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California DSRIP 2.0
Recommendations for Domain 4: Prevention

1. Broad Recommendations

a. Leverage the State of California's recent efforts related to prevention

- From the Let's Get Healthy California Report and the work of the HiAP task force to the 2014 California Wellness plan, the state has initiated a number of recent initiatives related to prevention and population health. Reference this excellent work within the project descriptions as appropriate and use it to guide the specific projects.

b. Leverage the work of CPHA members doing clinical and community prevention

- CPHA members are doing some cutting-edge work on clinical *AND* community prevention. Include a section within each domain 4 project that highlights existing work that is being leveraged or how this work relates to other existing projects. For example, in relation to healthy food initiatives, many hospitals within the DSRIP hospital group are already working on improving the food environment.

- The American Heart Association published an article in 2012 which rated community-based population approaches based on available peer-reviewed research. Mozaffarian D, et al.; on behalf of the American Heart Association Council on Epidemiology and Prevention… *Population approaches to improve diet, physical activity, and smoking habits: a scientific statement from the American Heart Association*. *Circulation.* 2012;126:1514 –1563. This is an evidence-based source might serve as one guide for expanding the prevention categories to include community-based and public policy approaches.

c. Recognize existing clinical-community linkages

- Many, if not all of the DSRIP hospitals, already have community linkages. Highlight successful partnerships within the concept paper. Also ask providers to identify these linkages as one of their objectives. Consider setting up learning communities of providers so leaders can work with other hospitals that are not so far along on prevention strategies.

d. Reorganize Domain 4 into five distinct projects

- Separate the Million Hearts Initiative and the Obesity Prevention Initiative so each is its own project with distinct metrics and goals.

- Add a section on Tobacco Control rather than spreading tobacco control goals across Domain 4.

e. Revise the template used to describe each project

- *Rationale/evidence base* section*:* Include baseline data about the California Medi-Cal population and each category; **and lay out what is known about the relevant health disparities.** (http://www.dhcs.ca.gov/dataandstats/reports/Pages/HealthDisparities.aspx)

- *Goals/objectives* section: Reorganize based on five categories rather than three. Include more specific, targeted goals that are related to each prevention project.

- *Core components:* Lay out the components by project.

- *Clinical event outcomes*: Separate clinical and process outcomes. Where possible, connect the Domain 4 efforts to the Category 3 data that were collected as part of the 2010 – 2015 DSRIP

2. Specific Recommendations on Million Hearts Initiative

a. Evidence Base

- Lay out the relevant data for the Medi-Cal population related to cardiac health.
- Explain how the risk factors for the Medi-Cal differ from the general population and then use that data, along with the Million Hearts framework, to drive strategy.
- Clarify the connection between data here and the Category 3 data that was collected under DRSIP1.0. Hospitals are collecting at least two relevant measures which can serve as baseline data:
    - "Report results of the 30-Day Congestive Heart Failure Readmission Rate measure to the State"
    - "Report results of the Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure to the State"

b. Goals/Objectives

- Lay out goals specific to Million Hearts and cardiac health.
- Be more specific about the disparities that exist and then lay out targets for improvement. An example of such a target could be to improve systolic blood pressure numbers among African-Americans in a system's patient population.
- Be more specific about the screening targets. Lay out what is happening now and how hospitals will improve performance.

c. Core Components

- The Million Hearts initiative has two parts – a clinical component and a community component. Include goals related to the community component. Examples of both are laid in this article, *The "Million Hearts" Initiative — Preventing Heart Attacks and Strokes*,

Frieden T. and Berwick D., New England Journal of Medicine, September 29, 2011. Make linkages between the clinical component and the community component.

- Campus-based strategies related to tobacco use and healthy food compliment the clinical elements of the Million Heart Initiatives and leverage the work on the other prevention priorities within DSRIP. Examples from the Frieden and Berwick article include reducing sodium and transfats in food and implementing policies to reduce exposure to second-hand smoke.

d. Clinical Event Outcomes

- Separate clinical outcomes from important process outcomes. Process outcomes could include the items below (taken from New York DSRIP):

    - Providers will develop or partner with community resources to expand the availability of evidence-based self-management programs such as the Stanford Chronic Disease Self-Management Program (CDSMP).
    - Providers will develop protocols to refer patients with HTN or at high risk for onset of hypertension to community-based self-management programs.
    - Providers will collaborate with community-based self-management programs to monitor progress of referred patients and make ongoing recommendations.
    - Performing provider systems that serve food to employees, patients and/or the public will improve the nutritional quality of foods served, including reducing sodium, by adopting comprehensive nutrition standards.
    - A protocol should be developed that includes referral to a Health Home when it is evident that that level of care management may be indicated for the patient. When a patient is already part of a Health Home, the program should include the care manager in all communications and collaborate with that person as needed.

3. Specific Recommendations on Obesity Prevention

a. Evidence Base

- Clarify the baseline relevant data for the Medi-Cal population related to obesity and the disparities in obesity rates.

- Clarify the connection between data here and the Category 3 data that was collected under DRSIP1.0. Hospitals are collecting a number of measures which might be relevant including:

    - “Report results of the Diabetes, short-term complications measure to the State”
    - “Report results of the Uncontrolled Diabetes measure to the State”
    - “Report results of the Child Weight Screening measure to the State”
    - “Report results of the Pediatrics Body Mass Index (BMI) measure to the State”

b. Goals/Objectives

- The Child Weight screening measure could help to set a baseline and then a specific target could be developed from that baseline.

- The goal of reducing disparities in receipt of targeted prevention services is critical but a baseline should be indicated and a target or target range established.

c. Core Components

- Create a tiered menu of options for institutions. Expand concepts beyond healthy hospital food for those institutions that are well on the way to addressing the food environment.
- In addition to PHA's Healthier Hospital Food Initiative, consider referring to California Healthy Hospital Food Initiative. (http://sfbaypsr.org/what-we-do/healthy-food-in-health-care/) A number of the public hospitals are part of this effort already. Perhaps there are some baseline data.
- For hospitals that have not started working on this issue, consider starting with a goal of eliminating SSBs from all public hospital facilities. Evidence linking SSBs to diabetes is very strong. Many hospitals have already taken this step. For example, the San Mateo County Health System, has removed sugar-sweetened beverages from their vending machines and may have a broader policy on selling SSBs.
- Implement screening and referral to community services related to food insecurity.

d. Clinical Event Outcomes

- Clearly separate clinical outcomes from important process outcomes.
- Include specific metrics. E.g., X number of patients received screening

e. Process Outcomes

- Additional process outcomes might include:
    - Demonstrated partnerships with community based organizations that facilitate patient adherence to relevant treatment.
    - Food audits of participating hospital facilities indicate that XX% of the beverages are healthy beverages.

4. Specific Recommendations on Tobacco Control

a. Evidence Base

- Clarify the baseline relevant data for the Medi-Cal population related to tobacco use and disparities in tobacco use rates. What's the current evidence?
- Include any relevant data from DSRIP 1.0 category 3.
- Clarify the connection between data here and the Category 3 data that was collected under DRSIP1.0. Hospitals are collecting the following measure which is relevant:
    - Report results of the Tobacco Cessation measure to the State

b. Goals/Objectives

- Identify a specific goal related to smoking/tobacco use rates among the Medi-Cal population.

c. Core Components

- Expand the core components related to tobacco use to include:
    - Adopt tobacco-free outdoor policies on campuses and support broader community polices.
    - Implement the US Public Health Services Guidelines for Treating Tobacco Use.
    - Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
    - Facilitate referrals to the California Smokers Helpline (http://www.californiasmokershelpline.org/) and other community-based support programs.
    - Increase Medicaid coverage of tobacco dependence treatment counseling and medications.
    - Promote smoking cessation benefits among Medicaid providers.