YEAR 3 REVISED COLORADO CANCER EVALUATION PLAN

Prepared by the Center for Health and Environmental Data | Colorado Department of Public Health and Environment | September 30, 2019

This document serves as an addendum to the final five-year evaluation plan that represents the integration approach to assess the Colorado Department of Public Health and Environment's cancer prevention and control efforts. This document includes updates to the evaluation and performance matrix only. While changes focused on evaluation specific to Year 3 (June 20, 2019 – June 29, 2020), revisions may also be included as appropriate for current evaluation activities that continue into Years 4 and 5. Additional details, including a comprehensive overview of CDPHE's evaluation and performance measurement approach to cancer, can be found in the *Colorado Cancer Evaluation Plan* submitted on September 27, 2018.

Contents

Summary of Changes

The following updates were made to Appendix C: Evaluation Matrix related to Year 3 revisions:

- Partnership: 3 performance measures added; 1 removed; 2 targets updated. Evaluation questions 2-3 include updates to the timing/use section. Evaluation question 3 reworded. Evaluation question 4 moved to Program: HNCS section and redefined to align with Outreach question.
- Plan: 1 performance measure added; 1 removed; 1 moved to new Health Equity section; 1 moved to indicator section of Evaluation Question 1. Evaluation questions 1 & 2 include updates to Indicators and Timing/Use sections.
- Program
    - Prevention: 4 performance measures removed; 1 moved to new Health Equity section; 1 redefined. Evaluation question 1 was revised to reflect the final CCPD evaluation plan.
    - Screening and Early Detection
        - Outreach and Education: 3 performance measures removed; all targets updated for Year 3; 2 baselines established in Year 2 updated. Evaluation questions 1-4 include updates to the timing/use section. Question 1 updated to included specific information related to CRC. Questions 2-3 merged and updated to align with corresponding HNCS question.
        - Clinic Quality Improvement: 4 performance measures removed; 2 added; 1 target updated; 3 include lead updates. Evaluation question 6 was revised to reflect the final CCPD evaluation plan.
        - Health Navigation and Clinical Services (HNCS): 3 performance measure targets updated. Evaluation question 1 includes updates to the timing/use section, Question 3 removed due to completion in previous year and replaced with the reach question (moved from Partnership section and revised to align with similar Outreach question), Question 4 was added to reflect the final CCPD evaluation plan.
        - Cancer Screening: 9 performance measures removed; 4 targets updated.
    - Diagnosis/Treatment: No changes.
    - Survivorship: 1 performance measure revised; 2 removed.
- Health Equity Priorities: section added to include 3 performance measured revised and moved from other sections. Evaluation Question 1 added to reflect the final CCPD evaluation plan.
- Appendices A – E were added as references for CCPD evaluation activities referenced in evaluations questions (Prevention Q1, Clinic Quality Improvement Q6, Health Navigation Q4, Health Equity Q1).

As a result of these revisions, all tables have been renumbered, which is also reflected in the List of Tables on page 4.

Evaluation Matrix

This living document details the evaluation activities and performance measures for CDPHE's integrated breast, cervical and colorectal cancer programs. This matrix covers the five-year period from June 30, 2017 to June 29, 2022 and includes both single- and multi-year priorities for evaluation and performance measurement determined by the ESW. This evaluation matrix will be revised annually to reflect the changing priorities of CDPHE's cancer work. **This version includes specific revisions for Year 3 (June 30, 2019 to June 29, 2020)** as well as known evaluation activities that extend beyond Year 3. This matrix can be used as follows:

SECTIONS: The evaluation matrix is divided into three primary sections that mirror CDPHE's three-pronged approach to cancer prevention and control**:** Partnerships, Plan and Program. The Program section also includes four sub-sections organized by the stages of the cancer continuum of care: Prevention, Screening/Early Detection, Diagnosis/Treatment, and Survivorship/End-of-Life Care. Each sub-section includes prioritized interventions or activities that will be monitored or evaluated.

PERFORMANCE MEASUREMENT TABLES: This plan includes process and outcome performance measures for each aspect of cancer work funded at CDPHE that will be monitored over the evaluation period. Progress will be tracked as available and updates reported annually or as needed. Each performance measure table includes a description of the intended purpose for that measure or set of measures. Measures are primarily intended to track data over time to monitor program **progress** and/or inform the **reach** or **effectiveness** of CDPHE's cancer prevention and control efforts.

Performance measurement data are collected from various surveillance sources, including population health surveys (e.g., BRFSS, NIS-TEEN, etc.) and other surveillance systems such as the Colorado Cancer Registry, the Colorado Immunization Information System (CIIS) and Environmental Public Health Tracking (EPHT). Additionally, program records, including individual-level data (MDEs, collected through eCaST) and clinic-level data (collected through cQM and/or the Assessment and Planning process), will be assessed as needed. Performance measurement tables include the following descriptive columns:

- **Report:** the CDC-funded program(s) receiving reports. Reporting method (MDE, BCBARS, CBARS) or objective (PPO) may be included in parentheses, if applicable.
- **Frequency:** the interval with which information will be reported.[1]
- **Lead:** the person responsible for reporting data.
- **Focus:** the cancer type or site, if applicable.
- **Measure/Indicator:** the description of the metric being used.
- **Source:** the source from which data is being collected (e.g., eCaST, survey, focus group/interview, administrative data, etc.).
- **Baseline:** the quantifiable measurement and type (e.g., percentage, volume, etc.), including the year.
- **Target:** the quantifiable measurement and type (e.g., percentage, volume, etc.), including the year.
- **CDC Strategy:** the strategy identified by the CDC for 17-1701 awards, if applicable.
- **EBI:** the evidence-based intervention associated with the measure for 17-1701 awards, if applicable.

[1] Performance measures relying on data from population health surveillance systems will be reported based on availability. Additionally, some performance measures will align with activities funded through CDPHE grant programs, including CPED or CCPD. Thus, reporting timeframes may occur beyond the defined scope of this evaluation plan.

EVALUATION QUESTIONS TABLES: Focused evaluation questions are included only for specific interventions and activities any given approach, based on priorities set for evaluation by the ESW and other primary intended users of the evaluation. Evaluation tables include the following descriptive columns:

- **Report:** the CDC-funded programs receiving reports. Reporting method will be by evaluation report unless otherwise noted.
- **Evaluation Question:** the specific question(s) related to that evaluation.
- **Indicators:** the metrics that define what is being evaluated (e.g., "Success" "reach" "representation," etc.) and that will be used to answer the evaluation question.
- **Methods:** the data source, data collection and analysis methods used to inform the indicators and data range, if applicable. The individual(s) or units responsible for conducting this work are noted in parentheses.
- **Timing/Use:** The range during which evaluation findings will be analyzed and disseminated, and for what purpose.

LIST OF TABLES

Table	Program			Type		Approach			Stage				Cancer Focus						**Strategy** (if applicable)
	NCCCP	NBCCEDP	CRCCP	Performance Measure	Evaluation Question	Partnership	Plan	Program	Prevention	Screening & Early Detection	Diagnosis & Treatment	Survivorship/ End-of-Life Care	Breast	Cervical	Colorectal	Lung	Skin	All/other	
Table 1-1	X	X		X		X												X	Environmental approaches
Table 1-2	X	X			X	X												X	
Table 2-1	X			X			X											X	
Table 2-2	X				X		X											X	
Table 3-1	X			X				X	X					X					
Table 3-2	X				X			X	X					X					
Table 3-3A		X	X	X				X		X			X	X	X				Community Education & Outreach
Table 3-3B		X	X		X			X		X			X	X	X				Community Education & Outreach
Table 3-4A	X	X	X	X				X		X			X	X	X				Clinic Quality Improvement
Table 3-4B	X	X	X		X			X		X			X	X	X				Clinic Quality Improvement
Table 3-5A		X		X				X		X			X	X					Health Navigation
Table 3-5B	X	X			X			X		X			X	X					Health Navigation
Table 3-6		X		X				X		X			X	X					Cancer Screening
Table 3-7		X		X				X			X		X	X					Health Navigation
Table 3-8	X			X				X				X						X	Provider education
Table 4-1	X		X	X		X	X	X	X	X	X	X			X			X	Health Equity
Table 4-2	X				X	X	X	X	X									X	Health Equity

SECTION 1: PARTNERSHIP APPROACH *(5 performance measures; 3 evaluation questions)*

TABLE 1-1. PARTNERSHIP PERFORMANCE MEASURES

n=5

These performance measures will inform CDPHE about the reach and engagement of external partners with statewide cancer prevention and control efforts.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NCCCP	1x/year	C. Cahill	All	Percent of Coalition members actively engaged in task forces	Admin records	0 (FY16-17)	10% (FY19-20)	Partnership	N/A
NCCCP	1x/year	C. Cahill	All	Percent increase in volume of Coalition website traffic (total number of views)	Web analytics	19,230 (FY16-17)	10% (FY19-20)	Partnership	N/A
NBCCEDP NCCCP	1x/year	E. Kinsella	All	Number of partnerships established to address employer screening policies	Admin records	0 (FY18-19)	1 (FY19-20)	Environmental	N/A
NBCCEDP NCCCP	1x/year	E. Kinsella	All	Number of activities developed with partners to address employer screening policies	Admin records	0 (FY18-19)	2 (FY19-20)	Environmental	N/A
NBCCEDP NCCCP	1x/year	E. Kinsella	All	Number of evaluation plans designed for partnership activities related to employer screening policies	Admin records	0 (FY18-19)	1 (FY19-20)	Environmental	N/A

TABLE 1-2. PARTNERSHIP EVALUATION QUESTIONS

Report	Evaluation Question	Indicator(s)	Methods (Lead)	Timing/Use
NCCCP	**1. How successful are our partnerships through the Colorado Cancer Coalition? How do partners (members) perceive the Coalition? (Process)**	• Engagement and motivation self-indicated by interview or survey respondents. • Perceptions of coalition organization (structure, practice, appropriate work/focus) self-indicated by KIIs/focus groups with Coalition leadership, key members and key cancer stakeholders not involved in the Coalition and/or survey respondents. • Satisfaction self-indicated by KII/focus group or survey respondents.	• Descriptive and thematic analysis of the interview/focus group or survey responses. [HSEB/S. Lawrence]	Annual: Cancer symposium evaluation will inform Coalition event and topical priorities. July - November 2019: KIIs will inform CCC about engagement/ motivation to help direct Coalition recruitment efforts. Initial finding will also help determine next steps and methods to be used in future data collection. 2020, 2022: Focus group and/or survey findings will inform Coalition leadership and steering committee regarding ongoing Coalition partnership needs.

TABLE 1-2. PARTNERSHIP EVALUATION QUESTIONS

Report	Evaluation Question	Indicator(s)	Methods (Lead)	Timing/Use
NCCCP	**2. What is the membership of the Colorado Cancer Coalition? Does the Coalition membership represent Colorado's population and cancer needs, including those characteristics and affiliations identified by the CDC? What representation is missing? (Process)**	• Characteristics/affiliations listed in CDMIS, such as: o Number and percent of Coalition members representing specific regions (rural/frontier, urban), populations (race/ethnicity, gender, survivors), cancer types, cancer stages, etc. o Number and percent of Coalition members by role/position, expertise and organizational affiliation	• Descriptive analysis (frequencies) of Coalition members [CCCCP/B. Selig, C. Cahill with HSEB consult]	2017: Initial membership assessment will identify member characteristics/affiliations for CDMIS. February 2020: Gap analysis to inform Coalition leadership in recruiting efforts. February 2022: Membership assessment will help to inform progress toward closing gaps in membership needs.
NBCCEDP NCCCP	**3. Has the integrated approach to cancer prevention and control at CDPHE been successful, including the CPED program, for external partners as well as internal partners at CDPHE? What are the facilitators and barriers to success? (Process)**	• Percentage of funded organizations reporting high levels of satisfaction with the CPED program. • Percentage of funded organizations reporting improved experience with CDPHE as a result of the CPED program. • Successes self-indicated by funded organizations and internal partners. • Barriers self-indicated by funded organizations and/or internal partners. • Perceptions of CPED Program (structure, priorities, effectiveness, facilitators and barriers) self-indicated by CPED funded organizations, external partners and internal partners, including those no longer funded. • Percentage of organizations demonstrating improved performance with grant management (e.g., meeting spending targets, deadlines, deliverables, etc.). • Percentage of organizations demonstrating improved performance serving priority populations (e.g., women served, screening rates, intervention fidelity, etc.).	• Descriptive and thematic analysis of responses from biannual HSCB contractor survey and exit interviews [HSCB & HSEB/S. Lawrence] • Thematic analysis of responses from focus group and/or KIIs with funded organizations or internal or external partners (if needed) [HSEB, S. Lawrence] • Document review of administrative records (e.g., site visit reports, screening rates, spending performance, CMS ratings, etc.) [WWC/ I. Hontz, K. McCracken with HSEB consult]	December 2018 & 2020: Findings from external contractor surveys will inform successes and areas in need of improvement for HSCB and CPED in particular. September 2019 & 2020: Findings from internal partner feedback survey and interviews will be compared to inform successes and areas in need of improvement for CDPHE's overall cancer prevention and control coordinated efforts. Comparisons to baseline (June 2017) will inform change. February 2022: Performance indicators from external partners will inform whether outcomes align with perceived change.

SECTION 2: PLAN APPROACH

(1 performance measure; 2 evaluation questions)

TABLE 2-1. PLAN PERFORMANCE MEASURES *n=1*

These performance measures will inform CDPHE about progress toward the development of the Colorado Statewide Cancer Plan.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NCCCP	Every 5 years	B. Selig	All	Development and publication of Colorado Cancer Plan 2021-2025	Admin records	0 (FY18-19)	1 (FY20-21)	Plan	N/A

TABLE 2-2. PLAN EVALUATION QUESTIONS

Report	Evaluation Question	Indicator(s)	Methods (Lead)	Timing/Use
NCCCP	**1. How, and to what extent, do Colorado cancer professionals use the statewide Colorado Cancer Plan to inform their work? (Process)**	• Number/percentage of respondents reporting high value of cancer plan in key informant interviews/focus groups and/or survey conducted every other year • Type of use self-indicated by respondents • Percent increase in volume of Cancer Plan website traffic.	• Descriptive and thematic analysis of survey and/or KII/focus group responses [HSEB/S. Lawrence]	May 2019: Partner with Cancer Plan Steering Committee to determine best methods to assess needs for new cancer plan. January - December 2020: Findings from KIIs/focus groups and/or survey will identify priorities and potential gap areas to inform the development of the next statewide cancer plan, which is used to prioritize Coalition/task force and/or CDPHE work/resources.
NCCCP	**2. What are the key accomplishments that task forces have made toward cancer plan goals and objectives? (Process and Outcome)**	• Number of task force and Coalition meetings • Number of volunteer hours contributed by Coalition members toward task force work • Number and type of actions/projects completed • Percentage point increase towards cancer plan targets	Document review of administrative reports; Descriptive and thematic analysis of task force progress (CCCCP/B. Selig, C. Cahill]	Annually: Findings will inform Coalition and cancer partners about work accomplished and help inform Coalition/task force priorities.

SECTION 3a: PROGRAM APPROACH | Prevention

(1 performance measure; 1 evaluation question)

TABLE 3-1. HPV VACCINATION PERFORMANCE MEASURES

n=1

These performance measures will inform behavior change related to HPV vaccinations.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NCCCP PPO 1	1x/year	B. Selig	Cervical	Adolescent males and females aged 13-17 that have completed the HPV vaccination series	NIS-TEEN	48% (2016)	58% (2022)	Health systems change	Health care system-based interventions implemented in combination to increase appropriate vaccination

TABLE 3-2. PREVENTION EVALUATION QUESTIONS

Report	Evaluation Question	Indicator(s)	Methods (Lead)	Timing/Use
NCCCP	**1. What are the evaluation findings for CCPD's cancer prevention activities related to lung cancer?**	See Appendix A for implementation, reach and effectiveness indicators related to community engagement activities, policies, and/or environmental changes related to radon mitigation.	Mixed methods [PiER Center]	April 2019: Evaluation plan finalized February 2022: Outcomes available

SECTION 3b: PROGRAM APPROACH | Screening/Early Detection

(34 performance measures, 13 evaluation questions)

TABLE 3-3A. COMMUNITY EDUCATION AND OUTREACH PERFORMANCE MEASURES *n=8*

These performance measures will inform CDPHE about the reach and effectiveness of community education and outreach interventions to reduce health disparities.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NBCCEDP	1x/year (August)	S. Lawrence	Breast, Cervical	Among women who received direct assistance through CPED TCO strategy, percentage who accessed a health care system	TCO Data Portal and/or eCaST	49% (FY17-18)	80% (FY19-20)	Community-clinical linkages	Small media Group education 1:1 education Reducing structural barriers Reducing out-of-pocket costs
NBCCEDP	1x/year (August)	S. Lawrence	Breast	Among women who received direct assistance through CPED TCO strategy, percentage who completed a mammogram		48% (FY17-18)	60% (FY19-20)		
NBCCEDP	1x/year (August)	S. Lawrence	Cervical	Among women who received direct assistance through CPED TCO strategy, percentage who completed a Pap test		28% (FY17-18)	30% (FY19-20)		
NBCCEDP	1x/year (August)	S. Lawrence	Breast	Among women who received direct assistance through CPED TCO strategy and completed an initial mammogram, percentage who indicated that direct assistance greatly improved their ability to obtain a mammogram	Client self report	89% (FY19-20)	90% (FY19-20)		
NBCCEDP	1x/year (August)	S. Lawrence	Cervical	Among women who received direct assistance through CPED TCO strategy and completed a Pap test, percentage who indicated that direct assistance greatly improved their ability to obtain a Pap test		90% (FY19-20)	90% (FY19-20)		
NBCCEDP	1x/year (July)	S. Lawrence	Breast, Cervical, Colorectal	Number of organizations funded to implement the CPED TCO strategy[2]	Admin. records	13 (FY17-18)	14 (FY19-20)	Program management, partnerships	
NBCCEDP CRCCP	1x/year (August)	S. Lawrence	Breast, Cervical, Colorectal	Number of community education events (for cancer risk factors and screening guidelines) held or participated in by organizations funded for the TCO strategy	Progress reports	262 (FY17-18)	560 (FY19-20)	Community-clinical linkages	Small media Group education
NBCCEDP	1x/year (August)	S. Lawrence	Breast, Cervical	Number of women receiving direct assistance through CPED TCO strategy	Progress reports, TCO Data Portal	1,088 (FY17-18)	800 (FY19-20)	Community-clinical linkages	1:1 education; Reducing structural barriers; reducing out-of-pocket costs

[2] This includes health systems and community-based organizations funded through CPED as well as tribal organizations funded through separate contracts.

TABLE 3-3B. COMMUNITY EDUCATION AND OUTREACH EVALUATION QUESTIONS

Report	Evaluation Question	Indicator(s)	Methods (Lead)	Timing/Use
NBCCEDP CRCCP	**1. How do organizations implement CPED's Targeted Community Outreach (TCO) strategy? (Process)** • **What are the different methods utilized to deliver community outreach and direct assistance?** • **How is colorectal cancer education being delivered?** • **How are women in priority populations identified within communities?**	• Types and description of community education methods used by each funded organization (e.g., locations, partners, events self-identified by funded organizations). • Type and description of methods used to provide direct assistance. • Factors informing outreach strategy decision-making self-identified by funded organizations. • Type and description of strategies used to identify women in need of direct assistance.	• Thematic analysis of open-ended responses provided in progress report survey. [HSEB/S. Lawrence] • Summative description of outreach methods utilized by organizations. [HSEB/S. Lawrence] • Thematic analysis of focus group/ interviews (if needed). [HSEB/S. Lawrence]	February 2020: Findings will inform programmatic decisions about best approaches for identifying populations in need of outreach.
NBCCEDP CRCCP	**2. Among organizations funded for the TCO strategy, what barriers prevent outreach workers from getting into the community? (Process)**	• Barriers self-identified by funded organizations.		
NBCCEDP	**3. Are organizations funded for TCO through CPED reaching both the areas of highest need and the identified priority populations related to the TCO strategy? What gaps still exist?**	• Percent of CPED-funded organizations serving counties with a high proportion of individuals at risk for not being screened. • Percent of women served through TCO who reside in counties with a high proportion of individuals at risk for not being screened	• Descriptive analysis of TCO Data Portal data and administrative records [HSEB/R.Wauters] • Descriptive analysis (frequencies/crosstabs) of values reported in the TCO Data Portal to define and determine predictors	January 2019 - February 2020. Test methodology, develop data analysis plan. Findings from this trial run will be used to inform the formal

TABLE 3-3B. COMMUNITY EDUCATION AND OUTREACH EVALUATION QUESTIONS

Report	Evaluation Question	Indicator(s)	Methods (Lead)	Timing/Use
	4. Among women served through CPED's Targeted Community Outreach (TCO) strategy, what factors contribute to women accessing a health system and/or completing initial screening procedures (Pap tests and/or Mammograms)? What factors continue to be barriers among the priority population?? (Process) • **To what extent do organization characteristics or outreach methods contribute to completion of initial screening procedures?**	• Percent of women served through TCO who have one or more characteristics associated with being at risk for not being screened. • Distribution of clients served through TCO by characteristics associated with being at risk for not being screened. • Number, percent and combination of potential predictors of interest, such as: location of first client encounter (or how client heard about TCO), type of assistance received, number of contacts, length of direct assistance, type of organization providing direct assistance, • Number, percent and combination of organizational characteristics, such as: organization rate of success, outreach methods implemented, number of outreach workers or budget size. • Parameter estimates derived from regression analyses representing the effect of organizational characteristics, outreach methods, and population characteristics on health system access and screening completion.	of interest [HSEB/R. Wauters & I. Danielson] • Inferential analysis (principal component analysis and/or multiple regression, TBD) to determine predictive sets of characteristics in determining successful screening outcomes [HSEB/I .Danielson & R. Wauters] • Thematic analysis of progress report open-ended responses (if needed). [HSEB/S. Lawrence] • Document review of budgets/invoices, site visit reports, and other administrative data (if needed). [WWC/I. Hontz and K. McCracken].	analyses scheduled in FY19-20. February 2021, 2022. Findings will inform programmatic decisions about best methods for conducting outreach and inform guidance included in the program manual.

TABLE 3-4A. CLINIC QUALITY IMPROVEMENT PERFORMANCE MEASURES *n=8*

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NCCCP PPO 3 CRCCP	Every 2 years	B. Selig	Colorectal	Percentage of adults aged 50-75 who are up-to-date on a USPSTF-recommended CRC screening test	BRFSS	66.7% (2016)	72% (2022)	Community-clinical linkages; Health systems change	Reducing Structural Barriers; Provider assessment and feedback
NCCCP PPO 4	1x/year	B. Selig	Lung	Rate of lung cancer mortality per 100,000 people	CCCR	27.5 (2016)	17.5 (2022)	Health systems change	N/A[3]
CRCCP	1x/year	R. Wauters	Colorectal	Percent of CQI-participant health systems with at least one year of substantive work on colorectal cancer screening that have improved their colorectal cancer screening rate since baseline	cQM	0% (FY17-18)	50% (FY19-20)	Health systems change (Enhancing Service Delivery Using Evidence-Based Interventions)	All
NBCCEDP	1x/year	R. Wauters	Cervical	Percent of CQI-participant health systems with at least one year of substantive work on cervical cancer screening that have improved their cervical cancer screening rate since baseline	cQM	0% (FY17-18)	50% (FY19-20)		
NBCCEDP	1x/year	R. Wauters	Breast	Percent of CQI-participant health systems with at least one year of substantive work on breast cancer screening that have improved their breast cancer screening rate since baseline	cQM	0% (FY17-18)	50% (FY19-20)		
NBCCEDP CRCCP	1x/year	S. Grassmeyer	Breast, Cervical, Colorectal	Number of CQI-participant health systems working on cancer-related work funded through CPED	Admin data	0 (FY17-18)	11 (FY19-20)	Program management, partnerships	N/A
				Number of CQI-participant health systems working on cancer-related work funded through CDPHE non-CPED sources	Admin data	10 (FY17-18)	0 (FY21-22)		
NBCCEDP CRCCP	1x/year	S. Lawrence	Breast, Cervical, Colorectal	Percent decrease of CQI-participant health systems working on cancer-related work funded through CDPHE non-CPED sources	Admin data	0% (FY17-18)	100% (FY21-22)		

[3] The USPTF recommends annual screening for lung cancer with low-dose computed tomography in adults aged 55-80 years who have a 30 pack-year smoking (patient navigation, community awareness, provider education).

TABLE 3-4B. CLINIC QUALITY IMPROVEMENT EVALUATION QUESTIONS

Reporting	Evaluation Question	Indicator	Methods (Lead)	Timing/Use
CRCCP NBCCEDP	**1. How do measures of cancer screening change over time amongst CQI-participant health systems? (Outcome)**	By cancer type: • Number/percent of health systems who experienced statistically significant improvements to targeted clinical outcome measures (i.e., cancer screening rates, etc.) from baseline, by years of CQI participation • Number/percent of health systems who experienced statistically significant improvements to targeted clinical outcome measures (i.e., cancer screening rates, etc.) from baseline, by activity/EBI implemented • Average change in targeted clinical outcome measures (i.e., cancer screening rates, etc.) from baseline	Descriptive and inferential analysis (i.e., paired T-test) using EHR-reported data [HSEB/CQI evaluator]	October 2020: Outcomes will be reported to CDC and CDPHE-related programs to determine impact
CRCCP NBCCEDP	**2. To what extent do health systems participating in CPED's CQI strategy increase implementation of established, evidence-based best practices for primary care? (Outcome)**	• Of eligible health systems, number/percent of health systems that have adopted and follow a nationally recognized screening guideline system-wide • Of eligible health systems, number/percent of health systems that have developed a policy and/or standard workflow for delivering age- and risk-appropriate colorectal cancer screening tests • Of health systems using colonoscopy as their primary colorectal cancer screening test at baseline, number/percent of health systems that use FIT/FOBT or FIT-DNA as their primary colorectal cancer screening test post-implementation • Of eligible health systems, number/percent of health systems that have developed a policy and/or standard workflow for closed loop referrals to targeted internal or external programs (i.e., specialty care for follow-up cancer screening, lifestyle interventions, etc.) • Among eligible health systems, average percentage increase in number of closed loop referrals to targeted internal or external programs (i.e., specialty care for follow-up cancer screening, lifestyle interventions, etc.)* • Of eligible health systems, number/percent of health systems that have improved utilization of best practices for team-based care from baseline • Among eligible health systems, average change in care team utilization of staff (i.e., medical assistants, nurses, lay-persons, etc.) to their maximum skill and practice authority • Of eligible health systems, number/percent of health systems that routinely collect and share patient experience data with staff (i.e., patient satisfaction, average wait time, no show rates, etc.) • Among eligible health systems, average change in self-reported, estimated staff time spent delivering primary care services (per patient or patient encounter type) from baseline* • Successes, barriers, and lessons learned from CQI implementation	• Descriptive analysis of program data (pre- and post-implementation) [HSEB/CQI evaluator] • Thematic analysis of interviews/focus groups and open-ended survey responses [HSEB/CQI evaluator]	

TABLE 3-4B. CLINIC QUALITY IMPROVEMENT EVALUATION QUESTIONS

Reporting	Evaluation Question	Indicator	Methods (Lead)	Timing/Use
CRCCP NBCCEDP	**3. Do CQI-participating health systems build and sustain meaningful Health Information Technology (HIT) infrastructure?**	• Of health systems reporting inaccurate rates at baseline, number/percent of health systems that are able to accurately report cancer screening rates and chronic disease control measures post-implementation • Of health systems without a registry at baseline, number/percent of health systems who have successfully created a registry in their EHR to identify, track, and monitor patients eligible for cancer screening and/or other targeted areas in preventive care • Of health systems without a closed loop referral system at baseline, number/percent of health systems who have established a documented, closed loop referral system within their HER • Of health systems not documenting demographic data at baseline, number/percent of health systems that document patient demographic information (i.e., race/ethnicity, income, payor, etc.) in their EHR • Of eligible health systems, number/percent of health systems that implement provider reminder and recall systems within their EHR	• Descriptive analysis of EHR data, chart reviews and program data [HSEB/CQI evaluator]	
CRCCP NBCCEDP	**4. To what extent do CQI-participant health systems build and sustain a culture of quality improvement within their organization?**	• Of eligible health systems, number/percent of health systems who have developed a patient experience program and/or routinely utilize patient experience data as a part of their quality improvement efforts • Of health systems who self-report limited leadership buy-in pre-implementation, number/percent of health systems who have achieved buy-in from health system leadership (i.e., their Chief Medical Officer actively participates in QI activities, delegates funding to QI work, etc.) • Of health systems without a designated QI champion/lead at baseline, number/percent of health systems who have designated a QI champion/lead post-implementation • Of health systems not sharing data with staff at baseline, number/percent of health systems who actively, routinely share clinical outcome measures with all staff • Number/percent of health systems who experienced improvements in their staff-reported organizational culture of quality improvement • Of eligible health systems, number/percent of health systems who fully implement provider assessment and feedback system-wide	• Thematic analysis of interviews/focus groups and open-ended survey responses [HSEB/CQI evaluator] • Descriptive analysis of EHR data, chart reviews and program data [HSEB/CQI evaluator]	
CRCCP NBCCEDP	**5. How is CQI leveraging opportunities and partnerships to help participant health systems meet national guidelines and goals?**	• Number/percent of health systems that were able to leverage their work with CQI to meet goals for recognition, accreditation, or certification programs (i.e., PCMH, DSME, etc.) • Description of collaboration and integration efforts between CQI program staff and internal and external partners	• Descriptive analysis of survey and program data, and thematic analysis of focus group/focused conversations. [HSEB/CQI evaluator]	

TABLE 3-4B. CLINIC QUALITY IMPROVEMENT EVALUATION QUESTIONS

Reporting	Evaluation Question	Indicator	Methods (Lead)	Timing/Use
NCCCP	**6. What are the evaluation findings for CCPD's clinical system quality improvement activities related to cancer?**	**HPV vaccination and cancer screening (lung, CRC, hereditary cancers):** See Appendix B and Appendix C for evaluation plans that include indicators for: descriptive characteristics of evidence-based policy, practice or procedure changes implements, reach of changes made, and effectiveness of CSQI change at improving patient services and care.	• Mixed methods [PiER Center]	April 2019 evaluation plan finalized February 2022: outcomes available

TABLE 3-5A. HEALTH NAVIGATION PERFORMANCE MEASURES

n=10

The following measures will help to inform the reach and effectiveness of the health navigation intervention for insured and uninsured women.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NBCCEDP	2x/year	M.Milzner	Cervical	Percentage of Pap test with follow up indicated that complete follow-up (overall, and by insurance status)	eCaST/ HIDS	87.9%[4] (FY16-17)	>=90%	Health system change (Direct Screening and Patient Navigation)	Reducing structural barriers Reducing out-of-pocket costs 1:1 education
NBCCEDP	2x/year	M.Milzner	Cervical	Percentage of Pap tests with follow up indicated and completed where the time between the Pap test/referral and final diagnosis was > 60 days (overall, and by insurance status)	eCaST/ HIDS	87.6%[4] (FY16-17)	<=25%		
NBCCEDP	2x/year	M.Milzner	Cervical	Percentage of abnormal Pap tests with complete follow up (overall, and by insurance status)	eCaST/ HIDS	81.0%[4] (FY16-17)	>=90%		
NBCCEDP	Monthly, 1x/year	M.Milzner	Breast	Percentage of abnormal breast screenings with complete follow-up (overall, and by insurance status)	eCaST/ HIDS	94.5%[4] (FY16-17)	>=90%		
NBCCEDP MDE	2x/year				eCaST/ MDEs[5]	93.7%[4] (FY16-17)			
NBCCEDP	Monthly, 1x/year	M.Milzner	Breast	Percentage of abnormal breast screenings where the time between the screening/referral and final diagnosis was > 60 days (overall, and by insurance status)	eCaST/ HIDS	6.0%[4] (FY16-17)	<=25%		
NBCCEDP MDE	2x/year				eCaST/ MDEs[5]	5.4%[4] (FY16-17)			
NBCCEDP	1x/year	M.Milzner	Breast, cervical	Number of additional unique women who have ONLY received patient navigation support into and through the screening process AND were not included in the NBCCEDP-funded screening estimates [testing was reimbursed through other sources (e.g., state funds, private insurance, Medicaid, Medicare, etc.)] (overall, and by insurance status)	eCaST	6,387 (FY16-17)	4,342 (FY19-20)		
NBCCEDP	1x/year	E.Kinsella	Breast, cervical	Number of organizations funded to implement the CPED Health Navigation & Clinical Services strategy for uninsured and underinsured women	Admin data	36 (FY16-17)	34 (FY19-20)	Program management, partnerships	
NBCCEDP	1x/year	E.Kinsella	Breast, cervical	Number of organizations funded to implement the CPED Health Navigation strategy for insured women	Admin data	24 (FY16-17)	23 (FY19-20)		

[4] The numbers included here demonstrate the overall rate for insured and uninsured clients combined. When reporting measures, these percentages will be broken down as indicated.

[5] The numbers generated here represent those calculated through the preliminary MDE core performance indicator report that CDPHE submits to CDC, which is produced from CDC's MDE Edits application.

TABLE 3-5B. HEALTH NAVIGATION EVALUATION QUESTIONS

Reporting	Evaluation Question	Indicator	Methods (Lead)	Timing/Use
NBCCEDP	**1. How are organizations funded for the Health Navigation (HN) strategy providing navigation to clients? (Process)** **a. Where does navigation happen most frequently in the screening cycle?** **b. What is the process and who is responsible for conducting each component of health navigation (barrier assessment, client reminders, etc.)?** **c. Is health navigation being implemented with fidelity to CPED program guidance?**	• Description and timing of navigation components and processes self-reported by funded organizations through interviews, surveys and visuals (e.g., flow chart) • Percent of funded organizations implementing HN and undergo data chart reviews who are adhering to CPED program guidance	• Document review of site visits, data chart reviews (client barrier assessment tool documentation), process flow charts, etc. [WWC/I. Hontz, K. McCracken with HSEB consult] • Descriptive and thematic analyses of administrative documents and past progress reports [HSEB/S. Lawrence] • Thematic analysis of focus group or interviews (if needed). [HSEB/S. Lawrence]	August 2020: Determine implementation fidelity at individual organizations, identify TA needs to improve program administration
NBCCEDP	**2. What client barriers are most common for women being navigated? (Process)** **a. Which barriers are the most difficult to address, and why?** **b. How do barriers vary between insured and uninsured populations?**	• Client barriers self-identified by funded organizations • Challenges to addressing client barriers self-identified by funded organizations • Differences in barriers among demographics self-identified by funded organizations • Number and type of barriers most commonly noted in sample of client charts	• Document review and/or descriptive analysis of data chart reviews and site visit reports. [WWC/I. Hontz, K. McCracken with HSEB consult] • Thematic analysis of open-ended responses in progress reports and/or focus group or interviews. [HSEB/S. Lawrence] • Descriptive and thematic analysis of survey to funded organizations regarding records not meeting diagnostic work-up indicators. [HSEB/S. Lawrence]	January 2020: Identify most common barriers and best practices to identify TA needs.
NBCCEDP	**3. Are organizations funded for HNCS strategy through CPED reaching both the areas of highest need and the priority populations related to the HNCS strategy? What gaps still exists? (Process)**	• Percent of HNCS organizations serving counties with a high proportion of individuals at risk for not being screened • Percent of women served through HNCS who reside in counties with a high proportion of individuals at risk for not being screened • Percent of women served through HNCS who have one or more characteristics associated with being at risk for not being screened • Distribution of clients served through HNCS by characteristics associated with being at risk for not being screened	• Descriptive analysis of eCaST data and administrative records [HSEB/R.Wauters Informatics/C.Lara]	December 2020, 2021, 2022: Findings will inform program improvement and funding decisions.

TABLE 3-5B. HEALTH NAVIGATION EVALUATION QUESTIONS				
NCCCP	**4. What are the evaluation findings for CCPD's health navigation workforce development activities?**	• See Appendix D for evaluation plan indicators related to training implementation processes, reach of training programs, and effectiveness of training programs.	• Mixed methods [PiER Center]	April 2019: evaluation plan finalized February 2022: outcomes available

TABLE 3-6. CANCER SCREENING PERFORMANCE MEASURES *n=8*

These performance measures will inform the effectiveness and reach of breast and cervical cancer screening interventions, including CPED's Clinical Services strategy.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NBCCEDP	1x/year	M. Milzer	Cervical	Percentage of initial program Pap tests provided to never/rarely screened women	eCaST/HIDS	45.4% (FY16-17)	>=20%	Health equity	Reducing out of pocket costs
					eCaST/MDEs[6]	47.9% (FY16-17)			
NBCCEDP	1x/year	M. Milzer	Breast	Percentage of NBCCEDP funded mammograms provided to women 50 years of age and older	eCaST/HIDS	65.4% (FY16-17)	>=75%	Program management	Reducing out of pocket costs
					eCaST/MDEs[6]	63.0% (FY16-17)			
NBCCEDP	1x/year	M. Milzer	Breast, cervical	Number of women who received at least one NBCCEDP-funded clinical service: Mammogram, Clinical Breast Exam, Pap test, HPV test, or Diagnostic service.	eCaST Monthly report	4,233 (FY16-17)	6,248 (FY19-20)	Health systems change (Direct Screening and Patient Navigation)	Reducing out of pocket costs
			Breast	Number of women who received at least one NBCCEDP-funded mammogram or other breast diagnostic service	eCaST Monthly report	2,944 (FY16-17)	3,704 (FY19-20)		
			Cervical	Number of women who received at least one NBCCEDP-funded pap test, HPV test or other cervical diagnostic service	eCaST Monthly report	2,962 (FY16-17)	4,028 (FY19-20)		
NBCCEDP	1x/year	E. Kinsella	Breast, Cervical	Number of contractors implementing the CPED Clinical Services strategy (same as uninsured in PN/HN strategy)	Admin records	36 (FY17-18)	34 (FY19-20)	Program management, Partnerships	Reducing out of pocket costs

[6] The numbers generated here represent those calculated through the preliminary MDE core performance indicator report that CDPHE submits to CDC, which is produced from CDC's MDE Edits application.

SECTION 3c: PROGRAM APPROACH | Diagnosis/Treatment

(5 performance measures)

TABLE 3-7. HEALTH NAVIGATION PERFORMANCE MEASURES *n=5*

These performance measures will inform the effectiveness of health navigation at the diagnostic stage of cancer screening.

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NBCCEDP (MDEs)	2x/year	M. Milzer	Breast	Percentage of final diagnosis of breast cancer where treatment has been started	eCaST	97.7% (FY16-17)	>=90%	Health systems change (Direct Screening and Patient Navigation)	Reducing structural barriers
NBCCEDP (MDEs)	2x/year	M. Milzer	Breast	Percentage of final diagnosis of breast cancer where the time between the date of final diagnosis and the date of treatment initiation is >60 days	eCaST	2.3% (FY16-17)	<=20%		
NBCCEDP (MDEs)	2x/year	M. Milzer	Cervical	Percentage of final diagnosis of HSIL, CIN2, or CIN3/CIS where treatment has been started	eCaST	80.8% (FY16-17)	>=90%		
NBCCEDP (MDEs)	2x/year	M. Milzer	Cervical	Percentage of final diagnosis of HSIL, CIN2, or CIN3/CIS where the time between the date of final diagnosis and the date of treatment initiation is > 90 days	eCaST	9.5% (FY16-17)	<=20%		
NBCCEDP (MDEs)	2x/year	M. Milzer	Cervical	Percentage of final diagnosis of invasive cervical carcinoma where the time between the date of final diagnosis and the date of treatment initiation is >60 days	eCaST	0% (FY16-17)	<=20%		

SECTION 3d: PROGRAM APPROACH | Survivorship/End-of-Life Care

(1 performance measure)

TABLE 3-8. CANCER SURVIVAL PERFORMANCE MEASURES

This performance measure will inform reach related to cancer survivorship. *n=1*

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NCCCP PPO 5	Every 2 years	B. Selig	All	Rate of survival for all cancers	BRFSS	67.3% (2016)	72% (2020)	• Health systems change • Community Clinical Linkages • Environmental approaches	• Establish and/or disseminate guidelines that support quality and timely service provision to cancer survivors • Teach survivors how to access and evaluate available information • Educate policy- and decision-makers about the role and value of long-term follow-up care for survivors

SECTION 4: HEALTH EQUITY PRIORITIES

(3 performance measures; 1 evaluation question)

TABLE 4-1. HEALTH EQUITY PRIORITIES
This performance measure will inform reach and effectiveness in health equity priorities. *n=3*

Report	Frequency	Lead	Focus	Measure/Indicator	Source	Baseline	Target	CDC Strategy	EBI
NCCCP PPO 6	1x/year	B. Selig	All	Number of periodic assessments of data gaps	Admin records	0 (FY17-18)	13 (FY21-22)	Environmental approaches	Enhancing methods to identify and describe health disparities (Cancer and Poverty Report)
CRCCP NCCCP PPO 7	1x/year	B. Selig	CRC	Incidence of advanced stage colorectal cancer per 100,000 people	CCCR	18.8 (2016)	17.6 (2022)	Community-Clinical Linkages	Reducing Structural Barriers to increase community access to cancer screening services (Links of Care)
NCCCP PPO 8	Every 2 years (even)	B. Selig	Obesity	Percentage of the population adults ages 18+ who are overweight and obese	BRFSS	57.4% (2016)	57.45% (2022)	Environmental approaches	Community-scale urban design and land use policies to increase physical activity

TABLE 4-2. HEALTH EQUITY EVALUATION QUESTIONS

Reporting	Evaluation Question	Indicator	Methods (Lead)	Timing/Use
NCCCP	**1. What are the evaluation findings for CCPD's activities related to obesity prevention and control?**	See Appendix E for evaluation plans that include indicators for: descriptive characteristics of policies or built environment changes have been adopted or implemented to increase opportunities for physical activity/active transportation, reach of changes made, and impact of policy and/or environmental change on physical activity and active transportation.	Mixed Methods [PiER Center]	April 2019: Evaluation plan finalized February 2022: Outcomes available

APPENDIX A: CCPD Cross-site Evaluation Plan for Strategy 2. Radon Exposure Reduction Training and Technical Assistance Strategy-Level Evaluation (Lung Cancer)

Evaluation Question	Indicators	Data Source	Reported	Notes

What community engagement activities, policies, and/or environmental changes have been implemented related to radon mitigation?	• # of counties/LPHAs recruited/engaged (e.g., established memorandum of agreements or understanding)
	• # of counties/LPHA voluntarily implementing community engagement activities, policies, and/or environmental changes
	• # and type of social mobilization and social norming strategies supporting reduction of unsafe radon exposure that are **implemented by key stakeholders**, by county/LPHA
	  • # of real estate professionals educated in radon in real estate best practices and pledged to provide their clients with best practice radon information during real estate transactions, by county/LPHA
	  • # of residential home builders recognized for use of radon reduction new construction techniques (i.e., voluntary adoption and accurate implementation of RRNC practices), by county/LPHA
	  • # of National Radon Proficiency Program (NRPP) or National Radon Safety Board (NRSB) home inspectors and radon mitigators trained and certified in radon testing and mitigation techniques, by county/LPHA
	  • # of homebuyers that participate in educational session about radon testing and mitigation prior to buying new home, by county/LPHA
	  • # of Housing Agencies that own or manage or build low-income housing buildings, and/or multi-family units that were educated and took action (e.g., tested, educated, mitigated, implemented RRRC to reduce radon exposure for low-income occupants
	• # & type of policies, building codes, and construction standards adopted to reduce radon exposure, by county/LPHA
	• Target population (demographic/geographic scope), by county/LPHA
		Grantee Tracking	Annually to PiER in DoCK System
			
			Policy Impact Assessment (PiER-led)[7]
			
			Grantee-led Annual Evaluation Report	

[7] PiER will conduct a Policy Impact Assessment with grantees once a policy/environmental change has been implemented to gather additional details regarding the potential reach and impact on individuals in your target population

Evaluation Question	Indicators	Data Source	Reported	Notes
What is the reach of the community engagement activities, policies, and/or environmental changes? [8]	• *# of existing housing units with radon mitigation systems installed as a result of intervention efforts (i.e., trainings, new radon policies, best practices, building codes, etc.; includes single-family and multi-unit developments that meeting radon construction standards)* • *# of new housing units constructed with Radon Reduction New Construction (RRNC) techniques (includes single-family and multi-unit developments that meeting radon construction standards)* • *# individuals residing in sites or communities with new radon policies, best practices, building codes, and/or environmental changes that reduce opportunities for radon exposure* • *# of individuals residing in housing units with safe radon levels as a result of new radon policies, best practices, building codes, and/or environmental changes that reduce opportunities for radon exposure*	Grantee Tracking Surveillance (PiER) Literature (PiER)	Annually to PiER in DoCK System Policy Impact Assessment (PiER-led)[1] Grantee-led Annual Evaluation Report	
Among those reached, how effective were the community engagement activities, policies, and/or environmental changes in mitigating radon exposure?	• *# of residents exposed to unsafe radon levels before and after exposure to intervention efforts*	Surveillance (PiER) Literature (PiER)	Policy Impact Assessment (PiER-led)[1]	

[8] Metrics in italics are optional. If grantee can collect, these metrics can be reported in DoCK. Otherwise, PiER will estimate using Policy Impact Assessment and supplemental data.

APPENDIX B: CCPD Cross-Site Evaluation Plan for Strategy 12. Clinic Systems Quality Improvement Strategy-Level Evaluation – HPV

Evaluation Question	Indicators	Data Source	Reported	Notes
What evidence-based policy, practice, or procedure changes are implemented?	• #, type, & location of sites • # & type of clinic-based EBIs, policies, practices implemented, by site • # & type of providers trained in communication strategies to prompt/promote HPV vaccinations, by site • # of patients receiving HN services, by site (if applicable) • # & type of encounters/services/learning opportunities provided through HN, by site (if applicable)		Annually to PiER via DOCK System Grantee Annual Evaluation Report to CDPHE	
What is the reach of these policy, practice, or procedure changes?	HPV • # of eligible patients in clinic population prompted to initiate HPV vaccinations as a result of clinic-based EBIs, policy, practices implemented (i.e., provider education, reminder calls, etc.) • # & demographics individuals that initiate HPV vaccination series as a result of clinic-based EBIs, policy, practices implemented, by age group • # & demographics of individuals that complete HPV vaccination series as a result of clinic-based EBIs, policy, practices implemented, by age group		Annually to PiER via DOCK System Grantee Annual Evaluation Report to CDPHE	UCD: serving ages 19-26 DPH: serving ages 11-17 age 11-14: 2 shots (6-12 months apart); ages 15-26: 3 shots Initiation and completion of HPV vaccination series must occur during the funding cycle - July 2018-June 2021) Prompted = eligible patients that are educated about HPV vaccinations and prompted to initiate the vaccination series by provider, HN, EMR prompt, etc.
How effective is each clinical systems change at improving patient services and care? *Depending on the EBI, effectiveness may be found in other strategies.	HPV • # of patients in health system population that are in adherence with HPV vaccination guidelines • # of patients in health system population that are NOT in adherence with HPV vaccination guidelines		Annually to PiER via DOCK System Grantee Annual Evaluation Report to CDPHE	

Appendix C: CCPD Cross-Site Evaluation Plan for Strategy 12. Clinic Systems Quality Improvement Strategy-Level Evaluation – Cancer Screening (CCSP)

Evaluation Question	Indicators	Data Source	Reported	Notes
What evidence-based policy, practice, or procedure changes are implemented?	For each type of cancer screening (CRC, Lung, Hereditary) • #, type, & location of sites • # & type of clinic-based EBIs, policies, practices implemented, by site		Annually to PiER in DOCK System Grantee Annual Evaluation Report	Site: Health system
What is the reach of these policy, practice, or procedure changes?	CRC • # & demographics of patients screened for CRC as a result of EBI implemented in target site, by site Lung Cancer • # of patients for which a risk assessment for lung cancer was completed, by site[a] • # of patients that completed a provider session to determine if a diagnostic test for lung cancer was warranted, by site • # of patients that were referred to diagnostic screening for lung cancer after completing a provider session to determine if a diagnostic test was warranted, by site • # and demographics of patients screened for lung cancer as a result of EBI implemented in target site, by site Hereditary Cancers[b] • # and demographics of patients who completed family history screening tool for hereditary cancers, by site • # of patients that were identified as high risk after completing the family history screening tool, by site • # of patients that were referred to genetic counselor after being identified as high risk on the family history screening tool, by site • # of patients that met with genetic counselor after being identified as high risk on the family history screening tool, by site • # of patients for whom genetic counselor order a diagnostic test after patient attended appointment with genetic counselor, by site • # of patients that completed diagnostic test for heredity cancer per genetic counselor referral, by site		Annually to PiER via DOCK System Grantee Annual Evaluation Report to CDPHE	[a] This refers to the number of patients that are identified as potential candidates for lung cancer screening upon completing an eligibility criteria questionnaire (prior to completion of shared decision-making visit), as opposed to all who are approached about lung cancer screening [b] Grantee is not able to report by cancer type

Evaluation Question	Indicators	Data Source	Reported	Notes
How effective is each clinical systems change at improving patient services and care? *Depending on the EBI, effectiveness may be found in other strategies.	CRC • # of patients screening positive for CRC as a result of EBI implemented in target site, by site • % of patients in health system population that are in adherence with CRC screening guidelines, by site[c] Lung Cancer • # of patients screening positive for lung cancer as a result of EBI implemented in target site, by site Hereditary Cancers • # of patients screening positive for genetic mutation (or variance of uncertain significance) on the diagnostic test, by site		Annually to PiER via DOCK System Grantee Annual Evaluation Report to CDPHE	[c] Grantee unable to report number of patients

APPENDIX D: CCPD Cross-Site Evaluation Plan for Strategy 13: Workforce Development (Health Navigation)

Evaluation Question	Indicators	Data Source	Reported	Notes
What training is offered to students of health navigation or community health work?	• # of participating colleges offering degree in HN and/or certificate in CHW (which includes location) • # & type of degree and certificate programs offered via competency-based curricula, by college • # of courses by modality and college (which includes location) • Target population (demographic/geographic scope by county), by college	List of courses provided to CCPD for quarterly reporting	Annually (school year) DOCK System Annual Evaluation Report	Modalities: in-person (001-007, FTL) , hybrid (008), online (00L) Degree: Health Navigator AAS Certificate: CHW Colleges: Lamar Community College (LCC) Otero Junior College (OJC) Trinidad State Junior College (TSJC) Demographic: Traditional (18-22 yr old) Non-traditional (23+)

What is the reach of these training programs?	• # & demographics of students registered for program curricula, by:
	  • Degree/Certificate Program
	  • By county of residence (for geographic reach)
	  • Online usage
	  • College
	  • Incumbent/Non-Incumbent
	• # & demographics of students who have graduated, by:
	  • Degree/Certificate Program
	  • By county of residence (for geographic reach)
	  • College
	  • Online Usage
	  • Incumbent/Non-Incumbent
		Banner Student Data Base	Annually (school year)
			
			DOCK System
			
			Annual Evaluation Report
				Registered students:
				Unduplicated head count of students having registered for two or more PBH courses
				Demographics:
				-age, gender, race, ethnicity, education levels
				
				College: Based on permanent address of student by assigned college service area
				
				Online usage:
				% of PBH program courses completed online (ranges: 0-25%, 26-50%, 51-75%, 76-100%)
				
				Incumbent/Non-Incumbent won't be implemented until Y3 – no data until Y3

How effective are these programs at training competent, competitive HNs and CHWs?	• # of students of students who have graduated and been placed in CHW/HN job in Colorado, by:
	  • Degree/Certificate Program
	  • Ncumbent/Non-Incumbent
	  • County of CHW/HN Employment
	  • Type of agency where employed
	• # of students who have graduated and enrolled in continuing education advance degree program:
	  • Degree or certificate
	  • College continuing to
	  • Incumbent/non-incumbent
		OJC Degrees Granted report
		
		Banner Student Data Base
		
		Graduate Survey -VE-135 with supplemental questions
			Annually (school year)
			
			DOCK System
			
			Annual Evaluation Report
				Incumbent/Non-Incumbent won't be implemented until Y3 – no data until Y3

Appendix E: CCPD Cross-Site Evaluation Plan for Strategy 3. Built Environment Strategy-Level Evaluation – Obesity

Evaluation Question	Indicators	Data Source	Reported	Notes
What policies or built environment changes have been adopted or implemented to increase opportunities for physical activity/active transportation?	• # of plans supporting active living and built environment enhancements that are completed/updated • # of policy strategies that support active living prioritized • # of built environment strategies that support active living prioritized • # & type of policies adopted that support active living • # & type of built environment infrastructure improvements made to support active living • # & type of funding sources identified to support policies and built environment changes • *Target population (demographic/geographic scope), by site/setting* <u>Safe Routes to School (SRTS) Intervention (DDPHE only)</u> • # of SRTS ambassadors trained • # SRTS ambassadors active • # of schools, students/parents that received SRTS programs and/or support through ambassadors	Grantee Tracking	Annually to PiER in DoCK System Policy Impact Assessment (PiER-led)[9] Grantee-led Annual Evaluation Report	
What is the reach of the policy and/or environmental changes?	• *#, type, and location of sites impacted by policy and/or built environment change* [10] • *# & demographics of individuals within scope of new policy or built environmental change* • *# & demographics of individuals exposed to new policy or built environmental change*	Grantee Tracking Surveillance/ Literature (PiER)	Policy Impact Assessment (PiER-led)[1] Grantee-led Annual Evaluation Report	
Among those reached, how did the policy and/or environmental change impact physical activity and active transportation?	• *Change in [target physical activity behavior] before and after exposed to the new policy/environmental change*	Surveillance/ Literature (PiER)	Policy Impact Assessment (PiER-led)[1]	

[9] PiER will conduct a Policy Impact Assessment with grantees once a policy/environmental change has been implemented to gather additional details regarding the potential reach and impact on individuals in your target population.
[10] Metrics in italics are optional. If grantee can collect, metrics will be reported in DoCK. Otherwise, PiER will estimate using Policy Impact Assessment and supplemental data.