



Support the Prevention Agenda by

## Promoting Evidence-Based Interventions to Prevent or Manage Chronic Diseases

You can support the Prevention Agenda goal of **Reducing Chronic Disease** by promoting evidence-based interventions in your county.

### AIM:

Increase the availability, accessibility, and use of evidence-based interventions to prevent or manage chronic diseases through promotion and referral.

## Why promote evidence-based interventions to prevent or manage chronic diseases in your county?

- Approximately 6.2 million adult New Yorkers (41.1%) suffer from a chronic disease such as arthritis, asthma, stroke, heart disease, diabetes, or cancer and New Yorkers with chronic diseases are more likely to report poor health status and activity limitations than those without a chronic disease.<sup>i</sup> The risks of adverse outcomes, including mortality, hospitalizations, and poor functional status, increase as the number of chronic conditions in an individual increases.<sup>ii</sup>
- Estimates indicate that there are between 3.7 and 4.2 million (25-30%) adult New Yorkers with prediabetes.<sup>iii</sup> A diagnosis of prediabetes increases the risk of developing type 2 diabetes and without lifestyle interventions to improve health, 15% to 30% of people with prediabetes will develop type 2 diabetes within five years.<sup>iv</sup>
- Even the highest quality of clinical care to individuals with chronic conditions will not guarantee improved health outcomes. Individuals must be informed, motivated, and involved as partners in their own care.<sup>v</sup> The Expanded Chronic Care Model (ECCM)<sup>v</sup> integrates population health promotion into the delivery of chronic illness care, requiring connections between health care systems and community resources. Self-management support is an integral component of the ECCM.
- Evidence-based interventions (EBIs) promoted by the New York State Department of Health (NYSDOH) for the prevention and management of chronic conditions have significantly helped people develop self-management skills and adopt behaviors to prevent or manage conditions—leading to enhanced well-being and improved health outcomes.<sup>vii,viii,ix,x</sup>
- New York State has a network of local partners providing EBIs to prevent or manage chronic diseases and a state-level support system provided by the University at Albany's Center for Excellence in Aging and Community Wellness but significant gaps exist. Local health departments are encouraged to partner with local organizations to increase the availability and use of EBIs to support the delivery of specific programs. Local health departments are in a unique position to encourage health care providers to refer patients to existing EBIs to prevent or manage chronic diseases.

## ACTION:

Take these steps to increase availability, access, and use of evidence-based interventions to prevent or manage chronic diseases in your community through promotion and referral.

Recommended Step	Brief Description
<p><b>Identify community partners engaged in EBI delivery</b></p> <p>Use recommended resources to gather information on programs and identify existing delivery partners in your area. Your efforts to promote programs and generate referrals will increase availability, access, and use of EBIs statewide.</p>	<p>The Evidence-Based Health Programs Quality and Technical Assistance Center (QTAC) houses data and information on a multitude of interventions delivered in New York State. Consult with the QTAC (see Resources) to learn more about EBIs and identify existing partners engaging in program delivery in your area.</p> <p><b>Examples of EBIs promoted by the NYSDOH include:</b></p> <ul style="list-style-type: none"> <li>• Active Living Every Day (ALED)</li> <li>• Arthritis Foundation Walk With Ease Program (WWE)</li> <li>• Asthma Self-Management Training (ASMT)</li> <li>• Diabetes Prevention Program (DPP)</li> <li>• Diabetes Self-Management Education (DSME)</li> <li>• Stanford Chronic Disease Self-Management Program (CDSMP)</li> <li>• Stanford Diabetes Self-Management Program (DSMP)</li> <li>• CDSMP plus (Stanford Chronic Disease Self-Management Program plus hypertension module)</li> </ul>
<p><b>Determine population(s) of focus</b></p> <p>Targeting promotion of and referral to EBIs to specific populations can help improve the health of those disparately affected by chronic disease.</p>	<p><b>Focus on disparate populations:</b></p> <ul style="list-style-type: none"> <li>• Chronic disease disparately affects communities of color, persons with disabilities, and low-income neighborhoods.</li> <li>• Your community may have other specific sub-populations of focus.</li> </ul>
<p><b>Identify and address gaps to increase the availability and use of EBIs among the population(s) of focus</b></p> <p>Interventions might not be available in certain areas. Create a plan for increasing EBI capacity in your community.</p>	<p><b>Tools and resources to identify gaps:</b></p> <ul style="list-style-type: none"> <li>• Consult the QTAC to determine where workshops are being offered in your county</li> <li>• Work with delivery partners to determine how gaps in capacity can be addressed through increased program delivery</li> <li>• Identify potential or new delivery partners</li> </ul>

## ACTION:

Take these steps to increase availability, access, and use of evidence-based interventions to prevent or manage chronic diseases in your community through promotion and referral.

Recommended Step	Brief Description
<p><b>Collaborate with delivery partners to promote the benefits of EBIs to prevent or manage chronic diseases plus develop and implement strategies for promotion and referral</b></p> <p>Develop a plan to increase the visibility of EBIs offered locally by delivery partners. Implementation of these strategies will raise awareness among health care providers and the general public of the benefits and availability of EBIs.</p>	<p><b>Potential key partners may include:</b></p> <ul style="list-style-type: none"> <li>• Area Agencies on Aging (AAAs) and senior service providers</li> <li>• Community-based organizations</li> <li>• Community Health Centers</li> <li>• Disability service and advocacy organizations</li> <li>• Faith-based organizations</li> <li>• Health care providers, hospitals, and local health departments</li> <li>• Insurers</li> <li>• Medical societies</li> <li>• NY Connects/211</li> <li>• Unions and employers</li> <li>• YMCAs and other recreation and fitness groups</li> </ul> <p>The QTAC maintains an online portal that allows for health care provider referral and direct registration.</p>
<p><b>Increase health care provider recommendations and referrals to EBIs to prevent or manage chronic diseases</b></p> <p>Monitor data that will illustrate progress toward short and long term performance measures (see Achievement).</p>	
<p><b>Monitor and evaluate progress to identify new promotion avenues and opportunities for expansion of EBIs</b></p> <p>Monitor data that will illustrate progress toward short- and long-term performance measures (see Achievement).</p>	<p><b>Monitoring should include:</b></p> <ul style="list-style-type: none"> <li>• Consultation with the QTAC to obtain information and data</li> <li>• Periodic review of data and progress made toward increasing promotion and referrals</li> <li>• A schedule for reporting milestones to partners</li> </ul>

## Achievement

Improving access to evidence-based interventions to prevent or manage chronic diseases supports this Prevention Agenda objective:

### Objective 3.3.1

**By December 31, 2017, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.**

Local Health Departments can include these objectives in the Community Health Assessment.

Tracking performance and process measures can be important for reporting progress to stakeholders and for fundraising. Here are measures that you should use to track progress:

#### Short-Term Performance Measures:

- Number and type of EBIs offered by partners (Data source: QTAC)
- Number of participants at EBIs offered by partners (Data source: QTAC)
- Percent of adults with one or more chronic diseases who have attended a self-management program (Data source: eBRFSS)
- Number of referrals to EBIs from health care professionals (Data source: QTAC)
- Number and percent of adults among population(s) of focus (e.g., communities of color, persons with disabilities, low income neighborhoods) who have attended EBIs (Data source: QTAC, U.S. Census)

#### Long-Term Performance Measures:

- Percentage of adults who are overweight or obese
- Age-adjusted hospital discharge rate for diabetes per 10,000 population
- Percentage of health plan members with hypertension who have controlled their blood pressure
- Age-adjusted rate for heart attack

## RESOURCES:

Ready to get started? The resources below have more details about promotion and referral of evidence-based interventions to prevent or manage chronic diseases at the local level:

### Model Standards

#### **The University at Albany's Center for Excellence in Aging and Community Wellness Quality and Technical Assistance Center**

The Quality and Technical Assistance Center serves as New York's statewide coordinator of evidence-based interventions. Their website provides information about all evidence-based interventions offered in New York State, including program availability, delivery partners, and promotion and marketing resources.

[www.ceacw.org](http://www.ceacw.org)

#### **Administration for Community Living (a new federal organization in which the Administration on Aging resides)**

The Administration for Community Living endorses EBIs as appropriate for people with disabilities and for older adults. ACL provides information and strategies on engaging these populations.

[www.acl.gov](http://www.acl.gov)

#### **Engaging and Activating Patients for Better Health: The Power of the Chronic Disease Self-Management Program (Public Health Live)**

This satellite broadcast features information about the Chronic Disease Self-Management Program (CDMSP), one of the EBIs available in NYS, and its value as an easily-recommended community-based intervention that can help individuals manage their chronic conditions.

[www.albany.edu/sph/cphce/phl\\_0212.shtml](http://www.albany.edu/sph/cphce/phl_0212.shtml)

#### **1-2-3 Approach to Provider Outreach**

The 1-2-3 Approach tool kit is a guide to marketing EBIs to health care providers. Although it was designed specifically with arthritis in mind, the customizable materials are comprehensive and appropriate for promoting all EBIs addressing a variety of chronic conditions.

[www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach](http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach)

### ADDITIONAL RESOURCES

**Living Well with Chronic Illness: A Call for Public Health Action (IOM Report Brief)<sup>xi</sup>**

**Translating the Diabetes Prevention Program into the Community: The DEPLOY Pilot Study<sup>vii</sup>**

**SUNY Albany Public Health Live. Engaging and Activating Patients for Better Health: The Power of the Chronic Disease Self-Management Program**

[www.albany.edu/sph/cphce/phl\\_0212.shtml](http://www.albany.edu/sph/cphce/phl_0212.shtml)

## CITATIONS

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