Diabetes Advisory Council

WELCOME

April 11, 2017

Legislative Office Building

Hartford, CT

Agenda

- Welcome and introductions
- Approval of minutes
- Public comment
- Workgroup updates:

  DSME

  CQM

  DPP
- Legislative update
- Time line for final report
- Next meeting: none planned. Diabetes partnership resumes.

DIABETES SELF-MANAGEMENT EDUCATION WORKGROUP

Recommendation 1: Secure Medicaid coverage for DSME at American Diabetes Association/ American Association of Diabetes Educators accredited programs

Action step 1:Between May 2017 and April 2018: DPH will secure actuarial services to assess the cost benefit analysis of DSME for the Medicaid population in CT and then share results *with key change agents e.g. legislators*

Revision: added share results *with key change agents e.g. legislators*

Recommendation 2: Devise a plan and seek financial support to increase CT's pool of lay and professional diabetes educators who represent at risk populations including, but not limited to, minorities and those residing in lower socio-economic and rural areas.

Action step 1: Between May 2017 and April 2018, *DPH will convene stakeholders who have vested interest in seeing more culturally diverse educators develop, including workforce development boards, to identify one or two organizations to spearhead this initiative.*

Revision: added *workforce development boards*

Recommendation 2: Devise a plan and seek financial support to increase CT's pool of lay and professional diabetes educators who represent at risk populations including, but not limited to, minorities and those residing in lower socio-economic and rural areas.

Action step 2: Between May 2017 and April 2018*, DPH will identify one Certified Diabetes Educator to be part of the SIM CHW taskforce to ensure alignment of efforts with the SIM process*

Topics for discussion: This is a "brand new" action step

- How does this action step align with the recommendation?
- With whom should the results be shared?
- How should the results be disseminated?
- How does this action step tie in to existing priorities of organizations represented on the DAC?

Recommendation 3: Modify cost sharing of DSME by reforming insurance plans to decrease barriers such that DSME is not subject to insurance deductibles and co-payments

Action step 1: Between May 2017 and October 2017, *CT Community Care Inc. to conduct literature search on how cost, even with insurance coverage, affects accessing DSME and then share results with key change agents.*

Revision: CCCI added as lead on this

Recommendation 3: Modify cost sharing of DSME by reforming insurance plans to decrease barriers such that DSME is not subject to insurance deductibles and co-payments

Action step 2: Between May 2017 and April 2018, *DPH will convene stakeholders in insurance industry to address financial barriers to DSME access.*

Topics for discussion: New action step

- How does this action step align with the recommendation?
- With whom should the results be shared?
- How should the results be disseminated?
- How does this action step tie in to existing priorities of organizations represented on the DAC?

Recommendation 4: Build state-wide Diabetes Self-Management Education program capacity with an emphasis on culturally and linguistically appropriate standards and improved access.

Action step 1: Between May 2017 and April 2018, *CCCI* will convene interested diabetes education providers to pursue ADA/AADE recognition in Tolland County.

Topics for discussion: New action step

- How does this action step align with the recommendation?
- With whom should the results be shared?
- How should the results be disseminated?
- How does this action step tie in to existing priorities of organizations represented on the DAC?

CLINICAL QUALITY MEASURES WORKGROUP

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

a) Statewide and regional health dashboards to monitor and report the effectiveness of diabetes control efforts, and
b) An all-payer scorecard of Advanced Network/FQHC's diabetes control performance, aligned with the measures recommended by the SIM Quality Council, to enable quality improvement efforts.

Between May 2017 and April 2018, the Diabetes Partnership will track the progress of the SIM Program Management Office (PMO) in developing and maintaining statewide and regional dashboards and an all-payer scorecard.

No revisions

Recommendation 2: Reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity

1. By September 2017, CHCACT undertakes a review to determine whether CHCACT and its member's existing data systems are sufficient to undertake the process of meeting CCIP data collection and analytic standards.

Revisions:

- Moved to 1st action step of recommendation 2
- Changed the date from January 2018 to September 2017

Recommendation 2: Reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity

2. By December 2017, the Department of Public Health (DPH) meets with or convenes state agencies with health care authority including the Department of Social Services (DSS), Department of Children and Families (DCF), Department of Mental Health and Addiction Services (DMHAS) and the Department of Developmental Services (DDS) to seek endorsement of the Community and Clinical Integration Program (CCIP) Health Equity Improvement data collection and analytic standards for race and ethnicity.

Revisions:

- Changed the date from May 2018 to December 2017

Recommendation 2: Reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity

3. By December 2017, the Department of Public Health (DPH) and the SIM Program Management Office (PMO) meets with the Department of Social Services (DSS) to discuss making the Community and Clinical Integration Program (CCIP) Health Equity Improvement data collection and analytic standards for race and ethnicity a requirement of FQHCs that are participating in PCMH+, and not already subject to the standards.

Revisions:

- Changed date from May 2018 to December 2017
- Added SIM PMO

Recommendation 2: Reporting organizations and data administrators develop data systems to build analytic capabilities, stratify, and report clinical quality data by race and ethnicity

3. By May 2018, as a result of meeting with the Department of Public Health (DPH) and SIM Program Management Office (PMO), the Department of Social Services (DSS) includes the CCIP Health Equity Improvement data collection and analytic standards for race and ethnicity as a requirement of FQHCs that are participating in PCMH+, and not already subject to the standards.

Revisions:

- Added SIM PMO

DIABETES PREVENTION WORKGROUP

Prevention workgroup suggested following change to recommendation 1 to better align with action steps:

Recommendation 1: Secure coverage through accountable care organizations, commercial, state employee and Medicaid health plans for CDC recognized Diabetes Prevention Programs.

Action step 1: By December 2017, DPH working through the SIM Prevention Services Center Model will assess the interest and capability of at least 2 Accountable Care Organizations, *including PCMH+ practices* in offering DPP as a benefit to their attributed commercial or Medicaid members

Modification made to recommendation. The action step is recap from March DAC meeting.

Recommendation 1: Secure coverage through accountable care organizations, commercial, state employee and Medicaid health plans for CDC recognized Diabetes Prevention Programs.

Action step 2: By April 2018, DPH working through the SIM Prevention Services Center Model, will aim to obtain commitments from at least two Accountable Care Organizations , *including PCMH+ practices* to provide DPP for all or part of their eligible attributed Medicaid and/or Commercial Population.

Modification made to recommendation. The action step is re-cap from March DAC meeting

Recommendation 2: 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.

Action step : Between May 2017 and April 2018, the CT YMCA DPP provider network will hold a minimum of 2 state-wide learning collaborative meetings among DPP coordinators/educators to share best practices and resources with respect to provider outreach and engagement and patient recruitment and retention

Represents a minor change to action step

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

Action step: By April 2018, DPH will identify up to five geographic areas in the state with a high prevalence of at-risk populations and work with the ~~YMCA~~ DPP provider network to identify the steps and funding needed to implement DPPs in up to three of those areas"

Revisions:
The initial action step proposed deployment of 3 DPPs by April 2018.
Concerns were raised about feasibility, target population, funding.
Referred by DAC back to workgroup for revisions which are reflected above.
ALSO- Removed "YMCA" from the provider network aspect

??? SEPARATE SECTION ON ACTION STEPS WITH OUT LEAD– “OTHER REC”

Diabetes Advisory Council

THANK YOU FOR YOUR COMMITMENT TO THE DAC!