Diabetes Advisory Council
Legislative Office Building, Hartford CT Room 1A
October 20, 2016

Present: L. Bak, A. Camp, M. Chasse, T. Comrie-Scheer, S. Czunas, M. Dalal, N. Dunn, T. Everett, M. Farrell, D. Foley, S. Gordon, B. Gould, S. Habbe, C. Kozak, L. Krikiwa, P. Leibovitz, K. McAvoy, R. Picone, D. Robinson- Rush, S. Poulin, K. Snow, K. Vaughn.

The meeting convened at 2:05 pm

Public comment: None

Approval of minutes: A motion to approve the minutes was made by K. McAvoy and seconded by L. Bak. One correction was offered by Linda Krikawa on the spelling of her last name. The motion carried unanimously by voice vote.

Recap of September meeting: S. Gordon provided an overview of diabetes prevention for type 2 and diabetes education in the hospital and community, the State Innovation Model (SIM) and workgroup charges.

Review of Outreach 2015-16 by DPH: C. Kozak reviewed awareness campaigns including: 211 United Way featuring diabetes education and diabetes prevention in June 2015; the Live Well Stanford community diabetes program from December 2015; the Diabetes Partnership Project Tool Kit to promote diabetes education project geared to family physicians and APRNs; Spanish Live Well in the Community and Diabetes Prevention for type 2 screening card.

Diabetes Prevention Program (DPP) Workgroup: M. Dalal summarized the discussion. He reviewed: 1.The need to identify sufficient capacity to meet demand; and 2. Reimbursement including the need to look at Medicare memo on cost savings as well as coverage via commercial and Medicaid in other states. He explained that CDC recognition program information was requested by Medicaid and was provided. It is now under review at Medicaid. D. Robinson-Rush described that the delivery of service under current Medicaid regulations requires a credentialed provider. M. Dalal also reviewed Diabetes Prevention Program (DPP) enrollment barriers, which include patients not being aware of program and benefits, program costs and the need for child care, transportation and culturally and linguistically appropriate leaders. Also, physicians may not understand benefit. Additionally, there are no accepted quality measures and better referral systems are needed.

Draft recommendation #1: Work towards DPP coverage in state employee program and through Medicaid. Discussion ensued on the number of state employees, retirees and dependents who are covered, including municipalities, which are now 230,000 lives.

For all recommendations, M. Dalal stressed the need for specific action items. For example, can we identify committed partners?

The work group recommended looking at what other states have done and the Centers for Medicaid and Medicare Services (CMS) plan to roll out DPP coverage in 2018. The question was raised, "Can what other states have done be applied in Connecticut? " M. Dalal wants to identify who can do what steps. For state employees, S. Czunas has started to look at A1c lab data, however, there are limits as to what the data can tell. Further research is needed. Sandra stated that pre-diabetes is not a condition that is followed under Health Enhancement Plan. According the National Association of Chronic Disease Directors (NACDD), Montana Medicaid covers DPP and 12-15 states offer state employee coverage. A question was raised regarding coverage for state employees, "Would program need to be provided by credentialed provider?" Discussion ensued regarding who makes decisions on coverage for state employees. Per S. Czunas, it is the health care cost containment committee and labor management who look at this on a coverage basis. A recommendation would need to come from medical director and board.

Potential action steps: program under review at Medicaid including the DPP manual. Next steps include assessing if Registered Dietitian or nutritionist can be Medicaid enrolled provider. DSS will look at it from member service and financial sustainability perspective. Dana from mentioned that Diabetes Self-Management Education (DSME) could probably expand more. DPP may be covered if a DPP coordinator is credentialed as registered dietician (RD) or nutritionist.

A question was asked regarding whether this could be considered as part of the role of a community health worker, but it was determined that health educators are not enrollable. Medicaid states within current state regulations that education is not covered. A question raised about what other states cover. Montana does cover DPP. However, they are waiting for Medicare roll out. Dana asked about how the YMCAs in Montanaare defining providers eligible for reimbursement. They are waiting for a Medicare determination. S. Habbe will share contact information for Kelly McGratten from the NACDD. M. Dalal noted several action steps are needed.

Draft recommendation #2: Work toward making DPP standard of care for medical and other health providers. M. Chasse added the grass root effort is best. It was noted that meetings with speakers sharing basic information gets greatest response, therefore, one action step should be grass root efforts. P. Leibovitz wants to be sure to include registered dietitians. M. Farrell added that hospitals are moving towards networks with EHRs. The work group wants to include patient centered medical homes (PCMH) in outreach. This may also dovetail with SIM efforts. DPP should be embedded in SIM, and may also be part of PCMH plus.

A. Camp raised the question of tracking referrals. CDC does send reports of numbers they receive from recognized DPPs. A. Camp suggested examining numbers of those referred and have it embedded in Electronic Health Records (HER). M. Farrell recommended looking at the number of people referred vs. those actually enrolled.

M. Dalal noted that, currently, there are no quality measures for DPPs. He has been in communication with Diabetes Advocacy Alliance, and they are advocating for some of the aformentioned measures.

#3 Draft recommendations were skipped in the interest of time.

M. Dalal also raised the DPP discussion on sugar sweetened beverage tax. S. Habbe described momentum on this across the country as part of population health and healthy environments. S. Habbe wants to consider this as a sub-set action. M. Dalal was not sure where this should fall. He thought it might be better for the full Council to take this up.

Clinical Quality Measures (CQM) Workgroup

S. Poulin reviewed the call on CQM; including the status of reporting for diabetes and pre-diabetes measures. She described that there can be many different EHR systems, so sharing data is difficult, and it is hard to verify accuracy. She also noted that insurance payers only have claims data. SIM has recommended a number of measures so Council members do not need to start from scratch.

S. Poulin explained that there are no vetted measures for pre-diabetes. Also, although it is great to identify pre-diabetes, there need for services to which people can be referred. Some organizations are developing these pre-diabetes measures.

CQM recommendations are pending. One action step is to define the use case. i.e. What is goal? Is it quality or payment? This will determine what measures to use. Ideas should be sent to S. Poulin. T. Everette stated that we need to measure outcomes using quality measures. In terms of SIM, measures are needed for value based payment.

Diabetes Self-Management Education/Support (DSME/S):

C. Kozak reviewed DSME/S. She covered the distinction between Certified Diabetes Educator (CDE) and health educator. The goal is to work together to build collaboration among various DSME providers, especially in underserved areas. Another goal is to increase awareness of what is available. 211 has been used to spread the message, but members also to post information through social media; e.g. Facebook pages for health departments, pharmacists associations, etc. C. Kozak also reviewed health equity aspects including the need for culturally prepared instructors. She then reviewed the role of DSME in preventing hospital re-admissions and discussed insurance barriers; e.g. lack of CT Medicaid coverage and high deductible/copays.

Draft Recommendation #1: Pursue Medicaid Reimbursement for DSME. C. Kozak noted that, according the National Association of Chronic Disease Directors (NACDD), 30 states have Medicaid coverage as of 2013. To address Medicaid concerns it was stressed that DSME should be done by credentialed professionals. C. Kozak explained that hospitals need to cover their costs. D. Robinson-Rush from the Department of Social Services (DSS) outlined that FQHCs and hospitals can get some reimbursement through the facility. She noted that YMCAs are not an option as they need licensed personnel. It was stressed to her that in hospitals the patients would see a credentialed professional. The intent is to make DSME more available so 26 programs on Connecticut's list of American Diabetes Association and

American Association of Diabetes Educators recognized program would be access point for Medicaid patients. DSS is investigating whether registered dietitians can bill for service. This should open access. L. Bak added for emphasis that currently there is no Medicaid re-imbursement for DSME programs. C. Kozak described that for diabetes education the current standard is to see a Certified Diabetes Educator (CDE) in hospital for DSME as they are credential and typically provide 10 hours of information. D. Robinson-Rush went on to describe that DSME can happen in hospital out-patient setting but these is clearly some confusion that needs to be worked out. D. Robinson Rush will send information to C. Kozak and M. Dalal.

L. Krikawa also added that an important aspect is the patient activation piece, which needs to be incorporated to get patients to attend. Perhaps providing a script that providers can follow. She suggested that we look into this more, especially as there is a shift to value based payment where providers should be providing stronger recommendations.

Draft Recommendation #2: Devise and financially support a plan to recruit diabetes educators in minority populations by fostering mentors and supporting those who wish to pursue becoming certified diabetes educators. C. Kozak reviewed the lack of CDEs who speak Spanish. We may want to survey Connecticut Alliance of Diabetes Educators to learn who speaks Spanish. The recommendation is "Mentor and financially support CDE development in minority communities". There are concerns that the patient population does not match the professional profile. Previously there was a scholarship to help develop this but it is no longer available. M. Dalal described a network of pharmacists working in at risk communities that may be interested.

Draft Recommendation #3: Investigate reform of insurance policies to make them more diabetes friendly e.g. eliminating high deductible and co-pays for DSME. C. Kozak discussed the high deductible and copay insurance plans. Connecticut based insurance must cover DSME but often see trouble accessing this. The workgroup wants to look at this. ADA looked at this in the past. It is legal to impose these.

A question was raised regarding the 30 states with Medicaid coverage and how much demand there was for this benefit. It was discussed that there will be a "trickle" of people. Do not anticipate large response. A question was raised about incentives. These are not generally provided. L. Bak and T. Comrie- Scheer referred to a memo out of Alaska which reported a $5670 saved by covering DSME for patient with diabetes in first year.

The next meeting will be held on Tuesday, November 15th from 2:00-3:30 in LOB Room IA. The meeting was adjourned at 3:28 pm.