State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (1305)

Heart Disease & Stroke Program
Chronic Disease Prevention and Health Promotion Section
Nevada Division of Public and Behavioral Health
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The Problem

- Diseases of the heart and stroke accounted for nearly 1 out of 3 deaths in Nevada. In 2012, diseases of the heart were the leading cause of death (24.8%).[1]
- 30.8% of adult Nevadans reported to have ever had high blood pressure.[1]
- Over 13,000 Nevadans were hospitalized for coronary heart disease and stroke (primary diagnosis) in 2012.[1]
- Charges per hospital inpatient stroke case was one the highest in the nation at $66,341 statewide and $72,492 in Las Vegas Market[2]

Need to Support a Coordinated Approach to Chronic Disease

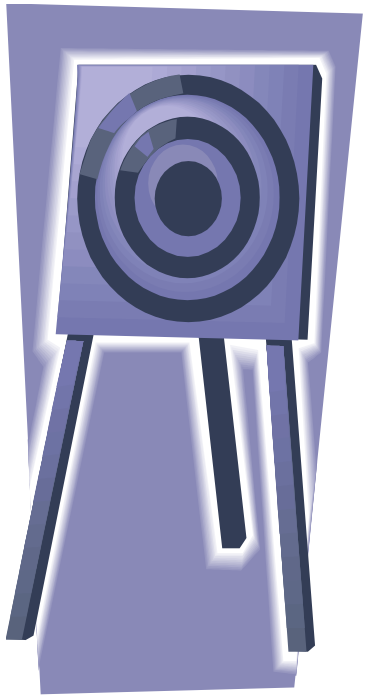
- Recognize that chronic diseases, conditions, and risk factors are interrelated and often co-occur.
- Acknowledge strategies used to address risk factors and improve public health are complimentary, and sometimes similar, across programs.
- Maximize the investment of the modest resources available relative to the chronic disease burden in the U.S

1305 Funding

- Supports statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors.
- Four chronic disease prevention programs:
  - Diabetes
  - Heart Disease and Stroke Prevention
  - Nutrition, Physical Activity, and Obesity
  - School Health
- The five-year project began on July 1, 2013.
- Two Components:
  - Basic Component (All five years)
    - Obesity Prevention and School Health Programs Coordinator
    - Diabetes & Heart Disease Prevention and Control Program Coordinator
  - Basic-Plus (Year 2)

1305 Short-term Outcomes

- Improve state, community, worksite school and early childhood environments to promote and reinforce healthful behaviors related to diabetes, cardiovascular health, physical activity, healthful foods and beverages, obesity, and breast feeding
- Improve effective delivery and use of quality clinical and other preventive services aimed at preventing and managing diabetes and hypertension
- Increase community-clinical linkages to support prevention, self-management, and control of diabetes, hypertension and obesity

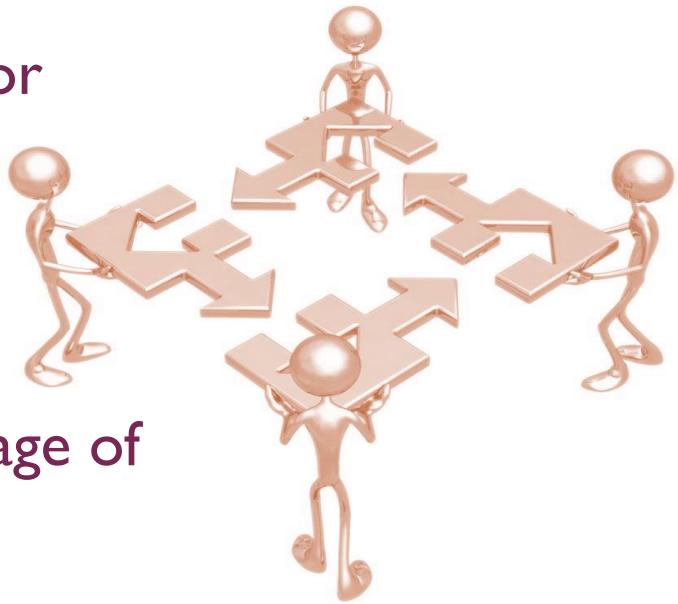


1305 Long Term Outcomes

- Improved prevention and control of hypertension
- Improved prevention and control of diabetes
- Improved prevention and control of overweight and obesity

Four Domains

1. Epidemiology, surveillance, and evaluation to inform and monitor
2. Environmental approaches that promote health
3. Health system interventions to improve access, delivery, and usage of preventive services
4. Community-clinical linkages for prevention and management of chronic diseases



Heart Disease and Stroke Prevention

Health Systems Strategies

- Promote reporting of blood pressure and A1C measures; and, as able, initiate activities that promote clinical innovations, team-based care, and self-monitoring of blood pressure
- Promote awareness of high blood pressure among patients
- Increase implementation of quality improvement processes in health systems
- Increase use of team-based care in health systems

Health System Interventions

Health System Interventions

- Increase Implementation of quality improvement processes in health systems.
  - Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance.
  - Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level.
- Increase use of team-based care in health systems
  - Increase use of self-measured-blood pressure monitoring tied with clinical support.

Current partners

- HealthInsight, Inc. – Nevada
- HealtHIE Nevada
- Nevada Health Centers
- St. Rose Dominican
- Division of Health Policy and Finance (Medicaid/Medicare)

Performance Measures

- Proportion of healthcare systems with EHRs appropriate for treating patients with high blood pressure.
- Proportion of adults with high blood pressure in adherence to medication regimens.
- Proportion of patients with high blood pressure that have a self-management plan (may include medications adherence, self-monitoring of blood pressure levels, increased consumption of nutritious foods and beverages, increased physical activity, maintaining medical appointments.)

Performance Measures

- Proportion of adults with known high blood pressure who have achieved blood pressure control.
- Proportion of healthcare systems with policies or systems to encourage patient self-management of high blood pressure.
- Proportion of patients that are in healthcare systems that have policies or systems to encourage patient self-management of high blood pressure

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References

1. *Mburia-Mwalili, A. (2014)*, Heart Disease and Stroke in Nevada, *Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services*
2. *Nevada Type 2 Diabetes Report 2013*, Managed Care Digest Services, Forte Information Resources, LLC Denver, CO