Amendment 35 Cancer, Cardiovascular and Pulmonary Disease Grants Program

Strategy Specifications and Metrics for FY 2016-18

Introduction to Analytic Framework

The following framework is designed to provide consistency throughout the Cancer, Cardiovascular and Pulmonary Disease (CCPD) approved strategies to be implemented during the FY 2016-18 grant funding cycle. It identifies specific objectives, outcomes and intervention methods applicable to each strategy, and should serve as a guide for grantees as each strategy is implemented and evaluated. Below are brief explanations of the core language used throughout the framework.

CCPD Approved Strategy is an overall goal or prioritized area of work for the FY 2016-18 grant cycle.

Objectives specify expected program results to be achieved over a defined period of time.

Process Measures provide supporting evidence for the proper implementation of the program.

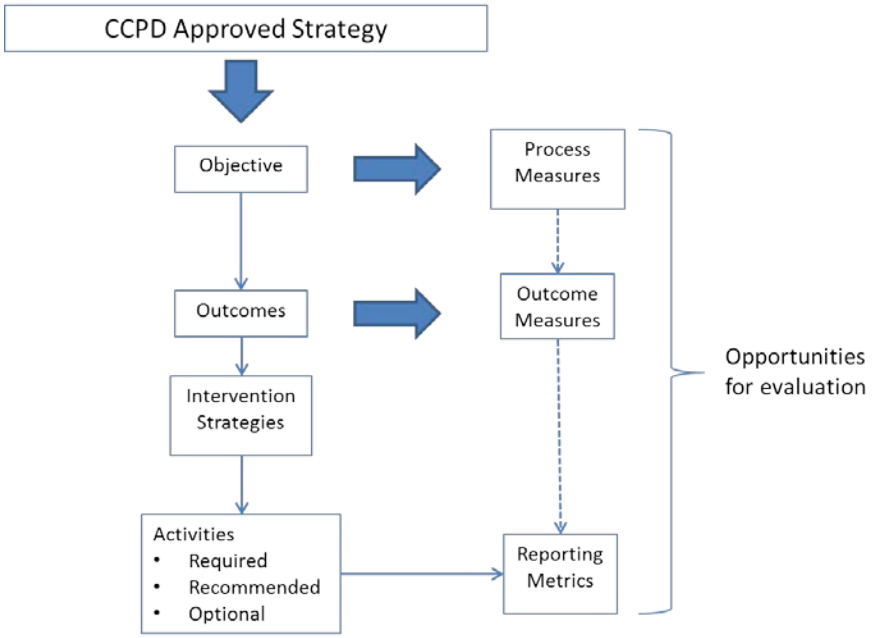
Outcomes specify expected impact of the program on specific health measures and/or individual behaviors over a defined period of time.

Outcome Measures provide supporting evidence for the impact of the program on specific health measures and/or individual behaviors.

Intervention Strategies are recommended, evidence-based plans of action to achieve specific objectives and/or outcomes.

Activities are required, recommended or optional actions to achieve the established objectives and/or outcomes.

Reporting Metrics provide supporting evidence concerning the reach, implementation and completion of specific program activities.



CCPD HEAL Strategy #1: Built Environment

Regional, county, or municipal policies that lead to the development of enhanced access to walking, biking and other physical activity.

Intended Population:
County or municipal populations

Objectives and metrics
[***Outcomes*** are in ***underlined bold italic*** typeface.]

1. **Objective**: By year 1, the grantee will facilitate formation and operation of an ***Active Living Coalition*** that represents community residents, including low-income residents and residents facing health disparities, and community institutions (schools, businesses, faith communities, employers, local government, etc.).

   Process Measures:

   (accountability) Coalition member letters of commitment, meeting attendance.

   (reach) Description of coalition members and assessment of coalition members' values and perceptions of HEAL strategies.

   (implementation quality) Coalition effectiveness survey

   Intervention Strategies:

   - Identify core group of coalition members who are representative of community stakeholders and share a demonstrated interest in improving the built environment.
   - Develop an organizational document for the Active Living Coalition that includes mission and vision statements, meeting schedules, project timeline, etc.

2. **Objective:** By year 1, the Coalition will conduct a comprehensive assessment (inventory) of built-environment policies and infrastructure that affect active living choices, and produce a ***document*** that identifies existing resources and gaps including supporting media such as videos, web-based maps and photo voice.

   Process Measures:

   (accountability) descriptions of search strategies, annotated list of policies and built-environment infrastructure assessed.

   (implementation) List of positive and negative forces in the community to promote or hinder the adoption of an Active Living Plan.

   Intervention Strategies:

   - Conduct a formal needs assessment and an evaluation of conditions of existing built environment infrastructure in a designated community, including resources and limitations. This assessment can include measures of community walkability, still images and video of the existing built environment issues, maps of existing resources, and other media.
   - Inventory existing built environment guidelines in current zoning and development statutes.

3. **Objective**: By year 2, the Coalition will develop and adopt an ***Active Living Plan*** that recommends improvements in built-environment policies and infrastructure based on documented resources and gaps from the needs assessment.

   Process Measures:

   (accountability) Coalition will adopt the plan.

   (implementation) Documentation of the process implemented to draft the Active Living Plan including challenges and strategies to overcome barriers.

   (implementation) Policy analysis of Active Living Plan in terms of public acceptance and political feasibility

   Intervention Strategies:

   - Develop and prioritize a list of recommended, evidence-based built environment strategies to advance active living such as, but not limited to: complete streets, enhanced sidewalk/trail network, pedestrian-friendly design and land use policies, park development and access, shade, joint use agreement, crime prevention for parks, traffic calming and smoke-free parks and trails *.
     *Note: While applicants will not receive funding through CCPD to implement or operationalize smoke- free policy, there is an expectation to link a community's existing or concurrent evidence-based smoke-free policies to built environment strategies.

4. **Objective**: By year 3, the Coalition will seek adoption and implementation of Plan recommendations by appropriate decision-makers, such as developers, local government, worksite managers, etc.

   Process Measures:

   (accountability) number and scope of adopted and/or implemented recommendations.

   (reach) perceived change in quality of relationship with decision makers and/or change in number of supportive decision makers as a result of coalition activities.

   Intervention Strategies:

   - Develop an active living toolkit that focuses on health consequences of built environment policies and infrastructure for local government decision makers to use in the review of zoning changes and development proposals.
   - Work with local government and community leaders to identify funding sources for improvements to existing built environment resources.

5. **Objective**: By year 3, the Coalition will develop and implement ***a communication and engagement plan*** to promote increased physical activity and active transportation, improved attitudes towards physical activity, and increased perceptions of safety.

   Process Measures:

   (accountability) media impressions, other measures of communication contact

   Intervention Strategies:

- Develop social media campaigns highlighting the importance of and opportunities for physical activity and active transportation
- Hold community meetings sponsored by coalition members and partner organizations
- Organize community events to promote physical activity, perceptions of safety

Activities

Required

- Develop and prioritize a list of recommended, evidence-based built environment strategies to advance active living, such as: complete streets, enhanced sidewalk/trail network, pedestrian-friendly design and land use policies, park development and access, shade, joint use agreements, crime prevention measures for parks, and traffic calming.
- Assess economic, political, equity and environmental sustainability of recommended built environment strategies and develop a funding plan to identify financial resources to implement built environment strategies (e.g., in the capital budget, bonds, grants, etc.).
- Assess the potential public health effects of the Active Living Plan and policies by identifying appropriate metrics and tools such a Health Impact Assessment.

Optional

- Experienced applicants may propose to provide technical assistance to communities with less capacity and experience in implementing built environment strategies to enhance active living.

Reporting Metrics

- County level obesity prevalence, physical activity levels and melanoma levels
- Municipal level data on socio-economic, demographic and health disparities.
- Short term - # of local planning documents scanned for inclusion of active living and shade policies to promote pedestrian experience, safety , and (E.g., comprehensive plan, parks and recreation plan, bike and pedestrian plan, complete streets plan)
- # of documents developed as tools for decision makers to connecting active living policies already in existence
- # of stakeholders engaged to inform built environment policy to enhance access to and availability of physical activity opportunities
- # assessments of built environment existing conditions (e.g., Map trail, park, play, physical activity locations: assess walkability and bikeability, safe routes to schools; identify limitations of the built environment and infrastructure for physical activity such as sidewalk conditions and traffic speed)
- Results of community needs assessment for active **l**iving
- # of opportunities identified active living education/promotion and policy development/ enhancement
- # of recommended evidence-based built environment strategies to advance active living
- Results of sustainability assessment of recommended built environment strategies
- # of policies with language drafted for built environment strategies to enhance equitable access to and availability of physical activity opportunities (community-scale, neighborhood scale, street-scale, etc.)
- # Active Living plans formally adopted

- # Active Living plan policies adopted in comprehensive plan
- # of funding sources identified to implement built environment strategies and policies
- # of funding plans developed to implement high priority built environment strategies and policies
- # of active living communication and engagement plans developed
- # of strategies from active living communication and engagement plan implemented
- # of evaluation tools developed to track the status of built environment recommendations, policies, projects, events, and programs including results of health impact assessment
- Long-term: infrastructure changes
- Long term: - increased access to quality physical activity opportunities
- # of budget allocations for improvements to existing parks, playgrounds , sidewalks, streets or trail networks to improve quality.
- # of budgets or dollars reprioritized to avoid closing or limiting hours at parks or recreation centers making it more difficult for residents to be physically active.

Exclusions
NA

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Physical Activity Guidelines for Americans Midcourse Report Subcommittee of the President's Council on Fitness, Sports & Nutrition. *Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity Among Youth.* Washington, DC: U.S. Department of Health and Human

Services, 2012. Retrieved from http://www.health.gov/paguidelines/midcourse/pag-mid-course-report-final.pdf

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CCPD HEAL Strategy #2: Breastfeeding-Friendly Environments
Policies and programs (regional, municipal, private sector) that protect, promote and support breastfeeding-friendly environments

Intended Population:
County or municipal settings, public venues, health care providers (e.g., hospitals, primary care clinics), child care providers serving predominantly low income children, and employers with predominantly hourly workers.

Objectives and metrics
[***Outcomes*** are in ***underlined bold italic*** typeface.]

1. **Objective**: By year 3, the grantee will seek adoption and implementation of ***written breastfeeding policies*** by appropriate decision-makers to create environments in worksites and childcare settings that promote and sustain breastfeeding among the target population.

   Process Measures:
   (accountability) Number and scope of adopted and implemented policies.

   (implementation quality) Compliance with and fidelity to adopted policies.

   Intervention Strategies:

   - Assessment of current policies and practices among target employers and childcare providers.
   - Work with key decision-makers to identify opportunities to encourage and protect breastfeeding in public venues and workplaces (e.g., creation and maintenance of "mothers' rooms" for breastfeeding in public venues).
   - Encourage and develop a recognition program for child care centers that implement model policies and practices to supporting breastfeeding families.
   - Provide technical assistance to employers to support their compliance with the Colorado Workplace Accommodation for Nursing Mothers Act.

2. **Objective**: By year 3, the grantee will implement ***continuity-of-lactation-care initiatives*** that link maternity facilities and community providers to support breastfeeding families.

   Process Measures:
   (accountability) Number and type of initiatives successfully launched.

   (reach) Description of partners committed to participate in and/or support initiatives.

   (reach) Number and characteristics of end-users (i.e., breastfeeding mothers) served.

   (implementation) Assessment of community resources to support and sustain initiatives.

   Intervention Strategies:

   - Inventory of current lactation resources within a given community including existing resources, potential barriers, provider interest, and sustainability assessment.

- Convene a task force of individuals representing public and primary care clinics, hospitals, and others to develop a referral system to enhance continuity of lactation care between community providers and maternity facilities.
- Evidence-based activities that establish partnerships among existing community social and health-related resources and facilitate the creation of new resources for continuous, integrated post-partum lactation support, such as peer-led breastfeeding support groups, collaborative initiatives linking community providers to lactation experts, and education initiatives for obstetric, pediatric, family practice, and midwifery providers to increase knowledge and skills directly related to breastfeeding management.

Activities

Recommended

- Assess existing accommodations for breastfed children in a targeted group of child care centers that serve predominantly low income children and for breastfeeding mothers in a targeted group of employers that employ predominantly hourly workers.
- Participate as a community member on a committee of a hospital in the process of becoming designated Baby-Friendly in the local community.

Optional

- Develop or strengthen programs to provide peer support by identifying community based organizations that can provide a site and a facilitator for breast feeding support groups.

Reporting Metrics

- # of stakeholders engaged in local breastfeeding coalition
- # of public venues where large number of people congregate (e.g. airport, malls, sports arenas, amusement parks, churches, pools, fair grounds) that provide and publicize a designated private space for mothers to breastfeed if they choose not to publicly
- # of (or portion of) targeted child care providers that implement written policies to support breastfeeding families
- # of (or portion of) targeted employers that provide space and time for mothers to express breast milk
- # of targeted employers with written policies that describe workplace accommodation for nursing mothers
- # of (or portion of) birthing facilities in the county or defined community certified Baby-Friendly

Exclusions

NA

References

Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases: *The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies*. Atlanta: U.S. Department of Health and Human Services; 2013.

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CCPD HEAL Strategy #3: Healthy Food Retail

Technical assistance at the county and municipal level that supports access to healthier food retail in underserved areas.

Intended Population

Colorado communities with low levels of access to healthy food retail establishments

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic*** typeface.]

1. **Objective**: By year 1, the grantee will facilitate the formation and operation of a ***Healthy Food Retail Coalition*** that represents community residents, including low-income residents and residents facing health disparities, food retailers, and community institutions (such as schools, businesses, faith communities, employers, local government, etc.).

   Process Measures:

   (accountability) Coalition member letters of commitment and meeting attendance.

   (reach) Description of coalition members and assessment of coalition members' values and perceptions of HEAL strategies.

   (implementation quality) Coalition effectiveness survey.

   Intervention Strategies:

   - Identify and recruit a core group of coalition members who are representative of community stakeholders and share a demonstrated interest in improving retail access to healthy food options.
   - Develop an organizational document for the Healthy Food Retail Coalition that includes mission and vision statements, meeting schedules, project timeline, criteria for participation on the coalition, etc.

2. **Objective**: By Year 3, the coalition and its technical assistance provider will ***increase the availability of healthy and affordable foods in small retail food stores in underserved communities*** and produce a document that identifies changes implemented in the retail environment, and identifies existing resources and gaps.

   Process Measures:

   (accountability) Description of types and extent of changes implemented in retail food stores in targeted communities, such as inventory, product placement and store layout changes, capital improvements, merchandising and promotional activities, and other activities designed to increase supply and stimulate demand for healthy food at retail store locations.

   (reach) Number and description of stores partnering with coalition to adopt and promote healthy food retail changes.

   (reach) Number of stores adopting and implementing changes to retail environment to increase access to and promote healthy eating options.

Intervention Strategies:

- Assist small retail store owners in creating healthy retail stores by conducting store assessments, developing store improvement plans and providing tailored technical assistance as needed.
- Link small retail store owners to funding resources for healthy food financing such as the Healthy Food Financing Initiative (HFFI), Colorado Fresh Food Financing Fund (CO4F) or similar funding, and assist retailers with application process.
- Link small retail stores to SNAP/WIC programs, and provide resource materials and technical support during the application process to participate as a vendor for these programs.
- Identify alternative sources for healthy foods for small retail stores such as aggregation/distribution centers, food hubs, farmers' markets, co-operatives, mobile markets and farm-to-table programs.
- Support community and economic development efforts to sustain healthy food retail stores in underserved communities.

Activities

Recommended

- Identify and recruit food retailers to participate in healthy food retail initiatives.
- Assess and evaluate availability of and demand for healthy food options among small retail food stores using store audits, customer surveys and other tools.
- Measure store owner perceptions, knowledge, and level of support for increased healthy food options through interviews and other tools.
- Provide tailored technical assistance to small retail food stores based on assessments and store improvement plans , including:
    - Healthy food inventory changes, product placement, store design, merchandising and promotional activities, infrastructure changes, capital improvements, and other changes as recommended.
    - Culturally-appropriate resources and outreach activities such as in-store healthy food education and promotion activities.
    - Fresh food procurement, handling and storage best-practices.
    - Other evidence-based support activities that improve small retail stores' capacity to handle, store, place, and promote healthier food and beverages.
- Support, as appropriate, policy development and advocacy initiatives sponsored by the coalition.
- Facilitate and promote positive media coverage of initiatives and activities at the local and regional level, in cooperation with the coalition.

Optional

- Preference will be given to programs and/or grantees serving rural or low income communities

Reporting Metrics

- Number of persons within targeted areas
- Number of stores receiving assistance

- Types of assistance provided
- Number of stores participating in program activities
- Number of stores that improve inventory/marketing of healthy food and beverages
- Number of agency partners engaged in healthy food retail initiatives

Exclusions
NA

References

Centers for Disease Control and Prevention, 2013. Access to Healthier Food Retailers – United States, 2011. MMWR 2013; 62 (Suppl 3): 20-26.

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CCPD HEAL Strategy #4: Healthy Food and Beverages

Regional, county, municipal, and/or private institutions will adopt and implement policies that support the consumption of healthy foods and beverages in government settings, hospitals, and other public venues.

Intended Population

(1) Adults, children and youth ages 0-18.

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic*** typeface.]

1. **Objective**: By year 1, the grantee will facilitate the formation and operation of a ***Healthy Foods and Beverages Steering Committee*** that represents community residents, including low-income residents and residents facing health disparities, and community institutions (schools, businesses, faith communities, employers, local government, etc.).

   Process Measures:

   (accountability) Steering Committee member letters of commitment and meeting attendance.

   (reach) Description of Steering Committee members and assessment of committee members' values and perceptions of HEAL strategies.

   (implementation quality) Steering Committee effectiveness survey.

   Intervention Strategies:

   - Identify core group of Steering Committee members who are representative of community stakeholders and share a demonstrated interest in increasing the availability of healthy foods and beverages in government settings schools, hospitals, and other public venues.
   - Develop an organizational document for the Steering Committee that includes mission and vision statements, meeting schedules, project timeline, criteria for participation on the committee, etc.

2. **Objective**: By year 1, the Steering Committee will conduct a comprehensive community assessment of existing food and beverage policies or practices in one or more of the following settings: government, hospitals or public venues and produce a ***written summary of such assessment.***

   Process Measures:

   (accountability) Descriptions of search strategies and annotated list of policies and practices assessed.

   (implementation) List of positive and negative forces in the community and among potential partners that could potentially promote or hinder adoption and implementation of healthy food and beverage policies.

   Intervention Strategies:

   - Conduct a baseline assessment of foods and beverage offerings in vending and concessions operations.
   - Conduct a baseline assessment of food procurement policy and practice.

- Coordinate with existing Colorado initiatives (e.g., Colorado Healthy Hospital Compact, HEAL Cities Campaign, etc.) to inform baseline assessments and Steering Committee's recommendations.

3. **Objective**: By year 2, the Steering Committee will adopt a ***model healthy food and beverages policy*** based on existing evidence-based policy guidelines that focuses on access to free drinking water, limits sugar-sweetened beverages and unhealthy foods, and includes implementation guidelines for vending and concessions.

   Process Measures:

   (accountability) Steering Committee will adopt the policy.

   (accountability) Steering Committee will describe how the model policy meets or exceeds minimum standards as described in the Health & Sustainability Guidelines for Federal Concessions and Vending Operations (HHS/GSA) or other evidence-based policies.

   Intervention Strategies:

   - Identify and select evidence-based nutritional standards or guidelines to inform policy development and implementation.
   - Identify a list of recommended, evidence-based strategies to advance adoption of healthy food and beverage policies.

4. **Objective**: By year 3, the grantee (Steering Committee) will seek adoption and implementation of policy guidelines by appropriate decision-makers such as government(s) and hospitals.

   Process Measures:

   (accountability) Number and scope of adopted and/or implemented recommendations.

   (reach/outcome) Perceived change in quality of relationships with decision makers and/or change in number of supportive decision makers as a result of steering committee activities.

   Intervention Strategies:

   - Implement evidence-based nutritional standards in vending and/or concessions.
   - Provide technical assistance to modify vender contracts so that at least 50% of options are healthy in accordance with evidence-based nutritional standards or guidelines.
   - Modify promotional policies covering, e.g., pricing, signage, displays, advertisements, flyers, and email blasts, to promote healthy foods and beverages.

5. **Objective**: By year 3, the grantee (Steering Committee) will develop and implement a ***communications and engagement plan*** to provide evidence-based activities, events, and/or educational materials to promote the consumption of healthy foods and beverages that are in support of proposed policy changes.

   Process Measures:

   (accountability) Media impressions and other measures of communication contact.

   (implementation quality) Fidelity to engagement plan during implementation.

   (outcomes) Measures of attitudes, knowledge, and behavior change as a result of engagement.

Intervention Strategies:

- Partner with target organizations,venues, and/or population groups to launch print and social media campaigns to advertise policy changes and promote healthy food and beverage choices.
- Organize community events with partner organizations to promote healthy food and beverage choices and are in support of policy or practice changes

Activities

Required

- Develop and adopt a phased approach to increase the consumption of healthy foods and beverages and to decrease the availability and consumption of unhealthy foods and beverages based on evidence-based practices and guidelines
- Ensure that free drinking water is available in government settings, hospitals or public venues
- Pilot a healthy foods and/or beverages program following evidence-based practices and guidelines
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Recommended

- Work with vendors and concessions to adjust prices to encourage purchase and consumption of healthy foods and beverages; offer discounts and promotions only for healthier items in vending and concessions operations.
- Implement a system such as the stoplight system or other modification to identify healthier foods and beverages in vending and concessions operations.
- Eliminate use of trans fats in food preparation and remove all fryers and deep fat fried products from the cafeteria menu.
- Remove prepackaged food items containing trans fats from vending and concessions operations.
- Form a youth coalition(s) to conduct peer education and outreach on the advantages of water consumption and the health effects of unhealthy food and beverage consumption.

Optional

Applicants with demonstrated experience and success in this strategy may submit an application to provide technical assistance to local governments or hospitals that have less capacity and experience in this strategy.

Reporting Metrics

- Number of stakeholders engaged in reducing prevalence of sugar-sweetened beverages and unhealthy foods
- Number of policies restricting access to sugar-sweetened beverages
- Number of policies restricting access to unhealthy foods
- Number of policies increasing access to free drinking water
- Number of policies increasing access to healthy foods
- Comparison tools tracking purchases of healthier foods/beverages in relation to unhealthy foods/beverages
- Number of individuals reached through targeted outreach
- Number of venues implementing healthy checkouts

- Number of settings (hospital, government) that develop and/or adopt policies to implement food service guidelines, including sodium (cafeterias, vending, snack bars)
- Number of individuals who are impacted by the settings (public, hospital, government) that have developed and/or adopted policies to implement food service guidelines, including sodium

Exclusions
NA

References
California Center for Public Health Advocacy (n.d.). *Kick the can*. Retrieved from http://www.kickthecan.info/.

Center for Science in the Public Interest (n.d.). *Life's sweeter with fewer sugary drinks*. Retrieved from http://fewersugarydrinks.org/index.html.

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U.S. Department of Health and Human Services (n.d.). *Health and sustainability guidelines for federal concessions and vending operations*. Retrieved from http://www.cdc.gov/chronicdisease/pdf/Guidelines_for_Federal_Concessions_and_Vending_Operations.pdf.

CCPD HEAL Strategy #5: Comprehensive Worksite Wellness

Regional, county, municipal, and/or private employer adoption of comprehensive worksite wellness that combines physical activity and healthy eating.

Intended Population

All employed adults, including straight-to-work youth ages 18-21 years, with a focus on rural and frontier communities and small businesses

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic*** typeface.]

1. **Objective:** By year 1, the grantee will facilitate the formation of a ***Worksite Wellness Coalition*** and/or ***trained corps of Worksite Wellness Advisors*** that is representative of worksite employee populations and/or demographic characteristics of the target population, including low-income residents and residents facing health disparities, and inclusive of community institutions (schools, faith communities, local government, small, medium, and large businesses/employers, etc.). Grantees are encouraged to consider approaches that involve cross jurisdictional collaboration, sharing of resources and planning.

   Process Measures:

   (accountability) Coalition member letters of commitment, meeting attendance.

   (reach) Description of coalition members and assessment of coalition members' values and perception of worksite wellness strategies.

   (reach) Number and description of Advisor Corps members.

   (effectiveness) Measures of minimum knowledge, attitudes and skills for Advisors Corps.

   (implementation quality) Advisor Corps' effectiveness survey.

   (implementation quality) Coalition effectiveness survey.

   Intervention Strategies:

   - Identify core group of coalition members who are representative of community stakeholders and share a demonstrated interest in improving wellness and health promotion in community worksites.
   - Develop an organizational document for the Worksite Wellness Coalition that includes mission and vision statements, meeting schedules, project timeline, etc.
   - Identify group of potential Advisors who are representative of stakeholders and have demonstrated knowledge and/or capability to promote worksite wellness.
   - Develop an organizational and training document to establish minimum knowledge base for Advisor corps members and measure training milestones.

2. **Objective**:
   By year 1 or 2, Advisor Corps and/or Coalition will conduct a comprehensive assessment that will include information on: resources, gaps, needs, potential funding resources and sustainability

mechanisms, current policies or practices that promote healthy eating, active living and prevent chronic disease for employees in local/regional worksites and produce a ***written summary of such assessment***.

Process Measures:

(accountability) Description of search strategies, programs, vendors, providers, services/resources, and annotated list of policies or practices assessed.
(implementation) List of positive and negative forces within the community and among potential partner employers that might influence employer adoption of worksite wellness and worksite wellness policies.

Intervention Strategies:

- Coordination of Advisor Corps' worksite wellness efforts with local resources including public health agencies and Small Business Development Center Network regional offices.
- Conduct the comprehensive assessment to document and gain understanding of local/regional context for worksite wellness, healthy eating, active living and prevention of chronic disease and related gaps, resources, funding sources and sustainability mechanisms, practices and policies to inform coalition and/or Advisor Corps work with local/regional employers and partners.

3. **Objective:** By year 2, Advisor Corps and/or Coalition will use the local/regional comprehensive assessment (conducted in objective 2.1) to produce or adopt /enhance an existing online, searchable ***community resource database*** and develop a local/regional **Worksite Wellness Plan** that includes recommendations and strategies to increase employer adoption of worksite wellness policies, reduce barriers, and strengthen local policy supports.

Process Measures:

(accountability) Development and/or adoptionof existing database with functional search capability.
(accountability) Coalition will adopt a worksite wellness plan.
(implementation) Documentation of the process implemented to draft the Worksite Wellness Plan including challenges and strategies to overcome barriers.

Intervention Strategies:

- Develop and prioritize a list of recommended, evidenced based strategies to advance healthy eating and active living in worksites such as, but not limited to: active transportation, flexible work scheduling, healthy meeting policy, free or reduced cost access to onsite or nearby fitness, health insurance and benefit structure, and family inclusive policies.

Optional: Objective 4.1 is only required if grantee implements Advisor Corps

4. **Objective**: By year 1 or 2, Worksite Wellness Advisors will coordinate with employers to develop and implement employer-specific ***worksite wellness engagement plans*** outlining worksite wellness improvement recommendations such as: policies or practices, changes/enhancements to infrastructure and built environment, or other evidence-based improvements or programs for employees.

Process Measures:

(reach) Number and description of employers adopting worksite wellness engagement plans and worksite wellness policies.
(accountability) number and scope of adopted and/or implemented recommendations and description of worksite wellness engagement plans adopted by employers.
(implementation quality) Assessment of employers' perception of Advisors' effectiveness.
(outcome) Measures of change to infrastructure, policy and built environment as a result of employer adoption of engagement plan [Measures of change at the individual level, i.e., observed or self-reported physical activity, requires external evaluation resources and may not be feasible for grantee collection].

Intervention Strategies:

- Provide technical assistance to employers, including:
  - Conducting preliminary assessment of extent of interest in worksite wellness program and employer capacity to support evidence-based initiatives.
  - Implementing Worksite Wellness Engagement Plan including developing model organizational policies that support worksite wellness best practices combining physical activity and healthy eating.
  - Linking employers to existing local and regional resources to support worksite wellness efforts.
- Address employee policies, infrastructure and built environment to encourage participation in physical activity, such as wellness break policy, flex time policy, onsite access to physical activity, walking meetings, and active transportation.
- Conduct baseline assessment of resources, barriers, and challenges to adopting worksite wellness plan including food and beverage offerings in vending and concessions operations.
- Recommend policies to ensure that free drinking water is available to all employees.
- Propose alternative evidence-based Worksite Wellness policy recommendations including those that may overlap with other public health priority areas such as, but not limited to: access to affordable health care, prevention of communicable disease, injury prevention, safety, mental health, and Healthy Eating Active Living or Cardiovascular and Chronic Disease Prevention strategies. These may include: the adoption of a Diabetes Prevention Program (DPP) as a covered employee health benefit; the implementation of policies to protect, promote, and support breastfeeding friendly environments, e.g., written lactation accommodation policy, environment changes to encourage breastfeeding, and the availability of flex time; and the evaluation of worksite healthy food retail policies covering all internal and external vending, concessions, and cafeteria food and beverage sales.
- Work with local government and community leaders to recognize employers that effectively implement and publically document evidence of effective adoption of comprehensive worksite wellness strategies.
- Work with local government and community leaders to identify funding sources to support community adoption worksite wellness by employers.

Activities

Optional

- Experienced applicants may propose to provide technical assistance to communities with less experience and capacity in this strategy.

Reporting Metrics

- Municipal level socio- economic and demographic data
- Number of employers in target area
- Size and category of businesses in target area
- County level obesity prevalence, physical activity levels, tobacco use, immunization rates by socioeconomic status, demographics to identify any health disparities
- # employers that implement plan to increase physical activity
- # of employees who work in worksites that implement plan to increase physical activity# employers that adopt and implement food and nutrition guidelines, including sodium
- # of employees who work in worksites that have developed and/or adopted policies to implement food and nutrition guidelines, including sodium# employers that comply with state and federal accommodation of lactation in the workplace
- # employers that provide onsite access or nearby community access to the Diabetes Prevention Program
- # employees that participate in the DPP
- # employers that provide coverage for Diabetes Prevention Program as a covered benefit

Exclusions

NA

References

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CCPD Strategy #6: Provider/Clinic-based Cancer Prevention

Provider communication (PC) and clinic policy (CP) Interventions that increase uptake and adherence to nationally recognized colorectal and lung cancer screening; HPV vaccination; cancer genomics; and cancer survivorship. PC interventions include: systems for feedback, patient/provider reminders, compliance rate assessments, tracking and recall, and care coordination. CP interventions include: enhancements to written policies, clinic hours and standing orders.

Strategic Objective: By the end of year 3, provider communication (PC) and clinic policy (CP) interventions will increase uptake and adherence to nationally recognized cancer screening and vaccination guidelines.

Intended Population
Health care providers (e.g., hospitals, primary care clinics, etc.)

Objectives and Outcomes
[***Outcomes*** are in ***underlined bold italic*** typeface.]

1. **Objective:** By [Year 1, 2 or 3], compared to baseline rates (i.e. current practice), implementation of systems level approach ***to increase cancer screening (colorectal, lung) adherence among eligible clinic populations, including evidence-based collection of family history of cancer***, will increase among those clinics that have implemented a systems-level approach to cancer prevention best practices.

   Process Measures:

   - Documentation of system-level processes implemented
   - Number of clients whose family history is tracked with system-level changes to increase cancer screenings.

   Outcome Measures:

   - Annual proportion of clients eligible for cancer screening who are in adherence with USPSTF guidelines.
   - Annual proportion of clients identified as increased risk based on assessment of family history of cancer.
   - Annual proportion of clients that are in adherence with evidence-based best practices for genetic counseling and testing.

   Intervention strategies:

   - Evidence-based clinical quality improvement practices (e.g., provider reminder and recall systems).

- Evidence-based clinical decision support tools (e.g., tailored patient assessment and evidence-based treatment recommendations).
- Implement interventions using multiple strategies, such as individual-based or community-based cancer prevention (Strategy 7 and 8), and/or Patient Navigation or Community Health Worker programs (Strategy 15 and 16).

Activities:

Required

- Clinical quality improvement should follow procedures and process outlined in, "How to Increase Colorectal Cancer Screening Rates in Practice: *A Primary Care Clinician's Evidenced-Based Toolbox and Guide*," for USPSTF A/B cancer screening recommendations.
- Systems approaches should target the entire patient population eligible for screening within the system.
- Annual assessment of clinical cancer screening compliance rates for eligible populations according to USPSTF guidelines.
- Collection of comprehensive and clinically appropriate family history of cancer.
- By the end of year 3, appropriate genetic counseling and testing referral system established

Recommended

- Implementation of office policies and workflows to ensure appropriate, timely cancer screenings occur.
- Provider reminder and recall system
- Electronic Health Record reporting and workflow capacity.

Reporting Metrics:

- Assessment of a baseline cancer screening adherence rate of target clinic population using USPSTF guidelines.
- Office/Clinic/System policy & workflow
- EHR reports- annual re-assessment of cancer screening rates for relevant associated National Quality Forum (NQF) measure (i.e. Colon Cancer Screening NQF 0034)
- Common metrics will be required for genomic strategies after consultation with evaluation group.

Exclusions:

- USPSTF cancer screening guidelines that are *not* A or B

- CCPD funding may not be used to purchase or upgrade EHR systems; minor changes to existing systems may be considered only in support of larger programmatic effort.
- Strategies that are not recommended by the Community Guide

2. **Objective:** By [Year 1, 2 or 3], compared to baseline rates, ***HPV vaccinations will increase*** among those clinics that have implemented a systems-level approach to cancer prevention best practices.

Process Measures:

- Documentation of system-level processes implemented

Outcome Measures:

- Annual proportion of clients who are eligible for the HPV vaccine who are in adherence with ACIP guidelines.

Intervention strategies:

- Evidence-based clinical quality improvement practices (e.g., provider reminder and recall systems).
- Implement interventions using multiple strategies, such as patient-based or community-based cancer prevention (Strategy 7 and 8).

Activities:

Required

- Clinical quality improvement should follow procedures and process outlined in, "How to Increase Colorectal Cancer Screening Rates in Practice: *A Primary Care Clinician's Evidenced-Based Toolbox and Guide*," by applying ACIP guidelines.
- Systems approaches should target the entire patient population eligible for HPV vaccination within the system.
- Annual assessment of vaccination compliance rates for eligible populations according to ACIP guidelines.
- Participation in the Colorado Immunization Information System (CIIS)

Recommended

- Office/Clinic/System policy & Workflow
- Provider reminder and recall system
- Electronic Health Record reporting and workflow capacity.

Reporting Metrics:

- Assessment of a baseline HPV vaccination adherence rate of target clinic population using nationally recognized ACIP guidelines.

- Office/Clinic/System policy & workflow
- EHR reports- annual re-assessment of HPV vaccination adherence rates for relevant associated National Quality Forum (NQF) measure 1959 (modifiable based on target population).

Exclusions:

- CCPD funding may not be used to purchase or upgrade EHR systems; minor changes to existing systems may be considered only in support of larger programmatic effort.
- Strategies that are not recommended by the Community Guide

3. **Objective:** By [Year 1, 2 or 3], compared to baseline rates, implementation of ***patient-specific cancer treatment summary and self-management care plans*** will increase among those clinics that have implemented a systems-level approach to cancer prevention best practices.

Process Measures:

- Number of clients who are identified as cancer survivors in clinic system

Outcome Measures

- Annual proportion of cancer survivors who have a cancer treatment summary and self-management care plan on record with their primary care provider.
- Annual proportion of cancer survivors who are in adherence with evidence-based best practices within their cancer treatment summary and self-management care plans.

Intervention strategies:

- Evidence-based clinical quality improvement practices (e.g., provider reminder and recall systems).
- Evidence-based clinical decision support tools (e.g., tailored patient assessment and evidence-based treatment recommendations).
- Implement interventions using multiple strategies, such as Patient Navigation or Community Health Worker programs (Strategy 15 and 16).

Activities:

Required

- Annual assessment of cancer survivor population within the clinic/primary care practice.

- Existence of cancer treatment summary and self-management care plans for cancer survivors within the clinic/primary care practice.
- Cancer survivor adherence to cancer treatment summary and self-management care plans within clinic/primary care practice.

Recommended

- Electronic Health Record reporting and workflow capacity.

Reporting Metrics:

- Office/Clinic/System policy & Workflow
- Common metrics will be required for survivorship strategies after consultation with evaluation group.

Exclusions:

- CCPD funding may not be used to purchase or upgrade EHR systems; minor changes to existing systems may be considered only in support of larger programmatic effort.
- Strategies that are not recommended by the Community Guide

CCPD Strategy #7: Individual-level Cancer Prevention

Client-focused interventions that increase uptake and adherence to nationally recognized colorectal and lung cancer screening and HPV vaccination.

1. **Objective**: By [Year 1, 2 or 3], the grantee will develop and implement a ***communication and engagement*** plan to increase cancer screening (colorectal, lung) and/or HPV vaccination at the individual level.

Process Measures:

(accountability) Number and type of contacts made through engagement activities

(outcomes) Measures of individual attitudes, knowledge, and behavior change as a result of engagement

Outcome Measures

- Annual proportion of clients who are eligible for colorectal or lung cancer screening and are in adherence with USPSTF screening guidelines.
- Annual proportion of clients who are eligible for HPV vaccination and are in adherence with ACIP guidelines.

Intervention Strategies:

- Client-focused communication systems to promote early detection and prevention of cancer (e.g., patient reminder systems)
- Evidence-based education programs (e.g., tailored risk/health communication information) for appropriate cancer screening or HPV vaccination
- Clinical -based initiatives to eliminate or reduce structural barriers to access cancer screening for colorectal, lung cancer or HPV vaccination. (see CCPD Strategy 15 and/or 16)

Activities

Required

- Interventions that focus on barrier-reduction must adhere to guidance for patient navigation and/or community health worker components referenced in CCPD Strategies 15 and 16).
- Collaborate with the appropriate Colorado Cancer Coalition task force(s)
- One or more of the following activities:
  - Client reminders
  - Small/targeted media
  - One-on-one education

Recommended

- Implement one or more of the activities within this CCPD Strategy in conjunction with CCPD Strategy #6

Reporting Metrics

- Target population demographics.
- Number of clients reached with intervention.
- Number of clients who completed recommended screening/vaccination

Exclusions

- USPSTF Guidelines that *are not* A or B or are not in ACIP.
- Strategies that are not recommended by the Community Guide.

References

http://www.thecommunityguide.org/cancer/index.htm

CCPD Strategy #8: Community-based Cancer Prevention
Combination of approaches in non-clinical settings including education, promotion, awareness, and policy/systems interventions for HPV vaccination, skin cancer prevention, and/or reduction of radon exposure.

Objectives and metrics
[***Outcomes*** are in ***underlined bold italic*** typeface.]

A. Strategic Objective: By [Year 1, 2 or 3], compared to baseline rates, a higher proportion of eligible Coloradans within a defined geographic area will have completed the HPV vaccine series.

Intended Population

- Youth aged 11-12 (initial vaccination), males and females
- Females aged 13-26 (including 'catch-up' vaccination if not already started the series or for series completion)
- Males aged 13-21, or 22-26 if male is immunocompromised or having sex with another male (including 'catch-up' vaccination if not already started the series or for series completion)
- Parents of any of the above target populations

1. Objective: By [Year 1, 2 or 3], the grantee will develop and implement ***a communication and engagement plan*** to promote community demand, enhanced access, and clinical strategies to increase compliance with HPV vaccination best-practices.

Process Measures:
(accountability) Media impressions and other measures of communication contact.

Intervention Strategies:
- Develop educational resources or portfolios for providers and parents to increase awareness of the HPV vaccine, its effectiveness, and facts and myths, including financial incentives such as insurance coverage for the vaccine series.
- Implement evidence-based media strategies (e.g., http://www.cdc.gov/vaccines/who/teens/products/index.html)
- Work with clinics in targeted communities to offer HPV vaccine series (see CCPD Strategy 6)
- Establish relationships with providers and clinics to encourage participation in the Colorado Immunization Information System (CIIS) and in HPV Vaccine-specific promotion initiatives.

2. Objective: By [Year 1, 2 or 3], the grantee will develop a ***model immunization policy*** for schools that includes HPV immunization requirements for enrollment, and seek adoption and implementation of the proposed policy by appropriate decision-makers at targeted educational institutions (including higher-education).

Process Measures:
(accountability) Number and scope of adopted and/or implemented policies related to HPV vaccination.

(implementation) Documentation of the process implemented to draft the model HPV immunization policy including challenges and strategies to overcome barriers.
(implementation) Policy analysis of adding HPV to existing immunization policies in educational settings, including public acceptance and political feasibility.

Intervention Strategies:

- Develop and prioritize a list of recommended, evidence-based policy strategies to advance acceptance and adoption of HPV vaccination among eligible Coloradans.
- Identify appropriate local stakeholders and other partners for relationship building and policy change.

Activities

Required

- This project must be multi-component. Incorporate activities that address multiple intervention strategies from above. (see exclusions).
- Grantee will coordinate with the Colorado Cancer Coalition to implement project.

Recommended

- To address sustainability, it is recommended that policy intervention strategies and activities (Objective 2) are included as one of the components in this multi-component strategy.

Reporting Metrics

- Reach data, with demographics if possible, for awareness/media activities
- Policy Stage / # of University or Child Care Center HPV vaccine policies implemented
- Number of vaccine access point partners who use the Colorado Immunization Information System (CIIS)
- Number of youth initiating vaccine & number of youth completing vaccine series as documented in CIIS

Exclusions

- Implementing only 1 strategy.
- Targeted HPV vaccine outreach to individuals over the age of 26 (unless targeting outreach to parents of age-eligible populations).

B. Strategic Objective: **By [Year 1, 2 or 3], compared to baseline rates, reported habitual use of at least one method of <u>sun protection</u> will be more prevalent and sunburn will be less prevalent among Coloradans within a defined geographic area..**

1. **Objective**: By [Year 1, 2 or 3], the grantee will develop and implement ***<u>a communication and engagement plan</u>*** to promote UV-protective behaviors.

   Process Measures:

   (accountability) Media impressions and other measures of communication contact.

   Intervention Strategies:

   - Integrated, multicomponent community-wide interventions to influence and increase UV-protective behaviors including:
     - Develop educational resources or portfolios for consumers to increase awareness of UV-protective behaviors (including covering up, using shade, avoiding sun during peak UV hours and sunscreen use,) their effectiveness, and facts and myths.
     - Implement evidence-based media strategies

2. **Objective**: By [Year 1, 2 or 3], the grantee will develop a ***<u>model Sun Safety Plan</u>*** including guidelines, procedures and policies for one or more community settings including: 1) educational settings (including childcare facilities and preschools); 2) worksites; 3) public spaces, and to inform built environment infrastructure, and will seek adoption and implementation of the plan by appropriate decision-makers such as school administrators, worksite managers, community planners, local appointed and elected officials, etc.

   Process Measures:

   (implementation) Documentation of the process implemented to draft model guidelines, policies and procedures including challenges and strategies to overcome barriers.
   (accountability) Number and scope of adopted and/or implemented policies related to sun safety.
   (accountability) Description of stakeholders and decision-makers approached for plan adoption.
   (implementation) Policy analysis of UV-protective policies and procedures in public space and built environment infrastructure, including public acceptance, and political feasibility.

   Intervention Strategies:

   - Develop and prioritize a list of recommended, evidence-based policy strategies to advance acceptance and adoption of sun safety and UV-protective behaviors.
   - Identify appropriate local stakeholders and other partners for relationship building and policy change.

Activities

<u>Required</u>

- This project must be multi-component. Incorporate activities that address multiple intervention strategies from above. (see exclusions).

- Grantee will coordinate with the Colorado Cancer Coalition's Skin Cancer Task Force to implement project.

Recommended

- To address sustainability, it is recommended that policy intervention strategies and activities (Objective 2) are included as one of the components in this multi-component strategy.

Reporting Metrics

- Reach data, with demographics if possible, for awareness/media activities
- Policy Stage / # of local policies proposed, # of local policies adopted/enacted
- Behavior change data on covering up, sunscreen use, using shade

Exclusions

- Implementing only 1 strategy
- Implementing targeted, multi-component community activities for less than a year (must be more than one year)

Strategic Objective: **By [Year 1, 2 or 3], compared to baseline rates, residential exposure to radon will be less prevalent among Coloradans within a targeted geographic location.**

1. **Objective**: By [Year 1, 2 or 3], the grantee will develop and implement ***a communication and engagement plan*** to promote awareness of the risks of residential radon exposure, and available techniques for measurement and mitigation.

   Process Measures:

   (accountability) media impressions, other measures of communication contact

   Intervention Strategies:

   - Develop educational resources or portfolios for local policy makers, developers, Colorado residents and other stakeholders to increase awareness of radon risks, facts and myths, and steps to prevent and/ or mitigate residential radon exposure.
   - Implement evidence-based education and awareness activities to increase knowledge and possible actions to mitigate radon exposure.

   Activities

   Required

   - Combine with Objective 2 strategies and activities

   Reporting Metrics

   - Number and type of educational activities implemented

2. **Objective**: By [Year1, 2 or 3], the grantee will develop ***model policies*** for real estate transactions and local and regional building codes to promote adoption and implementation of consistent, systematic, evidence-based methods to reduce radon exposure, and will seek adoption and implementation of these radon mitigation policies by appropriate decision-makers such as local government and policy makers, etc.

Process Measures:

(implementation) Documentation of the process implemented to draft model guidelines, policies and procedures including challenges and strategies to overcome barriers.
(accountability) Number and scope of adopted and/or implemented policies related to radon exposure.
(accountability) Description of stakeholders and decision-makers approached for plan adoption.
(implementation) Policy analysis of adopting radon measurement and mitigation policies and procedures, including public acceptance and political feasibility.

Intervention Strategies:

- Develop and prioritize a list of recommended, evidence-based policy strategies to advance acceptance and adoption of residential radon mitigation, including updates to building codes for new construction, real estate transaction policies requiring radon testing and notification, school policies defining maximum tolerable exposure before mandating mitigation efforts, and recommended use of professionals when testing, mitigating or constructing dwellings.
- Identify appropriate local stakeholders and other partners for relationship building and policy change.

Activities

Required

- Combine with Objective 1 strategies and activities

Reporting Metrics

- Policy Stage / # of local policies proposed, # of local policies adopted/enacted
- Reach data, with demographics if possible, for awareness/media activities
- Radon testing measurement data (pre & post if mitigation occurs)

Exclusions

- Covering costs of mitigation efforts
- Covering costs of testing efforts

REFERENCES

- The Community Guide, Cancer & Vaccination Sections: http://www.thecommunityguide.org/index.html
- Office of Adolescent Health: http://www.hhs.gov/ash/oah/news/e-updates/july-2012.html
- CDC Immunization Schedule: http://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
- Environmental Protection Agency: http://www.epa.gov/radon/index.html
- WHO Handbook on Indoor Radon: A Public Health Perspective: http://www.ncbi.nlm.nih.gov/books/NBK143225/

CCPD Strategy #9: Self-measured Blood Pressure Monitoring

Regular measure of blood pressure by the patient outside the clinical setting either at home or elsewhere; additional support includes one-on-one counseling, web-based or telephonic support tools and educational classes.

Intended Population

Adults who have been diagnosed as pre-hypertensive, defined as individuals with blood pressure consistently measuring 120-139/80-89, and those identified as having high blood pressure (hypertension), defined as blood pressure greater than or equal to 140/90.

Outcome: By [Year 1, 2 or 3], compared to baseline rates, adherence to blood pressure monitoring best-practice guidelines will be more prevalent among patients diagnosed as pre-hypertensive or hypertensive.

Outcome: By [Year 1, 2 or 3], compared to baseline rates, self-management plans will be more prevalent among patients with diagnosed hypertension.

Outcome: By [Year 1, 2 or 3], compared to baseline rates, blood pressure control, defined as consistently measuring below 120-139/80-89, will be more prevalent among those hypertensive and pre-hypertensive patients who routinely self-monitor their blood pressure.

Outcome: By [Year 1, 2 or 3], compared to baseline rates, medication adherence will be more prevalent among hypertensive and pre-hypertensive patients who routinely monitor their blood pressure.

Outcome Measures

- Annual proportion of hypertensive patients with controlled hypertension (National Quality Forum Measure 0018).
- Annual proportion of patients who report self-measured blood pressure.
- Annual proportion of patients with diagnosed hypertension who have self-management plans.
- Annual assessment of patient feedback on program, including a measure of patient involvement in developing care plans.

Intervention Strategies

- Provide necessary self-monitoring equipment, training, education on best-practices, and technical assistance to patients (end-users).
- Establish or strengthen existing relationships with primary care providers to share patient health information to improve continuity of care.
- Provide continuing education for primary care providers to increase compliance with evidence-based best practices for screening, monitoring and treatment.
- Link to or provide additional supports which may include one-on-one counseling, web-based or telephonic support tools, and educational classes.

Activities

Required

- Provide home blood pressure monitors to patient participants or otherwise arrange for them at no or low cost to the patient
- Train patient participants on equipment use and reporting best-practices.
- Provide blood pressure self-monitoring education, counseling, technical assistance, and other support to patient participants through existing resources (such as one-on-one counseling, web-based or telephonic support tools and educational classes) or in cooperation with community health workers (CHWs) and patient navigators (PNs).
- Establish or strengthen existing relationships with primary care providers who manage the care for patient participants.
- Establish or strengthen existing communication mechanisms to communicate patients' health information to patients' primary care providers.
- Train primary care providers on relevant topics including evidence-based hypertension treatment guidelines, effective use of patient self-reported data, patient-driven care, etc.
- Organization must adhere to evidence-based guidelines for blood pressure assessment and monitoring, and if applicable, treatment.

Optional

- Incorporate community health workers (CHWs) and patient navigators (PNs) into program to implement on-going technical support, counseling, and guidance to hypertensive patients. Additional support includes one-on-one counseling, web-based or telephonic support tools and educational classes.
- Grantee may be a community-based organization serving priority populations (African-American, Latino, Asian, Native American, low-income) with culturally-tailored resources, materials and communications.

Reporting Metrics

- Numbers of patients included in the system intervention.
- Number of patients with hypertension.
- Number of patients with controlled hypertension (National Quality Forum Measure 0018).
- Number of patients with diagnosed hypertension who have self-management plans.
- Frequency of client reporting of self-measured blood pressure.
- Number of patients who participate in additional support programs.
- Assessment of provider feedback on program.
- Assessment of patient feedback on program, including a measure of patient involvement in their care plan.
- Number of patients with hypertension who are in adherence to medication regimens (optional).
- Number of patients with an Electronic Health Record (optional)

Exclusions

- Organizations that do not serve hypertensive and/or prehypertensive patients.

References

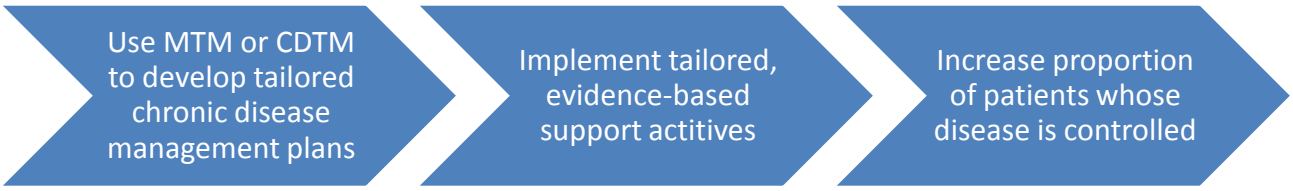
Clinical Usefulness and Cost Effectiveness of Home Blood Pressure Tele-monitoring: Meta-Analysis of Randomized Controlled Studies, Journal of Hypertension, March 31, 2013.

Community Health Workers in Low, Middle and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness, Annual Review of Public Health, Vol. 35, April, 2014.

Self-measured Blood Pressure Monitoring in the Management of Hypertension: A Systematic Review and Meta-Analysis, Annals of Internal Medicine, August 6, 2013.

CCPD Strategy #10: Team-based Care (MTMS)

Provision of health services to individuals, families and/or their communities by at least two health providers who work collaboratively with patients and their caregivers-to the extent preferred by each patient-to accomplish shared goals within and across settings to achieve coordinated, high quality care.



Intended Population

Individuals ages 18 or older with one or more chronic condition(s) requiring the use of prescription medication to manage symptoms or prevent progression of chronic disease, particularly hypertension, dyslipidemia and diabetes

Outcome: By [Year 1, 2, or 3], compared to baseline rates, medication adherence will be more prevalent among patients prescribed blood pressure, diabetes and/or cholesterol management medications.

Outcome: By [Year 1, 2, or 3], compared to the baseline rate, self-management plans will be more prevalent among patients with diagnosed hypertension.

Outcome: By [Year 1, 2 or 3], compared to baseline rates, controlled hypertension will be more prevalent

Outcome: By [Year 1,2 or 3], compared to baseline rates, uncontrolled diabetes will be less prevalent among patients with diagnosed hypertension or diabetes, respectively.

Outcome Measures

- Annual proportion of diabetic patients with prescribed diabetes-controlling medications who are in adherence with medication regimens (for example, see National Quality Forum Measure 0545, Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Annual proportion of hypertensive patients with prescribed hypertension-controlling medication who are in adherence with medication regimens (for example, see National Quality Forum Measure 0541, Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Annual proportion of patients with diagnosed hypertension who have self-management plans.
- Annual proportion of hypertensive patients with controlled hypertension (for example, see National Quality Forum Measure 0018)
- Annual proportion of diabetic patients with poorly controlled diabetes (for example, see National Quality Forum Measure 0059)

- Annual proportion of patients with hyperlipidemia who are in adherence to their statin medication regimen (for example, see National Quality Forum Measure 0569)

Intervention strategies

- Provide team-based care either through Medication Therapy Management (MTM) or Collaborative Drug Therapy Management (CDTM).
    a. MTM optimizes therapeutic outcomes for individual patients through team-based care coordinated by a Clinical Pharmacist or other qualified care team member such as a Physician, Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Physician Assistant.
    b. CDMT is permits qualified pharmacists working within the context of a defined protocol to assume professional responsibility for performing patient assessments, ordering drug therapy-related laboratory tests, administering drugs, and selecting, initiating, monitoring, continuing and adjusting drug regimens.

Activities

<u>Required</u>

- Patient assignment to either MTM or CDTM
- MTM services must include at minimum the following 5 components:
    1. Patient-directed medication management action plan with or without an equivalent prescriber-directed action plan
    2. Patient-directed education and counseling or other resources to enhance understanding of the use of medication
    3. Coordination of care, including prescriber-directed interventions; documentation of MTM services for use by the patient's other providers
    4. Referral to other providers, clinicians, or resources when appropriate
    5. Establishment and maintenance of a connection to the patient's primary care provider and regular communication with the primary care provider.
- Grantees providing CDTM must:
    1. Develop a formal practice agreement between a pharmacist(s) and physician(s) to allow the pharmacist(s) to manage patients' drug therapy.
    2. Maintain adherence to Collaborative Drug Therapy Management (CDTM) scope of services dictated by Colorado state pharmacy practice laws
        - Colorado Revised Statute Annotated §12-42.5-102 (West 2013)
        - 3 Colo. Code regs. 719-1 §§6.00.10 to 6.01.20
        - 3 Colo. Code regs. 719-1 §6.01.40
        - 3 Colo. Code regs. 713-32 (2013)
    3. Establish minimum criteria for written treatment plans including: clear description of the nature and scope of CDTM appropriate for the specified condition or diagnosis, a plan of treatment concurrent with evidence-based medicine, and appropriate documentation (i.e., signature and date) by authorizing physician or authority.
    4. Establishment and maintenance of a connection to the patient's primary care provider and regular communication with the primary care provider.

Recommended

- MTM Team composition will depend on the size and resources of the practice and the needs of the patient population and should include the patient, the patient's primary care provider, and other professionals such as Nurses, Pharmacists, Dietitians, Social Workers, and Community Health Workers.
- MTM Team Responsibilities should include the following:
  1. Assignment of roles and responsibilities commensurate with level of licensure.
  2. Provide support and share responsibility for chronic disease care to supplement primary care provider's activities. For example: medication management, case management, regular monitoring of blood pressure, care plan adherence support, provision of resources for patient self-management, etc.
  3. Facilitate communication and coordination of patient-centered care support among various team members.
  4. Ensure that electronic systems routinely provide data about the measures that matter to the teams providing care and can be immediately updated as indicated by frontline teams.
  5. Development of routine protocols for measurement of team function, aimed at continuous improvement of the processes of team-based care.

Optional

- Although the primary focus of this strategy is on populations with chronic diseases (hypertension, diabetes, hyperlipidemia, or any combination), systems-based approaches may benefit additional groups of patients within the health system as well as the target population.

Reporting Metrics

Required

- Numbers of patients included in the intervention
- Number of patients with hypertension
- Number of patients with controlled hypertension (National Quality Forum Measure 0018)
- Number of patients with diagnosed hypertension who have self-management plans (by year 3)
- Number of patients with hypertension who are in adherence to medication regimens
- Number of patients with diabetes
- Number of patients with poorly controlled diabetes (National Quality Forum Measure 0059)
- Number of patients with diabetes who are in adherence to medication regimens
- Number of patients with hyperlipidemia
- Number of patients with hyperlipidemia who are in adherence to their statin medication regimen (see NQF 0569)
- Number of providers who have improved hypertension and diabetes control rates among their patient panel
- Number and severity of adverse events including drug reactions, hospitalizations, emergency department visits, and physician office visits.
- Patient assignment to intervention (MTM or CDTM)
- Documentation of patient assignment to specific treatment strategy, and description of specific components of intervention (MTM or CDTM) including duration of intervention, team

composition, specific measures collected (i.e., scales or instruments used), and services provided
- Number of patients with an Electronic Health Record

Optional
- Additional disease-specific laboratory or biometric outcomes (disease-specific lab or biometric outcomes)
- Patient self-reported quality of life using evidence-based measure such as SF-36 or SF-12, EuroQOL or disease-specific tools.
- Self-reported patient knowledge
- Patient engagement (e.g., initial and continuing patient participation in the MTM program)
- Patient satisfaction with care
- Disease-specific or all-cause morbidity and mortality
- Reduced (actual) adverse drug events (frequency and/or severity)
- Health-related quality of life as measured by generally accepted generic health-related quality-of-life measures (e.g., short-form questionnaires, EuroQOL) or disease-specific
- Prescription drug costs and appropriate prescription drug expenditures
- Health care utilization (hospitalizations, emergency department visits, and physician office visits

Exclusions

- One-time corrective actions related to medication management
- Disease self-management interventions
- Isolated medication reconciliation interventions

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CCPD Strategy #11: Clinical Systems Quality Improvement

Provide point-of-care guides in primary care settings to increase the likelihood that providers adhere to recommended guidelines

Intended Population

Clients with chronic disease, primarily diabetes and cardiovascular disease.

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic*** typeface.]

Objective: By [Year 1, 2 or 3], the grantee will adopt and implement system-level changes using existing electronic health records systems to maximize use of evidence-based, patient-tailored chronic disease treatment and management plans.

Process Measures

(accountability) Documentation of system-level processes implemented to accommodate diabetes and/or hypertension treatment and management best-practices.

(reach) Number of clients (patients) who participate in initiatives associated with system-level changes to facilitate chronic disease treatment and management.

Outcome Measures

- Annual proportion of healthcare systems with EHRs appropriate for treating patients with high blood pressure and/or diabetes.
- Annual proportion of hypertensive patients with controlled hypertension (for example, see National Quality Forum Measure 0018)
- Annual proportion of diabetic patients with poorly controlled diabetes (for example, see National Quality Forum Measure 0059)

Intervention Strategies

- Use electronic health records to develop tailored chronic disease management plans and evidence-based support activities to increase the proportion of patients whose disease is well-controlled.
- Record referral and case management activities, and link data management initiatives to case management and community resources such as the Quitline, the Diabetes Prevention Program (DPP), Diabetes Self-Management Education, or hypertension clinics.

Activities

Required

- Implement clinical quality improvement (CQI) support tools to enhance EHR effectiveness in treating and managing chronic disease within primary care settings. CQI may include:
    - Computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care and which use patient data to provide tailored patient assessments and evidence-based treatment recommendations
    - Systems that allow patient data to be filtered to identify patients with criteria who may benefit from follow-up calls, group visits, educational opportunities, referrals or other options and/or
    - Patient portals or communication systems which promote the use and reporting of home monitoring (ie. blood pressure, glucose)
- Implement EHR-based systems to enhance patient care within primary care settings. Data-based systems may include:
    - Patient call backs or check-ins to assess medication adherence or barriers to care plan adherence
    - Referrals to programs such as the Quitline, the Diabetes Prevention Program, Diabetes Self-Management Education, or hypertension clinic
    - Utilizing provider-level and/or clinic-level performance reports for quality improvement
    - Aggregating patient data at the provider or system level for the purposes of quality improvement

Optional

- Applicants are encouraged to include partnerships that promote cross-utilization of data, for example, data sharing with pharmacy.

Reporting Metrics

- Total number of patients included in the system intervention.
- Total number of patients with hypertension.
- Annual proportion of patients with known high blood pressure who have achieved controlled hypertension (National Quality Forum Measure 0018).
- Annual proportion of patients with diagnosed hypertensions who have self-management plans.
- Annual proportion of hypertensive patients with prescribed hypertension-controlling medication who are in adherence to medication regimens (for example, see National Quality Forum Measure 0541 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008]).
- Total number of patients with diabetes.
- Annual proportion of patients with poorly controlled diabetes (National Quality Forum Measure 0059).

- Annual proportion of patients with diabetes with prescribed diabetes-controlling medications who are in adherence to medication regimens (for example, see National Quality Forum Measure 0545 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008]).
- Annual proportion of patients in the health system that have a certified Electronic Health Record.
- Annual proportion of providers who have improved hypertension and diabetes control rates among their patient panel.

Exclusions

- CCPD funding may not be used to purchase or upgrade EHR systems; minor changes to existing systems may be considered only in support of larger programmatic effort.

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CCPD Strategy #12: National Diabetes Prevention Program (DPP)

CDC-recognized, group-based program which is proven to prevent type 2 diabetes; can be taught by trained non-professionals in community-based settings; currently only offered by two health plans, and not covered by Medicaid. This strategy should include policy and system change activities.

Intended Population

Patients ages 18 or older with a body mass index (BMI) of ≥24 kg/m^2 (≥22 kg/m^2, if Asian) and 1) diagnosis of prediabetes, 2) a history of gestational diabetes (GDM) or a score of nine or higher on the CDC Prediabetes Screening Test; and who do not have the Diabetes Prevention Program as a covered health benefit.

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic*** typeface.]

Objective: By [Year 1, 2, or 3], the grantee will seek adoption and implementation of the National Diabetes Prevention Program (***DPP programs***) internally or in appropriate clinical or community settings, such as worksites, recreational centers, community-based organizations, health clinics, etc.

Process Measures:

(accountability) DPP initiative(s) was launched.
(reach) Documentation of number and description of DPP program participants.
(implementation quality) Number of trained lifestyle coaches to lead DPP initiative.
(outcome) Measures of evidence-based behavior change (weight loss and minutes of activity) as a result of DPP initiatives.

Intervention strategies:

- Participate in the Colorado Community-Based Organization DPP Work Group
- Provide trained Lifestyle Coaches to lead DPP initiatives

Outcome: By [Year 1, 2 or 3], compared to baseline rates, individuals who participate in DPP programs are more likely to experience a 5-7% decrease in overall body weight and are more likely to report consistently exercising a minimum of 150 minutes per week as a result of program participation.

Objective: By [Year 1, 2 or 3], the grantee will identify and establish partnerships with the Colorado DPP Advisory Group and outside organizations such as health plans, 3rd party administrators, employers or health care systems to develop a funding plan, identify financial resources and referral sources which will sustain the program(s).

Process Measures:

(accountability) List and description of potential partners and activities related to partnership development.

(implementation) Establishment of fiscal partnership to sustain DPP program(s).

(implementation) Establishment of referral policies or practices with health care systems to support enrollment into DPP program(s).

(implementation) Establishment of patient information feedback loops to share necessary patient data with primary care providers to enhance care coordination.

Intervention strategies:

- Attend the bi-monthly Colorado DPP Advisory Group meetings
- Link DPP initiatives to local and regional resources, such as health care systems, health plans, employers, the Diabetes Prevention and Control Alliance (DPCA) or Viridian Health Management, to identify funding and referral sources that will support and sustain DPP initiatives.

Activities

Required

- Completion of The Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program Application to achieve pending recognition status from the CDC.
- Identify appropriate candidates to be trained as Lifestyle Coaches for the DPP program.
    - Lifestyle Coach Training may be obtained through the Diabetes Training and Technical Assistance Center (DTTAC), Viridian Health Management or other CDC and CDPHE-approved Lifestyle Coach Training organization or master trainer.
- Use the National Diabetes Prevention Program Curriculum or CDC-approved alternative curriculum for the DPP program.
- Collect and submit standardized datasets on participant performance metrics and outcomes to CDC and CDPHE every 6 months.
- Collect and submit referral source data for the DPP program to CDPHE every 6 months.
- Establish referral policies or practices with health care systems to support enrollment into DPP program(s).
- Establish patient information feedback loops to share necessary patient data with primary care providers to enhance care coordination.
- Establish fiscal partnerships with partners such as health plans, 3rd party administrators, employers or health systems to sustain DPP program(s).

Recommended

- Use of Community Health Workers as Lifestyle Coaches to teach the DPP classes.
- Develop and implement a communication and engagement plan to promote participation in DPP programs among target high risk groups. Components of this plan may include:
    - Social media campaigns highlighting the importance of diabetes prevention and opportunities for DPP class enrollment

- Presentations at community meetings to promote the importance of diabetes prevention and opportunities for DPP class enrollment
- Community events to promote the importance of diabetes prevention, as well as screening (with the paper/pencil CDC Prediabetes Screening Test) and enrollment into DPP classes

Reporting Metrics (as required by CDC Diabetes Prevention Recognition Program)

- Client number enrolled
- Client demographics (age, ethnicity, race, sex)
- Client height
- Session attendance
- Documentation of baseline and change in body weight
- Documentation of baseline and change in physical activity minutes
- Client referral source data

Exclusions

- Organizations that offer the DPP exclusively to participants who have the Diabetes Prevention Program as a covered health benefit

References

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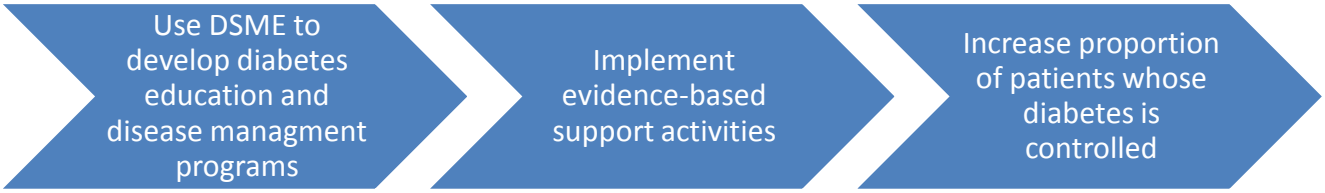
CCPD Strategy #13: Diabetes Self-Management Education (DSME)

DSME is an accredited program which has proven to significantly decrease hemoglobin A1C levels, has a return on investment of $4.34:1, and decreases hospitalization rates. Group-based classes are recommended and can be taught in the community setting under clinical supervision. Currently not reimbursed by Medicaid. This strategy should include policy and system change activities.



Intended Population

Medicaid beneficiaries who have diabetes and individuals with diabetes.

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic*** typeface.]

Objective: By [Year 1, 2 or 3], the grantee will adopt and implement a DSME program(s).

Process Measures:

(accountability) Organization will implement the program.
(implementation) Documentation of the process used to implement the program including challenges and strategies to overcome barriers to adoption and implementation.
(implementation) Establishment of referral policies or practices to increase enrollment in DSME services.
(reach) Number and description of locations where DSME services are provided.
(reach and impact) Number of participants and extent of participant engagement in DSME services (i.e. number of classes attended).

Intervention Strategies:

- Identify key partner(s) (i.e. medical clinics, health systems, community-based organizations, etc.) to (1) host DSME classes (2) create referral systems to support enrollment into DSME services and (3) create patient information feedback loops to share necessary patient data with primary care providers to enhance care coordination.

Outcome*:* By [Year 1, 2, or 3], compared to baseline HgbA1Cs, patients who participate in DSME will have lower HgbA1Cs upon completion of the program

Outcome: By [Year 1, 2, or 3], compared to baseline rates, medication adherence will be more prevalent among patients with diabetes who are prescribed chronic medications for their diabetes.

Outcome: By [Year 1, 2, or 3], compared to baseline rates, uncontrolled diabetes will be less prevalent among patients with diagnosed diabetes.

Outcomes Measures

- HgbA1C of patients at baseline and upon completion of DSME program
- Number of patients with diabetes who are in adherence to medication regimens (for example, see National Quality Forum Measure 0545 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Annual proportion of patients with poorly controlled diabetes (National Quality Forum Measure 0059) *(this measure is indicated for a clinic or health system implementing DSME)*

Activities

Required

- Grantee must serve a population of at least 200 Medicaid beneficiaries with diabetes.
- The Diabetes Self-Management Education (DSME) program must be in accordance with the 2012 National Standards (see reference below) and have taken at least one patient through the program (by quarter three of the first year of the grant award) to apply for accreditation.
- *Obtain accreditation through one of the two accrediting organizations: American Association of Diabetes Educators (AADE) or American Diabetes Association (ADA).*
- *Establish reimbursement mechanisms for patients who have private health plans and/or Medicare.*
- Establish referral policies or practices with health care systems to support enrollment into DSME program(s).
- Establish patient information feedback loops to share necessary patient data with primary care providers to enhance care coordination.
- *Grantee must have established data management systems that will allow it to filter critical patient-level data to identify and report (in aggregate form) on DSME participants with certain criteria (for example, Medicaid beneficiaries).*

Optional

- Community health workers and patient navigators can supplement education by providing on-going support and assistance to participants via Diabetes Self-Management Support (DSMS).
- Inclusion of the Centers for Disease Control and Prevention Recognized Diabetes Prevention Program can be part of the offerings of the DSME program for people with prediabetes.
- *Grantees already implementing The Diabetes Self-Management Program (DSMP), a Stanford supported community course for people with type 2 diabetes, can take appropriate steps to expand their program to meet DSME standards for accreditation by AADE or ADA (see* Diabetes Self-Management Program Model for Area Agencies on Aging reference).

Reporting Metrics

Use of electronic health records to collect these metrics is encouraged. Please note, frequency of measurements varies.

- HgbA1C

- Annual proportion of patients with poorly controlled diabetes (National Quality Forum Measure 0059) *(this measure is indicated for a clinic or health system implementing DSME)*
- Number of patients with diabetes who are in adherence to medication regimens (for example, see National Quality Forum Measure 0545 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Body mass index
- Documented self-management goals
- Number of locations where DSME services are provided.
- Total number of patients seen in DSME program(s) in the past 12 months
- Number of patients attending DSME classes/visits (average on a regular basis)
- Patient referral source data to DSME services

Optional Reporting Metrics

- Feet examination
- Comprehensive eye examination
- Frequency of medical appointments and visits
- Blood pressure
- Number of patients with hypertension
- Number of patients with controlled hypertension (National Quality Forum Measure 0018) *(this measure is indicated for a clinic or health system implementing DSME)*
- Number of patients with high blood pressure that have a self-management plan
- Number of patients with hypertension who are in adherence to medication regimens (for example, see National Quality Forum Measure 0541 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])

Exclusions

- Clinics or organizations that serve less than 200 Medicaid beneficiaries with diabetes.

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CCPD Strategy #14: School-Centered Asthma Management

Primary (preferably) and middle school focused asthma management programs, including asthma and self-management education, asthma action plans, asthma monitoring, and care coordination with families and health care providers

Target Population

Low income, primary school students with history of poorly controlled asthma, students in schools with high prevalence of asthma, defined as ≥ 10% students with reported asthma, and students in schools with high percentage who qualify for free or reduced price lunch (i.e., ≥ 40%).

Outcome: By [Year 1, 2, or 3], compared to baseline rates, asthma control will be more prevalent among students diagnosed with asthma.

Outcome: By [Year 1, 2, or 3], compared to the baseline rate, asthma action plans and self-management activities will be more prevalent among students with diagnosed asthma.

Outcome: By [Year 1, 2, or 3], compared to baseline rates, adherence to treatment guidelines and best-practices will be more prevalent among students who are prescribed chronic medications for their asthma.

Measures

- Annual proportion of students with asthma with prescribed asthma-controlling medications who are in adherence with medication regimens
- Annual proportion of students with asthma who have documented asthma action plans and prescribed quick relief inhaler available at school
- Annual proportion of students with asthma who have controlled symptoms
- Annual proportion of diabetic patients with poorly controlled diabetes (National Quality Forum Measure 0059)
- Individual-level engagement and/or behavior change as a result of school-centered asthma management initiatives [Measures of behavior change and risk reduction at the individual level require external evaluation resources and may not be feasible for grantee collection]

Intervention Strategies

- Conduct feasibility assessments in target schools to determine whether, and the extent to which, designated school(s) can integrate asthma management activities.
- Identify an asthma management program champion in each target school to partner to facilitate adoption and implementation of program components such as family and student outreach, tailored asthma action plans and self-management training for individual students, independent monitoring of asthma management and medication compliance, staff education, asthma care coordination with primary care providers and other referral services, and other program related activities.

Activities

Required

- Work with CCPD-designated technical assistance provider to plan and organize project implementation and train project staff
- Recruit and hire 1 asthma counselor per (approx.) 150 students with asthma
    - Asthma counselors may have previous community health worker or patient navigator training, community engagement experience, or school health technician experience.
    - Asthma counselors should also be Spanish speaking as appropriate
- Pilot test activities to be fully implemented in subsequent years (i.e., Year 2/3)
- Identify students with asthma at primary (elementary) schools
- Enroll student/family in program; collect history & demographics with standard questionnaire
- Assess asthma severity using standardized tool (Colorado Asthma Intake Form)
- Assure completion of asthma action plans using standardized form, including availability of "quick relief" inhaler, through working with parents and primary care provider
- Provide asthma education using evidence-based curriculum (Open Airways for Schools) with pre/post assessment
- Provide asthma self-management training for enrollees
- Provide asthma education for school staff
- Conduct asthma monitoring with use of standardized tool (Childhood Asthma Control Test) and peak flow meter assessment
- Provide communication with and engagement of primary care providers
- Provide care coordination to assure Medicaid/health insurance enrollment, linkage to medical home and referral to other services as needed
- Perform data collection, data entry management and analysis

NOTE: Year 1 BUDGET should reflect time to hire new staff and the nature of Year 1 activities (i.e., planning, training, pilot testing). Year 1 budget is expected to be less than the fully implemented project budgets for Years 2 & 3.

Optional

- Applicants with demonstrated experience providing school centered asthma management programs may propose to provide technical assistance (TA) to new grantees.
    - Specific work plan objectives/activities and budget line items for providing TA should be included and clearly indicated.

Reporting Metrics

- Number of students enrolled by demographic characteristics [e.g., school, age and grade, gender, race/ethnicity, insurance status/type] and asthma control/risk status.
- Percent of student participants with completed asthma action plans on file and prescribed quick relief inhaler at school.
- Student participants' change in asthma knowledge scores
- Student participants' change in asthma skills (i.e., inhaler technique)
- Student participants' Change in asthma control test score (questionnaire)
- Change in family reported school days missed for asthma, urgent care visits and hospital admissions for asthma for student participants.

- Change in school days missed from all causes from school records for student participants.

Exclusions

- High schools
- Middle Schools
    - All new programs should focus on primary schools, or on grades K-6 for schools that include grades K-8.

References

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CCPD Strategy #15: Patient Navigator Programs

Strategies that use PNs as part of the health care team within health care systems to reduce barriers to screening and treatment. These include: guiding individuals and families through complex health care systems, linking them with appropriate services, information and resources, helping them interact with their providers and supporting the continuum of care.

Intended Population

This strategy is intended for three groups:

1) Low SES populations and those with the highest risk for chronic disease including co-morbidities leading to reduced productivity, disability and mortality in socioeconomically disadvantaged urban, rural and frontier areas;
2) Population groups that live in health professional shortage areas with limited access to healthcare and are at high risk for chronic disease (based on county health assessments), and that may benefit from services of allied health staff such as patient navigators, community health workers, or promotoras(es).
3) Groups with limited English language proficiency that require translation services in clinical settings.

Objectives and metrics

[***Outcomes*** are in ***underlined bold italic typeface***.]d

1. **Objective**: By [Year 1, 2 or 3], the grantee will be able to show ***evidence of having established collaborative partnerships with clinical care and community settings*** to increase use of patient navigators for outreach to and recruitment of high risk populations for referrals into patient-centered medical homes or primary care medical practices.

   Process Measures:

   (reach and implementation) Evidence of extent and scope of cooperative relationships with medical staff and clinical providers (e.g. documentation of ongoing collaborative strategies, documentation of routine office protocols integrating PNs).

   (reach and implementation) Evidence of extent and scope of cooperative relationships with evidence-based community programming (e.g. Diabetes Prevention Program, etc)

   (reach and implementation) List of patient centered medical homes/primary care practices with which the PN works and/or refers.

   (reach and implementation) List of community programs and resources utilized to reduce barriers to appropriate medical care

   (implementation) Description of client barriers and how they were addressed

(system change) Description of program challenges/ barriers and how they were addressed

(implementation) Description of extent and scope of participation in Colorado Patient Navigator and Community Health Worker Collaborative.

Intervention strategies:

- Seek collaboration and build networks including enlisting community resources, organizations, clinics and providers in addressing patient needs.
- Increase communication and collaboration including promoting integration of patient navigators into the clinical team using ongoing collaborative strategies (e.g. working closely with medical providers and program staff for referrals ("warm hand-off"), educating medical providers about community needs) to improve care coordination for high-risk clients.
- Connect clients to Medicaid, CHP+ services or other health plans in compliance with the Patient Protection and Affordable Care Act (ACA*).*
- Work with the Colorado Patient Navigator and Community Health Worker Collaborative to establish minimum standards for knowledge, skills and core competencies for patient navigators, community health workers, and other targeted professional and lay groups.

2. **Objective**: By [Year 1, 2 or 3], grantee will increase systematic use of best-practices among high risk groups to prevent and/or manage chronic diseases and reduce barriers to screening and /or treatment.

Outcome: By [Year 1, 2, or 3], compared to baseline rates, medication adherence will be more prevalent among hypertensive patients and diabetic patients who are prescribed chronic medications for their hypertension or diabetes, respectively.

Outcome: By [Year 1, 2, or 3], compared to the baseline rate, written self-management plans will be more prevalent among patients with diagnosed hypertension and/or diabetes.

Outcome: By [Year 1, 2, or 3], compared to baseline rates, controlled hypertension or diabetes will be more prevalent among patients with diagnosed hypertension or diabetes, respectively.

Outcome: By [Year 1, 2, or 3], compared to the baseline rate, treatment summary and written self-management plans will be more prevalent among cancer survivors.

Outcome: By [Year 1, 2, or 3], compared to baseline rates, patients working with PN's will have higher rates of screening for cancer, diabetes, hypertension, and/or other chronic conditions.

Outcome Measures:

- Annual proportion of diabetic patients with prescribed diabetes-controlling medications who are in adherence with medication regimens (for example, see National Quality Forum Measure 0545 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Annual proportion of hypertensive patients with prescribed hypertension-controlling medication who are in adherence with medication regimens (for example, see National Quality Forum Measure 0541 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Annual proportion of patients with diagnosed hypertension who have written self-management plans.
- Annual proportion of hypertensive patients with controlled hypertension (National Quality Forum Measure 0018) *(this measure is indicated for a clinic or health system with embedded Patient Navigators as part of their care team)*
- Annual proportion of patients with poorly controlled diabetes (National Quality Forum Measure 0059) *(this measure is indicated for a clinic or health system with embedded Patient Navigators as part of their care team)*
- Annual proportion of cancer survivors who have written self-management plans.
- Annual proportion of eligible patients who have undergone screening by type.

Intervention strategies:

- Provide comprehensive health education.
- Refer clients to existing evidence-based resources such as a Diabetes Prevention Program, Diabetes (or Chronic Disease) Self-Management, tobacco cessation and healthy eating, active living or other community or e-technology based programs.
- Refer clients to other evidence-based programs that prevent chronic disease or promote chronic disease self-management skills and strategies.
- Refer clients to supportive services that will help to reduce barriers to screening and treatment, such as health care systems, childcare, transportation and other related services.

3. **Objective:** By [Year 1, 2 or 3], grantee will ***utilize a systematic data collection process***, incorporating specific standardized metrics (as applicable to each specific program), with guidance from CDPHE (general outline of metrics detailed below).

Process Measures:

(accountability) Evidence of a data collection form or system.

(accountability) Data submitted at least yearly for program evaluation and continuous quality improvement purposes.

(implementation) Description of how collected data is being utilized.

Intervention strategies:

- Develop a comprehensive plan for systematic data collection.
- Utilize a database or other data tracking system with written and/or electronic tracking and reporting mechanisms to collect standardized metrics (see metrics below), link existing patient resources, reduce barriers to access, and document coordination of care between patients, clients and providers, and oversee follow-up on referrals for services such as healthcare, human services and health insurance.

Activities

PN duties are based upon the competencies of health education and coaching, advocacy and capacity building, assessment and referral, communication, cultural responsiveness, outreach and recruitment. The PN is to also elicit health behavioral change, complete tracking (documentation), evaluation, reporting and use of public health concepts and approaches.

<u>Required</u>

- Workforce Development
  - Partner with local and statewide resources to encourage and promote statewide standards for patient navigation designation and training, and build the patient navigation workforce.
- Health Education and Coaching
  - Provides health education and teaches strategies that enable the patient to self-manage the health condition.
  - Supports positive behavior change through culturally-tailored, promising/best-practices public health theory and strategies.
- Assessment and Referral
  - Identify patient and community assets for obtainment of optimal care and facilitate communication with and patient participation in relevant services and programs
- Communication
  - Demonstrate interpersonal communication and communication accommodation skills that enable exchange of ideas and information effectively with patients, families, health care providers and collaborators at all levels. This includes writing, speaking and listening skills.

- Care Coordination and Case Management
  - Facilitates the appropriate and efficient delivery of healthcare services, both within and across systems, to promote optimal outcomes while delivering patient-based care.
- Reporting, Evaluation, and Tracking
  - Develop and maintain (or utilize existing) organizational system to record and update medical, cultural, literacy and linguistically-relevant resources pertinent to the patients/clients.
- Cultural Responsiveness
  - The ability to exhibit skills, protocols and behaviors that integrate the value of diversity and intentionally promote effective work among clients and partners.
- Outreach Methods and Strategies
  - Comprehends and has the ability to implement multi-prong approaches to engage un- and under-served communities through a variety of innovative (promising) and best practices and strategies (health promotion / behavior practices that are effective).
- Use of Public Health Concepts and Approaches
  - Promote prevention, problem-solving, and policy change for better health outcomes.
  - Supports positive behavior change through culturally-tailored, promising/best-practices for public health theory and strategies

<u>Optional</u>

- Advocacy and Community Capacity Building
  - Communicates barriers and human rights violations that the patient experiences in the health care system to providers and staff in order to assure that these setbacks or discriminatory events are addressed, and optimally resolved.
  - Seeks and facilitates opportunities for community capacity building to address health inequities.

Reporting Metrics

- Number of patients recruited to program and outreach sites
- Basic demographic, racial/ethnic, and socio-demographic data on clients/patients served including income level, educational level, marital status, employment status, primary language spoken in the home, and family/caregiver support
- Type of health insurance or document uninsured

- Type of chronic health issues addressed including cancer, cardiovascular disease, pulmonary disease and associated risk factors (e.g. diabetes, obesity, tobacco use prevention and cessation)
- Baseline disease specific data (in aggregate, de-identified)
- Type of screening data/biometrics collected.
- Number of enrolled program participants, e.g., attending health education classes, healthy eating/active living activities (and type).
- Number of client referrals to PCMH, primary care providers, other healthcare professionals, human services or community-based organizations by type, such as dentist, behavioral health organization, Medicaid, food banks or food stamp program, etc. (and reason for referral) and if followed-through on referral.
- Number of referrals to health risk prevention or self-management programs, i.e., Diabetes Prevention Program, Diabetes Self-Management Education or Chronic Disease Self-Management, Colorado QuitLine, exercise classes, etc.
- Documentation of client/patient follow-up, appointments made and kept (and results).
- Client barriers addressed/method, example: client with limited English proficiency/community health worker provided translation or referred to a patient navigator fluent in client's preferred language.
- Share data as appropriate such as with health systems or provide individuals with their risk factor information, including coaching clients, so that they are prepared to discuss with a provider.
- Proportion of diabetic patients with prescribed diabetes-controlling medications who are in adherence with medication regimens (for example, see National Quality Forum Measure 0545 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Proportion of hypertensive patients with prescribed hypertension-controlling medication who are in adherence with medication regimens (for example, see National Quality Forum Measure 0541 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Proportion of patients with diagnosed hypertension who have written self-management plans.
- Proportion of hypertensive patients with controlled hypertension (National Quality Forum Measure 0018) *(this measure is indicated for a clinic or health system with embedded Patient Navigators as part of their care team)*
- Proportion of patients with poorly controlled diabetes (National Quality Forum Measure 0059) *(this measure is indicated for a clinic or health system with embedded Patient Navigators as part of their care team)*
- Proportion of adults with asthma in adherence to medication regimens.

- Proportion of adults with asthma that have a written self-management plan.
- Proportion of cancer survivors that have a written self-management plan.
- Proportion of adults eligible for cancer screening in adherence with national screening guidelines.
- Proportion of clients diagnosed with cancer that are navigated through cancer treatment

Exclusions

- Screenings and/or health assessments ***without*** documented referrals to patient-centered medical home (PCMH) or primary care provider (PCP) and follow up to ensure reduction in barriers to care and resources as needed. (See RFA language for guidance on screening provision).
- Informal "in-home" health education group classes unless accompanied by health coaching and referrals to PCMH.
- Purchase, development or version upgrades of electronic health records systems and patient portal systems (however, modifications to existing EHRs and patient portals will be considered with prior approval from CDPHE)

References

MAQ- Medication Adherence Questionnaire, 8 Item Scale, 4-Item Scale
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2562622/
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2231556/table/t1-0532144/

CCPD Strategy #16: Community Health Worker Program

Strategies that use CHWs to act as connectors to health care systems (providers, hospitals, community health programming, etc.). CHWs can do outreach work, health screening and education, community advocacy/empowerment and connect/refer to resources. It is important that the CHW is a trusted member of the community or target population.

Intended Population

This strategy is intended for three groups:

1. Low SES populations and those with the highest risk for chronic disease including co-morbidities leading to reduced productivity, disability and mortality in socioeconomically disadvantaged urban, rural and frontier areas;
2. Population groups that live in health professional shortage areas with limited access to healthcare and are at high risk for chronic disease (based on county health assessments), and that may benefit from services of allied health staff such as patient navigators, community health workers, or promotoras(es).
3. Groups with limited English language proficiency that require translation services in clinical settings.

Objectives and metrics

[***Outcomes*** are in ***underlined*** ***bold italic typeface***.]

1. **Objective:** By [Year 1, 2, or 3), the grantee will be able to show ***evidence of having relationships or engaging in activity to build relationships*** with the health care systems in their area**.**

   Process Measures:

   (effectiveness) Number and description of partners who work with Community Health Workers(including referrals)for inclusion in a statewide resource portal.

   (accountability) Number and description of outreach activities and outcomes to include follow-up with clients on referrals.

   Intervention strategies:

   - Work with health systems and community partners to create referral systems to support client outcomes and sustainability of Community Health Worker services.

2. **Objective**: By [Year 1, 2 or 3], the grantee will develop and implement health education, risk-factor assessment and referral plans that promotes positive behavior changes with

regard to chronic disease prevention (healthy eating active living), and/or chronic disease screening and self-management.

Process Measures:

(reach) Extent and scope of contact with target participants.

(accountability) Media impressions and other measures of communication contact. (if applicable)

(accountability) Number of CHW's trained, and type of training, to provide basic risk factor screening.

(reach) Number and type of referrals made, percent of referral follow-throughs by type.

Outcome Measures:

- Measures of change at the individual level, i.e., observed or self-reported physical activity, screening, referral to resources

Intervention strategies:

- Provide health education and support to client to self-manage cancer, cardiovascular disease, pulmonary disease and associated risk factors;
- Support positive behavior change by connecting clients to to culturally-appropriate and evidence-based outreach activities and resources for chronic disease prevention and risk factor reduction such as the Diabetes Prevention Program, shopping demonstrations, cooking classes on a budget, walking groups, exercise classes, active transportation, and education programs to address perception of neighborhood safety.
- Perform health and risk factor assessments such as blood pressure, cardiovascular disease and diabetes risk assessment, BMI, weight, et al. (Those not requiring clinical licensure).
- Connect clients to patient-centered medical home or primary care provider for quality care with referrals for direct services, such as medical/clinical screenings for high cholesterol, glucose or A1c, blood pressure, cardiovascular disease risk assessment, cancer, etc.
- Connect clients to Medicaid, CHP+ services (or other health plans) in alignment with the Patient Protection and Affordable Care Act (ACA)

3. **Objective:** By [Year 1, 2 or 3], grantee will ***utilize a systematic data collection process***, incorporating specific standardized metrics (as applicable to each specific program), with guidance from CDPHE (general outline of metrics detailed below).

   Process Measures:

   (accountability) Evidence of a data collection form or system.

   (accountability) Data submitted at least yearly for program evaluation and continuous quality improvement purposes.

   Intervention strategies:
   - Develop a comprehensive plan for systematic data collection.
   - Utilize a database or other data tracking system with written and/or electronic tracking and reporting mechanisms to collect standardized metrics, link existing patient resources, reduce barriers to access, and document coordination of care between patients, clients and providers, and oversee follow-up on referrals for services such as healthcare, human services and health insurance.

Activities

CHW duties are based upon the competencies of health education and coaching, advocacy and capacity building, assessment and referral, communication, cultural responsiveness, outreach and recruitment. The CHW is to also elicit health behavioral change, complete tracking (documentation), evaluation, reporting and use of public health concepts and approaches.

Required

- Health Education and Support
  - Provides health education and supports positive behavior change by connecting to evidence-based strategies and culturally-tailored resources that enable the patient to manage the health condition.
- Assessment and Referral
  - Identify patient and community assets for obtainment of optimal care and facilitate communication with and patient participation in relevant services and programs
- Communication
  - Demonstrate interpersonal communication and communication accommodation skills that enable exchange of ideas and information effectively with patients,

families, health care providers and collaborators at all levels. This includes writing, speaking and listening skills.

- Connect to Care Coordination
    - ~~o~~ Facilitates the appropriate and efficient delivery of healthcare services, both within and across systems, to promote optimal outcomes while delivering ~~p~~atient-based care.
- Reporting, Evaluation, and Tracking
    - Systematically track client status (referrals, resources accessed, etc) to ensure appropriate linkages and track success/barriers.
- Cultural Responsiveness
    - The ability to exhibit skills, protocols and behaviors that integrate the value of diversity.
- Outreach Methods and Strategies
    - Comprehends and has the ability to implement multi-prong approaches to engage un- and under-served communities through a variety of innovative (promising) and best practices and strategies (health promotion / behavior practices that are effective).
- Use of Public Health Concepts and Approaches
    - Promote prevention, problem-solving, and policy change for better health outcomes.
    - Supports positive behavior change through culturally-tailored, promising/best-practices for public health theory and strategies

<u>Optional</u>

- Workforce Development
    - Partner with local and statewide resources to encourage and promote standards for community health worker training, and build the CHW workforce.
- Advocacy and Community Capacity Building
    - Communicates barriers and human rights violations that the patient experiences in the health care system to providers and staff in order to assure that these setbacks or discriminatory events are addressed, and optimally resolved.
    - Seeks and facilitates opportunities for community capacity building to address health inequities.
- Use of Public Health Concepts and Approaches
    - Promote prevention, problem-solving, and policy change for better health outcomes.
    - Supports positive behavior change through culturally-tailored, promising/best-practices for public health theory and strategies

Reporting Metrics

- Measures of progress towards positive behavior change
- List of health systems (and PCMHs) that CHWs are working with to link patients to community resources.
- Number of patients recruited to program and outreach sites
- Number of people screened for chronic disease or risk factors (if applicable)
- Basic demographics of clients/patients served i.e., racial/ethnic, and socio-demographic data on clients/patients served including income level, educational level, marital status, employment status, primary language spoken in the home, and family/caregiver support
- Type of health insurance or document uninsured
- Type of chronic health issues addressed including cancer, cardiovascular disease, pulmonary disease and associated risk factors (e.g. diabetes, obesity, tobacco use prevention and cessation)
- Baseline disease specific data (in aggregate, de-identified)
- Type of screening data/biometrics collected (if applicable)
- Number of enrolled program participants, i.e., attending health education classes, healthy eating/active living activities including type and duration.
- Number of client referrals to PCMH, primary care providers, other healthcare professionals, human services or community-based organizations by type, such as dentist, behavioral health organization, Medicaid, food banks or food stamp program, etc. (and reason for referral) and if followed-through on referral.
- Number of referrals to health risk prevention or self-management programs, i.e., Diabetes Prevention Program, Diabetes Self-Management Education or Chronic Disease Self-Management, Colorado QuitLine, exercise classes.
- Documentation of client/patient follow-up, appointments made and kept (and results).
- Client barriers addressed/method, example: client with limited English proficiency/community health worker provided translation or referred to a patient navigator fluent in client's preferred language.
- Share data as appropriate such as with health systems or providing individuals with their risk factor information so that they are prepared to discuss with a provider.

<u>Optional Reporting Metrics</u>

The following data collection is optional, unless applicant is working within a health system to provide direct services of medication adherence, health screening for asthma, CVD, cancer, diabetes, and risk factors such as pre-diabetes, high blood pressure, A1c>9, and/or disease self-management.

- Proportion of adults with high blood pressure in adherence to medication regimens. Adherence can be measured using an established scale. (for example, see National Quality Forum Measure 0541 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Proportion of adults with diabetes in high adherence to medication regimens. Adherence can be measured using an established scale. (for example, see National Quality Forum Measure 0545 or Medication Adherence Questionnaire [Morisky et al., 2007, 2008])
- Proportion of adults with known high blood pressure who have a written self-management plan as documented by a health care or social services provider.
- Proportion of adults with known high blood pressure who have achieved blood pressure control.
- Proportion of adults with asthma in adherence to medication regimens.
- Proportion of adults with asthma that have a written self-management plan.
- Proportion of clients with diabetes with decreased A1c (A1c>9)
- Proportion of clients in adherence with national guidelines for cancer screening

Exclusions

- Regular preventive screenings (including those that have an A or B recommendation from the USPSTF.) (See RFA language for guidance on screening provision).
- Any medical/clinical risk factor assessment or screening (i.e., finger stick cholesterol) *unless the assessment includes* documented referrals to patient-centered medical home (PCMH) or primary care provider (PCP) and follow up to ensure reduction in barriers to care and resources as needed.
- Informal "in-home" health education group classes unless accompanied by documented health coaching and referrals to PCMH.

References

MAQ- Medication Adherence Questionnaire, 8 Item Scale, 4-Item Scale
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2562622/
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2231556/table/t1-0532144/

CCPD Strategy #17: Patient Navigator and Community Health Worker Training
Standardized training programs for patient navigators and/or community health workers.

Intended Population

The intended population includes patient navigators, community health workers, and promotores de Salud. Care coordinators, lay health workers and other lay health advocates may also be included.

Objectives and metrics
[***Outcomes*** are in ***underlined*** ***bold italic typeface***.]

4. **Objective**: By [Year 1, 2 or 3], the grantee will ***adopt statewide core competencies*** and deliver training and education program curriculums for patient navigators, community health workers, and other targeted professional and lay groups.

   Process Measures:
   (reach) Number and scope of education initiatives.
   (reach) Number of participants who enroll and who complete the program.
   (implementation) Education and training programs in alignment with statewide guidelines.
   (implementation) Copy of training guide and curriculum.
   (effectiveness) Measures of change in knowledge and skills in training and education program participants.

   Intervention strategies:
   - Partner with professional groups and organizations to provide diverse educational and training opportunities and offerings.
   - Identify alternative funding sources to assure sustainability of education and training initiatives.
   - Work with state-level professional groups including the Colorado Patient Navigator and Community Health Worker Collaborative to establish minimum standards for patient navigation and/or community health worker training.

Activities

Required
- Applicant must demonstrate evidence of previous effectiveness of training program.
- Participation in the Colorado Community Health Worker and Patient Navigator Collaborative.
- Develop and pursue funding plan for program sustainability beyond CCPD funding.

Reporting Metrics

- Number of trainees who enrolled in training program
- Number of trainees who completed training successfully
- Number of trainees that are funded by other CCPD programs
- Number of different training modules and trainees in each
- Number of trainers trained
- Number and description of training curricula—current and newly developed
- Number of CHW and PN Collaborative Meetings and/or work groups attended
- Facilitator guide or materials for others to consistently provide the training.
- Written sustainability plan

Exclusions

- For-profit training programs.
- Programs with no other funding strategy/support.

References

http://patientnavigatortraining.org/