Chronic Disease (CD)

A chronic condition is a health condition or disease that is long-term and affects a person's quality of life over time. Chronic illnesses included heart disease, cancer, stroke, lung diseases such as asthma and Chronic Obstructive Pulmonary Disease (COPD), and diabetes. Many chronic diseases are caused by risk behaviors including unhealthy eating, inactive living, and tobacco use. When communities focus on strategies to prevent chronic diseases and control complications associated with them, they improve population health and minimize the financial burden associated with chronic diseases.

This section outlines the **Chronic Disease Objectives** which will be monitored over time by HSMP in order to measure local health improvement as well as examples of evidence-based strategies that can be or are currently being implemented to prevent and control chronic diseases among St. Mary's County residents.

Chronic Disease Objectives

CD 1: Reduce the percentage of adolescents who currently use tobacco products.

	County Baseline	County 2026 Target
Current (during past 30 days) use of any tobacco product by high school students	38.2%	34.4%

Source: YRBS, 2018

CD 2: Reduce the percentage of residents who are considered overweight and obese.

	County Baseline	County 2026 Target
Percentage of adults who are at a healthy weight*	25.4%	27.9%
Percentage of high school students who are considered overweight**	16.2%	14.6%
Percentage of high school students who are considered obese**	14%	12.6%

*Source: BRFSS, 2018
**Source: YRBS, 2018

CD 3: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes.

	County Baseline	County 2026 Target
Age-adjusted prevalence of diabetes*	10.6%	9.9%
Age-adjusted incidence rate of diabetes (per 1,000 population)**	10	9
Rate of emergency department visits due to diabetes (per 100,000 population)***	4,032.2	3,629

*Source: CDC Division of Diabetes Translation, United States Diabetes Surveillance System, 2018
**Source: CDC Division of Diabetes Translation, United States Diabetes Surveillance System, 2017
***Source: CRISP, 2017 *(Please note: This data, including baseline and target, have been updated in 2022 to reflect data from CRISP. Previously data was being utilized from the Maryland SHIP Dashboard)*

CD 4: (Developmental) Reduce racial disparities in chronic disease control and prevention.

CD 5: Help people get recommended preventive health care services.

	County Baseline	County 2026 Target
Percentage of adults who had a routine checkup in the past year	74.7%	82.2%

Source: BRFSS, 2018

CD 6: Improve health, fitness, and quality of life through regular physical activity.

	County Baseline	County 2026 Target
Percentage of residents who have adequate access to exercise opportunities*	76.6%	84.7%
Percentage of youth reporting at least 60 minutes of daily physical activity per week**	39.2%	43.1%
Percentage of physically active adults***	49.5%	54.5%

*Source: County Health Rankings & Roadmaps, 2010 & 2019
**Source: YRBS, 2018
***Source: BRFSS, 2018

CD 7: Improve cardiovascular health.

	County Baseline	County 2026 Target
Rate of emergency department visits due to hypertension (per 100,000 population)	8,853.5	7,968.2

Source: CRISP, 2017 *(Please note: This data, including baseline and target, have been updated in 2022 to reflect data from CRISP. Previously data was being utilized from the Maryland SHIP Dashboard)*

CD 8: Reduce the occurrence of asthma complications.

	County Baseline	County 2026 Target
Rate of emergency department visits due to asthma (per 10,000 population)	68.1	61.3

Source: HSCRC Research Level Statewide Outpatient Data Files, MD SHIP, 2017

CD 9: Reduce new cases of cancer and cancer-related illness, disability, and death.

	County Baseline	County 2026 Target
Incidence rate of cancer (per 100,000 population)*	440	396
Death rate due to cancer (per 100,000 population)**	167.7	150.9

Source: Centers for Disease Control and Prevention and National Cancer Institute, U.S. Cancer Statistics Data Visualizations Tool, *2013-2017, **2016-2018

Chronic Disease Strategies

Action Team Level

- Develop a resource guide of quit tobacco resources and promote a variety of cessation resources.
- Educate the community on the risks of secondhand and thirdhand smoke exposure.
- Address tobacco-related disparities.
- Increase the number of lifestyle change programs available in the community and promote programs that are already available.
- Expand the implementation of healthy cooking, teaching kitchens, and healthy eating education and skill-building opportunities.
- Collaborate with partners to establish support groups for people with diabetes.
- Support education around language disparities, health literacy, and health equity.
- Support insurance education and enrollment efforts.
- Conduct asset mapping and gap analysis of local exercise opportunities.
- Promote local exercise opportunities and facilities.
- Promote regular monitoring of blood pressure.
- Support community-wide media campaigns and programs to promote increased fruit and vegetable consumption and healthy diets.
- Support community-wide education and awareness on hypertension.
- Promote Green & Healthy Homes initiative and host trainings for parents.
- Collaborate with partners to establish support groups for people with cancer.
- Promote cancer screenings including home screenings.
- Support community-wide education on cancer risk factors.
- Establish a Food Prescription program.
- Expand the More to Explore program to include nutrition programs and education.

Organization-Specific Strategies

- Expand on peer prevention strategies. *(SMCPS, SMCM, CSM, SMCHD)*
- Host educational events for local youth that promote the experiences of someone who has quit smoking on their journey. *(SMCHD, SMCPS)*
- Promote pre-diabetes screening. *(Clinicians, SMCHD, MSMH, DAHS)*
- Expand case management programs for chronic diseases. *(MSMH, Clinicians, MCOs)*
- Engage community health workers (CHWs) to educate the community on chronic diseases. *(SMCHD)*
- Provide training for healthcare clinicians on cultural competency/health disparities. *(MSMH, SMCHD)*
- Expand access to telehealth services. *(Clinicians)*
- Promote local transportation assistance programs and advocate for decreased restrictions on these programs. *(MSMH, SMCHD, DPW&T)*
- Identify funding sources for outdoor fitness equipment. *(Recreation & Parks)*

- Expand options and promote existing after-school exercises and clubs. *(SMCPS, Private Schools)*
- Promote medication compliance for chronic diseases (hypertension, diabetes, etc.). *(Clinicians, MSMH, SMCHD)*
- Support community-wide education on seasonal asthma triggers. *(SMCHD)*
- Encourage all asthma patients to have a rescue inhaler. *(Clinicians, SMCHD)*
- Improve access to nutritional education and counseling for children and adults. *(MSMH, SMCHD, University of Maryland Extension)*

Community Member Strategies

- Advocate for more effective tobacco control policies.
- Advocate for more tobacco-free environments in St. Mary's County.
- Increase the number of businesses in St. Mary's County registered in the Healthiest Maryland Businesses initiative.
- Advocate for funding for translation support services.
- Advocate for increased insurance coverage for preventative screenings.
- Advocate for funding for new exercise opportunities and facilities.
- Advocate for Complete Streets.
- Incorporate floor activity stickers into schools, businesses, and workplaces.
- Promote healthy coping skills and mindfulness that are proven to reduce blood pressure.
- Improve community knowledge and understanding of palliative care.