



# 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

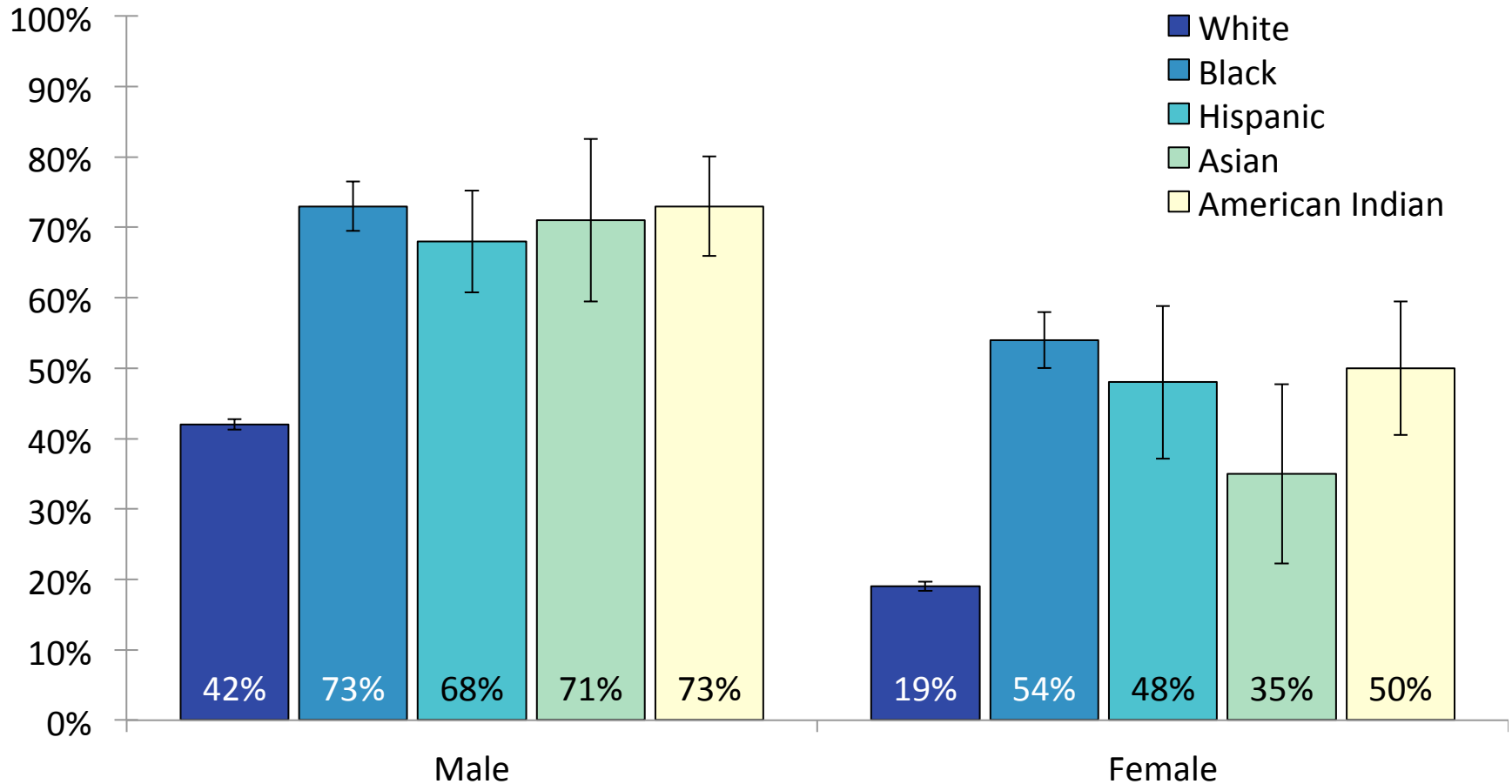


## Chronic Disease

- 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



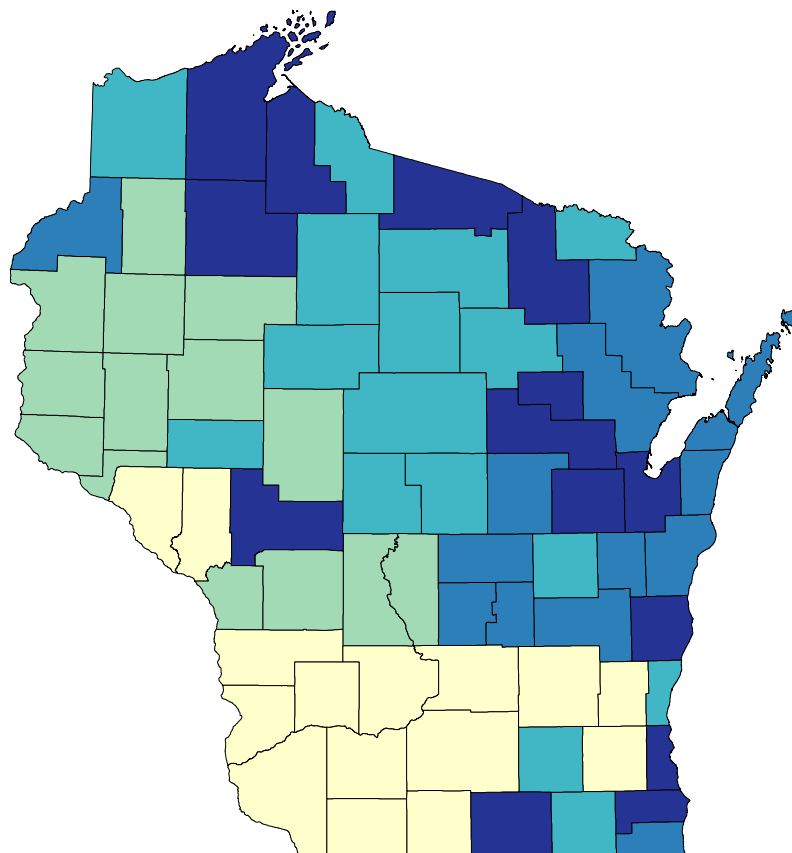
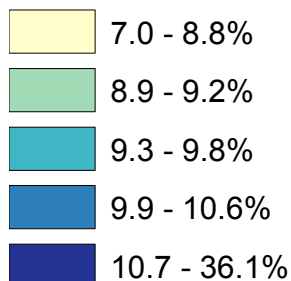
Source: Wisconsin Interactive Statistics on Health (WISH), Wisconsin resident death certificates.



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

### Estimated prevalence of diabetes

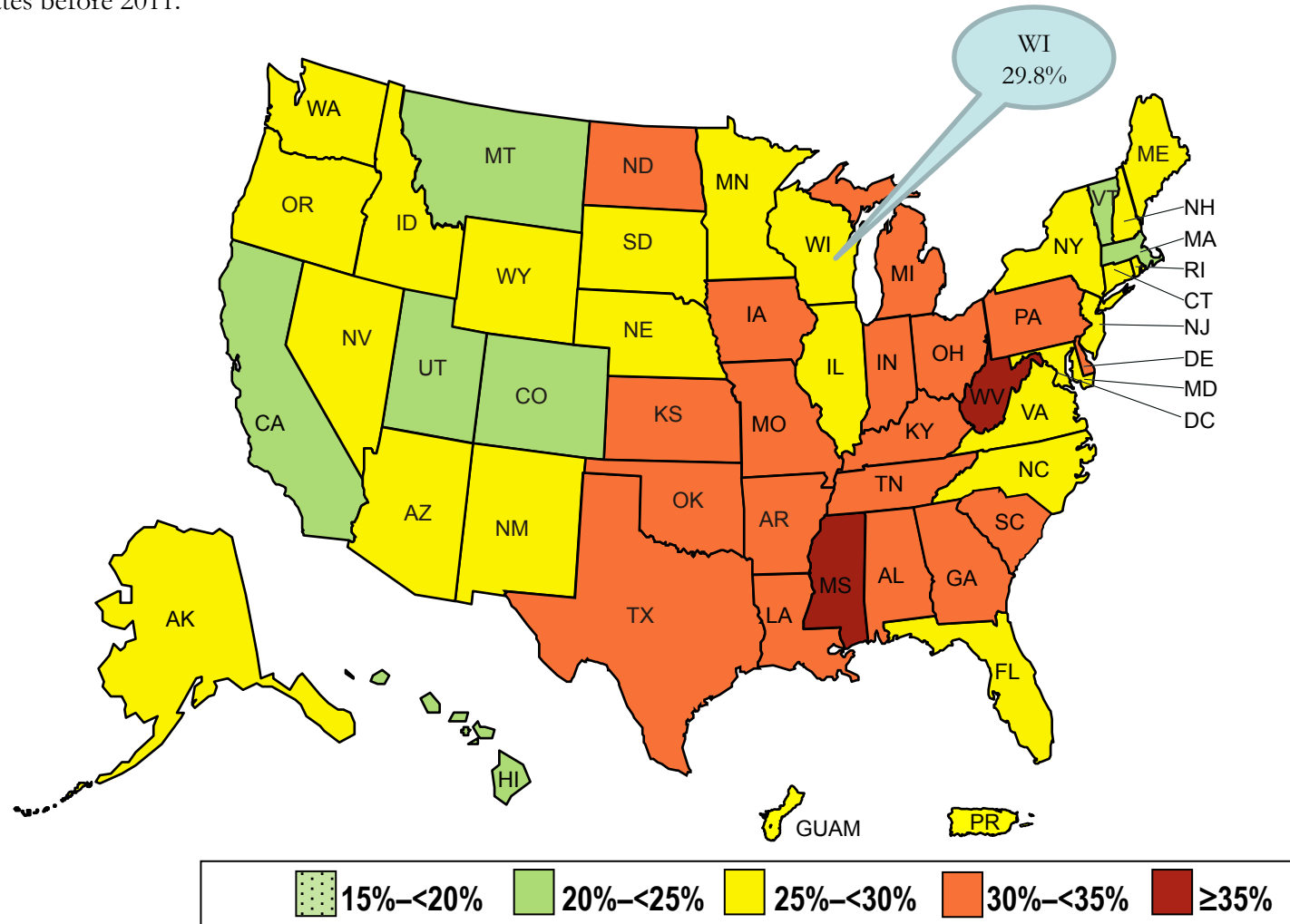
Statewide = 10.1%

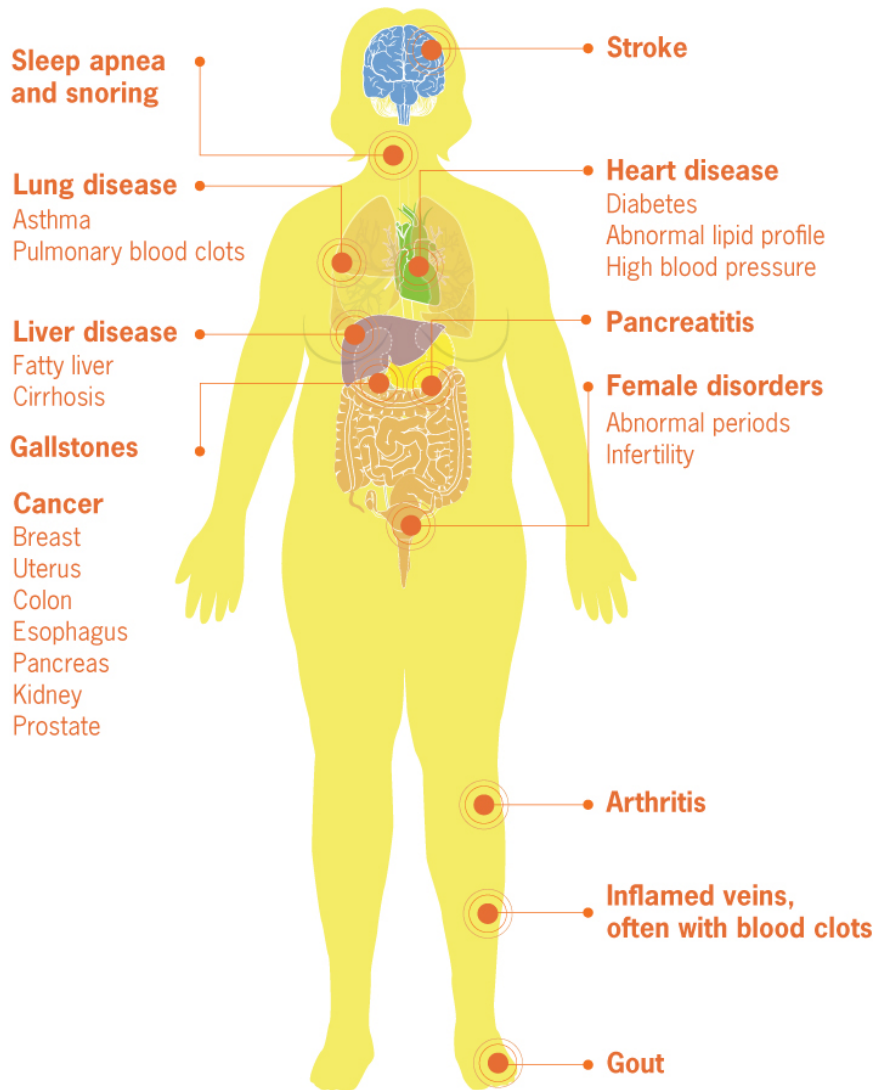


Source: Wisconsin Department of Health Services, Division of Public Health, Wisconsin Diabetes Prevention and Control Program, The 2011 Burden of Diabetes in Wisconsin.

# 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

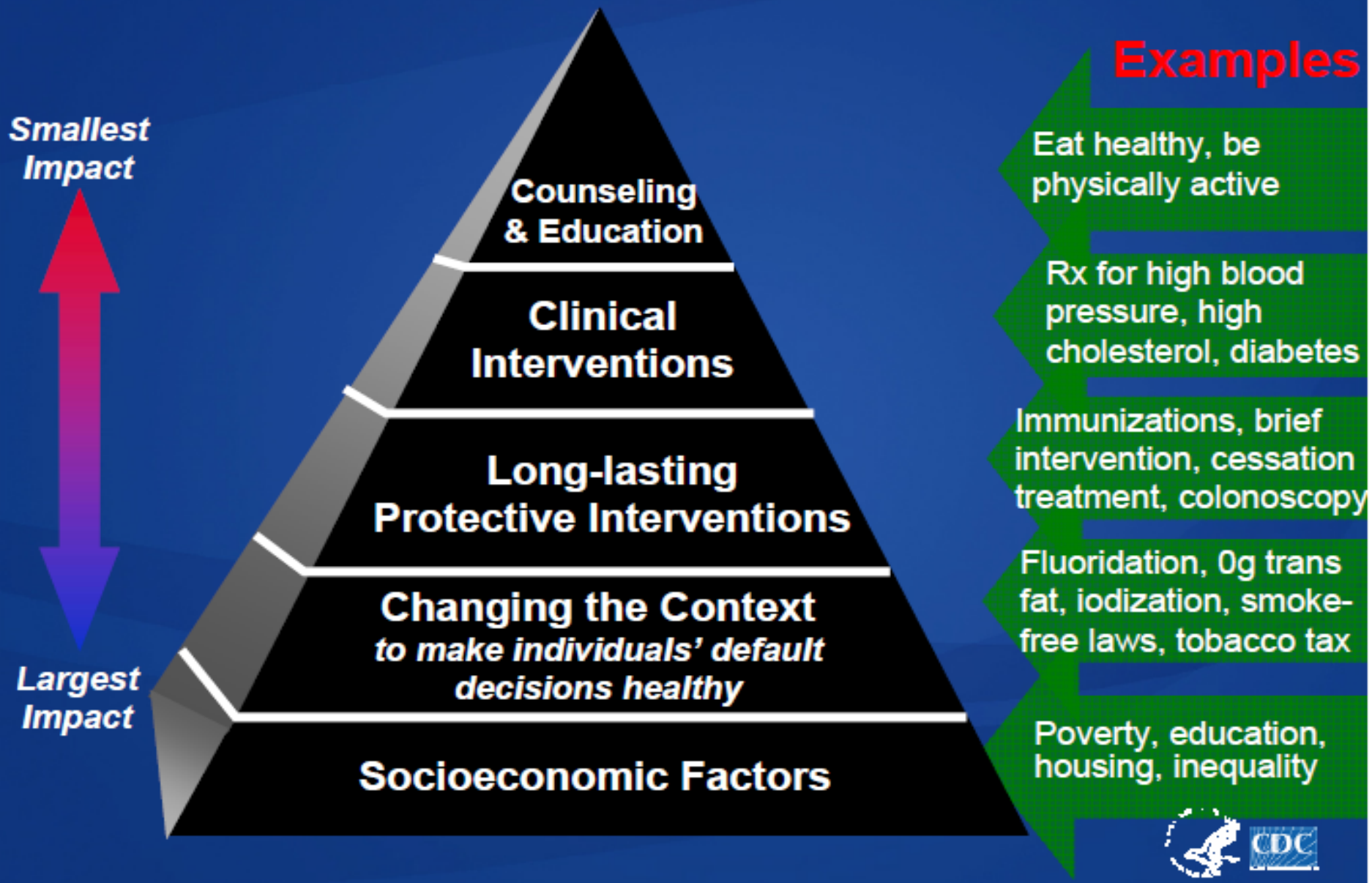
Improve prevention and control of **hypertension, diabetes, excess weight and obesity.**

### 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.

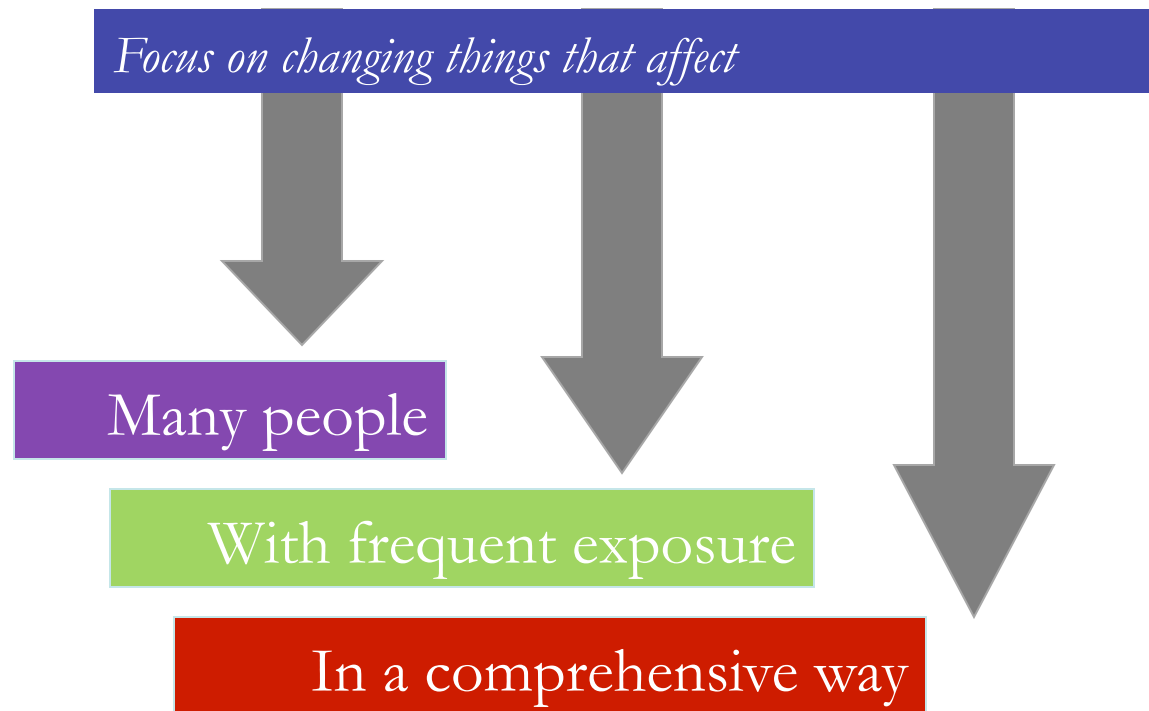


# Factors that Affect Health



# 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

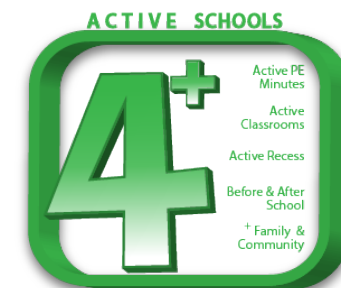
Physical activity in ECE

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<sup>®</sup>

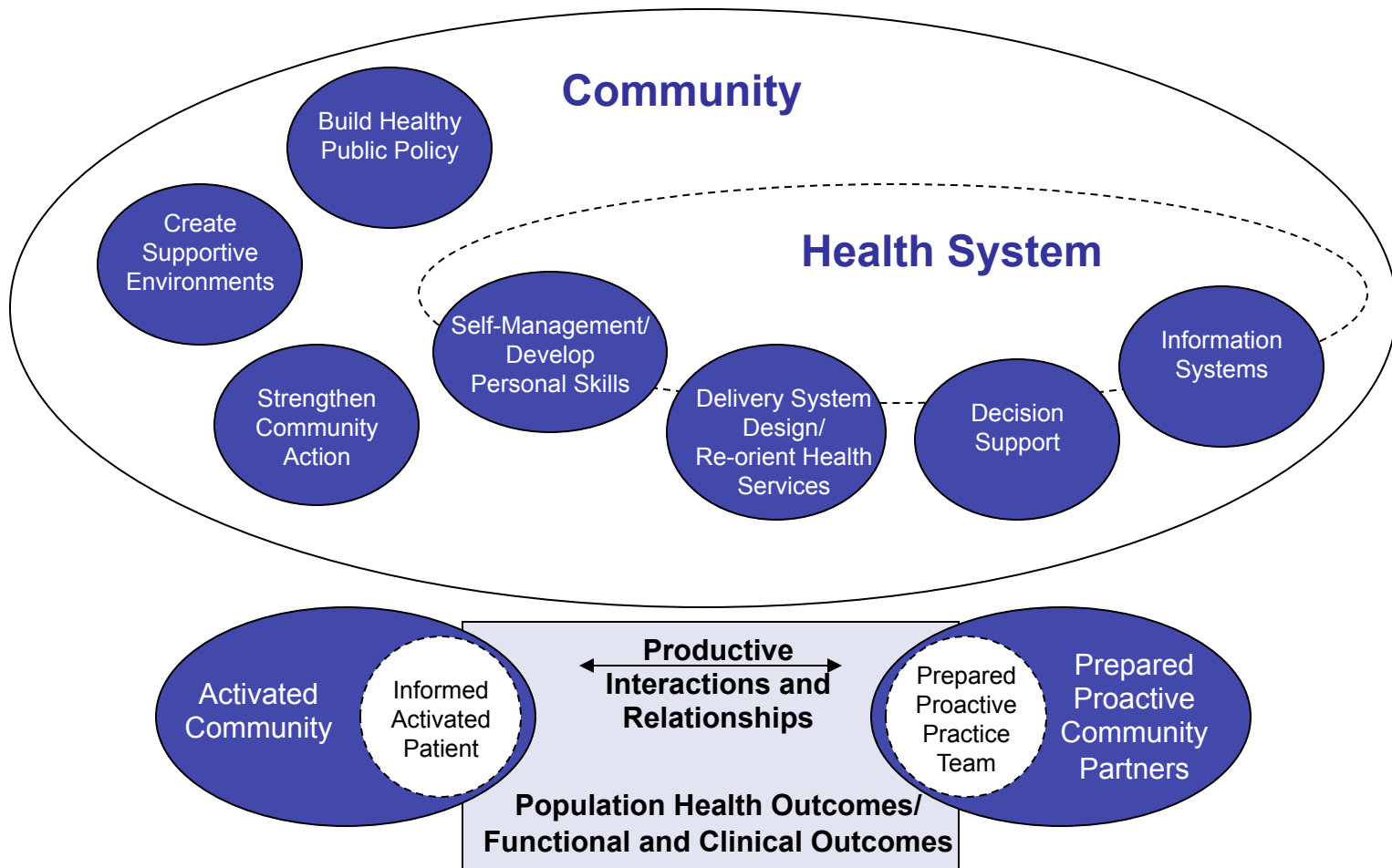


## Community-Clinical Linkages

- 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>