Health need: Diabetes

Objective – Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for all persons who *have* or are *at risk* for DM.

Goal Direction – Education, Prevention, Behavior change.

2030 Bold Goal: Increase prevalence of adults knowing they are pre-diabetes status by 30%. *(will use pre-diabetes risk test on HWC to track)*
Reduce the Washington County incidence of newly diagnosed DM Type 2 by 5%. *(will use MD Diabetes Action Plan tracking measurements)*
Reduce *preventable* hospital admissions/E.D. visits related to DM Type 2 self-management complications by 10%. *(Utilize CRISP Reporting Services to compare 2019 calendar year to 2021 calendar year for overall preventable visits, readmissions, and Preventable Quality Indicator – will update annually after 2021)*
2019 Baseline # visits: 303 2019 Readmission rate: 15.8% 2019 PQI Rate: 20.42%

Strategy	Goals	Measures	Progress
Provide National Diabetes Prevention Program	• Prevent type 2 diabetes • Reduce risk for developing type 2 diabetes • Reduce BMI • Reduce HbA1C values	• # classes offered • # participants • # HbA1C < 5.7% after program • # ≥ 5% weight loss after program	
Create centralized community DM Resource tab on HWC website to include: • Prediabetes Risk Screenings via on HWC website via Google Forms • Pool of all partner organization resources for DM prevention & self-management to one centralized location. Education resources to include: disease prevention, disease self-management, health screenings, support groups, nutrition, cooking demos, exercise, weight loss, mental health, stoplight tools, brochures, food coupons. • Once created, will push out to all local providers via postcards containing HWC website information. Providers to share postcards with their patients. Will use press release (WDVM) to promote for community members. Will ask Walgreens pharmacists to place HWC postcard in patient bags when	• Improve community awareness for diabetes resources • Increase website traffic/resource engagement by 10%	• # of engagements on listed DM resources • Community partner organizations will report increased attendance for diabetes classes, events, activities.	

filling DM medication Rx to direct customers to DM resources. Develop a county-wide referral system for diabetes programs	• Prevent type 2 diabetes • Reduce hospitalizations/ED visits for unmanaged diabetes • Increase participation in diabetes programs	• Referral system implemented • # referring practices • # referrals made to programs • # participants enrolled in programs	

Health need: Heart Disease and Hypertension

Objective – Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart disease

Goal direction – Early detection, education, and management of blood pressure and heart disease

2030 Bold Goals: Reduce the Washington County heart disease mortality rate by 10%
Reduce *preventable* hospital admissions/ED visits related to CV self-management complications by 10% for both heart failure & hypertension *(Utilize CRISP Reporting Services to compare 2019 calendar year to 2021 calendar year for overall preventable visits, readmissions, and Preventable Quality Indicator – will update annually after 2021)*
Heart Failure – 2019 Baseline # visits: 397 2019 Readmission rate: 17.53% 2019 PQI Rate: 30.95%
Hypertension – 2019 Baseline # visits: 80 2019 Readmission rate: 13.74% 2019 PQI Rate: 15.73%

Strategy	Goals	Measures	Progress
Educate community on social determinants of health	• Promote/share information about for five trainings on social determinants of health & health literacy on HWC website that reach > 250 people during 2021	• # trainings shared • # persons viewing info	

Create centralized CV Resource on HWC website to include: • disease prevention, disease self-management, health screenings, support groups, smoking cessation classes, nutrition, cooking demos, exercise, weight loss, mental health, stoplight tools, brochures, food coupons. • Once created will push out to all local providers via postcards containing HWC website information. Providers can share postcards with their patients. Will use press release (WDVM) to promote for community members. Will ask Walgreens pharmacists to place HWC postcard in patient bags when filling CV medication Rx to direct customers to DM resources.	• Improve community awareness for CV resources • Increase website traffic/resource engagement by 10%	• # of engagements on listed CV resources • Community partner organizations will report increased attendance for diabetes classes, events, activities.	
Distribute 150 BP monitors	• 50% reported improvement by BP self-monitoring in 2021.	• # of participants reporting	