2023 CHIP/CSP WORK PLAN

Counties: Columbia County; Greene County
Organiztions: Columbia County Department of Health
Greene County Public Health
Columbia Memorial Health
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.4: Increase the percentage of adults age 18 years and older with obesity (among all adults)	N/A	Expand access to the Biggest Loser Contest, a 16 week, independent weight loss program.	Number of registrants; Number of participants initiating the program; Number of participants completing the program; Number of participants who have lost at least 5% of their beginning weight	...recruiting participants and implementing one 16-week cycle of Biggest Loser Contest	Community-based organizations	Staff experience and support initiating and maintaining engagement of participatns for Biggest Loser Contest
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.6: Decrease the percentage of adults ages 18 years and older with obesity (among adults living with a disability)	N/A	Provide nutritional education in one-on-one and group settings to patients in the inpatient psychiatric unit at Columbia Memorial Hospital	Number of patients receiving nutrition education one-on-one; Number of patients receiving nutrition education in groups	Developing a mechanism for referring to/engaging patients in nutrition education, whether one-on-one or in the group setting, and tracking their participation	Other (please describe partner and role(s) in column D)	The Hospital will rely upon the nutritionists from its contracted food service agency to deliver the nutrition education
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.6: Increase the percentage of adults age 18 years and older with obesity (among adults living with a disability)	N/A	Provide an exercise program to patients in the inpatient psychiatric unit at Columbia Memorial Hospital	Number of patients who participate in the program when offered; Percent of patients who participate in the program when offered	...developing a mechanism for referring to/engaging patients in the exercise program and tracking their participation	Other (please describe partner and role(s) in column D)	The Hospital will contract with a third-party to provide an exercise program
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Objective 4.3.1: Decrease the percentage of adult patients with diabetes whose most recent HbA1c level indicated poor control (>9%)	N/A	Promote evidence-based medical management in accordance with national guidelines	Track a variety of measures related to diabetes control in the outpatient setting, including diabetic eye exams, HgbA1C, nephropathy screenings, blood pressure control, and Statin use	...an inventory of staff needing education on evidence-based medical management of obesity, prediabetes and diabetes; training of staff; the development of a mechanism for collecting and reporting these data points	Providers	The Hospital will rely upon its network of primary care providers and nursing staff to deliver the appropriate care; staff engaged in quality assurance and the management and monitoring of performance of value-based payment arrangements with a variety of health plans will also be engaged
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	By December 31, 2024, increase the percentage of adults (18+) who were given a diabetes action plan by a health professional by 10%	N/A	Utilizing a diabetes educator, provide nutrition education and dietary consults to patients of the family care centers (i.e. outpatient) with a diabetes diagnosis	Number of patients with a diabetes diagnosis who meet with a diabetes educator; Percent of patients with a diabetes diagnosis who meet with a diabetes educator	...hiring of the diabetes educator; establishing patient referral protocols; a mechanism for tracking referrals; a mechanism for tracking completed consultations between the educator and patients	Providers	The Hospital will rely upon its network of primary care providers and nursing staff to develop protocols for identifying and referring appropriate patients to the educator
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Objective 4.4.1: By December 31, 2024, increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or classes to learn how to manage their condition by 25 % from 6.0 to 7.5 (Columbia), 5.3 to 6.6 (Greene).	N/A	Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.	Number of health systems that have policies/practices for identifying and referring patients to the National DPP programs; Number of National DPP programs in the community setting; Number of patients referred to the National DPP; Number of patients who participate in the National DPP; Percentage of patients who complete the National DPP	....recruiting participants and initiating the National DPP Program in a community setting	Community-based organizations	Assist in hosting and coordinating National DPP program
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Objective 4.4.1: By December 31, 2024, increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or classes to learn how to manage their condition by 25 % from 6.0 to 7.5 (Columbia), 5.3 to 6.6 (Greene).	N/A	Increase knowledge and awareness of Type 2 Diabetes through a media campaign.	Number of awareness campaigns; Number of mediums used to reach the public; Number of impressions; Number of clicks to webpage; Number of ads run; Number of post-engagements	...creating and implementing digital media campaign for diabetes education and awareness, which will be focused during November 2023, National Diabetes Awareness month	Community-based organizations	Assist in creation and promotion of Diabetes education and awareness materials through earned media and local media partners