individuals are ineligible for the program, their Physicians are notified of ineligibility. They are referred for additional resources if resources are available. The most requested medications include diabetic, asthmatic, and depression medication(s) which is why these three medication types are tracked.

Contributing Community Participants:

John Corbin / Chris Baker / Diana Boller / Jim Keough / Tiffany Fratz /

Generated by the Universal Community Planning Tool (UCPT).

Flag this group as inappropriate



Access to Care and Community Linkages

Garrett Guide

https://mygarrettcounty.com/groups/garrett-county-community-engagement/garrett-guide/

Snapshot Generated: 2019-02-14

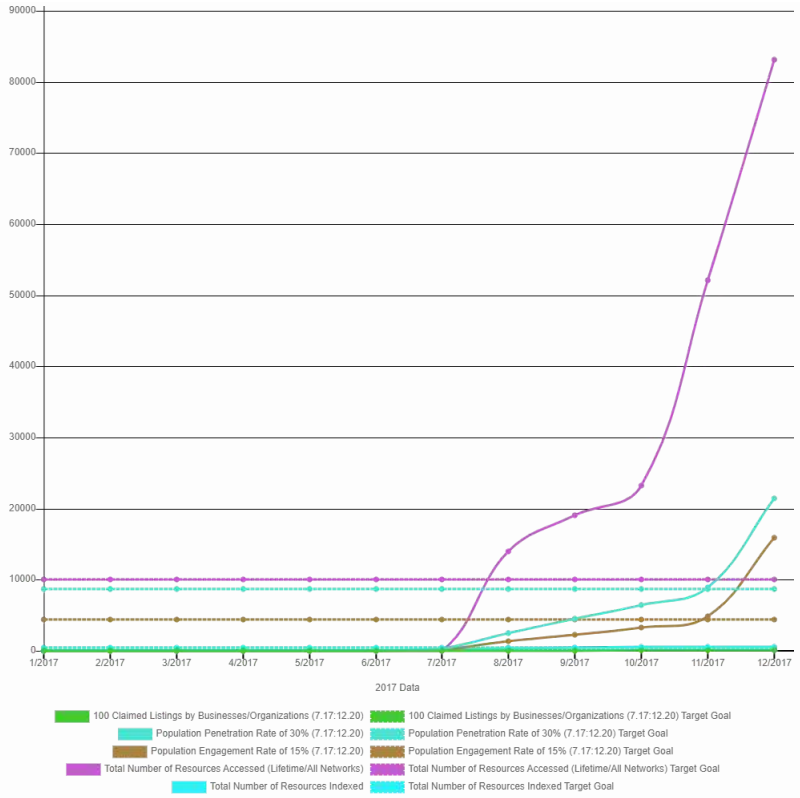
Narrative: When we think about what the term access actually means for a person in the community, it's helpful to consider it in a broad sense. Factors like availability of medical appointments, clinic hours, medical transportation, adequate healthcare providers, and specialty care can be viewed with an access lens and are essential as we consider how we can best meet the medical needs of a community. Crisis services, government assistance and benefit programs should be at everyone's fingertips when issues arise like the need for an emergency shelter. Non-profits, faith based organizations, and civic clubs offer unique services and ways to become more involved in a community helping to address quality of life factors in a community.

Strategy Description: Garrett Guide is the new and improved Community Resource Directory with the framework found at Garrettguide.org. This innovative process connects communities to available resources on demand, including essential services by increasing community awareness and engagement through utilization within and around Garrett Guide. Local agencies, organizations, businesses and residents have the opportunity to provide additional detail for information already included or submit new resources for the community. Information can be entered by visiting: www.garrettguide.org

Level of Change: Systems

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2017-01-01 | **Estimated Completion Date:** 2020-12-31



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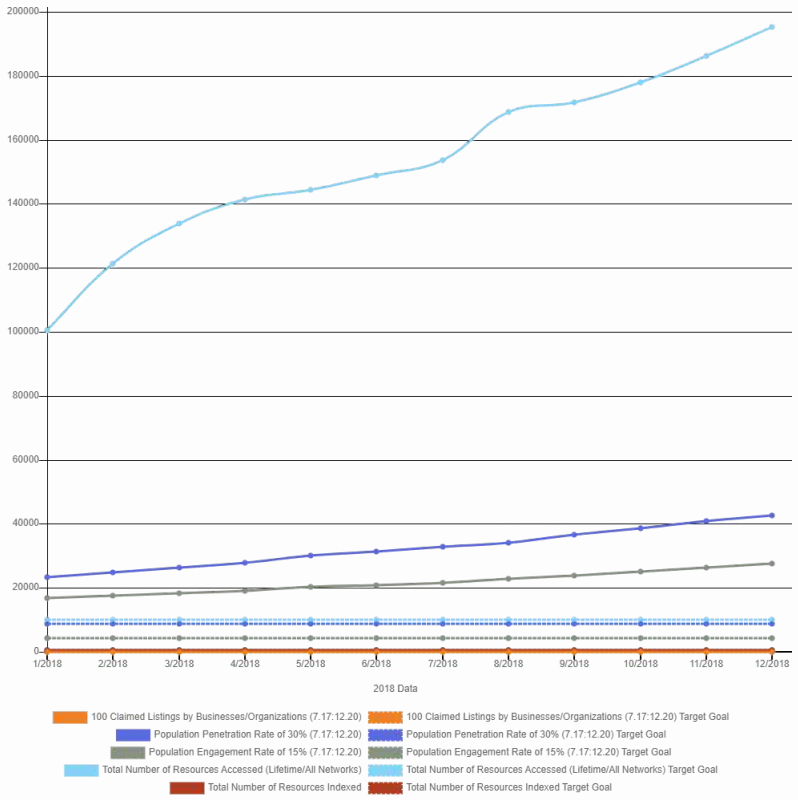
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
100 Claimed Listings by Businesses/Organizations (7.17:12.20)	100	Active	Garrett County Local Management Board							2	41	55	64	70	77
Population Penetration Rate of 30% (7.17:12.20)	8700	Active	Garrett County Local Management Board							333	2468	4483	6467	8906	21400

Population Engagement Rate of 15% (7.17:12.20)	4350	Active	Garrett County Local Management Board							226	1340	2273	3221	4804	15874
Total Number of Resources Accessed (Lifetime/All Networks)	10000	Active	Garrett County Local Management Board								13958	19087	23228	52104	83128
Total Number of Resources Indexed	500	Active	Garrett County Local Management Board							240	350	485	522	536	536



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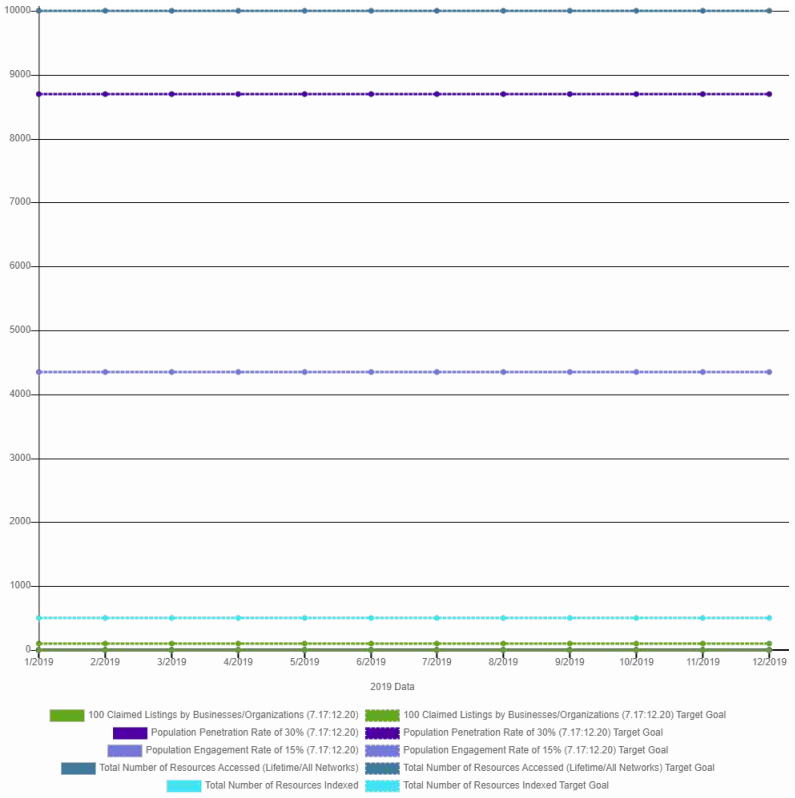
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
100 Claimed Listings by Businesses/Organizations (7.17:12.20)	100	Active	Garrett County Local Management Board	79	83	84	85	87	87	76	78	79	79	79	79
Population Penetration Rate of 30% (7.17:12.20)	8700	Active	Garrett County Local Management Board	23215	24734	26331	27890	30066	31296	32836	34147	36703	38664	40752	42670
Population Engagement Rate of 15% (7.17:12.20)	4350	Active	Garrett County Local Management Board	16746	17445	18234	19084	20181	20836	21619	22777	23734	24984	26304	27543
Total Number of Resources Accessed (Lifetime/All Networks)	10000	Active	Garrett County Local Management Board	100616	121264	133847	141269	144432	148988	153543	168687	171562	178053	186149	195339
Total Number of Resources Indexed	500	Active	Garrett County Local Management Board	538	555	554	554	556	556	556	558	561	561	561	563



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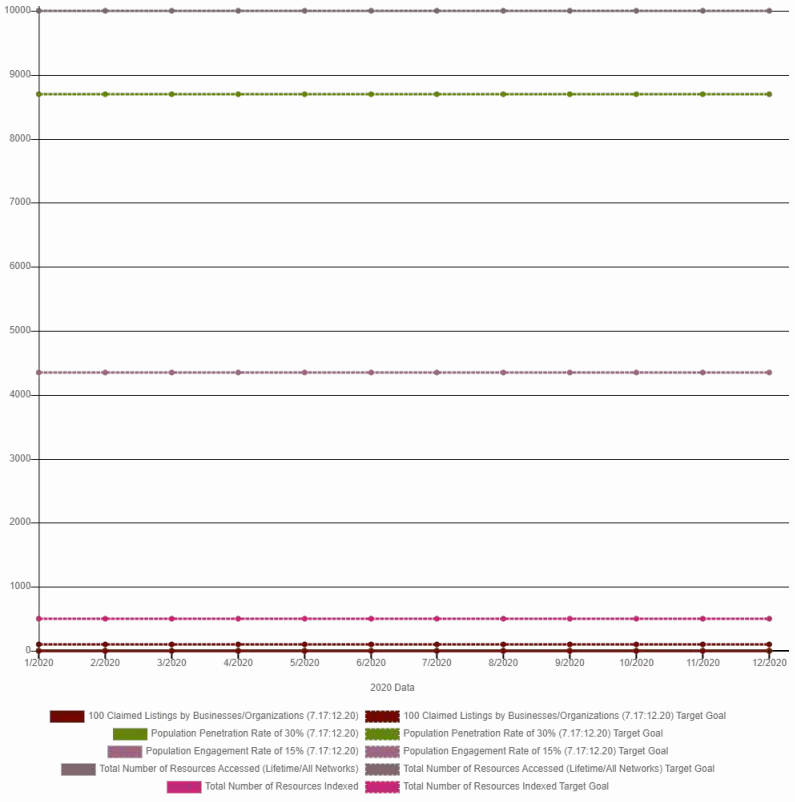
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
100 Claimed Listings by Businesses/Organizations (7.17:12.20)	100	Active	Garrett County Local Management Board												
Population Penetration Rate of 30% (7.17:12.20)	8700	Active	Garrett County Local Management Board												
Population Engagement Rate of 15% (7.17:12.20)	4350	Active	Garrett County Local Management Board												
Total Number of Resources Accessed (Lifetime/All Networks)	10000	Active	Garrett County Local Management Board												
Total Number of Resources Indexed	500	Active	Garrett County Local Management Board												



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020

100 Claimed Listings by Businesses/Organizations (7.17:12.20)	100	Active	Garrett County Local Management Board													
Population Penetration Rate of 30% (7.17:12.20)	8700	Active	Garrett County Local Management Board													
Population Engagement Rate of 15% (7.17:12.20)	4350	Active	Garrett County Local Management Board													
Total Number of Resources Accessed (Lifetime/All Networks)	10000	Active	Garrett County Local Management Board													
Total Number of Resources Indexed	500	Active	Garrett County Local Management Board													

Data Narrative:

July 2018 Eleven listing claims were released to allow claims to be processed by new program coordinators as a result of retirements and role transitions. Data Dictionary Population Penetration Rate - The number of users accessing the resource guide site. Population Engagement Rate - The number of user sessions in which they engaged (clicked on) specific resources while accessing the guide. Number of Resources Accessed - The total number of times that individual resources have been accessed via the digital resource guide.

Contributing Community Participants:

Joseph M Casey / Kristi Cassada / Mike / Jenny / Virgie / Kelly / Susie / Richard Kerns / Melissa Clark / jessica howard / Diana Boller / Christy Lambert / Steven / Kate / Mary Johnson / Karen George / Ashlee Boyd / Rose M Clark / Jessica / Christine / Deborah Carpenter / Donna Fost / clark ianthier / Eric Robison / Lindsey Bernal / Shelley Menear / Lisa Skipper / Chris Jones / Gina Artice / Amy Barnhouse / Jessica Cooper / Miranda / Kim Durst / Judy Sines / Kristen Walker / Terah Crawford / judy@corgi-cottage.com / Caroline / Charee Reckner / Karen DeVore / Carol Bass / McKenzie Wotring / Karen Matthews / Jillian Kelly / Cindy Mankamyer / Eric Cvetnick / sharon rounds / Melinda Smith / Jessica / Barbara Unger / Ed Kight / Bryce Manges / Alicia Cignatta / Scott Hollingsworth / Steve Watkins / Craig Umbel / Kathaleen Skipper / Nicole McCullough / Maria Friend / Gary Fitzwater / LaRena M. Naylor / Jennifer Lee-Steckman / Les McDaniel / Kathy Reese / Jean Tumbarello / Kathy Powell / Sadie Liller / Sandy Miller / James Michaels / Jennifer Corder / Evan Byrne / Teresa Friend / Brenda Sisler / Diane Lee / Tina Buckel / Heather Cooper / Anita Rhodes / Pam Hageman / Shelley Argabrite / Bev Tucker / Lori Lewis / Matthew Friend / kristina wadidii / Kendra McLaughlin / Jennifer Brenneman / Amy Ritchie / Cheryl DeBerry / Paul Edwards / Karen Keefer / Scott Germain / Jodi Roberson / Michelle Ford / Christinia Kemper / Daphne Gooding / Debbie Durben / Rebecca Aiken / Steven Green / Katie Welch / Charles Wilt / Amy Barnhouse / Venessa Stacy / mark geiger / Cody Suggs / Wayne Mowbray / Kathy Molnar / Melissa Rank / HEATHER BERG / Brittany Hamilton / Willie Lantz / Cindy Sharon / Lori Reichard / Karen Wright / Serena Lucas / John Corbin / Jennifer Loughry / Bob Stephens / Kelly Rock / Marianne Knotts / Lisa Nichols / Kendall Ludwig / Linda Costello / Michelle Ross / Beth Brenneman / Kara Taylor / Laura Schroyer / Steve Putnam / Fred Polce /

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Improving Healthy Birth Weights

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Improving Healthy Birth Weights

Improving Healthy Birth Weights

https://mygarrettcounty.com/groups/improving-health-birth-weights/

Snapshot Generated: 2019-02-14

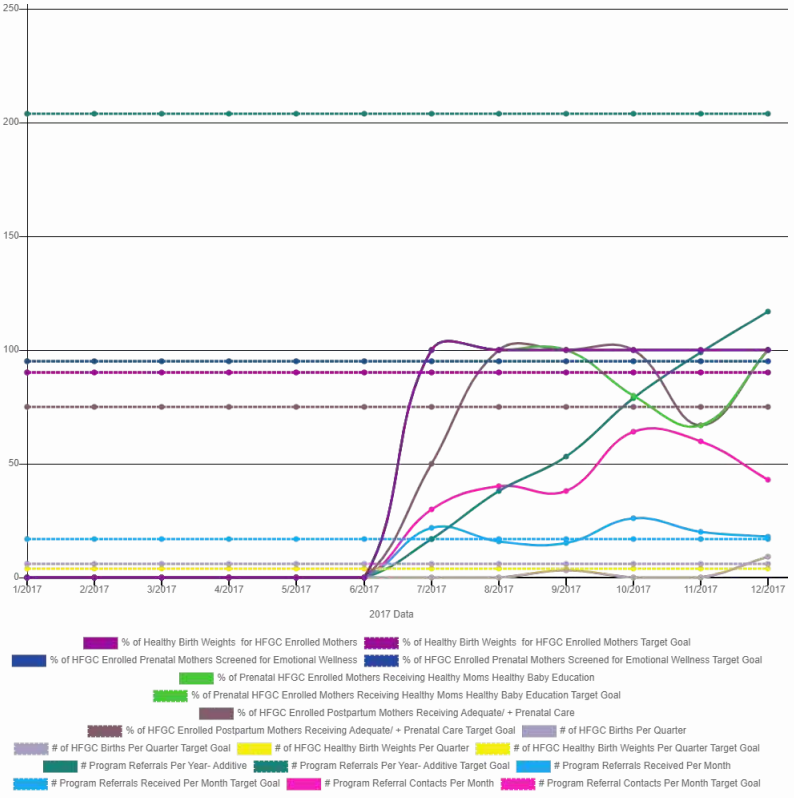
Narrative: Garrett County Health Department's Early Care Programs System of Care provides free voluntary home visitation services to families and children prenatally and up to age 5. Additionally, the program offers a free "Warm Line" service, which is a phone number families can call to speak to a Registered Nurse to ask questions about their family/health concerns . The program focus includes babies born healthy and healthy children and has set goals of increasing healthy birth weights and babies born full term. Program services are provided to empower parents to give their children the best beginning in life!

Strategy Description: 1. Mothers enrolled prenatally in Healthy Families home visiting will receive health promotion and education during pregnancy on topics to promote a healthy pregnancy to include prevention of preterm labor, warning signs during pregnancy, nutrition, and babies born healthy. 2. Mothers enrolled prenatally in Healthy Families home visiting will be linked to a primary care provider to receive early and consistent prental care. 3. Mothers enrolled prentally in Healthy Families home visiting will be linked to medical insurance during and after pregnancy. 4. Mothers enrolled prenatall in Healthy Families home visiting will be sreened for emotional wellness. 5. Mothers enrolled prenatall in Healthy Families home visiting will receive Healthy Moms/Healthy Babies information. 6. Mothers enrolled prenatally in Healthy Families home visiting will receive education on good oral hygiene to prevent preterm labor. 7. Mothers enrolled prenatally in Healthy Families home visiting will be linked to nutritional resources (WIC, SNAP, food bank, ect.). 8. Mothers enrolled prenatally in Healthy Families home visiting will receive education on substance free pregnancy. 9. Early Care Program makes contact with pregnant women throughout the county and offers education on healthy pregnancy and full- term delivery.

Level of Change: Programs

Primary Focus Area: Maternal, Child, and Adolescent Health

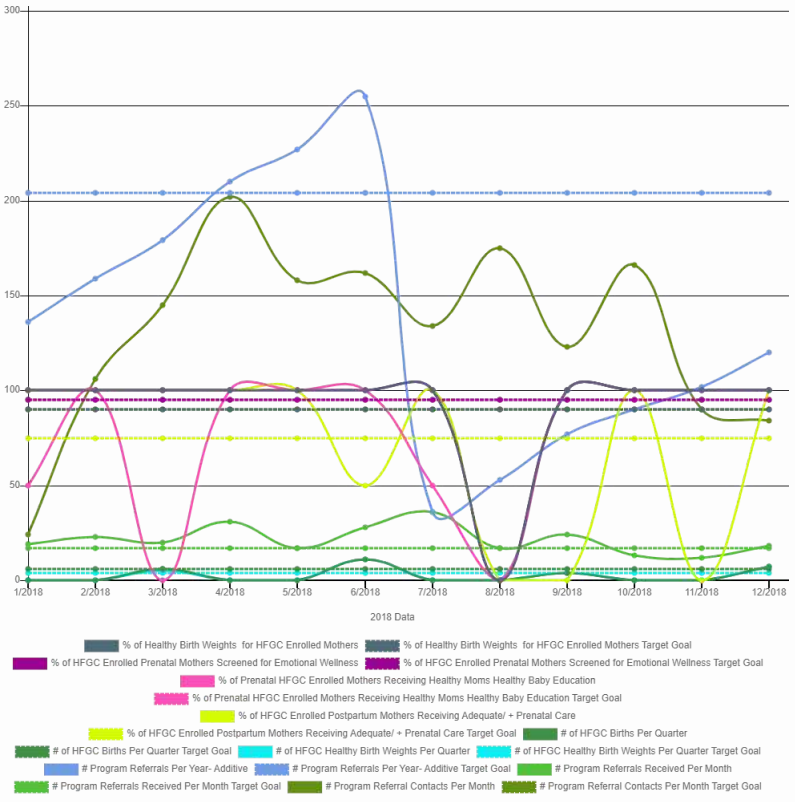
Estimated Implementation Date: 2017-07-01 | **Estimated Completion Date:** 2018-06-30



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017

% of Healthy Birth Weights for HFGC Enrolled Mothers	90	Active								100	100	100	100	100	100
% of HFGC Enrolled Prenatal Mothers Screened for Emotional Wellness	95	Active								100	100	100	100	100	100
% of Prenatal HFGC Enrolled Mothers Receiving Healthy Moms Healthy Baby Education	95	Active								100	100	100	80	67	100
% of HFGC Enrolled Postpartum Mothers Receiving Adequate/ + Prenatal Care	75	Active								50	100	100	100	67	100
# of HFGC Births Per Quarter	6	Active										3			9
# of HFGC Healthy Birth Weights Per Quarter	4	Active										3			9
# Program Referrals Per Year- Additive	204	Active								17	38	53	79	99	117
# Program Referrals Received Per Month	17	Active								22	16	15	26	20	18
# Program Referral Contacts Per Month	90	Active								30	40	38	64	60	43



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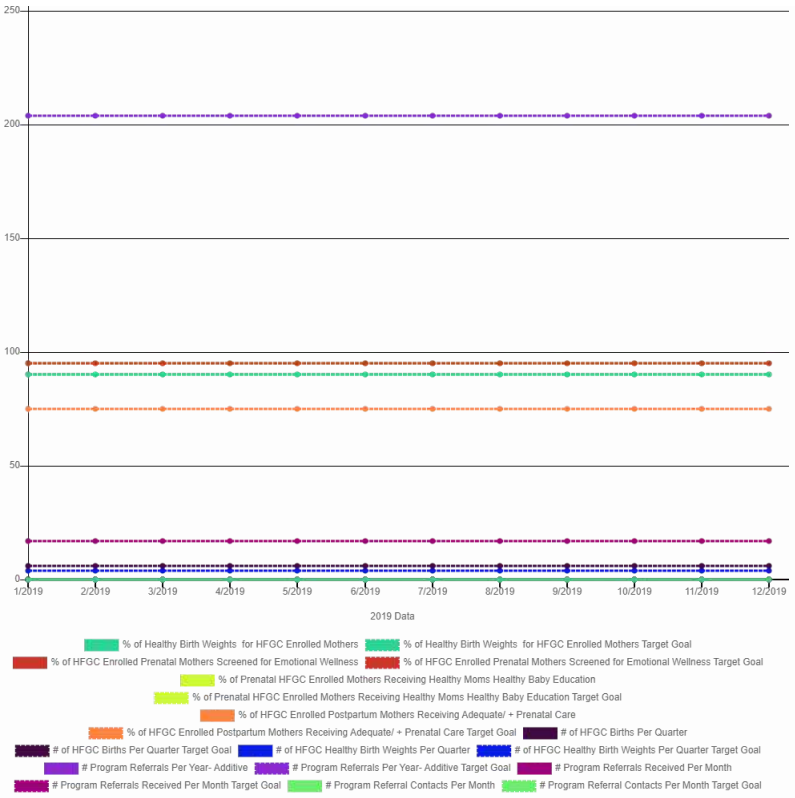
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
% of Healthy Birth Weights for HFGC Enrolled Mothers	90	Active		100	100	100	100	100	100	100		100	100	100	100
% of HFGC Enrolled Prenatal Mothers Screened for Emotional Wellness	95	Active		100	100	100	100	100	100	100		100	100	100	100
% of Prenatal HFGC Enrolled Mothers Receiving Healthy Moms Healthy Baby Education	95	Active		50	100	0	100	100	100	50		100	100	100	100
% of HFGC Enrolled Postpartum Mothers Receiving Adequate/ + Prenatal Care	75	Active		100	100	100	100	100	50	100			100		100
# of HFGC Births Per Quarter	6	Active				6			11			4			7
# of HFGC Healthy Birth Weights Per Quarter	4	Active				5			11			4			7
# Program Referrals Per Year- Additive	204	Active		136	159	179	210	227	255	36	53	77	90	102	120
# Program Referrals Received Per Month	17	Active		19	23	20	31	17	28	36	17	24	13	12	18
# Program Referral Contacts Per Month	90	Active		24	106	145	202	158	162	134	175	123	166	90	84



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2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
% of Healthy Birth Weights for HFGC Enrolled Mothers	90	Active													
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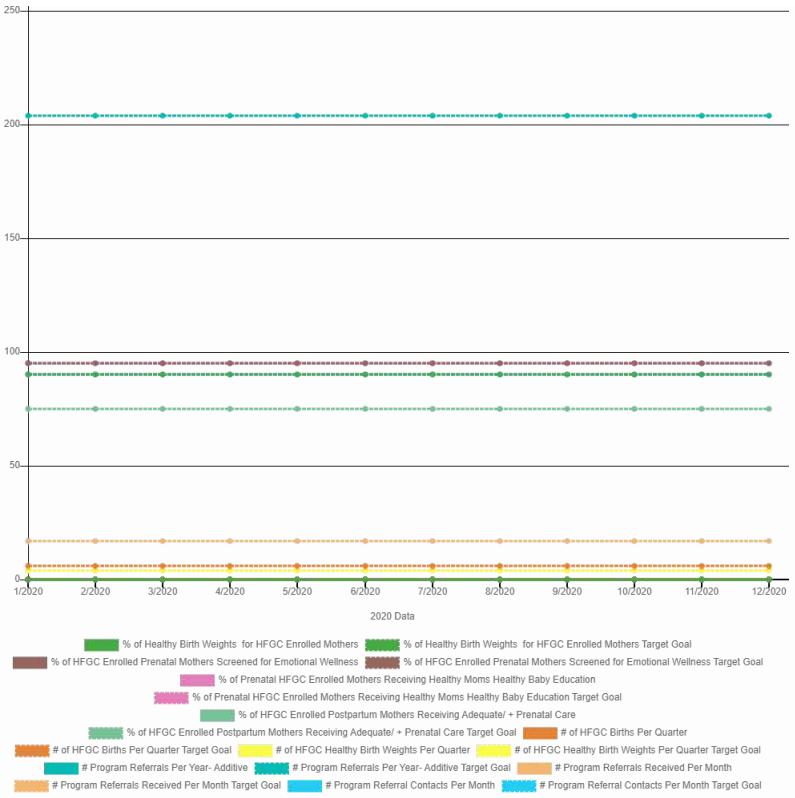
# of HFGC Births Per Quarter	6	Active													
# of HFGC Healthy Birth Weights Per Quarter	4	Active													
# Program Referrals Per Year- Additive	204	Active													
# Program Referrals Received Per Month	17	Active													
# Program Referral Contacts Per Month	90	Active													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
% of Healthy Birth Weights for HFGC Enrolled Mothers	90	Active													
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% of Prenatal HFGC Enrolled Mothers Receiving Healthy Moms Healthy Baby Education	95	Active													
% of HFGC Enrolled Postpartum Mothers Receiving Adequate/ + Prenatal Care	75	Active													
# of HFGC Births Per Quarter	6	Active													
# of HFGC Healthy Birth Weights Per Quarter	4	Active													
# Program Referrals Per Year- Additive	204	Active													
# Program Referrals Received Per Month	17	Active													
# Program Referral Contacts Per Month	90	Active													

Data Narrative:

Measure #5 and #6 (# of HFGC Births per Quarter and # HFGC Healthy Birth Weights per Quarter) data is entered every 3 months. Measure # 7 (# of Program Referrals per Year) is an annual measure. Calculation begins July 1st and ends June 30th. Data collection starts over for the next year beginning July 1st.

Research: Babies born with low birth weights (below 2,500 grams or below 5.5 pounds): This is one of the 39 measures from The SHIP and is located under the Focus Area of Healthy Beginnings. Current Data 2014→8.6% below healthy birth weight- Maryland out of 73,588 births 2014→10.6% below healthy birth weight- Garrett County out of 284 births 2015→ 8.6% below healthy birth weight- Maryland out of 73,544 births 2015→ 8.2% below healthy birth weight- Garrett County out of 294 births (Data Source: https://health.maryland.gov - Maryland Annual Vital Statistics 2014 and 2015 Annual Reports; and https://healthy.maryland.gov/SHIP) Goal (SHIP) less than 8% of babies will be born below healthy birth weights (less than 2,500 grams or less than 5.5 pounds) (Data Source: https://healthy.maryland.gov/SHIP) Healthy People 2020 Goal less than 7.8% of babies will be born below healthy birth weights (less than 2,500 grams of less than 5.5 pounds) (Data Source: https://health.maryland.gov/SHIP) Number of Births Per Year in Garrett County, Maryland Current Data CY 2016- 311 Births CY 2015- 294 Births CY 2014- 284 Biths (Data Source: https://health.maryland.gov)

Contributing Community Participants:

Erin Marsh / jessica howard / Carrie Hook / Mary Johnson / Jennifer VanPelt / Tricia / Christine / Lindsey Bernal / Dierdre Shue / Maria Friend / Alisha Plessinger / Bob Stephens / Carol Bass / Karen Matthews / bonnie tichnell / Karen George / Jennifer Lee-Steckman / Kathy Powell / joanne roberts / Jennifer Loughry / Shelley Argabrite / Teresa Friend / HEATHER BERG / Debra House / bonnie paugh / Marcia Ashby / Marilyn Kight / Theresa Cavalier / Bev Tucker / linda welch RN.BSN / Debbie Durben / Karen Keefer / Tracy Savage / Michelle Ford / Christinia Kemper / Fred Polce / Melina Manley / Kimberly Hawes / Katie Welch / Jodi Roberson / Heather Cooper / John Corbin / Earleen Beckman /

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Maryland Health Connection

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GROUP ADMINS

Maryland Health Connection

Maryland Health Connection

https://mygarrettcounty.com/groups/maryland-health-connection/

Snapshot Generated: 2019-02-14

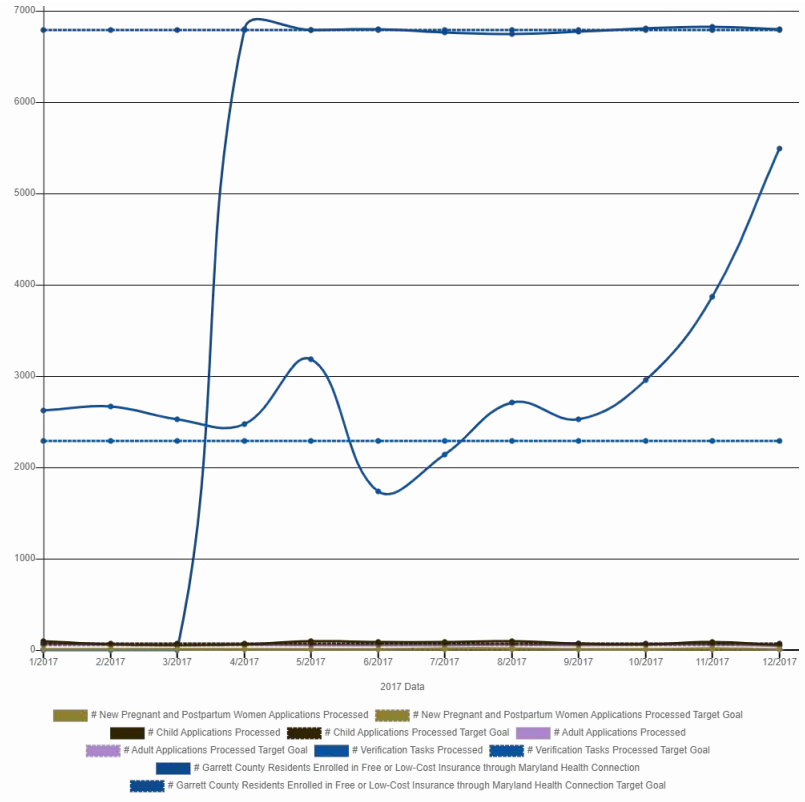
Narrative: Maryland Health Connection (MHC) offers free or low-cost health insurance coverage to eligible men, women, and children. Eligibility is based on family size and income.

Strategy Description: The Garrett County Health Department's (GCHD) Maryland Children's Health Program (MCHP), Eligibility Determination Unit provides eligibility determinations for the Maryland Children Health insurance coverage per the Maryland Medical Assistance Program (Medicaid) Monthly Income and Asset Guidelines.

Level of Change: Programs

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2018-03-09 | **Estimated Completion Date:** 2018-06-30



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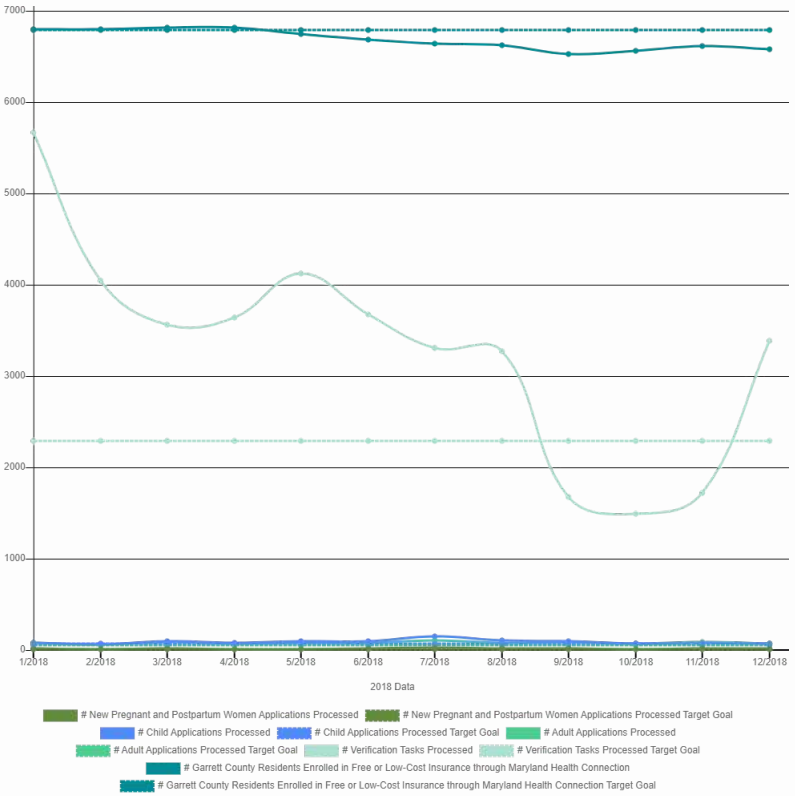
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
# New Pregnant and Postpartum Women Applications Processed	7	Active	Monthly LHD/MCHP Tracking Report	12	8	8	9	9	10	14	17	10	11	20	11
# Child Applications Processed	70	Active	Monthly LHD/MCHP Tracking Report	100	63	55	65	93	87	91	96	69	58	86	49
# Adult Applications Processed	55	Active	Monthly LHD/MCHP Tracking Report	66	59	61	65	53	49	54	61	53	61	62	48

# Verification Tasks Processed	2290	Active	Monthly LHD/MCHP Tracking Report	2626	2670	2524	2474	3182	1737	2144	2710	2529	2953	3870	5490
# Garrett County Residents Enrolled in Free or Low-Cost Insurance through Maryland Health Connection	6790	Active	Office of Eligibility/Maryland Children Heath Program--MMIS Monthly Report				6802	6791	6800	6763	6749	6769	6803	6828	6801



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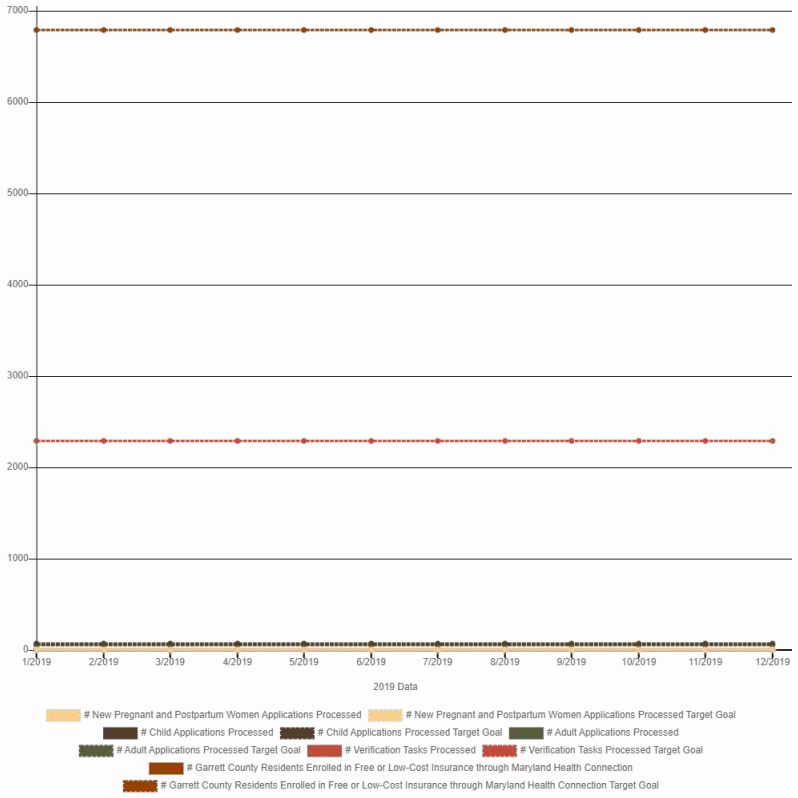
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
# New Pregnant and Postpartum Women Applications Processed	7	Active	Monthly LHD/MCHP Tracking Report	16	12	17	7	10	18	28	15	19	9	14	14
# Child Applications Processed	70	Active	Monthly LHD/MCHP Tracking Report	83	59	100	78	97	97	145	107	96	68	83	73
# Adult Applications Processed	55	Active	Monthly LHD/MCHP Tracking Report	75	64	84	66	83	77	101	79	85	70	88	74
# Verification Tasks Processed	2290	Active	Monthly LHD/MCHP Tracking Report	5663	4044	3563	3642	4120	3673	3308	3276	1677	1495	1716	3386
# Garrett County Residents Enrolled in Free or Low-Cost Insurance through Maryland Health Connection	6790	Active	Office of Eligibility/Maryland Children Heath Program--MMIS Monthly Report	6799	6801	6814	6813	6750	6680	6636	6619	6528	6563	6614	6578



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2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
# New Pregnant and Postpartum Women Applications Processed	7	Active	Monthly LHD/MCHP Tracking Report												
# Child Applications Processed	70	Active	Monthly LHD/MCHP Tracking Report												
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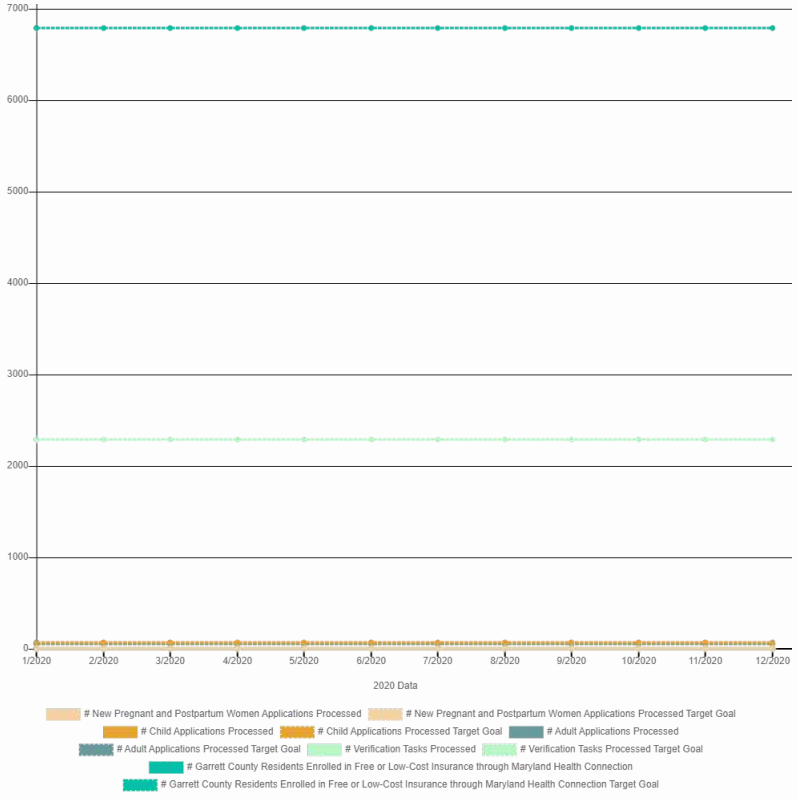

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# New Pregnant and Postpartum Women Applications Processed	7	Active	Monthly LHD/MCHP Tracking Report												
# Child Applications Processed	70	Active	Monthly LHD/MCHP Tracking Report												
# Adult Applications Processed	55	Active	Monthly LHD/MCHP Tracking Report												
# Verification Tasks Processed	2290	Active	Monthly LHD/MCHP Tracking Report												
# Garrett County Residents Enrolled in Free or Low-Cost Insurance through Maryland Health Connection	6790	Active	Office of Eligibility/Maryland Children Heath Program--MMIS Monthly Report												

Research: https://www.marylandhealthconnection.gov/

Contributing Community Participants:

David Stewart / faith friend / Jenny / Virgie / Kelly / Sbroadwater / Jodi Kulak / jessica howard / Cameron Pollock / Jessica / bonnie paugh / Katie Welch / Maria Friend /

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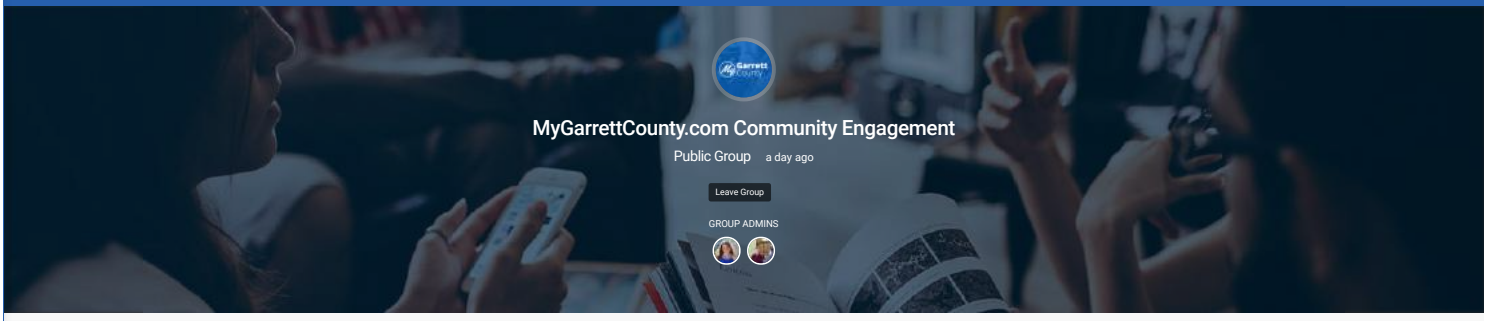

MyGarrettCounty.com Community Engagement

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Navigation Navigation

A New Approach

MyGarrettCounty.com Community Engagement

https://mygarrettcounty.com/groups/garrett-county-community-engagement/mygarrettcounty-com-community-engagement/

Snapshot Generated: 2019-02-14

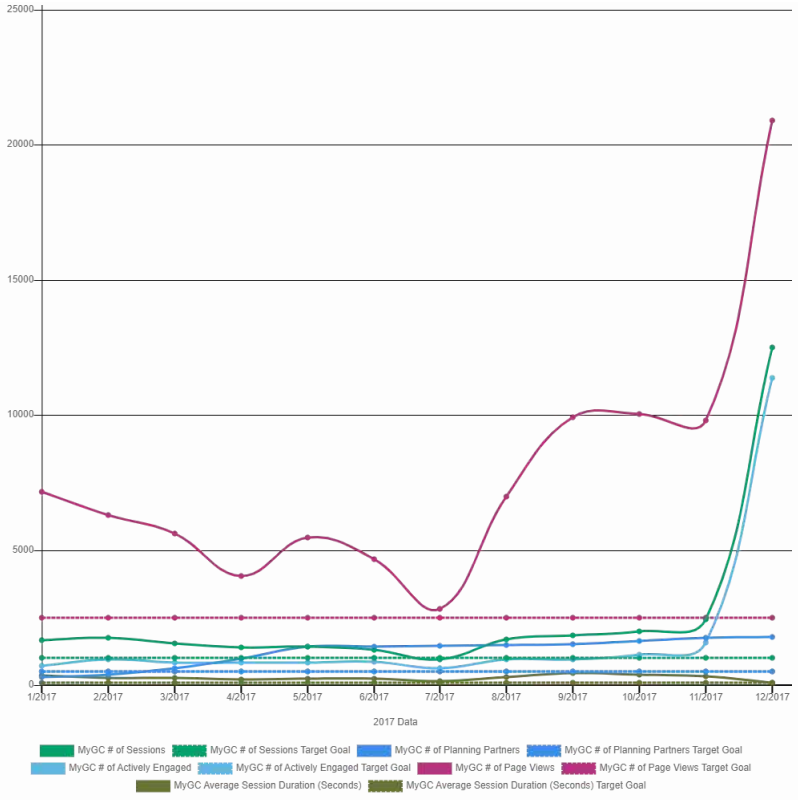
Narrative: MyGarrettCounty.com is an award winning community engagement collaborative created and implemented by the population health unit of the Garrett County Health Department with support from local stakeholders to increase connectivity, representation in planning processes through community engagement and operate as a centralized data portal for tracking the community health improvement plan as well as the overall health status of the county.

Strategy Description: As an innovative platform, the multifaceted planning tool collects quantitative and qualitative data to guide our community as we make data informed decisions that impacts the health and well-being of residents and visitors of Garrett County. The strategy continues to increase equity through community engagement on mygarrettcounty.com to promote a true community of collaboration.

Level of Change: Systems

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2016-11-01 | **Estimated Completion Date:** 2020-12-31



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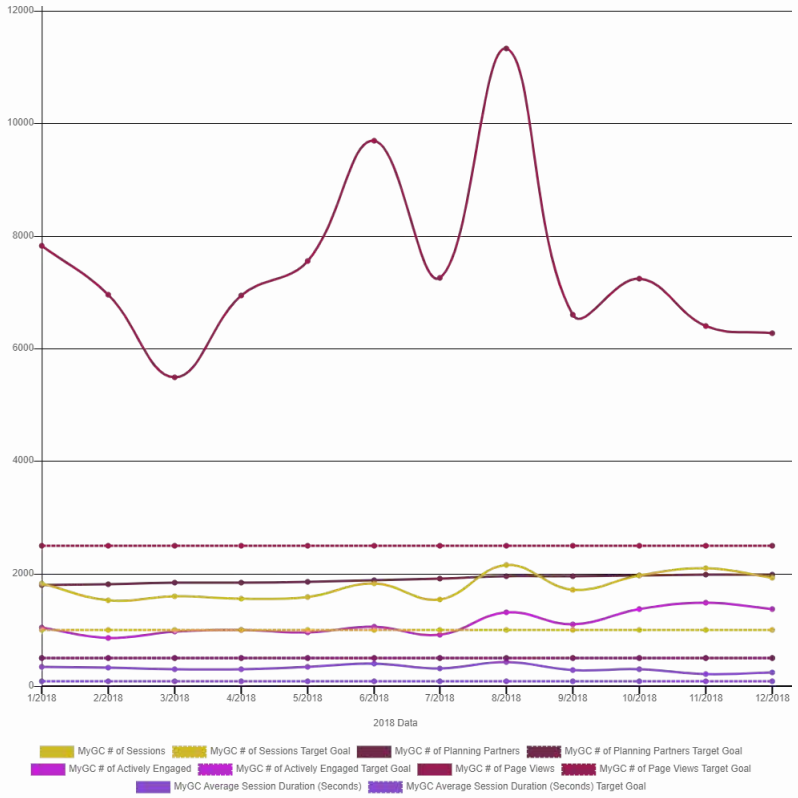
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
MyGC # of Sessions	1000	Active	John Corbin Pulls Google Analytics	1672	1757	1530	1389	1431	1306	946	1690	1847	1984	2439	12494
MyGC # of Planning Partners	500	Active	John Corbin Pulls Google Analytics	286	377	624	980	1416	1431	1447	1488	1513	1630	1759	1777
MyGC # of Actively Engaged	500	Active	John Corbin Pulls Google Analytics	723	955	843	833	830	847	613	943	954	1121	1583	11377

MyGC # of Page Views	2500	Active	John Corbin Pulls Google Analytics	7160	6297	5611	4038	5469	4659	2808	6965	9913	10022	9789	20917
MyGC Average Session Duration (Seconds)	90	Active	John Corbin Pulls Google Analytics	348	271	275	201	242	229	160	293	449	384	312	78



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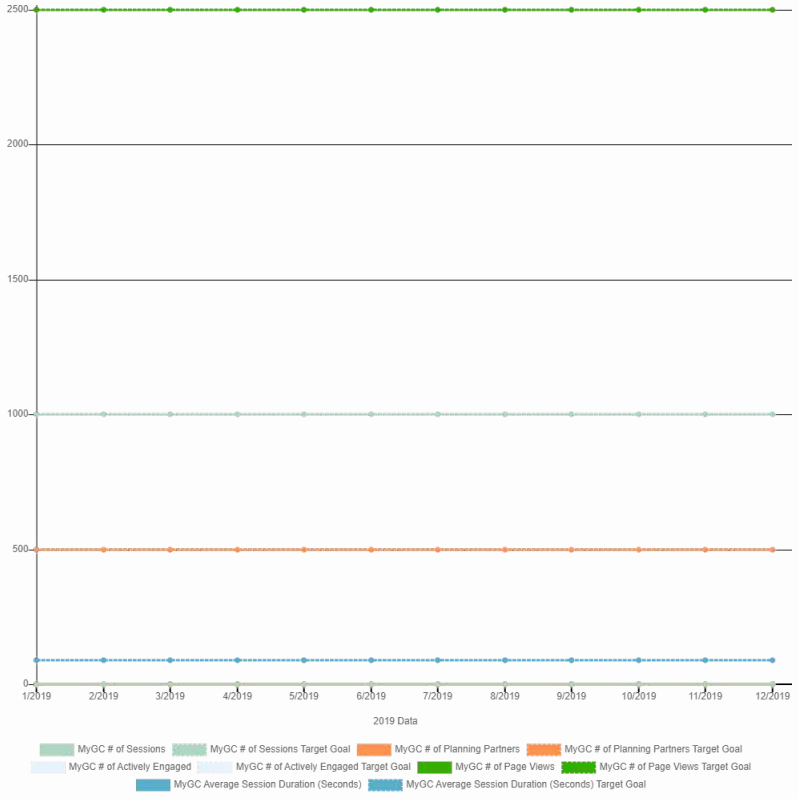
MyGC # of Sessions	1000	Active	John Corbin Pulls Google Analytics	1831	1519	1597	1559	1577	1829	1540	2158	1709	1961	2088	1918
MyGC # of Planning Partners	500	Active	John Corbin Pulls Google Analytics	1789	1816	1832	1834	1850	1884	1908	1948	1955	1971	1979	1982
MyGC # of Actively Engaged	500	Active	John Corbin Pulls Google Analytics	1042	851	966	992	950	1056	909	1311	1096	1372	1482	1370
MyGC # of Page Views	2500	Active	John Corbin Pulls Google Analytics	7824	6958	5494	6939	7553	9686	7250	11337	6598	7237	6394	6273
MyGC Average Session Duration (Seconds)	90	Active	John Corbin Pulls Google Analytics	339	330	306	298	340	394	317	429	290	298	216	246



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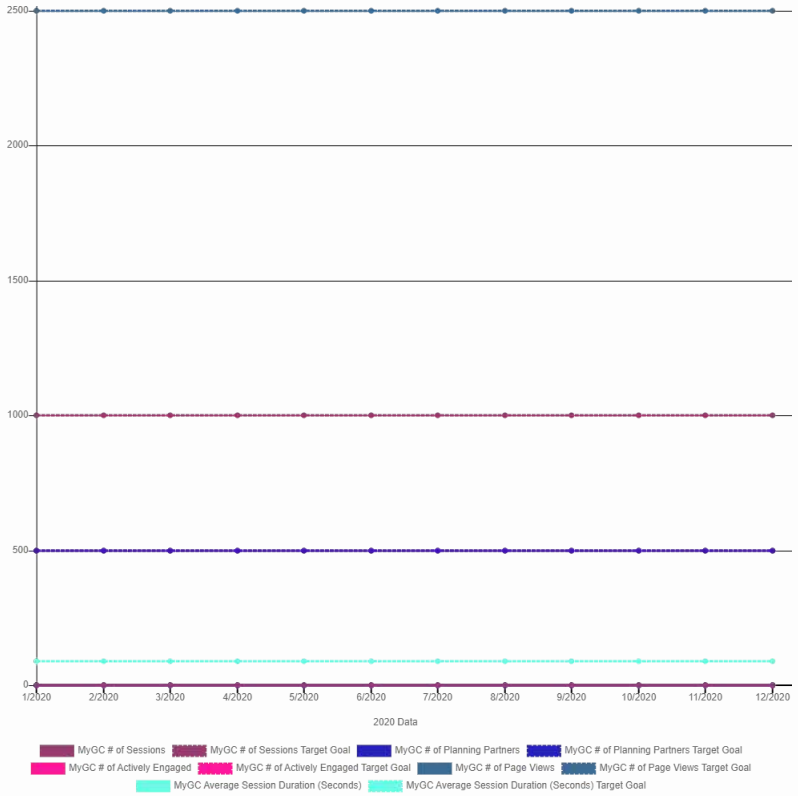
MyGC Average Session Duration (Seconds)	90	Active	John Corbin Pulls Google Analytics												



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MyGC # of Actively Engaged	500	Active	John Corbin Pulls Google Analytics												
MyGC # of Page Views	2500	Active	John Corbin Pulls Google Analytics												
MyGC Average Session Duration (Seconds)	90	Active	John Corbin Pulls Google Analytics												

Data Narrative:

Data provided via analytics.

Data Dictionary

- # of Sessions - The total number of times users have interacted with MyGarrettCounty.com
- # of Planning Partners - The total number of stakeholders who have registered for accounts on MyGarrettCounty.com
- # of Actively Engaged - The total number of users that have completed actions on MyGarrettCounty.com (post, download, etc...)
- # of Page Views - The total number of pages accessed on MyGarrettCounty.com
- Average Session Duration - The average amount of time (in seconds) that people spend on MyGarrettCounty.com per visit.

Contributing Community Participants:

Christy Thomas / Joseph Burger / Brian X. Murray / Charee Reckner / Mike / Jenny / Virgie / Sbroadwater / Susie / Richard Kerns / Melissa Clark / Kendra McLaughlin / ANNIE MAY SHORT / Charles Wilt / Jackie Stein / Thomas J. Killian Jr. / clark lanthier / Chris Baker / Philmont Beautification / Caroline Stachowiak / Carrie Hook / Kate / Mary Johnson / Ashlee Boyd / Jessica / Miranda / Amanda Oliverio / Kristen Hildreth / Christine / Carol Bass / Deborah Carpenter / Jennifer Corder / Steve Putnam / Brenda Sisler / Kathaleen Skipper / Diane Lee / Rose M Clark / Bob Stephens / Beth Brenneman / Sadie Liller / Fred Polce / Jim Bailey / Lindsey Bernal / Miriam Sincell Burton / Dierdre Shue / Shylo Dennison / Jim Smedes / Hospice of GC / Amy Ritchie / Kim Durst / Shelley Argabrite / judy@corgi-cottage.com / John Corbin /

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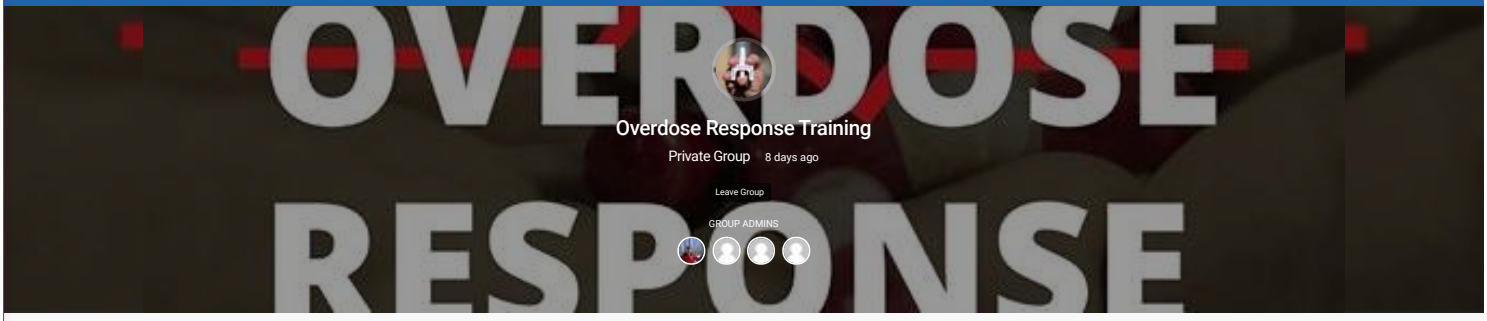


Overdose Response Training

Private Group 8 days ago

Leave Group

GROUP ADMINS

Behavioral Health

Overdose Response Training

https://mygarrettcounty.com/groups/opioid-intervention-team/overdose-response-training/

Snapshot Generated: 2019-02-14

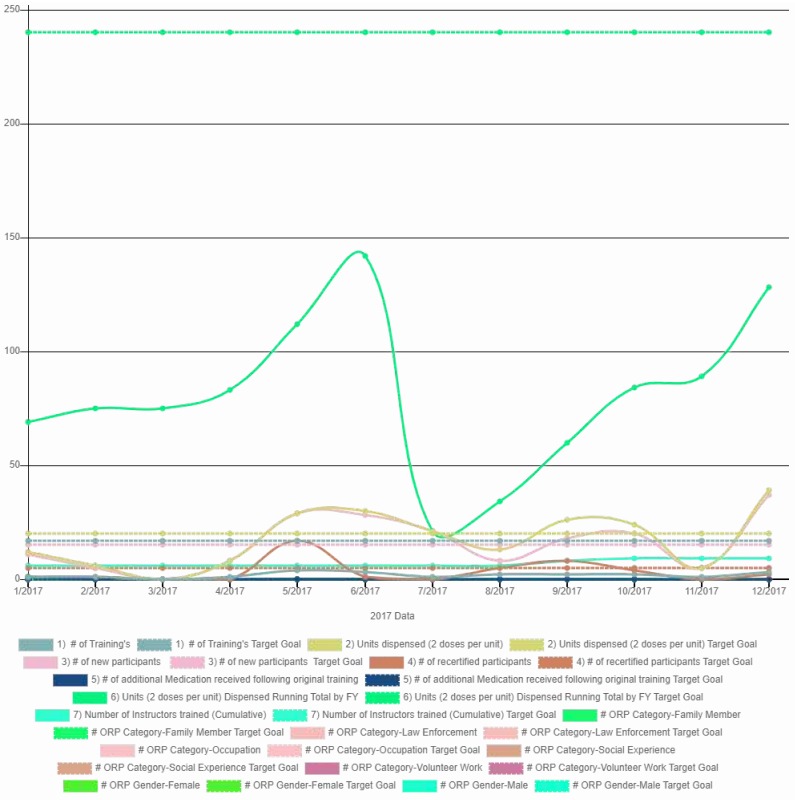
Narrative: The Overdose Response Training (ORT) Group is focused on maximizing the resources for reduction and/or prevention of fatal opioid overdose in our community. Administration of Narcan (naloxone) in the setting of an opioid overdose that results in inadequate breathing is considered a harm reduction strategy. Narcan (naloxone) administration is part of a much larger comprehensive program addressing the opioid epidemic also including education, prevention, and treatment. Classes teaching indications and technique for Narcan (naloxone) administration are held at the Garrett County Health Department (Oakland and Grantsville locations) and at sites outside of the Health Department upon request.

Strategy Description: Reduce and/or prevent opioid overdose deaths in Garrett County Advertise the Overdose Response Training (ORT) classes to the community.

Level of Change: Programs

Primary Focus Area: Behavioral Health: including Substance Abuse and Mental Health

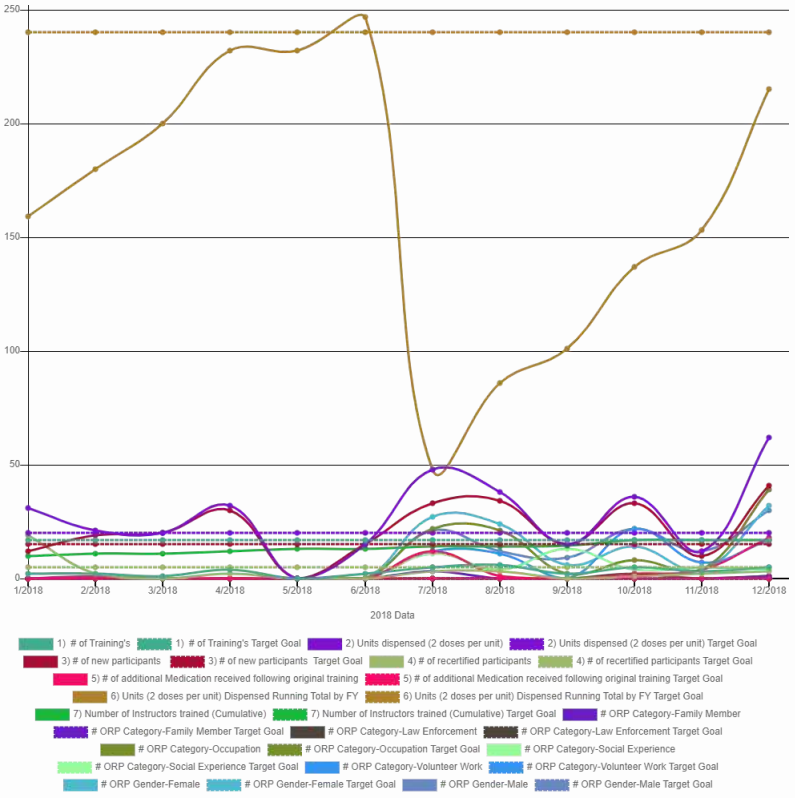
Estimated Implementation Date: 2017-08-21 | **Estimated Completion Date:** 2020-12-31



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
1) # of Training's	17	Active		1	1	0	1	4	3	1	2	2	2	1	3
2) Units dispensed (2 doses per unit)	20	Active		12	6	0	8	29	30	21	13	26	24	5	39
3) # of new participants	15	Active		11	5	0	8	29	28	21	8	18	20	5	37

4) # of recertified participants	5	Active		1	1	0	0	17	1	0	5	8	4	0	2
5) # of additional Medication received following original training	0	Active		1	0	0	0	0	0	0	0	0	0	0	0
6) Units (2 doses per unit) Dispensed Running Total by FY	240	Active		69	75	75	83	112	142	21	34	60	84	89	128
7) Number of Instructors trained (Cumulative)		Active		6	6	6	6	6	6	6	6	8	9	9	9
# ORP Category-Family Member		Active													
# ORP Category-Law Enforcement		Active													
# ORP Category-Occupation		Active													
# ORP Category-Social Experience		Active													
# ORP Category-Volunteer Work		Active													
# ORP Gender-Female		Active													
# ORP Gender-Male		Active													



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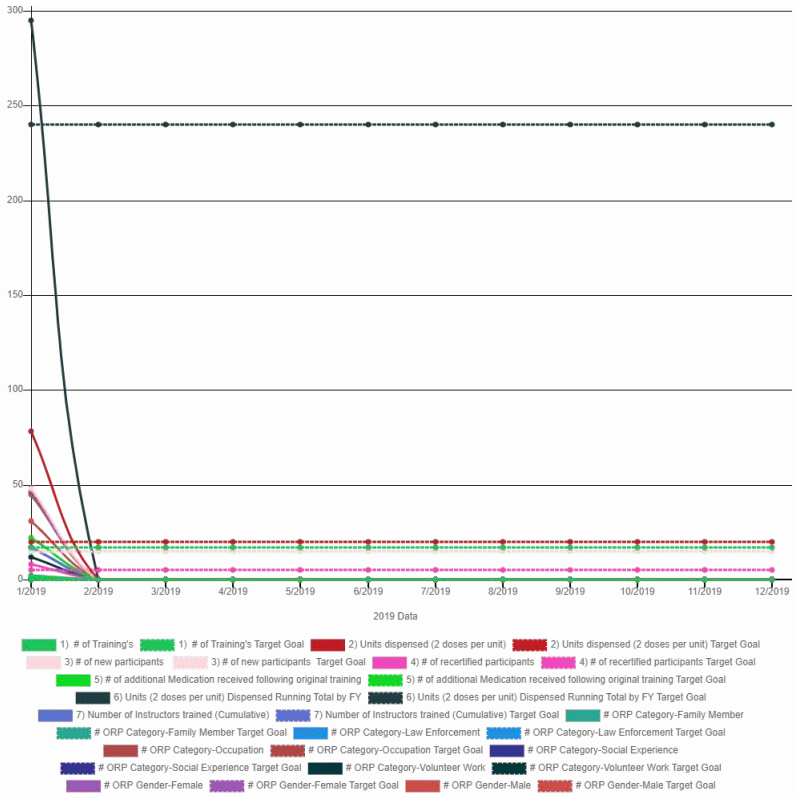
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
1) # of Training's	17	Active		2	2	1	4	0	2	5	6	2	5	3	5
2) Units dispensed (2 doses per unit)	20	Active		31	21	20	32	0	15	48	38	15	36	12	62
3) # of new participants	15	Active		12	19	20	30	0	15	33	34	15	33	10	41
4) # of recertified participants	5	Active		19	2	0	2	0	0	3	3	0	1	2	3
5) # of additional Medication received following original training	0	Active		0	1	0	0	0	0	12	1	0	2	4	18
6) Units (2 doses per unit) Dispensed Running Total by FY	240	Active		159	180	200	232	232	247	48	86	101	137	153	215
7) Number of Instructors trained (Cumulative)		Active		10	11	11	12	13	13	14	14	14.32	17	17	17
# ORP Category-Family Member		Active								3	0	0	0	0	1
# ORP Category-Law Enforcement		Active								0	0	0	2	0	1
# ORP Category-Occupation		Active								22	21	2	8	4	39
# ORP Category-Social Experience		Active								11	4	13	4	5	4
# ORP Category-Volunteer Work		Active								12	11	0	22	7	17
# ORP Gender-Female		Active								27	24	6	14	4	32
# ORP Gender-Male		Active								21	12	9	22	12	30



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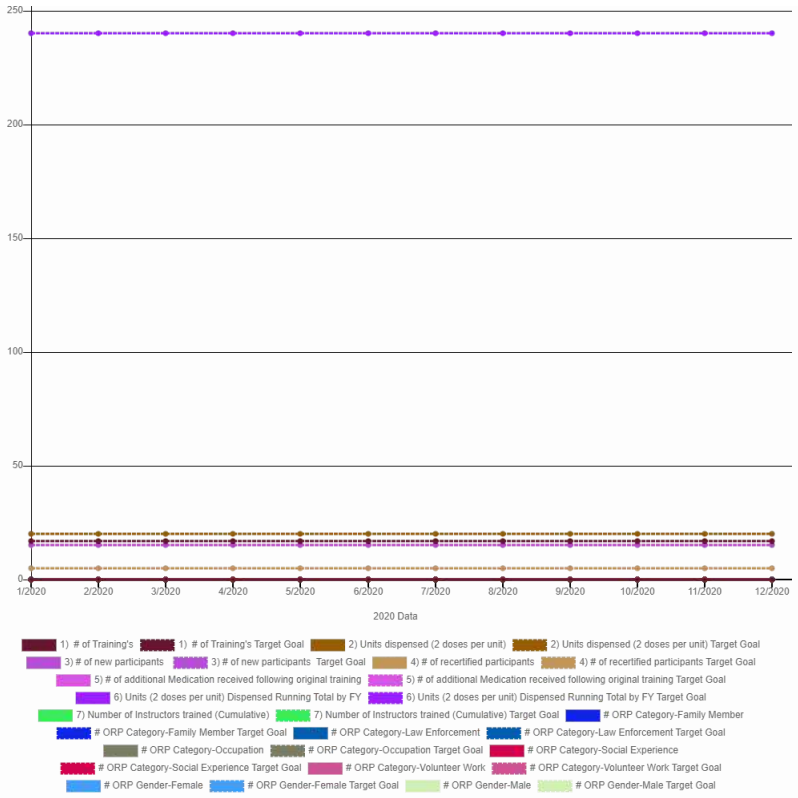
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
1) # of Training's	17	Active		2											
2) Units dispensed (2 doses per unit)	20	Active		78											
3) # of new participants	15	Active		48											
4) # of recertified participants	5	Active		8											
5) # of additional Medication received following original training	0	Active		22											
6) Units (2 doses per unit) Dispensed Running Total by FY	240	Active		295											
7) Number of Instructors trained (Cumulative)		Active		17											
# ORP Category-Family Member		Active		1											
# ORP Category-Law Enforcement		Active		17											
# ORP Category-Occupation		Active		46											
# ORP Category-Social Experience		Active		1											
# ORP Category-Volunteer Work		Active		12											
# ORP Gender-Female		Active		45											
# ORP Gender-Male		Active		31											



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
1) # of Training's	17	Active													
2) Units dispensed (2 doses per unit)	20	Active													
3) # of new participants	15	Active													
4) # of recertified participants	5	Active													
5) # of additional Medication received following original training	0	Active													
6) Units (2 doses per unit) Dispensed Running Total by FY	240	Active													
7) Number of Instructors trained (Cumulative)		Active													
# ORP Category-Family Member		Active													
# ORP Category-Law Enforcement		Active													
# ORP Category-Occupation		Active													
# ORP Category-Social Experience		Active													
# ORP Category-Volunteer Work		Active													
# ORP Gender-Female		Active													
# ORP Gender-Male		Active													

Data Narrative:

Goals may be set by month or by year. Running total = Measure begins at zero each fiscal year. (eg. 6. Units dispensed running total) Cumulative = Measure will continue to climb from year to year. (eg. 7. Number of trainers trained)

Contributing Community Participants:

Kathryn Beals / Sandra / Joseph M Casey / Jodi Kulak / Sadie Liller / Caroline / Andy / Matthew Friend / Ed Kight / Sandy Miller / Rose M Clark / Fred Polce / linda welch RN.BSN / Kathy Beals / Cindy Mankamyer / Bob Stephens / Cherylann Cogley / Sadie Liller / Karen Matthews / Jennifer Lee-Steckman / Shelley Argabrite / John Corbin / Jennifer Corder /

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Partners After School in Oakland

Partners After School @ Oakland

https://mygarrettcounty.com/groups/partners-after-school-oakland/

Snapshot Generated: 2019-02-14

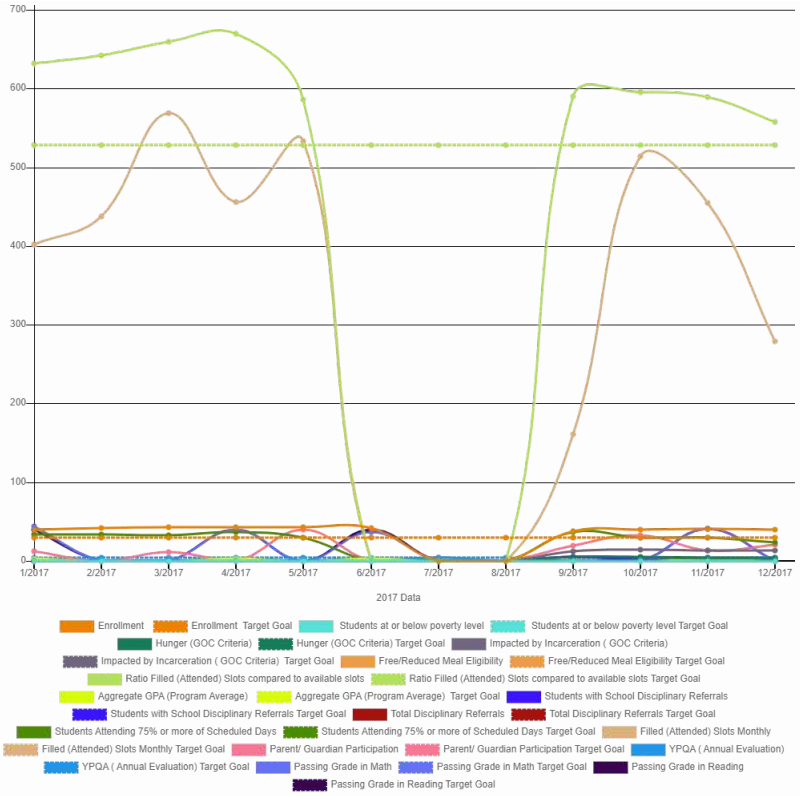
Narrative:

Strategy Description: PAS will operate Monday- Friday from 3:15 pm- 6:00 pm providing 30-45 minutes of recreation-physical activity/exercise and play. 45 minutes of homework and tutoring and also provide the students with a meal (provided from the SMS Cafeteria/ Board or Education). In correspondence with the University of Maryland Extension and the Adventure Sports Program at Garrett College enrichment activities will happen throughout the school year. Field trips, family meals and training also happen throughout the school year to promote positive parenting and interaction between children and their parents/guardians. Staff of the Partners After School (PAS) Program at Oakland will conduct outreach to the following agencies, who are aware of the PAS Program at Oakland, to increase participation and recruitment for in PAS from the Strategic Goal populations (children impacted by incarceration or hunger): Garrett County Extension Office – Food Stamp Nutrition Education (FSNE) Program PAS Director will meet with the Nutrition Educator at the Garrett County Extension Office to enlist her support in promoting PAS to all her clients. The Nutrition Educator offers FSNE programs to support the work of community agencies serving low income families and may offer programming to: Public schools where 50% or more students qualify for free or reduced school lunch (or community agencies located within these school districts), community agencies servicing food stamp eligible audiences, and local food banks, soup kitchens, homeless shelters, etc. PAS Director will provide promotional flyer to distribute at every FSNE presentation that targets families from the schools served by the PAS@Oakland program. Western Maryland Food Council Western Maryland Food Council, in one of its roles, acts as a clearinghouse of information about free food resources in Western Maryland counties. The PAS Director will stay in contact with the Food Council to maintain an up-to-date list of Garrett County free food resources, and then will outreach to those contacts which currently include the following: Food Connect at St. Peter the Apostle Parish House of Hope food pantry and monthly dinners Garrett County Community Action food pantry Mountain Laurel Medical Center (Federally Qualified Health Center) food distribution site Mountain Top Food Pantry Garrett College S.I.N.G. Food Pantry Calvary Tabernacle food pantry Loch Lynn Church of God food pantry and Feed the Flock dinners It's in the Bag, backpack ministry program Oak Park Church of the Brethren monthly meals Matthew's Episcopal Church Stephen's Table community suppers Divine Hope Church community soup kitchen Christ Lutheran Church weekly community meals Hoyes United Methodist Church monthly spaghetti dinners Summer Feeding Program through Board of Education PAS Director will ask a contact person from each food resource group to share the promotional flyer with families that attend or access the food resources. Garrett County Department of Social Services PAS Director will meet with various staff of Social Services to enlist their support in sharing information about the PAS program to clients. Social Services programs to be included are foster care, child support services, Supplemental Nutrition Assistance Program, Temporary Cash Assistance Program, and Temporary Assistance to Needy Families Program. PAS Director will provide promotional flyer to distribute to each potential family that could benefit from the PAS Program. Social Services staff will be educated about the enrollment process for the after school program so that they can assist the families as needed. Garrett County Parole and Probation PAS Director will meet with the staff at Garrett County's Parole and Probation office who are responsible for supervising parolees, probationers and those on mandatory release from the correctional facilities to make them aware of the services provided by PAS and to enlist their support in promoting PAS to all their clients. PAS Director will provide promotional flyer to distribute to each potential family that could benefit from the PAS Program. Parole and Probation staff will be educated about the enrollment process for the after school program so that they can assist the families as needed. Garrett County Public Schools PAS Director will meet with the principals, vice principals, and/or guidance staff at Broad Ford Elementary School, Yough Glades Elementary School, and Southern Middle School to make sure that they understand the Strategic Goal targeted populations in order to effectively assist in promoting PAS to those students and their families. Staff will be asked to share the promotional flyer with all targeted students and their families over the course of the school year through day to day interactions, school events, or school mailings. PAS Director will work with school staff to send home a promotional flyer with applications for Free and Reduced Meals Garrett County Dove Center The Dove Center provides shelter services for women and children who have left their primary residence due to a domestic violence experience or other traumatic experience. Additionally, the Dove Center provides shelter for homeless women and their children, without requiring evidence of leaving a domestic violence incident. PAS Director will meet with the staff at the Dove Center to make them aware of the PAS Program and how to refer or enroll students from the targeted schools that come into contact with Dove Center services. These services include individual and group counseling and emergency shelter to victims of domestic violence. Those families who are accessing the emergency shelter are impacted by childhood hunger and often time by incarceration of a family member. PAS Director will provide promotional flyers to distribute to each potential family that could benefit from the PAS Program. Garrett County Health Department PAS Director will regularly share information about recruitment and referral into the PAS@Oakland Program with the divisions of the health department that come into contact with families that may be impacted by incarceration or be facing hunger issues. These include the following: Women, Infants, and Children Program Early Care Home Visiting Program Dental Program Personal Health Services such as immunization and family planning Behavioral Health Services including Substance Abuse and Mental Health PAS Director will provide promotional flyer to distribute to health department clients that could benefit from the PAS Program. Health department staff also have the option to give a warm hand-off of clients directly to the after school staff that are housed within the agency. In addition to outreach provided to partner agencies, PAS staff will also attend Back to School Night at each of the three target schools in order to make parents aware of the after school program, eligibility criteria, services and activities provided. Included, for reference: PAS @ Oakland Application and Program Flyerupdated-PAS-Flyer-2018-2019-flyer

Level of Change: Programs

Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2018-10-15 | **Estimated Completion Date:** 2019-06-15



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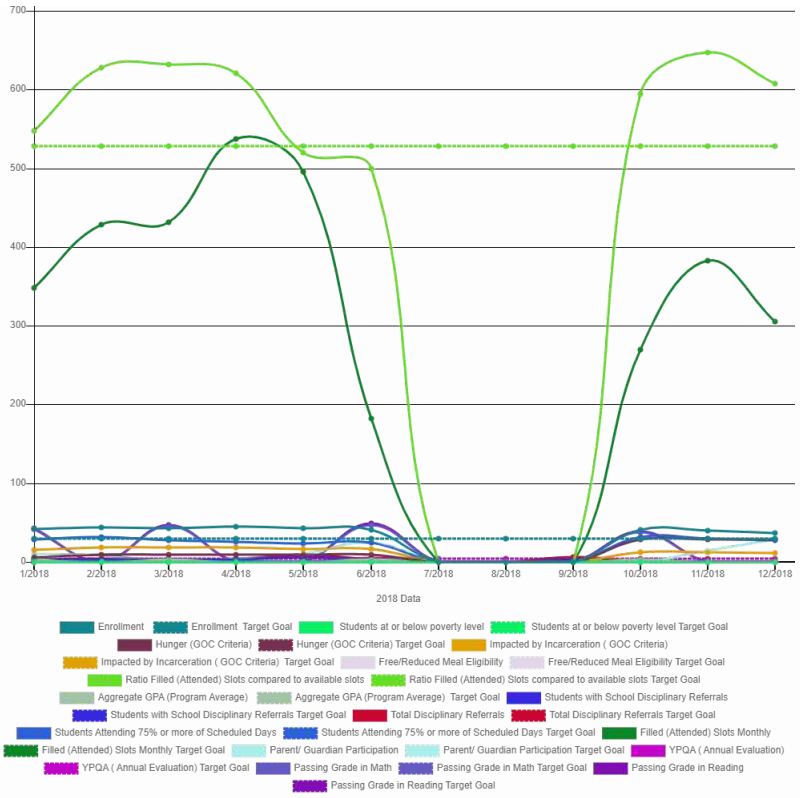
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Enrollment	30	Active		40	42	43	43	43	42			38	40	41	40
Students at or below poverty level		Archived	GCPS												
Hunger (GOC Criteria)		Active	Paent Self Report/ Application									5	5	4	4
Impacted by Incarceration (GOC Criteria)		Active	Parent -Self Report/ Application									12	14	13	13
Free/Reduced Meal Eligibility		Archived	GCPS												
Ratio Filled (Attended) Slots compared to available slots	528	Active		632	642	659	669	586				590	595	589	558
Aggregate GPA (Program Average)		Active	GCPS-Report Cards	3.11			2.96		3.04					3.0	
Students with School Disciplinary Referrals		Active	GCPS									5	2	2	2
Total Disciplinary Referrals		Active	GCPS									5	2	2	2
Students Attending 75% or more of Scheduled Days		Active		34	34	33	37	29				37	30	30	23
Filled (Attended) Slots Monthly		Active		402	438	569	456	533				161	514	455	279
Parent/ Guardian Participation		Active		12	0	11	0	40				19	33	13	20
YPQA (Annual Evaluation)	4.1	Active								3.72					
Passing Grade in Math		Active	GCPS	44			40		37					41	
Passing Grade in Reading		Active	GCPS	40			40		40					41	



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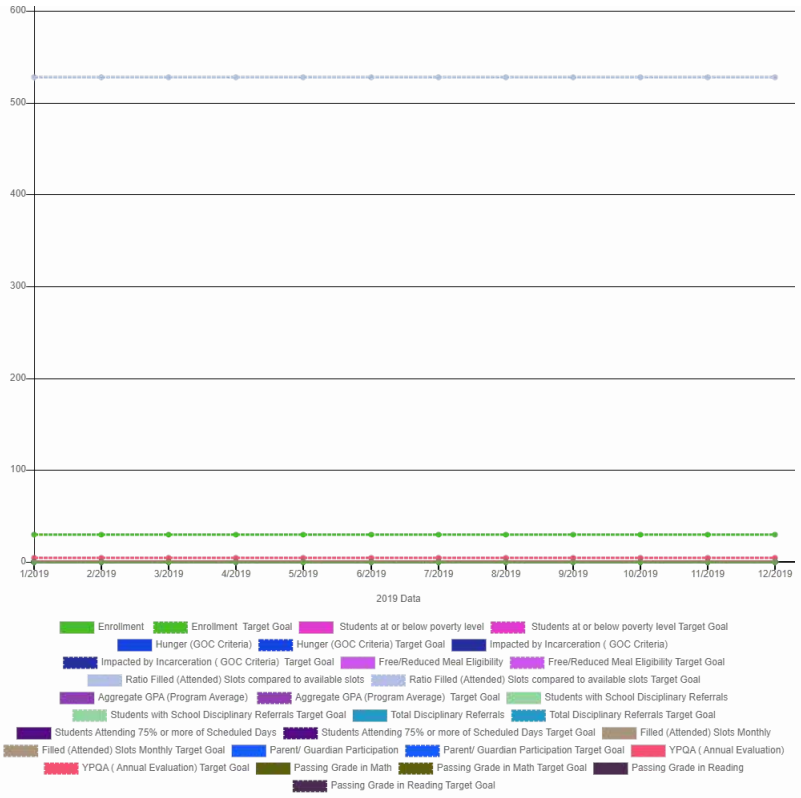
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Enrollment	30	Active		42	44	43	45	43	41				41	40	37
Students at or below poverty level		Archived	GCPS												
Hunger (GOC Criteria)		Active	Paent Self Report/ Application	6	9	9	9	9	9				28	28	28
Impacted by Incarceration (GOC Criteria)		Active	Parent -Self Report/ Application	15	18	18	18	16	16				12	12	11
Free/Reduced Meal Eligibility		Archived	GCPS												
Ratio Filled (Attended) Slots compared to available slots	528	Active		547	628	632	621	520	500				594	647	607
Aggregate GPA (Program Average)		Active	GCPS-Report Cards	2.9		2.7			2.9				2.62		
Students with School Disciplinary Referrals		Active	GCPS	3	3	3	3	6	3			3	1		
Total Disciplinary Referrals		Active	GCPS	3	4	3	3	9	3			6	1		
Students Attending 75% or more of Scheduled Days		Active		28	32	27	25	23	24				32	30	27
Filled (Attended) Slots Monthly		Active		348	428	431	537	496	182				270	383	305
Parent/ Guardian Participation		Active		10	8	1	4	10	24				0	14	28
YPQA (Annual Evaluation)	4.1	Active							4.66						
Passing Grade in Math		Active	GCPS	43		46			47				38		
Passing Grade in Reading		Active	GCPS	42		47			49				39		



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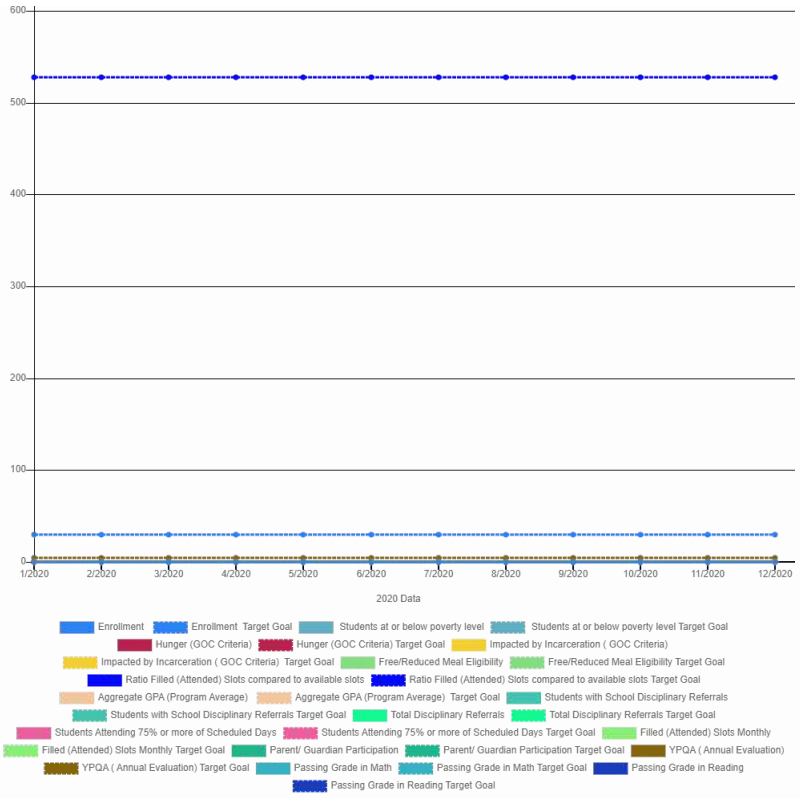
Enrollment	30	Active													
Students at or below poverty level		Archived	GCPS												
Hunger (GOC Criteria)		Active	Paent Self Report/ Application												
Impacted by Incarceration (GOC Criteria)		Active	Parent -Self Report/ Application												
Free/Reduced Meal Eligibility		Archived	GCPS												
Ratio Filled (Attended) Slots compared to available slots	528	Active													
Aggregate GPA (Program Average)		Active	GCPS-Report Cards												
Students with School Disciplinary Referrals		Active	GCPS												
Total Disciplinary Referrals		Active	GCPS												
Students Attending 75% or more of Scheduled Days		Active													
Filled (Attended) Slots Monthly		Active													
Parent/ Guardian Participation		Active													
YPQA (Annual Evaluation)	4.1	Active													
Passing Grade in Math		Active	GCPS												
Passing Grade in Reading		Active	GCPS												



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Enrollment	30	Active													
Students at or below poverty level		Archived	GCPS												
Hunger (GOC Criteria)		Active	Paent Self Report/ Application												
Impacted by Incarceration (GOC Criteria)		Active	Parent -Self Report/ Application												
Free/Reduced Meal Eligibility		Archived	GCPS												
Ratio Filled (Attended) Slots compared to available slots	528	Active													
Aggregate GPA (Program Average)		Active	GCPS-Report Cards												
Students with School Disciplinary Referrals		Active	GCPS												
Total Disciplinary Referrals		Active	GCPS												
Students Attending 75% or more of Scheduled Days		Active													
Filled (Attended) Slots Monthly		Active													
Parent/ Guardian Participation		Active													
YPQA (Annual Evaluation)	4.1	Active													
Passing Grade in Math		Active	GCPS												
Passing Grade in Reading		Active	GCPS												

Data Narrative:

- will collect disciplinary referrals and update with the next report cards
- As of this year Elementary Schools have stopped using Star 360 (Archived)
- We currently have 1 student enrolled that we do not have permission to collect school data for.
- As of October 2018: Ratio of filled (attended) slots compared to available slots: Answers the question "how close to capacity is the program filled". Proportional number of client contacts when compared to an optimal 660 contacts per month. The closer to 660 the monthly number is, the closer the program was to filling all available slots throughout the month. The goal would be to reach the equivalent of at least 528 client contacts, representing 80% of available slots were filled. The base number of 660 available slots was based on a maximum of 22 days of programming per month x 30 available slots per day. Because of school closings, each month allows for a different number of program days, so the actual number of Filled slots has been used to calculate the same ratio as a month with 660 possible client contacts. (old target 704- new target 528)

Enrollment - new target set to 30- (Loss of funding)decreased the enrollment from 40 students to 30 student per night Start Date FY19- October 15th 2017 Data not collected for Hunger (GOC Criteria) and Impacted by Incarceration until September 2018 Students with School Disciplinary Referrals-data collected annually (15 students received disciplinary referrals within the 2016-2017 school year)

- Enrollment- Number students enrolled at beginning of each month of the program, duplicative
- Student at/or below poverty level: individual data not accessible via GCPS.
- Hunger: Parents self-report on application based on GOC Strategies criteria for hunger. http://goc.maryland.gov/wp-content/uploads/sites/8/2013/11/GOC_Strategic_Plan_FINAL.pdf
- Impacted by incarceration: Parents self-report on application based on GOC Strategies criteria for incarceration/probation. http://goc.maryland.gov/wp-content/uploads/sites/8/2013/11/GOC_Strategic_Plan_FINAL.pdf
- Free / reduced meal eligibility: Individual data not accessible via GCPS.
- Ratio of filled (attended) slots compared to available slots: Answers the question "how close to capacity is the program filled". Proportional number of client contacts when compared to an optimal 880 contacts per month. The closer to 880 the monthly number is, the closer the program was to filling all available slots throughout the month. The goal would be to reach the equivalent of at least 704 client contacts, representing 80% of available slots were filled. The base number of 880 available slots was based on a maximum of 22 days of programming per month x 40 available slots per day. Because of school closings, each month allows for a different number of program days, so the actual number of filled slots has been used to calculate the same ratio as a month with 880 possible client contacts.
-
- # of PAS participants with school disciplinary referrals

- Total # of disciplinary referrals among PAS participants (how many referrals students received)
- Passing grade in Math: Note that, for any student attending 8 or more days, grades are collected even if they withdraw from the program.
- Passing grade in Reading: Note that, for any student attending 8 or more days, grades are collected even if they withdraw from the program.
- School disciplinary referrals: Collected for students for whom parent consent was given to program. Reported by principals.
- Filled (attended) slots (monthly): Total occurrences of youth served by (attending) program.
- % Filled (attended) slots (monthly): Number above divided by total number of possible occurrences for youth by be served (attend) program. Answering the question "how well attended is the program as a whole".
- Parent / Guardian participation: An un-duplicated monthly count of those who participate in the program, either by attending a parent training, attending a parent-child activity, or by volunteering . The count resets each month.
- YPQA: Youth Program Quality Tool developed by Center for Youth Program Quality to "measure the quality of programs and identify staff training needs". Scores range from 1.0-5.0 http://www.cypq.org/assessment

Research: 2012- "The Relationship of Food and Academic Performance:A Preliminary Examination of the Factors of Nutritional Neuroscience, Malnutrition, and Diet Adequacy" Woodhouse, Allison and Lamport, Ph.D., Mark A. (2012) "The Relationship of Food and Academic Performance: A Preliminary Examination of the Factors of Nutritional Neuroscience, Malnutrition, and Diet Adequacy,"Christian Perspectives in Education, 5(1). Available at: http://digitalcommons.liberty.edu/cpe/vol5/iss1/1 https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1074&context=cpe "Children of Incarcerated Parents and Academic Success" Megan Sullivan-National Council of Teachers of English http://www2.ncte.org/blog/2017/05/children-incarcerated-parents-academic-success/ "Effects of Parental Incarceration on Young Children" U.S. Department of Health & Human Services https://aspe.hhs.gov/basic-report/effects-parental-incarceration-young-children Children Trauma Toolkit for Educators- The National Child Traumatic Stress Network https://www.nctsn.org/sites/default/files/resources//child_trauma_toolkit_educators.pdf Strengthening families impacted by incaceration: A review of current research and practice Prepared by: Jessica Meyerson and Christa Otterson- Wilder Research https://www.wilder.org/wilder-research/research-library/strengthening-families-impacted-incarceration-evaluation

Contributing Community Participants:

Juliet / Anon / John Corbin / Kristi Cassada / Amanda Oliverio / Chris Baker / Venessa Stacy / James Michaels /

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Promoting Quitting Tobacco Among Adults

Public Group a month ago

Leave Group

GROUP ADMINS

Tobacco

Promoting Quitting Tobacco Among Adults

https://mygarrettcounty.com/groups/tobacco-use/promoting-quitting-among-adults/

Snapshot Generated: 2019-02-14

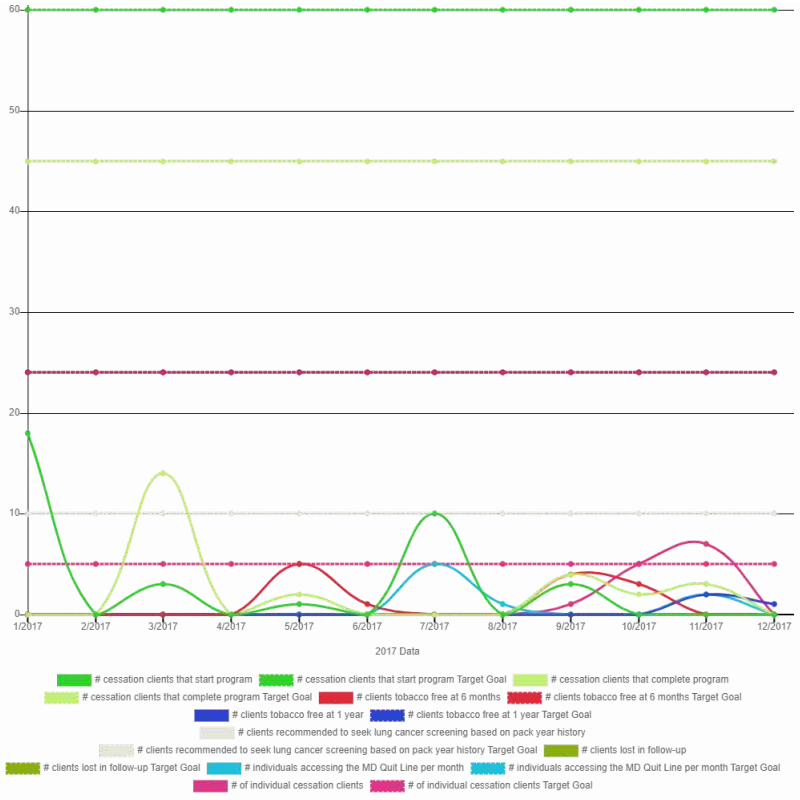
Narrative: Did you know that Garrett County has the highest percentage (33%) of reported youth using tobacco products in the state of Maryland according to the latest data from Maryland's State Health Improvement Process, mdship 2014. Our goal is to reduce the burden of Chronic Diseases in Garrett County by addressing three modifiable risk factors; tobacco use, nutrition and physical activity. There are many evidence based strategies our community is using to address tobacco use in both youth and adults from preventing initial use to helping people quit.

Strategy Description: Garrett County Health Department provides smoking cessation classes for Garrett County adults. Cessation aids such as Zyban or the nicotine patch are covered by the program. Quit rates are tracked at 6 months, and 1 year after the class ends.

Level of Change: Programs

Primary Focus Area: Chronic Diseases and their common risk factors: lack of physical activity, poor nutrition, and tobacco use

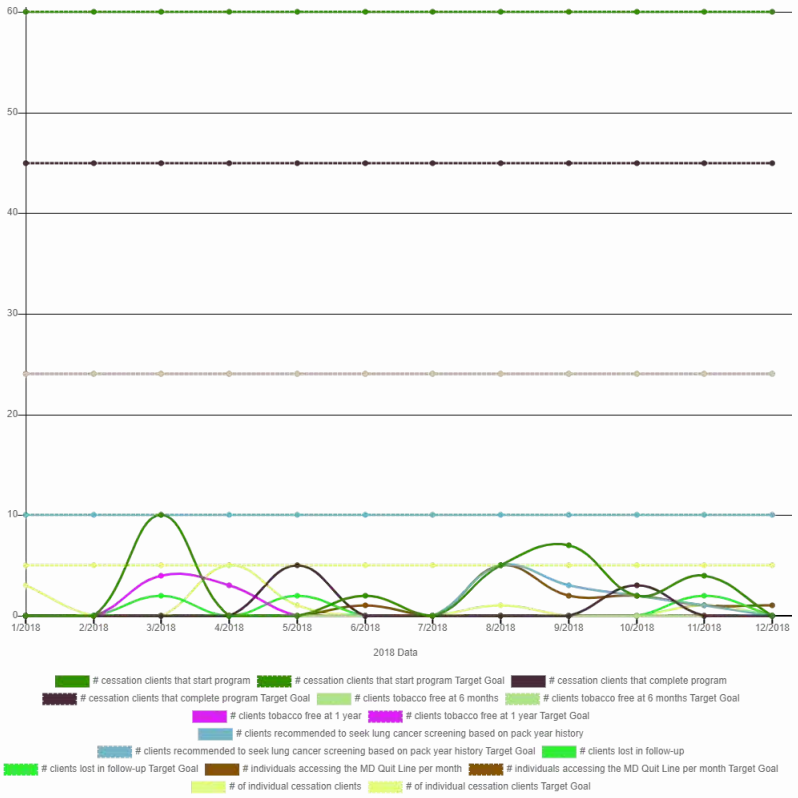
Estimated Implementation Date: 2016-07-01 | **Estimated Completion Date:** 2020-12-31



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
# cessation clients that start program	60	Active	Mike Wilburn, Betty Anderson	18		3		1		10		3			
# cessation clients that complete program	45	Active	Mike Wilburn, Betty Anderson			14		2				4	2	3	
# clients tobacco free at 6 months	24	Active	Mike Wilburn					5	1			4	3		

# clients tobacco free at 1 year	24	Active	Mike Wilburn											2	1
# clients recommended to seek lung cancer screening based on pack year history	10	Active	Kendra McLaughlin												
# clients lost in follow-up		Active	Mike Wilburn		0										
# individuals accessing the MD Quit Line per month		Active	MD Quit Line Coordinator							5	1	0	0	2	0
# of individual cessation clients	5	Active	Mike Wilburn, Betty Anderson									1	5	7	



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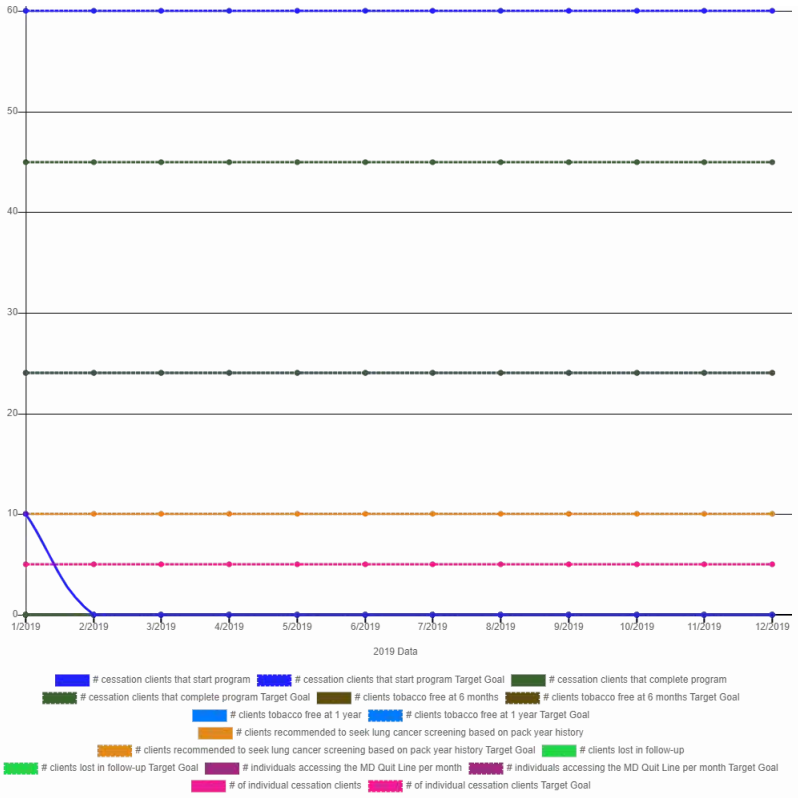
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
# cessation clients that start program	60	Active	Mike Wilburn, Betty Anderson			10			2		5	7	2	4	
# cessation clients that complete program	45	Active	Mike Wilburn, Betty Anderson					5					3		
# clients tobacco free at 6 months	24	Active	Mike Wilburn				0								
# clients tobacco free at 1 year	24	Active	Mike Wilburn			4	3								
# clients recommended to seek lung cancer screening based on pack year history	10	Active	Kendra McLaughlin								5	3	2	1	
# clients lost in follow-up		Active	Mike Wilburn			2		2						2	
# individuals accessing the MD Quit Line per month		Active	MD Quit Line Coordinator	0	0	0	0	0	1	0	5	2	2	1	1
# of individual cessation clients	5	Active	Mike Wilburn, Betty Anderson	3			5	1			1			1	



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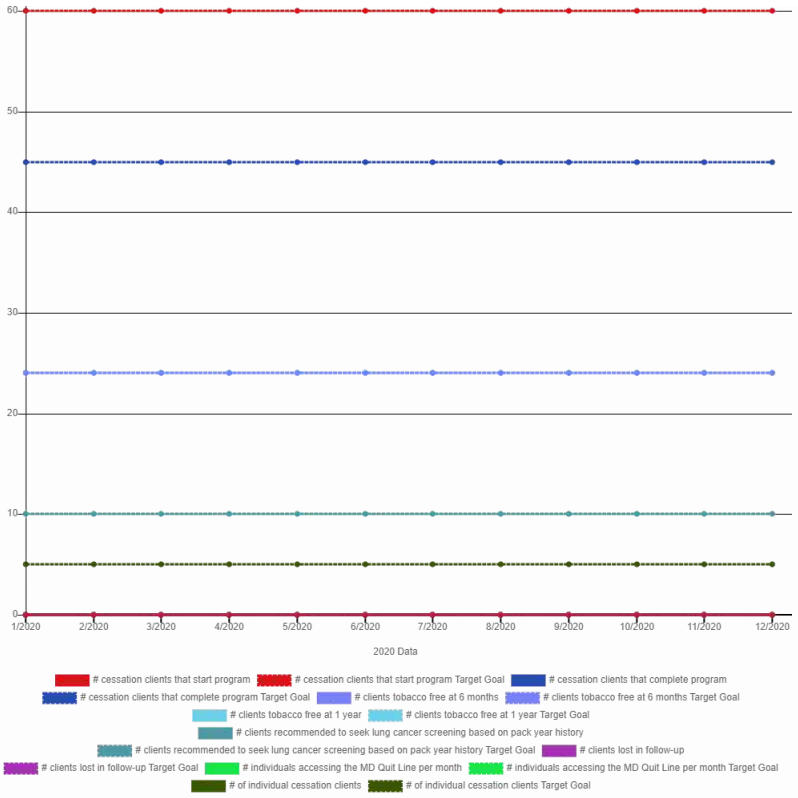
# cessation clients that start program	60	Active	Mike Wilburn, Betty Anderson	10											
# cessation clients that complete program	45	Active	Mike Wilburn, Betty Anderson												
# clients tobacco free at 6 months	24	Active	Mike Wilburn												
# clients tobacco free at 1 year	24	Active	Mike Wilburn												
# clients recommended to seek lung cancer screening based on pack year history	10	Active	Kendra McLaughlin												
# clients lost in follow-up		Active	Mike Wilburn												
# individuals accessing the MD Quit Line per month		Active	MD Quit Line Coordinator												
# of individual cessation clients	5	Active	Mike Wilburn, Betty Anderson												



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# clients tobacco free at 6 months	24	Active	Mike Wilburn												
# clients tobacco free at 1 year	24	Active	Mike Wilburn												
# clients recommended to seek lung cancer screening based on pack year history	10	Active	Kendra McLaughlin												
# clients lost in follow-up		Active	Mike Wilburn												
# individuals accessing the MD Quit Line per month		Active	MD Quit Line Coordinator												
# of individual cessation clients	5	Active	Mike Wilburn, Betty Anderson												

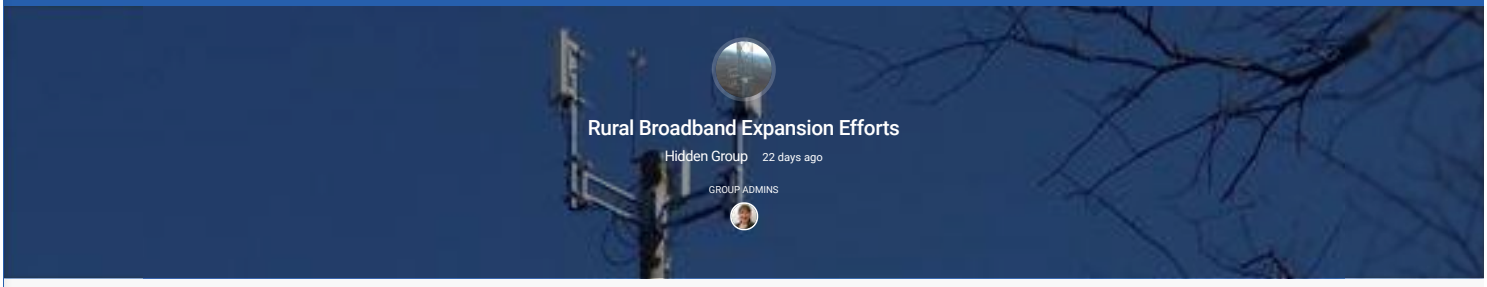
Data Narrative:

1. Number of participants that begin the smoking cessation class
2. Number of participants that started and completed the smoking cessation class.
3. Number of clients who are still tobacco free six months after the class ends. Staff makes 3 attempts to reach each client for follow-up. In March 2018 there were 2 clients at 6 month follow-up that were not reachable for follow-up. In April 2018, both clients that reached the 6 month mark had started smoking again. In May 2018 there were 2 clients at 6 month follow-up that were not reachable for follow-up.
4. Number of clients who are still tobacco free 1 year after the class ends. Staff makes 3 attempts to reach each client for follow-up.
5. Number of clients referred for lung cancer screening. According to the U.S. Preventive Services Task Force, a CT scan to screen for lung cancer is recommended for any individual between the ages of 55 and 80 that has a 30 pack year history. In the GCHD Cessation classes, beginning in Sept. 2018, clients will calculate their pack year history at one of the first 3 classes. The instructor will recommend that each client with a 30 pack year history take their calculation worksheet to their health care provider to suggest a CT scan.
6. Number of clients that could not be reached when attempting to contact for 6 month or 1 year cessation follow up. Three attempts are made before discontinuing follow-up.
7. Number of individuals accessing the MD Quit Line per month. These numbers are retrieved from the monthly reports shared with county Cigarette Restitution Fund Coordinators from the MD Quit Line.
8. Number of individual cessation clients. Some clients, for one reason or another, can not make it to the group cessation clients, and so, the instructor provides one or more individual cessation consultations.

Research: The Community Guide

Contributing Community Participants:

Brian X. Murray / Joseph M Casey / John Corbin / ANNIE MAY SHORT / Amanda Oliverio / Chris Baker / Steve Putnam / Carrie Hook / Diana Boller / Krista Wasowski / Christy / Christine / Lindsey Bernal / Sandy Miller / Ed Kight / Teresa Friend / Bev Tucker / Christinia Kemper / Daphne Gooding / Melina Manley / Linda Costello / HEATHER BERG / Serena Lucas / Kendra McLaughlin /



Rural Broadband Expansion Efforts

Hidden Group 22 days ago

GROUP ADMINS

Community Linkages

Rural Broadband Expansion Efforts

https://mygarrettcounty.com/groups/rural-broadband-expansion-efforts/

Snapshot Generated: 2019-02-14

Narrative:

Garrett County Government is committed to helping the private sector extend broadband service to unserved and underserved residents and businesses in the county. The county began a pilot project with an incumbent provider to extend service to at least 10 passings by 12/31/17 and are pleased to report they more than tripled the goal. They will continue connecting new customers through the TV White Space wireless broadband project and have set a goal of 500 by 12/31/2018. The county is working with a private provider to extend service and use county assets (manpower, equipment) to trench a 1/2 mile stretch along county roads, just outside the provider's territory with the goal of utilizing the information to develop the framework for working with other providers to increase access for more residents.

Strategy Description:

Work with a private provider to extend service.

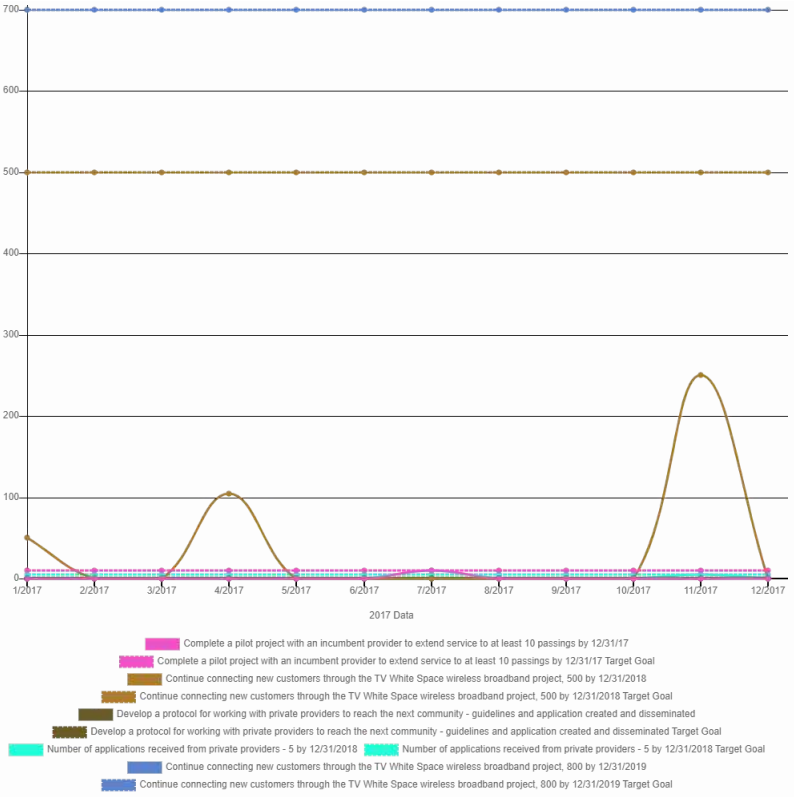
Use county assets (manpower, equipment) to trench 1/2 mile stretch along county roads, just outside the provider's territory.

Assess the project and use the info to develop the framework for working with other providers.

Level of Change: Programs

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2014-01-01 | **Estimated Completion Date:** 2020-01-01



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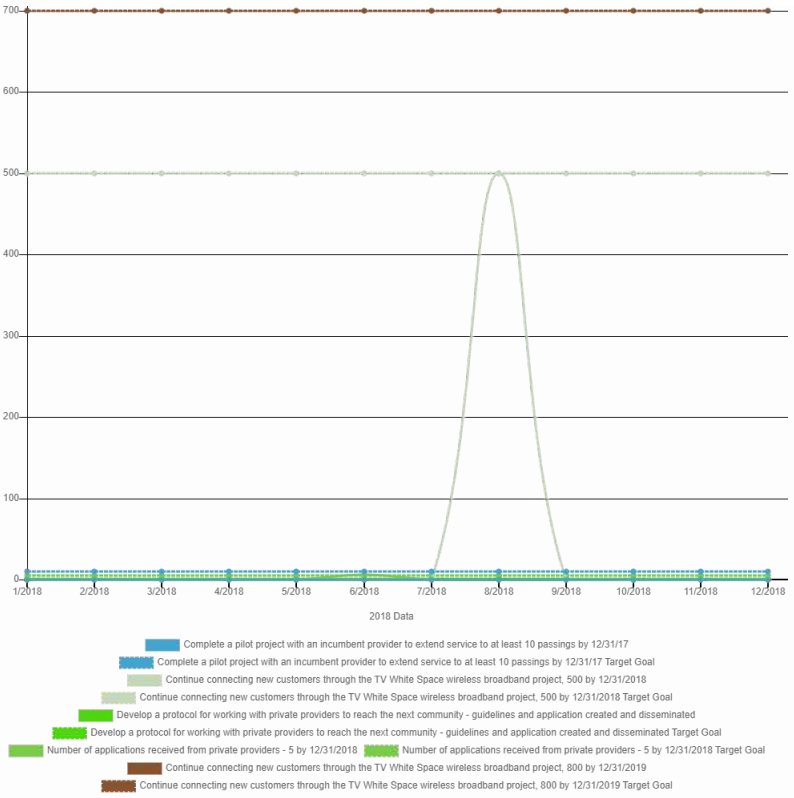
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Complete a pilot project with an incumbent provider to extend service to at least 10 passings by 12/31/17	10	Archived		0						10					
Continue connecting new customers through the TV White Space wireless broadband project, 500 by 12/31/2018	500	Archived		50			105							250	
Develop a protocol for working with private providers to reach the next community - guidelines and application created and disseminated	1	Active													1
Number of applications received from private providers - 5 by 12/31/2018	5	Archived												5	
Continue connecting new customers through the TV White Space wireless broadband project, 800 by 12/31/2019	700	Active													



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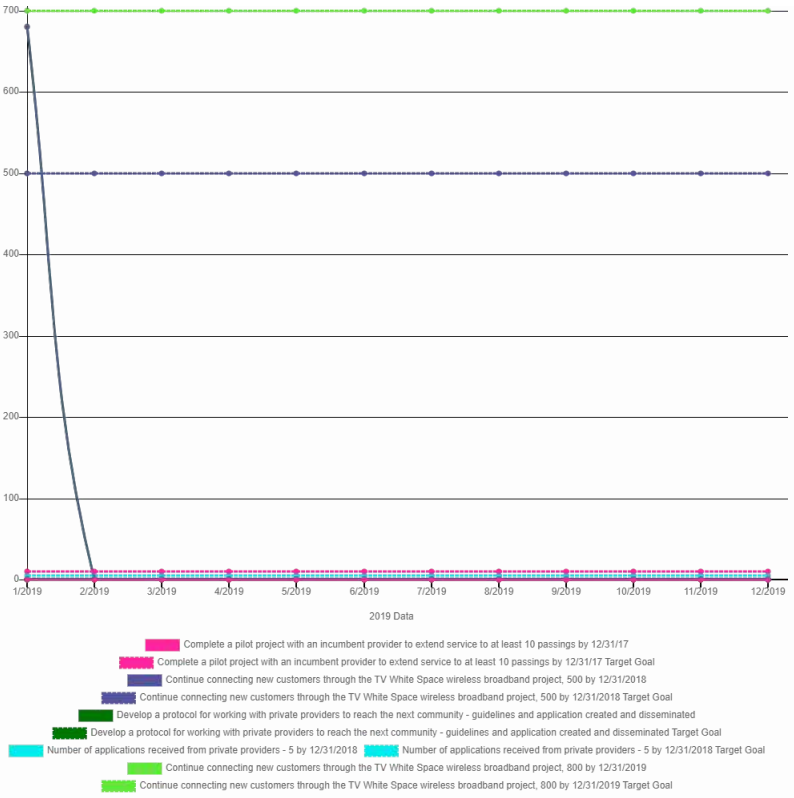
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Complete a pilot project with an incumbent provider to extend service to at least 10 passings by 12/31/17	10	Archived													
Continue connecting new customers through the TV White Space wireless broadband project, 500 by 12/31/2018	500	Archived									500				
Develop a protocol for working with private providers to reach the next community - guidelines and application created and disseminated	1	Active													
Number of applications received from private providers - 5 by 12/31/2018	5	Archived							6						
Continue connecting new customers through the TV White Space wireless broadband project, 800 by 12/31/2019	700	Active													



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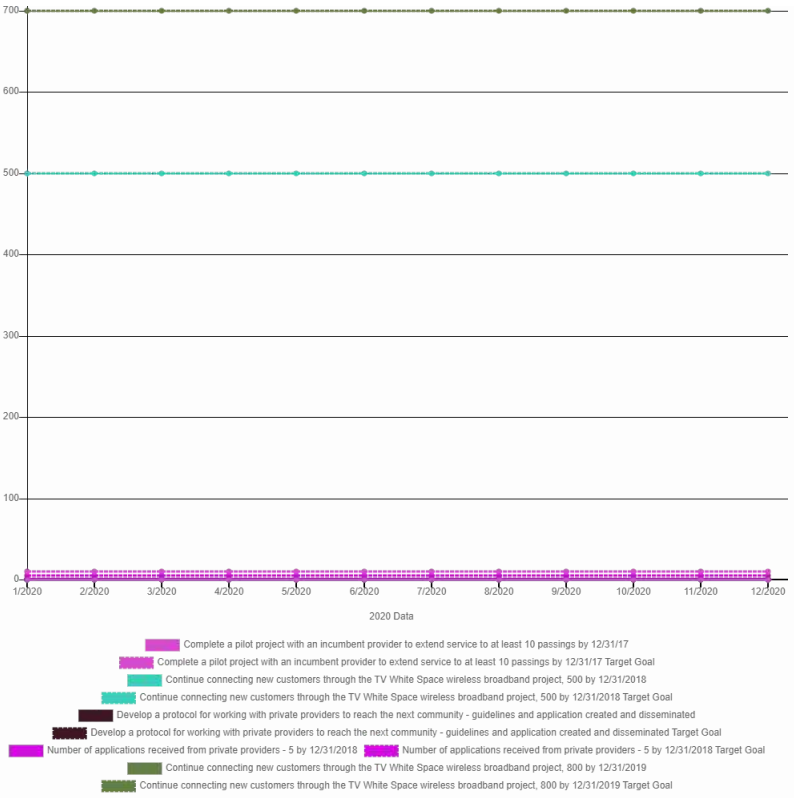
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Complete a pilot project with an incumbent provider to extend service to at least 10 passings by 12/31/17	10	Archived													
Continue connecting new customers through the TV White Space wireless broadband project, 500 by 12/31/2018	500	Archived		680											
Develop a protocol for working with private providers to reach the next community - guidelines and application created and disseminated	1	Active													
Number of applications received from private providers - 5 by 12/31/2018	5	Archived													
Continue connecting new customers through the TV White Space wireless broadband project, 800 by 12/31/2019	700	Active		680											



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Complete a pilot project with an incumbent provider to extend service to at least 10 passings by 12/31/17	10	Archived													
Continue connecting new customers through the TV White Space wireless broadband project, 500 by 12/31/2018	500	Archived													
Develop a protocol for working with private providers to reach the next community - guidelines and application created and disseminated	1	Active													
Number of applications received from private providers - 5 by 12/31/2018	5	Archived													
Continue connecting new customers through the TV White Space wireless broadband project, 800 by 12/31/2019	700	Active													

Data Narrative:

As of January 2018, we have over 680 connected customers on the fixed wireless system. We have over 700 on the waiting list. We are accessing additional funding sources to expand the project to unserved areas.

Research:

Broadband feasibility study

Contributing Community Participants:

Nathaniel Watkins / Cheryl DeBerry /

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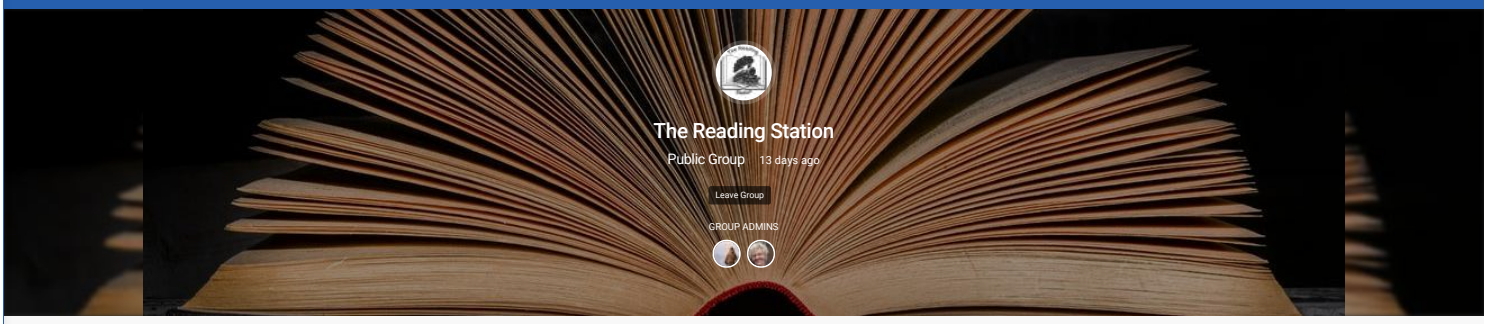


Improving Literacy in Garrett County

The Reading Station

https://mygarrettcounty.com/groups/the-reading-station/

Snapshot Generated: 2019-02-14

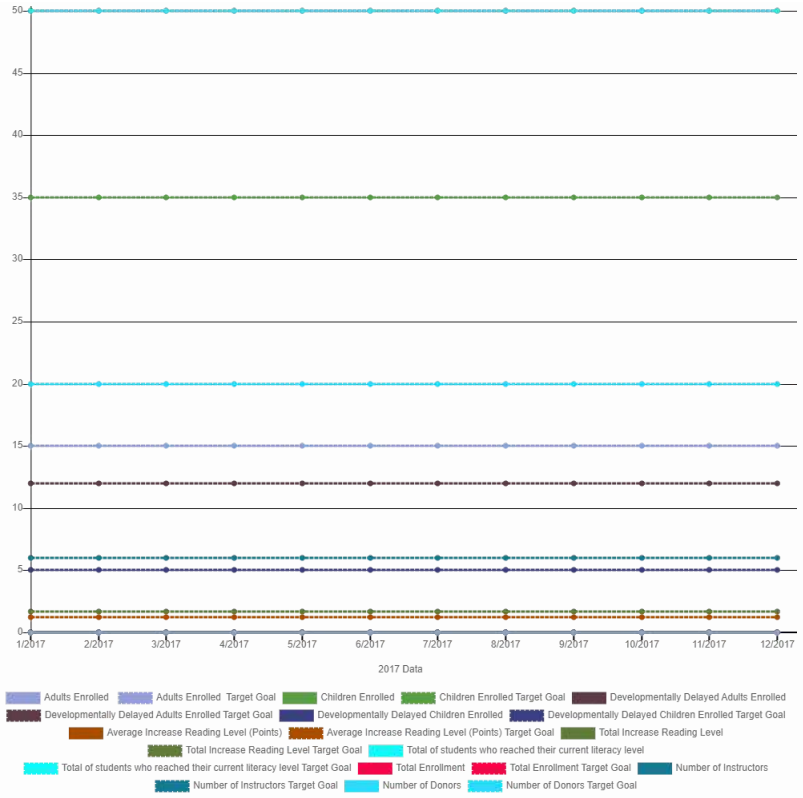
Narrative: The Reading Station is a 501 (c)(3) non-profit organization located in Oakland, Maryland focused on improving literacy in Garrett County by offering free functional reading instruction to children and adults.

Strategy Description: Offer free reading instruction to children and adults.

Level of Change: Programs

Primary Focus Area: Access to Care and Linkages to Community Resources

Estimated Implementation Date: 2017-08-23 | **Estimated Completion Date:** 2020-01-31



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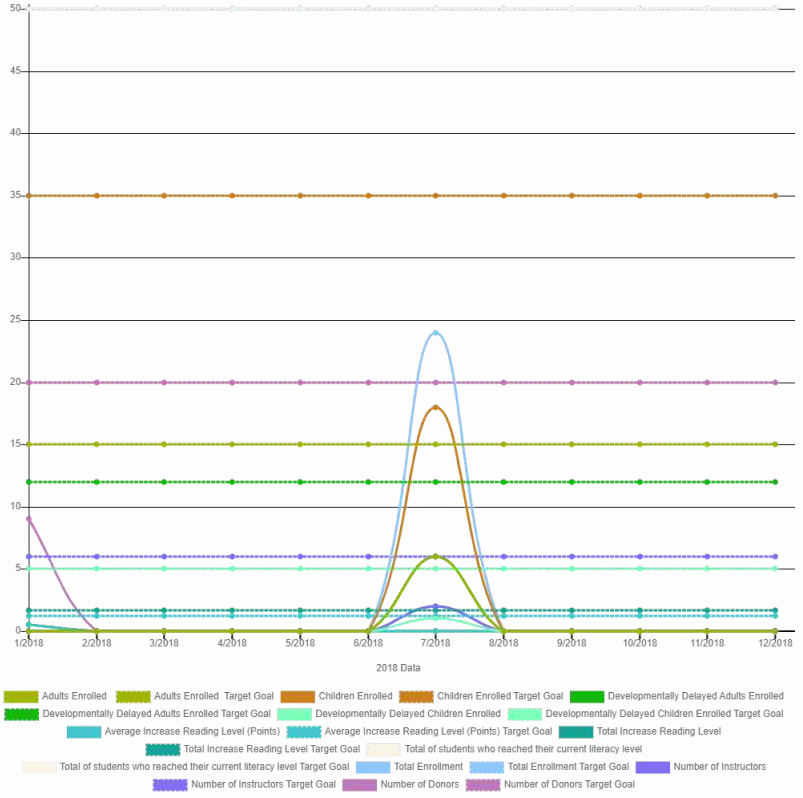
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Adults Enrolled	15	Active													
Children Enrolled	35	Active													
Developmentally Delayed Adults Enrolled	12	Active													
Developmentally Delayed Children Enrolled	5	Active													

Average Increase Reading Level (Points)	1.2	Active													
Total Increase Reading Level	1.7	Active													
Total of students who reached their current literacy level	50	Active													
Total Enrollment	50	Active													
Number of Instructors	6	Active													
Number of Donors	20	Active													



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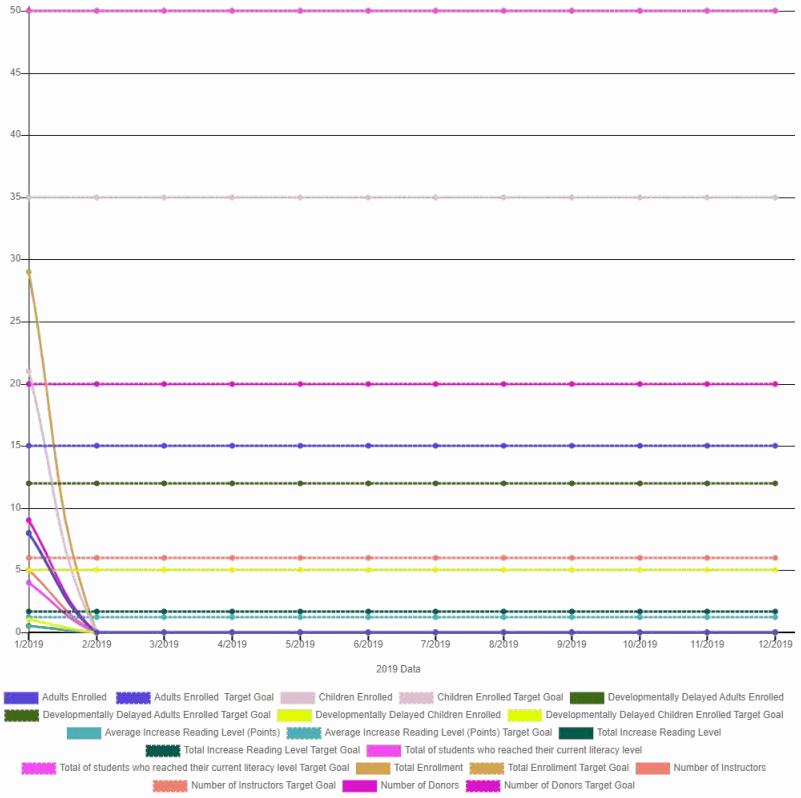
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Adults Enrolled	15	Active								6					
Children Enrolled	35	Active								18					
Developmentally Delayed Adults Enrolled	12	Active								6					
Developmentally Delayed Children Enrolled	5	Active								1					
Average Increase Reading Level (Points)	1.2	Active		.5											
Total Increase Reading Level	1.7	Active		.5											
Total of students who reached their current literacy level	50	Active													
Total Enrollment	50	Active								24					
Number of Instructors	6	Active								2					
Number of Donors	20	Active		9						2					



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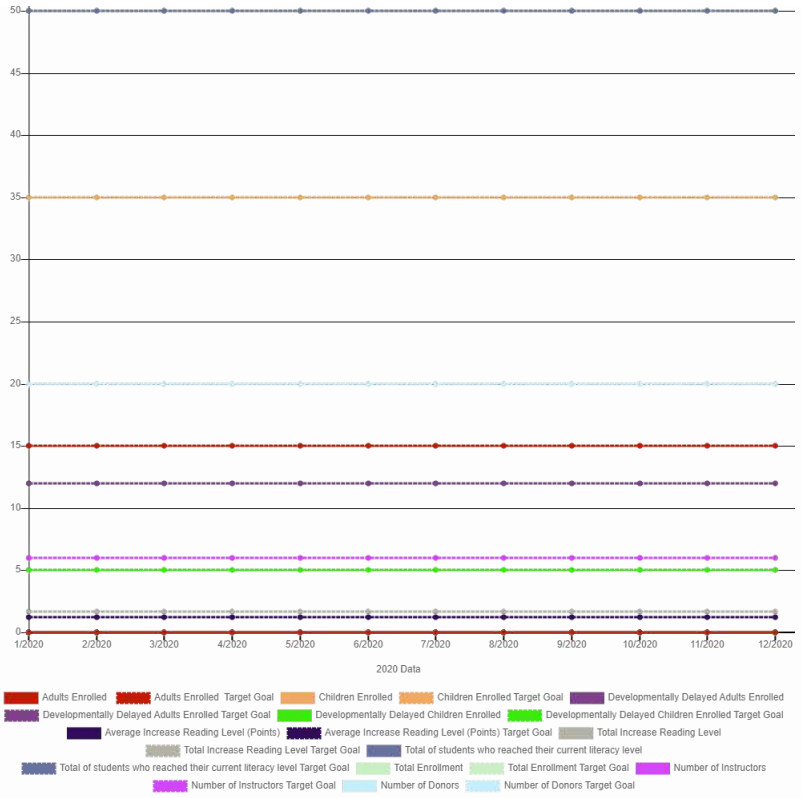
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Adults Enrolled	15	Active		8											
Children Enrolled	35	Active		21											
Developmentally Delayed Adults Enrolled	12	Active		8											
Developmentally Delayed Children Enrolled	5	Active		1											
Average Increase Reading Level (Points)	1.2	Active		.5											
Total Increase Reading Level	1.7	Active		.5											
Total of students who reached their current literacy level	50	Active		4											
Total Enrollment	50	Active		29											
Number of Instructors	6	Active		5											
Number of Donors	20	Active		9											



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Adults Enrolled	15	Active													
Children Enrolled	35	Active													
Developmentally Delayed Adults Enrolled	12	Active													
Developmentally Delayed Children Enrolled	5	Active													
Average Increase Reading Level (Points)	1.2	Active													
Total Increase Reading Level	1.7	Active													
Total of students who reached their current literacy level	50	Active													
Total Enrollment	50	Active													
Number of Instructors	6	Active													
Number of Donors	20	Active													

Data Narrative:

#1 Adults Enrolled:

Contributing Community Participants:

Caroline Argabrite / HEATHER BERG / Jenny / Susie / Sarah Humberson / ANNIE MAY SHORT / Carrie Hook / Mary Johnson / Chris Duckworth / Kathaleen Skipper / Shelley Argabrite / Christine / Lindsey Bernal / John Corbin / Sue Lisantti /

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Vaccines for adults and children

Public Group 10 days ago

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GROUP ADMINS

Vaccines for Adults and Children

Vaccines for adults and children

https://mygarrettcounty.com/groups/vaccines-for-adults-and-children/

Snapshot Generated: 2019-02-14

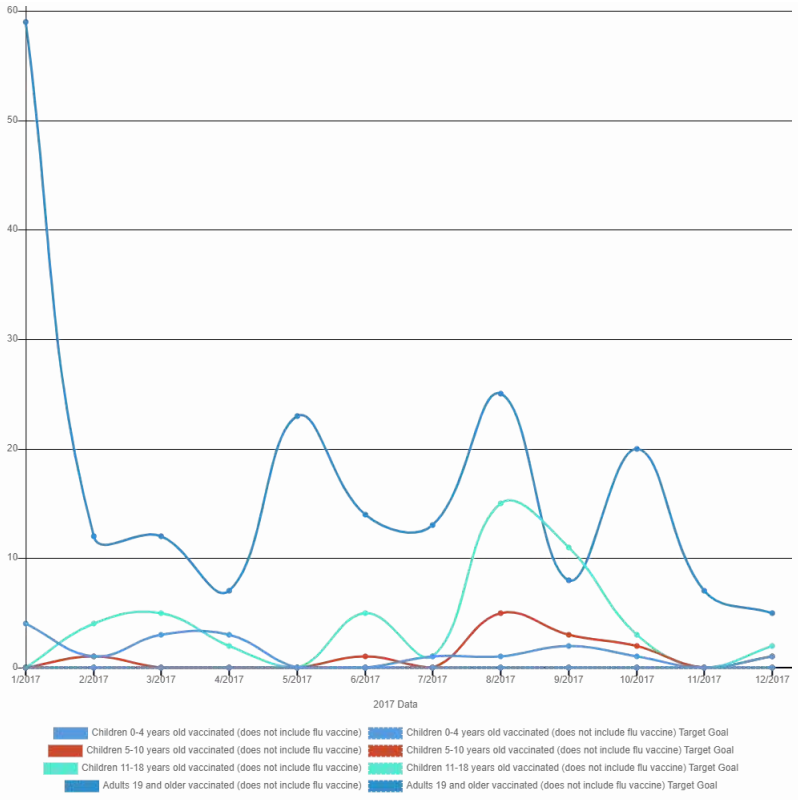
Narrative: The health department is a safety net for those in the community who need vaccines. We offer recommended vaccines as per the Advisory Committee on Immunization Practices across all age groups.

Strategy Description: The Garrett County Health Department will maintain a supply of recommended vaccines for children and adults, including Vaccines for Children supply of vaccines for un or underinsured children aged 0-18 years.

Level of Change: Programs

Primary Focus Area: Chronic Diseases and their common risk factors: lack of physical activity, poor nutrition, and tobacco use

Estimated Implementation Date: 2017-10-06 | **Estimated Completion Date:** 2017-01-06



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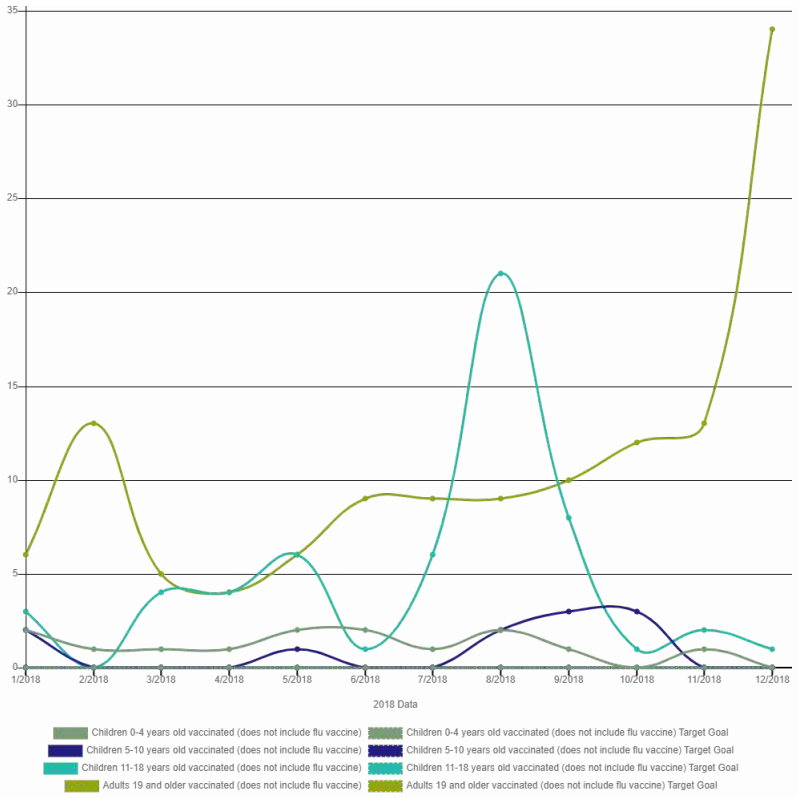
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
Children 0-4 years old vaccinated (does not include flu vaccine)		Active		4	1	3	3	0	0	1	1	2	1	0	1
Children 5-10 years old vaccinated (does not include flu vaccine)		Active		0	1	0	0	0	1	0	5	3	2	0	1
Children 11-18 years old vaccinated (does not include flu vaccine)		Active		0	4	5	2	0	5	1	15	11	3	0	2
Adults 19 and older vaccinated (does not include flu vaccine)		Active		59	12	12	7	23	14	13	25	8	20	7	5



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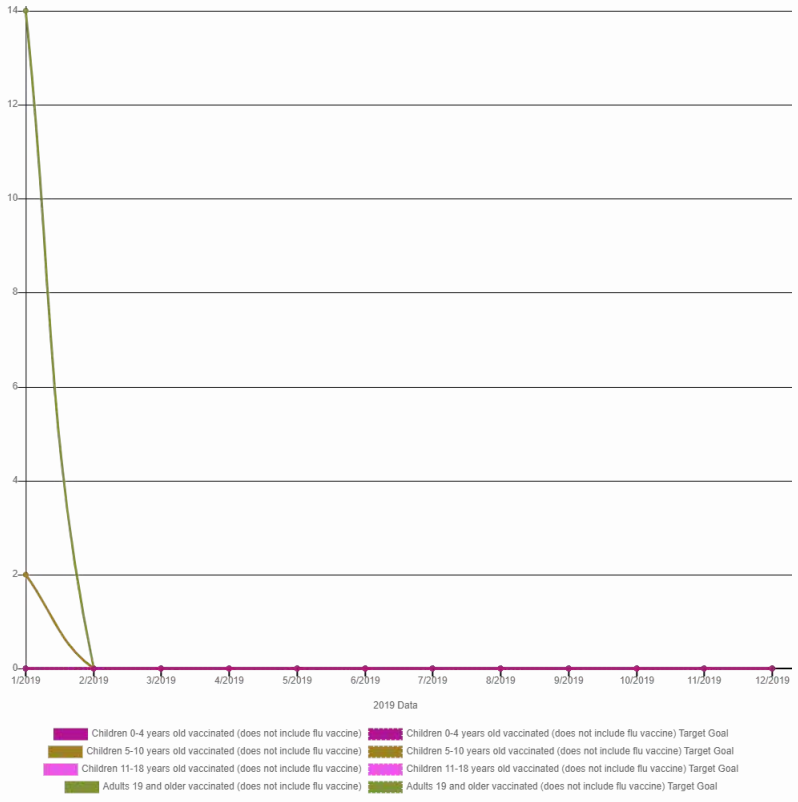
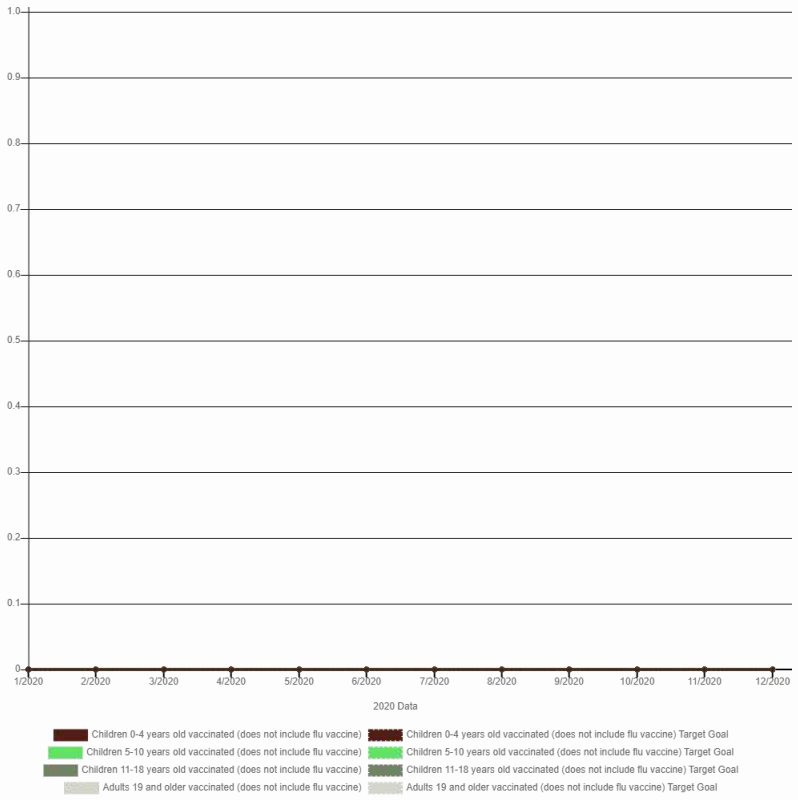
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
Children 0-4 years old vaccinated (does not include flu vaccine)		Active		2	1	1	1	2	2	1	2	1	0	1	0
Children 5-10 years old vaccinated (does not include flu vaccine)		Active		2	0	0	0	1	0	0	2	3	3	0	0
Children 11-18 years old vaccinated (does not include flu vaccine)		Active		3	0	4	4	6	1	6	21	8	1	2	1
Adults 19 and older vaccinated (does not include flu vaccine)		Active		6	13	5	4	6	9	9	9	10	12	13	34



The chart above is a way to help visualize data. In the digital version, you can turn fields on and off by clicking on them. In this picture all of the fields are turned on.

2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
Children 0-4 years old vaccinated (does not include flu vaccine)		Active		0											

Children 5-10 years old vaccinated (does not include flu vaccine)		Active		2											
Children 11-18 years old vaccinated (does not include flu vaccine)		Active		0											
Adults 19 and older vaccinated (does not include flu vaccine)		Active		14											



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
Children 0-4 years old vaccinated (does not include flu vaccine)		Active													
Children 5-10 years old vaccinated (does not include flu vaccine)		Active													
Children 11-18 years old vaccinated (does not include flu vaccine)		Active													
Adults 19 and older vaccinated (does not include flu vaccine)		Active													

Contributing Community Participants:

Patrick / Emilee Friend / servant / Juliet / Karen George / Christine / Lindsey Bernal / Carol Bass / Kara Taylor / Katie Welch / Heather Cooper / Tiffany Fratz / Maria Friend / Jennifer Lee-Steckman / John Corbin / Jennifer Corder / Karen Keefer / Karen Matthews / Cindy Mankamyer /

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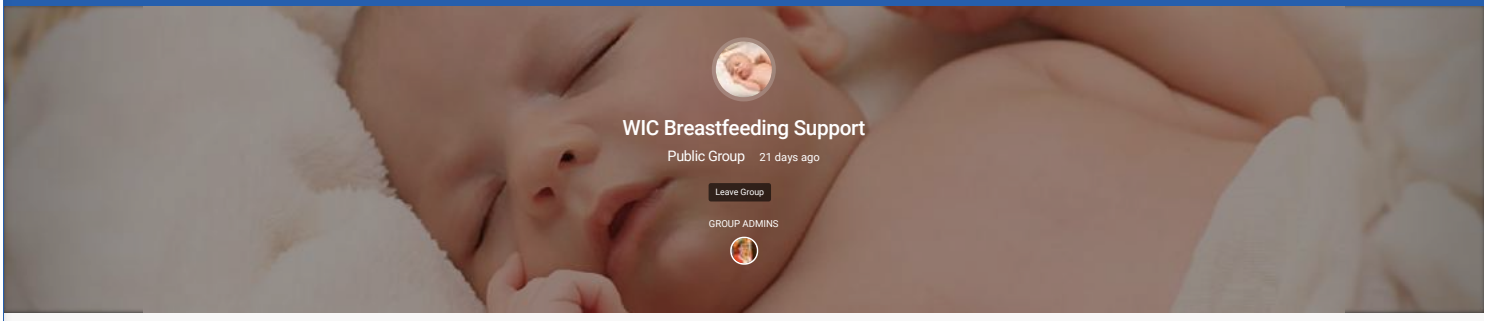

WIC Breastfeeding Support

Public Group 21 days ago

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GROUP ADMINS

WIC Breastfeeding Support

WIC Breastfeeding Support

https://mygarrettcounty.com/groups/wic-breastfeeding-support/

Snapshot Generated: 2019-02-14

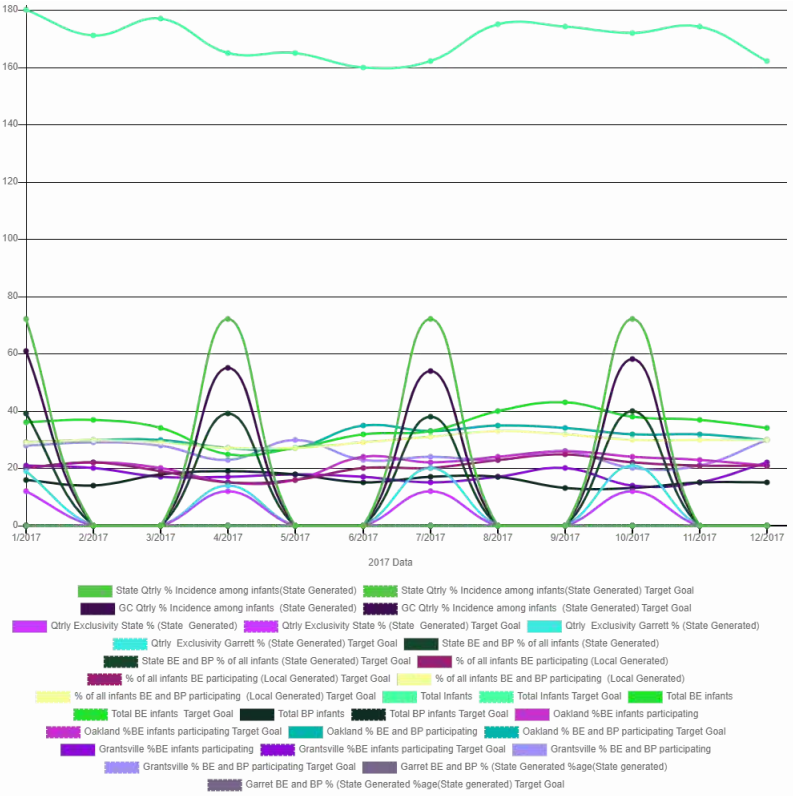
Narrative: Most breastfeeding families report not being able to meet their breastfeeding goals in relationship to exclusivity and duration. WIC provides education and support to participants, but opportunities exist to improve and to assist families in reaching their breastfeeding goals. We have been reliant on State generated statistics generated quarterly from a snapshot of caseload. This group will provide a more robust examination of clinic trends, initiative impact, and a different way of looking at local statistics utilizing WOW reporting and special reports. Benefits of breastfeeding is dose related, with exclusivity having greater impact on health.

Strategy Description: 1. Certification within 3 days of hospital discharge. 2. Support exclusivity through education and support. 3. Referral to IBCLC if any factors identified which may affect continued breastfeeding. 4. Schedule breastfeeding families according to local procedures.

Level of Change: Systems

Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2018-02-12 | **Estimated Completion Date:** 2019-02-12



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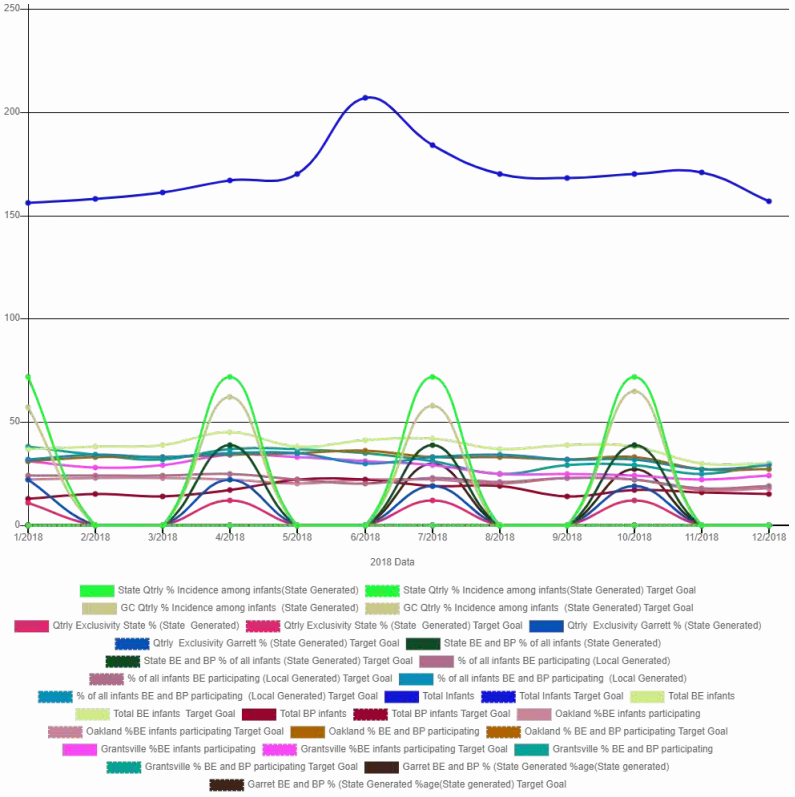
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
State Qtrly % Incidence among infants(State Generated)		Active	State Office WIC	72			72			72			72		
GC Qtrly % Incidence among infants (State Generated)		Active	State Office WIC	61			55			54			58		

Qtrly Exclusivity State % (State Generated)		Active	State Office WIC	12			12			12			12		
Qtrly Exclusivity Garrett % (State Generated)		Active	State Office WIC	19			14			20			21		
State BE and BP % of all infants (State Generated)		Active	State Office WIC	39			39			38			40		
% of all infants BE participating (Local Generated)		Active	Local WOW Data	20	22	19	15	16	20	20	23	25	22	21	21
% of all infants BE and BP participating (Local Generated)		Active	Local WOW Data	29	30	29	27	27	29	31	33	32	30	30	30
Total Infants		Active	Local WOW Data	180	171	177	165	165	160	162	175	174	172	174	162
Total BE infants		Active	Local WOW Data	36	37	34	25	27	32	33	40	43	38	37	34
Total BP infants		Active	Local WOW Data	16	14	18	19	18	15	17	17	13	13	15	15
Oakland %BE infants participating		Active	Local WOW Data	20	22	20	15	16	24	22	24	26	24	23	21
Oakland % BE and BP participating		Active	Local WOW Data	29	30	30	27	27	35	33	35	34	32	32	30
Grantsville %BE infants participating		Active	Local WOW Data	21	20	17	17	18	17	15	17	20	14	15	22
Grantsville % BE and BP participating		Active	Local WOW Data	28	29	28	23	30	23	24	23	26	20	21	30
Garret BE and BP % (State Generated %age(State generated)		Active													



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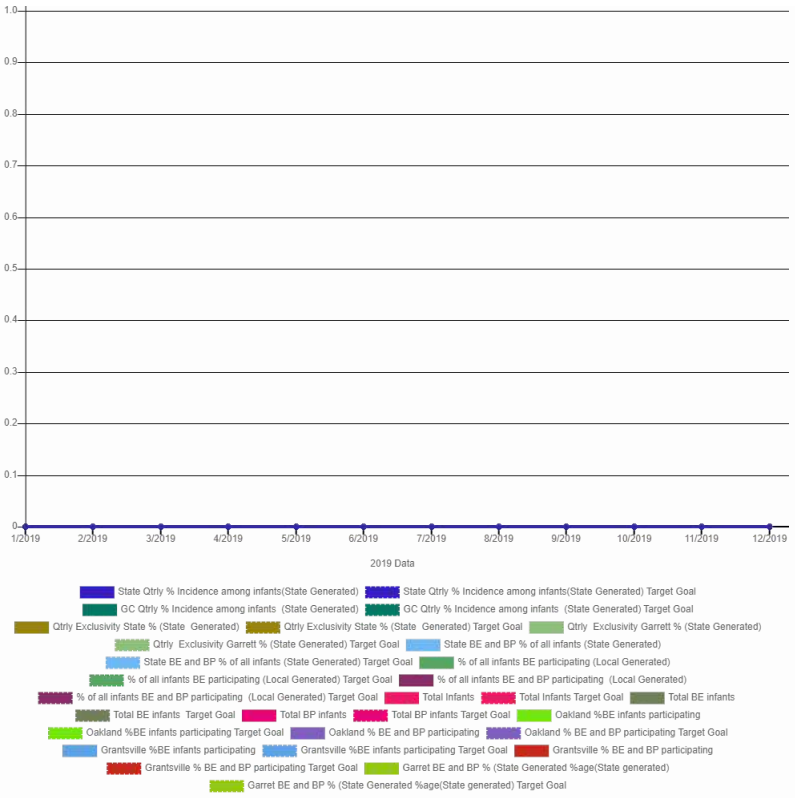
2018 Measurements	Target Goal	Status	Contributor	1/2018	2/2018	3/2018	4/2018	5/2018	6/2018	7/2018	8/2018	9/2018	10/2018	11/2018	12/2018
State Qtrly % Incidence among infants(State Generated)		Active	State Office WIC	72			72			72			72		
GC Qtrly % Incidence among infants (State Generated)		Active	State Office WIC	57			62			58			65		
Qtrly Exclusivity State % (State Generated)		Active	State Office WIC	11			12			12			12		
Qtrly Exclusivity Garrett % (State Generated)		Active	State Office WIC	22			22			19			19		
State BE and BP % of all infants (State Generated)		Active	State Office WIC				39			39			39		
% of all infants BE participating (Local Generated)		Active	Local WOW Data	24	24	24	25	22	20	23	21	23	22	18	19
% of all infants BE and BP participating (Local Generated)		Active	Local WOW Data	32	34	33	35	35	30	33	34	32	32	27	29
Total Infants		Active	Local WOW Data	156	158	161	167	170	207	184	170	168	170	171	157
Total BE infants		Active	Local WOW Data	37	38	39	45	38	41	42	37	39	38	30	30
Total BP infants		Active	Local WOW Data	13	15	14	17	22	22	19	19	14	17	16	15
Oakland %BE infants participating		Active	Local WOW Data	22	23	23	22	20	22	22	20	23	22	17	18
Oakland % BE and BP participating		Active	Local WOW Data	31	33	33	34	35	36	33	33	32	33	27	27
Grantsville %BE infants participating		Active	Local WOW Data	31	28	29	34	33	31	29	25	25	24	22	24
Grantsville % BE and BP participating		Active	Local WOW Data	38	34	32	37	37	35	31	25	29	29	25	30
Garret BE and BP % (State Generated %age(State generated)		Active								30			27		



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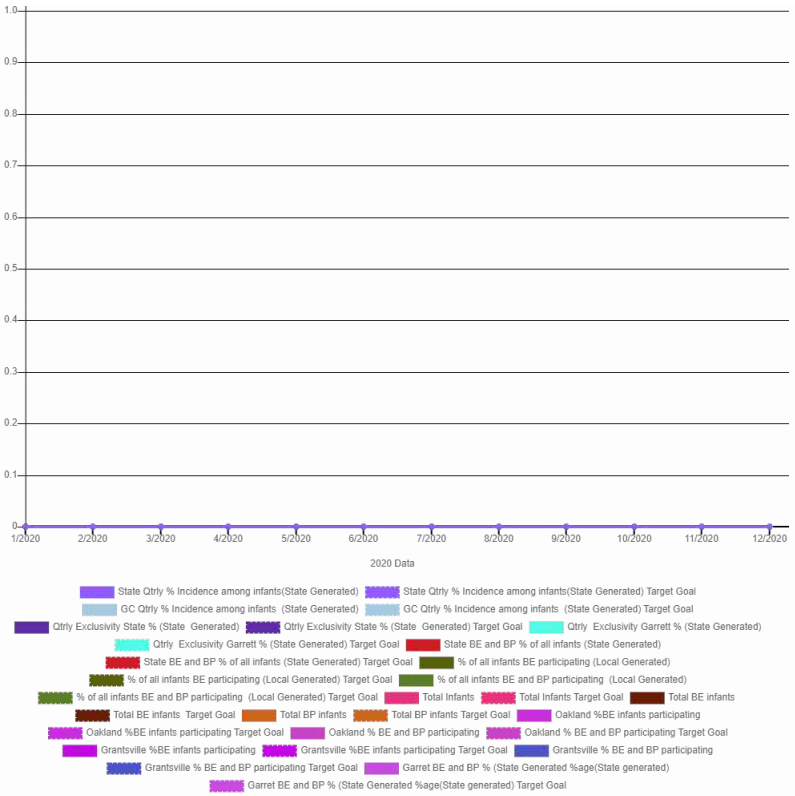
2019 Measurements	Target Goal	Status	Contributor	1/2019	2/2019	3/2019	4/2019	5/2019	6/2019	7/2019	8/2019	9/2019	10/2019	11/2019	12/2019
State Qtrly % Incidence among infants(State Generated)		Active	State Office WIC												
GC Qtrly % Incidence among infants (State Generated)		Active	State Office WIC												
Qtrly Exclusivity State % (State Generated)		Active	State Office WIC												
Qtrly Exclusivity Garrett % (State Generated)		Active	State Office WIC												
State BE and BP % of all infants (State Generated)		Active	State Office WIC												
% of all infants BE participating (Local Generated)		Active	Local WOW Data												
% of all infants BE and BP participating (Local Generated)		Active	Local WOW Data												
Total Infants		Active	Local WOW Data												
Total BE infants		Active	Local WOW Data												
Total BP infants		Active	Local WOW Data												
Oakland %BE infants participating		Active	Local WOW Data												
Oakland % BE and BP participating		Active	Local WOW Data												
Grantsville %BE infants participating		Active	Local WOW Data												
Grantsville % BE and BP participating		Active	Local WOW Data												
Garret BE and BP % (State Generated %age(State generated)		Active													



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
State Qtrly % Incidence among infants(State Generated)		Active	State Office WIC												
GC Qtrly % Incidence among infants (State Generated)		Active	State Office WIC												
Qtrly Exclusivity State % (State Generated)		Active	State Office WIC												
Qtrly Exclusivity Garrett % (State Generated)		Active	State Office WIC												
State BE and BP % of all infants (State Generated)		Active	State Office WIC												
% of all infants BE participating (Local Generated)		Active	Local WOW Data												
% of all infants BE and BP participating (Local Generated)		Active	Local WOW Data												
Total Infants		Active	Local WOW Data												
Total BE infants		Active	Local WOW Data												
Total BP infants		Active	Local WOW Data												
Oakland %BE infants participating		Active	Local WOW Data												
Oakland % BE and BP participating		Active	Local WOW Data												
Grantsville %BE infants participating		Active	Local WOW Data												
Grantsville % BE and BP participating		Active	Local WOW Data												
Garret BE and BP % (State Generated %age(State generated)		Active													

Data Narrative:

Statistics are generated from The Office of the Maryland WIC Program using a snapshot of caseload once a quarter (State Generated). Local numbers (Local generated) are generated using reports available in the WIC Management Information System (WOW) on a monthly basis and reflect actual participation numbers.

Contributing Community Participants:

Jenny / Sarah Humberson / Carrie Hook / Tricia / Christine / Jennifer Lee-Steckman / Lindsey Bernal / Dierdre Shue / Shelley Argabrite / John Corbin / Carol Bass /

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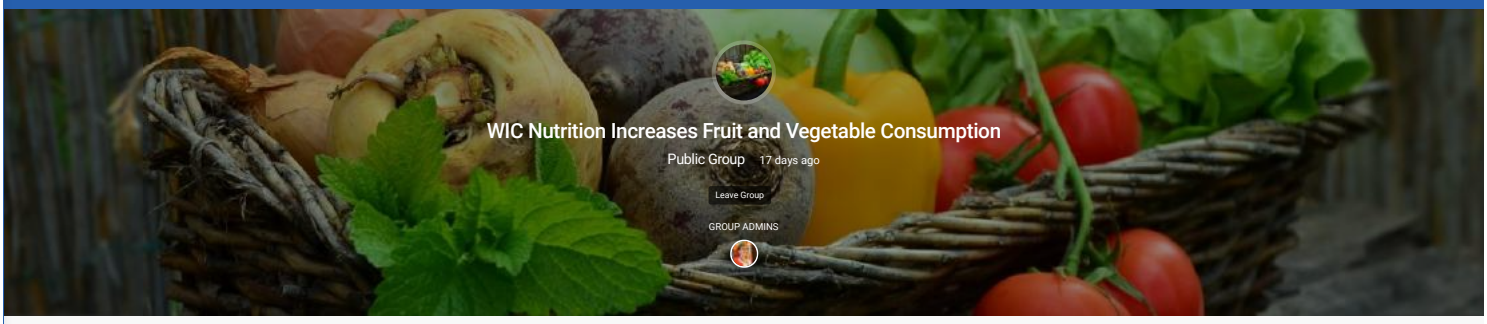

WIC Nutrition Increases Fruit and Vegetable Consumption

Public Group 17 days ago

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Nutrition

WIC Nutrition Increases Fruit and Vegetable Consumption

https://mygarrettcounty.com/groups/wic-nutrition-increases-fruit-and-vegetable-consumption-1738748979/

Snapshot Generated: 2019-02-14

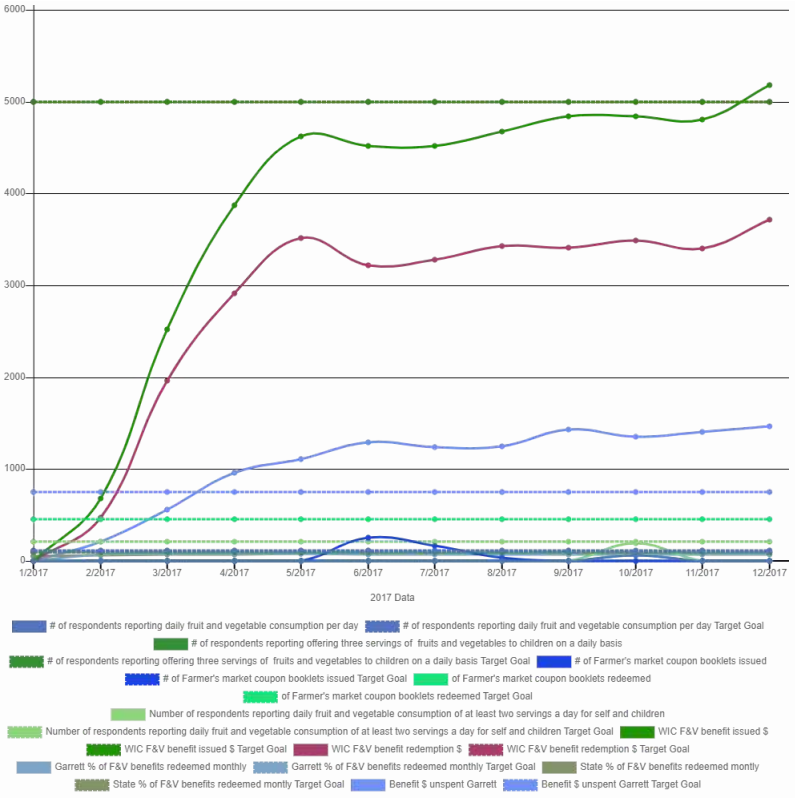
Narrative: "Optimum nutrition, providing all nutrients in both kind and amount, is the cornerstone of good health and the cutting edge of prevention. The foods we eat, and the nutrients they should provide, are the most important continuing environmental factors influencing our growth, development, functional abilities, and health. Nutritional knowledge, with education of both the general public, and particularly health professionals is critical if we are to succeed in significantly reducing the excessive premature morbidity and mortality from our leading killer diseases - heart disease, cancer, and stroke. How we structure our lifestyles, with proper nutrition, health habit discipline, and exercise programming, will have a great influence on personal health, and will help reduce our current catastrophic medical care expenditures." Source: Krehl WA. (1983). The role of nutrition in maintaining health and preventing disease. Health Values. Mar-Apr;7(2):9-13 Efforts to help families enrolled in Women, Infants, and Children (WIC) a federal supplemental nutrition program are being measured as families are encouraged to include more fruits and vegetables in their diets and family meals. August 1, 2018 After review of benefits issued and redeemed, WIC Staff met and began a CQI Initiative to improve utilization of fruit and vegetable utilization by WIC Participants. Individual usage of benefits will be reviewed with participants at all upcoming appointments for benefits. A general education program is planned for January - March 2019 highlighting that all forms (canned, frozen, and fresh) of fruits and vegetables are beneficial, with an emphasis on utilizing full benefits in WIC. We will continue to monitor issuance and usage, adjust strategies if current initiative is not successful.

Strategy Description: Target nutrition education on importance and acceptance of fruits and vegetables in family diets. 1. Individual counseling with families during certification and recertification on health benefits of consuming fruits and vegetables. 2. Quarterly nutrition education program about use of fruits and vegetables. 3. Provide Farmer's Market coupons to eligible families for local produce. 4. Supplemental clinic and promotional materials available during appointments and in waiting areas. 5. Individualized discussion based on individual family usage of fruit and vegetable benefit.

Level of Change: Programs

Primary Focus Area: Maternal, Child, and Adolescent Health

Estimated Implementation Date: 2017-08-01 | **Estimated Completion Date:** 2018-06-30



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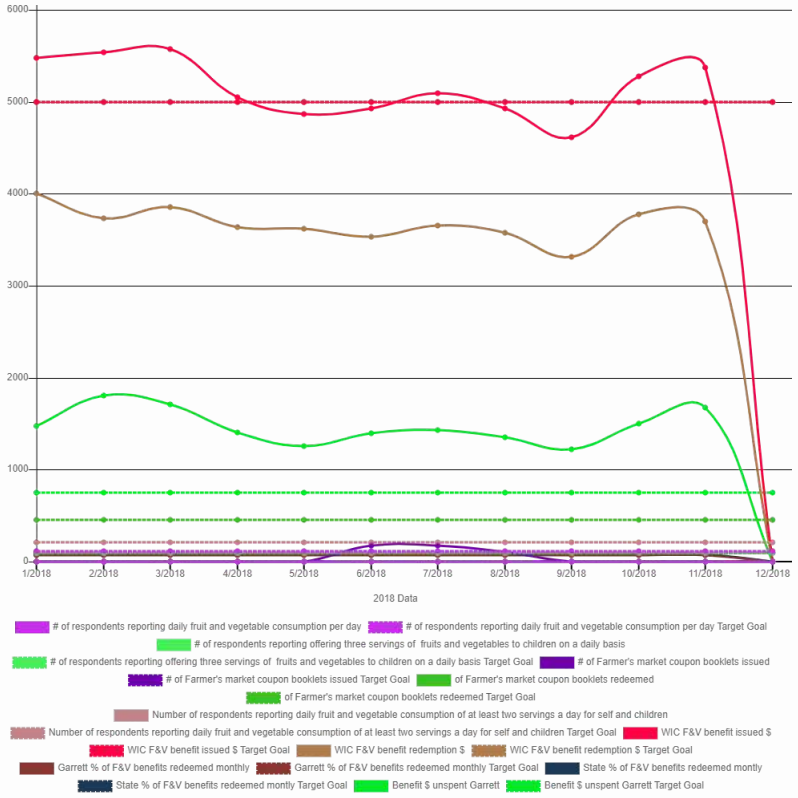
2017 Measurements	Target Goal	Status	Contributor	1/2017	2/2017	3/2017	4/2017	5/2017	6/2017	7/2017	8/2017	9/2017	10/2017	11/2017	12/2017
# of respondents reporting daily fruit and vegetable consumption per day	110	Active	Carol B										58		
# of respondents reporting offering three servings of fruits and vegetables to children on a daily basis	97	Active	Carol B										59		
# of Farmer's market coupon booklets issued		Active							252	163	35				
of Farmer's market coupon booklets redeemed	450	Active													
Number of respondents reporting daily fruit and vegetable consumption of at least two servings a day for self and children	207	Active											191		
WIC F&V benefit issued $	5000	Active	Carol B	0	678	2523	3872	4620	4515	4518	4673	4840	4842	4806	5178
WIC F&V benefit redemption $	5000	Active	Carol B	0	467	1964	2909	3515	3220	3279	3426	3407	3486	3399	3716
Garrett % of F&V benefits redeemed monthly	95	Active	Carol B	0	69	77	75	76	71	73	73	70	72	71	72
State % of F&V benefits redeemed montly	95	Active	Carol B	54	65	70	72	78	78	78	78	77	77	76	77
Benefit $ unspent Garrett	750	Active	Carol B	0	211	559	963	1105	1295	1239	1247	1433	1356	1407	1462



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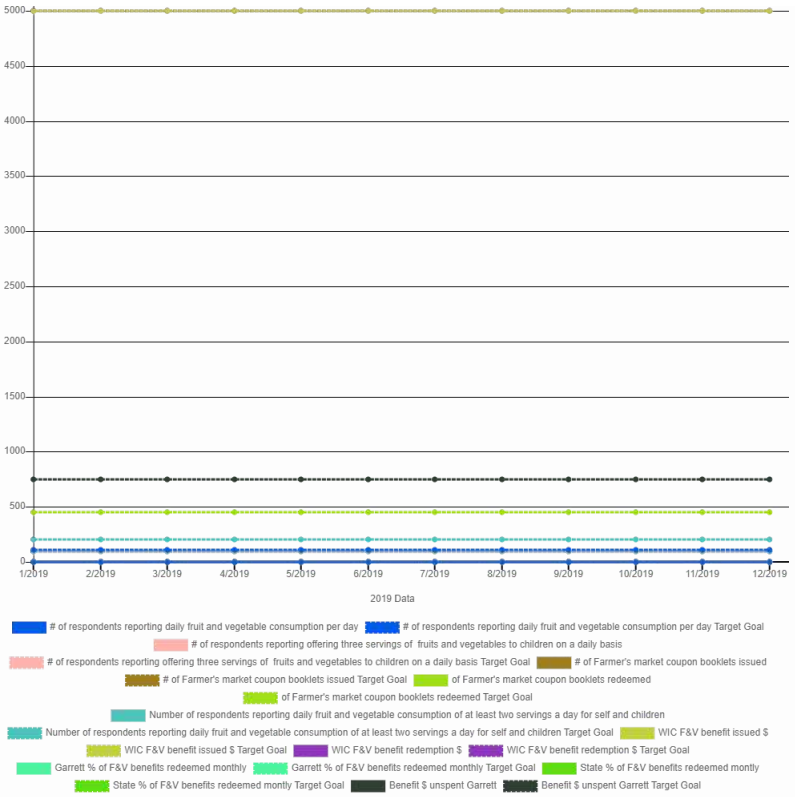
# of respondents reporting daily fruit and vegetable consumption per day	110	Active	Carol B												
# of respondents reporting offering three servings of fruits and vegetables to children on a daily basis	97	Active	Carol B												
# of Farmer's market coupon booklets issued		Active							171	173	106				
of Farmer's market coupon booklets redeemed	450	Active													
Number of respondents reporting daily fruit and vegetable consumption of at least two servings a day for self and children	207	Active													
WIC F&V benefit issued $	5000	Active	Carol B	5478	5542	5570	5046	4869	4924	5092	4923	4614	5273	5371	
WIC F&V benefit redemption $	5000	Active	Carol B	4002	3733	3859	3640	3617	3533	3658	3573	3315	3776	3694	
Garrett % of F&V benefits redeemed monthly	95	Active	Carol B	73	67	69	72	74	72	71	73	72	72	69	
State % of F&V benefits redeemed montly	95	Active	Carol B	79	76	78	78	78	78	79	79	79	78	77	
Benefit $ unspent Garrett	750	Active	Carol B	1476	1809	1711	1406	1252	1391	1433	1350	1219	1497	1677	



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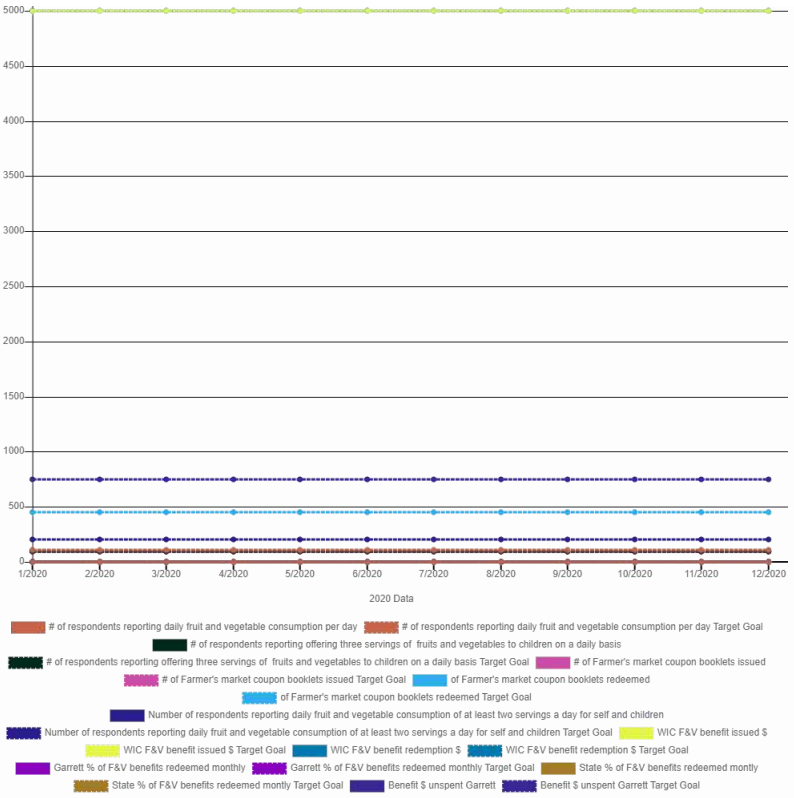
State % of F&V benefits redeemed montly	95	Active	Carol B												
Benefit $ unspent Garrett	750	Active	Carol B												



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2020 Measurements	Target Goal	Status	Contributor	1/2020	2/2020	3/2020	4/2020	5/2020	6/2020	7/2020	8/2020	9/2020	10/2020	11/2020	12/2020
# of respondents reporting daily fruit and vegetable consumption per day	110	Active	Carol B												
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State % of F&V benefits redeemed montly	95	Active	Carol B												
Benefit $ unspent Garrett	750	Active	Carol B												

Data Narrative:

Measure #1, #2, and #5: from Annual Customer Service Survey administered to WIC Participants late fall. Measure #3 and #4 Issuance and final redemption of Farmer's Market Coupon Booklets from Maryland Department of Agriculture (each book has four $5 coupons). Coupons may be redeemed at authorized Farmer Markets in Maryland. Supplemental benefit for WIC participants. Issuance is derived from issue logs at WIC, final redemption from reporting Maryland Department of Agriculture. Measures #6-10 Actual Dollar amount issued and redeemed for WIC Participants in Garrett County for fruit and vegetable benefit of food prescription for each participant. Source of data is State generated Report derived from WOW (WIC on The Web Management information System). Currently available special request from State Office Deputy Director Deborah Morgan. Data is always two months behind on current month. Issuance is through the end of the month of any calendar month, redemption occurs in month following issuance. After long-term monitoring of under-redemption of fruit and vegetable benefit, staff began several initiatives in July 2018 to attempt to positively impact utilization of benefits. Strategies include personalized review of utilization with participants when in clinic and encouragement to use all benefits issued. General education on types of fruits and vegetables which may be purchased and shopping tips are also covered. A general education program is scheduled as part of the FY19 Nutrition Services Plan January-March 2019 to reinforce that all forms count and encourage use. We hope to see an improvement in utilization over the next year. Staff began asking participants about fruit and vegetable usage during visits in September, October and December 2018. Percentages dropped. In January 2019 began a quarterly nutrition education program related to benefits of Canned, Frozen and Fresh Fruits and Vegetables. Following education all staff have been instructed to review fruit and vegetable usage with participants, attempt to identify barriers, and develop strategies with participants on ways to increase utilization.

Research: Data pending, waiting for WIC Management Information System WOW(WIC on the Web) reporting on eWIC usage of fruit and vegtable benefit redemption. Requesting special reporting. Nutrition Survey being conducted Aug-September 2017 includes questions about fruit and vegetable servings consumed daily. Will be basis for baseline.

Contributing Community Participants:

Joseph Burger / Jenny / Patrick / Sarah Humberson / jessica howard / Cameron Pollock / Carrie Hook / Tricia / Christine / John Corbin / Lindsey Bernal / Dierdre Shue / Jennifer Corder / Cherylann Cogley / Susan Mills / Karen George / Heather Cooper / HEATHER BERG / Shelley Argabrite / Carol Bass /

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