WICOMICO COUNTY LOCAL HEALTH IMPROVEMENT COALITION (LHIC)
LOCAL HEALTH DIABETES ACTION PLAN 2015 – 2017 Draft
Submitted by: LHIC Diabetes Sub-Committee (Updated Plan 12/3/14)

Background: Diabetes was identified by the Wicomico County Local Health Improvement Coalition as a priority concern for the county in 2010 after reviewing the results of the 2009 Professional Research Consultants (PRC) Community Health Assessment and has been driven by the State Health Improvement Process (SHIP) since that time. A diabetes sub-committee was convened in April 2011 to develop an action plan for diabetes in the community. The action plan was completed and approved March 2012 with continuous review and updates. Most recently a progress report was completed June 2014 as the committee embarked on revising the action plan for 2015 – 2017 to realistically reflect what this committee can achieve in the community. Prevention of diabetes through education and healthy living is the focus for the current plan.

Measure:

1a. Rate of Emergency Department (ED) visits for diabetes per 100,000 population

Data Sources and Definitions:

- Health Services Cost Review Committee (HSCRC) Research Level Statewide Inpatient and Outpatient Data Files. Only visits made by Maryland residents to Maryland hospitals were used for analysis; emergency department visits made by Maryland residents to out-of-state hospitals were not included. Data are coded by patient's county of residence. (Source: SHIP)

2a. Percentage of adults who are at a healthy weight (i.e. not overweight or obese) based on their Body Mass Index (BMI).

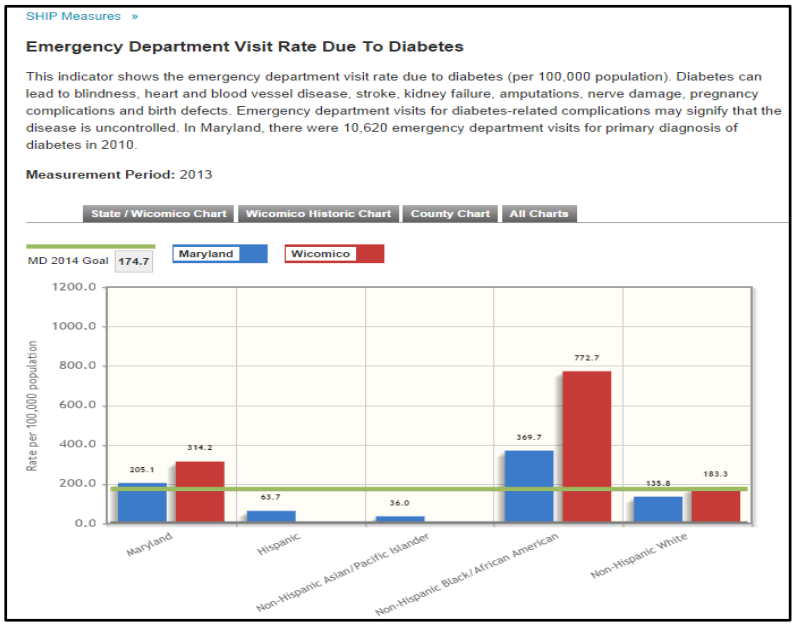
Data Sources and Definitions:

- Behavioral Risk Factor Surveillance Survey (BRFSS). Body Mass Index (BMI) determined through self-reported height and weight that is less than 25.0kg/m^2. (Source: SHIP)

Note: This measure chosen because 40 percent of heart disease, stroke, and diabetes can be prevented through maintaining a healthy weight. Healthy weight can aid in the control of these conditions if they develop. (Source: SHIP)

Baseline Data

	County Baseline 2010	County Baseline 2011	County Update 2011	County Update 2012	County Update 2013	County 2017 Goal	MD 2014 Goal	STATUS	Source
Rate of ED visits for diabetes per 100,000 population	**361.6**	**n/a**	**384.1**	**330.9**	**314.2**	**289.3** (20% reduction from baseline)	**174.7**		*HSCRC Research Level Statewide Inpatient and Outpatient Data Files
Percentage of adults who are at a healthy weight (not overweight or obese.	**n/a**	31%	n/a	n/a	**32.4%**	**37%**	**35.7%**		BRFSS 2008 – 2010



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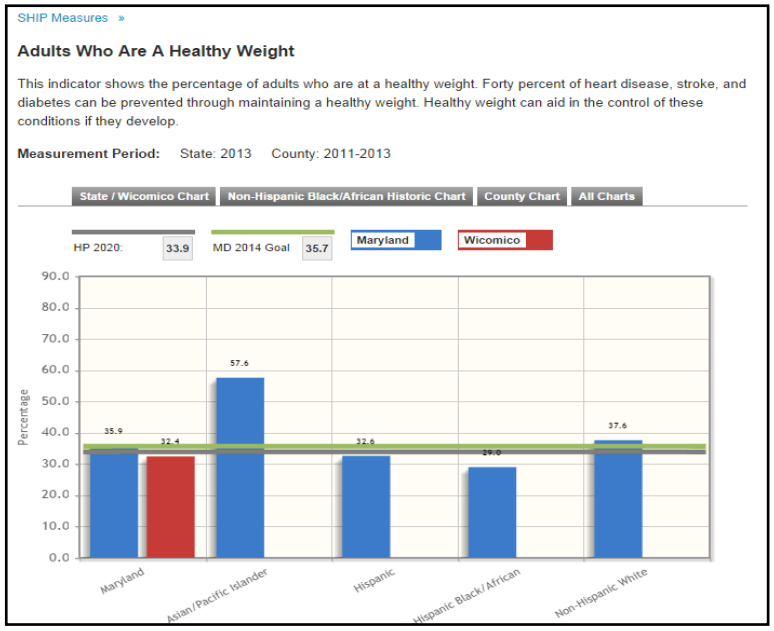

[1] Source: SHIP Data on Network of Care Website: http://wicomico.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship27

Goals:

1. Decrease the rate of ED visits for diabetes by 20% by 2017 (2010 baseline: 361.6 per 100,000 population; 2017 goal: 289.3 per 100,000 population).
2. Increase the percentage of adults in Wicomico County who are at a healthy weight by 20% by 2017 (2011 baseline: 31%; 2017 goal: 37%)

In order to address these issue areas, the actionable strategies below were developed to meaningfully impact lifestyle risk behaviors which will lead to an improved health status and health outcomes for residents of Wicomico County within 3-5 years. Research has demonstrated that by promoting healthier lifestyles to affect a weight loss of 5 – 7%, individuals can prevent type 2 diabetes or delay the start of it. Many organizations and government agencies in the County provide programs and services and implement policies to reduce and prevent obesity and improve health among County residents. It is the goal of this plan to bring all of these entities together to work in collaboration to eliminate duplicative services and enhance all community efforts to improve lifestyle risk behaviors.

Strategies

A. Increase diabetes and pre-diabetes awareness.
B. Increase evidence based obesity management by hospitals and primary care providers.
C. Establish formal referral systems linking at risk patients to follow-up health care.
D. Improve identification of undiagnosed persons with pre-diabetes and diabetes in clinical settings.
E. Improve diagnosis, treatment, and follow-up of persons with diabetes.

STRATEGY A: INCREASE DIABETES AND PRE-DIABETES AWARENESS.				
ACTION	**WHO**	**Outputs**	**Intermediate Measures**	**End Measures**
Conduct two new Lifestyle Balance (LSB) sessions in FY 2015.	WiCHD Community partner	Number of LSB sessions completed. Number of participants.	Percent of participants completing at least nine core classes and four post core classes. Percent of participants with a 5 – 7 percent weight loss.	1. Decreased Rates of diabetes ED Visits (HSCRC/SHIP). 2. Obesity Prevalence at county and state level: Self-reported BMI (BRFSS/SHIP).
Support the Diabetes Care Manager's efforts in Wicomico County to decrease ED visits for diabetes related issues.	WiCHD PRMC Three Lower Counties Community Services (TLC)	Number of referrals to Diabetes Care Manager.	Diabetes Care Manager's case load.	
Attend Tri-County Diabetes Alliance (TCDA) meetings and participate in and support all activities.	All partners	Number of meetings. Number of activities.	Number of individuals reached.	
STRATEGY B: INCREASE EVIDENCE BASED OBESITY MANAGEMENT BY HOSPITALS AND PRIMARY CARE PROVIDERS.				
ACTION	**WHO**	**OUTPUTS**	**INTERMEDIATE MEASURES**	**END MEASURES**
Increase the capacity of primary care providers to implement screening, prevention, and treatment measures for obesity in children and adults through quality	PRMC TLC Local Physicians Health South	Number of participating physician practices. Number of primary care practices participating in 'severe obesity plan'.	Obesity related hospitalizations (HSCRC).	1. Decreased Rates of diabetes ED Visits (HSCRC/SHIP). 2. Obesity Prevalence at county and state level: Self-reported BMI (BRFSS/SHIP).

improvement (QI) methods and other training approaches, reimbursement, and payment incentives.				
STRATEGY C: ESTABLISH FORMAL REFERRAL SYSTEMS LINKING AT RISK PATIENTS TO FOLLOW-UP HEALTH CARE.				
ACTION	**WHO**	**OUTPUTS**	**INTERMEDIATE MEASURES**	**END MEASURES**
Develop formal referral system to follow-up care for at risk patients identified in the community.	PRMC WiCHD Community partners	Unified referral form.	Number of referrals.	1. Decreased Rates of diabetes ED Visits (HSCRC/SHIP). 2. Obesity Prevalence at county and state level: Self-reported BMI (BRFSS/SHIP).
STRATEGY D: IMPROVE IDENTIFICATION OF UNDIAGNOSED PERSONS WITH PRE-DIABETES AND DIABETES IN CLINICAL SETTINGS.				
ACTION	**WHO**	**OUTPUTS**	**INTERMEDIATE MEASURES**	**END MEASURES**
Develop guide for private providers to screen individuals for pre-diabetes and diabetes.	PRMC WiCHD	Pre-diabetes and diabetes screening resource guide.	Number of newly diagnosed diabetics. Number of newly diagnosed pre-diabetics.	1. Decreased Rates of diabetes ED Visits (HSCRC/SHIP). 2. Obesity Prevalence at county and state level: Self-reported BMI (BRFSS/SHIP).
STRATEGY E: IMPROVE DIAGNOSIS, TREATMENT, AND FOLLOW-UP OF PERSONS WITH DIABETES.				
ACTION	**WHO**	**OUTPUTS**	**INTERMEDIATE MEASURES**	**END MEASURES**
Enhance existing resource guide for use by providers to diagnose, treat, and follow-up persons with diabetes.	PRMC Private providers WiCHD	Resource guide	Number of newly diagnosed diabetics.	1. Decreased Rates of diabetes ED Visits (HSCRC/SHIP). 2. Obesity Prevalence at county and state level: Self-reported BMI (BRFSS/SHIP).