

Goal #1: Epidemiology and Surveillance – CDPCP establishes the burden associated with chronic disease and frames the problems to be addressed								
<p>Background - Compared to other states, Wisconsin has a high degree of epidemiologic capacity and support built into virtually all chronic disease programs. The Arthritis, Tobacco Prevention and Control, Diabetes Prevention and Control, Nutrition and Physical Activity, Heart Disease and Stroke Prevention, and Comprehensive Cancer Control Programs all have dedicated epidemiologists who work with program data and develop regular burden reports. Wisconsin also has an epidemiology workgroup that brings together the epidemiologists from each of the individual programs. The group meets quarterly to share ideas, provide updates on work within programs, and to look for ways to better integrate epidemiology work across all programs. In addition, Wisconsin has just recently developed an annual statewide epidemiology conference that brings together epidemiologists from all foci (i.e., chronic disease, communicable disease, environmental health, injury prevention, maternal and child health) and practice areas (i.e., state, regional, county, public health preparedness consortia, university affiliates working in public health) to update skills, share best practices, and network.</p> <p>Wisconsin is also a state funded for the Common Ground initiative, and aims to use that project to better integrate data sources state epidemiologists use. Even with all that has already been established, Wisconsin is looking to take all of these advancements to the next level, and an integrated chronic disease report would be a great way to tie all the chronic disease programs together and make a strong case to policy makers on the importance of funding for chronic disease. Given Wisconsin’s unique standing and capacity with respect to epidemiology as mentioned above, the potential exists for Wisconsin to develop a cutting edge integrated chronic disease report that can serve as a model for the nation.</p> <p>Lessons Learned - The Colorado Integrated Risk Factor Report will be used as a reference point. Program leads and epidemiologists will determine which aspects of that report may fit in an Integrated Burden of Disease Report for Wisconsin that takes advantage of Wisconsin’s unique strengths and provides information relevant to Wisconsin’s programmatic and political environment. Also, Wisconsin’s existing program burden reports will be examined to determine which elements would have the greatest impact, and best present the case for chronic disease.</p> <p>Evaluation - The current baseline is that all programs develop their own burden reports on various schedules. Components included in those reports will become part of the baseline for what information should be included in the report. Success on this goal will be measured by the completion of an integrated burden of disease report that achieves consensus from all programs as to the content and format, and that resonates with the target audience. The integrated report is meant to supplement and enhance, and not take the place of individual program burden reports. Thus, it is expected that individual program burden reports will continue to be developed on a regular basis.</p>								
Objective and Strategies		Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators
<p><b>1.1 By March 2010, the Surveillance and Epidemiology Ad Hoc Subcommittee and the Chronic Disease Program Epidemiologists will assure that key components of the burden reports for Arthritis Prevention &amp; Control, Nutrition &amp; Physical Activity, Diabetes Prevention &amp; Control, Comprehensive Cancer Prevention &amp; Control, Tobacco Prevention and Control, Heart Disease and Stroke Prevention, BRFSS, and Asthma will be integrated into one comprehensive chronic disease report.</b></p> <p><b>Strategies</b></p> <p>Determine what components would make up an integrated burden report, and what such a report should look like</p>		<p>CD Medical Director (Wegner)</p> <p>CD Program Epis</p> <p>Surveillance and Epi Ad Hoc Subcommittee of the DPH</p>	<p>DPH PI Epi Group</p> <p>DPH Common Ground Work Group (Hanrahan and Chudy)</p> <p>DPH Public Health Information</p>	1	2	3	4	<p>Consensus on data elements and report format</p> <p>Production of report using common data sources</p> <p>Data consistency</p> <p>Data analysis best practices guidelines</p>

Wisconsin Chronic Disease Program Integrated Work Plan  
 January 1, 2009 – December 31, 2011  
 December 29, 2008

Solicit input from program representatives to identify needs for this report	Program Integration Work Group	Network (PHIN) and AVR (Grant)	X			DPH common data set use agreement  Completed plan  Demonstration of usefulness and comprehension by target audience
Develop a list of key constituents to whom key findings from this report should be shared (i.e., develop a dissemination plan)			X			
Assess program report timelines because programs vary			X		X	
Assess cost for report production and dissemination and explore integrated funding					X	
Disseminate report to key legislators and policy makers in order to make chronic disease issues a higher priority (complete in 2010)						

Objective and Strategies								Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators
<p><b>Goal #1: Epidemiology and Surveillance – CDPCP establishes the burden associated with chronic disease and frames the problems to be addressed</b></p> <p>Background - Wisconsin is the only one of the four Program Integration Demonstration Project sites to also be a state funded for Common Ground. As part of that project, intensive efforts have been made to streamline data sources and develop a common portal for all program epidemiologists to access data and generate reports. Therefore, the efforts of those working with the Common Ground project in Wisconsin will be critical to the development of an integrated chronic disease report that concisely displays key aspects of the burden of chronic disease throughout the state.</p> <p>Lessons Learned - Coordination among epidemiologists has historically been difficult at times, as each program may have its own data sources and unique purposes for developing a burden report which results in duplication of efforts. There have been instances where different programs have inconsistent data in their reports when discussing the same outcome measure, or use data from a different year than another program reported. This can cause confusion among the target audience. By making the data sources consistent and of high quality, Wisconsin can deliver a stronger and clearer message about the important impact of chronic disease in the state.</p> <p>Evaluation - Wisconsin’s data sources are currently not integrated, and regular use of the PHIN portal for data analysis by program epidemiologists is low. We will work closely with the UW – Madison Population Health Evaluation Team to develop a survey that will get us information on the exact use of the PHIN portal and common data elements. At the end of the three-year demonstration project, we expect at least 75% of all program epidemiologists will be using the PHIN portal regularly in their data reporting.</p>														
<p><b>1.2 By March 2010, the BCHP will assure that the analytics for the comprehensive chronic disease report will be implemented through the Wisconsin Public Health Information Network (PHIN) portal in the Common Ground collaborative environment.</b></p> <p><b>Strategies</b></p> <p>Engage in cross fertilization between the existing DPH PI Epidemiology work group and the Common Ground work group.</p> <p>The DPH PI Epidemiology Work Group will actively participate in the development of Common Ground in Wisconsin, leading to a broader understanding of the Common Ground project among program epidemiologists, and a greater likelihood of using the tools developed by the project in program activities</p> <p>Assess cost of data sources and how to integrate into a common interface</p> <p>Use the existing epidemiology work group to develop a critical review process for all program burden reports, ensuring consistency and quality of data</p> <p>Convene a facilitated work group that will help to develop SAS code that would have</p>								<p>CD Medical Director (Wegner)</p> <p>Common Ground Program (Hanrahan, Chudy)</p>	<p>DPH PI Epi Group</p> <p>DPH Public Health Information Network (PHIN) and AVR (Grant)</p>	<p>1</p> <p>X</p> <p>X</p> <p>X</p>	<p>2</p> <p>X</p> <p>X</p> <p>X</p>	<p>3</p> <p>X</p> <p>X</p>	<p>4</p> <p>X</p> <p>X</p>	<p>Use of the PHIN portal</p> <p>Consistency in data reporting</p> <p>Review process for epidemiological reports is established</p>

common use across multiple programs							
Create a portal that program epidemiologists can log into and feel comfortable working with it					X	X	

**Goal #2: Partnerships – CDPCP establishes strong working relationships with other government agencies and with nongovernmental lay and professional groups.**

Background - In June 2008, the NACDD launched a State Technical Assistance and Review Program (STAR) in Wisconsin. (STAR focuses on the overall chronic disease prevention and control “unit’s” **comprehensive approach**, and not its categorical program elements. The STAR assessment aligns with the core components of a successful state health department chronic disease prevention and control program: Leadership, Epidemiology and Surveillance, Informatics/Information Systems, Partnerships, State Plans, Targeted Interventions, Evaluation, Program Management and Administration, and Program Integration.)

Wisconsin has a long standing DPH Program Integration Work Group with membership that includes staff from chronic disease programs as well as maternal and child health, lead, coordinated school health, asthma, injury prevention, oral health, minority health, etc. The DPH Program Integration Work Group meets six times a year. On October 2, 2008, we held a DPH Program Integration Work Group Retreat (a STAR recommendation) to focus on four STAR components: Epidemiology and Surveillance, **Partnerships**, Interventions and Program Integration. These four STAR components were selected because the respective recommendations fit best with the activities that Wisconsin would be in position to accomplish in 2009. At the Retreat we asked participants to self-select into one of the four Ad Hoc Subcommittees. We intend for the Ad Hoc Subcommittees to be viable through 2009 and then re-evaluate our focus on these components or work on other STAR components. The Ad Hoc Subcommittees were charged with identifying activities to achieve STAR recommendations and were prioritized by Retreat participants.

The Partnership Ad Hoc Subcommittee has diverse staff representation: the Well Woman Program, MCH, WIC, DPH Regional Office, Violence Prevention, and Minority Health. The Partnership Ad Hoc Subcommittee decided to focus on the STAR recommendation “Evaluate partnerships to make sure right partners at the table, including those outside of public health”.

The Partnership Ad Hoc Subcommittee has met three times between October 2nd and December 4<sup>th</sup>. To date, the Partnership Ad Hoc Subcommittee has established a comprehensive DPH partnership list (over 300) and compiled staffs’ perceived levels of partner involvement (i.e., ranging from information, consultation, deciding together, acting together, to jointly supporting initiatives). Ad Hoc Subcommittees provided progress reports at the December 4<sup>th</sup> DPH PI Work Group meeting. The Partnership Ad Hoc Subcommittee prepared a handout detailing the number of times a particular partnering agency was selected by our DPH programs. This information will provide the basis for selecting key agencies for our next steps.

Lessons Learned – The STAR report identifies Wisconsin’s key challenges in improving partnerships which will provide the direction for our work in 2009 and beyond. The STAR report highlighted several challenges related to partnerships: duplication of partners and staff on coalition and advisory groups; need for better communication; not taking full advantage of the university resources, existence of multiple local coalitions (that might deplete limited local resources), and multiple programs contracting with the same outside agencies or local health departments.

Evaluation – In 2007, the DPH PI Work Group participated in an internal comprehensive chronic disease program inventory to review: infrastructure (e.g., partner groups and data and surveillance); resources and materials; interventions and anticipated future programming. We used this baseline information to further develop a comprehensive partnership list for DPH and BCHP representing over 300 different partners. To determine next steps, we will use the staff survey information that details the number of times a particular partnering agency was selected by at least five or more DPH programs... We will work closely with the UW – Madison Population Health Evaluation Team to develop a partnership gap analysis, and satisfaction survey including baseline advocacy efforts by partners.

Objective and Strategies	Lead Staff/ Program	Key Partners	2009 Quarters				Evaluation Indicators
<b>2.1 By December 31, 2009, the Partnership Ad Hoc Subcommittee will work with</b>			1	2	3	4	Satisfaction survey

<p><b>three to five external partners to improve working relationships with the DPH, BCHP.</b></p> <p><b>Strategies</b></p> <p>Gather feedback from DPH PI Work Group to select 3 – 5 partnering agencies for pilot activity</p> <p>Recruit additional BCHP staff and/or DPH PI Work Group members based on the partnering agencies selected</p> <p>Hold pre-meetings with the respective programs that have indicated common partners to: determine level of involvement, areas of potential duplication, methods used for successful communication; pursue the opportunity to promote Healthy People at Every Stage of Life messaging, etc.</p> <p>Hold separate, strategic meetings with the identified partner and common DPH programs to identify what needs to be done to improve partnership relationships</p> <p>Develop and implement a tool to measure improved relationships with partners</p> <p>Provide regular progress reports to the DPH PI Work Group</p> <p>Prepare written summary of lessons learned from the 3 – 5 partnership pilots</p> <p>Share findings with the HW 2020 planning process</p> <p>Share findings with the Governor-appointed Wisconsin Public Health Council</p> <p>Incorporate changes to partnership pilot interactions</p> <p>Develop materials that will help advance lessons learned to other partnerships</p>	<p>DPH PI Work Group - Partnership Ad Hoc Subcommittee</p>	<p>Selected 3 – 5 DPH, BCHP key partners</p> <p>BCHP program staff who identified the selected partners</p> <p>UW Population Health Evaluation Team</p>					<p>completed of 3 -5 external partners including level of current advocacy efforts</p>	
			X					
				X				
			X					
				X				
			X	X				
				X	X	X	X	
						X		
						X		
						X		
						X	X	

Goal #2: Partnerships - CDPCP establishes strong working relationships with other government agencies and with nongovernmental lay and professional groups.				
Objective and Strategies	Lead Staff/ Program	Key Partners	2010	Evaluation Indicators
<p><b>2.2 By December 2010, the Partnership Ad Hoc Subcommittee will work with the remaining partners (who were selected five or more times by DPH program staff) to improve working relations with DPH BCHP.</b></p> <p><b>Strategies</b></p> <p>Repeat steps developed in 2009 for remaining partners</p> <p>Develop tool to evaluate if the right partners are at the table</p> <p>Provide regular progress reports to the DPH PI Work Group</p> <p>Prepare written summary of lessons learned</p> <p>Incorporate changes to partnership pilot interactions</p> <p>With assistance from the UW Population Health Evaluation Team, document changes in the depth and breadth of intervention activities with selected state partners</p>	<p>DPH PI Work Group Partnership Ad Hoc Subcommittee</p>	<p>Remaining identified partners</p> <p>BCHP program staff</p> <p>UW Population Health Evaluation Team</p>	<p>X</p>	<p>In conjunction with UW develop a partnership gap analysis tool to determine if right partners are at the table</p>

Goal #2: Partnerships – CDPCP establishes strong working relationships with other government agencies and with nongovernmental lay and professional groups.				
Objective and Strategies	Lead Staff/ Program	Key Partners	2011	Evaluation Indicators
<p><b>2.3 By December 2011, the DPH BCHP partners will demonstrate an increase in the leading of , or participating in policy and environmental advocacy efforts</b></p> <p><b>Strategies</b></p> <p>Provide uniform messages and education, technical assistance and support, and consultation to chronic disease program partners regarding key policy and environmental changes that will impact health outcomes</p>	<p>Healthy Communities Coordinator</p>	<p>DPH BCHP partners</p> <p>UW Population Health Evaluation Team</p>	<p>X</p>	<p>Survey DPH BCHP partners regarding level of advocacy efforts</p>

Utilize the Chronic Disease Work Plan or equivalent to provide direction and next steps				
Evaluate depth and breadth of policy and environmental advocacy demonstrated by key partners				
Work with the Public Health Council to voice need for public health funding				

<b>Goal #3: Interventions - CDPCP identifies specific targets for change, chooses the best channels to effect such changes and selects appropriate strategies for doing so</b>										
<p>Background - In June 2008, the NACDD launched a State Technical Assistance and Review Program (STAR) in Wisconsin. (STAR focuses on the overall chronic disease prevention and control “unit’s” comprehensive approach, and not its categorical program elements. The STAR assessment focuses on the core components of a successful state health department chronic disease prevention and control program: Leadership, Epidemiology and Surveillance, Informatics/Information Systems, Partnerships, State Plans, Targeted Interventions, Evaluation, Program Management and Administration, and Program Integration.) Wisconsin has a long standing DPH Program Integration Work Group with membership that includes staff from chronic disease programs as well as maternal and child health, lead, coordinated school health, asthma, injury prevention, oral health, minority health, etc. The DPH Program Integration Work Group meets six times a year. On October 2, 2008, we held a DPH Program Integration Work Group Retreat (also a STAR recommendation) to focus on four STAR components: Epidemiology and Surveillance, Partnerships, <b>Interventions</b>, and Program Integration. At the Retreat we asked participants to self-select into one of the four Ad Hoc Subcommittees. We intend for the Ad Hoc Subcommittees to be viable through 2009 and then re-evaluate. The Ad Hoc Subcommittees’ were charged with identifying activities to achieve STAR recommendations prioritized by staff at the Retreat.</p> <p>The Interventions Ad Hoc Subcommittee has diverse staff representation: Comprehensive Cancer, Asthma, Diabetes, Nutrition and Physical Activity, Tobacco, Arthritis, and Minority Health. At the Retreat, the Interventions Ad Hoc Subcommittee decided to focus on the STAR recommendation “Strengthen program’s focus on policy, systems and environmental change”. The Interventions Ad Hoc Subcommittee, to date, has adopted a framework and definitions of policy and advocacy, health system and environmental changes in order to establish common language and understanding for the DPH PI Workgroup. The Intervention Ad Hoc Subcommittee work has incorporated a framework that includes not just health promotion but also policy and advocacy, health systems, and environmental changes. The framework recognizes that in order to bring about the greatest degree of positive change to a community, policy and advocacy, systems, and environmental change strategies have shown to be the most cost effective with outcome driven impacts.</p> <p>Lessons Learned – The STAR report identifies Wisconsin’s key challenges related to interventions which will provide the direction for our work in 2009 and beyond. The STAR report highlighted several challenges: getting programs to embrace Healthy People at Every Stage of Life framework; limited resources within BCHP and BHIP to address minority health; and providing product people want to “buy”.</p> <p>Evaluation – In 2007, the DPH PI Work Group participated in an internal comprehensive chronic disease program inventory which identified interventions and anticipated programming. In January 2008, we collected detail to describe current program integration efforts for inclusion in the demonstration pilot project application. These summaries will be used to establish a baseline of program activity for our three year demonstration project.</p>										
Objective and Strategies				Lead Staff/ Program	Key Partners	2009		Evaluation Indicators		
						Quarter				
<p><b>3.1 By December 31, 2009, the Interventions Ad Hoc Subcommittee will complete an inventory of policy, system, and environmental best practices for chronic disease prevention.</b></p> <p><b>Strategies</b></p> <p>Utilizing current baseline data, conduct a more in-depth DPH internal program assessment</p>				DPH PI Work Group Interventions Ad Hoc Subcommittee	BCHP program staff	1	2	3	4	Inventory completed

Review inventory of environmental change policies organized by settings					X	
Analyze inventory gaps					X	
Share best practices and create a menu of intervention options for programs to consider						X
Assess and create skill building capacity with internal and external partners						X

<b>Goal #3: Interventions - CDPCP identifies specific targets for change, chooses the best channels to effect such changes and selects appropriate strategies for doing so</b>								
Background - The TPCP and NPAO Program uses a local coalition model to support the implementation of policy and environmental changes. TPCP has 42 coalitions funded through 2009 and the NPAO program will be providing funds to support ~15 local coalitions in 2009. In an effort to build local coalition capacity for policy and environmental change work we identified that many of the skills needed crossed coalitions (policy change, media, advocacy, facilitation, etc) and that in smaller communities the same people served on multiple coalitions. The TPCP surveyed coalitions and asked about possible benefits and risks of creating a broader coalition to address multiple health issues. Overall, the coalitions were supportive but had many questions about how this would work. From this, it was determined to learn from some existing models through a pilot project.								
Lessons Learned - New initiative								
Evaluation - New initiative, baseline will be gathered from pilots and an evaluation plan developed.								
Objective and Strategies	Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators	
<p><b>3.2 By December 31, 2009, the BCHP will pilot a Healthy Lifestyle coalition concept to identify models that mobilize communities to address tobacco consumption, poor nutrition and lack of physical activity through environmental and policy change.</b></p> <p><b>Strategies</b>                      Establish selection criteria, develop the boundary statement and deliverables for Healthy Lifestyle Coalition pilots</p> <p>Select 3-5 pilot communities</p> <p>Develop an evaluation plan for the pilot</p> <p>Provide training and technical assistance to coalitions related to coalition capacity building (e.g. asset mapping), policy change skill building, media advocacy, development of a unified work plan and others based on coalition need</p> <p>Facilitate networking and sharing amongst pilot sites</p> <p>Gather and analyze data and information to learn how each model worked, barriers faced and how there were addressed, strengths, opportunities, and lessons learned</p> <p>Share finding with internal and external stakeholders</p>	Nutrition, Physical Activity and Obesity Program Director (Pesik)	Selected local public health departments/ coalitions	1	2	3	4	Pilots selected  Evaluation Plan Developed  Trainings attended and session evaluation results  Report of project findings disseminated	
	Healthy WI Leadership Institute	X						
	Tobacco Prevention Program Director (Stauffer0)	X	Local Coalition Support Team	X				
	BCHP Director (Uttech)	X			X	X		X
	Health Communities Coordinator				X	X		X
								X

Utilize the findings to determine the feasibility, methodology, and resources required for expanding the Healthy Lifestyles Coalition concept in 2010 and beyond						X	
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<b>Goal #3 Interventions - CDPCP identifies specific targets for change, chooses the best channels to effect such changes and selects appropriate strategies for doing so</b>							
<p>Background - An ad-hoc subcommittee of WI PAN members and representatives from other chronic disease programs met several times in the spring of 2006 to develop the Wisconsin Worksite Wellness Resource Kit. This was in response to several programs wanting to engage worksites. The kit was designed to walk worksites through the steps of developing a wellness program, from the starting stages to a finished program. The kit was initially released in August 2006 and 6 coalitions piloted the kit with funding from the Comprehensive Cancer Control Program. Additional funds were received from the National Governors Association in 2007 to support an additional 11 coalitions to use the toolkit, host a Governor’s Summit and explore options for a state employee wellness program. The DPCP sponsored several "Diabetes at Work" breakfast meetings around the state and other program participated as exhibitors. The TPCP also has a Tobacco-Free Workplace toolkit. In 2007, version 2 of the Resource kit was released and additional components were added based on coalition feedback, including mental health. In 2008, a series of 6 regional trainings were attended by over 350 people with excellent evaluations. The Governor’s Worksite Award was developed as a companion to the Resource kit to recognize worksites that are implementing comprehensive wellness programs. There has been interest from other programs to include information in the toolkit – alcohol use, reproductive health, sexual assault and violence.</p>							
<p>Lessons Learned - Worksites are very interested in wellness, but want easy to use strategies and materials made available. Packaging materials into a comprehensive CDPCP approach will be most effective when trying to engage and mobilize worksites.</p>							
<p>Evaluation - As of December 2008, twenty-six worksites have achieved the Governor’s Worksite Wellness Award since its launch in September 2008.</p>							
Objective and Strategies	Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators
<p><b>3.3 By December 31, 2009, the BCHP will assure an increase in the number of worksites with a comprehensive wellness program.</b></p> <p><b>Strategy</b></p> <p>Expand the WI PAN Business Committee to include representatives from CDPCP to provide leadership and facilitate the promotion of worksite wellness utilizing available tools (Wisconsin Worksite Wellness Resource Kit, Diabetes at Work, Tobacco Free Workplace toolkit, etc)</p> <p>Conduct targeted “train-the-trainer” sessions for partners who interact with local worksites. Webcast and archive one of the training sessions.</p> <p>Create a list of “approved/certified” Resource Kit trainers and post on the website</p> <p>Contact key university and technical colleges to inquire about including the Resource Kit as part of their college class offerings for future health promotion professionals</p> <p>Expand the Diabetes at Work newsletter to reach more worksites and explore the</p>	<p>Nutrition, Physical Activity and Obesity Program (Pesik)</p>	<p>CD Program Directors</p> <p>DPH PI Work Group</p> <p>WIPAN Business Committee</p> <p>Governor’s Office and Council</p>	1	2	3	4	<p>Number of worksites achieving the Governor’s Worksite Award</p> <p>Number of trainings provided</p> <p>Number of downloads of resource kit</p> <p>Number of worksite reached through trainers/outreach agents</p>
			X	X	X	X	
			X				
			X	X			
					X		
					X		

feasibility of changing it to a CDPCP focus								
Update the Worksite Wellness Resource Kit and determine criteria for inclusion of additional evidence-based chronic disease prevention and health promotion approaches (e.g. alcohol, reproductive health, etc.)							X	
Promote the Governor's Worksite Wellness Award			X	X	X	X		

Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so				
Objective and Strategies	Lead Staff/ Program	Key Partners	2010	Evaluation Indicators
<b>3. 4 By December 31, 2010, the BCHP will assure an increase in the number of worksites with a comprehensive wellness program.</b>  Develop annual work plan based on progress of 2009 strategies	Nutrition, Physical Activity and Obesity Program (Pesik0	CD Program Directors  DPH PI Work Group  WIPAN Business Committee  Governor's Office and Council	X	Number of worksites achieving the Governor's Worksite Award

Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so				
Objective and Strategies	Lead Staff/ Program	Key Partners	2011	Evaluation Indicators
<b>3. 5 By December 31, 2011, the BCHP will assure an increase in the number of worksites with a comprehensive wellness program.</b>  Develop annual work plan based on progress of 2009 strategies	Nutrition, Physical Activity and Obesity	CD Program Directors  DPH PI Work	X	Number of worksites achieving the Governor's Worksite Award

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	Program (Pesik)	Group  WIPAN Business Committee  Governor's Office and Council		
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Goal #3 Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so							
<p><b>Background</b> - The Diabetes Quality Improvement Project (DQIP) is in its 10<sup>th</sup> year. This collaborative effort with Wisconsin’s Community, Migrant and Homeless Health Centers focuses on providing quality of care to people with diabetes through implementation of the Wisconsin’s Essential Diabetes Mellitus Care Guidelines. This project is funded by the Wisconsin Diabetes Prevention Program, coordinated and implemented through a contract with the Wisconsin Primary Health Care Association (WPHCA). Heart Disease and Stroke Prevention (HDSP) Comprehensive Cancer Control and Tobacco Prevention and Control have also provided funds for projects to WPHCA. Community Health Centers use a team approach to provide diabetes care that is population-based, evidence base and patient-centered. A Patient Electronic Care System (PECS) registry is used to collect key indicator data which serves as a benchmark for measuring change and has historically been used to drive on-going quality improvement, promotion of proactive diabetes management and self management.</p>							
<p><b>Lessons Learned</b> - The DQIP is modeled after the federal Bureau of Primary Health Care’s Health Disparities Collaborative (the Collaborative), which focuses on eliminating disparities in health care. The DQIP goal and objectives are similar to the Collaborative with an emphasis on improving health care access and quality care to people with diabetes. The DQIP used three models to build diabetes quality improvement capacity in the primary health care settings. These models emphasize rapid Plan-Do-Study-Act (PDSA) cycles, and incorporate the Planned Care Model (delivery system redesign, decision support, clinical information systems, leadership, patient self-management, health system organization and community outreach).</p> <p>The DQIP created a foundation for improving health system change in the primary care setting. The work of the WI DPCP, FQHCs and the WPHCA is recognized by other chronic disease programs and these programs have asked the WPHCA to assist them with their categorical program quality improvement efforts. Due to growth and attempts to promote efficiency WPHCA staff began integration and coordination efforts. Additional integration is needed across all organizations and departments engaged in QI work with the FQHCs.</p> <p>Enhanced integration can reduce duplication, increase consistent effective communication, and promote further quality improvement efforts to increase chronic disease prevention and care</p>							
<p><b>Evaluation</b> - The WI DPCP maintains historical and current data from the DQIP. This includes an evaluation completed by the UW- Population Health in 2006. Project changes were made to the DQIP based on the 2006 evaluation results. Other chronic disease programs engaged in QI initiatives use different approaches than the DPCP model therefore a baseline is needed before integration efforts move forward. Funding amounts and use needs to be assessed. Categorical data reports, learning opportunities, technical support, and communication with stakeholders may be different therefore baseline data is needed before infrastructure and capacity improvements can be measured. The DQIP project model has created a solid base and holds promise for testing program/organizational integration for continued health system improvements</p>							
Objective and Strategies	Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators
<p><b>3.6 By December 31, 2009, the BCHP will assure an increase in program integration efforts to improve health system quality improvement for chronic disease prevention and control.</b>  <b>Strategies</b></p>	<p>Diabetes Prevention and Control Program</p>	<p><i>Internal:</i>                      CD Program Directors                      (Heart Disease</p>	1	2	3	4	<p>using mechanisms requiring best practices before and after pilot</p>

Collect baseline evaluation data (from internal and external stakeholders) of existing process for chronic disease prevention and control health care system quality improvement	and Stroke Prevention, Comprehensive Cancer Control Program, Tobacco Prevention and Control Program and others as appropriate)	X	X			Evaluations conducted for year 1, 2, 3 with key DPH, FQHC, and WPHCA staff
Use baseline evaluation data to design draft pilot chronic disease quality improvement project (CDQIP)					X	Stakeholders and partners informed/satisfied
Create a forum to build internal infrastructure/integration process improvement to successfully implement CDQIP					X	Number of key programs engaged
Pilot implementation of new infrastructure changes working toward single contract		X	X	X	X	Lead person identified and oriented to Project
Maintain engagement and trust of external stakeholders to successfully integrate and implement CDQIP modeled after the DQIP ( <i>with Wisconsin's Community, Migrant and Homeless Health Centers through the Wisconsin Primary Health Care Association</i> )	<i>External: Professional organizations (AAP, WDA, Medical Society)</i>	X	X	X	X	Work group meets monthly
Coordinate dissemination of chronic disease evidence-based Guidelines for screening/early detection and prevention of complications	Medicaid	X	X	X	X	Increased satisfaction of stakeholders in key areas (communication, fiscal, efficiency, resource allocation, technical assistance)
Monitor chronic disease key indicators and incorporate new data/technology (Common Ground Pilot)	Wisconsin Primary Health Care Association	X	X	X	X	New CDQIP pilot implemented
Provide integrated health communication messages, technical assistance, interventions and resources for prevention and control of chronic diseases	Federally Qualified Health Centers			X	X	Increased satisfaction of FQHC staff and leadership
Incorporate, implement, and support existing models, based on the Federal Bureau of Primary Health Care's Health Disparities Collaborative and other new evidence-based quality improvement initiative models and accomplishments addressing prevention and control of chronic disease (e.g., CDSMP, RWJ Diabetes Initiative and other tools)	UW Population Health			X	X	Guidelines disseminated
Provide translation technical assistance and anticipatory guidance on new, innovative, and evidence-based approaches to enhance community and health system resources for improving chronic disease self- management	Communities and community groups					Registry data collected and analyzed  Clinics in Common

		Health Care Systems				Ground pilot share success and lessons learned  Disease specific TA log maintained  Other Programs engaged  Models implemented  New approaches designed and piloted
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Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so					
Objective and Strategies	Lead Staff/ Program	Key Partners	Year		Evaluation Indicators
			2010	2011	
<p><b>3.7 By December 31 2010 and December 31, 2011, the BCHIP will continue to increase program integration efforts to improve health system quality improvement for chronic disease prevention and control.</b></p> <p><b>Strategies</b></p> <p>Conduct mid-course evaluation to ensure project integrity and to ensure adequate data</p> <p>Continue to strengthen chronic disease programs’ implementation of CDQIP project, implementation evidence-based interventions for chronic disease prevention and control</p> <p>Monitor integrated project assessing satisfaction and needs of stakeholders through increase internal infrastructure/ integration process improvement</p> <p>Maintain engagement and trust of external stakeholders</p> <p>Continue implementing and promoting chronic disease evidence-base Guidelines for</p>	Same as 3.6	Same as 3.6	X	X	Conduct evaluation, with key stakeholders  CDQIP project implemented  Evidence-based interventions used  Improved ease of business Stakeholders partnership maintained  Guidelines implemented

screening/early detection and prevention of complications					Registry data collected and analyzed and used as indicators of change
Continue monitoring chronic diseases key indicators and incorporate new data/technology (Common Ground Pilot)			X		
Maintain integrated health communication, technical assistance interventions, resources for prevention and control			X		Information Exchange completed and logged
Continue translation technical assistance and anticipatory guidance for new, innovative, and evidence based approaches to enhance community and health system resources to improve chronic disease self management			X		Final evaluation completed
Conduct final evaluation to measure project success				X	Document project success and outcomes
Ensure ongoing CDQIP project implementation and monitoring to continue and strengthen chronic disease programs implementation of evidence-based interventions for prevention and control with health systems				X	Other programs engaged
Engage, collaborate, and partner with others ( e.g., WISEWOMAN, Asthma, Nutrition and Physical Activity, Injury Prevention)				X	Internal infrastructure improves
Continue internal infrastructure/integration process improvement				X	Trust and engagement continues
Maintain engagement and trust of external stakeholders to successfully implement CDQIP				X	Guidelines implemented
Continue implementing and promoting chronic disease evidence-base Guidelines for screening/early detection and prevention of complications				X	Registry data collected and analyzed/used as indicators of change
Continue monitoring chronic diseases key indicators and incorporate new data/technology (integrate with Common Ground Pilot)				X	Information Exchange completed and logged
Maintain integrated health communication, technical assistance, interventions, resources for prevention and control				X	Community and health system increase evidence based practice initiatives
Continue translation technical assistance and anticipatory guidance for new, innovative, and evidence based approaches to enhance community and health system resources to improve chronic disease self- management				X	Improvement seen in screening practices of

					health care facilities
<b>Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so</b>					
Objective and Strategies	Lead Staff/ Program	Key Partners	2011	Evaluation Indicators	
<p><b>3. 8 By December 31, 2011, the BCHP will assure an increase in REACH and “Living Well with Chronic Conditions” programming to 10,000 people from a baseline of 800.</b></p> <p><b>Strategies</b></p> <p>Enhance infrastructure to increase public health and health system awareness of the benefits of evidence-based programming that supports chronic disease self management</p> <p>Promote evidence-based programs to public health partners to increase awareness and referral capacity to link individuals with chronic conditions to the appropriate programs</p> <p>Work with DPH – AoA EBP Steering Committee to establish an 800 number for training, community-self management sessions, and clinical referral as resources allow</p>	Arthritis Program (Kissack)	CD Program Directors	X	<p>List of programs implemented</p> <p>Template objectives for LPHDs to increase infrastructure</p> <p>Inventory of tools for referral</p> <p>Number of training opportunities</p> <p>Number of local champions promoting</p>	

<b>Goal #3: Interventions - CDPCP identifies targets for change, chooses the best channels to effect such changes, and selects appropriate strategies for doing so</b>								
<p>Background - Several CDPCP have been working on disparity reduction over the past years, but for the most part independently. The UW Population Health Institute’s Healthiest State Project published a <i>Health of Wisconsin Report Card</i> which gave Wisconsin a grade of D for health disparity. The NPAO Program had done a review of their NPAO State Plan progress and found little to no progress had been made in the area of disparity reduction. The NPAO Program included a work plan goal to create a disparity strategic plan related to nutrition, physical activity and obesity. Through the work of the Program Integration work, it was determined that disparity reduction was a priority for BHCP and a broader strategic plan would be developed. One model that will be used is the TPCP disparity plan, “Bringing Everyone Along”. Work has begun on the plan development, as well as exploring new, integrated opportunities. An example is the Exploring Social Determinants of Health project which is being lead by TPCP and supported by several programs.</p> <p>Wisconsin is also a state with a significant population living on tribal land. In Wisconsin, county and other local governments are political sub-divisions of state government and as such, the state has the ability to mandate and enforce state law and policies. However, tribal governments are distinct, independent political communities qualified to exercise powers of self-government, not by virtue of any delegation of powers, but rather by reason of their original tribal sovereignty. State jurisdiction is preempted both by federal protection of tribal self-government and by federal statutes. This can pose unique challenges to ensuring efforts to reduce disparities in these regions. However, in 2004, the Governor of Wisconsin issued Executive Order #39, recognizing the government-to-government relationship between the state and tribal governments and requiring strengthening of the working relationship between the two governments. On June 28th, 2005, Governor Doyle signed State-Tribal consultation policies with the 11 Tribes. Fourteen state agencies, including the Department of Health Services (DHS) have developed Tribal consultation policies. There is an Office of Tribal Affairs within DHS, and the major function that office is to assist in the effort to maintain an effective government to government relationship with Wisconsin tribes.</p>								
Lessons Learned - There is limited evidence of evidence-based strategies for disparate populations. A deliberate and intentional effort needs to be made to effectively address and reduce disparities.								
Evaluation - Disparity grade of D – Health of Wisconsin Report Card. Additional analysis will be done to determine a baseline for specific population indicators and numbers of interventions in the field.								
Objective and Strategies		Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators
<p><b>3.9 By December 31, 2009, the BCHP will have a strategic plan in place to reduce disparities in chronic diseases.</b></p> <p><b>Strategies</b></p> <p>Convene chronic disease program directors and the Minority Health Program to formulate one strategic plan to reduce chronic disease related disparities through a collaborative planning process</p>		BCHP Director (Uttech)	CD Program Directors	1	2	3	4	Disparity plan completed reflecting the six chronic disease programs at a minimum d
		Nutrition, Physical Activity and Obesity Program Director	Minority Health Leadership Council  BEOH Asthma Program	X	X	X	X	Disparity plan disseminated

<p>Establish linkages with the newly created UW-Madison Center for Health Disparities and the UW Population Health Institute’s Healthiest State Project</p> <p>Assess available data for children (YRBS, PedNSS) and adults (BRFS) to identify disparities (racial/ethnic, age, gender, SES, location and disability) and populations at greatest risk of chronic disease</p> <p>Inventory current projects and interventions that are being implemented by CDPCP and partners that have a disparity focus or include a disparate population</p> <p>Review literature and existing disparity plans (e.g., TPCP “Bringing Everyone Along”) to identify common elements, strategies and evaluation methodology</p> <p>Develop a dissemination plan to share the Disparity Plan with the Minority Health Leadership Council, the Public Health Council and other key stakeholders to create a focus on disparity reduction for chronic disease</p> <p>Publish and promote disparity plan</p> <p>Work with the Office of Tribal Affairs within DHS to ensure implementation of efforts to reduce disparities within tribes</p>	(Pesik)	Public Health Council  Program Partner Groups	X  X  X   X	X      X	X      X	X      X	
<p><b>Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so</b></p>							
Objective and Strategies	Lead Staff/ Program	Key Partners	2010		Evaluation Indicators		
<p><b>3.10 By December 31, 2010, the BCHP will assure an increase in the number of interventions targeted to populations disparately affected by chronic disease.</b></p> <p><b>Strategies</b></p> <p>Incorporate a deliberate focus on disparity reduction into current funding opportunities for local/state intervention projects</p> <p>Identify funding opportunities, including joint funding, based on CDPCP priorities</p> <p>Develop common evaluation indicators for funded interventions that support the</p>	<p>BCHP Director (Uttech)</p> <p>Nutrition, Physical Activity and Obesity Program Director (Pesik)</p>	<p>CD Program Directors</p> <p>Minority Health Leadership Council</p> <p>BEOH Asthma Program</p>	<p>X</p>		<p>Number, reach and results of CDPCP interventions targeting disparate populations</p> <p>Number, reach and results of partner interventions targeting disparate populations</p>		

<p>overall evaluation of the disparity strategic plan</p> <p>Engage partners to promote and implement the disparity strategic plan</p> <p>Collect and share success stories and results to build the body of evidence of effective strategies for disparate populations</p>		<p>Public Health Council</p> <p>Program Partner Groups</p>		
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Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so							
Background -							
Lessons Learned -							
Evaluation -							
Objective and Strategies	Lead Staff/ Program	Key Partners	2009				Evaluation Indicators
<p><b>3.11 By 2009, a statewide 100% smoke-free workplace law will be passed and implemented.</b></p> <p><b>Strategies</b></p> <p>Outreach and education to key local and state leaders regarding secondhand smoke and smoke-free air</p> <ul style="list-style-type: none"> <li>• Conduct in-district meeting to provide education and resources</li> <li>• Conduct presentations to educate local organizations and agencies</li> <li>• Plan and implement collaborative community events</li> </ul> <p>Media Advocacy supporting smoke-free air policy</p> <ul style="list-style-type: none"> <li>• Implement media outreach efforts, such as letters to the editor, press conferences, press releases, media advisories</li> <li>• Maintain relationships with local media</li> <li>• Support and promote the My Smoke Free Story campaign by recruiting individuals to submit stories</li> </ul> <p>Coalition building for smoke-free air efforts at the local and state levels</p> <ul style="list-style-type: none"> <li>• Develop partnerships with existing organizations and groups to build diversity within coalitions</li> <li>• Recruit and identify supporters through grassroots efforts, such as participation at community events, newspaper inserts or phone banking</li> <li>• Train coalition members and supporters to conduct outreach and education activities</li> <li>• Identify and involve supportive Class B liquor license holders at community events activities</li> <li>• Engage 5 college campuses in smoke-free air policy efforts through training and technical assistance</li> </ul>	<p>Tobacco Prevention and Control Staff</p>	<p>Local coalitions</p> <p>State advocacy partners</p> <p>Statewide partners</p> <p>Program Integration Partners</p> <p>Taverns Clearing the Air</p> <p>18-24 YO Project</p> <p>Local Health Departments</p>	X	X	X	X	<p><b>CDC Indicator 2.4.1</b></p> <p><b>Data Source:</b> Wisconsin State Statues</p> <p><b>Data History</b> Wisconsin’s Clean Indoor Air Act, Section 101.123 Wisconsin Statues</p>

<p>Development of an implementation plan and timeline</p> <ul style="list-style-type: none"> <li>• Research available resources and materials from state and national organizations</li> <li>• Consult with state and national organizations for information and technical assistance</li> <li>• Conduct plan strategies and activities</li> </ul> <p>Promotion of education efforts regarding statewide smoke-free air law</p> <ul style="list-style-type: none"> <li>• Develop reporting mechanism</li> <li>• Develop and distribute materials and resources regarding the implementation of the statewide smoke-free air law</li> <li>• Provide resources and information regarding reporting violations to the public</li> </ul>							
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<b>Goal #3: Interventions – CDPCP identifies specific targets for change, chooses the best channels to effect such changes, and selects appropriate strategies to do so</b>							
Background -							
Lessons Learned -							
Evaluation -							
Objective and Strategies	Lead Staff/ Program	Key Partners	2009				Evaluation Indicators
<p><b>3.12 By December 2010, the number of cigarette packs sold per adult aged 18 years and older will decrease from 69 in 2007 to 67.</b></p> <p><b>Strategies</b></p> <p>Outreach and education to key local and state leaders regarding cigarette tax increase</p> <ul style="list-style-type: none"> <li>• Conduct in-district meeting to provide education and resources</li> <li>• Conduct presentations to educate local organizations and agencies</li> <li>• Plan and implement collaborative community events</li> </ul> <p>Media Advocacy supporting cigarette tax increase policy</p> <ul style="list-style-type: none"> <li>• Implement media outreach efforts, such as letters to the editor, press conferences, press releases, media advisories</li> <li>• Maintain relationships with local media</li> </ul> <p>Coalition building for cigarette tax increase efforts at the local and state levels</p>	<p>Tobacco Prevention and Control Staff</p>	<p>Local coalitions</p> <p>State advocacy partners</p> <p>Statewide partners</p> <p>Program Integration Partners</p> <p>18-24 YO Project</p>					<p><b>CDC Indicator:</b> 2.8.1</p> <p><b>Data Source:</b> Department of Revenue</p> <p><b>Data History:</b> 2007 -69</p> <p><b>CDC Indicator:</b> 1.12.1</p> <p><b>Data Source:</b> DOR Wisconsin Tax</p>

<ul style="list-style-type: none"> <li>• Develop partnerships with existing organizations and groups to build diversity within coalitions</li> <li>• Recruit and identify supporters through grassroots efforts, such as participation at community events, newspaper inserts or phone banking</li> <li>• Train coalition members and supporters to conduct outreach and education activities</li> </ul>		<p style="text-align: center;">Local Health Departments</p>					<p style="text-align: right;">Code</p> <p style="text-align: right;"><b>Data History:</b> Current Tax Rate - \$1.77</p>
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**Goal #4: Program Integration – CDPCP has strategically aligned chronic disease categorical program resources to increase effectiveness and efficiency of each program in a partnership without compromising the integrity of categorical program objectives.**

Background – In 2007, the Bureau Director asked the DPH PI Work Group to help bureau programs integrate the Healthy People at Every Stage of Life framework. The HPESL framework is constructed around five age groups through the life span: Start Strong, Grow Safe and Strong, Achieve Healthy Independence, Life a Healthy, Productive and Satisfying Life, and Live Better, Longer. The process occurred over three PI work group meetings in 2007 as well as other meetings until message similarities and consensus was achieved. The DPH PI Work Group created five key messages that could be incorporated into any BHP program: plan ahead – eat well – be active – stay clear of tobacco – and stay safe. The final messages were presented at an all bureau staff meeting and staff was encouraged to think about how to implement these common messages within their programs.

In June 2008, the NACDD launched a State Technical Assistance and Review Program (STAR) in Wisconsin. (STAR focuses on the overall chronic disease prevention and control “unit’s” comprehensive approach, and not its categorical program elements. The STAR assessment focuses on the core components of a successful state health department chronic disease prevention and control program: Leadership, Epidemiology and Surveillance, Informatics/Information Systems, Partnerships, State Plans, Targeted Interventions, Evaluation, Program Management and Administration, and Program Integration.) Wisconsin has a long standing DPH Program Integration Work Group with membership that includes staff from chronic disease programs as well as maternal and child health, lead, coordinated school health, asthma, injury prevention, oral health, minority health, etc. The DPH Program Integration Work Group meets six times a year. On October 2, 2008, we held a DPH Program Integration Work Group Retreat (also a STAR recommendation) to focus on four STAR components: Epidemiology and Surveillance, Partnerships, Interventions and **Program Integration**. At the Retreat we asked participants to self-select into one of the four Ad Hoc Subcommittees. We intend for the Ad Hoc Subcommittees to be viable through 2009 and then re-evaluate. The Ad Hoc Subcommittees’ were charged with identifying activities to achieve STAR recommendations prioritized by staff at the Retreat.

The Program Integration Ad Hoc Subcommittee has diverse staff representation: MCH, CYSCHN, Oral Health, Lead, Coordinated School Health Program and DPH Regional Office. At the Retreat the Program Integration Ad Hoc Subcommittee decided to focus on the STAR recommendation “Address these cross-cutting issues in the integration workgroup: health disparities, CDSMP, work force development, policy/systems change priorities implementing the HPESL Framework; quality improvement; and epidemiology and surveillance”. In order to do this the Program Integration Ad Hoc Subcommittee selected an activity based on the HPESL framework. Some of the Retreat participants were not familiar with the HPESL development so needed to be updated on it. The PI Ad Hoc Subcommittee decided to develop a 3-4 dimension matrix based on previous PI work. The matrix will embed program specific messages that directly relate to the broader HPESL framework. The PI Ad Hoc Subcommittee will increase the number of programs that will use the HPESL messages.

In addition, the BHP Director has assigned the BHP Health Educator to develop a plan to create buy in for the HPESL framework and messaging with each section. The Health Educator compiled a summary of action steps gleaned from each section. These steps will be discussed at a Bureau Section Chief and Medical Director biweekly meeting. The Bureau Director created a power point presentation using a garden analogy to help staff understand where they fit in regarding program integration as well as the importance of agreeing with the HPESL framework and key messages. For example, the Bureau Director presented at the Family Health Section (MCH and CYSCHN Programs) with the hope to recruit MCH staff to attend the DPH PI Work Group Retreat. We successfully encouraged some new participants. The Bureau Director shared the PI Logic Model Impact Statements and asked the Family Health Section Staff to identify those impact statements that were also relevant to their work in MCH/CYSHCN. Of the 21 staff, 15 responded that they identified with more than half of the impact statements in their daily work. This indicates a clear opportunity to link MCH and Chronic Disease program integration efforts.

**Lessons Learned - The STAR report identifies Wisconsin’s key challenges in advancing program integration which will provide the direction for our work in 2009**

and beyond. The STAR report highlighted several challenges related to program integration: maintaining chronic disease unit identity that partner can recognize; monitoring the size of the DPH PI Work Group; Address perception that integration adds work and takes too much time; Address staff definitions of integration and gaps between leader’s vision and staff understanding; informal structure of integration work group; setting cross-cutting priorities; and power of the single issue and threat of losing focus with integration.

Feedback received from the MCH / CYSHCN Programs indicates the importance of using the terminology “life course” because that alignment pulls MCH into the chronic disease world.

**Evaluation – Establish baseline and change in promoting the messages and framework with BHCP**

Objective and Strategies	Lead Staff/ Program	Key Partners	2009				Evaluation Indicators
			1	2	3	4	
<p><b>4.1 By December 31, 2009, the BHCP Programs will integrate the Healthy People at Every Stage of Life Framework and five key messages.</b></p> <p><b>Strategy</b></p> <p>Increase awareness of HPESL framework and staff communication</p> <p>Work with staff to increase awareness of expanded HPESL matrix as a means of embedding program specific messages into HPESL framework</p> <p>Review summary of action steps with Bureau Section Chiefs and Medical Directors</p> <p>Reach audiences in regular meetings to provide updates, gain feedback and promote program integration of MCH and Chronic Disease</p> <p>Increase program integration efforts between MCH and chronic disease by outreaching to MCH programs and encourage their involvement in the DPH PI Work Group and Ad Hoc Subcommittees</p> <p>Demonstrate HPESL framework and key messages in BCHP program work plans, written communication to partners, etc.</p>	<p>Program Integration Ad Hoc Subcommittee</p> <p>BCHP Director (Uttech)</p> <p>BCHP Health Educator (Gothard)</p> <p>BCHP Section Chiefs (Conway, Hale, Herrick, Stauffer)</p>	BCHP Program Staff	X	X	X	X	<p>Matrix completion</p> <p>Inclusion of HPESL in program workplans and program activities</p> <p>Staff survey</p>

Goal #4: Program Integration – CDPCP has strategically aligned chronic disease categorical program resources to increase effectiveness and efficiency of each program in a partnership without compromising the integrity of categorical program objectives				
Objective and Strategies	Lead Staff/ Program	Key Partners	2010	Evaluation Indicators
<p><b>4. 2 By December 31, 2010 the Program Integration Ad Hoc Subcommittee will monitor the use of HPESL messages in BCHP programming.</b></p> <p><b>Strategies</b></p> <p>Document how HPESL messages are being used by BCHP programs</p> <p>Determine if having a unified HPESL message is considered successful by participating programs</p>	<p>Program Integration Ad Hoc Subcommittee</p>	<p>Program Coordinators, other staff</p>	<p>X</p>	<p>Program examples</p> <p>Inclusion of HPESL in program workplans</p> <p>Inventory of how HPESL messages were used</p>

Goal #5: Evaluation - CDPCP establishes systematic approaches for determining whether its comprehensive chronic disease control program is being implemented successfully and whether its objectives are being achieved							
Background - The Healthy Lifestyles Coalition pilots will be a new activity in 2009.							
Lessons Learned - The STAR report recommended that Wisconsin examine our current multiple, single-focused coalitions to determine if we could pursue using our established coalitions to focus on several chronic disease prevention programs activities simultaneously. In October 2008, we surveyed the local public health departments to determine their interest in a program integration effort like a Healthy Lifestyles Coalition. Of the 132 responses from local public health departments, 74 agencies answered favorably about the concept. They cited benefits such as: increase effectiveness, decrease duplicative efforts, maximize “common” partners, encourages a wider base for more community involvement, and already doing it at the local level. This gave us the confidence to proceed with establishing Healthy Lifestyle Coalitions pilots for 2009.							
Evaluation - We will work closely with the UW – Madison Population Health Evaluation Team and the Healthy Communities Coordinator to establish a policy and environmental baseline and the impact Healthy Lifestyle Coalitions have on influencing policy and environmental changes.							
Objective and Strategies	Lead Staff/ Program	Key Partners	2009				Evaluation Indicators
			Quarter				
<p><b>5.1 By June 2009, Healthy Communities Coordinator will provide the Healthy Lifestyle Coalitions pilots with technical assistance in working on policy and environmental changes that influence health outcomes.</b></p> <p><b>Strategies</b></p> <p>With joint chronic disease prevention program funding, hire a Healthy Communities Coordinator</p> <p>The Healthy Communities Coordinator will provide consultation, technical assistance and training, and evaluation related to policy and environmental changes and improved communication between pilots and the state chronic disease program.</p> <p>The Healthy Communities Coordinator will develop materials and reports for the HLC pilots detailing what chronic disease prevention programs and program integration strategies work, and why.</p> <p>The Healthy Communities Coordinator will work with the HLC pilots to evaluate the effectiveness of policy and environmental change at the local project level</p>	BCHP Bureau Director (Uttech)	Chronic Disease Prevention and Control Section Chief	1	2	3	4	<p>Healthy Communities Coordinator hired</p> <p>Baseline of policy and environmental policies at local level and impact of HLC</p>
	Healthy Lifestyles Communities Coordinator (Vacant)		Local public health department pilots	X			
	Tobacco and Prevention Control Program Director (Stauffer)	DPH regional staff consultants		X	X	X	
	Nutrition and Physical Activity Program Director (Pesik)				X		

Goal #5: Evaluation - CDPCP establishes systematic approaches for determining whether its comprehensive chronic disease control program is being implemented successfully and whether its objectives are being achieved								
Background - The Wisconsin Department of Health Services has a long-standing history of partnership with the University of Wisconsin. The current Director of the Population Health Institute at the UW started his career as the Chronic Disease Chief Medical Officer for DHS and has maintained a close working relationship with DHS ever since. Currently, the Wisconsin Comprehensive Cancer Control Program is housed at the UW, and the surveillance and evaluation work done for Wisconsin's Tobacco Prevention and Control Program is done in collaboration with individuals employed at the UW. Mark Wegner, the current Chronic Disease Medical Director for DHS holds an adjunct faculty position at the UW and spends one day a week at a UW office working with the Comprehensive Cancer Program and the Tobacco Surveillance and Evaluation activities. Given this long standing close relationship, it was determined that it would be most efficient to handle the evaluation needs of Wisconsin's participation in the Program Integration Demonstration Project by collaborating with evaluators at the UW.								
Lessons Learned - Clear and regular communication will be critical during this process. Funding for evaluation is limited. Therefore, funds will have to be apportioned very efficiently. The UW evaluators will help with work on the front end to help establish criteria for developing and measuring a baseline, but the bulk of the work of monitoring progress will need to be done by DHS staff.								
Evaluation - A formal contract will need to be established. The UW evaluators will develop a pre/post survey that captures elements of the program and will allow for monitoring of progress.								
Objective and Strategies		Lead Staff/ Program	Key Partners	2009 Quarter				Evaluation Indicators
<b>5.2 By March 2009, BCHIP in conjunction with the UW evaluation team will establish a baseline for key measures of performance with respect to the Program Integration Demonstration Pilot in Wisconsin.</b>  <b>Strategies</b>  Contract in place  Develop a survey instrument that will capture baseline measures of Wisconsin's chronic disease programs  Develop goals for improvement based on survey results		Chronic Disease Medical Director (Wegner)  BCHIP Bureau Director (Uttech)	UW evaluation team	1	2	3	4	Survey developed  Baseline measures defined  Goals clearly established
Objective and Strategies		Lead Staff/ Program	Key Partners	Year				
				2010	2011			
<b>5.3 By December 2011, BCHIP in conjunction with the UW evaluation team will</b>		Chronic	UW evaluation			Consultations occur to		

<p><b>evaluate progress toward desired outcomes and determine the effectiveness of Wisconsin's program integration efforts.</b></p>	<p>Disease Medical Director (Wegner)</p>	<p>team</p>			<p>keep on track toward goals</p>
<p><b>Strategies</b></p>					
<p>Consultation as needed to ensure progress toward goals and determine if any changes in course are necessary</p>	<p>BCHP Bureau Director (Uttech)</p>		<p>X</p>	<p>X</p>	<p>Post survey disseminated</p>
<p>Follow up survey to determine extent to which goals were achieved</p>				<p>X</p>	<p>Extent to which goals were achieved is measured</p>

Goal #5: Evaluation - CDPCP establishes systematic approaches for determining whether its comprehensive chronic disease control program is being implemented successfully and whether its objectives are being achieved				
Objective and Strategies	Lead Staff/ Program	Key Partners	2010	Evaluation Indicators
<p><b>5. 4 By January 2010, at least one HLC pilot will expand program integration activities to include topics on maternal and child health and oral health.</b></p> <p><b>Strategy</b></p> <p>The Health Communities Coordinator will expand the technical assistance provided to pilots to include maternal and child health and oral health program integration activities.</p>	<p>BCHP Bureau Director (Uttech)</p> <p>Healthy Lifestyles Communities Coordinator (Vacant)</p>	<p>Family Health Section Chief (Hale)</p> <p>Oral Health Program Director (LeMay)</p>	X	

<p>Goal #5: Evaluation - CDPCP establishes systematic approaches for determining whether its comprehensive chronic disease control program is being implemented successfully and whether its objectives are being achieved</p>				
<p>Background - The DPH Program Integration Work Group has been in existence since 1994 for the purpose of working together in new ways to maximize program resources and ultimately impacting health outcomes. In our state demonstration pilot application (submitted in January 2009) we provided an inventory of past and current program integration efforts as follows: Wisconsin Work Site Wellness Resource Kit Development; Diabetes at Work: Making the Business Case Breakfast; Healthy Lifestyles Worksite Project; Wisconsin Collaborative Diabetes Quality Improvement Project; Diabetes Quality Improvement Project with the Federal Qualified Community Health Centers; Physical Activity: The Arthritis Pain Reliever; First Breath and Minority Health Min Grants. Since January 2009, we have added to our program integration list with the following initiatives: Healthy Lifestyle Coalition pilots (with tobacco and nutrition and physical activity); Exploring social determinants of health (with tobacco, heart disease and stroke prevention and minority health); Exploring integration with the new WISEWOMAN effort and chronic disease prevention activities; Common Ground and integrating chronic disease informatics systems; aiming for one disparity strategic plan among all chronic disease prevention programs; working with the FQHCs to track referral to cessation services (with comprehensive cancer, tobacco and diabetes) ; improved worksite wellness messaging; completing a third grader oral health and BMI survey (with joint funding from maternal and child health, nutrition and physical activity and diabetes prevention and control program).</p>				
<p>Lessons Learned – Often, we have failed to take the necessary steps to evaluate the success of our program integration activities. We need to be sure that evaluation is an integral part of all of our program integration design.</p>				
<p>Evaluation and Baseline - In 2009, working with the UW – Population Health Evaluation Team, we will establish a baseline of program integration activities and their effectiveness,</p>				
Objective and Strategies	Lead Staff/ Program	Key Partners	2010 and 2011	Evaluation Indicators
<p><b>5.5 By December 31, 2010 and 2011, BCHP programs will demonstrate an increase in the number of program integration activities each year.</b></p> <p><b>Strategies</b></p> <p>Establish a baseline of current program integration activity within the BCHP and the DPH PI Work Group in 2009</p> <p>Create a menu of new program integration activity options</p> <p>Monitor selection of new program integration activity options</p> <p>Develop a process for collecting and sharing success stories</p> <p>Develop an inventory of collaborative projects that involve two or more programs</p> <p>Expand funding and support to increase the number of Healthy Lifestyle Coalitions</p>	<p>BCHP Bureau Director (Uttech)</p> <p>BCHP Program Staff</p>	<p>UW Evaluation Team</p> <p>BCHP Medical Director</p> <p>DPH PI Work Group co-chairs</p>	<p>X</p>	<p>Track number of program integration activities beginning of pilot to end of pilot</p> <p>Track number of new program integration options selected each year</p> <p>Collect success stories</p> <p>Conduct inventory of programs</p> <p>Monitor cross cutting issues in program integration activities</p>

Goal # 6 Program Management and Administration – CDPCP provides a consistent administrative, financial, and staff support necessary to maintain successful programs.							
Background – The BCHP and the section of Chronic Disease Prevention and Cancer Control have many years of experience with federal categorical cooperative agreements. As federal grants have become more competitive the management team and program staff had focused on ways to improve the internal process by developing a series of protocols and tools to decrease errors in budget development, etc.							
Wisconsin has a history of sharing chronic disease prevention program funds for program integration activities. However, there are times that barriers exist that make the joint funding difficult, overly cumbersome, and sometimes impossible to do. Being a part of the demonstration pilot project will give Wisconsin an opportunity to break down some of these barriers as we encounter them. One frequently mentioned barrier is the varying federal program funding cycles and planning accordingly across federal funded programs...							
Lessons Learned – We know that joint funding results in creating a win-win environment that otherwise would not happen because the resources would not have been available. We need to learn how we can make this process even better and be sure that joint funding will DO NO HARM to the integrity of a chronic disease program.							
Evaluation - Determine current barriers and compare progress on eliminating these barriers at the end of the pilot							
Objective and Strategies	Lead Staff/ Program	Key Partners	2009				Evaluation Indicators
			Quarters				
<b>6.1 By December 31, 2009, BCHP will begin to eliminate barriers that prevent joint program funding to best promote program integration activity.</b>  <b>Strategies</b>  Examine business processes that would eliminate barriers such as improved flexible carry-over policy  Develop a template that could be used when programs want to pursue joint funding for the purpose of program integration activity  Identify varying funding sources and funding cycles with key programs  Share with appropriate federal staff and discuss the advantages and disadvantages of coordinating funding/budgeting cycles  Provide CDC with business practice barriers and solutions  Convene a work group of Program Directors and managers to identify opportunities for joint funding to partners	BCHP managers  BCHP budget staff	BCHP Program Directors and staff  Contractees	1	2	3	4	
			X				
			X				
			X				
				X			
					X		
						X	

Improve the efficiency of multiple programs contracting with the same external agencies by bundling contracts whenever possible						X	
Provide joint funding with contractees						X	
Fund joint program positions and activities when possible			X	X	X	X	

Goal # 6: Program Management and Administration – CDPCP provides consistent administrative, financial, and staff support necessary to maintain successful programs.

Background – The STAR Report mentioned several communication challenges for both internal staff and external partners. Internal staff mentioned the lack of an internal communication plan, and the fact that program staff had varying definitions of program integration. They also expressed a concern about a gap between the leader’s vision and staffs’ understanding about program integration. The report also mentioned that partners said they wanted better communication from chronic disease programs.

When we learned that we would be a pilot state, it raised (the importance of) communication to another level. It began with our regular interaction with CDC and the demonstration pilot states, and sharing updates with internal staff. Our frequent, weekly conference calls and our face-to-face meeting with CDC and the other states set the foundation for our direction during the first several months of the pilot. Future communication exchanges like this will prove invaluable to the process, as well as the opportunity to utilize Site Scape. With the onset of the program integration demonstration pilot, one of the most frequently asked question by DPH and BCHP staff was, “Where do I fit in [to program integration and this demonstration pilot]?”

In order to communicate information to staff most effectively, Mark Wegner and Susan Uttech established several different program integration teams. The **Wisconsin PI Core Team** includes Susan Uttech and Mark Wegner as pilot co-chairs; Millie Jones and Nancy Chudy, co-chairs of the DPH PI Work Group; and Vicki Stauffer and Mary Pesik, Program Directors for Tobacco, and Nutrition and Physical Activity, respectively. The core team is responsible for the regular communication with CDC (Carol MacGowan). The **Wisconsin Core Team PLUS** is an expanded team that includes all six Program Directors for Behavioral Risk Factor Surveillance System (Ann Ziege), Comprehensive Cancer (Amy Conlon), Diabetes (Leah Ludlum), Heart Disease and Stroke Prevention (Catherine Brue), Nutrition and Physical Activity (Mary Pesik), and Tobacco (Vicki Stauffer), as well as several additional key staff to include program directors from Arthritis (Anne Kissack) and Asthma (Chris Rameker) and Tom Conway and Patti Herrick who are BCHP Section Chiefs. The **DPH Program Integration Work Group** was in place before we received the CDC demonstration pilot. The DPH PI Work Group members consists of 25 people representing chronic disease programs, and other related DPH programs such as coordinated school health, maternal and child health, lead, oral health, minority health, injury prevention, etc. The last formal group established to improve communication is the **BCHP Management Team**. In order to create “a culture where program integration is the organization norm” BCHP managers must be on board.

To address staffs’ concerns about where they fit in to program integration activities, a presentation was developed with the purpose to establish common language, identify and clarify people’s roles and expectations, and engage more stakeholders including BCHP management. It was important for staff to understand that this demonstration project was not taking the place of the hard work they have done over the years in program integration, but was going to provide Wisconsin with an opportunity to further enhance our program integration efforts. For several weeks, Susan Uttech delivered the presentation and garden analogy to multiple internal BCHP and DPH audiences such as the DPH Program Integration Work Group and at Section and Management meetings. The purpose of using a garden analogy (flowers, vegetables, and herbs) was to help people understand their roles and like a garden many things are growing simultaneously. (Internally, we make reference to the Wisconsin Core Team Plus as the flowers section of the garden, DPH PI Work Group as the vegetables section, and BCHP Management as the herbs section.)

During the October Retreat, participants identified additional recommendations for the STAR report. These “staff” recommendations to the STAR report will be discussed during this pilot project and regular communication on progress will be provided to BCHP and DPH staff.

Lessons Learned – In October 2009, we held a Retreat for the DPH Program Integration Work Group. After the Retreat, participants were asked to complete a survey. (We had a 78% response rate, N = 25).

- 96% felt that they could clearly articulate the definition of program integration
- 96% felt that participating in the Retreat helped them to understand their role in program integration
- 100% agreed with the statement “I believe that program integration activity will DO NO HARM to the integrity of my program.
- Benefits of Program Integration mentioned were:
  - Improved messaging
  - Decreased duplication
  - Increased communication
  - Maximized resources and partners for increased effectiveness
  - Enhanced collaboration
  - Established common language and understanding

Evaluation - Establish baseline of internal communication strategies and perceived level of effectiveness regarding communication

Objective and Strategies	Lead Staff/ Program	Key Partners	2009 Quarters				Evaluation Indicators
			1	2	3	4	
<p><b>6.2. By December 31, 2009, the BCHP will assure improved internal communication about program integration between managers and staff; between chronic disease programs (as well as maternal and child health); and with external partners.</b></p> <p><b>Strategies</b></p> <p>Convene PI Core Team Plus to discuss and determine communication needs</p> <p>Survey key BCHP staff groups to determine communication needs</p> <p>Develop a communication plan for internal staff and external partner</p> <p>Coordinate efforts with DPH PI Ad Hoc Subcommittees as it relates to similar activities such as the promotion and integration of Healthy People at Every Stage of Life; improved partner relationships, etc.</p> <p>Continue to formally meet with BCHP staff by utilizing existing meetings such as bureau meetings, section meetings, and DPH Program Integration Work Group meetings. PI Core Team PLUS, etc.</p> <p>Explore ways to increase public awareness of the importance of healthy lifestyles and risk reduction</p>	PI Core Team	PI Core Team PLUS  DPH PI Work Group  BCHP Management	X				Establish baseline of communication strategies.  Perceived level of effectiveness of communication pre/post
				X			
			X				
			X	X	X	X	
			X	X	X	X	
			X	X	X	X	

<p>Develop a tool that will help Wisconsin communities conduct public health impact assessments that include chronic disease prevention and risk reduction efforts</p> <p>Provider regular progress updates on the STAR report recommendations including the recommendations that DPH staff added at the October Retreat</p>				X			
			X	X	X	X	