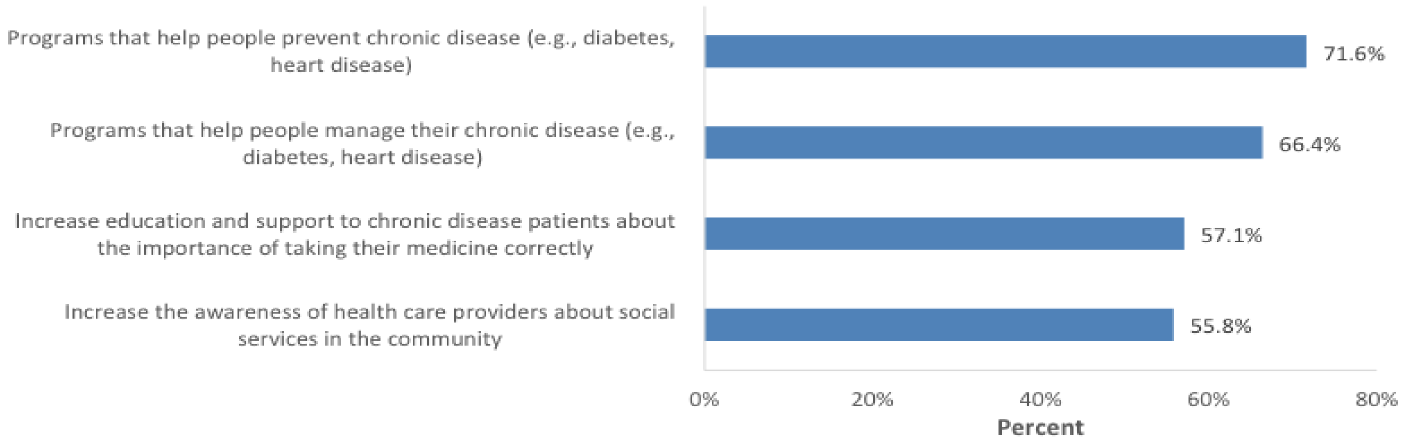
Chronic Disease Priority Group

Figure 48. Chronic Disease Strategies Considered High Priority by Survey Respondents for Future Resource Allocation and Spending, 2015



DATA SOURCE: Mercer County Community Health Assessment Survey, 2015; NOTE: Arranged in descending order

Priority 3: Chronic Disease Year 1 Action Plan

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).			
Objective 3.1: By 2017, increase the number of venues that provide access to information about the continuum of chronic disease services (i.e., prevention, treatment, maintenance) especially for those in areas of greatest disparity.			
Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Increase in # of people served from underserved population groups	#		Population/Economic Data, 2015
• Decrease in % existing vulnerable groups in ER use	#		ER Claims Data, 2015
• Increase in # of organizations/venues providing services in areas of need	#		CAB connection, 2015
• Decrease in % of existing vulnerable groups' hospital re-admission rate	#		2015
Partners for this Objective			
• Acute Care hospitals • Trenton Health Team • Web Design Consultant			
Resources Required (human, partnerships, financial, infrastructure or other)			
• Financial support for website infrastructure and mobile app development • Vendor/human resources •			

Year 1 Action Plan

PRIORITY AREA 3: Chronic Disease

Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).

Monitoring/Evaluation Approaches

- Utilization rate for existing programs and services.
- Number of community organizations connected to website.
- Number of townships connected to the website (added healthymercer.org link to their website).
- Website hit rates for community organizations.

Strategy 3.1.1: Work with community organizations to disseminate information about chronic disease through access to our website.

Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line** Q1	Q2	Q3	Q4
a. Publicize process for posting information on screenings, access, treatment, social services, financial services/support, patient education	GMPH Steering Darlene Chronic Diagnosis Group	Traffic on website		a	c	
b. Link website						b. Y2, Q4
c. Identify CAB members with a desire to post on the website.		Inventory of CAB members				
d. Provide link to GMPHP website on existing CAB member sites and community organizations.					x	
e. Convene organizational groups to communicate this strategy					x	
f. Add link to website on senior page on Township website.	L-Carol I-Health Officers				x	
g. Develop and implement a web and print-based community calendar.		Website calendar				x

Year 1 Action Plan						
PRIORITY AREA 3: Chronic Disease						
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h. Create brochures for distribution with website information for people not connected.		update website postcard				Y2 Q1
i. Make sure information is available in Spanish.		Seek translation in print.				Y2 Q2
j. Publicize information at health fairs, PSA's (radio).		Develop marketing messaging materials.				Y2 Q3
Strategy 3.1.2: Research or use existing evidence-based programs with local healthcare professionals and agencies to offer programs for specific underserved target populations/audiences.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify priority communities through the CHA.	Chronic Disease Work Group Amanda HJ Austin	Inventory on website			x	Year 2
b. Work with community leaders of high-priority populations to garner support for initiatives.	Chronic Disease Work Group Amanda HJ Austin				x	
c. Develop an approach and areas of focus to create a logic model that can be used for different chronic diseases. Outcome for the logic model will be a presentable logic model template.						

Year 1 Action Plan						
PRIORITY AREA 3: Chronic Disease						
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).						
Strategy 3.1.3: Identify and engage partner organizations that provide community screening and preventative services.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Inventory existing resources. Identify access points: where, when who goes?	Chronic Disease Work Group Jill	Number of facilities identified			x	
b. Identify source or contact person.		Number of new CAB recruits.			x	
c. Invite organizations to join CAB.		Number of organizations actively participating in CAB				x
d. Identify agencies collecting data		Lead agencies				Y2Q4

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).			
Objective 3.3: By 2018, increase by 5% the number of chronic disease patients educated on and adherent to their medication plans.			
Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Track re-admissions for congestive heart failure and COPD within 30 days of hospitalization.	2015		ER Claims Data
• Track number of patients seen in ED/Urgent Care office with the primary diagnosis of diabetes.	2015		ER Claims Data
• Track number of patients who have had a visit to an ED/Urgent Care office for asthma in the past six months	2015		ER Claims Data
Partners for this Objective			
• Acute care hospitals • Chronic Disease Team			
Resources Required (human, partnerships, financial, infrastructure or other)			
• Data extraction from ER claims data.			
Monitoring/Evaluation Approaches			
• Internal hospital monitoring processes.			
Strategy 3.3.1: Identify, select, and utilize evidence-based community education tools to promote medication adherence.			

Action Steps	Organizations(s) Responsible L=Lead, M=Manage, I=Implement	Outcome (Products) or Results	Year 1 Time Line			
			Q1	Q2	Q3	Q4
a. Survey CAB organizations as to the standard educational tools they utilize.	Hospitals Community Health Organizations Agencies Chronic Health Team				x	
b. Invite organizations to share their evidence-based education tools for medication adherence.	Hospitals				x	
c. Evaluate all tools and identify best practices.	Community Health Organizations Chronic Health Team	Tools standardized and disseminated among providers			x	

Year 1 Action Plan						
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d. Create a health education literacy committee to evaluate, translate, and ensure materials are at a fifth grade level.	Hospitals Community Health Organizations Agencies Chronic Health Tools					X
e. Post the tools on the website.	GMPHP					
Strategy 3.3.6: Establish an effective Mercer County Chronic Disease Work Group.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Develop a process to establish priority areas of focus for chronic disease	Community leaders	The health Literacy Committee is formalized as a global, strategic committee for the GMPHP and defines and monitors approaches across all priority areas.				
b. Use the logic model developed in 3.1.2 to develop model template for programs to address priority areas of focus. (See where other chronic diseases fit in. In order to replicate the program for other chronic disease.)	Community leaders					Y2 Q4