



Diabetes Prevention and Control – A Comprehensive Process

Massachusetts Department of Public Health

**Like everywhere else,
Massachusetts has a growing
diabetes problem**



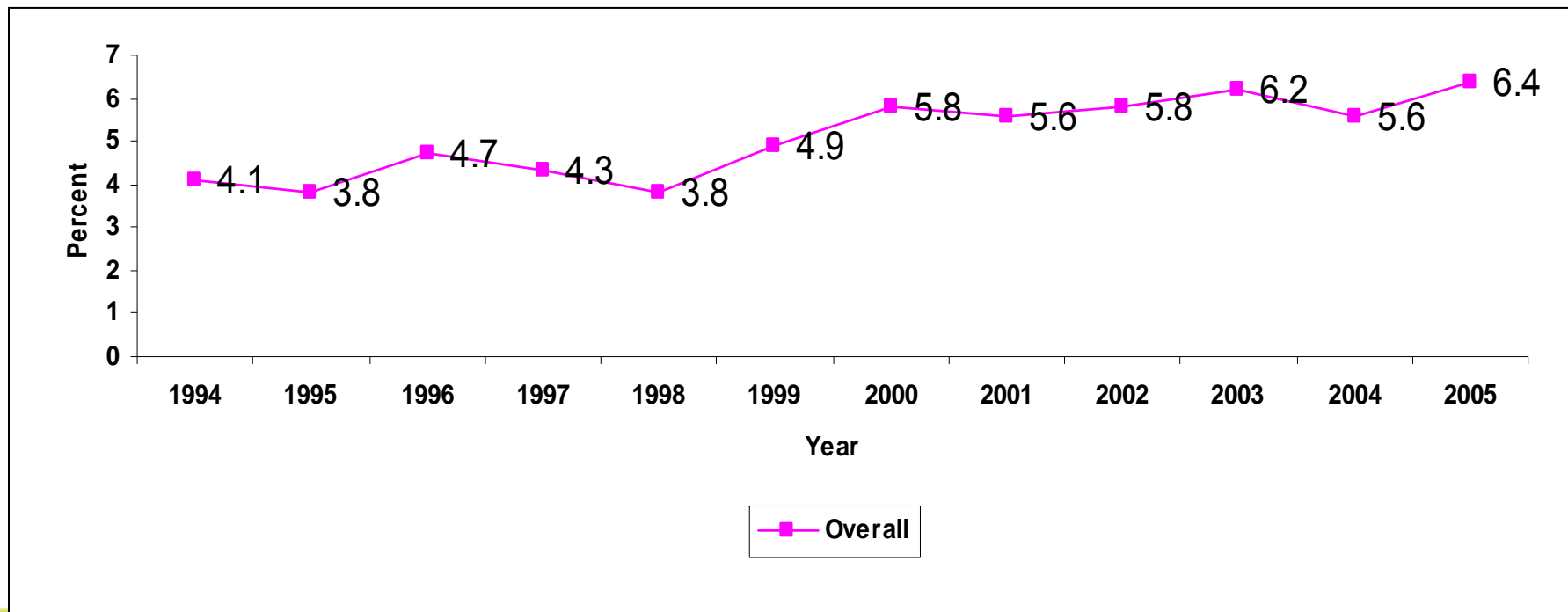
Diabetes in Massachusetts

- ~ **330,000** diagnosed people with diabetes
- **100,000-140,000** are undiagnosed
- Even more with pre-diabetes
- #9 leading cause of death
- New severe complications per year
 - 675 cases of blindness
 - 1,150 cases of renal failure
 - 2,300 lower extremity amputations
- 6,000 deaths with diabetes as major contributor



Prevalence in Massachusetts has increased ~50% over the past decade

Prevalence of Diabetes in Massachusetts, 1994-2005



Source: Massachusetts Behavioral Risk Factor Surveillance System (BRFSS); 1994-2005. Note: Estimates have been age-adjusted to 2000 US standard population



An Initial Step:

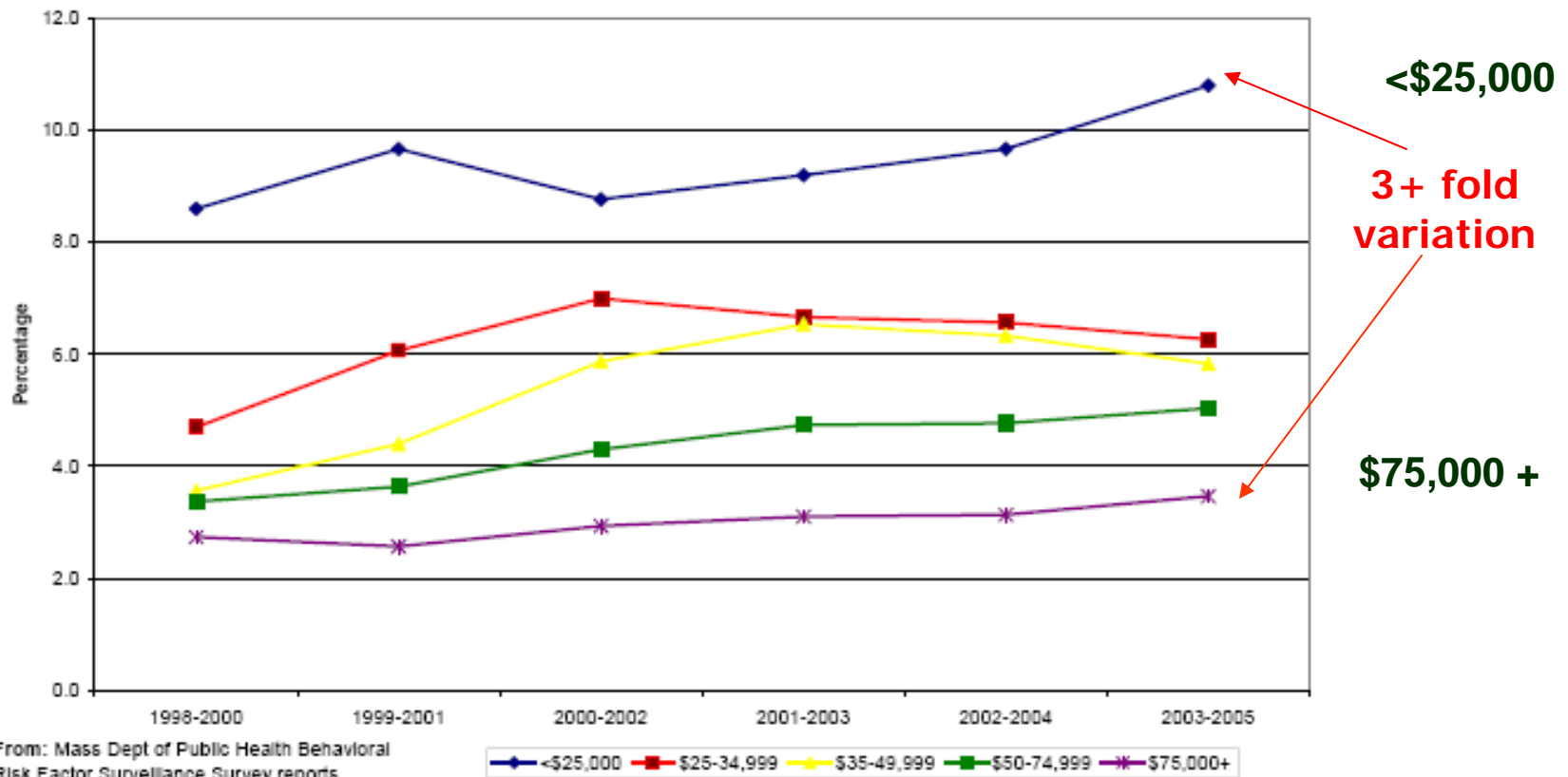
Expand efforts to gather and analyze data

- Attention to social determinants of health
- Access to utilization patterns and opportunities for improvement
- New focus on costs and potential savings



Substantial Variation in Diabetes Rates by Household Income

Prevalence of Diabetes: By Household Income

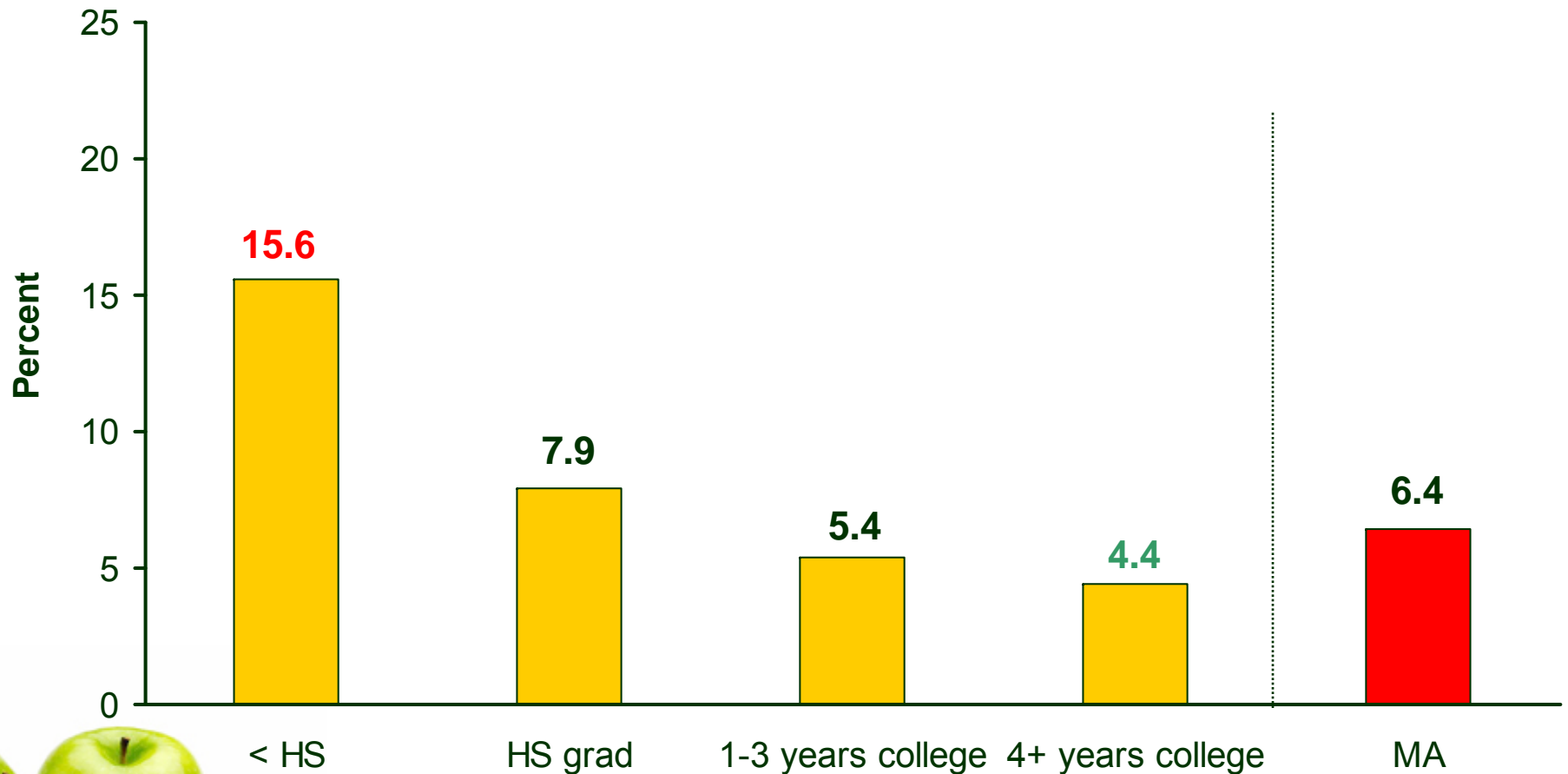


Source: NEHI/Boston Foundation: *Boston Paradox*



Diabetes by Education, 2006

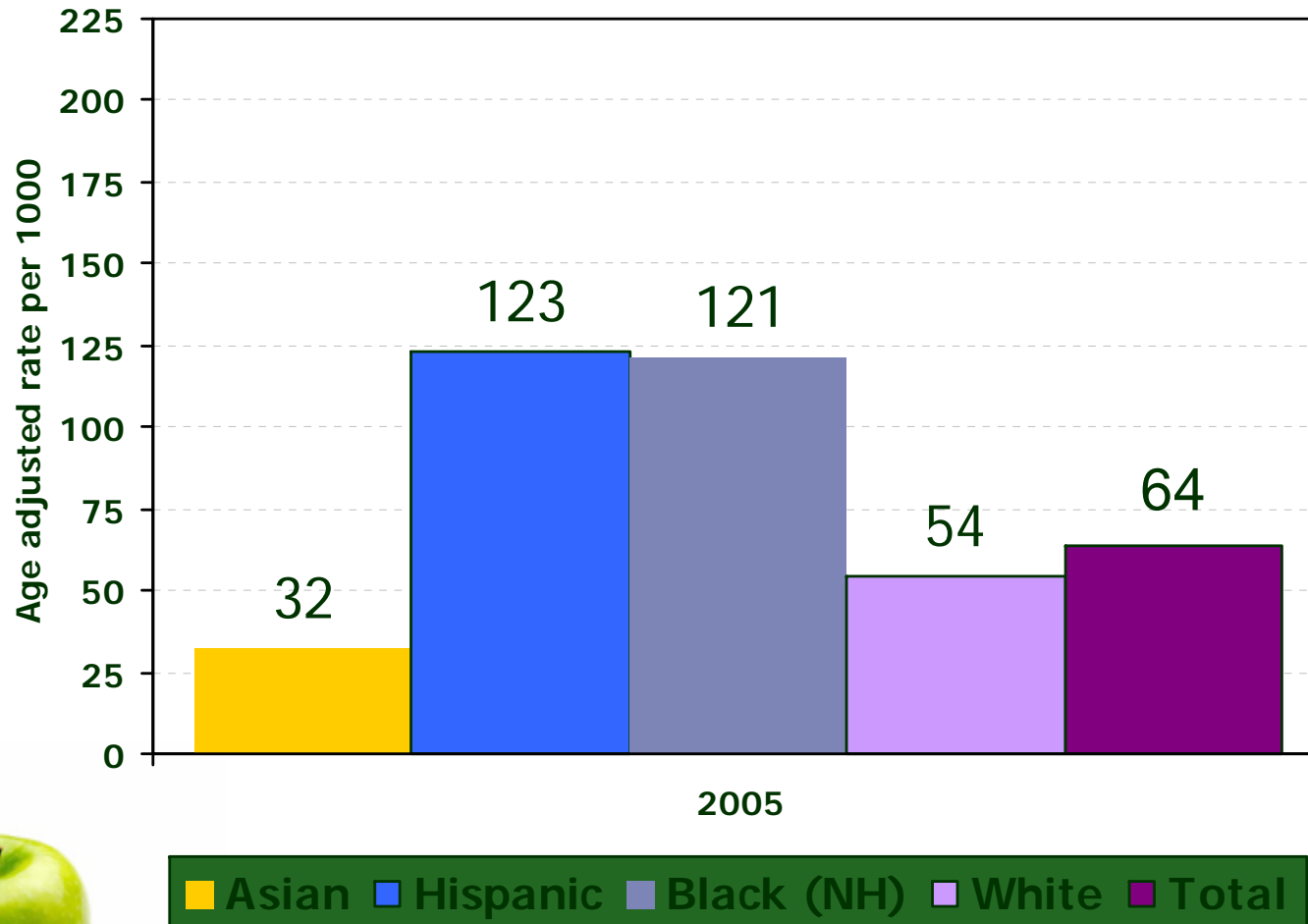
3.5 time more likely in least educated



Statistically different from state ($p \leq .05$)– Red (*) Statistically worse than state- Green (**) statistically better than state

Source: MDPH, Bureau of Health Information, Statistics, Research and Evaluation, Health Survey Program

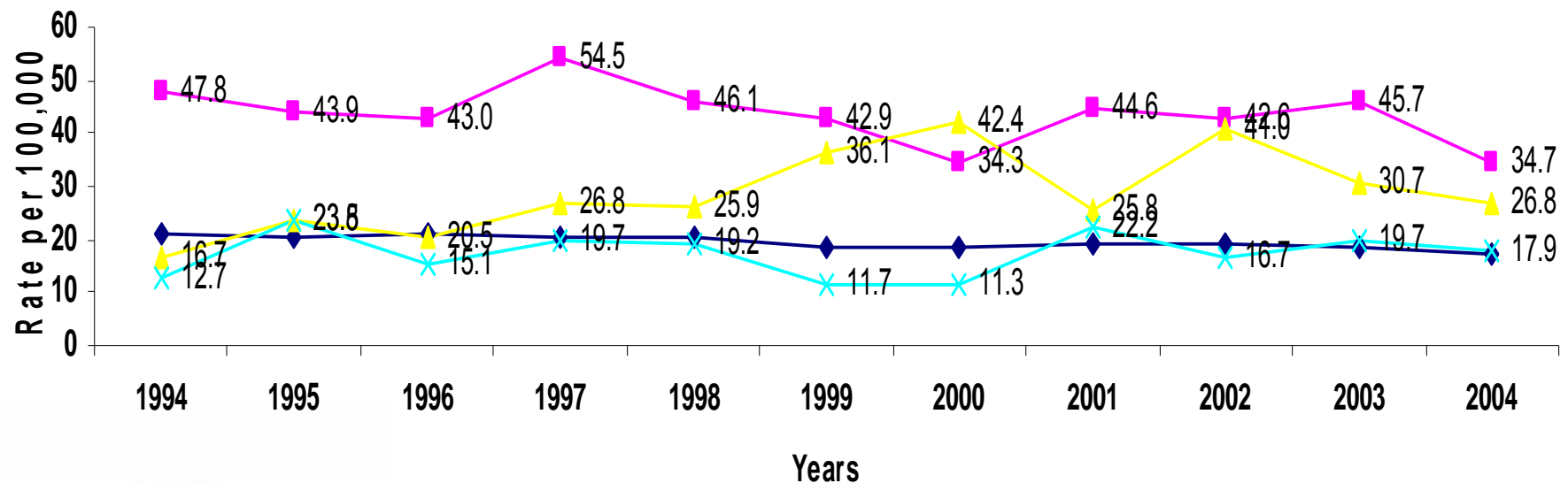
Prevalence of Diabetes in Massachusetts Varies Significantly by Race/Ethnicity



SOURCE: Mass DPH.

Mortality Rates are Much Higher for Blacks and Hispanics

Mortality Rates for Diabetes as the Primary Cause of Death, by Race, 1994 - 2004



◆ White, NH ■ Black, NH ▲ Hispanic ✕ Asian/Pacific Islander, NH

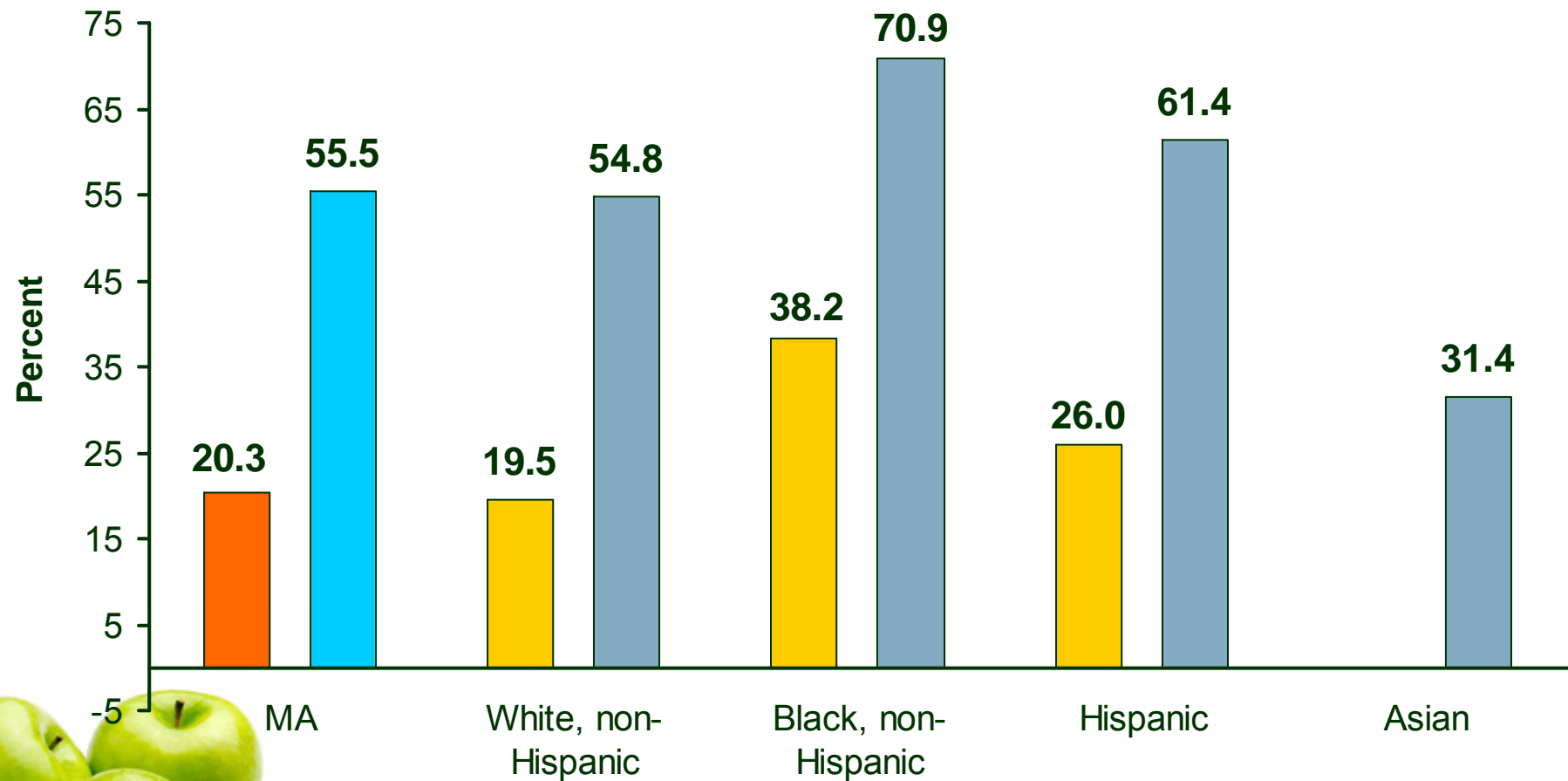
Source: Mass Dept of Public Health

Diabetes in Massachusetts

Contributing Factors



Obesity and Overweight by Race/Ethnicity, 2006



Statistically different from state ($p \leq .05$)– Red (*) Statistically worse than state- Green (**) statistically better than state

Source: MDPH, Bureau of Health Information, Statistics, Research and Evaluation, Health Survey Program



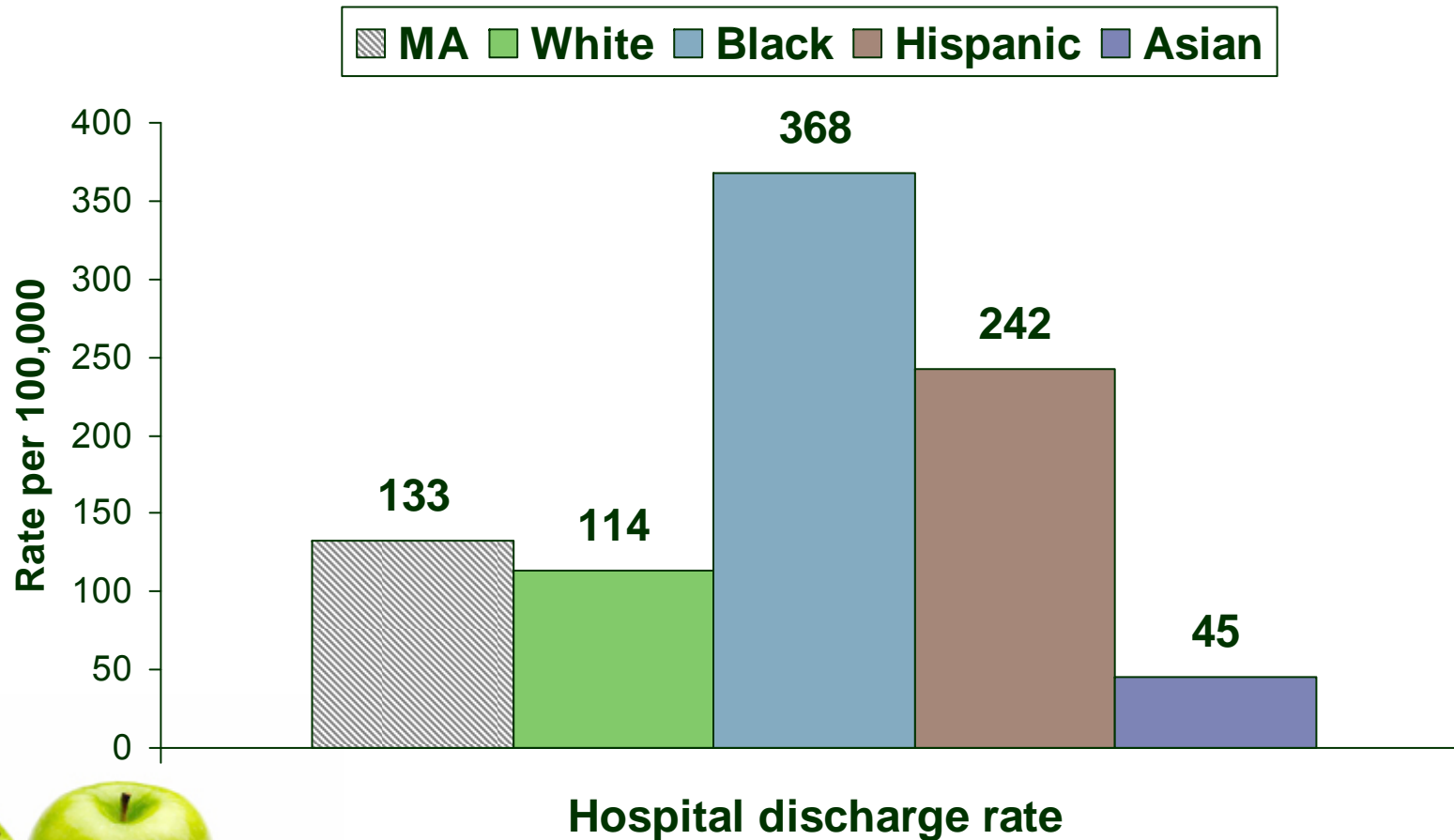
Diabetes in Massachusetts

Health Care Utilization & Morbidity



Utilization Patterns Highlight Disparities

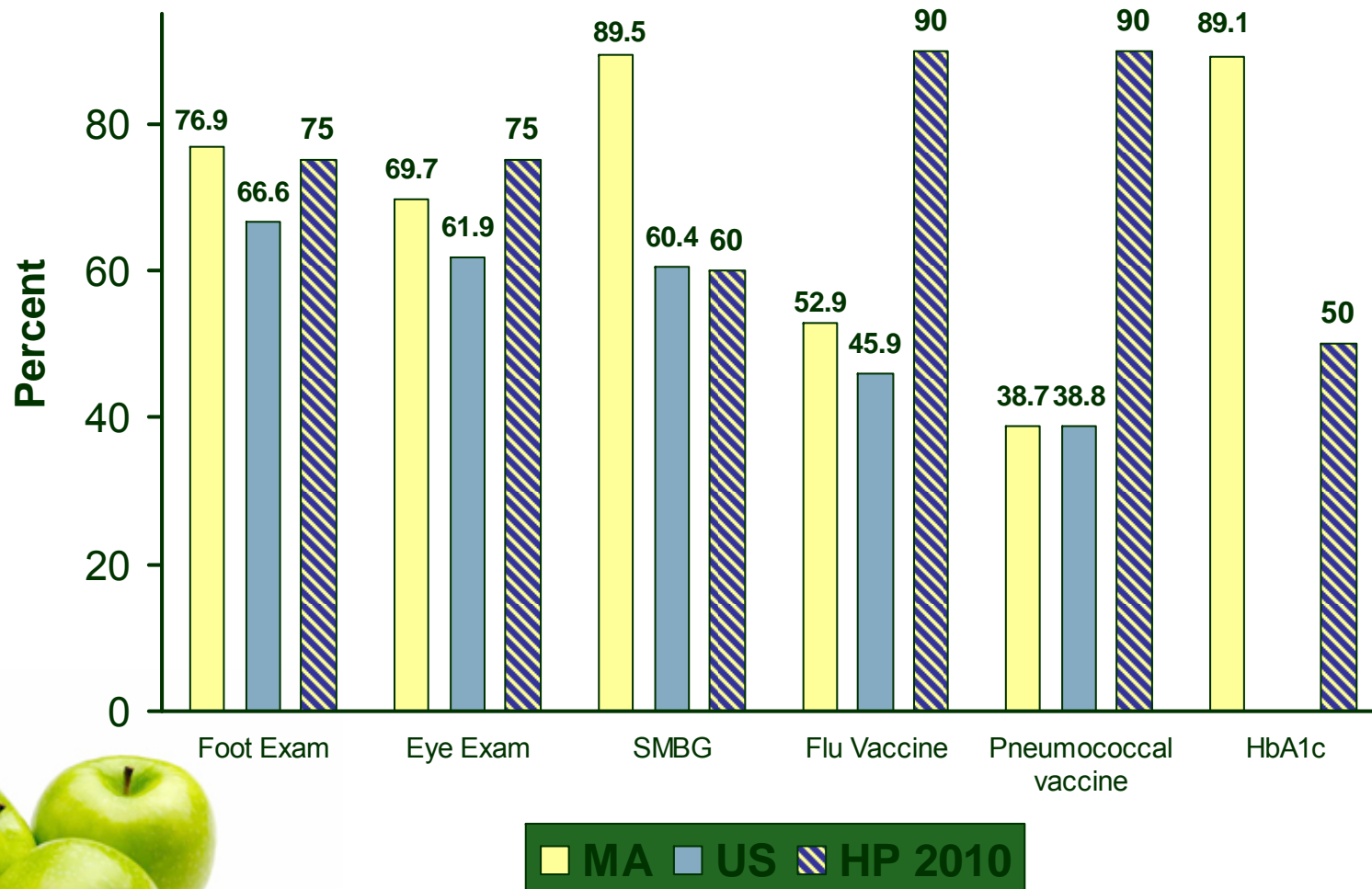
Diabetes Hosp. Discharges: 2003-2005



Source: Division of Health Care Finance and Policy, Inpatient Hospital Discharge Database

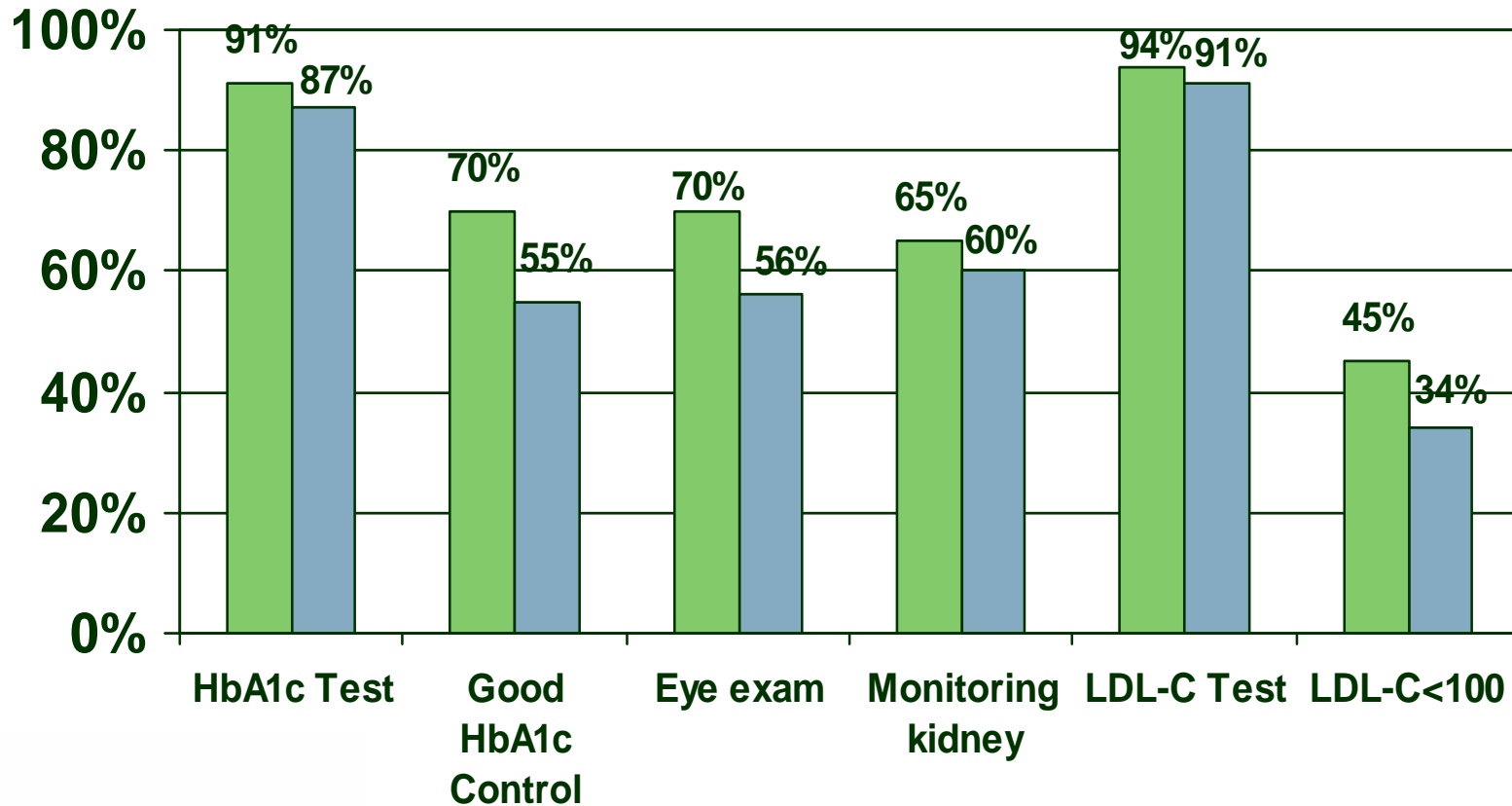
Room for Improvement in Preventive care

% Receiving Recommended Care:2003-2005



Source: MDPH, Bureau of Health Information, Statistics, Research and Evaluation, Health Survey Program

Room for Improvement by Payor



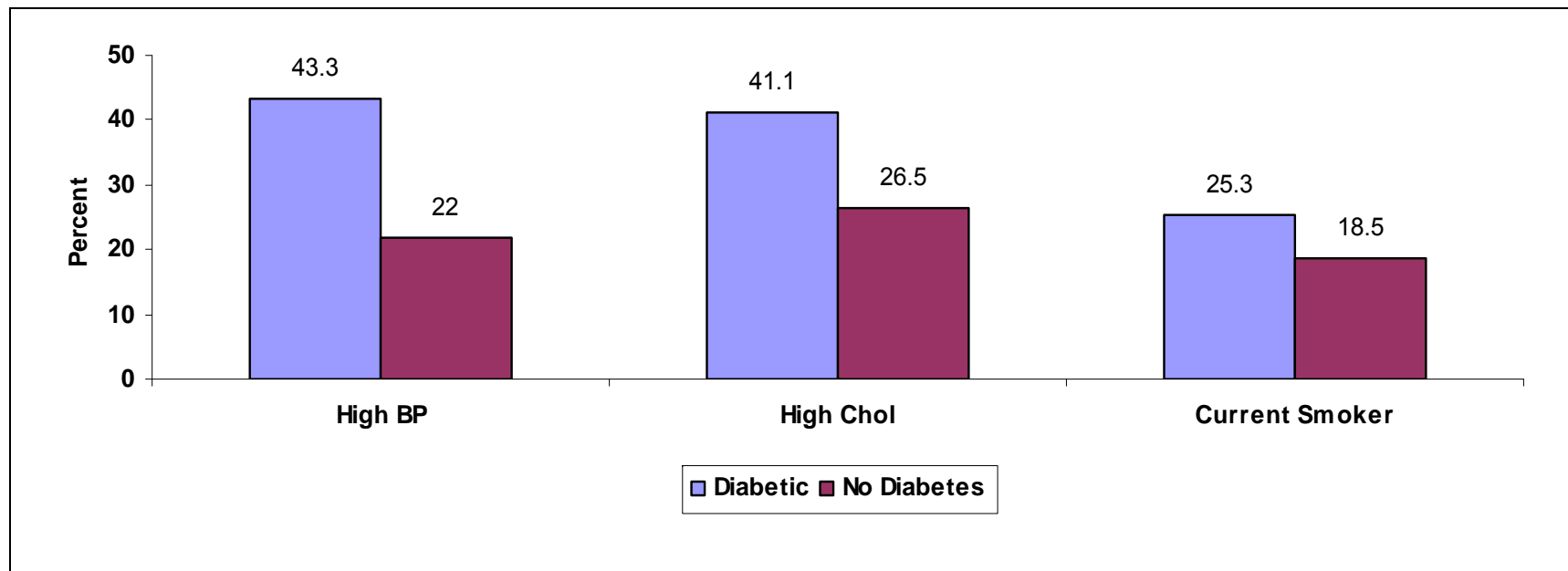
■ Mass Commercial ■ MassHealth

Source: MassHealth Managed Care 2006 HEDIS report



Lots of Opportunities to Improve Modifiable Risk Factors

Prevalence of Modifiable Risk Factors That Cause Complications of Diabetes, 2003-2005



Source: Massachusetts Behavioral Risk Factor Surveillance System (MA-BRFSS); 2003-2005. Note: Estimates have been age-adjusted to 2000 US standard population

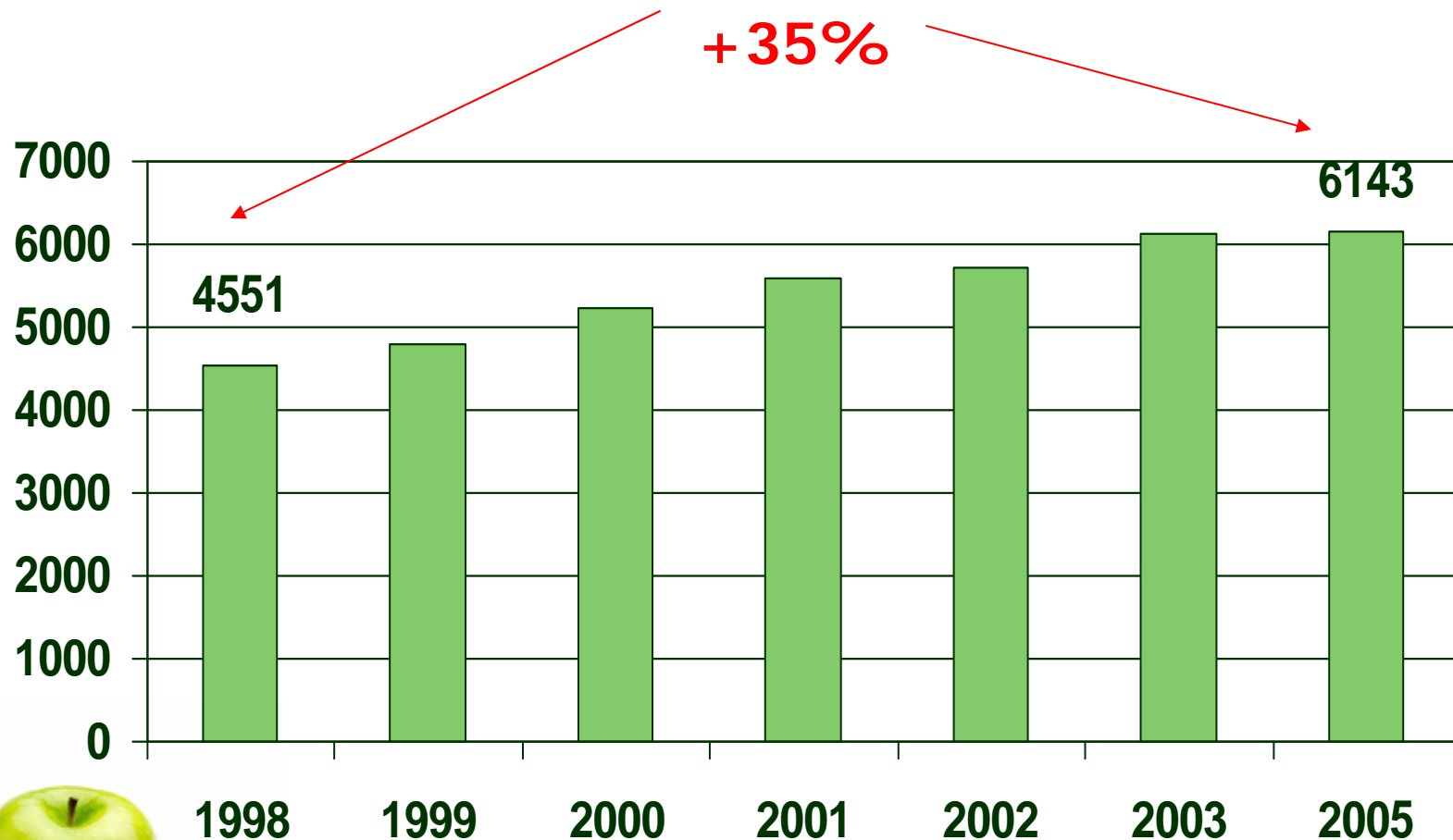


Diabetes in Massachusetts

Economic Costs



Preventable Hospitalizations for Diabetes Have Risen Significantly



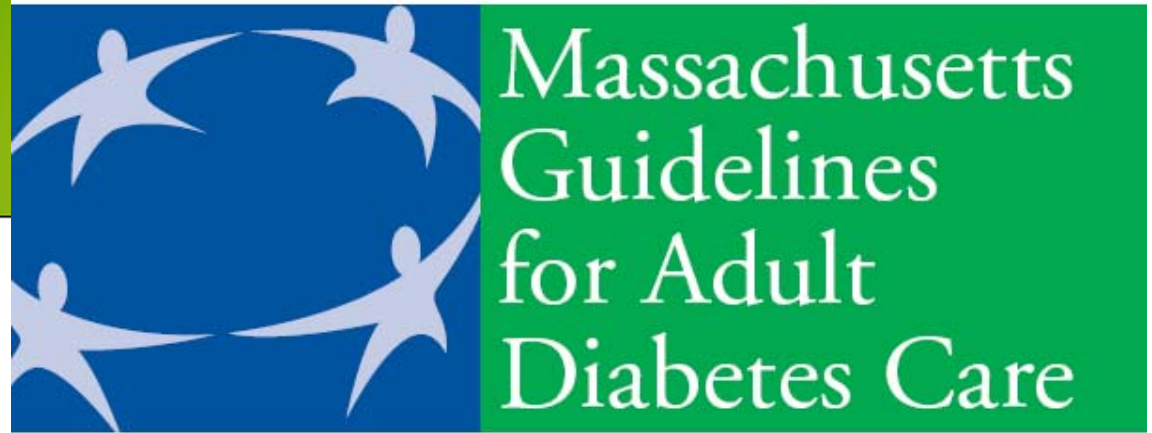
Source: Division of Health Care Finance and Policy

**For years, the Department
has slowly built its diabetes
program**



Diabetes Guidelines Developed

- DPH worked with all insurers to agree on optimal care for diabetes treatment
- Focus was on clinical consensus not on guaranteeing coverage was provided



DIABETES
GUIDELINES
WORK GROUP

2007

DIABETES
PREVENTION
AND CONTROL
PROGRAM



*Developed 1999
Revised 2001, 2003, 2005, 2007*

This program was partially funded by a cooperative agreement between the Centers for Disease Control and Prevention, Division of Diabetes Translation, and the Massachusetts Department of Public Health, Diabetes Prevention and Control Program.

*Diabetes Prevention and Control Program
Bureau of Family and Community Health
Massachusetts Department of Public Health
250 Washington Street, 4th Floor
Boston, MA 02108-4619*



**In 2008, a decision was made
to dramatically alter its
approach to preventing and
controlling diabetes**



Diabetes efforts became part of a new initiative: *HealthyMass*

- Coordinated approach on health across all state government
- 5 initial task forces charged with developing goals and recommendations in short time frame
- Announced in December 2007 by Governor Patrick
- Governor's most senior team have committed to coordinating efforts and working on this issue



HealthyMass: Goals

1. Ensure access to care
2. Advance health care quality
3. Contain health care costs
4. Promote individual wellness
5. Promote healthy communities



Disease Management and Wellness: Diabetes



Task Force Objective

Develop an action-oriented framework for preventing and managing chronic disease in Massachusetts in order to optimize health, improve quality of care, and control costs



Decision Made to Separate Work on Primary Prevention

- Department forms a Fitness Coalition charged with developing broad-based efforts promoting healthy eating and exercise
- Secondary prevention for pre-diabetics and diabetics to be addressed by Diabetes Task Force



Overview

- **Task Force Lead:**
 - John Auerbach, Commissioner, Department of Public Health
- **State participants from more than a dozen agencies including:**
 - 16 State health and human services agencies, Corrections, Education, Medicaid, Governor's Office
- **Task force meetings are held monthly.** The task force has met five times: beginning is spring, 2008.



Strategies and Timeline

- **Begin with a focus on diabetes**
 - Select short-term diabetes-related outcomes that are achievable but ambitious
- **Identify key elements of the process that are applicable to chronic disease more generally**
 - Identify model framework for chronic care prevention and management
- **Utilize skilled facilitation with inclusive process**
 - implement the Casey Foundation's "Leadership in Action" program



Themes of initial meetings

- **First and Second meetings:** Clarify task; Review data; Experts from Joslin Diabetes Center provide “Diabetes 101” seminar on clinical and social/environmental issues – only State agency representative attend
- **Third meeting:** Vermont Department of Health Commissioner reviews their work with focus on lessons;
- **Fourth and Fifth meetings:** Task Force expands membership by adding 40 clinical and community partners; clarifies tasks and establishes goals and work plan



Discussion: Strategies and Timeline

July 2008 – June 2009

- Meet approximately monthly for ½ day sessions to achieve short-term goals through collective and individual action steps – action steps to be taken during the process
- Draft blueprint for chronic care management by Spring 2009



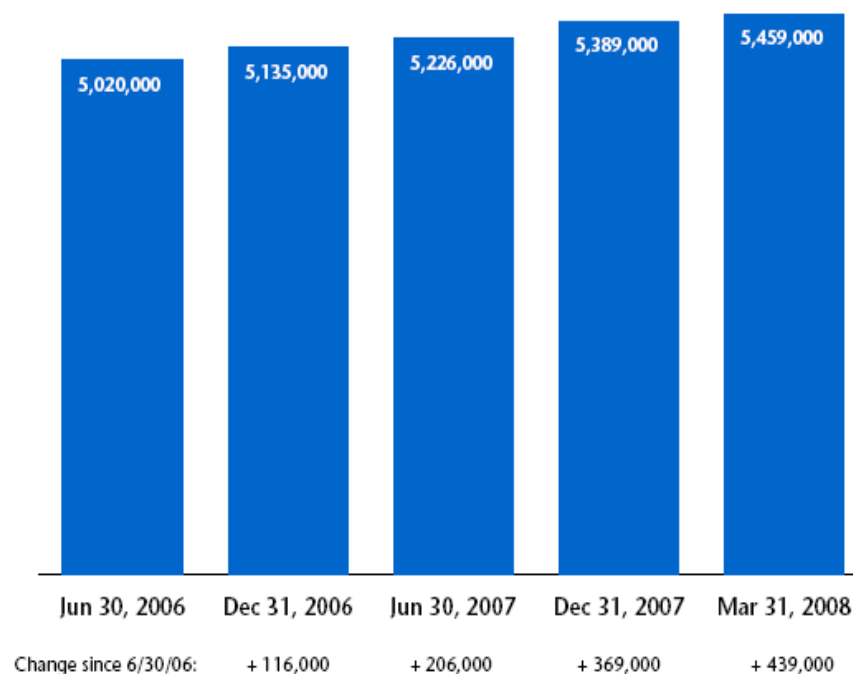
Example of First Action Step

Health Care Reform overcomes a major obstacle to access to care for diabetics and pre-diabetics – 100,000s more receive insurance for the first time



People with Health Insurance

Excludes Medicare Enrollees



Examples of First Action Steps

- **Comprehensive Data Report** prepared examining the prevalence of diabetes as well as service utilization, appropriateness of care and costs
- **Identify outcomes** that can be tracked with existing data sources so short term changes can be monitored



Employer Wellness Initiative Unveiled

12 employers trained, provided TA, offered seed funding



Mission & Vision

Vision: All worksites in Massachusetts will provide social, cultural and physical environments that support optimum employee health and well-being



Mission: the mission of the Massachusetts Worksite Wellness Initiative is to promote worksite wellness through information, training, regulation and technical assistance



Other Likely Action Steps

- **Grants** - Provide grants for community agency/clinician systems changes that support a) chronic care model and b) patient self-management activities
- **Pay for performance** - Link related P4P efforts to diabetes and chronic disease efforts
- **Diabetes registry** – A mechanism to track newly diagnosed cases and offer linkages to care will be piloted
- **Use of electronic medical records** – Efforts will be made to insure that newly approved state funding for e-records includes consistent best-practice messages
- **Develop diabetes public information campaign**



Special Efforts Anticipated to Address Health Equity Concerns

- Strong representation of community of color representatives
- Key involvement of Medicaid leadership in Task Force
- Plan to focus attention on areas where disparities are greatest – such as elevated amputations for Black patients
- Plan to insure that efforts are linguistically and culturally appropriate for key communities



Summary of Place to Begin

- Gather most comprehensive listing of all relevant data sources
- Review materials from other states with successful comprehensive efforts
- Convene relevant agencies/partners to review data, consider costs and develop strategy for action

