Evidence-Based Health Promotion and Disease Prevention Programs on a Budget

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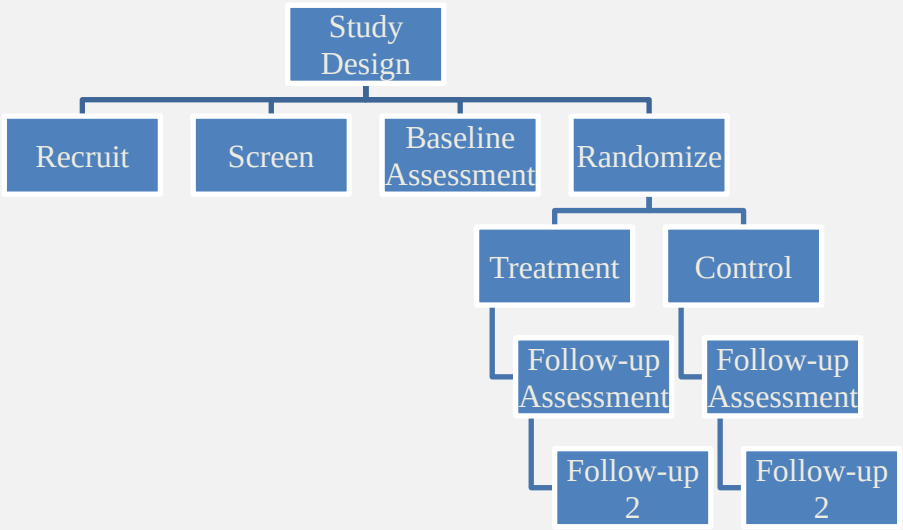
Building an Evidence Base: Randomized Control Trials

- Gold standard for evaluating efficacy of interventions - a properly conducted randomized controlled trial (RCT).

- Randomly assigning subjects to an intervention eliminates any bias from unknown characteristics of the sample that might contribute to treatment effects by balancing these characteristics evenly across intervention groups.



OAA Title IIID & Evidence based Programming

- OAA Title IIID - programs designed to help older adults prevent and/or manage chronic diseases and promote healthier lifestyles. Healthy aging reduces healthcare costs and increases quality of life.

- Older Americans disproportionately affected by chronic disease. Evidence-based programs mitigate negative impact of chronic diseases and falls and reduce use of hospital services and emergency room visits.

- Evidence-based programs empower older adults to take control of their health. Evidence-based initiatives provide the greatest impact given available OAA Title IIID funding.

Minimal Criteria

- Demonstrated through evaluation to be effective for improving the health and wellbeing or reducing disease, disability and/or injury among older adults; *and*
- Ready for translation, implementation and/or broad dissemination by community-based organizations using appropriately credentialed practitioners.

- *Examples: Silver sneakers; Healthy Eating for Successful Living among Older Adults*

Intermediate Criteria

- Published in a peer-review journal; and
- Proven effective with older adult population, using some form of a control condition (e.g. pre-post study, case control design, etc.); and
- Some basis in translation for implementation by community level organization.

- *Examples include: Eat Better Move More and Healthy-Steps*

Highest-level Criteria

- Undergone Experimental or Quasi-Experimental Design; and
- Level at which full translation has occurred in a community site; and
- Level at which dissemination products have been developed and are available to the public.

- *Examples include: CDSMEs; online CDSME; A Matter of Balance; National Diabetes Prevention Program; Active Choices, Active Living Every Day; Walk with Ease; Stepping On; New York University Caregiver Intervention (NYUCI); Healthy IDEAS; PEARLS; Care Transitions.*

Types of Interventions

- **Chronic Health Condition Focus**

  Educational programs designed to help people develop skills and confidence to manage their health condition

- **Physical Activity Focus**

  Small groups or self-directed interventions where people learn strategies to increase physical activity safely

- **Falls**

  Strengths-building, educational and environmental interventions.

Building New York's Capacity

- New York State Office for the Aging
  - Administration on Aging (Administration on Community Living)/ARRA/Prevention & Public Health Fund demonstration projects
- New York State Department of Health
  - CDC Arthritis/Diabetes/Healthy Heart and Integrated Programs
- The NYS Quality & Technical Assistance Center at the University at Albany

NYS QTAC

- Function as a backbone organization to support statewide scaling up and sustainability of evidence based programs

- Assist with bulk purchases and printing
- Provide Technical Assistance through webinars, site visits and call center

- Manage reach, quality assurance and fidelity data
- Operate a statewide partner registration and data entry portal

- Provide training for most EBIs we promote
- Work with state agency, community provider, health system and insurer partners

- Assist with sustainability planning

Our Partners Include:

- County offices for the Aging
- County Departments of Health
- Aging network agencies
- Health systems and Hospitals
- Physician practices
- Insurers
- Grass roots organizations/faith communities
- Independent Living Centers
- And more…

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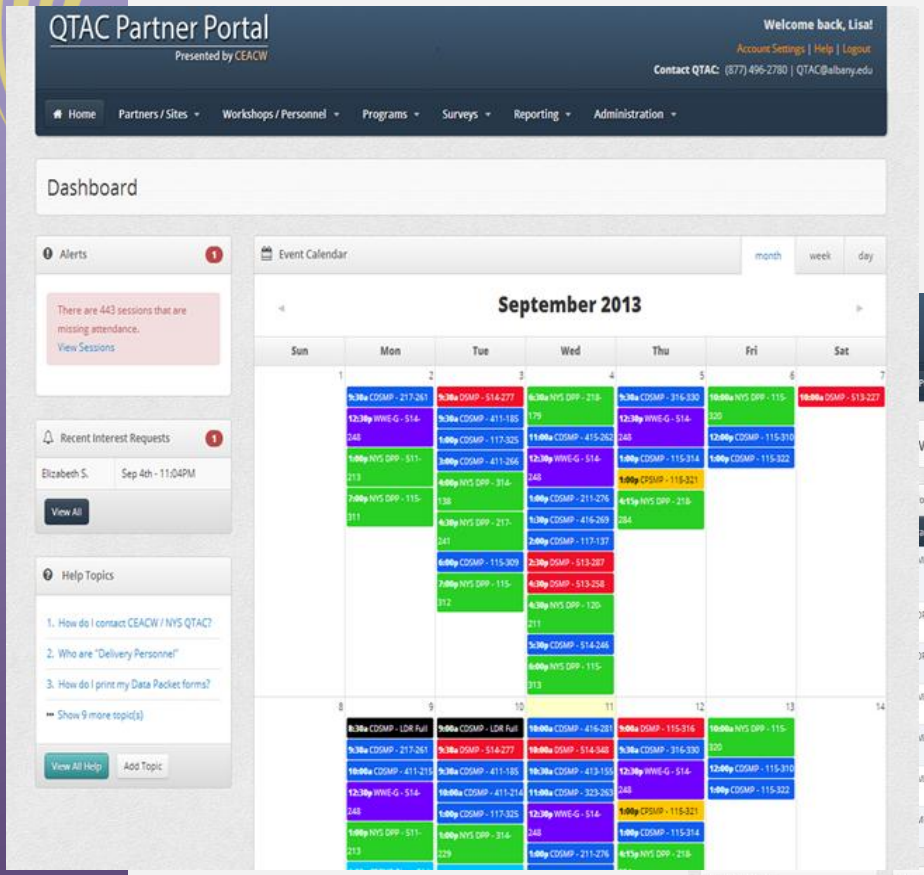
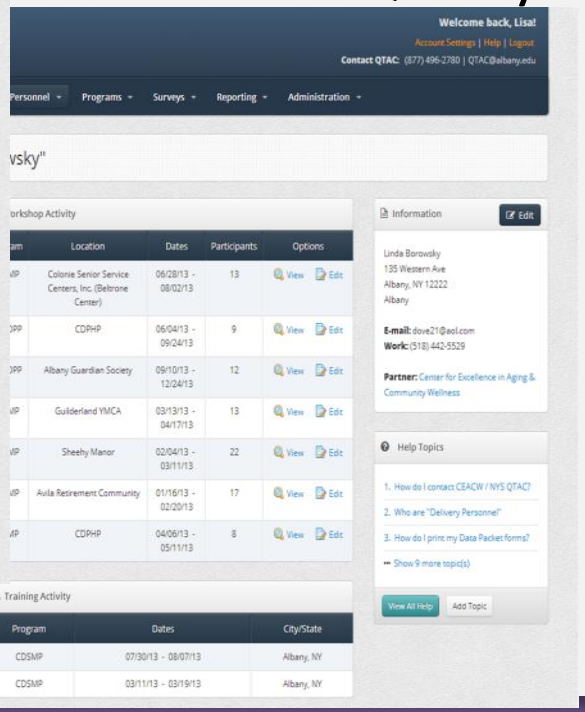
Partner Portal

- Registration system for self-referral and provider referral
- Project management tool
- Project data tool
- Data reporting/sharing
- Continuous Quality Improvement





Programs We Promote

- CDSME Suite of Programs
- Walk with Ease (self-directed)
- Active Living Everyday
- Active Choices
- National Diabetes Prevention Program
- A Matter of Balance

Randomized Control Trial Results for Supported Programs

- Improved physical activity
- Improved symptom management
- Reduced weight
- Reduced health care utilization
- Improved quality of life
- Greater likelihood of remaining in the community

CDSME Suite of Programs

- Chronic Disease Self-Management
  - Any chronic health condition and/or multiple conditions
- Diabetes Self-Management
  - Type 2 Diabetes
- Positive Self-Management
  - HIV/AIDS
- Chronic Pain Self-Management
  - Chronic Pain

Chronic Disease Self-Management Education Programs

- **Target audience:** Adults 18+ with chronic health conditions.
- **Program Goals:** To enable participants to build self-confidence to take part in maintaining their health and managing their chronic health conditions, such as hypertension, arthritis, heart disease, stroke, lung disease and diabetes. May be specific to program version.
- **Program Description:** Group program consisting of 6 weekly, 2.5 hour sessions (7 week for PSMP). Program provides information and teaches practical skills on managing chronic health problems.

CDSME
Implementation Basics

- **License: YES –** through Stanford University
- **Delivery and Training:** 2 Trained Leaders facilitate each workshop; 4.5 days of training and certification required through Stanford University. Training provided free or at a reduced cost.
- **Materials: YES** – book and CD for each participant.
- **Support from QTAC**: License, online registration and data entry and quality assurance and business planning assistance; bulk purchasing for participant materials.

Diabetes Self-Management Program

- Stanford University developed program
- Utilizes about 50% of the content from the CDSMP with a Type 2 Diabetes focus
- Remaining content is specific to concerns of people living with Type 2 Diabetes
- Topics include:
  - Menu planning, nutrition label reading
  - Managing High/Low Blood Sugar
  - Managing Sick Days, Foot Care, Testing
  - Monitoring Blood Sugar

CDSMP Plus for People Living with Hypertension

- Post CDSMP/DSMP module for people with hypertension
- Developed by Center for Excellence in Aging & Community Wellness with NYS DOH
- Hybrid health education and self-management to address health behaviors for people living with hypertension

Walk with Ease

- **Target audience:** adults over 18 with arthritis and or other lower extremity concerns and other chronic conditions, such as diabetes, heart disease and hypertension.
- **Program Goals:** Arthritis Foundation Walk With Ease program teaches strategies to make physical activity part of everyday life
- **Program Description:** self managed or 6 week group program that encourages developing, implementing and maintaining a safe walking routine

Walk With Ease
Implementation Basics

- **License: NO –** Cooperative Agreement needed for small group format
- **Delivery and Training:** Trained Leaders for small group format); training not needed (for self-directed format)
- **Materials: YES** – book for each participant
- **Support from QTAC**: Online registration and data entry and quality assurance and business planning assistance; bulk purchasing

Active Living Every Day

- **Target audience:** Adults interested in integrating physical activity into their daily lives.
- **Program Goals:** Active Living Every Day helps participants overcome their barriers to physical activity and make positive changes that improve their health and well-being.
- **Program Description:** 12 week class which incorporates a short lecture and group discussion

Active Living Every Day
Implementation Basics

- **License: NO –** Cooperative Agreement needed.
- **Delivery and Training:** At least 1 trained facilitator is needed for each class; training can be provided for free or at a reduced cost.
- **Materials: YES** – book and step counter or pedometer for each participant. Optional online tools.
- **Support from QTAC**: Online registration and data entry and quality assurance and business planning assistance; material ordering support.

Active Choices

- **Target audience:** Adults 50 and over.
- **Program Goals:** Active Choices helps participants incorporate preferred physical activities in their daily lives.
- **Program Description:** 6-month telephone-based individualized program that provides remote guidance and support and builds self-management skills.

Active Choices
Implementation Basics

- **License: NO –** Cooperative Agreement needed.
- **Delivery and Training:** Trained activity coach/peer counselor/facilitator who monitors progress, modifies exercise strategies and provides exercise tips; training can be provided for free or at a reduced cost.
- **Materials: YES** – information sheets for each participant.
- **Support from QTAC**: Online registration and data entry and quality assurance and business planning assistance.

National Diabetes Prevention Program

- **Target audience:** Adults 18+ who are at high risk for developing Type 2 Diabetes based on a fasting glucose or A1C or via a short risk survey.
- **Program Goals:** To prevent or delay the onset of Type 2 Diabetes, increase physical activity to 150 minutes per week and lose a minimum of 5% bodyweight.
- **Program Description:** 16 weekly, 1-hour core sessions followed by 6 monthly post-core sessions. 12-15 group participants. Program emphasizes sustainable lifestyle changes including improved nutrition, increased physical activity, stress reduction and coping strategies.

National Diabetes Prevention Program
Implementation Basics

- **License: NO –** Cooperative Agreement needed.
- **Delivery and Training:** Trained Lifestyle Coach facilitates each group session; free or reduced cost for 2-day training and ongoing mentoring.
- **Materials: YES –** participant handouts, book and weekly “Food & Activity” trackers.
- **Support from QTAC**: Online registration and data entry and quality assurance and business planning assistance; material ordering support.

Target Audience: Who Will Participate in the Lifestyle Change Program?

Overweight Adults:

- Limited to persons 18 years and older with a BMI of 24 or greater (Asian Americans: 22 or greater)

AND ALSO HAVE

Pre-diabetes:

- 50% of participants must have pre-diabetes **diagnosed** through blood test (FPG, OGTT, HbA1c) **OR** history of **gestational diabetes.**

- Other 50% eligible if screen positive for pre-diabetes based on **National Diabetes Prevention Program Risk Test**

A Matter of Balance

- **Target audience:** Adults 60 and over who are ambulatory, able to problem solve, concerned about falling, interested in improving flexibility, balance and strength and have restricted their activities because of concerns about falling.
- **Program Goals:** A Matter of Balance helps participants to reduce fall risk and rear of falling, improve falls self-management and improve falls self-efficacy and promote physical activity.
- **Program Description:** 8 weekly or twice weekly group sessions that emphasizes practical coping strategies to reduce fear of falling and teach fall prevention strategies.

A Matter of Balance
Implementation Basics

- **License: NO –** Cooperative Agreement needed.
- **Delivery and Training:** Trained Coaches facilitate each class; training can be provided for free or at a reduced cost.
- **Materials: YES** – workshop information packet and handouts for each participant.
- **Support from QTAC**: Online registration and data entry and quality assurance and business planning assistance.

Building a Sustainable Infrastructure for Successful Delivery of EBIs

Delivery Models: Centralized

- Centralized Models
  - Single coordinating organization
  - Manage key delivery activities for multiple partners
  - Utilize multiple funding sources to achieve capacity goals for all
  - Generally most successful way to serve targeted populations

Centralized Models: Advantages/Challenges

- Advantages
  - Streamline access for implementation sites, leaders, participants and evaluation data processes
  - Simplify cost structures for payment/reimbursement
  - Less complex structures needed to manage quality protocols
- Challenges
  - Limited by outreach territory
  - May present reach concerns for partners

Delivery Models: De-Centralized

- De-centralized Models
  - Multiple partners are key stakeholders
  - Each partner manages specific key delivery activities
  - Program resources shared across programs

De-Centralized Models: Advantages/Challenges

- Advantages
  - Workload shared across organizational partners
  - Resources shared across organizational partners
  - Reach potential possibly increased
- Challenges
  - More complex structures needed to manage quality protocols (who will do what, when and for whom?)
  - Access possibly more complex for partners, leaders, participants
  - More complex cost structures