2017 Public Policy and Advocacy Forum: A Local Approach with a Maximum Impact

MAY 5, 2017- MAY 6, 2017
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ROSEMONT, IL
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Medtronic
MERCK
SANOFI
Janssen
Novo Nordisk
AADE American Association of Diabetes Educators
Welcome
Nancy D’Hondt, RPh, CDE, FAADE
2017 AADE President
Thank You

- Sanofi
- Lilly Diabetes
- Merck
- Medtronic
- Novo Nordisk
- Janssen
AADE Regulatory Priorities

- Critical Issues in Healthcare Reform
  - Preserve pre-existing conditions
  - Dependent coverage to age 26
  - Prevention as priority
  - Prohibit discrimination

- Ongoing Focus in:
  - Reimbursement
  - Competitive Bidding
  - Expansion of NDPP
State Initiatives

• Diabetes Action Plans
• Stepped Therapy
• Licensure
The Purpose of this Forum

Kurt Anderson

Director, AADE State and Federal Advocacy
AADE Three Main Focal Points for Advocacy 2017-2019 = 2017 Public Policy Forum

- Federal Regulatory Issues/Legislation
- State Issues
- Membership Activity
Federal/Regulatory Issues
State Issues
Membership Activity
The Fate of the Affordable Care Act
Implications for People With Diabetes and Other Chronic Conditions

Marc Boutin, JD
CEO, National Health Council
The Fate of the Affordable Care Act: Implications for People with Diabetes and Other Chronic Conditions

Marc Boutin, JD
Chief Executive Officer
mboutin@nhcouncil.org
New Balance of Power

Cap Federal Healthcare Spending and Cost Growth

Lower, more predictable Medicaid and premium support funding

Offer More Flexibility to Private Sector and States

Flexibility to states and more relaxed regulation for health plans
Three-Pronged Approach

- Executive and Regulatory Action
- Reconciliation
- Piecemeal Legislation
Potential Scenarios Quickly Emerged/Submerged

<table>
<thead>
<tr>
<th>Repeal and Delay</th>
<th>Repeal and Repair</th>
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</thead>
<tbody>
<tr>
<td>Repeal and Rebrand</td>
<td>Repeal and Replace</td>
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</tbody>
</table>
While Many Prominent ACA Provisions May Be Repealed, Some Policies Are Likely to Remain Intact

<table>
<thead>
<tr>
<th>Likely to be Repealed</th>
<th>Currently Being Debated</th>
<th>Likely to Remain Intact</th>
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<tbody>
<tr>
<td>Taxes</td>
<td>Medicaid expansion</td>
<td>Most drug-related provisions</td>
</tr>
<tr>
<td>Individual and employer mandates</td>
<td>Essential Health Benefits</td>
<td>Some payment &amp; delivery reform</td>
</tr>
<tr>
<td>Subsidies</td>
<td>Community rating</td>
<td>CMMI</td>
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# Key Provisions of American Health Care Act

<table>
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<tr>
<th>Mandates</th>
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<tr>
<td>Medicaid</td>
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<td>Subsidies</td>
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<td>Premium Rating for Age and Health Status</td>
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<tr>
<td>Essential Health Benefits</td>
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<tr>
<td>Taxes</td>
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<td>Domains</td>
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| Ensure Meaningful and Affordable Access | 1. Ensure access to affordable coverage, including those with pre-existing and chronic conditions and the financially disadvantaged through subsidies  
2. Maintain current – and increase future – levels of access to Medicare, Medicaid, employer-sponsored, and individual market insurance  
3. Ensure health plans offer comprehensive coverage options, including preventative services, long-term and end-of-life care, robust provider networks, and formularies with affordable and predictable out-of-pocket costs  
4. Create appropriate mechanisms to pool and spread insurance risk across broad groups of people to promote affordability and stability of premiums and ensure access for high-risk people with chronic conditions |
| Coverage For Pre-existing Conditions | 1. Guarantee the continuity of health access and ban limitations on coverage of pre-existing conditions  
2. Prohibit wrongful termination of an individual’s health insurance coverage for having or developing any condition  
3. Prohibit medical underwriting and community rating that discriminates on the basis of health status, age, or gender  
4. Eliminate adverse selection through plan design elements such as high cost-sharing and utilization management |
| Eliminate Annual and Lifetime Benefit Caps | 1. Ban lifetime limits on health insurance coverage and annual limits on all benefits  
2. Include a reasonable cap on annual out-of-pocket expenses that is spread throughout the calendar year |
Next Stop: The Senate
Medicaid Expansion


*The Governor-elect of Kentucky announced plans to roll back the state’s expansion of Medicaid; however, to-date no plans have been finalized.
Project Goal and Approach

Task 1. Identify the Universe of Policy Proposals

Task 2. Create Patient Centered Framework

Task 3. Prioritize Proposals

Task 4. Assess Policy Proposals
Task 1: Determine the Universe of Prominent Policy Proposals

- ~175 proposals
- 64 proposals
- 42 proposals
Task 2: Patient Centered Framework

- Promote High-Value Health Care
- Curb Costs Responsibly
- Stimulate Research and Competition
## Task 3: Analysis

### Proposals

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Promote High-Value Health Care</th>
<th>Stimulate Research &amp; Competition</th>
<th>Curb Costs Responsibly</th>
<th>Overall Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement fixed, per-person Medicaid payments</td>
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<td>Allow providers and patients to reimport drugs</td>
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<td>Reform patent process (i.e., evergreening; pay for delay)</td>
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<td>Shorten exclusivity periods</td>
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<tr>
<td>Permit Medicare to negotiate drug prices</td>
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# Task 3: Analysis

## Proposals

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<tr>
<td>Reduce barriers for development of generic and biosimilar products</td>
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<tr>
<td>Incorporate the patient perspective in research and development</td>
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<tr>
<td>Promote meaningful transparency on price and cost sharing</td>
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<td>Encourage outcomes-based contracting</td>
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<td>Facilitate the implementation of value-based insurance design</td>
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<td>Develop patient-relevant quality measures</td>
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### Task 4: Assessment

<table>
<thead>
<tr>
<th>Potential for Cost Savings</th>
<th>Political Feasibility</th>
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<tbody>
<tr>
<td>Reduce barriers for development of generic and biosimilar products</td>
<td>FDA analysis shows that generic entry has downward pressure on drug prices</td>
</tr>
<tr>
<td>Promote meaningful transparency on price and cost sharing</td>
<td>CBO has characterized potential savings as “ambiguous”</td>
</tr>
<tr>
<td>Encourage outcomes-based contracting</td>
<td>Savings from publicly announced OBCs have not been disclosed</td>
</tr>
<tr>
<td>Facilitate the implementation of value-based insurance design</td>
<td>Savings from VBID programs have been mixed</td>
</tr>
</tbody>
</table>
NHC Value Model Rubric
Value Model Development Process

- Planning
- Drafting and Refinement
- Dissemination and Implementation
- Evaluation
- Update and Maintenance

- Patient Partnership
- Transparency to Patients
- Inclusiveness of Patients
- Diversity of Patients/Populations
- Outcomes Patients Care About
- Patient-Centered Data Sources
Shifting from the Average to the Individual

The **time is right** because of:

- Sequencing of the human genome
- Improved technologies for biomedical analysis
- New tools for using large datasets

Source: www.nih.gov/precisionmedicine
Care Delivery

Life Experiences

Quality

Clinical Outcomes

Financing

Goals/Aspirations
Questions?
Break

Program will resume in 10 minutes
Membership Panel: Advocacy
Leisa Blanchard, APRN, BSN, RN, CDE, CPT; Kathy Gold, RN, MSN, CDE, FAADE; Jasmine Gonzalvo, PHARM.D.; BCPS, BCADM, CDE, LDE; and Francine Grabowksi, MS, RD, CDE

Members of the AADE Advocacy Committee and Board of Directors
Leisa Blanchard
Best Practices from Leisa Blanchard

• Keep up with the AADE Advocacy page
  – You can share interesting new items with friends and colleagues

• Follow legislators on social media (Facebook, Twitter, et al…) and subscribing to their newsletters.
  – This keeps you informed of when legislators are in-district, and can be met with outside of office hours.

• Maintain relationships with Legislators’ staff
  – They are the key to access
Kathy Gold
Best Practices from Kathy Gold

• Learn about legislative processes
  – Keep track of relevant dates, how committees are set up, bills get introduced, and how to comment communicate with Legislators about bills

• Learn how to navigate legislative websites
  – This will help you identify your legislators, and other influential members of the legislature

• Identify the committees that may be involved in reviewing legislation of interest
  – Identify the key players on that committee

• Befriend lobbyists who work on diabetes issues
  – In addition to AADE, American Diabetes Association, Nurses Association, and RD Association all have lobbyists to advocate for people with Diabetes
2 bills were submitted and the final result was then amended

• Stuart:
  – SB 1116 - Provides that any school employee who is authorized and trained in the administration of insulin and glucagon (1) may assist with the insertion or reinsertion of an insulin pump or any of its parts and (2) shall be immune from liability as long as certain criteria are met.

• McPeak
  – SB 1214 of 10 or more (i) at least three employees have current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator and (ii) if one or more students diagnosed as having diabetes attend such school, at least two employees have been trained in the administration of insulin including the use and insertion of insulin pumps and the administration of glucagon. In school buildings with an instructional and administrative staff of fewer than 10, school boards shall ensure that (a) at least two employees have current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator and (b) if one or more students diagnosed as having diabetes attend such school, at least one employee has been trained in the administration of insulin including the use and insertion of insulin pumps and the administration of glucagon. "Employee" includes any person employed by a local health department who is assigned to the public school pursuant to an agreement between the local health department and the school board. When a registered nurse, nurse practitioner, physician, or physician assistant is present, no employee who is not a registered nurse, nurse practitioner, physician, or physician assistant shall assist with the administration of insulin or administer glucagon. Prescriber authorization and parental consent.
• Final Bill
  – Is an employee of (i) a school board, (ii) a school for students with disabilities as defined in licensed by the Board of Education, or (iii) a private school accredited pursuant to as administered by the Virginia Council for Private Education and is authorized by a prescriber and trained in the administration of insulin and glucagon, who, upon the written request of the parents as defined in § 22.1-1, assists with the administration of insulin or with the insertion or reinsertion of an insulin pump or any of its parts pursuant to subsection B of § 22.1-274.01:1 or administers glucagon to a student diagnosed as having diabetes who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if the insulin is administered according to the child's medication schedule or such employee has reason to believe that the individual receiving the glucagon is suffering or is about to suffer life-threatening hypoglycemia. Whenever any such employee is covered by the immunity granted herein, the school board or school employing him shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such insulin or glucagon treatment. Is a school nurse, an employee of a school board, an employee of a local governing body, or

• Amendment
  – A local school board employee who is a registered nurse, licensed practical nurse, or certified nurse aide and who has been trained in the administration of insulin and glucagon may assist a student who is diagnosed with diabetes and who carries an insulin pump with the insertion or reinsertion of the pump or any of its parts. For the purposes of this subsection, "employee" has the same meaning as in subsection E of § 22.1-274. Prescriber authorization and parental consent shall be obtained for any such employee to assist with the insertion or reinsertion of the pump or any of its parts. Nothing in this section shall require any employee to assist with the insertion or reinsertion of the pump or any of its parts.
An Act to amend and reenact §§ 8.01-225 and 22.1-274.01:1 of the Code of Virginia, relating to public schools; certain employees; insulin pump assistance.

Be it enacted by the General Assembly of Virginia:

1. Sections 8.01-225 and 22.1-274.01:1 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-225. Persons rendering emergency care, obstetrical services exempt from liability.

1. Any person who:
   i. In good faith, renders emergency care or assistance, without compensation, to any ill or injured person (i) at the scene of an accident, fire, or any life-threatening emergency; (ii) at a location for the purpose of rendering or stabilizing an emergency medical condition arising from an accident, fire, or any life-threatening emergency; or (iii) en route to any hospital, medical clinic, or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance.

2. In the absence of gross negligence, renders emergency obstetrical care or assistance to a female in active labor who has not previously been cared for in connection with the pregnancy by such person or by another professionally associated with such person and whose medical records are reasonably available to such person shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care or assistance. The immunity herein granted shall apply only to the emergency medical care rendered.

3. In good faith and without compensation, including any emergency medical services provider who holds a valid certificate issued by the Commissioner of Health, administers epinephrine in an emergency to an adult or minor who is not able to take an oral dose of epinephrine or by injection, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if such person has reason to believe that the individual receiving the injection is suffering or is about to suffer a life-threatening anaphylactic reaction.

4. In good faith and without compensation, including any emergency medical services provider who holds a valid certificate issued by the Commissioner of Health, administers epinephrine in an emergency to an adult or minor who is not able to take an oral dose of epinephrine or by injection, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if such person has reason to believe that the individual receiving the injection is suffering or is about to suffer a life-threatening anaphylactic reaction.

5. Is an emergency medical services provider possessing a valid certificate issued by authority of the State Board of Health who in good faith renders emergency care or assistance, whether in person or by telephone, to a victim of a cardiac arrest, without compensation, who is not able to swallow an oral dose of epinephrine, or who is unable to give informed consent, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment or assistance, including but in no way limited to acts or omissions which involve violations of State Department of Health regulations or any other state regulations in the rendering of such emergency care or assistance.

6. In good faith and without compensation, renders or administers emergency cardiopulmonary resuscitation (CPR); cardiac defibrillation, including, but not limited to, the use of an automated external defibrillator (AED); or other emergency life-sustaining or resuscitative treatments or procedures which have been approved by the State Board of Health to any sick or injured person, whether at the scene of an accident, fire, or any other place, or while transporting such person to or from any hospital, clinic, doctor's office, or other medical facility, shall be deemed qualified to administer such emergency treatments and procedures and shall not be liable for acts or omissions resulting from the rendering of such treatments or procedures.

7. Operates an AED at the scene of an emergency, trains individuals to be operators of AEDs, or orders AEDs, shall be immune from civil liability for any personal injury that results from any act or omission in the use of an AED in an emergency where the person performing the defibrillation acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances.

8. Maintains an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.

9. In an emergency, an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.

10. Is an employee of a school board or of a local health department approved by the local governing body to provide health services pursuant to § 22.1-274.1 who, while on school property or at a school-sponsored event, (i) renders emergency care or assistance to any sick or injured person; (ii) renders or administers emergency cardiopulmonary resuscitation (CPR); cardiac defibrillation, including, but not limited to, the use of an automated external defibrillator (AED); or other emergency life-sustaining or resuscitative treatments or procedures that have been approved by the State Board of Health to any sick or injured person; (iii) operates an AED, trains individuals to be operators of AEDs, or orders AEDs; or (iv) maintains an AED shall not be liable for civil damages for ordinary negligence in acts or omissions on the part of such employee while engaged in the acts described in this subdivision.

11. A volunteer in good standing and certified to render emergency care by the National Ski Patrol System, Inc., who, in good faith and without compensation, renders emergency care or assistance to any injured or ill person, whether at the scene of a ski area rescue, outdoor emergency rescue, or any other place or while transporting such injured or ill person to a place accessible for transfer to any available emergency medical system unit, or any resort owner voluntarily providing a ski patrol employee by loan to engage in rescue or recovery work at a resort not owned or operated by him, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment, or assistance, including but not limited to acts or omissions which involve violations of any state regulation or any standard of the National Ski Patrol System, Inc., in the rendering of such emergency care or assistance, unless such act or omission was the result of gross negligence or willful misconduct.

12. Is an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 trained in the administration of insulin and glucagon, who, upon the written request of the parents as defined in § 22.1-19, assists with the administration of insulin or glucagon, or who has been prescribed by the hazardous waste as defined in § 10.1-1000 or regulations of the Virginia Waste Management Board shall not be liable for any civil damages resulting from any act of commission or omission in the course of rendering such assistance in good faith.

13. Is an emergency medical services provider possessing a valid certificate issued by authority of the State Board of Health who in good faith renders emergency care or assistance, whether in person or by telephone, to a victim of a cardiac arrest, without compensation, who is not able to swallow an oral dose of epinephrine, or who is unable to give informed consent, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment or assistance, including but in no way limited to acts or omissions which involve violations of State Department of Health regulations or any other state regulations in the rendering of such emergency care or assistance.

14. In an emergency, an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED in an emergency where the person performing the defibrillation acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances.

15. Maintains an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.

16. In an emergency, an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.

17. In an emergency, an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.

18. In an emergency, an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.

19. In an emergency, an AED located on real property owned or controlled by such person shall be immune from civil liability for any personal injury that results from any act or omission in the use of an emergency AED located on such property unless such personal injury results from gross negligence on the part of the person who maintains the AED or his agent.
Department of Behavioral Health and Developmental Services, who has been trained in the
administration of insulin and glucagon and who administers or assists with the administration of insulin
when a person diagnosed with diabetes is suffering an acute episode of hypoglycemia unable to safely
respond to rapid-acting insulin or oral hypoglycemic agents.

158. A person diagnosed with diabetes shall be liable for any civil damages for ordinary negligence or willful misconduct.

159. Any provider of a Voice-over-Internet Protocol service, in the Commonwealth shall not be liable for any

160. civil damages for any act or omission resulting from rendering such service with or without charge
related to emergency calls unless such act or omission was the result of such service provider's gross
negligence or willful misconduct.

161. Any volunteer engaging in rescue or recovery work at a mine, or any mine operator voluntarily
providing personnel to engage in rescue or recovery work at a mine not owned or operated by such
operator, shall not be liable for civil damages for acts or omissions resulting from the rendering of such

162. rescue or recovery work in good faith unless such act or omission was the result of gross negligence or
willful misconduct. For purposes of this subsection, "Voice-over-Internet Protocol service" or "VoIP service"
means any Internet protocol-enabled services utilizing a broadband connection, actually
originating or terminating in Internet Protocol from either or both ends of a channel of communication
offering real time, multidirectional voice functionality, including, but not limited to, services similar to
traditional telephone service.

163. Nothing contained in this section shall be construed to provide immunity from liability arising out
of the operation of a motor vehicle.

164. For the purposes of this section, "compensation" shall not be construed to include (i) the salaries of
police, fire, or other public officials or personnel who render such emergency assistance; (ii) the
salaries or wages of employees of a coal producer engaging in emergency medical services or first aid
services pursuant to the provisions of § 45.1-161.38, 45.1-161.101, 45.1-161.199, or 45.1-161.263; (iii)
complimentary lift tickets, food, lodging, or other gifts provided as a gratuity to volunteer members of
the National Ski Patrol System, Inc., by any resort, group, or agency; (iv) the salary of any person who
(a) owns an AED for the use at the scene of an emergency, (b) trains individuals, in courses approved
by the Board of Health, to operate AEDs at the scene of emergencies, (c) orders AEDs for use at the
scene of emergencies, or (d) operates an AED at the scene of an emergency; or (v) expenses reimbursed
to any person providing care or assistance pursuant to this section.

165. For the purposes of this section, "emergency medical services provider" shall include a person
licensed or certified as such or its equivalent by any other state when he is performing services that he is
licensed or certified to perform by such other state in caring for a patient in transit in the
Commonwealth, which care originated in such other state.

166. Further, the public shall be urged to receive training on how to use CPR and an AED in order to
acquire the skills and confidence to respond to emergencies using both CPR and an AED.

167. § 22.1-274.101. Students who are diagnosed with diabetes; self-care.

168. A. Each local school board shall permit each enrolled student who is diagnosed with diabetes, with
parental consent and written approval from the prescriber, as that term is defined in § 54.1-3401, to (i)
carry with him and use supplies, including a reasonable and appropriate short-term supply of
carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose
levels, and (ii) self-check his own blood glucose levels on a school bus, on school property, and at a
school-sponsored activity.

169. B. A local school board employee who is a registered nurse, licensed practical nurse, or certified
nurse aide and who has been trained in the administration of insulin and glucagon may assist a student
who is diagnosed with diabetes and who carries an insulin pump with the insertion or reinserction of the
pump or any of its parts. For the purposes of this subsection, "employee" has the same meaning as in
subdivision E of § 22.1-274. Prescriber authorization and parental consent shall be obtained for any
such employee to assist with the insertion or reinserterion of the pump or any of its parts. Nothing in this
section shall require any employee to assist with the insertion or reinserterion of the pump or any of its
parts.
Jasmine Gonzalvo
Best Practices from Jasmine Gonzalvo

• Do your research
  – Ask a lot of questions
• Utilize your existing network
• Build new relationships
HOUSE BILL No. 1642

DIGEST OF HB 1642 (Updated February 1, 2017 7:20 pm -- DR 77)

Citations Affected: None.

Synopsis: Diabetes in Indiana. Urges the legislative council to assign the study of diabetes issues to a study committee during the 2017 legislative interim.

Effective: Upon passage.

Summers, Clere, Kirchhofer, Macer

February 2, 2017, committee reported — The Pass.

February 3, 2017

First Regular Session of the 120th General Assembly (2017)

PRINTING CODE: Amendments: Whenever an existing statute or a provision of the Indiana Constitution is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being adopted (or a new constitutional provision adopted), the text of the new provision will appear in this style type. Also, the word NEW will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict resolution: Text in sections of this act is a cross reference from the 2016 Regular Session of the General Assembly.

HOUSE BILL No. 1642

A BILL FOR AN ACT concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. (EFFECTIVE UPON PASSAGE) (a) As used in this SECTION, "legislative council" means the legislative council created by IC 2-5.1-1.
(b) As used in this SECTION, "study committee" means either of the following:
(1) A statutory committee established under IC 2-5.
(2) An interim study committee.
(c) The legislative council is urged to assign to the appropriate study committee during the 2017 interim the task of studying goals, benchmarks, and plans to reduce the incidence of diabetes in Indiana, improve diabetes care, and control complications associated with diabetes, including the following:
(1) An assessment of the financial impact and reach of diabetes of all types in Indiana.
(2) The benefits of current programs to address diabetes.
(3) Identifying current and collaborative efforts to address diabetes.
(4) If an appropriate study committee is assigned the topics
COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1642, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following: A BILL FOR AN ACT concerning health.

Page 1, delete lines 1 through 14, begin a new paragraph and insert:

“SECTION 1. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "legislative council" refers to the legislative council created by IC 2-5.1-1.

(b) As used in this SECTION, "study committee" means either of the following:

(1) A statutory committee established under IC 2-5.

(2) An interim study committee.

(c) The legislative council is urged to assign to the appropriate study committee during the 2017 interim the task of studying goals, benchmarks, and plans to reduce the incidence of diabetes in Indiana, improve diabetes care, and control complications associated with diabetes, including the following:

Page 1, line 16, delete "The assessment must include":

Page 1, delete line 17, begin a new line block indented and insert:

(2) The benefits of current programs to address diabetes.

(3) Identifying current and collaborative efforts to address diabetes.

(4) If an appropriate study committee is assigned the topics described under subsection (c), the study committee shall issue to the legislative council a final report containing the study committee’s findings and recommendations, including evidence based recommendations for legislative action to reduce the impact of prediabetes, diabetes and diabetes-related complications, an estimated cost for each recommendation, and any recommended legislation concerning the topics, in an electronic format under IC 5-14-6, not later than November 1, 2017.”
(c) This SECTION expires December 31, 2017.

SECTION 2. An emergency is declared for this act.*

Delete pages 2 through 3.

and when so amended that said bill do pass.

(Reference is to HB 1642 as introduced.)

KEROBIOFER

Committee Vote: yeas 11, nays 0.
April 24, 2017

Dear Senator Long and members of the Legislative Council,

Thank you for your recent support of HB1642: Diabetes in Indiana. As the Chief Executive Officer of Eskenazi Health, I’m writing to encourage you to ensure that the interim study committee is formed.

In the last decade, according to the Centers for Disease Control (CDC), the percentage of Hoosiers diagnosed with diabetes has risen from 7.6% to 12.9%, over one half million individuals. Another 1,719,000 (35.6%) Hoosiers have prediabetes and will likely go on to develop diabetes without appropriate interventions. According to the American Diabetes Association, diabetes and prediabetes cost an estimated $6.6 billion in Indiana each year. The serious complications include heart disease, stroke, amputation, end-stage kidney disease, blindness, and death.

Eskenazi Health serves as the public hospital division of the Health & Hospital Corporation of Marion County with a 315-bed inpatient hospital and 11 community health centers around the city. Our mission is to advocate, care, teach, and serve with special emphasis on the vulnerable populations of Marion County. Eskenazi Health offers nationally accredited Diabetes Self-Management Education (DSME) programming led by interdisciplinary health care professionals, pharmacist-managed Cardiovascular Risk Reduction services in primary care, and is in the process of developing standardized Diabetes Prevention Program (DPP) services in an effort to stop the progression to diabetes for hundreds of the most vulnerable individuals.

Significant areas of improvement exist for health insurance coverage across the State. Health care systems, such as Eskenazi Health, provide uncompensated care for a disproportionate amount of the underserved population in Indiana. Diabetes is the gateway condition that repeatedly brings people to the ER, which results in costly inpatient admissions to manage the complications that result from uncontrolled diabetes such as diabetic foot infections and amputations, diabetic ketoacidosis, and kidney failure and dialysis. Access to DSME could help prevent frequent ER visits and inpatient admissions.

DSME provided by diabetes educators is the key for better clinical and economic outcomes. Patients with the appropriate amount of diabetes literacy have the best opportunity to live productive lives, have jobs, pay taxes and cost the healthcare system less. In 2014, only half of Hoosiers diagnosed with diabetes received DSME.

The interim study committee could play an integral role in helping to slow the growing epidemic of diabetes in Indiana by examining the impact of DSME programs, identifying the most effective DSME interventions, and developing a comprehensive plan and time line for facilities to implement DSME programs.

I respectfully request you to move forward with the interim study committee for diabetes.
Francine Grabowski
Best Practices from Francine Grabowski

• Build collaborative networks
  – Share your passion for diabetes education with your supervisors and all management. Be generous and share with other diabetes educators in your area, be supportive and stay in touch with peers. They will return the favor!

• Be involved as an advocate for your patients. Share your stories, and theirs
  – Speak about your unique set of skills and knowledge as a diabetes educator.
  – Stories of patients who struggle to get medicine, to make and keep multiple appointments, to follow complex care regimens and to learn the new skills, needed to self-manage diabetes. Are often the most compelling when talking to policy-makers.
  – Often, the repetitive nature of medication denials may seem like routine quirks of the healthcare system. On the contrary, this is a signal that the system is broken- legislators the human toll of bad policy can help bring reform
SENATE, No. 1305
STATE OF NEW JERSEY
217th LEGISLATURE
INTRODUCED FEBRUARY 8, 2016

S1305 VITALE, MADDEN

AN ACT concerning Medicaid coverage for diabetes treatment and
amending P.L.1968, c.413.

BE IT ENACTED by the Senate and General Assembly of the State
of New Jersey:

1. Section 6 of P.L.1968, c.413 (C.39:6-4D-6) is amended to read
as follows:

6. a. Subject to the requirements of Title XIX of the federal
Social Security Act, the limitations imposed by this act and by the
rules and regulations promulgated pursuant thereto, the department
shall provide medical assistance to qualified applicants, including
authorized services within each of the following classifications:

(1) Inpatient hospital services;
(2) Outpatient hospital services;
(3) Other laboratory and X-ray services;
(4) (a) Skilled nursing or intermediate care facility services;
(b) Early and periodic screening and diagnosis of individuals
who are eligible under the program and are under age 21, to
ascertain their physical or mental defects and the health care,
treatment, and other measures to correct or ameliorate defects and
chronic conditions discovered thereby, as may be provided in
regulations of the Secretary of the Federal Department of Health and
Human Services and approved by the commissioner;
(5) Physician’s services furnished in the office, the patient’s
home, a hospital, a skilled nursing, or intermediate care facility or
elsewhere.

As used in this subsection, “laboratory and X-ray services”
includes HIV drug resistance testing, including, but not limited to,
genotype assays that have been cleared or approved by the federal
Food and Drug Administration, laboratory developed genotype
assays, phenotype assays, and other assays using phenotype
prediction with genotype comparison, for persons diagnosed with
HIV infection or AIDS.

b. Subject to the limitations imposed by federal law, by this
act, and by the rules and regulations promulgated pursuant thereto,
the medical assistance program may be expanded to include
authorized services within each of the following classifications:

(1) Medical care not included in subsection a.(5) above, or any
other type of remedial care recognized under State law, furnished
by licensed practitioners within the scope of their practice, as
defined by State law;
(2) Home health care services;
(3) Clinic services;
(4) Dental services;

EXPLANATION – Matter enclosed in bold-faced brackets [here] in the above bill is
not enacted and is intended to be omitted in the law.
Matter underlined [here] is new matter.
(5) Physical therapy and related services;
(6) Prescribed drugs, dentures, and prosthetic devices; and
(7) Optometric services;
(8) Podiatric services;
(9) Chiropractic services;
(10) Psychological services;
(11) Inpatient psychiatric hospital services for individuals under
21 years of age, or under age 22 if they are receiving such services
immediately before attaining age 21;
(12) Other diagnostic, screening, preventive, and rehabilitative
services, and other remedial care;
(13) Inpatient hospital services, nursing facility services, and
intermediate care facility services for individuals 65 years of age or
over in an institution for mental diseases;
(14) Intermediate care facility services;
(15) Transportation services;
(16) Services in connection with the inpatient or outpatient
treatment or care of drug abuse, when the treatment is prescribed by
a physician and provided in a licensed hospital or in a narcotic and
drug abuse treatment center approved by the Department of Health
pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.) and whose staff
includes a medical director, and limited to those services eligible
for federal financial participation under Title XIX of the federal
Social Security Act;
(17) Any other medical care and any other type of remedial care
recognized under State law, specified by the Secretary of the federal
Department of Health and Human Services, and approved by the
commissioner;
(18) Comprehensive maternity care, which may include:
the basic number of prenatal and postpartum visits recommended by
the American College of Obstetrics and Gynecology; additional
prenatal and postpartum visits that are medically necessary;
necessary laboratory, nutritional assessment and counseling, health
education, personal counseling, managed care, outreach, and
follow-up services; treatment of conditions which may complicate
pregnancy; and physician or certified nurse-midwife delivery
services;
(19) Comprehensive pediatrics care, which may include:
ambulatory, preventive, and primary care health services. The
preventive services shall include, at a minimum, the basic number
of preventive visits recommended by the American Academy of
Pediatrics;
(20) Services provided by a hospice which is participating in the
Medicare program established pursuant to Title XVIII of the Social
Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
services shall be provided subject to approval of the Secretary of
the federal Department of Health and Human Services for federal
reimbursement;
(21) Mammograms, subject to approval of the Secretary of the
federal Department of Health and Human Services for federal
reimbursement, including one baseline mammogram for women
who are at least 35 but less than 40 years of age; one mammogram
examination every two years or more frequently, if recommended
by a physician, for women who are at least 40 but less than 50 years
of age; and one mammogram examination every year for women
age 50 and over;
(22) Referral by a physician, an advanced practice nurse, or
physician assistant of a person diagnosed with diabetes, gestational
diabetes, or pre-diabetes;
(a) Expenses for diabetes self-management education or training
to ensure that a person with diabetes, gestational diabetes, or pre-
 diabetes can optimize metabolic control, prevent and manage
complications, and maximize quality of life. Diabetes self-
management education shall be provided by:
(1) A licensed, registered, or certified health care professional
who is certified by the National Certification Board of Dieticians
in the Certified Diabetes Educator or certified by the
American Association of Diabetes Educators and Board
Certified-Advanced Diabetes Management credential, including but
not limited to a physician, advanced practice nurse, physician
assistant, pharmacist, or dietitian
registered by a nationally recognized professional association of
dietitians or
(2) An entity meeting the National Standards for Diabetes Self-
Management Education and Support, as evidenced by a recognition
by the American Diabetes Association or accreditation by the
American Association of Diabetes Educators;
(b) Expenses for medical nutrition therapy as an effective
component of the person’s overall treatment plan upon a diagnosis
of diabetes, gestational diabetes, or pre-diabetes; change in the
beneficiary’s medical condition, treatment, or diagnosis; or
determination of a physician, advanced practice nurse, or physician
assistant that reeducation or refresher education is necessary.
Medical nutrition therapy shall be provided by a dietitian
registered by a nationally recognized professional association of dietitians
familiar with the components of diabetes medical nutrition therapy;
(c) For a person diagnosed with pre-diabetes, items and services
furnished under a diabetes prevention program that meets the
standards of the National Diabetes Prevention Program, as
established by the Centers for Disease Control and Prevention;
and
(d) Expenses for any supplies and equipment recommended or
prescribed by a physician, advanced practice nurse, or physician
assistant for the management and treatment of diabetes, gestational
diabetes, or pre-diabetes, including but not limited to: equipment
and supplies for self-management of blood glucose; insulin pens; insulin pumps and related supplies; and other insulin delivery devices.

c. Payments for the foregoing services, goods, and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. The payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, the recipient's family, the recipient's representative or others on the recipient's behalf for the services, goods, and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods, or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods, and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods, or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.

d. Any individual eligible for medical assistance (including drugs) may obtain such assistance from any person qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability on a prepayment basis), who undertakes to provide the individual such services.

No copayment or other form of cost-sharing shall be imposed on any individual eligible for medical assistance, except as mandated by federal law as a condition of federal financial participation.

e. Anything in this act to the contrary notwithstanding, no payments for medical assistance shall be made under this act with respect to care or services for any individual who:

   (1) Is an inmate of a public institution (except as a patient in a medical institution); provided, however, that an individual who is otherwise eligible may continue to receive services for the month in which he becomes an inmate, should the commissioner determine to expand the scope of Medicaid eligibility to include such an individual, subject to the limitations imposed by federal law and regulations, or

   (2) Has not attained 65 years of age and who is a patient in an institution for mental diseases, or

   (3) Is over 21 years of age and who is receiving inpatient psychiatric hospital services in a psychiatric facility; provided, however, that an individual who was receiving such services immediately prior to attaining age 21 may continue to receive such

services until the individual reaches age 22. Nothing in this subsection shall prohibit the commissioner from extending medical assistance to all eligible persons receiving inpatient psychiatric services; provided that there is federal financial participation available.

f. (1) A third party as defined in section 3 of P.L.1968, c.413 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in this or another state when determining the person's eligibility for enrollment or the provision of benefits by that third party.

(2) In addition, any provision in a contract of insurance, health benefits plan, or other health care coverage document, will, trust, agreement, court order, or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential eligibility for or receipt of Medicaid benefits shall be null and void, and no payments shall be made under this act as a result of any such provision.

(3) Notwithstanding any provision of law to the contrary, the provisions of paragraph (2) of this subsection shall not apply to a trust agreement that is established pursuant to 42 U.S.C. s.1396p(d)(4)(A) or (C) to supplement and augment assistance provided by government entities to a person who is disabled as defined in section 1614(a)(3) of the federal Social Security Act (42 U.S.C. s.1382c(a)(3)).

g. The following services shall be provided to medically needy individuals as follows:

(1) Pregnant women shall be provided prenatal care and delivery services and postpartum care, including the services cited in subsection a.(1), (3), and (5) of this section and subsection b.(1)-(10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(2) Dependent children shall be provided with services cited in subsection a.(3) and (5) of this section and subsection b.(1), (2), (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(3) Individuals who are 65 years of age or older shall be provided with services cited in subsection a.(5) and (5) of this section, and subsection b.(11)-(15), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(4) Individuals who are blind or disabled shall be provided with services cited in subsection a.(3) and (5) of this section and subsection b.(11)-(15), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(5) (a) Inpatient hospital services, subsection a.(1) of this section, shall only be provided to eligible medically needy
individuals, other than pregnant women, if the federal Department
of Health and Human Services discontinues the State's waiver to
establish inpatient hospital reimbursement rates for the Medicare
and Medicaid programs under the authority of section 601(c)(3) of
the Social Security Act Amendments of 1983, Pub.L.98-21 (42
U.S.C. s.1395ww(c)(3)). Inpatient hospital services may be
extended to other eligible medically needy individuals if the federal
Department of Health and Human Services directs that these
services be included.

(b) Outpatient hospital services, subsection a.(2) of this section,
shall only be provided to eligible medically needy individuals if the
federal Department of Health and Human Services discontinues the
State's waiver to establish outpatient hospital reimbursement rates
for the Medicare and Medicaid programs under the authority of
section 601(c)(3) of the Social Security Amendments of 1983,
Pub.L.98-21 (42 U.S.C. s.1395ww(c)(3)). Outpatient hospital
services may be extended to all or to certain medically needy
individuals if the federal Department of Health and Human Services
directs that these services be included. However, the use of
outpatient hospital services shall be limited to clinic services and to
emergency room services for injuries and significant acute medical
conditions.

(c) The division shall monitor the use of inpatient and outpatient
hospital services by medically needy persons.

h. In the case of a qualified disabled and working individual
pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
only medical assistance provided under this act shall be the payment of premiums
for Medicare part A under 42 U.S.C.
s.1395t.2 and 1395t.
i. In the case of a specified low-income Medicare beneficiary
pursuant to 42 U.S.C. s.1396a(a110(E)(iii), the only medical
assistance provided under this act shall be the payment of premiums
for Medicare part B under 42 U.S.C. s.1395 as provided for in 42

j. In the case of a qualified individual pursuant to 42 U.S.C.
s.1396a(a110), the only medical assistance provided under this act
shall be payment for authorized services provided during the period
in which the individual requires treatment for breast or cervical
cancer, in accordance with criteria established by the commissioner.
(cf: P.L.2012, c.17, s.359)

2. (New section) The Commissioner of Human Services shall
apply for such State plan amendments or waivers as may be
necessary to implement the provisions of this act and to secure
federal financial participation for State Medicaid expenditures
under the federal Medicaid program.

STATEMENT

This bill requires Medicaid coverage for diabetes self-management
education, training, services, and equipment for patients diagnosed
with diabetes, gestational diabetes, and pre-diabetes.

The bill specifically requires the State Medicaid program to cover
expenses for diabetes self-management education or training for
persons diagnosed with diabetes, gestational diabetes, or pre-diabetes.
This education or training is to help ensure that the patient can
optimize metabolic control, prevent and manage complications, and
maximize quality of life. The bill requires diabetes self-management
education to be provided by: a health care professional who has been
certified by the National Certification Board of Diabetes Educators or
by the American Association of Diabetes Educators, including a
physician, an advanced practice nurse or registered nurse, a physician
assistant, a pharmacist, a chiropractor, or a registered dietitian; or by
an entity meeting the National Standards for Diabetes Self-
Management Education and Support, as evidenced by a recognition by
the American Diabetes Association or accreditation by the American
Association of Diabetes Educators.

The bill requires the State Medicaid program to cover expenses for
medical nutrition therapy as a component of a patient’s overall
treatment plan when: the person is diagnosed with diabetes, gestational
diabetes, or pre-diabetes; there is a change in the person’s medical
condition, treatment, or diagnosis; or when the health care provider
determines that reeducation or refresher education is necessary. Under
the bill, medical nutrition therapy is required to be provided by a
dietitian registered with a nationally-recognized professional
association.

The bill requires the State Medicaid program to cover items and
services furnished under a diabetes prevention program that meets the
standards of the National Diabetes Prevention Program established by
the Centers for Disease Control and Prevention for persons diagnosed
with pre-diabetes.
The bill also requires the State Medicaid program to cover expenses for any supplies and equipment recommended or prescribed for the management and treatment of diabetes, gestational diabetes, or pre-diabetes, including but not limited to: equipment and supplies for self-management of blood glucose; insulin pens; insulin pumps and related supplies, and other insulin delivery devices.

The bill limits coverage for the education, training, services, and equipment enumerated by the bill to persons diagnosed with diabetes, gestational diabetes, or pre-diabetes who have received a referral from a physician, advanced practice nurse, or physician assistant.

The bill directs the Commissioner of Human Services to apply for State plan amendments or waivers necessary to implement the provisions of the bill and to secure federal financial participation.

The bill authorizes the commissioner to adopt rules and regulations necessary to effectuate the purposes of the bill, and allows for the immediate filing of those rules and regulations with the Office of Administrative Law, effective for a period not to exceed six months.
2014 NEW JERSEY STATE REPORT

PATHS
Providing Access to Healthy Solutions

An Analysis of New Jersey's Opportunities to Enhance Prevention and Management of Type 2 Diabetes

WRITTEN BY
Amy Katzen and Allison Condra

PREPARED BY THE CENTER FOR HEALTH LAW AND POLICY INNOVATION OF HARVARD LAW SCHOOL
Break
Program will resume in 10 minutes
DISCLOSURES
Overview

- Diabetes Burden in Illinois
- Diabetes Program Locations
- Diabetes Statewide Assessment
Diabetes Prevalence

- Highest Prevalence Areas:
  - Edgar (17.0)
  - Macoupin (17.3)
  - Livingston (15.1)
  - Marion (15.1)
  - Gallatin (14.7)
  - Saline (14.7)

Source: IL Behavior Risk Factor Survey, 2010 – 2014, by County
Diabetes Programs

- Chicago (26)
- Cook County (24)
- Dupage County (17)
- Will County (9)
- Madison County (8)
- Sangamon County (7)
Illinois Diabetes State-wide Assessment
Organization Type

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
Scope of Services

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
Scope of Services

(Continued)

Specialty Care

- Cardiavascular: 21.3%
- Neurology: 21.3%
- Podiatry: 19.1%
- Wound Care: 17.0%
- Ophthalmology: 19.1%
- Medical Nutrition Therapy: 31.8%
- Nephrology: 21.3%

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
Service Delivery Mechanisms

- DPRP
- Evaluation
- Research
- Coalitions
- Grants
- Referrals
- Trainings
- Health Screenings
- Community Outreach
- DSME Programs
- Nutrition Education
- Health Education

Source: Statewide assessment of Diabetes Strategies (Jan 2017)

Diabetes Statewide Assessment
Populations Served

- Pregnant Women
- LGBTQ
- People with BH Dx
- Parents
- Men
- People with Disabilities
- Women (non-pregnant)
- Urban
- Healthcare Prof
- Children
- People with Pre-Diabetes/At Risk
- People with Diabetes
- Adults (18+)

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
Populations Served

(Continued)

Race / Ethnicity

- Hispanic: 40.4%
- Black: 38.3%
- White: 36.2%
- Asian: 34.0%
- AI/AN: 25.0%
- Native Hawaiian/Pacific Islander: 25.0%

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
Strategy Summaries

- Strategy 1: Finance / Reimbursement
- Strategy 2: Community – Clinical Linkages
- Strategy 3: Data / Health IT

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
# Strategy Summaries

## Key Objectives / Tactics

<table>
<thead>
<tr>
<th>Strategy 1</th>
<th>Strategy 2</th>
<th>Strategy 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Finance / Reimbursement</strong></td>
<td><strong>Community – Clinical Linkages</strong></td>
<td><strong>Data / Health IT</strong></td>
</tr>
<tr>
<td>- Learning opportunities to educate on sustainable payment mechanisms for DPP/ensure max reimbursement for DSME/DPP</td>
<td>- Education (e.g. physician referral systems for DSME and DPP) to emerging health professions.</td>
<td>- Monitor/Share data</td>
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<tr>
<td>- Partnerships</td>
<td>- Educating on referral mechanisms</td>
<td>- Partnerships</td>
</tr>
<tr>
<td>- Financial support/reimbursement is part of national recognition requirements</td>
<td>- Develop service model including electronic screening tools / referral processes</td>
<td>- Working on sustainable and effective Health Information Exchange</td>
</tr>
<tr>
<td>- Program funding opportunities (public/private sources)</td>
<td>- Creation of a telephonic case management program</td>
<td>- Use of latest technology (data management/reporting/sharing)</td>
</tr>
<tr>
<td>- IL Medicaid reimbursement for DSMT/MNT</td>
<td>- Standards of Care (Diabetes/PCMH)</td>
<td>- Data entered into centralized system</td>
</tr>
<tr>
<td>-- Various reimbursement mechanisms</td>
<td>- Best Practices (telehealth / nutrition)</td>
<td>- Performance data base system for DPRP that are also DSME programs</td>
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<tr>
<td>- Care Coordination</td>
<td>- Care Coordination</td>
<td>- Internal data use (share through ACO, but local only)</td>
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<td>- Communicate with other stakeholder groups (i.e. AMA)</td>
<td>- DPP program tracking</td>
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<td>- Network to connect patients to resources.</td>
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Strategy Summaries
Identified Gaps / Needs

- Partnerships
- Sharing best practices, data, resources, and tools
- Access to care (and other SDOH to include affordable insurance, ability to pay for Rx, etc.)
- Communication / breaking down of Healthcare silos / Coordination of efforts
- Funding
- Using a patient-centered approach
- Sharing of the “reimbursement pie”
- Leverage healthcare team members that can utilize their knowledge & expertise

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
Strategy Summaries

Identified Gaps / Needs
(Continued)

• Lack of education/resources in Southern Illinois, and though the number of individuals diagnosed has tripled in the last 20 years, the healthcare hasn't risen to meet the need.

• Need for mental health professionals/support

• DSME programs in IL to add-on DPP program.

• Strategies that result in collection of data levers to substantiate improvement of the burden of illness and reduction of costs to the state.

• Sustainment of DSME and building potential centers of DSME

• State wide PR campaign

Source: Statewide assessment of Diabetes Strategies (Jan 2017)
How to address Diabetes in Illinois

- Assessment
- ASTHO Project
- Completed Activities
- Priority Areas
- Future Activities
ASTHO Grant Overview

**ASTHO**
- Association of State and Territorial Health Officials

**November 2016**
- ASTHO requested bids to participate in demonstration project to align state diabetes plans

**December 2016**
- Illinois one of two states awarded
Priority Areas for Diabetes State Plan

- Standardization of clinical and community practice linkages and protocols
- Implementation of financial and reimbursement mechanisms
- Leverage existing and new statewide systems around data and health information technology (IT)
Priority: Data and Health IT

- FQHCs
- ICAHN
- Data Collection & Sharing
- EHR Providers
- IHA
Priority: Reimbursement

1. Determine existing reimbursement mechanisms
2. Provide training on mechanics of reimbursement
3. Review successful implementing statewide reimbursement mechanisms
4. Identify strategies and sustainable models that will be effective for Illinoisans
Priority: Clinical/Community Linkages

- Referral and care coordination is a central concern
- Collaboration with others to better understand referral mechanisms and barriers
- Holistic approach to assist MCO enrollees
Activities for ASTHO Project

January – February
- Identify workgroup team leads
- Develop and disseminate strategy packets
- Develop agendas and meeting dates

February – May
- Convene work groups monthly
- Initial framework for Diabetes Action Plan

Late May
- Create and submit final drafts of Diabetes Action Plan
- Attend virtual learning session

June – August
- Attend virtual learning session
- Submit and publish final version of Diabetes State Plan
Illinois Diabetes State Plan
(2018 – 2021)

Provides a guide for the Illinois Diabetes Prevention and Control Program and its partners to strengthen state systems to improve diabetes management and outcomes using a coordinated approach. Specifically, this plan provides a roadmap that Illinois diabetes prevention stakeholders can use to accomplish two goals:

Goal #1
- Reduce the burden of diabetes among Illinoisans

Goal #2
- Identify and implement systems, policies, and practice approaches to improve diabetes management and associated outcomes

<table>
<thead>
<tr>
<th>Priority Area #1</th>
<th>Leverage existing and statewide systems around data and health IT</th>
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</thead>
<tbody>
<tr>
<td>Priority Area #2</td>
<td>Implementation of financial and reimbursement mechanisms</td>
</tr>
<tr>
<td>Priority Area #3</td>
<td>Standardization of clinical and community practice linkages and protocols</td>
</tr>
</tbody>
</table>
THANK YOU

QUESTIONS, PLEASE EMAIL DPH.DIRECTOR@ILLINOIS.GOV

DPH.ILLINOIS.GOV
Lunch & Group Photo

Program will resume at 1:30
Controlling Health Outcomes for Patients Living with Diabetes

Dr. Gary Puckrein, PhD
President and CEO
National Minority Quality Forum
Controlling Health Outcomes: for Patients Living with Diabetes
Presentation Overview

- Beyond Health Disparities
- Building Sustainable Communities
- NMQF’s Role
- The Diabetes Epidemic in the United States
- Diabetes Consumption Patterns
- Diabetes In Zip Code 60620
- Closing Thought
Closing the Gap

For most of the 20th century, the core idea was to close the outcomes gap – to reach equity, where health outcomes for racial and ethnic minorities would be quantitatively and qualitatively equivalent to those for whites.
21\textsuperscript{st} Century Goal

The National Minority Quality Forum recognizes that aspiring to achieve minority health outcomes equivalent to those of whites misunderstands our future.

The aspiration that all populations can share in the 21\textsuperscript{st} century is to take command of our future as it relates to the existential struggle to survive. The 21\textsuperscript{st} century is about building sustainable healthy communities.
BUILDING SUSTAINABLE COMMUNITIES
Defining a Sustainable Healthy Community

The prime objective of a sustainable healthy community is to maintain high-quality, longer lives free of preventable disease, disability, injury, and premature death.

A sustainable community uses its resources to meet current needs while ensuring that adequate resources are available for future generations. It seeks a better quality of life for all its residents while maintaining an ecosystem that supports life by minimizing waste, preventing pollution, promoting efficiency, and developing local resources to revitalize the local economy.
Sustaining a Healthy Community

Decision-making in a sustainable community stems from a rich civic life and shared information among community members.

A sustainable community resembles a living system in which human, natural, and economic elements are interdependent and draw strength from one another.
Sustainability Is Not a Fixed Quantity

A sustainable community is not just one type of neighborhood, town, city, or region.

Activities that the environment can sustain and that citizens want and can afford may be quite different from community to community.

A sustainable community is continually adjusting to meet the social and economic needs of its residents while preserving the environment’s ability to support it.
Equilibrium

The core assumption of sustainable health is that the objective reality can be managed to sustain human life for an indeterminate length of time.

Sustainable healthy communities work to manage conditions affecting human life. Within the equilibrium of these conditions, wellness is sustained and death becomes an anomaly.

In the 21st century, medicine will play a critical role in defining, establishing, and maintaining this equilibrium.
Medicine in the 21st Century

Medicine is on the front line in the struggle against disease, disability, and aging.

Without progress in medicine, community well-being will be confined to its present context, uncontrolled and unsustainable.
Innovative Therapies Are Infrastructure

Investment in innovative therapies is fundamental infrastructure, essential to achieving sustainability.

The investments that we make today will benefit future generations, easing the burden of suffering and arbitrariness that has been our fate.
No Medical Deserts

The ability to distribute effective medical therapies readily across diverse populations will inform the health and well-being of sustainable communities.

We cannot have sustainable healthy communities where medical deserts exist.
Moving Toward Equilibrium

VISION
A society in which all people live long, healthy lives.

MISSION
Healthy People 2020 strives to:
• Identify nationwide health improvement priorities.
• Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
• Provide measurable objectives and goals that are applicable at the national, State, and local levels.
• Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
• Identify critical research, evaluation, and data collection needs.

OVERARCHING GOALS
• Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
• Achieve health equity, eliminate disparities, and improve the health of all groups.
• Create social and physical environments that promote good health for all.
• Promote quality of life, healthy development, and healthy behaviors across all life stages.
The NMQF Contribution
Founded in 1998, NMQF is a non-profit Washington, D.C.-based, health care research and education organization whose mission is to strengthen the ability of communities and policy-makers to eliminate the disproportionate burden of premature death and preventable illness in special populations through the use of evidence-based, data-driven initiatives.

National Minority Quality Forum (NMQF)
The National Minority Quality Forum Data Warehouse

The Forum has developed a comprehensive database comprised of over 2 billion patient records, which it uses to define disease prevalence, costs and outcomes for demographic subpopulations at the zip code level.
Big Data: Challenges and Solutions

**CHALLENGES**

- Volume
- Rapidly changing
- Complex technology platforms
- Different data sets
- Expert analysis required
- Outputs not always actionable, understandable

**A SOLUTION**

MAKE IT VISUAL
NMQF develops maps to provide demographic intelligence about acute and chronic disorders at the zip code level – segmented by age, gender, race/ethnicity – to:

• Map any index disease by prevalence, cost, outcomes, comorbidities, socioeconomic status or other data type for any state, MSA, congressional and state legislative districts

• Define where the unmet needs exist

• Forecast trends using predictive analytics

• Produce customized reports to support educational, advocacy and policy efforts
Key Learnings

- Geography matters
- Predictable forces shape markets
- Consumption patterns can be shaped
- Resource management can be improved
The Diabetes Epidemic in the United States
Diabetes Epidemic 2014
## Hospital Encounters Per 100 People with Diabetes

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>45.5</td>
<td>46.6</td>
<td>44.9</td>
<td>41.6</td>
<td>43.0</td>
</tr>
<tr>
<td>2007</td>
<td>46.6</td>
<td>48.3</td>
<td>46.4</td>
<td>36.8</td>
<td>51.8</td>
</tr>
<tr>
<td>2008</td>
<td>48.9</td>
<td>54.0</td>
<td>47.4</td>
<td>29.3</td>
<td>46.8</td>
</tr>
</tbody>
</table>
Diabetes Consumption Patterns in A Medicare Fee for Service Population 2000-2014
The Diabetes Acute Care Pyramid

- **Crisis Consumers**
  - 5% of Diabetes Population
  - 38% of Cost

- **Heavy Consumers**
  - 19% of Diabetes Population
  - 42% of Cost

- **Moderate Consumers**
  - 21% of Diabetes Population
  - 14% of Cost

- **Light Consumers**
  - 24% of Diabetes Population
  - 5% of Cost

- **Low Consumers**
  - 31% of Diabetes Population
  - 1% of Cost

Costs associated with:
- Cost Driven by Hospitalizations
- Cost Associated with Non Adherence to Clinical Guidelines

African American Consumption Patterns
# Diabetes Consumption Groups

<table>
<thead>
<tr>
<th>Cluster</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2000</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Consumers</td>
<td>120,992</td>
<td>2%</td>
</tr>
<tr>
<td>Heavy Consumers</td>
<td>732,797</td>
<td>15%</td>
</tr>
<tr>
<td>Moderate Consumers</td>
<td>1,039,763</td>
<td>21%</td>
</tr>
<tr>
<td>Light Consumers</td>
<td>1,450,210</td>
<td>29%</td>
</tr>
<tr>
<td>Low Consumers</td>
<td>1,611,638</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,955,400</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2009</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Consumers</td>
<td>164,064</td>
<td>2%</td>
</tr>
<tr>
<td>Heavy Consumers</td>
<td>1,009,131</td>
<td>14%</td>
</tr>
<tr>
<td>Moderate Consumers</td>
<td>1,486,655</td>
<td>20%</td>
</tr>
<tr>
<td>Light Consumers</td>
<td>2,097,069</td>
<td>29%</td>
</tr>
<tr>
<td>Low Consumers</td>
<td>2,529,871</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,286,790</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Consumers</td>
<td>113,344</td>
<td>2%</td>
</tr>
<tr>
<td>Heavy Consumers</td>
<td>753,821</td>
<td>13%</td>
</tr>
<tr>
<td>Moderate Consumers</td>
<td>1,129,554</td>
<td>20%</td>
</tr>
<tr>
<td>Light Consumers</td>
<td>1,616,470</td>
<td>29%</td>
</tr>
<tr>
<td>Low Consumers</td>
<td>1,991,310</td>
<td>36%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,604,499</td>
<td>100%</td>
</tr>
</tbody>
</table>
## Diabetes Consumption Patterns

### 2001 Beneficiaries migrating to: Diagnosis Consumers

<table>
<thead>
<tr>
<th>Migrating from:</th>
<th>Cluster</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Consumers</td>
<td></td>
<td>29,449</td>
<td>24.3</td>
<td>51,815</td>
<td>42.8</td>
<td>23,770</td>
<td>19.6</td>
<td>10,856</td>
<td>9</td>
<td>5,102</td>
<td>4.2</td>
<td>36,903</td>
<td>30.50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy Consumers</td>
<td></td>
<td>53,168</td>
<td>7.3</td>
<td>262,131</td>
<td>35.8</td>
<td>204,039</td>
<td>27.8</td>
<td>135,025</td>
<td>18.4</td>
<td>78,434</td>
<td>10.7</td>
<td>135,567</td>
<td>18.50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Consumers</td>
<td></td>
<td>27,039</td>
<td>2.6</td>
<td>210,688</td>
<td>20.3</td>
<td>342,145</td>
<td>32.9</td>
<td>287,782</td>
<td>27.7</td>
<td>172,109</td>
<td>16.6</td>
<td>100,857</td>
<td>9.70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Light Consumers</td>
<td></td>
<td>18,861</td>
<td>1.3</td>
<td>164,678</td>
<td>11.4</td>
<td>305,791</td>
<td>21.1</td>
<td>576,618</td>
<td>39.8</td>
<td>384,262</td>
<td>26.5</td>
<td>73,961</td>
<td>5.10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Consumers</td>
<td></td>
<td>11,378</td>
<td>0.7</td>
<td>108,513</td>
<td>6.7</td>
<td>183,205</td>
<td>11.4</td>
<td>358,407</td>
<td>22.2</td>
<td>950,135</td>
<td>59</td>
<td>61,242</td>
<td>3.80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>139,895</td>
<td>2.8</td>
<td>797,825</td>
<td>16.1</td>
<td>1,058,950</td>
<td>21.4</td>
<td>1,368,688</td>
<td>27.6</td>
<td>1,590,042</td>
<td>32.1</td>
<td>411,298</td>
<td>8.30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### No. of Deaths

<table>
<thead>
<tr>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>36,903</td>
<td>30.50%</td>
</tr>
<tr>
<td>135,567</td>
<td>18.50%</td>
</tr>
<tr>
<td>100,857</td>
<td>9.70%</td>
</tr>
<tr>
<td>73,961</td>
<td>5.10%</td>
</tr>
<tr>
<td>61,242</td>
<td>3.80%</td>
</tr>
<tr>
<td>411,298</td>
<td>8.30%</td>
</tr>
<tr>
<td>Migrating from:</td>
<td>Cluster</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>2004</td>
<td>Crisis Consumers</td>
</tr>
<tr>
<td></td>
<td>Heavy Consumers</td>
</tr>
<tr>
<td></td>
<td>Moderate Consumers</td>
</tr>
<tr>
<td></td>
<td>Light Consumers</td>
</tr>
<tr>
<td></td>
<td>Low Consumers</td>
</tr>
<tr>
<td></td>
<td>Total</td>
</tr>
</tbody>
</table>

Diabetes Consumption Patterns
## Diabetes Consumption Patterns

### In 2014 Beneficiaries migrating to:

<table>
<thead>
<tr>
<th>Migrating from: Cluster</th>
<th>Crisis Consumers</th>
<th>Heavy Consumers</th>
<th>Moderate Consumers</th>
<th>Light Consumers</th>
<th>Low Consumers</th>
<th>Died</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Consumers</td>
<td>27,423</td>
<td>24.2</td>
<td>49,817</td>
<td>44</td>
<td>22,179</td>
<td>19.6</td>
</tr>
<tr>
<td>Heavy Consumers</td>
<td>51,670</td>
<td>6.9</td>
<td>288,495</td>
<td>38.3</td>
<td>206,074</td>
<td>27.3</td>
</tr>
<tr>
<td>Moderate Consumers</td>
<td>27,051</td>
<td>2.4</td>
<td>226,929</td>
<td>20.1</td>
<td>382,425</td>
<td>33.9</td>
</tr>
<tr>
<td>Light Consumers</td>
<td>16,919</td>
<td>1</td>
<td>169,524</td>
<td>10.5</td>
<td>336,425</td>
<td>20.8</td>
</tr>
<tr>
<td>Low Consumers</td>
<td>11,432</td>
<td>0.6</td>
<td>113,783</td>
<td>5.7</td>
<td>198,827</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>134,495</td>
<td>2.4</td>
<td>848,548</td>
<td>15.1</td>
<td>1,145,930</td>
<td>20.4</td>
</tr>
</tbody>
</table>
**Diabetes Consumption Patterns: Crisis Consumers**

<table>
<thead>
<tr>
<th>Year</th>
<th>Crisis</th>
<th>Heavy</th>
<th>Moderate</th>
<th>Light</th>
<th>Low</th>
<th>Died</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>24</td>
<td>43</td>
<td>20</td>
<td>9</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>2009</td>
<td>27</td>
<td>43</td>
<td>18</td>
<td>7</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>2013</td>
<td>24</td>
<td>44</td>
<td>20</td>
<td>8</td>
<td>4</td>
<td>29</td>
</tr>
</tbody>
</table>
Crisis Consumer Migration Patterns

Source data: Medicare Claims 2012
## Cluster Analysis: Diabetes Medicare Fee for Service 2014

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Zip Codes</th>
<th>Total Number of Beneficiaries</th>
<th>Percent of all</th>
<th>Cumm Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Ethnic mixed (WNH 63%), esp Calif and TX, middle income</td>
<td>3,177</td>
<td>2,786,499</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>13 BNH majority, low income, low private health insurance, south eastern states</td>
<td>1,460</td>
<td>1,256,804</td>
<td>14%</td>
<td>46%</td>
</tr>
<tr>
<td>18 Hispanic majority, esp Texas, high poverty</td>
<td>1,350</td>
<td>1,086,181</td>
<td>12%</td>
<td>59%</td>
</tr>
<tr>
<td>10 middle income WNH</td>
<td>960</td>
<td>629,116</td>
<td>7%</td>
<td>66%</td>
</tr>
<tr>
<td>06 metro sububs, WNH, mortgage home owners, family, above average income</td>
<td>970</td>
<td>621,442</td>
<td>7%</td>
<td>73%</td>
</tr>
<tr>
<td>01 Metro centre and suburbs, 79% WNH</td>
<td>873</td>
<td>527,037</td>
<td>6%</td>
<td>79%</td>
</tr>
<tr>
<td>17 WNH, high poverty, low college, Kentucky, West Virginia, Tenn, Oklah</td>
<td>1,010</td>
<td>472,828</td>
<td>5%</td>
<td>85%</td>
</tr>
<tr>
<td>12 WNH 93%, middle income, midwest</td>
<td>759</td>
<td>410,245</td>
<td>5%</td>
<td>90%</td>
</tr>
<tr>
<td>09 WNH majority (90%), low income, low college (19%), but poverty not high, rust belt</td>
<td>736</td>
<td>297,618</td>
<td>3%</td>
<td>93%</td>
</tr>
<tr>
<td>19 Metropolitan, high turnover, high renting, many one person hhlds, college 59%</td>
<td>528</td>
<td>239,340</td>
<td>3%</td>
<td>96%</td>
</tr>
<tr>
<td>02 Metropolitan centre, high turnover and renting, family, high income and college</td>
<td>221</td>
<td>215,369</td>
<td>2%</td>
<td>98%</td>
</tr>
<tr>
<td>14 WNH and Asian groups, above average income, college 49%, esp Calif</td>
<td>79</td>
<td>54,044</td>
<td>1%</td>
<td>99%</td>
</tr>
<tr>
<td>04 metro sububs, WNH, mortgage home owners, family, very high income and college</td>
<td>137</td>
<td>47,203</td>
<td>1%</td>
<td>99%</td>
</tr>
<tr>
<td>20 middle income commuting areas, WNH 88%</td>
<td>154</td>
<td>32,824</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>05 non metro retirement areas</td>
<td>22</td>
<td>6,948</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>03 Rural areas, low population density, large farming sector</td>
<td>59</td>
<td>5,229</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>08.3 high poverty and unemployment, Hispanic</td>
<td>17</td>
<td>4,559</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>16 Native American majority</td>
<td>10</td>
<td>3,345</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>08.1 high unemployment, Poor, WNH</td>
<td>7</td>
<td>2,767</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>11 Hawaii</td>
<td>14</td>
<td>936</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>07 High turnover, academic</td>
<td>2</td>
<td>61</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

8,699,945
Diabetes In Zip Code 60620
Medicare Fee For Service 2013
### Zip Code 60620: Consumption Patterns

<table>
<thead>
<tr>
<th>Consumption Group</th>
<th># Benes</th>
<th>% Benes</th>
<th>Total All Cause Cost</th>
<th>% All Cause Cost</th>
<th>Unique Inpatient Stays</th>
<th>% Unique Inpatient Stays</th>
<th>Total Inpatient Cost</th>
<th>% Inpatient Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Consumers</td>
<td>196</td>
<td>8%</td>
<td>$27,325,084</td>
<td>41%</td>
<td>847</td>
<td>4</td>
<td>$15,102,092</td>
<td>57%</td>
</tr>
<tr>
<td>Heavy Consumers</td>
<td>599</td>
<td>23%</td>
<td>$26,485,528</td>
<td>40%</td>
<td>944</td>
<td>2</td>
<td>$9,832,244</td>
<td>37%</td>
</tr>
<tr>
<td>Moderate Consumers</td>
<td>743</td>
<td>29%</td>
<td>$9,885,760</td>
<td>15%</td>
<td>249</td>
<td>0.34</td>
<td>$1,570,811</td>
<td>6%</td>
</tr>
<tr>
<td>Light Consumers</td>
<td>425</td>
<td>16%</td>
<td>$1,624,537</td>
<td>2%</td>
<td>17</td>
<td>0.04</td>
<td>$56,476</td>
<td>0%</td>
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<tr>
<td>Low Consumers</td>
<td>633</td>
<td>24%</td>
<td>$581,277</td>
<td>1%</td>
<td>9</td>
<td>0.01</td>
<td>$0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>2,596</td>
<td></td>
<td>$65,902,186</td>
<td></td>
<td>2,066</td>
<td>0.80</td>
<td>$26,561,623</td>
<td>100%</td>
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## Zip Code 60620: Average Per Bene Cost

<table>
<thead>
<tr>
<th>Consumption Group</th>
<th># Benes</th>
<th>Total All Cause Cost</th>
<th>Average Per Patient Cost</th>
<th>Total Inpatient Cost</th>
<th>% Total Cost</th>
<th>Average Per Patient Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Consumers</td>
<td>196</td>
<td>$27,325,084</td>
<td>$139,414</td>
<td>$15,102,092</td>
<td>55%</td>
<td>$77,051</td>
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<td>Heavy Consumers</td>
<td>599</td>
<td>$26,485,528</td>
<td>$44,216</td>
<td>$9,832,244</td>
<td>37%</td>
<td>$16,414</td>
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<tr>
<td>Moderate Consumers</td>
<td>743</td>
<td>$9,885,760</td>
<td>$13,305</td>
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<td>16%</td>
<td>$2,114</td>
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<tr>
<td>Light Consumers</td>
<td>425</td>
<td>$1,624,537</td>
<td>$3,822</td>
<td>$56,476</td>
<td>3%</td>
<td>$133</td>
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<tr>
<td>Low Consumers</td>
<td>633</td>
<td>$581,277</td>
<td>$918</td>
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<td>0%</td>
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<tr>
<td><strong>Total</strong></td>
<td>2,596</td>
<td>$65,902,186</td>
<td><strong>$25,386</strong></td>
<td><strong>$26,561,623</strong></td>
<td><strong>40%</strong></td>
<td><strong>$10,232</strong></td>
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</table>
## Zip Code 60620: Hospital Encounters

<table>
<thead>
<tr>
<th>Consumption Group</th>
<th># Benes</th>
<th>Unique ER Visits</th>
<th>Unique Inpatient Stays</th>
<th>Hospital Encounters</th>
<th>% Hospital Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Consumers</td>
<td>196</td>
<td>628</td>
<td>847</td>
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<td>944</td>
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<td>Moderate Consumers</td>
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<td>201</td>
<td>249</td>
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<tr>
<td>Light Consumers</td>
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<td>17</td>
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<tr>
<td>Low Consumers</td>
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<td>4</td>
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<td><strong>Total</strong></td>
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<td>1,586</td>
<td>2,066</td>
<td>3,652</td>
<td>1.41</td>
</tr>
</tbody>
</table>
### Zip Code 60620: Physician Profile

**Syed A Ather M.D.**  
**Offices At:**  
**10661 S Roberts RD**  
**Suite 103**  
**Palos Hills, Illinois 60465-1954**

<table>
<thead>
<tr>
<th>Consumption Group</th>
<th># Benes</th>
<th>Total All Cause Cost</th>
<th>Unique Inpatient Stays</th>
<th>Total Inpatient Cost</th>
<th>Unique ER Visits</th>
<th>Hospital Encounters</th>
<th>% Hospital Encounters</th>
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</thead>
<tbody>
<tr>
<td>Crisis Consumers</td>
<td>4</td>
<td>$586,864</td>
<td>19</td>
<td>$248,933</td>
<td>17</td>
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<tr>
<td>Heavy Consumers</td>
<td>5</td>
<td>$236,763</td>
<td>7</td>
<td>$63,997</td>
<td>7</td>
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<td>3</td>
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<td><strong>Total</strong></td>
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<td><strong>$320,136</strong></td>
<td>25</td>
<td>53</td>
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CLOSING THOUGHTS
The Diabetes Working Group

If we are to control health outcomes as we move toward building healthy sustainable communities, we will necessarily have to reduce diabetes related hospitalizations and emergency room visits in underserved communities.

The National Minority Quality Forum is reaching out to organizations asking them to come together as a Diabetes Working Group to meet the challenge of diabetes in underserved communities.

AADE could play a large role in that effort.
Break
Program will resume in 10 minutes
State Diabetes Advocacy in 2017

Lisa Murdock
Vice President, State Government Affairs & Advocacy
American Diabetes Association
STATE DIABETES ADVOCACY IN 2017

Lisa Murdock
Vice President, State Government Affairs & Advocacy
TODAY’S DISCUSSION

• Health Insurance
• Discrimination
• Health Disparities
• Prevention
• Program Funding
• State Coordination
• Making a Difference

Everyone’s invited to play!
The Affordable Care Act provided health insurance protections and improved access to adequate and affordable health insurance for people with and at risk for diabetes.

- Maintain or improve existing access to coverage
- Protect patients with chronic conditions
- Prioritize prevention
STATES TAKING THE LEAD

• Preserve coverage
• Repeal coverage
• Expand/improve Medicaid
• Restrict/harm Medicaid
• Repeal mandates
• Interstate sales
• Transparency
• Access to medications
• Benefit design
DISCRIMINATION

• Safe at School
• Driver’s licensing
• Law enforcement
SAFE AT SCHOOL

Main Goals
• Medically safe environment
• Equal access to educational opportunities
• Transition to independence

Principles
• School personnel trained to administer glucagon
• School personnel trained to administer insulin
• Student self-management when appropriate
Driver’s Licensing

- Ensure laws and policies result in fair treatment of people with diabetes

Law Enforcement

- Support efforts to train law enforcement officers about diabetes
Why does health equity matter?

When health equity is achieved, “everyone has the opportunity to attain full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance”

- Health Care
- Prevention
- Food Access
- Funding
ADDRESSING INADEQUACIES IN HEALTH CARE

Not all health care is equal

• Medicaid coverage and parity
• Language and literacy
• Transparency
ADDRESSING DISPARITIES THROUGH PREVENTION

Prevention—Addressing obesity, improving access to healthy foods, and opportunities for physical activity

- Food deserts and healthy food financing
- Breakfast after the bell in low income school districts
- Shared use agreements
- Program and infrastructure funding
PRIMARY PREVENTION OF TYPE 2 DIABETES

Aimed at individuals with prediabetes and in the general population, including efforts to reduce obesity and improve nutrition and physical activity

- Sugar sweetened beverage policy
- PE and PA requirements
- Nutrition standards in school/daycare
- Safe Routes to School
- Program Funding
STATE COORDINATION ON DIABETES

Diabetes Action Plan legislation has been passed in 23 states

- Legislation that shines a light on diabetes and the resources being allocated to diabetes
- Identifies the best practices for addressing the burden of diabetes
- Makes policy recommendations
- Provides a mechanism for policy makers to get critical information
WHY ADVOCACY?

It Works!

60 state level victories and incremental progress in dozens of additional initiatives including:

• 15 health care wins
• 12 discrimination wins
• 27 prevention and health disparity wins
• 4 state coordination on diabetes wins
• 2 research funding/policy wins
ADVOCACY WORKS BECAUSE...

- Personal stories are powerful
- District feedback matters
- Puts a face to an issue
- Extends professional lobbying
GET INVOLVED

Sign up to be an Advocate

iPhone and iPad Users
Search Diabetes Advocacy at the Apple App Store

Android Users
Search Diabetes Advocacy at the Google play store
BE A VOICE FOR YOUR PATIENTS
CONNECT WITH ADA LOCALLY

American Diabetes Association

[Map of the United States with states color-coded for different regions]
ADA’S STATE GOVERNMENT AFFAIRS TEAM

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(800) 676-4065 x7415  
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Lisa Murdock
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lmurdock@diabetes.org
Step Therapy Legislation In The States – A Collaborative Effort

Patrick Stone
Director, State Government Relations
National Psoriasis Foundation
Step Therapy Legislation In The States – A Collaborative Effort

Presented by:
Patrick Stone, Director of State Government Relations
National Psoriasis Foundation
Agenda

• NPF - Creation of the State Advocacy team
• Elevating the patient/advocate voice
• Coalitions
• Start of a campaign
• What is Step Therapy?
• Victories, losses and lessons learned
• Questions
• Celebrating 50 years – Beverly Foster
• Driven by a strategic plan
• Decades of advocacy
• Pivot to the states - 2014
Creation of a State Advocacy Team

• Establishing a presence
• Engaging current assets
• Creating new assets
• Thought leadership
• Direct leadership
Elevating the Patient Voice

- The old guard, “Champion” volunteers
- Education, repeat, repeat, repeat
- Creating a rewarding experience
- What is important to the advocate?
- Deliver outcomes – Not always a legislative victory
Elevating the Patient Voice

- Creation of the Action Networks
- Structure and goals
- No more fire-drills
- Monthly calls
- Webinars
- Coordination of activities
- Lobby days, individual outreach
Midwest Advocacy Action Network

13 States
MaryAnn McCabe
Deborah Barnard
Southern Advocacy Action Network

14 States
Amy Prentice
Noreen Kennedy
New ATL CDM
Northeast Advocacy Action Network

- 11 States
- Patrick Stone
- Kim Schleyer
Elevating the Patient Voice
Elevating the Patient Voice
Lobby Days
Press
NPF State Government Relations Team

For more information, please contact:

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Director, State Government Relations
pstone@psoriasis.org

Amy Prentice
State Government Relations Manager
aprentice@psoriasis.org

MaryAnn McCabe
State Government Relations Manager
mmccabe@psoriasis.org

Biosimilar Target

Step Therapy Target

Out-of-Pocket Target

Patrick ST / Amy OOP
Working in Coalition

• Focused involvement in coalitions
• No longer a singular disease effort
• Strength in unity not numbers
• SAIM, Biologics coalition, CAT
• Leadership where appropriate
Coalition members
State Access to Innovative Medicines (SAIM)

American Cancer Society
Cancer Action Network, Inc.

Crohn's & Colitis Foundation of America

Hemophilia Federation of America

The Leukemia & Lymphoma Society

Lupus Foundation of America

National Hemophilia Foundation

National Organization for Rare Disorders

Pfizer

US Pain Foundation

Astellas

Celgene

Alliance for Patient Access

American Academy of Dermatology Association

Coalition of State Rheumatology Organizations

Leavitt Partners
Working in Coalition

- Coalition was formed in 2014
- Focuses on two core issues
- Out of pocket costs and Step Therapy
- Model Legislation – Key to success
- Leadership structure and working groups
- NPF focus on Step Therapy
What is Step Therapy?
www.StepTherapyInfo.co
What is Step Therapy?
https://www.youtube.com/watch?v=zg6mjEnUMv0
https://www.youtube.com/watch?v=zg6mjEnUMv0
Step Therapy Explained

- Step therapy is a cost containment tool used by health insurance plans that requires patients to try and fail on less costly medications before receiving the treatment prescribed for them by their doctor.

- Insurers may insert several cheaper drugs and wait for them all to fail before agreeing to cover the drug originally prescribed by the doctor.

- There is little oversight of step therapy and insurers do not have to prove effectiveness of the step therapy policies or take into account the side effects of their substitute drugs.

- To lessen the burden on patients, the SAIM coalition is collaborating with patient, doctor and advocacy groups to pass legislation in several states that would give a patient’s health care provider the ability to override insurer’s step therapy protocols requiring insurers to cover the right drugs for patients.
“Step therapy allows payers to practice medicine without a medical license. When I tell you that I cannot walk because of my pain, you do not have the right to tell me that you understand my disease more than my doctor and I. You do not have the right to say that you are protecting me, by choosing alternative medications for me.”

~ Melissa, NPF Advocate and Psoriasis Patient
Starting a campaign

• Precedent in Connecticut, Louisiana...
• Defining capabilities
• Building on existing relationships
• Focused target states
• Define the problem...
Define the Problem

• Appeal process is too long
• Rejections are often made based on preferred drug status
• Peer review are conducted by doctors outside the applicable field
• Protocol for setting step therapy guidelines is inconsistent
• Guidelines are not based on the most current data
• Appeals process is inconsistent and doctors lack leverage
What does the bill do?

- Clinical Review
- Transparency
- Timelines
- Defining an override
Clinical Review

Step therapy protocols should be grounded in clinical evidence/peer-reviewed publications, nothing new for the state/insurers

• Step Therapy protocols:
  • Should be developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups
  • Are based on high quality studies, research, and medical practice.
  • Created by an explicit and transparent process
  • Are continually updated through a review of new evidence, research and newly developed treatments
  • Utilization review agent shall take into account needs of atypical patient populations and diagnoses
Transparency

When coverage for a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan or utilization review organization through a step therapy protocol, the patient and prescribing practitioner shall have access to a clear readily accessible and convenient process to request a step therapy exception determination.

Step therapy process should be easily accessible on insurer, health plan or utilization review organization’s web site.
72/24 Hour Timelines

Response time for step therapy exception requests and appeals

• The insurer, health plan or utilization review organization shall respond to step therapy override exception request or an appeal within 72 hours of receipt and 24 hours for exigent circumstances.

• Should a response not be received within the 72/24 hour timeframe, the exception or appeal shall be deemed granted.
A step therapy override shall be granted if:

- Required drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient
- Required drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen
- Patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event
- The required prescription drug is not in the best interest of the patient, based on medical necessity
- The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.
Lessons Learned

*Kansas passed protections for Medicaid - bill for the commercial space is pending in 2017*
Lessons from the campaign
Opponents and Barriers

- AHIP and local chapters
- Pharmacy Benefit Managers
- Departments of Insurance
- Entrenched leadership
- Drug Pricing Optics
- Cost to the state
- “we are already doing this”
- Can’t handle the timeframe
- Uncertainty in D.C.
- Premium impact
- State Health Plans
Breaking the mold -- Negotiating

• Prior stance was to hold the line
• Coalition forced local groups to engage and dust off old grudges and relationships
• Being prepared with data
• We will go neutral, “I promise”
• “Sign the bill back”
• Bringing forth advocates that can negotiate
• Thank the opponents
New York

- Bill signed by Governor Cuomo on NYE 2016
- Six year campaign
- Coalition was large but in disarray
- Focused leadership
- The right contract counsel
Illinois

- Two year campaign
- First year coalition killed the bill
- Groundwork laid for second year
- Lobbyist worked issue in the interim
- Bill sponsor didn’t give up
Oregon

- Ineffective lobbying
- Optics of coalition
- Drug Pricing
- Patient Testimony
- Bill sponsor absent
- Angry committee leadership
Maine

- A continuing effort
- Bill has been vetoed twice
- A change in the committee layout
- Powerful patient testimony
- SME follow-up
Follow up after signing

• Effort does not stop after a victory
• Education continues
• Webinars with experts that are not focused on one disease
• Materials

An eye on the Regulatory
Questions?

Patrick Stone
pstone@psoriasis.org
Break
Programs are Closing at an Alarming Rate
Time to Think Differently and Advocate…. 

Leslie Kolb  
AADE Vice President of Science and Practice

Jodi Lavin-Tomkins  
AADE Director of Accreditation
Presenters

Leslie E. Kolb RN, BSN, MBA
Vice President of Science & Practice
American Association of Diabetes Educators

Jodi Lavin-Tompkins, MSN, RN, CDE, BC-ADM
Director of Accreditation
American Association of Diabetes Educators
Objectives

• Define reasons for closures
• Evaluate the strength of your program beyond reimbursement
• Understanding New Models of Care
• How to create added value for your organization
Activity

• Pair up with 2 people near you for 5 minutes and come up with a description of what kind of entity a diabetes education program is in 10 words or less

Is it a Program? A Business? A Service? Other Entity?
What Kind? (use descriptors)
DEAP

DIABETES EDUCATION ACCREDITATION PROGRAM

DIABETES EDUCATION AS A PATIENT-CENTERED BUSINESS
Why are programs closing?

• Reimbursement
  – Billing
  – Medicare Confusion
  – Lack of referrals
  – Insurer criteria's

• Lack of Administration Support

• Staff turnover

• Return of Investment (ROI) is low compared to…..
From the business point of view, here are 4 C’s You Need to Consider

- Customers
- Competition
- Collaboration
- Community
Who are your customers and what drives them?

• Payers-Triple Aim (Health/Experience/Cost), Quality, Sales
• Providers-HEDIS, Pay for Performance
• Hospitals-lower readmission rates
• Patients-help with costs, knowing how to self-manage
• Employees-meeting requirements for wellness incentives
• Outpatient entity-timely access, avoidance of denied claims
Models and Providers are Expanding

• Accountable Care Organizations
• Patient Center Medical Care
• Shared Appointments
• Traditional Fee for Service
• Consultative Model
• Valued Based Care
• Merit Based Incentive Programs (MIPS)
• Federally Qualified Health Clinics
• Community Centers
• Area Agency on Aging
Use Data to Support Work

• Different kinds of data are useful in promoting sustainability for self-management services among administrators, insurers and others:
  – Clinical outcomes
  – Patient expectations / demand for services
  – Self-management behavior changes
  – Quality improvement process data
  – Patient and providers satisfaction

Know who you are talking to and what makes them listen!
The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care.
HEDIS Quality Measures

• Comprehensive Diabetes Care:
  – Eye Exam
  – Medical Attention for Nephropathy
  – LDL-C Control <100 mg/Dl
  – Hemoglobin A1c (HbA1c) Control (<8.0%)
  – Blood Pressure Control (<140/90 mm Hg)

• Diabetes Foot exam
Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and prescription drug (Part D) plans perform. Medicare scores how well plans did in several categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score.

Higher Scores:
• Higher Payments
• Longer enrollment Periods
• Advertisement of 5 Star Ratings

Low ratings could result in a freeze on enrollment into a plan.
Star Ratings

Medication Adherence

Managing Chronic (Long Term) Conditions

Eye Exam to Check for Damage from Diabetes

Kidney Function Testing for Members with Diabetes

Plan Members with Diabetes whose Blood Sugar is Under Control
Who’s your competition?

• Where are similar services being offered and by whom? What do those look like?
• Is there anything they don’t like about the current offerings?
• Are there gaps in services you could fill?
• What makes your services unique in comparison?
• What are the community standards? (e.g. number of patients seen in a day, hours allowed for charting and calls, educator-to-patient staffing ratio)
• Are there other services you should add that would help you stand out?
Who do you need to **collaborate** with in advocating for your program?

- Referring providers
- Internal customers
- Payers
- Employers
- Community organizations
- Specialists
Providers

AADE has tools to share with providers to increase the awareness of diabetes self-management education and increase referrals.
How can you help the provider?

– Save them time
– Increase patient satisfaction
– Help them meet their measures
– Figure out individualized way to advance treatment or simplify regimen
– Help determine what patient is willing and financially able to do
– Assist with follow up in between visits
Providers as Referral and Marketing Sources

Referral Sources
- Primary Care providers
- Endocrinologists – If treating Provider
- PA’s
- NP’s

Marketing Sources
- OB
- Cardiac Rehab
- Dental
- Ophthalmologist
Data summarizing what your community population looks like-helps determine needs and accommodations (like a business plan would have)

- Language
- Age
- Distance to your center
- Educational level/literacy
- Ethnicity
- Income level
Promotional Advice

- Present at professional meetings
- Attend appropriate social functions – fundraisers
- Provide healthy treats in the physicians’ lounge—introduce yourself, provide business cards and brochures
- Give seminars and lectures
- Teach a class at a providers office
- Give a group presentation at a hospital meeting
- Use direct mail, local resources, cable, or anything else that might be appropriate in your area
What have your peers done?

- Aligned services with other initiatives in their organization such as patient center medical homes and P4P
- Expanded services to include inpatient consult
- Educated specialists and hospitalists
- Offered to host an awareness talk at churches, library’s and community centers
- Wrote small articles for local papers
- Offered to speak on a local radio station
- Developed an effective elevator speech
Reimbursement

• Who are the insurers in your area?
• Are you contracted with them? How?
• Did Medicare get your certificate?
• Is your certificate connected to your NPI (provider)?
• Did you know we have a reimbursement expert?
• Did you reach out to AADE?
• Did Medicare say something crazy?
• Do you talk to your billing department and do they know what a G-Code is?
Billers

- Are you talking to them? Bringing them presents?
- Can you and are you billing MNT & DSMT?
- Is coding correct?
- Are Copays and Deductibles being collected?
- Is action being taken on rejected or denied claims?
Other Revenue-generating services

• Diagnostic and Personal Continuous Glucose Monitoring
  – 95250 sensor placement, 95251 interpretation of results

• KDE coding for chronic kidney disease N18.4, stage IV severe
  – G0420, G0421

• New Complex Chronic Care Management (CCM) codes
  – 99487 ($93) and 99489 ($47)

New CPT codes for Initiation of CCM: G0506
Diabetes Prevention Program

• Public Payers
  – Medicaid
  – Medicare

• States are working toward receiving Medicaid.

• CPT Code: 0403T (tracking code for DPP)

• Medicare coverage on its way (DSMES Programs are doing really well with outcomes – SPEAK UP!)
Messaging around importance of referring newly diagnosed

- Providers/patients may not know about the use it or lose it 10 hours that Medicare covers
- Legacy effect—good control early in the course has lasting effects down the road
- Is a time of high patient motivation
- Can introduce patient to progressive nature of diabetes and the need to intensify treatment over time, how to delay progression with lifestyle changes
Learn to Advocate for you and the people with Diabetes!

**DSME Utilization within First Year of Diabetes Diagnosis**

- Privately Insured Beneficiaries: <7%
- Medicare Beneficiaries: ~5%


American Association of Diabetes Educators (AADE)
Advocate for Diabetes Education

• System/Organization level advocacy
  – Ensure:
    • Valuable and meaningful metrics are established including both cost and quality
    • Documentation supports an exceptional diabetes education program to obtain new or continuing accreditation/recognition
    • Key leadership and decision makers support the diabetes education program
    • Engage physician champions to advocate for diabetes education

• Be a cultural change agent within your organization!
We know it works
Systematic Review

Findings:

• Observations from the 126 randomized clinical trials (RCT) examining improvement in HbA1c is for those participating in DSME compared to the control group.

1. ~70% of the studies demonstrate statistically significant improvement in HbA1c was greater in the DSME group.
   a. ADA Standards of Diabetes Care 2014 refers to the evidence of benefit from DSME as ‘E’ (expert opinion). Data from RCTs is evidence level ‘A’

2. Examining methods for delivery of DSME – individual combined with group resulted in the largest proportion of significant improvement.

3. 73% of the interventions where DSME was provided by a team was more effective than control
   a. When provided by a sole, non-MD healthcare professional (i.e. a diabetes educator) this was only 46%

4. 69% of the interventions where the maximum contact time of DSME was >10 hours were more effective than control
   a. When contact time was ≤ 10 hours, only 42% of the DSME was more effective than controls.
We know it works........

Multiple studies and papers have demonstrated benefits and cost savings

- Reduction in
  - A1C
  - Hospital and E.R. Visits
  - Healthcare Costs


Chevon M. Rariy, MD1,2, Janice Koshinsky, RN, MS, CDE1, Tammie Payne, RN, MSN, CDE1, Robert Powell, PhD, CDE3, Jodi Krall, PhD4, Linda Siminerio RN, PhD, CDE2,4UPMC, 2University of Pittsburgh Department of Medicine, 3Marshall University, 4University of Pittsburgh Diabetes Institute

Tucker, Mirian E., Internal Medicine News, Sept 15, 2010 v43 115 p36
We know it works………..

• 1% reduction in A1C levels has been found to be associated with risk reductions

  – 21% decrease in diabetes-related deaths
  – 14% decrease in heart attacks
  – 37% decrease in microvascular complications
  – Eyes ~ Kidney ~ Nerves

Administration Support

Stop Checking the Box……..

- Standard 1 requirement – Letter of Support
- Standard 2 – Advisory Committee
- Standard 9-10 – What data are you collecting?
- Close program or move program?
- Staffing cost
- Return of Investment (ROI) is low compared to…..
Staff Turnover

• THE BINDER
• Call AADE
• When we find out:
  – Annual Status Report
  – Renewal
  – Audit time
Thank You!
Honorable James B. Durkin
House Republican Leader
*Illinois General Assembly*
Networking Reception
Please proceed to the Lindbergh Room
Thanks to our Sponsors!
Effective Advocacy in a Shifting Healthcare Environment

Hon. Julie Hamos
Principal, Health Management Associates
Retired Director, Illinois Department of Healthcare and Family Services
Retired Illinois State Representative, 18th District
Effective Advocacy in a Shifting Healthcare Environment

AADE Public Policy Forum
May 6, 2017
My Background

- Lawyer by training
- Learned about policy, lobbying, advocacy on Capitol Hill
- Set up first public interest lobbying office for low-income legal aid clients in the 1970s
- Elected State Representative for 11 years
- Director of state healthcare agency
- Have been an advocate forever....
What I’ve Learned

- State government touches people’s lives
- Relationships are key
- Legislators care about getting re-elected, i.e. their constituents
- Advocacy skills are common-sense, not rocket science
- My personal “cockroach theory”
- The art of “creative” coalitions
- You really can impact state policy!
Today’s goals

- Why the Affordable Care Act is needed
- What the future may look like
- Where you fit in
- Do’s and don’ts of public policy advocacy
The Current System is Not Sustainable...

US spends two-and-a-half times the OECD average

Total health expenditure per capita, public and private, 2010 (or nearest year)

USD PPP

1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.
Information on data for Israel: http://dx.doi.org/10.1787/888932315602

Source: OECD Health Data 2012.
...And Not Producing Great Results

OVERALL HEALTHCARE RANKING
Including quality of care, access, efficiency and equity and other indicators like infant mortality rates

UK
SWITZERLAND
SWEDEN
AUSTRALIA
GERMANY
HOLLAND
N.Z.
NORWAY
FRANCE
CANADA
U.S.A.
Refresher: Why Was ACA Needed?

- 50 million without health insurance
- Wasteful and expensive health system
- Fragmented health system difficult to navigate
- People without health insurance have worse health outcomes
- Emergency care costs more
- Older adult population growth
- Only industrialized country without universal system
Key ACA Successes

- Consumer benefits
  - No lifetime maximums
  - Pre-existing condition coverage
  - Closing the donut hole
  - Children up to 26 on parents’ insurance
  - Free preventive services
- Marketplace, with tax subsidies based on income
- Medicaid expansion
- Innovations in service delivery
- Payments to providers for quality and outcomes
What the Future May Look Like

- As of now, do not know what “Repeal and Replace” legislation will look like
  - May eliminate mandates – individual and employer
  - May eliminate Marketplaces
  - May reduce tax subsidies to purchase health insurance

- There will likely be changes in Medicaid
  - Medicaid expansion population
  - Medicaid block grant
More Predictions

- New “Repeal and Replace” law could result in millions more uninsured
- But Medicaid and Medicare will continue to grow
- Managed care health plans are here to stay
  - Medicaid: only 3 states have no comprehensive managed care today
  - Medicare fee-for-service system is likely to change in the future
  - Important for providers and community partners to develop relationships with managed care plans
Where You Fit In

- Health systems, health plans and policy-makers now understand that diabetes is serious, costly and potentially deadly
- But they don’t necessarily get the “upstream” approaches: diabetes self-management and pre-diabetes prevention
- There continue to be disparities in coverage by Medicare, Medicaid, commercial plans
- Your advocacy is needed!
Do’s and Don’ts of Effective Advocacy

- Do develop a game plan: evidence of the problem, the “ask”, and your strategy
- Don’t underestimate the power of anecdotes and human interest stories
- Do master the art of the one-page fact sheet
- Do memorize a short “elevator speech” (attention span is a problem)
- Do cultivate a legislative champion(s)
More Do’s and Don’ts

- Do mobilize your coalition and grassroots supporters (your “cockroaches”)
- Don’t waste a lot of time and money on mass emails and online petitions – personal contacts of constituents are key
- Do use the media to focus public debate and generate interest
- Do get ready to compromise
More Do’s and Don’ts

- Do state the other side’s position fairly and completely – don’t lie!
- Don’t make political predictions or threats
- Don’t worry if you don’t have all the answers on the spot, but follow through
- Do have fun doing this – you will feel powerful and effective when you change policy
My Contact Info

Julie Hamos
Health Management Associates

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312-641-5007
Panel Discussion: Lobbying Best Practices
Hon. Julie Hamos, Ray Harris, Kathryn Lavriha, Hon. Stacey Reece, and Hon. Mike Tryon
Hon. Julie Hamos

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Hon. Mike Tryon

• Let legislators know how prevalent diabetes is in their district
• Tell legislators personal stories
• Tell them that diabetes educators have the tools to help
• Ask them to support any legislation that helps fight diabetes
Hon. Stacey Reece

Do

• Spend time getting know your elected official prior to lobbying them
  – Attend their town hall meetings and other events. It can be a BBQ – it doesn’t have to be a high dollar fundraiser. Bottom line – Spend time with them before you need them!

• Do your research and provide it in bullet format.
  – Create bulleted notes for the brief meeting with the elected official. Don’t expect them to remember what you share with them.
  – Ask if you can follow up with an aid to provide more detailed information. Leave a position paper with them.

• Understand they see a bigger picture. You are a “small”, but extremely integral part.
  – Sell your passion! Passion will be seen over your Lobby – Passion wins over Lobby!
  – Let them know you are available to assist in way.

Don’t

• Don’t expect them to comprehend your passion.
  – Elected officials are inundated with great causes. You have to sell them on yours!
  – DO NOT act frustrated, they will sense this and will be turned off. Don’t tell them you disagree with their party, that you voted against them, or that you will vote for their opponent in the next election.

• Don’t bring your deceased spouse’s lung in Mason jar and shove it in their face!
  – Things you feel are passionate and helpful may be perceived as over the top!
  – Think through the things in life that alienate you and don’t cast upon your elected official!
Ray Harris

• When attending scheduled meetings with elected officials
  – Be prompt and courteous
  – Prepare a one page fact sheet and highlight your position

• When lobbying an Elected Official in a Group
  – Designate one person to lead the discussion
  – Do not threaten or argue with Elected Official
  – Make your point, but keep it brief
  – Do not lecture

• Remain engaged during course of meeting
  – No food or drink
  – Cell phones on silent
Kathryn Lavriha

• Best Lobbying Practices
  – Come prepared with three or four concise talking points.
  – Close the deal – do you support or oppose the bill we are discussing?
  – Pick the key people decision makers to lobby, no need to see everyone in legislature.

• Bad Lobbying Practices
  – Talking too much in generalities. Be specific on issue and ask.
  – Letting legislator get away with not committing on issue.
  – See the wrong legislator to get bill moved. For example, if a house majority is Republican and you meet with only Democrats. A bill won’t move without Republican leadership.
Break
Program will resume in 10 minutes
Making the Case for Diabetes Education

Kurt Anderson, Ray Harris, Kathryn Lavriha, Hon. Stacey Reece, and Hon. Mike Tryon
Lobbying Role Play
Making the Case for Diabetes Education: How to Put Your Best Foot Forward

• Rules:
  – You have 2:00 minutes to lobby the legislator about the Step-Therapy legislation.
  – The legislator’s name is Mr. Smith from the 1st District (your district).
  – Use your name.
  – You are representing the American Association of Diabetes Educators.
Remember the basics!
It’s like any other conversation.
Remember the basics! It’s like any other conversation.

• Who
  ❖ you are.
  ❖ you represent.

• What
  ❖ the bill number is.
  ❖ The bill does.

• How
  ❖ the bill does it.
Remember the basics!
It’s like any other conversation.

• Why
  ❖ the bill is necessary.
  ❖ give facts and
  ❖ examples – if you have any.

• What
  ❖ you want the legislator to do.
Goal of Conversation: Sponsorship of legislation
Next Steps
Kurt Anderson
How to be an Effective Advocate

Know your audience
- Learn about the legislator’s background and how it may relate to your issue. Understand their district and who they represent.

Identify the issues
- Focus on key issues and craft a clear message. You will need a clearly defined “ask.” Use AADE statements to create a "leave behind" fact sheet for the legislator.

Follow up
- Send a “thank you” note after your meeting. Touch on key points you discussed. Keep in touch with the legislator to maintain this new relationship.

Build a relationship
- Tell the legislator about your background and practice. Offer to be a resource to them on healthcare and diabetes issues. Leave a business card or other contact.

Stick to the point
- Stay on the message by clearly stating your position. Use facts and personal stories to support your case. Remember that you are the expert.
Adjournment