

## New York State Prevention Agenda *Preventing Chronic Diseases Action Plan*

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Chronic diseases such as cancer, diabetes, heart disease, stroke and asthma are conditions of long duration and generally slow progression. Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State (NYS). Specifically, they account for approximately 70 percent of all deaths in NYS and affect the quality of life for millions of New Yorkers, causing major limitations in daily living for about one in ten residents. Costs associated with chronic diseases and their major risk factors consume more than 75 percent of our nation's spending on health care.<sup>1</sup>

However, chronic diseases are also among the most preventable. Three modifiable risk behaviors – lack of physical activity, unhealthy nutrition, and tobacco use – are largely responsible for the incidence, severity and adverse outcomes of chronic disease. The World Health Organization has estimated that if the major risk factors for chronic disease were eliminated, at least 80 percent of all heart disease, stroke and type-2 diabetes would be prevented, and more than 40 percent of cancer cases would be avoided.<sup>2</sup>

As such, increasing physical activity, improving nutrition, and decreasing tobacco use form the core of the *Preventing Chronic Diseases Action Plan* for the *New York State Prevention Agenda*. Within this framework, the Action Plan places emphasis on three key areas: 1) *health promotion* activities to encourage healthy living and limit the onset of chronic diseases; 2) *early detection* opportunities that include screening populations at risk; and 3) *successful management* strategies for existing diseases and related complications. In addition, because of well-documented and widespread disparities in chronic disease incidence and mortality among vulnerable populations, addressing these health disparities is a focal point for the chronic disease action plan.

It is vital that NYS address chronic diseases and their causes to effectively stem the tide of escalating health care costs and ensure that New Yorkers lead healthy and productive lives. Without doing so, these persistent conditions will leave in their wake a growing burden of disability, compromised quality of life, and death, with well-considered and concerted action, could have been prevented.

### ***Sections of the Preventing Chronic Diseases Action Plan***

The *Preventing Chronic Diseases Action Plan* contains three Focus Areas:

**Focus Area 1:** Reduce obesity in children and adults.

**Focus Area 2:** Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.

**Focus Area 3:** Increase access to high-quality chronic disease preventive care and management in clinical and community settings.

Reducing obesity and tobacco use were selected as the first two focus areas because they are the leading causes of preventable death. Both conditions disproportionately impact low-income and minority communities, and both obesity and tobacco use directly and significantly contribute to other chronic diseases, including diabetes, cancer, heart disease, arthritis, asthma and others. Increasing access to high-quality chronic disease preventive care and management was selected as the third focus area, in recognition of the critical role of health care and community-based organizations in reducing the devastating impact of chronic diseases through prevention, screening, early detection, treatment, and self-management support. Achieving equitable outcomes and enhancing the well-being of vulnerable communities is integrated into all three focus areas.

### ***Objectives and Indicators***

Each focus area, and its accompanying goals, includes the objectives and indicators that will be used to measure the State's progress. A subset of these objectives will be tracked and published electronically in yearly reports for the State and counties (where county data is available); these objectives are marked as a *Prevention Agenda (PA) Tracking Indicators*. In addition, indicators that will track the State's progress towards reducing health disparities are marked as a *Health Disparities Indicator*. **Appendix 1** includes a list of the indicators with the data source; frequency of data collection; whether the data are available at the State, county or other level; and whether the data are available for subpopulations.

### ***Recommended Interventions for Consideration***

The Action Plan recommends interventions to address each focus area and related goals. Many of these interventions for consideration are intended for community level action; which interventions are selected by a community will depend on that community's needs and circumstances.

The interventions listed were selected after taking into account the interventions' evidence base, potential to address health inequities, ability to measure success, potential reach, potential for broad partner support and collaboration, and political feasibility. Each intervention refers to key documents that provide its evidence base and/or source. These references also show how the intervention aligns with and builds on existing Federal and State recommendations and initiatives. **Appendix 2** summarizes these key documents.

### ***Interventions (abbreviated) by Level of Health Impact Pyramid***

Each recommended intervention corresponds to one of the five tiers of the Health Impact Pyramid, a framework based on potential reach and the relative impact of interventions at each tier.<sup>3</sup> At the base are efforts to address socio-economic determinants of health (Tier 1). In ascending order are interventions that change the context to make individuals' default decisions healthy (Tier 2), clinical interventions that confer long-term protection (Tier 3), ongoing direct clinical care (Tier 4), and health education and counseling (Tier 5). Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort. Implementing the interventions at each level can achieve the maximum sustained public health benefit.

### ***Distribution of Interventions and Activities by Sector***

All organizations, or sectors, must play a role to effectively implement these interventions. These sectors include the health care delivery system; employers, business and unions; media; academia; community-based health and human service agencies; State and local government and non-governmental public health; other government agencies; policymakers and elected officials; and communities; and philanthropy. Activities taken by these different sectors to accomplish the objectives are listed for each goal area.

# Preventing Chronic Diseases Action Plan

## Focus Area 1: Reduce Obesity in Children and Adults

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### ***Defining the Problem***

Childhood and adult overweight and obesity have reached epidemic proportions in New York State (NYS) and across the nation. Nationally, 17 percent of American children and adolescents aged 2-19 years are obese, and obesity prevalence among adults exceeds 35 percent.<sup>4,5</sup> In NYS, 24.6 percent of adults are obese and another 35.6 percent are overweight, affecting an estimated 8.5 million.<sup>6</sup> Overweight and obesity affect 40 percent of New York City (NYC) public school students ages 6-12 years<sup>7</sup> and 32 percent of students in the rest of the State.<sup>8</sup> Among children ages 2-4 years, living in low-income families who participate in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in NYS, 31.5 percent are overweight or obese.<sup>9</sup>

Obesity and overweight are the second leading cause of preventable death in the United States (US) and may soon overtake tobacco as the leading cause of death.<sup>10</sup> By the year 2050, obesity is predicted to shorten life expectancy in the US by two to five years.<sup>11</sup>

Obesity is a significant risk factor for many chronic diseases and conditions, which reduce the quality of life, including type-2 diabetes, asthma, high blood pressure and high cholesterol. Increasingly, these conditions are being seen in children and adolescents.<sup>12</sup>

New York ranks second highest among states for medical expenditures attributable to obesity. Expenditures totaled \$11.1 billion (in 2009 dollars); \$4 billion financed by Medicaid and \$2.7 billion financed by Medicare.<sup>13</sup> Preventing and controlling obesity has the potential to save hundreds of millions of dollars annually. Failing to win the battle against obesity will mean premature death and disability for an increasingly large segment of NYS residents. Without strong action to reverse the obesity epidemic, for the first time in our history, children are predicted to have a shorter lifespan than their parents.<sup>14</sup>

The causes of obesity in the US and NYS are complex, occurring at social, economic, environmental and individual levels. There is no single solution sufficient to turn the tide on this epidemic. Successful prevention efforts will require multiple strategies, such as national, State and local policies and environmental changes that promote and support more healthful eating and active living and that reach large numbers of children and adults. These strategies must be supported and implemented in multiple sectors, including government agencies, businesses, communities, schools, child care, health care and worksites, to make the easy choice also the healthy choice.

## Focus Area 1: Goals, Objectives and Interventions

### Focus Area 1: Reduce obesity in children and adults.

**Overarching Objective 1.0.1:** By December 31, 2017, reduce the percentage of children who are obese:

- By 5% from 13.1% (2010) to 12.4% among WIC children (ages 2-4 years). *(Data Source: NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS])*
- By 5% from 17.6% (2010-12) to 16.7% among public school children Statewide reported to the Student Weight Status Category Reporting system. *(Data Source: NYS Student Weight Status Category Reporting [SWSCR]) (Prevention Agenda [PA] Tracking Indicator)*
- By 5% from 20.7% (2010-11) to 19.7% among public school children in New York City represented in the NYC Fitnessgram. *(Data Source: NYC Fitnessgram) (PA Tracking Indicator)*

**Overarching Objective 1.0.2:** By December 31, 2017, reduce the percentage of adults ages 18 years and older who are obese:

- By 5% from 24.5% (2011) to 23.2% among all adults.
- By 5% from 26.8% (2011) to 25.4% among adults with an annual household income of < \$25,000.
- By 10% from 34.9% (2011) to 31.4% among adults with disabilities.

*(Data source: NYS Behavioral Risk Factor Surveillance System [BRFSS]) (PA Tracking Indicators; Health Disparities Indicator)*

### Goal #1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.

**Objective 1.1.1:** By December 31, 2017, decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day:

- By 5% from 20.5% (2009) to 19.5% among all adults.
- By 10% from 42.9% (2009) to 38.6% among adults with an annual household income of < \$25,000.

*(Data source: NYS BRFSS) (Health Disparities Indicator)*

**Objective 1.1.2:** By December 31, 2017, increase the percentage of adults ages 18 years and older who participate in leisure-time physical activity:

- By 5% from 73.7% (2011) to 77.4% among all adults.
- By 10% from 59.0% (2011) to 65.0% among adults with less than a high school education.
- By 10% from 49.9% (2011) to 54.9% among adults with disabilities.

*(Data source: NYS BRFSS) (Health Disparities Indicator)*

*(Also, see: Focus Area – Built Environment)*

**Objective 1.1.3:** By December 31, 2017, increase the number of municipalities that have passed complete streets policies from 23 (2011) to 46. Complete streets are designed to allow residents to travel easily and safely, whether walking, biking or riding the bus, connecting roadways to complementary trails and bike paths that provide safe places to walk and bike.

*(Data source: Tri-States Transportation Campaign)*

*(Also, see: Focus Area - Built Environment)*

## Interventions for Consideration

### OVERALL

- Adequately invest in proven community-based programs that result in increased levels of physical activity and improved nutrition. (*Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*)

### HEALTHY EATING

- a) Increase retail availability of affordable healthy foods that meet the needs of communities, especially those with limited access to nutritious foods. This includes but is not limited to: developing business models that support increased use of healthy, locally grown/developed and minimally processed foods, especially in high-need areas; linking to the Regional Economic Development Councils, establishing local and regional food hubs to provide new market outlets for local and regional “producers” and providing technical assistance on production planning and sustainable production practices; attracting retail grocery stores; improving offerings at small stores; starting and sustaining farmers’ markets, fruits and veggies carts; and other innovative opportunities. (*Institute of Medicine – Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth [IOM Nutrition Standards for Schools]; IOM – Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation [IOM Obesity Prevention]; Healthy People 2020 [HP2020]; MMWR Recommended Community Strategies and Measurements to Prevent Obesity in the United States [CDC Community Strategies]*)
- b) Adopt policies and implement practices to reduce overconsumption of sugary drinks, such as make clean, potable water readily available in public places, worksites and recreation areas; implement policies aimed at reducing overconsumption of sugary drinks; and educate the public about the risks associated with overconsumption of sugary drinks. (*IOM Nutrition Standards in Schools; IOM Obesity Prevention; CDC Community Strategies*)
- c) Adopt policies and implement practices to increase access to affordable healthy foods for individuals living in group homes or adult homes for people with disabilities. This includes linking with the NYS Office for Persons with Developmental Disabilities, the NYS Office of Mental Health, and the NYS Office of Alcoholism and Substance Abuse Services to improve offerings of healthful foods and health education activities in these settings.

### PHYSICAL ACTIVITY

- a) Establish joint use agreements to open public areas and facilities for safe physical activity. (*IOM Nutrition Standards in Schools; IOM Obesity Prevention; HP 2020; CDC Community Strategies*)
- b) Adopt, strengthen and implement local policies and guidelines that facilitate increased physical activity for residents of all ages and abilities, including but not limited to: adopting complete streets policies that change how streets are designed and built, so that residents can travel easily and safely along community streets, whether they are walking, biking or riding the bus; connecting roadways to complementary systems of trails and bike paths that provide safe places to walk and bike; implementing traffic enforcement programs to improve safety for pedestrians and bicyclists; incorporating clear policy statements on pedestrian needs in a municipal Comprehensive Plan; considering pedestrian and non-auto transportation in site plan reviews; adopting zoning and other land-use regulations that place a priority on pedestrians over auto transportation; adopting active design guidelines that support the design of healthy buildings, streets and urban spaces; and, supporting smart growth strategies and zoning for new developments and revitalizing communities. Ensure that accessibility for people with disabilities and the elderly is a priority when adopting active design guidelines. (*IOM – Local Government Actions to Prevent Childhood Obesity, 2009; HP 2020; CDC Community Strategies; HHS 2008 Physical Activity Guidelines for Americans*)

## **Goal #1.2: Prevent childhood obesity through early child-care and schools.**

**Objective 1.2.1:** By December 31, 2017, increase the number of school districts whose competitive food policies meet or exceed the Institute of Medicine recommendations. (Baseline is expected to be determined in 2012 from a collaborative NYS Department of Health/NYS Education Department project.) (*Data Source: NYS Education Department Local Wellness Policies, 2012*)

**Objective 1.2.2:** By December 31, 2017, increase the number of school districts that meet or exceed NYS regulations for physical education (120 minutes per week of quality physical education in elementary grades K-6; daily physical education for children in grades K-3). (Baseline compliance: 5% 2008) (*Data Source: Office of the New York State Comptroller*)

### **Interventions for Consideration**

#### **EARLY CHILD CARE**

##### **Healthy Eating and Physical Activity**

- Adopt regulations and policies designed to implement standards that will support breastfeeding, quality nutrition, increased physical activity and reduced screen time in early childcare settings and increase staff training, community support and reinforcement of these regulations and policies. (*IOM Obesity Prevention; IOM – Early Childhood Obesity Prevention Policies; The Surgeon General’s Call to Action to Support Breastfeeding, 2011; Caring for Our Children, National Health and Safety Performance Standards, 2011*)

#### **SCHOOLS**

##### **General**

- Incorporate time into the school day so that students have adequate time to eat a nutritious lunch/snacks and engage in physical activity.

##### **Healthy Eating**

- Increase the number of schools that establish strong nutritional standards for all foods and beverages sold and provided through schools, such as establishing sugary drink policies, promoting access to free drinking water and adopting Institute of Medicine nutrition standards for school foods sold/served outside of federal child nutrition programs (competitive foods and foods sold through fundraisers). (*IOM Nutrition Standards in Schools; IOM Obesity Prevention*)

##### **Physical Activity**

- a) Increase the number of school districts that meet the NYS Education Department Regulations of the Commissioner Section 135.4 – Physical Education. Interventions include opportunities to increase physical activity before, during and after school, such as active recess and encouraging school transportation policies that support walking and bicycling to school. (*HP 2020; IOM Obesity Prevention; CDC School Health Guidelines to Promote Healthy Eating and Physical Activity [CDC School Health Guidelines]; National Association for Sport and Physical Education – Comprehensive School Physical Activity Guidelines [NASPE Guidelines]; NYS Education Department Regulations; HHS 2008 Physical Activity Guidelines for Americans*)
- b) Develop and provide support for the implementation, monitoring and enforcement of NYS Education Department learning standards for physical education and nutrition in grades K-12. (*HP 2020; IOM Obesity Prevention; CDC School Health Guidelines; NASPE Guidelines; NYS Education Department Regulations; HHS 2008 Physical Activity Guidelines for Americans*)

### **Goal #1.3: Expand the role of health care and health service providers and insurers in obesity prevention.**

**Objective 1.3.1:** By December 31, 2017, increase the percentage of children and adolescents ages 3-17 years with an outpatient visit with a primary care provider or obstetrics/gynecology practitioner during the measurement year, who received appropriate assessment for weight status during the measurement year:

- 29% from 58% (2011) to 75% among residents enrolled in commercial managed care health insurance.
- 5% from 72% (2011) to 75% among residents enrolled in Medicaid Managed Care or Child Health Plus.

*(Data Source: NYS Quality Assurance Reporting Requirements [QARR]) (PA Tracking Indicator)*

*(Also, see: Focus Area – Child Health)*

**Objective 1.3.2:** By 2017, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%. *(Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH)*

*(Also, see: Focus Area – Maternal and Infant Health)*

#### **Interventions for Consideration**

- a) Ensure public and private health insurance coverage of, access to, and incentives for breastfeeding education, lactation counseling and support. *(The Guide to Clinical Preventive Services)*
- b) Ensure public and private health insurance coverage of, access to, and incentives for routine obesity prevention screening, diagnosis and treatment, including diabetes prevention programs. *(IOM Obesity Prevention)*
- c) Increase the capacity of primary care providers to implement screening, prevention and treatment measures for obesity in children and adults through quality improvement methods and other training approaches, reimbursement and payment incentives. *(IOM Obesity Prevention)*
- d) Establish professional training programs in prevention, screening, diagnosis and treatment of overweight and obesity. Training should reach across the spectrum of medical, nursing, physician assistant schools; dietetics; allied health programs such as community health workers; and in continuing education. *(IOM Obesity Prevention)*
- e) Link health care-based efforts with community prevention activities such as comprehensive school-based obesity prevention programs; community-based, nationally recognized diabetes prevention programs; and breastfeeding counseling and support systems. *(IOM Obesity Prevention)*

**Goal #1.4: Expand the role of public and private employers in obesity prevention.**

**Objective 1.4.1:** By December 31, 2017, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities.

*(Baseline to be determined.) (Data Source: NYSDOH Healthy Heart Program Worksite Survey)*

**Objective 1.4.2:** By December 31, 2017, increase the percentage of employers with supports for breastfeeding at the worksite by 10%.

*(Baseline to be determined.) (Data Source: NYSDOH Healthy Heart Program Worksite Survey)*

*(Also, see: Focus Area – Maternal and Infant Health)*

**Interventions for Consideration**

- a) Increase the number of employers who offer benefits, coverage and/or incentives for obesity prevention, including breastfeeding support and obesity treatment. *(IOM Obesity Prevention)*
- b) Strengthen business practices that are aligned with NYS Labor Law to support breastfeeding at work, including but not limited to: providing an accessible, clean, private and safe space other than a restroom where breastfeeding mothers can express or pump breast milk; having a refrigerator available to store expressed breast milk; having a written policy allowing time off during the work day for mothers to express breast milk; and establishing a NYS Worksite Breastfeeding Friendly Designation Program.
- c) Develop community partnerships to increase comprehensive worksite wellness programs among small-to medium-sized employers, and ensure that the programs are appropriate for people with disabilities. *(IOM Obesity Prevention)*
- d) Implement evidence-based wellness programs for all public and private employees, retirees and their dependents through collaborations with unions, health plans and community partnerships that include but are not limited to increased opportunities for physical activity; access to and promotion of healthful foods and beverages; and health benefit coverage and/or incentives for obesity prevention and treatment, including breastfeeding support. *(IOM Obesity Prevention)*
- e) Increase adoption of food procurement and vending policies based on the Dietary Guidelines for Americans among public and private employers, including government agencies. *(CDC Community Strategies)*



## ***Interventions (abbreviated) by Level of Health Impact Pyramid***

<b><i>Focus Area 1: Reduce obesity in children and adults.</i></b>	
<b>Levels of Health Impact Pyramid*</b>	<b>Interventions</b>
<b><i>Counseling and Education</i></b>	<ul style="list-style-type: none"> <li>• Ensure public and private health insurance coverage of, access to and incentives for breastfeeding education, lactation counseling and support.</li> </ul>
<b><i>Clinical Interventions</i></b>	<ul style="list-style-type: none"> <li>• Ensure public and private health insurance coverage of, access to and incentives for routine obesity prevention screening, diagnosis and treatment.</li> <li>• Increase the capacity of primary care and other providers to implement screening, prevention and treatment measures for obesity in children and adults through quality improvement and other training methods, plus reimbursement and payment incentives.</li> <li>• Establish health training programs across the professional spectrum to include instruction in prevention, screening, diagnosis and treatment of overweight and obesity.</li> </ul>
<b><i>Long-Lasting Protective Interventions</i></b>	<ul style="list-style-type: none"> <li>• Link health care-based efforts with community prevention activities.</li> <li>• Develop community partnerships to increase comprehensive worksite wellness programs among small- to medium-sized employers.</li> <li>• Implement evidence-based wellness programs for all public and private employees, retirees and their dependents through collaboration with unions, health plans and community partnerships.</li> </ul>
<b><i>Changing the Context to Make Individuals' Decisions Healthy</i></b>	<ul style="list-style-type: none"> <li>• Adequately invest in proven community-based programs that result in increased levels of physical activity and improved nutrition.</li> <li>• Define/Innovate business models that support increased use of healthy, locally grown/developed/ minimally processed foods.</li> <li>• Increase retail availability of affordable healthy foods that meet community needs, especially those with limited access to nutritious foods.</li> <li>• Adopt policies and implement practices to reduce overconsumption of sugary drinks.</li> <li>• Adopt policies and implement practices to increase access to affordable healthy foods for individuals living in group homes or adult homes for people with disabilities.</li> <li>• Establish joint use agreements to open public areas and facilities for safe physical activity for all, including people with disabilities.</li> <li>• Adopt, strengthen and implement local policies and guidelines that facilitate increased physical activity for residents of all ages and abilities.</li> <li>• Adopt regulations and policies to implement standards supporting breastfeeding, quality nutrition, increased physical activity and reduced screen time in early childcare settings. Increase community support and reinforcement of these regulations and policies.</li> </ul>

<p><i>Changing the Context to Make Individuals' Decisions Healthy</i></p>	<ul style="list-style-type: none"> <li>• Incorporate time into the school day so that students have adequate time to eat a nutritious lunch/snacks and engage in physical activity.</li> <li>• Increase the number of schools that establish strong nutritional standards for all foods and beverages sold and provided through schools.</li> <li>• Increase the number of school districts that meet the NYS Education Department Regulations of the Commissioner Section 135.4 – Physical Education.</li> <li>• Develop and provide financial support for the implementation of NYS Education Department learning standards for physical education and nutrition in grades K-12.</li> <li>• Increase the number of employers who offer benefits, coverage and/or incentives for obesity prevention and treatment.</li> <li>• Strengthen NYS Labor Law and business practices that support breastfeeding at work.</li> <li>• Increase adoption of food procurement and vending policies based on the Dietary Guidelines for Americans among public and private employers, including government agencies.</li> </ul>
<p><i>Socioeconomic Factors</i></p>	<ul style="list-style-type: none"> <li>• Develop and implement community-led, place-based interventions targeted to address the social determinants of health in high-priority vulnerable communities.</li> <li>• Reduce educational disparities by race, ethnicity, and income that underlie disparities in obesity risk factors, obesity, and obesity-related diseases.</li> </ul>

\* Frieden T., "A Framework for Public Health Action: The Health Impact Pyramid". *American Journal of Public Health*. 2010; 100(4): 590-595

## ***Distribution of Interventions and Activities by Sector***

Changes can be made across all sectors to reduce illness, disability and death related to reduce obesity in children and adults. Below are examples of how your sector can make a difference.

### **Healthcare Delivery System**

- Adopt hospital policies to support use of healthy, locally grown foods in cafeteria and patient meals.
- Adopt healthy meal and beverage standards for meals sold and served in hospitals.
- Set example for community through breastfeeding-friendly hospitals and practices.
- Increase the number of *Baby-Friendly Hospitals*.
- Promote preventive interventions for obesity in pre- and post-natal care.
- Assist with referrals to community resources.
- Conduct Continuing Medical Education (CME) programs for health professionals, including programs on diet, exercise, stress, coping, obesity and disabilities.
- Offer information regarding availability of parks and trails to and in discussions with patients seeking free activities close to home.
- Support school-based health centers in obesity prevention interventions.
- Facilitate referrals for wellness services.

### **Employers, Businesses, and Unions**

- Partner with regional economic development councils and State business association for messaging on obesity prevention, including promoting access to healthy foods and increasing opportunities for physical activity.
- Connect schools and hospitals in rural areas to cross-promote obesity reduction activities.
- Engage business associations to promote/make visible and value obesity reduction.
- Site businesses with access to transit, walking and bicycling facilities, and develop workplace facilities and incentives that encourage active commuting.
- Require health insurance contracts to cover obesity and diabetes prevention programs.
- Require health insurers to cover nutrition education, lactation counseling, and other preventive strategies during pre- and post-natal care to promote recommended gestational weight gain and breastfeeding, and to prevent maternal, infant and child obesity.

### **Media**

- Use public service announcements to promote healthy eating, physical activity and breastfeeding.
- Increase the time allotted for programming that supports disease prevention.
- Help community organizations develop communication strategies to promote disease prevention and breastfeeding.
- Increase the time allotted for programming that supports breastfeeding.
- Conduct breastfeeding promotion/obesity prevention media campaigns.
- Create public service announcements and other programs that show people with disabilities included in public health activities as well as in healthy eating and physical activity messages.

## Academia

- Conduct research to support evidence-based approaches to reducing obesity.
- Identify emerging best practices.
- Evaluate obesity prevention initiatives.
- Develop data to strengthen the case for return on investment in obesity reduction programs and share with policymakers.
- Develop information for regional economic development councils about the benefits of locally produced, minimally processed foods.
- Develop the economic case for active transportation at the local level.
- Develop lists of model practices and resources for schools.
- Develop an economic benefits argument on implementing worksite wellness that is specific to New York State.
- Identify model practices in breastfeeding promotion among NYS employers.

## Community-Based Health and Human Service Agencies

- Create linkages with local health care systems to connect patients to community preventive resources.
- Expand public-private partnerships to implement community-based obesity preventive services.
- Support training and use of community health workers to provide breastfeeding support.

## Other Government Agencies

- Advocate for nutrition education in high-needs area by local dietetics clubs/associations.
- Develop standards for healthy eating and physical activity for individuals in group homes and adult homes.
- Assist in the development of nutrition education standards.
- Support education opportunities for school food-service workers on nutrition and wellness.
- Assist in the development of food procurement policies.

## Governmental (G) and Non-Governmental (NG) Public Health

- Provide technical assistance to community groups and local government wishing to create or enhance parks, playgrounds and trails as physical activity opportunities for residents, including those with disabilities. (NG)
- Provide guidance, training and support to communities to have skills to increase access to physical activity and nutrition. (G)
- Promote opportunities for availability of healthy foods. (G)
- Use social media to promote awareness of key obesity prevention strategies/practices, including a focus on populations affected by racial, ethnic, educational attainment and economic disparities. (G)
- Increase awareness of obesity as a risk factor for chronic disease. (G, NG)
- Educate lawmakers about the need for increased prevention funding. (NG)
- Share information with policymakers about benefits of promoting healthy local foods. (NG)
- Dedicate funds for trails, complete streets, safe routes to school and active transportation infrastructure and programs. (G)

- Increase State parks infrastructure repairs and improved park operations. (G)
- Collaborate with Child and Adult Care Food Program (CACFP) and WIC to promote breastfeeding-friendly early childcare centers. (G)
- Recognize schools and daycares that have policies/practices that promote obesity prevention. (G)
- Educate lawmakers about schools' low compliance of schools with physical education standards and the need to increase monitoring, evaluation and enforcement. (G, NG)
- Encourage the community to support implementation and compliance with Office of Children and Family Services (OCFS) new regulations affecting child day care centers and homes. (NG)
- Push for improved compliance with physical education requirements. (NG)
- Develop training for allied health professionals on obesity screening, prevention and referrals. (G)
- Create social marketing messages to promote breastfeeding education as the norm. (G)
- Advocate for insurance coverage for obesity and diabetes prevention programs. (NG)
- Work with the NYS Council on Food Policy to develop, promote and enforce food procurement guidelines for all State agencies. (G)
- Help identify models for best practices for worksite wellness at small and medium businesses/worksites. (G)
- Encourage participation in online tools such as the "Fit-Friendly" programs. (NG)
- Support establishment of obesity prevention coverage for public and private insurance. (NG)
- Provide private insurance and Medicaid incentives for births in *Baby-Friendly Hospitals*. (G)

### **Policymakers and Elected Officials**

- Strengthen enforcement and investigation of motor vehicle traffic violations that endanger pedestrians and bicyclists.
- Implement measures to preserve green space equitably, especially throughout urban neighborhoods.
- Increase local and State parks infrastructure repairs and improved park operations.
- Expand providers' awareness and knowledge of standards for obesity screening and prevention.
- Educate and advocate for restrictions on marketing and distribution of baby formula "gifts" through health care providers and hospitals.

### **Communities**

- Mobilize advocates to increase demand for healthy environments, food choices and improved opportunities for physical activity.
- Support use of funds for trails, complete streets, safe routes to school, active transportation infrastructure and programs and other non- motorized transportation enhancements.
- Increase awareness of and demand for additional local and State parks infrastructure repairs and improvements in park operations.
- Increase awareness of and demand for open space protection in each community.
- Support pedestrian facilities with all new development and open space or other recreational facilities with all new residential development.
- Increase awareness of and demand for improved school and child care practices.

- Encourage awareness of and demand for breastfeeding counseling/education.
- Advocate for restriction of marketing of unhealthful products to kids.
- Advocate for restriction of marketing of infant formula.
- Provide resources and availability of parks and trails to employers to augment worksite wellness programs.
- Advocate for stronger breastfeeding support at work laws/enforcement.

## Philanthropy

- Fund training programs for education and child care professionals on obesity interventions and related regulations.
- Provide resources to communities for obesity prevention interventions.
- Support research efforts aimed at informing the evidence base for obesity prevention.

**New York State Prevention Agenda**  
***Preventing Chronic Diseases Action Plan***

***Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure***

***Defining the Problem***

Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS) and in the United States.<sup>15</sup> Cigarette use, alone, results in an estimated 440,000 deaths each year in the United States, and 25,000 deaths in NYS.<sup>16</sup> There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer, including lung and oral; heart disease; stroke; chronic obstructive pulmonary disease and other lung diseases.<sup>17</sup>

The economic costs of tobacco use in NYS are staggering. Smoking-attributable health care costs are \$8.2 billion annually, including \$3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in \$6 billion in lost productivity.<sup>18</sup> Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health.<sup>19</sup>

This plan proposes a comprehensive program of interventions built upon evidence-based strategies from the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*<sup>20</sup> and *The Guide to Community Preventive Services*.<sup>21</sup> Interventions include media and counter-marketing, cessation and other activities to maximize the prevention and reduction of tobacco use among minors and adults. This plan envisions a tobacco-free society for all New Yorkers and interventions that work to eliminate morbidity and mortality caused by tobacco use.

## Focus Area 2: Goals, Objectives and Interventions

### **Goal #2.1: Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations.**

**Objective 2.1.1:** By December 31, 2017, decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students by 30% from 21.2% (2010) to 15.0%. (*Data source: NY Youth Tobacco Survey*) (*PA Tracking Indicator*)

**Objective 2.1.2:** By December 31, 2017, decrease the prevalence of cigarette smoking by adults ages 18-24 years by 17% from 21.6% (2011) to 18%. (*Data source: NY BRFSS*) (*PA Tracking Indicator*)

**Objective 2.1.3:** By December 31, 2017, increase the number of municipalities that restrict tobacco marketing (including banning store displays, limiting the density of tobacco vendors and their proximity to schools) from zero (2011) to 10. (*Data Source: Community Activity Tracking, CAT*)

### **Interventions for Consideration**

- a) Increase Tobacco Control Program funding to the CDC-recommended level, utilizing revenue from NYS tobacco excise tax to fund a comprehensive tobacco control program, as resources become available. (*Best Practices for Comprehensive Tobacco Control Programs [Best Practices]; 2011 Independent Evaluation Report of the New York Tobacco Control Program*)
- b) Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms. (*CDC Winnable Battles [CDC WB]; Guide to Community Preventive Services [Community Guide]; The Role of the Media in Promoting and Reducing Tobacco Use*)
- c) Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities. (*Healthy People 2020 [HP2020]; CDC WB*)
- d) Keep the price of tobacco uniformly high by regulating tobacco company practices that reduce the real price of cigarettes through discounts. (*HP 2020*)
- e) Increase community interventions, especially in disadvantaged urban neighborhoods and rural areas. (*Best Practices*)



**Goal #2.2: Promote tobacco use cessation, especially among low SES populations and those with poor mental health.**

*(Also, see: Focus Area – Prevent Substance Abuse and Other Mental, Emotional and Behavioral Disorders)*

**Objective 2.2.1:** By December 31, 2017, increase the number of unique callers to the *NYS Smokers' Quitline* by 22% from 163,428 (2011) to 200,000 annually. *(Data source: NYS Smokers' Quitline Annual Report)*

**Objective 2.2.2:** By December 31, 2017, decrease the prevalence of cigarette smoking by adults ages 18 years and older:

- By 17% from 18.1% to 15.0% among all adults. *(Data Source: NYS BRFSS) (PA Tracking Indicator)*
- By 28% from 27.8% (2011) to 20.0% among adults with income less than \$25,000. *(Data Source: NYS BRFSS) (PA Tracking Indicator; Health Disparities Indicator)*
- By 17% from 29% (2011) to 24% among adults who report poor mental health. *(Data source: NY Adult Tobacco Survey) (PA Tracking Indicator; Health Disparities Indicator)*

**Objective 2.2.3:** By December 31, 2017, increase the utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care by 141% from 17% (2011) to 41%. *(Data source: Medicaid) (PA Tracking Indicator; Health Disparities Indicator)*

**Interventions for Consideration**

- a) Use health communication to increase the impact and utilization of the *NYS Smoker's Quitline*, particularly among disparate populations. *(Best Practices)*
- b) Help health care organizations and providers establish policies, procedures and practices to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers and behavioral health providers. *(HP 2020; CDC WB; Community Guide; Treating Tobacco Use and Dependence; Treating Tobacco Use and Dependence: 2008 Update)*
- c) Advocate for expanded Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications. *(HP 2020)*
- d) Promote smoking cessation benefits among Medicaid beneficiaries and providers. *(HP 2020; CDC WB)*

**Goal #2.3: Eliminate exposure to secondhand smoke.**

**Objective 2.3.1:** By December 31, 2017, decrease the percentage of adults who report being exposed to secondhand smoke during the past seven days by 28% from 27.8% (2009) to 20%. (*Data source: NY Adult Tobacco Survey*)

**Objective 2.3.2:** By December 31, 2017, increase the number of local housing authorities that adopt a tobacco-free policy for all housing units from 3 (2012) to 12. (*Data source: Community Activity Tracking, CAT*)

**Interventions for Consideration**

- a) Promote smoke-free policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents. (*HP 2020; CDC WB; Community Guide*)
- b) Increase the number of smoke-free parks, beaches, playgrounds, college and hospital campuses, and other public spaces. (*HP 2020; CDC WB; Community Guide*)
- c) Advocate with organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of secondhand smoke exposure. (*HP 2020; CDC WB*)

## Interventions (abbreviated) by Level of Health Impact Pyramid

<b>Focus Area 2: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure</b>	
<b>Levels of Health Impact Pyramid*</b>	<b>Interventions</b>
<b>Counseling and Education</b>	<ul style="list-style-type: none"> <li>• Use media and health communications to highlight the dangers of tobacco and motivate tobacco users to quit.</li> <li>• Ensure media communications target those with highest tobacco use.<sup>22</sup></li> <li>• Provide cessation counseling and education through the <i>NYS Smokers' Quitline</i>.</li> </ul>
<b>Clinical Interventions</b>	<ul style="list-style-type: none"> <li>• Deliver tobacco dependence treatment, with a focus on federally qualified health centers and behavioral health.</li> <li>• Promote cessation benefits to Medicaid beneficiaries and providers.</li> <li>• Expand health plan coverage of tobacco treatment counseling and medications.</li> </ul>
<b>Long-Lasting Protective Interventions</b>	<ul style="list-style-type: none"> <li>• Increase Tobacco Control Program funding to the CDC-recommended level as resources become available.</li> <li>• Conduct community interventions, with a focus in disparate areas.</li> <li>• Strengthen media to increase impact and utilization of the <i>NYS Smokers' Quitline</i>.</li> <li>• Advocate with organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of exposure to secondhand smoke.</li> </ul>
<b>Changing the Context to Make Individuals' Decisions Healthy</b>	<ul style="list-style-type: none"> <li>• Use media and health communications to promote effective tobacco control policies and reshape social norms.</li> <li>• Promote policies to reduce the impact of tobacco marketing, with a focus on low-SES communities.</li> <li>• Keep the price of tobacco uniformly high by regulating tobacco company practices that reduce the real price of cigarettes through discounts.</li> <li>• Promote smoke-free multi-unit housing policies.</li> <li>• Increase smoke-free outdoor spaces.</li> </ul>
<b>Socioeconomic Factors</b>	<ul style="list-style-type: none"> <li>• Develop and implement community-led, place-based interventions targeted to address the social determinants of health in identified high-priority vulnerable communities.</li> </ul>

\* Frieden T., "A Framework for Public Health Action: The Health Impact Pyramid". *American Journal of Public Health*. 2010; 100(4): 590-595

## ***Distribution of Interventions and Activities by Sector***

Changes can be made across all sectors to reduce illness, disability and death related to tobacco use and secondhand smoke exposure. Below are examples of how your sector can make a difference.

### **Healthcare Delivery System**

- Adopt tobacco-free outdoor policies.
- Implement the US Public Health Services Guidelines for Treating Tobacco Use.
- Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
- Facilitate referrals to the *NYS Smokers' Quitline*.
- Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.
- Promote smoking cessation benefits among Medicaid providers.
- Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.
- Promote cessation counseling to people with disabilities.

### **Employers, Businesses, and Unions**

- Support and adopt tobacco-free outdoor policies.
- Educate community leaders and policymakers on the problems of youth smoking.
- Educate community leaders and policymakers on the impact of tobacco marketing on youth smoking.
- Offer health plan coverage of tobacco dependence treatment, counseling and medications.
- Promote *NYS Smokers' Quitline*.

### **Media**

- Highlight dangers of tobacco through public service announcements.
- Promote effective tobacco control policies through media.
- Use earned media to promote education on youth smoking and the impact of tobacco marketing.
- Eliminate onscreen use of tobacco products.
- Adopt tobacco-free policies.

### **Academia**

- Conduct research to support evidence-based approaches.
- Help identify emerging best practices.
- Evaluate Tobacco Control Program initiatives.

### **Community-Based Health and Human Service Agencies**

- Implement tobacco-free outdoor policies.
- Conduct public education activities to create an environment for policy change.
- Promote smoking cessation benefits among Medicaid beneficiaries.
- Conduct community interventions, with a focus in disparate areas.

- Promote *NYS Smokers' Quitline*.
- Promote tobacco dependence treatment through partnerships with independent living centers.

### Other Government Agencies

- Promote smoking cessation benefits among Medicaid beneficiaries.
- Promote smoking cessation among people with mental health disabilities through partnerships with the NYS Office of Mental Health.
- Adopt tobacco-free outdoor policies.
- Promote *NYS Smokers' Quitline*.

### Governmental (G) and Non-Governmental (NG) Public Health

- Promote smoking cessation benefits among Medicaid beneficiaries. (G) (NG)
- Promote *NYS Smokers' Quitline*. (G) (NG)
- Adopt tobacco-free outdoor policies. (G)
- Educate policymakers about the problem of youth smoking. (G)
- Educate policymakers about the impact of tobacco marketing on youth smoking. (G)
- Advocate policies that reduce the impact of tobacco marketing. (NG)

### Policymakers and Elected Officials

- Increase Tobacco Control Program funding to the CDC-recommended level as resources become available.
- Pursue policy action to reduce the impact of tobacco marketing.
- Pursue policy action to increase tobacco-free outdoor spaces.
- Keep price of tobacco uniformly high.
- Expand Medicaid coverage of medications and type of provider eligible for reimbursement for tobacco dependence treatment.

### Communities

- Mobilize advocates to create a demand for tobacco-free policies.
- Mobilize advocates to support increased funding.
- Increase awareness of the problem of youth smoking.
- Increase awareness of the impact of tobacco marketing on youth smoking.

### Philanthropy

- Strengthen evidence-based tobacco use prevention, cessation and media initiatives.
- Promote media campaigns with hard-hitting cessation messages.
- Promote *NYS Smokers' Quitline*.

## **New York State Prevention Agenda**

### ***Preventing Chronic Diseases Action Plan***

#### ***Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings***

##### ***Defining the Problem***

Delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications.<sup>23,24</sup> Many of these services have been shown to be cost-effective or even cost-saving.<sup>25</sup> However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications.<sup>23,24,25</sup>

For example, cancer screening rates in New York State should increase. The NYS Behavioral Risk Factor Surveillance System indicates that breast cancer screening has remained stable between 2000 and 2010. In 2010, 80.6 percent of women 50 years and older reported having a mammogram in the past two years. Cervical cancer screening rates have also remained stable between 2000 and 2010. In 2010, 88.6 percent of women 21-65 years of age reported having a Pap test in the past three years. In contrast, although colorectal cancer screening rates have increased during the past decade, in 2010 only 69.2 percent of adults 50-75 years old reported having a blood stool test in the last year or lower endoscopy in the past ten years. There are some subpopulations that are less likely to be screened for breast, cervical or colorectal cancer, including individuals with disabilities, lower incomes and those without health insurance.<sup>26</sup>

New York State data also show that individuals with diabetes are not receiving recommended preventive care services. Despite quality improvement efforts, in 2007 only half of Medicaid managed care enrollees with diabetes (49%) received all four recommended clinical preventive care services (HbA1c test, lipid profile, nephropathy screening and eye exam) based on national guidelines for diabetes management.<sup>27</sup>

Finally, many New York State adults have more than one chronic disease. The number of Americans living with two or more chronic conditions increased from 24 percent in 2001 to 28 percent in 2006.<sup>28</sup> In 2009, 58 percent of adult New Yorkers reported having one or more chronic conditions.<sup>29</sup> Individuals with multiple chronic conditions require a coordinated, comprehensive approach to their care.

A combination of clinical and community preventive services (i.e., policies, laws, programs and initiatives, education programs and health system interventions) are needed to promote healthy behaviors, increase use of clinical preventive services and to help individuals with one or more chronic diseases manage their chronic conditions and improve their quality of life.<sup>30</sup> Logistical, financial, cultural and health literacy barriers to care need to be removed. Information and clinical supports need to be made available to clinicians. Patients need to be supported by a multidisciplinary team of lifestyle, clinical and behavioral experts to optimally manage their disease/condition(s).

### Focus Area 3: Goals, Objectives and Interventions

#### **Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.**

**Objective 3.1.1:** By December 31, 2017, increase the percentage of women aged 50-74 years with an income of < \$25,000 who receive breast cancer screening, based on the most recent clinical guidelines (mammography within the past two years), by 5% from 76.7% (2010) to 80.5%.

*(Data Source: NYS BRFSS) (Health Disparities Indicator)*

*(Also, see: Focus Area – Preconception and Reproductive Health)*

**Objective 3.1.2:** By December 31, 2017, increase the percentage of women aged 21-65 years with an income of < \$25,000 who receive a cervical cancer screening, based on the most recent clinical guidelines (Pap test within the past three years), by 5% from 83.8% (2010) to 88.0%.

*(Data Source: NYS BRFSS) (Health Disparities Indicator)*

*(Also, see: Focus Area – Preconception and Reproductive Health)*

**Objective 3.1.3:** By December 31, 2017, increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or sigmoidoscopy in the past 5 years and a blood stool test in the past years or a colonoscopy in the past 10 years):

- By 5% from 68.0% (2010) to 71.4% for all adults.
- By 10% from 59.4% to 65.4% for adults with an income <\$25,000.

*(Data Source: NYS BRFSS) (PA Tracking Indicator; Health Disparities Indicator)*

**Objective 3.1.4:** By December 31, 2017, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%.

*(Data Source: NYS BRFSS)*

#### **Interventions for Consideration**

- a) Use media and health communications to build public awareness and demand. *(Guide to Community Preventive Services [Community Guide])*
- b) Foster collaboration among community-based organizations, the education and faith-based sectors, independent living centers, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive services. *(National Prevention Strategy)*
- c) Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills, disability literacy and providers' cultural competence. *(Community Guide)*
- d) Ensure consumer access to and coverage for preventive services, and enhance reimbursement and incentive models. *(Community Guide; National Prevention Strategy)*
- e) Expand use of health information technology to remind, provide feedback and incentivize clinicians and health care systems. *(Community Guide; National Prevention Strategy)*

**Goal #3.2: Promote use of evidence-based care to manage chronic diseases.**

**Objective 3.2.1:** By December 31, 2017, reduce the asthma emergency department visit rate:

- By 28% from 218.3 per 10,000 (2007-2009) to 156.9 per 10,000 for residents ages 0-4 years.
- By 20% from 81.6 per 10,000 (2007-2009) to 65.4 per 10,000 for residents ages 5-64 years.
- By 29% from 31.4 per 10,000 (2007-2009) to 22.3 per 10,000 for residents ages 65 years and older.
- By 10% from 83.4 per 10,000 (2007-2009) to 75.1 per 10,000 for residents of all ages.

*(Data Source: SPARCS) (PA Tracking Indicator; Health Disparities Indicator)*

**Objective 3.2.2:** By December 31, 2017, reduce the asthma hospital discharge rate:

- By 35% from 58.8 per 10,000 (2007-2009) to 38.5 per 10,000 for residents ages 0-4 years.
- By 23% from 15.5 per 10,000 (2007-2009) to 11.9 per 10,000 for residents ages 5-64 years.
- By 17% from 31.2 per 10,000 (2007-2009) to 25.8 per 10,000 for residents ages 65 years and older.

*(Data Source: SPARCS)*

**Objective 3.2.3:** By December 31, 2017, increase the percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period:

- By 12% from 58% (2012) to 65% among residents enrolled in NYS Government sponsored managed care health insurance (Medicaid or Child Health Plus).
- By 10% from 65% (2012) to 71.5% among residents enrolled in commercial managed care health insurance.

*(Data Source: NYS QARR)*

**Objective 3.2.4:** By December 31, 2017, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90):

- By 10% from 63% (2011) to 69.3% for residents enrolled in commercial managed care health insurance.
- By 7% from 67% (2011) to 72% for residents enrolled in Medicaid Managed Care.
- By 15% among black adults enrolled in Medicaid Managed Care from 58% (2011) to 66.7%.

*(Data Source: NYS QARR) (PA Tracking Indicator; Health Disparities Indicator)*

**Objective 3.2.5:** By December 31, 2017, reduce the age-adjusted hospitalization rate for heart attack by 10% from 15.5 per 10,000 residents (2010) to 14.0 per 10,000 residents of all ages. *(Data Source: SPARCS) (PA Tracking Indicator)*

**Objective 3.2.6:** By December 31, 2017, increase the percentage of adult health plan members with diabetes whose blood glucose is in good control (hemoglobin A1C less than 8%):

- By 7% from 58% (2011) to 62% for residents enrolled in Medicaid Managed Care.
- By 10% from 55% (2011) to 60.5% for residents enrolled in commercial managed care insurance.
- By 10% from 56% (2011) to 62% for black adults enrolled in Medicaid Managed Care.

*(Data Source: NYS QARR) (PA Tracking Indicator; Health Disparities Indicator)*



**Objective 3.2.7:** By December 31, 2017, increase the percentage of Medicaid managed care plan members who received all four screening tests for diabetes (HbA1c testing, lipid profile, dilated eye exam and nephropathy monitoring):

- By 5% from 50% (2009) to 52.5% among all adults with diabetes.
- By 10% from 45% (2009) to 49.5% among Black adults with diabetes.
- By 10% from 46% (2009) to 50.6% among non-Hispanic white adults with diabetes.

*(Data Source: NYS QARR) (Health Disparities Indicator)*

**Objective 3.2.8:** By December 31, 2017, reduce the rate of hospitalizations for short-term diabetes complications:

- By 10% from 3.4 per 10,000 (2007-2009) to 3.06 per 10,000 for residents ages 6-17 years.
- By 10% from 5.4 per 10,000 (2007-2009) to 4.86 per 10,000 for residents 18 years and older.

*(Data Source: SPARCS) (PA Tracking Indicator)*

### **Interventions for Consideration**

- a) Support the adoption and use of electronic health records. *(Community Guide)*
- b) Promote the inclusion of decision support tools/reminder system modules in the basic electronic medical record packages offered by vendors. *(Community Guide)*
- c) Adopt medical home or team-based care models, especially in practices that serve disparate communities. *(Community Guide)*
- d) Provide technical assistance and quality improvement training to health care organizations and providers, especially those serving disparate communities. *(NYSDOH Chronic Disease Program Goal)*

**Goal #3.3: Promote culturally relevant chronic disease self-management education.**

**Objective 3.3.1:** By December 31, 2017, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. *(Data Source: BRFSS; annual measure, beginning 2013)*

**Objective 3.3.2:** By December 31, 2017, increase by 38% the percentage of adults with current asthma who have received a written asthma action plan from their health care provider from 29% (2010) to 40%. *(Data Source: BRFSS)*

**Interventions for Consideration**

- a) Implement policies to support coverage of chronic disease self-management programs. *(NYSDOH Chronic Disease Program Goal)*
- b) Develop a sustainable infrastructure for widely accessible, readily available self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists and social workers. *(NYSDOH Chronic Disease Program Goal)*
- c) Develop a sustainable infrastructure for widely accessible, readily available self-management interventions linked to the clinical setting. *(NYSDOH Chronic Disease Program Goal)*
- d) Establish clinical-community linkages that connect patients to self-management education and community resources, such as the *NYS Smokers' Quitline*. *(NYSDOH Chronic Disease Program Goal)*
- e) Use health information technology to support a clinical referral/recommendation system that links patients to community-based resources. *(National Prevention Strategy)*

## Interventions (abbreviated) by Level of Health Impact Pyramid

<b>Focus Area 3: Increase access to high-quality chronic disease preventive care and management in clinical and community settings.</b>	
<b>Levels of Health Impact Pyramid*</b>	<b>Interventions</b>
<b>Counseling and Education</b>	<ul style="list-style-type: none"> <li>• Use media and health communications to build public awareness about and demand for chronic disease prevention and management programs.</li> <li>• Establish training programs across the health professional spectrum, to include enhancement of patient-centered skills and providers' cultural competence.</li> <li>• Provide technical assistance and quality improvement training to health care organizations and providers.</li> </ul>
<b>Clinical Interventions</b>	<ul style="list-style-type: none"> <li>• Foster collaboration among community-based organizations, the education and faith-based sectors, businesses and clinicians to identify underserved groups and implement programs to improve access to preventive health care.</li> <li>• Expand use of health information technology to remind, provide feedback and incentivize clinicians and health care systems.</li> <li>• Support the meaningful use of electronic health records in improving prevention and control of chronic diseases.</li> <li>• Promote the inclusion of decision support tools/reminder system modules in vendors' basic electronic medical record packages.</li> <li>• Use health information technology to support a clinical referral/recommendation system that links patients to community-based resources.</li> </ul>
<b>Long-Lasting Protective Interventions</b>	<ul style="list-style-type: none"> <li>• Establish clinical-community linkages that connect patients to self-management education and community resources, such as the <i>NYS Smokers' Quitline</i>.</li> </ul>
<b>Changing the Context to Make Individuals' Decisions Healthy</b>	<ul style="list-style-type: none"> <li>• Ensure consumer access and coverage for preventive services, and enhance reimbursement and incentive models.</li> <li>• Adopt medical home or team-based care models.</li> <li>• Implement policies to support coverage of chronic disease self-management programs.</li> <li>• Develop a sustainable infrastructure for widely accessible, readily available self-management interventions linked to the clinical setting.</li> </ul>
<b>Socioeconomic Factors</b>	<ul style="list-style-type: none"> <li>• Develop and implement community-led, place-based interventions targeted to address the social determinants of health in high-priority vulnerable communities.</li> </ul>

\* Frieden T., "A Framework for Public Health Action: The Health Impact Pyramid". *American Journal of Public Health*. 2010; 100(4): 590-595

## ***Distribution of Interventions and Activities by Sector***

Changes can be made across all sectors to increase access to high-quality chronic disease preventive care and management in clinical and community settings. Below are examples of how your sector can make a difference.

### **Healthcare Delivery System**

- Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
- Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
- Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
- Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
- Adopt medical home or team-based care models.
- Create linkages with and connect patients to community preventive resources.
- Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
- Reduce or eliminate out-of-pocket costs for clinical and community preventive services.
- Educate and encourage enrollees to access clinical and community preventive services.
- Coordinate with clinicians to establish and implement patient reminder systems for preventive and follow-up care.

### **Employers, Businesses, and Unions**

- Offer health coverage that provides employees and their families with access to preventive services with no or reduced out-of-pocket costs.
- Provide incentives for employees and their families to access clinical and community preventive services.
- Give employees time off or flextime to access preventive services and to attend community programs aimed at disease self-management.
- Provide employees with comprehensive wellness programs.

### **Media**

- Coordinate health-related messaging with local health care systems and public health agencies.
- Promote awareness of and demand for community preventive services.
- Highlight community needs and communicate disease burden to engage consumers, communities and relevant stakeholders.
- Support local community initiatives that increase access to high-quality chronic disease preventive care and management services.

### **Academia**

- Provide health care organizations and clinicians with trainings related to quality improvement and the use of health information technology to increase the use of clinical preventive services and disease management.

- Train community volunteers to become community health workers or patient navigators.
- Promote the use of preventive services within their own health service provisions.
- Engage in research and research translation to inform the evidence-base for chronic disease prevention and management.

### **Community-Based Health and Human Service Agencies**

- Inform people about the range of preventive services they should receive and their benefits.
- Create linkages with local health care systems to connect patients to community preventive resources.
- Support use of alternative locations to deliver preventive services.
- Expand public-private partnerships to implement community preventive services.
- Support training and use of community health workers and patient navigators.

### **Other Government Agencies**

- Promote the use of preventive services within their own health service networks.
- Expand the use of community health workers and patient navigators.
- Adopt a “health in all policies” approach to regulation and policy development and implementation.
- Revise regulations to allow reimbursement for services provided by non-licensed professionals who receive formal training and certification in the delivery of preventive services (e.g., community health workers, lactation consultants).
- Incorporate Prevention Agenda goals and objectives in county health planning initiatives.

### **Governmental (G) and Non-Governmental (NG) Public Health**

- Increase delivery of preventive services by Medicaid and other public insurance program providers. (G)
- Improve monitoring capacity for quality and performance of recommended clinical preventive services Statewide and provide resources to improve monitoring capacity at the local level. (G) (NG)
- Educate clinicians and the public about coverage improvements for clinical preventive services as outlined in the Affordable Care Act. (G) (NG)
- Support adoption of certified electronic health records that meet federal “meaningful use” criteria.
- Expand use of patient-centered medical home models. (G) (NG)
- Identify high-priority clinical and community preventive services and test innovative strategies. (G) (NG)
- Foster collaboration among traditional and non-traditional community partners to improve access to clinical and community preventive services. (G) (NG)

### **Policymakers and Elected Officials**

- Promote awareness of and demand for clinical and community preventive services.
- Support adequate funding for evidence-based projects focusing on increasing awareness of and access to clinical and community preventive services.
- Support adequate government reimbursement for preventive services and expanded access to insurance coverage that includes preventive care benefits.
- Support a “health in all policies” approach to legislation.

- Participate in/lend support to local community initiatives that increase access to high-quality chronic disease prevention and management services.

### Communities

- Encourage individuals and families to visit health care providers to receive clinical preventive services.
- Advocate for improved access to and delivery of quality clinical and community preventive services.
- Raise funds and promote awareness of clinical and community preventive services.

### Philanthropy

- Provide resources to communities for initiatives that increase access to high-quality chronic disease preventive care and management services (e.g., community health workers, chronic disease self-management programs).
- Convene relevant stakeholders to coordinate efforts aimed at increasing access to and provision of high-quality chronic disease prevention and management services.
- Provide scholarships to address health care workforce shortages.
- Support research efforts aimed at informing the evidence base for chronic disease prevention and management.

## References

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**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

Indicator	Data Source	Frequency	Geographic Granularity	Sub-Populations	Baseline (Year)	Target for 2017 (Method)
<b>Focus Area 1: Reduce obesity in children and adults</b>						
The percentage of WIC children (ages 2 through 4) who are obese <i>(Overarching Objective 1.0.1)</i>	Data Source: NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS]	Annually	Reported by county  Collected by WIC Provider	Race/ethnicity % Poverty	13.1% (2010)	12.4% (5% reduction)
The percentage of public school children in New York State reported to the Student Weight Status Category Reporting who are obese <i>(Overarching Objective 1.0.1)</i>	NYS Student Weight Status Category Reporting [SWSCR]	Reported Bi-Annually  Collected annually	Reported by school district and county  Collected by schools	NA	17.6% (2010-12)	16.7% (5% reduction)
The percentage of public school children in New York City represented in the NYC Fitnessgram who are obese <i>(Overarching Objective 1.0.1)</i>	NYC Fitnessgram	Annually	Reported by borough  Collected by schools	Race/ethnicity  Participation in free/reduced meal program	20.7% (2010-11)	19.7% (5% reduction)
The percentage of adult New Yorkers ages 18 years and older who are obese (and among adults with income of <\$25,000 and adults with disabilities) <i>(Overarching Objective 1.0.2)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	State – Annually  County – every 5 years	Statewide NYC/ROS County	Race/ethnicity  Income  Education  Disability	All adults: 24.5%  Low income: 26.7%  Disabilities: 34.9% (2011)	All adults: 23.2% (5% reduction)  Low income: 25.4% (5% reduction)  Disabilities: 31.4% (10% reduction)
The percentage of adults who consume one or more sugary drinks per day (and among adults with income of <\$25,000) <i>(Goal 1.1; Objective 1.1.1)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	State – Bi-Annually	Statewide NYC/ROS County	Race/ethnicity  Income  Education  Disability	All adults: 20.5%  Low income: 42.9% (2009)	All adults: 19.5% (5% reduction)  Low income: 38.6% (10% reduction)
The percentage of adults who participate in leisure-time physical activity (and among adults with less	NYS Behavioral Risk Factor Surveillance System [BRFSS]	State – Annually  County – every	Statewide County	Race/ethnicity  Income  Education	All adults: 73.7%  Low education:	All adults: 77.4% (5% improvement)  Low education: 65.0%



**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

<b>Indicator</b>	<b>Data Source</b>	<b>Frequency</b>	<b>Geographic Granularity</b>	<b>Sub-Populations</b>	<b>Baseline (Year)</b>	<b>Target for 2017 (Method)</b>
than a high school education) <i>(Goal 1.1; Objective 1.1.2)</i>		5 years		Disability	59.0% Disabilities: 49.9% (2011)	(10% improvement)  Disabilities: 54.9% (10% improvement)
The number of municipalities that have passed complete streets policies <i>(Goal 1.1; Objective 1.1.3)</i>	Tri-States Transportation Campaign	Updated Regularly	Municipality County Statewide	NA	23 (2011)	46 (100% improvement)
Increase the number of school districts whose competitive food policies meet or exceed Institute of Medicine recommendations <i>(Goal 1.2; Objective 1.2.1)</i>	Local Wellness Policy Database (NYSDOH/NYSED)	To be updated Annually	School District County Statewide	NA	Not yet available (2012)	TBD
The number of school districts that meet or exceed NYS regulations for Physical Education <i>(Goal 1.2; Objective 1.2.2)</i>	Office of the New York State Comptroller; New York State Department of Education	Periodic Audits (OSC)  Ongoing Collection (NYSED)	School District County Statewide	NA	5% compliance (2008)	TBD
The percentage of children and adolescents ages 3 through 17 years who had an outpatient visit with a primary care provider or obstetrics/gynecology practitioner during the measurement year, receiving appropriate assessment for weight status <i>(Goal 1.3; Objective 1.3.1)</i>	NYS Quality Assurance Reporting Requirements [eQARR]	Bi-Annually	Statewide Health Plan Provider Region	Race/ethnicity Participation in Medicaid or Child Health Plus	Commercial MC: 58% MMC or CHP: 72% (2011)	Commercial MC: 75% (29% improvement)  MMC or CHP: 75% (5% improvement)
The percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization <i>(Goal 1.3; Objective 1.3.2)</i>	Electronic Birth Certificate Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital	Annually	Statewide County Hospital Specific	Race/Ethnicity Participation in Medicaid or Child Health Plus	43.7% (2011)	48.1% (10% improvement)

**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

Indicator	Data Source	Frequency	Geographic Granularity	Sub-Populations	Baseline (Year)	Target for 2017 (Method)
	Records, NYC DOHMH			WIC Participation		
The percent of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities <i>(Goal 1.4; Objective 1.4.1)</i>	NYSDOH Healthy Heart Program Worksite Survey	Every 5 years	Statewide; Criteria for determining comprehensive can be applied to individual worksites	NA	Not yet available	TBD (10% improvement)
The percent of employers with supports for breastfeeding at the worksite <i>(Goal 1.4; Objective 1.4.2)</i>	NYSDOH Healthy Heart Program Worksite Survey	Every 5 years	Statewide; Criteria for determining comprehensive can be applied to individual worksites	NA	Not yet available	TBD (10% improvement)
<b>Focus Area 2: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure</b>						
The prevalence of any tobacco use by high school age students <i>(Goal 2.1; Objective 2.1.1)</i>	NYS Youth Tobacco Survey	Collected Bi-Annually (even years)	Statewide New York City (NYC includes the 5 counties of Bronx, Kings, New York, Queens, and Richmond) and Rest of State (ROS)	Gender Race/ethnicity Grade (6-8 & 9-12)	21.2% (2010)	15.0% (30% reduction)
The prevalence of any cigarette smoking by adults ages 18 to 24 years <i>(Goal 2.1; Objective 2.1.2)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Annually	Statewide NYC/ROS County	Gender Race/ethnicity Income Education Disability	21.6% (2011)	18.0% (17% reduction)

**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

<b>Indicator</b>	<b>Data Source</b>	<b>Frequency</b>	<b>Geographic Granularity</b>	<b>Sub-Populations</b>	<b>Baseline (Year)</b>	<b>Target for 2017 (Method)</b>
Increase the number of municipalities that restrict tobacco marketing (including display bans, density and proximity to schools) <i>(Goal 2.1; Objective 2.1.3)</i>	Community Activity Tracking, CAT	Collected continually; reported Annually	Statewide	N/A	0 (2011)	10 (Improvement)
The number of unique callers to the NYS Smokers' Quitline <i>(Goal 2.2; Objective 2.2.1)</i>	NYS Smokers' Quitline Annual Report	Collected Annually	Counties	Gender Race/ethnicity Age group Income Education Insurance Disability	163,428 (2011)	200,000 (22% improvement)
The prevalence of cigarette smoking among all adults (and among adults with income less than \$25,000 and adults with poor mental health) <i>(Goal 2.2; Objective 2.2.2)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]; NY Adult Tobacco Survey	Collected Annually	Statewide NYC/ROS County	Gender Race/ethnicity Age group Income Education Disability	All adults: 18.1% Low income: 27.8% Poor mental health: 31.2% (2011)	All adults: 15.0% (18% reduction) Low income: 20% (30% reduction) Poor mental health: 26.5% (15% reduction)
The utilization of smoking cessation benefits among smokers who are members of Medicaid Managed Care plans <i>(Goal 2.2; Objective 2.2.3)</i>	Medicaid	Collected continually; Reported Annually	Counties	Race/ethnicity Income	17% (2011)	41% (141% improvement)
The percentage of adults who report being exposed to secondhand smoke during the past 7 days <i>(Goal 2.2; Objective 2.3.1)</i>	NYS Adult Tobacco Survey	Fielded Quarterly; Reported Annually	Statewide NYC/ROS	Gender Race/ethnicity Age group Income Education	27.8% (2009)	20.0% (28% reduction)

**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

Indicator	Data Source	Frequency	Geographic Granularity	Sub-Populations	Baseline (Year)	Target for 2017 (Method)
				Insurance		
The number of Local Housing Authorities that adopt a tobacco-free policy for all housing units <i>(Goal 2.3; Objective 2.3.2)</i>	Community Activity Tracking, CAT	Collected continually; Reported Annually	Statewide	N/A	3 (2012)	12 (400% improvement)
<b>Focus Area 3: Increase access to high quality chronic disease preventive care and management</b>						
The percentage of women aged 50 to 74 with an income of <\$25,000 who receive breast cancer screening based on the most recent clinical guidelines (mammography within past 2 years) <i>(Goal 3.1; Objective 3.1.1)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Bi-Annually (even years)	Statewide	Race/ethnicity Income Education Disability	76.7% (2010)	80.5% (5% improvement)
The percentage of women aged 21 to 65 years with an income of <\$25,000 who receive a cervical cancer screening based on the most recent clinical guidelines (Pap test within the past 3 years) <i>(Goal 3.1; Objective 3.1.2)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Bi-Annually (even years)	Statewide	Race/ethnicity Income Education Disability	83.8% (2010)	88.0% (5% improvement)
The percentage of all adults (50-75 years) and those with an income of <\$25,000, who receive a colorectal cancer screening based on the most recent clinical guidelines (blood stool test in the past year or sigmoidoscopy in the past 5 years and a blood stool test in the past years or a colonoscopy in the past 10 years) <i>(Goal 3.1; Objective 3.1.3)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Bi-Annually (even years)	Statewide	Gender Race/ethnicity Income Education Disability	All >50 adults: 68.0% Low income: 59.4% (2010)	71.4% (5% improvement) 65.4% (10% improvement)

**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

<b>Indicator</b>	<b>Data Source</b>	<b>Frequency</b>	<b>Geographic Granularity</b>	<b>Sub-Populations</b>	<b>Baseline (Year)</b>	<b>Target for 2017 (Method)</b>
The percentage of adults 18 years of age and older who had a test for high blood sugar or diabetes within the past three years <i>(Goal 3.1; Objective 3.1.4)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Annually	Statewide	Age group Race/ethnicity Income Education Disability	58.8% (2011)	61.7% (5% improvement)
The rate of asthma emergency department visits among NYS residents ages 0-4; 5-64; and 65+ years (and all residents) <i>(Goal 3.2; Objective 3.2.1)</i>	New York Statewide Planning & Research Cooperative System [SPARCS]	Rolling data collection; Rates calculated Annually (As 3-year moving averages)	Statewide Region County	Age group Gender Race/ethnicity	0-4y: 218.3 per 10,000 5-64y: 81.6 per 10,000 65+y: 31.4 per 10,000 (2007-09) all ages: 83.4 per 10,000 (2007-09)	0-4y: 156.9 per 10,000 (28% reduction) 5-64y: 65.4 per 10,000 (20% reduction) 65+y: 22.3 per 10,000 (29% reduction) all ages: 75.1 per 10,000 (10% reduction)
The rate of asthma hospital discharges among NYS residents ages 0-4; 5-64; 65+ years <i>(Goal 3.2; Objective 3.2.2)</i>	New York Statewide Planning & Research Cooperative System [SPARCS]	Rolling data collection; Rates calculated Annually (As 3-year moving averages)	Statewide Region County	Age group Gender Race/ethnicity	0-4y: 58.8 per 10,000 5-64y: 15.5 per 10,000 65+y: 31.2 per 10,000 (2007-09)	0-4y: 38.5 per 10,000 (35% reduction) 5-64y: 11.9 per 10,000 (23% reduction) 65+y: per 25.8 10,000 (17% reduction)
The percentage of health plan members, ages 5 to 64 years, with persistent asthma who were dispensed appropriate asthma controller medication for at least 50% of the treatment period <i>(Goal 3.2; Objective 3.2.3)</i>	NYS Electronic Quality Assurance Reporting Requirements [eQARR]	Reported Bi-Annually (Odd years)	Statewide Region	Plan type (Medicaid vs. Commercial managed care)  For MMC enrollees only: By gender, age, race/ethnicity	MMC or CHP: 58% Commercial MC: 65% (2012)	MMC or CHP: 65% (12% improvement) Commercial MC: 71.5% (10% improvement)

**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

<b>Indicator</b>	<b>Data Source</b>	<b>Frequency</b>	<b>Geographic Granularity</b>	<b>Sub-Populations</b>	<b>Baseline (Year)</b>	<b>Target for 2017 (Method)</b>
The percentage of health plan members, ages 18 to 85 years, with hypertension who have controlled their blood pressure (below 140/90) <i>(Goal 3.2; Objective 3.2.4)</i>	NYS Electronic Quality Assurance Reporting Requirements [eQARR]	Reported Bi-Annually (Odd years)	Statewide  Region	Plan type (Medicaid vs. Commercial managed care)  For MMC enrollees only: By gender, age, race/ethnicity	Commercial MC: 63%  MMC: 67%  Black adults among MMC: 58%  (2011)	Commercial MC: 69.3% (10% improvement)  MMC: 72% (7% improvement)  MMC among black adults: 66.7% (15% improvement)
The age-adjusted rate of hospitalization for heart attack among NYS residents <i>(Goal 3.2; Objective 3.2.5)</i>	New York Statewide Planning & Research Cooperative System [SPARCS]	Rolling data collection;  Rates calculated Annually  (As single year rates)	Statewide  Region  County	Age group  Gender  Race/ethnicity	16.0 per 10,000  (2010)	14.4 per 10,000 (10% reduction)
The percentage of health plan members with diabetes whose blood glucose is in good control (hemoglobin A1C less than 8.0%) <i>(Goal 3.2; Objective 3.2.6)</i>	NYS Electronic Quality Assurance Reporting Requirements [eQARR]	Reported Bi-Annually (Odd years)	Statewide  Health Plan Provider  Region	Plan type (Medicaid vs. Commercial managed care)  For MMC enrollees only: By gender, age, race/ethnicity	MMC: 58%  Commercial MC: 55% Black adults among MMC: 56%  (2009)	MMC: 62% (7% improvement)  Commercial MC: 60.5% (10% improvement)  Black adults among MMC: 62% (10% improvement)
The percentage of Medicaid Managed Care plan members who received all four screening tests for diabetes (HbA1c testing, lipid profile, dilated eye exam and nephropathy monitoring) <i>(Goal 3.2; Objective 3.2.7)</i>	NYS Electronic Quality Assurance Reporting Requirements [eQARR]	Reported Bi-Annually (Odd years)	Statewide  Health Plan Provider  Region	Plan type (Medicaid vs. Commercial managed care)  For MMC enrollees only: By gender, age, race/ethnicity	All adults w/ diabetes: 50%  Black adults w/ diabetes: 45% Non-Hispanic white adults w/ diabetes: 46%	All adults with diabetes: 52.5% (5% improvement)  Black adults with diabetes: 49.5% (10% improvement)  Non-Hispanic white adults with diabetes: 50.6% (10% improvement)

**Appendix 1: Preventing Chronic Diseases Action Plan Indicators**

<b>Indicator</b>	<b>Data Source</b>	<b>Frequency</b>	<b>Geographic Granularity</b>	<b>Sub-Populations</b>	<b>Baseline (Year)</b>	<b>Target for 2017 (Method)</b>
Reduce the rate of hospitalizations for short-term complications of diabetes <i>(Goal 3.2; Objective 3.2.8)</i>	New York Statewide Planning & Research Cooperative System [SPARCS]	Rolling data collection; Rates calculated Annually  (As single-year rates)	Statewide  Region  County	Age group  Gender  Race/ethnicity	6-17y: 3.4 per 10,000  18+y: 5.4 per 10,000  (2007-09)	6-17y: 3.06 per 10,000 (10% reduction)  18+y: 4.86 per 10,000 (10% reduction)
The percentage of adults with arthritis, asthma, cardiovascular disease, and/or diabetes who have taken a course or class to learn how to manage their condition <i>(Goal 3.3; Objective 3.3.1)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Annually  (beginning in 2013)	Statewide  NYC/ROS  County	Type of chronic condition  Age group  Race/ethnicity  Income  Education  Disability	Not yet available  (2013)	TBD  (5% improvement)
The percentage of adults with current asthma who have received a written asthma action plan from their health care provider <i>(Goal 3.3; Objective 3.3.2)</i>	NYS Behavioral Risk Factor Surveillance System [BRFSS]	Collected Annually	Statewide	Age group  Race/ethnicity  Income  Education  Disability	29%  (2010)	40%  (38% improvement)

**Appendix 2: Alignment with National and State Key Documents, Objectives and Evidence Base.**

Key Document, Goal or Objective	Reference
<b>Focus Area 1: Reduce obesity in children and adults</b>	
CDC Winnable Battle	Centers for Disease Control and Prevention. Winnable Battles. Available at <a href="http://www.cdc.gov/winnablebattles/">http://www.cdc.gov/winnablebattles/</a>
<i>Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities</i>	Trust for America’s Health. <i>Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities</i> . Available at <a href="http://healthyamericans.org/reports/prevention08/">http://healthyamericans.org/reports/prevention08/</a>
<i>Nutrition Standards for Foods in Schools: Leading the Way toward Healthier Youth</i>	Institute of Medicine of the National Academies. Nutrition Standards for Foods in Schools: Leading the Way toward Healthier Youth. <a href="http://www.iom.edu/Reports/2007/Nutrition-Standards-for-Foods-in-Schools-Leading-the-Way-toward-Healthier-Youth.aspx">http://www.iom.edu/Reports/2007/Nutrition-Standards-for-Foods-in-Schools-Leading-the-Way-toward-Healthier-Youth.aspx</a>
<i>Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation</i>	Institute of Medicine of the National Academies. Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation <a href="http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx">http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx</a>
Healthy People 2020	U.S. Department of Health and Human Services. Healthy People 2020. Available at <a href="http://www.healthypeople.gov/2020/default.aspx">http://www.healthypeople.gov/2020/default.aspx</a>
<i>MMWR Recommended Community Strategies and Measurements to Prevent Obesity in the United States</i>	Centers for Disease Control and Prevention. Recommended Community Strategies and Measurements to Prevent Obesity in the United States <a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm">http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm</a>
<i>Local Government Actions to Prevent Childhood Obesity</i>	Institute of Medicine. Local Government Actions to Prevent Childhood Obesity <a href="http://iom.edu/Reports/2009/Local-Government-Actions-to-Prevent-Childhood-Obesity.aspx">http://iom.edu/Reports/2009/Local-Government-Actions-to-Prevent-Childhood-Obesity.aspx</a>
<i>2008 Physical Activity Guidelines for Americans</i>	U.S. Department of Health and Human Services. 2008 Physical Activity Guidelines for Americans <a href="http://www.health.gov/paguidelines/guidelines/default.aspx">http://www.health.gov/paguidelines/guidelines/default.aspx</a>
<i>Early Childhood Obesity Prevention Policies, 2011</i>	Institute of Medicine of the National Academies. Early Childhood Obesity Prevention Policies <a href="http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies.aspx">http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies.aspx</a>
<i>The Surgeon General’s Call to Action to Support Breastfeeding, 2011</i>	U.S. Department of Health and Human Services. The Surgeon General’s Call to Action to Support Breastfeeding. <a href="http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html">http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html</a>
<i>Caring for our Children, National Health and Safety Performance Standards, 2011</i>	National Resource Center for Health and Safety in Child Care and Early Education. <i>Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs</i> , 3rd Edition (CFOC3). <a href="http://nrckids.org/CFOC3/">http://nrckids.org/CFOC3/</a>
<i>MMWR School Health Guidelines to Promote Healthy Eating and Physical Activity</i>	Centers for Disease Control and Prevention. School Health Guidelines to Promote Healthy Eating and Physical Activity. <a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6005a1.htm">http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6005a1.htm</a>
<i>National Association for Sport and Physical Education - Comprehensive School Physical Activity Guidelines</i>	National Association for Sport and Physical Education. Comprehensive School Physical Activity Program Package. <a href="http://www.aahperd.org/naspe/publications/teachingTools/cspa.cfm">http://www.aahperd.org/naspe/publications/teachingTools/cspa.cfm</a>



**Appendix 2: Alignment with National and State Key Documents, Objectives and Evidence Base.**

<p><i>New York State Education Department Regulations of the Commissioner for Physical Education</i></p>	<p>New York State Education Department. Regulations of the Commissioner of Education. <a href="http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/CR135.pdf">http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/CR135.pdf</a></p>
<p><b>Focus Area 2: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure</b></p>	
<p><i>CDC Winnable Battle</i></p>	<p>Centers for Disease Control and Prevention. Winnable Battles. Available at <a href="http://www.cdc.gov/winnablebattles/">http://www.cdc.gov/winnablebattles/</a></p>
<p><i>The Guide to Community Preventive Services, Task Force on Community Preventive Services</i></p>	<p>Task Force on Community Preventive Services. The Guide to Community Preventive Services. New York: Oxford University Press; 2005. Available at <a href="http://www.thecommunityguide.org/library/book/Front-Matter.pdf">http://www.thecommunityguide.org/library/book/Front-Matter.pdf</a></p>
<p><i>Healthy People 2020</i></p>	<p>U.S. Department of Health and Human Services. Healthy People 2020. Available at <a href="http://www.healthypeople.gov/2020/default.aspx">http://www.healthypeople.gov/2020/default.aspx</a></p>
<p><i>The Guide to Clinical Preventive Services, U.S. Preventive Services Task Force</i></p>	<p>U.S. Preventive Services Task Force. The Guide to Clinical Preventive Services 2010 – 2011: Recommendations of the U.S. Preventive Services Task Force. 2010. Available at <a href="http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf">http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf</a></p>
<p><i>CDC Best Practices for Comprehensive Tobacco Control Programs</i></p>	<p>Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007. Available at <a href="http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm">http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm</a></p>
<p><i>U.S. Public Health Service: Treating Tobacco Use and Dependence</i></p>	<p>U.S. Department of Health and Human Services. Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update. U.S. Department of Health and Human Services, U.S. Public Health Service; May 2008. Available at <a href="http://www.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf">http://www.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf</a></p>
<p><b>Focus Area 3: Increase access to high quality chronic disease preventive care and management</b></p>	
<p><i>The Guide to Community Preventive Services</i></p>	<p>Task Force on Community Preventive Services. The Guide to Community Preventive Services. New York: Oxford University Press; 2005. Available at <a href="http://www.thecommunityguide.org/library/book/Front-Matter.pdf">http://www.thecommunityguide.org/library/book/Front-Matter.pdf</a></p>
<p><i>National Prevention Strategy</i></p>	<p>National Prevention Council, National Prevention Strategy. Washington, DC: U.S. Department of Health and Human and Services, Office of the Surgeon General, 2011. Available at <a href="http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf">http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf</a></p>
<p><i>The Guide to Clinical Preventive Services, U.S. Preventive Services Task Force</i></p>	<p>U.S. Preventive Services Task Force. The Guide to Clinical Preventive Services 2010 – 2011: Recommendations of the U.S. Preventive Services Task Force. 2010. Available at <a href="http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf">http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf</a></p>
<p><i>NYSDOH Chronic Disease Program Goal</i></p>	<p>New York State Department of Health. Division of Chronic Disease and Injury Prevention Strategic Plan 2010-2013; September 2010. Available at <a href="http://www.health.ny.gov/diseases/chronic/plans_reports/2010-2013_strategic_plan.htm">http://www.health.ny.gov/diseases/chronic/plans_reports/2010-2013_strategic_plan.htm</a></p>
<p><i>Multiple Chronic Conditions: A Strategic Framework</i></p>	<p>U.S. Department of Health and Human Services. Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. Washington, DC. December 2010. Available at <a href="http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf">http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf</a></p>

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