National Clinical Care Commission Webinar Meeting 12
Wednesday, September 8, 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 12th NCCC public meeting and conducted roll cal. The meeting started with a quorum (see Appendix for Commission member attendance).

Dr. William Herman, Chair of the Commission, welcomed everyone to the meeting and turned the meeting to Dr. Dorothy Fink, Deputy Assistant Secretary for Women's Health; Director, Office on Women's Health (OWH).

Opening Remarks

Dr. Fink welcomed all meeting attendees to the last public meeting of the NCCC and expressed gratitude for the Commission's work. Dr. Fink highlighted the prevalence and burden of diabetes and stated that improving diabetes care and reducing the burden of the current diabetes epidemic is a major priority of the Department of Health and Human Services (HHS).

Dr. Fink introduced Dr. Rachel L. Levine, the 17th Assistant Secretary for Health.

Dr. Levine thanked Commission members for their dedication, emphasized the importance of improving care, and expressed concern of the rising rates of diabetes and diabetes burden on society and the U.S. health care system. She stated that HHS is committed to reverse the rising trends through improvements in federal diabetes prevention and treatment as well as through collaboration with federal partners.

Dr. Levine noted that the COVID-19 pandemic has brought to the forefront the need to prioritize diabetes prevention. She highlighted HHS's efforts in combating the COVID-19 pandemic and providing clinical care to populations affected by the pandemic. She urged everyone to get the COVID-19 vaccine and to help others get vaccinated as well.

Dr. Levine highlighted the importance of addressing social determinants of health (SDOH) and health inequity. She stated that achieving health equity is a key part of HHS's mission, and she noted that reducing the inequities requires coordination across government agencies and with public and private stakeholders.

Dr. Levine explained that another of HHS's top priorities is addressing the impact of the environment on public health, especially as it relates to diabetes risk and prevention efforts. She noted that HHS has established the Office of Climate Change and Health Equity (OCCHE) to address the impact of climate change on the health of the American people. Dr. Levine emphasized that advancing these priorities requires continued investment in education and cross-agency coordination of diabetes care and prevention.

Dr. Levine thanked the Commission for their work and expressed eagerness to hear the Commission's recommendations and vision on ensuring that all people are able to live their healthiest and happiest lives in the U.S.

Dr. Herman thanked Dr. Levine for her comments and expressed the Commission's enthusiasm to work with HHS to disseminate the report.

Review of NCCC's Charge and Approach and Meeting Agenda

NCCC's Charge

Dr. Herman briefly reviewed the Commission's charge and duties, as follows:
The Commission shall evaluate and make recommendations, as appropriate, to the HHS Secretary and Congress regarding:

1. Federal programs of the Department of Health and Human Services that focus on preventing and reducing the incidence of complex metabolic or autoimmune diseases [diabetes] that results from insulin-related issues and represent a significant disease burden in the United States
2. Current activities and gaps in Federal efforts to support clinicians in providing integrated, high-quality care to individuals with the diseases and complications
3. 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
4. Methods for outreach and dissemination of education and awareness materials that
    a) Address the diseases and complications
    b) Are funded by the Federal Government
    c) Are intended for health care professionals and the public
5. Whether there are opportunities for consolidation of inappropriately overlapping or duplicative Federal programs related to the diseases and complications

NCCC's Approach

Dr. Herman explained that the Commission conducted 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 have addressed crosscutting issues related to health equity, social determinants of health, and research needs.

Goal of NCCC Meeting 12

Dr. Herman explained that the main goal of today's meeting is to review and vote on the chapters.

Review, Discussion, and Vote on the Report to Congress and the HHS Secretary

The Commission reviewed the report chapter by chapter, discussed major comments from Commission members, revised the content, when needed, to improve clarity, and voted on each chapter.

Table of Contents and Contributions

Discussion

Commission members first reviewed the page containing the Table of Contents and Contributions. Multiple members suggested including in the Contributions list all former DFOs, technical advisors, and Commission members, including those who are retired or were deployed in response to the COVID-19 pandemic.

Considering that the Table of Contents will be affected by changes in the following chapters, the Commission agreed to discuss and vote on this page after reviewing and voting on other chapters.

Executive Summary

Discussion

Type 2 diabetes prevention

Ms. Pat Schumacher suggested adding "type 2 diabetes" when referring to prevention.

Dr. Herman suggested using the phrase "prevent type 2 diabetes and control complications" when appropriate.

Drs. Bill Chong and Dean Schillinger cautioned that the Commission should not limit research to type 2 diabetes prevention.

Motion and vote

Dr. Herman made a motion to go through the report to make needed changes to be specific about type 2 diabetes prevention. Ms. Ellen Leake seconded the motion. Commission members unanimously voted to accept the motion.

Comment on overarching recommendations

Dr. Herman suggested revising the first two sentences under the subheading Overarching Recommendations to improve clarity.

Dr. Barbara Linder suggested not limiting SDOH to type 2 diabetes. Other members agreed.

Commission members together revised the two sentences into the following:

"Historically, diabetes prevention and treatment have been considered to be medical problems requiring medical treatment. Limited attention has been paid to the social and environmental conditions that contribute to diabetes and make managing diabetes more challenging. To improve diabetes awareness, prevention, and treatment, additional federal efforts are needed to improve access to health care, address the social determinants of health, and improve trans-agency collaboration."

Motion and vote

Dr. John Boltri made a motion to accept the changes. Dr. Bill Chong seconded the motion. Commission members unanimously voted to accept the motion.

Dr. Herman motioned to include all Commission members, including the retired members, in the Contributions list. Dr. Boltri suggested adding Dr. Ann Albright as a former co-chair of the Prevention—Targeted Population Subcommittee.

Ms. Jennifer Gillissen, contractor supporting the Commission, explained that the topic will be discussed later. Dr. Herman withdrew his motion.

Chapter 1. Background

Discussion

Clarifications about type 1 and type 2 diabetes

Commission members briefly reviewed the paragraphs describing type 1 and type 2 diabetes added by Dr. Herman. After a brief discussion, Commission members agreed to keep the paragraphs as written.

CDC's and NIH's contributions

Commission members agreed to add NIH in the sentence beginning with "In 1998, CDC and *NIH* began the SEARCH and …" and the sentence beginning with "In response to…CDC and *NIH* also co-funded NEXT-D initiative…"

Federal agency engagement

Commission members discussed the wording, particularly the word "insufficient." Different views were expressed. While some members pointed out that it is important to call out the insufficient engagement, others commented that the word might give the wrong impression that the agencies do not care.

Dr. Schillinger clarified that the intent of the sentence is about insufficient engagement of non-health federal agencies that influence the conditions that are relevant to diabetes risk.

Dr. Donald Shell suggested adding "tasked" or "required" because agencies do what they are required to do.

After further discussion, Commission members agreed to revise the original sentence into: "National efforts to prevent and treat diabetes have been hindered by (1) failure to address social determinants of health; (2) lack of directives for trans-agency engagement of non-health federal agencies and insufficient coordination among all federal agencies (non-health and health); and (3) persistent gaps in access to health care." Commission members also agreed to move up the last two sentences of the paragraph.

Motion and vote

Dr. Herman motioned to accept the changes and Chapter 1. Dr. Schillinger seconded the motion. Commission members unanimously voted to accept the motion.

Chapter 2. Methods

Dr. Schillinger suggested adding a paragraph to clarify the writing process and acknowledge the writing group. DFO Kara Elam clarified that she had responded to Dr. Schillinger's suggestion via email. Dr. Schillinger dropped his request.

Motion and vote

Dr. Chong motioned to accept Chapter 2 as written. Dr. Boltri seconded the motion. Commission members unanimously approved Chapter 2.

Chapter 3. Foundational Recommendations to Address Diabetes in the U.S.

Discussion

Trans-sectoral governmental activities

Drs. Herman, Schillinger, and Fukagawa expressed preference for reverting the revision to the original language describing trans-sectorial governmental activities in the U.S.

Motion and vote

Dr. Fukagawa motioned to keep the original wording. Dr. Herman seconded the motion. Commission member unanimously voted to keep the original language.

Recommendation 3.1

Commission members agreed to change "…a national diabetes strategy that develops, leverages, and coordinates work across federal agencies and departments…" to "…a national diabetes strategy that leverages and coordinates work across federal agencies and departments…"

Rationale for Recommendation 3.2

Commission members discussed the last sentence under the Rationale for Recommendation 3.2. Commission members agreed to accept Dr. Carol Greenlee's edits: "Nonadherence due to costs has been reported in 20% to 40% of people with diabetes. For those with self-reported financial insecurity, the nonadherence rate is even higher (60%)."

Recommendation 3.3a

Dr. Herman suggested revising the wording to improve clarity. Other Commission members agreed.

Revised Recommendation 3.3a: Federal agencies consider and evaluate the impact on health disparities of all new, all revised, and selected existing policies and programs that affect diabetes prevention, diabetes, and the complications of diabetes.

Motion and vote

Dr. John Boltri motioned to accept Chapter 3. Dr. Shari Bolen seconded the motion. All Commission members voted to approve the Chapter with the revisions.

Chapter 4. Population-Level Diabetes Prevention and Control

Discussion

CDC's contribution

Dr. Schillinger suggested adding CDC after NIH in the following sentence:

"The American Diabetes Association, the National Academy of Medicine (NAM), NIH, *CDC,* and the Centers for Medicare & Medicaid Services (CMS) all endorse…"

Other members agreed.

Recommendation 4.2c

Dr. Herman and Dr. Schillinger briefly discussed and agreed to not add "to access to drinking water" in the last sentence because the bullet point as written is clear.

Government guidance over sugar-sweetened beverages

Commission members reviewed and discussed Dr. Schillinger's revision in response to the OWH team's comments. Different views were expressed.

Ms. Pat Schumacher explained that CDC has revised the National Diabetes Prevention Program (DPP) curriculum around sugar-sweetened beverages, and that the updated curriculum will be released this month. Ms. Schumacher and Dr. Chong commented that it may not be accurate to use the word "absent" in the sentence describing the National DPP curriculum.

However, other Commission members stated that the language as written was accurate, and that they would not feel comfortable to change the language before seeing the updated curriculum. After further discussion, Commission members agreed to change the last sentence to "Recommendations to reduce or eliminate sugar-sweetened beverages from the daily diet *has largely been absent* from the CDC's National DPP curriculum *in the past*" and add the following sentence*:* "It comes to the Commission's attention that by the time this report is released, CDC is expected to have updated the DPP program around the language related to sugar-sweetened beverages."

Recommendation 4.4d

Dr. Schillinger suggested replacing "CDC and NIDDK should…" with "CDC, NIDDK, and USDA should…"

To avoid unfunded mandates to the agencies, Commission members agreed to add "With additional funding, " in the beginning of the sentence.

Revised Recommendation 4.4d: *With additional funding, CDC, NIH, and USDA should* develop and implement a national campaign and associated materials to both promote consumption of water and reduce consumption of sugar-sweetened beverages as a strategy to promote overall health, including the prevention of obesity, type 2 diabetes, and cardiovascular disease. CDC should also include such messages across all its relevant programs.

Food labeling
Dr. Chong questioned if there is evidence supporting the statement around toddler milk. Dr. Schillinger explained that the two references cited adequately support the statement.

Recommendation 4.5b and 4.5c
Dr. Chong explained that FDA received comments requesting nutrients on the Nutrition Facts label (NFL) be declared in household measurements, and that the agency declined the request because using a volume measure (e.g., teaspoons) instead of weight (e.g., grams) would provide inaccurate information.

Commission members briefly discussed if they should revise Recommendation 4.5c by adding "With additional funding, FDA should…" Considering that implementing every recommendation may need additional funding, the Commission decided not to add the wording.

Motion and vote
Dr. Chong motioned to accept Chapter 4 and the revisions. Dr. Boltri seconded the motion. Commission members unanimously voted to accept the motion.

Chapter 5. Diabetes Prevention in Populations at High-Risk

Discussion
Prediabetes
Dr. Herman suggested revising the language to clarify that prediabetes is a state of increased risk, not a disease. Commission members agreed to defer it to Dr. Howard Tracer who was absent from the meeting.

National DPP
Ms. Pat Schumacher suggested adding "and subsequent translation studies" in the following sentence: "The DPP *and subsequent translation studies* served as the model for the National DPP,…"

Dr. Herman and Dr. Boltri expressed acceptance of the revision.

Quality measures for screening for prediabetes
Dr. Herman and Ms. Schumacher suggested acknowledging the updated United States Preventive Services Task Force (USPSTF) recommendation (that is, screening for prediabetes starts at age 35 without changing the AMA's recommendation. Others agreed.

Support metformin use for type 2 diabetes prevention
Dr. Herman suggested changing "Support Metformin Use for Prediabetes" to "Support Metformin Use for Type 2 Diabetes Prevention." Dr. Boltri accepted the revision.

Recommendation 5.4
Dr. Herman suggested clarifying that the data to be summarized are from the DPP study. Dr. Boltri accepted the suggested revision.

Revised Recommendation 5.4: The National Clinical Care Commission recommends that funding be provided to NIH to collect, analyze, and summarize the available *data from the Diabetes Prevention Program study* describing the effectiveness and safety of metformin for type 2 diabetes delay or prevention in patients with prediabetes, including subpopulations most likely to benefit. Such a summary (with safety and efficacy data) should then be used to inform an appropriate submitter's request for FDA to review and consider an indication for the use of metformin in high-risk patients with prediabetes.

Recommendation 5.5

Dr. Herman suggested adding "…for those who are eligible" at the end of the recommendation to improve clarity. Others agreed.

Revised Recommendation 5.5: The National Clinical Care Commission recommends, consistent with provisions of the Patient Protection and Affordable Care Act, that all insurers be required to provide coverage for participation in and completion of a CDC-recognized diabetes prevention program *for those who are eligible*.

Number of states that have enacted Medicaid coverage of the National DPP

Ms. Schumacher pointed out that the number "18" should be changed to "16."

DPP study

Dr. Herman suggested clarifying that the DPP study was a large "NIH- and CDC-funded" national research project. Others agreed.

Research need and additional references

Dr. Barry Marx suggested citing the recent CDC study on HbA1c performance in people of African American descent and adding "further research is needed to further understand and evaluate alternate tests in place of the HbA1c in specific African descent populations, especially Afro-Caribbean people" as a bullet point following Recommendation 5.12

Dr. Schillinger expressed concern that including the language might limit the reach to only African Americans.

Dr. Boltri explained that the Prevention—Targeted Population Subcommittee had discussed this topic and that Dr. Howard Tracer disagreed with adding it. Dr. Boltri suggested including the information in the Background section.

After further discussion, Commission members agreed to add, at the end of the last paragraph under Background and Rationale, the following sentence (along with the refence Dr. Marx mentioned): "Research to assess the performance of screening tests and efficacy of interventions across racial and ethnicity populations is needed."

Diabetic ketoacidosis (DKA)

Dr. Herman suggested clarifying that DKA is a serious yet avoidable "acute metabolic complication" that can lead to coma and even death. Dr. Boltri agreed.

Recommendation 5.13

Dr. Herman suggested changing the last sentence of the 2nd bullet to "In the future, annual increases in funding should, at a minimum, address the costs of inflation." Others agreed.

Revised Recommendation 5.13: The National Clinical Care Commission recommends

- Funding the Special Diabetes Program (SDP) in five-year increments so that new, innovative research can effectively be developed.
- An increase in SDP program funding to address inflation costs, which have consumed more than 34% of the program's resources since 2004, the last year Congress increased funding for SDP. *In the future, annual increases in funding should, at a minimum, address the costs of inflation.*

Ms. Ellen Leake and Dr. Herman suggested adding the same qualifier in Recommendation 5.11 regarding funding for the Special Diabetes Program for Indians (SPDI).

Revised Recommendation 5.11: The National Clinical Care Commission recommends

- Funding for the Special Diabetes Program for Indians (SDPI) in five-year increments so that evidenced-based tribal diabetes prevention programs have the resources to (1) sustain the effort to combat diabetes and its complications; (2) develop additional culturally appropriate, high-impact type 2 diabetes prevention interventions; and (3) evaluate outcomes.
- An increase in SDPI funding to address inflation costs, which have consumed more than 34% of the program's resources since 2004, the last year Congress increased funding for the Special Diabetes Program. *In the future, annual increases in funding should, at a minimum, address the costs of inflation.*
- An increase in funding to HRSA's Delta States Network Grant Program to allow the program to include type 2 diabetes prevention as a focus.

Motion and vote

Dr. Boltri motioned to approve Chapter 5. Dr. Herman seconded the motion. Commission members unanimously voted to accept the motion.

Chapter 6. Treatment and Complications

Discussion

Background

Dr. Herman suggested a few minor edits in the Background section to improve clarity. Dr. Paul Conlin, co-chair of the Treatment and Complications Subcommittee, accepted the edits.

National Standards for Diabetes Self-Management Education and Support (NSDSMES)

Dr. Marx suggested revising the paragraph describing discrepancies between diabetes self-management education and support (DSMES) and NSDSMES to improve clarity.

Dr. Gonzalvo and Dr. Greenlee clarified the intent of the language and suggested changing the last sentence starting with "Although…." to "Even though the NSDSMES quality standards have regularly been revised, each iteration must align with the CMS quality standards, which themselves need to be updated as they no longer align with evidence-based best practices." Others agreed.

Diabetes Self-Management Training (DSMT)

Dr. Marx suggested adding references to support the statement around evidence-based best practices as well as the recommendations (e.g., what evidence-based best practices were reviewed and how they support the recommendations).

Dr. Gonzalvo explained that stakeholders and key informants provided feedback on issues at the practice level. She agreed to provide additional references.

Recommendation 6.3

Dr. Marx suggested revising the recommendation to improve precision and clarity.

Dr. Chong expressed acceptance of the first two of Dr. Marx's additions. He explained that the Subcommittee decided to keep the last sentence general to give CMS flexibility.

Commission members discussed the value of peer-reviewed publications and if it is necessary to specify them in the recommendation. Dr. Conlin suggested and Dr. Marx agreed with the following revision:

"CMS Evaluate current evidence, including published peer-reviewed evidence…"

Revised Recommendation 6. 3: The National Clinical Care Commission recommends that CMS use existing processes to update and regularly reevaluate (at least every three years) eligibility requirements for various diabetes devices leading to appropriate coverage determinations *when there is sufficient evidence to support such national determinations*. CMS should ensure that, *to the extent there are national requirements established, eligibility, documentation, and reimbursement requirements are clearly defined*, and that they are consistently applied across all parties involved, including Medicare Administrative Contractors and auditors. In evaluating the data to revise eligibility requirements, CMS should evaluate the current evidence, *including published, peer-reviewed evidence*, and consider both glycemic benefits and non-glycemic benefits (including patient-reported outcomes, *which may include quality-of-life and diabetes distress*).

Citations to support evidence-based practices

Dr. Marx suggested adding references to support the statements related to evidence-based best practices in the area discussing diabetes technologies.

Dr. Chong agreed to provide references.

Examples of existing requirements that may pose barriers to patients and providers
Dr. Herman and Dr. Schillinger commented that the 3rd example is broad and suggested either being more specific or removing it.

Dr. Chong and Dr. Greenlee acknowledged that the example applies primarily to continuous glucose monitors (CGMs), and they agreed to change the original sentence to: "Multiple daily injections of insulin should be removed as an eligibility criterion for *CGMs*."

Dr. Herman also suggested adding "may pose barriers to patients and clinicians" in the general sentence.

Health care professional training budget
Dr. Shari Bolen agreed to clarify the following sentence by adding "annually": "Health care professional training is primarily supported by CMS with graduate medical education payments to teaching hospitals (about $11 billion *annually*)."

Cooperative agreements and funding to CDC
Ms. Schumacher pointed out that all cooperative agreements have time limits and suggested revising the statements containing a specific CDC cooperative agreement.

Dr. Bolen expressed acceptance of Ms. Schumacher's suggested revision.

Dr. Conlin suggested removing the sentence containing a specific cooperative agreement and replacing the last sentence with "Increased funding to *CDC* would accelerate the implementation and sustainability of community health workers (CHWs) by addressing system and policy level barriers to integration at the state level." Others agreed.

Research recommendation
Dr. Herman suggested replacing "initiated" with "supported" in the following sentence: "Research should be *supported* by federal agencies to study new models of care delivery." Others agreed.

Recommendation 6.12
Dr. Herman suggested and Drs. Greenlee and Bolen agreed with adding "payment systems" in the recommendation.

Revised Recommendation 6.12: The National Clinical Care Commission recommends increased funding for implementation research across federal agencies (for example, AHRQ, NIH, CMS, HRSA, IHS, CDC, VA, and the Department of Defense [DoD]) to better translate team-based care into practice and test new team-based care models *and payment systems* to improve diabetes care and outcomes.

Motion and vote
Dr. Schillinger motioned to approve Chapter 6. Dr. Bill Cook seconded the motion. Commission members unanimously voted to accept the motion.

Public Comments

Kate Thomas, Diabetes Advocacy Alliance (DAA)
Ms. Thomas stated that the DAA appreciates the Commission for the opportunities to provide input and applauds the Commission's efforts in preparing the report to Congress and the HHS Secretary. She noted that the DAA is pleased to see that the Commission seeks to better understand and address the impact of socioeconomic and environmental factors on health disparities in the U.S. as well as the role of social determinants of health in improving health outcomes for people with or at risk for diabetes. She said that as the Commission prepares to submit its report to Congress, the DAA stands ready to support the adoption and implementation of these policies and looks forward to partnering with the federal agencies in these efforts, specifically

- Advancing polices that can reduce health disparities and address social determinants of health, including looking to the federal agencies to evaluate the impact on health disparities of each of the new policies related to diabetes.
- Urging Congress, CMS, and the Center for Medicare & Medicaid Innovation (CMMI) to make changes to the Medicare Diabetes Prevention Program (MDPP) expanded model that would help increase the utilization of MDPP among beneficiaries and ease the burden on suppliers. DAA believes that this can be done by fully aligning the requirements for MDPP and the National DPP such as making virtual programs available to beneficiaries and removing the once-in-a-lifetime limit.
- Allowing CMS beneficiaries access to the full continuum care to treat obesity to reduce new cases of type 2 diabetes and to help adults sustain weight lost in the longer-term, including coverage for medications and services for existing conditions that can delay or prevent the onset of type 2 diabetes and its complications.
- Prioritizing that CMS provide coverage for HbA1C testing when used to screen for prediabetes and endorsing and promoting the 2018 American Medical Association (AMA)-proposed diabetes quality measures related to screening for normal blood glucose by all agencies that deliver or influence the delivery of care.
- Exploring options to expand coverage for medical nutrition therapy to include individuals with diabetes or obesity.
- Removing barriers to access DSMT services such as reducing the administrative burden related to providing those services, addressing known beneficiary barriers, improving referrals, and updating CMS quality standards.
- Recommending regulatory reform that would allow CMS flexibility to cover innovative diabetes technologies and services.

Ms. Thomas noted that the DAA looks forward to continuing interagency-stakeholder collaborations to improve access to care for millions of Americans with diabetes, prediabetes, and obesity.

Kate Kirley, AMA

Dr. Kate Kirley, a family physician and the director of Chronic Disease Prevention at AMA, provided comments on behalf of AMA. Dr. Kirley said that her following comments will reinforce AMA's previous written comments and also address what the Commission presented today.

- Overall, the AMA supports the comprehensive approach in the Commission's report.
- The AMA supports a team-based care approach for both diabetes care and prevention but recommends that the Commission adds "physician-led" to the recommendation because it is important to have a physician lead the team to ensure appropriate diagnosis and treatment plan.
- The AMA supports Medicare coverage of screening for hemoglobin A1c tests. This coverage is needed to align with clinical guidelines. Hemoglobin A1c is generally preferred by physicians and is the most programatic test for screening patients.
- The AMA appreciates the Commission's continued inclusion of all three measures from AMA's prediabetes quality measure set. These measures are intended to be used together to incentivize comprehensive diabetes preventive care. The AMA will review its measures to ensure they are in line with the updated USPSTF recommendation for screening for prediabetes.
- Regarding the new USPSTF recommendations, key changes include lowering the recommended screening age from 40 to 35 and recommending more options for treatment, including metformin; and recognizing prediabetes as a condition. The Commission's report should reflect the recommendations of the task force. Additionally, the Commission should recommend that all commercial and public insurers cover all the evidence-based interventions.
- The AMA urges the Commission to recommend that the CDC's Division of Diabetes Translation establish a system to track the outcomes of all evidence-based interventions for preventing type 2 diabetes and not to limit it to the lifestyle change program and its weight loss metrics. The Commission should also recommend that all commercial and public insurers cover all of these evidence-based preventions.
- The AMA appreciates the updated recommendation for improving the MDPP. However, the AMA does not think that new model tests are needed and believes that the CMS can fix several problems that threaten the existence of the MDPP through the Medicare Physician Fee Schedule process or via statute.

Dr. Kirley noted that the AMA welcomes an opportunity to discuss their comments with the Commission and identify other areas that would benefit from the inclusion of organized medicine.

Review, Discussion, and Vote on the Report to Congress and the HHS Secretary (continued)

Chapter 7. Looking Forward

Discussion

Commission members briefly reviewed and agreed to accept a few minor editorial changes.

Motion and vote

Dr. Conlin motioned to accept Chapter 7. Dr. Meredith Hawkins seconded the motion. Commission members unanimously voted to accept the motion.

Appendices

Ms. Gillissen briefly explained the Appendices.

- Appendix A. Commission Members
- Appendix B. Subcommittees
- Appendix C. Summary of Recommendations
    - Ms. Gillissen confirmed that Appendix C, along with the grid (alignment between the Charter and the recommendations) will be updated based on today's discussion and revisions.
- Appendix D. The National Clinical Care Act
- Appendix E. Charter
- Appendix F. Acronyms and Abbreviations
- Appendix G. References
    - Ms. Gillissen explained that Appendix G also will be updated to include new references from Dr. Chong, Dr. Marx, and Dr. Gonzalvo.

Motion and vote

Dr. Chong motioned to accept the appendices noting that changes will be made based on the discussion today. Dr. Carol Greenlee seconded the motion. Commission members unanimously voted to accept the motion.

Contributions and Table of Contents

Dr. Herman suggested including all the previous DFOs and listing them by year.

Dr. Schillinger suggested specially acknowledging Dr. Clydette Powell's contribution.

Dr. Elam cited the Federal Advisory Committee Act (FACA) and suggested including only current federal support personnel on this page (that is, Dr. Elam as the current DFO and Dr. Powell as the technical advisor).

Other Commission members agreed with including all of the previous DFOs.

Motion and vote

Dr. Fukagawa motioned to include all DFOs in the order of their service (Dr. Clydette Powell will be the first) and all Commission members (including those who are retired) under Contributions. Dr. Schillinger seconded the motion. Commission members unanimously voted to accept the motion.

Dr. Bolen motioned to add "Subcommittee Co-Chairs" to recognize the co-chairs' leadership and contributions to writing the final report. Dr. Ayotunde Dokun seconded the motion. Commission members unanimously voted to accept the motion.

Dr. Schillinger motioned to add a special acknowledgement in the appendix to thank Dr. Clydette Powell. Dr. Herman seconded the motion. Commission members unanimously vote to accept the motion.

Dr. Fukagawa motioned to accept the Table of Contents. Dr. Herman seconded the motion. Commission members unanimously voted to accept the motion.

Meeting Review, Next Steps, and Acknowledgement

Dr. Herman commented that the meeting was productive and asked what the next steps would be and when the Commission could review the report before it is submitted to Congress and the HHS Secretary.

Ms. Gillissen explained that after today's meeting, the report will be updated based on the discussion, copyedited, and made 508 compliant; and that the report will then go through courtesy review before being submitted to Congress before September 30, 2021.

Dr. Herman asked if the Commission could review the report before submission. Ms. Gillissen responded that she would work with OWH to see if that could be done.

Courtesy clearance

In response to Commission members' questions, Dr. Elam clarified that the agencies may fix factual errors but would not change the content. She assured the Commission that it will be a transparent process, and that she will let the Commission know if the agencies find errors. She added that September 18th, 2021 is the estimated date for the courtesy clearance.

Dissemination of the Commission's report

Dr. Herman asked to review the slides that he had prepared to discuss the dissemination plan with the entire commission. Dr. Elam suggested not discussing the dissemination plan at this meeting and explained that OWH will have a meeting with the co-chairs on September 20, 2021 to review, discuss, and seek the co-chairs' input regarding the dissemination plan, which, she said, will be finalized by OWH and the OASH's Communications Office.

Dr. Herman stated that the dissemination plan was relevant to all NCCC members and suggested opening the meeting to all Commission members.

Dr. Elam clarified that the call on September 20, 2021 is not a public meeting and is not open to all Commission members.

Dr. Schillinger encouraged all Commission members to communicate ideas regarding dissemination with co-chairs.

Dr. Barbara Linder asked if Commission members will receive a final copy of the report. Dr. Elam said yes.

Ms. Gillissen added that once Congress accepts the report, it will be posted on health.gov.

Acknowledgement
Dr. Herman thanked all Commission members for their hard work, the contractor for their support, and all of the organizations as well as individuals who have provided comments and feedback.

Closing Remarks

Dr. Fink thanked all Commission members for their hard work and expressed appreciation for the Commission's efforts in helping improve the health outcomes for people at risk for diabetes and those with diabetes. She acknowledged the Commission Chair's and the Subcommittee Co-Chairs' leadership and guidance and thanked the OWH team for supporting the Commission in completing their report. She commented that the Commission's final report will lay the foundation for the collaborative work to strengthen the federal public health infrastructure and improve health equity across the nation.

Dr. Fink said that the vision for Healthy People 2030 is a society in which all people can achieve their full potential for health and wellbeing across the lifespan, and that the Commission's report contains large steps towards making the vision a reality.

Adjournment

The meeting was adjourned at 5:28 pm.

Appendix: Commission Members and HHS Support Staff

Commission Members Present at NCCC Meeting 12

Commission Chair
William Herman, MD, MPH, Professor of Medicine and Epidemiology, University of Michigan, Ann Arbor, MI

Public Members (Special Government Employees)
Shari Bolen, MD, MPH, Director, Population Health Research Institute; Associate Professor of Medicine, Department of Population and Quantitative Health Services, MetroHealth System, 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, 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, MBA, 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 (*Joined after roll call*)

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 R. 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, U.S. 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, 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 (*absent*);

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

Commission Members Absent from NCCC Meeting 12

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

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

HHS Staff in Attendance

Office on Women's Health

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

Dorothy Fink, MD, Deputy Assistant Secretary for Women's Health, Director, Office on Women's Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services

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

Richelle Marshall, Deputy Director of Operations and Management, 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

Ursuline Singleton, MPH, Office on Women's Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services