Diabetes Prevention Training
Guest Speakers

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

A Snapshot of Diabetes in Washington

Type 1 & 2 Diabetes

627 Thousand people have diabetes
That's about 1 out of 9 people

1 out of 4 do not know they have diabetes
Prediabetes Snapshot

**Prediabetes**

- 2 million people have prediabetes.
- 1 out of 3 adults have prediabetes.
- 15–30% of people with prediabetes will develop type 2 diabetes within 5 years.
- Only 1 out of 12 adults are aware they have prediabetes.
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.
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 and glucose gets used as energy.
Type 1 Diabetes

Blood Vessel

Glucose from food

- Glucose levels increase
- No insulin attaches to cell
- Glucose is unable to enter cell to be used as energy
Type 2 Diabetes

Glucose levels increase

Insulin Resistance

Not enough insulin to keep up with demand

Glucose from food
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
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

- **Deaths**: 6,046
- **Hospitalizations**: 125,032
- **People with diabetes**: 685,570 (1 in 11)
- **People with prediabetes**: 2 million (1 in 3)

**Total cost** = $6.7 billion
Supporting Screening

- Encourage prediabetes screening by sharing these questionnaires
## Blood Test Values

<table>
<thead>
<tr>
<th>Test</th>
<th>Normal</th>
<th>Prediabetes</th>
<th>Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin A1C</td>
<td>&lt;5.7</td>
<td>5.7 – 6.4</td>
<td>≥6.5</td>
</tr>
<tr>
<td>Fasting Plasma Glucose Levels</td>
<td>70-99</td>
<td>100-125</td>
<td>≥126</td>
</tr>
<tr>
<td>2-h Oral Glucose Tolerance Test</td>
<td>&lt;140</td>
<td>140 – 199</td>
<td>≥200</td>
</tr>
</tbody>
</table>

*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)

Diabetes Self-Management Education and Support (DSME)

Marketing and Promotion

Healthcare providers, diabetes educators, and other key stakeholders understand that DSME services have many benefits, including increasing satisfaction, improving clinical quality, enhancing clinical outcomes, and reducing costs. Nonetheless, participation in DSME 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.²⁶

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

Resources for additional information for marketing DSME services:


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 revised and updated to incorporate new content and updates. The 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

WIN 2-1-1

Washington State Department of Health | 22
Support Management and understanding
Contact Information

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Diabetes Consultant
Alexandro.PowSang@doh.wa.gov
360-236-3750

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

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<th>Overview of Diabetes Management</th>
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<td>Health Equity</td>
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<td>Resources for our Members</td>
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## Diabetes Program

KPWA 2016 Implementation of our Updated Care Model

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<th>Purpose</th>
<th>People</th>
<th>Process</th>
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<tr>
<td>Support Primary Care</td>
<td>Diabetes Team</td>
<td>Chronic Disease Management</td>
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<tr>
<td>Deliver Education and Training</td>
<td>– Diabetologists</td>
<td>– Opportunistic Referral</td>
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<tr>
<td>Provide Consultation</td>
<td>– Clinical Nurse Specialists</td>
<td>– Proactive Outreach</td>
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<td>Program Coordination and Development</td>
<td>– Insulin Technology Nurses</td>
<td>– Clinical Nurse Specialists</td>
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<td></td>
<td>– Pharmacy</td>
<td>– Clinical Pharmacists</td>
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<td><strong>Primary Care Clinics</strong></td>
<td><strong>Consultation</strong></td>
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<td></td>
<td>– Diabetes Primary Care Champs</td>
<td>– Face to face</td>
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<tr>
<td></td>
<td>– Team RN</td>
<td>– Virtual</td>
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<tr>
<td></td>
<td>– Population RN</td>
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<tr>
<td></td>
<td>– PCP</td>
<td></td>
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<tr>
<td></td>
<td>– Clinic Support Staff</td>
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<tr>
<td></td>
<td>– Clinical Pharmacists</td>
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</table>
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 develops 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 to 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 dieticians (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

Percentage

HEDIS Rate

Month  Target

June 78  58
July 57.5
August 57.1
September 56.9
October 58.3
November 59.8
December 60.5
January 61
February 61.4
March 58.4
April 58.7
May 57.7
June 56.1
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 Español*– 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
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 undiagnosed

Increased risk of complications

Stroke

Blindness

Kidney Disease

Amputation

Cost of diagnosed diabetes

$327B in 2017

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 it\(^1\)

The annual cost of prediabetes\(^1\)

58%

Reduction in incidence of diabetes with 5%-7% weight loss\(^2\)

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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:

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?

<table>
<thead>
<tr>
<th>Topic</th>
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<tbody>
<tr>
<td>Health Topics</td>
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<tr>
<td>Medical Tests</td>
<td>+</td>
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<tr>
<td>Make a Wise Decision</td>
<td>+</td>
</tr>
<tr>
<td>Take Action</td>
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</tbody>
</table>
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

- OBSESE

OR

- PREDIABETES
- OVERWEIGHT
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.
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

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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

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.
Aaron Huff MPH, Health Promotion Consultant
aaron.huff@hca.wa.gov
360-789-0575