Healthier Washington - Plan for Improving Population Health

Work plan for Implementing Diabetes Prevention Activities

August 18, 2017

Overview

The Healthier Washington Plan for Improving Population Health (P4IPH) is an actionable, focused work plan 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), Department of Health (DOH), and Department of Social and Health Services (DSHS), implemented a structured process to identify initial priority focus areas for P4IPH. The process resulted in the selection of diabetes prevention and treatment as a primary focus area and well-child visits as a secondary focus area.

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

Traditional clinical prevention interventions. Care provided most often by health care providers in a doctor's office, in a routine one-to-one encounter.
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.
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 innovative clinical prevention interventions, particularly creating linkages to key parts of Healthier Washington to promote greater use of community diabetes education and support programs.

Work plan

Existing activities and proposed new P4IPH work are presented for each of the three buckets in the CDC framework. The table at the end of this document lays out a detailed draft work plan 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 and in the Community Check Up Report.
- **New P4IPH activities.** The principal new activity will be to expand the number of providers receiving value-based payments as part of Domain 1 of the Medicaid Transformation Demonstration. The move to value-based purchasing will provide incentives for prevention and management vs. treatment. For example, expand the number of MCO contracts where there is a 1 percent withhold of the monthly premium payment for quality improvement, of which .75 percent 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, as ACHs engage in a behavioral health integration project (Demonstration Project 2A) they will ensure that screening for diabetes is included as part of a behavioral health provider's workflow.

Innovative clinical preventive interventions and community linkages

- **Existing activities.** DOH provides statewide support to a range of activities related to diabetes education and fostering linkages across clinical and community settings, including certifying diabetes education programs that serve Medicaid enrollees and providing Community Health Worker (CHW) training that helps CHWs link people with diabetes to community resources. In addition, the Practice Transformation Support Hub is working with behavioral health agencies to encourage integrating physical health screening into their settings, beginning with diabetes, BMI and hypertension. The Hub has also conducted an environmental scan of innovative community-based resources, including the Diabetes Prevention Program (DPP) and Chronic Disease Self-Management Program (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 DPP and CDSMP that are typically offered in community settings. The reach of these programs 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**.** The work plan calls for ensuring that the CHWs in the diabetes pathway fully exploit the existing classes and programs DOH sponsors.
    - ***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. This work plan includes regular engagement with ACHs to explore these opportunities.

Total population or communitywide 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 funds for fruits, vegetables and other healthy foods and beverages for pregnant, breastfeeding and postpartum women and children age 5 and under who qualify. WIC also provides health education to participants.
    - ***Healthiest Next Generation Initiative*****.** Launched in 2014, Gov. 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 health care, 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 ACHs, 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, 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. Information about the initiatives/programs will be added to the P4IPH web tool/planning guide to make it more accessible to the ACHs. (Note: DOH will be participating in the CHCS/Nemours Technical Assistance opportunity related to the Demonstration 3D projects, providing another opportunity to tie ACH and DOH work.)

Detailed work plan and timeline

Table shows a draft work plan for implementing the proposed activities. For many of the activities an initial meeting will determine next steps.

Work plan for proposed activities

P4IPH activity	*Task*	*Who*	*Timeline*
Traditional clinical prevention interventions			
Expanding value-based payments (VBP)	Meet with VBP teams at HCA and ACHs to identify ways P4IPH might contribute to the effort. Next steps to be determined.	DOH chronic disease program staff, ACH VBP teams	Jan-Mar 2018
Behavioral health (BH) provider diabetes screening	Meet with behavioral health integration team at each ACH to ensure diabetes screening and referral is incorporated into the BH provider's 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 Support Hub to promote DPP, CDSMP	Identify ways of promoting awareness of community-based diabetes education programs with practice transformation coach/connectors. Next steps to be determined.	DOH staff	Jan-Mar 2018
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. Next steps to be determined.	DOH staff, ACH staff and committees	Jan-Mar 2018
Total population or communitywide interventions			
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
	Meet 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.	To be determined, based on opportunities identified	