Diabetes Advisory Council

MEETING MINUTES
Thursday, August 18, 2016
2:00 PM in Room 1112 of the State Public Health Laboratory

The following members were present: Leigh Bak, Anne Camp, Donna Campbell, Sandra Czunas, Mehul Dalal, John Domenichini, Tekisha Everette, Maureen Farrell, Subira Gordon, Bruce Gould, Steve Habbe, Jennifer Kelley, Cindy Kozak, Linda Krikawa, Paula Leibovitz, Susan Levine, Karen McAvoy, Sherry Ostrout, Rob Piccone, Stephanie Poulin, Debbye Rosen, Dana Rush, Mark Schaefer, Kenneth Snow and Kelly Vaughan.

1.) Welcome and Introductions

The meeting was called to order by Dr. Mehul Dalal at 2:06 PM.

Mehul Dalal welcomed members to the first meeting of the Diabetes Advisory Council (DAC). Each member took their turn introducing themselves and shared their favorite memory from the summer.

2.) Opportunity for Public Comment

None was offered.

3.) Review of Council Responsibilities

Cindy Kozak summarized the Council's charge as outlined in Section 51 of Public Act 16-66. Two sets of study criteria were put forward in the new law – one mandatory and the other permissive. The mandatory section comports with the parameters of the Centers for Disease Control and Prevention (CDC) grant that the Diabetes Prevention and Control Program receives.

Members chose to address all of the mandatory components as well as examine pieces of the permissive section. Steve Habbe agreed that the required components of the study should be taken up, but also recommended the Council develop an action plan to reduce the impact of diabetes on the state. He explained that this may be the opportunity to craft meaningful public policy that has real application, but cautioned that an action plan would need financial investment to be successful. Sherry Ostrout echoed that policies should be coupled with financial investments to ensure their viability. Anne Camp noted that there is more detail in the permissive section of the study and advocated that both move ahead. Mehul Dalal offered a compromise to incorporate some of the permissive components into the Council's work.

4.) Presentation on Burden of Diabetes in Connecticut

Stephanie Poulin reviewed the Department's presentation on the state of diabetes. 8.9 percent, or about 250,000, adults in Connecticut have been diagnosed with type 1 or 2 diabetes. An additional 83,000 adults have undiagnosed diabetes. Data shows that certain populations are more at risk to contract the disease. Black or African American and Hispanic or Latino adults

have a higher prevalence of diabetes than their White counterparts. A person's annual household income is also a factor in diabetes prevalence in that the higher the income the lower the rate of disease. Diabetes leads to premature mortality (death before age 75), which also disproportionately affects Black or African American and Latino individuals at a higher rate. Hospital discharge data, or the Inpatient Hospital Discharge Database (HIDD), shows a similar picture. Mark Schaefer thought that this data could be broken down by zip code, which may give a geographical snapshot of the population. Mehul Dalal pointed out that the Department uses zip codes from HIDD data when looking at asthma.

John Domenichini asked how many new diabetics were identified during hospitalizations. He had worked with Hartford Hospital in the past, which has been aggressively identifying diabetics post open heart surgery. Stephanie Poulin acknowledged that the Department did not have access to that data. Debbye Rosen pointed out that the source of the data can be a shortcoming as most is culled from random self-reported surveys. John Domenichini mentioned that it might become easier to identify pre-diabetics through ICD 10 codes captured in electronic medical records.

The pre-diabetic population is significantly larger than the identified diabetic community. The fiscal impact to the state may be much greater if that population is factored into the equation. Debbye Rosen mentioned that we could comply with one of the permissive parts the study by using mortality data to demonstrate the cost of lost productivity to the state, and hospital data to pinpoint a more tangible cost of treatment and late intervention. John Domenichini highlighted Hartford Hospital's use of Diabetes Management Teams to treat patients. It's effective, but expensive.

Stephanie Poulin explained that she only has access to data on hospital charges (shows what hospital are billing payers), not hospital cost data, , so she used the Office of Health Care Access's ratio of cost to charge to estimate cost. She hopes to use the All Payer Claims Database (APCD) when it becomes available.

There are many preventative care practices that help reduce diabetes complications, e.g. annual dilated eye and foot exams, annual influenza immunizations, diabetes self-management classes, etc. Data from the Behavioral Risk Factor Surveillance (BRFS) System indicates that rates of preventative care among adults diagnosed with diabetes are below Healthy People 2020 goals. Other studies conducted by the Department show those who voluntarily attend diabetes management classes are more apt to exhibit higher rates of preventive care practices Kenneth Snow cautioned that requiring an individual to attend the self-management class may not have the same impact if they do not apply what they learned. Cindy Kozak added the literature states that diabetes education lowers A1c level by .74% and reviewed the joint position statement from the American Diabetes Association, American Association of Diabetes Educators and the Academy of Nutrition and Dietetics on diabetes self-management education and support included in the meeting packet. Debbye Rosen highlighted that the state's vaccination rates are comparatively high, but they reflect all adults, not just the diabetes population. Anne Camp indicated that the data made more sense knowing that the population surveyed was 6,000 predominately white and older adults in Connecticut. She does not see such high immunization rates at her community health center.

Mehul Dalal explained that the BRFS is conducted nationwide and is telephonic, which includes both land lines and cell phones. It is the only continuous, population-based survey on health risk information available. Ideally, we would like to expand the population that is surveyed in order to get a better sample size to drill down geographically and compare different groups. He supported Kenneth Snow's assertion that with a cross sectional survey one cannot draw any conclusion around causation. . Kenneth Snow highlighted a challenge that the literature faces, which is that they do not disclose how many people they contacted versus how many people actually participated in the trial.

Debbye Rosen affirmed that the best indicator on whether someone will become vaccinated is if a provider asked them if they would like to be. The same may be true for diabetes self-care. She

wondered if we could look at the rates of providers recommending self-management classes to their patients. Linda Krikawa thought that we should consider what tools activate people to attend classes. There is a patient activation measure being used in the field. Provider reimbursement for a diabetes interview may also be an incentive to weigh.

Bruce Gould mentioned that we tend to study people who are already motivated. He contemplated if there was a way to develop a coordinated approach in the ambulatory primary care setting where patients are identified and assigned to ambulatory education on self-management that is culturally and linguistically appropriate.

Mark Schaefer wondered what fiscal sustainability looked like and what it is that the Council would promote. He theorized that it may not be cost effective to invest in something that benefits only a quarter of the population. There are ways to segment the patient panel to see who would benefit from certain interventions. We should consider the opportunity to address measures based on outcomes, not the process. The Council could also recommend rewarding providers for achieving A1C outcomes and teaching them to fine tune their classes to the culture of the population served. New payment models will most likely lend themselves to this approach.

Mehul Dalal said that it was helpful to hear members question the data and encouraged them to inform him of other data sets that the Council should examine. John Domenichini suggested looking at rates of adolescent obesity and making sure that youth are engaging in physical education each day. Kenneth Snow cited CDC data on rates of obesity juxtaposed with the rate of diabetes prevalence; and they overlap. Mehul Dalal has information that he can share about obesity, some of which was collected in working with the schools. Kelly Vaugh mentioned that most diabetes prevention programs are family oriented. Hopefully the information trickles down to the child.

Debbye Rosen wondered if Council members had data on whether state residents with diabetes have a primary care provider. Bruce Gould thought the problem may be that the population's health care providers are not be trained on educating patients who have diabetes. Cindy Kozak pointed out that the American Diabetes Association, American Association of Diabetes Educators and the Academy of Nutrition and Dietetics have a position paper that asserts the standard of care for physicians is to refer patients to diabetes educators.

There are 25 hospital-based education programs in Connecticut and several train the trainer programs in the community. The Department has the number of people who have attended CDC certified Diabetes Prevention Programs (DPPs). Steve Habbe highlighted that Medicare has made the decision to cover DPPs starting January 1, 2018 (note that Medicare already covers diabetes education). There is a proposed rule and associated comment period through September 6, 2016. Cindy Kozak encouraged members to submit comments and circulated the link where they can be made (https://www.regulations.gov/document?D=CMS-2016-0116-0006 Note deadline is Sept 6 at 5 pm). She also shared the list of Diabetes Prevention Programs certified by the CDC. https://nccd.cdc.gov/DDT_DPRP/CitiesList.aspx?STATE=CT Debbye Rosen asked for the age and race of the participants in the DPPs. The Department has that data for the Stanford Live Well program and will disseminate it at the next meeting. Dana Rush wondered if the Council could get a snapshot of the structure of a DPP, specifically the requirements for becoming a certified trainer. Kelly Vaughan, and Maureen Farrell will get that information.

5.) Review of Process

Mehul Dalal informed members that, moving forward, meetings will be held in a different location to better facilitate public participation. Additionally, the set monthly meeting dates did not work for a few members and will be changed. A Doodle Poll will be circulated. Fifty one percent of members will constitute a quorum. Members will not be reimbursed for their time or

travel. Two reports are due to the Public Health Committee at the Connecticut General Assembly – one in January and the other in May of 2017. A bulk of the Council's work will be done in three work groups – prevention, education and clinical quality measures related to control. The work done in the control group may be specialized and could include consultation from experts who are not officially appointed to the Council. Cindy Kozak requested that members inform her on which work group they would like to serve.

6.) Identification of a Chair

A motion was made by Sherry Ostrout and seconded by Donna Campbell to nominate Subira Gordon, Executive Director of the Commission on Equity and Opportunity, to serve as Chair of the Council. The motion carried unanimously by voice vote.

7.) Other Business

No other business was raised. The meeting adjourned at 3:37 PM.