How Diabetes Educators Can Work with Federal and State Policymakers to Promote Quality Diabetes Care and Education

Learning Objectives

- Educate and inform on state-based and federal issues
- Describe opportunities for membership involvement in key federal and state issues relative to diabetes education
- Provide training for skills necessary to interact with legislators, other policy makers and patient facing organizations
- Transfer what has been learned to home-state members
- Apply what has been learned in states

Why should I care about advocacy?

Laws touch on every aspect of our lives.

Disclosure to Participants

Notice of Requirements For Successful Completion

Please refer to learning goals and objectives. Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours.

Conflict of Interest (COI) and Financial Relationship Disclosures:

Presenter: XX, PharmD, CDE – Speaker’s Bureau: XYZ Pharmaceuticals; Advisory Board: ABC, Inc
Presenter: XX, MS, RD – No COI/Financial Relationship to disclose

Non-Endorsement of Products:

Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products displayed in conjunction with this educational activity.

Off-Label Use:

Information is provided by speakers to any product used for a purpose other than for which it was approved by the Food and Drug Administration.
Who is speaking for you?

Introduction to State-Based Issues and Politics

Lobbyists
- Illinois - 1,636
- California – 1,760
- Montana – over 450
- Massachusetts – over 1,700
- Georgia - 980
- Washington State – over 960

Diabetes Action Plans

What are Diabetes Action Plans or DAPs?
• Diabetes Action Plan (DAP) legislation is designed to encourage all state agencies and other stakeholders impacted by diabetes to collaborate on designing the report to highlight the costs and burden of diabetes; document current state activities that address the burden; and make recommendations to the Legislature on evidence-based strategies that can be implemented to decrease the costs and burden.

• DAPs are a vehicle which can help ensure that state legislators and other state policymakers are thinking strategically and taking steps toward reducing the prevalence of diabetes in their state.

• DAPs are a result of legislation or resolution passed by both chambers of a state’s legislature, although DAPS can also be mandated via an executive order from a Governor.

• The fundamental intent of the DAP legislation is to require state officials from the departments of health, the Medicaid agency and the state agency responsible for purchasing state employee health insurance benefits, to develop a report every other year for the state legislature that reflects the financial and health impact of diabetes.

• The report is intended to detail the ongoing efforts of state programs that are currently addressing this disease.
DAPs
• Currently, 18 states have passed DAPs and another 10 are considering passing their own DAP.

DAP Tiers
• Tier 2 – States with Proposed Legislation Establishing DAPS
  – Minnesota, Wisconsin, Kansas, Indiana, Ohio, West Virginia, Pennsylvania, Maryland, Connecticut, Massachusetts

Diabetes Action Plans

DAP Tiers
• Tier 3 – States which Have Neither a DAP nor Introduced Legislation for a DAP
  – California, Nevada, Arizona, Utah, Idaho, New Mexico, Colorado, Montana, South Dakota, Nebraska, Iowa, Alabama, South Carolina, Virginia, New York, Vermont, New Hampshire, Maine, Rhode Island, Delaware, Hawaii, Alaska

DAP Tiers
• Tier 1 – States with DAPs

Illinois DAP Legislation
Illinois Diabetes State Plan

November 2014

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Illinois – Economic Cost of Diabetes

Economic costs to society are massive, and this resource recognizes the costs at both the national and state levels. The American Diabetes Association (ADA) Cost of Diabetes in America report estimates national costs at $179 billion in 2010, compared with $175 billion in 2007, and expects that the national cost of diabetes will exceed $245 billion by 2020. State estimates indicate that economic costs related to diabetes exceed $43 billion in 2010, compared with $37 billion in 2007, and project that the economic costs will exceed $50 billion in 2020. These costs include direct and indirect costs. Direct costs include medical care and treatment, as well as lost productivity through morbidity and mortality. Indirect costs include increased taxes, increased healthcare costs, and lost productivity of persons due to morbidity.

Illinois – Role of DSMT in Illinois Plan

Goals:
1. Ensure those at risk for diabetes have access to quality, evidence-based screening programs to identify diabetes risk.
2. Ensure diabetes self-management education and support services are available and accessible.
3. Ensure evidence-based diabetes self-management education programs are available and accessible.
4. Ensure comprehensive diabetes self-management education and support services are available and accessible.

Action Steps:
- Provide ongoing access to evidence-based programs that include diabetes self-management support services.
- Provide ongoing access to evidence-based diabetes education programs.
- Increase access to evidence-based diabetes self-management support services.
- Increase access to evidence-based diabetes self-management education programs.
- Increase access to evidence-based diabetes self-management education and support services.
- Increase access to evidence-based diabetes self-management education and support services.
Strategy 3: Increase the number of evidence-based interventions offered to at-risk populations in diabetes high-prevalence areas.

Action Steps:
- Increase referrals to the MDP and Chronic Disease Self-Management and Diabetes Self-Management Programs through the Illinois Tobacco Quitline.
- Refer partners to CDC evidence-based online resources and guidelines and develop a single point of access for these resources through the Department’s website.
- Provide technical assistance to clinical community utilizing information from the CDC recognized National Diabetes Prevention Program Change Program.
- Expand reach of American Diabetes Association (ADA) recognized American Association of Diabetes Education (AADE) accredited and/or Stanford recognized diabetes self-management education programs.

Strategy 4: Enhance the ability of state and local providers to establish a reimbursement mechanism for implementation of evidence-based interventions.

Action Steps:
- Provide technical assistance to organizations throughout Illinois, including providers/hospital care settings, community-based organizations, local health departments, faith-based organizations and others through implementation of a diabetes education (DAP) program and obtain recognition/credits/endorsement for their program.
- Support new and/or enhanced models of DAP reimbursement to facilitate health care coordination and reduce disparities in cost and quality of care for individuals with third party providers.
- Collaborate with ADA and AADE to research funding opportunities to fund future DAP locations within diabetes high-prevalence areas.

Examples:

Georgia DAP: The Senate Resolution

2015 Georgia Diabetes Report and Action Plan
# Georgia DAP table of contents

<table>
<thead>
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<th>Page</th>
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<tr>
<td>Executive Summary</td>
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<td>What is Diabetes?</td>
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<td>How Diabetes is Managed</td>
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<td>The Financial Impact of Diabetes and its Complications</td>
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<td>Diabetes Prevention</td>
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# Georgia DAP and DSMT

The return on investment for self-management programs is high. For example, an economic analysis published in 2006 by the American Diabetes Association found that every $1 spent on DAP led to $3.52 in savings for individuals, and $10.45 in savings for the health care system overall. Additional analysis by researchers from the University of California in San Francisco found that the overall cost-effectiveness of self-management programs was higher than that of other chronic diseases, including asthma, hypertension, and arthritis. Overall, every $1 spent on self-management programs was associated with an increase in life expectancy of 0.5 years for type 2 diabetes patients and 0.4 years for type 1 diabetes patients compared with a control group of people with diabetes who did not have a self-management program. People with diabetes who had a self-management program spent on average $100 less per year and were 80% more likely to be in good health compared with people without a program. A well-conducted self-management program can lead to lower costs and reduced complications. These worthy outcomes make well-exploited self-management programs even more essential as a cornerstone of diabetes care.

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# Georgia – Financial Impact of Diabetes

The financial impact of diabetes and its complications is significant. Diabetes is one of the leading causes of death in the United States, and it is estimated that 29.1 million Americans (8.5% of the population) have diabetes. In 2015, diabetes was the seventh leading cause of death in the United States, and it was the cause of 10% of all deaths. The overall cost of diabetes care in the United States was estimated to be $245 billion in 2015, or $7,800 per person with diabetes. The cost of treating diabetes includes both direct medical costs and indirect costs, such as lost productivity and reduced quality of life. Direct medical costs include the cost of medications, doctor visits, and hospitalizations. Indirect costs include lost wages due to sickness, disability, and premature death.

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# Georgia DAP and DSMT

During the education program, the participants are taught how to problem-solve, make informed decisions, and minimize stress. After the program is completed, the participant will be able to play an active role in their management of this disease. In Georgia, accredited programs are eligible for reimbursement by Medicare and some private insurers. The 10 national standards for accredited programs are—

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# Georgia DAP and DSMT

Support Self-Management of the Community Level

Self-management support is critical to successful intervention efforts. Existing research indicates that diabetes self-management programs are more effective when they use strategies to improve self-management behaviors. One goal of self-management education is to develop skills for living with diabetes, including problem-solving, decision-making, and self-efficacy. These skills are critical for successful diabetes management.

1. Promote self-efficacy for patients to develop self-management skills.
2. Encourage patients to maintain regular monitoring of blood glucose levels.
4. Establish a patient-centered, comprehensive diabetes self-management program in community settings, such as hospitals, community centers, and senior centers.
How Do DAPS Help Our Grassroots Efforts?

• If your state has a DAP:
  – a point of introduction to the legislator and policy makers;
    • Discuss diabetes education
    • Discuss DAP
    • Discuss changes to DAP

• If your state does not have a DAP:
  – A point of introduction to the legislator:
    • Discuss diabetes education
    • Discuss premise of DAPs
    • Don’t ask them to introduce bill.

State of Pennsylvania – Medicaid Overview

• State population (2011-2012): 12,693,000
• State medical cost of diabetes (2012): $10.24 billion
• State diabetes incidence (2013): 8.7%, 1,104,000 total lives
• Medicaid population: Disabled Non-Dual and TANF
• Medicaid enrollment: 2,622,491
• Demographic distribution: Estimated
• Medicaid population incidence of diabetes: 4.9%, 128,261 total lives
• Medicaid medical cost of diabetes (adults only in 2011): $1,126 million
• Medicaid diabetes prevention & control program funding (FY 2013): $522,169

Pennsylvania Medicaid Savings for A1C Level Reduction

<table>
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<tr>
<th>A1C</th>
<th>Total Cost per Member with Diabetes</th>
<th>Number of Members</th>
<th>Total Direct Cost for Population with Diabetes</th>
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Change A1C

<table>
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<th>Change A1C</th>
<th>Total Cost Savings</th>
<th>Portion of Population with Diabetes to be Reduced by 1% of A1C level</th>
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<tr>
<td>10 to 9</td>
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<tr>
<td>9 to 8</td>
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<tr>
<td>7 to &lt;7</td>
<td>$698</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Sources: a) “A Diabetes Report Card for the United States: Quality of Care in the 1990s” by J.B. Saaddine et al.
  b) “Association between glycemic control and short-term healthcare costs” by Mark Aagren and Wenli Luo

The values shown in the above chart do not reflect state specific experience. The projections were based on public and proprietary third-party vendor data.
AADE State Licensure Initiatives

Background
• Kentucky and Indiana have passed licensure bills for diabetes educators.
• The regulations for the Indiana bill are moving through process.
• The regulations for the Indiana bill could be completed by the end of September.

Current Activity around Licensure
• Florida and Pennsylvania have introduced licensure bills during their most recent legislative sessions.

Key Provisions in Florida and Pennsylvania Legislation as Introduced
• The Florida and Pennsylvania share the following key provisions:

Those who already hold an active CDE or a BC-ADM credential will be considered Licensed Diabetes Educators once their application is approved.

Those who do not hold a CDE or BC-ADM credential currently and who want to call themselves Licensed Diabetes Educator will need to have a professional health-care background, pass the NCDBE exam, and have a minimum number of 250 hours of experience with diabetes education.

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Those who do not hold a CDE or BC-ADM credential currently and who want to call themselves Licensed Diabetes Educator will need to have a professional health-care background, pass the NCDBE exam, and have a minimum number of 250 hours of experience with diabetes education.
Instead of direct route to licensure via a single bill, a three step process will be the only way to achieve licensure in Florida.

Question: Why?
Answer: Political and philosophical roadblocks

Florida Three Step Process
• Registration of diabetes educators;
• Certification of diabetes educators (different from national certifications) and, finally;
• Licensure of diabetes educators.

Registration as a Diabetes Educator
• Registration will be voluntary. Those who claim to be Registered Diabetes Educator and are not could be fined by the state for misrepresenting themselves. There will not be a Florida board for RDEs which oversees discipline and other activities relative to RDEs.
• Registration will permit those who already hold an active and current CDE or a BC-ADM credential to be considered RDEs once they register with the State of Florida.
• Registration will require those who do not hold an active and current CDE or BC-ADM credential currently and who want to call themselves a RDE to have a professional health-care background, pass the NCSPDE exam, and have a minimum of 250 hours of experience with diabetes education.
• permit the creation of a scope of practice for RDEs in Florida.

Protection
Section 4. Section 468.533, Florida Statutes, is created to read:
468.533 License required. A person may not engage for compensation in diabetes education or CDE/BC-ADM or hold himself or herself out as a practitioner of diabetes education or CDE/BC-ADM unless he or she is licensed in accordance with this section.
Certification of Diabetes Educators

- Certification will require more legislation. Under certification, the state of Florida will validate the credentials of those who claim to be RDEs. Those who misrepresent their registration may be fined. Those who meet the criteria of registration will be designated as being Certified Diabetes Educators in the state of Florida. This title is not to be confused with the credential given by NCBDE. Again, there will not be a Florida board which oversees discipline and other activities relative to RDEs.

Current Political Landscape

Who can build a stronger base in the states?

Democratic Legislative Campaign Committee 2016 goal of $20 million
The Democrats’ Advantage 2020 PAC is hoping to chip away at Republican legislative majorities in a half-dozen states won at least once by President Barack Obama — Florida, Michigan, North Carolina, Ohio, Pennsylvania and Wisconsin.

3 Main Issues for discussion
- Access to Quality Diabetes Education Act: S. 1345/H.R. 1726
- Expansion of the National Diabetes Prevention Program (NDPP)
- Competitive bidding: impact on access to diabetes testing supplies for patients

Republican State Leadership Committee 2016 goal of $40 million

Access To Quality Diabetes Education Act: S. 1345/H.R. 1726:
Background: Why is this bill important?
- In 1997, Congress created the DSMT benefit. The statute defines a DSMT provider as a physician or other Medicare provider — The term ‘diabetes educator’ was not included and does not exist today in the Medicare statute. So, a ‘certified diabetes educator’ is not considered a provider, for purposes of reimbursement.
- Diabetes care has evolved since 1997: smaller, community based settings. AADE now recognized by CMS as an accrediting body

S. 1345/H.R. 1726, background, cont.
- AADE was instrumental in convincing CMS to include “DSMT” as a telehealth service under Medicare in 2011
- CMS has – and will continue to develop – new payment models for chronic care in the coming years that will involve active participation of non-physician health providers.
- Without passage of S. 1345/H.R. 1726, diabetes educators as a profession are not able to be reimbursed for DSMT either in person or by telehealth, or be specifically named in any other CMS payment models
What would S. 1345/H.R. 1726 do?

- Amends title XVIII (Medicare) of the Social Security Act to recognize state-licensed or -registered certified diabetes educators or state-licensed or -registered health care professionals who specialize in teaching individuals with diabetes to develop the necessary skills and knowledge to manage the individual’s diabetic condition and are certified as a diabetes educator by a recognized certifying body.
- Directs the Government Accountability Office to study the barriers that exist for Medicare beneficiaries with diabetes in accessing diabetes self-management training services under the Medicare program.
- Requires the Director of the Agency for Health Care Research and Quality of the Department of Health and Human Services to develop a series of recommendations on effective outreach methods to educate primary care physicians and other health care providers as well as the public about the benefits of diabetes self-management training.

Next steps:

- AADE working with H and S targets:
  1) Cosponsor the bill
  2) Include H.R. 1726/S. 1345 as part of any ‘moving’ Medicare bill

Current official supporters of S. 1345/H.R. 1726

Managed by CDC, the National Diabetes Prevention Program (NDPP) reduces the impact of prediabetes and type 2 diabetes. Without intervention, individuals with pre-diabetes are 15-30% more likely to develop diabetes within 5 years.

- Original DPP was a major multi-center trial: showed that diabetes can be prevented or delayed
- AADE has worked in partnership as a grantee with CDC since 2012: 45 CDC DPP funded sites in 17 states, serving 2,500+ participants
- 89% of AADE DPP site participants attend more than 4 sessions
- 5.8% average weight loss among participants

AADE-generated letter to E&C Chair and Senior Committee Democrat

National Diabetes Prevention Program
NDPP goals: March 23, 2016 marks a shift in strategy

Traditional goals:
1) Ensure that CDC grant program has stable funding source (annual appropriations)
2) Enact legislation to require Medicare coverage of NDPP

March 23, 2016: HHS Secretary announces that DPP will be expanded to Medicare!

Next steps:
• CMS included provisions on the planned NDPP expansion in the annual physician reimbursement fee schedule.
• AADE and other stakeholders (like you!) will submit comments
• AADE meeting with CMS directly
• AADE working with our diabetes partners
• CMS will likely consider all the comments received during the ‘public comment period’ and include more specific verbiage about how they plan to implement NDPP in the final rule.
• When do we think this will actually be implemented? Most likely, not before 2018.

AADE goals for NDPP expansion: what matters to educators
• Increase participation of diabetes educators and certified diabetes self-management education programs in the delivery of NDPP
• Increase the number of sites delivering the NDPP curriculum and applying for CDC’s register of approved sites through their Diabetes Prevention Recognition Program (DPRP).
• Increase the number of DSME sites delivering the NDPP Lifestyle Change Curriculum and applying for and maintaining CDC’s Diabetes Prevention and Recognition Program (DPRP) registry of pending and fully recognized NDPP programs
• Increase eligible participant’s enrollment in the NDPP
• Increase the number of employers and insurers who offer the Lifestyle Change program as a reimbursed health benefit.

You can submit comments on this proposed rule!
Competitive bidding

Background
- The competitive bidding program for DME (durable medical equipment) was mandated by Congress in 2003. The intent was to replace the then-existing fee schedule with a competitively bid price.
- Why was it established?
  - It's all about the money: bring down Medicare spending on items with high rates of utilization (Diabetes supplies ranked in the top tier)
- The competitive bidding program for mail order suppliers of diabetes testing equipment was established in select markets in January 2011. In 2012, CMS expanded the scope to include the entire nation, which went into effect July 2013.
- Recent development: CMS will reduce prices/# of mail order suppliers – starting July 1
- Soon after implementation, widespread anecdotal reports suggested that suppliers were denying access to the specific brands and types of supplies that had been promised would be available

AADE conducted surveys in 2011 and 2014:
- No suppliers carry products representing 50% of the marketplace, as required by Congress
- 3 (out of 23 suppliers surveyed) carried the brands they purport to CMS they carry
- In early 2016, AADE repeated the basic constructs of the survey with a small subset of likely affected educators
- Inherent problems surrounding mail order are still present

Bottom line: patients may not be getting the products they need to manage their diabetes

Other competitive bidding efforts
- AACE and ACE convened a consensus conference in September 2014, to evaluate the clinical science, utility, and access to blood and continuous glucose monitoring, finding:
  - A proliferation of unbranded and often inaccurate glucose monitoring (GM) systems has occurred in the market place, driven by mail-order diabetes suppliers under the Center for Medicare and Medicaid Services (CMS)-mandated competitive bidding process. Patients typically gain no real savings benefits from unbranded meter use, and safety risks imposed by GM inaccuracies are reported and well known. Switching from branded to unbranded meters and glucose strips is frequently initiated by intermediary profit-driven durable medical equipment (DME) suppliers. Such behavior should be prohibited by regulators and should not be tolerated by prescribers
Other efforts, cont.

- June 2015, Puckrein et al. “CMS Competitive Bidding Program Disrupted Access to Diabetics Supplies. Suppliers with
  Reduced Increased Mortality” American Diabetes Association 75th Scientific Session, 5–7 June 2015, Boston, MA reported that Medicare beneficiary access to diabetes testing supplies was disrupted in the case test markets during Round 1 of the Competitive Bidding Program implementation in 2011. This disruption was
  linked to reductions in use of testing supplies, increase in mortality, a doubling of inpatient admissions, and
  higher associated medical costs.

- November 2015, the National Minority Quality Forum issued a report “Centers for Medicare & Medicaid
  Services Competitive Bidding Program: Assessment of Impact on Beneficiary Acquisition of Diabetes Testing
  Supplies”, which showed:
  
  Disruption in physician-prescribed patient care plans for testing blood glucose increased with the
  implementation of Round 2 of the Competitive Bidding Program in 2013.
  
  Increased patient mortality: more than twice as many hospital admissions
  Medicare cost increases: overall Medicare cost doubled for beneficiaries in the study group.

- Other published studies show variability in blood glucose monitoring systems.

AADE’s activity around competitive bidding

AADE President Hope Warshaw participated in a Capitol Hill legislative staff briefing on June 20. The briefing
highlighted AADE’s years of active involvement in highlighting the problems with the CBP and the most
recently study released by the National Minority Quality Forum Report.

Most importantly…

TAKE ACTION NOW!

Tell Congress the Medicare competitive bidding program helps patients with diabetes and you want the problem fixed.

Click here to send your U.S. Representative and Senator a message.

Building In-District Relationships
What exactly is meant by “developing a relationship”?

- The word, as used here, refers to a working arrangement that will foster pleasant and effective two-way communication between you and a legislator and her staff.
- The relationship doesn’t have to be highly personal, or a friendship — although it may develop in those directions, depending on the personalities involved — but it needs to be one of mutual trust and respect.
- Relationships are based on mutual interest in a particular set of issues and on mutual benefit.
- You are planting seeds and seeds take time to grow.

Can I lobby?

- Yes!
  - Legally you are entitled to talk to your legislator about any range of issues.
  - You are already equipped to be a fantastic lobbyist.
  - Bring a patient!

What Can Diabetes Educators Offer Legislators?

- We have a message that legislators need to hear.
- You can be a resource for legislators and staff for a problem they are dealing with in their districts.

Messaging

- Problem
- Solution
- Action Steps

Here Is the Problem:
Here is the Solution

Diabetes Education and Educators

Evidence

- We are effective at reducing A1C levels.
  - Systematic Review
- We save the state and health care systems money.

Action Steps

- Baby steps
- Make money for the legislator and you
- Make easy:
  - Make it easy for the legislator
  - Leave the Legislator/Staff Materials
  - Leave the Legislator/Staff Materials
- Ask the legislator to keep in touch
- “Are there other legislators concerned about diabetes I should speak with?”
- “Do you have a diabetes resident in your state?”
- “Have we added another staff member for the legislator?”
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Leaving the Legislator/Staff Materials

Pennsylvania Medicaid Savings for A1C Level Reduction

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<thead>
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<th>A1C Level</th>
<th>Population with Diabetes</th>
<th>Total Direct Costs for Population with Diabetes</th>
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Leaving the Legislator/Staff Materials

Studies Support RISE: Value and Cost Effectiveness

Pennsylvania Medicaid Savings for A1C Level Reduction

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<td>$198,933,150</td>
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Activating Your Grassroots Action Plan/ Next Steps

• working with CBs to publicize federal and state legislative outreach and actions;

• creating a detailed two year plan for advocacy outreach which will include setting up quarterly district meetings with federal and state legislators and/or their staff to:
  – educate policy makers on what a diabetes educator is and does and
  – discuss issues of importance to AADE and their allies;

• Creating a calendar of webinars around advocacy issues that you feel would be useful to your advocacy program and your members.

What do you need to be successful at advocacy?

• Advocacy isn’t only about passing bills and working on laws and regulation.

• More information on:
  – using social media
  – creating effective diabetes coalitions in your state
  – creating/growing Diabetes Advisory Councils
  – how to lobby
  – small group trainings for activists

Thank you!
Questions or comments?