DEAR Summit Recap

October 25, 2016 – Washington State Capitol Campus

Background

The Washington State Department of Health, Department of Social and Health Services, and Health Care Authority hosted the *Diabetes Epidemic and Action Report Stakeholder Policy Summit* on Tuesday, October 25, 2016. The summit took place from 9:00 AM – 4:00 PM in Olympia, Washington on the State Capitol Campus.

A cross-agency group known as the Diabetes Epidemic and Action Report (DEAR) Team has been convened to address a proviso in the 2015-2017 budget (ESSB 6052). This legislation directs the Department of Health, the Health Care Authority and the Department of Social and Health Services to, among other directives, create individual agency action plans and actionable items for the legislature's consideration. The completed report and action plans are due to the Legislature in June 2017; a draft for stakeholder review is anticipated by February 2017.

The purpose of the summit was for stakeholders to participate in reviewing progress on goals in the 2014 DEAR, and identify action steps for agencies, the legislature, and partners to take to improve diabetes care and management. These action steps will complement the Diabetes Prevention Action Plan developed at the Stakeholder Engagement Meeting in June 2016. This Summit focused on actions to impact the populations of people in Washington who have diabetes.

Agenda

Time	Description	Presenter(s)
8:30 AM	Check-in	
9:00 AM	Diabetes Epidemic and Action Report *Where we've been, where we're at, and where we're going*	Kathy Lofy, MD Dan Lessler, MD, MHA, FFACP Bea Rector
10:15 AM	Break	
10:30 AM	Talking about Costs: A Discussion with Experts on the Costs of Diabetes in Washington	**Host:** David Hudson **Guests:** John Bauer, Ph.D, Donna Sullivan, PharmD, MS
11:45 AM	Lunch on your own	
1:15 PM	Afternoon action planning sessions - Introductions and Overview - Identify Problem Statement - Brainstorm Potential Policy Actions - Review and Narrow Actions	**Facilitated by:** - Lisa Packard, MS - Colette Rush, RN, BSN, CCM - Angela Nottage, RN, BSN - Jamie Hunter-Mitchell
3:00 PM	Stretch Break	

3:10 PM	Complete Action Planning Grid & Designate spokesperson
3:50 PM	Closing statements & Action Planning Group Report Out
4:00 PM	Adjourn

Demographics

Number of People	Number of Organizations
66	37

Organizations in attendance		
Amerigroup	Kitsap Public Health District	WA Department of Health
Center for Multicultural Health	Neighborcare Health	WA Department of Social and Health Services
Chelan-Douglas Health District	Nooksack School District	WA Health Care Authority
Community Choice	Northshore School District	Washington State House
Confluence Health	Northwest Kidney Centers	Washington State Institute for Public Policy
Cowlitz Indian Tribe	Novo Nordisk	Washington State Pharmacy Association
Educational Service District 113	People for People	Washington State Senate
Franciscan	Public Health Seattle and King County	Washington State University
Governor's Interagency Council on Health Disparities	Puget Sound Educational Service District	Washington State University Extension
Governor's Office	Qualis	Yakima Valley Memorial Hospital
Grant County Health District	Sanofi	
Group Health Cooperative of Puget Sound	Tacoma Pierce County Health Department	
Healthy Living Collaborative	Washington Dental Service Foundation	
Inland Northwest Health Services		
Issaquah School District		

Evaluation results

Number of Evaluations
32

Was This Event a Valuable use of your time?	Please Rate the Appropriateness of the content for the amount of time allowed.	How Valuable Was this meeting for action planning and networking?	Please rate the effectiveness of your action planning session	How well do you think your input and your organizations voice was heard and valued?	Overall, how would you rate this summit?
4.38	4.13	4.45	4.28	4.13	4.42

Before this summit, were you aware of the DEAReport?		Have you read the DEAReport?	
Yes	No	Yes	No
24	8	25	6

Major themes from the open ended evaluation questions include:

- Participants would like an opportunity to review the Report before it's published.
- The DEAR team should gather input from people affected by diabetes, and other organizations who couldn't attend the Summit before finalizing agency action plans.
- Participants would be welcoming of more information about the diabetes epidemic in Washington, and what's being done about it, including training opportunities.

Based on the evaluation results, participants felt that the Summit was a valuable use of time and useful for networking and action planning. They also felt their input and voices were heard.

Of those who filled out an evaluation form, most people were familiar with, and have read the 2014 *Diabetes Epidemic and Action Report*

Presentation Slides and Notes

Opening Presentation:

Thank you to Dr. Kathy Lofy, Dr. Dan Lessler, and Bea Rector for providing the opening presentation about our progress since the 2014 *Diabetes Epidemic and Action Report* was published.

Their slides have been posted on the Diabetes Connection for your reference. Additionally, below is a brief recap of the Q&A session after their presentation. Click here to download presentation slides.

Diabetes prevalence doubled since 1994- Is this in proportion with population growth?

- Yes, prevalence is adjusted for age (this adjusts numbers to standard population)

Dr. Lessler chalk talk – Is this accessible?

- Dr. Lessler's chalk talk presentation is available online.

How is Medicare shared savings being applied?

- Healthier WA 1115 waiver counts on intervention that will save dollars
- These saved dollars will be reinvested or put towards other efforts (still in question)
- Medicare specific savings were booked into budget to pay for expansion of services and to help general fund balance
- 1115 wavier is making investments – Need to be building towards system that leverages these investments so that total cost of care is not going up (part of this is how you reimburse)

One regional health system that serves all four counties – Can only share stories of successes of (C)DSME *BUT needs numbers* to show return on investments – How do we get sustainability?

- Fundamentally, deals with how you finance healthcare – Health system must see themselves as responsible for population
- CDC model discusses prevention in healthcare system, prevention in community level, and interventions that can be delivered to individuals in community – We need to grow this innovative space to grow linkages between healthcare and community

What is there for minorities (e.g. immigrants, seasonal workers, etc.) who lack basic right/access to services? Is there a model that can be applied to these underserved communities?

- Public health efforts and community health workers are in some communities
- Must look at: Are we deploying resources as efficiently as possible?
- Federally Qualified Health Centers serves low income, migrant individuals, etc.

Costs Discussion:

Thank you to Donna Sullivan, Dr. John Bauer, and our host David Hudson for providing an engaging discussion on costs of diabetes in Washington. Below is a recap of the discussion, including questions from the audience.

What do you see as the greatest factors (biggest driver) related to cost of diabetes?	
John:	○ Depends on excess cost for person with disease ○ $8,000/year healthcare dollar difference for patient with diabetes versus patient without diabetes ○ Big money being spent on complications ○ Think about lifetime costs associated with someone who has developed diabetes ○ If diagnosed later in life, lifetime costs decreases ○ 40% of costs due to managing disease while 60% of costs due to complications (e.g. heart disease) ○ Biggest cost is due to increased hospital stays (over 40%) ○ Pharmacy costs are near 30% (more than half of these are related to complications such as managing heart disease) ○ Physician visits 9% ○ Nursing home visits 8%
Donna:	○ Incredible increase in the cost of long-acting insulin

If talking to decision maker/legislature, what messages would resonate the most related to cost of diabetes?	
John:	○ 70-80% (?) of those with prediabetes will go on to develop diabetes
Donna:	○ Paying for value – There is value in treating diabetes ○ The newest drugs are not necessarily the most value-added drugs

What worries you most about cost of diabetes?	
John:	○ Setting at which these higher costs are coming on – Healthcare system is already stressed by rising costs and limited budgets ○ Other costs: premature death, health homes, etc.

Donna:	○ Cost of treating diabetes going up – Cost to entire population goes up

What solutions do you see?	
John:	○ Need solutions at all three levels of prevention (primary, secondary, tertiary) ○ Need efficient management of disease continually ○ Focus on how do we minimize complications ○ Better mgmt. of disease is cost beneficial (You save money by managing it better) ○ How we pay for care is essential (i.e. value-based care, health homes, etc.) ○ Diabetes Prevention Programs – starting with people at high risk – don't reach everyone – We need to start earlier!
Donna:	○ Needs to start with prevention – *Needs to start with kids* ○ Need educational learning about what it means to get diabetes, to live with diabetes ○ Diabetes needs to be managed, not just disregarded ○ Payers say: Why do we want to pay for preventive service when that patient might not be in my plan two years from now? Maybe we should shift to *tax pool* where all are paying into preventive services for patients.

How do we reduce cost but at the same time ensure quality and increase access?	
Donna:	○ Solution is at federal government ○ Manufacturers set price ○ Coordinated care

Questions from audience:

How are you promoting self-education/learning so that people can learn what to do with diabetes independently? What are you providing to doctors or community workers to give to individuals? How do you make families aware of diabetes history?
○ HCA has employee wellness program with access to health assessment (online educational tool) – Can sign up for education classes (DPP, DSME, CDSME) ○ Employee newsletters with health alerts/awareness ○ Individual health plans

If prevention is cure, why is there coverage for state employees but not for other populations (Apple Health, Molina, etc.)? How to sustain if you can't get paid for it?
○ Have performance goals around diabetes measures for insurance plans ○ Nothing for this in fee for service model ○ Need funding sources

How to reach minorities? Access and funding are huge barriers.
○ Emergency Department initiative is trying to reduce (avoidable) ER visits. *Additional thoughts from DOH:*

Currently there is a lack of services available for the populations most at risk for diabetes. We recognize this and are actively working to address it. To help bridge this gap, there are Community Health Workers (CHWs) working in various capacities throughout the state. For more information about CHWs, the services they can provide, and how to get connected with CHWs in your area, contact chwts@doh.wa.gov or 360-236-3792. You can also find information about the Community Health Worker Training System online at: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem

For John Bauer: Report in 2015 about DPP and efficacies… When to expect benefit-cost analysis?

- Benefit-cost analysis on website – shows benefit of DPP (far outweigh costs)
- DPP costs about $450 – Save estimated $6,000 in lifetime medical costs per participant
- Will save society additional monies on labor market (i.e. increased lifetime earnings… tax benefits, etc.)

How to bring together health systems, payers, etc.?

- Accountable Communities of Health – all these professionals are working together
- EX: Yakima has embedded preventive programs in EMR – Not relaying on patient minimal knowledge about these programs --- *When physicians refer there is greater chance of patient going to program and greater retention*
- EX: Center for Multicultural Health – Clients could not pay $400 – Never charged clients – Needs physicians to more boldly tell their PTs to manage their weight and attend these programs – Lost funding and had to stop direct classes

Additional comments:

- Disproportionality in health insurance plans – Frustrations
  - HCA trying to focus on plans offering some benefits – With some freedom on how to offer these benefits
- As much as we can support moving away from fee-for-service the more we can pay for other things – Patient must be full transparent AND healthcare team must know social determinants
  - Need to also teach how to time manage or stress manage
- Minorities are developing diabetes at the fastest rate – Prevention is not always a priority because they come from rural areas where there is no money invested in prevention – Use ER for primary care – *NEED to apply theory to interventions, study different strategies for different communities – INCLUDE patients in strategies*

Afternoon Action Planning Sessions

Thank you to everyone who participated in the afternoon action planning sessions. It was clear that there were magnitudes of passion and expertise in the room. We recognize that the acoustics of the room were a barrier to effectively work as a group. We also recognize that we should reach out to not only other organizations who weren't able to attend, but also to people who are living with diabetes and possibly experiencing some of the barriers we discussed.

Below is a recap of the suggested action items and problem statements from each group. Raw notes from the action planning groups will be published in the report, and are available upon request until then.

Action Planning Group – Costs:

Problem statement:

Top recommendations:

1. Consistent benefit for Diabetes Self-Management Education across Medicaid – alignment with Medicare benefit
2. Savings that come from Diabetes-related improvements stay with Diabetes-related prevention/treatment
3. Increase awareness of Diabetes Self-Management Education benefit to all insured people with diabetes
4. Incentivize patients/enrollees/members of health plans to use DSME and improve diabetes-related outcomes

Action Planning Group – Quality:

Problem statement: Lack of flexible infrastructure and care coordination impedes quality team-based patient-centered care across settings

We are exploring ways to gather input from organizations who could not attend, and from people living with diabetes.

Top recommendations:

1. Simplify process related to diabetes care delivery through two different tracks 1- Patient and 2- Provider.
2. Create access to and use relevant data to inform priorities for specific populations and interventions.
3. Through the vehicle of the ACH continue to evaluate and identify within the community support services and linkages back to the health system- a partnership between community and health services made bi-directional through technology.

Action Planning Group – Access for Populations:

Problem statement: Failure to recognize individuals as experts in their own health. Policy, systems, and environment change doesn't always consider impacts to populations & can lead to health inequality.

Top recommendations:

1. Create efficient, culturally, linguistically-sensitive and competent Diabetes Education awareness program that includes human theory.
2. Funding and resources need to be focused on populations experiencing inequities.

3. Providers and legislators required to take implicit bias course; Thus, increasing cultural sensitivity, diversity of providers for populations they serve; & patient-centered care.
4. Free cost of healthcare and barrier-free referrals (possibly self-referrals).
5. Host community focus groups and outreach in communities with inequities.

Action Planning Group – Access in Settings:

Problem statement: Lack of flexible diabetes care infrastructure impedes patient care in and between clinics and communities

Top recommendations:

1. Funding for providing services where, when and how PATIENT wants
2. Flexible care coordination system (standardized)
3. Electronic medical record interface

Additional Reading and Resources

- Dan Lessler, Kathy Lofy, and Bea Rector opening presentation slides
- Washington State Institute for Public Policy Benefit-Cost Results: Lifestyle interventions to prevent diabetes: Long-term, intensive, individual counseling programs
- Washington State Institute for Public Policy Benefit-Cost Results: Lifestyle interventions to prevent diabetes: Shorter-term, programs with group-based counseling
- Washington State Institute for Public Policy: Diabetes Prevention Program: A Review of the Evidence
- Harvard's Project Implicit
- Dan Lessler's chalk talk presentation
- DPP Action Plan – developed in June 2016
- Washington State Diabetes Connection website
- 1115 Medicaid Waiver resources:
    - Health Care Authority's Waiver Application
    - Health Management Associates News: WA Approved for Waiver
    - Health Care Authority's Medicaid Transformation webpage