Healthier WASHINGTON

Healthier Washington Plan for Improving Population Health Deliverable 3: Workplan for Implementing Diabetes Prevention Activities

August 18, 2017

Overview

The Healthier Washington (Healthier WA) Plan for Improving Population Health (P4IPH) is an actionable, focused workplan designed to identify and implement specific system and policy changes that will integrate ("hard wire") prevention activities into the ongoing operation of the health and health care system. The Washington State Health Care Authority (HCA) and Department of Health (DOH), along with the Department of Health and Social Services (DSHS), implemented a structured process to identify initial priority focus areas for P4IPH. The process resulted in the selection of one primary focus area – diabetes prevention and treatment – along with one secondary area: well-child visits.

This document presents a workplan for integrating new and enhanced diabetes primary and secondary prevention activities into the WA state health system. The proposed activities are organized by a framework developed by the Centers for Disease Control and Prevention (CDC):

1. **Traditional clinical prevention interventions**. Care provided most often by healthcare providers in a doctor's office setting in a routine one-to-one encounter
2. **Innovative clinical preventive interventions and community linkages**. Approaches that are still clinical in nature and patient focused, but allow for the opportunity to extend care from the clinical to community setting
3. **Total population or community-wide interventions**. Interventions that target an entire population or subpopulation typically identified by a geographic area such as a neighborhood, city, or county

The sections below outline the planned P4IPH diabetes-related activities. The primary focus will be on the second bucket above—innovative clinical prevention interventions—particularly creating linkages to key parts of Healthier WA to promote greater use of community diabetes education and support programs.

Workplan

Existing activities and proposed new P4IPH work are presented for each of the three buckets in the CDC framework. Table 1 at the end of the document lays out a more detailed draft workplan for implementing the activities. (Note: more details on the existing activities are in Deliverable 2 of the P4IPH).

Traditional clinical prevention interventions

- **Existing activities.** A number of activities targeting diabetes prevention and treatment within the clinical system are already in place, including incentives in Medicaid managed care organization contracts based on quality metrics. In addition, diabetes metrics are included in the statewide common measure set created as part of Healthier WA: https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf , and in the Community Check Up (https://wacommunitycheckup.org/)

- **New P4IPH activities.** The principal new activity will be working to expand the number of providers receiving value-based payments as part of Domain 1 of the Demonstration toolkit. The move to value-based purchasing, supported by both Healthier WA and the Demonstration, will provide incentives for prevention and management vs. treatment: https://www.hca.wa.gov/about-hca/value-based-purchasing. For example, expand the number of MCO contracts where there is a 1% withhold of the monthly premium payment for quality improvement, of which .75% may be earned back through meeting performance targets. Performance indicators may include Hemoglobin A1c (HbA1c) testing, HbA1c poor control (>9.0%), HbA1c control (<8.0%) and eye exams.
  In addition, we will work with ACHs around their behavioral health integration project (Demonstration Project 2A) to insure that screening for diabetes is included as part of the behavioral health providers' workflow.

Innovative clinical preventive interventions and community linkages

- **Existing activities.** DOH provides statewide support to a range of activities related to diabetes education and community-clinical linkages, including certifying diabetes education programs that serve Medicaid enrollees and providing Community Health Worker (CHW) trainings that help CHWs link people with diabetes to community resources. In addition, the Practice Transformation Support Hub has ongoing work to encourage Behavioral Health Agencies integrating physical health screening into their settings to begin with diabetes, BMI and hypertension screening. The Hub has also conducted an environmental scan of innovative community based resources including DPP and CDSMP in their inventory. Hub coach/connectors share these resources with providers and train them to make full use of these community clinical linkages.
- **New P4IPH activities.** New activities will focus on expanding the number of people reached by evidence-based primary and secondary prevention programs, including the Diabetes Prevention Program (DPP) and Chronic Disease Self-Management Program (CDSMP), that are typically offered in community settings. The reach of these program will be expanded by:
  - ***Integrating DPP, CDSMP into Pathways.*** Several regions are using the Pathways care management model for their Demonstration Project 2B – Care Management. There is a pathway for diabetes that includes referral to community resources**.** We will work to ensure that the CHWs in the diabetes Pathway fully exploit the existing DOH-sponsored classes and programs.
  - ***Expanding connections to the Accountable Communities of Health.*** There will likely be other ACH projects, apart from Pathways and the Hub, where diabetes education and support could be integrated to improve care for patients with diabetes. We will connect with ACHs on a regular basis to explore these opportunities.

Total population or community-wide interventions

- **Existing activities.** DOH houses several programs and initiatives that support population and community-level approaches to diabetes prevention, primarily through healthy eating and active living:
  - ***WIC Program.*** Women, Infants and Children (WIC) Nutrition Program provides checks for fruits, vegetables and other healthy foods and beverages for pregnant, breastfeeding and postpartum women and children 5 and under who qualify. WIC also provides health education to participants.
  - ***Healthiest Next Generation Initiative*****.** Launched in 2014, Governor Inslee's initiative brings together leaders in child health with business, community and government to develop a common agenda to create healthy early learning settings, schools, and communities. Current priorities include school curriculum enhancements, supporting

recess, increasing affordable access to fruits and vegetables, and additional healthy early learning requirements and training.
    - ***Healthy Eating Active Living (HEAL) Program***. Works through state and local systems to promote policies, system changes and environmental changes to improve healthy eating and physical activity. This work includes breastfeeding support in healthcare, Complete Streets in communities, Safe Routes to School support, Food Insecurity Nutrition Incentives for purchasing more fruits and vegetables by SNAP recipients, healthy nutrition guidelines, and access to healthy choices in schools and early learning settings.
- **New P4IPH Activities.** The P4IPH activity in this area will be to enhance linkages between three statewide initiatives/programs and the ACH's, particularly those with a strategic priority of preventing and managing diabetes. In each region there are many areas of overlap between the goals of, and populations targeted by, the statewide initiatives/programs and ACHs, and therefore opportunities for productive collaboration. P4IPH will work to inform both ACHs and the statewide initiatives/programs about each other and help identify and exploit these collaboration opportunities. We will add information about the initiatives/programs to the P4IPH web tool/planning guide to make it more accessible to the ACHs. (Note – DOH will be participating in the CHCS/Nemours TA opportunity related to the Demonstration 3D projects, providing another opportunity to tie ACH and DOH work together).

Detailed workplan and timeline

Table 1 shows a draft workplan for implementing the activities proposed above. Note that for many of the activities there is an initial meeting that will determine subsequent next steps.

Table 1. Workplan for proposed activities

P4IPH activity	*Task*	*Who*	*Timeline*
Traditional clinical prevention interventions			
Expanding value-based payments	Meet with VBP teams at HCA and ACHs to identify ways P4IPH might contribute to the effort	DOH chronic disease program staff, ACH VBP teams	Jan-Mar 2018
	(next steps to be determined (TBD))		
Behavioral health (BH) provider diabetes screening	Meet with behavioral health integration team at each ACH to insure that diabetes screening and referral is incorporated into the BH providers' workflow	DOH staff, ACH BH integration team	Jan-Mar 2018
Innovative clinical preventive interventions and community linkages			
Integrating DPP, CDSMP into Pathways	Identify ACHs implementing Pathways as part of Demonstration Project 2B	DOH staff	Jan-Mar 2018
	Begin conversations with Pathways to identify ways of increasing referrals to DPP, CDSMP	DOH staff, Pathways	Feb-April 2018
Using the Practice Transformation Hub to promote DPP, CDSMP	Meet with Qualis to identify ways of promoting practice coach awareness of community-based diabetes education programs	DOH staff, Qualis	Jan-Mar 2018
	(next steps TBD)		
Expanding connections to the Accountable Communities of Health	Meet with each ACH to learn more about their planned projects (particularly Demonstration Project 3D) and identify areas for collaboration around linking people with diabetes to community resources	DOH staff, ACH staff and committees	Jan-Mar 2018
Total population or community-wide interventions			

P4IPH activity	*Task*	*Who*	*Timeline*
Linking ACHs with statewide health promotion initiatives	Gather information on the three statewide initiatives/programs, focusing on aspects most relevant for ACHs	DOH staff	Jan-Mar 2018
	Set up meetings with ACHs to introduce them to the statewide initiatives and identify collaboration opportunities	DOH staff, ACH staff and committees	Feb-April 2018
	Follow-up with ACHs and statewide initiatives to facilitate implementation of opportunities identified	TBD based on opportunities identified	

Status update – Q1-Q2 2018

P4IPH activity	*Proposed Task*	*Status/Update*
Traditional clinical prevention interventions		
Expanding value-based payments	Meet with VBP teams at HCA and ACHs to identify ways P4IPH might contribute to the effort	Moved to 2nd quarter
Behavioral health (BH) provider diabetes screening	Meet with behavioral health integration team at each ACH to insure that diabetes screening and referral is incorporated into the BH providers' workflow	The Hub has completed face-to-face meetings will all ACHs. ACHs are aware of Hub coaches working in BH agencies and that their work includes integrating diabetes screening and referral to community resources into workflows. Qualis Health developed and posted to the Practice Transformation Resource Portal a 2-part document promoting chronic disease management for behavioral health providers. Some behavioral health agencies that participated in the VBP Academy selected stretch projects that addressed the needs of people with diabetes.
Innovative clinical preventive interventions and community linkages		
Integrating DPP, CDSMP into Pathways	Identify ACHs implementing Pathways as part of Demonstration Project 2B	Six ACHs are implementing Pathways and conversations are ongoing as related to making a common investment in the data platform. ACHs continue to work on their Medicaid transformation implementation plans as related to chronic disease and diabetes.
	Begin conversations with Pathways to identify ways of increasing referrals to DPP, CDSMP	Moved to 2nd quarter
Using the Practice Transformation Hub to promote DPP, CDSMP	Meet with Qualis to identify ways of promoting practice coach awareness of community-based diabetes education programs	The Hub coaches have prioritized identifying community based diabetes education resources in their regions to introduce to practices and BH agencies. They use the Safety Net Medical Home Model approach to introduce a structured referral process to BH and primary care practices as the framework for reaching out to these community based resources that support patient activation in managing their diabetes.
Expanding connections to the Accountable Communities of Health	Meet with each ACH to learn more about their planned projects (particularly Demonstration Project 3D) and identify areas for collaboration around linking people with diabetes to community resources	ACH project implementation staff met with the Practice Transformation Consortium. Three ACHs and the Washington Council on BH presented approaches to working directly with providers, including goals around identifying populations and connecting them with community based resources, including diabetes education programs. Pierce ACH is doing a pilot with the Practice Transformation Resource Portal to map diabetes resources in the ACH.

P4IPH activity	*Proposed Task*	*Status/Update*
Total population or community-wide interventions		
Linking ACHs with statewide health promotion initiatives	Gather information on the three statewide initiatives/programs, focusing on aspects most relevant for ACHs	Moved to 4th quarter – ACHs are focusing on developing implementation plans for their Medicaid projects. DOH has started a Community of Practice within the Prevention and Community Health division to categorize program activities into the three buckets of prevention in order to identify gaps (to guide future planning and grant applications) and create alignments. DOH continues to develop and update the Population Health Planning Guide.
	Set up meetings with ACHs to introduce them to the statewide initiatives and identify collaboration opportunities	Moved to 4th quarter
	Follow-up with ACHs and statewide initiatives to facilitate implementation of opportunities identified	Moved to 4th quarter