Chronic Care Management Plan Straw Man Outline
[DRAFT]
March 2, 2009

Executive summary (Lead writer, DHMH)
Chapters

1. Statement of Council's charge from Governor and General Assembly (Lead writer, DHMH)

2. Statement of Council's process (Lead writer, DHMH)
    a. Membership
    b. Vision and Mission
    c. Goals
    d. Meeting schedule summary

3. Defining the problems: why a plan is necessary (Lead writer, DHMH)
    a. National and Maryland trends in childhood wellness
        i. Prevalence
        ii. Behaviors
        iii. Disparities
    b. National and Maryland trends in adult chronic disease
        i. Health Risk Behaviors
        ii. Prevalence
        iii. Quality of Care
        iv. Mortality
        v. Disparities

4. Goals, Objective, Strategies, Strategic Actions (per chart) (Lead writer, DHMH)

Appendix to provide details for each strategic action step
    a. Priority
    b. Feasibility of Implementation
    c. Estimated Costs to State
    d. Estimated Cost to Health Care System
    e. Estimated Benefits
    f. Measure specifications
    g. Detailed timeline
    h. Partners responsible for implementing action steps

(Wellness and Prevention DHMH staff responsible for research , writing, and ID implementation partners except actions marked with * to be addressed by Primary Care or Hospital Workgroup DHMH staff)

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Actions (Activities and Systems Changes for Addressing Strategies)*
Promote a culture of wellness in the family, school, healthcare, and worksite setting	Community-based strategies to combat obesity and physical inactivity	Creating an environment that is supportive of eating healthy and fitness	**Physical Activity** Safe neighborhoods, communities, and buildings support physical activity Promote active transport (walking and biking) to school and work and access to recreation facilities Support quality physical education and physical activity in school and afterschool and physical activity in licensed childcare settings Decrease television viewing and sedentary activity Implement signage prompting use of stairs **Nutrition** Fresh, local, and healthy food is available and affordable in all communities and neighborhoods Comprehensive school nutrition policies including breakfast promotion; healthy lunch and snacks, including classroom celebrations and incentives, fundraising, concessions, vending; school gardens; farm-to-school initiatives Support breastfeeding through education, providing space and time for milk expression at work, and high-quality breast pumps **Comprehensive** Employee wellness including health assessment with follow-up coaching; ongoing health education; and policies and environmental supports for healthy behaviors Healthcare providers recommend healthy eating and physical activity for all children and for patients at-risk for or with chronic diseases	Assessment: Identify the best channels for reaching families and school/healthcare/employer leadership groups Assurance: Public awareness—Media campaign (VERB); Fruits and Veggies More Matters campaign; campaign emphasizing the benefit to the business community of a healthier population (based on CDC's Healthiest Nation) Daycare/School—promoting implementation of coordinated school health model; CATCH; Planet Health or Eat Well, Move More; I Am Moving, I Am Learning for all daycares, school-based walking programs Healthcare- Provider & clinical staff education on promoting wellness for patients at-risk for or with chronic disease Community—Shape up Somerville or EPODE model; "We Can!"; Healthy Corner Stores; social support for walking Worksite--State Center as a model employer in individual/family behavior change; sharing best practices in worksite wellness through MidAtlantic Business Group on Health Policy: Comprehensive promotion of physical education, physical activity, and healthy eating in schools and licensed childcare Incentives for grocery stores and farmers' markets to locate in low-access areas; Food Policy Council Nutrition labeling on menus WIC food package changes Built Environment, as part of Smart, Green and Growing (including health impact assessments in planning)

(Wellness and Prevention DHMH staff responsible for research , writing, and ID implementation partners except actions marked with * to be addressed by Primary Care or Hospital Workgroup DHMH staff)

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Activities and Systems Changes for Addressing Strategies*
Enhance access to multiple opportunities for patient self-management education for high-risk populations	Patient self-management	Engaging patients and families in managing their health and making decisions about their care	Patient participation in diabetes and/ other chronic disease self-management education Assess diabetic patients' status with self-management goal at each visit with a healthcare provider Multi-disciplinary, family-based childhood obesity treatment	Assessment: Identify the barriers and gaps in access to self-management education Assurance: Healthcare--Self-management education provided by pharmacists (P3 program); childhood obesity treatment Community--Stanford model Chronic Disease Self-Management Program, Worksite--self-management education as part of health risk assessment and feedback; P3 at State Center for State employees Policy: Explore healthcare system or other sustainable financing for self-management education including prediabetes Explore financial incentives for patients to manage their own care

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Activities and Systems Changes for Addressing Strategies*
Enhance infrastructure for DHMH leadership and evaluation	Leveraging of public and private initiatives	Ensuring that resources are maximized	Coordinate public and private initiatives throughout Maryland and with national initiatives	Assessment: Identifying public and private sector initiatives in childhood obesity, heart disease, cancer, stroke, COPD, diabetes, and other IOM priority areas; Assurance: Enhance DHMH infrastructure for chronic disease prevention Policy: Coordination of community benefits provided by non-profit hospitals
	Data collection	Ensuring that all activities are data-driven	Benchmark Maryland data to national data Use the RE-AIM evaluation framework to evaluate progress and allow for course corrections (Reach, Efficacy/ Effectiveness, Adoption, Implementation, Maintenance)	Assessment: Produce a Chronic Disease Report Card for Maryland by consolidating disparate data bases with special attention to disparities, local differences, and diseases with common risk factors Assurance: Enhance DHMH infrastructure for assessment Policy: Standardization of data collection to permit aggregated analysis

(Wellness and Prevention DHMH staff responsible for research , writing, and ID implementation partners except actions marked with * to be addressed by Primary Care or Hospital Workgroup DHMH staff)

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Activities and Systems Changes for Addressing Strategies*
Enhanced delivery of high-priority preventive services and care management	Dissemination of evidence-based information on prevention and treatment	Creating a healthcare system that prioritizes prevention and improves delivery of evidence-based treatment	Identify prediabetics and translate the Diabetes Prevention Program into practice for those with prediabetes Delivery of the underused high-priority preventive services including aspirin prophylaxis, colorectal cancer screening, and tobacco cessation Treatment to target for high blood pressure, high cholesterol, and diabetes Receipt of appropriate diabetes-specific screening for diabetics (eye, feet)	Assessment: Identify current rates of delivery of high-priority preventive services and treatments Identify current rates of aspirin use, blood pressure control, cholesterol control, diabetes control, eye screening, foot screening, goal-setting, and smoking among diabetics Assurance: Community or worksite—availability of DPP Healthcare—Expanding existing public health services to include screening and treatment for obesity, hypertension, dyslipidemia, diabetes Healthcare—Continuous Quality Improvement with MidAtlantic Association of Community Health Centers *Healthcare--Academic detailing at the primary care provider practice level to implement Chronic Care Model *Healthcare—Improving medical education on high-priority preventive services and chronic care management Policy: Coverage of evidence-based preventive services Coverage of therapeutic lifestyle change (DPP) for prediabetics
	Information technology that supports care management	Supporting care management through information technology	Use IT to implement patient and provider reminder systems Use technology to improve access to care Use IT to manage patient populations and target interventions	Assurance: *Healthcare—MHCC's CMS demonstration project for creating Health Information Exchanage *Healthcare—Using IT infrastructure and care coordination to prevent rehospitalization and ER visits (Get With the Guidelines, explicit provider-to-provider handoff for care transitions) Worksite—State Center and others use P3/Healthmap Rx to promote coordination with Medical Home Policy: Telemedicine
	Linking financing mechanisms and performance measures	Providing incentives for evidence-based care	*Evaluate effectiveness of incentives for providers for providing evidence-based care	Policy: *Incentives for delivering high-priority preventive services and chronic disease treatments(Pay-for-Performance) *Promoting Patient-Centered Medical Home principles in collaboration with payors

(Wellness and Prevention DHMH staff responsible for research , writing, and ID implementation partners except actions marked with * to be addressed by Primary Care or Hospital Workgroup DHMH staff)