PREPARING STATES FOR DIABETES ACTION PLAN LEGISLATION

CSG Policy Webinar Series

The Council of State Governments
Sharing capital ideas.
DIABETES ACTION PLAN

LEGISLATION:

POLICY CHANGE FOR DIABETES PREVENTION AND CONTROL

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Diabetes Webinar
August 22, 2013
National Association of Chronic Disease Directors

- National public health association
- Provides a national forum for chronic disease prevention and control efforts
- Founded in 1988
- Headquartered in Atlanta, GA
  - 11 professional staff
  - 25 national subject matter experts
- 1,500+ members
Today’s Agenda

• Diabetes Crisis -- We Have a Problem
• Components of current Diabetes Action Plan Legislation
• Diabetes Action Plan Legislation– Current landscape
• Using plans to guide states’ actions aimed at people with and at risk for diabetes
  • Detection, Prevention and Treatment
  • Policy levers
• Expectations and potential possibilities
We Have a Problem
26 million with Diabetes

79 million with Prediabetes
1 in 3 U.S. Adults will have Diabetes in 2050....

- If current trends continue
  - Americans are living longer
  - People with diabetes also are living longer
  - Increases in minority groups at high risk for type 2 diabetes
  - New cases of diabetes
- 1 in 10 U.S. adults have diabetes now

Boyle, Thompson, Gregg, Barker, Williamson. Population Health Metrics 2010: 8:29 (22 October 2010)
At Risk and Pre-Diabetes

• Obesity
  • About 2/3 of all populations are overweight or obese

• Pre-diabetes
  • About 35% of adults (79 million or 1 in 3)
  • Generally, less than 10% are aware
Facts about Diabetes and its Personal and Financial Costs

• The number of Americans with diabetes has more than tripled in the past two decades
• Medical costs for people with diabetes are 2.3 times higher than for people without the disease (Total Costs = $174 Billion)
  • Direct -- $116 Billion
  • Indirect -- $58 Billion
• Diabetes is the leading cause of kidney failure, amputation, and new cases of blindness among adults in the U.S.
• Nationwide implementation of diabetes prevention programs could save the U.S. health care system $5.7 billion and prevent about 885,000 cases of type 2 diabetes within 25 years, according to CDC research
We’re only touching the surface…..

- People with diabetes complications
- People with diagnosed diabetes
- People with undiagnosed diabetes
- People with Prediabetes
- People at risk for diabetes
Diabetes Action Plan Legislation (aka DAP Legislation)

• Aims to establish a collaborative process across state agencies
  • Medicaid
  • Department of Health (Diabetes Program Staff)
  • Agency responsible for state employee health benefits
• Directs agencies to develop a collaborative plan of action
• DAP to include 3 parts
  • Data illustrating the costs and impact of diabetes by each agency
  • Current efforts to address diabetes by each agency
  • Evidence-based recommendations for legislative action including a blueprint for no-cost and cost strategies
DAP Legislation– Current Landscape

Legislation Passed in 2013
- North Dakota
- Louisiana
- North Carolina
- Oregon
- Washington
- New Jersey
- Illinois

States implementing DAP
- Kentucky (2011)
- Texas (2011)

States with DAP Legislation Activity
- Michigan
- Hawaii
Using Plans to Guide Policy Actions
Policy Solution Categories

- Detection
- Prevention
- Treatment
Detection

Screening is the entry point to containing the epidemic

• Screen state employees to prevent and detect diabetes
• Engage physicians to screen to detect diabetes and pre-diabetes and refer for appropriate treatment
• Screen for gestational diabetes (GDM) in the Medicaid and state employee population at the end of the second trimester and measure for the frequency of testing
Screening is the Entry Point to Prevention

- Approximately 79 million (35%) with prediabetes and 7 million with undiagnosed diabetes
- If you don’t screen, you won’t find them...
- If you don’t find them, you can’t:
  - Treat the undiagnosed
  - Intervene with those who have prediabetes

To prevent complications  To prevent diabetes
Pre-diabetes: Intervening Can Make a Difference

DPP Research Study: Can type 2 diabetes be prevented/delayed through a lifestyle intervention or metformin in people with impaired glucose tolerance?

- Lifestyle goal 7% weight loss and 150 min PA/wk
- Lifestyle group reduced risk of type 2 diabetes by 58% (71% in those over age 60), true for all participating ethnic groups and for both men and women
- Metformin reduced diabetes risk by 31%
- 10-year f/u incidence of diabetes was reduced by 34% in lifestyle group and 18% in those taking metformin
Summary of Benefits of Diabetes Prevention Program

Treating 100 high risk adults (age 50) for 3 years...

- Prevents 15 new cases of type 2 diabetes\(^1\)
- Prevents 162 missed work days\(^2\)
- Avoids the need for BP/Chol pills in 11 people\(^3\)
- Adds the equivalent of 20 perfect years of health\(^4\)
- Avoids $91,400 in healthcare costs\(^5\)

\(^2\) DPP Research Group. Diabetes Care. 2003 Sep;26(9):2693-4
\(^3\) Ratner, et al. 2005 Diabetes Care 28 (4), pp. 888-894
Prevention

Prevention is key to containing healthcare costs

• Cover National Diabetes Prevention Program for state employees at high risk for type 2 diabetes as a health benefit

• Cover National Diabetes Prevention Program for Medicaid beneficiaries at high risk for type 2 diabetes as a health benefit
Treatment/Management

Treatment is vital to manage the impact of diabetes on state health programs

- Coordinate data and information related to the treatment of diabetes to understand the true reach and scope of the disease
- Upon reform of data collection, develop a plan of action recommending evidence based practice to improve upon results
Improve Quality of Care

Improve Quality of Clinical Care for People With and at Risk for Diabetes

**Policy-related Strategies:**

- Policies within health care organizations that contribute to and help sustain quality care improvements for people with diabetes/pre-diabetes
- Implementation of team-based care
- Implementation or maintenance of evidence-based reimbursement strategies and policies
  - reduced patient insurance copayments
  - public insurance reimbursement of medications and testing supplies
  - physician reimbursement incentives and performance-based payment
  - value-based insurance designs
Increase Access to Self-Management Education and Support Services for People With Diabetes

Policy-related Strategies:

- Sustainability/reimbursement for ADA/AADE diabetes self-management education programs
- Sustainability/reimbursement for Community Health Workers involved in providing self-management education and support services for people with diabetes
- Expand the role of allied health professionals (e.g., pharmacists, nurses, community health workers) in providing diabetes self-management education (e.g., Asheville Model)
- Implement policies to meet the management and care needs for students with diabetes
Expectations and Possibilities

Expectations
• Narrowly focused *Call to Action*
• Spotlight on costs and burden of diabetes
• Evidence based recommendations
• Increased collaboration among state agencies

Possibilities
• Reduction in the burden/impact of diabetes
• Improved prevention and management of those with and at risk for diabetes
Thank You

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Kentucky Diabetes Report
the Kentucky Experience
Council of State Governments
August 22, 2013
Outline

• Introductions
• Background on the Legislation in Kentucky
• Partners Involved
• Process
• Results/Progress to date
• Lessons Learned
Background

• Legislation was passed in June, 2011
  – KDPCP became aware of the bill after it was filed and sent to DPH for review
  – Department’s review included concern about the data collection required
  – Legislation was amended to address this concern and require only existing data

• Required a report to the legislature in January of each odd numbered year – beginning Jan., 2013
Early Concerns

- Where did this legislation come from?
- Potential duplication of effort between this plan and other diabetes/chronic disease plans
  - What kind of “plan” was required
- Other entities/diabetes advocates were not included in the required participants
- Time required
Legislation

• KRS 211.752 - The Department for Medicaid Services, the Department for Public Health, the Office of Health Policy, and the Personnel Cabinet shall submit a report to the Legislative Research Commission by January 10 of each odd-numbered year on the following:
  – The financial impact and reach diabetes of all types is having on the entity, the Commonwealth, and localities.
  – An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease.
  – A description of the level of coordination existing between the entities on activities, programmatic activities, and messaging on managing, treating, or preventing all forms of diabetes and its complications
  – The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the General Assembly
  – The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified
Partners

• Legislation required the participation of:
  – Department for Public Health (DPH)
  – Office of Health Policy (OHP)
  – Department for Medicaid Services (DMS)
  – Personnel Cabinet
    • Kentucky Employees Health Plan
• Kentucky is fortunate that DPH, OHP and DMS are all in the same Cabinet
• Kentucky chose to include a representative from the National Association of Chronic Disease Directors (NACDD) in our discussions/planning in August, 2012
Process

• The Cabinet Secretary assigned DPH to be the lead agency
• The DPH Commissioner asked the diabetes program manager to coordinate the effort
• Representatives were selected and meetings began in June, 2011
• The group spent quite a bit of time trying to determine what the legislation was really asking for and what the report should look like
  – Especially for the data section
Process (continued)

• It was determined that the report would contain:
  – Data about diabetes in Kentucky
  – What each agency was currently doing individually to address this burden
  – What the agencies were currently doing together to address this burden
  – What should/could the agencies be doing (Recommendations)
  – What would that cost (budget)
Process (cont.)

- Note: it was not called a “Diabetes Action Plan”
- It was called the “Kentucky Diabetes Report”
- Each agency produced data content, as well as information about current programming and effectiveness
  - Shared Chronic Disease and Diabetes State Plans
- Lead agency combined these into a document for editing.
Process (continued)

- Multiple edits and reviews took place
- Recommendations/plan was developed jointly
- Lead agency drafted the final document
Final Report

• The final report was submitted in January, 2013
• You may access a copy of the report at: www.chfs.ky.gov/dph/info/dpqid/cd/diabetes
Plan Highlights

• Data Highlights
  – Saw data from Personnel for the first time
  – Very rich data source

• Describing our work
  – DPH’s diabetes work was in a state of transition
  – DMS was in the middle of implementing managed care

• Recommendations/plan
  – Group decided that there was no need for a new “plan” since there are many plans
    • Coordinated Chronic Disease Plan, Diabetes Plan, and 2020 were all in progress
Plan Highlights (cont.)

– Support expansion of, and sustainability strategies for the Diabetes Prevention Program (DPP).

– Expand the availability and sustainability of Diabetes Self-Management Education opportunities across a wide variety of possible providers.

– Implement pilot projects with the Kentucky Employee Health Plan (KEHP) related to DPP and Diabetes Self-Management Education (DSME).

– Support policies that will move health care providers toward the use of electronic health records (EHR) AND connecting those EHR’s to the Kentucky Health Information Exchange (KHIE).
Plan Highlights (cont.)

– Require unique record identifiers on administrative claims data collected by the Office of Health Policy to allow Kentucky to better understand patterns of hospitalization and emergency department visits.

– Support expansion of the Kentucky Behavioral Risk Factor Survey (BRFS) to better understand the health disparities facing the Commonwealth.

– Take advantage of the opportunity for expansion of the access to care provision of the Affordable Care Act such as the Health Benefit Exchange and Medicaid eligibility expansion.
Results/Progress

• No response from the legislature yet – but the 2014 session is gearing up so . . . .?

• Progress
  – Received a DPP grant from NACDD
  – Discussions are ongoing regarding:
    • DPP pilot for state employees
    • Making DPP a covered benefit
    • Medicaid DPP pilot
  – Medicaid Expansion/KHIE
Next Steps

• The committee has already started meeting regarding the 2015 report.
• Efforts to maximize plan alignment
Lessons Learned

• This is not just another report!
• Assignment for project management for this level of task needs to be carefully considered when working between agencies/departments
• People involved need to have the ability to make decisions/speak for their agency – or have clear access to someone who can
  – Involve your DPCP!
• Time consuming process. We were able to do it with existing resources/personnel – but that may not be possible for everyone
Lessons Learned (cont.)

• The term “Diabetes Action Plan” can create confusion for leadership as well as stakeholders since there are other diabetes plans
  – We developed a “Kentucky Diabetes Report”
• Assistance from NACDD was helpful
Summary

• The development of the report was a long and challenging process but:
  – Multiple agencies working together across Divisions, Agencies, Cabinets, etc. on how to address diabetes is a great thing!
  – The report is a worthwhile product and will be a valuable tool for diabetes prevention and control advocates at the state and national level.
  – The relationship with KEHP built during this process has been extremely valuable
For More Information

• You may access a copy of the report at:
  www.chfs.ky.gov/dph/info/dpqcd/cd/diabetes

• Contact for more information:
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