New York State Department of Health

Division of Chronic Disease Prevention

Coordinated Chronic Disease Prevention Framework

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Contents

The mission of the New York State Department of Health's Division of Chronic Disease Prevention (Division) is to enhance opportunities for all New Yorkers to live more healthful lives by implementing integrated initiatives to promote policy, systems, and environmental improvements that support health in all the communities where New Yorkers live, play, work and learn.

Purpose

The purpose of the Division's Coordinated Chronic Disease Prevention Framework is to describe and depict the coordinated set of strategies and activities conducted by chronic disease public health practitioners to create an environment that support health and health equity. This division-level framework was developed recognizing that bureaus and programs in the Division are often targeting closely related chronic diseases and conditions, and the modifiable risk and protective factors shared by these diseases and conditions. There is considerable overlap in our programs' partners, contractors, strategies, target audiences, health messages and interventions. By sharing a common framework for how the Division conducts its work across the lifespan, chronic diseases and risk factors, and across a variety of sectors, we will improve coordination, ensure consistency and increase our efficiency and effectiveness.

Background on the Framework Domains and Strategies

In 2011, the Centers for Disease Control and Prevention (CDC) launched the Coordinated Chronic Disease Prevention and Health Promotion Program and awarded funds to State health departments to build and strengthen their capacity to prevent chronic disease and promote health. The purpose of the program is to: 1) ensure that every state has a strong foundation for chronic disease prevention and health promotion; 2) maximize the reach of categorical chronic disease programs in states (i.e., heart disease and stroke, diabetes, obesity, cancer, arthritis, tobacco, nutrition, and physical activity) by sharing basic services and functions such as data management, communication, and partnership development; and 3) provide leadership and expertise to work collaboratively across chronic disease conditions and risk factors to most effectively meet population health needs, especially for populations at greatest risk or with the greatest burden.

The Coordinated Chronic Disease Prevention and Health Promotion Program outlines the following four key **domains** around which state health departments and other chronic disease public health practitioners must focus their activities in order to maximize their impact:

1. Epidemiology and surveillance: gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver and monitor program activities and population health, including health disparities.
2. Environmental approaches that promote health and support and reinforce healthy behaviors (statewide in schools, child care centers, worksites and communities).
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, reduce or eliminate risk factors and mitigate or manage complications.
4. Strategies to improve community-clinical linkages ensuring that communities support and health care providers refer patients to programs that improve management of chronic conditions. Such interventions ensure that those with, or at high risk for, chronic diseases have access to quality community resources to best manage their conditions or disease risk.

The four CDC domains closely align with the Division's **strategies** that are outlined in the 2010-2013 Division Strategic Plan. These strategies were adapted from the Expanded Chronic Care Model[1] and combine the resources of public health organizations, the health care system, communities, government, and individuals to effect change for the prevention of chronic disease and elimination of health disparities:

1. Generate and disseminate information for action;
2. Build health-promoting public policy;
3. Create safe and supportive environments;
4. Strengthen community action;
5. Promote delivery of clinical preventive services;
6. Reorient health care to emphasize prevention and quality of care;
7. Develop individual chronic disease self-management skills; and
8. Organize health care and community resources to provide ongoing self-management support for patient populations.

Coordinated Chronic Disease Prevention Framework

The Coordinated Chronic Disease Prevention Framework is a schematic that maps the four CDC domains to the eight Division strategies. Under each CDC domain and the corresponding Division strategy(ies) are the activities that need to be conducted by Division staff and/or our contractors to accomplish our goals. These activities illustrate how we accomplish this work, rather than what we accomplish, which is outlined in other documents (e.g., strategic plans). As listed in the schematic, each activity is written in a broad sense; these activities are described in additional detail on pages 6-12. The outcomes of the Coordinated Chronic Disease Prevention Framework (framework) include communities supportive of health-promoting policy and environmental changes; prepared and proactive health care systems; informed, supported and activated individuals, families and communities; and evidence-based programs and policies.

Use of the Framework

The framework was designed to help the Division design and deliver interventions in a more coordinated, systematic and focused way. The framework is applicable to our work regardless of the chronic diseases, conditions or risk factors being addressed and regardless of the type of setting (e.g., community, healthcare, child care, school, worksite). The framework allows us to map the activities of the Division and its contractors onto the key domains and strategies of the schematic to determine if we are adequately addressing each domain/strategy. As a result of this mapping process, we can identify where we may have gaps and what activities we may need to undertake to fill those gaps. Use of this framework also allows us to identify opportunities for enhanced coordination of our work across disease-specific programs.

Coordinated Chronic Disease Prevention Framework

CDC Domains	1. Epidemiology and surveillance: gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver and monitor program activities and population-level risk factors, diseases and health	2. Environmental approaches that promote health and support and reinforce healthy behaviors (statewide in schools, child care centers, worksites and communities)	3. Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to reduce or eliminate risk factors, prevent disease, detect diseases early and mitigate or manage complications	4. Strategies to improve community-clinical linkages to ensure health care providers refer patients to programs that improve management of chronic conditions and that communities support these programs
Division Strategies	• Generate and disseminate information for action	• Strengthen community action • Build health promoting public policy • Create safe and supportive environments	• Promote delivery of clinical preventive services • Reorient health care to emphasize prevention and quality care	• Develop individual chronic disease self-management skills • Organize health care and community resources to provide ongoing self-management support for patient populations
Division and Partners' Activities	• Conducting surveillance using key surveillance systems • Ensuring systems capacity for performance measurement • Conducting program evaluation • Integrating information into programmatic decision-making	• Educating and engaging communities • Mobilizing and empowering communities • Engaging organizational decision makers • Educating governmental decision makers	• Educating and engaging clinicians, consumers and communities • Mobilizing public/private partnerships • Engaging organizational decision makers • Promoting evidence-based quality improvement initiatives • Aligning benefits and payment mechanisms/structures	• Educating and engaging clinicians, consumers and communities • Mobilizing public/private partnerships • Engaging organizational decision makers • Advancing the cycle of self-management support • Aligning benefits and payment mechanisms/structures
Outcomes	• Evidence-based programs and policies	• Communities are healthy places to live, work, learn and play	• Prepared and proactive health care system	• Informed, supported and activated consumers, clinicians and communities
Goals	Health behaviors of New Yorkers improve, risk factors for chronic disease decline, incidence and prevalence of chronic diseases decrease, health disparities are reduced, access to preventive health services is increased, health care costs are reduced, and New Yorkers are living healthier lives.			

Division and Partners' Activities

Domain #1: **Epidemiology and surveillance: gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver and monitor program activities and population-level risk factors, diseases and health including health disparities.**

Conducting Surveillance Using Key Surveillance Systems

"Surveillance is the ongoing systematic collection, analysis, and interpretation of health data that are essential to the planning, implementation, and evaluation of public health practice."[2] With these data, staff will assess: policies, systems and environmental conditions; practices, awareness and attitudes of New Yorkers and organizational and governmental decision makers; behavioral risk factors; health outcomes and indicators and populations disproportionally affected. Reports from surveillance activities will be shared with partners. Analysis and interpretation of surveillance data will be used to maximize the population health impact of prevention programs by informing where to invest resources.

Ensuring Systems Capacity for Performance Measurement

"**Performance measurement** is an ongoing monitoring and reporting of program accomplishments, against progress towards pre-established goals."[3] Capacity will be enhanced by uniform standards of data collection and processing across all Division projects. Project-specific reports are disseminated to Division contract managers and contractors routinely to assess whether work plan activities are on course and defined performance standards are being met and enable quality improvement.

Conducting Program Evaluation

Process Evaluation. While performance measurement is ongoing monitoring and reporting of progress towards pre-established goals, process evaluation examines program factors in a more comprehensive way. Process evaluation provides the means "to identify the key components of an intervention that are effective, to identify for whom the intervention is effective, and to identify under what conditions the intervention is effective."[4] Process evaluation activities measure factors such as the number of settings where partnerships have been built, where needs have been assessed, where policy and practice changes have been planned and where none of these activities have occurred. In addition, factors that interfered with or contributed to success in these settings are also measured. Process evaluation describes what was done and identifies factors that represent barriers and facilitators to achieving and exceeding performance standards.

Impact/Outcome Evaluation. Outcome evaluation activities measure the number of settings where policies have been adopted and implemented; where systems have been modified; where environments have been modified; and where none of these policy, systems or environmental changes has occurred. The number of individuals potentially affected by the policy, systems or environmental changes is also measured. Outcome evaluation answers the question of how effective were we in reaching our goals. An impact evaluation aims to measure the health impact of a public health program by quantifying the change in health or health-related behavior in the population reached through a program. Impact considers both the magnitude of the health related change associated with an intervention and the size of the population over which the change is observed.

Local Level Evaluation. Contractors conduct process and outcome evaluation activities at the local level to document local support for change, quantify local need for change, understand local barriers to change and measure progress toward change in specific geographic areas.

Evaluation Reports. Reports are prepared and disseminated to internal and external partners to gauge program success and to guide planning for future programs.

Integrating Information into Programmatic Decision-Making

Information from performance measurement is used to drive changes in program activities as the program is implemented. Information from program evaluation efforts drives day-to-day programmatic changes and is valuable for guiding future program efforts, such as replicating successful programs into a different geographic area or type of setting. It is also helpful in providing an assessment of what contributed to a program which did not meet its initial goals and standards. Economic evaluation applies analytic methods to identify, measure, value and compare the cost and consequence of treatment and prevention strategies. Health Impact Assessment is a means of assessing the health impacts of policies, plans and projects.[5] Both techniques represent opportunities for the Division to integrate additional information into programmatic decision-making.

Domain #2: **Environmental approaches that promote health and support and reinforce health behaviors (statewide in schools, child care centers, worksites and communities).**

Educating and Engaging Communities

Community education refers to conducting targeted activities that educate the public (or subsets of the public) about chronic disease issues with the intention of raising awareness and influencing individual opinions, beliefs, attitudes and behaviors. Community education may involve conducting market research and testing to ensure that messages are effective and resonate with the target population. Community education may involve discrete events, earned and paid media and other types of information dissemination. Successful community education will ensure there is public understanding and support for chronic disease prevention and control policies and environmental changes; help mobilize the community to voice its support for chronic disease prevention and control policies and environmental changes; and help educate policy makers about the issue and the extent of community support for evidence-based solutions.

Mobilizing and Empowering Communities

Community mobilization refers to engaging influential community members and organizations to publicly support and call for actions to advance chronic disease prevention and control policies. For example, there is a broad constituency that should be committed to increasing access to opportunities for physical activity. Reducing childhood obesity is a primary goal of the Division's physical activity initiatives. Youth, parents, schools, day care centers, and other youth-focused organizations must be actively engaged in promoting and supporting physical activity programs and policy promotion. Low-income and racial/ethnic minority groups should also be actively engaged. Community mobilization refers to engaging influential community members and organizations to advance community education and government policy maker education efforts related to reducing the burden of chronic disease. Successful community mobilization will ensure that there is broad engagement from constituents, including community leaders and organizations, to actively support chronic disease prevention and control policies.

Engaging Organizational Decision Makers

Engaging organizational decision makers refers to strategies undertaken to change non-governmental organizations' policies, programs or practices. For example, public health professionals can advocate with landlords and property management companies for the adoption of smoke-free multi-unit housing policies. They can identify and empower champions within these organizations who are committed to smoke-free housing policies. Public health professionals can also provide technical assistance to landlords and property management companies in the adoption of smoke-free policies. Successfully advocating with organizational decision makers will ensure that decision makers are taking meaningful, verifiable and sustainable action in support of chronic disease prevention and control policies and environmental changes.

Educating Government Policy Makers

Government policy maker education refers to educating local, state, regional or national policy-makers about chronic disease issues, and the implications of policy change. For example, public health professionals can educate policy-makers about the harms caused by excessive sodium intake, the public health benefits of sodium reduction policies, and the experiences of communities that have adopted food procurement policies requiring lower sodium content in foods. Lobbying to introduce or support legislation is prohibited.

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.**

Educating and Engaging Clinicians, Consumers and Communities

Educating and engaging clinicians, consumers and communities refers to conducting activities that support and influence consumers and/or communities-at-large to be actively involved as decision makers in their own care.[6] Activities may also influence consumers to understand and demand improved quality of care as defined by evidence-based guidelines from the health care systems with which they interface. Engagement includes involvement of patient advocates in health care system re-design efforts, earned and paid media and other types of information dissemination. Successful engagement will ensure there is public support for health system improvement efforts; help mobilize consumers to voice support for such efforts; and support efforts aimed at clinical-community linkages and care coordination.

Mobilizing Public/Private Partnerships

Mobilizing public/private partnerships refers to engaging influential organizations and community leaders to publicly support and call for actions to endorse adoption of evidence-based guidelines and advance health care system re-design and quality improvement efforts. Key partner groups include providers, health plans, purchasers, legislators, public health professionals, and other community representatives. Actions include, but are not limited to, mobilizing professional organizations to take action to support adoption of system-level changes through strategies such as presenting at hearings, governing board meetings and other appropriate decision maker venues on the benefits of adopting system-level policy and environmental changes.

Engaging Organizational Decision Makers

Engaging organizational decision makers refers to strategies undertaken to change non-governmental organizations' policies, programs and/or practices. For example, public health professionals can advocate with leadership within health care settings or professional organizations that represent health care for the adoption of system changes or policies supportive of the prevention and control of chronic diseases. They can identify and empower champions within these organizations who are committed to improving chronic disease care. Public health professionals can also provide technical assistance in support of needed changes and the adoption of policies. Successfully advocating with organizational decision makers will ensure that they are taking meaningful, verifiable and sustainable action in support of chronic disease prevention and control policies and environmental changes.

Promoting Evidence-Based Quality Improvement Initiatives

Promoting evidence-based quality improvement initiatives refers to supporting health care providers and system leadership in their efforts to redesign care systems in order to provide high-quality, cost-effective health care.[6] Actions include, but are not limited to, facilitating consensus on evidence-based practice guidelines; providing access to clinical resources and tools that support use of clinical guidelines; providing educational opportunities to health care providers; sponsoring the hiring, training and/or deployment of care managers/ patient navigators; promoting quality improvement models and best practices; and supporting the development and meaningful use of information technology advances.

Aligning Benefits and Payment Mechanisms/Structures

Aligning benefits and payment mechanisms/structures refers to strategies undertaken to re-orient health services to emphasize prevention and quality of care by improving organizations' benefits and payment mechanisms, structures, policies or practices.[6] Examples of activities may include: working with content experts to compare current public health benefits with evidence-based guidelines in order to identify benefit gaps; and, working with agency directors, insurance directors and other organizational decision makers to recommend and advocate for implementation of new policies and/or to create incentives for consumers to seek, and providers to deliver, the most cost-effective chronic disease guideline-concordant care. Other actions include, but are not limited to, identifying and establishing funding for services or benefits either through payers or other mechanisms.

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

Engaging Clinicians, Consumers, and Communities

Clinician, consumer and community engagement refers to conducting activities that support/influence clinicians, consumers and/or communities-at-large to be actively involved in the processes that create demand for, promotion and availability of, and access to evidence-based self-management support programs and services (e.g., diabetes prevention programs, chronic disease self-management programs, Walk with Ease programs, diabetes and asthma self-management training, patient navigation, NYS Smokers Quitline). Activities may include, but are not limited to, offering outreach and education to consumers and communities in order to increase their understanding of, and demand for, quality chronic disease prevention and management resources; and, providing training and technical assistance to clinicians on quality improvement methods that can be employed to support a system of seamless linkages and routine utilization of self-management resources and programs within and between the health care and community systems. Successful engagement will ensure there is public support for health system improvement efforts, help mobilize consumers to voice support for such efforts, and support efforts aimed at clinical-community linkages and care coordination.

Mobilizing Public/Private Partnerships

Mobilizing public/private partnerships refers to engaging the health care community and community-based organizations to collaborate on the development of a system which sustains and promotes the utilization of evidence-based self-management support resources and programs shown to help individuals prevent, delay and/or manage chronic diseases. Key partner groups include clinicians, health plans, public health professionals, community-based organizations, employers, lawmakers and community representatives. Activities include, but are not limited to: assessing population needs and identifying gaps in resources in order to develop a plan for addressing these needs and gaps; developing a catalog of existing resources and system attributes; fostering the adoption and utilization of evidence-based resources and programs by the health care system and community-based organizations; improving access to and the availability of evidence-based resources and programs; and implementing policies and system changes for sustaining these programs and services. Influential public and private partners would be mobilized to educate targeted populations, such as communities, professionals, industry and policy makers, to better understand the burden of chronic disease, the essential role of individuals in managing their health, and chronic disease prevention and control policies which could positively impact the health outcomes of those with or at risk for chronic disease.

Engaging Organizational Decision Makers

Engaging organizational decision makers refers to conducting activities that support/influence changes to health care and community organizations' policies, programs and/or practices to assure a seamless cycle of self-management support for patients with and at risk for chronic disease. For example, public health professionals can collaborate with and support health care and community organizational leaders to establish policies, change systems, make the needed environmental changes, establish and monitor program fidelity and engage the community to integrate self-management support into routine care. They can identify and empower champions within these organizations who are committed to building and maintaining a sustainable system for self-management support. Public health professionals can also provide or coordinate training and technical assistance with health care and community organizations in the adoption of evidence-based and nationally recognized self-management support programs. Successfully supporting the unique role of organizational

decision makers will ensure that they are setting and implementing strategic goals for self-management support, aligning efforts within the organization to achieve these goals, providing resources for the creation of effective systems, removing obstacles for clinicians, staff and consumers, and requiring adherence to best practices that promote seamless community and clinical linkages.

Advancing the Cycle of Self-Management Support

Advancing the cycle of self-management support refers to embedding a self-management support system and infrastructure within and between the health care and community systems, such that individuals with or at risk for chronic conditions have improved access to, and regularly, utilize self-management support programs and resources with the goal of improved health behaviors and clinical outcomes.[7] Activities pertain to the development and implementation of policies and evidence-based system change interventions that ensure individuals with chronic conditions have opportunities to improve self-care behaviors during their interaction with a multi-disciplinary health care team. Such activities include, but are not limited to: supporting implementation of the medical home model; promoting the incorporation of experts in disease management/education (e.g., certified diabetes educators, certified asthma educators, community health workers, patient navigators, tobacco dependence treatment specialists) into the health care team; providing training to all health care team members around motivational interviewing, collaborative goal setting and use of a shared care plan; implementing systems that ensure development and utilization of shared care plans; collaborative goal setting and referrals to evidence-based programs for self-management support; fostering regular communication between the healthcare organization and community based programs, including the reporting of programmatic results; monitoring the fidelity of established self-management programs; and ensuring continuous quality improvement of the system by providing training and resources to support performance monitoring and evaluation.

Aligning Benefits and Payment Mechanisms/Structures

Aligning benefits and payment mechanisms/structures refers to activities that close the gap between guideline-concordant care, evidence-based programs and insurance benefits, and establish provider payment structures that incent the cycle of self-management support. Actions include, but are not limited to, identifying and establishing funding for services or benefits not adopted by payers; working with content experts to compare current public health benefits with evidence-based guidelines in order to identify benefit gaps; and, working with agency directors, insurance directors and other organizational decision makers to recommend and advocate for implementation of new policies and/or to create incentives for consumers to seek, and providers to deliver, a seamless self-management support system and infrastructure.

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