

VERSION 2.0 WORK IN PROGRESS: Evidence Related to Chronic Disease June 2020



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This document represents findings from a scan of the literature related to activities health departments conduct to address chronic diseases. It is not meant to be an exhaustive search. It concludes with articles about the link between accreditation and chronic disease. If there are other resources on this topic of which you think PHAB should be aware, please contact Jessica Kronstadt at jkronstadt@phaboard.org.

Current State

It is evident that health departments prioritize chronic disease (CD) prevention and treatment. The Association of State and Territorial Health Officials (ASTHO) report an overall increase in the percentage of state health departments that listed chronic disease prevention as the top priority from 14.5% in 2014 to 23.9% in 2016.¹ The National Association of County and City Health Officials (NACCHO) Profile also indicates that many health departments screen for indicators of chronic disease, including 62% of local health departments screen for HIV/AIDS, 54% screen for high blood pressure, 53% screen for body mass index (BMI), 34% screen for diabetes cases, 32% screen for cancer cases, and 25% screen for cardiovascular diseases.²

Screening and treatment are key activities within chronic disease management that are nested within policy, systems, and environmental multilevel interventions centered around health equity.³ Furthering health equity requires health departments to continue incorporating culturally competent strategies throughout partnerships, collaborations and organizational capacity building. Such strategies enable health departments to continue engaging in activities that tackle barriers pertaining to social determinants of health.

Effective implementation of these multilevel interventions requires health departments to develop organizational environments that are conducive to chronic disease management. Various studies note the following features as priority areas that facilitate these conducive environments.

Capacity Development

Priority practice areas must continuously be improved. One way to engage in improvement is through the use of STAR, a tool developed by Jay Galbraith and adapted by the National Association of Chronic Disease Directors that specifically focuses on chronic disease management. STAR stands for state activation and response and is an "opportunity for continuous capacity development through rapid cycle improvement process for organizational capacity development."⁴ This tool

defines its organizational framework into six pieces: workforce development, evidence-based public health practice, leadership, management and administration, organizational climate and culture, and partnerships and relationships. Each of the six pieces are aligned with the twelve PHAB domains. A total of twenty-one states and territories utilize this tool.

Workforce and Evidence-Based Public Health

The use of evidence-based approaches is key to addressing chronic disease.

- One study suggests utilizing competencies to promote effective public health practice and chronic disease prevention and control since practitioners may not be coming from a public health background. This study notes using the competencies for chronic disease practice “highlights interrelationships among the specific skills and knowledge required for leading and managing state chronic disease programs.” Additionally, the competencies are in line with priorities outlined by key agencies such as the US Public Health Service, Centers for Disease Control and Prevention, and the Institute of Medicine.⁵
- Barriers related to training, resources, time, funds, and management buy-in make it challenging for practitioners to use EBPH. A lack of training in finding, using, and evaluating evidence-based interventions (EBI) and a lack of a foundational understanding in biostatistics and epidemiology deters practitioners from adapting EBI for their respective jurisdictions. However, practitioners also noted they do not have time to learn EBIs. Funding constraints and barriers in obtaining buy-in from management also make it difficult to engage in utilizing EBIs.⁶
- However, solutions such as increasing funding to include evidence database subscription fees allow practitioners to have digital access to literature which encourages the use of EBPH.⁷ Additionally, buy-in from leadership, work culture and communication are factors that facilitate an environment that uses EBPH.⁸

Health Equity and Social Determinants of Health

Chronic disease approaches must be centered around the principle of health equity.

- LHD work units with a strong commitment to achieve health equity “were more likely to encourage the use of evidence-based decision making (OR: 2.6) and to be perceived as capable of leading such decision making.” These units tend to incorporate health equity throughout their work by building trust with the target populations, utilizing epidemiology and various methods of evaluations to find the gaps in health outcomes, and tailor EBI to close those gaps.⁹
- Additionally, these units tended to have strong, effective leadership as well as strong, diverse collaborations and partnerships. Another project identified reducing health inequities as a core value and incorporated approaches such as selecting subgrantees from populations and jurisdictions with poor health outcomes, supporting community coalitions and engaging in community mobilization.¹⁰
- The study recommended implementing policies that enable training on best-practice models and approaches, structuring units to incorporate health equity rather than separating it into one unit, drawing on existing programs to form diverse partnerships, engaging different stakeholder groups and aligning funding with community organizations that work with underserved groups.⁹

Partnerships

- Eighty-four percent of state health agencies indicated they are part of one or more formal partnerships in general. 88% of local public health agencies noted collaborating with health care entities including hospitals, medical groups, community health centers, insurers as well as educational institutions (primary, secondary, universities, medical schools), and law enforcement for information exchange. There has been an increase in collaboration with

health insurers due to implementation of the HiTECH Act, Affordable Care Act, as well as state and federal regulations and the All-Payer Claims Database (APCD).¹

- Partnerships with local universities allow practitioners to access resources through universities. Additionally, partnerships with local organizations outside of the health sector including transportation and religious organizations can be instrumental in tailoring EBPH in the respective communities they serve. LHDs should maintain and establish these partnerships through a dedicated point person.⁷
- One study found that policy, systems, environment and infrastructure (PSEI) change is best done in a dyad, or a partnership between a backbone organization that provides technical assistance, expertise, and funding aligned with the PSEI change, and an organization with readiness for change and a staff champion with sectoral knowledge. The study found that the champion is key in helping the organization move toward change and the backbone organization's relationships and partnerships with multiple sectors is what allows for the dyad.¹⁰ Additionally, findings indicate close, trusting relationships support the coaching model built around the dyad.

System Structure and Performance

- Success factors in the implementation of the Coordinated Chronic Disease Program indicate that supporting strong program infrastructure hinges on consistent communication and messaging.¹¹ "States with well-articulated theories of change reported less difficulty communicating with purpose + goals of an integrated approach of staff and stakeholders."¹¹
- Internal communication can be greatly impacted by the layout or location of different chronic disease programs within LHDs.¹¹ Chronic disease programs housed on the same floor were found to have improved communications and collaborations.¹²
- Additionally, one state's cross-chronic disease leadership team was found to improve internal communication.¹² The leadership team needs to communicate to decrease internal resistance and concern over potential loss of disease-specific focus.
- Another project found that, "coordination of services across chronic disease conditions represents prime opportunity for public health programs to increase sustainability of their program by reducing spending and improving service delivery."¹²

Information and Technology

- One study found that harnessing electronic health records (EHRs) for chronic disease surveillance can increase use of evidence-based decision-making. Similarly, findings from another study found that a regional EHR-based public health surveillance with distributed data networks improves representativeness of the population and can help LHDs assess across continuum relevant for LHD planning.¹²
- Additionally, utilizing electronic health records containing data from large information systems such as vital records and hospital discharge data allow for enhanced chronic disease monitoring.¹³

Chronic Disease and Accreditation

One study that included interviews with state chronic disease directors found that accreditation was an impetus for evidence-based practice.¹⁴ Similarly, a survey of local health department chronic disease directors found a significant relationship between accreditation and having higher capacity for evidence-based decision making.¹⁵ Another study found that accreditation is associated with increased likelihood of including an evidence-based active transportation strategy in the community health improvement plan.¹⁶ Local health department engagement in policy work to address obesity is also associated with accreditation.¹⁷

Meaza Belachew compiled this scan as part of an internship for PHAB.

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