Colorado Department of Public Health and Environment

CENTER FOR HEALTHY LIVING AND CHRONIC DISEASE PREVENTION + BRFSS

INTEGRATED WORKPLAN 2009-2013

INTRODUCTION

Early in 2008, Colorado was chosen as one of four states to participate in a chronic disease integration demonstration project through the Centers for Disease Control and Prevention. The CDPHE Center for Healthy Living and Chronic Disease Prevention had already begun a process of strategic planning that included all chronic disease and risk factor programs—Asthma, Comprehensive Cancer, Physical Activity and Nutrition, Diabetes Prevention and Control, Healthy Aging, Heart Disease and Stroke Prevention, Oral Health, Tobacco Education and Prevention, and Women's Wellness Connection. In joining the CDC demonstration project, the plan was broadened to include the Behavioral Risk Factor Surveillance System (BRFSS), which is housed in the CDPHE Center for Health and Environmental Information Services. The BRFSS is the primary source of surveillance data on chronic disease and risk factors for the Colorado population.

The 2009-2013 integrated workplan is the first product of the strategic planning process and is meant to replace separate program workplans focused on a single disease or risk factor. The integrated plan, which covers all programs in the Center plus BRFSS, builds on the best work of the categorical programs and recognizes where shared purpose, functions, strategies and target populations can lead to increased efficiency and effectiveness. The plan includes cross-cutting strategies (numbered 1-25), with responsibility shared among most or all programs, and program-specific strategies (numbered with the program name), with primary responsibility resting with one program. During the first year of this plan, many of the cross-cutting initiatives consist of assessing current efforts across categorical programs and developing a plan for streamlined and integrated work in that area.

All strategies have a goal of improving health outcomes related to chronic disease and risk factors or strengthening state health department infrastructure to maximize effectiveness of chronic disease prevention efforts. These goals and related objectives, developed jointly by all programs, are detailed below. The workplan is organized by imperatives, that is, the types of strategies that *must* be implemented in order to effectively address chronic disease and risk factors in Colorado. These are: policy and environmental change, health communications, public health linkages to healthcare systems, data and surveillance, and partnerships.

Part 1 of the integrated workplan lists all strategies. Part 2 includes a detailed action plan for each strategy. Part 3 sorts the strategies by program, underscoring the commitment made by each categorical program to the integrated work of the Center.

PURPOSE OF THE CENTER FOR HEALTHY LIVING AND CHRONIC DISEASE PREVENTION

To improve health-related quality of life for all Coloradans through preventing and postponing chronic disease and its complications.

GOALS AND OBJECTIVES

GOAL I: Improve health outcomes related to chronic disease and risk factors.

OBJECTIVES:

1. By 2013, maintain prevalence of obesity among Colorado adults below 20% *(2007 baseline = 19.3%, BRFSS)*

2. By 2013, increase prevalence of healthy weight.
    a. Among Colorado high school students above 85% *(Baseline = 79.2%, 2007 YRBS)*
    b. Among Colorado children above 75% *(Baseline = 63.5%, 2007 CHS)*

3. By 2013, reduce prevalence of smoking.
    a. Among Colorado adults below 17.5% (*Baseline = 18.7%, 2007 BRFSS)*
    b. Among Colorado high school students below 11% *(Baseline = 14.6%, 2006 Youth TABS)*

4. By 2013, increase prevalence of recommended level of physical activity.
    a. Among Colorado adults above 75% *(Baseline = 72.0%, 2007 BRFSS)*
    b. Among Colorado high school students above 25% *(Baseline = 19.3%, 2006Youth TABS)*
    c. Among Colorado children above 60% *(Baseline = 55.0%, 2007 CHS)*

5. By 2013, increase participation in recommended screening and early detection practices among Colorado adults.
    a. Pap smear above 90% (*Baseline = 85.3%, 2007 BRFSS)*
    b. Colonoscopy, endoscopy for persons age 50 and older above 75% (*Baseline = 57.2%, 2007 BRFSS)*
    c. Mammography for women age 40 and older above 78% (*Baseline = 72.0%, 2007 BRFSS)*
    d. Lipid testing in the past five years above 80% (*Baseline = 73.7%, 2007 BRFSS)*
    e. Physician advice to quit smoking (proxy for screening) above 68% (*Baseline = 64.0%, 2007BRFSS)*
    f. Physician advice to lose weight (proxy for screening), for overweight clients 20%, for obese clients 50% (*Baseline* = 17.0% for overweight clients, 40.7% for obese clients, 2007 BRFSS)

6. By 2013, increase participation in the Stanford Chronic Disease Self-Management Program to 3% of Coloradans between the ages of 45-84 with at least one chronic condition. *(3% = approx. 24,000 persons; May 2008 reach = 450 persons)*

7. By 2013, eliminate health disparities based on race, ethnicity, and low income for the above indicators.

GOAL II. Improve state health department infrastructure to maximize effectiveness of chronic disease prevention efforts.

OBJECTIVES:

1. Enhance and fully utilize Colorado's surveillance system to accurately describe chronic diseases and related factors for all Coloradans and to improve program planning, implementation and evaluation.

2. Create a Center work environment that values respect, shared knowledge, efficiency and effectiveness in reaching goals while sustaining accountability to coworkers, stakeholders and the public, and in which staff are empowered leaders with high job satisfaction.

3. Recruit and retain a diverse, skilled workforce at adequate staffing levels through development and implementation of efficient human resources policies, processes, and practices.

4. Increase the alignment of current and new public and private, federal, state and local funds to accomplish health outcomes.

DISCUSSION OF GOALS AND OBJECTIVES

The health outcome goal and objectives were determined by the Center's Integration Leadership Team in a deliberative process based on review of chronic disease, risk factor, and demographic data for Colorado. A Health Outcomes Work Group subsequently identified data sources, established baselines, recommended 5-year targets and raised issues of concern that required further decision-making by the larger group.

Although the Center's work spans the range of chronic diseases and risk factors, the Integration Leadership Team did not include prevalence of diabetes, heart disease or cancer among the main objectives. The group reasoned that an emphasis on reducing key risk factors and promoting screening for conditions related to the range of chronic diseases was in keeping with the intent of an integrated strategic plan. Further, the lesson of system dynamics modeling is that relying on prevalence of disease as a measure of progress can be misleading. If screening efforts are successful, more cases of disease are identified and prevalence increases. However, this may also lead to better management of disease and potential delay of premature death—both benefits that also increase prevalence levels.

A main objective on blood pressure screening was originally included in the plan but later deleted. The Health Outcomes Work Group pointed out that screening for blood pressure was universally accessible (e.g., drug stores, home kits) but this did not necessarily lead to management of the condition, as might a screening for cancer or lipids conducted through a clinical setting. The desired outcome is *control* of hypertension, and this is included as a long-term objective in program-specific strategies for diabetes (DPCP-1) and heart disease (HDSP-1). There is currently no identified data source for monitoring progress on this objective, but this will be part of the initial integration work on data and surveillance. If a reliable population estimate for control of hypertension is identified, it may be added to the list of main Center objectives.

The Integration Leadership Team deliberately chose to set an objective of eliminating, rather than reducing, health disparities based on race, ethnicity and income. While it is not possible to be successful on this objective in five years, the team decided that it was unacceptable for the state health agency to agree to different—that is, lower—health outcomes expectations for separate populations groups.

There has been little improvement on statewide chronic disease and risk factor indicators in Colorado in recent years, other than smoking prevalence. Consequently, the contribution of integration to achieving health outcomes is generally defined as a positive change in indicators, and the workplan objectives have been designed in this way. Targets have been set for each objective based upon the most recent baseline data and reflect modest but realistic progress to be made in five years.

IMPERATIVES

The following types of strategies must be emphasized to successfully reach Center goals:

- Policy and environmental change
- Health communications
- Public health linkages with the health care system
- Data and surveillance
- Partnerships

COMMONLY-USED ACRONYMS

- A-35: Amendment 35 tobacco excise tax funding
- APEG: Amendment 35 Program Evaluation Group
- BRFSS: Behavioral Risk Factor Surveillance System
- CCGC: Colorado Clinical Guidelines Collaborative
- CCPD: Cancer, Cardiovascular and Pulmonary Disease Grants Program
- CDPHE: Colorado Department of Public Health and Environment
- CDSM: Stanford Chronic Disease Self-Management Program
- CHS: Colorado Child Health Survey
- COPAN: Colorado Physical Activity and Nutrition Program
- DPCP: Diabetes Prevention and Control Program
- EPE: Epidemiology, Planning and Evaluation Branch
- HA: Healthy Aging Unit
- HC: Healthy Communities (if funding awarded by CDC)
- HDSP: Heart Disease and Stroke Prevention Program
- LHA: local health agency
- OH: Oral Health Unit
- PSD: Prevention Services Division
- STEPP: State Tobacco Education and Prevention Partnership
- TABS: Tobacco Attitudes and Behavior Survey
- WWC: Women's Wellness Connection
- YRBS: Youth Risk Behavior Surveillance System

PART 1: STRATEGIES FOR ALL PROGRAMS, ORGANIZED BY IMPERATIVES

IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAMS	PAGE
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	Part 2-1
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	Part 2-2
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HDSP, HA, STEPP, WWC	Part 2-4
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HDSP, OH, STEPP, WWC	Part 2-6
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HDSP, OH, STEPP, WWC	Part 2-7
	Obesity, physical activity	COPAN-1. Create and support active community environments that promote walking, biking, trails, parks and improvement to community planning.	COPAN (Contributing: DPCP, HDSP)	Part 2-8
	Breastfeeding	COPAN-2. Support policies in healthcare settings and worksites that maintain breastfeeding initiation and increase breastfeeding duration.	COPAN	Part 2-10
	Smoking	STEPP-1. Prevent tobacco initiation among youth and young adults.	STEPP	Part 2-11
	Smoking	STEPP-2. Eliminate exposure to secondhand smoke.	STEPP (Contributing: Asthma)	Part 2-13

IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAMS	PAGE
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	Part 2-15
	Screening	Comp Cancer-1: Educate consumers on the importance of colorectal cancer screening and the availability of statewide screening services.	Comp Cancer	Part 2-17
	Nutrition	COPAN-3. Increase identification and selection of healthy food and beverage options.	COPAN (Contributing: DPCP, HDSP)	Part 2-18
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	Asthma, Comp Cancer, COPAN, DPCP, HDSP, OH, STEPP, WWC	Part 2-20
	Obesity, smoking, physical inactivity, screening, health disparities	8. Expand reach of Healthier Living (Stanford Chronic Disease Self-Management Program) and *Tomando* throughout the state.	HA, HDSP, DPCP	Part 2-21
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	Part 2-22
	Asthma	Asthma-1. Increase access to quality care and quality one-on-one education for those who have asthma, particularly in rural and disparate communities.	Asthma	Part 2-24
	Diabetes complications	DPCP-1. Increase availability of diabetes self-management in Colorado.	DPCP	Part 2-25
	Obesity, diabetes	DPCP-2. Promote weight loss among overweight/obese women of childbearing age.	DPCP (Contributing: COPAN)	Part 2-27
	Screening, heart disease, hypertension	HDSP-1. Enhance capacity of community systems to prevent and address heart disease and stroke.	HDSP	Part 2-28
	Oral health	OH-1. Support services and programs that focus on primary and secondary prevention (sealants).	OH	Part 2-30
	Oral health	OH-2. Support services and programs that focus on primary and secondary prevention (fluoride).	OH	Part 2-32
	Smoking	STEPP-3. Promote smoking cessation among Colorado adults and youth.	STEPP	Part 2-33
	Screening	WWC-1. Provide breast and cervical cancer screening and selected diagnostic services to low income women.	WWC	Part 2-35

IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAMS	PAGE
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Part 2-37
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Part 2-38
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Part 2-39
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Part 2-40
	Surveillance system, health disparities	BRFSS-1. Ensure collaboration among state, local and other agencies, organizations and universities that analyze data or seek to reduce chronic disease and injury morbidity and mortality.	BRFSS	Part 2-41
	Surveillance system, health disparities	BRFSS-2. Ensure the highest level of BRFSS data quality for the state of Colorado.	BRFSS	Part 2-42
	Surveillance system, health disparities	BRFSS-3. Ensure that BRFSS data are widely disseminated and used for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends, and targeting relevant population groups.	BRFSS	Part 2-43
	Surveillance system, health disparities	BRFSS-4: Ensure that BRFSS data are widely disseminated and used for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends and targeting population groups (non-chronic disease programs).	BRFSS	Part 2-44
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	Part 2-45

IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAMS	PAGE
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-46
	Smoking, obesity, physical inactivity, screenings, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	Asthma, Comp Cancer, COPAN, DPCP, OH, STEPP, WWC	Part 2-48
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	BRFSS, Comp Cancer, COPAN, DPCP, HDSP, OH, STEPP	Part 2-49
	Physical activity, nutrition	COPAN-4. Promote best practices for nutrition and physical activity in early childhood settings.	COPAN	Part 2-50
	Screen time	COPAN-5. Promote TV Turnoff Week in Colorado.	COPAN	Part 2-51
	Obesity, smoking, physical inactivity, screening, health disparities	COPAN-6 Promote best practices for worksite wellness to support chronic disease prevention and management through Colorado worksites.	COPAN (Contributing: DPCP, HDSP)	Part 2-52
	Heart disease, stroke	HDSP-2. Contribute to heart disease and stroke prevention initiatives of primary partners.	HDSP	Part 2-54
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-55
	Infrastructure	19. Align Center staffing with the integrated workplan.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-56
	Infrastructure	20. Streamline Center business practices.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-57

IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAMS	PAGE
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-58
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-59
	Work environment	23. Implement clear and effective communication protocols and practices.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-60
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-61
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Part 2-62

PART 2 – STRATEGY ACTION PLANS

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change			
Strategy 1: Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives.	**Programs Involved**			**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC			BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2013, enact three healthcare system incentive policy changes addressing one or more of the chronic disease objectives. ▪ By December 2011, enact one health care system incentive policy change addressing one or more of the chronic disease objectives.				Program records
Short-Term Outcome Objective ▪ By December 2010, draft at least one financial incentive policy option addressing each chronic disease objective, based on assessment results.				Program records
Annual Objective ▪				
Process Evaluation ▪				
Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
THIS INTEGRATED STRATEGY WILL BEGIN IN YEAR 2				

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy 2: Define and implement a policy agenda for chronic disease prevention and management.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objectives ▪ By June 2013, at least three new state policies will be enacted that support prevention or management of chronic disease. ▪ By December 2012, collaborate or oversee adherence and enforcement of a target number of state and local policies for chronic disease prevention and control in Colorado. (Target to be set following year 1 activities, below)		Legislative records Program records
Short-Term Outcome Objectives ▪ By September 2012, at least three policy priorities related to chronic disease will have been placed on the CDPHE legislative agenda. ▪ By December 2011, adopt a target number of state and local policies to prevent and delay the onset of chronic diseases. (Target to be set following year 1 activities, below) ▪ By December 2010, at least five partner organizations will be engaged with the Center in a common policy agenda to support chronic disease prevention and management.		State and local government documents
Annual Objective A. By December 2009, a policy agenda will be established for the Center. B. By December 2009, a community mobilization model will be identified.		Program records
Process Evaluation ▪ The policy agenda and community mobilization model are documented.		

Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Crosswalk Center program statutory mandates, workplans and goals, and local plans that include policy development.	March 2009	CDC	Jason Vahling, STEPP Program Director	Voluntary associations, health care provider organizations
2. Assess evidence base, political feasibility and potential partners for state and local policies related to prevention and management of chronic disease.	March 2009			

3. Convene partners to plan and prioritize Center policy agenda.	May 2009			organizations, chronic disease coalitions, other advocacy groups, Colorado Association of Local Public Health Officials, Colorado School of Public Health
4. Assemble existing information on research-based or theoretical models for community mobilization and policy development and adopt a standardized model.	May 2009			
5. Put forward suggestions for inclusion on 2010 CDPHE policy recommendations.	July 09			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative**: Policy and environmental change	
Strategy 3: Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HDSP, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By 2012, more than 80% of projects funded through Amendment 35 grant programs will focus on evidence-based interventions (as defined by the PSD's evidence-based framework) to reduce smoking, obesity, and health disparities, and increase health screenings and early detection programs. ▪ By 2011, more than 50% of projects funded through Amendment 35 grant programs will focus on evidence-based interventions (as defined by the PSD's evidence-based framework) to reduce smoking, obesity, and health disparities, and increase health screenings and early detection programs.		Annual reports from the Amendment 35 Program Evaluation Group (APEG)
Short-Term Outcome Objective ▪ By December 2010, grant application requirements will be minimized and standardized for the Amendment 35 grants programs for increased emphasis on reducing smoking, obesity and health disparities and increasing health screenings and early detection programs.		Program records
Annual Objective ▪ By December 2009, a strategic plan for all Amendment 35 funding (tobacco, CCPD and health disparities) will be developed.		Program records
Process Evaluation ▪ The strategic plan will be documented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Convene STEPP, CCPD, and OHD Review Committees for a collaborative strategic planning process that meets grant program requirements and leads to achieving health outcome goals.	December 2009	Amend-ment 35	Gloria Latimer, Director, Chronic Disease Prevention Branch	Review Committee members, EPE, APEG

2. Train review committee members in EPE classification system for evidence base.	June 2009		Jason Vahling, STEPP Program Director Mauricio Palacio, Director, Office of Health Disparities	
3. Critically examine APEG categorization of type of services currently being provided with A35 funding and determine the desired breadth and focus of services.	August 2009			
4. Review strategies and resources for technical assistance to grantees and coordinate technical assistance services accordingly.	July 2009		Montelle Tamez, CCPD Project Coordinator	

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy 4: Promote best practices for chronic disease prevention and control in local health agencies.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2013, a system of chronic disease prevention and control services will be initiated in all local health agencies in Colorado.		Program records
Short-Term Outcome Objective ▪ By June 2011, chronic disease prevention and control services will be established in 50% of local health agencies in Colorado.		Program records
Annual Objective ▪ By December 2009, local level services for chronic disease prevention and control that focus on chronic disease objectives, include strategies consistent with the EPE evidence-based classification system, and can be disseminated statewide will be identified.		Program records
Process Evaluation ▪ The range of local services is documented through the SB 194 process.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Participate in Public Health Revitalization Act (SB194) implementation process.	Ongoing	CDC	Gloria Latimer, Director, Chronic Disease Prevention Branch	CALPHO Advisory Group to the Prevention Services Division, CDPHE Office of Planning and Partnerships
2. Confer with CALPHO-PSD local advisory committee for advice and direction on model for chronic disease prevention and control services through local health agencies.	Ongoing			
3. Build and define the role of CDC Health Communities program funding, if awarded	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy 5: Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, eliminate health disparities based on race, ethnicity and low income.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2012, provide culturally proficient services through the Prevention Services Division.		External assessment of PSD services
Short-Term Outcome Objective ▪ By December 2011, establish processes and protocols for all PSD programs that address cultural differences, and language, interpretation and translation services.		Division records
Annual Objective ▪ By December 2009, develop a plan to address cultural proficiency gaps among Center staff.		Program records
Process Evaluation ▪ Cultural proficiency assessment is completed with Center staff. The plan is documented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Conduct cultural proficiency assessment with Center staff.	April 2009	CDC	Maria Carreon Ayers, DPCP Program Coordinator	Office of Health Disparities, Limited English Proficiency Steering Committee, Health Disparities Leadership Group, Workforce Language Services
2. Develop a plan for addressing gaps identified through the assessment.	August 2009			
3. Participate in PSD planning for CLAS implementation.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy COPAN-1: Create and support active community environments that promote walking, biking, trails, parks and improvement to community planning.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Increase recommended level of physical activity among Colorado adults above 75% ▪ Increase recommended level of physical activity among Colorado high school students above 25% ▪ Increase recommended level of physical activity among Colorado children above 60%	COPAN Contributing: DPCP, HDSP	BRFSS, Youth TABS, CHS
Intermediate-Term Outcome Objective ▪ By December 2013, work with at least five planning departments in communities with low-income populations to incorporate health and active community environment language into comprehensive plans. ▪ By December 2011, assist three local health agencies with low-income and geographic isolation to organize and implement a basic plan to address ACE improvements to their communities.		Program records.
Annual Objectives A. By December 2009, utilize five past COPAN active community environments grant recipients as field experts in their region for purposes of enhancing reach throughout the state. B. By December 2009, work with the Colorado Chapter of the American Planning Association to identify communities that are or will be updating their 10-year comprehensive plans.		Program records
Process Evaluation A. Work of field experts is documented in program records. B. List of communities is documented.		

Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Collect and organize comprehensive health data on the local and regional level to be used active community environments planning. Provide the data as local "fact sheets." Promote and advocate for the use of data in local planning and development.	August 2009	CDC	COPAN Active Community Environ-ments Coordinator	Active Community Environments Task Force, COPAN Coalition, local health agencies, local governments, EPE Branch
2. Develop guidelines for incorporating health language (and/or Complete Street Concepts) into master/comprehensive plans, including burden of chronic disease and health inequities.	June 2009			
3. Host monthly Active Community Environments Task Force meetings to implement workplan strategies and identify possible integration opportunities.	Ongoing			
4. Recruit and train past active community environments grant recipients to provide technical assistance to local community groups and local public health agencies on principles of active community environments.	September 2009			

5. Provide opportunities for partners to become more involved with active community environments in efforts to increase reach and understanding throughout the state of active community environments principles, including submitting an abstract for presentation at the Colorado chapter of the American Planning Association Conference (fall 2009).	Ongoing			
6. Partner with LiveWell Colorado to coordinate the new LiveWell strategic plan.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy COPAN-2: Support policies in healthcare settings and worksites that maintain breastfeeding initiation and increase breastfeeding duration.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Maintain breastfeeding initiation at 85% or higher *(Baseline = 85.9%, NIS*)* ▪ Increase exclusive breastfeeding through three months to 40% *(Baseline = 36.2%, NIS*)* ▪ Increase continued breastfeeding for at least six months to 50% *(Baseline = 42.0%, NIS*)* ▪ Increase exclusive breastfeeding through six months to 17% *(Baseline = 10.8%, NIS*)* ▪ Maintain continued breastfeeding through one year at 25% or higher *(Baseline = 23.6%, NIS*)*	COPAN	CDC National Immunization Survey *All baselines are for children born in 2004, with data reported in 2007
Intermediate-Term Outcome Objective ▪ By December 2011, collaborate with at least ten LiveWell Colorado communities and ten local health agencies to provide resources and training on promoting breastfeeding best practices to worksites, healthcare centers and hospitals, including around the Colorado Workplace Accommodation of Nursing Mothers Act.		Program records
Annual Objective ▪ By December 2009, train at least twenty hospitals on "Colorado Can Do 5," which promotes five hospital practices that are linked to prolonged duration of breastfeeding.		Program records
Process Evaluation ▪ Trainers and education resources are identified; training and workshops are held; meetings attended and collaboration created.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Participate in the Colorado Breastfeeding Coalition, assisting with strategic planning and workgroups including hospital recognition, legislative, worksite recognition, website, newsletter and provider education.	Ongoing	CDC	COPAN Breast-feeding Coordinator	Breastfeeding Coalition, COPAN Coalition, local health agencies, hospitals, community health centers, CDPHE WIC Program
2. Distribute the breastfeeding resource kit and findings of the report, *Getting It Right After Delivery: Five Hospital Practices That Support Breastfeeding* to an additional 20 hospitals. Provide training, materials and TA to hospitals requesting help in developing policies.	Ongoing			
3. Create an Action Guide on Breastfeeding to provide ideas for effective strategies to improve breastfeeding promotion and support as a part of the MCH local agency planning process.	Ongoing			
4. Update CDPHE breastfeeding website and current guidelines and best practices.	December 2009			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy STEPP-1: Prevent tobacco initiation among youth and young adults.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ By December 2013, reduce smoking among Colorado adults below 17.5% ▪ By December 2013, reduce smoking among Colorado high school students below 11% ▪ By December 2010, increase the proportion of Colorado high school students who have never tried a cigarette, not even one or two puffs, to 67% *(Baseline = 57.0%, 2006 Youth TABS)*	STEPP	BRFSS Youth TABS
Intermediate-Term Outcome Objectives By December 2013: ▪ Reduce the proportion of Colorado high school students who report they usually got their cigarettes from a store to 14%. *(Baseline = 19.0%, 2006 Youth TABS)*		Youth TABS
Short-Term Outcome Objectives By December 2011: ▪ Maintain the number of retailer checks for compliance with laws prohibiting tobacco sales to minors. ▪ Increase to 100% the proportion of school districts reporting implementation of 100% tobacco-free policies		Program records
Annual Objective ▪ By December 2009, engage at least 42 local health agencies and 32 community-based organizations in policy and programmatic efforts to prevent youth tobacco use. Targets for other activities will be determined after grants are awarded through review process.		Program records

Process Evaluation
- Coordination contracts are in place. Contractors document engagement and results per activities below.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Fund one lead agency contractor to award a portion of their grants to fund schools throughout Colorado. This lead agency provides technical assistance, training, expertise and support to ensure the programs are implemented according to CDC Best Practices criteria.	Ongoing	Amend-ment 35, CDC Tobacco	Katy Kupecz, STEPP Youth and Young Adult Program Director	Colorado Tobacco Education and Prevention Alliance

2.	Fund at least 42 local health agencies serving all 64 counties to convene community coalitions to advocate for adoption of youth access polices such as retailer licensing, local advertising and zoning restrictions, and policies to prohibit the tobacco industry sponsorship, sampling and giveaways.	Ongoing		Director Alicia Oletski, STEPP TTI Program Manager	Alliance, American Heart Association, American Cancer Society, American Lung Association, CALPHO, CO Department of Revenue (Synar), CO Department of Education
3.	Fund one contractor to expand the multi-pronged (counter-) marketing campaign focusing on youth choices (*Own Your C*) and decision-making related to tobacco, reaching targeted 12-18 year olds. (Link with strategy 6.)	Ongoing			
4.	Fund 32 community-based organizations to provide youth programming to high-risk youth and encourage the adoption of organizational policies within these agencies.	Ongoing			
5.	Continue to fund one contractor to oversee the Technical Assistance Resource Partnership to provide technical assistance and training to at least 30 communities to advance youth access policy.	Ongoing			
6.	Fund one lead agency to award a portion of its grants to fund youth empowerment coalitions throughout Colorado. This lead agency provides technical assistance, training, expertise to empower youth ages 12-18 to engage in and advance youth access and smoke-free policies while de-normalizing the tobacco industry.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Policy and environmental change	
Strategy STEPP-2: Eliminate exposure to secondhand smoke.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce smoking among adults below 17.5% ▪ Reduce smoking among adolescents below 11% ▪ Reduce the proportion of students (grades 9-12) who are regularly exposed to secondhand smoke in rooms during the previous week to 40% *(Baseline = 46.0%, 2006 Youth TABS)* ▪ Reduce the proportion of students (grades 9-12) who are regularly exposed to secondhand smoke in vehicles during the previous week to 35% *(Baseline = 39.0%, 2006 Youth TABS)*	STEPP Contributing: Asthma	BRFSS Youth TABS
Intermediate-Term Outcome Objectives By December 2013: ▪ Increase the proportion of adults who report smoke-free behavior in their homes to 90%. *(Baseline = 86.0%, 2005 Adult TABS)* ▪ Increase the proportion of adults who report compliance with smoke-free policies in their vehicles to 75%. *(Baseline TBD in 2009)*		Adult TABS
Short-Term Outcome Objectives By December 2011: ▪ Increase the proportion of adults who do not allow smoking inside their homes to 87%. *(Baseline = 81.0%, 2005 Adult TABS)* ▪ Increase the proportion of adults who never allow smoking in their personal vehicle to 73%. (*Baseline = 69%, 2005 Adult TABS)*		Adult TABS
Annual Objective ▪ By December 2009, at least 42 local health agencies and 32 community-based organizations are engaged in policy and programmatic efforts to eliminate exposure to secondhand smoke. Targets for other activities will be determined after grants are awarded through review process.		Program records
Process Evaluation ▪ Coordination contracts are in place. Contractors document engagement and results per activities below.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Fund one contractor to conduct one statewide media campaign educating and promoting the adoption of smoke-free homes and autos. (Link with strategy 6.)	Ongoing	Amend-ment 35,	Jill Bednarek, STEPP	Colorado Tobacco

2. Fund at least 42 local health agencies serving all 64 counties to convene community coalitions to advocate for adoption of tobacco free polices such as strengthening the Colorado Clean Indoor Air Act, promoting smoke-free public housing and tobacco-free campuses and encouraging voluntary smoke-free homes and auto pledges.	Ongoing	CDC Tobacco	Secondhand Smoke Director Alicia Oletski, TTI Program Manager	Education and Prevention Alliance, American Heart Association, American Cancer Society, American Lung Association, CALPHO, CO Department of Revenue (Synar), CO Department of Education
3. Fund one contractor to train childcare center staff to provide secondhand smoke educational contacts with parents.	Ongoing			
4. Fund 32 community-based organizations to execute educational contacts with parents of high-risk youth.	Ongoing			
5. Continue to fund one contractor to oversee the Technical Assistance Resource Partnership to provide technical assistance and training to at least 30 communities to advance secondhand smoke policies.	Ongoing			
6. Fund and monitor one contractor to provide training and technical assistance to colleges on creating tobacco-free campuses and reduced tobacco industry influence policies.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Health communications	
Strategy 6: Implement a coordinated health communications plan that includes strategic marketing campaigns for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, CCPD, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objectives ▪ By December 2013, provide key information to support education, screening and treatment of chronic disease to at least 15,000 healthcare and oral health professionals. ▪ By December 2011, provide information to support decision-making on chronic disease prevention and management to at least 500,000 Coloradans, including target populations.		Dependent on communication/education methods chosen (e.g., website analytics, training evaluations)
Short-Term Outcome Objectives ▪ By December 2012, increase Coloradans' awareness of chronic disease risk factors and recommended screenings to prevent and manage chronic diseases. *(Baseline to be determined in 2009)* ▪ By December 2011, implement at least three health communications and marketing campaigns that combine messages from multiple chronic disease or risk factor programs. ▪ By December 2011, increase number of adolescents participating and engaging with *Own Your C* campaign. *(Baseline = 38,978 unique Colorado visitors, 2008 website data)*		Awareness data source TBD in 2009 Program records Website
Annual Objectives A. By December 2009, implement findings from pilot chronic disease and cessation media evaluations to use in CCPD marketing plan, including addressing limited English proficiency and health literacy gaps and incorporating input from all target populations. B. By December 2009, identify ways to further refine and broaden messaging for new *Own Your C* media campaign (incorporating wise food choices and increased physical activity). C. By December 2009, develop a plan for streamlining delivery of prioritized professional education messages. D. By December 2009, develop a plan for streamlining delivery of prioritized consumer education messages.		Program records
Process Evaluation A. Media metrics measure reach, frequency, and conversion rates (to Quitline) from landing page of pilot media campaign. Quitline data indicate whether increased calls or online enrollments were received from target areas due to pilot media campaign's TV, print or website. Media campaign is adjusted based on pilot findings.		

B. Website data indicate whether new *Own Your C* campaign increased participation and engagement with online tools.
C. The professional education priorities are documented.
D. The consumer education priorities are documented.

Activities	Target Completion Date	Funding Sources	Lead Person	Partners
1. Evaluate effectiveness of pilot chronic disease and cessation media campaign (ends 3/4/09).	June 2009	CDC CCPD	Karen Phelan, Interim Director, STEPP Health Communica-tions and Marketing	Local health agencies, statewide partners, media contractors (Cactus, Shift), healthcare and oral health professional organizations, Area Health Education Centers, professional education vendors, representatives of target populations
2. Create strategic marketing plan with CCPD/WWC to address chronic diseases, risk factors, and screening/early detection, with a focus on reducing health disparities.	June 2009			
3. Evaluate effectiveness of new *Own Your C* campaign with state-of-the-art database (ends 5/31/09).	June 2009			
4. Conduct a communications audit with Center external partners.	January 2009			
5. Inventory types of professional education and consumer education information to be communicated by the Center and methods that are currently being used, to identify commonalities and needs.	June 2009			
6. Identify additional professional education and consumer education channels, as possible.	August 2009			
7. Develop a plan for shared professional education and consumer education strategies that build upon existing efforts and includes the input of target populations.	December 2009			
8. Continue categorical professional education and consumer education efforts pending development of integrated Center plans.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Health communications			
Strategy Comp Cancer-1: Educate consumers on the importance of colorectal cancer screening and the availability of statewide screening services.	**Programs Involved**		**Data Sources**	
Long-Term Outcome Objective ▪ By December 2013, increase participation in colonoscopy or endoscopy screening for colorectal cancer among adults over age 50 to 75%.	Comp Cancer		BRFSS	
Intermediate Outcome Objective ▪ By December 2011, increase participation in colonoscopy or endoscopy screening for colorectal cancer among adults over age 50 to 65%.				
Annual Objective A. By December 2009, support and publicize at least nine Screen the Screener sites in Colorado B. By December 2009, host four regional meetings related to colorectal cancer in Colorado.			Program records	
Process Evaluation A. Screen the Screener program will be implemented. B. Agendas, minutes and outcomes of meetings on colorectal cancer in Colorado will be available.				
Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Plan and implement meetings on colorectal cancer.	May 2009	CDC supple-mental funding	Comp Cancer Program Manager	University of Colorado Cancer Center, Colorado Cancer Coalition, and Colorectal Cancer Task Force
2. Work with partners to promote Screen the Screener.	June 2009			
3. Work with CCPD grant for statewide colorectal cancer screening on promotional messages and education.	Ongoing			
4. Participate with national partners and statewide coalition in program development, maintenance and technical assistance needs related to colorectal cancer.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Health communications	
Strategy COPAN-3: Increase identification and selection of healthy food and beverage options.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective By December 2013: ▪ Increase to 35% the proportion of Colorado adults who consume at least five fruits/vegetables per day. *(Baseline = 25.8, 2007 BRFSS)* ▪ Increase the proportion of Colorado high school students who consume at least five fruits/vegetables per day to 30%. *(Baseline = 26.2%, 2007 YRBS)* ▪ Increase the proportion of Colorado children (ages 1-14) who consume at least five fruits/vegetables per day to 10%. *(Baseline = 8.0%, 2007 CHS)*	COPAN Contributing: DPCP, HSDP	BRFSS YRBS CHS
Short-Tem Objectives ▪ By December 2011, assist state agency programs to create and promote ways to increase fruit and vegetable consumption in populations with health disparities and geographic isolation. ▪ By June 2010, create consumer demand by enhancing private partnerships that promote the Smart Meal Seal program, to include LiveWell Colorado, Colorado Restaurant Association and Smart Meal participating restaurants and food establishments.		Program records
Annual Objectives A. By December 2009, ensure that healthy eating options are available and identified in at least 300 Colorado restaurants and other places where food is sold. B. By December 2009, support implementation of the Healthy Beverages in Colorado Schools Act.		Program records

Process Evaluation
A. Number of restaurants that are participating and have received training and educational materials is documented.
B. Meeting attendance and collaboration with partners is documented.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Identify funding sources to develop a Smart Meal communications campaign to include messaging, partnership support, website development and outreach. (Link with strategy 6)	March 2009	CDC Physical Activity, Nutrition and Obesity	COPAN Nutrition and Physical Activity Coordinator	COPAN Coalition, local health agencies, restaurants, worksites, schools, WIC, Nurse Family Partnership, Prenatal Plus
2. Expand the reach and availability of Smart Meal program by creating new website to host the program and on-line training.	December 2009			
3. Work with public and private partners to educate those invested in healthy food policies and in promoting physical activity, to include vending, worksite wellness, and school nutrition.	Ongoing			
4. Participate with the Colorado School Board to support the implementation of the nutritional beverage guidelines for school vending machines, cafeterias, and stores.	Ongoing			

5. In conjunction with WIC and the new WIC food package, create a “how to use” guide for parents and families for use in WIC and other family service programs.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy 7: Promote healthcare system change through widespread implementation of clinical practice guidelines.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, Comp Cancer, COPAN, DPCP, HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2011, healthcare provider utilization of clinical practice guidelines related to chronic disease will increase, as compared to a baseline established in 2009.		TBD in 2009
Short-Term Outcome Objective ▪ By December 2010, reach at 25% of practitioners in each guideline specialty area, with clinical guidelines related to chronic disease.		TBD in 2009
Annual Objective ▪ By December 2009, develop a plan for common implementation of clinical practice guidelines related to chronic disease.		Survey

Process Evaluation
- The implementation plan is documented. The survey of healthcare providers is completed and information from the survey is reflected in the plan.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Inventory current efforts to distribute and train healthcare providers on clinical practice guidelines.	February 2009	CDC	Marsha Wilde, HDSP Program Manager	Healthcare provider organizations, Colorado Clinical Guidelines Collaborative
2. Compile information on learning preferences and incentives likely to change practice behavior, including through a healthcare provider survey.	June 2009			
3. Draft implementation plan based on healthcare provider preferences.	December 2009			
4. Determine baseline for current utilization of clinical guidelines.	December 2009			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy 8: Expand reach of Healthier Living (Stanford Chronic Disease Self-Management Program) and *Tomando* (Spanish version) throughout the state.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	HA, HDSP, DPCP	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2013, 3% of Coloradans between the ages of 45-85 with at least one chronic condition will have participated in Healthier Living Colorado or *Tomando*.		Program records, health plans, Medicaid
Short-Term Outcome Objective ▪ By December 2011, Healthier Living or *Tomando* will be integrated into at least five health plans or healthcare systems (e.g., CCGC Patient Centered Medical Home Model, Health Care Policy and Financing/Medicaid Single Entry Point pilot program).		Program records, health plans, Medicaid
Annual Objective ▪ By December 2009, identify and recruit five new partners to support and/or implement Healthier Living or *Tomando*.		Program records
Process Evaluation ▪ Support of partners will be documented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Participate in planning and discussions for CCGC Patient Centered Medical Home pilot and HCPF Single Entry Point pilot.	Ongoing	Administration on Aging, The CO Health Foundation, CCPD	Penny Studebaker Healthy Aging Program Coordinator	CCGC, The Colorado Health Foundation, health plans, Health Care Policy and Financing, Univ of Colorado at Denver, Consortium for Older Adult Wellness, Healthy Aging Service System
2. Develop presentation on Healthier Living effectiveness and reach for use in recruiting partners.	February 2009			
3. Build partnerships that result in increased participation in Healthier Living or *Tomando*.	Ongoing			
4. Continue to advocate for support of Healthier Living and *Tomando* through the CCPD Grant Program.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy 9: Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2012, increase the proportion of adult smokes diagnosed with chronic diseases who have made a smoking cessation attempt to 60% *(Baseline = 55.0%, 2007 BRFSS)* ▪ By December 2010, 100% of callers to the Colorado Quitline will be offered advice on chronic disease risk reduction strategies or referrals to chronic disease screening or management resources.		BRFSS Program records
Short-Term Outcome Objective ▪ By December 2011, increase the proportion of adult smokers diagnosed with a chronic disease who call the Colorado Quitline to 20%. *(Baseline = 18.0%, 2007 BRFSS)*		BRFSS
Annual Objectives A. By December 2009, screen callers to the Colorado Quitline for chronic diseases, and offer advice on chronic disease risk reduction strategies and referrals to chronic disease screening and management resources, as appropriate. B. By December 2009, increase the proportion of tobacco users with a chronic disease that are aware of the Colorado Quitline to 80%. *(Baseline = 77%, 2007 BRFSS)* C. By December 2009, increase the proportion of tobacco users with a chronic disease that report a doctor or other healthcare professional advised them to quit using tobacco to 70%. *(Baseline = 64.0%, 2007 BRFSS)*		A. Program records B. BRFSS C. BRFSS
Process Evaluation ▪ Quitline protocols are in place.		

Activities	Target Completion Date	Funding Sources	Lead Person	Partners
1. Develop and implement protocols through the Colorado Quitline for screening for chronic disease, and advice on chronic disease risk reduction strategies and referrals to chronic disease screening and management programs.	March 2009	CDC	Deb Montgomery, STEPP Adult Cessation Program Director	National Jewish, Colorado Clinical Guidelines Collaborative
2. Promote the Colorado Quitline to chronic disease clients through a media campaign and educational materials for healthcare providers. (Link with strategy 6.)	Ongoing			
3. Promote use of the Colorado Quitline to healthcare providers for their clients with chronic disease who use tobacco.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy Asthma-1: Increase access to quality care and quality one-on-one education for those who have asthma, particularly in rural and disparate communities	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, reduce asthma hospitalizations by 10% from 2006 baseline	Asthma	Colorado Health and Hospital Association
Annual Objective ▪ By December 2009, increase number of Certified Asthma Educators in Colorado by 45% (**from 45 to 65)**		National Asthma Educators Certification Board
Process Evaluation: ▪ New Certified Asthma Educators will be documented on the National Asthma Educators Certification Board website.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Assess current number of Certified Asthma Educators in Colorado.	April 2009	CDC Asthma, Children's Hospital, Colorado Asthma Coalition	Diane Herrick, The Children's Hospital	Colorado Asthma Coalition, The Children's Hospital, Merck
2. Implement the Asthma Prep Course.	May 2009			
3. Evaluate effectiveness of course.	May 2009		Mario Rivera, EPE Branch	
4. Monitor number of new Certified Asthma Educators through website	Ongoing		Mario Rivera	

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy DPCP-1: Increase availability of diabetes self-management education in Colorado.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Increase the proportion of persons with diabetes who report self-monitoring blood sugar at least once daily to 75% *(Baseline = 59.3%, 2005-07 BRFSS)* ▪ Increase the proportion of persons with diabetes who report gycosylated hemoglobin (A1C) checked at least once per year to 90% *(Baseline = 85.0%, 2005-07 BRFSS)* ▪ Increase the proportion of persons with diabetes who report receiving a foot exam by a health professional at least once per year to 75% *(Baseline = 74.1%, 2005-07 BRFSS)* ▪ Increase the proportion of persons with diabetes who report receiving a dilated eye exam at least once per year to 75% *(Baseline = 66.6%, 2005-07 BRFSS)* ▪ Increase the proportion of persons with diabetes who report having cholesterol (lipids) checked within the past year to 95% *(Baseline = 91.5%, 2005-07 BRFSS)* ▪ Increase the proportion of adults who have their high blood pressure under control *(Target TBD in 2009)*	DPCP	BRFSS Data source for control of blood pressure TBD in 2009
Intermediate-Term Outcome Objective ▪ By December 2013, increase the proportion of Colorado adults with diabetes who receive formal diabetes education to 75% for the general population, and groups with health disparities such as Hispanic persons and Tribal members. *(Baseline = 60.7% for general population, 2005-07 BRFSS)*		BRFSS
Short-Term Outcome Objective ▪ By December 2011, implement a system to effectively address the gaps in availability of culturally appropriate diabetes self-management education in five communities.		Survey evaluating the effectiveness of the diabetes self - management program by target audience
Annual Objective ▪ By December 2009, implement a comprehensive statewide assessment to identify existing local diabetes education resources, gaps in availability of culturally appropriate services, and communities with the greatest need for diabetes self-management education.		Focus group reports of target audiences, program records.
Process Evaluation ▪ Report of state gaps and resources for diabetes self-management education is available.		

Activities	Target Completion Date	Funding Sources	Lead Person	Partners
1. Form an advisory group representative of statewide and community organizations and the target populations to inform the project. Establish roles and responsibilities.	March 2009	CDC Diabetes Prevention and Control	Gloria Vellinga, Diabetes Program Coordina-tor	Diabetes Advisory Committee, American Diabetes Association, Rocky Mountain Association of Diabetes Educators, persons with diabetes, community leaders
2. Conduct assessments.	December 2009			
3. Identify a system to meet community needs for diabetes self-management education in identified gap areas.	December 2009			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy DPCP-2: Promote weight loss among overweight/obese women of childbearing age in local public health systems of care.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, 5-10 local public health clinics will incorporate healthy weight counseling into routine systems of care.	DPCP Contributing: COPAN	Local health agency program data
Intermediate-Term Outcome Objective ▪ By December 2011, 50% of women of childbearing age who are overweight or obese and clients of local public health programs participating in the intervention will choose 1-2 lifestyle changes to promote healthy weight (BMI).		Local health agency program data
Short-Term Outcome Objective ▪ By September 2010, clinical staff in participating local public health programs will accurately identify overweight and obese women by Body Mass Index (BMI) and assess each woman's readiness for change (based on Prochaska's theory of change) regarding healthy weight achievement.		Training evaluation, staff survey
Annual Objective ▪ By December 2009, clinic staff in participating local public health programs will receive education and resources to implement client-based counseling for healthy weight based on Prochaska's stages of change.		Program records
Process Evaluation ▪ A training evaluation and a survey of clinic staff indicate willingness and ability to implement client-based counseling for healthy weight.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Determine strategies for healthy weight messaging based on Prochaska's stages of change model and build on lessons learned from the COPAN Family Planning pilot project.	March 2009	CDC Diabetes Prevention and Control	Michelle Hansen, DPCP Program Manager	CDPHE Women's Health Unit, local health agencies
2. Identify 2-5 public health clinics willing to participate in delivering lifestyle modification counseling for healthy weight.	June 2009			
3. Educate local public health clinic staff on Prochaska's stages of change and/or client-based counseling as it relates to healthy weight.	December 2009			
4. Provide technical assistance to local public health clinics on program logistics for client-centered healthy weight counseling.	December 2009			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy HDSP-1: Enhance capacity of community systems to prevent and address heart disease and stroke.	**Programs Involved**	**Data Source**
Long-Term Outcome Objectives By December 2013: ▪ Increase the proportion of adults being treated for high blood pressure who have their blood pressure under control *(Baseline and target TBD in 2009)* ▪ Increase the proportion of adults being treated for high blood cholesterol who have their blood cholesterol under control *(Baseline and target TBD in 2009)* ▪ Increase the proportion of adults who recognize the signs of a heart attack to 40% *(Baseline = 25%, 2006 BRFSS)* ▪ Increase the proportion of adults who recognize the signs of a stoke to 40% *(Baseline = 18%, 2006 BRFSS)* ▪ Increase the proportion of adults who know the importance of calling 9-1-1 for a heart attack or stroke *(Baseline and target TBD in 2010)* ▪ Eliminate health disparities based on race, ethnicity and low income	HDSP	Data source for control of blood pressure and cholesterol TBD in 2009 BRFSS
Intermediate-Term Outcome Objectives By December 2013: ▪ Recognize at least seven Colorado communities as a Heart and Stroke Healthy Community. ▪ Ensure that at least seven Colorado communities have a plan to address disparities related to heart and stroke health in their communities. By December 2011: ▪ Ensure that COPAN, STEPP and other Center objectives that impact heart disease and stroke are fully integrated with the Heart and Stroke Healthy Community project.		Program records
Short-Term Outcome Objective ▪ By June 2009, increase the number of active members in the HDSP coalition by 50%, from current active membership of 20 members.		Program records
Annual Objective A. By December 2009, implement media campaign in at least five communities. B. By December 2009, begin recruitment for fully developed Heart and Stroke Healthy Community project.		Program records
Process Evaluation A. Reach of media campaign is documented. B. Program materials are available to use in recruitment.		

Activities	Target Completion Date	Funding Sources	Lead Person	Partners
1. Establish state and community baseline data for measuring outcomes for all long-term objectives.	June 2009	CDC Heart and Stroke Prevention	Marsha Wilde, HDSP Program Manager	Data and evaluation work group, EPE
2. Develop a minimum of one media campaign designed for use at the local level to raise awareness of cardiovascular disease risk factors.	December 2009			Communications work group, media contractor
3. Establish community indicators to guide communities in achieving heart and stroke health.	April 2009			HDSP Steering Committee, data and evaluation work group
4. Define application process, forms and schedules for assessing heart and stroke healthy communities.	June 2009			Implementation work group
5. Establish evaluation plan for process and outcome evaluation measures for long-term outcomes.	June 2009			Data and evaluation work group, EPE
6. Develop a community recruitment and marketing plan to encourage participation in the Heart and Stroke Healthy Community project.	December 2009			Implementation work group, local health agencies, other community agencies

Goal: Improve health outcomes related to chronic disease and risk factors.	**Imperative:** Public health linkages with healthcare systems

Strategy OH-1: Support services and programs that focus on primary and secondary prevention (Sealants)	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By July 2013, increase the proportion of eligible third-grade students receiving at least one permanent molar sealant to 45%. *(Baseline = 35%, 2006-07 Basic Screening Survey)*	Oral Health	Sealant Efficiency and Assessment for Locals and States (SEALS) software Program records Participant/grantee surveys Oral Health surveillance data Basic Screening Survey
Intermediate Outcome Objective ▪ By December 2011, increase the proportion of eligible third-grade students receiving at least one permanent molar sealant by 35%. *(Baseline = 2700 students, 2006-07 SEALS)*		
Annual Objectives By June 2009: A. Develop a sealant program overview for contractors, potential contractors and funders. B. Develop legislation to support state general fund for sealant programs. C. Continue to evaluate the performance of sealant contractors in comparison with the sealant expansion plan and Healthy People objectives. D. Provide technical assistance to sealant contractors, based on the results of the evaluation, on improving outcomes and increasing utilization. E. Convene one sealant advisory committee meeting		

Process Evaluation

A. Sealant evaluation report is written and routed for approval. Dissemination strategy is developed and implemented.
B. Legislative initiative and attendant decision items, FAQ's, fact sheets and stakeholder lists and bill language are drafted, sponsor secured, and testimony provided.
D. Quarterly sealant contractor meeting is conducted and data collected for TA planning. Technical assistance that best meets contractors' needs is provided. Results and effectiveness of technical assistance are evaluated.
E. Stakeholder group (sealant advisory group) is convened and contractor application is updated and disseminated in a timely manner.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Review and update sealant program logic model to reflect additional contractors**.** Update contractor application and post on website. Notify stakeholders and funders.	July 2009	CDC Oral Health	OH Unit Manager, Dental Director, Sealant Coordinator	Sealant contractors, funders and participants, Oral Health Awareness Colorado!, CDPHE Legislative Liaison
2. Submit legislative initiative background paper to Dept Management/Governor's Office for approval. Work with bill drafter to draft legislation. Identify bill sponsors, key stakeholders to provide testimony.	July 2009			
3. Finalize sealant evaluation report. Distribute to contractors, key stakeholders, and potential funders.	July 2009			
4. Identify technical assistance (TA) needs for each contractor. Contact contractors for TA. Evaluate results of TA	July 2009			

5.	Identify potential members for advisory committee. Send out invitations to participate with agenda. Convene first meeting	July 2009			

Goal: Improve health outcomes related to chronic disease and risk factors.	**Imperative:** Public health linkages with healthcare systems	
Strategy OH-2: Support services and programs that focus on primary and secondary prevention (fluoride)	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, working with the Water Quality Control Division, provide expertise, staffing, and collaborative activity to assist in meeting Healthy People 2010 fluoridation objectives and assuring optimal compliance with Engineering Administration for Water Fluoridation recommendations.	Oral Health	Water Fluoridation Reporting System database Program records
Intermediate Objectives By December 2011: ▪ Assure 30% of all non-participating, and 75% of all participating, communities in the Water Fluoridation Program have at least one staff member complete on-line fluoridation training. ▪ Provide current information on the science and efficacy of fluoridation to key health providers annually in two communities. ▪ Increase by 20% (to 42) the number of water systems optimally adjusting for nine months of the year. *(Baseline = 35 plants, 2008 WFRS)* ▪ Update the water fluoridation reporting system to accurately reflect the population in Colorado served by optimal levels of fluoride in public drinking water systems.		
Annual Objectives By July 2009: A. Complete a management document and fluoridation plan and a document that incorporates the Engineering Administration for Water Fluoridation guidelines. B. Have 100% participation in monthly reporting of fluoridation as verified through data entry into the Water Fluoridation Reporting System.		
Process Evaluation A. Documents are finalized and submitted to CDC. B. Self-monitoring form submissions are tracked monthly. Follow-up protocol for non-submittal is established and implemented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Complete management document including a fluoridation program plan. Review relevant literature and previous documentation. Convene expert and community members to contribute and review drafts. Draft document and route for review. Implement the management the plan, processes, and protocols. Evaluate implementation in a continuous and iterative manner using a Plan, Do, Study, Act cycle.	July 2009	CDC Oral Health	Oral Health Unit Manager, Fluoridation Specialist/ Adult and Community Program Coordinator	Water systems, CDPHE Water Quality Control Division
2. Verify systems that have fluoridation status as "Adjusted" in WFRS. Ensure Fluoridation Specialist and data entry are trained in the management and data protocols of the monthly self-monitoring reports and WFRS data entry. Follow-up on missing reports in a timely manner. Submit WFRS reports to CDC in annual report via MOLAR MIS system.	July 2009			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy STEPP-3: **Promote smoking cessation among Colorado adults and youth**	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce smoking among adults below 17.5%	STEPP	BRFSS
Intermediate-Term Outcome Objectives By December 2013: ▪ Increase the proportion of adult smokers who have made a smoking cessation attempt to 77%. *(Baseline = 68%, 2005 Adult TABS)* ▪ Increase the proportion of Colorado high school students who smoke and who have made a smoking cessation attempt to 66%. *(Baseline = 63%, 2006 Youth TABS)*		Adult TABS Youth TABS
Short-Term Outcome Objectives By December 2011: ▪ Increase the proportion of adult smokers who report their doctor advised them to quit smoking in the past 12 months to 68%. *(Baseline = 64%, 2007 BRFSS)* ▪ Increase the proportion of adult smokers who know about Quitline services to 75%. *(Baseline = 69%, 2005 Adult TABS)*		BRFSS
Annual Objective ▪ By December 2009, at least 75 community agencies are engaged in promoting tobacco cessation at the local level. Targets for other activities will be determined after grants are awarded through review process.		Program records
Process Evaluation ▪ Promotion efforts are documented. Lead agency contracts are in place. Contractors document engagement and results per activities below.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Fund one contractor to conduct four statewide media campaigns promoting Quitline services and oversee an on-line cessation service (Fix Nixer) for 18-24 year olds. (See strategy 6.)	Ongoing	Amend-ment 35, CDC Tobacco	Deb Montgomery, STEPP Adult Cessation Program Director	National Jewish
2. Fund one contractor to provide telephone-based cessation services, free nicotine replacement therapy, and on-line cessation services to all 64 counties.				
3. Fund one lead agency contractor to award a portion of its grants to fund healthcare systems throughout Colorado. This lead agency provides technical assistance, training, expertise and support to ensure healthcare systems are institutionalizing the Public Health Service Guidelines into their systems.				

4. Fund one contractor to provide tobacco cessation services in schools.				
5. Fund at least 75 community-based organizations and local public health agencies to promote tobacco cessation at the community level.				
6. Convene an advisory group to advocate for health plans and Medicaid to increase benefits for tobacco cessation and increase private support, such as financial support, for the Colorado Quitline. (Link with strategy 1)				

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Public health linkages with healthcare systems	
Strategy WWC-1: Provide breast and cervical cancer screening and selected diagnostic services to low income women.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives ▪ By December 2013, each year screen at least 15,000 uninsured women, ages 40-64 and with incomes at or below 250% of the Federal Poverty Level, for breast and cervical cancer. ▪ By December 2013, increase participation in Pap tests for adult women above 90%. ▪ By December 2013, increase participation in mammography for women age 40 and older above 78%.	WWC, Fiscal/Grants, CCPD, STEPP	**eCast, BRFSS**
Intermediate-Term Outcome Objectives ▪ By December 2010, expand awareness of services available through the Women's Wellness Connection. (Baseline TBD in 2009.)		Media metrics Hotlines (American Cancer Society, 2-1-1)
Short-Term Outcome Objectives ▪ By June 2010, identify additional uses of surveillance and other data in program planning, decision-making and evaluation. ▪ By June 2012, working with contracted service providers, integrate quality assurance and quality improvement measures into local service systems.		Program records eCast Colorado Cancer Registry
Annual Objectives A. By December 2009, use information from the treatment navigation survey and priority population participatory research to recommend at least two changes to the recruitment and screening service system. B. By December 2009, establish baseline for reach of marketing campaign. C. By December 2009, reach at least 90% of contracted providers through training efforts.		Program records Media metrics Hotlines (American Cancer Society, 2-1-1) Webcast evaluations
Process Evaluation A. Changes to the recruitment and screening systems are documented. B. Baseline for marketing efforts is established. C. Participation in trainings is documented.		

Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Conduct treatment navigation survey.	June 2009	A35	Sandy Mortensen, WWC Program Manager	EPE, current WWC provider sites, media contractor (Cactus)

2. Conduct participatory research with CDC priority populations.	December 2009	A35	Joanne Vermeulen, WWC Outreach Coordinator	(Cactus), Breast and Cervical Cancer Screening Advisory Board, hotline staff at American Cancer Society and 2-1-1, CCGC
3. Contract with partners for service delivery using an evolving scope of work that reflects new objectives and budget.	June 2009	CDC, A35	Sandy Mortensen	
4. Implement marketing campaign with targeted populations. (Link with strategy 6.)	Ongoing	A35	Karen Phelan, Health Communica-tions and Marketing Director	
5. Support development of infrastructure at local health agencies through provider training efforts.	Ongoing	A35	Sandy Mortensen	
6. Engage Center programs in discussion of medical home as a support for implementation of the chronic care model.	**December 2009**	CDC	Sandy Mortensen	

Goal: Enhance and fully utilize Colorado's surveillance system to accurately describe chronic diseases and related factors for all Coloradans and to improve program planning, implementation and evaluation.	**Imperative:** Data and surveillance

Strategy 10: Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, use surveillance data to identify changes in risk groups and monitor progress on health objectives for interventions implemented through the Center.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Program records of surveillance plans, data results and uses for chronic diseases and risk factors
Intermediate-Term Outcome Objective ▪ By May 2012, analysis of comprehensive surveillance data on chronic disease and risk factors is available for use. ▪ By May 2011, the Health Statistics Section will have completed a new schedule of data collection.		
Short-Term Outcome Objective ▪ By January 2010, Center staff have the schedule of data collection for BRFSS questions related to chronic disease and risk factors.		
Annual Objective ▪ By July 2009, establish a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.		
Process Evaluation ▪ The Surveillance Advisory Board approves the plan.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Convene a chronic disease surveillance workgroup to analyze data gaps in chronic disease and risk factors and to prioritize data gaps to address.	May 2009	CDC	Barbara Gabella, Epidemiology and Surveillance Unit Manager	External funders and users of BRFSS
2. Based upon gap analysis, priorities and potential cost, develop a long-range plan for the schedule of rotating optional modules and state-added questions on the BRFSS.	June 2009			
3. Submit the plan to the Surveillance Advisory Board for approval.	July 2009			
4. Prepare for implementation of the plan with the 2010 BRFSS.	December 2009		Alyson Shupe, Chief, Health Statistics Section	Survey Research Unit

Goal: Enhance and fully utilize Colorado's surveillance system to accurately describe chronic diseases and related factors for all Coloradans and to improve program planning, implementation and evaluation.	**Imperative:** Data and surveillance

Strategy 11: Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, use surveillance data to identify changes in risk groups and monitor progress on health objectives for interventions implemented through the Center.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By May 2011, analysis of comprehensive surveillance data on chronic disease and risk factors is available for use.		Program records
Short-Term Outcome Objective ▪ By January 2010, Center staff have the analysis plan for BRFSS and Colorado Child Health Survey questions related to chronic disease and risk factors.		Program records
Annual Objective ▪ By December 2009, develop an analytic plan for each core, state-added question set and optional module on chronic disease added to the 2009 BRFSS and CHS.		Program records
Process Evaluation ▪ The plan is documented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Reach agreement between EPE staff and Center program managers on the analytic needs for 2008 and 2009 BRFSS and Child Health Survey data.	August 2009	CDC	Barbara Gabella, Epidemiology and Surveillance Unit Manager	External funders and users of BRFSS
2. Develop an analysis plan for chronic disease and risk factor surveillance data.	November 2009			
3. Determine guidelines for data report formats and schedule for chronic disease and risk factors.	December 2009			
4. Prepare request for analysis of the data by the Health Statistics Section that matches the analysis plan and submit according to schedule of availability of data.	December 2009			

Goal: Enhance and fully utilize Colorado's surveillance system to accurately describe chronic diseases and related factors for all Coloradans and to improve program planning, implementation and evaluation.	**Imperative:** Data and surveillance

Strategy 12: Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of data sources.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, use surveillance data to identify risk groups and monitor progress on health objectives for interventions implemented through the Center.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By May 2012, analysis of comprehensive surveillance data indicating trends for chronic disease and risk factors are available for reference. ▪ By May 2011, the analysis plan will be completed.		Program records
Short-Term Outcome Objective ▪ By August 2009, Center staff have access to analyzed data related to chronic disease and risk factors that are being tracked.		Program records
Annual Objective ▪ By August 2009, begin utilizing a tracking system for key chronic disease and risk factor outcomes that includes data from a range of data sources.		Program records
Process Evaluation ▪ The tracking system is ready for use.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Identify top indicators for chronic disease and risk factors that will be tracked on an annual basis.	February 2009	CDC	Barbara Gabella, Epidemiology and Surveillance Unit Manager	Sources of non-CDPHE data (e.g., Colorado Health and Hospital Association)
2. Request desired data from each data source.	April 2009			
3. Develop the tracking system and enter the data from each source.	June 2009			
4. Train Center staff in the use of the tracking system.	August 2009			

Goal: Enhance and fully utilize Colorado's surveillance system to accurately describe chronic diseases and related factors for all Coloradans and to improve program planning, implementation and evaluation.	**Imperative:** Data and surveillance	
Strategy 13: Increase availability and use of data to identify and monitor health disparities.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, use surveillance data to identify risk groups and monitor progress on health objectives for interventions implemented through the Center.	Asthma, BRFSS, Comp Cancer, COPAN, DPCP, EPE, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By May 2012, surveillance data that can detect true differences among racial or ethnic groups in Colorado are available. ▪ By May 2011, the analysis plan will be completed.		BRFSS, CHS
Annual Objective ▪ By July 2009, identify and secure funding for a plan for over sampling one or more racial or ethnic minority groups through the 2010 BRFSS and Child Health Survey.		Program records
Process Evaluation ▪ The Surveillance Advisory Board approves the plan.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Identify racial or ethnic minority groups to be over sampled in 2010 BRFSS and CHS.	May 2009	CDC, other TBD	Barbara Gabella, Surveillance Unit Manager	Office of Health Disparities
2. Identify sampling frame.	June 2009			
3. Work with internal and external partners to secure funding for the over sample.	July 2009			
4. Submit over sampling plan to the Surveillance Advisory Board for approval.	July 2009			

Strategy BRFSS-1: Ensure collaboration among state, local and other agencies, organizations and universities that analyze data or seek to reduce chronic disease and injury morbidity and mortality.

Imperative: Data and surveillance	**Programs Involved**	**Data Sources**
Annual Objectives A. By December 2009, BRFSS staff will be active participants in at least five statewide coalitions and committees B. By December 2009, the Surveillance Advisory Board will meet a minimum of three times to determine which state-added questions should be included on the 2010 BRFSS instrument, and the sampling plan, with attention to emerging health issues.	BRFSS	Program records

Process Evaluation
A. Participation is documented in program records.
B. Surveillance Advisory Board meetings are documented in program records.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. BRFSS coordinator and other Health Statistics Section staff will attend coalition and committee meetings.	Ongoing	CDC BRFSS	Kieu Vu, BRFSS Coordinator	Public health community
2. Convene and facilitate meetings and work groups of the Surveillance Advisory Board.	August 2009		Alyson Shupe, Chief, Health Statistics Section	Surveillance Advisory Board

Strategy BRFSS-2: Ensure the highest level of BRFSS data quality for the state of Colorado.				
Imperative: Data and surveillance	**Programs Involved**		**Data Sources**	
Annual Objectives ▪ By December 2009, ensure that all BRFSS data collection activity is in conformance with the BRFSS User's Guide and Numbered Memorandums.	BRFSS		Program records	
Process Evaluation ▪ Compliance is documented in program records.				
Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Maintain interviewing staff, including at least one bilingual interviewer trained to call on BRFSS. Train new staff as needed, utilizing an extensive training program in which staff receive a minimum of 30 hours of training.	Ongoing	CDC BRFSS	Becky Rosenblatt, Director, Survey Research Unit	Kieu Vu, Alyson Shupe
2. Monitor the survey process to ensure that methods used conform to the BRFSS User's Guide.	Ongoing			
3. Maintain data quality and efficiency of survey operations (e.g., use CATI, disproportionate stratified sampling methodology, track CASRO rate)	Ongoing			
4. Provide monthly data files and reports to the Behavioral Surveillance Branch as required.	Ongoing			

Strategy BRFSS-3: Ensure that BRFSS data are widely disseminated and used for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends, and targeting relevant population groups.

Imperative: Data and surveillance	**Programs Involved**	**Data Sources**
Annual Objectives A. By December 2009, provide data to meet requests from media, academic institutions, foundations, community-based organizations, local and state public health departments and other health agencies. B. By December 2009, use BRFSS data in a minimum of five major reports/planning documents and in evaluation plans for at least two major health department state level efforts. C. By December 2009, provide a minimum of three trainings and presentations on BRFSS. D. By December 2009, publish a minimum of two reports based on Colorado BRFSS data in the grant period.	BRFSS	Program records

Process Evaluation

- All activities are documented in program records.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Provide tabled data within three days of the request and custom analyses within the time frame negotiated with the requestor.	Ongoing	CDC BRFSS	Kieu Vu, BRFSS Coordinator	Public health community
2. Promote and facilitate the use of BRFSS data in key state reports, planning processes, and evaluations.	Ongoing			
3. Provide technical assistance and training on the interpretation and use of BRFSS data.	Ongoing			
4. Publish and disseminate reports containing BRFSS data.	Ongoing			

Strategy BRFSS-4: Ensure that BRFSS data are widely disseminated and used for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends, and targeting relevant population groups (non-chronic disease programs)

Imperative: Data and surveillance	**Programs Involved**	**Data Sources**
Intermediate-Term Outcome Objectives: ▪ By June 2010, data collected for non-chronic disease programs are weighted and available for analysis. ▪ By October 2010, a report on findings from the environmental health state-added questions is published.	**BRFSS**	Program records of surveillance plans, data results and uses for injury, violence, maternal and child health, environmental health and risk factors, and environmental health report
Short-Term Outcome Objective ▪ By March 2010, environmental health professionals from state and local public health agencies develop an analysis plan and data dissemination strategy for the environmental health state-added questions.		
Annual Objectives ▪ By December 2009, data are collected for the following optional modules/state-added questions: a. Sexual assault b. Suicidal ideation and behavior c. Family planning d. Nutrition, physical activity and built environment e. Environmental health (food safety, water quality, outdoor air quality, radon, sustainability)		

Process Evaluation

▪All activities are documented in program records.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. The 2009 questionnaire is developed, programmed into CATI, tested, and implemented according to protocol.	December 2009	CDC, EPA, Private Founda-tions	Kieu Vu, BRFSS Coor-dinator	Survey Research Unit, Injury, Suicide and Violence Prevention Unit, Women's Health Section, Kaiser Permanente, LiveWell Colorado, The Colorado Health Foundation, Air Pollution and Control Division, Water Quality Division, Hazardous Materials and Solid Waste Division, local public and environmental health agencies

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships	
Strategy 14: Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, Comp Cancer, COPAN, DPCP, HA, HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2011, establish a cohesive network of partnerships that identifies and addresses chronic diseases, shared risk factors, and health disparities through evidence-based prevention and control activities across Colorado.		Meeting minutes, Amendment 35 grants, program records
Short-Term Outcome Objective ▪ By December 2010, obtain at least ten Memoranda of Understanding/Agreement with statewide or local partners to support Center interventions.		Program records
Annual Objective ▪ By December 2009, work with partner groups according to identified strategic roles and responsibilities to reduce duplication of efforts, coordinate and leverage resources, and maximize impact of activities.		Program records

Process Evaluation

▪ Decisions on roles, responsibilities and structure are documented. Coalition chairs and key partners respond to a satisfaction survey.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Determine strategic roles and responsibilities of partners and assess current partnership roles, agreements and structure among Center programs.	January 2009	CDC	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	Coalition chairs, other key partners, LiveWell Colorado
2. Convene Center coalition chairs and other key partners to determine desired structure for partnerships, including possibility of single chronic disease coalition.	February 2009			
3. Implement plan for communicating agreed-upon structure, roles and responsibilities.	April 2009			
4. Continue to enhance and clarify roles and relationships between COPAN and LiveWell Colorado.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships	
Strategy 15: Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, eliminate health disparities based on race, ethnicity and low income	Asthma, CCPD, Comp Cancer, COPAN, DPCP, HA, HC (if awarded), HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS
Intermediate-Term Outcome Objective ▪ By December 2011, implement at least three Center interventions that reflect an approach consistent with the social determinants of health framework. ▪ By December 2011, work with one Colorado community to implement a plan that addresses the social determinants of health.		Program records
Short-Term Outcome Objective ▪ By December 2010, develop a plan, in collaboration with communities and other partners, for the implementation of model(s) consistent with the social determinants framework and integrate it with all other relevant plans in and outside the department.		Program records
Annual Objectives A. By December 2009, educate PSD staff on the basics of the social determinants framework and how it applies to the work of the Division. B. By December 2009, invite key external partners to assist in the development of a plan that shows the new direction of the Center in relation to the framework.		Program records
Process Evaluation A. A pre/post survey of PSD staff will demonstrate learning on the model. B. Convening of a partnership group will be documented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Train PSD staff on the basics of the framework including critical differences from the current public health model.	June 2009	CDC	Healthy Communities Program Coordinator (if award is received)	EPE, Office of Health Disparities, Colorado School of Public Health, key representatives of target populations, Interagency Health Disparities Leadership Council, Health and Wellness
2. Complete outreach to key external partners for training on the social determinants framework and inclusion in the development of an implementation plan.	September 2009			
3. Communicate with state and national leaders to identify successful implementation models consistent with the framework. Conduct additional research into implementation models.	December 2009			
4. Work with EPE to assemble data needed to describe health disparities in Colorado. (Link to strategy 13)	December 2009			

5. Build and define the role of the CDC Healthy Communities program funding, if awarded.	Ongoing			Health and Wellness Committee of the Colorado Commission on Indian Affairs
6. Identify opportunities to work in partnership with the Southern Ute Indian Tribe and the Ute Mountain Ute Tribe through the Health and Wellness Committee of the Colorado Commission on Indian Affairs, and using guidance from the CDC Tribal Consultation Policy.				

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships	
Strategy 16: Expand integrated work with the CDPHE Center for Healthy Families and Communities.	**Programs Involved**	**Data Sourced**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, Comp Cancer, COPAN, DPCP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS
Intermediate-Term Outcome Objective ▪ By December 2011, at least one intervention will be launched that approaches chronic disease prevention from a perspective of adverse childhood experiences.		Program records
Short-Term Outcome Objective ▪ By June 2010, 50% of staff from both PSD Centers will be knowledgeable about the link between adverse childhood experiences and chronic disease.		Pre-post test of staff attending training
Annual Objective ▪ By December 2009, a PSD workgroup will have identified the strongest areas of intervention linking adverse childhood experiences with chronic disease.		Program records
Process Evaluation ▪ Results of literature search and recommendations of the workgroup will be documented for use in program planning.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Convene a cross-Center discussion to explore literature on the link between adverse childhood experiences and chronic disease. Link to work on social determinants of health.	December 2009	CDC	Theresa Anselmo, Oral Health Program Director	Center for Healthy Families and Communities
2. Continue cross-Center collaboration to prevent chronic disease through Coordinated School Health and school-based health centers.	Ongoing	CDC	Child, Adolescent and School Health Unit and COPAN staff	Colorado Department of Education, Rocky Mountain Center for Health Promotion and Education

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships			
Strategy 17: Participate in CDC integration demonstration project.		**Programs Involved**	**Data Sources**	
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income.		BRFSS, Comp Cancer, COPAN, DPCP, HDSP, OH, STEPP	BRFSS, YRBS, Youth TABS, CHS, CDSM data system	
Intermediate-Term Outcome Objective ▪ By December 2011, identify costs and benefits of integration of chronic disease and risk factor programming.			Program records	
Short-Term Outcome Objective ▪ By December 2009, ensure that 90% of Center staff understand the purpose and process of the CDC integration demonstration project.			Staff survey	
Annual Objective ▪ By December 2009, communicate with CDC integration team at least once per month.			Program records	
Process Evaluation ▪ Communication with CDC is documented.				
Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Participate in CDC cross-state evaluation of the demonstration project.	Ongoing	CDC	Andrea Poniers, Deputy Director, Chronic Disease Prevention Branch	CDC integration team, integration teams from MA, NC and WI
2. Participate in CDC conference calls and meetings related to the demonstration project.	Ongoing			
3. Maintain communication with CDC integration project officer.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative**: Partnerships			
Strategy COPAN-4: Promote best practices for nutrition and physical activity in early childhood settings.	**Programs Involved**		**Data Sources**	
Long-Term Outcome Objectives By December 2013: ▪ Increase recommended levels of physical activity among Colorado children above 60% ▪ Increase proportion of Colorado children who consume at least five fruits/vegetables per day to 10%	COPAN		CHS	
Intermediate-Term Outcome Objective ▪ By December 2011, develop an integrated network of early childhood obesity experts to implement the Colorado early childhood obesity prevention plan, including sharing the plan with LiveWell Colorado communities and local public health agencies.			Program records	
Annual Objectives A. By June 2009, create the position and hire the Early Childhood Obesity Prevention Specialist, in partnership with the Center for Healthy Families and Communities. B. By December 2009, provide assistance to at least 300 childcare providers and other early childhood professionals to employ best practices for nutrition and physical activity.			Program records	
Process Evaluation A. Early Childhood Obesity Prevention Specialist is hired. B. Distribution of best practices resources and participation in trainings are documented.				
Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Complete early childhood obesity prevention scan of gaps and needs.	January 2009	CDC Physical Activity, Nutrition and Obesity	Eric Aakko, COPAN Program Manager	COPAN Coalition, local health agencies, child care providers
2. Identify best practices and resources, disseminate resources and provide training to childcare providers.	January 2009			
3. Establish position, recruit, and hire Early Childhood Obesity Prevention Specialist	June 2009			
4. Complete draft of an early childhood obesity prevention plan.	August 2009		COPAN Early Childhood Obesity Prevention Specialist	

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships	
Strategy COPAN-5: Promote TV Turnoff Week in Colorado.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, decrease to 15% the proportion of Colorado children ages 5-14 who spend three hours or more per school day watching TV, DVDs or videos. *(Baseline = 16.5%, 2007 CHS)*	COPAN	CHS
Short-Term Outcome Objective ▪ By December 2011, maintain partnerships with LiveWell Colorado, the Colorado Department of Education and other groups to promote the benefits of reduced screen time for obesity prevention.		Program records
Annual Objective ▪ By June 2009, distribute materials at least 21 communities with activities to promote TV Turnoff Week.		Program records

Process Evaluation

▪ Activities in communities are documented.

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Promote media release and fact sheet with statewide partners.	February 2009	CDC	COPAN staff (TBD)	COPAN Coalition, local health agencies, Kaiser Permanente, schools
2. Promote TV Turnoff Week to local health agencies, schools and parent groups with training materials, a media release and fact sheets.	April 2009			
3. Reach out to other organizations to take on TV Turnoff Week activities, including the Interagency School Health Team.	April 2009			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships	
Strategy COPAN-6: Promote best practices for worksite wellness to support chronic disease prevention and management through Colorado worksites.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	COPAN Contributing: DPCP, HDSP	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objective ▪ By December 2013, promote worksite wellness best practices that support chronic disease prevention and management to at least 400 Colorado worksites with a majority of lower wage paying jobs.		Program records
Short-Term Outcome Objective ▪ By December 2011, promote worksite wellness best practices to at least 200 worksites with a majority of lower wage paying jobs.		Program records
Annual Objective A. By December 2009, build the capacity of at least 150 Colorado worksites to implement comprehensive worksite health promotion programs. B. By December 2009, identify needs and gaps in worksite wellness activities and programs across the state.		Program records
Process Evaluation A. Participation in worksite wellness training workshops or web casts is documented; training evaluations show increase in knowledge regarding worksite wellness practices. B. Analysis of needs and gaps is documented in program records.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Identify and organize data on employee demographics, wages and other factors related to social determinants of health.	May 2009	CDC	Eric Aakko, COPAN Program Manager and COPAN Worksite Wellness	COPAN Worksite Wellness Task Force
2. Work with partners to evaluate status of worksite wellness activities and programs across the state, identify needs and gaps, and identify non-traditional partners.	June 2009			
3. Complete a worksite wellness toolkit that promotes best practices for health promotion and environmental change at the worksite, highlighting success stories for worksites.	August 2009			

4. Promote regional worksite wellness training workshops or web casts.	Ongoing		Coordinator	
5. Work with other Center chronic disease and risk factor programs on worksite outreach.	Ongoing			
6. Promote and improve CDPHE worksite wellness program for state employees.	Ongoing			

Goal: Improve health outcomes related to chronic disease and risk factors	**Imperative:** Partnerships	
Strategy HDSP-2: Contribute to heart disease and stroke prevention initiatives of primary partners.	**Programs Involved**	**Data Sources**
Intermediate-Term Objective ▪ By December 2011, the stroke system of care will be implemented in at least two RETAC regions in Colorado.	HDSP	Colorado Stroke Alliance program records
Annual Objectives A. By December 2009, participate in the planning of the development of a statewide stroke system of care. B. By December 2009, participate in American Heart Association/American Stroke Association efforts to improve quality of care for stroke and heart disease patients through support of the implementation of the *Get with the Guidelines* in Colorado hospitals. C. By December 2009, support the activities of the Heart Association/American Stroke Association priority programs and cause initiatives.		Program records
Process Evaluation ▪ Document participation in all partnership activities.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Attend meetings with the American Heart Association, Colorado Stroke Alliance and other partners to plan activities.	Ongoing	CDC Heart and Stroke Prevention	Marsha Wilde, HDSP Program Manager	American Heart Association, American Stroke Association, Colorado Stroke Alliance
2. Provide resources, as possible, to support activities associated with implementation.	Ongoing			
3. Include information in coalition newsletter to promote initiatives.	Ongoing			

Goal: Improve state health department infrastructure to maximize effectiveness of chronic disease prevention efforts.

Strategy 18: Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, ensure that 90% of strategies included in the CDPHE chronic disease strategic (state) plan and the Center integrated workplan are evidence-based. *(Baseline to be established in 2009)*	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By June 2011, create a CDPHE chronic disease state plan document.		Program records
Short-Term Outcome Objective ▪ By June 2009, establish a common understanding of the EPE evidence-based classification system among at least 75% of Center staff.		Training evaluations
Annual Objective ▪ By December 2009, increase the number of evidence-based strategies included in 2010 Center integrated workplan, as compared to 2009 plan.		Program records
Process Evaluation ▪ Program records will document an increased number of strategies meeting Class I and II evidence base, according to the EPE classification system.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Train Center staff in EPE classification system for evidence base.	June 2009	CDC	Gabriel Kaplan, EPE Director	
2. Assess Center integrated workplan according to evidence-based classification system.	August 2009		Andrea Poniers, Deputy Director, Chronic Disease Prevention Branch	
3. Convene a workgroup for development of the chronic disease state plan document.	September 2009			Key coalition leaders
4. Review and revise Center integrated workplan.	December 2009			

Goal: Recruit and retain a skilled workforce at adequate staffing levels through development and implementation of efficient human resources policies, processes and practices**.**

Strategy 19: Align Center staffing with the integrated workplan.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, align Center staffing with shared goals and functions.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By December 2011, at least 20% of positions are shared across Center programs.		Program records
Short-Term Outcome Objectives ▪ By December 2010, at least 75% of Center staff will be able to provide a broad overview of all Center chronic disease and risk factor programs.		Staff assessment, observation
Annual Objectives A. By December 2009, develop a staffing plan that identifies needed positions and skills and addresses strategies for filling gaps. B. By December 2009, establish and fill at least one new position shared across Center programs.		Program records
Process Evaluation A. The staffing plan is documented. B. The shared position is documented.		

Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Define functions and skills needed to implement Center strategies and assess against current staffing.	March 2009	CDC, Amend-ment 35	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	N/A
2. Identify strategies to fill gaps in needed functions and skills.	June 2009			
3. Begin to implement strategies for staffing alignment.	September 2009			
4. Determine methods for establishing a working knowledge of all Center programs among Center staff.	December 2009			

Goal: Create a Center work environment that values respect, shared knowledge, efficiency and effectiveness in reaching goals while sustaining accountability to coworkers, stakeholders and the public, and in which staff are empowered leaders with high job satisfaction.

Strategy 20: Streamline business practices.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, support shared goals through efficient business practices across the Center.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By December 2011, coordinate and streamline at least two business practices per year that create efficiencies in reaching Center goals.		
Short-Term Outcome Objective ▪ By December 2010, establish processes for identifying, reviewing and prioritizing efficiencies in Center business practices.		
Annual Objective ▪ By December 2009, coordinate and streamline business practices in two priority areas.		
Process Evaluation ▪ Center records reflect new processes/policies.		

Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Develop and begin implementing a plan for a single fulfillment center for all Center materials.	December 2009	CDC, Amend-ment 35	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	N/A
2. Develop and begin use of single grants management database	June 2009			
3. Identify additional priorities for efficient business practices.	December 2009			

Goal Area: Improve state health department infrastructure to maximize effectiveness of chronic disease prevention efforts.

Strategy 21: Evaluate chronic disease and risk factor program activities.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objectives By December 2013: ▪ Reduce obesity and increase healthy weight ▪ Reduce smoking ▪ Increase physical activity ▪ Increase participation in recommended screenings and Chronic Disease Self-Management ▪ Eliminate health disparities based on race, ethnicity and low income	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	BRFSS, YRBS, Youth TABS, CHS, CDSM data system
Intermediate-Term Outcome Objectives ▪ By June 2013, utilize evaluation results to improve effectiveness and efficiency of Center chronic disease and risk factor programs. ▪ By June 2012, report evaluation results of the Center integration effort.		Program records
Short-Term Outcome Objectives By March 2010: ▪ 50% of Center staff, including all program managers, will have proficient knowledge of evaluation strategies. ▪ 50% of Center staff will be knowledgeable of program evaluation activities.		Proficiency measure TBD Staff survey
Annual Objectives A. By February 2009, begin implementing an evaluation plan for the Center integration effort. B. By June 2009, begin implementing an evaluation plan for Center chronic disease and risk factor program activities.		Program records
Process Evaluation A. A chronic disease evaluation plan is documented and monitored. B. An integration evaluation plan is documented and monitored.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Develop and begin implementation of an evaluation plan for Center chronic disease and risk factor programs.	Ongoing	CDC, Amend-ment 35	Gabriel Kaplan, Director, Epidemiology, Planning and Evaluation Branch	CDC evaluation consultants, APEG project team
2. Develop and begin implementation of an evaluation plan for Center integration efforts.	Ongoing			
3. Coordinate evaluation efforts with APEG evaluation and tracking of Amendment 35 grants.	Ongoing			
4. Participate in CDC cross-state evaluation of the integration demonstration project. (See strategy 17.)	Ongoing			

Goal: Increase the alignment of current and new public and private, federal, state and local funds to achieve health outcomes.		
Strategy 22: Secure diversified funding and align resources to support Center goals.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, support Center chronic disease prevention and management efforts through diversified funding.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By December 2013, ensure that at least 80% of projects funded through Amendment 35 grants support Center priorities for chronic disease prevention and management. (See Strategy 3)		Program records
Short-Term Outcome Objective ▪ By December 2011, obtain program funds from at least three new non-CDC sources.		Program records
Annual Objective ▪ By December 2009, begin implementation of a plan for integrated funding across Center programs.		Program records
Process Evaluation ▪ Fiscal records demonstrate shared funding across programs.		

Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Create a Center resource development team to review funding for alignment with Center workplan.	January 2009	CDC, Amend-ment 35, other as identified	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	CDC, A35 Review Committees
2. Develop an integrated funding pattern for shared positions and functions.	June 2009			
3. Begin to implement shared funding pattern.	December 2009			
4. Comply with all grant requirements from current funding.	Ongoing			

Goal: Create a Center work environment that values respect, shared knowledge, efficiency and effectiveness in reaching goals while sustaining accountability to coworkers, stakeholders and the public, and in which staff are empowered leaders with high job satisfaction.

Strategy 23: Implement clear and effective communication protocols and practices.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, all Center staff will have the information they need to work toward shared goals.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Staff survey
Intermediate-Term Outcome Objective ▪ By December 2010, establish a mechanism for annual review of communication protocols.		Program records
Short-Term Outcome Objective ▪ By December 2011, obtain agreement from at least 75% of Center staff that communication protocols keep them informed of activities, events and decisions in the Center and Department.		Staff survey
Annual Objective ▪ By December 2009, obtain agreement from at least 50% of Center staff that communication protocols keep them informed of activities, events and decisions in the Center and Department.		Staff survey
Process Evaluation ▪ Staff will respond to a satisfaction survey regarding implementation of new communication protocols.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Inventory existing Center communication structures, protocols and tools, including meetings, electronic updates, etc.	February 2009	CDC	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	N/A
2. Disseminate clarified and streamlined Center communication protocols.	June 2009			
3. Review communication protocols and implementation and revise as needed.	December 2009			
4. Define, discuss and internally publicize clear roles, responsibilities, lines of authority and decision-making protocols for the Center.	December 2009			

Goal: Create a Center work environment that values respect, shared knowledge, efficiency and effectiveness in reaching goals while sustaining accountability to coworkers, stakeholders and the public, and in which staff are empowered leaders with high job satisfaction.				
Strategy 24: Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	**Programs Involved**			**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, 75% of Center staff will report satisfaction relative to respect, shared knowledge, accountability and leadership opportunities in the workplace	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC			Staff survey
Intermediate-Term Outcome Objective ▪ By December 2011, 50% of Center staff will report satisfaction relative to respect, shared knowledge, accountability and leadership opportunities in the workplace.				Staff survey
Short-Term Outcome Objective ▪ By December 2009, 50% of Center staff will identify three ways in which the work environment is improving in any of the following areas: respect, shared knowledge, accountability, and leadership opportunities.				Staff survey
Annual Objective ▪ By April 2009, provide training in learning organizations to 80% of Center staff.				Program records
Process Evaluation ▪ Participation in training will be documented.				
Activities:	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Arrange training in creating a learning organization and environment.	April 2009	CDC	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	N/A
2. Reinforce Respectful Workplace training and Crucial Conversations training as frameworks for staff relationships and conflict resolution.	Ongoing			
3. Ensure managers at all levels are consistently applying expectations around performance and PSD core values.	Ongoing			

Goal: Recruit and retain a diverse, skilled workforce at adequate staffing levels through development and implementation of efficient human resources policies, processes, and practices.

Strategy 25: Establish policies, processes and practices that support workforce development.	**Programs Involved**	**Data Sources**
Long-Term Outcome Objective ▪ By December 2013, at least 80% of program managers and unit/branch/center directors will score competent or above relative to competencies for their positions.	Asthma, CCPD, Comp Cancer, COPAN, DPCP, Fiscal/Grants, HA, HC (if awarded), HDSP, OH, STEPP, WWC	Program records
Intermediate-Term Outcome Objective ▪ By December 2011, remove at least three identified obstacles to recruiting and retaining a diverse, skilled workforce.		Program records
Short-Term Outcome Objective ▪ By December 2009, routinely train all Center supervisors in developing effective skills in employee development and retention.		Program records
Annual Objective ▪ By December 2009, recommend one change in personnel practices to the CDPHE Office of Human Resources.		Program records
Process Evaluation ▪ Discussion with Office of Human Resources is documented.		

Activities	**Target Completion Date**	**Funding Sources**	**Lead Person**	**Partners**
1. Participate in PSD effort to define best practices and identify obstacles to recruiting and hiring a diverse workforce.	Ongoing	CDC	Karen DeLeeuw, Director, Center for Healthy Living and Chronic Disease Prevention	PSD Program Integration and Improvement Team (PIIT)
2. With PSD, define competencies for program managers and unit/branch/center directors.	June 2009			
3. Prioritize desired changes in recruitment and retention that are within the purview of the Department.	November 2009			
4. With PSD, develop and implement performance expectations for supervisors, including delivering developmental feedback and coaching/mentoring.	December 2009			

PART 3: CROSS-INDEX OF STRATGIES BY PROGRAM

ASTHMA PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	Provide technical assistance to grantees.
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
	Smoking	STEPP-2. Eliminate exposure to secondhand smoke.	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	Increase number of asthma media placements by 12.
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	▪ Complete an evaluation of the asthma guidelines developed in 2008. ▪ Evaluate implementation of the asthma guideline through 20 IPIP and 10 non-IPIP practices to answer questions regarding the use of public education tools and materials and the CCGC website.

ASTHMA PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	
	Asthma	Asthma-1. Increase access to quality care and quality one-on-one education for those who have asthma, particularly in rural and disparate communities.	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	Complete two surveillance reports.
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	
	Smoking, obesity, physical activity, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	
	Obesity, smoking, physical inactivity, screening, health disparities	COPAN-6 Promote best practices for worksite wellness to support chronic disease prevention and management through Colorado worksites.	
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	

ASTHMA PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
	Surveillance system, health disparities	BRFSS-1. Ensure collaboration among state, local and other agencies, organizations and universities that analyze data or seek to reduce chronic disease and injury morbidity and mortality.	
	Surveillance system, health disparities	BRFSS-2. Ensure the highest level of BRFSS data quality for the state of Colorado.	

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Surveillance system, health disparities	BRFSS-3. Ensure that BRFSS data are widely disseminated and used for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends, and targeting relevant population groups.	
	Surveillance system, health disparities	BRFSS-4: Ensure that BRFSS data are widely disseminated and used for directing program planning, program evaluation, setting program priorities, developing interventions, assessing trends and targeting population groups (non-chronic disease programs).	
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	

CCPD PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	

CCPD PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

COMPREHENSIVE CANCER PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	

COMPREHENSIVE CANCER PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	Provide technical assistance to grantees.
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	Promote recommended cancer screenings.
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	▪ Promote recommended cancer screenings. ▪ Implement the second in a five-part series of web-based training, focusing on cancer screening. ▪ Implement a prostate cancer forum. ▪ Promote recommended cancer screenings. ▪ Issue three press releases or media advisories to inform and educate Colorado citizens about cancer prevention and best practices. ▪ Conduct three public awareness and education activities, coordinated with national campaigns. ▪ Promote recommended cancer screenings.
	Screening	Comp Cancer-1: Educate consumers on the importance of colorectal cancer screening and the availability of statewide screening services.	
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	

COMPREHENSIVE CANCER PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	▪ Produce three Cancer Facts and Figures reports. ▪ Participate in two GIS projects.
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	▪ Conduct three activities to engage members of the Colorado Cancer Coalition, including communication, planning and support of task forces. ▪ Conduct a partner satisfaction survey. ▪ Communicate with partners about the activities of the Colorado Cancer Coalition and the Comprehensive Cancer Program.
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	▪ Administer and participate in the Diversity Awareness and Cultural Beliefs Conference, including the possibility of expanding the focus beyond cancer. ▪ Implement strategies for tribal nations set forth in 2007-08.
	Smoking, obesity, physical activity, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	Continue participation in the HPV/Cervical Cancer Task Force.
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	Develop a plan for updating the state cancer plan in 2010.
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	

COMPREHENSIVE CANCER PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

COPAN PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	▪ Promote new physical activity guidelines. ▪ Promote active community environments. ▪ Promote best practices for obesity prevention.
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
	Obesity, physical activity	COPAN-1. Create and support active community environments that promote walking, biking, trails, parks and improvement to community planning.	
	Breastfeeding	COPAN-2. Support policies in healthcare settings and worksites that maintain breastfeeding initiation and increase breastfeeding duration.	

COPAN PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	▪ Promote new physical activity guidelines. ▪ Promote best practices for obesity prevention. ▪ Promote TV Turnoff Week.
	Nutrition	COPAN-3. Increase identification and selection of healthy food and beverage options.	
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	Promote new physical activity guidelines.
	Obesity, diabetes	DPCP-2. Promote weight loss among overweight/obese women of childbearing age.	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	Participate with LiveWell Colorado and other partners in statewide strategic planning for an obesity prevention system.
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	

COPAN PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Smoking, obesity, physical activity, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	▪ Promote new physical activity guidelines. ▪ Promote best practices for obesity prevention. ▪ Promote TV Turnoff Week. ▪ Partner with Coordinated School Health Program.
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	
	Physical activity, nutrition	COPAN-4. Promote best practices for nutrition and physical activity in early childhood settings.	
	Screen time	COPAN-5. Promote TV Turnoff Week in Colorado.	
	Obesity, smoking, physical inactivity, screening, health disparities	COPAN-6 Promote best practices for worksite wellness to support chronic disease prevention and management through Colorado worksites.	
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	Update COPAN state plan.
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

DIABETES PREVENTION AND CONTROL PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	▪ Promote reimbursement for diabetes self-management education. ▪ Promote reimbursement for intensive lifestyle modification for pre-diabetes.
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	Promote policies that identify and treat people with pre-diabetes or at increased risk for diabetes (includes racial/ethnic groups with health disparities).
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	Provide technical assistance and awareness of diabetes as a risk factor and co-morbidity with heart disease.
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	Promote diabetes self-management education as an evidence-based practice.
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division	
	Obesity, physical activity	COPAN-1. Create and support active community environments that promote walking, biking, trails, parks and improvement to community planning.	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	▪ Support a joint health care provider website for chronic disease including on-line training resources. ▪ Increase usability and availability of diabetes resources and data by improving DPCP website location and design.
	Nutrition	COPAN-3. Increase identification and selection of healthy food and beverage options.	
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	Promote the use of the Colorado's Diabetes Clinical Guidelines and Gestational Diabetes Guidelines.

DIABETES PREVENTION AND CONTROL PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Obesity, smoking, physical inactivity, screening, health disparities	8. Expand reach of Healthier Living (Stanford Chronic Disease Self-Management Program) and Tomando throughout the state.	Coordinate with disease-specific initiatives such as the Stanford's Diabetes Self-Management Education program in English and Spanish.
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	Provide resource and referrals for diabetes-specific resources.
	Diabetes complications	DPCP-1. Increase availability of diabetes self-management in Colorado.	
	Obesity, diabetes	DPCP-2. Promote weight loss among overweight/obese women of childbearing age.	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	Determine and implement questions to accurately measure pre-diabetes.
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	Include ESRD (End-Stage Renal Disease), HEDIS, SEARCH (diabetes in youth), hospital discharge, Medicaid and Medicare data.
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	Obtain and publish diabetes data from Denver Indian Family Health Services (DIFHS) and Colorado Asian Health Education and Promotion (CAHEP).
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	▪ Clarify roles of Diabetes Advisory Council (DAC), Colorado Diabetes Network (CDN), and Diabetes Regional Directors. ▪ Enhance relationships with Colorado chapter of the American Diabetes Association and Rocky Mountain Association of Diabetes Educators. ▪ Develop and foster relationships with Native American population through the Commission on Indian Health.

DIABETES PREVENTION AND CONTROL PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	
	Smoking, obesity, physical activity, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	**Strategy DPCP-2**: Promote weight loss among overweight/obese women of child-bearing age
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	
	Obesity, smoking, physical inactivity, screening, health disparities	COPAN-6 Promote best practices for worksite wellness to support chronic disease prevention and management through Colorado worksites.	
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

HEALTHY AGING PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	Increase awareness of health options available to older adults to maximize quality of life (resources, consumer choice, delivery of services in home and community settings).
	Obesity, smoking, physical inactivity, screening, health disparities	8. Expand reach of Healthier Living (Stanford Chronic Disease Self-Management Program) and *Tomando* throughout the state.	
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	

HEALTHY AGING PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

HEART DISEASE AND STROKE PREVENTION PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	Explore as an option for Heart and Stroke Healthy Community criteria.
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	Include HDSP partners.
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	Provide technical assistance to grantees.
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	Explore as an option for Heart and Stroke Healthy Community.
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
	Obesity, physical activity	COPAN-1. Create and support active community environments that promote walking, biking, trails, parks and improvement to community planning.	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	Promote awareness of signs and symptoms of heart disease and stroke and 9-1-1.
	Nutrition	COPAN-3. Increase identification and selection of healthy food and beverage options.	
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	Promote guidelines related to risk assessment and screening.
	Obesity, smoking, physical inactivity, screening, health disparities	8. Expand reach of Healthier Living (Stanford Chronic Disease Self-Management Program) and Tomando throughout the state.	Promote program to reduce recurrence of heart attack and stroke.

HEART DISEASE AND STROKE PREVENTION PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.	
	Screening, heart disease, hypertension	HDSP-1. Enhance capacity of community systems to prevent and address heart disease and stroke.	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	Update heart disease and stroke burden report.
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	
	Obesity, smoking, physical inactivity, screening, health disparities	COPAN-6 Promote best practices for worksite wellness to support chronic disease prevention and management through Colorado worksites.	
	Heart disease, stroke	HDSP-2. Contribute to heart disease and stroke prevention initiatives of primary partners.	

HEART DISEASE AND STROKE PREVENTION PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	Update state plan for heart disease and stroke prevention.
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

ORAL HEALTH PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	Promote smoking cessation code in dental insurance.

ORAL HEALTH PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Obesity, smoking, physical inactivity, screening, health disparities	Define and implement a policy agenda for chronic disease prevention and management	▪ Mobilize community partnerships between and among policy makers, professionals, organizations, groups, the public and others to identify and implement solutions to oral health problems. ▪ Promote and enforce laws and regulations that protect and improve oral health, ensure safety, and assure public accountability for the public's well-being. ▪ Develop plans and policies through a collaborative process that support individual and community oral health efforts to address oral health needs. ▪ Conduct assessment of policy and systems strategies. ▪ Develop policy action plan and implement activities.
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	Contribute to oral health initiatives.
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	▪ Inform, educate, and empower the public regarding oral health problems and solutions. ▪ Provide content and information. ▪ Provide access to network of oral health professionals. ▪ Inform, educate, and empower the public regarding oral health problems and solutions.
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	▪ Assist in educating oral health care providers on utilization of practice guidelines that are relevant (tobacco cessation). Possibly develop new (Fluoride Supplementation). ▪ Conduct research and support demonstrations to gain new insights and applications of innovative solutions to oral health problems.

ORAL HEALTH PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	
	Oral health	OH-1. Support services and programs that focus on primary and secondary prevention (sealants).	
	Oral health	OH-2. Support services and programs that focus on primary and secondary prevention (fluoride).	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	Assess oral health status and needs so that problems can be identified and addressed.
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	Implement an oral health surveillance system to identify, investigate, and monitor oral health problems and health hazards.
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	▪ Implement an oral health surveillance system to identify, investigate, and monitor oral health problems and health hazards. ▪ Conduct research and support demonstrations to gain new insights and applications of innovative solutions to oral health problems.
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	Analyze determinants of oral health status and needs, including resources.
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	Mobilize community partnerships between and among policy makers, professionals, organizations, groups, the public and others to identify and implement solutions to oral health problems.
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	Analyze determinants of oral health status and needs, including resources.

ORAL HEALTH PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Smoking, obesity, physical activity, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	▪ Work on oral injury prevention. ▪ Collaborate on data collection (e.g., CDC SLIMS, BMI collection with oral screening). Support services and programs that focus on primary and secondary prevention. ▪ Link people to needed population-based oral health services, personal oral health services, and support services and assure the availability, access and acceptability of these services by enhancing system capacity, including directly supporting services when necessary.
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	▪ Demonstrate rationale, progress, and outcomes of programmatic integration with Chronic Disease (including diabetes, cardio-vascular disease, tobacco prevention and control, healthy aging), and Maternal Child Health programs. ▪ Integrate oral health with chronic disease, consistent with the CDC Integration Demonstration Project, and with MCH programs consistent with Block Grant performance measures.
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	Assure that the Colorado Oral Health Unit and the state level public health work force has the capacity and expertise to effectively address oral health needs in Colorado.
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	Evaluate effectiveness, accessibility, and quality of population-based oral health services and personal oral health services and evaluate progress on Oral Health RFA 802.
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	

ORAL HEALTH PROGRAM STRATEGIES			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	Assure that the Colorado Oral Health Unit and the state level public health workforce has the capacity and expertise to effectively address oral health needs in Colorado.

STATE TOBACCO EDUCATION AND PREVENTION PARTNERSHIP			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	
	Smoking	STEPP-1. Prevent tobacco initiation among youth and young adults.	
	Smoking	STEPP-2. Eliminate exposure to secondhand smoke.	

STATE TOBACCO EDUCATION AND PREVENTION PARTNERSHIP			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	
	Smoking	STEPP-3. Promote smoking cessation among Colorado adults and youth.	
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	

STATE TOBACCO EDUCATION AND PREVENTION PARTNERSHIP			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	▪ Provide funding to organizations to reach, involve and mobilize communities disparately affected by tobacco to reduce the health and economic burden of tobacco. ▪ Identify health-related tobacco disparities and ensure all programming is reaching communities with the highest tobacco use or burden.
	Smoking, obesity, physical activity, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	
	Obesity, smoking, physical inactivity, screening, health disparities	17. Participate in CDC chronic disease integration demonstration project.	
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	

WOMEN'S WELLNESS CONNECTION			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Policy and environmental change	Obesity, smoking, physical inactivity, screening, health disparities	1. Establish financial incentives within the healthcare system to encourage clinical practices that support chronic disease objectives. (Link with strategy 6, health communications plan.) Begin in year 2.	
	Obesity, smoking, physical inactivity, screening, health disparities	2. Define and implement a policy agenda for chronic disease prevention and management	
	Obesity, smoking, physical inactivity, screening, health disparities	3. Work with review committees to align Amendment 35 funding with Center priorities for chronic disease prevention and management.	
	Obesity, smoking, physical inactivity, screening, health disparities	4. Promote best practices for chronic disease prevention and management in local health agencies.	Promote the Chronic Care Model during annual provider trainings.
	Health disparities	5. Implement federal Culturally and Linguistically Appropriate Services (CLAS) standards for programs within the Prevention Services Division.	Promote and support one training to WWC providers via an educational event.
Health communications	Obesity, smoking, physical inactivity, screening, health disparities	6. Implement a coordinated health communications plan that includes strategic marketing for healthcare providers and consumers addressing chronic disease, risk factors and recommended screenings.	▪ Coordinate at least one chronic disease campaign targeted to WWC providers annually. ▪ Coordinate at least one chronic disease campaign targeted to WWC clients annually. ▪ Provide the opportunity for WWC providers to be interviewed or highlighted for press releases.
Public health linkages with healthcare systems	Obesity, smoking, physical inactivity, screening	7. Promote healthcare system change through widespread implementation of clinical practice guidelines. (Link with strategy 1, financial incentives.)	Support efforts to distribute guidelines and provide opportunity for training.
	Obesity, smoking, physical inactivity, screening	9. Implement protocols for Quitline callers that address chronic disease, risk factors, recommended screenings and self-management. (Link to strategies 1 on reimbursement and 6 on health communications.)	Coordinate at least one chronic disease campaign targeted to WWC providers annually.
	Screening	WWC-1. Provide breast and cervical cancer screening and selected diagnostic services to low income women.	

WOMEN'S WELLNESS CONNECTION			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
Data and surveillance	Surveillance system	10. Implement a long-range plan to add optional modules and state-added questions to the BRFSS to measure chronic disease risk factors and outcomes.	
	Surveillance system	11. Establish an analysis plan for each BRFSS core, state-added question set and optional module related to chronic disease and risk factors.	
	Surveillance system	12. Develop a tracking system for key chronic disease and risk factor outcomes that summarizes data from a range of sources.	Support efforts to distribute guidelines and provide opportunity for training.
	Surveillance system, health disparities	13. Increase availability and use of data to identify and monitor health disparities.	Coordinate at least one chronic disease campaign targeted to WWC providers annually.
Partnerships	Obesity, smoking, physical inactivity, screening, health disparities	14. Clarify roles and structure of strategic partnerships to support chronic disease and risk factor objectives.	
	Health disparities	15. Develop new approaches to preventing and addressing chronic diseases that are consistent with the social determinants of health framework.	Provide support and distribute information to WWC providers.
	Smoking, obesity, physical inactivity, screenings, health disparities	16. Expand integrated work with the CDPHE Center for Healthy Families and Communities.	Participate in integrated efforts with Family Planning.
	Infrastructure	18. Establish a coordinated planning process to identify, articulate and guide implementation of evidence-based strategies across all Center programs.	
	Infrastructure	19. Align Center staffing with the integrated workplan.	
	Infrastructure	20. Streamline Center business practices.	
	Infrastructure	21. Evaluate Center chronic disease and risk factor interventions.	
	Infrastructure	22. Secure diversified funding and align resources to support Center goals.	
	Work environment	23. Implement clear and effective communication protocols and practices.	

WOMEN'S WELLNESS CONNECTION			
IMPERATIVE	LEADS TO GOAL/OBJECTIVE	STRATEGY	PROGRAM FOCUS WITHIN INTEGRATED STRATEGY, IF ANY
	Work environment	24. Create a work environment with expectation and reinforcement of respect, shared knowledge, accountability and leadership.	
	HR processes, practices, procedures	25. Establish policies, processes and practices that support workforce development.	