

PREVENTION FIRST, ADVANCING SYNERGY FOR HEALTH

*DIRECTION FOR DIABETES IN CALIFORNIA
JULY 7, 2014*

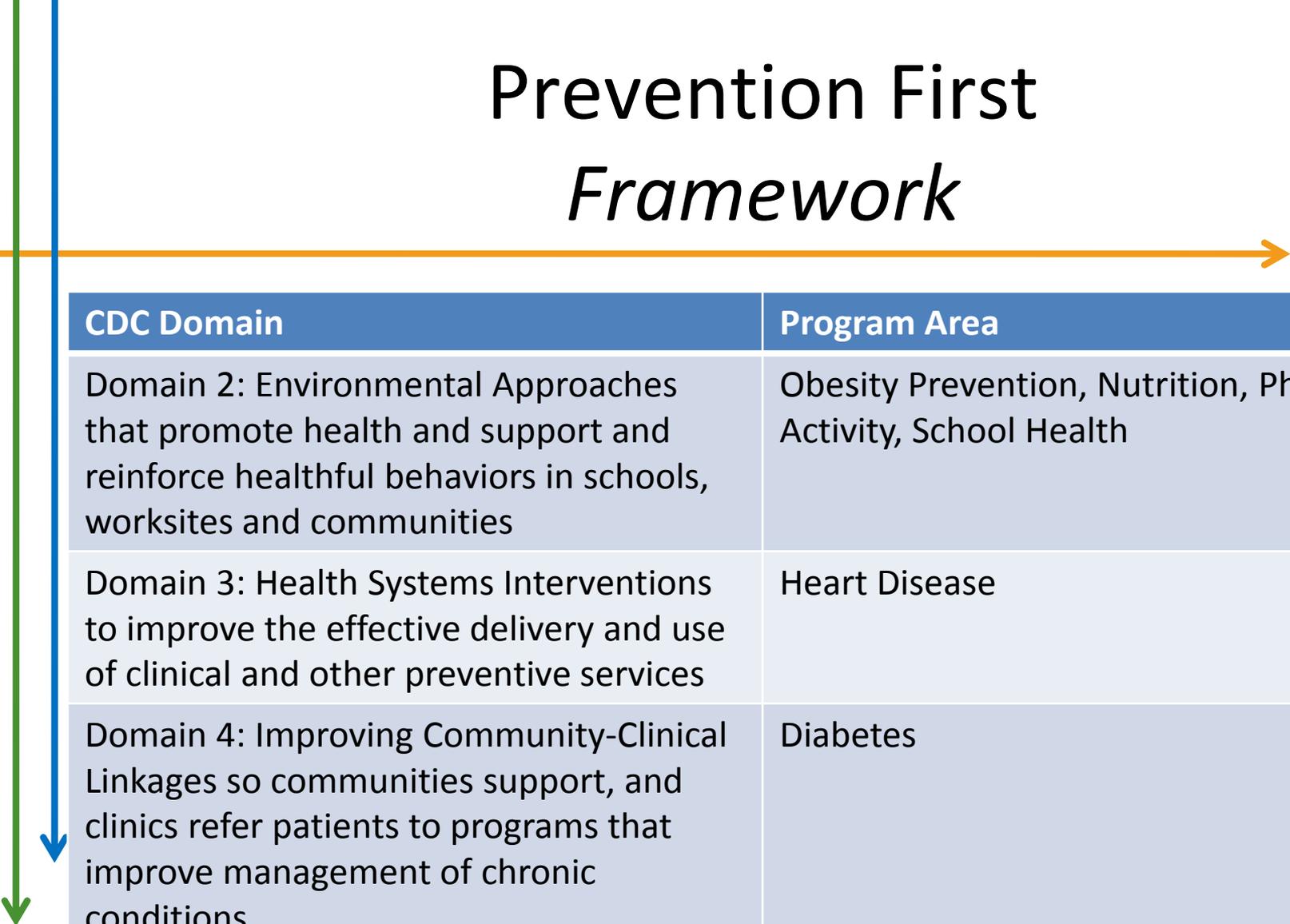


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Summary

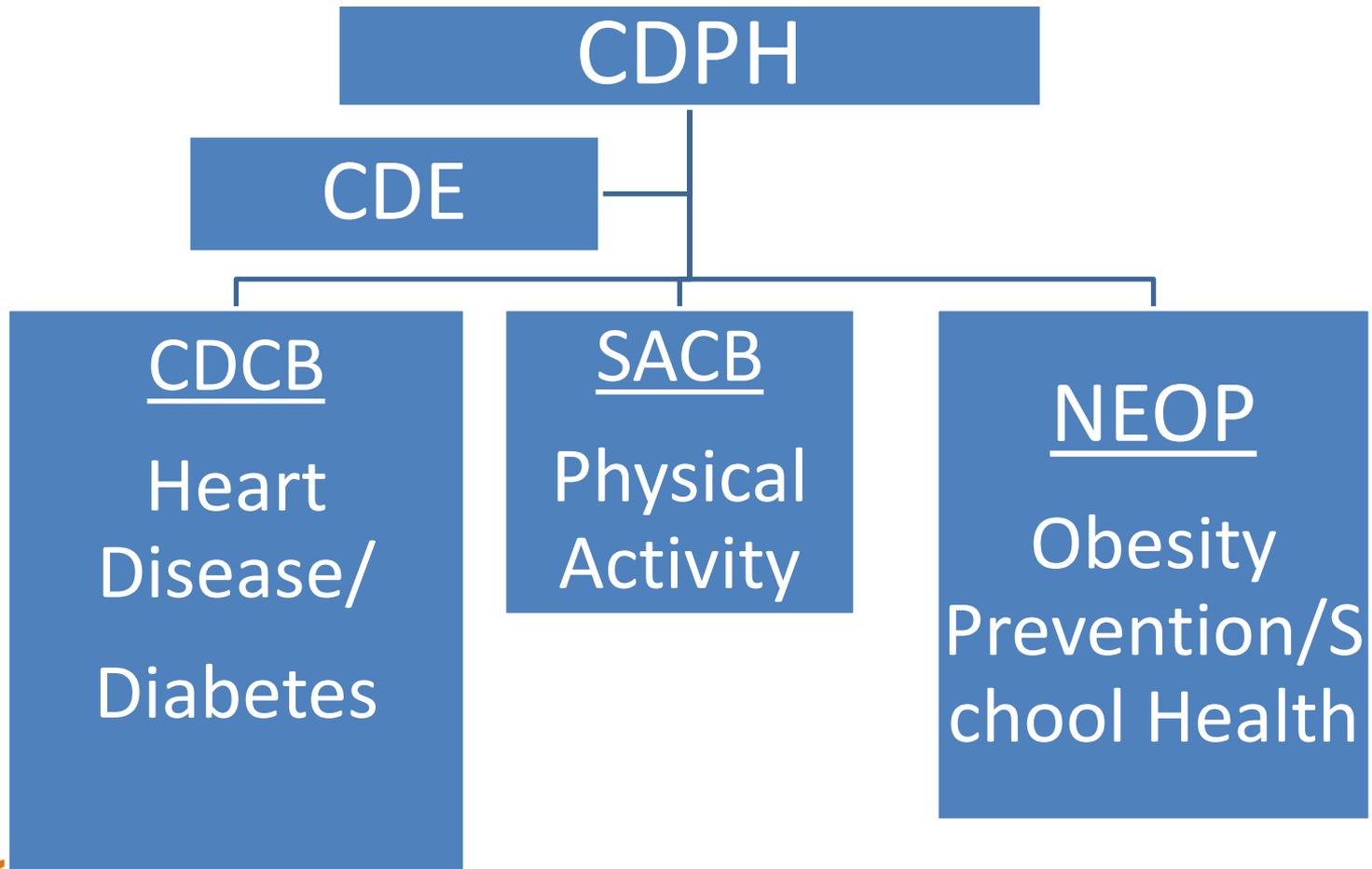
- *Funding Opportunity, State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (CDC-1305)*
- Term of funding is 5 years, July 1, 2013 – June 30, 2017
- CDPH Programs funded through this funding opportunity:
 - Diabetes Prevention, Heart Disease, Obesity Prevention, School Health

Prevention First *Framework*



CDC Domain	Program Area
Domain 2: Environmental Approaches that promote health and support and reinforce healthful behaviors in schools, worksites and communities	Obesity Prevention, Nutrition, Physical Activity, School Health
Domain 3: Health Systems Interventions to improve the effective delivery and use of clinical and other preventive services	Heart Disease
Domain 4: Improving Community-Clinical Linkages so communities support, and clinics refer patients to programs that improve management of chronic conditions	Diabetes

Prevention First *Staffing*



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Diabetes-Related Strategies

Promote reporting of blood pressure and hemoglobinA1C measures; and as able, initiate activities that promote clinical innovations, team-based care, and self-monitoring of blood pressure. (Domain 3)

Promote awareness of high blood pressure among patients (Domain 4)

Promote awareness of prediabetes among people at high risk for type 2 diabetes (Domain 4)

Promote participation in American Diabetes Association-recognized, American Association of Diabetes Educators-accredited, state-accredited/certified, and/or Stanford licensed Diabetes Self Management Education programs (Domain 4)

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Diabetes-Related Strategies →

Domain 3: Health System Interventions

Increase implementation of quality improvement processes in health systems

- Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance
- Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level

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Diabetes-Related Strategies →

Domain 3: Health System Interventions

Increase use of team-based care in health systems

Increase engagement of non-physician team members (i.e., nurses, pharmacists, and patient navigators) in hypertension (HTN) and diabetes management in health care systems

Increase use of self-measured blood pressure monitoring tied with clinical support

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Diabetes-Related Strategies →

Domain 4: Community-Clinical Linkages

Increase use of diabetes self-management programs in community settings

Increase access, referrals, and reimbursement for AADE-accredited, ADA-recognized, State-accredited/certified, or Stanford-licensed DSME programs

Increase use of lifestyle intervention programs in community settings for the primary prevention of type 2 diabetes

Increase referrals to, use of, and/or reimbursement for CDC recognized lifestyle change programs for the prevention of type 2 diabetes (national diabetes prevention program)

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Diabetes-Related Strategies →

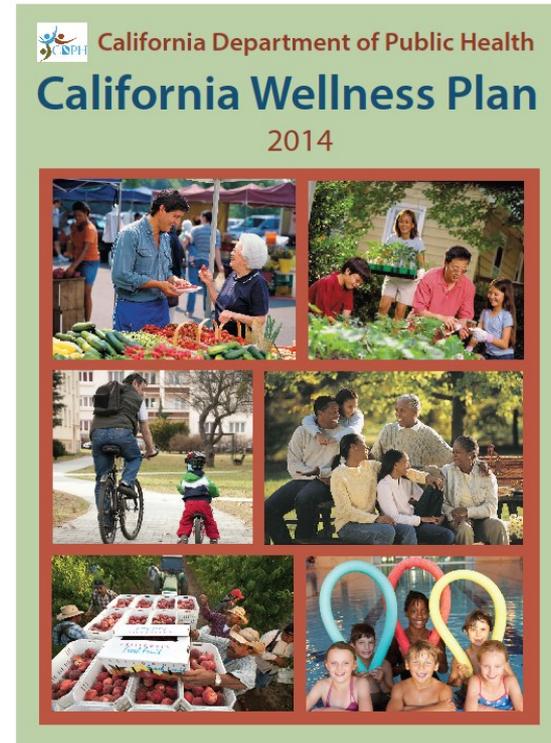
Domain 4: Community-Clinical Linkages

Increase use of chronic disease self-management programs in community settings

Increase access to and use of Chronic Disease Self-Management (CDSM) programs

California Wellness Plan 2014

Roadmap for government and
partners to prevent chronic
disease



www.cdph.ca.gov/programs/cdcb/Pages/CAWellnessPlan.aspx

California Wellness Plan

Goals



Overarching: Equity in Health and Wellness

1. Healthy Communities

- Create healthy, safe, built environments

2. Optimal Health Systems Linked with Community Prevention

- Create systems approach to improve patient and community health

California Wellness Plan

Goals

3. Accessible and Usable Health Information

- Comprehensive statewide data

4. Prevention Sustainability and Capacity

- Greater investment in community-based prevention approaches



P21

Advancing Prevention in 21st Century

February 13 & 14, 2014

- Brought together statewide partners from public and private sector organizations to showcase the California Wellness Plan (Plan)
- Determined 4 priority strategies and action steps to advance shared policy, health system, community and health information goals

California Wellness Plan

Linking Diabetes Prevention & Management

Goal 2: Optimal Health Systems Linked with Community Prevention

		Lifestyle Intervention Programs	
2	2.3.2S HDDPU & WW	By 2015, increase the proportion of WISEWOMAN participants in evidence-based lifestyle intervention programs, including those addressing social and emotional support, who were referred by a health care provider from 1,300 women in 2013 to 1,800 women, as federal funding allows	<i>WW Minimum Data Elements, CDPH</i>
3	2.3.3S HDDPU & DHCS	By 2015, increase the percentage of Medi-Cal recipients with pre-diabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle intervention programs (Developmental)	<i>Medi-Cal Managed Care Plan Data, Department of Health Care Services</i>

California Wellness Plan

Linking Diabetes Prevention & Management

		Self-Management Programs	
4	2.3.4S HDDPU, CAPP, CTG & CDA	By 2015, increase the number of participants with a chronic health condition and/or disability who attend evidence-based chronic disease self-management programs in California from 15,149 from 2008 to 2012 to 25,000 from 2013 to 2017	<i>Data repositories, California Department of Aging, CDPH</i>
5	2.3.5S HDDPU, CAPP, & CDA	By 2015, increase the number of counties with evidence-based chronic disease self-management programs from 38 to 44, as federal funding allows	<i>Data repositories, California Department of Aging, CDPH</i>
6	2.3.6S HDDPU & DHCS	By 2015, increase the percentage of Medi-Cal recipients with diabetes who have access to Diabetes Self-Management Education (DSME) (Developmental)	<i>Medi-Cal Managed Care Plan Data, Department of Health Care Services</i>
7	2.3.7S HDDPU	By 2015, increase the number of DSME programs from 159 to 176	<i>Data repositories, Heart Disease and Diabetes Prevention Unit, CDPH</i>
8	2.3.8S HDDPU	By 2015, increase the proportion of counties with DSME programs from 66 to 76 percent, as federal funding allows	<i>Data repositories, Heart Disease and Diabetes Prevention Unit, CDPH</i>
9	2.3.9S HDDPU & DHCS	By 2015, increase number of smokers in the Medi-Cal program who call the California Smokers' Helpline (Quitline) through the Medi-Cal Incentives to Quit Smoking Project from approximately 17,500 callers to 25,000 callers annually	<i>California Smokers' Helpline, DHCS</i>



California Wellness Plan

Linking Diabetes Prevention & Management

Intermediate Objectives			Data Source
Self-Management Programs			
3	2.3.3I HDDPU	By 2018, increase the proportion of people with diabetes in targeted settings who have at least one encounter at a DSME program per year (Developmental)	<i>No known data source</i>
4	2.3.4I CTCP & WW	By 2018, increase the number of calls to the California Smokers' Helpline referred from health care providers from 14,221 to 15,000	<i>California Smokers' Helpline, CDPH; WW Minimum Data Elements, CDPH</i>



California Wellness Plan

Linking Diabetes Prevention & Management

2.5		Decrease Adult and Childhood Obesity and Diabetes	
Short-term Objectives			Data Source
1	2.5.1S WIC	By 2015, decrease the obesity rate among 4 year old children participating in WIC by 1 percent from 20 percent overweight in 2012 to 19 percent	<i>WIC Integrated Statewide Information System, CDPH</i>
2	2.5.2S HDDPU	By 2015, increase awareness of pre-diabetes so that the prevalence of people who self-report having pre-diabetes increases from 9 percent in 2011 to 12 percent	<i>National Nutrition and Health Examination Survey, CDC; California Health Interview Survey, University of California Los Angeles</i>
Intermediate Objectives			Data Source
1	2.5.1I HDDPU & WW	By 2018, increase the proportion of WW participants with diabetes in adherence to medication regimens from 63 percent in 2012 to 69 percent, as federal funding allows	<i>Medi-Cal EHR Incentive Program, Department of Health Care Services; National Quality Forum; WW Minimum Data Elements, CDPH</i>
2	2.5.2I HDDPU	By 2018, decrease the proportion of people with diabetes who have Hemoglobin A1C > 9 (Developmental)	<i>Medi-Cal EHR Incentive Program, Department of Health Care Services; National Quality Forum</i>

California Wellness Plan

Linking Diabetes Prevention & Management

Long-term Objectives			Data Source
3	2.5.3L MCAH	By 2020, increase the proportion of mothers who achieve a recommended weight gain (per IOM standards) during their pregnancies (Developmental)	<i>Vital Statistics, Birth Statistical Master Files, Maternal and Infant Health Assessment Survey, CDPH</i>
4	2.5.4L	By 2020, decrease the prevalence of diagnosed gestational diabetes mellitus in hospital deliveries (Developmental)	<i>Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development</i>
5	2.5.5L HDDPU & WW LGH	By 2022, decrease the prevalence of diagnosed diabetes, in adults, from 9 to 8 per 100	<i>Behavioral Risk Factor Surveillance System, CDC; California Health Interview Survey, University of California Los Angeles</i>
6	2.5.6L HDDPU	By 2020, decrease the age-adjusted hospital discharge rate for diabetes as any-listed diagnosis for persons with diabetes from 337 per 1,000 in 2008 to 275 per 1,000	<i>Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development</i>

California Wellness Plan

Linking Diabetes Prevention & Management

Goal 3: Accessible and Usable Health Information

3.1		Increase Transparent Information on Cost and Quality of Care	
Short-term Objectives			Data Source
3	3.1.3S HDDPU	By 2015, increase the proportion of health care providers participating in Medi-Cal EHR Incentive Program who report on the percentage of adults with diabetes who have Hgb A1C > 9 percent (National Quality Forum Measure 59) (Developmental)	<i>Medi-Cal Managed Care Plan data, Department of Health Care Services</i>
Long-term Objectives			Data Source
1	3.1.1L DMHC	By 2020, the 10 largest health plans in California will achieve the National 90th percentile in performance of HEDIS control measures for hypertension, heart disease and diabetes (Developmental)	<i>California Office of the Patient Advocate</i>

California Wellness Plan

Role of Partners

- Contributed to development of the Plan over the past two years
- Advised CDPH to ensure Goals, Priorities, Strategies, and Objectives met needs of public and partner organizations
- Made commitments to implement *Advancing Prevention in the 21st Century* Strategies and Action Steps that align with their mission and area of expertise

California Wellness Plan

CDPH Commitments

1. Coordinate state chronic disease prevention programs
2. Participate in statewide Coalitions
 - Health Happens Here
 - California Chronic Care Coalition (CCCC) and Right Care Initiative (RCI)
 - California Healthier Living Coalition (CHLC)
 - California Conference of Local Health Officers Chronic Disease Committee

3. Monitor California Wellness Plan

Contact Information

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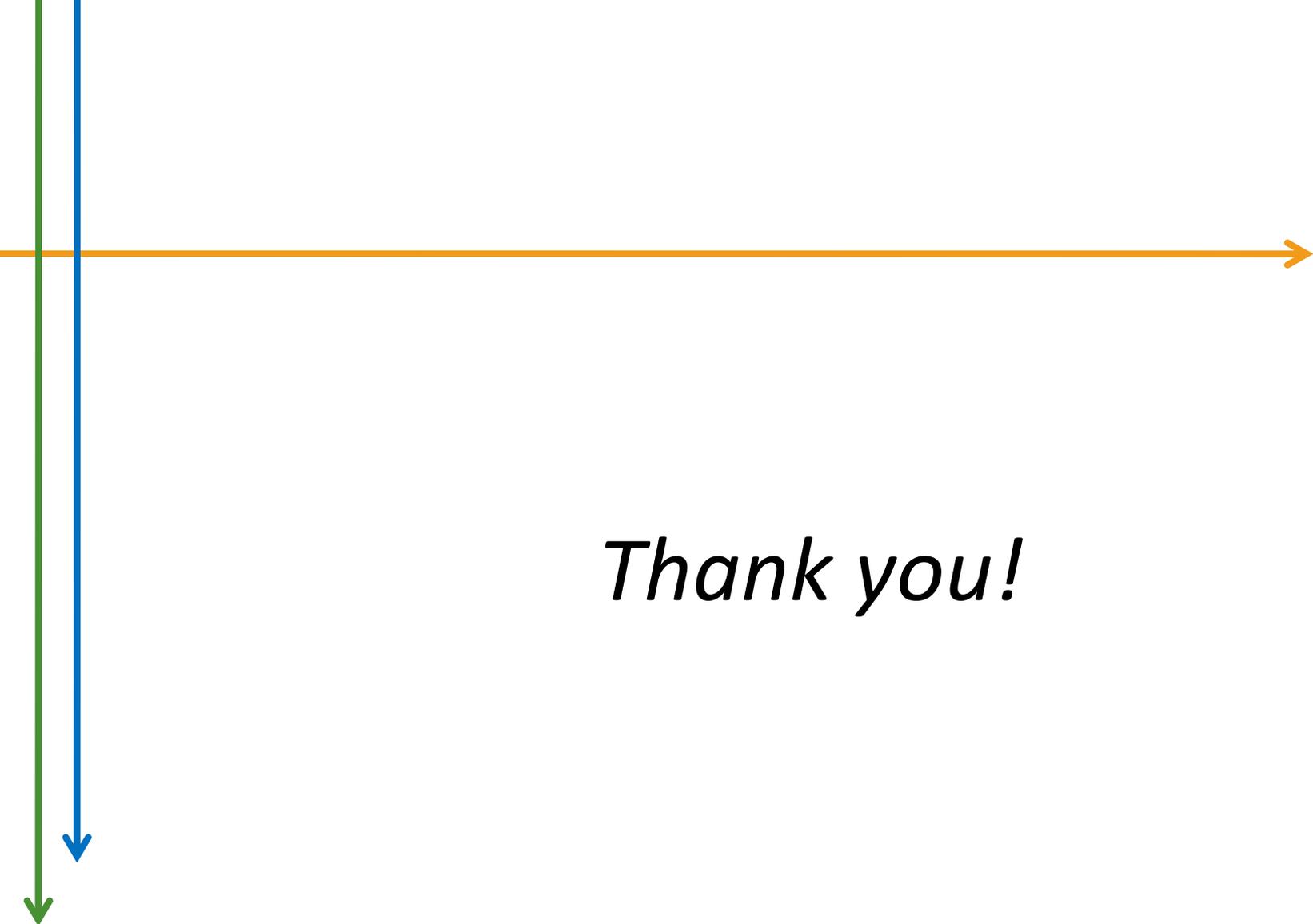
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Thank you!

