

Diabetes Prevention Training



Guest Speakers

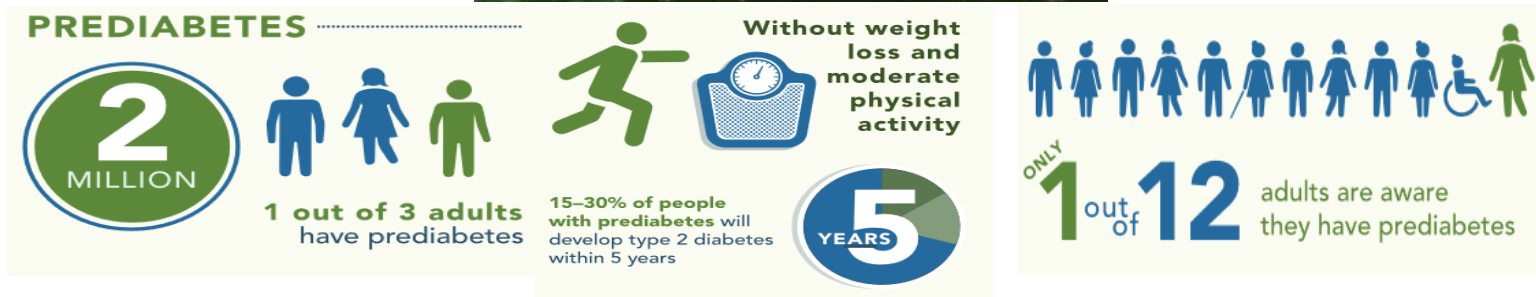
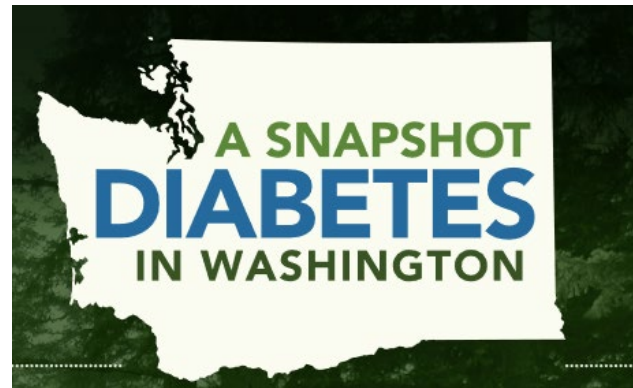
- ▶ Alexandro Pow Sang
- ▶ Dr. Avantika C. Waring, MD
- ▶ Grace Silverio
- ▶ Craig Ikens
- ▶ Ashley Knight
- ▶ Ramon Navarro



Diabetes Snapshot



Prediabetes Snapshot



Objectives

- ▶ How diabetes and prediabetes impact the workplace.
- ▶ Provide an overview of diabetes programs for PEBB and SEBB.
- ▶ Review best practice guidelines for including diabetes prevention in your wellness plan.

Guest Speaker: Alexandro Pow Sang

- ▶ Alexandro Pow Sang is a cross-cultural, bilingual professional with experience working in direct and indirect services on diabetes management and prevention for almost 12 years. In 2015 he joined the Heart Disease, Stroke, and Diabetes Prevention Unit at the Washington State Department of Health as the Diabetes Consultant. In his current position, he promotes the Medicaid Diabetes Education Reimbursement Program.



DIABETES IN WASHINGTON 2020

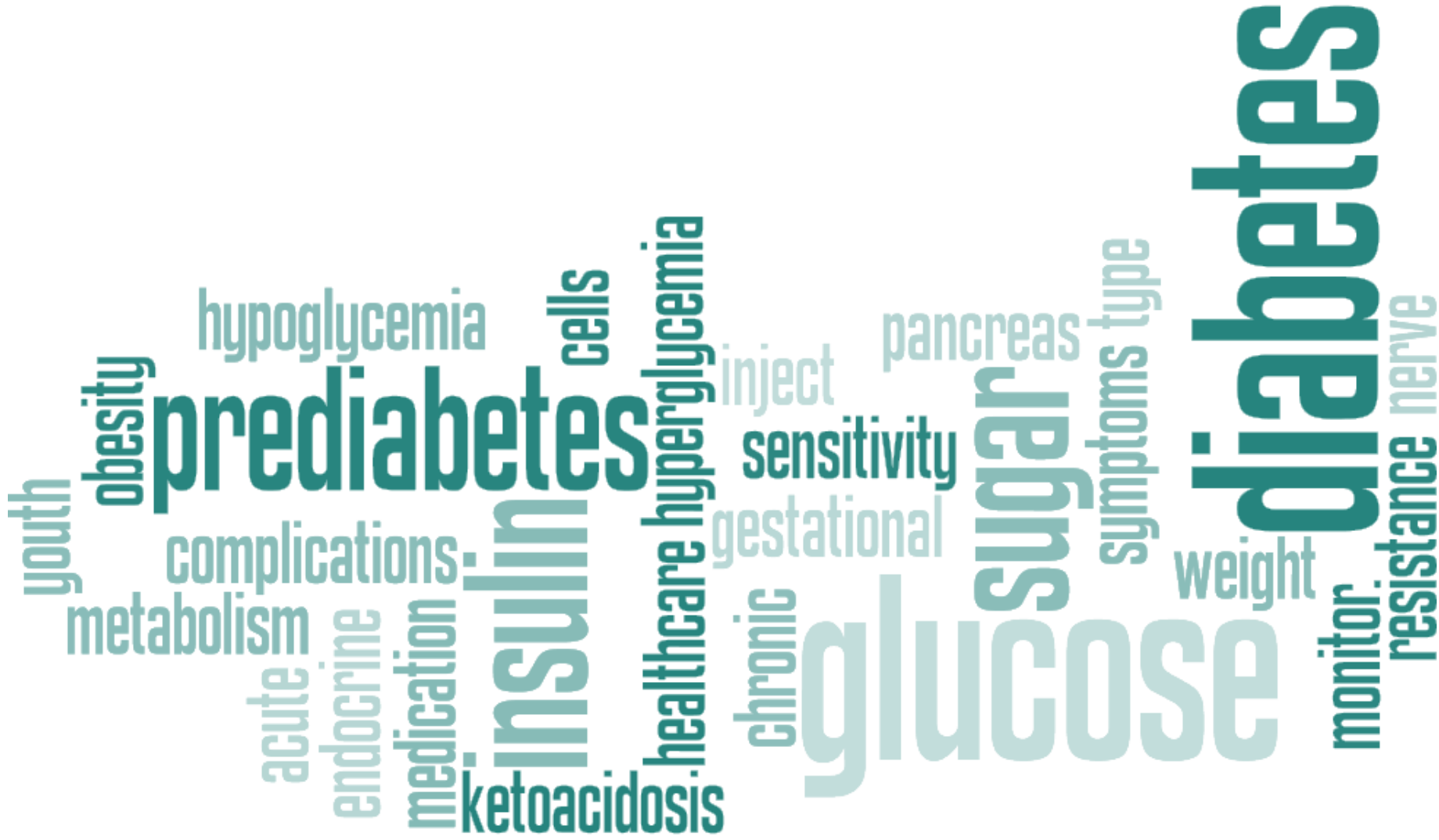
Understanding Diabetes Management and Prevention
November 12, 2020

Objectives

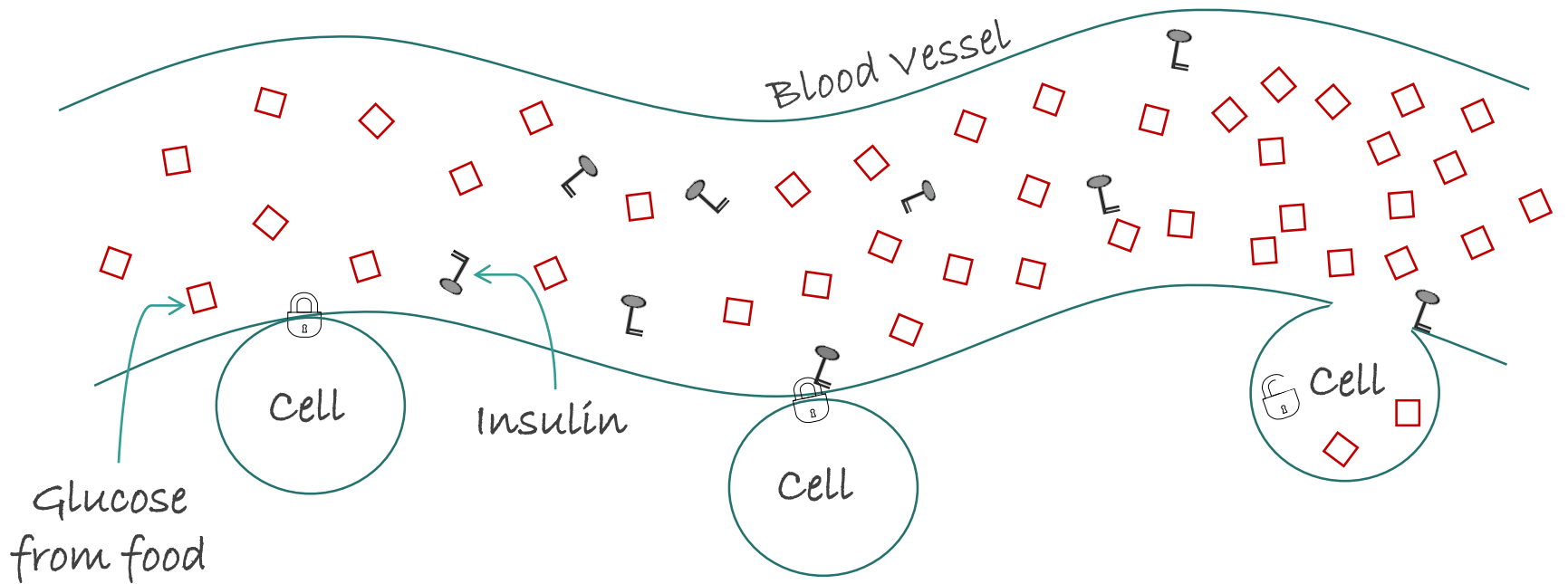
- Understand and describe basic information about diabetes and prediabetes
- Understand the current impact of diabetes and prediabetes in Washington State
- Understand and describe diabetes and prediabetes screening methods
- Learn how to address diabetes management and prevention
 - Prediabetes risk test
 - Diabetes Prevention Program
 - Diabetes Self-Management Education and Support



You may know someone with diabetes.



Prediabetes

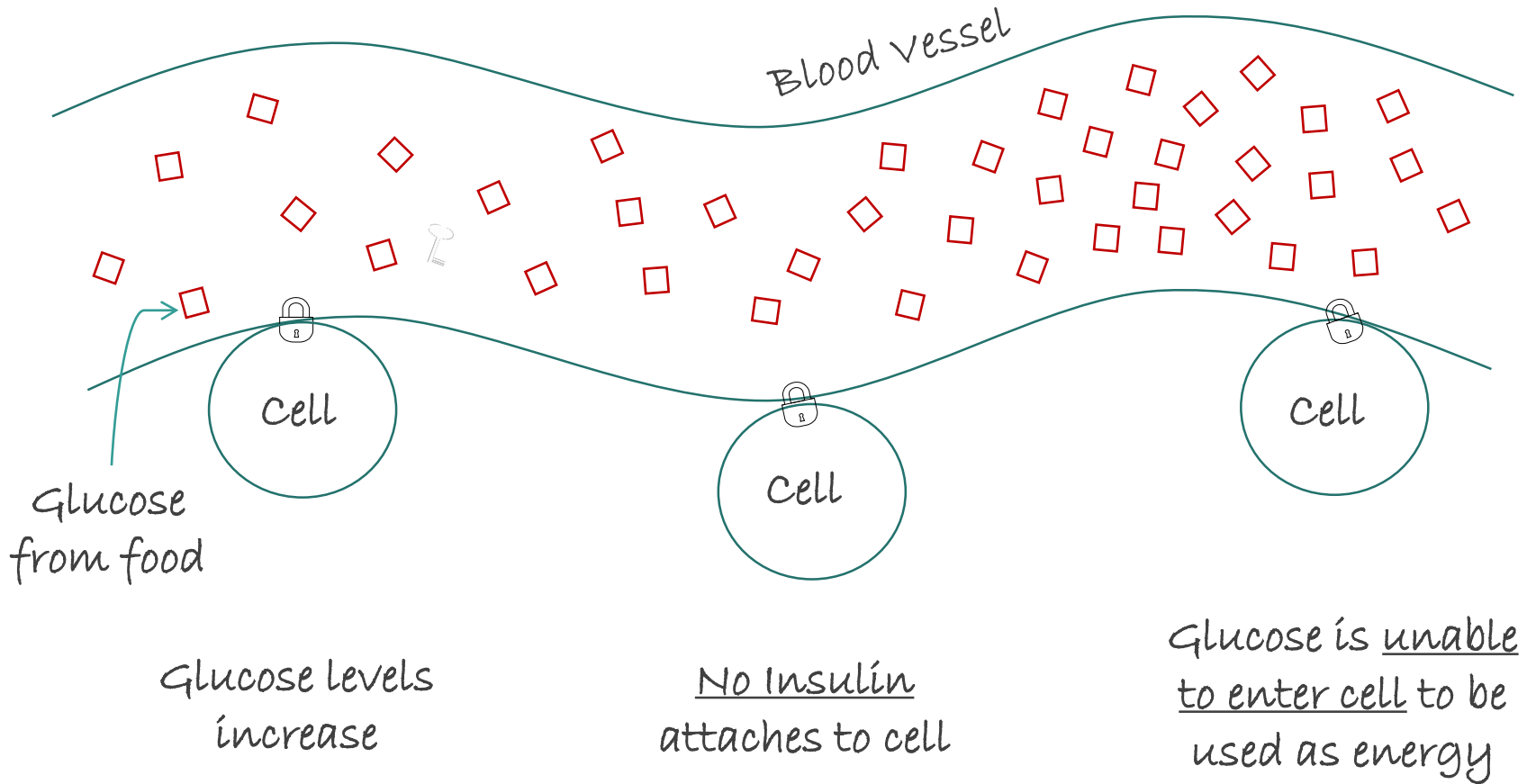


As glucose levels increase, insulin goes up

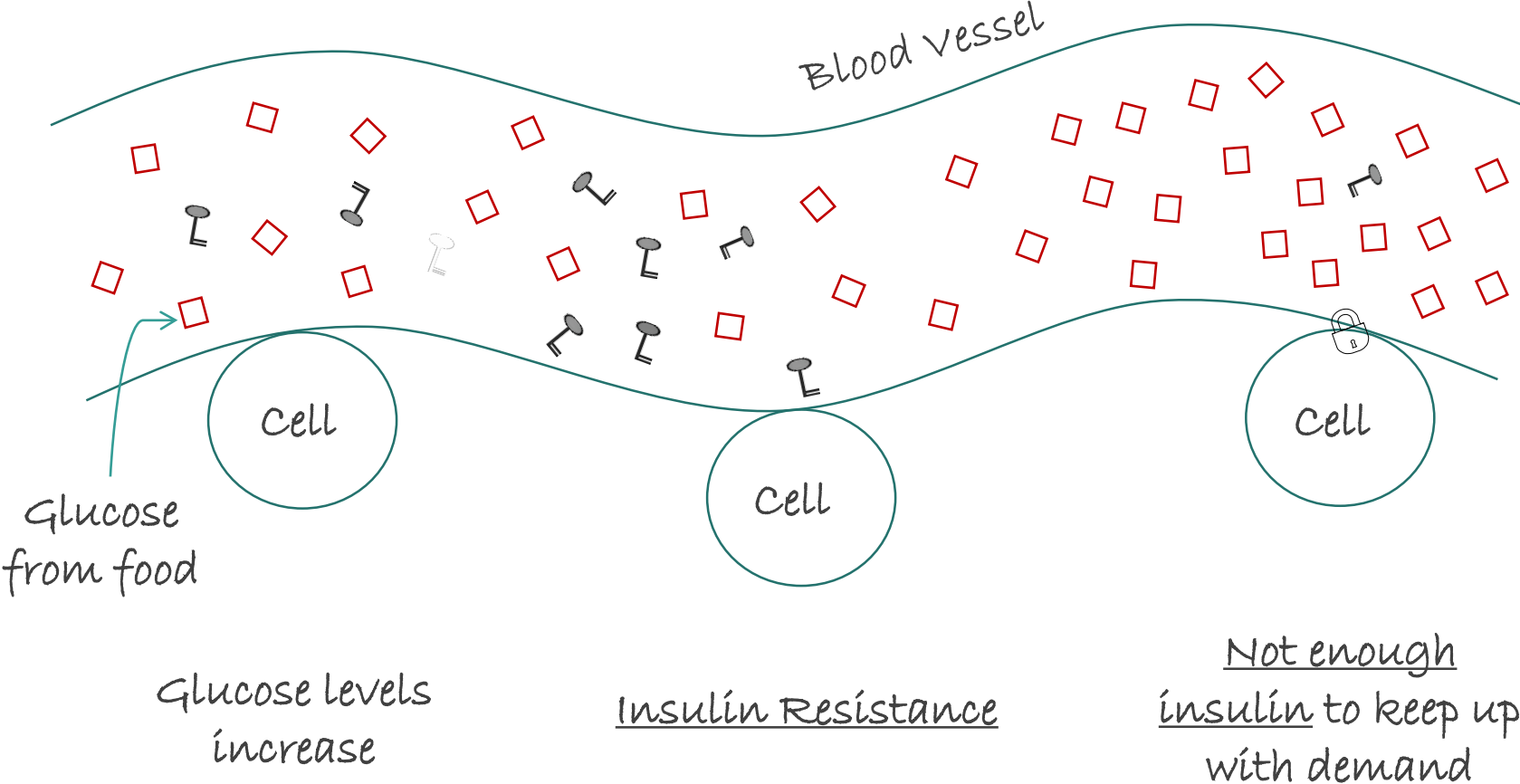
Insulin attaches to cell

Insulin opens cell and glucose gets used as energy

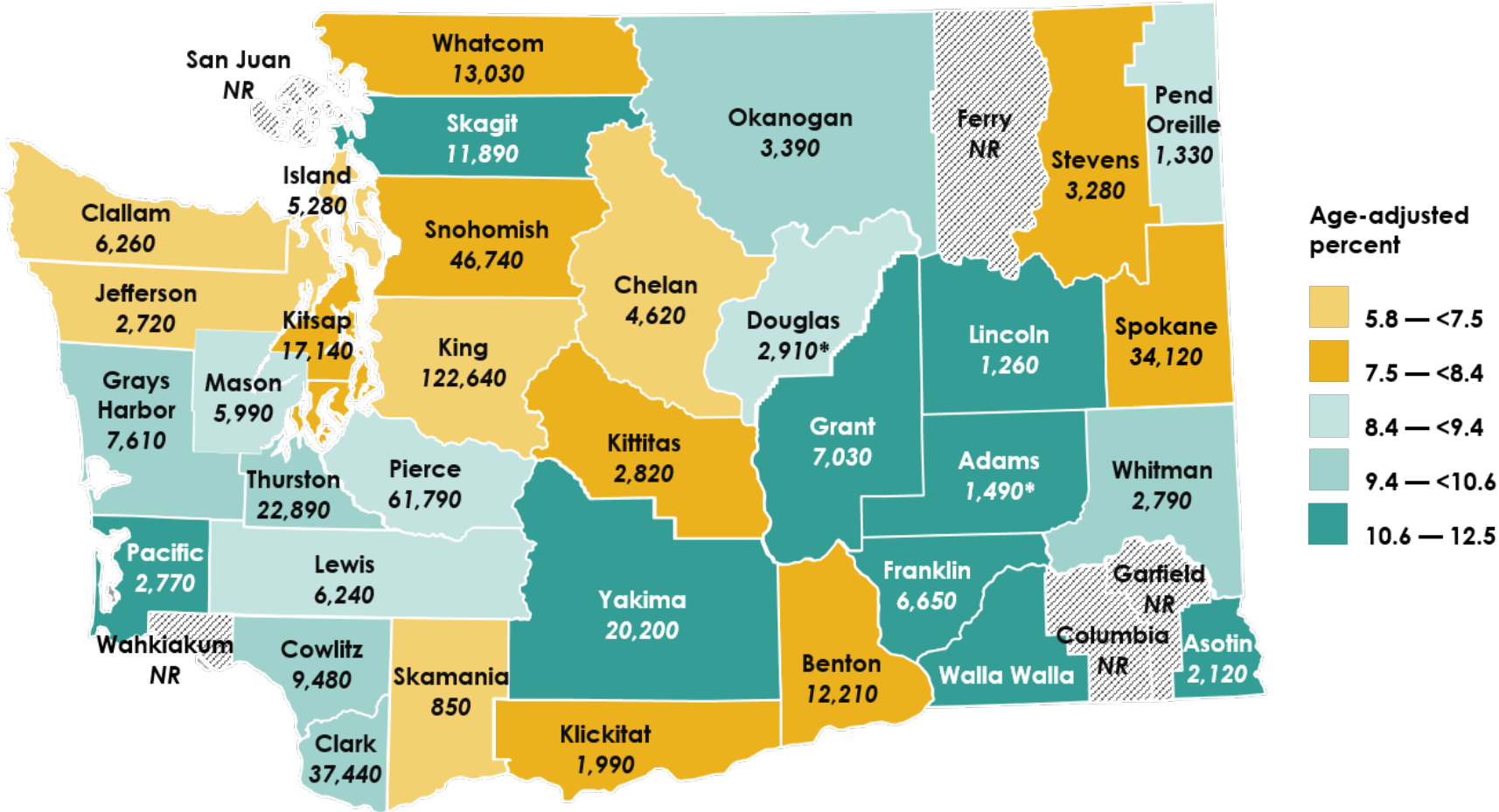
Type 1 Diabetes



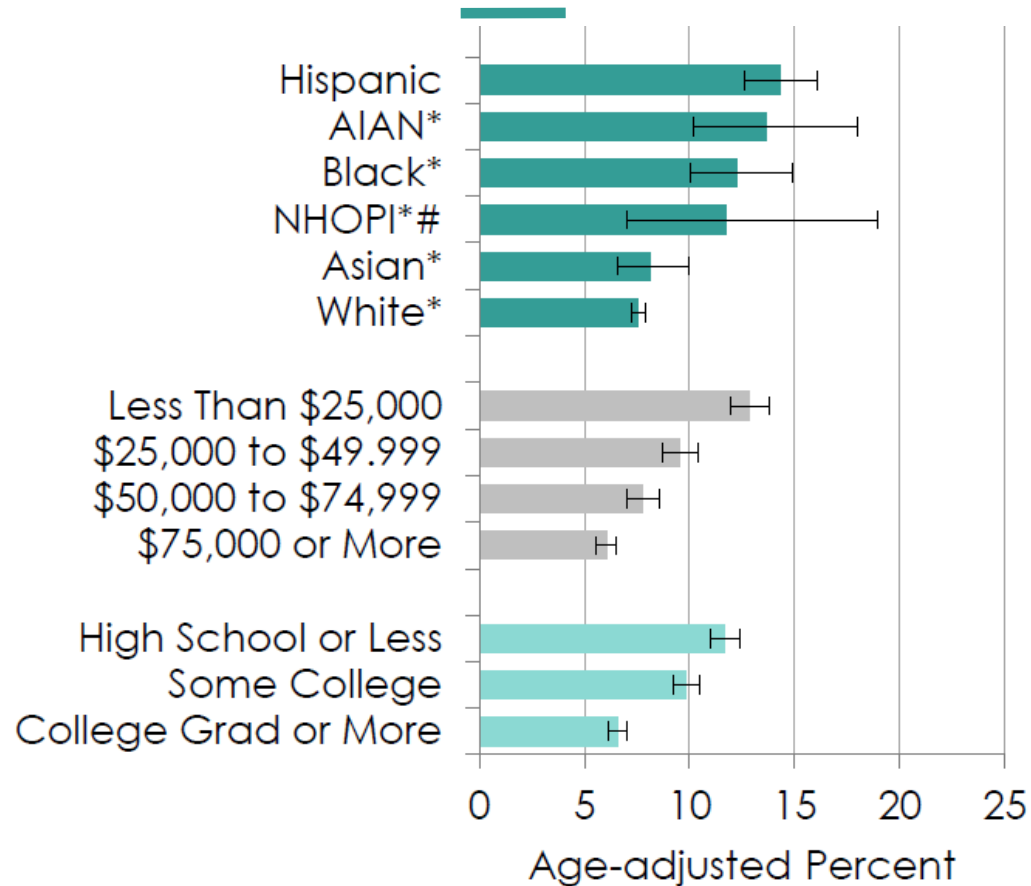
Type 2 Diabetes



Geographic disparities across Washington



Sociodemographic disparities across Washington



*Non-Hispanic, AIAN: American Indian/Alaska Native, NHOPI: Native Hawaiian/Other Pacific Islander

RSE 25-29%, suggest using caution with potentially unreliable estimate

Source: Washington State Behavioral Risk Factor Surveillance System Survey

Diabetes in Washington



686,000

People in
Washington have
diabetes

*That is about **1** out
of **11** people*

Prediabetes in Washington



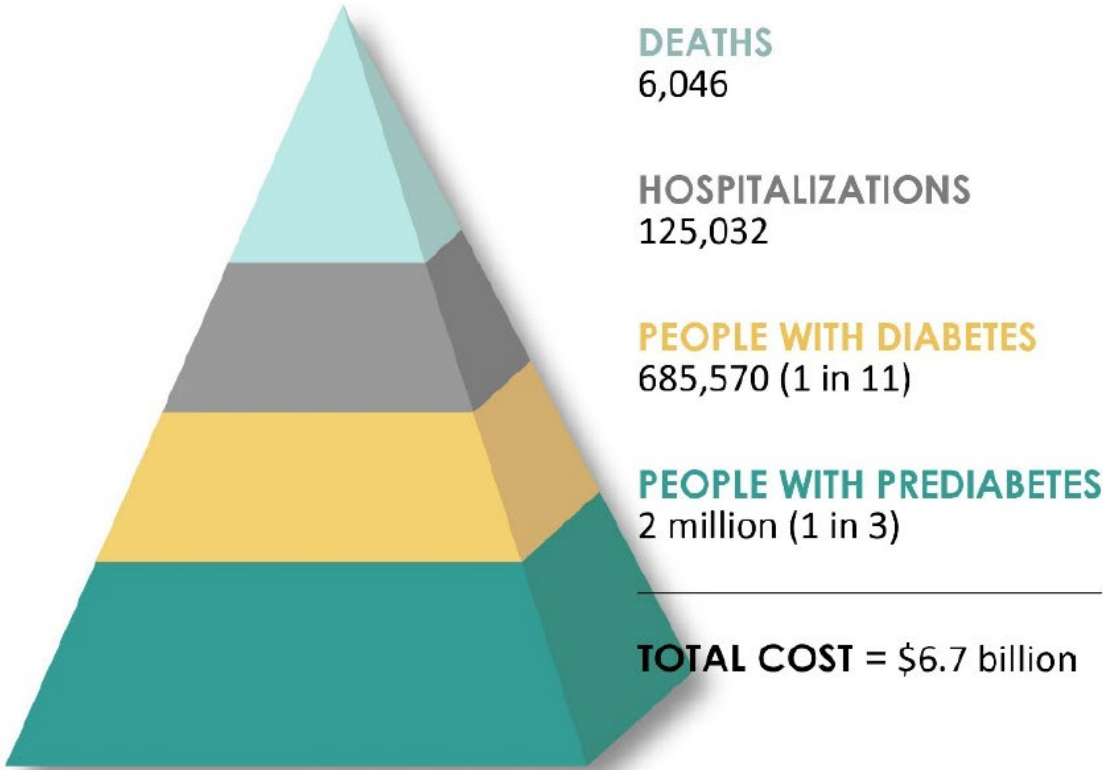
2 million

Adults in
Washington have
prediabetes

*That is about **1**
out of **3** people*

A current look at diabetes in Washington

Burden and financial impact of diabetes, 2017



Supporting Screening

- Encourage **prediabetes screening** by sharing these questionnaires

DO YOU HAVE PREDIABETES?
Prediabetes Risk Test

1. How old are you?
Younger than 40 years (0 points)
40-49 years (1 point)
50-59 years (2 points)
60 years or older (3 points)

2. Are you a man or a woman?
Men (1 point) Women (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?
Yes (1 point) No (0 points)

4. Do you have a mother, father, with high blood pressure?
Yes (1 point) No (0 points)

5. Have you ever been diagnosed with high blood pressure?
Yes (1 point) No (0 points)

6. Are you physically active?
Yes (1 point) No (1 point)

7. What is your weight category?
(One check or right)

Write your score in the boxes below

Height	Weight (lbs.)
4'10"	119-142
4'11"	124-147
5'0"	128-152
5'1"	132-157
5'2"	136-163
5'3"	141-168
5'4"	145-173
5'5"	150-179
5'6"	155-185
5'7"	159-190
5'8"	164-196
5'9"	169-202
5'10"	174-208
5'11"	179-214
6'0"	184-220
6'1"	189-226
6'2"	194-232
6'3"	200-239
6'4"	205-245
	210-246
	215-251
	220-257
	225-263
	230-269
	235-275
	240-281
	245-287
	250-293
	255-299
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	820-977
	825-983
	830-989
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	840-1001
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	2735-3275

Blood Test Values

Test	Normal	Prediabetes	Type 2 Diabetes
Hemoglobin A1C	<5.7	5.7 – 6.4	≥6.5
Fasting Plasma Glucose Levels	70-99	100-125	≥126
2-h Oral Glucose Tolerance Test	<140	140 – 199	≥200

If result is positive, a second test is needed to confirm diagnosis

Hemoglobin A1C:

- Average glucose level of the last 2 to 3 months

Fasting Plasma Glucose:

- Glucose level after 8 hour fasting period

Oral Glucose Tolerance Test (OGTT):

- Two readings; One fasting and one 2 hours after glucose drink is taken

Supporting Self-Management

Encourage participation in DPP and DSME programs

Diabetes Prevention Program (DPP)

The screenshot shows the CDC National Diabetes Prevention Program website. At the top, there is the CDC logo and navigation elements like a search bar and a dropdown menu for 'CDC A-Z INDEX'. Below the header is a dark green banner with the text 'National Diabetes Prevention Program' and social media icons. The main content area features a large blue and green banner with the text 'PROVEN LIFESTYLE CHANGE PROGRAM' and 'NEW CURRICULUM PREVENT 2'. Below this is a 'GENERAL INFORMATION' section with six cards:

- 1. About Prediabetes & Type 2 Diabetes:** Prediabetes is a serious condition affecting 1 out of 3 American adults—that's 86 million people!
- 2. Research-Based Prevention Program:** A CDC-recognized lifestyle change program is a proven way to prevent or delay type 2 diabetes.
- 3. Lifestyle Change Program Details:** Learn what to expect when joining a CDC-recognized lifestyle change program to prevent type 2 diabetes.
- 4. Testimonials from Participants:** Hear from real people who benefited from a CDC-recognized lifestyle change program.
- 5. Find a Program:** Find a CDC-recognized lifestyle change program near you or join one of the online programs!
- 6. What is the National DPP?:** Learn about this national partnership to prevent or delay type 2 diabetes in the United States.

Diabetes Self-Management Education and Support (DSME)

The screenshot shows the CDC Diabetes Self-Management Education and Support (DSMES) Toolkit website. It features a purple header with the title 'Diabetes Self-Management Education and Support (DSMES) Toolkit' and navigation elements. Below the header is a sidebar with a list of topics:

- DSMES Toolkit
- Background, Terminology and Benefits
- National Standards for DSMES
- DSMES Accreditation and Recognition Process
- Increasing Referrals and Overcoming Barriers to Participation
- Service Staffing and Delivery Models
- Building the Business Case for DSMES
- Marketing and Promotion**
- Reimbursement and Sustainability
- Glossary
- References

The main content area is titled 'Marketing and Promotion' and contains the following text:


Healthcare providers, diabetes educators, and other key stakeholders understand that DSMES services have many benefits, including increasing satisfaction, improving clinical quality, enhancing clinical outcomes, and reducing costs. Nonetheless, participation in DSMES by people with diabetes is low. According to research by the American Association of Diabetes Educators, diabetes education is generally highly regarded by providers; however, "it's only recommended on average for just 62 percent of their patients."¹⁶

Although clinicians recognize that diabetes education is effective, some providers are not aware of existing DSMES services. Promoting DSMES and highlighting its value are critical to encourage referrals as well as ensure long-term sustainability. It is essential that healthcare providers understand a service's scope and how it can improve health, but also how it can help them meet quality measures and increase productivity. Communication with providers is a good first step toward increasing awareness and referrals.

A common reason for business failure is the absence of an achievable marketing plan that is customized to meet the needs of the target market. Marketing is the act of promoting and selling products or services, including market research and advertising. It is essential to create a marketing plan to effectively promote DSMES services and increase referrals.

Resources for additional information for marketing DSMES services:

[The Diabetes Self-Management Education and Support Joint Position Statement User Guide](#) [PDF - 540 KB] Diabetes educators can use this guide when making presentations to groups that can influence referrals, including local educators, physician and nursing leaders, performance improvement and quality departments, administrators, and other individuals and groups (depending on the local practice site context). Educators can use the Joint Position Statement and algorithm to communicate with providers who refer as well as those who do not make referrals. The User Guide has items created specifically to support communication and marketing. The User Guide also includes the following:



Supporting Self-Management

Program locators (and visits to healthcare providers!) can help guide community members to local Diabetes Prevention Programs (DPP) and Diabetes Self Management Education (DSME)

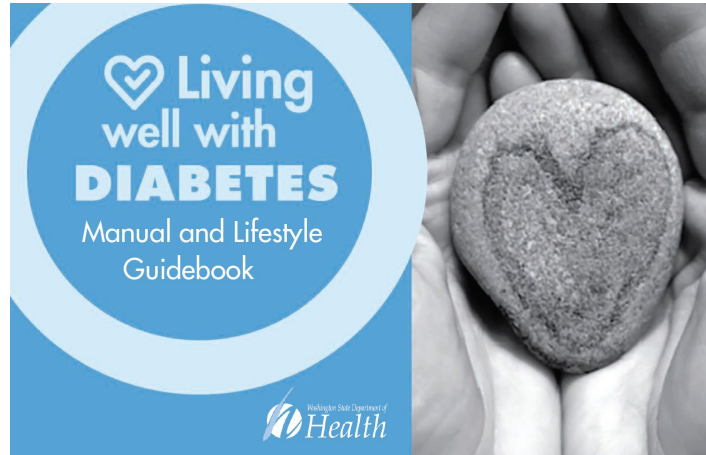
Center for Disease Control and Prevention

The screenshot shows the CDC's National Diabetes Prevention Program website. The header includes 'HOME: National Diabetes Prevention Program'. A sidebar on the left lists various program details and a 'Find a Program' section. The main content area is titled 'Find a Program Near You' and includes social media icons, a search prompt, and a map of the United States. A 'GO' button is visible next to the location dropdown menu.

WIN 2-1-1

The screenshot shows the WIN 2-1-1 website, a Washington Information Network. The header features the '2-1-1' logo and navigation links for 'Popular Topics', 'My Favorites', 'Contact Us', and 'Chat With Us'. The main content area is titled 'Focus On Health' and includes a search bar for 'My County' and 'Statewide'. Below the search bar are sections for 'TOPICS' (listing various health programs), 'News' (with an article about health insurance), and 'Helpful Links' (including 'Living Well' and 'WSDA Outreach Program').

Support Management and understanding



A blood glucose tracker helps you and your doctor see if your care plan is working. Your doctor will set your target levels.

My blood glucose GOAL IS:

BEFORE MEALS: mg/dL TO mg/dL

AFTER MEALS: mg/dL

2 HOURS after start of meal: BELOW:

MY HEALTHCARE PROVIDER:

Name: _____

Phone: _____


BLOOD Glucose TRACKER

My provider wants me TO CHECK:

PER DAY PER WEEK

Before breakfast After meals

Before meals Before bed



Contact Information



Alexandro Pow Sang

Diabetes Consultant

Alexandro.PowSang@doh.wa.gov

360-236-3750

Washington State Department of Health
Heart Disease, Stroke, and Diabetes Prevention Program

Guest Speaker: Avantika C. Waring, MD

- ▶ Dr. Waring joined the Washington Permanente Medical Group (WPMG) in 2016 as an endocrinology physician at Kaiser Permanente's Capitol Hill campus. Avantika currently serves as both the medical director for KPWA's Diabetes Program and the medical director for Commercial Business.

Diabetes Care at Kaiser Permanente

An Introduction and Overview

Avantika C. Waring, MD
Medical Director Diabetes Program, KPWA



Welcome!

Overview of Diabetes Management

Our Care Team

Health Equity

Resources for our Members

Diabetes Program

KPWA 2016 Implementation of our Updated Care Model

Purpose	People	Process
<ul style="list-style-type: none">■ Support Primary Care■ Deliver Education and Training■ Provide Consultation■ Program Coordination and Development	<ul style="list-style-type: none">■ Diabetes Team<ul style="list-style-type: none">– Diabetologists– Clinical Nurse Specialists– Insulin Technology Nurses– Pharmacy■ Primary Care Clinics<ul style="list-style-type: none">– Diabetes Primary Care Champs– Team RN– Population RN– PCP– Clinic Support Staff– Clinical Pharmacists	<ul style="list-style-type: none">■ Chronic Disease Management<ul style="list-style-type: none">– Opportunistic Referral– Proactive Outreach– Clinical Nurse Specialists– Clinical Pharmacists■ Consultation<ul style="list-style-type: none">– Face to face– Virtual

Our Care Team

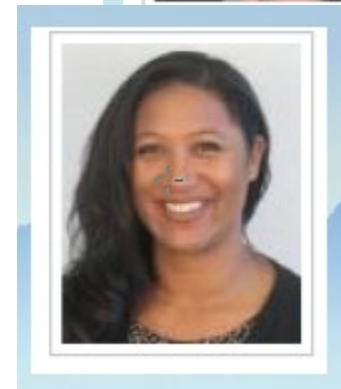
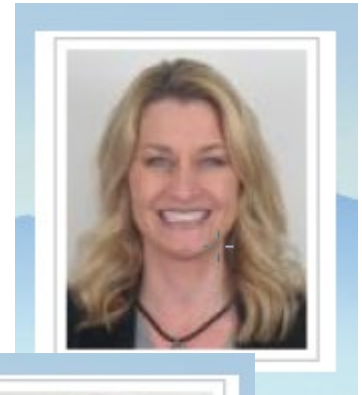
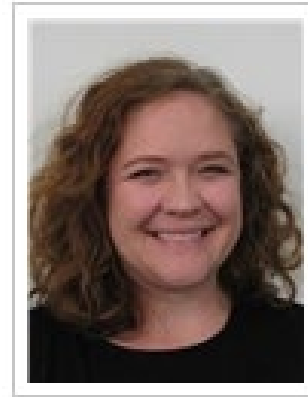
Clinical Pharmacy

- Virtual visits with the patient
- Remote glucose monitoring review
- Medication initiation and adjustment
- Particularly helpful for managing medication side effects, and promoting drug titrations
- Address medication cost concerns

Chronic Disease Management RNs

- Located with the member's primary care clinic
- Available for urgent and initial management issues
 - New diagnosis, glucometer teaching, insulin start
- Work with PCP to develop a care plan for diabetes management
- Standard order set includes medication titration instructions that are aligned with our formulary and KP guidelines
- Review care gaps & provide holistic care
 - HTN control, depression screening, nutrition referrals
- Monthly team meetings

Population Care RN Team



Population Care RN

- Sole focus is diabetes management, and each RN covers several clinic locations
- Largely virtual, but also offer face 2 face visits
- Review care gaps & provide holistic care
- Meet monthly with team
- Higher level of experience with type 1 diabetes, insulin technologies, and more complex cases

Insulin Technology Nurses

- Work with our endocrinologists and primary care providers to identify patients who may benefit from technologies such as insulin pumps and continuous glucose monitors
- Virtual and In-person visits at several locations across the state
- Provides teaching and mentoring to local teams (RNs, pharmacists, primary care providers)

Endocrinology Specialists

- Provide electronic consultation (provider to provider)
- Virtual and Face-to-Face visit with complex patients at local clinics or at our Endocrinology clinic locations
- Available system wide for urgent diabetes issues
- Provides teaching on an individual and group basis

Nutrition Services

- New for KPWA in 2020, six registered dietitians (RDs)
- Several locations, though to date mostly virtual
- Diabetes Type 1, Type 2, Gestational Diabetes
- Coordinated care within our medical record system
- Recommendations are aligned with our KP guidelines
- True team-based care approach!

Disease and care management



Full Range of Support

- Chronic condition management
- Complex case management
- Specialty care management
- Emergency visit management
- Hospitalization management
- Post-hospitalization care transitions
- Utilization management

Health Equity

Health Equity

2019 Pilot Implementation

- KPWA Diabetes Program has improved outcomes, but it doesn't necessarily work as well for all patient groups
- Every year KP National sets an equitable care goal
- 2020 – improve glycemic control in patients with diabetes by centering work around hemoglobin A1c less than 8 and to reduce the rate between the HEDIS 90th percentile rate and that of the priority racial group (Latinx).

Health Equity Pilot

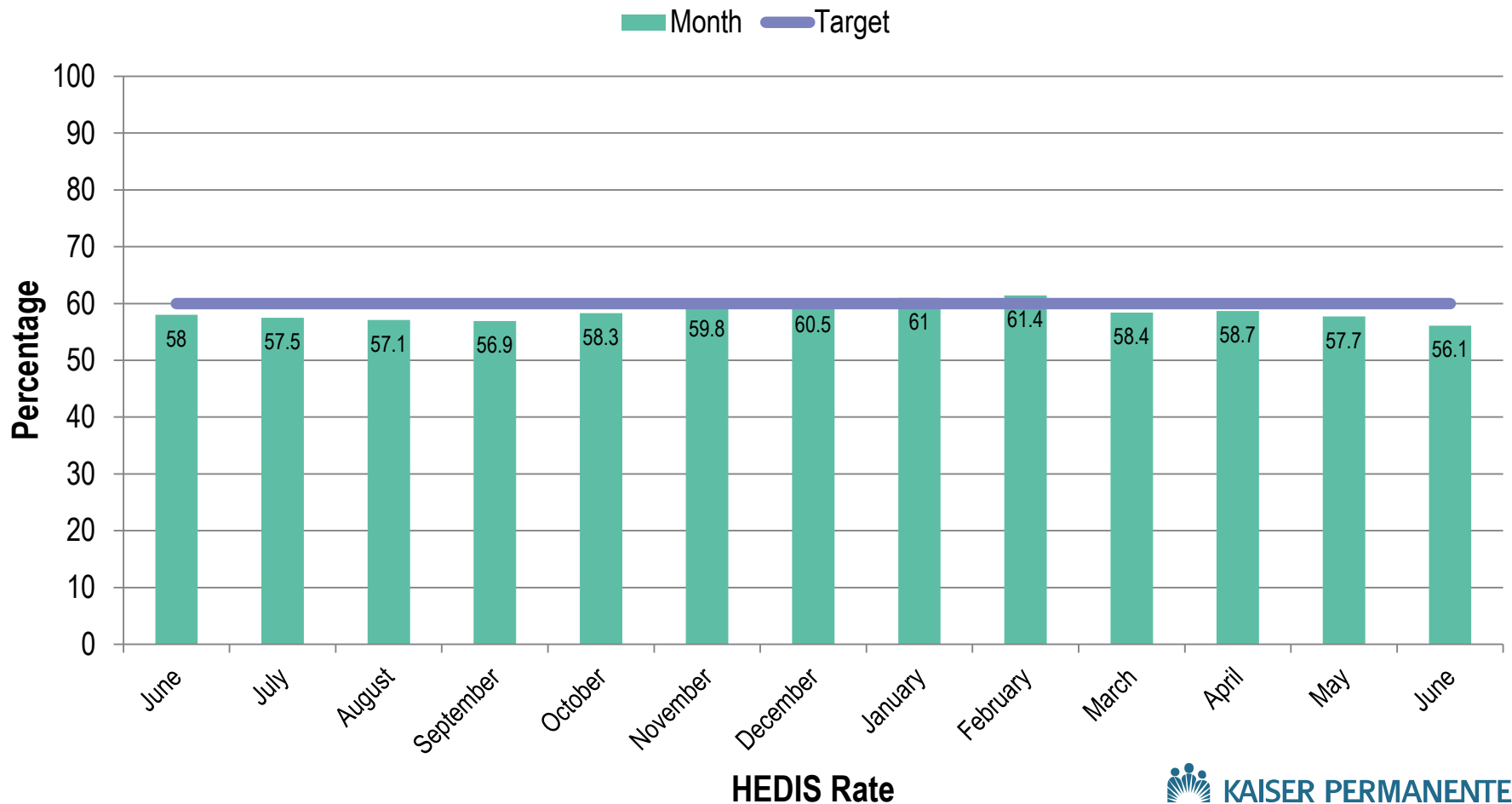
2019 Everett & South King

- Cultural competency training
- Patient education material in Spanish
- Registry with targeted outreach
- Dedicated Population RN with a focus on Latinx population

Health Equity Pilot Data

2019 & 2020

Overall KPWA Hispanic Diabetes Care Pilot Performance



Health Equity Strategies

2020 Spread

- Provide 3 series of health equity training sessions for clinical teams spread over 9 months (Nov 2020 - May 2021)
- Population care RNs continue to prioritize Latinx population with proactive outreach
- Begin screening for social determinants of health (SDOH) as a part of CDM intake
- Stratify patient experience surveys of our chronic disease management program by race and ethnicity
- Use our region's IHI participation to generate new programmatic approaches to address disparities in diabetes care

Resources for our Members

Living well workshops for patients - KPWA

- Focuses on chronic conditions; taught **on-line** or **in-person** by specially trained volunteers who have personal experience
- Originally developed by researchers at Stanford who have demonstrated improved outcomes and lower costs
- Participants set goals and develop action plans, solving problems together

TOPICS COVERED:

- Pain management
- Medication management
- Nutrition choices
- Exercise
- Making treatment decisions
- Working with clinicians

Workshops offered at most clinics:

- Living Well with Chronic Conditions
- Living Well with Diabetes
- Living Well with Chronic Pain

Member outreach for needed care - KPWA



- Birthday letter – 2 weeks before birthday. Notes overdue or soon-to-be-due screenings
- Care gap letter – 2 to 3 times a year



- Automated call – 9 months after birthday
- Clinic outreach call – 1 month after birthday. At Kaiser Permanente facilities and many other network providers



- Opportunistic care – When patients come in with an issue, providers check for other needed screenings or tests. At Kaiser Permanente facilities and many other network providers

Clinical Resources - KPNW

- Diabetes One Stop – triage and navigation
- Lab protocol and outreach: centralized letter and phone outreach
- Medication management– pharmacy program to treat to target including all CVD risk reduction
- Primary care nurse visits (phone, video, f2f); insulin starts
- Diabetes disparity work- *Salud en Espanol*– fully bilingual modules in several locations to support Spanish speaking members
- Videos/podcasts:
 - Prediabetes, steps I can take now

Educational Resources

- Free telephonic health coaching:
 - Available Mon-Fri., English and Spanish
- Classes and webinars:
 - Managing Diabetes
(diabetes basics, insulin information, pediatric diabetes program)
 - Preventing diabetes
- Videos/podcasts:
 - Prediabetes, steps I can take now

Guest Speakers: Craig Ikens and Grace Silverio

- ▶ Craig Ikens is Vice President, Health Services at Livongo and responsible for the overall partnership with Premera. He joined Livongo in June 2016 to do sales into health plans after having spent the prior decade at a large BCBS plan overseeing its mergers and acquisitions.
- ▶ Grace Silverio is a Solution Sales Consultant and subject matter expert for Livongo Diabetes Prevention, Weight Management, and Whole Person Solutions. Grace is also a registered nurse for over 13 years, a Certified Diabetes Care and Education Specialist, and Certified Case Manager.



2020 Chronic Condition Support

—
Washington State Health Care Authority

November 12, 2020

Confidential.





Livongo is the leading Applied Health Signals company that empowers people with chronic conditions to live better and healthier lives.



We create a consumer-first, data-driven experience for health and care.



For Members, we provide effortless data collection and a human-centered approach to deliver actionable, personalized and timely feedback when and where they need it most.



The Challenge of Diabetes

High prevalence

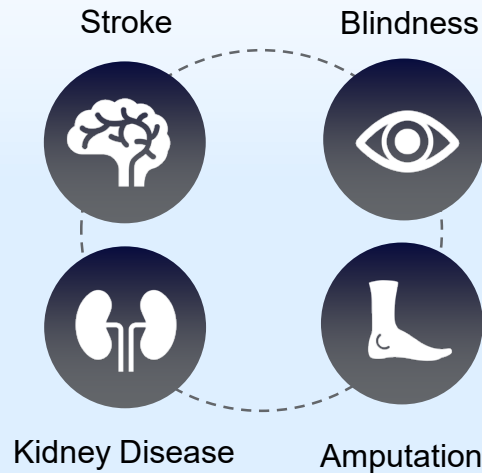
1 in 10 Adults have diabetes



25%

Are undiagnosed¹

Increased risk of complications



Cost of diagnosed diabetes^{2,3,4}



1. CDC Diabetes Quick Facts. (2019) <https://www.cdc.gov/diabetes/basics/quick-facts.html>. Accessed 9 August 2019
2. ADA Economic Costs of Diabetes in the U.S. in 2007. Diabetes Care. 2008 Mar; 31(3): 596-615. <https://doi.org/10.2337/dc08-9017>
3. ADA Economic Costs of Diabetes in the U.S. in 2012. Diabetes Care. 2013 Apr; 36(4): 1033-1046. <https://doi.org/10.2337/dc12-2625>
4. ADA Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care. 2018 May; 41(5): 917-928. <https://doi.org/10.2337/dc18-0007>

Why Livongo is Different



Effortless Data Collection

- ✓ Cellular meter provides realtime feedback for glucose reading
- ✓ Unlimited strips remove barriers for checking
- ✓ Food and activity tracking to understand lifestyle habits



Personalized Health Signals

- ✓ Health challenges drive small changes for big wins
- ✓ Health Nudges™ deliver calls to action when Members are most receptive



Human-Centered Approach

- ✓ 24/7 remote monitoring with emergency outreach
- ✓ 1:1 live coaching from Livongo Expert Coaches

The Challenge of Prediabetes

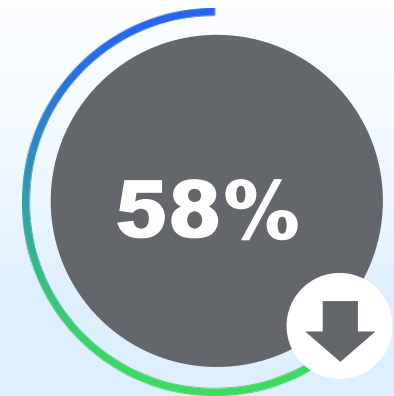
1 in 3 US adults have prediabetes.



Only 1 in 10 are aware of it¹



The annual cost of prediabetes¹



Reduction in incidence of diabetes with 5%-7% weight loss²

1. Adult Obesity Facts CDD 2018 Accessed 9 August 2019
2. CDC Diabetes Prevention Recognition Program, Standards, and Operating Procedures. CDC. March 2018

Why Livongo is Different



Effortless Data Collection

- ✓ Cellular scale
- ✓ Food and activity tracking
- ✓ Livongo app



Personalized Health Signals

- ✓ Health challenges
- ✓ Evidence-based curriculum



Human-Centered Approach

- ✓ Highly experienced and credentialed coaches
- ✓ Community learning
- ✓ Unlimited messaging and 1-on-1 coaching

Thank You.

Guest Speaker: Ashley Knight

- ▶ Ashley has a background in nursing and case management, both in the outpatient and inpatient setting. She is a Clinical Account Manager on the HCA account team at Regence and works with the HCA to improve healthcare for UMP members.



Diabetes Resources for UMP Members

Ashley Knight, Clinical Account Manager

November 12th, 2020

Diabetes Control Program

Access

- No cost program
- Available by Self-Referral
 - Members can self-refer by calling 1-866-543-5765
 - Process is outlined in COC
 - Details can be found on the UMP website:
 - <https://ump.regence.com/pebb/benefits/programs#diabetes-programs>
 - <https://ump.regence.com/sebb/benefits/programs#diabetes-programs>



Diabetes Control Program

Program Goals

- Reduce the risk of complications
- Manage:
 - blood sugar
 - cholesterol levels
 - blood pressure
 - weight

Diabetes Control Program

Support

- Quarterly Touch Base with a nurse
 - General wellness
 - Weight and diet management
 - Review labs
 - Foot care
- Cross Functional Collaboration
 - Pharmacy Services
 - Medication Reconciliation



Diabetes Control Program

Shared Decision-Making Tools

- HealthWise
 - Tool used by Case Managers for key topics
 - Diet Management
 - Labs
 - Glucose Management
 - Available directly to members
 - Share decision making tools
 - Link to shared decision-making tools for diabetes:
 - <https://www.healthwise.net/regencebs/Content/StdDocument.aspx?DOCHWID=center1010>

Diabetes

Learn about the type of diabetes you have, whether you just found out you have the disease or have been living with it for some time. Our topics will teach you about eating well and about controlling your blood sugar levels. You will learn how to manage diabetes and prevent further health problems. You will find helpful tips on how to take care of your feet, and you will learn how to manage other health problems related to diabetes.



Get the information you need in our diabetes and related topics such as:

[Prediabetes.](#)

[Type 2 Diabetes.](#)

[Type 1 Diabetes.](#)

[Gestational Diabetes.](#)

[Diabetes: Taking Care of Your Feet.](#)

[Diabetes: Should I Get an Insulin Pump?](#)

Health Topics	+
Medical Tests	+
Make a Wise Decision	+
Take Action	+



Diabetes Control Program

Newsletters

- StayWell Newsletters
 - Bi-annual condition specific newsletter
 - Tips
 - Foot care
 - Questions to ask your provider
 - etc.
 - Recipes

Guest Speaker: Ramon Navarro

- ▶ Ramon has worked in virtually delivered health care for over a decade, partnering with enterprise employers, national health plans, and large public entities to decrease the impact of chronic diseases. Today, Ramon works for Omada Health, managing key relationships and deployments, including those through the HCA.



Pre-Diabetes for UMP & Kaiser Members



PEBB & SEBB IN OMADA



4,278 (and counting..)

Members Enrolled



32,312 (and counting..)

Pounds Lost

“

Omada is about long term health. The support is amazing. I loved my coach, [and] our online group was supportive and offered helpful ideas. Omada is really about learning about healthy habits and long term health. I have met my initial goal, [which] gave me the confidence to set a new one, all within the initial 16 week part of the program. **Kudos to the developers of the program, the inspirational coaches, and to my insurance plan for offering the Omada program!**

—Gail, 66, Goodrich, MI

Participant Experience

CLINICAL ENROLLMENT CRITERIA

DIABETES RELATED RISK FACTORS



Omadahealth.com/WAPEBB

Omadahealth.com/WASEBB



LOG IN

AM I ELIGIBLE?

Better health, one step at a time

Omada is personalized to help you reach your health goals—whether that's losing weight, gaining energy, or improving your overall health. All at no cost to you.

AM I ELIGIBLE?

The Omada Journey



AWARENESS

Targeted Outreach & Enrollment



ENGAGEMENT & CONNECTION

Smart Tools & Technology



ENCOURAGEMENT & ACCOUNTABILITY

Online Peer Groups



EDUCATION THAT EMPOWERS

Interactive Lessons



GUIDANCE & SUPPORT

Professional Health Coach



PERSONALIZED RECOMMENDATIONS

Whole Person Care

- In-program referrals
- Evolving care over time



I'm really stressed at work, and I'm worried I will let down my family if I don't succeed in getting healthier.



SAMANTHA



COACH

- Topics
- Health Focus
-

Suggest Behavioral

Give food feedback

Birthday today

WA Wellness Workplace Diabetes Prevention Resources

- ▶ Take a thoughtful, holistic approach to worksite wellness.
- ▶ Utilize CDC's [Healthier Worksite Initiative](#).
- ▶ Implement the [Healthy Nutrition Guidelines](#).
- ▶ Develop activities that increase physical activity.

WA Wellness Workplace Diabetes Prevention Resources Continued...

- ▶ Support employees going tobacco free.
- ▶ Promote diabetes prevention resources using our toolkit.
- ▶ Consider offering presentations in the workplace around diabetes.



Questions?

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