

Idaho Coordinated Chronic Disease Plan 2014-2019



**Bureau of Community and Environmental Health
Idaho Department of Health and Welfare**

Table of Contents

Introduction	1
Background	2
Bureau of Community and Environmental Health	2
Idaho Coordinated Chronic Disease Efforts	2
Comprehensive Cancer Control Program.....	2
Diabetes Prevention and Control Program	3
Heart Disease and Stroke Prevention Program	3
Oral Health Program	4
Physical Activity and Nutrition Program	4
Tobacco Prevention and Control Program (Project Filter).....	4
Operational Services.....	5
Burden of Chronic Disease in Idaho	5
Frieden’s Health Impact Pyramid	6
Socio-Ecological Model	7
Coordinated Chronic Disease Plan	8
Methodology	9
CCDP Vision for 2019	10
Values	10
Goals, Objectives, Strategies, and Performance Measures	11
Goals, Objectives, and Strategies	11
Infrastructure	16
Goals, Objectives and Strategies Matrix	17
Performance Measures	21

Introduction

*“The greater danger for most of us lies
not in setting our aim too high and falling short,
but in setting our aim too low and achieving our mark.”*

Michelangelo

A strategic plan provides a powerful roadmap to align and navigate organizational activities in pursuit of an impactful and inspiring future vision. This report presents the results of the Idaho Coordinated Chronic Disease Plan strategic planning process, and defines the direction for the next five years. Moreover, it represents a commitment to optimizing chronic disease prevention and management for Idaho’s internal and external stakeholders. It is a flexible roadmap: a living document that will be added to or modified as needed throughout implementation.

Background

Bureau of Community and Environmental Health

The Bureau of Community and Environmental Health (BCEH) is located in the Division of Public Health in the Idaho Department of Health and Welfare (DHW). It exists to promote, protect and improve the health of the people of Idaho by providing public health leadership, education and outreach programs, and technical assistance and analysis in order to prevent injuries, change risk behaviors, prevent and control chronic disease, and prevent and reduce exposure to contaminants. Current BCEH programs include:

- Environmental Health Education and Assessment
- Indoor Environment
- Toxicology
- Injury Prevention
- Adolescent Pregnancy Prevention
- Sexual Violence Prevention
- Oral Health
- Diabetes Prevention and Control
- Heart Disease and Stroke Prevention
- Comprehensive Cancer Control
- Physical Activity and Nutrition
- Tobacco Prevention and Control (Project Filter©)
- Fit and Fall Proof™
- Operational Services

Idaho Coordinated Chronic Disease Efforts

Although BCEH retains distinct chronic disease programs, it does so with the realization that many chronic diseases share common risk factors. In order to reduce chronic disease in Idaho in the most efficient and cost-effective manner, it is necessary to develop an integrated plan to address these common risk factors. While categorical funding is important, consolidated efforts to reach target populations are critical. The creation of this shared and integrated plan will help facilitate the focus of the programs to better address the needs of Idahoans with chronic disease(s). The following are descriptions of the BCEH programs that focus on chronic disease and the risk behaviors that can lead to chronic disease:

Comprehensive Cancer Control Program

The Idaho Comprehensive Cancer Control Program (ICCCP) was established in June 2005. The program strives to reduce the number of preventable cancers and decrease late stage diagnosis of treatable and survivable forms of cancer and to improve the quality of life of Idahoans impacted by cancer.

The goals of the ICCCP program are to:

- Maintain and expand a coordinated, effective program that defines and raises awareness of the burden of cancer and cancer issues in Idaho;
- Develop new, and coordinates existing, resources statewide;
- Implement strategies to reduce the burden of cancer and improve the quality of life for people from diagnosis through survivorship and end-of-life;
- Increase awareness of the importance of early detection and diagnosis, which leads to the improvement of cancer screening rates according to current science and recommendations.

To help meet these goals, the Comprehensive Cancer Alliance for Idaho (CCAI) was formed. CCAI membership includes individuals and organizations from healthcare and professional organizations, cancer-related and other non-profit organizations, cancer survivors and individuals touched by cancer. CCAI developed and prioritized goals and objectives in an Idaho Comprehensive Cancer Strategic Plan. CCAI selected three priority areas with increasing screening rates for colon cancer being the top priority. CCAI was awarded 501(c)3 non-profit status in May 2010. All seven local public health districts maintain a local cancer coalition or advisory group.

Diabetes Prevention and Control Program

The Idaho Diabetes Prevention and Control Program (DPCP) was funded in 1995 by the Centers for Disease Control (CDC), Division of Diabetes Translation. The Idaho DPCP works closely with the Idaho Heart Disease and Stroke Prevention Program to improve the delivery and use of quality clinical and other health services aimed at preventing and managing high blood pressure and diabetes. The Idaho DPCP also focuses on clinical and community linkages to better support chronic disease self-management. The Idaho DPCP is working to increase links between community and clinical organizations to support prevention, self-management and control of diabetes, high blood pressure, and obesity.

The DPCP has established a large statewide partnership network called the Diabetes Alliance of Idaho (DAI). Partners include healthcare professionals, local public health districts, non-profit organizations, health plans, physician networks, university programs, and the Idaho Indian Tribes. The DAI works to improve access to quality health care, increase awareness and support through education, promote prevention of diabetes and reduce diabetes-related complications for those challenged with diabetes in Idaho.

Heart Disease and Stroke Prevention Program

The Idaho Heart Disease and Stroke Prevention Program (HDSP) was first funded in 2008 by the CDC, Division of Heart Disease and Stroke Prevention. The HDSP focuses primarily on addressing healthcare system interventions to improve the effective delivery and use of quality clinical care for the prevention and management of hypertension and diabetes. The HDSP also works with the DPCP to increase healthcare provider referrals to community resources that support chronic disease self-management and to increase the use of those community resources by Idahoans.

Oral Health Program

The Idaho Oral Health Program (IOHP) is funded by the Maternal and Child Health Block Grant Title V of the Social Security Act and has been in existence for over 35 years. In September 2011, the program received funding from the DentaQuest Foundation Oral Health 2014 Initiative to focus specifically on Medical-Dental Collaboration and Prevention/Public Health Infrastructure. In September 2013, the program was funded by CDC, Division of Oral Health, to build program infrastructure and capacity.

The IOHP works with local public health districts throughout Idaho to target at-risk children from birth to 18 years of age and their families, pregnant woman, and healthcare providers. Activities conducted in public health settings by dental hygienists with extended access endorsements include Fluoride Varnish Programs in Women, Infants, and Children Clinics, Early Head Start, and Head Start offices; School-Based Sealant Clinics at schools with >35% free and reduced school lunch; oral health screenings and assessments, oral health education, and dental home referrals to all children seen in Fluoride Varnish Programs and School-Based Sealant Clinics; and additional programs with local dentists and other community partners and stakeholders.

The IOHP also works with various Community Health Centers to help develop Medical-Dental Collaboration Models and with the Idaho State University Department of Physician Assistant Studies and Family Medicine Residency of Idaho to implement the Smiles for Life: A National Oral Health Curriculum.

Physical Activity and Nutrition Program

The Idaho Physical Activity and Nutrition Program (IPAN) has received state general funds since its inception in 2004. In 2013, IPAN received federal funds from the 1305 grant. IPAN works with Idaho organizations, businesses, communities, the seven local public health districts, and the State Department of Education to provide public health education on physical activity and nutrition initiatives. IPAN impacts several community sectors including farmer's markets, schools, child care facilities, worksites and the community at large. IPAN strives to improve access to healthy foods and physical activity opportunities in every environment, making the healthy choice the easy choice. IPAN also provides oversight for Fit and Fall Proof™, a fall prevention program for seniors. While Idaho does not currently have a CDC-funded arthritis program, many adults with arthritis are impacted by participation in Fit and Fall Proof™. IPAN also manages the Healthy Eating, Active Living (HEAL) Idaho Network, a statewide network of partners invested in physical activity and healthy nutrition initiatives in the places they live, learn, work and play.

Tobacco Prevention and Control Program (Project Filter® Program)

Idaho has been fighting the negative effects of tobacco since the development of its Tobacco Prevention and Control Program in 1993. The Idaho Tobacco Prevention and Control Program, referred to as Project Filter, was created to oversee the efforts of local grass-roots prevention and control initiatives. Project Filter contracts with the seven local public health districts to conduct specific tobacco prevention and control activities. Project Filter develops objectives and activities based on the four priority areas as defined by the CDC: 1) prevent initiation of tobacco use among young people, 2) eliminate nonsmokers' exposure to secondhand smoke, 3) promote quitting among adults and young people, and 4) identify and eliminate tobacco related disparities.

Project Filter also contracts with four of the six Idaho Tribes and The Idaho Commission on Hispanic Affairs (ICHA). The program developed a Health Disparities Plan in 2002 to identify and eliminate tobacco related disparities.

A Health Equities Report is currently being developed by the Operational Services Program to address health disparities across BCEH programs.

Operational Services

The Operational Services Program (OSP) provides technical assistance with chronic disease program surveillance and evaluation, epidemiology, health equity and communication to BCEH programs and key partners. The OSP was developed in 2012 as part of a strategy to facilitate cross-program chronic disease prevention efforts. Currently there are four staff who comprise the Operational Services Program: a Surveillance and Evaluation Specialist, Chronic Disease Epidemiologist, Health Equity Specialist, and Health Communication Specialist.

Burden of Chronic Disease in Idaho

According to the CDC, chronic disease accounts for 70% of deaths in the United States and 75% of the annual healthcare costs. In conjunction with the Idaho Coordinated Chronic Disease Plan, the Idaho Chronic Disease Burden Report has been developed. The purpose of this report is to integrate the chronic disease data for Idaho, allowing the Coordinated Chronic Disease Program to better identify program goals and objectives for priority populations. The following is a brief summary of current chronic disease data for Idaho.

The diseases with highest prevalence among the Idaho population (2012 BRFSS):

1. Arthritis (26.0%)
2. Cancer (other than skin cancer) (6.0%)
3. Asthma (8.5%)
4. Diabetes (9.3%)
5. Pre-diabetes (7.3%)*

*Data Source: 2011 BRFSS

The leading causes of death (age-adjusted death rate per 100,000 population, 2011):

1. Cancer (156.5)
2. Heart disease (155.7)
3. Chronic lower respiratory disease (51.8)
4. Unintentional injury (43.6)
5. Stroke (38.9)

In terms of the leading causes of premature death (i.e., years of potential life lost, 2011), cancer and unintentional injury top the list followed by heart disease, suicide and chronic lower respiratory disease.

A number of factors can contribute to the development of chronic disease. Many of these factors cannot be changed, including age, gender, race or ethnic origin, family history, and genetic predisposition. However, risk behaviors associated with chronic disease development and severity are modifiable, and are the focus of many public health efforts.

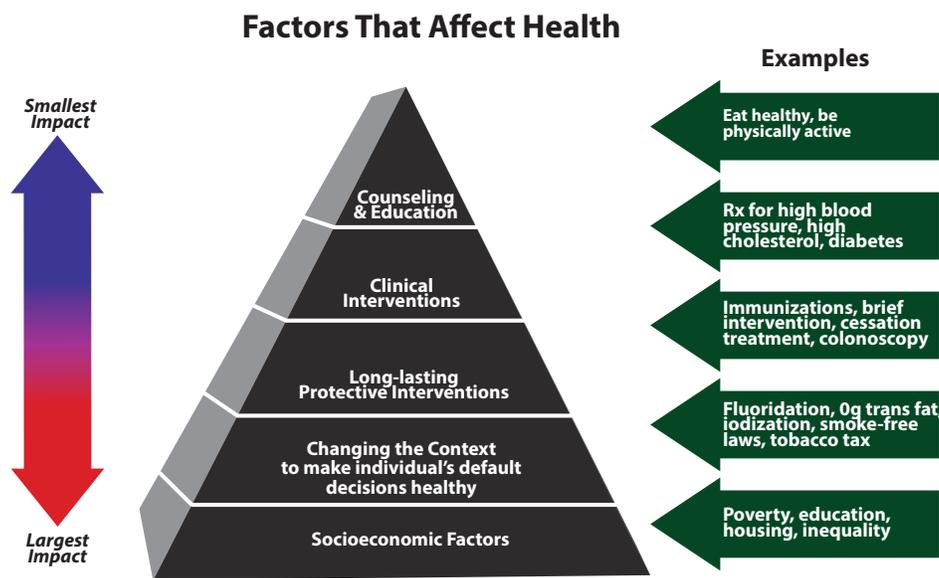
Selected modifiable risk factors and behaviors that lead to chronic disease (2012 BRFSS) include:

- Being overweight (62.6%)
- High blood pressure (29.4%)*
- Obesity (26.8%)
- Physical inactivity (77.6%)*
- Smoking (16.4%)

*Data Source: 2011 BRFSS

Frieden’s Health Impact Pyramid

Thomas Frieden’s Health Impact Pyramid best describes the impact of different types of public health interventions and provides a framework to improve health. It is one of the many pieces of “business intelligence” used in developing the CCDP.



Source: Adapted from Frieden TR. A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health. 2010;100(4):590-5.

At the base of this pyramid, indicating interventions with the greatest potential impact, are efforts to address socio-economic determinants of health. In ascending order are interventions that change the context to make individuals’ default decisions healthy; clinical interventions that require limited contact but confer long-term protection; ongoing direct clinical care; and health education and counseling.

Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of the population and require less individual effort. Implementing interventions at each of the levels can achieve the maximum possible public health benefit. (Thomas R. Frieden, 2010)

Socio-Ecological Model

The Socio-Ecological Model recognizes the interwoven relationship that exists between the individual and their environment. While individuals are responsible for maintaining a healthy lifestyle, behavior can be largely determined by the environment through social norms, attitudes, and public policies. Health promotion programs must focus on all levels of the model with attention toward multi-level interventions. (CDC, The Socio-Ecological Model: A Framework for Prevention, 2009)



“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change. If successful programs are to be developed...attention must be given not only to the behavior of individuals, but also to the environmental context within which people live...”

Smedley and Syme, 2000

Coordinated Chronic Disease Plan

The purpose of the Idaho Coordinated Chronic Disease Plan (CCDP) is to outline outcome measures, goals, objectives, strategies, and deliverables that will decrease mortality and morbidity as a result of chronic disease and the risk factors associated with those diseases. The plan is intended to be a guideline for all programs and organizations, working in chronic disease prevention and control, to use in developing activities and interventions that are cross-cutting and have statewide reach.

This document has been created to align chronic disease prevention and control work with CDC initiatives. CDC's vision is that all state objectives and activities fall under the following four domains: Epidemiology and Surveillance; Environmental Change; Healthcare Systems Change; and Community/Clinical Linkages. The desired result is to increase cost effectiveness of programs; demonstrate improvement in categorical programs; demonstrate positive outcomes from coordinated projects; increase sustainability of chronic disease programs; increase staff leadership capacity; and increase cross-program sharing of staff expertise, skills, and knowledge to build capacity of all staff. The following is a description of the four domains:

Domain 1: Epidemiology and Surveillance

Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.

Domain 2: Environmental Change

Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities).

Domain 3: Healthcare Systems Change

Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, reduce or eliminate risk factors, and mitigate or manage complications.

Domain 4: Community/Clinical Linkages

Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

All of the goals, objectives, and strategies outlined in this plan fall within at least one of the four domains, and include interventions that affect the five population sectors as defined by the CDC Community Health Assessment and Group Evaluation (CHANGE) model: (CDC, 2010)

1. Community-at-large: Community-wide efforts that impact the social and built environments.
2. Community Institution/organization: Entities within the community that provide a broad range of human services and access to facilities.
3. Healthcare: Places people go to receive preventive care or treatment, or emergency healthcare services.
4. Schools: All primary and secondary learning institutions.
5. Worksites: Places of employment.

Methodology

The Coordinated Chronic Disease Team engaged in a highly participative process to develop a five-year strategic plan to chart its future. Team members all contributed valuable knowledge, ideas, and skills in developing the plan.

First, the team developed the five-year vision for the ideal future impact of the Coordinated Chronic Disease Plan (i.e., the ideal state of chronic disease prevention and management in 2019). Then, a comprehensive list of stakeholders was generated, capturing all those who impact and/or are affected by the work of the CCDP. This also helps ensure a highly inclusive perspective throughout the planning process.

Next, the team conducted a comprehensive environmental assessment: an analysis of all factors that have the potential to either help or hinder achievement of the vision. Business intelligence was identified and reviewed in advance to support this effort. The results of the environmental assessment were synthesized into critical success factors, identifying the most significant areas of focus to cultivate future success. Goals were developed to address each of the critical success factors, and then aligned with the four domains. Objectives and strategies were created to define how each goal would be attained. Performance measures were established to enable evaluation of progress toward reaching the goals and objectives.

Although not included in this version of the report, action plans detailing the steps and responsibilities in carrying out each strategy will drive implementation of this plan. Additional key components essential to successful strategic plan implementation will include regular action plan review, shared accountability, and recognition of efforts and resulting accomplishments.

CCDP leadership and implementation will be guided by the following team members:

Implementation Team

- Sonja Schriever, RN, Chief, Bureau of Community and Environmental Health
- Kara Stevens, BA, Section Manager, Bureau of Community and Environmental Health
- Jack Miller, MHE, Section Manager, Bureau of Community and Environmental Health
- Joseph Pollard, BS, Surveillance and Evaluation Specialist, Bureau of Community and Environmental Health
- Robert Graff, PhD, Chronic Disease Epidemiologist, Bureau of Community and Environmental Health

Management Team

- Angela Gribble, MHS, Program Manager, Physical Activity and Nutrition Program
- Angie Bailey, RDH-EA, BSDH, Program Manager, Oral Health Program
- April Dunham, BS, Program Manager, Heart Disease and Stroke Prevention Program
- Ivie Smart, MHE, CHES, Program Manager, Project Filter
- Nicole Runner, BS, CHES, Program Manager, Diabetes Prevention and Control Program
- Patti Moran, MHS, Program Manager, Comprehensive Cancer Control Program

CCDP Vision for 2019

The vision describes an organization's desired future state. It is the guiding force that inspires internal and external stakeholders to be involved with the organization, and provides a point of alignment for all organizational activities. The BCEH's vision for chronic disease is:

*“To guide the collaboration and integration
among chronic disease stakeholders
toward a culture of health in Idaho.”*

Values

Values reveal the character of an organization: beliefs, attitudes, and behaviors that provide the foundation for conduct and decision-making. The BCEH's values are:

- Innovation
- Communication
- Transparency
- Utilizing data and evaluation to drive programming
- Using evidence-based and best-practice programming
- Addressing health disparities
- Being collaborative and integrative

The CCDP affirms and aligns its activities with these values.

Goals, Objectives, Strategies, and Performance Measures

This section contains the goals, strategies, and performance measures of the 2014 - 2019 Coordinated Chronic Disease Strategic Plan. They are organized by each of the CDC's four domains. Goals articulate the outcomes the organization will achieve in order to reach its vision. Objectives and strategies define how the goals will be achieved. Performance measures are designed to assess the outcomes and impacts of plan activities. Measurement data is translated into intelligence that informs progress toward achieving the goals, and guides any course adjustments needed to maximize success at reaching the vision.

Goals, Objectives, and Strategies

DOMAIN 1: Epidemiology and Surveillance: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.

Goal 1: Identify and use data needed to drive program decision-making and planning.

Objective 1: By January 2016, develop an integrative and interactive data-driven framework to create a coherent picture of chronic disease in Idaho.

Strategy 1: Define system platform requirements and framework through the investigation of existing or novel surveillance framework(s) that can support multiple data resources.

Objective 2: By July 2016, Ensure that staff are effectively trained on utilizing data for program planning, implementation, and evaluation.

Strategy 1: Train BCEH chronic disease staff on applying data driven utilization-focused methods to program planning, implementation, and evaluation.

Objective 3: By July 2017, Ensure that staff utilize data for program planning, implementation, and evaluation.

Strategy 1: Ensure that data Chronic Disease Programs are involved in the development, administration, and utilization of reliable and sound chronic disease and associated risk factor data sources (surveillance-based or otherwise).

Objective 4: By July 2016, implement a coordinated approach for chronic disease assessments designed to determine capacity and drive decision-making.

Strategy 1: Develop a decision-making process that will ensure that coordinated assessment opportunities can be identified (where/when appropriate).

Strategy 2: Develop a more systematic approach to disseminate assessment results among chronic disease programs to highlight in order to highlight results (promote utilization) and leverage future collaboration opportunities.

Strategy 3: Promote the adoption of policies that promote accurate data collection and evaluation, for example, provide technical assistance to internal and external partners with the utilization of chronic disease data/outcomes/measures.

Objective 5: By January 2016, develop a process for monitoring health disparities in communities at high risk for multiple chronic diseases.

Strategy 1: Develop a State Health Equity Report to help inform coordinated chronic disease priority setting and strategies that could impact health disparities in Idaho.

Strategy 2: Partner with regional and state health equity partners to identify and collect promising practices and effective strategies appropriate for diverse sub-populations.

Goal 2: Disseminate data to drive program decision-making and planning.

Objective 1: By January 2016, utilize existing and novel avenues for disseminating chronic disease data.

Strategy 1: Highlight BCEH data and/or disseminate chronic disease data through the DHW website.

Strategy 2: Continue to present chronic disease data internally and to external Key Partners and Stakeholders as requested.

Objective 2: By July 2016, strategically convene and facilitate partner groups and key stakeholders to disseminate information and provide education.

Strategy 1: Continue to leverage opportunities to share data and information at chronic disease and associated risk factor alliance meetings/webinars/gatherings, etc.

Objective 3: By July 2016, inform and educate policy and decision makers on the effectiveness of evidence-based strategies.

Strategy 1: Train BCEH program staff on evidence-based and/or best-practices strategies in order to develop a common understanding.

DOMAIN 2: Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities).

Goal 1: Address and facilitate system and environmental development to implement evidence-based and/or best practice programs.

Objective 1: By March 2019, increase the number of practices and policies that create healthy environments in educational settings.

Strategy 1: Establish new and foster existing relationships with key educational stakeholders and partners.

Objective 2: By March 2019, increase the number of practices and policies that create healthy environments in worksites.

Strategy 1: Establish new and foster existing relationships with key worksite stakeholders and partners.

Strategy 2: Provide support and technical assistance to decision-makers and other stakeholders on practices and policies that create healthy environments in worksites.

Strategy 3: Educate decision-makers and other stakeholders on policies and practices that create healthy environments in the worksite.

Objective 3: By March 2019, increase the number of practices and policies that create healthy environments in communities.

Strategy 1: Establish new and foster existing relationships with key community stakeholders and partners.

Strategy 2: Provide support and technical assistance to decision-makers and other stakeholders on practices and policies that create healthy community environments.

Strategy 3: Educate decision-makers and other stakeholders on policies and practices that create healthy community environments.

Goal 2: Market environmental approaches

Objective 1: By March 2019, promote the role of public health in creating a significant impact on population health outcomes.

Strategy 1: Convene and participate in appropriate community stakeholder groups and coalitions.

Objective 2: By March 2019, promote the successful implementation of environmental and systems changes.

Strategy 1: Develop and disseminate significant accomplishments to the general public.

DOMAIN 3: Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

Goal 1: Identify and implement evidence-based care protocols to promote health systems interventions.

Objective 1: By June 2016, establish evidence-based referral relationships between Federally Qualified Health Centers (FQHCs) and community resources.

Strategy 1: Support healthcare transformation efforts of Federally Qualified Health Centers (FQHCs).

Strategy 2: Support the implementation of Chronic Disease Quality Improvement activities.

Strategy 3: Work with health care systems to refer individuals to appropriate evidence-based supportive services including but not limited to:

- Tobacco Cessation referrals
- DSME/DSMP/CDSMP
- National Diabetes Prevention Program (NDPP)
- Pharmacy Medication Therapy Management
- Fit and Fall Proof™ Program
- Oral Health
- Cancer long term/late effects management
- Caregiver support
- Community Paramedics
- Behavioral Health

Objective 2: By June 2018, establish evidence-based referral relationships between non-FQHC primary care providers and community resources.

Strategy 1: Support healthcare transformation efforts of non-Federally Qualified Health Centers (Non-FQHCs).

Strategy 2: Support the implementation of Chronic Disease Quality Improvement activities.

Strategy 3: Work with health care systems to refer individuals to appropriate evidence-based supportive services including but not limited to:

- Tobacco Cessation referrals
- DSME/DSMP/CDSMP
- National Diabetes Prevention Program (NDPP)
- Pharmacy Medication Therapy Management
- Fit and Fall Proof™ Program
- Oral Health

- Cancer long term/late effects management
- Caregiver support
- Community Paramedics
- Behavioral Health

Goal 2: Market health system interventions

Objective 1: By June 2019, promote the successful collaboration and implementation of health system interventions.

Strategy 1: Promote the benefits of patient participation in best practice recognized lifestyle change programs to healthcare providers throughout Idaho through regular publications to the healthcare community.

Strategy 2: Use partnerships, promotions, and outreach activities to increase awareness about best practice recognized lifestyle change programs within Idaho communities.

DOMAIN 4: Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

Goal 1: Improve community-clinical linkages.

Objective 1: By 2019, identify opportunities to improve community-clinical linkages.

Strategy 1: Analyze intake and exit data from community health programs to determine factors of success.

Objective 2: By June 2018, increase the number of evidence-based chronic disease related programs.

Strategy 1: Promote the implementation of evidence-based Chronic Disease Programs in targeted communities.

Objective 3: By June 2019, increase referrals to evidence-based chronic disease community programs.

Strategy 1: Coordinate and implement health communication and marketing campaigns that promote successful collaborations between primary care providers and community resources.

Strategy 2: Raise awareness and use evidenced based and/or best practice marketing strategies to increase public use of community resources.

Infrastructure

Goal 1: Ensure BCEH has a sustainable workforce.

Objective 1: By 2019, assess effectiveness and sustainability of internal workforce resources.

Strategy 1: Assess staffing needs across BCEH programs to define and develop immediate and long term staffing needs to ensure programs are adequately staffed.

Strategy 2: Ensure the BCEH has the infrastructure in place to identify and add additional programs. This could include realigning staff, utilizing contractors, interns and partners.

Strategy 3: Ensure BCEH staff has the skills needed to stay current on relevant program data, trends, and strategies to address program goals, objectives and outcomes.

Goal 2: Continue to evaluate Chronic Disease stakeholder relationships.

Objective 1: By 2019, annually leverage resources to maintain effective internal and external relationships and increase partnerships as needed.

Strategy 1: Participate in and/or lead local, regional and statewide chronic disease coalitions, partnerships and advisory boards.

Objective 2: By 2019, maintain effective internal and external relationships and increase partnerships as needed.

Strategy 1: Maintain a leadership role and continue to foster and cultivate current BCEH coalitions and partnerships including, but not limited to:

- Diabetes Alliance of Idaho
- Heart Disease and Stroke Advisory Committee
- Idaho Oral Health Alliance
- Comprehensive Cancer Alliance of Idaho
- Healthy Eating Active Living (HEAL)
- Tobacco Free Idaho Alliance
- Preventive Health and Health Services Block Grant Advisory Committee

Strategy 2: Participate in local, regional and statewide chronic disease coalitions, partnerships and advisory boards.

Strategy 3: Leverage resources to develop and build new partnerships as needed to address coordinated chronic disease.

Goals, Objectives and Strategies Matrix

DOMAIN I		
Epidemiology and Surveillance: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.		
GOAL	OBJECTIVES	STRATEGIES
Goal 1: Identify and use data needed to drive program decision-making and planning.	<u>Objective 1:</u> By January 2016, develop an integrative and interactive data-driven framework to create a coherent picture of chronic disease in Idaho.	Strategy 1: Define system platform requirements and framework through the investigation of existing or novel surveillance framework(s) that can support multiple data resources.
	<u>Objective 2:</u> By July 2016, Ensure that staff are effectively trained on utilizing data for program planning, implementation, and evaluation.	Strategy 1: Train BCEH chronic disease staff on applying data driven utilization-focused methods to program planning, implementation, and evaluation. Strategy 2: Train additional BCEH, Division of Public Health, and Key Partner chronic disease staff on data driven utilization-focused program planning, implementation, and evaluation.
	<u>Objective 3:</u> By July 2017, Ensure that staff utilize data for program planning, implementation, and evaluation.	Strategy 1: Ensure that data Chronic Disease Programs are involved in the development, administration, and utilization of reliable and sound chronic disease and associated risk factor data sources (surveillance-based or otherwise).
	<u>Objective 4:</u> By July 2016, implement a coordinated approach for chronic disease assessments designed to determine capacity and drive decision-making.	Strategy 1: Develop a decision-making process that will ensure that coordinated assessment opportunities can be identified (where/when appropriate). Strategy 2: Develop a more systematic approach to disseminate assessment results among chronic disease programs to highlight in order to highlight results (promote utilization) and leverage future collaboration opportunities.
	<u>Objective 5:</u> By January 2016, develop a process for monitoring health disparities in communities at high risk for multiple chronic diseases.	Strategy 1: Develop a State Health Equity Report to help inform coordinated chronic disease priority setting and strategies that could impact health disparities in Idaho. Strategy 2: Partner with regional and state health equity partners to identify and collect promising practices and effective strategies appropriate for diverse sub-populations.
Goal 2: Disseminate data to drive program decision-making and planning.	<u>Objective 1:</u> By January 2016, utilize existing and novel avenues for disseminating chronic disease data.	Strategy 1: Highlight BCEH data and/or disseminate chronic disease data through the DHW website. Strategy 2: Continue to present chronic disease data internally and to external Key Partners and Stakeholders as requested.
	<u>Objective 2:</u> By July 2016, strategically convene and facilitate partner groups and key stakeholders to disseminate information and provide education.	Strategy 1: Continue to leverage opportunities to share data and information at chronic disease and associated risk factor alliance meetings/webinars/gatherings, etc.
	<u>Objective 3:</u> By July 2016, inform and educate policy and decision-makers on the effectiveness of evidence-based strategies.	Strategy 1: Train BCEH program staff on evidence-based and/or best practice strategies in order to develop a common understanding.

DOMAIN 2

**Environmental approaches that promote health and support and reinforce healthful behaviors
(statewide in schools, worksites, and communities).**

GOAL	OBJECTIVES	STRATEGIES
<p>Goal 1: Address and facilitate system and environmental development to implement evidence-based and/or best practice programs.</p>	<p><u>Objective 1:</u> By March 2019, increase the number of practices and policies that create healthy environments in educational settings.</p>	<p>Strategy 1: Establish new and foster existing relationships with key educational stakeholders and partners.</p>
	<p><u>Objective 2:</u> By March 2019, increase the number of practices and policies that create healthy environments in worksites.</p>	<p>Strategy 1: Establish new and foster existing relationships with key worksite stakeholders and partners.</p> <p>Strategy 2: Provide support and technical assistance to decision-makers and other stakeholders on practices and policies that create healthy environments in worksites.</p> <p>Strategy 3: Educate decision-makers and other stakeholders on policies and practices that create healthy environments in the worksite.</p>
	<p><u>Objective 3:</u> By March 2019, increase the number of practices and policies that create healthy environments in communities.</p>	<p>Strategy 1: Establish new and foster existing relationships with key community stakeholders and partners.</p> <p>Strategy 2: Provide support and technical assistance to decision-makers and other stakeholders on practices and policies that create healthy community environments.</p> <p>Strategy 3: Educate decision-makers and other stakeholders on policies and practices that create healthy community environments.</p>
<p>Goal 2: Market environmental approaches.</p>	<p><u>Objective 1:</u> By March 2019, promote the role of public health in creating a significant impact on population health outcomes.</p>	<p>Strategy 1: Convene and participate in appropriate community stakeholder groups and coalitions.</p>
	<p><u>Objective 2:</u> By March 2019, promote the successful implementation of environmental and systems changes.</p>	<p>Strategy 1: Develop and disseminate significant accomplishments to the general public.</p>

DOMAIN 3

Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

GOAL	OBJECTIVES	STRATEGIES
<p>Goal 1: Identify and implement evidence-based care protocols to promote health systems interventions.</p>	<p><u>Objective 1:</u> By June 2016, establish evidence-based referral relationships between Federally Qualified Health Centers (FQHCs) and community resources.</p>	<p>Strategy 1: Support healthcare transformation efforts of Federally Qualified Health Centers (FQHCs).</p> <p>Strategy 2: Support the implementation of Chronic Disease Quality Improvement activities.</p> <p>Strategy 3: Work with health care systems to refer individuals to appropriate evidence-based supportive services including but not limited to:</p> <ul style="list-style-type: none"> • Tobacco Cessation referrals • DSME/DSMP/CDSMP • DPP • Pharmacy Medication Therapy Management • Fit and Fall Proof™ Program • Oral Health • Cancer long term/late effects management • Caregiver support • Community Paramedics • Behavioral Health
	<p><u>Objective 2:</u> By June 2018, establish evidence-based referral relationships between non-FQHC primary care providers and community resources.</p>	<p>Strategy 1: Support healthcare transformation efforts of non-Federally Qualified Health Centers (Non-FQHCs).</p> <p>Strategy 2: Support the implementation of Chronic Disease Quality Improvement activities.</p> <p>Strategy 3: Work with health care systems to refer individuals to appropriate evidence-based supportive services including but not limited to:</p> <ul style="list-style-type: none"> • Tobacco Cessation referrals • DSME/DSMP/CDSMP • DPP • Pharmacy Medication Therapy Management • Fit and Fall Proof™ Program • Oral Health • Cancer long term/late effects management • Caregiver support • Community Paramedics • Behavioral Health
<p>Goal 2: Market health system interventions.</p>	<p><u>Objective 1:</u> By June 2019, promote the successful collaboration and implementation of health system interventions.</p>	<p>Strategy 1: Promote the benefits of patient participation in best practice recognized lifestyle change programs to healthcare providers throughout Idaho through regular publications to the healthcare community.</p> <p>Strategy 2: Use partnerships, promotions, and outreach activities to increase awareness about best practice recognized lifestyle change programs within Idaho communities.</p>

DOMAIN 4		
Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.		
GOAL	OBJECTIVES	STRATEGIES
Goal 1: Improve community-clinical linkages.	<u>Objective 1:</u> By 2019, identify opportunities to improve community-clinical linkages.	Strategy 3: Analyze intake and exit data from community health programs to determine factors of success.
	<u>Objective 2:</u> By June 2018, increase the number of evidence-based Chronic Disease related programs.	Strategy 1: Identify opportunities for professional education, trainings and outreach supporting new chronic disease community resources. Strategy 2: Promote the implementation of evidence-based Chronic Disease Programs in targeted communities.
	<u>Objective 3:</u> By June 2019, increase referrals to evidence-based chronic disease community programs.	Strategy 1: Coordinate and implement health communication and marketing campaigns that promote successful collaborations between primary care providers and community resources. Strategy 2: Raise awareness and use evidenced-based and/or best practice marketing strategies to increase public utilization of community resources.

INFRASTRUCTURE		
GOAL	OBJECTIVES	STRATEGIES
Goal 1: Ensure BCEH has a sustainable workforce.	<u>Objective 1:</u> By 2019, assess effectiveness and sustainability of internal workforce resources.	Strategy 1: Assess staffing needs across BCEH programs to define and develop immediate and long term staffing needs to ensure programs are adequately staffed. Strategy 2: Ensure that BCEH has the infrastructure in place to identify and add additional programs. This could include realigning staff, utilizing contractors, interns and partners. Strategy 3: Ensure BCEH staff has the skills needed to stay current on relevant program data, trends, and strategies to address program goals, objectives and outcomes.
Goal 2: Continue to evaluate Chronic Disease stakeholder relationships.	<u>Objective 1:</u> By 2019, annually leverage resources to maintain effective internal and external relationships and increase partnerships as needed.	Strategy 1: Participate in and/or lead local, regional and statewide chronic disease coalitions, partnerships and advisory boards.

Performance Measures

DOMAIN I		
Epidemiology and Surveillance: Gather analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.		
GOAL	OBJECTIVE	PERFORMANCE MEASURE
Goal 1: Identify and use data needed to drive program decision making and planning.	(Obj. 1.1.1) By July 2015, develop an integrative and interactive framework to create a coherent picture of chronic disease in Idaho.	(PM 1.1.1a) Written recommendations (if appropriate) for a framework to develop a chronic disease surveillance system (as appropriate), including but not limited to: <ul style="list-style-type: none"> - Decision around feasibility for an interactive system - Data source to be included - Inclusion of chronic disease program interventions and success - Methods and process for updating surveillance system
	(Obj. 1.1.2) By July 2015, Chronic Disease programs support Chronic Disease surveillance systems.	(PM 1.1.2a) Inventory of specific chronic disease related measures which have been requested and funded by BCEH as part of Behavioral Risk Factor Surveillance System (BRFSS) and other appropriate surveillance systems
		(PM 1.1.2b) Evidence of utilization of existing chronic disease surveillance system data, including but not limited to: <ul style="list-style-type: none"> - BRFSS - YRBS/Profiles - Vital Records - CDRI - EMS
	(Obj. 1.1.3) By July 2016, work with stakeholders to aggregate and share data to analyze population health measures to drive continuous quality improvement.	(PM 1.1.3a) Proportion of BCEH chronic disease program staff that have been trained on utilization focused approaches to program planning and delivery
		(PM 1.1.3b) Development of a written strategy for promoting and delivering utilization focused training to external partners/stakeholders
		(PM 1.1.3c) Number of external partners/stakeholders who have participated in utilization focused training in the previous 12 months
		(PM 1.1.3d) Documentation of consultation and technical assistance delivered to internal and external partners around chronic disease surveillance, epidemiology, and program evaluation
	(Obj. 1.1.4) By July 2015, implement a coordinated approach to assessment to determine capacity and drive decision-making.	(PM 1.1.4a)
	(Obj. 1.1.5) By January 2015, develop a process for monitoring health disparities in communities at high risk for multiple chronic diseases.	(PM 1.1.5a) Development of statewide Health Equity Plan

Goal 2: Cultivate recognition, knowledge, and trust of Chronic Disease Programs.	(Obj 1.2.1) By July 2015, implement public relation and marketing strategies to intentionally increase trust, awareness and visibility of Coordinated Chronic Disease, and establish BCEH as a reliable source of data, surveillance, evaluation, etc.	(PM 1.2.1a) Document activities to increase trust, awareness and visibility of chronic disease programs.
		(PM 1.2.1b) Number of requests for public health data and/or technical assistance with data, program surveillance, or chronic disease epidemiology.
	(Obj 1.2.2) By January 2015, begin to strategically convene and facilitate partner groups and key stakeholders to disseminate information and provide education.	(PM 1.2.2a) Development of dissemination plan highlighting opportunities for coordinated chronic disease prevention information and education.
		(PM 1.2.2b) Number of partners and key stakeholders which received chronic disease prevention information and education through strategic dissemination.
	(Obj. 1.2.3) By July 2016, inform and educate policy and decision-makers on the effectiveness of evidence-based strategies.	(PM 1.2.3a) Document activities to inform and educate policy and decision-makers on the effectiveness of evidence-based strategies.

DOMAIN 2

Environmental approaches that promote health and support and reinforce healthful behaviors.

GOAL	OBJECTIVE	PERFORMANCE MEASURE
Goal 1: Address and facilitate system and environmental development to implement best practice based programs.	(Obj. 2.1.1) By March 2019, increase the number of practices and policies that create healthy environments in educational settings.	(PM 2.1.1a) Evidence of work done with key educational stakeholders and partners (e.g., progress reports, meeting minutes, etc.)
		(PM 2.1.1b) Contract scope of work with State Department of Education (SDE) containing elements that involve working with local education agencies (LEAs) towards the development of policies that create healthy environments.
		(PM 2.1.1c) Number of ECEs that develop and/or adopt policies to implement food service guidelines, including sodium.
		(PM 2.1.1d) Number of ECEs that develop and implement standards to increase physical activity.
		(PM 2.1.1e) Number of LEAs that receive professional development and technical assistance on strategies to create a healthy school nutrition environment.
		(PM 2.1.1f) Number of LEAs that have adopted and implemented policies that prohibit all forms of advertising and promotion (e.g., contests and coupons) of less nutritious foods and beverages on school property.
		(PM 2.1.1g) Number of state-level multi-component physical education policies for schools developed and adopted by the state.
	(Obj. 2.1.2) By March 2019, increase the number of practices and policies that create healthy environments in worksites.	(PM 2.1.2a) Documentation of work done with key stakeholders and partners working towards the implementation of healthy worksite environments (e.g., progress reports, meeting minutes, etc.).
		(PM 2.1.2b) Contract scope of work with Idaho's public health districts (PHDs) containing elements that involve working with worksites on the development of policies that create healthy worksite environments.
		(PM 2.1.2c) Number of workshops, conferences, and/or trainings in which BCEH chronic disease prevention programs provide education through presentations or dissemination of educational materials. (Note: this should be reported/collected quarterly)

	(Obj. 2.1.3) By March 2019, increase the number of practices and policies that create healthy environments in communities.	(PM 2.1.3a) Documentation of work done with key stakeholders and partners working towards the implementation of healthy worksite environments (e.g., progress reports, meeting minutes, etc.).
		(PM 2.1.3b) Contract scope of work containing elements that involve working with communities on the development of policies that create healthy environments.
		(PM 2.1.3c) Number of adults or youth who have access to places for physical activity, with a focus on walking.
		(PM 2.1.3d) Number of local or state policies that include language that supports environmental changes to enhance places for physical activity, emphasizing walking.
Goal 2: Market environmental approaches.	(Obj. 2.2.1) By March 2019, promote the role of public health in creating a significant impact on population health outcomes.	(PM 2.2.1a) Documentation of BCEH participation in stakeholder groups, coalitions, or alliances.
		(PM 2.2.1b) Level of general population's recognition of public health
	(Obj. 2.2.2) By March 2019, promote the successful implementation of environmental and systems changes.	(PM 2.2.2a) Documentation of efforts to disseminate successful environmental and systems change initiatives to the general public.
		(PM 2.2.2b) Number and/or reach of educational materials disseminated to stakeholders for the purpose of informing them on the impact of environmental change (Process measures)

DOMAIN 3

Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

GOAL	OBJECTIVE	PERFORMANCE MEASURE
Goal 1: Identify and implement evidence-based care protocols to promote health systems interventions.	(Obj. 3.1.1) By June 2016, establish evidence-based referral relationships between Federal Qualified Health Centers (FQHCs) and community resources.	(PM 3.1.1a) Proportion of health care systems that routinely refer patients to appropriate evidence-based supportive services including but not limited to: <ul style="list-style-type: none"> - Tobacco cessation - DSME/DSMP/CDSMP - DPP - Pharmacy Medication Therapy Management - Fit and Fall Proof™ Program - Oral Health - Cancers long term/late effects management - Caregiver support - Community paramedics - Behavioral Health
		(PM 3.1.1b) Evidence of BCEH support of chronic disease quality improvement activities among FQHCs (process measures).
	(Obj. 3.1.2) By June 2018, establish evidence-based referral relationships between non-FQHC primary care providers and community resources.	(PM 3.1.2a) Proportion of health care systems that routinely refer patients to appropriate evidence-based supportive services including but not limited to: <ul style="list-style-type: none"> - Tobacco cessation - DSME/DSMP/CDSMP - DPP - Pharmacy Medication Therapy Management - Fit and Fall Proof™ Program - Oral Health - Cancers long term/late effects management - Caregiver support - Community paramedics - Behavioral Health
Goal 2: Market health system interventions	(Obj. 3.2.1) By June 2019, promote the successful collaboration and implementation of health system interventions.	(PM 3.2.1a) Utilization of lifestyle programs (through referral) by healthcare providers.
		(PM 3.2.1b) Proportion of Idaho adults who are aware of best practice-recognized lifestyle change programs within Idaho communities.

DOMAIN 4

Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

GOAL	OBJECTIVE	PERFORMANCE MEASURE
Goal 1 – Improve community-clinical linkages.	(Obj. 4.1.1) By 2019, identify opportunities to improve community-clinical linkages.	(PM 4.1.1a) Documentation of opportunities to improve community-clinical linkages.
		(PM 4.1.1b) Document work with key partners and stakeholder to improve community-clinical linkages (e.g., meeting minutes, agendas, etc.)
	(Obj. 4.1.2) By June 2018, increase the number of best practice-based Chronic Disease-related community resources.	(PM 4.1.2a) Number of best practice-based chronic disease community programs which address specific chronic disease conditions or lifestyle change
	(Obj. 4.1.3) By June 2019, increase referrals to best practice-based Chronic Disease community programs.	(PM 4.1.3a) Number of referrals to best practice-based Chronic Disease community programs.



Idaho Department of Health and Welfare
Bureau of Community and
Environmental Health
450 W. State St.
Boise, Idaho 83720

June 2014