Healthiest Wisconsin 2020 Everyone Living Better, Longer, is the public health agenda that identifies priority objectives for improving health and quality of life. Through a coordinated approach, we can strengthen our capacity to improve health across the lifespan and eliminate health disparities and achieve health equity.

COMMUNITY-CLINICAL LINKAGES

- Aimed to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions.

POPULATION HEALTH CHALLENGE

- According to the CDC, 582,000 Wisconsin adults have diabetes (420,000 diagnosed; 162,000 undiagnosed) and 1.7 million Wisconsin adults have prediabetes.
- Diabetes is a major cause of heart disease and stroke; and, a leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of blindness among adults in the United States.

ACTION TEAM FOCUS

- Community-clinical linkages help ensure that people with or at high risk of chronic diseases (pre-diabetes, diabetes, heart disease, etc.) have access to community resources and support to prevent, delay or manage chronic conditions once they occur.

PRIORITIES

- To be determined

MEASURABLE OBJECTIVES OR INDICATORS

- To be determined

IMPORTANT RESOURCES

- Self-Management & Prevention Programs
  - Healthy Living with Diabetes – www.wihealthyaging.org/healthy-living-with-diabetes
  - Living Well with Chronic Conditions – www.wihealthyaging.org/living-well
  - National Diabetes Prevention Program - http://www.cdc.gov/diabetes/prevention/
- MetaStar - Atrium www.metastar.com/atrium
- WCHQ's Publically Reported Data- http://www.wchq.org/reporting/

ACTION TEAM PROGRESS

Plan | Implement | Communicate

	Actions	Timeline
Plan	Convene stakeholders, map assets and gaps	December 11th at 10:00 am
	Identify resources and potential strategies	January-March
	Analyze, discuss & prioritize strategies	March-April
	Collectively decide on priorities	Spring 2015
Implement	Develop action plan (objectives, milestones, accountability, how progress will be measured)	Summer 2015
	Implement action plan and monitor progress	Summer-Fall 2015
Communicate	Monitor and evaluate progress	TBD
	Communicate and promote results	TBD

SUPPORT THE ACTION TEAM – ACTION OPPORTUNITIES

- Identify partners who should be in the conversation (public health, community based programs, clinics, researchers, advocates, etc.)

ACTION TEAM POINT OF CONTACT

- Jessica Stansell, jessica.stansell@wi.gov

ALIGNMENT WITH CDC CHRONIC DISEASE PREVENTION STRATEGIES AND MEASURES (1305)

Promote awareness of high blood pressure among patients

- Proportion of adults in the state aware they have high blood pressure

Promote awareness of prediabetes among people at high risk for type 2 diabetes

- Prevalence (%) of people with self-reported prediabetes

Promote participation in ADA-recognized, AADE-accredited, state-accredited/certified, and/or Stanford licensed DSME programs

- Proportion of people with diabetes in targeted settings who have at least one encounter at an ADA recognized, AADE accredited, state accredited/certified, and/or Stanford licensed DSME program

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

- Number of Medicaid recipients with diabetes who have DSME as a covered Medicaid benefit
- Number of ADA recognized, AADE accredited, or state accredited/certified DSME programs during the funding year
- Proportion of counties with ADA recognized, AADE accredited, or state accredited/certified DSME programs
- Number of Stanford DSMP workshops offered during the funding year
- Proportion of counties with Stanford DSMP workshops
- Proportion of people with diabetes in targeted settings who have at least one encounter at an ADA recognized, AADE accredited, state accredited/certified, and/or Stanford licensed DSME program during the funding year
- Decreased proportion of people with diabetes with A1C >9
- Age-adjusted hospital discharge rate for diabetes as any-listed diagnosis per 1,000 persons with diabetes

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

- Proportion of health care systems with policies or practices to refer persons with prediabetes or at high risk for type 2 diabetes to a CDC-recognized lifestyle change program
- Proportion of participants in CDC-recognized lifestyle change programs who were referred by a health care provider (developmental measure dependent on OMB approval of revised data collection protocols)
- Number of Medicaid recipients or state/local public employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle change programs as a covered benefit
- Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program
- Percent of participants in CDC-recognized lifestyle change programs achieving 5-7% weight loss

Increase use of health-care extenders in the community in support of self-management of high blood pressure and diabetes

- Proportion of recognized/accredited DSME programs in targeted settings using CHWs in the delivery of education/services
- Proportion of adults with diabetes in adherence to medication regimens
- Number of participants in recognized/ accredited DSME programs using CHWs in the delivery of education/services
- Proportion of health systems that engage CHWs to link patients to community resources that promote self-management
- Proportion of adults with known high blood pressure who have achieved high blood pressure control

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

- Number of CDSM workshops offered during the funding year
- Proportion of counties with CDSM workshops
- Number of CDSM program participants who self-report having diabetes and complete at least 4 out of 6 workshop sessions, as a proportion of the total number of people with diabetes in the state