Priority Area 1: Social Determinants of Health Risk Factors

Promote Wellness, Behavior Change, and Engagement In Appropriate Care *(Physical, mental, emotional, and behavioral health)*

Activities/Tasks

Health Education and Primary Prevention Activities

* **Participate in health fairs** for enhanced screening, health literacy, and community education
* **Promote and organize community workshops and educational sessions via speakers bureau** on key health issues with the goal of educating the public and engaging participants in appropriate primary care and specialty care services
* **Work with community partners and schools to organize education and awareness events** for their constituencies
* **Promote employee wellness programs**: co-sponsor employee wellness forum with PGC Chamber of Commerce, featuring MGM's wellness programs.

Objectives	Measures
Raise awareness about health risk factors, health promotion, and wellness	# of speaker bureau events focused on health promotion
Promote engagement in primary care and behavioral health services	# screened for pre-diabetes, diabetes, hypertension, obesity, COPD
Raise awareness about mental, emotional, and behavioral risk factors	Age-adjusted death rates from heart disease, by race/ethnicity

Priority Area 2: Physical Health and Chronic Disease Management

Improve Chronic Disease Management

Activities/Tasks

Living Well- Diabetes Self- Management Program, Congestive Heart Failure Initiative, Pulmonary Home Initiative

* Organize and support programs in Dimensions' Family Health and Wellness Centers and within other primary care clinics that screen those at-risk for various complex/chronic conditions and provide evidence-based education, prevention messages, and basic self-management support.
* Provide evidenced-based counseling/coaching (including intensive self-management support) and treatment
* Link those with complex or chronic conditions to appropriate specialty care services, particularly those with diabetes, hypertension, HIV/AIDS, and asthma

Objectives	Measures
Increase proportion of adults with chronic disease or other complex conditions who receive evidence-based screening, education, referral, and/or treatment services	# of high risk assessments
	# of patients participating in chronic disease self-management/lifestyle change programs

Priority Area 2: Physical Health and Chronic Disease Management

Improve Transitional Care

Activities/Tasks

Care Coordination and Care Transitions Support Program

* Provide intensive coordination services in the ED and inpatient settings to ensure clinical follow up, medication management, and appropriate linkages to community services (focused specifically on high-utilizers with chronic or complex conditions)
* Implement Ambulatory Care Transitions Team (ACTT) and Ambulatory Care Center for Evaluation and Stabilization Models (ACCESS)
* Enroll high utilizers in mobile integrated health home visiting program
* Utilize HEZ community health workers for patients residing in HEZ-designated area.
* Work with Elder Service Agencies and Councils on Aging to develop programs to link those discharged to needed services

Objectives	Measures
Conduct assessment to identify condition-specific priorities and barriers to care coordination	# of high utilizers assigned to care transition coordinator
Develop and implement enhanced care coordination plans for adults with chronic conditions who are discharged from the hospital	# of high utilizers receiving home visits
Promote enhanced primary care follow-up and home care services	Emergency department utilization rate by race/ethnicity
Develop partnerships with elder services agencies to enhance linkages to services	Hospital PQI
Reduce 30 day ED/inpatient readmission	