CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid Prevention Learning Network

Diabetes Prevention and Management Affinity Group

A. Your Project and Goals

1. The Diabetes Prevention and Management Affinity Group will focus on projects to improve quality and utilization of diabetes prevention and management for Medicaid/CHIP enrollees. Has your state previously undertaken activities in this area, or are you currently engaged in related activities?

   ☐ No, our state has not yet undertaken work to improve quality and utilization of diabetes prevention and management services. (Note: Previous work in this area is not required to participate.)

   ☐ Yes, our state has previously undertaken work to improve quality and utilization of diabetes prevention and management services.

   If **yes**, please describe your efforts in this area:

2. Briefly describe the project that will be the focus of your participation in the Diabetes Prevention and Management Affinity Group. (This could be a quality improvement project, a data linkage effort, or other.)

3. Has your state already started working on this project?

   ☐ Yes ☐ No

   If **yes,** what is the current status of the project?

4. What results does your state hope to achieve by the end of 2016?

5. Is there any specific assistance your state will need, or are there barriers to your success that you can anticipate? If so, please describe below.

B. Your Team

6. Please identify the state Medicaid agency official who will lead your team.

Name:	Title:
Mailing Address:	City/State/Zip:
Phone:	Email:

7. Who else will participate on your team? Please specify names and roles (e.g., quality leader, data manager, health plan representative, external quality review organization representative, health care provider, consumer/patient representative, other).

C. Medicaid Senior Leadership Expression of Support

8. State teams are expected to have the support of the Medicaid Medical Director or some other senior leadership in the agency to demonstrate the state's interest in achieving the project's goals. Please indicate below the name of the senior Medicaid official supporting participation.

Senior Medicaid Official supporting participation
Name:
Title:
Agency:

Send completed Expression of Interest forms or any questions about participating to diabetes@air.org.