



COLORADO

Department of Public
Health & Environment

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Amendment 35

Cancer, Cardiovascular and Pulmonary Disease (CCPD) Competitive Grants Program

FY17-18 CCPD Strategy Specifications and Metrics Document

February 2016

Background

The Cancer, Cardiovascular and Pulmonary Disease (CCPD) Competitive Grants Program seeks to build a cohesive, comprehensive approach to reduce chronic disease in Colorado by focusing on prevention, early detection, and treatment for cancer, cardiovascular disease and pulmonary disease. To that end, the CCPD Review Committee adopted a strategic framework that aligns with the Chronic Disease State Plan www.colorado.gov/cdphe/chronicdisease, and focuses on specific strategies.

Seventeen strategies were included in the FY 2016-18 CCPD Request for Applications (RFA) and a subset of ten are included in the FY 2017-18 CCPD RFA. Determinations for the subset of strategies included in this RFA were based on the strategic direction of the grant program, the amount of current CCPD Grant Program investment in each strategy area, and the availability of funding from other sources.

CCPD RFA Strategies	FY 2016-2018	FY 2017-2018
Healthy Eating and Active Living		
Strategy 1: Built Environment	●	●
Strategy 2: Breastfeeding-friendly Environments	●	
Strategy 3: Healthy Food Retail	●	●
Strategy 4: Healthy Food and Beverages	●	●
Strategy 5: Comprehensive Worksite Wellness	●	
Cancer		
Strategy 6: Provide/Clinic-based Cancer Prevention	●	●
Strategy 7: Individual-level Cancer Prevention	●	
Strategy 8: Community-based Cancer Prevention	●	●
Cardiovascular Disease		
Strategy 9: Self-measured Blood Pressure Monitoring	●	●
Strategy 10: Team-based Care	●	●
Strategy 11: Clinical Systems Quality Improvement	●	●
Strategy 12: National Diabetes Prevention Program (DPP)	●	●
Strategy 13: Diabetes Self-management Education (DSME)	●	
Pulmonary Disease		
Strategy 14: School-centered Asthma Management	●	●
Patient Navigator/Community Health Worker/Cross-Cutting		
Strategy 15: Patient Navigator Programs	●	
Strategy 16: Community Health Worker Program	●	
Strategy 17: Patient Navigator & Community Health Worker Training	●	

Purpose

This document provides an overview of each strategy as well as **suggested** objectives, measures, intervention strategies, activities, and reporting metrics. This document was developed from the FY16-18 Strategy Specifications and Metrics document, and has been updated to align with the FY17-18 CCPD RFA. Specifically, modifications from the original document to this version include:

- Only including the strategies which are included in the FY 2017-18 CCPD RFA
- Updating the content to align with current evaluation efforts underway

These have been offered in order to assist applicants in preparing their applications because the Review Committee believes it will make the drafting of project narratives and work plans easier. ***Nevertheless, the details provided in Attachment F are not required.***

Introduction to Analytic Framework

The following framework is designed to provide consistency throughout CCPD approved strategies. It identifies specific objectives, outcomes, and intervention methods applicable to each strategy, and should serve as a **guide** for applicants, reviewers, and prospective grantees developing work plans. Below are brief explanations of the core language throughout the framework.

CCPD Approved Strategy is an overall goal or prioritized area of work for the FY16-18 grant cycle.

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

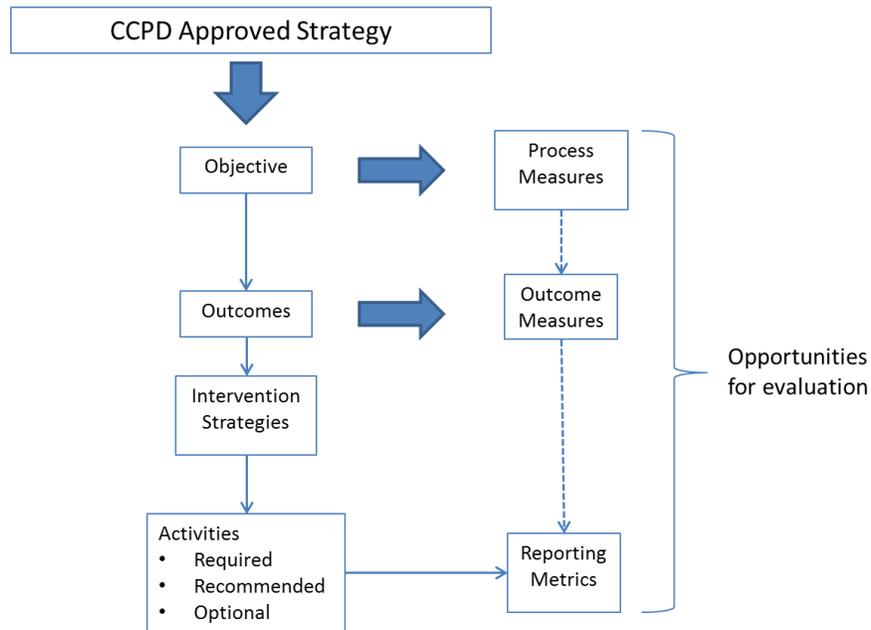
Process or Output Measures provide supporting evidence for the proper implementation of the program.

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, completion of specific program activities and outcomes.



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

1. **Objective:** Phase 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.).

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:** Phase 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.

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:** Phase 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.

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.

Attachment F—CCPD Strategy Specifications and Metrics

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

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.

Activities

- 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 as Health Impact Assessment.
- 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

- **Coalition Details and Outputs:** description of partners/stakeholders participating and roles, meeting attendance, coalition strength, level of engagement and effectiveness, coalition activities, level of collaboration
- **Built Environment Policy Change Outputs:** demographic information of people within target area (count, race/ethnicity, socio-economic status, etc), stage of policy development, count and type of policies/planning documents related to built environment assessed, count and type of sites/settings assessed for built environment opportunities, count and type of gaps or limitations to active living identified, count and type of resources to support active , count and type of policy or strategies being recommended by coalition, count of stakeholders engaged outside of coalition, facilitators and barriers to adoption and implementation of plan and strategies to overcome challenges, count and type of communication outreach strategies, count and type of tools or documents developed for decision makers
- **Short and Medium Term Outcomes:** count of decision makers engaged/supportive of decision (readiness), count of existing opportunities promoted, count of strategies recommended, count and amount of funding sources identified, count of funding plans developed, count of active living plans adopted and by whom
- **Long Term Outcomes:** count and type of strategies adopted, count and type of strategies implemented, count and type of policies adopted to enhance equitable access and availability,

percent of overweight or obese among target population, count and amount of budget allocations for built environment and for what type of improvements

Exclusions

NA

References

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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

1. **Objective:** Phase 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.).

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:** Phase 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.

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

- 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.

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

Reporting Metrics

- **Coalition Details and Outputs:** description of partners/stakeholders participating and roles, meeting attendance, coalition strength, level of engagement and effectiveness, coalition activities, level of collaboration
- **Healthy Food Retail Policy Change Outputs:** demographic information of people and stores within target area (count, race/ethnicity, socio-economic status, etc), stage of policy development, count and description of food retailers identified to date as potential participant, count of store owners and list of stores who completed assessment of perceptions, knowledge and support for healthy food to date, count of customers at each store who completed assessment of perceptions, knowledge and support for healthy food, demographics of customers who completed assessment, count of food retailers recruited and participating in healthy food retail initiative, count of food procurement policies and practices assessed, amount and type of technical assistance provided to food retailers, count and type of communication outreach strategies used
- **Short and Medium Term Outcomes:** count of food retailers participating as vendor of SNAP/WIC programs, count of food retailers considering alternative sources for healthy food inventory (Coop, Farmer's Market), count and description of policies developed to sustain healthy food retail stores, count of food retailers that adopt and implement policies to improve access to healthy food, count of advocacy efforts or community events organized as related to healthy food and beverage choices in support of policy change, count and type of promotional policies modified by food retailer to support healthy food and beverage choices (pricing, signage, displays, etc)

- **Long Term Outcomes:** count of healthy food and beverage options provided in each store, purchase amounts (sales) of healthy foods and unhealthy foods by store, obesity rates

Exclusions

NA

References

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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.

- 1. Objective:** Phase 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.).

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:** Phase 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.**

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:** Phase 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.

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

Intervention Strategies:

- Implement evidence-based nutritional standards in vending and/or concessions.
- Provide technical assistance to modify venter 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.

Activities

- 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
- 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.

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

- **Steering Committee Details and Outputs:** description of partners/stakeholders participating and roles, meeting attendance, steering committee strength, level of engagement and effectiveness, steering committee activities, level of collaboration, number of youth participating in steering committee or number of youth on youth advisory committee (if applicable)
- **Healthy Food and Beverage Policy Change Outputs:** demographic information of people within target area (count, race/ethnicity, socio-economic status, etc), stage of policy development, facilitators and barriers to adoption and implementation of healthy food and beverage policies and practices, count and type of sites assessed for healthy food and beverage offerings, count and type of sites assessed for food procurement policy and practices, description of any

complementary or competing policies found during assessments, count and type of communication outreach strategies used and count of potential individuals reached

- **Short and Medium Term Outcomes:** count of decision makers engaged/supportive of decision (readiness), count of policies restricting access to sugar sweetened beverages by site, count of sites improving water availability, count of policies restricting access to unhealthy foods by site, count of policies increasing access to healthy foods by site, count of sites that develop and implement a practice or procedure to improve access to healthy food and beverage, count of sites that develop and/or adopt policies to improve access to healthy food and beverage, count of vending contracts that are modified to support healthy food and beverage options, count and type of promotional policies modified to support healthy food and beverage choices (pricing, signage, displays, etc), count and percent of healthy foods and beverages offered in vending and concessions by site
- **Long Term Outcomes:** count and type of policies implemented to improve access to healthy food and beverage, purchase amounts (sales) of healthy foods and unhealthy foods by site, percent of overweight or obese among target population

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.

Intended Population

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

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

- 1. Objective:** 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.

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 community-based cancer prevention (Strategy 8).

Activities:

- 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

- 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.

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:** Compared to baseline rates, ***HPV vaccinations will increase*** among those clinics that have implemented a systems-level approach to cancer prevention best practices.

Intervention strategies:

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

Activities:

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

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:** 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.

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).

Activities:

- 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.
- Electronic Health Record reporting and workflow capacity.

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

Reporting Metrics:

- **Provider/Clinic Based Cancer Prevention Outputs:** count and description of clinical sites, demographics of target population (age, race/ethnicity, urban/rural, socioeconomic status), count and type of clinic policy and practice interventions implemented, count and type of provider communication interventions implemented, count of providers/staff trained to identify high risk patients, cancer screening rates of eligible target population, count of individuals referred to survivorship clinic, count of individuals referred for risk assessment with appropriate genetic specialist, appointment show or no-show rates for referrals made to survivorship clinic or risk assessment, count of patients referred for patient navigation services, count of eligible individuals adhering to HPV guidelines, count of educational materials for providers/staff
- **Short and Medium Term Outcomes:** count of provider reminders, count of clients eligible for cancer screening who are in adherence with USPSTF guidelines, count of patient-specific cancer treatment summaries developed, count of self-management care plans developed, count of

clients identified as increased risk based on family history of cancer, count of patients in adherence with best practices for genetic counseling and testing, count of eligible target clinic population who completed recommended HPV vaccinations (completed series of 3), count of cancer survivors who are in adherence with evidence-based best practices within their cancer treatment summary and self-management care plans

- **Long Term Outcomes:** colorectal cancer screening rates of eligible patients, lung cancer screening rates of eligible patients, HPV vaccination rates among eligible patients, common metrics will be required for survivorship and genomic strategies after consultation with evaluation group

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.

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

A. Strategic Outcome: Compared to baseline rates, a higher proportion of eligible Coloradans within a defined geographic area will have completed the HPV vaccine series.

1. Objective: 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.

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: 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).

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

- 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.
- 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

- **Steering Committee or Coalition Details and Outputs:** description of partners/stakeholders participating and roles, meeting attendance, coalition strength, level of engagement and effectiveness, coalition activities, level of collaboration, number of youth participating in steering committee or number of youth on youth advisory committee (if applicable)
- **HPV Vaccination Policy Change Outcomes:** stage of policy development, description of how existing HPV materials feedback was reviewed and received (focus groups, interviews, etc) and with whom (committee, providers, target audience), count of higher education institutions worked with to promote HPV vaccination enrollment policies, count of providers worked with to promote HPV awareness, counts of HPV resources developed and disseminated and to whom, count and type of communication outreach strategies, potential reach of communication outreach strategies, count and type of decision-making tools developed and shared
- **Short and Medium Term Outcomes:** count and scope of drafted model HPV policies, measures of communication contact (parent/public acceptance of HPV vaccination, count of schools with HPV vaccine requirement implemented into policy, count of implemented HPV vaccination access points that use CIIS
- **Long Term Outcomes:** count of youth initiating HPV vaccination, count of youth completing HPV vaccination series, frequency of HPV cases

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 Outcome: Compared to baseline rates, reported habitual use of at least one method of sun protection will be more prevalent and sunburn will be less prevalent among Coloradans within a defined geographic area.

1. Objective: The grantee will develop and implement a communication and engagement plan to promote UV-protective behaviors.

Intervention Strategies:

- Integrated, multi-component 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:** The grantee will develop a ***model Sun Safety Plan*** 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.

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

- 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.
- 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

- **Coalition Details and Outputs:** description of partners/stakeholders participating and roles, meeting attendance, coalition strength, level of engagement and effectiveness, coalition activities, level of collaboration
- **Sun Safety/Built Environment Policy Change Outputs:** demographic information of people within target area (count, race/ethnicity, socio-economic status, etc), stage of policy development, count and type of policies/planning documents related to built environment assessed, policy analysis of UV-protective policies and procedures in public space and built environment infrastructure, including public acceptance, and political feasibility, count and type of policy or strategies being recommended by coalition, count of stakeholders engaged outside of coalition, facilitators and barriers to adoption and implementation of plan and strategies to overcome challenges, count and type of communication outreach strategies, count and type of tools or documents developed for decision makers
- **Short and Medium Term Outcomes:** count of decision makers engaged/supportive of decision (readiness), count of existing opportunities promoted, count of strategies recommended, count and amount of funding sources identified, count of funding plans developed, count of sun safety/built environment plans adopted and by whom
- **Long Term Outcomes:** count and type of strategies adopted, count and type of strategies implemented, count and type of policies adopted to enhance sun safety, sun safety behavior

change (covering up, sunscreen use, using shade), count and amount of budget allocations for built environment related to sun safety and for what type of improvements

Exclusions

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

C. Strategic Outcome: Compared to baseline rates, residential exposure to radon will be less prevalent among Coloradans within a targeted geographic location.

1. Objective: 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.

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

- Combine with Objective 2 strategies and activities

2. Objective: 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.

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

- Combine with Objective 1 strategies and activities

Reporting Metrics

- **Coalition/Steering Committee Details and Outputs:** description of partners/stakeholders participating and roles, meeting attendance, coalition strength, level of engagement and effectiveness, coalition activities, level of collaboration
- **Radon Policy Change Outputs:** stage of policy development, count and type of communication outreach strategies developed, count and type of education resources developed and disseminated and to whom, count and type of tools or documents developed for decision makers, count and type of organizations involved in policy discussions (state division of real estate, etc)
- **Short and Medium Term Outcomes:** count and scope of drafted model policies for real estate transactions and building codes, measures of communication contact (public acceptance, political feasibility), count of prioritized strategies recommended (update building codes for new construction, real estate transaction policies, etc)
- **Long Term Outcomes:** count and scope of radon policies adopted, count and type of building codes or processes changed, count of existing homes with reduction in radon levels

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.

A. Strategic Outcomes

- Compared to baseline rates, adherence to blood pressure monitoring best-practice guidelines will be more prevalent among patients diagnosed as pre-hypertensive or hypertensive.
- Compared to baseline rates, self-management plans will be more prevalent among patients with diagnosed hypertension.
- 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.
- Compared to baseline rates, medication adherence will be more prevalent among hypertensive and pre-hypertensive patients who routinely monitor their blood pressure.

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

- 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.
- 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

- **Self Measured Blood Pressure Outputs:** count of patients in target population with hypertension, demographics of target population, count of patients enrolled into a self-measured blood pressure monitoring program, demographics of patients participating in self-measured blood pressure monitoring program, count of patients who received monitor, count of patients trained to use monitor (and trained by whom), count of patients that participated in additional educational support or lifestyle change programs, count of patients that participated in additional counseling support programs, count of patients referred to community resources (including description of community resources), count of patients that participated in additional technical assistance support programs
- **Short and Medium Term Outcomes:** count of patients in adherence to blood pressure monitoring best practices, count of patients with self-management plans to help control hypertension, count of patients with blood pressure consistently under 120-139/80-89, count of patients adhering to medication, patient satisfaction of self-measured blood pressure monitoring program and support, provider satisfaction and feedback of self-measured blood pressure monitoring program and support provided to their patients
- **Long Term Outcomes:** proportion of patients with controlled hypertension (NQF 0018), proportion of patient diagnosed with hypertension who have self-management plans

Exclusions

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

References

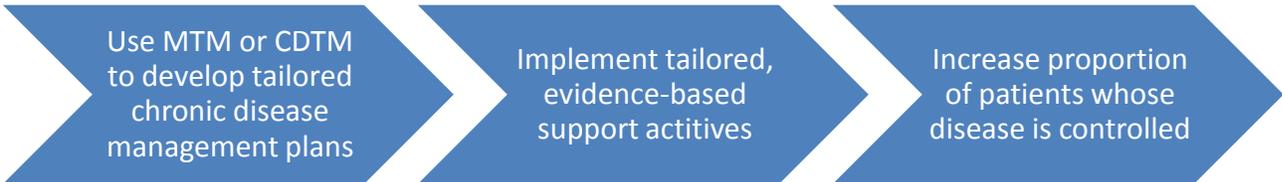
Clinical Usefulness and Cost Effectiveness of Home Blood Pressure Tele-monitoring: Meta-Analysis of Randomized Controlled Studies, *Journal of Hypertension*, March 31, 2013.

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, hyperlipidemia and diabetes

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

- 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.
- 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.
 - 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

- **Team-based Care (MTM or CDTM) Outputs:** total number of patients in target population, count of patients in target population with hypertension, diabetes and hyperlipidemia, demographics of patients with each chronic disease and in patient population, count of patients referred to and enrolled in MTM, count of MTM and CDTM patients that have received an activity tracker, count of MTM patients referred to a specialty care provider, number of hours of MTM provided by pharmacist, count of MTM patients who received a comprehensive medication review, count of agreements established with pharmacists to offer CDTM, number of hours of CDTM provided by pharmacists, count of CDTM patients that have received a comprehensive medication review, count of CDTM patients referred to a LCSW, count of CDTM

patients referred to a specialty provider, count of CDTM participants participating in individual and/or group sessions, count and type of referral policies and acceptance criteria, count of primary care providers participating in programs,

- **Short and Medium Term Outcomes:** count of patients with self-management plans to help control by chronic disease, count of patients adhering to medication by chronic disease, count and severity of adverse events avoided, patient satisfaction with MTM or CDTM program, provider feedback and satisfaction with MTM or CDTM program, documentation of communication feedback loop between primary care provider, pharmacists and other members of team, count of practice agreements in place to maintain or support team-based care processes implemented
- **Long Term Outcomes:** count of patients with controlled hypertension (NQF 0018), count of patients with poorly controlled diabetes (A1c) (NQF 0059), count of providers who have improved hypertension and diabetes control rates among patient panel

Exclusions

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

References

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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2231556/table/t1-0532144/>

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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.

Objective: 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.

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

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

Reporting Metrics

- **CQI Process Outputs:** count of individual clinics or sites, count of clinic providers and staff reached, description of CQI implementation activities, type of chronic condition(s) being addressed in target population, description of activities and priorities for CQI support tools to enhance EHR effectiveness in treating and managing chronic diseases by clinic or site, count of sites receiving technical assistance, types of technical assistance provided, count of patients with tailored chronic disease self-management plans in EHRs by site, count of patients with hypertension by site (including demographics), count of patients with diabetes by site (including demographics), count of patients with hypertension who have self-management plans by site, count of patients with diabetes who have self-management plans by site, count of patients in system with a certified electronic health record by site
- **Short and Medium Term Outcomes:** count of clinics or sites with certified EHR, count of patients who participate in system-level changes/initiatives (including demographics), count of patients referred to other services and types of services (DPP, DSME, health coaching, etc)(including demographics), count of patients with hypertension who are adherent to hypertension-controlling medication, count of patients with diabetes who are adherent to diabetes-controlling medications, count of sites with EHRs appropriate for treating patients with diabetes and/or high blood pressure
- **Long Term Outcomes:** count of patients with controlled hypertension (NQF 0018), count of patients with poorly controlled diabetes (A1c) (NQF 0059), count of providers who have improved hypertension and diabetes control rates among 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 $\geq 24 \text{ kg/m}^2$ ($\geq 22 \text{ kg/m}^2$, 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.

Objective: 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.

Intervention strategies:

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

Objective: 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).

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

- 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).
- 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

- **CDC Diabetes Prevention Recognition Program Required Process and Outcomes:** 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
- **DPP Infrastructure Outputs:** DPP initiative(s) was launched, Number of trained lifestyle coaches to lead DPP initiative, count and description of potential partners and activities related to partnership development, description of established fiscal partnership to sustain DPP program(s), count and description of established referral policies or practices with health care systems to support enrollment into DPP program(s), count and description of patient feedback loops to share necessary patient data with primary care providers to enhance coordination
- **Short and Medium Term Outcomes:** count of DPP core completers, count of DPP post-core completers
- **Long Term Outcomes:** count of clients who achieved 5-7% decrease in overall body weight, count of clients consistently reporting exercising a minimum of 150 minutes per week

Exclusions

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

Targeted Population

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

Strategic Outcomes:

- Compared to baseline rates, asthma control will be more prevalent among students diagnosed with asthma.
- Compared to the baseline rate, asthma action plans and self-management activities will be more prevalent among students with diagnosed asthma.
- 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.

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

- 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
- 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

- **School-Centered Asthma Management Process and Outputs:** count and identification of targeted school district (s), school district readiness for asthma management program (buy-in from leadership, district liaison and school personnel assignments, etc), count of meetings with school staff (administrative, liaison, nursing, leadership, etc), count of students with asthma and severity of asthma (include demographics), count of students with asthma counselor, count of students and families linked to medical assistance programs or medical homes, count of students with school action plans/self management plans, count of students with asthma who have a documented asthma action plans at home,
- **Short and Medium Term Outcomes:** district commitment to make changes and provide needed resources for asthma management program, count and description of student’s activities limited by asthma, description of negative impact on grades or school performance, student knowledge of asthma treatment and asthma prevention, number of students with asthma with prescribed asthma-controlling medications used properly, number of students with asthma who have prescribed quick relief inhaler available at school
- **Long Term Outcomes:** number of students with asthma who have documented school asthma action plans at school, number of number of students with controlled asthma, number of school days missed due to asthma per student and overall, number of urgent care/emergency room visits due to asthma per student and overall, number of hospital admissions due to asthma

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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