FY 2016-2018 Charles County Chronic Disease Prevention Team Action Plan

Strategies	Actions	Outputs	Intermediate Measures	End Measures
A. Increase access to healthy foods	1. Re-establish and enhance the Grow It, Eat It Program.	-Number of partners -Number of schools participating -Number of students educated through the program Number of new community gardens established	Increase the percent of county residents who report eating 5 or more servings of fruits and vegetables. Source Maryland BRFSS Farmers market rates (USDA)	**1. Obesity** A. Increase the percentage of Charles County adults who are at a healthy weight from 27.9% to 28.5% by 2017 (2% increase). Source: 2013 Maryland BRFSS B. Childhood Obesity Decrease the percentage of Charles County 13-18 year older who are obese from 12.3% to 11.3% (1% reduction). Source: 2013 Maryland YRBS
B. Enhance the built environment to support active living	2. Support county businesses in their adoption of policy changes for nutrition and physical activity strategies.	Number of policy changes made Number of businesses making policy change Number of businesses enrolled in Maryland Healthiest Businesses	Rate of Recreation and fitness facilities (county rankings) Sweet beverage drink percentages (BRFSS and YTRBS)	
C. Create a 'Community of Wellness' through community engagement	1. Support and promote worksite (and/or community) wellness/group exercise programs	Number of programs offered and participants -Number of worksites participating in the Maryland Healthiest Businesses Number of events held	Increase the percent of adults who are physically active and meet the requirements for moderate to vigorous physical activity (BRFSS/SHIP)	
	2. Support walking groups that encourage community-wide organized physical activity, social support, and enhanced access to local facilities.	Number of people participating Number of organizations		

		partnering		
	3. Increase the membership of the Chronic Disease Prevention Team to enhance their abilities to reach the general population and the underserved communities.	Number of new members Number of meetings held		

Strategies	Actions	Outputs	Intermediate Measures	End Measures
D. Increase evidence based chronic disease self management by hospitals and primary care providers	1. Increase the capacity of primary care providers to implement screening, prevention and treatment measures for hypertension and diabetes in adults through QI methods and other training approaches.	Number of participating physician practices Percent of patients with their hypertension under control Percent of patients with their diabetes under control	NQF Measures 18 and 59 for hypertension and diabetes control Increase the proportion of individuals taking medication to control their high blood pressure. Source: Maryland BRFSS	**2. Major Cardiovascular Disease** Reduce the Charles County hypertension emergency department visit rate from 308.1 per 100,000 to 305 per 100,000 (1% reduction) Source: 2013 Maryland HSCRC data from SHIP website 3. **Diabetes Prevalence** Reduce the Charles County diabetes emergency department visit rate from 208.7 per 100,000 to the Maryland rate of 205.0 per 100,000. Source: 2013 Maryland HSCRC data from SHIP website
	2. Link health care-based efforts with community prevention activities.	Number of referral forms established for county providers to refer to community resources and programs Number of chronic disease resource directories developed for use by county providers and health systems	Decrease mortality rates due to hypertension, heart disease, diabetes, stroke,	

		Number of physician referrals to diabetes classes Number of physician referrals to CDSMP classes Number of hospital physician referrals to the Quitline through Fax to Assist Number of physician referrals to health department smoking cessation classes Number of health department dental clinic patients referred to community resources Number of community events attended for outreach		
	3. Implement the Stanford Chronic Disease Self Management Program, utilizing many community agencies and partners.	Number of education sessions held Number of partners assisting with sessions Number of participants educated through CDSMP	Decrease racial disparities in hypertension and diabetes ED Visit Rates between AA and White.	

		Pre and Post data of CDSMP participants		
	4. Promote the University of Maryland Charles Regional Medical Center's increased efforts to provide free and low cost chronic disease and diabetes education to the community.	Number of people participating in the Outpatient Diabetes Self Management Training Program Number of people educated in the free Diabetes class Number of new programs developed Pre and Post data of diabetes education participants Number of people participating in Gentle Movement and Relaxation Yoga, i.e. COPD, diabetes, stroke patients and chronic illnesses.	Diabetes Prevalence Rate and Risk Factor and Management Data (BRFSS)Source: Maryland BRFSS	
<u>Mobile Integrated Healthcare:</u> Reduce Emergency Department (ED) utilization and Emergency Medical	-Identify and recruit 10 chronic disease ED or EMS high utilizers to participate in the program	-Number of hospital high utilizers educated on the program	Reduce the Charles County hospital readmission rate. Reduce the Charles	

Services (EMS) transports among chronic disease high utilizers by linking them with care coordination and community health services.	-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.	-Number recruited as participants -Number of initial team visits conducted within 24-48 hours of discharge -Number of participants who visit their primary care providers twice a year for routine care -Number of participants who are connected or reconnected to a health provider for care. -Number of emergency medical services transports among participants -Number of emergency department visits among participants	County preventable hospital stay rate. Source: County Health Rankings	