

**ALLEGANY COUNTY HEALTH PLANNING COALITION**  
Local Health Action Plan

**Priority #6: Screening**

**Baseline and Goal for 2014:**


|  | County Baseline | MD 2014 Goal | Local 2014 Goal | Source  |
|--|-----------------|--------------|-----------------|---|
| Rate of ED visits for hypertension per 100,000 | 246.4           | 225.0        | 233.5*          | SHIP #28<br>Reduce # Hypertension related ED visits |
| Rate of ED visits for diabetes per 100,000     | 456.8           | 330          | 439.6*          | SHIP #27<br>Reduce # ED visits related to diabetes  |

\*Based on the % difference between the state baseline and the state 2014 goal


**Strategies:**

- A. Improve delivery of clinical prevention services consistent with USPSTF recommendations
- B. Support self management programs for diabetes and other chronic diseases as needed

**Actions**

| <b>Strategy A: Improve delivery of clinical prevention services consistent with USPSTF recommendations</b>  |  |             |  |   |
|---|--|-------------|--|---|
| <b>ACTION</b>   | <b>WHO</b>   | <b>WHEN</b> | <b>MEASURES</b>  | <b>PROGRESS AS OF 5-10-2012</b>   |
| 1. Implement a education campaign for both providers and consumers regarding consistent screening recommendations that includes STI and the high risk to minority populations | Medical staff, ACHD, WMHS, ACS, Providers; Tristate CHC,AHEC | Phase 1-2   | ECW-# screened for lipid and blood pressure<br><br># STI Cases |  |
| 2. Promote where screenings are available and address environmental barriers to participation   | Medical staff, ACHD, WMHS, ACS, Providers, Tristate CHC      | Phase 1-3   | List of resources and barriers addressed                       | [Future Initiative]   |

**Strategy B:** Support self management programs for diabetes and other chronic diseases as needed

| ACTION   | WHO  | WHEN           | MEASURES   | PROGRESS<br>AS OF 5-10-2012   |
|--|--|----------------|--|---|
| 1. Promote and expand diabetes self management program at WMHS   | WMHS, Providers, ACHD-WIC, Parish Nurses, Comm Partners, TSCHC, AHEC, Chamber                        | Phase2-3       | # participants in program, increasing over time                      | [Future Initiative]   |
| 2. Identify other self management programs that are feasible in the area                                     | WMHS, ACHD, AHEC, Tristate CHC   | Phase 2-3, 4-5 | # initiated programs   | [Future Initiative]   |
| 3. Seek options to assist underserved populations with affordable testing, medical supplies and healthy food | WMHS, ACHD, AHEC, Tristate CHC, Food Bank, HRDC, Family Junction, Hope Station, Associated Charities | Phase 2-3,6    | # low income persons assisted<br><br># persons requesting assistance |  |