

Health Systems  
Intervention

Epidemiology  
and Surveillance

# CHRONIC DISEASE PREVENTION STATE PLAN FOR THE DISTRICT OF COLUMBIA 2014-2019

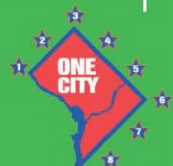
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Government of the District of Columbia  
Department of Health



Office of the Director

## Message from the Director of Health

The publication of the *Chronic Disease Prevention State Plan for the District of Columbia (2014-2019)* is a noteworthy milestone in our recognition of the importance of the District's health challenges and successes. Recognizing the complexity of chronic diseases, the Department of Health (DOH) has established a collaborative and comprehensive approach involving public, private and community-based organizations to develop, update and implement a five-year Chronic Disease State Plan for the District of Columbia.

DOH has improved collaborations with the Centers for Disease Control and Prevention (CDC) to stimulate greater access to services and support, but the Department has also worked to improve system performance and efficiency. As a public health agency, we are responsible for identifying health risks, educating the public, preventing and controlling diseases, injuries, and exposure to environmental hazards, promoting effective community collaborations, and optimizing equitable access to community resources.

The expected outcomes of the Chronic Disease Prevention State Plan will prove to be an invaluable resource for the Mayor, City Council and advocates to facilitate the success of public health programs for the District.

This effort is an opportunity for on-going community engagement in how DOH addresses chronic disease. We look forward to the community's support and feedback as we continue to develop programmatic responses to solve challenges with health equity in the District of Columbia.

Best Regards,



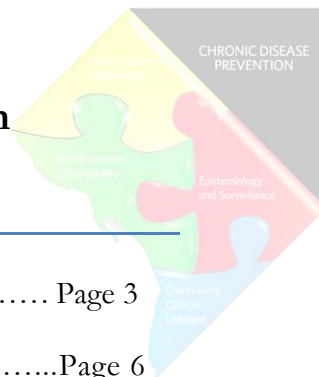
Joxel Garcia, MD, MBA  
Director

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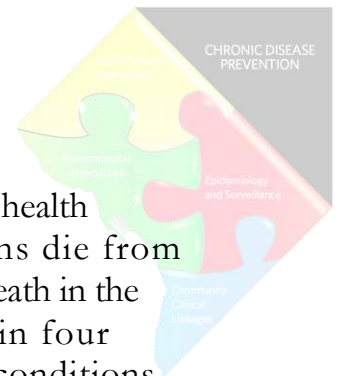
# The District of Columbia Chronic Disease State Action Plan

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## Executive Summary



**Chronic disease in the US:** Chronic disease has become a serious public health concern in the United States today. Approximately 1.6 million Americans die from chronic disease each year and in 2010, 8 of the 15 leading causes of death in the US and in the District of Columbia (DC) were from chronic diseases. One in four Americans has more than one chronic disease condition, and these conditions are associated with decreased quality of life, increasing health-care expenditures and premature death.

Many chronic diseases are interrelated, occurring at the same time and acting as risk factors for one another. For example:

- Obesity and overweight, physical inactivity, high blood cholesterol, hypertension, obesity, and smoking are common risk factors for cancer, cardiovascular diseases, diabetes, and kidney diseases.
- Cardiovascular diseases and diabetes are both risk factors for kidney diseases, which may result in end stage renal disease (ESRD).
- Adults with diabetes have heart disease death rates about two-to-four times higher than adults without diabetes, and the risk for stroke is two-to-four times higher among people with diabetes.

While some risk factors, such as genetic predisposition, cannot be modified, many risk factors, such as obesity and hypertension, can be modified, treated, or controlled. Interventions aimed at this population and other high-risk populations are crucial to providing effective chronic disease prevention and control.

**Chronic Disease in DC:** Although DC is small compared to many of the States, the population has been increasing since 2000, after a 50-year decline. According to the Census Bureau, in 2011 Washington, DC was the 24<sup>th</sup> most populous place in the United States, with a population of 617,996.

DC is divided geographically into four quadrants (Northwest, Northeast, Southwest, and Southeast), and eight electoral Wards. The Wards are evenly divided in terms of population size, but they differ greatly in terms of socioeconomic status and health conditions. For example, the majority of residents in Wards 2 and 3 are white, and the average income in those two wards is more than double the average income of any of the other wards. Wards 1 and 4, located in the Northwest quadrant, are home to a substantial Hispanic population, while the populations of Wards 5 and 6 in the Northeast quadrant are predominantly African-American. The populations of Wards 7 and 8 in the Southeast quadrant are more than 90 percent African-American.

Personal behaviors that constitute risk factors for chronic disease also vary among the Wards. On average, approximately three-quarters of the adult population in DC

participates in moderate physical exercise, but participation rates in Wards 7 and 8, where the population is more disadvantaged, is substantially lower than both the DC and the national average. Rates of alcohol use are much higher in the District than nationally, but smoking in DC mirrors the national average. The rates of asthma and diabetes are also three times higher in Wards 7 and 8 than in the wealthier Wards 2 and 3, where the population is predominantly white. Diabetes rates are also much higher in Wards 7 and 8, although rates of being overweight are highest in Wards 5 and 6, about 10-to-20 percent higher than the overall average for the District. In addition, obesity, which contributes to the severity of most chronic diseases, is widespread in the District of Columbia. Overall, 55 percent of adults in DC are overweight, but in Wards 7 and 8, the rate is 72 percent, and, more DC residents die each year from the complications of obesity than from AIDS, cancer, and homicide, combined.

### **Addressing Chronic Disease:**

Addressing the complex issues presented by chronic disease requires a comprehensive understanding of the risk factors for chronic disease, as well as, an effort that is community-wide and tailored to the needs of small subgroups. Several of the strategies currently in use or in development in the District are discussed below.

**The Community Leadership Team:** The Community Leadership Team was established to bring together public, private, and community-based organizations to form a collaborative to provide a coordinated approach to chronic disease prevention and health promotion. The Team's leading priority is to assist in developing, updating, and implementing a five-year Chronic Disease State Plan for the District of Columbia. In addition, the members of the Community Leadership Team will serve in the following capacity:

- Reviewing and advising on best practices;
- Recommending standards for the health and wellness issues in the District;
- Collaborating in the development of an outreach and public education program to inform the public about the chronic diseases and how to address them; and
- Making recommendations on enhancing collaborative efforts.

In order to develop and implement the ambitious plan that follows, DC also needs input and support from key individuals and organizations in the community, who will implement and disseminate many of the strategies included in the plan. The successful implementation and sustainability of the plan depend on collaboration, negotiation, and buy-in from community organizations and constituencies in all parts of DC. In addition, DC residents must feel that the plan addresses their needs, so they will be motivated to participate in the personal and environmental changes envisioned by the plan.

The members of the Community Leadership Team will continue to serve in their capacity throughout the five-year State Plan.

**Three-year Assessment Cycle:** In Domain 2, Objectives 2A and 2B, DOH has introduced the concept of a three-year assessment cycle, to encourage continuous review of policy, resources, and data. These are areas that would benefit from regular monitoring, to keep up with new research and improved processes. Too often, however, this monitoring process falls through the cracks. By creating an assessment cycle and integrating it into the regular duties of the DOH, assessment can become a part of the everyday activities of DOH without becoming a burden on anyone. This regular review and recommendation process could support and improve services in the District.

**Evaluation and Sustainability:** The District of Columbia Chronic Disease State Action Plan will be accompanied by an evaluation plan, with a focus on monitoring the progress towards the achievement of program goals, objectives and long-term results. The plan assessment will include:

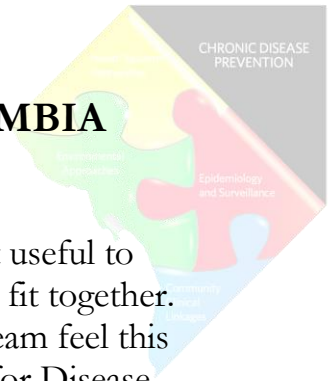
- 1) Evaluation questions of both the process and impact levels;
- 2) Results and measurable indicators of chronic disease;
- 3) Data sources (as available); and
- 4) Baseline and target indicators important to the District of Columbia.

The State Action Plan will also be accompanied by a sustainability plan, with a focus on maintenance and expansion of efforts. The sustainability plan will include the following:

- 1) Support leadership and guidance in defining and monitoring the chronic disease surveillance and monitoring system;
- 2) Support for outreach and engagement of the community in utilization of services and improvements in population health; and
- 3) Develop, sustain, and expand capacity to advance chronic disease prevention and health promotion in the District of Columbia.

The evaluation and sustainability plans are works in progress. Similar to the State Action Plan, the evaluation plan is a work in progress that will be modified and amended, as objectives are met or new opportunities arise.

# A GUIDE TO READING THE DISTRICT OF COLUMBIA CHRONIC DISEASE STATE ACTION PLAN



Before getting into the Chronic Disease Action Plan, the reader may find it useful to review the various elements that make up the plan and how these elements fit together. The DC Department of Health (DOH) and the Community Leadership Team feel this structure is the best way to meld the visions of the DOH and the Centers for Disease Control and Prevention (CDC) to create a workable plan that addresses the many needs of the residents of the District of Columbia.

**Domains:** The framework for the Chronic Disease State Action Plan begins with the four domains identified by the CDC, which includes the following:

- Epidemiology and Surveillance
- Environmental Approaches
- Health Care Systems
- Community-Clinical Linkages

**Goals:** Within these four domains, DOH and the Community Leadership Team developed seven priority goals that align with the four domains. In addition, because of their importance in the overall plan, evaluation and sustainability have been added as goals, for a total of nine goals. Each goal includes the following elements:

- **Sectors:** DOH identified four public health system sectors, which include:
  - Government;
  - Healthcare delivery system;
  - Community organizations/advocates; and
  - Private sector/business.
- **Objectives:** To achieve each of the nine goals, specific objectives were identified for each of the four public health system sectors:
- **Strategic Actions:** To address chronic disease issues, a list of strategic actions was developed to meet plan objectives.
- **Summary of Expected Outputs:** The strategic action steps taken by the four sectors of the health system can be expected to result in a number of outputs. Specific outputs cannot be predicted at this time, but each goal contains a list of the types of outputs expected from the strategic actions.
- **Summary of Expected Outcomes:** As the implementation of the plan progresses, the strategic action steps of the sectors can be expected to result in a number of changes in outcomes. Specific outcomes cannot be predicted at this time, but each goal includes a list of the types of outcomes expected from the strategic actions.

**Summary of the Domains, Goals, and Objectives:** The following summary of the domains, goals, and objectives provides a simple checklist of the contents of the Chronic Disease State Action Plan.

### **Domain 1: Epidemiology and Surveillance**

**Goal 1:** to enhance the capability of the DC health system to provide data and conduct research to inform, prioritize, deliver, and monitor programs and population health.

**Objectives** include the following:

- Develop a centralized surveillance system;
- Update the surveillance system annually;
- Expand the use of electronic health records;
- Collect and disseminate data on effectiveness of care; and
- Increase data sharing with private entities.

### **Domain 2: Public Policy Guidance**

**Goal 2:** to develop and implement policies that support chronic disease prevention and control by reducing environmental barriers to health behaviors.

**Objectives** include the following:

- Reduce environmental barriers;
- Develop policy toolkits;
- Encourage worksite wellness;
- Develop interagency collaboration;
- Decrease barriers to medical treatment and prevention;
- Implement an advocacy agenda; and
- Develop an initiative for environmental improvements in the private sector.

### **Domain 3: Health Care Systems**

**Goal 3:** to improve the capacity and coordination of the public and private health care systems so they can provide clinical services that prevent chronic disease, support early detection, manage risk factors, and reduce health disparities.

**Objectives** include the following:

- Coordinate community resources;
- Improve integration of healthcare services;
- Develop Community Leadership Team; and
- Integrate private sector into prevention and control.



**Goal 4:** to improve the ability of the District healthcare system to deliver integrated high-quality chronic disease care and to reduce or eliminate health disparities and inequities in DC.

**Objectives** include the following:

- Restructure medical care to address chronic disease;
- Expand healthcare capacity to care for those with chronic diseases;
- Increase patient self-sufficiency; and
- Expand healthcare benefits to cover treatment and prevention.

#### **Domain 4: Community-clinical linkages**

**Goal 5:** to facilitate access to chronic disease outreach, education, and navigation, with focused attention on special populations.

**Objectives** include the following:

- Develop and disseminate educational materials for special populations;
- Develop communications to promote healthy eating and active living;
- Address the healthcare needs of special populations;
- Improve community outreach, expand educational events and materials; and
- Expand workplace wellness in the private sector

**Goal 6:** to promote early detection and primary prevention of chronic disease among individuals with elevated risk.

**Objectives** include the following:

- Develop more intergovernmental coordination;
- Improve primary prevention;
- Raise community awareness of early detection; and
- Develop a model workplace wellness program at DOH.

#### **Additional Goals, outside the domains**

**Goal 7: Children, Adolescent, and Guardian Services:** DOH will collaborate with schools and early childhood centers to implement health promotion approaches to influence the development and implementation of healthy chronic disease policies for children and youth in the District.

**Objectives** include the following:

- Implement strategies to involve the school system in chronic disease treatment and prevention;
- Address the needs of children and youth outside of school;
- Raise standards of care for youth and adolescents;
- Implement outreach to youth;
- Increase outdoor opportunities for children; and
- Strengthen workplace support of families with children.

**Goal 8: Evaluation:** The District of Columbia Chronic Disease State Action Plan will be accompanied by an evaluation plan, with a focus in monitoring the progress towards the achievement of program goals, objectives and long-term results. The plan assessment will include:

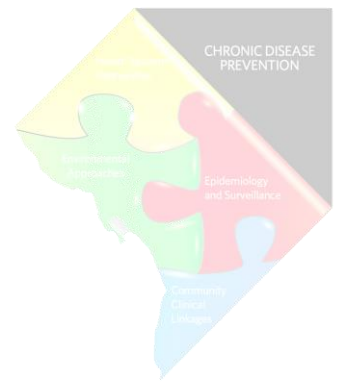
- Evaluation questions of both the process and impact levels;
- Results and measurable indicators of chronic disease;
- Data sources (as available); and
- Baseline and target indicators important to the District of Columbia.

Annual updates will be provided for the District of Columbia Chronic Disease State Action Plan. Major achievements and outcomes of DOH and related programs risk factors will be documented, as well as support of our partners for our evidence-based programs.

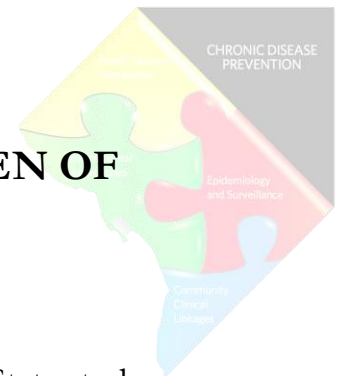
**Goal 9: Sustainability:** The District of Columbia Chronic Disease State Action Plan will also be accompanied by a sustainability plan, with a focus on maintenance and expansion of efforts. The sustainability plan will include the following:

- Support leadership and guidance in defining and monitoring the chronic disease surveillance and monitoring system;
- Support for outreach and engagement of the community in utilization of services and improvements in population health; and
- Develop, sustain, and expand capacity to advance chronic disease prevention and health promotion in the District of Columbia.

Like the District of Columbia Chronic Disease State Action Plan itself and the evaluation plan, the sustainability plan is a work in progress, and updates to the sustainability plan will be incorporated into the annual updates of the State Action Plan. These updates will document our progress in finding ways to support, sustain, and expand cancer and chronic disease programs throughout the community.



# STATEMENT OF NEED: THE DISTRICT OF COLUMBIA AND THE BURDEN OF CHRONIC DISEASE



## Chronic Disease in America

Chronic disease has become a serious public health concern in the United States today. Data from the Centers for Disease Control (CDC) in Exhibit 1 show that approximately 1.6 million Americans die from chronic disease each year. One in four Americans has more than one chronic disease condition,<sup>1</sup> and chronic conditions are associated with decreased quality of life, increasing health-care expenditures, and premature death. As Table 1 shows, in CY2010, 8 of the 15 leading causes of death in the US and in the District of Columbia were from chronic diseases.

Exhibit 1. Chronic Disease in Top Fifteen Causes of Death, US and DC 2010<sup>2</sup>

	US -- # of deaths	US -- % of deaths	DC -- # of deaths	DC -- % of deaths
Total deaths	2,468,435	100.0%	4,672	100.0%
1. Cardiovascular disease	597,689	24.2%	1,306	28.0%
2. Cancer	574,743	23.3%	1,041	22.3%
3. Respiratory disease, including asthma	138,080	5.6%	147	3.1%
4. Stroke	129,476	5.2%	196	4.2%
7. Diabetes	69,071	2.8%	145	3.1%
8. Kidney disease	50,476	2.0%	84	1.8%
12. Chronic Liver disease and cirrhosis	31,903	1.3%	54	1.2%
13. Hypertension	26,634	1.1%	57	1.2%
Total chronic disease in top 15 causes of death	1,618,072	65.6%	3,030	64.9%

Many chronic diseases are interrelated. They often occur at the same time and act as risk factors for one another. For example:

- Obesity and overweight, physical inactivity, high blood cholesterol, hypertension, obesity, and smoking are common risk factors for cancer, cardiovascular diseases, diabetes, and kidney diseases.
- Cardiovascular diseases and diabetes are both risk factors for kidney diseases, which may result in end stage renal disease (ESRD).
- The risk for cardiovascular diseases is 10-to-20 times higher among individuals who develop ESRD than among the general population.
- Adults with diabetes have heart disease death rates about two- to-four times higher than adults without diabetes, and the risk for stroke is two-to-four times higher among people with diabetes.<sup>3</sup>

<sup>1</sup> Anderson, G. Chronic Care: making the case for ongoing care. Princeton, NJ: Robert Wood Johnson Foundation, 2010. Also, Dr. Anand Parekh, HHS Deputy Secretary for Health, on Bio Century, WUSA Channel 9, Sunday, February 9, 2014.

<sup>2</sup> National Vital Statistics Reports, Vol. 61, No. 4, May 8, 2013. [www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf).

<sup>3</sup> Fast Facts: data and Statistics about diabetes, American Diabetes Association at [www.professional.diabetes.org/facts](http://www.professional.diabetes.org/facts).

**Risk Factors:** Risk factors are traits and habits that increase the risk of developing a disease. While risk factors correlate with the development of disease, it is more difficult to show a causal relationship between the risk factor and the disease. Risk factors also cut across disease classifications and are common to many diagnoses.

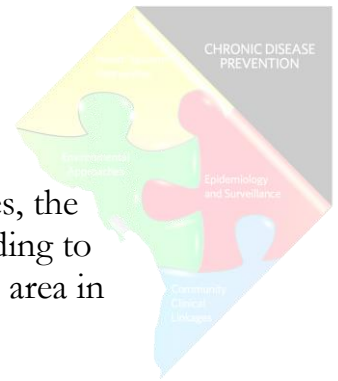
While some risk factors such as genetic predisposition cannot be modified, many others, such as obesity and hypertension can be modified, treated, or controlled. For instance, pre-diabetes is the major risk factor for developing diabetes. The CDC estimates that 41 million people in the US have pre-diabetes. It is estimated that approximately 35,000 District resident may have pre-diabetes, so interventions aimed at high-risk populations such as this are crucial to providing effective chronic disease prevention and control.

Obesity is associated with an increased risk for many serious health conditions, including coronary heart disease, hypertension, stroke, Type 2 diabetes, certain types of cancer, and premature death. These are all conditions that can be addressed through public education, increased use of preventive services and coordination of policies and programs that promote and support physical activity, healthy eating, and safe physical environments.

Because many of the same risk factors contribute to a wide range of chronic diseases, an integrated and collaborative approach is necessary for a comprehensive chronic disease prevention program. This requires integration of the DOH public health programs which focus on reducing many of the same risk factors, and most importantly, collaboration with primary care practitioners who play a central role in providing individualized health promotion, disease prevention and early intervention for chronic diseases. Also, important is the need to integrate policy directions and strategic initiatives on chronic disease prevention that build upon and strengthen existing coordinated, multidisciplinary and collaborative strategies.

## Chronic Disease in the District

Although the District of Columbia is small compared to many of the states, the population has been increasing since 2000, after a 50-year decline. According to the Census Bureau<sup>4</sup>, in 2011 Washington, DC was the 24<sup>th</sup> most populous area in the United States, with a population of 617,996.



DC is divided geographically into four quadrants (Northwest, Northeast, Southwest, and Southeast), and eight electoral Wards (see Exhibit 2). The Wards are evenly divided in terms of population size, but differ greatly in terms of socio-economic status and health conditions. For example, the majority of the population in Wards 2 and 3 is white, and the average income in those two Wards is more than double the average income of any of the other Wards. Wards 1 and 4, located in the Northwest quadrant of the city, are home to a substantial Hispanic population, while

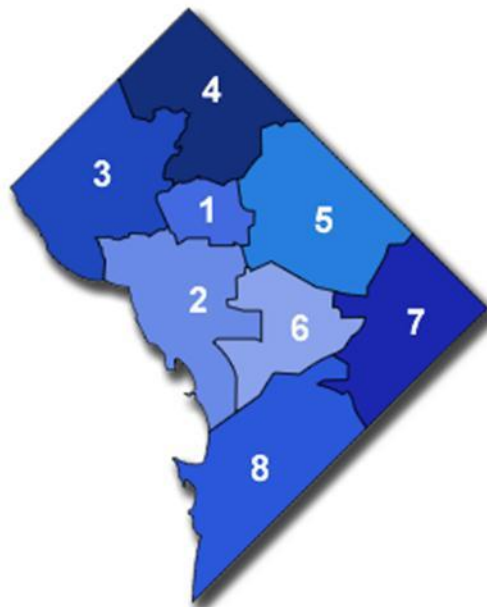


Exhibit 2: DC Map by Ward

the populations of Wards 5 and 6 in the Northeast quadrant, are predominantly African-American. The populations of Wards 7 and 8 in the Southeast quadrant are more than 90 percent African-American. Table 3 presents chronic disease and socio-economic indicators by Ward, and Table 4 presents data on risk factors at the national and the local level.

The rates of asthma and diabetes are also much higher in Southeast, about three times higher in Wards 7 and 8 than in the wealthier Wards 2 and 3, where the population is

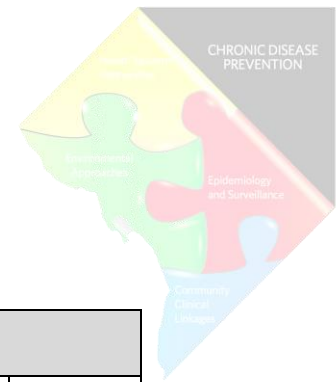
<sup>4</sup> US Census Bureau, Deaths: Final Data for 2010, tables 1,7,10,20.

predominantly white. Diabetes rates are also much higher in Wards 7 and 8, and exercise rates much lower, although rates of being overweight are highest in Wards 5 and 6, about 10-to-20 percent higher than the overall average for the District.

Exhibit 4. Risk behaviors, District of Columbia and US, 2012<sup>5</sup>

	Percentage of affirmative responses	
	DC	US
Participated in physical activity in the past month	82.6	77.1
Adults who have had at least one alcoholic drink in the past 30 days	63.4	55.3
Binge drinkers (men 5+ drinks, women 4+ drinks at any one time)	23.1	16.9
Heavy drinkers (men 2+, women 1+ drinks per day)	8.1	6.1
Adults who are current smokers	19.6	19.6

<sup>5</sup> District of Columbia Behavioral Risk Factor Surveillance System 2014



### EXHIBIT 3. DISTRICT OF COLUMBIA: CHRONIC DISEASE AND SOCIOECONOMIC INDICATORS BY WARD

	WARDS								
	1	2	3	4	5	6	7	8	DC
Chronic Diseases 2011 <sup>6</sup>									
Smoking	21.9%	8.1%	10.5%	19.2%	24.0%	16.2%	30.4%	37.2%	20.8%
Overweight	31.7%	26.9%	26.6%	29.1%	32.0%	33.6%	28.2%	22.0%	29.1%
Moderate Physical Activity <sup>7</sup>	85.6%	90.5%	89.3%	76.2%	77.7%	82.6%	70.3%	64.6%	76.5%
Diabetes (prevalence)	4.8%	4.0%	4.4%	9.6%	12.5%	8.4%	13.5%	20.4%	10.2%
Stroke (prevalence)	2.2%	2.4%	2.3%	3.2%	4.2%	2.4%	5.0%	6.2%	3.6%
Coronary Heart Disease (prevalence)	1.4%	2.9%	3.8%	4.3%	3.8%	1.9%	2.4%	5.0%	3.3%
Asthma (prevalence)	2.8%	1.8%	1.9%	3.7%	5.3%	3.2%	6.7%	5.8%	4.1%
Cancer (incidence per 100,000 population)	500.4	345.1	359.0	451.0	578.6	522.6	494.4	544.4	499.5
Socioeconomic Indicators <sup>8</sup>									
Total Population 2010	74,462	76,883	78,887	75,773	74,308	76,000	71,748	73,662	601,723
• Black 2010	33.0%	9.8%	5.6%	59.0%	77.0%	43.0%	95.0%	94.0%	51.0%
• White 2010	40.0%	70.0%	78.0%	20.0%	15.0%	47.0%	1.5%	3.2%	35.0%
• Hispanic 2010	21.0%	9.5%	7.5%	19.0%	6.3%	4.8%	2.7%	1.8%	9.1%
• Asian/Pacific Islander 2010	5.0%	10.0%	8.2%	2.0%	1.7%	5.1%	0.3%	0.5%	4.2%
• Children 2010	12.0%	4.8%	13.0%	20.0%	17.0%	14.0%	24.0%	30.0%	17.0%
Average Family Income 2007-2011	\$99,428	\$222,345	\$240,044	\$115,482	\$79,153	\$129,074	\$57,387	\$43,255	\$118,384
% Unemployed 2007-2011	7.2%	3.9%	3.4%	7.6%	13.2%	6.4%	16.7%	17.4%	8.7%
% Female Headed Families with Children 2007-2011	42.0%	12.0%	12.0%	38.0%	56.0%	45.0%	74.0%	74.0%	50.0%
Persons without HS diploma 2007-2011	16.0%	6.3%	2.9%	16.0%	18.0%	10.0%	17.0%	19.0%	13.0%
Poverty Rate 2007-2011	15.0%	15.0%	7.9%	12.0%	20.0%	16.0%	26.0%	36.0%	18.0%

<sup>6</sup> Unless otherwise noted, all data in this section is from District of Columbia Behavioral Risk Factor Surveillance System (BRFSS) 2011.

<sup>7</sup> District of Columbia BRFSS 2010 Annual Report.

<sup>8</sup> Urban Institute and Washington DC Local Initiatives Support Corporation (LISC). Neighborhood Info DC, [www.neighborhoodinfodc.org/profiles.html](http://www.neighborhoodinfodc.org/profiles.html). Profiles updated as of last quarter 2013. (Original data primarily from the US Census Decennial Census and the American Community Survey (ACS) of the US Census.)

Personal behaviors that constitute risk factors for chronic disease are also important. Exhibit 3 shows that, on average, approximately three-quarters of the adult population in DC participate in moderate physical exercise. While the data in Exhibit 4 show that the average rate of physical activity in DC is higher than the national average, the more specific data in Exhibit 3 show that the participation rate in Wards 7 and 8, where the population is more disadvantaged, is substantially lower than both the DC average and the national average. The latest data from the DC Behavioral Risk Factor Surveillance System (BRFSS) in Exhibit 4 show that rates of alcohol use in general, as well as, binge drinking and heavy drinking, are much higher in DC than nationally, but smoking in DC mirrors the national average.

## Addressing Chronic Disease

Addressing the complex issues presented by chronic disease requires a comprehensive understanding of the risk factors for chronic disease. It also requires an effort on behalf of the entire community that is, at the same time, both coordinated to ensure the use of evidence-based methods and scientific evaluation based on sound data collection, as well as tailored to the needs of micro-communities and sub-groups with specific needs. Several of the strategies currently in use or in development in the District of Columbia are discussed below.

### The Community Leadership Team

The Community Leadership Team was established August 2013 following the Chronic Disease Prevention Workshop “*Building Healthier Communities*”. The Workshop was designed to bring together public, private, and community-based organizations to form a collaborative that would have a shared understanding of the four domains developed by the CDC, which includes the following:

- Epidemiology and Surveillance;
- Environmental Approaches;
- Health System Interventions; and
- Community Clinical Linkages.

The CDC developed these domains to provide a coordinated approach to chronic disease prevention and health promotion among the health department and its partners. The domains also help develop a shared understanding of planning needs and engagement opportunities, as well as providing a shared framework for identifying opportunities for advancing chronic disease coordination in Washington, DC.

The Community Leadership Team is comprised of government agencies, private entities, public hospitals, universities, faith-based community and private consumers.



The Team's leading priority is to assist in developing, updating, and implementing a five year Chronic Disease State Action Plan for the District of Columbia. In addition, the members of the Community Leadership Team will serve in the following capacity:

- Reviewing and advising on the best practices in health and wellness programs across the United States;
- Recommending standards, or revisions to existing standards, concerning the health and wellness issues for residents and visitors in the District;
- Advising on the development of an ongoing program of public information and outreach on health and wellness issues; and
- Making recommendations on enhancing collaborative efforts among District government, Federal government, local nonprofit organizations, colleges and universities, and the private sector in connection with health and wellness.

The members of the Community Leadership Team will continue to serve in their capacity throughout the five year State Plan. A list of organizations that have joined the Community Leadership Team to participate in this process appears at the end of the document.

### **Three-year Assessment Cycle**

In Domain 2, Objectives 2A and 2B, DOH has introduced the concept of a three-year assessment cycle, to encourage continuous review of policy, resources, and data. These are areas that would benefit from regular monitoring, to keep up with new research and improved processes. By creating an assessment cycle and integrating it into the regular duties of the DOH, the assessment can become a part of the everyday activities of DOH without becoming a burden on anyone. This regular review and recommendation process could support and improve services in the District.

DOH is proposing a three-year cycle to review policy, resources, and data. Each year, one of these areas would be reviewed, for example:

- Year One: policy
- Year Two: resources
- Year Three: data

The next year would start again with policy. Each assessment will include a summary of the current state, with recommendations for priorities and new ideas for the next two years. For example, in Year One, the report would summarize current District policy relevant to chronic care. It would also include recommendations for the next two years – which policies seem to be constructive, and how to support those efforts; which policies require tweaking or substantial change; and what new policies should

be considered to facilitate the treatment and prevention of chronic illness. Under resources, the assessment would identify gaps in available services and the needs for training and technical assistance for workers, and make recommendations to close these gaps. Under data, the assessment would look at the data collected by the various programs and make recommendations to improve the data collection and dissemination, and suggest other data that would be useful to improve services in the District.

## Evaluation and Sustainability

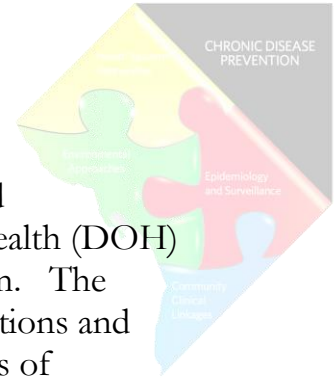
The District of Columbia Chronic Disease State Action Plan will be accompanied by an evaluation plan, with a focus in monitoring the progress towards the achievement of program goals, objectives and long-term results.

The plan assessment will include:

- 1) Evaluation questions of both the process and impact levels;
- 2) Results and measurable indicators of chronic disease;
- 3) Data sources (as available); and
- 4) Baseline and target indicators important to the District of Columbia.

Annual updates will be provided for the District of Columbia Chronic Disease State Action Plan. Major achievements and outcomes of DOH and related programs risk factors will be documented, as well as support of our partners for our evidence-based programs.

The evaluation plan is a work in progress—much in the same manner as the State Action Plan itself. It will be modified and amended as objectives are met or new opportunities arise.



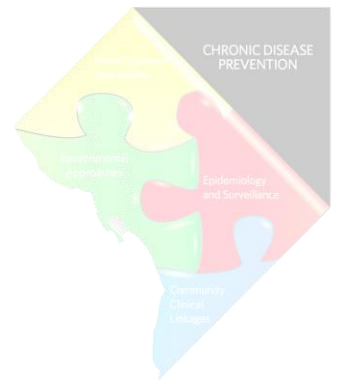
# The Gap Analysis

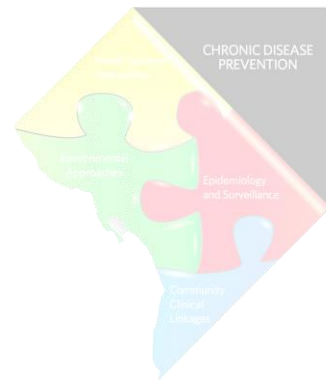
As part of our continuing effort to involve the community in planning and implementing services for the District of Columbia, the Department of Health (DOH) circulated a Gap Analysis to members of the Community Leadership Team. The purpose of the Gap Analysis was to gain the input of community organizations and individuals to help set priorities for DOH. DOH will continue the process of integrating the Community Leadership Team into the decision-making and implementation processes of DOH, in order to ensure that the focus is maintained on the needs and desires of the community. A summary of the major results of the Gap Analysis appears below.

Exhibit 5: Summary of Results from the Gap Analysis

1. Top three chronic disease where DOH should focus public health efforts to reduce disability, increase function, and improve quality of life
  - Cardiovascular disease
  - Diabetes
  - Physical activity and nutrition (obesity)
2. Three most important chronic diseases for the health and economic wellbeing of the District of Columbia
  - Arthritis
  - Cancer
  - Respiratory disorders (asthma)
3. Most important underserved populations in the District
  - Income under \$15,000
  - Education less than high school diploma
  - Black or African-American
  - Age 35-44
  - Male
  - Ward 8
4. Most effective population-based interventions to reduce disability, increase function, and improve quality of life in the District of Columbia
  - Parks
  - Prescription (encourages outdoor activities)
  - Women’s Health Initiative (WHI Project)
  - Tobacco Free Living (smoke-free housing program)
  - Baby-friendly Hospitals (breast-feeding)
  - Farmers’ Markets
  - Health Information Data Exchange (HIE)
  - Colorectal Cancer Screening Initiatives
  - Asthma Hospital-based Case Management
  - Breast Cancer Screening
  - School Health Program

5. Top communication methods to form public policy decisions
  - Policy briefs
  - Fact sheets and study reports
  - E-newsletters and other publications
  - Special presentations for interested groups
  - Facebook/Twitter
6. Policy priorities to improve the impact of chronic disease
  - Strategies to implement mandatory daily physical education and physical activity requirements in schools and child care centers
  - Mandatory health education in high school
  - City-wide chronic disease navigator program
  - Continued improvement in healthy school lunches
  - Increased numbers of healthy corner stores
  - Peer educators and park ambassadors to maintain green spaces
  - Establishment of a prevention fund to support community-based wellness initiatives
  - Require developers receiving DC funds to include wellness initiatives such as safe sidewalks and green spaces for gardening and parks
  - Funding for cardiovascular research and community linkages
  - Public policy focus on social determinants of health
  - Payment reform
  - Medicaid reimbursement for complex care coordination, transition from hospital to home, and self-management education by lay educators
7. Top three technical assistance needs of your organization
  - Performance evaluation
  - Development and sustainability
  - Effective collaboration





# THE DISTRICT OF COLUMBIA CHRONIC DISEASE STATE ACTION PLAN

## **DOMAIN 1: EPIDEMIOLOGY AND SURVEILLANCE**

### **1. Data Capacity and Utilization**

**Goal: Enhance the capability of the District health system to provide data and conduct research to inform, prioritize, deliver, and monitor programs and population health.**

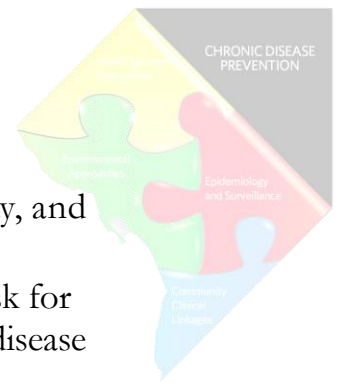
#### **I. Government Objectives and Strategic Actions**

**Objective 1A – Centralized Surveillance System:** By CY2017, DOH with substantial input from the Community Leadership Team, will develop and implement a centralized surveillance system to report DC chronic disease data, in order to improve programs and population health.

##### **Strategic Actions**

- Promote funding for chronic disease program surveillance and evaluation.
- Evaluate data attributes and variables and establish access to the following sources of data
  1. DC Fire and EMS 911 call data;
  2. Medicare and Medicaid data;
  3. Emergency room (ER) data; and
  4. Hospital Discharge data (HD).
- Integrate and modify data collection systems to collect data on youth.
- Establish, collect, and monitor chronic disease data among at least three racial and ethnic minority populations as determined by numbers or percentages in the DC population, including those with high incidence of limited English proficiency (LEP).
- Produce and disseminate reports documenting chronic disease high-risk zones.
- Use geographical information systems (GIS) technology to map available data.
- Establish benchmarks and/or key performance indicators.
- Identify representatives of chronic disease grantees to serve on a standardization workgroup and a larger community task force data subcommittee.
- Build capacity to increase data collection and reporting on community-based organizations.

**Objective 1B – Annual Update of Surveillance:** By CY2017, DOH, working with the Community Leadership Team, will update surveillance, evaluation, and research information annually, to facilitate community planning, increase the quality of services for chronic disease patients, and improve community health programs for those living with chronic disease or at increased risk for chronic disease.



## Strategic Actions

- Establish health indicators, including incidence, prevalence, morbidity, and mortality.
- Expand data collection to include populations in DC at significant risk for chronic disease but for whom we lack data on their specific chronic disease burdens, such as the following examples:
  - Hispanic population and its ethnic subsets;
  - Other populations with limited English proficiency (LEP);
  - Populations with low literacy;
  - Children and adolescents;
  - Seniors;
  - Low socio-economic level populations; and
  - Sexual minorities and gender variants.
- Publish a comprehensive chronic disease surveillance report every five years.
- Produce chronic disease fact sheets.
- Produce data fact sheets and report summaries in diverse languages in compliance with the Language Access Act (e.g., Amharic, Chinese, Korean, Spanish, and Vietnamese).
- Produce chronic disease high-risk zone community maps.

## II. Healthcare Delivery System Objectives and Strategic Actions

**Objective 1C – Expand Use of Electronic Health Records:** By CY2016, DOH will work with at least four additional healthcare system providers to adopt electronic health records (EHR) to improve the collection and updating of institutional healthcare data, facilitate transmission of data to DOH, and ensure security in the collection, transmission, and storage of data. The EHR format will incorporate key measures of effectiveness of care. Data transmitted to DOH will be de-identified before transmission.

### Strategic Actions

- Identify opportunities and implement programs to demonstrate improvement in Healthcare Effectiveness Data and Information Set (HEDIS) measures effectiveness of care results and other measures that the Government of the District of Columbia collects for planning purposes.
- Partner with healthcare service providers under contract with the Department of Health Care Finance (DHCF) to utilize electronic health records to report on key measures of effectiveness of care, based on existing models of provision and quality of clinical preventive services.

- Identify benchmarks from the electronic health records (HER) to serve as an evidence base from which to formulate policy decisions and programmatic interventions to guide prevention and control practices for chronic disease.

### III. Community Organizations/Advocates Objectives and Strategic Actions

**Objective 1D – Data on Effectiveness of Care:** By CY2016, at least five community-based organizations will enhance the data collection and reporting requirements among chronic disease grantees by incorporating key measures of effectiveness of care into the EHR format of the participating community-based organizations. This collaboration is expected to increase the quality of planning, improve service delivery, and support more effective quality improvement.

#### Strategic Actions

- Participate in the development of grantee data collection standards.
- Integrate community surveillance, and research information in accordance with DOH standards.

### IV. Private Sector/Business Objectives and Strategic Actions

**Objective 1E – Increased Data Sharing with Private Entities:** By CY2016, three private sector healthcare insurance businesses, including Medicaid Managed Care organizations, will provide DOH access to their chronic disease services utilization data, to be used for planning, improvement of service delivery, and increased effectiveness of quality improvement. Safeguards taken to ensure secure storage and transmission of data will encourage other similar businesses to participate in data collection.

#### Strategic Actions

- Healthcare insurance businesses will provide electronic health records (EHRs) to enhance planning and quality improvement strategies.

#### Outputs and Outcomes

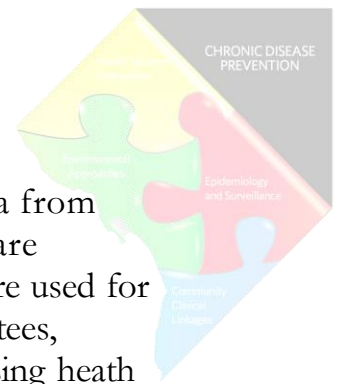
As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to, the following:

**Selected Possible Outputs:** GIS maps; modified and standardized data collection systems; data on special populations such as low - income, LEP, and priority populations; worksite wellness data; fact sheets and disease surveillance



documents; and identification of community high-risk zones.

**Selected Possible Outcomes:** Improved ability to collect and utilize data from healthcare system providers, community organizations, and healthcare insurance businesses on special populations, improved resources that are used for planning and distribution of resources, improved data standards for grantees, improved decision-making capacity of private sector business for purchasing health care benefits, and increased availability of chronic disease-related data.



## DOMAIN 2: ENVIRONMENTAL APPROACHES

### 1. Public Policy Guidance

**Goal:** The District of Columbia will develop and implement policies to support chronic disease prevention and control services by reducing environmental barriers to healthy behaviors, to help make healthy choices the easy choices.

#### I. Government Objectives and Strategic Actions

**Objective 2A – Environmental Barriers:** By CY2016, DOH will work with the Community Leadership Team to develop and implement a periodic process to review and update on a regular basis policies that address environmental barriers to healthy behaviors, to develop strategies to ensure the implementation of those policies, and to engage District residents to help remedy barriers and disparities that prevent communities from achieving healthy behaviors.

##### Strategic Actions

- Identify chronic disease priority areas through evidence-based approaches, including, but not limited to, obesity, cancer, diabetes, cardiovascular disease, stroke, hypertension, asthma, kidney disease.
- Identify policies to facilitate the elimination or reduction of environmental barriers to demonstrated methods of prevention and control of chronic disease, such as health promotion, physical activity, and breast-feeding. These should include nationally recognized best practices, as well as newer programs.
- Review and document evidence-based policy interventions in DC to prevent chronic disease, improve healthy behaviors, and improve access to health care related to environmental approaches.
- Review and update existing DOH plans
- Provide toolkits containing evidence-based information for key chronic disease policy issues to organizational members of the Community Leadership Team.
- Develop a three-year cycle for continuous review of policy, resources, and data issues, reviewing one each year (for example, policy in Year One, resources in Year Two, data in Year Three), to keep these areas current (see description under Statement of Need, p. 4).

**Objective 2B – Policy Toolkits:** By CY2016, DOH will work with the Community Leadership Team to develop evidence-based policy intervention toolkits to implement measurable interventions for the prevention and control of chronic

disease. These toolkits should be easy to read and understand for people with low literacy, adaptable to LEP populations, and should incorporate strategies already developed under other DOH grants and initiatives. The toolkits will be field tested before publication to ensure cultural and linguistic appropriateness, readability, and usefulness to potential audience.

### Strategic Actions:

- Assess skill sets of community organizations, especially those on the Community Leadership Team, to develop or use existing appropriate toolkits that will support implementation of measurable interventions.
- Assess stakeholder skill set capacity and needs every three years as part of the three-year assessment cycle (see description under Statement of Need, p. 4) and provide technical assistance in skill building as needed.
- Utilize and update existing community resource maps that use GIS technology to show shortages.

**Objective 2C – Worksite Wellness:** By CY2017, DOH will develop and implement a comprehensive worksite wellness program for DOH employees that support healthy eating, encourages regular physical activity, and supports preventive health services for DOH employees to address risk factors for chronic diseases.

### Strategic Actions

- Develop worksite wellness programs from existing evidence-based prototypes or new material as appropriate, and develop policies to support the health and well being of all employees.
- Create and disseminate a tool kit based on national best practices to employees to disseminate information on wellness activities (e.g., exercise and healthier foods).
- Develop and adopt worksite policies that encourage wellness activities such as walking and biking, indoor physical activities, healthy eating, and breast-feeding.
- Continue to implement and expand policies that improve access at work to healthy food.

**Objective 2D – Interagency Collaboration:** By CY2017, DOH will expand its ability to collaborate with other components of DOH and DC government involved in issues that affect the prevention and management of chronic disease. DOH will also work to increase the capacity of DOH to serve as a leader and role model in the promotion of workplace wellness, physical activity, and healthy eating.

### Strategic Actions

- Create a DOH Workplace Wellness Team that will develop or adapt materials

and encourage presentations and collaborations that promote physical activity and healthy eating throughout DOH and other agencies and offices of DC government.

- Through training and advocacy, expand capacity of DOH staff to serve as leaders across DC agencies to disseminate workplace wellness throughout DC government, as part of the Mayor's Initiative.
- Provide leadership and support for a citywide campaign, building on existing public, private, and community initiatives, to promote and facilitate outdoor activity as a strategy to promote health and prevent obesity and other chronic diseases.
- Assess barriers to workplace wellness in selected agencies and offices of DC government and work with those entities on strategies to reduce the barriers.
- Identify key DC government agencies linked with prevention and reduction of chronic disease; create and update an ongoing annual summary of key activities, initiatives, and resources of these agencies, available to all DOH personnel.

## II. Healthcare Delivery System Objectives and Strategic Actions

**Objective 2E – Barriers to Medical Treatment and Prevention:** By CY2017, DOH will work with members of the Community Leadership Team who are involved in the healthcare delivery system to develop and implement a plan to identify and address policies that affect prevention and treatment of chronic disease in the community.

### Strategic Actions

- Define key policy issues, review and assess current activities addressing these key policy issues.
- Modify actions based upon current best practice information such as the best practice tool kit, federal and local government technical assistance, and community task force recommendations.
- Evaluate modified actions to assess their impact on cancer and other chronic disease issues, organizations, and the broader community.

## III. Community Organizations/Advocates Objectives and Strategic Actions

**Objective 2F – Advocacy Agenda:** By CY2017, DOH will work with the Community Leadership Team to develop and implement an advocacy agenda to improve the environment for one chronic disease domain, such as epidemiology and surveillance, environmental approaches, health care systems, or community-clinical linkages, to improve policy and programs in that domain.

## Strategic Actions:

- Select one domain, identify community efforts in that area, and identify what needs to be done to support and strengthen community needs in that area.
- Identify existing programs, task forces, and other activities of DC government related to health and wellness promotion and work to link these entities, their efforts, and their findings.
- Define and implement strategies for community engagement.
- Define priorities and develop an advocacy plan to support disease management and prevention behaviors, especially in chronic disease high-risk zones, for issues such as:
  - Promotion of physical activities in nature;
  - Increased governmental funding of chronic disease prevention, treatment, and management;
  - Increased provider reimbursement for prevention and disease management;
  - Medicaid reimbursement for services such as nutrition counseling, community-based physical activity initiatives, evidence-based initiatives to support health eating and active living, and self-management education and support for diabetes and other conditions;
  - Education for primary care providers;
  - Transportation assistance;
  - Restaurant menu labeling;
  - Placement of blood pressure measurement stations in government buildings (DC, federal, post offices, schools) and private businesses (pharmacies, general retail);
  - Implementation of existing school policies for physical education and expansion of family nutrition training;
  - Promotion of “outdoors for health” concept;
  - Limitations on the promotion of tobacco and unhealthy foods to children using evidence-based best practices; and
  - Utilization of community-based social marketing to promote healthy living.
- Utilize the advocacy plan as a communication tool.
- Educate legislators and government officials about current key chronic disease management policies and programs, such as Restaurant Menu Labeling or Chronic Disease Self-Management.
- Identify and utilize community representatives to recount personal stories at key legislative events.
- Assess advocacy efforts by members of the Community Leadership Team and other community organizations and provide appropriate support and technical assistance to support these efforts.

## IV. Private Sector/Business Objectives and Strategic Actions

### Objective 2G – Initiative for Environmental Improvements in the Private Sector:

By CY2016, DOH will develop and implement at least one additional evidence-based outreach initiative that cuts across chronic diseases, such as active living or healthy eating, to support private businesses in addressing chronic diseases through environmental improvements.

#### Strategic Actions

- Identify key private sector business representatives who will participate in developing and implementing the community advocacy agenda and subsequent policy change efforts.
- Utilize the *Train the Trainer Model* in adoption of wellness policies.
- Partner with professional associations to support the development, implementation, and improvement of policy and advocacy efforts to address risk factors for chronic disease.
- Develop partnerships with the faith community to implement and support chronic disease activities.

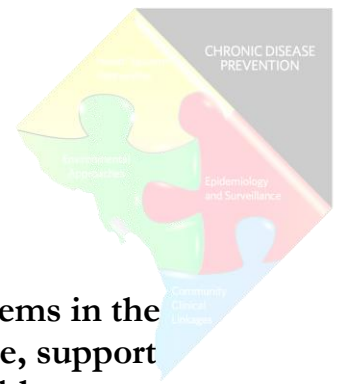
#### Outputs and Outcomes

As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to, the following:

**Selected Possible Outputs:** Best practice documents and toolkits, maps identifying community resources and shortages, training and technical assistance, identified policy issues, community advocacy agenda, and key policy advocates.

**Selected Possible Outcomes:** Community advocacy agenda implementation, policy change or initiation for healthcare provider reimbursement, placement of nutritional information in restaurants, supportive school health and nutrition policies, needle disposal programs, and funding and staffing allocation to Chronic Disease programs.

## DOMAIN 3: HEALTH CARE SYSTEMS



### 3. System Coordination and Capacity

**Goal: Improve the capacity of the public and private health care systems in the District to provide clinical services that prevent chronic disease, support early detection, manage risk factors, reduce and eliminate health disparities.**

#### I. Government Objectives and Strategic Actions

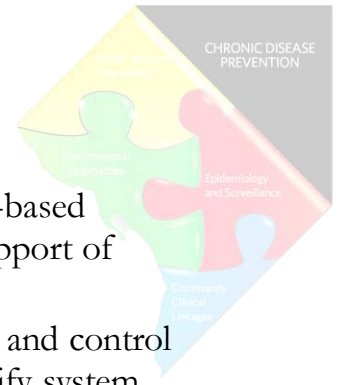
**Objective 3A – Coordinating Community Resources:** By CY2015, working with the Community Leadership Team, DOH will develop and implement a process for regularly assessing, planning, and coordinating the resources of the chronic disease prevention and control system among all stakeholders in DC. This process will improve our ability to coordinate program planning between DOH and the community, improve service integration, allow crosscutting and system-wide assessments, and advocate for the adoption of policies that will enhance capacity to improve the infrastructure needed to prevent and treat chronic diseases.

#### Strategic Actions

- Provide information about this Coordinated Chronic Disease State Action Plan to community-based organizations.
- Advocate for the allocation of funding and staffing resources to effectively implement the Coordinated Chronic Disease State Action Plan.
- Develop strategies to facilitate collaboration between DOH and the Department of Health Care Finance for the prevention and control of chronic disease, including the engagement of community-based organizations offering services that promote wellness, health eating, and physical activity.
- Strengthen strategies to facilitate collaboration between DOH and other key DC government agencies, such as the Department of Parks and Recreation, Office of Planning, Office of the State Superintendent of Education, that link with healthcare system coordination.
- As part of the Community Leadership Team, create and maintain appropriate technical and advisory teams that include community and consumer representatives.
- Ensure that relevant DC government contractors and grantees are required to participate in planning and integration activities.
- Develop recommendations and strategies for the integration of social services workers, case managers, community health workers, peer educators, and other health and social service services extenders into disease management teams and

programs in partnership with health system and community organizations/advocates stakeholders.

- Expand focus on policies, programs, and services, including school-based services that target children and youth, including promotion and support of breast-feeding.
- Periodically convene key sectors of the chronic disease prevention and control system to conduct a cross cutting, system-wide assessment to identify system strengths and weaknesses, determine future priorities, and modify interventions.



## II. Healthcare Delivery System Objectives and Strategic Actions

**Objective 3B – Improved Integration of Healthcare Services:** By CY2017, DOH will work with members of the Community Leadership Team involved in the healthcare delivery system to focus on improving assessment, joint planning, and service integration issues that affect service delivery and treatment within the healthcare system.

### Strategic Actions

- Expand and integrate the Community Leadership Team to include subcommittees, task forces, forums, or other means to help integrate the government sector planning process with those of the community, to develop common goals, limit programmatic duplication, expand needed services, and improve the quality of healthcare services and prevention efforts.
- Develop and implement an ongoing training curriculum for primary care providers, leveraging the skill set and resources of the Community Leadership Team, to improve the diagnosis, treatment, and referral to specialty care, of DC residents affected by chronic disease.
- Engage community organizations as partners with health care providers to develop and implement strategies to prevent unnecessary hospital readmissions and emergency department visits.

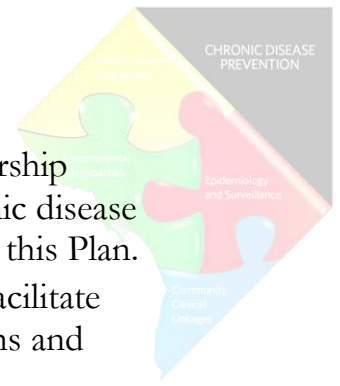
## III. Community Organizations/Advocates Objectives and Strategic Actions

**Objective 3C – Community Leadership Team:** By CY2015, DOH will build upon the existing Community Leadership Team to establish and maintain a Chronic Care Coalition to enhance system-wide planning to address chronic diseases, implement the Coordinated Chronic Disease State Action Plan, and conduct system-wide assessments. This may require further training and technical support.



## Strategic Actions

- Identify and recruit additional members for the Community Leadership Team, ensuring representation from wards with high rates of chronic disease and from organizations that serve special populations as defined in this Plan.
- Identify and implement strategies for community engagement, to facilitate and support involvement from grass-roots community organizations and residents.
- Establish guidelines for participation and operation for the Community Leadership Team.
- Establish mission, vision, and goals for the Community Leadership Team aligned with the Chronic Disease State Action Plan.
- Conduct quarterly meetings of the Community Leadership Team that result in specific actions related to the Chronic Disease State Action Plan.
- Continue to involve the Community Leadership Team in activities and reviews conducted to implement the Chronic Disease State Action Plan.



## IV. Private Sector/Business Objectives and Strategic Actions

**Objective 3D – Integrate Private Sector into Prevention and Control:** By CY2016, DOH and the Community Leadership Team will develop a continuous process to recruit and integrate private sector businesses to join the Community Leadership Team in order to coordinate and integrate chronic disease prevention, control programs, and services.

### Strategic Actions

- Identify and engage health champions from the business community in identifying key representatives for participation in the Community Leadership Team and to serve on advisory boards, task forces, and other forums.
- Recruit representatives from the food and beverage industry, as well as non-profits working to improve food access, to serve on the Community Leadership Teams committees and task forces and to plan and implement public policy and community interventions.
- Educate representatives from small and large businesses, as well as labor and labor management initiatives, to raise their awareness of the impact of chronic disease and potential strategies for chronic disease prevention and reduction. Leverage this awareness to increase private sector business participation in chronic disease related advisory boards, task forces, and other forums.
- Secure private sector support for citywide healthy living campaigns, including support of breast-feeding mothers in the workplace.

## Outputs and Outcomes

As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to the following:



**Selected Possible Outputs:** Funding and staffing allocated for DOH coordination and oversight role, online directory of key citywide initiatives related to chronic disease prevention and reduction, Community Leadership Team and Chronic Care Coalition, stakeholder forums, stakeholder recommendations and guidance with emphasis on special populations.

**Selected Possible Outcomes:** Improved planning, resource distribution, and coordination. Integration of chronic disease-related services and resources. Increased public awareness of chronic disease-related programs and services.

## 4. Quality of Healthcare

**Goal: Improve the ability of the DC healthcare system to deliver integrated, high-quality chronic disease care and to reduce/eliminate health disparities and inequities in DC**

### I. Government Objectives and Strategic Actions

**Objective 4A – Restructuring of Medical Care:** By CY2016, DOH and the Community Leadership Team will develop and implement a plan to promote the use of evidence-based prevention and disease management models to restructure the care delivered to populations with chronic diseases or at risk for chronic diseases.

#### Strategic Actions

- Ensure the periodic collection of data by race/ethnicity, gender, primary language, income, and other key variables, in order to monitor quality of services, treatment, and outcomes for special populations.
- Require District of Columbia government-contracted healthcare providers to use the Healthcare Effectiveness Data and Information Set (HEDIS) and other validated, comparable measures for performance feedback.
- Disseminate chronic disease care management resources to include information and tools such as:
  - Team-based care;
  - Unified standards of care;
  - Treatment algorithms; and
  - Chronic Disease Self-Management programs.
- Deliver technical assistance, including stakeholder summits, to facilitate the implementation of best practice models.

### II. Healthcare Delivery System Objectives and Strategic Actions

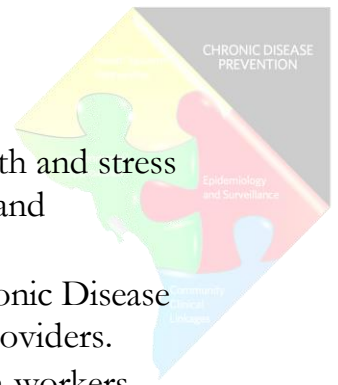
**Objective 4B – Expand Health Care Capacity:** By CY2017, DOH, with input from the Community Leadership Team, will develop and implement a program to improve the chronic disease care capacity of healthcare providers.

#### Strategic Actions

- Provide the Healthcare Effectiveness Data and Information Set (HEDIS) and other measures as feedback to healthcare providers (primary and specialty care).
- Assess the number of healthcare providers recognized by the National Committee for Quality Assurance (NCQA) in the Diabetes Physician Recognition Program and the Heart/Stroke Recognition Program.
- Implement task force recommendations, such as integration of social services,

case management, and patient navigation into chronic disease care.

- Research and implement recommendations to integrate mental health and stress reduction interventions into chronic disease prevention, reduction, and treatment.
- Promote the input of service information into the Cancer and Chronic Disease online resource directory, and promote utilization among service providers.
- Establish chronic disease action teams, including community health workers and mobile vans staffed by hospitals, Medicaid managed care partners, the Capitol Association of Diabetes Educators, primary care clinic staff, and other system partners, to deliver disease management and case management services in the chronic disease high-risk zones.
- Increase the number of healthcare providers in chronic disease relevant specialty areas who are culturally and linguistically competent to interact with low-income, minority, and LEP populations through the expansion of the J-1 visa program, DC Primary Care Association (DCPCA) Area Health Education Center (AHEC) program, the National Health Service Corps, and other volunteer organizations that send health care providers to underserved areas.
- Identify and document use of health information technology (e.g., electronic health records, patient portals, personal health records, mobile health applications) among special populations and assess impact on patient self-management, provider/patient communications, and improved health outcomes.
- Assist in the development of mechanisms that will develop and sustain community health centers, hospitals, and other provider-based locations with cadres of community health workers trained to assist with chronic disease management.
- Identify strategies that will increase community engagement in the prevention and reduction of chronic disease, including increased collaboration with community-based organizations, (such as faith-based institutions) with the capacity to reach large numbers of persons with high rates of health disparities.
- Increase the number of healthcare systems using evidence-based provider and patient reminder systems to increase utilization of cancer and other preventive health screenings.
- Increase the number of tobacco cessation interventions, especially in special populations in which tobacco use has remained constant or is increasing.
- Increase the promotion and support of breast-feeding and baby-friendly programs in healthcare settings.



### III. Community Organizations/Advocates Objectives and Strategic Actions

**Objective 4C – Patient Self-Sufficiency:** By CY2016, DOH, with input from the Community Leadership Team, will develop and implement a program to work with community organizations and advocates to promote patient empowerment and self-sufficiency, and self-care for individuals with chronic diseases and at risk for chronic diseases. Promote policies to support patient self-sufficiency, such as increased support for home health care services.

#### Strategic Actions

- Distribute multi-media (print, websites, on-line videos) chronic disease patient-provider interaction materials that are culturally-relevant and linguistically-appropriate using resources from members of the Community Leadership Team and other community-based organizations that may include:
  - National Diabetes Education Program (NDEP);
  - American Heart Association (AHA);
  - National Kidney Foundation (NKF);
  - American Cancer Society (ACS);
  - American Stroke Association (ASA); and
  - Other organizations with appropriate materials and social media approaches in relevant areas, such as asthma and obesity.
- Disseminate culturally-relevant and linguistically-appropriate cancer and chronic disease patient provider materials and social media in:
  - Chronic disease high-risk zones;
  - Community-based settings; and
  - Other locations that serve special populations such as Hispanic, African-American, seniors, low-income, caregiver, and LEP.
- Define and advocate for implementation of health care finance policies to promote self-sufficiency for disabled patients with chronic disease, such as increased support for home health care systems.

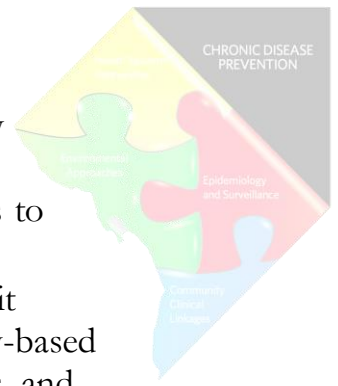
### IV. Private Sector/Business Objectives and Strategic Actions

**Objective 4D – Expand Healthcare Benefits to Cover Treatment and Prevention:** By CY2018, DOH, in conjunction with the Community Leadership Team, will work with District officials to encourage the adoption of evidence-based health benefit programs that address the health care needs of those with chronic diseases, as well as including benefits that address the ability to prevent chronic disease, such as support for healthy eating, increased physical activity, and tobacco cessation.

#### Strategic Actions

- Use data and technical assistance from chronic disease partners to review and modify health benefits.

- Promote the adoption of programs such as the National Pharmacy Association (NPA) Asheville Project and the Delmarva Foundation Medication Therapy Management project, which utilize pharmacists to deliver chronic disease management services.
- Research and promote the adoption and expansion of health benefit programs that increase access to healthy food, promote community-based physical activity, support a range of tobacco cessation interventions, and support and promotion of breast-feeding.



## Outputs and Outcomes

As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to, the following:

**Selected Possible Outputs:** Culturally-appropriate healthcare provider and patient education print materials and social media, evidence-based disease management models, healthcare quality improvement programs, technical assistance and training, social services for disease management, expansion of J-1 visa program, chronic disease healthcare action teams, evidence-based pharmacy benefits and programs, and dissemination of standards of care, treatment algorithms, and primary prevention methods.

**Selected Possible Outcomes:** Improved disease management, increased number of providers that offer appropriate primary prevention and treatment for chronic diseases, increased number of healthcare providers in chronic disease specialty areas that are culturally competent and linguistically appropriate for non-English speaking populations, improved pharmaceutical adherence, improved access to healthy foods, physical activity, stress reduction, and tobacco cessation interventions, improved quality of life for affected residents, and reduction in health system costs.

## DOMAIN 4: COMMUNITY-CLINICAL LINKAGES

### 5. Community Outreach and Education

**Goal: Facilitate access to chronic disease outreach and education, with focused attention on special populations such as seniors, low-income, African-American, Hispanic, limited English proficiency (LEP), and LGBT.**

#### I. Government Objectives and Strategic Actions

**Objective 5A – Materials for Special Populations:** By CY2015, DOH, in cooperation with the Community Leadership Team, will develop and implement a plan to increase the number of chronic disease policies, programs, and information materials that serve special populations, such as low-income, Hispanic, African-American, LEP, children and youth, children with special needs, seniors, and sexual minorities, especially in high-risk zones and other community-based locations. The programs and materials will be designed for ease of evaluation, and an evaluation component will be included in the plan.

#### Strategic Actions

- Ensure compliance with the Language Access Act of 2004.
- Identify and implement strategies to share information, such as the creation of a resource exhibit display unit that raises awareness about the risks, prevention, and treatment of chronic disease and can be used to deliver information and materials at community events such as health and community fairs, and other community-based events.
- Leverage media efforts among members of the Community Leadership Team and other chronic disease stakeholders to create a well-coordinated multi-year media campaign that communicates risk factors, burdens, and responses to health crises related to particular types of chronic diseases. (e.g., the recognition of signs and symptoms of a heart attack or stroke and when to dial 911).
- Develop and provide community grants to community-based organizations: implement culturally-relevant and linguistically-appropriate chronic disease education programs, such as a “Lifestyle Balance” program, an evidence-based 16-week program addressing pre-diabetes that serves men with cancer and/or chronic disease, focusing on low income, African American, and men with limited English proficiency (LEP).
- Provide technical assistance to business and community-based organizations to support their outreach and education efforts.
- Support and expand existing programs and plans addressing kidney disease, asthma, obesity, inappropriate use of infant formula, and other risk factors

of chronic disease.

- Expand programs sponsored by DOH into all eight wards of the city, with special focus on the wards with the highest rates of chronic disease.
- Develop and provide grants to community-based organizations that implement programs and initiatives to prevent and reduce chronic disease morbidity and mortality.
- Evaluate and assess the effectiveness of community outreach and education efforts using outcomes data as key measures of success.
- Identify resources to engage DC residents, particularly in wards with high chronic disease rates, as health and social service extenders, such as park ambassadors/rangers, community health workers, peer educators, lay health assistants, translators, and other kinds of service extenders.



### **Objective 5B – Communication to Promote Healthy Eating and Active Living:**

By CY2016, DOH, with input from the Community Leadership Team, will develop and implement a multi-year health communication program that can be shown to effectively support and promote healthy eating and active living within neighborhoods with highest rates of chronic disease.

#### **Strategic Actions**

- With the Community Leadership Team, plan and implement a multi-year policy and behavior changing information campaign that reaches target audiences and promotes healthy eating and active living.
- Explore innovative mechanisms to obtain financial support to design and implement a community-based social marketing campaign to promote healthy eating, using both conventional approaches and “new media” targeted to youth (Internet, Twitter, etc.) and engaging community organizations and residents, including youth, to assist in the design and evaluation of the campaign.
- Identify policies to limit the promotion of tobacco to children, limit the promotion of unhealthy foods, and promote and support breast-feeding, using evidence-based best practices from across the country.

## **II. Healthcare Delivery System Objectives and Strategic Actions**

**Objective 5C – Healthcare Needs of Special Populations:** By CY2015, DOH, with input from the Community Leadership Team, will develop and implement a plan to enhance the ability of the healthcare system to meet the needs of special populations, such as seniors, low-income, African-American, Hispanic, and other individuals with limited English proficiency (LEP). Feedback from the populations served will be incorporated in the evaluation, to improve access and acceptability.



## Strategic Actions

- Increase the number of culturally relevant and linguistically appropriate community health workers trained in chronic disease prevention and control by:
  - Building on recommendations in the Brookings Institute Policy Brief for the Medical Homes DC Area Health Education Center (AHEC); and
  - Engaging community-based organizations in identifying effective approaches and strategies for increasing the numbers of community health workers and expanding their reach and impact.
- Health system providers will refer patients to community programs.
- Chronic Disease Action Teams will deliver disease management, case management, and education services in areas that have been identified as chronic disease high-risk zones.
- Chronic Disease Action Teams will use community health workers, peer educators, and other health and social service extenders to promote action team services at the neighborhood level.
- Develop and implement training modules for primary care providers, including community health workers, to raise awareness about risks, how to prevent chronic disease, and treatment options that are available.
- Promote usage of smoking cessation services, including those covered by Medicaid.
- Seek opportunities to build more strategic partnerships, for example with faith-based organizations, to more effectively reach larger numbers of individuals within the targeted populations.
- Increase the number of healthcare providers who practice *Ask, Advise, and Refer* to reduce tobacco usage.

### III. Community Organizations/Advocates Objectives and Strategic Actions

**Objective 5D – Community Outreach and Education Events:** By CY2016, DOH, with input from the Community Leadership Team, will develop and implement a plan for a continuous schedule of outreach and education events focused on chronic disease, to encourage community residents to participate in and adopt healthy behaviors, and to support advocacy efforts to increase supportive environments that encourage physical activity, healthy eating, and other behaviors that decrease the risk of chronic disease. On-going programs will be included in the plan, and an evaluation component will be developed.

#### Strategic Actions:

- Participate in an assessment that identifies the root causes, barriers, and solutions related to chronic disease prevention and control in high-risk

zones.

- Identify strategies to support community champions to promote new and existing chronic disease outreach and education programs such as: *Lifestyle Balance*, Chronic Disease Action Teams, faith-based programs, The *Diabetes for Life* Learning Center, the Quitline, and evidence-based community mobilization activities, such as walking clubs. Support funding for these programs.
- Support the development and implementation of the chronic disease social marketing campaign by participating in the pre-testing of campaign materials, message development, and message dissemination.
- Educate community members on smoking cessation services that are covered through Medicaid and other financial assistance programs available to prevent and treat chronic disease.
- Investigate and document need for increased resources to support smoking cessation service; explore the need for new strategies to reduce tobacco consumption.
- Develop technical assistance (TA) and integrate into organizational policy, systems and procedures.
- Promote healthy behaviors, new programs, and referrals to appropriate and existing chronic disease programs.

#### IV. Private Sector/Business Objectives and Strategic Actions

**Objective 5E – Expand Workplace Wellness in the Private Sector:** By CY2016, DOH, with input from the Community Leadership Team, will develop and implement a plan to encourage businesses in each ward to promote existing health behavior resources and adopt at least one new wellness program or initiative.

##### Strategic Actions

- Encourage the use of the Quitline to reduce tobacco use.
- Incorporate chronic disease risk reduction and wellness programs such as the American Heart Association (AHA) *Start and Fit Friendly Company* designation, the National Diabetes Education Program (NDEP) *Diabetes at Work* program, CDC Worksite Wellness Toolkit, and the National Kidney Foundation (NKF) *KEEP Healthy* program.
- Support businesses participating in social marketing campaigns, such as efforts to promote increased access to healthy food.
- Encourage businesses to install automatic external defibrillators (AEDs) at worksite locations, and train staff in cardiopulmonary resuscitation (CPR) and the use of AEDs.
- Encourage development and piloting of mobile health care applications and other forms of health information technology for DC residents, particularly in wards with high chronic disease rates.

## Outputs and Outcomes

As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to, the following:

**Selected Possible Outputs:** Culturally- and linguistically-appropriate community disease management programs and community health workers, coordinated media efforts, community grants, culturally appropriate educational materials (brochures, PSAs, posters, etc.), community champions, toolkits, and other business resources for benefit planning.

**Selected Possible Outcomes:** Increased knowledge and awareness of chronic disease risk factors and complications, improved health disease management behaviors, and reductions in preventable necessary healthcare utilization.



## 6. Prevention and Testing

**Goal: Promote early detection and primary prevention of chronic disease among individuals with elevated risk.**

### I. Government Objectives and Strategic Actions

**Objective 6A – Intergovernmental Coordination:** By CY2016, DOH, with input from the Community Leadership Team, will write and activate a plan to increase coordination of the development, implementation, and evaluation of chronic disease prevention and testing efforts through partnerships, technical assistance, and grants. This will include developing a process for on-going coordination of chronic disease efforts within DOH, and also, with other DC government agencies, such as the Department of Parks and Recreation, the Office on Aging, the Office on Planning, the Office of the State Superintendent of Education (OSSE), and the DOH Child and Adolescent School Health Bureau (CASH).

#### Strategic Actions

- Develop new partnerships and strengthen existing partnerships with the Community Leadership Team and other stakeholders to identify, diagnose, treat, and refer persons at high-risk for chronic disease.
- Provide technical assistance and training to members of the Community Leadership Team regarding best practices for prevention, testing, and use of cost-effectiveness data, and use of cost-savings data.
- Provide grants for and support research of chronic disease early detection, prevention, and reduction programs, focusing on special populations such as seniors, low-income, Hispanics, African-American, and LEP residents at high-risk for chronic disease.
- Provide community-based chronic disease primary prevention grants to promote healthy eating and increased physical activities.

### II. Healthcare Delivery System Objectives and Strategic Actions

**Objective 6B – Improve Primary Prevention:** By CY2017, DOH, with input from the Community Leadership Team, will assess primary prevention services in DC for their ability to address the risks of chronic disease, and to develop and implement a plan to improve the capacity of the local healthcare system to deliver primary prevention services that help lower the risk of chronic disease.

#### Strategic Actions

- Encourage medical and nursing schools to incorporate standards of care into primary prevention training curricula.

- Train medical and nursing association members to provide primary prevention for chronic diseases.
- Provide training to DC government-contracted entities on evidenced-based practices of chronic disease primary prevention.
- Increase collaboration with the Department of Health Care Finance to strengthen primary care standards of care in Medicaid managed care contracts.
- Implement and evaluate the effectiveness of chronic disease primary prevention services.
- Partner with healthcare systems that promote and evaluate the effectiveness of chronic disease prevention services and standards of care such as the *Kidney Disease Improving Global Outcomes (KDIGO)* and *Guideline Advantage* programs. Refer patients to community-based chronic disease primary prevention programs and track their progress.
- When appropriate, require DC government-contracted entities to screen high-risk individuals for pre-diabetes and other risk factors for chronic disease, and develop mechanisms for follow-up care.

### III. Community Organizations/Advocates Objectives and Strategic Actions

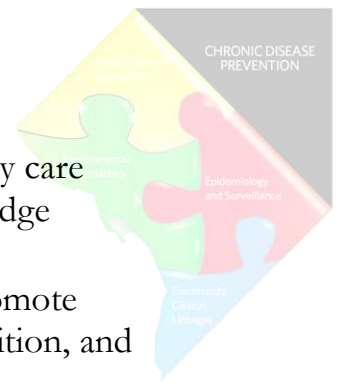
**Objective 6C – Raise Community Awareness of Early Detection:** By CY2016, DOH, with substantial participation by the members of the Community Leadership Team, will develop and implement a plan to increase community messages, programs, and services that raise awareness of early detection, prevention, and treatment, including pre-diabetes, pre-hypertension, nutrition, and physical activity, in order to motivate high-risk individuals to take action to protect their health.

#### Strategic Actions:

- Implement a community-screening program in wards with high chronic disease rates, linked with providers of healthcare services, to promote and encourage the use of medical homes, especially by special populations.
- Implement chronic disease primary prevention programs, such as wellness programs in partnership with healthcare plans and providers, for individuals with pre-diabetes, pre-hypertension and other important high-risk conditions.
- Utilize community champions to aid in the dissemination of chronic disease primary prevention community messages and use of chronic disease screening and primary prevention services.
- Utilize community health workers, patient navigators, peer educators, and other health and social service to engage hard-to-reach, high-risk groups

and connect them with medical homes.

- Develop and distribute evidence-based training modules to primary care providers and community health workers, to disseminate cutting-edge methods to detect, prevent, and treat chronic disease.
- Help organize and engage local residents in each ward who will promote healthy living activities such as weight management programs, nutrition, and physical activity.
- Working with the Community Leadership Team, assess availability of access to healthy food and opportunities for physical activity, and provide input on progress implementing the Coordinated Chronic Disease State Action Plan.



#### IV. Private Sector/Business Objectives and Strategic Actions

**Objective 6D – Workplace Wellness at DOH:** By CY2016, DOH will develop and disseminate a list of guidelines to encourage District government employers to provide worksite primary prevention programs, policies, and environmental supports that promote physical activity and healthy nutrition.

##### Strategic Actions

- Work with employers regarding their health plans on reimbursement for chronic disease primary prevention screening and services such as reimbursement for physical activity, nutrition, community-based weight management programs and support groups, counseling, wellness coaching, tobacco cessation interventions, and related problem solving.
- Create supportive working environments that offer flextime for employees to engage in physical activity programs during the workday.
- Develop strategic plans for DC government employers, Federal offices, large private employers, including labor unions and unionized shops, and small businesses to identify and implement workplace wellness initiatives.

##### Outputs and Outcomes

As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to the following:

**Selected Possible Outputs:** Guidance documents and evidenced-based documents, training and technical assistance, community primary prevention programs, worksite prevention programs, and an increased number of trained community health workers.

**Selected Possible Outcomes:** Supportive prevention policies, increased knowledge about chronic disease, an increase in healthy practices among the

affected population, and an increased number of high-risk residents who have a prevention-focused medical home.

## 7. Children, Adolescent, and Guardian Services

**Goal: DOH will collaborate with public, chartered, and private school boards and school staff, early childhood centers, and other agencies outside the school system to implement comprehensive health promotion approaches to influence the development and implementation of healthy policies for children and youth in the District.**

### I. Government Objectives and Strategic Actions

**Objective 7A – School System Strategies:** By CY2015, DOH will continue to implement strategic partnerships with the DC school system and other community partners to carry out goals, objectives, and strategies for increasing healthy eating and physical activity legislated under the DC 2010 Healthy Schools Act and as defined within major multi-year CDC grants that link the prevention of chronic disease with improving school health. DOH and the Community Leadership Team will explore strategies for supplementing and strengthening these efforts.

#### Strategic Actions

- Increase DOH collaboration with existing committees established to monitor implementation of the DC Healthy Schools Act.
- Lead citywide initiative to inform DC residents about risk factors for chronic disease in children, including obesity and overweight.
- DOH Cancer and Chronic Disease Bureau staff meet with the DOH Child, Adolescent, and School Health (CASH) Bureau on issues unrelated to nutrition and physical activity, but related to chronic disease
- Collaborate with the Office of the State Superintendent of Education (OSSE) to conduct a needs assessment of educational settings and after school programs to support efforts to improve nutrition, increase physical activity, and contribute to chronic disease prevention. Collaborate with OSSE and CASH to develop guidelines for chronic disease curricula.
- Provide technical assistance to OSSE for the development and/or review of school health curricula.
- Work with CASH and OSSE to educate school system personnel, healthcare providers, and parents/guardians on chronic disease healthcare guidelines.
  - Use existing guidelines or adapt as appropriate to a school-based audience.
  - Collaborate with parent groups to increase awareness of and engagement in school-based physical education, physical activity, and nutrition programs and policies.
- Promote expansion of school health facilities, in partnership with healthcare systems and providers.



- Disseminate to community partners and parent support groups relevant regulations, guidelines, and evidence-based practices on youth-related chronic diseases.

**Objective 7B – Needs of Children/Youth Outside School:** By CY2016, DOH in collaboration with the Community Leadership Team, will identify additional governmental strategic needs outside the early childhood and school systems that affect the health of DC children and youth and develop policy and program recommendations to address these needs.

### Strategic Actions

- Identify the chronic health care needs of children and youth in the foster care system.
- Identify mental health need of children and youth that affect chronic disease prevention and treatment; establish collaboration with the Department of Behavioral Health, and develop and implement policy and program recommendations to address these needs.
- Support funding of programs that target children at high-risk for chronic disease and their parents/guardians/ caregivers (i.e. Project Power, youth and parent support groups, diabetes camps, Project Move, Kids for Kidneys, and YMCA PhD programs, breast-feeding programs).

## II. Healthcare Delivery System Objectives and Strategic Actions

**Objective 7C – Standards of Care for Youth and Adolescents:** By CY2017, DOH will work with the four Medicaid managed care organizations in DC to support the adoption of evidence-based standards of care and treatment algorithms for the prevention and control of chronic disease in youth and adolescents.

### Strategic Actions

- Develop and implement an initiative with the Department of Health Care Finance to develop standards of care, including best practices, for the prevention and treatment of chronic disease for children, youth, and families.
- Collaborate with Community Leadership Team to develop an action agenda for working with the Medicaid managed care organizations about prevention and treatment of chronic disease for children, youth, and families.
- Contracted entities will conduct mandatory screening of youth/adolescents using existing measures of childhood and adolescent chronic disease risk profiles.
- Identify and address service gaps, such as treatment services for obese children and encouragement of breast-feeding in healthcare settings and in the workplace.
- Collaborate with Medicaid managed care organizations to create integrated, patient centered programs with comprehensive continuums of care designed to

help members to maintain, restore or improve their health, including evidence-based intensive lifestyle modification programs for youth at risk for chronic disease.

### III. Community Organizations/Advocates Objectives and Strategic Actions

**Objective 7D – Outreach to Youth:** By CY2015, DOH will continue to work with at least five community-based organizational partners to provide outreach and activities designed to improve health and prevent chronic disease among youth/adolescents and their parents/guardians.

#### Strategic Actions:

- Community-based organizations will serve on the youth chronic disease subcommittee.
- Continue to participate in programs that can have a positive impact on the quality, clinical outcomes and cost effectiveness of chronic disease care of youth/adolescents, such as Project Power, DC Action for Healthy Kids, Project Move, Kids for Kidneys, youth and parent support groups.
- Support the dissemination of media and social marketing efforts that target youth and adolescents at-risk for chronic disease.
- Continue to support and expand parent and guardian social network resource programs that provide a safe and secure outlet for parents and guardians to share experiences, lesson learned, tips for how to deal with difficult situations, and other key aspects of chronic disease management for youth, especially in neighborhoods with highest levels of health disparities.
- Engage the community in the identification of a high profile, celebrity spokesperson to promote a chronic disease prevention effort that is tied to the parent and guardian support network in the District.

**Objective 7E – Outdoor Opportunities for Children:** By CY2015, DOH, in collaboration with the Community Leadership Team, will support the use of the outdoors to increase opportunities for physical activity among children, youth, families, and adults, as recommended by the American Academy of Pediatrics.

#### Strategic Actions:

- Work with community-based partners to assess opportunities for physical activity, especially within chronic disease high-risk zones.
- Identify and support implementation of existing initiatives and appropriate additional programs.

## IV. Private Sector/Business Objectives and Strategic Actions

**Objective 7F – Workplace Support of Families:** By CY2016, at least three private business entities will be identified to empower and support a working environment for parents and guardians of children with chronic diseases.

### Strategic Actions

- Develop and implement policies that support parents and guardians caring for children with chronic disease.
- Encourage and empower all employers to provide insurance coverage of all healthcare services for children at high risk for chronic disease.
- Provide training on how parents can create safe and supportive environments that promote a healthy child development.
- Promote mobile health application development contests for youth, sponsored by health information technology and other IT vendors.
- Promote programs that support breast-feeding mothers in the workplace.

### Outputs and Outcomes

As the plan is implemented, outputs and outcomes will be selected and quantified to demonstrate the progress of implementation. These outputs and outcomes may include, but are not limited to, the following:

**Selected Possible Outputs:** Modified tracking forms, school-care guidelines and regulations, case management services, youth chronic disease subcommittees, youth advocacy champions, and youth-related camps and programs.

**Selected Possible Outcomes:** Increased number of healthcare providers qualified to provide appropriate care for youth and adolescents with chronic disease and at-risk for chronic disease; increased availability of youth-related programs that promote healthy habits; increased preventive practices for youth such as physical activity and improved nutrition; and improved management measures, such as A1C control, for youth with chronic disease and those at risk for chronic disease.



## 8. Evaluation

The District of Columbia Chronic Disease State Action Plan will be accompanied by an evaluation plan, with a focus on monitoring the progress towards the achievement of program goals, objectives and long-term results.

The plan assessment will include:

- 1) Evaluation questions of both the process and impact levels;
- 2) Results and measurable indicators of chronic disease;
- 3) Data sources (as available); and
- 4) Baseline and target indicators important to the District of Columbia.

Annual updates will be provided for the District of Columbia Chronic Disease State Action Plan. Major achievements and outcomes of DOH and related programs risk factors will be documented, as well as support of our partners for our evidence-based programs.

The evaluation plan is a work in progress—much in the same manner as the State Action Plan itself. It will be modified and amended as objectives are met or new opportunities arise.

The following evaluation goals will be used to better support the progress of the evidence-based Cancer and Chronic Disease programs:

- Goal 1:** Evaluate the effects of evidence-based programs, using indicators of health-related quality of life and functional status of District residents. Rate the impact of evidence-based programs, using indicators of health-related quality of life and functional status of District of Columbia residents.
- Goal 2:** Evaluate the impact of evidence-based programs, using indicators of health-related quality of life and functional status of District of Columbia residents.
- Goal 3:** In order to evaluate major health disparities among wards in the District, we will identify the gaps and barriers in obtaining comprehensive needs assessments.
- Goal 4:** Establish benchmarks for reducing health disparities across the District of Columbia.
- Goal 5:** Evaluate the adoption and long-term maintenance of healthy lifestyles and effective prevention services (e.g., promoting physical activity, healthy eating patterns, proper weight, and effective healthcare) of residents with chronic diseases. Analysis will focus on how long-term effective lifestyle messaging in community settings will improve quality of life for residents living with a chronic disease.



## 9. Sustainability

The District of Columbia Chronic Disease State Action Plan will also be accompanied by a sustainability plan, with a focus on maintenance and expansion of efforts. The sustainability plan will include the following:

- 1) Support leadership and guidance in defining and monitoring the chronic disease surveillance and monitoring system;
- 2) Support for outreach and engagement of the community in utilization of services and improvements in population health; and
- 3) Develop, sustain, and expand capacity to advance chronic disease prevention and health promotion in the District of Columbia.

Like the District of Columbia Chronic Disease State Action Plan itself and the evaluation plan, the sustainability plan is a work in progress, and updates to the sustainability plan will be incorporated into the annual updates of the State Action Plan. These updates will document our progress in finding ways to support, sustain, and expand our cancer and chronic disease programs throughout the community.

The following goals will be used to measure our sustainability efforts:

- Goal 1:** Complete and maintain an accessible comprehensive chronic disease surveillance and evaluation system that includes the identification of disparities, supports comprehensive data analysis, results in strategic interpretation and dissemination of findings, addresses programmatic goals and objectives and is utilized for planning, implementing and evaluating chronic disease program activities.
- Goal 2:** Support engagement of individuals in their efforts to reach optimal health through multiple, frequent, and culturally appropriate channels for engaging individuals in prevention and self-management strategies.
- Goal 3:** Develop capacity to advance chronic disease prevention and health promotion in the District of Columbia, including leadership, management, training, leveraging of resources, and increasing partnerships. Capacity includes both resources and technical expertise, and it is the key to long-term sustainability of health and disease prevention in all sectors of our community.

## OBJECTIVES BY YEAR

In this section, the Objectives are grouped by year of projected implementation, to enable readers and planners to better envision the activities included in the Chronic Disease State Action Plan.

### CY2015

- Objective 3A – Coordinating Community Resources:** Working with the Community Leadership Team, DOH will develop and implement a process for regularly assessing, planning, and coordinating the resources of the chronic disease prevention and control system among all stakeholders in DC. This process will improve our ability to coordinate program planning between DOH and the community, improve service integration, allow crosscutting and system-wide assessments, and advocate for the adoption of policies that will enhance capacity to improve the infrastructure needed to prevent and treat chronic diseases.
- Objective 3C -- Community Leadership Team:** DOH will build upon the existing Community Leadership Team to establish and maintain a Chronic Care Coalition to enhance system-wide planning to address chronic diseases, implement the Coordinated Chronic Disease State Action Plan, and conduct system-wide assessments. This may require further training and technical support.
- Objective 5A – Materials for Special Populations:** DOH, in cooperation with the Community Leadership Team, will develop and implement a plan to increase the number of chronic disease policies, programs, and information materials that serve special populations, such as low-income, Hispanic, African-American, LEP, children and youth, children with special needs, seniors, and sexual minorities, especially in high-risk zones and other community-based locations. The programs and materials will be designed for ease of evaluation, and an evaluation component will be included in the plan.
- Objective 5C – Healthcare Needs of Special Populations:** DOH, with input from the Community Leadership Team, will develop and implement a plan to enhance the ability of the healthcare system to meet the needs of special populations, such as seniors, low-income, African-American, Hispanic, and individuals with limited English proficiency (LEP). Feedback from the populations will be incorporated in the evaluation, to improve access and acceptability.
- Objective 7A – School System Strategies:** DOH will continue to implement strategic partnerships with the DC school system and other community partners to carry out goals, objectives, and strategies for increasing healthy eating and physical activity legislated under the DC 2010 Healthy Schools Act and as defined within major multi-year CDC grants that link the prevention of chronic disease with improving school health. DOH and the Community Leadership Team will explore strategies for supplementing and strengthening these efforts.

- **Objective 7D – Outreach to Youth:** DOH will continue to work with at least five community-based organizational partners to provide outreach and activities designed to improve health and prevent chronic disease among youth/adolescents and their parents/guardians.
- **Objective 7E – Outdoor Opportunities for Children:** DOH, in collaboration with the Community Leadership Team, will support the use of the outdoors to increase opportunities for physical activity among children, youth, families, and adults, as recommended by the American Academy of Pediatrics.

## CY2016

- **Objective 1C – Expand Use of Electronic Health Records:** DOH will work with at least four additional healthcare system providers to adopt electronic health records (EHR) to improve the collection and updating of institutional healthcare data, facilitate transmission of data to DOH, and ensure security in the collection, transmission, and storage of data. The EHR format will incorporate key measures of effectiveness of care. Data transmitted to DOH will be de-identified before transmission.
- **Objective 1D – Data on Effectiveness of Care:** At least five community-based organizations will enhance the data collection and reporting requirements among chronic disease grantees by incorporating key measures of effectiveness of care into the EHR format of the participating community-based organizations. This collaboration is expected to increase the quality of planning, improve service delivery, and support more effective quality improvement.
- **Objective 1E – Increased Data Sharing with Private Entities:** Three private sector healthcare insurance businesses, including Medicaid Managed Care organizations, will provide DOH access to their chronic disease services utilization data, to be used for planning, improvement of service delivery, and increased effectiveness of quality improvement. Safeguards taken to ensure secure storage and transmission of data will encourage other similar businesses to participate in the data collection.
- **Objective 2A – Environmental Barriers:** DOH will work with the Community Leadership Team to develop and implement a periodic process to review and update on a regular basis policies that address environmental barriers to healthy behaviors, to develop strategies to ensure the implementation of those policies, and to engage DC residents to help remedy barriers and disparities that prevent communities from achieving healthy behaviors.
- **Objective 2B – Policy Toolkits:** DOH will work with the Community Leadership Team to develop evidence-based policy intervention toolkits to implement measurable interventions for the prevention and control of chronic disease. These toolkits should be easy to read and understand for people with low literacy, adaptable to LEP populations, and should incorporate strategies already developed

under other DOH grants and initiatives. The toolkits will be field tested before publication to ensure cultural and linguistic appropriateness, readability, and usefulness to potential audience.

- **Objective 2C – Worksite Wellness:** DOH will develop and implement a comprehensive worksite wellness program for DOH employees that supports healthy eating, encourages regular physical activity, and supports preventive health services for DOH employees to address risks factors for chronic diseases.
- **Objective 2G – Initiative for Environmental Improvements in the Private Sector:** DOH will develop and implement at least one additional evidence-based outreach initiative that cuts across chronic diseases, such as active living or healthy eating, to support private businesses in addressing chronic diseases through environmental improvements.
- **Objective 3D – Integrate Private Sector into Prevention and Control:** DOH and the Community Leadership Team will develop a continuous process to recruit and integrate private sector businesses to join the Chronic Care Coalition in order to coordinate and integrate chronic disease prevention, control programs, and services.
- **Objective 4A – Restructuring of Medical Care:** DOH and the Community Leadership Team will develop and implement a plan to promote the use of evidence-based prevention and disease management models to restructure the care delivered to populations with chronic diseases or at risk for chronic diseases.
- **Objective 4C – Patient Self-Sufficiency:** DOH, with input from the Community Leadership Team, will develop and implement a program to work with community organizations and advocates to promote patient empowerment and self-sufficiency, and self-care for individuals with chronic diseases and at risk for chronic diseases. Promote policies to support patient self-sufficiency, such as increased support for home health care services.
- **Objective 5B – Communication to Promote Healthy Eating and Active Living:** DOH, with input from the Community Leadership Team, will develop and implement a multi-year health communication program that can be shown to effectively support and promote healthy eating and active living within neighborhoods with highest rates of chronic disease.
- **Objective 5D – Community Outreach and Education Events:** DOH, with input from the Community Leadership Team, will develop and implement a plan for a continuous schedule of outreach and education events focused on chronic disease, to encourage community residents to participate in and adopt healthy behaviors, and to support advocacy efforts to increase supportive environments that encourage physical activity, healthy eating, and other behaviors that decrease the risk of chronic disease. On-going programs will be included in the plan, and an evaluation component will be developed.
- **Objective 5E – Expand Workplace Wellness in the Private Sector:** DOH, with input from the Community Leadership Team, will develop and implement a plan to



encourage businesses in each ward to promote existing health behavior resources and adopt at least one new wellness program or initiative.

- **Objective 6A – Intergovernmental Coordination:** DOH, with input from the Community Leadership Team, will write and activate a plan to increase coordination of the development, implementation, and evaluation of chronic disease prevention and testing efforts through partnerships, technical assistance, and grants. This will include developing a process for on-going coordination of chronic disease efforts within DOH, and also with other DC government agencies such as Department of Parks and Recreation, the Office on Aging, and the Office on Planning.
- **Objective 6C – Raise Community Awareness of Early Detection:** DOH, with substantial participation by the members of the Community Leadership Team, will develop and implement a plan to increase community messages, programs, and services that raise awareness of early detection, prevention, and treatment, in order to motivate high-risk individuals to take action to protect their health.
- **Objective 6D – Workplace Wellness at DOH:** DOH will develop and disseminate a list of guidelines to encourage District government employers to provide worksite primary prevention programs, policies, and environmental supports that promote physical activity and healthy nutrition.
- **Objective 7B – Needs of Children/Youth Outside School:** DOH, in collaboration with the Community Leadership Team, will identify additional governmental strategic needs outside the early childhood and school systems that affect the health of DC children and youth and develop policy and program recommendations to address these needs.
- **Objective 7F – Workplace Support of Families:** At least three private business entities will be identified to empower and support a working environment for parents and guardians of children with chronic diseases.

## CY2017

- **Objective 1A – Centralized Surveillance System:** DOH, with substantial input from the Community Leadership Team, will develop and implement a centralized surveillance system to report DC chronic disease data, in order to improve programs and population health.
- **Objective 1B – Annual Update of Surveillance:** DOH, in collaboration with the Community Leadership Team, will update surveillance, evaluation, and research information annually, to facilitate community planning, increase the quality of services for chronic disease patients, and improve community health programs for those living with chronic disease or at risk for chronic disease.
- **Objective 2D – Interagency Collaboration:** DOH will expand its ability to collaborate with other components of DOH and DC government involved in issues that affect the prevention and management of chronic disease. DOH will also work to increase its capacity to serve as a leader and role model in the promotion of workplace wellness, physical activity, and healthy eating.

- **Objective 2E – Barriers to Medical Treatment and Prevention:** DOH will work with members of the Community Leadership Team who are involved in the healthcare delivery system to develop and implement a plan to identify and address policies that affect prevention and treatment of chronic disease in the community.
- **Objective 2F – Advocacy Agenda:** DOH will work with the Community Leadership Team to develop and implement an advocacy agenda to improve the environment for one chronic disease domain, such as epidemiology and surveillance, environmental approaches, health care systems, or community-clinical linkages, to improve policy and programs in that domain.
- **Objective 3B – Improved Integration of Healthcare Service:** DOH will work with members of the Community Leadership Team who are involved in the healthcare delivery system to focus on improving assessment, joint planning, and service integration issues that affect service delivery and treatment within the healthcare system.
- **Objective 4B – Expand Healthcare Capacity:** DOH, with input from the Community Leadership Team, will develop and implement a program to improve the chronic disease care capacity of healthcare providers.
- **Objective 6B -- Improve Primary Prevention:** DOH, with input from the Community Leadership Team, will assess primary prevention services in DC for their ability to address the risks of chronic disease, and to develop and implement a plan to improve the capacity of the local healthcare system to deliver primary prevention services that help lower the risk of chronic disease.
- **Objective 7C – Standards of Care for Youth and Adolescents:** DOH will work with the four Medicaid managed care organizations in DC to support the adoption of evidence-based standards of care and treatment algorithms for the prevention and control of chronic disease in youth and adolescents.

## CY2018

**Objective 4D – Expand Healthcare Benefits to Cover Treatment and Prevention:** DOH, in conjunction with the Community Leadership Team, will work with District officials to encourage the adoption of evidence-based health benefit programs that address the health care needs of those with chronic diseases, as well as including benefits that address the ability to prevent chronic disease, such as support for healthy eating, increased physical activity, and tobacco cessation

## COMMUNITY LEADERSHIP TEAM

### DC DEPARTMENT OF HEALTH (DOH) CANCER AND CHRONIC DISEASE COMMUNITY LEADERSHIP TEAM

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## DEFINITIONS

**Barriers:** obstacles inside or outside a health care or social services system that prevent vulnerable populations from receiving needed services, or that impair the health and welfare of the vulnerable populations, especially in comparison to more advantaged populations.

**Chronic Disease Action Team:** a team of individuals with appropriate skills and expertise matched to a task under the Chronic Disease State Action Plan. For example, a group with skills in dealing with diabetes might be assembled to focus on special problems or to provide enhanced services in high-risk zones.

**Community Leadership Team:** representatives of community-based health and social service organizations, governmental entities, business interests, and others, who have been convened by DOH to help formulate policies, advocacy, and activities to address chronic disease in the District of Columbia through epidemiology and surveillance, environmental approaches, health care systems, and community-clinical linkages. The Community Leadership Team meets at least four times a year, and in the interim, an Executive Leadership Team makes decisions for the group. The Community Leadership Team contributed substantially to this update of the Chronic Disease State Action Plan.

**Chronic Disease State Action Plan:** the plan presented in this document, created by the District of Columbia Department of Health, with substantial input from the Community Leadership Team, funded by a grant from the Centers for Disease Control and Prevention (CDC).

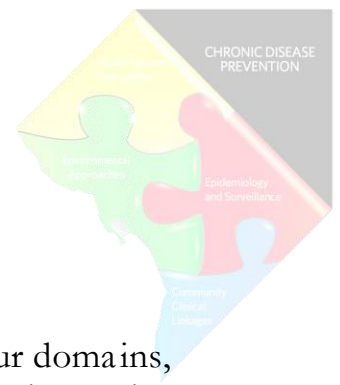
**Department of Health (DOH):** the District of Columbia Department of Health, whose mission is to promote and protect the health, safety, and quality of life for residents, visitors, and those doing business in DC.

**District of Columbia (DC or the District):** the capital of the United States. Situated between the States of Maryland and Virginia, the District was home to 617,996 people in CY2011, making it the 24<sup>th</sup> most populous area in the United States.

**Department of Health Care Finance (DHCF):** DHCF is the state Medicaid agency of the District of Columbia. In addition, DHCF also administers insurance programs for immigrant children, the State Child Health Insurance Program (S-CHIP), and Medical Charities (a locally funded program.)

**Domain:** the CDC requires that each chronic disease state plan address four key areas, called domains, which include the following:

- Epidemiology and surveillance
- Environmental approaches
- Health care systems
- Community-clinical linkages



The states are not required to organize their state plans around these four domains, but it may make it easier to fulfill agency requirements for disease prevention and health promotion programs that call for state plans in specific disease or risk factor areas. The CDC also feels these domains are related to categorical program staff who develop chronic disease state plans. If they choose to use the domains for their plans, the states are free to organize their services and programs under the domains as they see fit.

**Evidence-based interventions:** treatments or processes that have been shown to be effective through outcome evaluation, which raises the probability that the same process will create similar change when used with integrity in a different setting.

**Geographical Information System (GIS):** a system designed to collect and use geographical information to support service delivery and plan implementation.

**Health disparities:** differences among groups that are associated with social and economic disadvantages that affect certain groups persistently, inequitably, and adversely in comparison with other sectors of the population.<sup>9</sup>

**High-risk zone:** an area that demonstrates above average per capita chronic disease rates.

**Incidence:** the number of new cases during a specified time period (often a year); the risk of developing a condition within a specified period of time.

**Language Access Act:** enacted in 2004, this legislation holds covered agencies accountable for providing greater access to and participation in programs, services, and activities for limited English proficiency and non-English proficient (LEP/NEP) residents of the District of Columbia.

**Limited English proficiency (LEP):** persons and populations who are unable to communicate effectively in English because it is not their primary language, and they are not fluent in English. Members of LEP populations may have trouble speaking or reading English; they may require the services of an interpreter; and they need documents related to health and social services written in their primary

<sup>9</sup> National Partnership for Action, Office of Minority Health, US Department of Health and Human Services.

language. This facilitates communication with patients and populations and minimizes misunderstandings that may prevent or skew understanding of healthcare and social needs.

**Medical home:** a team based health care delivery model that provides continuous and comprehensive medical care to patients, with the goal of obtaining maximized health outcomes. This approach to comprehensive primary care allows better access to healthcare services, increased patient satisfaction, and improved health.

**Prevalence:** the proportion or percentage of a population currently suffering from a disease or condition.

**Quitline:** a toll-free telephone line run by DC Tobacco Free Families. Certified cessation counselors are available 24 hours a day in both English and Spanish, to provide counseling and free help quitting. A ten-week smoking cessation program is also available, as well as free patches and lozenges for District residents.

**Special Populations:** populations that have special health and social needs. These may include, but are not limited to: seniors, children and youth, children with special needs sexual minorities, Hispanics, African Americans, people with limited English proficiency (LEP), people with limited literacy, disabled, caregivers, low income, and high risk.

**Toolkit:** a collection of resources to help expand implementation, communication, or training around an issue. Depending on the task for which it is intended, a toolkit may include for example items such as model information flyers or brochures that can be individualized to a project, clip art, bibliographies or lists of web sites or other sources of useful data, training materials, evaluation forms, or anything else that may be of use to those working in the field.

## Acronyms

**ACS:** American Cancer Society  
**AED:** automatic external defibrillator  
**AHA:** American Heart Association  
**AHEC:** Area Health Education Center  
**ASA:** American Stroke Association  
**CASH:** DOH Child, Adolescent, and School Health Bureau  
**CDC:** Centers for Disease Control and Prevention  
**CHA:** Community Health Administration  
**CPR:** cardiopulmonary resuscitation  
**CY:** calendar year  
**DC:** District of Columbia  
**DHCF:** DC Department of Health Care Finance  
**DCPCA:** DC Primary Care Association  
**DOA:** DC Department of Aging  
**DOH:** DC Department of Health  
**GIS:** Geographical Information System  
**LEP:** low-English proficiency  
**LGBT:** Lesbian, gay, bi-sexual, and transgender  
**NDEP:** National Diabetes Education Program  
**NEP:** non-English proficient  
**NKF:** National Kidney Foundation  
**OSSE:** DC Office of the State Superintendent of Education  
**TA:** technical assistance

