Diabetes Advisory Council (DAC)
December 8, 2016
Legislative Office Building, Hearing Room 1A, Hartford, CT

The following members were present: L. Bak, A. Camp, D. Campbell, M. Chasse, S. Czunas, T. Everette, M. Farrell, B. Gould, R. Guerrierre, S. Habbe, C. Kozak, L. Krikawa, P. Leibovitz, S. Levine, R. Picone, S. Poulin, K. Snow, H. Sparrow, K. Vaughn, B. Wolf.

Meeting was called to order by C. Kozak at 2:15 p.m.

Approval of Meeting Minutes

A motion to approve the November 15th meeting minutes was made by M. Chasse and seconded by S. Habbe. The motion carried unanimously by voice vote.

Opportunity for Public Comment

None was offered.

Workgroup Updates

Clinical Quality Measures (CQMs)

S. Poulin noted we are voting on the wording for the interim report. There may be minor revisions for final report.

CQM Recommendation # 1: Implement diabetes-related clinical quality measures as part of:

1. state wide and regional health dashboards to monitor and report diabetes control efforts at state and community levels (note: measure to be determined and listed in action steps) and
2. an all payer scorecard, aligned with the measures recommended by the SIM Quality Council, to enable Advanced Network/FQHC's quality improvement efforts.

M. Farrell asked about the all payer scorecard. S. Poulin described this was through the SIM Quality Council. The measures recommended by the SIM Quality Council are A1c poor control, A1c screening, medical attention to nephropathy and diabetes eye exam. These are measures to monitor short term progress. The goal is to put these into a scorecard for Federally Qualified Health Centers (FQHCs) so they can compare themselves to the state to see how they rate to encourage quality improvement.

A motion to adopt the recommendation was made by T. Everette and seconded by M. Chasse. The motion passed unanimously by voice vote.

CQM Recommendation # 2: Reporting organizations and data administrators develop data systems and analytic capabilities to stratify clinical quality measures by race and ethnicity.

S. Poulin noted that data administrators were added from the previous version. S. Czunas gave an example of data administrators as entities who warehouse data.

Discussion on this included comment from T. Everette that the challenge now is the way the data are reported. Data systems don't allow for collection of race and ethnicity data. The first goal is to have data administrators make sure systems can account for race and ethnicity, then collect and report it. S. Czunas pointed out that data administrators don't collect the data. Discussion ensued that this is building a system. T. Everette added that the need is to build AND report. M. Farrell wondered who would be receiving the data reported. S. Czunas added this was not what was discussed in the workgroup as now a reporting requirement is being added. T. Everette noted that a reporting requirement harkens back to recommendation number one. She pointed out that SIM is in part about health equity. It can feed into the scorecard. She added "with ability to report vs. expectation to report," therefore adding "and report as part of state wide dashboard".

The wording of the recommendation was modified to reflect group consensus: Reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity.

A motion to adopt the modified recommendation was made by H. Sparrow and seconded by T. Everette seconded. The motion passed unanimously by voice vote.

CQM Recommendation # 3 was not addressed. A recommendation on the status of healthcare organizations reporting on clinical quality measures related to diabetes control is still being considered.

Diabetes Self-Management Education (DSME)

DSME Recommendation # 1 from November meeting was already voted on and accepted as: "Secure Medicaid coverage for DSME at an American Diabetes Association recognized or American Association of Diabetes Educators accredited program."

DSME Recommendation # 2: Devise a plan for and seek financial support to increase Connecticut's pool of lay and professional diabetes educators who represent at-risk populations

including, but not limited to, minorities, those residing in lower socio-economic areas and rural areas.

The revised language changed term “diabetes leader” to “diabetes educator.” The workgroup also omitted the word “certified” to increase the pool of who could be considered an educator. A question was raised by M. Farrell regarding the word “educator” – she was wondering if it would be a problem from a Medicaid perspective. Members concluded that it could be addressed moving forward, and decided to leave as written.

A motion to adopt the modified recommendation, as written above, was made by H. Sparrow and seconded by A. Camp. The motion passed unanimously by voice vote.

DSME Recommendation # 3: Modify cost sharing of diabetes self-management education (DSME) by restructuring insurance plans to reduce barriers, e.g. limiting high deductibles and co-payments for DSME.

Discussion ensued on the wording. The intent is that DSME not be subject to a deductible and that the co-payment for these services be eliminated. A. Camp suggested it mirror the preventive treatment services portion of the Affordable Care Act so that insurance covers the service without any patient cost sharing.

The language of the recommendation was modified to reflect group consensus: “Modify cost sharing of diabetes self-management education (DSME) by reforming insurance plans to decrease barriers such that DSME is not subject to insurance deductibles and co-payments.”

A motion to adopt the modified recommendation was made by H. Sparrow and seconded M. Farrell. The motion passed unanimously by voice vote.

Diabetes Prevention for Type 2

DPP Recommendation # 1: Secure coverage in commercial, state employee and Medicaid health plans for Centers for Disease Control and Prevention (CDC) recognized Diabetes Prevention Programs.

Members chose to strengthen the recommendation’s language by using the term “secure coverage.” Discussion was had regarding the official title of the program. Members wanted to the recommendations’ wording to reflect the official CDC program name. According to the CDC website says, the program title is National DPP. The distinction among programs revolves around the curriculum used. CDC has an established curriculum that is used for the National

DPP. To be CDC recognized one can also submit their own curriculum that CDC approves. All curriculums are based on the same components.

A program cannot submit data for review until they have an approved curriculum. The CDC review process takes two years, and during which time the program receives pending recognition. After you reach the required benchmarks, then the program achieves CDC full recognition.

CDC Diabetes Recognition Program does not use the word "national." Important to have this rigor in place. At our last meeting we referred to the "extent covered by Medicare". The intent was to align with the language that Medicare has in place. S. Habbe felt we could keep the recommendation language as is.

A motion to adopt the recommendation was made by S. Habbe and seconded by H. Sparrow. The motion was passed with S. Czunas abstaining.

DPP Recommendation # 2: Establish as a standard of care the referral of patients to a Diabetes Prevention Program by medical providers, other health service providers, and by self- referral.

Discussion ensued regarding whether the wording needed to include type 2 diabetes. Members decided that to include, "patients with pre-diabetes or at risk for type 2 diabetes" so the new recommendation would read: Establish as a standard of care the referral of patients with pre-diabetes or at risk for type 2 diabetes to a CDC Diabetes Prevention Program by medical providers, other health service providers, and by self- referral.

T. Everette raised the question of who would establish the standard of car since we don't legislate standards of care and we don't have Connecticut specific standards of care. It was determined that although this is not a legislative recommendation, it should be included in the Council interim report. Action steps would be developed will spell out more details.

A motion to adopt the recommendation was made by and then withdrawn S. Habbe.

The recommendation was further revised to read: Establish as a standard of care, the referral of patients with pre-diabetes or at risk for type 2 diabetes to CDC recognized Diabetes Prevention Programs by medical providers, other health service providers, or by self- referral.

A motion to adopt the modified recommendation was made by S. Habbe and seconded by M. Farrell. The motion passed unanimously by voice vote.

DPP Recommendation # 3: Build state-wide Diabetes Prevention Program capacity with an emphasis on culturally and linguistically appropriate standards and improved access.

The workgroup added "improved access" to the recommendation language, and also changed "support building" to "build." A suggestion was made to add "CDC recognized" to the wording but was then removed to make it broader. B. Wolf explained that access could include a variety of aspects, e.g. better access for people with disabilities, living in remote geographic areas with limited providers nearby, etc.

Discussion ensued that we don't just want to build capacity for DPP but for DSME as well. P. Leibovitz suggested we may modify the DSME recommendation or add DSME language to the DPP recommendation. B. Wolf described an alternative – insert a fourth DSME recommendation with the same wording as DPP Recommendation # 3. Separate the concepts, with the same intent for each. T. Everette disagreed; and stated that she would rather add DSME to the DPP recommendation. Currently the DSME Recommendation # 2 is broad as diabetes education includes DPP, Stanford programs and certified diabetes educators. Discussion continued, focusing on the fact that there are 26 recognized DSME centers in Connecticut but only 5-6 DPPs. The intent of the recommendation was described as being sure that we are working together to increase access, especially for those at highest risk of contracting diabetes.

The conversation shifted back to whether to keep the recommendations separate, i.e. to keep them in the three workgroup categories. It was noted that action steps will be added to make them more specific. There was concern raised about blurring the lines between DPP and DSME because there was confusion in the legislature last year when a bill that combined DPP and DSME was raised. B. Wolf felt that the Public Health Committee would most likely combine the recommendations and give equal weight to both.

It was decided to add a fourth DSME recommendation that reads: Build state-wide Diabetes Self-Management Education Program capacity with an emphasis on culturally and linguistically appropriate standards and improved access.

A motion to adopt DPP Recommendation # 3 as above and DSME Recommendation # 4 together was made by H. Sparrow and seconded by S. Habbe. The motion was passed with T. Everette abstaining.

In the interest of time, the DPP recommendation to support good public policy introduced in the 2017 legislative session was not taken up for a vote. This policy reads: The DAC supports consideration of legislative polices that target the overall population. and can reduce the risk of developing diabetes and/or improve the health status of persons with diabetes; e.g. polices to

curb the consumption of sugar sweetened beverages and promote comprehensive tobacco control.

Next steps were reviewed. These include the submission of a draft interim report to the DAC members by approximately December 15, 2016 with group comments due December 22, 2016 This allows time to finalize the preliminary report due to the legislature by January 1, 2017.

The 2017 DAC meeting dates are pending. They will be identified and circulated as soon as possible.

A motion to adjourn the meeting was made by M. Chasse, seconded by T. Everette. The motion carried unanimously. The meeting concluded at 3:35 p.m.