Evidence-Based Approaches to Preventing Chronic Disease: Evidence-Based Self-Management Approaches

NYS Prevention Agenda Webinar Series
May 29, 2014

Welcome!

• Today you will hear a presentation and have the opportunity to ask questions.
• Find resources and materials at nyspreventschronicdisease.com

Evaluations

Nursing Contact Hours, CME and CHES credits are available.

Please visit nyspreventschronicdisease.com to fill out your evaluation and complete the post-test.

Partners and Sponsors

• New York State Department of Health
• University at Albany, School of Public Health, Center for Public Health Continuing Education

The planners, moderators, and presenters do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity.
No commercial funding has been accepted for this activity.

Today’s Objectives

• Define Evidence-Based Self-Management.
• Identify 3 community partners with which to work in implementing Evidence-Based Self-Management Programs.
• Summarize the roles local health departments can play in implementing Evidence-Based Self-Management Programs in their communities.
• Illustrate the application of an Evidence Based Self-Management Program in practice

Webinar Guidelines

• Please designate one person at the computer
• Adobe Features you will use today:
  – Chat Box
  – Polls
Today’s Speakers

Sue Millstein, LCSW, MPH
Program Manager, Diabetes/Chronic Disease
NYS Department of Health

Kerri Brown, M Ed.
Project Coordinator
Chautauqua County Health Network

Overview of webinar

1. Pathway from Prevention Agenda to Evidence-Based Self-Management
2. What are Evidence-Based Self-Management Programs
3. Roles necessary to implement and sustain
4. Resources

NYS Prevention Agenda 2013-2017

• Goal is improved health status of New Yorkers and reduction in health disparities through increased emphasis on prevention.

• Call to action to broad range of stakeholders to collaborate at the community level to assess local health status and needs; identify local health priorities; and plan, implement and evaluate strategies for local health improvement.

Five Prevention Agenda Priorities

• Prevent chronic diseases
• Promote a healthy and safe environment
• Promote healthy women, infants and children
• Promote mental health and prevent substance abuse
• Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated infections

Pathway From Prevention Agenda to Evidence Based Self-Management Programs: How did we get here?

• Prevention Agenda 5 Priority Areas
  – 3-4 Focus Areas for each Priority
  – 3-5 Goals for each Focus Area
  – Many strategies for each Goal

Pathway Example:

• Priority Area: Preventing Chronic Disease
  ➢ Focus area: Increase access to high quality chronic disease preventative care and management in both clinical and community settings.
  ➢ Goals: Promote culturally relevant chronic disease self-management education.
What are Evidence-Based Self-Management Programs?

Evidence-based Self-Management Programs: What do we mean?
- Based on sound scientific research
- Found to be effective when implemented with fidelity
  - Dr. Kate Lorig, Stanford University - pioneer of CDSMPs
  - NDPP: NIH DPP Randomized Control Trial

Self-Management: What do we mean?
- Education
- Support
- Self-efficacy
  - Sessions are highly interactive, focusing on building skills, sharing experiences and support.
  - Programs are designed to help people gain self-confidence in their ability to manage their disease and cope with health problems affecting their lives.

Also Known As...
- Self-Management
- Self-Care
- Health Promotion
- Patient Education
- CDSME's (Chronic Disease Self-Management Education Programs)

Examples of EB Self-Management Programs
- Active Living Every Day
- Chronic Disease Self-Management Program
- Chronic Disease Self-Management Program with Hypertension Module
- Diabetes Self-Management Program
- National Diabetes Prevention Program
- Spanish Language Diabetes Self-Management Program
- Tomando Control de su Salad (Spanish Language Chronic Disease Self-Management Program)
- Walk With Ease

Roles Necessary to Implement and Sustain
Roles and Functions Needed to Plan, Implement and Sustain Programs in Communities

Increasing availability, accessibility, use of EB self-management programs

Champions
Coordination
Program Delivery
Recruitment
Materials provision
Training of master trainers and lay leaders
Site identification and management
Data Collection and Reporting
Fidelity and Quality Assurance
Marketing and Promotion

Champions
Coordination
Program Delivery
Recruitment
Materials provision
Training of master trainers and lay leaders
Site identification and management
Data Collection and Reporting
Fidelity and Quality Assurance
Marketing and Promotion

Partners

Local Health Department

Communities
Philanthropy
Healthcare delivery systems
Businesses & Unions
The Media
Academia

Article 6 Reimbursable Activities

• Reimbursable activities include:
  – Promotion and coordination of evidence based self-management programs
  – Work to increase access and referrals to evidence based self-management programs
  – Non-Reimbursable:
    • Delivery of evidence based self-management programs

Alignment Across the State

• This work helps to position local health departments and stakeholders to be valued partners in other emerging systems changes
  – DSRIP - aligned with PA
  – SHIP – aligned with PA
  – BIP - aligned with PA and DSRIP
  – ACO’s - Aligned with ACA

Resources

• For implementing the Prevention Agenda
  – Additional SPH Webinars - linkages with healthcare systems and processes for linkages to EBIs for patients with chronic diseases
  – NYS Prevention Agenda website - nyspreventschronicdisease.com
    • EB Fact Sheet
    • For implementing the Chronic Disease and Mental Health portions of the Prevention Agenda
    • NYAM Technical Assistance
University at Albany Quality and Technical Assistance Center (QTAC)

- For planning and implementing evidence based self-management programs:
  - Make the connection!!
  - Partner Portal
  - Training, TA, Data Collection, CQI
  - http://ceacw.org/qtac/q-training

Evidenced-based Interventions in Chautauqua County
Where Clinical Care meets Public Health

Background

- Chautauqua County Health Network is a state designated rural health network comprised of four hospital organizations, physicians, and more than 50 local health and community based organizations including skilled nursing, home care, hospice, county government, business, and human service agencies.

Partner Agencies

- Chautauqua County Community Health Planning Team
  - Convened and facilitated by the Chautauqua County Department of Health and Human Services
  - Includes DHHS, Office of Mental Hygiene, 4 hospitals, 1 FQHC, 1 rural health network, and our regional health planning collaborative.
  - Works to align CSPs, CHAs, CHIP with prevention agenda
  - Carries out CHIP activities collaboratively

- CCHN also has two sister-organizations, the Integrated Delivery System and Chautauqua Region Associated Medical Partners (AMP).
  - IDS is an Independent Practice Association (IPA) comprised of 140 physician members, both primary care and specialties, along with the same three hospital systems as CCHN;
  - AMP is a recently formed Accountable Care Organization that includes eight primary care physician groups (35 physicians), all three hospital organizations, two skilled nursing facilities, as well as beneficiary and community based agency representation.
- Our organizations are co-located which has enabled us to share staff and leverage our respective resources to sustain and improve the delivery of services locally.

- Convened and facilitated by the Chautauqua County Department of Health and Human Services
- Includes DHHS, Office of Mental Hygiene, 4 hospitals, 1 FQHC, 1 rural health network, and our regional health planning collaborative.
- Works to align CSPs, CHAs, CHIP with prevention agenda
- Carries out CHIP activities collaboratively
Partner Agencies

- **Roles**
  - DHHS: Convener and facilitator
  - CCHN: Represents and coordinates clinical side of activities
  - Hospitals and Clinic: Delivers Services
  - Collaborative: Guides and advises

The Beginning of EBI's in Chautauqua

- **2008** - Trained first Master Trainer for Chronic Disease Self Management Program; 2nd Master Trainer added in 2009
  - 17 Lay Leaders trained from 2010-2013, 13 of which are still active
- **2012** - Trained Master Trainer in Diabetes Self Management Program
  - 9 Lay Leaders trained in 2013
- **2013** - Trained Master Trainer in Chronic Pain Self Management Program
  - 8 Lay Leaders trained in 2013

Delivery Organizations

- CCHN
- DHHS
- Office for the Aging
- Primary Care Practices
- Clinics

Development of a Referral Process

- CDSMP referral process was piloted in 2012 with 4 practices to help meet requirements for Self Management Support for PCMH.
  - Staff established a referral protocol to manage intake, follow-up, and reporting back to participating physicians.
  - Practice in-services were completed to orient over 20 Primary Care staff members to the CDSMP program and referral process
  - Marketing and educational materials were distributed to the practices including posters for exam rooms, handouts for patients, and referral forms.
  - A targeted work list was created for practices using a Diabetes Registry which identified more than 100 potential diabetic candidates for the program

Refined Referral Process in 2013

- A secure online database was created to track referrals, class participation, and generate physician letters; later became a NYS QTAC partner and have transitioned to their system for part of the process
- Staff continued to use Disease Registries and ACO claims data to generate work lists to target specific patient populations
- The Patient Activation Measure was introduced to Lay Leaders and Practices to measure a patient’s confidence in managing their condition

Living Healthy Outcomes

- Over 350 physician referrals generated
- 112 completed out of 178 enrolled
CHIP Activity – Expanding the National Diabetes Prevention Program

- 2 NDPP classes were piloted in 2012-2013
- CCCHPT partners agreed the expansion of NDPP should be included in the CHIP
  - Subsequently, CCHN sought and was awarded a grant from the New York State Health Foundation to support expansion efforts

In progress:
- 2014-2015 schedule being developed to offer 5 classes over the next year
- Lifestyle coach training
- Creation of pre-diabetic work lists for practices
- Scheduling practice in-services to begin referral process

Wrapping Up.....
More webinars and technical assistance opportunities to come......
Contact:
Susan Millstein susan.millstein@health.ny.gov
(518) 408-5142
THANK YOU!!!!