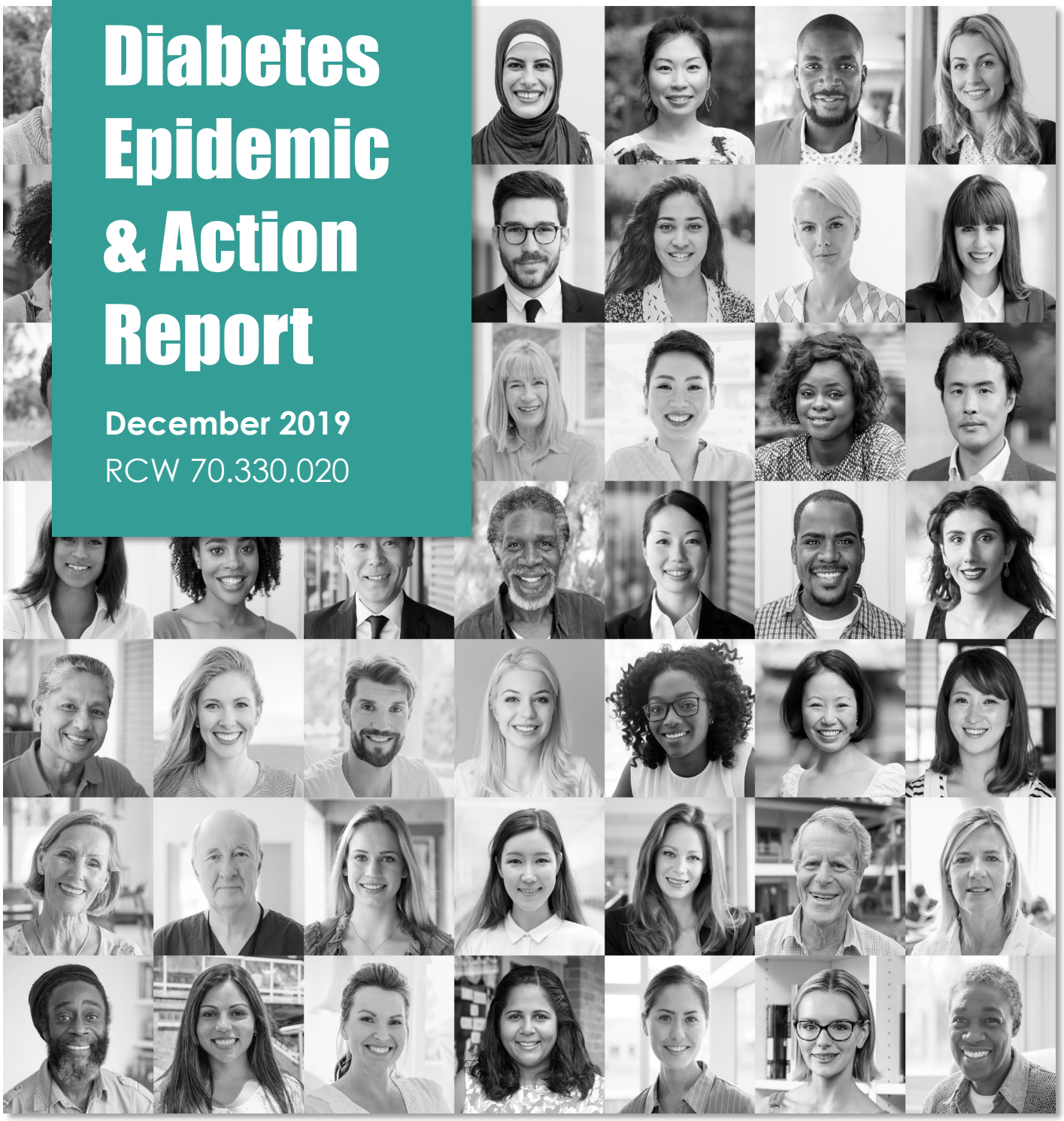
Report to the Legislature

Diabetes Epidemic & Action Report

December 2019

RCW 70.330.020



Washington State Department of Health

Washington State Department of Social & Health Services

Transforming lives

Washington State Health Care Authority

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For more information or additional copies of this report, contact:

Washington State Department of Health
Division of Prevention & Community Health
Office of Healthy & Safe Communities
243 Israel Road SE
Tumwater, WA 98501

diabetes@doh.wa.gov
360-236-3730
www.doh.wa.gov/diabetes

Additional contacts

Department of Social & Health Services
360-725-2312

Washington State Health Care Authority
360-725-1640

Previous Reports

Diabetes Epidemic & Action Report (2017)
www.doh.wa.gov/Portals/1/Documents/Pubs/345-349-DiabetesEpidemicActionReport.pdf

Diabetes Epidemic & Action Report (2014)
www.doh.wa.gov/Portals/1/Documents/Pubs/345-342-DiabetesEpidemicActionReport.pdf

John Wiesman, DrPH
Secretary of Health

Washington State Department of Health

Contents

Authors & Contributors

Department of Health

Alexandro Pow Sang, BS
Amy D. Sullivan, PhD, MPH
Angela Kemple, MS
Ashley Noble, JD, MPIA
Cathy Wasserman, PhD, MPH
Cheryl Farmer, MD
Colleen Thompson, MPA
Daisye Orr, MPH, CHES
Kathy Lofy, MD
Liz Clement, BA
Sara Eve Sarliker, MPH

Department of Social & Health Services

Bea-Alise Rector, MPA
Beverly Court, PhD
Dawn Shuford-Pavlich, BA
Jingping Xing, PhD
Todd Dubble, MA, LMHCA

Office of Financial Management

Dennis McDermot, PhD
Mandy Stahre, PhD, MPH

Health Care Authority

Aaron Huff, MPH
Allen Hall
Dan Bolton, PhD, MS
Dean Runolfson, MPA
Deepinder Singh, MPA
Patti-Jo Farr
Rae Simpson, RN, MSN
Ryan Ramsdell, BA
Sara Whitley, MBA
Tom Bishop, CPC, CPIP

Diabetes Defined

The term diabetes refers to a complex group of diseases all related to harmfully high blood glucose (also called high blood sugar or hyperglycemia). On the whole, diabetes is a chronic condition; there is no cure, but it can be controlled. When uncontrolled, high blood glucose damages eyes, heart, kidneys, nervous system, and other organs. In combination with uncontrolled high blood pressure and other risk factors, uncontrolled high blood glucose greatly increases risk of heart disease, stroke, kidney disease, and other complications from diabetes. Recommended health care, including Diabetes Self-Management Education and Support (DSMES), has improved outcomes for people with diabetes.

Type 1 diabetes (also called juvenile diabetes or insulin-dependent diabetes) occurs when the body's immune system attacks and destroys certain cells in the pancreas which produce insulin. People with type 1 diabetes need to use insulin constantly to stay alive, via multiple daily injections or an insulin pump. Type 1 diabetes is usually, but not exclusively, diagnosed in children, teenagers, or young adults. Exact causes of type 1 diabetes and methods to prevent the onset of type 1 diabetes are not yet known.

Type 2 diabetes occurs when the pancreas makes some insulin but not enough, the body is unable to use insulin correctly, or both. Type 2 diabetes accounts for 90–95% of all people with diabetes nationally. Many risk factors for type 2 diabetes have been identified. Some, such as age and family history, cannot be changed. Modifiable risk factors that significantly increase the risk of developing type 2 diabetes include being overweight or obese, lack of physical activity, high blood pressure and cholesterol, and smoking. Once someone has diabetes (of any type), these risk factors can make the impacts and consequences of diabetes worse. New medications for type 2 diabetes are available, as well as generic medications and insulin.

Gestational diabetes is a form of diabetes that occurs during pregnancy, affecting about 7% of pregnant women. Distinct from gestational diabetes, **maternal diabetes** occurs when a woman had diabetes (type 1 or 2) before becoming pregnant. To improve pregnancy outcomes, women with diabetes who wish to become pregnant are encouraged to plan pregnancies in advance, to appropriately manage blood glucose and weight. Both gestational and maternal diabetes can create serious threats to mother and baby, including premature birth, preeclampsia (a disorder occurring only during pregnancy and the postpartum period that can cause death), higher risk of birth injury, or Caesarean delivery. Gestational and maternal diabetes can be managed with appropriate prenatal care. Women who have had gestational diabetes are at increased risk of developing type 2 diabetes.

Prediabetes is having blood glucose levels higher than normal, but not high enough to be classified as diabetes. It shares the same risk factors that contribute to type 2 diabetes. Prediabetes is largely asymptomatic and is diagnosed through blood tests. People with prediabetes have a much greater chance of developing type 2 diabetes or gestational diabetes, but not type 1 diabetes. Those with prediabetes are also at higher risk of cardiovascular disease, whether they later develop type 2 diabetes or not. Prediabetes indicates that abnormalities in glucose levels have begun, but may be reversed. Once type 2 diabetes is diagnosed, few individuals are able to return to blood glucose levels in normal ranges. To support prevention, CDC maintains a national registry of evidence-based Diabetes Prevention Programs.

Executive Summary

RCW 70.330.020 directs the Department of Health (DOH), Department of Social and Health Services (DSHS), and Health Care Authority (HCA) to report on diabetes in Washington to the governor and the legislature by December 31, 2019, and every second year thereafter. The 2019 Diabetes Epidemic & Action Report (DEAR) is the result of collaboration and coordination among the three agencies. Overall, this law directs the three agencies to describe:

1. The impact of diabetes on agency programs.
2. The benefits of programs addressing diabetes administered by the agencies and level of coordination between the agencies.
3. Action plans for battling diabetes, including considerations for the legislature.

Impact of Diabetes in Washington

The term diabetes refers to a complex group of diseases all related to harmfully high blood sugar. One in eight adults in Washington has diabetes. Diabetes in youth is increasing in Washington and nationally. Type 1 diabetes remains the most common form of diabetes in youth, for which access to insulin is critical for survival. Over a third of adults with diabetes (type 1, type 2, and gestational diabetes) are currently using insulin.

Diabetes contributes to more than 125,000 hospitalizations each year and is the seventh leading cause of death in Washington. Socioeconomic status, education level, race/ethnicity, and age all play a significant role in the impact of diabetes. In addition to the health impacts, diabetes also carries significant financial costs. The total estimated cost of diagnosed diabetes in Washington was $6.7 billion in 2017. About 7 percent (142,058) of Apple Health enrollees and 8 percent of Washington's 400,000 public employees and their dependents had diabetes in 2017.

Programs Addressing Diabetes

During the 2017-2019 biennium, the three agencies implemented or continued programs to prevent or manage diabetes and its complications. This report includes program assessments and a summary of the coordination between agencies.

Action Plans

The report lists action plans to address diabetes, including steps aimed at controlling diabetes and preventing type 2 diabetes, and associated costs and resources. Where relevant, these plans include considerations for the legislature.

Considerations for the Legislature

To address the overall burden of diabetes and reduce health inequities in diabetes prevention and management, the legislature may wish to consider a range of actions, including:

- Encouraging expanding networks of providers to include pharmacists trained to provide self-management education and medication management.
- Supporting policies that compensate for community-based efforts that utilize community health workers in diabetes self-management and prevention, and encourage implementation of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).
- Increasing resources for monitoring and evaluating diabetes-related care and the health status of those with diabetes.
- Funding a study on barriers to care caused by increasing out-of-pocket costs associated with diabetes management, within the overall context of costs, to be completed in partnership with the Office of the Insurance Commissioner.
- Continuing to fund existing initiatives that improve social determinants of health.
- Investing in evidence-informed health promotion and chronic disease prevention for ages 0-18, in collaboration with state agencies serving youth.

DOH, DSHS, and HCA – along with many partner organizations – have implemented policies and programs designed to address the diabetes epidemic. These policies and programs have contributed to reducing the burden of diabetes for individuals, families, communities, and health care systems. The agencies have leveraged existing infrastructure and resources to strengthen efforts to address diabetes prevention and management. With continued legislative funding and support, initiatives that improve social determinants of health directly impacting diabetes-related outcomes and care can reduce population risk of developing diabetes or diabetes complications.

Introduction: The Reach of Diabetes in Washington

According to current estimates, about 682,600 adults (or 1 in 8) have diabetes in Washington. National studies estimate that one quarter of these adults have blood glucose levels in the diabetes range, but they are not aware of a diagnosis of diabetes. Diabetes remains one of the most common serious medical conditions facing youth: an estimated 2,970 youth (or 1 in 550) ages 18 and under in our state have diagnosed diabetes. About 9 percent of births are to women with gestational diabetes, which can be an indicator of future type 2 diabetes risk for women. For detailed information on the burden of diabetes in Washington, see the 2019 Diabetes Data Supplement.

Overall, Washington's performance in meeting benchmarks for diabetes care is comparable to that of other states and national rates.[1,2] Washington's performance is likely due to the expansion of Medicaid and other health coverage and efforts to maintain quality care for people with diabetes. However, even among insured populations, not all Washington adults with diabetes are receiving clinical screenings for diabetes complications on the recommended schedule. When patients do not receive these screenings, early detection is delayed, and patients are at an increased risk of developing diabetes-related complications.

New diabetes diagnosis rates appear to have plateaued in Washington since 2014 but much work remains to be done. The state must address the unmet needs of people who live with diabetes. Improved health and reduced costs in the state as a whole may result from a focus on these areas and populations where gaps in services and care exist.

Diabetes in Washington

After nearly doubling from 1990 to 2010, the growth in diagnosed diabetes among adults began to slow as of 2011, remaining around 9 percent through 2017. Similarly, the incidence of diagnosed diabetes (the rate of newly diagnosed cases in a given year) also remained stable at 8 per 1,000 adults from 2014 to 2017.[3] In 2017, there were 41,470 adults with a new diagnosis of diabetes.[4] Type 1 diabetes generally accounts for around 5 percent of new diagnoses, while type 2 diabetes constitutes the remaining 95 percent. Although the prevalence (the proportion of people in a population who have a given health condition) and incidence of diagnosed diabetes among adults is stable, the number of people living with diabetes in Washington remains substantial,[5] and diabetes is the seventh leading cause of death in Washington.

Age, race, gender, and socioeconomic status can significantly influence the likelihood of whether a person will develop or die from diabetes. People of color, including Native Hawaiian/Pacific Islander, Hispanic, African American/Black, and American Indian/Alaska Native adults experience higher prevalence of diagnosed diabetes than non-Hispanic white adults. People of Hispanic heritage are twice as likely and African Americans are 1.6 times as likely to have diabetes as whites. Patterns of diabetes death rates by age, gender, and race are similar to those for diabetes prevalence.

Adults with a high school education or less are almost twice as likely to have diagnosed diabetes as those with a college degree. Adults with annual incomes of less than $25,000 are twice as likely to have diagnosed diabetes as those with incomes of $75,000 or more.

Financial Impact

Nationally, total health care costs related to diabetes increased by 26 percent, and lost productivity costs increased 23 percent between 2012 and 2017. **Error! Bookmark not defined.** Individual health care costs per person with diabetes grew by 14 percent and lost productivity costs per person increased 11 percent during this timeframe. The growing number of people with diabetes, and increased costs per person with diabetes, especially among adults 65 years and older, influenced these increases. The largest increase occurred in spending for insulin, partly due to an increased cost per unit of insulin.[6]

The total estimated cost of diagnosed diabetes in Washington was $6.7 billion in 2017 – including $5 billion in direct health care costs and $1.7 billion in indirect costs. Direct health care costs include hospital care, institutional care, physician visits, emergency department visits, other outpatient care, and outpatient medications, equipment, and supplies. Indirect costs include work-related absences, reduced productivity, unemployment from chronic disability, and premature death.[7] Compared with other health conditions, one national study found that diabetes had the highest health care spending in 2013, while ischemic heart disease accounted for the second-highest amount of health care spending in 2013.[8]

Data from the Washington State All-Payer Health Care Claims Database (WA-APCD) estimate that health care costs for people with diabetes included in the database totaled $4.9 billion in 2017. These costs included paid and out-of-pocket expenses for medical service and pharmacy claims (medications prescribed by physicians). In 2017, the total average cost per person with diabetes was $23,761, compared to $4,608 for patients without diabetes. About 43 percent of total prescription costs for those in the WA-APCD with diabetes were for diabetes-specific medications. Detailed data from the WA-APCD are located in the 2019 Diabetes Data Supplement.

The prevalence of diabetes among people who are aged, blind, or disabled under Medicaid and receive long-term services and supports is significant. Roughly 40 percent of individuals receiving long-term services and support have a diagnosis of diabetes. The impact of diabetes is a significant cost driver in the provision of supporting people with personal care and nursing needs. For specific information on the financial impact on agencies and their activities, see Program Assessments on page six.

A June 2019 Kaiser Family Foundation Data Note reports that half of U.S. adults say they or a family member put off or skipped receiving health care or relied on an alternative treatment in the past year because of cost. Surveys found that putting off care due to costs is more common in households with someone with a serious medical condition, such as diabetes. Nearly 64 percent of these households say they or a family member put off or skipped health care in the past year because of the cost. These impacts were not limited only to those who were uninsured; more than one quarter of those surveyed with health insurance reported difficulty affording their deductible and other health insurance costs. Twenty-nine percent of those surveyed also report not taking their medicines as prescribed at some point in the past year because of the cost.[9]

This report highlights that diabetes can negatively impact not only people with diabetes, but also their family members.[10] The financial impacts of diabetes can contribute to social and economic stress.[11] Across the economic spectrum, higher health care costs for individuals with diabetes affect families' available financial resources, whether a person with diabetes is a child, older adult, or head of household. Specific information on insulin, which accounts for a large portion of out-of-pocket costs, was not addressed in the report.

People with Diabetes in State Programs

In 2017, approximately 2 million Washingtonians were enrolled in Washington Apple Health (Medicaid), the state's Medicaid program. In 2017, 142,058 Apple Health clients had diabetes, or about 7 percent of total enrollment. This percentage remained stable from 2012 to 2017, comparable to statewide trends in non-Medicaid populations.

The percentage of Apple Health clients with diabetes varies greatly across coverage groups, which have vastly different health risk profiles and use patterns. Use patterns range from 0.5 percent in non-disabled children to 39 percent in clients who are dually eligible for Medicare and Medicaid. Under Medicaid expansion through the *Affordable Care Act*, an additional 35,480 adults with diabetes became newly eligible for Medicaid coverage. This newly eligible population included people with relatively complex health needs who were previously eligible for medical assistance under *Presumptive Supplemental Security Income, Disability Lifeline, and Alcohol and Drug Addiction and Treatment Support Act* programs in the disabled adult coverage group in 2012 and 2013.

In 2017, 7.6 percent of Washington's 400,000 public employees and their dependents had diabetes. Public employees, retirees, and dependents are served by Uniform Medical Plan, Kaiser Foundation Health Plan of Washington, and Kaiser Foundation Health Plan of the Northwest. The percent of employees and dependents with diabetes ranges from 4.5 percent among members who do not qualify for Medicare and who are less than 65 years old, to 20.5 percent among members who are at least 65 years of age and qualify for Medicare.

Program Assessments

In this section, each agency provides information on the benefits of implemented programs and activities aimed at controlling diabetes, and when possible, preventing diabetes.

Department of Health

The Washington State Department of Health addresses diabetes and prediabetes through multiple initiatives. This work is funded by and coordinated with the department's Centers for Disease Control and Prevention (CDC)-funded Heart Disease, Stroke, and Diabetes Prevention Program, which focuses on adults. CDC has increased the focus on prediabetes through these funding opportunities, because in addition to those who already have diabetes, an estimated 2 million adults statewide had prediabetes in 2017. Three of four adults with prediabetes were not aware of their condition.
Detailed documentation of the amount and source of these programs and benefits, along with detailed descriptions, is included in this section's tables. Overall, program activities to address these initiatives include:

- Increasing access to and participation in recognized Diabetes Self-Management Education and Support programs (DSMES), which have been shown to improve diabetes management, reduce complications of diabetes, and reduce associated costs.[12]
- Increasing participation in nationally recognized Diabetes Prevention Programs (DPP).
- Implementing systems to identify people with prediabetes for referral to DPP.

As a result of this work, DOH has:

- Tracked improvements in access to and participation in diabetes prevention and management programs, including increases in access to DSMES and DPP.
- Confirmed through the Behavioral Risk Factor Surveillance Survey (BRFSS) that more adults with prediabetes are now aware they have the condition than previously recorded, from 7 percent in 2013 to 9 percent in 2017.

Table 1: Diabetes Prevention and Control Actions – DP13-1305

Overview

State public health actions to prevent and control diabetes, heart disease, obesity and associated risk factors and promote school health (DP13-1305) – Specific actions to control diabetes

Jul 2017 - Sep 2018

Funding

Source

CDC Cooperative agreement

Total Expenditures

$2,198,000

(for both prevention and control activities)

NOTE: Does not include essential in-kind contributions from partner organizations

Program & Benefits

Diabetes Self-Management Education & Support

Increase access to and participation in Diabetes Self-Management Education and Support Programs (DSMES) in community settings to improve diabetes management and reduce complications of diabetes among adults

Realized Benefits

- Increased number of recognized programs from 162 in 2014 to 173 in 2018 (a 7% improvement)[13,14]
- Increased proportion of counties with programs from 28 out of 39 (72%) in 2014 to 30 out of 39 (77%) in 2018
- Increased number of individuals participating in recognized DSMES programs from 22,611 visits in 2012 to 32,547 in 2017 (44% improvement)[15]
- Increased the percent of people with diabetes who visited an accredited program by nearly one-third from 4.9% in 2012 to 7.0% in 2017
- More than doubled the number of Diabetes Self-Management program workshops (offered in English and Spanish) from 6 in 2012 to 15 in 2017, and the number of workshop participants from 58 individuals in 2012 to 133 in 2017[16]

Diabetes Prevention Program

Increase use of lifestyle intervention programs for prediabetes in community settings among adults, such as the Diabetes Prevention Program (DPP)

Realized Benefits

- Nine organizations were added to the national DPP registry, resulting in a 45% increase, from 20 in July 2016 to 29 in September 2018
- Seven additional counties implemented DPP, increasing from 13 counties in December 2016 to 20 in September 2018[17]
- An additional 3,923 people participated in DPP, from 5,357 in July 2016 to 9,280 in January 2018 (a 73% increase)[18]
- The rate of program completion among participants improved from 35% in July 2016 to 47% in January 2018
- 894 individuals who were referred by a health care provider attended at least four sessions, increasing from 700 in July 2016 to 1,594 in January 2018[19]
- The average percent of weight loss among individuals completing the class was 4.7% in January 2018, near the 5%-7% weight loss expected to lower risk for diabetes[20]

Table 2: Specific Actions to Prevent Type 2 Diabetes – DP13-1422

Overview

State and local public health actions to prevent obesity, diabetes, heart disease, and stroke (DP14-1422) – Specific actions to prevent type 2 diabetes

Jul 2017 - Sep 2018

Funding

Source

CDC Cooperative agreement

Total Expenditures

$3,520,000

NOTE: Does not include essential in-kind contributions from partner organizations

Program & Benefits

Implement systems to identify of people with prediabetes

Realized Benefits

- Eight health care sites reported having procedures in place to identify and track patients with prediabetes, which impacts about 45,000 patients a month. Settings included: three medical clinics, two community health centers, one tribal clinic, one school-based family planning health center, and one behavioral health clinic.
- Populations served: low-income (eight sites), racial and ethnic minorities (six sites), rural (five sites), elderly (five sites), and the general public (five sites)
- Prediabetes awareness increase: The percent of adults aware of a prediabetes diagnosis increased from 7% in 2013 to 9% in 2017 (awareness ranged from 7% to 13% among within five selected communities)[21]

Olympic Community (Clallam, Jefferson, and Kitsap counties), Tacoma Pierce County Health Department (Pierce County), Healthy Living Collaborative (Wahkiakum, Cowlitz, Skamania, and Clark counties), North Central Community (Okanogan, Chelan, Douglas, Kittitas, and Grant counties), Better Health Together (Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams, and Whitman counties)

Table 3: Improving Health through Prevention and Management of Diabetes (DP18-1815)

Overview

Improving the health of Americans through prevention and management of diabetes, heart disease and stroke – financed in part by 2018 Prevention and Public Health Funds (PPHF) (DP18-1815)

Oct 2018 - Jun 2023

Funding

Source

CDC Cooperative agreement

Allocations

Year 1 (2018-2019)
$851,100

Year 2 (2019-2020)
$1,040,234

Years 3-5 (2020-2023)
$1,040,234
(projected per year)

Program & Benefits

Prevention and control of diabetes

Realized Benefits

Currently in implementation, benefits not yet captured. See Department of Health Action Plan (page 31) for desired outcomes and benchmarks.

Department of Social & Health Services

The Department of Social and Health Services provides services and resources to help improve clinical outcomes for children and adults with diabetes. As with the Department of Health, most DSHS services address chronic diseases in general, or offer personalized care for each client, many of whom have diabetes, instead of focusing on diabetes alone.

DSHS has focused efforts on high-cost, high health-risk patients who are dually enrolled in Medicare and Medicaid programs. This focus is based on the principle that intensive care coordination of clients with the greatest needs provides the greatest potential for improved health outcomes and cost savings. DSHS helps generate positive client outcomes by integrating care across multiple delivery systems and helping enrollees and caregivers to set health action goals and increase self-management to achieve optimal physical and cognitive health.

DSHS focuses on patient engagement, family and caregiver support and training, transitional care support at hospital release, and skilled nursing care in less expensive community settings to improve outcomes for clients with diabetes and other health conditions. See tables below for details on these programs.

Table 4: Medicaid Health Home

Overview

Medicaid Health Home

since 2013

Funding

Source

Centers for Medicare and Medicaid Services (CMS)[22]

Total Budget

$794,000

Program & Benefits

The program serves clients of all ages who have at least one chronic condition and are at high risk of another. Diabetes is one of the identified chronic conditions. Health Home services promote person-centered health action planning to empower clients to take charge of their own health. DSHS and HCA partner on this effort.

Realized Benefits

- The program was first piloted in selected counties in 2013, and then expanded to include King and Snohomish counties on July 1, 2018, making the program available statewide
- As of December 2018, 10,310 individuals are engaged in Health Homes
- Hospital inpatient utilization reduced by 4.5%
- Nursing home utilization reduced by 20%
- Reduced probability of long-stay nursing facility admission
- Gross reduction of Medicare expenditures of $167 million between 2013 and 2017

Table 5: Family Caregiver Support Program

Overview

Family Caregiver Support Program and Medicaid Alternative Care

since 2000

Funding

Source

Title III E of the Older Americans Act

Healthier Washington Medicaid Transformation demonstration

Medicaid 1115 waiver authority

Total Expenditures

$11,600,000

Program & Benefits

The program offers an evidence-based caregiver assessment, consultation, and care planning process (TCARE®) in addition to other supportive services, including: help accessing local resources and services; caregiver support groups and counseling; and training on specific caregiving topics

Realized Benefits

- In 2018, 5,460 caregivers received one or more caregiver support services
- Delay and diversion from more intense Medicaid-funded LTSS
- Improved health and well-being of caregivers, including statistically significant reductions in depression

Table 6: Chronic Disease-Self Management Education

Overview

Chronic Disease-Self Management Education

since 2010

Funding

Source

U.S. Administration for Community Living

Total Allocations

$870,000

Program & Benefits

DSHS provides service coordination among agencies to deliver Chronic Disease Self-Management Education (CDSME). DSHS continues to support CDSME programs through a two-year grant from Prevention Public Health Funds.

The Diabetes Self-Management Program (DSMP) is one of the programs offered within CDSME. DSMP is provided in community settings. Participants make weekly action plans, share experiences, and support each other.

Realized Benefits

- Sixty organizations are now licensed to provide Chronic Disease Self-Management Education programs, serving 7,700 Washingtonians
- A regionalized network hub model with a referral and reporting capacity is being designed to increase and sustain client access to CDSME for underserved and rural populations

Table 7: Long- Term Care Support Services (LTCSS)

Overview

Community First Choice

Funding

Source

Title XIX federal funding through a 1915 (k) state plan amendment and state funding

Total Expenditures

$1.31 billion

Program & Benefits

Long-Term Care Services and Supports are provided through the Aging and Long-Term Support Administration (ALTSA), Area Agencies on Aging (AAA), and Developmental Disabilities Administration (DDA). These services include personal care provided in individuals' private residences and in community-based residential care facilities. Priority attention is given to low-income individuals and families. Many (48 percent) of the clients are receiving long-term services and supports and have a diagnosis of diabetes.

Realized Benefits

- Provides services to more than 60,000 individuals in their own homes and community residential settings and provides an alternative to more expensive nursing facility care
- Approximately 40,000 individuals choose to hire a family or friend to provide personal care services, and they are able to assist with medication management and skilled tasks by nature of their familial relationship or under direction from the person being cared for

Table 8: Care Transitions Programs

Overview	Program & Benefits
Care Transitions Programs **Funding** **Source** Health and Human Services	Coordinate with hospitals to decrease participant readmission rates and improve health and chronic condition self-management using a coaching model. Individuals participating in care transitions programs commonly have multiple chronic conditions including diabetes. Local Area Agencies on Aging and area hospitals administer these programs. **Realized Benefits** Data showed an 8.3% average reduction in readmission rates. This shows an overall improvement in chronic disease self-management that lasts nine months or more following an intervention.[23]

Table 9: Skilled Nurse Waiver Program

Overview	Program & Benefits
Skilled Nursing Waiver Program **Funding** **Source** Health and Human Services **Total Expenditures** **$287,296**	Provides Registered Nurses (RN) and Licensed Practical Nurses (LPN) with the skills required to manage client health in a community setting. Skills may include glucose monitoring, insulin administration, and wound care. **Realized Benefits** 143 people currently benefit from the Skilled Nursing program

Table 10: Nurse Delegation Program

Overview

Nurse Delegation Program

Funding

Source

Health and Human Services

NOTE: Cost for Nurse Delegation Services for people with diabetes dependent on insulin: $2,442,000.00 (average estimated monthly cost for Nurse delegation is $250 per month per client)

Program & Benefits

Enhances client choice and quality of care in a community-based setting. Registered nurse delegators delegate specific nursing care tasks to long-term care workers. Tasks include blood glucose monitoring, insulin injections, and diabetes education. The nurses support, supervise, teach, and assess caregivers, which allows clients to safely manage their diabetes.

Realized Benefits

- The program serves approximately 8,000 people and contracts with approximately 200 independent nurses in the community. Of the 8,000 people successfully served through nurse delegation, 2,258 have a diabetes-related diagnosis and 814 are insulin dependent.
- Nurse delegation allows individuals to have their needs met in their own homes and community settings

Table 11: Fostering Well-Being (FWB) Care Coordination Unit

Overview

Fostering Well-Being (FWB) Care Coordination Unit

Funding

Source

Managed though Health Care Authority

Program & Benefits

In partnership with HCA, FWB provides services for children who are in foster care or tribal care, including extended foster care for Medicaid-eligible youths ages 18 through 21. Children in care placement often have fragmented, inconsistent health care, which can result in delayed diagnosis of conditions like diabetes.

Realized Benefits

FWB recipients experienced dramatically reduced medical utilization, including fewer emergency room visits and other hospitalizations. These reductions were similar in magnitude to those experienced by other medically complex children in out-of-home placement settings who were not served by the FWB program.

Health Care Authority

During the 2017-2019 biennium, the Health Care Authority (HCA) implemented or continued the following programs to prevent or manage diabetes and its complications:

1. The Better Choices, Better Health® Pilot Program.
2. In-person and virtual diabetes prevention programs.
3. Value-based purchasing in Apple Health managed care and PEBB Programs.
4. Diabetes education in Apple Health.
5. Healthier Washington Medicaid Transformation, Initiative 1: Transformation through Accountable Communities of Health.

Better Choices, Better Health® Pilot Program

The Department of Social and Health Services (DSHS) received a grant from the U.S. Department of Health and Human Services Administration for Community Living to implement the Better Choices, Better Health® Pilot Program. The pilot program is a online self-management program that provides an evidence-based, interactive workshop that helps address key behaviors in chronic disease self-management over the course of six weeks.[24] HCA advertised the pilot program to its PEBB Program population in Uniform Medical Plans (UMP) through its SmartHealth benefit.[25] See Table 12 below for additional information.

Table 12: Better Choices, Better Health® Pilot Program Summary Information

Overview

Better Choices, Better Health® Pilot Program

Mar 2017 - Sep 2017

Enrollment

430 people

Jul 2017 – Jun 2019

Funding

Source

U.S. Department of Health and Human Services Administration for Community Living Grant

Total Expenditures

$82,500

Program & Benefits

Prevention and control of multiple chronic diseases, including diabetes

Realized Benefits

Of the 430 people who enrolled in the pilot program:

- 430 received information and resources related to their chronic health condition(s)
- 212 participated in the online community with peers with the same chronic conditions and learned what to do about their chronic conditions
- 107 completed the six-week online program and received evidence-based support that addressed social determinants of health and increased participants' quality of life

NOTE: $270 average expenditure per enrolled person, based on original grant approval for 300 enrollees; the vendor that administered the pilot program covered an additional 130 participants at no additional costs.

Source: DSHS Aging and Long-Term Support Administration, Home and Community Services Division

HCA In-Person and Virtual Diabetes Prevention Programs

Both the in-person and the virtual Diabetes Prevention Programs (DPP) are lifestyle change programs with a CDC-approved curriculum that helps participants to adopt healthier eating habits, increase physical activity levels, and improve problem solving and coping skills.[26] These lifestyle changes can reduce the risk of developing type 2 diabetes by almost 60 percent.[27] During the 2017-2019 biennium, PEBB Program participation in the in-person DPP was minimal. See Table 13 below for additional information.

Table 13a: HCA In-Person and Virtual Diabetes Prevention Program Summary Information

Overview

In-Person Diabetes Prevention Program

Jan 2014 - Dec 2018

Enrollment

Low, due to changes with the previous vendor and securing new contractual agreements with health plans

Jul 2017 - Jun 2019

Funding

Source

Covered benefit from the plans includes the DPP program, onsite blood sugar testing, and nutrition counseling. Claims budget Uniform Medical Plan; carrier rates Kaiser Foundation Health Plan of Washington

Total Expenditures

$9,030

Program & Benefits

Diabetes prevention

Realized Benefits

Through the program curriculum, enrolled participants became more aware of their risk of developing type 2 diabetes and the benefits of weight loss and increase in physical activity.

NOTE: $531 average expenditures per enrolled person (amounts per person varied based on pay-for-performance model)

Table 13b: Virtual Diabetes Prevention Program

Overview

Virtual Diabetes Prevention Program (online)

Jan 2019 - present

Enrollment

2,171 people

Jan - Jun 2019

Funding

Source

Claims budget Uniform Medical Plan; carrier rates Kaiser Northwest and Kaiser Washington

Total Expenditures

Uniform Medical Plan's expenditures are based upon estimated enrollment of more than 46,000 members. Kaiser Northwest and Kaiser Washington monthly premiums include the expenditures.

Program & Benefits

Diabetes prevention

Realized Benefits

To be determined after HCA evaluates the program in 2020

NOTE: $600 average expenditure per enrolled person in Uniform Medical Plan; monthly premiums include expenditures per enrolled person in Kaiser Northwest and Kaiser Washington

Sources: (1) HCA Employee and Retiree Benefits Division; (2) HCA Financial Services Division; and (3) ProviderOne Operational Data Store, data pulled April 2019.

HCA Value-Based Purchasing in Apple Health Managed Care and the Public Employee Benefits Board (PEBB) Program

In addition to UMP Classic, HCA offers UMP Plus and UMP Consumer-Directed Health Plan (UMP CDHP) plans. UMP Plus plans provide lower costs and a local network of doctors and specialists who coordinate to improve patient care. HCA included value-based purchasing in both Apple Health Managed Care Organization (MCO) and UMP Plus contracts to promote better health care quality for plan members and lower costs for carriers and members. Both the Apple Health MCOs and the UMP Plus networks realize a financial incentive as they improve their plan members' health, which the value-based purchasing programs determine by comparing performance measures in the Healthcare Effectiveness Data and Information Set (HEDIS).[28] The three diabetes management HEDIS measures improved during the 2017-2019 biennium, including:

1. **HbA1C Poor Control (>9 percent)** – The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0 percent (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year. HbA1C is a blood test that measures the average blood glucose level over the past 3 months. This test can be used in the process of diagnosis, or to see how well a person's diabetes is being managed.
2. **Blood Pressure Control (<140/90 mm Hg)** – The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year was <140/90 mm Hg. Blood pressure higher than 140 mm Hg systolic, and/or higher than 90 mm Hg diastolic, falls in the category of stage 2 hypertension.
3. **Eye Exam (Retinal) Performed** – The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam during the measurement year or the year prior.

See Tables 14a and 14b below for additional information.

Table 14a: HCA Value Based Purchasing Summary Information

Overview

Apple Health Managed Care Value-Based Purchasing Incentives

Jan 2017 - present

Enrollment

1,592,073 members

Jan - Dec 2017

Funding

Source

State and Federal Medicaid Funds

Total Expenditures

$33,360,000
(estimate) for 2017 performance

Program & Benefits

Improve health care quality to produce better health outcomes and lower expenditures

Realized Benefits

- Average HbA1C Poor Control measure performance improved from 39.0 percent in 2016 to 37.4 percent 2017 (lower is better for this measure)
- Average Blood Pressure Control measure performance improved from 66.0 percent in 2016 to 67.8 percent in 2017 (higher is better for this measure)
- Data from 2018 are forthcoming

NOTE: $20 average expenditures per enrolled person

Table 14b: HCA Value Based Purchasing Summary Information

Overview

PEBB Value-Based Purchasing – UMP Plus (Quality Achievement Measurement Program)

Jan 2016 - present

Enrollment

31,111 members

As of June 2019

UMP Plus membership has grown every year since plan implementation, with 16,996 UMP Plus members in 2017, and 26,658 members in 2018

Funding

Source

PEBB Fund 721

Total Expenditure

Confidential, per terms of contract

Program & Benefits

To provide an accountable care program option to PEBB members that achieve the triple aim of: better health, better care, lower cost

Realized Benefits

With respect to most diabetes performance measures, UMP Plus performance on Blood Pressure Control, Eye Exams (Retinal), and HbA1C Poor Control measures continue to out-perform other UMP plans' performance

NOTE: Average expenditures per enrolled person are confidential, per terms of contract

Sources: (1) HCA Medicaid Programs and Operational Integrity Division; (2) HCA Employee and Retiree Benefits Division; (3) HCA Financial Services Division; and (4) ProviderOne Operational Data Store, data pulled July 2019.

HCA Apple Health Managed Care and Fee-for-Service Diabetes Education Programs

Both Apple Health managed care and fee-for-service programs provide outpatient hospital-based diabetes education to help clients diagnosed with diabetes manage their chronic illness. HCA requires the diabetes education teaching curriculum to have measurable, behaviorally stated educational objectives. The diabetes curriculum must include the following core modules:

1. An overview of diabetes
2. Nutrition education, including individualized meal plan instruction apart from the Women, Infants, and Children (WIC) program
3. Exercise, including an individualized physical activity plan
4. Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management
5. Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, and foot and skin problems
6. Monitoring, including immediate and long-term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin
7. Medication management, including administration of oral agents and insulin, and insulin startup[29]

HCA pays for a maximum of six hours of outpatient diabetes education, including individual core survival skills per calendar year per client.[30] Additional hours may be requested through prior authorization. For more information, see the July 2019 Washington Apple Health Diabetes Education Program Billing Guide.[31]

See Table 15 below for additional information.

Table 15a: HCA Diabetes Education Program Summary Information

Overview

Apple Health Managed Care Diabetes Education Program

Jan 1998 - present

Enrollment

1,560 clients

Jul 2017 - Jun 2019

underestimate, due to claims lag

Funding

Source

State and Federal Medicaid Funds

Total Expenditure

$70,200

Program & Benefits

Provide medically necessary diabetes education to Managed Care Apple Health clients with diabetes

Realized Benefits

Program enrollment increased slightly, from 1,501 clients during the 2015-17 fiscal biennium, to 1,560 clients during the 2017-19 fiscal biennium

NOTE: $45 average expenditures per enrolled person

Table 15b: HCA Diabetes Education Program Summary Information

Overview

Apple Health Fee-for-Service Diabetes Education Program

Jan 1998 - present

Enrollment

1,560 clients

Jul 2017 - Jun 2019

underestimate, due to claims lag

Funding

Source

State and Federal Medicaid Funds

Total Expenditure

$70,237

Program & Benefits

Provide medically necessary diabetes education to Fee-for-Service Apple Health clients with diabetes

Realized Benefits

Program enrollment increased slightly, from 1,501 clients during the 2015-17 fiscal biennium, to 1,560 clients in the 2017-19 fiscal biennium

NOTE: $45 average expenditures per enrolled person

Sources: (1) Washington Apple Health (Medicaid) Diabetes Education Program Billing Guide[32]; (2) HCA Financial Services Division; and (3) ProviderOne Operational Data Store, data pulled July 2019.

Healthier Washington Medicaid Transformation, Initiative 1: Delivery system reform incentive payment (DSRIP) program/ Transformation through Accountable Communities of Health

In 2017, Washington state and the Centers for Medicare and Medicaid Services (CMS) finalized an agreement for a five-year Medicaid transformation project to improve the state's health care systems, provide better health care, and control costs. Initiative 1 of the transformation empowers communities to improve the health system at the local level. Each region, led by its Accountable Community of Health (ACH), is pursuing transformation projects specific to the region's needs. All nine ACHs selected Project 3D: Chronic Disease Prevention and Control from the CMS-approved Project Toolkit, with all ACHs citing diabetes as a key focus. Washington state recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches to improve chronic disease management and control.

Because federal investment in the Medicaid Transformation is not a grant, ACHs and their partners receive funds only after they achieve milestones and performance metrics, as identified in their project plans. Although regions may tailor their implementation approach to the needs of their respective regions, ACHs must demonstrate improvements across a common set of metrics, which include diabetes management HEDIS measures that align with HCA's value-based purchasing contract arrangements.

As of June 2019, ACHs were mid-way through Year 3 of the Medicaid Transformation projects, with core efforts focused on implementation of strategies defined in approved project plans. Key milestones for summer 2019 include partnering provider adoption of necessary policies, procedures, and guidelines to move ahead with implementing transformation strategies in their organizations, as well as comprehensive quality improvement plans that each ACH will use to monitor and support selected transformation strategies.

Most ACHs are focusing on diabetes prevention and control, as well as asthma, hypertension, and obesity. Key objectives include: increasing access to care; educating consumers and their families; identifying risk earlier; and increasing coordination of services that link clinical providers and services to social supports and other service needs.

All nine ACHs are implementing the Chronic Care model, and are supporting provider training for a number of specific strategies under the model (including the Diabetes Prevention Program). In addition, many regions are implementing community paramedicine programs to improve chronic disease prevention and management in their region, and, where possible, supporting the implementation of diabetes programs specific to tribal health providers.

ACHs have intentionally integrated strategies to improve chronic disease prevention and control with the implementation of integrated behavioral health and physical health care, community-based care coordination, and care transitions strategies.

With work well underway, the emerging system draws strength, stability, efficiency, and flexibility from state-community partnerships. These regional collaborations are streamlining delivery of person-centered, integrated health services, while also addressing social determinants of health and holding down costs. See Table 16 below for additional information.

Table 16: Healthier Washington Medicaid Transformation, Initiative 1: Transformation through Accountable Communities of Health Summary Information

Overview

Delivery System Reform Incentive Payment Program (DSRIP) (also known as Initiative 1), Healthier Washington Medicaid Transformation

Jan 2019 - present

Enrollment

N/A. Successful implementation of project strategies to drive improvements in the delivery system are expected to not only benefit Medicaid beneficiaries, but the population as a whole

Funding

Source

Delivery System Reform Incentive Payment Program (DSRIP), Healthier Washington Medicaid Transformation

Distributed Incentives

$506,000,000
(DSRIP)

Program & Benefits

Aim to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services

Realized Benefits

As implementation efforts ramp up, ACHs and partnering providers are accountable for performance as measured during demonstration year 3 (2019). ACHs and partnering providers have a portion of project incentives at risk for demonstrating improvement and attainment of performance targets for key metrics (as approved by CMS). Results from the first performance year will be available fall 2020.

NOTE: Average expenditures per enrolled person N/A. The Medicaid Transformation is budget neutral, which means that the state must show that it will not spend more federal dollars on its Medicaid program than it would have spent without the Section 1115 waiver authority.

Expenditures include payments made to the ACHs for design funds, integration and project incentives, and value-based purchasing efforts. A portion of the expenditures have been paid to Indian Health Care Providers for tribal specific activities. ACHs have earned $42.8M in the Chronic Disease Prevention and Control project category.

Source: HCA Policy Division

Collaboration between State Agencies

During the 2017-2019 biennium, the Department of Health (DOH), the Department of Social and Human Services (DSHS), and the Health Care Authority (HCA) worked together to address diabetes and its complications. These collaborations include:

1. **Better Choices, Better Health® Pilot Program**

   DSHS received a grant from the U.S. Department of Health and Human Services (DHHS) Administration for Community Living to implement the Better Choices, Better Health® Pilot Program. The pilot program is a digital self-management program that provides patients with an evidence-based, interactive, six-week online workshop to help address key behaviors in chronic disease self-management.[33] As part of its SmartHealth benefit, HCA advertised the pilot program through its Public Employees Benefit Board Program for Uniform Medical Plans.[34]

2. **Washington Health Home Program**

   The Medicaid health home state plan option became available to states in 2011 to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. Washington was one of the first to adopt the Medicaid health home model, which operates in 22 states and the District of Columbia.[35] Since 2013, DSHS and HCA have collaborated on the Medicaid Health Home Program, which promotes individualized, person-centered health action planning to empower clients to take charge of their own health care.[36,37] The program serves clients of all ages who have at least one chronic condition, such as diabetes, and are at risk of developing additional conditions. DSHS administers the program and HCA provides the funding. DOH has supported the program by providing training on diabetes and hypertension to care coordinators convened by DSHS. The program was first piloted in select counties in 2013, and then expanded to include King and Snohomish counties on July 1, 2018, making the program available statewide.

3. **Washington State Cardiovascular Disease and Diabetes Network Leadership Team**

   Washington State Cardiovascular Disease and Diabetes Network Leadership Team (CDNLT) members work in public, private, tribal, community, academic, and training sectors to prevent and control diabetes.[38] "Members of the leadership team meet quarterly to identify priorities and develop strategies to align with the goals and mission of the participating organizations."[39] DOH, DSHS, and HCA participate in the leadership team. Some of their successes during the 2017-2019 biennium include:

   - Leading the National Association of Chronic Disease Directors state action plan initiatives to increase access to the DPP.[40] The action plan supports health coverage for those who have Medicare, Medicaid, or employer-based insurance, or who are uninsured or underinsured.
   - Changing the name of the group to include cardiovascular disease, to broaden the scope of the work while addressing the leading cause of mortality among people with diabetes.
   - Developing a Washington state Diabetes Prevention Program Site List as a statewide resource.[41]
   - Providing education at annual Community Health Worker Conferences about prediabetes, diabetes, and hypertension management.[42]
   - Providing an employer toolkit to encourage employers to learn about and offer the Diabetes Prevention Program to their employees at risk for diabetes.[43]

4. **Diabetes Education for Apple Health**

   DOH and HCA have partnered to facilitate Medicaid coverage for diabetes education since 2003, although this work began at DSHS in 1998.[44] Through this current partnership, DOH manages the processing of provider applications for this program. HCA reimburses the providers for their services. As of June 2019, there are 111 recognized programs approved to bill Medicaid for fee-for-service diabetes education. Agencies collaborated by:

   - Creating a billing guide for providers.
   - Promoting the list of approved programs to Medicaid Managed Care Plans.
   - Educating providers to ensure they understand the benefit and how to bill for services.
   - Working with clinical program staff to ensure they connect with billing departments.
   - Building partnerships with organizations offering diabetes education across the state to provide and support expansion of diabetes education.

5. **World Diabetes Day Washington**

   National Diabetes Month and World Diabetes Day occur every November.[45] Through these events, HCA and DOH engage state partners to broadcast messaging that increases Washingtonians' awareness of prediabetes and diabetes. In 2018, a social marketing campaign and toolkit were created for partners to use, and these materials were updated in 2019.[46]

6. **Healthier Washington Medicaid Transformation**

   In 2017, Washington state and the Centers for Medicare and Medicaid Services (CMS) finalized an agreement for a five-year Medicaid transformation project to improve the state's health care systems, provide better health care, and control costs. Through December 2021, the state will receive up to $1.5 billion in federal investment to restructure, improve, and enhance the Apple Health service delivery system. DSHS and HCA coordinate on the operations of the Healthier Washington Medicaid Transformation. Examples of programs and strategies under the transformation to address diabetes and its complications include:

   - DSHS is administering the Family Caregiver Support Program. The objective is to support families in caring for loved ones while increasing well-being of the caregiver, as well as delay or avoid the need for more intensive Medicaid-funded long-term supports and services where possible.
   - Nine regional Accountable Communities of Health (ACH) form robust organizations under which a fast-growing number of providers and partner organizations are collaborating to transform Washington's health care and delivery systems through local health initiatives. HCA oversees regional efforts led by ACHs to support care delivery redesign and improve prevention and health promotion. ACHs and partners are implementing local strategies to ensure individuals with chronic conditions, including diabetes, get the right level of care at the right time and in the appropriate setting.
   - The Healthier Washington Collaboration Portal (WA Portal) is a web-based resource that supports transformation and team collaboration for Washington's health and wellness system. WA Portal was built by Washington health care providers, educators, web developers, public health practitioners, and community-based professionals working together to create flexible solutions that apply across the state. It was originally designed as part of the Healthier Washington Practice Transformation Support Hub

through State Innovation Model funding. It has since grown to meet a variety of information-sharing and collaboration needs for partners throughout Washington's health and wellness community. WA Portal is managed through a partnership between DOH and the University of Washington's Department of Family Medicine Primary Care Innovations Lab. The Population Health Guide, which highlights diabetes as one of six top health focus areas, was developed and is managed by DOH and is housed on WA Portal.

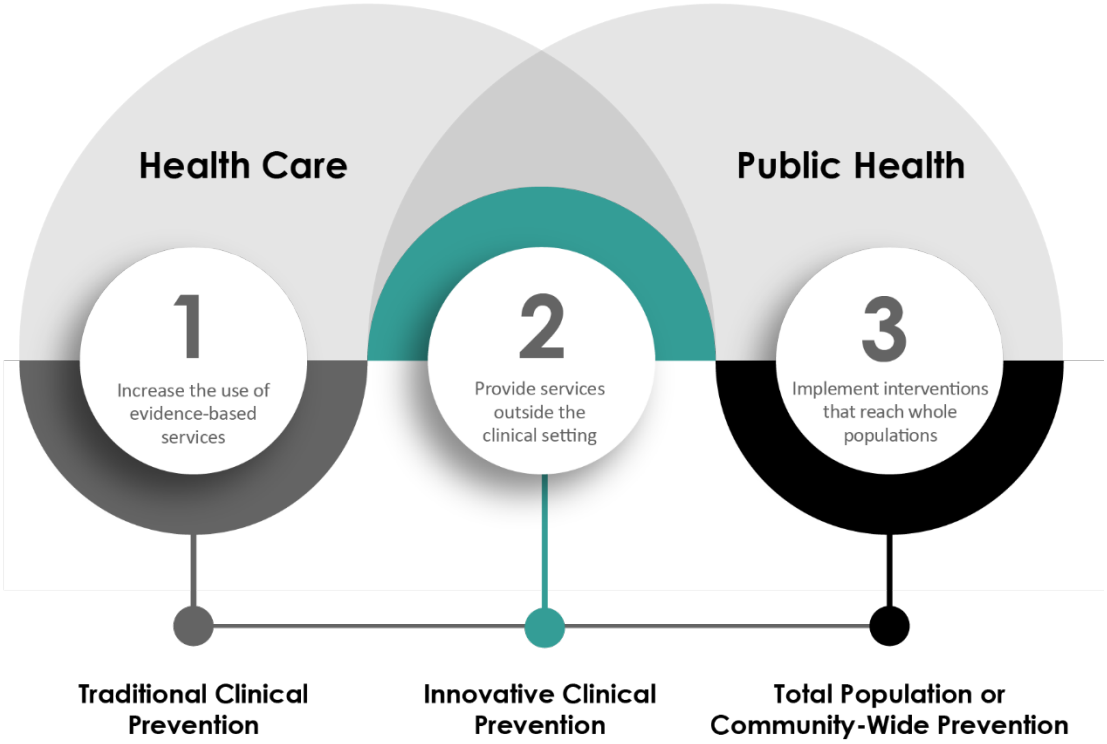
7. Federal grants received through partnership

Strong partnerships between agencies resulted in federal grant awards to support chronic disease self-management and prevention, which in turn impact people with diabetes and prediabetes in Washington.

- DSHS-Aging and Long Term Support Administration (ALTSA) was awarded the Association for Community Living's 2019 Sustainable Systems Grant. Partners in this grant include Comagine Health (a Medicare quality improvement organization), DOH, HCA, three Area Agencies on Aging, and Cascade Pacific Action Alliance, an Accountable Community of Health. One major goal of this grant work is testing the feasibility of a sustainable, regionalized approach for providing evidence-based chronic disease management education workshops in English and Spanish to increase access to underserved, primarily rural populations. A portion of the funding will go towards creating a bi-directional referral and reporting network involving Area Agencies on Aging, DOH, and HCA. These agencies will identify and track how people who have participated in chronic disease management education programs utilize health care and other outcome measures. Projected outcomes include: 74 workshops in six new counties; 520 primarily rural participants; and 365 program completers. Projected products include a "Best Practices and Overcoming Barriers" handbook, marketing/outreach material, and trainings for Master Trainers and Lay Leaders to expand capacity in rural areas of the state.
- DOH was awarded CDC's Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease and Stroke – financed in part by a 2018 Prevention and Public Health Funds (DP18-1815) cooperative agreement in 2018. The funding was awarded based on key partnerships, including with DSHS and HCA, and CDC recognized the application's commitment to promoting health equity. This funding advances the work of increasing access to Diabetes Self-Management Education and Support programs in underserved areas; partnering with DSHS-ALTSA to improve access to and participation in chronic disease self-management education; increasing the engagement of pharmacists in support of adults with diabetes; assisting health care organizations, including community health centers, in identifying adults with prediabetes and referring them to recognized diabetes prevention programs; and supporting statewide infrastructure to promote long-term sustainability and financing of community health workers in diabetes prevention and management.

Agency Action Plans (July 2019 – June 2021)

This section includes updated strategic plans to address diabetes from DOH, DSHS, and HCA, as well as a cross-agency plan, include action steps aimed at controlling and preventing relevant forms of diabetes. One framework for organizing solutions is the Three Buckets of Prevention, used by Healthier Washington's Population Health Guide[47].



Source: Infographic modeled after the Three Buckets of Prevention[48], used by Healthier Washington's Population Health Guide.

The actions listed in these plans fall under one or more of these categories, and are identified as prevention areas 1, 2, and/or 3 to show where the actions would impact health care (1), community services (2), and whole population health (3).

Department of Health Action Plan

Department of Health's Diabetes Action Plan aligns with the agency's strategic plan and focuses on population health strategies that impact diabetes and its risk factors. The Washington State Cardiovascular Disease and Diabetes Network Leadership Team is a key partner in successful implementation of these action plans. The timeline for the below action items is through June 2021.

Table 17: Department of Health Action Plan Summary Information

Action Step 1	Expected Outcome	Benchmark
Improve access to and participation in recognized Diabetes Self-Management Education and Support (DSMES) programs in underserved areas **Prevention Areas** 1 2 3	30 new programs	173 programs as of September 2018
	Resources	**Legislative Considerations**
	Federal funding from Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease and Stroke (DP18-1815); Partnership with HCA	None

Action Step 2	Expected Outcome	Benchmark
Improve access to and participation in Diabetes Self-Management and Chronic Disease Self-Management Program workshops for adults with diabetes, including encouraging e-referrals from health systems. These workshops serve as a form of DSMES. **Prevention Area** 2	40 new workshops	36 workshops were offered in calendar year 2018
	Resources	**Legislative Considerations**
	Federal funding from DP18-1815; Partnership with HCA and DSHS	None

Action Step 3	Expected Outcome	Benchmark
Increase engagement of pharmacists in the provision of medication management or DSMES for people with diabetes **Prevention Areas** 1 2 3	Increase the number of pharmacy locations and pharmacists using patient care processes that promote medication management or DSMES for people with diabetes	To be determined
	Resources	**Legislative Considerations**
	Federal funding from DP18-1815	Take actions to support increasing networks of providers that include pharmacists whose work can be compensated for and who are trained to provide DSMES and medication management for people with diabetes

Action Step 4

In partnership with DSHS, HCA, and Office of the Insurance Commissioner (OIC), study newly available data (such as the All-Payers Claims Database) to understand utilization patterns of evidence-based DSMES so that diabetes-related health outcomes can be improved using existing resources

Prevention Areas 1 2 3

Expected Outcome

Improve utilization of existing evidence-based resources for DSMES, in turn leading to improved diabetes-related health outcomes

Benchmark

To be determined through study

Resources

Partnerships with HCA, OIC, and DSHS

Legislative Considerations

None

Action Step 5

Increase availability of Diabetes Prevention Programs (DPP)

- Partner with Office of the Insurance Commissioner (OIC) to identify inclusion of coverage for nationally recognized Diabetes Prevention Programs in insurance plans regulated by OIC.
- Assist health care organizations in identifying adults with prediabetes and referring them to programs, including encouraging e-referrals from health systems

Prevention Areas 2 3

Expected Outcome

Increase the number of participants enrolled in Diabetes Prevention Programs in Washington

Benchmark

14,905 participants (as of January 2019)

Resources

Federal funding from DP18-1815

Legislative Considerations

None

Action Step 6

Support statewide infrastructure to promote long-term sustainability/payment for Community Health Workers (CHWs) to expand their use in programs for diabetes self-management and prevention

Prevention Areas 2 3

Expected Outcome

Increase the number of CHWs receiving training in diabetes self-management and prevention

Benchmark

To be determined

Resources

Federal funding from DP18-1815

Legislative Considerations

Identify mechanisms and sources for payment for community-based efforts that utilize CHWs in diabetes self-management and prevention

Department of Social & Health Services Action Plan

The Department of Social and Health Services Diabetes Action Plan aligns with the agency's strategic plan and focuses on providing home- and community-based services. The goal of Washington's long-term services and supports system is that, whenever possible, individuals get the opportunity to live and receive services in their own homes or in community settings. Chronic Disease Self-Management Education (CDSME) provides support to better build community linkages and foster more productive interactions between informed, engaged, and activated people living with chronic conditions. DSHS supports the Cardiovascular Disease and Diabetes Network Leadership Team to better serve populations with diabetes.

Table 18: Department of Social and Health Services Action Plan Summary Information

Action Step 1	Expected Outcome	Benchmark
Partner with DOH and HCA to promote multiple modalities of Diabetes Self-Management Education to patients **Prevention Areas** 1 2 3	Increased expansion of and access to CDSME programs to include Diabetes Self-Management and other evidenced based programs	
	Resources	**Legislative Considerations**
	Partnership with HCA and DOH	None

Action Step 2	Expected Outcome	Benchmark
Partner with DOH and Office of the Insurance Commissioner (OIC) to identify inclusion of coverage of evidence-based programs for Diabetes Self-Management Education and Support in insurance plans regulated by OIC **Prevention Areas** 2 3	Greater access to and participation in evidence-based programs for DSMES through insurance plans regulated in Washington	Will work with OIC to establish benchmark
	Resources	**Legislative Considerations**
	Partnership with DOH, staffing at OIC	None

Action Step 3	Expected Outcome	Benchmark
Support efforts to develop a community-based organizations hub-and-spoke network business model that supports efforts to obtain funding to pay for programs and build infrastructure that demonstrate return on investment and whole person care related to diabetes and other evidenced-based programs **Prevention Areas** 2 3	Resources and partnerships in place with a "no wrong door" approach so that clients easily access diabetes self-management and other evidenced based programs	
	Resources	**Legislative Considerations**
	Partnership with HCA	None

Action Step 4

Support existing coordination of diabetes care and management and work to integrate physical and behavioral health services to better care for people. DSHS accomplishes this through services for Home and Community Based clients

Prevention Areas 1 2

Expected Outcome

- Improved health of all people with diabetes
- Reduced hospital costs, especially for those at disproportionate risk of poor health outcomes

Benchmark

Resources

Partnership with HCA

Legislative Considerations

None

Action Step 5

Support existing long-term care programs for diabetes care and management through services for Home and Community Based clients as defined in the following Long Term Care Manuals

State Plan Program: Community First Choice, Medicaid Personal Care, PACE and ALTSA/HCBS 1915c Waiver: COPES, New Freedom Waiver

Prevention Areas 1 2

Expected Outcome

- Reduced hospitalizations and associated costs
- Improved quality of life for clients with chronic conditions such as diabetes

Benchmark

Resources

Partnership with HCA

Legislative Considerations

None

Action Step 6

Build a robust long-term care workforce through effective marketing. Continue to educate Workforce Development Council representatives statewide and increase Home Care Aide training programs in high schools, skill centers, and community and technical colleges

Prevention Area 3

Expected Outcome

Development of a competent paid workforce available to deliver long-term services and supports to people with diabetes and other chronic conditions

Benchmark

Resources

Partnership with DOH

Legislative Considerations

None

Action Step 7

Continue to partner with HCA to administer the Health Home program. Provide training to ensure fidelity of Health Home model with emphasis on strengthening self-management for individuals participating in the Health Home program

Prevention Areas 1 2

Expected Outcome

- Improvement in health outcomes for clients including behavioral and long term services and supports.
- Facilitated delivery of evidence-based health care services.
- Increased patient confidence and skills for self-management of health goals.

Benchmark

Resources

Partnership with HCA

Legislative Considerations

Health Care Authority Action Plan

HCA complies with Governor Jay Inslee's Executive Order 13-06 by offering a Diabetes Prevention Program (DPP) benefit to Public Employee Benefits Board (PEBB) plan subscribers and their dependents ages 18 and older who are not enrolled in Medicare.[49] The DPP benefit is a lifestyle change program with a CDC-approved curriculum that helps participants adopt healthier eating habits, increase physical activity levels, and improve problem solving and coping skills.[50] These lifestyle changes can reduce the risk of developing type 2 diabetes by almost 60 percent.[51]

During the 2017-2019 biennium, PEBB member participation in an in-person DPP was minimal. Since January 2019, PEBB member participation in a new, virtual DPP has greatly improved.

Beginning in January 2020, HCA will procure and administer health care coverage for an estimated 150,000 employees of Washington School districts and charter schools and represented employees of Washington Educational Scholl Districts (ESD's). School Employees Benefits Board (SEBB) Program medical carriers will offer a DPP benefit to their subscribers and dependents who are 18 and older, and not enrolled in Medicare. As of April 2018, eligible Medicare beneficiaries have coverage of DPP services with no cost-sharing through Medicare-enrolled MDPP suppliers.[52] See Table 19 below for additional information.

Apple Health managed care organizations (MCO) are implementing several action plans to improve diabetes outcomes for their plan members. Some example action plans include:

- A retinal eye camera pilot program to increase diabetes eye exams and related care for plan members with diabetes.
- Care management to address the complex needs of plan members with diabetes and other chronic illnesses.
- Early screening and intervention among plan members with pre-diabetes indicators.
- In-home nurse visits to screen or monitor members for diabetes-related health concerns.
- Collaboration between clinicians within the MCO plan network to discuss and address issues related to plan members' diabetes.

See Appendix B for MCO action plans.

Table 19: Health Care Authority Action Plan Summary Information

Action Step 1	Expected Outcome	Improvement Benchmark
Support PEBB Program Virtual Diabetes Prevention Program  Launched Jan 2019 **Prevention Areas** 1 2	Increased access to the lifestyle change program, compared to the in-person program[53, 54, 55, 56, 57]	At least 5.0 percent enrollment among the PEBB program population with prediabetes, compared to less than 0.1 percent in the in-person DPP during the 2017-2019 biennium. Additional benchmarks to be determined after HCA develops its program evaluation plan
	Resources	**Legislative Considerations**
	Both fully insured and self-insured PEBB Program plans cover the Virtual DPP benefit for PEBB Program members ages 18 and older and not enrolled in Medicare	None

Action Step 2	Expected Outcome	Improvement Benchmark
SEBB Program Diabetes Prevention Program to be implemented per plan contract  launch Jan 2020 (proposed) **Prevention Areas** 1 2	Provide SEBB enrollee access to the lifestyle change program	To be determined after implementation and after HCA develops its program evaluation plan
	Resources	**Legislative Considerations**
	Appropriated 1.0 full-time equivalent (FTE) Health Services Consultant 4 in HCA. A portion of this FTE will support the promotion of DPP within the SEBB Program population	None

Cross-Agency Collaborative Action Plan

The following action plans, if implemented, will require ongoing collaboration with additional impacted agencies. Implementation of these plans may be based on available resources, and will depend on legislative interest and agency capacity.

Table 20: Proposed Cross-Agency Action Plan Summary Information

Action Step 1	Expected Outcome	Benchmark
Expand and diversify the Cardiovascular Disease and Diabetes Network Leadership Team (CDNLT) **Prevention Area** 3	30 voting members	25 voting members of the CDNLT as of July 2019
	Resources	**Legislative Considerations**
	Federal funding from the CDC, and partnerships between DOH, DSHS, HCA, and other impacted agencies	None

Action Step 2	Expected Outcome	Benchmark
Build, maintain, and improve diabetes-related data capacity • Increase capacity for and access to shared resources with partners to monitor and evaluate diabetes-related health status, access, quality, cost, and effectiveness of interventions that address diabetes prevention and management across communities in Washington State • Ensure availability of accurate, clear, relevant, and timely information to inform data- and science-drive program and policy decision making **Prevention Area** 3	Increased ability to report on diabetes in Washington	Diabetes Epidemic and Action Report 2019
	Resources	**Legislative Considerations**
	Staffing and technology from agencies, higher education institutions, and health systems organizations, and partnerships between DOH, DSHS, HCA, and other impacted agencies	Increase funding for monitoring and evaluating health status, health care access, quality of care, cost of care, and effectiveness of interventions among people with diabetes

Action Step 3	Expected Outcome	Benchmark
Reduce barriers to care and affordability for low-income individuals and families caused by increasing out-of-pocket costs associated with diabetes management, in partnership with the Office of the Insurance Commissioner (OIC), **Prevention Areas** 1 3	Identification of proposed solutions	Information from report exploring the issue of patient out-of-pocket costs in Washington from 2016 SSB 6569: Creation of a task force on patient out-of-pocket costs
	Resources	**Legislative Considerations**
	Funding for a study to identify solutions, and partnership with OIC	Allocate funding for study

Action Step 4

Support initiatives to improve access to healthy food, affordable access to safe physical activity, and increased public transportation to reduce barriers to access to care, self-management, and support for populations with diabetes at higher risk and/or need.

These populations include people who lack housing, people with co-occurring mental health diagnoses, people with dementia, and children and adults with disabilities and neurodevelopmental differences.

Prevention Area 3

Expected Outcome

Improvement in diabetes care and health outcomes for populations at higher risk and/or need

Benchmark

To be determined after system enters planning phase

Resources

Funding and staffing for creating a system to identify and track existing initiatives, new initiatives, and diabetes care and health outcomes, and partnerships between DOH, DSHS, HCA, and other impacted agencies

Legislative Considerations

Continue to fund existing initiatives that improve social determinants of health that impact diabetes-related outcomes and care for populations at greater risk and/or need, and funding for establishing benchmark and tracking outcomes

Action Step 5

Increase access to diabetes self-management and support in all languages spoken in Washington, and culturally-specific diabetes self-management education and support

Prevention Area 2

Expected Outcome

Greater number of DSMES programs that support a variety of cultures and languages in Washington

Benchmark

To be determined based on program assessment, which requires funding not yet identified

Resources

Existing agency expertise in DOH, DSHS, and HCA, and identification of funding for program assessment

Legislative Considerations

Continue to support and fund National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards), and provide support through funding, staffing, and cooperation to develop a system to capture and share DSMES information

Action Step 6

Increase investment in children/ youth to prevent pre-diabetes and type 2 diabetes:

- Ensure effective and evidence-based health and nutrition education that can help with diabetes management and type 2 diabetes delay or prevention
- Fund student health supports in schools, such as increased student health staffing and health center models
- Provide funding for appropriate nutrition options in schools and youth settings
- Ensure access to appropriate and engaging physical activity
- Increase education about growing, shopping, and preparing foods that support health

Prevention Areas 2 3

Expected Outcome

Increased state spending on investments in prevention

Benchmark

To be determined based on assessment of current funding, not yet identified

Resources

Funding and staffing at DOH, HCA, and other impacted agencies

Legislative Considerations

Identify additional funding streams for investment in prevention

Action Step 7

Increase investment in healthy behavior supports across the lifespan, to impact people with type 1, type 2, and gestational or maternal diabetes:

- Ensure access to appropriate and engaging physical activity, including as part of the built environment
- Increase education and support for growing, shopping for, and preparing foods that support health

Prevention Areas 2 3

Expected Outcome

Increased state spending on investments in prevention

Benchmark

To be determined based on assessment of current funding, not yet identified

Resources

- Funding and staffing at DOH, DSHS, and other impacted
- Identify additional funding streams for investment in prevention d agencies

Legislative Considerations

Identify additional funding streams for investment in prevention

Conclusion

Washington's policies and programs designed to impact the diabetes epidemic have helped reduce the burden of diabetes for individuals, families, communities, and health care systems.

DOH, DSHS, and HCA plan to leverage existing infrastructure and resources to continue to address diabetes prevention and management. These efforts include: Healthier Washington, including Accountable Communities of Health; federal funding and grants; alignment of key diabetes performance measures tied to value-based purchasing across state purchasing contracts; partnerships, such as those realized through the Cardiovascular and Diabetes Network Leadership Team; and development of infrastructure for evidence-based community programs, such as the Chronic Disease Self-Management Program, and programs that support physical activity and improved nutrition.

To address the overall burden of diabetes, and reduce health inequities in diabetes prevention and management, the legislature may wish to consider a range of actions outlined in proposed action plans. In brief, proposed actions recommended in this report include:

- Encouraging expanding networks of providers to include pharmacists trained to provide self-management education and medication management.
- Supporting policies that compensate for community-based efforts that utilize community health workers in diabetes self-management and prevention, and encourage implementation of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).
- Increasing resources for monitoring and evaluation of diabetes-related care and the health status of those with diabetes.
- Funding a study on barriers to care caused by increasing out-of-pocket costs associated with diabetes management, within the overall context of costs, to be completed in partnership with the Office of the Insurance Commissioner.
- Continuing to fund existing initiatives that improve social determinants of health. Investing in evidence-informed health promotion and chronic disease prevention for ages 0-18, in collaboration with state agencies serving youth.

Appendix A: Legislative Mandates

RCW 70.330.010: Identification of goals and benchmarks—Agency plans

The Health Care Authority, Department of Social and Health Services, and Department of Health shall collaborate to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in Washington, improve diabetes care, and control complications associated with diabetes.

[2016 c 56 § 1.]

RCW 70.330.020: Reports to governor and legislature

The Health Care Authority, Department of Social and Health Services, and Department of Health shall each submit a report to the governor and the legislature by December 31, 2019, and every second year thereafter, on the following:

> (1) The financial impact and reach diabetes of all types is having on programs administered by each agency and individuals enrolled in those programs. Items included in this assessment must include the number of lives with diabetes impacted or covered by programs administered by the agency; the number of lives with diabetes and family members impacted by prevention and diabetes control programs implemented by the agency; the financial toll or impact diabetes and its complications places on these programs; and the financial toll or impact diabetes and its complications places on these programs in comparison to other chronic diseases and conditions.
>
> (2) An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment must also document the amount and source for any funding directed to the agency for programs and activities aimed at reaching those with diabetes.
>
> (3) A description of the level of coordination existing between the agencies on activities, programmatic activities, and messaging on managing, treating, or preventing all forms of diabetes and its complications.
>
> (4) A development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the legislature. The plans must identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan must also identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing relevant forms of diabetes.
>
> (5) An estimate of costs and resources required to implement the plan identified in subsection (4) of this section.

[2016 c 56 § 2.]

(2013) 3ESSB 5034 §219(23): $77,000 of the general fund—--state appropriation for fiscal year 2014 and $38,000 of the general fund—--state appropriation for fiscal year 2015 are provided solely to develop a report on state efforts to prevent and control diabetes. The Department of Health, the Health Care Authority, and the Department of Social and Health Services shall submit a coordinated report to the governor and the appropriate committees of the legislature by December 31, 2014, on the following:

(a) The financial impacts and reach that diabetes of all types and undiagnosed gestational diabetes are having on the programs administered by each agency and individuals, including children with mothers with undiagnosed gestational diabetes, enrolled in those programs. Items in this assessment must include: (i) The number of lives with diabetes and undiagnosed gestational diabetes impacted or covered by the programs administered by each agency; (ii) the number of lives with diabetes, or at risk for diabetes, and family members impacted by prevention and diabetes control programs implemented by each agency; (iii) the financial toll or impact diabetes and its complications, and undiagnosed gestational diabetes and the complications experienced during labor to children of mothers with gestational diabetes places on these programs in comparison to other chronic diseases and conditions; and (iv) the financial toll or impact diabetes and its complications, and diagnosed gestational diabetes and the complications experienced during labor to children of mothers with gestational diabetes places on these programs;

(b) An assessment of the benefits of implemented and existing programs and activities aimed at controlling all types of diabetes and preventing the disease. This assessment must also document the amount and source for any funding directed to each agency for the programs and activities aimed at reaching those with diabetes of all types;

(c) A description of the level of coordination existing between the agencies on activities, programmatic activities, and messaging on managing, treating, or preventing all types of diabetes and its complications;

(d) The development or revision of detailed policy-related action plans and budget recommendations for battling diabetes and undiagnosed gestational diabetes that includes a range of actionable items for consideration by the legislature. The plans and budget recommendations must identify proposed action steps to reduce the impact of diabetes, prediabetes, related diabetes complications, and undiagnosed gestational diabetes. The plans and budget recommendations must also identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing all types of diabetes; and

(e) An estimate of savings, efficiencies, costs, and budgetary savings and resources required to implement the plans and budget recommendations identified in (d) of this subsection (23).

See also: (2013) 3ESSB 5034 §211(3) and §213(17).

(2015) ESSB 6052 §219(3): $38,000 of the general fund—state appropriation for fiscal year 2016 and $38,000 of the general fund—state appropriation for fiscal year 2017 are provided solely for the Department of Health, the Department of Social and Health Services, and the Health Care Authority to continue to collaborate to submit a coordinated report on diabetes to the governor and appropriate committees of the legislature by June 30, 2017. The report on diabetes must include the following:

(a) An analysis of the financial impact and reach that diabetes of all types is having on programs administered by each agency and individuals enrolled in those programs, including:

(i) The number of individuals with diabetes that are impacted or covered by these programs;

(ii) The number of family members of individuals with diabetes that are impacted by these programs;

(iii) The financial toll or impact that diabetes and its complications places on these programs, and how the financial toll or impact compares to that of other chronic diseases and conditions;

(b) An assessment of the benefits of programs and activities implemented by the agencies to control and prevent diabetes, including documentation of the amount and source of the agencies' funding for these programs and activities;

(c) A description of the level of coordination existing between the agencies on activities; programmatic activities; and messaging on managing, treating, or preventing all forms of diabetes and its complications;

(d) The development of or revision to each agency's action plan for addressing the impact of diabetes together with a range of actionable items for either each agency or consideration by the legislature, or both. The plans must, at a minimum:

(i) Identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications, especially for Medicaid populations;

(ii) Identify expected outcomes in subsequent biennia; and

(iii) Establish benchmarks for controlling and preventing relevant forms of diabetes and appropriate measures for success;

(e) An estimate of the costs, return on investment, and resources required to implement the plans identified in subsection (d) of this section.

Appendix B: Apple Health Managed Care Organization Action Plan

This appendix includes action plans from Apple Health managed care organizations (MCO) to improve diabetes outcomes for their plan members.

Action Step 1

MCO – Retinal Eye Camera Pilot

launch Jan 2020 (proposed)

Prevention Areas 1 2

Expected Outcome

MCO plan members with type 1 or type 2 diabetes will complete a retinal eye exam during PCP visit; this will reduce the need for a referral to an eye care specialist and allow members to receive all the needed diabetes care in one place

Improvement Benchmark

The comprehensive diabetes care eye exam HEDIS measure performance in calendar year 2021 will improve (increase) year over year, compared to calendar year 2019

Resources

Purchase digital retinal eye cameras for select pilot clinics, funded by Anthem Inc.

Legislative Considerations

None

Action Step 2

MCO – Managing Multiple Chronic Illnesses

launch Jan 2019

Prevention Areas 1 2

Expected Outcome

Increase Diabetic medication adherence

Improvement Benchmark

MCO plan members with type 1 or type 2 diabetes will engage in Care Management: a collaborative process that includes assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to individuals and families, health needs through communication and available resources to promote quality, cost effective outcomes

Resources

None

Legislative Considerations

None

Action Step 3

MCO –
Pre-Diabetes Identification and Early intervention

TBD

Prevention Area 1

Expected Outcome

Decrease in overall morbidity/mortality from disease progression through early intervention in MCO plan members with pre-diabetes indicators, including: impaired glucose tolerance, impaired fasting glucose, elevated blood glucose, elevated A1C, prediabetes, and borderline diabetes

Improvement Benchmark

Increase screening (HbA1c test) for MCO plan members at high risk for pre-diabetes

Resources

None

Legislative Considerations

None

Action Step 4

MCO –
In-Home Diabetes Visit

launch Jun 2019

Prevention Areas 1 2

Expected Outcome

Visiting nurses will provide in-home visits for diabetes screening or monitoring to members

Improvement Benchmark

Increase HEDIS rates for Comprehensive Diabetes Care to meet target/goal of 75th percentile

Resources

None

Legislative Considerations

None

Action Step 5

MCO –
Diabetes Discussion Group Roundtable on Demand

launch Aug 2020

Prevention Area 1

Expected Outcome

Clinicians will connect with other clinicians across the MCO plan network to discuss diabetes

Improvement Benchmark

MCO plan members with type 1 and type 2 diabetes will make lifestyle changes will result in a statistically significant increase month-over-month in HbA1c, dilated retinal eye exam, and kidney function HEDIS measure performance during calendar years 2019 and 2020

Resources

None

Legislative Considerations

None

Sources: (1) HCA Employee and Retiree Benefits Division; and (2) Apple Health Managed Care Organizations

Appendix C: Endnotes

[1] Centers for Disease Control and Prevention. Diabetes Report Card 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2018.

[2] Washington State Department of Health. Diabetes Data Supplement. Olympia, WA: Washington State Department of Health; December 2019. Available at: https://www.doh.wa.gov/Portals/1/Documents/Pubs/140-222-DiabetesDataSupplement2019.pdf

[3] Washington State Department of Health. Washington State Behavioral Risk Factor Surveillance System 1993–2017.

[4] Washington State Department of Health, Washington State Behavioral Risk Factor Surveillance System Survey, 2017.

[5] Geiss LS, Wang J, Cheng YJ, et al. Prevalence and incidence trends for diagnosed diabetes among adults aged 20 to 79 years, United States, 1980-2012. JAMA. 2014; 312(12):1218-26.

[6] Riddle MC, Herman WH. The Cost of Diabetes Care-An Elephant in the Room. Diabetes Care. 2018 May; 41(5):929-932.

[7] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care. 2018 May; 41(5):917-928, appendix with supplementary state-level data. Available at: http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007.

[8] Dieleman JL, Baral R, Birger M, et al. US Spending on Personal Health Care and Public Health, 1996-2013. JAMA. 2016;316(24):2627–2646.

[9] Kaiser Family Foundation. Data Note: Americans' Challenges with Health Care Costs. June 11, 2019. Accessed November 20, 2019, from: https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/

[10] Kovacs Burns K, Nicolucci A, Holt RI, Willaing I, Hermanns N, Kalra S, Wens J, Pouwer F, Skovlund SE, Peyrot M; DAWN2 Study Group. Diabetes Attitudes, Wishes and Needs second study (DAWN2™): cross-national benchmarking indicators for family members living with people with diabetes. Diabet Med. 2013 Jul; 30(7):778-88.

[11] Justus N. How Can Your Diabetes Affect Your Friends, Family & Others Around You? TheDiabetesCouncil.com Web site. www.thediabetescouncil.com/can-diabetes-affect-friends-family-others-around/. September 11, 2018. Accessed July 12, 2019.

[12] American Diabetes Association Lifestyle Management: Standards of Medical Care in Diabetes—2019. Diabetes Care Jan 2019, 42 (Supplement 1) S46-S60. Accessed November 20, 2019, from: https://care.diabetesjournals.org/content/42/Supplement_1/S46

[13] American Diabetes Association-recognized and American Association of Diabetes Educators-accredited Diabetes Self-Management Education Program Sites, online CDC map at www.diabeteseducator.org/living-with-diabetes/find-an-education-program

[14] Washington State Medicaid-Eligible Diabetes Self-Management Education Services Program Record database, Washington State Department of Health, Health Care Authority.

[15] American Diabetes Association and the American Association of Diabetes Educators – Aggregate Diabetes Self-Management Education Encounter Data by State, 2012-2017, provide by Centers for Disease Control and Prevention.

[16] Department of Social and Human Services, Chronic Disease Self-Management Education Program Participant Data, 2012-2017.

[17] Diabetes Prevention Recognition Program – Registry of Recognized Organizations, National Diabetes Prevention Program, Centers for Disease Control and Prevention.

[18] Diabetes Prevention Recognition Program – Aggregate Participant Data by State, National Diabetes Prevention Program, Centers for Disease Control and Prevention.

[19] Ibid

[20] Ibid

[21] Washington State Behavioral Risk Factor Surveillance System Data, 2017, Washington State Department of Health.

[22] Health Homes Program Dashboard Report. June 2018. Accessed November 20, 2019, from: www.hca.wa.gov/assets/billers-and-providers/HH-Dashboard.pdf

[23] 26 Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006 Sep 25; 166(17):1822-8.

[24] National Council on Aging. Better Choices, Better Health® Online Chronic Disease Self-Management Program. Retrieved April 17, 2019, from www.ncoa.org/wp-content/uploads/BCBH-overview.pdf

[25] Health Care Authority. Smart Health. Retrieved April 17, 2019, from www.hca.wa.gov/employee-retiree-benefits/smarthealth

[26] The National Diabetes Prevention Program. Retrieved April 17, 2019, from www.chronicdisease.org/mpage/domain4_ndppreso

[27] Health Care Authority. Diabetes prevention. Retrieved April 17, 2019, from www.hca.wa.gov/about-hca/washington-wellness/diabetes-prevention

[28] National Council on Quality Assurance. HEDIS and Performance Measurement. Retrieved July 11, 2019, from www.ncqa.org/hedis/

[29] WAC 182-550-6400 Outpatient hospital diabetes education. Retrieved July 11, 2019, from https://app.leg.wa.gov/WAC/default.aspx?cite=182-550-6400

[30] Ibid

[31] Washington Apple Health (Medicaid). Diabetes Education Program Billing Guide. Retrieved November 20, 2019, from: www.hca.wa.gov/assets/billers-and-providers/diabetes-education-bi-20190701.pdf

[32] ibid

[33] National Council on Aging. Better Choices, Better Health® Online Chronic Disease Self-Management Program. Retrieved April 17, 2019, from www.ncoa.org/wp-content/uploads/BCBH-overview.pdf

[34] Health Care Authority. Smart Health. Retrieved April 17, 2019, from www.hca.wa.gov/employee-retiree-benefits/smarthealth

[35] Integrated Care Resource Center. Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences. February 2019. Retrieved November 20, 2019, from: www.chcs.org/media/Washington-case-study_Final.pdf

[36] Washington State Department of Social and Health Services. Washington Health Home Program. Retrieved April 17, 2019, from www.dshs.wa.gov/altsa/washington-health-home-program

[37] Washington State Health Care Authority. Health Home. Retrieved April 17, 2019, from www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

[38] Washington State Department of Health. Diabetes Statewide Partnerships. Retrieved April 17, 2019, from www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/DiabetesStatewidePartnerships

[39] Washington State Diabetes Connection. Diabetes Network Leadership Team. Retrieved April 17, 2019, from https://diabetes.doh.wa.gov/LeadershipTeam

[40] National Association of Chronic Disease Directors. Diabetes Council. Retrieved April 17, 2019, from www.chronicdisease.org/page/Diabetes

[41] Washington State Diabetes Connection. Washington State Diabetes Prevention Program Site List. Published August 15, 2018. Retrieved April 17, 2019, from https://diabetes.doh.wa.gov/Portals/13/DNNGalleryPro/uploads/2018/8/24/DPPSiteListforConnection-8-24-2018.pdf

[42] Washington State Diabetes Connection. 2019 Community Health Worker Conference. Retrieved April 17, 2019, from https://diabetes.doh.wa.gov/Events/EventID/203/CRC/B9C7CBE282AA89BE08C420F13FAE7361/2019-Community-Health-Worker-Conference

[43] Centers for Disease Control and Prevention. Diabetes Prevention Impact Toolkit. Retrieved April 17, 2019, from https://nccd.cdc.gov/Toolkit/DiabetesImpact/

[44] National Association of Chronic Disease Directors. Establishing and Operationalizing Medicaid Coverage of Diabetes Self-Management Education and Support: A Resource Guide for State Medicaid and Public Health Agencies. April 2019. Retrieved November 20, 2019, from: https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/website-2019/diabetesselfmanagementeducat.pdf

[45] Washington State Diabetes Connection. World Diabetes Day Washington. Retrieved April 17, 2019, from https://diabetes.doh.wa.gov/Events/EventID/10/CRC/3DE3985CB26B2D1FDC95C6791AED8C65/World-Diabetes-Day-Washington

[46] Washington State Diabetes Connection. World Diabetes Day Washington Social Media Toolkit. Retrieved April 17, 2019, from https://diabetes.doh.wa.gov/Portals/13/Doc/WDDWashingtonSocial-Media-Toolkit.pdf?ver=2017-10-13-111224-073

[47] Population Health Guide. Healthier Washington Collaboration Portal. Retrieved November 17, 2019 from https://waportal.org/population-health-guide

[48] Auerbach J. The 3 Buckets of Prevention. J Public Health Manag Pract. 2016;22 (3):215–218.

[49] Office of the Governor. Executive Order 13-06: Improving the Health and Productivity of State Employees and Access to Healthy Foods in State Facilities. Published October 30, 2013. Retrieved April 17, 2019, from www.hca.wa.gov/assets/program/ExecOrder-13-06.pdf

[50] The National Diabetes Prevention Program. Retrieved April 17, 2019, from www.chronicdisease.org/mpage/domain4_ndppreso

[51] Health Care Authority. Diabetes prevention. Retrieved April 17, 2019, from www.hca.wa.gov/about-hca/washington-wellness/diabetes-prevention

[52] Medicare Diabetes Prevention Program (MDPP) Expanded Model. Retrieved November 20, 2019, from https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

[53] Increase in participation in VDPP from in-person DPP. Retrieved April 17, 2019, from www.ajpmonline.org/article/S0749-3797(18)32104-4/fulltext

[54] Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, Hamman RF, Christophi CA, Hoffman HJ, Brenneman AT, Brown-Friday JO, Goldberg R, Venditti E, Nathan DM. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. Lancet. 2009; 374(9702):1677–86. doi: 10.1016/S0140-6736(09)61457-4. Epub 2009 Oct 29. Retrieved April 17, 2019, from www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022

[55] Tuomilehto J, Lindstrom J, Eriksson J, et al.; Finnish Diabetes Prevention Study Group. Prevention of type2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. N Engl J Med 2001; 344:1343–1350. Retrieved April 17, 2019, from www.ncbi.nlm.nih.gov/pubmed/11333990

[56] Wilson, M. G., HSD, MS, Castro Sweet, C. M., PhD, Edge, M. D., PhD, Madero, E. N., MS, McGuire, M., BA, Carpenter, D., MPH, & Kirschner, S., BA. (August 2017). Evaluation of a Digital Behavioral Counseling Program for Reducing Risk Factors for Chronic Disease in a Workforce. Journal of Occupational and Environmental Medicine, 59(8), E150-E155. doi:10.1097/JOM.0000000000001091. Retrieved April 17, 2019, from https://journals.lww.com/joem/Fulltext/2017/08000/Evaluation_of_a_Digital_Behavioral_Counseling.20.aspx

[57] www.doh.wa.gov/Portals/1/Documents/1000/SSB6569_Patient-Out-of-Pocket-Costs_Taskforce_Report.pdf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