State of the State

State Level Strategies for Diabetes and Cardiovascular Disease Prevention and Management in Wyoming

Amber Nolte, MPH, CPM
Kacie Hutton, MPH

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Amber Nolte

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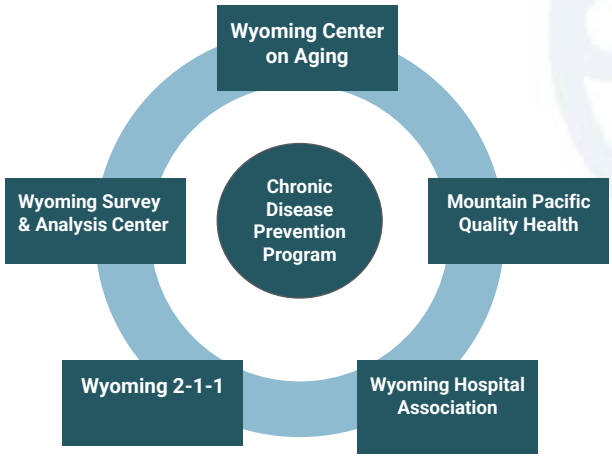
Program History

- 2019 - 2023 funded by CDC Cooperative Agreement “1815”
  - Combined Diabetes & Cardiovascular strategies into one grant
  - Ended June 29, 2023
- 2023 - 2028 funded by CDC Cooperative Agreements “2320 & 2304”
  - Started June 30, 2023
  - 2320: A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes
  - 2304: The National Cardiovascular Health Program
- Populations of Focus
  - Rural & Frontier populations
  - American Indian
  - Older Adults (65+)
  - Uninsured & Underinsured

Our Contracted Team



Who is in the room?

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Strategy 1

Strengthen self-care practices by improving access, appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority populations.

How are we measuring success?

01 # of new ADA-recognized or ADCES-accredited DSMES services established.

02 # of new diabetes support programs or services established.

03 # of existing DSMES sites & diabetes support programs that have tailored their programs or recruitment strategies.

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Strategy 1 in Wyoming

Tenika Eardley with Big Horn Nutrition

- DSMES Accreditation
- Telehealth expansion

BIG HORN NUTRITION

Strategy 2

Improve acceptability and quality of care for priority populations with diabetes.

- Increase adoption or enhancement of team-based care for people with diabetes supported by sustainable payment models.
- Increase adoption and use of clinical systems and care practices to improve quality of care and resulting health outcomes for people with diabetes in alignment with the American Diabetes Association (ADA) Medical Standards of Ca

How ar ?

01 # of healthcare orgs that have adopted or enhanced team-based care

02 # of healthcare orgs that have adopted or enhanced practices to improve health outcomes for people with diabetes.

Strategy 2 in Wyoming

Chronic Care Management (CCM)

Hot Springs Health

- 200 active patients
- Diverse care team of RN's, LPN's, Social Work, and a Psych Nurse Practitioner

Strategy 3

Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.

How are we measuring success?

01 # of total participants enrolled by CDC-recognized National DPP delivery organizations.

02 # of priority population participants enrolled by CDC-recognized National DPP delivery organizations.

Strategy 3 in Wyoming

Denyse Ute with Intertribal Wellness

- Graduated 4 DPP cohorts
- Increased sustainability with Value Based Payments from CDPP
- Statewide online DPP platform
  - Coming July 2024

Sustainability Project

- UW School of Nursing
- Lifestyle Coach interviews
  - Interview requests coming soon!

University of Wyoming
College of Health Sciences
Fay W. Whitney School of Nursing

Strategy 4

Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension.

How are we measuring success?

01 # of adults with HTN, HBP, CHOL or at risk of CVD who are referred to lifestyle change programs or support.

02 # of patients participating in SMBP programs with clinical support.

Strategy 4 in Wyoming

Denyse Ute with Intertribal Wellness

- HHA 🤝 DPP
  - Graduated 4 HHA cohorts
  - Created culturally appropriate recipes for her audience
  - Partnered with the Alzheimer's Association to deliver healthy heart & healthy brain content

Cody Senior Center

- Graduated 3 HHA cohorts
- Making big organizational changes!

Cody Council on Aging, Inc.
613 16th Street
Cody, Wyoming 82414
587-6221

Million Hearts Learning Collaborative

Purpose: Improve cardiovascular health outcomes for all persons but specifically for those with or at highest risk of poor cardiovascular health outcomes.

Goal: Directly intervene on a clinical or community basis to address the social determinants of health.

Goshen County Project:

- Census tract level data
- Library initiatives
- Partnerships with Public Health Nursing, WyoHelp, Goshen County Public Library

DPP & DSMES Peer Learning Network

- Quarterly Meetings
  - Continuing education opportunities
  - Sustainability plans
  - Marketing and media assistance
  - CDC/ADCES updates

We need your input!

Strategy 5

Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.

How are we measuring success?

01

# of CHWs (or their equivalent) who engage with community organizations to extend care beyond the clinical environment to address social services and support needs for those with hypertension, high cholesterol, or other risk of cardiovascular disease.

Strategy 5 in Wyoming

American Heart Association's HeartCorps

- Host site: Salvation Army in Gillette, WY
  - Library Outreach
  - Food Pantry
- Host site: Goshen County Public Library in Torrington, WY
  - Coming Soon!

Strategy 6

Improve the capacity of the diabetes workforce to address factors related to the SDOH that impact health outcomes for priority populations with and at risk for diabetes.

How are we measuring success?

01 # and type of staff trained on SDOH strategies and training type.

Strategy 6 in Wyoming

Faith Jones with HealthTech

- "Are you Ready for Screening Requirements"?
- Access it on the WyoLearn catalog of courses
- Today at 1:45 & 3:00 in Ballroom A & B

Community Cares Events

- 9 Statewide Events
- Connecting Healthcare, State Programs, and Community Based Organizations
- Next Event: April 25th in Worland

Strategy 7

Support the development of multi-directional e-referral systems that support electronic exchange of information between health care and CBOs.

How are we measuring success?

01 # and types of new multi-directional e-referral systems established.

02 # of healthcare orgs using referral systems to exchange info with DPP programs.

03 # of healthcare orgs using referral systems to exchange info with DSMES.

04 # of healthcare orgs using referral systems to exchange info with CBOs.

05 The total # of patients served within these health care orgs.

Strategy 7 in Wyoming

Wyoming 211

- Expanding by one community each year
- Funding connections between EHR and community based programs
  - Diabetes, Cardiovascular disease, and SDoH
- Cheyenne pilot project

Strategy 8

Implement, spread, and sustain one of the following evidence-based, family-centered childhood obesity interventions:

- Mind, Exercise, Nutrition…Do it!
- Family Based Behavioral Therapy
- Bright Bodies
- Healthy Weight and Your Child.

How are we measuring success?

01 # of organizations offering the intervention

Strategy 8 Programs

For children and adolescents

- Ages 2-18 years
- BMI ≥85th percentile
- **Family-centered,** involving parents or caregivers

- *Intensive* health behavior and lifestyle treatment
  - 26+hours over 3 - 12 months
  - Curriculum-based
  - Group and individual sessions
  - Virtual or in-person
  - Community or clinic models
  - Delivered by trained staff

Strategy 8 Programs

	Smart Moves for Kids (Bright Bodies)	Mind, Exercise, Nutrition... Do it (MEND)	Family Based Behavioral Treatment	YMCA Healthy Weight & Your Child
Age	7 to 18 yrs	2 to 13 yrs	2 to 20 yrs	7 to 13 yrs
Eligibility: - With Overweight	•	•	•	
- With Obesity	•	•	•	•
Duration	12 weeks	10 weeks	One year, tailored	4 months
Setting	Community, Clinic	Community, Clinic	Clinic	YMCA, community
Program Staff	Dietitian Exercise phys Behavioral health CHW	CHW Health coaches, educators	Behavioral health Registered Dietitian	CHW Health coaches, educators

DISCUSSION
Breakout

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Strategy 8 Discussion

With your group, please discuss and write down the answers to the following questions:

1. Is there another organization in your community focusing on childhood obesity? If so, what organization?
2. Who do you think should be at the table for childhood obesity planning and implementation discussions?
3. What resources would you or your community need to implement a childhood obesity program?
4. Do you (or your organization) have the interest and capacity to offer a curriculum based program?

When you're done, nominate one spokesperson from your group to share your discussion findings.

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Thank you!

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Questions?

Amber Nolte
Amber.Nolte@wyo.gov

Kacie Hutton
Kacie.Hutton1@wyo.gov

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