Regional Community Health Improvement Plan

Outcome Measurement Strategies

Albany and Rensselaer Counties

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Goal	Outcome Objective	Intervention/ Strategies, Activities	Partner Resources	Partner roles	Process Measures
Prevention Agenda Goal 3.1 Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, economically among disparate populations.	Prevention Agenda overarching objective 3.1.4: Increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 17% from 58.8% (2011) to 61.7%. (Data Source: NYS BRFSS)	Promote prediabetes screenings and education through the use of evidence based tools.	**Counties**: Serves county residents in physical health and mental health activities. **Hospitals:** Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers. **Community Based Organizations** Diabetes association, and diabetes educators. Health and wellness facilities, and recreation.	**Counties**: Educate and provide technical assistance to primary care offices (Public Health Detailing). **Hospitals**: Provide access to professionals to become trained on the Prediabetes Screening and resources available. **Partner C:** Provide technical assistance and guidance on algorithms of care. Provide community resources for physicians referring to diabetes self-management supports.	Number of Healthcare Professionals educated on the Evidenced Based Screening tool. {http://www.cdc.gov/diabetes/prevention/pdf/prediabetestest.pdf} Number of primary care offices receiving visits, materials.
Prevention Agenda Goal #3.3: Promote culturally relevant chronic disease self-management education.	Prevention Agenda overarching objective 3.3.1: Reduce use of hospital for short-term complications of diabetes 18+ years by 3% {7.7/10,000 (2012-14) to 7.4/10,000 (2018)}.	Participation of adults in self-management programs.	**Counties:** National Diabetes Prevention Program (NDPP) Lifestyle coaches are on staff. Promote existing NDPP programs. **Hospitals:** Primary Care, Urgent Care, Behavioral Health, Endocrinology, Outpatient Nutrition Counseling, CDE Services and Hospital Providers. **Community Based Organizations:** Local NDPP programs. Parks and recreation and health and wellness programs. Diabetes association and diabetes educators.	**Counties:** Promote and provide NDPP Training. **Hospitals:** Offer NDPP to employees, and encourage patients to participate in NDPP. **Community Based Organizations:** Provide NDPP Programs. Provide community self-management resources.	Number of new sites providing Prediabetes NDPP and YDPP. Number of participants enrolled in the NDPP and YDPP. Number of Resource Guides circulated.

2016-2018- PHIP CHIP Implementation Plan

Quarter Deadline	Action Planning	Description
First Quarter	Who Does What?	• Organizational description • Contacts for lead intervention strategies and process measures
	How will it be measured, and implementation plan development.	• Identify current baseline and develop a plan to track activities • Identify who will implement measurement plan
	Implement measurement	• Begin tracking intervention strategies and activities
	First quarter tracking report (January-March activities)	• Report out 1st quarter activities • Review successes and barriers to reaching 1st quarter goals • HCDI: Record 1st quarter success stories

Multi-county *quarterly tracker*

PROCESS MEASURE	Organization	Responsible Partners Incl. Name and Direct Contact Information	Current Status	Successes or Challenges
Number of Healthcare Professionals educated on the Prediabetes Evidenced Based Screening tool.				
Number of YDPP/NDPP Participants & Graduates				
Number of YDPP/NDPP new sites				