# Logic Model – Wisconsin Program Integration Demonstration Pilot Project

| RESOURCES | CURRENT ACTIVITIES | OUTPUTS | SHORT-TERM OUTCOMES "Expect to see" 2009 - 2011 | INTERMEDIATE OUTCOMES "Want to see" 2012 - 2014 | IMPACT "Hope to see" 2015 – 2018 |
|---|---|---|---|---|---|
| *In order to accomplish our set of activities we will need the following:* | *In order to address our problem or asset we will accomplish the following activities:* | *We expect that once accomplished these activities will produce the following evidence of service delivery:* | *We expect that if accomplished these activities will lead to the following changes in 1-3 years:* | *We expect that if accomplished these activities will lead to the following changes in 4-6 years:* | *We expect that if accomplished these activities will lead to the following changes in 7-10 years:* |
| Program staff (BRFSS, Diabetes Prevention and Control, Heart Disease and Stroke Prevention, Tobacco Prevention and Control, Comprehensive Cancer Control, Arthritis, Nutrition and Physical Activity, Asthma)<br><br>Program funding<br><br>Upper management support | **BRFSS Program**<br>• Combined data systems for tracking, etc.<br>• Indirectly - Reduce overweight/obesity to decrease chronic diseases<br>**Diabetes Prevention and Control Program**<br>• Update DM Essential Care Guidelines<br>• Update Resource Guide<br>• Incorporate medical nutrition therapy (MNT) in all diabetes platforms<br>• HMO Collaborative<br>• FQHCS and WI PHCA<br>**Chronic Disease Prevention Program**<br>• Integrate Oral Health Program<br>• Aggressively seek funding sources<br>• Streamline the budget development / management process<br>• Streamline the CARS pre-packet process<br>**Heart Disease and Stroke Prevention**<br>• Create 2010-2015 Heart Disease and Stroke Prevention Plan<br>• Develop Heart Disease and Stroke Prevention Policy Blueprint<br>• Continue QI initiatives in health care systems (including WICORE implementation, stroke rehab registry planning and QI training, GWTG-Stroke collaboration, partnering with Diabetes HMO, work with FQHCs)<br>• Implement Hypertension initiative (includes attention to physical activity, nutrition, tobacco, diabetes, kidney disease)<br>• Update Heart Disease and Stroke burden<br>• Address social determinants and disease specific disparities. | Efficiency of data reporting<br><br>Consistent numbers used in all burden reports<br><br>Improvement in HEDIS measures<br><br>Increase in use of proper clinical guidelines by providers<br><br>Increase in non traditional sources of funding<br><br>Development of a strategic vision<br><br>Decrease in disease disparities<br><br>Increased program collaboration<br><br>Healthy lifestyle choices are made more readily available and easier to access<br><br>Improved birth | By March 2009, a statewide comprehensive smoke free work site law will be passed and implemented.<br><br>By March 2009, BCHP, in conjunction with the UW evaluation team will establish a baseline for key measures of performance with respect to the Program Integration Demonstration Pilot in Wisconsin.<br><br>By June 2009, the Healthy Communities Coordinator will provide the Healthy Lifestyle Coalitions pilots with technical assistance in working on policy and environmental changes that influence health outcomes.<br><br>By December 31, 2009, he Partnership Ad Hoc Subcommittee will work with three to five external partners to improved working relationships with the DPH, BCHP<br><br>By December 31, 2009, the Interventions Ad Hoc Subcommittee will complete an inventory of policy, system, and environmental best practices for chronic disease prevention.<br><br>By December 31, 2009, the BCHP will pilot a Healthy Lifestyle Coalition concept to identify models that mobilize communities to address tobacco consumption, poor nutrition and lack of physical activity through environmental and policy change.<br><br>By December 31, 2009, the BCHP will assure an increase in the number of worksites with a comprehensive wellness program.<br><br>By December 31, 2009, the BCHP will assure an increase | By 2012, the percentage of adults who are current smokers will decrease from 24% to 17%.<br><br>By 2012, the percent of middle school students exposed to secondhand smoke at homes or in vehicles will decrease from 64% in 2000 to 45%.<br><br>By 2012, the percent of high school students who are current smokers will decrease from 33% in 2000 to 16%.<br><br>By 2012, the cigarette excise tax will increase by an additional $1.00.<br><br>By 2014, integrate quality improvement efforts in health systems regarding the delivery of chronic disease programs including tobacco assessment and cessation.<br><br>By 2014, document system change in clinical practice that is relevant to all chronic disease areas.<br><br>By 2014, decrease the chronic disease prevalence rate by 10%.<br><br>By 2014, decrease disability among Wisconsin residents.<br><br>By 2014, demonstrate clear evidence of a decrease in chronic disease disparities | Improve Wisconsin's healthy system delivery<br><br>Reduce prevalence, disability and mortality due to chronic disease<br><br>Reduce overweight and obesity<br><br>Reduce tobacco consumption<br><br>Increase in policies that support healthy lifestyles<br><br>Increase in environments that support healthy lifestyles<br><br>Increased focus on prevention in making healthy lifestyle choices the norm<br><br>Decrease healthy inequity<br>Assure adequate funding |

| | | | | | |
|---|---|---|---|---|---|
| | **Tobacco Prevention and Control Program**<br>• Reflect PI in new 5-year plan for CDC and State<br>• Engage External Partners to support PI<br>• Fund Pilot of Healthy Life Style Coalitions<br>• Fund Unnatural causes through Poverty Network<br>• Incorporate Health Life Style messages in media campaigns<br>• Collaborate on Healthy Birth Outcome through First Breath and media<br>• Fund tobacco-related disease FQHC Project<br>**Comprehensive Cancer Control Program**<br>• Promote tobacco cessation within FQHCs<br>• Increase physical activity and nutrition through worksite wellness<br>• Increase use of cancer screenings<br>• Improve quality of life for cancer survivors in care management through end of life<br>• Increase access to screening and treatment for all, especially the underserved.<br>**Arthritis Program**<br>• Evidence based programming – arthritis condition, exercise program, chronic disease self management<br>• PI – chronic disease plan, epidemiology, chronic disease self management<br>• Systems change and partnership – State Advisory Council, evidence based program (implementation and collaboration)<br>• Policy and communications (IFTE Health Communication Coordinator, policy Inventory for Arthritis risk factors, active press, press release, stories and hype<br>• Communication campaign - social marketing for physical activity, linking public health to aging, expand evidence based programming, retrospective evaluation of campaigns to have a State specific "How to" implementation manual<br>• Surveillance and evaluation - burden report, evidence based program utilization, external evaluation<br>**Asthma Program**<br>• Prioritize interventions based on data<br>• Collaborate with statewide partners<br>• Maintain working relationship with WI Asthma Coalition<br>• Contact with statewide partners on implementation | outcomes<br><br>Decrease in tobacco use rates<br><br>Cancers detected at earlier and more treatable stage<br><br>Improvement in communication among programs<br><br>Increased awareness of the burden of chronic disease and the toll it takes on society<br><br>Increase in number of local coalitions responding to chronic disease issues<br><br>Increase in community programs that target chronic disease risk factors<br><br>Policy makers have an increase in awareness of need for funding chronic disease programs | in program integration efforts to improve health system quality improvement for chronic disease prevention and control.<br><br>By December 31, 2009, the BCHP will have a strategic plan in place to reduce disparities in chronic disease.<br><br>By December 31, 2009, the BCHP programs will integrate the Healthy People at Every Stage of Life Framework and five key messages.<br><br>By December 31, 2009, the BCHP will begin to eliminate barriers that prevent joint program funding to best promote program integration activity.<br><br>By December 31, 2009, the BCHP will assure improved internal communication about program integration between managers and staff; between chronic disease programs (as well as maternal and child health); and with external partners.<br><br>By January 2010, at least one HLC pilot will expand program integration activities to include topics on maternal and child health and oral health.<br><br>By March 2010, the Surveillance and Epidemiology Ad Hoc Subcommittee and the Chronic Disease Program Epidemiologists will assure that key components of the burden reports for Arthritis Prevention & Control, Nutrition & Physical Activity, Diabetes Prevention & Control, Comprehensive Cancer Prevention & Control, Tobacco Prevention and Control, Heart Disease and Stroke Prevention, BRFSSS, and Asthma will be integrated into one comprehensive chronic disease report.<br><br>By March 2010, the BCHP will assure that analytics for the comprehensive chronic disease report will be implemented through the Wisconsin Public Health Information Network (PHIN) portal in the Common Ground collaborative environment<br><br>By December 2010, the Partnership Ad Hoc Subcommittee will work with the remaining partners (who were selected five or more times by DPH program staff) to improve working relations with DPH, BCHP. | in Wisconsin.<br><br>By 2014, the Division of Public Health will maximize resources across chronic disease programs.<br><br>By 2014, promote citizen empowerment across the life span in the areas of health, work, family, and community.<br><br>By 2014, demonstrate a sustained increase in program integration efforts in the Bureau of Community Health Promotion.<br><br>By 2014, demonstrate sustained improvement in communication across the Bureau of Community Health Promotion programs. | Maximize resources<br><br>Institutionalize program collaboration in DPH<br><br>Promote a life course approach in DPH to achieve healthy lifestyles |

| | | | | | |
|---|---|---|---|---|---|
| | activities<br>• WI Asthma Plan revision<br>• Grant writing and reporting<br><br>**Nutrition and Physical Activity Program**<br>• Funding (RFP) to support local implementation of State Plan<br>• Training to local communities (policy, environmental change, media advocacy, social marketing, planning process)<br>• Leverage other funds to support work<br>• Engage partners (retain current partners)<br>• Data Surveillance Plan<br>• Data Reporting Plan<br>• Plan to address disparities<br>• Sustainability Planning<br>• Evaluation indicators<br><br>**Additional activities**<br>• Work with CYSHCN on an internal Program Integration project starting in October 2009<br>• Incorporate a life style/healthy behavior focus with the family planning providers – based on WISEWOMAN Model<br>• Work with policy makes to ensure prevention concepts take priority<br>• Improve communication among programs – determine a way to facilitate enhanced and positive communication<br>• Determine data needs across programs and how common needs can be met<br>• Identify burden, epidemiology<br>• Early detection<br>• Advocacy<br>• Health Communication<br>• Promote self management<br>• Decrease activity limitation<br>• Maintain independence<br>• Ensure each section's programs are informed of each others' program goals & major activities for better collaboration<br>• Ensure each section's programs are integrated (to the extent possible) with and among programs in other | | By December 2010, the number of cigarette packs sold per adult aged 18 years or older will decrease from 80 in 2000 to 60 in 2010.<br><br>By December 31, 2010, the Program Integration Ad Hoc Subcommittee will monitor the use of HPESL messages in BCHP programming.<br><br>By December 31, 2010, the BCHP will assure an increase in the number of worksites with a comprehensive wellness program.<br><br>By December 31, 2010, the BCHP will assure an increase in the number of interventions targeted to populations disparately affected by chronic disease.<br><br>By December 31, 2010 and 2011, the BCHP will continue to increase program integration efforts to improve health system quality improvement for chronic disease prevention and control.<br><br>By December 31, 2010 and 2011, BCHP programs will demonstrate an in the number of program integration activities each year.<br><br>By December 2011, the DPH BCHP partners will demonstrate an increase in the leading of, or participating in policy and environmental advocacy effort<br><br>By December 2011, BCHP, in conjunction with the UW evaluation team, will evaluate progress toward desired outcomes and determine the effectiveness of Wisconsin's program integration efforts.<br><br>By December 31, 2011, the BCHP will assure an increase in the number of worksites with a comprehensive wellness program.<br><br>By December 31, 2011, the BCHP will assure an increase in REACH and "Living Well with Chronic Conditions" programming to 10,000 people from a baseline of 800. | | |

| | | | | | |
|---|---|---|---|---|---|
| | sections<br><br>**Activities from Short Term Objective Work**<br>• Demonstrate an increase in EBG and EBP screenings<br>• HMO Collaborative Plans will demonstrate an increased detection of high BP and cholesterol<br>• Develop menu labeling strategy to include sodium, etc.<br>• Develop a method to be used for such things as zoning decisions<br>• Increase home visits in high-risk populations<br>• Reduce exposure to triggers in workplace, home and from ambient sources<br>• Provide prevention in-services to key stakeholders<br>• Increase the number of local asthma coalitions<br>• Convene advocates and partners from all programs to develop a strategic approach to increase public funding for public health<br>• Evaluate current legislative efforts to partners who can advocate for our issues<br>• Co-sponsor appropriate conferences with joint funding<br>• Promote joint funded positions to build capacity and infrastructure of a comprehensive chronic disease program as well as meeting CDC requirements<br>• Jointly fund Healthy Lifestyle coalition pilot projects<br>• Engage chronic disease program coordinators in the development of the WISEWOMAN intervention model<br>• Develop and conduct staff training by chronic disease managers across to other program sections<br>• Promote evidence-based practice and guidelines across programs<br>• Develop a worksite wellness initiative that incorporates all chronic disease program areas<br>• MCH directors will provide staff training to chronic disease program directors to provide an annual update or policy framework<br>• Increase information and best practices regarding neighborhood watch related to community parks | | | | |