Summary of PHM Roadmap Goals and Objectives

Target Population

- Minority Population (Minority population is defined as non-white)
- Must be within six county area: Onondaga, Oswego, Oneida, Lewis, Madison, and Cayuga
- And/or specific to City of Syracuse census blocks which contain 40% or greater percentage of minority

Goals and Objectives

Goal: Increase screening rates for cardiovascular disease, diabetes, and breast and prostate cancers, especia lly among disparate populations.

Objective: Develop and implement interventions/protocols that will lead to:

- Increasing the number of adults 18 years and older who has been tested for high blood sugar or diabetes
- Reducing the female breast cancer mortality rate
- Reducing the prostate cancer mortality rate

Goal: Promote use of evidence-based care to manage chronic diseases.

Objectives: Develop and implement interventions/protocols that will lead to:

- Increasing the number of adults enrolled in Medicaid Managed Care between the ages of 18-85 years with hypertension who have controlled their blood pressure.
- Reducing the "age adjusted hospitalization" rate for heart attack.
- Increase the percentage of adult with diabetes whose blood glucose is in good control (hemoglobin A 1C less than 8%) who are enrolled in Medicaid Manage Care.
- Increase the percentage of Medicaid Managed Care plan members who received all four screening te sts for diabetes (HbA1c testing, lipid profile, dilated eye exam, and nephropathy monitoring).

Goal: Promote culturally relevant chronic disease self-management education.

Objective: Develop and implement protocols that will:

- Educate/train staff on culturally appropriate/relevant practices that will lead to increase in chronic disease self-management for patients/clients.

Population Health Management Roadmap Requirements

Requirement 2: Identification of priority target populations and define plans for addressing their health disparities by establishing goals that reflect the State of New York's Prevention Agenda

The CNYCC is required to develop and submit to the NYSDOH, a Population Health Management Roadmap which addresses among other requirements, “identification of priority target populations and defines plans for addressing their health disparities by establishing goals that reflect the State of New York’s Prevention Agenda. For review, comment and revision is the organization’s response to this element of the PHM Roadmap which encompasses clinical outcomes being overseen by the Clinical Quality Reporting and Clinical Governance Committees.

A Roadmap which establishes goals reflecting the State of New York's Prevention Agenda and addresses health disparities for priority target populations in the Central New York region

Introduction

Racial and ethnic health disparities in access and quality outcomes have been a well-established observation in the evidence-based public health and medical literature over the past decade. Many initiatives have been undertaken to study the problem as well as identify effective strategies for addressing the health inequities. Since the reported findings of the Heckler and Kelly Reports in 1985 and 2015 respectively, the New York State Department of Health has sought to incorporate health disparities prevention strategies into its programs. More recently, the efforts have been incorporated into the New York State Prevention Agenda which has in turn become a central element of the NYS DSRIP initiative.

As part of its DSRIP Project, the NYSDOH requires every Participating Provider System (PPS) to develop a Population Health Management Roadmap which addresses among other elements, a plan for addressing health disparities for priority target populations within the PPS's region which reflects the goals of the NYS Prevention Agenda. In developing a plan for addressing health disparities which reflect the goals of the NYS Prevention Agenda, the CNYCC has adopted the findings and initiatives reflected in the following reports:

- The Central New York Care Collaborative Community Needs Assessment
- The NYS Health Equity Report County Edition January 2016,
- 2013 – 2018 New York State Prevention Agenda Dashboard
- New York State DOH cause of death data for the 6 counties
- The Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan

The PPS has sought to frame its plan consistent with the Frieden's CDC Health Impact Pyramid which prioritizes interventions according to evidence based findings for their effectiveness in eliciting desired outcomes for public health projects.

Roadmap Development Process: Findings, Assessment, Plan

The CNYCC considered the 8 objectives of the 2013 – 2018 New York State Prevention Agenda (See Table 1). The PPS subsequently examined the New York State DOH data for the causes of death amongst residents of the PPS's 6 counties. The 2013 – 2018 NYS Prevention Agenda Dashboard results were then considered focusing on the Prevention Agenda (PA) Indicators for Improving Health Status and Reducing Health Disparities. These findings were then assessed against the findings reported in the NYS Health Equity County Edition January 2016. Using the information garnered and reflecting upon these against the NYS Prevention Agenda, a plan was developed which aims to reduce disparities and improve outcomes for premature deaths and preventable hospitalizations.

Findings and Assessment

Health Disparities and Goal Selection

Data from the NYS DOH Leading Cause of Death 2008 – 2015 for CNYCC's 6 counties are reflected in the Table 2. The 2013 – 2018 NYS Prevention Agenda Dashboard indicates that across all 6 counties in the CNYCC, the Premature Deaths Ratio of Black non-Hispanics to White non-Hispanics was above the state's target rate. Comparable findings were observed for Hispanics to White non-Hispanics in 5 of 6 counties (See Table 3). Similarly, the NYS Health Equity Report County Edition January 2016 revealed health disparities for Blacks and Hispanics when compared to White non-Hispanics amongst its Heart Disease and Stroke, Diabetes and Cancer (See Table 4). New York State Cancer Registry, while not providing data for every county, did reveal health disparities for Blacks and Hispanics in Upstate New York (See Table 5)

These findings of health disparities were assessed against the 2013 – 2018 NYS Prevention Agenda. The Agenda has 3 areas of focus. The findings catalyzed development of goals primarily within the scope of Focus area 3 (Increase access to high-quality chronic disease preventive care and management in clinical and community settings) and represent the best alignment of CNYCC goals for addressing health disparities to the NYS Prevention Agenda. Five NYS Prevention Agenda Focus area 3 modified goals most pertinent to addressing critical health disparities in CNYCC's 6 county region have been selected and are listed in Tables 6 and 7. In addition, two additional objectives have been added consistent with NYS Preventive Agenda Goal #3.1 which address cancer health disparities for both Black and Hispanic men and women.

Table 1: New York State Prevention Agenda 2013-2018: Priorities, Focus Areas and Objectives, 1/25/2013 (revised March 16, 2015)

Improve Health Status and Reduce Health Disparities		
Focus Area	**Goal**	**Objective - By December 31, 2018**
Improve Health Status and Reduce Health Disparities	Improve the health status of all New Yorkers	Reduce the percentage of premature deaths (before age 65 years) by 10% to 21.8%. (Baseline: 24.2%; Year 2010; Source: NYS Vital Statistics; Data Availability: state, county) Reduce disparities* by 10%: Ratio of Hispanic to White non-Hispanic percentage of deaths that are premature (before age 65 years) (Target: 1.87; Baseline: 2.08; Year 2010; Source: NYS Vital Statistics) (Data Availability: state, county) Ratio of Hispanic to White non-Hispanic percentage of premature deaths (before age 65 years) (Target: 1.86; Baseline: 2.07; Year 2010; Source: NYS Vital Statistics; Data Availability: state, county)
		Reduce the age-adjusted rate of preventable hospitalizations among adults by 10% to 133.3 per 10,000 adults. In 2015, a revised target of 122 per 10,000 adults was set for 2018. (Baseline: 135.8; Year 2012; Source: NYS Statewide Planning and Research Cooperative System (SPARCS); Data Availability: state, county) Reduce disparities* by 10%: Ratio of Black Non-Hispanic to White non-Hispanic age-adjusted rate of preventable hospitalizations (Target: 1.85; Baseline: 2.06; Year 2010; Source: NYS Statewide Planning and Research Cooperative System (SPARCS); Data Availability: state, county) Ratio of Hispanic to White non-Hispanic age-adjusted rate of preventable hospitalizations (Target: 1.38; Baseline: 1.53; Year 2010; Source: NYS Statewide Planning and Research Cooperative System (SPARCS); Data Availability: state, county)
		Increase the percentage of adults (ages 18-64) with health insurance to the HP 2020 target of 100% (Baseline: 83.1%; Year 2010; Source: U.S. Census Bureau, Small Area Health Insurance Estimates; Data Availability: state, county), HP 2020 (AHS-1.1) target: 100%)
		Increase the age-adjusted percentage of adults who have a regular health care provider by 10% to 90.8%. (Baseline: 82.5%; Year 2011; Source: Behavior Risk Factor Surveillance System; Data Availability: state, county), HP 2020 (AHS-3) target: 83.9%)

Table 2: Number of deaths and age-adjusted death rates across CNYCC's 6 counties

		Number of deaths and age-adjusted death rate					
		Total Deaths	#1 Cause of Death	#2 Cause of Death	#3 Cause of Death	#4 Cause of Death	#5 Cause of Death
Cayuga	2015	Total Deaths 815 759.7 per 100,000	Heart Disease 219 192.8 per 100,000	Cancer 194 181.6 per 100,000	CLRD 52 46.5 per 100,000	Stroke 38 35.5 per 100,000	Unintentional Injury 33 41.8 per 100,000
Lewis	2015	Total Deaths 259 716.8 per 100,000	Heart Disease 63 167.4 per 100,000	Cancer 55 152.3 per 100,000	CLRD 16 43.9 per 100,000	Alzheimer's Disease 10 25.4 per 100,000	Stroke 9 23.2* per 100,000
Madison	2015	Total Deaths 609 699.8 per 100,000	Heart Disease 140 158.7 per 100,000	Cancer 132 142.9 per 100,000	CLRD 55 59.7 per 100,000	Unintentional Injury 24 36.2 per 100,000	Stroke 24 27.4 per 100,000
Oneida	2015	Total Deaths 2,615 780.9 per 100,000	Heart Disease 756 212.9 per 100,000	Cancer 551 171.3 per 100,000	CLRD 162 47.2 per 100,000	Unintentional Injury 110 42.3 per 100,000	Stroke 107 29.7 per 100,000
Onondaga	2015	Total Deaths 4,404 730.3 per 100,000	Heart Disease 1,038 166.0 per 100,000	Cancer 951 162.6 per 100,000	Unintentional Injury 248 45.7 per 100,000	CLRD 215 35.3 per 100,000	Stroke 199 31.6 per 100,000
Oswego	2015	Total Deaths 1,059 789.5 per 100,000	Cancer 254 177.0 per 100,000	Heart Disease 230 169.8 per 100,000	CLRD 65 48.4 per 100,000	Unintentional Injury 52 44.2 per 100,000	Diabetes 41 31.7 per 100,000

CLRD: Chronic Lower Respiratory Diseases
*Rates based on fewer than 10 events in the numerator are unstable.
Note: Ranks are based on numbers of deaths, then on mortality rates. Where county's death counts and rates are tied, '(tie)' appears at the bottom of the corresponding cells, and causes are further ranked alphabetically.
If a cell is blank, then there were no deaths from any of the 25 causes used in our tables. These causes are listed in the technical notes.

Source: Vital Statistics Data as of January 2018

Table 3: New York State County Comparison – Prevention Agenda Indicators

New York State County Comparison - Prevention Agenda Indicators Table

Notes:

[a]: The Prevention Agenda 2013-2017 has been extended to 2018 to align and coordinate timelines with other state and federal health care reform initiatives.

[b]: A new target has been set for 2018.

[c]: Indicator baseline data, trend data, and 2018 objective were revised and updated.

s: Data do not meet reporting criteria.

*** Fewer than 10 events in the numerator, therefore the rate/percentage is unstable.**

+ Fewer than 10 events in the numerators of the rates/percentages, therefore the ratio is unstable.

Indicator #	Prevention Agenda (PA) Indicator	Data Years	PA 2018 Objective	Cayuga		Madison		Oneida		Onondaga		Lewis		Oswego	
				Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
				Rate	Ratio	Rate	Ratio	Rate	Ratio	Rate	Ratio	Rate	Ratio	Rate	Ratio
				Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage
Improve Health Status and Reduce Health Disparities															
1	Percentage of premature deaths (before age 65 years)	2015	21.8	196	22.8	142	22.5	526	20.1	987	22.3	75	20	282	26.5
1.1	Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics	2013-2015	1.87	42.1	1.96	57.1*	2.52+	53	2.8	47.7	2.47	44.4*	2.15+	75.0*	2.83+
1.2	Premature deaths: Ratio of Hispanics to White non-Hispanics	2013-2015	1.86	53.8*	2.50+	33.3*	1.47+	56.6	2.99	56.6	2.93	44.4	2.15	55	2.07
2	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years[b]	2014	122	1,057	136	608	97.6	2,903	131.7	4,689	112.4	262	100.6	1,301	129.6
2.1	Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	1.85	203.9	1.45	132.5	1.26	261.5	1.97	245.2	2.39	s	s	189.1	1.38
2.2	Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics	2012-2014	1.38	29.6*	0.21+	s	s	72.9	0.55	119.7	1.17	0.0*	0.00+	64.4	0.47
3	Percentage of adults (aged 18-64) with health insurance	2015	100		92		93.4		92.6		92.9		91.7		92.2
4	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2013-2014	90.8		82.6		89.2		85.1		84.3		88.2		80.4

Table 4: Health Disparities across CNYCC 6 counties for select indicators in Heart Disease, Stroke and Diabetes

	Cayuga			Lewis			Madison			Oneida			Onondaga			Oswego		
	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic
Health Indicator																		
Diseases of the heart mortality per 100,000 population, age-adjusted	172	289.6	226.4	175.9	0.0*	0.0*	158.7	55.0*	115.0*	194.6	289.2	100.5	146.1	191.7	111.4	195.4	89.4	166.2
Diseases of the heart hospitalizations per 10,000 population, age-adjusted	106.4	220	30.8	96.1	s	s	72.2	79.5	s	98.1	118	34	75.8	139.6	65.9	92.1	57.9	70.2
Cerebrovascular disease (stroke) mortality per 100,000 population, age-adjusted	35.8	83.8	40.3	32.5	0.0*	0.0*	41.7	172.3*	0.0*	32.1	75	11	32	48.7	56	34.6	0.0*	0.0*
Cerebrovascular disease (stroke) hospitalizations per 10,000 population, age-adjusted	24	31.1	27.4	19.9	0.0*	0.0*	20.6	s	s	29.4	48.3	6.7	22.2	39.5	20.5	24.3	s	0.0*
Coronary heart disease mortality per 100,000 population, age-adjusted	128.5	164.7	164.3	127.9	0.0*	0.0*	106	0.0*	115.0*	135.1	195.5	46.6*	99.7	120.5	84.9	144.9	89.4*	148.0*
Coronary heart disease hospitalizations per 10,000 population, age-adjusted	43.3	102.6	23.4	39.7	s	0	26.2	s	s	34.4	36	10.1	25.6	39.1	22.3	42.4	24.0*	41.9
Diabetes mortality per 100,000 population, age-adjusted	14.3	25.2	0.0*	23.3	0.0*	0.0*	13	0.0*	0.0*	19	26.5*	6.2*	15.3	31.4	6.9*	21.3	64.1*	0.0*
Diabetes (any diagnosis) hospitalizations per 10,000 population , age-adjusted	186.7	328.7	s	177.4	201*	213.2*	148.3	439.6	s	212.8	467.7	109.5	165.1	441.6	262.1	192	293	137.2+B1 :T2

Table 5: 2014 Cancer Incidence and Mortality by Race and Ethnicity for New York State excluding New York City

2014 Cancer Incidence and Mortality by Race and Ethnicity for New York State excluding New York City													
		Incidence						Mortality					
		Males			Females			Males			Females		
Site of Cancer	Race/Ethnicity	Cases	Rates per 100,000 Males	95% CI (+/-)	Cases	Rates per 100,000 Females	95% CI (+/-)	Cases	Rates per 100,000 Males	95% CI (+/-)	Cases	Rates per 100,000 Females	95% CI (+/-)
All Cancers	Whites	30504	529	6.1	30972	473.8	5.5	10355	183.1	3.6	9818	135.4	2.8
	Blacks	2434	544	22.9	2197	385.7	16.4	774	201.4	15.1	755	135.5	9.8
Female Breast	Whites				9072	142.2	3.1				1246	17.5	1
	Blacks				700	122	9.2				138	24.5	4.1
Lung	Whites	4099	71.2	2.2	4330	61.2	1.9	2783	48.8	1.8	2651	37.1	1.4
	Blacks	309	74.4	8.8	254	45.1	5.6	205	50	7.3	156	27.5	4.4
Colorectal	Whites	2463	43.5	1.8	2351	33.9	1.4	853	15.2	1	813	10.7	0.8
	Blacks	214	49.9	7.1	204	36.2	5	79	19.2	4.5	69	12.9	3.1
Colon	Whites	1631	29.1	1.4	1770	25.1	1.2	666	12	0.9	667	8.7	0.7
	Blacks	148	35.2	6	150	27	4.4	62	15	4	62	11.8	3
Prostate	Whites	6921	111.5	2.7				902	16.5	1.1			
	Blacks	885	190.4	13.2				102	31.9	6.5			
Cervical	Whites				344	6.6	0.7				115	2	0.4
	Blacks				48	8.1	2.3				15	2.4	1.2

Table 6: NYS Preventive Agenda Focus Area 3 adopted and modified Goal 3.1 and Objectives

Goal #3.1: Increase screening rates for cardiovascular disease, diabetes and breast and prostate cancers, especially among disparate populations.	
Objective	
3.1.4	By December 31, 2020, increase the percentage of adults 18 years and older who had a test for high blood sugar or diabetes within the past three years by 5% from 58.8% (2011) to 61.7%. (DATA SOURCE: NYS BRFSS)
3.1.5	By December 31, 2020, reduce the female breast cancer mortality per 100,000 female population by 20% from 24.5 to 19.7 (DATA SOURCE: NYSCR)
3.1.6	By December 31, 2020, reduce the prostate cancer mortality per 100,000 male population by 20% from 31.9 to 25.5 (DATA SOURCE: NYSCR)

Table 7: NYS Preventive Agenda Focus Area 3 adopted and modified Goal 3.2 and Objectives

Goal #3.2: Promote use of evidence-based care to manage chronic diseases	
Objective	
3.2.4	By December 31, 2020, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90): By 15% among black adults enrolled in Medicaid Managed Care from 58% (2011) to 66.7%. (DATA SOURCE: NYS QARR, PA Tracking Indicator; Health Disparities Indicator)
3.2.5	By December 31, 2020, reduce the age-adjusted hospitalization rate for heart attack By 10% from 15.5 per 10,000 residents (2010) to 14.0 per 10,000 residents of all ages. (DATA SOURCE: SPARCS; PA Tracking Indicator)
3.2.6	By December 31, 2020, increase the percentage of adult health plan members with diabetes whose blood glucose is in good control (hemoglobin A1C less than 8%): By 10% from 56% (2011) to 62% for black adults enrolled in Medicaid Managed Care. (DATA SOURCE: NYS QARR; PA Tracking Indicator; Health Disparities Indicator)
3.2.7	By December 31, 2020, increase the percentage of Medicaid managed care plan members who received all four screening tests for diabetes (HbA1c testing, lipid profile, dilated eye exam and nephropathy monitoring): • By 10% from 45% (2009) to 49.5% among Black adults with diabetes. • By 10% from 46% (2009) to 50.6% among non-Hispanic white adults with diabetes. (DATA SOURCE: NYS QARR; Health Disparities Indicator)

Priority Target Population

Demographic data from the NYS Health Equity Report County Edition January 2016 was reviewed and reported in Table 8.

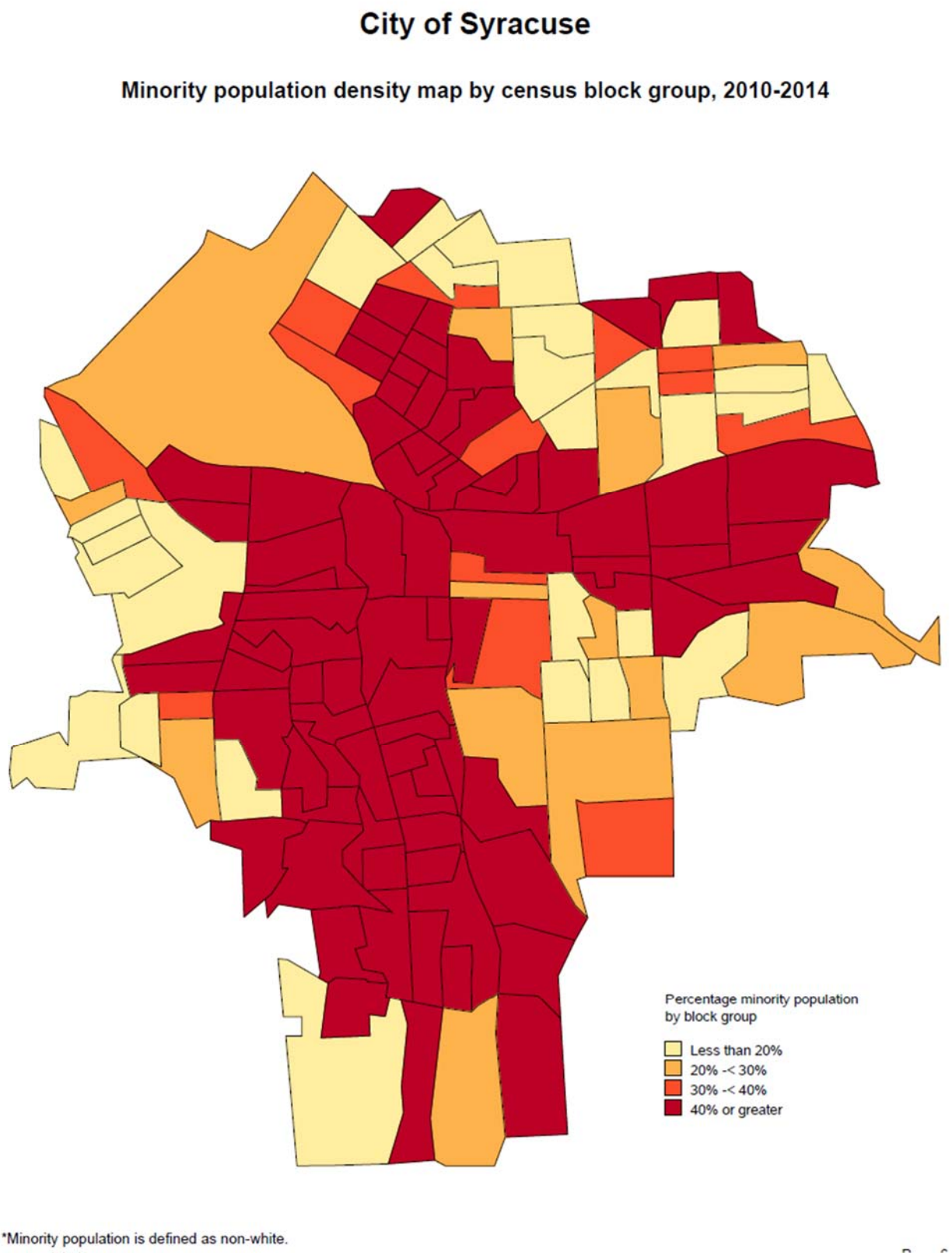
Table 8: Racial and ethnic demographic breakdown across CNYCC's six counties 2011-2013

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian	Total
Cayuga	72,948	3,650	2,032	562	79,477
Lewis	26,234	307	429	111	27,149
Madison	68,284	1,477	1,422	725	72,382
Oneida	197,423	15,410	12,020	8,117	233,585
Onondaga	372,416	54,427	20,958	16,642	468,387
Oswego	115,552	1,383	2,761	917	121,165
CNYCC Totals	852,857	76,654	39,622	27,074	1,002,145

Source: NYS Health Equity Report County Edition January 2016

Further consideration of the New York State 2017 Health Equity Reports indicated that Onondaga County is the only CNYCC County with a greater than 40% Section 240 Medicaid population, the City of Syracuse containing said population. The NYSDOH City of Syracuse Health Equity Report February 2017 identifies by census blocks, communities with the highest minority populations and is shown in Figure 1.

Figure 1: City of Syracuse Minority population density map, 2010-2014



Plan

The CNYCC considered strategic approaches for its plans considering rolling out a strategy across all six counties versus selecting a more targeted community. Consistent with the intent of the NYSDOH's quest for development of a plan which identified a "priority targeted population", the PPS has selected the City of Syracuse census blocks which contain 40% or greater percentage of minority population for priority intervention. Nonetheless, in an effort to promote health equity across the 6 county, the PPS will support efforts by partners which advance interventions addressing the targeted goals for addressing health disparities which use more effective interventions supported by the Frieden Pyramid strategy for interventions.

CNYCC has adopted the Prevention Agenda Action Plan Re-Fresh Chart for Focus Area 3 Table 9 as types of intervention which partners can consider for innovation projects which address the 7 targeted goals for Black and Hispanic communities both in priority target communities as well as other communities within our 6 counties which offer the best opportunities for achieving the targeted goal objectives.

In July, 2018, CNYCC will announce the Innovation Grants Health Disparities Priority Selection Criteria for the Funds Flow 3 Innovation Grant monies which will dispersed in the Fall of 2018. In addition, CNYCC will publicize to partners, the organization's strategy for addressing Health Disparities in our six county region. In addition to strategies involving the Innovation Grant monies, CNYCC will provide education to partners regarding Health Disparities within our region, resources available for developing strategies to address these and collaborate with partners engaging in efforts to promote the CNYCC Population Health Management Roadmap for addressing Health Disparities.

Finally, CNYCC will monitor the PPS's performance in addressing health disparities as the metrics reporting on the selected goals and objectives are made available by the NYS DOH.

Table 9: Prevention Agenda Action Plan Re-Fresh Chart

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings			
Goals	**Recommended Intervention for Local Action**	**Recommended Short Term Process Measures**	**Resources**
Increase screening rates for cardiovascular diseases, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	Implement policy and environmental approaches to increase the number of community members with access to recommended colorectal cancer screening services.	Number of worksites implementing paid time off or flex time policies for cancer screening Number of patients navigated to and/or through screening	Prevention Agenda Fact Sheet: Reducing Structural Barriers to Cancer Screening
		Number of screening events held in partnership Number of transit vouchers provided	Prevention Agenda Fact Sheet: Increasing Cancer Screening through Public Awareness and Promotion
	Implement evidence-based activities that increase public awareness about colorectal cancer screening.	Number of partners, employers, and local elected officials participating in awareness events	National Colorectal Cancer Roundtable: 80% by 2018 Communications Guidebook: Effective messaging to reach the unscreened
	Promote uptake of guideline-recommended cancer screening by increasing awareness that cancer screening is a covered benefit among newly insured men and women.	Number of media alerts (press releases, sample articles) distributed Number of media mentions/stories promoting cancer screening Number of events held, promoted and attended	National Colorectal Cancer Roundtable. Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers
	Promote provider practice implementation of evidence-based interventions to increase evidence-based cancer screening including the recommendation that patients be offered options for colorectal cancer screening.	Number of mobile vans offering colorectal cancer screening through take-home fecal tests Number of providers that deliver evidence-based interventions	The Guide to Community Preventive Services

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings			
Goals	**Recommended Intervention for Local Action**	**Recommended Short Term Process Measures**	**Resources**
Promote evidence-based care to manage chronic diseases. Promote culturally relevant chronic disease self-management education.	Promote the use of evidence-based interventions to prevent or manage chronic diseases.	Number and type of evidence-based self-management programs (also called evidence-based intervention, or EBIs) offered by partners Number of participants at EBIs offered by partners Percent of adults with one or more chronic diseases who have attended a self-management program Number of referrals to EBIs from health care professionals Number and percent of adults among population(s) of focus (e.g., communities of color, persons with disability, low-income neighborhoods) who have attended EBIs	NYS Prevention Agenda: Community Wide Systems to Deliver Evidence-Based Interventions to Address Chronic Diseases Prevention Agenda Fact Sheet: Promoting Evidence-Based Interventions to Prevent or Manage Chronic Diseases