



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

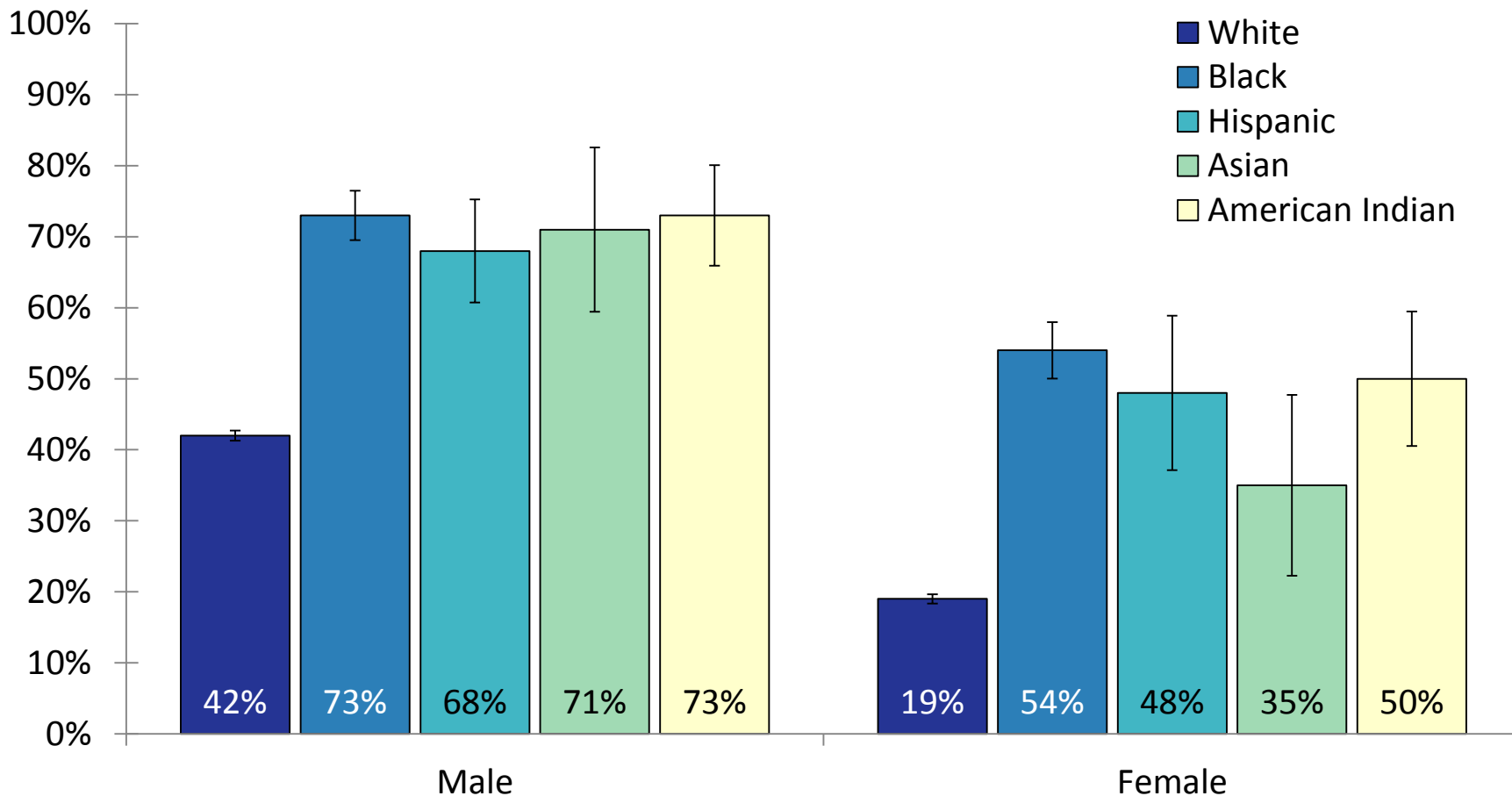


Chronic Disease

- 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



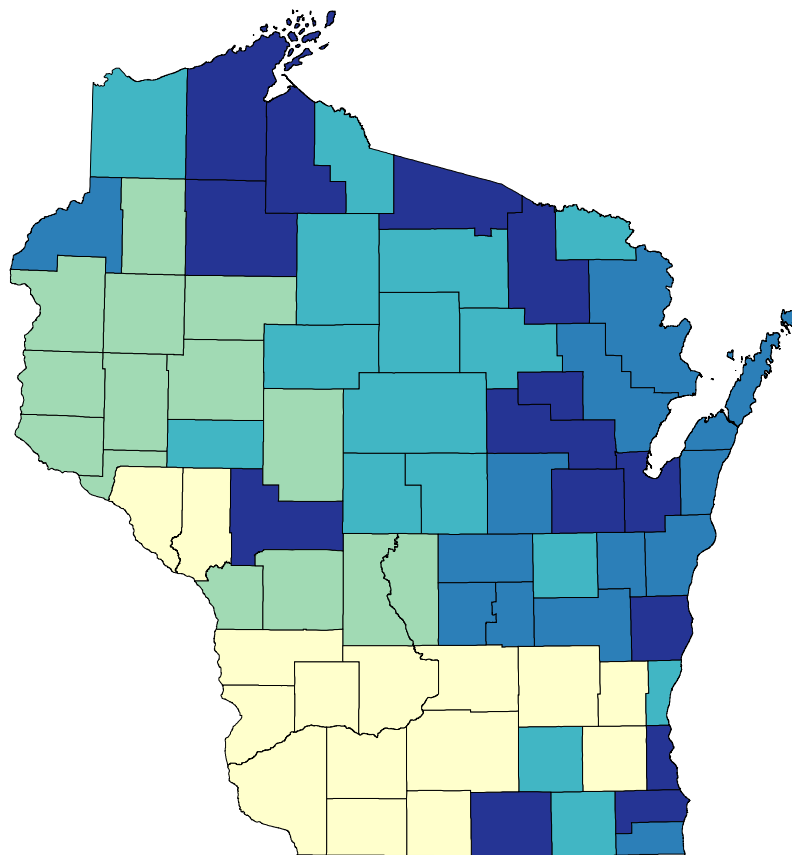
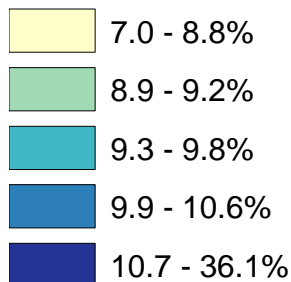
Source: Wisconsin Interactive Statistics on Health (WISH), Wisconsin resident death certificates.



Estimated prevalence of diabetes among Wisconsin adults, age-adjusted percentage, by county, 2008–2010

Estimated prevalence of diabetes

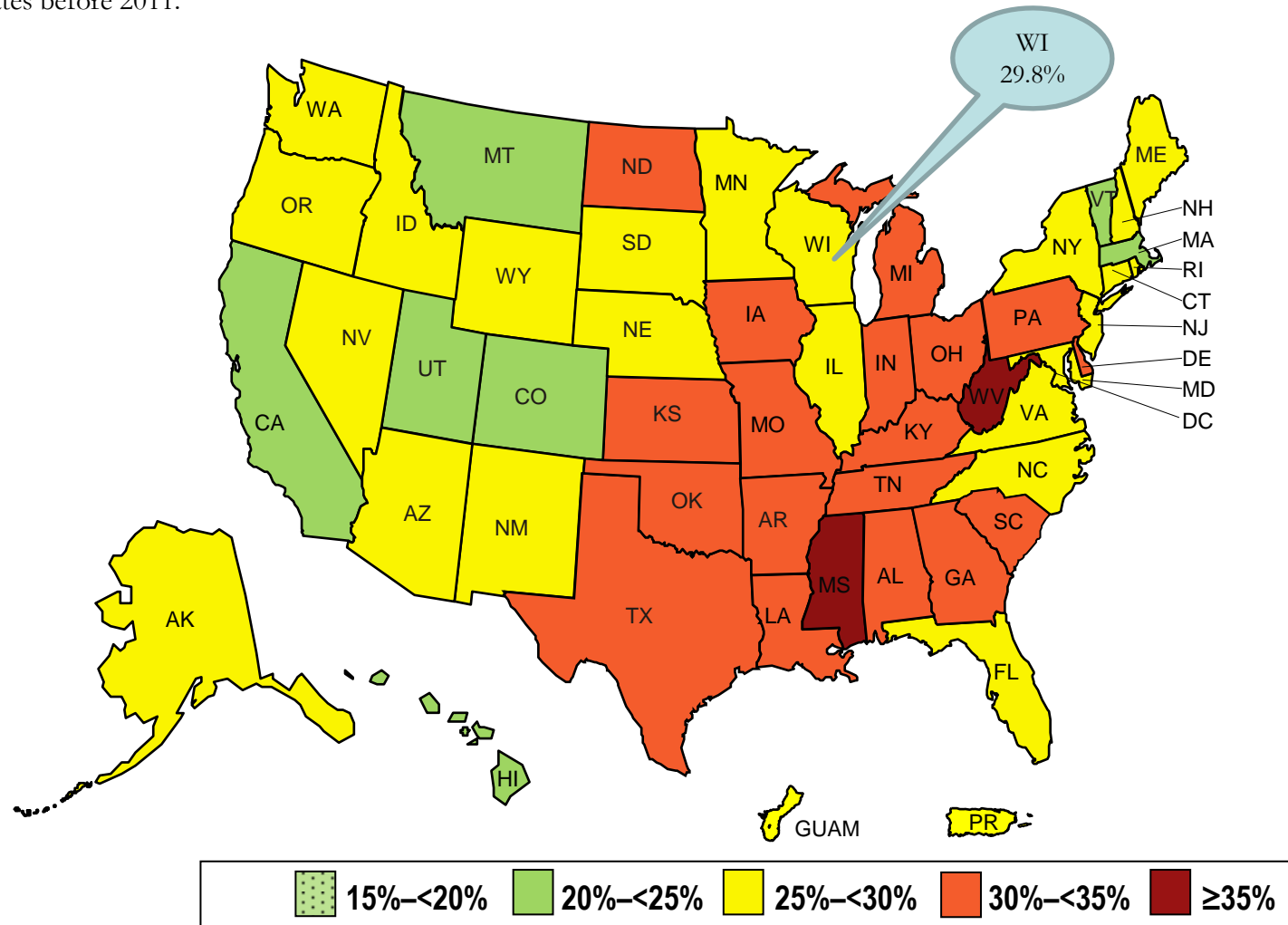
Statewide = 10.1%

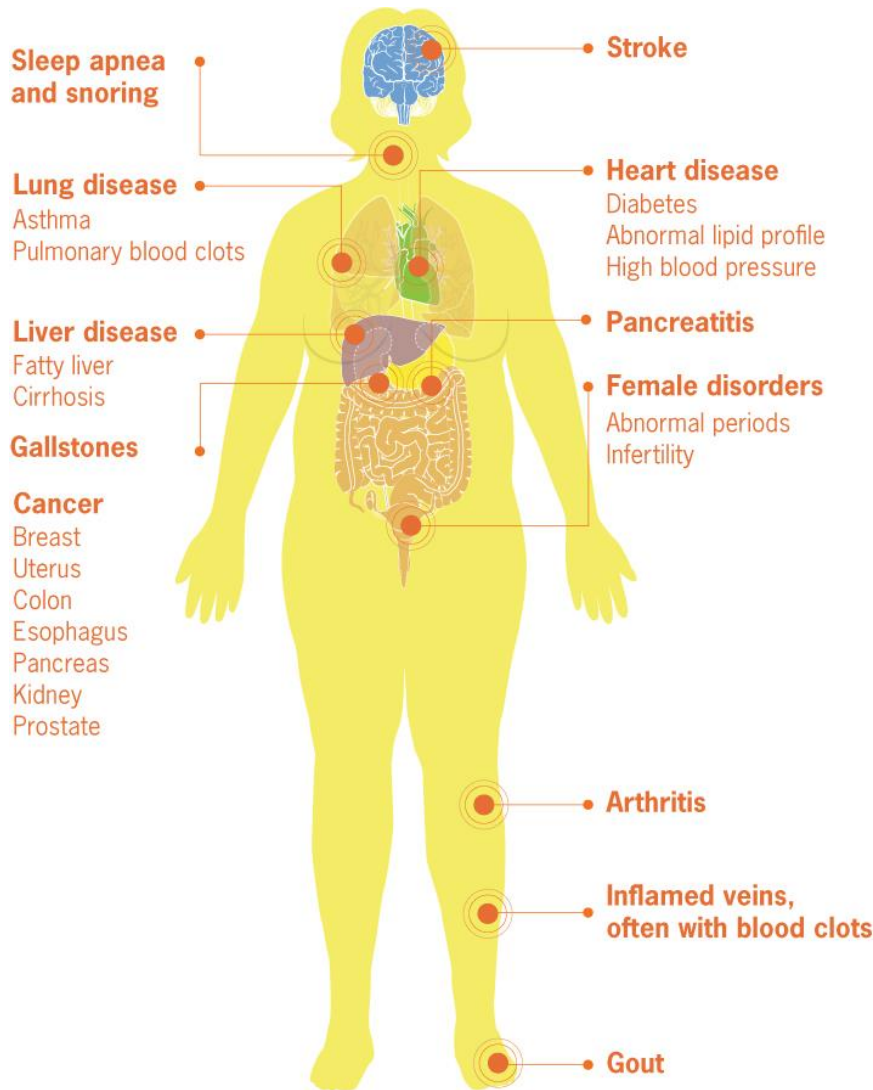


Source: Wisconsin Department of Health Services, Division of Public Health, Wisconsin Diabetes Prevention and Control Program, The 2011 Burden of Diabetes in Wisconsin.

Prevalence* of Self-Reported Obesity Among U.S. Adults by State and Territory, Behavioral Risk Factor Surveillance System, 2013

*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

Smallest
Impact

Counseling
& Education

Clinical
Interventions

Long-lasting
Protective Interventions

Changing the Context
*to make individuals' default
decisions healthy*

Socioeconomic Factors

Largest
Impact

Examples

Eat healthy, be
physically active

Rx for high blood
pressure, high
cholesterol, diabetes

Immunizations, brief
intervention, cessation
treatment, colonoscopy

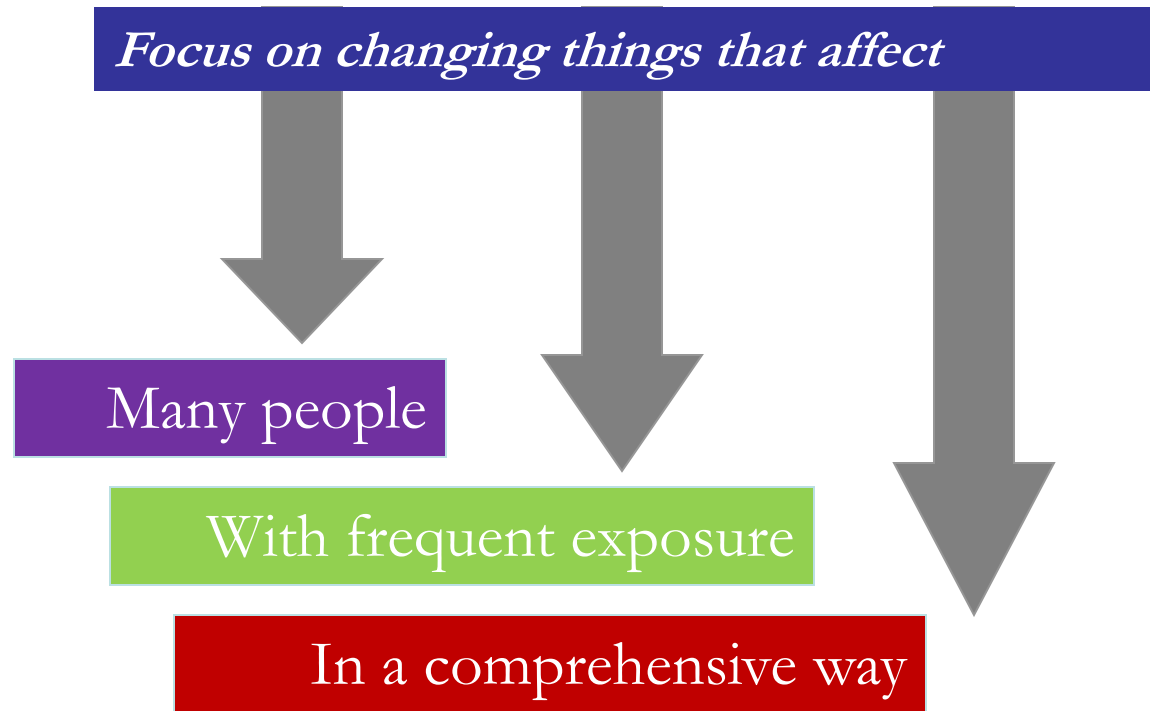
Fluoridation, 0g trans
fat, iodization, smoke-
free laws, tobacco tax

Poverty, education,
housing, inequality



Maximizing Public Health Impact

$$\text{Impact} = \text{Reach} \times \text{Exposure} \times \text{Potency}$$



Keys to Success

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



Adapted from: Frieden, T. Six Components Necessary for Effective Public Health Program Implementation. American Journal of Public Health. November 14, 2013.

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

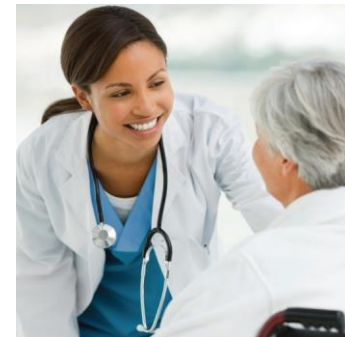
Comprehensive School Physical Activity Program



Health System Interventions

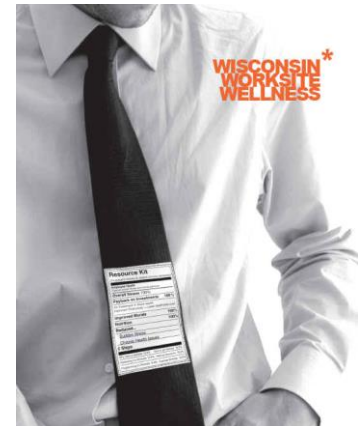
- Promote **reporting of blood pressure and A1c** measures and promote clinical innovations
- Increase **implementation of quality improvement processes**
 - **Electronic health record (EHR) adoption** and use of health information technology for hypertension and diabetes
 - **Monitoring** of standard 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®

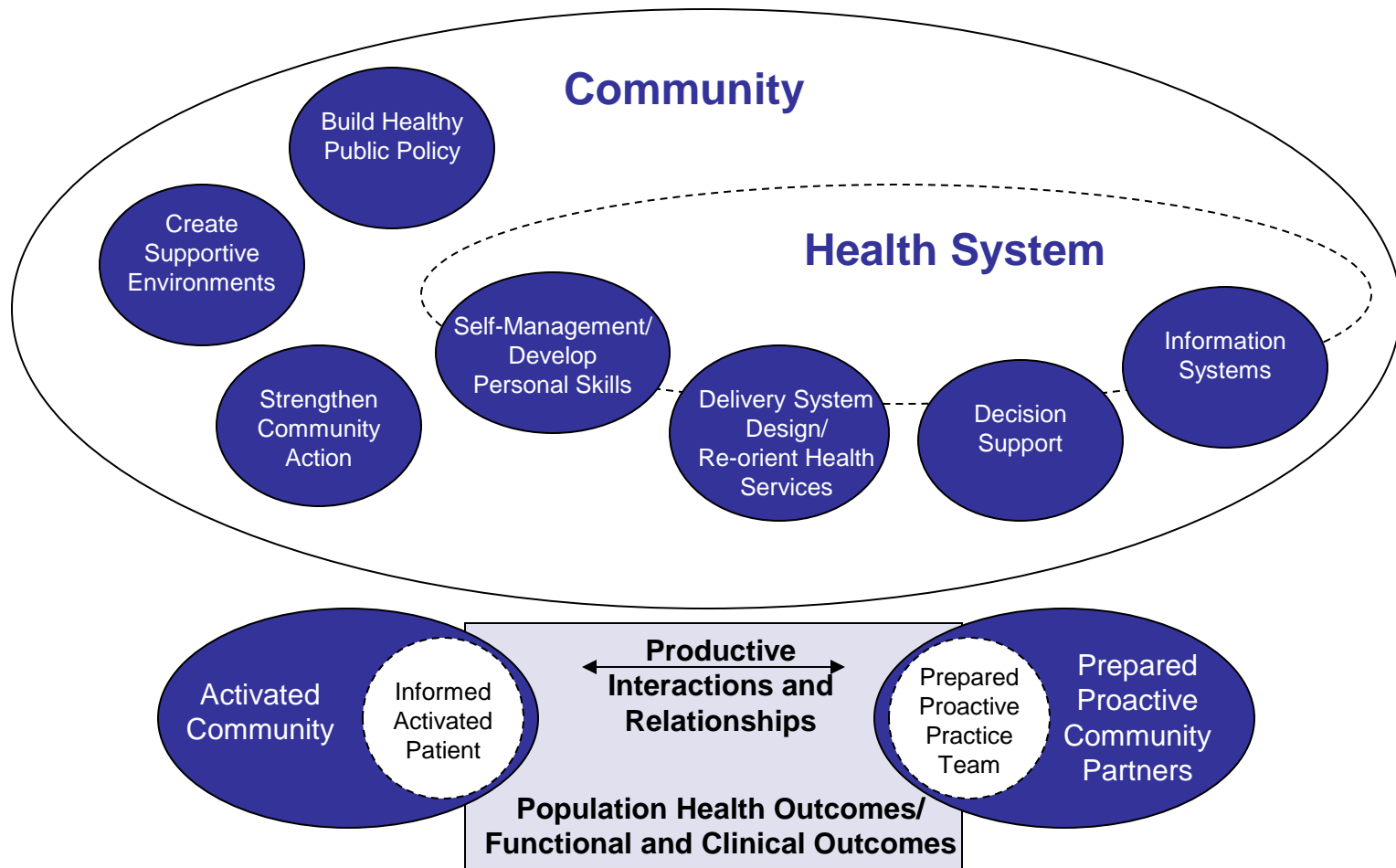


Community-Clinical Linkages

- 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





Questions

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