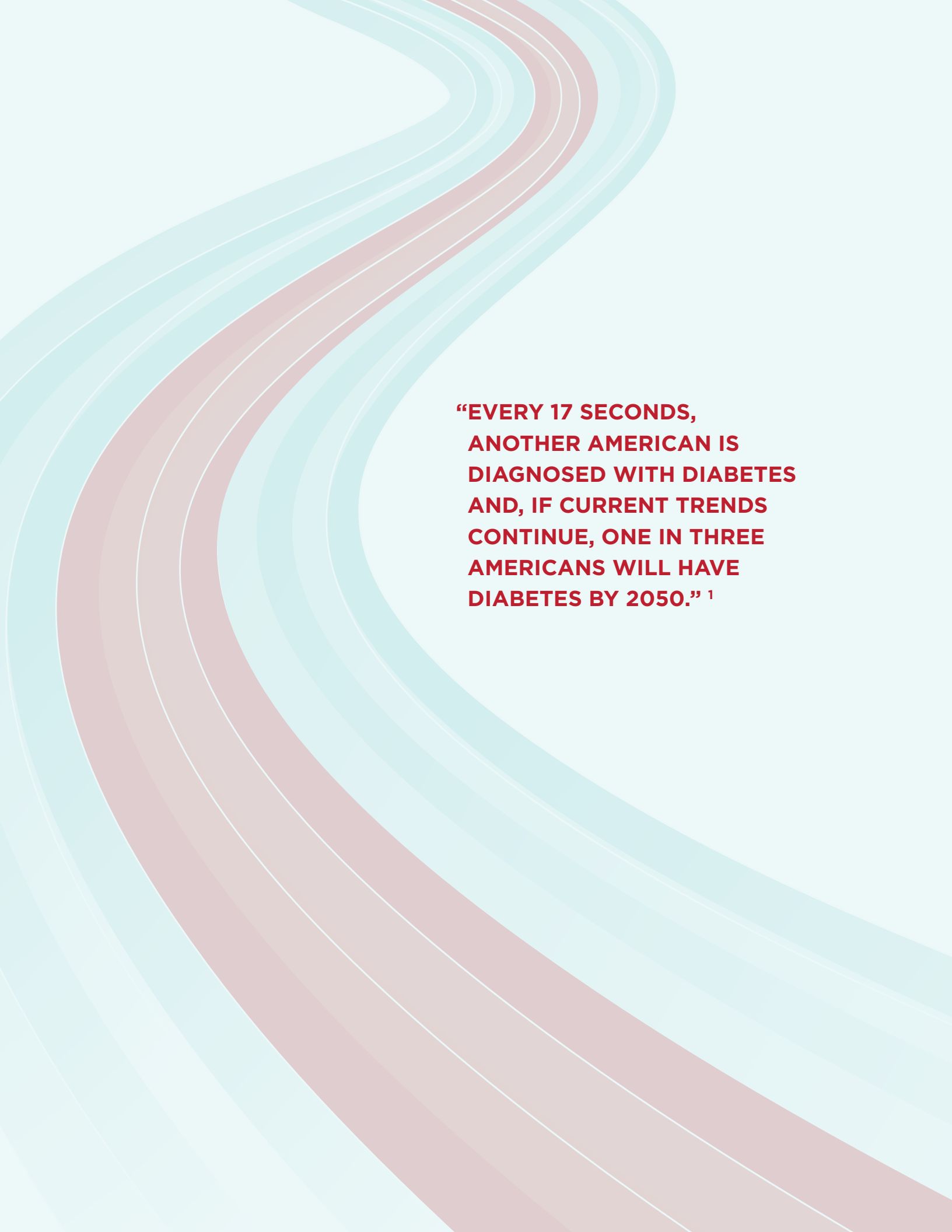
2016 Executive Summary

PATHS

Providing Access to Healthy Solutions

Beating Type 2 Diabetes: Best Practices for States

PREPARED BY THE CENTER FOR HEALTH LAW AND POLICY INNOVATION OF HARVARD LAW SCHOOL



"EVERY 17 SECONDS, ANOTHER AMERICAN IS DIAGNOSED WITH DIABETES AND, IF CURRENT TRENDS CONTINUE, ONE IN THREE AMERICANS WILL HAVE DIABETES BY 2050." [1]

ABOUT THE AUTHORS

About the Center for Health Law & Policy Innovation of Harvard Law School

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

About Providing Access to Healthy Solutions – The PATHS Project

For the past four years, CHLPI has been deeply engaged in research and analysis on type 2 diabetes policy. Intensive state-based research and coalition-building culminated in two comprehensive diabetes policy reports in New Jersey and North Carolina, released in 2014. In 2015, CHLPI released *Beating Type 2 Diabetes: Recommendations for Federal Policy Reform* and conducted a series of roundtables with key stakeholders in Washington, D.C., to advocate for high-impact policy change at the federal level. In addition to state and federal policy reports, CHLPI has published resources and materials on specific issues within diabetes prevention and care, such as the economic case for eliminating cost-sharing for key services, model guidelines for credentialing community health workers, the role for collaboration among healthcare providers and food and nutrition service organizations, and how innovations in managed care can support care access and quality for people living with prediabetes or diabetes. *Beating Type 2 Diabetes: Best Practices for States* is the final publication of the PATHS project. All publications and presentations related to this work can be found on CHLPI's website (www.chlpi.org) and on the project's web portal at www.diabetespolicy.org. This work has been generously supported by the Bristol-Myers Squibb Foundation's *Together on Diabetes* initiative.

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EXECUTIVE SUMMARY

Between 1980 and 2011, the number of diabetes cases in the United States more than tripled, imposing enormous psychosocial and financial costs on individuals living with the disease and straining public and private healthcare systems.[2] All policymakers must take immediate action to reduce the burden of diabetes in our nation. With the right care and interventions, diabetes can be effectively managed or entirely prevented. State decision-makers can make a significant difference by implementing the following Best Practices:

1. Close the health insurance "coverage gap" by expanding Medicaid or adopting an alternative strategy for healthcare coverage completion.

The uninsured are less likely than those with insurance to seek and receive preventive care and services for major health conditions and chronic illnesses such as diabetes.[3] People with diabetes who do not have health insurance are twice as likely to experience devastating and expensive complications associated with the disease.[4] States should ensure that all citizens with incomes below 138% of the Federal Poverty Level (FPL) have access to healthcare by expanding Medicaid or by adopting alternative strategies to extend healthcare coverage to this population. Under the Affordable Care Act, the federal government will pay 90% of the costs of expanding Medicaid.

DECISION-MAKER	REQUESTED ACTION
State Legislators and/or Executive Officials	To best increase access to affordable healthcare coverage for low-income residents, expand Medicaid to cover all uninsured adults up to 138% FPL or, if necessary, develop an alternative strategy for expanding access to health insurance for all uninsured adults who fall into the coverage gap.

2. Develop state Diabetes Action Plans.

Coordination between various state players to utilize limited funds and resources within a state is crucial in addressing the diabetes epidemic effectively. A Diabetes Action Plan (DAP) promotes communication and collaboration across agencies, institutions, and public and private actors. States should convene stakeholders to develop Diabetes Action Plans that establish statewide strategies and set priorities for resource allocation for the prevention, management, and treatment of type 2 diabetes.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation calling for the convening of stakeholders to develop a Diabetes Action Plan.
Governor and State Officials	Convene a Task Force or Working Group charged with developing a Diabetes Action Plan.

3. Amend scope of practice laws and regulations so that non-physician providers can provide more primary care.

Many individuals with diabetes experience difficulty in accessing the primary care they need.[5] In many states, non-physician providers (NPPs) such as nurse practitioners, physician assistants, and pharmacists who could step in to increase access to primary care are barred from doing so by scope of practice laws that limit the types of interactions they can have with patients. States should pursue efforts to amend the scope of practice for non-physician providers in order to broaden access to primary care and other health services and to ensure a continuum of care is available to effectively prevent, manage, and treat type 2 diabetes.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation expanding the scope of practice for NPPs like nurse practitioners, physician assistants, and pharmacists, or delegate broad authority to define scope of practice to state boards or agencies.
State Regulators	Broaden scope of practice for NPPs through regulation to increase access to primary care.

4. Develop a statewide credentialing or recognition system for Community Health Workers.

Community Health Workers (CHWs), also known as lay health educators or *promotores de salud*, perform a range of tasks that help patients engage in care, from health education and healthy behavior coaching to care coordination.[6] Incorporating CHWs into care teams has been shown to reduce rates of chronic illness, improve medication adherence, encourage patient empowerment, augment community health, and reduce healthcare costs.[7] Despite the evidence demonstrating CHW effectiveness, barriers to full integration of CHWs into care teams continue to exist, such as lack of coverage by insurance. States should enact legislation that establishes a credentialing mechanism for certifying CHWs and/or the programs and institutions that employ CHWs.[8] Formal credentialing will increase opportunities for integration of CHW services into diabetes and prediabetes care.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation directing the appropriate state agency to develop a credentialing system for CHWs.
State Regulators	Work with stakeholders to ensure that CHW credentialing will foster a strong workforce with close ties to the community.

5. Include coverage of the National Diabetes Prevention Program and Diabetes Self-Management Education in Medicaid and State Essential Health Benefits benchmark plans.

The National Diabetes Prevention Program (National DPP) and Diabetes Self-Management Education (DSME) are evidence-based, cost-effective services that have the potential to reduce incidence of diabetes and help individuals manage the disease effectively after diagnosis. Research shows that participation in the National DPP reduces the likelihood of developing diabetes by 58%, thus improving patient outcomes and decreasing the costs associated with diabetes care and complications.[9] DSME has been shown to lower blood glucose levels in individuals diagnosed with diabetes, which translates into fewer diabetes complications and reduced medical costs.[10] States should add the National DPP and DSME to the list of benefits covered under their Medicaid plans. States should also choose Essential Health Benefits (EHB) benchmark plans that include coverage of the National DPP and DSME in order to encourage increased coverage in the private insurance market.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation requiring the National DPP and DSME to be covered benefits in Medicaid.
State Legislators	Enact legislation that requires private health insurers operating in the state to cover the National DPP and DSME.
State Regulators	Select a state benchmark plan that includes coverage of the National DPP and DSME in order to expand coverage for these critical services in the private market.
State Regulators	Add coverage for the National DPP and DSME to Medicaid through the development of State Plan Amendments or waivers.

6. Develop bidirectional electronic communication systems that allow referrals and sharing of select patient information between clinical and community-based resource providers.

Clinical and community-based resource providers and people living with diabetes consistently cite lack of effective communication as a barrier to more efficient and effective diabetes care. Although robust resources such as diabetes prevention or management programs, nutrition classes, and exercise programs often exist in the community, providers are challenged by lack of awareness or by not knowing whether patients are able to make a successful connection with the resource or service. At the other end of the feedback loop, community-based providers have information about patients that would be useful to providers for creating or modifying treatment plans, like progress in weight loss and level of physical activity. States should invest in the creation of bidirectional electronic referral systems that enable clinical providers to easily refer patients to community-based resources and allow administrators of community-based resources to communicate key information about patient services and progress back to clinical providers.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation calling for the development of a bidirectional communication system and appropriate funding for its development.
State Regulators	Convene stakeholders and develop a bidirectional communication system that clinical providers and community-based resource providers can use to enhance patient care.

7. Cover prescribed medically-tailored food for individuals with type 2 diabetes enrolled in Medicaid who meet certain criteria.

Diet is a crucial component of diabetes prevention, management, and treatment, and food can and should be used as a medical intervention. For the average cost of a Medicaid hospital stay ($7,800), Medicaid could provide three healthy, medically-tailored meals per day (at $20 per day) to someone living with diabetes for more than one year.[11] The impact of providing food to people with diabetes can be quite significant; for example, early results from a Medicaid Managed Care plan initiative that delivers medically-tailored meals to beneficiaries with diabetes showed that 85% of study participants lowered their A1Cs after receiving these meals, some by as much as 50%.[12] States should add coverage of prescribed medically-tailored food to the list of Medicaid benefits for people at risk for or living with type 2 diabetes in order to improve health outcomes and reduce healthcare costs.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation that requires medically-tailored meals or prescribed healthy food to be a covered benefit in Medicaid.
State Legislators	Enact legislation calling for development of Medicaid waivers (HCBS 1915(c) or 1115) that include medically-tailored meals or prescribed healthy food as a benefit for appropriate populations.
State Regulators	Include medically-tailored meals or prescribed healthy food as a covered benefit in all waivers (HCBS 1915(c) and 1115) and in all demonstration projects.
State Regulators	Pursue opportunities to participate in CMMI demonstration projects that include or can include provision of medically-tailored meals or prescribed healthy food.

8. Remove barriers to SNAP participation and increase participants' ability to purchase fruits and vegetables.

Among adults with diabetes, food insecurity is associated with increased rates of depression, diabetes distress, hospitalizations, and low medication adherence.[13] Conversely, SNAP participation is associated with better glucose control[14] among food-insecure adults living with diabetes.[15] States should increase participation in SNAP among eligible households in order to (1) provide low-income individuals living with or at risk for type 2 diabetes the food they need to stay healthy and (2) increase participation in other nutrition programs, such as the National School Lunch Program, for which SNAP participants are categorically eligible. Increased participation in SNAP also means that more individuals can benefit from nutrition incentive programs that further subsidize the purchase of healthy food such as fruits and vegetables.

DECISION-MAKER	REQUESTED ACTION
State Legislators and/or Executive Officials	Increase the gross income limit for SNAP eligibility to 200% FPL and eliminate the use of an asset test.
State Legislators	Appropriate money for a state nutrition incentive grant program.
State Regulators	Collaborate with local partners to apply for federal FINI grants.

9. Provide financing for healthy food retailers in underserved communities.

Improving geographic access to healthy foods can contribute to both the prevention and management of type 2 diabetes. Greater proximity to healthy food retailers is associated with a reduced risk for obesity, even after controlling for other factors such as income, race and ethnicity, and physical activity.[16] Relatedly, residents of neighborhoods with better geographic access to healthy food retailers have healthier food intakes.[17] States should appropriate money for financing programs that bring supermarkets and other healthy food retailers into communities that lack adequate access to healthy food options.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation establishing a financing fund to bring healthy food retailers into underserved communities.
State Regulators	Collaborate with local partners and stakeholders to assess the healthy food retail needs of individual communities and determine how financing funds can be best used to meet those needs.

10. Improve school nutrition programs.

Many students consume over 50% of their daily calories at school.[18] Increasing access to nutritious food in schools is critical to reversing rising rates of obesity and type 2 diabetes among children and future generations of adults, particularly those in low-income households. States should take steps to increase participation in, and improve the quality of, school lunch and breakfast programs.

DECISION-MAKER	REQUESTED ACTION
State Legislators	Enact legislation providing targeted funding and support for school breakfast.
State Legislators	Enact legislation requiring universal school breakfast to be served at schools in high poverty locations.
State Regulators	Implement direct certification for *all* programs that bestow categorical eligibility and conduct direct certification matches on a monthly basis.
State Regulators	Apply for federal Direct Certification Improvement grants to strengthen statewide matching systems.
State Regulators	Provide outreach, education, and training about the Community Eligibility Provision (CEP) and encourage its adoption among eligible schools and school districts.
State Regulators	Expand the scope of foods covered under the federal Smart Snacks Rule and eliminate the fundraiser exemption.

CONCLUSION

The diabetes epidemic requires urgent attention from all government actors, from federal to state to local policymakers.

Implementation of the Best Practices detailed in this report would yield significant results for people living with or at risk for type 2 diabetes.

REFERENCES

1. John Anderson et al., *How Proven Primary Prevention Can Stop Diabetes*, 30 Clinical Diabetes, no. 2, at 76 (Apr. 2012).
2. *Number (in Millions) of Civilian, Noninstitutionalized Persons with Diagnosed Diabetes, United States, 1980–2011*, Ctrs. for Disease Control & Prevention, http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm (last visited December 3, 2014).
3. *Key Facts About The Uninsured Population*, The Henry J. Kaiser Family Foundation, Oct. 5 2015, http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ (last visited Nov. 23, 2015).
4. Nina E. Flavin et al., *Health Insurance and the Development of Diabetic Complications*, 102(8) Southern Med. J. 805, 805 (2009).
5. *The Crisis in Rural Primary Care*, WWAMI Rural Health Research Ctr. (Apr. 2009).
6. *Recommended Model Guidelines for Community Health Worker Programs and Community Health Workers*, Ctr. For Health Law & Policy Innovation of Harvard Law School, Nat'l Council of La Raza, Amer. Academy of Family Physicians Foundations, (May 2015), http://www.chlpi.org/wp-content/uploads/2013/12/PATHS-Credentialing-Guidelines-Final-070815.pdf (last viewed Apr. 27, 2016).
7. Regina Otero-Sabogal et al., *Physician-Community Health Worker Partnering to Support Diabetes Self-Management in Primary Care*, 18 Quality in Primary Care, 363, 369-370 (2010); Michele Heisler et al., *Participants' Assessments of the Effects of a Community Health Worker Intervention on Their Diabetes Self-Management and Interactions with Health Care Providers*, 37 American Journal of Preventive Medicine S270, S275 (2009); Kia Davis et al., *Teaching How, Not What: The Contributions of Community Health Workers to Diabetes Self Management*, 33 The Diabetes Educator 208S, 213S-214S (2007).
8. This term Community Health Worker is used to encompass all forms of peer support and includes *promotores de salud*, patient navigators, health coaches, and lay health advisers.
9. Diabetes Prevention Program Research Group, *Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin*, 346 New Eng. J. Med., 393, 393 (2002). A follow-up study showed that diabetes incidence was still reduced by 34% in the original DPP group in the 10 years since initial randomization. Diabetes Prevention Program Research Group, *10-Year Follow-Up of Diabetes Incidence and Weight Loss in the Diabetes Prevention Program Outcomes Study*, 374 The Lancet, 1677, 1677 (2009).
10. Susan L. Norris et al., *Self-Management Education for Adults with Type 2 Diabetes: A Meta-Analysis of the Effect on Glycemic Control*, 25 Diabetes Care 1159, 1159 (2002).
11. Anne Pfunter et al., *Costs for Hospital Stays in the United States, 2010: Statistical Brief #146* Agency for Healthcare Research & Quality (Jan 2013).
12. *"Prescribing" Nutrition for Medicaid Members in Need*, Health Partners Plans, (Nov. 4, 2015), https://www.healthpartnersplans.com/about-us/newsroom/news-releases/2015/%E2%80%9Cprescribing%E2%80%9D-nutrition-for-medicaid-members-in-need (last visited Apr. 29, 2016).
13. *See* Julie Silverman, *The Relationship Between Food Insecurity and Depression, Diabetes Distress, and Medication Adherence Among Low-Income Patients with Poorly-Controlled Diabetes*, 30 J. Gen. Internal Medicine 1476 (2015); Ashley Sullivan et al., *Food Security, Health, and Medication Expenditures of Emergency Department Patients*, 38 J. Emergency Med. 524 (2010).
14. Among adults, the association between SNAP and weight gain has been more difficult to define. While some studies have found that SNAP participation is associated with higher BMI and rates of obesity, others have found that SNAP participation, particularly among those with low or very low food security, is associated with lower BMI. *Compare* Leung et al., *Dietary intake and dietary quality of low-income adults in the Supplemental Nutrition Assistance Program*, 96 Am. J Clinical Nutrition 977 (2012) *with* Binh Nguyen et al., *The Supplemental Nutrition Assistance Program, Food Insecurity, Dietary Quality, and Obesity Among US Adults*, 105 Am. J. Pub. Health 1453 (2015).
15. Victoria Mayer et al., *Food Insecurity, Coping Strategies, and Glucose Control in Low-Income Patients with Diabetes*, Pub. Health & Nutrition (forthcoming 2016).
16. *See* Kimberly Morland et al., *Supermarkets, Other Food Stores, and Obesity*: *The Atherosclerosis Risk in Communities Study*, 30 Am. J. Preventative Med. 333 (2006); Lisa Powell et al., *Associations Between Access to Food Stores and Adolescent Body Mass Index*, 33 Am. J. Preventative Med. S301 (2007); Gilbert C. Liu et al., *Green Neighborhoods, Food Retail, and Childhood Overweight: Differences by Population Density*, 21 Am. J. Health Promotion 317 (2007).
17. *See* Latetia Moore et al., *Associations of the Local Food Environment with Diet Quality – A Comparison of Assessments Based on Surveys and Geographic Information Systems*, 167 Am. J. Epidemiology 917 (2008); Donald Rose & Rickelle Richards, *Food Store Access and Household Fruit and Vegetable Use Among Participants in the US Food Stamp Program*, 7 Pub. H. Nutrition 1081 (2004); Kimberly Morland et al., *The Contextual Effect of the Local Food Environment on Residents' Diets: The Atherosclerosis Risk in Communities Study*, 92 Am. J. Public Health 1761 (2002).
18. Lisa Manchino et al., USDA Economic Research Service, *How Food Away From Home Affects Children's Diet Quality* 3, http://www.ers.usda.gov/media/136261/err104_3_.pdf.

TABLE OF ACRONYMS

ACA = Affordable Care Act

CDC = Centers for Disease Control and Prevention

CEP = Community Eligibility Provision

CHLPI = Center for Health Law & Policy Innovation of Harvard Law School

CHW = Community Health Worker

CMMI = Center for Medicare & Medicaid Innovation

CMS = Centers for Medicare & Medicaid Services

DAP = Diabetes Action Plan

DPP = Diabetes Prevention Program

DSME = Diabetes Self-Management Education

EHB = Essential Health Benefits

EHR = Electronic Health Record

FINI = Food Insecurity Nutrition Incentive

FPL = Federal Poverty Level

HCBS = Home and Community-Based Services

HFFI = Healthy Food Financing Initiative

HHS = U.S. Department of Health and Human Services

MCO = Managed Care Organization

MTM = Medically-Tailored Meals

NPP = Non-Physician Providers

NSLP = National School Lunch Program

SBP = School Breakfast Program

SNAP = Supplemental Nutrition Assistance Program

SPA = State Plan Amendment

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