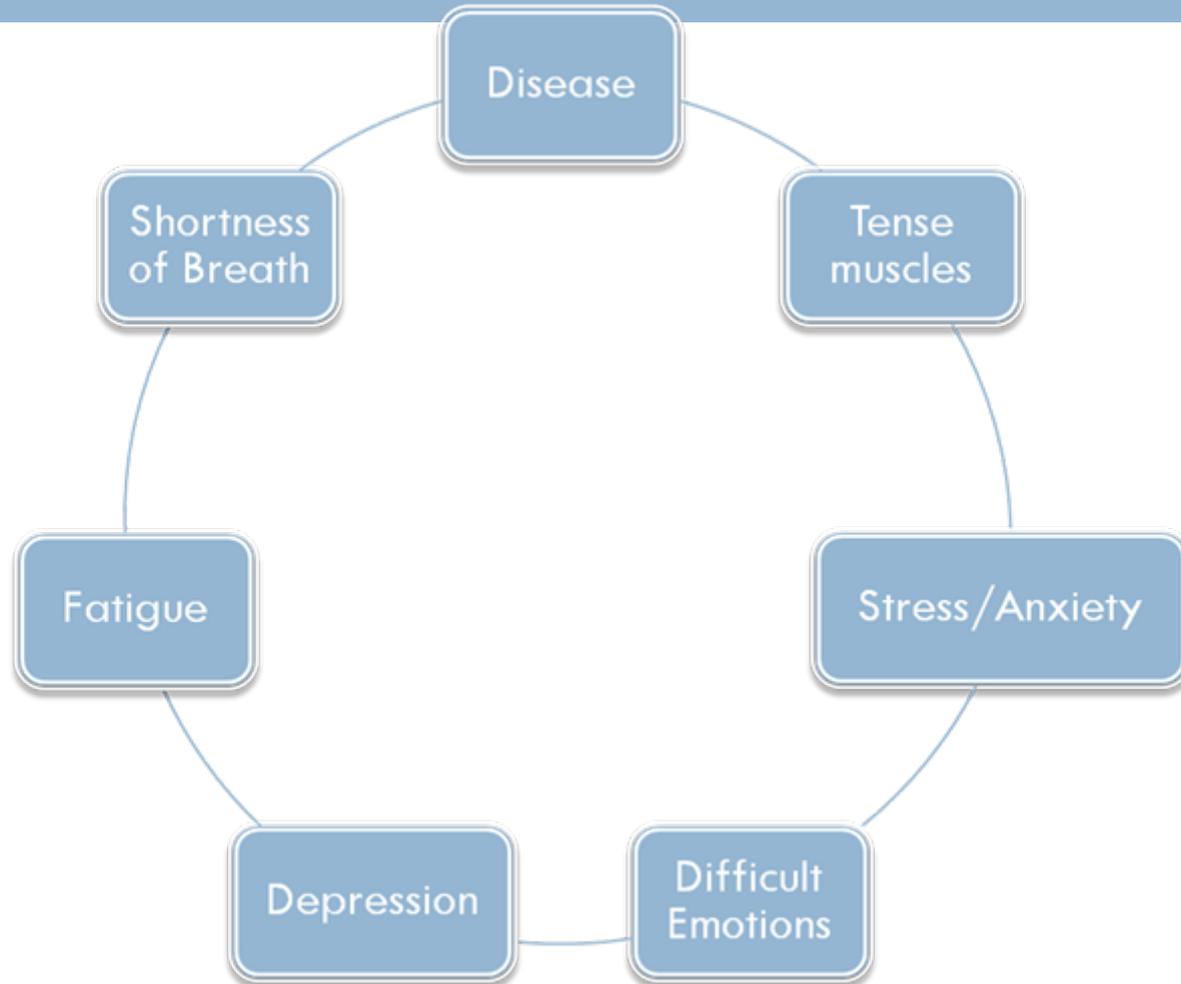


# SUPPORTING PEOPLE IN MOVING TOWARDS HEALTH

Betsy Stapleton RN FNP

# Lost In the Symptom Cycle





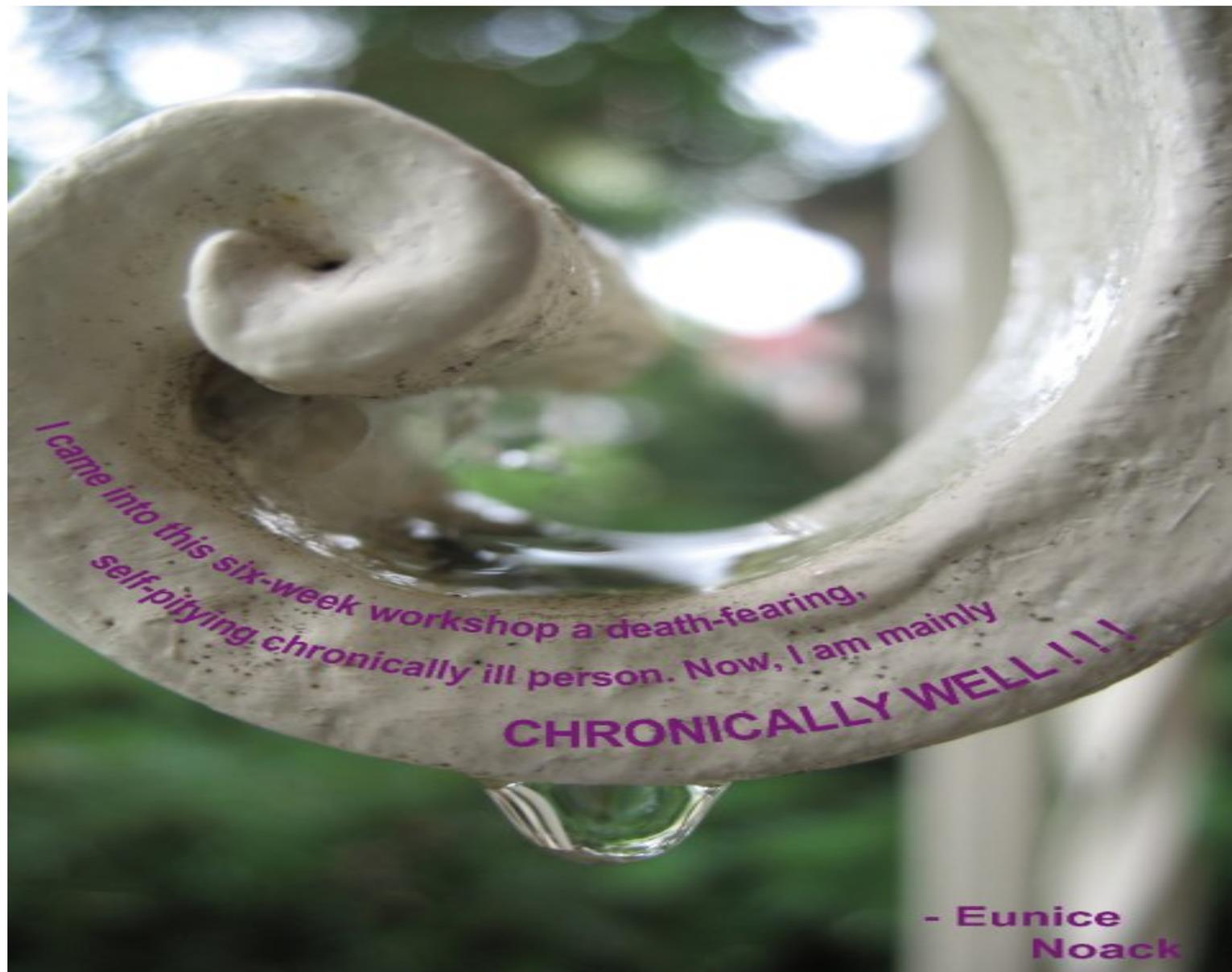
2007 6 2

# DO YOU.....

- Eat Five Fruits and Vegetables a Day
- Exercise at least 30 Minutes 5 Days a Week
- Not Smoke
- Sleep Eight Hours a Night
- Relax Regularly with Meditation
- Brush and Floss Your Teeth Every Day
- Maintain a normal BMI
- ETC

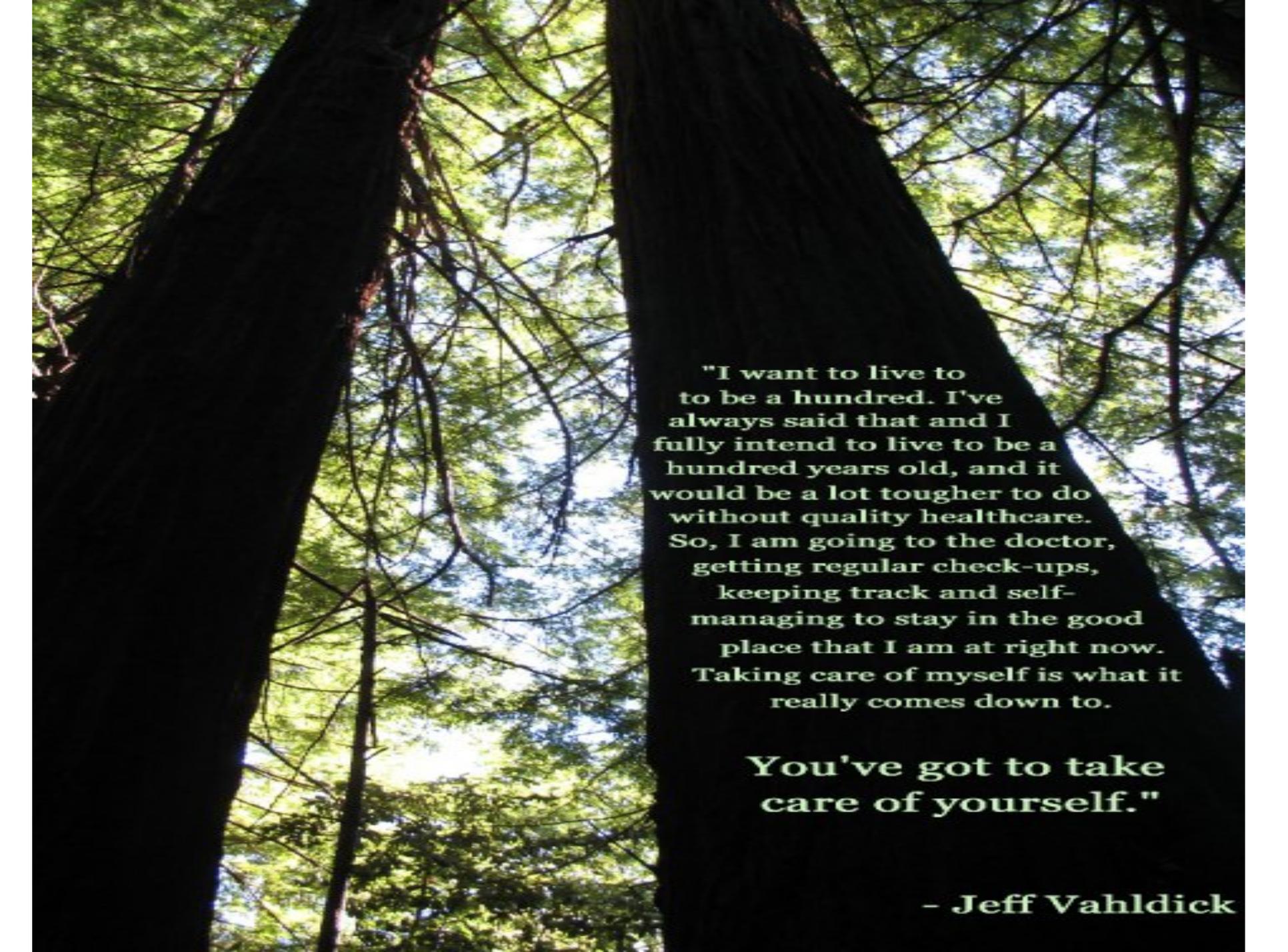


2007 6 2



*I came into this six-week workshop a death-fearing,  
self-pitying, chronically ill person. Now, I am mainly  
**CHRONICALLY WELL!!!***

**- Eunice  
Noack**

A low-angle photograph of a forest. The image shows several large, dark tree trunks in the foreground, reaching upwards. The background is filled with a dense canopy of green leaves, with bright sunlight filtering through, creating a dappled light effect. The overall mood is serene and natural.

**"I want to live to  
to be a hundred. I've  
always said that and I  
fully intend to live to be a  
hundred years old, and it  
would be a lot tougher to do  
without quality healthcare.  
So, I am going to the doctor,  
getting regular check-ups,  
keeping track and self-  
managing to stay in the good  
place that I am at right now.  
Taking care of myself is what it  
really comes down to.**

**You've got to take  
care of yourself."**

**- Jeff Vahldick**

Based on the best available estimates from scientifically rigorous CDSMP evaluations in other settings, and using Oregon Living Well data from August 2005-December 31, 2009, Living Well is predicted to have resulted in

107 quality adjusted life years (QALY) gained

**557 avoided emergency department (ED) visits, saving \$2,783**

**634,980 avoided hospital days, saving \$6,501,088**

If Living Well enrolled **only 5% (78,300)** of eligible Oregonians, its estimated five-year effects could include

2,138 quality adjusted life years gained

**11,119 avoided ED visits, saving \$12,675,660**

**55,593 avoided hospital days, saving \$129,865,248**

Dr. Viktor E. Bovbjerg

Ms. Sarah Jane Kingston

Partners in Care Foundation

CDSMP data collected from the Top 10 Counties in California - July 27, 2010

Ranking	County	# of Workshops	# of Sites	# of Participants	Participation per Capita	% completing all 6 sessions	% completing at least 4 sessions	Populations as of Census 2008
1	Humboldt	35	9	425	0.327	32%	70%	130,000
2	Nevada	10	7	115	0.118	N/A	N/A	97,118
3	Los Angeles	243	79	3147	0.032	35%	68%	9,862,049
4	San Francisco	16	11	243	0.030	44%	70%	808,976
5	Santa Clara	26	19	409	0.023	N/A	N/A	1,764,499
6	Orange	40	21	649	0.022	33%	70%	3,010,759
7	Kern	11	5	142	0.018	40%	73%	800,458
8	Riverside	37	4	357	0.017	29%	65%	2,100,516
9	San Bernardino	19	3	272	0.013	46%	73%	2,015,355
10	San Diego	12	4	150	0.005	39%	68%	3,001,072

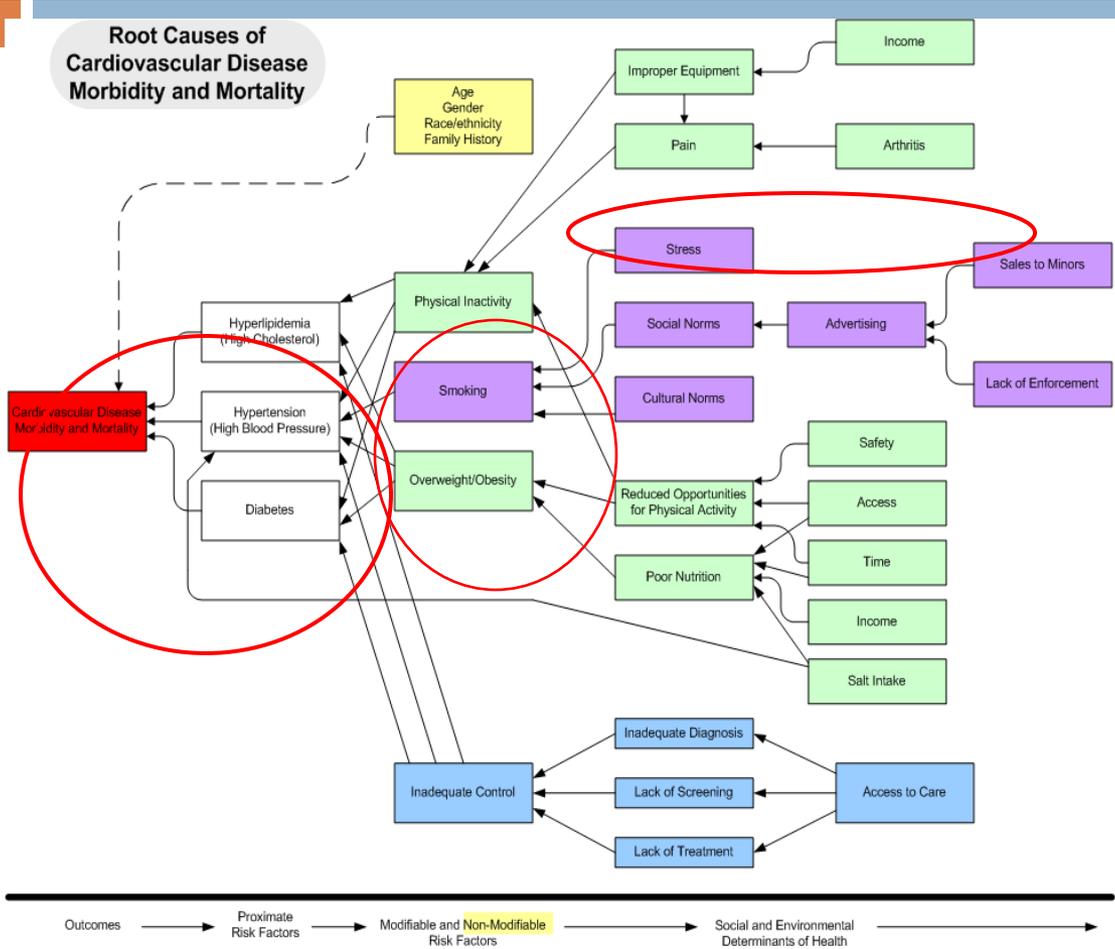
# California Collaborative for Chronic Disease Prevention

**Kern, Nevada, Mendocino, Sacramento, and Shasta,  
Counties (October 2009 – June 2012)**

California Collaborative for Chronic Disease Prevention (CCCDP) is an integrated chronic disease project of the California Heart Disease and Stroke Prevention Program implemented in collaboration with the California Arthritis Partnership Program, the California Diabetes Program, and the California Smokers' Helpline to enhance local chronic disease prevention and health promotion.

***California's Master Plan for Heart Disease and Stroke Prevention and Treatment recommends strategies for communities, schools, workplaces, and healthcare systems to reduce high blood pressure and lower cholesterol. The Plan also recognizes that there are many established statewide programs that also target risk factors for heart disease and stroke or other chronic***

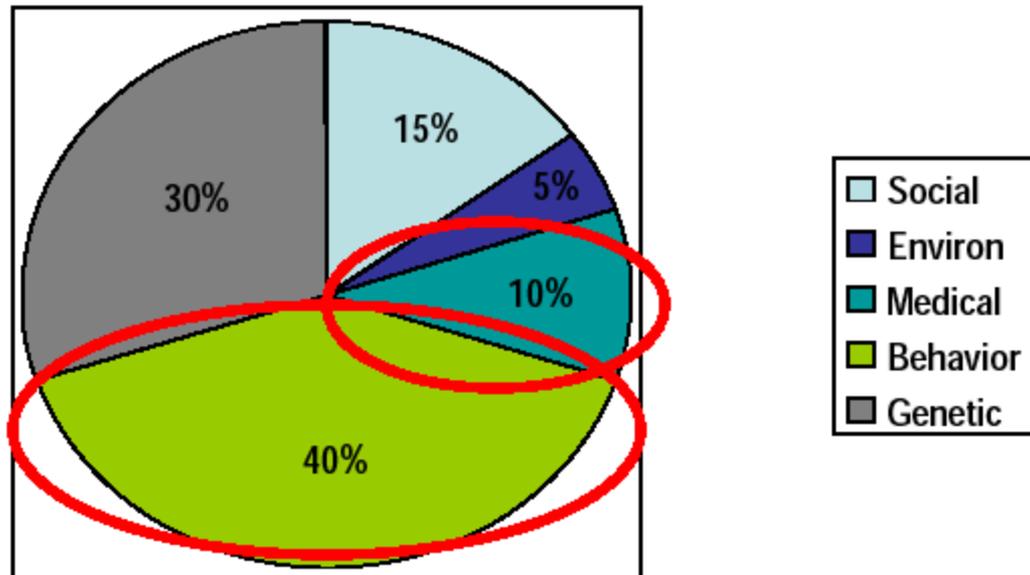
# CDPH Chronic Disease Program Partners



## ASSETS

- Interest and expertise
- Tobacco Control Program LLA Infrastructure
- Evidence-based Interventions
- Data

# Determinants of Health and Their Contribution to Premature Death



# CCCDP Project: Overarching Goal and Chronic Disease Objectives

- To **reduce cardiovascular disease** by creating linkages between the healthcare and worksite sectors with community based organization to improve **self-management and control of cardiovascular risk factors**.
  - **Hypertension Objective:**
    - (1) reduce the proportion of adults with high blood pressure;
    - (2) increase the proportion of adults with high blood pressure who are taking action (for example stopping tobacco, losing weight, increasing PA, or reducing sodium intake) to help control their blood pressure
  - **Diabetes Objective:**
    - Increase the number of call to the California Smokers' Helpline referred by health care providers.
  - **Arthritis Objective:**
    - To expand the reach of and access to evidence-based self-management program to adults with chronic conditions, focusing on adults with cardiovascular disease, diabetes, and arthritis.

# What is policy, systems, and environmental change?

- ▣ **Policy** interventions may be a law, ordinance, resolution, mandate, regulation, or rule (both formal and informal).
- ▣ **Systems** interventions are changes that impact all elements of an organization, institution, or system.
- ▣ **Environmental** interventions involve physical or material changes to the economic, social, or physical environment.

# CCCDP Systems Change

- Increase access to self management education workshops
  - ▣ In Community settings
  - ▣ By linking healthcare system with community based organizations providing self management education workshops
  
- ▣ Result: Systems Change!



Determinants of Health and Their Contribution to Premature Death

Problem-Solving Process

PROBLEM-SOLVING STEPS

1. IDENTIFY THE PROBLEM  
2. LIST IDEAS  
3. SELECT ONE  
4. ASSESS THE CHOICE

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