Report to the Legislature

Diabetes Epidemic Action Report

December 2021

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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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 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 (716,200) in Washington has diabetes. Diabetes also carries significant financial costs. About six percent (143,323) of Apple Health enrollees and eight percent (35,084) of Washington's 438,553 public employees and their dependents had diabetes from July 2019 through June 2021. Total related health care service expenditures for those clients exceeded $4.82 billion during the 2019-2021 biennium.

Programs Addressing Diabetes

During the 2019-2021 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 those agencies.

Action Plans

This report lists action plans to address diabetes in Washington state, including steps aimed at controlling diabetes, preventing type 2 diabetes, and controlling associated costs and resources. Where relevant, these plans contain considerations for the legislature that include:

- Expanding networks of providers to include pharmacists trained to provide self-management education and medication management.
- Supporting policies that compensate for culturally appropriate community-based efforts that utilize community health workers (CHW) in diabetes self-management and prevention.
- 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 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 children and youths ages birth to 18 years, in collaboration with state agencies serving youth.
- Continue efforts to mitigate the impact of the COVID-19 pandemic, such as access to telehealth, options for home-based testing, and prescription delivery services.
- Continuing agency-wide efforts to improve health equity and address social determinants of health, which particularly impact the diabetes population.

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 of all types is having on programs administered by each agency and individuals enrolled in those programs.
- An assessment of the benefits of implemented programs and activities aimed at controlling 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 2019—2021 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. There is no cure for diabetes, but it can be managed. When uncontrolled, high blood glucose levels can damage the eyes, heart, kidneys, nervous system, and other organs. In combination with high blood pressure and other risk factors, uncontrolled blood glucose greatly increases risk of heart disease, stroke, kidney disease, and other adverse health outcomes. 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 regularly to stay alive. Exact causes of type 1 diabetes and methods to prevent the onset of type 1 diabetes are not yet known. Type 1 diabetes accounts for 5–10% of all people with diabetes nationally.

Type 2 diabetes occurs 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 people with diabetes nationally. There is no cure for type 2 diabetes but it can be prevented in some cases or managed by eating a well-balanced meal and keeping physically active. If diet and exercise aren't enough, a medical provider may recommend medication management or insulin therapy.

Prediabetes is 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. People with prediabetes have a much greater chance of developing type 2 diabetes or gestational diabetes. Those with prediabetes are also at higher risk of cardiovascular disease, regardless of whether they later develop type 2 diabetes. Prediabetes indicates that abnormalities in glucose levels have begun but may be reversed.

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. Both gestational and maternal diabetes can create serious threats to mother and baby, including premature birth, preeclampsia, higher risk of birth injury, or Caesarean delivery. Both 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.

In Washington state an estimated 716,200 adults aged 18 and older (12 percent) had diabetes in 2019. Nearly one quarter (23 percent) of those were undiagnosed.[1] In the same year there were 41,470 new cases of diagnosed diabetes among adults.[2]

In addition, almost 2 million adults aged 18 years and older (35 percent) had prediabetes, about two thirds of whom were unaware of their prediabetic status.[3, 4] Among those who have developed prediabetes, 15 to 30 percent could develop type 2 diabetes in the next five years unless they make changes to their diets and levels of physical activity.[5] For additional information on the burden of diabetes in Washington, see the Heart Disease, Stroke, and Diabetes Data and Publications webpage.

Diabetes and the COVID-19 Pandemic

SARS-Cov-2, commonly known as the COVID-19 virus, has impacted individuals worldwide and across Washington, but disproportionately affects persons of color and people with chronic conditions. Many people have been adversely affected by the reduced ability to remain physically active and participate in evidenced-based programs due to the stay-at-home orders to help control the spread of the virus.

People with chronic conditions like diabetes are at increased risk of developing complications and increased risk of death from COVID-19. As the virus continues to overwhelm many health care systems, this limits the necessary health care services a person with diabetes has access to, such as DSMES and Diabetes Prevention Programs (DPP). These programs suspended in-person meetings and face-to-face education in an effort to mitigate the spread of COVID-19. They needed to quickly adapt and shift services to computer-based modalities and telehealth so they could continue to provide services to people with diabetes and at risk of developing diabetes. Unfortunately, these changes have resulted in reduced effectiveness for patients who lack internet access and other equipment. For more information on the current status of how COVID-19 is affecting Washington state, please visit the COVID-19 data dashboard.

Program Assessments

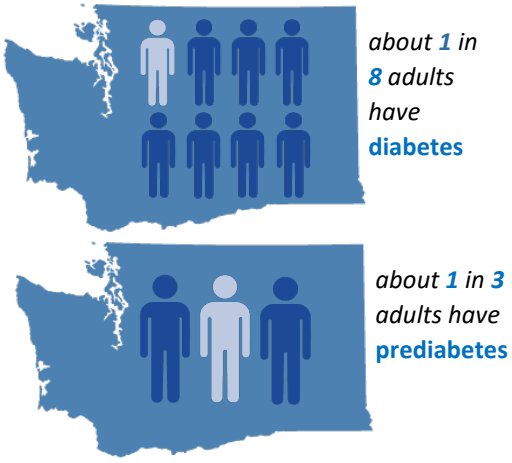
This section contains information for each agency's programmatic impacts, expenditures, and benefits.

Department of Health

DOH addresses diabetes and prediabetes through multiple initiatives. 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, 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 DSMES programs, which have been shown to improve diabetes management, reduce complications of diabetes, and reduce associated costs.[6]
- Increasing participation in nationally recognized DPP.
- Implementing systems to identify people with prediabetes for referral to DPP.
- Increasing access to Chronic Disease Self-Management Programs (CDSMP).



As a result of this work, DOH has:

- Tracked improvements in access to and participation in evidenced based programs that include CDSMP, DPP, and DSMES.
- Increased the proportion of adults in Washington state with prediabetes who are aware they have the condition, from 7 percent in 2011 to 10 percent in 2019.[7]
- Partnered 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

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 2019-June 2021

Funding

Source

CDC Cooperative agreement

Total Expenditures

$1,579,861

(for both prevention and control activities)

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

Program & Benefits

Diabetes Self-Management Education & Support

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 2021, 32 organizations continued and 10 new organizations began to offer, DSMES programs that have been approved for Medicaid reimbursement, representing 133 individual sites across the state.[8]
- The annual number of individuals visiting a recognized DSMES program grew from 22,611 in 2012 to 25,314 in 2020 (12% improvement).[9]

Diabetes Prevention Program

Increase use of DPP in community settings among adults.

Realized Benefits[10,11,12]

- Total number of organizations offering DPP grew from 29 in September 2018 to 34 in July 2021. During this period:
  - 18 organizations continued and 9 additional organizations began to offer nationally recognized DPP.
  - 7 additional organizations began to offer Medicare DPP.
- More organizations ensured sustainability by achieving full recognition status for nationally recognized DPP, from 21% in October 2018 to 59% in March 2021.
  - This is higher than the most recent national average achieving full recognition (41%).
- As of March 2021, almost two-thirds (63%) of organizations met the primary goal of DPP, which is to help individuals to lose at least 5% of their weight. The goal is associated with a clinically significant reduction in risk for type 2 diabetes.
  - Nationally, 37% of organizations that offer DPP meet this primary program goal.
- Enrollment in DPP grew by 46%, with 6,925 additional people participating in the program. Enrollment grew from 14,905 in October 2018 to 21,830 in March 2021.

Chronic Disease Self-Management Program (CDSMP)

Increase use of CDSMP in community settings and health systems.

Realized Benefits

- Supplied books and resources to four organizations that provide CDSMP services. CDSMP and DSMP services were provided to 212 clients in 2021.

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, many of whom have diabetes, instead of focusing solely on diabetes. 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 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)[13]

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. DSHS and HCA partner on this effort.

Realized Benefits

- The program was implemented in 37 counties in 2013. On April 1, 2017 it expanded to include King and Snohomish counties, making the program available statewide.
- As of December 2020, 10,317 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
- Medicare savings of $293 million between 2013 and 2019.

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

Care Transitions Programs

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

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

$23,300,000

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 2020, approximately 12,700 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 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 facilities.

Funding

Source

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

Total Expenditures

$2.38 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. 48% of the clients are receiving long-term services and supports and have a diagnosis of diabetes.

Realized Benefits

- 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 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 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

- 212 workshop participants with 153 completers.
- Virtual CDSME programming in response to COVID-19 pandemic.
- Forming the beginning of a statewide network to connect CDSME providers and provide infrastructure and support for continued program delivery.

Table 7: Skilled Nurse Waiver Program

Overview

Provides Registered Nurses (RN) and Licensed Practical Nurses (LPN) with the skills required to manage client health in a community setting.

Funding

Source

Health and Human Services

Program & Benefits

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

Realized Benefits

339 people currently benefit from the Skilled Nursing program. (increase from 149 in the previous report).

Table 8: Nurse Delegation Program

Overview

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

Funding

Source

Health and Human Services

NOTE: Cost for Nurse Delegation Services for people with diabetes dependent on insulin: $2,442,000.00

The 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. Delegated 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 13,706 people and contracts with approximately 268 independent nurses in the community. Of the 13,706 people successfully served through nurse delegation, 4,098 have a diabetes-related diagnosis and 1,964 are insulin dependent.
- 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.

Reach and Financial Impact of Diabetes in HCA-Administered Programs

Table 10 below shows that about 143,323 Apple Health clients (both managed care and fee-for-service combined) had diabetes with or without other chronic diseases, from July 2019 through June 2021. Of those clients, 57,063 had both diabetes and other chronic diseases. Total health care service expenditures for clients who had diabetes with or without other chronic diseases exceeded $4.67 billion during the 2019-21 biennium. Average (mean) 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 2019 through June 2021, and Health Care Expenditures[14]

Apple Health Population	Client Count	Total Health Care Expenditures	Total Expenditures per Client	Disease-Related Expenditures	Disease-Related Expenditures per Client
Clients with diabetes, without other chronic diseases	86,260	$2,025,900,545	Mean = $23,486 Median = $6,803	$268,482,964	Mean = $3,113 Median = $416
Clients with both diabetes and other chronic diseases	57,063	$2,649,843,791	Mean = $46,437 Median = $24,426	$620,638,623	Mean = $10,876 Median = $1,364
Clients without diabetes, with other chronic diseases	205,488	$4,342,418,473	Mean = $21,132 Median = $5,265	$551,935,097	Mean = $2,685 Median = $275

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 27,939 UMP members in PEBB and about 5,074 UMP members in SEBB had diabetes with or without other chronic diseases from July 2019 through June 2021. Of those in PEBB, 9,431 had diabetes with other chronic diseases. Of those in SEBB, 948 had diabetes with other chronic diseases. Disease-related expenditures during that biennium exceeded $125.4 million for members in PEBB and was about $26.1 million for members in SEBB. Average disease-related expenditures for clients with both diabetes and other chronic diseases were about three or four times as great as per-client expenditures for clients with either diabetes alone or other chronic diseases for PEBB and SEBB, respectively.

Table 11 – Counts of Uniform Medical Plan Members with Diabetes, Other Chronic Diseases, or Both from July 2019 through June 2021, and Disease-Related Health Care Expenditures[15]

UMP Population	Member Count	Disease-Related Expenditures	Disease-Related Expenditures per Member
Clients with diabetes, without other chronic diseases	PEBB = 18,508	$49,817,146	$2,692
	SEBB = 4,126	$13,786,420	$3,341
Clients with both diabetes and other chronic diseases	PEBB = 9,431	$75,620,021	$8,018
	SEBB = 948	$12,279,701	$12,953
Clients without diabetes, with other chronic diseases	PEBB = 33,990	$93,916,088	$2,763
	SEBB = 7,100	$22,478,580	$3,166

HCA Programs to Prevent or Manage Diabetes and Its Complications

During the 2019-2021 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 and Apple Health programs.

Employee and Retiree Benefits

All PEBB and SEBB health plans contracted by HCA prioritize the care and management of diabetes through innovative value-based purchasing. HCA utilizes the national Healthcare Effectiveness Data and Information Set (HEDIS) set 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 target members that may have identified gaps in recommended or necessary care. Programs and initiatives for PEBB and SEBB members with diabetes are available through each of our contracted payers includes, but is not limited to:

- Nutritional Counseling and Therapy
- Livongo Virtual Diabetes Program
- Virtual Diabetes Prevention Programs
- Care Management
- Value Based Purchasing
- SmartHealth initiatives
- Care Gap Closure home kits

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 VDPP 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.[16] These changes can reduce the risk of developing type 2 diabetes by almost 60 percent.[17] Use of a virtual format lowers barriers to participation by enabling 24-hour access to the program statewide. See Table 12 for additional information.

Table 12: Uniform Medical Plan VDPP Summary Information[18]

Overview

UMP Virtual Diabetes Prevention Programs (Powered by Omada)

Jan 2019 - present

Enrollment

1,921 people

June 2019 - May 2021

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. Between June 2019 and May 2021, 1,586 PEBB beneficiaries have participated in the VDPP. Enrollment in the SEBB VDPP started on January 1, 2020. Between January 2020 and May 2021, 335 SEBB members have participated in the VDPP.

Average participant engagement with the Omada VDPP is 34.4 times per week; about 30 percent of engaged participants achieved 5 percent weight loss.

NOTE: The same client 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 - PEBB and SEBB members enrolled in the Uniform Medical Plan and living with a diabetes diagnosis may opt into the Care Management program through Regence Blue Shield. Once a member opts into the program, they have access to a nurse who acts as a facilitator for each member enrolled in any of the UMP health management programs. This single nurse does the heavy lifting of orchestrating care conversations, appointments, and recommendations so the member and their family can focus on being healthy and well. Dedicated clinicians support members transitioning to different levels of care across the care continuum and work directly with the member's provider(s) as part of an internal team of clinicians, including physicians with varied expertise and specialties. This ensures that the nurse has the necessary knowledge to support members holistically.

UMP members receive condition specific newsletter education twice per year and have access to related information through SmartHealth opportunities dedicated to improving awareness and access to these care opportunities.

Care Gap Closure Program - The Care Gap Closure Program encourages members to receive recommended preventive and chronic care serves and screenings, also known as "gaps in care." These include screenings for diabetes and more, at no cost to members. This support includes helping members find a PCP, making appointments, ensuring members understand their benefits, and providing members ongoing support through case management. In the fall of 2020, a care gap initiative was implemented through which 1,858 home testing kits were shipped to members that were identified as in need of diabetes-related assessment and follow up.

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 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 of six hours of individual "core survival skills" outpatient diabetes education per calendar year per client. [19] Additional hours may be requested through prior authorization. For more information on hours, see the July 2021 Washington Diabetes Education Program Billing Guide.[20] See Table 13 below for additional information on the education programs.

Table 13: Apple Health Diabetes Education Programs Summary Information[21]

Overview

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

Jan 1998 - present

Enrollment

8,949 clients

Jul 2019 - Jun 2021

Funding

Source

State and Federal Medicaid Funds

Total Expenditure

$805,076

Program & Benefits

Provide medically necessary diabetes education to Apple Health clients with diabetes

Realized Benefits

Enrolled clients received information to help them manage their diabetes. Approximately 7,809 clients in managed care and 1,140 clients in fee-for-service received diabetes education services. A total of $756,859 was spent in managed care and $48,218 in fee-for-service. Average expenditures per enrolled person was $97 in managed care and $42 in fee-for-service.

NOTE: Enrollment and expenditure data in this table are approximate, due to claims lag for recent months, and because the same client could have been enrolled in both managed care and fee-for-service during the biennium.

Collaboration Between State Agencies

During the 2019-2021 biennium, DOH, DSHS, and HCA worked together to address diabetes and its complications. These collaborative efforts include:

1. **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. 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.[22] 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.[23, 24] It 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 2013, and then expanded in 2017, making the program available statewide.

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 control diabetes.[25] The CDNLT members meet quarterly to identify priorities and develop strategies that align with the missions and goals of the participating organizations.[26] DOH, DSHS, and HCA participate on the CDNLT. Some successes the CDNLT achieved in the 2019-2021 biennium include:

   - Publishing new diabetes education resources on the Washington State Diabetes Connection website[27] in April 2020 for patients who have or are at risk for developing diabetes. One publication is the Living Well with Diabetes: Manual and Lifestyle Guidebook, which defines diabetes, offers tips for healthy living, explains common diabetes-related tests, and provides a diabetes care checklists and a blood glucose tracker.[28]
   - Launching the Washington State Cardiovascular Connection page[29] on the WA Portal (Healthier Washington Collaboration Portal) website in May 2021. Someone who has diabetes is twice as likely to have heart disease or a stroke than someone who does not have diabetes.[30] This page supports the CDNLT's efforts to produce cardiovascular health-related communications for clinicians and community partners.

3. **Medicaid Transformation Project (MTP), Initiative 1: Delivery System Reform Incentive Payment (DSRIP) program**
   In 2017, Washington state and CMS finalized an agreement for a five-year Section 1115 Medicaid demonstration waiver (MTP) 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 (Medicaid) service delivery system. DSHS and HCA coordinate on the operations of the MTP. Examples of programs and strategies under MTP 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 or maintaining the well-being of the caregiver, as well as

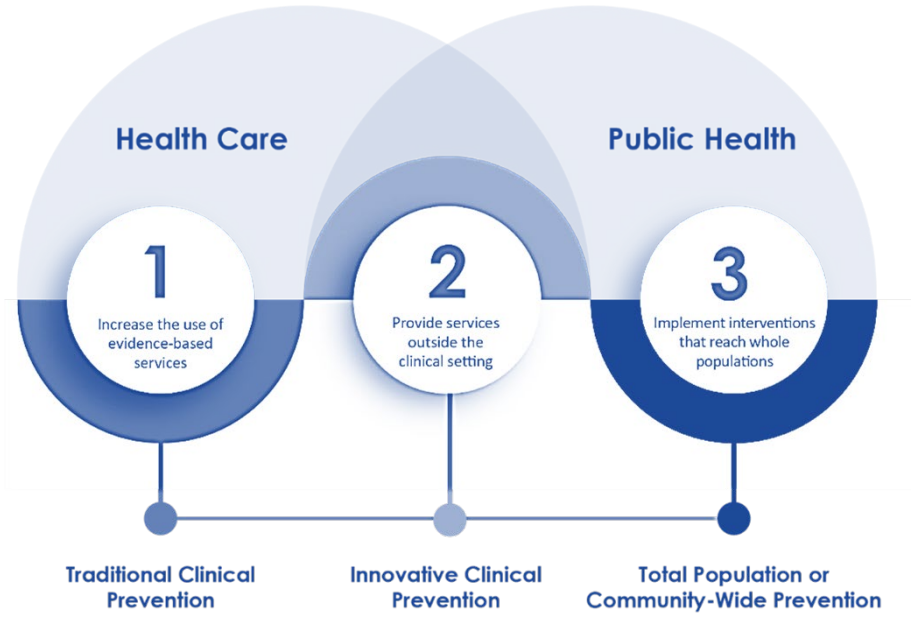
delay or avoid the need for more intensive Medicaid-funded long-term supports and services where possible.

- Nine regional Accountable Communities of Health (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, and get the right level of care at the right time and in the appropriate setting.
- 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.

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.[31] 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 with a total of 135 active sites in Washington 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 Washington**
   National Diabetes Month and World Diabetes Day occur every November.[32] 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 and 2020.[33]
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 (DP18-1815) 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-ALTSA

to improve access to and participation in CDSME; 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 DPP; and supporting statewide infrastructure to promote long-term sustainability and financing of CHW in diabetes prevention and management.

Agency Action Plans



Infographic modeled after the Three Buckets of Prevention, used by Healthier Washington's Population Health Guide.

This section includes updated strategic plans to address diabetes from DOH, DSHS, and HCA as well as a cross-agency plan, including action steps aimed at controlling and preventing relevant forms of diabetes. One framework for organizing solutions is the Three Buckets of Prevention[34] used by Healthier Washington's Population Health Planning Guide.[35]

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 strategic plan and focuses on population health strategies that impact diabetes and its risk factors. The Washington State CDNLT is a key partner in 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	Expected Outcome	Benchmark	Resources	Legislative Considerations
Action 1 Improve access to and participation in recognized DSMES programs in underserved areas **Prevention Areas** 1 2 3	10 new nationally accredited programs	There are currently 56 active programs with a total of 135 active sites in Washington (as of August 10, 2021)	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 2 Improve access to and participation in Diabetes Self-Management and Chronic Disease Self-Management Program workshops (to support DSMES services) for adults with diabetes, including encouraging e-referrals from health systems. **Prevention Area** 2	30 new workshops	36 workshops were offered in calendar year 2019	Federal funding from DP18-1815; Partnership with DSHS	None
Action 3 Increase engagement of pharmacists in the provision of medication management or DSMES for people with diabetes. **Prevention Areas** 1 2	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	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 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 5

Increase availability of DPP by:

- Partnering with OIC to identify inclusion of coverage for nationally recognized DPP in insurance plans.
- Assisting health care organizations in identifying adults with prediabetes and referring them to existing resources

Prevention Areas 2 3

Expected Outcome

Increase the number of participants enrolled in DPP in Washington.

Benchmark

21,830 participants (as of April 2021)

Resources

Federal funding from DP18-1815

Legislative Considerations

None

Action 6

Support statewide infrastructure to promote long-term sustainability and payment for CHW 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

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, whenever possible, individuals have the opportunity to live and receive services in their own homes or in community settings. 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 CDNLT to better serve populations with diabetes.

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

Action 1 Partner with DOH and HCA to promote multiple modalities of Diabetes Self-Management Education to patients. **Prevention Areas** 1 2 3	**Expected Outcome** Increased expansion of and access to CDSME programs to include Diabetes Self-Management and other evidenced based programs.	**Benchmark**
	Resources Partnership with HCA and DOH	**Legislative Considerations** None
Action 2 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	**Expected Outcome** Greater access to and participation in evidence-based programs for DSMES through insurance plans regulated in Washington.	**Benchmark** Will work with OIC to establish benchmark
	Resources Partnership with DOH, staffing at OIC	**Legislative Considerations** None
Action 3 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	**Expected Outcome** Resources and partnerships in place with a "no wrong door" approach so that clients easily access diabetes self-management and other evidence-based programs.	**Benchmark**
	Resources Partnership with HCA	**Legislative Considerations** None
Action 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 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 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 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

- 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

None

Health Care Authority Action Plan

Diabetes Prevention Program in PEBB and SEBB

During the 2021-23 biennium, HCA plans to expand and improve upon the VDPPs in both PEBB and SEBB. Table 16 below contains additional information.

HCA will continue to work to expand use of virtual diabetes management programs to aid those already diagnosed with diabetes in self-management techniques.

Diabetes performance metrics will continue to be incentivized in all PEBB and SEBB contracts, to drive improvement of diabetes management in these populations. 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 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 2021-23 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 Launch 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	**Legislative Considerations**
	Budgeted	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 (APM)
- Diabetes monitoring for people with diabetes and schizophrenia (SMD)
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)

Resources

Budgeted

Legislative Considerations

None

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 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 development 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 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 culturally appropriate community-based efforts that utilize CHW in diabetes self-management and prevention.
- 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 in partnership with OIC.
- Continuing to fund existing initiatives that improve social determinants of health.
- Investing in evidence-informed health promotion and chronic disease prevention for ages birth to 18 years, in collaboration with state agencies serving youth.
- Continue efforts to mitigate the impact of the COVID-19 pandemic, including access to telehealth, options for home-based testing, etc.
- Continuing agency-wide efforts to improve health equity and address social determinants of health, which particularly impact the diabetes population.

Appendix A

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.

Endnotes

[1] Washington State Department of Health. Washington State Behavioral Risk Factor Surveillance System Survey; 2019 (self-reported diagnosed diabetes). National Center for Health Statistics, Centers for Disease Control and Prevention. National Health and Nutrition Exam Survey; 2013-2016 (national age-specific percentages applied to corresponding Washington State resident population estimates to obtain number of people with undiagnosed diabetes).

[2] Washington State Department of Health. Washington State Behavioral Risk Factor Surveillance System Survey; 2019.

[3] Washington State Department of Health. Washington State Behavioral Risk Factor Surveillance System Survey; 2019.

[4] National Center for Health Statistics, Centers for Disease Control and Prevention. National Health and Nutrition Exam Survey; 2013-2016 (national age-specific percentages applied to corresponding Washington State resident population estimates to obtain number of people with prediabetes).

[5] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2020. Available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html.

[6] 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

[7] Washington State Department of Health. Washington State Behavioral Risk Factor Surveillance System Survey; 2011-2019.

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

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

[10] 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.

[11] 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.

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

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

[14] Health Care Authority Clinical Quality and Care Transformation Division Data Team; Centers for Medicare and Medicaid Services (CMS) Chronic Condition Warehouse (CCW) Condition Algorithms (revised February 2021) for disease definitions; and ProviderOne Operational Data Store, data pulled July 2021. (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, 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. "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, 2019, through June 30, 2021. "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, 2019, through June 30, 2021. "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.)

[15] 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.)

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

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

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

[19] WAC 182-550-6400 Outpatient hospital diabetes education. Retrieved July 7, 2021, from app.leg.wa.gov/WAC/default.aspx?cite=182-550-6400

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[21] Washington Apple Health (Medicaid) Diabetes Education Program Billing Guide (ibid.); HCA Financial Services Division; and ProviderOne Operational Data Store, data pulled July 2021.

[22] Integrated Care Resource Center. Using Health Homes to Integrate Care of Dually Eligible Individuals: Washington State's Experience. Retrieved July 7, 2021, from https://www.chcs.org/media/Washington-case-study_Final.pdf

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[26] Washington State Diabetes Connection. Diabetes Network Leadership Team. Retrieved July 9, 2021, from diabetes.doh.wa.gov/LeadershipTeam

[27] Patient Education Resources. Washington State Diabetes Connection. Retrieved July 13, 2021, from https://diabetes.doh.wa.gov/DiabetesResources/HealthProfessionalResources/PatientEducation

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[30] Diabetes and Your Heart. Centers for Disease Control and Prevention. Retrieved July 13, 2021, from https://www.cdc.gov/diabetes/library/features/diabetes-and-heart.html

[31] 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://chronicdisease.org/resource/resmgr/website-2019/diabetesselfmanagementeducat.pdf

[32] 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

[33] 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

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

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