# 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 |
|---|---|
| Maintain collaboration with the Health Department and other community health stakeholders | # of high risk assessments |
| Promote use of the 2016 Community Health Needs Assessment (CHNA) findings to better target community health initiatives | # of patients participating in chronic disease self-management/lifestyle change programs |
| Support the development of effective community health programming | |
| Build a network of non-profit community based organizations (CBOs) in Prince George's County that can help to carry out Community Benefit strategic initiatives | |

# 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 |
|---|---|
| Maintain collaboration with the Health Department and other community health stakeholders | # of high risk assessments |
| Promote use of the 2016 Community Health Needs Assessment (CHNA) findings to better target community health initiatives | # of patients participating in chronic disease self-management/lifestyle change programs |
| Support the development of effective community health programming | |
| Build a network of non-profit community based organizations (CBOs) in Prince George's County that can help to carry out Community Benefit strategic initiatives | |

# Priority Area 3: Behavioral Health

***Develop Behavioral Health Outreach and Education Programs in Clinical and Community-based Settings***

## Activities/Tasks

**Health Education and Primary Prevention Activities (Behavioral Health)**

* Support behavioral health awareness, education and stigma reduction
* Provide behavioral health education and screening in primary care settings (provider education and written materials)
* Conduct Mental Health First Aid Workshops with first responders and staff at community-based organizations

| Objectives | Measures |
|---|---|
| Educate the public about behavioral health risk factors, behavioral health promotion, and basic wellness issues | # of Mental Health First Aid Workshops conducted |
| Promote engagement in appropriate primary and specialty care | # of attendees at Mental Health First Aid Workshops |
| Educate service providers and educators on behavioral health first aid | |
| Increase screening and referral activities in clinical, community, school-based, and worksite settings | |