AADE
American Association of Diabetes Educators
ADVOCACY

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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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


PLAN YOUR CAMPAIGN
1
CREATE AWARENESS
2
?!
3 GENERATE ENGAGEMENT
ENCOURAGE 4 ACTION
5 SUSTAIN THE MOMENTUM

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

American Association of Diabetes Educators


American Heart Association
Learn and Live
American Diabetes Association
Cure • Care • Commitment
National Alopecia Areata Foundation
American Kidney Fund
FIRST
Foundation for Ichthyosis & Related Skin Types
Educate • Inspire • Connect
COPD FOUNDATION
Alpha-1 Foundation
THE MICHAEL J. FOX FOUNDATION FOR PARKINSON'S RESEARCH
American Autoimmune Related Diseases Association, Inc.
Huntington's Disease Society of America
PKD FOUNDATION
Polycystic Kidney Disease
National Eczema Association
National Psoriasis Foundation
COLON CANCER ALLIANCE
AMERICAN LIVER FOUNDATION
Your Liver. Your Life.
amputee coalition
alzheimer's association
LEUKEMIA & LYMPHOMA SOCIETY
fighting blood cancers
THE MARFAN FOUNDATION
Know the signs. Fight for victory.
resolve
THE NATIONAL INFERTILITY ASSOCIATION
National Foundation for Ectodermal Dysplasias
march of dimes
PUTTING PATIENTS FIRST
NATIONAL HEALTH COUNCIL
Immune Deficiency Foundation
Arthritis Foundation
Champion of Yes
MGFA Myasthenia Gravis Foundation of America, Inc.
American Cancer Society
aafa Asthma and Allergy Foundation of America
National Kidney Foundation
BEYOND CELIAC
awareness • advocacy • action
Women Heart
The National Coalition for Women with Heart Disease
Sjögren's Syndrome Foundation
Affected by Prostate Cancer?
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Barth Syndrome Foundation
MS National Multiple Sclerosis Society
NATIONAL OSTEOPOROSIS FOUNDATION
OSTEOGENESIS IMPERFECTA FOUNDATION
Unbreakable Spirit
ALS ASSOCIATION
The LAM Foundation
A BREATH OF HOPE
Prevent Blindness
Our Vision Is Vision
Spina Bifida Association of America
Hydrocephalus Association
American Foundation for Suicide Prevention
NATIONAL HEMOPHILIA FOUNDATION
for all bleeding and clotting disorders
prevent cancer FOUNDATION
Mended Hearts
nfed
Supporting you. Supporting each other.
NATIONAL FOUNDATION FOR ECTODERMAL DYSPLASIAS
LUNG CANCER ALLIANCE
National Blood Clot Alliance
Stop The Clot
THE MYOSITIS ASSOCIATION
Parent Project Muscular Dystrophy
LEADING THE FIGHT TO END DUCHENNE
NORD
National Organization for Rare Disorders
NATIONAL PSORIASIS FOUNDATION
National Alopecia Areata Foundation

New Balance of Power

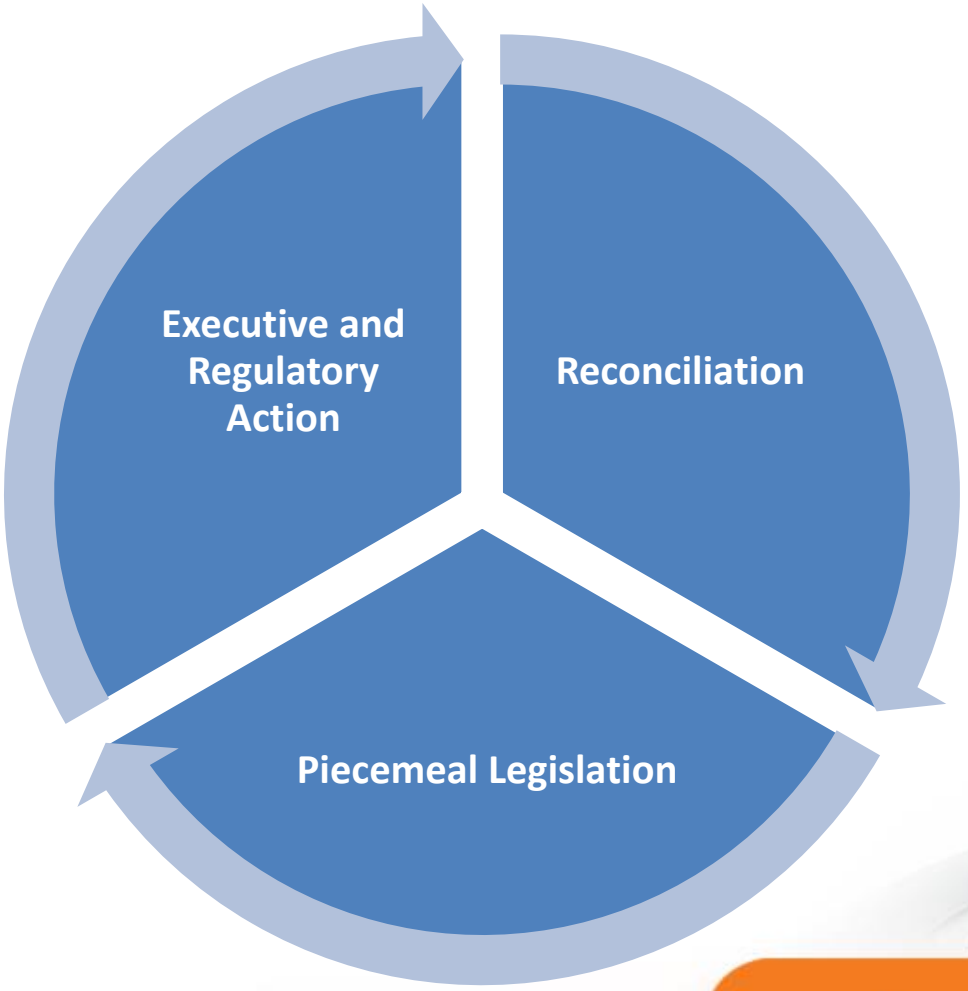
Cap Federal Healthcare Spending and Cost Growth

Lower, more predictable Medicaid and premium support funding

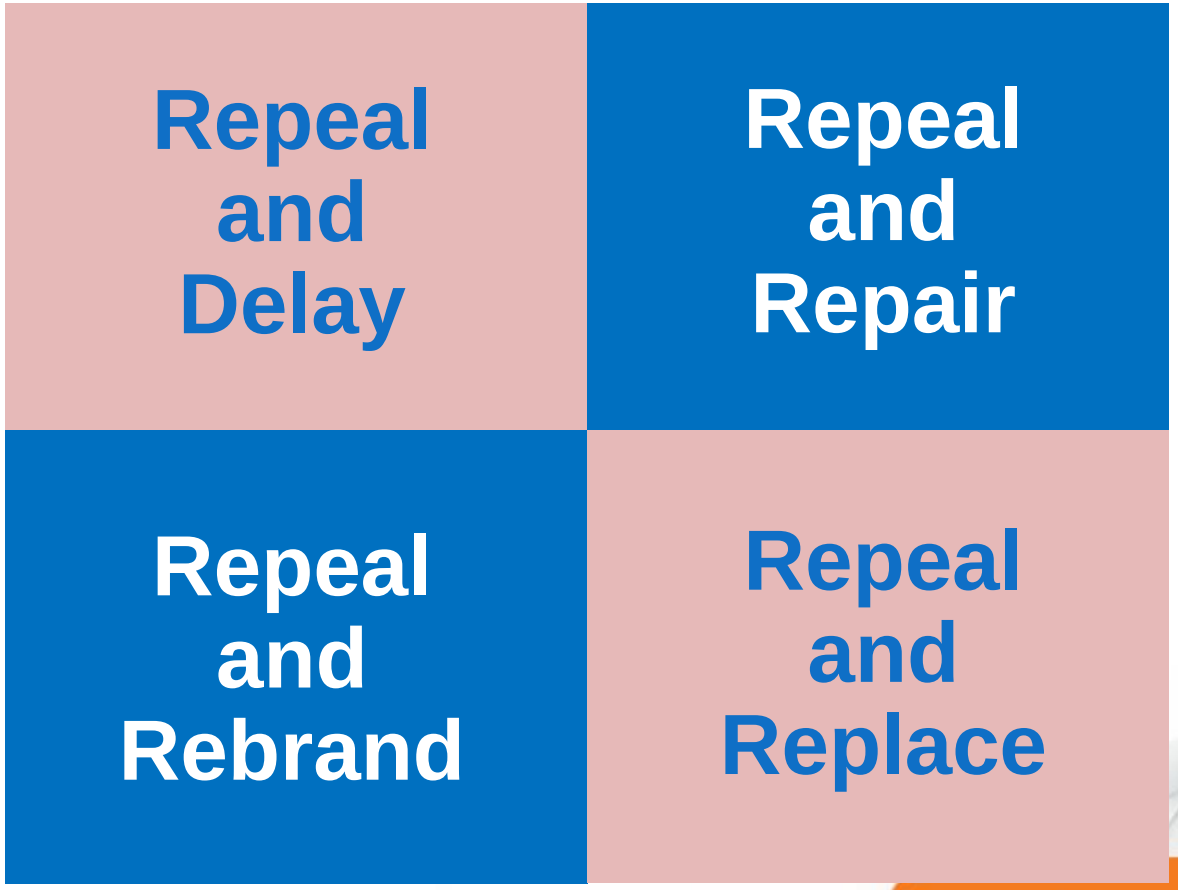
Offer More Flexibility to Private Sector and States

Flexibility to states and more relaxed regulation for health plans

Three-Pronged Approach



Potential Scenarios Quickly Emerged/Submerged



While Many Prominent ACA Provisions May Be Repealed, Some Policies Are Likely to Remain

Likely to be Repealed	Currently Being Debated	Likely to Remain Intact
Taxes	Medicaid expansion	Most drug-related provisions
Individual and employer mandates	Essential Health Benefits	Some payment & delivery reform
Subsidies	Community rating	CMMI

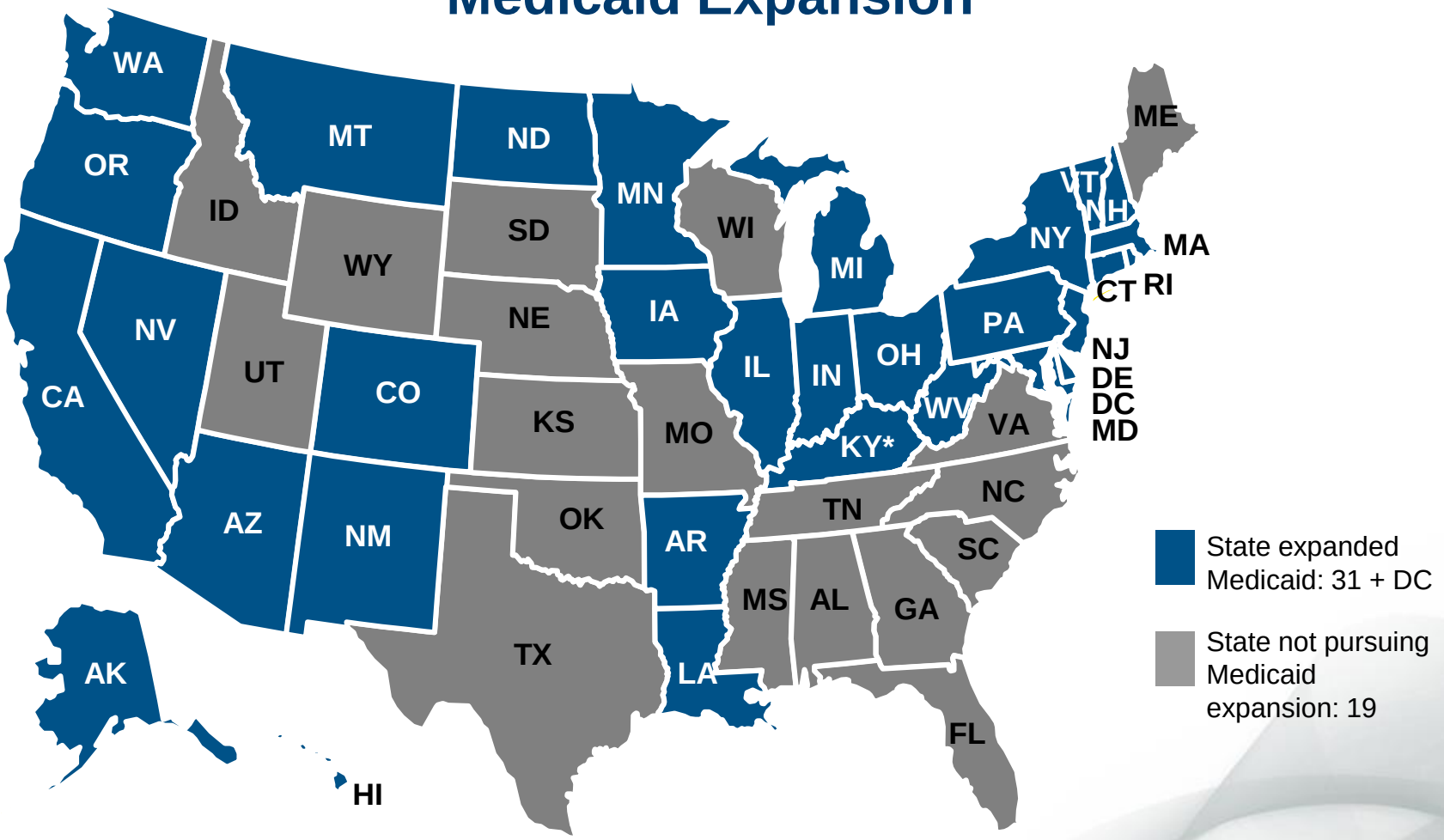
Key Provisions of American Health Care Act

- Mandates
- Medicaid
- Subsidies
- Premium Rating for Age and Health Status
- Essential Health Benefits
- Taxes

Domains	Values
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

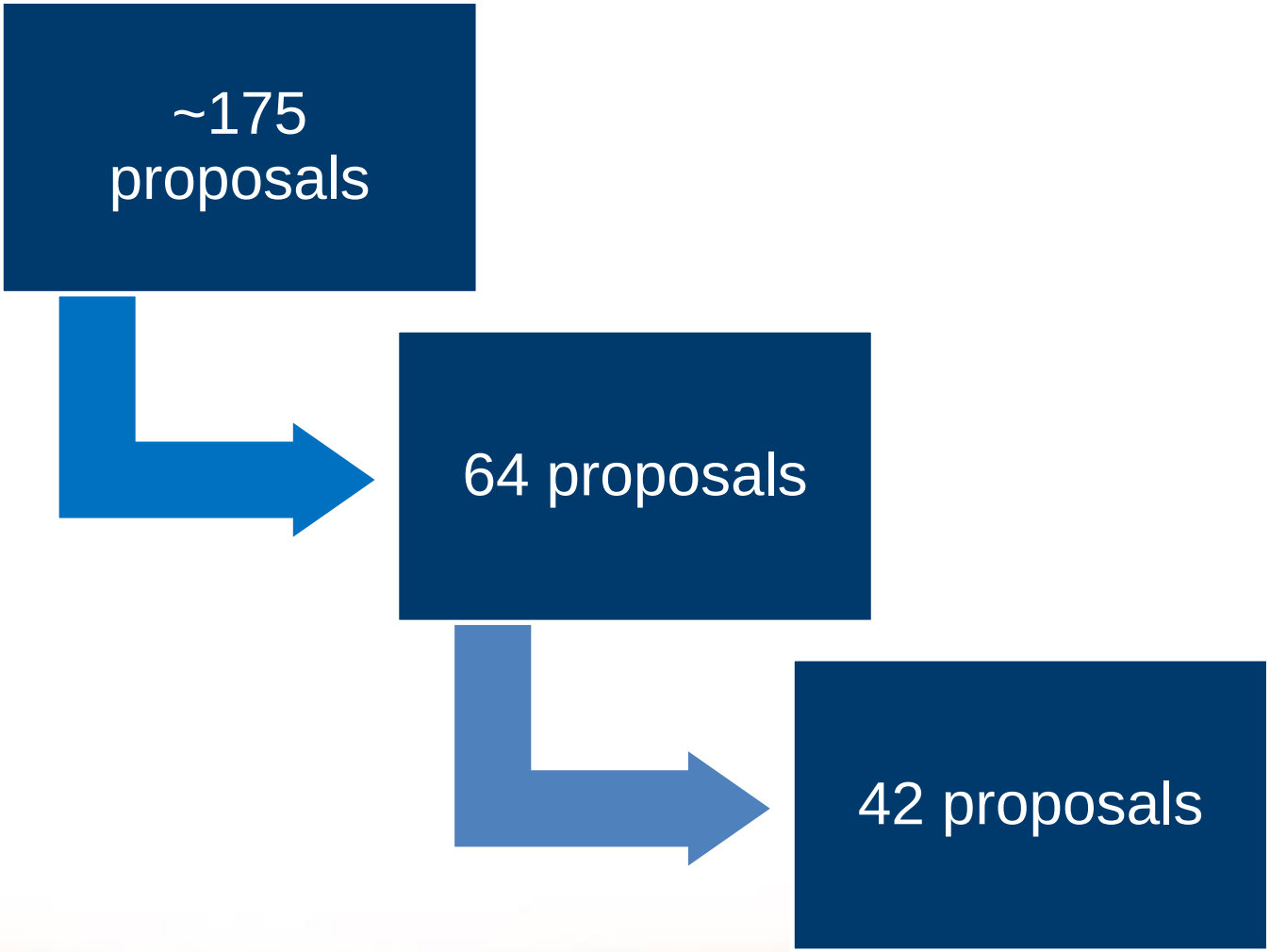
Medicaid Expansion



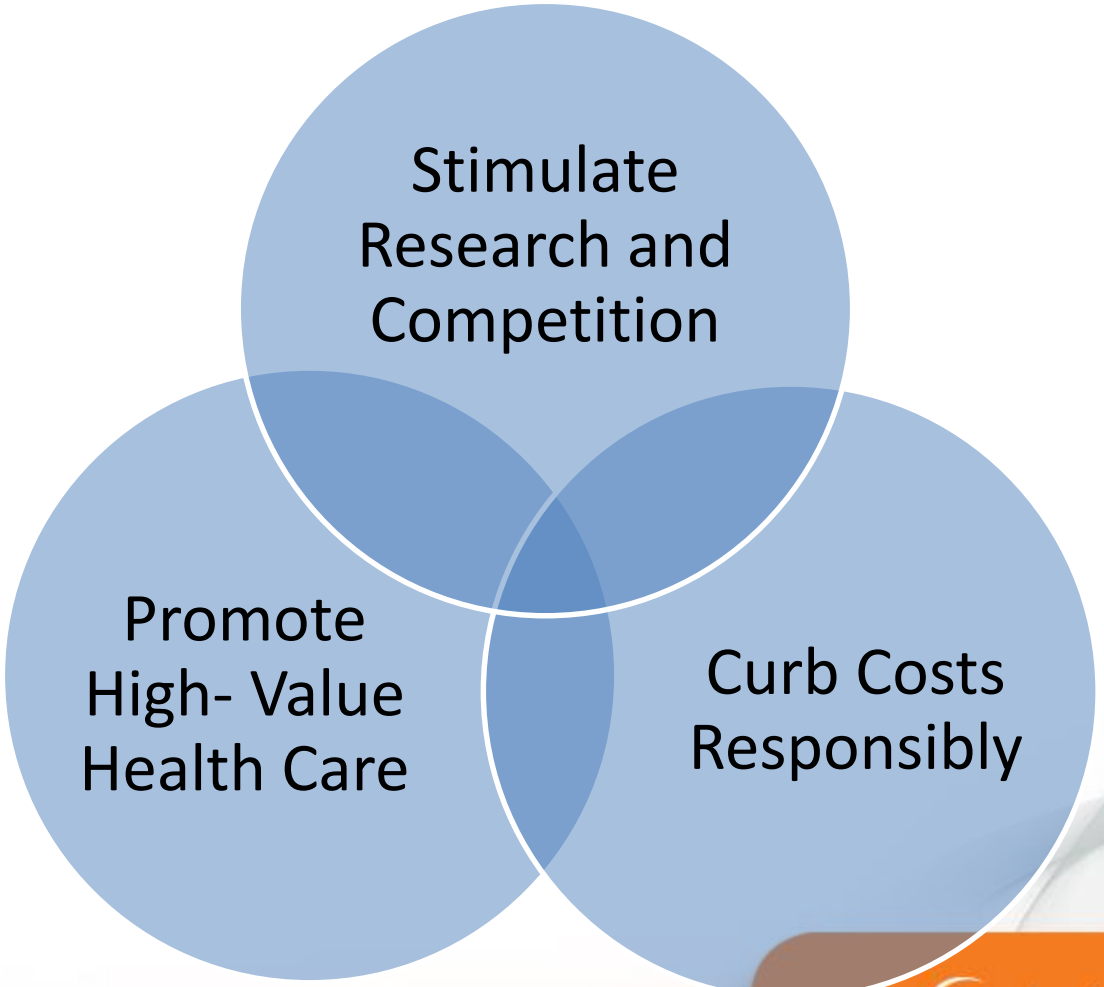
Source: Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision", as of January 2017.
*The Governor-elect of Kentucky announced plans to roll back the state's expansion of Medicaid; however, to-date no plans have been finalized.

Project Goal and Approach

Task 1: Determine the Universe of Prominent Policy Proposals



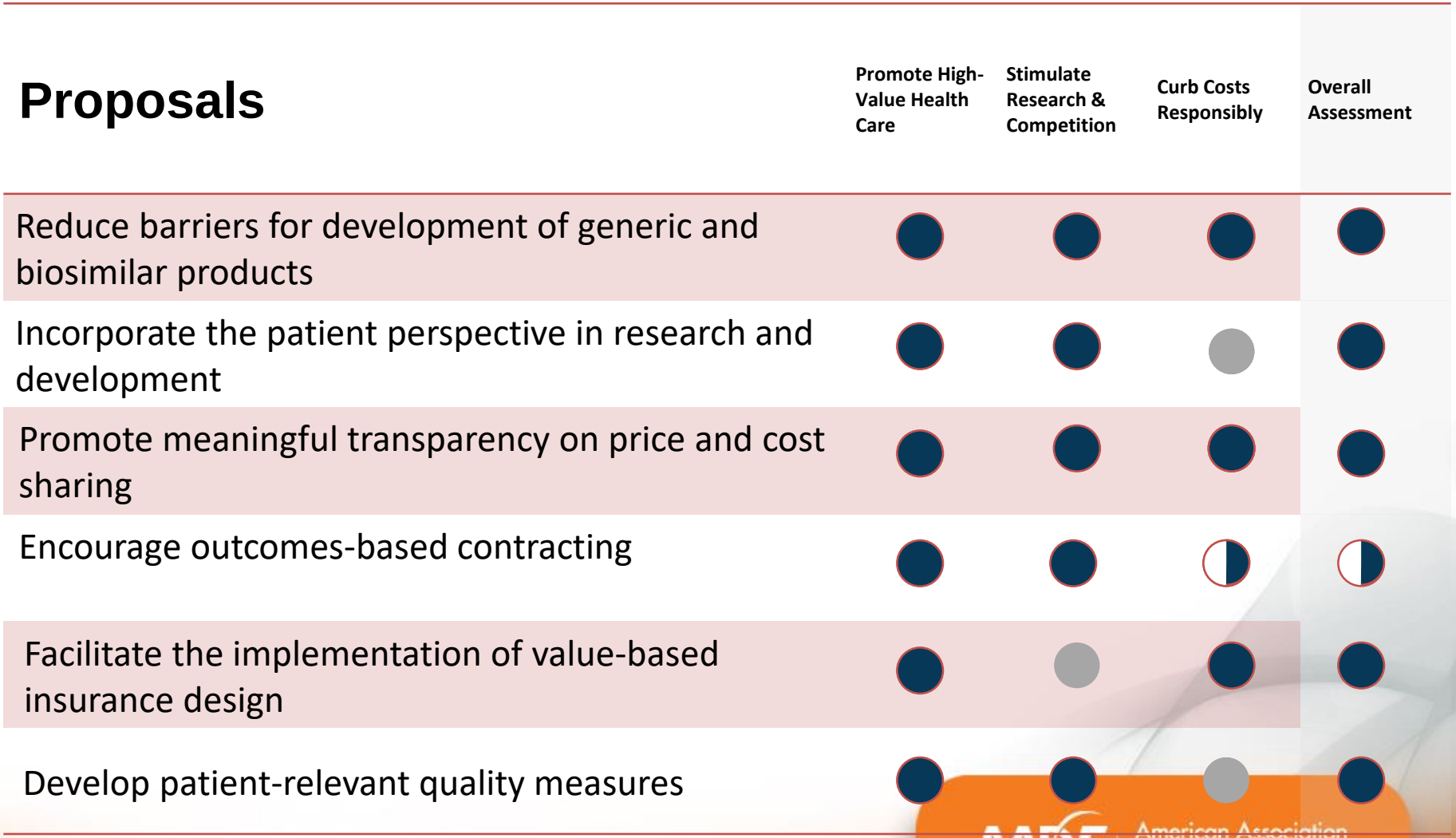
Task 2: Patient Centered Framework



Task 3: Analysis

Proposals	Promote High-Value Health Care	Stimulate Research & Competition	Curb Costs Responsibly	Overall Assessment
Implement fixed, per-person Medicaid payments	○	●	○	○
Allow providers and patients to reimport drugs	◑	◑	○	◑
Reform patent process (i.e., evergreening; pay for delay)	◑	◑	◑	◑
Shorten exclusivity periods	●	○	◑	○
Permit Medicare to negotiate drug prices	◑	◑	◑	◑

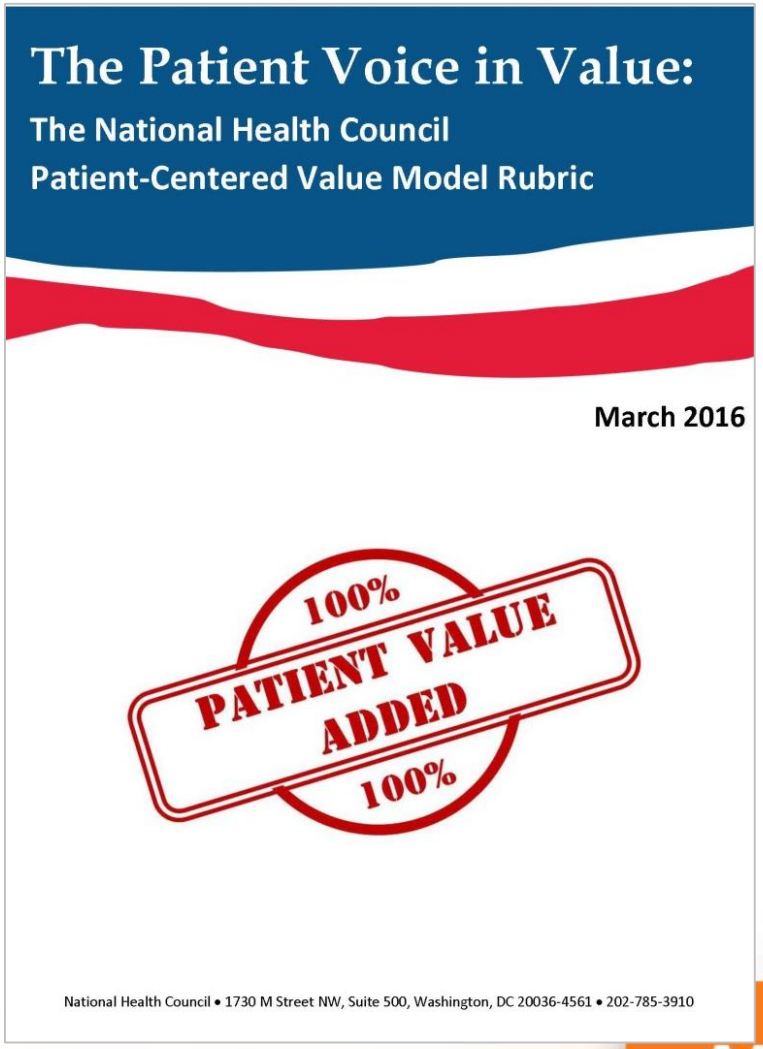
Task 3: Analysis



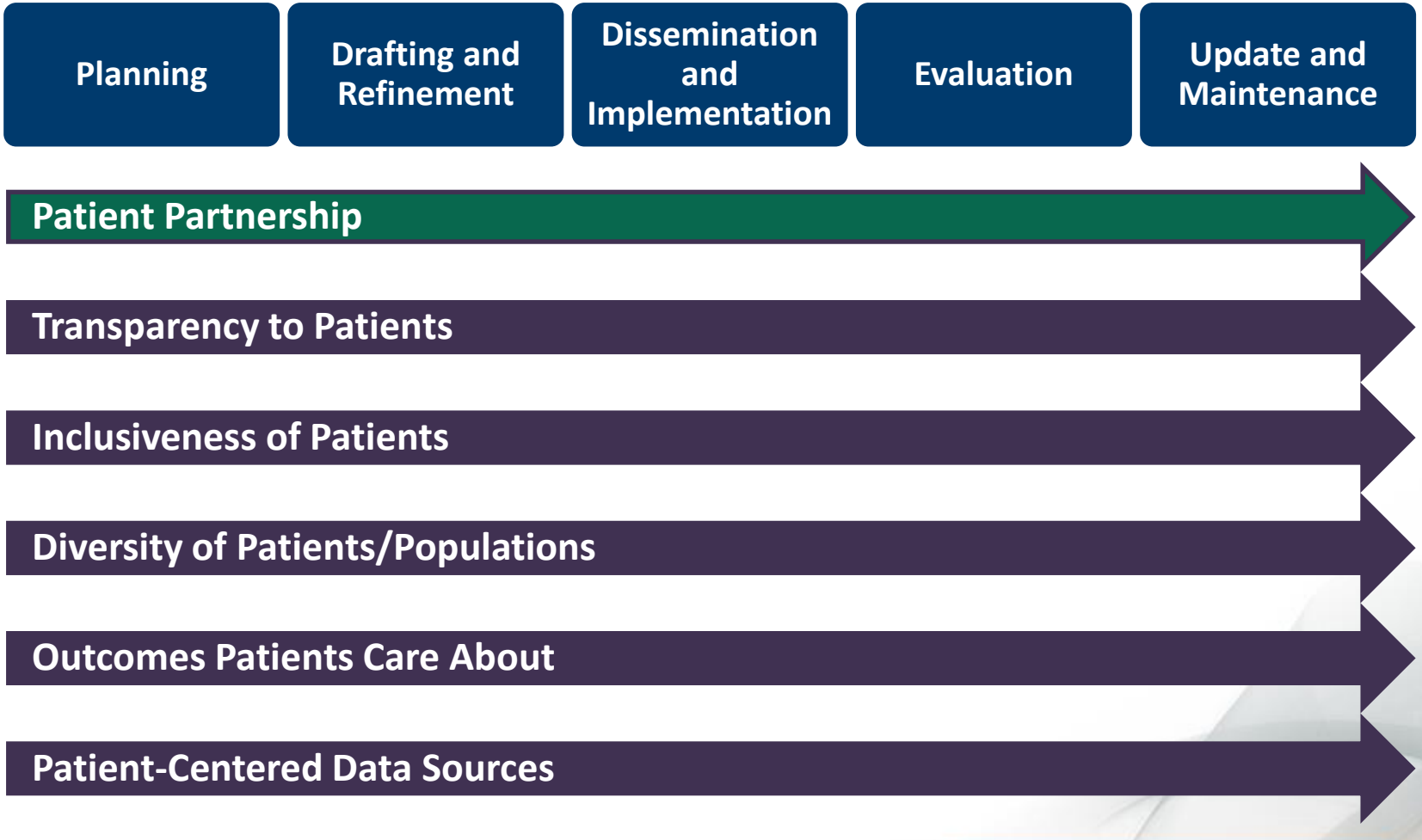
Task 4: Assessment

	Potential for Cost Savings	Political Feasibility
Reduce barriers for development of generic and biosimilar products	FDA analysis shows that generic entry has downward pressure on drug prices	
Promote meaningful transparency on price and cost sharing	CBO has characterized potential savings as "ambiguous"	
Encourage outcomes-based contracting	Savings from publicly announced OBCs have not been disclosed	
Facilitate the implementation of value-based insurance design	Savings from VBID programs have been mixed	

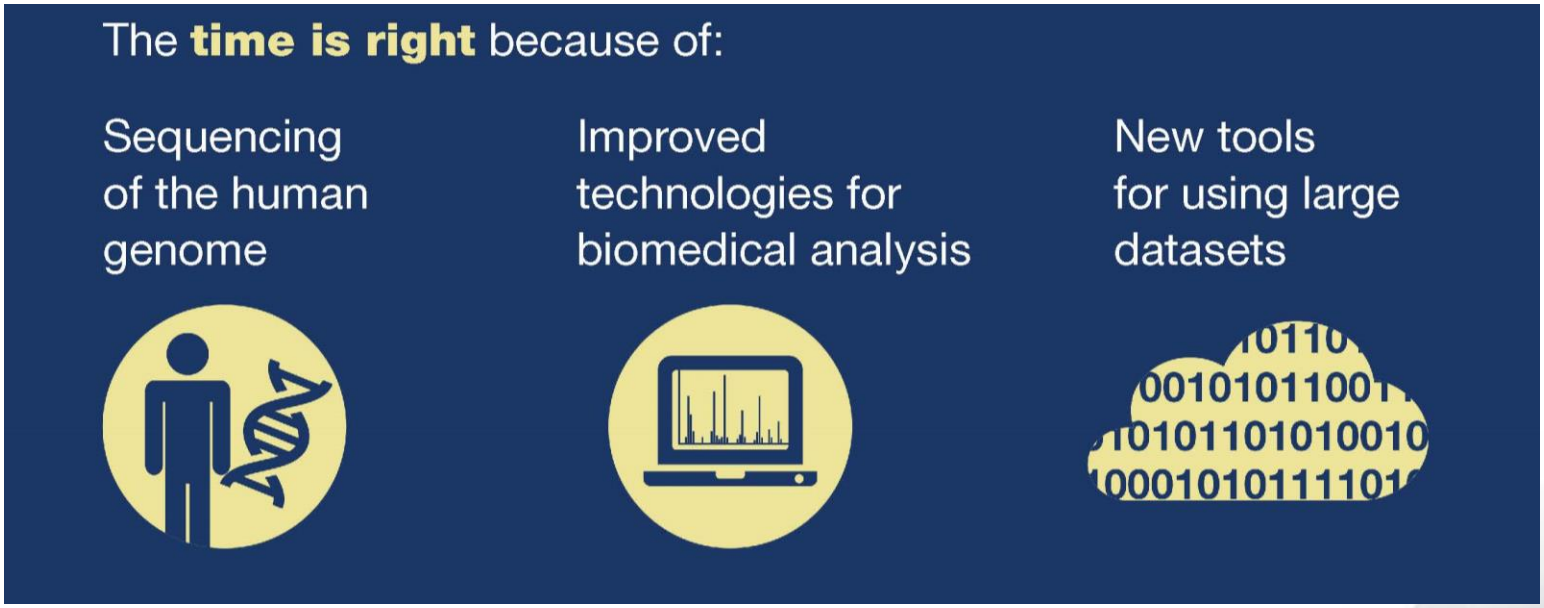
NHC Value Model Rubric



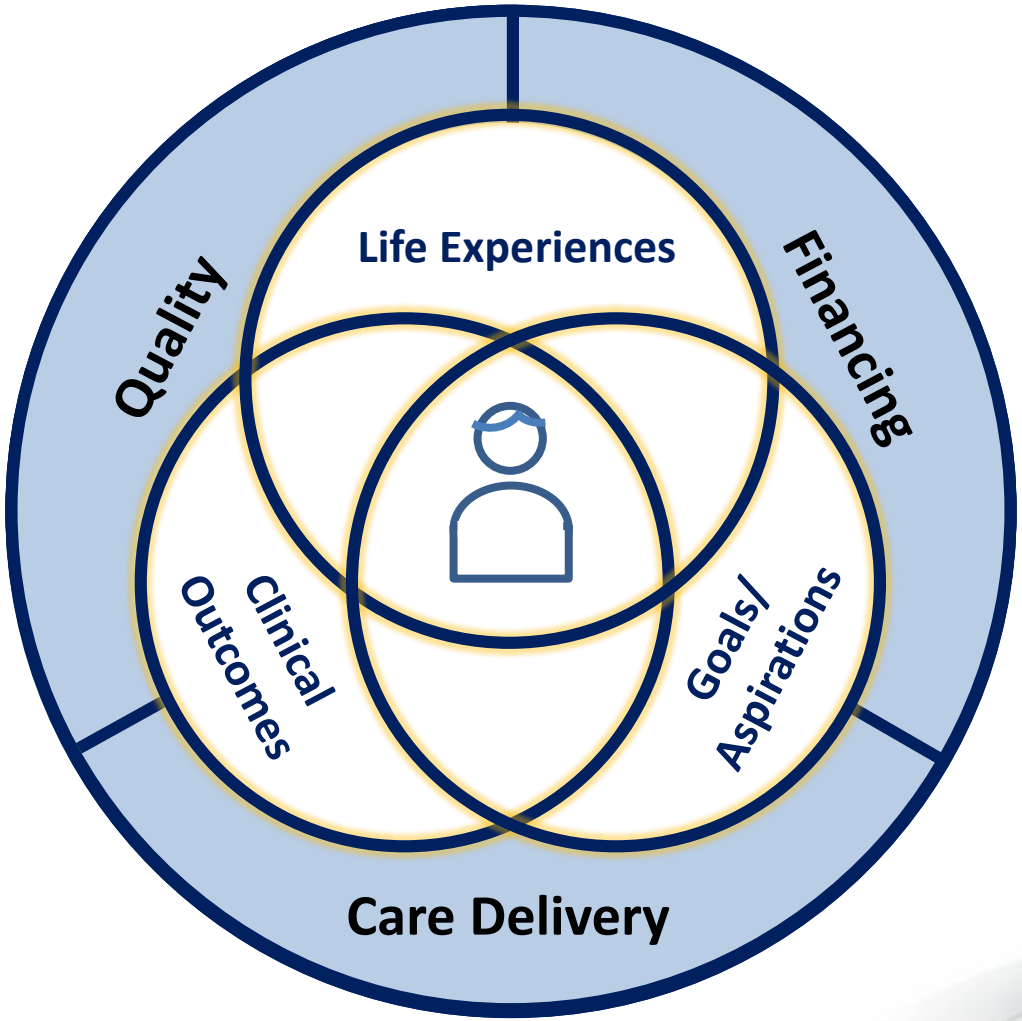
Value Model Development Process



Shifting from the Average to the Individual



Source: www.nih.gov/precisionmedicine



CARE MATCH WITH PATIENT GOALS

PUTTING PATIENTS FIRST®
NATIONAL HEALTH COUNCIL

AADE American Association of Diabetes Educators

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.

2017 SESSION

Final Bill

ENROLLED

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

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.

[S 1116]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 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.

A. Any person who:

1. 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 screening or stabilization of 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. For purposes of this subdivision, emergency care or assistance includes the forcible entry of a motor vehicle in order to remove an unattended minor at risk of serious bodily injury or death, provided the person has attempted to contact a law-enforcement officer, as defined in § 9.1-101, a firefighter, as defined in § 65.2-102, emergency medical services personnel, as defined in § 32.1-111.1, or an emergency 911 system, if feasible under the circumstances.

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 not 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 provided.

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 individual 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. Provides assistance upon request of any police agency, fire department, emergency medical services agency, or governmental agency in the event of an accident or other emergency involving the use, handling, transportation, transmission, or storage of liquefied petroleum gas, liquefied natural gas, hazardous material, or hazardous waste as defined in § 10.1-1400 or regulations of the Virginia Waste Management Board shall not be liable for any civil damages resulting from any act of commission or omission on his part in the course of his rendering such assistance in good faith.

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 or other means of communication, without compensation, to any injured or ill person, whether at the scene of an accident, fire, or any other place, or while transporting such injured or ill person to, from, or between any hospital, medical facility, medical clinic, doctor's office, or other similar or related medical facility, 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 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 a fire, an accident, 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 emergency resuscitative 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, unless such personal injury results from gross negligence or willful or wanton misconduct of the person rendering such emergency care.

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 in an emergency of an AED located on such property unless such personal injury results from gross negligence or willful or wanton misconduct of the person who maintains the AED or his agent or employee.

9. 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 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.

10. Is 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 resort 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 patroller employed by him 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.

11. 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 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.

12. Is a school nurse, an employee of a school board, an employee of a local governing body, or an employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine and who provides, administers, or assists in the administration of epinephrine to a student believed in good faith to be having an anaphylactic reaction, or is the prescriber of the epinephrine, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment.

13. Is an employee of a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education, or an employee of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is authorized by a prescriber and trained in the administration of epinephrine and who administers or assists in the administration of epinephrine to a student believed in good faith to be having an anaphylactic reaction, or is the prescriber of the epinephrine, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment. Whenever any employee is covered by the immunity granted in this subdivision, the school shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from such administration or assistance.

14. Is an employee of a provider licensed by the Department of Behavioral Health and Developmental Services, or provides services pursuant to a contract with a provider licensed by the

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 or administers glucagon to a person diagnosed as having diabetes who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia in accordance with § 54.1-3408 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 in accordance with the prescriber's instructions or such person has reason to believe that the individual receiving the glucagon is suffering or is about to suffer life-threatening hypoglycemia. Whenever any employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person who provides services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services is covered by the immunity granted herein, the provider 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.

15. Is an employee of a provider licensed by the Department of Behavioral Health and Developmental Services, or provides services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services, who has been trained in the administration of epinephrine and who administers or assists in the administration of epinephrine to a person believed in good faith to be having an anaphylactic reaction in accordance with the prescriber's instructions shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment.

16. In good faith prescribes, dispenses, or administers naloxone or other opioid antagonist used for overdose reversal in an emergency to an individual who is believed to be experiencing or about to experience a life-threatening opiate overdose shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if acting in accordance with the provisions of subsection X of § 54.1-3408 or in his role as a member of an emergency medical services agency.

B. Any licensed physician serving without compensation as the operational medical director for an emergency medical services agency that holds a valid license as an emergency medical services agency issued by the Commissioner of Health shall not be liable for any civil damages for any act or omission resulting from the rendering of emergency medical services in good faith by the personnel of such licensed agency unless such act or omission was the result of such physician's gross negligence or willful misconduct.

Any person serving without compensation as a dispatcher for any licensed public or nonprofit emergency medical services agency in the Commonwealth shall not be liable for any civil damages for any act or omission resulting from the rendering of emergency services in good faith by the personnel of such licensed agency unless such act or omission was the result of such dispatcher's gross negligence or willful misconduct.

Any individual, certified by the State Office of Emergency Medical Services as an emergency medical services instructor and pursuant to a written agreement with such office, who, in good faith and in the performance of his duties, provides instruction to persons for certification or recertification as a certified basic life support or advanced life support emergency medical services provider shall not be liable for any civil damages for acts or omissions on his part directly relating to his activities on behalf of such office unless such act or omission was the result of such emergency medical services instructor's gross negligence or willful misconduct.

Any licensed physician serving without compensation as a medical advisor to an E-911 system in the Commonwealth shall not be liable for any civil damages for any act or omission resulting from rendering medical advice in good faith to establish protocols to be used by the personnel of the E-911 service, as defined in § 58.1-1730, when answering emergency calls unless such act or omission was the result of such physician's gross negligence or willful misconduct.

Any licensed physician who directs the provision of emergency medical services, as authorized by the State Board of Health, through a communications device shall not be liable for any civil damages for any act or omission resulting from the rendering of such emergency medical services unless such act or omission was the result of such physician's gross negligence or willful misconduct.

Any licensed physician serving without compensation as a supervisor of an AED in the Commonwealth shall not be liable for any civil damages for any act or omission resulting from rendering medical advice in good faith to the owner of the AED relating to personnel training, local emergency medical services coordination, protocol approval, AED deployment strategies, and equipment maintenance plans and records unless such act or omission was the result of such physician's gross negligence or willful misconduct.

C. Any communications services provider, as defined in § 58.1-647, including mobile service, and any provider of Voice-over-Internet Protocol service, in the Commonwealth shall not be liable for any

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.

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 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.

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

E. 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.

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.

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.

§ 22.1-274.01:1. Students who are diagnosed with diabetes; self-care.

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.

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 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.

Jasmine Gonzalvo

Best Practices from Jasmine Gonzalvo

- Do your research
  - Ask a lot of questions
- Utilize your existing network
- Build new relationships

February 3, 2017

HOUSE BILL No. 1642

DIGEST OF HB 1642 (Updated February 1, 2017 7:28 pm - DI 77)

Citations Affected: Noncode.

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

January 24, 2017, read first time and referred to Committee on Public Health.
February 2, 2017, amended, reported — Do Pass.

February 3, 2017

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

PRINTING CODE. Amendments: Whenever an existing statute (or a section 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 enacted (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 reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by 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" refers to the legislative council created by IC 2-5-1.1-1.**

(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.

(d) If an appropriate study committee is assigned the topics

HB 1642—LS 7152/DI 104

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.

(e) This SECTION expires December 31, 2017.

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

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 2-5-1.1-1.**

(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.

(d) 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.

(e) 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.)

KIRCHHOFER

Committee Vote: yeas 11, nays 0.

Eskenazi Health
720 Eskenazi Ave.
Indianapolis, IN 46202
317.880.0000
EskenaziHealth.edu

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 pre-diabetes 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

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator FRED H. MADDEN, JR.
District 4 (Camden and Gloucester)

Co-Sponsored by:
Senator Gordon

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 1/31/2017)

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.30:4D-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 [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

(5) Physical therapy and related services;

(6) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(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 pediatric 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)Upon referral by a physician, 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 Diabetes Educators as a Certified Diabetes Educator, or certified by the American Association of Diabetes Educators with a Board Certified-Advanced Diabetes Management credential, including, but not limited to: a physician, an advanced practice or registered nurse, a physician assistant, a pharmacist, a chiropractor, or a 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 eligible 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.(3) and (5) of this section and subsection b.(1)-(5), (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.(1)-(5), (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)(5)). 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)(5)). 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. ss.1395i-2 and 1395r.

i. In the case of a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(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.1395r as provided for in 42 U.S.C. s.1396d(p)(3)(A)(ii).

j. In the case of a qualified individual pursuant to 42 U.S.C. s.1396a(aa), 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.

3. (New section) The Commissioner of Human Services shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner shall adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and shall thereafter be amended, adopted, or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect immediately.

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.

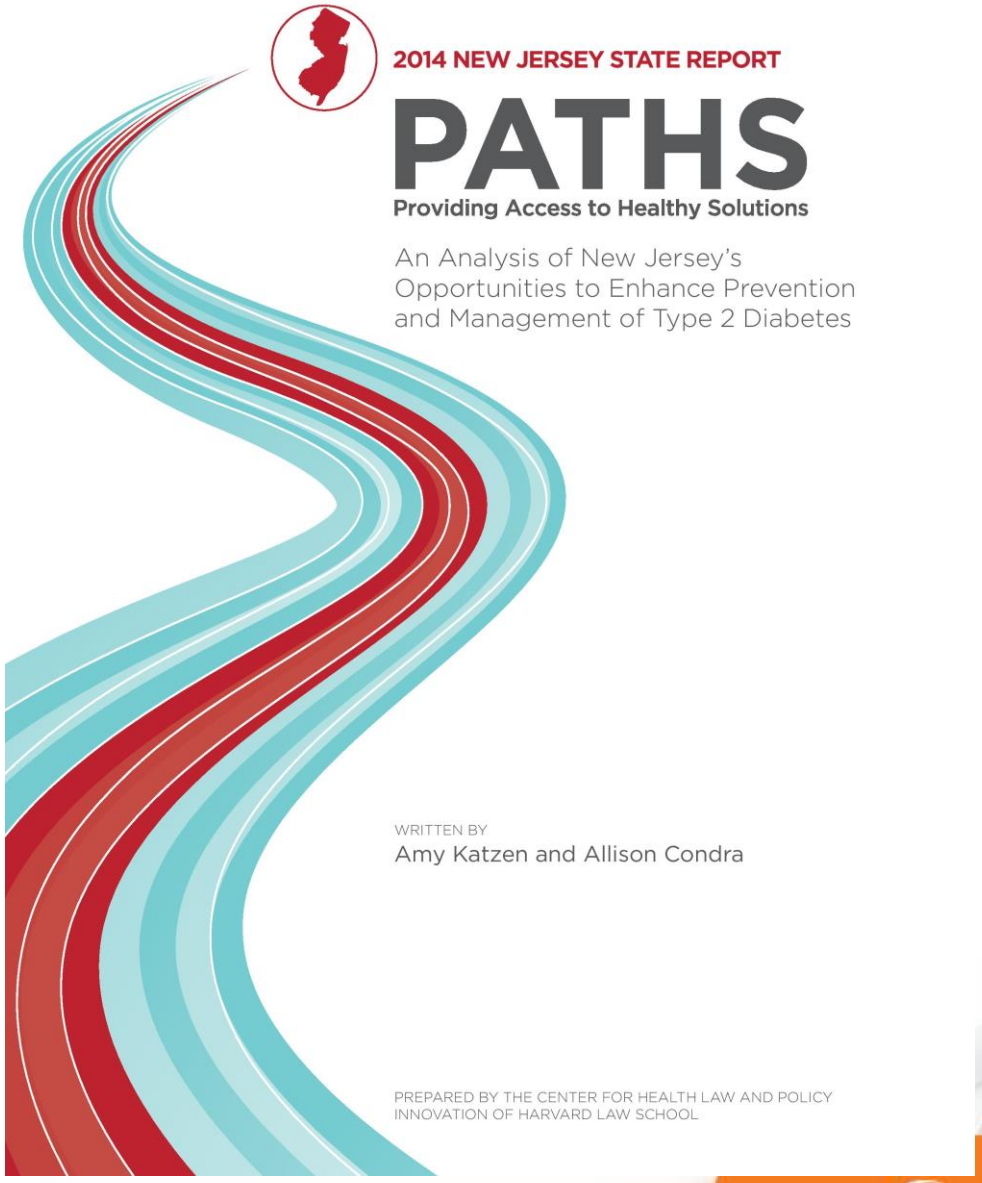
The bill requires the State Medicaid program to cover items and services furnished under a diabetes prevention program that meets the standards of the National Diabetes Prevention Program established by the Centers for Disease Control and Prevention for persons diagnosed with pre-diabetes.

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

Dr. Nirav D. Shah, MD, JD

Director

Illinois Department of Public Health

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

State Of The State: Diabetes In Illinois

Nirav D. Shah, M.D., J.D.
Director, Illinois Department of Public Health

May 5, 2017

DISCLOSURES

IDPH
Illinois Department of Public Health

Overview

Diabetes Burden in Illinois

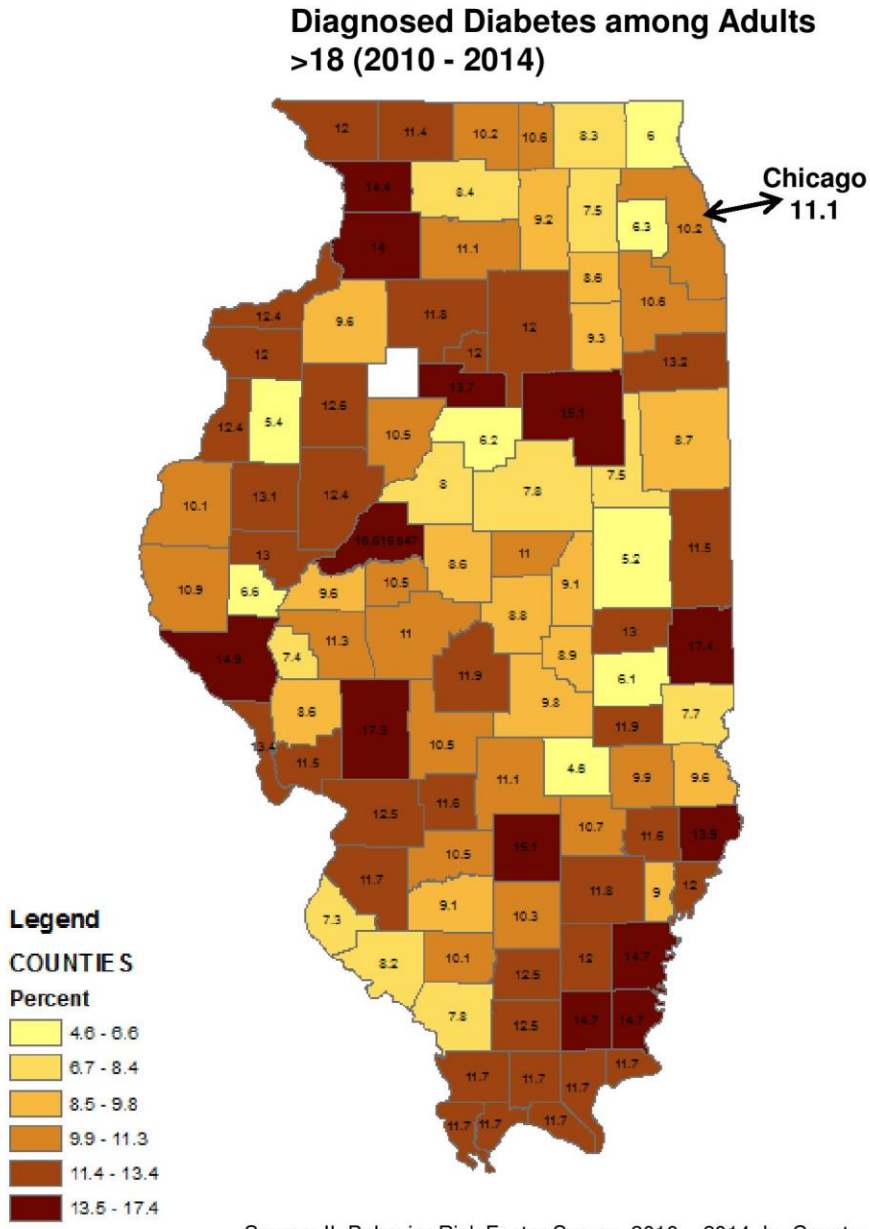
Diabetes Program Locations

Diabetes Statewide Assessment

IDPH
Illinois Department of Public Health

Diabetes Prevalence

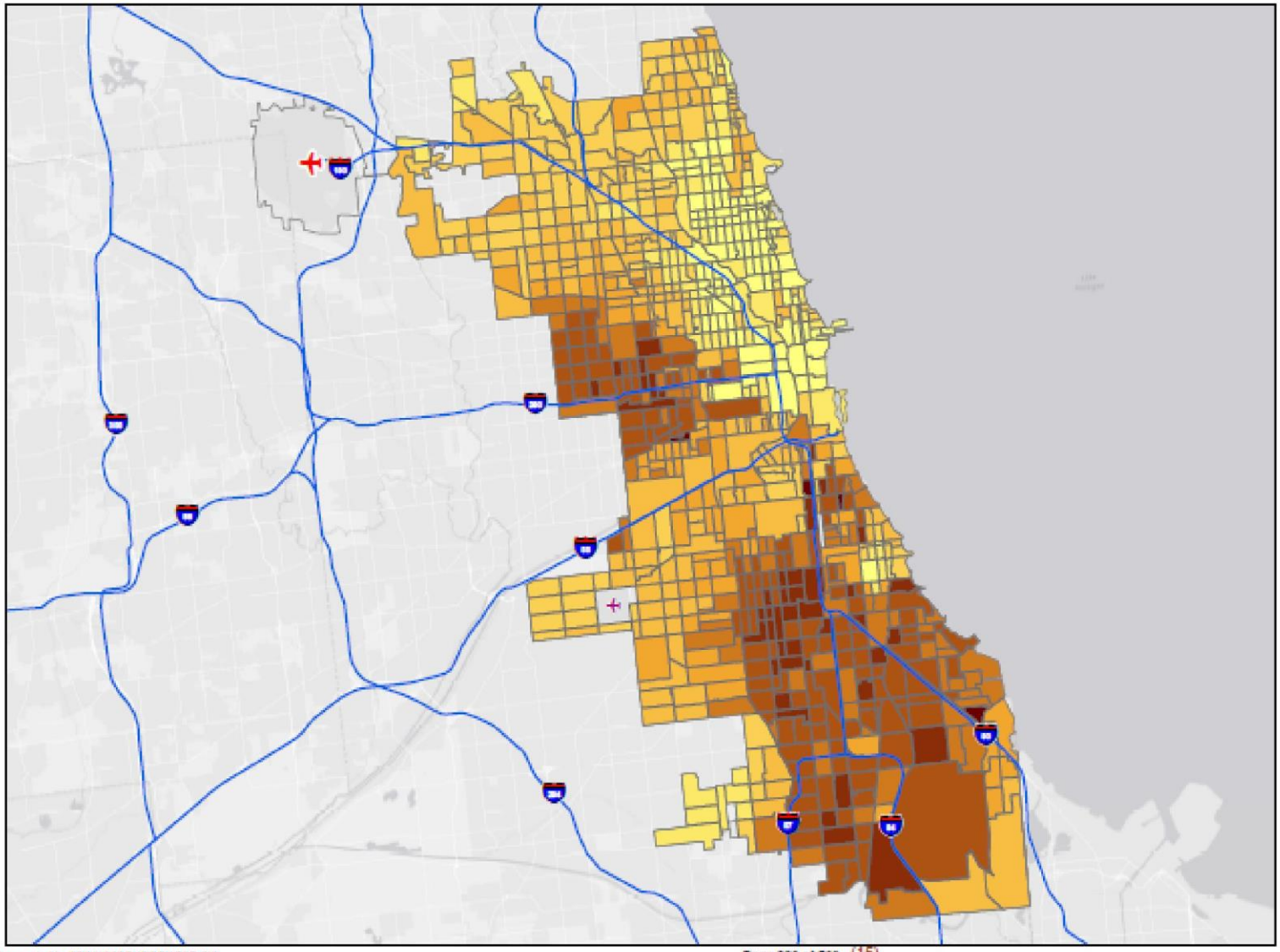
- Highest Prevalence Areas:
  - Edgar (17.0)
  - Macoupin (17.3)
  - Livingston (15.1)
  - Marion (15.1)
  - Gallatin (14.7)
  - Saline (14.7)



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

IDPH
Illinois Department of Public Health

Diagnosed diabetes among adults aged ≥18 years by census tract, Chicago, IL, 2014



Percent (%)
- 0.8 - 5.6
- 5.7 - 7.9
- 8.0 - 9.9
- 10.0 - 12.0
- 12.1 - 14.3
- 14.4 - 16.9
- 17.0 - 19.8
- 19.9 - 23.4
- 23.5 - 37.0
- City boundary

Classification:
Jenks natural breaks (9 classes) based on data for all 500 cities' census tracts. Legend depicts only those data classes within this map extent.

Census tracts with population less than 50 were excluded from the map.

Data sources:
CDC BRFSS 2014, US Census Bureau 2010 Census, ACS 2010-2014.

Map created by CDC/NCCDPHP/DPH/ESB-GIS

Date: 3/24/2016

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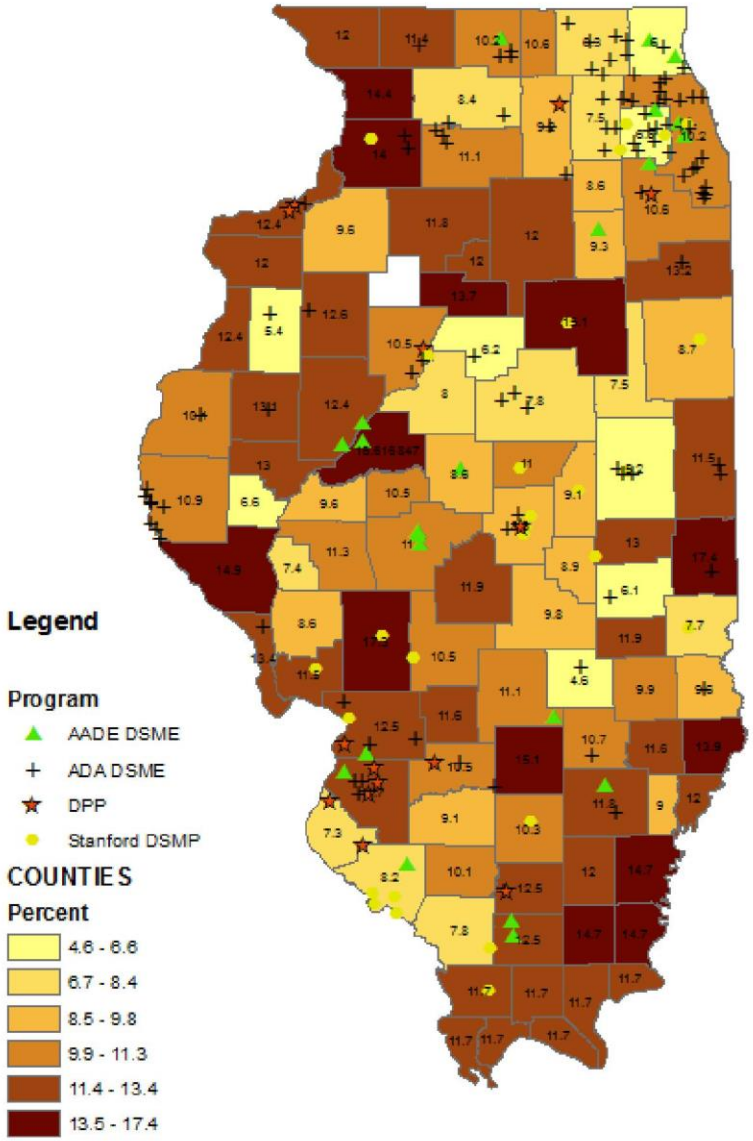
Diabetes Programs

- Chicago (26)
- Cook County (24)
- Dupage County (17)
- Will County (9)
- Madison County (8)
- Sangamon County (7)



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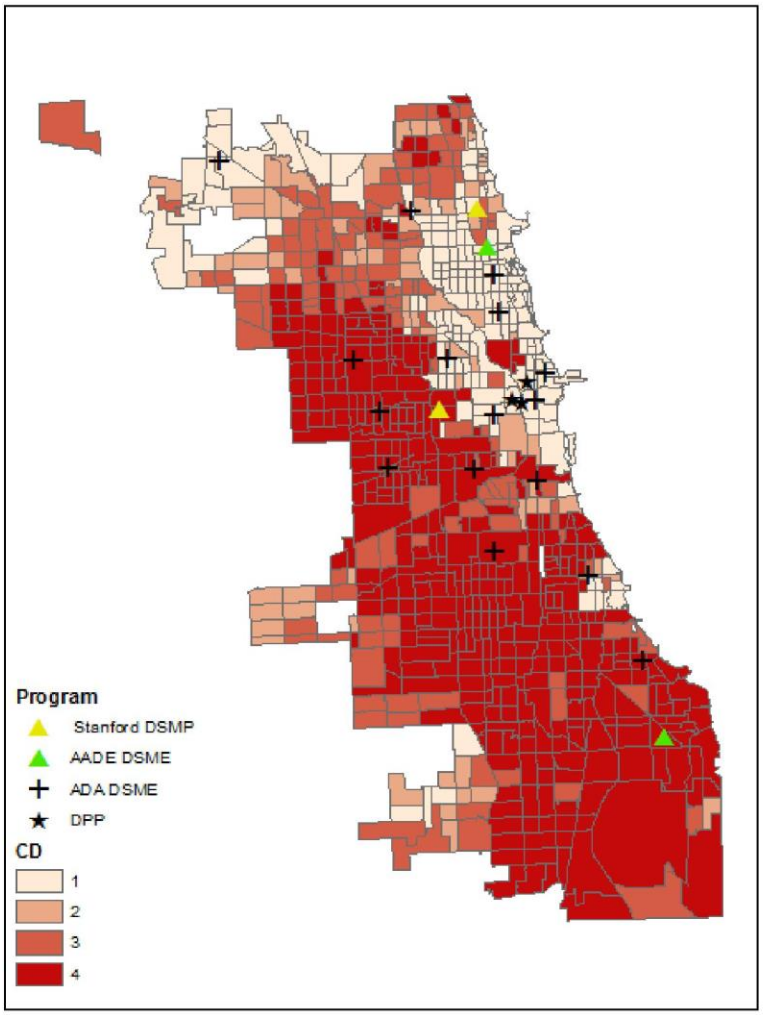

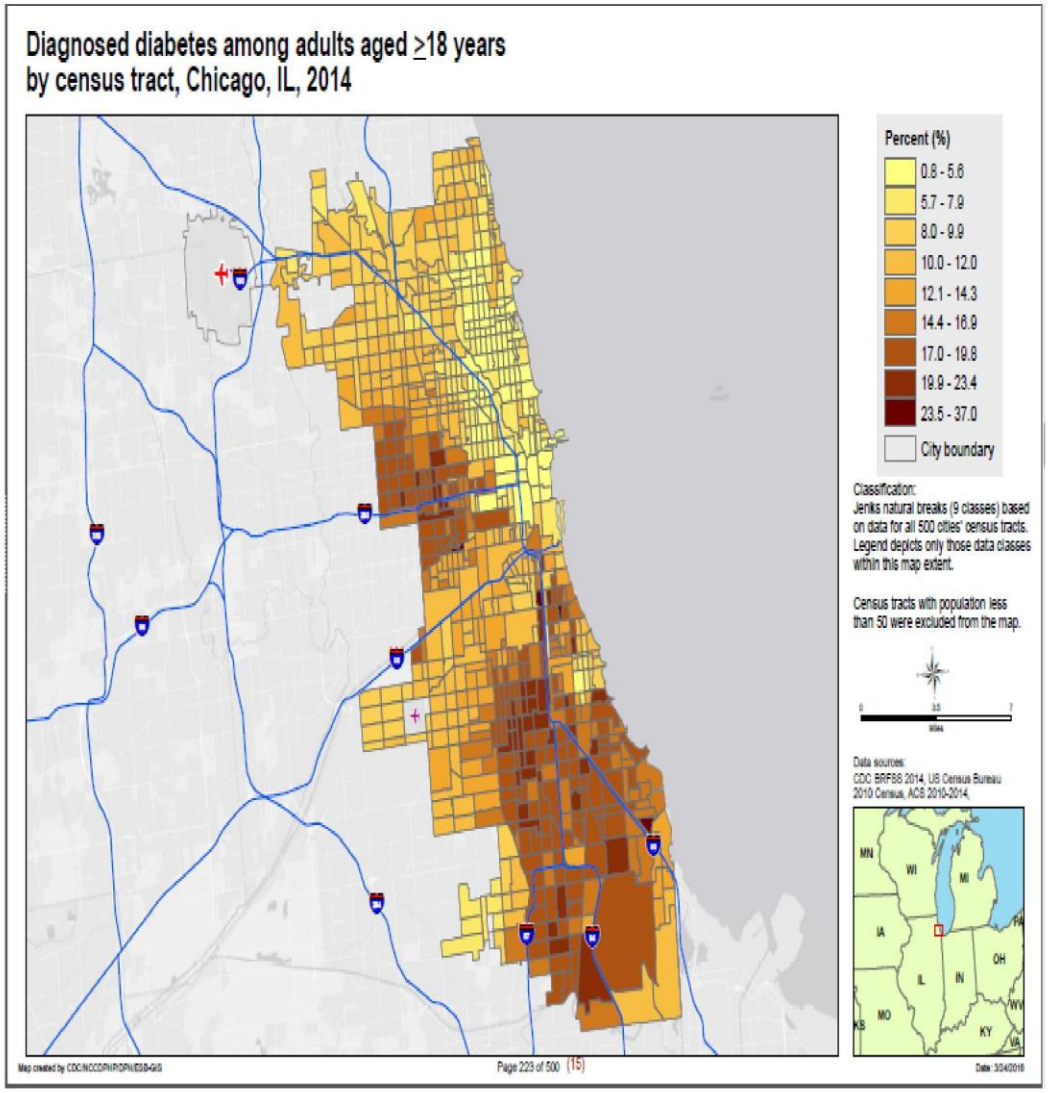

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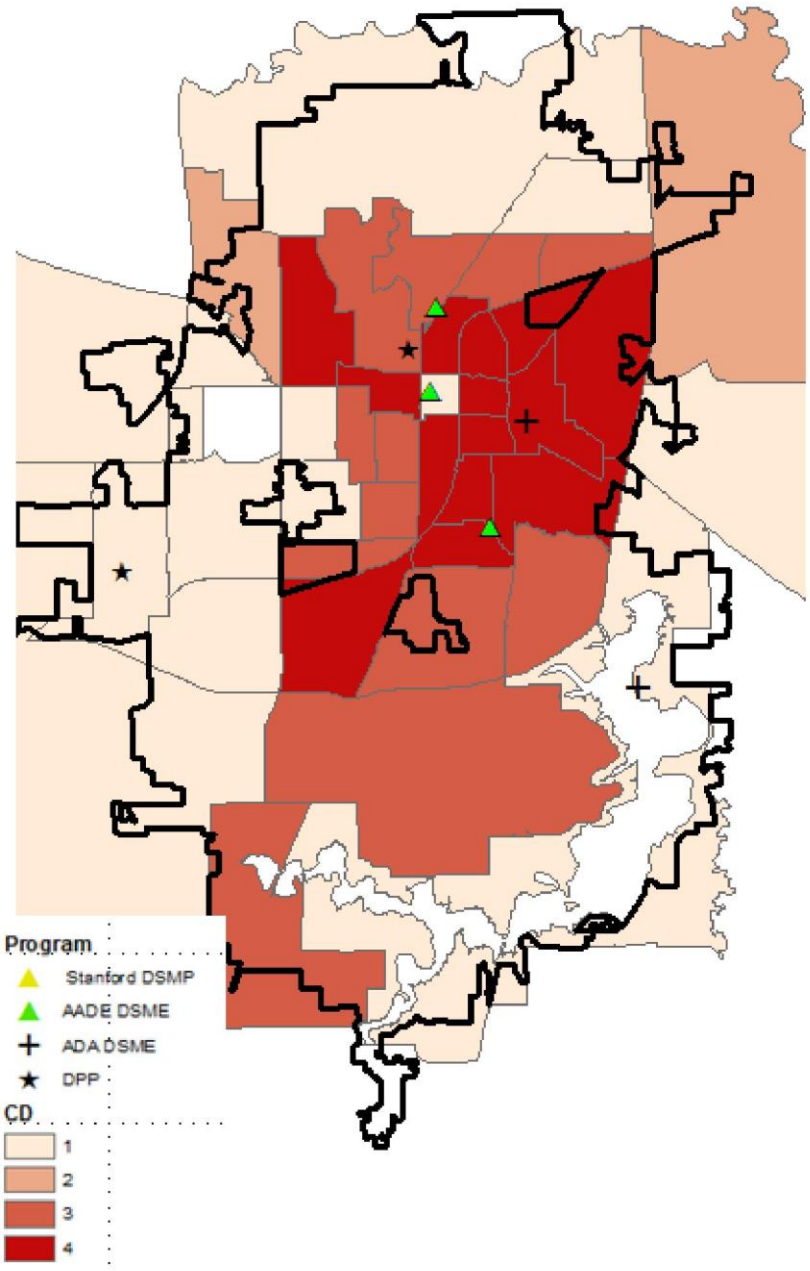
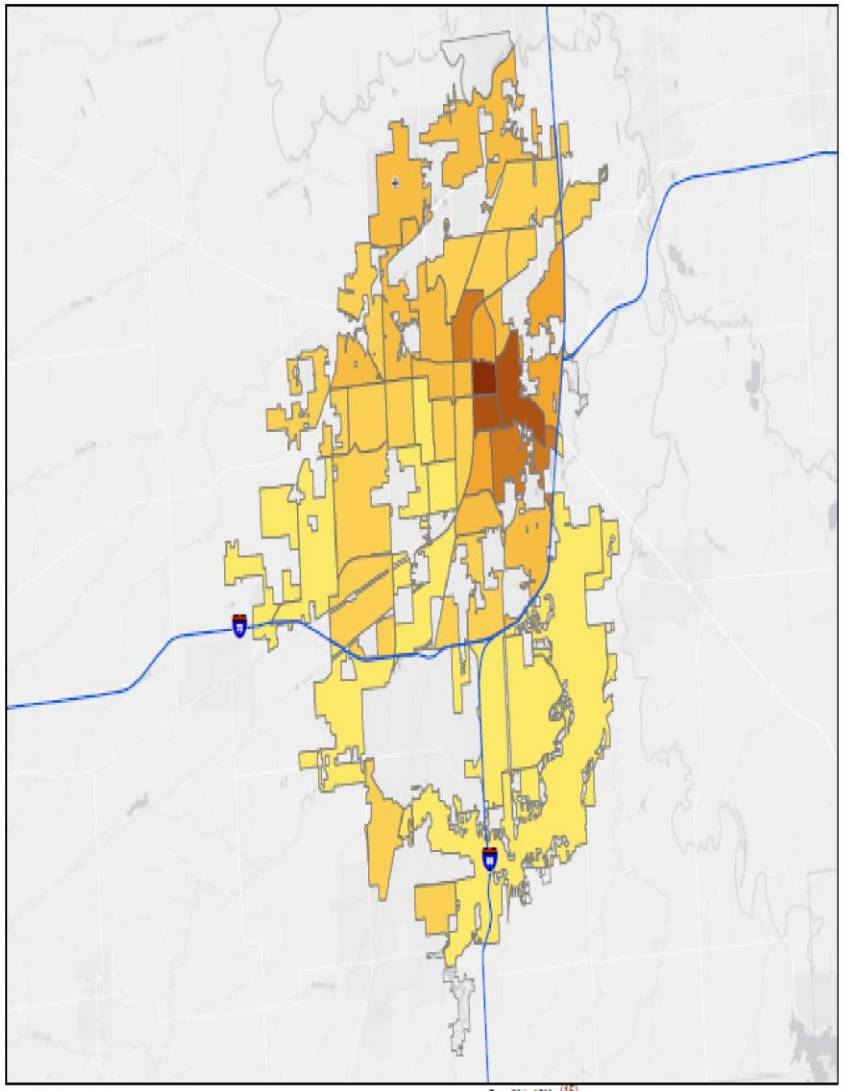


Diagnosed diabetes among adults aged ≥18 years
by census tract, Springfield, IL, 2014



Diabetes Programs

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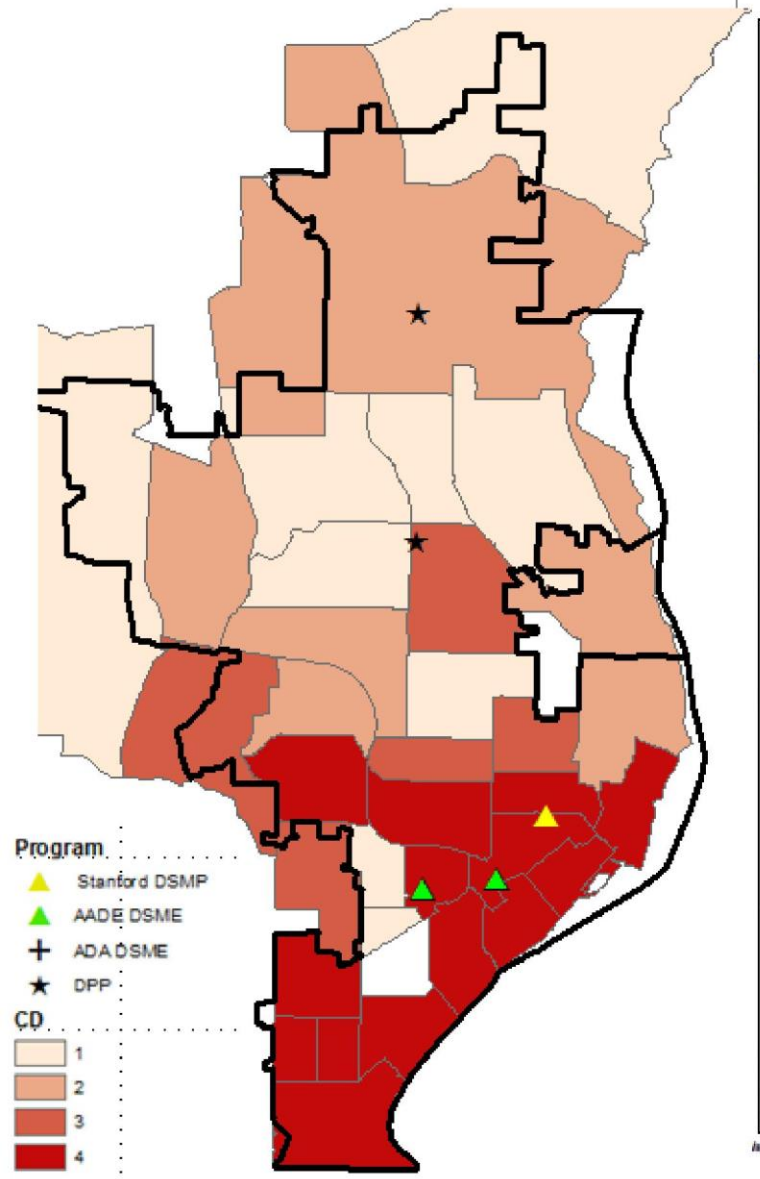
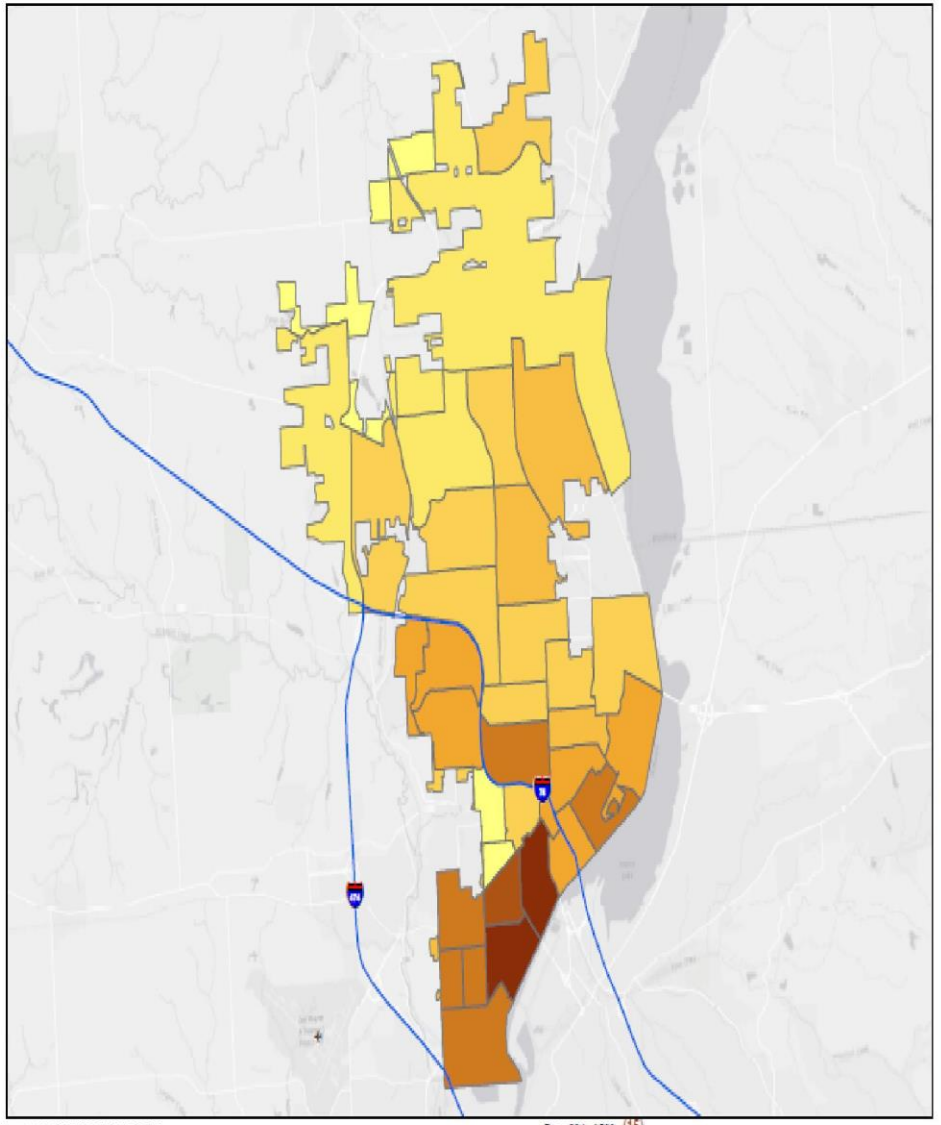


Diagnosed diabetes among adults aged ≥18 years by census tract, Peoria, IL, 2014



Diabetes Programs

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Illinois Diabetes State-wide Assessment

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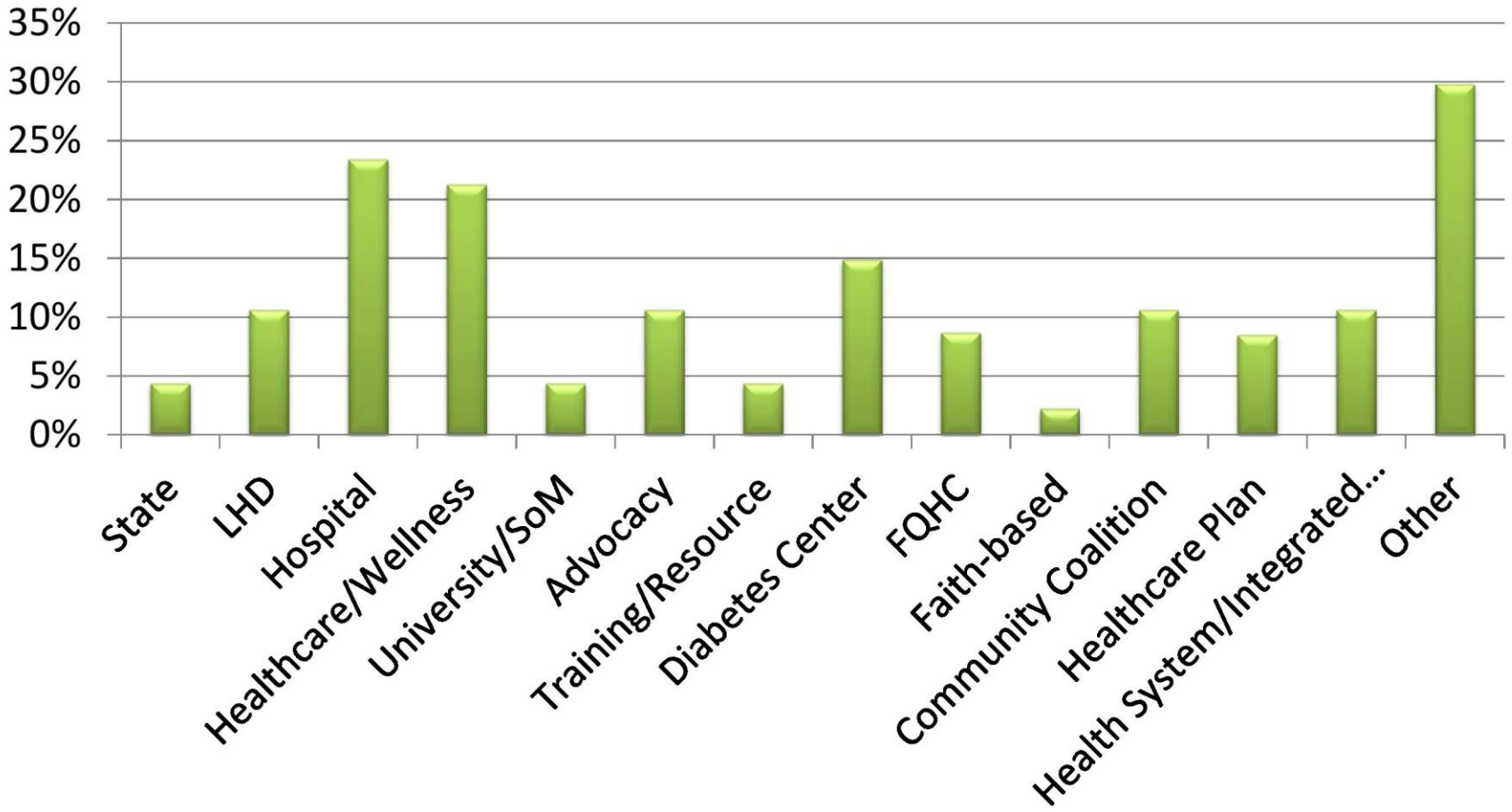
Organization Type



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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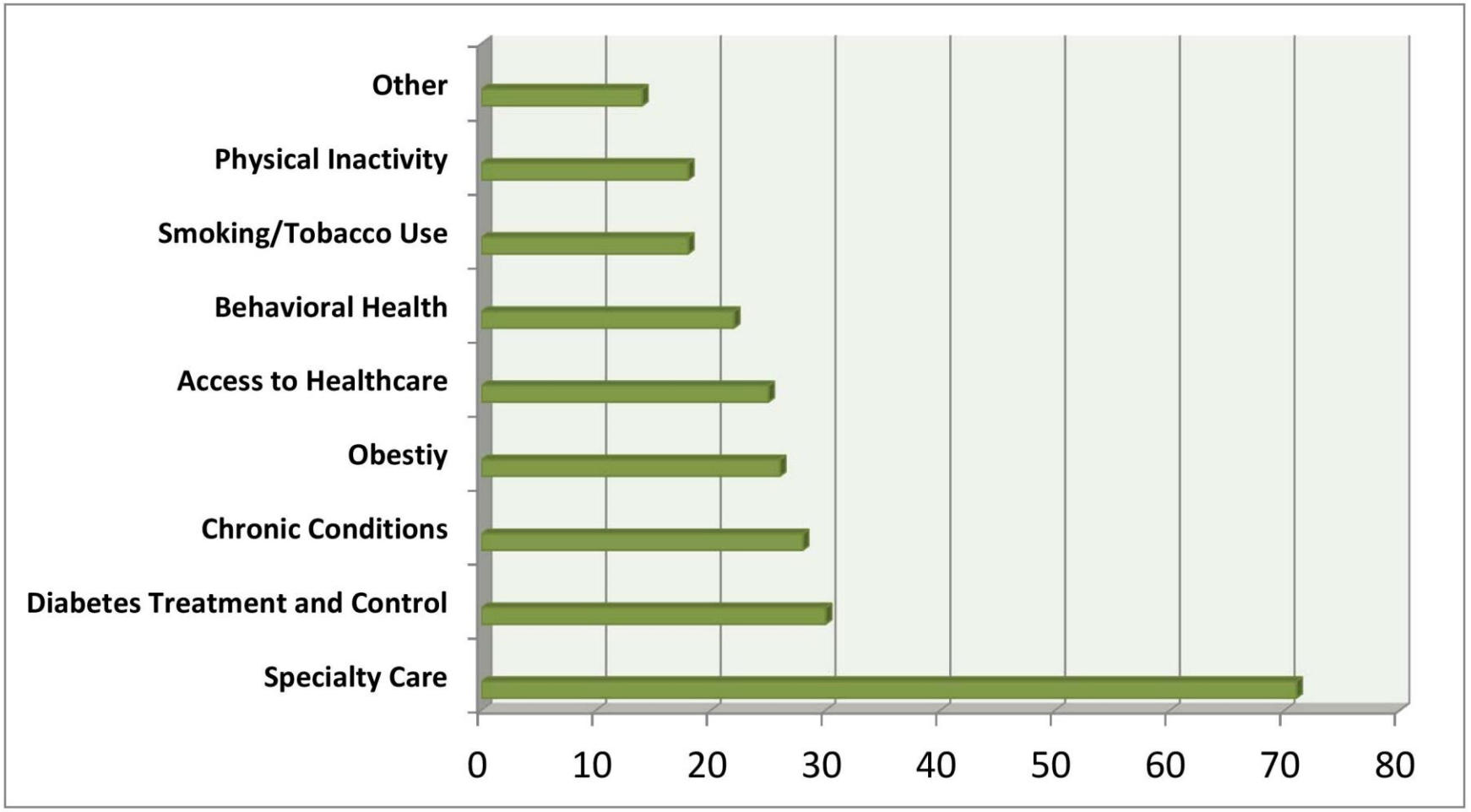
Scope of Services



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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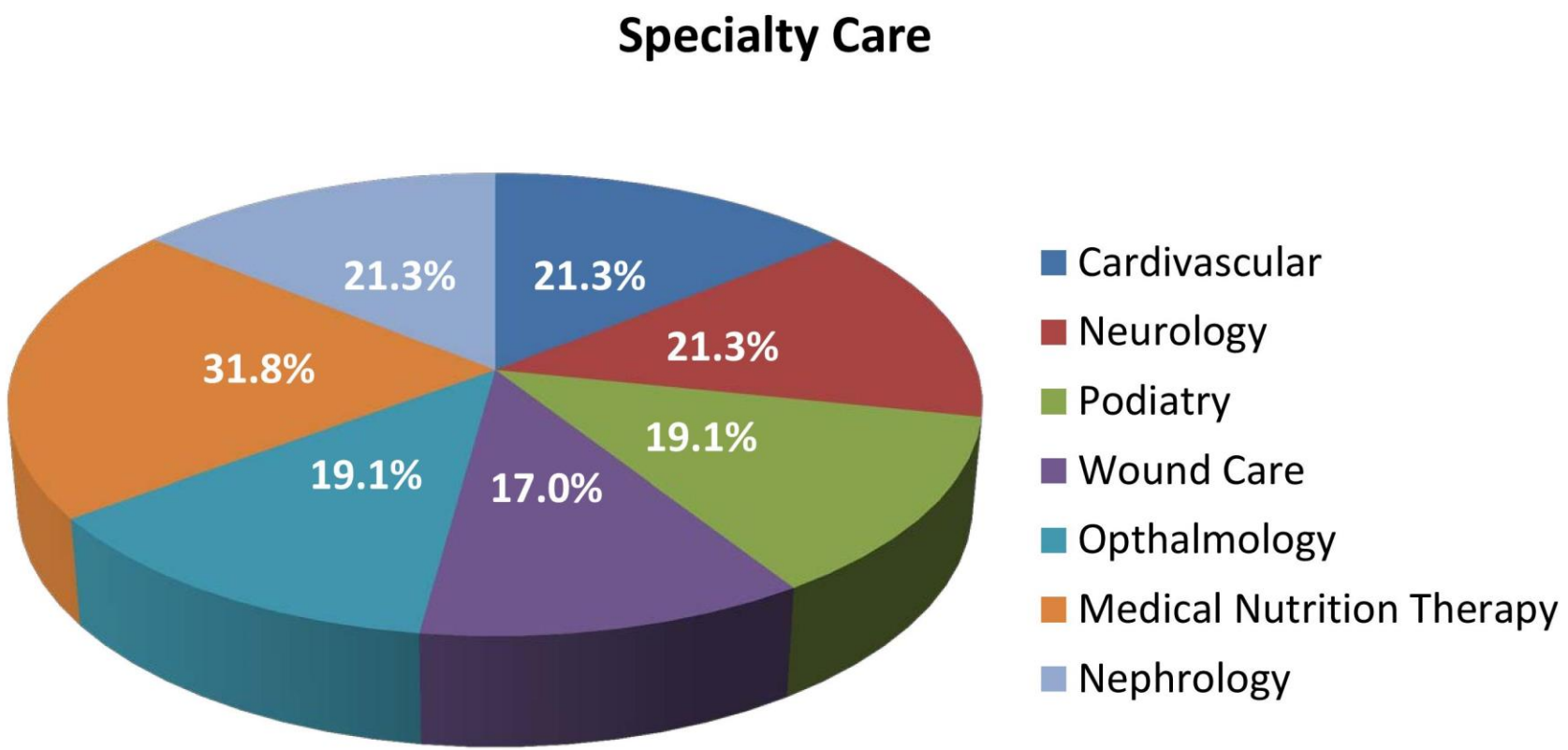
Scope of Services

(Continued)



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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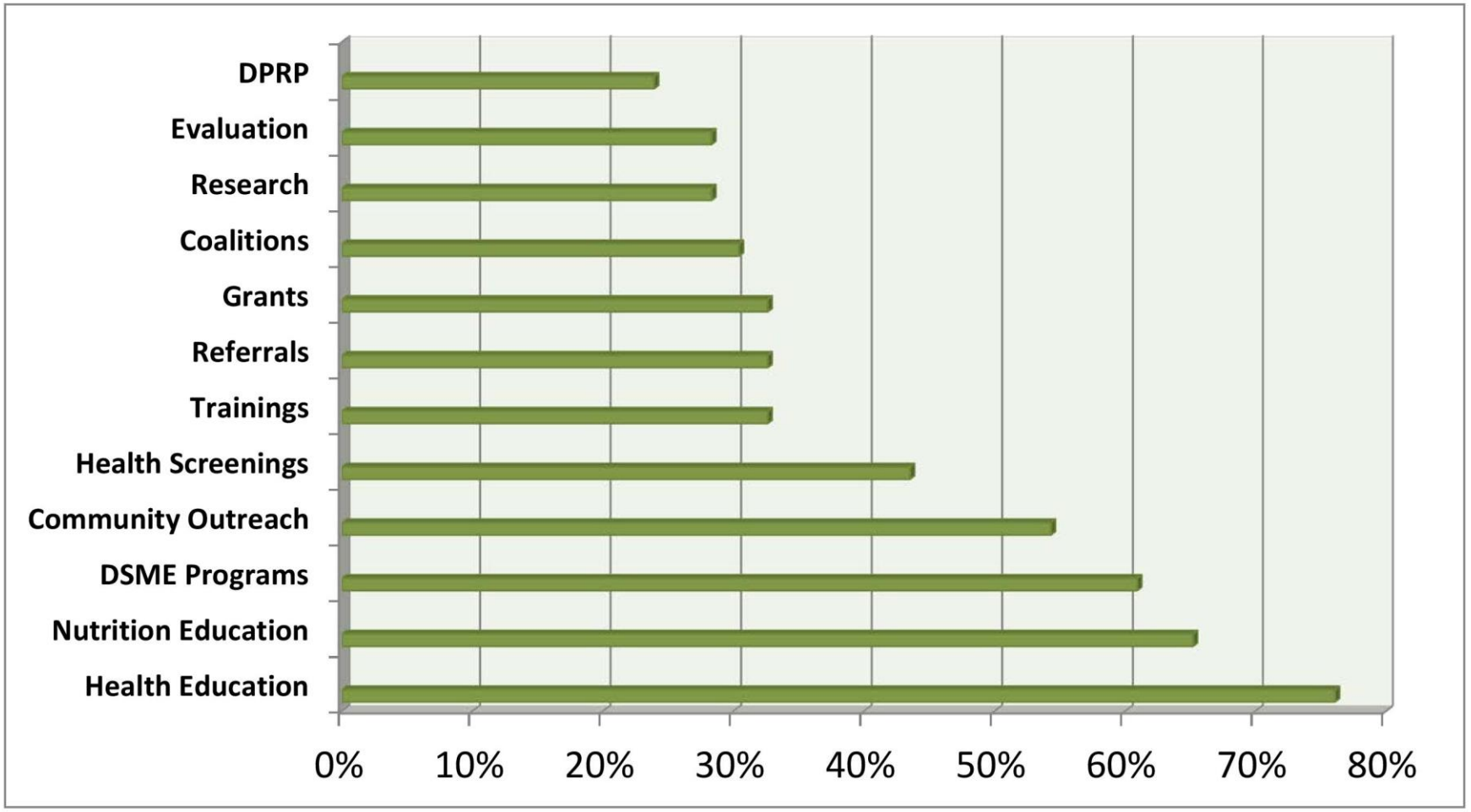
Service Delivery Mechanisms



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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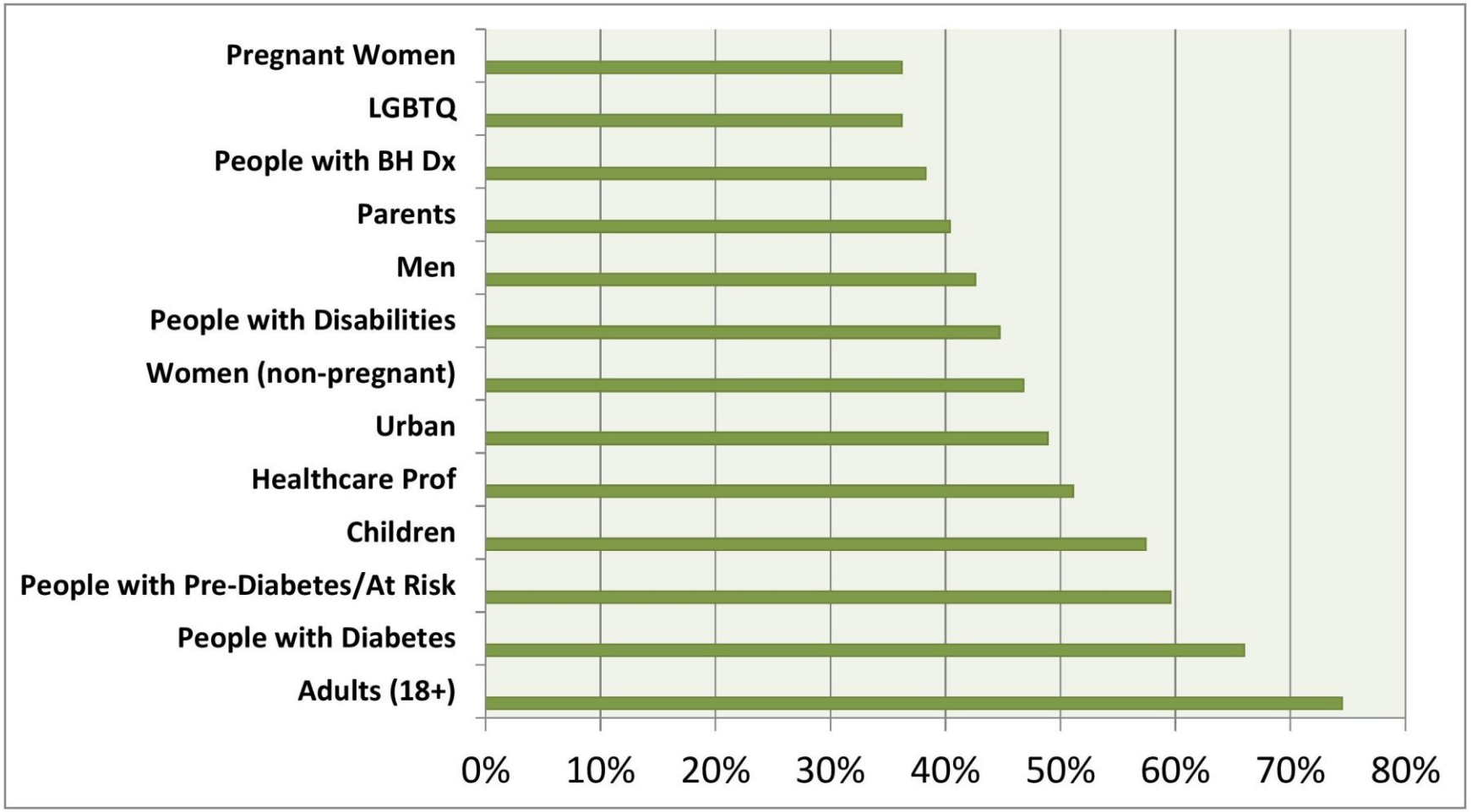
Populations Served



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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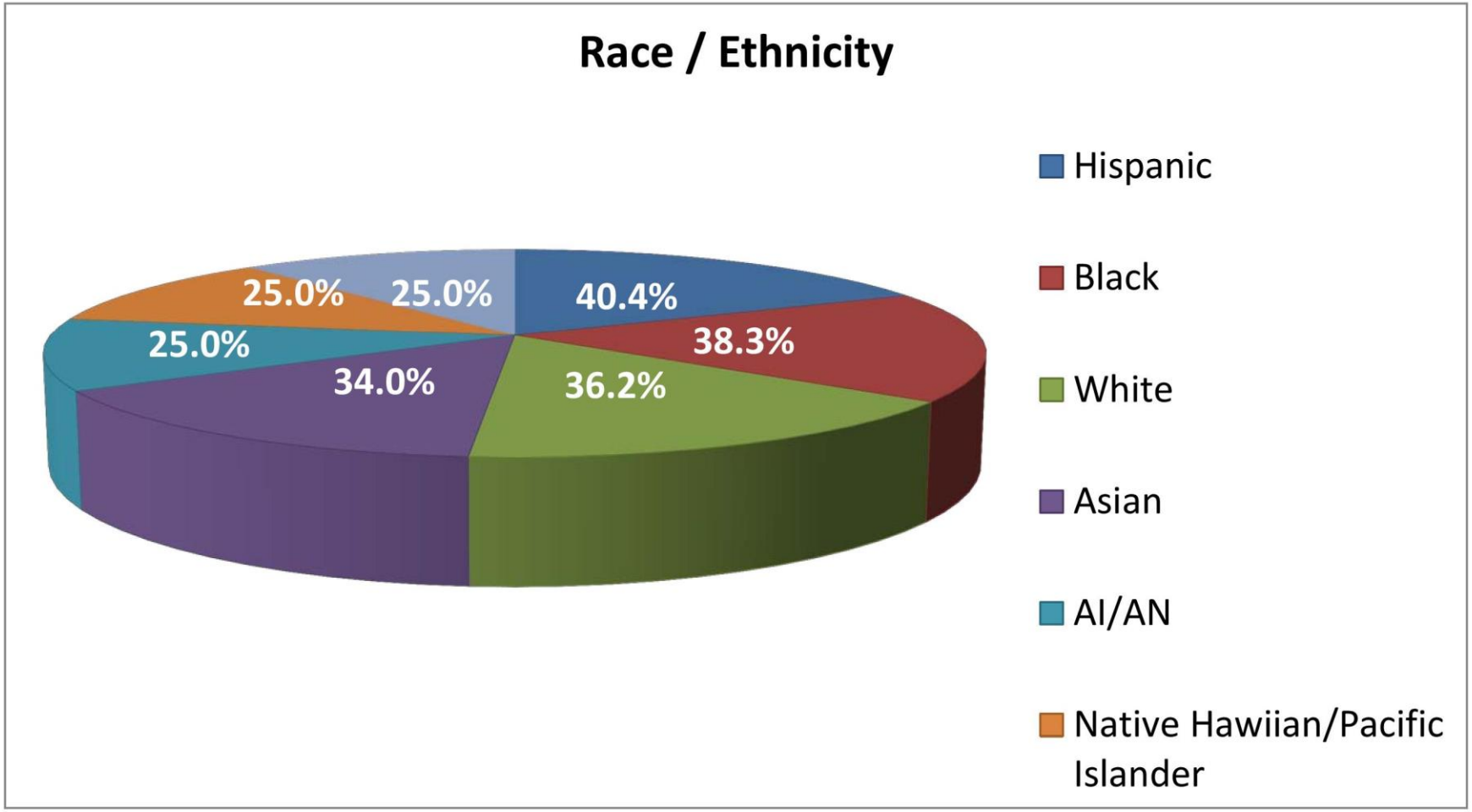
Populations Served

(Continued)



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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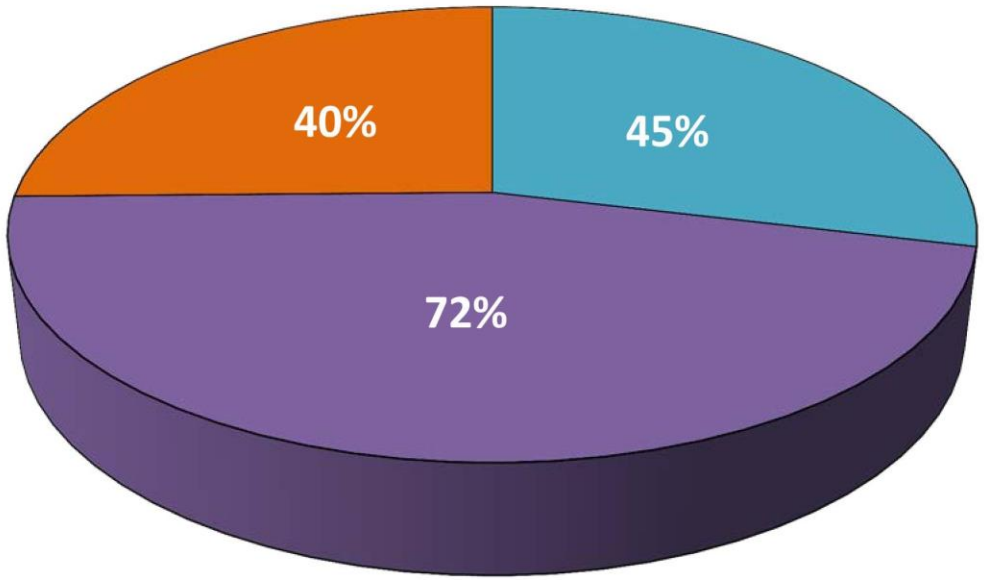
Strategy Summaries

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



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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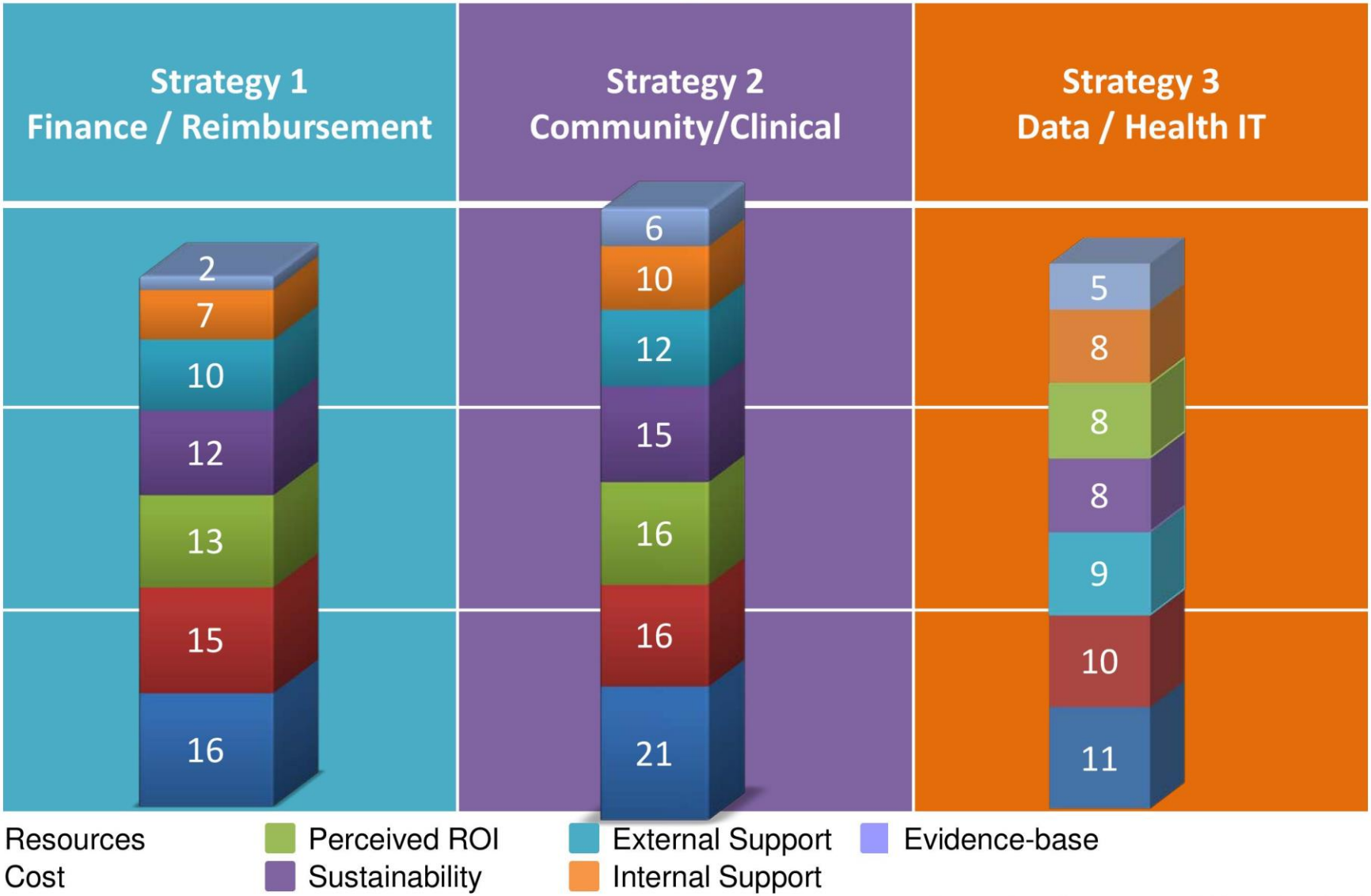
Strategy Summaries

Key Objectives / Tactics

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

Strategy Summaries

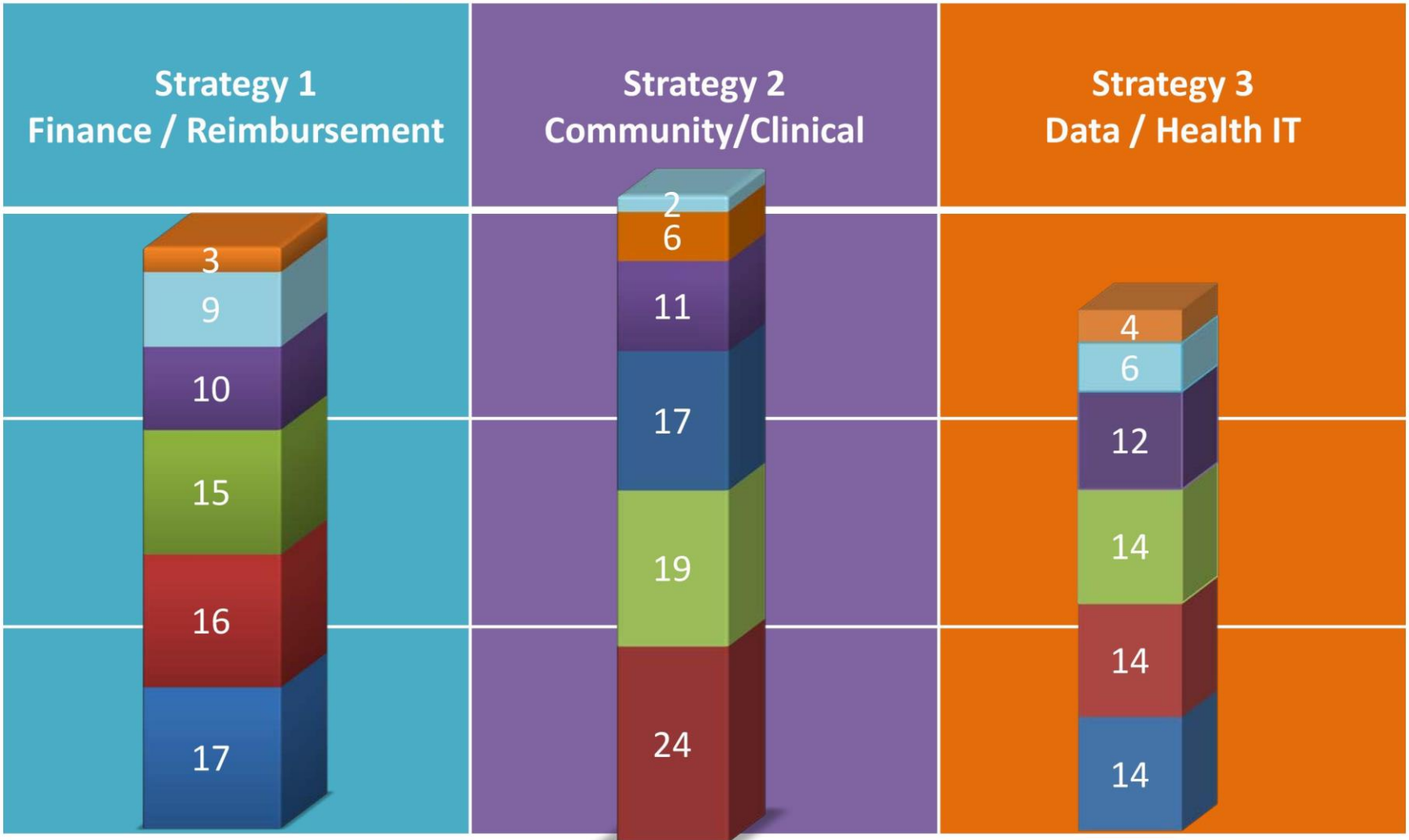
Barriers to Implementation



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

Strategy Summaries

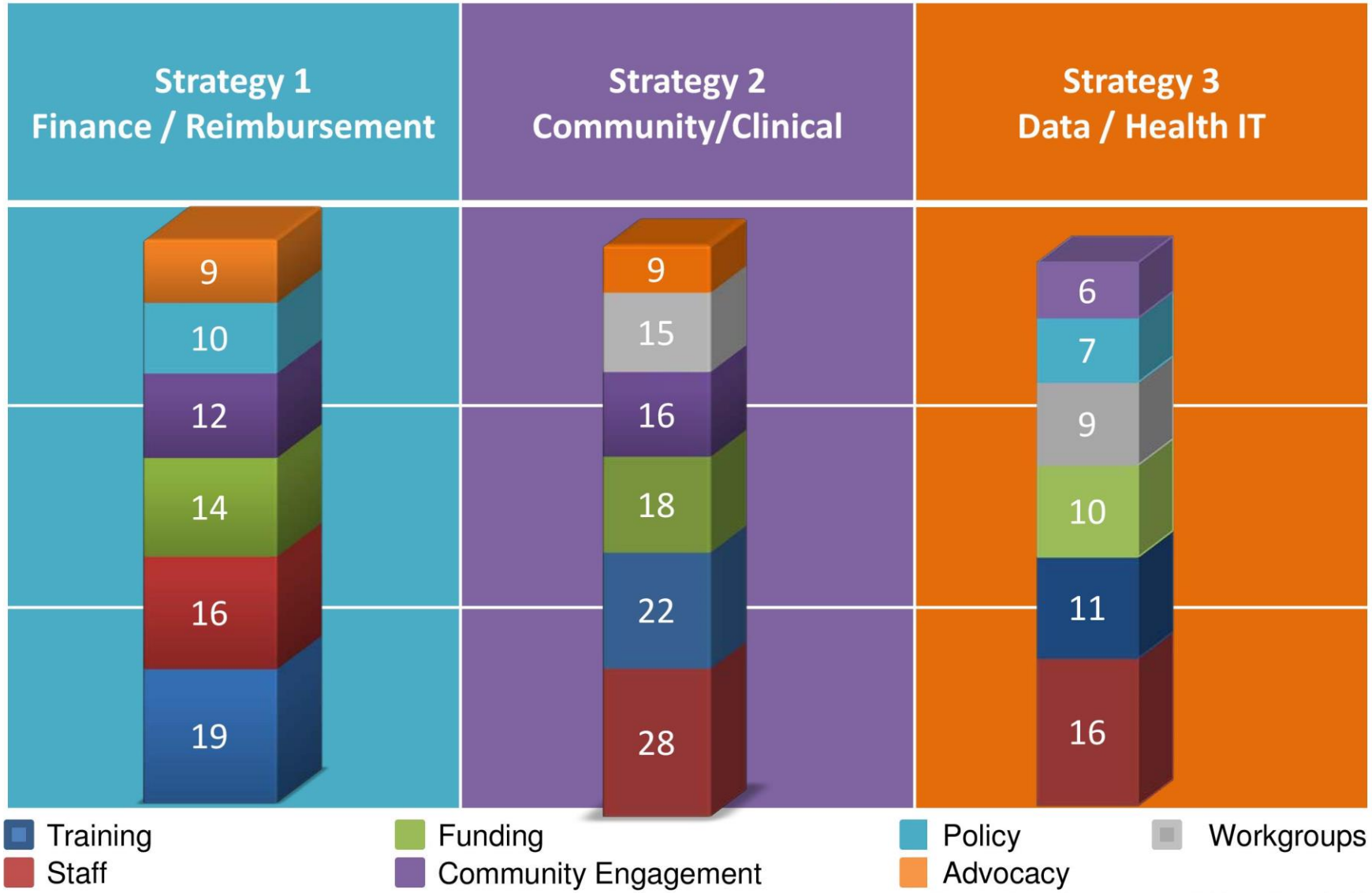
Key Measures / Data for Evaluation



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

Strategy Summaries

Resources Dedicated to Implementation



Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

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

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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

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Source: *Statewide assessment of Diabetes Strategies (Jan 2017)*

How to address Diabetes in Illinois

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

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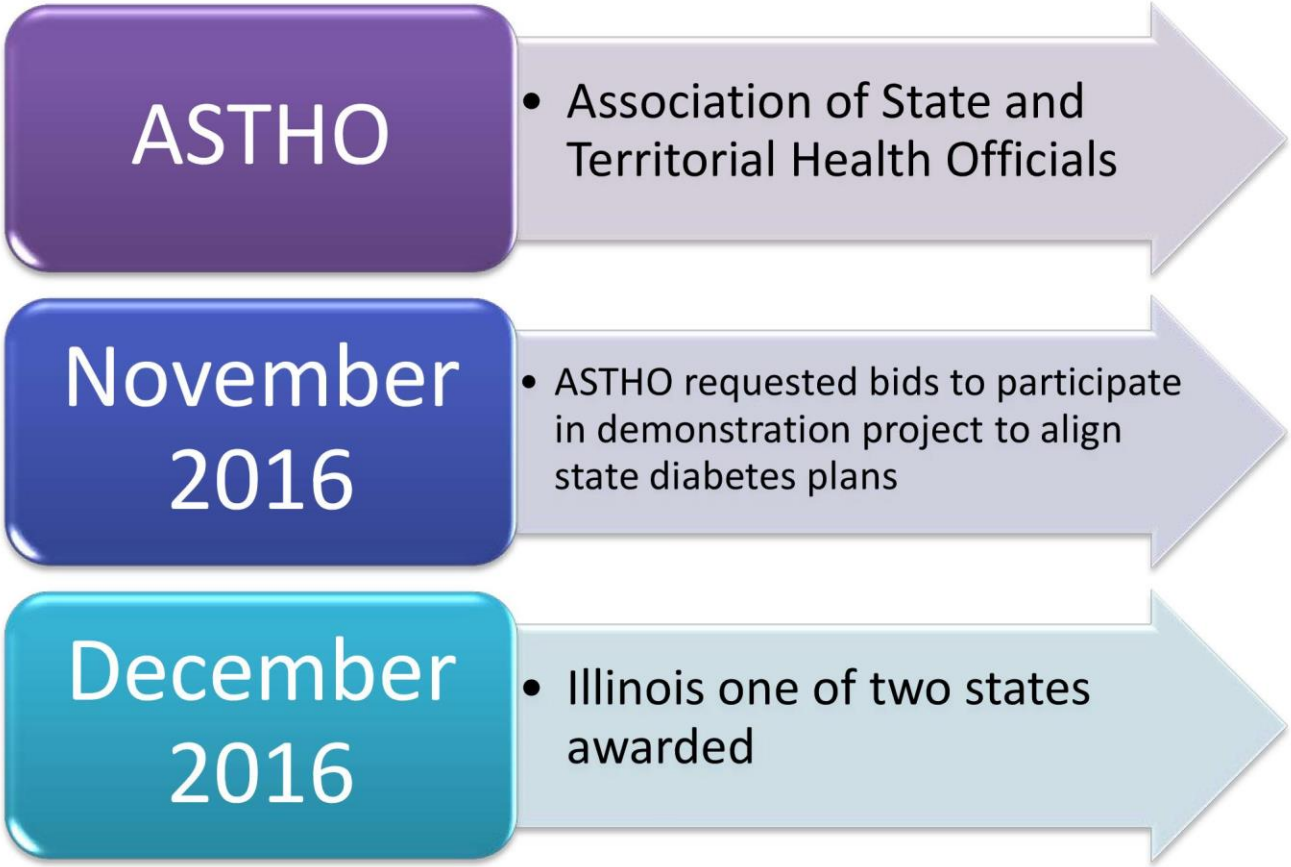
ASTHO Grant Overview



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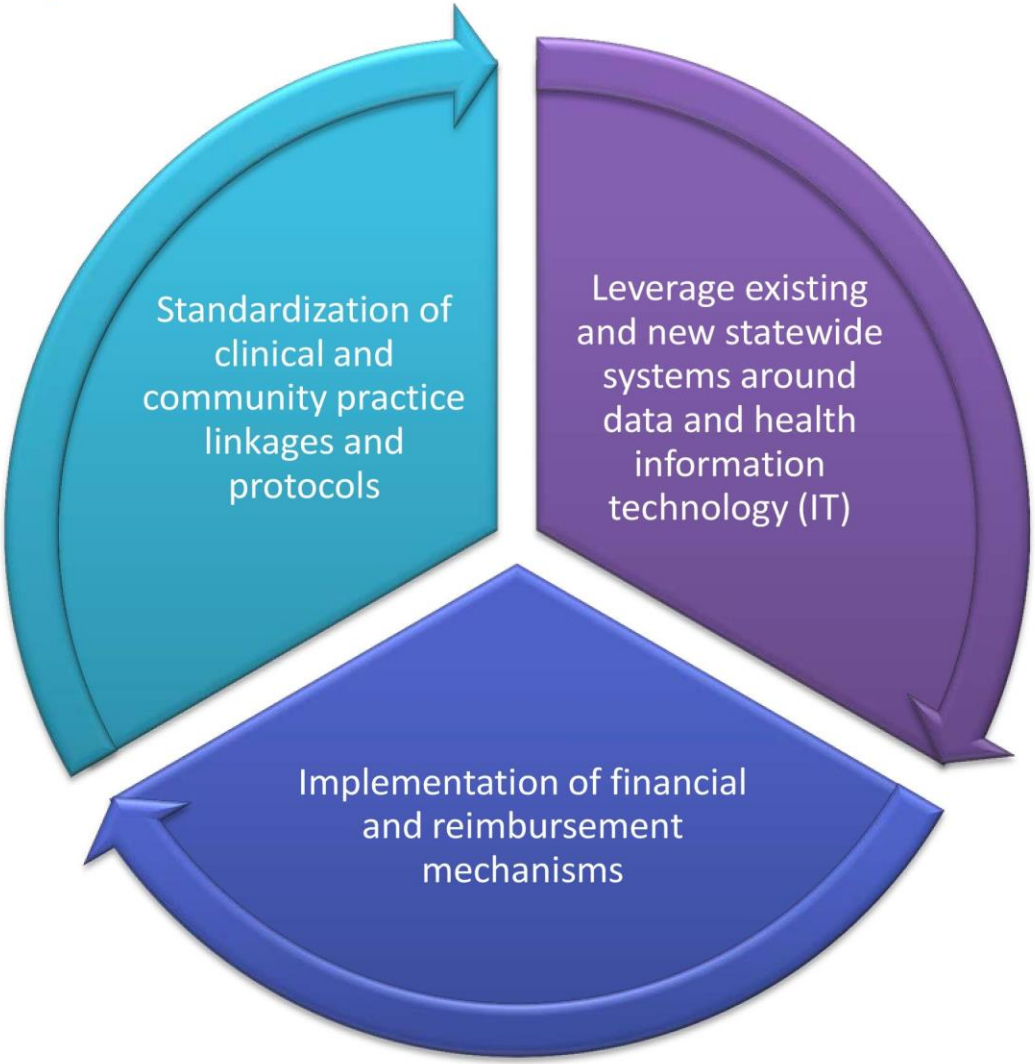
Priority Areas for Diabetes State Plan



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Priority: Data and Health IT

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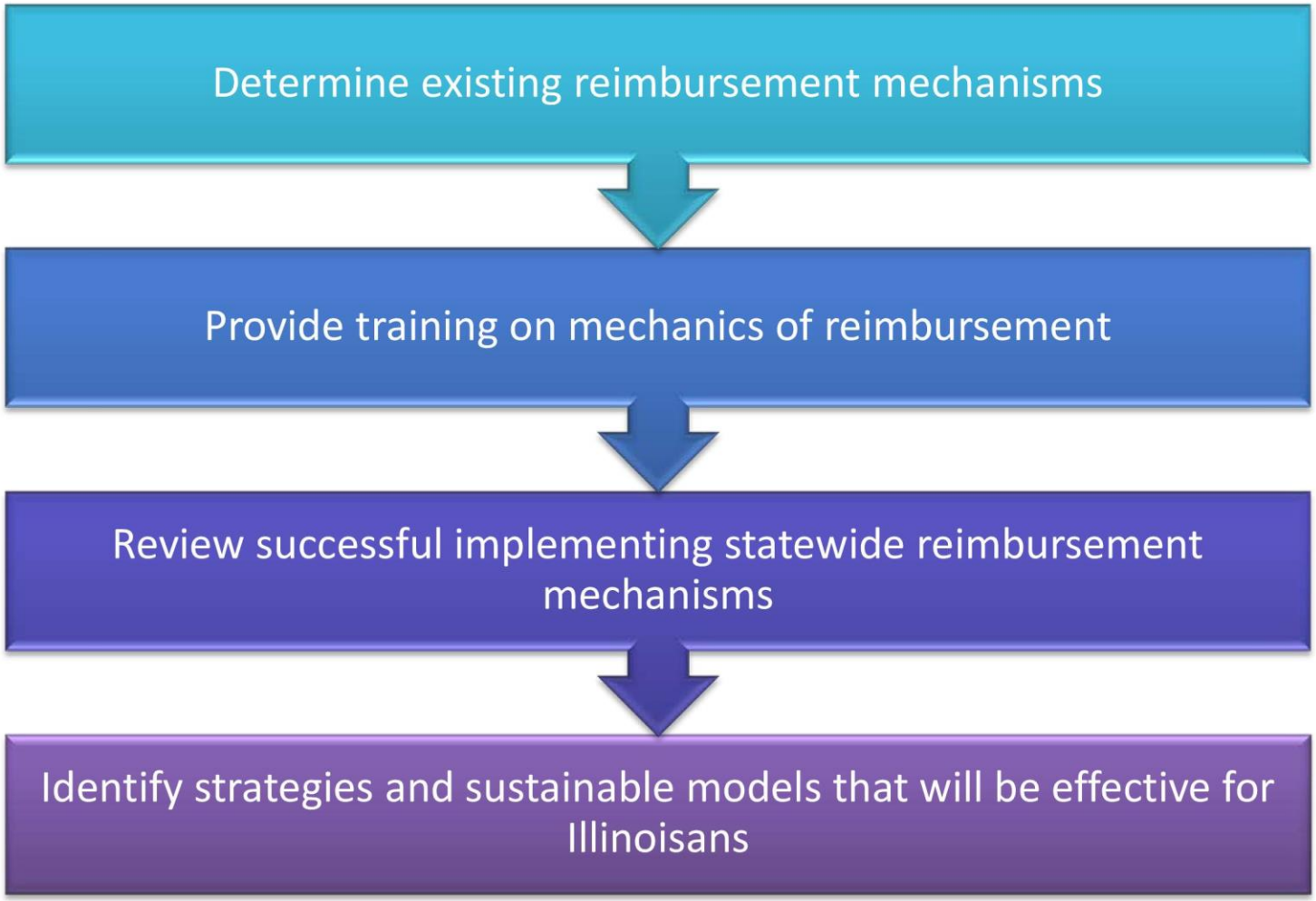
Priority: Reimbursement



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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

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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

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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*

Priority Area #1	Leverage existing and statewide systems around data and health IT
Priority Area #2	Implementation of financial and reimbursement mechanisms
Priority Area #3	Standardization of clinical and community practice linkages and protocols

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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

NATIONAL Minority Quality Forum

Controlling Health Outcomes:
for Patients Living with Diabetes

AADE American Association of Diabetes Educators

NATIONAL Minority Quality Forum

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

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BEYOND
HEALTH DISPARITIES

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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.

21st 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 21st century is to take command of our future as it relates to the existential struggle to survive. The 21st century is about building sustainable healthy communities.

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BUILDING
SUSTAINABLE COMMUNITIES

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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.

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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.

Healthy People 2020

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.

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NATIONAL Minority Quality Forum

The NMQF Contribution

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National Minority Quality Forum (NMQF)

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.

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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

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Big Data: Challenges and Solutions

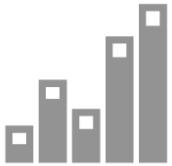
CHALLENGES

Volume

Rapidly changing

Complex technology platforms

Different data sets



Expert analysis required

Outputs not always actionable, understandable

A SOLUTION

MAKE IT VISUAL

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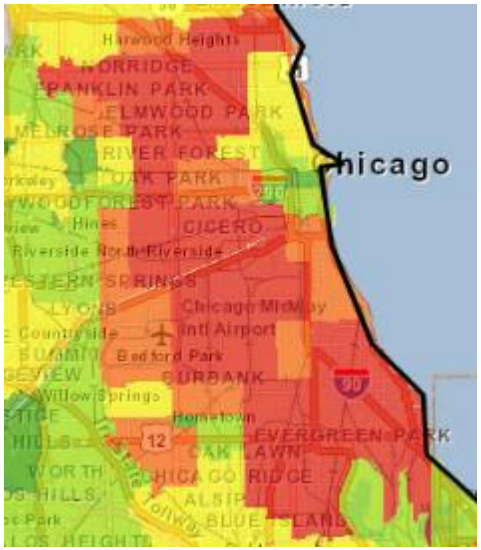
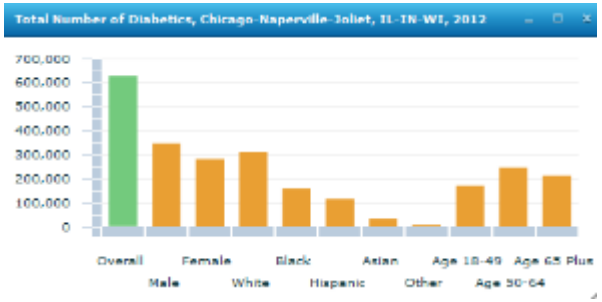
GIS-based Data Visualization

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





u.s. diabetes INDEX

NATIONAL Minority Quality Forum

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Key Learnings

Geography matters

Predictable forces shape markets

Consumption patterns can be shaped

Resource management can be improved

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The Diabetes Epidemic in the United States

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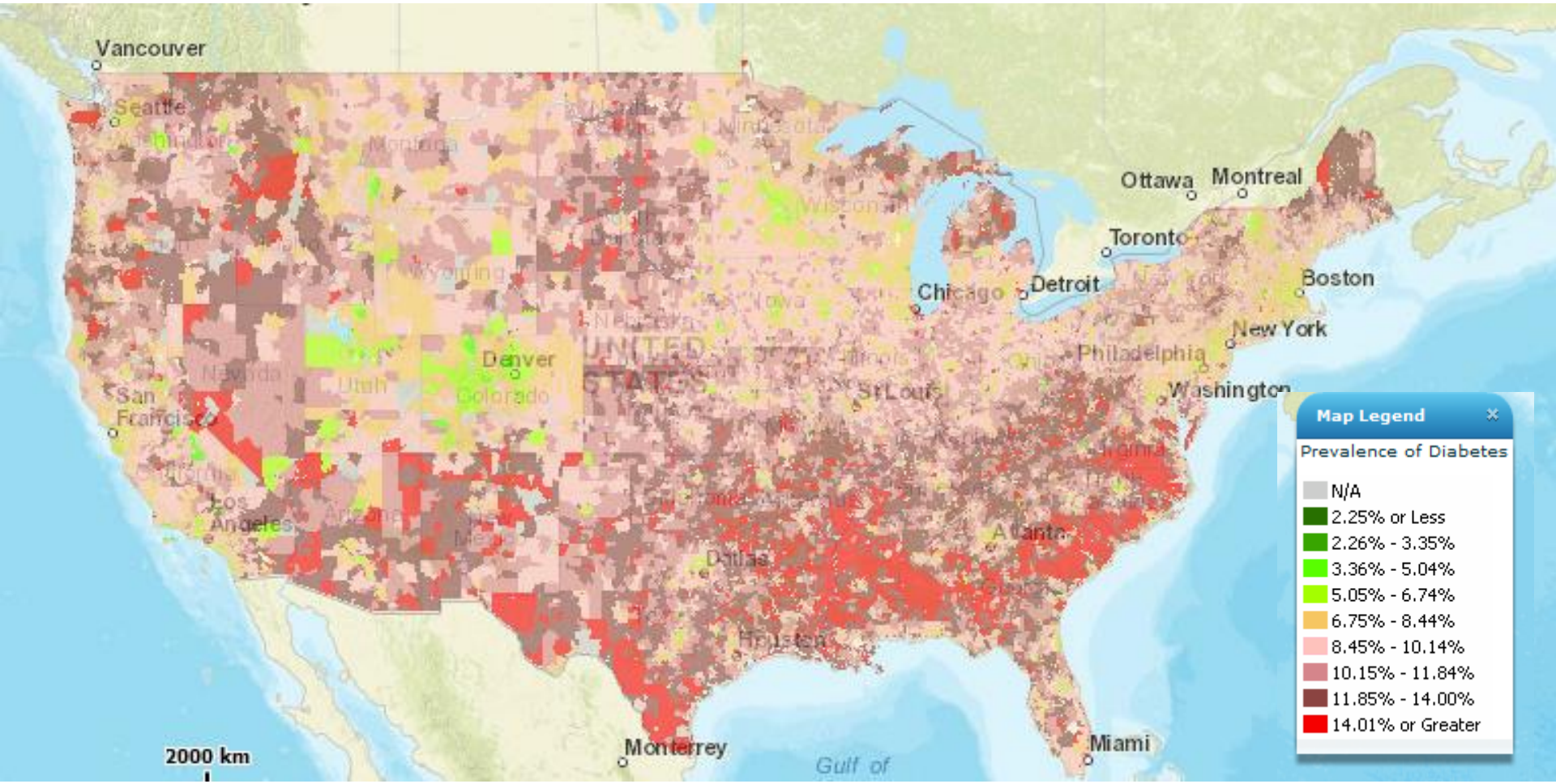
Diabetes Epidemic 2014



Hospital Encounters Per 100 People with Diabetes

Year	Total	White	Black	Hispanic	Other
2006	45.5	46.6	44.9	41.6	43.0
2007	46.6	48.3	46.4	36.8	51.8
2008	48.9	54.0	47.4	29.3	46.8

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Diabetes Consumption Patterns in A Medicare Fee for Service Population 2000-2014

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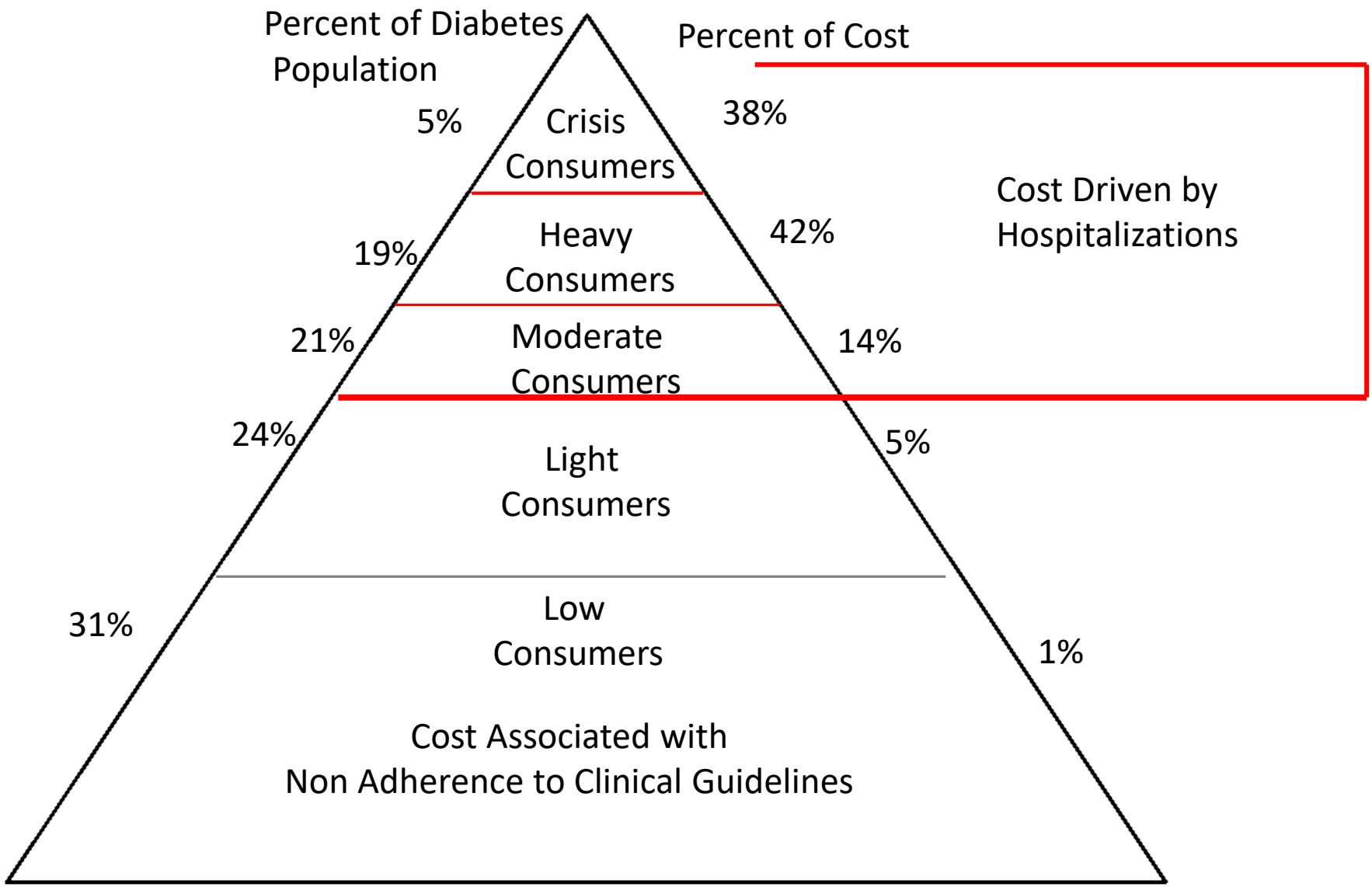
The Diabetes Acute Care Pyramid



African American Consumption Patterns

Diabetes Consumption Groups

		Total	
		No.	%
	Cluster		
2000	Crisis Consumers	120,992	2%
	Heavy Consumers	732,797	15%
	Moderate Consumers	1,039,763	21%
	Light Consumers	1,450,210	29%
	Low Consumers	1,611,638	33%
	Total	4,955,400	100

		Total	
		No.	%
	Cluster		
2009	Crisis Consumers	164,064	2%
	Heavy Consumers	1,009,131	14%
	Moderate Consumers	1,486,655	20%
	Light Consumers	2,097,069	29%
	Low Consumers	2,529,871	35%
	Total	7,286,790	100

		Total	
		No.	%
	Cluster		
2014	Crisis Consumers	113,344	2%
	Heavy Consumers	753,821	13%
	Moderate Consumers	1,129,554	20%
	Light Consumers	1,616,470	29%
	Low Consumers	1,991,310	36%
	Total	5,604,499	100

Diabetes Consumption Patterns

		In 2001 Beneficiaries migrating to:										Died	
		Crisis Consumers		Heavy Consumers		Moderate Consumers		Light Consumers		Low Consumers			
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Migrating from:	Cluster												
2000	Crisis Consumers	29,449	24.3	51,815	42.8	23,770	19.6	10,856	9	5,102	4.2	36,903	30.50%
	Heavy Consumers	53,168	7.3	262,131	35.8	204,039	27.8	135,025	18.4	78,434	10.7	135,567	18.50%
	Moderate Consumers	27,039	2.6	210,688	20.3	342,145	32.9	287,782	27.7	172,109	16.6	100,857	9.70%
	Light Consumers	18,861	1.3	164,678	11.4	305,791	21.1	576,618	39.8	384,262	26.5	73,961	5.10%
	Low Consumers	11,378	0.7	108,513	6.7	183,205	11.4	358,407	22.2	950,135	59	61,242	3.80%
	Total	139,895	2.8	797,825	16.1	1,058,950	21.4	1,368,688	27.6	1,590,042	32.1	411,298	8.30%

Diabetes Consumption Patterns

		In 2005 Beneficiaries migrating to:										Died	
		Crisis Consumers		Heavy Consumers		Moderate Consumers		Light Consumers		Low Consumers			
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Migrating from:	Cluster												
2004	Crisis Consumers	38,797	25.2	65,469	42.5	30,999	20.1	12,676	8.2	6,087	4	46,054	29.90%
	Heavy Consumers	65,852	7	339,955	36.1	266,050	28.3	169,565	18	99,296	10.6	160,863	17.10%
	Moderate Consumers	33,196	2.4	269,326	19.6	454,873	33.2	387,112	28.2	227,460	16.6	117,989	8.60%
	Light Consumers	20,443	1.1	197,179	10.5	391,594	20.8	732,004	38.8	544,969	28.9	81,106	4.30%
	Low Consumers	13,252	0.6	131,749	5.9	237,886	10.7	478,673	21.5	1,360,297	61.2	73,321	3.30%
	Total	171,540	2.6	1,003,678	15.3	1,381,402	21	1,780,030	27.1	2,238,109	34	479,957	7.30%

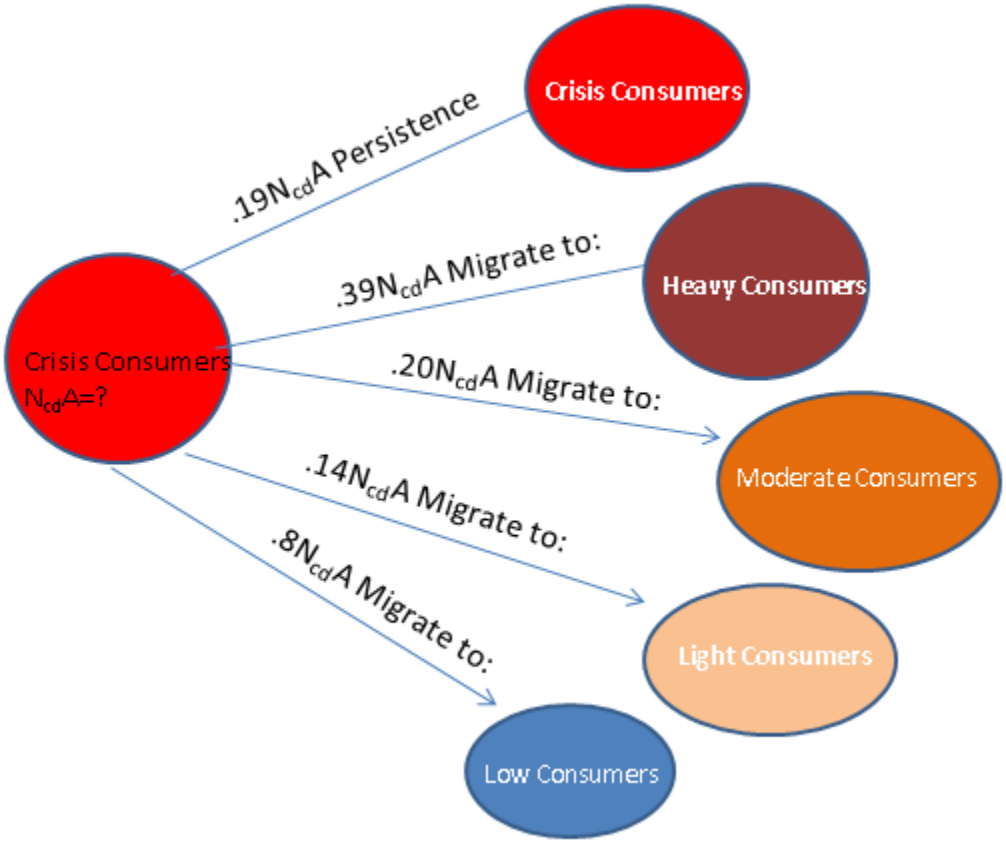
Diabetes Consumption Patterns

		In 2014 Beneficiaries migrating to:										Died	
		Crisis Consumers		Heavy Consumers		Moderate Consumers		Light Consumers		Low Consumers			
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Migrating from:	Cluster												
2013	Crisis Consumers	27,423	24.2	49,817	44	22,179	19.6	9,390	8.3	4,535	4	113,344	29.30%
	Heavy Consumers	51,670	6.9	288,495	38.3	206,074	27.3	133,596	17.7	73,986	9.8	753,821	16.40%
	Moderate Consumers	27,051	2.4	226,929	20.1	382,425	33.9	320,141	28.3	173,008	15.3	1,129,554	7.30%
	Light Consumers	16,919	1	169,524	10.5	336,425	20.8	648,138	40.1	445,464	27.6	1,616,470	3.60%
	Low Consumers	11,432	0.6	113,783	5.7	198,827	10	431,061	21.6	1,236,207	62.1	1,991,310	2.60%
	Total	134,495	2.4	848,548	15.1	1,145,930	20.4	1,542,326	27.5	1,933,200	34.5	5,604,499	6.20%

Diabetes Consumption Patterns: Crisis Consumers

Crisis Migration Patterns						
Year	Crisis	Heavy	Moderate	Light	Low	Died
2000	24	43	20	9	4	31
2009	27	43	18	7	4	29
2013	24	44	20	8	4	29

Crisis Consumer Migration Patterns



Source data: Medicare Claims 2012

Cluster Analysis: Diabetes Medicare Fee for Service 2014

Description	Number of Zip Codes	Total Number of Benes	Percent of all	Cumm Percent
15 Ethnic mixed (WNH 63%), esp Calif and TX, middle income	**3,177**	**2,786,499**	**32%**	**32%**
13 BNH majority, low income, low private health insurance, south eastern states	**1,460**	**1,256,804**	**14%**	**46%**
18 Hispanic majority, esp Texas, high poverty	**1,350**	**1,086,181**	**12%**	**59%**
10 middle income WNH	960	629,116	7%	66%
06 metro sububs, WNH, mortgage home owners, family, above average income	970	621,442	7%	73%
01 Metro centre and suburbs, 79% WNH	873	527,037	6%	79%
17 WNH, high poverty, low college, Kentucky, West Virginia, Tenn, Oklah	1,010	472,828	5%	85%
12 WNH 93%, middle income, midwest	759	410,245	5%	90%
09 WNH majority (90%), low income, low college (19%), but poverty not high, rust belt	736	297,618	3%	93%
19 Metropolitan, high turnover, high renting, many one person hhlds, college 59%	528	239,340	3%	96%
02 Metropolitan centre, high turnover and renting, family, high income and college	221	215,369	2%	98%
14 WNH and Asian groups, above average income, college 49%, esp Calif	79	54,044	1%	99%
04 metro sububs, WNH, mortgage home owners, family, very high income and college	137	47,203	1%	99%
20 middle income commuting areas, WNH 88%	154	32,824	0%	100%
05 non metro retirement areas	22	6,498	0%	100%
03 Rural areas, low population density, large farming sector	59	5,229	0%	100%
08.3 high poverty and unemployment, Hispanic	17	4,559	0%	100%
16 Native American majority	10	3,345	0%	100%
08.1 high unemployment, Poor, WNH	7	2,767	0%	100%
11 Hawaii	14	936	0%	100%
07 High turnover, academic	2	61	0%	100%
		8,699,945		

NATIONAL Minority Quality Forum

Diabetes In Zip Code 60620 Medicare Fee For Service 2013

AADE American Association of Diabetes Educators

Zip Code 60620: Consumption Patterns

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

Zip Code 60620: Average Per Bene Cost

Consumption Group	# Benes	Total All Cause Cost	Average Per Patient Cost	Total Inpatient Cost	% Total Cost	Average Per Patient Cost
Crisis Consumers	196	$27,325,084	$139,414	$15,102,092	55%	$77,051
Heavy Consumers	599	$26,485,528	$44,216	$9,832,244	37%	$16,414
Moderate Consumers	743	$9,885,760	$13,305	$1,570,811	16%	$2,114
Light Consumers	425	$1,624,537	$3,822	$56,476	3%	$133
Low Consumers	633	$581,277	$918	$0	0%	$0
Total	2,596	$65,902,186	$25,386	$26,561,623	40%	$10,232

Zip Code 60620: Hospital Encounters

Consumption Group	# Benes	Unique ER Visits	Unique Inpatient Stays	Hospital Encounters	% Hospital Encounters
Crisis Consumers	196	628	847	1,475	8
Heavy Consumers	599	738	944	1,682	3
Moderate Consumers	743	201	249	450	1
Light Consumers	425	15	17	32	0.08
Low Consumers	633	4	9	13	0.02
Total	2,596	1,586	2,066	3,652	1.41

Zip Code 60620: Physician Profile

Consumption Group	# Benes	Total All Cause Cost	Unique Inpatient Stays	Total Inpatient Cost	Unique ER Visits	Hospital Encounters	% Hospital Encounters
Crisis Consumers	4	$586,864	19	$248,933	17	36	9
Heavy Consumers	5	$236,763	7	$63,997	7	14	2.8
Moderate Consumers	7	$108,703	2	$7,207	1	3	0.43
Total	16	$932,330	28	$320,136	25	53	3.3125

SYED A ATHER M.D
Offices At:
10661 S ROBERTS RD
Suite 103
PALOS HILLS, Illinois 60465-1954

NATIONAL Minority Quality Forum

CLOSING THOUGHTS

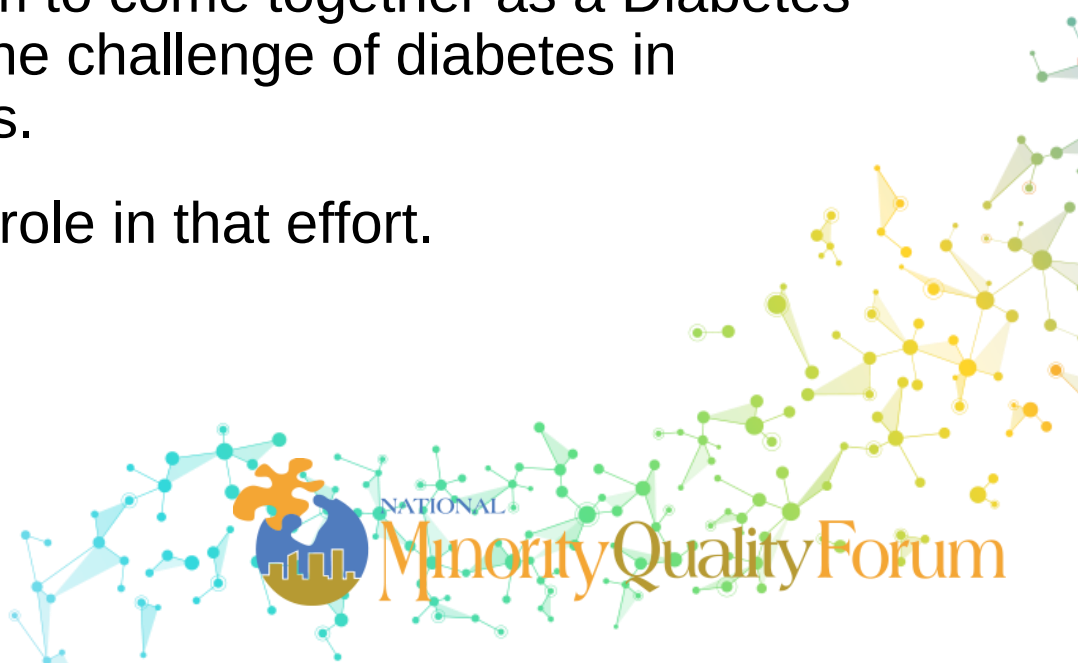
AADE American Association of Diabetes Educators

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

American Diabetes Association.

AADE American Association of Diabetes Educators

TODAY'S DISCUSSION

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

Everyone's invited to play!

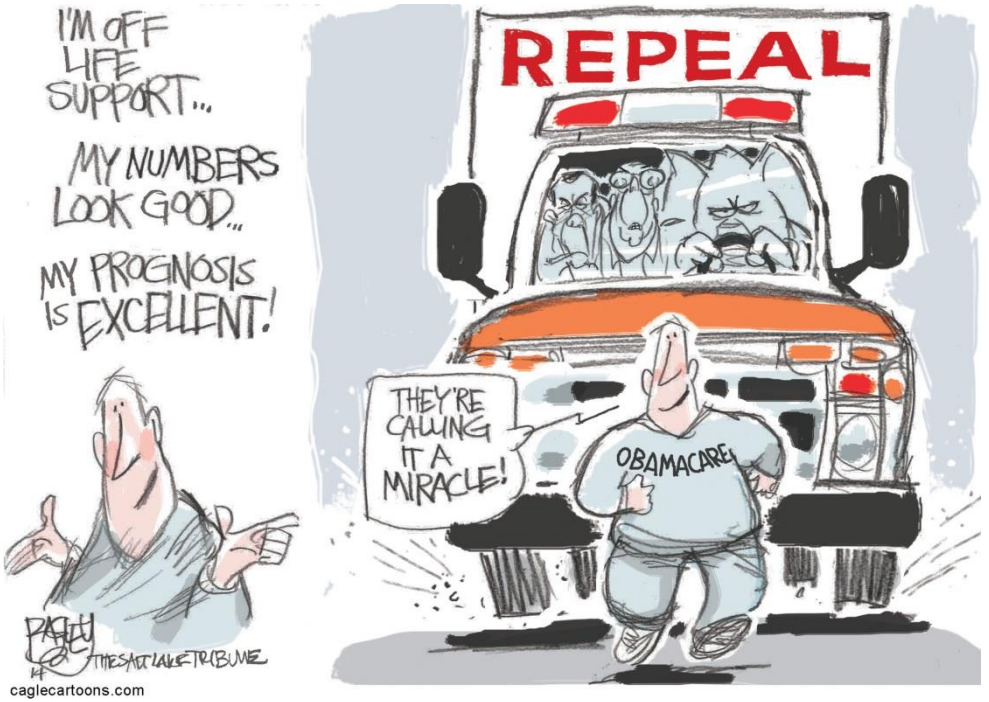
THE FIGHT TO PRESERVE HEALTH CARE

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

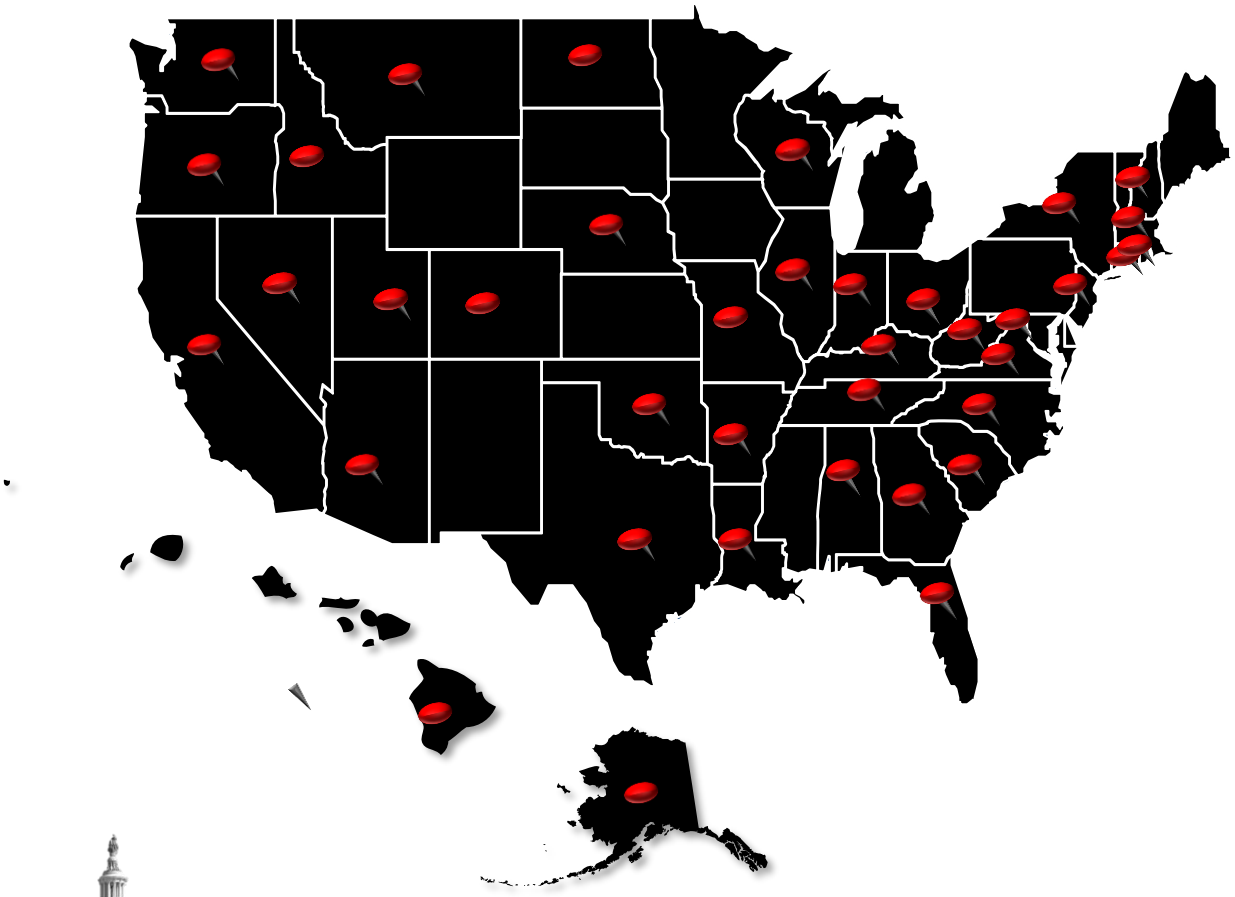
Main Goals

- 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

SCHOOL DIABTES CARE LAWS/REGULATION



Alabama
Alaska*
Arizona
Arkansas
California
Colorado*
Connecticut
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Kentucky
Louisiana
Maryland
Massachusetts
Missouri
Montana
Nebraska
New Hampshire
New Jersey
New York
Nevada*
North Carolina
North Dakota*
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Texas
Utah*
Virginia
Washington
West Virginia
Wisconsin

American Diabetes Association.

AADE American Association of Diabetes Educators

**Achieved through Board of Nursing Regulation*

DRIVER'S LICENSING & LAW ENFORCEMENT

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

REDUCING DISPARITIES THROUGH STATE POLICY

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

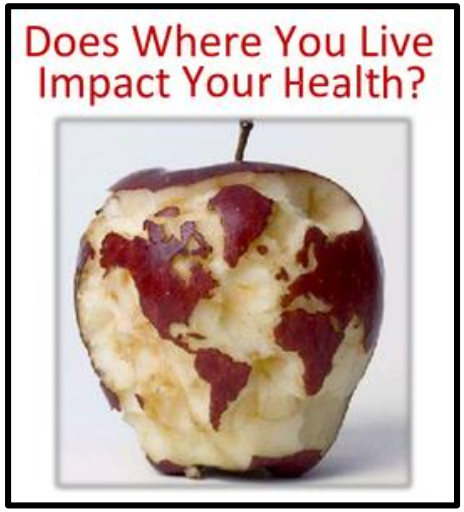
ADDRESSING INADEQUACIES IN HEALTH CARE

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

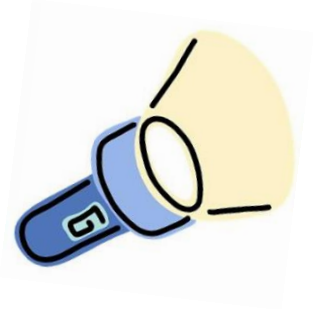
PRIMARY PREVENTION OF TYPE 2 DIABETES

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:

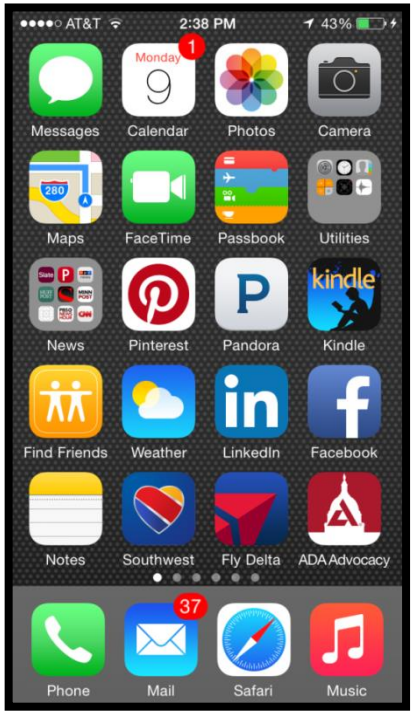
- 15 health care wins
- 12 discrimination wins
- 27 prevention and health disparity wins
- 4 state coordination on diabetes wins
- 2 research funding/policy wins

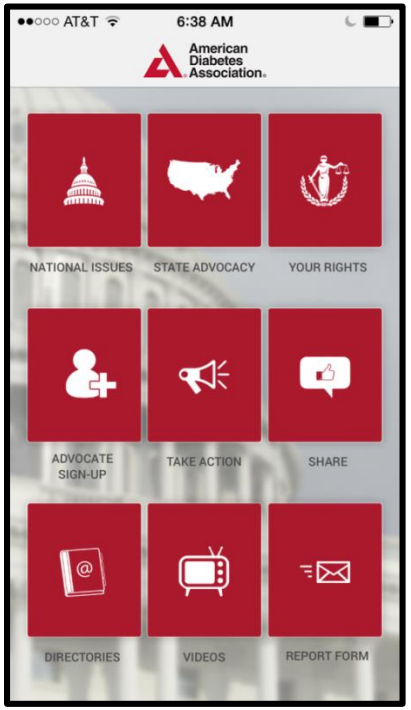
ADVOCACY WORKS BECAUSE…

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

GET INVOLVED

Sign up to be an Advocate





Available on the App Store

iPhone and iPad Users

Search Diabetes Advocacy at the Apple App Store

ANDROID APP ON Google play

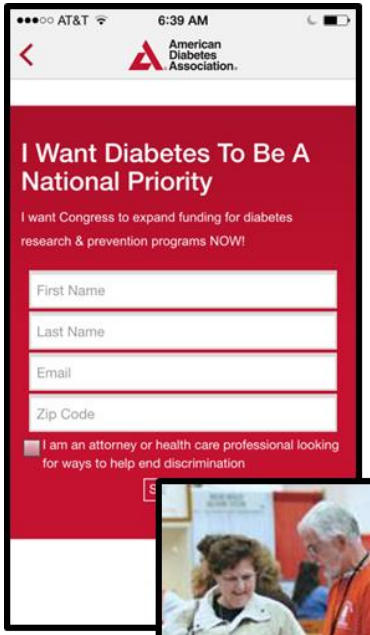
Android Users

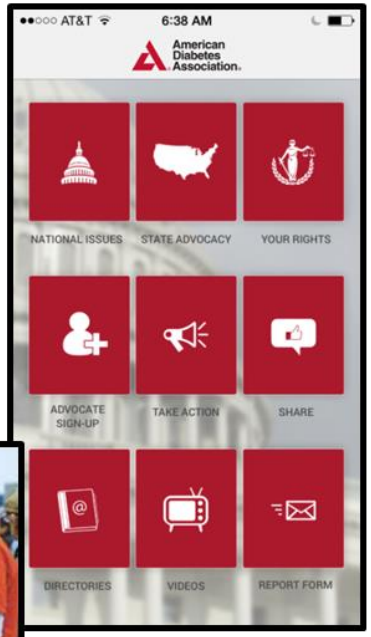
Search Diabetes Advocacy at the Google play store

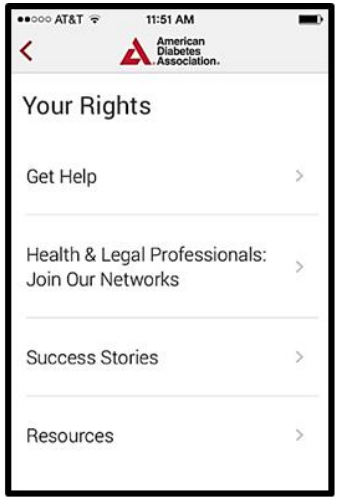
American Diabetes Association.

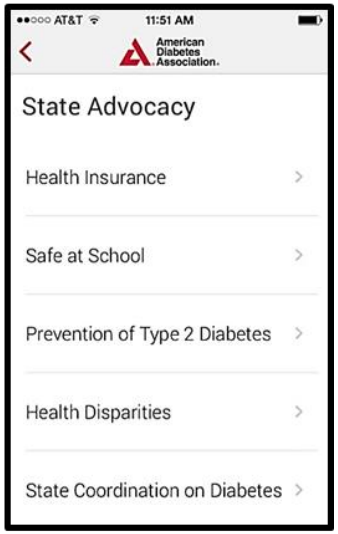
AADE American Association of Diabetes Educators

BE A VOICE FOR YOUR PATIENTS





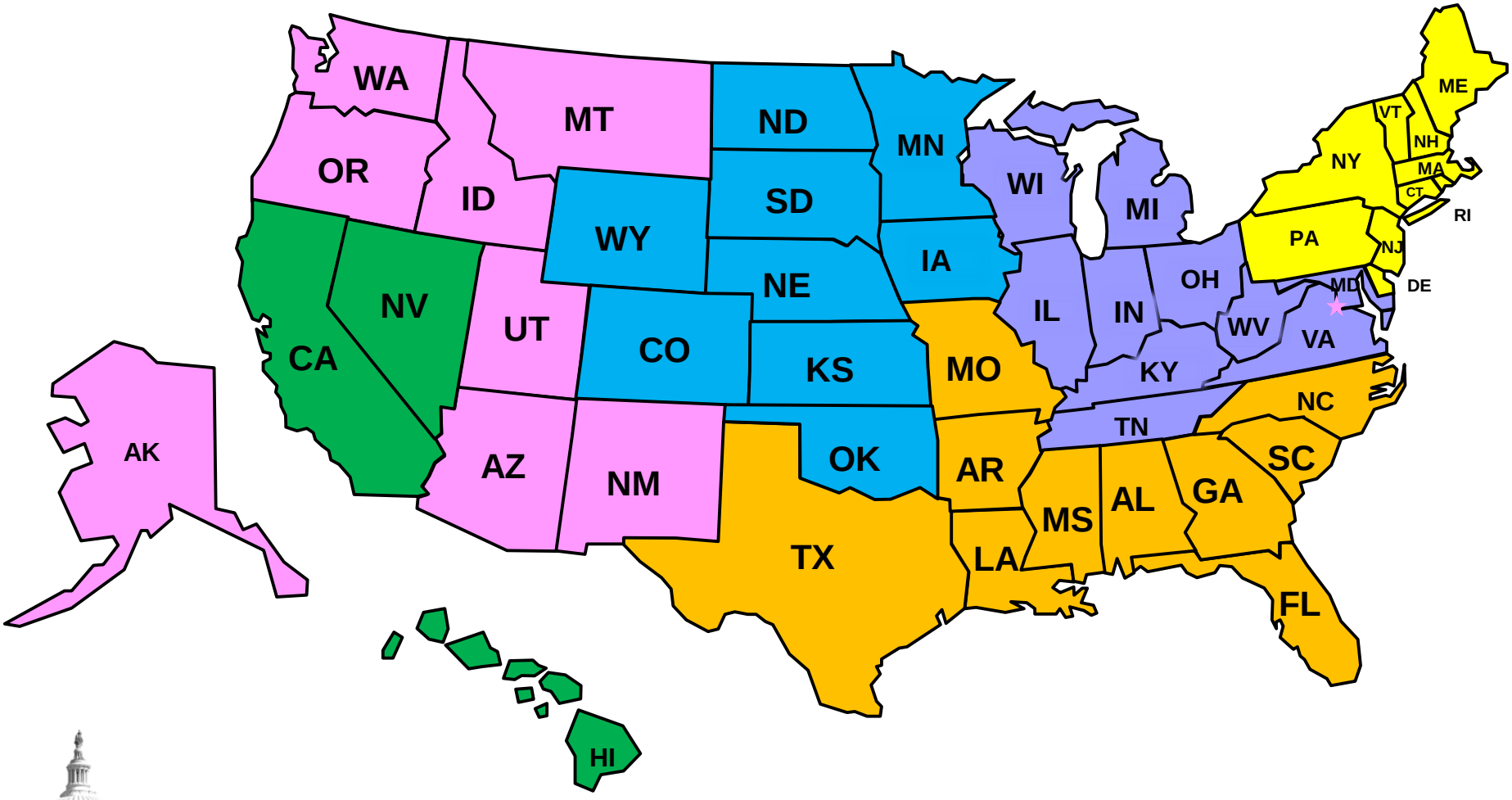




American Diabetes Association.

AADE American Association of Diabetes Educators

CONNECT WITH ADA LOCALLY



American Diabetes Association.

AADE American Association of Diabetes Educators

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Lisa Murdock
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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

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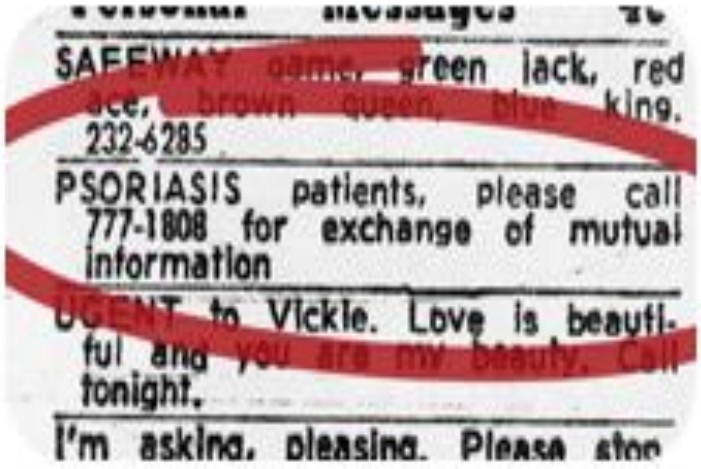
National Psoriasis Foundation

- Celebrating 50 years – Beverly Foster
- Driven by a strategic plan
- Decades of advocacy
- Pivot to the states - 2014



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50 YEARS

NATIONAL PSORIASIS FOUNDATION®

Creation of a State Advocacy Team

- Establishing a presence
- Engaging current assets
- Creating new assets
- Thought leadership
- Direct leadership

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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

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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

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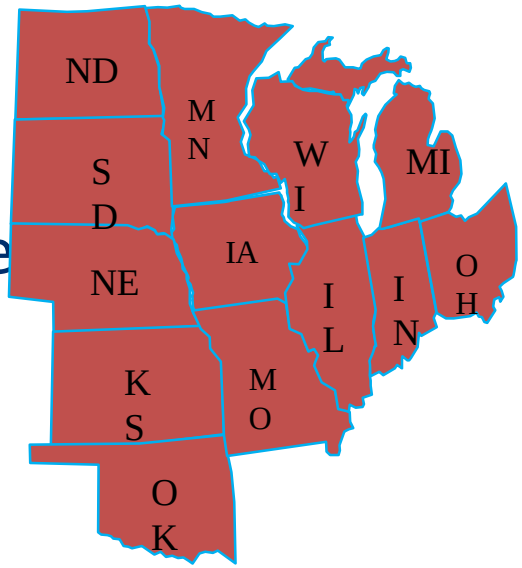
Midwest Advocacy Action Network

13 States

MaryAnn McCabe

Deborah Barnard



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Southern Advocacy Action Network

14 States

Amy Prentice

Noreen Kennedy

New ATL CDM

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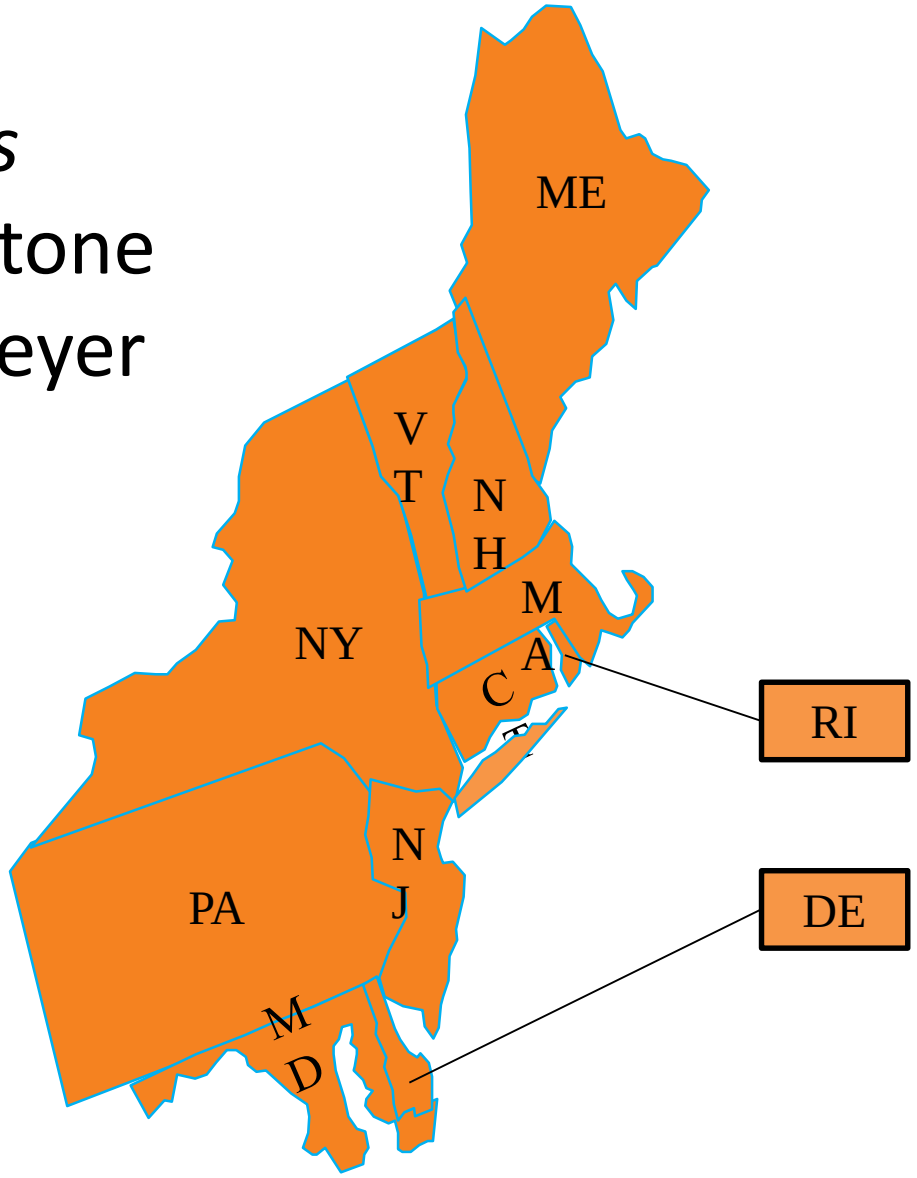
Northeast Advocacy Action Network

- *11 States*
- Patrick Stone
- Kim Schleyer



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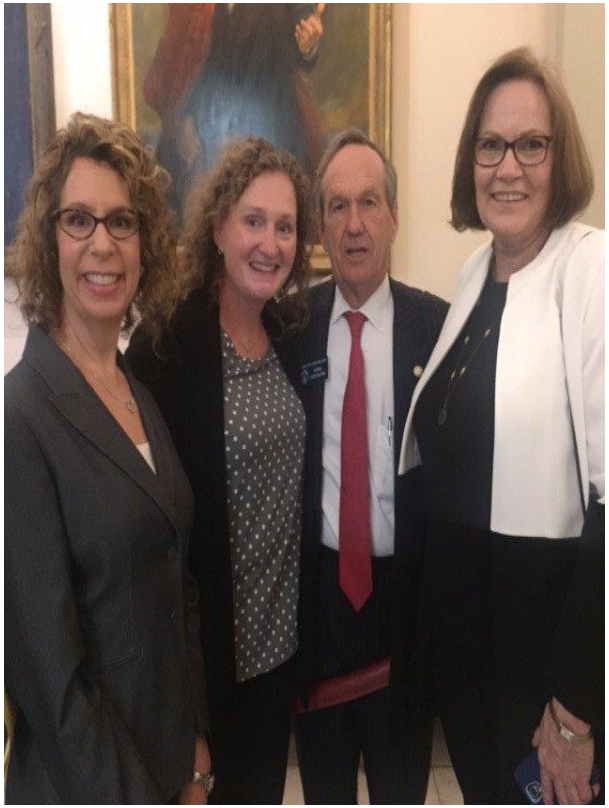
Elevating the Patient Voice

NATIONAL PSORIASIS FOUNDATION®

Elevating the Patient Voice



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Lobby Days

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Press

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NPF State Government Relations Team

Amy Prentice
State Government
Relations Manager
aprentice@psoriasis.org

For more information, please contact:
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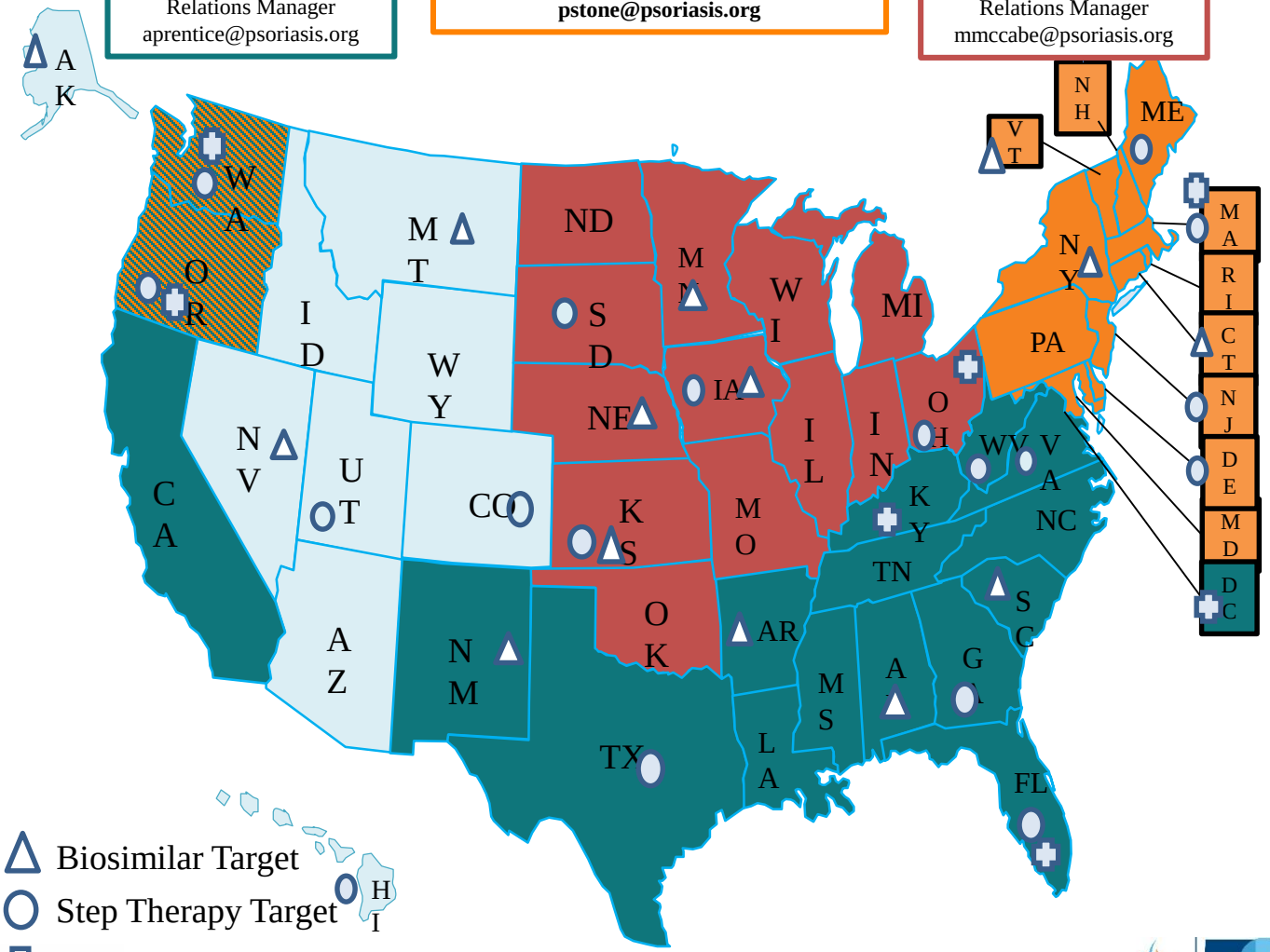

- Biosimilar Target
- Step Therapy Target
- Out-of-Pocket Target
- Patrick ST / Amy OOP

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

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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
- National Psoriasis Foundation
- 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

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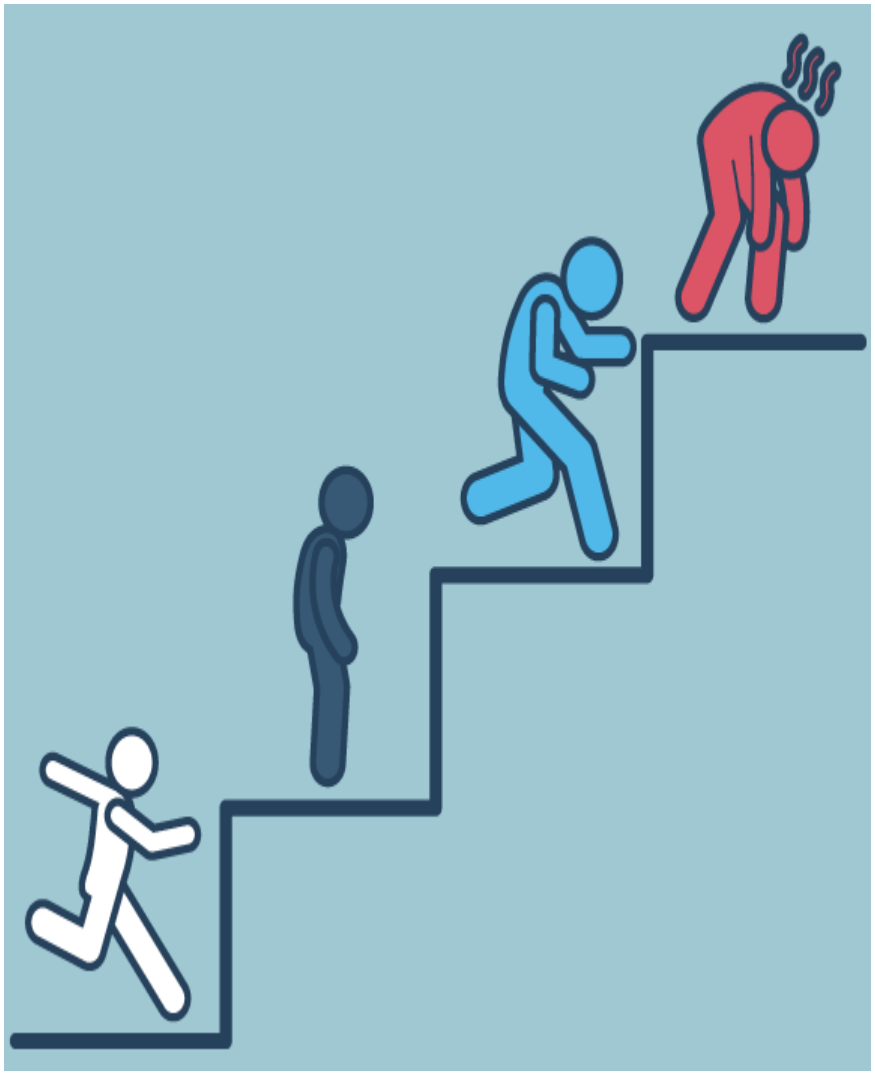
What is Step Therapy?
www.StepTherapyInfo.co



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What is Step Therapy?

https://www.youtube.com/watch?v=zg6mjEnUMv0

https://www.youtube.com/watch?v=zg6mjEnUMv0

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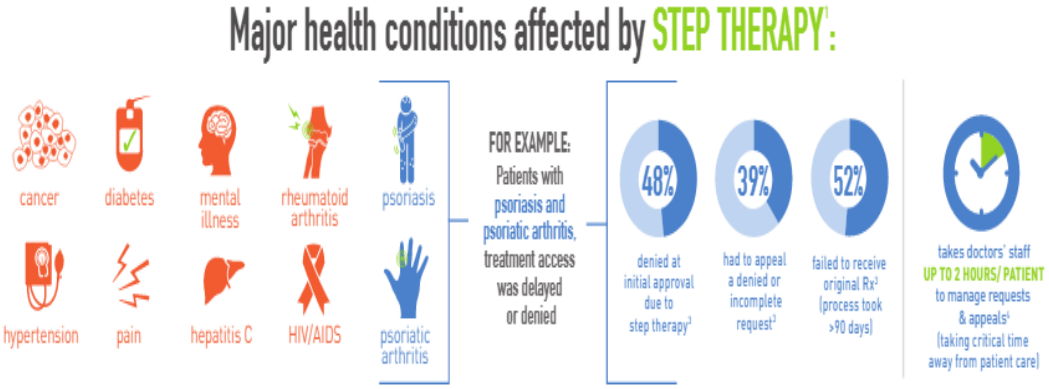
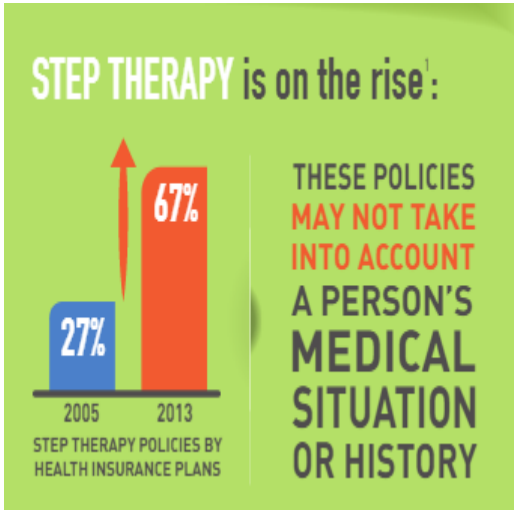
Step Therapy Explained

- 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 provide 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

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Starting a campaign

- Precedent in Connecticut, Louisiana…
- Defining capabilities
- Building on existing relationships
- Focused target states
- Define the problem…

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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

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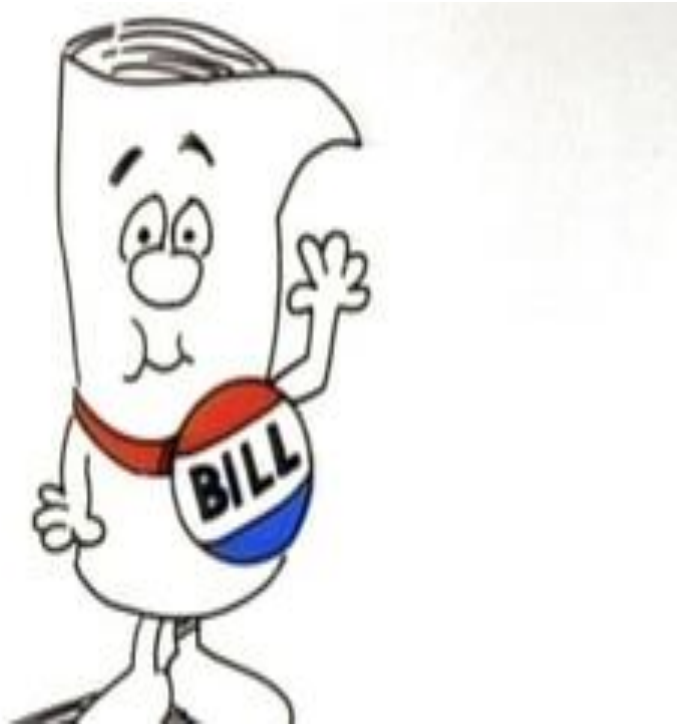
What does the bill do?

- Clinical Review
- Transparency
- Timelines
- Defining an ove



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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

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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.

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Step Therapy Overrides

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.

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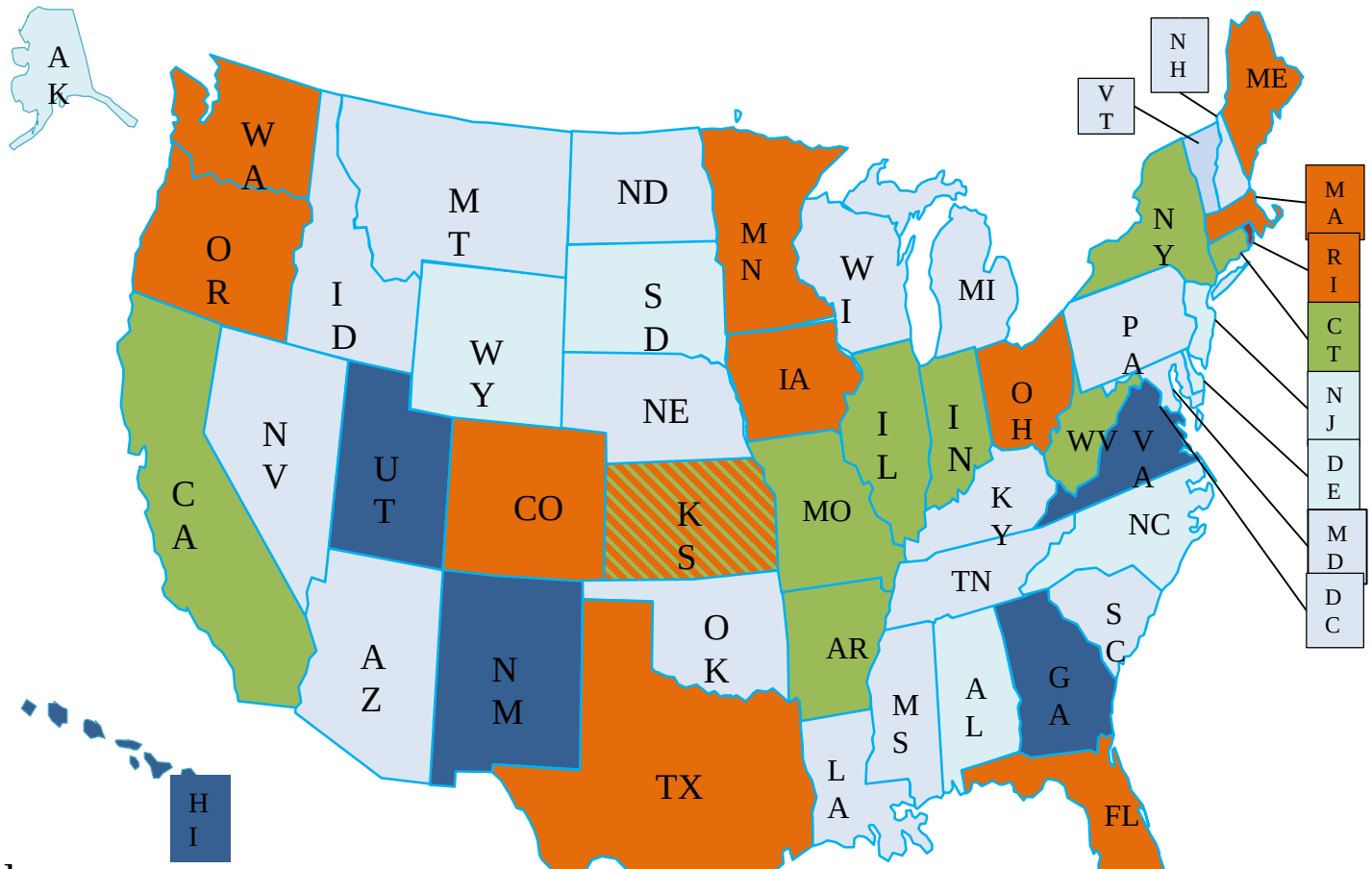
Lessons Learned



Enacted

Pending

Failed to advance in 2017

*Kansas passed protections for Medicaid - bill for the commercial space is pending

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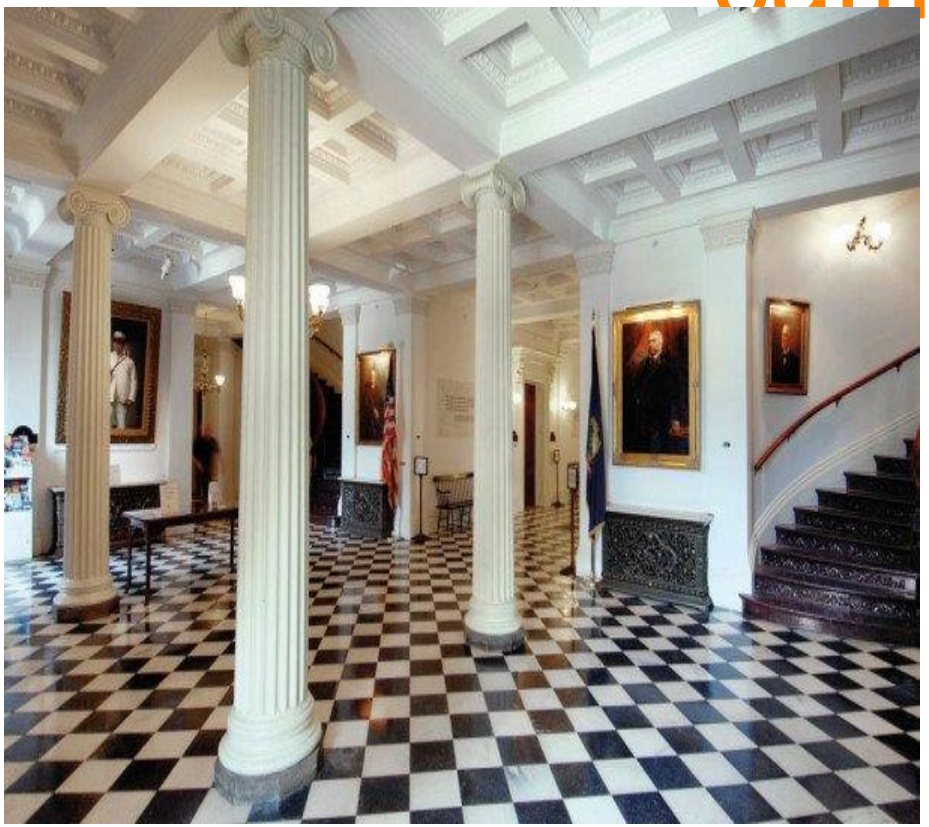
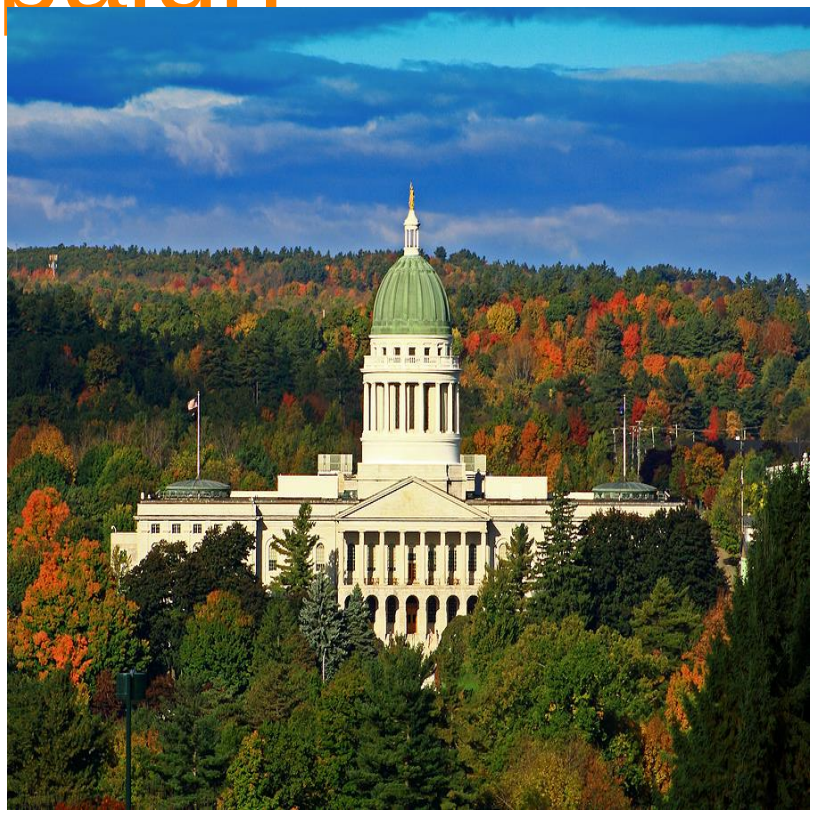
Lessons from the campaign





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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

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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

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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

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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 **E**DUCATION
ACCREDITATION **P**ROGRAM

DIABETES **E**DUCATION **A**S 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!

HEDIS MEASURES - Healthcare Effectiveness Data and Information Set

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.

www.ncqa.org/hedis-quality-measurement

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

www.Medicare.gov

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%

Strawbridge, L. M., Lloyd, J. T., Meadow, A., Riley, G. F., & Howell, B. L. (2015). Use of Medicare's Diabetes Self-Management Training Benefit. *Health Education & Behavior*, 1090198114566271

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 contract time was ≤ 10 hours, only 42% of the DSME was more effective than controls.

Diabetes self-management education for adults with type 2 diabetes mellitus: A systematic review of the effect on glycemic control - Carole A. Chrvala, Dawn Sherr,*, Ruth D. Lipman

We know it works…….

Multiple studies and papers have demonstrated benefits and cost savings

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

Garfield, Katie, Center for Health Law and Policy Innovation of Harvard Law School. *Reconsidering Cost-Sharing for Diabetes Self-Management Education: Recommendation for Policy Reform*

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, CDE2,41UPMC, 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

Irene M. Stratton et al., Association of Glycaemia with Macrovascular and Microvascular Complications of Type 2 Diabetes (UKPDS 35): Prospective Observational Study, 321 THE BMJ 405, 405, 409 (Aug. 2000).

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

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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

HEALTH MANAGEMENT ASSOCIATES

Effective Advocacy in a Shifting Healthcare Environment

AADE Public Policy Forum

May 6, 2017

WWW.HEALTHMANAGEMENT.COM

AADE American Association of Diabetes Educators

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

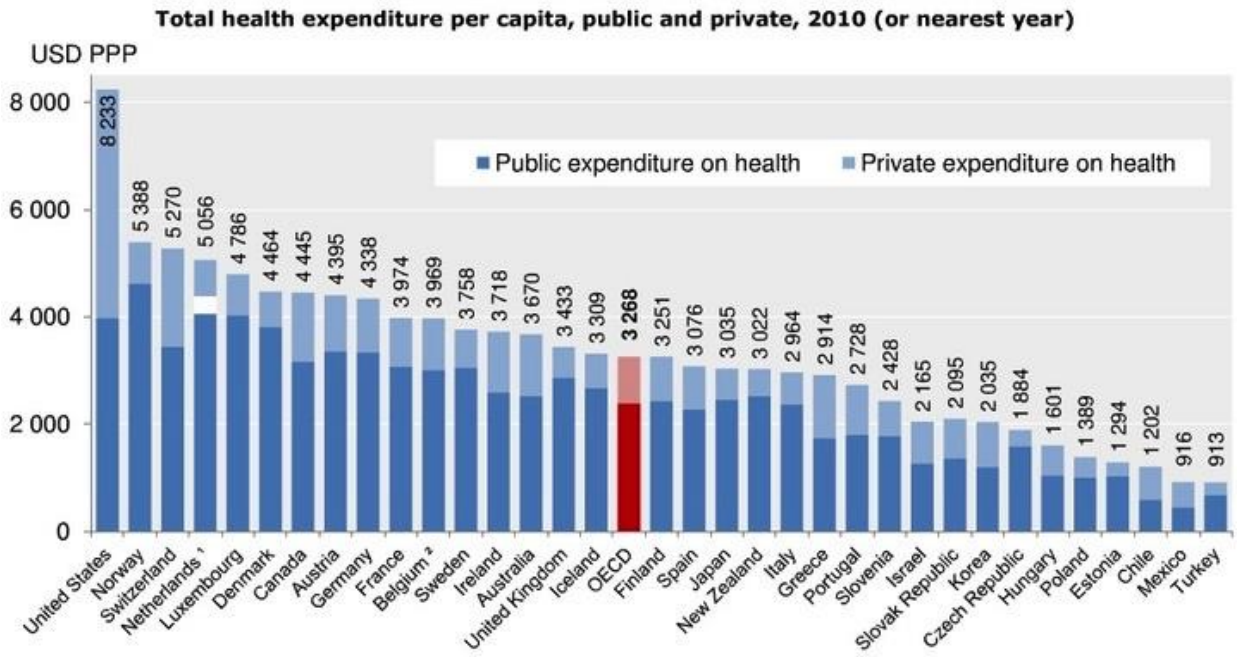
- State government touches people's lives
- Relationships are key
- Legislators care about getting re-elected, i.e. their constituents
- Advocacy skills are common-sense, not rocket science
- My personal "cockroach theory"
- The art of "creative" coalitions
- You really can impact state policy!

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

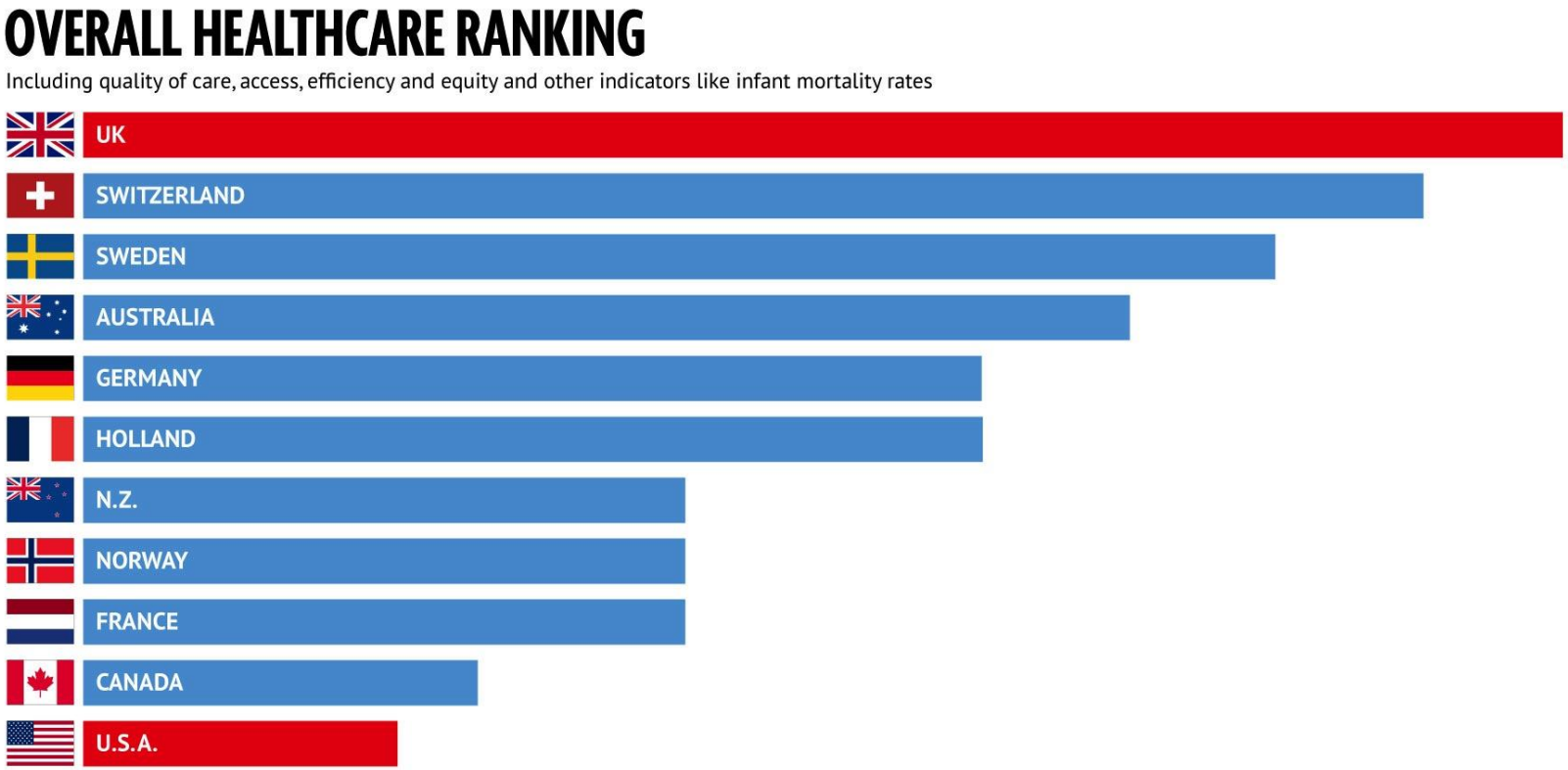


1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.

Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD Health Data 2012.

…And Not Producing Great Results



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

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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

- 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
- 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
- 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)

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

- Lean 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. Remembers that you are the expert.

Adjournment