

UNBRIDLED HEALTH



A Plan for Coordinated Chronic Disease Prevention and Health Promotion

2012 – 2016



Kentucky Public Health

Prevent. Promote. Protect.

November 2013

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August 26, 2013

A Letter from the Kentucky Department for Public Health Commissioner:

The Kentucky Department for Public Health is pleased to present Kentucky's *Unbridled Health, A Plan for Coordinated Chronic Disease Prevention and Health Promotion 2012-2016*. This plan outlines objectives and strategies built on the collaboration among communities and healthcare professionals to address chronic disease prevention and health promotion in the Commonwealth.

The overarching performance objective areas included are reducing age adjusted mortality due to chronic diseases; reducing prevalence of disabling chronic diseases; improving quality of life and health outcomes by promoting environmental and policy changes pertaining to nutrition, physical activity, clinical preventive services related to chronic disease prevention, early detection and management; promoting education and management skills for those diagnosed with or at risk for chronic diseases.

The foundation for this coordinated effort was accomplished by strengthening linkages with existing partners as well as the development of nontraditional partnerships. Kentucky Department for Public Health led the efforts of over a 60 member Steering Committee as well as 160 plus stakeholders to create this Unbridled Health Plan. It is a comprehensive chronic disease prevention and health promotion state plan that utilizes strategies to improve policies, environments, programs and infrastructure in order to achieve measurable improvements across the top five leading chronic disease cause of death and disability (e.g. heart disease, cancer, stroke, diabetes and arthritis) and their associated risk factors. This was accomplished by utilizing collaborative workgroups to turn knowledge into behavioral change and to increase the use of evidenced based guidelines for health systems change.

This plan delineates the strategies and objectives developed to continue to address prevention and treatment improvements through policy and systems changes to improve the health of Kentuckians.

I would like to express my appreciation to all those individuals who assisted in the preparation of this very important document. My thanks is also expressed to every reader who will become more informed about the diligent efforts needed to address the issues of chronic disease prevention and health promotion in our Commonwealth.

Sincerely,

Commissioner

Acknowledgements

Many thanks to the organizations, agencies and programs who served on the Coordinated Chronic Disease Prevention and Health Promotion Steering Committee:

American Heart Association	Kentucky Cancer Program West
Arthritis/Osteoporosis Program	Kentucky COPD Coalition
Asthma/COPD Program	Kentucky Department of Education
Kentucky Women’s Cancer Screening Program	Kentucky Diabetes Network
Behavioral Risk Factor Surveillance System Program	Kentucky Health Department Association
Cancer Leadership Team	Kentucky Health Department Health Educators
Center for Performance Management Team	Kentucky Heart Disease and Stroke Prevention Task Force
Chronic Disease Prevention Branch	Kentucky Primary Care Association
Coordinated Chronic Disease Program	Kentucky Safe Aging Coalition
Colon Cancer Screening Program	Kentucky Safety and Prevention Alignment Network
Comprehensive Cancer Program	Kentucky Transportation Cabinet
Coordinated School Health Program	Kentucky Youth Advocates
Community Transformation Grant (CTG) Louisville Metro	Kentucky Voices for Health
Community Transformation Grant CTG-Operation UNITE	Maternal and Child Health Division
Department of Aging and Independent Living	Office of Health Equity
Diabetes Prevention and Control Program	Obesity Prevention Program
Foundation for a Healthy Kentucky	Oral Health Program
Health Promotion Branch	Partnership for a Fit Kentucky
Health Care Access Branch	Prevention and Quality Improvement Division
Health Care Excel	Tobacco Prevention and Cessation Program
Healthy Communities Program	University of Louisville School of Public Health
Heart Disease and Stroke Prevention Program	University of Kentucky College of Public Health
Jewish Hospital and St. Mary’s HealthCare	Upstream to Health Equity Project
Kentuckiana Health Collaborative	Walgreens Pharmacy
Kentucky Asthma Partnership	Western Kentucky College of Public Health
Kentucky Cancer Consortium	Women’s Health Division
Kentucky Cancer Program East	Worksite Wellness Program

Table of Contents

Executive Summary	6
Kentucky's Call to Action	8
The High Burden of Chronic Disease in Kentucky	10
The Framework	18

The Plan: Strategic Areas, Key Initiatives and Action Items	19
• Strategic Area 1: Promote policy, environmental and system changes that will support healthy choices and healthy living in Kentucky and its communities.	19
• Strategic Area 2: Expand access to coordinated, quality, evidence-based clinical screenings, clinical management and chronic disease self-management.	21
• Strategic Area 3: Cultivate strong connections linking individuals, community organizations, businesses, schools, the health care system and other partners to improve health outcomes, reduce health care costs, and improve quality of life.	24
• Strategic Area 4: Translate surveillance, research and evaluation findings into information that is easily accessible to and useful to the community partners, health advocates and decision makers.	26

Appendix A - Health Outcomes Indicators	28
Appendix B – Glossary of Terms	34
Appendix C – Acronyms Defined	45
Appendix D – References: A Topical Index	47

Appendix E – The Planning Process	58
Appendix F – The Communication Plan	60
Appendix G – The Evaluation Plan	62
Appendix H – Accountability	65
Appendix I - KY Unbridled Health Plan Template	67

Executive Summary

Mission: To create a healthier Kentucky through a collaborative coordinated approach to health promotion and chronic disease prevention and management.

The Coordinated Chronic Disease Prevention and Health Promotion State Plan is representative of hundreds of organizations united through shared vision, common commitment, and collaborative activities. Health departments, hospitals, non-profit organizations, schools, community coalitions, health advocacy groups, professional associations, and employee wellness programs all share a common goal – a healthier Kentucky. Key stakeholders from each of these venues have worked over the last year to develop the Coordinated Chronic Disease Prevention and Health Promotion State Plan. Chronic disease is too big and complex a problem for any one group to address efficiently. By pooling information, ideas, skills and strategies into one common document, the Plan seeks to equip organizations and individuals with a unified call to action. A coordinated approach to chronic disease challenges stakeholders not to do more with less, but instead to unite forces and do a few things well. Together, we can work to improve the health and quality of life for all Kentuckians – in their homes, workplaces and communities -- and move the state from a focus on sickness and chronic disease to one based on prevention and wellness.

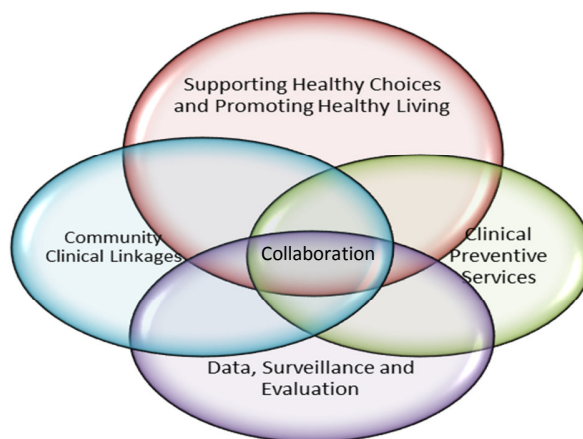
By uniting multiple stakeholders around common goals, strategic areas, initiatives and action items, the Coordinated Chronic Disease Prevention and Health Promotion State Plan provides a framework in which organizations and individuals can unite as one powerful force to reduce the significant chronic disease burden in our state. **The framework includes policy, systems and environmental changes that support healthy choices; expanded access to health screenings and self-management programs; strong linkages among community networks; and research data that are used as a catalyst for change.** Each strategic area in the Plan provides a variety of action items for potential implementation, as well as health outcome indicators which provide both a baseline from which to begin, and a target to gauge our progress as a state.

Chronic diseases – such as heart disease, stroke, cancer, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the U.S. In 2005, 133 million Americans – almost 1 out of every 2 adults – had at least one chronic illness. Management of this public health epidemic has devastating consequences on an individual level -- about one in four people with chronic conditions report daily activity limitations. Each and every day, millions of Americans are limited in what they are able to do because of chronic disease.

Kentucky leads the nation in several indicators of the burden of chronic disease. Kentucky has the highest rate of new cases and deaths from lung cancer in the nation, the highest rate of new cases of colorectal cancer, the highest rate of arthritis, the 2nd highest rate of deaths from COPD (Chronic Obstructive Pulmonary Disease), the 3rd highest adult obesity rate, and Kentucky ranks 4th highest in current adult asthma prevalence. Kentucky's high school youth smoking rate leads the nation. As of 2010, 370,000 or 10% of adult Kentuckians are estimated to have diabetes.

With statistics such as these, it is likely that every Kentuckian has a family member, friend or co-worker that has been affected by chronic disease.

And yet, among these grim statistics there is hope for Kentucky's future. Almost 60% of deaths from colon cancer could be prevented if everyone age 50 and older were screened regularly. Lexington's smoke-free law resulted in a 22% reduction in emergency department visits for asthma. High school students who participate in physical education five days a week are 28% less likely to be overweight adults. Residents are 65% more likely to walk in neighborhoods with sidewalks. Within just a few weeks, most people experience a reduction in blood pressure when their salt intake is reduced. These examples represent a handful of modifiable health risk behaviors—physical activity, nutrition, and tobacco use – which are responsible for much of the illness, suffering, and early death related to chronic diseases. Changes in policy, systems and the environment, as well as individual modifications, clearly make an impact.



The Coordinated Chronic Disease Prevention and Health Promotion State Plan is intended to be a living document. While the health outcome objectives and targets in Appendix A will remain the same, our key initiatives and action items will be updated periodically based on the latest evidence and evaluation results from implementation efforts. This plan is meant to be very alive in our communities throughout the state. Please share this plan with other groups and organizations, implement key initiatives, and evaluate efforts to find new ways of working together!

While one entity or organization cannot be accountable for all of the “public health” and “population health” improvements that will take place over the years of this Unbridled Health Plan, the leadership team along with the Kentucky Department for Public Health will continue to facilitate communication, training, resources and support of policies that will ensure that Kentucky has a vested interest in making the healthy choice the easy choice.

Kentucky's Call to Action

Nearly every Kentuckian has a family member, friend, or co-worker who has been affected by a chronic disease. Kentucky's Coordinated Chronic Disease Prevention and Health Promotion State Plan can change this through a united effort and shared vision to create healthier communities by making healthy living easier and more affordable where people live, learn, work, play and receive care.

Collaboration ensures that the whole is greater than the sum of its parts. Where do you fit in? You are a key part of the team, and here are some examples of ways you can begin to make a difference:



School or university:

- Make your entire campus a tobacco-free environment.
- Provide healthy foods in vending machines and cafeterias.
- Include health promotion messages in health classes.
- Include comprehensive school physical activity programs.
- Adopt comprehensive school and staff wellness policies.



Community or state organization:

- Support policy, environmental, and systems changes for chronic disease prevention and control.
- Collaborate to provide community or state prevention programs.
- Provide chronic disease prevention awareness information and screening programs for clients.



Hospital:

- Collaborate to sponsor community screening and education programs.
- Implement comprehensive tobacco-free policies at your facility.
- Seek or maintain accreditation/certification to ensure quality (Heart, Stroke, Cancer, Baby Friendly or other).
- Collaborate to sponsor patient navigation and survivorship programs.



Employer:

- Implement comprehensive tobacco-free policies at your facility.
- Use incentives and implement programs (paid time off for screenings, worksite wellness programs) to reduce barriers and encourage regular screenings.
- Provide healthy food options in vending machines and cafeterias.
- Adopt comprehensive worksite wellness policies and programs.



Local health department:

- Support policy, environmental and systems changes for chronic disease prevention and control.
- Provide navigation services for clients.
- Collaborate in community prevention and health promotion campaigns.
- Consider the benefits of public health accreditation.
- Promote age appropriate preventive vaccinations



Faith-based organization:

- Encourage members to get preventive screening tests.
- Provide space for physical activity programs.
- Learn how to provide healthy potluck and meeting meals.
- Provide chronic disease prevention and health promotion information to members.



Legislator:

- Sponsor or support legislation and funding that promotes chronic disease prevention and control.
- Raise constituents' awareness about chronic disease prevention and control programs in your district and help establish new programs as needed.
- Ensure that all Kentuckians have access to health care, screenings and early detection services.



Health care provider:

- Provide culturally relevant counseling, information, and referrals for screening tests.
- Adhere to guidelines and best practices for prevention, treatment and supportive care.
- Refer patients to smoking cessation, physical activity, nutrition, breastfeeding, self-management and mental health programs.



Kentuckian:

- Stop using tobacco products or never start.
- Support comprehensive tobacco-free environment policies.
- Increase your daily physical activity.
- Eat more fruits and vegetables and maintain a healthy weight.
- Know when to be screened and do it on schedule.
- Take an active role in your health care decisions.

The High Burden of Chronic Disease in Kentucky

The chronic disease burden data presented for Kentucky is primarily taken from items included in the CDC Chronic Disease Indicators Profile. By using data from the Chronic Disease Indicators Profile, we have a standard for national comparisons and the ability to rank Kentucky among other states on these key measures. We have defined 40 health outcome indicators for Kentucky which are listed in Appendix A of this document.

A review of the Chronic Disease Indicators shows that Kentuckians experience a high burden of chronic diseases compared to the nation overall. Most frequently, the rates of chronic disease prevalence, risk factors and mortality are highest across eastern Kentucky as compared to the rest of the state. However, it is also important to recognize that for almost all indicators, ALL regions of Kentucky fare more poorly than the nation as a whole. In addition, we see that Kentuckians with lower levels of income, those with less than a high school education and African Americans experience higher rates of illness and mortality due to chronic diseases than other groups.

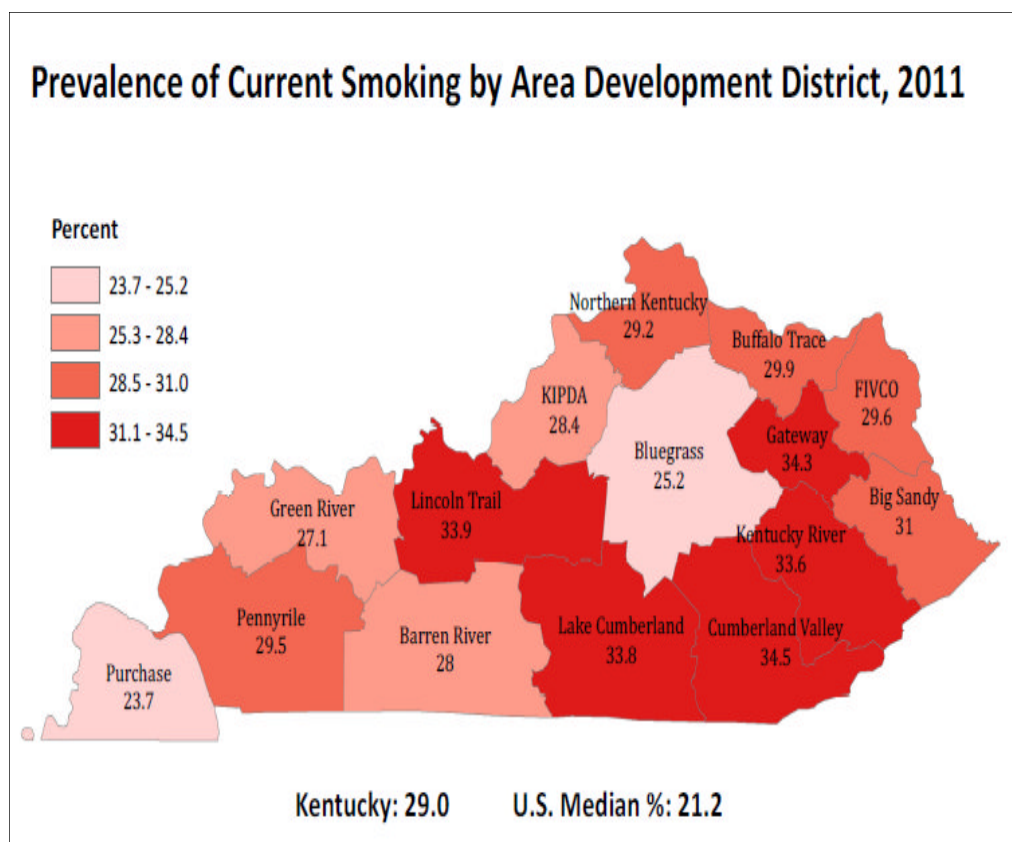
Table 1 shows the relationship between common modifiable behavioral risk factors and common, serious chronic diseases. The relationship between these risk factors and chronic diseases give us strong support for working together in a coordinated and collaborative way to address the health problems facing Kentucky.

Table 1: Common Behavioral Risk Factors Related to Prevention of Chronic Diseases					
Chronic Diseases	Modifiable Risk Factors				
	Lack of Physical Activity	Poor Nutrition	Tobacco Use	Exposure to Second Hand Smoke	Excessive Alcohol Consumption
Arthritis	✓	✓			
Asthma	✓	✓	✓	✓	
Breast Cancer	✓	✓	✓		✓
Cervical Cancer		✓	✓	✓	
COPD			✓	✓	
Colorectal Cancer	✓	✓	✓		✓
Coronary Heart Disease	✓	✓	✓	✓	✓
Cerebrovascular Disease	✓	✓	✓	✓	✓
Diabetes	✓	✓		✓	✓
Lung Cancer			✓	✓	

Tobacco Use and Respiratory Diseases

Adults

- Kentucky has the highest rate of tobacco use in the nation at 29% of the adult population compared to a national median of 21.2% (2011 KYBRFSS)
- Rates among those with lower incomes or less than a high school education are substantially higher, at over 43% of the population. (2011 KYBRFSS)
- As shown in the map below prevalence of cigarette smoking is higher in Appalachia, but rates are much higher than the national average across all of Kentucky.



Source: <http://chfs.ky.gov/dph/info/dpqj/cd/brfss.htm>

Youth

- The prevalence of current smoking among high school students in Kentucky ranks **first in the nation**: 24.1 percent compared to 18.1 percent nationwide. (2011 YRBS)
Kentucky high school students have the highest rate of smokeless tobacco product use in the nation, both for all students and for male students. Eighteen percent of Kentucky high school students use smokeless tobacco compared to 7.7% nationally. Smokeless

tobacco use among male Kentucky high school students is 28.1% compared to 12.8% nationally. (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>)

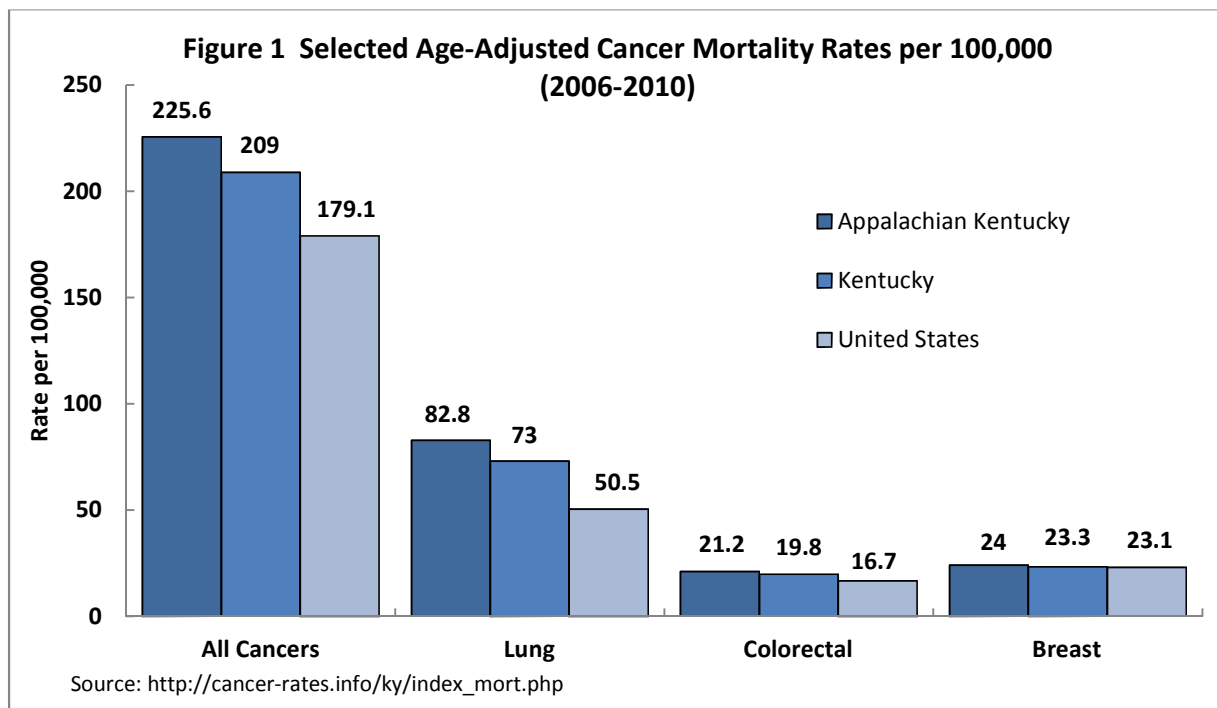
Health Outcomes

- This high level of tobacco use is further reflected by poor health outcomes, including lung and bronchus cancer mortality and chronic lower respiratory disease.
- Kentucky has the highest rate in the nation for lung and bronchus cancer at 73.1 per 100,000 compared to a national rate of 49.5 per 100,000.
<http://wonder.cdc.gov/cmfi-icd10.html> (CDC Compressed Mortality Files 2006-2010)
- Kentucky has the third highest rate of mortality for chronic lower respiratory disease at 60.6 per 100,000 compared to a national rate of 42.4 per 100,000.
<http://wonder.cdc.gov/cmfi-icd10.html> (CDC Compressed Mortality Files 2006-2010)

Table 2: Tobacco Use and Tobacco Related Respiratory Diseases – Kentucky - US Comparison				
Region	Adult Smoking Prevalence (2011 BRFSS)	Cancer of the Lung and Bronchus: Age Adjusted Mortality Rate/100,000 (2006-2010 CDC Wonder)	Adult Asthma Prevalence (2011 BRFSS)	Chronic Lower Respiratory Disease: Age Adjusted Mortality Rate/100,000 (2006-2010 CDC Wonder)
United States	21.2%	49.5/100,000	9.0%	42.4/100,000
Kentucky	29.0%	73.1/100,000	10.4%	60.6/100,000

Cancer

- Lung, colorectal, and breast cancers account for almost 50% of all cancer cases in Kentucky.
- Kentucky has the highest rate of both lung cancer incidence and mortality in the nation.
- Lung cancer represents the greatest cancer burden in the state. (Fig 1)
 - The age-adjusted lung cancer incidence rate in Kentucky was 100.4 per 100,000 persons during 2005-2009. (NAACCR)
 - The age-adjusted mortality rate was 73.1 per 100,000 persons during 2006-2010 (NAACCR)
- Kentucky has the highest rate of colorectal cancer incidence and the third highest rate of colorectal cancer mortality in the nation.
- Kentucky has the 26th highest rate of breast cancer incidence and 18th highest rate of breast cancer mortality in the nation. (2005-2009 NAACCR)
- As with other diseases discussed in this document, cancer incidence and mortality rates are higher in Appalachia. Socio-economic factors such as poverty, lower literacy, unemployment and less access to medical care are believed to impact the health disparity seen in this region of the state.



Nutrition, Physical Activity and Obesity

Nutrition

- 21% of Kentucky adults eat 5 servings of fruits and vegetables a day compared to the national mean of 23.4%. (2009 BRFSS)
- 17.8% of those with low incomes and 18.2% of those with a low level of education eat 5 servings of fruits and vegetables a day. (2009 BRFSS)
- 14.2% of Kentucky youth eat 5 servings of fruits and vegetables a day. (2009 YRBS)
- 42% of Kentucky infants never receive breast milk.

Physical Activity

- Kentucky adults are 39th in the nation for those who meet the recommended standard of being physically active for at least 150 minutes per week. Only 46.8% of Kentucky adults meet this standard compared to 51.7% of adults nationwide. (2011 BRFSS)
- More than 60% of those with lower incomes and lower levels of education do not meet physical activity recommendations (2011 BRFSS)
- Sixty minutes of daily physical activity is recommended for young people (ages 6-17). In Kentucky, 52.3% of middle school students and 39.3% of high school students were physically active for a total of at least 60 minutes per day on five or more of the past seven days. (2011 YRBS)

- Some physical activity is supported at school, 45.5% of middle school and 35.4% of high school students having attended physical education (PE) classes one or more days in an average week when they were in school. (2011 YRBS)
- 34.9% of Kentucky middle school students reported having played video or computer games or used a computer for something that was not school work for three or more hours per day on an average school day. (2011 YRBS)
- 36.6% of Kentucky middle school students watched three or more hours per day of TV on an average school day. (2011 YRBS)

Obesity

- Kentucky has the 11th highest rate of obesity in the nation among adults at 30.4% compared to 27.7% nationwide. (2011 BRFSS)
- These rates increase to approximately 35% among both those with low incomes and low levels of education. (2011 BRFSS)
- Kentucky has some of the highest rates in the country of youth who are obese (16.5%) or overweight (15.4%). (2011 YRBS)
- Many high school students are trying to lose weight in unhealthy ways by taking diet pills, powders, or liquids (7.6%) or by not eating for 24 or more hours (14.6%). (2011 YRBS)

Health Outcomes

- Kentucky ranks second highest in the proportion of the population diagnosed with arthritis (31.9% compared to national median of 24.4%).
- Arthritis prevalence is higher among those with low incomes (46.4%) and those with less than a high school education (46.5%).
- Obesity and arthritis rates are high all across Kentucky, but are highest in the Appalachian region of the state. Similarly, this region has the lowest rates of fruit and vegetable consumption and physical activity consistent with the higher rates of obesity.

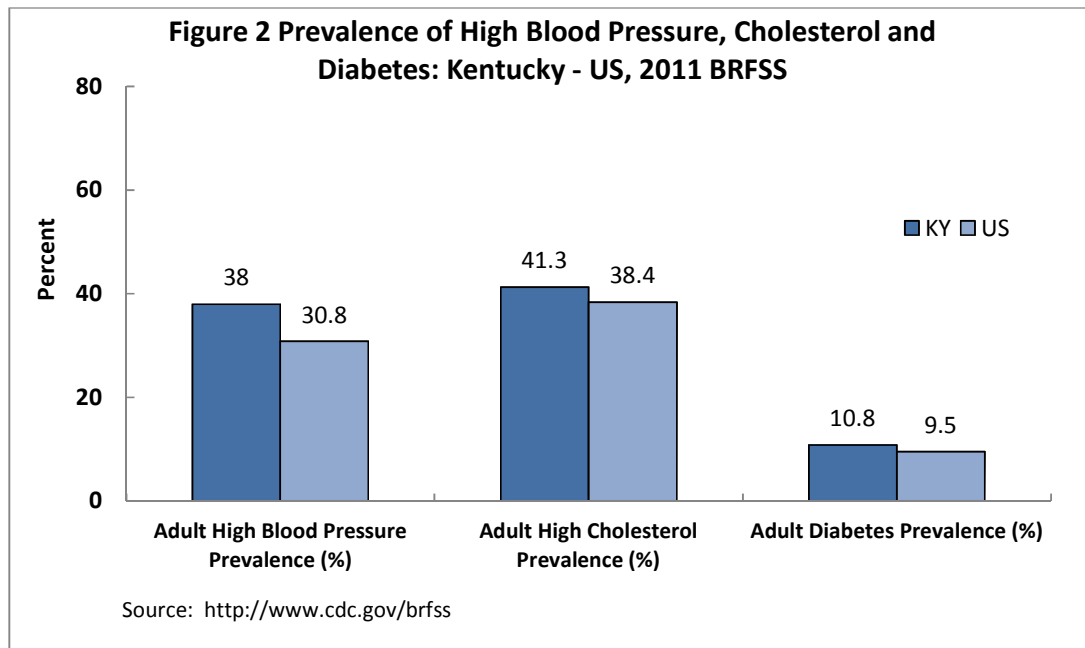
Table 4 Prevalence of Nutrition and Physical Activity Risk factors, Obesity & Arthritis (2011 BRFSS)

Geographic Region	Adult Adequate Fruits & Vegetables (%) (2009)	Adults Physically Active for 150 or more minutes per week (%)	Adult Obesity Prevalence (%)	Adult Arthritis Prevalence (%)
United States	23.4	51.7	27.8	24.4
Kentucky	21.0	46.8	30.4	31.9
Demographic Group				
Low Income	17.8	63.6	36.6	46.4
Less Than High School	18.2	60.6	34.0	46.5

SOURCE: Prevalence from <http://www.cdc.gov/brfss>

Blood Pressure, Cholesterol and Diabetes

Figure 2 shows prevalence rates for high blood pressure, high cholesterol and diabetes. Development of these health problems is directly related to poor dietary choices, lack of physical activity and to a lesser extent, genetics. In addition, tobacco use and exposure worsens each of these health problems and contributes to mortality due to these conditions.



High Blood Pressure

- Kentucky has the fifth highest prevalence rate for adults who have been diagnosed with high blood pressure at 38% compared to a national median of 30.8% (2011 BRFSS)
- Forty five percent of Kentuckians with low incomes and 51% of those with less than a high school education have been diagnosed with high blood pressure. (2011 BRFSS)
- Once high blood pressure is diagnosed, it is very important that it be controlled (lowered) to help prevent or delay serious problems such as stroke, heart attack, heart failure, kidney failure and early death.
 - Blood pressure can sometimes be controlled by changes in diet and exercise..
- In Kentucky, about 79% of those who have been diagnosed with high blood pressure are taking medication to control the condition. This is comparable to the national rate of 77.7%. (2011 BRFSS)
 - Women (82.6%) and African Americans (85.6%), who have been diagnosed with hypertension, are more likely to be taking blood pressure control medication than other groups. (2011 BRFSS)

Cholesterol

- Forty one percent of Kentuckians have high cholesterol levels, compared to a national median of 38.4% (2011 BRFSS)
 - This puts Kentuckians at higher risk for heart attack and stroke.
- Higher prevalence rates are seen for those with low incomes (52.6%) and with less than a high school education (50.6%). (2011 BRFSS)

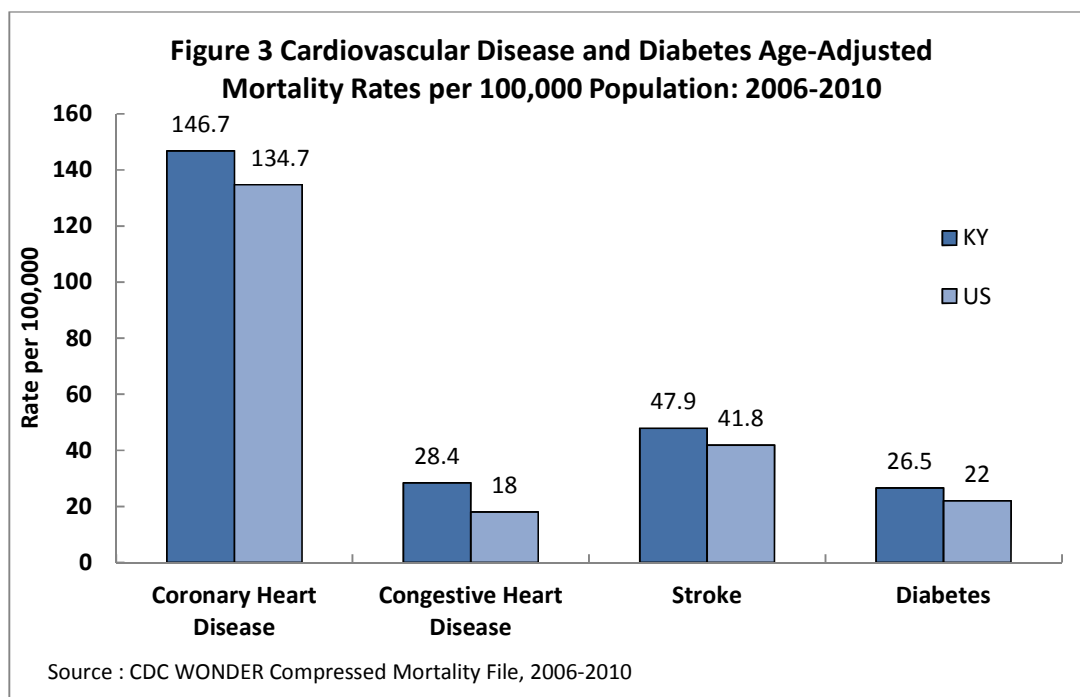
Diabetes

- Kentucky has the 8th highest rate of diabetes at 10.8% compared to a national rate of 9.5% (2011 BRFSS)
 - Diabetes rates are higher among those with low incomes (17.7%), and those who did not graduate from high school (16.3%). (2011 BRFSS)
 - Diabetes prevalence increases with age. The diabetes rate is 12.3% for 45-54 year olds, 18.7% for 55 to 64 year olds and 21.9% for those aged 65 and older. (2011 BRFSS)
- An additional 8.7% of Kentuckians have been diagnosed with pre-diabetes putting them at high risk of developing the disease within the next few years.(2011 BRFSS)

Cardiovascular and Diabetes Mortality Rates

Figure 3 shows mortality rates for coronary heart disease, congestive heart failure, stroke and diabetes. Mortality due to each of these conditions can be connected directly to tobacco use or exposure, obesity, poor nutrition, lack of physical activity, uncontrolled high blood pressure, high cholesterol, complications of poor glucose control or a combination of these factors.

- Kentucky has an age-adjusted mortality rate of 146.7 per 100,000 for coronary heart disease (CHD), which is higher than the national rate of 134.7 per 100,000. (CDC WONDER, 2006-2010)
- Kentucky ranks 12th highest in the nation for mortality due to stroke, at 47.9 per 100,000, compared to 41.8 per 100,000 for the nation.
- Kentucky ranks 8th in the nation in deaths due to diabetes at 26.5 per 100,000, compared to a national rate of 22.0 per 100,000.
 - It is well documented that a third of deaths among those with diabetes occur due to cardiovascular diseases, thus potentially masking some of the mortality that might otherwise be attributed to the disease.



Mental Health

- Kentucky adults report an average of 4.8 mentally unhealthy days per month compared to 3.6 for the nation. (2011 BRFSS)
- Kentucky ranks 4th in the nation for adults who are limited in any activity because of physical, mental or emotional health problems with a rate of 29.3% compared to a national median of 24.3%. (2011 BRFSS)
- About 16% of Kentucky adults reported that they felt mental distress on 14 or more days in the pervious month. (2011 BRFSS)
- Almost 1 in 5 Kentucky adults (19.7%) reported having been diagnosed with a depressive disorder compared to a national median of 17.5%. (2011 BRFSS)

The Framework

Joint Goals:

1. Increase physical activity, healthy eating and tobacco free living.
2. Reduce age-adjusted premature mortality due to common chronic diseases.
3. Reduce preventable hospitalizations due to common chronic diseases.
4. Increase evidence-based screening/testing for early diagnosis and treatment of common chronic diseases.
5. Increase availability and utilization of community based self-management or behavior change programs to prevent chronic diseases and complications from chronic diseases.
6. Address social determinants of health in planning strategies to impact health of all people living in Kentucky.

Joint Objectives: See Appendix A – Health Outcome Indicators

Joint Strategies:

We will reach our health improvement targets by developing a plan which focuses on the following four strategic areas.

Strategic Area 1: Promote policy, environmental and system changes that will support healthy choices and healthy living in Kentucky and its communities.

Strategic Area 2: Expand access to coordinated, quality, evidence-based clinical screenings, clinical management and chronic disease self-management.

Strategic Area 3: Cultivate strong connections linking individuals, community organizations, businesses, schools, the health care system and other partners to improve health outcomes, reduce health care costs, and improve quality of life.

Strategic Area 4: Translate surveillance, research and evaluation findings into information that is easily accessible to and useful to the community partners, health advocates and decision makers.

The Plan: Strategic Areas, Key Initiatives and Action Items

Strategic Area 1: Promote policy, environmental and system changes that will support healthy choices and healthy living in Kentucky and its communities.

The Coordinated Chronic Disease Prevention and Health Promotion State Plan Strategic Area 1 seeks to invest available resources in key behaviors and services that have the greatest influence on chronic disease. Examples of these key strategies include: tobacco prevention and smoke-free policies, access to healthy foods and nutrition education, promotion of breast feeding, and comprehensive physical activity policies and environments in communities. The strategies cover a wide breadth of topic areas, making coordination of efforts among the many diverse stakeholders essential to success. Collaboration towards implementation of the following five key strategies -- among community organizations, work places, schools, homes, health care entities, and non-traditional sectors -- is critical to achieving systems-level change.

Key Initiative: Tobacco prevention and control policies

Action Items:

- Promote local comprehensive smoke-free policies
- Promote state-wide comprehensive smoke-free law
- Promote 100% Tobacco Free Schools
- Support significantly increasing tobacco excise tax

Key Initiative: Access to healthy foods and nutrition education

Action Items:

- Promote the availability of healthier foods and nutrition services in government agencies, schools and child care centers
- Establish community gardens
- Organize state and local food policy councils
- Promote healthier food options in retail venues
- Support reimbursement for nutrition counseling
- Promote comprehensive school wellness policies
- Promote staff wellness programs in child care centers and schools

Key Initiative: Comprehensive physical activity policies and environments in schools, child care centers and communities

Action Items:

- Promote the availability of moderate-to-vigorous intensity physical activity in schools and child care centers
- Encourage schools to provide comprehensive school physical activity programs
- Promote comprehensive school wellness policies

- Promote schools providing access to their physical activity spaces outside normal school hours (Shared Use Agreements)
- Promote staff wellness programs in child care centers and schools
- Promote safe routes to schools
- Adopt and support complete street ordinances at state and local level
- Promote the development of Pedestrian/Bike Master Plans at the state and local level

Key Initiative: Worksite wellness policies and programs to Kentucky businesses

Action Items:

- Support and promote a tax credit to employers for the cost of implementing qualified employee wellness programs
- Promote comprehensive worksite wellness policies and programs to Kentucky businesses
- Promote the creation of a State wellness council or business group on health

Key Initiative: Breastfeeding

Action Items:

- Promote breastfeeding through Maternity Care and Hospital Practice
- Support breastfeeding in the workplace
- Support Peer Counseling Program
- Educate mothers and families on benefits of breastfeeding
- Encourage Healthcare Professional Support
- Promote breastfeeding through media and social marketing

Strategic Area 2: Expand access to coordinated, quality, evidence-based clinical screenings, clinical management and chronic disease self-management.

The Coordinated Chronic Disease Prevention and Health Promotion State Plan Strategic Area 2 focuses on the prevention and early detection of chronic diseases as well as self- and clinical management strategies necessary to manage risk factors and follow-up care across the lifespan. An inherent characteristic throughout this area is a collaborative partnership between the consumer/patient and the provider along with a health care system that supports a chronic care model for disease prevention and treatment. By reducing the barriers for patients receiving care, we hope to improve health outcomes for all Kentuckians.

Key Initiative: Evidence-based clinical screenings for chronic diseases

Action Items:

- Promote evidence-based preventive cancer screenings (breast, cervical and colorectal cancer)
- Promote evidence-based screenings for chronic disease conditions such as high blood pressure, elevated cholesterol, diabetes and depression
- Promote Body Mass Index (BMI) screening and weight status assessment in children and adults
- Promote evidence-based oral health preventive screenings

Key Initiative: Evidence-based clinical management practices for chronic diseases

Action Items:

- Promote clinical management of cancer survivors
- Promote clinical management of diabetes, heart disease, and stroke through the use of ABC's (A = Aspirin or A1C; B = Blood Pressure; C = Cholesterol; S = Smoking Cessation)
- Assess tobacco use and provision of tobacco dependence treatment
- Promote appropriate interventions and referral for depression or other mental health issues
- Promote age appropriate preventive vaccinations
- Promote appropriate interventions for children and adults regarding weight management
- Promote data transparency and sharing of information electronically through the Kentucky Health Information Exchange to improve the continuity of care and encourage individuals to maintain their personal health records
- Promote medication reconciliation at transitions of care
- Promote comprehensive medication reviews (CMR) between pharmacists, patients/caregivers and physicians

Key Initiative: Provider and individual awareness of and referral to self-management opportunities in the community

Action Items:

- Promote the development and maintenance of a state-wide directory of community chronic disease resources for use by providers and individuals for education and self-management
- Promote the availability of education regarding self-management programs for individuals with chronic diseases

Key Initiative: Reduction in out-of-pocket cost to the consumer for clinical preventive services

Action Items:

- Support reduction of out-of-pocket costs to the consumer for clinical preventive services
- Support insurance coverage for screening and treatment for tobacco use/dependence
- Support coverage for screening and treatment for breast, cervical and colon cancer
- Promote insurance coverage for Diabetes Self-management Education/Training (DSME/T) classes and testing supplies
- Support insurance coverage/reduction of out-of-pocket costs for mental health services

Key Initiative: Patient navigation and coordination of care

Action Items:

- Promote referrals to high-quality resources provided through patient navigation services to facilitate needed medical services
- Promote Patient-Centered Health Care or the Patient-Centered Medical Home and the Chronic Care Model to increase coordination of health care services, especially to those at-risk communities and individuals
- Promote access to appropriate information and resources for providers, healthcare systems, caregivers and patient to help provide/access optimal, coordinated care
- Support interventions to support and transform our healthcare system from an acute care model to a chronic care model

Key Initiative: Efforts to improve health literacy/understanding among Kentuckians

Action Items:

- Support educational activities designed to increase the individual's understanding of basic health information
- Support strategies to help individuals talk to their health care providers about their healthcare concerns
- Support strategies to help individuals make informed decisions about their health

- Promote Culturally and Linguistically Appropriate Services (CLAS) educational materials and explanations regarding screening services, clinical management services and costs for preventative services

Key Initiative: Employment of health care quality measures that are in alignment with national recognition/certification program standards

Action Items:

- Promote nationally recognized quality improvement initiatives focused on the Patient-Centered Medical Home Model, such as those offered by the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations
- Promote nationally recognized certification and recognition programs such as the NCQA for Disease Management, Multicultural Health, Diabetes, Heart Disease, and Stroke
- Promote accreditation by the American College of Surgeons Commission on Cancer and use of National Comprehensive Cancer Network guidelines for cancer treatment and care
- Promote quality reporting using National Quality Forum endorsed quality metrics
- Support public reporting of quality performance in regards to providers, facilities, and plans
- Support educational activities to inform consumers on why quality matters through greater transparency of quality data

Strategic Area 3: Cultivate strong connections linking individuals, community organizations, businesses, schools, the health care system and other partners to improve health outcomes, reduce health care costs, and improve quality of life.

Effective public health programs require the development and nurturing of strong networks in the community among multiple entities. Intentional effort towards maintaining these networks will increase community support, clinic/provider referrals, and patient utilization of programs that improve management of chronic conditions. Targeted interventions among those with or at high risk for chronic diseases will facilitate access to quality community resources to better manage their conditions. Interventions include activities to improve the quality of clinical care (standards of care), access to sustainable self-management and support services, data sharing/transparency, and communication/collaboration. Widespread utilization of the following strategies will strengthen the many linkages that facilitate a healthier Kentucky.

Key Initiative: Sustainable networks to address chronic disease prevention and health promotion efforts at local, regional and state levels

Action Items:

- Develop a directory of chronic disease prevention and health promotion professional resources utilized among professionals implementing programs, policies and services
- Develop a communication plan that promotes connections among partners, stakeholders, and the public
- Provide opportunities at the local, regional and state levels for partners to network, coordinate and collaborate efforts
- Develop and promote coordinated health promotion efforts between public and private entities
- Identify and include nontraditional partners, such as the faith community, local boards of health, elected officials and employers
- Develop and implement a sustainability plan for the provision of ongoing support and facilitation within the network to equip them to implement chronic disease prevention and health promotion efforts
- Provide education regarding the 'social determinants of health' and collaboration in the development of a plan to improve health equity

Key Initiative: Community assessments to address health needs and barriers

Action Items:

- Include questions pertaining to 'social determinants of health' in all community assessments
- Encourage involvement of all relevant partners (zoning, economic development, faith, education)
- Develop community engagement strategies to solve community issues

- Encourage local health departments to consider the benefits of public health accreditation
- Provide data to leverage support among the business community for health improvement efforts

Key Initiative: Coordinated evidence-based public health education messages engaging the community in programs, policies and practices

Action Items:

- Ensure that 'social determinants of health' are considered in message development to improve health literacy, address cultural differences and non-English speaking populations
- Develop strategies to accommodate individuals and communities that have differing amounts of internet access or technology
- Utilize Kentucky Health Information Exchange (KHIE) to encourage consumer engagement, increasing data transparency on costs, quality, and value

Key Initiative: Availability and utilization of evidence-based chronic disease *self-management programs* (for Arthritis, Asthma, Cancer, COPD, Diabetes, Depression, Heart Disease & Stroke, etc.)

Action Items:

- Promote the use of evidence-based chronic disease prevention and self-management programs in a variety of settings
- Promote Kentucky Health Information Exchange (KHIE) to increase transparency of clinical data and encourage sharing of data across provider teams
- Encourage and promote individuals to maintain personal health records, including biometric measurements, medications, and medical history
- Develop and provide an accessible, user-friendly directory of chronic disease prevention, self-management and health promotion programs and resources

Key Initiative: Availability and utilization of chronic disease *prevention education programs* (for Arthritis, Asthma, Cancer, COPD, Diabetes, Depression, Heart Disease & Stroke, etc.)

Action Items:

- Promote the use of evidence-based prevention programs in a variety of settings
- Develop and provide a directory of health promotion programs and resources for the general public
- Promote investment in chronic disease surveillance systems including surveillance, research and evaluation data

Strategic Area 4: Translate surveillance, research and evaluation findings into information that is easily accessible to and useful to the community partners, health advocates and decision makers.

The Coordinated Chronic Disease Prevention and Health Promotion State Plan Strategic Area 4 addresses the critical role of surveillance and epidemiology in monitoring and improving the state's public health. Surveillance is defined as the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health.

In our attempts to reduce the morbidity and mortality from chronic disease, we must also consider rigorous evaluation of programs. Evaluative efforts monitor progress in the development and implementation of the statewide coordinated plan, as well as achievement of programmatic objectives and long-term objectives. Performance can be measured by the documented use of surveillance and epidemiology data. These data assist in identifying public health and programmatic needs, identifying gaps in programs, and demonstrating program impact.

The main focus of this strategic area is the interpretation of data findings. This information will be useful for decision-makers as they determine appropriate and feasible actions. Implementation of the following strategies will be key in translating research into public health practice.

Key Initiative: Chronic disease surveillance and evaluation systems needed to describe the extent and impact of chronic disease in the Commonwealth

Action Items:

- Identification of gaps in health promotion and chronic disease prevention surveillance, research and evaluation data
- Support investment in chronic disease surveillance systems, including collection of data at the local level and for disparate populations
- Support provision of training on evaluation of health programs/interventions
- Explore use of Kentucky Health Information Exchange and/or Electronic Health Records to improve reporting on chronic disease prevalence and quality outcomes

Key Initiative: Reports, policy briefings, fact sheets and publications to support key decision-makers in understanding the scope and impact of chronic diseases and their related risk factors as well as best practices to improve health outcomes

Action Items:

- Produce reports that are "user friendly" with minimal technical language
- Include data on health disparities whenever possible
- Include local or regional data whenever possible

Key Initiative: The integration of surveillance, evaluation and research data into health-related planning and funding decisions

Action Items:

- Support the use of data showing the human and financial impact of chronic diseases on Kentucky when making decisions about the development, operation and funding of health programs/interventions
- Build partnerships to maximize data availability and utilization
- Include data on health disparities in all planning and funding decisions

Key Initiative: Partnerships between academic public health researchers and public health practitioners to identify best practices in real world settings

Action Items:

- Engage community members, state and local public health practitioners, and academic researchers involved in the process of developing public health research priorities, approaches, and evaluation methods.
- Collaborate with funders at all levels to assist in distributing practice-based research to all stakeholders
- Produce fact sheets, presentations, and other tools needed to share best practices with all appropriate community partners

Appendix A

Kentucky Chronic Disease Prevention and Health Promotion Plan: Health Outcome Indicators

	Objective	Data source	Baseline	Recommended Target (2016)
Access to Primary and Secondary Preventive Services				
1.	Decrease the proportion of adults aged 18 to 64 without medical insurance		20.3%	18.2%
i.	Decrease the proportion of men aged 18-64 without medical insurance	BRFSS (2010)	21.6%	19.4%
ii.	Increase the proportion of adults aged 18 to 64 in household earning \$25,000 or less with medical insurance		41.5%	45.6%
2.	Increase the proportion of adults with a usual medical provider (LHI)		74.2%	81.6%
i.	Increase the proportion of adults in households earning \$25,000 or less with a usual medical provider	BRFSS (2010)	77.2%	84.9%
3.	Increase the proportion of adults with high blood pressure who have been prescribed medication (Modified 2020 LHI – also a KY 2020 measure)	BRFSS (2010)	80.7%	88.7%
4.	Increase the proportion of adults with diabetes who receive 2 or more A1C tests each year	BRFSS (2010)	76.0%	78.0%
5.	Increase the percentage of adults with diabetes served by an FQHC who have an A1C value less than 9% (Modified 2020 LHI, KY 2020 measure)	FQHC (Uniform Data System)	73.0%	80.3%

Access to Cancer Screening Services			
6. Increase the percentage of adults aged 50+ who receive colorectal cancer screening based on most current guidelines (2020 LHI)	BRFSS (2010)	63.7%	70.0%
7. Increase the proportion of women who receive breast cancer screening (mammogram within past 2 years) based on most recent guidelines	BRFSS (2010)	74.3% (age 50 or older)	81.7%
		69.9% (age 40 or older)	76.8%
8. Increase the proportion of women who receive cervical cancer screening (PAP in past 3 years) based on the most recent guidelines	BRFSS (2010)	80.9%	88.9%
9. Increase the percentage of Kentucky women diagnosed at an early stage of breast cancer	KCR (2006)	84.0%	92.4%
10. Increase the percentage of Kentucky women diagnosed with early-stage cervical cancer	KCR (2006)	63.0%	69.3%
11. Increase the percentage of Kentuckians diagnosed at an early stage of colon cancer	KCR (2006)	49.7%	54.6%
Access to self-management/behavior change support			
12. Increase the number of adults with a doctor-diagnosed chronic disease who have participated in evidence-based chronic disease self-management education			
i. Diabetes self-management classes	BRFSS (2010)	50.1%	55.1%
ii. Chronic Disease Self-			

Management Classes – number of adults		1,504	3,000
13. Increase availability of evidence-based chronic disease self-management education programs available in Kentucky communities			
i. Maintain or increase the number of counties with DSME/T classes available (Baseline 90 counties - Resource Directory)	Resource Directory	90	100
ii. Maintain or increase the number of counties with CDSMP classes	CDSMP Database	34	50
Tobacco Control			
14. Decrease the proportion of adults who are current smokers (LHI)	BRFSS (2010)	25.0%	22.5%
15. Decrease the proportion of adolescents who have smoked cigarettes in the past 30 days (LHI)	YRBSS (2011)	24.1%	23.4% (2020 Target)
16. Reduce the proportion of adults with diabetes who are current smokers	BRFSS (2010)	23.0%	20.7%
17. Reduce the proportion of adults with high blood pressure who are current smokers	BRFSS (2009)	24.6%	22.1%
18. Increase the proportion of the population covered by public area smoke-free laws	KY Center for Smoke Free Policy (2010)	33.0%	100%
Physical Activity and Nutrition			
19. Increase the proportion of			

adults who consume five daily servings of fruits and vegetables	BRFSS (2010)	21.1%	23.2%
20. Decrease the proportion of adolescents who consume a can, bottle, or glass of soda or pop one or more times per day during the past seven days	YRBSS (2011)	36.4%	32.7%
21. Increase the proportion of mothers who breastfeed for at least the first 6 months of their baby's life	NIS (2011)	32.9%	36.2%
22. Increase the proportion of adolescents who are physically active for 60 minutes on five or more days a week	YRBSS (2011)	39.3%	43.2%
23. Increase the proportion of adults who meet guidelines for moderate or vigorous physical activity (LHI)	BRFSS (2010)	45.7%	50.2%
24. Decrease the proportion of adults who are obese	BRFSS (2010)	32.0%	28.8%
25. Decrease the proportion of obese adolescents	YRBSS (2011)	17.6%	15.8%
Hospitalizations Due to Chronic Diseases			
26. Decrease hospitalizations due to short term complications of diabetes	AHRQ (2010)	0.79 (rate per 1,000)	0.71 (rate per 1,000)
27. Decrease hospitalizations due to long term complications of diabetes	AHRQ (2010)	1.16 (rate per 1,000)	1.0 (rate per 1,000)
28. Decrease hospitalizations due to uncontrolled diabetes	AHRQ (2010)	0.24 (rate per	0.21 (rate per 1,000)

		1,000)	
29. Decrease hospitalizations due to chronic obstructive pulmonary disease	AHRQ (2010)	4.62 (rate per 1,000)	4.10 (rate per 1,000)
30. Decrease hospitalizations due to hypertension	AHRQ (2010)	0.74 (rate per 1,000)	0.60 (rate per 1,000)
31. Decrease hospitalizations due to angina	AHRQ (2010)	0.32 (rate per 1,000)	0.28 (rate per 1,000)
32. Decrease hospitalizations due to congestive heart failure	AHRQ (2010)	4.85 (rate per 1,000)	4.36 (rate per 1,000)
33. Decrease hospitalizations due to adult asthma	AHRQ (2010)	1.29 (rate per 1,000)	1.10 (rate per 1,000)
34. Decrease hospitalizations for hip fractures	AHRQ (2010)	3.0 (rate per 1,000)	2.70 (rate per 1,000)
Quality of Life Indicators			
35. Reduce the proportion of adults with chronic disease who have activity limitation	BRFSS (2010)	22.1%	19.8%
i. Asthma	BRFSS (2009)	46.0%	41.4%
ii. Arthritis	BRFSS (2010)	48.2%	43.3%
iii. Diabetes	BRFSS (2010)		
Health Disparities by Age-adjusted Mortality Rates			
36. Among African Americans, reduce the age-adjusted mortality rate for cardiovascular disease	CDC WONDER (2009)	236.2 (rate per 100,000)	212.5 (rate per 100,000)

37. Among African Americans, reduce the age-adjusted mortality rate for stroke	CDC WONDER (2009)	50.3 (rate per 100,000)	45.2 (rate per 100,000)
38. Among African Americans, reduce the age-adjusted mortality rate for diabetes	CDC WONDER (2009)	56.4 (rate per 100,000)	50.7 (rate per 100,000)
39. In the white population, reduce the age-adjusted mortality rate for chronic lower respiratory disease	CDC WONDER (2009)	63.4 (rate per 100,000)	57.0 (rate per 100,000)
40. Among African Americans, reduce the age-adjusted mortality rate for colorectal cancer	CDC WONDER (2009)	29.2 (rate per 100,000)	26.2 (rate per 100,000)

Sources: Agency for Healthcare Research and Quality (AHRQ)
Behavioral Risk Factor Surveillance System (BRFSS)
CDC WONDER (Wide-ranging Online Data for Epidemiologic Research)
Chronic Disease Self-Management Program (CDSMP)
Federally Qualified Health Center (FQHC)
Kentucky Cancer Registry (KCR)
Local Health Indicator (LHI)
National Immunization Survey (NIS)
Youth Risk Behavior Surveillance System (YRBSS)

Appendix B

Glossary of Terms

ABCs: Acronym referring to key elements of care for diabetes, heart disease, and stroke. The letter “A” may be used to stand for “Aspirin” and or “A1C”; the letter “B” for “blood pressure”; the letter “C” for “cholesterol / lipid management”; the letter “s” for “smoking / tobacco cessation”.

A1C: Blood test that provides information about a person’s average levels of blood glucose, also called blood sugar, over the past 3 months. The A1C test is sometimes called the hemoglobin A1c, HbA1c, or glycohemoglobin test. The A1C test is the primary test used for diabetes management and diabetes research.

American College of Surgeons Commission on Cancer: The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.

Baby Friendly Hospitals: [The Baby Friendly Hospital Initiative](#) was introduced in 1991 by the World Health Organization/United Nations Children's Fund (WHO/UNICEF) to promote, protect and support breastfeeding in the hospital or birth setting. A key element in this promotion and support is outlined in their [Ten Steps to Successful Breastfeeding](#).

Benign disease: Disease that is not cancerous, or a mild type of disease that does not threaten life.

Biennial Screening: Screening occurring every two years.

Body Mass Index (BMI): Measure of body fat based on height and weight that applies to adult men and women. To calculate body mass index: <http://www.nhlbisupport.com/bmi/>

BRCA Gene: BRCA1 and BRCA2 are human genes that belong to a class of genes known as tumor suppressors. Mutation of these genes has been linked to hereditary breast and ovarian cancer. A woman's risk of developing breast and/or ovarian cancer is greatly increased if she inherits a deleterious (harmful) BRCA1 or BRCA2 mutation. Men with these mutations also have an increased risk of breast cancer. Both men and women who have harmful BRCA1 or BRCA2 mutations may be at increased risk of other cancers.

Breast Self-exam: An examination of the breasts performed by the patient evaluating for changes in size, shape, color, or texture.

Cessation Services: Services that help people stop smoking or stop using other forms of tobacco. Examples include: Kentucky’s Tobacco Quitline, online and text messaging, Health Care Professional Recommendations and local cessation services, such as the Cooper Clayton Method to Stop Smoking.

Chronic Care Model: Also known as the “Planned Care Model”. Identifies the essential elements of a health care system that encourages high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems.

Chronic Disease: Diseases of long duration and generally slow progression. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world.

Chronic Disease Management: Encompasses the oversight and education activities conducted by health care professionals to help patients with chronic diseases learn to understand their condition and live successfully with it. This term is equivalent to disease management (health) for chronic conditions. The work involves motivating patients to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life.

Chronic Disease Self-Management Protocol or CDSMP: An evidence-based self-management education program for people with chronic health problems. The program specifically addresses arthritis, diabetes, lung and heart disease, but teaches skills useful for managing a variety of chronic diseases. Developed at Stanford University, CDSMP covers topics such as: techniques to deal with problems associated with chronic disease, appropriate exercise, appropriate use of medications, communicating effectively with family, friends, and health professionals, nutrition, and how to evaluate new treatments.

Chronic Disease Resource Directory: A state-wide resource directory listing what agencies and/or organizations “are working on” regarding chronic disease initiatives. (Resource Directory is currently in development.)

Client: Refers to the patient or consumer of the healthcare services.

Clinical Breast Examination (CBE): An examination of the breasts by a health professional such as a doctor, nurse practitioner, nurse, or physician assistant looking for changes in size, shape, color, or texture.

Clinical Preventive Services: U.S. Preventive Services Task Force (USPSTF) provides recommendations regarding screening, counseling, and preventive medication topics and includes clinical considerations for each health topic.

Colonoscopy: Medical procedure in which a healthcare provider checks the inside of the patient’s colon and rectum using a lighted tube called a colonoscope. During the test, the healthcare provider can remove growths (called polyps) that may turn into cancer over time.

Communication Plan: (or *Communications Plan*) Describes how you intend to communicate the right messages to the right people at the right time. Step by step process to ensure that the intended message is received, understood, and acted upon by the recipient. It involves:

determining the objectives, choosing the audience, and selecting appropriate channel(s) to reach them.

Community Assessments: A systematic and ongoing process of providing usable and useful information about the needs of a target population, often utilized by those who can and will use it to make judgments about policy and programs. It is a description of a community and its people. Assessments help community teams (such as coalitions) identify community strengths and areas for improvement, identify and understand the status of community health needs, and define improvement areas to guide the community toward implementing and sustaining policy, systems, and environmental changes around healthy living strategies (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management). Assists with prioritizing community needs and consider appropriate allocation of available resources. Example of community assessment: Community Health Assessment and Group Evaluation (CHANGE): Building a Foundation of Knowledge to Prioritize Community Needs (see References section).

Community: A) people who live in the same area, or the area in which they live; B) people with a common background or with shared interests within society, C) nations with a common history or common economic or political interests, or D) the public or society in general.

Community Gardens: Collaborative projects based on shared open spaces where participants share in the maintenance and products of the garden, including healthful and affordable fresh fruits and vegetables.

Complete Streets Policy: Policy which ensures that transportation planners and engineers consistently design and operate the entire roadway with all users in mind, including bicyclists, public transportation vehicles and riders, and pedestrians of all ages and abilities.

Comprehensive Medication Review: See Medication Review.

Comprehensive School Physical Activity Program (CSPAP): Program which encompasses physical activity programming before, during and after the school day.

Comprehensive School Wellness Policies: Local wellness policies are an important tool for parents, local education agencies (LEAs) and school districts in promoting student wellness, preventing and reducing childhood obesity, and providing assurance that school meal nutrition guidelines meet the minimum federal school meal standards. Section 204 of the [Healthy, Hunger-Free Kids Act of 2010](#), Public Law 111-296, expands the scope of wellness policies; brings in additional stakeholders in its development, implementation and review; and requires public updates on the content and implementation of the wellness policies.

Comprehensive Smoke-free Policy: Policy in which smoke-free ordinances/regulation include all workplaces (workplaces include both public and private non-hospitality workplaces, including, but not limited to, offices, factories, and warehouses), that do not allow smoking in attached bars or separately ventilated rooms and do not include workplace size exemptions.

Comprehensive Worksite Wellness Programs: Programs which include: health education strategies, employee health services and benefits, physical fitness and nutrition strategies, policies and procedures, counseling and employee assistance programs, a safe and healthy work environment, and the integration of company and community resources. This model can be used to evaluate and plan for worksite wellness programs that are truly comprehensive in nature, focusing on primary, secondary, and tertiary prevention strategies for staff members.

Computed Tomographic Colonography: Also called a virtual colonoscopy; it is a screening examination of the colon in which x-rays obtained by CAT scan are used to generate computerized three-dimensional images of the colonic mucosa.

Consumer: refers to the patient or client of the healthcare services.

Coordination of Care: The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services.

Cultural Diversity: Is the understanding and respect for all cultures and their differences (language, dress and traditions).

Culturally and Linguistically Appropriate Services (CLAS): Strategy to help eliminate health inequities. Involves the tailoring of services to an individual's culture and language preference, in order to aid health professionals bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.

- **CLAS Standards:** In 2000, the Office of Minority Health published the National Standards for culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), which provides the framework for all health care organizations to best serve the nation's increasingly diverse communities. The CLAS Standards are a collective set of mandates, guidelines, and recommendations intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The CLAS Standards provide guidance on improving quality care under three areas in particular: Culturally Competent Care, Language Access Services and Organizational Supports.

Deleterious Mutations: A harmful change in the body's cells that can lead to cancer.

Digital Mammography: The use of a computer, rather than x-ray film, to create a picture of the breast.

Electronic Health Record (EHR): A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Designed to share

information with other health care providers so that data can be created, managed and consulted by authorized clinicians and staff across more than one healthcare organization.

Electronic Medical Record (EMR): A computer/digital version of the paper charts in the provider's office. The EMR allows providers to track data over time, easily identify which patients are due for preventive screenings, vaccinations, and monitor overall quality of care within the practice/organization.

Evidence-based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Evidence-based Practice (EBP): See **Evidence-based medicine**

Excise Tax (Tobacco): The amount of state excise tax, in dollars, on a pack of 20 cigarettes. The Task Force on Community Preventive Services recommends interventions that increase the price of tobacco products based on strong evidence of their effectiveness in: 1) Reducing tobacco use among adolescents and adults, 2) Reducing population consumption of tobacco products, and 3) Increasing tobacco use cessation.

Fecal DNA Testing: A stool DNA test designed to identify recognizable DNA changes (DNA markers) in cells that are continually shed from the lining of the colon through stool. These markers are associated with the surfaces of the cells of precancerous polyps and cancerous tumors.

Fecal Occult Blood Testing: A test to check for blood in the stool. Small samples of stool are placed on special cards and sent to a doctor or laboratory for testing. Blood in the stool may be a sign of colorectal cancer. Also called FOBT.

Federally Qualified Health Center (FQHC): A public or private non-profit entity which provides primary and preventive care services to all age groups. They are responsive to their surrounding community's health needs. Services are provided on a sliding scale with discounts based on the patient family's size and income in accordance with the federal poverty guidelines. However, FQHCs are open to all regardless of ability to pay.

Food Policy Council (FPC): A council made up of stakeholders from diverse food-related sectors to examine how the food system is operating and to develop recommendations on how to improve it. FPCs may take many forms, but are typically either commissioned by state or local government, or predominately grassroots efforts. FPCs have been successful at educating officials and the public, shaping public policy, improving coordination between existing programs, and starting new programs. Examples include: mapping and publicizing local food resources; creating new transit routes to connect underserved areas with full-service grocery stores; persuading government agencies to purchase from local farmers; and organizing community gardens and farmers' markets.

FQHC Locations in Kentucky: <http://chfs.ky.gov/nr/rdonlyres/8021e7c4-24da-449d-93f4-8c7e9bd480ad/0/granteesfqhclocations.doc>

Genetic Counseling: Guidance relating to genetic disorders that is provided by a medical professional typically to individuals with an increased risk for certain health conditions such as cancer.

Health Disparity: A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Health Equity: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health Information Technology: A global term (which encompasses electronic health records and personal health records) to indicate the use of computers, software programs, electronic devices and the Internet to store, retrieve, update and transmit information about patients' health.

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It includes reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. It is an essential part of patient-centered care and engaging the patient as a partner in their health care.

Health Outcomes: A term referring to measuring the impact healthcare activities have on people- whether their health improves or gets worse. It includes an examination of the patients' symptoms, their ability to do what they want to do (functional status), and whether their life is extended or not as a result of the treatment they received.

Healthier Food in School and Child Care Settings: Examples: including nutrition standards in school wellness policies; "farm to school" programs that connect schools (K-12) and local farms, with the objectives of serving healthy meals in school cafeterias, improving student nutrition, providing agriculture, health and nutrition education opportunities, and supporting local and regional farmers.

HPV or Human Papillomavirus: A type of virus that can cause abnormal tissue growth (for example, warts) and other changes to cells. Infection for a long time with certain types of HPV can cause cervical cancer. HPV may also play a role in some other types of cancer, such as anal, vaginal, vulvar, penile, oropharyngeal, and squamous cell skin cancers. Also called human

papillomavirus. HPV is sexually transmitted, spread through skin-to-skin contact, particularly genital contact.

Hysterectomy: Surgery to remove the uterus and, sometimes, the cervix. When the uterus and the cervix are removed, it is called a total hysterectomy. When only the uterus is removed, it is called a partial hysterectomy

Informed Decision Making: A process by which an individual understands the disease or condition being addressed and comprehends what the clinical service involves, including its benefits, risks, limitations, alternatives, and uncertainties; has considered his or her preferences and makes a decision consistent with them; and believes he or she has participated in decision making at the level desired.

Insufficient Evidence: Term used in the United States Preventative Services Task Force grade scale; the current evidence is not able to provide enough information on the benefits or risks for a certain health-related action.

Joint Commission on Accreditation of Health Care: An independent, not-for-profit organization which certifies health care organizations and programs throughout the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Kentucky Health Information Exchange (KHIE): The Kentucky Health Information Exchange (KHIE) is the information system that will support statewide exchange of health information among healthcare providers and organizations, according to nationally recognized standards. KHIE is a federated system—which means a physician can access a patient's health information directly from the electronic health records of the other physicians, hospitals, laboratories, and imaging centers, by whom a patient has been seen.

Mammography: X-ray examination of the breasts (as for early detection of cancer).

Medication Reconciliation: The formal process of comparing a patient's medication orders to all of the medications (including over the counter) that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care.

MAPP/Mobilizing for Action through Planning and Partnerships: MAPP is a community-wide strategic planning framework for improving public health. MAPP helps communities prioritize their public health issues, identify resources for addressing them, and implement strategies relevant to their unique community contexts. MAPP will help communities use broad-based partnerships, performance improvement, and strategic planning in public health practice.

Medication Review: Comprehensive Medication Review (CMR) formerly called Medication Therapy Management, is a systematic process of collecting patient-specific information,

assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber. A CMR is an interactive person-to-person consultation conducted between the patient and/or caregiver and the pharmacist and is designed to improve patients' knowledge of their prescription, over-the-counter (OTC) medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self-manage their medications and their health condition(s).

Messaging Campaigns: The use of paid and earned media, media advocacy and grassroots campaigns to reach key population groups with a specific message.

Moderate-to-vigorous Physical Activity in School and Childcare Settings: National guidelines are 30 minutes day/150 minutes a week. This can be done through regulations in child care settings and policies in schools (K-12). This can also be done through individual child care center or school wellness policies.

MRI: A procedure in which radio waves and a powerful magnet linked to a computer are used to create detailed pictures of areas inside the body. These pictures can show the difference between normal and diseased tissue, such as breast cancer.

National Committee for Quality Assurance (NCQA): A private, non-profit organization dedicated to improving health care quality. NCQA accredits or certifies a wide range of health care organizations such as physician practices, hospitals, insurers, pharmaceutical companies, accountable care organizations and other health solution vendors according to specific standards.

National Comprehensive Cancer Network: The National Comprehensive Cancer Network® (NCCN®), a not-for-profit alliance of 21 of the world's leading cancer centers, is dedicated to improving the quality and effectiveness of care provided to patients with cancer. NCCN promotes the importance of continuous quality improvement and recognizes the significance of creating clinical practice guidelines appropriate for use by patients, clinicians, and other health care decision-makers. The primary goal of all NCCN initiatives is to improve the quality, effectiveness, and efficiency of oncology practice so patients can live better lives.

Out of Pocket Costs: Expenses that the patient/consumer is required to pay themselves.

Pap Smear: A procedure in which cells are collected from the cervix for examination under a microscope. It is used to detect cancer and changes that may lead to cancer. A Pap smear can also show conditions, such as infection or inflammation that are not cancer. Also called Pap test and Papanicolaou test.

Patient: Refers to the client or consumer of the healthcare services.

Patient-Centered Care: See Patient-Centered Medical Home.

Patient-Centered Health Care: See Patient-Centered Medical Home.

Patient-Centered Medical Home: Refers to the health care delivery model led by a healthcare provider, and in partnership with the patient, who provides comprehensive, coordinated and continuous medical care for all aspects of preventive, acute and chronic needs of the patient, utilizing the best evidence and technology available to assist with care. This model of care facilitates partnerships and coordination between not only different health care professionals, but also with patients and their caregivers when appropriate.

Patient Navigation: Refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical services.

Pedestrian/Bicycle Master Plan: A long-term action plan to make communities more walkable. The plan establishes the policies, programs, design criteria, and projects that will further enhance pedestrian and bike safety, comfort, and access in community neighborhoods. The goal of a master plan is to make transportation system more environmentally, economically, and socially sustainable.

Public Health Department Accreditation: The development of a set of standards, and a process to measure health department performance against those standards, resulting in a reward or recognition for those health departments who meet the standards.

Public Health Program Evaluation: The systematic collection of information about the activities, characteristics, and results of programs to make judgments about the program, improve or further develop program effectiveness, inform decisions about future programing, and/or increase understanding.

Public Health Research: Systemic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable public health knowledge.

Public Health Surveillance: The process of systematically collecting, analyzing and using data on specific health conditions to understand the extent of disease existing in a community, the pattern of disease among different groups of people or in different geographic locations, and as an aide in making health policy decisions.

Quality Improvement Initiatives: Efforts to improve performance on various aspects of patients' experiences of health care.

Quality Measures: Tools that measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals of health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.

Safe Routes to School (SRTS): A national and international movement to create safe, convenient, and fun opportunities for children to bicycle and walk to and from schools. The program has been designed to reverse the decline in children walking and bicycling to schools. SRTS can also play a critical role in reversing the alarming nationwide trend toward childhood obesity and inactivity.

Screening: A strategy used to detect a disease in patients without signs or symptoms of that disease.

Screening Modality: One of the ways that screening can occur.

Self-management Programs: The systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support. Self-management support programs are expected to reduce costly health crises and improve health outcomes for chronically ill patients with conditions such as asthma, cardiovascular disease, depression, diabetes, heart failure, and migraine headaches.

Shared Use (also known as Joint Use): A way to increase opportunities for children and adults to be more physically active. It refers to two or more entities — usually a school and a city or private organization — sharing indoor and outdoor spaces like gymnasiums, athletic fields and playgrounds. The concept looks to reduce the cost of exercise and give community members more options for exercise.

Sigmoidoscopy: Procedure in which a healthcare provider checks the patient's rectum and the lower part of the colon, the sigmoid, with a lighted tube called a sigmoidoscope. If polyps are found, the doctor takes them out and a complete colon exam, such as a colonoscopy, will be done to check for polyps in higher parts of the colon.

Sliding Scale Fee: Fees that are reduced for those who have lower incomes or less money to spare after their personal expenses, usually based on income.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

Stakeholder: A person, group or organization with an interest in a project.

Sustainable: Capable of being continued.

Tobacco Free (100%) School: A 100% tobacco-free, smoke-free environment for all students, staff and visitors in school functions, in school vehicles, on school grounds, and at off-site school events, applicable 24 hours a day, 7 days a week; includes private schools, universities and community colleges.

Transitions in Care: The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Virtual Colonoscopy: See **Computed Tomographic Colonography**.

Worksite Wellness Tax Credit: A tax credit provided to employers for the cost of implementing qualified employee wellness programs. The yearly credit could be equal to 50% of the costs incurred by the employer, not to exceed \$100 per employee. Qualified programs are comprehensive and include at least three of the following elements: health education, behavioral change, supportive environment and employee engagement.

Appendix C

Acronyms Defined

A1C	Blood test that averages blood glucose levels over a period of 3 months
AARP	American Association of Retired Persons
ABC'S	Aspirin, A1C, Blood Pressure, Cholesterol and Smoking
ABCS	Aspirin, Blood Pressure Control, Cholesterol Control, Smoking Cessation
ADA	American Diabetes Association
AHPERD	American Alliance for Health, Physical Education, Recreation, and Dance
AHRQ	Agency for Healthcare Research and Quality
ALA	American Lung Association
ANR	Americans for Nonsmokers' Rights
AoA	Administration on Aging
ARRA	American Recovery and Reinvestment Act
BMI	Body Mass Index
BRCA	Gene marker to detect breast and ovarian cancer susceptibility
BRCA testing	Testing for Breast and Ovarian Cancer Susceptibility
BRFSS	Behavioral Risk Factor Surveillance System
CAT	Computerized Axial Tomography
CBE	Clinical Breast Exam
CDC	Centers for Disease Control
CDC WONDER	CDC Wide-ranging Online Data for Epidemiologic Research
CDSMP	Chronic Disease Self-Management Program
CHANGE	Community Health Assessment aNd Group Evaluation
CLAS	Culturally and Linguistically Appropriate Services
CMS	Center for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CSPAP	Comprehensive School Physical Activity Programs
CT Scan	Computerized Tomography (Formerly CAT scan)
DDHSP	Division for Heart Disease and Stroke Prevention - CDC
DHHS	Department of Health and Human Services
DNA	deoxyribonucleic acid, molecule that encodes genetic information
DNPAO	Division of Nutrition, Physical Activity, Overweight & Obesity – CDC
EHR	Electronic Health Records
EMR	Electronic Medical Records
EPR-3	Asthma Education Prevention Program- Expert Panel Report 3 (EPR-3)
FGDC	Federal Geographic Data Committee
FOBT	Fecal Occult Blood Testing
FPCs	Food Policy Councils
FQHC	Federally Qualified Health Center
GINA	Global Strategy for Asthma Management and Prevention
HHS	US Department of Health and Human Services
HIT	Health Information Technology

HPV	Human Papillomavirus
HPW	Health, Prevention, and Wellness
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KCR	Kentucky Cancer Registry
KHIE	Kentucky Health Information Exchange
LHI	Local Health Indicator
MAPP	Mobilizing for Action through Planning and Partnerships
MRI	Magnetic Resonance Imaging
MVPA	Moderate to Vigorous Physical Activity
NACDD	National Association of Chronic Disease Directors
NAP	National Academies Press
NCBI	National Center for Biotechnology
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCI	National Cancer Institute
NCQA	National Committee for Quality Assurance
NIS	National Immunization Survey
NHLBI	National Heart Lung and Blood Institute
NIH	National Institutes of Health
NLM	National Library of Medicine
NNLM	National Network of Libraries of Medicine
NQF	National Quality Forum
OMH	Office of Minority Health
PANTA Plus	Physical Activity, Nutrition, Tobacco & Asthma Plus School Resource Guide
PHAB	Public Health Accreditation Board
PHAC	Public Health Advisory Committee
PHS	Public Health Service
q-corp	Oregon Health Care Quality Corporation
SBDM	Site-Based Decision Making
SEER	Surveillance Epidemiology and End Results
SHI	School Health Index
SHPPS	School Health Policies and Practices Study
SRTS	Safe Routes to School
STEPS	WHO STEPwise approach to surveillance
USPSTF	U. S. Preventive Services Task Force
WHO	World Health Organization
YRBSS	Youth Risk Behavior Surveillance System

Appendix D

References: A Topical Index

- **Aging**
 - *Clearinghouse of home and community-based services that helps elderly individuals maintain their health and independence*
 - Administration on Aging (AOA), U.S. Department of Health and Human Services
<http://www.aoa.gov>
- **Arthritis**
 - *Arthritis Intervention Programs*
 - Centers for Disease Control and Prevention
<http://www.cdc.gov/arthritis/interventions.htm>
- **Asthma**
 - *Guidelines for the Diagnosis and Management of Asthma - Summary Report 2007*
 - National Institutes of Health-National Heart, Lung Blood Institute/National Asthma Education Prevention Program- Expert Panel Report 3 (EPR-3)
<http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.htm>
 - *GINA- Global Initiative for Asthma*
 - Global Strategy for Asthma Management and Prevention- GINA
http://www.ginasthma.org/uploads/users/files/GINA_Report_2011
- **Blood Pressure**
 - *Screening for High Blood Pressure in Adults*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspshype.htm>
 - *Treatment of High Blood Pressure*
 - National Heart, Lung and Blood Institute
<http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.htm>
- **Breastfeeding**
 - *Baby Friendly Hospital Initiative*
 - www.babyfriendlyusa.org.
 - *United States Institute for Kangaroo Care*
 - <http://www.kangaroocareusa.org/>
 - *The Surgeon General's Call to Action to Support Breastfeeding*
 - U. S. Department of Health and Human Services, Offices of the Surgeon General; 2011.
<http://www.surgeongeneral.gov/>
- **Cancer/Community Interventions**
 - *Cancer Prevention & Control, Client-oriented Screening Interventions*

- The Guide to Community Preventive Services
<http://www.thecommunityguide.org/cancer/screening/client-oriented/index.html>
 - *Cancer Prevention & Control, Provider-oriented Screening Interventions*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/cancer/screening/provider-oriented/index.html>
 - *Cancer/Informed Decision-Making*
 - *Cancer Prevention & Control: Promoting Informed Decision Making for Cancer Screening*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/cancer/idm/index.html>
- **Cancer/Screening**
 - *Genetic Risk Assessment and BRCA Testing for Breast and Ovarian Cancer Susceptibility*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrgen.htm>
 - *Recommendations: Screening for Breast Cancer*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm>
 - *Recommendations: Screening for Cervical Cancer*
 - U.S. Preventive Services Task Force
 - <http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>
 - *Recommendations: Screening for Colorectal Cancer*
 - U.S. Preventive Services Task Force
 - <http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm>
- **Cancer/Skin Cancer**
 - *Preventing Skin Cancer: Education and Policy*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/cancer/skin/education-policy/index.html>
- **Cardiovascular Disease**
 - See also **Cholesterol** and **Diet/Healthy Diet**.
 - *Aspirin for the Prevention of Cardiovascular Disease*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsasmi.htm>
 - *Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults*
 - U.S. Preventive Services Task Force

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsphys.htm>

- **Cholesterol**

- See also **Cardiovascular Disease** and **Diet/Healthy Diet**.
- *Screening for Lipid Disorders in Adults*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm>
- *Cholesterol: What you can do*
 - Centers for Disease Control and Prevention
http://www.cdc.gov/cholesterol/what_you_can_do.htm
- *Heart and Vascular Disease: Cholesterol*
 - National Institutes of Health-National Heart, Lung and Blood Institute
<http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04.htm>
- *Behavioral Counseling in Primary Care to Promote a Healthy Diet*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsdiet.htm>

- **Chronic Obstructive Pulmonary Disease**

- *Screening for Chronic Obstructive Pulmonary Disease Using Spirometry*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspscopd.htm>
- *Breathing Better with a COPD Diagnosis*
 - National Heart, Lung Blood Institute
<http://www.nhlbi.nih.gov/health/public/lung/copd/campaign-materials/html/copd-patient.htm>
- *COPD Management Tools*
 - American Lung Association
<http://www.lung.org/lung-disease/copd/living-with-copd/copd-management-tools.html>
- *COPD: Resources for Health Professionals*
 - National Institutes of Health-National Heart, Lung Blood Institute
<http://www.nhlbi.nih.gov/health/public/lung/copd/health-care-professionals/index.htm>

- **Community-Clinical Linkages**

- *Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships*
 - Centers for Disease Control and Prevention
<http://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf>
- *Description of an integrated framework for building linkages among primary care clinics and community organizations for the prevention of type 2 diabetes: emerging themes from the CC-Link Study*
 - Akermann, RT, *Chronic Illness*, 2010 June;6(2):89-100

- *Tools for Building Clinic-Community Partnerships to Support Chronic Disease Control and Prevention.*
 - Barnidge EK, Brownson CA, Baker EA, Shetty G, Rose F, & Fitzgerald T. Diabetes Educator, Feb. 2010 (Epub ahead of print).
- *Clinic-Community Partnerships: A Foundation for Providing Community Supports for Diabetes Care and Self-Management.*
 - Brownson CA, O'Toole ML, Shetty G, Anwuri VV, & Fisher EB. Diabetes Spectrum, Fall 2007, 20(4): 209-214.
- *Integrating evidence-based clinical and community strategies to improve health.*
 - Ockene JK, Edgerton EA, Teutsch SM, Marion LN, Miller T, Genevro JL, Loveland-Cherry CJ, Fielding JE, Briss PA. Am J Prev Med 2007;32:244-252.
- *Exploring Integration to Improve Population Health*
 - Committee on Integrating Primary Care and Public Health; Board on Population Health and Public Health Practice; Institute of Medicine, 2012.
<http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>
- **Culturally and Linguistically Appropriate Services (CLAS)**
 - *Think Cultural Health*
 - U.S. Dept. of Health and Human Services, Office of Minority Health
<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>
- **Diabetes**
 - *Screening for Type 2 Diabetes Mellitus in Adults*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspdiab.htm>
 - *Self-Management Education/Support Community Based Interventions*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/diabetes/index.html>
 - *Diabetes Basics*
 - American Diabetes Association
<http://www.diabetes.org/diabetes-basics/prevention/?loc=DropDownDB-prevention>
- **Diet/Healthy Diet**
 - See also **Cholesterol** and **Obesity**.
 - *Behavioral Counseling in Primary Care to Promote a Healthy Diet*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspdiat.htm>
 - *Promoting Good Nutrition*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/nutrition/index.html>
- **Health Literacy**

- *Health Communication. Chapter 11. Healthy People 2010.*
 - U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC.
<http://www.healthypeople.gov/2010/document/html/volume1/11healthcom.htm?visit=1> . Accessed 7/19/12.
- *Health Literacy*
 - National Network of Libraries of Medicine
www.nnlm.gov/outreach/consumer/hlthlit.html
- *Health Literacy Interventions and Outcomes: An Updated Systematic Review*
 - Berkman et al. Agency for Healthcare Research and Quality (AHRQ). March 2011.
www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacyup.pdf
- *Materials and Strategies That Work in Low Literacy Health Communication*
 - Plimpton and Root. Public Health Rep. 1994 Jan-Feb; 109(1):86-92.
www.ncbi.nlm.nih.gov/pubmed/8303020
- *Quick Guide to Healthy Living (example of a consumer friendly health website)*
 - U.S. Department of Health and Human Services
<http://www.healthfinder.gov/prevention/>
- **Heart Disease and Stroke**
 - *Screening for Coronary Heart Disease*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsacad.htm>
 - *Screening for Carotid Artery Stenosis*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf07/cas/casrs.htm>
 - *“ABCS” of Heart Disease and Stroke Prevention*
 - Centers for Disease Control and Prevention
http://www.cdc.gov/DHDSP/programs/nhdsp_program/docs/ABCS_Guide.pdf
 - *Heart Disease Prevention: What you can do*
 - Centers for Disease Control and Prevention
http://www.cdc.gov/heartdisease/what_you_can_do.htm
- **Mental Health**
 - *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention 2011-2015 (CDC)*
http://www.cdc.gov/mentalhealth/docs/11_220990_Sturgis_MHMIActionPlan_FINAL-Web_tag508.pdf
 - *National Institute of Mental Health*
<http://www.nimh.nih.gov/index.shtml>
- **Nutrition and Weight Status- See Diet/Healthy Diet and Obesity**

- **Obesity**
 - *Screening for Obesity in Adults*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm>
 - *Screening for Obesity in Children and Adolescents*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspschobes.htm>
 - *Obesity Prevention and Control: Interventions in Community Settings*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/obesity/communitysettings.html>
 - *Obesity Prevention and Control: Provider-Oriented Interventions*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/obesity/provider.html>
- **Oral Health**
 - *Promoting Oral Health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/oral/index.html>
- **Osteoporosis**
 - *Recommendations for Screening for Osteoporosis*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsoste.htm>
 - *Management of osteoporosis. A national clinical guideline.*
 - Agency for Healthcare Research and Quality (AHRQ)
<http://www.guideline.gov/content.aspx?id=3876>
- **Physical Activity**
 - *Promoting Physical Activity: Campaigns and Informational Approaches*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/pa/campaigns/index.html>
 - *Promoting Physical Activity: Behavioral and Social Approaches*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/pa/behavioral-social/index.html>
 - *Promoting Physical Activity: Environmental and Policy Approaches*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/pa/environmental-policy/index.html>
- **Prevention**
 - *The Guide to Community Preventive Services*
 - The Community Preventive Services Task Force
www.thecommunityguide.org
 - *National Prevention Strategy*

- National Prevention Council, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.
<http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>
 - *Healthy People 2020*
 - U.S. Department of Health and Human Services
<http://healthypeople.gov/2020/default.aspx>
- **School Health**
 - *School Health Policies and Practices Study (SHPPS)*
 - Centers for Disease Control and Prevention
www.cdc.gov/SHPPS
 - *School Health Index*
 - Centers for Disease Control and Prevention
www.cdc.gov/HealthyYouth/SHI
 - *Building a Healthier Future Through School Health Programs*
 - Chapter 9-1 of *Promising Practices in Chronic Disease Prevention and Control. A Public Health Framework for Action*. Fisher et al. Centers for Disease Control and Prevention. Department of Health and Human Services. (2003).
<http://www.cdc.gov/healthyyouth/publications/pdf/PP-Ch9.pdf>
- **Smoke-free Policy**
 - *Fundamentals of Smoke-free Workplace Laws*
 - Americans for Non-smokers' Rights
http://www.no-smoke.org/pdf/CIA_Fundamentals.pdf
 - *CDC Evaluation Toolkit for Smoke-Free Policies*
 - Centers for Disease Control and Prevention
http://www.cdc.gov/tobacco/basic_information/secondhand_smoke/evaluation_toolkit/index.htm
- **Stroke- See Heart Disease and Stroke**
- **Tobacco/Tobacco Use**
 - *Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women*
 - U.S. Preventive Services Task Force
<http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac2.htm>
 - *Reducing Tobacco Use Initiation*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/tobacco/initiation/index.html>
 - *Increasing Tobacco Use Cessation*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/tobacco/cessation/index.html>

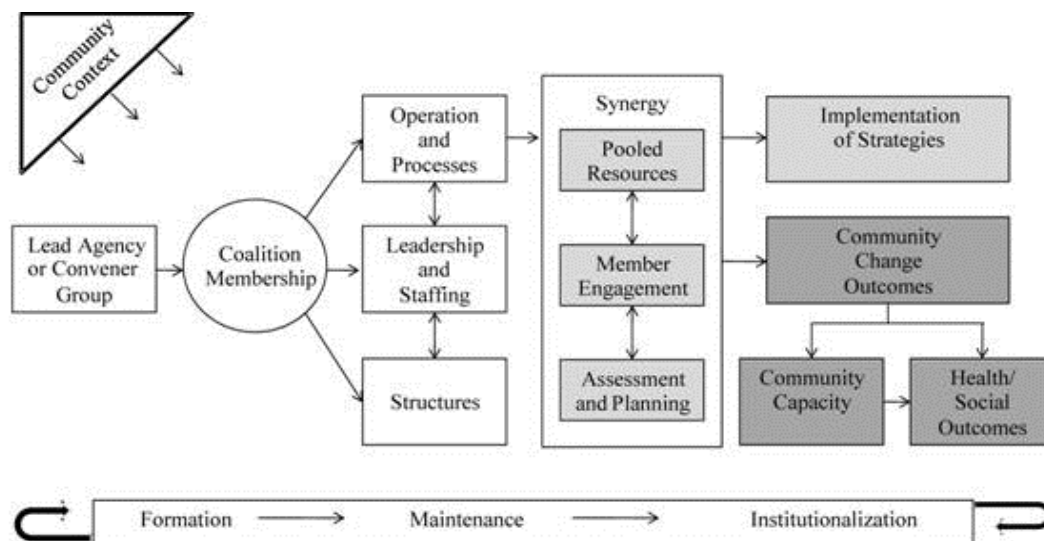
- *Reducing Exposure to Environmental Tobacco Smoke*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/tobacco/environmental/index.html>
- *Restricting Minors' Access to Tobacco Products*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/tobacco/restrictingaccess/index.html>
- *Decreasing Tobacco Use Among Workers*
 - The Guide to Community Preventive Services
<http://www.thecommunityguide.org/tobacco/worksites/index.html>
- *New Recommendations in the PHS-Sponsored Clinical Practice Guideline—Treating Tobacco Use and Dependence: 2008 Update*
 - Agency for Healthcare Research and Quality (AHRQ)
<http://www.ahrq.gov/clinic/tobacco/tobaqrg3.htm#new>
- *Best Practices for Comprehensive Tobacco Control Programs—2007*
 - Centers for Disease Control and Prevention
http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf
- **Self-Management Programs**
 - *Stanford Patient Education Research Center website*
 - Department of Medicine at the Stanford University School of Medicine
<http://patienteducation.stanford.edu/>
 - *American Recovery and Reinvestment Act Communities Putting Prevention to Work: Chronic Disease Self-Management Program*
 - Administration on Aging
http://www.aoa.gov/AoARoot/AoA_Programs/HPW/ARRA/index.aspx
 - *Challenges and Successes in Implementing the Chronic Disease Self-Management Program*
 - National Council on Aging
<http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/CDSMPFinalReport.pdf>
 - *Chronic Disease Self-Management Program: From Development to Dissemination*
 - Sobel, Lorig and Hobbs. The Permanente Journal. Spring 2002. Volume 6 No. 2.
<http://xnet.kp.org/permanentejournal/spring02/selfmanage.pdf>
- **Surveillance, Research and Evaluation**
 - *WHO STEPS Stroke Manual: The WHO STEPwise approach to stroke surveillance.*
 - World Health Organization (2006). Geneva, World Health Organization.
<http://www.who.int/chp/steps/Manual.pdf>
 - *WHO STEPS Surveillance Manual: The WHO STEPwise approach to chronic disease risk factor surveillance.*

- World Health Organization (2005). Geneva, World Health Organization.
http://whqlibdoc.who.int/publications/2005/9241593830_eng.pdf
- *CDC's National Center for Chronic Disease Prevention and Health Promotion Statistics and Tracking website*
 - Centers for Disease Control and Prevention
<http://www.cdc.gov/chronicdisease/stats/index.htm>
- *Developing an Effective Evaluation Plan: Setting the Course for Effective Program Evaluation*
 - Centers for Disease Control and Prevention
<http://www.cdc.gov/obesity/downloads/CDC-Evaluation-Workbook-508.pdf>
- *Making Data Talk: Communicating Public Health Data to the Public, Policy Makers and the Press*
 - Nelson, Hesse and Croyle. Oxford University Press. 2009.
<http://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780195381535.001.0001/acprof-9780195381535>
- *Making Data Talk: A Workbook*
 - National Cancer Institute
<http://www.cancer.gov/cancertopics/cancerlibrary/MDT-Workbook.pdf>
- *Eliminating Health Disparities: Measurement and Data Needs*
 - Panel on DHHS Collection of Race and Ethnic Data, Michele Ver Ploeg and Edward Perrin, *Editors*, National Research Council
http://www.nap.edu/catalog.php?record_id=10979#toc
- *CDC Framework for Program Evaluation in Public Health*
 - Centers for Disease Control and Prevention Office of the Associate Director for Program
<http://www.cdc.gov/eval/framework/index.htm>
- *Using Data to Improve Chronic Care: Building Capacity and Connectivity in Oregon.*
 - Chronic Disease Data Clearinghouse; Pilot Project; Project Summary and Recommendations; September 2005.
http://q-corp.org/wp-content/uploads/2009/12/CDDC_SumRecs.pdf
- *Competencies for Chronic Disease Practice*
 - National Association of Chronic Disease Directors
<http://www.cdph.ca.gov/programs/Documents/Competencies%20for%20Chronic%20Disease%20Practice.pdf>
- *Essential Functions of Chronic Disease Epidemiology in State Health Departments*
 - A Report of the Council of State and Territorial Epidemiologists, Chronic Disease Epidemiology, Capacity Building Workgroup. 2004.
<http://www.cste.org/dnn/LinkClick.aspx?fileticket=z%2Fe66IM10%2Bs%3D&tabid=175&mid=716>
- *Updated Guidelines for Evaluating Public Health Surveillance Systems*
 - Guidelines Working Group. MMWR. July 27, 2001: 50 (RR13); 1-35
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm>
- *Ten Essential Public Health Services*
 - Centers for Disease Control and Prevention

http://www.cdc.gov/stltpublichealth/hop/pdfs/Ten_Essential_Public_Health_Services_2011-09_508.pdf

- *Availability of Data to Measure Disparities in Leading Health Indicators at the State and Local Levels*
 - Gold, M., A. Hedley-Dodd, and M. Neuman. *Journal of Public Health Management and Practice*, 2008, pp. S36-44.
<http://www.rwif.org/publichealth/product.jsp?id=36148>
- *Evidence-Based Decision Making for Community Health Programs: Making Funding Decisions*
 - Jackson, Pikton and Kington. Chapter 4. pg. 19-27. Rand: Santa Monica. 1998.
http://www.rand.org/pubs/monograph_reports/2009/MR933.pdf
- *Demonstrating Excellence in Practice-Based Research for Public Health*
 - Potter and Quill, eds. Association of Schools of Public Health Special Publication. January–February 2006.
http://www.phac-aspc.gc.ca/php-ppsp/pdf/demonstrating_excellence_in_practice_based_research_for_public_health.pdf

• Theory



Source: Recreated from Butterfoss, 2007

- *The Community Coalition Action Theory.*
 - Butterfoss, F.D. and Kegler, M.C. (2009). R. DiClemente, R. Crosby & M. Kegler (Eds), *Emerging Theories in Health Promotion Practice and Research* (pp. 237-276). San Francisco, CA: Jossey-Bass

• Worksite Wellness

- *Worksite Health Promotion*

- The Guide to Community Preventive Services
<http://www.thecommunityguide.org/worksites/index.html>

Appendix E

The Planning Process

The development of the statewide Chronic Disease Prevention and Health Promotion State Plan has been a process grounded upon the experience and collaborative efforts of the Kentucky Department for Public Health's (KDPH) categorical programs, as well as internal and external partners. Stemming from a successful 2011 grant application with the Centers for Disease Control and Prevention, multiple partners gathered to discuss cross-cutting objectives to reduce chronic disease.

The first area of focus was in the formation of the Steering Committee and the selection of a facilitator to provide guidance for the planning process. The committee consists of strategic stakeholders including but not limited to: representatives from the KDPH Chronic Disease Prevention and Health Promotion Programs; KDPH Center for Performance Management; KDPH Office of Health Equity; representatives from coalitions (e.g., the Kentucky Diabetes Network (KDN), Partnership for a FIT Kentucky, Kentucky Cancer Consortium, Kentucky Voices for Health, Kentucky Heart Disease and Stroke Taskforce, etc.); the Kentucky Primary Care Association; the Kentucky Health Department Association; the Foundation for a Healthy Kentucky; University partners; and representatives from the Kentucky Departments of Transportation, Agriculture and Education.

The Steering Committee and the facilitator became the planning team and began the work of determining the framework to be utilized for Plan development. A number of different frameworks and approaches were reviewed and evaluated. The Plan includes measureable, quantitative outcome objectives directly linked to the outcome performance measures for the National Center for Chronic Disease Prevention and Health Promotion, and are listed in the appendix.

Identification of the organizations and individuals selected to participate in the development of the Plan was a critical activity. The Steering Committee, as well as the vast networks of partners and coalitions that exist in Kentucky, ensured that adequate representation across the categorical areas and venues was achieved. Also critical was the "buy-in" necessary for successful planning and implementation. In November 2011, a Stakeholders Meeting of over 160 partners was conducted to tap into and channel the enthusiasm and expertise of such a diverse group. A variety of methods for obtaining input from stakeholders was utilized. In addition to the stakeholders meeting; web-based surveys, webinars, conference calls, in-person meetings and focus groups, and combinations thereof have all been successfully utilized in the planning efforts.

To warrant that the stakeholders' time was used efficiently and effectively, and to guarantee the best plan, it was critical for the Steering Committee to identify, obtain, and review data that

could inform the planning process. Information such as burden data, current chronic disease activities, current categorical program plan objectives, current evidence-based chronic disease interventions, all provided a valuable foundation for our participants in the planning process. The synthesis of this information into the most user-friendly format possible was of great assistance in facilitating discussion and decision-making during the planning process. In addition, the development of a preliminary mission statement and potential objectives were effective in facilitating discussion during the Stakeholders and Steering Committee Meetings.

In developing the State Plan, stakeholders were encouraged to include strategies with well-defined activities and timelines for achievement. Thorough and thoughtful planning laid the foundation to reach the stated long-term objectives for population-wide improvements in health and reducing gaps in health status for disparate populations.

The participatory approach fostered by this collaborative process demonstrated the high priority assigned to this effort, providing a broad range of ideas, expertise, and input from around the Commonwealth. Regular, interactive meetings established a sense of immediacy, ownership, and manageability for the Plan's action items by the groups that are most responsible for their implementation.

It should be noted that the State Plan was created to provide a coordinated strategy to the efforts of stakeholders across various categorical chronic diseases in order to increase collaboration and focus their efforts synergistically in addressing common risk factors and objectives for many chronic diseases. As such, this Plan will not supersede individual chronic disease plans but act as an impetus to them. Stakeholders may look at the individual plans to see where the efforts are focused.

The final step was the drafted version of the State Plan. Drafts were circulated to the Steering Committee and stakeholders both electronically and during meetings to finalize content. The final Plan has been made available for printing via electronic copy and shared with the stakeholders, their networks and Kentucky citizens at large.

Appendix F

The Communication Plan

The Communication Strategy Team, a subset of the larger Steering Committee, has developed a multi-pronged approach for sharing and promoting the Plan. First, the Plan will be disseminated electronically to a targeted group of partners, who are identified by members of the Steering Committee and by the larger stakeholder group. Next, during both the initial release phase and beyond, general communication strategies will include:

- Stakeholders will reach out to communities via online listserv, newsletters and emails;
- Earned media, including letters to the editors, press releases and media alerts about key events and milestones;
- Social and mass media channel utilization.

The foundation for the Communication Strategy aligns with the State Plan's four priority areas. Basic themes were created to guide communication regarding each Issue Area:

- Area 1: Supporting Healthy Choices & Promoting Healthy Living
- Area 2: Expanding Access to Prevention
- Area 3: Building Connections to Help Improve Outcomes
- Area 4: Creating Useful Information

The Communications Strategy Team will also develop a **Key Messages Tree** which will form the basis of all communications regarding the Plan. These three messages speak broadly about the plan, while the 'branch' messages speak more directly about each area of interest or action items. The three key messages address critical questions, such as:

- Why is the Plan needed?
- What are the goals of the Plan?
- How will the Plan accomplish the goals?

An outreach strategy and timeline was developed for activities needed to build and execute the Communication Plan. The strategy involves three phases:

- **Phase One: Development & Planning**
Phase 1 began during the Chronic Disease Prevention and Health Promotion State Plan formation and continued until the initial launch of the Plan. It included communication strategy team meetings, agreement on plan items, and division of responsibilities. This phase required standard due diligence tasks associated with preparing the Plan to be shared with the public (identification of audiences as well as those stakeholders who will actively disseminate and promote the Plan, key media outlets, potential avenues for earned media, etc.).
- **Phase Two: Initial Rollout of the Plan**
Phase 2 will take place during a thirty-day period directly after the formal release of the Plan. During this time local media and stakeholders will promote awareness of the Plan to respective audiences.

- **Phase Three: Active Engagement**

Phase 3, will continue for 60 – 120 days beyond Phase 2 and will focus on keeping audiences engaged and active in discussions regarding the Plan. It will also include, as addressed above, facilitating ongoing earned media outreach, social media outreach and community engagement.

Appendix G

The Evaluation Plan

In response to the work being done by State chronic disease leaders and all their stakeholder partners across Kentucky in order to address the chronic disease epidemic in a coordinated effort, it is important to take steps for accountability and sustainability. The following narrative is a brief summary of plans formed and actions taken by an evaluation team serving the Chronic Disease Plan project. The broad outline of evaluation is now established, though over the next few months, some of the specific components of the plan will evolve in response to further analysis and input received from many stakeholders.

Logic Model

The Evaluation Team has constructed a logic model (see page 62) that outlines the flow of effort from resources and activities to short and long term outcomes. The logic model is a detailed portrait of possible evaluation targets and measures. The analysis is ongoing and will continue to determine which of the particular measures should be pursued. All of the measures in the logic model have merit, but it is unrealistic to invest evaluation resources into every possible indicator. Instead, the Evaluation Team is trying to define those indicators which will be most efficient in assessing the process and results of the Chronic Disease Prevention and Health Promotion Plan.

Implementation Process

An underlying premise of the Chronic Disease Plan is that Kentucky's chronic disease burden can be more effectively diminished if: 1) The State and federal chronic disease leaders will work in a more integrated and coordinated way and 2) there is a team effort to bring together state government officials with local health department chronic disease workers, health care providers, and the many private sector agencies playing a role in chronic disease prevention and early intervention. The Evaluation Team is doing qualitative research to better understand the baseline interaction of state government chronic disease officials and how those leaders interact with partners across the state. These efforts are currently under way, and results will be reported to relevant stakeholders in the next two months. These research tools will be applied again toward the end of the project (approximately in spring, 2014) to assess how procedures and work patterns have changed as a result of the Plan intervention.

Chronic Disease Outcomes

The Data Team has partnered with the Evaluation Team to select a set of chronic disease burden indicators, for which tracking data are readily available. These outcome measures, as a

set, are comprehensive indicators; they do not capture every possible measure, but as a group, provide a sound perspective on Kentucky's progress in reducing the destructive impact of chronic diseases on our Commonwealth's vitality. The indicators are presented in an earlier Appendix (A) of this Plan. The Evaluation Team will be monitoring the outcome indicators on an annual basis, to track changes in over-all Plan impact.

The results of all evaluation effort will be shared with stakeholders as findings become available.

Kentucky Coordinated Chronic Disease Prevention Logic Model

Inputs	Activities	Outputs	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
<ul style="list-style-type: none"> • Special CCDPHP CDC funding • Existing program infrastructure, experience, expertise • CDC leadership and technical assistance • Project Facilitator (JR) • Project evaluator (RW) • Limited models from other states • Diverse Stakeholders • Baseline health relatively poor • Categorical funding • Dynamics of health care reform 	<ul style="list-style-type: none"> • Planning meetings with leadership team • Monthly meetings of Steering Committee • Periodic meetings of the Stakeholder Group • Draft state chronic disease plan • Engage participation of stakeholders in plan development and prioritization • Develop project evaluation plan • Form collaborative working groups • Design sustainable KY CCDPHP evaluation infrastructure 	<ul style="list-style-type: none"> • Complete state plan • Complete monthly meetings of collaboration working groups • Complete project evaluation plan • Complete CCPD evaluation infrastructure • Establish formal interaction structure between CCDPHP and KY's public health academic programs • Evidence of efficiencies in chronic disease prevention and management • Complete communication plan • Complete staffing and training plan 	<ul style="list-style-type: none"> • Expanded referral programs • Special training efforts completed • Improved competencies among staff and collaborators • Evidence of coalition engagement with state government • Evidence of cross-cutting efforts • Evidence of new health equity efforts • Evidence of partners using state plan • Attention to plan by General Assembly • Evidence of increased evaluation efforts • Evidence of expanded CCDPHP reach • Evidence of increased engagement by high-level leaders • Publications /presentations on KY CCDPHP • Public policy initiatives • Evidence of engagement by HD directors • Evidence of efficiencies 	<ul style="list-style-type: none"> • Increase in related policy/systems change • Increase in environmental factors/change • Improved health systems outreach • Improved clinical/community linkages • Improved use and delivery of clinical preventive services • Improved delivery and use of disease self-management • Improved self-management skills among those with/at risk for chronic disease 	<p>By 2016:</p> <ul style="list-style-type: none"> • Decrease the proportion of adults who are current smokers to 22.5%. • Decrease the proportion of adolescents who have smoked cigarettes in the past 30 days to 23.4%. (2020 Target) • At least 23.2% of adults will consume 5 daily fruit and vegetable servings. • At least 36.2% of new mothers will breastfeed for at least 6 months. • Increase the proportion of adults meeting guidelines for moderate or vigorous physical activity to 50.2%. • The rate of hospitalization due to uncontrolled diabetes will be no greater than 0.21 (rate per 1,000). • Increase the % of adults with diabetes served by an FQHC who have an A1C value less than 9% to at least 80.3%.
Environment: poor health status; poverty; underserved population groups; unique disparities					

Appendix H

Accountability

The Institute of Medicine issued a series of reports in 2012 which built upon earlier IOM efforts to describe the activities and role of the public health system which were defined in a 2003 IOM report aptly named *The Future of the Public's Health in the 21st Century*. Even earlier in 1988, the IOM had defined health status of the public as not merely the result of medical or clinical care, but the result of the sum of what we do as a society to create the conditions in which people can be healthy. The Unbridled Health leadership team and stakeholders group once again finds that this definition works for helping to set parameters for accountability.

Multi-sectoral partners and stakeholders all share responsibility for the goals, activities and outcomes that are described in this coordinated chronic disease prevention and health promotion plan for Kentucky. Recommendations from the 2012 IOM report *For the Public's Health: Investing in a Healthier Future* includes Appendix F: The Role of Measurement in Action and Accountability will be reviewed over the next year by this Unbridled Health leadership team and shared with our large stakeholders group. Opportunities to consider implementation of those recommendations at a local, regional and state level will be considered. An issue brief and communication plan will be developed by the leadership team in connection with this state plan and an annual report on outcomes will be published by the Kentucky Department for Public Health with input of the leadership team. When possible, statewide policy changes such as a comprehensive smoke free law for Kentucky will be actively pursued to provide maximum impact. Other policy changes may be pursued by decision makers including Medicaid expansion and reform and a Kentucky Health Benefits Exchange. The systematic use of the Kentucky Health Information Exchange (KHIE) will progress with more providers, hospitals, clinics and individuals sharing health related data in order to improve care coordination.

At this same time, the Kentucky Department for Public Health will be pursuing public health accreditation along with a number of the local, independent and district health departments in Kentucky. The State Health Assessment (SHA) and the State Health Improvement Plan (SHIP) are requirements for the accreditation process and will be used as strategic supporting components of accountability. Health departments at the community level will be bringing together coalitions to complete community assessments and strategic plans for improving population health. These coalitions will be prioritizing goals at the community level and accountability for those objectives will be managed by those communities.

While one entity or organization cannot be accountable for all of the “public health” and “population health” improvements that will take place over the years of this Unbridled Health Plan, the leadership team along with the Kentucky Department for Public Health will continue

to facilitate communication, training, resources and support of policies that will ensure that Kentucky has a vested interest in making the healthy choice the easy choice.

Appendix I

KY – Unbridled Health Plan Template



Unbridled Health Plan

The Kentucky Coordinated Chronic Disease Prevention and Health Promotion State Plan, *Unbridled Health*, is intended to be a living document. While the health outcome objectives and targets will remain the same, our key initiatives and action items will be updated periodically based on the latest evidence and evaluation results from implementation efforts. This plan is meant to be very alive in our communities throughout the state. Please share this plan with other groups and organizations, implement key initiatives, and evaluate efforts and find new ways of working together!

For us to continually improve our processes and ensure the Unbridled Health Plan meets the needs of Kentucky citizens, we ask you to complete the following assessment. You might find the questions helpful as you plan your next steps for Kentucky's Call to Action.

In the spirit of collaboration, we encourage you to duplicate the following pages and ask your co-workers and community partners to answer the questions. To complete the survey electronically, go to the following URL link:

<https://www.surveymonkey.com/s/UnbridledHealthPlan>

Thank you. We appreciate your feedback.

1. Please indicate how you have responded to Kentucky's Call to Action (pages 6-7). The first question is organized by agency or institution type; just respond to those sections of which you are a representative. Bypass the other sections. Within the sections, please check all that you have done.
 - a. If you are affiliated with a **school or university**:
 - i. Advocated to make your entire campus a tobacco-free environment.
 - ii. Advocated to provide healthy foods and beverages (e.g. low sugar, low salt, high fiber) in vending machines and cafeterias.
 - iii. Advocated to include new or revised health promotion messages in the curriculum.
 - iv. Advocated to increase the opportunities for in-school physical activity for all students.
 - v. Advocated to establish comprehensive wellness policies for all personnel.
 - vi. Taken other Key Initiative/Action
Item _____
 - b. If you are affiliated with a **community or state organization**:
 - i. Advocated for policy, environmental, and systems changes for chronic disease prevention and control.
 - ii. Collaborated with other agencies and institutions to provide community or state prevention programs.
 - iii. Provided chronic disease prevention awareness information and screening programs for clients.
 - iv. Taken other Key Initiative/Action
Item _____
 - c. If you are affiliated with a **hospital**:
 - i. Collaborated with other agencies and institutions to sponsor community screening and education programs.
 - ii. Advocated to make your facility a smoke-free campus.
 - iii. Participated in seeking or maintaining additional accreditation/certification to ensure quality (Heart, Stroke, Cancer, Baby Friendly or other).
 - iv. Collaborated with other agencies and institutions to sponsor patient navigation and survivorship programs.
 - v. Taken other Key Initiative/Action
Item _____
 - d. If you are an **employer**:
 - i. Implemented comprehensive tobacco-free policies at your facility.
 - ii. Used incentives and implemented programs (paid time off for screenings, worksite wellness programs) to reduce barriers and encourage regular health screenings.

- iii. Provided healthy food and beverages (e.g. low sugar, low salt, high fiber) in vending machines and cafeterias.
 - iv. Initiated comprehensive worksite wellness policies and programs for all personnel.
 - v. Taken other Key Initiative/Action
Item_____
- e. If you are affiliated with a **local health department**:
 - i. Advocated policy, environmental and systems changes for chronic disease prevention and control.
 - ii. Provided navigation services for clients.
 - iii. Collaborated with other agencies and institutions in community prevention and health promotion campaigns.
 - iv. Taken steps to achieve public health accreditation.
 - v. Advocated to initiate comprehensive worksite wellness policies for all personnel.
 - vi. Taken other Key Initiative/Action
Item_____
- f. If you are affiliated with a **faith-based organization**:
 - i. Encouraged members to get preventive screening tests.
 - ii. Advocated for the provision of space for physical activity programs.
 - iii. Taken steps to provide healthy potluck and meeting meals.
 - iv. Advocated for the provision of chronic disease prevention and health promotion information to members.
 - v. Other Key Initiative/Action
Item_____
- g. If you are a **legislator**:
 - i. Sponsored or supported legislation and funding that promotes chronic disease prevention and control.
 - ii. Communicated with constituents' to raise awareness about chronic disease prevention and control programs in your district and help establish new programs as needed.
 - iii. Taken steps to ensure that all Kentuckians have access to health care, screenings and early detection services.
 - iv. Taken other Key Initiative/Action
Item_____
- h. If you are a **health care provider**:
 - i. Provided culturally relevant counseling, information, and referrals for screening tests.
 - ii. Incorporated best practice regarding health literacy in chronic disease communications with patients and communities.

- iii. Adhered to guidelines and best practices for prevention, treatment and supportive care.
- iv. Referred patients to smoking cessation, physical activity, nutrition, breastfeeding, self-management and mental health programs.
- v. Taken other Key Initiative/Action
Item_____

i. If you are **private citizen/community representative**:

- i. Stopped using tobacco products.
- ii. Supported comprehensive tobacco-free policies for workplaces and public spaces.
- iii. Increased your daily physical activity.
- iv. Ate more fruits and vegetables and maintained a healthy weight.
- v. Got health screening.
- vi. Taken an active role in your health care decisions.
- vii. Taken other Key Initiative/Action
Item_____

2. I obtained a copy of the Unbridled Health Plan from

- a. KY Department of Public Health
- b. My local or district health department
- c. A local nonprofit health agency
- d. A professional colleague
- e. A local hospital or clinic
- f. Other_____

3. I live in_____County.

4. Would you recommend the Unbridled Health Plan to others?

- a. Yes
- b. No

5. If yes, who would you recommend the Unbridled Health Plan to (please check/circle all that apply)?

- a. Friends
- b. Family
- c. Church
- d. Colleague
- e. Partners
- f. Other (Please specify)_____

6. Please share any of the following in the space below:

- a. Suggested areas of improvement

- b. Lessons learned
- c. Best practices
- d. Quality improvement ideas
- e. Additional comments and/or questions

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