



Association of Public Health Nursing (APHN) Public Health Policy 2015-2016 Position Paper

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Supporting Community/Public Health Nursing Involvement in the Prevention and Management of Chronic Disease

The management of chronic disease has a huge impact on the health care system through rising health care costs, complex care requirements, and burden on caregivers and families. The cost of treating those with chronic diseases accounts for 86% of all health care costs in the United States (Centers for Disease Control and Prevention (CDC), 2015). Half of all Americans have one or more chronic health condition(s) and one in four adults live with two or more, known as multiple chronic conditions (MCC)(CDC, 2015); MCC results in multiple treatment regimens and visits to providers. Chronic diseases, namely heart disease and cancer, cause seven in 10 deaths each year. These top causes of death, along with diabetes and stroke and conditions such as obesity and arthritis, are preventable.

MCC primarily affects adults, however one in 15 children lives with MCC including physical, developmental, mental, and behavioral disorders and learning disabilities (Anderson, 2010). In addition, mental health illnesses such as depression, bipolar disorder, and anxiety are among the top ten chronic illnesses for adults over age 19 (Gerteis, et. al., 2014). Depressive disorders in particular are associated with increased prevalence of chronic diseases (NAMI, 2013). In children under 17 years of age, the most prevalent chronic illnesses include autism and other developmental disorders, learning disorders, mood disorders, anxiety, and behavioral disorders (Gerteis, et. al., 2014).

The current U.S. health care system, focused on treating and curing illness and a fee-for-service structure, is neither able to adequately address prevention and management of chronic health conditions, nor sustainably fund community-based programs that can help address these top causes of death and disability in the nation. The U.S. healthcare system has been touted as poorly organized, overly complex, uncoordinated, guilty of patient hand-offs, and unprepared to meet the challenges of the public's health care needs (Institute of Medicine (IOM), 2001). The growing prevalence of chronic conditions has brought urgency to finding solutions to these system problems. Living with an incurable chronic disease involves the challenges of managing chronic symptoms, uncertainty of diagnosis, and the limited value of diagnostics, (Lorig, et al., 2012). Within the current health care system, the result is ineffective and inefficient management of chronic disease (Holman & Lorig, 2004). Further, those within the growing aging population are faced with additional challenges specific to aging, such as sensory loss, continence issues, falls and fall-related injuries, and dementia, making the management of chronic diseases even more complex (Institute of Medicine, 2008).



These noted gaps and challenges in the system are a call to action for payers to consider the needs of the growing population that is living with multiple chronic disease and how care delivery can be improved to be more effective and efficient. Dr. Edward Wagner’s Chronic Care Model supports that the health system, in partnership with the community, helps drive productive interactions between a prepared, proactive practice team and an informed, activated patients (Improving Chronic Illness Care, 2015). Therefore, the system must be equipped to prepare practitioners and inform and activate patients for better prevention and management of chronic disease.

Although a likely partner to address chronic disease, the public health system has faced cuts in federal funding and has been traditionally focused on fighting infectious disease. In an attempt to find more funding, public health departments turned to offering direct care services, losing its intended focus on population-health (Institute of Medicine, 2003). While public health has had great success in areas like smoking cessation, motor vehicle safety, immunizations, and workplace safety (CDC, 1999), it seems to be “asleep at the switch” (Frieden, 2004) when it comes to successfully planning for and meeting the demands of chronic disease.

The U.S. Department of Health & Human Services (HHS) has responded to the growing population with chronic conditions through nearly \$212 million in grants to prevent chronic diseases, funded in part by the Affordable Care Act. Funds have focused on preventing tobacco use, obesity, diabetes, heart disease, and stroke (HHS, 2014). Some of these efforts include:

- **HHS Multiple Chronic Conditions Framework:**
http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf
- **CDC/CMS Million Hearts Initiative** (2012-2016) with the goal of preventing one million heart attacks and strokes by 2017: <http://millionhearts.hhs.gov/index.html>
- **ASTHO State Million Hearts Learning Collaborative** includes 22 states as of 2016. APHN has participated as a partner of ASTHO since 2014 to support of the role of community/public health nurses in the prevention and control of hypertension:
<http://www.astho.org/Million-Hearts/State-Learning-Collaborative-to-Improve-Blood-Pressure-Control/>
- **AHRQ Multiple Chronic Conditions Research Network:**
<http://www.ahrq.gov/professionals/prevention-chronic-care/decision/mcc/index.html>
- **The Administration for Community Living (ACL)** funds the Stanford Chronic Disease Self-Management Program (CDSMP), which has been disseminated in all 50 states. This evidence-based, peer-led program helps those with chronic conditions to learn skills to self-manage their chronic symptoms:
http://www.aoa.acl.gov/AoA_Programs/HPW/ARRA/PPHF.aspx



These successful initiatives are only possible with the work of community and public health at the state and local level working with health care providers. Additionally, the prevention and management of chronic disease cannot occur as a program; instead, system change is needed to address this population-wide need. The Association of Public Health Nurses (APHN) role in contributing to this systems change includes:

- Developing partnerships across a variety of disciplines and settings.
- Exploring funding mechanisms to support C/PH nurse roles in chronic disease prevention and control.
- Providing technical support for collection and dissemination of outcome data related to C/PH nurse efforts aimed at the prevention and management of chronic disease.
- Advocating for improved systems of care and public health infrastructure to prevent and manage chronic illness across the lifespan.

While there is great diversity among state and local public health departments, there is the common need of a growing U.S. population living with chronic disease. Therefore, public health must move from the provision of clinical services to population health. As the largest percentage of the public health workforce, community/public health (C/PH) nurses are leading this change through the ASTHO Million Hearts State Learning Collaborative by providing patient education, blood pressure screening and monitoring, health coaching, and care coordination. Similarly, these roles can be applied to other chronic disease and risk areas. To further develop these roles, APHN recommends that C/PH nurses:

- Advocate for clearly defined roles in the prevention/control of chronic disease within public health and community settings.
- Perform community assessments that can advise provider partners on the chronic health needs of the community where they live, learn, work, play and pray.
- Incorporate evidence-based strategies into existing services that address the prevention and management of chronic disease, specific to the unique needs of the community.
- Partner with health care providers to help them understand the chronic health needs of the population served and to ensure greater follow-up for chronic care.
- Partner with non-governmental organizations/community partners to develop programs that can reach the population and address the prevalence and prevention of chronic disease.
- Collect data to provide evidence of the value of the role of C/PH nursing in the prevention and management of chronic disease.



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