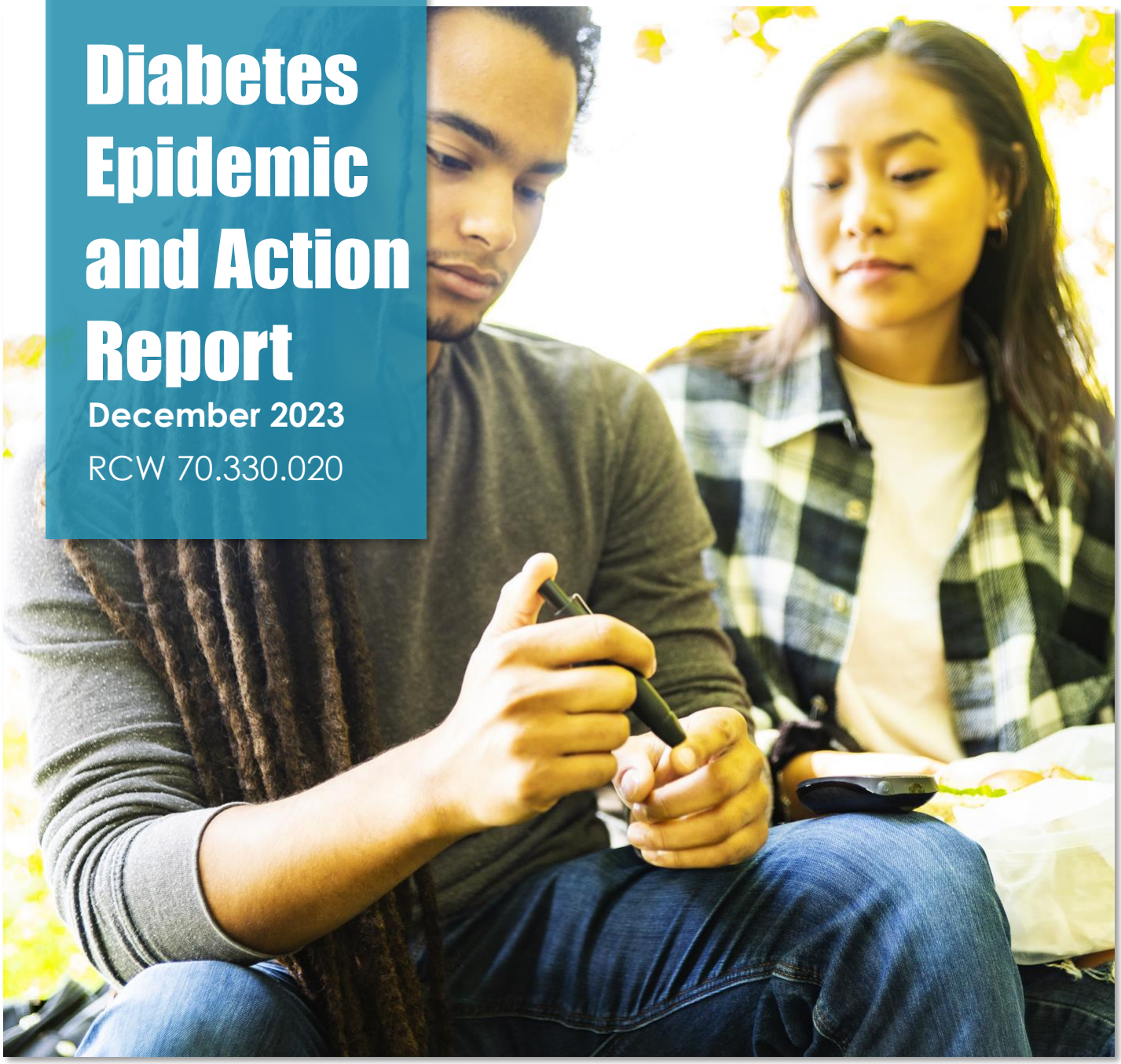
Report to the Legislature

Diabetes Epidemic and Action Report

December 2023

RCW 70.330.020



Washington State Department of HEALTH

Washington State Health Care Authority

Washington State Department of Social & Health Services

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Previous Reports
2021 Diabetes Epidemic Action Report
2019 Diabetes Epidemic Action Report

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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 (Appendix A). The law directs the agencies to describe:

1. The impact of diabetes on agency programs.
2. The benefits of programs addressing diabetes administered/coordinated between the three state agencies.
3. Action plans for addressing diabetes, including considerations for the legislature.

Impact of Diabetes in Washington

The term diabetes refers to a complex group of metabolic diseases all related to harmfully high blood glucose levels. One in eleven adults (531,250) in Washington has been diagnosed with a type of diabetes.[1] Diabetes also carries significant financial costs (medical treatment and reduced productivity) equal to $6.7 billion for Washington state during the 2021-2023 biennium.

Programs Addressing Diabetes

During the 2021-2023 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

This report lists action plans to address diabetes in Washington. It includes steps to manage the health and economic impact of diabetes, current and ongoing work to prevent type 2 diabetes, and ways to control associated costs and resources. Where relevant, these plans contain **considerations for the legislature** that include:

- Expand networks of providers to include pharmacists trained to provide self-management education and medication management.
- Support policies that compensate for culturally appropriate community-based efforts that utilize community health workers in diabetes self-management and prevention.
- Increase resources for early identification of type 1 and type 2 diabetes, monitoring and evaluating diabetes-related care, and the health status of those with diabetes.
- Fund a study on barriers to care caused by increasing out-of-pocket costs associated with diabetes management in partnership with the Office of the Insurance Commissioner.
- Increase resources to support Multi-state EHR-based Network and Disease Surveillance (MENDS) and other related projects to collect more accurate data on prevalence of diabetes among Washingtonians.
- Invest in evidence-informed type 1 and type 2 diabetes screening health promotion and chronic disease prevention for children and youths ages birth to 18 years, in collaboration with state agencies serving youth.
- Expand access to telehealth services, options for home-based testing, and prescription delivery services.
- Continue to fund existing initiatives to improve health equity and address social determinants of health, which particularly impact people with diabetes.

Introduction

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. This report contains:

- The financial impact and reach that diabetes has on programs administered by each agency and individuals enrolled in those programs.
- An assessment of the benefits of implemented programs and activities aimed at managing diabetes and preventing the disease.
- A description of the level of coordination existing between the agencies.
- A development or revision of detailed action plans for battling diabetes, with a range of actionable items for consideration by the legislature.
- An estimate of costs and resources required to implement the action plans.

The full text of the statute is included in Appendix A. This report contains information from the three named agencies for diabetes programming over the course of the 2021—2023 biennium.

Background

Diabetes Mellitus, also known as diabetes, is a chronic condition that refers to a complex group of diseases all related to harmfully high blood glucose levels. When uncontrolled, high blood glucose levels can damage the eyes, heart, kidneys, nervous system, and other organs. Uncontrolled blood glucose greatly increases risk of heart disease, stroke, kidney disease, and other adverse health outcomes, especially if a person also has high blood pressure and other risk factors. There is no cure for diabetes, but it can be managed. Health care services including Diabetes Prevention Programs (DPP) and Diabetes Self-Management Education and Support (DSMES) can improve outcomes for prevention and management of diabetes.

Type 1 diabetes, Type 1 diabetes is an autoimmune disease that causes destruction to the insulin-producing cells in the pancreas and accounts for 5-10% of all people with diabetes nationally. People with clinical type 1 diabetes will eventually need to take insulin via multiple daily injections or continuous insulin pump to stay healthy. We do not know the exact cause of type 1 diabetes. There are ways to screen for type 1 diabetes, and a new therapy was approved recently to delay onset of clinical type 1 diabetes in certain patients.

Type 2 diabetes happens when the pancreas does not make enough insulin, the cells in the body do not interact with insulin properly, or both. Type 2 diabetes accounts for 90–95% of all diagnoses nationally. There is no cure for type 2 diabetes. In certain cases, it can be managed or prevented by losing weight, following a well-balanced meal plan, and keeping physically active. If diet and exercise aren't enough, a provider may recommend medication or insulin.

Prediabetes means having blood glucose levels higher than normal, but not high enough to be classified as diabetes. Prediabetes is largely asymptomatic and is diagnosed through blood tests. Prediabetes is a metabolic diagnosis and not autoimmune in nature. People with prediabetes have negative diabetes autoantibodies (no evidence of type 1 diabetes) and a much greater chance of developing type 2 diabetes or gestational diabetes. Those with prediabetes are also at higher risk of cardiovascular disease. Prediabetes indicates that abnormalities in glucose levels have begun but may be reversed.

Gestational and maternal diabetes occur during pregnancy and affect about 7% of pregnant people. Gestational diabetes develops during pregnancy and maternal diabetes occurs when someone had diabetes (type 1 or 2) prior to becoming pregnant. Both gestational and maternal diabetes can create serious threats to parent and baby. Risks include premature birth, preeclampsia (high blood pressure and other factors during pregnancy), higher risk of birth injury, or Caesarean (c-section) delivery. Both gestational and maternal diabetes can be managed with appropriate prenatal care. People who have had gestational diabetes are at increased risk of developing type 2 diabetes.

Impact of Diabetes in Washington

In 2021, about 531,250 Washington adults (9 percent) had a diagnosis of diabetes. 46,750 were newly diagnosed.[2] Diabetes contributed to 105,020 hospitalizations in 2021 and was the 8th leading cause of death in 2020.[3,4]

Additionally, 691,230 Washington adults (or 11 percent) had a diagnosis of prediabetes in 2021.[2] Nationally 38 percent of adults have prediabetes. This means it is very likely that many people in Washington may not know they are prediabetic.[5] Among those who have developed prediabetes, 15-30% could develop type 2 diabetes in the next five years unless they make changes to their diets and levels of physical activity.[6,7] For additional information on the impact of diabetes in Washington, see the Heart Disease, Stroke, and Diabetes Data and Publications webpage.

Diabetes also carries significant financial costs to the state (medical treatment and reduced productivity) - equal to $6.7 billion for Washington state during the 2021-2023 biennium. Understanding the impact of diabetes continues to become more difficult as historical surveillance methods are becoming out of date and not capturing information from population most affected by diabetes.

Program Assessments

This section contains information for each agency's programmatic impacts, expenditures, and benefits. There is overlap across many programs in the three agencies.

Department of Health

DOH addresses diabetes and prediabetes in many ways. Many of these initiatives are funded by and coordinated with the Centers for Disease Control and Prevention (CDC)'s Heart Disease, Stroke, and Diabetes Prevention Program, which focuses on adults.

Detailed documentation of the amount and source of these programs and benefits is included in this section's table. Overall, program activities to address these initiatives include:

- Increasing access to and participation in recognized Diabetes Self-Management Education and Support (DSMES) programs. These programs have been shown to improve diabetes management, reduce complications of diabetes, and reduce associated costs.[8]
- Increasing participation in nationally recognized Diabetes Prevention Programs (DPPs).
- Implementing systems to identify people with prediabetes for referral to DPPs.
- Increasing access to Chronic Disease Self-Management Programs (CDSMP).
- Facilitating research to determine feasibility of predicting type 1 diabetes in children as part of the Newborn Screening Program.
- Working with other state agencies and partners to develop a new system to collect diabetes-related data that will provide essential information and capacity to prevent and treat diabetes in Washington State.

As a result of this work, DOH has worked to:

- Track improvements in access to and participation in evidenced based programs that include CDSMP, DPP, and DSMES.
- Increase the proportion of adults in Washington state with prediabetes who are aware they have the condition, from 7 percent in 2011 to 11 percent in 2021.[9]
- Partner with multiple organizations across the state to promote awareness campaigns that aim to decrease the impact of diabetes in Washington.

Table 1: Improving Health through Prevention and Management of Diabetes (DP18-1815)

Overview	Program & Benefits
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) July 2021 - June 2023	**Diabetes Self-Management Education & Support** Goal: Increase access to and participation in DSMES in community settings to improve diabetes management and reduce complications of diabetes among adults. **Realized Benefits** • By the end of June 2023, 36 organizations offered DSMES programs that have been approved for Medicaid reimbursement, representing 151 sites in Washington.[10] • The annual number of individuals visiting a recognized DSMES program grew from 25,314 in 2020 to 31,607in 2022 (24.9% improvement).[11]

Funding Source

CDC Cooperative agreement

Total Expenditures

$4,302,328

(for both prevention and control activities)

NOTE: The expenditures do not include essential in-kind contributions from partner organizations.

Diabetes Prevention Program

Goal: Increase use of DPP in community settings among adults.

Realized Benefits[12,13,14]

- As of January 2023, there are 23 recognized organizations offering DPP in Washington State:
  - 6 organizations are Medicare DPP, 6 have full recognition, 6 have full plus recognition and 5 have pending recognition.
  - 18 programs are offered in person, 1 is offered online and 4 are distanced learning programs.
    - (Note: Online delivery is defined as participants logging into sessions via a computer, tablet, or smartphone, with coach interactions taking place outside of the self-paced sessions. Distance-learning delivery is defined as the coach being present in one location and participants simultaneously calling in/videoconferencing from another location).
- Enrollment grew by 5.2%, with 1,223 more people participating in the program. Enrollment grew from 23,631 in January 2022 to 24,854 in January 2023.

Chronic Disease Self-Management Program (CDSMP)

Goal: Increase use of CDSMP in community settings and health systems.

Realized Benefits

- Supplied books and resources to four organizations that provide CDSMP services via telehealth in response to COVID-19 pandemic.
- Held 257 workshop participants with 184 completers.
- Supported the beginning of a statewide network to connect CDSME providers and provide infrastructure and support for continued program delivery.
- Supported the purchase of a Compass license to support a program locator and data management system for evidence-based programs.

Diabetes prevention and management at DOH has not been limited to programs funded by CDC's Heart Disease, Stroke, and Diabetes Prevention Program. Other programs within DOH that help decrease the impact of diabetes include:

- Fruit & Vegetables Incentives Program, which provides means for low-income individuals and families to gain access to healthy foods like fruits and vegetables.
- State physical activity and nutrition programs, which have allowed the state to work on equitable and sustainable solutions to improve nutrition, increase physical activity, and support breastfeeding in early learning, schools, communities, worksites, and health care settings. Federal funding for this program ended in 2023.
- According to a U.S. Surgeon General Report (pg. 537-545), commercial tobacco use is a direct cause of type 2 diabetes and for those who smoke they are 30-40% more likely to develop the disease. DOH's Commercial Tobacco Prevention Program focuses on several initiatives to reduce tobacco use and its adverse effects, such as chronic disease, among diverse populations in Washington state including youth and people with behavioral health disorders.
- Diabetes surveillance, which includes working with HCA and OneHealthPort on the MENDS Project to gather diabetes data to better inform diabetes impact in the state of Washington.

Department of Social & Health Services

DSHS provides services and resources to help improve clinical outcomes for children and adults with diabetes. As with DOH, most DSHS services address chronic diseases in general or offer personalized care for each client or patient, many of whom have diabetes, instead of focusing solely on diabetes. DSHS has focused efforts on high-health-risk, high-cost patients who are dually enrolled in Medicare and Medicaid. 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 client engagement, family and caregiver support and training, and transitional care support for hospital discharge to skilled nursing care and non-institutional community settings to improve outcomes for clients with diabetes and other health conditions. See tables below for details on these programs.

The data below is for 2022 since this is the last full year that data was available for publication.

Table 2: Medicaid Health Home

Overview

Health Home services promote person-centered health action planning to empower clients to take charge of their own health.

Since 2013

Funding Source

Centers for Medicare and Medicaid Services (CMS)[15]

Program & Benefits

The program serves clients of all ages who have at least one chronic condition and are at high risk of others. Diabetes is one of the identified chronic conditions. DSHS and HCA partner on this effort.

Realized Benefits

- The program was implemented in 37 counties in 2013. In 2017 it expanded to include King and Snohomish counties, making the program available statewide.
- As of December 2022, 10,159 individuals were 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
- Medicare savings of $331.8 million between 2013 and 2020.

Table 3: Care Transitions Program

Overview

Coordinate with hospitals to decrease participant readmission rates and improve health and chronic condition self-management using a coaching model.

Funding Source

Program & Benefits

Individuals participating in care transitions programs commonly have multiple chronic conditions including diabetes. Local Area Agencies on Aging and hospitals administer these programs.

Realized Benefits

Care Transitions Programs	Studies 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.

Table 4: Family Caregiver Support Program and Medicaid Alternative Care

Overview

The program offers an evidence-based caregiver assessment, consultation, and care planning process (TCARE®).

Since 2000

Funding Source

Title III E of the Older Americans Act

Healthier Washington Medicaid Transformation Project

Medicaid 1115 waiver authority

Total Expenditures

$24,104,255

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 2022, approximately 13,738 caregivers received one or more caregiver support services
- Delay and diversion from more intense Medicaid-funded Long Term Support Services
- Improved health and well-being of caregivers, including statistically significant reductions in depression

Table 5: Long-Term Care Support Services (LTCSS)

Overview

Community First Choice (CFC) provides personal care in individuals' private residences and in community-based residential care settings.

Funding Source

Title XIX federal funding through a 1915(k) state plan amendment and state funding, CARE & ProviderOne DataMart

Total Expenditures

$4.29 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). Priority attention is given to low-income individuals and families. 73% of the clients in Community First Choice programs have a diagnosis of diabetes.

Realized Benefits

- In 2022, the CFC provided personal care support to more than 102,000 clients.
- Provides services to more than 62,000 individuals in their own homes and community residential settings and provides an alternative to more expensive nursing facility care.
- Approximately 40,000 individuals hire family or friends to provide personal care services. Services include medication management and skilled tasks provided by an eligible caregiver, such as a spouse, relative, or friend responsible for caring for an adult with a functional disability who does not receive financial compensation for the care provided.

Table 6: Chronic Disease-Self Management Education (CDSME)

Overview

Workshops and classes provided in community settings. Participants make weekly action plans, share experiences, and support each other.

Since 2010

Funding Source

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

Total Allocations

$840,000

Program & Benefits

DSHS provides service coordination among agencies to deliver 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.

Realized Benefits

- 257 workshop participants (with 184 completing the workshop).
- Virtual CDSME programming made available in response to COVID-19 pandemic.
- Beginning a statewide network to connect CDSME providers and provide infrastructure and support for continued program delivery.
- Purchased an umbrella license for statewide use.
- Implementation of a program locator and data management system.

Table 7: Skilled Nurse Waiver Program

Overview

Skilled Nursing Services provide direct skilled and intermittent nursing tasks to clients living in a community setting under the supervision of a registered nurse.

Funding

Source

ProviderOne Authorizations DataMart

Total Allocations

$739,000

Program & Benefits

Skills may include glucose monitoring, insulin administration, and wound care.

Realized Benefits

- 397 individuals currently benefit from the Skilled Nursing program (Increase from 339 in the previous report).
- Provides safety, comfort, and convenience to patients unable to travel but still have medical needs making sure patients receive the right care at the right time using evidence-based practices and standards of care.
- High quality care in a home setting for lab draws, wound care, IV therapy, catheter placement and care, injections, medication management, and skilled tasks as directed by physicians.

Table 8: Nurse Delegation Program

Overview

Registered nurse delegators delegate specific nursing care tasks to long-term care workers.

Program & Benefits

Enhances client choice and quality of care in a community-based setting. Delegated tasks include blood glucose monitoring, insulin injections, and

Funding

Source

ProviderOne Authorizations DataMart & Health and Human Services

Total Allocations

$21,954,000

diabetes education. The nurses support, supervise, teach, and assess caregivers, which allows clients to safely manage their diabetes.

Realized Benefits

- The program serves 14,607 people and contracts with approximately 398 independent nurses in the community.
- Of the 14,607 people successfully served through nurse delegation, over 4,000 have a diabetes-related diagnosis.
- Nurse delegation allows individuals to have their needs met in their own homes and community settings.

Table 9: Fostering Well-Being (FWB) Care Coordination Unit

Overview

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 years.

Funding

Source

Managed though the state Health Care Authority

Program & Benefits

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

HCA administers Washington Apple Health (Medicaid) and both Public Employees Benefits Board (PEBB) and School Employee Benefits Board (SEBB) programs. In this section, HCA provides information about:

- The reach and financial impact of diabetes in HCA-administered programs.
- Costs and benefits of HCA programs to prevent or manage diabetes and its complications.

People with Diabetes in HCA-Administered Programs

Apple Health

From July 2021-June 2023, approximately 2,611,396 Washingtonians were enrolled in Washington Apple Health (Medicaid). During this period, 164,585 Apple Health clients — about 6.3 percent of the total enrollees — had diabetes. Of those clients, 63,786 had both diabetes and other chronic diseases. Total health care service expenditures for clients with diabetes exceeded $6.02 billion during the 2021-23 biennium. Average total health care service expenditures for clients with both diabetes and other chronic diseases were about twice as great as per-client expenditures for clients with either diabetes or other chronic diseases.

Table 10 – Counts of Apple Health Clients with Diabetes, Other Chronic Diseases, or Both from July 2021 through June 2023, and Health Care Expenditures[16]

Apple Health Population	Client Count	Percent of Apple Health Clients	Total Health Care Expenditures	Total Expenditures per Client	Disease-Related Expenditures	Disease-Related Expenditures per Client
Clients with diabetes, without other chronic diseases	106,570	4.07%	$2,888,127,345	$27,101 (Median = $8,128)	$314,592,825	$2,952 (Median = $494)
Clients with both diabetes and other chronic diseases	66,079	2.53%	$3,574,973,266	$54,102 (Median = $26,421)	$741,453,024	$11,221 (Median = $1,297)
Clients without diabetes, with other chronic diseases	221,689	8.48%	$5,683,185,762	$25,636 (Median = $6,009)	$649,267,273	$2,929 (Median = $359)

Uniform Medical Plan

HCA contracts with Regence BlueShield to administer the Uniform Medical Plan (UMP), which serves a majority of PEBB and SEBB members. Table 11 below shows that about 29,630 UMP members in PEBB and about 6,317 UMP members in SEBB had diabetes with or without other chronic diseases from July 2021 through June 2023. Of those in PEBB, 3,568 had diabetes with other chronic diseases. Of those in SEBB, 347 had diabetes with other chronic diseases. Disease-related expenditures during that biennium for clients with diabetes (with or without other chronic conditions) were over $84 million for members in PEBB and were over $27 million for members in SEBB.

Table 11 – Counts of Uniform Medical Plan Members with Diabetes, Other Chronic Diseases, or Both from July 2021 through June 2023, and Disease-Related Health Care Expenditures[17]

UMP Population	Member Count	Percent of UMP Members	Total related health care service expenditures	Total health care expenditures per Member
Clients with diabetes, without other chronic diseases	PEBB = 26,062	7.6%	$78,234,795	$2,791
	SEBB = 5,970	4.1%	$25,623,630	$4,109
Clients with both diabetes and other chronic diseases	PEBB = 3,568	1.0%	$6,683,334	$1,775
	SEBB = 347	0.2%	$2,282,752	$6,542

Table 11 – Counts of Uniform Medical Plan Members with Diabetes, Other Chronic Diseases, or Both from July 2021 through June 2023, and Disease-Related Health Care Expenditures[17]				
UMP Population	**Member Count**	**Percent of UMP Members**	**Total related health care service expenditures**	**Total health care expenditures per Member**
Clients without diabetes, with other chronic diseases	PEBB = 28,999	8.4 %	$115,225,609	$3,864
	SEBB = 6,127	4.2%	$38,574	$6,116

Note: Numbers are understated due to timing of data availability.

HCA Programs to Prevent or Manage Diabetes and Its Complications

During the 2021-2023 biennium, HCA participated in the implementation or continuation of multiple programs to prevent or manage diabetes and its complications as part of its Employee and Retiree Benefits (ERB) and Apple Health programs.

Employee and Retiree Benefits

All PEBB and SEBB health plans contracted with HCA prioritize the care and management of diabetes through innovative value-based purchasing. HCA uses the national Healthcare Effectiveness Data and Information Set (HEDIS) of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA) to assess the status of disease management by population, evaluate the impact of current programs, and prioritize new incentives for continued improvement. Performance results compiled annually are also referenced to plan new initiatives for member level intervention and outreach, as well as to target members that may have gaps in care. Programs and initiatives for PEBB and SEBB members with diabetes are available through each of our contracted payers. These include, but are not limited to:

- Nutritional Counseling and Therapy
- Virtual Diabetes Prevention Programs (VDPP)
- Care Management
- Value-Based Purchasing
- SmartHealth initiatives
- Hemoglobin A1c (HgA1c) home test kits to check for diabetes control

Virtual Diabetes Prevention Programs - HCA offers a Virtual Diabetes Prevention Program (VDPP) benefit to PEBB and SEBB plan subscribers and their dependents ages 18 years and older who are not enrolled in Medicare. The 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 with a dedicated health coach.[18] These changes can reduce the risk of developing type 2 diabetes by almost 60 percent.[19] Use of a virtual format lowers barriers to participation by enabling 24-hour access to the program statewide. See Table 12 for additional information.

Kaiser Permanente and Premera offer Virtual Diabetes Management Programs (VDMP) to eligible PEBB and SEBB plan subscribers and their dependents who are not enrolled in Medicare. These VDMP benefits provide a professional health coach, Bluetooth enabled scale, glucose meter and strips, weekly online lessons, and may offer a small online community of peers with similar health conditions. VDMP can help members improve:

- Nutrition
- Physical activity

- Motivation to sustain behavior changes
- Stress management
- HgA1c level

Uniform Medical Plan (UMP) did not offer a VDMP during the 2021-2023 biennium. Funding for a VDMP for the SEBB population ONLY will be provided beginning in 2024.

Table 12: Uniform Medical Plan VDPP Summary Information[20]

Overview

UMP Virtual Diabetes Prevention Programs (Powered by Omada)

Jan 2019 - present

Enrollment

1,355 PEBB and SEBB members

Calendar Year 2022

Funding

Source

Claims budget Uniform Medical Plan

Total Expenditures

Regence monthly premiums includes the expenditures

Program & Benefits

Realized Benefits

VDPP benefit to PEBB plan subscribers started on January 1, 2019, and began enrolling SEBB subscribers on January 1, 2020.

On average, members engage in the program about 29 times per week by participating in activities such as using their Bluetooth enabled scale, messaging their coach, and logging their food intake.

During the calendar year 2022, members' combined weight loss was 8,505 pounds.

NOTE: Someone could have been enrolled in two or more VDPPs during the biennium. This table does not contain data from Kaiser Permanente or Premera Blue Cross about their VDPPs.

Care Management:

UMP offers an option for eligible members to self-refer to a Diabetes Control Program (DCP) administered by the Care Management Program at Regence. The DCP is exempt from the medical deductible and provides access to Case managers who are trained to help reduce the risk of complications of diabetes by tracking and managing blood glucose, cholesterol levels, blood pressure, and weight in a series of quarterly consultations.

UMP members get newsletter education for specific conditions like diabetes twice per year. They also have access to related information through SmartHealth opportunities that help them manage and understand their conditions.

Care Gap Closure Program:

The Care Gap Closure Program encourages members to receive recommended preventive and chronic care services and screenings, also known as "gaps in care." These include screenings for diabetes at no cost to members. Support includes helping members find a primary care provider, making appointments, helping members understand their benefits, and providing members ongoing support through case management.

Pharmacy Initiatives:

Continuous glucose monitors (CGM) for Uniform Medical Plan

CGMs are devices that automatically estimate blood glucose levels in real time. The information allows patients to make better decisions about their food and beverage choices, physical activity, and what medications to take. In 2022, UMP began covering CGMs for non-Medicare members exclusively through the pharmacy benefit. This decreased costs to the plan, member cost shares, and improved access. In the first year, 2,504 UMP members got CGM or associated supplies through the pharmacy benefit. Previously, CGMs were only available from the preferred durable medical equipment (DME) supplier through medical benefits. UMP members now get their CGM and supplies through any network pharmacy, including the plan's mail order pharmacies. CGMs continue to be available for Medicare members through the Medicare Part B benefit.

UMP Pharmacoadherence program for diabetes

Taking medications as directed improves blood glucose levels and minimizes the risk of long-term complications associated with diabetes. In 2022, UMP identified 2,897 members with diabetes who were non-adherent to their diabetes medications based on a review of how often they filled their prescriptions. Letters were sent to members and their primary care physician, emphasizing the importance of taking medications consistently and as prescribed. Six months after mailing the letters, UMP found that 50% of members improved their adherence by having medications for at least 80% of days.

Value-Based Purchasing

HCA uses value-based purchasing to promote health care quality and lower costs in all Apple Health Managed Care Organization (MCO), PEBB, and SEBB contracts. Apple Health MCOs and PEBB and SEBB carriers are financially incentivized to improve members' health. Incentives are determined using performance measures in HEDIS. HCA prioritizes diabetes HEDIS measures, aligning across HCA purchasing contracts, where appropriate.

Overall performance for diabetes care improved for all PEBB and SEBB carriers during the 2021-2023 biennium. Rates for diabetes measures improved for all commercial carriers and all but one carrier's performance were higher than the national 75th percentile and in many cases over the 90th.

Due to high performance of diabetes care, diabetes care measures are no longer on the list of value-based purchasing measures for the MCOs because it's more advantageous to incentivize performance in other lower-performing areas. However, reporting is still required and monitored.

Apple Health Diabetes Education Programs

Apple Health programs provide outpatient hospital-based diabetes education to help clients manage their diabetes. Diabetes education teaching curriculum must have measurable, behaviorally-stated educational objectives, including:

1. An overview of diabetes.
2. Nutrition education, including individualized meal plan instruction apart from the Women, Infants, and Children 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.

HCA pays for up to six hours of individual "core survival skills" outpatient diabetes education per calendar year per client. [21] Additional hours can be requested through prior authorization. For more info, see the July 2021 Washington Diabetes Education Program Billing Guide.[22] See Table 13 for more info on education programs.

Table 13: Apple Health Diabetes Education Programs Summary Information[23]

Overview

Apple Health Managed Care/Fee-for-Service Diabetes Education Program

Jan 1998 - present

Enrollment

9,825 clients

July 1, 2021- June 30, 2023

Funding

Source
State and Federal Medicaid Funds

Total Expenditure
$242,694

Program & Benefits

Provide medically necessary diabetes education to Managed Care and Fee-for-Service Apple Health clients with diabetes.

Realized Benefits

Enrolled clients received information to help them manage their diabetes. 9,480 clients in managed care and 1,941 clients in fee-for-service received DSMES services. The State spent a total of $844,236 on managed care and $46,095 in fee-for-service. Average Expenditures per enrolled Person was $89 in managed care and $24 in fee-for-service.

NOTE: Enrollment and expenditure data are approximate, as it takes time to process claims.

Collaboration Between State Agencies

During the 2021-2023 biennium, DOH, DSHS, and HCA worked together to address diabetes and its complications. These efforts included:

1. **Washington Health Home Program**
   The Medicaid Health Home state plan option became available to states in 2011. This allows states to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. In 2013, Washington was one of the first states to adopt the Medicaid Health Home model, which operates in 22 states and the District of Columbia.[24] Since then, DSHS, the Centers for Medicare and Medicaid Services (CMS) and HCA have collaborated on the Medicaid Health Home Program. The program promotes individualized, person-centered health action planning to empower clients to take charge of their own health care.[25, 26] It serves clients of all ages who have at least one chronic condition and are at risk of developing additional conditions. DSHS

administers the program and HCA funds it. DOH supports the program by training care coordinators on diabetes and hypertension. The program was first piloted in 2013 and was made available statewide in 2017.

2. **Washington State Cardiovascular Disease and Diabetes Network Leadership Team (CDNLT)**
CDNLT members work in public, private, tribal, community, academic, and training sectors to prevent and manage diabetes.[27] The CDNLT members meet quarterly to identify priorities and develop strategies that align with the missions and goals of the participating organizations.[28] DOH, DSHS, and HCA participate on the CDNLT. Some successes the CDNLT achieved in the 2021-2023 biennium include:

    - Collected and shared information to state partners about the various roles of health care system partners and how they contribute to diabetes management.
    - Supported the development of the Great 8 visual-based communication tool. This tool improves diabetes and cardiovascular health communications between community health workers, health professionals, and patients. Great 8 is especially helpful for patients with low health literacy and limited English proficiency.
    - Supported hosting the Great 8 tool on the WA Portal on the Cardiovascular Connection site. This tool is now available in 37 languages and is available in 3 formats including a "mobile-friendly" version that can be used with clients over the phone.
    - Collaborated with Care Connect Washington to provide training for community hubs about chronic conditions, prediabetes, and diabetes.
    - Worked with Care Connect community hubs to create a standardized screening tool for social determinants of health. The tool helps Community Health Workers assist people to address social determinants of health so they can better manage or prevent diabetes.
    - Worked with two Accountable Communities of Health (ACHs), Better Health Together and Elevate Health Accountable Communities of Health, to support a bi-directional referral system between community partners and the healthcare system.

3. **Medicaid Transformation Project (MTP 1.0), Initiative 1: Delivery System Reform Incentive Payment (DSRIP) program and MTP renewal (MTP 2.0).**
DSHS and HCA together coordinate the operations of the Medicaid Transformation Project (MTP). In 2017, Washington state and the Centers for Medicare & Medicaid Services (CMS) finalized an agreement to improve the state's health care systems, provide better health care, and control costs. Through December 2021, the state received up to $1.5 billion in federal investment to restructure, improve, and enhance the Apple Health service delivery system. The Section 1115 Medicaid demonstration waiver (called the "MTP 1.0") was originally set to end December 31, 2022. CMS approved an extension of MTP 1.0 through June 30, 2023.

    Examples of programs and strategies to address diabetes and its complications under MTP 1.0 include:

    - Nine regional Accountable Communities of Health (ACHs) form robust organizations under which several 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.
    - DSHS is administering the Family Caregiver Support Program. The objective is to support families caring for loved ones while increasing or maintaining the well-being of the caregiver.

- 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 originally was 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.

On June 30, 2023, CMS renewed MTP for another five years, beginning on July 1, 2023 (called "MTP 2.0"). Under MTP 2.0, existing MTP programs (under MTP 1.0) will continue or expand. Examples of programs and strategies to address diabetes under MTP 2.0 include:

- A lack of coverage or access to services may have a negative, cumulative effect on achieving health and wellbeing through subsequent life stages. Access to coverage and services reduces the need for costly, invasive care and improves health outcomes and community integration. High-risk, historically under-resourced populations may benefit most from strategies tailored to address life stages and transitions:
    - Continuous Apple Health enrollment for children: Washington has new federal authority to provide continuous enrollment in Medicaid for young children who have incomes below 215 percent of the federal poverty level (FPL) at the time of application through the first six years of life.
    - Re-entry coverage for continuity of care: Washington can authorize federal Medicaid matching funds to provide services for people who are soon to be released from prisons and jails. This set of services will be provided in the 30-day window prior to the person's release for eligible justice-involved populations, as well for individuals confined in state hospitals or mental health treatment institutions who are discharged to the community. Services include a 30-day supply of medication and medical equipment as people are reentering the community.
    - Apple Health postpartum coverage expansion: Washington is approved to authorize federal Medicaid matching funds to provide 12 months of continuous postpartum coverage for eligible individuals.
- Health Related Social Needs (HRSN) Services (formerly referred to as social determinants of health): HRSN services include things such as nutrition supports, housing supports, home modifications, and respite services. To address gaps and broaden the continuum of available HRSN services and support in Washington, the state has two new Medicaid authorities. First, the state will implement in-lieu of services (ILOS) for the managed care population to allow HRSN services to be covered as a medically appropriate substitute for certain state plan services. Second, the state received authority to cover a similar set of services for fee-for-service Apple Health enrollees.

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.[29] Through this current partnership, DOH manages the processing of provider applications for this program. HCA reimburses the providers for their services. As of August 2021, there are 56

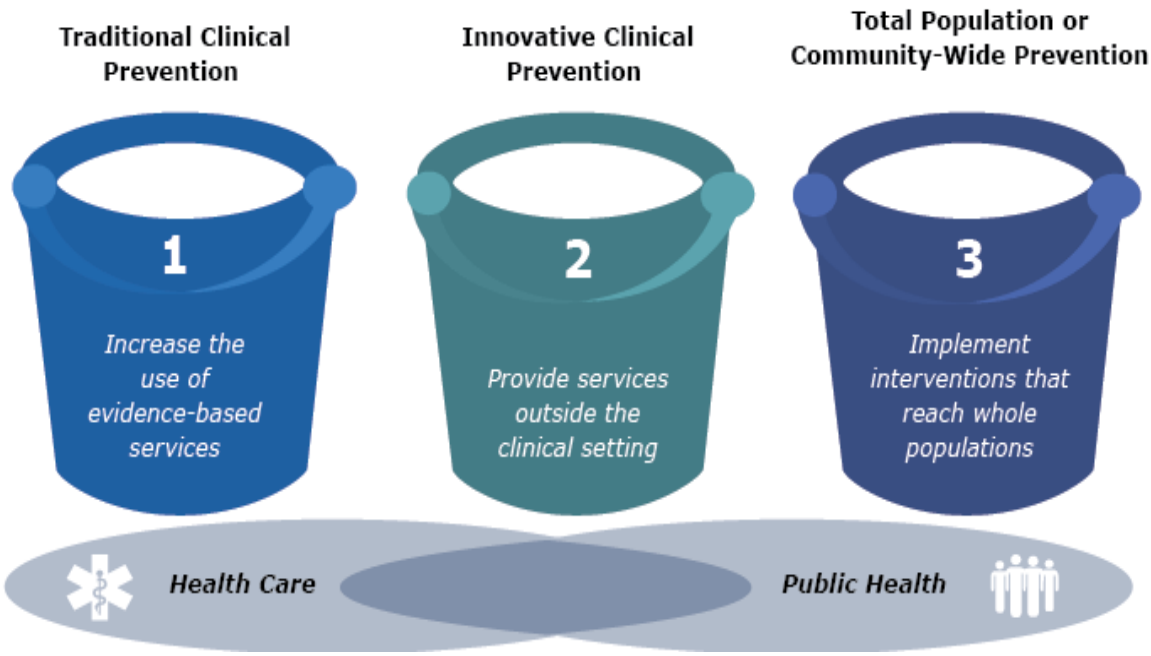
active programs at 135 active sites that can bill Medicaid for fee-for-service diabetes education. Agencies collaborated by:

- 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**
   National Diabetes Month and World Diabetes Day occur every November.[30] 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 2021 and 2022.[31]

6. **Federal grants received through partnership**
   Strong partnerships between agencies resulted in federal grant awards to support chronic disease self-management programs that also support people with diabetes and prediabetes in Washington. 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 Prevention and Public Health Funds (DP 18-1815) cooperative agreement in 2018. The funding was awarded based on key partnerships, and strong commitment to promoting health equity. This funding advances the work of increasing access to DSMES programs in underserved areas; partnering with DSHS-ALTS to improve access to and participation in CDSME; increasing the engagement of pharmacists to support adults with diabetes; assisting health care organizations, including community health centers, in identifying adults with prediabetes and referring them to recognized DPP; and supporting statewide infrastructure to promote long-term sustainability and financing CHW in diabetes prevention and management.

Agency Action Plans



This section includes updated strategic plans to address diabetes from DOH, DSHS, and HCA. It also includes a cross-agency plan with action steps aimed at controlling and preventing relevant forms of diabetes. One framework for organizing solutions is the Three Buckets of Prevention,[32] (above, source: CDC) used by Healthier Washington's Population Health Planning Guide[33] as well as the CDC.

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

Department of Health

DOH's Diabetes Action Plan aligns with the agency's Transformational Plan and focuses on population health strategies that impact diabetes and its risk factors. The Washington State CDNLT is a key partner in the successful implementation of these action plans. The timeline for the below action items is through June 2023.

Table 14: Department of Health Action Plan Summary Information

Action 1	Expected Outcome	Benchmark
Strengthen self-care practices by improving access, cultural appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority populations. **Prevention Areas** 1 2 3	Increase the number of new American Diabetes Association (ADA)-recognized or Association of Diabetes Care and Education Specialists (ADCES)-accredited DSMES services and state recognized programs established	Utilize current data from ADA and ADCES and state recorded data
	Resources	**Legislative Considerations**

	Federal funding from CDC-RFA-DP23-0020 - A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes; Partnership with HCA	None

Action 2

Prevent diabetes complications for priority populations through early detection.

- Increase screening of type 1 diabetes through diabetes autoantibody measurement
- Build, strengthen, and formalize partnerships that will lay the groundwork to implement, spread, and sustain childhood obesity prevention and treatment, particularly with priority populations
- To target obesity in children, CDC is promoting a life course approach of reducing obesity among children to prevent diabetes in adulthood.

Prevention Area 2

Expected Outcome

Work with health care organizations and Community Based Organizations to implement strategies that:

- Amplify referral mechanisms for early detection of type 1 diabetes in partnership with the Newborn Screening (NBS) Program.
- Promoting the utilization of evidenced based programs that focuses on childhood obesity prevention and treatment.

Benchmark

To be determined

Resources

Federal funding from CDC-RFA-DP23-0020 with DSHS

Legislative Considerations

Increase funding (from state) to support expected outcomes. More resources are needed to increase sustainability efforts of programs beyond federal funds.

Action 3

Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.

Prevention Areas 1 2

Expected Outcome

Increase the number of participants enrolled by CDC- recognized National Diabetes Prevention Programs

Benchmark

24,854 participants (as of January 2023)

Resources

Federal funding from CDC-RFA-DP23-0020

Legislative Considerations

Support the inclusion of DPP as a covered health benefit through all health insurance plans in Washington.

Action 4

Support development of multi-directional referral systems and multistate EHR-based Networks and disease surveillance (MENDS) that allow electronic exchange of information between Health

Expected Outcome

Number and types of new multi-directional e-referral systems established

Benchmark

To be determined

Resources

Legislative Considerations

Systems and Community Based Organizations and the collection of more accurate data on prevalence of diabetes in Washington State to help connect individuals to DPP, DSMES services and or diabetes support programs in the community. **Prevention Areas**	Partnerships with HCA, Office of the Insurance Commissioner (OIC), and DSHS. Federal funding from CDC-RFA-DP23-0020	• Increase resources (i.e. state funding) to support MENDS and other related projects to collect more accurate data on prevalence of diabetes among Washingtonians.

Action 5

Improve the sustainability of Community Health Workers (CHWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services.

Prevention Areas 2 3

Expected Outcome	Benchmark
Increase the number of CHWs in the workforce who provide support to a DSME or DPP	To be determined
Resources	**Legislative Considerations**
Federal funding from CDC-RFA-DP23-0020	Identify mechanisms and sources for payment for community-based efforts that use CHWs in the referral process and retention of clients in diabetes self-management and prevention programs.

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Action 6

Improve the capacity of the diabetes workforce to address factors related to Health Related Social Needs (HRSN) that impact health outcomes for priority populations with and at risk for diabetes.

Prevention Areas 2 3

Expected Outcome	Benchmark
Increase the number and type of diabetes workforce staff trained on HRSN strategies and training type	To be determined
Resources	**Legislative Considerations**
Federal funding from CDC-RFA-DP23-0020	None

Action 7

Support Health Sciences Research to determine the feasibility and cost effectiveness of predicting type 1 diabetes in children as part of the Newborn Screening Program. This can prevent severe complications at onset.

Prevention Areas 1 2 3

Expected Outcome	Benchmark
Practical and cost-effective testing framework	Evaluation by WA State Board of Health
Resources	**Legislative Considerations**
Partnership with University of Washington and other Researchers	Directed by WA State Board of Health evaluation outcome

Department of Social & Health Services

The DSHS 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 individuals can live and receive services in their own homes or in community settings whenever possible. CDSME provides support to better build community linkages and foster more productive interactions between informed, engaged, and activated individuals living with chronic conditions. DSHS supports the CDNLT to better serve people living with diabetes.

Table 15: Department of Social and Health Services Action Plan Summary Information

Action 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	More use and access to CDSME programs to include Diabetes Self-Management and other evidenced based programs.	None
	Resources	**Legislative Considerations**
	Partnership with HCA and DOH	None

Action 2	Expected Outcome	Benchmark
Partner with DOH and OIC to identify inclusion of coverage of evidence-based programs for DSMES 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 3	Expected Outcome	Benchmark
Support efforts to develop a community-based organizations hub-and-spoke network business model. This will support efforts to obtain funding to pay for programs and build infrastructure whole person care related to diabetes and other evidenced-based programs. This should improve costs and outcomes. **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 evidence-based programs.	None
	Resources	**Legislative Considerations**
	Partnership with HCA	None

Action 4	Expected Outcome	Benchmark
Support existing coordination of diabetes care and management work to integrate physical and behavioral health services. DSHS accomplishes this through	• Improved health of all people with diabetes • Reduced hospital costs, especially for those at disproportionate risk of poor health outcomes	None

services for Home and Community Based clients.

Prevention Areas

Resources	Legislative Considerations
Partnership with HCA	None

Action 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	Benchmark
• Reduced hospitalizations and associated costs • Improved quality of life for clients with chronic conditions such as diabetes	None

Resources	Legislative Considerations
Partnership with HCA	None

Action 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	Benchmark
Development of a competent, paid workforce available to deliver long-term services and supports to people with diabetes and other chronic conditions.	None

Resources	Legislative Considerations
Partnership with DOH	None

Action 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 3

Expected Outcome	Benchmark
• 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.	None

Resources	Legislative Considerations
Partnership with HCA	None

Health Care Authority Action Plan

Diabetes Prevention Program in PEBB and SEBB

During the 2021-23 biennium, HCA expanded and improved upon the VDPPs in both PEBB and SEBB. Table 16 below contains additional information.

HCA received funding to provide a virtual diabetes management program beginning in January 2024 to UMP members in SEBB already diagnosed with diabetes. Efforts are being made to obtain funding to include the PEBB population in 2025.

Diabetes performance metrics will continue to be incentivized in all PEBB and SEBB contracts to drive improvements. Health plan incentivized metrics are generally incorporated into provider contracts as well, creating alignment across the system.

HCA will continue to update its voluntary wellness program, SmartHealth, so PEBB and SEBB members can increase their awareness of and access to programs that support diabetes prevention and management.

Table 16: HCA Action Plan Summary Information (DPP in PEBB and SEBB)

Action 1	Expected Outcome	Improvement Benchmark
PEBB and SEBB UMP Program Virtual Diabetes Prevention Program (Powered by OMADA) PEBB Launched Jan 2019 2 SEBB Launched Jan 2020 Prevention Areas 1 2	Continue offering access to the diabetes prevention program powered by Omada. Continued enrollment in the program. Continue member engagement of at least 28 points per week.	• At least a 2% enrollment increase among the PEBB and SEBB programs, compared to current enrollment statistics. • Maintain or exceed satisfaction rates. • Continue to outperform clinical benchmarks for average weight loss and percent of patients achieving 5% weight loss at 16, 26, and 52 weeks.
	Resources	**Legislative Considerations**
	Budgeted	None

Apple Health Managed Care Organizations' Action Plans

Apple Health managed care organizations (MCO) have several action plans to improve diabetes outcomes for their plan members during the 2023-25 biennium. Table 17 below contains information about the following action plan examples:

- Distribute glycosylated hemoglobin (HbA1c) home test kits to members with diabetes.
- Contact members with diabetes via health coaches with an outreach phone call or diabetes education materials in the mail based on their diabetes-related risk scores.
- Provide members with prediabetes management services, including health coach engagement and establishing diabetes prevention goals.
- Use HEDIS data to inform members with diabetes about related preventive services they are missing (e.g., retinal eye exams).
- Promote metabolic screenings for members with diabetes receiving long-term antipsychotics by notifying those members' behavioral health and medical providers.

Table 17: Apple Health Managed Care Organizations' diabetes action plans

Action 1	Expected Outcome	Improvement Benchmark

Distribute HbA1c home test kits

Launched Q3 2021

Prevention Area 2

Members with diabetes will have better blood sugar control.

The HbA1c Poor Control (>9%) HEDIS performance measure in calendar year (CY) 2021 will improve (decrease) year-over-year compared to CY 2020.

Resources

Budgeted

Legislative Considerations

None

Action 2

Health coach outreach

Launched Dec 2020

Prevention Area 1

Expected Outcome

Members with diabetes will have better blood sugar control.

Improvement Benchmark

Diabetes HEDIS rates will improve by 5% year-over-year.

Resources

Budgeted

Legislative Considerations

None

Action 3

Prediabetes management

Launched prior to July 2021

Prevention Area 1

Expected Outcome

Improved diet via reduction in sugar and overall caloric intake, increased physical activity and lower A1c.

Improvement Benchmark

To be determined

Resources

TBD

Legislative Considerations

None

Action 4

Preventive health services notification

Launched July 2021

Prevention Areas 1 2

Expected Outcome

- Improve low diabetes-control rates for members
- Increase awareness of members needing services to meet care gap closures
- Improve HEDIS rates

Improvement Benchmark

Achieve or exceed the HEDIS Quality Compass 75th Percentile.

Resources

Budgeted

Legislative Considerations

None

Action 5

Metabolic screenings promotion for members with diabetes receiving long-term antipsychotics

Launched July 2021

Prevention Area 1

Expected Outcome

Completion of metabolic screening for those members with co-occurring diabetes and behavioral health diagnoses.

Improvement Benchmark

Increased compliance and related HEDIS measure performance:

- Metabolic monitoring for children and adolescents on antipsychotics
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

Resources

Budgeted

Legislative Considerations

None

Conclusion

Washington's policies and programs across state agencies are designed to help reduce the burden that the diabetes epidemic has on our state's individuals, families, and health care systems.

Moving forward, DOH, DSHS, and HCA plan to leverage existing infrastructure and resources to continue to address diabetes prevention and management. These coordinated efforts include: Healthier Washington, including ACH; 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 CDNLT; and d-evelopment of infrastructure for evidence-based community programs, such as the CDSMP, 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 agency action plans mentioned above or in previous iterations of this report. **In brief, proposed actions recommended in this report include:**

- Expand networks of providers to include pharmacists trained to provide self-management education and medication management.
- Support policies that compensate for culturally appropriate community-based efforts that utilize community health workers in diabetes self-management and prevention.
- Increase resources for early identification of type 1 and type 2 diabetes, monitoring and evaluating diabetes-related care, and the health status of those with diabetes.
- Fund a study on barriers to care caused by increasing out-of-pocket costs associated with diabetes management in partnership with the Office of the Insurance Commissioner.
- Increase resources to support Multi-state EHR-based Network and Disease Surveillance (MENDS) and other related projects to collect more accurate data on prevalence of diabetes among Washingtonians.
- Invest in evidence-informed type 1 and type 2 diabetes screening health promotion and chronic disease prevention for children and youths ages birth to 18 years, in collaboration with state agencies serving youth.
- Expand access to telehealth services, options for home-based testing, and prescription delivery services.
- Continue to fund existing initiatives to improve health equity and address social determinants of health, which particularly impact people with diabetes.

Appendix A: Legislative Mandate

Revised Code of Washington 70.330.020: Reports to the 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; and

(5) An estimate of costs and resources required to implement the plan identified in subsection (4) of this section.

Appendix B: Endnotes

[1] Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by the Centers for Disease Control and Prevention, Cooperative Agreement NU58/DP006865-02 (2021).

[2] Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by the Centers for Disease Control and Prevention, Cooperative Agreement NU58/DP006865-02 (2021).

[3] Washington State Department of Health, Comprehensive Hospitalization Abstract Reporting System (CHARS) 2021.

[4] Washington State Department of Health, Center for Health Statistics, Death Certificate Data 2021.

[5] Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed February 9, 2023.

[6] Centers for Disease Control and Prevention. About Prediabetes & Type 2 Diabetes website. https://www.cdc.gov/diabetes/prevention/about-prediabetes.html. Accessed February 9, 2023.

[7] Knowler WC, Barrett-Connor E, Fowler SE, Hamman RF, Lachin JM, Walker EA, Nathan DM; Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med. 2002 Feb 7;346(6):393-403.

[8] 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

[9] Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by the Centers for Disease Control and Prevention, Cooperative Agreement U58/SO000047-1 (2011), NU58/DP006865-02 (2021).

[10] Statewide Registry of Medicaid-Reimbursable Diabetes Education Programs (MRDEP database). Washington State Department of Health & Health Care Authority.

[11] Annual Status Reports (ASR), American Diabetes Association and the Association of Diabetes Care and Education Specialists, Centers for Disease Control and Prevention; 2012-2020.

[12] National Registry of Recognized Diabetes Prevention Programs (DPP), National Diabetes Prevention Program, Centers for Disease Control and Prevention (CDC). Available at https://dprp.cdc.gov/Registry.

[13] Medicare Diabetes Prevention Program (MDPP) Dataset, Centers for Medicare & Medicaid Services (CMS). Available at https://data.cms.gov/cms-innovation-center-programs/alternative-payments-medicare-diabetes-prevention-program/medicare-diabetes-prevention-program.

[14] Diabetes Prevention Recognition Program (DPRP) State Level Participant Data Reports, National Diabetes Prevention Program, Centers for Disease Control and Prevention; January 2019-April 2021.

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

[16] HCA Clinical Quality and Care Transformation Division Data Team; (2) Centers for Medicare and Medicaid Services (CMS) Chronic Condition Warehouse (CCW) Condition Algorithms (revised February 2023) for disease definitions; and (3) ProviderOne Operational Data Store, data pulled on August 30, 2023.

Notes: "Diabetes" means type 1, type 2, gestational, and other forms of diabetes. "Other chronic diseases" means coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or asthma. "Client count" means the number of unique Apple Health clients with diabetes and/or other chronic disease diagnoses during the period July 1, 2021, through June 30, 2023, with a two-year lookback for asthma, COPD, CAD, CHF, and diabetes. "Percent of Apple Health clients" means the percentage of all unique clients enrolled in Apple Health at any time during the period July 1, 2021, through June 30, 2023 (i.e., 2,615,478 unique clients), who had diabetes and/or other chronic disease diagnoses. "Total health care expenditures" means the sum of Apple Health expenditures for all health care procedures and services including those for diabetes and/or other chronic disease during the period July 1, 2021, through June 30, 2023. "Total expenditures per client" means "Total health care expenditures" divided by "Client count". "Disease-Related expenditures" means the sum of Apple Health medical expenditures for procedures and services related to diabetes and/or other chronic diseases during the period July 1, 2021, through June 30, 2023. "Disease-related expenditures per client" means "Disease-related expenditures" divided by "Client count". Median values of expenditures per client are provided to account for outliers. Client counts and expenditure data in this table are approximate, due to claims lag for recent months.

[17] Regence Blue Shield, Healthcare Informatics, Consulting and Reporting Analytics; data pulled July 2021; and Centers for Medicare and Medicaid Services (CMS) Chronic Condition Warehouse (CCW) Condition Algorithms (revised February 2021) for disease definitions. (Notes: "Diabetes" means type 1, type 2, gestational, and other forms of diabetes. "Other chronic diseases" means coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or asthma. "Member count" means the number of unique Uniform Medical Plan (UMP) members with diabetes and/or other chronic disease diagnoses during the period July 1, 2019, through June 30, 2021, with a one-year lookback period for asthma and COPD, and a two-year lookback for CAD, CHF, and diabetes. "Disease-related expenditures" means the sum of UMP expenditures for health care procedures and services including diabetes and/or other chronic disease diagnosis codes for clients with diabetes and/or other chronic disease diagnoses during the period July 1, 2019, through June 30, 2021. "Disease-related expenditures per member" means "Disease-related expenditures" divided by "Member count". Member counts and expenditure data in this table are approximate, due to claims lag for recent months. SEBB data might also be more incomplete than PEBB data, because it began on January 1, 2020.)

[18] The National Diabetes Prevention Program. Retrieved July 7, 2021, from www.chronicdisease.org/mpage/domain4_ndppreso

[19] Health Care Authority. Diabetes prevention. Retrieved July 7, 2021, from www.hca.wa.gov/about-hca/washington-wellness/diabetes-prevention

[20] Health Care Authority. Employee and Retiree Benefits Division. Provided July 2021.

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