Evidence Based Approaches to Preventing Chronic Disease: Community-Wide Systems to Deliver Evidence-Based Interventions to Address Chronic Disease

NYS PREVENTION AGENDA TRAINING FOLLOW UP WEBINAR

MARCH 14, 2014
Webinar Guidelines

- Please designate one person at the computer
- Adobe Features you will use today:
  - Chat Box
  - Polls
- Today’s session is being recorded
Welcome!

• Today you will hear a presentation and have the opportunity to ask questions.

• Please refer to the Evidence-Based Interventions Fact Sheet for more information.

• Find this fact sheet plus other resources and materials at nyspreventschronicdisease.com
Today’s Objectives

- The Language of Evidence-Based Programs
- Review of the Research on Efficacy Data
- Evaluating Your Work
- Program Sustainability
Partners and Sponsors

- New York State Department of Health
- University at Albany, School of Public Health, Center for Public Health Continuing Education
- New York Academy of Medicine
  - Designing a Strong and Healthy New York Obesity Prevention Coalition and Policy Center (DASH-NY)

_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 Speakers

- Lisa Ferretti, LMSW
- Mari Brick
New York State Department of Health
Prevention Agenda Webinar:
Promoting Evidence-Based Interventions
March 14, 2014
Welcome from the Presenters:

- **Mari Brick** - Associate Director, NYS Evidence-Based Health Programs Quality & Technical Assistance Center

- **Lisa A Ferretti** – Director, Center for Excellence in Aging & Community Wellness; New York State Evidence-Based Health Programs Quality and Technical Assistance Center
What Are Evidence-Based Health Promotion and Disease Prevention Programs?
Webinar Agenda

Evidence-based Interventions
  What is Evidence-based?
  Full Menu of EBIs
    Description
    Efficacy

Putting it Into Practice
  National Influences
  Reaching Providers

Creating Value in Your Programs
  The Value Proposition
  Self-Management Support

Building Sustainability
  Define the Delivery System
  Delivery Models

Sustainability Framework
  Workforce Development
  Referral Networks
  Marketing

QTAC
  Data Collection and Management
    Partner Portal
    CQI
    Tools

Q&A
The Rise in Popularity of the Term “Evidence-Based” (Hoagwood & Johnson, 2003)

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What is Evidence?
Lonigan, Ebert & Johnson, 1998; Chambless et al., 1998

At least two controlled group design studies or a large series of single-case design studies

Minimum of two investigators (to be well-established)

Use of a treatment manual

Uniform therapist training and adherence

Tested with clinical samples

Tests of clinical and functional outcomes

Long-term outcomes beyond termination of treatment
Grading the Quality of Evidence:

*Biglan, Mrazek, Carnine, & Flay (2003)*

- Grades 1-7
  - 1 = multiple RCTs or multiple time series experiments by two or more independent teams + data on implementation effectiveness
  - 2 = multiple RCTs or multiple time series experiments by two or more independent teams
  - 3 = multiple RCTs or multiple time series experiments but no independent teams
  - 4 = 1 RCT or time series
  - 5 = comparisons between groups without randomization
  - 6 = pre-post comparison for one group
  - 7 = endorsement by authorities
Health Promotion & Evidence-Based Practice

- Some are highly rated as evidence-based
- Many do NOT meet criteria for evidence-based
- For others the quality of the evidence would not be highly rated

...Consideration of Program/Treatment Fidelity issues is still important
Types of Self-Management Behavior-Change Interventions

- **Chronic Health Condition Focus**
  Educational programs designed to help people develop skills and confidence to manage their health condition

- **Physical Activity Focus**
  Small groups or self-directed interventions where people learn strategies to increase physical activity safely
Why Self-Management Interventions?

- Effective, affordable, and evidence-based
- Convenient: workshops held in community settings
- Developed by university researchers and other reputable groups
- Taught by trained and certified instructors
- Evidence-based and proven effective
Evidence-Based Interventions
Promoted by NYS DOH and
Supported by NYS QTAC
Interventions

- Stanford University Suite of Self-Management Programs
- Active Living Every Day
- Walk With Ease
- Active Choices
- CDC National Diabetes Prevention Program
Stanford University Chronic Disease Self-Management Programs
CDSMP Suite of Programs

- Chronic Disease Self-Management
  - Any chronic health condition and multiple conditions
- Diabetes Self-Management
  - Type 2 Diabetes
- Positive Self-Management
  - HIV/AIDS
- Chronic Pain Self-Management
  - Chronic Pain
Chronic Disease Self-Management Program (CDSMP)

- **Target Population:** adults 18 and over living with one or more chronic conditions or providing care to someone living with a chronic condition

- **About the Program:**
  - lay led, interactive program
  - offered in the US and internationally
  - evidenced-based curriculum developed at Stanford University-Patient Education Research Center in the early 90’s

- **Program Goal:** to help participants build confidence in their ability to manage their health condition(s).
What Are the Benefits of CDSMP?

Health Outcomes

- Increased physical activity
- Better coping strategies and symptom management
- Improvements in self-rated health, social and role activities
- More energy and less fatigue

Evidence Supporting Health Outcomes

- Subjects that participated in CDSMP demonstrated significant improvements in energy, health status, social and role activities and self efficacy when compared to those that did not
- Over 1,000 people with heart disease, lung disease, stroke, or arthritis participated in a randomized, controlled trial of CDSMP and were followed for up to three years
- Researchers also found that CDSMP participants had fewer visits to the ER; there was also a trend toward fewer outpatient visits and hospitalizations
Recent Studies

Ory et al. (2013):

- Significant improvements for all better health and better health care outcome measures were observed from baseline to 12-month.
- The odds of ER visits significantly reduced from baseline to 12-month, whereas significant reductions in hospitalization were only observed from baseline to 6-month.
Ahn et al. (2013):

- Findings from analyses showed significant reductions in ER visits (5%) at both the 6-month and 12-month assessments as well as hospitalizations (3%) at 6 months among national CDSMP participants.
- This equates to potential net savings of $364 per participant and a national savings of $3.3 billion if 5% of adults with one or more chronic conditions were reached.
Recent Studies

Brady et al. (2012):

- **Self-efficacy:** showed moderate and significant increases in the 4-to 6-month and 9- to 12-month
- **Psychological Health Status:** Health distress and depression outcomes showed consistent small to moderate improvements in both the 4- to 6-month and 9- to 12-month
- **Physical Health Status:** energy, fatigue, pain, functional disability, and shortness of breath changes were less consistent than changes in the psychological health status variables.
- **Health Behaviors:** Aerobic exercise, cognitive symptom management, communication with physician, and stretching/strengthening exercise - three showed small to moderate significant improvements in the overall analysis at 4–6 months. Most improvements persisted at 9–12 months.
Recent Studies

Brady et al. (2012):

- **Health Care Utilization**: Changes were minimal. Three of the four variables measured showed no significant effect sizes at 4–6 months or 9–12 months. There was a small but significant change in the fourth measure, days in the hospital, at 4–6 months that did not persist at 9–12 months.

- **Self-Rated Health**: Measures improved modestly but significantly at 4–6 months but did not persist at 9–12 months.

- **Social/Role Limitations**: Measures showed a small but significant effect at 4–6 months that persisted at 9–12 months.
Diabetes Self-Management Program

- Stanford University developed program
- Utilizes about 50% of the content from the CDSMP with a Type 2 Diabetes focus
- Remaining content is specific to concerns of people living with Type 2 Diabetes
- Topics include:
  - Menu planning, nutrition label reading
  - Managing High/Low Blood Sugar
  - Managing Sick Days, Foot Care, Testing
  - Monitoring Blood Sugar
The Evidence Supporting the DSMP

- Originally developed in Spanish, the results showed:
  - Improved health status, including lower HbA1c levels (*Spanish version only*)
  - Improved health behavior
  - Increased self-efficacy
  - Fewer emergency room visits
Active Living Every Day
Active Living Every Day

- Target audience: adults over 18 who want to increase their physical activity
- Small group in-person meeting
- 12 weeks, 1 hour per week
- Evidence-based program
- Uses behavior change models to empower people to overcome barriers to physical activity
- Not a traditional exercise program
What is the Evidence?

- Tested under Random Control Trial conditions, and in a quasi-experimental “community based” design. (Wilcox, et al., 2008)

- Significant increases in:
  - Moderate to vigorous intensity physical activity
  - Total physical activity
  - Satisfaction with body appearance and function

- Decreases in BMI

- Decreases in depressive symptoms & perceived stress
Active Living Every Day program philosophy

- Moderate physical activity = significant health benefits
- Lifestyle physical activity: an important alternative
- People are more likely to become and stay active when they learn lifestyle skills based on their readiness to change
Walk with Ease
Walk with Ease

- Target audience: adults over 18 with arthritis and or other lower extremity concerns and other chronic conditions, such as diabetes, heart disease and hypertension.
- Arthritis Foundation Walk With Ease program teaches strategies to make physical activity part of everyday life
- Self managed or 6 week group program
- Assessing starting point – Contract with self – walking diary – warm-up/stretch/cool down exercises – assess ending point
Evaluation Results

- Study data shows that the program:
  - Reduced pain and discomfort of arthritis
  - Increased balance, strength and walking pace
  - Built confidence in ability to be physically active
  - Improved overall health
Active Choices
What is Active Choices?

- Individualized, tailored physical activity counseling delivered by phone and mail.
- Six months of telephone coaching
- Coach guides participant to:
  - Create plan to fit lifestyle, preferences & resources
  - Develop self-management skills
    - Goal-setting, Problem solving, Build self-efficacy, Self-monitoring, Access to social support, Relapse Prevention
Active Choices

- Six-month physical activity program that helps individuals incorporate preferred physical activities in their daily lives.
- Program is individualized for each person.
- Staff or volunteers are trained to provide regular, brief **telephone-based** guidance and support, and mail follow-up is delivered to participants’ homes.
- More information: [www.ceaw.org](http://www.ceaw.org)
Translational Research Outcomes

- 2503 participants averaged 65.8 years
- Successfully translated across a range of real-world settings
- Study samples were substantially larger, more ethnically and economically diverse, and more representative of older adult’s health conditions than in original efficacy studies
- Significant increases found:
  - moderate- to vigorous-intensity physical activity
  - total physical activity
  - satisfaction with body appearance and function
  - decreases in BMI

Implementation Study (Wilcox et al, 2008)
The National Diabetes Prevention Program
Target Audience: Who Will Participate in the Lifestyle Change Program?

Overweight Adults:
- Limited to persons 18 years and older with a BMI of 24 or greater (Asian Americans: 22 or greater)

AND ALSO HAVE

Pre-diabetes:
- 50% of participants must have pre-diabetes diagnosed through blood test (FPG, OGTT, HbA1c) OR history of gestational diabetes.

- Other 50% eligible if screen positive for pre-diabetes based on National Diabetes Prevention Program Risk Test
Results of Translational Research so far...

- Similar levels of weight-loss were achieved
  - Delivered in community-based sites
  - Delivered in small groups
  - Delivered by a trained Lifestyle Coach
  - Eliminated participant incentives

For more information on published translational research:

- Deploy Research Study
- Special Diabetes Program for American Indians Diabetes Prevention Demonstration Project
- Montana Diabetes Prevention Program
- I CAN Prevent Diabetes Sites in Minnesota
- YMCA-led classes with DPCA
Recent Study

- Meta-analysis of 28 translational studies
- Average 4% weight loss at 12 months
- Change in weight similar regardless of delivery by trained professionals or lay persons
- With every additional lifestyle session
- attended, weight loss increased by 0.26 percentage point
Putting It Into Practice
National Influence and Emphasis

- The Patient Protection and Affordable Care Act
- Realigning systems from acute to chronic care
- Broader emphasis on prevention and chronic care management
- Support for screenings and other prevention efforts
- Reduction in avoidable readmissions
Reaching Health Care Providers

- Academic detailing
- Patient-centered medical homes
- Chronic care model
- Mailing lists
- Continuing education
- Program champions
- Health systems
1,2,3 Approach to Provider Outreach

- Developed by the CDC Arthritis Program
- Contains:
  - Marketing Guide
  - Customizable Marketing Materials
  - Marketing Tools
  - Evaluation Tools
- [http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/index.html](http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/index.html)
The 1.2.3 Approach to Provider Outreach

Marketing Chronic Disease Interventions to Primary Care Practices

The 1-2-3 Approach to Provider Outreach is a guide for using direct-to-provider outreach to market arthritis self-management education and physical activity interventions. Learn about the rationale behind this method and find out what tools and tips are available on this Web site to guide your marketing team. More...

Customizable Marketing Materials

Download templates that you can customize with local information. Prepare the materials that marketers will leave behind with providers following an outreach visit.

- Provider fact sheet template: An Overview- [PDF - 7MB]
- Follow-up card templates - [PDF - 865KB]
- Poster [PDF - 4MB]

More marketing materials, including intervention-specific fact sheets for providers.

Marketing Tools

Find tools to help you at each step of the outreach process. Download scripts, spreadsheets, and other templates to help you plan and prepare, train marketers, conduct outreach visits, and track your progress.

- Provider outreach tracking spreadsheet - [XLS - 261KB]
- Phone call and outreach visit scripts - [PDF - 567KB]
- PowerPoint slides - [PPT - 3MB] - or - PDF version [PDF - 568KB]

See what happens in a typical outreach visit. Watch the video and get tips for making an effective pitch to providers and office staff.

Download Entire Marketing Guide - [PDF - 10MB].

The 1-2-3 Approach to Provider Outreach: Marketing Chronic Disease Interventions to Primary Care Practices is a complete guide to the entire outreach process, from planning to evaluation.
Drivers for Success

- Interventions responding to prevention/screening/readmission reduction
- Preparation of a workforce to deliver and sustain these interventions
- Prepared patients activated to engage in their care AND able to access self-management supports from the community and health care system
Creating Value in Your Programs
Developing a Value Proposition Statement

- WHY should WE be CONCERNED about a VALUE PROPOSITION?
- WHAT is a Value Proposition?
- WHAT is Our Strategy?
Framework for Value Creation: 
*Not-for-profit and Public Sector Organizations*

Our Mission

**Fiduciary Perspective:**
If we succeed, how will we look to our funders?

**Internal Perspective:**
To satisfy our funders and customers, which business processes must we excel at?

**Customer Perspective:**
To achieve our vision, how must we look to our customers?

**Learning and Growth Perspective:**
To achieve our vision, how must the org learn and improve?
Definition For Our Use

A clear, compelling and credible **expression** of the **experience** that a customer will receive from a supplier’s measurably **value-creating offering**.

*(Barnes et al.)*
Value Proposition Process: A Peek Inside

1. Market: specific group of customers you are targeting

2. Value Experience: benefits minus cost, as perceived by customers

3. Offerings: The product/service mix you are selling

4. Benefits: How offering delivers clear customer value

5. Alternatives & Differentiation: How you are different from and better than the alternative

6. Proof: substantiated credibility and believability of your offering

Barnes et al.
The Value Proposition Is...

• About customers, but for your organization;
• Not addressed to customers but meant to drive these communications;
• Articulates the essence of a business, defining exactly what the organization intends to fully make happen in the customer’s life.

(Lanning, 1998)
What Do They VALUE?

- Evidence-based
- Health Improvements
- Self Management Support Opportunities
- Customer Satisfaction
- Turn Key Programs
Evidence Based Programs

- Proven results
- Structured delivery
- Works with intended audience
- Developed materials
The systematic provision of education and supportive interventions by healthcare or other providers to strengthen patients’ skills and confidence in managing their health problems; includes regular assessment of progress and problems, goal setting, and problem solving support.

http://www.cdc.gov/arthritis/docs/oaagenda.pdf
Helpful SMS Resource

CDC Arthritis

Encourage Participation in Self-Management Programs

Chronic Disease Workshops Help Your Patients Manage Their Disease

Every day, you see the toll of chronic disease on people’s lives—the pain, the restrictions, and the emotional stress, which can compromise the quality of life. These workshops are designed to increase awareness and understanding of chronic disease prevention through on-demand training for basic skills change like increasing physical activity, improving nutrition, and reducing stress. Workshop participants will learn specific strategies for managing their condition, such as managing pain and disability, improving physical function, and interacting with healthcare providers. They will also receive information on how to prevent future episodes of the illness.

My Self-management is Important

Myths about self-management are common, but they can be dispelled with accurate information. A recent study found that people who self-manage their chronic conditions have better health outcomes than those who do not. The study also found that people who self-manage their chronic conditions are more likely to report improvements in their physical and mental health.

Low-Cost Intervention That Complements Clinical Treatment

Evidence-based, self-management education programs have been proven to significantly help people with chronic diseases. Together, with your clinical care, these programs reach patients who need emotional and social support, but who might not otherwise seek care. Participants learn effective skills in self-management, and they benefit from increased self-efficacy and reduced healthcare costs.

Proven Self-Management Programs That Can Make a Difference to Your Patients

Two research studies, each involving the use of self-management programs, found that the programs significantly improved patients’ health outcomes. In one study, the program participants reported a 30% reduction in hospitalizations, and a 40% reduction in the number of visits to the emergency department. In the other study, the program participants reported a 25% reduction in the number of doctor visits, and a 30% reduction in the number of hospitalizations.


CDC Diabetes

Diabetes Prevention Program Research Study Overview

The Diabetes Prevention Program (DPP), also called the National Diabetes Prevention Program, is an evidence-based program that helps people who are at high risk for diabetes to prevent or delay the onset of the disease. The program includes six monthly group classes, where participants learn about healthy eating, physical activity, and stress management. Participants also receive ongoing support from their healthcare provider and a network of other people who are interested in preventing diabetes.

Do This Page

- Diabetes Prevention Program Study Research
- Resources Available in Spanish
- Frequently Asked Questions
- Physical Activity Calculator
- Quick Diet Tips
-National Diabetes Prevention Program

Explore the Site

- About the Program
- Program Overview
- Lifestyle Change Tips
- Resources
- National Diabetes Prevention Program Research Study Overview

http://www.cdc.gov/diabetes/prevention/resources.htm#overview
Cost implications of self-management education intervention programmes in arthritis

Teresa J. Brady*

Arthritis Program, Centers for Disease Control and Prevention, 4770 Buford Hwy, NE, MS K-51, Atlanta, GA 30341, USA

Keywords:
Cost-effectiveness analyses
Self-management education
Self-management support
Arthritis Self-Management Program
Chronic Disease Self-Management Program

The purpose of this review is to examine cost implications, including cost-effectiveness analyses, cost-savings calculated from health-care utilisation and intervention delivery costs of arthritis-related self-management education (SME) interventions.

Methods: Literature searches, covering 1980–March 2012, using arthritis, self-management and cost-related terms, identified 487 articles; abstracts were reviewed to identify those with cost information.

Results: Three formal cost-effectiveness analyses emerged; results were equivocal but analyses done from the societal perspective, including out-of-pocket and other indirect costs, were more promising. Eight studies of individual, group and telephone-delivered SME calculated cost-savings based on health-care utilisation changes. These studies had variable results but the cost-savings extrapolation methods are questionable. Meta-analyses of health-care utilisation changes in two specific SME interventions demonstrated only one significant result at 6 months, which did not persist at 12 months. Eleven studies reported intervention delivery costs ranging from $35 to $740 per participant; the variability is likely due to costing methods and differences in delivery mode.

Conclusions: Economic analysis in arthritis-related SME is in its infancy; more robust economic evaluations are required to reach...
Customer Satisfaction
Turn Key

- Standardized Programs
- Trained Workforce
- Technical Assistance Support
- Low Start Up Cost
- Networked Infrastructure
Thoughts on Program Sustainability
Delivery System

- Delivery System
- Resources
- Site #1
- Site #2
- Site #3
Sustainability Problems

- Less attention has been paid to what happens to programs after implementation.
- Maintaining effective public health programs once they are implemented is challenging.
- Public health programs can only deliver benefits if they are allowed to achieve a level of maturity.
Introducing the Sustainability Framework

Capacity for Sustainability

“The ability to maintain programming and its benefits over time.”
8 Sustainability Domains

- Political Support (Environmental Support)
- Funding Stability
- Partnerships
- Organizational Capacity
- Program Evaluation
- Program Adaptation
- Communications
- Strategic Planning
Subscale Definition and Items: *Partnerships*

*Cultivating connections between your program and stakeholders*

1. Diverse community organizations are invested in the success of the program.
2. The program communicates with community leaders.
3. Community leaders are involved with the program.
4. Community members are passionately committed to the program.
5. The community is engaged in the development of program goals.
Results

- Ability to capture the distinct elements of program sustainability
- Easy to use by design in a wide variety of settings both public health and social service
- Paper or online versions: www.sustaintool.org
- 3-part sustainability planning process
A 3-Part Process

- Prepare and Assess Your Program
- Develop an Action Plan
- Take Action

www.sustaintool.org
Workforce Development

- Consider capacity to meet program needs
- Health professionals, program staff and volunteers
- Workforce includes multiple roles
  - Coordination, delivery, data collection/management, etc.
- Training is only the beginning
- Workforce must be held accountable to program quality standards
Referral Networks

- Important for sustainability
- Include Multiple sources: Local Coalition
- Consider Marketing needs and Marketing Venues
- Develop a Market niche
Marketing

- Use NYSDOH materials
- QTAC
- Use of local media
- Radio
- Church bulletins
- Engage support of local respected leaders:
  - Formal
  - Informal
Program Quality

An Important Component of Sustainability
Quality and Fidelity: Believing in Program/Treatment Fidelity

.....If an otherwise effective therapy is brought to a real-world setting and crucial core elements of the intervention are omitted, the treatment may be abandoned because it failed to provide results.

A *Type III error* - *the mistake of concluding an intervention is ineffective when it was not implemented in full* (Basch, Sliepcevich, Gold, Duncan, & Kolbe, 1985; Glasgow, 2002)....
Quality assurance - assuring that activities that require good quality in delivery are being performed effectively.

“Good quality” is established through comparison with an external standard.

Quality Improvement - raising the quality of program delivery.

“Improvement” is established primarily by comparing current performance with past performance with a goal of better attaining the “Quality Assurance” set standard.
Evaluation
Measures and Methods for Quality and Fidelity

- Checklists/Rating scales to objectively quantify accuracy in delivery
- Manuals, training, supervision & observation protocols to standardize QA/QI activities
- Consultation to determine
  - 1) core “non-negotiable” elements and
  - 2) appropriateness of local adaptations
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
Delivery and Execution

- Marketing (Mass, targeted, media)
- Referral process (who makes, who manages)
- Establishing classes (location, timing, leaders)
- Data collection and reporting requirements
Finding Funds/Resources

- What are foundations looking for in projects?
- What other grant funding sources are possible?
- What is the fit for NYSDOH and NYSOFA funding?
- What new funding streams are out there: Healthy Aging/Health Communities, ACOs, Medicare, PCMH, HCRA, reducing re-admissions,....
- Role of Article 6 funding
Right sizing and leverage

- Building a level of delivery that is possible and sustainable

- Building a level of delivery sufficiently robust to leverage referrals and resources
Key Things to Consider

- QTAC and linkages to community partners
- Alignment with Prevention Agenda Team
  Exercise: Finding partners rather than self-delivery
- QTAC - mechanism for coordination with NYSDOH and NYSOFA
- Sustainability: Article 6 funds may support outreach and program promotion, not delivery
Data Collection and Management
QTAC Partner Portal Overview

- Registration system for self-referral and provider referral
- Project management tool
- Project data tool
- Data reporting/sharing
- Continuous Quality Improvement
Data Collection Opportunities

- Linkage to QTAC portal
- Project management AND data management
- Preparing for reimbursement and Electronic Health Records
- Giving credibility to community-clinical linkages
Find a Workshop

Search here to find and enroll in evidence-based health and wellness workshops being offered all over New York State. Enter your zip code, find the workshop for you and register online!

Enter Your Zip Code: [ ] Search Workshops

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Our Location

Center for Excellence in Aging & Community Wellness
University at Albany
School of Social Welfare
135 Western Avenue, Albany, NY 12222

Contact Us

Phone: (877) 496-2780
Email: ceacw@albany.edu

Shortcuts

NYS QTAC
Healthy Hearts on the Hill
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<td>10</td>
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<td>Aug 7, 2013</td>
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<td>NDPP - 314-0138</td>
<td>CDPHP</td>
<td>16</td>
<td>In Progress</td>
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<td>CDSMP - 216-0139</td>
<td>Access to Independence</td>
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<td>CDSMP - 611-0140</td>
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<td>CDSMP - 611-0143</td>
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<td>8</td>
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<td>May 22, 2013</td>
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<td>CDSMP - 511-0144</td>
<td>Kingston Family Practice</td>
<td>7</td>
<td>Completed</td>
<td>Jun 4, 2013</td>
<td>Show, Edit, Delete</td>
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</tbody>
</table>
Data Collection

Data Sources:

- Participant information survey
- Satisfaction survey
- Program specific – WWE, ALED, CDSMP+
- Randomized 6-month follow-up
Resources/Tools

www.ceacw.org

NYS Quality & Technical Assistance Center

Promoting evidence-based health and wellness and disease prevention programs throughout New York State.

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NYS Diabetes Prevention Program
Thank You

- http://www.nyspreventschronicdisease.com

- Public Health Live is 3/20 at 9am.
Comprehensive School Physical Activity Programs: Enhancing Student Health and Academic Performance
  - Register now:
    http://www.albany.edu/sph/cphce/phl_0314.shtml