Preventing and Controlling Chronic Disease in Wisconsin

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Presentation Outline

• Impact of Chronic Disease
• Population Health Approach
• Keys to Success
• Strategies for Improvement
Chronic Disease

• Chronic diseases are illnesses that persist for a long time or last at least three months. Chronic diseases are rarely cured and often are progressive, resulting in disability later in life.

• Chronic diseases, such as heart disease, stroke, cancer, diabetes, asthma and arthritis, are among the most common and costly of all health problems in the United States; however, they are also among the most preventable.

• Four modifiable health risk behaviors are responsible for much of the illness, suffering and early death related to chronic diseases: (1) unhealthy diet, (2) insufficient physical activity, (3) tobacco use and secondhand smoke exposure, and (4) excessive alcohol consumption.
Percentage of coronary heart disease deaths under the age of 75, by race and ethnicity and sex, Wisconsin, 2006–2010

Source: Wisconsin Interactive Statistics on Health (WISH), Wisconsin resident death certificates.
Estimated prevalence of diabetes among Wisconsin adults, age-adjusted percentage, by county, 2008–2010

Estimated prevalence of diabetes

Statewide = 10.1%

- 7.0 - 8.8%
- 8.9 - 9.2%
- 9.3 - 9.8%
- 9.9 - 10.6%
- 10.7 - 36.1%


*Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.

Medical Complications of Obesity

Source: Adapted from Yale University Rudd Center for Food Policy and Obesity
http://www.cdc.gov/vitalsigns/adultobesity/
Chronic Disease Prevention and Control Outcomes

Long-term

Improve prevention and control of hypertension, diabetes, excess weight and obesity.

Short-term

- Promote and reinforce healthful behaviors and practices across the life span and settings.
- Improve quality and delivery of services for hypertension and diabetes prevention and management.
- Support lifestyle change programs and self-management and control of diabetes, hypertension and obesity.
Factors that Affect Health

- Socioeconomic Factors
  - Changing the Context to make individuals’ default decisions healthy
  - Long-lasting Protective Interventions
  - Clinical Interventions
  - Counseling & Education

Examples
- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

Source: Centers for Disease Control and Prevention
Maximizing Public Health Impact

Impact = Reach \times Exposure \times Potency

Focus on changing things that affect

Many people

With frequent exposure

In a comprehensive way

Source: National Center for Chronic Disease Prevention
Division of Population Health
Keys to Success

- Innovation
- Technical Package
- Managing Performance
- Partnerships
- Communication
- Leadership and Commitment
- Stable and Flexible Funding

Environmental Approaches to Promote Health

Nutrition

Settings: early care and education (ECE), schools, community, worksites

Access to healthy foods and beverages
  - Corner stores
  - Farmers’ Markets

Food service guidelines, including sodium

Supportive school nutrition environments
Environmental Approaches to Promote Health

Physical Activity

Settings: ECE, schools, community, worksites

Physical activity access
- Active community environments

Physical activity in ECE
- Active Early

Quality physical education and physical activity in K-12
- Active Schools
- Comprehensive School Physical Activity Program
Health System Interventions

• Promote **reporting of blood pressure and A1c** measures and promote clinical innovations

• Increase **implementation of quality improvement processes**
  - Electronic health record (EHR) adoption and use of health information technology for hypertension and diabetes
  - Monitoring of standard aggregated measures (provider and system level)

• **Increase team-based care in health systems**
  - Engagement of non-physicians (e.g., nurses, pharmacists, patient navigators) for HTN and diabetes management
  - Increase use of self-measured blood pressure tied with clinical support

*NOTE: Strategies reflect those in Million Hearts®*
Community-Clinical Linkages

- Promote **awareness** of high blood pressure and prediabetes
- Promote **participation** in Diabetes Self-Management Education (DSME)
  - Access, referrals, reimbursement
- Increase **utilization** of lifestyle programs and chronic disease self-management program in the community
- Increase **engagement** of community health workers
- Meeting the care needs of **students with chronic conditions**
Expanded Chronic Care Model

Community

- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action
- Self-Management/Develop Personal Skills
- Delivery System Design/Re-orient Health Services
- Decision Support
- Information Systems

Health System

- Productive Interactions and Relationships
  - Activated Community
  - Informed Activated Patient
  - Prepared Proactive Practice Team
  - Prepared Proactive Community Partners

Population Health Outcomes/Functional and Clinical Outcomes

National Center for Chronic Disease Prevention
Division of Population Health
Questions

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Visit our website: http://www.dhs.wisconsin.gov/health/Chronic-Disease/index.htm