

National Clinical Care Commission Webinar Meeting 4
Friday, September 27, 2019
1:30 pm — 5:00 pm EST

Meeting Summary

Welcome

Clydette Powell, MD, MPH, FAAP, Medical Officer, Office of Disease Prevention and Health Promotion (ODPHP), Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services (HHS); former Designated Federal Officer (DFO) for the National Clinical Care Commission, welcomed the Commission members and the public at 2:00 pm.

Dr. Powell announced that due to increased responsibilities of the National Clinical Care Commission, in late August Dr. Don Wright, Director of ODPHP, Deputy Assistant Secretary for Health, HHS, has transitioned the role of DFO to Linda Harris, PhD, ODPHP, HHS. Dr. Powell explained that she will continue supporting the Commission as a Technical Lead. After the announcement, Dr. Powell officially called the meeting to order and then turned the meeting to Dr. Harris.

Roll Call

Dr. Harris introduced herself and conducted roll call (see Appendix for Commission members). She announced that the meeting started with a quorum and then turned the meeting to William (Bill) Herman, MD, Chair of the National Clinical Care Commission.

Opening Remarks and Review of Agenda

Dr. Herman welcomed Commission members and the public, and briefly reviewed the meeting agenda.

Update on the Data Call

Dr. Powell provided an update on the data call. She first reviewed the Commission's responsibilities.

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

1. Federal programs of the Department of Health and Human Services that focus on preventing and reducing the incidence of complex metabolic or autoimmune diseases that result from insulin-related issues and represent a significant disease burden in the United States, including complications from diseases
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 use of new and existing technologies
4. Methods for outreach and dissemination of education and awareness materials that
 - Address the diseases and complications,
 - Are funded by the federal Government, and
 - Are intended for health care professionals and the public.

5. Opportunities for consolidating any inappropriately overlapping or duplicative federal programs related to the diseases and complications

Dr. Powell thanked the Commission members and the subcommittee members for providing input for the data call. She also expressed gratitude to all of those who supported the efforts.

Dr. Powell explained that the data call consists of two sets of questions. The first set of questions (about 13-pages long) was developed for federal agencies that provide direct clinical services. The second set of questions (about three-pages long) was designed to explore programs and policies that work in the larger context of population well-being, and were tailored for agencies that do not provide clinical care but whose policies and programs contribute to the well-being of the American population and may play a role in diabetes (for example, agriculture, education, transportation, housing, etc.).

Dr. Powell stated that the Commission, per Dr. Don Wright's request, has provided justification for asking non-HHS agencies for information, and that the questions are currently under Dr. Wright's review. She explained that the data call will be sent out once it is reviewed and approved. It was anticipated that it would take the agencies 2-3 months to provide answers to the questions. After receiving the answers, the Commission will use the data and information received to develop their report and make recommendations to Congress and the Secretary of Health and Human Services by October 2021.

In response to Commission members' questions, Dr. Powell clarified that the Deputy Assistant Secretary is currently reviewing the overall progress made by the Commission, and that the result of the review probably would become available in October. Regarding the data call, Dr. Powell clarified that once approved, both sets of questions would be sent out at the same time.

Presentation and Discussion for Socioecological Model on Obesity and Diabetes Risk and the Expanded Chronic Care Model

After Dr. Powell's update on the data call, Dr. Herman transitioned the meeting to discussion on two models of health promotion and intervention. He asked the Commission members to think if the models could be adapted or modified to help the Commission organize the subcommittees' focus areas and recommendations. He then introduced Dean Schillinger, MD, Chief, UCSF Division of General Internal Medicine, San Francisco General Hospital; Interim Co-Chair of the Prevention—General Population Subcommittee, who presented the two models.

Dr. Schillinger explained that there are many versions of the models available online and the two selected are the most straightforward, inclusive, and specifically related to diabetes risk. He noted that both socioecological determinants (for example, biological, geographic, and built environment factors) and health care are important for people with prediabetes and for people with type 2 diabetes, and both models therefore need to be reviewed.

The Socioecological Model for Obesity and Diabetes Risk

Dr. Schillinger explained that the Socioecological Model consists of multiple levels of factors, and that each level of factors is affected by other levels of factors. According to this model, to reduce the risk of obesity and diabetes, people need to keep a balance between energy intake (for example, food and beverage intake) and energy expenditure (for example, physical activity).

However, food and beverage intake, physical activity, and stress, which affects the metabolic balance but is not included in the model, are often influenced by many individual factors (for example, demographic factors, psychological factors, and gene-environment interactions). Individual factors again are influenced by settings such as communities, work places, health care systems, schools and child care centers, and home. Behavioral settings in turn are influenced by other factors such as government policies, public health, education, transportation systems, agriculture, food and beverage industries, and more. In addition, social norms and values around energy intake, physical activity, and stress also affect personal behavior and choices.

While the Socioecological Model includes many important factors related to diabetes, Dr. Schillinger pointed out that the model as presented does not include stress and trauma, both of which are important factors for diabetes prevention and treatment. Dr. Schillinger also pointed out that the model misrepresents energy balance, instead of metabolic regulation, as the only important outcome.

Discussion of the Socioecological Model

Following Dr. Schillinger's presentation, the Commission members discussed and highlighted the importance of the following topics.

- Genetics, epigenetics, environment, and the interactions among them are important and will need to be extensively studied.
- Variations exist at the individual level.
- Diabetes prevalence and body mass index differ in different ethnic groups.
- Diabetes is about behavior but is more than behavior.

The Commission members pointed out that the following factors also play important roles.

- Stress
- Trauma
- Food security, both quantity and quality
- Biologically embedded risk factors such as those associated with food insecurity during pregnancy
- Interactions between behavior and environment

A Commission member commented that there is no general consensus around “quality food” and cautioned about making a causal association between food and diabetes.

Dr. Schillinger explained that the two models presented are population-based, and that they are not causally linked to individuals.

The Expanded Chronic Care Model

Dr. Schillinger explained that this model has been validated in various settings and is widely accepted. He pointed out that the model as presented does not adequately address Health IT, which is increasingly important in contemporary health care; however, he added, it would not be difficult for the Commission to add in factors related to devices and technology, which is part of the Commission’s charge.

Dr. Schillinger noted that the goals of the Chronic Care Model are primarily functional and clinical outcomes of the patients; the Expanded Chronic Care Model, however, also includes population health outcomes, partly because the model was developed for the notion of a health plan that is accountable to a population that is insured and enrolled in the health plan. He pointed out that certain parts of this model interact with the socioecological model.

Dr. Schillinger explained that in the Expanded Chronic Care Model, “population” is defined as enrollees of a health care plan. He pointed out that the most important part of the model is the productive interactions between care-providing teams, patients, and care givers. In addition, informed activated patients are inspired by an activated community. Similarly, proactive practice treatment is supported by prepared and proactive community partners as they care for the patients. Dr. Schillinger noted that these interactions are happening in real time (for example, in the doctor’s office) and digitally (for example, through health care portals).

Dr. Schillinger commented that these productive interactions can only happen if the health system supports the roles of the clinicians, partners, patients, and communities. He explained that the health systems reflected in this model are those that have an information system allowing health care providers to have real-time and thought-forward communication with patients and care givers, and between health care providers themselves.

He noted that the involvement of both the health system and the community is needed for self-management support, decision support, and delivery system design; and health systems are becoming increasingly important to enable teams to work together efficiently. Additionally, health care systems align with the model are those that understand patients with diabetes spend most of time at home and in the community. As a result, they need self-management support carried out by peers or special health professionals in person or online. Outside the health system, the Expanded Chronic Care Model acknowledges the roles of the community and public policies, as well as the need for a supportive environment. In this regard, there is a significant overlap between the two models, Dr. Schillinger noted.

Discussion of the Expanded Care Model

In response to Dr. Herman's question about community partners, Dr. Schillinger explained that for type 2 diabetes, community partners, in his view, are those who are involved in food safety, physical activity (for example, resources and social support), mental health, adult learning environment, and other areas related to type 2 diabetes.

A few Commission members pointed out that the Expanded Chronic Care Model misses payer engagement, which, they noted, needs to be extended to the community level.

The Commission members generally agreed that the two models operate individually and synergistically, and that a hybrid model synthesized based on the two models would work better to allow all the factors to operate within and outside the clinic.

Subcommittee Updates

Prevention—General Population Subcommittee

Ann Bullock, MD, Director, Division of Diabetes Treatment and Prevention, Office of Clinical and Preventive Services, Indian Health Services; Interim Co-Chair of the Prevention—General Population Subcommittee, highlighted the subcommittee's focused areas and explained how they may fit into the models Dr. Schillinger presented.

The Prevention—General Population Subcommittee's focus areas include the following.

- Advance science-and evidence-based recommendations
 - The type 2 diabetes epidemic trajectory and its downstream health and economic consequences are primarily a result of life-course exposures to
 - The rapidly changing and unhealthy food and beverage environment,
 - Limited availability and access to physical activity opportunities, and
 - Embodied stress responses to ambient socioeconomic conditions.
 - Collaboration between federal agencies in the health and non-health domains presents an unprecedented (and to data untapped) opportunity to prevent type 2 diabetes and to enable better self-management for those with type 2 diabetes at the population (non-clinical) level.
- Promote healthier dietary quality for all
 - Identify specific opportunities to engage and leverage agencies (for example, the U.S. Department of Agriculture [USDA], the Food and Drug Administration [FDA], the Department of Education [DoED], the Department of Labor [DOL], and the Environmental Protection Agency [EPA]) that have influence over food and beverage production, regulation, incentives, entitlements, and access, including access to clean water
 - Improve dietary quality for all, especially health disparity populations
- Promote more physical activity opportunities

- Identify specific opportunities to engage agencies that have influence over access to environments that provide safe and affordable physical activity opportunities (for example, education, transportation, labor, park services, and housing and urban development). Ensure that opportunities are available to all, especially disadvantaged populations
- Promote the well-being of pregnant mothers, children, youth, and disadvantaged populations to prevent lifelong exposures to stress
- Promote more population-level research
 - Identify topics and fund trans-agency research that could inform if and how altering policies, systems, and environmental conditions affect relevant risk factors, type 2 diabetes incidence, and type 2 diabetes control
 - Evaluate recommendations the Commission puts forward and economic assessments of the burden of type 2 diabetes that were conducted based on federal databases
- Promote communication initiatives to convey that changing social and environmental conditions through civic engagement is an important and cost-effective strategy to prevent and control diabetes

Dr. Bullock pointed out the importance of bringing all agencies together, including not just HHS agencies but other federal agencies that do not provide clinical care but whose policies and programs may play important roles in diabetes prevention and treatment (for example, the USDA and its agriculture policy, and EPA and air quality). Regarding promoting healthy diets, she encouraged the Commission to look at the large picture to ensure good quality food for all while recognizing that some populations are particularly at risk.

Dr. Bullock also emphasized the long-lasting effects of stress and trauma, and pointed out the need to address biological embedding of risks. She encouraged the Commission to examine policies, find out what the policies are doing, and think about what the Commission can do to make a difference.

Discussion

The Commission members briefly discussed collaboration between federal agencies in the health and non-health domains and the scope of the Commission's work.

Dr. Herman commented that the Charter makes it clear that the scope of activities of the Commission include evaluating and making recommendations regarding HHS and other federal agencies' activities. He noted that in his view, the Commission's scope of work encompasses both HHS agencies and other relevant agencies. With specific reference to the Socioecological Model, he noted that all of the factors included in the model are important to diabetes prevention and control.

Other members agreed that all socioecological determinants of care are important in addressing diabetes prevention, treatment, and control; and that focusing on either individuals or policies alone would not achieve the goals of the NCCC.

It was suggested that when making recommendations, the Commission needs to

- Consider the continuum of risk and intervention,
- Keep in mind that proven effective intervention programs need to be implemented nationwide to ensure success,
- Remain focused and address key drivers to help the large population,
- Understand federal agencies' authorities and under what policies or regulations they operate, and
- Decide if they are going to make actionable recommendations that agencies have the authority to implement, or broad recommendations that would require people and organizations outside the government to drive them forward.

Members of the Commission expressed hope that the data call would provide some useful information regarding the agencies' authorities. The challenge, however, is interpretations of the policies and authorities could vary.

After a short break, Dr. Harris conducted a quick roll call and the meeting resumed with a quorum.

Prevention—Targeted Population Subcommittee

John Boltri, MD, Chair and Professor of the Department of Family and Community Medicine, Northeast Ohio Medical University College of Medicine; Co-Chair of the Prevention—Targeted Population Subcommittee, presented the subcommittee's focus areas. He noted that the targeted population includes those who have prediabetes but have not developed diabetes. The Prevention—Targeted Population subcommittee's focuses include the following four areas.

- Screening/Diagnosis for prediabetes/diabetes
- Preventing/delaying the transition to type 2 diabetes and adverse health outcomes
- Sustaining the effectiveness of type 2 diabetes prevention interventions
- Developing new and more effective preventive strategies for type 1 and type 2 diabetes

Dr. Boltri noted that the subcommittee will emphasize the following topics.

- How to identify people with prediabetes, and how to achieve universal screening of everyone at risk for diabetes
- How to improve availability and uptake of proven effective interventions for preventing or delaying the onset of type 2 diabetes
- How to develop and implement models and programs to maintain improvements achieved from diabetes prevention programs

- How to develop more effective individual and population-based strategies to prevent both type 1 and type 2 diabetes

Ann Albright, PhD, RDN, Director, Division of Diabetes Translation, Centers for Disease Control and Prevention (CDC); Co-Chair of the Prevention—Targeted Population Subcommittee, pointed out that the focus areas and key topics of the Prevention—General Population Subcommittee and the Prevention—Targeted Population Subcommittee must be tied together to maximize the implementation and sustainability of proven effective interventions.

Discussion

Dr. Herman asked the Co-Chairs of the Prevention—Targeted Population Subcommittee if the subcommittee’s focus areas would fit in the two models that Dr. Schillinger presented.

The Co-Chairs commented that the Socioecological Model makes sense to the larger population, and the Extended Care Model makes more sense for those who already have type 2 diabetes. They also pointed out the importance of payment systems and structures, and the linkage between health care and the community.

In response to a Commission member’s question regarding screening and prevention for type 2 diabetes, Dr. Boltri clarified that the subcommittee does not exclude hemoglobin A1c as a screening tool or medication treatment as a targeted prevention strategy.

Treatment and Complications Subcommittee

Carol Greenlee, MD, Faculty, TCPI, Western Slope Endocrinology, Co-Chair of the Treatment and Complications Subcommittee, briefly reviewed the subcommittee’s priority topic areas, which include the following.

- Diabetes self-management, education, and support
 - Effectiveness
 - Barriers identification and reduction
- Care delivery and payment models
 - Interventions at the practice and the system levels to optimize the receipt of appropriate and beneficial care by people with diabetes
 - Value-based payment models to support new care delivery models
- Health disparities and individualized care
 - Access to timely diagnosis and care appropriate to and individualized to patient needs
 - Identification of and reduction in barriers, including knowledge gaps (for example, biologic heterogeneity in risks and response to therapies)

Dr. Greenlee explained that access to health care, in her view, means receiving needed care in a timely manner. However, “needed care” is affected by many factors, including biological factors and factors contributing to health disparities. She pointed out that one size does not fit all

when it comes to factors such as food availability, response to physical activity or stress, the effects of other co-morbidities, etc., these impact not only diabetes prevention but also treatment. She noted that more information is needed to address what is needed for individualized care and how to reduce barriers to receiving it.

Regarding care delivery, Dr. Greenlee noted that population health management-related tools and methods, team-based care, virtual care, and other innovative ways of providing care are needed. She recalled that care delivery is often referred to as “the last mile” for ensuring patients get the care they need. However, for those with diabetes, the ability to do self-care is actually the final mile to achieving receipt of that “needed care”. She pointed out that patients with diabetes spend most of their time at home self-management, education, and support are therefore critical.

Len Pogach, MD, Veterans Health Administration (VHA), alternate Commission member for Dr. Paul Conlin, shared that the VHA is trying to put in place a national campaign to address issues around hypoglycemia as well as numeracy because so many errors can occur. He acknowledged that it is a complex issue.

Discussion

Dr. Herman asked the Co-Chairs of Treatment and Complications Subcommittee if all their priority topics would fit in the two models Dr. Schillinger presented.

Dr. Greenlee noted that both models are needed and she liked the idea of generating synergy by combining the two models.

Dr. Pogach commented that realignment is perhaps needed regarding the intersection between the Chronic Care Model, quality, and decision making. He noted that some performance measures do not align with the goal of individualized care and risk reduction. Many of these measures are currently specified by the National Committee for Quality Assurance. He suggested that it might be worthwhile to revisit the National Action Plan to obtain synergy among federal agencies.

Dr. Schillinger asked if the subcommittee’s priority area around “access to treatment” includes access to health care, which, he noted, is problematic to many people in the United States, especially those at risk for diabetes.

Dr. Greenlee responded that the subcommittee does emphasize the issue. Regarding barriers, she noted that the biggest one perhaps is the inability to afford care and access to critical therapies is impacted. The subcommittee thinks supporting payment models are needed for health care systems and communities to be able to provide and sustain delivery of pro-active care to reduce long-term harms and ultimately lower costs with better outcomes. These improvements in care delivery can’t be achieved if treated as voluntary add-on activities.

Ayotunde Dokun, MD, PhD, FACE, Chief of Endocrine Service, Division of Endocrinology, Diabetes and Metabolism Regional One Health System, Iowa, commented on patient self-management, education, and support. He suggested that implementations such as reduction in intensified therapy need to be done in a way that does not further increase health disparity.

Update on Crosscutting Research Areas

Barbara Linder, MD, PhD, Program Director, Division of Diabetes, Endocrinology, and Metabolic Diseases, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health (NIH), was asked to discuss focus areas for research. She highlighted the following three areas. Many topics in these areas, she noted, were highlighted by the subcommittees.

Health Disparities

Dr. Linder pointed out the needs to

- Better understand social determinants of health,
- Identify barriers hindering people from achieving optimal health outcomes, and
- Develop strategies to reduce barriers.

She noted that one potential research topic in these areas could be around linkages between health care and the community.

Therapeutic Inertia

Dr. Linder noted that therapeutic inertia needs to be addressed at multiple levels, including the patient, the provider, the health care system, and the policy levels.

She explained that at the care provider level, research is needed to better understand providers' understanding of guidelines and barriers preventing them from adopting the clinical care guidelines on screening and treatment. Regarding patients and care givers, research is needed to better understand how to facilitate patients' understanding of treatment regimens in order to enhance adherence to treatment. This, she noted, includes better understanding barriers to care, determinants of health, communication between providers and patients, implementation of shared-decision making, and other patient-centered approaches.

Individualized Medicine

Dr. Linder noted that to achieve long-term health, prevention and treatment need individualized approaches for both type 1 and type 2 diabetes. She noted that more research is needed 1) to understand the heterogeneity of diabetes pathophysiology, and 2) to appropriately phenotype each person to inform optional treatment approaches. Research is also needed to better understand both biological and psychological drivers of behavior that may inhibit people from adopting a healthy lifestyle.

Discussion

Dr. Herman commented that the Commission needs to think about how to fill the gaps in evidence. He stressed that the Commission's recommendations need to be evidence-based.

Ellen Leake, Chair, Juvenile Diabetes Research Foundation, International Board of Directors, Jackson, MS, commented that some NIH research studies ask a lot of questions such as where people live. She wanted to know if the information gathered through the studies would be useful to the Commission's work.

Dr. Linder responded that she does not know how the information will be used and what will be available; however, that information could be potential resources.

In response to a Commission member's questions on various federal agencies' scopes, initiatives, and authorities, Dr. Linder noted that she is not the person who can answer the questions broadly, and that she does not know the regulations governing the agencies. She shared that at NIH, they are trying to do more pragmatic studies that could make real-world impacts.

Dr. Herman shared that based on his experience, there is strong support at NIH for research on disparity and social determinants. For agencies the Commission does not know whether or not they support research (for example the Department of Transportation, he suggested the Commission try to understand the agencies' missions and make recommendations accordingly.

Further Discussion of the Socioecological Model and the Expanded Chronic Care Model

Led by Dr. Herman, the Commission members further discussed the two models. It was generally agreed that combining the two models and adding missing factors highlighted above such as payment systems and benefit structure would provide an adequate framework for the work of the commission.

The Commission also briefly discussed the possibility of using the models to address economic costs and possible strategies for improving efficiency and enhancing viability. Dr. Herman commented that there is a great opportunity for research in this area.

Public Comment

Prior to the meeting, two public members registered to provide public comment during the meeting. However, neither of them called in at the time. After a short period of waiting, the Commission moved on to the next session.

Next Steps and Closing Remarks

The Commission members discussed their next steps around the following topics.

A Hybrid Model

The Commission members agreed that the Commission should develop a hybrid model based on the Socioecological Model and the Extended Chronic Care Model that Dr. Schillinger presented and then use the hybrid model to organize their work.

The Commission discussed how to develop a hybrid model and who should take a lead in the effort. Upon Dr. Herman's request, Dr. Harris agreed that her team would help develop a draft based on the input from the subcommittee co-chairs.

Literature Review

Dr. Herman noted that the Commission members have been sharing among themselves a number of reports, including a recent study published in the *Journal of American Medical Association*, a National Academy of Medicine report, an NIH workshop on diabetes disparity, and other studies published by NIH and CDC. He asked the subcommittee members to identify important publications (ideally, systematic reviews) that are related to the subcommittees' focus areas. He suggested the subcommittee members assemble and read published review articles before reviewing publications on original research studies.

The Commission also discussed the possibility of conducting a systematic literature review. Dr. Herman and other members of the Commission expressed their preference for not conducting their own systematic reviews due to concerns of time. A Commission member suggested perhaps the HHS team could help synthesize the list of systematic reviews and review articles identified and provided by the Commission members.

Input from Other Organizations

A few Commission members suggested reaching out to relevant organizations to seek their input, as the Commission has discussed before. It was pointed out that many national organizations have conducted their own literature reviews, and that reaching out to these organizations could help enrich the Commission's knowledge in a timely fashion.

Dr. Herman agreed with reaching out to other organizations. He suggested the Commission first decide whose input the Commission wants to hear and prioritize that list during future Commission/subcommittee calls.

Regarding Medicare and Medicaid, Dr. Pogach suggested reaching out to state departments of health.

Dr. Powell reminded the Commission members to stay focused because the Charter asks them to evaluate federal programs.

Key Informant Interviews

A Commission member pointed out that peer-reviewed publications often do not reflect diversity, and that the Commission may not be able to obtain all important information through

the data call. He suggested taking a pragmatic approach. For example, reaching out to agencies as well as key informants in the private sector. Another Commission member suggested using key informant interviews to enrich the Commission members' knowledge.

Dr. Herman asked the subcommittees to develop a list of key informants for the full Commission to review. To avoid subcommittees reaching out to the same people, the Commission members agreed to coordinate the effort. After a brief discussion, the Commission decided to put together a list of key contacts within the next 2-3 weeks, before the Commission's next meeting.

In response to Dr. Powell's request for clarification, Dr. Herman clarified that

- Members of the subcommittees will identify key informants and provide their contact information to subcommittee co-chairs;
- The co-chairs will submit the information to Dr. Harris; and
- Dr. Harris and her team will then compile the information and share the final list with the whole Commission.
- The NCCC will then decide who will be contacted and by whom.

At the end of the discussion, Dr. Herman clarified that the Commission would need to work on the following three items after the meeting.

- Developing a blended model
- Putting together lists of key organizations and informants
- Compiling a list of key publications

Dr. Harris noted that the HHS team will develop a timeline for the three tasks and send the timeline to the Commission members for them to review.

Next Meetings

Dr. Powell announced that the next Commission in-person meeting will take place on November 21-22, 2019 at the Bethesda North Marriott Hotel and Conference Center in Maryland. The subcommittees will conduct their work meeting on day one of the meeting, and the full Commission will hold their public meeting on day two.

Adjournment

The meeting was adjourned at 5:00 pm.

Appendix: Commission Members and HHS Support Staff

Commission Members Present for NCCC Meeting 4

Commission Chair

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

Public Members (Special Government Employees)

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

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

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

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

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

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

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

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

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

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

Federal Members (Regular Government Employees)

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

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

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

Len Pogach, MD, Veterans Health Administration, Department of Veterans Affairs; Alternate Member for **Paul R. Conlin**, MD, Chief, Medical Service, Veterans Affairs Boston Healthcare System, Department of Veterans Affairs

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

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

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

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

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

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

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

Commission Members Absent from NCCC Meeting 4

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

Paul Conlin, MD, Chief, Medical Service, Veterans Affairs Boston Healthcare System

HHS Support Staff in Attendance

Linda Harris, PhD, Designated Federal Officer, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services.

Clydette Powell, MD, MPH, FAAP, Medical Officer and Technical Lead, Division of Health Care Quality, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services