

**North Carolina
Chronic Disease and Injury
Program Integration Work Plan
2009- 2011**



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Background

The North Carolina Division of Public Health has a proven track record for addressing chronic disease prevention and control through collaboration and sustained capacity at the state, regional and local levels. During the last 3 years, the Chronic Disease and Injury (CDI) Section has increased its efforts at collaboration and program integration. In 2005, structural changes were made in the management hierarchy by establishing a Chronic Disease Manager position and Health Promotion Program Manager position. Strategic activities included organization of a state chronic disease conference with a thematic focus on program integration, completion of a staff survey on knowledge and attitudes about integration and a Section retreat focused on integration.

North Carolina has existing state plans to target all of the chronic diseases and risk factors that are the focus of CDC categorical funding. In order to pursue program integration in a more deliberate and organized fashion, the Section developed a formal Chronic Disease plan, the NC Integration Blueprint. The Blueprint is designed to increase integration, efficiency and effectiveness across all of these programs. It serves as a tool to establish priorities for the Section, maximize resources, enhance credibility, avoid duplication and ultimately support the implementation of each state plan targeting a specific disease or risk factors area.

North Carolina has a well-developed local public health infrastructure that includes 85 local health departments that have influenced state level program integration efforts. Because funding and personnel resources are limited at the local level, successful health departments have developed well integrated programs. One staff member is often responsible for multiple disease areas and community coalitions prioritize community needs and focus on cross-cutting issues.

Lessons Learned from Integration Efforts Prior to the 2009-2011 Work Plan

The North Carolina Chronic Disease and Injury Section has demonstrated several areas of programmatic success in our previous integration efforts. Lessons from this process, especially those related to healthcare systems, community-based health promotion, and business and operations integration efforts are outlined below. Further discussion of these topics is included in the individual community of practice descriptions.

Healthcare Systems

One of the sections earliest efforts at integration involved expanding our efforts to organize chronic disease collaboratives. Funding from Diabetes, Heart Disease and Stroke Prevention, Comprehensive Cancer and Asthma were pooled to support a statewide quality improvement project based on the chronic care model. Use of these relatively small funds helped leverage a larger, statewide quality improvement effort through selective investment of funds and collaboration with influential partners in the academic, professional association and health financing sector. The initiative has also fostered linkages between state and local health departments and primary care practices to expand the evidenced-based Chronic Disease Self Management Program to patients in participating initiative practices.

Community Based Health Promotion

Progress with integrating community based health promotion activities has exceeded the section's expectations. The section's approach to integration of community based health promotion led to a proposed reorganization of the health promotion technical assistance program. This decision

generated controversy among health promotion stakeholders across the state. In response, focus groups were held with core stakeholders. The findings have helped clarify technical assistance needs, documented the need for content experts and expanded the scope of the project to include rethinking current local funding mechanisms.

Business and Operations

Early in the integration effort it was determined that increased management capacity would be needed to manage the transition of integration. Funds from categorical programs were pooled to create and hire a Chronic Disease Program Manager and a Health Promotion Program Manager to oversee the work across the Sections categorical programs. Integration efforts focused on business and operations also emerged as a priority for the section early in our process. Shared staff can increase organizational capacity of small categorical programs. Section staff have worked collaboratively to combine contracts, which saves time and requires only one staff to develop and monitor.

Two themes have emerged from the section's experience with program integration: 1) Centralized management capacity is needed to effect significant organizational change; and 2) Organizational change creates significant anxiety which must be anticipated and managed attentively. In order to assuage staff fears, it is imperative to develop clear, consistent messages at the onset of the process, ensure organization has the infrastructure to support integration and assess and address concerns regularly.

Integration is a proactive management strategy and an important form of strategic planning. Our success has been dependent on the active support of senior management and a designated integration team to develop a plan. Early efforts should focus demonstrating increased efficiency and effectiveness across programs. Experiences with the medical care system and the State Employees Health Plan have taught us that integrated programs increase external credibility, however, some areas are not appropriate for integration. The integrity of categorical programs should remain a key priority of integration efforts

Program Integration Goals

The overarching goal for the North Carolina Chronic Disease and Injury Integration Work Plan is to create a new organizational culture, where collaboration and integration are defined as a normative priority process and expectation. The Work Plan is a tool to establish priorities for the Section, support policy initiatives, maximize resources and garner new ones, and avoid duplication of effort. North Carolina has established four key goals for program integration that are described in the remainder of the document. Long term program integration opportunities are included in the plan and briefly outlined, but are not a part of the three year timeline for this Work Plan.

1. Establish a well-articulated vision of the Chronic Disease and Injury Section (CDIS) as a fully integrated organization. (Page 6)
2. Develop infrastructure and build best management practices to support integration efforts. (Page 10)
3. Prioritize and implement integrated programs and processes using evidence-based science and best practice models. (Page 13)
4. Continuously evaluate integration outputs and health outcomes. (Page 57)

Based on these goals, North Carolina presents the following Work Plan for program integration across all of the state's chronic disease programs over a three year period.

North Carolina Work Plan for Program Integration

Overarching Goal

Create a new organizational culture where collaboration and integration are defined as a normative priority process and expectation.

Purpose Statement

The Chronic Disease and Injury Section will improve health outcomes and decrease health disparities by increasing state capacity and resources and improving efficiency through a coordinated and integrated approach. This will be evidenced by mutual planning, sharing of resources and accountability, and a focus on common issues, barriers and goals.

Goal I: Establish a well-articulated vision of the CDI Section as a fully integrated organization.

North Carolina has a strong tradition of leadership among its categorically-funded chronic disease programs. Prior to hiring the current Chronic Disease Director, the position was held by multiple acting directors over a three year period. The result was the emergence of even more independent categorical programs in their efforts to survive in the state bureaucracy. Stable leadership and management capacity for the Chronic Disease Section has only been developed over the last 4 years.

The Section's senior leadership has demonstrated its commitment to enhanced integration. In 2005, structural changes were made in the management hierarchy by establishing a Chronic Disease Manager position and a Health Promotion Manager position. Since then the Section has taken additional steps to develop a more integrated approach to chronic disease prevention and control and to engage in team building and organizational change activities.

An existing matrix team, the CDIS Quality Team, which was comprised of management and non-management staff from across the Section, was utilized as the key venue for exploring and mapping the integration process. Formed in the late 1990s to promote cross-program coordination and collaboration for the heart disease and stroke prevention and the diabetes branches, the Quality Team has evolved to encompass members from all chronic disease and risk factor related branches and programs in the CDI Section and was renamed the CDI Exchange meeting in August 2008. The structured meetings include presentations on relevant cross-cutting topics such as policy, social marketing or highlights of a particular program or branch, followed by team discussion of collaborative or integrated initiatives and new opportunities. The meeting also creates a forum for training and professional development of program staff in a highly collaborative and integrated setting.

Integration of categorical programs will require significant organizational and cultural change among our state's established categorical programs. The Section has also recognized that not every intervention or initiative can or should be integrated, and so adopted the national principle of "do no harm" to categorical funding initiatives. Efforts to achieve successful integration in North Carolina will require significant attention and deliberate reinforcement of the process of organizational change. A common concern expressed by members of the Section is a lack of clarity about the

practical significance of integration. A well-articulated vision of the Section as a fully integrated organization is required to address this issue.

The vision will build on the previously developed Integration Blueprint to describe the Section’s organizational structure and reporting relationships, including the organization of content/programmatic units (e.g. tobacco, diabetes) and the support units (i.e. services required by most or all the programmatic units.) It will also describe the necessary infrastructure, policy and procedures, and will describe relationships between the Section and important external stakeholders and customers. Given that this vision has reporting and resource allocation implications, it is likely that the vision itself will raise new questions and, probably, concerns. The core program integration team composition and steps undertaken to develop the vision will therefore need to recognize and minimize these concerns.

The vision will include evaluation guidelines for an integration based on the following management objectives:

- To design a Section-wide integrated organizational structure including both programmatic and support functions;
- To develop policies and practices necessary to reward and support integrated operations/programs;
- To identify infrastructure requirements for an integrated organization; and
- To design and develop standard evaluation tools for integrated programs.

While the different objectives will need to be well integrated into a common vision, the tasks associated with each of the objectives will be executed largely in parallel with one another. In addition, the deliverables associated with each objective will contribute to a comprehensive and concrete vision and are intended to enrich sharing and learning among the participant states and the CDC in the overall demonstration project.

Below are the deliverables, teams and high-level tasks associated with each of the vision-related objectives.

Integrated vision			
Objectives	Deliverables	Team/staff	High-level steps
To design a Section-wide integrated organizational structure including programmatic and support functions	<ul style="list-style-type: none"> - Organization chart - Description of and logic behind the org. chart and reporting relationships - Description of the visioning process with lessons learned 	<ul style="list-style-type: none"> - Core Integration Team - Section Management Team - Visioning Team (selected representatives from the Division) - Staff selected on an ad hoc basis for 	<ul style="list-style-type: none"> - Complete ongoing inventory and analysis of current programs, functions, and competencies to identify overlaps and complementary areas - Identify and vet preliminary opportunities (e.g. program functions

Integrated vision			
Objectives	Deliverables	Team/staff	High-level steps
		specific expertise (e.g. budgeting, IT) - Representatives from selected external stakeholders on an ad hoc basis for specific perspectives (e.g. other units in DPH, LHDs, members from other demonstration projects)	and services) where integration would appear to prove beneficial - Identify and vet preliminary ideas regarding potential support functions that would promote and improve integrated initiatives - Draft and vet organizational scenarios around promising program functions and services
To develop policies and practices necessary to reward and support integrated operations/programs	- Documented policies and procedures that pertain specifically to integrated operations (e.g. staff performance evaluation, project team formation and composition, RFA & proposal development, reporting, contract development & management, reporting relationships) - Description of policy development process with lessons learned	- Core Integration Team - Policy Community of Practice Team - SMT - Staff selected on an ad hoc basis for specific expertise (e.g. budgeting, IT) - Representatives from selected external organizations on a ad hoc basis for specific perspectives (e.g. other units in DPH, LHDs, members from other demonstration projects)	- Review existing policy and procedures to determine applicability and potential barriers that may stem from existing policy to effective integration
To identify infrastructure requirements for an integrated organization	- Inventory and analysis of communication, conferencing, and document archiving and sharing tools that support integrated activities/functions - Analysis of Section's current technology capacity	- Core Integration Team - Representatives from private sector vendors, internal experts on a ad hoc basis for specific perspectives and expertise	- Conduct literature review and analysis and develop recommendations - Conduct benchmarking exercise of firms/organizations currently using tools for cross-functional purposes - Survey branches regarding their familiarity with and use of

Integrated vision			
Objectives	Deliverables	Team/staff	High-level steps
	related to communications and information sharing - Infrastructure recommendations document		conferencing and data sharing tools - Draft infrastructure vision - Identify and implement basic systems changes to improve communication
To design and develop standard evaluation tools for integrated programs	- Customer-oriented goals document - Organizational and staff-related performance metrics based on the goals - Data collection & reporting protocol (Also part of the policy objective deliverables)	- Core Integration Team - Health Data Community of Practice - External evaluation support - Representatives from selected external organizations on an ad hoc basis for specific perspectives (e.g. other units in DPH, LHD's, members from other demonstration projects)	-Survey/focus groups of selected LHD's regarding provision of services from "silo" organizations and service preferences -Based on findings, develop goals document -Work with Data Collaborative CoP to develop and implement data collection and reporting protocol -Evaluate the value and practicality of the protocol, making adjustments as necessary

Goal II: Develop infrastructure and build best management practices to support integration efforts.

In recent years, the Section has capitalized on multiple opportunities for enhanced efficiency through collaboration, partnering and integration, but formal processes, procedures, training and resources required to do this have not been established.

Resources and staff time will be dedicated to the task, and many of the common processes and procedures will be standardized. Communication will be a focal point to implementation of integrated initiatives and staff development will need constant attention to maintain a focus on integrated work plans. Many of these tasks can be made simpler and less time-consuming if efficient information technology processes are implemented and well utilized. Specific objectives to support integration efforts are outlined below.

Communication

Objective 1

By January 31, 2009 develop communication channels that promote and support integration.

Strategies

- Re-design the CDIS web site with updated information and links to each of the branches and programs.
- Initiate a committee to analyze, assess, and determine policy and procedures for information posted on the CDIS website.
- Publish an annual chronic disease integration report, disseminate and post broadly.
- Internally reward innovative integrated projects and ideas and promote these in the Section and DPH media.
- Make minutes from all CoP and SMT meetings accessible to all staff on the intranet or share drive.
- Compile all federal and state program goals and objectives to determine cross-cutting opportunities
- Convene biannual “all hands” meetings with the Section Chief as a venue for staff to share concerns, issues and success stories, and provide general feedback to the leadership team.
- Conduct annual staff satisfaction survey and review results during collaborative meeting.

Operations

Objective 2

By March 31, 2009, develop processes and procedures to assure timely, coordinated and appropriate expenditure of all state and federal funds.

Strategies

- Adopt and train managers and staff in use of the 100 percent spending plan model.
- Increase Section operations’ staffing capacity by at least 0.5 FTE to continuously monitor state and federal funds.
- Convene Section Operations Managers every two months with DPH budget officers to monitor contracts and local health department agreement addenda and realign budgets as needed to assure appropriate expenditure of funds.

- Utilize the CDIS Operations Manager to review budgets globally and discuss with the Section chief and Management Team on a monthly basis.
- Realign non- allocated funding to support collaborative and integrated projects as defined by the communities of practice.
- Develop a list of additional supplies, materials, initiatives, training, etc., that may be purchased or initiated later in the fiscal year if funds are available and can be shifted.
- Develop a strategic plan to advocate for high priority improvements in administrative policies, procedures and systems that hinder the timely processing, allocation and expenditure of new funds.

Objective 3

By June 30, 2009, develop new operational procedures and processes used by the Section to promote efficiency.

Strategies

- Develop a standardized CDIS collaborative agreement template for use among programs and branches.
- Complete a review of anticipated purchasing needs of large equipment every six months during regular Operations Managers Team meetings and consider joint purchases as appropriate.
- Publish common operations-related templates that are specific to the CDIS on the intranet or share drive.
- Create a CDIS Operations Training Manual for new employees and integrate into the Section's orientation package.
- Utilize the existing CDIS Operations Managers meeting as a venue for problem-solving and collaboration, and record progress and action items.

Human Resources and Staff Development

Objective 4

By June 30, 2009, develop processes that support coordinated recruitment and hiring of a competent chronic disease and injury workforce.

Strategies

- Develop succession plans for Section leadership and other core function positions.
- Develop a core list of sites for posting job vacancies, and maintain on the share drive and intranet.
- Post expected or actual vacancies on the Section Management Team listserv, share drive and intranet.
- Identify opportunities to share staff or resources through the CoP teams as well as the listserv.
- Maintain a list of competency-based interview questions on the share drive and intranet that build off of the NACCD questions for chronic disease and injury competencies and the CDC/CSTE applied epidemiology competencies.

Information Technology

Objective 5

By June 30, 2009, leverage the use of information technology (IT) systems and processes that significantly enhance communication and collaboration.

Strategies

- Develop and maintain a Section intranet and/or share drive that is accessible to all staff.
- Post standardized templates for meeting minutes and other common forms used in CDIS to the intranet and share drive.
- Include a spreadsheet on the intranet or share drive denoting which branches or programs are funding local health departments.
- Configure the corporate calendar system on every computer in CDIS for the purpose of enhancing existing planning, meeting and organizational efforts.
- Develop and maintain a system for tracking and oversight of required staff training using the intranet and/or share drive.
- Identify and pursue other new technology options available to assure compatibility of administrative and management systems across programs and administration.

Goal III: Prioritize and implement integrated programs and processes using evidence-based science and best practice models.

The ultimate goal of North Carolina’s chronic disease and injury programs is to improve health outcomes related to chronic disease and injury by prevention and control of risk factors, early detection, and appropriate treatment. All North Carolina’s long term health goals are correlated to 2010 Health Objectives focus areas and specific benchmarks for North Carolina are set in the 2010 Health Objectives format. These will be updated and revised for 2020.

The Section continues to seek opportunities to work with the state’s most underserved populations. In response to the strong recommendations of CDC’s Division of Diabetes Translation, the NC Diabetes Prevention and Control Branch is in the process of negotiating specific public health projects with the Cherokee Nation in our state. A letter of collaboration is included in the appendix.

It is anticipated that the CDI integration project will contribute to and expedite the attainment of North Carolina’s 2010 and 2020 Health Objectives by:

1. Creating organizational economies of scale that reduce costs and allow sustainable resources to be invested back directly into specific programs.
2. Improving the availability and efficiency of technical support and resources for evidence-based activities in local communities and prioritized settings.
3. Enhancing strategic work across the Social-Ecological Model to advance measurable changes in public policy and systems change.
4. Increasing satisfaction and engagement among state and local staff working in chronic disease programs.

The Integration Blueprint will be operationalized through existing matrix teams and the creation of new ones as priorities are determined. These “Communities of Practice” (CoPs) will signify the formation of groups within the CDIS that work toward a mutual goal that could not be achieved independently. Many ongoing CoPs already exist in Public Health that could be utilized, so the Section conducted an assessment of these and mapped them in a CoP inventory. Current examples of CoPs include Section Management, Quality, Epidemiology and Evaluation, and the Social Marketing Matrix teams. Section “champions” will be proposed by the management team and staff, and will coordinate the work of each new CoP. Selection of these key staff members will be based on their expertise and interest in the topic area. CoP champions should be influential in pushing the agenda forward for each designated group. Collectively, the aim of the integration process is to empower CoPs to drive the design and implementation of North Carolina’s program integration efforts.

The North Carolina Integration Blueprint identified and defined integration efforts around cross-cutting programmatic areas that support categorical program deliverables related to this goal. Priorities were identified based on specific criteria: 1) common goals and objectives; 2) feasibility; 3) community support of the initiative; 4) political will at the local, state and/or national levels; 5) magnitude of the problem or issue; 6) presence of evidence-based strategies to address the problem; 7) availability of resources to address the problem; and 8) relevance of the problem to multiple programs. Based on these criteria, the following priority integration areas for the Chronic Disease and Injury Section have been identified:

1. Community-based health promotion and coalition development;
2. Policy and environmental change;
3. Evaluation, epidemiology, and surveillance;
4. Healthcare systems;
5. Worksite wellness interventions;
6. Health disparities; and
7. Health communications and social marketing.

Recommendations have been defined for all seven priorities in the Integration Blueprint. Integration efforts across these seven priorities will be organized into Communities of Practice. The activities and outputs of each of these CoPs define the short and intermediate term outcomes for North Carolina's integration efforts. Communities of Practice have been organized for the first four priority areas. These are described below. Justification for the Healthy Communities Initiative funding is included in the Community-based Health Promotion section. The remaining three priorities are beyond the scope of this Work Plan. They are briefly addressed in the plan and will be implemented after the Work Plan's three year timeline.

Communities of Practice

Community-based Health Promotion and Coalition Development Community of Practice

Background/History

North Carolina has an excellent opportunity for integrating its community-based health promotion and coalition development resources for local communities. The Chronic Disease and Injury Section houses the Office of Healthy Carolinians/Health Education, the Physical Activity and Nutrition Branch, the Tobacco Prevention and Control Branch along with the NC Healthy Schools Initiative. Each of these programs has a long history of providing technical assistance and training to local communities across the state in implementing policy, systems and environmental changes. The experience, expertise and collaboration of the programs' staff in addressing chronic disease risk factors and health disparities have empowered communities throughout North Carolina to create sustainable changes. Integration will strengthen the impact of these programs.

The goal of the Office of Healthy Carolinians/Health Education (HC/HE) is to improve the health status of North Carolinians by establishing and supporting community-based, multi-agency partnerships that facilitate planning and implementation of projects that are guided by the NC 2010 Health Objectives and its' 12 focus areas. The Office receives state appropriations in addition to federal funding. Currently there are 77 Healthy Carolinians (HC) partnerships in 83 counties. This unique network has received national recognition for its scope of work, which includes a state mechanism to certify partnerships that meet ambitious standards including community health assessment and cultural competency. HC partnerships use a highly integrative planning process that brings together representatives from public health, hospitals, healthcare providers, health and human service agencies, churches, schools, businesses, as well as community members, elected

officials and organizations. These local coalitions conduct community health assessments, identify and establish health priorities based on NC 2010 Health Objectives, develop and implement programs to address the priorities, and mobilize resources to support community health improvement and address health disparities. In addition to supporting local Healthy Carolinians partnerships in the certification process, the Office of HC/HE is also responsible for guiding and supporting local health departments to meet the statewide standards for Community Health Assessment necessary for accreditation of the local health department. Five Program Consultants within the Office of HC/HE provide technical assistance, training and consultation to community-based local partnerships and local health departments in building and sustaining local partnerships, implementing policy and systems changes, and evaluating efforts.

The Statewide Health Promotion Program (SWHP), led by the Physical Activity and Nutrition Branch, supports community-based programs that improve the health of North Carolinians by reducing the prevalence of chronic diseases. The Program receives funding through the Preventive Health and Health Services Block Grant (PHHSBG) and North Carolina state appropriations. One hundred percent of this funding is disseminated to 83 local health departments serving 98 counties to support staff positions, referred to as Health Promotion Coordinators. The Health Promotion Coordinators build partnerships within their local communities to develop and implement policy changes and environmental supports that provide opportunities for increased physical activity, healthy eating and tobacco use prevention and control at the state level. Three Community Development Specialists, supported by the CDC's Physical Activity, Nutrition and Obesity grant provide technical assistance and consultation to Health Promotion Coordinators in the local health departments. SWHP program staff have also developed an integrated evaluation system that assesses progress made in local communities towards policy and environmental changes.

The North Carolina Tobacco Prevention and Control Branch (TPCB) works to improve the health of North Carolina residents by promoting smoke-free environments and tobacco-free lifestyles. Funded through a CDC Cooperative Agreement, Master Settlement Agreement Foundation and other state funds, its goal is to build capacity of diverse organizations and communities to implement and carry out effective, culturally appropriate strategies to reduce deaths and health problems due to tobacco use and secondhand smoke. The TPCB has three regional consultants that provide technical assistance to all 100 counties. In addition, these field coordinators work with local coordinators through a local grants program that funds 8 local health department staffed coalitions covering 23 counties. Coalition coordinators submit annual action plans outlining strategies to prevent the initiation of tobacco use among young people, eliminate exposure to secondhand smoke, promote quitting tobacco among adults and youth; and eliminate tobacco-related health disparities among populations. Progress toward these goals is monitored through an Indicator Progress Tracking System. The TPCB staff also provide technical assistance to all local health departments on tobacco prevention and control; assist in assuring compliance of the 100% tobacco free schools law and local policies; serve 53 HWTF tobacco prevention and cessation grantees upon request, and assist Healthy Carolinians and Health Promotion programs that have an interest in tobacco prevention and control.

The North Carolina Healthy Schools Initiative, funded through the Centers for Disease Control and Prevention's (CDC) Division of Adolescent and School Health, provides a working infrastructure between education and health to enable schools and communities to create a Coordinated School

Health approach to quality school health systems. NC Healthy Schools focuses on improving the health of students and staff by providing training, technical assistance and tools to coordinate resources in the eight component areas of school health, which include physical education, nutrition services, school site health promotion for staff, and community involvement in schools. Each school district is required to have a School Health Advisory Council (SHAC). The SHACs are required to have membership from each of the eight component areas along with representatives from the local health department and school administration. NC Healthy Schools provides training and technical assistance to SHACs on the School Health Index, the Health Education Curriculum Assessment Tool and the Physical Education Curriculum Assessment Tool.

The programs listed above have a history of collaboration in working with local communities focusing on health promotion issues. This collaboration includes joint trainings for local communities through regional meetings, linking local partners and resources, and shared initiatives, such as smoke free policies in dining venues and government buildings. Each program has an established network of local coalitions, systems for monitoring and evaluating local efforts, and funding streams that support local efforts.

The process for integrating these programs will occur in several phases, the first of which will involve the Statewide Health Promotion Program and the Office of HC/HE. These are the only two chronic disease programs that currently have programmatic efforts in nearly every local health department and are the source of immediate local and state concern. Health Directors in local health departments began voicing concern regarding the overlap between the consultative services provided by the Office of HC/HE and the SWHP Program in 2005. Concerns included competing program deliverables, local staff expectations, and site visits from multiple consultants. Since local health departments are a primary constituent of the Division of Public Health, input from local health directors and local staff supported by the two programs was gathered through focus groups. Feedback was sought on what is working well with having two separate consultative programs, what is not working well, and how the current structure can be improved.

In addition to local concerns, state legislators sensed duplicate funding requests for the same purpose, that of community health promotion, by the two programs, thus making it difficult for either to receive additional state funding. As a result, the primary recommendation from the 2008 National Association of Chronic Disease Directors (NACDD) State Technical Assistance and Review team was to develop an integrated regional consultation approach and cross train consultants to serve as point people in their regions with ability to access special expertise as needed. Through this process, a recommendation was also made to assure equitable geographical distribution of integrated regional consultants.

In response to these issues, the Section has proposed that health promotion funding from the state be provided to local health departments to support the work of local coalitions to address obesity, tobacco, and one other priority identified through local community health assessments. As a first step, staff from the Office of HC/HE and the SWHP program initiated a strategic planning process in October 2008 to develop strategies to address the concerns of local health directors and state legislators. An external consultant was hired to facilitate the process of gathering stakeholder input about the structure of these two programs, which will be completed by January 2009. This input will guide the development of recommendations for integrating the two programs.

Assessing and addressing the immediate concerns for the Office of HC/HE and SWHP programs are priorities for the integration process. However, strategies to involve the Tobacco Prevention and Control Branch and the NC Healthy Schools Initiative will also be developed in conjunction with program staff. Other related CDI Section programs will be engaged in this process after Year 2 of the Integration Demonstration Project. This CoP will also coordinate with the Policy and Environmental Change CoP, the Data Collaborative CoP, and the Healthcare Systems CoP to implement local policies and programs addressing chronic disease and their associated risk factors. The following Work Plan outlines the steps for the process.

**Community-based Health Promotion and Coalition Development Community of Practice
Basic Team Information**

Team Mission: To integrate the programs within the CDI Section that fund and support health promotion and coalition development activities in all counties and increase resources available for these efforts.	
<p>Team Champion: Dr. Marcus Plescia The team Champion will:</p> <ul style="list-style-type: none"> ▪ advocate for resources for the team, ▪ give guidance on team goals and objectives ▪ acknowledge the work of the team with the Senior Management Team (SMT) and others, ▪ attend meetings when possible, and ▪ ensure that Section Management assign at least one member of each program/branch to this team 	<p>Team co-leaders: Sharon Nelson/Debi Nelson The team co-leaders will:</p> <ul style="list-style-type: none"> ▪ convene meetings, set agendas, and rotate minute taking, ▪ facilitate meetings or communicate the need for external facilitation to the Team Champion, ▪ communicate team accomplishments and needs to the Team Champion, and ▪ assemble, safeguard and discharge team correspondence
Team Members:	Area of Expertise:
Sharon Nelson	<i>MPH, member of core integration team, Statewide Health Promotion Program Manager</i>
Debi Nelson	<i>MAEd, RHed, Office of Healthy Carolinians/Health Education Director</i>
Mary Bea Kolbe	<i>MPH, ESMM Community Grants Program Coordinator</i>
Karen Stanley	<i>B.S. Nutrition, Eat Smart, Move More Coalition Program Coordinator</i>
Deborah Dolan	<i>B.S. Health Education, Eat Smart, Move More Coalition Program Coordinator</i>
Marla Smith	<i>MEd, Regional Healthy Carolinians/Health Education Consultant</i>
Jean Caldwell	<i>BS, RHed, Certification/Recertification Lead</i>
Emily Perry	<i>MSW, Health Education Lead</i>
Sarah Thach	<i>MPH, Community Health Assessment Lead</i>
Denise Houghton	<i>BS, Regional Healthy Carolinians/Health Education Consultant</i>
Elisabeth Constandy	<i>MS, Director of Program Development, Tobacco Prevention and Control Branch</i>

Targeted Key Partners:
Association of Local Health Directors, local Healthy Carolinians partnerships, local physical activity and nutrition coalitions, local tobacco coalitions

**Community-Based Health Promotion and Coalition Development
Community of Practice Goals, Focus Areas, and Objectives**

Goal #1: *Develop a framework and determine a structure for all CDI health promotion outcome measures.*

Focus Area 1: Determine the best organizational structure to manage and lead the work of the Section as it relates to community-based health promotion (policy, programs,) and education in worksites, schools, homes, healthcare and other community settings.

Objective 1a: By February 2009, assess and gather stakeholder input regarding the structure of the Statewide Health Promotion (SWHP) Program and the Office of Healthy Carolinians/Health Education (HC/HE).

Objective 1b: By February 2009, conduct 2 program consultant meetings to reorganize the roles of the SWHP program and Office of HC/HE consultative services.

Objective 1c: By March 2009, develop recommendations for integrating SWHP Program with Office of HC/HE consultative services.

Objective 1d: By June 2009, work with tobacco prevention and control stakeholder groups to assess the strategic advantages and disadvantages of integrating the Tobacco Prevention and Control Branch’s regional and local focus on building support for and implementing evidence-based tobacco prevention and control policies and programs into the community-based health promotion structure.

Objective 1e: By December 2009, develop a plan on how to integrate aspects of the Tobacco Prevention and Control Branch’s strategic plans into community-based health promotion structure without doing harm to the TPCB infrastructure

Objective 1f: By March 2011, gather input from additional stakeholders within CDI Section regarding expansion of community-based health promotion structure to include additional CDI programs and branches.

Objective 1g: By June 2011, design an organizational structure to include additional CDI positions to work with health promotion and education.

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Summary of stakeholder input Minutes from stakeholder meetings Revised organizational chart	The Community-based Health Promotion and Coalition Development CoP will monitor the organizational change process by measuring knowledge and attitudes on the	By July 2011, community and other partners will recognize the CDI health promotion and coalition development organizational structure as effective	

	integration survey	and coordinated as evidenced by responding to joint RFAs, and by reports of multiple branches planning and putting resources into interventions that cross categorical lines	
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Focus Area 2: Incorporate North Carolina 2010/2020 Health Objectives, the three leading preventable causes of death, the ten essential services of public health, the social determinants of health, and health disparities into the framework.

Objective 2a: By June 2009, identify community-based health promotion and coalition development outcomes to be addressed.

Objective 2b: By January 2010, identify all CDI health promotion outcomes to be addressed.

Objective 2c: By June 2010, identify strategies and process to create a framework of outcome measures addressing North Carolina 2010/2020 Health Objectives for Chronic Disease and Injury Section.

Objective 2d: By June 2010, develop measures to support the framework that will address Public Health Ten Essential Services, the three leading preventable causes of death and the social determinants of health and health disparities.

Objective 2e: By August 2010, articulate goals of the framework.

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
List of outcomes List of evaluation measures Developed goals	The Community-based Health Promotion and Coalition Development CoP will monitor the development of the framework via meeting minutes	By January 2011, the CDI Section will adopt a framework that is informed by leading public health indicators that guide the work of our chronic disease plan as evidenced by assessment from the Section Chief, Senior Management Team and Section Management Team	Work in collaboration with other CoPs to assure that the framework is measurable (Data CoP), consistent with evidenced-based healthcare approaches (Healthcare Systems CoP), and something that our partners can help us accomplish (Policy CoP)

Focus Area 3: Create an integrated evaluation system to monitor progress in achieving outcomes in health promotion and education.

Objective 3a: By December 2009, develop outcome measures evaluation tool for community-based health promotion and coalition development.

Objective 3b: By June 2010, pilot and implement outcome measures evaluation.

Objective 3c: By June 2011, integrate an on-going monitoring process for CDI health promotion and education outcomes.

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Evaluation tool Compilation of data collected through the tool	The Community-Based Health Promotion and Coalition Development CoP will monitor the development of the evaluation system via minutes	By June 2011, all CDI health promotion and education outcomes will be measured by a single evaluation system that will generate reports for use at the categorical and state levels	Work with the Data CoP to develop the evaluation system

Goal #2: *Coordinate and streamline services to local health departments.*

Focus Area 4: Develop a system whereby one state consultant serves each health department to oversee and support all Section health promotion funding and technical support.

Objective 4a: By December 2008, conduct focus groups and surveys with stakeholders on integration of regional consultants.

Objective 4b: By February 2009, define regional approach to health promotion and education activities and how this should relate to our work at the local level.

Objective 4c: By March 2009, expand the CoP team to include staff from the Tobacco Prevention and Control program and the NC coordinated school health program.

Objective 4d: By June 2009, complete cross-training of regional consultants, including technical assistance and training.

Objective 4e: By July 2009, implement an integrated approach plan for regional consultants with Statewide Health Promotion and Healthy Carolinians.

Objective 4f: By December 2009, evaluate first six months integration efforts of Statewide Health Promotion Program and Healthy Carolinians.

Objective 4g: By March 2010, integrate the Tobacco Prevention and Control program’s technical assistance infrastructure into this system.

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Results of focus groups and surveys Revised regional structure document Evaluation report	The Community-based Health Promotion and Coalition Development CoP will monitor the integration of health promotion via consultant reports and meeting minutes.	By June 2011, CDI statewide health promotion technical assistance will be funneled through a general consultant as evidenced by reports from local health directors and community-based partners	The Data CoP may provide evaluation expertise Tobacco prevention and control staff and stakeholders will be invited to be part of the decision-making process.

Goal #3: *Develop and activate methods across CDI programs to strategically communicate, educate, and mobilize local community support for evidence-based interventions and/or promising practices.*

Focus Area 5: Implement an integrated system of state funding distribution for health promotion.

Objective 5a: By June 2009, identify feasibility of methods to provide health promotion funding to local health departments, hospitals, independent HC partnerships (HCPs) and outside agency-sponsored HCPs that must be used to support the work of HCPs to address obesity, tobacco, and one other priority identified through Community Health Assessment.

Objective 5b: By October 2009, establish funding stream method for health promotion funds to be distributed for SFY 2010-2011 in support of community-based health promotion and education activities at the local level.

Objective 5c: By December 2010, develop a campaign to increase state funding to support community-based health promotion and health education activities.

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Established process for distributing funding locally	The Community-based Health Promotion and Coalition Development CoP will track steps towards implementing an integrated system of state funding for health promotion via meeting minutes	By January 2011, the CDI Section will have a sustainable funding source for community health promotion and coalition building activities as evidenced by budget line items in categorical programs and increased funding from other state and federal sources	

Focus Area 6: Increase community implementation of evidence-based interventions and/or promising practices.

Objective 6a: By June 2009, design a needs assessment to identify CDI program gaps in community level support for evidence-based interventions or promising practices.

Objective 6b: By October 2009, compile assessment results and develop methods to address gaps in community level support.

Objective 6c: By June 2010, develop a support network of CDI health promotion and education technical assistance positions to work collaboratively at the local level.

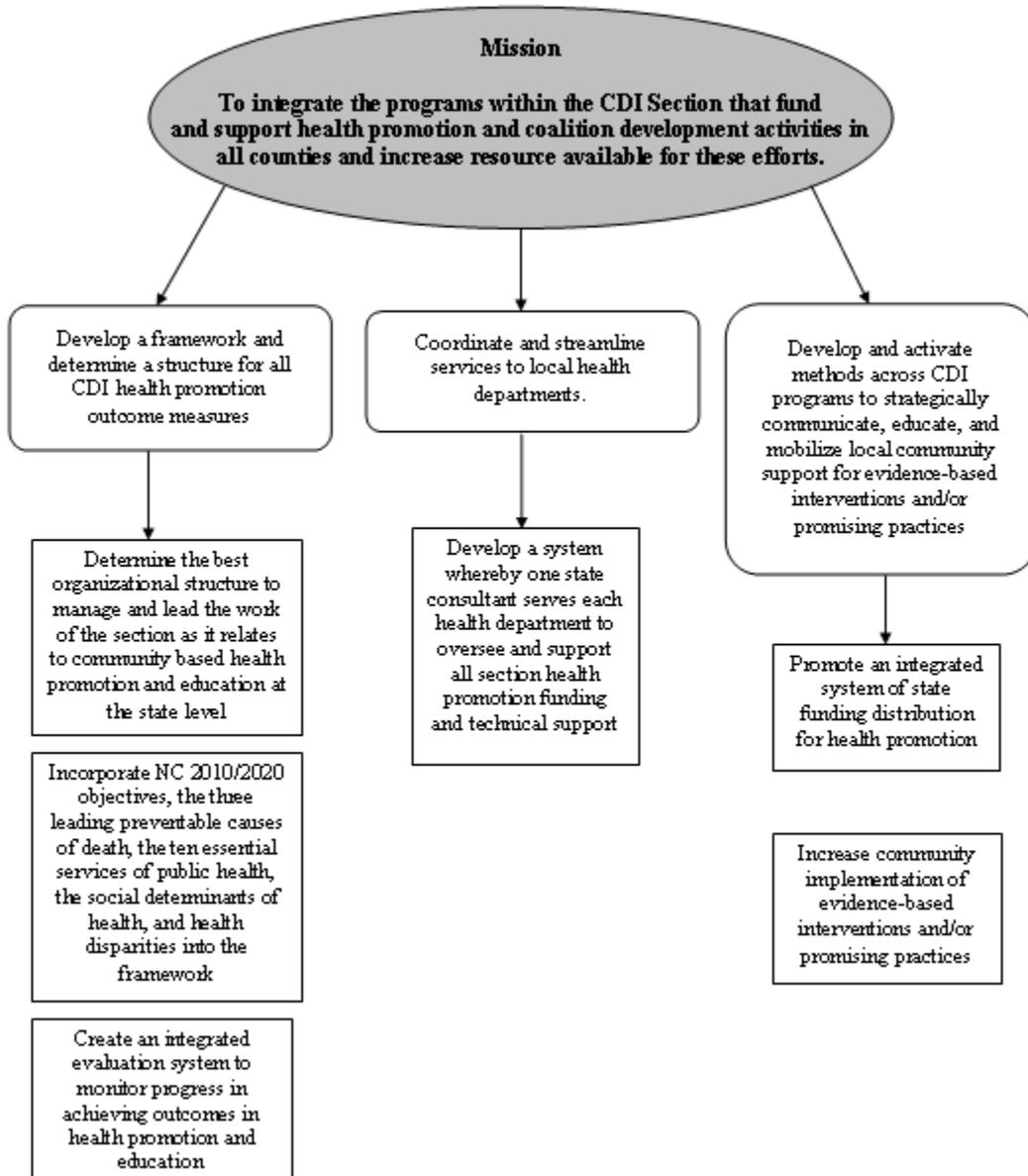
Objective 6d: By June 2010, develop an advocacy network of CDI health promotion and education to work collaboratively on communications and media at the local level.

Objective 6e: By June 2010, implement strategic plan for increased support for evidence- based interventions or promising practices.

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Needs assessment tool developed Assessment results compiled Strategic plan developed	The Community-based Health Promotion and Coalition Development CoP will establish a baseline of local networks that implement evidenced-based interventions and promising practices that promote or support CDI health promotion. Thereafter, the CoP will track the number of annual additions and track stakeholder satisfaction via a joint coalition assessments tool	By July 2010, a percent of N.C. counties will have a minimum number of networks that implement evidenced-based interventions and promising practices that promote or support CDI health promotion as evidenced by report to Section Management	

Community-Based Health Promotion and Coalition Development CoP Strategy Map



Healthy Communities Initiative

The Community-based Health Promotion and Coalition Development Community of Practice (CoP) provides a solid foundation for the Healthy Communities initiative. Training and technical assistance for the Initiative will be built upon the capacity of the Office of HC/HE, the PAN Branch, the Tobacco Branch, and NC Healthy Schools. Staff within the four programs has expertise in assessing community health needs, mobilizing community partners, implementing policy, environmental, and systems changes, addressing health disparities and program evaluation. Technical assistance will be coordinated between the four programs to build local community capacity for implementing effective chronic disease prevention strategies. The work within the Community-based Health Promotion and Coalition Development CoP will be supported by the work of the Data CoP as well as the Policy CoP in working with local communities.

Funding from the Healthy Communities Initiative will be used to support a half time position to coordinate efforts of the four programs in providing technical assistance and training to local communities in implementing policy, environmental, and systems changes supportive of physical activity, healthy eating, and tobacco use prevention and control. The position will be responsible for ensuring cross-program information sharing, coordinating funding and training opportunities for local communities, and linking this CoP with other Sections, branches and programs supporting healthy communities.

Policy and Environmental Change Community of Practice

Background/History

The Policy and Environmental Change Community of Practice was established by the Chronic Disease and Injury Section in 2008 when the Section Management Team and the Chronic Disease Director prioritized policy and environmental change as a main area of focus for program integration efforts. Policy and environmental change is recognized in public health as one of the most useful tools to effectively achieve population-based preventive health outcomes. Critical success factors for policy and environmental change in public health include a strong data/science base, collaboration of internal and external partner organizations, community mobilization, active and vocal community support, and supportive decision makers. It was recognized by Section leadership that more training and capacity building in policy and environmental change was necessary across chronic disease programs, that policy oriented partner organizations' efforts could be better utilized, and that the Section would benefit from stronger collaboration and organization of policy and environmental change efforts.

North Carolina's Tobacco Prevention and Control program, in partnership with the Heart Disease and Stroke Prevention Program and the Justus-Warren Heart Disease and Stroke Prevention Task Force, has accomplished strategic policy and environmental change success despite NC's strong historical, economic and political ties to tobacco. Recent legislation mandates that all schools be 100% tobacco-free and that all state owned and operated buildings are smoke free. However, key evidence-based policies (smoke free workplaces and public places and a substantial tobacco tax) remain as significant policy and environmental change goals. The Tobacco program has been successful by developing statewide support for tobacco control policy, utilizing earned media and social marketing techniques, and empowering local governments to implement successful legislation. A number of NC chronic disease programs would benefit from mentoring and training from Section members who are more experienced in policy and environmental change, such as members of the Tobacco program. The Policy and Environmental Change Community of Practice aims to increase knowledge and skills through assessments and training to improve overall chronic disease policy and environmental change success in state and local forums.

North Carolina chronic disease programs are recognized nationally for their effective use of partnerships to achieve policy and environmental change goals. In 1994, Division of Community Health (precursor to the now Chronic Disease & Injury Section) staff worked with many partner organizations across the state to develop and implement a preliminary plan to prevent heart disease and stroke. The first activity in the plan was to establish and fund a legislative CVD prevention task force. In 1995, the N.C. General Assembly established the Heart Disease and Stroke Prevention Task Force (now named the Justus-Warren Heart Disease and Stroke Prevention Task Force), which includes six legislators and representatives of partner organizations and distinguished professions. The Task Force is charged with raising awareness of CVD, profiling its burden, and developing and promoting a statewide CVD plan. In partnership with the CDI Section and other key stakeholders, the Justus-Warren Heart Disease and Stroke Prevention Task Force has achieved high-level policy and environmental changes in N.C. Other legislatively appointed task forces for chronic disease issues include the Governor's Task Force on Healthy Carolinians, and the Advisory Committee on Cancer Coordination and Control. Better policy and environmental change coordination with these entities would increase opportunities to promote the chronic disease policy agenda.

Governmental agencies are limited in their ability to advocate for policy change. Effective programs have developed external partners to promote a Chronic Disease Policy Agenda or have built relationships with influential professional organizations or trade associations. The Division is currently working with the NC Institute of Medicine to convene a number of task forces composed of legislators, content experts and community leaders to make policy recommendations to the NC General Assembly and other state policy makers and funders. These include a Prevention Task Force, an Adolescent Task Force, a Substance Abuse Task Force, and the Task Force on Prevention of Childhood Obesity. CDIS staff provide expertise and staff support to these efforts. In addition, the State Health Director has developed an agreement with the NC Hospital Association to identify and pursue common legislative priorities each biennial session. The Chronic Disease Director chairs the Public Health Committee of the NC Medical Society and has recently been elected to its Board of Directors.

Policy and Environmental Change Community of Practice Basic Team Information

<p>Team Mission: To maximize the effectiveness of the Chronic Disease and Injury (CDI) Section for development, advocacy and the successful adoption of evidence-based and promising practices policies at the state and local level to prevent and reduce chronic disease in NC.</p>	
<p>Team Champion: Sally Herndon Malek, MPH</p> <p>The team champion will:</p> <ul style="list-style-type: none"> ▪ advocate for resources for the team, ▪ give guidance on team goals and objectives ▪ acknowledge the work of the team with the Senior Management Team (SMT) and others, ▪ attend meetings when possible, and ▪ ensure that Section Management assign at least one member of each program/branch to this team 	<p>Team leader: Elizabeth Zurick, MA, MPH</p> <p>The team leader will:</p> <ul style="list-style-type: none"> ▪ convene meetings, set agendas, and rotate minute taking, ▪ facilitate meetings or communicate the need for external facilitation to the Team Champion, ▪ communicate team accomplishments and needs to the Team Champion, and ▪ assemble, safeguard and discharge team correspondence
Team Members:	Area of Expertise:
Christopher Bryant/Program Director, Diabetes Prevention and Control Branch	<i>MEd, Primary Liaison to Diabetes Advisory Council, experience in non-profit and public health policy and environmental change advocacy</i>
Caroline Chappell/ Program Director, Asthma Prevention and Control Program	<i>MPA, lead for Asthma Alliance of North Carolina</i>
Anita Holmes/Program Director Heart Disease and Stroke Prevention Branch	<i>JD, MPH, Executive Director of Justus-Warren Heart Disease and Stroke Prevention Task Force, experience working with non profits, faith communities, and state agencies on public health policy</i>
Karen Knight/ Director, Central Cancer Registry/ NC State Center for Health Statistics	<i>PhD, epidemiologist with experience in application of data to health policy</i>
Jim Martin/ Director of Policy and Programs, Tobacco Prevention and Control Branch	<i>MS, advisor to the Health and Wellness Trust Fund, NC Governor Jim Hunt’s Advisor on teen tobacco use prevention, experience working at Federal, state, and local levels in policy and environmental change drafting, implementing, and advocating</i>
Sally Herndon Malek/ Program Director, Tobacco Prevention and Control Branch	<i>MPH, w/focus in policy and planning. 30 years experience in public health policy at the, state, national and local levels, extensive training and experience in tobacco control policy and interest in building policy and environmental change capacity for chronic disease and injury prevention and control</i>
Paris Mock/Nurse Consultant, Breast and Cervical Cancer Control Program and	<i>BSN, RN, experience working with Medicare and Medicaid on health administration issues</i>

WISEWOMAN	<i>and at state level on access to care issues</i>
Debi Nelson/ Interim Director, Office of Healthy Carolinians and Health Education	<i>MEd, Executive Staffperson for Governor's Task Force for Healthy Carolinians, experience in garnering community-based support for local and state health policy and environmental change</i>
Jimmy Newkirk/ Deputy Director, Physical Activity and Nutrition Branch	<i>Staff to Advocacy Committee of the Eat Smart Move More Leadership Team, Public Health Representative to multi-agency Healthy Environments Collaborative, experience in statewide and local physical activity policy and environmental change</i>
April Reese/Evaluation Coordinator Diabetes Prevention and Control Branch	<i>MPH, member of core program integration team, cross-discipline experience in policy, social marketing and evaluation and leadership</i>
Rebecca Reeve/Senior Advisor, NC Healthy Schools Initiative	<i>PhD, experience working at Federal, local, and state levels on school health, food security, and public health issues</i>
Sharon Rhyne/ Health Promotion Manager	<i>MHA and MBA, manager of all 5 Section health promotion programs, former Executive Director of NC Traumatic Brain Injury Task Force</i>
Valerie Russell/Program Director, Injury Prevention and Control Branch	<i>DHSc and MEd, experience in developing teen pregnancy prevention and state injury prevention policy and environmental change</i>
Walter Shepherd/ Program Director, Comprehensive Cancer Control Branch	<i>MA, Executive Director of NC Advisory Committee on Cancer Coordination & Control</i>
Alexander White/ Policy Intervention Specialist, Heart Disease and Stroke Prevention Branch	<i>JD and MPH, staff for Legislative Committee of Justus-Warren Heart Disease and Stroke Prevention Task Force, experience in health policy at the state and national levels</i>
Elizabeth Zurick/ Policy Advisor, Centers for Disease Control and Prevention Assignee	<i>MA and MPH, member of core program integration team, experience working at Federal and state level on public health policy and environmental change issues</i>

Targeted Key Partners:
NC Alliance for Health, NC Local Health Directors Association, American Heart Association, American Cancer Society, American Diabetes Association, NC Hospital Association, NC Medical Society, NC Institute of Medicine, NC Public Health Commission, Justus Warren Heart Disease and Stroke Prevention Task Force, Advisory Committee on Comprehensive Cancer Control, Governor's Task Force on Healthy Carolinians, Diabetes Advisory Council, Eat Smart Move More Leadership Team, NC Asthma Alliance

Policy and Environmental Change Community of Practice Goals, Focus Areas, and Objectives

Goal #1: *Develop Section policy platform*

Focus Area 1: Develop a coordinated, prioritized Chronic Disease and Injury (CDI) Section evidence-based policy agenda

Objective 1a: By March 2009, develop policy prioritization criteria using evidence-based policy and environmental change development tools

Objective 1b By July September 2009, conduct at least 2 meetings to review and provide input to each Branch’s 2020 policy objectives

Objective 1c: By September 2009, collect Section policy priorities from all branches and programs

Objective 1d: By October 2009, ensure that CoP, Section Management Team, and Chronic Disease Director use policy prioritization criteria to rank policies

Objective 1e: By November2009, publish Section policy agenda and share with Office of State Health Director and other stakeholders in the NC Department of Health and Human Services

Objective 1f: By February 2010, disseminate policy platform to grassroots partners and influential stakeholders

Objective 1g: By February 2010, develop and implement social marketing and media campaigns that support policy and environmental change priorities

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Criteria protocol Policy agenda Social marketing/ media campaign	The Policy and Environmental Change CoP will monitor criteria protocol satisfaction via integration survey, policy adoption by partners via written documentation, and media campaign via reach reports	By February 2010, a percent of influential partners and grassroots partners will provide advocacy for the CDI Section policy agenda as evidenced by legislative summaries	

Focus Area 2: Create a policy tracking tool of Section and Branch policy priorities

Objective 2a: By March 2009, conduct a needs assessment of necessary tracking tool components with Section leadership

Objective 2b: By April 2009, collect recommendations based on needs assessment from Section leadership

Objective 2c: By May 2009, develop and implement policy tracking tool

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Needs assessment tool Policy tracking tool	The Policy and Environmental Change CoP will monitor needs assessment and tool development via meeting minutes and tool satisfaction via integration survey	By May 2009, the Section will use the policy tracking tool for all relevant legislation	The Section will create and maintain an intranet

Focus Area 3: Create a policy calendar of critical policy events and deadlines

Objective 3a: By March 2009, conduct a needs assessment of necessary calendar events with Division and Section leadership

Objective 3b: By March 2009, collect recommendations based on needs assessment from Section leadership

Objective 3c: By April 2009, develop perpetual policy calendar with critical timelines

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Needs assessment tool Perpetual policy calendar	The Policy and Environmental Change CoP will monitor needs assessment and tool development via meeting minutes and tool utilization via Section Management Team	By April 2009, all Section Branches and Programs will use the perpetual policy calendar	

Goal #2: *Increase capacity for policy and environmental change development*

Focus Area 4: Establish sustainable Section policy and environmental change training program

Objective 4a: By June 2009, create an assessment tool of policy and environmental change training needs

Objective 4b: By August 2009, survey Section policy staff using training assessment tool

Objective 4c: By October 2009, analyze results of assessment to identify gaps and resources

Objective 4d: By March 2010, create training program curriculum, including webinars, site visits, and seminars

Objective 4e: By May 2010, implement policy and environmental change training program

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Needs assessment tool	The Policy and Environmental Change CoP will monitor needs assessment and tool development via meeting minutes and tool utilization via Section Management Team	By February 2011 all Section policy staff will be trained using Section policy and environmental change curriculum	Sufficient personnel to create training curriculum
Survey results report			
Training curriculum			

Focus Area 5: Develop and support program staff with experience and skills in policy and environmental change development

Objective 5a: By August 2010, review position descriptions and current qualifications for policy positions in the Section

Objective 5b: By November 2010, draft model job descriptions for policy positions that list core duties and competencies (including core public health competencies and essential public health services)

Objective 5c: By February 2011, disseminate model job descriptions to CoP, Section Management Team, and others in Section

Objective 5d: By May 2011, disseminate at least one interview/resume protocol that provides questions and measures to assess core competencies critical to policy positions

Objective 5e: By January 2012, develop at least one shared position across categorical programs to work on policy development

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Draft model job descriptions Interview protocol	The Policy and Environmental Change CoP will monitor progress on developing an interview protocol and job descriptions through review of subcommittee reports and meeting minutes. When both are completed, the CoP will annually track the number of positions hired using the protocol by management voice or e-mail confirmation	By May 2011, a percent of Section positions will match the model job descriptions as monitored by a database which will be developed by the Policy and Environmental Change CoP and stored on the intranet By January 2012, all policy positions will be hired using the interview protocol	Section Management Team is willing to disclose this information and allow for standards to be used

Goal #3: *Enhance relationships with internal and external policy and environmental change partners*

Focus Area 6: Coordinate Section managed Task Forces and partner organizations

Objective 6a: By February 2011, create a descriptive inventory of all Section managed Task Forces and partner organizations

Objective 6b: By March 2011, determine shared policy and environmental change goals and opportunities

Objective 6c: By September 2011, establish quarterly meetings of lead staff of Section managed Task Forces and partner organizations

Objective 6d: By January 2012, disseminate Section policy platform to Task Forces and partner organizations for review and request support for implementation

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Task Force and partner organization inventory	The Policy and Environmental Change CoP will monitor partner satisfaction via survey	By January 2012 all Task Force and partner organization will demonstrate advocacy support of policy agenda via survey results	Task Force and partner organization members support Section priorities that are in alignment with their overall goals, objectives, and priorities

Focus Area 7: Coordinate and improve partner organizations’ policy and environmental change efforts

Objective 7a: By September 2009, recruit influential internal and external public health stakeholders as CDI Section policy and environmental change champions

Objective 7b: By January 2010, create a descriptive inventory of all partner organizations and develop consensus documents on policy and environmental change priorities

Objective 7c: By February 2010, disseminate Section policy platform to partner organizations for review and request support for implementation

Objective 7d: By February 2010, under the supervision of Division Leadership, meet with legislative bill drafting staff and agree on language for Section priorities

Objective 7e: By March 2010, assign roles and continue execution of media awareness strategies for policy platform

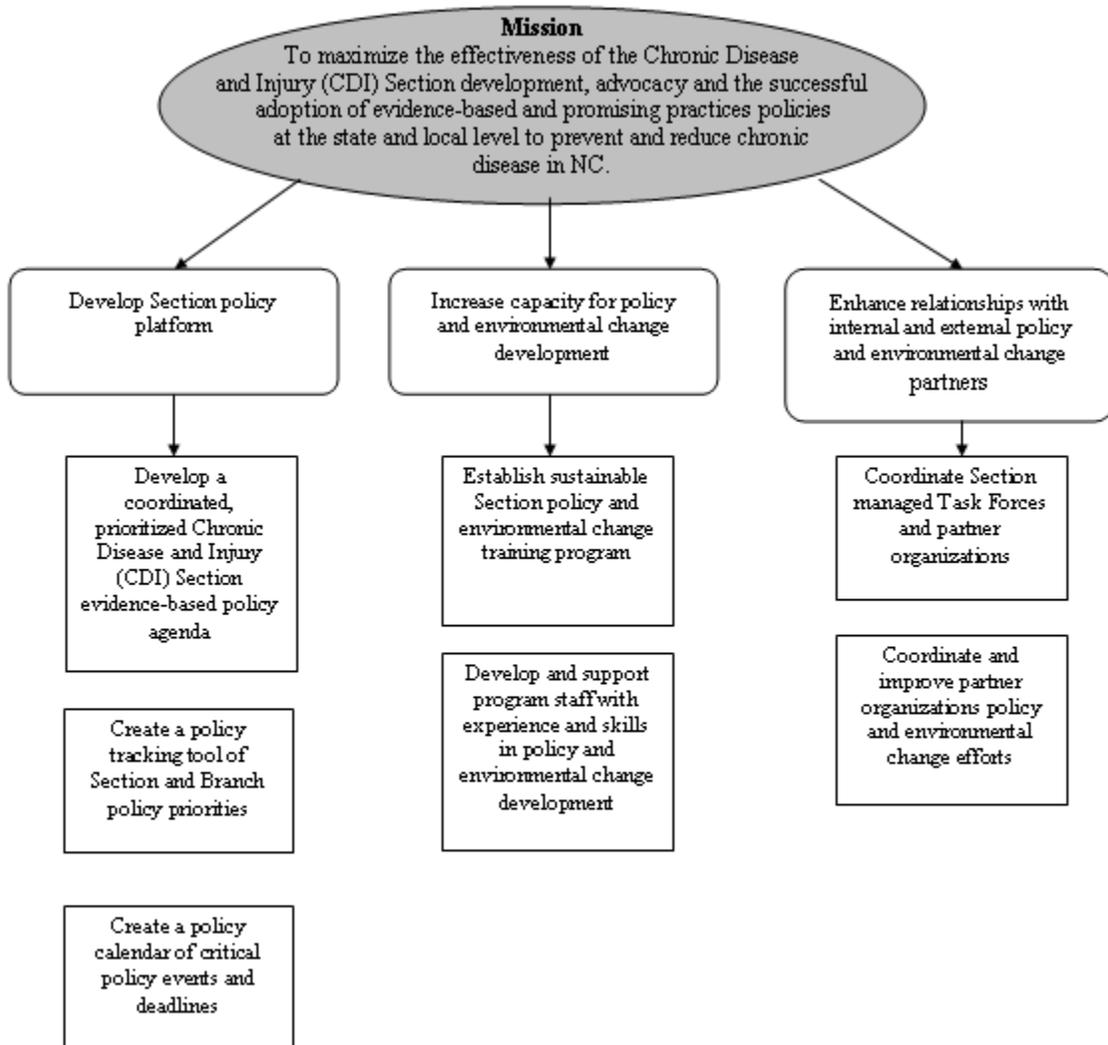
Objective 7f: By April 2010, share legislative strategies with newspaper editorial boards

Objective 7g: By April 2010, develop and disseminate technical assistance plans to partners to support policy platform, especially the NC Alliance for Health

Evaluation Metrics

Output	Process measure(s)	Outcome objective	Critical assumptions
Partner inventory List of assigned roles for media awareness campaigns List of editorial board strategies Technical assistance plans for partners	The Policy and Environmental Change CoP will annually review and update partner inventory and revise roles as needed	By April 2010, have the endorsement of a majority of newspaper editorial boards for policy and environmental change priorities By September 2009, have at least two priorities supported by influential professional organizations/trade associations By September 2009, have at least two policy and environmental change priorities supported by most chronic disease advocacy groups	Section policy and environmental change priorities meet the priority criteria and are supported by partner organizations

Policy and Environmental Change CoP Strategy Map



Health Data Community of Practice

Background/History

Since 1998, members of the N.C. Division of Public Health Epidemiology and Evaluation staff have met monthly to share information and promote professional development. The Heart Disease and Stroke Prevention Epidemiologist (PhD level), and the Data Manager for the Women's and Children's Section, serve as co-chairs. Early in 2008, the Epi/Eval Team agreed to use the Communities of Practice Assessment Rubric tool to assess their current level of functioning as a Community of Practice (CoP). While the group members scored themselves high in terms of ability to take on integrated tasks, they resisted formalizing aspects such as keeping minutes and reporting on member participation. The main barrier to formalization was lack of administrative support. The Section Management Team prioritized evaluation, epidemiology and surveillance as focus areas for integration, leading to the need to have a data focused CoP. It was also felt that a CDI Section specific CoP for evaluation and epidemiology was needed in order to have dedicated time to work on CDI-specific integration efforts. Because current literature on Communities of Practice suggests that they be formalized and because integration is concentrated within the CDI Section, it became necessary to convene a CoP, in addition to the Epi/Eval Team. Further demonstration of need for this CoP includes the following:

- Section epidemiology capacity, particularly in terms of coordination across branches, has not recovered since the loss of the lead chronic disease epidemiologist position, nearly 10 years ago.
- The STAR report and the Integration Blueprint reference the need for increased epidemiology and evaluation capacity.
- Some projects require coordination across the Section, such as the gathering of map data for the aging grant, the creation of a chronic disease burden book, mapping health disparities, etc. These tasks are routinely assigned to staff already overburdened with categorical work.
- Many of the local health departments and some Chronic Disease programs do not have access to an Epidemiologist and there is a possibility that these needs could be addressed in a fiscally sustainable way by hiring a Lead Chronic Disease Epidemiologist, enhancing the State Center's capacity to conduct Chronic Disease tasks and/or by using the CoP in this role.
- Most Chronic Disease programs collect evaluation data on local health department progress towards environmental and policy change in separate systems. There is a need to create a system that is consistent for the local health departments and provides accountability to funders.
- There are many partnerships within the Section, but very little evaluation of these partnerships. Training on collaboration evaluation would be beneficial.
- There is a focus on process evaluation for program planning that needs to be augmented with impact and outcome-based evaluation.

The strength of the Data CoP is in the quality of epi/eval staff and their willingness to work together. Current major projects include, the UNC-CH Management Academy of Public Health (MAPH) business plan, which will create a workforce development program called *NC EpiSmart*. *EpiSmart* will offer continuing education to state and local health department staff in epidemiology, evaluation, and statistics. National and state experts will provide professional development in the form of webinars. State staff will provide technical assistance on concepts that may be unclear. *EpiSmart* will offer state and local staff the opportunity to learn from each other through webinars, site visits, and telephone consultations that will exceed current level of epidemiology, evaluation and statistical technical assistance. Local health agencies will pay for the advanced technical assistance services; these fees will sustain the *NC EpiSmart* program. Also, the State Center for Health Statistics recently launched the North Carolina CATCH (Comprehensive Assessment for Tracking Community Health) system. NC-CATCH is a collaborative effort between UNC Charlotte and state and local public health agencies in the state that provides the public with a wide array of demographic and community health data, along with comparisons with peer counties and the state. In addition, the NC-CATCH "Indicator Fact Sheets" supply users with trends in indicators over time, as well as breakdowns by race and ethnicity for many health measures. The history of collaboration among the epi/eval team positions the Data Collaborative Community of Practice for success. The goals and objectives of the CoP reflect a mix of Section priorities and identified gaps and needs.

Health Data Community of Practice Basic Team Information

Team Mission: To enhance CDI and local epidemiology and evaluation capacity; to lead data collection and reporting initiatives; and, to address health disparity data needs..	
<p>Team Champion: Dr. Paul Buescher</p> <p>The team Champion will:</p> <ul style="list-style-type: none"> ▪ advocate for resources for the team, ▪ give guidance on team goals and objectives ▪ acknowledge the work of the team with the Senior Management Team (SMT) and others, ▪ attend meetings when possible, and ▪ ensure that Section Management assign at least one member of each program/branch to this team 	<p>Team co-leaders: April Reese/Jennifer Woody</p> <p>The team co-leaders will:</p> <ul style="list-style-type: none"> ▪ convene meetings, set agendas, and rotate minute taking, ▪ facilitate meetings or communicate the need for external facilitation to the Team Champion, ▪ communicate team accomplishments and needs to the Team Champion, and ▪ assemble, safeguard and discharge team correspondence
Team Members:	Area of Expertise:
Jenni Albright/Evaluation Coordinator Physical Activity and Nutrition Branch	<i>MPH, RD, experienced evaluator of community interventions</i>
Kim Angelon-Gaetz/Epidemiologist Healthy Carolinians Program	<i>MSPH level environmental epidemiologist with experience in community health assessments</i>
Michael Bramwell/Evaluator WISEWOMAN Program	<i>MS, with program planning, evaluation and compliance monitoring</i>
Paul Buescher/Branch Head State Center for Health Statistics	<i>PhD level demographer with 28 years of experience working with public health data</i>
Manzoor Choudry Comprehensive Cancer	<i>MS, epidemiology and evaluation training, experience in statistics and economic forecasting</i>
Dee Dee Downie/CDC Fellow CDI Section with particular emphasis in Physical Activity and Nutrition Branch	<i>MPH with CDC epidemiology and evaluation training</i>
Terence Fitz-Simmons/ Breast and Cervical Cancer Branch	<i>PhD level epidemiologist with experience in breast and cervical cancer</i>
Sara Huston/Epidemiologist Heart Disease and Stroke Prevention Branch	<i>PhD level epidemiologist with organizational history and national contacts, cardiovascular epidemiology</i>
Winston Liao/Epidemiologist Asthma Program	<i>Experienced evaluator with management, clinical trial research and quality assurance experience.</i>
Mike Placona/Evaluator Tobacco Prevention and Control Branch	<i>MS with over 20 years of experience in planning and evaluation of educational, training and community programs</i>
Parvati Potru/Epidemiologist Diabetes Prevention and Control Branch	<i>MS with experience in burden documents and fact sheets</i>
Scott Proescholdbell/Senior Epidemiologist Injury and Violence Prevention Branch	<i>MPH, with 15 years of public health experience at the local, state and national levels.</i>

April Reese/Evaluation Coordinator Diabetes Prevention and Control Branch	<i>MPH, with cross-discipline experience in policy, social marketing and evaluation</i>
Rebecca Reeve/Senior Advisor, NC Healthy Schools Initiative	<i>PhD, experience working at Federal, local, and state levels on school health, food security, and public health issues</i>
Nicole Standberry/Epidemiologist CDC Fellow assigned to the Heart Disease and Stroke Prevention, Tobacco Prevention and Control and Injury Prevention Branches	<i>MPH, applied epidemiology fellow with experience in data management, analysis, and evaluation.</i>
Jennifer Woody/Planner/Evaluator Injury Prevention Branch	<i>Experience planning and writing strategic plans, burden documents and performance metrics</i>
Tobacco Prevention and Control Director of Epidemiology and Surveillance	<i>Vacant position, to be filled by March 2009</i>

Targeted Key Partners:
Office of Minority Health, State Center for Health Statistics, CDIS CoP champions and team leads, N.C. State Association of Local Health Directors

Health Data Community of Practice Goals, Focus Areas, and Objectives

Goal #1: *Increase state and local chronic disease evaluation and epidemiology capacity*

Focus Area 1: Research and recommend pathways to hire a CDI chronic disease epidemiologist

Objective 1a: By August 2008, research ways to hire a chronic disease epidemiologist.

Objective 1b: By October 2008, present research to Section Chief.

Objective 1c: By December 2009, then annually, report to Section Chief additional pathways to hire a CDI chronic disease epidemiologist.

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Report to Section Chief	The Health Data CoP will report annually on the results of methods to research and hire a chronic disease epidemiologist	By June 2011, the CDI Section will have a chronic disease epidemiology position	Funds will become available to support this position or existing staff will serve in this capacity

Focus Area 2: Implement EpiSmart Workforce Development Initiative

Objective 2a: By August 2009, identify staff to write a start up grant.

Objective 2b: By June, 2010, obtain start up funds.

Objective 2c: By December 2010, begin implementing EpiSmart in phases.

Objective 2d: By December 2011, evaluate EpiSmart for continued implementation.

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Workforce development training program for state and local staff that focuses on enhancing competencies in epidemiology, evaluation and statistics	The Health Data CoP will track EpiSmart implementation	By December 2011, EpiSmart will attract enough participants to sustain itself	Funds will become available to support this position or existing staff will serve in this capacity

Focus Area 3: Provide evaluation guidance to all CoPs

Objective 3a: By March 2009, identify year one projects to evaluate.

Objective 3b: By June 2009, assign member(s) to give guidance on year one projects.

Objective 3c: By November 2009, provide guidance on projects.

Objective 3d: By December 2009, report on evaluation progress.

Objective 3e: By March 2010, identify year two projects to evaluate.

Objective 3f: By June 2010, assign member(s) to give guidance on year two projects.

Objective 3g: By November 2010, provide guidance on projects.

Objective 3h: By December 2010, report on evaluation progress.

Objective 3i: By March 2011, identify year three projects to evaluate.

Objective 3j: By June 2011, assign member(s) to give guidance on year three projects.

Objective 3k: By November 2011, provide guidance on projects.

Objective 3l: By December 2011, report on evaluation progress.

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Update evaluation reports on CoP projects	The Health Data CoP will provide annual updates on the evaluation process for CoP projects	By December 2011, integration projects will be fully evaluated and lessons learned shared	CoP's will have funds or staff time to implement evaluations

Goal #2: *Address health disparities and other Section priorities through coordinated data collection and reporting*

Focus Area 4: Develop and maintain a Chronic Disease Burden Book

Objective 4a: By December 2008, review the Integration Blueprint to determine how it can be expanded into a chronic disease burden book

Objective 4b: By June 2009, develop a chronic disease burden book

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Chronic disease burden book to be published and maintained on the CDI website and branch/program websites	The Data CoP will track development of the chronic disease burden book via sub-committee reports and meeting minutes and will monitor use thereafter	By June, 2009, the CDI Section will develop and maintain a chronic disease burden book as evidenced by publication on branch/program and CDI websites	There will be sufficient staff or staff time to develop and maintain the book

Focus Area 5: Collaborate with the Office of Minority Health and SCHS to add specific chronic disease and risk factor data to the health disparities report card

Objective 5a: By January 2009, meet with the Director of the Office of Minority Health (OMH) and the Director of the State Center for Health Statistics to determine what type of crosswalk is possible between the disparities data collected by CDI staff and the Minority Health Report Card.

Objective 5b: By June 2009, provide ongoing input into Minority Health Report Card.

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Minority health disparities report card	The Data CoP will track meetings with OMH and SCHS via sub-committee reports and meeting minutes. Will track how often the link to the OMH website is accessed via the CDI website	By June, 2009, the CDI Section, will offer support for the bi-annual OMH and SCHS disparities data report cards	It is possible that the timeline for publishing the report card is not flexible to accommodate additional comments at this time, so we may miss the first cycle, but will be able to provide assistance in the future

Focus Area 6: Develop a guidance document and data review protocol for burden documents

Objective 6a: By March 2009, develop a data review protocol for burden documents

Objective 6b: By June 2009, work with all Epi/Eval Team to determine what data elements are critical for burden documents

Objective 6c: By July 2009, pilot test the data review protocol

Objective 6d: By August 2009, conduct informal interviews with external partners to determine which data elements are critical for burden documents

Objective 6e: By December 2009, revise data review protocol and begin formal implementation

Objective 6f: By January 2010, develop a list of critical data elements for burden documents

Objective 6g: By June 2011, all burden documents will include critical elements

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Data review protocol document and burden book critical elements list	The Data CoP will track the development of the review protocol and burden book critical elements, then annually measure the number of burden books that use them.	By December 2010, all CDI burden books will be reviewed following the established data review protocol By December 2011, all CDI burden books will include critical elements	

Focus Area 7: Work with SCHS to develop a chronic disease dynamic mapping system

Objective 7a: By March 2009, propose a list of diseases to map, based on an assessment of CDI needs, also determine if mapping in Phase 2 of CATCH will be sufficient. If not, proceed with the rest of the objectives

Objective 7b: By September 2009, establish an agreement with SCHS regarding the cost and timeline of maps to be provided by SCHS to Section

Objective 7c: By January 2010, obtain funding for on-demand integrated disease and risk factor maps

Objective 7d: By June 2011, initiate on-demand integrated disease and risk factor maps

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Dynamic integrated chronic disease and risk factor maps	The Data CoP will track map service progress via sub-committee reports and meeting minutes. If dynamic mapping becomes available, the Data CoP will monitor staff satisfaction annually on the integration survey	By June, 2011, the SCHS will offer a dynamic integrated chronic disease and risk factor map system as evidenced by the SCHS website	That SCHS can offer this service by expanding the existing Health Atlas mapping functions and that funds can be obtained to make it technologically feasible

Focus Area 8: Explore coordinated system for LHD reporting

Objective 8a: By December 2009, gather input from LHD staff to assess the perceived needs, opportunities and barriers related to a coordinated LHD reporting system.

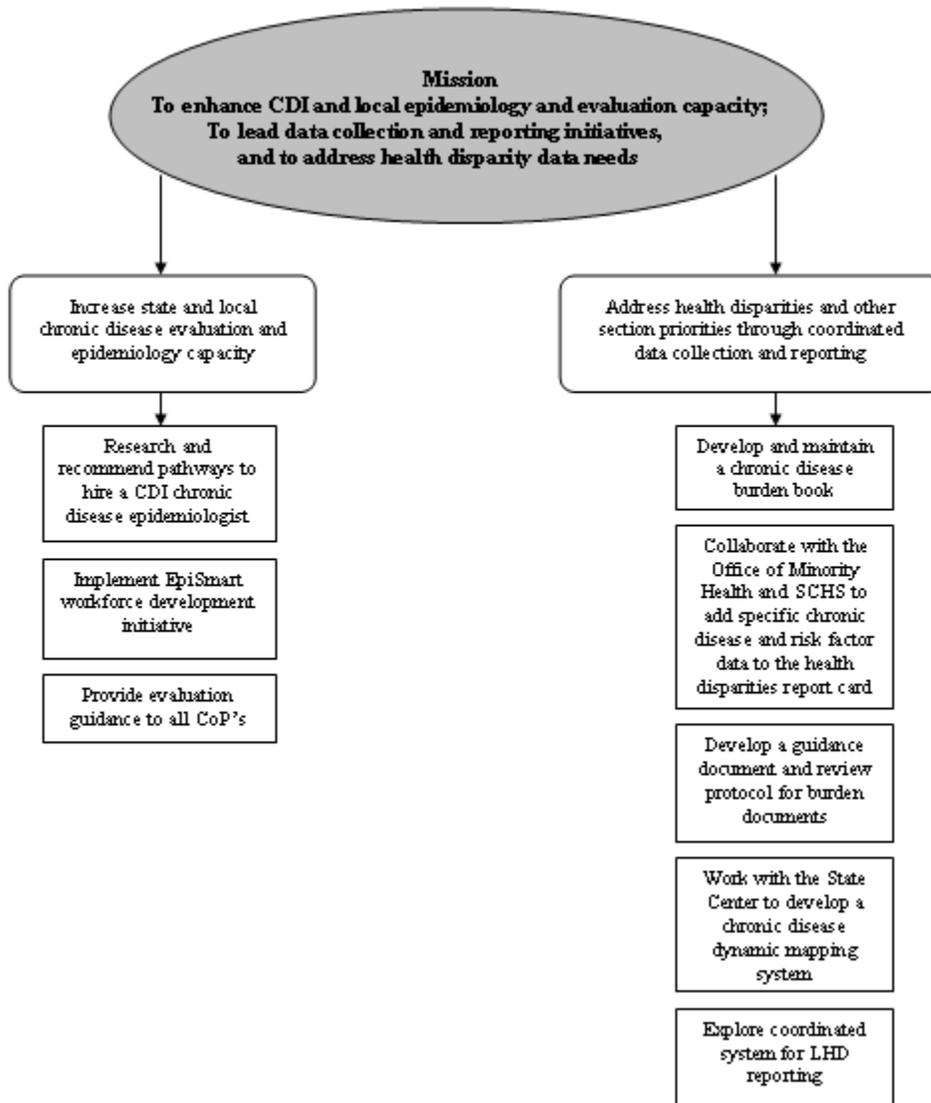
Objective 8b: By December 2010, gather input from Section staff and other state stakeholders to assess data needs and perceived barriers related to the development of a coordinated LHD reporting system.

Objective 8c: By June 2011, make recommendations to Section Management related to a coordinated LHD reporting system, based on assessment results.

Evaluation Metrics

Output(s) and data storage	Process measure(s) (include data source & monitor)	Outcome objective(s) (include data source & monitor)	Critical assumptions (if any)
Due diligence report to be maintained on the CDI intranet	The Data CoP will track the coordinated system progress via sub-committee reports and meeting minutes	By June, 2011, the CDI Section will begin implementation of a coordinated system for LHD reporting or better coordinate the technical assistance for each system at the local level	Staff will use a coordinated system as previous attempts have been unsuccessful

Health Data CoP Strategic Map



Healthcare Systems Community of Practice

Background/History

The Healthcare Systems Community of Practice was established to support current state quality improvement efforts. Specifically, it strives to promote effective primary care models for clinical management of chronic diseases through systems change. In 2006, the NC Chronic Disease programs embarked on an effort to expand our primary care Chronic Disease Collaborative pilot to a statewide primary care systems change model. The Section collaborated with highly-respected state medical system partners - North Carolina's provider driven Medicaid managed care program, NC Area Health Education Centers, the University of North Carolina School of Medicine and the state's primary care specialty societies - to participate as a founding partner in NC 'Improving Performance In Practice' (NC-IPIP).

Initially a pilot project in North Carolina and Colorado, IPIP was created through a joint effort of the American Board of Medical Specialties, American Board of Family Medicine, American Board of Pediatrics, and the American Academy of Family Physicians as a national initiative to dramatically improve performance of primary care practices across states. The initiative is based on the Chronic Care Model and emphasizes a systems change approach to data collection, practice organization and staff roles. Specific methods include (a) Quality Improvement Coordinators (QICs) working with individual practices, (b) an emphasis on whole practice population-based data collection on common measures, (c) rapid cycle quality improvement approach, and (d) a variety of collaborative learning strategies. This staged approach includes implementing an electronic registry for medical conditions, developing templates for planned care, defining and using practice-wide care protocols, and implementing strategies to support patient self-management efforts.

The NC Division of Public Health (DPH) provided initial financial support for IPIP and continues its support through contributions from the asthma, diabetes, kidney, comprehensive cancer, and heart disease and stroke prevention programs. The integrated activities of this Healthcare Systems Community of Practice serve to build upon this foundation. Program integration is demonstrated through a variety of avenues. As an example, two of the Heart Disease and Stroke Prevention Program Regional Coordinators work with IPIP Quality Improvement Consultants in their region in addressing CVD related risk factors.

The Chronic Care Model also calls for expanded use of community resources and development of new policies to produce informed, motivated patients. The result is productive interactions between patients and providers and improved health outcomes. Through initiatives in the Diabetes, Heart Disease and Stroke Branches, DPH is also promoting the Chronic Disease Self Management Program (CDSMP) as another method of system change. CDSMP provides information and teaches practical skills on managing chronic health problems to build confidence and promote the maintenance of health. As the result of a formal partnership between DPH and the NC Division of Aging and Adult Services, DPH is also helping fund staff for a three year US Administration on Aging grant to promote CDSMP in 46 counties in the state by utilizing the aging network and its many partners.

The Healthcare Systems Community of Practice was formed to: 1) formalize the relationship and coordinate efforts between IPIP and the DPH chronic disease programs; 2) facilitate, within DPH, the dissemination and utilization of IPIP data; 3) enhance the sharing of programmatic resources

between DPH, IPIP and related partners; 4) promote IPIP as a principal portal to promote systems change and institutionalize quality improvement in clinical practices across North Carolina; 5) support the development of self-management strategies that empower individuals to manage their health and healthcare, and 6) promote care that is consistent with evidence-based guidelines.

Healthcare Systems Community of Practice Basic Team Information

Team Mission: To support current state quality improvement efforts to promote effective primary care models for clinical management of chronic diseases by improving systems in practices across the state.	
Team Champions: Sharon Rhyne/Chris Ogden The team Champions will: <ul style="list-style-type: none"> • Advocate for resources for the team • Give guidance on team goals and objectives • Acknowledge the work of the team with the Senior Management Team (SMT) and others • Attend meetings when possible, and • Ensure that Section Management assign necessary team members of appropriate branches to this team 	Team Leader: Cindy Haynes-Morgan The team leader will: <ul style="list-style-type: none"> • Convene meetings, set agendas, and rotate minute taking • Facilitate meetings or communicate the need for external facilitation to the Team Champion • Communicate team accomplishments and needs to the Team Champion and • Assemble, safeguard and discharge team correspondence
Team Members	Area of Expertise
Caroline Chappell	<i>MPA - Branch Head/Asthma</i>
Donna Dayer	<i>BS, RRT-Tobacco Cessation Specialist, Certified Asthma Educator</i>
Katrina Donahue	<i>MD, MPH – Physician Consultant</i>
Laura Edwards	<i>RN, MPA - Kidney/Epilepsy/Diabetes Education Recognition Program Coordinator</i>
Jacque Halladay	<i>MD, MPH – Physician Consultant/Epidemiologist</i>
Cindy Haynes-Morgan	<i>MSA-PA, CHES, RHed -Diabetes Health Education</i>
Anita Holmes	<i>JD, MPH - Branch Head/Heart Disease and Stroke Prevention</i>
Ann Lefebvre	<i>MSW, CPHQ - Director of Improving Performance and Practice</i>
Sally Herndon Malek	<i>MPH, Branch Head/Tobacco Prevention & Control and Administrator of NC Tobacco Use Quitline</i>
Chris Ogden	<i>RN - Chronic Disease Manager</i>
Linda Rascoe	<i>BSPH, MED - Branch Head/Breast and Cervical Cancer</i>
Sharon Rhyne	<i>MHA, MBA - Health Promotions Manager</i>
Walter Shepherd	<i>Branch Head/Comprehensive Cancer</i>

Targeted Key Partners:

Area Health Education Centers; Carolinas Center for Medical Excellence; Community Care of NC; Improving Performance in Practice (IPIP), the IPIP Steering Committee, and IPIP Quality Improvement Coordinators; NC Academy of Family Physicians; NC

Chapter of the American College of Physicians; NC Division of Aging and Adult Services; NC Division of Medical Assistance; NC Health Quality Alliance; NC Hospital Association; NC Institute of Medicine; NC Local Health Departments; NC Medical Society; NC Pediatric Society; and UNC School of Medicine

Healthcare Systems Community of Practice Focus Areas, Goals, and Objectives

Goal #1: *Support current state quality improvement efforts (Improving Performance in Practice and the NC Healthcare Quality Alliance) to promote effective primary care models for clinical management of chronic diseases by improving systems in practices across the state.*

Focus Area 1: Foster process improvement in primary care practices.

Objective 1a: By June 2009, identify and promote 5 integrated measures (implement a registry, develop a template of planned care, use clinical practice protocols, implement patient self-management support and maintain team engagement) to document systems changes in clinical practices that are relevant to all chronic disease areas.

Objective 1b: By June 2010, conduct an evaluation of the effectiveness of the five integrated measures and revise as indicated.

Objective 1c: By June 2011, address the spectrum of chronic disease care by compiling a comprehensive, integrated chronic disease management curriculum in partnership with the quality improvement consultants from IPIP.

Objective 1d: By June 2011, initiate the formal process to request new measures from the national IPIP project to address cancer prevention and early detection in the NC IPIP.

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective	Critical assumptions
Evaluation report of the five integrated measures	The Healthcare CoP will annually monitor progress of the 5 integrated measures via the QIC reports.	By June 2011, a percent of IPIP practices will adopt the CDI/IPIP curriculum as evidenced by correspondence from IPIP Coordinators	Funds and/or staff will be available to conduct the evaluation
Integrated chronic disease management curriculum	The CoP will monitor curriculum usefulness by customer satisfaction survey		

Focus Area 2: Improve communication between DPH branches and other organizations to increase awareness and use of chronic disease programs.

Objective 2a: By June 2009, implement at least 3 strategic interface activities which include planning, oversight, and evaluation efforts among DPH and IPIP.

Objective 2b: By August 2009, conduct an environmental scan of programmatic resources for chronic diseases in partnership with IPIP.

Objective 2c: By June 2010, facilitate sharing of programmatic resources between at least 10 state and regional organizations.

Objective 2d: By June 2011, conduct a partnership evaluation to assess satisfaction with chronic disease integration efforts with at least ten of the state and regional organizations as referenced in Objective 2c.

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Programmatic resource environmental scan report Partnership evaluation report	The Healthcare CoP will annually monitor increased internal communication in reference to IPIP via the integration survey The CoP will monitor the number of resources shared with state and regional organizations and the number of these organizations that receive materials	By June 2011, all CDI programs will demonstrate enhanced understanding of IPIP and the Section’s role in healthcare systems improvement via assessment by the Section Chief, CoP Champions and Co-leads By June 2011, the CDI Section will be respected as a chronic disease resource as evidenced by the number of request for resources by influential partners such as the N.C. Academy of Family Physicians, the N.C. Hospital Association and N.C. Medical Society	

Goal #2: *Foster the development and use of community resources and policies to promote patient self management and pilot new models of care and/or communication strategies through collaboration between local health departments and primary care practices.*

Focus Area 3: Promote chronic disease self-management programs in communities and plan for sustainability through DPH efforts.

Objective 3a: By April 2009, establish a baseline of number of practices referring patients for current chronic disease self-management programs, such as Living Healthy, the NC Tobacco Use Quitline, and the NC Diabetes Education Recognition Program.

Objective 3b: By April 2010, identify and facilitate three mechanisms to promote chronic disease self management programs.

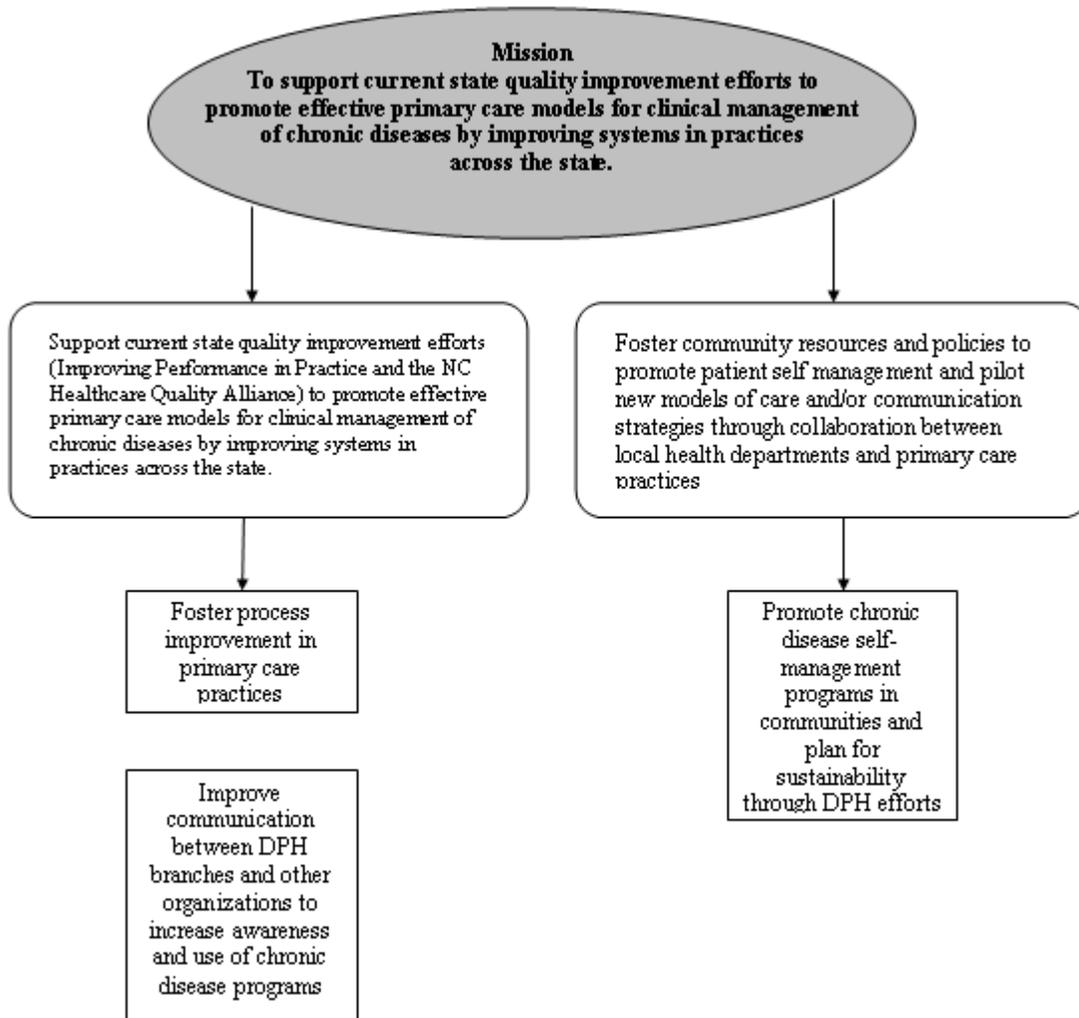
Objective 3c: By April 2011, demonstrate a 30% improvement in the number of practices referring patients for the chronic disease self-management programs.

Objective 3d: By April 2010, identify three possible sources of funding to sustain the Chronic Disease Self Management Program (CDSMP).

Evaluation Metrics

Output(s)	Process measure(s)	Outcome objective(s)	Critical assumptions
Database of practices referring patients to CDSMP List of funding sources to sustain CDSMP	The Healthcare CoP will establish a baseline number of practices and other entities referring patients to CDSMP programs then increase annually as evidenced by meeting minutes The Healthcare CoP will increase its sustainability funds each year	By June 2011, CDSMP referrals from effort within CDI will increase by a percent as evidenced by reports from the CoP to the Senior Management Team	CDSMP will remain an evidence-based approach that is supported by North Carolina and CDC

Healthcare Systems CoP Strategic Map



Other Integration Priority Areas for Community of Practice Development

The remaining three opportunities identified for program integration are beyond the scope of the three year timeline for this Work Plan. The priorities are identified in this Section but will be implemented at a later date.

Worksite Wellness Integration Priority Area

The North Carolina Division of Public Health has ready access to state employees and their worksites. These employees represent a broad socio-economic and demographic range. The state of North Carolina is the largest employer. A well developed state employee worksite wellness program can serve as a demonstration project for other employers in the state so that best practices and cost savings demonstrated in this setting are applied to other worksites. For the last two years, the Division has worked collaboratively with the State Employees Health Plan to develop a Department of Health and Human Services worksite wellness demonstration project based on the development and organization of worksite wellness committees. The CDIS Physical Activity and Nutrition program has developed a worksite wellness toolkit to provide training on policy and environmental change strategies for worksite wellness committees to address, nutrition, physical activity, tobacco use and stress. The Tobacco program designed a policy development campaign that has resulted in all state worksites being smoke free, and all public schools being 100% tobacco free. Current funding from the state health plan will end in June of 2009. A Community of Practice will be recruited and convened in the future to provide North Carolina's chronic disease funded programs an integrated focus on worksite wellness activities targeting the state employee work force. Efforts will expand existing statewide oversight, program resources, training, and evaluation of agency, university, and school employees for tobacco, obesity and injury prevention and chronic disease control interventions to improve the health of NC state employees and control increases in State Health Plan costs for state employees and teachers.

Health Disparities Integration Priority Area

It is anticipated that the Office of Minority Health and Health Disparities (OMHHD) will be moved organizationally into the Division of Public Health within the next year. This event will be used to drive the formation of a community of practice to work on an integrated health disparities effort across chronic disease programs and in collaboration with OMHHD. The state has compelling opportunities to draw from the experience and best practices of Project Direct and the Charlotte REACH project. A Health Disparities Community of Practice will be recruited and convened in the future to address an integrated health disparities effort across chronic disease programs and in collaboration with OMHHD.

Health Communication and Social Marketing Integration Priority Area

A group currently exists within the Division of Public Health, the Social Marketing Matrix Team, to foster collaboration and share best practices related to social marketing across the division. A social marketing Community of Practice will be recruited and convened in the future to address integration of social marketing efforts among chronic disease programs.

Goal IV: Continuously evaluate integrated outputs and health outcomes.

Introduction

The overarching goals for integration consist of the following: 1) Establish a well-articulated vision of the CDI Section as a fully integrated organization; 2) Develop infrastructure and build best management practices to support integration efforts; 3) Prioritize and implement integrated programs and processes using evidenced-based science and best practice models; and, 4) Continuously evaluate integration outputs and health outcomes. Section integration activities to date include: Creation of cross-cutting CoPs to perform integration activities; regular meetings of a Core Integration Team comprised of key Branch members; annual surveys measuring CDI staff knowledge, awareness and attitudes about integration; and development of integration orientation materials for CDI staff.

Improved health outcomes as evidenced by changes in chronic disease and risk factor rates in the Behavioral Risk Factor Surveillance System (BRFSS) are an anticipated long-term outcome of integration. Each categorical program monitors BRFSS rates and other data sources to measure performance by NC and national 2010 Health Objectives. These measures will now be tracked across programs in a centralized chronic disease database. However, improved health outcomes may not be demonstrated in the three-year integration implementation period or correlate to these activities. Therefore, we will monitor integration implementation through the CoP focus areas evaluation metrics that were described earlier in this Work Plan. The evaluation metrics for each CoP focus area includes outputs, process measures and outcome evaluation measures. The overall integration evaluation framework contains feasible methods to measure the success of program integration that are described below.

Purpose of the Evaluation

The purpose of the evaluation is to assess the CDI integration initiative as described in the Integration Work Plan through 1) examining the CDI's development and implementation of an integrated vision for the Section and 2) examining the development and efficacy of the Communities of Practice. As part of this effort, evaluation staff will design and develop standard evaluation tools for integrated programs.

Evaluation Framework

The evaluation will be conducted by the North Carolina Institute for Public Health (NCIPH) through a contractual relationship. The evaluation process will follow the CDC Evaluation Framework as follows.

Engage stakeholders: Primary stakeholders include CDI Branch heads, the CDI Section Chief, the Core Integration Team, CoP members, other CDI staff, and the CDC. Evaluation staff have met and will continue to meet regularly with stakeholders to design and refine evaluation objectives and activities.

Describe the program: Staff from the North Carolina Institute for Public Health have collaborated with the CDI Section to develop an Evaluation Plan for the Integration Work Plan describing integration goals/objectives and activities for the next three years. This evaluation will be informed by the following overarching objectives in the Integration Work Plan.

- Reduce unit cost in participating programs
- Reinvest savings or enhance staff productivity in participating programs
- Integrate evidence-based activities across participating programs
- Enhance the productivity and customer satisfaction in local communities
- Enhance the engagement and satisfaction of participating program and support staff
- Work across the social-ecologic model to include measurable changes in public policy and the community environment.

As described in the Work Plan, the integration initiative will proceed along three parallel, interrelated tracks: integration vision, communities of practice, and collaboration with other integration demonstration sites.

Focus the Evaluation Design: NCIPH staff will work together with the CDI Section and stakeholders to develop an evaluation logic model as well as specific logic models for each community of practice, and determine key evaluation questions and assessment indicators. Evaluation objectives, deliverables and key steps for the three Integration Work Plan tracks are described below. Key indicators/measures developed for the four CDC Program Integration Demonstration states in the areas of planning, administration, implementation and impact will be included as appropriate.

Objectives	Deliverables	Key Steps
Integrated Vision		
Evaluate the development and implementation of a CDI integration vision	- Report summarizing integration vision implementation with a focus on facilitators and barriers	- Identify indicators; define evaluation design and data collection methods - Conduct process evaluation
Design and develop standard evaluation tools for integrated programs	- Organizational and staff-related performance metrics based on the goals	- Survey/focus groups of selected LHD's regarding provision of services from "silo" organization and service preferences - Based on findings, develop goals document
Evaluate Communities of Practice		
Evaluate the efficacy of the Communities of Practice	Report describing implementation and effectiveness of pilot intervention in relation to overall project objectives and CDI Section goals	- Identify stakeholders, evaluation questions, and indicators; define evaluation design and data collection methods - Assess utilization and efficacy of performance metrics and data

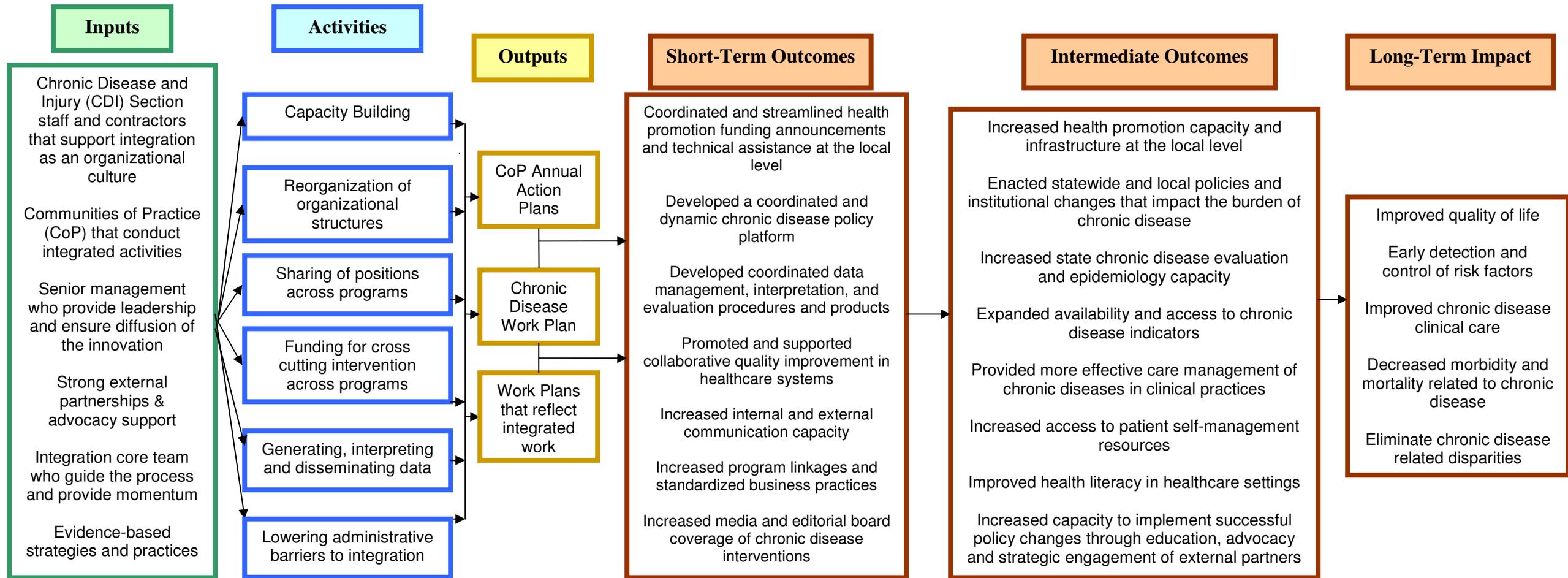
Objectives	Deliverables	Key Steps
		collection and reporting protocols
Collaboration with CDC and Other Demonstration Sites		
Inform integration efforts at CDC and in other states; learn from other demonstration states' integration efforts	Periodic updates and final report describing evaluation of integration project with focus on lessons learned	<ul style="list-style-type: none"> - Present findings to key stakeholders for review and feedback - Develop dissemination plan - Ensure use of findings and share lessons learned with CDC and other states with integration demonstration projects

Gather credible evidence: Evaluation staff will employ mixed methods of data collection, likely to include document review, observation of meetings, surveys, and interviews with stakeholders and key informants. Where possible, we will use existing data or data that CDI is already collecting as part of this effort.

Justify conclusions: Both quantitative and qualitative methods will be used to analyze the data. Quantitative data analysis will include frequencies, percentages, and any appropriate measures of association; qualitative data analysis will include content analysis of documents, meeting observations, and interviews. Data will be presented to project stakeholders for feedback and insights.

Ensure use and share lessons learned: Because this is a demonstration project, findings, including “lessons learned,” will be important for the CDI Section, CDC, other stakeholders, and other states considering chronic disease integration activities. Evaluation staff will collaborate with the CDI Section to develop a dissemination plan and identify ways to implement evaluation findings into CDI integration activities.

N.C. Chronic Disease and Injury Section Program Integration Logic Model



Evaluation

Integration Priorities
Health Data, Community-based Health Promotion and Coalition Development, Business and Operations, Healthcare Systems, Policy and Environmental Change