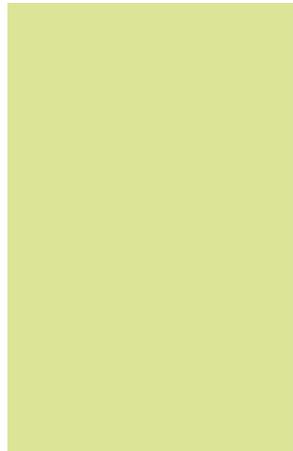
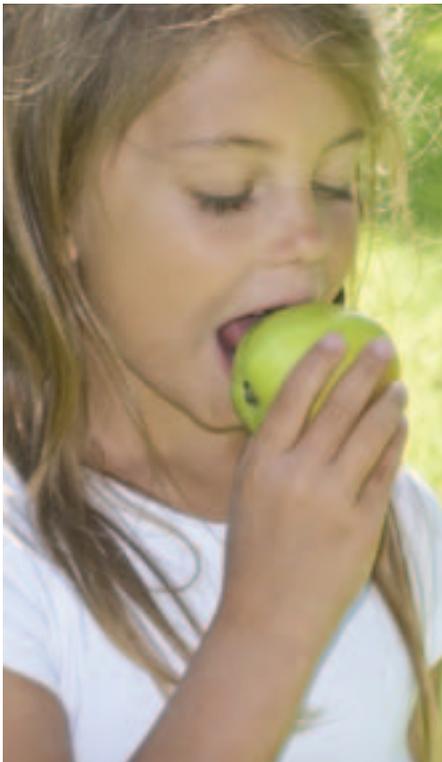




MASSACHUSETTS COORDINATED HEALTH PROMOTION
AND CHRONIC DISEASE PREVENTION PLAN

A Community of Practice Approach



Background

THIS DOCUMENT PROVIDES
A SUMMARY OF THE MORE
DETAILED STATE PLAN
DOCUMENT THAT WILL BE
AVAILABLE IN EARLY FALL,
2012 AT [WWW.MASS.GOV/
DPH/CHRONICDISEASE](http://WWW.MASS.GOV/DPH/CHRONICDISEASE)

In January 2012, the Division of Prevention and Wellness at the Massachusetts Department of Public Health (MDPH) embarked on a planning process with more than 25 public sector and community-based partners to create the Commonwealth's first *Coordinated Health Promotion and Chronic Disease Prevention Plan (Plan)*. Historically, the partners have focused their efforts on specific diseases (e.g., cancer, asthma, diabetes), populations (e.g., children, people who are elderly, people with disabilities), or systems (e.g., healthcare, transportation, early education). There is widespread recognition, however, that people affected by one chronic disease often experience a co-morbid condition or disease. Further, there is growing acknowledgment that those organizational partners with a disease focus should partner with organizations that have expertise with different populations and systems to ensure effective planning, interventions, and policies and to extend the reach of health promotion and disease prevention efforts. Lastly, many chronic diseases share similar risk factors. Coordinating strategies that focus on shared risk factors will enhance overall efforts. The diverse group of partners involved in this planning effort resolved to develop a plan that 1) builds on the strength of their existing work, 2) identifies areas for collaboration and synergy, and 3) begins to develop a more coordinated chronic disease prevention and management system in the Commonwealth.

As a starting point, the partners defined chronic disease as heart disease and stroke, diabetes, cancer, asthma, arthritis and obesity. They anticipate that other conditions (e.g., substance abuse, HIV/AIDS, mental health, oral health) may be added to this list after the partnership gains more experience planning and implementing coordinated strategies.

Through several facilitated meetings convened by the Division of Prevention and Wellness, the partners developed a vision, mission and goals for their work, and inventoried their current strategies for addressing chronic disease and risk factors. Next they identified multiple priority objectives that will serve as the focus of their planning and activities for the first five years of the Plan. Finally, these initial partners organized the priority objectives into seven Communities of Practice (CoPs), and identified additional partners to be invited to join the growing Massachusetts Partnership for Health Promotion and Chronic Disease Prevention (Partnership). This Partnership will assume responsibility for implementing the state plan. A list of initial partners is presented on page 12.

Partnership Vision

Everyone in Massachusetts enjoys a healthy community and has equal access to resources that support their choices for optimal health and well-being.

Our Mission

The MA Partnership for Health Promotion and Chronic Disease Prevention is comprised of a broad range of public and private organizations with a shared interest in the primary prevention of chronic disease, in reducing the burden of chronic disease, and in reducing health disparities while promoting health equity in the Commonwealth through policy, systems and environmental change strategies. Through the collective work of our organizations and collaborative planning we will:

- » Improve environments to support and increase healthy behaviors among MA residents across the lifespan
- » Improve detection, management and control of chronic disease and associated risk factors
- » Create and strengthen linkages between healthcare settings and communities to remove barriers to care and improve self-management of chronic disease and associated risk factors
- » Improve capacity to use data to inform and improve public health strategies

Our Goals

HEART ATTACK AND STROKE

Prevent 20,000 heart attacks & strokes (10% reduction in heart attacks and strokes by 2017)

DIABETES

Prevent 1,500 diabetes-related hospitalizations (1% decrease in diabetes-related hospitalizations by 2017)

CANCER

Prevent 800 cancer deaths (6% decrease in cancer deaths by 2017)

ARTHRITIS

Engage an additional 34,000 adults with arthritis in the recommended amount of physical activity (5% increase in adults with arthritis that are getting the recommended amount of physical activity by 2017)

ASTHMA

Prevent 1,000 asthma-related hospitalizations (1.5% decrease in asthma-related hospitalizations by 2017)

OBESITY

Decrease obesity among Massachusetts youth and adults by 5% by 2017

The Ongoing Work of Partnership Organizations

An effective system for reducing chronic diseases in Massachusetts requires multiple dedicated partners and a vast array of strategies at the individual, family, community, systems and state levels supported by a variety of funding streams. Together, the organizations involved in the Partnership provide direct services, training and technical assistance; develop and influence policy; plan and develop infrastructure for safe and healthy communities; improve systems of and access to care; and reduce health disparities by improving health equity.

The collective work of partners falls within four strategic areas:

1. Improving environments and increasing healthy behaviors among Massachusetts residents across the lifespan through strategies related to healthy eating, active living, the built environment and tobacco-free living in communities, schools, day care, homes, work sites, healthcare and other venues.
2. Improving the detection, management and control of chronic disease and associated risk factors by employing strategies related to the delivery of clinical preventive services and population health management.
3. Creating linkages between healthcare settings and communities to remove barriers to care and to improve self-management of chronic disease and associated risk factors through strategies that link community and healthcare resources to improve access to information, resources and services.
4. Improving the capacity to use data to inform and improve public health initiatives, including strategies that will improve access to state and local level data for use in planning, management, and evaluation.

**THE ONGOING
WORK OF THE
PARTNERS IS
DESCRIBED IN
THE STATE PLAN
DOCUMENT.**





Priority Objectives

In addition to our individual agency efforts, the Partnership members will engage in collaborative planning to address 11 priority objectives which correspond to the strategic areas described above. These particular objectives were selected because they:

- » Provide opportunities to test and evaluate strategies that will inform similar efforts to address other risk factors or diseases in the future;
- » Involve strategies (or policies) that can have a statewide impact;
- » Increase the scope of health promotion and chronic disease management in Massachusetts and fill gaps;
- » Offer opportunity for each of our partners to work in a coordinated way to achieve one or more objectives;
- » Focus limited resources on high-impact initiatives;
- » Are aligned with the priorities of the Million Hearts Campaign and the National Prevention Strategies including blood pressure control, healthy eating, active living and smoking cessation.

Priority Objectives for the State Plan

1. By 2017, increase the percentage of Massachusetts youth and adults who report eating five fruits and vegetables per day by 1.5%.
2. By 2017, increase the percentage of children ages 3 to 18 who report engaging in moderate to vigorous physical activity for 60 minutes on five or more days per week by 3%.
3. By 2017, at least 5% of Massachusetts residents will live in communities with a Complete Streets policy.
4. By 2017, increase the percentage of smokers who report that they have a “no smoking in the home” policy by 5%.
5. By 2017, increase screenings for colorectal cancer by 5%.
6. By 2017, increase vaccination against influenza by 3% and pneumonia by 4% among populations for whom immunizations are recommended.
7. By 2017, increase the percentage of smokers who are screened and counseled on tobacco use by 4%.
8. By 2017, increase the percentage of people whose blood pressure is within normal range by 2.5%.
9. By 2017, develop and disseminate at least three best practice models for better clinic-to-community linkages for preventing and controlling chronic disease (e.g., community health workers).
10. By 2017, develop and disseminate two-page public health community profiles for cities/towns and legislative districts across the Commonwealth to describe the health of communities.
11. By 2017, identify and pursue other collaborative data initiatives that will inform and improve public health strategies to address chronic disease.

Communities of Practice



The infrastructure of the Partnership will be comprised of seven CoPs (workgroups) which will meet regularly to plan, implement, evaluate and improve strategies to achieve their assigned objectives. Each CoP is comprised of a subset of the Partnership and has members whose knowledge, skills and experience are suited to the CoP's objectives. A member of each CoP will serve on the Partnership's leadership group and report on the progress of their respective CoP. Two full Partnership meetings will occur annually for the purposes of sharing lessons learned, reporting on the annual work of the member organizations, and engaging in annual planning to expand or modify the list of priority objectives. The focus of each CoP is described in more detail below. The CoPs will utilize data on health disparities when developing strategies to ensure that health equity is addressed in all strategies in order to improve the health of those most at-risk for chronic disease.

Healthy Eating CoP

Good nutrition is known to lower people's risk for obesity and many other chronic diseases. Among the various strategies for addressing this risk factor, the Healthy Eating CoP will focus on increasing fruit and vegetable consumption among both children and adults in the Commonwealth. The 2009 Youth Health Survey found that only 14% of high school students reported eating five or more servings of fruits and vegetables per day. Adults reported higher numbers, with slightly over one in four Massachusetts adults reporting consumption of five or more servings daily (26.2%). Men were less likely to report consuming five or more servings of

fruits and vegetables per day (20.1%) than were women (31.7%). Race/ethnicity and income disparities also impacted fruit and vegetable consumption. Black non-Hispanic adults were less likely to report consuming five or more servings per day (20%) than were White non-Hispanic adults (27%). Only 22% of respondents living in households with incomes of less than \$25,000 per year reported consuming 5 or more servings compared to 29% of respondents living in households earning \$75,000 or more. The Healthy Eating CoP will work together to achieve **Objective 1: Increase the percentage of youth and adults who report eating five fruits and vegetables per day by 1.5% by 2017.**

Physical Activity CoP

Regular moderate to vigorous physical activity can improve overall health, reduce obesity, and reduce the risk for some chronic diseases. This CoP focuses on increasing physical activity among youth ages 3-18. Although physical education is mandated for every student in Massachusetts public schools, there are currently no policies in place to ensure that children of all ages engage in moderate to vigorous physical activity during the school day. According to students' self-reported height and weight, 27% of middle school students and 25% of high school students are overweight or obese. In 2009, only 33% of middle school students and 34% of high school students reported engaging in moderate to vigorous physical activity for 60 minutes at least five days a week. A greater percentage of high school and middle school students reported some aerobic activity for at least 20 minutes, 3 days a week (63% and 75%, respectively). Less is known about rates of physical activity among those ages 3 to 11. This CoP will collaborate with the Improved Access to State and Local Data CoP to establish a baseline for this younger cohort and measure progress over time. The Physical Activity CoP will work together to achieve **Objective 2: Increase the percentage of youth ages 3 to 18 who report in engaging in moderate to vigorous physical activity for 60 minutes on five or more days a week by 3% by 2017.**

Built Environment CoP

Built environments that support active living lead to healthier communities. Physical activity is associated with decreased obesity and reduced risk for several chronic diseases, from arthritis to heart disease. A Complete Streets policy encourages the creation and operation of road networks that support physical activity by enacting change at the policy level. In addition, a Complete Streets Policy is designed for all users by supporting activities such as walking and biking. Enactment of a Complete Streets policy indicates that a community is committed to building and maintaining road networks in ways that support public health and safety. Massachusetts residents who live in communities with Complete Streets will have increased opportunity to be physically active. The Built Environment CoP will work together to accomplish **Objective 3: By 2017, at least 5% of Massachusetts residents will live in communities with a Complete Streets policy.**

Tobacco-Free Living CoP

Smoking in the home has negative health consequences not only because environmental tobacco smoke (ETS) is a known carcinogen and risk factor for cardiovascular disease, asthma and cancer, but also because ETS can act as a trigger for asthma attacks. The Tobacco-Free Living CoP aims to minimize people's exposure to ETS through the promotion of smoke-free housing policies in multi-unit dwellings. According to the 2010 Massachusetts BRFSS, most respondents (83.8%) reported that they live in a

household where smoking is not allowed, but disparities were evident. Respondents who reported that they have a disability were significantly less likely to respond that they lived in a household where smoking is not allowed (75.4%) than respondents who did not report that they had a disability (86%). Respondents with a household income of less than \$25,000 per year (71.2%) were also significantly less likely to

Clinical Preventive Services and Population Health Management CoP

This CoP will focus on increasing and improving the delivery of clinical preventive care to prevent chronic disease, detect chronic diseases early in the disease process, and appropriately manage existing chronic conditions. To this end, the group will focus on three clinical preventive objectives related to colorectal screening, vaccination against influenza and pneumonia, and smoking screening and cessation counseling, as well an objective targeting the management and treatment of high blood pressure.

Colorectal cancer screening is a preventive service recommended for those age 50 and older. In 2010, 63.2% of Massachusetts residents age 50 and older reported that they had had a colonoscopy or sigmoidoscopy in the past five years. As of 2010, the CDC recommends a universal influenza vaccine for everyone 6 months and older. In Massachusetts, 50.1% of residents reported receiving a flu shot in 2010. For pneumonia prevention, the CDC recommends that the pneumococcal vaccine be administered to children under 2 years of age, adults 65 and older, anyone with heart disease, diabetes, or asthma, and anyone who smokes, among other medical conditions. In 2010, 50.0% of the Massachusetts population that should have received a pneumococcal vaccine reported having ever been vaccinated against pneumonia. The last clinical preventive service in this CoP focuses on tobacco use. A medical visit is an important

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.
~World Health Organization, 1948

report that they lived in a household where smoking is not allowed versus those with income of \$25,000 or more (85.9%).

As of 2010, 14.1% of Massachusetts residents reported that they currently smoke. Of current smokers, only 49.9% reported that they had a “no smoking in the home” policy, compared to 89.4% of nonsmokers. The Tobacco-Free Living CoP will work together to achieve **Objective 4: Increase the percentage of smokers who report that they have a “no smoking in the home” policy by 10% by 2017.**



opportunity for a medical provider to initiate a conversation about smoking cessation with current smokers. In 2010, 79.8% of current smokers who had seen a healthcare provider in the past 12 months reported that a medical provider had advised them not to smoke.

High blood pressure, if left untreated over time, can cause damage to the cardiovascular and renal (kidney) systems as well as to the brain. This objective aims to increase the percentage of adults with a blood pressure within normal range by 2017. In 2009, just over one in four Massachusetts adults (25.7%) reported that they had ever been told that they have high blood pressure. Among Massachusetts residents with high blood pressure, 78.8% were taking medications to lower or control their blood pressure. In addition to medication, behavior changes can play an important role in lowering or controlling blood pressure. Among those who were taking medications, 93.0% were making at least one of the following behavior changes for their hypertension: changing eating habits (70.1%), reducing salt intake (74.6%), reducing alcohol use (37.3%), or exercising (71.6%). However, 17.6% of the adults with self-reported hypertension were neither using blood pressure medication nor changing their behavior to lower or control their high blood pressure.

The Clinical Preventive Services and Population Health Management CoP will work together to address objectives 5 through 8:

Objective 5. Increase screening for colorectal cancer by 5%,

Objective 6. Increase vaccination against influenza by 3% and pneumonia by 4%

among populations for whom these immunizations are recommended,

Objective 7. Increase the percentage of smokers who are screened and counseled on tobacco use in a healthcare provider's office by 4%—all by 2017, and

Objective 8. Increase the percentage of people whose blood pressure is within normal range by 2.5% by 2017.

Community and Healthcare Linkages CoP

Many people who are at risk for chronic disease (or who currently have one or more chronic diseases) lack the resources that could help them decrease their risk, such as access to preventive services, nutritious food options, or availability of safe places to engage in physical activity. The Community Linkages CoP objective aims to connect clinical settings to community resources that can help individuals prevent and control chronic diseases. This CoP will develop best practice models to connect clinical healthcare settings to community resources through such means as community health workers, pharmacists, and direct referrals to community resources by medical providers (community prescriptions). In addition, this CoP will provide an opportunity to engage the healthcare community in efforts to improve environments for policy, systems and environmental changes at the community level. The Community Linkages CoP will work together to achieve **Objective 9: Developing and disseminating at least three best practice models for better clinic-to-community linkages for preventing and controlling chronic disease by 2017.**

ON-GOING WORK OF PARTNERSHIP MEMBER ORGANIZATIONS

	HEART ATTACK & STROKE	DIABETES	CANCER	ASTHMA	ARTHRITIS	OBESITY
COMMUNITIES OF PRACTICE	▼	▼	▼	▼	▼	▼
▶ HEALTHY EATING	X	X	X	X		X
▶ PHYSICAL ACTIVITY	X	X	X	X	X	X
▶ BUILT ENVIRONMENT	X	X	X	X	X	X
▶ TOBACCO-FREE LIVING	X		X	X		
▶ CLINICAL PREVENTIVE SERVICES & POPULATION HEALTH MANAGEMENT	X	X	X	X		
▶ COMMUNITY LINKAGES	X	X	X	X	X	X
▶ IMPROVED ACCESS TO STATE AND LOCAL DATA	X	X	X	X	X	X



Improved Access to State and Local Data CoP

Data collected by the DPH is used to support policy that improves the public health of Massachusetts. The Improved Access to State and Local Data CoP has three aims: increasing data availability at the community level; improving data linkages; and supporting other Partnership evaluation efforts.

Currently, most health-related data in Massachusetts are available only at the state level. This CoP will create public health community profiles to allow cities and towns to learn about their health in relation to the state. Using these profiles, decision makers, local communities, legislators and residents will be able to better understand their community's health. Secondly, this group will undertake more comprehensive data initiatives such as data linkage projects. Through improved data linkages, they will be able to identify health needs and health disparities in greater detail which, in turn, will be used to refine chronic disease-related interventions.

This CoP will also support data needs that arise in other CoPs (e.g., developing a baseline measure for children ages 3–11 for the Physical Activity CoP).

The Improved Access to State and Local Data CoP will work together to achieve the following:

Objective 10: Develop and disseminate two-page public health community profiles for cities/towns and legislative districts across the Commonwealth to describe the health of communities by 2017;

Objective 11: Identify and pursue other collaborative data initiatives that will inform and improve public health strategies to address chronic disease (i.e., partners who have data that could be integrated with data at MDPH).

THERE ARE 11 PRIORITY OBJECTIVES. ALL STRATEGIES UNDER THESE OBJECTIVES WILL BE MONITORED USING TOOLS DEVELOPED TO TRACK PROGRESS AND HELP IN THE COLLECTION OF DATA.

How we will meet our goals

Partnership members are confident that both the ongoing work of its member organizations and the focused work by the CoPs will lead to reducing the burden of asthma, arthritis, cancer, diabetes, obesity, heart attack, and stroke. The diagram at left demonstrates the alignment between the strategies that are currently being implemented by Partnership member organizations and the Plan's six goals, and also illustrates which of the CoPs will support the Plan's goals.

Surveillance and Evaluation

The surveillance and evaluation of the Coordinated Health Promotion and Chronic Disease Prevention Plan will be led by the Improved Access to State and Local Data CoP. This CoP will monitor the performance of chronic disease and risk factor indicators relevant to the Plan's goals and objectives. In addition, the Improved Access to State and Local Data CoP will conduct quantitative and qualitative surveys of internal and external stakeholders on the development of the plan, creation of the Partnership, selection of strategies and accomplishments of the CoPs. The data CoP is comprised of data analysts, epidemiologists, and evaluators from both the Division of Prevention and Wellness (DP&W) at the MDPH and external partners participating in the development and implementation of the plan. It is envisioned that the Improved Access to State and Local Data CoP will also be responsible for providing technical and analytic support to each of the CoPs. To accomplish this, at least one member from the Improved Access to State and Local Data CoP or other epidemiologists from the DP&W will participate in each CoP.

Performance Measures

The plan has already identified preferred performance measures for each of the 11 priority objectives. The majority of these performance measures will be tracked through already-existing surveillance tools such as Behavioral Risk Factor Surveillance System (BRFSS), Youth Health Survey (YHS), Youth Risk Behavioral Survey (YRBS), Community Surveys, Acute Hospital Discharge Data, and Vital Statistics. Other performance measures will be captured by data sources that will become available early on in the Plan such as Meaningful Use reports and the All Payer Claims Database. All strategies that are implemented to support the priority objectives will be tracked using activity monitoring tools. These tools will capture accomplishments, strengths and challenges for each objective and strategy and will document the extent to which both the objectives and their strategies have been successfully implemented. An annual evaluation report will be prepared to document evaluation results for all the CoP activities. This report will be disseminated to all members of the Partnership, MDPH, and Centers for Disease Control and Prevention (CDC).

The Massachusetts Partnership for Health Promotion and Chronic Disease Prevention

Partners who have participated in the planning effort to date include:

Action for Healthy Kids	MA Dept. of Agriculture	Massachusetts Department of Public Health
American Cancer Society	MA Dept. of Disability Planning/Policy	» Bureau of Substance Abuse Services
Alliance of MA YMCAs	MA Dept. of Early Education and Care	» Bureau of Environmental Health
Boston Public Health Commission	MA Dept. of Elementary and Secondary Education	» Division of Prevention and Wellness
Boys and Girls Clubs	MA Dept. of Transportation	» Office of Community Health Workers
Diabetes Educators of MA	MA Executive Office of Elder Affairs	» Office of Statistics and Evaluation
Disability Policy Consortium	MA Farm Bureau Federation	» Office of Health Equity
Head Start	MA Health Officers Association	» Office of Rural Health
Health Resources in Action	MA League of Community Health Centers	» School Health Services
Interagency Council on Housing and Homelessness	MA Municipal Association	» Tobacco Cessation and Prevention Program
Latino Center of Excellence for Elimination of Disparities	MA Pharmacists Association	» Women, Infants and Children Nutrition Program
MA Area Health Education Councils	MA Public Health Association	
MA Association of Health Boards	MassHealth	
MA Association of Health Plans	Metropolitan Area Planning Council	
MA Councils on Aging	South Coast Physicians' Network	
	University of Massachusetts Lowell	

The Partnership welcomes new member organizations engaged in health promotion and chronic disease prevention and treatment. All members are expected to participate in at least one of the seven CoPs described in this document. If your organization is interested in joining the Partnership, please contact:

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