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Working together to improve health care quality, outcomes, affordability, and equity in Washington State

**Diabetes Care 2023**

# Background

Diabetes is common, with approximately 9% of adults being diagnosed in Washington State in 2021.[[1]](#endnote-2) In the same year, about 11% of Washington adults had been diagnosed with pre-diabetes.[[2]](#endnote-3) Another, one-third of the adult population in Washington state has pre-diabetes, putting them at high risk for developing diabetes over time. Diabetes was the 8th leading cause of death in 2020 and the year before impaired plasma glucose was the 3rd leading cause of death and disability in Washington.[[3]](#endnote-4)[[4]](#endnote-5) At the same time, Washington state performs below the NCQA 25th percentile for blood sugar testing for people with diabetes.[[5]](#endnote-6) Additionally, there are significant disparities in diagnosis and access to medication with Black, Latinx/Hispanic, and American Indian and Alaskan Natives (AIAN) having a higher prevalence of diabetes.[[6]](#endnote-7) People with lower socioeconomic status are more likely to have type II diabetes, associated with a lower utilization of insulin, experience more complications, and die sooner than those with a higher socioeconomic status.[[7]](#endnote-8),[[8]](#endnote-9) The estimated costs attributed to diabetes is $6.7 billion each year in Washington.[[9]](#endnote-10)

Diabetes is a chronic health condition caused by the body’s impaired ability to produce or use insulin to process sugar (glucose) and turn it into energy. Commonly this results in elevated blood sugar which over time leads to serious health complications such as heart disease, vision loss, and limb amputation.,[[10]](#endnote-11) Diabetes may be categorized into types three main types- Type I, Type II, and Gestational Diabetes (occurring during pregnancy); and pre-diabetes. Individuals across the age spectrum can be diagnosed with diabetes. A diagnosis of diabetes among children and adolescents is becoming more prevalent.[[11]](#endnote-12)

There are modifiable risks factors for diabetes that can decrease one’s likelihood of having the disease such as increased knowledge and access to healthy foods, ability to safely engage in physical activity in one’s built environment, and improved management of stress and mental health well-being.[[12]](#endnote-13) Furthermore, supporting access to monitoring tests, allows individuals to know if they are among the one of five Americans who do not know they have diabetes or the 8 of 10 people who are unaware they have prediabetes.[[13]](#endnote-14) By completing a test like an Hemoglobin A1C, people can receive medical care from an interdisciplinary team, medications, and increased linkages to community resources like a recognized National Diabetes Prevention Program (NDPP) or Special Diabetes Program for Indians (SDPI) to promote their optimal health and receive culturally humble care.

## **Bree Collaborative Workgroup**

Selected as a high-priority topic September 2022 by Bree Members, the workgroup met from January to *December* 2023. Key takeaways are:

* Increase access to prevention and health promotion activities.
* Utilization of team-based care to support whole person care for individuals with diabetes or at risk for diabetes.
* Promotion of linkages to care and community resources to provide education on self-management and address social needs such as access to healthy foods.
* Medications that should not require a prior-authorization, co-pay or go towards a person’s deductible to receive.

**Aim**

Improve health care quality, outcomes, affordability, equity, and workforce sustainability related to diabetes care in Washington state.

# Guidelines

## ***Clinicians and Health Care Professionals***

Medications

* Adhere to latest evidence-based guidelines for pharmacologic treatment for diabetes and associated co-morbidities and risk factors.[[14]](#endnote-15)[[15]](#endnote-16)

Population Health & Community Engagement

* Complete prediabetes screening for patients as indicated by the [AMA Prediabetes Quality Measure set](https://www.ama-assn.org/system/files/ama-prediabetes-measure-set.pdf). This includes three (3) electronic clinical quality measures (eCQMs):[[16]](#endnote-17)
	+ Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes (
	+ Diabetes Prevention Interventions for Patients at High-Risk for Developing Diabetes
	+ Diabetes Prevention among Patients at High-Risk for Developing Diabetes.
* Refer patients to social workers, care manager and community support to seek opportunities to address food insecurity. [[17]](#endnote-18)
* Refer clients to [Nationally Diabetes Prevention Program (NDPP)](https://www.cdc.gov/diabetes/prevention/index.html) or [Special Diabetes program for Indians (SDPI).](https://www.ihs.gov/sdpi/)
* ~~Become educated on the role of Community Health Workers to support patient care and how they may interact with patients (in-person, tele-visit, or group classes~~.)
* Refer clients to community health workers through patient’s health clinic, plan, a local Community Care Hub or Community Based Organization for care management items related to diabetes and diabetes prevention such as:[[18]](#endnote-19),[[19]](#endnote-20)
	+ Screening and health education
	+ Outreach, enrollment, and information
	+ Patient navigation
* ~~Follow the health system’s diabetes care pathway that includes prediabetes screening..[[20]](#endnote-21)~~~~,~~~~[[21]](#endnote-22)~~

Team-Based Care

* Diabetes and Dental Care
	+ Inform patients of increased risk of serious oral and systemic complications when Periodontal Disease is untreated in patients with diabetes and that successful periodontal therapy may have a positive impact on these factors.[[22]](#endnote-23)
	+ For all people with newly diagnosed diabetes, ask about a prior diagnosis of Periodontal Disease. Ask all patients about signs and symptoms of Periodontal Disease (bleeding gums during brushing or eating, loose teeth, spacing or spreading of the teeth, oral malodor and/or abscesses in the bums or gingival suppuration.) [[23]](#endnote-24)
		- Positive signs or no history of periodontal exam: refer for periodontal care.
		- Negative signs: monitor for symptoms and if positive, see the dentist promptly.
		- Recommend annual evaluation for all patients with diabetes, including children and adolescents, or more if they have a hx of periodontal disease
* Nurse
* Pharmacist
* Behavioral Health

DCES

## ***Health Delivery Systems***

Team Based Care

* Patients shall have a diabetes care team accessible to them who are accountable for managing blood sugar, blood pressure, lipids, and tobacco smoking cessation counseling. The group should include, as a minimum, a certified diabetes care and education specialist (either a registered dietitian nutritionist or nurse) and clinical pharmacist, with ot
* her members needed to address specific needs of patients. The team will be led by the certified diabetes care and education specialist and be supported by the primary care clinician (e.g., physician, PA-C, ARNP.) The team will report results concerning glycohemoglobin, lipids, tobacco smoking cessation, and diabetes-related hospitalizations, and make them available to patients.[[24]](#endnote-25)
* Care will be delivered according to the attributes of primary care according to the [Bree Collaborative Primary Care report](https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2021/01/Recommendations-Primary-Care-FINAL-2021.pdf).
* Provide telehealth options for outpatient management with Clinical Pharmacists, especially for patients with uncontrolled diabetes (HbA1c > 8%).[[25]](#endnote-26)
* Diabetes and Dental Care
	+ Correspond with dental provider to provide current lab work and medication list.[[26]](#endnote-27)
	+ Ask patients when they were last seen by a dentist. If not recently, encourage the patient to schedule an appointment or refer them to establish care with a dentist.

Population Health & Community Engagement

* Host health fairs where Hemoglobin A1C, or blood sugar testing screening, is provided as part of the health system’s community benefit work to identify individuals at risk for diabetes
	+ Develop referral pathways for individuals that screen positive to be connected with the appropriate level of care and/or establish with a PCP.
* Develop a Diabetes care pathway that includes prediabetes screening.[[27]](#endnote-28),[[28]](#endnote-29)
* When referring clients to a recognized [Nationally Diabetes Prevention Program (NDPP)](https://www.cdc.gov/diabetes/prevention/index.html) or [Special Diabetes program for Indians (SDPI),](https://www.ihs.gov/sdpi/) assist them in finding a program that aligns with their learning needs and is inclusive of their identities (e.g., language, culturally appropriate, or provided in connection with a faith-based organizations.)
* Consider having Community Health Workers (CHW) as part of interdisciplinary teams[[29]](#endnote-30)
	+ Consider hiring or partnering with Community Health Workers to support the care of individuals with diabetes or at risk for diabetes.
		- Follow the [NCQA/Penn Medicine](https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs_White-Paper_Final.pdf) guidelines for supporting community health workers.
		- Provide opportunities for CHW to engage with clients.
	+ Contract with Community Care Hubs and Community Based Organizations to work with CHW to support the care of individuals with diabetes or at risk for diabetes.
* Refer patients to social workers, care manager and community support to seek opportunities to address food insecurity. [[30]](#endnote-31)
* Educate medical staff on the role of CHWs to support patient care and how they may interact with patients (in-person, tele-visit, or group classes.) Provide patients with diabetes or at risk for diabetes with the opportunity to engage in group visits to receive education and resources on diabetes and health promotion. [[31]](#endnote-32) Consider providing shared medical visits

## ***Health Plans and Dental Plans***

Medications & Supplies

* Minimize barriers to pre-authorization by ensuring individuals meet inclusion criteria for on label prescribing for medication, supplies, and equipment designated as recommended by the most current version of ADA Standards with grade A evidence.
	+ Example: Pharmacy benefit manager approves grade A medications if there is a history of billed diagnosis of diabetes.
	+ Example: Approve these medications with grade A evidence automatically if there is a previous prescription in patient history for metformin.
* Minimize barriers to access and cost for members to receive insulin pumps by covering insulin pumps under a pharmacy benefit in addition to those covered as DME.

Population Health

* Partner with community organizations and provider groups to increase access for patients to healthy produce such as fruit and veggie Prescription Program. [[32]](#endnote-33)
* Ensure Hemoglobin A1C (A1C), Fasting Plasma Glucose, or random or post-prandial plasma glucose test monitoring is completely covered once per year by eliminating co-pays for:
	+ Individuals with pre-diabetes cover A1C monitoring a minimum of twice a year.
		- Preventative diabetes services, such as A1C monitoring, do not require co-pay and do not count against their deductible.
	+ Person with diabetes cover A1C monitoring a minimum of 4 times a year.
* Consider Washington State be one of the states to test Prediabetes Measures for Medicaid beneficiaries in concert with AMA's work to have quality measures vetted through Medicare Mock Measures for NDPP. These measures for Medicare are under appeal.[[33]](#endnote-34)
* Washington state HCA to cover the National Diabetes Prevention Program as Medicare does and any certified NDPP of the patient's choosing with guidance from their health care provider.[[34]](#endnote-35)

Team-based Care

* If a client is at risk for, or has Periodontal Disease, reimburse for full-mouth subgingival instrumentation and four supportive (periodontal) maintenance visits annually. [[35]](#endnote-36)

## ***Purchasers***

Medications

Population Health & Community Engagement

* Cover visits
	+ for diabetes education and care for a minimum of six visits a year.
	+ with a Certified Diabetes Care and Education Specialist for a minimum of six hours a year.
	+ with Registered Dieticians for individuals with diabetes or diagnosis with pre-diabetes for minimum of six visits a year for medical nutrition therapy.
	+ visits with a Community Health Worker including virtual visits.[[36]](#endnote-37),[[37]](#endnote-38)
	+ Group visits for education and resources
* Do not require co-pay, coinsurance nor have visits count against their deductible to receive visits for diabetes, pre-diabetes, care, or prevention.
* Cover Diabetes Prevention Program as Medicare does and any certified NDPP of the patient's choosing with guidance from their health care provider.[[38]](#endnote-39)
* Provide coverage for remote patient monitoring codes (e.g., reviewing information from Continuous Glucose Monitors) for billable actions.
* Increase the allotted time for clients to work with Diabetes Care and Education Specialists by ensuring patients can see them for at least 6 hours per year.
	+ If a client requires more time with Specialist due to a medical necessity, then approve more hours through prior authorization process.

Team-based Care

* Ensure there is coverage for the appropriate dental care for clients.

## ***DOH/Public Health Agencies***

Medications & Supplies

* The HTCC should consider re-evaluating coverage guidelines for continuous glucose monitoring considering the updated CMS coverage[[39]](#endnote-40)[[40]](#endnote-41)

Population Health & Community Engagement

* Develop a patient facing diabetes resource platform to inform clients where they may receive support in managing their diabetes.[[41]](#endnote-42), [[42]](#endnote-43)
	+ Provide information on clinics to establish care (clinics who accept sliding scale fee/uninsured), Primary Care Providers accepting new clients, Diabetes Care and Education Specialist, community resources, resources to support SDOH.)
* Support a mobile van outreach systems to engage with communities with known disparities (e.g., low-income areas, rural settings, agricultural workers.)[[43]](#endnote-44)
* Develop interventions to support individuals in accessing and affording healthy foods such as a Fruit and Veggie Prescription Program.[[44]](#endnote-45),[[45]](#endnote-46)
* Train Community Health Workers on diabetes care and self-management for individuals with diabetes or at risk for diabetes such as the [WA DOH’s Health Specific Module on Diabetes and Pre-diabetes course](https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/local-health-resources-and-tools/community-health-worker-training-program).
	+ Encourage clinicians to meet with CHWs to review patient panels, educational learning material and topics to answer any questions or concerns. [[46]](#endnote-47)
* BCCP model for screening in uninsured and underinsured?Consider supporting community health worker programs, whether developing new public health programs, providing funding for community-based programs, or offering reimbursement for care coordination as a health-related service.

## ***Legislation***

Medications

Population Health & Community Engagement

* Encourage subsidies of healthy fruit and veggies for individuals to increase access and address food insecurity.
* Washington state HCA to support a State Plan Amendment for coverage of the National Diabetes Prevention Program (see [Case for Coverage](https://coveragetoolkit.org/medicaid-agencies/case-for-coverage/) resources for states engaging in coverage policies for the National Diabetes Prevention Program)

Diabetes and Dental Care

## **Patients**

Medications

Population health

Team-based Care

* Diabetes and Dental Care
	+ Tell your dentist if you have been diagnosed with diabetes[[47]](#endnote-48)
	+ Let your PCP and non-dental providers know about upcoming dental and surgical visits.
	+ Complete a dental checkup as per standards of care, or more frequently if recommended.
		- Get your teeth and gums cleaned once a year (or more if your provider recommends)[[48]](#endnote-49)
	+ Quit tobacco. Ask your PCP or dentist for help quitting.
	+ Brush well twice a day and floss daily.
	+ If you notice bleeding gums, white patches, bad taste, or mouth soreness consult your dentist promptly.
	+ Make sure your dentures fit well and don’t cause mouth pain or sores.

## ***Schools***

Population Health & Community Engagement

* Follow [American Diabetes’s Association’ Guide for School Personnel](https://diabetes.org/sites/default/files/2022-11/School-guide-final-11-16-22.pdf) on how to support students’ with diabetes.[[49]](#endnote-50)
* Provide education to nurses and staff on diabetes, diabetes management, and how to provide insulin to support students.
	+ Provide virtual and asynchronous education opportunities for school staff to learn about diabetes who may not be able to attend in-person training.
* Provide healthy food options in cafeteria for school meals and in school vending machines for students to access.[[50]](#endnote-51)
* Engage with children, adolescents, parents, and school staff to support the development of educational lifestyle health programs for children and adolescents with diabetes or at risk for diabetes.[[51]](#endnote-52)

## ***Dentists and Dental Clinics***

Team-based Care

* Follow [American Dental Association’s](https://www.ada.org/en/resources/research/science-and-research-institute/oral-health-topics/diabetes) recommendations on providing dental care to patients with diabetes.[[52]](#endnote-53)
* Follow [International Consensus Report](https://pubmed.ncbi.nlm.nih.gov/29280174/) guidelines for management of periodontal disease among patients with diabetes.[[53]](#endnote-54)
* Inform patients with diabetes: they are at increased risk for oral complications (dry and/or burning mouth, fungal infections, poorer wound healing) and serious systemic complications (cardiovascular and kidney disease); successful periodontal therapy may have a positive impact on these factors.[[54]](#endnote-55)
* Consult with the Patient’s Primary Care Provider (PCP) prior to oral interventions and/or surgery to avoid hypoglycemia and to consider its potential impact on the patient’s ability to eat (e.g., delayed wound healing). Ensure the Electronic Dental Record is current with lab values and medications.[[55]](#endnote-56)
* Screen patients to determine if they have been evaluated by a PCP within the past 6 months. If not, encourage the patient to schedule an appointment or refer them to establish care with a PCP.
* Screen patients for tobacco use. Provide tobacco cessation support to patients who use tobacco or refer to a PCP.
* Offer dental rehabilitation to restore adequate mastication for proper nutrition.[[56]](#endnote-57),[[57]](#endnote-58),[[58]](#endnote-59)
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