Chronic Disease Prevention & Health Promotion

STRATEGIC PLAN
FY 2013-2017

Identifying and advancing the conditions that lead to safe and healthy lives for Alaskans.

Section of Chronic Disease Prevention and Health Promotion
STRATEGIC PLAN

FY 2013-2017

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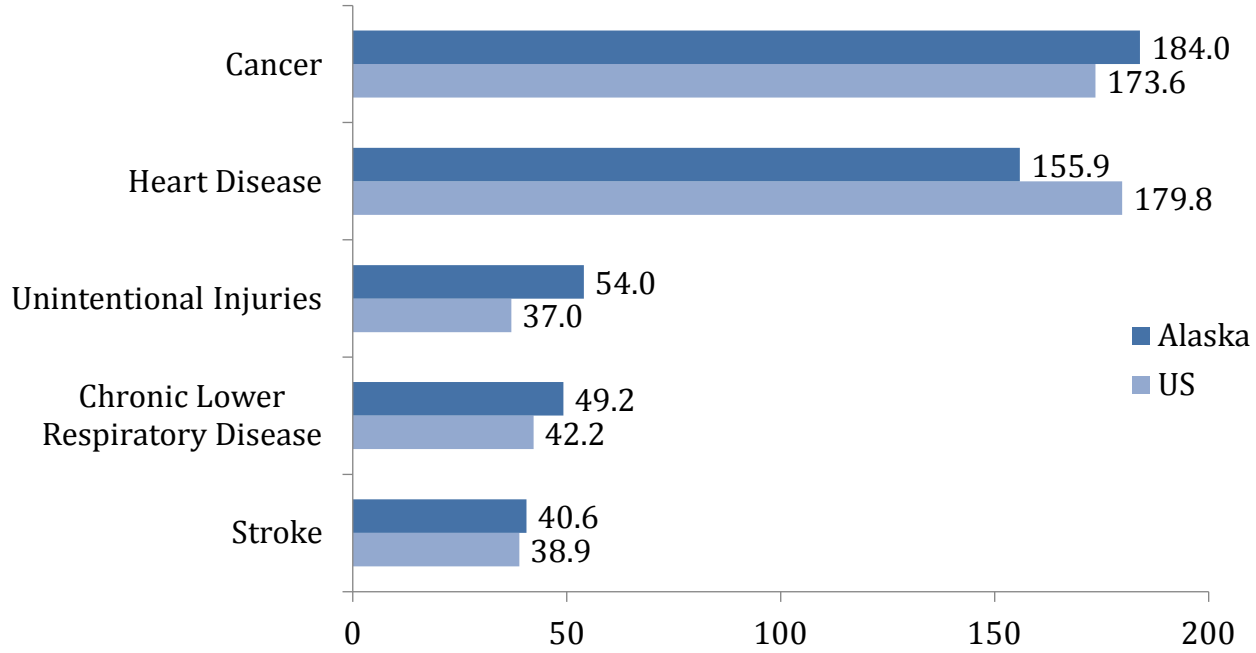
Chronic Disease and Injury Mortality

Chronic disease accounts for 6 out of the 10 leading causes of death in Alaska. This statistic mirrors the national level data where 7 out of 10 deaths among Americans and more than 75% of health care spending is related to chronic disease. Although chronic diseases are among the most common and costly of all health problems, they are also among the most preventable.

Cancer has been the leading cause of death in Alaska since 1993, followed closely by heart disease as the second leading cause of death. Chronic obstructive pulmonary disease (COPD), stroke and diabetes complete the list of the top five leading chronic disease causes of death among Alaskans. Age-adjusted Alaska mortality rates and comparable U.S. rates for these causes of death are presented in the following figure.

5 MOST COMMON CAUSES OF DEATH, ALASKA COMPARED WITH UNITED STATES, 2009



Data Sources: Alaska Bureau of Vital Statistics (AK); National Center for Health Statistics (US)

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Chronic Disease and Injury Morbidity

Cancer

- 25% of all deaths in Alaska in 2009 were due to cancer. (Alaska Bureau of Vital Statistics [ABVS])
- The most commonly diagnosed cancers in Alaska are: (1) breast, (2) prostate, (3) lung, and (4) colorectal. These four cancers account for 53% of all cancer cases. (Alaska Cancer Registry database, 2/2012)

Heart Disease and Stroke

- Heart disease accounted for 20% of deaths in Alaska in 2009, while stroke accounted for 5% of deaths. (ABVS, 2009)
- In 2009, 26% of adults in Alaska reported having high blood pressure (hypertension) and 35% of those who had their cholesterol tested reported having high blood cholesterol, which puts them at greater risk for developing heart disease and stroke. (BRFSS)

Unintentional Injury

- The leading cause of non-fatal hospitalizations for Alaska adults age 35 years and older is falls (Alaska Trauma Registry [ATR]).
- Falls are also the leading cause of unintentional injury deaths among older adults (ATR)

Diabetes

In 2009, diabetes was the 8th leading cause of death in Alaska and 7th in the US. Likely to be underreported as a cause of death, the risk of death among people with diabetes is about twice that of people without diabetes of similar age.

- 84 Alaskans died from diabetes mellitus in 2009. (ABVS)
- In 2009, 6% of adults in Alaska reported being diagnosed with non-pregnancy related diabetes.

Arthritis

- Arthritis is the most common cause of disability in the US, affecting more than 50 million Americans.
- In 2009, 23% of adults in Alaska reported being diagnosed with arthritis. (Behavioral Risk Factor Surveillance System [BRFSS])

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Chronic Disease Risk and Protective Factors

Four healthy lifestyle factors—never smoking, maintaining a healthy weight, exercising regularly and following a healthy diet—together appear to be associated with as much as an 80 percent reduction in the risk of developing the most common and deadly chronic diseases.[1] Conversely, engaging in tobacco use, being inactive, having a poor diet, and being overweight or obese greatly increase the likelihood that one will develop, have reduced quality of life from, and ultimately die from a chronic disease.

Broadly, the Alaska chronic disease prevention efforts encompass health promotion activities, screening and early detection efforts, strategies for effective management of existing chronic diseases, advocacy and policy efforts, capacity building, and health equity activities. More specifically the Alaska prevention efforts are targeted around three of the risk factors that contribute to the burden of the leading causes of preventable deaths and major illness. These risk factors include tobacco use, poor nutrition, and physical inactivity.

[1]Ford ES, Bergmann MM, Kroger J, Schienkiewitz A, Weikert C, Boeing H. Healthy living is the best revenge. Findings from the European Prospective Investigation Into Cancer and Nutrition-Potsdam Study. *Arch Intern Med* 2009;169(15):1355-1362

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As demonstrated by the following table, lifestyle behaviors and/or modifiable conditions are a factor in development of several chronic diseases.

INTERRELATIONSHIPS BETWEEN VARIOUS CHRONIC DISEASE AND MODIFIABLE RISK FACTORS, US*

	Cardiovascular Disease	Cancer	Chronic Lung Disease	Diabetes	Cirrhosis	Musculo-skeletal Diseases	Neurologic Disorders
Tobacco use	+	+	+			+	?
Alcohol use	+	+			+	+	+
High cholesterol	+						
High blood pressure	+						+
Diet	+	+		+		+	?
Physical inactivity	+	+		+		+	+
Obesity	+	+		+		+	+
Stress	+	?					
Secondhand smoke	+	+	+				?
Occupation	?	+	+		?	+	?
Pollution	+	+	+				+
Low SES	+	+	+	+	+	+	

+ = established risk factor ? = possible risk factor

* Remington PL, Brownson RC, Wegner MV, eds. *Chronic Disease Epidemiology and Control, 3rd Ed*. Washington DC: American Public Health Association; 2010.

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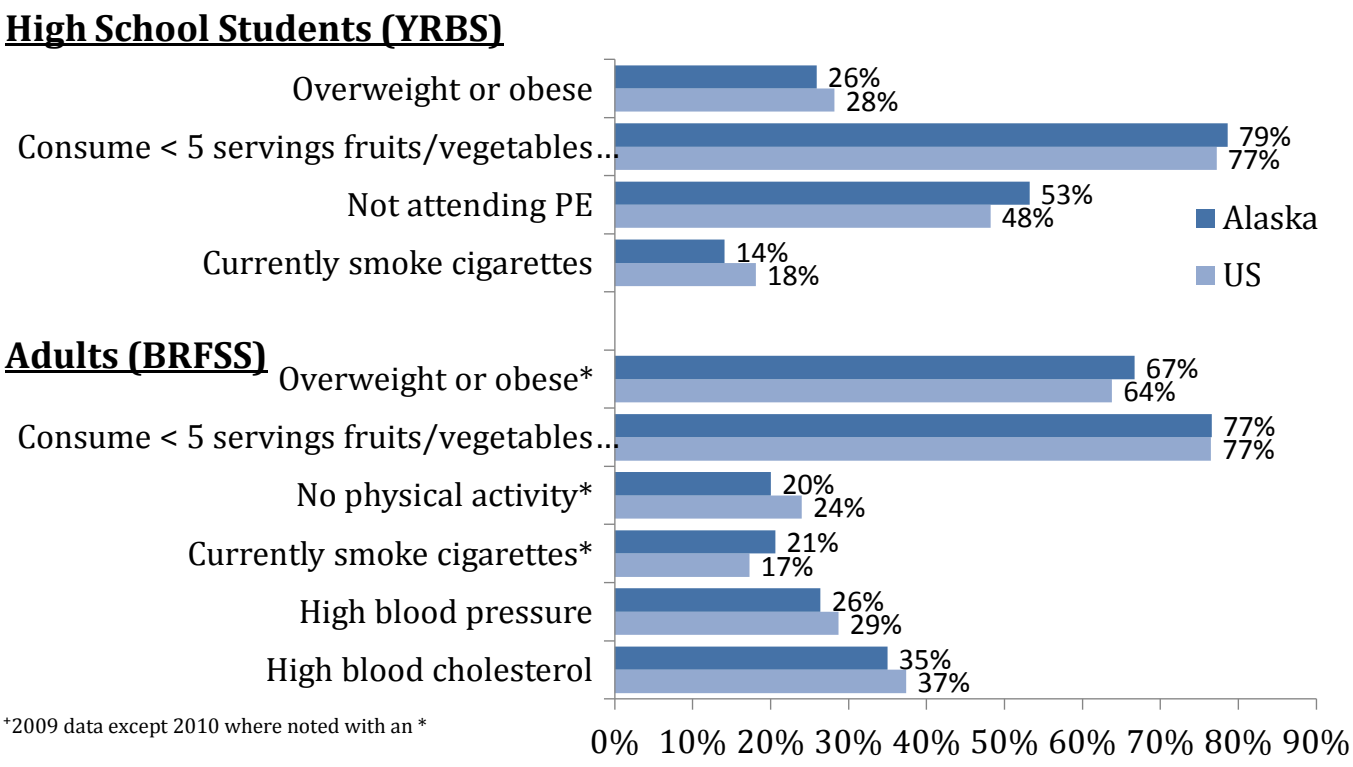
The following graph shows Alaska compared to US prevalence rates for select chronic disease risk factors.

CHRONIC DISEASE RISK FACTORS, ALASKA COMPARED WITH UNITED STATES, YOUTH RISK BEHAVIOR SURVEY (YRBS, 2011) AND BRFSS+



+2009 data except 2010 where noted with an *

TOBACCO

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, nearly 500,000 people in the US die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million have a serious illness caused by smoking. For every person who dies from smoking, 20 people suffer from at least one serious tobacco-related illness.[2]

In Alaska in 2010, 21% of adults and 14% of high school students in Alaska reported being current smokers. Both prevalence estimates are significantly down over the past decade and a half (28% adult smokers in 1996 and 36% high school student smokers in 1995). Despite this decline, Alaska BRFSS data show that three groups have disproportionately higher tobacco use prevalence, including Alaska Native adults, non-Native adults of low socioeconomic status, and young adults

[2]U.S. Department of Health and Human Services. A Report of the Surgeon General: How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

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aged 18-29.[3] Significant gains have been achieved through evidence-based strategies such as incremental increases of local and state tobacco sales taxes and with the continuing adoption of smoke-free policies and regulations around the state.

PHYSICAL INACTIVITY, POOR NUTRITION, AND OBESITY

In the past 30 years, the prevalence of overweight and obesity has increased sharply for both adults and children.[4,5] Physical inactivity and unhealthy eating contribute to overweight and obesity and a number of chronic diseases, including some cancers, cardiovascular disease, and diabetes.[6]

- 67% of Alaska adults (BRFSS, 2010) and 26% of Alaska high school students (YRBS, 2011) were overweight or obese, based on self-reported height and weight.
- 77% of adults (BRFSS, 2009) and 79% of high school students (YRBS, 2011) in Alaska consumed fewer than 5 servings of fruits and vegetables per day.
- 55% of Alaska high school students did not attend PE class in the past week (YRBS, 2011).
- 26% of adults in Alaska did not get enough physical activity to meet federal recommendations (BRFSS, 2009).

The *Burden of Overweight and Obesity in Alaska*[7] and *Childhood Obesity in Alaska*[8] reports were published in 2009, and have been followed up more recently with fact sheet-style updates. Alaska BRFSS data show that between 1991 and 2010, the percentage of Alaskan adults above a normal weight (i.e., overweight or obese) went from about half (49%) to two-thirds (67%). In 2003, the Anchorage School District (ASD) began a collaborative project with the State of Alaska Division of Public Health to analyze objectively measured height and weight data and monitor trends in the weight status of the student population. According to the 2010-2011 school year data, 36% of kindergarten through 12th grade students were above a normal weight.[9] Even more troubling was the fact that nearly one-third (31%) of children entering kindergarten or first grade were above a normal weight, with 17% considered overweight and 14% obese.[9]

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[3]Alaska Tobacco Facts, 2012. http://www.hss.state.ak.us/dph/chronic/tobacco/alaska_tobacco_facts.pdf. Accessed 8-6-2012.

[4]Flegal KM, Carroll MD, Ogden CL, and Johnson CL. Prevalence and trends in obesity among US adults, 1999-2000. *JAMA*. 2002;288:1723-1727.

[5]Ogden CL, Flegal KM, Carroll MD, and Johnson CL. Prevalence and trends in overweight among US children and adolescents, 1999–2000. *JAMA*. 2002;288:1728–1732.

[6]US Department of Health and Human Services. *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.* Rockville, MD: HHS, Public Health Service, Office of the Surgeon General; 2001.

[7]Fenaughty A, Fink K, Peck D, Wells R, Utermohle C, Peterson E. The Burden of Overweight and Obesity in Alaska. February 2010. Anchorage, AK: Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services. http://www.hss.state.ak.us/dph/chronic/obesity/pubs/ObesityBurdenReport_2010.pdf. Accessed 8-7-2012.

[8]Fenaughty AM, Fink K, Peck D, Utermohle CJ. *Childhood Obesity in Alaska*. Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. March 2009. http://www.hss.state.ak.us/dph/chronic/obesity/pubs/Childhood_Obesity.pdf. Accessed 8-6-2012.

[9]Alaska Section of Chronic Disease Prevention and Health Promotion. Prevalence of Overweight and Obesity among Students in the Anchorage School District, 1998-1999 through 2010-2011. Chronicles Volume 4, Issue 2, June 2012.

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PREVENTIVE SERVICES

Access to health services includes gaining entry into the health care system, accessing a health care location where needed services are provided, and finding a health care provider with whom the patient can communicate and trust.[10] Access to health care impacts prevention of disease and disability, quality of life, and life expectancy. Among the health care services one can access are clinical preventive services, such as routine disease screening and scheduled immunizations. Optimal provision of these services can both prevent and detect illnesses and diseases in their earlier, more treatable stages, significantly reducing the risk of illness, disability, and early death.[11]

Uninsured adults are less likely than insured adults to receive preventive services or screenings, such as mammograms, pap smears, or prostate screening. In turn, inadequate prevention and screening increase the likelihood of preventable illness, missed diagnoses, and delays in treatment.[12,13,14] In 2009, 19% of adults aged 18-64 in Alaska reported having no health care coverage (BRFSS).

Mammography is a screening method that has been shown to reduce mortality due to breast cancer by approximately 20-25% over 10 years among women 40 years and over. In 2008, 32% of women in Alaska aged 40 years or older reported not having had a mammogram within the last 2 years (which was the recommendation at the time).

Up to 60% of deaths from colorectal cancer could be prevented if persons aged 50 and older were screened regularly. Colorectal cancer can be prevented by removing precancerous polyps or abnormal growths, which can be identified during a fecal occult blood test, sigmoidoscopy, or colonoscopy. In 2008, among Alaskans aged 50 years or older 42% reported never having had a sigmoidoscopy or colonoscopy (BRFSS).

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[10]Bierman A, Magari ES, Jette AM, et al. Assessing access as a first step toward improving the quality of care for very old adults. *J Ambul Care Manage*. 1998 Jul;121(3):17-26.

[11]Coates RJ, Yoon PW, Zaza S, Ogden L, Thacker SB. Rationale for periodic reporting on the use of selected adult clinical preventive services—United States. *MMWR* 2012;61(02):3-10.

[12] Robinson J, Shavers V. The role of health insurance coverage in cancer screening utilization. *J of Health Care for the Poor and Underserved* 2008;19(3):842–856.

[13]DeVoe JE, Graham A, Krois L, Smith J, Fairbrother GL. Mind the gap in children's health insurance coverage: does the length of a child's coverage gap matter? *Ambulatory Pediatrics* 2008;8(2):129–134.

[14]Institute of Medicine. *Hidden Costs, Value Lost: Uninsurance in America.* Washington, DC: National Academy Press, 2003.

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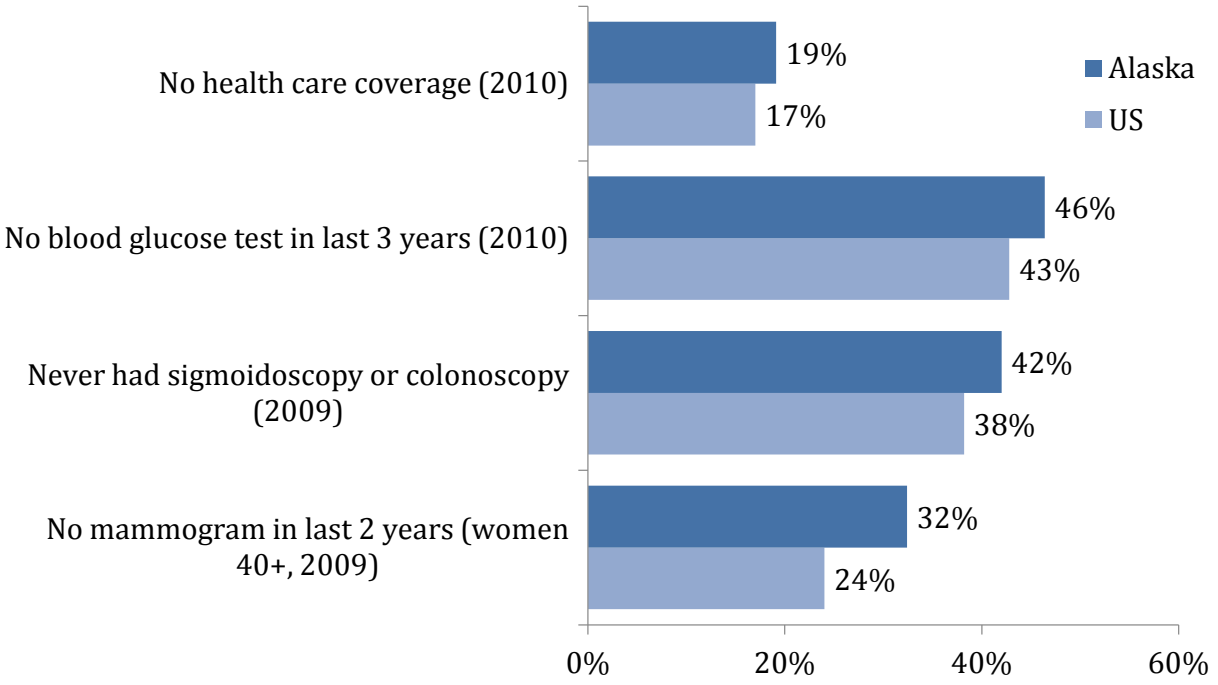
PREVENTIVE SERVICES, ALASKA COMPARED WITH UNITED STATES, BRFSS



HEALTH INEQUITY IN CHRONIC DISEASE AND RELATED RISK FACTORS

Scientific evidence suggests that social and economic conditions drive population health to an equal or greater degree as individual choice, genetic make-up, and access to health care.[15] Consequently, to prevent chronic disease and optimize the health of all Alaskans, the focus of public health must extend beyond healthy behaviors and health insurance to address health equity. Health equity is achieved when every person has the opportunity to "attain his or her full health potential."[16]

[15]Braveman PA, Egerter SA, Mockenhaupt RE. Broadening the focus. The need to address the social determinants of health. *Am J Prev Med* 2011;40(1S1):S4-S18.

[16]Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Health Equity. http://www.cdc.gov/chronicdisease/healthequity/. Accessed 7-11-2012.

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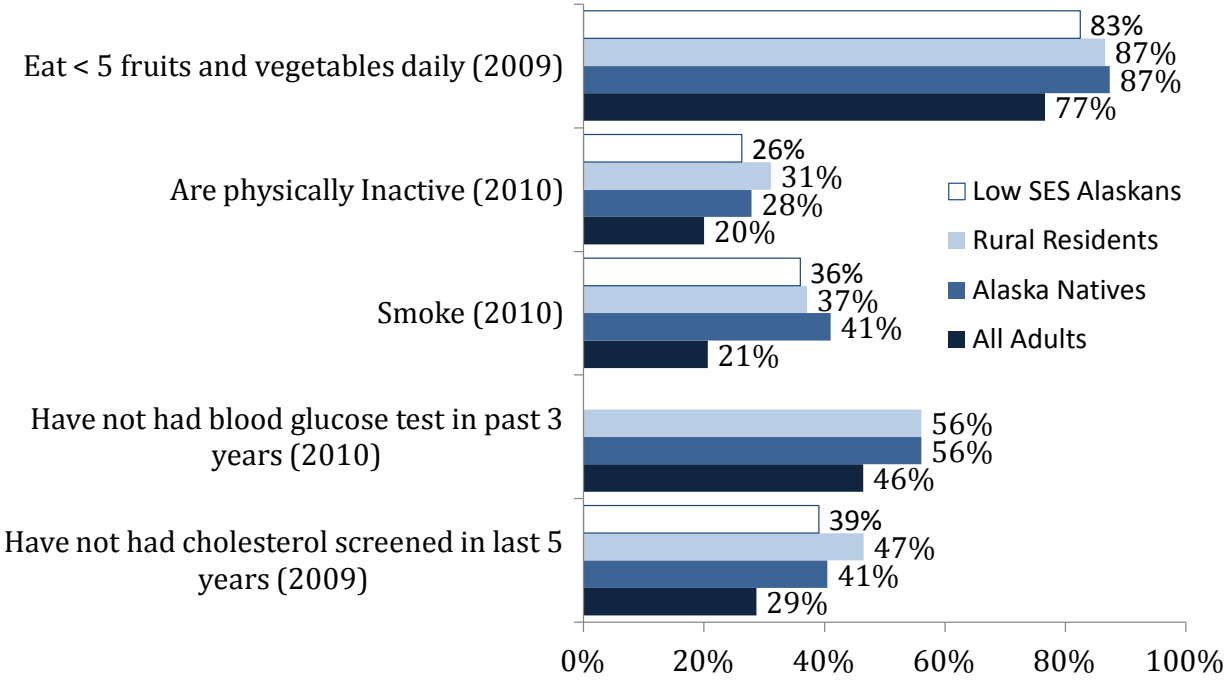
CHRONIC DISEASE RISK FACTORS AND PREVENTIVE SERVICES, ALL ALASKA ADULTS COMPARED WITH SELECT POPULATIONS, BRFSS



Notes:

Low Socioeconomic Status (SES) **=** adult 25 to 64 years of age at or below 185% of the Federal poverty level OR with less than a high school education;

Rural Residents **=** adults living in the BRFSS-defined Rural region of the state. Subgroup only displayed if prevalence differs significantly from the lower risk groups.

Such disparity in risk factors translates to disparities in chronic disease morbidity and mortality. For example:

- In 2009, the Alaska Native age-adjusted rate of death from stroke, chronic lower respiratory disease, heart disease, and cancer (all sites) was 1.4 to 2.1 times that of their White peers (ABVS).
- Age-adjusted all-site cancer mortality rates are highest in the Northern and western regions of Alaska, and lowest in southeast Alaska (National Cancer Institute [NCI], Centers for Chronic Disease Control and Prevention [CDC], State Cancer Profiles, 2005-2009).

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About Us

VISION: HEALTHY AND SAFE ALASKANS

The Section of Chronic Disease Prevention and Health Promotion strives to create the conditions most conducive to achieving health and safety for all Alaskans. We recognize that the social, cultural and physical characteristics of a community influence our everyday choices that in turn affect our health and safety. To promote the behaviors that prevent injuries and reduce the prevalence of chronic diseases will require significant changes in the environments in which we live. By transforming our communities to encourage active and safe lifestyles, making informed health decisions, and healthy eating, our vision of healthy and safe Alaskans can be realized.

MISSION: TO IDENTIFY AND ADVANCE THE CONDITIONS THAT LEAD TO SAFE AND HEALTHY LIVES FOR ALASKANS.

To achieve our mission the Section of Chronic Disease Prevention and Health Promotion:

- Collects and shares scientific data and promotes evidence-based practices;
- Builds capacity in communities to promote health and reduce chronic disease and injuries and their effects;
- Promotes community conditions that result in health equity; and,
- Works collaboratively and effectively to reduce healthcare expenditures and improve quality of life.

The Section is guided by the following values:

Stewardship – we use our resources carefully and responsibly for the greatest public benefit

Effectiveness – we make a measurable difference in Alaskan's health and safety

Collaboration – we strategically engage with each other and with partners in the tribal and non-tribal health systems, communities, schools, and worksites

Commitment – our commitment to our values, mission and goals as well as to one another is evident in our everyday work

Excellence – we strive for excellence in every aspect of our work

Leadership – we provide leadership in tackling the serious safety risks and health challenges facing Alaskans

In addition, the Section recognizes that health inequities are an obstacle to achieving optimal health for all Alaskans. Therefore the Section has made a commitment to engage in and support

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activities that promote health equity and respect for diversity. To facilitate this, the Section had drafted health equity language to be used in all its requests for proposals.

The framework set forth in this plan is founded on research. Modifying our environment so that healthy choices are the easy choices is a powerful way to address the serious health challenges facing the state of Alaska. Pursuing this strategy requires interventions at all levels, from the individual and interpersonal levels to the organizational and community levels to the public policy level. As such, this plan calls upon individuals, groups, organizations, and decision makers to influence health practices and create the infrastructure needed to transform Alaska's communities.

We call upon Alaskans to:

- Eat healthy diets, maintain healthy weights and engage in regular physical activity
- Abstain from or quit using tobacco products
- Use preventive health services, including chronic disease early detection and screening
- Engage in recommended treatments, follow up screening, and health management programs
- Partner with health care providers to make individual health decisions
- Take measures to avoid injuries

With Alaska's communities and organizations we will use evidence-based practices to:

- Improve access to physical activity and healthy foods
- Work toward eliminating health disparities and increased access to care
- Promote healthy behaviors and injury prevention through education and media
- Adopt policies that reinforce healthy behaviors (i.e. for their employees, customers, and/or members); monitor the impact of these policies and adjust as needed
- Measure the success of efforts, make program improvements and/or adjustments accordingly
- Monitor indicators of the health of the population
- Incorporate prevention into health-related systems of care and promote patient self-management
- Reduce health care and associated costs by investing in injury prevention, health promotion, and chronic disease prevention

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Collaborative Efforts to Prevent Chronic Disease

Prevention of chronic disease and injury is key to improving the health of Alaska's residents and requires a collaborative approach that reaches across a broad network of partners. Internally, several subcommittees are in place to help facilitate collaboration and coordination across categorical programs including the Integration Steering Committee, the Integrated Communications Workgroup, Disparities Integration Group (DIG), and the Surveillance and Evaluation Team (SAET). These groups are working on crosscutting issues and members include key staff from all categorical programs within the Section. The CDPHP collaborates extensively with other sections and programs within the State Department of Health and Social Services (DHSS). Collaboration with external groups is broad and includes school districts, as well as non-governmental agencies such as the American Heart Association, American Diabetes Association, American Cancer Society, and American Lung Association. Collaboration is also extensive with health care partners such as tribal health organizations, Federally Qualified Health Centers, hospitals, provider groups, community-based wellness organizations, and hospital and health plan associations.

Active coalitions provide broad-based support and serve as the external structure and support for many of chronic disease prevention and health promotion initiatives. The Alaska Tobacco Control Alliance (ATCA) was formed in 1992 to create a statewide network of health advocates to develop, support and sustain comprehensive tobacco control programming. ATCA organizes its efforts through nine workgroups, including the Leadership for Eliminating Alaskan Disparities (LEAD) workgroup. Take Heart Alaska is a statewide coalition of agencies, organizations, and individuals working together to improve cardiovascular health in Alaska. The Alaska Comprehensive Cancer Partnership (ACCP) is a diverse group of individuals and organizations representing many key stakeholders in cancer prevention, control and treatment. The Alaska Food Policy Council works to strengthen Alaska's food systems to spur local economic development, increase food security, and improve nutrition and health. Alaskans Taking on Childhood Obesity (ATCO) is an interagency taskforce of leaders in the health and education fields who are committed to preventing childhood obesity in Alaska. With these many collaborative efforts already in place, Alaska is well poised to engage in a comprehensive and coordinated approach to chronic disease prevention and health promotion.

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About the Plan

This state plan for chronic disease prevention and health promotion involved numerous internal and external partner agencies and individuals. The planning process included a State Technical Assistance and Review site visit from the National Association of Chronic Disease Directors. Site visitors interviewed 22 individuals representing agencies concerned about health promotion and chronic disease prevention and who partner with the Section in various endeavors. The site visit also involved an extensive self-review. Recommendations from the site visit were considered in developing this plan.

Partners involved in the development and review of this state plan represent voluntary organizations, health care providers, state staff from the Department of Health & Social Services, the Chronic Disease Prevention and Health Promotion Collaborative (CDPHP Collaborative) and its Clinical Screening Task Force, coalition members, non-profit organizations, tribal partners, and state staff. We thank them for their time and input.

This plan organizes the Section's activities around projects, rather than by programs, in an effort to strengthen collaboration and increase integration of chronic disease prevention and health promotion initiatives. It is intentionally focused on a limited number of goals and objectives to allow for concerted and focused work, and to align staff toward achieving these goals. The plan is consistent with guidance from the Centers for Disease Control and Prevention.

There will be an annual update to the plan. While the goals cover a five-year period, only those activities occurring in year one have complete action plans. Activities for upcoming years will be added and published annually. The plan is intentionally high level, and will be used to build yearly work and action plans for staff. It should also be noted that this plan does not capture every aspect of the Section's work; rather it concentrates on selected strategic areas identified as most critical, and where disparities exist in health outcomes. As such, all the goals are high priority for the Section's work.

The development of a Section-wide evaluation plan is underway and will be a companion to the CDPHP strategic plan. Guided by the priorities identified in the Section strategic planning effort, the evaluation plan will identify indicators of program process, outputs, and intermediate and long-term outcomes and clear objectives related to each. The plan will specify methods to be used to track and report on progress, including timelines, data sources, and responsible Section staff. A dashboard of key indicators will be developed and monitored regularly by the Leadership Team to assess progress and inform mid-course corrections that may be needed.

Although the evaluation plan has yet to be developed, several preliminary steps have been initiated. These include selection of an experienced chronic disease evaluator to provide

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consultation on the planning effort, identification of a member of the Leadership Team who will be lead on this project, and identification of a framework to use in plan development (the CDC Evaluation Framework). After identifying gaps in evaluation competencies during a Section-wide assessment process in 2011, the Leadership Team provided all Section staff with an opportunity to attend a 2-day, in-house training on the CDC Evaluation Framework. The training was well attended, and 100% of participants indicated the training gave them a better understanding of the evaluation framework and improved their ability to conduct an evaluation.

With the assistance of the consultant, the project lead will guide the members of the Surveillance and Evaluation Team (SAET) through an evaluation planning process from August to December 2012. Additional key stakeholders will be identified and included early in the evaluation planning process. The evaluation plan will be finalized by December 31, 2012.

In the meantime, a focus on evaluation was present in the development of the strategic plan (2 of 4 Leadership Team members are epidemiologists). Preliminary evaluation indicators have been included throughout the plan, linked to each strategy. Although the final evaluation plan will no doubt contain additional detail—both in terms of process and content, the main indicators identified in the strategic plan will likely be reflected in the finalized evaluation plan.

BACKGROUND

The Problem of Obesity

Overweight and obesity are growing problems in Alaska, in all socio-demographic groups. This rapid increase in obesity rates will impact Alaskans' health as well as both the length and quality of life.[17] Obesity is also putting an ever-increasing burden on a healthcare system better suited to treating the sick than preventing illness.

Two out of three Alaska adults are overweight or obese, and many of these adults are already or will soon be dealing with obesity-related health issues, such as diabetes, heart disease, cancer and high blood pressure. Between 1991 and 2010, the percentage of adults above a normal weight (i.e., overweight or obese) went from about half (49%) to two-thirds (67%) of the adult population. During this time obesity rates doubled (from 13% to 27%); rates of overweight remained relatively flat (BRFSS).

Alaska's youth are affected by obesity as well, and they too will be facing significant obesity-related chronic diseases in their future. Self-report data indicates that currently 26% of high school youth are above a normal weight, with 12% obese (YRBS, 2011). Data based on objectively measured height and weight data reveal an even larger problem: 36% of K-12 students in the largest school district in Alaska are above a normal weight, as are 31% of Kindergartners and first graders.[18]

Obesity is associated with a number of poor health outcomes among Alaska adults, including high blood pressure, diabetes, and overall health status. Obesity and its contributors are linked to poor academic performance among Alaska high school youth. For example, 72% of normal weight students report getting mostly A's and B's, compared to only 56% of obese students.[17]

In addition to costs defined by lives and quality of life, obesity exacts a heavy economic price tag in Alaska. It is estimated that Alaska is spending $459 million each year on direct medical expenses related to obesity.[19] A significant amount of obesity's costs are borne by Medicaid, and these costs are only expected to rise along with predicted increases in Medicaid enrollment and obesity prevalence. At the current rate of growth, by 2030, Alaska may be paying close to $300 million per year just for the state's share of Medicaid dollars needed to cover direct medical costs of obesity.[20]

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[17]Fenaughty A, Fink K, Peck D, Wells R, Utermohle C, Peterson E. The Burden of Overweight and Obesity in Alaska. February 2010. Anchorage, AK: Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services. http://www.hss.state.ak.us/dph/chronic/obesity/pubs/ObesityBurdenReport_2010.pdf. Accessed 8-8-2012.

[18]Alaska Section of Chronic Disease Prevention and Health Promotion. Prevalence of Overweight and Obesity among Students in the Anchorage School District, 1998-1999 through 2010-2011. Chronicles Volume 4, Issue 2, June 2012. http://www.hss.state.ak.us/dph/chronic/pubs/assets/ChroniclesV4-2.pdf. Accessed 8-8-2012.

[19]Trogdon JG, Finkelstein EA, Feagan CW, Cohen JW. State- and payer-specific estimates of annual medical expenditures attributable to obesity. *Obesity*.2012;20(1):214-220.

[20]Alaska Division of Public Health projections. http://www.hss.state.ak.us/dph/chronic/obesity/pubs/10-11ObesityStatus_web.pdf. Accessed 8-8-2012.

BACKGROUND

The Obesity Prevention and Control Program uses a variety of data sources to estimate the burden of obesity in Alaska and monitor trends. These include: the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), the Pregnancy Risk Assessment Monitoring System (PRAMS), and student health records (for BMI) from select school districts. These and other data sources are described in more detail here: http://www.hss.state.ak.us/dph/chronic/obesity/pubs/AKObesityDataSources.pdf

Clearly the burden created by obesity is large, and it will take a concerted effort on the part of many players in and out of state government to address that burden. Fortunately, the Section has the benefit of strong internal and external partners who share this goal. Dr. Ward Hurlburt, Alaska's Chief Medical Officer, calls childhood obesity the predominant public health threat of this generation. Key stakeholders in the non-profit sector—e.g., Alaska's representatives in the American Cancer Society, the American Heart Association, and the AARP—also have agenda's built around prevention of obesity in Alaska.

Despite these allies and resources, the obesity prevention and control effort in Alaska currently lacks the level of sustained funding needed to support a comprehensive approach, such as has been used to make great strides in the area of tobacco use in Alaska. By applying significant and sustained resources to the CDC best practice model of a comprehensive tobacco prevention and control program, the Alaska Tobacco Prevention and Control Program (TPC) and its partners have been successful it cutting youth smoking by 60% and curbing per adult cigarette consumption by 51%.[21] A similar comprehensive, sustained program will be necessary to turn the tide on obesity and overweight in Alaska.

[21] http://www.hss.state.ak.us/dph/chronic/tobacco/PDF/2012_alaska_tobacco_facts.pdf. Accessed 8-10-2012.

GOAL 1

Reduce the prevalence of overweight and obesity among school-aged children by 5% by 2017.

OBJECTIVE 1.1. ESTABLISH A GRANT PROGRAM FOR SCHOOL DISTRICTS FOCUSED ON REDUCING THE PREVALENCE OF CHILDHOOD OBESITY BY JUNE 2013.

Strategy 1.1.1. Expand from 2 to 3 the number of school districts participating in Body Mass Index studies of their student population by December 2012.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	Internal Partners • Section Data Analyst External Partners • Contractor • Section of Public Health Nursing • Anchorage, Mat-Su Borough, Kenai Peninsula Borough School Districts': o School Nurses o Administration o School Board members	Ongoing December 2012 June 2013	Continued collaboration with Anchorage and Mat-Su School Districts. BMI studies for these districts have been published providing baseline data. Updated studies will be published at 3 year intervals. BMI report is developed and published for the Kenai Peninsula Borough School District. Presentations of findings to school officials and the Kenai Peninsula Borough School District Board.

Rationale: Baseline data reporting of student BMI is the first step toward school officials and decision-makers understanding the nature of the problem in their jurisdictions. Through analyzing electronic health records of student heights and weights, the prevalence of obesity and overweight in specific school districts is objectively presented and provides the district with baseline data. This information has prompted school officials in these two districts to consider and adopt environmental changes to reduce obesity and overweight in their student populations. Continued, objective monitoring of BMI within these two engaged school districts—and expansion to a third—will

GOAL 1

prompt school officials to consider environmental changes to reduce the prevalence of obesity and help them measure their success.

Evidence: The American Public Health Association,[22] the Institute of Medicine,[23] and the American Heart Association[24] each endorse the use of BMI measurement for surveillance purposes.

Estimated Reach: The student population of the Anchorage School District is approximately 49,000, (in nearly 100 schools) while the Matanuska-Susitna Borough School District has 17,500 students in 44 schools. There are approximately 8,900 students in the Kenai Peninsula Borough School District.

Domain: This strategy is directly related to domain 1 – gathering, analyzing and disseminating data and information, to monitor population health, focusing on the highest priority of the Alaska Division of Public Health.

Strategy 1.1.2. Assess the capacity of school districts to implement a grant program.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	Internal Partners • Section TPC staff • Section School Health staff External Partners • School Nurse consultant group • ATCO • Dept of Education & Early Development (DEED) • School Health & Wellness Institute	February 2013	Capacity assessment completed.

Rationale: For a grant program to be successful, a formal or informal assessment of capacity, and an understanding of what will and will not work in a school or school district setting is necessary. Building on the tobacco program's experience with grants to schools and districts, the Section will seek information from educators about level of interest and how to structure a grant program for

[22]American Public Health Association. Policy statements adopted by the governing council of the American Public Health Association, October 24, 2001. Am J Public Health.2002;92 (3):451– 483.

[23]Institute of Medicine. Preventing Childhood Obesity: Health in the Balance. Washington, DC: National Academies Press; 2005.

[24]American Heart Association. Policy position statement on body mass index (BMI) surveillance and assessment in schools. Washington, DC: American Heart Association; 2008

success given the competing academic and other demands in educational settings. Designing a grant program with this information will be essential to future grantee success.

Evidence: As outlined in the L.E.A.D. framework of evidence-based public health, progress in obesity prevention depends upon the use of data to inform decisions.[25] Capacity assessments, such as those proposed in this plan, are one example of the type of evidence that will need to be collected in Alaska in order to inform the development of an effective grant program.

Estimated Reach: Statewide

Domain: This strategy targets environmental approaches to promote health and support and reinforce healthful behaviors in school and community settings (Domain 2).

Strategy 1.1.3. Develop a menu of endorsed, evidence-based strategies from which grantees can choose.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	Internal Partners • Section School Health staff • External Partners • DEED	April 2013	Menu of school-based strategies is developed and included in the Request for Proposals

Rationale: Using Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide, published by CDC in July 2009, a menu of strategies will be selected for inclusion in the Request for Proposals. Applicants for the grant program will be required to choose from the evidence-based strategies, and select those best matched to the level of support and capacity in their community and school/school district for such activities.

Evidence: Statewide programs can provide the skills, resources and information needed for the coordinated, strategic implementation of effective community programs. For example, training local community coalition about the recommended community strategies to prevent obesity can be provided most efficiently through statewide partner who have experience in providing these services. Direct funding provided to statewide organization can be used to mobilize their organizational assets to strengthen community resources.[26]

[25] Kumanyika S, Brownson RC, Cheadle A. The L.E.A.D. framework: using tools from evidence-based public health to address evidence needs for obesity prevention. [Erratum appears in Prev Chronic Dis 2012;9. http://www.cdc.gov/pcd/issues/2012/12_0157e.htm.] *Prev Chronic Dis* 2012;9:120157. DOI: http://dx.doi.org/10.5888/pcd9:120157.

[26] Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs – 2007. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health: October 2007.

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Estimated Reach: Five school districts

Domain: This strategy targets environmental approaches to promote health and support and reinforce healthful behaviors in school and community settings (Domain 2).

Strategy 1.1.4. Issue Request for Proposals for school/district grantees and fund up to five grantees, each for three years.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	Internal Partners • Section School Health staff • Section TPC staff External Partners • DEED • Grants and Contracts • Section of Women's, Children's, and Family Health • Section of Public Health Nursing	April 2013 June 2013	Request for Proposals is issued in April 2013 Up to 5 grants are awarded to begin July 1, 2013

Rationale: Funding grants in five school districts will support organizational capacity to build an obesity prevention program in local communities. Grants will be awarded to those schools/districts that have the backing of the administration, baseline BMI data or a commitment to gather these data in the first year of the grant, and capacity to reverse the trend of obesity.

Evidence: Although, unlike for tobacco prevention[27], there is no single, authoritative set of recommendations for developing an effective obesity prevention program, many in public health have made the case that a similarly comprehensive program—including one that supports community and statewide coalitions—will be necessary to address the obesity epidemic.[28,29]

Estimated Reach: Five school districts

Domain: This strategy targets environmental approaches to promote health and support and reinforce healthful behaviors in school and community settings (Domain 2).

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[27]Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs*—2007. Atlanta:U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.
[28]AARP Public Policy Institute. *Changing health behavior: reducing obesity by applying lessons learned from the campaign to control tobacco use.* http://assets.aarp.org/rgcenter/ppi/health-care/i37-obesity.pdf. Accessed 8-9-2012.
[29]Engelhard CL, Garson A, Dorn S. *Reducing obesity: Policy strategies from the tobacco wars. The Urban Institute.* July 2009. http://www.urban.org/uploadedpdf/411926_reducing_obesity.pdf. Accessed 8-9-2012.

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Strategy 1.1.5. Develop the content for training and technical assistance to five grantees by June 2013.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	Internal Partners • Section School Health staff • Section TPC staff External Partners • Contractor • DEED	June 2013	Documentation of decisions regarding the content to be offered through training and technical assistance RFP issued reflecting the content expertise desired and training/TA to be provided

Rationale: To ensure that grantees are well-acquainted and versed in evidence-based best practices, and that action plans adhere to these, the content of training and technical assistance must be determined.

Evidence: Technical assistance has proven to be "the engine powering social change" for our peers working in the tobacco prevention and control arena.[30] To better meet the needs of communities and the program, this type of adaptive support has been especially effective.

Estimated Reach: Five grantees

Domain: This strategy targets environmental approaches to promote health and support and reinforce healthful behaviors in school and community settings (Domain 2).

Objective 1.1: Strategies for Years 2 through 5

In years 2-5, BMI studies will be conducted with at least two additional school districts to establish the baseline from which progress can be measured. Participation in this study will be a requirement of the obesity prevention grant program.

Grantees will submit annual continuation applications and continue to develop obesity prevention activities at the local level. They will report on performance measures noting progress toward achieving the goal of reducing the trend of obesity in their respective schools or school districts. In year 4 a new grant application will be developed with new three-year grants awarded in 2017.

[30]Roeseler A, Hagaman T, Kurtz C. The use of training and technical assistance to drive and improve performance of California's Tobacco Control Program. *Health Promot Pract.* 2011;12:130S-143S. http://hpp.sagepub.com/content/12/6_suppl_2/130S. Accessed 8-8-2012.

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Training and technical assistance will be provided to 5 grantees, with an initial orientation and midyear training by June 30, 2014. It is insufficient to provide funding without attaching training and technical assistance to assure success in meeting expected indicators for reducing the trend of obesity. Once the content is determined, grantees will attend a fall orientation to ensure that action plans adhere to evidence-based strategies, as well as to gain information about administrative requirements involved in reporting, budgeting, and revisions. Mid-year trainings will provide further guidance to grantees, to assure continued communication, monitoring of progress, and assisting with developing strong grantees.

OBJECTIVE 1.2. BUILD A STATEWIDE COALITION TO ADDRESS CHILDHOOD OVERWEIGHT AND OBESITY.

Strategy 1.2.1. Determine elements and partners needed for a successful obesity coalition.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	Internal Partners • Section's Tobacco Prevention & Control Program • Section's Heart Disease & Stroke Prevention Program • Section's Comprehensive Cancer Program • Section's Diabetes programs External Partners • Division of Public Health • Section of Public Health Nursing • Section of Women's, Children's and Family Health	September 2012	The content of the Request for Proposals will reflect elements needed for a successful coalition focused on obesity – Alaskans Taking on Childhood Obesity (ATCO).

Rationale: Building on the success of the tobacco prevention model, coordination of partner activities toward common goals is a necessary component of a comprehensive program. As a first step toward building a coalition, a compilation of factors that are critical for a successful coalition is needed.

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Evidence: Although, unlike for tobacco prevention[31], there is no single, authoritative set of recommendations for developing an effective obesity prevention program, many in public health have made the case that a similarly comprehensive program—including one that supports community and statewide coalitions—will be necessary to address the obesity epidemic.[32,33]

Estimated Reach: Coalition membership will be statewide.

Domain: This strategy is aimed at creating an organizational structure to engage new and existing partners, who will promote an enhanced obesity prevention effort throughout the state of Alaska.

Strategy 1.2.2. Provide logistical and administrative support to the childhood obesity prevention coalition on an on-going basis.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	External Partners • Grants and Contracts staff • Voluntary organizations, • Non-profit organizations dedicated to physical activity and nutrition • Food Policy Council • CDPHP Collaborative • Schools and School Districts • DEED	Contract Award: 12/2012 ATCO Meetings held quarterly	The contractor will be hired by December 2012. The ATCO coalition minutes will reflect they met quarterly

Rationale: The coalition will function in collaboration with the obesity prevention activities, but operate independently of the State of Alaska. The best means to achieve this independence and accomplish effective coordination of efforts is through a contract. The coalition will work toward building comprehensive, collaborative, evidence-based and sustainable obesity prevention activities.

Evidence: Community coalitions, composed of a diverse group of community members who are committed to effecting change, are successful in engaging community partners in health

[31]Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs*—2007. Atlanta:U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.
[32]AARP Public Policy Institute. *Changing health behavior: reducing obesity by applying lessons learned from the campaign to control tobacco use.* http://assets.aarp.org/rgcenter/ppi/health-care/i37-obesity.pdf. Accessed 8-9-2012.
[33]Engelhard CL, Garson A, Dorn S. *Reducing obesity: Policy strategies from the tobacco wars. The Urban Institute.* July 2009. http://www.urban.org/uploadedpdf/411926_reducing_obesity.pdf. Accessed 8-9-2012.

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improvement.[34,35] The collaborative work of a coalition is more effective than the efforts of individuals or individual groups, because it is composed of partners representing multiple sectors, reduce duplication of effort, and use various resources to accomplish a common goal.[36]

Estimated Reach: Statewide

Domain: This strategy is aimed at creating an organizational structure to engage new and existing partners, who will promote an enhanced obesity prevention effort throughout the state of Alaska. (Domain 2).

Strategy 1.2.3. Complete policy analysis and Return on Investment (ROI) study on critical aspects of obesity prevention and control.

Lead	Partners	When	Result/Evaluation
Section Obesity staff	External Partners • School Health Collaborative • ATCO • DEED • Contractor	Contract Award: 12/2012	Policy Analyses will be published on the web and in print.

Rationale: This strategy will result in an objective and analytic view of the positive and negative implications of specific policies within the state of Alaska. These analyses can be used by lawmakers, executive staff and partners to more fully understand how decisions will impact the problem of obesity in Alaska.

Evidence: Policymakers need more than the findings of systematic reviews: they need advice on how to translate these findings into policy and action.[37]

Estimated Reach: Statewide

Domain: This strategy supports improvements to the environment, and promotion of healthy behaviors in school environments (Domain 2).

[34]Makenzie JF, Neiger BL, Smeltzer JL. Planning, implementing and evaluating health promotion programs: a primer. 4th edition. San Francisco (CA): Benjamin Cummings; 2005.

[35]Minkler M. Community organizing and community building for health. 2nd edition. Piscataway Township (NJ): Rutgers University Press; 2007.

[36]Wandersman A, Goodman RM, Butterfoss FD. Understanding coalitions and how they operate as organizations. In: Minkler M, editor. Community organizing and community building for health. 2nd edition. Piscataway Township (NJ): Rutgers University Press; 2007. p. 292-313.

[37]Sweet M, Moynihan R. Improving Population Health: The Uses of Systematic Reviews. Milbank Memorial Fund. December 2007. http://www.milbank.org/reports/0712populationhealth/0712populationhealth.html#obesity. Accessed 8-8-2012.

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Objective 1.2: Strategies for Years 2 through 5

Based on the tobacco prevention and control model, an essential component in creating sustained and comprehensive prevention activities is involvement of strategic partners. The coalition needs to be an independent body, but requires logistical and administrative support to be successful.

In years 2 through 5, the ATCO Coalition will continue to receive administrative and logistical support through a contractual agreement, allowing them to meet quarterly. The composition of ATCO will be reviewed annually, and new partners will be invited to participate as needed. As obesity efforts expand and evolve, it will be important to re-evaluate membership on the coalition. There will be continued focus on selection of strategic partners.

Coalition strategies are expected to focus on building awareness of issues and solutions surrounding the obesity epidemic, promoting environmental approaches to prevent or reduce obesity, working toward securing incremental increases to funding levels, and expanding obesity prevention strategies. Through the Coalition's work, the reach of public awareness and obesity prevention efforts will be strengthened and extend throughout the state.

OBJECTIVE 1.3. CREATE, IMPLEMENT, AND EVALUATE A NEW OBESITY PREVENTION MEDIA CAMPAIGN BY JUNE 2013.

Strategy 1.3.1. Hire full-time social marketing position.

Lead	Partners	When	Result/Evaluation
Section Chief	Internal Partners • Section's Leadership Team • Section Obesity staff	July 2012	Job Description is created, recruitment completed and position is filled.

Rationale: The Section has a significant gap in the ability to conduct social marketing efforts for all content areas with the exception of tobacco. An in-house, full-time position is needed to achieve the strategic goals outlined in this plan. A strong communication plan and social marketing activities will be used to educate the public about the problem of obesity, and the role that society, communities and government play in contributing to the prevalence as well as prevention of obesity.

Evidence: Social marketing campaigns can change awareness, beliefs, attitudes and behaviors. For example, tobacco prevention media campaigns are powerful tools for preventing smoking initiation,

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promoting and facilitating cessation, and shaping social norms related to tobacco use.[38] The CDC effectively promoted physical activity among children age 9–13 years (tweens) through the VERB™ campaign. VERB™ also included messages for parents, the secondary target audience, to encourage them to support their tween's physical activity. Parents' awareness of VERB™ was associated with positive attitudes, beliefs, and behavior about physical activity. Additionally, tween physical activity increased the more familiar the tween was with VERB™.[39]

Estimated Reach: N/A

Domain: This strategy contributes to public awareness and understanding of the status of obesity in Alaska, its underlying causes as well as consequences, and how changing the environment through evidence-based practices can reduce prevalence rates of obesity and overweight in Alaska.

Strategy 1.3.2. Build the conceptual model and components of a media campaign.

Lead	Partners	When	Result/Evaluation
Section's Communications/ Social Marketing Specialist	Internal Partners • Section Obesity staff • External Partners • Grants and Contracts staff • DHSS Public Information Team (PIT Group) • Section of Women's, Children's and Family Health • Section of Public Health Nursing • ATCO	October 2012	Results of focus groups will guide the concepts for a media campaign. Conducting focus groups prior to guide development of messages and follow-up surveys to evaluate recall and changes in behavior

Rationale: Obesity prevention is the highest priority of the Division. In order to create high visibility for this issue, a strong communication and social marketing campaign is needed. Generating awareness of the problem and its solutions lays the foundation for building a constituency of support that will be needed to expand efforts annually. A media campaign is a known, effective strategy for

[38]Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs*—2007. Atlanta: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

[39]Berkowitz JM, Cavill N, Maibach E, Wong AF, eds. The VERB Campaign: Not about health, all about fun: marketing physical activity to children. American Journal of Preventive Medicine. 2008;34(6)(supple 1). http://www.cdc.gov/youthcampaign/research/publication.htm. Accessed 8-8-2010.

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keeping this issue in front of decision-makers as well as the public, both of which will be essential to meeting the overall program goal.

Estimated Reach: N/A

Evidence: Social marketing campaigns can change awareness, beliefs, attitudes and behaviors. For example, tobacco prevention media campaigns are powerful tools for preventing smoking initiation, promoting and facilitating cessation, and shaping social norms related to tobacco use.[40] The CDC effectively promoted physical activity among children age 9–13 years (tweens) through the VERB™ campaign. VERB™ also included messages for parents, the secondary target audience, to encourage them to support their tween's physical activity. Parents' awareness of VERB™ was associated with positive attitudes, beliefs, and behavior about physical activity. Additionally, tween physical activity increased the more familiar the tween was with VERB™.[41]

Domain: This strategy involves the collection and dissemination of obesity data at the state level through the Youth Risk Behavior Survey, Body Mass Index studies within school districts, and Behavioral Risk Factor Surveillance data. (Domain 1). In addition, the communication and social marketing campaign is intended to directly promote healthy behaviors, especially among school-aged children and their families (Domain 2).

[40] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs*—2007. Atlanta: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

[41] Berkowitz JM, Cavill N, Maibach E, Wong AF, eds. The VERB Campaign: Not about health, all about fun: marketing physical activity to children. *Am J Prev Med*. 2008;34(6)(supple 1). http://www.cdc.gov/youthcampaign/research/publication.htm. Accessed 8-8-2012.

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Strategy 1.3.3. Award contracts for and execute 1) media buys, and 2) internal contract with the Public Information Team for production and filming of public service announcements, and 3) social marketing of a physical activity challenge.

Lead	Partners	When	Result/Evaluation
Section's Communications/ Social Marketing Specialist	Internal Partners • Section Obesity staff External Partners • Grants and Contracts staff • PIT Group • Division of Public Health • ATCO	Sept, 2012	Contracts executed for: • Purchasing air time on TV, radio of public service announcements • Reimbursable Services Agreement is issued for filming and production of public service announcements • Social marketing of a physical activity challenge among elementary-aged students in at least 100 schools

Rationale: This strategy outlines how messages will be conceived, developed, executed and evaluated. Following best practices for social marketing, focus groups will be used to understand what messages the public gauge to be effective in motivating behavior change, and to identify who could deliver the message credibly. Story boards will be created and further tested with new focus groups, the results of which will be used to film and produce public service announcements. A media buyer will purchase time on radio and TV to air the ads based on market analysis to reach the targeted demographic audience. Finally, a social marketing campaign will engage over 100 schools in a physical activity challenge, utilizing a physical activity log, incentives and special events. The physical activity challenge has a two-fold purpose: first to engage youth in order to encourage the development of lifelong engagement in physical activity, and second to use media to promote participation, and encourage families to build physical activity into their daily lives and routines, while building awareness of the problem of obesity and how to fix it.

Evidence: Social marketing campaigns can change awareness, beliefs, attitudes and behaviors. For example, tobacco prevention media campaigns are powerful tools for preventing smoking initiation,

promoting and facilitating cessation, and shaping social norms related to tobacco use.[42] *The CDC effectively promoted physical activity among children age 9–13 years (tweens) through the VERB™ campaign. VERB™ also included messages for parents, the secondary target audience, to encourage them to support their tween's physical activity. Parents' awareness of VERB™ was associated with positive attitudes, beliefs, and behavior about physical activity. Additionally, tween physical activity increased the more familiar the tween was with VERB™.*[43]

Estimated Reach: Statewide

Domain: This strategy is primarily aimed at promotion and reinforcement of healthy behaviors, in particular focusing on school environments (Domain 2).

Objective 1.3: Strategies for Years 2 through 5

Informed by annual focus groups, the media and public education campaign will be refreshed and retooled to match current obesity prevention strategic priorities. Expansion of all media and social marketing efforts are anticipated.

[42]Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs*—2007. Atlanta: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

[43]Berkowitz JM, Cavill N, Maibach E, Wong AF, eds. The VERB Campaign: Not about health, all about fun: marketing physical activity to children. *Am J Prev Med*. 2008;34(6)(supple 1). http://www.cdc.gov/youthcampaign/research/publication.htm. Accessed 8-8-2012.

BACKGROUND

The Potential of Preventive Screening

Screening services that include advice and referrals are a critical component in the clinical preventive services that have been shown to reduce the burden of illness, death and disability. Other components are clinical interventions to reduce the risk for an adverse health condition and clinical interventions to reduce complications from a condition or recurrence of a condition.[44]

The health-related costs of underuse of recommended clinical preventive services are substantial. Researchers have reported that increasing use of nine clinical preventive services to more optimal levels (i.e., levels achieved by high-performing health plans) could prevent an estimated 50,000–100,000 deaths each year among adults aged <80 years.[45]

Key Alaskan preventive screening data trends show little improvement over the past 10 years. For example: 72% of women 40 and older have received a mammogram in the past two years, no change in the last decade; only 71% of adults 18 and over had cholesterol tested in the past five years; although improving, only 62% of adults 50 and over have ever been screened for colorectal cancer; only 77% of adult smokers have been advised by their health care provider to quit (BRFSS).

The CDPHP Collaborative Clinical Screening Task Force that includes Collaborative members, primary care physicians and staff of the Section of Women's Children's and Family Health and CDPHP met to select the core screening services that will be promoted and monitored by the Collaborative. A review of United States Preventative Services Task Force recommended screenings for adults and other advisory statements was completed. The core screenings include risk factors for heart disease, stroke and diabetes, and screenable cancers.

[44]Coates RJ, Yoon PW, Zaza S, Ogden L, Thacker SB. Rationale for periodic reporting on the use of selected adult clinical preventive services—United States. *MMWR* 2012;61(02):3-10.

[45]Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths preventable in the U.S. by improvements in the use of clinical preventive services. Am J Prev Med 2010;38:600–9.

GOAL 2

By 2017, increase rates of selected preventive health screenings by 5%.

OBJECTIVE 2.1. MONITOR AND REPORT DATA ON 8-10 PREVENTIVE SCREENINGS BY JUNE 2013.

Strategy 2.1.1. Finalize the set of measurable screenings.

Lead	Partners	When	Result/Evaluation
Clinical Screening Task Force	External Partners • Voluntary organizations • Non-profit organizations • Primary Care Providers • Chronic Disease Prevention & Health Promotion Collaborative	October 2012	Finalized screenings will be presented to CDPHP Collaborative. Develop dashboard to monitor screening data

Rationale: Focus on a set that are measurable and reflect screenings that are of high importance to prevent and detect chronic disease.

Evidence: There is strong evidence that preventive screenings reduce the burden of illness, death and disability.[46]

Estimated Reach: Adults (18+) statewide

Domain: This strategy is aimed at collecting core data to analyze for population health and disseminate the data to the public. (Domain 1).

Objective 2.1: Strategies for Years 2 through 5

In subsequent years, we will continue to explore and review alternate sources of data and continue to participate in the Health Information Exchange and to have annual CDPHP Collaborative meetings. A final report to the CDPHP Collaborative on the five year results of the strategies on preventive screening behaviors in Alaska will be completed in 2017.

[46]Coates RJ, Yoon PW, Zaza S, Ogden L, Thacker SB. Rationale for periodic reporting on the use of selected adult clinical preventive services—United States. *MMWR* 2012;61(02):3-10.

GOAL 2

OBJECTIVE 2.2. DEVELOP A COORDINATED PREVENTIVE SCREENINGS COMMUNICATION PLAN BY JUNE 2013.

Strategy 2.2.1. Convene appropriate staff and partners for input and draft communication plan.

Lead	Partners	When	Result/Evaluation
Integrated Communications Committee	External Partners • Voluntary organizations • Non-profit organizations • Primary Care Providers • CDPHP Collaborative	June 2013	Consistent messages developed and implementation strategies identified.

Rationale: Current communication efforts are not coordinated across programs and partners in a manner sufficient to make an impact on screening behaviors and chronic disease.

Evidence: Research shows an increase in utilization of core preventive services prevents death. The Guide to Community Prevention Services (The Community Guide) recommends the use of patient reminders to increase screenings and small media campaigns. [47,48]

Estimated Reach: Adults (18+) statewide

Domain: These strategies are focused on effective delivery of quality preventive services, and helping Alaskans more effectively use and benefit from those services (Domain 3).

Objective 2.2: Strategies for Years 2 through 5

In subsequent years, a consistent message will be used and evaluated annually to improve the message with input from internal and external partners.

[47] Coates RJ, Yoon PW, Zaza S, Ogden L, Thacker SB. Rationale for periodic reporting on the use of selected adult clinical preventive services—United States. *MMWR* 2012;61(02):3-10.

[48] Guide to Community Preventive Services. Increasing cancer screening: client reminders. July 2010. http://www.thecommunityguide.org/cancer/screening/client-oriented/reminders.html Accessed 8-16-2012.

GOAL 2

OBJECTIVE 2.3. IDENTIFY A PRIORITIZED AND MODIFIABLE LIST OF GAPS IN ACCESS TO PREVENTIVE SCREENINGS BY JUNE 2013.

Strategy 2.3.1. Complete a gap analysis to identify areas in the state where preventive screenings are low, ACA opportunities, and Medicaid limitations related to preventive screening.

Lead	Partners	When	Result/Evaluation
Clinical Screening Task Force	External Partners • Voluntary organizations • Non-profit organizations • Primary Care Providers • CDPHP Collaborative	March 2013	Gap analysis presented to CDPHP Collaborative

Rationale: Given limited resources, we need to narrow our focus to gaps that we have the ability to impact and that have far-reaching impact.

Evidence: Evaluate effectiveness, accessibility, and quality of personal and population-based health services.[49]

Estimated Reach: Adults (18+) statewide

Domain: This strategy aims to address health system interventions to improve access to preventive screenings (Domain 3) and the collection and dissemination of data to monitor population health (Domain 1).

Objective 2.3: Strategies for Years 2 through 5

A collaborative approach will be used to address the systemic barriers to preventive screenings with annual objectives to address priority areas.

[49]Centers for Disease Control and Prevention. National Public Health Performance Standards Program. 10 Essential Public Health Services. December 2010. http://www.cdc.gov/nphpsp/essentialservices.html Accessed 8-16-2012.

GOAL 2

OBJECTIVE 2.4. IDENTIFY AND ESTABLISH SELF-MANAGEMENT (SM) EDUCATION REFERRAL PROTOCOLS AMONG 3 PARTNER MEMBERS IN EACH OF THE DIABETES, HEART DISEASE, AND CANCER COALITIONS BY JUNE 2013.

Strategy 2.4.1. Present to each of the 3 coalitions on self-management education.

Lead	Partners	When	Result/Evaluation
Section program managers of Diabetes Prevention and Control (DM), Heart Disease and Stroke Prevention (HD), and Cancer Prevention and Control (CA) programs	External Partners • American Diabetes Association • American Heart Association • American Cancer Society • Alaska Native Tribal Health Consortium • Southeast Alaska Regional Health Corporation • AK Medicaid • AARP Alaska Chapter • AK Primary Care Association • University of Alaska • AK Academy of Family Physicians • Medicare Clinic	Nov 2012	Presentations given

Rationale: Coalition partners have direct access to target populations with chronic conditions.

Evidence: Published studies document the following evidence across multiple settings and participant types: referrals from primary providers increase the probability that a person will attend a SM class; persons who attend SM classes are more likely to have increased screening rates and have better clinical outcomes.[50]

Estimated Reach: Adults 45+ statewide

Domain: This strategy is focused on effective delivery of quality preventive services, and helping Alaskans more effectively use and benefit from those services (Domain 3)and addresses improvement of community-clinical linkages ensuring access to chronic disease self management (Domain 4).

[50]Brady TJ, Murphy L. (May, 2011) Sorting Through the Evidence for the Arthritis Self-Management Program and the Chronic Disease Self-Management Program, *Executive Summary of ASMP/CDSMP Meta-Analyses.* http://www.cdc.gov/arthritis/docs/asmp-executive-summary.pdf Accessed 8-10-12.

GOAL 2

Strategy 2.4.2. Identification of agencies and healthcare providers that would refer appropriate participants to self-management education.

Lead	Partners	When	Result/Evaluation
Section program managers of Diabetes Prevention and Control (DM), Heart Disease and Stroke Prevention (HD), and Cancer Prevention and Control (CA) programs	External Partners • American Diabetes Association • American Heart Association • American Cancer Society • Alaska Native Tribal Health Consortium • AK Medicaid • AK AARP • AK Primary Care Association • University of Alaska • AK Academy of Family Physicians • Medicare Clinic	Feb 2013	Follow-up results from presentation meetings; list of potential referral agencies and providers

Rationale: Coalition partners have direct access to target populations with chronic conditions.

Evidence: Published studies document the following evidence across multiple settings and participant types: referrals from primary providers increase the probability that a person will attend a SM class; persons who attend SM classes are more likely to have increased screening rates and have better clinical outcomes.[51]

Estimated Reach: Adults 45+ statewide

Domain: This strategy is focused on effective delivery of quality preventive services, and helping Alaskans more effectively use and benefit from those services (Domain 3).

Strategy 2.4.3. Development of referral agency and participant recruiting materials

Lead	Partners	When	Result/Evaluation
Section program managers of Diabetes Prevention and Control (DM),	Internal partners • Communication Workgroup • PIT Group • External Partners • Administration on Aging,	April 2013	Materials printed and disseminated

[51] Brady TJ, Murphy L. (May, 2011) Sorting Through the Evidence for the Arthritis Self-Management Program and the Chronic Disease Self-Management Program, *Executive Summary of ASMP/CDSMP Meta-Analyses.* http://www.cdc.gov/arthritis/docs/asmp-executive-summary.pdf Accessed 8-10-12.

GOAL 2

Heart Disease and Stroke Prevention (HD), and Cancer Prevention and Control (CA) programs	Stanford University		

Rationale: Printed materials can be used to educate and inform patients of resources in the community; they also assist providers in that they can reinforce information she/he has provided the patient.

Evidence: Published studies document the following evidence across multiple settings and participant types: referrals from primary providers increase the probability that a person will attend a SM class; persons who attend SM classes are more likely to have increased screening rates and have better clinical outcomes[52]

Estimated Reach: Adults 45+ statewide

Domain: This strategy is focused on effective delivery of quality preventive services, and helping Alaskans more effectively use and benefit from those services (Domain 3).

Objective 2.4: Strategies for Years 2 through 5

Increase self-management education workshop referrals from partner members of the Diabetes, Heart Disease and Stroke Prevention, and Cancer Coalitions by 5%.

In subsequent years, partner members of the three coalitions will have referral systems in which potential participants from their agencies would be referred to self-management classes.

[52] Brady TJ, Murphy L. (May, 2011) Sorting Through the Evidence for the Arthritis Self-Management Program and the Chronic Disease Self-Management Program, *Executive Summary of ASMP/CDSMP Meta-Analyses.* http://www.cdc.gov/arthritis/docs/asmp-executive-summary.pdf Accessed 8-10-12.

BACKGROUND

The Problem of Tobacco Use

Tobacco use remains Alaska's leading preventable cause of disease and death. More Alaskans die as a result of tobacco use than from infectious diseases, alcohol, car accidents, illegal drugs, murders and suicides combined. Tobacco use exacts an enormous burden on the State of Alaska and its residents, causing premature death and millions of dollars of avoidable medical care expenditures. The single best thing that Alaskans who use tobacco can do to improve their health and the health of those around them is to quit using any tobacco products. More than 500 deaths per year as a direct result of tobacco-related diseases, including cancers, heart disease, respiratory disease and harm to unborn children. Furthermore, in 2010, tobacco use cost Alaska $348 million in direct medical expenditures and an additional $231 million in lost productivity due to tobacco-related deaths.[53,54]

Over the past decade and a half, Alaska has made significant strides in reducing the burden of tobacco[53]:

- Per adult cigarette consumption declined 51% from State Fiscal Year (SFY) 1996 to SFY 2010; ***436 million fewer cigarettes*** were sold in 2010 compared to 1996.
- ***The percentage of adult smokers in Alaska has declined*** by one-fourth since 1996 to 20.6 percent in 2010, a statistically significant decrease.
- The majority of Alaska adults who currently smoke want to quit; about three out of five tried to quit in the last 12 months.
- Smoking among high school students has declined more than 60%, from 37% in 1995 to 14% in 2011.
- Secondhand smoke exposure has decreased significantly among children at home, and among high school students at home and other indoor spaces.
- Nine out of ten adults believe people should be protected from smoke from other people's cigarettes and a similar proportion say they would visit bars and other establishments as often or more often if smoking were not allowed there.

However, significant challenges remain:

- Alaska Native adults are still twice as likely to smoke as non-Native adults.
- Alaska adults with less education, with lower incomes, and who live in rural areas of the state also smoke more than their peers.

[53]Alaska Tobacco Facts, 2012. http://www.hss.state.ak.us/dph/chronic/tobacco/alaska_tobacco_facts.pdf. Accessed 8-8-2012.

[54]Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. *Tobacco in the Great Land, A Portrait of Alaska's Leading Cause of Death, 2012 Update*. Anchorage, AK: Alaska Department of Health and Social Services; 2012. http://www.hss.state.ak.us/dph/chronic/tobacco/PDF/2012_TobaccoInGreatLand.pdf. Accessed 8-10-2012.

BACKGROUND

- Alaska Native high school students—both boys and girls—are significantly more likely to smoke than students from other race groups, although the gap has decreased considerably since 2003.
- One out of three high school students are still regularly exposed to secondhand smoke.
- Among those who work primarily indoors, younger adults (age 18 to 29) are significantly less likely to be protected by a clean indoor air policy.

Data Sources

The Tobacco Prevention and Control Program (TPC) uses a variety of data sources to estimate the burden of tobacco in Alaska and monitor trends. These include: Tobacco tax reports, the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, the Pregnancy Risk Assessment Monitoring System, and the Synar vendor compliance database. These and other data sources are described in more detail on pp 50-55 of *Alaska Tobacco Facts*.[55]

[55] Alaska Tobacco Facts, 2012. http://www.hss.state.ak.us/dph/chronic/tobacco/alaska_tobacco_facts.pdf. Accessed 8-10-2012.

GOAL 3

By 2017, lower tobacco use rates among young adults (age 18-29), Alaska Natives, and Alaskans of low socioeconomic status by 5%.

OBJECTIVE 3.1. PROVIDE EDUCATION AND INFORMATION ON EVIDENCE-BASED POLICY APPROACHES THAT IMPROVE HEALTH TO ALL TOBACCO GRANTEES STATEWIDE BY JUNE 2013.

Strategy 3.1.1. Build inventory of community, school, and behavioral health tobacco-free policies.

Lead	Partners	When	Result/Evaluation
TPC Evaluation staff	Internal Partners • Comprehensive Cancer staff External Partners • Contractors • Tribal Health	Ongoing	Policy Database is built.

Rationale: In order to support the development of tobacco-free policies, both locally and statewide, it is critical to know the current extent and quality of policies in various settings. The development of this policy database will allow the analysis that will provide this information.

Evidence: Decisions in public health need to be based—to the extent possible—upon sound evidence.[56] Without a baseline of the extent and quality of tobacco-free policies around the state, it will be impossible to target support to those areas in most need, where there is momentum, or that meet some other criterion for readiness for tobacco-free policy development.

Estimated Reach: At least in the first year, the policy data base will not cover 100% of all settings (community, school, healthcare, behavioral health, etc.). Tobacco-free policies for all school districts in Alaska have already been collected. Collection of policies for community ordinances & tribal resolutions have been ongoing while collection of healthcare & behavioral health policies are in preliminary stages .

Domain: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health (Domain 1).

[56]Anderson LM, Brownson RC, Fullilove MT et al. Evidence-based public health and practice: promises and limits. *Am J Prev Med.*2005;28(5S):226-230.

GOAL 3

Strategy 3.1.2. Analyze tobacco-free policy inventory and select top priorities for education and support.

Lead	Partners	When	Result/Evaluation
TPC staff	External Partners • Contractors • Tribal Health	Ongoing	Priority communities, schools, healthcare or other settings identified

Rationale: In order to target policy development support in the most efficient manner, staff require an up-to-date analysis of high priority areas. Analysis needed to inform this type of prioritization will be ongoing, becoming more effective as the comprehensiveness of the policy database increases.

Evidence: Decisions in public health need to be based—to the extent possible—upon sound evidence.[57] Without a baseline of the extent and quality of tobacco-free policies around the state, it will be impossible to target support to those areas in most need, where there is momentum, or that meet some other criterion for readiness for tobacco-free policy development.

Estimated Reach: The estimated reach for this strategy is closely linked with that for the development of the policy database. At least in the first year, the policy database will not cover 100% of all settings (community, school, healthcare, tribal, behavioral health, etc.). Tobacco-free policies for all school districts in Alaska have already been collected. Collection of policies for community ordinances & tribal resolutions has been ongoing. Collection of healthcare & behavioral health policies are in preliminary stages.

Domain: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health (Domain 1).

Strategy 3.1.3. Build strategic partnerships with organizations serving identified priority populations (young adults, Alaska Natives, and Alaskans of low socioeconomic status).

Lead	Partners	When	Result/Evaluation
TPC staff	Internal Partners • DIG External Partners • LEAD • ATCA • Project Homeless Connect	Ongoing	LEAD group & ATCA membership includes increased representation from young adults and Alaskans of low socioeconomic status &

[57] Anderson LM, Brownson RC, Fullilove MT et al. Evidence-based public health and practice: promises and limits. *Am J Prev Med.* 2005;28(5S):226-230.

GOAL 3

	• College/Vocational Campuses • Dept of Behavioral Health (DBH) • Contractors • Community Health Centers (CHCs) • Tribal Councils/Leaders • Organizations serving 3 priority populations		organizations serving priority populations. Minutes of LEAD meetings Training and TA provided to grantees serving priority populations

Rationale: Implementation of tobacco-free policy is one of the most effective strategies for reducing tobacco prevalence and negative outcomes. Because CDC and State of Alaska grantees are restricted from directly lobbying for these or any policies, it is critical that CDPHP staff have strong, strategic partners who can carry out the specific tasks that move such efforts forward.

Evidence: Unlike individual-focused approaches, community-based approaches to implement evidence-based interventions (such as development of a community- or organization-wide tobacco-free policy) require partnerships that involve multiple sectors of the community.[58]

Estimated Reach: The estimated reach for this strategy is statewide, but strategically so. Efforts will be focused on building those partnerships most likely to influence policies that will impact the 3 identified priority populations. The ultimate reach will not be limited to members of the 3 priority populations (currently: a. 138,000 American Indian/Alaska Natives, b. 130,000 adults aged 18-29, and c. 90,000 adults of low socioeconomic status; groups not mutually exclusive), but will also extend to all Alaskans, given that strong tobacco-free policies impact all members of a community.

Domain: This strategy focuses on expanding the support of those strategic partners who have influence in the state and their communities and can promote passage of local and statewide tobacco-free policies (Domain 2).

Objective 3.1: Strategies for Years 2 through 5

In subsequent years, the policy database will be expanded to include additional settings (e.g., behavioral health) and to improve the comprehensiveness of those settings already included in the database. Correspondingly, analysis of the policy database will expand over time, resulting in a strategic targeting of focus areas for education and information on evidence-based policy approaches that improve health. Priority focus areas will also guide the direction of partnership development efforts.

[58]Malveaux FJ, Butterfoss FD. Translating evidence-based interventions into practice. *Health Promot Pract.* 2011;12(6):5S-8S.

GOAL 3

OBJECTIVE 3.2. INCREASE THE NUMBER OF PROVIDER TYPES THAT CAN BE REIMBURSED FOR IMPLEMENTING THE CLINICAL PRACTICE GUIDELINE FOR TREATING TOBACCO USE AND DEPENDENCE FROM 3 TO 4 BY JUNE 2013.

Strategy 3.2.1. Educate strategic partners about the need to expand provider types eligible for reimbursement for cessation services.

Lead	Partners	When	Result/Evaluation
TPC staff	External Partners • DBH • Oral Health • Medicaid • LEAD, especially behavioral health subgroup • Tribal health/CHAP program • Alaska Dental Action Coalition (ADAC) • Alaska Dental Association • Contractors • HCCMA • ADCA	Ongoing	Technical assistance provided to strategic partners.

Rationale: The US Public Health Service Clinical Practice Guideline advises providers to ask every patient if they smoke, counsel smokers to quit, and refer smokers to appropriate treatment services. Anecdotally, in Alaska the more traditional providers are more likely to follow this guideline than are less traditional providers such as Behavioral Health Aides, dental professionals, and Community Health Aides. The latter types comprise a considerable amount of the patient-provider interactions in Alaska, and thus a huge opportunity for promotion of effective cessation services may be being missed. By expanding the types of providers who have the awareness, tools and resources needed to implement the USPHSCP Guideline, and furthermore can be reimbursed for providing such services, we should be able to increase the percentage of Alaskans who receive appropriate cessation services and ultimately successfully quit.

Evidence: Health insurance coverage of medication and counseling increases the use of effective treatments.[59]

Estimated Reach: Statewide

[59] Hopkins DP, Briss PA, Ricard CJ, et al. Task Force on Community Preventive Services. *Am J Prev Med* 2001;20(2 Suppl):16–66.

GOAL 3

Domain: This strategy focuses on expanding the effective delivery of cessation services (Domain 3).

Objective 3.2: Strategies for Years 2 through 5

During project years 2 through 5, CDPHP staff will continue to work with partners to expand the number of provider types who can be reimbursed for cessation services. This work will be paired with education and outreach to providers around reimbursement opportunities and screening protocols.

OBJECTIVE 3.3. DEVELOP AND IMPLEMENT AT LEAST ONE MEDIA CYCLE (INCLUDING MARKET RESEARCH, DEVELOPMENT, AND BROADCAST/IMPLEMENTATION) THAT TARGETS ONE OR MORE OF THE 3 HIGH PRIORITY POPULATIONS BY JUNE 2013.

Strategy 3.3.1. Strengthen focus of media campaign on the high priority populations.

Who	Partners	When	Result/Evaluation
TPC staff	External Partners • Grantees • Representatives/Organizations serving the high priority populations • Contractors	Ongoing	Culturally appropriate media aired/disseminated

Rationale: Social marketing suggests that communications campaigns are only as effective as they are well targeted. By developing media in a culturally appropriate manner and distributing media products in a manner that optimizes exposure among the targeted priority groups, we will be enhancing the effectiveness of all of the other tobacco program components.

Evidence: The Task Force on Community Preventive Services has determined that there is strong evidence to support the use of mass media campaigns, when combined with additional interventions, to reduce tobacco use among both adolescents and adults.[60]

Estimated Reach: The estimated reach for this strategy depends on which of the 3 priority populations is targeted (a. 138,000 American Indian/Alaska Natives, b. 130,000 adults aged 18-29, and c. 90,000 adults of low socioeconomic status; groups not mutually exclusive). The ultimate reach will not be limited to members of the 3 priority populations, but will also extend to other members of the community who also are exposed to the messaging.

[60]Task Force on Community Preventive Services. Tobacco. In : Zaza S, Briss PA, Harris KW, eds. The Guide to Community Preventive Services: What Works to Promote Health? Atlanta (GA): Oxford University Press;2005:3-79.

GOAL 3

Domain: This strategy focuses on using communications campaigns to reinforce the effectiveness of environmental approaches that promote health (Domain 2).

Strategy 3.3.2. Evaluate implemented media that targets one or more of the 3 high priority populations.

Who	Partners	When	Result/Evaluation
TPC Evaluation staff	External Partners • Contractors	Ongoing	Media awareness survey results

Rationale: Ongoing evaluation of media/communications efforts is necessary to ensure targeted priority populations have awareness of and exposure to the messaging. Results from media evaluations inform changes in subsequent media cycles.

Evidence: Evaluation is critical to the effectiveness of tobacco control media campaigns.[61]

Estimated Reach: As the evaluation informs the development of media that will subsequently target 1 or more of the 3 high priority populations, the estimated reach for this strategy depends on which of the 3 priority populations is targeted (a. 138,000 American Indian/Alaska Natives, b. 130,000 adults aged 18-29, and c. 90,000 adults of low socioeconomic status; groups not mutually exclusive). The ultimate reach will not be limited to members of the 3 priority populations, but will also extend to other members of the community who also are exposed to the messaging.

Domain: This strategy focuses on use of evaluation to inform programs (Domain 1).

Objective 3.3: Strategies for Years 2 through 5

There will be an additional media cycle—including market research, media development, implementation, and evaluation—in each of years 2 through 5, each of which will target at least 1 of the 3 high priority populations.

[61] Valente TW. Evaluating Health Promotion/Health Communication Programs. New York: Oxford University Press; 2002.

BACKGROUND

The Problem of Falls in Adults 65 and Older

Each year, one in every three adults age 65 and older falls, and only half of them talk to their healthcare provider about it. Falls can cause moderate to severe injuries, such as hip fractures and head traumas, and can increase the risk of early death. Falls have been shown to cause older adults to limit their activities, which leads to decreased mobility and further increased risk of falling.[62]

During 2005–2009, the Alaska Trauma Registry (ATR) identified 3,356 cases of fall related injury hospitalizations for older Alaskans, which accounted for 79% of all recorded injury hospitalizations in the registry.[63]

Nationally, the total direct medical costs of all fall injuries in 2000 for people 65 and older exceeded $19 billion: $0.2 billion for fatal falls, and $19 billion for nonfatal falls.[64] By 2020, the annual direct and indirect cost of fall injuries is expected to reach $54.9 billion (in 2007 dollars),[65] making fall-related injuries one of the 20 most expensive medical conditions in the country.[66]

Fortunately, falls are a public health problem that is largely preventable. After appropriate assessments, interventions that address strength and balance exercises, Vitamin D supplementation, medication interactions, vision checkups, home safety issues and proper footwear have been effective in reducing falls.[67]

Fewer and less serious falls for older Alaskans would reduce medical costs and significantly improve the quality of life for our oldest citizens. The primary source of data for Alaska injury data is the Alaska Trauma Registry (ATR). It is currently the most complete source of data for injuries in Alaska. The Hospital Discharge data (HDD) system is not as complete with injury coding as the ATR, therefore efforts will be focused on improving the usability of HDD for injury projects. The Emergency Department (ED) data system is also not as complete as the ATR and will be examined for accessibility and use in injury projects. The Behavioral Risk Factor Surveillance System (BRFSS) currently provides minimal self-report data related to older adult falls in Alaska, and will be incorporated into findings as appropriate.

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[62]Hausdorff JM, Rios DA, Edelber HK. Gait variability and fall risk in community–living older adults: a 1–year prospective study. *Archives of Physical Medicine and Rehabilitation* 2001;82(8):1050–6.

[63]Alaska Department of Health and Social Services, Division of Public Health. *Fall-related Injury Hospitalizations among Older Adults – Alaska, 2005-2009*. Anchorage, AK: Alaska Department of Health and Social Services; 2012. http://www.epi.alaska.gov/bulletins/docs/b2012_02.pdf Accessed 8-16-2012.

[64]Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. *Injury Prevention* 2006b;12:290–5

[65]Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. *Journal of Forensic Science* 1996;41(5):733–46.trial. The Gerontologist 1994;34(1):16–23.

[66]Carroll NV, Slattum PW, Cox FM. The cost of falls among the community-dwelling elderly. *Journal of Managed Care Pharmacy*. 2005;11(4):307-16

[67]Centers for Disease Control and Prevention, Injury Prevention and Control: Home and Recreational Safety. CDC Falls Prevention Activities. *National Center for Injury Prevention and Control. Division of Unintentional Injury Prevention*. Sept. 2010 http://www.cdc.gov/HomeandRecreationalSafety/Falls/FallsPreventionActivity.html Accessed 8-17-12.

GOAL 4

By 2017, decrease the rate of hospitalizations due to falls among adults 65 and older by 5%.

OBJECTIVE 4.1. DEVELOP RECOMMENDATIONS ADDRESSING GAPS IN E-CODE RECORDING DURING FY 2013.

Strategy 4.1.1. Develop and convene an injury data group quarterly.

Lead	Partners	When	Result/Evaluation
Section Injury Prevention staff	External Partners • Tribal Injury Prevention staff • Alaska Trauma Registry • Epi Surveillance • Health Planning and Systems Development • Vital Statistics • Alaska Native Tribal Health Consortium (ANTHC)	Ongoing	Group meets quarterly in FY 2013 Meeting minutes for injury data group

Rationale: To understand the extent of hospitalizations and deaths related to adult falls, all data sources need to include e-codes (external cause-of-injury coding) While the Alaska Trauma Registry reports e-codes and is used extensively by Alaska injury prevention programs, the Hospital Discharge Database (HDD) and Vital Records are less consistent. The HDD and Emergency Department (ED) data systems are used extensively by CDC, therefore Alaska injury prevention programs would greatly benefit from improved HDD and ED databases. It will be necessary to gain an understanding of the rationale and barriers to improving the quality of injury data in order to recommend actions. Currently injury data analysts are housed in multiple sections within the Division of Public Health and the tribal health system. Quarterly meetings will establish regular communication – a necessary first step to identify and create coordinated solutions to gaps in data

GOAL 4

Evidence: E-codes are the data standard for coding the external cause of injuries in healthcare databases.[68]

Estimated Reach: Statewide

Domain: This strategy is aimed at creating an organizational structure to engage new and existing partners, who will promote enhanced fall prevention data availability throughout the state of Alaska. (Domain 1).

Strategy 4.1.2. Complete an assessment of gaps in data across injury prevention.

Lead	Partners	When	Result/Evaluation
Injury Data Group	Internal Partners • Section Injury Prevention staff External Partners • Alaska Violence and Injury Prevention Data Group (AK VIP) • Alaska Trauma Registry • Epi Surveillance • Health Planning and Systems Development • Vital Statistics • ANTHC	June 2013	Summary document of injury data gaps developed

Rationale: See To understand the extent of hospitalizations and deaths related to adult falls, all data sources need to include e-codes (external cause-of-injury coding) While the Alaska Trauma Registry reports e-codes and is used extensively by Alaska injury prevention programs, the Hospital Discharge Database (HDD) and Vital Records are less consistent. The HDD and Emergency Department (ED) data systems are used extensively by CDC, therefore Alaska injury prevention programs would greatly benefit from improved HDD and ED databases. It will be necessary to gain an understanding of the rationale and barriers to improving the quality of injury data in order to recommend actions. Currently injury data analysts are housed in multiple sections within the Division of Public Health and the tribal health system. Quarterly meetings will establish regular communication – a necessary first step to identify and create coordinated solutions to gaps in data.

[68] Annest JL, Fingerhut LA, Gallagher SS, et al. Strategies to Improve External Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems.Recommendations of the CDC Workgroup for Improvement of External Cause-of-Injury Coding. *MMWR* March 28, 2008 / 57(RR01);1-15

GOAL 4

Evidence: The CDC uses the Hospital Discharge Data (HDD) system for gathering injury data. In Alaska, the Alaska Trauma Registry (ATR) has been the standard for injury data for many years. For Alaska to include HDD information that database needs to be a more complete statewide data system, and include E-codes. Alaska's death certificates also need to consistently include either actual E-codes or entries specifying when a fall was involved in the death.[69]

Estimated Reach: Statewide

Domain: This strategy involves the assessment of the quality and availability of injury data (Domain 1).

Strategy 4.1.3. Study the feasibility of and develop recommendations for collection of e-codes in Vital Records and Hospital Discharge data.

Lead	Partners	When	Result/Evaluation
AK VIP Data Group	Internal Partners • Section injury prevention staff External Partners • Alaska Trauma Registry • Epi Surveillance • Health Planning and Systems Development • Vital Statistics • ANTHC	June 2013	Summary document of feasibility and recommendations regarding the inclusion of e-codes on death certificates and hospital discharge data.

Rationale: To understand the extent of hospitalizations and deaths related to adult falls, all data sources need to include e-codes (external cause-of-injury coding) While the Alaska Trauma Registry reports e-codes and is used extensively by Alaska injury prevention programs, the Hospital Discharge Database (HDD) and Vital Records are less consistent. The HDD and Emergency Department (ED) data systems are used extensively by CDC, therefore Alaska injury prevention programs would greatly benefit from improved HDD and ED databases. It will be necessary to gain an understanding of the rationale and barriers to improving the quality of injury data in order to recommend actions. Currently injury data analysts are housed in multiple sections within the Division of Public Health and the tribal health system. Quarterly meetings will establish regular communication – a necessary first step to identify and create coordinated solutions to gaps in data.

[69]Frieden T, Arias I, Galaska L, et al. Recommended Actions to Improve External-Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems. Atlanta (GA): US Department of Health and Human Services, Centers for Disease Control and Prevention; December 2009. http://www.cdc.gov/injury/pdfs/ecode-a.pdf Accessed 8-16-2012.

GOAL 4

Evidence: The CDC uses the Hospital Discharge Data (HDD) system for gathering injury data. In Alaska, the Alaska Trauma Registry (ATR) has been the standard for injury data for many years. For Alaska to include HDD information that database needs to be a more complete statewide data system, and include E-codes. Alaska's death certificates also need to consistently include either actual E-codes or entries specifying when a fall was involved in the death.[70]

Estimated Reach: Statewide

Domain: This strategy involves improving the quantity and quality of injury data available in Alaska (Domain 1).

Objective 4.1: Strategies for Years 2 through 5

In subsequent years, the injury data group will continue to meet to assess any new injury data gaps or new injury data for Alaska that has become available. One data source that will contribute to the comprehensiveness of Alaska's injury data are e-codes. These are expected to be available for analysis from death certificates and hospital discharge data by year 3.

OBJECTIVE 4.2. GAIN ACCESS TO MEDICARE DATA TO ESTABLISH BASELINE ON FALL RISK SCREENINGS FOR PERSONS 65 AND OLDER BY JUNE 2013.

Strategy 4.2.1. Provide education to providers on fall-risk screenings for adults age 65 and older in FY 2013.

Lead	Partners	When	Result/Evaluation
Section Injury Prevention staff	External Partners • Senior Falls Coalition • Healthcare Providers (hospital/clinic staff, OT/PT, pharmacists, optometrists)	June 2013	Materials developed, website updated and presentations delivered.

Rationale: Many healthcare providers are unaware of screening tools for fall prevention. Providing the information in an easily accessible format (e.g., webpage; newsletter, etc) would decrease clinical time, thus enabling more quality screenings to be conducted.

[70]Frieden T, Arias I, Galaska L, et al. Recommended Actions to Improve External-Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems. Atlanta (GA): US Department of Health and Human Services, Centers for Disease Control and Prevention; December 2009. http://www.cdc.gov/injury/pdfs/ecode-a.pdf Accessed 8-16-2012.

GOAL 4

Evidence: Providers are more likely to provide fall risk screenings when they are aware of the types of screenings available and where to find pertinent information. Follow-up care is enhanced when the screenings become a routine part of a patient's personal preventative plan.[71,72]

Estimated Reach: Healthcare providers

Domain: This strategy is aimed at improving the effective use of clinical services to prevent, reduce or eliminate risk factors (Domain 3).

Strategy 4.2.2. Develop media campaign to promote fall prevention screenings targeting adults age 65 and older in FY 2013.

Lead	Partners	When	Result/Evaluation
Section Injury Prevention staff	Internal Partners • Section Communications/Social marketing specialist • External Partners • PIT Group • Senior Falls Coalition • AK VIP • AK Commission on Aging	June 2013	TV, Radio, Website and printed materials for media campaign developed

Rationale: Many Medicare recipients, and their family members or care providers, are unaware of their right to a fall-risk screening under Medicare's Welcome and Wellness visits. The media campaign will encourage recipients to request the screening to identify possible factors that may be addressed in an effort to prevent serious injury due to falls.

Evidence: Consumers are more likely to request screenings when they are aware of the types of screenings included in Medicare's Welcome and Wellness visits. Providing data related to fall injuries and long-term consequences has been shown to motivate older adults to address factors that increase the chance of falling.[73]

Estimated Reach: Adults age 65 and older statewide

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[71]Stevens JA. Falls Among Older Adults – Risk Factors and Prevention Strategies. *NCOA Falls Free: Promoting a National Falls Prevention Action Plan.* 2005.http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/Review-Paper_Final.pdf#page=9 Accessed 8-17-2012.

[72]Hausdorff JM, Rios DA, Edelber HK. Gait variability and fall risk in community–living older adults: a 1–year prospective study. *Archives of Physical Medicine and Rehabilitation.* 2001;82(8):1050–6.

[73]Centers for Disease Control and Prevention. Preventing Falls: How to Develop Community-based Fall Prevention Programs for Older Adults. *National Center for Injury Prevention and Control.* Altlanta, GA. 2008. http://www.cdc.gov/HomeandRecreationalSafety/images/CDC_Guide-a.pdf Accessed 8-17-2012.

GOAL 4

Domain: This strategy is aimed at helping Alaskans more effectively use and benefit from fall prevention risk assessment services. (Domain 3).

Strategy 4.2.3. Investigate the feasibility of establishing fall prevention clinics.

Lead	Partners	When	Result/Evaluation
Section Injury Prevention staff	External Partners • Senior Falls Coalition • AK VIP • AK Commission on Aging • Healthcare providers • Healthcare organizations	June 2013	Assessment of what work is being done, reimbursement options and ACA law completed and summary document developed.

Rationale: The use of 'clinics' has been shown to be cost effective as well as efficacious in providing assessments and treatment. Bringing specialists together for a designated time and purpose is beginning to be applied to older adult fall prevention efforts in other states. No such clinic currently exists in Alaska.

Evidence: Fall prevention clinics have been shown to reduce costs, time and increase the number of fall risk screenings completed.[74]

Estimated Reach: Adults age 65 and older statewide

Domain: This strategy targets improvement of effective delivery and use of clinical and other preventive services. (Domain 3).

Strategy 4.2.4. Update website design and content in FY 2013.

Lead	Partners	When	Result/Evaluation
Section Injury Prevention staff	Internal Partners • Section Publications specialist • Section Communications/Social marketing specialist • External Partners	June 2013	Website design and content updated

[74]Moore M, Williams B, Ragsdale S, et al. Translating a Multifactorial Fall Prevention Intervention into Practice: A Controlled Evaluation of a Fall Prevention Clinic. *Journal of the American Geriatrics Society*. February 2010; 58(2): 357–363.DOI: 10.1111/j.1532-5415.2009.02683.x

GOAL 4

	• PIT Group		

Rationale: The use of the internet to convey information is an important component in today's environment. Consumers and healthcare providers are directed towards Alaska's fall prevention websites via many different media campaigns. The websites need to present information in a professional manner that is easy to navigate and mobile-friendly.

Evidence: Information provided via the internet is the most frequently used media by many professionals. There are more older adults accessing health-related information on the internet each year. [75,76]

Estimated Reach: Statewide

Domain: This strategy targets improvement of effective delivery and use of clinical and other preventive services. (Domain 3).

Objective 4.2: Strategies for Years 2 through 5

In subsequent years, the media campaign promoting fall prevention screenings will continue. The campaign will be updated in later years as new targets for increased fall prevention screenings are assessed. Correspondingly, education for providers on fall prevention screening will be offered. The content of the website will be reviewed annually and updated as needed. In later years, following the assessment of work on fall prevention clinics, one fall risk clinic will be offered annually.

OBJECTIVE 4.3. PUBLISH INFORMATION ON AVAILABLE COMMUNITY FALL PREVENTION RESOURCES FOR ADULTS 65 AND OLDER BY JUNE 2013.

Strategy 4.3.1. Inventory trainers and fall prevention courses for adults 65 and older in FY 2013.

Who	Partners	When	Result/Evaluation
Section Injury Prevention staff	Internal Partners • Section Project Assistant External Partners	June 2013	List of courses published on website, Printed inventory disseminated to senior activity centers

[75]Centers for Disease Control and Prevention. The Health Communicator's Social Media Toolkit. July 2011. http://www.cdc.gov/socialmedia/Tools/guidelines/pdf/SocialMediaToolkit_BM.pdf Accessed 8-17-2012.

[76]Centers for Disease Control and Prevention. CDC's Guide to Writing for Social Media. April 2012. http://www.cdc.gov/socialmedia/Tools/guidelines/pdf/GuidetoWritingforSocialMedia.pdf Accessed 8-17-2012.

GOAL 4

	• PIT Group • Senior Falls Coalition • AK VIP • AK Commission on Aging • Alaska Pioneer Homes • AARP • Older Persons Action Group • Senior Centers		

Rationale: The fall risk screenings can help identifying older adults that may benefit from exercise programs and other types of fall prevention activities. The media campaigns may also direct people towards appropriate exercise programs. The next logical step is to develop a knowledge base of the availability of appropriate exercise programs and certified trainers across the state. This information can then be available to the healthcare providers to pass on to their patients, and for the general public to access through the fall prevention website.

Evidence: Appropriate exercise programs are a primary intervention for older adults at risk for serious injury from falling.[77,78]

Estimated Reach: Adults age 65 and older statewide

Domain: This strategy improves community-clinical linkages to improve referral of patients to programs that improve management of risk factors. (Domain 4).

Objective 4.3: Strategies for Years 2 through 5

The inventory of trainers and fall prevention courses for adults age 65 and older will be updated annually. Updated information will be available on the website and disseminated to senior activity centers as in year 1. To promote awareness of home safety, information on home hazards will be made available on the website. In addition to home safety, education on vision checks, balance assessments and associations with medications will also be included on the website.

[77] Chang JT, Morton SC, Rubenstein LZ, et al. Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomized clinical trials. *BMJ.* March 18 2004; 328-680.DOI: 10.1136/bmj.328.7441.680

[78] Centers for Disease Control and Prevention, Injury Prevention and Control: Home and Recreational Safety. CDC Falls Prevention Activities. *National Center for Injury Prevention and Control. Division of Unintentional Injury Prevention*. Sept. 2010 http://www.cdc.gov/HomeandRecreationalSafety/Falls/FallsPreventionActivity.html Accessed 8-17-12.

Alaska Section of Chronic Disease Prevention and Health Promotion

STRATEGIC PLAN FY 2013-2017

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