Updated:
August 2017

Data Dashboard Key	
✓	Completed
★	Ahead
●	On Schedule
✗	Behind

Health Improvement Partnership-Cuyahoga Data Dashboard

Chronic Disease Management	Lead Organization/Person(s)	Expected Completion Date	Actual Completion Date	2nd Half 2016	1st Half 2017	2nd Half 2017	1st Half 2018
Objective 1							
Develop and disseminate 10 messages to increase awareness of and participation in of the chronic disease management initiatives.	CCBH and Steering Committee	9/30/2017		●			
Major Activities							
Assess the effectiveness of the educational and outreach campaign from 2016	CDM subcommittee and C/CE members, Conceptual Geniuses	9/30/2017		✓	✓	✓	✓
Develop community outreach and educational campaign with refined targets and at least 10 messages to public.	CDM subcommittee and C/CE members, Conceptual Geniuses	9/30/2017		●			
Implement campaign in target neighborhoods and clinics	CDM subcommittee and C/CE members, Conceptual Geniuses	9/30/2017		●			
Based on assessment and feedback, revise messages, materials, visuals etc. for outreach.	CDM subcommittee and C/CE members, Conceptual Geniuses	9/30/2017		●			
Objective 2							
Increase the number of Primary Care clinics from 0 to 9 that will implement an evidence-based program (adapted from Kaiser Permanente's model) for blood pressure management–a hypertension best practice.		12/31/2017		★	★		
Major Activities							

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Identify the diverse population and where they live using: clinic specific measures, community level measures	BHP, CCBH, PRC	12/31/2017		✓	✓	✓	✓
Select a diverse population to engage in this objective ie; African Americans, Caucasians	BHP, CCBH, PRC	12/31/2017		✓	✓	✓	✓
Describe the social, economic and environmental factors to establish whether there is imbalance w.r.t health equity or not.	BHP, CCBH, PRC	12/31/2017		✓	✓	✓	✓
Perform environmental scan of area providers using hypertension (HTN) best practice interventions for vulnerable populations	BHP	12/31/2017		✓	✓	✓	✓
Hypertension best practice implementation and maintenance	BHP	12/31/2017		●	●		
Upstream Impact: Recommend system level changes as appropriate to "hypertension best practice" findings for targeted populations. Report findings through HIP-C website and other communication channels.	BHP	12/31/2017		●	●		
Objective 2							
Increase the number of clinics that refer patients to community resources for healthy eating, active living (HEAL) and disease self-management from 0 to 9.		12/31/2017		●	✓	✓	✓
Major Activities							
Perform environmental scan of providers implementing the hypertension best practice and identify those referring patients to community resources for healthy eating, active living and disease self-management programs in a standard manner.	BHP, Fairhill Partners, PRC, CCBH	12/31/2017		✓	✓	✓	✓
Select neighborhoods to target intervention	BHP, Fairhill Partners, PRC< CCBH	12/31/2017		✓	✓	✓	✓
Create list of healthy eating active living resources in selected neighborhoods	PRC, BHP	12/31/2017		✓	✓	✓	✓
Recruit and train lay health leaders to lead the Stanford Chronic Disease or Diabetes Self-Management Programs (CDSMP/DSMP)	Fairhill Partners	12/31/2017		●	●		

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Health Improvement Partnership-Cuyahoga Data Dashboard

Develop and implement a clinic referral process for HEAL and CDSMP/DSMP at clinics implementing the HTN Best Practice	BHP	12/31/2017		●	✓	✓	✓
Implement community CDSMP/DSMP workshops in targeted high-need communities as determined by environmental scan	BHP, PRC, Fairhill Partners, CCBH	12/31/2017		●	●		
Measure impact of CDSMP/DSMP and Produce Prescription Program on health behaviors	CCBH, PRC, BHP, Fairhill Partners, OSU-EC	12/31/2017		●	●		
with community resources for HEAL and self-management for targeted populations. Report findings through HIP-C website and other communication channels.	BHP, PRC, Fairhill Partners	12/31/2017		●	●		