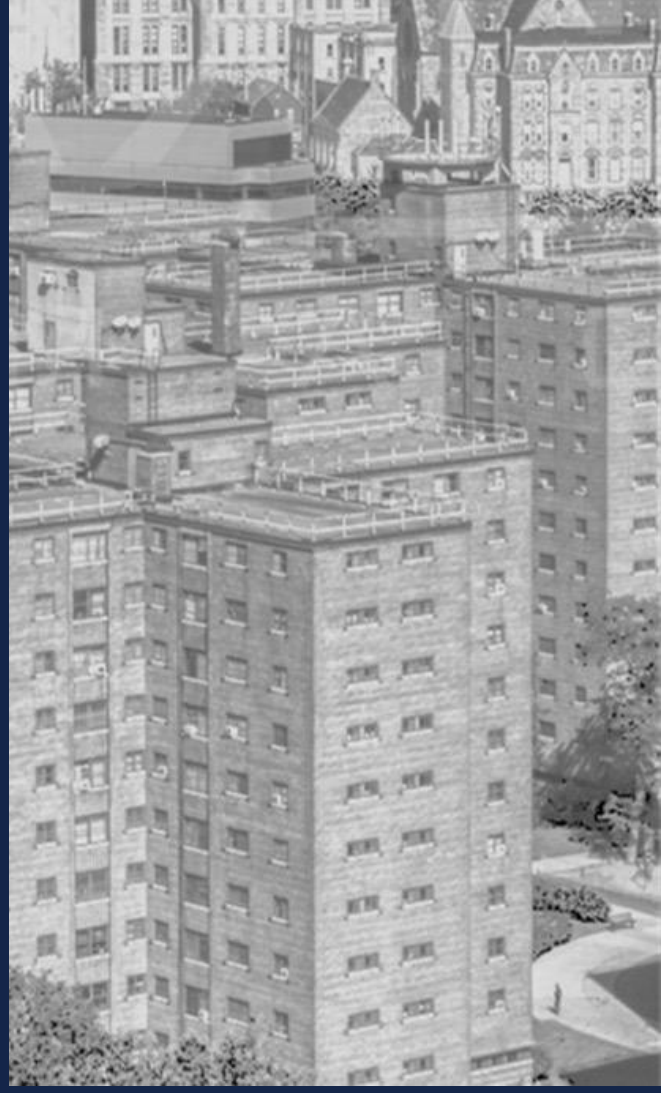
PUBLIC HEALTH DETAILING AND COALITION-BUILDING

ADDRESSING CHRONIC DISEASE DISPARITIES IN A DIVERSE, AT-RISK POPULATION



Liz Urbanski-Farrell MBA, MS
Senior Fellow, NYS Public Health Corps
Erie County Department of Health

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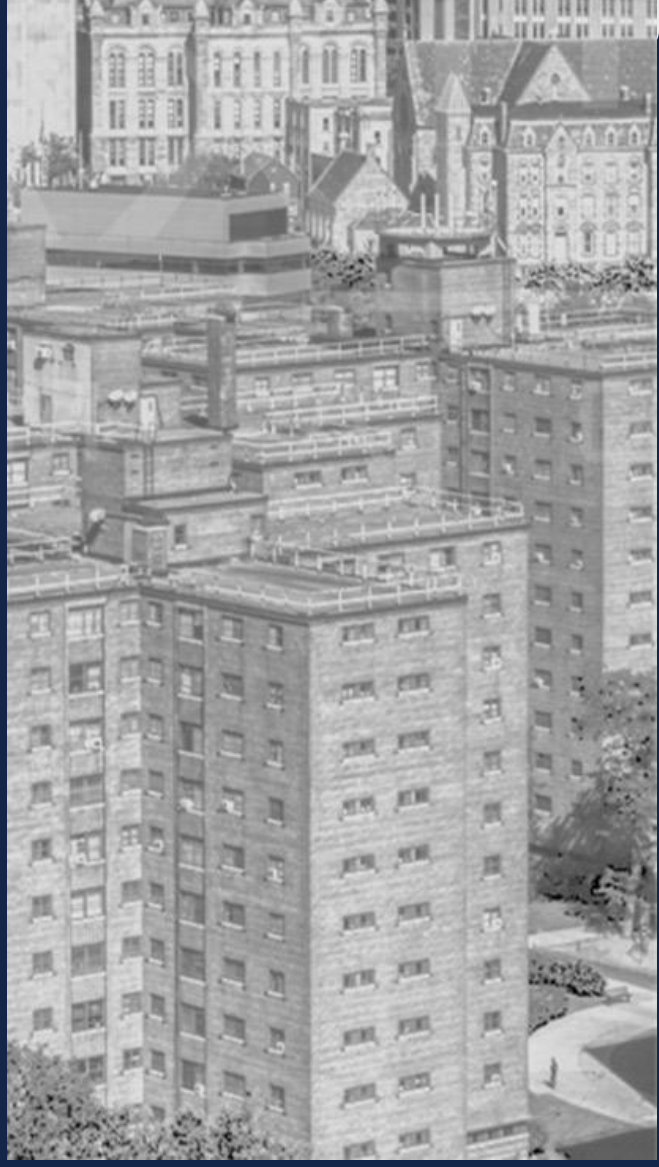
PUBLIC HEALTH DETAILING AND COALITION-BUILDING

ADDRESSING CHRONIC DISEASE DISPARITIES IN A DIVERSE, AT-RISK POPULATION



Co-Presenters

- Elijah Tyner, Staff Supervisor
  NYS Public Health Corps
  Erie County Department of Health
- Devin Hurley, Outreach Referral Manager
  Western New York Integrated Care Collaborative
- Devon Hannan, Senior Fellow
  NYS Public Health Corps
  NYS Department of Health

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NYS PUBLIC HEALTH CORPS SENIOR FELLOW

Projects And Placement:

Erie County Department Of Health

- Community Wellness (CHA)
- Office Of Health Equity (Detailing)
- Rural Outreach Center (Current)

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WHERE I WORK NOW

Rural Outreach Center: "The ROC"

https://theroc.co

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1

Describe Public Health Detailing and its use in encouraging clinical evidence-based referrals; and the process for establishing census tract-level need and disparities in context of health goals and objectives.

Understand and walk away with a template for public health detailing and links to learning resources for use of this technique.

2

Define processes for identifying specific barriers to wellness in a given population. Outline a process to develop and use partnerships to share information and action plans to address identified barriers to health and wellness in a given population.

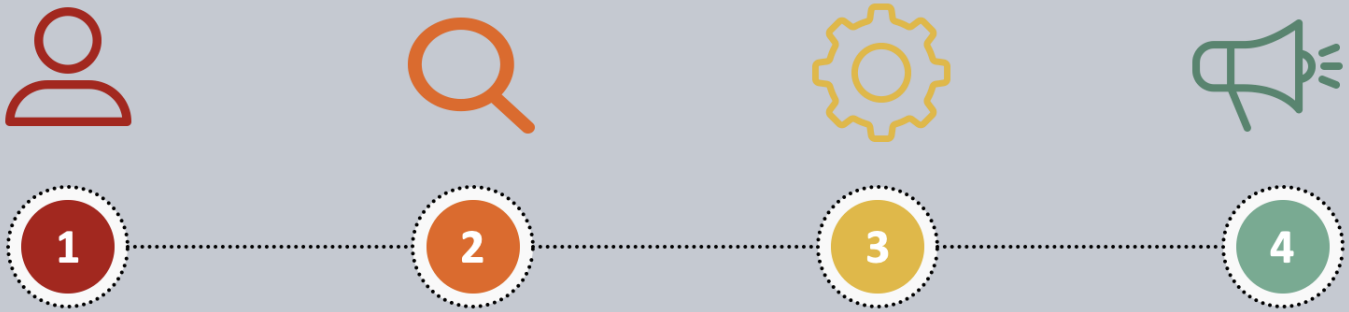
Describe and conduct effective communication feedback loops.

WHY WHAT HOW

BUILDING RELATIONSHIPS, BUILDING HEALTH

PUBLIC HEALTH DETAILING

Addressing Chronic Health Disparities in Erie County, NY



WHY= The PUBLIC HEALTH challenge

WHAT are the solutions?

HOW can you customize this approach to address health issues in your community?

GAIN and SHARE templates, tips and tricks

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Swag! Swag!

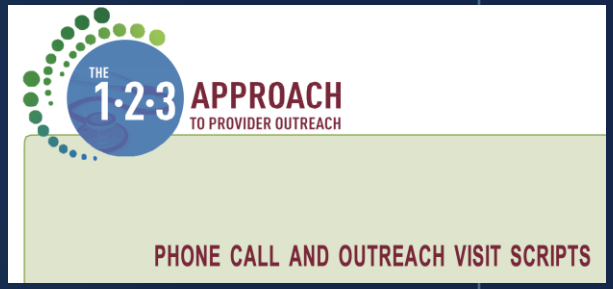
ONLINE RESOURCES to find:

TRUSTED RESEARCH

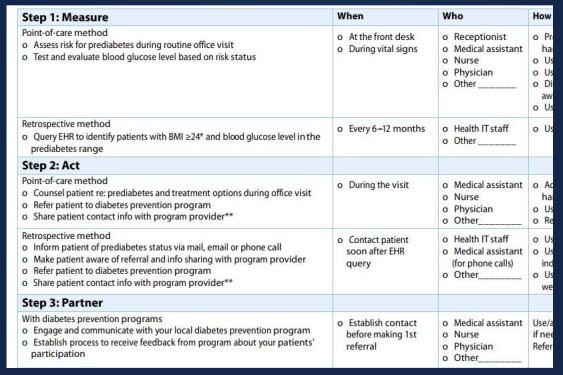
TARGET CONDITION

PUBLIC HEALTH INTERVENTIONS

CALL AND VISIT SCRIPT TEMPLATES



MEDICAL OFFICE WORKFLOW MAPPING



Step 1: Measure	When	Who	How
Point-of-care method o Assess risk for prediabetes during routine office visit o Test and evaluate blood glucose level based on risk status	o At the front desk o During vital signs	o Receptionist o Medical assistant o Nurse o Physician o Other _____	o Pr ha o Us o Us o Di aw o Us
Retrospective method o Query EHR to identify patients with BMI ≥24* and blood glucose level in the prediabetes range	o Every 6–12 months	o Health IT staff o Other _____	o Us
Step 2: Act			
Point-of-care method o Counsel patient re: prediabetes and treatment options during office visit o Refer patient to diabetes prevention program o Share patient contact info with program provider**	o During the visit	o Medical assistant o Nurse o Physician o Other_____	o Ac ha o Us o Re
Retrospective method o Inform patient of prediabetes status via mail, email or phone call o Make patient aware of referral and info sharing with program provider o Refer patient to diabetes prevention program o Share patient contact info with program provider**	o Contact patient soon after EHR query	o Health IT staff o Medical assistant (for phone calls) o Other_____	o Us o Us inc o Us we
Step 3: Partner			
With diabetes prevention programs o Engage and communicate with your local diabetes prevention program o Establish process to receive feedback from program about your patients' participation	o Establish contact before making 1st referral	o Medical assistant o Nurse o Physician o Other_____	Use/a if ne Refer

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PUBLIC HEALTH *DETAILING* ESSENTIALS

3

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PUBLIC HEALTH DETAILING

- 1 CLINICAL CHANGE
- *ONLY ONE!!*
- FOSTERS POSITIVE HEALTH DEPARTMENT RELATIONSHIPS WITH MEDICAL PROVIDERS

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PUBLIC HEALTH DETAILING

3

ROOTS IN PHARMA & DEVICE SALES

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What Public Health Detailing is NOT

What Detailing CAN BE

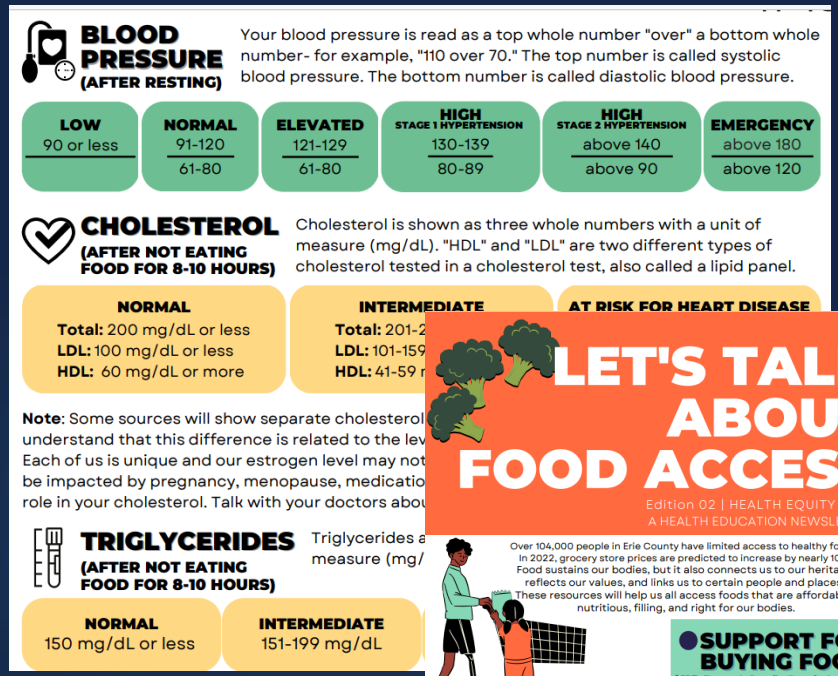
3

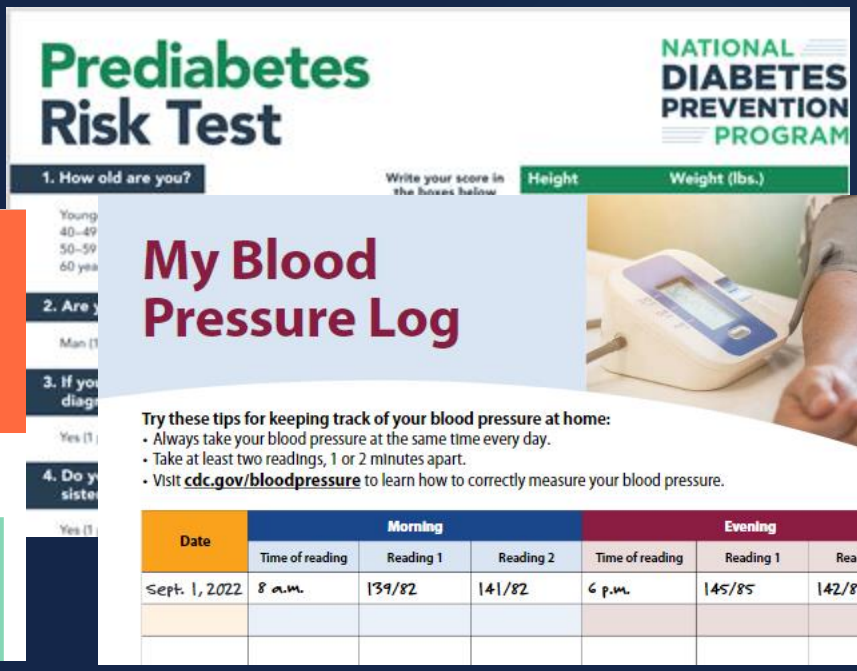
Accredited and Informational:

- Posters
- Brochures
- Customizable Workflow Templates
- Required Referral Forms
- Course Schedules

HOW

TOOLS: KNOW YOUR HEALTH NUMBERS, RISK TEST & MORE





References: Office of Health Equity, Erie County Department of Health; U.S. Centers for Disease Control (CDC)

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PUBLIC HEALTH DETAILING:

3

An effective template for adoption of public health initiatives

Existing uses:

- Partner Therapy for Sexually Acquired Conditions
- Maternal-Child Health Initiatives
- Pediatric Dental Care, Dental Opioid Education
- Pediatric HPV Vaccinations

REFERENCES AND RESOURCES: NYS Department of Health Learning Management System course (NYSPHA)

RESULTS by the numbers

5 months

104 medical practices identified for project

70 medical practice visits

38 presentations given: 25 virtual & 13 in-person

23 presentations to clinical decision-makers

Average: **4** phone calls, **3** office visits before **1** formal presentation

91% (21 of 23) success rate of presentation to decision maker

6,425 patient-supportive and program promotional materials given away to:

106 individual medical providers working in the **70** medical practice offices visited

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ACTIVITY!

COMMUNICATION PROCESS

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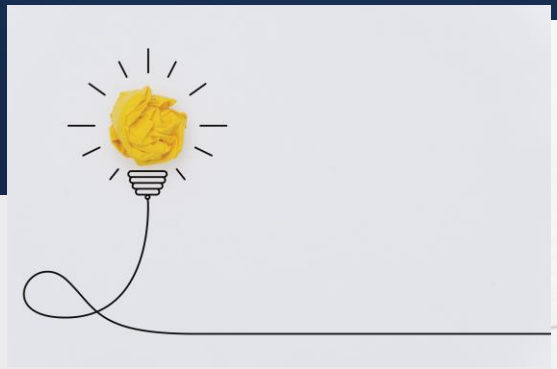
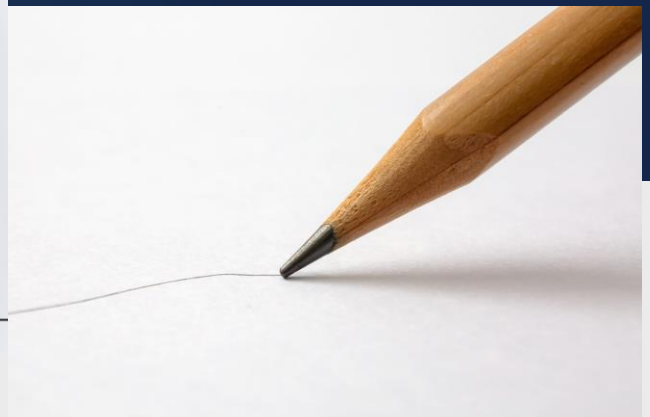
DRAWING with WORDS

Objective: Teaching your team members about the importance of feedback in communication
Time: 15 minutes
Materials and resources: Simple pictograms and blank sheets of paper

Instructions:
•Team members split into pairs with one partner holding a simple picture. This person instructs their partner on how to draw the picture without letting them see the picture.
•The person making the picture is encouraged to ask clarifying questions and request feedback on their progress.





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WHY?

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COUNTY OF ERIE
MARK C. POLONCARZ
COUNTY EXECUTIVE

GALE R. BURSTEIN, MD, MPH
COMMISSIONER OF HEALTH

Erie County, NY
Community Health Assessment
Community Health Improvement Plan
2022- 2024

2023 Workplan

Planning Report Liaison Michael Wiese
E-mail: michael.wiese@erie.gov michael.wiese@erie.gov

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Obj
Prevent Chronic Diseases	Preventive care and management	Goal 1.1: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	To give E tools nee disease s and halt a chronic are living evidence Disease S Program.

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FOCUS ON EQUITY: HEALTH AND WELLNESS

1

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WHY

RACIAL/ETHNIC DISPARITIES

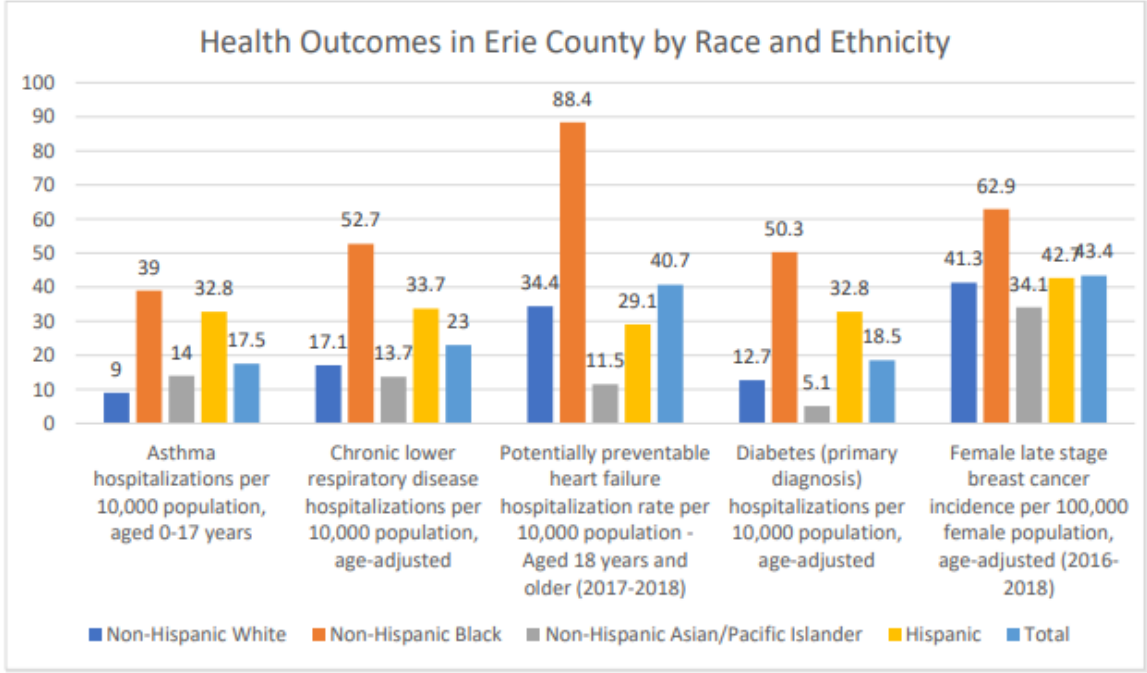

Figure 4: NYS County Health Indicators Report, 2017-2019, for Health Outcomes in Erie County by Race and Ethnicity

Sources: Health Equity in Erie County Report, January 2023

Erie County Health Indicators by Race/Ethnicity, 2017-2019, https://www.health.ny.gov/statistics/community/minority/county/erie.htm

"Health Equity in Erie County: An Initial Disparities Report", https://www3.erie.gov/health/sites/www3.erie.gov.health/files/2023-02/healthequityreport.pdf

NYS County Indicators by Race/Ethnicity, 2017-2019, for Health Outcomes in Erie County by Race and Ethnicity, https://www.health.ny.gov/statistics/community/minority/county/erie.htm

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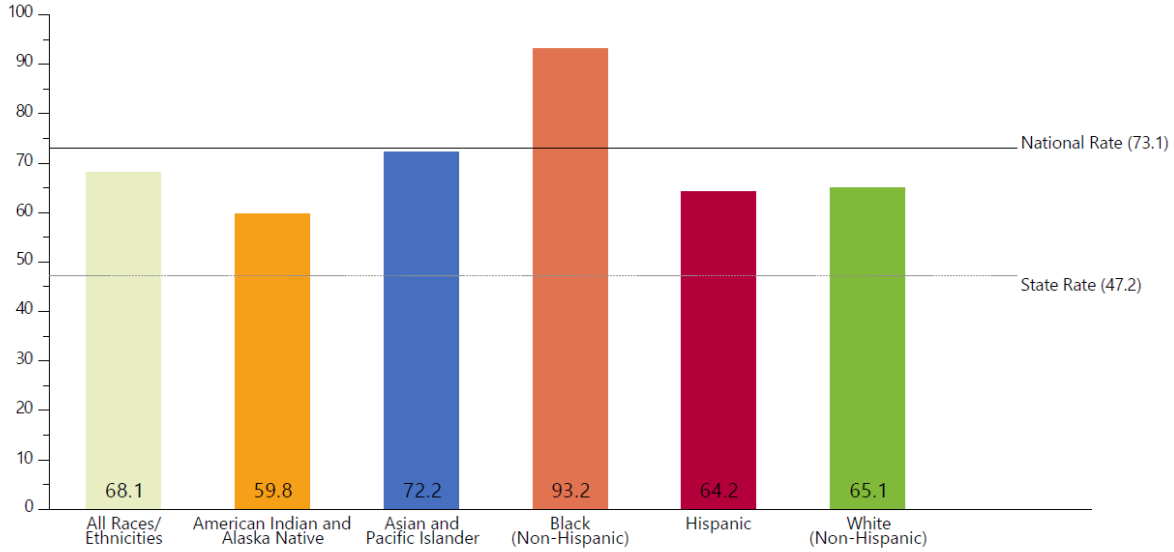
Stroke Death Rate per 100,000, All Races/Ethnicities, All Genders, Ages 35+, 2018-2020



In Erie, the average estimated stroke death rate for All Races/Ethnicities, All Genders, Ages 35+ for 2018-2020 is 68.1 Age-Standardized Rate per 100,000.

In the state of NY, the average estimated stroke death rate for All Races/Ethnicities, All Genders, Ages 35+ for 2018-2020 is 47.2 Age-Standardized Rate per 100,000.

The national average estimated is stroke death rate for All Races/Ethnicities, All Genders, Ages 35+ for 2018-2020 is 73.1 Age-Standardized Rate per 100,000.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Source: Interactive Atlas of Heart Disease and Stroke
www.cdc.gov/dhdsp/maps/atlas

WHY

TYPE 2 DIABETES:

1

- In 2020, **10.3%** of adults in Erie County aged 18 and older were diagnosed with Type 2 diabetes, or **1 in 10 adults**
- Age-adjusted prevalence **was 8.8%***

In **some Erie County census tracts,** the rate of individuals 18 and older with Type 2 diabetes is as high as

1 in 5 to 1 in 4 adults*

*Sources: Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion, Atlanta, GA. Model-based estimates generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.

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WHY

CARDIOVASCULAR DISEASE:

- CVD accounted for 32% of all deaths statewide in 2020 (BRFSS 2022)
- #1 cause of death in Erie County and across NYS

In **some Erie County census tracts,** the rate of individuals 18 and older with the CVD risk factor of High Blood Pressure is as high as

1 in 3 to more than 1 in 2 adults*

*Sources: Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion, Atlanta, GA. Model-based estimates generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.

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Search

PLACES: Local Data for Better Health

Print

PLACES is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. PLACES provides health data for small areas across the country. This allows local health departments and jurisdictions, regardless of population size and rurality, to better understand the burden and geographic distribution of health measures in their areas and assist them in planning public health interventions.

PLACES provides model-based, population-level analysis and community estimates of health measures to all counties, places (incorporated and census designated places), census tracts, and ZIP Code Tabulation Areas (ZCTAs) across the United States. Learn more about PLACES.

New Release as of July 2023

Estimates based on Behavioral Risk Factor Surveillance System data from 2021 (29 measures) or 2020 (7 measures).

Help is Available!

New how-to videos for some of the most frequently ask questions.

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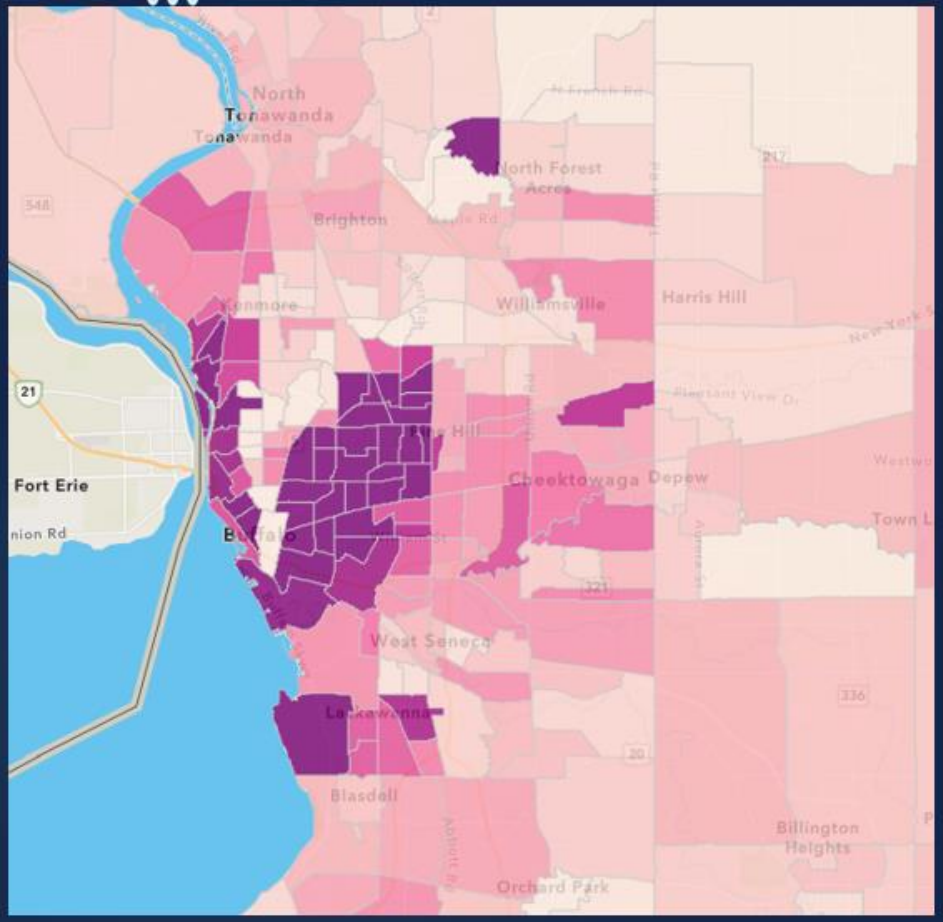

Erie County, NY

- Diabetes Crude Prevalence Rate, Adults 18+ =10.3% (2020)

Legend

Tracts

Diabetes crude prevalence (%)

- >= 14.4
- 10.8 - national average
- < 7.2

1

CDC

Sources: The model-based estimates were generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.

Note: Estimates are not available for areas shaded in gray. For more information visit https://www.cdc.gov/places.

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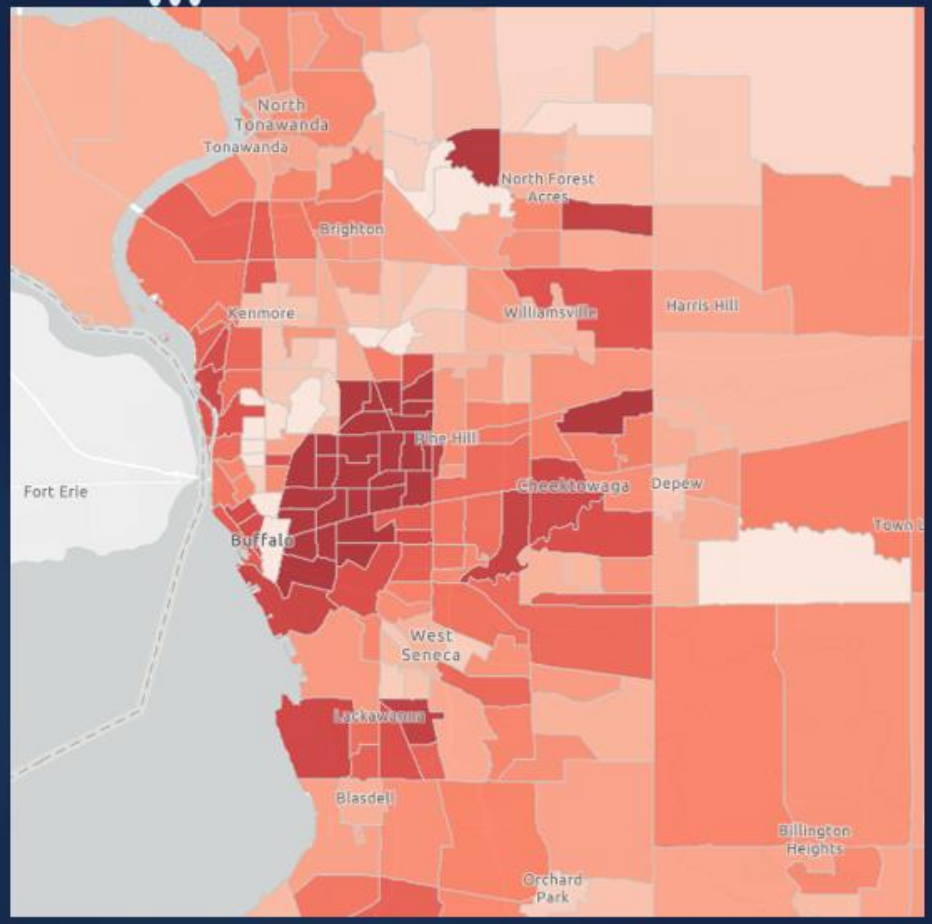

Erie County, NY

- High Blood Pressure Crude Prevalence Rate, Adults 18+
- = 32.4% (2019)

1

Legend

Tracts

High blood pressure crude prevalence (%)

> 39.7

32.4

< 25.2

CDC

Sources: The model-based estimates were generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.

Note: Estimates are not available for areas shaded in gray. For more information visit https://www.cdc.gov/places.

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WHAT

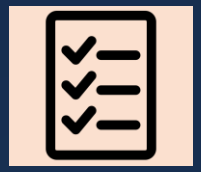
CDSMP and National DPP lifestyle change programs

2

- Program oversight, recognition and quality assurance occurs through the Centers for Disease Control and Prevention (CDC)

Trained lifestyle coaches facilitate group sessions of up to 20 participants

Follows specific curriculum and national standards



Emphasize participant empowerment through a personal action plan

DPP Program providers required to submit data on participant outcomes

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WHAT

Helping patients with any chronic health condition: evidence-based Chronic Disease Self-Management lifestyle change program

2

Core curriculum
Participants attend one 2 ½-hour session weekly, for six weeks.

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CHOOSE HEALTHY WNY

EVIDENCE-BASED PROGRAMS

Chronic Disease Self-Management
Chronic Pain Self-Management
Diabetes Self-Management

Program Details:

- Fun, interactive group workshops
- 1 day/week for 6 weeks
- In-person at community locations, Virtual, or Telephonic

CHOOSE HEALTHY WNY

Program Outcomes/Impact:

Participants learn tools to:

- Cope with pain, frustration, fatigue & stress
- Manage your blood sugars
- Lose weight gradually
- Explore new treatment options
- Effectively communicate with doctors and health care providers

Eligibility:
Varies, please call for more information

Western New York Integrated Care Collaborative

WHAT

2

Offered in Partnership with Erie County Department of Senior Services *and* ECDOH Department of Community Wellness

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Preventing type 2 diabetes

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Good news! We can take steps to help prevent type 2 prediabetes.

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

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WHAT

2

Helping patients with prediabetes: the National Diabetes Prevention Program (National DPP) lifestyle change program

Core curriculum
Participants attend 16 weekly sessions during the first six months.

Follow-up phase
Participants attend one session a month (minimum of 6 sessions).

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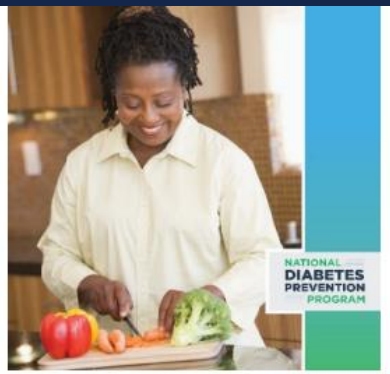
WHAT

DIABETES PREVENTION PROGRAM

Program Details:

- **Participants**: adults with diagnosed prediabetes or who are at high risk for developing Type 2 Diabetes
- **Full Recognition** from the CDC
- Facilitated by a **certified Lifestyle Coach**
- **Group workshop:** 24 sessions/year



Program Topics:

- Utilizing the ***Prevent T2*** curriculum. PREVENT T2 A PROVEN PROGRAM TO PREVENT OR DELAY TYPE 2 DIABETES
- Sessions cover healthy eating, physical activity, and lifestyle changes to help participants achieve the goals that lead to the prevention or delay of a diabetes diagnosis.

Program Goals:

- **5 - 7%** weight loss and maintenance
- Gradual increase in **physical activity to 150 min. per week.**
- **May include Program Supports** to help member reach goals
  - ie gym membership or fitness trackers

Populations Eligible:
Must have an insurance plan, WNYICC to verify prior to start that insurance covers program.

Western New York Integrated Care Collaborative

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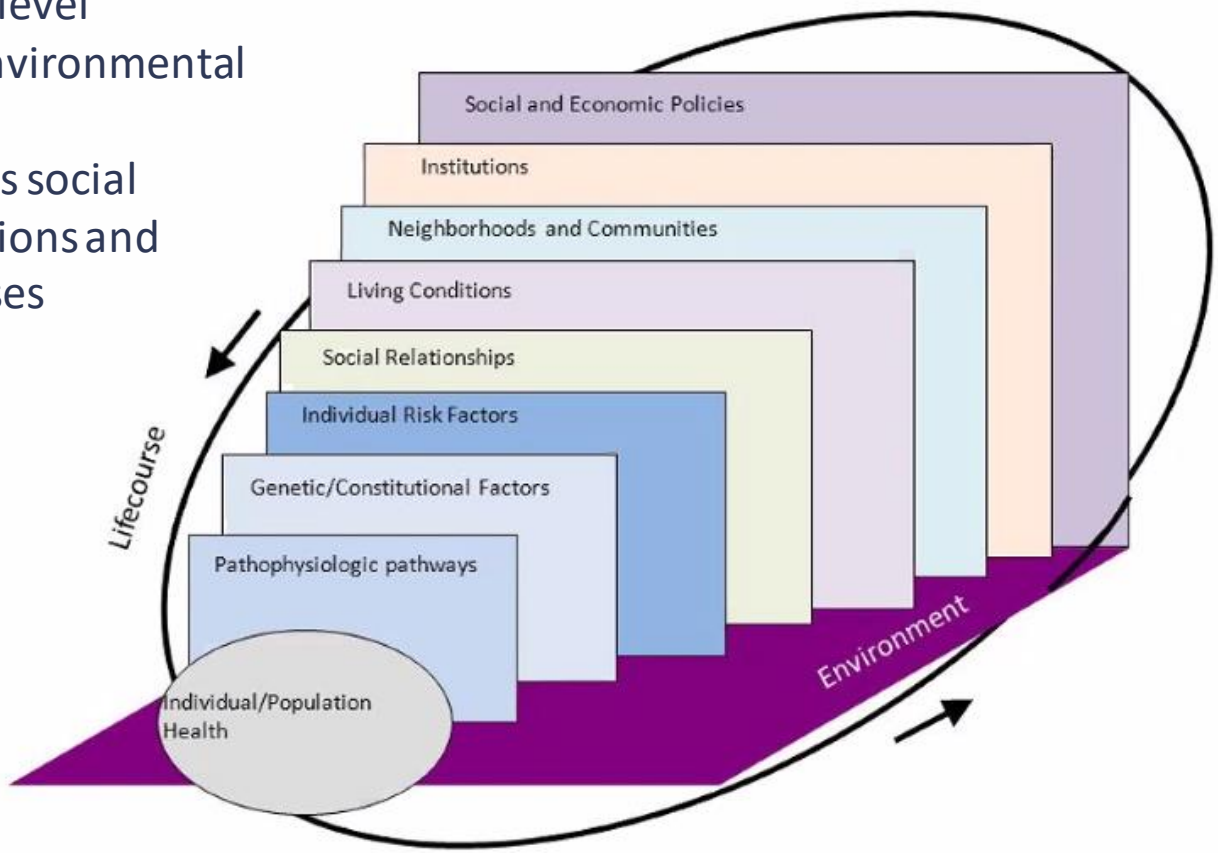
An ecosocial framework

2

- Macro-level socioenvironmental factors
- Includes social institutions and processes



Source: Kaplan, et al.; Socioenvironmental Model

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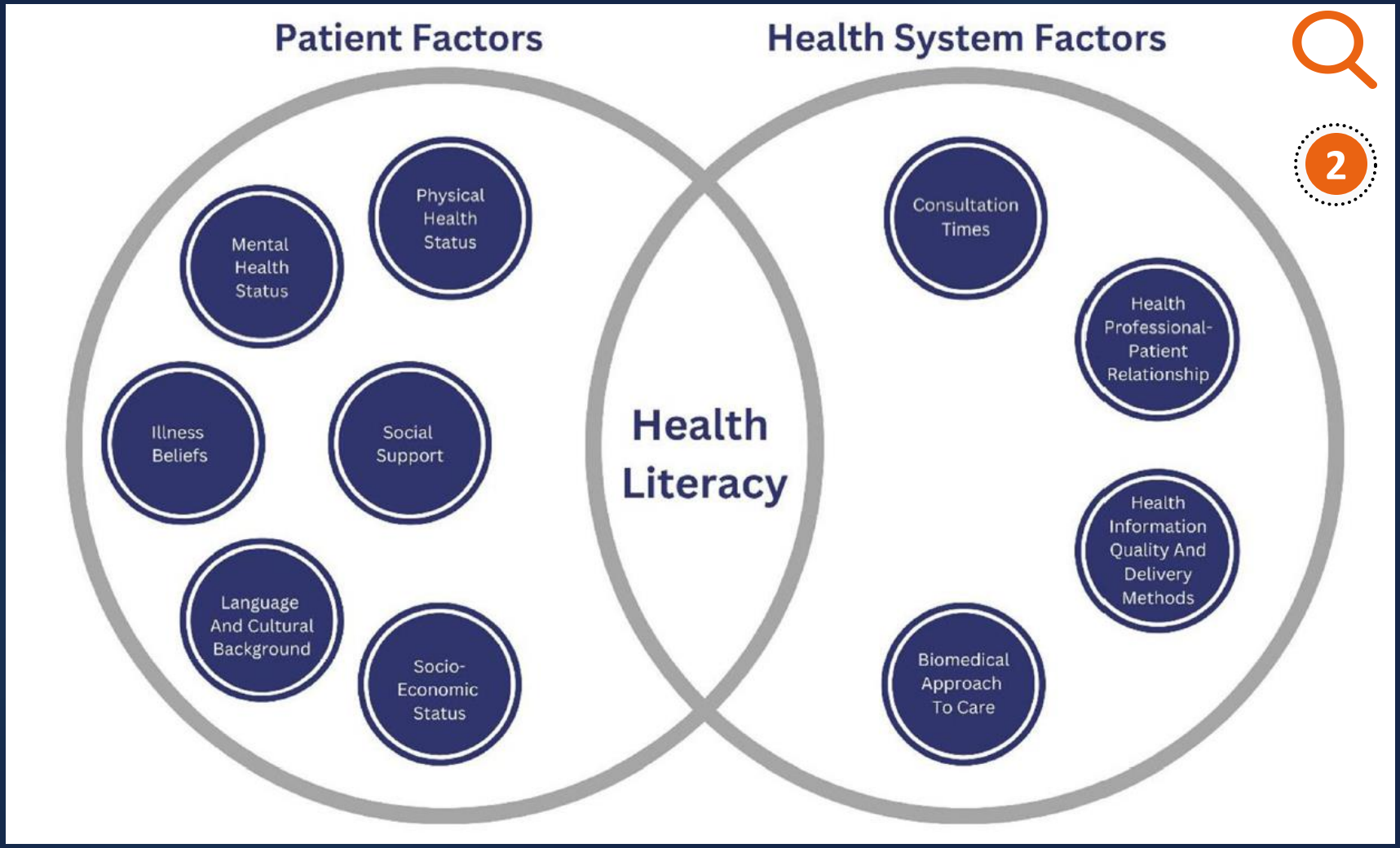
HOW



Source: Maddocks, S., Camp, P. & Tang, C. Engaging Ethnically Diverse Populations in Self-Management Interventions for Chronic Respiratory Diseases: A Narrative Review. Pulm Ther (2023). https://doi.org/10.1007/s41030-023-00218-y

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1

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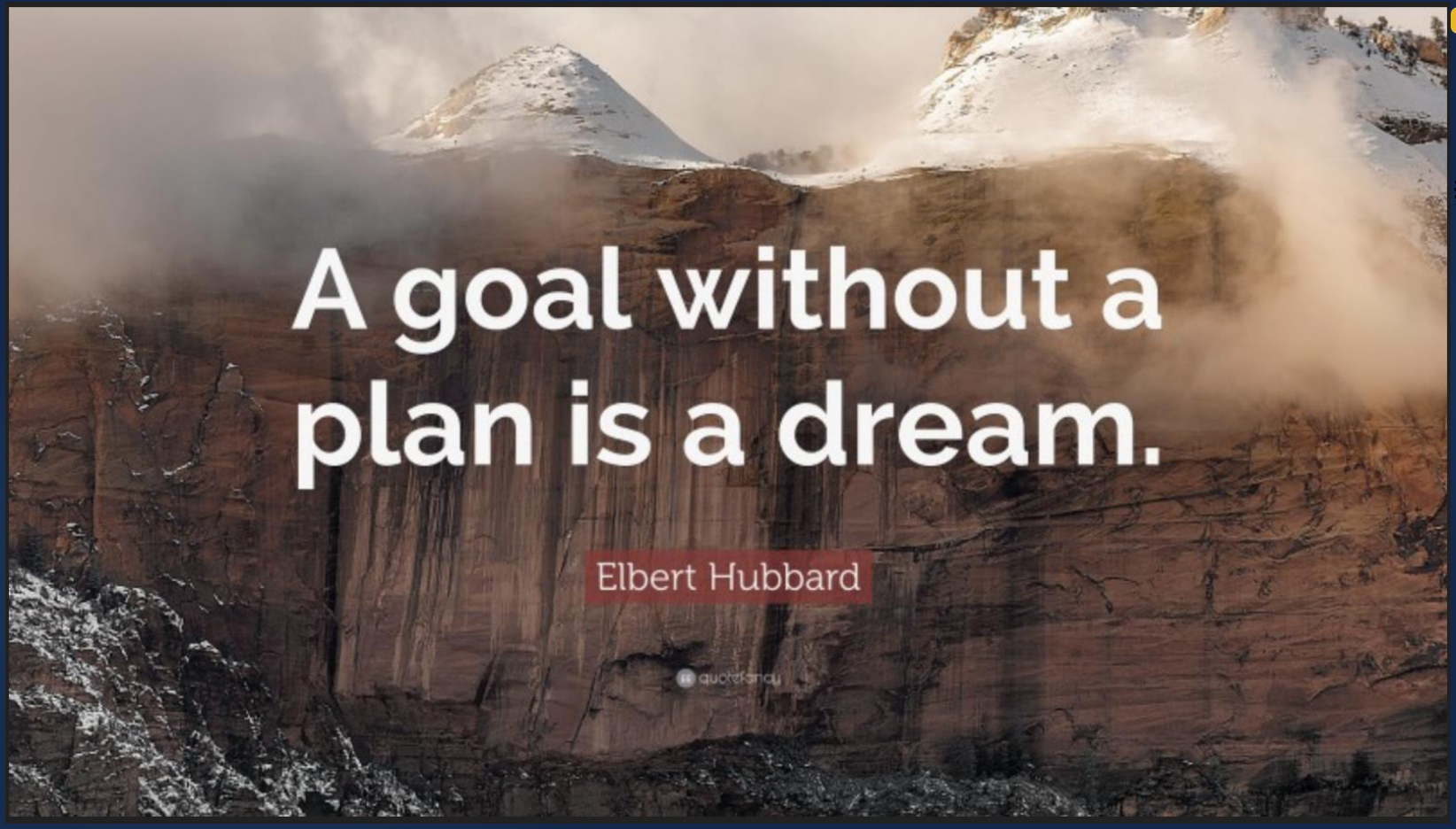

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PUBLIC HEALTH DETAILING PLAN

Encourage Patient Referral to Chronic Disease Education

NYS Public Health Corps

Erie County Department of Health
Second Floor, Lincoln Building

Liz Urbanski-Farrell urbanskifarrellliz@gmail.com 716-228-2884

2

Erie County Department of Health Public Health Detailing Plan: Spring 2023

CHIP: Manage Chronic Disease, Enhance Wellness

Goals:

1. Develop a templ
   desired public he
2. Successfully enh
   linking with 2-1-1
   disease patient s
   to track key metr
   HEALTHeLINK.
   leadership of Da
   with the help of N
3. IDENTIFY ECDC

3

14

Phase 0.1 Research:

- Outcomes among members of the target practices and/or their patients' neighborhoods (CDC data using ZIP Code/US Census tract/similar)
- Relevant latest medical journal articles on best practice related t the clinical behavior we are looking to change (recommend chro health self-management education courses; and
- How results might be tracked.

0.2 Identify:

- Handouts and poster-type materials that could be handed out to practices on detailing visits with clear, concise relevant informati laminated for front desk and clinical staff and poster-style for bul boards and in rooms;
- Inquire about likelihood of getting cardboard stands to hold mate as the lack of stands and holders is cited as one reason that suc items are not handed out or made available to patients.

0.3 Consider

- PH partners and 'goodies' that could be given out to cross-promo at detailing visits -- make inquiries about existing ECDOH partnerships for these items

0.4 Create

- Write and practice a standard pitch to use with practices on visits variations based on answers (response-based script)
- Identify potential challenges and good follow-up responses;

OUTCOMES
10-minute QUICK, ORGANIZED, FOCUSED AND STRATEGIC visit to practices.

Develop templates for:
PHASE I. FIRST VISITS: Three (3) visits to each provider, 6-8 weeks apart; Five minutes or less. Script the visit: DELIVER INFO IN LESS THAN 5 MINUTES TO LEAVE TIME FOR QUESTIONS. Visit time goal: 10 minutes. Key To Bring with You: *A Positive, Patient and Friendly Attitude*

1. Identify self
2. Ask for the person who refers patients to health education programs. (Future, could be used for breastfeeding education and breastfeeding support). Identify who has influence in the practice, could be practice administrator vs. MD.
1. Give topic overview. (Why are you there?)
2. Assess current practices related to the clinic practice we want to chang (referrals to education programs).
3. Share key messages. Info. about this practice if you have it. Best-pract outcome journal articles and incentives to change.
4. Share relevant materials. Review folder of BASIC info. Provide info. for patients, educational info.
5. Answer or take down questions to return with answers to.
6. Plan strategies for achieving objectives`
7. Distribute goodies: tote bags, clip boards, hand sanitizers, pens, etc.

PHASE II. Second visit plus: Distribute 'action kits' with practice tools, provi information and patient education materials.
Handouts can include:
- Flow sheets

ACTIVE PROJECT TIMELINE

1. Research and program development phase: Through Jan. 31
2. Gather Materials and background research: through Feb. 7
3. Create detailing kits targeted to phases I, II and III: through Feb. 14
4. Write, practice, record and gain approval for scripts: through Feb. 21

Detailing visits begin: Wed. Feb. 22
Phase I Part 1-2 visits: Feb. 22-April 5, two visits, two weeks apart
Part I.1 Feb. 22, March 8;
Part I.2 March 22, April 5

Phase I Part 3 visits: May 5-15

Phase II Part 1 visits: May 15-30
Phase II **Part 2 visits: June 1-20**

Phase III visits: June 21-August 24

Modifications:
Unanticipated delays will remove Survey Comparison work and calculations (before and after project detailing work surveys, self-reported by practice clinicians/contacts) as follows: **July 30-Aug. 12**
1. Phase timing varies
-Phases occur simultaneous to each other depending on the practice and their interest level in making active patient referrals. For example,
- UB Family Medicine requested a presentation to quality improvement

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PROJECT WORKFLOW

PUBLIC HEALTH DETAILING PROJECTS:

PLAN, DO, STUDY, ACT: COMMUNICATE & BUILD A COALITION!

PREPARE TO BEGIN THE PROCESS

RESEARCH	IDENTIFY	CONSIDER	CREATE	PREPARE
HEALTH DISPARITIES AND OUTCOMES	HANDOUTS	PH PARTNERS	WRITE AND PRACTICE A STANDARD PITCH	TEMPLATES IN EXCEL, LISTS OF TARGET PRACTICES
MEDICAL JOURNALS, PUBLISHED RESEARCH	POSTERS/ ONE-PAGERS	GOODIES AND GIVEAWAYS	IDENTIFY POTENTIAL CHALLENGES AND BARRIERS	TRACKING WORKSHEET FOR MATERIALS AND GIVEAWAYS
EVIDENCE-BASED INTERVEN-TIONS				

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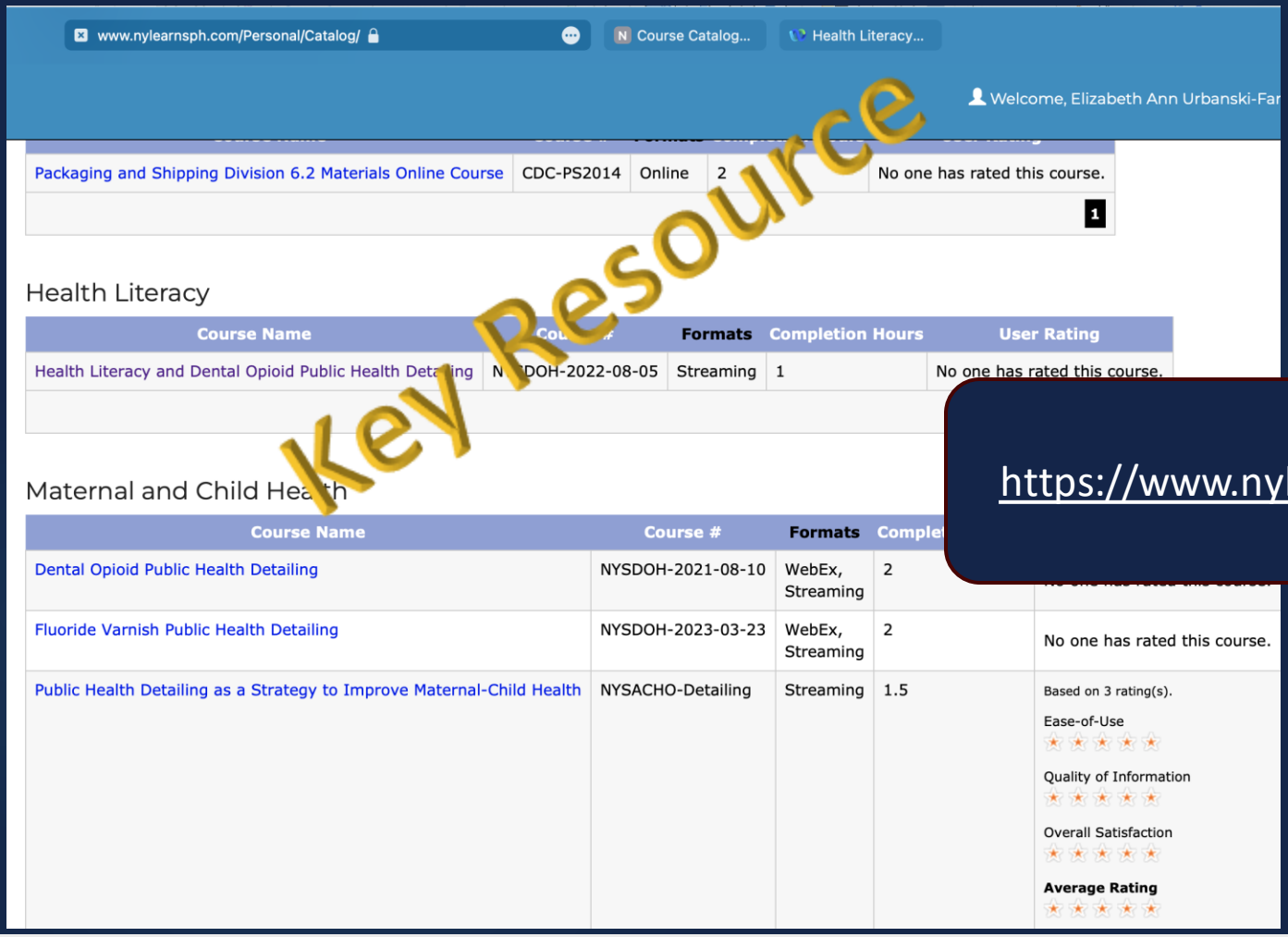

Key Resource

1

TAKE DETAILING TRAINING COURSE

https://www.nylearnsph.com

TO ENROLL:
https://nylearnsph.com/Personal/Catalog/Description.aspx?u=kM6WW0gCRpnAbAzs%2bZm51WZQQvwbRbdLk486UvBVN0fxtEdZYs1f7rXK7rG6VjDaeyTIo%2fUSHNQ%3d

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THE REAL DEAL


IT'S ALL ABOUT…
RELATIONSHIPS
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Agency and Community Partners

Western New York Integrated Care Collaborative

Jewish Community Center of Greater Buffalo

Erie County Department of Health (ECDOH)

Locations | Frequently Requested | Programs/Services | Permits/Applications/Forms

Home

Community Wellness, Disease Control & Prevention

Racial and Ethnic Approaches to Community Health (REACH) Ferry Good Health Project

REACH
The Ferry Street Health & Wellness Project

CAI

Erie County
Cancer Services Program
Your partner for cancer screening, support and information

Senior Services

American Heart Association
Eastern States

YMCA BUFFALO NIAGARA

the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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OFFICE OF HEALTH EQUITY
www.erie.gov/health-equity

Who's WHO and THANK YOUs

The following clinics are NCQA recognized Patient Centered Medical Homes:

- Family Health Center
- Internal Medicine Clinic
- Grider Family Health

Thank you!

Michele Wysocki	Erie County Cancer Services Program
Katie Herzog	Community Wellness, ECDOH
Janice Nowak	Erie County Senior Services
Caitlyn Critharis	Office of Health Equity, ECDOH
Kelly Wofford	Office of Health Equity, ECDOH
Lisa Neff	American Heart Association
Betsy Vazquez-Aradio	Office of Health Equity, ECDOH
Danielle Rovillo	Office of Health Equity, ECDOH
Mel LeMay	Office of Health Equity, ECDOH
Tania Islam	Erie County Department of Health
El Tyner	SSO/PCG, ECDOH
Devin Hurley	WNY Integrated Care Collaborative
Nikki Kmicinski	WNY Integrated Care Collaborative

And all my program partners!

STEP BY STEP!


3


1
TAKE DETAILING TRAINING COURSE
2
STAKEHOLDER MEETINGS IN & OUTSIDE AGENCY
3
RESEARCH: CLINICAL PROCESS, TARGET GROUP/S
4
PLAN AND CREATE PRESENTATIONS
5
IMPLEMENT DETAILING PROCESS
6
REVISE AS NEEDED
7
DOCUMENT RESULTS

C O L L A B O R A T E !

- Check in with agency colleagues:

Who else is doing this?

  - Gather ‘lessons learned’
  - Barriers
  - Suggestions
  - Help and resources

2

STAKEHOLDER MEETINGS IN & OUTSIDE AGENCY

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PUBLIC HEALTH DETAILING ESSENTIALS

2

STAKEHOLDER MEETINGS

- ‘Swag’
  - Branded Water Bottles, Pens, Frisbees, Veggie Peelers, Clipboards
  - Beg, Borrow, Steal!

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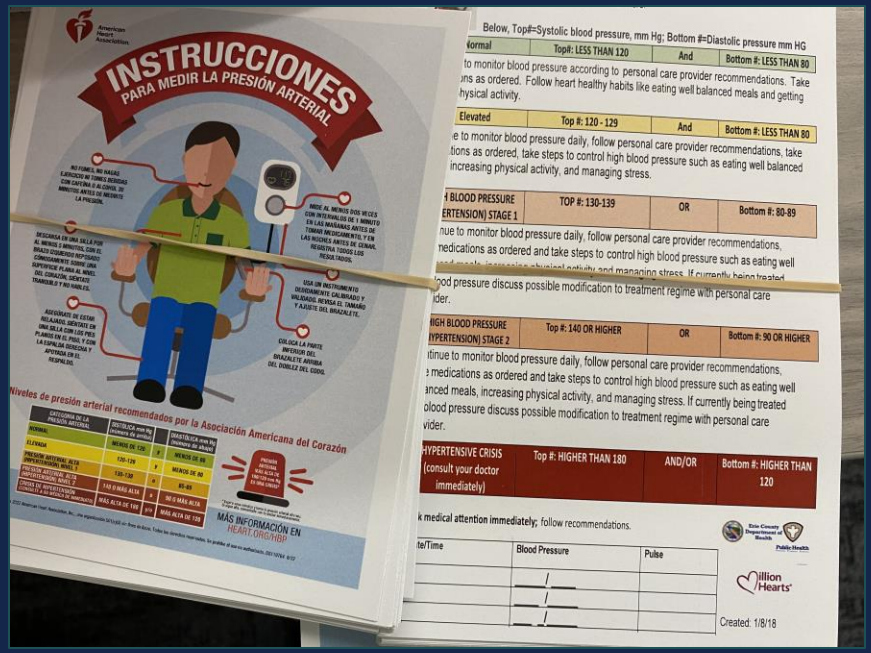
Aligned incentives and handouts:

- OHE newsletter, trusted references and tools for patients



FIND YOUR TARGET

3

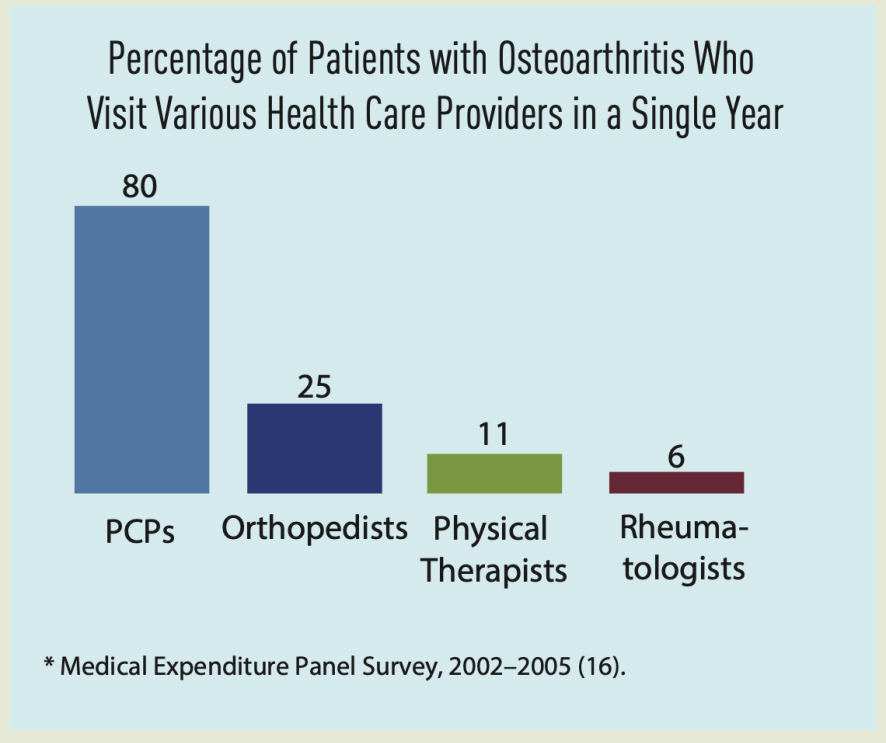
RESEARCH

TARGET MEDICAL PRACTICES

I.E., "SELLING" CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

3

RESEARCH



https://www.cdc.gov/arthritis/marketing-support/1-2-3-approach/docs/pdf/Arthritis-Marketing-Guide_Introduction.pdf

TRUST

- RESEARCH trusted sources for Target Audience
  - WHO does your target population trust?
  - Get comfortable with the data--backward and forward

RESEARCH CLINICAL PROCESS

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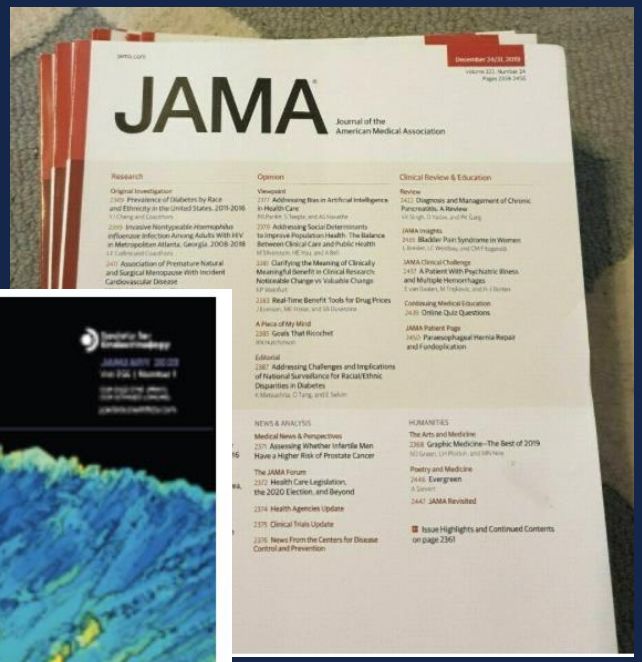
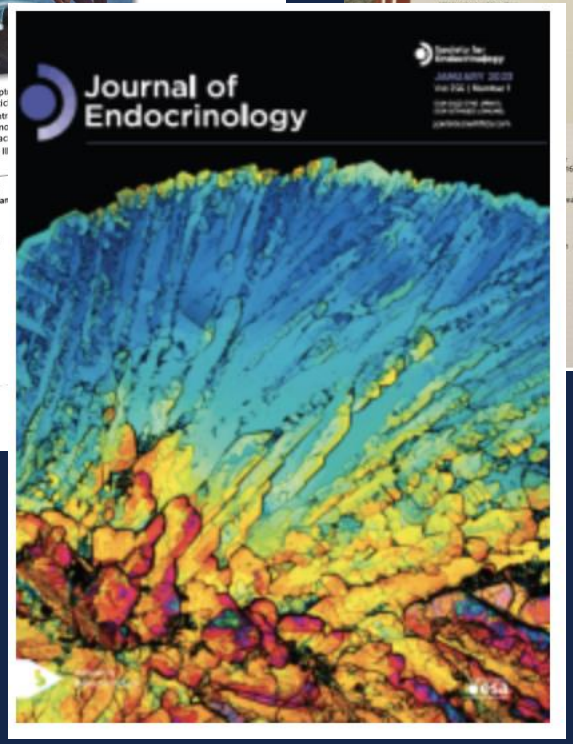
RESEARCH

TIMELY ARTICLES FROM JOURNALS RESPECTED BY TARGET AUDIENCE

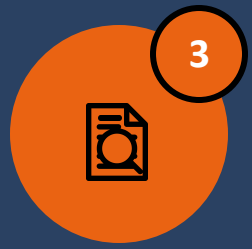




3

RESEARCH
CLINICAL
PROCESS/CHANGE
YOU ARE 'SELLING'

INCENTIVES



To meet your goal….
Find your target’s *WHY*

INCENTIVES

3

RESEARCH

ARE CRITICAL

WHY will your target audience WANT or NEED to make a change?

- FEEL-GOOD incentive: PATIENTS' CONDITIONS ARE WELL-CONTROLLED
- WHAT TYPES OF MONETARY INCENTIVES EXIST?
- WHO WILL BENEFIT MOST/WHAT TYPE OF MEDICAL PROVIDER (i.e., primary care)

WHY

Chronic Disease Prevention Program Savings

2

CDC Meta Analysis Research, CDSMP

2013 article re: potential ER visit reduction due to patient use of CDSMP, studied:

- 1,170 community-dwelling participants at baseline, 6 mo. & 12 mo.
- 22 different organizations, across 17 states

The impact of chronic disease self-management programs: healthcare savings through a community-based intervention: Ahn, SangNam;Basu, Rashmita;Smith, Matthew Lee;Jiang, Luohua;Lorig, Kate;Whitelaw, Nancy;Ory, Marcia G; Published Date : Dec 06 2013, Source : BMC Public Health. 2013; 13:1141. URL : https://stacks.cdc.gov/view/cdc/22476

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SAVINGS

2

- **ER Visits down by 5%** at 6 months and 12 months
- **Hospitalization down by 3%** at 6 months, and 12 months
- Medical Care **cost reduction of $364/patient, per year**

**Using 2010 Medical Expenditure Panel Survey reference after deducting CDSMP program cost*

UPDATED SAVINGS: Multiplying x 30% for 2023, **potential savings per participant = $473.20 *or more*** in 1st year after CDSMP program completion

**Statistics: Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion, Atlanta, GA. Model-based estimates generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.*

Citation: The impact of chronic disease self-management programs: healthcare savings through a community-based intervention: Ahn, SangNam;Basu, Rashmita;Smith, Matthew Lee;Jiang,

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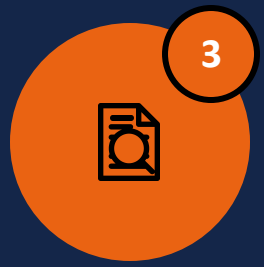
INCENTIVES



What applies to your target group?

- Quality Ratings: CMS Star Ratings
- Value-Based Purchasing Goals
- Where to find them?
  - STATE DOH
  - CDC, CMS, American Medical Association

INCENTIVES

VALUE-BASED PURCHASING: Monetary rewards for medical practices reducing costly treatments, medical conditions, hospitalizations and prescriptions

ACCREDITATION: May require achievement of goals your program/s help to reach

QUALITY MEASURES: How could they be improved by using your program?

WHY

slide sample

National DPP lifestyle change program

Randomized controlled trial that compared placebo, medication (metformin) and intensive lifestyle intervention in over 3,000 adults at high risk for diabetes

At average three years follow-up, the **lifestyle intervention** reduced the incidence of diabetes by **58%** compared to placebo.

During the same time period, **metformin** reduced the incidence of diabetes by **31%** compared to placebo.

Knowler WC, Barrett-Connor E, Fowler SE, et al.; Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med.* 2002;346:393–403.

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WHY

slide sample

PRACTICE BENEFITS
ROI=Reduced medical expenditures

Potential medical expenditure reduction associated with diabetes and other chronic diseases.[1]

- Potential savings **of nearly $500 per patient in the first year[1] + approximately $8,000** in medical spending for EACH participant who does not progress to type 2 diabetes.[2,3]

PROJECTED MEDICAL COST SAVINGS LINK
CDC Calculator (State, Employer, Insurer): Diabetes Prevention Impact Toolkit - Diabetes Toolkit (cdc.gov)

Individual results vary depending on the cost of program participation, the prevalence of prediabetes, course enrollment rate and completion rate.

1. The impact of chronic disease self-management programs: healthcare savings through a community-based intervention: Ahn, SangNam;Basu, Rashmita;Smith, Matthew Lee;Jiang, Luohua;Lorig, Kate;Whitelaw, Nancy;Ory, Marcia G; Published Date : Dec 06 2013, Source : BMC Public Health. 2013; 13:1141. URL : https://stacks.cdc.gov/view/cdc/22476
2. American Diabetes Association. Economic Costs of Diabetes in the US in 2017. *Diabetes Care*. 2018; 41(5): 917-928.
3. Khan, Tamkeen, Stavros Tsipas, and Gregory Wozniak. "Medical care expenditures for individuals with prediabetes: the

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WHY

slide sample

Diabetes Prevention Program Savings Calculators:

Calculate Potential Cost Savings with Diabetes Prevention Program (DPP), Employer (CDC):
https://nccd.cdc.gov/Toolkit/DiabetesImpact/Employer

Calculate Potential Cost Savings with DPP, Insurer (CDC):
https://nccd.cdc.gov/Toolkit/DiabetesImpact/Insurer

WHY

slide sample

Benefits to Your Practice

Lifestyle change program course referrals:

- **Reinforce** important medical advice from you;
- **Provide your patients with evidence-based information about** weight loss, diet, exercise, & important lifestyle changes; and
- Increase patient knowledge, which **saves staff time** during office visits.

slide sample

WHY

Benefits to Your Practice

Referring patients to Chronic Disease Self-Management and Diabetes Prevention Courses also supports:

- Patient Centered Medical Home **(PCMH) recognition**,
- **Meaningful use** of your electronic medical record; and
- Supports **PCMH recognition** via Standard 4:
  - A. Self-Care Support, and
  - B. Provide Referrals to Community Resources. *Last Reviewed: December 30, 2022*

WHY

slide sample

National DPP lifestyle change program

PERSISTENT Relative Risk Reduction VS. Metformin

- VERIFIED at 10, 15 and 22 years in multi-year retrospective study review

(Hostalek, U., & Campbell, I. (2021). Metformin for diabetes prevention: update of the evidence base.
Current medical research and opinion, 37(10), 1705–1717.
https://doi.org/10.1080/03007995.2021.1955667)

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2

DETAILING TOOLKITS

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YOUR DETAILING TOOLKIT

- ✓ Provider Outreach Tracking Spreadsheet
- ✓ Provider outreach packets containing the following:
  - Overview fact sheet for providers, one copy for each provider or staff member
  - Intervention-specific fact sheet on each program you're promoting, one copy for each provider or staff member
  - Evidence table (if needed) on each program you're promoting, one copy for each provider or staff member
  - Patient brochure and class schedules, 50–100 copies each
- ✓ Posters (1–3)
- ✓ Your business cards
- ✓ Power Point slides (as needed)

TOOLKIT FOR MEDICAL PROVIDERS:

Folders, Electronic and Print

- Articles, slides, research summary, posters/pamphlets
- Basic and customizable
- Suggested Work Flow Chart for target audience: customizable template/s

Toolkit for Medical Providers: Your turn!

Suggested Work Flow Chart for target audience

- Customizable template

Step 1: Measure	When	Who	How (draw from AMA-CDC tools)
Point-of-care method o Assess risk for prediabetes during routine office visit o Test and evaluate blood glucose level based on risk status	o At the front desk o During vital signs	o Receptionist o Medical assistant o Nurse o Physician o Other _____	o Provide "Are you at risk for prediabetes?" patient education handout in waiting area o Use/adapt "Patient flow process" tool o Use CDC or ADA risk assessment questionnaire at check-in o Display 8 x 11" patient-facing poster promoting prediabetes awareness to your patients o Use/adapt "Point-of-care algorithm"
Retrospective method o Query EHR to identify patients with BMI ≥24* and blood glucose level in the prediabetes range	o Every 6–12 months	o Health IT staff o Other _____	o Use/adapt "Retrospective algorithm"
Step 2: Act			
Point-of-care method o Counsel patient re: prediabetes and treatment options during office visit o Refer patient to diabetes prevention program o Share patient contact info with program provider**	o During the visit	o Medical assistant o Nurse o Physician o Other_____	o Advise patient using "So you have prediabetes … now what?" handout o Use/adapt "Health care practitioner referral form" o Refer to "Commonly used CPT and ICD codes"
Retrospective method o Inform patient of prediabetes status via mail, email or phone call o Make patient aware of referral and info sharing with program provider o Refer patient to diabetes prevention program o Share patient contact info with program provider**	o Contact patient soon after EHR query	o Health IT staff o Medical assistant (for phone calls) o Other_____	o Use/adapt "Patient letter/phone call" template o Use/adapt "Health care practitioner referral form" for making individual referrals o Use/adapt "Business Associate Agreement" template on AMA's website if needed
Step 3: Partner			
With diabetes prevention programs o Engage and communicate with your local diabetes prevention program o Establish process to receive feedback from program about your patients' participation	o Establish contact before making 1st referral	o Medical assistant o Nurse o Physician o Other_____	Use/adapt "Business Associate Agreement" template on AMA's website if needed Refer to "Commonly used CPT and ICD codes"
With patients o Explore motivating factors important to the patient o At follow-up visit, order/review blood tests to determine impact of program	o During office visit o Other_____	o Office manager o Other_____	o Advise patient using "So you have prediabetes … now what?" handout and provide CDC physical activity fact sheet

https://www.cdc.gov/diabetes/prevention/pdf/map-to-diabetes-prevention-for-your-practice_tag508.pdf

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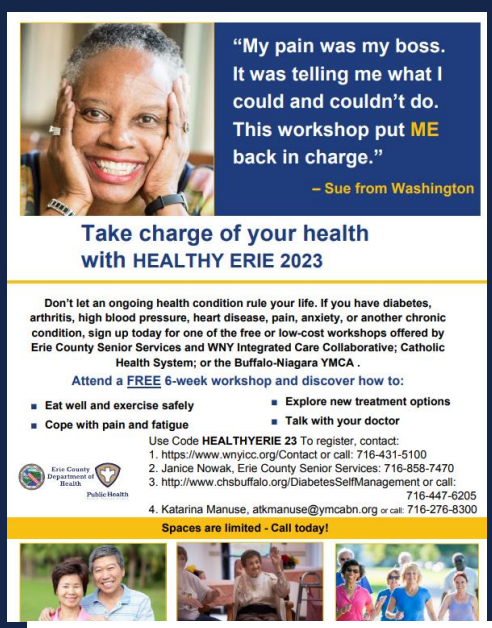

TO REGISTER FOR CLASSES, PLEASE USE REFERRAL CODE: "HEALTHY ERIE COUNTY 2023"

ATION Self-Management Programs and DIABETES SELF-MANAGEMENT PROGRAMS for individuals diagnosed with diabetes

ogram	Facility	Location	Date and Time	
anagement Program DSMP)	North Buffalo Community Center (Development Corporation), 203 Sanders Road	Buffalo, NY, 14216	February 3-March 10, @ 9:30AM-12PM *(Fridays)*	Wee
ion Self-Management ogram	Sisters of Charity Hospital, 2157 Main Street	Buffalo NY 14214	March 14, 15, 16 (T,W,Th), 9AM-11:30AM	2.5 hours a d
anagement Program DSMP)	Hamburg Senior Center, 4540 Southwestern Boulevard	Hamburg, NY, 14075	March 23-April 27, 1:00PM-3:30PM *(Thursdays)*	Wee
anagement Program DSMP)	Gloria J. Parks Community Center, 3242 Main Street	Buffalo, NY 14214	April 17-May 22, 2023, 1:30PM-4:00PM *(Mondays)*	Wee
ion Self-Management ogram	St. Joseph Campus of Sisters' Hospital, 2605	Cheektowaga, NY 14225	May 2, 3, 4 (T,W,Th), 9AM-11:30AM	2.5 hours a d

National Diabetes Prevention Program (National DPP) lifestyle change program referral template

This resource can be used as a guide for creating a form to refer patients from clinical settings to a National DPP lifestyle change program provider. The elements noted comprise potential key information to include in a referral and a sample template is also displayed below.

- Patient information: Name, contact information (address, phone, email), birth date/age, gender, health insurance, employer, preferred method of contact, preferred time to contact.
- Health care provider information: Physician/provider name, practice name, practice contact name, practice information (address, phone, fax, etc.)
- Other information: Date of referral, authorization information (language that meets your organization's specific legal requirements for privacy and security, etc.), eligibility for program information (patient body mass index, medical history and blood test results), signatures of physician/ordering provider and patient OR patient representative.

This resource is provided for informational purposes only and does not constitute legal advice. Please consult with a qualified legal advisor to create a resource for use within your organization.

Send to (program name): **Fax/Email:**

Patient information	
Name	Address
Gender	City
Birth date (mm/dd/yy)	State
Employer	ZIP code
Preferred method of contact	Phone
Preferred time to contact	Health Insurance
Health care provider information	
Physician/NP/PA name	Address
Practice name	City
Phone	State
Fax	ZIP code

Date: _____ **Health care provider signature:** _____

Authorization for release of health information [Insert your organization's specific legal language here.]

Referral eligibility information:

Criteria	Reference range	Result
☐ Body Mass Index (BMI)	Eligibility = ≥25 (≥23 if Asian)	_____
☐ Blood test		
• Hemoglobin A1C	5.7-6.4%	_____
• Fasting plasma glucose	100-125 mg/dL	_____
• 2-hour oral glucose tolerance test	140-199 mg/dL	_____
Date of blood test (mm/dd/yy): _____		
☐ History of Gestational Diabetes		

VISITS: HOW-TO

4

CREATE PRESENTATIONS

1. 1. Initial phone call to schedule an
    1. outreach visit
2. 2. Confirmation phone call
3. 3. Outreach visit

https://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/docs/pdf/chronic_toolkit_scripts.pdf

In-person visits

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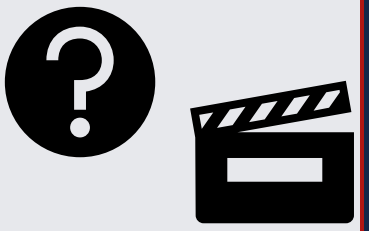
VISIT PLANNING

START WITH A SMILE

1



END WITH AN ASK (ACTION)

2

PARTNER WITH PRACTICE

3

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VISIT PLANNING

FIRST VISIT

- **ASSESS** Relevant practices
- **IDENTIFY GATEKEEPER**, DECISION-MAKER; GET PHONE # (DIRECT) AND EMAIL/S
- **PROVIDE OVERVIEW & KEY MESSAGES**
- **ACTION KIT/FOLDER HANDOUT**

SECOND VISIT

- **REVIEW SLIDES, FLOW SHEEET**
- SELF-ADMINISTERED QUESTIONNAIRES
- **GIVEAWAY ITEMS, PATIENT SUPPORTS**

FINAL VISIT

- **REINFORCE KEY MESSAGES**
- DELIVER **GIVEAWAY ITEMS**
- **REPLENISH PATIENT HANDOUTS**

CALL AND VISIT SCRIPT AND PROCESS FLOW:

"Be ready to be ready"

Element Title

OPTION 03

CREATE PRESENTATIONS

OPTION 04

Element Title

Element Title

OPTION 05

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Briefly describe the intervention

Key elements:

- Overall goals
- Types of patients likely to benefit
- Proven benefits
- Costs
- Availability and locations of intervention/s

✪ Refer to the key points for specific interventions

✪ Use fact sheets and evidence tables to supplement your discussion as necessary.

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YOUR TURN: SCRIPT AND FLOW

For Responses & Follow-Up

- Even if you don't follow exactly!

4

CREATE PRESENTATIONS

INITIAL PHONE CALL TO PCP OFFICES

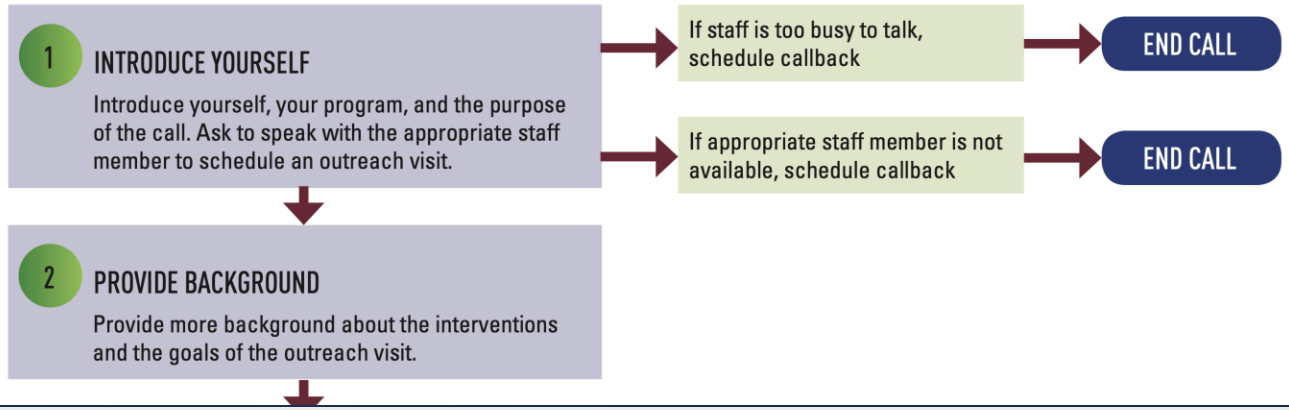
Purpose

To persuade office staff to schedule an outreach visit with an intervention marketer to discuss locally available self-management education workshops and physical activity classes.

Tools Needed

Provider Outreach Tracking Spreadsheet

Call Flow



https://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/docs/pdf/chronic_toolkit_scripts.pdf

Call Script

1 INTRODUCE YOURSELF

✪ Introduce yourself and briefly describe the purpose of your call.

"Good morning / afternoon, I'm **[NAME]**, calling from the **[NAME OF ORGANIZATION]**. We're working with the Centers for Disease Control and Prevention to get the word out to area health care providers about classes offered in our community that are proven to help people with chronic disease manage their symptoms and improve their quality of life. We'd like to visit your practice to discuss the interventions and how your patients can benefit. Is there someone I could speak with about scheduling a 5-minute meeting with Dr. **[NAME]** and members of your staff?"

IF you are speaking to the appropriate staff person → GO TO STEP 2

IF transferred to new staff member, repeat introduction as follows:

"Good morning / afternoon, I'm **[NAME]**, calling from the **[NAME OF ORGANIZATION]**. We're working with the Centers for Disease Control and Prevention to get the word out to area health care providers about classes offered in our community that are proven to help people with chronic disease manage their symptoms and improve their quality of life. We'd like to visit your practice to discuss the interventions and how your patients could benefit."

GO TO STEP 2

IF staff is too busy to talk:

"I understand. When would be a better time for me to call back?"

"Whom shall I ask to speak with?"

"Great. I'll call back **[DATE AND TIME—e.g., at 4 p.m. tomorrow, before 10:00 tomorrow morning, after 5 p.m. on Wednesday]**. Thanks so much for your time."

END VISIT

IF If the appropriate person to schedule the visit is not available:

"Whom should I speak with to schedule a meeting?"

"When is a good time for me to reach **[NAME]**?"

"Great. I'll call back **[DATE AND TIME—e.g., at 4 p.m. tomorrow, before 10:00 tomorrow morning, after 5 p.m. on Wednesday]** to speak with **[NAME]**. Shall I use this phone number or is it better for me to call **[NAME]** on a direct line?"

"Thanks so much for your time."

END VISIT

4

CREATE PRESENTATIONS

https://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/docs/pdf/chronic_toolkit_scripts.pdf

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CALLS AND MEETINGS: KEEP IT SIMPLE

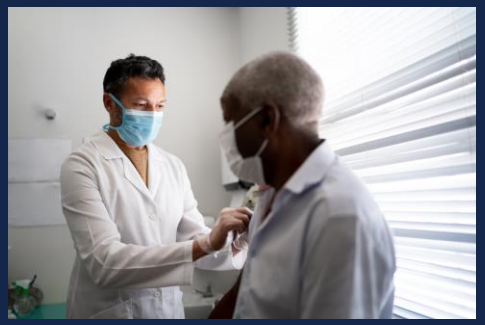
5

IMPLEMENT DETAILING PROCESS

CHALLENGES:

- NOT ENOUGH TIME
- LIMITED ADMIN PERSONNEL
- LIMITED FINANCIAL RESOURCES

ALL EXACERBATED BY COVID-19 PANDEMIC



AT THE HEART OF THE PROCESS….

5

IMPLEMENT DETAILING PROCESS

Centers for Disease Control and Prevention
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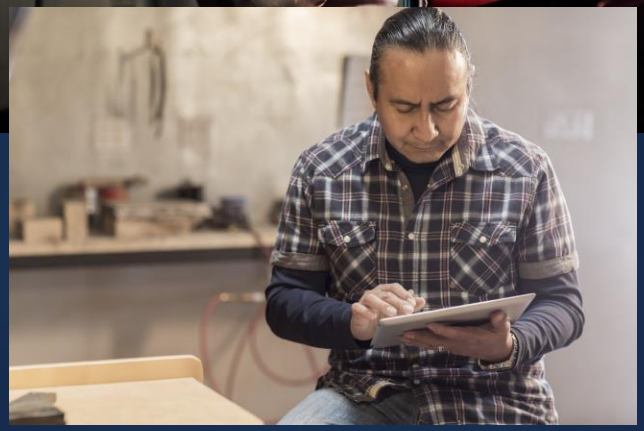

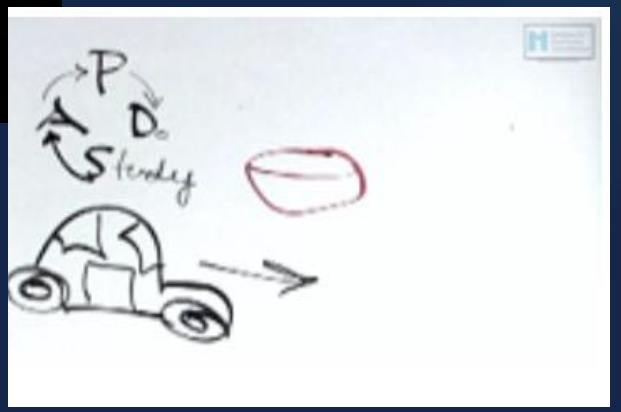

5

IMPLEMENT
DETAILING PROCESS

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slide sample

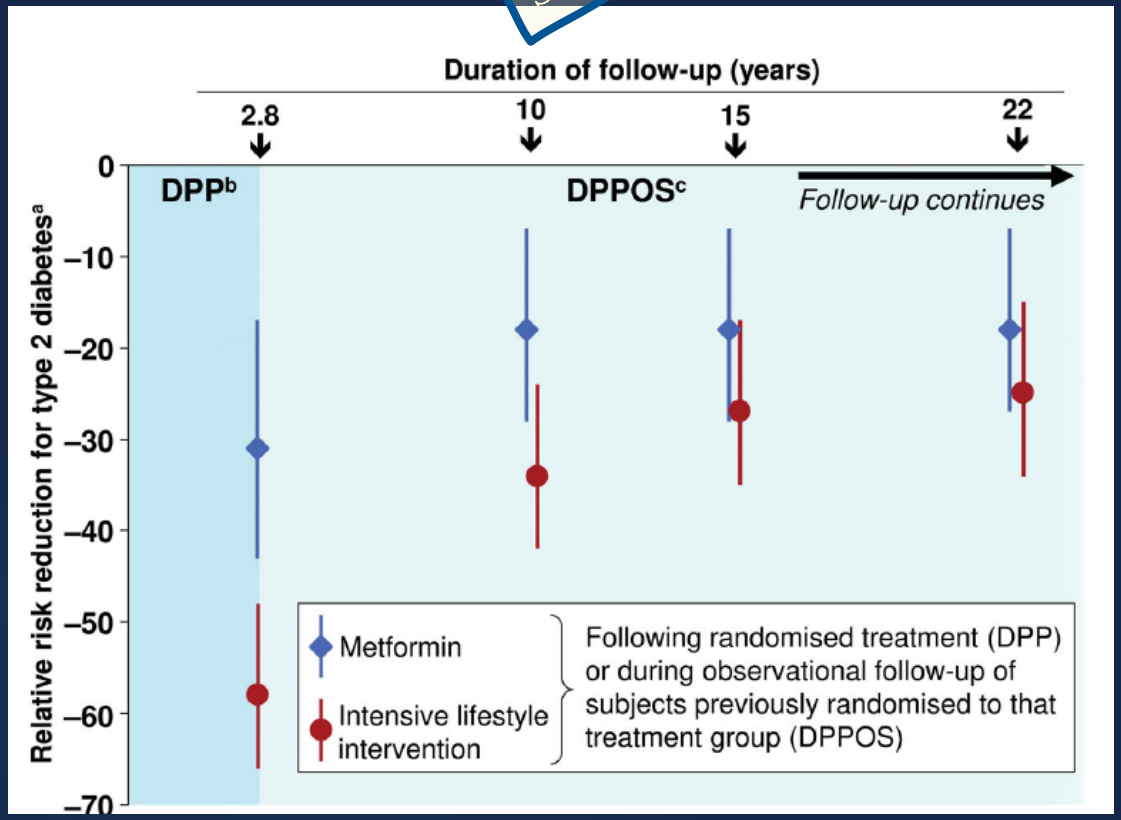

Figure 2. Summary of relative risk reductions for type 2 diabetes in the Diabetes Prevention Program (DPP) and its epidemiological follow-up study, the Diabetes Prevention Program Outcomes Study (DPPOS). **A)** Relative to placebo (DPP) or subjects formerly randomised to placebo (DPPOS). **B)** Randomized phase. **C)** Epidemiologic follow-up. Bars are 95%CI. Points and bars have been displaced laterally where they overlap to improve clarity (all pairs of measurements were from the same time points).

Above chart is compiled from data presented in references14,62,65–68.: Hostalek, U., & Campbell, I. (2021). Metformin for diabetes prevention: update of the evidence base. Current medical research and opinion, 37(10), 1705–1717. https://doi.org/10.1080/03007995.2021.1955667)

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TRACKING!

- Excel, Access, Contact Relationship Management
  - Tracking Materials
  - Tracking Results

#	FOLDER	Presentatio	CONTACT NAME				IMPLEMENT DETAILING PROCESS
1	X	X	Dr. Frances Ilozue	Follc 3/2; invit Wed prog	Presented slides to Dr. Ilozue Wed. 3/7 and received positive feedback, Dr. Ilozue ordered 20 copies of brochures at each site along with posters	On 3/8 went into the office to print the handouts, which I plan to drop off at Rapha's Main Street locations, 20 brochures for each location	3/10, dropped off handouts at Rapha's UB-Main Street location; on 3/15. dropped off additional handouts at Rapha's Sisters' Hospital Main Street office and spoke briefly with the office manager there
2		X	Ciera Ladd, front office management: 716-881-6191 Ext 308/304	Stop 2/24	Called back and spoke with Ciera 3/2/23; she will find out who is most appropriate to meet with and call back by end of day/3 pm; Laurene Walker, Operations Manager for the practice, has my contact information and will call back to set a time to discuss the program. (3/2/23)	Stopped by the Barton Road office 3/8 and spoke with Ciera, who set up an 8:45 a.m. time for me to meet with Laurene Walker tomrrow (Friday 3/10) on Broadway, third floor	Met with Lorene Walker on Friday, 3/10, to discuss the project and CDSMP classes, also took a paper survey from Lorene before the discussion. Gave her the presentation that could be shared with clinical staff, from my computer. I will follow up this week.

between 9 -11 am

MAP YOUR VISITS

5

IMPLEMENT DETAILING PROCESS

- PLAN BY ZONE/REGION/ZIP CODE
- USE MAPPING TOOLS TO MAXIMIZE VISITS

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HEALTHY ERIE COUNTY 2023 PROGRAM

Erie County Department of Health

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CHRONIC DISEASE SUPPORTIVE PATIENT HANDOUTS

ORDER FORM FOR PRINTED COPIES

DATE REQUEST FILED: 05/04/2023

REQUESTER'S NAME: K[redacted]

REQUESTER'S PHONE NUMBER: 716[redacted]

REQUESTER'S EMAIL ADDRESS: K[redacted].com

NYS Public Health Corps Fellowship Support Contact:

Liz Urbanski-Farrell, Senior Graduate Fellow

716-228-2884

elizabeth.urbanski-farrell@erie.gov

DELIVERY address, contact name and phone# and special instructions:

[redacted]

ITEM DESCRIPTION	# OF COPIES REQUESTED
CHRONIC DISEASE SELF-MANAGEMENT PROGRAM POSTER (English and Spanish)	English #10
CHRONIC DISEASE SELF-MANAGEMENT PROGRAM BROCHURES (English and Spanish)	English #20
AREA COURSE LISTING WITH REGISTRATION INFORMATION (English)	English #10
ERIE COUNTY DOH OHE KNOW YOUR NUMBERS HANDOUT-ENGLISH, SPANISH, BENGALI, ARABIC (Specify # of each)	English #30
BLOOD PRESSURE LOG-ENGLISH and SPANISH	

Ordered 7/7/23; DELIVERED: 7/18/23

Item	Description	Special requests	Cardstock	Language	Quantity		Amount	
	BLOOD PRESSURE LOG			English, Spanish	10 each language		20	
	MY PLATE visual meal planner			Eng., Sp., Bengali and Arabic	20 ea. Language		80	
	CDC Prediabetes Risk Test			Eng. Sp.	15 Eng., 10 Sp.		25	
	Updated course listing w/registration info.				30		30	
	Updated CDSMP DPP posters			English, Sp	5 ea		10	
	Updated CDSMP DPP Brochures			Eng., Sp	20 ea		20	
	Flexible flyers				40			
	Veggie Peelers				20			
	Water bottles				3	Total	185	

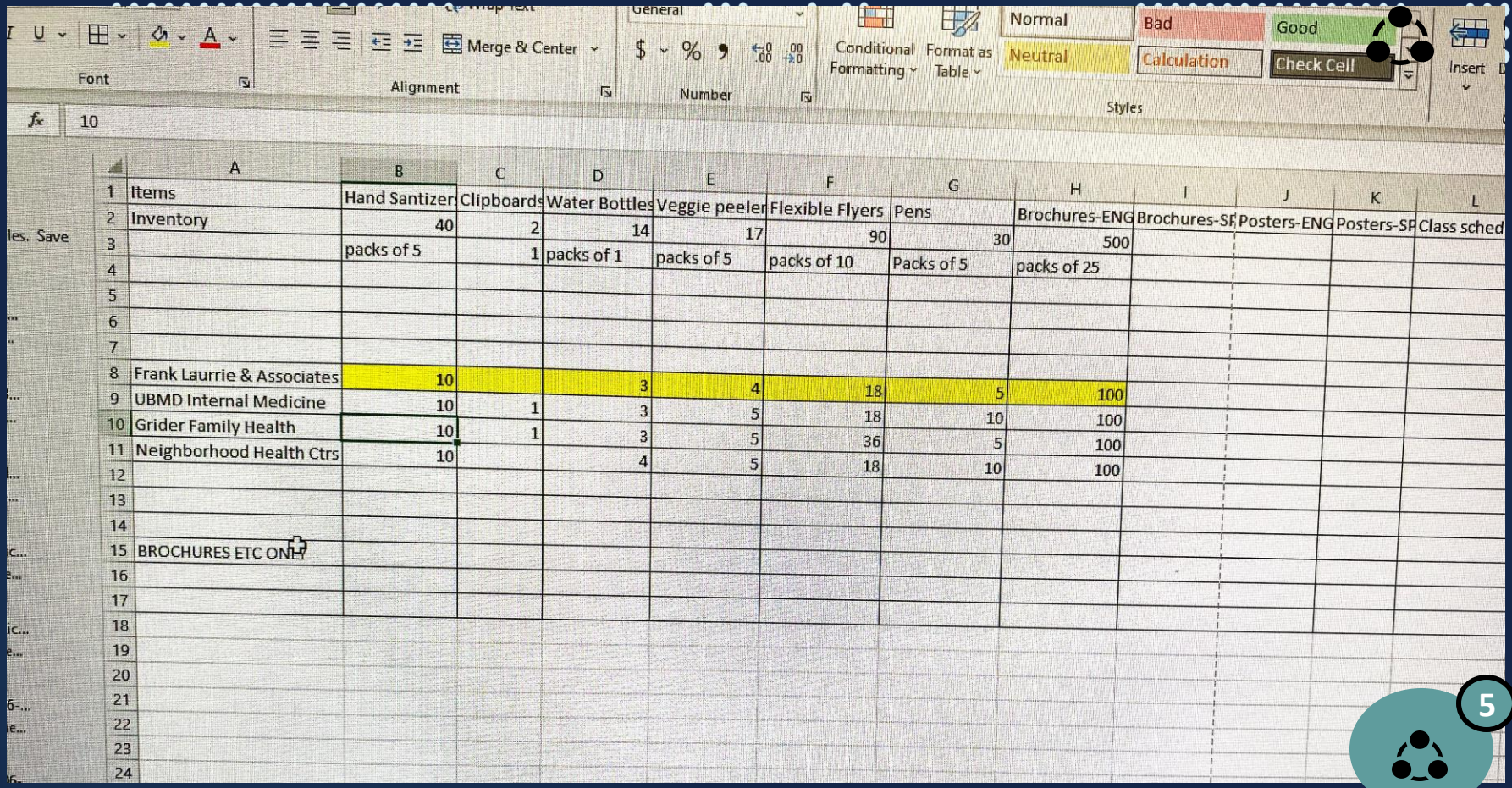
City/State/Zip Buffalo NY 14207

Note: Ordered 7/14/2023; Delivered 7/31/2023

Item	Description	Special requests	Cardstock	Language	Quantity		Amount	
	Chronic Disease SM Poster	X		English and Spanish	2 English, 2 Spanish		4	
	Blood Pressure Log			English, Spanish	100 English, 100 Spanish		200	
	Make the Connection: CKD, Heart Disease, Diabetes			English	50		50	
	CDC Prediabetes Risk Test			English, Spanish	100 English; 50 Spanish		150	
	Reading Food Labels			English, Spanish	200 English; 50 Spanish		150	
	Measure BP Accurately at Home			English, Spanish	100 English; 50 Spanish		150	
						Total	704	

5

IMPLEMENT DETAILING PROCESS



	A	B	C	D	E	F	G	H	I	J	K	L
1	Items	Hand Santizer	Clipboards	Water Bottles	Veggie peeler	Flexible Flyers	Pens	Brochures-ENG	Brochures-SP	Posters-ENG	Posters-SP	Class sched
2	Inventory	40	2	14	17	90	30	500				
3		packs of 5	1	packs of 1	packs of 5	packs of 10	Packs of 5	packs of 25				
4												
5												
6												
7												
8	Frank Laurrie & Associates	10		3	4	18	5	100				
9	UBMD Internal Medicine	10	1	3	5	18	10	100				
10	Grider Family Health	10	1	3	5	36	5	100				
11	Neighborhood Health Ctrs	10		4	5	18	10	100				
12												
13												
14												
15	BROCHURES ETC ONLY											
16												
17												
18												
19												
20												
21												
22												
23												
24												

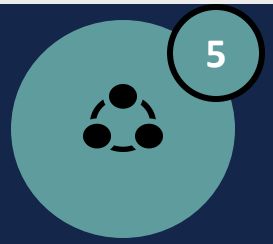
5

IMPLEMENT
DETAILING
PROCESS

PERSISTENCE

AVERAGE OF four (4) PHONE CALLS, (3) in-person public health detailing visits and two (2) emails per practice before a presentation could be given to a decision-maker in a medical practice.

PAYOFF



- When individualized PowerPoint presentations were made in front of clinical practice decision-makers, **91% --21 of 23--** practice locations decided to implement the target behavior (refer patients to lifestyle programs)


Prediabetes Risk Test
LET'S TALK ABOUT FOOD ACCESS
My Plate Planner
A Healthy Meal Tastes Great
DO YOU KNOW YOUR HEALTH NUMBERS?
Managing My Blood Pressure

Surveys: Before and After

- If doing a formal survey study, this is human-subject research and must have Internal Review/Board of Review approval

Informal for your information only:

Check with supervisors at your agency

5

IMPLEMENT DETAILING PROCESS

- Can help with continuous process improvement in detailing
- There may be an accessible agency survey tool

  Free Survey Monkey account limited to one survey, nine responses
- Be aware of bias in electronic surveys

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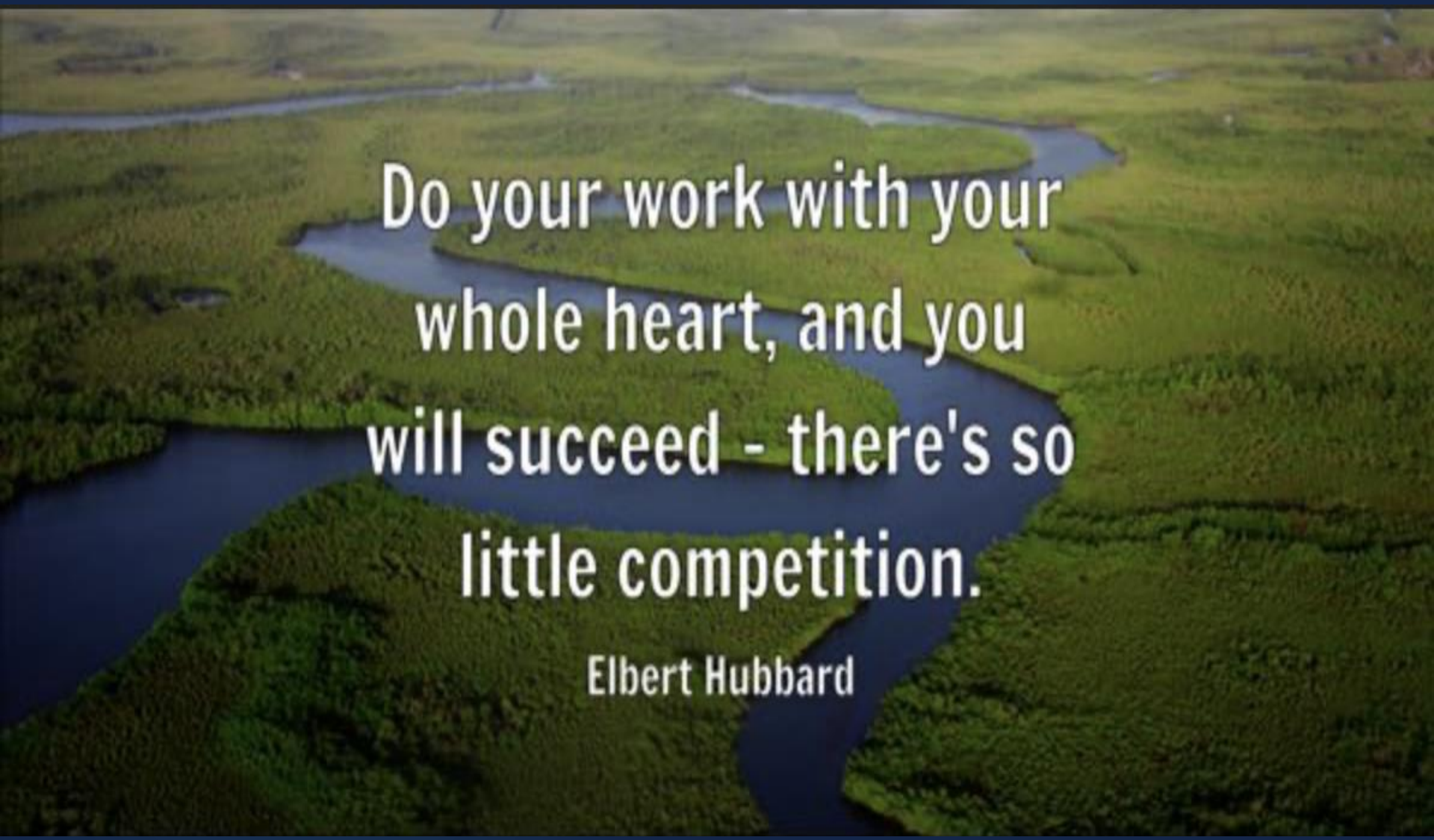
YOUR TURN!

NAME YOUR INITIATIVE

- **LIST OF POTENTIAL TARGET PRACTICES OR INDIVIDUALS FOR CLINICAL CHANGE EFFORTS:**
  - **WHERE CAN TARGET SERVICE RECIPIENT BE FOUND--WHAT TYPE OF PROVIDER HAS THE MOST INCENTIVE TO PARTICIPATE?**
- **INFLUENTIAL JOURNALS TO REVIEW FOR RESEARCH**
- **COLLABORATORS!**
  - NAMES AND NUMBERS OF **AGENCY RESOURCES: INDIVIDUALS AND DIVISIONS WHO CAN HELP**
  - NAMES AND NUMBERS OF **OUTSIDE AGENCY RESOURCES**

- **RESOURCE LIST WITH HYPERLINKS:**
  - **CDC, RWJF, KAISER FAMILY FOUNDATION AND NYS DOH**
  - MEDICAL PROVIDER **INCENTIVES**
- **SAMPLE SCRIPT: TEMPLATE**
- **SAMPLE PROCESS WORKFLOW** FOR MEDICAL OFFICE
- **POTENTIAL OR LIKELY BARRIERS** AND HOW TO OVERCOME THEM



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THANK YOU !

Liz Urbanski-Farrell, MBA, MS
Senior Graduate Public Health Fellow
NYS Public Health Corps/ECDOH/Rural Outreach Center

eufarrell@theroc.co
urbanskifarrellliz@gmail.com
716-228-2884

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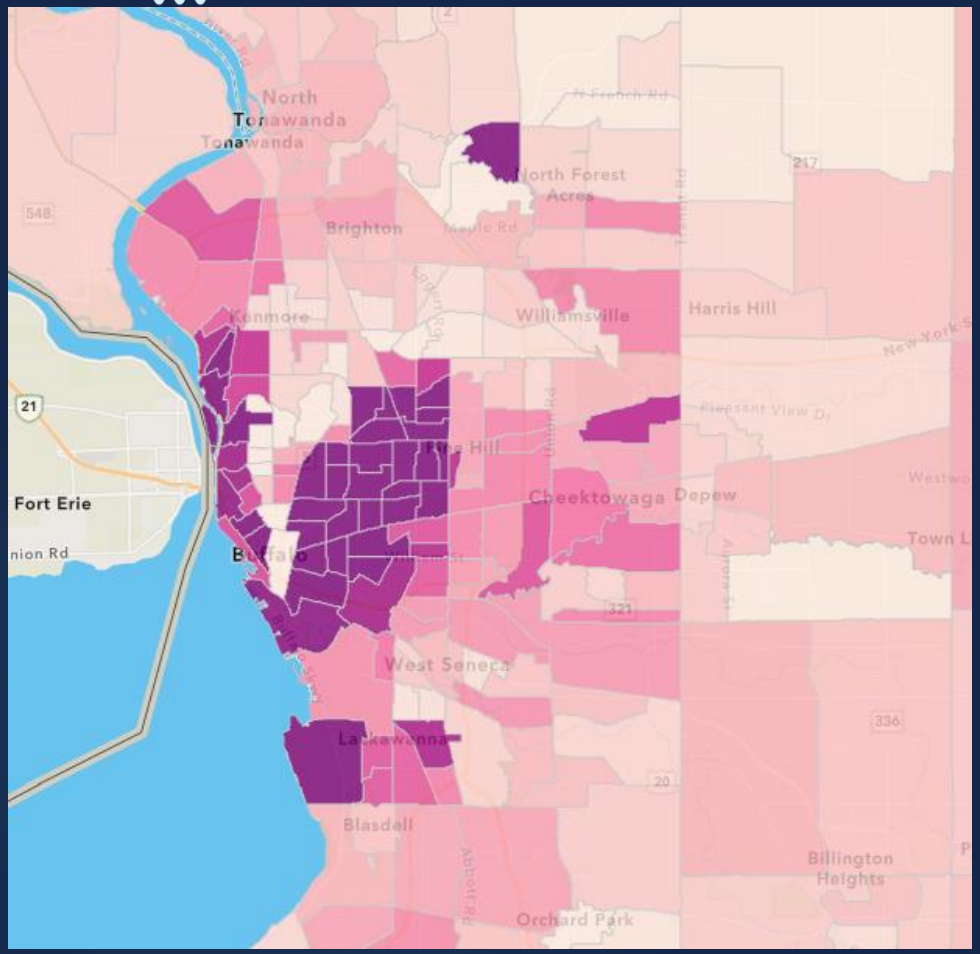
WHY



Erie County, NY

- Diabetes Crude Prevalence Rate, Adults 18+ =10.3% (2020) [1]

Sources: The model-based estimates were generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.
Note: Estimates are not available for areas shaded in gray. For more information visit https://www.cdc.gov/places.

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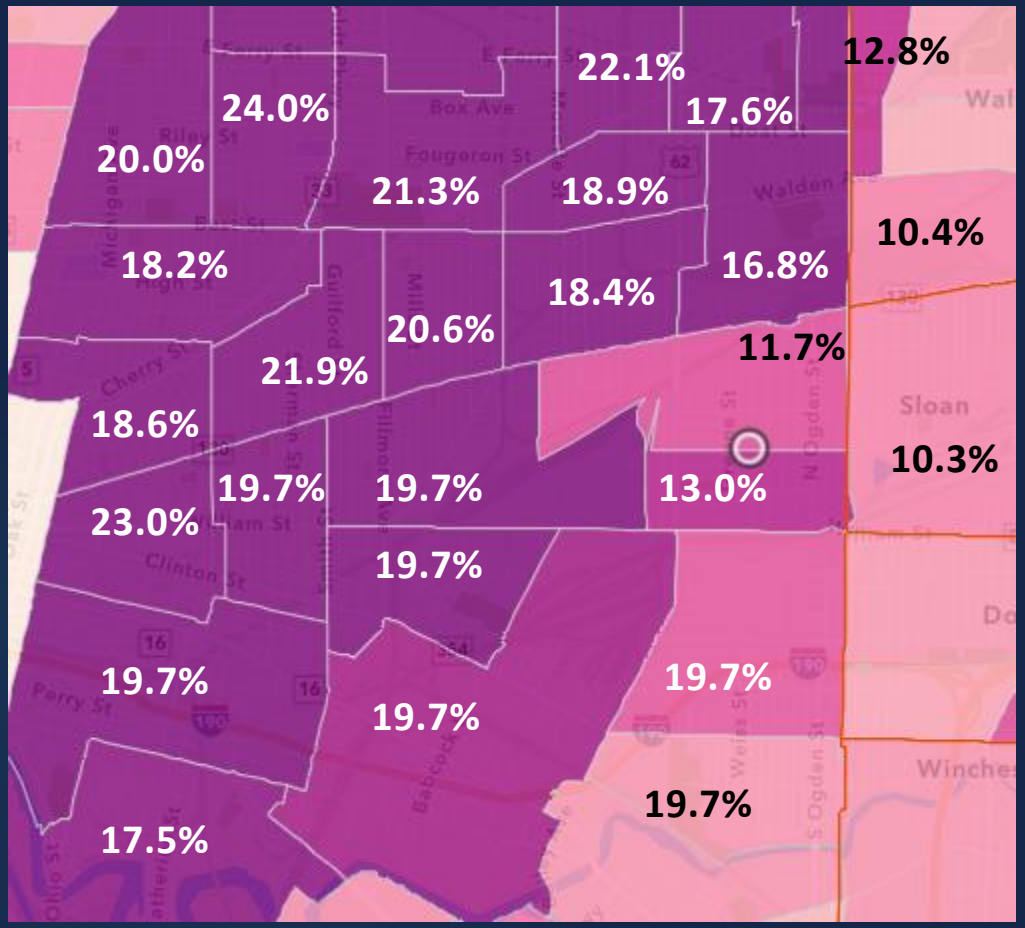

Diabetes

1

Legend

Tracts

Diabetes crude prevalence (%)

>= 14.4

10.8 - national average

< 7.2

Data sources: The model-based estimates were generated using BRFSS 2021 or 2020, Census 2010 population counts or census county population estimates of 2021 or 2020, and ACS 2015-2019 or ACS 2016-2020, ACS 2017-2021.

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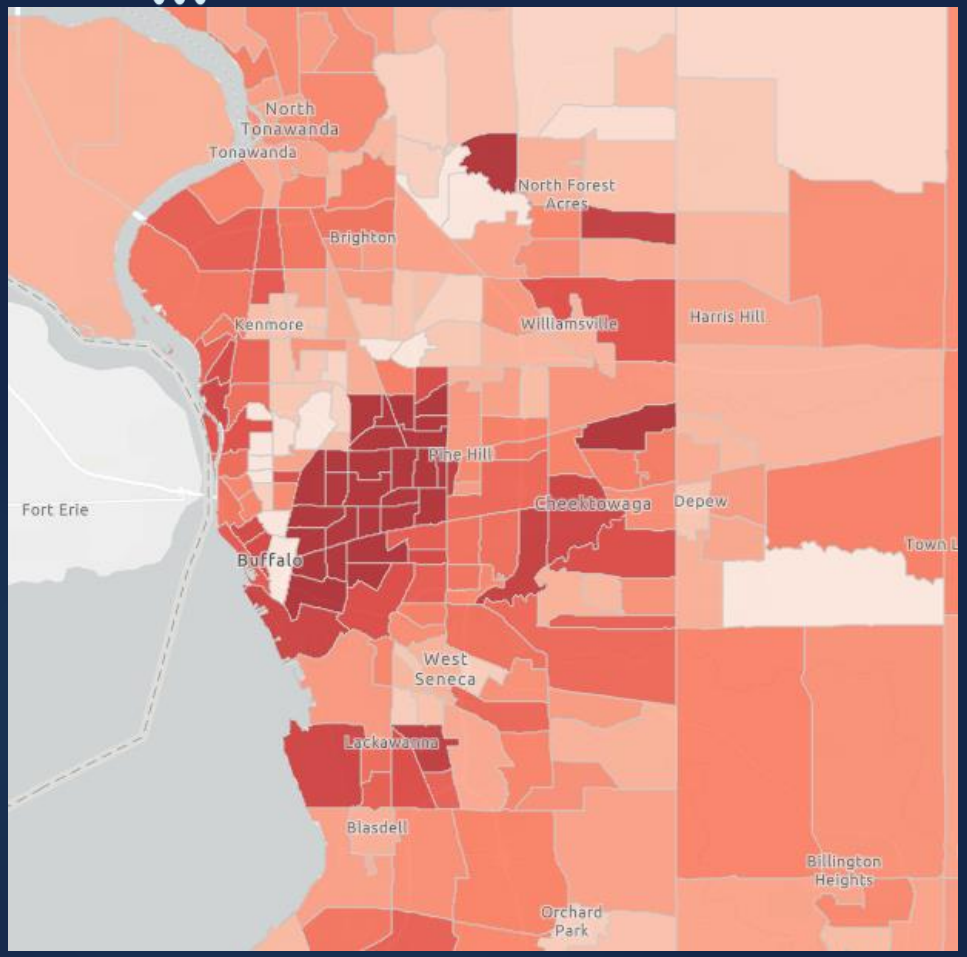
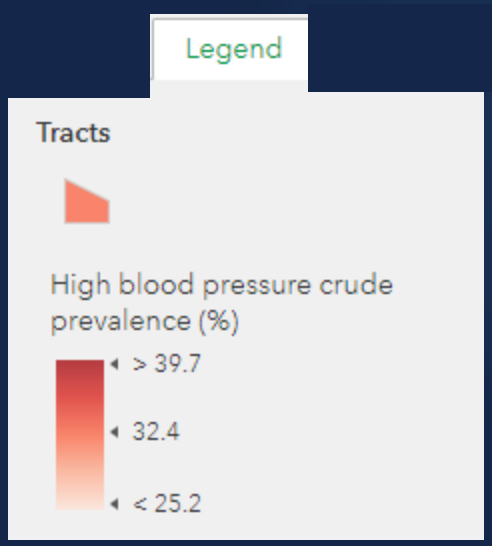
WHY



Erie County, NY

- High Blood Pressure Crude Prevalence Rate, Adults 18+
- = 32.4% (2019)



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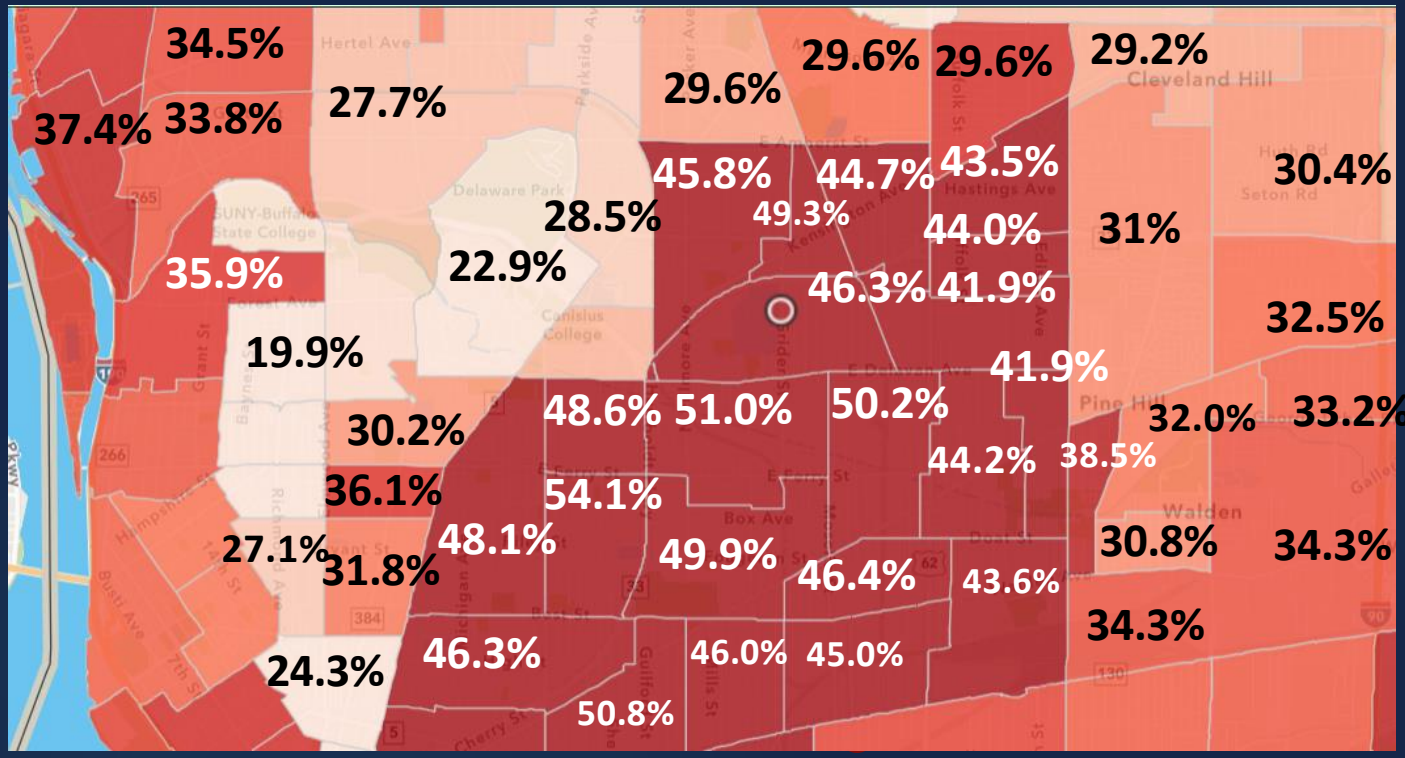
WHY



High Blood Pressure

Legend 1

Tracts

High blood pressure crude prevalence (%)

> 39.7

32.4

< 25.2

Sources: The model-based estimates were generated using BRFSS 2020 or 2019, Census 2010 population counts or census county population estimates of 2020 or 2019, and ACS 2015-2019.

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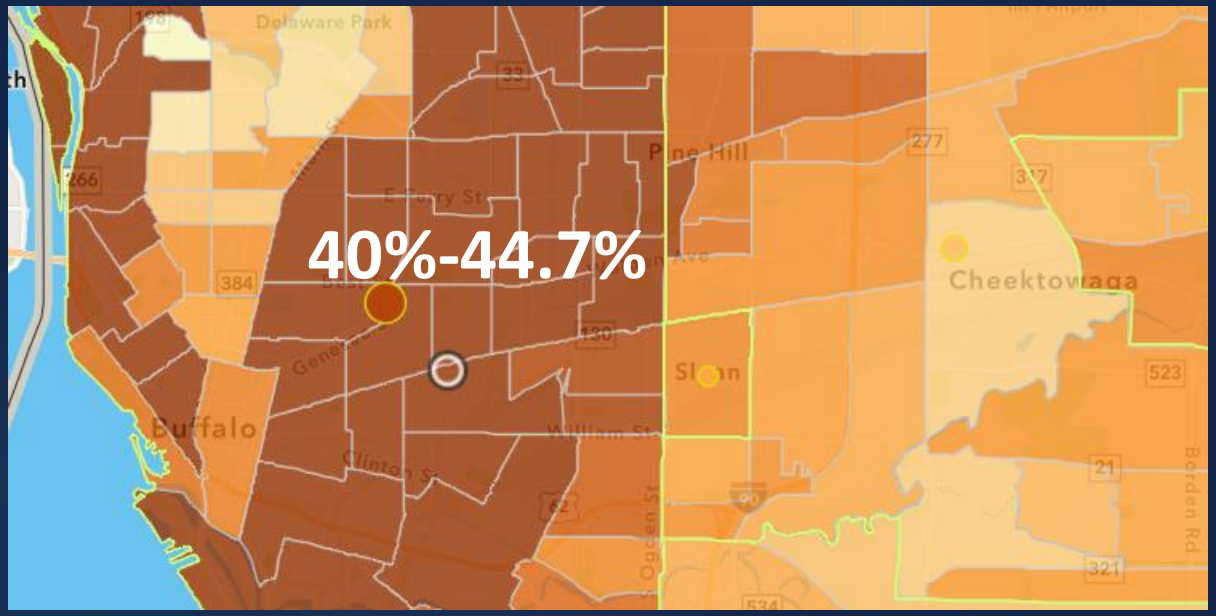
Obesity

Erie County
Crude Prevalence
Rate (18+) = 28.9%



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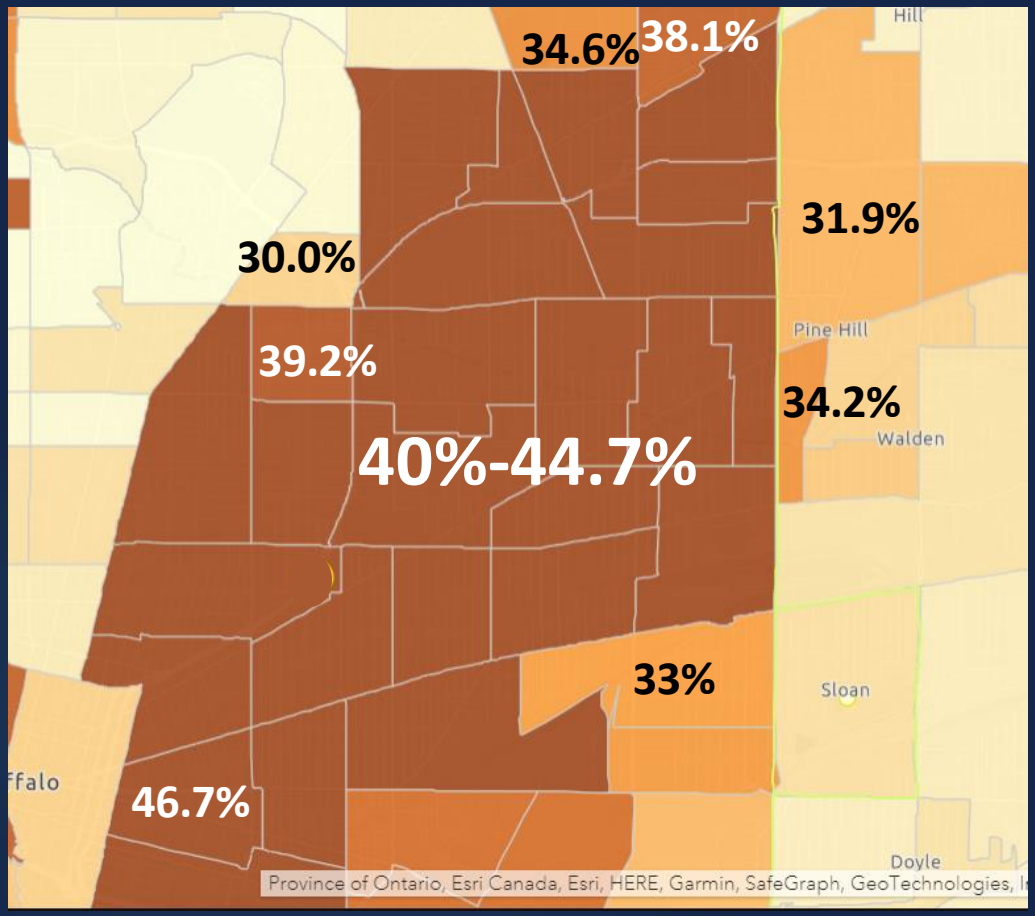

Obesity

1

Erie County
Crude Prevalence
Rate (18+) = 28.9%

Legend

Places

Obesity crude prevalence (%)

>= 40.2

34.6 - national average

< 29.0

Data sources: The model-based estimates were generated using BRFSS 2021 or 2020, Census 2010 population counts or census county population estimates of 2021 or 2020, and ACS 2015-2019 or ACS 2016-2020, ACS 2017-2021.
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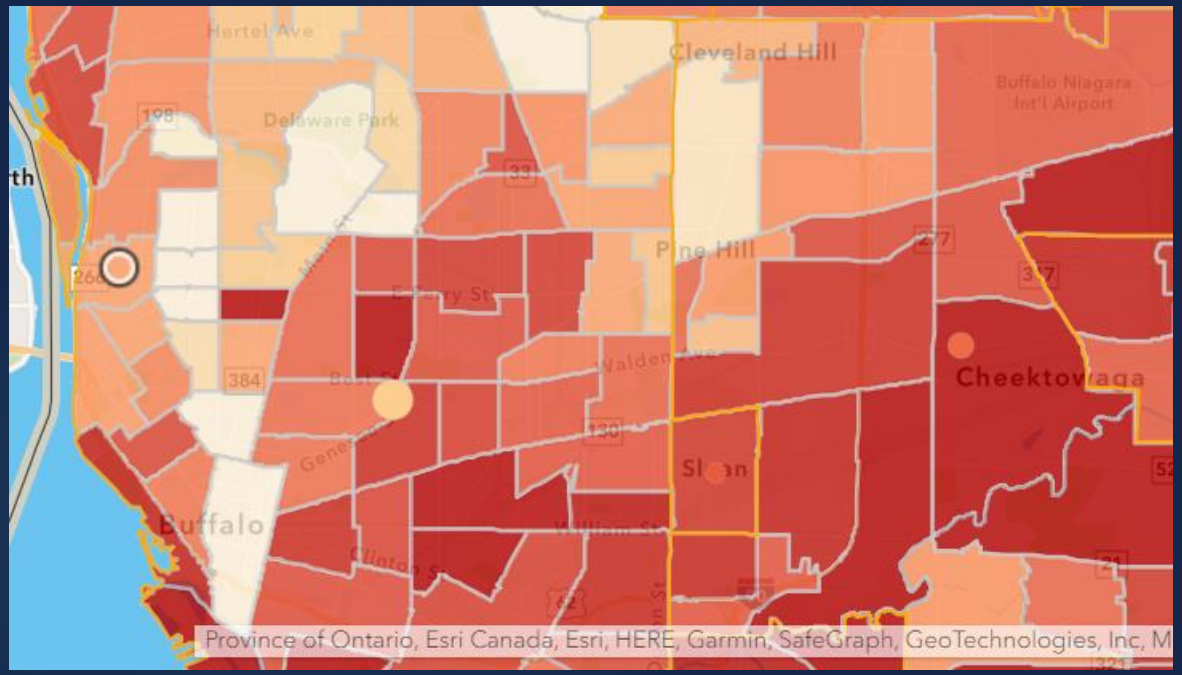
High Cholesterol

1

Erie County Crude Prevalence Rate = 32.8% (18+, screened in past 5 years)



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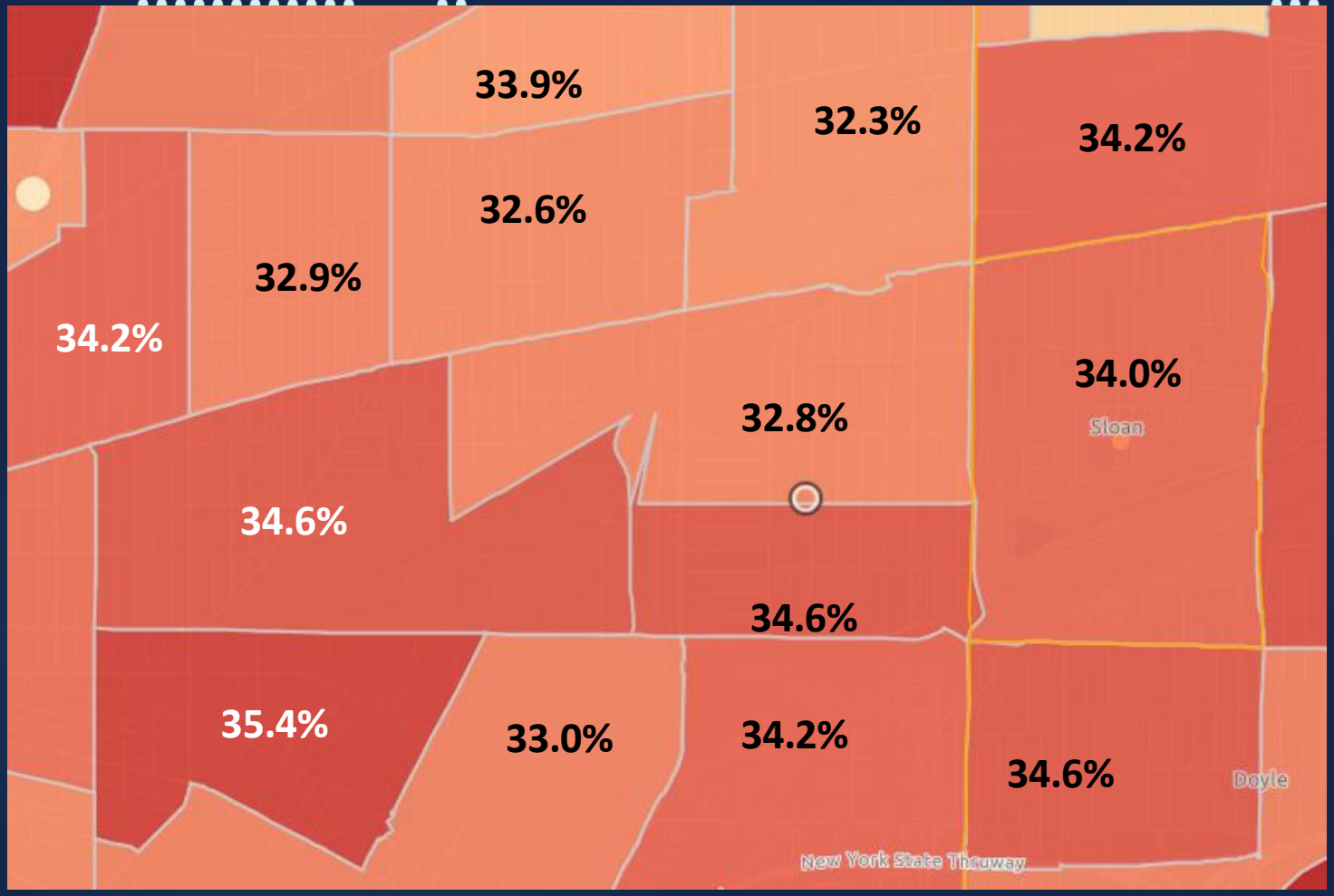

High Cholesterol

Erie County Crude Prevalence Rate = 32.8% (18+, screened in past 5 years)

Legend

Tracts

High cholesterol crude prevalence (%)

> 36.5

31.8

< 27.1

Data sources: The model-based estimates were generated using BRFSS 2021 or 2020, Census 2010 population counts or census county population estimates of 2021 or 2020, and ACS 2015-2019 or ACS 2016-2020, ACS 2017-2021.

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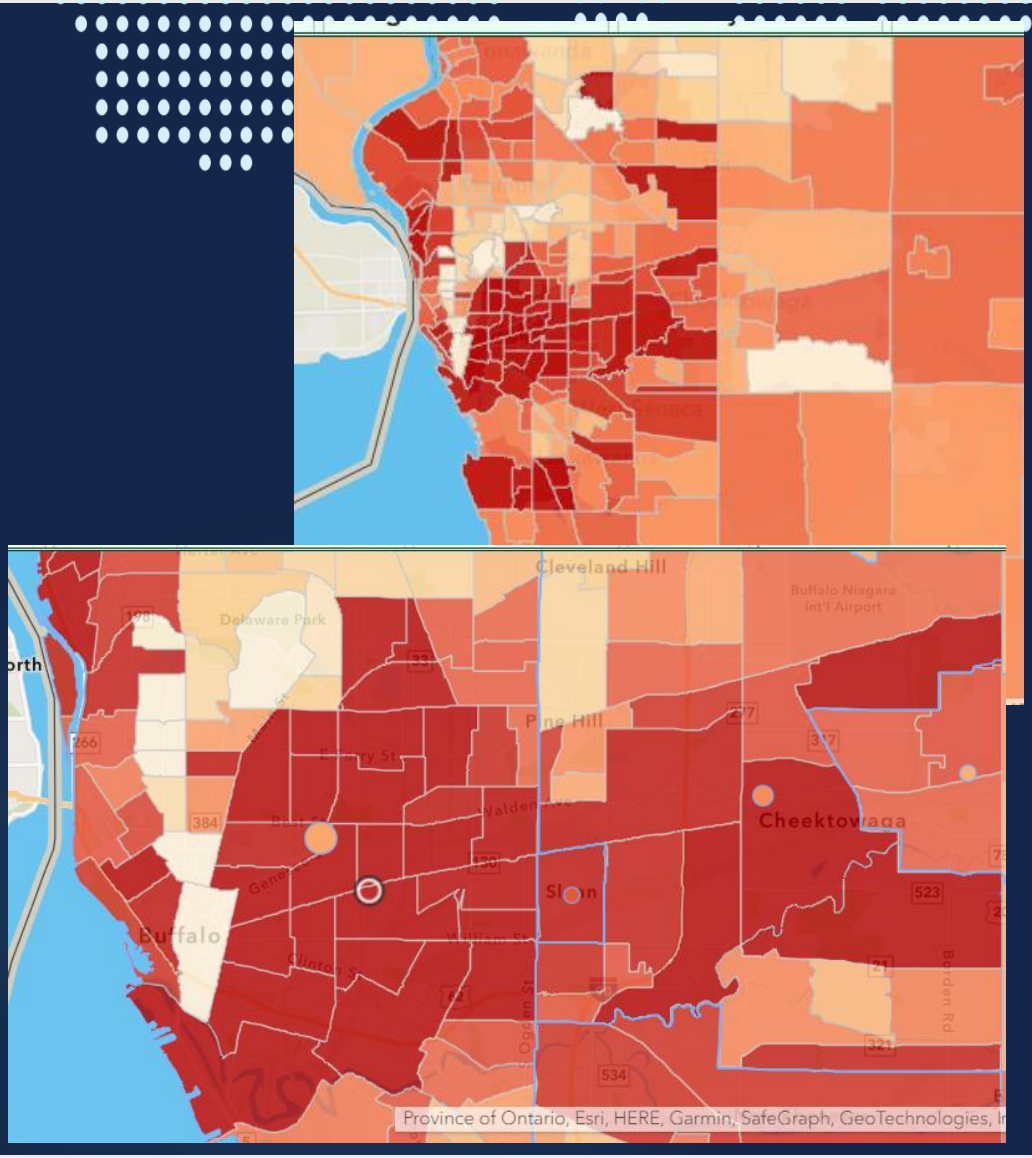

CORONARY HEART DISEASE

1

Erie County
Crude Prevalence
Rate (18+) = 6.6% (2020)

Legend

Places

Coronary heart disease crude prevalence (%)

- >= 9.0
- 7.1 - national average
- < 5.2

Data sources: The model-based estimates were generated using BRFSS 2021 or 2020, Census 2010 population counts or census county population estimates of 2021 or 2020, and ACS 2015-2019 or ACS 2016-2020, ACS 2017-2021.
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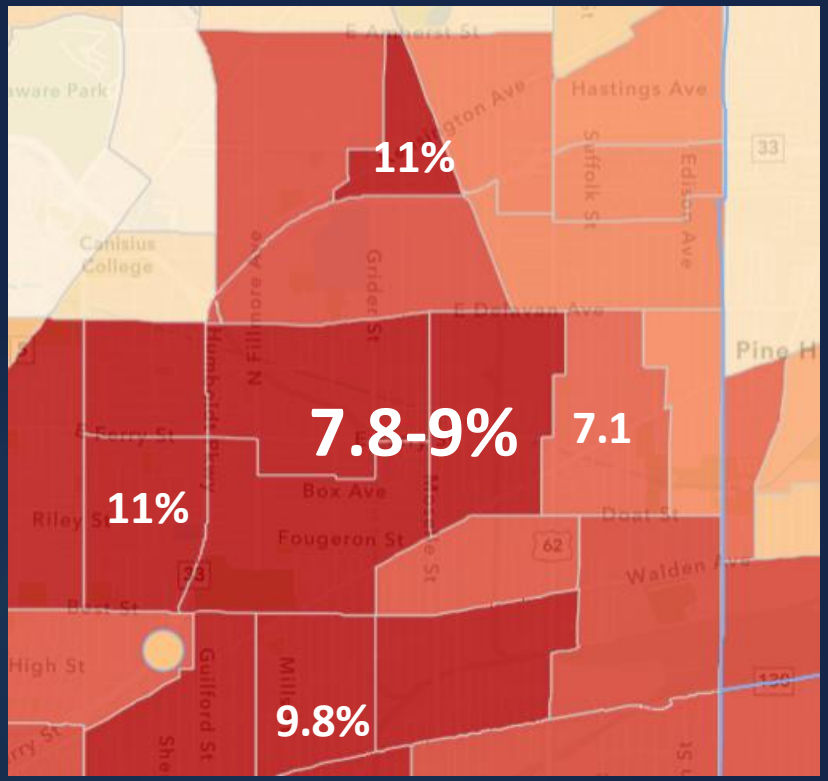
CORONARY HEART DISEASE

1



Erie County
Crude Prevalence
Rate (18+) = 6.6% (2020)

Legend

Places

Coronary heart disease crude prevalence (%)

- >= 9.0
- 7.1 - national average
- < 5.2

Data sources: The model-based estimates were generated using BRFSS 2021 or 2020, Census 2010 population counts or census county population estimates of 2021 or 2020, and ACS 2015-2019 or ACS 2016-2020, ACS 2017-2021.
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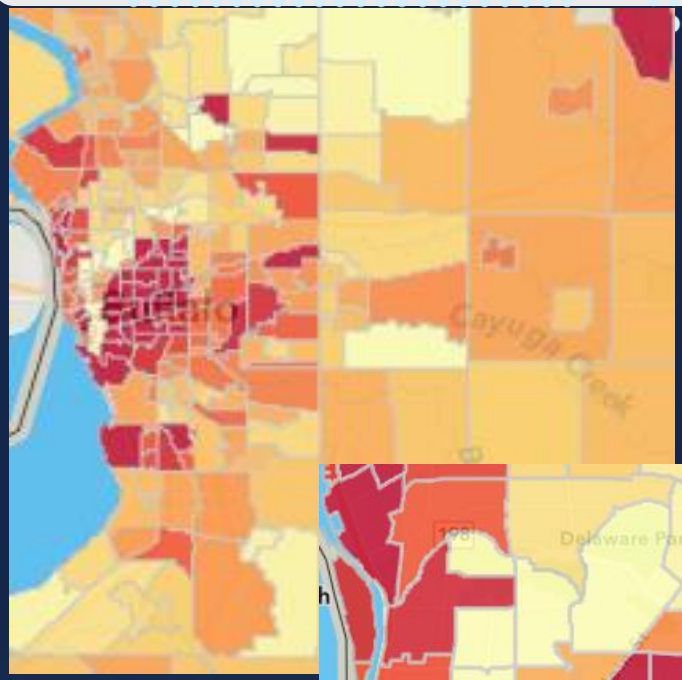
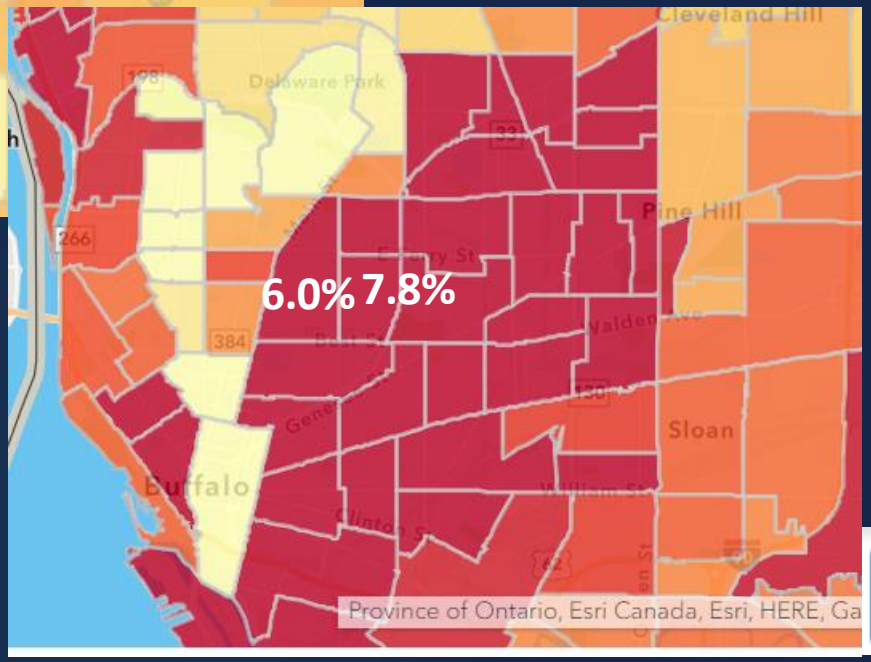
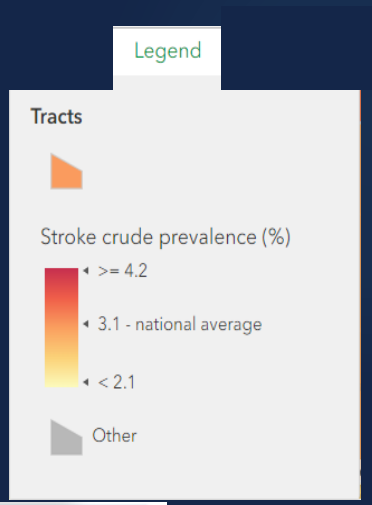
STROKE

Erie County
Crude Prevalence
Rate (18+) = AS HIGH AS 7.8% (2020) in some census tract areas, more than 2x the national average







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