National Clinical Care Commission Public Meeting 3
Thursday, June 27, 2019
8:00 am — 5:00 pm EST
Meeting Summary

National Institutes of Health, Building 35
John Edward Porter Neuroscience Research Center
35 Convent Drive, Bethesda, MD 20892

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Welcome

Dr. Clydette Powell, Designated Federal Officer (DFO) for the National Clinical Care Commission (NCCC), called the meeting to order at 8:30 am. She welcomed the Commission members and the public and thanked the supporting teams.

Dr. Powell noted that Dr. Don Wright, Deputy Assistant Secretary for Health; Director, Office of Disease Prevention and Health Promotion, fully supports the Commission's work but will not be able to attend today's meeting in person.

Dr. William (Bill) Herman, Chair of the Commission, welcomed everyone, reviewed the Commission's activities, and explained plans moving forward.

Overview of History, Charter, and Membership

Dr. Herman briefly reviewed the Commission's history and the work the Commission has done since its formation.

The Commission was established on November 2, 2017, by the Secretary of Health and Human Services to evaluate and make recommendations regarding improvements to the coordination and leveraging of programs within the Department and other Federal agencies related to awareness and clinical care for at least one, but not more than two, complex metabolic or autoimmune diseases resulting from issues related to insulin that represent a significant disease burden in the United States, which may include complications due to such diseases (type 1 and type 2 diabetes).

The Commission's duties are to evaluate and make recommendations, as appropriate, to the Secretary and Congress regarding

- Federal programs of the Department of Health and Human Services that focus on preventing and reducing the incidence of diabetes
- Current activities and gaps in Federal efforts to support clinicians in providing integrated, high-quality care to individuals with the diseases and complications
- The improvement in, and improved coordination of, Federal education and awareness activities related to the prevention and treatment of the diseases and complications, which may include the utilization of new and existing technologies
- Methods for outreach and dissemination of education and awareness materials that
    - Address the diseases and complications
    - Are funded by the Federal Government
    - Are intended for health care professionals and the public
- Whether there are opportunities for consolidation of inappropriately overlapping or duplicative Federal programs related to the diseases and complications

Dr. Herman explained that the Commission consists of a DFO and 23 voting members (see Appendix for Commission members), including 11 regular government members representing 11 Federal agencies and Departments and 12 public members representing physician specialists including endocrinologists, primary care physicians, non-physician health care professionals, patient advocates, public health experts, and health care providers serving Medicaid and underserved populations. He noted that the Commission welcomes the public's comments and suggestions, and that the Commission will develop their report based on the subcommittees' reports and public input.

Dr. Herman further explained that the subcommittees' recommendations and their reports to the Commission shall be discussed at an open public Commission meeting that is conducted by the Commission. He encouraged the Commission members to begin thinking about engaging other relevant organizations regarding the Commission's work.

Roll Call

Dr. Powell conducted roll call at 8:40 am (see Appendix for Commission member attendance), and she pointed out the geographical and gender diversities of the membership. The meeting continued with a quorum.

Overview of Timeline and Progress

Dr. Herman then reviewed the timeline of the Commission's 2021 report.

- 2019: Year 1—Gather Information
    - Establish subcommittees
    - Define scopes of work
    - Gather information about relevant Federal programs and policies
- 2020: Year 2—Analyze Data and Information
    - Identify relevant Federal policies and programs
    - Identify gaps
    - Assess coordination among the programs
- 2021: Year 3—Make Recommendations
    - Review findings and develop recommendations to the Secretary and Congress; the final report containing all of the findings and recommendations are due October 31, 2021.

Dr. Herman noted that the Commission submitted to the Secretary and Congress an operating plan on January 31, 2019, and has established three general focus areas that will be addressed by three subcommittees, including Prevention—General Population (PGP) Subcommittee, Prevention—Targeted Population (PTP) Subcommittee, and Treatment and Complications (TC) Subcommittee. The subcommittees have developed framing statements—which will be presented by the subcommittee co-chairs later during the meeting, established scopes of work, identified focus areas, and developed tools to move forward with their work.

Dr. Herman explained that the Commission has also identified the following crosscutting themes.

- Social determinants of health (SDOH)
- Health disparities
- Outreach
- Public, patient, and professional education
- Access to care
- Clinical care
- Coordination of care
- Disease management
- Payment
- Public health
- Research on diabetes

He further explained that to effectively conduct their work, the Commission has developed a grid defining focus areas, including prevention for the general population, prevention for the targeted population, diabetes treatment, and complications; and that the Commission will review these topics across the life course in various settings.

Dr. Herman then review the grid that contains seven columns (that is, Focus Areas, Life Course, Settings, Topics, Facilitators/Barriers, Policies, and Programs), and he briefly explained the main topics under each column that the Commission will address.

Focus Areas

- Prevention—General Population
- Prevention—Targeted Population
- Diabetes Treatment
- Complications

Life Course

- Pregnancy and maternal child
- Child
- Adolescent
- Young adult
- Adult
- Older adult

Settings

- Home
- Neighborhood

- Food manufacturers
- Food stores
- Restaurants
- Food banks
- Schools
- Worksites
- Health systems
- Community
- Faith-based settings
- Organizations

Topics

- Social environment
- Physical environment/activity
- Food environment/nutrition
- Tobacco
- Weight loss/activity programs
- Diabetes prevention programs (both lifestyle and medication)
- Metformin
- Health system organizations and structures
- Data systems
- Shared decision making
- Behavior changes and research
- Diabetes self-management education (DSME)/Diabetes self-management support (DSMS)
- Tools for disease management
- Payment systems
- Weight management interventions
- Access to medications, including antihyperglycemic medications
- Self-monitoring of blood glucose (SMBG)
- Technologies, including continuing glucose monitoring systems and insulin pump therapy
- Cardiovascular disease (CVD) risk management
- Mental health in diabetes
- Complication diagnosis, treatment, and rehabilitation for people with advanced complications

Facilitators and Barriers

- Evidence of efficacy
- Evidence of translation
- Resources
- Providers
- Programs

- Access/disparities/SDOH
- Costs
- Coverage
- Education
- Shared decision making
- Mental health

Policies

- Feeding programs
- School lunch/snacks
- Worksite policies
- Transportation
- Prices/subsidies
- Incentives
- Taxes
- Regulations
- Legislation
- Insurance coverage
- Out-of-pocket costs
- Benefit structure

Programs

Dr. Herman explained that the Commission will review, in great detail, the Federal programs, assess what works and what does not, identify overlaps, and determine if there are resources that might need to be reallocated.

- Public awareness campaigns
- Skills development (for example, cooking skills)
- Food distribution programs
- Walking/cycling paths
- Product placement
- Broadcast media restrictions
- Taxes
- Regulations
- Legislation
- Healthy retail champions
- Screening/risk stratification
- Case finding
- DSME/DSMS
- Shared decision making
- Health system organizations and structures
- Data systems
- Disease management strategies

- Payment strategies
- Weight management
- Antihyperglycemic medications
- SMBG
- Technologies
- Diagnosis
- Treatment
- Rehabilitation

Overview of NCCC Meeting 3

Dr. Herman explained that the objectives of today's meeting are to

- Review subcommittee framing statements
- Develop a framework for a detailed inventory of relevant Federal policies and programs
- Develop plans to solicit external input about topics and issues pertinent to the Commission and encourage members within their work scope to seek existing data to support the work

Dr. Herman encouraged the subcommittees to focus on the big picture and develop a coherent product. He then highlighted the major recommendations made in the 1970s by the National Commission on Diabetes (NCD), and pointed out the tremendous impact the recommendations made to diabetes research (for example, the creation of Diabetes Centers), education, prevention, and treatment and care (for example, team-based care and patient-empowered treatment approach). The recommendations, he added, also provided a foundation for the establishment of the National Diabetes Prevention Program (NDPP).

Dr. Herman encouraged the Commission to think and address diabetes as a complex societal problem instead of just a personal medical problem. He then used cholera as an example to illustrate how multifactorial factors are involved in diabetes, including the environment (for example, pollution), risk factors (for example, unhealthy diet, physical inactivity, psychosocial stress, and poverty), and the individuals (for example, people with genetic risks, inadequate education, and social disadvantage). He encouraged the Commission to keep all these factors in mind while addressing diabetes prevention and intervention.

Dr. Herman then turned the meeting to Dr. Powell, who invited the subcommittee co-chairs to present their work to the full Commission and the public.

Subcommittee Presentations

Prevention General Population (PGP) Subcommittee

Dr. Bill Cook, Co-Chair of the PGP Subcommittee, first presented a slide listing all members of the subcommittee (see Appendix for subcommittee members). He then presented the

subcommittee's framing statement, explained their focus areas, and shared how they plan to move forward with their work.

Framing Statement of the PGP Subcommittee

In the United States, more than one out of three adults have pre-diabetes, according to the current diagnostic criteria in the American Diabetes Association Standards of Care, and an increasing number of individuals are being diagnosed with type 1 diabetes (T1D). Some risk factors for developing type 2 diabetes (T2D) pre-diabetes and T1D are nonmodifiable, such as age and genetics. Most factors for T2D pre-diabetes, however, are potentially modifiable. Major contributory behaviors include inadequate physical activity and dietary choices, but social and environmental factors, also known as structural factors, such as stress and economic opportunity, have emerged as key exposures driving the type 2 diabetes epidemic in the country. Attention to these factors may also benefit those with T1D or at risk for T1D. The subcommittee recognizes the need to start interventions early in life, including intrauterine life-initially in families, extending to schools and community, and ultimately to society as a whole. It also recognizes that risk factors and exposures are differentially and unequally distributed across the population based on socioeconomic, racial/ethnic, and geographic characteristics, which has variable impact on individuals and communities at different points both within and across the life course. The subcommittee believes that our efforts at prevention of pre-diabetes should be approached from a socioecological perspective. Scalable, proven, effective interventions targeted at the individual, family, workplace, institutional, neighborhood, commercial entities (food manufacturers, restaurants, retail stores) and policy levels need to be implemented with attention to the settings of the intervention at each of those levels. Sometimes these programs will be broad-based, but other times, tailored to social and demographic (that is language/culture/age-specific) subgroups.

Screening programs that identify people as having developed T2D prediabetes, as well as those at high-risk for T1D, as opposed to those who have yet to develop it, would seem to be the intersection of the General Population and Targeted Population Subcommittees. The General Population Subcommittee has determined that screening, because of the targeted and heterogeneous way it needs to be implemented, should fall under the work of the Targeted Population Subcommittee. Because the majority of opportunity for prevention currently is associated with type 2 diabetes, the Subcommittee will devote its efforts to that form of the disease, recognizing that emerging data suggests that the interventions that prevent type 2 diabetes also may impact development of type 1 diabetes.

Guided by the principles laid out above, our subcommittee will focus on:

1. The environment and food systems that could promote a healthy lifestyle that would lead to a decrease in the number of people developing prediabetes.
2. Review of outreach and education efforts across government agencies to harmonize programs and assess the effectiveness of Federal programs.

We will start by reviewing Federal programs and policies that are aimed at the general population, that is, those who have not been diagnosed with prediabetes or diabetes. Once these programs are reviewed, we can establish if there is redundancy, areas of opportunity that have not been addressed, or successful programs that could be scaled across a broader population.

Dr. Cook explained that while developing their framing statement, the subcommittee also spent a lot of time discussing type 1 diabetes and relevant programs run by states and/or involving private-public collaborations.

Dr. Naomi Fukagawa, the other co-chair of the PGP Subcommittee, pointed out there are many crosscutting themes across the subcommittees. She acknowledged it was challenging to review and assess all the Federal programs. She noted that after extensive discussion the subcommittee decided to focus on the highlighted areas shown on the Commission's grid, and they will assess, across different settings, the Federal programs relevant to the subcommittee's focus areas, including

- Social environment,
- Physical environment,
- Food environment,
- Physical activity,
- Nutrition,
- Life course trajectory,
- Tobacco prevention and cessation, and
- SDOH.

Dr. Fukagawa explained that the subcommittee is still in the process of assessing the programs, and they plan to continue working on the grid and identifying programs relevant to their focuse areas.

Prevention Targeted Population (PTP) Subcommittee

Dr. Ann Albright, Co-Chair of the PTP Subcommittee, first presented the slide listing subcommittee members (see Appendix for subcommittee members). She then presented the PTP Subcommittee's framing statement.

Framing Statement of the PTP Subcommittee

In the United States more than one out of three adults have prediabetes according to the current diagnostic criteria in the American Diabetes Association Standards of Care. Data from the Centers for Disease Control and Prevention (CDC) show that, among those 84 million Americans with prediabetes, 90% are unaware they have this serious precursor for type 2 diabetes and elevated risk of heart attack and stroke. Individuals at high risk for the transition to prediabetes and type 2 diabetes include those with obesity, low physical activity levels, a family history of diabetes; come from high-risk racial/ethnic populations; and women with a history of gestational diabetes. Effective prevention interventions, such as certain structured

lifestyle change programs and medications, will markedly reduce the progression of prediabetes and have been shown to be cost effective and cost saving. To promote better uptake of effective interventions, the at-risk population needs to be identified, provided with increased understanding of risk factors, improved access to proven prevention strategies, and tools for positive behavior change. Health care providers also need strategies to increase their uptake of prediabetes screening and tools to increase awareness and implementation of proven prevention strategies. Both those at risk and clinicians need support for increasing awareness, accessibility and affordability of screening and prevention programs for type 2 diabetes. Additional research is needed to develop improved strategies for promotion of and adherence to positive behavior change to prevent type 2 diabetes, especially over the long-term. Research is also needed to develop interventions to prevent development or slow progression of type 1 diabetes.

The focus of the targeted population subcommittee is on the following four areas.

- How to best identify people with prediabetes
- How to improve the availability and uptake of proven effective interventions for preventing or delaying the onset of type 2 diabetes in people with prediabetes
- How to sustain the effectiveness of type 2 diabetes prevention interventions
- How to better prevent or delay the transition of patients who have prediabetes to type 2 diabetes and related adverse health outcomes

Dr. Albright emphasized the importance of engaging and keeping people in the prevention programs. She then briefly reviewed the grid, and pointed out the following four main areas that the subcommittee will focus their work on, and will need information from the agencies.

- Screening/Diagnosis for prediabetes/diabetes
- Improve access to and utilization of effective type 2 diabetes preventive interventions
- Sustainability of type 2 diabetes prevention healthy lifestyle interventions (programmatic and individual)
- Develop new and more effective preventive strategies for type 1 and type 2 diabetes

The co-chairs of the subcommittee then explained their grid and how they plan to move forward. Dr. Albright noted that the subcommittee will discuss the focus areas across life course (that is, pregnancy, maternal child, child, adolescent, young adult, adult, and older adult) and different settings (that is, health system, worksite, community, and virtual settings).

Dr. John Boltri, Co-chair of the PTP Subcommittee, added that for enablers/facilitators/barriers, the subcommittee plans to review and discuss the following topics:

- The Food and Drug Administration (FDA) approval for preventive therapies
- Costs
- Evidence of efficacy and effectiveness
- Mental health
- SDOH

- Effective infrastructure
    - Trained workforce
    - Capacity and availability of programs
    - Lifestyle systems
- Funding/coverage/reimbursement
- Shared decision making
- Private-public partnerships

Dr. Boltri noted that under policies, the subcommittee will assess insurance coverage, subsidies, incentives, regulations, and co-pays for screening. He pointed out the interactions between Federal agencies and states and the role of private-public partnership in diabetes prevention and intervention. Under interventions, the subcommittee will assess risk stratification, screening, awareness, the DPP program—which, he noted, is proven effective but is not universally accessible to everyone who needs it, pharmaceuticals, and other weight loss programs.

Treatement and Complications (TC) Subcommittee

Dr. Paul Conlin, Co-Chair of the TC Subcommittee, reported that to carry out their work, the subcommittee has conducted three conference calls and one in-person meeting, and the members have exchanged many emails. He thanked all subcommittee members (see Appendix for subcommittee members) for their work and then presented the subcommittee's framing statement.

Framing Statement of the TC Subcommittee

Diabetes is a complex metabolic condition that significantly impacts personal choices, affects both quality of life and life expectancy, and requires substantial healthcare system resources.

Achieving and maintaining one's maximal potential health status and well-being while living with diabetes requires the availability of appropriate and comprehensive treatment options and the ability of the patient/caregiver to attend to self-care/self-management aspects of the condition. This requires that the patient/caregiver (1) have access to and understand information about diabetes, its management, and potential complications; (2) participate with health care providers in selecting appropriate treatment options; (3) have the skills, confidence, and psychosocial support to perform the necessary and beneficial self-management tasks; and (4) collaborate with health care providers to achieve treatment targets that are consistent with their unique characteristics and goals of care. It also requires that healthcare systems proactively deliver high-quality, individualized diabetes care and support population health improvement activities for the communities they serve.

Thus, the work of this subcommittee will identify factors at the person, practice, healthcare system, environmental, and policy levels that facilitate or hinder the delivery and receipt of high-quality care by all persons with diabetes and its complications.

Dr. Conlin pointed out that the scope of the subcommittee's work is wide, and the subcommittee felt that the key concepts are patient-centered care and shared decision making. He explained that after extensive discussion, the subcommittee decided to arrange their many focus areas into two big categories: treatment and complications, each of which has its own set of topics that the subcommittee would like to address.

Dr. Conlin and Dr. Carrol Greenlee, the other co-chair of TC Subcommittee, explained the tools (for example, a detailed checklist resulted from the framing statement and grid) they developed and approaches they took to review the high-level inventory. Dr. Greenlee noted that the subcommittee thinks it is important to assess the Federal programs across the life course in different key areas, including care and care delivery, education for patients and families, education for care teams, policy, payment models, and research and epidemiology.

Dr. Greenlee then presented the subcommittee's guiding questions and a 3-D graph illustrating the preliminary list of programs that the subcommittee has received so far. Dr. Greenlee explained that the graph is a tool that the subcommittee uses to sort the programs related to treatment and complications, and it is not a gap analysis.

Guiding Questions of the TC Subcommittee
To determine if Federal agencies have the capacity to move diabetes care to where it needs to be for better outcomes and toward health care of the future, the subcommittee will need to find out and assess

- How are, or how can, the "data" generated by Federal agencies be better utilized in communities and at the point of care to identify gaps in care and/or areas of needed attention to drive efforts?
    - What data will the subcommittee need in order to comprehensively assess the impact of diabetes on patient outcomes and/or impact of the efforts?

Looking at the agencies that provide care, education, policies, research, and methods of payment, the subcommittee would like to know

- Do the agencies, or how do the agencies, adequately and effectively enable the patient's and/or caregiver's role in care in order to optimize self-management?
- Do the agencies, or how do the agencies, provide, or allow for, individualized care in a comprehensive approach to allow optimization of outcomes for patients as regards glycemic management as well as prevention and treatment of complications across various aspects of care and care delivery systems?
- Do the agencies, or how do the agencies, address and/or rectify disparities?

Following the subcommittees' presentations, Dr. Powell thanked all members of the three subcommittees for their dedication and hard work. She pointed out that the Commission is addressing a complex issue and many Commission members serve on more than one subcommittee.

Discussion of the Data Call

Overview

Dr. Herman noted that the next step would be for the Commission to develop questions and generate a more detailed data call based on the subcommittees' focus areas and the high-level inventory. Through the data call, the Commission would like to obtain information on Federal diabetes policies and programs so that they could identify gaps, and recognize opportunities for coordination and expansion of successful programs and policies. He then used the grid to summarize the areas that the Commission would like to obtain more information from the agencies.

For the PGP Subcommittee, Dr. Herman highlighted the following four areas that, in his view, the subcommittee would need to obtain more information from the Federal agencies through the data call.

- Food environment, including food supply, labelling, and marketing; economic incentives for fruits and vegetables; regulation of food safety and quality; potentially bans on adverting unhealthy food; and food warning and taxes
- Built environment, including creation of more areas for leisure activities, youth sports, and health-promoting transport options
- Additional interventions, including raising the level of general education and health literacy, reducing poverty and social disadvantage, and controlling pollution
- Special issues, including the lack of evidence resulted from randomized controlled clinical trials for intervention to address pollution and poverty, and policy level interventions followed by rigorous short- and long-term evaluation of processes and outcomes

For the PTP Subcommittee, Dr. Herman noted, the task is to distill various programs that could be scaled up or scaled down. The subcommittee, he added, will need to address special issues related to diagnostic criteria for prediabetes, absolute risk at the individual level, absolute risk reduction, or the number of people needed to be treated with targeted intervention to prevent prediabetes from progressing to type 2 diabetes.

Dr. Herman pointed out there are enormous resource-related implications the subcommittee needs to think about. Identifying people with prediabetes, as well as people with previously undiagnosed diabetes identified through screening, he noted, will increase the number of people who will enter primary care programs. Resources and programs therefore will need to be considered to ensure people with newly diagnosed diabetes get optimal care and proactive follow up. He added that the subcommittee will also need to address periodic retesting because screening is not a one-time activity.

Dr. Herman suggested the PTP Subcommittee also consider pharmacotherapies for diabetes prevention and treatment (for example, metformin, alpha glucosidase inhibitors, and TZDs),

and think about different strategies (for example, glucose-centered diabetes treatment and prevention, and treatment and prevention for complications).

For the TC Subcommittee, Dr. Herman pointed out that reviewing and assessing the Federal programs related to treatment and complications will be a challenging task. He suggested the subcommittee first focus on obtaining information from the Federal agencies. He noted that it would be helpful to establish crosscutting themes, including

- Patient education and support;
- Provider education, training, and capacity building;
- Primary care for diabetes management;
- Multidisciplinary subspecialty care; and
- Rehabilitation.

Dr. Herman suggested the subcommittee also consider special issues in the data call. For example, how to define a core data set for population health management, and what can be done regarding benchmarking and best practices. He noted there is a real need to expand the focus beyond primary physicians to address task shifting (for example, from physician providers to non-physician providers) and facilitated relay (for example, delivering the information collected from the patient to the physician to improve efficiency). In addition, the subcommittee will also need to consider appropriate use of technology, including regulatory as well as access to care related issues.

Dr. Herman added that the subcommittee also needs to get information related to costs of essential medications and universal healthcare coverage to remove barriers so that people with prediabetes and diabetes can receive the care they need.

Dr. Herman also asked the subcommittee, and the Commission as a whole, to consider and address special populations with type 1 or type 2 diabetes, including

- Young onset of diabetes, involving adolescent and childhood type 1 diabetes and type 2 diabetes in youth, which is becoming an increasingly common issue with an aggressive clinical course and it is heterogeneous; and
- Adult onset of type 1 diabetes.

Dr. Herman noted that the Commission needs to obtain the information they need in a format that can be efficiently used by the agencies.

Content and Format of the Data Call

Led by Dr. Herman, the Commission discussed the content, format, process, and timeline for the data call. While some members suggested that the Commission should choose a format before developing questions, Dr. Herman suggested focusing on the information they need first and then discussing the approach/mechanism they could use to obtain the information.

Dr. Herman asked the subcommittees one by one to propose questions that they would like to include in the data call.

PGP Subcommittee

Where to start
The Commission first discussed where to start: policies or programs.

One approach proposed by Ms. Ellen Leake is to start with questions on policies and then move on to questions about programs. The rationale for this approach is that programs are generally developed based on policies. Other members pointed out that many agencies such as CDC, the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA) do not set policies. While some agencies (for example, CDC and NIH) support research and generate data that can be used to develop policies, others (for example, HRSA) provides services that are governed by polices set by the Executive or Legislative branch of the Federal government based on the evidence/data collected by agencies such as CDC and NIH. Dr. Ann Bullock noted that the Commission needs to take a big-picture view and ask what Congress can do.

Other members pointed out there are differences between internal policies, external policies, and regulations; and suggested clarifying the differences between "policies" and "programs" first to avoid potential confusion, and to help the Commission get the information they need.

Another approach proposed by Dr. Meredith Hawkins is to identify gaps first and then evaluate programs and assess policies. Dr. Bullock suggested that the Commission identify and call out the areas that do not work well.

Dr. Fukagawa noted that for policies and programs that are known not working effectively, the Commission might need data to demonstrate their assessment. For the PGP Subcommittee, she suggested that they may need a different way to conduct the data call.

The general consensus, as Dr. Herman noted, was starting with policies. Dr. Herman suggested that the Commission perhaps could start with policies on tobacco and then move on to food-related policies. The rationale for starting with policies on tobacco, he explained, is that there are many data available and there are also randomized clinical trials showing the effects of tobacco. He added that for polices that are known not effective, perhaps they could find out the reason(s) and make recommendations accordingly.

Dr. Fukagawa stressed the importance of food environment, which, she noted, affects the whole population, and she suggested starting with policies affecting food environment.

What types of questions to ask
Dr. Shari Bolen suggested asking questions in three main categories: policies, programs, and data.

Dr. Albright suggested adding gaps as another big category. She noted that it is important to determine gaps and think about how to solve the problems.

How to ask and organize the questions

Dr. Ayotunde Dokun suggested asking multiple-level questions, starting with broader and more general questions such as yes or no questions. For example, the subcommittee could ask if an agency has a specific policy on certain topics. If the answer is yes, the agency will be asked to answer more specific questions; if the answer is no, the agency will be instructed to answer different questions.

Dr. Herman suggested putting down all questions first and then sorting them into different domains. He asked the agency representatives to share their agencies' policies related to nutrition and food environment.

Dr. William (Bill) Chong pointed out that where the policies come from matters. He suggested perhaps starting with asking the agencies more generic questions (for example, is your agency responsible for implementing policies related to one of those factors listed?), and then asking more specific question (for example, in terms of implementing the policies, what programs does your agency have?), and finally asking if they have data showing the outcomes of the programs.

Dr. Donald Shell commented that the approach sounds reasonable. He noted that the Department of Defense (DoD) involves every aspect of the topics listed on the slide, and it has policies requiring that healthy food is available to service members. He pointed out that it is important for the Commission to know how each agency evaluates their policies and programs and try to identity common themes across agencies.

Dr. Albright pointed out that CDC does not set policies. They provide evidence and data for policy makers to make evidence-based decisions, and they implement policies and develop programs and services.

Dr. Barbara Linder shared that NIH conducts and funds research but does not set policies.

Dr. Aaron Lopata added that HRSA does not set policies either. He shared that at HRSA they rely on the evidence gathered by CDC and NIH to guide their programs providing care, and he emphasized the importance of having the most recent evidence.

Dr. Fukagawa shared that her agency at the USDA does not set or influence policies. However, the USDA's Food, Nutrition, and Consumer Services does set dietary guidelines and influence food programs.

Dr. Barry Marx shared that CMS operates under statutes that define the scope and type of work they do.

Dr. Lopata commented there are a lot of overlaps of policies and programs, and the two terms are sometimes used interchangeably.

Based on the discussion, Dr. Herman suggested asking five levels of questions, as follows.

- Does your agency conduct or support research that leads to policy making and program development?
- Does your agency have statutory authority to establish regulations and/or policies?
- Does your agency implement policies?
- Does your agency have programs that support implementation of policies (for example, funding and resources)?
- Does your agency have data to show the effectiveness of the policies and/or programs?

The subcommittee then discussed how to organize these questions. Dr. Dokun suggested, again, asking yes or no questions first. Dr. Herman suggested sorting the questions into the domains discussed earlier.

Dr. Marx suggested also asking if certain areas are an agency's core activities. He explained that if certain areas are considered core by the Commission but are not an agency's core activities, then he would consider it a gap.

To ensure clarity, Dr. Shell suggested using specific terms instead of broad terms such as social determinants of health, and defining social environment and food environment.

Dr. Herman asked the subcommittees to clarify the terms. Dr. Dokun agreed that they need to further define social and physical environment. He suggested in the data call the Commission explain what the terms mean to the Commission before asking questions around those topics.

Next step

Dr. Cook noted that the subcommittee plans to sort the programs listed in the high-level inventory pertain to the subcommittee. He added that empty "buckets" would help them identify gaps, and activities considered core by the subcommittee but not the agencies would be areas for which they would make recommendations. Dr. Greenlee commented that if the answer is no, they still need to dig deeper to get more information.

Dr. Herman noted that the high-level inventory is not inclusive, and he suggested the subcommittee develop questions for the data call based on today's conversation.

It was generally agreed that the Commission should develop a list of key terms (for example, policy, program, social determinant of health, and food environment) and clearly defining them.

Dr. Conlin added that all agencies have intramural policies that guide how the agencies operate, and those policies are different from regulatory guidelines and public policies that have a

broader impact. He suggested the Commission also clearly distinguish different types of policies.

How far to reach and where to focus
The Commission then discussed what agencies they should contact and how broad their recommendations should cover. One member asked if the Commission is restricted to only the agencies that are represented by the Federal members in the room.

Dr. Herman suggested thinking it broadly. Dr. Powell confirmed that the Commission can review programs of other Federal agencies. For example, during the Commission's last public meeting, a representative from the Federal Bureau of Prisons shared their experiences. Dr. Powell, however, also reminded the Commission not to reach beyond the scope of their Charter.

Some members suggested the Commission focus on greatest opportunities and areas that the Commission could make the most significant impact. Dr. Herman suggested the Commission take a broad approach to address all important issues, but at the end, he added, the Commission should limit their recommendations to no more than a dozen major recommendations.

Dr. Dokun pointed out that the Commission needs to evaluate all of the Federal programs in order to carry out their duties (for example, identify gaps) described in the Charter.

PTP Subcommittee

Questions to ask
Dr. Boltri noted that the following focus areas listed in the subcommittee's grid would be the areas they would like to ask questions.

- Screening/diagnosis for prediabetes and diabetes
- Improving access to and utilization of proven effective type 2 diabetes preventive interventions
- Sustainability of type 2 diabetes prevention and healthy lifestyle interventions (programmatic and individual)
- Developing new and more effective preventive strategies for type 1 and 2 diabetes

He suggested also looking outside the Federal agencies for further information. He noted that literature review perhaps could help provide answers and identify gaps.

Gaps, data, and barriers
Regarding gaps, one Commission member asked if there are data showing why people discontinue programs such as the DPP. Dr. Herman pointed out that CDC just published data on the high-level results from NDPP. Dr. Boltri noted there are also data in the literature. Dr. Linder added there are a lot of meta-analyses on lifestyle programs beyond the NDPP, but she was not sure if the analyses report why people drop out.

Dr. Boltri suggested assessing the impact of state Medicaid programs. He noted that some states do not provide coverage for NDPP services, and he suggested the Commission make a corresponding recommendation.

Dr. Marx noted that CDC is active in promoting the NDPP, and as a result many states are adopting the program.

Dr. Dokun wanted to know if there is research investigating why some people with prediabetes progress and other don't.

Dr. Herman expressed his view that the problem is how prediabetes is defined, and he pointed out there are variabilities between studies.

In response to Herman's question on regulatory approval paths for diabetes treatment medications and the barriers to wider applications of certain medications (for example, metformin), Dr. Chong noted that he would need to defer the question on approval pathways to colleagues who have more knowledge in the area, and he was not sure what the barriers would be if a health plan wants to promote metformin.

Commons areas between subcommittees
Dr. Fukagawa pointed out that the third focus area (that is, sustainability of type 2 diabetes prevention–healthy lifestyle interventions [programmatic and individual]) overlaps with the PGP's focus area, and she suggested the Commission make sure the data call incorporates both subcommittees' questions. She also suggested the questions in the data call are inclusive because some agencies such as the USDA do not address specific diseases.

Dr. Herman clarified that the Commission will put together one data call that includes questions from all three subcommittees.

Public Comments

Dr. Powell explained that a total of 15 minutes is allocated to public comments, and each speaker has 3 minutes to provide comment. She encouraged the public to send written comments to OHQ@hhs.gov, which she monitors and responds.

The following speakers from the public provided their comments.

Comment from Kate Sullivan-Hare

Ms. Sullivan-Hare first spoke on behalf of the Diabetes Advocacy Alliance (DAA). She highlighted the following key suggestions included in her written comment.

Medicare Diabetes Prevention Program (MDPP) Expanded Model
DAA urges the Commission to support the following recommendations aimed to improve the MDPP expanded model.

- Align MDPP services with evidence-based and CDC's National DPP
- Modify reimbursement to cover reasonable costs
- Provide targeted solutions for special populations
- Remove the once-per-lifetime limit
- Allow virtual programs to participate in MDPP

Diabetes Self-Management Training
Ms. Sullivan-Hare pointed out the underutilization of the diabetes self-management training (DSMT) program, which is a covered benefit of Medicare. She noted that DAA has identified several barriers to DSMT and urged the Commission to help support the following:

- Expand the initial 10 hours of DSMT covered by Medicare beyond the first year until fully utilized and cover additional hours based on individual need
- Allow medical nutrition therapy and DSMT to be provided on the same day
- Remove patient cost sharing
- Broaden which providers can refer to DSMT beyond the provider managing the beneficiary's diabetes to include other providers caring for the patient
- Clarify agency policy that hospital outpatient department-based DSMT programs can expand to community-based locations, including alternate non-hospital locations
- Pilot virtual DSMT through the Innovation Center

Medicare Coverage of Innovative Diabetes Technologies and Services
Ms. Sullivan-Hare noted that DAA is concerned that CMS lacks flexibility to cover innovative diabetes technologies and services, and that DAA urges the Commission to examine the issue so that when new diabetes technologies and services are approved by FDA, Medicare has a pathway to cover them.

Ms. Sullivan-Hare stated that DAA is ready to serve the Commission as a resource, and she welcomed questions from the Commission.

Ms. Sullivan-Hare then spoke on behalf of the American Association of Clinical Endocrinologists (AACE), which represents physicians specializing in the treatment of patients with complex metabolic and autoimmune diseases including diabetes. AACE urges the Commission to

- Recommend CMS streamline diabetes care when people age into Medicare,
- Recommend that FDA and CMS collaborate more closely when new technologies are approved, and remove barriers for Medicare enrollees to use the new and innovative technologies, and
- Do everything possible to address the soaring cost of insulin.

Comment from Richard Price

Mr. Price provided comment on behalf of the Advanced Medical Technology Association (AdvaMed), which represents companies producing medical devices, diagnostic products, and

health information systems that help patients with diabetes. He shared that leaders of their diabetes companies and their coverage and payment experts have been working on a proposal to establish under CMS leadership a Task Force for Improving Medicare Coverage and Payment for Innovation Technologies. He explained the rationales and the need for establishing such a Task Force, and noted that he has attached a draft bill to his written comment that explains the objectives for the Task Force provisions. He asked the Commission to support the need for the Task Force to ensure that Medicare beneficiaries have access to new technologies. He expressed his belief that that an endorsement from the Commission could help facilitate the establishment and ongoing operation of the Task Force, and ultimately lead to positive changes to beneficiaries.

Discussion of the Data Call (Continued)

TC Subcommittee

After the Public Comment session and lunch break, the Commission continued their discussion on the data call and discussed possible questions related to treatment and complications.

Structure

Dr. Herman noted that treatment and complications are the most complex topic the Commission needs to address, and he asked the Commission members to think about how to structure the data call. He proposed four different ways to organize the questions in the data call. The firs way, he said, is starting with questions asking whether or not the agencies provide care. Another way is by primary care versus specialty care, and the third is by looking at different types of issues related to treatment (for example issues related to treatment, issues related to pharmaceutical products, issues related to education and workforce training, and issues related to access to treatment and timely access to advanced technologies). The fourth approach is based on the healthcare system structure. Along this line, he explained, the questions would be care management, guidelines, population health management, reminders for feedback, different tools used to improve outcomes, and access to care and coverage for people with prediabetes and diabetes.

Dr. Greenlee pointed out that the subcommittee has worked very hard in their focus areas, including how to categorize them, and they strongly believe the patient's and the provider's role in diabetes care. The subcommittee, she added, would need to think about how to organize their questions based on Dr. Herman's suggestions.

Dr. Conlin wanted to know if they need to generate agency-specific questions. He pointed out that the biggest issue is how granular their questions need to be.

Dr. Shari Bolen pointed out that the overarching questions would apply to multiple subcommittees and suggested the TC Subcommittee use a similar structure.

Dr. Chong commented that a similar structure/approach could help ensure consistency in agencies' responses.

Other members pointed out the challenges associated with the subcommittee's long list of focus areas. They generally agreed that the subcommittee could follow a structure similar to other subcommittees'.

Policies and guidelines

The Commission then discussed the differences between policies and guidelines, as well as differences between internal policies and external policies. They also debated if they need to ask questions around both policies and guidelines; if yes, what questions to ask and how to ask the questions, given that the agencies are very different. While some members think that the Commission should also consider guidelines, others noted that it would be redundant to ask both.

Dr. Bullock reminded the Commission to focus on the big picture. She suggested the subcommittee also ask the agencies what the agencies think they need to do, or want to do, but do not have the authority or capacity to do.

Dr. Powell added that the Commission could also ask the agencies if they had to shift resources, which direction they would go or what gaps they would like to fill.

Representatives of the agencies that provide care shared that their agencies (for example, DoD and VA) have great programs and provide high-quality diabetes care. They also mentioned areas that could be improved or expanded to make a bigger impact.

In response to Dr. Greenlee's question on TRICARE, Dr. Shell explained that TRICARE is a health care program of DoD, and it provides services to all servicemembers and their beneficiaries. He noted that DoD submits annual evaluation reports to Congress, and the reports are freely available to the public.

The Commission then discussed how to categorize the questions. For example, where the subcommittee should put guidelines. While some members commented that it should be part of care delivery, others suggested addressing it under education or policy, and still others expressed their view that it could be both.

Dr. Albright suggested differentiating internal policies that affect the agencies' work from external or public policies that could impact the whole population (for example, policies affecting sugary beverages).

For agencies that do not provide patient care, Dr. Herman asked the Commission members to think about how to ask them questions and obtain information about policies and programs that support patient education and training, payment, research, and epidemiology.

Dr. Fukagawa suggested looking at various agencies under the USDA that are responsible for education, and reviewing their extension program, which provides non-formal education and learning activities to farmers and other residents of rural communities as well as to people

living in urban areas across the country. Through extension, land-grant institutions offer resources to address public needs. She noted that a number of institutions with extension needs are considering including provision of education with respect of wellness.

Dr. Greenlee asked members representing other agencies to suggest categories that have not been captured in the subcommittee's primary list of categories.

Dr. Howard Tracer noted that the Agency for Healthcare Research and Quality (AHRQ) does not have programs directly related to diabetes; however as long as the Commission considers research/epidemiology as a way of gathering data and evidence and synthesizing evidence, and asks questions accordingly, AHRQ should be able to provide information that could be used for topics related to diabetes (for example, gathering and synthesizing evidence around disparity).

Regarding collecting data from agencies that do not provide care, Dr. Albright asked how far they should reach (for example, how many divisions within CDC they should consult). Dr. Herman encouraged the Commission to be inclusive.

Dr. Greenlee asked Dr. Albright to provide guidance on how to ask questions around shared decision making, and she wanted to know how to get all the available data. Dr. Albright and other members recommended potential sources to retrieve data, including NIH publications on diabetes and reports from CDC, and pointed out that reimbursement affects the uptake of the programs.

Dr. Albright suggested the Commission address gaps in obtaining data. CDC, she explained, collects surveillance data and there are other data they'd like to have. She noted that CDC freely shares their data with everyone else, but the agency has to buy certain data from some sources. The agency, she added, then has to clean up and analyze the data to make the data useful. Dr. Albright also pointed out the differences between different types of data, and asked the Commission to ensure that they "compare apple to apple" when evaluating data.

In response to questions regarding data from the Centers for Medicare and Medicaid Services (CMS), Dr. Marx noted that CMS operates under statues, and he would be happy to take the subcommittees' questions and comments back to the agency. He reminded the Commission to clearly articulate their questions.

In response to questions about getting data from CDC, Dr. Albright pointed out the limitations in the data sources. She suggested the subcommittees be clear about what data they want and from which division they want the data.

Regarding barriers to data and data limitations, Dr. Powell asked if the Commission could make recommendations, and think about a long-term goal.

In response to Dr. Herman's question on FDA regulations and approvals, Dr. Chong noted that the more specific the questions are, the clearer the answers would be. Other members

suggested the Commission also ask information on programs that affect sub-populations (for example, tobacco-related programs).

Complications-related questions
The Commission members agreed that diabetes is a complex issue, and the list of complications of diabetes, as shown in the TC Subcommittee's grid, is long. They discussed what complications have the biggest impact and if the subcommittee needs to prioritize.

In addition to traditional macrovascular and microvascular complications, Dr. Greenlee pointed out other complications (for example, non-alcohol-related liver diseases and mental health) that affect diabetes. The TC Subcommittee, she noted, tried to develop a mechanism to do the work, which they call a comprehensive checklist.

Dr. Conlin suggested drawing some lines. He noted that a data call perhaps could provide a first round of information, and the subcommittee will likely need to invite experts from outside the agencies to provide information through a less formal approach (for example, interviews). Dr. Albright shared that CDC will be able to provide information on kidney care (for example, kidney transplantation and dialysis), and suggested the Commission asking for information that the agencies have already collected.

In response to Dr. Fukagawa's question regarding liver disease, which, she noted, is intertwined with obesity, Dr. Greenlee pointed out that for people with liver disease but without obesity, having diabetes changes the trajectory of complications and affects treatment options.

Based on the discussion, Dr. Herman asked Dr. Greenlee if she would like to start with traditional complications and then move on to special and common complications (for example, mental health and liver disease).

Additional complications to consider
Dr. Greenlee pointed out the impacts of diabetes onset at a young age and diabetes during pregnancy, and asked if there are other comorbidities the subcommittee should consider. Dr. Linder agreed and reiterated the importance of addressing the two topics.

Dr. Cook pointed out complications in the older population, and noted that treatment and prevention of neuropathy, which is a risk factor for falls, is a big issue.

Dr. Greenlee asked the Commission if they need to add cognitive impairment and management to their list. Dr. Herman agreed that people with diabetes-related cognitive impairment should be a sub-population.

Regarding the effect of diabetes during pregnancy on the offspring, Dr. Fukagawa asked which subcommittee should address the issue. Dr. Herman clarified that effects of various factors on the offspring would fall in the scope of the PGP Subcommittee.

Dr. Jasmine Gonzalvo suggested looking at complications as a whole so that the Commission does not miss important information from the agencies. Dr. Herman clarified his suggestion on the structure of the data call and noted the Commission may need to identify additional agencies to seek information regarding less common complications such as mental health.

After a short break, the Commission continued their discussion on questions related to treatment and complications. They debated whether treatment and complications should be discussed separately. Dr. Greenlee expressed her view that treatment and complications are related to each other and should be discussed together.

Dr. Herman noted, based on his background in epidemiology, that the primary intervention is preventing diabetes, secondary intervention is treating people with diabetes to prevent the development of complications, tertiary intervention is treating complications to prevent them from getting worse, and the fourth level of intervention is rehabilitation, which is providing care to those with advanced complications such as blindness and amputation.

Dr. Greenlee responded that the subcommittee may need further discussion to figure out how to follow the approach that Dr. Herman suggested.

One Commission member suggested finding out the approaches other advisory committees or studies (for example, the multicenter, randomized Diabetes Control and Complications Trial [DCCT]) use to handle challenging issues.

Dr. Herman responded that other advisory committees are charged differently, and he offered to find and share the report of DCCT, which, other members suggested, the Commission could discuss while waiting for responses to the data call.

Moving Forward: Approach and Process

Dr. Conlin asked for guidance on the next steps that could help the subcommittees move forward along the same line. He pointed out that the Commission's discussions so far have been high level and they have not developed specific questions. He expressed his concern that without clear guidance, the subcommittees may continue struggling with the right direction to go and appropriate questions to ask.

Dr. Albright agreed. She suggested turning the challenges of prioritizing issues associated with diabetes into the Commission's advantage, and pointing out the complexity of diabetes in their report to Congress. She expressed her hope that the Commission's report could help raise awareness of the issue to the national level, spur prominent conversations, advance the field of diabetes, and prevent diabetes from becoming another crisis like opioid.

Other Commission members agreed.

Dr. Herman noted that they will send the outline for the data call to the subcommittees to help them develop a list of questions they think are important. The Commission Chair and

representative from the subcommittees can then work together to make a comprehensive data call that goes to all agencies.

Approach and Process

The Commission then discussed how to streamline their approach. Dr. Dokun expressed his preference for a broader approach first. For example, high-level questions first, and then more detailed questions depending on the answers to the high-level questions.

Dr. Conlin pointed out that the agencies differ, and the Commission may miss certain information if they do not ask agency-specific questions.

Dr. Fukagawa agreed with Dr. Dokun's approach. She added that who answer the data call could also make a difference, depending on the person's knowledge of the agency's policies and programs.

Dr. Chong agreed. He added that it would make sense to send the data call to the Commission's office, which can then direct where to go. He also agreed that starting with broad questions can help the Commission get some basic data quickly, and Commission can obtain more data later if needed.

After further discussion, it was clarified that the Secretary's office will send the data call to the heads of the agencies, who will then ask an appropriate division within the agency to respond to the data call within a deadline. It was suggested that it might be helpful if the Commission could suggest which division(s) they wish to review the data call and provide answers.

Structure and Granularity

Dr. Shell reminded the Commission members of the five duties specified in the Charter, and suggested the Commission ask and organize their questions around the duties.

Dr. Lopata agreed that the Charter provides clarity. He added that if the Commission asks questions around the issues highlighted in the Charter, the agencies should be able to provide answers.

Dr. Herman pointed out that the agencies may not know if there is an overlap between their and other agencies' activities.

A few members asked for clarification about the extensiveness of the data call and the granularity of the questions. Some members voiced concern that a high-level data call may result in the same list of high-level programs the Commission already has, and without granularity some agencies (for example, the USDA) may not able to provide the specific information the Commission needs.

Dr. Herman noted that the Commission should send out a comprehensive data call containing combined and streamlined questions from all three subcommittee, and that different agencies

may answer different sections of the data call. The Commission, he explained, can ask high-level/broader questions first and then drill down to more detailed questions.

Dr. Dokun added that a "No" answer to the first set of broad questions does not mean the agency should stop there; instead, the answer will guide the agency to a different set of questions (for example, more specific and perhaps agency-specific questions). He noted that a set of broad questions would help Commission move forward at least.

In addition to the broad-to-narrow approach suggested by Dr. Dokun, the Commission also discussed another approach pointed out by Dr. Conlin and originally proposed by Dr. Gonzalvo during a subcommittee meeting. Using this approach, the subcommittee would ask two sets of questions, one set for agencies supporting clinical care, and the other set for agencies do regulations.

The Commission further discussed if the TC Subcommittee should narrow down their focus areas in order to make the list manageable, and which approach the TC Subcommittee should use to organize their questions. Dr. Bolen suggested perhaps using a hybrid approach. Dr. Conlin noted that the subcommittee has already developed a lot of specific questions. Dr. Greenlee expressed her preference for a sequential data call.

Next Steps and Timeline

Dr. Herman noted that the next step is for the subcommittees to develop questions and put together the data call based on their focus areas. He clarified that if the subcommittees need further information after receiving the agencies' responses to the data call, they can ask for more detailed information.

The Commission then discussed the timeline. The subcommittee co-chairs proposed to have one month for them to develop questions, given that the July 4th holiday is coming up. Dr. Herman estimated it might take another couple weeks for Dr. Powell's office to combine the questions from the three subcommittees, and another couple of weeks for the Commission to discuss and finalize the questions, perhaps during the Commission's next meeting in September, 2019.

Dr. Powell noted that the data call will need to go through a clearance process before it can be sent out from the Secretary's office to the heads of the agencies. She expressed, again, her concern about the timeline, and urged the Commission to find a way to move forward faster.

Closing Remarks

Chairperson

Dr. Herman thanked the Commission members and the public for attending and observing the meeting. He noted that he will try to share with the Commission members the report of NCD so

that they can see what NCD had done, and he encouraged the subcommittees to provide their list of questions to Dr. Powell in a timely fashion.

DFO

Dr. Powell expressed her appreciation to all the members and the public. She noted that she is here to serve the Commission, and she encouraged the Commission members to contact her with questions.

Adjournment

The meeting was adjourned at 4:55 pm.

Appendix: Commission Members and HHS Support Staff

Commission Members Present for NCCC Meeting 3

Commission Chair

William H. Herman, MD, MPH, Stefan S. Fajans/GlaxoSmithKline Professor of Diabetes, Division of Metabolism, Endocrinology, and Diabetes, University of Michigan, Ann Arbor, MI

Public Members (Special Government Employees)

Shari Bolen, MD, MPH, Associate Division Director of Internal Medicine, Center for Health Care Research and Policy, Case Western Reserve University, Cleveland, OH

John Boltri, MD, FAAFP, Chair and Professor, Department of Family and Community Medicine, Northeast Ohio Medical University College of Medicine, Rootstown, OH

J. William (Bill) Cook, MD, Chair, Board of Directors, Ascension Medical Group, Baltimore, MD

Ayotunde Dokun, MD, PhD, FACE, Chief of Endocrine Service, Division of Endocrinology, Diabetes and Metabolism Regional One Health System, Memphis, TN

Jasmine Gonzalvo, PharmD, BCPS, BC-ADM, CDE, LDE, Clinical Pharmacy Specialist, Primary Care, Midtown Medical, Eskenazi Health, Indianapolis, IN

Carol Greenlee, MD, FACP, FACE, Faculty Co-Chair, Center for Medicare and Medicaid Innovation Transforming Clinical Practice Initiative, Grand Junction, CO

Shannon Idzik, DNP, ANP-BC, FAAN, FAANP, Associated Dean and Professor, Doctor of Nursing Practice Program, University of Maryland Baltimore School of Nursing, Baltimore, MD

Ellen Leake, Chair, Juvenile Diabetes Research Foundation, International Board of Directors, Jackson, MS

Meredith Hawkins, MD, MS, Director, Global Diabetes Institute, Albert Einstein College of Medicine, Bronx, NY

David Strogatz, PhD, MSPH, Director, Center for Rural Community Health, Bassett Research Institute, Bassett Health Care Network, Cooperstown, NY

Federal Members (Regular Government Employees)

Ann Albright, PhD, RDN, Division Director, Division of Diabetes Translation, Centers for Disease Control and Prevention, Department of Health and Human Services

Ann Bullock, MD, Director, Division of Diabetes Treatment and Prevention, Office of Clinical and Preventive Services, Indian Health Service, Department of Health and Human Services

William Chong, MD, Acting Division Director, Division of Metabolism and Endocrinology Products, Office of New Drugs, Center for Drug Evaluation and Research, Food and Drug Administration, Department of Health and Human Services

Paul R. Conlin, MD, Chief, Medical Service, Veterans Affairs Boston Healthcare System, Department of Veterans Affairs

Naomi K. Fukagawa, MD, PhD, Director, Beltsville Human Nutrition Research Center, Department of Agriculture

Barbara Linder, MD, PhD, Program Director, Division of Diabetes, Endocrinology, and Metabolic Diseases, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, Department of Health and Human Services

Aaron Lopata, MD, Senior Medical Advisor, Maternal and Child Health Bureau, Office of the Associate Administrator, Health Resources and Services Administration, Department of Health and Human Services

Barry Marx, MD, Director, Office of Clinician Engagement, Center for Clinical Standards and Quality, Centers for Medicare and Medicaid Services, Department of Health and Human Services

Donald Shell, MD, MA, Director, Disease Prevention, Disease Management and Population Health Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs Health Services Policy and Oversight, Department of Defense

Howard Tracer, MD, Medical Officer, U.S. Preventive Services Task Force Program, Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, Department of Health and Human Services

CAPT David Wong, MD, FAAP, Medical Officer, Office of Minority Health, Office of Assistant Secretary for Health, Department of Health and Human Services

HHS Support Staff in Attendance

Clydette Powell, MD, MPH, FAAP, Designated Federal Officer for the NCCC, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Department of Health and Human Services

Erika Kim, Pharm D, incoming ORISE fellow

Commission Members Absent from NCCC Meeting 3

Dean Schillinger, MD, Chief, UCSF Division of General Internal Medicine, San Francisco General Hospital, San Francisco, CA

Subcommittees and Members

Prevention—General Population Subcommittee

- Naomi Fukagawa, Co-Chair
- Bill Cook, Co-Chair
- Ann Bullock
- Aaron Lopata
- Carol Greenlee
- Ellen Leake
- Bill Herman
- Dean Schillinger
- John Boltri
- Jasmine Gonzalvo

Prevention—Target Population Subcommittee

- Ann Albright, Co-Chair
- John Boltri, Co-Chair
- Donald Shell
- Naomi Fukagawa
- Barbara Linder
- Howard Tracer
- David Strogatz
- Shannon Idzik
- David Wong
- Barry Marx

Treatment and Complications Subcommittee

- Paul Conlin, Co-Chair
- Carol Greenlee, Co-Chair
- William Chong
- Barbara Linder
- Shari Bolen
- Jasmine Gonzalvo
- Ayotunde Dokun
- Meredith Hawkins
- Bill Herman
- Ellen Leake