

DIABETES LHIP WORKGROUP
Subcommittee: Awareness
ACTION PLAN

Vision Statement: Frederick County is a thriving community that provides access to healthy lifestyles for all residents and supports all people living with or at risk for diabetes.

Subcommittee Goal: Frederick County residents will understand what pre-diabetes and diabetes is, what their individual risk is and how it can be modified.

Subcommittee Members: Maria Herrera, Mary Ann Van Duyn, Susan Baldwin, Christina Brockett, Mary Ann Grossnickle, Janet Harding, Ulric Hetsberger, Cynthia Ithier, Linda Ryan, Virginia (Ginny) Skelley, and Sr. Roberta Treppa

Outcome	Action	How will you measure?	Person(s) Responsible	Deadline/Status
<p>Increase the number of individuals from priority populations that know what pre-diabetes and diabetes is.</p> <ul style="list-style-type: none"> • Risk factors and how to decrease risk • Impact of COVID • Severity of complications if undiagnosed/untreated <p>Increase understanding of importance of healthy blood glucose management</p>	<p>Identify priority populations.</p> <p>Conduct listening sessions to understand how best to reach identified priority populations (locations, methods, etc). These sessions will help guide what education is provided to which population.</p> <p>Feedback from listening sessions to be brought back to the DM workgroup for review and inclusion into the other subcommittee action plans as appropriate.</p> <p>Create/adapt educational and resource materials that are culturally competent and appropriate from a health literacy perspective. Include non-print materials (videos may be particularly useful in working with hard-to-reach populations).</p> <p>Pulling from available resources (such as socio determinants research), create a T2D resource guide or toolkit for dissemination (via events and on line) to include:</p> <ul style="list-style-type: none"> • Standardized, culturally tailored messages • 5-2-1-0, DWD, DSMP, and DPP flyers • Healthy Lifestyle Tip Sheets • Access/Barrier Tip Sheets, with specific clinic and physical activity information, insurance support, etc . <p>Create an educational campaign for youth. Use wellness goals as a guide in schools. Engage with youth community groups (especially youth living with or at risk for T2D).</p>	<p>Priority populations identified</p> <p># listening sessions conducted</p> <p>Feedback reported back to group and action plan updated.</p>	<p>TBD</p> <p>M. Herrera</p> <p>M. Grossnickle</p> <p>L. Ryan</p> <p>U. Hetsberger</p> <p>S. Baldwin</p> <p>J. Harding</p> <p>V. Skelley</p> <p>School Health Nurses</p>	<p>Proposed priority population (by Subcommittee Member): individuals who are at high-risk, such as those who are obese, positive family history, poverty, stress, covid, mental health issues, especially from the following proposed priority populations:</p> <ul style="list-style-type: none"> • AA (Housing Authority) • Hispanic (Spanish Community of MD) • Asian (AACF of MD) • Under- and un-insured (Mission of Mercy) • Patients (Care First, Frederick Health) • General Community (Frederick Health Dept) <p>Also include, rural communities with access issues (check high risk/socially vulnerability index zip codes).</p>

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	<p>Conduct workshops/outreach to local employers to provide them with educational materials/sessions for their employees.</p> <p>Plan and conduct 3-4 community outreach events, starting with one in November (Diabetes Awareness Month as well as World Diabetes Day, Nov. 14). Partner with existing community efforts (FH, Bridges, CBOs, etc.).</p> <p>Possible upcoming events include:</p> <ul style="list-style-type: none"> • Pick a food distribution site and coordinate with Community Action -- October • Arrange with Love for Lochlin to attend one or two clinics – November • Health Dept. location on 40th – Danielle • Holiday events—toys for tots pickup, Rescue Mission Holiday event, etc. – December <p>Partner with Bridges lay health educators already engaged in community screening and educational outreach.</p> <p>Partner with other CBOs such as the Food Bank that can assist with appropriate delivery methods and community outreach.</p> <p>Provide training on motivational interviewing for CHWs, healthcare providers, partners, etc.</p>	# employer workshops # employees at each workshop # events # flyers distributed # trained		

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Increased linkages with community partners that build leadership, support referrals, and help design interventions.	Identify specific organizations to reach out to based on priority population focus (county libraries, churches, Mission of Mercy, Love for Lochlin). Brief partner organizations on workgroup goals. Identify opportunities for partnership to educate and raise awareness about pre-diabetes and diabetes.	# briefings for CBOs and report on feedback gathered	J. Harding Coalition? J. Waters (contact) J. Harding Others?	
Increase number of individuals that have access to and know where to find education about and resources for pre-diabetes and diabetes.	Develop central T2D information resources guide and hub/website with resources for county residents and providers (i.e., LiveWell Frederick website &/or new Coalition website) Develop an app for easy phone access.	Tracking analytics	Partner with Frederick Dept of Health, Communications, to develop tailored messaging and branding.	
Increase awareness of available community life style change programs. Increase understanding of how to refer to community lifestyle change programs.	Connect with provider practices to distribute educational materials (include community nurses, community health educators and allied health professionals). Create and educate on how to refer to lifestyle change programs using a seamless process. Establish a seamless referral process to community lifestyle change programs.	# of providers trained/given info on local lifestyle change programs/resources	J. Waters (contact)	Partner with nurses to broaden training and community outreach around DM2 prevention and management.
Increase the number of individuals aware of resources to assist with transportation needs.	Create an awareness campaign to educate county residents, providers, and CBOs about what options exist to assist with transportation. This will help address transportation barriers to healthy lifestyle for county residents without access to a vehicle (ie,	# residents educated on low-cost transportation options # providers educated on low-cost transportation options # CBOs educated on low-cost transportation options.		

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	transportation to doctors' visits, grocery store, safe areas for physical activities).			

DIABETES LHIP WORKGROUP
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Subcommittee Goal: Identify Frederick County residents with pre-diabetes. Of those identified, increase the percent who are aware of their increased risk of diabetes and the available resources.

Subcommittee Members: Sharon Edelstein, Margie McWilliams, Crissy Barry, Dionna Ali, Laura DeFeo, Jen Cooper, Angie Blair, Diane Tomasky, Aida Gonzalez, Jordan Diacumakos, Joan Daley, Buck Browning, Julie Couillard, Kitty Devilbiss, Chipe Geaty, Brian Griffith, Suzanne Markowitz, Judy Smoot, Carrie Sorenson, Joi Vigin

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Increase # of people who are screened for pre-diabetes.	Host or participate in community events to conduct screening and resource navigation.	# of community events # attendees at each event	Laura, Jen, Crissy, Dionna, Sharon, Suzanne	By June 2023: Complete at least 4 screening events.
T2D to support early detection	Screening location options:	# of people screened with risk test (including # in priority populations, # screened in languages other than English) # of positive screens # referred to lifestyle change programs		Target to have at least 250 people screened by June 2023. No goal for each specific event, but pick out specific events, balancing large vs. smaller/targeted events.
Focus on awareness of diabetes risk in specific populations including: • Seniors and caregivers • People with a history of gestational diabetes				
Increase number of people screened at risk that are referred to lifestyle change programs				
Increase number of people screened for diabetes.				

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	<p>Individuals that are identified at risk from the screening have a follow up.</p> <p>Conduct Hemoglobin A1c screenings in high priority groups.</p> <p>Navigate individuals that have an elevated hemoglobin A1c to appropriate follow up.</p> <p>Create a community shared calendar of events, persons responsible and volunteers by October 2022.</p> <p>Identify fairs and carnivals along with points of contact for summer 2023 that we might attend.</p>			
Reduce the number of care gaps associated with diabetes in targeted populations. Increase % of high risk individuals connected to primary care providers (regardless of insurance status)	<p>Connect residents without PCP to a primary care provider</p> <p>Hospital and provider outreach for post-partum and longer-term screening of people who had a history of gestational diabetes.</p> <p>Develop a referral manual AND handouts, what's covered by various insurance.</p> <p>Determine if other counties/areas have materials already developed that we could rebrand (with permission).</p> <p>Insurance: Refer to ACA (Maryland Access Point - MAP - 211) or Veteran's Administration.</p> <p>Assist residents without insurance to provide them information or help connect them to coverage. Include removing barriers that would prevent an individual from obtaining insurance (obtain birth certificate, letters that certify an individual isn't eligible for insurance, etc.).</p>	# referred to primary care/medical provider # referred to lifestyle change program # referred to health department/MD Health Connection for HealthChoice enrollment	Jordan, Margie, Jenn, Maria, Diane	<p>Ongoing – might be attached to screenings above. Quarterly check-in to provide information to and get data from various groups already doing this work.</p> <p>Year 1 goal: Discovery: finding out what existing guides and materials are available; identify gaps; develop initial draft of local manual</p> <p>Ultimate 3-year goal: Develop a resource guide along with marketing/communications materials as needed</p>

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Outcome	Action	How will you measure?	Person(s) Responsible	Deadline/Status
	Connect residents with prediabetes/diabetes to wrap around community resources like food banks, etc. to address barriers related to health/diabetes care.			
Increase % people with prediabetes connected to lifestyle change programs and secondary prevention efforts (regardless of insurance status).	Increase capacity of local lifestyle change programs (i.e., DPP, DSMP, DSMT?, and DWD) by recruiting and training more leaders/coaches and other program expansion activities. Get information and reports from various groups on DPP programs for: Capacity (number of classes, sufficient coaches) Medicaid/Medicare providers Private programs Other community partners, e.g., schools, churches, gyms, nonprofits, Sorority/Fraternity, colleges/universities, Chamber of Commerce	# of new coaches trained # of new workshops offered	Angie, Joan, Aida, Brian, Buck	In year 1: Start to connect programs/agencies. In year 2: Prompting programs. Evaluate the number of participants reached due to the connections made in year 1.
Increase recruitment and retention in lifestyle change programs (DPP, DSMP, DWD, DSMT?)	SDOH screening and navigation to appropriate wrap around services. Establish, identify, or promote support groups to create opportunities for connection and belonging so people are comfortable with discussing their risk for chronic health outcomes and accessing assistance. Remove barriers related to social connection/isolation.			

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Outcome	Action	How will you measure?	Person(s) Responsible	Deadline/Status
	Conduct lifestyle change programs (DPP, DSMP, and DWD) in the neighborhoods of priority populations/high risk areas. Include, for example, demos at trusted restaurants or grocery stores that are convenient to the local community.	# workshops # referred, # enrolled, # completed		
Increase % FCPS students reporting healthy food choices (YRBS-next release) Increase % FCPS students reporting higher levels of physical activity (YRBS-next release)	Conduct more promotions of 5210 healthy lifestyle campaign in FCPS and for the general public. Partner with 5210 program which is already engaged in healthy lifestyle campaign within the schools. Conduct other healthy eating/physical activity challenges for youth using social media/Instagram with prize incentives.	# promotions/ wellness challenges # of participants		
	Conduct workshops/outreach to local employers to encourage them to provide incentives for employee screening & appropriate follow-up.	# employer workshops # employees screened		

DIABETES LHIP WORKGROUP
Subcommittee: Management (Formerly known as Treatment)
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Subcommittee Goal: Decrease volume of patients seen in local emergency departments, doctors' offices, and Urgent care centers for acute diabetes treatment.

Subcommittee Members: Brooke DeSantis, Danielle Haskin, Anne Williams, Barbara Brookmyer, Patricia Cash, Elizabeth Chung, Terri Kemmerer, Martin Sarkar, Emily Spear, Jenifer Donato

Outcome	Action	How will you measure?	Person(s) Responsible	Deadline/Status
Identify and understand diabetes management needs of priority populations in Frederick County.				
Increase community knowledge of best practices for managing diabetes.				
Increase community knowledge of the benefits to following identified best practices for managing diabetes.				
Identify barriers to adhering to best practices.				
Increase # of healthy food options for FCPS school meals (what data led to this to say it's a problem)	Partner with FCPS to advocate for healthier food choices for school meals <ul style="list-style-type: none"> • Starting conversation on potential for a policy with City and County leadership by the end of Aug • Review FCPS food & wellness policy (Reg. No. 400-82) to understand restrictions by Dec 31.2022 • Meet with FCPS food and nutrition dept FCPS to identify wellness policy restriction (ask for most recent landscape) • Create partnership with food and nutrition services in FCPS (do after school programs / sports events follow the guidelines?) • Look at other Counties and policies around food choices in school system • Utilize food markets for further outreach 	<ul style="list-style-type: none"> • Conversation took place • Food and wellness policy reviewed • Met with FCPS food and nutrition department and identified policy restrictions. • Partnership established with food and nutrition services at FCPS • Conducted scan of policies in neighboring county schools 		<ul style="list-style-type: none"> • End of August • December 31, 2022

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Increase the percentage of individuals connected to the appropriate resources.	<p>Develop and implement a closed loop referral system for medical care and local diabetes programs & resources.</p> <p>Identify challenges to current referral system.</p> <p>Identify eligibility requirements for diabetes programs and resources.</p>	# of healthcare providers "enrolled/informed"		
Increased # people knowledgeable of healthy food preparation.	<ul style="list-style-type: none"> Conduct healthy cooking/ meal prep classes for families. Include kid-friendly recipes (UW health eating trail (grant from LHIC) can we get evaluation after implementation - OED potential partner (farm guide 2011)). 	# classes # participants Pre/post evaluation Teach back demonstrations Action planning/goal setting based on what was learned in class.	Brooke (FHH / FCPS / local food banks) Tricia Danielle	<ul style="list-style-type: none"> Collaborate to host 80 healthy cooking classes by the end of June 2023
Increase the number of individuals educated about affordable food options.	<p>Provide education on healthy eating and cooking on a budget.</p> <ul style="list-style-type: none"> Recipe modification Grocery store tours 			
Increase the number of individuals that have access to affordable healthy food options.	<p>Programs to increase availability & accessibility of healthy foods in food deserts. (i.e., community gardens)</p> <p>Access to meal prep companies.</p>			
Increase opportunities available for safe physical activity in the community (i.e., beginner 5Ks with giveaways).	<p>Conduct events to promote physical activity, including for those with disabilities (i.e., beginner 5Ks with giveaways, partner to create neighborhood walking clubs); collaborate with existing local programs; include those with disabilities.</p>	# physical activity focused events held / supported # attendees (include demographic information)	Annie	Identifying how many 5ks are scheduled in Frederick County by the end of August (https://runningintheusa.com/classic/list/map/upcoming/within-50-miles-of-frederick-md)

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% increase of residents that get at least 150 minutes physical activity per week (data that led to this to say it's a problem?).	Shield grant for 7th graders increase activity	# walking clubs created / supported # enrolled (include demographic information)		
Increased % FC residents have access to green spaces and exercise opportunities (what data led to this to say it's a problem).	Reach out to P&R (Kari) to discuss the option of adding stations to trails and paths (legislation / funding).	# of FC residents with increased access to green spaces and exercise opportunities	Danielle	
Increased % FC residents who have access to transportation for PCP visits, pharmacy, healthy grocery store (what data led to say this is a problem)	Collect feedback from DPP, DSMT, other lifestyle change programs that evaluate barriers, what helps with success/engagement		Tricia	

(DIABETES Action Plan -Board approved -
09.07.22)