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 (MD Physician Workforce Study)	1. Physician Recruitment and Retention A. Increase the number of Charles County physicians by 5 providers.
	2. Provide support to present PCP practices in Charles County by providing resources and offering Care Transition Organization services through UMMS.	• Number of county practices educated on resources • Number of materials disseminated • Number of practices accepting care transition organization services	Decrease in County and Zip Code Inpatient Hospitalization Rates (HSCRC)	
B. Increase awareness of county health services in the	1. Develop an awareness campaign surrounding appropriate setting of care: primary care,	• Number of banners developed	Decrease in County and Zip Code Inpatient Hospitalization Rates (HSCRC)	2. Unnecessary Hospital Utilization

Strategies	Actions	Outputs	Intermediate Measures	End Measures
Community	urgent care, emergency department, and 911.	• Number of flyers developed • Number of flyers disseminated • Number of events attended		A. Reduce the Charles County preventable hospital stay rate from 55 per 1000 Medicare enrollees to 52.3 per 1000 Medicare enrollees. Source: County Health Rankings
	2. Engage community stakeholders in the monthly Access to Care Coalition meetings to share and gather information on services available.	• Number of new members recruited • Number of meetings held	Decrease in County and Zip Code ED Outpatient Visit Rates overall and for mental health, addictions, hypertension, asthma, diabetes, congestive heart failure (HSCRC and SHIP)	
	3. Attend community events and programs to provide information on available county health services.	• Number of events attended • Number of flyers or information disseminated	Decrease the percentage of people who report that there was a time in the past 12 months when they could not receive the medical care they needed or when they did not have health insurance (BRFSS).	
C. Increase the health literacy of Charles County residents.	1. Adapt the health literacy focus to include advanced care planning conversations and recruit volunteers, including the faith-based community, our trusted community	• Number of trainings developed • Number of presentations given • Number of	Increase the percentage of residents who report that they can see a doctor when they needed one (BRFSS)	

Strategies	Actions	Outputs	Intermediate Measures	End Measures
	leaders for community presentations.	people trained on Health Literacy		
	2. Increase the county's capacity to implement evidence-based community health worker models which can provide culturally competent, individualized case management, patient navigation, and health education.	• Number of community health worker models created, developed, or planned • Number of new programs initiated		
D. Address transportation barriers through new and innovative approaches.	1. Explore the possibility of a buddy system to help elderly patients to get to appointments and to check in on each other.	• Number of partners involved • Number of new collaborations established • Number of new programs developed • Number of people served	Decrease the percentage of residents who report delaying getting medical care due to transportation (BRFSS)	

Strategies	Actions	Outputs	Intermediate Measures	End Measures
	2. Seek other resources/programs to bring care to our homebound population. Especially focusing on the MD and NP level providers. Investigate telemedicine options for pilot programs in the community.	• Number of partners involved • Number of new collaborations established • Number of new programs developed • Number of people served	Decrease the percentage of residents who report delaying getting medical care due to transportation (BRFSS)	
D. Mobile Integrated Healthcare: Reduce Emergency Department (ED) utilization and Emergency Medical Services (EMS) transports among high utilizers by linking them with care coordination and community health services.	1. Identify and recruit ED or EMS high utilizers to participate in the program 2. Conduct all initial contacts within 24-48 hours of discharge 3. Increase health literacy by educating participants on prevention/management of disease	• Number of hospital high utilizers educated on the program • Number of participants • Number of initial contacts 24-48 hours after discharge • Number of participants	Reduce the Charles County hospital readmission rate. Reduce the Charles County preventable hospital stay rate. Source: County Health Rankings	

Strategies	Actions	Outputs	Intermediate Measures	End Measures
	4. Improve the safety of the home through an environmental scan and subsequent education 5. Connect people to a primary care or behavioral health provider or re-connect them to their provider 6. Educate on appropriate use of the emergency department and emergency medical services 7. Link individuals to social services and transportation to prevent barriers to access 8. Connect them to specialists	who visit their primary care providers twice a year for routine care • Number of participants who are connected to health care provider. • Number of emergency medical services transports among participants • Number of emergency department visits among participants		