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**PUBLIC HEALTH INSTITUTE
WEBINAR
“FIGHTING TYPE 2 DIABETES THROUGH POLICY REFORM:
NEW JERSEY AND NORTH CAROLINA AS CASE STUDIES”**

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**ROUGH DRAFT TRANSCRIPT
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>> Star Tiffany: Hello and welcome to "Fighting Type 2 Diabetes through Policy Reform: New Jersey and North Carolina as Case Studies." My name is Star Tiffany. Along with my colleague, Joanna Hathaway, we will be running today's web forum.

Closed captioning will be available throughout today's web forum. Christine, with Home Team Captions, will be providing realtime captioning. The closed captioning text will be available in the Media Viewer panel. The Media Viewer panel can be accessed by clicking on an icon that looks like a small circle with a film strip running through it. On a PC this can be found in the top right-hand corner of your screen. And on a MAC it should be located in the bottom right-hand corner of your screen. In that Media Viewer window, on the bottom right-hand corner, you'll see the show/hide header text. Go ahead and take a moment to click on this and that will show you more of the closed captioning and get rid of that header.

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Once the web forum ends today, a survey evaluation will open in a new window.

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Please take a moment to complete the evaluation as we need your feedback to improve our web forum. The recording and presentation slides will be posted on our website. We would like to invite you to connect with us via the links on screen now. And our handle is Dialoge4Health.

We are encouraging you to ask questions throughout today's presentation. To do so, simply click the question mark icon, type your question in and hit send. Please send your questions to all panelists. We will be addressing questions at the end of the presentation.

Again, if that window collapses, this is how you re-open the closed captioning, by clicking on the world icon and with the film strip running through it.

It is my pleasure to introduce our moderator for the day, An Nguyen. An Nguyen is a Program Manager at the National Network of Public Health Institute where she leads the workforce and leadership development projects and initiatives and manages the health disparities programming. NNPHI programs and projects that Miss Nguyen manages include the Toolkit for Health and Resilience in Vulnerable Environments or THRIVE, Bristol-Myers Squibb Foundation Together on Diabetes initiatives, Robert Wood Johnson Foundation project on public health nursing, and various CDC Workforce Development projects. Ms. Nguyen holds a Master of Health Administration from Tulane University School of Public Health and Tropical Medicine in New Orleans.

An, please go ahead.

>> An Nguyen: Thanks so much, Star. Welcome, everyone, to today's web forum. We're so glad that you can join us this early afternoon or late morning depending on where you're joining

us today. We're really excited to bring today's web forum which has been sponsored by the Bristol-Myers Squibb Foundation, Together on Diabetes, Center for Health Law & Policy Innovation at Harvard School of Law and by the National Network of Public Health Institutes. As you see on the screen, there is a description of Together on Diabetes initiative. If you're interested in learning more about the larger initiative, we encourage you to go to the website which is www.togetherondiabetes.org.

Just a little bit of description of today's sponsors of today's web forum. The Center for Health Law & Policy Innovation of Harvard School of Law, also known as CHLPI, advocates a legal regulatory and policy reform to improve the health of underserved populations with the focus of the needs of low-income people living with chronic illnesses and disabilities. If you want to find out more about the center, you can go to their website and their Facebook page, their Twitter handle, which are on the screen now. And for those of you that do Tweet, we recommend -- and want to Tweet about today's web forum, we recommend using the hashtag #diabetespolicy.

For more information about the National Network of Public Health Institutes here are some links to our social media pages, our website as well as our Twitter.

On today's call we'll be identifying diabetes prevention and management policy opportunities in New Jersey and North Carolina, describing state-level strategies to move forward in community-identified diabetes policy priority areas, and also discussing national implications of diabetes policy state work in North Carolina and New Jersey.

With that, I would like to introduce our speakers on today's forum. First we have

Sarah Downer. She is a Clinical Instructor on Law Health and Food Law and Policy Clinics at the Center for Health Law and Policy Innovation. You see on the screen a description, a short bio, which I won't go into but you can read for yourself.

And I would also like to introduce Allison Condra, a Senior Clinical Fellow at the Food Law and Policy Clinic at the Center for Health Law and Policy Clinic.

I'd also like to introduce Francine Grabowski, a Lead Diabetes Educator at the Camden Citywide Diabetes Collaborative. Again, her bio is on the screen if you would like to read it. And I also wanted to point out the website for the Camden Health Collaborative, which is at the bottom of the screen.

Again, if at any point you have any questions during the presentation, we encourage you to use the Q&A feature which should be at the bottom right-hand corner of your screen. As indicated, this is how you submit questions to us. We'll have ample time for Q&A at the end of the presentations. We will do our best to answer all of your questions.

Again, if you need to connect to the closed captioning in the Media Viewer, you can do so as indicated on the screen.

And with that, I'm going to go ahead and pass it on to Allison and Sarah who will be presenting first.

>> Allison Condra: Hi, everybody. Good afternoon or good morning. My name is Allison Condra. My colleague Sarah Downer and I are happy to talk about our project, what we've accomplished so far, what's in the pipeline, and how you can be involved in reducing the incidences of Type 2 Diabetes and helping people manage the disease. We're going to focus

much of the webinar today in our work in North Carolina and in New Jersey.

PATHS, as mentioned, is funded by the Bristol-Myers Squibb Foundation Together on Diabetes initiative. The Together on Diabetes initiative funds many on-the-ground diabetes interventions across the country. And our role at the Center for Health Law and Policy Innovation is to provide a policy overlay to much of this on-the-ground work to identify policy opportunities to enhance Type 2 Diabetes prevention and management.

As you can see here, the PATHS project is made up of many parts. We started our work about two years ago by research and writing reports focused on two states, North Carolina and New Jersey. We chose these states not only because there are other Together on Diabetes working in the states but also because the states are quite distinct from one another and can provide a solid foundation for us for identifying best practices for other states, as you'll see on the slide. We are going to be writing a state best practices report in 2016.

In addition to these two state level reports, we are going to be writing a federal level -- focusing on recommendations that the federal government can do in order to improve Type 2 Diabetes prevention management. And, again, state best practices so that what we've learned from our North Carolina and New Jersey work can be applicable across the U.S.

Each of the state reports that we're going to talk about today required us to conduct independent research as well as stakeholder interviews with community partners in each state. Our reports, as Fran will discuss shortly, are based largely on the information we gleaned through our stakeholder interviews. It was and is very important that we identify policy priorities that reflect the needs of the communities that are working in those states. Both the

federal level recommendations and the state best practices recommendations will be partly based on what we learned through the process of writing the state-based reports and will also require new research and interviews to ensure complete and helpful reports.

So, in addition to these reports, we are also working with stakeholders in both North Carolina and in New Jersey to help them identify and move forward with policy advocacy, which, again, Fran will discuss shortly.

Throughout the process of writing the New Jersey and North Carolina reports, we formed some stakeholder coalitions. And those groups are moving forward on policy advocacy on the priority that they have identified.

Finally, part of our PATHS project involves us offering policy-related technical assistance to other Together on Diabetes grantees, two organizations at a time, during six-month periods. So in our first six-month period, which we just ended at the end of June, we worked with Peers for Progress and the National Peer Support Collaborative Learning Network to draft a White Paper that exams pros and cons of different methods of Community Health Worker certification and identifies ways that the Affordable Care Act implementation can support those Community Health Workers.

In addition, we worked with a few of Marshall University's Appalachian Diabetes Coalitions, helping these groups identify food policy priorities and then working with them hands-on to help them create an action plan to pursue the policy priorities that they identified.

>> Sarah Downer: Thank you, Alli. This is Sarah Downer. When we looked at what would really change the environment with Type 2 Diabetes -- for those of you who work in this area,

as many of you, I know, do -- the central findings of the reports will not be that surprising. They are basically that both prevention and management of Type 2 Diabetes are essential priorities if states are going to reduce the burden of this disease. And prevention is primarily about ensuring access, of course, to healthy food and access to physical activity as well as to ensuring access to those really key services provided through the healthcare system or in community-based programs for people with pre-diabetes and while management is primarily about access to those key healthcare services and also ensuring that the healthcare delivery system is able to get those services to the people that need them at a high level of quality.

A couple of themes emerged as we went through and -- when we really did an in-depth policy scan in both states. The themes that emerged in terms of prevention, you know, prevention is mainly about having that healthy lifestyle. And there are six main areas in our recommendations about how to make a difference in the food and physical activity landscape. So we know we need access to healthy food, both in the sense that we can pay for it, economic access in the sense that we can get to it, geographic access. And so these factors led us to focus a lot on nutrition assistance programs like SNAP, led us to look really critically at school food programs and to really examine the problem of food desserts in the reports.

As you know, prevention of Type 2 Diabetes is tied to the ability to exercise and be physically active. So we really looked at ways that a community could facilitate that active transportation; making a big difference, as do other efforts, to make sure that people of all ages have safe places to exercise.

And then another integral component of prevention is the education about nutrition and obesity risks. We looked at programs like SNAP education, WIC education. We looked at nutrition education in schools and all the key pieces of nutrition information that assist individuals in learning about healthy eating.

And finally, for those who are pre-diabetic and, therefore, are at the most immediate risk for developing the disease, we looked at access to programs such as the Diabetes Prevention Programs. This is a really essential program. It's been proven to reduce the incidents of the disease by 58%, which is enormous. And it can be administered at a relatively low cost per patient. So it leads to really huge savings of healthcare dollars.

From the management side, the central message of the healthcare research that we've undertaken is deceptively simple. We know what services help people prevent and manage diabetes. And we need to have the right providers delivering those services to all patients in a sustainable manner.

To understand the current and potential capacity of our case study states, healthcare systems, to achieve this goal, we looked at enrollment in health insurance, at advocacy of insurance coverage for those key services, looked at the availability of primary care providers and specialist providers, and the potential to expand healthcare teams to include providers who can really make a difference in providing care. So that's those community health workers, pharmacists. And finally we looked at the overall design of the healthcare systems in both states and their ability to enhance care coordination.

So this is just a reminder of what we're up against. We just had new numbers come

out recently. 29 million people living with diabetes in this country, a quarter of them who likely don't even know that they have the disease, and 86 million people with pre-diabetes, which is a really staggering number and especially since a quarter of them are likely to develop diabetes within three to five years. So that's about 21.5 billion people. So that's as if everyone in our seven largest cities developed diabetes in the next three to five years. So we've got a lot of work to do.

In North Carolina and New Jersey the child obesity rates among low-income children, 2-4 years are incredibly high compared to other states. We know obesity is a major risk factor for Type 2. So while these states are very different in many ways, they share this need to transform their environments for these young residents so that we can eradicate some of the health disparities. We see a higher incidence of the disease and worse outcomes in the minority and low-income populations.

>> Allison Condra: This is Alli again. Next we're going to turn our attention to some of the major findings and recommendations that came out of our research and work in New Jersey. In terms of economic access, we found that only 60% of eligible people in New Jersey are enrolled in SNAP and WIC. I will say that this is just one of the things that we found. The reports, as you will see if you look on our website, are very in-depth and comprehensive reports.

So when we were talking about the things that we and some of the statistics that we discovered know that there is a whole host of other facts that you can find in the reports. But for our purposes today, I want to highlight the fact that only 60% of eligible people in New

Jersey are enrolled in SNAP or WIC compared to other states. This means New Jersey is towards the end of the pack in terms of SNAP and WIC participation. Not only should the state increase participation in these programs but New Jersey should also increase funding for the fruit and vegetable programs such as the Farmers Market Nutrition program to help participants purchase more fresh and healthy food.

Geographic access to healthy food is another critical issue in New Jersey. Even though New Jersey is a very urban state compared to North Carolina, there are still many issues with people's ability to access retail outlets that sell healthy food. Nearly 1 million people in the state are food insecure; meaning at some point in the last year they had trouble securing enough food for a healthy life.

Indeed, the U.S. Department of Agriculture identifies 134 food deserts in an urban area that means that residents in a low-income census tract are at least a mile away from a grocery store. So the state has 25% fewer supermarkets per capita than the national average and needs 269 new supermarkets just to reach the national average.

In New Jersey the New Jersey Food Access initiative provides low-interest loans and grants to grocery stores that open in these low-access areas. This is a really important policy and program that the state has. And a number of states also have similar healthy food financing initiatives. But this New Jersey Food Access initiative actually -- it's important that the state makes sure that funding exists to increase the number of healthy food outlets in low-access areas whether through these grants or low-interest loans or some other form of policy that will help incentivize these grocery stores to open in areas that have low food

access.

In terms of the Built Environment, New Jersey has done a really good job working to make the environment more conducive to physical activity. The State Department of Transportation has focused on building up its Safe Routes to School program which encourages kids to bike or walk to school as well as a Complete Streets program which requires communities to consider all forms of transportation when redoing their streets.

So in New Jersey communities when they're thinking about repaving or restructuring the street, they have to think about how friendly is it to walkers, to bikers. Where do people cross the street? What do they do about cars? Instead of focusing only on cars, the Complete Streets program requires those communities to think more holistically about how their communities can be built in order to support more physical activity. And New Jersey has actually been a leader in the complete streets programs. So that's really great.

New Jersey has also done a great job increasing their school breakfast participation but could use more support in increasing participation in that program. I believe in the course of a few years New Jersey went from being 48th in the U.S. in terms of school breakfast participation to 46th. And that is an impressive jump but 46th is still -- there's still room for improvement. So figuring out ways to help increase student participation in that program, whether by having breakfast on the go or breakfast in the classroom can really help more students who are eligible for that program participate and reduce or help improve their access to food.

Additionally in terms of schools, we found that ensuring children get enough time for

rigorous physical activity is also really important priority in this state and is also key in preventing diabetes.

And finally in terms of prevention and environment, having healthy food to eat, especially fruits and vegetables, requires having a strong agricultural sector that grows those foods. Some people are not shocked but just interested to find a whole section in the report about ways to support agricultural production in the state. But it is really important to have a strong agricultural sector to provide those fruits and vegetables.

So in New Jersey the state can work to increase local food purchasing by state institutions such as state colleges, universities, and agencies this would increase the amount of fruits and vegetables available to consumers in these places and would address some of the access issues that are faced by many New Jersey residents.

In terms of management, we heard a lot from a lot of stakeholders in New Jersey that reimbursement for key services was a major concern. Fran will talk more about this issue in her presentation, but let me just review them briefly for you.

Based on our discussions with community partners and our research, we recommend increasing primary care reimbursement in Medicaid and recommend that New Jersey authorize a pilot program to reimburse pharmacists for their Diabetes Self-Management services within Medicaid as well as cover Diabetes Self-Management Education and therapy for both pre-diabetics and diabetics.

We also heard from folks in New Jersey that insurance providers, private insurers and Medicaid Managed Care plans frequently change the brands of equipment that are covered by

their insurance. As you can imagine, this poses a real problem for patients. We've heard stories of patients that cut their insulin strips in half in order to save money because they can't get their new or their old insulin strips covered. And that's really disconcerting. So we recommend that all diabetes equipment recommended by providers be covered under Medicaid.

And finally, Community Health Workers are a really important part of the provider team for people with diabetes. Currently in New Jersey there is no Community Health Worker certification process which means that there is no reimbursement for their services through insurance. Right now Community Health Workers in the state are paid through grants, which is unsustainable in the long run. So we recommend the state work to create a state-level certification program so that Community Health Workers can be certified and then paid through insurance so that they can deliver their services to those people who really need it.

Next we're going to turn it over to Fran to talk about her experience with our PATHS work in New Jersey and tell us more about what she does.

>> Francine Grabowski: I'm here today because of my work with the Camden Coalition of Healthcare Providers. The coalition wants Camden City, one of the poorest cities in the United States, to be the first city to bend the cost curve through patient change, clinical change, systems change, and policy change. Just to give you an idea of what we mean by cost curve, we've identified about 7,000 residents in Camden living with Type 2 Diabetes. And between the years 2002 and 2008 these people accounted for over 62,000 visits to the Camden emergency departments in hospitals, accumulating charges of over \$1.2 billion. So this is not

sustainable.

Between 2011 and 2013, we've provided Diabetes Self-Management Education to 244 patients through grants funded by the alliance to reduce disparities of care and Together on Diabetes grant. You can see we have a long way to go considering there's about 7,000 residents in Camden. 79% of our participants have been Spanish speaking.

On this left-hand side of your screen there's a picture of our Spanish-speaking graduation class in North Camden. Our educator on the top row, the second from the left, is Maria Colon. She's been awarded the Garden State Educator of the Year. So we try really hard to have excellence in education in the poorest city -- one of the poorest cities in the United States.

And I want you to notice the sense of accomplishment for the attendees, for the graduates. They're empowered to self-care. There's a joy in these classes. Some people have come to classes as many as 32 times. You just don't believe it when you have people say that they don't want to take care of themselves or when people say that people in underserved communities don't want to take care of themselves.

What you're looking at here -- first of all, I want to tell you about one of my patients, one of the people that I've seen. She says she feels bad even when she is taking her insulin. One of the things that diabetes educator does is observe a patient taking insulin or demonstrating how they take insulin. I asked her to bring her insulin. She showed me how she took it. She dialed to 38, placed the pen on her leg. She did not use a pen needle and did not press the plunger or the injection button. She didn't take insulin. She thought she was

taking insulin. So I worked with her, showing her the correct technique for using a pen.

And in my experience, I have to observe a person demonstrating insulin injection at least three times before I know they get it. Then we finally begin problem solving. You know, why is your blood glucose high when you wake up, after dinner or low in the middle of the day? So we cannot problem solve when a person is not taking their medication properly.

In this same class everyone is asked to bring a meter. I watch them use their meter. 5 of the 13 people in my last class could not use the meter. We send them strips, send them a new meter. Unfortunately we send a new one every year when the contract changes and yet we do not give them instruction and feedback on the use of the meter called Diabetes Self-Management Education. Patients cannot learn how to problem solve unless they know how to use their meter.

Now, I'm in a quandary. Without grant funding, how will the residents of Camden and 33% of them have Medicaid coverage have access to diabetes education? There is no independently verifiable source of Medicaid coverage for DSME. It was clear to me that unless Diabetes Self-Management Education is covered by Medicaid, this is not sustainable. I want the people of Camden to have access to health with diabetes. And I want the future generations to have health without diabetes.

I've listed seven behaviors here. These are behavior goals for diabetes educators. They come from the American Association of Diabetes Educators. These behavior goals provide the framework for complex assessments and quality diabetes education. So you've got healthy eating, being active, taking medication, monitoring, problem solving, reducing risks,

healthy coping. Certified diabetes educators or clinicians working with recognized diabetes education centers assess and prioritize a person based on these behaviors. Without the clinical skills of a CDE or the guidelines of a recognized center, these patients may be told something like: Oh, avoid sugar, lose weight; exercise more. None of those recommendations are appropriate assessments if you're not taking your medication right or not checking your blood glucose.

I want to thank the Harvard School of Law Center for Health Law and Public Policy for New Jersey PATHS but also for making the working group feel invested and very excited in this policy initiative. So how did they generate this energy and get our investment? I'm usually on the teaching end, so I was just so excited and invigorated to be on the receiving end of this whole process. So they held focus group sessions around the state with all levels of healthcare workers that are involved in delivery of diabetes care to learn about the issues related to delivery of care in New Jersey; is present in one of the sessions in Camden. And I was excited to hear others talk about what they saw and what their vision was. But to be honest, I could not imagine the breadth and depth of these discussions could be incorporated into a document.

When I first read the New Jersey PATHS document or at least the first edition, I saw a document that was -- that truly, indeed, was comprehensive and inclusive. But I also saw in the draft that my area of expertise, diabetes education, needed several changes. And when I brought the attention -- the changes to the attention of Alli or Amy or Sarah, all of my suggestions were respected. And several drafts later I was so pleased with the draft.

This draft was unveiled in a Leadership Forum in front of a diverse group of people committed to improving diabetes care from industry, state government, clinicians, the Y, small innovative clinical practices, foundations, all addressing health in the state.

And at the end of the Leadership Forum we were asked for our feedback on where to go next. And in -- in a Survey Monkey, the Leadership Forum attendees chose to focus on -- I was very excited -- to focus on legislative change to require DSME coverage by New Jersey Medicaid. So they made it happen. And over the course of several weeks, many clinicians who formed a working group reviewed the proposed legislation. There were so many issues we addressed: Who provides DSME? Who refers? What about Medical Nutrition Therapy, diabetes prevention?

These discussions took place by e-mail late into the night. It was hard, hard talking by e-mail. But I'll tell you, by the end of it I have such a great respect for my colleagues and deeply understand the issues. The Harvard team was behind the scenes throughout the whole process, you know, taking up through the discussions, supporting us in our challenges, and giving us suggestions.

So from focus group to the working group, group discussions, editing of the legislation, we experienced empowerment, respect, and collaboration. You know, actually, it really felt like what I was being a part of was what we tried to do in diabetes education.

You know, I want to thank Assemblyman Conaway and Nancy Pinkin and Senator Vitale for their courage and wisdom to sponsor the addition of DSME in Medicaid. Assembly Bill 3460 was introduced June 26. For the first time, Medicaid patients will have access to

DSME. The bill includes most of what our working group developed. We're very excited about the inclusion of diabetes prevention. The visits necessary that need to be medically necessary, underserved communities need multiple visits to reinforce and support behavior change.

I want to just look at a couple of issues. We believe a Certified Diabetes Educator or a recognized entity; that is, an entity accredited by the American Diabetes Association or the American Association of Diabetes Educator, are best suited as the delivery of DSME. It's a complex assessment. CDEs know how to make this assessment. It's unique to diabetes care. A CDE is not going to say eat healthy if the person is not injecting insulin properly.

Also, diabetes education can be provided within a recognized diabetes education program. And while it's demanding to begin credentialing through the ADA or through the American Association of Diabetes Educators, it ensures excellence in patient care. And that really solves the problem of having peers and Community Health Workers and the Stanford program, these programs that have shown beyond a doubt that they are essential to a good DSME, that it allows them to be a part of recognized diabetes education program and qualify for reimbursement.

Another issue is: Do we provide the medication and supplies best suited to the patients, physical limitations and obstacles? In other words, as recommended by their provider. The patients I talked about early, they're not taking their insulin properly for years. They don't know how to take their insulin. We know how to get them to take their insulin. There are options for people who have complex medication needs such as, you know, different

insulin delivery devices, devices that can address hand grip limitations. Do we pay for hospitalizations? Emergency room visits? Nursing care and complications rather than offer more appropriate medications?

Two weeks ago one of our diabetes education stars said to the class that she prays for one thing when she gets sick. And she has multiple medical conditions. She doesn't pray for -- she prays that she will not be afraid. I took these words to heart and used them in my work that I'm doing being involved in this working group and in advocacy. Clinicians must be attentive and aware and advocate for care that their patients need based on what we know works. And we look forward to working with Assemblyman Conaway and Pinkin and Senator Vitale to meet the needs of the underserved in New Jersey.

Thank you.

>> Thank you so much, Fran. Fran really is just one of the people that we spoke to in the course of building these reports in New Jersey and North Carolina and we were really inspired by all of the stories that we heard from the people who are working on the front lines and all of the work that they're doing to really move these things forward.

In our reports, we've tried to be attentive to the comments and the input of our community partners. And many of you might be listening to this webinar right now. And we thank you so much. People donated a lot of their time and energy to making sure that these reports really reflected the reality on the ground.

So turning our attention to North Carolina and the major findings there, on the prevention side, we really identified some areas where North Carolina was ahead of other

states in and some areas also of concern. For example, North Carolina has been working for years to support the use of schools and other public spaces for community exercise and recreation after hours. This is a major priority of the American Heart Association. It's an obesity prevention strategy endorsed by the CDC. So it's really great that North Carolina is a leader here.

However, there's also room for improvement in North Carolina. They could really make a difference to the most at-risk population by having Medicaid reimbursed for participation in the Diabetes Prevention Program. This program, as I said earlier, is relatively low cost to administer but it has a huge payoff so it really educates and empowers the individual to take control of their own health. And it gives them the tools to change their lifestyles before they develop the disease. This is one of those to me it's a no-brainer because it's a win for public health insurance programs in terms of savings, and it's a win for individuals who avoid diabetes altogether.

On the management side, a few things rose to the top in terms of affecting the ability of North Carolinians with Type 2 to manage their disease. So the first, of course, is access to comprehensive diabetes self-management education. And Fran spoke to the need for this really powerfully. It's absolutely crucial.

There was a consensus around the state around the idea that it needed to look at the DSME programs in North Carolina to maximize their effects and to minimize some of the confusion and the administrative challenges that existed around billing and reimbursement. So because this is a really critical service for people with diabetes, it was felt that there needed to

be some organized and really formal attention to it to ensure that everyone who required it could, in fact, obtain it.

And then, of course, similar to New Jersey, access to the testing supplies, making them affordable was a huge concern and as was the really urgent need for case management and especially case management that is attune to the needs to coordinate the behavioral and physical healthcare. Because when those two forms of healthcare are coordinated, when they're working together, there's better self-management and then there's better treatment compliance in patients with Type 2.

We also heard over and over again in our focus groups about the need for a way for healthcare providers and community-based programs to share information and then at the most basic level, simply for them to be able to -- to be aware of each other.

So the most popular idea was to use an electronic web-based portal for communication and to actually build functionality into electronic medical records so that, for example, diabetes program providers in the community could see some data, of course with the patient's permission, then feed their own data back to the provider.

There was also a huge push for the expanded use of Community Health Workers, again similar to New Jersey, because these individuals are from the underserved communities and have proven to be really effective at increasing treatment compliance and helping patients learn about self-management.

So, after publication of the Policy Report in North Carolina we held two events in May and June to talk about the report. We brought leaders and advocates in the state together

similar to in New Jersey. We also, similar to New Jersey, sent a survey to all of our community partners to help identify the top priorities in the state, the things that we should really move on now.

So three issues rose to the forefront. Not surprisingly they were: the expansion of Community Health Workers, reimbursement of the Diabetes Prevention Program, and then a creation of a Diabetes Self-Management Task Force to look at billing challenges and other administration challenges for a diabetes self-management education in the state.

Right now we're just beginning to form the working groups in these areas. We're really excited to have the diabetes Advisory Council and some of the major philanthropic institutions in the state to partner with us in defining the specific objectives for each of the groups and move things forward.

As far as implications for other states, the recommendations in our PATHS reports grounded in interviews with stakeholders in North Carolina and in New Jersey. But we also looked at what other states were doing in the course of our research. We looked at what they were concerned about so that we could put these recommendations in context.

So we believe as we continue to research and draft our best practices report, there are some universal issues which will rise to the top in almost every state and that is the coverage, the reimbursement, and coverage, for these really crucial services. So that's Diabetes Self-Management Education, that's Medical Nutrition Therapy, medical supplies, those testing strips, those meters, and then the Diabetes Prevention Program.

In proving the connection between providers and the community-based programs is a

must as is finding ways to employ more Community Health Workers and expand their reach. This means looking at ways to make sure their services are reimbursable by insurers so that it is a sustainable practice to include Community Health Worker as part of the healthcare team.

On the prevention side, almost all states are already engaged in trying to increase access to healthy food and need to ensure those federal food assistance programs are reaching target populations, especially for school-aged children and younger children who can reap those benefits from forming healthy eating habits now.

So all of our reports, the upcoming reports that we have coming out as well as other resources that we've produced will be available on a new website that we're excited to launch. It's going to launch at the end of this month or maybe at the beginning of August.

[Www.diabetespolicy.org](http://www.diabetespolicy.org) is going to be a platform not just for our work but it's going to be also a platform for all of our partners and people that are working on Type 2 diabetes who wish to disseminate research, materials, and resources. Be on the lookout for that at the end of this month or beginning of August.

We really thank you for joining us today. We look forward to answering some of your questions.

Thank you.

>> An Nguyen: Thank you so much, Sarah, Alli, and Francine. We're going to go ahead and open it for questions right now. To do so, you can just simply click on the Q&A tab on the right column and then simply enter it into the dialogue box on the bottom.

As folks are putting in their questions, we've got a few questions in. I'd like to start

with -- I guess this would be a question for both Alli and Sarah.

How are you responding to different political environments in the two states and how do you recommend that advocates in other states begin to approach their legislatures with proposals and ideas?

>> Sarah Downer: Thanks. This is Sarah. That's a great question. For sure the makeup of the legislatures in both states are very different but what we found is that they're both really aware that diabetes is a huge issue so both from a human perspective, they know it's a disease that really limits the length of life, limits quality of life. And then from an economic perspective it's an incredibly costly disease to manage. So that really resonates with legislators.

Some of the statistics -- you know, the average cost of healthcare per person without diabetes is about \$2,800 a year. If the person has a diagnosis of diabetes, that costs jumps up to about \$12,000 a year. So it's a huge increase.

We've looked for, in the course of our research and in the course of our advocacy work, looked for motivated partners in both legislators. And we found them on both sides of the aisle, really. So in New Jersey we had Assemblyman Conaway and Senator Vitale. They're both democrats. In North Carolina we're aware that there's ongoing dialogue in the House about food deserts and food access issues and that that is chaired to Republican representatives. If you're going to think about approaching legislators in your state, we recommend first look at who has sponsored related legislation or related dialogue in the House or Senate either on diabetes or food access or physical activity related legislation in the past

and then approaching them as a first step to acquaint them with the issues that you want to move forward.

We also recommend not going into the search for a legislator who's going to be a champion for you with any of the preconceived notions about who is going to be most likely to support reform. What we've seen as we've looked at it in both states is that it's really a bipartisan issue. So you need to invite part in other words from both political parties to really help craft policy solution that are going to work in your state.

>> An Nguyen: Great. Thank you.

We've got a question from Bob. Given the two-way relationship between diabetes and [Inaudible] disease, how have these two states worked with the dental community to improve collaboration?

>> Sarah Downer: That's a great question as well. We did speak with lots of different partners and different providers. In the course of our work, we advocate increased access to all of the necessary providers and that includes the key providers like podiatrists and also dentists and mental health providers, the people that really sort of help close the loop on several of the preventable complications that happen with Type 2 Diabetes and are associated with, you know, with poorly managed incidences of the disease.

When we were looking at the priorities that we would really focus on in the states, we had to ask our partners what they wanted to focus on first. So the priorities that we've chosen to advance are the ones that there's really been a consensus around these are the things we need to do to have the biggest impact, but we do recognize, of course, that there are a lot of

areas to work in outside of those top priorities and that there are active communities and advocates in all areas working to advance reforms specific to certain areas like access to services that should be integrated into holistic -- whole person diabetes care.

>> An Nguyen: Great. Thanks so much for that. Another question from Katie Hodges.

Simply a clarification question, but: How does the state of New Jersey differentiate between Self-Management Education/Training which is indicated as a covered service per NCSL?

>> Allison Condra: This is Alli. I think I'm going to let Fran answer that if she can. I will say to all the participants that I focus mostly on the prevention and environment piece. So I think Fran will be better able to speak to that if she can.

>> Francine Grabowski: This is Fran speaking. I can -- my understanding as a diabetes educator is they are one in the same, DSME/T and as a program manager involved with reimbursement outside of underserved communities there is no reimbursement for either through Medicaid. I am unfamiliar with the entity that was mentioned, NCLS I think.

>> An Nguyen: The national conference of state legislatures.

Another question we have is from Barry Ross. Given that the education has only been able to reach 3.4% of the 7,000 residents, are there other strategies you are implementing to reach the broader number of patients?

>> Francine Grabowski: The coalition is working on a number of strategies. It's on the cutting edge. There are physician group visits or there is an entire organization that is devoted to providing group encounters during medical visits. So nurses and other educators would be involved to make the group more -- to make the experience more educated experience. We

have Community Health Workers that go to homes. There are just a whole array of tools that are being used to reach people in different ways. DSME is only a small fraction of the ways. It doesn't work for everybody. But if someone wants it, we want it available.

>> An Nguyen: Thanks so much. We have a question from Sarah Eichberger. Do you have any suggestions or comments on how to increase capacity of healthy food access and supporting built environments as a way to address diabetes?

>> Allison Condra: Can you repeat that one more time? There's a lot in that question.

>> An Nguyen: Sure. The question is: Do you have suggestions or any comments on how to increase capacity of health colleagues on healthy food access and supporting built environments as a way to address diabetes?

>> Allison Condra: That's a great question. One thing I would recommend first off is figuring out where there are resources to educate yourselves about what's been going on in other states. A lot of states and communities have been working to increase access through policy change and through other programmings like the Food Truck in Philadelphia has been doing a lot of work around healthy food access. So one of the first steps in it policy advocacy is doing that education piece.

I would be happy to be in touch with you to give you some of the resources that we have. But I think looking at what other communities have done and seeing how that might work in your own community is a good start for building capacity among people who are interested in this issue and trying to figure out how it ties -- or just learn about how it ties into diabetes prevention and management.

>> Sarah Downer: And then part of what we've been doing in the course of our advocacy work is trying to develop materials that really demonstrate the impact of changing food behaviors and changing physical activity behaviors on health. So, you know, thinking about ways that food policy councils, if you have one that's local to you, or other entities that are working on food policy and physical activity in the built environment can disseminate the data and the study that are out there, in a digestible way to your healthcare colleagues.

What we found is that a lot of health providers, they're really hungry for that information and they need to have it in a forum that is going to work for them. And getting healthcare providers involved in local food movements or movements towards physical activity is also a great way, inviting somebody to come and be a part of a movement or create a particular working group is also a great way to get them involved and up to speed on an issue that is particularly urgent.

>> Allison Condra: One more thing that I'd add about that -- it made me think about our New Jersey Diabetes Leadership Forum event that was at the end of March. We had a couple of panels that were made up of both sort of prevention folks, people who are involved in the food and physical activity realm, as well as people who are involved in the management side of things, the healthcare management. It's broader than just a healthy food access, but we asked them what they thought about way that they could work together, sort of bring these two groups that sometimes seem to be working in different spheres together. I think they came up with some really -- markets on hospital properties. So I think that part of building capacity is also identifying other people that you might not initially think of would be potential partners and

then building those relationships. Because it might be that these folks have also thought about this issue but from a different perspective. And then building that coalition is a really important step in moving any sort of advocacy forward.

>> Francine Grabowski: I'd like to add a couple of things. One of the things that we've seen in Camden is really having a clear message, the same message so the providers and any partner that's involved with healthy food access. So we use a diabetes healthy plate where half the plate are vegetables. That message is getting out more and more people are talking about that. And as soon as they know that vegetables -- that penetrates the small grocery stores, the doctor's office, and everybody is thinking, how can we incorporate more vegetable in our community.

Another thing that we've done is we have a monthly diabetes educator meeting. Anyone interested in educating about diabetes. It reminds me of, you know, you build it, they will come. And people are coming to the table who have access, who bring food to the table, bring healthy food to the table, and then we start linking up and seeing how we can cooperate and figure new ways to bring healthy access of food to the people we serve.

>> An Nguyen: We've got a question from Linda. This is probably more geared towards Fran. We know that patients need to know the skills of diabetes education but the real work is coaching behavior change. Coaching adjustments in medication is vital in diabetes. How will competence be validated?

>> Francine Grabowski: That's fascinating. I assume that means competence of the person doing the coaching. I've experienced that that it takes a long time to be able to work with

coaches so that they can help a person as they make changes related to their diabetes care. If the coaches are part of a recognized center, there will be a structure in place that can constantly support and give reinforcement to the coaching. I've also heard it called companionship. Once you have diabetes and once you're on insulin, you need to have a companion that can be there for you and answer the questions, particularly as changes occur. And changes will always occur. I would want to have a structure in place that can be there to answer questions for the coaches and help them design a care plan and really give them the CDE -- in companionship.

>> An Nguyen: A follow-up question. How is competence measured --

>> Francine Grabowski: I really can't answer that. The Community Health Workers that we have in the coalition are working in a different venue than I'm working. And we do have a nursing staff that works with the Community Health Workers. So I don't have help with that.

>> An Nguyen: A question from Shelley Shandler. New Jersey or North Carolina to enhance the connection between providers and community-based programs?

>> Sarah Downer: So honestly, as we did the focus groups and went through it, just the convening of all of the different players in one room would seem to be the most effective. After every focus group we held people were exchanging their materials and being, like, oh, you are just down the street from me; I didn't know that. So I think, you know, people are really looking for some kind of central electronic database where there's information would be where a provider could sort of click through the different programs in the community that were available and see if they had open slots and where community-based programs could update their

eligibility criteria or, you know, posts that they were looking for more participants in a certain program. So we haven't seen anything that has been that effective be put in place yet. We know that getting people in the same room works, but beyond that we haven't seen anything yet that has really been put in place.

In terms of a centralized website, we think that's one of the most promising solutions. But, again, would need somebody to maintain that. You would need, you know, a full-time person just to -- you know, we're a little ways yet I think from seeing it. If there are people listening in other states that know a great way to do this, we'd love to hear from you.

>> Francine Grabowski: I'd like to add a little bit about our experiences of working with -- in Camden. We connected, joined, with, let's say, a housing development. So there are a number of locations in the city that provide apartment rentals, subsidized apartment rentals. We worked with the social worker or some organizer in the housing development. It takes years to do this but what we're seeing is communities are coming together because they know that this locale has the foundation for bringing together different venues to improve health.

>> An Nguyen: Great. Thank you.

A question from Sarah Eichberger. How do you respond to people who question the evidence-base of PSE for DM prevention?

>> Sarah Downer: I'm sorry. Can you repeat that?

>> An Nguyen: Sure. How do you respond to people who question the evidence-base for PSE for DM prevention?

>> Sarah Downer: And what does PSE standing for?

>> An Nguyen: You know, I am not sure.

>> Francine Grabowski: I'm not sure either.

>> An Nguyen: Ok. We will move forward to another question.

Fran, this is a question for you. Using Community Health Workers for diabetes education, how are you able to get reimbursement?

>> Francine Grabowski: We have no reimbursement for what we're doing, no reimbursement. We are currently funded through grants, which is the problem. We must figure out a way to have reimbursement. What I envision, what I think is possible, is if you have a recognized diabetes center which is an entity that should be reimbursed for Diabetes Self-Management Education and that center has Community Health Workers as part of their curriculum.

>> An Nguyen: Great. I don't know, Sarah and Alli, if you have anything to add on suggestions on how to get reimbursed for Community Health Workers.

>> Allison Condra: I was going to jump in with another comment. I can think about that specifically. I just wanted to say that in both of the reports we talk about other types of providers that could be -- whose services could be reimbursed through insurance. So in our summary of the reports we focused largely on Community Health Workers because that's what both of the communities had identified as that -- we were talking about DSME and other providers in that way. Those were the things that had been identified by the community that was priority. But we also talk about the possibility of having pharmacists reimbursement and other providers. So if you're interested in learning about other types of people that could be provided, I would recommend just looking into the reports.

And then the other question that you just had was: Do we have any other strategies for reimbursing Community Health Workers? Was that the question?

>> Francine Grabowski: Yes.

>> An Nguyen: Yes.

>> Sarah Downer: So connecting Community Health Workers to Medicaid health homes and to other health homes and entities that are going to be receiving those capitated payments so that they can -- in way that make sense to them to improve outcomes while lowering costs. If accountable care organizations, those entities that are going to be receiving those capitated payments which just means a lump sum of money to provide healthcare in a way that makes sense to them, those are avenues where Community Health Workers can be part of a healthcare team right now. And then we would hope that as there are more sort of formal either credentialing or quality control programs that are put in place throughout the states that more insurers will be interested in reimbursing for the services of Community Health Workers because they're so cost effective.

>> An Nguyen: Great. Thank you.

So we got some clarification from Sarah Eichberger on what PSE means so I'm going to ask that question again.

How do you respond -- [Inaudible] of policy systems and environmental change for diabetes prevention?

>> Sarah Downer: Ok. Yes. Ok. We got it. When you're talking about creating the ideal environment to keep someone with diabetes healthy or helping someone prevent the disease

altogether, we have to look at the food and physical activities environment. But one of the biggest challenges in getting the attention of the key decision makers, be it legislators or the state and federal policymakers, whoever the decision maker is, is that lack of hard data that says this particular change is going to have the impact that we want and it's guaranteed to save this amount of dollars. You know, change A1C levels this much. Even when we have a fairly solid indication that a particular indication saves dollars, like the Diabetes Prevention Program, we have to work hard to get the insurers and policymakers behind it. So we need more data. So we need to keep supporting the scientifically rigorous studies and we need to keep research dollars in this area.

This is also one of the American Diabetes Association's main policy priorities as well; that we need to keep doing those data on health impact assessments and tying changes to the Built Environment, for example, to changes in -- that is really the language that is most effective, we found; framing it in that economic way to get the legislators pay attention.

>> Allison Condra: And I'll just briefly say that we've dealt with this in one of our focus groups in New Jersey. We had a pretty lengthy discussion about linking things like SNAP and WIC and increasing participation in those programs or increasing food and vegetable consumption through those programs and how that ties in to diabetes. So we did find a "New England Journal of Medicine" article that talked about the impact of healthy eating. So I would direct you to the New Jersey report. I would be happy to find that study and send it to you if you get in contact with us. But it is, as Sarah said, it is challenging. And with something like diabetes, that is really impacted by so many different factors. It is hard to say, well, if this, then this, you

know, outcome. But I think continuing to do more research will help in that way.

>> Sarah Downer: And that's also something that our community partners have expressed a lot of interest in, trying to figure out from insurers or from state Medicaid programs -- you know, what information do you need so we can show that you this is going to be a cost effective intervention?

Some of these interventions just aren't set up currently to evaluate in the way that's going to make an impact with these audiences, but they want to be. They just really need to know from them, you know, what do you need to know from us to make this happen? Track the data in a way that's going to make sense to you. So needing to make sure programs are able to track their outcomes and getting them in a room with insurers and other payers to say this is how we're going to use your data to make decisions about whether we should be reimbursing for this and whether this is really going to make fiscal sense for us.

>> An Nguyen: Great. Thank you for answering that question. We're just kind of reaching the end of the web forum. With that I'm going to ask if any of the presenters have any closing comments before we wrap up.

>> Sarah Downer: Just this which is that our contact information is on the Dialogue4Health website. We really welcome people to contact us after the webinar, tell us about interesting things that are going on in your state, or ask a clarifying question. You know, we want to have as much information as possible as we move into this next phase of our report and project. So we really do thank you for listening today. We thank you for your attention. We'd love to keep interacting with you and make you part of our network.

>> An Nguyen: Great. Thank you so much to all of the presenters on today's call. Also, thank you to our sponsors. And a special thank you to the staff at Public Health Institute, especially Star and Joanna for making everything run smoothly this afternoon.

Just a reminder that all of the slides will be available on the Dialogue4Health website. We'll keep in touch as far as resources. And if you have any additional questions, we recommend that you reach out to one of our presenters which we had provided some of the information.

Thank you to everyone who has joined us this afternoon and have a great afternoon.

Thank you.

[The webinar ended at 3:15 p.m.]