



Policy Considerations That Make the Link
*Connecting Community Experience and National Policy to
Reduce Disparities in Diabetes*

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Diabetes Disparities in America

There are persistent and pervasive health and health care disparities in America that affect low-income, minority populations, resulting in worse health outcomes for these populations than for other Americans. A health disparity is defined as a particular type of health inequality stemming from social, economic or environmental disadvantage. A health care disparity is defined as differences in the amount and quality of health care that different groups receive.ⁱ Such vexing disparities are readily apparent in the incidence, treatment and management of diabetes in the United States. Although both health and health care disparities must be addressed to effectively reduce disparities, the work of the Alliance to Reduce Disparities in Diabetes and the policy considerations put forward for discussion in this report are specifically focused on addressing health care disparities.

Diabetes affects 25.8 million Americans (about 8.3 percent of the U.S. population). Moreover, the Centers for Disease Control and Prevention (CDC) says this statistic understates the dimension of the problem. CDC estimates that approximately 7 million additional Americans are undiagnosed with diabetes and, therefore, are not treated. Individuals in specific racial and ethnic groups experience the greatest prevalence and widest disparity in outcomes for both type 1 and type 2 diabetes.ⁱⁱ Type 2 diabetes disproportionately affects African-Americans, American Indians, Asian Americans, Hispanics/Latinos and Pacific Islanders. These groups also comprise a disproportionate share of the poor and uninsured.ⁱⁱⁱ

Not surprisingly, the issue of reducing disparities in general and disparities in diabetes in particular has garnered broad public- and private-sector attention. The U.S. Department of Health and Human Services (HHS) issues the National Healthcare Disparities Report annually that includes a deeper look into diabetes, and the Department released its detailed Action Plan to Reduce Racial and Ethnic Health Disparities in 2011. That plan examined provisions in the Affordable Care Act (ACA) that could be used to affect reductions in disparities. Those opportunities build on other on-going policy and practice sharing activities, such as CDC's National Policy Initiative Project around diabetes and the Agency for Healthcare Research and Quality's Innovation Exchange. The impact of those efforts are measured, in part, by private-sector initiatives such as the U.S. Diabetes Index – a compilation of information about people living with diabetes, their care and the trends that are shaping the disease in the United States. Despite these and other activities, however, disparities in diabetes continue to grow.

As the costs associated with this disease skyrocket, it is critical not only to understand how and why disparities exist, but also to understand how prevention and management initiatives can address the special needs of underserved communities. The on-the-ground experiences of health care professionals working to reduce such disparities in their communities provide insight into ways that federal and state health policy decisions can be better shaped to reflect those experiences and thus to promote deeper reductions in health care disparities. Those experiences also suggest ways in which current regulations could be leveraged more effectively to reduce disparities. The federal Affordable Care Act (ACA) of 2010 includes many provisions important to people with diabetes and presents an opportunity to improve coordination of care and reduce disparities in diabetes. Under the ACA, insurance companies will no

longer be able to deny coverage to individuals with preexisting conditions (such as diabetes), out-of-pocket spending will be capped and insurance plans will no longer be able to set lifetime or annual limits on covered benefits. Health care coverage will also be expanded to many low-income, uninsured or underinsured individuals through state health insurance exchanges and a planned Medicaid expansion in 2014. All of these provisions will directly benefit vulnerable individuals living with and managing diabetes. The Act also creates a National Diabetes Prevention Program for adults at high risk for developing diabetes. HHS and the CDC are authorized to jointly establish the program.^{iv}

Extensive research has shown that disparities in health care are often a result of insufficient health resources and poor disease management. Success in identifying critical gaps in care and reducing disparities can be realized by addressing these factors together. The challenge is how best to balance the legislative and regulatory responsibilities of lawmakers and public health officials with the needs of local health care professionals. According to the experience of the Alliance grantee sites, these health care professionals need flexibility, incentives and comprehensive support to shape their care delivery in ways that maximize the use of evidence-based interventions and, thereby, improve diabetes outcomes for underserved communities.

The Alliance to Reduce Disparities in Diabetes – Progress and Opportunities Revealed Through On-the-Ground Programs

Since 2009, the Alliance to Reduce Disparities in Diabetes, a national program launched and supported by The Merck Foundation, has been working to improve health care delivery among those populations most at risk for diabetes – African-American, Hispanic/Latino and Native American adults.

The five health care delivery sites that comprise the Alliance to Reduce Disparities in Diabetes have implemented multifaceted evidence-based approaches designed to eliminate gaps produced by inequity and lack of targeted attention to those adults and their families who are most likely to be severely burdened by diabetes. The programs focus on improvements at the patient, provider and health system levels. The Alliance sites emphasize patient-centered care and communication and recognize that individuals with diabetes receive care within a health system that includes a variety of health professionals, including community health workers, registered dietitians, primary care providers and pharmacists. As such, those professionals must enhance coordination of their work and enable people to manage their diabetes effectively day-to-day.

Over the last few years, the Alliance has also convened experts from the field that have leant their perspectives to the barriers and potential solutions raised in this report through both individual discussions and a collective national summit.

The five Alliance sites are: the Camden Coalition of Healthcare Providers in Camden, New Jersey; the University of Chicago in Chicago, Illinois; Baylor Health Care System in Dallas, Texas; the Eastern Shoshone Tribe at the Wind River Indian Reservation in Fort Washakie, Wyoming; and the Healthy

Memphis Common Table in Memphis, Tennessee. The Alliance's National Program Office is located at the University of Michigan's Center for Managing Chronic Disease.

Despite these efforts and their success in making substantive progress in their communities, the Alliance sites continue to face an array of structural issues in the health care system that present real, systemic barriers that limit the success of the interventions. For example:

- **The health care system's focus on payments based on units of care** (e.g., number of physician appointments), **on specialty care** (e.g., acute care, surgical care) **and high-cost, high-tech interventions.**
- **State credentialing standards that present barriers to payments for vital health workers.** Those barriers, in part, prevent the creation of integrated health care teams that require greater flexibility in composition and payment to ensure wrap-around support of patient self-management efforts in community-based and home-care settings.
- **Technologies, costs and policies** [e.g., some Health Insurance Portability and Accountability Act of 1996 (HIPAA) provisions] **that can obstruct timely, comprehensive and robust exchange of patient information.** At the Wind River Alliance site, for example, data sharing takes place but it is not electronic. Wind River is not allowed to enter its patient experience data into the Indian Health Service (IHS) electronic medical records. As a result, IHS providers can't see what Wind River health care professionals have done for patients and vice versa. The experiences of the Alliance sites have underscored that unfettered but appropriate access by health care professionals to comprehensive patient disease management data are essential to coordinated treatment of complex conditions such as diabetes.
- **A lack of designated, adequate and consistent payment for community health worker/patient navigator services that can provide people with diabetes needed links to community resources and to education.** Beyond these health care professionals, Alliance site experience also shows that a variety of patient supports, including informal community-based supports such as those provided through faith-based communities like the Alliance's Memphis site, can play a vital role in supporting patient-centered and patient-directed management of the complex care associated with diabetes.
- **Inadequate integration between health care systems and public health departments that limit care coordination and optimal use of resources in assisting diabetes patients.** The public health community could play an important role in helping to facilitate enhancements in care in general and the collection and dissemination of electronic health data in particular.

In short, the on-the-ground experiences of the Alliance grantee sites revealed an overarching need to realign financial incentives affecting patients, providers and health systems as a mechanism for reducing disparities in diabetes. The question is how. The following sections of this report lay out a series of selected policy considerations that might point the way to answers.

Considerations to Address Diabetes Disparities through Public Policy Changes

Based on in-depth interviews with all Alliance sites, guidance and support from an expert Steering Committee (see panel to right for list of members), consultation with a group of external experts, a review of the outcomes literature (see supporting outcomes evidence in appendix), and conversations with a range of stakeholders at a national summit, an overarching theme emerged as a guiding goal for changes that would improve health care outcomes and reduce disparities in diabetes. This theme was that there is a need to realign financial incentives affecting patients, providers and health systems.

This report raises a series of considerations on how best to go about that realignment. The considerations are intended to spark discussion about achievable actions that can bring about significant reductions in health care disparities among people with diabetes. To further that conversation, this report:

- Lays the foundation for a broad-based national conversation about ways to more effectively reflect local health care provider experiences in reducing disparities in diabetes outcomes within federal and state health policy regarding diabetes.
- Provides examples of some policies that impede effective on-the-ground practices designed to reduce disparities and includes considerations to address these impediments derived from the experience of the Alliance grantees.
- Recognizes the complexity of making meaningful advances in reducing disparities in diabetes even as it questions how evolving health care policies and regulations can be effectively leveraged to bring about such change.

The policy considerations are presented in three sections: health system needs, provider needs and patient needs.

A special thanks to the Summit Steering Committee for their help in developing these considerations for discussion. Members included:

- Ann Albright, PhD, RD, Centers for Disease Control and Prevention, Division of Diabetes Translation
- Jeffrey Brenner, MD, Camden Coalition of Healthcare Providers
- Daniel Hawkins, National Association of Community Health Centers
- Iris Hunter, PhD, MEd, American Diabetes Association
- Dawn M. James, MSN, RN, CNS, CDE, Kit Carson County Health and Human Services (representing National Association of County and City Health Officials)
- James Krieger, MD, MPH, Public Health – Seattle and King County
- Guadalupe Pacheco, MSW, U.S. Department of Health and Human Services, Office of Minority Health
- John Robitscher, MPH, National Association of Chronic Disease Directors
- Andrew Webber, National Business Coalition on Health

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Policy Considerations to Address Health System Needs

Core Concept: Encourage greater integration of public health and health care systems

Policy Consideration:

In what ways could public health be better integrated with health care systems to increase communication and care coordination for people at risk of or living with diabetes?

The Problem

Connecting health providers and patients is only one component of an effective health system. Health promotion and disease management is another critical component and public health has a vital role to play. This is particularly true with diabetes, which is a largely manageable condition. The successful management of diabetes, particularly for vulnerable individuals with complex disease conditions, requires a more integrated health system with primary care and public health working closely together to help manage and coordinate care.

While health care systems and public health have primarily functioned independently of each other, there has been recent attention on the need for more integration between the two fields. In March 2012, the IOM released a report calling for more integration between primary care and public health. The report reviewed new and promising integration models, many of which include shared accountability for improved community and population health outcomes and suggested a set of principles that are deemed essential for successful integration. ^v

Unfortunately, the current lack of communication and insufficient care coordination has created a fragmented system, particularly for those low-income, uninsured or underinsured individuals who must rely on safety-net providers for their care. Many times these safety-net providers, such as hospital emergency rooms, public health clinics and federally qualified health centers, face barriers to enhanced coordination such as patient confidentiality issues, proprietary concerns among providers and insufficient or incompatible information technology systems. More needs to be done to help facilitate coordination in general and in particular, the sharing of timely patient data. For example, the creation of community-based data sets that include hospital data, community-level claims data, or information from community-level health information exchanges (HIEs) could enhance care coordination and decrease duplication of services. Community-based datasets can enable these providers to more effectively identify high-risk patients and target education and support resources to patients.

Alliance Experience

The need for greater integration between health systems and public health emerged as a consistent theme at the Alliance's National Summit held in March 2012. Experts from around the country identified this as a top concern. Alliance grantees have been partnering with public health organizations in their communities to help improve health outcomes and reduce disparities for individuals at risk of or living with diabetes.

- The Camden Diabetes Educators workgroup created a standardized referral form and process for all diabetes outpatient education in the city of Camden. They trained many Camden clinical providers and staff on how to use the form so that they can optimize their patients' 6

chances of actually attending and receiving diabetes education available in the community setting.

- The Wind River Reservation Diabetes Coalition is part of a coalition of providers comprised of Eastern Shoshone and Northern Arapaho Tribal Health and Tribal Diabetes programs, the Wind River Indian Health Service, the State of Wyoming Diabetes Prevention Program, Fremont County Public Health Nurses, and the University of Wyoming who meet regularly to identify ways that linkages between clinical providers and public health can facilitate better coordinated care and help to identify those at risk of diabetes or its complications.
- The Chicago team has forged partnerships with many health promotion organizations in their community such as:
 - Chicago Park District that provides free gym membership for 6 months for patients;
 - Sav-a-Lot that provides grocery gift cards for the purchase of healthy food; and
 - A local community center that provides nutrition and physical activity education and health screenings to patients.

Policy Questions Arising from the Alliance Experience:

- How can greater coordination between health care, public health systems and community-based programs be achieved? What incentives would increase opportunity for partnership regarding education and support services?
- How can communities utilize new funding through the ACA (e.g. Community Transformation Grants or funding from the new Prevention and Public Health Fund) to facilitate greater collaboration between health systems and public health?
- What federal or state resources/incentives can be used to improve the sharing of health information data between health systems and public health? For example, the development of electronic health records (EHRs), diabetes registries and health information exchanges (HIEs) that share timely patient data and identify at risk and vulnerable patients.
- How can new federal funding available for health information technology (e.g., through the ARRA or HITECH programs) be used to establish connectivity between health care systems and the public health community?
- How can CHWs serve as a link or bridge between community, public health and health systems? Would an expanded role for CHWs increase the chances for reimbursement of services?

Core Concept: Share and report community-wide health data

Policy Consideration:

What types of incentives or regulatory requirements are needed to prompt health systems to a) share timely patient data and b) consistently collect and report health data by race and ethnicity?

The Problem

Quality improvement efforts designed to reduce health care disparities in diabetes will require providers and health systems to more consistently and uniformly measure disparities. Federal requirements under health reform require providers and federally supported health care programs to collect a detailed list of demographic data. The ACA requires HHS to adopt new standards for data collection by race, ethnicity, sex, primary language and disability [status](#).^{vi} These new standards are expected to lead to improved identification of health disparities and the creation of better interventions to address them.

In addition to collecting more complete and uniform patient data, health systems are increasingly being challenged to develop other types of community-based datasets. The datasets could include timely patient data and describe hospitalizations, emergency department or urgent clinic visits, physician office visits, medication prescribed, and other data that describe the range of health services provided. This type of sharing of data can greatly enhance the care coordination so critical in managing diabetes patients.

Health systems face many challenges in their efforts to collect more comprehensive data and to create these datasets. Challenges include tight budgets, inadequate staff expertise, and lack of information technology infrastructure to meet regulatory requirements for data collection and to realize the benefits of such data collection. Furthermore, some providers express concerns that capturing such data could raise privacy concerns among patients and within the community.

The Alliance Experience

The Alliance's sites have demonstrated the impact of consistent and uniform collection and sharing of meaningful performance measures stratified by race and ethnicity. Such patient data are enabling Alliance site providers and health systems to better target interventions and to monitor performance on an ongoing basis. For example:

- At the Camden Alliance site, data sharing across institutions is helping to identify individuals who need the most intense case management. Data are also enabling the health system to better assess the impact of its various policies to improve health care quality, control costs and expand access to care in at-risk populations.

- Camden expects that all major EHRs will adopt automatic registry-building capabilities within the next year as a means of remaining competitive. At this point, all major EHR systems in Camden have promised to offer this function, an action that will allow providers across health systems to manage a population without duplicating work. The Camden Health Information Exchange (CHIE) will provide extensive patient data to providers across the city. The CHIE will, in effect, play the role of registry with respect to easy access to patient data across health systems.
- The use of a diabetes registry in the Diabetes Equity Project (DEP) in Dallas also has yielded benefits. Data from the registry have been included in electronic medical records and patient charts, allowing health staff in the DEP to identify high-risk patients. Program staff also implemented a series of uniform patient data collection protocols across 110 provider network clinics, protocols that systematically ensured the recording of patient self-declared race, ethnicity and language choices from a prescribed list. In combination, these data allowed the DEP to identify the percentage of each group (e.g., ethnic, racial, language) that met the diabetes management goal and to understand statistically significant differences in outcomes at a 95 percent confidence level.
- However, challenges remain. Providers working with the DEP can only see data on a patient that are recorded as part of the project. To find data on a patient's experiences in other care delivery settings, providers must engage in a complex matching process to identify that patient and sometimes still cannot gain access to other health systems' information.

Policy Questions Arising from the Alliance Experience:

- What is needed to allow state health data reporting requirements to include that clinical care and public health departments report data (e.g. A1C levels) by race, ethnicity, gender and payer? This stratification can reveal where disparities exist and allow for greater targeting of efforts.
- The American Recovery and Reinvestment Act (ARRA) of 2009 provided incentives for physicians to purchase and implement Health Information Technology (HIT) systems. While this is a good first step, how can these funds also be utilized to develop uniform electronic standards to allow various HIT systems to communicate with each other?
- What funding mechanisms exist for the development of health information exchanges (HIEs) that share timely patient data and identify at risk and vulnerable patients?
- How can privacy concerns about aggregation of and access to data through community health information exchanges (HIEs) be reduced? For example, some barriers to sharing data created by HIPPA could be overcome by creating processes for routinely consenting patients to allow for data sharing.
- How could Accountable Care Organizations serve as aggregators and disseminators of timely health care information from various health providers regarding at risk and vulnerable

patients?

- How can incentives for clinical and public health systems be created to enable reporting on and success in reducing disparities in diabetes?
- How can health clinics access new funding made available through the ACA to implement health information technologies?

Core Concept: Eliminate incentives that encourage underinvestment in low-income, high-risk patients

Policy Consideration:

Although current law and regulations have safeguards against financial incentives that encourage under-investment in health care for low-income, at-risk patients, how can those safeguards be further strengthened and what steps can be taken to improve the ability to monitor their effectiveness?

The Problem

Health systems and providers that treat at-risk, low-income populations face many challenges in helping patients to achieve better health. These patients are often the sickest, poorest patients who have the most barriers to achieving good health. Emerging quality improvement policies and payment structures, such as accountable care organizations (ACOs), may unintentionally create perverse incentives for providers serving minority patients.^{vii} At a time of health system transformation, when accommodation of new modes of financing and new delivery systems is taking place, some health systems may seek to minimize their financial risk. Monitoring for health system under-performance is required by Medicare and Medicaid managed care standards as well as by regulations recently published by the Centers for Medicare and Medicaid Services (CMS) for ACOs participating in Medicare's shared savings program. Still, several problems may arise:

- The information needed to monitor health system performance in a comprehensive and timely fashion may not be available or accessible.
- Even when collected, the data may not be analyzed and actively used.
- Health systems may engage in selectively choosing to treat only those patients for whom providers can demonstrate the largest improvement with the least amount of effort. In doing so, providers would avoid serving the sickest and most costly populations – actions that could jeopardize access to quality health care for low-income, at-risk patients and serve to further exacerbate disparities in diabetes.
- Incentive systems that use “payment withholds” and thus payment penalties for providers who don't meet performance targets, may place providers who serve a significant number of vulnerable and complex patients at a significant and challenging financial disadvantage.
- Policies that penalize hospitals with high readmission rates may disproportionately punish at-risk communities, exert additional financial burdens on already stressed local health systems and could have the unintended consequence of increasing health disparities.

The Alliance Experience

The Alliance sites have focused extensive efforts and resources to ensure that the diabetes health care needs of the people they serve are met. To that end, the sites have sought ways to build broad and more effective collaboratives to track patients and ensure they receive needed services in a timely manner.

- The University of Chicago site has created a quality improvement collaborative. This collaborative includes staff members from different health care sites and promotes learning about better care techniques and sharing of best practices. These quality improvement (QI) efforts have been shown to improve diabetes care in safety-net clinics and have taught QI team members the importance of team-based care and care integration.

Building such partnerships would complement and perhaps further spur development of community health teams that are being successfully modeled in states such as North Carolina and Vermont.

Policy Questions Arising from the Alliance Experience:

- How can safeguards be put in place to prevent underinvestment or disinvestment in health systems serving low-income patients? For example current Medicare policy that penalizes hospitals with higher readmission rates should be adjusted to prevent safety-net hospitals from being disproportionately impacted.
- How can financial incentives be realigned to reward positive health outcomes and reductions in health disparities in diabetes and other chronic conditions?
- How can payment mechanisms be established to support the development of multi-disciplinary community focused health teams?

Policy Considerations to Address Provider Needs

Core Concept: Optimize Accountable Care Organizations' (ACOs) abilities to reduce disparities

Policy Consideration:

Given increasing health care costs and the importance of coordinating care for the most at-risk patients with diabetes, how can ACOs be structured and utilized to reduce disparities in diabetes?

The Problem

Lack of care coordination is a persistent problem in our health care system today, creating a fragmented system where clinical services are organized around small groups of providers that function autonomously and services are sometimes duplicated or provided unnecessarily, thereby increasing

costs. This problem is especially marked for low-income, minority populations that are most affected by disparities.

These patients frequently seek care at emergency departments and from other safety-net providers but often do not have primary care providers or medical homes that can track their progress, monitor for potential problems and ensure that plans and prescriptions given by all of their providers fit together. As a result, low-income, minority populations frequently receive low-quality but high-cost care.^{viii}

Another challenge facing these populations is lack of consistent access to high-quality care. This can result from multiple factors, including:

- Lack of cultural competency on the part of the physician;
- Lack of follow-up by patients; and
- Problems with inconsistent health care coverage.

ACOs are networks of physicians and other health care providers that voluntarily work together to coordinate care and share in the cost savings realized from the coordination of a defined group of high-risk patients. ACOs have been suggested as one way to help improve health care coordination and, thereby, quality of care. The ACA establishes ACOs as a new payment model under Medicare and fosters pilot programs to extend the model to private payers and Medicaid.^{ix}

The Alliance Experience

The Alliance's sites have utilized a variety of ways to promote better care coordination for people with diabetes, including ACOs.

- The Alliance's Camden site was instrumental in persuading New Jersey legislators to enact legislation in September 2011 that establishes a Medicaid ACO demonstration project. The ACO model is presented as a mechanism that can improve health care quality and lower the overall costs of medical care by providing incentives to coordinate care among providers throughout a region.^x The Camden site has since worked with the state of New Jersey to draft regulations to implement the new law and is in the process of seeking accreditation to become the first Medicaid ACO in the nation.

Policy Questions Arising from the Alliance Experience:

- How can physicians, hospitals and other providers work together to forge new provider networks? For example, under the ACA, Medicare will be allowed to contract with ACOs to provide care to enrollees. The law also allows for experimentation with Medicaid ACOs by creating a five-year demonstration project where state Medicaid ACO pilot projects will be funded.
- How could a standardized Medicaid ACO accreditation process facilitate the creation of ACOs that meet the needs of vulnerable diabetes patients?

- How could the New Jersey example of recently enacted legislation and regulations to implement Medicaid ACOs serve as a model for other states?
- How can performance measures for ACOs and other health service providers be created specifically to focus on reducing disparities? For example, the National Committee for Quality Assurance (NCQA) has established quality metrics for its Diabetes Recognition Program,^{xi} but if these measures (HbA1c levels, blood pressure control or foot exams) were required to be stratified by race and ethnicity, or if other measures such as the rates of hospitalizations for ambulatory care-sensitive conditions in diabetes were required, attention may shift to reducing disparities.
- The ACA calls for the exploration and development of new care models such as patient-centered medical homes and models where health care teams provide continuous care to high-need groups. How can these new models be designed to best meet the needs of low-income, high utilizers with complex chronic disease conditions such as diabetes?
- How can new federal funding available through the Health Resources Services Administration (HRSA) for community health centers working to receive recognition as medical homes be leveraged to increase care coordination and reduce disparities in diabetes patients?
- What further/new incentives and rewards can move providers toward:
 - An integrated system of care where risk can be spread across providers;
 - Elimination of a fee-for-service based system of payment and establishment of a performance-based system;
 - Team-based health care delivery (e.g. team-based payments in lieu of individual practitioner payments with some level of legal agreement between different entities to share revenues, etc.);
 - Increased sharing of patient data; and
 - Realignment of provider payments for desirable health outcomes rather than provision of services?

Core Concept: Support deployment of Community Health Workers (CHWs)

Policy Consideration:

Given the important role CHWs play in reaching underserved, high-risk populations, how can coverage for these services be expanded?

The Problem

The populations most affected by disparities in diabetes face many hurdles to improved health outcomes, including distrust of medical care providers, lack of health literacy and lack of diabetes self-management education, among others. The ACA recognizes CHWs as important members of the health

care workforce that can help to achieve the goals of health reform, especially in poor and underserved communities.^{xii} However, the new law does not include any specific financing or reimbursement mechanism for these workers. CHWs (also known as health promoters or promotores, community health advisors, patient navigators, outreach workers, lay health advisors, or village health workers) have been shown to improve health outcomes by providing health information and helping patients to navigate the health care system.^{xiii}

Even though CHWs can play a vital role in connecting underserved populations with health care resources, CHW services are not widely covered by insurers. Federal rules do not recognize CHWs as a billable provider under the Medicaid program and as a result, the large majority of states do not include CHWs as part of their Medicaid programs. Nonetheless, a few state Medicaid programs have started experimenting with creative ways to fund CHWs, such as using capitated funds, federal funding for administrative costs or applying for a special waiver (Section 1115 Waiver). Some Federally Qualified Health Centers (FQHCs) have found ways to employ CHWs by utilizing other funding sources such as community grants.

The Alliance Experience

The Alliance's grantees have discovered that current credentialing standards sometimes present barriers to third-party payments for CHWs. Those barriers, in part, prevent the creation of integrated health care teams that require greater flexibility in composition and payment to ensure wrap-around support of patient self-management efforts in community-based and home-care settings.

Still, the Alliance's sites have explored a variety of different ways to effectively utilize CHWs to deliver diabetes support services. For example:

- The Alliance's Dallas site, the Diabetes Equity Project (DEP), has seen clear improvement in diabetes outcomes for their patients following the use of CHWs. DEP's CHW program, called CoDETM (Community Diabetes Education), has established diabetes health promotion "community hubs" at several of its clinics. Results of the CoDETM program reported at the close of its first year showed annual direct medical expenditures of \$461 per participant and significant reduction in hemoglobin A1C levels in patients who participated in the program for 12 months compared with a control group.
- Because of this success, the Dallas site has taken the next step to expand the role of these workers, utilizing a new job type, the "Diabetes Health Promoter." This medical assistant is state certified as a community health worker through a 160-hour program and participates in 50 hours of diabetes/clinical training initially, with several hours of ongoing continuing education each month. Frequent coordination with the patient's primary care provider and interaction with leaders of community partnerships is crucial to this model.

- The Alliance’s Chicago site is working to determine the types of roles and activities that patients prefer for CHWs to perform and has conducted four focus groups to learn more. This information will be used in the following years to explore possible CHW integration into health center quality improvement initiatives. Chicago is currently exploring an approach where CHWs are identified from the pool of patients who have completed diabetes education through the Chicago site’s program. Additionally, the use of text messaging through mobile phones is being explored as a way for CHWs and other care managers to conduct patient follow-up and continue to bolster patients’ self-management confidence and skills.

Policy Questions Arising from the Alliance Experience:

- How could private insurance coverage for CHWs be expanded?
- What are the reimbursement options for CHWs through Medicaid? While about half of the states have efforts underway to cover CHW services through their Medicaid programs, how could these services be included as part of the essential health benefits specified for Qualified Health Plans for all states under the ACA?
- How could Health Professional Opportunity grants through the ACA best be leveraged to help train CHWs?
- What minimal training standards and credentials for CHWs can ensure qualifications and at the same time, increase availability of these links to vulnerable populations?
- How can barriers be eliminated in credentialing standards that require certain high level individuals (e.g. registered dieticians) to oversee the certification requirements of CHWs to account for situations where such specific supervision is not available or affordable?
- How can services most appropriate to individual members of the health care team, including CHWs, be identified and incentivized?
- How could a standard scope of practice determination for CHWs help persuade public and private payers to provide direct reimbursement for their services?

Policy Consideration to Address Patient Needs

Core Concept: Enhance diabetes self-management supports

Policy Consideration:

How could coverage for diabetes self-management education and supports be expanded by insurers?

The Problem

The daily, active participation of diabetes patients in their own care is a critical factor in the

management of their disease progression. In a 2009 article in *Patient Education and Counseling*, “Patient Empowerment: Myths and Misconceptions,” authors Anderson and Funnell point out that patients provide 98 percent of their own diabetes care, including healthy eating, being active, monitoring, taking medication, problem-solving and reducing risks. As such, a person’s daily decisions have the greatest impact on their health, and they are responsible for the actions and the consequences.^{xiv}

Self-management supports are defined as the range of educational and supportive interventions provided by health care staff to increase patients’ skills and confidence in managing their health, including regular assessment of progress, goal setting, and problem-solving support.

Patients need ongoing assistance in that effort. Yet, research underscores the lack of effective dissemination of diabetes self-management supports by providers to low-income, at-risk populations and a corresponding lack of implementation of such supports by this patient population. Adults who rely on Medicaid or are uninsured, do not receive the amount, type or quality of diabetes self-management education needed to successfully manage their condition.

According to the experience of the Alliance grantee sites there is:

- Inadequate investment in diabetes management supports;
- Lack of sufficient funding for providers and/or non-clinical health workers;
- Lack of health literacy among patients and culturally relevant self-management supports and services available for provider dissemination; and
- Insufficient integration between the clinical and public health systems and with community-based prevention and education programs.

State Medicaid programs are not required by the federal government to pay for diabetes self-management supports; however, about half of states have elected to cover such services. In many cases, coverage is limited to just a few support services and according to the Alliance grantee sites, is usually inadequate to reimburse for the time required to provide such support. Of note, Medicare covers diabetes self-management training (DSMT) services for its enrollees furnished by a certified provider within an accredited DSMT program. Currently, Medicare covers up to 10 hours of initial self-management training and up to two hours of follow-up training each year.

The Alliance Experience

Many of the Alliance’s sites have identified the lack of patient diabetes education and access to diabetes self-management supports as one of the top challenges in caring for people with diabetes. The barriers created by low health literacy may result in additional time and more intensive interventions, which may result in higher costs. Actions by the Alliance’s sites have demonstrated the positive impact of addressing this lack of support. For example:

- The Chicago site has conducted focus groups with its patients to learn what types of community-based programs would support diabetes self-management and has created a

diabetes-specific directory that includes information on diabetes education and supports available. Based on this feedback, the Chicago site plans to create a new program designed to engage patients in their own communities and empower them to be more active within the health care setting.

- Chicago's preliminary data show that patient education classes and improved self-management supports have positively affected clinical outcomes.
- The Dallas site has seen improved clinical outcomes, such as lowered A1C and glucose levels, following the implementation of targeted diabetes self-management supports, such as providing advanced patient education and empowering patients to better manage their own care.
- Researchers at the Chicago site surveyed participants following a culturally-tailored intervention designed to improve self-management among African Americans with diabetes and found significant improvements across a range of diabetes self-management indicators, including self-efficacy and dietary behavior.
- The Camden Coalition provides diabetes self-management education and training in both English and Spanish and has recently revised the program to meet the needs of patients with complex problems.

Policy Questions Arising from the Alliance Experience:

- How can a consistent and core set of self-management support services be included in the Medicaid essential benefits packages of all states?
- How could the Medicare practice of coverage for diabetes self-management supports for enrollees be a model for Medicaid?
- What opportunities exist to leverage current private market reforms called for under the ACA to increase coverage for self-management supports?
- How can diabetes self-management programs be developed to be culturally appropriate and closely tailored to the needs of vulnerable patients?
- How could diabetes screenings and self-management training be included in preventive care coverage requirements for private insurers through the ACA?
- How can new state grants allocated through the ACA for primary prevention of chronic diseases (\$100 million over a 5-year period) be leveraged to help Medicaid beneficiaries better manage their diabetes?

Conclusion

The extraordinary surge in the prevalence of diabetes in the United States underscores the challenge ahead for the nation in its efforts not only to prevent, treat and manage this complex condition but also to significantly reduce the wide and growing gap in diabetes outcomes between low-income and minority populations and the rest of Americans. Success in turning the tide on diabetes and on those disparities hinges on a variety of factors, not the least of which is to ensure that real world experience among health care providers and health systems is reflected in health policies and regulations implemented at federal, state and local levels.

This report seeks to make the link between national and state-level policymaking and realities at the community level in affecting change. These policy considerations reflect the on-the-ground experiences of the five sites that comprise the Alliance to Reduce Disparities in Diabetes – organizations working every day to improve the health of people living with diabetes through innovative delivery of interventions designed to reduce health care disparities. A central lesson from providers in the field is the need for payers, including Medicaid, to align payment incentives so that health care providers, patients and health systems are rewarded for demonstrating measurable progress on actions over which they have agency. Demonstrating such progress will require systemic changes in the collection, sharing and analysis of health care data.

Appendix

Glossary

Culturally sensitive – A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations. Culture refers to integrated patterns of customs, beliefs, values and institutions of racial, ethnic, religious or social groups.^{xv} Culturally sensitive could also refer to the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population's relevant historical, environmental and social forces are incorporated in the design, delivery and evaluation of targeted health promotion materials and programs.^{xvi}

Financial incentive – Any type of performance-based provider payment arrangements, including those that target performance on cost measures.^{xvii}

Health care disparity - Differences in the amount and quality of health care that different groups receive.^{xviii}

Health disparity– Differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.^{xix}

Health literacy – Health literacy is the degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions. Health literacy also depends upon the skills, preferences and expectations of health information providers, including doctors, nurses, administrators, home health workers, the media and many others. Health literacy arises from a convergence of education, health services and social and cultural factors, and brings together research and practice from diverse fields.

Health system – A specific communities' base of providers who can coordinate the delivery of services in a way that reduces disparities in diabetes. Health systems are characterized by dynamic interchanges with their environments (e.g., markets, payers, regulators, and consumers) and interactions among internal system components. These components include people, physical settings, technologies, care processes and organization (e.g., rules, structure, information systems, communication, rewards, work flow, culture).^{xx}

Patient–Individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services or other health-related services.^{xxi}

Provider – A licensed doctor of medicine or osteopathy; other persons providing health services, if recognized by the Federal Employees Health Benefits Program (FEHBP) or licensed or certified under federal or state law, including practitioners outside of the United States authorized to practice in accordance with the laws of that country; Church of Christ practitioners, if listed with the Church of Christ Scientist in Boston; and Native Americans including an Eskimo, Aleut, and Native Hawaiian recognized as "traditional healing practitioners."^{xxii}

Supporting Outcomes Evidence

Policy Considerations to Address Health System Needs

Core Concept: Encourage greater integration of public health and health care systems

Policy Consideration:

In what ways could public health be better integrated with health care systems to increase communication and care coordination for people at risk of or living with diabetes?

The following research provides information on integrating health care systems and public health to enhance care coordination and prevention efforts.

Koo, Felix, Dankwa-Mullan, Miller and Waalen. A Call for Action on Primary Care and Public Health Integration. *American Journal of Preventive Medicine*, 42 (6S2) (2012):S89-S91.

This special supplement highlights how these two sectors intersect and discuss efforts currently underway to achieve true integration.

IOM. Primary Care and public health: exploring integration to improve population health. Washington, DC: The National Academies Press, 2012.

This report calls for more integration between primary care and public health. The report provides a review of new and promising integration models and suggests a set of principles that are deemed essential for successful integration.

Core Concept: Share and report community-wide health data

Policy Consideration:

What types of incentives or regulatory requirements are needed to prompt health systems to a) share timely patient data and b) consistently collect and report health data by race and ethnicity?

The following research provides information on financial incentives and regulatory requirements that could be used to prompt health systems to collect and utilize data in order to improve quality of care and to reduce disparities in diabetes.

Conrad and Perry. Quality-based Financial Incentives in Health Care: Can We Improve Quality by Paying for It? *Annual Review of Public Health*, 30 (2009): 357-71.

The article found that primary care medical homes and accountable care organizations will catalyze more powerful quality incentive models (risk- and quality-adjusted capitation; episode of care payments; enhanced fee-for-service payments for quality dimensions like prevention most amenable to piece-rate delivery).

Osborne, Mayberry, Mulvaney and Hess. Patient Web Portals to Improve Diabetes Outcomes: A Systematic Review. *Current Diabetes Reports*, 10(6) (2010): 422-435.

Review of evaluations of patient web portals to improve processes and outcomes in diabetes revealed positive impact on patient outcomes, patient-provider communication, disease management and access to and satisfaction with health care.

Core Concept: Eliminate incentives that encourage underinvestment in low-income, high-risk patients

Policy Considerations:

Although current law and regulations have safeguards against financial incentives that encourage under-investment in health care for low-income, at-risk patients, how can those safeguards be further strengthened and what steps can be taken to improve the ability to monitor their effectiveness?

The following research provides information on potential ways to strengthen safeguards against financial incentives that encourage under-investment in health care for low-income, at-risk patients.

Conrad and Perry (2009). Quality-based Financial Incentives in Health Care: Can We Improve Quality by Paying for It? *Annual Review of Public Health*, 30: 357-71.

The article found that primary care medical homes and accountable care organizations will catalyze more powerful quality incentive models (risk- and quality-adjusted capitation; episode of care payments; enhanced fee-for-service payments for quality dimensions like prevention most amenable to piece-rate delivery).

Lee et al. Increasing Access to Health Care Providers through Medical Home Model May Abolish Racial Disparity in Diabetes Care: Evidence From a Cross-sectional Study. *Journal of the National Medical Association*, 103(3) (2011): 250-256.

This study evaluated whether or not the medical home model is an effective intervention for decreasing health care disparities in minority patients with diabetes. Both African-American and Caucasian patients as well as men and women with HbA1c of at least 8 percent showed a significant improvement in those levels after the intervention.

Gabbay et al. Multipayer Patient-Centered Medical Home Implementation Guided by the Chronic Care Model. *The Joint Commission Journal on Quality and Patient Safety*, 37(6) (2011): 265-273.

This study found that the implementation of proactive chronic care coupled with multi-payer patient-centered medical homes saw significant improvement in percent of patients with diabetes who had evidence-based complications screening and who were on therapies to reduce morbidity and mortality. Significant improvements were observed in key clinical parameters (greatest absolute improvement was in highest-risk patients).

Policy Considerations to Address Provider Needs

Core Concept: Optimize Accountable Care Organizations' (ACOs) abilities to reduce disparities

Policy Consideration:

Given increasing health care costs and the importance of coordinating care for the most at-risk patients with diabetes, how can ACOs be structured and utilized to reduce disparities in diabetes?

The following research supports the case for utilizing accountable care organizations to help reduce disparities in diabetes.

Foels, Hewner. Integrating Pay for Performance with Educational Strategies to Improve Diabetes Care. *Population Health Management*, 12(3) (2009): 121-129.

The study showed steady improvement in all process and outcome measures for adult primary care physicians in adhering to diabetes clinical guidelines.

Cebul, Love, Jain, and Hebert. Electronic Health Records and Quality of Diabetes Care. *NEJM*, 365, 9 (2011): 825-833.

This study compared achievement of and improvement in quality standards for diabetes at practices using EHRs with those at practices using paper records. EHR sites were associated with higher levels of achievement of and improvement in regionally-vetted standards for diabetes care and outcomes.

Core Concept: Support deployment of Community Health Workers (CHWs)

Key Issue:

Given the important role CHWs play in reaching underserved, high-risk populations, how can coverage for these services be expanded?

The following research supports the case for expanding Medicaid coverage for the range of diabetes support services provided by community health workers.

Gibbons and Tyus. Systematic Review of U.S.-based Randomized Controlled Trials Using Community Health Workers. *Progress in Community Health Partnerships: Research, Education, and Action*. *Progress in Community Health and Partnership* (2007): 371-381.

These studies demonstrated the efficacy of community health workers in enhancing outcomes. Studies covered a broad array of behaviors and conditions.

Spencer et al. Effectiveness of a Community Health Worker Intervention among African-American and Latino Adults with Type 2 Diabetes: A Randomized Controlled Trial. *American Journal of Public Health*, in press. 2011.

This study evaluated a culturally tailored, behavioral theory-based community health worker intervention that resulted in significant improvements in glycemic control.

Valesky. Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council. Available at: <http://www.nhchc.org/Publications/CHWguide.pdf>. Accessed on August 26, 2011.

Initial data from an ongoing study by CMS found that the program resulted in a 28 percent increase in HbA1c tests, 25 percent increase in the tests for lipids, and an 8 percent increase in eye exams in six target states.

Rosenthal et al. Community Health Workers: Part of the Solution. Health Affairs, 29, no. 7 (2010): 1338- 1342.

Highlighting work in Massachusetts and Minnesota, the authors describe how policies were initiated to significantly increase the use of and reimbursement for community health workers.

Policy Consideration to Address Patient Needs

Core concept: Enhance diabetes self-management supports

Key Issue:

How could coverage for diabetes self-management education and supports be expanded by insurers?

The following research supports the case for considering ways that more flexibility in Medicaid payments for diabetes self-management supports for low-income, at-risk populations could help Medicaid to deliver improved care and greater value.

Weinick RM, Caglia JM, Friedman E, Flaherty K. Measuring Racial and Ethnic Health Care Disparities in Massachusetts. Health Affairs, 26, no. 5 (2007): 1293-302.

Boston and Massachusetts enacted race and ethnicity data collection regulations affecting all acute care hospitals in the city and state. This paper describes the regulations and early lessons learned from implementing these data collection efforts in three areas: the design of data collection tools, uses of the data for eliminating disparities and the role of the policy process in such efforts.

Lurie N, Jung M, Lavizzo-Mourey R. Disparities and Quality Improvement: Federal Policy Levers. Health Affairs, 24, no. 2 (2005): 354-64.

The use of a quality improvement framework to address racial and ethnic disparities in health care highlights multiple opportunities for federal and state governments to exert policy leverage, particularly through their roles as purchasers and regulators. Under such a framework, federal and state governments can expand their role in collecting race/ethnicity data and define universal and meaningful race/ethnicity categories.

Shaw K, Killeen M, Sullivan E, Bowman P. Disparities in Diabetes Self-management Education for Uninsured and Underinsured Adults. The Diabetes Educator, 37 (2011): 813-819.

This study found that limited availability of and inadequate access to quality DSME place vulnerable patients at increased risk for serious and costly disease complications (Shaw, et al., 2011).

End Notes

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