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Diabetes Advisory Council (DAC)

November 15, 2016

Legislative Office Building, Hearing Room 1A

The following members were present: L. Bak, A. Camp, M. Chasse, T. Comrie Schreer, M. Cook, M. Dalal, D. Domenichini, N. Dunn, T. Everette, M. Farrell, K. Foley, S. Gordon, B. Gould, R. Guerrierre, S. Habbe, C. Kozak, L. Krikawa, P. Leibovitz, S. Levine, K. McAvoy, S. Ostrout, R. Picone, S. Poulin, D. Robinson-Rush, D. Rosen, M. Schafer, H. Sparrow, K. Vaughn.

The meeting was called to order by S. Gordon at 2:05 p.m.

Approval of Meeting Minutes:

A motion to approve the October 20th meeting minutes was made by D. Rosen and seconded by M. Farrell. The motion carried unanimously by voice vote.

Opportunity for Public Comment:

None was offered.

Workgroup Updates:

**Diabetes Self-Management Education (DSME)**

DSME Recommendation # 1: Secure Medicaid coverage for DSME.

The wording of the recommendation was modified to reflect group consensus: “Secure Medicaid coverage for DSME at an American Diabetes Association recognized or American Association of Diabetes Educators accredited program.” A motion to adopt the recommendation was made by D. Rosen and seconded by H. Sparrow. The motion passed with M. Schafer, D. Robinson-Rush and T. Everette abstaining.

Members engaged in a robust discussion on a statistic cited in Ian Duncan’s article, [*Assessing the Value of Diabetes Education*](https://www.ncbi.nlm.nih.gov/pubmed/19783766)(2009)**,** which indicated a $2002 direct medical cost savings per patient per year for Medicare patients that received DSME**,** compared to those that did not receive DSME. In a [memo](http://dhss.alaska.gov/dph/Chronic/Documents/Diabetes/2014_AkDiabetesMedicaidClaimsAfterDSME.pdf) to Alaska’s Department of Health and Human Services (DHHS), Diabetes Prevention and Control Program, Evergreen Economics showed a $5670 savings in the first year for Medicaid patients who attended DSME. Other studies of cost savings were noted and the nature of chronic disease was also discussed, i.e. cumulative costs over many years. M. Dalal suggested that the Department of Public Health develop a summary of DSME cost literature. Members agreed that more data regarding the cost of diabetes to Connecticut’s Medicaid program needs to be gathered to better understand savings that could be achieved through DSME, and requested that the Department of Social Services (DSS) investigate.

R. Guerriere described that data analytics related to Medicaid claims should be possible including the need to risk stratify. Platforms can determine cost burden which is needed to create a value proposition. To do this we need current claims data. At ProHealth Physicians they look at the whole population with diabetes, they do not break it out in detail as they need to know their overall cost. A question was posed to DSS regarding whether is it possible to contract a formal actuarial analysis that is Connecticut specific. DSS will follow up with more information.

T. Everette raised the concern that we can’t sell on savings to Medicaid if we don’t know medical costs. She wanted to know how doing this will save money and stressed the need to know current Medicaid expenditures on diabetes in the state. The Office of Legislative Research (OLR) may also be able to assemble information. The question is more pertinent to DSS as they must know how much they are spending.

The discussion turned to how recommendations should be crafted in relation to the state fiscal climate, and members agreed to move forward concepts that will positively impact public health and allow the legislative body to address the fiscal component of the proposals. It was noted that many studies are rooted in the Medicare population, not the Medicaid population. Members will look for data from the 30 other states where Medicaid covers DSME.

Our goal was to increase access, not just at hospitals but in community programs recognized by the American Diabetes Association and/or the American Association of Diabetes Educators (ADA/AADE) as long as ADA standards are met. Members wanted to put it on par with Medicare and commercial plans.

DSME Recommendation # 2: Devise a plan for, and seek financial support, to increase Connecticut’s pool of diabetes education leaders, who reflect at-risk populations including: minorities, those residing in lower-socioeconomic and rural areas.

This recommendation aimed to cultivate a new crop of diabetes educators who reflect the current diabetes population. The recommendation was modified to insert, “but not limited to” after the word “including”. The spirit of the recommendation is to build up a larger cadre of leaders, who are both professionals and lay-people, to go into the community to educate the population. This could be an excellent job for Community Health Workers (CHWs), who are not yet defined in statute. The State Innovation Model (SIM) is considering a statutory definition for CHW. B. Gould hoped that in transforming from fee for service to value-based care CHWs will be the “point of the stick”. Members will have to consider existing statutory language when crafting this definition, and will look to other states and Medicare to see what definitions they use.

DSME Recommendation #2: Devise a plan for, and seek financial support, to increase CT’s pool of diabetes education leaders, who reflect at-risk populations including: minorities, those residing in lower-socioeconomic and rural areas. This recommendation was not taken up for a vote.

DSME Recommendation #3: Investigate reform of insurance policies to eliminate barriers, e.g. discontinuing high deductible and co-pays for DSME. This recommendation was not taken up for a vote in the interest of time.

**Clinical Quality Measures (CQM)**

The CQM workgroup needs to formalize their recommendations and, therefore, were not voted on during the DAC meeting.

M. Dalal provided an overview on planned state quality scorecard of CQM under the State Innovation Model (SIM). Participating Federally Qualified Health Centers and Advanced Networks will be the first to be part of this scorecard. The scorecard should include diabetes-related measures recommended by the SIM Quality Council (a1c poor control, a1c screening, diabetes eye exam, and medical attention for nephropathy). The CQM workgroup did not recommend prediabetes measures because development of these measures is a few years away. The Council discussed other CQMs related to poor diabetes control that the CQM workgroup may want to include in their recommendations. Suggested measures included foot exams, weight, LDL or statin use, immunizations (specifically flu), blood pressure, and smoking cessation. The SIM Quality Council recommended some of these measures for the overall population. The CQM workgroup may want to recommend stratifying these measures by diabetes.

There was discussion about the differences in measures for a provider performance scorecard compared with statewide or regional scorecards. Process measures and intermediate outcome measures are appropriate for a provider performance scorecard, while long term outcomes are appropriate for statewide or regional scorecards. Two long term measures suggested were amputations and all cause admits per 1,000.

A concern was raised about the lack of accuracy of the a1c poor control measure among people with glucose variability and among the African American population, e.g. sickle cell. It was suggested that all cause unplanned diabetes readmissions be used as a long term outcome of poor diabetes control (Yale-CORE measure). There may be other NQF-endorsed measures to use that are not on the list of measures recommended by the SIM Quality Council.

The CQM workgroup recommends stratifying CQMs by race and ethnicity.

The CQM workgroup will discuss the status of healthcare organizations reporting on CQM during their next conference call.

**Diabetes Prevention Program for Type 2 (DPP)**

Recommendation #1: Work towards coverage for DPP in Medicaid, state employee and commercial plans.

P. Leibovitz felt that the wording of “work towards” is not strong enough, and the group concurred. Discussion also ensued around whether we need the word “national” as a descriptor. Medicare language refers to the DPP as the diabetes prevention program model. It does not say national. The intent is to align our language with what Medicare has in place for 2018. National connotes recognized by CDC. Medicare payment programs must meet these CDC standards. It was suggested we change language to: “Secure coverage of national CDC Diabetes Prevention Recognized Programs in commercial, state employee, and Medicaid plans.”

M. Dalal cautioned that there could be changes to the program at national level based on the results of the election. If Medicare withdraws coverage of DPP, then Connecticut plans may not have coverage. It depends on how the recommendations are crafted. The group decided it best to table the vote as more work on wording needs to be done.

The next two recommendations were not taken up for a vote, and require revisions.

DPP Recommendation # 2: Work towards making referral to Diabetes Prevention Programs (or other evidence-based lifestyle change program) a “standard of care” for medical and other healthcare service providers. The language in this recommendation must align with DPP Recommendation # 1.

DPP Recommendation # 3: Support building state-wide program capacity with a focus on culturally and linguistically tailored awareness, referral, retention and program implementation strategies. M. Dalal emphasized that programs must be accessible to people that need them the most. There was a comment to add specificity of direction to DPP Recommendation # 3.

Final Comments:

Once the Council approves all of the recommendations, we must define action steps as well as identify responsible parties and timelines. T. Everette clarified that the recommendations do not have to be fully drafted into legislative language before they are proposed.

Next Meeting:

The next meeting will be held on Thursday, December 8, 2016 at 2:00 pm in Room 1A of the Legislative Office Building.

Adjournment:

A motion to adjourn the meeting was made by S. Gordon, seconded by L. Krikawa and carried unanimously. The meeting concluded at 3:33 p.m.