Strategies	Actions	Outputs	Intermediate Measures	End Measures	
A. Enhance county capacity to provide recruit and retain health care providers.	1. Recruit additional health care providers and specialists to the county through the University of Maryland Charles Regional Medical Center.	Number of providers recruited	How long since you visited a doctor for a routine check up (BRFSS) Percent of Medicaid adolescent who have had a well child visit in the last year (SHIP) Southern Maryland Physician Supply vs. HPSA standards (MHCC Maryland Health Care Workforce Study) Primary Care Provider Supply/Demand Rates per 10,000 population (2012 MD Physician Workforce Study)	1. Physician Recruitment and Retention A. Increase the number of Charles County physicians by 7 providers.	
	2. Establish a committee to review and advocate for federal designations of medically underserved areas/populations and health professional shortage areas and to review physician enticements such as incentives and reimbursements.	Number of meetings held Number of stakeholders in attendance			

		needing advocacy		
B. Increase awareness of county health services in the Community	awareness campaign surrounding appropriate setting of care: primary care, urgent care, emergency department, and 911.	nevelonea		2. Unnecessary Hospital Utilization A. Reduce the Charles County preventable hospital stay rate from
	monthly Community	members recruited Number of meetings	Docrosco in County and 7in Codo ED Outpatient	71 per 1000 Medicare enrollees to 69 per 1000 Medicare enrollees. Source: County Health Rankings
	department staff on how to educate their nationts on		Increase resident satisfaction with the health care they receive (BRFSS)	

	and appropriate			
	setting for their			
	level of care. Also			
	educate those			
	providers on			
	community			
	resources and			
	available services.			
	4. Attend	Number of events	Decrease the percentage of people who report	
	community events	arrennen	that there was a time in the past 12 months	
	and programs to		when they could not receive the medical care	
	provide information	Number of flyers or	they needed or when they did not have health	
	on available county	information	insurance (BRFSS).	
		aisseminated	insurance (Bitt 33).	
	· ·	Number of trainings		
		developed	Increase the percentage of residents who report that they can see a doctor when they needed one (BRFSS)	
	Literacy" training			
		Number of		
		presentations given		
	including the faith-			
		Number of people		
		trained on Health		
C. Increase the health	community leaders.	Litteracy		
literacy of Charles	2. Increase the			
County residents.	county's capacity to implement evidence-		one (Bitti 33)	
		community health		
		worker models		
		created, developed,		
		or planned		
	competent,	•		
	individualized case	Number of new		
	management,	programs initiated		
	patient navigation,			
	and health			

education.		

Strategies	Actions	Outputs	Intermediate Measures	End Measures
		Number of partners		
		involved		
		Number of new	Decrease the percentage	
	1. Explore the possibility of a buddy system		of residents who report	
		established	delaying getting medical	
	appointments and to check in on each		care due to transportation	
	other.	Number of new	(BRFSS)	
		programs developed		
D. Address		Number of poorle		
D. Address transportation barriers		Number of people served		
through new and		Number of partners		
innovative approaches.		involved		
		Number of new	Decrease the percentage	
	2. Continue to pursue new medical	collaborations	of residents who report	
	transportation options and possible grant funding for a collaborative project between	established	delaying getting medical care due to transportation	
	Volunteer EMS and local limo company.	Number of new	(BRFSS)	
	1	programs developed	(5111 55)	
		Number of people		
		served		

E. Mobile Integrated Healthcare: Reduce Emergency Departmen (ED) utilization and Emergency Medical Services (EMS) transports among high utilizers by linking then with care coordination and community health services.	-Identify and recruit ED or EMS high utilizers to participate in the program  -Conduct all initial team visits within 24-48 hours of discharge  -Increase health literacy by educating participants on prevention/management of their disease processes  -Improve the safety of the home through an environmental scan and subsequent education  -Connect people to a primary care or behavioral health provider or re-connect them to their provider  -Educate on appropriate use of the emergency department and emergency medical services  -Link individuals to social services and transportation to prevent barriers to access  -Connect them to specialists for disease processes.	participants who visit their primary care providers twice a year for routine care	Reduce the Charles County hospital readmission rate. Reduce the Charles County preventable hospital stay rate. Source: County Health Rankings		
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