PREVENTION LINK of Southern Maryland

Project Overview

Overview: The PreventionLink program integrates clinical practice with evidence-based public health programs to improve health outcomes for patients at all levels of risk for chronic disease, from persons at risk for diabetes and heart disease to high-system utilizers with frequent hospitalizations. Innovations in the use of health information technology and the development of communities of practice will bring together stakeholders in chronic disease care with a shared goal of reducing the burden of diabetes, hypertension, and stroke in underserved areas of Prince George's, St. Mary's, Charles, and Calvert counties.

Background: 10 percent of chronic disease patients in the project area are responsible for 80 percent of chronic care costs. Southern Maryland lacks quality public health programs for chronic disease prevention. Barriers to health care access in the region include transportation, low health literacy, lack of finances (and lack of adequate health insurance), and lack of social support.

Project Area: Southern Maryland (Prince George's, Calvert, Charles, and St. Mary's counties), population of 1,276,625 residents in urban, suburban, and rural communities

Lead Entity: Prince George's County Health Department
Funder: Centers for Disease Control and Prevention
Timeline: September 2018 – September 2023

Partners:

- Chesapeake Regional Information System for our Patients
- Community Care Coordination Team
- National Diabetes Prevention Program (DPP) lifestyle change programs
- Health Quality Innovators
- HealthCare Dynamics International
- Institute for Public Health Innovation
- Johns Hopkins Bloomberg School of Public Health
- Maryland Department of Health
- Maryland Rural Health Association
- P3 Pharmacist Network (University of Maryland School of Pharmacy, Maryland Pharmacists Association)
- Prince George's County Healthcare Alliance, Inc.
- St. Mary's AccessHealth
- Totally Linking Care in Maryland (CalvertHealth Memorial Hospital, University of Maryland Capital Region North, Doctors Community Hospital, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center, MedStar St. Mary's Hospital, Area Agencies on Aging, Maryland State Medical Society and Primary Care Providers, Prince George's County Health Department, Calvert County Health Department)
- University of Maryland, College of Arts and Humanities, Department of Communication
- University of Maryland, School of Public Health, Horowitz Center for Health Literacy

STRATEGIES

Category A: Diabetes Management and Type 2 Diabetes Prevention Strategies

A.1. Implement systems to facilitate bi-directional e-referrals between health care systems and the National DPP lifestyle change programs.

A.2. Support organizations in increasing enrollment in existing National DPP lifestyle change programs or establishing and sustaining new National DPP lifestyle change programs in underserved areas.

A.3. Implement tailored communication/messaging to reach underserved populations at greatest risk for type 2 diabetes to increase awareness of prediabetes and National DPP lifestyle change programs.

A.4. Support advanced training for lifestyle coaches working at the National DPP lifestyle change programs to strengthen skills needed to engage and retain patients.

A.5. Explore and test innovative ways to eliminate barriers to participation and retention in National DPP lifestyle change programs and/or American Diabetes Association-recognized (ADA-recognized) and American Association of Diabetes Educators-accredited (AADE-accredited) diabetes self-management education and support (DSMES) programs for diabetes management among high burden populations.

A.6. Work with health care systems to establish or expand use of telehealth technology to increase access to National DPP lifestyle change programs and ADA-recognized and AADE-accredited DSMES programs for diabetes management.

A.7. Increase adoption and use of clinical systems and care practices to improve health outcomes for persons with diabetes.

A.8. Increase use of clinical decision support within the electronic health record (EHR) to promote early detection of chronic kidney disease (CKD) in people with diabetes.

Category B: Cardiovascular Disease Prevention and Management Strategies

B.1. Increase identification of patients with undiagnosed hypertension using electronic health records (EHRs) and Health Information Technology (HIT).

B.2. Explore and test innovative ways to promote the adoption of evidence-based quality measurement at the provider level.

B.3. Explore and test innovative ways to engage non-physician team members (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers) in hypertension and cholesterol management (i.e., diagnosis and medication management) in clinical settings.

B.4. Promote the adoption of Medication Therapy Management (MTM) between community pharmacists and physicians for the purpose of managing high blood pressure, high blood cholesterol, and lifestyle modification.

B.5. Facilitate engagement of community health workers (CHWs) in hypertension and cholesterol management in clinical and community settings.

B.6. Implement systems to facilitate bi-directional e-referrals between community programs/resources and health care systems (e.g., using EHRs, 800 numbers, 211 referral systems, etc.).

B.7. Explore and test innovative ways to expand use of telehealth including mobile health technology.

B.8. Explore and test innovative ways to enhance referral, participation, and adherence in cardiac rehabilitation programs in traditional and community settings, including home-based settings.

LONG-TERM GOALS

Category A

- 25 percent increase over baseline in the number of people with prediabetes enrolled in a National DPP lifestyle change program who have achieved 5-7% weight loss.
- 25 percent decrease in the number of patients with diabetes and a Hemoglobin A1c (HbA1c) >9.0%.

Category B

- 50 percent increase in the number of patients with known high blood pressure who achieve blood pressure control.
- 50 percent increase in the number of patients at risk for cardiovascular events whose cholesterol is controlled.

EXPECTED OUTCOMES

- Increased access to diabetes, cardiovascular disease, and stroke prevention and treatment resources for priority populations (high utilizers, racial/ethnic minorities, and rural residents).
- Associated improvements in patient engagement in self-management and related clinical measures (HbA1c, blood pressure, cholesterol).
- Improved quality of diabetes, cardiovascular disease, and stroke clinical care as evidenced by provider uptake of clinical decision support tools, national practice guidelines, integrated workflows, team-based care, and use of non-clinical providers such as community health workers.
- Improved infrastructure to deliver quality diabetes, cardiovascular disease, and stroke prevention and treatment services such as services provided by telehealth and a community of practice devoted to identifying and disseminating best practices, lessons learned, and innovations in the region.
- Improved infrastructure to deliver quality diabetes management and type 2 diabetes prevention services as evidenced by increased payer reimbursement for the National DPP lifestyle change program.
- Decreased health care costs associated with chronic disease care.

Funding for PreventionLink was made possible (in part) by the Centers for Disease Control and Prevention (Cooperative Agreement No. 1 NU58DP006626-01-00).