Priority: Preventive Services for Chronic Disease Prevention and Control

Goal: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

What are Preventive Services for Chronic Disease Prevention and Control and Why are they Important?

Most chronic diseases are preventable and linked to modifiable risk factors such as poor nutrition, physical inactivity, tobacco use, and excessive alcohol consumption. They are a leading driver of health care costs and a major strain on the health care system. In NYS, chronic diseases such as heart disease, stroke, cancer, chronic obstructive pulmonary disease, diabetes, and obesity are the leading causes of disability and death. They have a significant burden and fundamentally reduce one's overall quality of life, causing 6 out of 10 deaths.

Social and structural inequities lead to stark racial and ethnic disparities and disproportionately impact the most vulnerable populations, including people of color. Hospitalization and mortality rates in NYS for both heart disease and stroke are highest among Black non-Hispanic individuals.[418] The prevalence of high blood pressure is also considerably higher among Black non-Hispanic adults (37.7%) and American Indian or Alaskan Native non-Hispanic adults (41.3%) when compared to White non-Hispanic adults (31.3%). White non-Hispanic individuals are more likely to be diagnosed with cancer, but their Black non-Hispanic counterparts are more likely to die. Asthma morbidity and mortality rates among Black non-Hispanic and Hispanic communities remain consistently higher when compared to other racial and ethnic populations. In 2021, asthma emergency department visit rates for Black non-Hispanic children aged 0-17 (160.2 per 10,000) were 5 times higher than White non-Hispanic children (18.1 per 10,000). The prevalence of diabetes and obesity among Black non-Hispanic and Hispanic adults is also greater.[148]

Many people across NYS live with more than one chronic disease. The importance of early screening and detection, the promotion of self-management skills, and increased access to providers and referral services can largely impact the incidence and severity of chronic diseases. Thus, evidence-based prevention and management is integral for improving overall quality of life and narrowing the gap on health inequities. By focusing on community environments and systems developing evidence-based policies, practices, and interventions; and prioritizing vulnerable populations, NYS can assist with dismantling systemic barriers and allowing all people to achieve optimal health.

SMART(IE) Objective:					
30.0 Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%. **30.1 Increase the percentage of younger adults aged 35-44 years who had a test for high blood sugar in the past year from 62.4% to 65.5%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
(Increase screening/early detection) Increase the percentage of adults who had a test for high blood sugar or diabetes within the past year, aged 35 years and older	High blood sugar/diabetes screening among adults, aged 35 years and older	BRFSS	Adults aged 35 years and older	78.1% (2023)	82.4% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Younger adults aged 35-44 years	62.4% (2023)	65.5% (2030)

SMART(IE) Objective:					
31.0 Decrease the asthma emergency department visit rate per 10,000 among children aged 0-17 years from 93.8 to 89.1. **31.1 Decrease the asthma emergency department visit rate per 10,000 among Black, non-Hispanic children aged 0-17 years from 235.9 to 212.3.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
(Management of diseases) Decrease the asthma emergency department visit rate per 10,000, aged 0-17 years	Asthma emergency department visit rate per 10,000, aged 0-17 years	SPARCS	Children aged 0-17 years	93.8 (2022)	89.1 (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Black, non-Hispanic children aged 0-17 years	235.9 (2022)	212.3 (2030)

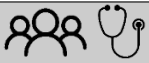
SMART(IE) Objective:					
32.0 Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%. **32.1 Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
(Management of disease) Increase the percentage of adults with hypertension who are currently taking medication to manage their high blood pressure	Hypertension management (percentage of adults reporting medication use to manage their hypertension, aged 18 years and older)	BRFSS	Adults aged 18 years and older with hypertension	77.0% (2023)	81.7% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Medicaid members aged 18 years and older with hypertension	66.9% (2023)	75.5% (2030)

SMART(IE) Objective:					
33.0 Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 73.7% to 82.3%. **33.1 Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 55.8% to 63.4%.**					
Desired Outcome	**Indicator**	**Data Source**	**Population**	**Baseline**	**Target**
Increase the percentage of adults aged 45-75 years who receive a colorectal cancer screening based on the most recent guidelines	Cancer Screening (percentage of adults who receive colorectal cancer screening)	BRFSS	Adults aged 45-75 years	73.7% (2023)	82.3% (2030)
			Subpopulation of Focus	**Baseline**	**Target**
			Adults aged 45-54 years	55.8% (2023)	63.4% (2030)

Interventions	Population of Focus	Age Range	Intermediate Measures
 **Featured Intervention:** (Chronic Disease, generally) Expand screening for social care needs among all adults and those with chronic diseases (prediabetes, diabetes, hypertension, cancer screening), and provide referrals to appropriate community resources and supports.[419] LHD H O	Adults in underserved communities	Ages 18+	Increased referrals to social services and support needs
 **Featured Intervention:** (Chronic Disease, generally) Partner with community-based organizations to promote access to prevention and screening services.[420] LHD H O	Adults	Ages 18+	Increased number of screenings in areas that are underserved
 (Chronic Disease, generally) Integrate community health workers into health care teams to improve chronic disease management for patients experiencing health inequities.[421] LHD H O	Multiple	Multiple	Availability of community health workers
 (Chronic Disease, generally) Improve utilization of peers/community health workers by establishing certification and/or training opportunities to build upon lived experiences while simultaneously assessing ways for peer delivered services to be reimbursed to providers/programs.[422] LHD H O	N/A	N/A	Curriculum development, trainings completed, peers utilized, job postings
 (Chronic Disease, generally) Include community voices in identifying changes, solutions, and innovations needed to address disparities.[423,424] LHD H O	Multiple	Multiple	Partnerships, community forums

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Chronic Disease, generally) Introduce and promote policies, practices, and programs that support and increase the primary care workforce and promote team-based, person-centered primary care at the local level. This may include: • Local health departments or hospitals involving primary care at local educational events for local schools, health fairs or community health events • Local health departments of hospitals coordinating local projects and available resources with primary care systems in their areas • Local entities advocating alongside their primary care colleagues to prioritize funding for primary care[425] LHD H O	Multiple	Multiple	Increased longevity of providers and reduced number of providers reporting burnout
 (Chronic Disease, generally) Implement or increase health insurance enrollment outreach and support programs.[426] LHD O	Adults	Ages 18+	Decreased in uninsured or underinsured individuals
 (Chronic Disease, generally) Expand the number of health care providers who provide chronic disease self-management education in areas with high chronic disease burden.[427] LHD H O	Adults	Ages 18+	Number of providers who have taken continuing education classes on chronic disease self-management
 (Chronic Disease, generally) Enhance the number of providers in New York State who are trained in Lifestyle Medicine.[428] H O	Providers (i.e., primary care providers, board-certified specialists)	N/A	Increased number of providers certified in Lifestyle Medicine
 (High Blood Pressure) Implement treatment and follow-up protocols within hospitals and ambulatory care settings, such as, Federally Qualified	Multiple	Multiple	Increased referrals to specialists of patients with documented hypertension

Interventions	Population of Focus	Age Range	Intermediate Measures
Health Centers (FQHCs) for patients exhibiting two or more in office blood pressure readings indicating stage 1 hypertension: 130-139/80-89 per American Heart Association guidelines.[429,430] H O			
(High Blood Pressure) Recruit, train, and deploy community health workers to deliver evidence-based, "self" monitoring blood pressure management programs.[431] LHD H O	Health Departments	Multiple	Programs have been implemented with Community Health Workers trained in blood pressure monitoring at home
(High Blood Pressure/Stroke) Provide evidence-based stroke prevention education in communities that are disproportionately affected by a high prevalence of undiagnosed and/or uncontrolled hypertension.[432] LHD H O	Everyone	All ages	Number of participating organizations, data regarding reach relevant to outreach method (number of education or outreach events held and attendance, number of awareness materials distributed, number of website clicks, etc.), trends in screening for hypertension
(High Blood Pressure/Stroke) Provide evidence-based education on stroke recognition and the use of emergent Emergency Medical Services (EMS) care within communities disproportionately affected by a high prevalence of stroke hospitalizations.[432] LHD H O	Everyone	All ages	Number of participating organizations, data regarding reach relevant to outreach method (number of education or outreach events held and attendance, number of awareness materials distributed, number of website clicks, etc.), number of EMS calls for stroke-related services
(High Blood Pressure) Implement community screenings to detect and address hypertension.[433] H O	Adults	Ages 18+	Decreased number of emergency room visits resulting in diabetes diagnosis
(High Blood Pressure) Implement community screenings to detect and address high cholesterol.[433] H O	Adults	Ages 18+	Decreased number of emergency room visits resulting in diabetes diagnosis

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Asthma) Adopt streamlined workflows, well-functioning electronic health records, clinical decision support tools, and patient registries to assess asthma control, step-up/down therapy, and ensure appropriate follow-up and preventive care.[434] H	Multiple	Multiple	Workflow and electronic medical record (EMR) improvements
 (Asthma) Ensure care providers offer personalized, culturally appropriate asthma action plans using the patients and caregivers' language and level of health literacy.[435] H O	Multiple	Multiple	Variety and availability of Asthma Action Plans
 (Asthma) Provide evidence-based asthma education tailored to family needs and health literacy.[434] LHD H O	Multiple	Multiple	Number of participating organizations, data regarding reach relevant to outreach method (number of education or outreach events held and attendance, number of awareness materials distributed, number of website clicks, etc.)
 (Diabetes) Improve diagnosis of prediabetes and referrals to the National Diabetes Prevention Program (DPP) lifestyle change programs among high-burden NYS adults.[436] H O	Adults	Ages 18+	Increased number of participants in Lifestyle Change Program
 (Diabetes) Implement community screenings to detect and address diabetes.[433] H O	Adults	Ages 18+	Decreased number of emergency room visits resulting in diabetes diagnosis
 (Diabetes) Improve access to specialty care for diabetes patients through telehealth.[437] H O	Adults	Ages 18+	Increased number of participants in Lifestyle Change Program

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Cancer Screening) Work with local cancer screening programs such as the NYS Cancer Screening Program, to improve access to cancer screening and diagnostic testing for individuals without health insurance.[438-440] LHD H O	Staff at the NYS Cancer screening program	Ages 18+	Number of practices participating in local cancer screening programs, number of cancer screenings delivered to uninsured individuals
 (Cancer Screening) Improve provider participation in cancer screening programs that benefit individuals without health insurance.[439,440] LHD H O	Health care providers who perform cancer screenings	N/A	Number of cancer screenings delivered to uninsured individuals
 (Cancer Screening) Encourage the use of client reminders by providers to increase cancer screening per the Community Guide national guidelines.[439] H O	Adults	Ages 18+	Number of practices that use client reminders, number of screenings performed
 (Cancer Screening) Encourage health systems to employ provider assessment and feedback systems to increase cancer screening per national guidelines.[439] LHD H O			Number of health systems that adopt provider assessment and feedback systems, number of cancer screenings performed
 (Cancer Screening) Use small media to promote cancer screening.[439] H O	Adults	Ages 18+	Practices that have an Electronic Health Record that enables them to track who is up to date with screening or not
 (Obesity) Develop and implement targeted social marketing programs aimed at reducing/deterring the consumption of unhealthy food and beverage options in alignment with national dietary standards and clinical practice guidelines.[437] LHD H O	Everyone	All ages	Decrease in the percentage of children, adolescents, and adults diagnosed with obesity

Interventions	Population of Focus	Age Range	Intermediate Measures
 (Obesity) Develop and implement targeted social marketing programs aimed at promoting increased physical activity which align with national standards and clinical practice guidelines.[437] LHD H O	Everyone	All ages	Decrease in the percentage of children, adolescents, and adults diagnosed with obesity
 (Obesity) Provide weight-bias education and sensitivity training to health care providers (e.g., primary care providers, board-certified specialists) focused on creating safe spaces for patients, improving patient-provider relationships, and reducing obesity stigma.[441] H O	Providers (i.e., primary care providers, board-certified specialists)	N/A	Increase in the percentage of children, adolescents, and adults already diagnosed with obesity, who are newly seeking management and treatment

Lead Partner Agencies and Organizations

U.S. Centers for Disease Control and Prevention (CDC)
U.S. Department of Health & Human Services (DHHS)
U.S. Department of Agriculture (USDA)
NYS Department of Health
- Medicaid Program
- Office of Primary Care & Health Systems Management
- Office of Health Insurance Plans

NYS Energy Research and Development Agency (NYSERDA)
NYS Education Department
American Cancer Society
NYS Cancer Consortium
NYS Cancer Services Program
American Academy of Pediatrics
NYS Academy of Family Physicians
American College of Lifestyle Medicine
American Society of Metabolic & Bariatric Surgery
American Medical Association
American Heart Association
American Lung Association
American Diabetes Association
The Obesity Society
Community Health Care Association of NYS (CHCANYS)
Primary Care Development Corporation
NYS Association of County Health Officials (NYSACHO)
Health care providers, health plans, insurance brokers
Nursing Schools, Medical Schools
Medicaid Social Care Networks
Youth-Based Organizations
School-based health centers
Springboard to Active Schools
Community Service Society
Azara
Empowering People with Invisible Chronic Illness (EPIC) Foundation

Implementation Resources

NYSDOL - Community Health Worker Training Program

American Lung Association - Asthma Educator Institute

New York Peer Specialist Certification Board

Dietary Guidelines for Americans

Office of Disease Prevention and Health Promotion - Physical Activity Guidelines for Americans

UConn Rudd Center Obesity Action Coalition - Stop Weight Bias Campaign

NYSDOH - Social Care Networks

Preventative Services for Chronic Disease Prevention and Control Citations

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