Dialogue4Health Web Forum
Beating Type 2 Diabetes: Recommendations for Federal Policy Reform
Wednesday, October 21, 2015
1:30 p.m. – 3:00 p.m.

Remote CART Captioning

Communication Access Realtime Translation (CART) captioning is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.
This transcript is being provided in rough-draft format.

>> Hello, and welcome to Beating Type 2 Diabetes: Recommendations for Federal Policy Reform. My name is Joanna. And I will be running this web forum. Closed captioning will be available throughout today's web forum. Regina with Home Team Captions will be providing real-time 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, should be in the bottom right hand corner of your screen. In the media viewer window, on the bottom right hand corner, see the show/hide header text. Click on this in order to see more of the live captioning. Another window may cause the media viewer panel to collapse. Don't worry. You can always reopen the window by clicking on that same icon.

If you experience technical difficulties, dial 866-229-3239 for assistance. Take a moment to write that number down in case you need it later. The audio portion of the web forum can be heard through your computer speakers or a head set plugged into your computer. If at any time you are having technical difficulties, send a question in the Q and A panel and Holly and I will provide information to you.

Once the web forum ends today, a survey evaluation will open in a new window. Take a moment to complete the evaluation as we need your feedback to improve our web forums. The recording and presentation slides will be posted on our web site at Dialogue4Health.org. We're encouraging you to ask questions throughout today's presentation. To do so, simply quick the question mark icon, type your question in, and hit send. Please send your questions to all panelists. We'll be addressing questions mostly at the end of the presentation. However, we encourage you to send them as they strike you. And we'll get to those at the end. Feel free to send questions throughout the event.

It is my pleasure to introduce our moderator today. Chris Kinabrew. Chris manages communications, new business development and strategy for the organization and its state and local partners. Chris worked with us on several web forums and so grateful for the ways he has built a warm and steady partnership. Over here at Dialogue4Health we love being part of his NN pH I efforts. And with great pleasure, Chris, take it away.

>>Christopher Kinabrew: Thanks so much. As she mentioned, my name is Chris. I'm chief

strategy officer with the National Network of Public Health Institutes. Includes multiple individuals including for our work together on diabetes. As well as Whitney our convening specialist. I wanted to share a few words about the National Network of Public Health Institutes as well as the together on diabetes initiative before we hear from our speakers today.

Just a little more about NNPHI, we're nongovernmental organizations implementing public health policy and program initiatives throughout the 50 states and our current membership includes 44 organizations in 32 states in DC. We're also serving as the new national coordinating center for public health training working with 10 centers serving the nation. So we support public health system initiatives including chronic disease prevention and control.

Our role together on diabetes has been to support the grantees of the initiative through a number of mechanisms including grantee meetings on an annual basis, web nears such as -- webinars such as this one and networking general connectivity with the public health community. A little more about together on diabetes, I want to say a special thank you to Patty Doykos, the director on that initiative as well as John DeMonte. They started off together on diabetes in 2010 with a goal of improving the health outcomes for people living with type 2 diabetes in the United States. Over the course of several years, relationships with over 25 grantees. Focusing on a number of things. But the general categories of work were strengthening patient, self-management education, community-based services and broad based community mobilization. So there's a lot of great work that's been done. I wanted to encourage anyone who is interesting to visit the together on diabetes web site. The URL is right there. And there's plenty of resources there in terms of learnings from the grantees. Information from the four grantee summits. And then also for the work we're going to hear about today, some of the policy work.

Another thing that's not included on the slide that I wanted to mention is one of the together on diabetes grantees has been learning through partnership diabetes health equity. And that web site is www.diabeteshealthequity.org.

We have three speakers from Harvard Law School. Emma, Sarah Downer and Jamille Fields. I will share a little about each of them before we hear from them.

Sarah Downer is a clinical instructor at the Center for Health Law and Policy Innovation. Focused on policy projects on health and food law. She has expertise in diabetes policy as well as a number of other areas.

Jamille joined the Center for Health Law and Policy Innovation at Harvard back in August. Been involved in a range of projects and we look forward to hearing from her today.

Emma is a clinical fellow in the food law and policy clinic at Harvard Law School. As you can see from her bio here, focused a lot on school foods, intersections of food and health and food policy counsels.

So I will turn it back over to Joanna to talk about the Q and A.

>>Sarah Downer: I'm Sarah, a clinical instructor here for policy and innovation. And welcome you to our webinar today. Next slide.

Today, we're talking about the work we've done here at the center on type 2 diabetes. Where we've been working together on diabetes initiative. We're going to start by talking about the status of the epidemic and the important role federal policy has to play in addressing it from multiple perspectives. And the meat is an overview of 7 policy recommendations that we've identified here at the center very important to creating a new health and wellness landscape for people who either have or are at risk for type 2 diabetes. And then we'll talk about how you, our audience together and colleagues and peers can advocate to employment these changes -- implement these changes.

Finally, we'll tell you about upcoming events. Next slide.

I'd like to introduce our center. The Center for Health Law and Policy Innovation sits at Harvard Law School. The first is health law and the second is food law and policy. Our type 2

diabetes work really sits at the intersection between those two areas and is consistent with our overarching mission at the center. We're try to go advance access to healthcare and healthful food for low income populations especially for people living with chronic disease. We have law students come and work with us to do hands on policy work in these two areas. Next slide.

Just to give you a little bit of a sense of the history of our work on diabetes in this space, as I said earlier, our diabetes project and we call it PATHS, providing access to healthy solutions, is part of the foundation together on diabetes initiative. We began by doing deep research and analysis in two states, North Carolina and New Jersey. We looked at the policy arenas that touch on diabetes. Healthcare policy reform, food policy, transportation, physical activity, anything that touches on diabetes, we looked at. And we issued two state level reports with recommendations that were unique to each state.

And following these, we engaged in providing legal technical assistance for some of the other partners on together on diabetes initiative. So we thought of ways to fund and encourage more holistic healthcare and helping to motivate communities on the ground, leverage the expertise of the wonderful coalitions they were part of to achieve food policy change. And building on that state level, an issue area focus work that we did. We shifted to thinking about what policy reforms could really create meaningful change at the federal level? So this is research and analysis we're presenting to you today.

And finally, looking forward into 2016, we'll be releasing a policy report on best practices for states when it come s to diabetes policy. So please look out for our contact information. That's going to pop up various points throughout this webinar. And then stay connected with us if you'd like to be on the list of our first release report. Next.

So as I said, today, we're focusing on policy changes that would be impact full for people living with or at risk for type 2 diabetes at the federal level. We know there are a host of extremely important and vital policy reforms that need to happen at the state level, at the local level. Today, we're going to stay federally focused. We're calling on congress, federal agencies to take action in key areas.

The recommendations that you are going to hear about today can be viewed in greater detail in our report. And you'll see the link here on this slide. You'll be able to visit that. And I want to note here, this is, of course, not an exhaustive list. We've chosen to highlight policy changes we at the enter -- center are crucial with all of the conversations we've had with providers and people living with type 2 diabetes. And we've selected these recommendations of policy expertise. Which is why we focus heavily on in addition to health policy, food policy changes as well. Next.

So before we dive into the recommendations, let's take a brief moment to describe what we're facing as a nation when it comes to type 2 diabetes. Almost 9% of the population in our country has diabetes. Over 29 million with the disease. 95% of that have type 2 diabetes. So we're looking at a disease this is serious, chronic and fairly common. So the complications are pretty grave. You can see the list of conditions that go along with diabetes diagnosis here on the right side of the slide. The incidents of type 2 is much higher in certain geographic areas as many of you well know. We've included the map from 2013 here on the slide with the states in dark red having the highest diabetes rates among adults. The American diabetes association has estimated the total cost of diabetes care in the United States is now over $245 billion a year. One in five healthcare dollars is spent caring for people with diabetes. One in three Medicare dollars are spent on treating diabetes. So the prevalence of diabetes in America also has other significant costs, loss productivity, increased unemployment, early mortality and disparities exist. Drastic disparities exist in the rate of diagnosis, treatment and rates of quality care for individuals who have lower socio economic status.

At this point, we need to pull together and move forward as a nation in a very forceful and coordinated way. And we need to direct serious resources toward addressing this disease. So I know we are going to make a lot of recommendations today about funding levels and

increasing funding. And we always get pushed back saying we can't pay for everything. That may be true. But there is a very urgent need to direct serious resources towards diabetes in particular. The CDC estimates 86 million or more than one in three has prediabetes. They have the elevated blood glucose levels and generally are going to have a 15 to 30% chance of developing diabetes within five years. So we're looking at millions of people poised to have this disease in a very short time frame. And the quote here on the slide that one in three Americans will have diabetes by 2050 is pretty sobering.

It's an incredibly complicated disease to live with and manage. People are doing it every day, of course. And should really be celebrated. Management really does mean thinking about regular self-monitoring of blood glucose levels. Thinking about diet, medications, the food they eat, the exercise they get and all of this on top of being employees, family members. As a nation, we really can't afford for barriers to continue to exist. So we can't afford to lose the contributions these folks have to make to our society. And can't afford to pay the financial costs of an unchecked epidemic.

So we need to be actively seeking to give people with diabetes or at risk to give their healthcare providers, to give broader communities the tools they need to maintain good health. That's where our 7 policy recommendations here come out of. Next.

So our recommendations today fall into three areas. The first is advocating for coverage of really impact full services by insurance. So we're in a post affordable care act world where many people have coverage. For people with diabetes or at risk, the coverage does need to include the services that are going to make a difference. We'll be talking about self-management education. Prevention programs and food interventions. The second area is funding. Funding research, funding evidence-based programs, and funding care models that are going to work better for folks with diabetes and prediabetes. And the third area, we're going to take a step back from the laser focus on diabetes and really look at the environment in which folks are developing prediabetes and diabetes with an eye toward food policy. What's going to be meaningful in terms of increasing access to helpful food for people of all ages?

Now I'm going to introduce Jamille Fields which is going to focus on insurance coverage of key services.

>>Jamille Fields: Thank you, Sarah. So our first recommendation for federal policy reform is to explicitly include evidence based prediabetes and diabetes services in the affordable care act definition of benefits. Under the ACA, 9 grandfathered individual and small group health insurance plans and Medicaid for newly eligible individuals and the Medicaid expansion must cover certain healthcare services which are known as the essential health benefits. I'll refer to them as EHBs. The purpose of requiring coverage was to create uniformity among small group plans. And ensure they are covered. As you can see, these categories are broadly defined and the specific services are not specified. The department of health and human services or HHS for short, decided EHBs in each state will be based on bench mark plans. Each state was then given the freedom to select the plans which would serve as the model for the services other required plans would cover.

And while the bench mark process does add some specificity to categories, because they are chosen at the state level, there's a lot of variation in the services that are covered.

The ACA does provide the secretary of HHS should periodically update the definition of EHBs and in February of this year, that happened. HHS issued the notice of benefit and payment parameters rule 4-2016 plans which finalized the standard. Next slide, please.

So two services we think should specifically be covered. First, the national diabetes prevention program or national DPP for short is a life style aimed at preventing type 2 diabetes. This year, the program helped participants make lifestyle changes including eating healthier foods and physical activity. The origination Al DPP trial generated 58% reduction in diabetes incident as well as high blood pressure and metabolic syndrome. These reductions were shown to persist a decade later. Currently, there are over 625 national DPP programs

available across the country. However, there's still currently a lack of general coverage by insurance carriers. And many individuals cannot afford it to enroll out of pocket. Very few of the bench mark plans available from 2014 through 2015 covered the national DPP. Among state and employee benefit plans which are the largest employee plans in the state, only 7 states including in DPP. And only one state, Montana's program included NDPP in covered benefits.

The other service I want to discuss is the diabetes self-management education. And it's aimed at preparing people with diabetes to manage the disease on their own and halt its on progression. DSME as the service is known for short, can be personized and delivered as often as needed.

The service provides individuals with information about diet, exercise, medications that they may be on and how to reduce the risk of complications.

The national standards for diabetes defined DSME and assists educators in providing evidence-based education. DSME is clinically shown to lower blood glucose levels and reduce the incidents and severity of diabetes. Coverage of some form of diabetes education does tend to be more prevalent. However, a recent study found only slightly over half of diabetes patients publically and privately insured received diabetes education.

With that, we offer a recommendation that during the next update to the EHB rule, the federal government should include the nation National Diabetes Prevention Program and diabetes self-management education within the required definition of EHBs. HHS could create a definition of the preventive services category which is one of the ten categories that includes national DPP and DSME. Next slide.

So the next recommendation I'll talk about also relates to national DPP. As we just discussed, national DPP can provide huge improvements in the health of those with prediabetes. The national DPP has also been shown to be affective for seniors with prediabetes and helping them change lifestyle habits and avoid diabetes. There are 50 million individuals on Medicare. And more than a quarter of people age 65, the Medicare population and older, have diabetes and nearly a quarter meet the criteria for prediabetes as evidence on the blue graph on your screen.

In at least one clinical trial, national DPP resulted in 71% reduction in developing diabetes in people over 65. National DPP garnered such positive results, Medicare does not currently cover the program. It is worth noting, Medicare does cover the DSME discussed on the previous slides.

There is also not a federal requirement to cover national DPP. This is particularly important as low-income communities are disproportionately affective which comes from the American diabetes association. Given national DPP costs around $450 a person. Lack of coverage makes the program out of reach for most recipients to pay out of pocket.

With that, next slide please.

We are asking for a couple action steps. So first, the Medicare diabetes prevention act which was introduced most recently earlier this year in congress. It would amend the social security act to reduce the incidents of diabetes among Medicare beneficiary. Would cover the national DPP through Medicare and would improve patient outcomes and state and federal spending over the long-term. If Medicare were to cover the national DPP, projected savings are $1.3 billion over nine years. Also CMS should issue guidance to state Medicaid programs outlining the option to include national DPP and process for including the program. Unlike Medicare, Medicaid is a federal state partnership and mandatory services that must be covered. States have the flexibility to cover additional services.

Guidance from the department of health and human services or HHS, in the farm of a -- form of a health official letter that explains that national DPP is available for coverage and the process for amending the state's plan to cover the services will go a long way to encouraging states to include this important benefit. Next, back over to Sarah to discuss the

next recommendation.
>>Sarah Downer: All right. So now we're on recommendation number three. Include coverage in Medicare of medically-appropriate food as a cost-effective diabetes intervention. The focus here is on Medicare, also a little on Medicaid and the federal government's power to influence the benefits both programs cover. As we're thinking federal here, we're going to focus in depth on Medicare. So one in three Medicare dollars is spent on people caring for diabetes. Pretty urgent within the program to take the steps that are going to have an impact on that population. Type 2 diabetes as we know is a diet-related chronic disease. Diet, meaning the whole of what a person is consuming from day-to-day. Interacts with all of the other risk factors and contributes to first increasing the likelihood of developing diabetes or prediabetes or helping to successfully lower blood glucose levels and avoid a diagnosis. So, in you have a lack of access and you are food insecure, you are more likely to develop diabetes. Also associated with poorly managed diabetes. So that means more hypoglycemic episodes which is scary for the individual and costly from healthcare dollars perspective.

Food has a really big role to play in type two diabetes. People who have Medicare medical coverage can sit down with a dietician and talk about how diet impacts the disease. How to change their diet. At the center for health innovation, we believe that in many cases, not all but many. Nutrition education simply isn't enough. Even individualized nutrition education really isn't enough. So we think the provision of medically tailored food. This means meals designed in consultation with a dietician for someone with diabetes is a valuable benefit going to improve health outcomes for people and lower the costs of care.

The provision of food as an insurance benefit is going to respond to the emerging body of research that shows providing meals can lower blood glucose levels and reduce emergency room visits in addition to all of the other benefits. We're asking -- only in discrete circumstances which I'll talk about. Next.

So Medicare is a very large and complex program. Medicare Part A hospital insurance, Part B Medicare coverage. Part C. Private insurance insurers like Blue Cross/Blue Shield have plans they offer to beneficiaries and offer all of the benefits Medicare covers. And part D which is prescription drug coverage. Medicare currently will cover the meals under limited circumstances. And it's not available to all Medicare recipients. Under Part A and B, those cover 44 million immediate dare recipients. The vast majority. So any coverage of meals in Medicare part C or advantage plans. If you remember, those are the ones offered by private insurers to Medicare recipients. They have the option of offering meals under the circumstances that you see here on the slide. So basically, they have the option, again, it's optional. Not required to offer meals for a temporary period following a surgery or hospital stay or lifestyle transition plan. And also within Medicare advantage plans special plans called duel eligible beneficiaries. So this is a population that has a high level of medical needs. They are likely to be expensive. For those folks eligible and have a special needs plan, they are to offer meals without restriction. Our recommendation is we're asking the ability to have meals as a covered benefit be expanded to all Medicare recipients. Within Medicare part C, plans would be required if it met the criteria. And that Medicare recipients would also be able to receive meals.

Next slide. So the ask here is that congress or CMS if it can do so, expand meals to all beneficiaries who meet that criteria of needing them for a temporary period or surgery or during that critical lifestyle transition program when people are try to go make a lot of changes to their diets. And to the extent possible, CMS and state programs should talk to each other. And Jamille talked about how that could happen when she talked about the national DPP. Offering guidance on how to draft state plan amendments that would cover this service. Next slide.

The next recommendations we're going to talk about focus on funding for diabetes research and implementation of care models for people with diabetes and prediabetes. Our fourth recommendation is increase federal funding for diabetes prevention and research. We

believe federal investments are too low to combat this disease. By 2025, we could be spending up to $514 billion in diabetes. That's comparable to the entire budget of Medicare today. So we need to be investing resources right now in prevention and research on treatment. Just like all federal agencies and programs, research and prevention endeavors have faced funding levels of all of the fiscal pressures we have been facing. The national diabetes prevention program which we discussed early on has never been fully funded. The funding appropriated has always fallen short as a truly national program. So fully funding the national DPP would enable the 86 million Americans living with diabetes would have access to this program. The national institute of diabetes and digestive and kidney diseases or NIDDK, is the leading supporter into treatment and cures. And that's also scenery deduction and funding from 2010 levels.

Finally, increasing funding for the division of diabetes translation within the CDC will enhance capacity to coordinate the nation-wide response to the epidemic. Next slide.

So we're calling on congress here to increase or appropriate full funding to the national DPP to the NIDDK and to the division of diabetes translation. We really believe that this is the time to direct significant resources to prevention efforts and boost the efforts of researchers searching for the treatments or cures. Next.

So our recommendation number five is to encourage states to develop coordinated diabetes care models through diabetes specific innovation rewards. And sits the center for Medicare and Medicaid or CMMI. And it's used rounds of funding if they can develop and test within Medicare and Medicaid so they can wave some of the traditional requirements for these programs and tryout new services. In continue to go think about funding, what we're looking for is a way to fund diabetes care model that really incorporates all of the services that have been used to such great affect in various pilot research projects. We're talking about evidence-based interventions. That have been tested and a one off because they've been grant funded and now need to be tested on a larger scale statewide.

So some of these pilot projects have been funded by private. Invite states to design care models as the primary focus from prevention to treatment. So there have been other funds awarded able to be used to address diabetes. We believe it could be more affective Leah dressed by a round of funds. Would be great to use the opportunities to test the services about what really works. Diabetes is complex and prevalent enough to warrant this kind of laser focus. Plus to the extent many conditions are found along with diabetes. Diabetes can be that lens through which to address this host of other health conditions. Should be directed towards state with the highest rate of diabetes and really not participated from the models even if they have had funds available to address diabetes as a component of a larger effort.

So the action we're asking for is CMS to develop an innovation model that focuses on prevention and treatment of diabetes. They are going to provide valuable insight into the best practices that are most affective in responding to the epidemic nationwide. And they are really going to be instrumental in transforming the quality of care.

And now, we're going to take a broader environmental view of the epidemic and introduce Emma who will talk about key policy recommendations that focus on the federal government's interactions with the food system.

>>Emma Clippinger: So our final two recommendations focus on food and the importance of increasing access to healthy foods. Eating healthy foods helps with prevention and management of type 2 diabetes. However, for many low-income individuals and households, accessing healthy foods is quite difficult. When we talk about access, tend to focus on two determinants. The money to purchase healthy foods and geographical access where you have the money but live in an area that does not have retailers selling healthy foods. To give you some sense of the scope of our access problems on the economic side, over 46.5 million individuals received food assistance through the federal government's assistance program in 2014. However, it is important to note many individuals who would be eligible are not actually

enrolled. On the geographic side, over 23.5 million individuals live in food deserts or in neighborhoods without easy access to fresh, healthy and affordable foods.

Food insecurity is a broader concept related to economic access. Measures whether over the course of a year, individuals had access to enough food for a healthy active lifestyle. The table on the slide has released data for 2014. Listing the highest food and security rates by states. The study did a great job explaining the connection between food and security and diabetes. Studies found the odds of developing diabetes are twice as high among low-income adults. And then for those who already have diabetes, food insecurity is associated with poor glycemic control. Doctors recommend consuming healthier foods, this is often easier said than done, particularly, for low-income individuals. In the current food system, it is a truth a diet rich in fruits and vegetables is more expensive than a high sugar, high calorie diet. Individuals who are both food insecure and chronically ill face the impossible decision between paying for food and paying for medication. Next slide.

So what federal programs do we have to increase access to healthy foods? I'm going to talk about three on this slide. As mentioned in the last slide, 46.5 million individuals receive food assistance through SNAP. The largest and most important nutrition program. While the budget of $74 billion sounds like a lot of money when you account for administration costs and spread it over 47 million individuals, the individual benefit is quite small. In 2014, the average benefit was only 125 per person and $257 per household. And estimated that for an individual, a healthy diet costs an additional $45 per month. If you think about it, that is over one-third of an individual's monthly benefit. You can see why purchasing unhealthy foods seems to make that money go farther. There are programs, however, that make that money go farther towards purchasing healthy foods. The WIC farmer's market program provide eligible mothers and seniors with coupons that can be exchanged for eligible foods. However, once again, the value is quite small. Between $6 and $50 a year.

The 2014 farm bill authorized the creation of nutrition grant program to expand programs that provide incentives for SNAP participants to purchase more fruits and vegetables. An example is the double up food bucks program which doubles SNAP benefits up to $20 a day for the purchase of fruits and vegetables at farmer's markets and participating grocery stores. Programs like this will be eligible to receive federal funding.

The last program is one that addresses geographic access. The healthy food financing initiative was launched in 2010 between the U.S. departments of treasury, agriculture and health and human services. The healthy food financing initiative provides tools for healthy food retailers in grants or low-cost loans or technical assistance. The healthy food financing initiative awarded over $167 million in grants and helped to leverage over $1 billion in additional financing. Supporting more than 200 projects. Grants have been awarded in over 30 state inside rural and urban areas. It was not until the 2014 farm bill that congress created a healthy food financing program by statute. So the 2014 farm bill authorized $125 million for the USDA's healthy food financing program. Congress has failed to appropriate any funds for it. Next slide.

So our action items. As you can see, federal dollars invested in the programs work to increase access to healthy food for all consumers. But those who are food insecure and at an increased risk of developing type 2 diabetes. But these programs are not sufficiently fund today meet the needs of those food insecure. Focus on increasing funding for these programs already in existence. First, congress should appropriate funds to USDA's financing program without funding that USDA program, the future of the healthy food financing program is uncertain. We also recommend congress allocate more money to treasury to increase the money. Congress should increase mandatory funding for FINI to help the program expand to more communities across the U.S. the first round of grants supported programs in 26 states. The second round will open for applications on December 16th. Good to note.

And finally, congress should overall provide more funding for participants to purchase foods given healthy foods do cost more. And increase funding for the farmer's market nutrition programs and support WIC recipients and seniors. Next slide.

So our final recommendation focuses on increasing access to healthy foods for a population. Although type 2 diabetes used to occur mainly in adults, has become prevalent in children as young as 10. Also more aggressive in children than adults. Healthy foods and physical activity are critical for prevention. Less than one quarter of high school students consume enough fruits and vegetables each day. Schools can play a significant role in reducing risk of developing type two diabetes. They consume half of daily calories. Each day, the school lunch program provides meals for over 32 million children and the breakfast program provides meals for over 12 million children. The healthy hunger free kids act strengthened standards for school meals for the first time in 15 years. Among other things, the 2010 nutrition standards require whole grains. And the next item here is a typo but an interesting one. The nutrition standards require at least half a cup of fruit and three quarters of a cup for vegetables. It's not either or, it's both. And we have fat free or low fat milk. No trans fats. There is a sodium guideline as well. And at the end, the healthy hunger free kids act increased the federal reimbursement rate by 6 cents. But it's important to note even by the USDA's conservative estimate, the entire reimbursement rate for a meal, for lunch, it's $2.99 per lunch. That does not even cover half of the cost of implementing these standards.

Also set regulations for competitive foods for the first time. These are snack food that's compete with school meals. For example, food and beverages sold in vending machines or bake sales, school stores and ala carte items. The guidelines for competitive foods include limit outside calories, sugar, total saturated fat and sodium. Most went into effect in the 2012-2013 school year. As of last May, 95% of school districts were up to date.

But despite the progress represented, they are actually under siege. The child nutrition act as well as on meal programs is reauthorized every five years. In 2010, that was called the healthy hunger free act. That act just expired this past September and congress has yet to reauthorize it. Hearings over the summer were contentious. Next slide.

So our action items are quite timely in this regard. Implementation takes time and also takes time to change the eating habits and taste preferences of kids. It is really important for kid s to continue to eat healthy foods if they are going to acquire the taste. The 2010 standards are validated and critical amongst children. We do recommend the 2015 reauthorization increased reimbursement rates. According to USDA estimates, the meal reimbursements do not cover the costs of these standards. Historically been sufficiently low and it's time to bring them up to the point where they can provide and reimburse healthy meals.

Over half of school meal operators anticipate their program will exceed revenue. And finally, congress maintain and enforce restrictions on competitive foods. Competitive foods tend to be less healthy under cutting the benefits of improved nutrition. And back to Sarah.
>>Sarah Downer: Thanks. Next slide. So that wraps up our overview of our recommendations. And moving on, we want to address how you can be part of working to create positive change at the federal level. We've identified on our action slides the policy-maker targets for each recommendation we've talked about. To the extent we've talked about calling on congress to take action, you can communicate with key congress members. Communicate with your own elected representatives. But also reach out to the heads of the diabetes caucus in the house or senate or other members. You can reach out to the chairs of relevant committee inside the house and senate. The health committees in the senate. You can also watch out for proposed regulations that are going to come that are going to impact those areas and comment on them. Either as part of a coalition or an individual. That's a really great way for your voice and perspective to be on record. To the extent that you have -- that you are someone who works with public or private dollars or influence over those to spend on pilot projects directed them on diabetes prevention. &%C1 within your state. Including any pilots that are going on. Any

demonstrations. Other programs that are involved with looking to become involved with and be an advocate for including more of the key services we talked about here in those programs. Finally, we want you all to be story tellers and make the urgency real. Legislatures, agency decision makers. For the media so we can see what's at stake moving forward for this epidemic.

We are going to be continuing to work on pushing for positive policy change. And a few upcoming events to note. For those of you who are intrigued by recommendation that talked about using food as a medicine for folks with type 2 diabetes. That's when we talked about medically tailored meals. At the center for health law and innovation, we are hosting a symposium taking place at Harvard Law School. The invitation link is here. If you are local or going to be in the area, we encourage you to register or join there. We're also going to be releasing early in 2016 a report that highlights the incredible ways they are transforming prevention and care through adopting the outcome driven innovations.

We've collected work at diabetespolicy.org. This slide has live links to a few publications that we've investigated in the course of our work with the together on diabetes initiatives. And then to contact us with any questions that you may have about that. Next slide. Thank you so much for joining us today. We're going to move into our Q and A portion of the webinar. We're excited to answer your questions. Pass it back over to Chris.

>>Christopher Kinabrew: I want to say thank you to Emma, Sarah and Jamille. Very dense. A lot of great information and really, lays out some helpful suggestions in terms of tackling this epidemic. We have a number of questions. Looks like we'll be able to get through them quickly. I want to encourage participants to still use the Q and A function if you have a question. We'll go straight into those questions right now. First one, what type of program does the CDC recognize as a National Diabetes Prevention Program participant?

>>Jamille Fields: I will handle that question. So the CDC must recognize the national diabetes prevention programs so during the first six months, things as eating less, eating healthy. Overcoming barrier services. And environmental cues. After that, the next six months, they are paired with a life style coach. And builds off of the topics that were covered.

>>Christopher Kinabrew: There's one question that I can articulate in myself coming from the audience. Is there a place where there's more information about the funds from CMMI. For those of you who aren't aware of it, the URL for the innovation center is easy to remember. Innovation.CMS.gov. Very informative web site for information about the grant programs as well as grantees.

A few other questions. And some suggestions. I'll read this one and colleagues from Harvard, if you have any comments on it, please feel free to share. Regarding CMMI, please consider enabling efforts that would not solely be single state initiatives but would allow a multi-state effort. An example, the questioner gives is interventions targeting diabetes management in economically distressed counties. Do you have any reaction to that recommendation in terms of multi state?

>>Sarah Downer: I think that would be an amazing idea. I think it's hard to figure out a way to do it. They are state specific. The way the programs are run and how they are staffed and the way they are structured at the state level are extremely different from state to state. So I think it would take a lot of coordination for states to kind of get together on that. And there may be more luck in thinking about Medicare. Insurers are offering Medicare plans in different states and Medicare advantage plans might be a good way to think about it. I absolutely agree with you that this would be a fantastic idea.

>>Christopher Kinabrew: Thank you for that reaction. Another question. This presentation has a lot of asks of congress. Given the current fiscal situation, which one of these changes is most crucial? Don't want to put you on the spot but give you an opportunity to make a recommendation or decline.

>>Sarah Downer: Obviously, we think all of the asks in here are very important. My sense is

that funding for the National Diabetes Prevention Program is really critical that we need to scale a program up and make it available to folks who have prediabetes. That's a crucial place to start when you consider the sheer number of folks who have prediabetes and likelihood of what we're looking at as a nation for millions more people is in a couple of years.
>>Jamille Fields: The only thing I would chime in to add is there are some of our recommendations relate to guidance such as including NDPP and state Medicaid programs. And those recommendations wouldn't be cost as much as it is effort.
>>Christopher Kinabrew: There were a couple questions about the specific information on the slides. I'll ask a couple of those. First one, is the information regarding slide 15 on Medicare available on a nice one-page fact sheet or available in other written format should someone who participated want to send it out to their constituencies. I don't know if you are able to --
>>Sarah Downer: Actually, we here have written an entire paper of coverage of meals. Meals throughout various programs. So we have a publication on that. It's called food of medicine and opportunities for medically tailored meals in public and private insurance. So we can include maybe in a follow up, we can include link s to some of those other things. There's information about that.
>> I'm going to interrupt to say we would be happy to post any of these on the Dialogue4Health web site. And I will talk to you, Sarah, about posting those after the event.
>>Sarah Downer: We would be happy to post that information for you.
>>Christopher Kinabrew: Thank you for that. Another question from the audience, are there any efforts toward establishing and promoting guidelines for or regulation of pre-school programs and the foods they provide to the children in attendance?
>>Sarah Downer: Found within the child and adult care food program and regulate the nutrition for programs participating in C ACF P and regulate the quality that those programs are going to adhere to. And that falls under the 2015 reauthorization.
>>Christopher Kinabrew: Thank you. There's a question about the National Diabetes Prevention Program. The cost of the nation National Diabetes Prevention Program varies from state to state in Alaska depending on the rural site. Can be $592 per person. Some recommend a business plan and Florida has one. Do we know of other states that have developed a business plan like Excel spread sheet for CDSMP? If you don't have an answer for that --
>>Sarah Downer: Yeah, maybe that can be one of the questions we post and answer on later. I need clarification.
>>Christopher Kinabrew: So question about economic benefits investment arguments for diabetes program and expansion.
>>Sarah Downer: Yeah, so I mean this has come up over and over again when we're talking about including the national diabetes prevention program specifically in Medicaid. Medicaid needs short turnaround times on recouping their investments in order to adopt some of the services or that's the argument that's made. And in respect to return on investment, I believe the National Diabetes Prevention Program doesn't qualify as the highest value service. It's right there among the valuable service. The return on investment that it can be a budget neutral investment. And then over the long-term, there would be a return on investment in the longer term.
>>Christopher Kinabrew: Great. Thank you. This is Chris, I'm going to defer to you whether we have time for one more question or we're at time and try and address a few questions in writing as a follow up?
>> I'm sorry we are going to have to close. We have a place on our web site for unanswered Q and A and I'd love to post them with our presenter's answers later on. Thank you.
>>Christopher Kinabrew: Thank you.
>> Do you want to carry on, Sarah?
>>Sarah Downer: Sure. Thank you.

>> That concludes our Q and A. Our contact information is here. You can connect with us at www.chlpi.org. Our presenters and moderators are here.