Name of County - Organization(s)
2019 Workplan

Broome County Health Department, United Health Services Hospitals, Our Lady of Lourdes Ascension Hospital

Broome County Health Department, United Health Services and Our Lady of Lourdes Acension Hospital

Planning Report Liaison Dr.Yvonne Johnston, Mary McFadden
E-mail: mary.mcfadden@broomecounty.us
yvonne.johnston@broomecounty.us

Dr.Yvonne Johnston, Mary McFadden
mary.mcfadden@broomecounty.us
yvonne.johnston@broomecounty.us

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.1 By December 31, 2024, decrease the percentage by 1, of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) from 13.9 % to 12. 9%.	WIC Children Ages 2-4	Continue to promote decreased fat WIC food package	Number of WIC participants receiving a reduced fat food package.	BCHD WIC 1) Continue to promote decreased fat WIC food package, 2) Healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC children once each year for 2-4 year olds. 3) Height, weight and BMIs measured for children ages 2-4 with nutrition counseling provided. LOURDES - (1) Parents and Children Together (PACT) and ImPACT home visiting programs promote breastfeeding and share information regarding healthy nutrition for infants, toddlers and youth. (2) PACT home	BCHD WIC 1) Continue to promote decreased fat WIC food package, 2) Healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC children once each year for 2-4 year olds. 3) Height, weight and BMIs measured for children ages 2-4 with nutrition counseling provided. LOURDES: Continue (1) Parents and Children Together (PACT) and ImPACT home visiting programs promote breastfeeding and share information regarding healthy nutrition for infants, toddlers and youth. (2) PACT	BCHD WIC 1) Continue to promote decreased fat WIC food package, 2) Healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC children once each year for 2-4 year olds. 3) Height, weight and BMIs measured for children ages 2-4 with nutrition counseling provided. LOURDES: Continue (1) Parents and Children Together (PACT) and ImPACT home visiting programs promote breastfeeding and share information regarding healthy nutrition for infants, toddlers and youth. (2) PACT	Local health department	BCHD provides promotion of healthy lifestyle education and services of the WIC program, UHS will oversee and administer UHS Stay Healthy Kids Program. LOURDES will oversee the activiteis conducted by the PACT program. Both UHS and Lourdes will ensure communication to providers about referrals to the Broome County WIC program, for pregnant women, lactating women, post partum women, infants and children up to 5 years of age
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.1 By December 31, 2024, decrease the percentage by 1, of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) from 13.9 % to 12. 9%.	WIC Children Ages 2-4	Healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC children once each year for 2-4 year olds.	Number of WIC participants receiving general nutrition education and active learning information	Healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC families once each year for 2-4 year olds. Broome County WIC program has completed this intervention	Continue healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC families once each year for 2-4 year olds.	Continue healthy lifestyle education about increased consumption of fruits and vegetables, decreased portions, and increased physical activity for all WIC families once each year for 2-4 year olds.	Local health department	Broome County Health Department is the lead agency for the WIC program. Resources for the WIC program come from NYSDOH.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.2 By December 31, 2024, decrease the percentage of children with obesity by 1 % from 17.7% to the Prevention Agenda goal of 16.7%.	School-age children who are obese	UHS - (1) UHS Stay Healthy Kids Coordinator continues to work with Head Start schools to provide monthly classes on site, to children age 3-5. Healthy eating and exercise tips are provided to children and their parents. The program has been expanded from 12 classes to 18 per month. (2) The "Kids on Track" 8-week program continues in the Spring and Fall for children 5-13. This program covers exercise and	(1) Number of students impacted by specific policies that address healthier nutrition standards for food and beverages sold in schools (2) Number of school districts adopting specific policies that address healthier nutrition standards for food and beverages sold in schools (3) Number of school district wellness policies that address free drinking water, 4)	UHS - (1) UHS Stay Healthy Kids Coordinator continues to work with Head Start schools to provide monthly classes on site, to children age 3-5. Healthy eating and exercise tips are provided to children and their parents. The program has been expanded from 12 classes to 18 per month. (2) The "Kids on Track" 8-week program continues in the Spring and Fall for children 5-13. This program covers exercise and nutrition appropriate to the age group. Anywhere from 50 -115 children attend. 1) School Wellness Programs - Establish and incorporate strong	UHS - 1) UHS Stay Healthy Kids Coordinator continues to work with Head Start schools to provide monthly classes on site, to children age 3-5. Healthy eating and exercise tips are provided to children and their parents. The program has been expanded from 12 classes to 18 per month. 2) The "Kids on Track" 8-week program continues in the Spring and Fall for children 5-13. This program covers exercise and nutrition appropriate to the age group. Anywhere from 50 -115 children attend. 1) Continue to implement school wellness program - incorporate strong	UHS - 1) UHS Stay Healthy Kids Coordinator continues to work with Head Start schools to provide monthly classes on site, to children age 3-5. Healthy eating and exercise tips are provided to children and their parents. The program has been expanded from 12 classes to 18 per month. 2) The "Kids on Track" 8-week program continues in the Spring and Fall for children 5-13. This program covers exercise and nutrition appropriate to the age group. Anywhere from 50 -115 children attend. Schools - 1) Continue to implement school wellness standards -	K-12 School	UHS provides a Stay Healthy Kids Coordinator who educates headstart students, and public school age children/parents on healthy eating and beverage consumption choices- Care Compass Network - Innovation funding to UHS: Community based Nutrition Wellness (education to take place at Cornell Cooperative Extension of Broome County). BCHD will work with school districts to ensure wellness policies are following the required standards set forth by the Healthy Hunger Free Kids Act, and provide technical
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.3 By December 31, 2024, decrease the percentage of adults ages 18 years and older with obesity, from 25.7% to 23.7%.	Adults 18 and older, Focus on Lower Socioeconomic Stauts	LOURDES - Develop medical weight loss program to support people aged 18 years and above with a BMI >30 in achieving a decrease in their BMI and improvement in overall health.	1) Lourdes (Adults) - Percentage of those engaged in the program that demonstrate a decrease in BMI.	Lourdes: Develop Medical Weight Loss Program in the community that provides a multidisciplinary team for patient support in teaching their weight loss goals. BCHD- 2) Work with municipalities to implement Complete Streets policies, 3) Garner earned media on healthy eating, sugar content of many beverages & promoting healthy beverages, 4) Work with community based organizations, worksites and recreation venues to create policies related to sugary drink reductions, healthy meeting guidelines and/or food procurement standards	Lourdes: Implement and Evaluate Medical Weight Loss Program, BCHD- Continue to 2) Work with municipalities to implement Complete Streets policies, 3) Garner earned media on healthy eating, sugar content of many beverages & promoting healthy beverages 4) Work with community based organizations, worksites and recreation venues to create policies related to sugary drink reductions, healthy meeting guidelines and/or food procurement standards	Lourdes: Continue to evaluate and sustain medical weight loss program. BCHD- Continue to 2) Work with municipalities to implement Complete Streets policies 3) Garner earned media on healthy eating, sugar content of many beverages & promoting healthy beverages 4) Work with community-based organizations, worksites and recreation venues to create healthy meeting guidelines and/or food procurement standards	Hospital	Lourdes Hospital will oversee their community weight loss initative and provide any necessary resources related to it.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.3 By December 31, 2024, decrease the percentage of adults ages 18 years and older with obesity, from 25.7% to 23.7%.	Adults 18 and older, Focus on Lower Socioeconomic Stauts	Utilize NYSDOH, CDC, and locally developed messaging to garner earned media on healthy eating, sugar content of many beverages & promoting healthy beverages	1) Number of earned media items garned around healthy eating, 2) Number of earned media items garned around sugary drinks, 3) Percentage of adults ages 18 years and older with obesity 4) Percentage of adults who consume more than one or more sugary drink per day	BCHD provided 5 earned media items around healthy eating/healthy beverage consumption	Continue to issue earned media items: social media posts, letters to the editor, news releases, news interviews and PSA's every quarter to increase public awarness around healthy eating/beverage consumption and obesity	Continue to issue earned media items: social media posts, letters to the editor, news releases, news interviews and PSA's every quarter to increase public awarness around healthy eating/beverage consumption and obesity	Local health department	BCHD will create content for public messaging to promote healthy eating and healthy beverage consumption, UHS will share BCHD earned media items in their social media, newsletters, and public facing venues, Lourdes will share BCHD earned media items in their social media, newsletters, and public facing venues
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.3 By December 31, 2024, decrease the percentage of adults ages 18 years and older with obesity, from 25.7% to 23.7%.	Adults 18 and older, Focus on Lower Socioeconomic Stauts	BCHD - Work with community based organizations, worksites and recreation venues to create policies related to sugary drink reductions, healthy meeting guidelines and/or food procurement standards	1) Percentage of adults ages 18 years and older with obesity 2) Percentage of adults who consume more than one or more sugary drink per day 3) Number of policies or food procurement standards adopted in worksites, commuity based organizations, recreation venues and health care institutions	BCHD worked with 8 worksites in 2019 to establish healthy meeting guidelines.	BCHD- Will work with community based organizations, worksites, healthcare systems, food pantries and recreation venues to create policies related to sugary drink reductions, healthy meeting guidelines and/or food procurement standards	BCHD- Will work with community based organizations, worksites, healthcare systems, food pantries and recreation venues to create policies related to sugary drink reductions, healthy meeting guidelines and/or food procurement standards	Local health department	BCHD will provide 2 $500 subawards through the Creating Healthy Schools and Communities Program, for an institution to establish policies related to sugary drink reductions, healthy meeting guidelines and/or food procurement standards, Rural Health Network of South Central New York will assist with recruitment of agencies, UHS and Lourdes Hospitals will work with BCHD and consider implementation of food standard policies
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	1.2.2 Decrease the percentage of adults from 31.9% to 27.9%, who consume less than one fruit and less than one vegetable per day.	Lower Socioeconomic Status adults living in highrisk neighborhoods	Increase CHOW mobile markets in high risk neighborhoods, Cornell Cooperative Extension to provide nutrition education, menu and budget planning to SNAP recipients, OFA - Provide healthy meals & snack at Senior Centers and community events, increase redemption of Office for	1) Percentage of adults who consume less than one fruit and less than one vegetable per day, 2) Number of SNAP recipients educated on nutrition,budget and meal planning, 3) Number of OFA Senior Sites providing healthy meals, 4) Number of Seniors	Provide 7 CHOW mobile markets in high risk neighborhoods, Cornell Cooperative Extension to provide nutrition education, menu and budget planning to SNAP recipients, OFA - Provide healthy meals & snack at Senior Centers and community events, increase redemption of Office for Aging and WIC participants farmer's market coupons, open grocery store on Northside of Binghamton	Provide 7 CHOW mobile markets in high risk neighborhoods, Cornell Cooperative Extension to provide nutrition education, menu and budget planning to identified SNAP recipients, OFA - Provide healthy meals & snack at Senior Centers and community events, increase redemption of Office for Aging and WIC participants farmer's market coupons, open grocery store on Northside	Based on evaluation of year 1 and 2 interventions, successful interventions will be continued and sustained in year 3.	Community-based organizations	Vines will provide expansion of community gardens, farm share opportunities, Cornell Cooperative Extension will provide nutrition education to SNAP beneficiaries ,OFA will provide healthy meals at Broome County Senior Centers and through Meals on Wheels Program, BC Council of Churches CHOW program will provide mobile markets in high need
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	1.2.3 LOURDES (Adults) Increase the number of adults by 100 (from 200 to 300), that improve their knowledge of and engagement in healthy eating habits by utilizing the fruit and veggie RX Program	Lower Socioeconomic Status Adults at Risk for Chronic Diseases	LOURDES - Dieticians in Lourdes Primary Care practices offer referred patients information on healthy eating habits and "coupons" to purchase fruits and veggies. (Lourdes Primary Care practices in collaboration with Rural Health Network and local farmers)	1) Number of adult patients participating in the fruit and veggie RX program 2) Number of adults patients to redeem fruit and veggie Rxs 3) Number/percentage of adult patients who improve knowledge of and engagement in healthy eating by using	LOURDES - Dieticians in Lourdes Primary Care practices offer referred patients information on healthy eating habits and "coupons" to purchase fruits and veggies. (Lourdes Primary Care practices in collaboration with Rural Health Network and local farmers)	LOURDES - Dieticians in Lourdes Primary Care practices continue to offer referred patients information on healthy eating habits and "coupons" to purchase fruits and veggies. Evaluate knowledge, attitudes and behaviors of participants in year 1 and 2 and use results to formulate year intervention modifications	TBD, based on years 1 and 2 evaluation	Hospital	Lourdes Primary Care practices will provide fruit and veggie Rx program in collaboration with Rural Health Network and local farmers, Care Compass Network provided innovation funding for this intervention pilot
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	1.3.1 Decrease percentage of population who did not have access to a reliable source of food during the past year from 13.8% to 12.6%	Lower Socieconomic Status Adults and Children	1) Promote and support screening of pediatric patients by healthcare providers, facilitate referral and support active connection to WIC and/or SNAP; 2) Promote screening of older-adult populations for food insecurity, facilitate referral and support active connection to	1) Percentage of population who did not have access to reliable source of food during the past year 2)Number of pediatric/primary care healthcare providers screening and providing referrals to WIC/and or SNAP, 3)Percentage of households receiving	1) Explore pilot project screening of pediatric patients by healthcare providers, facilitate referral and support active connection to WIC and/or SNAP; 2) Explore pilot project screening of older-adult populations for food insecurity in primary care, facilitate referral and support active connection to SNAP 3) Continue to provide universal breakfast. variations of free breakfast and lunch for k-12 in	1) Conduct pilot project screening of pediatric patients by UHS or Lourdes healthcare providers, facilitate referral and support active connection to WIC and/or SNAP; 2) Conduct pilot project screening of older-adult populations for food insecurity, in UHS or Lourdes primary care, facilitate referral and support active connection to SNAP 3) Continue to provide universal breakfast and lunch for k-12	1) Evaluate pilot project screening of pediatric patients by UHS or Lourdes healthcare providers, facilitate referral and support active connection to WIC and/or SNAP; 2) Evaluate pilot project screening of older-adult populations for food insecurity, in UHS or Lourdes primary care, facilitate referral and support active connection to SNAP 3) Continue to provide universal breakfast and lunch for k-12	Hospital	BCHD to facilitate discussions with UHS and Lourdes to conduct food security screening/make referrals in pediatric and primary care sites. RHN assist with development of screening tool, WIC, SNAP, CCE provide educational materials to enhance patients knowledge of food security programs and enrollment process
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices	1.2.0 By December 31, 2024, Increase by 10%, from 22% to 32%, the percentage of WIC infants who continue to be breastfed until 6 months	Lower Socioeconomic Status Adults and Children	All WIC prenatal clients will be offered breastfeeding peer counseling and free breastfeeding classes once a month	1) Percentage of WIC infants breastfed for 6 months 2) Number of WIC prenatal clients linked with breastfeeding peer counselor, 3) Number of WIC prenatal clients attending breastfeeding classes	All WIC prenatal clients will be offered breastfeeding peer counseling and free breastfeeding classes once a month, continue peer counseling support, and hospital lactation services	WIC prenatal clients will be offered breastfeeding peer counseling and free breastfeeding classes once a month, institute peer counseling case management protocol to ensure breastfeeding support activities are available as much as possible, evaluate peer counseling support and make changes based on feedback	WIC prenatal clients will be offered breastfeeding peer counseling and free breastfeeding classes once a month, institute peer counseling case management protocol to ensure breastfeeding support activities are available as much as possible, evaluate peer counseling support and make changes based on feedback	Local health department	BCHD WIC Peer Counseling Program and WIC Administrators will provide oversight to the intervention and evaluation activities. UHS and Lourdes will provide WIC participants with breastfeeding support through their lactation counseling services

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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.2: By December 31, 2024, increase the percentage of adults by 5% who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) from 72% to 78%	Lower socioeconomic status adults age 50 to 75	Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to	1) Number of health systems that implement or improve provider and patient reminder systems 2) Number of patients reached through patient reminder systems 3) Compliance with screening guidelines among patients reached through patient reminder	Work with Lourdes, UHS and Endwell Family health care providers/clinics to inventory and assess current systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts and remove barriers; such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation,	Identify two worksites that will create policies to provide employees with paid leave or the option to use flex time for cancer screenings	Work with the identified worksites to implement policies that will provide employees with paid leave or the option to use flex time for cancer screenings	Local health department	BCHD Cancer Services Program(CSP) - Outreach, Education BCHD CPIA Program- Paid Time Off Policy Subawards/Technical Assistance to Worksites Hospitals- Provide Flexible Hours for Colorectal Cancer Screening, Conduct Marketing/Communication Activities to Promote Screening to Underserved Populations UHS and Lourdes provide screening services regardless of patients ability to pay, and refer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	4.2.1 By December 31, 2024, increase the percentage of children and adolescents ages 3 -17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5% (baseline 75%)	Lower socioeconomic status children and adults	Utilizing the US Preventive Service Guidelines and HIT, consistently implement screening practices/policies to identify children at risk for overweight or overweight, and refer to behavioral and nutritional education programs.	1) Percentage of children who are overweight [defined as having an age and gender specific BMI at ≥85th to 95th percentile 2) Percentage of children who are obese [defined as having an age and gender specific BMI at ≥95th percentile] 3) Number & Percent of children screened 4)	Assess current BMI screening practices, train and educate primary care, pediatric and family care providers on the US Preventative Services Recommendations for BMI screening in children	Conduct quality assurance activities to ensure BMI screening, is done and nutrition/behavioral referrals are made as necessary	Continue conduct quality assurance activities to ensure BMI screening, is done and nutrition/behavioral referrals are made as necessary	Hospital	UHS will continue to train providers, oversee and administer BMI assessments, and refer those identified at risk for overweight or those who are overweight to the UHS Stay Healthy Kids Program. LOURDES will will continue to train providers, oversee and administer BMI assessments, and refer those identified at risk for overweight or those who are overweight to the behavioral and nutrition counseling. BCHD will provide
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	4.2.2 By December 31, 2024, promote at least 3 strategies that improve the detection of undiagnosed hypertension in health systems.	Lower Socioeconomic Status Adults over age 45	Promote strategies that improve the detection of undiagnosed hypertension in health systems using Million Hearts Program	1) Number of health systems with policies/practices to identify patients with undiagnosed HTN 2) Number/percentage of patients served by health systems with	Utlize Million Hearts Campaign "Hiding in Plain Site" health care provider promotion/education toolkit activities at UHS and Lourdes: Add campaign logo to email signatures, information in newsletter	Work with Lourdes, UHS and Endwell Family health care providers/clinics to inventory policies regarding HTN screening and propose policy updates as prescribed by the clinical quality measures created by the Million Hearts Program.	Work with Lourdes, UHS and Endwell Family health care providers/clinics to implement revised policies regarding HTN screening as prescribed by the clinical quality measures created by the Million Hearts Program.	Hospital	UHS and Loudes will use the Million Hearts https://professional.heart.org/professional/ScienceNews/UCM_496965_2017-Hypertension-Clinical-Guidelines.jsp to train providers and continue to monitor implementation of clinical guidelines. BCHD
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	4.3.1 By December 31, 2024, decrease the percentage by 5% of adult medicaid members, identified through DSRIP with diabetes whose most recent HbA1c level indicated poor control (>9%).	Lower Socioeconomic Status Adults over age 45	UHS and Lourdes Primary care network offices to work closely with the diabetes centers to implement standards of medical care in diabetes	1) Screening rate for diabetes and pre-diabetes among adults age 45+ 2) Number of patients identified as having diabetes or pre-diabetes who receive follow-up by Stay Healthy Center 3)Number of patients receiving	UHS and Lourdes Primary care network offices to work closely with the diabetes centers to implement standards of medical care in diabetes using https://professional.diabetes.org/content-page/standards-medical-care-diabetes http://www.nyspma.org/aws/NYSPMA/pt/sp/diabetes (2)	UHS and Lourdes to continue implement and evaluate evidence-based medical management in accordance with national guidelines, conducting follow up through chronic disease management systems. Promote a multidisciplinary approach in both institutions.	UHS and Lourdes to continue implement and evaluate evidence-based medical management for chronic diseases like diabetes and CVD in accordance with national guidelines, conducting follow up through chronic disease management systems and implementing a multidisciplinary approach in both institutions.	Hospital	Lourdes and UHS will continue to use chronic disease medical management guidelines and their respective chronic disease management systems while using a multidiscplinary team to assist with better outcomes
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	4.3.1 By December 31, 2024, decrease the percentage by 5% of adult medicaid members, identified through DSRIP with diabetes whose most recent HbA1c level indicated poor control (>9%).	Lower socioeconomic status children and adults	Work with HIT to implement/modify EMR to include reminder system for screening, follow up and case management activities	Percent of adult medicaid members with diabetes identified through DSRIP with controlled HbA1c	Using HIT and telehealth systems, create case management program to refer DSRIP medicaid members diagnosed with diabetes to Lourdes or UHS Diabetes Prevention Programs	Implement telehealth and case management program to refer DSRIP medicaid members diagnosed with diabetes to Lourdes or UHS Diabetes Prevention Programs	Sustain case management program to refer DSRIP medicaid members diagnosed with diabetes to Lourdes or UHS Diabetes Prevention Programs	Hospital	Lourdes and UHS Diabetes Prevention Programs will conduct education classes and testing to ensure proper control of HbA1c, provide follow up case management activities via telehealth/phone and refer to local Stamford Chronic Disease Self Management Programs
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	4.4.1 By December 31, 2024, increase from 225 to 325 the number of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have been identified and referred to take a course or class to learn how to manage their condition.	Lower Socioeconomic Status, Older Adults, Rural Residents	UHS and Lourdes will: 1. Promote testing for prediabetes, and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. 2. Promote testing for all other patients beginning at 45 years of age. 3. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status 4. Refer patients who are diagnosed with obesity, CVD, or diabetes to community chronic disease self mangement program(Stamford Evidence Based Program)	1) Number of health systems with policies/practices to identify, refer patients with diabetes or prediabetes, obesity, CVD 2) Number/percentage of patients served by health systems with policies/practices in place 3) Number of patients identified with diabetes/prediabetes 4) Number of patients referred to community based chronic disease self-managment programs like Chronic Disease self-management Programs or National Diabetes Prevention Program	Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status. Rural Health Network and Office for Aging will expand access to evidence-based self-management interventions like National DPP and Chronic Disease Self-Management Program by Stamford. Recruitment and training of new leaders will be complete in 2019.	Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status. LOURDES - Develop digital clinical data dashboards for the diabetic patient population, improving our ability to provide timely interventions and coordinated services to Type II diabetes served by the primary care network. Rural Health Network and Office for Aging will continue expansion of access to evidence-based self-management interventions like National DPP and Chronic Disease Self-Management Program by Stamford throughout high need areas in Broome County.	Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status. LOURDES - Adopt an evidence-based care pathway aimed at improving the management of adults with Type II Diabetes. Utilize the Lourdes Diabetes Prevention Project to assess the correlation between interventions patients receive and the progression to diabetes amongst the prediabetic population. Rural Health Network and Office for Aging will assess sustainability of programs expansion to increase access to evidence-based self-management interventions like National DPP and Chronic Disease Self-Management Program by Stamford throughout high need areas in Broome County.	Hospital	Lourdes Primary Care Network will test patients for Diabetes and refer to Lourdes Diabetes Prevention Project (LDPP), UHS Primary Care will test patients for Diabetes and refer to UHS DPP, OFA and Rural Health Network provide Stamford Chronic Disease Self Management Programs