Executive Summary

Keeping America Healthy

A Guide to Successful Programs

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Partnership to Fight Chronic Disease

www.fightchronicdisease.org/promisingpractices

EXECUTIVE SUMMARY

In the United States, chronic diseases are among the most prevalent and costly health care problems, as well as the most preventable. They have an enormous impact on health and quality of life, both for the people suf ering from chronic diseases, and for their families and caregivers. Additionally, chronic diseases are a major driver of health care costs.

This paper explores the ef ects of chronic disease and the evidence supporting the positive impact that population health improvement activities can have on health, health care costs, and overall economic gains. It provides examples of ef ective population health improvement programs that have been implemented in a variety of settings (workplaces, communities, schools, and within the health care system), and analyzes what makes them successful.

Finally, this resource includes a catalog of programs that can serve as examples of ways to change individual behavior, maintain or improve health, and manage the staggering health care costs associated with chronic disease.

The Burden of Chronic Disease

Chronic diseases account for seven out of ten deaths in America, and consume 75 cents of every dollar spent on health care. Nearly half of the people in America suf er from a chronic condition, such as high blood pressure, diabetes, or asthma.[1] More than two-thirds of all deaths are caused by one or more of five chronic diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes.[2] Many chronic diseases are lifelong conditions, and their impact lessens the quality of life — not only of those suf ering from the diseases, but also of their family members, caregivers, and others.

A recent study indicates that life expectancy has recently dropped for the first time in about 100 years, which may be the result of chronic disease resulting from smoking and obesity[3].

Chronic diseases af ect Americans of all ages, races, and socioeconomic backgrounds, although there are notable disparities in the degree to which certain diseases af ect various populations. While low-income people of all races report worse health status than their higher-income counterparts, dif erences in overall health status by race and ethnicity persist even within income groups.

Chronic disease not only af ects health and quality of life, but it also drives rising health care costs and threatens health care af ordability. Poor health and chronic disease reduce economic productivity by contributing to increased absenteeism, poor performance, and other losses. A Milken Institute analysis determined that treatment of the seven most common chronic diseases, coupled with productivity losses, costs the U.S. economy more than $1 trillion annually. The same analysis estimates that modest reductions in unhealthy behaviors could prevent or delay 40 million cases of chronic illness per year.[4]

Evidence in Support of Prevention and Chronic Disease Management

Evidence-based research suggests that well-designed prevention and chronic disease management programs can both improve health and provide financial value, including cost savings. Investments in high-impact, cost-ef ective population prevention and health improvement programs can increase the af ordability of health care, while helping Americans live longer, healthier lives, thus contributing to higher productivity and increased economic performance.[5]

Prevention programs must be appropriately tailored to specific populations; targeting people who are at higher risk is more ef ective than programs that screen large segments of the population for a particular illness or condition without regard to risk.[6] When directly tied to particular interventions or population groups, prevention can be cost-ef ective, even in the short term.

Following the diagnosis of a chronic disease, disease management interventions can also have a positive ef ect. Chronically ill populations — particularly those suf ering from multiple diseases and conditions, or receiving services from multiple health care providers — may require appropriate and ongoing management and intervention to ensure adherence to high-quality care, and, ultimately, to improve health outcomes.

Implementing Population Health Improvement Programs

Ef ective population health improvement strategies consider the range of physical, environmental, and socioeconomic factors that contribute to health. Recognizing both the significant problems with chronic disease and the opportunities for population health improvement, groups across the country are developing sustainable, adaptable programs that work to improve health and lower costs.

Private sector "for profit" and nonprofit organizations have led the movement by developing new approaches to improving health that take advantage of technology, and by nimbly adapting to evolving needs and circumstances. The public health community has demonstrated resourcefulness in its ability to accomplish tremendous results — of en with limited resources. Taking advantage of the strengths of both sectors, programs that involve public-private partnerships of en provide a significant source of innovative approaches and successful, sustainable programs.

Population health improvement programs are diverse and plentiful. They range in scale and scope and rely on a variety of means to change behavior and improve health. Despite the variety in scope and scale, successful programs share common elements that appear essential to their success.

Commonalities Among Successful Population Health Improvement Programs

The diversity in population health improvement efforts creates challenges for determining "model" or effective initiatives, and identifying the common elements that make them successful. For this analysis, we used three primary criteria for selecting exemplary programs:

- Outcomes data demonstrating cost-savings or -neutrality, positive behavior change and/or health improvement, or showing achievement of other defined goals.
- Sustainability (i.e., must have been in place for three or more years, which was a proxy for program sustainability); programs should change over time to meet the changing needs of the target population.
- Broad enough impact to be replicable in other geographic areas or target populations.

Successful population health improvement programs share essential elements that contribute to their success. We derived these elements from peer-reviewed literature, practical experience, and information from experts, program sponsors, and organizations focused on population health management. These elements provide the foundation for model practices that other organizations can follow to address the burdens of chronic disease.

Table 1. Nine Essential Elements of Successful Programs

	Essential Element	
1.	Define problem and program objective	Identify and clearly describe problem, program objective and target population using relevant, reputable data. Success is defined at inception and measures included in plans.
2.	Tailor to the target population	Tailor program and its resources to achieve objectives within the target population. Program materials and approach must reflect cultural sensitivities, health literacy levels and be relevant to the target population.
3.	Engage leadership	An individual or group is responsible for the program and its success. Leaders promote participation, shepherd resources, and provide overall, ongoing support. Engagement of leaders with particular influence over the target population is key. Leaders commit to engage for the length of time required to achieve the objective and are willing to experiment.
4.	Coordinate among stakeholders and across settings	The program engages the target population and those who can help achieve program success. Coordination involves collaboration, consistent communication, and transparency of program processes, data and goals among stakeholders and across settings. Stakeholders adopt the program's objectives and promote the program within their respective spheres of influence.
5.	Integrate throughout the organization or community	Program becomes part of the culture, messages and activities of the organization or sponsor and the target population.
6.	Empower target population	Program engages with the target population to develop knowledge needed to achieve the desired results. Programs facilitate engagement by identifying and removing informational, financial, procedural and access barriers.
7.	Motivate target population	Encourage participation by offering rewards, recognition and access to tools. Program manages change, builds individual accountability, and regularly communicates about program achievements and individual successes.
8.	Sustain and institutionalize program	Program is sustained and continues over time through support and appropriate focus from key leadership and maintains financial viability. Changes to policy are achieved.
9.	Measure, evaluate and refine program	Program includes ongoing evaluation, assessment of gaps between outcomes and stated goals, and evolves to improve outcomes, achieve refined goals or meet evolving needs.

Source: The Lewin Group analysis

Types of Population Health Improvement Programs

Because of the broad range of programs, we grouped the initiatives into four common program settings, for the purposes of this review:

- Communities
- Health care systems
- Schools
- Workplaces

This grouping reflects the natural division of significant activities occurring in population health improvement efforts. It also allowed for greater analysis of the nine essential elements and their adaptation to each of these settings. The health care system setting given the size and diversity of activity necessitated additional division into the following sub-settings: government programs (Medicaid, Medicare, and similar programs); health plan initiatives; and provider interventions.

Community-based programs are developed in response to health status of residents and the leading causes of health concerns for that community. Programs generally include those that promote physical activity; promote healthy behavior; offer prevention services such as screenings; reduce health disparities; and support people with chronic illness. Because schools are located in every community and developing healthy habits in childhood can help prevent chronic health problems, schools play an important role in improving the overall health of children. School-based programs often involve helping children develop healthy eating and physical activity habits as well as managing existing chronic conditions.

Concerned with rising coverage costs, employers are doing more to identify the drivers of those costs and are integrating health improvement strategies into benefits packages through participation incentives, workplace wellness offerings, and work processes. Workplace wellness initiatives include a vast variety of programs including ones that promote physical activity and healthy eating, incorporate wellness in health plan benefits packages and other incentives, and offer onsite, telephonic, or compensated time for screening, wellness activities, and disease management.

Health system-based efforts occur at multiple levels, including government programs like Medicaid and Medicare, health plans initiatives for members, and provider-based ef orts for patients. Government has the tools – laws, regulations, payment methodologies, and contracts with providers – to set goals for prevention and chronic disease management activities. It also has the ability to publicize results and realign incentives to promote broader adoption of those activities. As a major purchaser of health care services, the government can exercise its market leadership to adopt and inf uence a larger population health agenda.

As key players with access to information about health trends, utilization, and treatment patterns, health plans rely on these data to of er a myriad of programs to improve the health of their members. Ef orts include promoting provider adherence to evidence-based practice guidelines; providing physician and patient incentives for prevention and disease management activities; encouraging healthy behavior at the individual level; creating value-based insurance benefit designs; utilizing data to identify opportunities for disease management; and using health care information technology.

Providers, including hospitals, physicians, nurses, physician assistants, and pharmacists, interact with people with chronic illness every day. They are both instrumental in delivering health care and encouraging healthy behaviors and treatment compliance among the patients they see. Engaged providers can inf uence health status, health care costs, and the use of appropriate health care services and settings.

Adapting Essential Program Elements To Diverse Settings

Despite their diversity, ef ective programs across these settings share the nine elements essential to developing winning strategies, as described above.

While successful programs incorporate the essential elements, they target dif erent populations and have varying goals, strategies, and kinds of interventions.

In *Keeping America Healthy: Essential Elements of Successful Programs*, we adapt the nine essential elements to each of the settings, providing an explanation of each essential element for each setting.

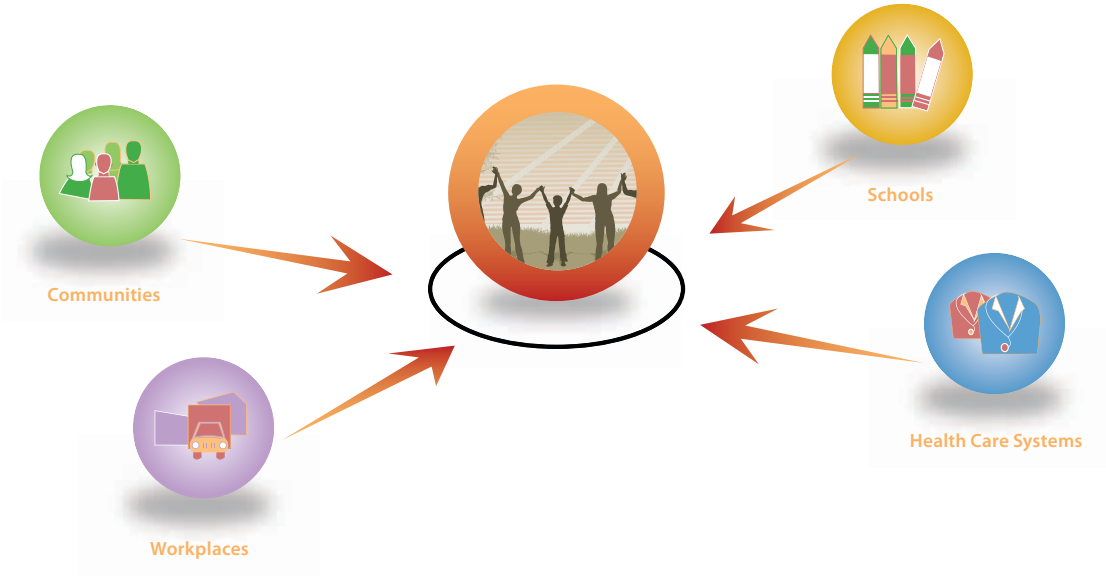
Conclusion

Prevention and health improvement initiatives can contribute to changing unhealthy behaviors, improving health, and mitigating costs. Health improvement initiatives reach people through a variety of settings — where they work, where they live, where they study, and within the health care system itself.

Because successful population health improvement efforts require tailoring to meet the unique opportunities and challenges they are designed to address, there is no template for program design that works for all settings or circumstances. Understanding the essential elements of successful programs, however, can help in developing ef ective population health improvement initiatives.

A catalog of examples of population health improvement programs accompanies these materials. The catalog is not exhaustive, but is intended to illustrate types of programs, how programs can be sponsored and constructed, and which programs work and why. It also seeks to spark interest in and ideas for preventing and managing chronic disease. These and additional programs may also be found online at: http://www.fightchronicdisease.org/promisingpractices.

Intervention Categories



Health improvement efforts take place in many settings. For this analysis, programs are divided into those occurring in communities, schools and workplaces, as well as in the health care system.

Endnotes

1 Centers for Disease Control and Prevention, *Chronic Disease Overview page*. Available online http://www.cdc.gov/nccdphp/overview.htm (accessed 14 May 2008).

2 National Association of Chronic Disease Directors, *An Urgent Reality: The Need to Prevent and Control Chronic Disease*, (2008) http://www.chronicdisease.org/files/public/Chronic_Disease_Prevention_White_Paper.pdf (accessed 14 May 2008).

3 M. Ezzati, A. B. Friedman, S. C. Kulkarni and C. J. L. Murray. "The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States " *PLoS Medicine* 5, no. 4, e66 doi:10.1371/journal.pmed.0050066 Available online: http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0050066&sid=ST2008042102630&ct=1(accessed 14 May 2008).

4 The Milken Institute, *An Unhealthy America: The Economic Burden of Chronic Disease*, October 2007.

5 S. Nussbaum, "Prevention: The Cornerstone of Quality Health Care," *American Journal of Preventive Medicine* 31, no. 1 (2006): 107-108.

6 L. Russell, *Prevention's Potential for Slowing the Growth of Medical Spending*, National Coalition on Health Care, October 2007.

Following is a table displaying programs that work in the dif erent settings:

Programs That Work

Communities

- Chronic Disease Self-Management Program (Stanford School of Medicine)
- EnhanceFitness (Senior Services of Seattle, Wash.)
- Healthy Hawaii Initiative (Hawaii Department of Health)
- Healthy Homes (Department of Public Health, Seattle & King County)
- HealthyTown (America's Pharmaceutical Research Companies)
- Hearts 'N Parks (National Heart, Lung, and Blood Institute & the National Recreation and Park Association)
- Project Dulce (Whittier Institute for Diabetes, San Diego County Calif.)
- Racial and Ethnic Approaches to Community Health (REACH 2010)
- Reducing Environmental Triggers of Asthma (RETA) Home Intervention Project (Minnesota Department of Health)
- Steps to a HealthierUS (U.S. Centers for Disease Control and Prevention)
- VERB: It's What You Do (U.S. Centers for Disease Control and Prevention)

Schools

- Action for Healthy Kids
- Assessment of Childhood and Adolescent Obesity in Arkansas (Arkansas Center for Health Improvement)
- CATCH–Coordinated Approach To Child Health
- Coronary Artery Risk Detection in Appalachian Communities – CARDIAC (State of West Virginia)
- The Delta H.O.P.E. Tri-State Initiative (Mississippi Alliance for Self-Sufficiency)
- Eat Well and Keep Moving (Harvard School of Public Health)
- Fun 5 (Hawaii Medical Service Association)
- Open Airways for Schools (American Lung Association)
- Pathways (Johns Hopkins Bloomberg School of Public Health)
- SPARK PE (San Diego State University)

Health Care Systems

- APN Transitional Care Model
- Community Care of North Carolina (North Carolina Division of Medical Assistance)
- Congestive Heart Failure Program (Blue Care Network of Michigan; Alere Medical)
- Diabetes Prevention Program (National Institute of Diabetes and Digestive and Kidney Diseases)
- Evercare Health Plans (Operating in 35 states)
- Fit Kids and TIPPS (Children's Healthcare of Atlanta)
- Freedom from Smoking® (American Lung Association)
- Healthy Outlook Program – Chronic Heart Failure Disease Management Program (Aetna)
- Marshfield Clinic (Centers for Medicare & Medicaid Services)
- Mayo Clinic
- Program of All-Inclusive Care for the Elderly (Centers for Medicare & Medicaid Services)

Workplaces

- Asheville Project (City of Asheville, N.C.)
- Bridges to Excellence (various employers, in 15 states and D.C.)
- Caterpillar, Inc.
- Health Care University (Pitney Bowes)
- Hip-Hop to Wellness (City of Farmers Branch, Texas, and Farmers Branch Parks and Recreation)
- IBM
- Johnson & Johnson Health&Wellness Program (*formerly known as* "LIVE FOR LIFE")
- Power to the Patient (Alegent HealthCare)
- Take Care of Your Health (USAA)
- Washoe County Good Health Incentive Program (Washoe County, Nev. School District)

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