Diabetes Advisory Council (DAC)

Feb. 14, 2017 Held at DPH with Conference Call 2-3:30 p.m.

Present: S. Habbe, S. Gordon, M. Dalal, S. Poulin, C. Kozak. K. Barry, R. Perry, L. Bak, K. Snow, A. Camp, T. Comrie-Scheer, M. Chasse, K. McAvoy, P. Leibovitz, L. Krikawa, S. Ostrout, R. Picone, S. Czunas, N. Dunn.

Meeting called to order at 2:03pm.

Approval of minutes from December and January meetings: M. Farrel made one minor change via email which was incorporated. S. Habbe accepted the minutes and K. Barry seconded.

Opportunity for public comment: None

Legislative update: Diabetes self-management education (DSME) bill (HB6237) up for public hearing on Feb 17. S. Gordon stressed it would be good if people on DAC could submit written or oral testimony. S. Habbe plans to testify in support of the bill and he offered to provide assistance with logistics as needed. S. Gordon has talked with Rep. Cook about it. There are three other bills that have been raised as well. L. Bak to re-send the email that S. Habbe sent to DAC members which contains information about all of the diabetes bills to date.

Existing state diabetes programs: DPH is developing a table of state of Connecticut government programs that address diabetes. Group provided input to develop the following listing of programs: Aging, Dept. Social Services, Dept. of Corrections, Comptroller, Dept. of Insurance, Access Health CT, State Board of Education, Dept. of Children and Families, Board of Education Services for the Blind and the VA (state chapter).

Workgroup updates: Review of action steps to accompany recommendations

DSME: Recommendation- Secure Medicaid coverage for DSME at ADA/AADE accredited programs.

Draft Action Step 1: By Dec 2017, DPH will secure actuarial services to assess the cost benefit analysis of DSME for the Medicaid population in CT and then share results.

Discussion: Group reviewed need for hard (CT) data to share to show benefit. Having an actuary do it would make it formal. This does not negate the current legislative action. S. Habbe described that NY *may* have done something similar, not sure if they had an actuary. Dr. Snow described that they have not done anything similar at the insurance company where he works. Dr. Dalal asked about the best dissemination approach. S. Habbe suggested a white paper with an executive summary as well as more detailed information to back it up. He referenced an Arkansas study done with the Medicaid population.

Draft Action Step 2: By Dec. 2017, DPH will collect hospital re-admission data comparing hospitals that have CDE in patient services to those who do not.

Discussion: Group questioned how the action step aligned with the recommendation. If it included insurance status, that would help to see if there is a disparity in outcomes. S. Poulin questioned if Office of Health Care Access can break this down. Group discussed that there is some benefit to see in-patient information but it does not support DSME as DSME may be done by non CDE. M. Chasse added however, in looking at value of education this does allow for "easy" comparison in reduced re-admissions. Others countered that to infer that education made a difference would need more rigor so may want to reconsider. Another option is to look at hospital systems in some risk based payment and identify ones that use out-patient DSME to see if the out-patient center is being used to address risk of re-admission. Question raised: "Is there a system in hospitald that at discharge a patient is assessed for risk of re-admission and then see if they are getting to DSME? L. Bak described that (for Medicare) referral must come from Primary care physician, (PCP). Some insurance companies do not require PCP referral, but this depends on policy too. The challenges of patient activation and social determinants of health were also discussed. Group concluded that the analysis could still be done but not as official action step.

Recommendation: Devise a plan and seek support to increase CT'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 and rural areas.

Draft action step 1: By Jan 2018, TBD organization will explore foundation support to address the recommendation to increase the pool of culturally appropriate diabetes educators.

Discussion: This action step aligns well. Question raised, "who is most appropriate to pursue this?" Another question- what type of person is being sought? Is it professional person or Community Health Worker? Both have benefit but question was raised if different approaches needed.

S. Ostrout from CCCI described the Metro Hartford Alliance for Health Care which is led by workforce development funders involved in this issue. She asked if we are looking at this issue in one neighborhood, in which case a foundation could help or, if broader, it would need to be addressed from a labor stance. Maybe worth convening of employers, educators and workforce investment board to see if groups can work on expanding diversity profile. Dr. Dalal suggested that the lay and professional groups could be led by different organizations which would then need 2 action steps. Referred back to State Innovation Model (SIM) timeline to see what their time line is, (for lay leaders/CHW). Goal is to join forces with workforce diversity groups and then funnel energy towards diabetes. S. Ostrout has contact for this topic. She also suggested

that perhaps it should be reframed to secure foundation support to address this recommendation in one area or one major city. She noted that many foundations work at the local level.

SIM activities also discussed around population health planning and implementation including Stanford model. However, this may not happen in action step time frame. Suggestion also raised to partner with academia. AHEC was also mentioned as possible partner on this but AHEC not represented at meeting.

Clinical Quality Measures: No action steps yet. S. Poulin explained that during the workgroup's last call the discussion focused on the workgroup's second recommendation: reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity. S. Poulin described the Community and Clinical Integration Program (CCIP) of SIM and that there are CCIP health equity data collection standards. Potential action steps may focus on supporting CCIP Health Equity Improvement data collection standards for race and ethnicity through endorsement at high agency levels, exploring the inclusion of the standards under state contracts with providers (ex. PCMH+), and exploring voluntary adoption of CCIP standards by providers.

Diabetes Prevention- call cancelled due to snow storm

Meeting adjourned a 3:24 pm.