FY2019-2021 Charles County Chronic Disease Prevention Team Action Plan

Strategies	Actions	Outputs	Intermediate Measures	End Measures
A. **Enhance the built environment to support active living**	1. 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)	**1. Obesity** A. Maintain the percentage of Charles County adults who are at a healthy weight at 23.1% by 2021 (2% increase). Source: 2015 Maryland BRFSS B. Childhood Obesity Decrease the percentage of Charles County 13-18 year older who are obese from 13.0% to 12.0% (1% reduction). Source: 2016 Maryland YRBS
B. Create a 'Community of Wellness' through community engagement and evidence based programming	1. Support and promote worksite (and/or community) wellness and/or group exercise programs and activities i.e. Parks and Recreation 2. Support walking groups that encourage community-wide organized physical activity, social support, and enhanced access to local facilities. 3. Offer Stanford University's Chronic Disease Self Management (CDSMP), Diabetes Self Management (DSMP), and Hypertension classes. Offer the CDCs Diabetes Prevention Program (DPP) in the county	• Number of programs offered and participants • Number of worksites participating in the Maryland Healthiest Businesses • Number of events held • Number of people participating • Number of organizations partnering • Number of evidence based programs offered • Number of Participants enrolled in CDSMP programs	Increase the percent of adults who are physically active and meet the requirements for moderate to vigorous physical activity (BRFSS/SHIP)	

FY2019-2021 Charles County Chronic Disease Prevention Team Action Plan

Strategies	Actions	Outputs	Intermediate Measures	End Measures
	4. Offer Gentle Movement and Relaxation Yoga Therapy 5. Provide tobacco cessation programming to county residents ready to quit. 6. Offer education on the benefits of routine cancer screening and information on how to prevent cancer through lifestyle changes and preventive vaccines such as HPV. 7. Educate children and families on the importance of physical activity	• Number of Participants enrolled in DSMP programs • Number of Participants enrolled in DPP programs • Number of Participants enrolled in Hypertension class • Number of people participating in Gentle Movement and Relaxation Yoga Therapy for People with Chronic Conditions (i.e. COPD, Diabetes, Stroke) • Number of people who quit smoking through cessation classes • Number of people educated on cancer prevention, screening, and early detection. • Number of people educated on physical activity		

FY2019-2021 Charles County Chronic Disease Prevention Team Action Plan

Strategies	Actions	Outputs	Intermediate Measures	End Measures
C. 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 chronic conditions 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 • Percent of patients who get screened for colorectal cancer	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 347.7 per 100,000 to 344.3 per 100,000 (1% reduction) Source: 2014 Maryland HSCRC data from SHIP website 3. **Diabetes Prevalence** Reduce the Charles County diabetes emergency department visit rate from 244.2 per 100,000 to the Maryland rate of 241.8 per 100,000. Source: 2014 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 • Number of physician referrals to diabetes classes • Number of physician referrals	Decrease mortality rates due to hypertension, heart disease, diabetes, stroke,	

Strategies	Actions	Outputs	Intermediate Measures	End Measures
		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 community events attended for outreach • Number of physician referrals to DPP		
	3. Promote the University of Maryland Charles Regional Medical Center's efforts to provide diabetes education to the community.	• Number of new patients receiving diabetes education • Number of group classes held • Number of return visits for diabetes education • Number of individuals with gestational diabetes educated	Diabetes Prevalence Rate and Risk Factor and Management Data (BRFSS)Source: Maryland BRFSS	

Strategies	Actions	Outputs	Intermediate Measures	End Measures
D. <u>Mobile Integrated Healthcare:</u> Reduce Emergency Department (ED) utilization and Emergency Medical Services (EMS) transports among chronic disease high utilizers by linking them with care coordination and community health services.	1. Identify and recruit 10 chronic disease ED or EMS high utilizers to participate in the program 2. Conduct all initial team visits within 24-48 hours of discharge 3. Increase health literacy by educating participants on prevention/management of their disease processes 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 for disease processes.	• Number of hospital high utilizers educated on the program • Number recruited as participants • Number of initial contacts 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. • Number of emergency medical services transports among participants • Number of ED visits among participants	Reduce the Charles County hospital readmission rate. Reduce the Charles County preventable hospital stay rate. Source: County Health Rankings	