On Common Ground for Health Expanded Plan

Our Coordinated Efforts to Prevent and Manage Chronic Disease in Missouri

2014 - 2018

Developed by the multi-stakeholder Chronic Disease State Plan Workgroup, *On Common Ground for Health* describes recommended strategies to coordinate the prevention and management of common chronic conditions in Missouri.

August 2013

Burden of Chronic Diseases in Missouri

BACKGROUND

Chronic diseases are defined by the Centers for Disease Control and Prevention (CDC) as those diseases that are prolonged, do not resolve spontaneously, and for which a complete cure is rarely achieved. According to the World Health Organization (WHO), chronic diseases such as cancer, heart disease and diabetes have reached global epidemic proportions and now cause more deaths than all other diseases combined.

Chronic diseases, such as cancer, heart disease and diabetes, have reached global epidemic proportions.

In the United States, almost 1 out of every 2 adults has at least one chronic illness. Chronic diseases steal the vigor of life and compromise the quality of life. These diseases cause major limitations in daily living for almost 1 out of every 10 adult Americans or about 24 million people. They account for almost 70 percent of all deaths in the U.S., which is about 1.7 million each year. Chronic diseases are costly. More than 75 percent of health care spending is on people with chronic conditions. Finally, chronic diseases are preventable.

BURDEN, TRENDS AND RACIAL DISPARITIES

Mortality

In Missouri, chronic diseases are major causes of death. In 2010, a total of 55,054 Missourians died and about 71 percent of these deaths were related to chronic diseases. Heart disease was the number one killer, accounting for 25.0 percent of all deaths; followed by cancer at 22.8 percent; chronic lower respiratory disease, 6.4 percent; stroke, 5.4 percent; and diabetes, 2.6 percent. In total, these five causes in Missouri accounted for 62.2 percent of all deaths in 2010. The death rates for heart disease, cancer, stroke, and diabetes declined significantly in the last decade in Missouri overall, and among white men and women and African-American men and women; however, the death rates for these five chronic diseases were higher in Missouri than in the U.S. In Missouri, the death rates were higher among African-

71%
of Missouri deaths in 2010 were related to chronic disease.

Americans than among whites, except for chronic lower respiratory diseases in which the rate among African-Americans was lower.

Prevalence

In 2011, about 30.2 percent of Missouri adults were obese, 34.3 percent had hypertension, 44.8 percent had high cholesterol, 10.7 percent had diabetes, 29.4 percent had arthritis, 10.2 percent had asthma, 8.1 percent had chronic lower respiratory disease (COPD), 2.6 percent had kidney disease, 18.5 percent had visual impairment, 20.6 percent had depressive disorders, 5.4 percent were heart attack survivors, 3.8 percent were stroke survivors, and 9.4 percent were cancer survivors. About 3 in 4 Missouri adults (74.4%) had at least one of the 13 chronic diseases/conditions, greater than 1 in 2 had at least two (51.7%), greater than 1 in 3 had at least three (34.5%), greater than 1 in 5 had at least four (21.7%), greater than 1 in 8 had at least 5 (12.9%), and about 1 in 14 had at least 6 of these diseases/conditions. The prevalences of all these chronic diseases/conditions were higher in Missouri than the US in 2011, except for the prevalence of vision impairment, which was similar to that in the US. In addition, the prevalences of most chronic diseases/conditions increased significantly in Missouri in the last decade, with the prevalence of obesity increasing at about one percentage point per year, hypertension 1.8 percentage points, diabetes 0.3 percentage points, and asthma 0.1 percentage points per year. African-Americans had a significantly higher prevalence of obesity, hypertension, diabetes, and asthma than whites, but significantly lower prevalence of high cholesterol.

51.7%

Missourians lived with at least two chronic diseases/conditions in 2011. (74.4% had at lease one.)

Screening and Early Detection

Screening and early detections are important for detecting disease at an early and treatable stage. For breast, cervical and colorectal cancer, screening is also a preventive measure. In 2010, 71.3 percent of women age 40 or older had a mammogram within the past two years in Missouri, compared to 75.2 percent in the US. About 80.1 percent of Missouri women age 18 or older had a Pap test within the past three years, compared

to 81.3 percent in the US. The prevalence of ever having had a sigmoidoscopy or colonoscopy among adults age 50 or older was 65.2 percent in Missouri, the same as the US prevalence.

Self-management and Health Behaviors

When people develop a chronic disease, its self-management is very important for preventing complications and exacerbations, and improving the quality of life. In 2011, among Missouri adults with diabetes, 56.3 percent had ever taken a diabetes self-management class to manage their diabetes, similar to US prevalence of 52.2 percent; 64.4 percent conducted daily self-monitoring of their blood glucose, compared to 63.2 percent in the US. About 10.8 percent of Missouri adults with arthritis had ever taken a class to learn how to manage their arthritis, compared to 12.5 percent in the US. Among people with chronic diseases, a healthy life-style is important for preventing complications. In 2011, among people with diabetes in Missouri, 19.0 percent were current smokers, 42.4 percent were physically inactive, and 77.3 percent were not consuming fruits and vegetables five or more times per day. Among adults with arthritis, 38.4 percent were physically inactive. The smoking prevalence among adults with asthma was 27.9 percent, among adults who ever had a stroke it was 24.0 percent and among adults who ever had a heart attack smoking prevalence was 26.1 percent.

Medical Care Quality

High quality of medical care and management are important for people with chronic diseases. In 2011, 73.5 percent of Missouri adults with diabetes had two or more hemoglobin A1C tests, 75.3 percent had their feet examined by a doctor in the last year, 68.8 percent had an annual dilated eye exam, 61.2 percent had a flu shot in the last year and 57.4 percent ever had a pneumococcal vaccination.

Health Care Utilization: Emergency Room Visits and Hospitalizations

When chronic diseases were not well managed and controlled, emergency room visits and hospitalizations followed. In 2009, the age-adjusted emergency room visit rate for heart disease was 12.8 per 1,000 and for asthma it was 5.1 per 1,000 in Missouri. The rates for heart disease increased significantly in the last decade. The rates for asthma

decreased significantly for the state. African-Americans had significantly higher emergency room visit rates for both diseases than whites.

In 2009, the age adjusted hospitalization rate for heart disease was 136.8 per 10,000 population, for osteoarthritis 29.3 per 10,000, for stroke 28.9 per 10,000, for COPD 23.9 per 10,000, for diabetes 17.4 per 10,000, and for asthma 13.5 per 10,000. These diseases led to more than $5.01 billion in hospital charges, including more than $3.13 billion in charges to Medicare and $400 million in charges to Medicaid. From 2000 to 2009, the age-adjusted hospitalization rates for heart disease and stroke have declined significantly among white men and women, but not among African-American men and women. The age-adjusted rates for asthma and diabetes have increased significantly among African-American men and women. The rate for osteoarthritis has increased significantly in Missouri for all four racial and gender groups. Obesity is a major risk factor for osteoarthritis and the obesity epidemic is a major contributing factor to this upward trend in osteoarthritis hospitalization. The hospitalization rates among African-Americans were significantly higher than among whites for heart disease, stroke, asthma, and diabetes, but lower than whites for osteoarthritis.

Risk Factors

These chronic diseases share common risk factors-- smoking, lack of physical activity, unhealthy diets and heavy drinking. In 2011, 23.0 percent of Missouri adults were current smokers, 23.7 percent were physically inactive, 87.4 percent did not consume fruits and vegetables five or more times per day, and 7.3 percent drank alcohol heavily. Overall, 88.0 percent of adults had at least one of the four risk factors, 41.8 percent had at least two, and 10.7 percent had at least three. Again, the prevalences of these risk factors were all higher in Missouri than in the US, although the prevalence of tobacco use declined significantly in Missouri in the last decade. The prevalence of physical inactivity was higher among African-Americans than among whites.

23.0%
current smokers

23.7%
physically inactive

87.4%
low fruit/vegetable consumption

Socioeconomic Disparities

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. The WHO Commission on social Determinants for Health concluded in 2008 that the social conditions are the single most important determinant of one's health status. Certainly, individual choices are important, but factors in the social environment are what influence lifestyle choices and determine access to health services in the first place.

Income In Missouri, household income level is associated with almost every indicator of health. Individuals in poverty have the worst health indicators, including the prevalence of chronic diseases, conditions, risk behaviors, preventive care practices, health care coverage, and living environments. People in middle income levels have worse health than people in the highest income level. In 2011, 15.8 percent of 920,188 Missourians lived in a family with a household income below the poverty level (e.g., $22,811 per year for a family of four in 2011). Poverty is distributed unevenly within the state. In 2010, poverty rates ranged from 6.1 percent in St. Charles County to 31.3 percent in Pemiscot County. Overall, the 2011 poverty rate was more than twice as high among African-Americans as among whites (15% vs. 39% in Missouri and 13% vs. 35% nationally).

Education Education is associated with almost all health indicators in Missouri. Data from the 2011 Missouri County-level Study showed that a high proportion of Missouri adults with less than a high school education lived in an environment that was unsafe and lacked access to healthy foods. The proportion decreased as the education level increased. A similar pattern was observed for the prevalence of risk behaviors, lack of preventative care, poor general health, and chronic diseases and conditions. In 2011, the proportion of Missouri adults aged 25 and older without a high school diploma was 31.4 percent, compared to 28.4 percent nationally. Education levels vary in different areas in Missouri. A cluster of 19 counties in southeast Missouri had the highest proportion of adults age 25 or older without a high school diploma.

Race and Ethnicity According to the 2011 Missouri County-level Study, a significantly higher proportion of non-Hispanic African-Americans were obese, had hypertension, diabetes, asthma and no leisure time physical activity compared to non-Hispanic whites. A significantly higher proportion of Hispanics did not follow the colorectal cancer screening guidelines compared to non-Hispanic whites. On the other hand, a significantly higher proportion of non-Hispanic whites did not follow the breast and cervical cancer screening guidelines and had high blood cholesterol compared to non-Hispanic African-Americans; and had high blood pressure compare to Hispanics. Racial and ethnic minorities make up a smaller proportion of Missouri's population than that of the U.S. as a whole. In 2010, 11.7 percent of Missourians were African-American and 7.5 percent were other non-white races. The Hispanic population in Missouri comprises 3.7 percent of the total population which is much lower than the national percentage of 16.7 percent. The proportion of racial and ethnic minorities varies widely in different areas of the state, from 5.7 percent of the population in Cass County to 54.2 percent in St. Louis City.

Urbanization Communities at different urbanization levels differ in their environmental, demographic, social and economic characteristics, and these characteristics greatly influence the magnitude and types of health problems communities face. The 2011 Missouri County-level Study showed that a higher proportion of Missouri adults living in a small town or isolated rural area lacked access to healthy foods in their neighborhood, had no healthcare coverage, did not meet cancer screening guidelines, engaged in risk behaviors, and had chronic conditions and diseases (arthritis, diabetes, COPD, cancer, and vision impairment), compared to residents living in other areas. In contract, a higher proportion of adults living in the urban core area considered their neighborhood to be somewhat unsafe or extremely safe, or currently had asthma.
The level of urbanization was determined using the method developed by the University of Washington's rural Health Research Center. Based on their method, about 56.1 percent of the Missouri adult population 18 years and older, lived in urban core areas, 13.5 percent in sub-urban areas, 12.9 percent in large rural towns and 17.5 percent in small rural towns or isolated rural areas.

Missouri Chronic Disease Burden Report

About the Planning Process

In large part due to categorical funding, the various chronic disease programs within DHSS have typically been disease specific and functioned independently with limited coordination among statewide chronic disease initiatives. DHSS recognized the need to break down the silos of these categorical programs and develop a more comprehensive and integrated approach to address chronic disease. In the fall of 2009, DHSS leadership established a project team to develop an integrated plan for chronic disease prevention and management.

The team obtained broad stakeholder input to inform the development of this plan. Structured interviews were conducted via telephone with 60 invited stakeholders representing local public health agencies, medical care providers, state government agencies, health plans, employers, advocacy organizations, etc. Information gathered from stakeholder interviews as well as sessions with DHSS program managers were compiled in a report that identified emerging themes which were, in turn, used to guide the team's further work. This report is the Integrated Chronic Disease Prevention & Management Framework for Strategic Planning.

In January 2012, the Missouri Department of Health and Senior Services (DHSS) launched a planning process to enhance coordination of chronic disease prevention and health promotion activities statewide. Members of the multi-stakeholder Chronic Disease State Plan Workgroup participated in multiple discussions to recommend strategies that could build a statewide infrastructure for interventions and policies to achieve measureable improvements across the leading chronic diseases – arthritis, asthma, cancer, diabetes, heart disease, and stroke. Aligned with analysis from the Institute of Medicine* and advice from the US Centers for Disease Control and Prevention, the Workgroup was guided by two simple principles – (1) support people to live well, regardless of their chronic illness or current state of health and (2) dissolve boundaries between categorical (aka, condition-specific) program activities. Informed

by surveillance data, the Workgroup built this plan from a foundation of prior work led by DHSS over the past three years, including *Integrated Chronic Disease Prevention & Management: Framework for Strategic Planning*.

About the Chronic Disease Prevention and Health Promotion Domains

According to the Centers for Disease Control and Prevention (CDC), chronic disease public health practitioners must make measurable contributions to the prevention and control of chronic disease — and by doing so, improve quality of life, increase life expectancy, improve the health of future generations, increase productivity and help control health care spending.

It is increasingly recognized that individual health depends on societal health and healthy communities. In addition to having strong medical care systems, healthy communities promote and protect health across the lifespan, across a variety of sectors, and through a range of policies, systems and environmental supports that put health in the people's hands and give Americans even greater opportunity to take charge of their health.

Transforming the nation's health and providing individuals with equitable opportunities to take charge of their health requires work within four key domains: epidemiology and surveillance, environmental approaches, health system interventions, and community-clinical linkages. Each of these domains link with this plan's five strategy areas and are the basis for action items. Domain descriptions can be found on pages 25-26.

* National Academy of Sciences, *Living Well with Chronic Illness: A Call for Public Health Action*. 2012. www.iom.edu/livingwell

Original Five Strategy Areas

planning	environmental factors	community linkages	health care quality	surveillance and evaluation

Strategy Recommendations

A total of 12 key strategies were developed within 5 broad areas: (1) planning, (2) environmental factors, (3) community linkages, (4) health care quality, and (5) surveillance and evaluation. The Workgroup ultimately selected progress indicators under each strategy to guide statewide activity through 2014. The indicators are specific, measureable items that, when accomplished, would ***advance Missouri's capabilities to implement an efficient, coordinated, public health approach to chronic disease.***

Further refinement of the strategies were made by the Department's Section for Community Health and Chronic Disease Prevention program managers. Refined strategies, goals, objectives and year one action items were developed through a series of facilitated strategic planning meetings over an eight month period. Workgroup recommendations and CDC's domain categories and descriptions (page vi) were used as a reference when developing the refined strategies, goals, objectives and action items.

Refined Strategy Areas

planning	environmental factors	community/ clinical linkages	health system interventions	epidemiology and surveillance

BUILDING ON A FOUNDATION

This document is intended for use as a foundation for the State of Missouri's categorical chronic disease control programs to emphasize coordinating approaches to reducing chronic disease morbidity and mortality. This framework will be helpful to local and statewide stakeholders engaged in chronic disease prevention and management activities, as they develop or revise their own plans. There is also explicit alignment

between the Missouri Actions to Prevent Chronic Disease (MAP) and other Missouri chronic disease programs including arthritis, asthma, cancer, diabetes, school health and tobacco.

CONTRIBUTE TO HEALTH EQUITY

The 12 key strategies in this coordinated plan will contribute to health equity. Achieving health equity results in enhanced quality of care and reduced costs due to improved communication between providers and patients. Enhanced communication improves patient adherence to prescribed diagnostics and therapy and fosters self-management of chronic conditions. Health system performance and efficiency is improved due to a reduction in medical errors and improved use of costly technology and resources. Achieving health equity improves health literacy ensuring that all patients have the skills to make optimal health decisions on their own behalf. Finally, efforts to achieve health equity impact the economy. Achieving health equity will result in a healthier workforce thereby improving productivity and reducing absenteeism in the workforce.

SHARED RESPONSIBILITY

It should be recognized that plan development and implementation is a shared responsibility by the public and private sector. Our vision is that the use of this strategic framework will help planners as we work toward improving the health and quality of life for Missourians.

1

STRATEGY AREA #1
Planning

Assure priorities for population-based health improvement are focused on equity among diverse socio-economic groups.

Strategies

1.1 Communication

Establish centralized communication channels for information about chronic disease prevention and management among stakeholders statewide.

Rationale: Successful coordination and collaboration requires responsive and proactive information-sharing. Open communication also helps establish and maintain trust among stakeholders.

Progress Indicators

- Develop common contact database of stakeholders from categorical programs (by Dec 2012)
- Develop and begin implementation of social networking strategy to link stakeholders (by Dec 2013)
- Increase number of stakeholders linked through social network tools (by Dec 2014)

1.2 Leadership

Establish coordination among partners to inform and guide evidence-based planning for chronic disease prevention and management.

Rationale: A forum for public health experts to discuss and develop ideas can facilitate collaboration, leverage resources, and promote strategies that meet the health needs of Missourians.

- Establish a chronic disease coordinating council drawn from existing partnerships (by Dec 2013)
- Develop and implement method for routine collection of input from diverse people with chronic disease to inform community health improvement efforts (by Dec 2012)
- Publish menu of evidence-based interventions for communities to use for local planning (by Dec 2013)

2

STRATEGY AREA #2

Environmental Factors

Promote physical activity, healthy eating, and tobacco free living by modifying influential environmental factors.

Strategies

2.1 Worksite Wellness

Build capacity among employers to adopt wellness programs targeting healthy eating, physical activity and tobacco free living.

Rationale: Working adults with or at risk for chronic disease spend many hours per day at their jobs. Employers can influence health behaviors through wellness programs, educational campaigns, and incentives as well as health insurance benefits.

Progress Indicators

- Assemble stakeholders from at least 3 categorical programs to develop coordinated worksite strategy (by Dec 2013)
- Complete baseline assessment of wellness programs offered by representative sample of employers in the state (by Dec 2014)
- Launch website with health education and other tools for human resource professionals to use for wellness program development and implementation (by Dec 2014)
- Offer training program for employers that are increasing investment in worksite wellness programs (by Dec 2014)

2.2 Activate Change Agents

Activate individuals and organizations to change environmental factors associated with physical activity, healthy eating, and tobacco free living.

Rationale: A public that is engaged in and educated about public health can make informed decisions about community-wide efforts to improve health.

- Increase use of key messages and materials that inform public about the association between environmental factors and physical activity, healthy eating, and tobacco free living (by Dec 2014)
- Increase number of municipalities adopting comprehensive smoke-free ordinances (by Dec 2014)
- Increase number of communities in the state that adopt ordinances or policies for safe alternate transportation modes (by Dec 2014)
- Increase percentage of adults who report healthy foods are easy to purchase in their neighborhood (by Dec 2014)

STRATEGY AREA #2: Environmental Factors

2

GOAL

Environmental and social factors support individuals engaging in healthy living.

Objective 1: Through 2018 increase community policies, rules, or ordinances that are proven to effectively promote healthy lifestyle environments for Missourians.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Conduct survey to determine baseline	All CHCDP programs and Epidemiology and evaluation teams	Pat Simmons	Number of surveys conducted
Work with communities to assess their environment	All CHCDP programs and Epidemiology and evaluation teams	Victoria Warren	Baselines determined Number of communities conducting assessments
Support coalition development and action	All CHCDP programs and Epidemiology and evaluation teams	Victoria Warren	Number of communities implementing changes Number of community coalitions working on policy changes
Support schools in School Health Index assessment	School Health; Tobacco Control; Nutrition, Physical Activity and Obesity; and Adolescent programs	Marjorie Cole	Number of health promoting policies or practices changed Number of new health promoting policies
Provide training and technical assistance to partners (existing and potential)	All CHCDP programs	Program Managers (Dependent on topic area.)	Number of programs offering technical assistance

2 FUTURE ACTION ITEMS

Action	Programs Involved	Team Lead	Measures
Identify gaps in policy			
Develop model policies as determined by gaps			
Disseminate model policies to assist communities with policy change			

STRATEGY AREA #2: Environmental Factors

2

GOAL

Environmental and social factors support individuals engaging in healthy living.

Objective 2: Through 2018 maintain existing and increase state laws and regulations that are proven to effectively promote healthy lifestyle environments for Missourians.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Inform DHSS legislative liaison on state laws and regulations that promote healthy lifestyle environments	All CHCDP programs	Belinda Heimericks	Number of grand rounds to which Department management is invited Number of subject matter briefs provided at grand rounds
Provide training and technical assistance to coalitions and partners to educate and advocate for environments that support a healthy lifestyle	All CHCDP programs	Victoria Warren Pat Simmons	Number of trainings conducted and technical assistance appointments provided for partners and coalitions
Evaluate and support improvement of existing laws to promote healthy lifestyle environments	All CHCDP programs	Pat Simmons Victoria Warren	Number of laws evaluated
Coordinate advocacy with partners	All CHCDP programs	Jim Pruitt	Number of partners attending policy training Number of efforts to coordinate with partners

STRATEGY AREA #2: Environmental Factors

2

GOAL

Environmental and social factors support individuals engaging in healthy living.

Objective 3: Through 2018 increase from baseline the number of coordinated, targeted, market-tested messages promoting healthy lifestyles that are delivered by the state.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Determine baseline of existing messages	All CHCDP programs	Dennis Spurling	Baseline determined
Review existing messages to determine if effectiveness evaluation is needed	All CHCDP programs	Dennis Spurling	Number of messages reviewed
Identify gaps in effective messaging	All CHCDP programs	Dennis Spurling	Gaps identified
Promote existing effective DHSS messages	All CHCDP programs	Dennis Spurling	Number of department messages promoted by CHCDP programs

FUTURE ACTION ITEMS

Increase funding to develop new messages that promote healthy lifestyles			
Coordinate dissemination of messages with partners			
Develop targeted messages based on gaps identified			

3

STRATEGY AREA #3—Community/Clinical Linkages

Community/Clinical Linkages

Link individuals to community resources that support their personal efforts to reach optimal health.

Strategies

3.1 Referral

Implement systems to drive referrals into chronic disease prevention and management interventions.

Rationale: Individuals and organizations that care for people with chronic conditions lack tools to coordinate referral and follow-up with specialized support program providers.

Progress Indicators

- Increase referrals from medical care providers to behavioral support programs for chronic disease self-management, weight reduction, and tobacco use cessation (by Dec 2014)
- Increase number of chronic disease prevention and management services available at the community-level (by Dec 2014)

3.2 Resource Awareness

Provide public access to tailored information about community-based resources for prevention and self-management education.

Rationale: Low awareness contributes to under-utilization of community-based prevention and self-management programs.

- Identify organizations in all counties that can serve as a key contact for community-based resources for prevention and self-management education (by Dec 2013)
- Develop framework and manual for local public health agencies to inventory, categorize and promote community-based resources for prevention and self-management education (by Dec 2013)
- Convene task force of stakeholders to create conceptual design and basic specifications for web-based tool for accessing community-specific resources (by Dec 2014)

3

STRATEGY AREA #3—Community/Clinical Linkages

GOAL

Linkages to evidence-based community resources are available to support efforts to reach optimal health.

Objective 1: Through 2018 seven regional health resource centers are providing evidence-based community resources that support optimal health across the life-span.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Clarify the role of the seven regional health resource centers (HRC) and how they will work with and be accountable to the communities they serve	All CHCDP programs	Jim Pruitt	Scope of work written
Seek funding for the HRCs	All CHCDP programs	Jim Pruitt	Amount of funding secured/allocated
Identify technical assistance needs of the HRCs	All CHCDP programs	Jim Pruitt	Technical assistance needs identified
Develop a technical assistance plan for the HRCs	All CHCDP programs	Jim Pruitt	Plan written
Provide technical assistance to HRCs	All CHCDP programs	Jim Pruitt	Number of technical assistance sessions provided
Establish contract for HRCs to facilitate integration of evidence-based interventions into the health-care systems	All CHCDP programs	Jim Pruitt	Contract established and implemented

STRATEGY AREA #3—Community/Clinical Linkages

3

GOAL

Linkages to evidence-based community resources are available to support efforts to reach optimal health.

Objective 2: Through 2018 expand the number of evidence-based interventions and best practices implemented at the community level that support optimal health across the lifespan.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Maintain contract with seven regional HRCs	All CHCDP programs	Jim Pruitt	Contract established (ongoing)
Expand collaborations with current coalitions on evidenced-based interventions to support optimal health	All CHCDP programs	Sandy Hentges	Number of coalitions merged with current efforts
Develop a plan for utilizing community health workers to assist the public in accessing community and/or clinical resources	All CHCDP programs	Barb Brendel	Plan developed
Develop a plan to map community assets of evidence-based interventions	All CHCDP programs	Kris Kummerfeld	Plan written Web-based program established
Utilize map of community assets to promote lifestyle changes	All CHCDP programs	Program Managers	To be determined
Survey health systems to ascertain pertinent navigation tools	All CHCDP programs	Mindy Laughlin	Survey completed and results published

3

Action	Programs Involved	Team Lead	Measures
Develop monitoring system to determine the number of people that access information to help control their chronic disease and/or risk factors	All CHCDP programs	Jim Pruitt	Monitoring system developed

FUTURE ACTION ITEMS

Implement monitoring system			Number of HRC referrals Number of people accessing information by intervention or program
Include chronic disease referrals to evidence-based interventions into the monitoring system			Number of people accessing evidence-based interventions
Establish community resources that support healthy habits			
Implement plan for utilizing community health workers			

STRATEGY AREA #3—Community/Clinical Linkages

3

GOAL

Linkages to evidence-based community resources are available to support efforts to reach optimal health.

Objective 3: Through 2018 increase from baseline the number of community partnerships with an operational plan for chronic disease prevention and management.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Identify baseline	All CHCDP programs	Brenda Maley	Baseline established
Identify gaps in partners	All CHCDP programs	Brenda Maley	Gaps identified
Educate communities and partnerships about the importance of chronic disease operational planning	All CHCDP programs	Brenda Maley	Number of coalitions and partners

FUTURE ACTION ITEMS

Train new partners on how to develop an operational plan			Number of written plans developed

4

STRATEGY AREA #4 — Health System Interventions

Health System Interventions

Enhance health care system capacity to deliver coordinated, proactive, and equitable services for people with chronic conditions.

Strategies

4.1 Enhancing EMR Usability

Facilitate use of quality improvement methodologies and population management functions (e.g., registries) through efficient use of electronic medical record (EMR) systems.

Rationale: The electronic medical record (EMR) has become part of standard practice in most primary care settings. It holds a widely untapped potential for data reporting and management which can drive improvements in quality and population health.

Progress Indicators

- Develop and begin implementation of an annual assessment of leading health care providers' use of electronic population health management tools for improving chronic care (by Dec 2013)
- Develop and publish analysis of payer policies for chronic disease prevention and management services (by Dec 2013)
- Form a team to provide technical assistance for supporting health care provider quality improvement efforts (by Dec 2013)

4.2 Understanding Quality Metrics

Inform public about quality performance metrics of health care providers in chronic disease management, including patient-centered models of care.

Rationale: Quality is a complex construct, but advances are being made to measure health care provider performance. In this era of consumer-driven health care, the public is seeking reliable information on how to assess quality and different models of care, especially for chronic conditions that require frequent interaction with the health care system.

- Release publication (e.g., brochure, website) to educate the public about attributes and benefits of patient-centered models of care (by June 2013)
- Create inventory of quality assessment and measurement projects underway in the state (by Dec 2013)
- Develop system for directing consumers to public information about health care provider quality (by Dec 2014)

STRATEGY AREA #4—Health System Interventions

4

GOAL

Health care systems deliver evidence-based, coordinated, proactive and equitable services to prevent, detect or control chronic disease.

Objective 1: Through 2018 increase from baseline the number of health care delivery system partnerships promoting continuous quality improvement for chronic disease care and management.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Develop a plan for recruitment of partners	All CHCDP programs with connections in health care delivery systems	Glenn Studebaker	Recruitment plan completed
Educate partners on the continuous quality improvement process	All CHCDP programs with connections in health care delivery systems	Glenn Studebaker	Number of partners educated
Monitor the number of providers that receive patient centered medical home status	All CHCDP programs that serve patients that are in health care systems	Glenn Studebaker	Number of providers with patient centered medical home status

FUTURE ACTION ITEMS

Recruit and maintain an adequate number of delivery systems in order to reach patients with chronic disease through evidence-based interventions			
Identify gaps in training			

4

FUTURE ACTION ITEMS

Action	Programs Involved	Team Lead	Measures
Identify professional development partners that can provide training which fills identified training gaps			
Promote available professional development trainings			

STRATEGY AREA #4—Health System Interventions

4

GOAL

Health care systems deliver evidence-based, coordinated, proactive and equitable services to prevent, detect or control chronic disease.

Objective 2: Through 2018 increase health system partnership to identify providers compliant with standards of care in the prevention and management of chronic disease.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Identify existing data sources	All CHCDP programs that work with health systems	Glenn Studebaker	Data sources identified
Utilize existing data sources to determine if standards of care are being met	All CHCDP programs that serve patients that are in health care systems	Glenn Studebaker	Number of providers using standards of care

FUTURE ACTION ITEMS

Identify gaps in training		Glenn Studebaker	Training gaps identified
Identify new data sources		Glenn Studebaker	New data sources identified

STRATEGY AREA #4—Health System Interventions

4

GOAL

Health care systems deliver evidence-based, coordinated, proactive and equitable services to prevent, detect or control chronic disease.

Objective 3: Through 2018 increase the percentage of patients with a chronic disease who receive care utilizing standards of care.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Determine baseline for percent of patients	All CHCDP programs that work with health systems	Glenn Studebaker	Baseline established
Promote available trainings on standards of care for aspirin, A1c, blood pressure, cholesterol, sodium and smoking (ABCS)	All CHCDP programs that work with health systems	Glenn Studebaker	Number of trainings promoted
Promote tools for measuring progress toward chronic disease risk factor control	All CHCDP programs that work with health systems	Glenn Studebaker	Number of inquiries about available tools Number of times tools promoted
Determine success indicators for use of tools	All CHCDP programs that work with health systems	Glenn Studebaker	Success indicators identified
Provide technical assistance to health care systems to increase compliance with standards of care	All CHCDP programs that work with health systems	Glenn Studebaker	Number of providers receiving technical assistance
Expand Million Hearts Initiative model to promote standards of care in prevention, early detection and treatment of chronic diseases	All CHCDP programs that work with health systems	Kris Kummerfeld	Number of health care providers utilizing the Million Hearts Initiative model

4

STRATEGY AREA #4—Health System Interventions

GOAL

Health care systems deliver evidence-based, coordinated, proactive and equitable services to prevent, detect or control chronic disease.

Objective 4: Through 2018 increase from baseline the number of health system partnerships with chronic disease prevention and management operational plans embedding evidence-based interventions into those plans.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Establish baseline of health system partnerships with chronic disease prevention and management in an operational plan	All CHCDP programs and regional HRCs	Jim Pruitt	Number of plans identified (baseline) Number of plans modified to include evidence-based interventions
Provide education and technical assistance to health care providers regarding evidence-based intervention programs	All CHCDP programs and regional HRCs	Jim Pruitt	Number of education sessions provided Number of technical assistance sessions provided
Establish a contract with regional HRCs to facilitate integration of evidence-based interventions into health care systems	All CHCDP programs and regional HRCs	Jim Pruitt	Contract established

STRATEGY AREA #4—Health System Interventions

4

GOAL

Health care systems deliver evidence-based, coordinated, proactive and equitable services to prevent, detect or control chronic disease.

Objective 5: Through 2018 partner with health systems statewide to address health equity in under-served populations with chronic disease.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Identify under-served populations	All CHCDP programs and Epidemiology and Evaluation teams	Shumei Yun	Under-served population identified
Provide education and technical assistance to partners regarding health equity	All CHCDP programs	Kris Kummerfeld	Number of educational sessions provided Number of technical assistance sessions provided

FUTURE ACTION ITEMS

Assist partners developing plans that include health equity	All CHCDP programs	Kris Kummerfeld	Number of plans written addressing health equity
Assist partners with incorporating health equity strategies in their chronic disease plans	All CHCDP programs	Kris Kummerfeld	To be determined

5

STRATEGY AREA #5
Epidemiology and Surveillance

Enhance utilization of surveillance data for guiding chronic disease and health promotion program planning and evaluation among state and local partners.

Strategies

5.1 Reporting.
Document the burden of chronic disease across the state.

Rationale: Stakeholders and decision-makers need valid and reliable information to guide planning, set priorities and assess change.

Progress Indicators

- Complete comprehensive chronic disease burden report documenting trends and disparities in diseases, conditions, risk behaviors, medical care, and self-management (by Dec 2012)
- Complete a report documenting people living with multiple chronic diseases, having shared risk factors and related disparities (by June 2013)

5.2 Dissemination.
Enhance avenues for making chronic disease and health promotion data available for diverse audiences through multiple mediums.

Rationale: Objective data can influence awareness, attitudes and public health planning only when it is accessible. The internet and social media are changing public expectations about the accessibility of health data.

- Assess current DHSS data dissemination systems (e.g., MICA, Profiles) for effectiveness of access and utilization by end users (by Dec 2012)
- Propose improvements to current DHSS data dissemination systems (by Dec 2013)
- Explore the potential of making data available through new avenues such as social media (by June 2013)

5.3 Training.
Provide training and technical assistance for interpretation and utilization of data in program planning and evaluation

Rationale: The skills for accessing and interpreting health data are teachable.

- Conduct hands-on training for state and local partners to increase utilization of DHSS data dissemination systems (by Dec 2013)
- Conduct training programs for state and local partners in data interpretation and utilization to improve program planning and evaluation (by Dec 2013)

5.4 Infrastructure.
Maintain the current chronic disease and nutritional epidemiology team which manages chronic disease surveillance systems and provides epidemiology and program evaluation supports to chronic disease and nutrition programs.

Rationale: Missouri currently has an infrastructure that integrates chronic disease surveillance, epidemiology, and program evaluation functions.

5

STRATEGY AREA #5—Epidemiology and Surveillance

GOAL

Linkages to evidence-based community resources are available to support efforts to reach optimal health.

Objective 1: Through 2018 maintain existing, identify available, and develop new surveillance systems to guide future public health efforts to reduce chronic disease.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Determine what data and evaluation sources are currently available	All CHCDP programs and Epidemiology and Evaluation teams	Shumei Yun	Number of programs sharing data
Identify internal and external data and evaluation gaps	All CHCDP programs and Epidemiology and Evaluation teams	Shumei Yun	Gaps identified
Develop plan to address data and evaluation gaps identified	All CHCDP programs and Epidemiology and Evaluation teams	Shumei Yun	Gap plan developed

FUTURE ACTION ITEMS

Explore being a part of the statewide data warehouse for meaningful use			
Identify new data elements to incorporate into existing data sets			
Strive to conduct county level survey every five years			
Investigate how Medicaid and Medicare data will be incorporated into the data warehouse			

5

STRATEGY AREA #5—Epidemiology and Surveillance

GOAL

Linkages to evidence-based community resources are available to support efforts to reach optimal health.

Objective 2: Through 2018 increase from baseline the number of evaluation plans measuring program process, impact and outcome.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Establish baseline	All CHCDP programs	Shumei Yun	Baseline established
Allocate funding and resources for evaluation for every program	All CHCDP programs	Belinda Heimericks	Number of programs with funding allocated for evaluation

FUTURE ACTION ITEMS

Develop a comprehensive evaluation plan for all programs, initiatives and strategic plan	Epidemiology and Evaluation Teams	Shumei Yun	CHCDP has a comprehensive evaluation plan written
Annually implement evaluation plans (ongoing)	All CHCDP programs	Program Managers	
Continually monitor evaluation findings and refine program processes and direction (ongoing)	All CHCDP programs, Surveillance and Evaluation teams and contractor and constituents feedback	Program Managers	

STRATEGY AREA #5—Epidemiology and Surveillance

5

GOAL

Linkages to evidence-based community resources are available to support efforts to reach optimal health.

Objective 3: Through 2018 increase reporting venues from baseline that disseminate data from surveillance and evaluation for reporting burden, impact and outcomes to funders, decision makers, partners, stakeholders and the public.

YEAR ONE ACTION PLAN

Action	Programs Involved	Team Lead	Measures
Establish baseline of reporting venues	All CHCDP programs and Epidemiology and Evaluation teams	Shumei Yun	Baseline established
Share evaluation and surveillance data	All CHCDP programs and Epidemiology and Evaluation teams	Shumei Yun	Number of venues in which evaluation data has been shared

FUTURE ACTION ITEMS

Develop surveillance communication system that alerts programs of data and data reports identified and created		Shumei Yun	Surveillance communi-cation system developed
Disseminate data through surveillance communication system			

Chronic Disease Prevention and Health Promotion Domains

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

Making the investment in epidemiology and surveillance provides states with the necessary expertise to collect data and information and to develop and deploy effective interventions, identify and address gaps in program delivery, and monitor and evaluate progress in achieving program goals. Data and information come with the responsibility to use it routinely to inform decision makers and the public regarding the effectiveness of preventive interventions and the burden of chronic diseases and their associated risk factors, public health impact, and program effectiveness. The need to publicize widely the results of state's work in public health and demonstrate to the American people the return on their investment in prevention has never been greater.

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

Improvements in social and physical environments make healthy behaviors easier and more convenient for Americans. A healthier society delivers healthier students to our schools and in childcare, healthier workers to our businesses and employers, and a healthier population to the health care system. These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for Americans to take charge of their health. They have broad reach, sustained health impact and are best buys for public health.

Health System Interventions: 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.

Health systems interventions improve the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result: some chronic diseases and conditions will be avoided completely, and others will be detected early, or managed better to avert complications and progression and improve health outcomes. Health system and quality improvement change such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is also key, as coverage alone will not ensure use of preventive services.

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.

Community/clinical linkages help ensure that people with or at high risk of chronic diseases have access to community resources and support to prevent, delay or manage chronic conditions once they occur. These supports include interventions such as | clinician referral, community delivery and third-party payment for effective programs that increase the likelihood that people with heart disease, diabetes or pre-diabetes, and arthritis will be able to "follow the doctor's orders" and take charge of their health—improving their quality of life, averting or delaying onset or progression of disease, avoiding complications (including during pregnancy), and reducing the need for additional health care.

Next Steps

On Common Ground for Health is an important comprehensive plan that unifies categorical (aka, condition-specific) program activities under a common framework with inter-related goals. The following steps are recommended next:

1. **Share Widely.** Continue using a variety of forums and present the recommended strategies in *On Common Ground for Health* to key stakeholders (e.g., local public health agency staff, community health organization leadership, health care system executives, categorical program advisory boards). The benefits of chronic disease resource coordination at state and local levels should also be described in the presentation. Compile feedback into a brief report.
2. **Align Partnerships.** Meet with partners across the state to identify opportunities in which their work can be aligned with 1 or 2 of the recommended strategies to achieve success.
3. **Workplan.** Each activity lead will develop an annual comprehensive plan of action that will outline the steps necessary to accomplish the objective, including detailed list of tasks, timeline, assignments, and performance measures, where necessary, so progress on all recommended strategies can be achieved by December 2018.
4. **Update the Plan.** Publish a biennial version of *On Common Ground for Health* which incorporates revised action item matrix. Continue utilizing the *Organizational Self-Assessment for Addressing Health Inequities Toolkit* which provides public health leaders with tools and guidelines that help identify the skills, organizational practices and infrastructure needed to address health equity and provide insights into the steps which can be taken to ensure DHSS can have an impact on the issue of health equity.
5. **Revisit and Revise.** Reconvene the Chronic Disease State Plan Workgroup and/or DHSS Program Team periodically to assess progress and consider revising or reprioritizing the strategies based on successes, challenges and available resources at that time. The Workgroup and Team will be guided by an evaluation of the plan using the *State Plan Index* from the Centers for Disease Control and Prevention. The evaluation will be conducted by an independent evaluator.

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On Common Ground for Health
Expanded Plan

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