

North Dakota State Plan To Prevent and Manage Chronic Disease

2012-2017

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Introduction

Chronic diseases impact a large portion of our state's residents, and all North Dakotans ought to be concerned about preventing and managing these health conditions. In fact, chronic diseases are responsible for seven out of 10 deaths among Americans each year and account for roughly an equivalent proportion of total health-care costs. If current trends continue, the proportion of deaths and health-care costs attributable to chronic diseases will grow even higher as the population ages. A closer look at deaths attributable to chronic diseases in North Dakota reveals a similar trend – five out of 10 deaths were attributable to heart disease, cancer, stroke and diabetes in 2009. If Alzheimer's disease and Chronic Obstructive Pulmonary Disease (COPD) are included, chronic diseases are responsible for nearly seven out of 10 deaths in North Dakota. Fortunately, many chronic diseases are preventable.

Since many chronic diseases share common risk factors, afflict similar population groups the hardest and can be effectively addressed by the same public health strategies, the *North Dakota State Plan to Prevent Chronic Disease* will aim to improve health and quality of life by:

- Promoting environmental and policy changes related to nutrition, physical activity, and tobacco-free living; and
- Promoting clinical preventive services related to chronic disease prevention, early detection and management; and promoting education and management skills for those diagnosed with or at risk for chronic diseases.

Chronic diseases and their risk factors are interrelated with many forces affecting risk. Thus, reducing the burden of chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis will require the involvement of health-care providers, work sites, schools, faith-based groups and other community groups that work closely with population groups afflicted the hardest. As a state, we need to take action now to prevent or greatly delay chronic disease and associated disabilities. We must identify approaches to deal with chronic diseases holistically, not just as separate conditions.

The *North Dakota State Plan to Prevent and Manage Chronic Disease* focuses on collaborative activities with a variety of partners to accomplish the stated goals, objectives and strategies. It addresses the major risk factors – physical inactivity, obesity, poor nutrition and tobacco use – and takes into account health inequities and the contributing social determinants of health (income and poverty, education, access to health services, housing, transportation and environmental structures) to identify opportunities for improving population health and shaping the systems put in place to deal with chronic disease.

This plan reflects strategies aimed at building capacity to address chronic disease in a coordinated, collaborative approach and to delay the development of serious chronic diseases as long as possible. Our interventions are aimed at:

- Promoting personal health behaviors and supportive environments where we live, learn, work and play to prevent disease, to slow the progress of disease, to reverse it where possible and to prevent the development of complications; and
- Encouraging the use of screening and early diagnosis that can lead to better disease identification, treatment and management or delay of complications.

Purpose of the Plan

The purpose of the plan is to delineate activities that will prevent chronic diseases, related risk factors and promote health. This will also help identify measurable outcomes and strategies to accomplish these outcomes and address a range of chronic diseases, conditions and risk factors.

Framework

Overarching strategies such as capacity and infrastructure, education and public information, policy changes, environmental supports and system changes were identified in the state plan to impact chronic disease death and disability on a population-wide basis. These overarching strategies were developed with the utilization of partners and the current data available.

In November 2011, approximately 50 stakeholders from around the state representing various diseases and organizations met in person to begin reviewing the integration opportunities for the Coordinated Chronic Disease Prevention Program (CCDPP) in North Dakota. This was accomplished through a modified community engagement process that utilized consensus-based decision making to ensure that all present were in agreement of the six goal areas. Input was offered into the development of the state plan. Since November 2011, there have been monthly conference calls with partners to further explore integration opportunities. Another in-person meeting was held in May 2012 to review the more comprehensive plan, including identifying integration opportunities and how the disease specific goals could be molded into the integration opportunities. Between January 2012 and May 2012, each categorical program advisory committee and/or coalition worked with their respective program to review disease specific goals and how they fit into the overall integrated chronic disease plan and goal areas. Although the North Dakota Department of Health (NDDoH) does not have an arthritis program, the chronic disease director will work with the Arthritis Foundation of the Upper Midwest to discuss disease specific goals related to the overall plan. The foundation has been actively engaged in the development process of the plan.

Following is a listing of the current partners that have been engaged in the planning process. Engaged is defined as receiving on-going communications, participation in conference calls and partner meetings and ability to review and provide input.

	Name	Affiliation
1.	Donna Amundson	Medcenter One Health Systems, Bismarck
2.	Wendy Anderson-Berg	Bismarck Parks and Recreation District
3.	Becky Bailey	Division of Family Health, ND Department of Health
4.	Bill Bauman	YMCA, Bismarck
5.	Rob Beattie	UND School of Medicine and Health Services
6.	Kelly Brekke	Arthritis Foundation Upper Midwest Region
7.	Sharon Buhr	Young People's Healthy Heart Program Mercy Hospital, Valley City
8.	Cathy Deics	Bismarck Burleigh Public Health
9.	Jared Eagle	North Dakota Cancer Coalition, Minne-Tohe Health Center
10	Karen Ehrens	<i>Healthy North Dakota</i> , Consultant
11	Joan Enderle	American Heart Association Greater Midwest Affiliate
12	Donene Feist	Family Voices of North Dakota
13	Eunah Fischer	BlueCross BlueShield of North Dakota
14	Tammy Gallup-Millner	Division of Children's Special Health Services, ND Department of Health
15	Barb Groutt	North Dakota Health Care Review, Inc.
16	Carma Hanson	Safe Kids Grand Forks, Altru Health System
17	Tania Hellman	Medical Services Division, ND Department of Human Services
18	June Herman	American Heart Association Greater Midwest Affiliate
19	Amy Heuer	ND AHPERD (Association for Health, Physical Education, Recreation & Dance)
20	Loretta Heuer	NDSU Nursing Program
21	Phyllis Howard	Office for Elimination of Health Disparities, ND Department of Health
22	Robin Iszler	Local Public Health Agencies, Central Valley Health District
23	Eric Johnson	UND School of Medicine and Health Sciences
24	Courtney Koebele	North Dakota Medical Association
25	Deb Knuth	American Cancer Society
26	John Leitch	North Dakota Cancer Coalition, Sanford Health Fargo
27	Nikki Massmann	UND Center for Rural Health, Grand Forks
28	Karin Mongeon	Traffic Safety Office, ND Department of Transportation
29	Brenda Munson	ND Center for Persons with Disabilities
30	Kelly Nagel	Public Health Liaison, ND Department of Health
31	Lori Obluck	Arthritis Foundation Upper Midwest Region
32	Sheryl Pfliger	Aging Services, ND Department of Human Services
33	Rich Preussler	Patient and Community Education Department, Sanford Health Fargo
34	Diana Read	Injury/Violence Prevention Program, ND Department of Health
35	Linda Schloer	Child Nutrition/Food Distribution Programs, ND Dept. of Public Instruction
36	Kari Schmidt	ND Center for Persons with Disabilities
37	Melissa Schroeder	Family Voices of North Dakota
38	Pete Seljevold	<i>Healthy North Dakota</i> Worksite Wellness

Overarching Goals

North Dakota adopted the *Healthy People 2020* overarching goals to:

- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death.
- Achieve health equity, eliminate disparities and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

Social Determinants of Health

Social determinants of health are the economic and social conditions that shape the health of individuals and communities and are the primary determinants of whether individuals stay healthy or become ill. Routine and systematic monitoring of health inequities and the contributing social determinants of health (income and poverty, education, access to health services, housing, transportation and environmental structures) are critical to identifying opportunities for improving population health and shaping the systems put in place to deal with illness. By utilizing data on social determinants of health in conjunction with health data, the added value to public health will be a healthier populace and fewer health inequities. Additionally, developing and/or linking health improvement interventions for multiple community sectors that are informed by social determinants of health will be important in the overall effort to prevent chronic disease in North Dakota.

Integration of Plans

Preventing the onset or progression of chronic disease is a complex process that requires changes in behaviors, policies and environments that can enhance health in the key settings that impact behavior – our schools, worksites, communities and health-care systems. To avoid duplicating efforts, the CCDPP Management Team (MT) carefully considered actions already being taken by other health promotion and disease prevention programs such as the Comprehensive Cancer Prevention and Control Program, Coordinated School Health, Diabetes Prevention and Control Program, Heart Disease and Stroke Prevention Program and Tobacco Prevention and Control Program. The CCDPP MT also adopted strategies developed by the *Healthy North Dakota* committees on physical activity, nutrition, worksite wellness and health disparities. *Healthy North Dakota* is a statewide health coalition addressing health and wellness of North Dakota citizens. The goals and strategies identified in our state plan are dependent on communities, health-care systems, organizations and schools to carry out activities or make changes that will

work toward improved health. This integrative approach provides abundant opportunities to increase impact on chronic disease prevention and health promotion efforts.

To ensure the plan identifies high priority policy and environmental changes, health systems changes and enhancements to clinic-community linkages with the potential for widespread impact statewide and includes those that can address a variety of chronic conditions, the NDDoH will continue to engage the program managers for each specific disease. We will continue to engage the partnerships that are already established as well as add additional partners as the opportunities arise. After the final plan is submitted, we will meet in November 2012 to prioritize the top two to three areas of focus for the next year. There are plans to continue with conference calls on a monthly basis and in-person meetings once per year with the statewide stakeholders group. There will also be an annual review of the plan which will be updated as needed; all stakeholders involved will view the plan as a fluid document.

The timeframe for the *North Dakota State Plan to Prevent and Manage Chronic Disease* is January 2012 through December 2017 and includes development, implementation, annual review, adjustment and evaluation.

Data

The chronic diseases and risk factors listed have a tremendous economic and quality-of-life impact on North Dakota. Costs associated with chronic diseases are direct medical costs and indirect costs. Indirect costs are those associated with lost productivity and income. Productivity losses include days missed from home or work tasks because of illness (personal or family member) and potential lost earnings due to premature death. Several of the risk factors for the chronic diseases are modifiable to the point of chronic disease prevention. North Dakota has prepared a number of disease specific documents assessing the burden of these chronic diseases utilizing a variety of data sources. In the future, the chronic diseases and risk factors assessing the burden will be combined to assist all programs involved in the impact that chronic diseases have on our population.

Identification of Needs and Gaps

Chronic disease surveillance involves the ongoing systematic collection, analysis, interpretation and dissemination of health data. In addition, surveillance is important for linking data and information to public health action. Having a comprehensive, effective surveillance system that meets the needs of stakeholders is essential to the planning, implementation and evaluation of public health practice and is closely integrated with the timely dissemination of this data to chronic disease stakeholders. The plan for North Dakota will be guided by integrated data and analysis. The analysis will provide a snapshot of high-need areas, disparities and geographic-specific issues, as well as gaps. The data will assist in answering these questions:

- What is the relationship among chronic diseases and risk factors, including, but not limited to, morbidity and mortality?
- Where is the disparity and what disparities can be impacted?
- What are the underlying issues that impact multiple disease outcomes?

Data analysis will be conducted to provide knowledge and information to identify the needs in North Dakota, to uncover issues of health disparities and to thoroughly understand the burden of chronic diseases and the risk factors in North Dakota. In addition, as programs are being implemented, data will be collected to evaluate effectiveness. Data analysis plays a crucial role in process and outcome evaluation. The NDDoH is committed to thorough and appropriate data analysis that utilizes the surveillance system and addresses program goals and objectives. The NDDoH knows it is important to provide current data and surveillance reports to meet partner needs, along with technical assistance to utilize this knowledge in planning and implementing interventions. Dissemination of data to partners in a timely manner is crucial for them to utilize the information for programs that will ultimately improve the health of North Dakotans which aligns with the essential public health services. In addition to producing and disseminating reports and statistics through the timeline established by the communications plan, there is an ongoing commitment to providing technical assistance, training and consultation to state and local staff to facilitate understanding, analyses, interpretation and use of surveillance data. Partners benefit from the data provided only if they understand how to analyze and interpret it to suit their needs for quality improvement and to strengthen their cases for policy, systems and environmental changes at every level.

North Dakota Surveillance Systems

North Dakota already has robust surveillance systems in the areas of diabetes, heart disease and stroke, cancer and tobacco through BRFSS, YRBS, YTS, ATS, ND Stroke Registry, Cancer Registry, and MediQHome. Burden documents and plans have been produced for these program areas, and partners regularly access the services of the epidemiology staff for specific data needs or for assistance in data interpretation and utilization. Through the use of this funding, we will be able to integrate these surveillance systems in a way to best utilize our epidemiologic capacity and form a comprehensive North Dakota chronic disease surveillance system that will result in:

- Development of a written surveillance plan that will address data sources, indicators, disparities and data dissemination.
- Development of a chronic disease burden document for North Dakota. This document will incorporate data from multiple sources and will address prevalence, mortality, risk

factors, disparities, prevention and care. Partners will be involved in the development and review of this document so that it addresses their areas of concern.

- Updating fact sheets to address current issues.
- Tracking of chronic disease indicators over time and production of a chronic disease indicator report.
- Dissemination of data to partners in a timely and efficient manner.
- Evaluating the usefulness of data and reports on a regular basis.
- Identifying data gaps and utilizing the results to inform and influence the planning of chronic disease programs.

Accomplishing Objectives and Outcomes

If North Dakota is going to address chronic disease for its population, collecting the data necessary to define the burden, identify the target population(s) and meet the needs of stakeholders is critical. By working to close the gaps that exist, North Dakota will be able to have a larger impact on chronic disease prevention and control for the state.

Unless appropriate data exists to define the burden of chronic disease and related risk factors, it is impossible to justify the need for funding efforts to prevent and control chronic diseases. Without data to demonstrate trends and identify disparate populations, it is impossible to focus efforts and plan programs that will make a difference, especially with limited available funding. As part of the strategic planning process we will consider the gaps that we already know exist and explore how to close those gaps, as well as identify other gaps that are not known at this time. Currently, North Dakota has three master level epidemiologists that work among the chronic disease programs within the Community Health Section (CHS). They work closely with the BRFSS coordinator, who is also housed in the CHS. Each epidemiologist has been involved in program specific tasks, as well as the overall Healthy People 2020 initiative.

North Dakota Chronic Disease Data

As noted earlier, chronic diseases – such as heart disease, stroke, cancer, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the United States. People who suffer from these chronic diseases experience limitations in function, health, activity, and work, affecting the quality of their lives as well as the lives of their families.

Certain health behaviors and conditions known as risk factors are associated with increased chances of developing chronic disease. “Non-modifiable” risk factors are those that people are not able to change, such as age, gender and heredity/family history.

There are also “modifiable” risk factors – those factors that people can modify or control through lifestyle changes. These preventable risk factors include poor dietary habits, overweight and obesity, physical inactivity and smoking/tobacco use. Trends in modifiable risk factors help assess the health of North Dakotans and areas where improvement is needed. Engaging in healthy behaviors, as well as obtaining the recommended health screenings, greatly reduces the risk for illness and death due to chronic diseases.

The following charts indicate the prevalence of chronic diseases among adults and the mortality rates for heart diseases, cancer, stroke and diabetes in our state. The charts also depict the percentage of North Dakotans engaged in the modifiable risk factors related to these chronic diseases. The data that is collected is used to guide program activities, assists in monitoring the progress of prevention efforts and help public health professionals and policymakers make more timely and effective decisions. It also contributes to better understanding the extent of health risk behaviors, preventive care practices and the burden of chronic diseases.

Chronic Disease in North Dakota

Prevalence of Chronic Diseases Among Adults

Heart Disease	6.4%
Heart Attack	4.2%
Angina or Coronary Heart Disease	4.3%
Stroke	2.4%
Diabetes	7.4%
Asthma – Ever	10.6%
Asthma – Current	7.4%
Arthritis	27.4%

Incidence and Prevalence of Cancer - All ages

New cancer diagnoses - rate per 100,000 population	529
State residents living with cancer	3.7%

Risk Factors – Adults

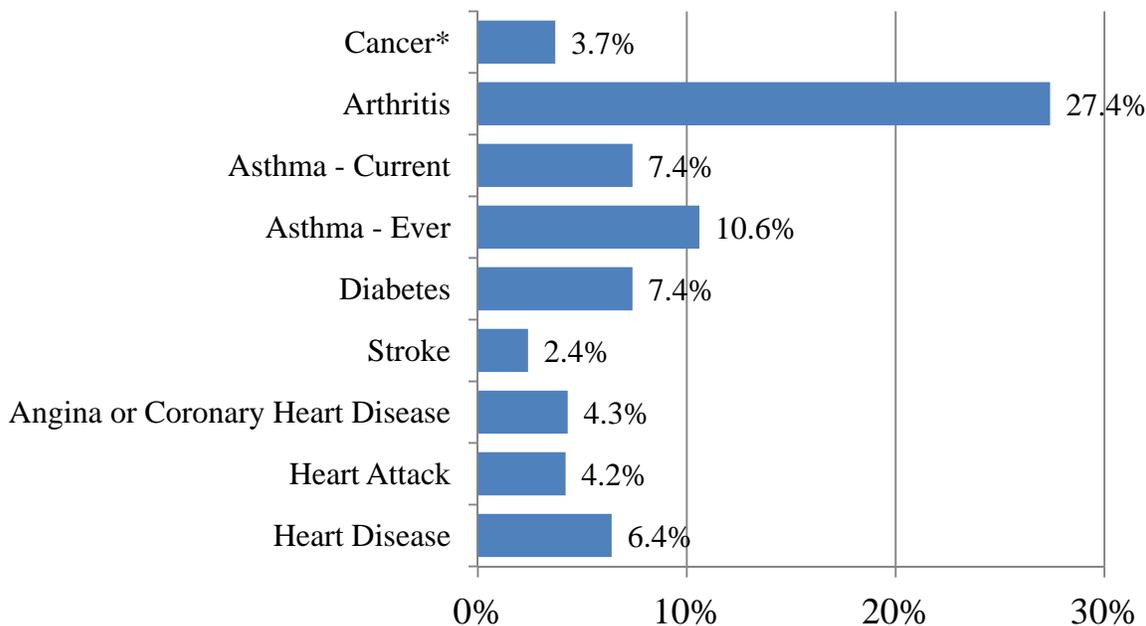
Current Smoking	21.9%
Obese	27.8%
Overweight or Obese	63.8%
Inadequate Physical Activity (vigorous or moderate)	47.3%
Hypertension (ever told)	29.1%
High Blood Cholesterol (checked and ever told)	34.8%
Fruit and Vegetable Intake – fewer than 5 daily	77.5%

Mortality - Age adjusted rate per 100,000 population

Heart Disease	191.8
Cancer	195.7
Stroke	48.9
Diabetes	31.1

Sources: Behavioral Risk Factor Surveillance System (2011),
North Dakota Vital Records (2011) and The Burden of Cancer in North Dakota - 2010

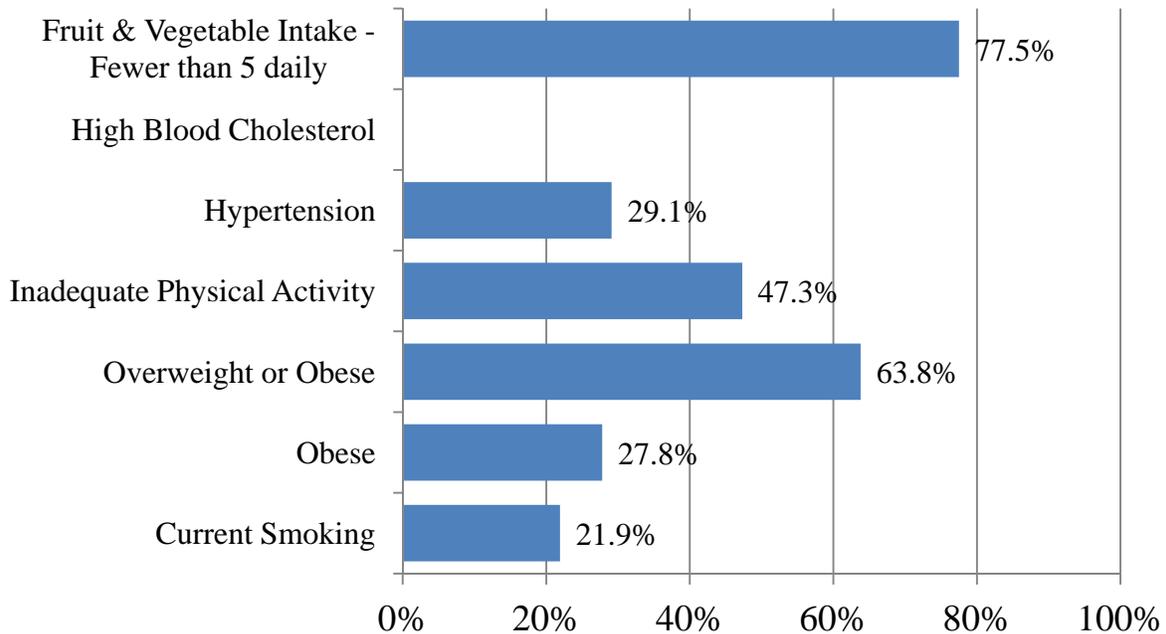
Prevalence of Chronic Disease North Dakota Adults



Source: 2011 Behavioral Risk Factor Surveillance System

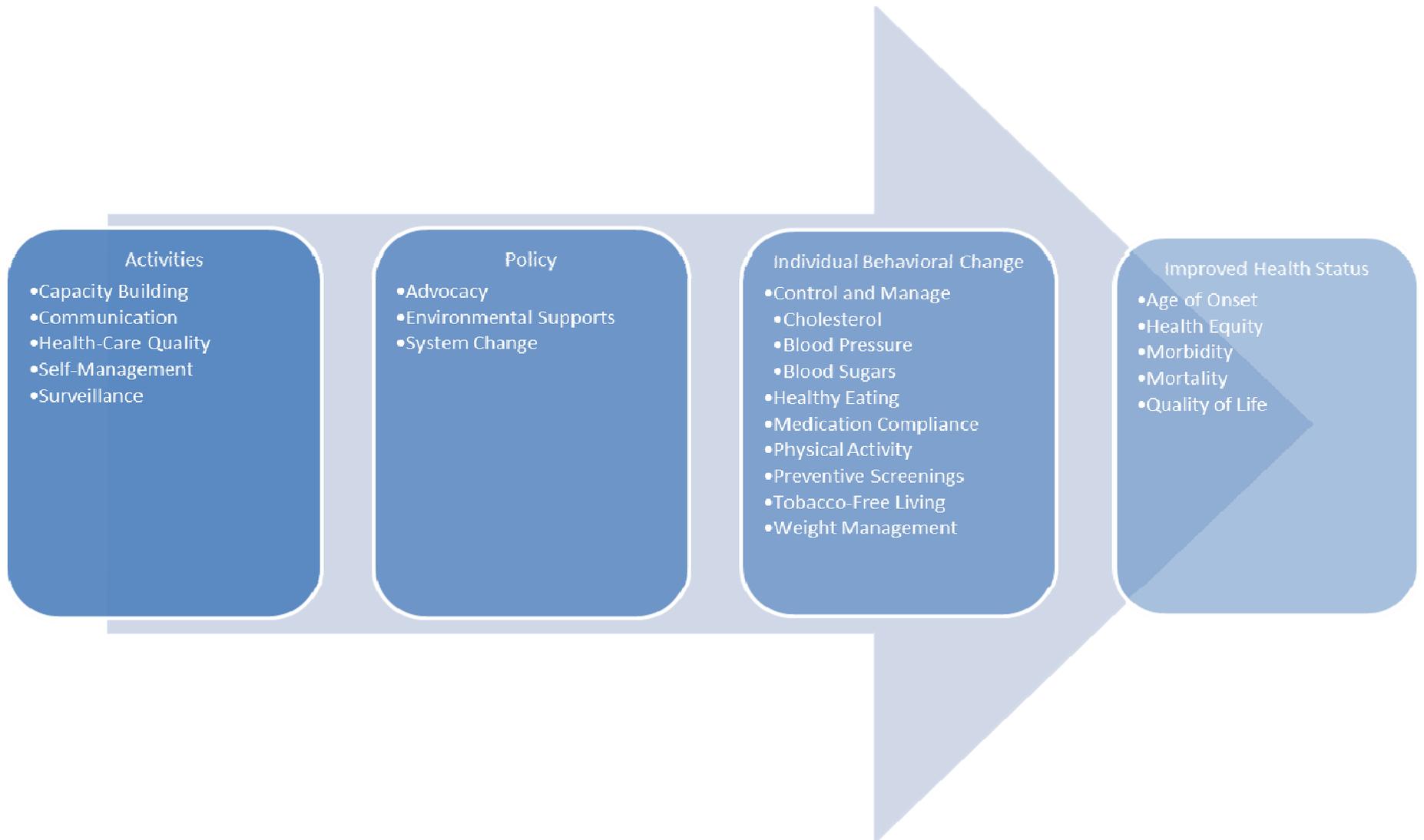
*The Burden of Cancer in North Dakota – 2010 (all ages)

Chronic Disease Risk Factors North Dakota Adults



Source: 2011 Behavioral Risk Factor Surveillance System

Logic Model Snapshot



North Dakota Coordinated Chronic Disease Prevention Program Structure

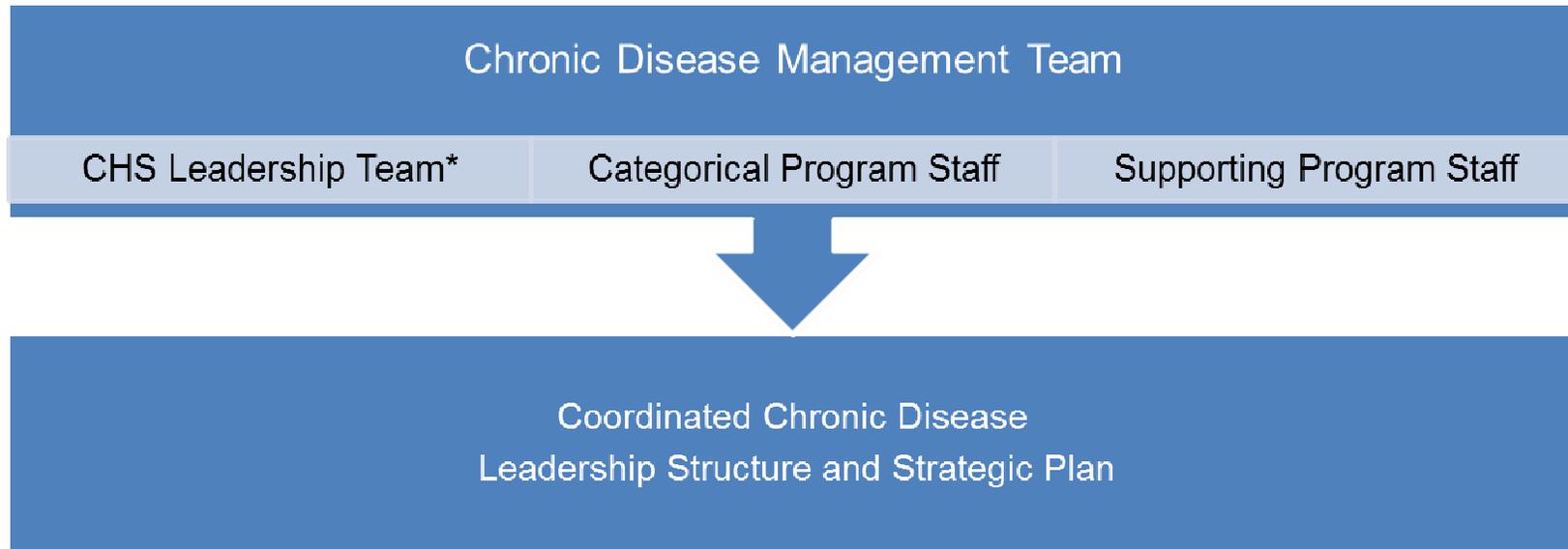
Chronic Disease Management Team

Members	Title	Program Affiliation	Division Affiliation
Deanna Askew***	Program Director	Healthy Communities	Nutrition & Physical Activity
Clint Boots	Chronic Disease Epidemiologist	Tobacco/Heart Disease & Stroke Prevention (HDSP)	Chronic Disease
Neil Charvat	Community Health Specialist	HDSP/Tobacco	Chronic Disease
Mary Dasovick	Division Director	Domestic Violence/Rape Crisis	Injury Prevention & Control
Susan Mormann	Division Director	<i>Women's Way</i>	Cancer Prevention & Control
Karalee Harper**	Division Director	Coordinated Chronic Disease/HDSP	Chronic Disease
Kim Mertz	Division Director	Title V/MCH (Maternal & Child Health)	Family Health
Joyal Meyer***	Program Director	Coordinated School Health	Family Health
Tera Miller	Program Director	Diabetes Prevention & Control	Nutrition & Physical Activity
Colleen Pearce	Division Director	WIC (Special Supplemental Nutrition Program for Women, Infants and Children)	Nutrition & Physical Activity
Joyce Saylor	Program Director	Comprehensive Cancer	Cancer Prevention & Control
Sandra Davidson	Administrative Assistant	Coordinated Chronic Disease/Cancer/Tobacco	Chronic Disease
Krista Headland	Program Director	Tobacco Prevention and Control	Chronic Disease

** Serves as Principal Investigator for the Coordinated Chronic Disease Prevention Grant.

*** Serves as Program Managers for the Coordinated Chronic Disease Prevention Grant.

Recipient Activities Decision-Making Model



This model depicts the decision-making influencers for the recipient activity implementation process. The Chronic Disease Management Team has the authority and responsibility to direct the coordinated chronic disease prevention and health promotion program. Efforts will be made to engage partners in the development and implementation phases of its work.

* The CHS Leadership Team (LT) reports directly to the state health officer and deputy state health officer. Members have responsibility for fiscal, human resources and program decisions impacting the section. This includes advocating for healthy behaviors; providing education, resources and services; developing effective policies; and engaging statewide partnerships. The CHS LT is comprised of the five division directors plus the two section lead administrative assistants.

Evaluation and Measurement

The chronic disease state plan will be accompanied by a *logic model and comprehensive evaluation plan* (separate from this document) to monitor progress toward achievement of programmatic objectives and long-term outcomes. An outside evaluation contractor has been hired and is currently working with an evaluation work group consisting of state health department staff and an outside partner to develop these evaluation components. The logic model and evaluation plan are projected to be completed by March 2013. The evaluation plan will be comprised of both process and impact level evaluation elements and will include:

- 1) Evaluation questions at both process and impact levels;
- 2) Measurable chronic disease outcomes and indicators;
- 3) Data sources (available, and identification of those needing to be developed); and
- 4) Baselines and Targets.

The following indicators will be measured and monitored through the evaluation plan:

A. Long term health status indicators: Percent of adults with chronic diseases (heart disease, stroke, diabetes, cancer, asthma, arthritis)

B. Intermediate indicators (behavior changes / risk factors)

- Percent of adults and adolescents who smoke / use tobacco products
- Percent of adults, adolescents, and children who are overweight or obese
- Percent of adults, adolescents, and children engaging in inadequate physical activity
- Percent of adults with hypertension
- Percent of adults and adolescents eating fewer than 5 fruits/vegetables daily

C. Indicators related to the 4 Domains:

1. *Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.*
 - Number and type of data sources used to monitor chronic disease burden in North Dakota
 - Number and type of new data sources secured to analyze chronic disease data, including those related to health disparities and social determinants of health
 - Number and type of chronic disease related data reports developed and disseminated
 - Number and type of evaluation reports developed and disseminated related to state plan implementation strategies
 - Number and type of evaluation strategies implemented to obtain specific evaluation data
2. *Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities).*
 - Number and type of environmental, policy, and systems changes implemented that support healthy behaviors for the people of North Dakota.
 - Number of environmental, policy, and systems changes at the state and local level
 - Number of environmental, policy, and systems changes in schools, worksites, communities, etc.

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.*
 - Number of new health care providers/organizations implementing quality improvement chronic disease models of care.
 - Number and types of trainings/technical assistance offered to health care providers/organizations about quality improvement models of chronic disease care
 - Number of patients showing improvements in clinical outcomes after implementation of quality improvement chronic disease models of care.
4. *Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.*
 - Percent of persons in North Dakota reached with messages and resources that encourage their personal health and prevent chronic disease.
 - Number of health care providers / organizations who have increased their capacity to reach their populations with personal health and self-management health messages, resources, and services.
 - Number of health care organizations / clinics referring their patients to community programs to improve the management of their chronic disease(s).
 - Number of new chronic disease management programs implemented in communities for people with chronic disease(s).

The following are data sources that will be used to track some of the surveillance and evaluation indicators:

- North Dakota Mortality Data (Division of Vital Records)
- North Dakota Behavioral Risk Factor Surveillance System (BRFSS)
- North Dakota Adult Tobacco Survey (ATS)
- North Dakota Youth Risk Behavior Survey (YRBS)
- North Dakota Youth Tobacco Survey (YTS)
- North Dakota Census Records and Population Estimates
- Medicare Data for North Dakota
- HEDIS Cardiovascular Measures
- BlueCross BlueShield MediQHome Quality Program (MediQHome)

Each year, state partners will be developing annual workplans to accomplish the state plan strategies that are the priority for that upcoming year . There will be a section in the state plan evaluation plan specific to evaluation of these annual strategies (short term indicators).

Updates on the chronic disease state plan and evaluation plan status will be provided annually. As described in Goal 1 of the state plan, a chronic disease evaluation report will be developed documenting major outcomes from the state health department chronic disease and risk factor related programs as well as their partners, including a section on chronic disease state plan progress.

The evaluation plan will be a working document much in the same manner as the State Plan itself and is conceptualized as a work-in-progress, subject to modification as goals are met or new opportunities become apparent.

Communication

Communication of program information is vital to identify the kind of useful support that will create positive publicity, increase program visibility, render chronic disease more competitive in acquiring financial and in-kind resources and most importantly, influence change in programs, policies, practices and community environments. The main intent of the current communication plan written for September 2012 to August 2014, is to serve as the conduit between the North Dakota CCDPP and the CDC Coordinated Chronic Disease Prevention and Health Promotion Program.

The communication plan articulates the strategies to be undertaken by the Chronic Disease Management Team (MT) and will serve as a programmatic road map for:

1. Internal communication within the North Dakota Department of Health (NDDoH) regarding coordinated chronic disease prevention and health promotion;
2. External communication throughout our state and for targeted audiences to make the case regarding chronic disease burden and proposed solutions, such as effective policy and environmental changes, health systems changes and enhancements to the clinic-community interface; and
3. Summation of our plans to develop a communications strategy to maximize visibility of our statewide chronic disease and health promotion plan and proposed solutions.

By planning long-term communication strategies for our coordinated chronic disease prevention and health promotion efforts, we will be positioned to be more proactive and strategic in making the case regarding chronic disease burden, prevention and health promotion. The communication plan will assist us in deploying human and financial resources more intentionally and effectively by highlighting synergies and shared opportunities in chronic disease prevention and health promotion thus allowing us to produce a result not independently obtainable. As the CCDPP strategies are implemented, communication efforts will draw from formative evaluation, dependable research, information about the health issue or selected intervention and the expertise of categorical program staff and our partners.

Effective communications can impact how the public, health-care providers, key decision makers and media react to health concerns. Strategic communication is the process by which information is formulated, produced and conveyed to achieve specific objectives vital to an organization's mission. As we devise our communication plan by August 2014 utilizing strategic communication approaches, we will identify strategies and activities for internal and external communication and ways to maximize visibility of our statewide chronic disease and health promotion plan and program efforts. Our communication plan will be developed by a

communications work group, whom will ensure that the plan is written in clear and understandable language for a variety of audiences, including but not limited to the public, decision makers, and partners. The plan will be logically organized into sections to make information easy to find. The communication work group will also have a timeline identified on how the plan will be distributed in future years. The plan will ensure that the planned communication efforts translate data for stakeholders, policy and decision-makers, partners, funders, and the public and that we established systems for this translation and dissemination of information so that key information is widely disseminated on a regular basis. The plan will also include an implementation plan and will be updated on a yearly basis.

Communication strategies to maximize visibility of state plan

The ability to persuasively communicate the need for policy and environmental changes that support personal health and prevent or significantly delay the onset of chronic disease is a critical competency of public health practice. From partnership and cross-cultural communication to media advocacy, communication skills will help define our future success in preventing chronic disease and its associated disabilities. However, thoughtful and all-inclusive team planning is an essential task for ensuring the success of the program.

Core members from the CCDPP MT and partners will be recruited to develop a communication plan. This will demonstrate a willingness to remain flexible and open to considering a multitude of strategic and creative suggestions. This core group will accomplish the following preliminary work:

- By December 2012, establish consensus on the reasons for entering a partnership and the goals of the communication efforts within the communication work group, which consists of members of the CCDPP MT, communications contractor, evaluation contractor and 1-2 external partners.
- By December 2012, the workgroup will set realistic expectations and effectively leverage the workgroup's combined skills, resources and associations.
- By May 2013, create guideposts to keep our work on track and to measure the success of our efforts.
- By August 2014, review information to help focus the communication priorities.

The Communication Work Group will need to select the audiences our communication efforts will target, which will occur by September 2013. Because chronic disease prevention and health promotion is a concern for all segments of society, the Communication Work Group will need to identify which audience segments are most important to reach with interventions to achieve policy and environmental changes related to chronic disease. To guide the prioritization of the key audience segments, the workgroup will ask the following questions:

- What is a realistic communication objective for this audience segment? What kind of policy and environmental change can this group make and how receptive is it to making that change?

- Will fulfilling the communication objective adequately support our program’s goal or objective? Will these key audience segments exert significant societal influence? This is extremely important since our efforts must be focused on facilitating population- and system-wide improvement.
- To what degree will members of this group benefit from the communication? Health-care, school, business and community leaders who stand to gain from their involvement in chronic disease prevention and health promotion efforts may be more receptive to messages about policy and environmental changes related to chronic disease and its associated disabilities.
- How effectively will available resources and channels reach this audience segment? Will the targeted group be receptive to the communication tools, media outreach and community education emphasized by the workgroup?

The initial work of the Communication Work Group will focus on developing a communication plan which is based on around our state chronic disease plan and seeks to increase awareness of and support for proposed solutions. To complete the development of this communication plan, the following tasks will be completed:

Target Audiences	<ul style="list-style-type: none"> • Define the program’s target audience(s) and determine the most appropriate communication channel.
Messages, Materials and Activities	<ul style="list-style-type: none"> • Frame appropriate messages and plan an appropriate mix of materials and activities.
Messages, Materials and Activities	<ul style="list-style-type: none"> • Include description of message strategies, directional content, tone and manner and identification of action(s) target audiences should take and benefits of the desired action(s) that can be taken.
Partners	<ul style="list-style-type: none"> • Identify key organizations to present to and recruit as supporters. • Detail the roles and responsibilities of workgroup members for implementing and evaluating the communication plan. • Identify other supporters and provide them with information and skills to express their support or reinforce specific program elements (e.g., phone scripts, talking points, elevator speech, sample letters, spokesperson training).
Timeline	<ul style="list-style-type: none"> • Outline step-by-step listing of all development and implementation activities, with appropriate time for proper review, revisions, approvals and clearance by all partners.
Evaluation	<ul style="list-style-type: none"> • Plan an approach for assessing communication effectiveness and reach through formative, process and/or outcome evaluation.

The way that information is formatted is crucial to how people will see and understand the messages. Not everyone wants to read a detailed report, especially if most of it is text and

complicated graphs. Many readers appreciate formats that are concise and easy to read, colorful and include a variety of photos and graphics. As messages are developed and designed, the Communication Work Group will utilize research in the area of health literacy and plain language so the program can provide information in ways that help people learn and apply information.

Associated milestones to maximize visibility of the statewide North Dakota coordinated chronic disease plan follow:

High Priority Milestones:	Target Date	Lead Person
Identify CCDPP MT members and recruit partners to serve on the Communication Work Group.	12/2012	<ul style="list-style-type: none"> • Karalee Harper
Convene CCDPP Communication Work Group on a regular basis to develop communication plan for disseminating statewide chronic disease plan.	ongoing	<ul style="list-style-type: none"> • Karalee Harper
Present draft communication plan for disseminating statewide chronic disease plan to partners and other stakeholders to CCDPP partnership group.	6/30/2013	<ul style="list-style-type: none"> • CCDPP Communication Work Group
Disseminate statewide chronic disease plan to partners and other stakeholders via selected communication channels for target audiences.	6/30/2014	<ul style="list-style-type: none"> • Karalee Harper

Long Term Objectives:

Heart Disease and Stroke

1. By 2017, decrease from 6.4% to 5% the percent of adults in North Dakota who have heart disease. (BRFSS)
2. By 2017, decrease from 179 to 175 the rate per 100,000 who die from heart disease. (ND Vital Records)
3. By 2017, decrease from 4.2% to 3% the percent of adults in North Dakota who have had a heart attack. (BRFSS)
4. By 2017, decrease from 4.3% to 3% the percent of adults in North Dakota with coronary heart disease. (BRFSS0)
5. By 2017, decrease from 2.4% to 1.5% the percent of adults in North Dakota who have had a stroke. (BRFSS)
6. By 2017, decrease from 38 to 35 the rate per 100,000 who die from a stroke. (ND Vital Records)

Diabetes

1. By 2017, decrease from 7.4% to 3% the percent of adults in North Dakota who have diabetes. (BRFSS)
2. By 2017, decrease from 28 to 24 the rate per 100,000 who die from diabetes. (ND Vital Records)
3. Increase from 69% to 72% the percent of adults with diabetes who have an A1c<7.

Cancer

1. By 2017, decrease from 3.7% to X% the percent of North Dakota residents living with cancer. (Contractor currently working on the objective and source)
2. By 2017, decrease from 170 to 165 the rate per 100,000 who die from cancer.
3. By 2017, decrease from X to X the incidence rate of cancer. (Contractor currently working on the objective and source)

Asthma

1. By 2017, decrease from 7.4% to 6.0% the percent of adults who currently have asthma. (BRFSS)

Arthritis

1. By 2017, decrease from 27.4% to 25.0% the percent of adults in North Dakota who have arthritis. (BRFSS)

Intermediate Term Objectives**Adults**

1. By 2016, decrease from 21.9% to 20% the percent of ND adults who are current smokers. (BRFSS)
2. By 2016, decrease from 27.8% to 25% the percent of ND adults who are obese. (BRFSS)
3. By 2016, decrease from 63.8% to 60% the percent of ND adults who are overweight or obese. (BRFSS)
4. By 2016, decrease from 47.3% to 45% the percent of ND adults engaging in inadequate physical activity. (BRFSS)
5. By 2016, decrease from 29.1% to 25% the percent of ND adults with hypertension. (BRFSS)
6. By 2016, decrease from 77.5% to 75% the percent of ND adults eating fewer than 5 fruits/vegetables daily. (BRFSS)

Adolescents and children

1. By 2016, decrease from 11% to 9% the percent of adolescents and children in ND who are obese. (YRBS)
2. By 2016, decrease from 25.5% to 20% the percent of ND youth grades 9-12 who are overweight or obese. (YRBS)
3. By 2016, decrease from 12.4% to 10% the percent of ND adolescents and children engaging in inadequate physical activity. (YRBS)
4. By 2016, increase from 17.4% to 20% the percent of ND adolescents eating at least 5 fruits/vegetables daily. (YRBS)
5. By 2016, decrease from 28.3% to 25% the percent of ND adolescents who use tobacco products. (YRBS)

Goal Areas

A systematic review of the categorical plans was completed in May 2012. The integration opportunities are those that the MT as well as the partners agreed would be cross-cutting among the five diseases. Each disease is reflected or identified in color. Following each opportunity, the respective state plan is noted. In some cases, more than one plan had very similar activities.

In November 2012, the partners and MT will meet in-person to prioritize the top two to three priorities and their related activities for the partners and programs to begin working in 2013. The prioritization meeting will be facilitated by an outside contractor to ensure there is consensus from all parties involved.

SURVEILLANCE AND EVALUATION

Goal 1: Develop and maintain an accessible comprehensive chronic disease surveillance and evaluation system that includes the identification of disparities, supports comprehensive data analysis, results in strategic interpretation and dissemination of findings, addresses programmatic goals and objectives and is utilized for planning, implementing and evaluating chronic disease program activities.

Rationale:

What is measured can be managed. The assessment of chronic disease requires attention to indicators known to reduce morbidity and mortality. This includes the measurement of improved personal health choices, quality of life, community and environmental supports, health systems performance and social determinants of health. In addition, evaluation is essential to determining the effectiveness of program activities and implemented interventions.

Making the investment in epidemiology and surveillance provides us 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 our work in public health and demonstrate to the citizens of North Dakota the return on their investment in prevention has never been greater.

Short Term Objectives:

By 2014, obtain data from at least 1 new data sources to monitor the burden of chronic disease in North Dakota.

By 2014, develop and distribute at least 2 chronic disease surveillance and evaluation data reports, ensuring they are accessible to all users.

By 2014, implement at least 7 chronic disease program activities (by the state health department and/or partners) using surveillance and evaluation data to guide program planning and implementation.

Strategies:

1.1 Maintain chronic disease surveillance and evaluation system.

Integration Activities:

- 1.1.1 Develop a sub-committee to provide guidance for further defining and monitoring the chronic disease surveillance and evaluation system.
- 1.1.2 Develop a set of chronic disease surveillance and evaluation indicators to be used for measuring chronic disease prevention and management outcomes.
 - 1.1.2a Create a surveillance plan which includes the sources of data, what will be collected and the frequency.
 - 1.1.2b Collect information on an ongoing basis.
 - 1.1.2c Identify data gaps on an ongoing basis.
 - 1.1.2d Disseminate data as scheduled and as available or as requested including publications of audience-specific reports.
- 1.1.3 Maintain quality of life questions in population-based surveys of health status.
- 1.1.4 Maintain and disseminate the chronic disease burden report.
- 1.1.5 Continue involvement with Healthy People 2020, including but not limited to, tracking selected outcome and dissemination of reports.
- 1.1.6 Explore expansion of access to data sources including hospital discharge data sharing.
 - 1.1.6a Work with local tribes to develop a data sharing agreement between tribes and the NDDoH that will provide access to tribal specific chronic disease data.
 - 1.1.6b Obtain Medicare chronic disease(s) data.
- 1.1.7 Ensure chronic disease data is accessible and user friendly for people to plan programs, make decisions and evaluate progress.
 - 1.1.7a Develop a comprehensive data communication plan.
 - 1.1.7b Provide resources on how to use data to your advantage.

- 1.1.8 Develop and disseminate a chronic disease evaluation report documenting major outcomes from the NDDoH chronic disease and risk factor-related programs as well as their partners, including a section on Coordinated Chronic Disease State Plan progress.
 - 1.1.8a Develop plan for dissemination of surveillance and evaluation regarding the individual categorical plan priorities.
 - 1.1.8b Complete annual reports, including surveillance and evaluation information.
 - 1.1.8c Evaluate success of dissemination activities.
 - 1.1.8d Utilize findings to guide future decision making.
- 1.1.9 Based on available data, develop a chronic disease data report organized by the social determinants of health.
 - 1.1.9a Support community-based participatory research for populations that experience challenges with health equity by involving the communities impacted by chronic disease inequities in the planning, implementation, analysis and dissemination of chronic disease research.
 - 1.1.9b Utilize reports regarding health disparities between people with and without disabilities.

1.2 Encourage partners to use a standard, validated method for assessment of chronic disease prevention and management.

Integration Activities:

- 1.2.1 Develop materials for use by partners that describe specific outcome measures aligned with categorical program goals (per state plans).
- 1.2.2 Identify a framework for assessment of chronic disease prevention and management effectiveness at program, community, region and state levels.
- 1.2.3 Provide technical assistance services and educational opportunities to support evaluation of community-based and state level projects for chronic disease prevention and management.

ENVIRONMENTAL APPROACHES THAT PROMOTE HEALTH AND SUPPORT AND REINFORCE HEALTHFUL BEHAVIORS

Goal 2: Change policies and environments to enhance personal health behaviors such as physical activity, healthy eating and tobacco-free living.

Rationale:

Traditional health promotion interventions focus on changing individual behavior one or two individuals at a time. Changes in public and organizational policies as well as environmental factors can provide essential support to influence individual behavior and social norms. Since research indicates that improvements in daily physical activity, food choices and exposure to tobacco and its by-products can produce substantial advances in community health, emphasis is placed on these three behaviors in settings where people live, learn, work and play.

Improvements in social and physical environments make healthy behaviors easier and more convenient for North Dakota citizens. A healthier society delivers healthier students to our schools, 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.

Short Term Objective: By 2014, begin implementation toward at least 10 policy and environmental changes that will support healthy behaviors for the people of North Dakota.

Strategies:

2.1 Advocate for environmental and policy changes at state and local levels.

Integration Activities:

- 2.1.1 Identify policies at the state and community levels (including schools, worksites, child and adult care programs, transportation, agriculture and health-care settings) that are facilitators and/or barriers to physical activity, healthy eating and tobacco-free living.
- 2.1.2 Explore leveraging categorical program advisory boards/committees for policy development, advocacy responsibilities and other resources.
- 2.1.3 Develop and implement a policy and environmental change plan with strategies that support health and personal health behaviors at the state, community and organizational levels.
 - 2.1.3a Consider developing a short-term and long-term policy agenda within the policy plan.

- 2.1.3b Partner to increase opportunities for physical activity in general by working with communities on making the environment more accessible through walking, biking, and other traditional modes of transportation.
- 2.1.3c Promote physical activity for K-12 students 30 minutes a day.
- 2.1.3d Promote school nurse coverage in all schools.
- 2.1.3e Promote the elimination of nonsmokers' exposure to secondhand smoke.
- 2.1.3f Promote the adoption of evidence-based or best practice worksite interventions (including sample policies) that work to address the inclusion of physical activity as part of the workday.
- 2.1.3g Promote healthy food and beverage choices for cafeterias, events and vending machines in various settings such as work sites, schools and community gathering places.
- 2.1.3h Promote regular physical activity and tobacco cessation through counseling and education from health-care providers and organizations.

2.2 Educate decision makers and the public regarding the effects of policies and environmental factors on personal health behaviors, morbidity and societal costs.

Integration Activities:

- 2.2.1 Develop consistent and constructive messaging about environmental factors on personal health behaviors, morbidity and societal costs.
- 2.2.2 Unify communication with stakeholders to coordinate consistent and constructive messaging about policies and environmental factors on personal health behaviors, morbidity and societal costs.
 - 2.2.2a Educate legislators about the impact of chronic disease in North Dakota and their role in preventing and controlling chronic disease, and identify and cultivate champions for chronic disease advocacy among the North Dakota legislature.
 - 2.2.2b Develop fact sheets highlighting the human and economic costs of chronic disease in North Dakota and the cost benefits of chronic disease prevention and care.
 - 2.2.2c Educate policymakers about chronic disease and its complications through personal stories, dissemination of materials and forums that enable people with chronic disease to testify.

2.2.2d Utilize social marketing and a deliberate media plan to increase key public health messages about arthritis to increase the public's recognition that arthritis is an important chronic condition.

2.2.2e Pursue a variety of methods (e.g., direct mail, website, webcasts, newsletter, publications, presentations, etc.) to inform health-care professionals about current research and resources available in the community for persons with chronic disease.

2.2.3 Develop a mechanism to facilitate regular communication between stakeholders, including the Community Transformation Grant (CTG) recipients, to maximize activities and minimize duplication of efforts.

2.3 Enhance local capacity to assist with developing and/or leveraging policy and environmental change as a means to improve indicators of community health.

Integration Activities:

2.3.1 Assist communities in determining their chronic disease priorities through community engagement processes.

2.3.2 Identify local community stakeholders and champions.

2.3.3 Leverage community, state and federal resources.

2.3.4 Provide technical assistance and educational activities that develop and implement policy and environmental change for personal health behaviors.

2.3.4a Develop or identify and implement a training curriculum that helps community leaders understand what environmental and policy change is about, why it's important and how to implement within sectors of the community.

2.3.4b Healthy Eating

2.3.4ba Advocate for local and state policies to improve access and intake of healthy foods.

2.3.4bb Promote access to healthy foods in the worksite.

2.3.4bc Promote access to healthy foods in the school settings.

2.3.4bd Promote implementation of culturally-appropriate nutrition programs, practices and policies.

2.3.4be Partner with existing coalitions, such as the Healthy Eating and Physical Activity Partnership, in their efforts to increase access to and

consumption of more fruits and vegetables, particularly among the underserved populations.

2.3.4c Physical Activity

2.3.4ca Advocate for local and state policies to increase physical activity in the schools.

2.3.4cb Advocate for statewide physical activity policies in child-care settings.

2.3.4cc Advocate for local policies and practices designed to provide opportunities to support and help people be more physically active in their communities.

2.3.4cd Conduct community-wide campaigns to increase access to physical activity opportunities.

2.3.4ce Promote implementation of culturally-appropriate physical activity programs, practices and policies.

2.3.4d Worksite Wellness

2.3.4da Support physical activity programs sponsored by *Healthy North Dakota* and other worksite wellness initiatives.

2.3.4db Support onsite physical activity programs in the workplace, or increase access to physical activity sites for workers.

2.3.4e Support legislative capacity to include chronic disease services and prevention measures through public policy for populations who experience inequity in chronic disease care.

2.3.4f Support education and training that promotes breastfeeding policies in the workplace.

2.3.4g Support partner efforts to advocate for breastfeeding policies in the workplace.

2.3.4h Encourage schools to include in their curriculum basic skills how to cook healthy meals.

2.4 Develop a mechanism for local stakeholders to exchange the successes and lessons learned for policies that support personal health behaviors.

2.4.1 Develop and disseminate media materials such as news releases, fact sheets, personal stories, media advisories and news conference kits.

HEALTH-CARE SYSTEMS AND QUALITY IMPROVEMENT (HEALTH SYSTEMS INTERVENTIONS)**Goal 3: Expand access to and utilization of coordinated, proactive and quality health-care services.***Rationale:*

Recent health-care system changes in managing chronic disease involve the move from the traditional specialty clinic-based, symptom-focused and uncoordinated care, to a more comprehensive disease management model of care. Effective use of information and medical technology is one of the strategies the Institute of Medicine recommended to improve the quality of health care in the United States. Access and utilization of high quality health care across the continuum of care must be improved to realize the full potential of prevention and disease management.

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 changes 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.

Short Term Objective: By 2014, at least 5 new health care providers/organizations will begin implementing quality improvement chronic disease models of care.

*Strategies:***3.1 Advocate for the adoption of quality improvement chronic disease models of care to advance consistent delivery of high quality care.***Integration Activities:*

- 3.1.1 Advocate for and/or support quality improvement projects for accelerating adoption of medical practice models that consistently deliver high-quality chronic disease care such as patient-centered medical home.
- 3.1.2 Provide technical and/or financial support to establish systems to enhance chronic disease models of care. These systems could include clinical information, patient management, electronic health records, use of decision support tools and protocols and/or feedback on provider performance.

- 3.1.3 Advocate for use of incentives for health-care providers to adopt chronic disease models of care.
- 3.1.4 Promote adoption of an interdisciplinary, team-based approach, including patient and family members, to support chronic disease care.
- 3.1.5 Advance use of electronic health records that incorporate algorithms that encourage provider adherence to current prevention and treatment guidelines for chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis.
- 3.1.6 Provide leadership and/or collaborate on systems change interventions, including clinical data exchanges, that support adherence to evidence-based guidelines for screening, treating and managing chronic disease along with tobacco cessation (ask, advise, refer).
 - 3.1.6a Promote the North Dakota Tobacco Prevention and Control Program--ND Quits cessation services.
 - 3.1.6b Promote insurance coverage for tobacco cessation services.
 - 3.1.6c Promote health-care provider training on Public Health Service Guidelines, Treating Tobacco Use and Dependence.
 - 3.1.6d Promote health-care systems change by institutionalizing Public Health Service Guidelines.
 - 3.1.6e Promote the use of quality and performance indicators in the delivery of quality care.
- 3.1.7 Convene and assist health-care providers in identifying actions to improve coordination and quality of care and facilitate systems change.
- 3.1.8 Encourage insurance purchasers and/or health plans to provide incentives for health-care providers to report and improve the proportion of patients achieving clinical standards for chronic disease management.

3.2 Provide information and technical support to health-care providers/organizations about national standards for prevention, services and benefits of chronic disease care models.

Integration Activities:

- 3.2.1 Employ interactive website to assist public with selection of appropriate screening services, organized by gender and age.

- 3.2.2 Make available resources that address billing and reimbursement issues related to provision of preventive services.
- 3.2.3 Coordinate consistent and constructive messaging about prevention, services and chronic disease care models.
 - 3.2.3a Encourage health insurance companies to increase communication on covered services and in terms lay people understand.
 - 3.2.3b Promote informed and/or shared decision making based on personal and family history, by age-appropriate and health-care providers.
 - 3.2.3c Reduce barriers to screening(s), including but not limited to, language, financial, geographic, access and low literacy.
 - 3.2.3d Promote chronic disease screening education using a multi-component approach, including small media and one-to-one education.
- 3.2.4 Provide and/or promote training on implementing evidence-based tools and guidelines and creating systems to deliver appropriate preventive care, detection and treatment for chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis.
 - 3.2.4a Provide leadership and collaborate on systems change interventions that support adherence to established guidelines and recommendations.
 - 3.2.4b Encourage use of telehealth and telemedicine options, especially for rural areas, for the elderly, and long-term care facilities.
 - 3.2.4c Support health-care professional education that promotes shared decision making regarding treatment options.
 - 3.2.4d Develop additional methods and channels for training to increase the number of trained group leaders available for self-help programs.
 - 3.2.4e Support health-care provider education about the importance of obtaining detailed personal and family history identifying risk factors (inherited predisposition for chronic disease) that can initiate appropriate chronic disease screening.
- 3.2.5 Link innovative academic programs with community-based providers to support implementation of interdisciplinary, team-based models of chronic disease management.
 - 3.2.5a Encourage the “one-stop shop concept” to make screening(s) more convenient.

- 3.2.5b Promote health-care providers' utilization of client reminders for screening(s).
- 3.2.5c Promote the business case to business leaders about the benefits of screening(s) and early detection, along with effective employer strategies to facilitate screening(s).
- 3.2.6 Link health-care providers and allied health workers to continuing education activities such as health literacy, cultural competency and community health workers.
 - 3.2.6a Design strategies and incentives to help more health-care professionals pursue Certified Diabetes Educator credentials and/or continuing education, including other provider recognitions, especially in underserved areas.
 - 3.2.6b Advocate for health-care workers to be trained in active listening and cultural sensitivity, including the health-care setting, to optimally care for patients of different cultures and backgrounds.
 - 3.2.6c Identify and work to eliminate obstacles for health systems tracking and evaluating quality improvement initiatives.

PERSONAL HEALTH AND SELF-MANAGEMENT (COMMUNITY-CLINICAL LINKAGES)**Goal 4: Support engagement of individuals in their efforts to reach optimal health.***Rationale:*

Individuals empowered with knowledge and skills are capable of making informed decisions about prevention medical care and self-management behaviors across the continuum of life. Their participation, however, depends on how they are engaged in the process of personal health improvement. It is imperative there are multiple, frequent and culturally-appropriate channels for engaging individuals in prevention and self-management strategies.

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 prediabetes, 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.

Short Term Objectives:

By 2014, reach at least 10% of the population of North Dakota with messages and resources that will encourage their personal health and prevent chronic disease.

By 2014, increase the capacity of at least 5 health care providers/organizations to reach their populations with personal health and self-management health messages, resources, and services.

Strategies:

4.1 Develop and implement communication strategies reaching the continuum of life, to engage individuals in prevention and personal health behaviors.

Integration Activities:

- 4.1.1 Implement strategies that connect individuals with shared interest in personal health improvement.
- 4.1.2 Work with a variety of entities, including but not limited to, school settings, worksites, child care settings, community and faith-based organizations to develop messaging to activate prevention behaviors such as getting blood pressure checks, utilizing ND Quits programs and injury prevention utilizing appropriate messaging based on the audience.

- 4.1.3 Educate public on the features and benefits of prevention, personal health behaviors, self-management and education services as a means to increase utilization for services.
 - 4.1.3a Use the Weight of the Nation conference materials and HBO series resources to increase the awareness of nutrition and physical activity as it relates to chronic disease.
 - 4.1.3b Educate faith organization leaders, parish nurses and/or volunteers about the role faith organizations can play in encouraging health promotion and the prevention and control of chronic disease (e.g., letter about taking care of your body, sermons, etc.).
 - 4.1.3c Educate community organization leaders about the role they can play in encouraging health promotion and the prevention and control of chronic disease (e.g. in newsletters, letters from leaders about taking care of your body).
 - 4.1.3d Engage physicians in providing information to their patients about prevention through healthy behavior choices and control through self-management strategies.
 - 4.1.3e Educate the general public, policymakers and business leaders about the ongoing needs of survivors (i.e., stroke, cancer, heart disease).
 - 4.1.3f Identify, develop and maintain accessible chronic disease survivorship resources.
 - 4.1.3g Use target communications through a variety of channels that reach those at high risk to increase awareness and provide referral to available programs.

4.2 Provide trainings/resources for health care providers and other organizations to increase the utilization of services for all individuals including those with chronic disease to receive regular prevention, personal health behavior, self-management and education services.

Integration Activities:

- 4.2.1 Raise employer and health plan awareness of benefit design factors (i.e., coverage) related to self-management, personal health behaviors and education services.
- 4.2.2 Explore the resources that address billing and reimbursement issues related to provision of self-management, preventative screening and education services in clinical and community settings.

- 4.2.3 Work with health-care providers, employers, community and faith-based organizations and insurance companies to offer incentives for individuals to seek appropriate screening and preventive services.
- 4.2.4 Promote availability of no- or low-cost cessation medication.
- 4.2.5 Connect individuals to prevention, self-management and education services.
 - 4.2.5a Work with local partners to offer Stanford's Chronic Disease Self-Management Program.
 - 4.2.5b Ensure needs for children with chronic disease are cared for appropriately in schools.
 - 4.2.5c Promote disease self-management training that is accessible, as well as culturally, individually and family appropriate.
- 4.2.6 Train health-care providers to assess prevention and self-management behaviors as part of routine clinical encounters as well as goal setting for personal health behaviors.
 - 4.2.6a Encourage providers to screen chronic disease patients for depression and follow up/link to needed resources based on screening results.
 - 4.2.6b Promote a comprehensive clinical approach to smoking cessation that includes screening for tobacco use, cessation counseling and pharmacotherapy.
 - 4.2.6c Promote referrals to NDQuits and other community resources for comprehensive cessation counseling.
- 4.2.7 Study reimbursement barriers and opportunities for health-care providers to facilitate goal setting and follow up with patients.
 - 4.2.7a Promote access to cessation products by reducing or eliminating co-pays or deductibles.
 - 4.2.7b Promote reimbursement for self-management support provided by pharmacists, Community Health Workers (CHWs), Community Paramedic and other health extenders.
- 4.2.8 Explore utilization of CHWs and/or Community Paramedic to assist individuals to improve or increase their capacity for self-management of chronic diseases including heart disease and stroke, cancer, diabetes and arthritis.

- 4.2.8a Promote and support the use of lay health workers, following the model of American Indian Community Health Representatives and other models.
- 4.2.8b Encourage/revitalize community-based chronic disease programs.
- 4.2.8c Support the use of properly trained and culturally competent CHWs and/or Community Paramedic experiencing chronic disease care inequities.
- 4.2.8d Promote use of pharmacists, dentists, case managers, CHWs, Community Paramedic and other health extenders to improve health outcomes.

4.3 Provide resources that encourage constructive self-management behaviors to the general population and friends and family members of people with chronic diseases.

Integration Activities:

- 4.3.1 Identify and communicate resources and tools for friends, family and co-workers that explain the fundamentals of the leading chronic diseases and tips for providing constructive and emotional support.
- 4.3.2 Educate patients on therapeutic lifestyle changes (TLC) to control and manage chronic disease and associated risk factors.
- 4.3.3 Connect friends and family to chronic disease support services in a variety of settings such as in schools, worksites, health-care, faith-based and community organizations.
- 4.3.4 Educate the public on the features and benefits of prevention, personal health behavior, self-management, survivorship and education services as a means to increase demand for services.
 - 4.3.4a Conduct a statewide social marketing/media chronic disease campaign.
 - 4.3.4aa Identify cross-cutting key messages.
 - 4.3.4ab Identify disease specific messages (e.g., diabetes, heart disease, stroke, cancer, arthritis, asthma, tobacco control, obesity).
 - 4.3.4b Consider the role that mental health, particularly depression, plays with chronic disease prevention and control and link mental health with chronic disease in education opportunities.

HEALTH INEQUITIES

Goal 5: Address health inequities in planning for the improvement of population health.

Rationale:

Social determinants of health are the economic and social conditions that shape the health of individuals and communities and are the primary determinants of whether individuals stay healthy or become ill. Routine and systematic monitoring of health inequities and the contributing social determinants of health (income and poverty, education, access to health services, housing, transportation and environmental structures) are critical to identifying opportunities for improving population health and shaping the systems put in place to deal with illness. By utilizing data on social determinants of health in conjunction with health data, the added value to public health will be a healthier populace and fewer health inequities

Short Term Objectives:

By 2014, implement at least 2 policy or systems changes in organizations that relate to the collection/use of data and/or implementation of activities that address social determinants of health and chronic diseases.

By 2014, increase the knowledge of and ability to address social determinants of health for at least 75 key stakeholders across the state, at the state and/or community level.

Strategies:

5.1 Ensure surveillance systems link social determinants of health to outcomes and behaviors across chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis.

Integration Activities:

- 5.1.1 Assess surveillance system capacity for measuring social determinants of health for analyzing health outcomes and health-related behaviors.
- 5.1.2 Collect social determinants of health indicators or link to other databases for analysis and incorporation into routine surveillance reporting and program planning.
 - 5.1.2a Support efforts to improve the availability, accuracy and completeness of data collection in terms of race/ethnicity classification, third-party payers and other pertinent data components.
 - 5.1.2b Determine potential data sources and disseminate chronic disease(s) health disparities data statewide to support chronic disease(s) control efforts.

5.2 Provide training and technical assistance to key stakeholders on the social determinants of health, including what they are and how to address them at the state and/or community level.

Integration Activities:

- 5.2.1 Provide technical assistance and educational opportunities that enhance and/or develop community-based and state-level projects that address social determinants of health for chronic disease prevention and management.
 - 5.2.1a Promote and support ongoing cultural competency education opportunities and curricula training on social determinants of health, including strategies that health-care professionals can implement into practice to address and reduce inequities in chronic disease care, including but not limited to, gender, race or ethnicity, education, income or employment, refugee or immigrant status, age, geographic location, physical or mental status and sexual orientation or gender identity.
 - 5.2.1b Support the local development of social determinants of health that are appropriate educational materials utilizing community feedback surrounding the topic of chronic disease.
 - 5.2.1c Support culturally competent and informed/shared decision-making tools regarding clinical trials, screening, treatment and survivorship.
 - 5.2.1d Advocate for policies that address tobacco-related disparities.
 - 5.2.1e Advocate for the development of outreach systems for the underserved and minority populations such as patient navigation.
 - 5.2.1f Support culturally-appropriate environments from prevention through survivorship, palliative and end-of-life care.
 - 5.2.1g Support collaborative efforts of tribal communities with other state and local partners.
 - 5.2.1h Advocate for facility practices that support the needs of ethnic or minority populations.
 - 5.2.1i Support and engage communities, minority health community organizations and those with health disparities in identifying and solving access to care issues.
 - 5.2.1k Support initiatives grounded in the unique historical and cultural contexts of communities and promote clinical, community and workplace prevention efforts that consider language, culture, age, preferred and accessible

communication channels and health literacy skills for information that encourages adoption of healthy behaviors.

- 5.2.11 Support access to treatment drugs for those who are medically underserved.
- 5.2.2 Support efforts to provide funding resources for the treatment and associated cost for the uninsured, underinsured and medically underserved populations.
 - 5.2.2a Inform stakeholders about the prevalence and incidence of chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis and related risk factors in terms of health inequities and social determinants of health.
 - 5.2.2b Use the PBS Unnatural Causes Series to educate coalition members and local community leaders/organizations about social determinants of health and how to use that information to effectively prevent and control chronic disease for disparate populations.
 - 5.2.2c Support activities that provide culturally competent treatment such as appropriate environments for treatment and educational material.
 - 5.2.2d Support efforts to increase the number of racial and ethnic minority individuals in the health-care field, including supporting education of the career opportunities.
 - 5.2.2e Promote access to culturally-appropriate health care and culturally-sensitive health materials.

CAPACITY

Goal 6: Develop capacity (including leadership, management, training, resources and partnerships) to advance chronic disease prevention and health promotion in North Dakota.

Rationale:

Vigorous, aggressive public health efforts are able to have great impact in preventing or significantly delaying chronic disease and associated disabilities. Beginning with the state health department, capacity must be developed to manage these efforts and secure the necessary resources to do so, including the technical expertise needed to plan, implement and evaluate interventions. Core capacity skills and capabilities are compulsory in order to be cost-efficient, effective and gain the insights, knowledge and experiences needed to solve health problems and implement change. Capacity is the key to long-term sustainability of health and disease prevention at all levels and in all sectors of the community.

Short Term Objectives:

By 2014, increase from 12 to 18 the number of partners coordinating and collaborating on chronic disease prevention and health promotion activities in the state plan.

By 2014, develop at least 5 capacity building resources/tools/systems to ensure state-level capacity is in place to advance chronic disease prevention and health promotion in North Dakota.

Strategies:

6.1 Establish the NDDoH's CCDPP MT with at least 10 team members and define operational and collaborative processes for the MT that will enhance coordination, improve efficiencies, provide a forum for sharing best practices and eliminate redundancies across multiple chronic disease related program areas at the health department.

Integration Activities:

- 6.1.1 Provide leadership and an environment that supports collaboration and coordination of efforts.
- 6.1.2 Integrate work plans with other chronic disease state program work plans.
- 6.1.3 Create a report and/or diagram of overlapping goals/activities between organizations and communities. Consider ways to integrate common activities to maximize resources and coordinate efforts.

- 6.1.4 Develop an organizational identity for the CCDPP and its governing body (partnership) that will help build the program into a recognized movement that promotes the importance of chronic disease prevention, provides leadership in communicating the need for policy and environmental changes that support healthy eating and active lifestyles and demonstrates knowledge in evidence-based strategies to prevent, treat and control chronic disease and its related risk factors.
- 6.1.5 Sponsor or jointly plan local, regional and statewide trainings, conferences and technical assistance on best practices for effective chronic disease prevention strategies for work sites, schools, tribal communities, public health, health organizations, health plans, employers and others.

6.2 Apply for funding opportunities and leverage resources for planning, implementing and evaluating chronic disease prevention and health promotion efforts.

Integration Activities:

- 6.2.1 Develop and offer a training opportunity for local partners on where to seek chronic disease funding opportunities and how to apply for grants (grant writing 101).
- 6.2.2 Secure and protect public funding and state appropriations that support chronic disease programs and other public health initiatives targeted at chronic disease, related risk factors and the disparities that exist in these areas.
- 6.2.3 Explore opportunities to generate and direct additional fiscal resources for chronic disease programming/initiatives and support efforts to leverage new and existing federal funds and grant opportunities to implement state plan objectives and strategies.

6.3 Develop infrastructure building plans that build capacity across the state for chronic disease prevention and health promotion.

Integration Activities:

- 6.3.1 Develop and implement a staffing and training plan to support a coordinated and collaborative approach to chronic disease prevention and health promotion with an emphasis on public health policy, environmental improvements and effective chronic disease prevention and management.
- 6.3.2 Develop and implement a communication plan to inform the public and stakeholders about chronic disease prevention and health promotion burden, interventions and impact.
 - 6.3.2a Develop a communication plan that assists in framing messages, presentations and materials that support implementation of the state plan and communicates the importance and urgency of addressing chronic disease.

6.3.3 Develop and implement a policy plan that describes how chronic disease prevention and health promotion policies will be developed collaboratively with partners and used to increase the number, reach, quality and impact of statewide, local and organizational policies to support health and healthy behaviors.

6.4 Implement opportunities that direct collaborative resources for programs and initiatives that support chronic disease prevention and health promotion efforts.

Integration Activities:

6.4.1 Explore coordination and integration of state health department community-based grant programs.

6.4.2 Engage and/or link with partners to identify ways to implement a coordinated chronic disease and health promotion approach for underserved or underrepresented populations as it specifically relates to the state health department.

6.4.3 Provide action plan training on goal, objective, strategy development and program evaluation.