

Integration Demonstration Project Workplan for Massachusetts

Massachusetts' Integration Demonstration Project Pilot is based on three goals which drive the workplan leading to the implementation of a sound integrated community based program, which incorporates the commonwealth's comprehensive health care reform initiatives, current evidenced-based practices and the developing of an infrastructure to support integration activities.

The workplan's three goals;

1. Develop an infrastructure to strengthen the role of Public Health in Health Care Reform
2. Develop internal structure to strengthen the principles and programmatic needs of integration of chronic disease programs
3. Develop and implement a comprehensive community approach supporting the prevention and improved management of chronic diseases.

Glossary: Abbreviations

ADA- American disability Act

A & F - Administration and Finance

APCP - Asthma Prevention and Control Program

BCHAP - Bureau Community Health and Prevention within DPH

BRFSS- Behavioral Risk Factor Surveillance System

Care Coordination- MDPH program including Women's Health Network (WHN), Men's Health Partnership (MHP) and WiseWoman programs

CDSMP - Chronic disease Self Management Program

CHC- Community Health Center

Chronic Care Blueprint- A vision for well being for residents with chronic conditions; a HCR initiative

CHW -Community Health Worker

CLAS-Community Legal Assistance Services?

DPCP - Diabetes Prevention and Control Program

DPH - Department of Public Health

DHPDP - Division Health Promotion and Disease Prevention

EOHHS- Executive Office of Health and Human Services

GIC- Group Insurance Commission

HADU - Healthy Aging and Disability Unit or Office of Healthy Aging/Health Disability

HCR – Health Care Reform. Massachusetts' program to achieve universal health coverage for all residents of MA

HD&S- Heart Disease and Stroke Program

HealthyMass Compact - EOHHS program supporting HCR focused on initiatives/activities targeting access, advancing quality, containing costs, promoting wellness and healthy communities

HRSA-Health Resources Service Administration

IDP- Integration Demonstration Project

ITS-Information Tracking system; A MDPH database product

JSI- John Snow, Inc.

EOHHS- Executive Office of Health and Human Services

MDPH- Massachusetts Department of Pubic Health

MAHB—Massachusetts Association Health Boards

MHOA-Massachusetts Health Officers Association

MMA- Medicare Modernization Act

MTCP- Massachusetts Tobacco Control Program

NHANES- National Health and Nutrition Examination Survey

NPAU- Nutrition Physical Activity Unit

PGO- Procurement and Grants Office

POS- Purchase of Services

QCC- Quality and cost Council: Established by HCR to implement policies that maximize quality and minimize costs; a HCR initiative

SOP- Standard Operating Procedures

TA- Technical Assistance

WNH/MHP- Women's Health Network/Men's Health Partnership

Key:

Funding Terms

State = S

Federal = F

In Kind = K

INTEGRATION DEMONSTRATION PROJECT WORKPLAN

Project Goal #1	Develop an infrastructure to strengthen the role of Public Health in Health Care Reform (HCR)							
Long-Term Objectives:	<ol style="list-style-type: none"> 1. Champion the prominence of health promotion and disease prevention within health care reform 2. Establish a communication mechanism to link DPH's Chronic disease Programs with related state-wide Health Care Reform initiatives including Healthy/Mass Compact and the Quality and Cost Council (QCC) 3. Increase coordination regarding the use of indicators including measures of integration 4. By 2014 implement the Massachusetts BRFSS survey to a sample most representative of Massachusetts population and subpopulations with a tool that is most relevant to MDPH program needs and emerging public health topics (BRFSS) 5. By 2015, work with partners to ensure legislation mandates a comprehensive smoking cessation benefit for all insurance plans that is aligned with the MassHealth benefit (MTCP) 							
Rationale	The IDP takes place in the context of a broad HCR initiative designed to provide health insurance to virtually all state residents. The HCR driven by the Governor with strong programmatic support from the Secretariat and DPH has many statewide initiatives and activities to support the services needed to support an increasing population of insured. DPH is taking the lead on many initiatives, such as developing a blueprint for chronic disease management, statewide task forces on diabetes and obesity. The HCR initiatives are an integral part of the integration of chronic disease programs making the goal to strengthen the role of public health in HCR significant for Massachusetts' IDP pilot.							
Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding*			Indicators	Data Sources
				S	F	K		
# 1- Maintain alignment and ensure constant communication with HCR initiatives and activities.	<ol style="list-style-type: none"> 1. Develop a "Communication Feedback Loop" to maintain alignment with the Secretary of Health and Governor's statewide initiatives. The Communication Feedback Loop will target Key state initiatives such as; Health Care Reform, the Chronic Care Blueprint, "HealthyMass" Compact, and the Diabetes and Obesity Task Forces. 2. Create a sub-group to develop the mechanisms necessary to ensure the Communication Feedback Loop functions efficiently and effectively. 3. Develop specific strategies to address individual initiatives, and develop overall processes for dissemination of information between the state and DPH, between DPH and state agencies. For example: Holding DPH internal information meetings, creating a BLOG for community members to read and/or interact with, using the state website for interagency communication, disseminating newsletters, and utilizing the current Commissioner's annual regional community meetings. 	<ul style="list-style-type: none"> • Commissioner • IDP Director • BCHAP Director and Deputy Director • ILT • PIT • ILT/PIT Sub-group 	Jan – June 2009	X	X		<ul style="list-style-type: none"> • Communication plan developed • Attendance at Community meetings • Newsletter disseminated to the communities • Departmental information sessions conducted • DPH Staff survey indicates awareness of statewide initiatives and satisfaction with communication mechanism increases 	<ul style="list-style-type: none"> • Policies • Newsletters • Participation lists
<p>* S =State F =Federal K = In Kind</p>								

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				S	F	K		
# 2-Increase the prominence of health promotion and disease prevention	<ol style="list-style-type: none"> 1. Work with and provide TA to employers within the Commonwealth to adopt worksite wellness programs in support of HCR. (Focus on employers with 11-50 employees) 2. Work with 3rd party payors to increase reimbursement for tobacco cessation 	<ul style="list-style-type: none"> • Program Director, Worksite Wellness • Director Wellness Division • Commissioner’s Office • BCHAP Director 		X	X		<ul style="list-style-type: none"> • Worksite survey • Meeting set with 3rd party payors to discuss reimbursements 	<ul style="list-style-type: none"> • Number of worksite wellness programs • Reimbursement increased
# 3- Lead the development of the Chronic Disease Blueprint for the Secretariat to be completed by March 2009 # 4 -Promote the utilization of the Chronic Care Blueprint	<ol style="list-style-type: none"> 1. Convene a multi-agency and multi-disciplinary sub-group 2. Support the Chronic Disease Blueprint by providing technical assistance (TA) for a successful comprehensive implementation. For example: <ol style="list-style-type: none"> a. Provide education and tools helping the development of Self Management of Chronic Disease b. Provide TA for providers and identify evidenced –based best practices supporting chronic disease management c. Provide TA for “transitions in care” from one level of care or location to another d. Identify community resources to support healthy lifestyles and self management e. Encourage a payment system that supports (aligns with) management of chronic diseases 	<ul style="list-style-type: none"> • ILT • BCHAP Director • IDP Director • Director Healthy Aging and Disability Unit • Commissioner’s Office • Sub-group represented by multiple state agencies and disciplines 	March 2009	X	X		<ul style="list-style-type: none"> • Sub-group meetings • Blueprint submitted for sign-off • Number of communities and health care sites receiving TA 	<ul style="list-style-type: none"> • Blueprint sign-off from EOHHS Secretary • Blueprint implemented in practice sites
# 5- Lead the state-wide Diabetes Disease Management Task Force	<ol style="list-style-type: none"> 1. Convene multi-agency and multi-discipline sub-group of the ILT/PIT to address the growing public health problems of Diabetes in the Commonwealth. 	<ul style="list-style-type: none"> • Statewide task force • Commissioner’s office • Program Director for DPCP 	January – December 2009 (already in progress)	X	X		<ul style="list-style-type: none"> • Sub-group meetings • Task force documents;- guidelines 	<ul style="list-style-type: none"> • Diabetes Disease Management Guidelines

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# 6- By 2010, implement Diabetes Task force recommendations and IDP activities (DPCP)	<ol style="list-style-type: none"> Continue to represent the DPCP on the Diabetes Task Force, the Task Force Planning Committee, and the Task Force Data Workgroup Support implementation of Diabetes Task Force recommendations Participate in monthly IDP meeting of the Integration Leadership Team (ILT) and the PIT. <ol style="list-style-type: none"> Work with the ILT to identify overlapping components and activities of the Diabetes Wordplay that supports integration Implement activities related to the IDP 	<ul style="list-style-type: none"> DPCP Team members 	Jan-Dec 2009	X			<ul style="list-style-type: none"> Participation in Task Force, Task Force Planning Committee, and Data Workgroup Participation in meetings of the IDP Integration activities implemented 	<ul style="list-style-type: none"> Program evaluation data and BRFSS Program evaluation data Program evaluation data
# 7 – Lead the state-wide Comprehensive Wellness Initiative in collaboration with the Statewide Wellness Advisory Committee	<ol style="list-style-type: none"> Provide a comprehensive framework for Wellness and primary prevention activities that link to activities across the EOHHS Secretariat. 	<ul style="list-style-type: none"> DPH Commissioner’s Office Director Wellness Division Wellness Division Staff Statewide Wellness Advisory Committee 	Jan-Dec 2009-	X			<ul style="list-style-type: none"> Framework developed for linking primary prevention activities to EOHHS activities 	<ul style="list-style-type: none"> Wellness Framework
# 8- Promote internal DPH programmatic goals & objectives to support Healthy Mass Compact goals of : <ul style="list-style-type: none"> ensure access to care advance health care quality contain health care costs promote individual wellness promote healthy communities 	<ol style="list-style-type: none"> Support Healthy Mass Compact by providing TA and developing programmatic goals and objectives that focus on specific components of the HealthyMass Compact. 	<ul style="list-style-type: none"> Commissioner’s Office ILT 	Ongoing				<ul style="list-style-type: none"> Progress on agreed upon indicators developed by working groups 	<ul style="list-style-type: none"> Various depending on measure

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# 9- Promote healthy communities throughout the Commonwealth	<ol style="list-style-type: none"> 1. Define parameters for what constitutes a healthy community 2. Provide TA to municipalities that demonstrate readiness to implement environmental policy changes that support healthy communities 	<ul style="list-style-type: none"> • Office of Community Liaison • ILT • IDP Director • DPH 	Jan- Dec 2009 Ongoing	X	X	X	<ul style="list-style-type: none"> • Number of communities receiving TA • Communities changes that support healthy living 	<ul style="list-style-type: none"> • Communities
# 10- Improve Massachusetts BRFSS through: <ol style="list-style-type: none"> 1. Support measurement of reach and impact of HCR 2. Develop mixed mode survey instrument 3. increase the sample, extending number of cell phone respondents 4. Conduct asthma call back survey for at least part of the survey sample 5. Oversample cities of Boston, Worcester, Lawrence, Lowell, Springfield, Fall River and New Bedford to increase number of minority respondents 	<ol style="list-style-type: none"> 1. To develop the mixed mode survey with national and state added questions 2. Expand MA sample for 2009 BRFSS (additional 7,900 state and program supported) to provide sub state estimates and expand survey scope 3. Analyze asthma call back data for 2008 4. Identify appropriate telephone exchange, verify sampling methods, conduct surveys in Spanish and Portuguese 	<ul style="list-style-type: none"> • BRFSS Team 	January 2010				<ul style="list-style-type: none"> • Completed instrument • Collected data • Data set • Monthly data sets and vendor's reports 	<ul style="list-style-type: none"> • Feedback from the testing • Data sets • Analytical results • Analysis of completeness

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# 11- Tobacco cessation 1 Create reports to educate stakeholders. 2 Work with partners to promote a comprehensive smoking cessation benefit as part of GIC coverage for state employees. (MTCP)	1. Conduct “return on investment” analysis of MassHealth and UHDDS data and prepare reports. 2. Survey major health plans in Massachusetts to determine existing benefit packages. Analyze results. Produce report. 3. Work with partners to create factsheets and PowerPoint presentations on proposed GIC smoking cessation benefit. Make presentations and support the Commissioner making presentations to key stakeholders.	<ul style="list-style-type: none"> • MTCP Staff • Tobacco Free Mass Coalition, • Commissioner 	April 2009-June 2010		X		<ul style="list-style-type: none"> • Increase % of adult smokers making evidence-based quit attempts from 36.7% (2007) to 53.4% (2015). 	<ul style="list-style-type: none"> • BRFSS
			July 2009-March 2010		X			
			July 2009-June 2010	X	X	X		
# 12- Workforce Development 1 By 2010, increase by 50% the number of primary care physicians, nurse practitioners and licensed dental professional receiving support from state loan repayment program 2 By 2014, maximize the number of health professional shortage designations (primary care, mental health and dental) allowable by HRSA definition and guidance (Division of Primary Care)	1. Release of an RFR for recruitment of identified professionals to meet recruitment goal 2. Award loans to selected candidates 3. Collaborate with HRSA to maximize the number of potential HPSA sites per regulations	<ul style="list-style-type: none"> • Division of Primary Care and Health Access 	January 2010	X			<ul style="list-style-type: none"> • RFR distributed to identified professionals • Number of Primary Care physicians, nurse practitioners and licensed dental professional • Number of loans given out 	<ul style="list-style-type: none"> • Office of Primary Care Loan Program Reports • Boards of Registration in Nursing and Medicine

Project Goal #2	Develop internal structure to strengthen the principles and programmatic needs of integration of chronic disease programs							
Long-Term Objectives:	<ol style="list-style-type: none"> 1. By 2012 Institutionalize policies and systems within DPH that facilitate program integration 2. Develop a culture and philosophy of integration within DPH by establishing operational cross-program working teams in key areas 3. Create an administrative and operational structure to sustain integration within DPH 4. By 2014, improve timeliness of data reports and provide access to data for MDPH programs, policy makers, and community members for use in policy and program development (BRFSS) 5. By 2010, 2 Diabetes indicators will be included in the core set of DPH indicators (DPCP) 							
Rationale	An efficient and effective infrastructure supporting integration within the MDPH will help drive successful IDP pilot outcomes, supporting the goal of improved quality of life for MA residents. Separating the capacity building strategies into four main categories; administrative/operations, surveillance and evaluation, health communications and training will assist in providing a comprehensive approach supporting the implementation of the IDP. Conducting an IDP strategic plan that develops a shared mission and vision within the MDPH for integration, and establishing formal mechanisms for alignment with the state's HCR agenda will provide a solid foundation for the IDP helping to create a culture and philosophy of integration, and mechanisms for institutionalizing integration within MDPH.							
Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
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# 1- Select and define the role and function of the Integration Leadership Team	<ol style="list-style-type: none"> 1. Identify an Integration Leadership Team (ILT) to lead the demonstration project. The team will be comprised of a cross-section of key areas needed for developing Massachusetts' IDP supporting CDC. The ILT team will include specialists in the following areas: <ul style="list-style-type: none"> • Implementation • Health Communication • Surveillance and Evaluation • Training • Administration/Operations • Commissioner's office representative 2. Develop roles, functions, responsibilities and commitment required for the ILT members 	<ul style="list-style-type: none"> • Commissioner's Office • IDP Project Director • Chronic Disease Programs 	Jan – June 2009	X	X		<ul style="list-style-type: none"> • Integration Leadership Team formed • Roles and Functions are developed and written 	<ul style="list-style-type: none"> • Meeting minutes • Participant List of participation • Project documents

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# 2-Develop a comprehensive strategic plan for IDP	<ol style="list-style-type: none"> The ILT based on the Integration Community Approach Model will develop a comprehensive strategic plan for the IDP that includes; <ul style="list-style-type: none"> Developing a shared Mission and Vision supported by goals and objectives Developing a timeline of critical success activities leading to implementation by July 2010 Identifying strengths and weaknesses within MDPH for implementation of a successful IDP Outlining the evaluation process to include the CDC's indicators for the IDP pilot Identify, re-design and develop as needed supervision structures, administration mechanisms supporting the IDP. 	<ul style="list-style-type: none"> IDP Director ILT Other programmatic specialist(s) BCHAP Bureau Director and Deputy Director Commissioner's Office 	Jan-June 2009	X	X		<ul style="list-style-type: none"> Strengths and weaknesses identified Policies developed as needed to support IDP Participation in discussions with CDC's IDP team's evaluation Process Roles and Functions are developed and written 	<ul style="list-style-type: none"> Project documents Organizational chart(s) Strategic Plan IDP Mission and Vision Written Roles and Responsibility
# 3- Select and define the role and function of the Project Implementation Team	<ol style="list-style-type: none"> Identify a Project Implementation Team (PIT) based on needed areas of expertise and programs involved to support the IDP. Team should include: <ul style="list-style-type: none"> Implementations Specialist Municipal Sector Specialist Social Services Specialist Healthcare Sector Specialist Worksite Specialist Surveillance and Evaluation Specialist Program Director(s) Develop the roles and functions, responsibilities and commitment of the PIT through team meetings, discussions and developing a shared vision for the IDP. 	<ul style="list-style-type: none"> IDP Director ILT Team Commissioner's Office BCHAP Director and Deputy Director 	Jan - June 2009	X	X		<ul style="list-style-type: none"> PIT formed Roles and functions are developed and written 	<ul style="list-style-type: none"> PIT Membership Project documents

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# 4- Conduct a detailed gap analysis of the four technical areas supporting an integrated model	<p>1 The ILT and the PIT will inventory and evaluate the four technical areas for <u>current level</u> of functioning and ability to support the IDP against <u>desired level</u>, and identify strategies to move from current to desired level in the following five technical areas:</p> <ul style="list-style-type: none"> • Administrative/operational • Surveillance & evaluation • Health communications • Training 	<ul style="list-style-type: none"> • IDP Director • ILT Team • PIT • Other leadership as needed 	Jan – June 2009	X	X		<ul style="list-style-type: none"> • Gap Analysis conducted looking at current level vs. desired level of functioning 	<ul style="list-style-type: none"> • Gap Analysis document outlining strategies for change
ADMINISTRATIVE/OPERATIONAL								
# 5- Inventory all existing funding opportunities external and internal to DPH	<p>The PIT and ILT will identify a task force to inventory the different funding that is currently available.</p> <p>1. External refers to community funding that is not DPH funded and supports IDP activities. Particular focus will be on funding that supports chronic diseases, program development, and integration as a component of</p> <p>2. Working with the Director Grants and Development <i>the</i> sub-group will identify other funding opportunities.</p>	<ul style="list-style-type: none"> • IDP Director • ILT Team • PIT Team • Task Force • Director Grants and Development 	March – June 2009 and ongoing	X	X		<ul style="list-style-type: none"> • Inventory List Generated • Other funding opportunities ID 	<ul style="list-style-type: none"> • Current Funding • Inventory • Project document
# 6- Improve processes with CDC's PGO	<p>1. Form an administrative task force (ATF) to work with the CDC to improve the processes and communication with the PGO using the gap analysis model of looking at current processes against desired and identifying steps to achieve desired outcomes.</p>	<ul style="list-style-type: none"> • IDP Director • CDC representatives • ATF 	Jan – Dec 2009	X	X		<ul style="list-style-type: none"> • ATF participation 	<ul style="list-style-type: none"> • Meeting minutes • Project documents

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
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# 7-Improve support with POS and A&F:	1. Using a gap analysis model of measuring current processes against desired, followed with identifying steps to achieve desired outcomes, the ILT and the ATF will focus on improving internal working communications and processes. For example: joint funding opportunities, grant submissions, including opportunities that support CLAS, ADA.	<ul style="list-style-type: none"> • IDP Director • ILT • A & F • POS • ATF 	Jan- Dec 2009	X	X		<ul style="list-style-type: none"> • Identified POS and A&F supports • Documented policy and procedure changes 	<ul style="list-style-type: none"> • Project documents • Policies and Procedures
# 8- Restructure interactions with statewide stakeholders to support integration goals and objectives	1. Establish a partnership with statewide stakeholders for integration and garner support for the IDP project Example of organizations: <ul style="list-style-type: none"> • Massachusetts League for Community Health Centers • Neighborhood Community Centers, such as community based agencies providing social services or health care • Public and private organizations- BCBS, Harvard Pilgrim • Professional bodies- American Cancer Association 	<ul style="list-style-type: none"> • Commissioner • IDP Director • BCHAP Director and Deputy Director • ILT • PIT 	March –Sept 2009	X	X		<ul style="list-style-type: none"> • Revised agendas focused less on categorical programs activities and more on integration of program design, goals and objectives 	<ul style="list-style-type: none"> • Action plans with follow-up activities • Reports back to team meetings outlining actions and number of activities that reflect cross-departmental/pro gram actions

SURVEILLANCE AND EVALUATION

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
<p># 9-Develop a core set of indicators to be monitored annually by MDPH.</p>	<p>Identify common data elements for monitoring and evaluation.</p> <ol style="list-style-type: none"> 1. Convene workgroup with staff from BRFSS, relevant chronic diseases, and staff from other surveillance systems. 2. Identify core indicators necessary for comprehensive chronic disease surveillance, monitoring, and evaluation. 3. Solicit upper-level buy-in for annual funding. 4. Develop a template, analysis plan, and distribution plan for an annual integrated chronic disease data brief, summary, or report. 	<ul style="list-style-type: none"> • Commissioner’s Office • IDP Director • Evaluators • Program Directors 	<p>Jan 2009 – Dec 2009</p>	<p>X</p>	<p>X</p>		<ul style="list-style-type: none"> • Workgroup convened • Core indicators identified • Upper-level buy-in supported through clear funding guidance and process • Template and plans developed 	<ul style="list-style-type: none"> • Internal documents (meeting minutes, agendas)
<p># 10- Systematize MDPH data requirements for external funding recipients</p>	<ol style="list-style-type: none"> 1. Convene a workgroup – identify relevant members and hold meetings. 2. Work with PGO to understand data collection requirements of existing grants, etc. to external venues. 3. Inventory current MDPH requirements for existing funding recipients. 4. Identify the overlapping data requirements. 5. Develop a standard operating procedure for streamlining existing and future data collection requirements. 	<ul style="list-style-type: none"> • Evaluators and relevant staff from PGO and MDPH programs • BRFSS staff 	<p>Jan 2009 – Dec 2009</p>	<p>X</p>	<p>X</p>		<ul style="list-style-type: none"> • Workgroup convened • Comprehensive inventory completed • Overlaps identified • SOP developed 	<ul style="list-style-type: none"> • Internal documents (meeting minutes, agendas) • Inventory • SOP

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
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# 11-Develop a baseline data collection and analysis plan for Integration Demonstration Project activities	<ol style="list-style-type: none"> 1. Convene a sub-group with BRFSS and evaluators. 2. Determine a core set of BRFSS questions needed to monitor and evaluate IDP outcomes. 3. Create a plan to administer a BRFSS-like survey in select pilot communities. 	<ul style="list-style-type: none"> • BRFSS staff and evaluators • ILT 	Jan 2009 – Dec 2009	X	X		<ul style="list-style-type: none"> • Workgroup convened • Core questions identified • Plan created 	<ul style="list-style-type: none"> • Internal documents (meeting minutes, agendas) • Plan
# 12-Create an IDP Evaluation Plan	<ol style="list-style-type: none"> 1. Convene a workgroup of evaluators and ILT. 2. Using the logic model, develop a comprehensive IDP evaluation plan. 	<ul style="list-style-type: none"> • Evaluators and ILT 	Jan 2009 – Mar 2009	X	X		<ul style="list-style-type: none"> • Workgroup convened • Completed Evaluation Plan 	<ul style="list-style-type: none"> • Internal documents • Evaluation Plan
# 13- By 2010, collaborate with the Surveillance and Evaluation focus area of the IDP to share knowledge and expertise around diabetes data elements and surveillance mechanisms (DPCP)	<ol style="list-style-type: none"> 1. Work with the IDP Evaluator, IDP ILT and the PIT to develop a core set of indicators for monitoring and evaluation 2. Assist in the development of the evaluation plan and evolution of the logic model for the IDP 	<ul style="list-style-type: none"> • DPCP Evaluator • IDP Evaluator 	Jan 2010	X	X		<ul style="list-style-type: none"> • Core set of indicators identified • Evaluation plan developed and Logic Model finalized 	<ul style="list-style-type: none"> • Indicator list • Evaluation Plan and Logic Model

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<p># 14- Data</p> <p>1- Provide MDPH programs with preliminary data set on first 6 months of BRFSS 2009 data by 9/09;</p> <p>2- Prepare annual data set and summary report for 2009 BRFSS data by 12/09 and distribute to MDPH programs, state officials, community organizations, local health departments and other institutions;</p> <p>3- Submit BRFSS 2008 data to MassCHIP (Mass Community Health Information Profile), a publicly accessible online health data system, by Feb 2009;</p> <p>4- Respond to individual requests for data analysis made throughout the year within 4 weeks from date requested.</p> <p>(BRFSS)</p>	<ol style="list-style-type: none"> 1. Create and analyze 6 months weighted dataset and share with MDPH programs 2. Determine focus of report and inclusion of new sections based on variables included in 2008 questionnaire 3. Solicit program input on how to tailor the report sections to suit programmatic needs 4. Analyze data and determine trends 5. Submit 2008 data set to publicly used system for utilization and sharing 6. Maintain relationships with programs through BRFSS Work Group 7. Maintain Knowledge of various program activities and reports related to BRFSS 	<ul style="list-style-type: none"> • BRFSS • BRFSS Working Group 	Jan-Dec 2009	X	X		<ul style="list-style-type: none"> • Weighted BRFSS SAS data set 	<ul style="list-style-type: none"> • Results of analysis • Completed report • Score of users • Score of filled data requests (number and timeliness)

Health Communication								
Program Goal Area(s):	IDP will maximize organizational capacity to achieve optimal health communication							
Long-Term Objectives:	<p>1. By 2014, health communication for all Massachusetts residents will consistently incorporate the following attributes as outlined by Healthy People 2010: accuracy, availability, balance, consistency, cultural competence, evidence-base, reach, reliability, repetition, timeliness and understandability.</p> <p>2. By 2014, IDP health communication will consistently incorporate the principles of social marketing, employ sound public relations strategies, and utilize all available communication channels and technologies to deliver audience-specific and relevant communication messages.</p>							
Rationale:	<p>1-Opportunities exist to optimize health message delivery, but, with multiple communication activities and campaigns, systems must be built or enhanced to maximize existing synergies, ensuring quality and consistency with every message delivered, while avoiding information overload or competing message. For example, the Diabetes Prevention and Control Program and the MA Tobacco Control Program have vital and important communication efforts addressing their respective areas. Also within our integration focus, all the other units, including Heart Disease and Stroke, Comprehensive Cancer Prevention and Control, Obesity Prevention and Control, Asthma Prevention and Control, the Offices of Healthy Aging and Disability, and the Women’s and Men’s Health Programs rely on health communication to address many of their goals.</p> <p>2- IDP will maximize organizational capacity to achieve optimal health communication providing Massachusetts residents accessible, accurate, relevant, and timely health information and communication interventions to protect and promote their health and the health of their families and communities through increased knowledge of social marketing, health literacy, plain language, and cultural/ethnic communication competency, utilizing evidence-based health communication/social marketing practice. Although MA is geographically a small state, its population is increasingly diverse with its at risk populations shifting over time. Internal capacity must be built to appropriately identify priority audiences, develop appropriate messaging and delivery mechanisms and evaluate communication campaigns and strategies.</p>							
Objectives	Strategies	Staff (Programs Involved) and Partners	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 15- Develop a internal health communication and messaging process within DPH	1. An internal communication team will be convened, meeting monthly.	<ul style="list-style-type: none"> DHPDP Health Communication Director MTCP Communication Manager Heart Disease and Stroke Communication Specialist A communication lead from each of the integrating units/programs, where no communication specialist exist Commissioner’s Health Communications staff 	Month 1	X	X		<ul style="list-style-type: none"> Convened meetings Processes implemented Identified mechanism for coordinated communication 	<ul style="list-style-type: none"> Meeting Minutes Communication Staff Quality controlled documents Calendar tracing tool
	2. Existing quality control review processes will be examined and refined for implementation across all programs and offices within the IDP. This review process will adhere to all departmental communication policy standards.		3-6 months					
	3. An IDP communication calendar will be incorporated as a mechanism for optimizing communication delivery.		3-6 months					
	4. Consolidate messages to support integration							

Objectives	Strategies	Staff (Programs Involved) and Partners	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 16 -By 2010, health communication staff's expertise in all areas of communication is expanded through internally provided training, funder-provided workshops and conferences (such as CDC mandatory trainings) and other opportunities available.	1. All program managers will be introduced to social marketing utilizing tools developed by RWJ.	<ul style="list-style-type: none"> DHPDP Health Communication Director MTCP Communication Manager Heart Disease and Stroke Communication Specialist Health Communications Team Other Departmental Staff with expertise in the areas described above Contracted vendors 	1-3 months	X	X		<ul style="list-style-type: none"> Social Marketing for Managers will be provided. "CDCynergy" sessions will be conducted. Training sessions will be held, on-line seminars or workshops offered, non-departmental training opportunities will be attended. 	<ul style="list-style-type: none"> Social Marketing for Managers PowerPoint and attendance list. Attendance list Verification of attendance will be provided.
	2. "CDCynergy" will be introduced to all health communication staff and others who lead communications for their units/programs.		3-6 months					
	3. Trainings will be provided on utilizing data for developing communication/ social marketing strategies, media advocacy, public relations, evaluation for communication campaigns, health literacy, cultural competency for communications, employing new technologies, and others.		6-12 months, then ongoing					

TRAINING								
Program Goal Area	IDP will maximize organizational capacity to achieve optimal and coordinated trainings							
Long-Term Objectives:	By 2014, all trainings will be coordinated, attention given to the social determinants of health, and have a competency-based component when appropriate.							
Rationale:	Forming a Training Sub-group of the ILT and PIT teams will serve in the role of overseeing and coordinating training development and activities and help to standardize trainings with evidence-based curriculums. The Sup-group will be a resource for the categorical programs and will assist in convening joint planning sessions directed at building DPH's capacity for integrated training for the IDP pilot and all future training needs.							
Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 17-Form a training sub-group to lead coordinated trainings and support and oversee and quality trainings	1. Determine the Training Sub-group membership	<ul style="list-style-type: none"> BCHAP Bureau Director IDP Director ILT PIT 	March 2009	X	X		<ul style="list-style-type: none"> Sub-group meetings 	<ul style="list-style-type: none"> Sub-group
# 18-Increase training expertise and capacity within IDP Pilot Sites and within DPH	1. The sub-group will oversee the development of trainings by providing TA for DPH and supporting the community pilot sites, such as: <ul style="list-style-type: none"> Development of trainings to improve skills within DPH that can be transferred to the community and utilizes the principles of adult learning, cultural and linguistic diversity, the social determinants of health, and working with an audience/participants with different or multiple chronic diseases. Identify a group of community/health care site instructors within the pilot sites to increase training skills and build capacity. 	<ul style="list-style-type: none"> Training Sub-Group ILT PIT Program leadership 	Ongoing	X	X		<ul style="list-style-type: none"> Trainings held Post trainings skills and competencies and evolutions completed 	<ul style="list-style-type: none"> ITS (DPH's Information Tracking System0
#19- Enhanced Workforce Development (HADU)	2. Conduct Academic Detailing, create centers of excellence to manage implementation of evidence-based programs (HADU) 3. Establish funding stream to support community health worker training and network to deliver CDSMP (HADU)							

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 20-Develop coordinated curriculums and consolidate identified trainings	1. Inventory existing curriculums and trainings and assess for overlaps and areas where improved coordination could occur to prevent redundancies with pilot site trainers and DPH Program Directors.	<ul style="list-style-type: none"> • ILT • PIT • Training Sub-group 	<ul style="list-style-type: none"> • April- June 2009 		X		<ul style="list-style-type: none"> • Inventory of curriculums completed • Redundancies in trainings reduced 	<ul style="list-style-type: none"> • Curriculums • Overlaps identified
# 21-Develop comprehensive trainings and curriculums	<p>1. Sub-group in conjunction with other members of the PIT and program directors identify gaps with current training curriculums.</p> <ul style="list-style-type: none"> • Develop strategies for shared resources focused on comprehensive trainings • Develop a coordinated process for creating/refining comprehensive chronic disease curriculums (toolkits, training modules, evidence-based system changes) and the development of guidelines for health care providers at various settings (school-based health centers, health care sites, hospitals, worksite-based health centers, etc.) 	<ul style="list-style-type: none"> • Training Sub-group • PIT • Identified Program Directors 	<ul style="list-style-type: none"> • April – December 2009 		X		<ul style="list-style-type: none"> • Gap and resources identified • Comprehensive Chronic Disease Curriculum • Policies and Procedures disseminated 	<ul style="list-style-type: none"> • Comprehensive trainings • Comprehensive Chronic Disease trainings • ITS Meeting Minutes
# 22-Reduce the cost of trainings through consolidating trainings sessions	1. Develop process, policies and procedures for a consolidated trainings session to accommodate a wider-audience in which to capitalize on training resources.	<ul style="list-style-type: none"> • Training Sub-group • ILT • BCHAP Director and Deputy Director 	<ul style="list-style-type: none"> • Ongoing 	X	X		<ul style="list-style-type: none"> • Policies and Procedures developed for consolidated trainings 	<ul style="list-style-type: none"> • Consolidated trainings

Project Goal #3	Develop and implement a comprehensive community approach supporting the prevention and improved management of chronic disease.
Long-Term Objectives:	<ol style="list-style-type: none"> 1. By 2014, (1) increase the percentage of people who have been told they have Prediabetes or borderline diabetes from 5.4% (2007, BRFSS [CDC's prediabetes awareness question]) to the NHANES National Estimates of 25.0% and (2) increase by 20% the percentage of people who self-reported they had a screening for diabetes within the past 3 years from 55.1% to 66.1% (2005, BRFSS). (DPCP) 2. By 2014, increase the number of schools that offer curriculums on healthy lifestyle that include diabetes prevention (no baseline data available). 3. By 2014, all 35 core WHN/MHP sites will utilize the Prediabetes Risk-Reduction Toolkit. (DPCP) 4. By 2014, all Community Health Workers (CHWs) will have access to the expanded CHW chronic disease prevention and management training (no baseline data available). (DPCP) 5. By 2014, increase by 10% the number of diabetes self-management education (DSME) programs in safety net site communities (there are currently 96 ADA recognized diabetes self-management education programs statewide). (DPCP) 6. By 2014 increase by 10% the proportion of adults with diabetes who self-report (DPCP) 7. By 2014, decrease by 10% the proportion of adults with diabetes who are overweight/obese from 75.6% to 68.0% (2007, BRFSS age-adjusted). (DPCP) 8. By 2014, increase by 10% the proportion of adults with diabetes who report engaging in regular physical activity from 65.3% to 71.8% (2007, BRFSS) y 2014, expand communication and collaboration with MDPH programs in order to include and report on targeted health topics and emerging health issues. (BRFSS) 9. By 2015, all hospitals and community health centers (CHC) will have implemented systems that support tobacco use screening and interventions and established performance standards consistent with national guidelines. (MTCP) 10. By 2015, secondhand smoke exposure on employees and the general public will be reduced due to municipalities strengthening local regulations to eliminate the current exemptions in the state law (MTCP) 11. By 2015, increase Massachusetts residents' knowledge and use of effective evidenced-based tobacco cessation methods. (Tobacco) 12. By 2015, increase Quitworks referrals to at least 7,500 per year. (MTCP) 13. By 2015, promote voluntary smoke-free housing by expanding MTCP landlord education program from two pilots to the entire Commonwealth. (MTCP) 14. By 2014, increase the number of municipalities that make positive changes to their built environment and/or food environment to support healthy community design and healthy food environments to address chronic disease prevention and health promotion (Baseline to be determined). (Healthy Communities) 15. By 2014, 35 Massachusetts communities will meet the definition of a healthy community (Healthy Communities) 16. TARGETED REGIONAL STRATEGY: Reduce asthma hospitalizations by 9% in three priority regions that have asthma hospitalization rates greater than the statewide average using strategies in the State Asthma Plan (APCP) 17. PREVENTION: Reduce asthma exposures in homes, childcare settings, schools and work places (APCP) 18. By 2014 increase by 50% the number of people with diabetes who have had all four preventive measures (at least 2 HbA1cs, foot exam for numbness or loss of feeling, eye exam, and flu vaccine) from 17>9% to 26.9% (DPCP)
Rationale	An Integrated Community Approach Model lays the ground work to have several communities (network) trained in the skills necessary to have a healthy community, focused on preventing chronic diseases and caring for citizens. The foundation for a healthy community is creating an environmental system that affords access to physical activity venues and healthy nutrition with strong linkages and referral processes between health care sites and community services.

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
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# 1- Define the Integrated Community Approach Model.	<ol style="list-style-type: none"> The ILT, PIT will work together with external partners and community members to define the MDPH's Integration Community Approach Model based on CDC's intended indicators, Massachusetts state-wide multiple initiatives for health care reform, and current care coordination activities within the MDPH. Work with the Office of Community Liaison to including healthy community criterion for the <u>Integrated</u> Community Model. 	<ul style="list-style-type: none"> IDP Director BCHAP Director & Deputy Director ILT PIT Community members such as, Neighborhood Development Corporations, Massachusetts League for Community Health Centers, Councils on Aging, American Diabetes Associations DPH's Office of Community Liaison 	Jan- Dec 2009	X	X		<ul style="list-style-type: none"> Integrated Community Approach model defined 	<ul style="list-style-type: none"> Integrated Community approach report
# 2-Define the Criteria for participating in IDP Pilot:	<ol style="list-style-type: none"> The ILT and PIT with the Office of Community Liaison will set criteria for participating in the IDP pilot, identifying the minimum required elements and resources necessary for a community or a health care site to participate, such as the ability to: <ul style="list-style-type: none"> Incorporate recommendations from state wide initiatives into practice and or community venues Support chronic disease management Build community relationships and partnerships promoting disease management and risk reduction Collect data Garner leadership and commitment with health care sites and community leaders Provide access to Chronic Disease Self-Management programs Serve disparate populations Develop a referral bank Provide access to risk reduction activities Utilize the Office of Community Liaison's expertise with identifying built environment needs 	<ul style="list-style-type: none"> IDP Director BCHAP Director and Deputy Director ILT Team PIT Team Office of Community Liaison BCHAP Division Directors; such as, Primary Care, Violence Prevention, Wellness Division 	Jan- Dec 2009	X	X		<ul style="list-style-type: none"> Participation criteria defined 	<ul style="list-style-type: none"> IDP Participation Criteria report

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 3-Develop or select existing assessment tool for participating in IDP based on the criteria developed	1. A task force comprised of ILT and PIT members will work with evaluators and Community Liaison Director to select or re-design an existing tool or design a new assessment tool to measure the potential pilot sites against for participation in IDP based on criteria developed.	<ul style="list-style-type: none"> • IDP Director • ILT • PIT • Evaluators • Community Liaison Director 	Dec 2009	X	X		<ul style="list-style-type: none"> • Assessment Tool chosen or designed 	<ul style="list-style-type: none"> • Assessment Tool
# 4-Inventory and gather data/ information about current care coordination program activities that exist in the communities	<ol style="list-style-type: none"> 1. Canvas the different communities gathering data about the current care coordination program models. 2. Assess and evaluate program elements for potential inclusion into the criteria being developed for participating in IDP. 3. Utilize tools developed by the PIT with input from the Office of Community Liaison to assess community programs. 	<ul style="list-style-type: none"> • ILT Team • PIT Team • Office of Community Liaison Director/Representative • Identified Community Leaders 	Jan- June 2009	X		X	<ul style="list-style-type: none"> • Sites Identified and Sites visited • Assessment tool(s) used to evaluate community program elements 	<ul style="list-style-type: none"> • Reports documents of visit(s) and findings • Assessment tool(s)
# 5-Administer the Integrated Community Assessment tool	<ol style="list-style-type: none"> 1. The ILT, PIT, and the Office of Community Liaison will determine potential sites based on a community's interest to participate, and their ability to meet the developed criteria. Interest and ability to meet criteria will serve as a proxy for "readiness" to adopt an integrated approach to participate in the IDP pilot. 2. Assessment tool is administered to interested communities. 	<ul style="list-style-type: none"> • ILT • PIT • Office of Community Liaison 	Jan- March 2010	X	X		<ul style="list-style-type: none"> • Assessment Tool administered 	<ul style="list-style-type: none"> • Assessment Tool
# 6-Develop an RFR/RFI for identified communities to designate pilot sites.	1. The ILT will develop an RFR or RFI to be distributed to the communities that have been deemed candidates for the IDP pilot. Potential language to include: a community's ability to philosophically and environmentally support in alignment with the mission, vision, goals and objectives of the IDP project.	<ul style="list-style-type: none"> • BCHAP Director and Deputy Director • IDP Director • ILT • Director of Grants and Development 	September-December 2009				<ul style="list-style-type: none"> • RFR developed 	<ul style="list-style-type: none"> • RFR

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
<p># 7-Investigate areas of resource sharing within the categorical programs</p> <p># 8-Utilize categorical work plans to identify integration activities (BRFSS, Diabetes, Comp Cancer, Heart & Stroke, Tobacco, Obesity, Healthy Communities)</p>	<p>1. The PIT will work with the categorical program directors to identify areas of resource sharing based on categorical work plan goals, objectives and activities. The focus will be on:</p> <ul style="list-style-type: none"> • Activities that cut across the programs • Activities that are targeting similar populations • Activities that are in same communities or targeting the same community resources • Potential joint communications and marketing • Joint trainings • Developing joint program goals and objectives. 	<ul style="list-style-type: none"> • IDP Director • PIT • ILT 	March – June 2009	X	X		<ul style="list-style-type: none"> • Categorical overlapping initiatives identified 	<ul style="list-style-type: none"> • Project documents; work plans,
<p># 9-By 2010, publish a chronic disease and risk factors data summary brief based on NHANES and BRFSS (DPCP)</p>	<p>1. With feedback from other chronic disease programs, BRFSS staff and NHANES staff, refine proposal according to specifications and feedback</p> <p>2. Submit 1 integrated chronic disease data proposal for NHANES state-level estimates</p> <p>3. Draft a chronic disease and risk factors data summary brief analyzing the NHANES data results and the corresponding BRFSS results</p>	<ul style="list-style-type: none"> • DPCP Team members • MTCP, APCP, HD&S, NPAU, OHA/HD and BRFSS 	Jan 2010	X	X		<ul style="list-style-type: none"> • Completed data proposal • Submitted proposal • Drafted data summary brief • Finalized data summary brief 	<ul style="list-style-type: none"> • Program evaluation data • Proposal • NHANES and BRFSS • NHANES and BRFSS

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 10 Implement evidenced-based health promotion programs to enable people with chronic disease to better manage their health care and prevent secondary conditions (HADU)	<ol style="list-style-type: none"> 1. Build health care and community capacity to deliver Chronic Disease Self-Management 2. Provide technical assistant to link health care providers and community organizations to implement CDSMP 3. Build a statewide network to deliver CDSMP by partnering with EOHHS agencies 4. Reach diverse populations with capacity to deliver CDSMP in English, Spanish, and Chinese 5. Evaluate outcomes and cost savings 	<ul style="list-style-type: none"> • Program Director, Healthy Aging Disability Unit • HADU Team 	2009-2011 Ongoing	X			<ul style="list-style-type: none"> • # of CDSMP programs offered statewide and analysis of reach • Organizational readiness evaluations and response • GIS mapping • List of leaders delivering CDSM • Demographic data and evaluation analysis 	<ul style="list-style-type: none"> • Communities • Statewide Network • EOHHS Agencies • Diverse populations participation • Cost of CDSMP
# 11- 1 Continue to play an active role in CDC initiatives such as pilot projects and development of multimode survey design; 2 Maintain open dialogue with other states about BRFSS activities; 3 Permanently share and exchange the information with other DPH programs; 4 Be alert about emerging state or national health concerns. (BRFSS)	<ol style="list-style-type: none"> 1. Continue to attend annual BRFSS conference, workshops and training 2. Implement Fruits and Vegetables pilot survey in one split in 2009 3. Keep up-to-date on national BRFSS research as cited in MMWR and other publications 4. Maintain communication with other states over involvement in pilot projects, workgroups, and research initiatives as applicable 5. Hold monthly BRFSS interdepartmental working group meetings and external quarterly advisory Committee meetings 6. Perform analysis on department priorities and health disparities for commissioner's office 	<ul style="list-style-type: none"> • BRFSS 	Ongoing	X	X		<ul style="list-style-type: none"> • Initiatives undertaken/ methods learned and implemented as result of training/ conference • /workshop • Results of the analysis, monthly reports on response rates from SRBI • Articles downloaded/ read by staff • Resulting research initiatives/ collaboration undertaken • Resulting changes in the survey planning and data analysis • Feedback 	<ul style="list-style-type: none"> • CDC training materials • BRFSS SAS data set, SRBI monthly reports • MMWR, CDC, relevant public health • publications • BRFSS data from MA and other states • Resulting surveys and analytical reports • Resulting analysis

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
<p># 12 -By 2010, contribute to the training component of the IDP by: (1) identifying an evidence-based healthy lifestyle curriculum that includes diabetes prevention for implementation at schools, (2) expanding the current WHN/MHP Healthy Heart Program to include Prediabetes Risk Reduction, and (3) expanding the existing CHW core curriculum to include chronic disease prevention and management (Primary Care)</p>	<ol style="list-style-type: none"> Collaborate with NPAU to identify educational opportunities (i.e., existing curriculums, trainings and tools) for children in schools on healthy lifestyle choices to prevent diabetes <ul style="list-style-type: none"> Determine baseline number of schools offering curriculums Collaborate with WHN/MHP and MTCP to develop a Prediabetes Risk-Reduction Toolkit as part of the Healthy Heart Program at safety net sites <ul style="list-style-type: none"> Pilot the toolkit Incorporate evaluation feedback into refined toolkit Collaborate with the Office of Primary Care and Health Outreach, the Outreach Worker Training Institute of Worcester, Community Health Education Center and MTCP <ul style="list-style-type: none"> Develop a CHW training on chronic disease prevention and management, including diabetes, Prediabetes and tobacco Support the training component of the IDP by identifying and developing curricula and providing comprehensive training in relevant skills 	<ul style="list-style-type: none"> DPCP NPAU WHN/MHP, MTCP HADU Office of Primary Care and Health Access, Outreach Worker Training Institute of Worcester, Community Health Education Center, WHN/MHP MTCP 	<p>Jan –Dec 2009 June 09- Dec 2010</p>	X	X		<ul style="list-style-type: none"> Identified educational component Baseline number of schools determined Toolkit developed Curriculum developed Trainings conducted 	<ul style="list-style-type: none"> Program evaluation data Toolkit Curriculum Training evaluation forms

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 13- By 2010, develop a protocol for identifying patients with Prediabetes and diabetes for referral into community-based interventions (DPCP)	<ol style="list-style-type: none"> Collaborate with Healthy Communities, OHA/HD, WHN/MHP, and MTCP to facilitate transition of care: <ul style="list-style-type: none"> Conduct an inventory of community-based DSME, CDSM and lifestyle intervention programs in WHN/MHP catchment areas Assist in the development of referral mechanisms at WHN/MHP safety net sites to link patients with prediabetes and diabetes to community- based interventions Identify 4 communities for training in lifestyle-based interventions Continue to work with the DPH Wellness Division (which includes Worksite Wellness) and regional worksite collaborative by providing technical assistance and education to develop worksites' capacity to implement policy and systems changes for diabetes and GDM prevention and management 	<ul style="list-style-type: none"> DPCP Healthy Communities, NPAU, OHA/HD, WHN/MHP, Wellness Division (Worksite Wellness), ESHS, MTCP DPCP Healthy Communities, Wellness Division 	Jan –Dec 2009	X	X		<ul style="list-style-type: none"> Completed inventory Identified referral mechanisms Communities identified Technical assistance provided 	<ul style="list-style-type: none"> Referral procedures Inventory

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
<p># 14-</p> <p>1 Document information on promising practices</p> <p>2 Survey hospitals and CHCs to assess current implementation</p> <p>3 Future MTCP funding for hospitals and CHCs projects will be prioritized according to the existence of recommended infrastructure (electronic medical records). (MTCP)</p>	<ol style="list-style-type: none"> 1. Document and disseminate promising practices gained from MTCP-funded hospital, CHC sites, and other health care organizations. 2. Develop survey instrument for hospitals and CHCs to assess level of implementation of recommendations on tobacco use screening and interventions. 3. Develop RFRs with stakeholder input to increase use of PHS guidelines utilizing electronic medical records. 4. Fund and manage approx. 12 programs 	<p>MTCP Staff UMass Medical School</p>	<p>April 09- September 09</p> <p>July 09-June 10</p>	X	X		<ul style="list-style-type: none"> • Increase % of adult smokers making evidence-based quit attempts from 36.7% (2007) to 53.4% (2015). • Increase % of smokers 18-64 who have used the MassHealth cessation benefit from 23% (2007) to 35% (2015). 	<ul style="list-style-type: none"> • BRFSS • MassHealth data
<p># 15- Provide technical assistance, training and web-based tools (MTCP)</p>	<ol style="list-style-type: none"> 1. Provide information to Boards of Health regarding hookah use and the development of hookah bars in Massachusetts. 2. Create technical assistance, training and web-based tools to strengthen local regulations and local housing authorities (LHAs) 	<ul style="list-style-type: none"> • MTCP, MMA, MHOA, MAHB • MMA, MHOA, MAHB 	<p>April 09- June 2010</p> <p>April 09- June 2010</p>	X	X		<ul style="list-style-type: none"> • Number of local municipal regulations stronger than the smoke-free workplace law (MTCP) will increase from 101 (2008) to 129 (2015) 	<ul style="list-style-type: none"> • MTCP ordinance database
<p># 16 -Expand QuitWorks use (MTCP)</p>	<ol style="list-style-type: none"> 1. Conduct quality assurance projects to improve QuitWorks. 2. Promote QuitWorks as a cessation resource for chronic disease management for organizations and practitioners treating patients for heart disease, stroke, diabetes, cancer and asthma. 3. Expand QuitWorks by promoting it to health care organizations and provider specialties that have not previously utilized QuitWorks. 	<ul style="list-style-type: none"> • MTCP Staff, JSI • UMass Medical School, JSI Quitline, DPH Chronic Disease Programs • UMass Medical School, JSI Quitline 	<p>April 09- June 2010</p> <p>April 09- June 2010</p> <p>April 09- June 2010</p>	X	X	X	<ul style="list-style-type: none"> • Increase the number of self-referred and physician connected fax referrals to the Massachusetts Quitline from 20,000 (FY 08) to 50,000 (FY 15). 	<ul style="list-style-type: none"> • JSI quitline data

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 17- Create partnerships and resources for voluntary smoke-free housing (MTCP)	1. Document successes and challenges in two current pilot areas.	<ul style="list-style-type: none"> Public Health Institute at Northeastern Law School MMA, DPH Asthma Program 	April 09-June 2010	X	X		<ul style="list-style-type: none"> Decrease the percentage of non-smoking adults who report exposure to secondhand smoke in the home from 4.7 % (2007) to 3.2 % (2015). Decrease the percentage of children who have exposure to secondhand smoke in the home from 14 % (2007) to 9.1% (2015). 	<ul style="list-style-type: none"> BRFSS BRFSS
	2. Collaborate with Mass Rental Housing Association, realtor associations, condo associations and legal professionals to educate landlords on smoke-free housing options.		April 09-June 2010					
	3. Gather information on how other states have promoted smoke-free housing incentives.		July 09-December 09					
	4. Develop the business case for providing smoke-free housing incentives.		January 10-June 10					

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 18- Tobacco Cessation 1 Coordinate free nicotine patch give-away to specific communities to promote quit attempts. 2 Provide information on evidence-based smoking cessation methods. (MTCP)	1. Conduct community interventions to promote free nicotine patch give-away to specific communities. In FY 10 – anticipate 14,000 calls to quitline from free patch give-away promotions.	<ul style="list-style-type: none"> Tobacco Staff, JSI quitline, JSI capacity building contract, Causemedia, Tobacco Staff, JSI quitline 	July 2009- June 2010	X	X		<ul style="list-style-type: none"> Increase the number of self-referred and physician connected fax referrals to the Massachusetts Quitline from 20,000 (FY 08) to 50,000 (FY 15). 	<ul style="list-style-type: none"> JSI quitline data
	2. Conduct communications interventions to promote free nicotine patch give-away to specific communities.	<ul style="list-style-type: none"> Tobacco Staff, JSI quitline 	July 2009- June 2010					
	3. Develop strategies to link chronic disease management programs for diabetes and cardiovascular disease to the quitline.	<ul style="list-style-type: none"> Tobacco Staff, The Medical Foundation 	July 2009-June 2010				<ul style="list-style-type: none"> Increase % of adult smokers making evidence-based quit attempts from 36.7% (2007) to 53.4% (2015). 	<ul style="list-style-type: none"> BRFSS
	4. Partner with DPH Diabetes Program and partners including the MA League of Community Health Centers to develop recommendations for integrating the applicable sections of the diabetes guidelines and clinical guidelines for treating tobacco use.	<ul style="list-style-type: none"> Tobacco Staff Tobacco staff, JSI quitline DPH Communication Division, Tobacco Staff 	July 2009- June 2010					
	5. Provide information on evidence-based smoking cessation methods on www.malesmokinghistory.org .		April 2009- June 2010					
	6. Create culturally appropriate adaptation of Key smoking cessation pages for Spanish-speakers.		April 2009-June 2010					
	7. Work with local programs and partners to promote the quitline and local cessation services.		April 2009-June 2010					
	8. Evaluate impact of free nicotine patch give-away and produce annual report.							

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
<p># 19- Healthy Communities 1- 29, 2010, 35 municipalities will receive tools, resources, and/or technical assistance on built environment or food environment solutions to increase physical activity and healthy eating. (Office of Community Liaison)</p> <p>2- By June 29, 2010 develop a communication mechanism to formally recognize the relationship between the built environment and health outcomes (Office of Community Liaison)</p> <p>3- By 2014, increase by 70% the number of residents receiving the health and economic benefits of community water fluoridation (Oral Health)</p>	<ol style="list-style-type: none"> 1. Prioritize communities based on readiness, existing opportunities, and disease burden 2. Develop tools to enhance local integration of public health and planning including Board of Health resolution, development checklist, and sample goals for master plans 3. Facilitate linkages between communities to share promising practices, lessons learned 	<ul style="list-style-type: none"> • DHPDP Office of Community Liaisons, • Massachusetts Association of Health Boards, • Massachusetts Municipal Association 	<p>0 – 3 months</p> <p>12 months</p> <p>6 – 12 months</p>		X		<ul style="list-style-type: none"> • Communities prioritized • Tools developed • Satisfaction among recipients 	<ul style="list-style-type: none"> • Community Survey Database • Program documents • Meeting minutes

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 20- By June 29, 2010, the Massachusetts Department of Public Health will have a coordinated approach to “healthy communities” which defines framework, scope, roles and responsibilities. (Office of Community Liaison)	1. Develop a “healthy communities” definition for use by all programs within the Department	<ul style="list-style-type: none"> MDPH Office of Healthy Communities, Commissioner’s Office, Bureau of Community Health Access and Promotion, Bureau of Substance Abuse Services, Bureau of Family Health and Nutrition, Bureau of Environmental Health, Bureau of Health Information, Statistics, Research and Evaluation 	0 – 6 months		X	X	<ul style="list-style-type: none"> Definition developed Inventory Completed Communities Identified Communities Prioritized 	<ul style="list-style-type: none"> Meeting minutes Internal documents Meeting minutes, internal documents
	2. Inventory all program activities involving healthy communities and/or work with municipalities		0 – 6 months					
	3. Work with the Integration Leadership Team to identify overlapping communities (“healthy communities”, DPH funded health care sites, Women’s Health Network/Men’s Health Partnership Safety Net Sites, WIC programs, Wellness Grants, etc)		6 – 9 months					
	4. Identify communities who meet the definition and are ready for integration of concepts and strategies from population health promotion and the chronic care model		9 – 12 months					
# 21-Increase by 10% the number of Black, non-Hispanic men in five target areas of Massachusetts who are educated on prostate and informed decision making by 2011 (baseline: number of men educated in FY09). (Comp Cancer)	1. Finalize structure and curriculum for new integrated community education and outreach initiative by January 30, 2009.	<ul style="list-style-type: none"> Project Director, Comp Cancer WHN/MHP Coordinator Mathematica 	January 2011	X	X		<ul style="list-style-type: none"> Number of Black, Non-Hispanic men educated by CHWs 	<ul style="list-style-type: none"> WHN/MHP Program Evaluation data
	2. Develop RFP for integrated community outreach and education program by October 2008.							
	3. Assist the development of a comprehensive curriculum and training program for Community Health Workers (CHW).							
	4. Collect data on the number of black NH men educated by CHWs in WHN/MHP.							
	5. Analyze data on the number of men who took action after talking to a Community Health Worker and evaluate the results of follow-up treatment.							
	6. Work with Men’s Health Partnership to track the number of men who sought treatment at a MHP facility.							

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 22- Increase the rate of colorectal screening in Massachusetts among adults age 50 years and older to 70% by 2011 (Baseline 68.4% BRFSS 2005).	<ol style="list-style-type: none"> 1. Implement three action steps from the list <i>Dialogue for Action</i> Summary Report 2006: 2. Work with CHCs to introduce a system for ensuring early detection screenings, case management and patient reminder systems. 3. Engage other primary care providers (family practice, internal medicine) across the state in adopting electronic medical reminder and other systems. 4. Devise, test and implement a mass and/or small media campaign for colorectal early detection screening. 	<ul style="list-style-type: none"> • Project Director, Comp Cancer • Division Communications • Director, Colorectal Work Group Co-chairs, • WHN/MHP Project Director 	January 2011	X	X		<ul style="list-style-type: none"> • Percent of adults reporting colorectal screening in Massachusetts in 2006. 	<ul style="list-style-type: none"> • BRFSS
# 23- By June 2011, using the Stroke Heroes Act FAST campaign, increase the percent of Massachusetts adults who can recognize the signs and symptoms of stroke from 17% to 22% (HD&S)	<ol style="list-style-type: none"> 1. Continue all tasks necessary to maintain and revise the Stroke Heroes Act FAST educational materials 2. Maintain or increase the number of community agencies and organizations who conduct education with the DPH stroke signs and symptoms message in English, Spanish and Portuguese 3. Increase the number of state-level agencies and organizations who conduct education with the DPH stroke signs and symptoms message in English, Spanish and Portuguese 4. Pending funding, continue statewide media campaigns in English, Spanish and Portuguese 	<ul style="list-style-type: none"> • HSPC 	Jan- Dec 2009 Jan-Dec 2010	X	X		<ul style="list-style-type: none"> • Completed distributed plan w/ completed orientations • Revised materials if needed 	<ul style="list-style-type: none"> • BRFSS
# 24- By June 2011, improve the health risk profile at 20 private/public worksites (HD&S)	<ol style="list-style-type: none"> 1. Conduct and analyze a worksite policy assessment 2. Develop and improve the framework for Worksite Health Improvement Initiative 3. Continue to enroll worksites to participate in policy and environmental changes 	<ul style="list-style-type: none"> • Wellness Division 	June 2011				<ul style="list-style-type: none"> • Worksite survey • Worksite framework 	<ul style="list-style-type: none"> • Survey analysis

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
# 25- By June 2011, decrease the percent of hypertensives with uncontrolled hypertension (HD&S)	<ol style="list-style-type: none"> 1. Assess health care providers for current practice in the blood pressure measurement and management 2. Develop strategies for measuring and controlling blood pressure in outpatient settings 3. Implement strategies 	<ul style="list-style-type: none"> • HSPC 	June 2011	X	X		<ul style="list-style-type: none"> • Healthcare survey • Strategies developed 	<ul style="list-style-type: none"> • HEDIS
# 26- By 2011, implement and sustain an EMS collaborative for improving acute stroke care (HD&S)	<ol style="list-style-type: none"> 1. Pilot an EMS collaborative to implement developed performance measures for acute stroke care 2. Spread the pilot to other EMS agencies 	<ul style="list-style-type: none"> • HSPC 	Jan 2009-2011	X	X		<ul style="list-style-type: none"> • Meeting attendance 	<ul style="list-style-type: none"> • Internal documents
#27- June 2011, the Partnership has 25 active organizations, a functioning Executive Committee, active standing committees, and MDPH is no longer the main contributor of funds (HD&S)	<ol style="list-style-type: none"> 1. Provide leadership to the Partnership as a core partner 2. Maintain the level of technical support provided to the Partnership through participation on the standing committees 3. Maintain support to lead and co-lead partners as requested to achieve the Statewide Plan objectives 4. Assist in keeping the Statewide Plan a current and evidence-based document by submitting new objectives to the Executive Committee 5. Assess the training needs of partners, annually 6. Conduct an evaluation of the PHHSFM 	<ul style="list-style-type: none"> • HSPC 	Jan 2009-2011	X	X		<ul style="list-style-type: none"> • Meeting attendance 	<ul style="list-style-type: none"> • Internal documents

Objectives	Strategies	Staff (Programs Involved)	Timeframe	Funding			Indicators	Data Sources
				S	F	K		
<p>#28- Support one evidence-based intervention in each priority region that responds to regional data and community need Baseline: 0 priority regions conducting evidence-based interventions Target: 3 priority regions with developed capacity to successfully implement interventions in Year two. (APCP)</p>	<ol style="list-style-type: none"> 1. Regional Asthma Collaboratives coordinate and collaborate with MAC on efforts related to State Plan 2. Safety Net site implements at least one evidence-based strategy designed to decrease the asthma hospitalization rate in a priority population in collaboration with Regional Asthma Collaborative 3. Two additional Regional Asthma Collaborative and Safety Net grantees develop joint work plan, based on grant proposal, to define tasks and activities relevant to meet objectives from the Statewide Asthma Plan, collaboration and communication strategies, methods for implementing evidence-based strategies, and strategies to develop capacity of asthma collaborative - tentative 	<ul style="list-style-type: none"> • MDPH Asthma Program Director and Evaluator/Funded regional collaborative • MAAP Executive Director/MDPH Asthma Program Director and Evaluator (for technical assistance as needed) • MAAP Executive Director/MDPH Asthma Program Director and Evaluator (for technical assistance as needed) 	<p>August 2008 – August 2009 September 2008 - August 2009 One month after the award</p>	X	X		<ul style="list-style-type: none"> • Active participation and attendance at MAC meetings (100%) • Safety Net site implements at least one evidence-based strategy and collaborates with Regional Asthma Collaborative • 9% decrease in asthma hospitalization rates among the priority population documented • Work plan with narrative which describes the interventions for each Regional Asthma Collaborative 	<ul style="list-style-type: none"> • ITS: Meeting minutes • ITS: Meeting minutes; work plans; reports • ITS Meeting minutes, work plans, reports
<p>#29- Increase the knowledge of CHWs and the regional priority areas on asthma and in-home and in-school trigger assessments and interventions (Objectives 1, 2, 5, and 7 from the Statewide Asthma Plan) Baseline: 0 priority regions Target: at least 3 priority regions (APCP)</p>	<ol style="list-style-type: none"> 1. Maintain membership in the full council of the Asthma Regional Council of New England and partnership in the ARC New England-wide Healthy Homes Promotion Project 	<ul style="list-style-type: none"> • MDPH APCP Director 	<p>August 2009</p>	X	X		<ul style="list-style-type: none"> • MDPH Program director (or designee) participate in at least 80% of related meetings 	<ul style="list-style-type: none"> • ITS Meetings minutes