Success Stories

Success Stories are concise and engaging two-page narratives used to reach stakeholders locally and nationally about ongoing chronic disease prevention initiatives. Success stories promote the exchange of ideas/promising practices, contribute to visibility, credibility and accountability, and foster sustainability. The CDC NCCDPHP maintains a database of success stories, which also serves as a large dissemination vehicle for this work.

Local IMPACT success stories are color coded as follows:

- **Environmental Approaches** - strategies in community settings that promote health and healthy behaviors through nutrition and physical activity

- **Lifestyle Change Participation** - strategies that build support for lifestyle change program participation

- **Health System Changes** - strategies that improve quality of preventive care in primary care settings

- **Community-Clinical Linkages** – strategies that connect clinicians and community-based service providers to improve population health

**Albany County Department of Health**
- Developing Community Partnerships to Prevent Diabetes in Albany County, NY
- Cohoes on the Move: Complete Streets Collaboration
- Albany County Successfully Provided a Network of Lifestyle Change Programs

**HealtheConnections**
- Strength in Numbers: Local Partners for Local IMPACT
- A Promising New Referral Platform for Central New York
- Scaling up the Diabetes Prevention Program to Serve Rural Central New York
- Mutually Reinforcing Strategies “Wrap Around” a Neighborhood in Syracuse, NY

**Hudson River Healthcare**
- Lifestyle Change Programs: Where Prevention Meets Primary Care
- Suffern Village Walking Path Promotes Physical Activity and Health Eating
- Local Walking Paths Promote Physical Activity in Yonkers, NY
- Utilizing Community Health Workers Helps to Stem the Prediabetes Wave

**Population Health Collaborative of Western NY (formerly P2 Collaborative of Western NY)**
- Working Together to Build Support for the National Diabetes Prevention Program
- Learning to Manage Hypertension through a Community-Based Pharmacy Program
- Decreasing Blood Pressure Rates in Western New York Through Target: BP™
- All of Us Together: Promoting Walkable Communities in Western New York

**New York State Department of Health**
- Standardizing Data Collection and Reporting in a Learning Collaborative
- NYS Department of Health Convenes Key Partners to Advise on Health Systems Work
Developing Community Partnerships to Prevent Diabetes in Albany County, NY

by: Tricia Bulatao, RDN

SUMMARY
Community partnerships can prevent diabetes among those experiencing health disparities. Albany County Department of Health works with primary care practices (PCPS) serving this population to guide health system changes that improve prediabetes diagnosis and referral into YMCA/National Diabetes Prevention Programs (Y/NDPP). Capacity for Y/NDPPs is built while addressing health equity issues. Community health workers connect with PCPs and Y/NDPP providers to form community-clinical links that empower participants to maintain healthy changes.

CHALLENGE
The 2017 National Diabetes Statistics Report indicated that 9.4% (23,603) of Albany County adult residents were diagnosed with diabetes. It is projected that 33.9% (85,121) of adult residents have prediabetes. The latest Behavioral Risk Factor Surveillance System survey conducted in Albany County estimates that 21.7% of adults do not participate in leisure time physical activity, 10% of adults do not have adequate access to locations for physical activity, and an estimated 62.8% of adults are overweight or obese, a significant increase from the 2003 estimate of 54%. Obesity is a significant risk factor for diabetes and other chronic diseases. These challenges are disproportionately occurring in communities with limited access to resources, socio-economic hardship and minority health disparities.

YOUR INVOLVEMENT IS KEY
You can help prevent diabetes by creating community collaborations that synergize the work of partners. Primary care practices, YMCA/National Diabetes Prevention Program providers and community health workers who work together will implement effective strategies that link at-risk individuals to sustainable food resources, physical activity opportunities and venues, and ongoing social supports. Working together reinforces healthy behaviors that reduce and delay the onset of diabetes.

""The CHW builds relationships and identifies barriers that limit the participants’ ability to manage their health. She connects them to other community programs to help with these barriers - which is a very valuable resource!"

- Marcy Pickert, RD, CDE
SOLUTION
The Albany County Department of Health (ACDOH) has partnerships with 4 primary care practices (PCPs) to make health system changes that promote the diagnosis of prediabetes and referral into evidence-based YMCA/National Diabetes Prevention Programs (Y/NDPP). The PCPs generate prediabetes registries that are used by staff or ACDOH's community health workers (CHWs) to enroll patients with health disparities into Y/NDPPs. ACDOH works with 3 Y/NDPP providers to schedule and sponsor 12 Y/NDPPs over 15 months. CHWs give participants ongoing support during weekly reminder calls and utilize motivational interviewing to assist enrollees with navigating challenges to implement healthy changes.

RESULTS
This collaborative approach has led to the scheduling of 12 Y/NDPPs over 15 months. Ten were held successfully and 2 cancelled due to low enrollment. The CHWs assisted with enrolling 133 Albany County residents diagnosed with prediabetes. In the 7 Y/NDPPs that successfully held their 16 core classes, there are 99 enrollees and 75 of those participants completed 9 of the 16 core classes – achieving a 75.8% completion rate. The average weight loss range for those participants is 1.6 to 4.2 %. Currently, there are 6 classes that are ongoing, 3 that are in the core class phase (classes 1 to 16 or months 1 to 4) and 3 that are in the maintenance phase (months 5 to 12).

SUSTAINING SUCCESS
The initiative's goal is to continue to deliver 10 Y/NDPPs serving the at-risk communities over the next 12 months. The objectives for each program are to enroll 15 residents, achieve a 75% completion rate defined as attending 9 of the 16 core classes, and attain a 5% weight loss at 6 months and maintain it for at least 12 months. In order to reach this goal, PCPs will continue to be engaged to implement health system changes that generate prediabetes registries. CHWs will be utilized to link participants to Y/NDPPs and to resources for healthy food and physical activity to support healthy lifestyle changes. Through these efforts, 100 to 150 additional individuals from our most at-risk neighborhoods will reduce their risk for diabetes.
Cohoes on the Move: Complete Streets Collaboration  

by: Charles Welge

SUMMARY
Staying physically active reduces the risk of chronic diseases. Complete Streets – a transportation policy and design approach aimed at making streets accessible and attractive to pedestrians, cyclists, and automobile traffic - increases opportunities for residents to be physically active and reduce their risk of chronic disease. The successful adoption of a Complete Streets policy in Cohoes demonstrates how local partnerships can collaborate to develop and/or implement transportation and community plans that promote walking.

CHALLENGE
Diabetes, cardiovascular disease (CVD), and obesity are costly and often preventable. Heart disease, stroke, and diabetes were responsible for 31.4% of deaths (2015) and 14.2% of hospitalizations (2014) in Albany County, NY. Risk factors underlying CVD and diabetes are poor nutrition, physical inactivity, and hypertension. Research shows that people living in areas where they can walk and bike safely and have access to public transportation, can complete 35+ more minutes of physical activity weekly and are less likely to be overweight (Sallis, 2009; Dannendberg, 2005). The City of Cohoes, a formerly bustling manufacturing center in Albany County, is confronted by disinvestment in aging transportation infrastructure, impaired ADA accessibility, pedestrian safety, and economic development demands.

YOUR INVOLVEMENT IS KEY
To learn more about the CDTC and Complete Streets in Albany County, visit http://www.cdtcmpo.org/plans-and-programs/complete-streets. This project is supported by the New York State Department of Health, through funding from the Centers for Disease Control and Prevention’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPF14).

"Cohoes on the Move provides an opportunity for people to develop a passion for alternative transportation that is both healthy for the commuter and the community," said Cohoes Mayor Shawn Morse.

- Cohoes Mayor Shawn Morse
SOLUTION
The Albany County Department of Health (ACDOH) partners with the Capital District Transportation Committee, local municipalities, and community organizations to provide technical guidance on projects that promote walking. These partners ensure communities have public spaces and transportation systems to promote healthy behaviors. Public support for Complete Streets policies in Cohoes was developed by leveraging opportunities and collaborations including leadership of multiple municipal officials; participation in the ACDOH Complete Streets Symposium; solicitation of input through community forums; sponsorship of a demonstration event, and installation of wayfinding signage and park benches.

RESULTS
Albany County Department of Health (ACDOH) and Capital District Transportation Committee (CDTC) assisted Cohoes in educating the public and decision makers about the importance of transportation and community plans that promote walking. Temporary “pop-up” events demonstrated safe opportunities for physical activity with dedicated bike lanes integrated into the streetscape and designed to accommodate auto and bike traffic. The collaboration of ACDOH, CDTC, community organizations and municipal leadership contributed to Cohoes successfully adopting a Complete Streets policy in 2017. This successful partnership has led more Albany County municipalities to consider the Complete Streets model. Cohoes is “on the move” towards integrating economic revitalization, multi-modal transportation, and improved access to recreational opportunities.

SUSTAINING SUCCESS
Complete Streets create safer streets; improve local economy; attract and benefit users of all abilities; support community growth and development; improve the attractiveness of streets, and improve connectivity. Cohoes has been able to leverage its adoption of Complete Streets policy into multiple funding resources to implement streetscape improvements (Remsen Street, Heritage Trail benches), install wayfinding signage, and conduct additional demonstration events. ACDOH and CDTC continue to support Cohoes in its implementation of Complete Streets policy through collaboration and education.

Contact
Charles Welge
Albany County Department of Health
175 Green Street
Albany, NY 12202
http://www.albanycounty.com/
Government/Departments/
DepartmentofHealth.aspx

Success Stories
http://nccd.cdc.gov/nccdsuccessstories/
Albany County Successfully Provided a Network of Lifestyle Change Programs
by: Tricia Bulatao, RDN

SUMMARY
Through the collaborative work of community-based organizations and diabetes prevention providers, eight Diabetes Prevention Programs (DPP) were scheduled over a 10-month span to serve communities experiencing health disparity in Albany County, New York. By strategically selecting and scheduling sites to increase accessibility and by engaging Community Health Workers (CHWs) to increase enrollment and participation, 80 -100 residents with prediabetes from these communities are expected to successfully complete 9 out of 16 of the DPP classes.

CHALLENGE
The 2014 National Diabetes Statistics Report indicated that 9.8% (22,790) of Albany County adult residents were diagnosed with diabetes. It is projected that 37% (86,043) of adult residents have prediabetes. The latest Behavioral Risk Factor Surveillance System survey conducted in Albany County estimates that 21.7% of adults do not participate in leisure time physical activity, 10% of adults do not have adequate access to locations for physical activity, and an estimated 62.8% of adults are overweight or obese, a significant increase from the 2003 estimate of 54%. Obesity is a significant risk factor for diabetes and other chronic diseases. Further analysis indicates that these challenges are disproportionately occurring in communities with limited access to resources, socio-economic hardship and minority health disparity.

YOUR INVOLVEMENT IS KEY
You can make a difference in your at-risk communities by taking a holistic approach to addressing the health care challenges that make lifestyle changes difficult to implement and maintain. These include identifying the environmental challenges that can hinder the commitment to healthy action plans, and the need to make health system changes to increase diagnosis of chronic disease risk and support for making healthy changes.

""By being a part of this program, I learned how to make healthy choices and lost eight pounds. By making good choices, I will be healthier, happier and wiser. ""
- Brenda P.
SOLUTION
A multi-pronged approach was implemented to build support for the evidence-based YMCA and National Diabetes Prevention Programs (Y/NDPP). Focus groups were conducted to identify opportunities and challenges for keeping enrollees engaged in Y/NDPPs. These findings were utilized to guide the coordination of Y/NDPPs (time, site location, incentives). Partnerships were formed with healthcare providers to increase diagnosis and referral of people with prediabetes. CHWs were trained as lifestyle coaches and partnered with Y/NDPPs to maintain engagement of enrollees. As peer mentors, they encourage and help enrollees navigate challenges that affect their progress towards meeting their health goals.

RESULTS
This initiative coordinated eight Y/NDPPs provided by three different agencies. Innovative program sites were selected at-risk communities and included health clinics, grocery stores, and churches. Recruitment efforts highlighted the no-cost for participation, weight loss as a benefit, and listed risk factors as suggested by the focus groups. CHWs call participants weekly to remind them of upcoming classes, offer relevant health coaching, and address challenges towards attendance and implementation of action plans. The three programs held to date have successfully enrolled 44 participants; one program completed 100% of its 13 enrollees and achieved a 2.86% average weight loss; the other two programs are ongoing and currently have a 75% attendance rate; recruitment is ongoing for the other five scheduled programs.

SUSTAINING SUCCESS
The initiative's goal is to build ongoing support for Y/NDPPs by producing a calendar of upcoming Y/NDPPs, increasing referrals into the programs, and utilizing CHWs to keep enrollees engaged in them. Specifically, our goal is to launch at least one new Y/NDPP serving the at-risk communities for 10 out of the next 12 months. The objective for each program is to start with 20 enrollees and to achieve a 50% completion rate defined as attending 9 of the 16 core classes. In order to achieve this, our goal is to engage four additional healthcare practices serving at-risk communities over the next 18 months. Through these efforts, 100 -150 additional individuals from our most at-risk neighborhoods will reduce their risk for diabetes.

Success Stories http://nccd.cdc.gov/nccdsuccessstories/
Strength in Numbers: Local Partners for Local IMPACT

Megan Lee

Summary
The Local IMPACT project covered a large, diverse region and required an intensive implementation of multiple strategies at once. To ensure success, we built a collaborative structure that empowered our partners to improve their nutrition environments, promote physical activity, and build capacity for the NDPP in a way that made sense at the local level. These experienced partners worked at many sites and maximized HealtheConnections’ regional reach, while building their own capacity through participation in the collaborative.

Challenge
The Local IMPACT project, consisting of multiple strategies focused on prevention of obesity, diabetes, heart disease, and stroke, covers 6 Central New York counties. These counties are mostly rural, with two small urban centers, the cities of Syracuse and Utica. As a whole, the region has a high prevalence of obesity and chronic disease, diverse populations, and intense socioeconomic need. To effectively and sustainably reach a large number of people with the environmental and lifestyle change strategies of Local IMPACT, an approach had to be devised that addressed many factors. Some of these factors include the varied demographics and geography; the nuanced socio-cultural environments; and the health and human service infrastructure of different locales in the region. Ultimately, HealtheConnections looked for a tailored approach to meet the distinctive needs of local communities.

Solution
Rather than implement the array of Local IMPACT project strategies from the urban center of the region, HealtheConnections chose to contract with a partner in each county served by the project. The rural health networks, health department, and health home network chosen were instrumental in defining areas of high need in each county and tapping into their local networks to rally the necessary experience, will, and resources to implement environmental and lifestyle change strategies. Using this collaborative structure, HealtheConnections expanded our regional reach and created an environment where partners could discuss progress and challenges, share resources, and learn from one another.

Your Involvement Is Key
To learn more about the Central New York Local IMPACT project, led by HealtheConnections, visit http://www.healtheconnections.org/what-we-do/population-health-improvement/local-impact/. This project is supported by the New York State Department of Health, through funding from the Centers for Disease Control and Prevention’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPHF14).
Results

Since the initiation of the project in 2015, our collective approach to implementing Local IMPACT allowed us to make improvements to a large number of sites in the region. To date, we engaged 51 community sites to implement nutrition standards and 36 small retail venues to improve pricing, promotion, or placement of healthy items in their stores. We promoted physical activity at 52 sites and walking through 16 transportation plan projects. We scaled up the National Diabetes Prevention Program (NDPP) by working with 20 local sites and 18 employers in efforts to make the preventive, evidence-based program a covered benefit. HealtheConnections’ county partners optimized the reach of the effort, matching each of the strategies with the right local partners and resources to build the local chronic disease prevention infrastructure.

"We benefited from being part of the multi-county Local IMPACT collaborative. It was gratifying to be considered a “model county” on some strategies, and to learn from partners about their successes and challenges on others."

- Susan Williams

Sustaining Success

HealtheConnections’ decentralized Local IMPACT model facilitated the project’s reach across the region’s diverse communities and impact at a large number of sites. The collaborative model will sustain the project’s success over time, since local partners built upon their community’s health and human service infrastructure. Stakeholders and service providers formed new relationships and shared the resources required to engage in a variety of strategies to prevent chronic disease. On a grander scale, our regional network of project partners that learned and worked together can continue to tap one another when engaging in chronic disease prevention efforts in the future. Local partners created local impact, and regional impact too.

Contact

Megan Lee
HealtheConnections
443 North Franklin Street
Suite 001
Syracuse, NY 13204
315-671-2241 phone
http://www.healtheconnections.org/

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
Summary

As a partner in Local Initiatives for Multi-Sector Public Health Action (Local IMPACT), HealtheConnections was tasked with facilitating multi-directional referrals between community resources and health systems for the National Diabetes Prevention Program (NDPP) within CNY. This resulted in a new referral platform embedded in HealtheConnections' HIE, a web-based service that allows for the secure transmission and sharing of medical records among healthcare and health-related entities.

Challenge

The purpose of Local IMPACT is to support high-need counties to implement intensive, location-specific strategies in community and health system settings to prevent obesity, and prevent and control diabetes, heart disease and stroke, with a focus on reducing health disparities among adults. The Central New York (CNY) Local IMPACT Initiative covers 6 counties that, collectively, have a chronic disease burden typically worse than the state average. At the same time, the region has fragmented healthcare delivery that does not readily refer to community services. Community organizations indicate that their efforts to integrate with healthcare have been difficult, and healthcare providers share that they are unaware of health-related community-based offerings. The challenge was to create a centralized mechanism to connect healthcare and community based services.

"Having a program like the Diabetes Prevention Program for our patients will be instrumental in improving the patient's quality of life and providing additional support to our organization for population health management."

- Matthew Kertesz, RD, CDN, CDE

Solution

In 2015, HealtheConnections was selected to participate in Local IMPACT, which is funded by the Centers for Disease Control and Prevention (CDC) and administered by the NYS Department of Health. In response to the regional need and to meet grant deliverables, HealtheConnections created a new technology-based referral platform to connect healthcare providers and community-based resources, like the National Diabetes Prevention Program (NDPP). The referral platform is an application embedded in HealtheConnections' Health Information Exchange (HIE).

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
Results
HealtheConnections worked with its technology vendor to create the referral platform within the HIE. The referral platform allows users to select a NDPP provider, complete a referral aligned with CDC's referral form, and then submit the form securely through the HIE. The referral platform was piloted with the YMCA (the local NDPP provider) and a primary care practice participating in Local IMPACT. In conjunction with HealtheConnections, the Healthcare team (a physician champion, quality improvement staff and diabetes educators) were able to design a workflow for patient referral on the new platform. The healthcare provider and the YMCA negotiated bi-directional information content and flow. The pilot goal of 45 referrals will be met within 3 months and at least 5 more contributors are signing on to use the platform.

Sustaining Success
The referral platform will become a standard service offering of HealtheConnections’ HIE. This means company resources will be allocated to sustain the platform, including the development of marketing materials for both healthcare providers and community services. The referral platform will initially include region-wide referrals to four evidence based programs including NDPP, Chronic Disease Self-Management, Diabetes Self-Management and the YMCA Blood Pressure Self-Monitoring Program. Future plans for the referral platform include expansion to other community efforts such as drug/alcohol services, nutrition services, and physical therapy.

Your Involvement Is Key
The HealtheConnections referral platform will only be available to participants in CNY. However, other communities may find a centralized referral platform would be beneficial. Following HealtheConnections approach, the first steps include assessing community readiness, learning and connecting with local HIE services and, finally, keeping in mind there are several other solutions that may be more appropriate for the community.

Contact
Bruce Hathaway
HealtheConnections
443 North Franklin Street
Suite 001
Syracuse, NY 13204
315-671-2241 phone
http://www.healtheconnections.org/

Success Stories
http://nccd.cdc.gov/nccdsuccessstories/
Scaling up the Diabetes Prevention Program to Serve Rural Central New York

by: Carolyn Ashley

SUMMARY
There are many Herkimer County residents who could benefit from lowering their risk of type 2 diabetes by participating in the National Diabetes Prevention Program (National DPP). However, the county’s rural environment creates barriers that make it challenging to recruit and maintain attendees. To address this unmet need and better serve the region, Herkimer County HealthNet has scaled up their National DPP capacity, offering classes throughout the county to increase accessibility and using health professionals to recruit and teach classes.

CHALLENGE
Herkimer County is a rural Central New York county with a high rate of adults with diabetes and prediabetes. 74.5% of adults in the region are overweight or obese. This is markedly higher than adults in New York State as a whole (60.5%).

People with prediabetes can lower their risk of developing type 2 diabetes by losing weight, eating healthy and engaging in regular physical activity. However, nearly a third of adults in Herkimer County do not participate in leisure time physical activity and 20.9% do not eat 5 servings of fruits and vegetables daily.

Additionally, the rural landscape of the region creates barriers in accessing opportunities to prevent chronic disease. Transportation is a major difficulty for this population to overcome, as people and services tend to be spread out over a large area. Other factors, like time, weather and cost can also limit access.

"I haven’t been diagnosed with diabetes yet, but I said, I need to start doing something about my weight, and start feeling better about myself. So [DPP] was very positive. I really enjoyed it. […] You learn to eat better [and] make better decisions."

- Herkimer Focus Group Participant

YOUR INVOLVEMENT IS KEY
To learn more about Herkimer County HealthNet’s approach for scaling and sustaining the Diabetes Prevention Program, visit www.herkimerhealthnet.com. To connect with HealtheConnections about Diabetes Prevention Programs in Central New York, visit www.healtheconnections.org.

The NYS Department of Health provides funding for these activities, with funds originating from the CDC’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPHF14).
SOLUTION

The National DPP is a yearlong program that provides participants who are at risk for type 2 diabetes with tools and support to improve eating habits, lose a modest amount of weight, and increase physical activity. Those who complete the program can lower their risk of type 2 diabetes by up to 58%.

In order to maximize the effectiveness of this evidence-based program and improve health outcomes in Herkimer County, the barriers that keep participants from attending and completing the program must be addressed. For this reason, Herkimer County HealthNet has scaled up their National DPP capacity, offering more classes in more locations so geographically dispersed residents can attend.

RESULTS

To address the unmet need in Herkimer County for diabetes prevention, Herkimer County HealthNet increased their program offerings from one location in the town of Herkimer to four locations throughout the county (Herkimer, Ilion, Little Falls and Dolgeville). The organization also built their capacity to offer classes by increasing the number of National DPP lifestyle coaches from one to six.

Offering more classes in more locations has significantly increased the number of individuals served by National DPP. Prior to the scale up, from 2014-2015 a total of 11 individuals participated in three classes. Since the scale up, from 2016-2017 a total of 42 persons were served in five classes. Sixty-seven percent of the participants in the 2016-2017 classes lost weight. The average weight loss was 9 pounds with a range of 3–13 pounds.

SUSTAINING SUCCESS

Herkimer County HealthNet will move ahead with their expansion efforts, with a goal of sustaining a 2-4 class per year National DPP delivery schedule and becoming the local experts on diabetes prevention. To recruit new participants, Herkimer County HealthNet will continue to promote their classes through various channels, including radio and newspaper advertisements, Facebook, and word of mouth. Additionally, the organization is pursuing a collaboration with Little Falls Hospital to develop a referral process to National DPP for patients diagnosed with prediabetes. Herkimer County HealthNet hopes to establish this mutually beneficial connection to receive more consistent referrals and improve health in the region.
Mutually Reinforcing Strategies “Wrap Around” A Neighborhood in Syracuse, NY

Bruce Hathaway

Summary
HealtheConnections, a not-for-profit organization located in Upstate New York in the City of Syracuse, received 1422 grant funding via the New York State Department of Health for the Local Initiatives for Multi-Sector Public Health Action (Local IMPACT) project. Under Local IMPACT, HealtheConnections and a network of partners implement fifteen mutually reinforcing strategies that together, aim to prevent and control obesity, diabetes, heart disease, and stroke. This wrap-around approach has been successful when applied to different priority populations and geographic areas across the region, but the work of HealtheConnections, Healthy Neighbors Partnership, and other partners in high-risk zip codes in urban Syracuse, NY illustrate the effectiveness of the application.

Challenge
In Onondaga County, the Local IMPACT project focuses on two zip codes in the downtown and southside of the City of Syracuse where, along with high rates of poverty, there is a high prevalence of chronic disease. In these neighborhoods, there are few appropriate places to engage in physical activity, and limited options for shopping for a full line of healthy grocery items. The residents of these zip codes face greater socioeconomic challenges compared to the rest of Onondaga County. Barriers such as poverty, unemployment, and low literacy can prevent them from achieving optimal health status.

Solution
Healthy Neighbors Partnership, a collaboration between Syracuse Housing Authority (SHA) and Upstate Medical University, employs Resident Health Advocates (RHAs) to engage their fellow residents on health topics, connect them with resources, and gain feedback on their needs. HealtheConnections partnered with Healthy Neighbors Partnership to leverage the reach of the RHAs into the community. The work of Healthy Neighbors Partnership and its RHAs, paired with the improvements made to community resources by other involved partners, ensure that important health information, improvements to the built environment, and accessible programming reinforce one another and surround people where they live, work, and socialize.

Your Involvement is Key
To learn more about the Central New York Local IMPACT project, led by HealtheConnections, visit http://www.healtheconnections.org/what-we-do/population-health-improvement/local-impact/. This project is supported by the New York State Department of Health, through funding from the Centers for Disease Control and Prevention’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPHF14).
Results

To date, work has been initiated at nearly 30 sites. Making these improvements ensures that the activities promoted by the RHAs are available and accessible. Each of these efforts is carefully planned to reinforce the other health promotion activities and the messaging around them. A SHA resident could discuss with an RHA the importance of managing their hypertension, and receive a referral to a community-based blood pressure self-monitoring program. In this program, they would receive equipment and health coaching. Working with their coach, they could learn how consuming less sodium will have a positive impact on their hypertension. In the following weeks, they might notice a flyer posted by the RHA in their residence about the new healthy food options offered locally, and join the walking group that meets in the building weekly.

“Now, when a Resident Health Advocate talks to a community member, they can do more than offer them information on how to improve an aspect of their health in a vacuum. They can point to additional times and places, or programs to assist them with their health goal.”

- Connie Gregory, Healthy Neighbors Partnership

Sustainable Success

Since the initiation of the Local IMPACT project in 2015, HealtheConnections has received additional funding to continue expanding these healthy eating, active living, and disease prevention and management strategies in the Syracuse Housing Authority residences and surrounding zip codes. HealtheConnections has invited new partners to join these efforts and is engaging in strategic planning around deepening the impact of the work with Healthy Neighbors Partnership. Current efforts are focused on improving health equity by making our strategies more inclusive of people with disabilities, aging adults, and people that have low health literacy skills.

Contact

Bruce Hathaway
HealtheConnections
109 South Warren Street
Syracuse, NY 13202
315-671-2241 phone
http://www.healtheconnections.org/

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
Lifestyle Change Programs: Where Prevention Meets Primary Care

by: Gina DeVito

SUMMARY
In collaboration with Local IMPACT partners, Open Door has implemented a new methodology for the delivery of National DPP and has successfully scaled program delivery across its two largest sites in Westchester County. The healthcare team at Open Door has a unified approach for the treatment of prediabetes, which includes direct communication in the patient health record, improved connection to on-site services, and measurable health outcome via aggregated data on various health information platforms.

CHALLENGE
The rise of prediabetes is a national health issue, contributing to the growing prevalence of type 2 diabetes and other preventable chronic conditions. It is imperative that health centers emerge as leaders in prevention. Federally qualified health centers and community-based organizations can serve as centralized locations to access evidence-based lifestyle change programs that benefit the most vulnerable, highest risk populations, but the program costs are burdensome to both the patient and community organizations alike. The Local IMPACT collaboration addresses the challenge of creating systems for scaling and sustaining diabetes prevention programs, reducing program costs, and sharing information securely and efficiently.

"Thanks to my coach and the Diabetes Prevention Program my life has changed, I’m a new person, I feel happy."

- Nelly Vasquez

YOUR INVOLVEMENT IS KEY
On-site programs are often the best option for patients and health centers alike, but there are several factors we will consider when scaling this model in additional Open Door communities. Currently, Open Door offers National DPP as a service specifically for its patients, which makes the partnership with the local YMCA valuable, as they provide an option for non-patient members of the community or Open Door patients who are unable to participate in a program offered at the health center.
SOLUTION
Open Door Family Medical Centers has provided a multi-faceted approach to delivering CDC-recognized diabetes prevention programs by using its own wellness program staff to coach National Diabetes Prevention Program (DPPs) and the YMCA’s DPP. Using health center staff as coaches helps to engage and empower patients through a member of their own healthcare team. The funding and support provided by Local IMPACT helped drive growth in Y/National DPPs, strengthened partnerships with local community-based organizations, and provided a platform to create and share best practices with local partners.

RESULTS
Delivering the National DPP in a patient-centered medical home improves patient health outcomes, lowers health system costs associated with type 2 diabetes, removes the burden of cost for low-income patients, and facilitates seamless communication with healthcare providers. Offering National DPP directly from our Wellness and Care Coordination Department streamlines the connection to services and resources to ensure patients are well-positioned for success. Open Door patients who participate in National DPP have the added benefit of on-site medical nutrition therapy, group exercise programs, various chronic disease management programs, patient support groups, behavioral health, and an array of resources that support participation in lifestyle change programs.

SUSTAINING SUCCESS
Advocacy for providing the National DPP as a covered health benefit must continue in order to secure revenue streams for the staff who are critical to delivery of evidence-based programs. Open Door currently relies solely on grants to support this impactful effort. Additionally, continuing to work in partnership with the YMCA prevents duplication of services, offers more schedule and language options and provides more community location options for people who are at risk for diabetes.

Contact
Gina DeVito
Open Door Family Medical Centers
165 Main Street
Ossining, NY 10562
914-502-1332 phone
http://opendoormedical.org

Success Stories
http://nccd.cdc.gov/nccdsuccessstories/
Suffern Village Walking Path Promotes Physical Activity and Healthy Eating

Agustina Lopez-Novillo

Summary
The partnership between the RCDOH, Village of Suffern, Good Samaritan Hospital, and Access Physical Therapy to promote walking in Suffern’s downtown business district allowed all the partners to collaborate in making Suffern a pedestrian friendly community and created significant and sustainable changes that benefit all member of the community by promoting physical activity.

Challenge
Rockland is a densely populated county heavily dependent on the automobile for mobility. Many communities lack the infrastructure to make safe walking possible. Unsafe conditions often result in lack of physical activity, one of the causes of soaring rates of chronic diseases such as obesity and diabetes. In Rockland County, the age-adjusted percentage of adults overweight or obese (BMI 25 or higher) 2013-2014 was 64.2% compared to 60.5% for New York State, and the age-adjusted percentage of adults with physician diagnosed diabetes was 7.4%, which is significant due to the fact that diabetes was the #5 cause of premature death in New York State, 2005-2014.

Solution
Promoting physical activity and opportunities for walking is a strategy to help reduce the burden of chronic diseases. The Rockland County Department of Health (RCDOH) partnered with the Village of Suffern, Good Samaritan Hospital, and Access Physical Therapy to promote walking in Suffern’s downtown business district. This partnership resulted in the creation of a 1.3-mile walking loop, a .9 mile loop, and a commitment from the village to bring more attention to the need for opportunities for physical activity and promotion of healthy lifestyles.

Your Involvement Is Key
To learn more about the walking path in the Village of Suffern, contact Cathym@suffernvillage.com. This project is supported by the New York State Department of Health, through funding from the Centers for Disease Control and Prevention’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPFH14).
Results

The RCDOH created a brochure with a detailed map to promote the walking path, and purchased wayfinding signs for the kick-off event on April 26, 2017. In addition, the walking path was promoted through weekly community walks with the Mayor throughout 2017 in the spring and summer months. Between 10 and 15 people joined the weekly walks.

In addition to promoting opportunities for physical activity in Suffern, the map supports efforts to increase access to healthier food in small retail venues by highlighting three corner stores located along on the walking path that have implemented changes in their stores to increase healthy offerings to their customers. Each store also displays the walking path brochure at the front register to promote the walking path.

“This is a great opportunity to partner with the County and Good Samaritan Hospital to promote walking as a daily activity to promote health and wellness” Mayor Ed Markunas

- Ed Markunas

Sustaining Success

The designation of a walking path is the start of an initiative to promote walking in Suffern. The new path also includes an extension from the downtown business district to the hospital, which Access Physical Therapy plans on using for their rehabilitation walks.

The RCDOH will continue to work with Suffern to develop a Complete Streets policy that creates safe roadways for all users, including pedestrians, bicyclists, motorists, and transit riders of all ages and abilities.

Contact

Agustina Lopez-Novillo
Rockland County Dept. of Health
50 Sanatorium Road
Building J
Pomona, NY 10970
845-364-3755 phone

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
Local Walking Paths Promote Physical Activity in Yonkers, New York

by: Jillian Pennacchio

SUMMARY
Through the addition of new “Food Walks”, community members are able to incorporate physical activity along with a healthy shopping experience. Adding a defined and measured walking path in the Yonkers YMCA is expected to increase the number of residents and staff engaging in physical activity. The clearly marked indoor route will also encourage more participation due to convenience. Both paths will increase recreational physical activity in downtown Yonkers by providing community members with safe ways to walk and a new sense of community.

CHALLENGE
Physical activity can lower the risk of heart disease, stroke, type 2 diabetes, and some cancers. In the 2008 Physical Activity Guidelines for Americans, the Department of Health and Human Services recommends that people get 150 minutes aerobic and muscle-building physical activity each week to improve their health. However, only 21% of American adults met those recommendations in 2015 according the CDC. The 2017 County Health Rankings states Westchester County, NY has an Obesity Prevalence value of 20.3%. This represents a 14% increase from 2015 which had a value of 17.8%. The County Health Rankings also show that residents in the target location of Yonkers, NY are affected by socioeconomic factors that impact healthy food access and physical activity opportunities. 16.7% of the population in Yonkers lives below the poverty line, which is higher than the county average of 10%.

YOUR INVOLVEMENT IS KEY
Community members can participate in these new organized walks and increase their own physical activity levels to improve their health and reduce risk for chronic disease. Find out how you can get involved and Keep Healthy and Move More! This project is supported by the New York State Department of Health, through funding from the Centers for Disease Control and Prevention’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPFH14).

“The Yonkers Food Walk is an exciting opportunity to bring community members together for a local healthy experience! Folks are able to meet others trying to get their steps in for the week and locate some good healthy eats.”

- Nathan Hunter
SOLUTION
Walking is a cost effective and easy way for most adults to incorporate physical activity into their everyday lives. To promote physical activity and provide opportunities for walking, the Westchester County Department of Health (WCDH) collaborated with local organizations Yonkers on the Move, Hudson Valley Groundwork (HVGW), LYFE coalition, and Yonkers YMCA to create walking paths within the heart of the city. Signs, banners, and maps were provided to mark out the paths and distance for guided weekly “Food Walks” through the community in connection to the local farmers market. Wayfinding signs were provided to Yonkers YMCA to create a 1 mile indoor walking path for visitors and employees.

RESULTS
The newly developed “Food Walk” has inspired community members to participate in approximately 60 additional minutes of physical activity each week throughout the summer months. In addition, participants were able to learn about healthy food options throughout the community, visit the self-sustaining greenhouse on the Yonkers Science Barge, and create community bonds while walking.

The YMCA walking path reaches more than 500 Yonkers community members. It includes several sets of stairs as well as an indoor track. After installation of the signage, YMCA staff report more people now engage in walking daily.

SUSTAINING SUCCESS
Maintaining current relationships with local community organizations is the key to sustaining successful physical activity promotion. These partnerships have created a more stable and inviting environment for community members to participate in physical activity. Preserving paths and walking routes will also sustain success. Hudson Valley Groundwork and Yonkers YMCA will maintain their respective path signage and keep the routes safe and clean when leading future walks. WCDH will continue to develop connections with new organizations to add 15 additional paths to impact maximum amounts of participation.
Utilizing Community Health Workers Helps to Stem the Prediabetes Wave

Summary

Hudson River HealthCare (HRHCare), a network of federally qualified community health centers (FQHCs) in New York State (NYS), received funding to prevent obesity, diabetes, heart disease and stroke in Rockland and Westchester Counties. The grant is referred to as Local Initiatives for Multi Sector Public Health Action, or Local IMPACT. HRHCare collaborated with the Rye YMCA to deliver the YMCA Diabetes Prevention Program (YDPP) and engage HRHCare Community Health Workers (CHWs) to increase referrals to the YDPP. Within a month of joining the primary care team, the CHW assisted with making nearly 60 patient referrals to the YDPP.

Challenge

Prediabetes is a relatively new diagnosis for providers and patients alike. Often patients are not aware of the risk factors associated with prediabetes. In sounding the alarm part of the challenge is to reach persons with prediabetes while raising awareness among all concerned. The other part is to link the vast number of persons with prediabetes to lifestyle change programs proven to prevent type 2 Diabetes. The NYSDOH estimates that up to 4.5 million New Yorkers may have prediabetes. The CDC estimates that without lifestyle changes to reduce the risk of diabetes, 15-30% of individuals with prediabetes, or 750,000 to 1.5 million New Yorkers, will develop type 2 diabetes within five to ten years. In the average primary care practice, it’s likely that one-third of patients over age 18, and half over age 65, have prediabetes. CHWs can be of great value to the healthcare team by increasing prediabetes awareness and promoting referrals to lifestyle change programs. They are often seen as the bridge between the patient and the health care team.

"Using CHW's in the referral process, we have increased our referral rate to DPP from 0% in May 2016 to 65%. Outreach efforts made by CHW's to assess risk factors for prediabetes have increased awareness of disease prevalence within our community."

- Olivia Velez, PhD MS MPH RN

Solution

With in-depth knowledge of their community, CHWs are able to provide culturally appropriate services to communities that are medically underserved. The CHW presence is felt & seen with a hands on approach which builds trust among staff, patients and community members. In this case our bilingual CHW was placed at the Park care practice. The City of Yonkers is NYS's fourth largest city with 200,000 residents; notably the largest in Westchester County. In order to identify & refer NDPP participants, a new workflow process was created so the provider could document the YDPP referrals in the electronic health record system to alert the CHW. This enabled the CHW to reach out to potential participants; explain the YDPP time commitment and secure consent to complete the outreach referral.

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
**Results**

The CHW helped to generate 60 YDPP referrals which resulted in participants being enrolled in this YDPP inaugural class. Surprisingly the biggest response primarily came from predominantly Spanish language households. Concurrent to the initial launch there was a combined effort with launching a prediabetes awareness campaign with fliers, press releases, bilingual posters installed at bus shelters, displayed on the interior of public buses and use of social media messages. In addition the CHW allocated time for community-based outreach that cross promoted YDPP outreach and blood pressure screenings at various venues including farmers markets and health fairs.

**Sustainable Success**

In this success story, the journey to prevent diabetes began as the participants were offered this resource as an option and decided to try this program. As participants choose to work with their YDPP Lifestyle Coach they are indeed taking control of their health to live at their best. Our aim in sustaining success is to spread the prediabetes workflow process within HRHCare and train other CHW’s especially among other priority populations at FQHCs. It is also feasible to share the workflow process with other medical providers as a best practice. In addition HCH Alliance stakeholders will continue to build support for the ongoing role of CHWs in promoting future YDPP cycles to link patients to community and clinical resources.

**Your Involvement is Key**

Community based organizations can make prediabetes even more visible by joining forces with primary care teams. Together we can tailor existing tools and adopt the CHW model to open up new avenues for DPP referral and outreach. CHWs are an invaluable part of the health care workforce who can help turn the tide of prediabetes.

**Contact**

Elizabeth Phillips, MPH,M-CHES
Hudson River HealthCare
1200 Brown Street
Peekskill, NY 10566
914-734-8612 phone
http://www.hrhcare.org
Working Together to Build Support for the National Diabetes Prevention Program

by: Penny Tracey RN

SUMMARY

Nearly 30 million Americans are living with type 2 diabetes, and 89 million more Americans are considered to have prediabetes. The National Diabetes Prevention Program (National DPP) is a year-long lifestyle change program, taught in the community by trained lifestyle coaches. This workshop in Niagara Falls served a population of patients who are largely obese/overweight, sedentary, high need and clinically/socially underserved. This collaborative effort provided an accessible location, a healthy lunch, and weekly incentives for participation.

CHALLENGE

According to the American Diabetes Association (ADA), 1.4 million new cases of type 2 diabetes are diagnosed each year. Diabetes is responsible for 12% of adult deaths in the United States, ranking it third on the list of leading causes of death. The ADA recommends maintaining a healthy weight and participating in regular physical activity, which align with the structure and instruction of the National DPP. In Niagara County, 8.1% of the population is living with diabetes, and this figure jumps to 27.5% in the Medicare population. Patients in this community also have limited access to transportation, and 42% of the population lives below the Federal Poverty Level. It was determined that this target population would be more engaged if there were incentives for attendance. At registration, it was learned that one of the attendees was deaf, and in need of an interpreter.

YOUR INVOLVEMENT IS KEY

Encourage your family, friends and coworkers to take advantage of the National DPP in their community. The National DPP recognizes a 5-7% weight loss combined with 150 minutes of weekly exercise can reduce a person’s risk by up to 58%.

Visit www.pophealthwny.org

The program is supported by the NYSDOH through funding from the CDC State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke

"I didn't think I'd ever be able to take the weight off, I've tried before but just got discouraged... I am getting more exercise, I'm eating much better and I feel really good not only about my health but in general."

- Barbara Pazik
SOLUTION
The NHC provides comprehensive health services to the medically underserved population in Niagara Falls’ inner city. A National DPP was delivered by the Niagara County Department of Health (NCDOH) to NHC patients at no charge. The Catholic Health System Foundation provided incentives including a healthy lunch at each session, gift cards for each participant per session, and a Fitbit raffle at the end of the program. The NCDOH also covered the cost of a sign language interpreter for the participant who is deaf. This workshop was the first in the community to provide incentives through partnership. This was also a new opportunity for the Foundation to lend support to the clinic’s patient base.

RESULTS
The goal of enrolling 10 participants was surpassed, as 15 participants registered, 13 of whom remain in the program. This is the largest class the NCDOH has held in this community. The class average weight loss to date is 14 pounds, with one participant losing 50 pounds. This is an especially remarkable achievement because this participant is also deaf and is succeeding with the assistance of a sign language interpreter. The class also averaged 180 minutes of exercise per week. The healthy lunches provided examples of good meals to have at home, and the weekly incentives to the grocery store helped participants to purchase fresh, healthy foods each week.

SUSTAINING SUCCESS
Continued support of the National DPP will help to reverse a patient’s risk of developing type 2 diabetes through developing better habits, making slight changes, moving daily and maintaining a healthy weight. The NCDOH will continue to educate primary care providers on diagnosing prediabetes and will continue to cultivate a cross-referring channel into diabetes prevention programs. The NHC will continue to identify people with prediabetes through their EHR and provide education to their patients on the long-term effects of developing type 2 diabetes.

Success Stories
http://nccd.cdc.gov/nccdsuccessstories/
Learning to Manage Hypertension through a Community-Based Pharmacy Program

by: Ryan Lindenau, PharmD

SUMMARY
High blood pressure or hypertension (HTN) is a major risk factor for heart disease and stroke. Self-measured blood pressure (SMBP) monitoring is one strategy that can be implemented in communities to reduce the risk of death and complication due to high blood pressure. The Population Health Collaborative of Western NY (WNY) received funding from New York State Department of Health to increase engagement of community pharmacists in the provision of medication-/self-management for adults with high blood pressure in WNY.

CHALLENGE
Hypertension affects nearly one-third of American adults aged 19 and older (67 million people). HTN is uncontrolled in more than half of adults with the condition and only 61% of adults with uncontrolled HTN are aware they have HTN. According to the NYS e BRFSS, 31.6% of adults in WNY have been diagnosed with HTN. The age adjusted ER rate per 100,000 due to HTN is 21 in the WNY region. Uncontrolled HTN is associated with increased cardiovascular morbidity and mortality and increase of health care costs. Self-monitoring of blood pressure helps in promoting patient activation and empowerment. It provides individuals the opportunity to monitor their blood pressure on a regular basis and facilitates self-promoted healthy behaviors that ultimately affect blood pressure.

"I always knew keeping blood pressure low was a good thing, but I never realized how it could affect my body, or how foods and exercise could change my readings. I have a new perspective on what it means and what it takes to control my blood pressure."

- Anonymous
**SOLUTION**

Middleport Family Pharmacy is piloting the distribution of blood pressure cuffs to patients diagnosed with HTN. The pharmacy implemented a medication synchronization program (Med Sync) in their facility to promote SMBP. This effort streamlines a patient’s medication refills, allowing multiple medications to be refilled at the same time each month. It also provides an opportunity for resident pharmacists to follow-up with patients regarding their blood-pressure readings from the past month and provide education to assist patients in blood pressure control. With the support of Local IMPACT funds, the team is developing a toolkit to assist other local pharmacies implement a similar program.

**RESULTS**

39 BP cuffs have been distributed to patients with uncontrolled HTN. 62% of patients have provided BP logs, demonstrating patient activation. Since beginning this program, the average adherence ratio (Medication Possession Ratio) at Middleport Family Health Center (MFHC) is 86%, compared to the national average ration of 51%. Through this program, 75% of MFHC patients have their blood pressure under control, compared to the national average of 54%. A participant who is pregnant and in the Med Sync program had great results from consistently monitoring her blood pressure. Having been prescribed the maximum dosage of medications for HTN due to her pregnancy, there were few options available for next steps. In working to self-monitor, her blood pressure readings have become more stable over the duration of her engagement with the program.

**SUSTAINING SUCCESS**

- This program seeks to: Increase opportunities for patients to monitor their blood pressure at home
- Promote patient activation, providing an opportunity for patients to take responsibility for their own health care.
- Provide a toolkit to other local pharmacies to assist them in implementing their own program

Follow-up will continue with patients who have already received blood pressure cuffs. Middleport Family Pharmacy will continue to identify new patients with HTN that can be enrolled in the Med Sync and SMBP programs. It is our hope that patients currently involved in the program will continue to be actively engaged in improving their HTN both now and beyond the program.

Contact

Ryan Lindenau, PharmD
Middleport Family Health Center
81 Rochester Rd
Middleport, NY 14105
716-735-3261 phone
http://www.middleportfamilyhealth.com

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
Decreasing Blood Pressure Rates in Western New York Through Target: BP™

Jessica Thomas

Summary
The Population Health Collaborative has partnered with the American Heart Association to implement their Target: BP™ (TBP) program throughout primary care practices in Western New York (WNY) to decrease the rates of hypertension. Implementing targeted changes within a primary care practice, including more frequent use of health system’s data and adopting practice-wide policies have proven increased health outcomes including reduced hypertension.

Challenge
Hypertension (HTN) affects approximately 85 million adults in the United States. HTN is uncontrolled in more than 45% of adults with the condition. According to the NYS e BRFSS, 31.6% of adults in WNY have been diagnosed with HTN. The age adjusted ER rate per 100,000 due to HTN is 21 in the WNY region. Uncontrolled HTN is associated with many serious health conditions including heart attack, heart failure, and stroke.

Solution
The AHA is implementing the TBP program in three large WNY practices: Aspire of WNY, Greater Buffalo United Accountable Healthcare Network (GBUAHN), and YourCare Healthplan. TBP helps healthcare providers and patients achieve better blood pressure control (goal of lower than 140/90mmHG) by encouraging a multi-disciplinary team approach with standardized treatment protocols. Physicians and their teams are provided a comprehensive source of tools for use in practice including AHA/ACC/CDC Hypertension Treatment Algorithm, the AMAs’ Measure, Act, Partner (MAP) Checklist, Community Health Worker training, in person technical assistance, and an online portal complete with webinars.

Your Involvement Is Key
To learn more about the TBP, visit targetbp.org or contact Marc Natale, Executive Director, marc.natale@heart.org, 716.243.4603. This project is supported by the New York State Department of Health, through funding from the Centers for Disease Control and Prevention’s State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPFH14).
Results

Within the three health systems the AHA is working with, approximately 25,000 patients have been touched through this initiative with an expected 150,000 additional patients over the next grant year. At Aspire of WNY, the practice where TBP has been implemented the longest of the three practices, 234 patients of the 263 patients diagnosed with hypertension reportedly have their blood pressure under control since the practice began implementing the program. That is an 89% success rate. “Bringing evidence-based treatment approaches to practices through Target: BP is a simple, effective way to help renew attention to blood pressure and bring more patients to their ideal goal,” Marc Natale, Executive Director, Rochester and Buffalo Region, American Heart Association.

“Bringing evidence-based treatment approaches to practices through Target: BP is a simple, effective way to help renew attention to blood pressure and bring more patients to their ideal goal.”

- Marc Natale

Sustaining Success

Through the collaboration with the AHA, physicians and their teams are provided continuous comprehensive sources for tools and resources, including:

- AHA/ACC/CDC Hypertension Treatment Algorithm
- AMA's M.A.P. Checklist, Community Health Worker training
- Marketing and educational materials such as self-monitoring infographics and instructions
- In-person technical assistance
- An online portal with webinars, complete with a central repository of all information.

Although continuous technical assistance is provided, the expectation is that through initial training through the AHA, the work becomes a lasting process within the practice and is a consistently present culture of patient interactions.

Contact

Jessica Thomas
Population Health Collaborative of WNY
355 Harlem Rd., Bldg C, 2nd Floor
West Seneca, NY 14224
716-923-6575 phone
http://www.pophealthwny.com

Success Stories http://nccd.cdc.gov/nccdsuccessstories/
Summary
Sedentary lifestyles increase the risk of serious health conditions. Development of Complete Street policies can assist communities in formalizing plans for design and maintenance of streets so they are safe and encourage mobility. The P² Collaborative of Western New York received funding from the New York State Department of Health for the Local Initiatives for Multi-Sector Public Health Action (Local IMPACT) initiative. Under Local IMPACT, P² is working in 8 counties in WNY to develop and/or implement community plans that promote walking.

Challenge
Many of today’s diseases can be attributed to how people live their lives. Chronic diseases such as obesity, diabetes, and stroke are prevalent in the WNY Community. According to the NYS 2014 e BRFSS, 63.7% of adults are overweight or obese, the incidence of diabetes is high in comparison to the rest of NYS, and 31.6% adults have been diagnosed with hypertension. The age-adjusted death rate per 100,000 population due to stroke is 36.6% for the WNY region. Being overweight or obese increases the risk of pre-diabetes, type-2 diabetes, heart disease and stroke, and many other chronic health conditions and diseases. Regular physical activity, such as walking or biking, can help to prevent these diseases. Therefore, promoting walking and physical activity can help to improve these population health indicators.

Get Involved
Encourage your family, friends and coworkers to take advantage of opportunities to walk or bike. Increasing physical activity can help our community reduce the risk of chronic disease, including hypertension and prediabetes.

To learn more about the WNY Local IMPACT program, led by P2 Collaborative of Western New York, visit p2wny.org. The program is supported by the NYSDOH through funding from the CDC State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke (DP14-1422PPHF14).
Solution

In support of P² Collaborative of Western New York's Local Initiatives for Multi-Sector Public Health Action (IMPACT) Program, the University at Buffalo Regional Institute, in partnership with the Greater Buffalo Niagara Regional Transportation Council and GoBike Buffalo, a regional environmental assessment of sixty target communities, and a pedestrian/bicycle assessment in all eight counties were completed. The findings from the assessments were used in the development of a Mobility Toolkit and Complete Streets Policy Handbook for local municipal planners, government officials and decision-makers.

Results

The environmental assessment revealed some regional strengths when it comes to promoting walking and physical activity through local planning and policy. 20 municipalities already had pedestrian-friendly community plans in place to promote walking. Most of the communities assessed support sustainable development strategies that promote physical activity. Many communities have completed or begun transportation improvement projects with a focus on pedestrian and bicyclist safety. Barriers such as limited financial resources and potential opportunities to leverage municipal capacity were identified. Collaboration across municipal boundaries may have the greatest potential to overcome the barriers.

Sustainability

A toolkit and a list of resources focused on policy, design guidelines, maintenance and funding was provided to county and local elected officials, planning and zoning board members, town and village planners, and business owners representing both urban and rural communities during a Complete Streets for Mobility Workshop. There is a commitment from respondents that participated in the regional survey and workshop to proactively approach and support mobility and improve health outcomes in their communities. Moving forward, P² Collaborative and its partners plan to provide conduct walkability audits in targeted communities and offer technical assistance and training about transportation and community plans that promote walking.

Contact:
Jessica Thomas, DrPH(c), MPH
P2 Collaborative of WNY
355 Harlem Road,
West Seneca NY 14224
716.923.6575
jthomas@p2wny.org

Success Stories

http://nccd.cdc.gov/nccdsuccessstories/
Standardizing Data Collection and Reporting in a Learning Collaborative

by: Renee Wing

SUMMARY
The learning collaborative model creates a valuable “all-teach, all-learn” environment. Key elements to the success of a learning collaborative include adoption of standardized measures and a structured data management system. To facilitate data collection and reporting in a health systems learning collaborative, New York State Department of Health (NYSDOH) developed tools and data flow processes to track quality improvement efforts. This enabled practices to monitor their individual and collective progress toward improved patient care.

CHALLENGE
The overarching challenge of this approach was to develop tools, standardized measures, and reporting processes for health systems with different electronic health records (EHRs). NYSDOH’s Quality Improvement Collaborative (QIC) included seven primary care practices; five Federally Qualified Health Centers (FQHCs) from two different networks and two private practices. To standardize data collection and reporting across practices, a comprehensive data management plan was required. The intent of the data management plan was to capture monthly practice-level data on a set of hypertension and prediabetes measures and collect qualitative data on tests of change implemented at the practice.

YOUR INVOLVEMENT IS KEY
Key actions to tracking improvement in health systems include:
1. Standardize clinical measures that are sensitive to the improvements health systems are trying to make.
2. Remove barriers to health systems in reporting on standardized measures by developing a data management system.
3. Create a learning environment where all participants can contribute.
4. Report back to health systems on their progress through run charts and other data visualization efforts on a regular basis.

"I really liked the analysis of the group data combined with handouts with our individual practice's data - it let us see where we are in relation to the whole."

- anonymous - participant survey
SOLUTION
Practices participating in the QIC were required to submit quantitative and qualitative data on a monthly basis. NYSDOH developed two primary tools to manage data collection.

1. A project website was created using a free website builder. The website served as the primary mechanism by which practices submitted their data and provided a location to share project information and resources.
2. A reporting template (Excel based) was developed to standardize quantitative data reporting. The template captured clinical quality measures and process measures and tracked progress by individual practice and by the collaborative average.

RESULTS
Data for the QIC came from a variety of sources. The five FQHCs were represented by either a Health Center Controlled Network or the Primary Care Association, both of which submitted clinical data on behalf of their associated practices. The two private practices submitted clinical data directly to the project website. All practices submitted process measure data and qualitative reports via the project website. Clinical and process measures were reported at practice level. NYSDOH compiled monthly data into the reporting template and created run charts for each practice and the collaborative average. The report was posted to the project website to give practices access to the data. Qualitative reports were tracked separately and used to provide specific technical assistance to practices and guide discussion on the action period calls.

SUSTAINING SUCCESS
NYSDOH has a set of standardized clinical measures for hypertension and prediabetes that have been tested in different EHRs and practice types. The QIC prompted development of a data management system, including a reporting template, that standardized data collection and provided a tool for reporting back to providers and their quality improvement teams. These tools can be used to facilitate future learning collaborative groups and shared among partners.

Contact
Renee Wing
New York State Department of Health
150 Broadway
Albany, NY 12204
518-408-5142 phone
https://www.health.ny.gov/

Success Stories
http://nccd.cdc.gov/nccdsuccessstories/
NYS Department of Health Convenes Key Partners to Advise on Health Systems Work

by: Tiana Wyrick

SUMMARY
Launched under the CDC-funded State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke (1422) program, New York State Department of Health (NYSDOH) convened a Health Systems Advisory Group to inform health systems initiatives and provide guidance on the standardizing of measures for reporting and performance monitoring. This diverse group of partners came to consensus on a set of measure definitions, tested the measures, and successfully spread the measures to health systems for reporting in 1422.

CHALLENGE
NYSDOH is involved in multiple quality improvement projects that rely on data from electronic health records (EHR) for reporting purposes. Since this work spans health systems using various EHR platforms, standardized measures were needed to ensure consistent reporting from external sources. Measures were needed that would be meaningful to primary care practices, but also standardized to evaluate improvement in population outcomes across health systems and provide consistent data reporting to CDC. NYSDOH faced a number of challenges in standardizing measures for 1422. First, NYSDOH lacks the clinical informatics capacity necessary to ensure measure definitions are comprehensive and able to produce data that is meaningful and actionable. Second, two clinical indicators in 1422 represent entirely new measures that are not currently defined by a standard healthcare reporting system.

YOUR INVOLVEMENT IS KEY
Public health departments increasingly have opportunities to engage with health systems on quality improvement initiatives. By leveraging existing partnerships and acting as a convener, a state or local health department can bring together a breadth and depth of expertise to offer a comprehensive and coordinated approach to health care systems in their communities.
SOLUTION
To address these and other challenges, NYSDOH convened a Health Systems Advisory Group comprised of both external and internal stakeholders. External membership includes NY state's primary care association, a health-center controlled network, an EHR vendor, a health information exchange organization, and the state’s Quality Improvement Organization and Quality Improvement Network (QIO/QIN). Internal representation includes NYSDOH staff from chronic disease prevention and control, surveillance and evaluation, and quality and patient safety. The purpose of the Advisory Group is to provide guidance and promote coordination of health system interventions, including measure development.

RESULTS
The innovative approach of creating an advisory group provides NYSDOH with clinical and health information technology (HIT) expertise and lends a practical and implementation-driven focus to the work. NYSDOH serves as the convener and brings a population health framework to the group which keeps consistency and standardization of reporting at the forefront when defining new measures. All members recognized the need for standardized measures and contributed their individual expertise around clinical guidelines, practice workflows, and EHR functionality. The group came to consensus on a set of defined measures for 1422, mapped the measure specifications, and tested the measures in multiple EHR platforms and one health information exchange. Currently, 17 primary care practices are reporting data on the standardized measures for 1422.

SUSTAINING SUCCESS
The Health Systems Advisory Group met every other month for six months and continues to meet quarterly. The group has been a resource for NYSDOH when questions arise related to health informatics, practice- or provider-level use of data, practice recruitment, and other health system issues. The Advisory Group has proven mutually beneficial for NYSDOH and the external partners as it provides a neutral forum to discuss barriers and share successes around quality improvement, clinical workflows, EHR reporting, and measure specifications. It is the intent of NYSDOH and the Advisory Group to continue to serve as a guiding body and provide support to health systems interventions addressing chronic conditions.