Bureau of Community Health and Chronic Disease Prevention (BCHCDP)

Collaboration Opportunities with HOPs

South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment

Data Source: SC BRFSS; Generated by the Division of Chronic Disease Epidemiology

March 2015
Prevalence of Overweight or Obese among Adults by Race and Gender, S.C. 1986 – 2013

Data Source: SC BRFSS; Generated by the Division of Chronic Disease Epidemiology

April 2015
Diabetes Hospitalization Rates as the Primary Diagnosis by Number of Comorbidities, S.C. 2004 – 2013

Data Source: SC Revenue & Fiscal Affairs Office; Generated by the Division of Chronic Disease Epidemiology     May 2015
The most common chronic illness in the United States

The #1 cause of disability

40.5% of adults with arthritis also have at least one other chronic (ongoing) condition or disease

- 60% have high blood pressure
- 40% are obese
- 24% have diabetes
- 15% have heart disease
Why do we want to collaborate with HOPs?

- For US, we have a **PREVENTION** mandate
  - *Primary prevention* - How to avoid a chronic condition/disease(s), to begin with?
  - *Secondary prevention* - How to better manage a chronic condition/disease(s), once established?
Why do we want to collaborate with HOPs?

• To prevent and better manage major chronic conditions and diseases in the state, including:
  ▪ Obesity
  ▪ Diabetes
  ▪ Heart Disease
  ▪ Tobacco related illnesses
  ▪ Arthritis
  ▪ Other
Why do we want to collaborate with HOPs? Two other fundamental aspects

- Culturally and linguistically appropriate services
- Community engagement
Why do we want to collaborate with HOPs?

- For US, improving the health of South Carolinians while meeting our grant and funder expectations
- Today, we are looking for that sweet spot of collaboration.....

Sweet Spot!!
Why do we want to collaborate with HOPs?

- We believe:

  HOPs that prevent diabetes, heart disease, obesity, and tobacco use among their patients, and HOPs that better manage their patients’ chronic diseases, and fully engage stakeholders and partners in the community, and that provide culturally and linguistically appropriate services.......  

  Will be More Successful!
Services of Interest to HOPs

South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment
Diabetes Prevention, Self Management & Hypertension Control

Director: Rhonda L. Hill, PhD, MCHES

Division of Diabetes, Heart Disease, Obesity and School Health

South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment
Diabetes Prevention, Self-Management and Hypertension Control

**Purpose** – To improve the quality of chronic disease care delivered and improve the leading health indicators of patients within health systems by providing technical assistance and support for:

- The modification of Electronic Health Records (EHR) to collect data on blood pressure and A1C measures; identify patients with undiagnosed hypertension, diabetes and prediabetes and promote medication adherence;

- A team-based approach to caring for patients with hypertension, diabetes, and prediabetes;

- Increasing clinical screening, testing, and referral to lifestyle change programs;

- The establishment of accredited/recognized diabetes self-management education/training programs or an appropriate referral system for their patients with diabetes.
National Diabetes Prevention Program (National DPP)

What is the National DPP? A Centers for Disease Control (CDC) evidence-based program whose goal is to prevent or delay the development of type 2 diabetes and reduce cardiovascular disease.

Why is the National DPP Important? Because it does the following:

- Provides patients at high risk for type 2 diabetes a resource to help stop the progression to diabetes
- Decreases the prevalence of diabetes
- Increases awareness of prediabetes
- Reduces the cost of care
- Reinforces community/clinical linkages and engages health providers on prediabetes
Diabetes Prevention, Self-Management and Hypertension Control

**Target Audience** - Adults, 18 years of age or older

- **National DPP** - Overweight with a BMI greater than or equal to 24; Have a diagnosis of prediabetes or self-report from risk assessment; 140% below poverty level
- **DSME/T** – Diagnosed with diabetes with a physician referral

**Counties Served** – Statewide

**Cost**

- **National DPP** – We are working on reimbursement. Let’s talk about it.
- **DSME/T** – DSME/T is reimbursable

Contact Rhonda L. Hill at 803-898-1643 or hillrl@dhec.sc.gov
Community Nutrition Education

Director: Phyllis Allen, MS, RD, LD

Office of Professional and Community Nutrition Services

South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment
Community Nutrition Education

- **Goal:** Increase healthier food choices for those on a limited budget & increase physical activity

- **Focus:** Behavior-focused changes, evidenced-based nutrition education

- **Target Audience:** Supplemental Nutrition Assistance Program (SNAP) recipients & other low-income groups; families with children; teens; adults

- **18 Target Counties:** Bamberg • Calhoun • Darlington • Dorchester • Fairfield • Florence • Kershaw • Lee • Lexington • Marion • Orangeburg • Richland • Sumter • Hampton • Dillon • Newberry • Saluda • Williamsburg

- **Evaluation Findings:** Reading labels; buying and cooking at home; ↓ sugar sweetened beverages; ↑ fruits & veggies

**SNAP Ed Works**

Contact Brooke Brittain at 803-898-0918 or brittaba@dhec.sc.gov
Community Nutrition Education

- **Goal:** Empower low-income families with the knowledge and skills to prepare nutritious & tasty meals on a budget.

- **Focus:** Six-week course taught by a chef & nutritionist covering meal planning, budgeting, shopping, meal preparation and nutrition. Participants prepare dishes in class.

- **Target Audience:** Low-income families with children, teens and adults.

- **12 Target Counties:** Bamberg ● Dorchester ● Fairfield ● Florence ● Hampton ● Kershaw ● Lexington ● Newberry ● Orangeburg ● Richland ● Saluda ● Sumter.

- **Evaluation Findings:** Saving money on groceries; reading labels; buying and cooking at home; fruits & veggies and whole grains.

Cooking Matters Works

Contact Ashley Raasch Nitzkorski at 803-898-1629 or raaschac@dhec.sc.gov
Chronic Disease Self Management/Arthritis Prevention
Director: Michele James, MSW

Division of Healthy Aging
South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment
Chronic Disease Self-Management Program

Better Choices, Better Health & Tomando Control de su Salud
(the culturally appropriate Spanish version)

- 6 week *Chronic Disease Self-Management Program* for people with chronic conditions, their family members and caregivers.

- The goal is to help participants gain self confidence in their ability to control symptoms and learn how their health problems affect their lives.

- There is strong evidence across studies that the following *Triple Aim–related outcome measures* can be accomplished through the implementation of this program:
  - better health
  - better health care
  - better value
Physical Activity Programs

The following programs are proven to improve the quality of life of people with arthritis and other chronic conditions.

- **Walk With Ease (WWE)** a walking program developed to encourage people with arthritis and other chronic diseases to get started walking and to stay motivated.

- **Arthritis Foundation Exercise Program (AFEP)** is a community based group exercise program developed by the Arthritis Foundation that can be modified to accommodate different levels of capability and can be done either standing or sitting.

- **EnhanceFitness** is a community based group exercise program designed to help older adults at all levels of fitness (from fit to frail) become more active, energized and empowered to sustain independent living.

Let us give you more information on becoming a partner.

Contact Michele James at 803-898-0349 or jamesmd@dhec.sc.gov
S.C. Tobacco Quitline / 1-800-QUIT-NOW (784-8669)

In South Carolina:
- S.C. Tobacco Quitline is the only free statewide tobacco cessation treatment service in South Carolina
- Toll-free telephone access / 7 days a week / 8am – 3am
- Available to all population groups who smoke or use any tobacco or alternative nicotine product
- Offer specialized behavioral counseling protocols for certain types of tobacco users (pregnant, smokeless, etc.)
- Behavioral counseling + medication available for registered participants
- Trained Tobacco Treatment Specialists serve as Quit Coaches
- Provider referral system via fax or electronic transfer
- Free NRT patch, gum, lozenge, or combo for enrolled participants whose health plan does not cover these meds
Since 2006:

46.3% of tobacco users contacting the Quitline for help have chronic conditions:
- COPD = 12,015
- Asthma = 10,961
- Diabetes = 8,517
- CAD = 6,013

Yet fewer than 20% of SC healthcare providers take advantage of the Quitline’s free treatment services for their patients.

**GOAL:** By 2020, 90% of South Carolina Healthcare Providers and Health/Hospital Systems will have standard protocols in place to conduct evidence-based Brief Tobacco Intervention (BTI) with all of their patients who smoke.
The Quitline Can Help HOPs Meet National Quality Assurance Standards

- **Meaningful Use Initiative**
  - Enabling Quitline EHR/eReferrals for Providers and Health Systems

- **The Joint Commission Hospital Cessation Performance Measures**
  - Evidence-based Cessation Referral for Hospitalized Patients upon Discharge

- **NCQA PCMH Recognition**
  - Addressing Smoking Cessation to Comply with PCMH Standards #3 & #4
DHEC Resources for Healthcare Providers

Division of Tobacco Prevention & Control

Free CME Training: www.helppatientsquitsc.org

Free Materials: www.scdhec.gov/quitforkeeps/HelpYourPatientsQuit/

Free Fax Referral Tool: www.scdhec.gov/Library/d-1617.pdf

Free eReferral Technical Assistance: www.scquitline.org

Contact Katy L. Wynne, EdD, MSW at 803-545-4464 or wynnekl@dhec.sc.gov
Why is CLAS important?

- Federal Mandate:
  - Ensures compliance with Title VI of the civil rights act of 1964
  - Federal Law that protects persons from discrimination based on their race, color or national origin in programs and activities that receive federal financial assistance.

- Culturally and Linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006).

- Ethical and Practical Reasons (National Center for Cultural Competence):
  - To respond to current and projected demographic changes in the United States
  - To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds
  - To improve the quality of services and primary care outcomes
  - To decrease the likelihood of liability/malpractice claims
National Standards for Culturally and Linguistically Appropriate Services

- **Purpose**
  - To provide a blueprint for health and healthcare organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality of care, and eliminate health care disparities

- **Components of the Standards** (15 standards total)
  
  *One principle standard and three themes:*

  - **Principle Standard**
    - Provide Effective, Equitable, Understandable, and Respectful Quality Care and Services
    - Theme 1: Governance, Leadership and Workforce
    - Theme 2: Communication and Language Assistance
    - Theme 3: Engagement, Continuous Improvement and Accountability

Contact Jacqlyn Atkins at 803-898-1597 or baylisjr@dhec.sc.gov
Community Engagement

Director: Barbara Grice, MSPH, MCHES

Office of Community Health Improvement

South Carolina Department of Health and Environmental Control

Promoting and Protecting the Health of the Public and the Environment
Structured Method of Community Engagement

The **Community Health Improvement Toolkit** is based on Mobilizing for Action through Planning and Partnerships (MAPP). The toolkit provides guidance through a six step process, beginning with the mobilization of community partners, and culminating in the implementation of a comprehensive plan designed to improve the health of the community. The toolkit can ultimately provide:

- More community voices being heard
- Better health improvement plans

The Community Health Improvement toolkit is compatible with the IRS-required Community Health Needs Assessment (CHNA) for non-profit hospitals.
Community Health Assessment work has started in 42 out of the 46 counties in the state.