

# National Clinical Care Commission Webinar Meeting 11: Day 2

## Tuesday, June 22, 2021

### 1:00 pm — 6:00 pm EDT

## Meeting Summary

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## **Welcome and Roll Call**

Dr. Kara Elam, Designated Federal Officer (DFO) for the National Clinical Care Commission (NCCC), welcomed everyone to the second day of the NCCC Public Meeting 11 and conducted roll call. The meeting started with a quorum (see Appendix for Commission member attendance).

## **Opening Remarks and Review of Agenda**

Dr. William Herman, chair of NCCC, reviewed the Charge to the Commission, as follows:

### **NCCC's Charge**

The Commission shall evaluate and make recommendations, as appropriate, to Congress and the Secretary of Health and Human Services regarding:

1. Federal programs of the Department of Health and Human Services (HHS) that focus on preventing and reducing the incidence of diabetes, including complications due to such disease
2. Current activities and gaps in federal efforts to support clinicians in providing integrated, high-quality care to individuals with the disease and complications
3. The improvement in, and improved coordination of, federal education and awareness activities related to the prevention and treatment of the disease and complications, which may include the use of new and existing technologies
4. Methods for outreach and dissemination of education and awareness materials that
  - a) Address the disease and complications
  - b) Are funded by the federal government
  - c) Are intended for health care professionals and the public
5. Opportunities for consolidating inappropriately overlapping or duplicative federal programs related to the disease and complications

### **NCCC's Approach**

Dr. Herman explained that the Commission has been conducting its work through three Subcommittees (the Prevention—General Population Subcommittee, the Prevention—Targeted Population Subcommittee, and the Treatment and Complications Subcommittee). Dr. Herman noted that the Subcommittees have addressed a broad range of issues to improve diabetes prevention and care. Additionally, the Subcommittees also address crosscutting issues related to health equity, social determinants of health, and research needs, he said.

### **Agenda for the Second Day of the NCCC Public Meeting 11**

Dr. Herman briefly reviewed the meeting agenda, which included review and discussion of draft recommendations that require modifications, voting on all of the Commission's near final draft recommendations, preparing the Commission's Report to Congress and the HHS Secretary, and planning next steps.

### **Rating the Draft Recommendations**

Dr. Herman explained that Commission members have reviewed each of the three Subcommittees' final lists of draft recommendations, provided comments, and rated each one of the draft recommendations using the following scoring scheme:

1. I agree with this recommendation as written.
2. I agree with this recommendation with minor modifications.
3. I agree with this recommendation with major modifications.
4. I do not agree with this recommendation.

Dr. Herman reported that none of the draft recommendations received more than three 4's, and therefore none of the three Subcommittees' near final draft recommendations were dismissed.

Dr. Herman explained that based on the rating result, the Commission will prioritize the recommendations with the lowest scores, and focus today's discussion on the draft recommendations with the most 3's and/or 4's.

Dr. Herman noted that the Commission will try to revise some of the draft recommendations at today's meeting. He encouraged Commission members to share their additional minor edits (if not addressed at today's meeting) with the Subcommittee co-chairs via email after the meeting.

### **Voting on the Draft Recommendations**

Dr. Herman further explained that at the end of the today's meeting, the Commission will vote on each of the Subcommittees' draft recommendations, including those that will not be discussed today due to time constraints but for which Commission members have general consensus (based on Commission members' ratings). Dr. Herman stated that approval of a recommendation will require a simple majority vote.

Dr. Herman noted that while the Commission's intent is to develop a list of succinct, actionable recommendations, the Commission is not limited to a specific number of recommendations.

### **Next Steps**

Dr. Herman explained that after today's vote, the Subcommittees are allowed to make minor changes to an approved recommendation as long as the edits do not change the intent or substance of the recommendation; however, recommendations that require substantive modifications will need to be voted on separately at the Commission's next (final) public meeting in September 2021, during which Commission members will cast their final votes to approve the final recommendations and the Report to Congress and the HHS Secretary.

### **Discussion**

Following Dr. Herman's introduction, Commission members asked for clarification about revisions to the draft recommendations. Dr. Dean Schillinger wanted to know if the Subcommittees are required to revise the draft recommendations that will be discussed today.

Dr. Herman responded that the Commission will discuss the draft recommendations that have received the most 3's and/or 4' and will try to edit them together during today's meeting.

Regarding minor wording changes, Dr. Carol Greenlee wanted to know if the Subcommittees could further combine or condense some of the draft recommendations; and whether the changes (i.e., combing and/or condensing) would be considered minor or major, if the changes do not affect the intent of the original recommendation(s).

Dr. Herman explained that those changes would still be considered minor if they do not affect the substance of the recommendation; however, those revised recommendations will need to be voted on separately at the Commission's September meeting.

## **Access to Health Care**

Dr. Herman reviewed the draft recommendation related to access to health care. He explained that other draft recommendations developed by the workgroup (e.g., recommendations on the affordability of insulin and quality measures) have been incorporated into the Treatment and Complications Subcommittee's recommendations.

Dr. Herman emphasized that access to health care is a large issue that needs to be addressed. He explained that the following draft recommendation has been revised to focus on diabetes.

**Draft recommendation:** We recommend that federal policies and programs be designed to ensure that all people at risk for and with diabetes have access to comprehensive, high-quality, and affordable health care; and that no one at risk for or with diabetes who needs health care cannot get it because of cost.

### **Discussion**

Commission members discussed if the draft recommendation is intended to address health care in the general population or specific populations.

Dr. Herman explained that the original draft recommendation was developed to address the general US population. However, based on the feedback the Commission has received and to stay within the Commission's scope, the draft recommendation has been revised to focus on people with diabetes as well as people at risk of developing diabetes. Dr. Herman expressed his view that access to health care is an overarching issue, and that the recommendation is an overarching recommendation.

Dr. Naomi Fukagawa commented on the importance of access to health care to everyone. She asked, if the Commission as a whole believes that all people should have access to health care, is it appropriate for the Commission to recommend health care for people with diabetes only?

Dr. Herman agreed with Dr. Fukagawa's view. He explained that the draft recommendation, however, has been revised based on comments suggesting that the Commission focus on diabetes.

Dr. Schillinger commented that based on the natural history of diabetes, everyone in this country is at risk for diabetes. He stated that he would be comfortable with expanding the draft commendation, if allowed.

Commission members further discussed the wording. Multiple Commission members expressed acceptance of the wording of the draft recommendation. They pointed out that while they agree that everyone should have access to health care, the Commission, however, has to stay within its Charge, which focuses on diabetes. Commission members also commented on the importance of keeping "all people at risk for and with diabetes" in the draft recommendation to help reach a broad population.

Dr. Schillinger commented that "federal policies and programs be designed" is vague, and he suggested revising the language to improve clarity.

Dr. Herman suggested removing "federal policies and programs be designed" from the draft recommendation.

**Revised draft recommendation:** We recommend that all people at risk for and people with diabetes have access to comprehensive, high-quality, and affordable health care; and that no one at risk for or with diabetes who needs health care cannot get it because of cost.

## **Prevention—General Population Subcommittee Update**

Dr. Dean Schillinger, co-chair of the Prevention—General Population Subcommittee, explained that Commission members suggested minor changes to the following draft recommendation in Domain 5.

### **Domain 5. Encourage the Consumption of Water Over Sugar-sweetened Beverages**

**Draft recommendation:** The NCCC recommends that all relevant federal agencies promote the consumption of water and reduce the consumption of sugar-sweetened beverages in the US population, and that they employ all the necessary tools to achieve these goals, including education, communication, accessibility, water infrastructure, and sugar-sweetened beverage taxation.

- USDA should add a symbol for drinking water to the MyPlate graphic and increase water promotion messaging in all consumer-facing materials issued by its Center for Nutrition Policy Promotion. Water is not currently depicted on the USDA MyPlate.
- Child nutrition programs should be a conduit for education to promote consumption of water and reduce consumption of sugar-sweetened beverages. USDA should encourage healthy hydration and provide safe water education in WIC nutrition education and in

childcare settings. Congress should harness the Child Nutrition Reauthorization to strengthen existing water provisions for school nutrition programs.

- HHS should commission a scientific report under the joint auspices of the US Surgeon General, the Centers for Disease Control and Prevention (CDC), and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to summarize and present a synthesis of the evidence regarding the causal relationship between sugar-sweetened beverage consumption and obesity and type 2 diabetes. The CDC and NIDDK should develop and implement a national campaign and associated materials to both promote the consumption of water and reduce consumption of sugar-sweetened beverages as a strategy to promote overall health, including the prevention of obesity, diabetes, and cardiovascular disease. CDC should also include such messages across all its relevant programs, including the National Diabetes Prevention Program (DPP) and its associated DPP curriculum.
- All federal agencies should promote drinking water and reduce sugar-sweetened beverage consumption within their own organizations and through the grants and programs they fund or administer. All agencies should increase access to free, clean, and appealing sources of water for their employees and visitors.
- HHS should serve as a federal model by (a) ensuring onsite access to safe, clean, and appealing water; (b) restricting the sale of sugar-sweetened beverages in HHS-owned or -leased offices, workplaces, and health care facilities; and (c) evaluating its impact on employee behavior and diabetes-related outcomes.
- Similar to the federal tobacco tax, the US Treasury Department should impose an *excise* (not sales) tax on sugar-sweetened beverages to cause at least a 10% increase in their shelf price. The revenues generated should be reinvested to promote the health of those communities that bear a disproportionate burden of type 2 diabetes (child health, clean water, etc.) in low-income communities and communities of color. This federal sugar-sweetened beverage tax should not serve as a means to pre-empt state or local authorities from levying their own additional excise tax on sugar-sweetened beverages.
- The Office of the US Trade Representative should ensure that all international trade agreements allow for the taxation of SSBs and front of package health advisory labels and icons (see also Recommendation #6).

### **Discussion**

Multiple Commission members commented on the fifth bullet of the draft recommendation (HHS as a federal model).

### ***Evaluating***

Dr. Linder commented that “evaluating its impact on employee behavior and diabetes-related outcomes” appears to require/mandate HHS to evaluate.

Dr. Schilling explained that the evaluation or survey would be voluntary.

Dr. Herman suggested minor revision to improve clarity.

### ***Restricting***

Dr. William Chong commented on the same bullet and he asked for clarification around “restricting.”

Dr. Schillinger explained the Subcommittee revised the wording based on Commission members’ comments, and that they replaced “prohibiting” with “restricting” to let HHS define how to do it.

### ***Adequate access***

Dr. Howard Tracer suggested adding “adequate” (i.e., ensure *adequate* access to safe, clean, and appealing drinking water).

### ***Format***

Dr. Chong commented on the format of the recommendation (i.e., a main recommendation followed by multiple bullets), and he wanted to know if the Commission will vote on the main recommendation only (the bold part in Dr. Schillinger’s presentation) or all of the bullets as well.

Dr. Schillinger explained that based on his understanding, the Commission will vote on all of them (i.e., the main recommendation and the bullets), and that the Subcommittee will tighten the recommendation.

Dr. Herman confirmed that the Commission will vote on the entirety of the recommendation, and he encouraged members to provide input if they have questions about the bullets.

## **Domain 8. Increase Breastfeeding Promotion**

Dr. Aaron Lopata, co-chair of the Prevention—General Population Subcommittee, presented the following draft recommendation for discussion.

**Draft recommendation 8:** The NCCC recommends that federal agencies promote and support breastfeeding in order to (a) increase breastfeeding rates, (b) enhance the intensity and duration of breastfeeding among mothers who breastfeed, and (c) reduce disparities in these breastfeeding outcomes. Additional funding should be provided for federal programs that promote and support breastfeeding to overcome societal and employment-based obstacles to breastfeeding.

- Provide additional funding for successful programs that promote and support breastfeeding including USDA’s Food and Nutrition Service WIC Peer Counselor programs; HRSA/MCHB -Healthy Start, the Maternal, Infant, and Early Childhood Home Visiting Program; and CDC’s Maternity Practices in Infant Nutrition and Care (mPINC) and Breastfeeding Report Card.
- The Department of Labor should expand existing federal protections for mothers in the workplace including mothers covered under the Fair Labor Standards Act (non-salaried employees) as well as those who are not covered under the Fair Labor Standards Act

(salaried employees); develop and disseminate resources to help employers comply with federal law requiring they provide the time and a place for nursing mothers to express breast milk; and employ a monitoring system to ensure employers are complying with federal law requiring that they implement lactation support programs.

- NIH, the Agency for Healthcare Research and Quality (AHRQ), the Center for Medicare and Medicaid Innovation (CMMI), USDA, and others should support community-based and -informed demonstration projects to identify and evaluate impacts of effective evidence-based breastfeeding support interventions among minority women and women of lower socioeconomic status and inform implementation and scaling efforts.
- HHS should update the 2011 *The Surgeon General's Call to Support Breastfeeding* to reflect the current landscape of breastfeeding research and to provide updated breastfeeding policy and program guidance for the new generation of health care providers, public health officials, women, and families.
- CMS should enact and adequately fund a Medicaid incentive payment program to incentivize hospitals and facilities providing maternal and newborn services to implement and successfully demonstrate adherence to the Ten Steps to Successful Breastfeeding framework developed by the World Health Organization and the United Nations Children's Funds (UNICEF).
- Enact national maternity leave legislation to provide mothers with up to three months of paid leave to care for and bond with a child following birth. The paid leave provided under this legislation would be distinct from unpaid leave available to employees as a result of the Family and Medical Leave Act.

### **Discussion**

Commission members commented on the format of the draft recommendation, and discussed how to revise the draft recommendation (including the bullets) to improve clarity and readability.

### **Format**

Dr. Chong commented that the draft recommendation with all the details (bullets) is long and would be challenging for the reader to digest. He suggested perhaps incorporating the core messages of the bullets into the main recommendation and providing examples in the report. Dr. Greenlee agreed.

Dr. Lopata explained that the Prevention—General Population Subcommittee used the same approach for all of their draft recommendations (i.e., main recommendation following by bullets that provide specific guidance).

Dr. Herman stated that the draft recommendations have been discussed before, and he voiced concern that changing the approach now might inadvertently affect the substance of the recommendations.

### ***Association between breastfeeding and diabetes***

Regarding the last bullet, Dr. Ayotunde Dokun suggested highlighting the connection between the duration of breastfeeding and reduction of diabetes.

Dr. Lopata agreed to revise the draft recommendation and call out the connection in the report.

### ***Medicaid incentive payment program***

Commission members discussed the intent of the second to last bullet related to CMS, and suggested revisions to improve clarity. Comments and suggestions provided included the following:

- Dr. Shari Bolen suggested replacing “...to the Ten Steps to Successful Breastfeeding framework developed by the World Health Organization and the UNICEF” with “...evidence-based breastfeeding framework such as the Ten Steps.”
- Dr. Barry Marx and a couple other members discussed if “enact” is the best word choice for this bullet. CAPT Jana Towne suggested using “implement” instead.

### ***Private sector and small businesses***

Multiple Commission members commented on the last bullet. Dr. Bolen suggested clarifying the language to ensure that small businesses could implement it.

Dr. Paul Conlin voiced concern that the bullet might be considered overarching. Dr. Meredith Hawkins agreed.

Dr. Lopata explained that the Subcommittee was advised not to be too prescriptive, and that the intent is to accomplish it with the government’s support. Dr. Dean Schillinger added that the intent is for Congress to decide how to accomplish it.

CAPT Towne commented that the last bullet as written could apply to fathers as well, and she suggested revising the wording to improve clarity of intent.

## **Domain 9. Improve the Ambient and Built Environments to Prevent Diabetes and Its Complications**

Dr. Schillinger presented the following draft recommendation for discussion.

**Draft recommendation:** The NCCC recommends that all federal agencies whose work influences the ambient (e.g., air, water, land, and chemical) and built environments should modify their policies, practices, regulations, and funding decisions so as to lead to environmental changes to prevent and control diabetes.

- All federal agencies should limit the extent to which their work contributes to individual- and population-level exposure to environmental pollutants and contaminants associated with diabetes and/or its complications. The Environmental Protection Agency (EPA) and the National Institute of Environmental Health Sciences should ensure that environmental protections are in place to limit individual- and population-level exposure

and implement abatement measures, prioritizing those exposures that contribute to diabetes-related disparities.

- All federal agencies (in particular, the Department of Transportation and the Department of Housing and Urban Development [HUD]) should modify their policies, practices, regulations, and funding decisions related to the built environment to prevent diabetes and its complications by enhancing walkability, green space, physical activity resources, and active transport opportunities. Priority should be given to those regions and projects that could mitigate the effects of unhealthy built environments on diabetes-related disparities.

### **Discussion**

Dr. Greenlee commented that this draft recommendation could be used as an example in Domain 1.

Dr. Schillinger replied that Domain 1 is an overarching recommendation and all of the draft recommendations could fit in Domain 1.

Dr. Conlin asked for clarification about the intent of “...implement abatement measures, prioritizing those exposures that contribute to diabetes-related disparities.” He commented that if there are strong data showing that certain abatement measures do help reduce diabetes incidence, then prioritizing them makes sense; however, if the evidence is not strong, those measures may not be prioritized.

Dr. Schillinger explained the impact of heavy metal contamination on people’s health in the Navajo Nation. He further explained that the Subcommittee has reached to EPA but did not receive input, and that’s why the Subcommittee kept the bullet general.

### **Domain 10. Revise Housing Policy to Better Prevent and Control Diabetes**

Dr. William Cook presented the following draft recommendation for discussion.

**Draft recommendation:** The NCCC recommends that, to reduce type 2 diabetes incidence and diabetes complications, housing opportunities for low-income individuals and families be expanded, and that such individuals and families be housed in health-promoting environments.

- HUD should expand its federal housing assistance programs to allow access for more qualifying families, such that over a 20-year period, all that qualify can access subsidized or public housing.
- The Internal Review Service (IRS) should further incentivize developers to place new housing units in areas of low poverty, as data show that moving people from areas of high poverty to low poverty favorably affects the prevalence of obesity and diabetes.
- The IRS should mandate that states include neighborhood health parameters (e.g., availability of health care services, transportation, employment opportunities, education opportunities, food availability, and physical activity resources) in the required IRS Qualified Allocation Plan criteria.

- The IRS should establish a means to fund or subsidize cost of embedding health services (if needed) in housing developments to incentivize committing space or employing unused space for such services in their plans.
- HUD should broaden implementation of indoor smoke-free policies to include subsidized multi-unit housing, require multi-unit housing adopting smoke-free policies to provide access to cessation resources (i.e., referrals to cessation resources); and in collaboration with the CDC Office on Smoking and Health, work to align these policies with its related policies in public housing to ensure that loss of housing is not an unintended consequence.

### **Discussion**

Dr. Cook explained that the Subcommittee has addressed Commission members' comments received before today's meeting. Regarding the comment on the format of the recommendation (that is, a main recommendation followed by multiple bullets), Dr. Cook said that he would let the Subcommittee decide.

### ***Evidence base***

Commission members discussed if all of the bullets are supported by adequate evidence.

Regarding the comment about the potential, unintended consequence of moving housing from areas of high poverty might make poor neighborhoods poorer, Dr. Cook explained that studies have shown that moving people out of poor neighborhoods works.

Dr. Chong wondered if Domain 9 and Domain 10 are premature without research highlighted in Domain 11 (Update Federal Research Priorities).

Dr. Cook explained there are adequate data supporting the second bullet of Domain 10, and that the third and fourth bullets were based on the second bullet. The recommendation, he explained, is based on literature search and review, and is evidence-based.

Dr. Schillinger concurred that Domain 9 and Domain 10 recommendations are supported by adequate evidence. He explained that the intent of Domain 11 is to fund more studies to address high-level issues, whereas Domain 9 is more specific about endocrine disruptors.

In response to Dr. Bolen's concern over the third bullet, Dr. Schillinger explained that the intent of the bullet is to bring health parameters into the incentives.

## **Prevention—Targeted Population Subcommittee Update**

### **Type 2 Diabetes Prevention Research**

Dr. John Boltri, co-chair of the Prevention—Targeted Population Subcommittee, presented the Subcommittee's draft recommendation related to type 2 diabetes prevention research. He explained that the background information remains the same.

**Draft recommendation 13:** The NCCC recommends funding

- to study impediments to participation in effective diabetes prevention programs for the communities at greatest need;
- to study programs that combine both lifestyle intervention and metformin to prevent diabetes mellitus;
- to study and develop new medications that safely and effectively delay or prevent the onset of type 2 diabetes mellitus and its complications;
- to understand the number, frequency, duration, and content of lifestyle intervention sessions needed to effectively prevent diabetes in the long term;
- to understand and mitigate barriers to long-term maintenance of weight loss achieved in diabetes prevention programs; and
- for dissemination and implementation research to promote the use of effective in-person and virtual diabetes prevention programs. Such efforts should understand and address barriers at multiple levels, including systemic policies, health care provider referrals, and patient uptake.

**Discussion**

***Drug development and comparative studies***

Commission members discussed if the third bullet is needed given that there are ongoing studies funded by pharmaceutical companies. Different views were expressed. While some Commission members commented that it is pharma's interest and responsibility to fund and test new medications, others noted that the federal government needs to support the development of medications for prevention as well.

Commission members further discussed the intent of the draft recommendation and NIH's role. In response to Dr. Schillinger's question regarding the intent of the draft recommendation, Dr. Boltri explained that it is about having more medications for prevention. Dr. Linder explained that NIH can conduct comparative-effectiveness studies on approved drugs; however, currently there are no approved drugs for diabetes prevention. Comparative studies, she added, generally are very expensive to perform.

A couple other Commission members commented that given that comparative-effectiveness studies are expensive to conduct, perhaps the federal government should provide support for such studies.

Commission members further discussed how to revise the bullet. One suggestion was for NIH to fund studies to investigate drugs that have been approved for other indications and have shown evidence of diabetes prevention to (1) explore if those drugs can prevent diabetes, and (2) compare their effectiveness in preventing diabetes.

***Biomarkers***

Commission members also discussed the research need to find biomarkers that could be used to identify people with prediabetes who are at high risk of developing diabetes and its

complications so that screening and interventions can be tailored to maximize the effectiveness of the interventions.

Dr. Boltri explained that the information is included in the background section.

Dr. Schillinger commented that the information should be included as a recommendation instead. Other Commission members agreed.

**Decision item:** The Subcommittee agreed to add the following bullet to the draft recommendation on research.

- Fund research to better identify people with prediabetes who are at high risk of developing diabetes and its complications so that screening and interventions can be tailored to maximize the effectiveness of the interventions.

### **Use Existing Administrative Data to Identify Patients Meeting Criteria for Prediabetes**

Dr. David Strogatz presented the Subcommittee's fourth draft recommendation and explained the comments the Subcommittee has received.

**Draft recommendation 4:** Federal agencies that deliver care (e.g., VA, DoD, IHS, BoP, HRSA) should implement a process for systematically using administrative and clinical data to identify patients at risk for or already meeting criteria for prediabetes and to confirm appropriate follow-up.

#### **Discussion**

Commission members discussed the possibility of combining this draft recommendation with the Subcommittee's third draft recommendation.

#### **Draft recommendation 3:**

- All federal agencies that directly deliver or influence the delivery of medical care should implement the 2019 AMA-proposed prediabetes quality measures related to screening for abnormal blood glucose, intervention for prediabetes, and retesting of abnormal blood glucose in patients with prediabetes.
- To support the implementation of these measures, quality-improvement programs should be introduced to improve performance and reduce disparities.

Dr. Herman commented that draft recommendation 4 appears to be more about implementation.

Dr. Strogatz explained that the second bullet of draft recommendation 3 addresses the implementation of AMA measures, and that incorporating draft recommendation 4 as an example makes sense.

Other Commission members agreed.

**Decision item:** The Subcommittee will consolidate their draft recommendations 3 and 4.

Dr. Chong commented on calling out AMA measures in draft recommendation 3. He asked what if there are other measures that are better than AMA's measures.

Dr. Strogatz explained that one of the AMA's measures is on CMS' Measures under Consideration (MUC) list; and that multiple comments from the public, not just AMA, suggested implementing the three measures.

Ms. Pat Schumacher concurred with what Dr. Strogatz said. She added that the AMA's three measures are the first set of measures related to intervention for prediabetes and it would be great to see them pass the evaluation.

## **Type 2 Diabetes Prevention Interventions**

Dr. Shannon Idzik presented the following draft recommendation for the Commission to discuss and provide input.

**Draft recommendation 5:** Provide funding to NIH to collect, analyze, and organize available data from the Diabetes Prevention Program describing the effectiveness and safety of metformin for diabetes delay or prevention in patients with prediabetes including subpopulations most likely to benefit. Such a summary should then be used to inform an appropriate submitter's request to FDA to review and consider an indication for the use of metformin in high-risk patients with prediabetes.

### **Discussion**

Dr. Idzik shared that one of the comments the Subcommittee received suggested incorporating this draft recommendation into the Prevention—Targeted Population Subcommittee's draft recommendation 13 on research priorities.

Dr. Herman commented that they are two different issues: implementation and research.

Commission members discussed the rationale for this draft recommendation. A couple Commission members commented that they were not sure if the recommendation would make a difference in the utilization of metformin.

Dr. Herman commented that without an FDA approval, metformin cannot be promoted, which affects the utilization of metformin. He expressed his view that it is important for the Commission to keep the draft recommendation.

Dr. Schillinger commented that lack of FDA approval is the number one barrier to prescribe metformin for primary care physicians. Multiple Commission members agreed.

**Decision item:** After extensive discussion, the Commission decided to keep the draft recommendation about metformin.

## **Improve Access to and Utilization of Evidence-based Effective Type 2 Diabetes Prevention Interventions**

Dr. Idzik presented the following draft recommendation for discussion.

### **Draft recommendation:**

- Approve Medicare Diabetes Prevention Program (MDPP) as a permanent covered benefit (not only a model expansion service)
- Expand coverage of MDPP to include virtual delivery
- Lift the “once-in-a-lifetime” limit on participation in MDPP

### **Discussion**

Dr. Idzik shared that the Subcommittee received one comment suggesting combining all of the draft recommendations on MDPP into one recommendation.

Commission members discussed the intent of the first bullet. Dr. Barry Marx commented that the bullet as currently written is not clear whether the Commission is recommending MDPP be approved based on CMMI evaluation or MDPP be approved without completing the evaluation. Dr. Marx suggested making it clear what the Commission is recommending.

Dr. Herman and Dr. Idzik confirmed that the intent is to approve MDPP as a permanent covered benefit based on available data and before the completion of the demonstration project.

## **Raise Public Awareness About Prediabetes and the National DPP**

Dr. Strogatz presented the following draft recommendation for discussion.

### **Draft recommendation:**

- Increase support to CDC for its campaign to improve awareness of prediabetes and promote enrollment in the National DPP lifestyle change program.
- To more effectively reach populations disproportionately impacted by type 2 diabetes risk, CDC should identify and engage popular social media influencers with numerous followers in key target audience populations to develop and post custom content on their platforms focusing on prediabetes awareness and the urgency to prevent or delay type 2 diabetes.
- CDC should continue tracking visits to the *Do I Have Prediabetes* campaign page and completions of the prediabetes risk test, with an expanded focus on the degree to which

populations at increased risk are being reached in order to reduce disparities in awareness and engagement in interventions.

### **Discussion**

Dr. Strogatz reported that the Subcommittee received comments regarding the focus on social media.

Ms. Schumacher explained that social media has been shown to be effective to reach the audience at high risk who may not get the message through traditional media channels. She agreed that the Commission should not limit other channels.

Dr. Herman suggested “...use multiple methods including social media...”

Dr. Strogatz and Ms. Schumacher agreed.

### **Treatment and Complications Subcommittee Update**

Dr. Paul Conlin, co-chair of the Treatment and Complications Subcommittee, explained that today the Subcommittee will present and seek Commission members’ input on draft recommendations around the following topics:

- Research to explore factors affecting referrals to and the uptake of diabetes self-management education and support (DSMES)
- Eligibility and reimbursement requirements for diabetes technology
- Implementation and sustainability of team-based care
- Quality measures to ensure patient safety

### **Diabetes Education and Support**

Dr. Conlin explained that despite the proven efficacy of DSMES, only a small percentage of people with diabetes receive the service within one year of their diagnosis (fewer than 7% of individuals with private insurance and fewer than 5% of Medicare beneficiaries). He noted that to address the barriers limiting referrals to and receipt of DSMES, the Subcommittee developed the following draft recommendation.

- We recommend that NIH prioritize funding for research to identify and address factors that affect referrals to and patient uptake of DSMES, such as patient, clinician, and system-level barriers, quality measures and incentives, and patient perspectives.

### **Diabetes Technology**

Dr. Conlin reported that the Subcommittee received substantial feedback from the public regarding access of diabetes technology. He explained that to improve patients’ access to diabetes technologies, the Subcommittee feels there is a need to routinely review and revise the eligibility and coverage requirements for diabetes technologies, and recommends the following:

- We recommend that CMS update current eligibility requirements for various diabetes technologies and establish a process for regular evaluation of the eligibility requirements (i.e., at least every 3 years) leading to a National Coverage Determination for different diabetes technologies. In evaluating the data to revise eligibility requirements as part of a National Coverage Determination, CMS should evaluate the current evidence and consider both glycemic benefits and non-glycemic benefits (including patient-reported outcomes such as quality-of-life and diabetes distress). CMS should ensure that eligibility, documentation, and reimbursement requirements are clearly defined; and that they are consistently applied across all parties involved, including Medicare Administrative Contractors and auditors.

### **Discussion**

Dr. Barry Marx pointed out that there is a process through which CMS makes coverage determinations, and that the process is authorized in statute and described in federal regulations. He wanted to know if the intent of this recommendation is to create a parallel process specific to diabetes technology. He commented that it is not clear to him whether the recommendation as written is intended to address specific operational elements of the current process or it is advocating for a different process.

Dr. Greenlee explained that many of the current eligibility requirements are created at the Medicare Administrative Contractor level and are not evidence-based. She clarified that the essence of the recommendation is asking that the requirements should be based on current evidence, and that the Subcommittee is not asking to create a separate process.

Dr. Chong commented that the coverage determination process would be the same at a high level; however, modifications may be needed to ensure regular, recurring evaluation for diabetes technologies.

Dr. Conlin explained that there is a general consensus that the criteria for access to diabetes technologies in many cases is out of date, the updating process for eligibility is haphazard, and there is no mechanism to suggest that the requirements will be periodically reviewed as well.

Dr. Marx expressed appreciation for the clarification. He further commented that there is an opportunity to look at the issues in the context of the current process and to see whether the recommendation would apply to other diabetes-related issues.

Dr. Conlin responded that the focus of this draft recommendation is on diabetes technology, and that it does not preclude the possibility that it could be broadened a bit, as appropriate, to include other devices that have similar issues.

Given that there were objections to the merit of the draft recommendation, the Commission moved on to discuss the Subcommittee's next draft recommendation.

## Team-based Care—Implementation and Sustainability

Dr. Conlin provided brief background information and presented the following draft recommendation for Commission members to provide input.

- We recommend that steps be taken to enhance implementation and sustainability of community health workers as critical members of the diabetes care team.
  - CMS should clarify and build on the 2013 final rule, expanding the scope of Medicaid-reimbursable services by community health workers to include social, behavioral, and economic support as part of covered services.
    - Clarify that Medicaid funding is available for community health workers to address social determinants of health, building on the January 7, 2021 *CMS Social Determinants of Health Roadmap*.
    - Clarify that the community health worker qualifications should focus on life experience, interpersonal skills as a natural helper, community membership, as well as formal education or clinical training.
    - Develop policies that require community health worker services be delivered in accordance with evidence-informed standards for community health worker programs such as those developed by the NCQA, the CDC C3 Project, the Community Guide, and the National Association of Community Health Workers (NACHW).
  - Increase funding for CDC to expand programs to assist all states in infrastructure development and processes to integrate community health worker services in a comprehensive, whole-person approach that includes economic, behavioral, and social supports, as well as clinical and preventive services.

### Discussion

Dr. Greenlee explained that the Subcommittee updated the wording based on suggestions from CDC.

Dr. Herman suggested revising the last bullet to improve clarity (e.g., explain integrating community health workers into what and for what purposes).

Dr. Greenlee explained that the purpose is to help states integrate community health workers into team-based care in various settings.

Ms. Schumacher added that CDC funds state health departments and collaborates with organizations to improve team-based care.

Dr. Herman commented that it would be helpful to provide details in the recommendation to explain where money goes and how it is being used to support team-based care.

Dr. Greenlee and Dr. Bolen explained that the Subcommittee are considering putting the details in the report.

Dr. Herman suggested revising the wording of the last bullet to improve clarity.

### **Quality Measures (Patient Safety)**

Dr. Conlin explained that the following draft recommendation on quality measures is new, and it was developed based on the Treatment and Complications Subcommittee's and the workgroup's work.

Dr. Conlin briefly explained the rationale and presented the draft recommendation.

**Background/rationale:** Hypoglycemia is not uncommon among people treated with insulin and sulfonylurea medications. Its attendant harms (e.g., falls, fractures, hospitalizations, and death) are increased in older adults. Therefore, less intensive glucose targets should be applied to older adults with diabetes who are taking medications that increase the risk of hypoglycemia, are unable to recognize and appropriately treat hypoglycemia, and have clinical conditions that limit life expectancy (e.g., dementia, end-stage renal disease, metastatic cancer). In such persons, the risks related to hypoglycemia, treatment burden, and costs far outweigh potential benefits.

**Draft recommendation:** We recommend that CMS develop and implement a quality measure to assess potential overtreatment, inappropriate treatment, or risk of harm among Medicare beneficiaries with diabetes and life-limiting conditions in order to reduce the incidence of severe hypoglycemia and improve patient safety.

### **Discussion**

Dr. Conlin explained that stakeholders and key informants have expressed broad acceptance of this draft recommendation.

Commission members discussed the purpose of developing and implementing such a quality measure. Dr. Conlin and Dr. Herman explained that the purpose is to use the measure to improve performance and ultimately to improve patient safety.

Commission members also discussed how the measure would be developed and how the parameters such as age would be determined. Dr. Herman briefly explained how quality measures are developed, and clarified that defining the criteria (e.g., age) is part of the development process.

### **Additional discussion on insulin and other medications**

Regarding the draft recommendation addressing the cost of insulin, a Commission member asked if other oral medications should be addressed as well.

Dr. Conlin explained that the Subcommittee focuses on insulin because it has been on the market for a long time, and the price has gone up over the years. He was concerned that if the Subcommittee expands to other treatments, it would be difficult to draw the line.

Dr. Greenlee added that insulin is lifesaving for many people, and that other medications may be addressed by the Subcommittee's draft recommendation 13 regarding pre-deductible high-value diabetes services.

Dr. Herman explained that the workgroup initially developed broader recommendations addressing the affordability of medications but ultimately decided to narrow them down to focus on insulin because it is lifesaving for people with diabetes.

Dr. Chong suggested adding "medications" in draft recommendation 13.

Dr. Conlin responded that the Subcommittee will clarify it in draft recommendation 13 or in the background.

## **Oral Public Comment**

None. (The individual who registered to provide oral comment was absent from the meeting.)

After a short break, DFO Kara Elam conducted roll call and the Commission resumed the meeting with a quorum.

## **Voting on the Recommendations**

Dr. Herman explained that approval of a recommendation would require a majority vote. He proposed the following:

- Commission members will first review the list of near final draft recommendations from each Subcommittee, and then vote on each Subcommittee's full set of draft recommendations together.
- If a Commission member would like to call out any specific draft recommendation, the Commission would vote on that individual draft recommendation separately.

## **Discussion**

Following Dr. Herman's suggestion, a couple Commission members asked for clarification regarding on which recommendations the Commission would be voting.

Dr. Herman clarified that

- The Commission will vote on the substance of each Subcommittee's full set of draft recommendations, including those that were discussed and edited at the meeting as well as those that the Commission did not discuss today but have received overall acceptance based on Commission members' ratings.
- After today's voting, the Subcommittees, if needed, could wordsmith the language of the draft recommendations based on today's discussion, as long as the edits do not change the substance of the recommendations.

### **Overarching recommendations**

Commission members briefly discussed how to handle overarching recommendations (e.g., access to care, environment, and interagency coordinating body) and where the overarching recommendations should be placed in the report.

Dr. Conlin pointed out that where to put the overarching recommendations would not affect the voting today, and he suggested that the Commission have the flexibility to move recommendations around, if needed, as they write the final report.

Dr. Herman agreed.

### **Draft recommendations to be revised**

In response to a Commission member's question regarding the draft recommendations that are still under development (e.g., draft recommendations needed to be revised based on today's discussion), Dr. Herman clarified that the Commission will vote on the substance of the recommendations today.

### **Voting on the Prevention—General Population Subcommittee's Recommendations**

Dr. Schillinger and Dr. Lopata stated that they have revised their draft recommendations based on the discussion and that the revisions did not change the intent of the recommendations.

Dr. Conlin made a motion to accept the Prevention—General Population Subcommittee's full set of recommendations (a total of 11) as discussed today:

- PGP recommendation 1 on the Office of National Diabetes Policy
- PGP recommendation 2 on USDA SNAP programs
- PGP recommendation 3 on USDA non-SNAP programs
- PGP recommendation 4 on USDA Specialty Crops
- PGP recommendation 5 on water and sugar-sweetened beverages
- PGP recommendation 6 on food labeling
- PGP recommendation 7 on marketing to children
- PGP recommendation 8 on breastfeeding
- PGP recommendation 9 on ambient and built environment
- PGP recommendation 10 on housing
- PGP recommendation 11 on research

Dr. Boltri seconded the motion. Twenty-two of the 23 Commission members (22/23) voted yes, one member abstained, and no one voted no. The motion was passed.

## **Voting on the Prevention—Targeted Population Subcommittee’s Recommendations**

### **Discussion**

Dr. Boltri asked if the Commission would vote on the additional recommendation/bullet added based on today’s discussion (i.e., turning the last sentence of the background information for the original recommendation 13 into a bullet/recommendation).

Dr. Herman confirmed that the Commission will vote on it today.

Dr. Herman clarified that the draft recommendation on metformin for diabetes prevention remains and the Commission will vote on it as well.

Dr. Greenlee pointed out that based on the discussion, the draft recommendation 3 (clinical quality measures) and draft recommendation 4 (use of existing data) will be combined. Dr. David Strogatz confirmed yes.

### **Voting on the Draft Recommendation on Metformin**

Dr. Chong made a motion to vote on (approve) the recommendation on metformin separately.

Dr. Conlin seconded the motion.

Twenty members (20/23) voted yes to approve the draft recommendation, two members abstained, and one member voted no. The motion was passed.

### **Voting on the Rest of the Recommendations**

Dr. Herman made a motion to approve the following recommendations from the Prevention—Targeted Population Subcommittee:

- PTP recommendation 1 on public awareness
- PTP recommendation 2 on coverage for A1c testing
- PTP recommendation 3 on clinical quality measures
- PTP recommendation 4 on use of existing data (to be combined with PTP recommendation 3)
- PTP recommendation 6 on coverage for alternative delivery methods and programs
- PTP recommendation 7 on MDPP coverage
- PTP recommendation 8 on improving recognition and payment process
- PTP recommendation 9 on testing new payment models to ensure MDPP sustainability
- PTP recommendation 10 on expanding Medicaid coverage
- PTP recommendation 11 on increasing insurance coverage
- PTP recommendation 12 on special diabetes program for American Indians/Delta States Network
- PTP recommendation 13 on research

- PTP recommendation 14 on Special Diabetes Program for type 1 diabetes

A Commission member seconded the motion. Twenty-two Commission members voted yes, one member voted abstention, and nobody voted no. The motion was passed.

## **Voting on the Treatment and Complications Subcommittee's Recommendations**

### **Discussion**

Commission members briefly discussed the Treatment and Complications Subcommittee's original draft recommendation about telehealth. Dr. Greenlee explained that the Subcommittee removed the draft recommendation because there is a bill in the house, which is expected to pass.

Commission members discussed whether or not to keep the recommendation. To ensure that the recommendation is not lost, the Commission decided to put it back to the list and vote on it today. The rationale for the decision was that if the bill is passed before the Commission submits its final report, the Commission can decide to remove it, or keep it and explain the voting process in the report.

Dr. Conlin read the following draft recommendation. Dr. Greenlee explained that the draft recommendation was extensively discussed at the previous meeting.

**Draft recommendation 14 on telehealth:** We recommend that Congress

- Remove geographic and originating site restrictions so that CMS can provide access to telehealth services as appropriate;
- Make permanent the ability for Federally Qualified Health Centers and Rural Health Centers to provide services by telehealth;
- Make permanent telehealth waiver for DSMES/DSMT; and
- Maintain coverage for audio-only visits as necessary to comply with the Executive Order on *Advancing Racial Equity and Support for Underserved Communities*.

### **Voting on the Draft Recommendation on Telehealth**

Dr. Dokun made a motion to approve the draft recommendation Dr. Conlin had read.

Dr. Boltri seconded the motion. Twenty-two Commission members voted yes, one Commission member abstained, and no one voted no. The motion was passed.

### **Voting on Treatment and Complications Subcommittee's Recommendations 1-13**

Dr. Herman suggested Commission members voted on the substance of the following recommendations together.

- TC recommendation 1 on health equity
- TC recommendation 2 on updating Medicare Quality Standards for DSMT

- TC recommendation 3 on developing reimbursement mechanisms for community-based diabetes education and support
- TC recommendation 4 on research to improve the uptake of DSMES
- TC recommendation 5 on eligibility for diabetes technology
- TC recommendation 6 on workforce adequacy
- TC recommendation 7 on community health workers
- TC recommendation 8 regarding research on team-based care
- TC recommendation 9 regarding a demonstration project of best practices in primary care
- TC recommendation 10 on improving digital connectivity
- TC recommendation 11 on improving insulin affordability
- TC recommendation 12 on quality measure for overtreatment
- TC recommendation 13 on preeductible high-value diabetes services

Dr. Boltri made a motion to approve the 13 recommendations together.

Dr. Bolen seconded the motion. Twenty-two Commission members voted yes, one member voted abstention, and nobody voted no. The motion was passed.

### **Voting on the Recommendation Regarding Access to Care**

Dr. Schillinger made a motion to approve the recommendation on ensuring access to health care for people with diabetes and people at risk for diabetes.

Another Commission member seconded the motion. All of the 23 Commission members voted yes. The motion was passed unanimously.

### **Preparing the Report to Congress**

Dr. Herman explained that Co-Chairs of the Subcommittees have discussed how to organize the report to Congress and the HHS Secretary.

### **Structure and Format of the Report**

Dr. Herman reviewed the outline and explained that the report will include the following:

- Executive summary
- Chapter 1. Background
- Chapter 2. Methods
- Chapter 3. Population-level Diabetes Prevention and Control
- Chapter 4. Targeted Interventions to Prevent Diabetes
- Chapter 5. Diabetes Treatment and Complications
- Chapter 6. Research Needs
- Chapter 7. National Diabetes Strategy
- Chapter 8. Conclusions

- Appendices

## **Discussion**

Following Dr. Herman's explanation, Commission members discussed various topics related to different chapters.

### ***Chapter 3***

Dr. Schillinger wanted to know if it would be okay to add details and provide examples after the recommendations to improve clarity.

Multiple Commission members expressed support for the approach and suggested including vignettes as well (e.g., in the overall background section of the main chapters) to strengthen the recommendations.

### ***Chapter 4***

Dr. Tracer clarified that Chapter 4 is about interventions to prevent diabetes in targeted populations who are at high risk for developing diabetes (e.g., people with prediabetes).

### ***Chapter 5***

Dr. Greenlee and Dr. Conlin stated that they did not have comments regarding the presented structure for Chapter 5, which calls out promising programs as well as gaps and barriers.

Dr. Herman said that it would be fine if the other two Subcommittees (the Prevention—General Population Subcommittee and the Prevention—Targeted Population Subcommittee) would like to use a similar approach.

### ***Chapter 6***

Commission members briefly discussed whether they should put all research-related recommendations together into one chapter and present them in aggregate, or keep them in individual Subcommittee chapters.

Dr. Schillinger suggested keeping all of them in one chapter and organizing them by subcommittee.

Dr. Linder expressed concern that unless adequate background is provided in this Chapter, it might be challenging for the reader to understand the rationale of the recommendations.

After further discussion of the pros and cons of the two approaches, Dr. Herman suggested Commission members think about the topic and decide what to do later.

### ***Chapter 7 and Chapter 8***

Commission members discussed the title of Chapter 7 (National Diabetes Strategy). Dr. Bolen voiced concern that the title may give the perception that other recommendations are not part of the national diabetes strategy. She suggested either changing the title of the chapter, or

adding a separate chapter to include all of the crosscutting recommendations, including the recommendation on the Office of National Diabetes Policy (ONDP). Dr. Greenlee commented that the Treatment and Complications Subcommittee's recommendation on health equity is a crosscutting recommendation as well.

Commission members briefly discussed the possibility of changing the title of Chapter 7 to include all crosscutting recommendations and addressing national strategy and action plan in Chapter 8.

Dr. Boltri suggested having some time to think about how to restructure those chapters and recommendations.

Dr. Herman urged Commission members to provide input quickly and finalize the outline soon.

### ***Appendices***

Dr. Herman explained that the Appendices would include the following:

- Full Commission roster of members with affiliations
- Subcommittee co-chairs and members
- Lists of stakeholders and key informants
- List of individuals and organizations that provided public comment
- Acronyms
- References

Dr. Schillinger suggested including literature search questions and search terms in the Appendices as well.

Dr. Clydette Powell and Dr. Herman agreed.

Commission members also discussed whether or not to include draft recommendations that the Subcommittees considered but did not make it to the final list. Different views were expressed. While some members suggested that including those draft recommendations in the Appendices would help address potential comments or questions from some key informants/stakeholders, other members cautioned that more communication may cause more problems.

Dr. Greenlee said that the Treatment and Complications Subcommittee will address in the report some of the draft recommendations that did not make it to the final list (e.g., original draft recommendations on e-consultation, VA/DoD Virtual Medical Center, etc.).

Dr. Herman suggested Commission members think about how to handle the issue as the Commission moves forward.

## Timeline for Writing

Dr. Herman reviewed the timeline for completing the report.

- June 23 to August 20, 2021: Commission members will write the chapters based on the recommendations approved today.
- August 20 to September 3, 2021: The support writer will help combine all chapters into one report for the Commission to review.
- September 3 to September 7, 2021: Commission members will review the report and provide comments and edits.
- September 8, 2021 (NCCC Public Meeting 12): The Commission will meet and vote to approve the final report (additional copyediting will be completed after the meeting).
- September 8 to September 17, 2021: The NCCC Report to Congress and the HHS Secretary will go through the final process prior to submission (task to be completed include final copyediting, 508 compliance, graphics, etc.)
- September 17 to September 24, 2021: The final 508 compliant version of the NCCC Report to Congress and the HHS Secretary will be provided to HHS.
- No later than September 30, 2021: The final 508 complaint version of the NCCC Report will be submitted to Congress and the HHS Secretary.

Dr. Herman encouraged everyone to work collaboratively and to complete the report as efficiently as possible.

## Writing Group Leads

Dr. Herman proposed the following assignments:

- Chapter 1. Background: Commission Chair
- Chapter 2. Methods: Dr. Powell, Dr. Elam, and Ms. Gillissen
- Chapter 3. Prevention—General Population Subcommittee
- Chapter 4. Prevention—Targeted Population Subcommittee
- Chapter 5. Treatment and Complications Subcommittee
- Chapter 6. Research: the three Subcommittees
- Chapter 7. National diabetes Strategy: Commission Chair and Subcommittees Co-chairs
- Conclusion: Commission Chair and Subcommittee Co-chairs
- Appendix: Ms. Gillissen

Dr. Schillinger volunteered to help write the Background Chapter. He commented that other Subcommittee co-chairs or their designees should be involved with writing the Chapter as well.

Dr. Herman agreed. Dr. Herman suggested (1) revising his proposed assignment based on the suggestions, (2) sending it to Commission members for comment, and (3) identifying/updating writing group leads.

## **Closing Remarks**

Dr. Herman commented that the Commission accomplished a lot at today's meeting, and he encouraged Commission members to keep the momentum going.

## **Adjournment**

The meeting was adjourned at 5:53 pm EDT.

## Appendix: Commission Members and HHS Support Staff

### Commission Members in Attendance

#### Commission Chair

**William H. Herman, MD, MPH**, Professor of Medicine and Epidemiology, Co-Director, Michigan Center for Diabetes Translational Research, University of Michigan, Ann Arbor, MI

#### Public Members (Special Government Employees)

**Shari Bolen, MD, MPH**, Associate Division Director of Internal Medicine, the MetroHealth System, Cleveland, OH (*joined after roll call*)

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

**J. William Cook IV, MD, FACP**, Primary Care Internal Medicine, President and Clinical Dyad Leader, Ascension Medical Group, Baltimore, MD

**Ayotunde Dokun, MD, PhD, FACE**, Associate Professor of Medicine and Endocrinology; Director, Division of Endocrinology and Metabolism, Carver School of Medicine, University of Iowa, IA

**Jasmine Gonzalvo, PharmD, BCPS, BC-ADM, CDE, LDE**, Clinical Associate Professor, Purdue University College of Pharmacy, Indianapolis, IN

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

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

**Shannon Idzik, DNP, ANP-BC, FAAN, FAANP**, Associate 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

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

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

**Federal Members (Regular Government Employees)**

**William Chong, MD**, Acting Deputy 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 Conlin, MD**, Chief, Medical Service, Veterans Affairs Boston Healthcare System, Department of Veterans Affairs

**Naomi Fukagawa, MD, PhD**, Director, Beltsville Human Nutrition Research Center, United States Department of Agriculture

**Barbara Linder, MD, PhD**, Senior Advisor, Childhood Diabetes Research, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, Department of Health and Human Services

**Aaron Lopata, MD**, Chief Medical Officer, 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 & Medicaid Services, Department of Health and Human Services

**Pat Schumacher, MS, RD**, Chief, Program Implementation Branch, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

**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

**CAPT Jana Towne, RN, BSN, MHA**, US Public Health Service, Division of Diabetes Treatment and Prevention, Office of Clinical and Preventive Services, Indian Health Service, Department of Health and Human Services

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

**CAPT Samuel Wu, PharmD**, Public Health Advisor, Office of Minority Health, Department of Health and Human Services

## **HHS Staff in Attendance**

### **Office on Women's Health**

**Kara Elam, PhD, MPH, MS**, Designated Federal Officer for the National Clinical Care Commission, Office on Women's Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services

**Erika Kim**, Health Care Policy Fellow, Office on Women's Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services

**Clydette Powell, MD, MPH, FAAP**, Medical Officer, Office on Women's Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services