VERSION 2.0 WORK IN PROGRESS:
Chronic Disease Think Tank Summary
February 26-27, 2020

The Public Health Accreditation Board is a 501(c)3 nonprofit organization dedicated to **improving and protecting the health of the public by advancing and transforming the quality and performance of governmental public health agencies in the U.S. and abroad.**

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The Public Health Accreditation Board (PHAB) held a Chronic Disease Think Tank on February 26-27, 2020 at the Task Force for Global Health in Decatur, GA. The purposes of the think tank were to review the current health department accreditation standards and measures related to chronic disease programs, interventions and strategies; to discuss any pertinent changes in public health practice related to chronic disease programs, interventions, and strategies and/or support for health departments work in this area; and, to recommend potential revisions in the accreditation standards and measures as PHAB prepares updates for its accreditation standards and measures.

Among the updates that were provided included information from Dr. Karen Hacker, Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention; a Public Health Practice Update which included the information from the NACDD Survey of States, the new Chronic Disease Competencies, and trends in chronic disease policy across the country by John Robitscher, Jean Alongi, Nancy Sutherland, and Liz Ruth from NACDD; perspectives from NACCHO by Bridget Kerner and from ASTHO by Alicia Smith. Think tank participants discussed health department performance on current PHAB standards and measures as well as practice changes since 2013 and projections for the future.

This document contains recommendations and overarching comments for PHAB to consider in Version 2.0 of initial accreditation and reaccreditation.

Overarching Recommendations for Proposed Changes to the PHAB Standards and Measures

Several pertinent areas were discussed that do not relate to a specific standard or measure. Those are included in the list below.

- PHAB should continue to consider that many health departments have lost resources, so they are not able to do as much as other health departments who have been able to access greater support for chronic disease prevention. This is also an area where different expectations for state health departments versus most local health departments would be in order.

- Alignment with the NACDD's STAR program would describe rapid cycle improvement processes for organizational capacity development to support chronic disease prevention and control. Six areas identified are evidence-based practice; leadership; management/administration; organizational climate and culture; partnerships and relationships; and workforce development.
- Leadership in chronic disease means that the health department is the "go-to" place for chronic disease expertise related to policy and surveillance and is similar to the chief health strategist role. There needs to be attention to how leadership is measured and how a health department documents leadership and leadership development; i.e., should it be addressed in the strategic plan, could documentation show that the health department leadership has been asked to participate in other sectors, could stakeholders assess the leadership?
- Alignment with current chronic disease best practices would require examples that included Alzheimer's and healthy aging, as well as opioids, in addition to the usual examples from chronic disease areas.
- Requiring examples from the area of chronic disease reflects the emphasis on prevention in public health and should be continued. There are chronic disease implications in many public health program areas (e.g., maternal-child health programs, environmental health) and across the community (e.g., the built environment), and in emergency preparedness.
- While consideration of best practices is important, health departments need to be encouraged to be innovative and develop initiatives that are specific to—or are tailored to meet the needs of—their populations (and not simply adopt "pre-packaged" programs).
- A concept of clinical connectedness to care was discussed as a role that health departments often play in chronic disease management. It was referred to the PHAB Public Health/Health Care Expert Panel for additional discussion.
- Some of the discussion focused on areas where other think tanks or expert panels had been completed. Those were:
    - Ensuring that workforce development includes professional development and competencies for chronic disease and/or health education practice, including the mid-level worker (who is generally more consistent and stays with the health department) and succession planning
    - Ensuring that that data/surveillance capacity includes data modernization for chronic disease surveillance and tracking
    - Ensuring strong partnerships with community organizations, including housing, transportation, and Medicaid providers
    - Ensuring a culture of improvement

Recommendations for Proposed Changes to the PHAB Standards and Measures

Domain 1

- Measure 1.1.2 – Clarify that the use of the data for decision-making is as important, if not more so, than where the data came from. Also clarify how residents of a community are involved – and not just partner organizations in the community. Look to the new National Academies of Medicine paper and PHAB's commissioned paper for additional clarification on meaningful community engagement.

Domain 3

- Measure 3.1.1, Required Documentation 1 – Consider adding, as a possible prompt for resources for evidence, the evidence-based resources that are cited in CDC Notice of Funding Opportunities (NOFOs). NOFOs often provide and cite the evidence and science that supports the activities and interventions being required. This will help HDs make connections between their funded activities and the evidence that supports interventions they are implementing. However, it would not be sufficient just to cite the NOFO; going to the source of the evidence would be more appropriate.
- Measure 3.1.1, Required Documentation 2 – Consider adding "selection, implementation, development, revision, or adjustment of educational materials/messages." Many health departments use off-the-shelf products, or products required by a grant, and therefore do not develop their own unique materials.
- Measure 3.1.1, Required Documentation 3 – Change the focus here to health education straies rather than message or materials. Switch the order with RD 2 above.
- Consider adding language that would give health departments credit for providing feedback to funders if specific materials are required by a grant. The feedback would reflect the feedback from the priority population with which the materials were used. For reaccreditation, PHAB could consider "testing" materials and using feedback from the priority population to make or suggest changes.
- 3.1.2 – adjust current language from "develop and implement" to "develop and/or implement" a health promotion strategy.
- Measure 3.2.6 – Update language and requirements to reflect intentional cultural sensitivity.

Domain 5

- PHAB should adjust the language and references related to Healthy People, in both the standards/measures document and the glossary, to be compatible with HP2030, to ensure alignment with the new version. When HP2030 launches the new website will include some updated definitions that can be used for alignment as well.

Domain 7

- Measure 7.1.1 – Recommend that PHAB remove any implication related to individual care and focus on a health equity vision that includes addressing social needs. Multi-sectoral work goes here, as does linkages to clinical care. The "buckets" of public health, health care, and social services may not be the right framework; health care and social services focus on individuals and public health focuses on the population.
- Measure 7.1.1- State health departments may have more responsibility for creating systems of care that ensure access while local health departments may work more with specific needs and providers. State health departments also often do work with state health insurance plans (as do some larger local health departments) and larger plans that cross local jurisdictional boundaries. System development is appropriate in this measure. Separate measures for state and local health departments are not needed, but options should be provided. State health departments and local health departments could work on any of them.

- Measure 7.1.3 – It was noted that this is a difficult measure for local health departments; their role is not clear. Clarify that partnerships with Medicaid are important here. Also, partnership with the health care system in preparing for and responding to disaster health care is relevant here. This is different than surge capacity; it's about disruptions in health care services. Additionally, documentation guidance could include examples of planning for women's health services if Planned Parenthood closes; if hospitals close clinics; or if a community loses a hospital, clinic, or service. PHAB should consider reducing the number of examples in Required Documentation 2 to one example, given the comprehensive nature of this work.
- Referred to the Public Health/Health Care Expert Panel – PHAB should develop a requirement for the health department to create/participate in creating systems of care during an outbreak such as Ebola or COVID19. All of this work could be a state/local collaboration.

Domain 11

- Refer to Administration/Management Think Tank requirements related to NACCHO's definition of organizational leadership. It might be difficult to document, but it is one of the key areas in chronic disease. Also, for this upcoming Think Tank, a requirement to have the capacity/competency to conduct cost effectiveness analysis or economic assessment of programs and services.

Recommendations Regarding Terminology and Definitions

Current Terms in PHAB Glossary	Existing Definition	Proposed Definition/ Recommendation/Notes
Barriers to Care	Barriers to receiving needed health care can include cost, language or knowledge barriers, and structural or logistical factors, such as long waiting times and not having transportation. Barriers to care contribute to socioeconomic, racial and ethnic, and geographic differences in health care utilization and health status. (http://mchb.hrsa.gov/whusa11/hsu/downloads/pdf/303bcunc.pdf)	Clarify this definition to include invisible barriers to care as well.
Best Practices	Best practices are the best clinical or administrative practice or approach at the moment, given the situation, the consumer or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term promising practices which may be defined as clinical or administrative practices for which there is considerable practice-based	No change

	evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence. (National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf)	
Chronic Disease	A chronic disease is a disease that has one or more of the following characteristics: it is permanent, leaves residual disability, is caused by a nonreversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require long period of supervision, observation, or care. (Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett, 2009). Examples of chronic disease include heart disease, stroke, cancer, chronic respiratory diseases and diabetes. (World Health Organization (Switzerland). Health Topics: Chronic Diseases [online]. 2012 [cited 2012 Nov 7]. Available from URL http://www.who.int/topics/chronic_diseases/en/)	Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the US. Many chronic diseases are caused by a short list of risk behaviors: • Tobacco use and exposure to secondhand smoke. • Poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats. • Lack of physical activity. • Excessive alcohol use. https://www.cdc.gov/chronicdisease/about/index.htm Add to examples in the documentation guidance mental health; emotional well-being; addiction; cognitive decline. It could also be noted that some infectious diseases

		cause chronic conditions, e.g., Lyme Disease and HIV.
Health Disparities	Health disparities are differences in population health status (incidence, prevalence, mortality, and burden of adverse health conditions) that can result from environmental, social and/or economic conditions, as well as public policy. These differences exist among specific population groups in the United States and are often preventable. *(*Adapted from: National Association of County and City Health Officials (US). *Operational Definition of a Functional Local Health Department [online]*. 2005 [cited 2012 Nov 8]. Available from URL http://www.naccho.org/topics/infrastructure/accreditation/OpDef.cfm. National Cancer Institute (US). *Health Disparities Defined [online]. 2010 [cited 2012 Nov 8]* *http://crchd.cancer.gov/disparities/defined.html)*	Ensure consistency with HP2030 when that definition is available
Health Education	Health education is any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conductive to good health. (Turnock, B.J. Public Health: What It Is and How It Works. 4th ed. Sudbury, MA: Jones and Bartlett; 2009.)	No change
Health Promotion	Health promotion is a set of intervention strategies that seek to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. This process enables individuals and communities to control and improve their own health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and	Health promotion is a set of intervention strategies that seek to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations

	work in partnerships that build on existing skills and strengths. Health promotion consists of planned combinations of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. Health promotion activities are any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities. (Turnock. Public Health: What It Is and How It Works (4th Ed). Jones and Bartlett. MA. 2009). Health Promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviors toward a wide range of social and environmental interventions.(http://www.whi.int/topics/health_promotion/en/) Health promotion approaches engage people and organizations in the transformation process, and their engagement in the process constitutes in itself a desired change (Institute of Medicine of the National Academies. An Integrated Framework for Assessing the Value of Community-based Prevention. The National Academies Press. 2012	that will improve or protect health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and work in partnerships that build on existing skills and strengths. Health promotion consists of planned combinations of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. Health promotion activities are any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities. (Turnock. Public Health: What It Is and How It Works (4th Ed). Jones and Bartlett. MA. 2009). Also, see WHO definition- health education is part of health promotion.
Non-infectious/ Non/communicable disease	Non-infectious/non-communicable diseases are conditions which affect the health status of populations, but which are not transmitted from one individual to another by micro-organisms. Non-communicable diseases represent the major causes of death and disability in most developed countries.	No change

	(Riegelman, R. *Public Health 101.* Jones and Bartlett. MA. 2010)	
Proposed New Terms		
Determinants of Health	None	Ensure consistency with HP2030 when that definition is available
Social Determinants of Health	Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. (World Health Organization (Switzerland). Health Topics: Social determinants of health [online]. 2012 [cited 2012 Nov 7].http://www.who.int/social_determinants/en/)	Ensure consistency with HP2030 when that definition is available. Need to clear about the difference between "determinants of health" and "social determinants of health." or do not use the determinants of health definition at all.
Social Needs	None	Ensure consistency with HP2030 when that definition is available.
Vulnerable Population Might want to use "High burden population" or "at risk" instead of "vulnerable"	A vulnerable population is a group of people with certain characteristics that cause them to be at greater risk of having poor health outcomes than the general population. These characteristics include, but are not limited to, age, culture, disability, education, ethnicity, health insurance, housing status, income, mental health, and race. (Adapted from: Institute of Medicine (US). Performance Measurement: Accelerating Improvement. Washington, DC: National Academies Press; 2006)	At-risk population refers to populations whose members may have different needs in different functional areas, including but not limited to maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from

		diverse cultures; who have limited English proficiency or are non-English speaking; or who are transportation disadvantaged. Before, during, and after an incident, members of at-risk populations may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance include those who have disabilities, live in institutionalized settings, are from diverse cultures, have limited English proficiency or are non-English speaking, are transportation disadvantaged, have chronic medical disorders, and have pharmacological dependency. https://www.health.state.mn.us/communities/ep/afn/atriskdef.html

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