Washington State Department of Health

Population Health Driver Diagram

Diabetes Prevention and Control

This Population Health Driver Diagram provides a high-level framework for state and local partners, and reinforces the approach of intervening at the clinical, linkage, and total-population levels in order to achieve desired change. Partners will be encouraged to individualize the diagram to adjust for their unique needs and resources.

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Driver Diagram:
Diabetes Prevention and Control

AIM

Reduce diabetes and its complications in Washington

GOALS

- Prevent or delay onset of Type 2 diabetes
- Improve quality of life for people with diabetes
- Reduce diabetes-related health disparities

PRIMARY DRIVERS

- Prevent obesity and improve health behaviors
- Improve early detection of people at high risk and prevent progression to diabetes
- Improve clinical care and support diabetes self-management education
- Reduce disparities in diabetes complications by providing appropriate patient-centered care
- Provide adequate resources for data to guide decisions

SECONDARY DRIVERS

- Consider including the following measures in Medicaid value-based contracts: "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents" and "Adult BMI Assessment."
- Enhance clinical-community linkages to nutrition classes, physical activity, cooking classes, community centers, YMCAs, etc.
- Promote healthy eating and increase physical activity in school and child care settings; Increase participation in Breastfeeding Friendly WA Program; Increase access to healthy foods; Implement policies to support healthy behaviors.

- Increase screenings for diabetes/prediabetes.
- Increase coverage for Diabetes Prevention Programs (DPPs); Increase availability of DPPs in communities; Enhance clinical-community linkages to DPPs.
- Change policies, systems, and environments to support healthy behaviors.

- Include the following measures in Medicaid value-based contracts: Comprehensive Diabetes Care - Hemoglobin A1c Testing, HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, Blood Pressure Control (<140/90 mm Hg); Identify social/environmental factors that contribute to a patient's poorly controlled diabetes; Integrate physical and behavioral health to improve health of people with diabetes and behavioral health issues.
- Improve clinical-community linkages to diabetes and chronic disease self-management programs, housing, employment, food banks, etc.; Implement community-based care coordination.
- Implement policies that maintain/expand access to healthcare.

- Deliver patient-centered, culturally and linguistically appropriate care in all geographic areas of need, including diabetes education.
- Use community health workers to engage patients with diabetes in communities experiencing disparities; Ensure chronic disease self-management programs are available in different languages and are culturally appropriate.
- Implement health policies to provide equitable service to all people impacted by diabetes; Improve outreach to and engagement of vulnerable populations.

Diagram template designed by Public Health Foundation