

Women and Diabetes Town Hall Meeting - May 20, 2003

>>NICOLE JOHNSON:

As we move into the next panel discussion, it's about managing your life with diabetes and preventing its complications.

That certainly is the aim and the goal of each and every one of us.

The moderator for this session is Dr. Francine Kaufman, there with a quote I found by Eleanor Roosevelt that explains what Dr. Kaufman does.

The future belongs to those who believe in the beauty of their dreams.

One of her dreams is taking care of and making sure people with diabetes can live wonderful, healthy, active, vibrant lives.

Let me mention that she's the president of the American Diabetes Association.

She's also professor of Pediatrics at the University of Southern California.

In 1998 -- since 1998 she's been the head of the Center for Diabetes,

Endocrinology and Metabolism at the Children's Hospital in Los Angeles.

She's been funded by the National Institutes of Health since 1980 and her research has been varied.

Focused on many aspects of the diabetes including prevention, treatment and complications.

Presently she's the chair of a new NIH-funded trial called Stop T-2.

The strategies to prevent and treat type 2 diabetes in children which, again, is Dr. Kaufman's passion.

She was a principal investigator in the diabetes prevention trial for type 2 which I was involved in and now an investigator in trial net the NIH study to try to prevent type 1 diabetes and preserve beta cell function.

She was given the woman of valor award.

Welcome Dr. Francine Kaufman.

President of the American Diabetes Association.

>>FRANCINE KAUFMAN: Thank you, Nicole and thank you again all for being here.

What is this morning about?

It's about partnership.

It's about all of us working together to improve the lives of people with diabetes and to attempt to prevent diabetes in those at risk.

This partnership is vast.

It involves so many agencies of Health and Human Services, and the tremendous leadership of Secretary Thompson who has undoubtedly since he's been secretary of HHS has realized the importance of treating and preventing diabetes in our nation and in our world.

I think we all owe a tremendous amount of thanks to Secretary Thompson for putting diabetes, really, on the forefront and on the front page of our nation's papers, of our nation's consciousness.

And it is also about the partnership of the American Diabetes Association who not only has a tremendous number of people affected by diabetes in its membership but it has the entire professional group of physicians and nurses

and nutritionists in this organization working with HHS to do these important studies that will one day show us not only how to better treat diabetes, but one day how to cure diabetes.

This morning's panel is about the treatment of diabetes.

Let me just tell you that it is incredibly complicated to treat diabetes.

For those with type 1 diabetes, particularly the children I care for in my practice, and let me just tell you that the other day I saw two twin girls, 14 years old, with type 1 diabetes.

One wearing a pump who checks her blood sugar eight to ten times a day.

Who watches what she eats.

Who calculates dosages of insulin five or six times a day to match her activity and her nutritional plan with her medical management.

That is a pretty awesome task for a 14-year-old.

Her twin sister who recently developed diabetes takes multiple injections of insulin every day.

Does the same number of blood tests, the same amount of calculations.

So that they can be healthy and well.

So that they can one day be mothers.

And so that they can one day go to college and they both want to be pediatric endocrinologist at this point in their lives.

At the same time in my clinic I saw a 14-year-old girl with type 2 diabetes.

This is a disease that was a disease of our grandparents until just recently.

Then one of our parents and now one of ourselves and now one of our children.

This girl weighs 220 pounds.

She has almost no physical activity throughout the day.

She doesn't have regard to her nutritional plan.

Her mother, her grandmother and her uncle all have type 2 diabetes.

She'll require first insulin and then a number of oral medications.

She must test her blood sugar as well.

We must convince her that to take care of herself and to take care of her family as well and hopefully they'll all learn by her example that they must alter their lifestyle if they're going to succeed with what her goals are, which is to one day become a mother, one day to go to college and to one day to become a pediatric endocrinologist.

So this is a very complicated event for people with type 2 diabetes.

They have to not only check their blood sugar and watch what they eat and their activity patterns, but they may take not only medications to lower their blood glucose.

They may need to take medication to control their blood pressure.

By the end of the day they could be taking nine or more pills.

These pills all have potential complications.

It's incredibly complicated to live that kind of regimen and we can imagine why there is so much failure still in diabetes management.

It requires support.

It requires resources.

And this requires access to a multi-dimensional health care team that can educate families.

And educate people with diabetes.

That can motivate people with diabetes and support them.

This requires access to a nutritionist who can teach people how to alter their lifestyle and it requires access to health care providers to check out the eyes and the feet and to be sure that these people are healthy and well in their diabetes management.

This takes partnership.

This takes research.

This takes commitment of so many, many people and so many of you today.

And I'm so very pleased to now introduce the panel that will give us some individual focus and elucidation of the complexity of diabetes management and hopefully the reduction of diabetes complications.

Our first panelist is John Miall, Director of Risk Management from the City of Asheville, North Carolina.

He worked for six years for the City of Asheville as an employer.

He's been involved with a very innovative design for disease management for its employees under its health plan.

The program has achieved international recognition and continues to yield significant reductions in health care costs for workers with diabetes and their families.

And equally good results in particularly the utilization and improved quality of life.

>>JOHN MIALL: Thank you, good morning.

Greetings from the Tar Heel state.

I'm from city hall and I'm here to help.

[LAUGHTER]

Why do people always laugh at that?

I would like to begin by thanking our hosts for the opportunity to address this body this morning.

I have known my entire working career that if you want something changed, leave a woman in charge.

I left home Saturday and I suspect by the time I return home there won't be a piece of furniture where I left it and there will be rooms that are different colors.

I have learned over the course of my career that women are risk takers and that's a good thing.

I want to address very quickly this morning a couple of issues.

Most importantly the business of health care and how it relates to diabetes or the lack of care for diabetics.

Would be of the things Asheville embarked upon six years ago as an employer was to see if we could make a difference in our employees' lives and their families lives who suffer by diabetes.

It was driven by financial consideration.

It's a shame to admit today because we've seen huge, dramatic improvements in their lives as a result.

It has a win/win.

Insanity is doing the same thing over and over the same way and expecting a different outcome.

To a large extent that sounds like health care.

As an employer the City of Asheville, we see our health care costs increase from year to year.

We increase deductibles, premiums, co-pays, trying to avoid some of the costs. And the next year our costs go up.

And the next year we increase deductibles and premiums and co-pays.

Historically that has been our response as employers and payers to the problems that diabetics and other disease patient represent to our plan.

We put a wall and said we'll stop the cycle in the City of Asheville.

What we did was through a true partnership with the School of Pharmacy at Chapel Hill.

Local physicians, the diabetes education center and our local hospital system, as well as community pharmacists have implemented a pharmaceutical care model for care.

In addition to seeing their physicians and getting diabetes education, our employees and their families who take part in this voluntary program are required to see their pharmacist once a month.

Glucose meters are downloaded, feet are checked and the information is provided to the provider network, to the physicians.

Through that gathering and sharing of information, which made it a little harder thanks to HIPA but we're managing to do it.

Several of the outcomes have been tremendous.

We just finished our sixth year.

We did six-year follow-ups last week where we drew blood and so forth.

Five years now we have seen an average A1C in that group of 100 diabetics below 7.50.

We've seen a 50% reduction in the sick leave utilization for our employees that are in the program.

We have seen a continued and sustained reduction of 26% in health care costs over the last five years.

If we laid that on a chart and overlaid it with what has happened to the rest of health care, one arrow would be markedly down while the other escalates up.

Our people now cost us less money than they did five years ago.

To bring it home, there are two very quick notes I would like to close with.

One is a lady whose name I use with permission.

MADGE.

She was one of our dispatchers in police and fire.

She and her husband and only son have all suffered from diabetes for many years.

When we ended our first year of the program and brought the folks together to look at how they were doing, she came to me with tears in her eyes and said, you don't know what this means, no one ever cared before.

And it was at that point in my life that I realized the operative word in health care is care.

For the millions and millions of dollars we pumped into a health plan every year, it wasn't enough.

People didn't care.

One of the incentives we put in place in the program is we told our people as long as you do the things you're contracting to do in this program we'll waive your co-pays under our drug card for your disease-specific medications.

Our folks are able to get free insulin, free syringes and free test strips.

What we found is there was a tremendous barrier between those people and the things that would make them well.

A gentleman whose name I don't have permission to use, I'll call him Allen.

He's a sanitation worker.

In Cities all over this country now there are people that are serving you as public servants who will never get rich doing what they do.

And when we saw Allen do better in the program, we questioned why of all the people in it, why does he seem to do better?

And our nurse had the answer.

She said for years he's come in here on Wednesday the middle of the week before pay day and he has enough money to get his insulin or buy his kids lunch for the rest of the week.

People will make those decisions about their lives and they'll show up on our bottom lines.

We have a chance to do something fundamentally different.

Together now with the American pharmaceutical association foundation under the executive leadership of Bill Ellis who is here today.

Bill and his folks have partnered, thanks to a generous grant from a pharmaceutical company, to implement a pilot program of the Asheville project in five major locations around the country.

Those locations and those tens of thousands of employees' lives will certainly never be the same again.

I want to thank you for the opportunity and look forward to spending some time with all of you today.

Thank you.

[APPLAUSE]

>>FRANCINE KAUFMAN: Thank you, so much.

You better be careful.

We may all move to Asheville.

Our next speaker is Suzanne Feetham, she's a senior adviser, Office of the Director at the Bureau of Primary Health Care, Health Resources and Services Administration.

Suzanne will describe several success stories of patients and families receiving primary health care in federally supported health centers participating in the diabetes health disparities collaborative.

The key elements of the care model are important for improving the health of individuals, families and communities.

Thank you.

>>SUZANNE FEETHAM: Thank you, I'm delighted to be here.

As noted I'm from HRSA.

It's known as the access agency.

Today I will share three stories from women and their families receiving primary health care at HRSA supported health centers.

With the stories I'll describe patients, families and how system factors contributing to the health of women with diabetes.

Over half of the HRSA-supported health centers participate in diabetes collaboratives and use the latest research to improve the quality of care and patient outcomes.

Our goal is that all health centers will participate in the health disparities collaboratives over the next few years.

We have a 65-year-old Hispanic woman who learned her blood glucose level was high after screening at a health care.

It is not uncommon, as noted today, for people to be unaware they have diabetes and in fact today there are 6 million undiagnosed people with diabetes in the country.

A few months after the screening Mrs. R and her daughter went to a health center in El Paso.

It was on a Saturday, the only day her daughter could drive her to the center.

At that time Mrs. R was diagnosed with diabetes.

When her family learned that she had diabetes, and that she had to make lifestyle changes they said, that's okay, we'll adapt to what you do.

We have found that successful changes in individual behavior are made possible by family support and the rewards are shared equally.

Today, Mrs. R states, I go to checkups at the health center because everyone treats me right.

The doctors, the nurses and others.

If I had given in to this I would be on a corner, -- in a corner not doing what I do today.

I sweep, mop, clean the house, and help my daughter with her three children.

I lead a pretty normal life.

You may ask, how did this happen?

The type of care Mrs. R receives is a result of the diabetes health disparity collaborative, an effort to provide patient and family-centered care in our health centers.

The collaboratives were developed as a response to a national effort to improve health outcomes for all people such as the 43 million in the country who are uninsured and the vulnerable people affected by health disparities.

Low incomes, homeless people, migrants and seasonal farm workers.

The expansion of the health centers was a goal set by 2006.

The health centers will reach 16 million persons in 6,000 care delivery sites around the country.

As noted in the next story the expansion efforts recognize the importance of the co-morbidity of chronic illnesses and the need for a wide range of services including mental and oral health.

The second story is about a woman.

Mrs. A is a 30-year-old obese woman who has chronic mental illness and arthritis.

She was under the care of a provider for her arthritis.

As can occur often with disease-focused care she was not aware of her risk for type 2 diabetes.

Through her primary care provider in our health center she was screened for diabetes.

She was found that she was at risk due to her weight.

After her pre-diabetes diagnosis she learned how her weight was affecting her health and she worked with a nutritionist to lose seven pounds.

In the collaborative she was encouraged to set goals for herself and have a clinical team to support these goals.

The prevention component of the collaborative emphasizes weight loss and 150 minutes of exercise per week.

Evidence has been noted today by the NIH study has found this type of lifestyle change is effective.

A significant part of our collaborative within months of the announcement from the NIH study the integration of these results were included in the care of our patients in our health centers, a pretty phenomenal outcome.

Attention to the risk for diabetes and screening for pre-diabetes is important at the health centers because we care for many women in the child bearing years. Promoting -- the final story illustrates another important factor contributing to the quality of care with women from diabetes.

A culturally sensitive environment where competent care can be delivered is central to the health disparities collaborative.

Mrs. M is 73, Chinese woman with no insurance.

She also has type 2 diabetes, high cholesterol and hypertension.

She came to the health center in Honolulu with members of her family to see a nurse practitioner who is also Chinese.

At the self-management visit her family said now we understand my mom's illness we'll help her to work together and make her better.

She's now doing lifestyle changes by doing exercise three times a week and incorporates all the components of the diabetes collaborative.

The components demonstrate the multiple components necessary to achieve the success in women's improving health in women with diabetes.

It requires knowing which patients have an illness or need preventive services.

Delivery of evidence-based care and actively involved the patients and their families.

After four months Mrs. M had lost eight pounds and had significant reduction in her cholesterol and hemoglobin, a pleasure of blood glucose control.

This reduction in hemoglobin can cause a reduction in mortality, heart attacks and stroke.

Mrs. A's family is pleased with the care and recommends the center as a place for great diabetes and blood pressure care.

It's an example of how women are often the gate keepers for health care for family members at the community.

Through effective care management, women with diabetes in a HRSA-supported center have a better chance of leading healthier lives.

It is a challenge and a goal for our health centers to be the model for the primary health care in the United States.

You can see from these stories that we have systems in place to reach this goal.

Thank you.

[APPLAUSE]

>>FRANCINE KAUFMAN: Thank you so much.

And our next speaker is Carol Guber, a lecturer and author.

She was diagnosed with type 2 diabetes in 1998.

She does boxing.

Be careful.

She'll speak on implementing clinical information into an action plan that produces long-term lifestyle changes.

>>CAROL GUBER: Thank you.

Well, I'm so excited to be here today because when I'm writing at home in New York City, I feel like I'm the only person who has diabetes in the world.

And when I'm taking my blood sugar every morning or making the decisions about what I'm eating, I feel like it's only me.

So to connect with other people and to communicate what it feels like and also to present my action plan makes a real difference.

As Fran said I have type 2 diabetes.

I'm the fourth generation in my family to have type 2 diabetes.

It wasn't until I was doing research for my book on diabetes that I found out that my great grandmother had died of complications related to diabetes.

But she seems like somebody from some distant time.

I'm here dealing with my own diabetes and that of my mother, who has severe complications.

My mother can hardly see anymore.

She had a heart attack and no one knew it.

She's an encyclopedia of problems related to diabetes.

For years I taught at New York University in the Department of Nutrition.

So I come armed with all this information.

And I also come armed with a belief that why did it happen to me?

Well, it did and I've come up with five steps to do something about it.

In doing that, I've had to look at, really, how could I make my life different than my mother's?

And my mother, who has all these complications, all she wants to do now is sit in her uncomfortable chair, as she calls it, in Philadelphia.

I feel like I'm at the top of my game.

I've lost over 40 pounds and that's no small matter.

I do real boxing, among other things, in order to keep myself really healthy.

So in looking at this, I've decided that the most important thing is that I become an activist for my own health.

That I can't assign my power to anybody else.

I think sometimes women related to medical treatments tend to think somebody is going to come along and save them.

I thought the white knight would come and save me from everything in life.

It doesn't happen that way.

We have to be the activist.

It's what my determination has been.

I say to myself, how many I going to be the activist?

I have to get out of my chair and do something about it.

So in 1998 when I was diagnosed, I unzipped my life and decided to take steps.

What did I do?

The first thing is looking at my mother, I realized that this wasn't some short-term event.

That I was going to have diabetes the rest of my life.

It wasn't about some great little diet that was going to have me get into the dress for the wedding coming up, it was about how is it going to lead the rest of my life?

In looking at that I came up with a plan that worked.

And I also realized that small changes could make a difference.

I didn't set out to lose -- I'm about to lose 45 pounds.

I'm just at that level now.

I didn't set out to do that.

What I did was set out to lose the first five pounds.

I didn't set out to start boxing and work out as vigorously as I do.

I started by doing small changes.

By walking three times a week.

I always say a random road leads nowhere.

I had to come up with a plan.

That was the beginning of my plan and I added to it week by week until now I work out six days a week for at least an hour to two hours.

Mainly because I enjoy it and I've become quite a gym rat.

The other thing is that I had to reassess my priorities and I think women tend to be the caregivers and assign over to other people the top priorities.

I decided my health and my well-being was the top priority.

The other thing was I became fierce about my well-being.

If my son was upset or needed care I would have done anything.

I decided, I had to start taking care of myself with the same fierceness.

And here is the most important thing was I stopped blaming myself for my diabetes.

And I think that's critical.

Because women tend to blame themselves for everything.

My mother says that everything is her responsibility or she feels guilty for everything in life except for the atom bomb, which is her friend Blanche's fault.

I wasn't going to feel guilty.

I was going to make changes.

My commitment is that not only will I make these changes but I communicate them to other women so that we're all connected in a way that we can all make a difference and don't end up with the really severe complications that my mother has.

Thank you so much.

[APPLAUSE]

>>FRANCINE KAUFMAN: I would like to thank the panel for truly illustrating that with the appropriate strategies and support, this complex management issue around diabetes can actually occur to the optimum health of those people involved.

Now I think we have some time for questions if anybody has any.

>>AUDIENCE QUESTION: I'm Susan Wood from the Food and Drug Administration.

I have a question for all of you.

But speaking primarily about the health care system programs at HRSA and the City of Asheville.

What were your biggest barriers in terms of being able to set these kind of programs into place.

It sounded easy but I know it wasn't.

I just wonder if you identify what were the key challenges.

>>JOHN MIALL: I think the single largest challenge may have been to incorporate physician support by empowering pharmacists to do some hands-on care.

There was actually some early resistance.

What we found instead after just even one or two years was a very high level of physician support for our program.

We recently had a young lady that came to work for us and told us that her doctor, who is one of the endocrinologists in town, suggested she get a job with the City of Asheville so she could take part in the program for diabetics. I think it's been a challenge.

We found you can integrate and coordinate all those pieces.

We have a health care system in this country right now that is second to none in terms of the capacity to provide care.

That it is disjointed and not knitted together in a good fabric to support people and their diseases is the challenge before us.

>>SUZANNE FEETHAM: For HRSA the major factor is the partnerships that we developed and that we followed a standard and developed care model which, as I mentioned, has multiple components.

As I visit the centers, the enthusiasm, they know they are providing the best care possible for their patient and family, it's very significant to them.

As we mentioned, the family and center focus is a very important component of this but also the fact that we use evidence-based care is important.

That we have designed the care delivery system to focus on patients and families, not just for the benefit of the time of day for the providers.

That we have some partnerships with our local government and community organizations and that's important.

It's a very multi-faceted total system delivery change.

It isn't just one aspect of the care of patients.

The outcomes you could hear in the stories from our patients and families, but also our providers are very excited about being part of this program.

>>AUDIENCE QUESTION: My name is Kristina with the American Pharmacists Association and I wanted -- appreciate the question that was asked because it does appear with all the data that supports pharmacist.

We spend a lot of our time advocating for medication therapy management services provided by pharmacists.

The barrier is financial.

Right now there are no -- very few ways in which pharmacists are paid.

It's when someone like the City of Asheville takes it upon themselves to pay pharmacists to provide these important patient care services.

We're working right now to include that kind of payment in a Medicare drug benefit.

It is also -- not only educating the other members of the health care team and the patient population in general, but it is also educating the payers for providing health care providers for those services.

>>AUDIENCE QUESTION: With all the different lifestyle changes that you've made, what has the impact been on your family?

>>CAROL GUBER: Well, it's a complicated issue.

I don't want to spill out my whole personal life but it caused a huge disruption in my family.

When I took a stand for myself, it sent shock waves all over the place.

In my family of five siblings, it has had almost no impact.

And it's really upsetting to me because it's sort of me and my mom and while everybody is worried about my mother and I guess there is some concern about me, I don't think that it makes the same difference.

It doesn't have the same impact until it happens to you.

And it's affected my mother in so many ways, yet I think everybody is really proud of me but I don't think that it's caused people to make the lifestyle changes in my family that I would hope they would make.

>>FRANCINE KAUFMAN: Maybe time for one more questions.

>>AUDIENCE QUESTION: Good, I'm always last.

I'm from the American Diabetes Association.

I was interested in the HRSA program.

I've had a chance to look at it.

Most people with diabetes in America do get their care from primary health care physicians and not specialists.

I guess my question would be, given what I think are very good results in the community health centers around the country, what can be done, what might be done to translate some of that collaborative work into the general population of physicians providing health care for people with diabetes?

>>SUZANNE FEETHAM: That's an excellent question and as I mentioned, one of the things we do, we are partnering with private groups and that is a factor. As we engage the physicians and other providers in our work, we're also publishing the results of our work and we're hoping that as that becomes more visible and the outcomes of our centers that we will have more private practice and other groups approaching us.

We are engaging family practice association.

So we hope our model becomes more well-known and people see the potential and benefit to the providers and patients and families by doing this.

>>FRANCINE KAUFMAN: I would like to thank you all and say in conclusion that obviously today is about people with diabetes, women, their mothers, fathers, daughters, sons and the men in their lives as well.

By collaboration and partnership between HHS and all of its agencies, the American Diabetes Association and the will to truly go forward to inform the American public, our elected officials so that we can improve the outcome of people with diabetes and one day truly find the prevention and the cure.

Now we're going to have some more PSA's thank you.

[APPLAUSE]