Diabetes Advisory Council (DAC)

Meeting Minutes
January 24, 2017
Katherine A. Kelley State Public Health Laboratory, Rocky Hill

Present:
Stephanie Poulin, Mehul Dalal, Cindy Kozak, Debbye Rosen, Linda Krikawa, Karen McAvoy, Leigh Bak, Bruce Gould, Rob Picone, Anne Camp, Steve Habbe, Trish Comrie- Scheer, Maureen Farrell, Mark Schaefer, Sandra Czunas, Subira Gordon.

1. Call to order:
Cindy Kozak called the meeting to order at 2:03 pm

2. Opportunity for public comment:
None offered.

3. Approval of minutes:
Due to the lack of quorum, the December 2016 meeting minutes were not voted on.

4. Review of Cost effectiveness of diabetes self-management education (DSME) table:
S. Poulin provided an overview of the information in the table. D. Rosen asked for clarification of where studies were done (e.g. community or education centers). She asked if the CDC Guide to Community Preventive Services, which shows effectiveness of DSME in the community, has information on cost-savings related to DSME in the community. S. Habbe referenced a meta-analysis of 118 studies which concluded a combination of group and 1:1 was most effective. L. Bak stated that she is unaware of any studies that suggest DSME is a waste of money and suggested that it might be appropriate for the council to search the literature for studies showing the DSME is cost-prohibitive. The table be presented would be good to include in the final report. M. Dalal requested the payer perspective on the cost effectiveness information but none was available. A discussion ensued about how short term cost savings could translate to **policy** coverage. This cost savings could be realized if a provider is under risk performance contract. There are codes for DSME, therefore, it was suggested that payers could look at data comparing those with diabetes who attended DSME vs. people with diabetes who did not attend. M. Schaefer added that ACO integrate DSME as part of risk contracts. He described plans for a stakeholder engagement meeting in February to explore current use of program and plans to increase use. He specifically mentioned PCMH plus programs (Patient Centered Medical Home).

M. Dalal directed a question to A. Camp about DSME in Community Health Centers. She described that her (Medicaid) patients do not have access to hospital programs. She described that Fair Haven Community Health Center is a PCMH. She stressed that developing capacity in the community is important because of that multiple barriers (e.g. transportation) that patients experience. Having an established program is necessary. D. Rosen described that her health department does a program in an internal medicine office. The group reviewed the need for flexibility and 1:1 work. A combination with a Community Health Worker would be appropriate to incorporate cultural needs. M. Schaefer added that as we look at ACOs and FQHCs to integrate use of diabetes self-management services, one challenge is the workflow. It needs to be cost effective by segmenting the population and paying for patients for whom it is needed, appreciating that groups are more cost effective than 1:1. The challenge is how to arrange workflow so linkages happen. M. Farrell described that the YMCA is working on community linkages and workflow from physician to referral to speaking with program coordinator for enrollment. There are many steps, yet it needs to be efficient. It was suggested to do group first then 1:1 as needed. Medicare has guidance on who needs 1:1 (e.g. hearing impaired, language barriers).

5. Review of Prediabetes and Diabetes Education Instructor Requirements:

C. Kozak reviewed the Prediabetes and Diabetes Education Instructor Requirements table. The distinctions between hospital based and community programs were reviewed. Pre-diabetes instructor requirements also covered. L. Krikawa commented that the community Stanford programs do not allow for teach back. She stressed the need for community programs to work with the hospital based programs. She also described that Qualidigm collects some clinical data as well as patient satisfaction and pre/post program knowledge on Stanford programs. This data is more for evaluation, not for research. Bruce Gould asked if there is any data collected for those who drop out, he is concerned that the Stanford program is "too intense" for many patients. This data is not collected; however, it was pointed out that Connecticut Stanford programs have a 73% retention rate.

6. Review of action steps for recommendations:

M. Dalal reviewed the process to move from intention to execution. He reminded the group that the recommendations span a five year time frame whereas the action steps should focus on a one year period. If action step requires more than one year it should continue. Action steps that require future action should be flagged. He reviewed "SMART" objectives. These are action steps that are specific, measureable, action oriented, relevant and time limited. He went on to describe that the action steps should identify what will be done, by whom, by when as well as being trackable, achievable (considering the current environment) and bound by the time frame of May 2017- April 2018. He stressed workgroups should use this framework. One example of a SMART objective (from education) is: By year 2 of project, local education agency staff will have trained 75% of teachers in the school district on selected curriculum.

The council's final report is due May 2018. The diabetes partnership that was previously in place would take on the role of monitoring progress. The partnership is open, informal and geared to sharing resources for diabetes and pre-diabetes. DPH will resume coordination of partnership after May 2017.

7. Workgroup updates:

During the Prevention of Type 2 Diabetes Workgroup's January Call, the workgroup discussed broad direction of action steps including reimbursement and the business case, influence of existing networks to promote referral and SIM integration, and targeted geographic deployment of DPP.

The Clinical Quality Measures workgroup is finalizing survey for health insurance carriers: any comments should be sent to Stephanie Poulin by Jan 31. One suggestion made was to add a questions about how the measure data are collected by the carriers (e.g. electronic or chart audit), how the data are used (e.g. inform value-based payments, provider tiers). The group discussed the need to limit survey burden so as to achieve a good response rate.

The Diabetes Self-Management Education Workgroup's January call included a general discussion on action steps including meetings with legislators by seeking support from professional organizations, reaching out to Black and Hispanic nurse associations , seeking input from (former) insurance company Certified Diabetes Educator (CDE), and clarifying recommendation four that addressed culturally appropriate standards.

8. Legislative update:

S. Gordon described that Rep. Cook has put in 4 bills which are working their way through the process. Rep. Cook took each recommendation from the council and put it into a bill. Discussion ensued about which bill would move forward. The Equity Commission is leaning towards having DSME covered by Medicaid, however, the cost associated with DSME is a concern. Short term benefits or savings must be stressed. The group discussed how it is likely that the Department of Social Services (DSS) will push back. The group discussed that legislative research is needed and that DSS will attach a fiscal note. Another comment was made about DSS/Medicaid not covering education and that this may also be an issue to achieving Medicaid coverage of DSME. S. Gordon and Rep. Cook have been and will continue to work on these bills. It was noted that the DAC cannot provide comment on these bills but individuals can. It was suggested that 10-12 comments are needed. Anne Camp raised the question of why DSME was selected over DPP. One reason is that 33 other states already have Medicaid coverage for DSME but only one or 2 cover DPP so it is long overdue.

Meeting adjourned at 3:37 pm