

Attachment C : PERFORMANCE MEASURES

Component 1 A: Environmental strategies to promote health and support and reinforce healthful behaviors

Strategy	Performance Measures
1A.1. Implement nutrition and beverage standards including sodium standards (i.e., food service guidelines for cafeterias and vending) in public institutions, worksites and other key locations such as hospitals	<p><u>Short-term:</u> 1) #of key community locations (e.g., number of separate public institutions, worksites, and hospitals, etc.) that implement nutrition and beverage standards 2) # of adults who have access to key community locations that implement nutrition and beverage standards</p> <p><u>Intermediate:</u> 1) Consumption of fruits, vegetables, and healthy drinks. Data source is purchase data from participating venues</p>
1A.2. Strengthen healthier food access and sales in retail venues (e.g., grocery stores, supermarkets, chain restaurants, and markets) and community venues (e.g. food banks) through increased availability (e.g. fruit and vegetables and more low/no sodium options), improved pricing, placement, and promotion	<p><u>Short-term:</u> 1) # of retail venues in the community or jurisdiction (e.g., grocery stores, supermarkets, chain restaurants, and markets) and community venues (e.g. food banks) that promote healthier food access through increased availability, and improved pricing, placement and promotion 2) # of adults, who have access to retail venues and community venues that promote healthier food access</p> <p><u>Intermediate:</u> 1) Consumption of fruits, vegetables, and healthy drinks. Data source is purchase data from participating venues (note: food bank measure more likely to be inventory data)</p>
1A.3. Strengthen community promotion of active modes of transportation and community venues for physical activity through signage, worksite policies and practices, social support, and joint use agreements for schools, community centers, parks, fitness facilities in communities and jurisdictions.	<p><u>Short-term:</u> 1) # and type of community venues that promote physical activity through signage, worksite policies and shared-use/joint use agreements 2) # of adults who have access to community venues that promote physical activity</p> <p><u>Intermediate:</u> 1) # of adults who meet physical activity guidelines. Data source: SMART BRFSS data, if available.</p>
1A.4. Develop and/or implement transportation and community plans that promote walking	<p><u>Short-term:</u> 1) # of communities that develop and/or implement a transportation plan that promotes walking 2) # of adults who have access to communities that develop and/or implement plans to promote walking</p> <p><u>Intermediate:</u> 1) # of adults who meet physical activity guidelines. Data source: SMART BRFSS data, if available</p>

1 B: Strategies to build support for healthy lifestyles, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts

Strategy	Performance Measures
1B.1. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for lifestyle change. For example, create and implement a comprehensive plan to build support for evidence-based lifestyle change; i.e., the Diabetes Prevention Program (DPP) and coordinate with existing organizations and programs supporting evidence-based lifestyle change.	<p><u>Short-term:</u> 1) # of unique sectors represented in the network (e.g. employers, insurers, health systems, representatives of community organizations, food banks, and others) 2) Annual participation/response rate of network partners in network self-assessments</p> <p><u>Intermediate:</u> # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC Diabetes Prevention Recognition Program "DPRP")</p>

1 B: Strategies to build support for healthy lifestyles, particularly for those at high risk, to support diabetes and heart disease and stroke prevention efforts (continued)	
Strategy	Performance Measures
1B.2. Implement evidence-based engagement strategies (e.g. tailored communications, incentives, etc.) to build support for lifestyle change; i.e., the Diabetes Prevention Program (DPP).	<u>Short-term:</u> 1) # of people reached through evidence-based engagement strategies <u>Intermediate:</u> 1) # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)
1B.3. Increase coverage of evidence-based supports for lifestyle change by working with network partners (e.g., educate employers about the benefits and cost-savings of evidence-based lifestyle change programs such as the DPP as a covered health benefit).	<u>Short-term:</u> 1) # of employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit <u>Intermediate:</u> 1) # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)
2 A. Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities	
Strategy	Performance Measures
2A.1. Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance (e.g., work with health system partners to implement advanced Meaningful Use data strategies to identify patient populations who experience CVD-related health disparities)	<u>Short-term:</u> 1) % of patients within health care systems with electronic health records appropriate for treating patients with high blood pressure <u>Intermediate:</u> 1) Proportion of adults with high blood pressure in adherence to medication regimens
2A.2. Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider level (e.g., use dashboard measures to monitor healthcare disparities and implement activities to eliminate healthcare disparities)	<u>Short-term:</u> 1) % of persons within health care systems with systems to report standardized clinical quality measures for the management and treatment of patients with high blood pressure <u>Intermediate:</u> 1) Proportion of adults with high blood pressure in adherence to medication regimens
2A.3. Increase engagement of non-physician team members (i.e. nurses, pharmacists, and nutritionists, physical therapists, and patient navigators/community health workers) in hypertension management in health care systems including FQHCs, local public health in communities	<u>Short-term:</u> 1) % of patients within health care systems with policies or systems to encourage a multi-disciplinary team approach to blood pressure control <u>Intermediate:</u> 1) Proportion of adults with high blood pressure in adherence to medication regimens
2A.4. Increase use of self-measured blood pressure monitoring tied with clinical support	<u>Short-term:</u> 1) % of patients within health care systems with policies or systems to encourage self-monitoring of high blood pressure <u>Intermediate:</u> 1) Proportion of patients with high blood pressure that have a self-management plan (may include medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments)

2 A. Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities (continued)	
Strategy	Performance Measures
2A.5. Implement systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes	<p><u>Short-term:</u> 1) % of patients within health care systems with policies or systems to facilitate identification of patients with undiagnosed hypertension and people with prediabetes</p> <p><u>Intermediate:</u> 1) Proportion of adults with high blood pressure in adherence to medication regimens 2) # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)</p>
2 B. Community Clinical Linkage Strategies to Support Heart Disease and Stroke and Diabetes Prevention Effort	
Strategy	Performance Measures
2B.1. Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes	<p><u>Short-term:</u> 1) # of health systems that engage CHWs to link patients to community resources that promote self-management of high blood pressure and prevention of type 2 diabetes</p> <p><u>Intermediate:</u> 1) Proportion of adults with high blood pressure in adherence to medication regimens 2) Proportion of patients with high blood pressure that have a self-management plan [including medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments] 3) # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC DPRP)</p>
2B.2. Increase engagement of community pharmacists in the provision of medication-/self- management for adults with high blood pressure	<p><u>Short-term:</u> 1) # of community pharmacists that promote medication-/self-management</p> <p><u>Intermediate:</u> 1) Proportion of adults with high blood pressure in adherence to medication regimens 2) Proportion of patients with high blood pressure that have a self-management plan (including medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments)</p>
2B.3. Implement systems and increase partnerships (e.g., EHRs, 800 numbers, 211 referral systems, etc.) to facilitate bi-directional referral between community resources and health systems including lifestyle change programs (i.e., DPP)	<p><u>Short-term:</u> 1) # of health care systems with an implemented community referral system for evidence-based lifestyle change programs</p> <p><u>Intermediate:</u> 1) # of persons with high blood pressure who enroll in an evidence-based lifestyle change program 2) # of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program</p>