

# Integrated Chronic Disease Prevention & Management Plan

State of Missouri Department of Health and Senior Services

## Contributing Programs & Offices

Arthritis and Osteoporosis  
Asthma  
Cancer  
Chronic Disease Primary Prevention  
Diabetes  
Heart Disease and Stroke  
Minority Health  
Nutrition/Physical Activity/Obesity  
Organ/Tissue Donor  
Primary Care and Rural Health  
Show Me Healthy Women  
Team Nutrition  
Tobacco Control  
WISEWOMAN  
Women's Health

**2010-2014**

*synchronized for optimal health*

## Introduction:

Chronic diseases account for nearly 7 out of 10 leading causes of deaths in Missouri. The Missouri Department of Health and Senior Services (DHSS) has several programs to support and assist in the prevention and control of chronic diseases such as asthma, cardiovascular disease, diabetes, and cancer.

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

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

This integrated chronic disease plan is intended to provide communities, health care providers, funding agencies, policy and decision makers, medical care providers, state and local government agencies, health plans, employers, advocacy organizations and consumers direction and support in creating systems of care that proactively addresses the prevention, early detection and treatment of chronic disease in Missouri.

The framework presented herein is designed to encourage the development of collaborations for comprehensive and integrated approaches to reducing chronic disease morbidity and mortality throughout Missouri.

*“We believe coordinated strategies  
yield the greatest dividends.”*

— Brad Hall, Administrator  
Section of Chronic Disease Prevention & Nutrition Services

## Guiding Principles of Program Integration:

Chronic disease program integration is defined as “the strategic alignment of chronic disease categorical program resources to increase the effectiveness and efficiency of each program in a partnership without compromising the integrity of categorical program objectives.” (Salinsky and Gursky, *Health Affairs*, 2006) The project team adopted the following basic principles to guide the development of this integrated plan:

- Do no harm to categorical program integrity
- Clearly identify and state mutual benefits and opportunities
- Be guided by efficiency-oriented processes
- Be focused on health outcomes
- Evaluate integration outputs and health outcomes
- Engage stakeholders
- Mobilize leaders

According to the National Association of Chronic Disease Directors (NACDD), the perceived benefits of program integration include efficient use of staff, funds, and surveillance and intervention efforts. The project team reviewed the 2006 recommendations from NACDD regarding planning and implementing chronic disease program integration initiatives and incorporated this guidance throughout the development of goals and objectives described herein.

## Using this Plan:

*Annual Action Plan.* This plan provides a framework for preparing a brief action plan each year that sets priority areas for integration among categorical programs and partners. Such a plan would address how and when objectives would be addressed.

*Categorical Program Plans.* The goals described in this plan are intended for use as the foundation for building categorical program state plans during the next five years. By using the overarching goals presented herein, condition-specific goals can be linked together with ease and clarity.

*Stakeholder Alignment.* This plan was designed for adoption by or alignment with local and statewide stakeholders engaged in chronic disease prevention and management. By organizing their strategies and activities with the context of the overarching goals, partnerships can be enhanced through identification of synergies and collaboration opportunities.

## Context:

This plan presents five overarching goals for coordinating the three major functions chronic disease prevention and management programs:

1. *Plan*: creating disease prevention and management plans,
2. *Partner*: developing partnerships to coordinate resources, and
3. *Provide*: providing services, information, or products that contribute to health improvement.



The plan goals are designed to reflect shared interests among the categorical programs *and* provide a framework for linking program-specific objectives, developing state plans, communicating integration efforts with stakeholders, etc. The objectives under each goal in this document represent shared interests among categorical programs rather than program-specific concerns. The *integration opportunities* described under each objective are presented as possible ways for coordinating categorical program activities; they are not commitments for future action and some may be underway. It is important to note that categorical program alignment with each goal is not expected to be uniform; some programs will have stronger linkage with certain goals than others.

GOAL STATEMENT	FOCUS AREA
Goal 1: Address social determinants in plans for health improvement.	Planning
Goal 2: Coordinate efforts for policy and environmental change to promote physical activity, healthy eating, and tobacco free living.	Policy
Goal 3: Support engagement of individuals in their efforts to reach optimal health.	Self-management
Goal 4: Expand access to and utilization of coordinated, proactive, and quality health care services.	Health Care Quality
Goal 5: Measure health system performance in terms risk factor reduction, chronic disease self-management support, and quality of life.	Surveillance & Evaluation

## Goal 1:

### Address social determinants in plans for health improvement

*Rationale:*

*The foundational causes of health status and health disparities include income and poverty, education, access to health services, housing, and transportation. Routine and systematic monitoring of health inequities and the contributing social determinants are critical to identifying opportunities for improving population health.*

#### **Objectives:**

##### **1.a. Surveillance systems link social determinants to health outcomes and behaviors across all chronic diseases.**

*Integration Opportunity*

- Assess surveillance system adequacy for measuring health outcomes, health-related behaviors and health system performance, by social determinants.
- Consult with statewide taskforce to update priorities and recommendations for enhancing chronic disease surveillance systems.
- Develop a framework for organizing how categorical program activities are guided by social determinants.
- Calculate morbidity and mortality rates for multiple chronic diseases according to leading social determinants.

##### **1.b. Stakeholders are informed about the prevalence and incidence of all chronic diseases and related risk factors in terms of health inequities.**

*Integration Opportunity*

- Develop and maintain centralized database of chronic disease prevention stakeholders.
- Identify and connect regional and statewide organizations with expertise in social determinants of health (e.g., poverty, education) to public health planning efforts.
- Unify print and electronic communication with stakeholders to coordinate consistent and constructive messaging about social determinants.

## Goal 1 (continued)

### 1.c. Policies for improving social conditions account for potential reductions in health disparities.

#### *Integration Opportunity*

- Develop and issue brief reports about the contributions of specific social conditions to health outcomes, health-related behaviors and health system performance.
- Analyze the potential benefits of state social programs and policies in terms of morbidity, mortality, and health economics.
- Develop and execute coordinated messaging campaigns in partnership with advocacy organizations to raise awareness among policy-makers about social determinants.

### 1.d. Health improvement interventions developed for or implemented in community settings are informed by contributing social determinants.

#### *Integration Opportunity*

- Develop tools for assisting non-profit hospitals with measurement of community benefit.
- Develop and publish online registry of community-based projects for chronic disease prevention and management.
- Establish annual award for innovative community health improvement strategies.
- Provide technical assistance services and educational opportunities that develop and implement new community-based projects for chronic disease prevention and management.
- Increase education and training regarding disparities offered to health profession students.

## Goal 2:

### **Coordinate efforts for policy and environmental change to promote 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, work, and play.*

#### **Objectives:**

##### **2.a. A multi-stakeholder advocacy agenda achieves policy changes at state and local levels.**

*Integration Opportunity*

- Consolidate advocacy functions of categorical program advisory boards/committees into one coalition with policy development and advocacy responsibilities.
- Set one annual priority for awareness and policy change that is promoted by government leaders and categorical program stakeholders.

##### **2.b. Coordinated messages educate public regarding the effects of policies and environmental factors on health behaviors, morbidity, and societal costs.**

*Integration Opportunity*

- Execute communication strategy that links “green movement” to health.
- Identify private (e.g., employer, school) and local and state government policies that are barriers to physical activity, healthy eating and tobacco free living.
- Unify print and electronic communication with stakeholders to coordinate consistent and constructive messaging about environmental factors on health behaviors, morbidity, and societal costs.

**Goal 2 (continued)**

**2.c. Innovations that leverage policy and environmental change as means to improve indicators of community health are recognized and rewarded.**

*Integration Opportunity*

- Develop and publish online registry of template policies for schools, worksites, health care facilities, and communities that address environmental factors.
- Explore state tax incentives for corporations that implement qualified employee wellness programs.
- Host annual conference of high school student leaders for health promotion training.

## Goal 3:

### 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 medical care and self-management behaviors. 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 strategies.*

#### **Objectives:**

##### **3.a. Communication strategies activate at-risk individuals to increase engagement in prevention behaviors.**

*Integration Opportunity*

- Implement social networking strategy that connects individuals with shared interest in personal health improvement.
- Commission community organizations with access to at-risk individuals to develop messages that activate targeted prevention behaviors, such as getting blood pressure checked, calling tobacco quit line, etc.
- Coordinate student contest (art, video or interactive media) to bring forth new ideas about prevention messages and attract mass media coverage.
- Retain celebrity spokesperson.
- Work with health care providers, employers and insurance companies to offer incentives for at-risk individuals to seek appropriate screening services.

##### **3.b. All individuals with chronic disease have access to and receive regular self-management education services.**

*Integration Opportunity*

- Raise employer and health plan awareness of benefit design factors (i.e., coverage) related to self-management education services.
- Develop resources that addresses billing and reimbursement

## Goal 3 (continued)

issues related to provision of self-management education services in clinical and community settings.

- Train professionals to provide self-management education services.
- Educate public on the features and benefits of self-management education services as a means to increase demand for services.

### **3.c. Friends and family members of people with chronic disease provide social and emotional support that encourages constructive self-management behaviors.**

#### *Integration Opportunity*

- Train professionals to provide nutrition education programs statewide for friends and family of people living with chronic disease.
- Develop online education modules for friends and family that explain the fundamentals of leading chronic diseases and tips for providing constructive social and emotional support.

### **3.d. Health care providers assess self-management behaviors and facilitate process of goal-setting.**

#### *Integration Opportunity*

- Train health care providers to assess self-management behaviors as part of routine clinical encounters.
- Study reimbursement barriers and opportunities for health care providers to facilitate goal-setting and telephonic follow-up with patients.

## Goal 4:

### Expand access to and utilization of coordinated, proactive and quality health care services.

*Rationale:*

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.

#### **Objectives:**

##### **4.a. Incentives are available for health care providers to adopt chronic disease models of care.**

*Integration Opportunity*

- Establish task force to develop recommendations for accelerating adoption of medical practice models that consistently deliver high quality chronic disease care (e.g., patient-centered medical home).
- Survey health plans to assess financial, contractual and market opportunities to implement chronic disease models of care.
- Explore technology needs of local public health agencies to implement registries for providing case management services to patients with chronic disease.

##### **4.b. Interdisciplinary, team-based approaches are employed to educate future physicians, nurses, pharmacists, physical/occupational therapists, and social workers.**

*Integration Opportunity*

- Convene task force with college and university leaders.
- Link innovative academic programs with community-based providers to support implementation of interdisciplinary, team-based models of chronic disease management.

##### **4.c. Electronic medical records incorporate algorithms that encourage provider adherence to current prevention and treatment guidelines for leading chronic diseases.**

*Integration Opportunity*

- Survey health care providers with electronic medical records regarding availability and use of current prevention and treatment guideline algorithms.

## Goal 4 (continued)

- Assure clinical data exchanges include mechanisms to improve adherence to evidence-based guidelines for chronic disease screening and treatment.

### **4.d. Transitions between health care settings are made smoothly and efficiently.**

#### *Integration Opportunity*

- Identify best-in-class operations among Missouri hospitals and health plans regarding coordination of care from in-patient hospitalization to out-patient follow-up, among those with chronic disease.
- Implement surveillance system to assess and report hospital re-admission rates attributable to poor care coordination.

### **4.e. Health care providers and the public are informed about national standards for preventive services.**

#### *Integration Opportunity*

- Serve as resource for stakeholder access to statewide database of primary care providers.
- Unify print and electronic communication with stakeholders to coordinate consistent and constructive messaging about prevention services.
- Make available resources that address billing and reimbursement issues related to provision of preventive services.
- Offer continuing education training to medical office support personnel regarding national standards for preventive services.
- Employ interactive website to assist public with selection of appropriate screening services, organized by gender and age.

## Goal 5:

### Measure health system performance in terms risk factor reduction, chronic disease self-management support, and quality of life.

*Rationale:*

*What is measured can be managed. The assessment of health system performance, in terms of chronic disease, requires attention to prevention indicators known to reduce morbidity and mortality many years later. Concurrently, full consideration must be given to patient-centric outcomes – those which reflect that the needs and preferences of patients are being met by the medical care and public health organizations. The ability to conduct trend analysis is essential for sustaining meaningful improvements in access, cost, and quality – three domains of health system outcomes.*

#### **Objectives:**

##### **5.a. Communities use a standard, validated method for regional assessment of chronic disease prevention and management effectiveness across time.**

*Integration Opportunity*

- Develop materials for use by community partners that describe specific outcome measures aligned with categorical program goals (per state plans).
- Convene experts in evaluation to develop framework for assessment of chronic disease prevention and management effectiveness at program, community and regional levels.
- Provide technical assistance services and educational opportunities to support evaluation of community-based projects for chronic disease prevention and management.

##### **5.b. Consumers are able to assess health care provider quality in terms of chronic disease prevention and management via transparent, publicly-reported measures.**

*Integration Opportunity*

- Compare ability of consumers in Missouri and other states to assess health care provider quality for chronic disease prevention and management.

## Goal 5 (continued)

- Develop online tools that assist consumers with decisions regarding health care provider selection for chronic disease management.

### **5.c. Measures of quality of life are incorporated into public health surveillance systems.**

#### *Integration Opportunity*

- Develop plan to add quality of life questions to population-based surveys of health status.
- Educate health care providers and public health officials about the importance of quality of life measures in the assessment of chronic disease prevention and management programs.

### **5.d. Tracking prescription medication adherence for treatment of chronic diseases is available to medical care and public health professionals.**

#### *Integration Opportunity*

- Obtain data sharing agreements with pharmacies, commercial health plans, or government health plans (i.e., Medicare, Medicaid) to evaluate medication adherence for leading chronic diseases.

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*“Plans are only good intentions  
unless they immediately degenerate  
into hard work.”*

*— Peter Drucker*

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