

2022



BLACK WOMEN'S  
HEALTH IMPERATIVE

# NATIONAL DIABETES AGENDA



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## THIS AGENDA IS DEDICATED TO FORMER PROGRAM PARTICIPANT

*Helenmarie White.*

Helenmarie joined our lifestyle change program in Maryland, weighing 341 pounds and having a diagnosis of prediabetes. Through the telling of her own story, Helenmarie admitted that she was scared about her declining health and really wanted to change her habits, but she had no idea how to do it or even where to start. Over the years, she had lost some weight before but always gained it back. She also knew her family was very worried about her health. When Helenmarie heard about the program, she decided to give it a try but never intended to stay for the required 12 months, even though having her own lifestyle coach was very appealing. After the first few weeks, she actually started believing that she could make the positive changes needed with the lifestyle coaching and group support the program offered. Helenmarie became one of our most committed and inspiring participants, ultimately losing over 100 pounds applying the positive behavior change strategies she learned during the yearlong program. In February 2021, Helenmarie died from complications related to COVID-19. Thank you for your dedication, Helenmarie.



**BLACK WOMEN'S**  
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## About Black Women's Health Imperative

The Black Women's Health Imperative (BWHI) is a national nonprofit organization dedicated to advancing health equity and social justice for Black women, across the lifespan, through policy, advocacy, education, research, and leadership development. The organization identifies the most pressing health issues that affect the nation's 22 million Black women and girls and invests in the best of the best strategies and organizations that accomplish its goals. For more information, please visit [www.bwhi.org](http://www.bwhi.org).



## About *Change Your Lifestyle. Change Your Life.* (CYL²)

CYL² is a yearlong group-based program in which trained lifestyle coaches teach participants how to make healthier food choices, increase physical activity, and manage stress. It helps participants deal with those elements in their environments that may create barriers to making the desired changes. These positive lifestyle changes help participants avoid hypertension, heart disease, high cholesterol, and numerous other chronic conditions.

## About Reclaim Your Wellness

In early 2021, **Black Women's Health Imperative** and **HealthyWomen**, both leading women's health experts, announced a partnership to raise awareness of obesity as a disease and national health crisis, in a manner that is free of stigma, judgment, and bias.

The multifaceted campaign, [Reclaim Your Wellness](#), is focused on:

- Educating women about the Obesity Continuum of Care
- Ensuring women have access to science-based comprehensive care that ensures patient access for all
- Convening renowned experts to elevate the conversation around underlying causes of obesity and treatments
- Bringing leaders together from across industry to make health, policy, and environmental changes to help reinforce active and healthy living
- Delivering tailored educational and lifestyle content
- Empowering women across diverse communities by providing a platform to share their stories

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*Change Your Lifestyle. Change Your Life.* (CYL²) is a program conducted by the Black Women's Health Imperative through a cooperative agreement with the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.





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## Letter from the President and CEO

Dear Readers:

Among Black women in the United States, diabetes is all too common. Type 2 diabetes, in particular, has grown into a major public health concern, affecting over 12% of Black women and imposing considerable health and economic burdens on patients, their families, and society.

The rising epidemic is a crisis that strikes at the soul of our community. Type 2 diabetes disproportionately affects Black women and girls, who face an uphill battle in preventing the disease. But type 2 diabetes IS preventable! While the inequities brought on by the disease are stark, we have reached a moment when our work at the Black Women's Health Imperative (BWHI) is most critical. We realize that making a difference on this disease will take increased efforts to ensure that every Black woman has the information, best practices, opportunities, and support systems in place to know her risk and protect her health—and for the health care systems that serve Black women to properly care for them.

In the spirit of offering a deeper understanding of type 2 diabetes and proposing solutions, we are pleased to release the Black Women's Health Imperative *2022 National Diabetes Agenda*. The report highlights the range of issues related to diabetes and factors contributing to inequities in risk factors, prevalence, complications, morbidity, and mortality. As you will see, the report also identifies policy gaps and opportunities to close them through action and engagement. We aim to make a difference in Black women's lives through initiatives that reduce the burden of disease, improve health care access and self-care, encourage innovation, and—most importantly—prevent type 2 diabetes.

As we navigate the challenges of type 2 diabetes, know that BWHI is working with passion and determination to promote wellness and a better quality of life. Also know that BWHI will remain steadfast as we endeavor to improve the health and strength of Black women.

We hope you share our true vision for the health and lives of Black women and girls, now and into the future.

A handwritten signature in black ink that reads "Linda Goley Blount". The signature is fluid and cursive.

**Linda Goley Blount, MPH**

*President & CEO*

Black Women's Health Imperative

## Type 2 Diabetes Can and Must Be Prevented

Social determinants of health,<sup>1</sup> including food and housing insecurity and access to quality health care, contribute to health disparities in America. One health disparity the Black Women's Health Imperative (BWHI) addresses through education and lifestyle coaching is type 2 diabetes (T2D)—a disease that if undetected or left untreated can cause other serious health problems, such as heart disease, nerve damage, vision loss, and kidney disease. According to 2020 data from the Centers for Disease Control and Prevention (CDC), 34.2 million Americans have diabetes, and 88 million American adults have prediabetes.<sup>2</sup>

There are thousands of Black women like Helenmarie who can actually make the necessary changes to prevent T2D and potentially save their lives if they have access to the opportunity, resources, and support offered through our lifestyle change program. Many still don't realize that this chronic condition can be prevented, and they assume that, because of family history, diabetes *is* their destiny. Others don't believe they can make the positive behavior changes required to lose the weight. Thousands of women most likely already have prediabetes and don't even know it; unfortunately, far too many women are not screened for it, even though they are at risk.

Recently, the US Preventive Services Task Force recommended that overweight adults should be screened for diabetes beginning at 35 years of age.<sup>3</sup> This new recommendation is five years earlier than previous recommendations. Years of research have shown that if you do have prediabetes, losing at least 5% of your body weight can delay or prevent T2D.<sup>4</sup>

Through the ***Change Your Lifestyle. Change Your Life.*** (CYL<sup>2</sup>) program, BWHI strives to help participants who have or who are at risk for prediabetes avoid T2D. Established in 2012 under the funding and guidance of CDC's National Diabetes Prevention Program, CYL<sup>2</sup> has led to positive weight loss outcomes for participants who have completed the evidence-based program. During the program, many participants experience positive changes related to other chronic conditions (e.g., blood tests, blood pressure, medications) they have as well. While the program is open to all adults meeting the CDC eligibility guidelines outlined in this agenda, BWHI has placed special emphasis on enrolling Black women and Latinas in CYL<sup>2</sup>. CDC recently recognized BWHI as a new distance learning program provider and also approved our adapted curriculum culturally tailored for Black women.

Our vision is to continue to develop this culturally tailored curriculum with the assistance of other Black women, making the program available throughout communities, accessible virtually to those who choose to participate in the program online, and through policy reform to further reduce the onset of diabetes and other chronic health conditions. The program is covered by some public and private insurance payers, including Medicare. There are also BWHI scholarships available. Join us in realizing this vision!

This policy agenda introduces our recommendations for addressing T2D. For example, screening for prediabetes should be added as a component of the *annual well-woman visit* for early detection and prevention, and it should be *covered by private and public health insurers*. Fasting blood sugar and hemoglobin A1c tests should be covered for anyone who is overweight, has a family history of T2D, has had gestational diabetes, or has other risk factors for diabetes.

BWHI also recommends policies that require doctors to screen and refer those who are eligible to federally recognized lifestyle change programs like CYL<sup>2</sup>. We know that community-based organizations play a critical role in program delivery and provide trusted environments for people most at risk for T2D. Proposed legislation targeting *sugary beverages* and *food deserts* will reduce unhealthy diet choices, increase the consumption of nutritious foods, and reduce the likelihood of diabetes. Public health efforts to increase *Black women's participation in clinical trials* will help produce treatments with higher efficacy for those living with diabetes.

BWHI believes that these and other recommendations presented in this policy agenda are steps toward a healthier, more equitable America.

**Angela F. Ford, PhD, MSW**  
Chief Programs Officer  
Black Women's Health Imperative







**BLACK WOMEN'S**  
HEALTH IMPERATIVE

## Black Women's Health Imperative 2022 National Diabetes Agenda

### What Is Diabetes?

**Diabetes** is the condition of having chronic elevated blood sugar (glucose) levels. High blood sugar often shows no outward symptoms for many years, but over time it causes damage to blood vessels and organs that can lead to many complications. As a result, people with diabetes are at higher risk for experiencing damage to their nerves, kidneys, heart, and blood vessels. There are three main diabetes “types.”

#### Type 1 Diabetes

- Sometimes called “juvenile” diabetes, but can occur in adults
- Results from the immune system attacking and destroying pancreatic cells that produce insulin
- Insulin treatment can help patients live healthy lives and avoid many complications
- Cannot be prevented
- Has no known cure

#### Type 2 Diabetes (T2D)

- Most common form of diabetes
- Sometimes referred to as non-insulin-dependent diabetes
- Insulin resistance: The body requires increasing amounts of insulin to regulate blood glucose
- Pancreas cannot make sufficient insulin to keep blood sugar within normal ranges
- Associated with other health issues and complications such as high blood pressure, high cholesterol, heart attack, and depression
- Can be managed with medications
- Can be prevented and potentially reversed with lifestyle changes—healthy eating, physical activity, and stopping smoking

#### Gestational Diabetes

- Similar to T2D but occurs in pregnant women with no previous history of elevated blood sugar
- Women are screened for diabetes at 24 to 28 weeks of pregnancy
- Women with a history of gestational diabetes are at higher risk of future health issues, including T2D

**Prediabetes means your blood glucose (sugar) level is higher than normal, but not high enough to be diagnosed as type 2 diabetes.**





### **Black women are disproportionately burdened by type 2 diabetes (T2D).**

The greatest disparity in subpopulation T2D rates is between Black women and white women; the variation appears to be due to modifiable risk factors.<sup>5</sup> Modifiable risk factors are ones that can be changed, though sometimes not easily. Drinking and smoking, overeating, and lack of physical activity are modifiable risk factors. Obesity is associated with both modifiable risk factors and lifestyle behavioral patterns, and it is a driving factor in diabetes<sup>6</sup> that accounts for most of the differences in rates of diabetes between subgroups.<sup>7</sup> Disparities between white and Black women also extend to health outcomes associated with a T2D diagnosis. (The following data apply to non-Hispanic Black and white adults.)

- Black adults are 60% more likely than white adults to be diagnosed with diabetes by a physician.
- In 2018, Black people were twice as likely as white people to die from diabetes.
- In 2017, Black patients were 3.2 times more likely to be diagnosed with end-stage renal disease (ESRD) compared to white patients.
- In 2017, Black people were 2.3 times more likely to be hospitalized for lower limb amputations compared to white patients.<sup>8</sup>
- Black Medicare beneficiaries with diabetes are more likely to receive lower-quality care<sup>9</sup> and have diabetes-related complications, such as end-stage renal disease, chronic kidney disease, and amputations.<sup>10 11</sup>

Black women with T2D that has progressed to ESRD face disproportionately poor health outcomes compared to white women.

- Black people make up nearly one-third of the half-million ESRD patients in the United States.<sup>12</sup>
- Compared with whites, fewer Black patients with chronic kidney disease receive care from a nephrologist and their rates of referral for peritoneal dialysis and kidney transplantation are significantly lower.<sup>13 14</sup>
- Black women on dialysis are less likely to receive an adequate dialysis dose, have a fistula placed, and achieve target hemoglobin levels—all accepted techniques that would improve survival rates.<sup>15</sup>
- Although kidney transplant is the standard of care for ESRD patients, Black patients are far less likely to have kidney transplant as an available option. Racial disparity in kidney transplant waitlisting persists even after adjusting for medical factors and social determinants of health.<sup>16</sup>
- Black transplant recipients experience poorer outcomes, including higher kidney rejection and patient death, than white transplant recipients.<sup>17</sup>

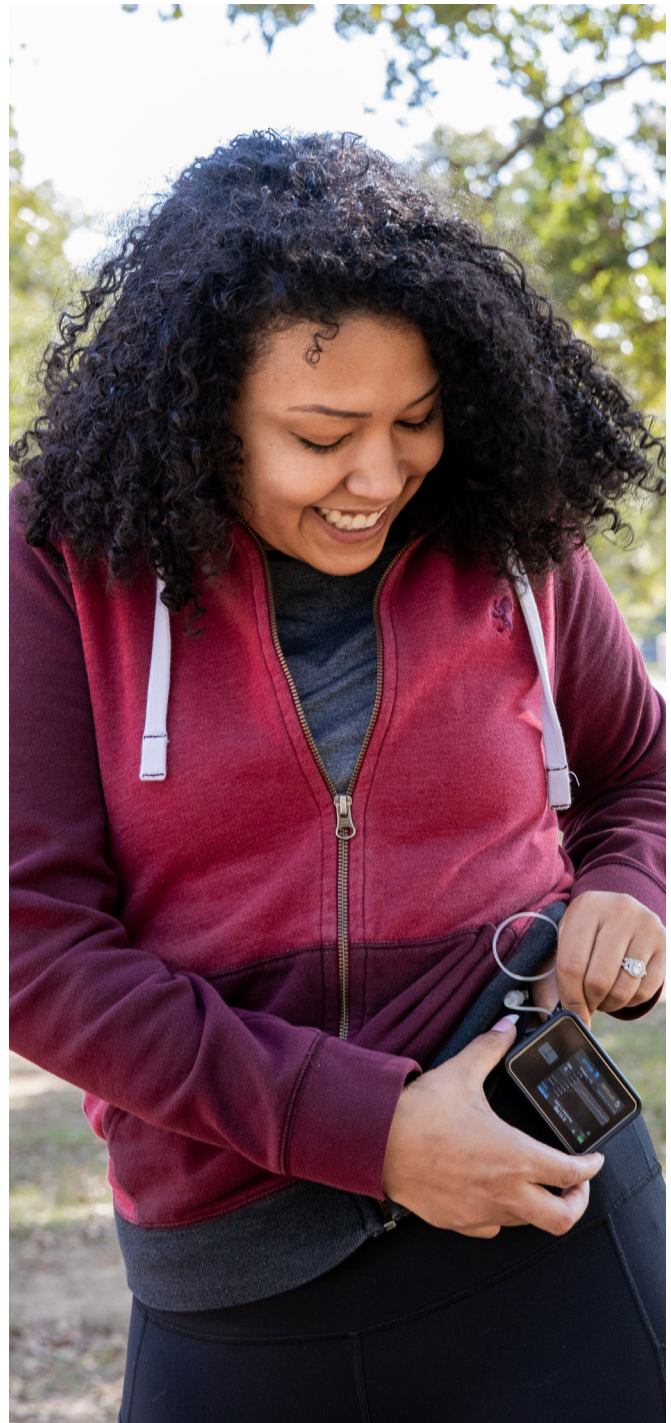
Type 2 diabetes exacts a heavy burden on Black women. However, the condition can be managed, and complications can be minimized with effective treatment and monitoring. Perhaps more importantly, empowering patients with knowledge about their T2D risk and the tools and resources to address that risk can enable them to take better control of their health and prevent T2D.

## The risk factors for developing T2D can be identified and addressed.

Risk factors related to body weight, physical activity, nutrition, and life stressors contribute to the high rate of T2D in Black women. The risk of developing T2D is higher among individuals who are classified as overweight or obese, are 45 years of age or older, have a close relative with T2D, are physically active fewer than three times a week, or have had gestational diabetes.<sup>18</sup> Most of these risk factors can be mitigated, but too many Black women who are at risk for T2D are not aware that it can be prevented.

**Overweight and Obesity.** High weight raises a person's risk for T2D, stroke and heart disease.<sup>19</sup> The two most common ways to determine obesity and overweight are by calculating the body mass index (BMI) and measuring waist circumference.<sup>20</sup> Waist circumference is an important measure.<sup>21</sup> BMI is a measure that takes into account both body height and weight and provides ranges for overweight and obesity, as well as underweight.<sup>22</sup>

- Black women have the highest rates of obesity and overweight of any US group—80%.<sup>23</sup>
- In 2018, non-Hispanic Blacks were 1.3 times more likely to have obesity than non-Hispanic whites.
- In 2018, Black women were 50% more likely to have obesity than white women.
- From 2013 to 2016, Black women were 2.3 times more likely to be overweight compared to white women.
- People who are overweight are more likely to suffer from high blood pressure, high levels of blood fats, diabetes, and high LDL cholesterol—all risk factors for heart disease and stroke.
- In 2018, Black individuals were 20% less likely to engage in physical activity as compared to whites.<sup>24</sup>





**Gestational Diabetes.** Gestational diabetes is, in and of itself, a serious health condition that can compromise the health and lives of women and their babies. The health threat for both mother and newborn remain after childbirth and resolution of the gestational diabetes. For Black women, the risk of developing T2D is almost 10 times greater if they have had gestational diabetes, compared to six or seven times higher for other racial and ethnic groups. Even the child is at increased risk of developing T2D later in life.

**CYL<sup>2</sup> Participant Corine, Los Angeles**

“Prior to joining *Change Your Lifestyle. Change Your Life.*, I had a history of gestational diabetes and also my mom had type 2 diabetes. Since the class was offered at work and I have been on a health journey myself, the program was perfect for me. I've lost 70 pounds. So it has been very motivating.”

**Fat Distribution.** In addition to body weight, the location of body fat within the body plays a role in the development of T2D.<sup>25</sup> People who carry their excess body fat mostly in the abdomen (sometimes referred to as “apple” shape) are at a greater risk than those carrying weight in the hips and thighs (“pear” shape). A waist measurement above 35 inches (88.9 centimeters) is associated with increased risk in women.

**Physical Activity.** Physical activity helps keep weight down and uses up blood glucose. It also makes your cells respond better to insulin. Little or no physical activity each day increases your risk of T2D. The CDC recommends that adults attain at least 150 minutes of moderate-to-vigorous intensity physical activity per week.<sup>26</sup> Build up gradually if you haven't been active. Physical activity is one of the best ways to prevent diabetes. Walking counts!

**Blood Lipid Levels.** Blood lipid levels (or blood cholesterol) also affect diabetes risk. T2D is associated with high levels of LDL (low-density lipoprotein) and triglycerides and with low levels of HDL (high-density lipoprotein) cholesterol—the “good” cholesterol. Black women have a higher incidence of high LDL (33.6%) than white women (32%), white men (29.4%), and Black men (30.7%).<sup>27</sup>

Black patients are more likely than white ones to have cholesterol levels within the highest risk category for heart disease and diabetes, and less likely to be using lipid drug therapy, taking high-efficacy statins, and receiving care from a subspecialist.<sup>28</sup>

**Chronic Stress.** Research shows that prolonged exposure to stress, including stress from coping with perceived racism, may produce higher levels of a hormone called cortisol. In Black women, cortisol—a stress hormone—is thought to lead to higher rates of obesity that drive development of T2D. Obesity also increases the risk of heart disease and other chronic illnesses.



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For as long as we can remember, diabetes has existed in African American families. Until recent years, it was often believed that diabetes was our destiny.

We at BWHI proclaim that diabetes is **NOT** our destiny, and we must feel empowered to break the family cycle through treatment and self-management of diabetes and adoption of healthier lifestyles.

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It is not always possible to eliminate or reduce the real-world experiences leading to chronic stress, but awareness that stress affects health can help people identify their modifiable and nonmodifiable stressors—and take steps to reduce the long-term risk to their health.

**Prediabetes.** Prediabetes is a condition where a person has high blood sugar levels that are not yet at the level for a diabetes diagnosis. Prediabetes, like diabetes, can increase a person's risk for heart disease and stroke. Many people who have prediabetes will go on to develop diabetes if it is left untreated. However, the majority of people with prediabetes do not know they have it.<sup>29</sup>

**Being diagnosed with prediabetes is a warning to change your lifestyle and an important opportunity to act to prevent T2D and the complications that can arise as a result.**

A diagnosis of prediabetes is modifiable, meaning that it can be changed. A person who has any of these risk factors can use a combination of changes in diet, exercise, and medication to lower their risk of developing prediabetes and T2D.

Some risk factors for developing T2D, like family history, polycystic ovary syndrome, or a previous diagnosis of gestational diabetes, cannot be changed. People with those nonmodifiable risk factors should be screened for diabetes and risk of developing diabetes on a regular basis—and pay close attention to their controllable risk factors.







## **BWHI is committed to reducing the burden of type 2 diabetes on the health and lives of Black women.**

Each year, approximately 80,000 Americans die from complications of diabetes.<sup>30</sup> This policy agenda focuses primarily on T2D, which affects one in every four Black women ages 55 and older and one in 10 people in the US general population.<sup>31</sup> CDC recently reported that fewer individuals are being diagnosed with T2D each year, but the decrease in newly diagnosed cases is mainly among white adults. Diabetes has continued to rise among young adults and in communities of color.<sup>32</sup>

The lived experience of Black women and girls in the United States drives disparities and inequities throughout the T2D disease trajectory—from risk factors and disease prevalence through increased disease severity, complications, morbidity, and

mortality. As a national thought leader for Black women's health, BWHI is committed to highlighting important issues, raising awareness about their impact on Black women, offering resources Black women can benefit from, and recommending policies that we believe can make a difference. BWHI's diabetes policy agenda identifies issues that are particularly likely to have an impact for Black women and girls seeking to prevent or manage T2D.

Our policy recommendations are outlined throughout this document and are aggregated in Appendix A. These recommendations were crafted to drive meaningful change in diabetes prevention, treatment, and self-management that will improve the health and lives of Black women and their families.

**Screening for prediabetes and diabetes risk is essential to empowering Black women with the information and tools they need to maintain healthy, productive, and happy lives.**

Preventive health care is a critical component of the medical practice paradigm. Under the Affordable Care Act, preventive health care through well-woman visits—including services such as mammograms, screenings for cervical cancer, osteoporosis screening, prenatal care, and other services—generally must be covered for all women with no cost to the patient.<sup>33</sup> A well-woman visit to the doctor might be called a periodic health exam, checkup, annual physical, or health maintenance visit.<sup>34</sup> The checkup includes screenings to detect diseases early (when they are easier to treat), preventive services like vaccinations, and education and counseling to help people make informed health decisions. Most women are getting well-woman visits. According to the 2017 Kaiser Women's Health Survey, 81% of women aged 18 to 64 had a checkup or well-woman visit in the last two years. Higher prevalence was reported among higher-income women, women who reported a good health status, and women with health insurance.<sup>35</sup>

Preventive care is particularly important in reducing the burden of T2D on Black women, their families, and society as a whole. Most people who develop T2D had prediabetes, whether or not they knew it. Since prediabetes does not have clear symptoms, individuals remain unaware unless their clinician identifies risk factors like obesity, follows through with screening, and communicates with the patient on what a prediabetes diagnosis is, what it means, and how the patient can proactively improve their odds of avoiding T2D.

Prediabetes screening involves the testing of asymptomatic, high-risk people to assess whether they meet the criteria for prediabetes or T2D.<sup>36</sup> Research demonstrates that prediabetes awareness has important implications for participation in diabetes risk-reducing behaviors. The hemoglobin A1c test can provide information about blood sugar levels to determine the risk of developing diabetes.<sup>37</sup>

Blood sugar level screenings are not included in the standard guidelines and protocol of a well-woman visit for all women, but they are listed for selective screening in women aged 40 to 70 who have extra weight and for women 13 or older with previous gestational diabetes.<sup>38</sup> (As mentioned in the introduction, the recommended start of the age range is 35 as of 2021.) These limited criteria are missing early-life-course opportunities to prevent

onset of diabetes, and they discourage physicians from adopting T2D screening more broadly to ensure that all patients have the opportunity to reverse course and prevent T2D.

A recent study found that diabetes screening guidelines in the United States that rely on age and weight alone as predictive factors:

- Miss up to half of prediabetes and diabetes cases;<sup>39</sup>
- Deprive patients of early T2D screening that can enable pharmacotherapy and lifestyle modification when they are most likely to ward off T2D and its complications; and
- Miss screening opportunities in other high-risk groups such as women with polycystic ovarian syndrome, along with younger age groups, who are increasingly at risk for diabetes.<sup>40</sup>

Adding diabetes screening to well-woman appointments is particularly important in reducing health inequities Black women experience given that the CDC has identified Black race as an independent risk factor for developing T2D. Early screening should be incorporated into routine wellcare visits for patients with any T2D risk factor, including being Black, overweight, obese, age 45 or older; having a familial history of diabetes; or having a personal history of gestational diabetes.

Gestational diabetes contributes to maternal morbidity and mortality by increasing the risk of hypoglycemia, preeclampsia, cesarean section, and large babies.<sup>41</sup> Continuing insurance coverage of preventive screening for gestational diabetes not only decreases the risk of perinatal morbidity for both the mother and infant but can enable women to avoid developing a future diagnosis of diabetes. Periodically monitoring diabetes risk factors in women who have had gestational diabetes and are still of childbearing age, as opposed to waiting until they are older, can detect T2D early and may enable lifestyle modifications to avoid its development.

Prediabetes and other T2D risk factors may be reversed, and T2D can be prevented by making significant behavioral changes. Unfortunately, patients cannot address health risks unless they are aware of them. Increased early detection of prediabetes by health care providers can provide opportunities to reduce future burden and costs. The long-term benefits of early screening include improving health-related quality of life, reducing medication needs for high blood pressure and high cholesterol, and helping people avoid missed workdays.

| POLICY/FINDING   | RECOMMENDATIONS   |
|--|---|
| <b>Screening for prediabetes and diabetes risk is essential to empowering Black women with the information and tools they need to maintain healthy, productive, and happy lives.</b> | Increase clinical screening for detection of prediabetes and diabetes by adding the screening to the annual well-woman visit and prenatal visits. These preventive care services should be fully covered without patient out-of-pocket costs. |
|  | Hemoglobin A1c, in addition to fasting blood sugar tests, should be covered by insurance for anyone who is overweight, has a family history, has had gestational diabetes, or has other risk factors for diabetes.                            |
|  | Continue insurance coverage of prevention screening for gestational diabetes.   |
|  | Screen all women diagnosed with gestational diabetes for type 2 diabetes, starting soon after their delivery and subsequently at regular intervals.   |

### **Diabetes prevention should be a focus for all prediabetes patients.**

For the millions of US adults diagnosed with prediabetes, the good news is that progression to T2D is not inevitable. It is possible to bring blood sugar levels to the normal range and prevent progression to T2D through a combination of maintaining a healthy diet,<sup>42</sup> controlling stress levels,<sup>43</sup> getting enough sleep at night,<sup>44</sup> and increasing physical activity.<sup>45</sup> Obesity and diabetes are interconnected; however, individuals can make minor improvements in the present that can improve the trajectory of their health and well-being in the future. Losing 5% to 10% of body weight can reduce the risk of T2D.

### **Following a treatment plan and making lifestyle changes to include physical activity and dietary changes can curb the path of the condition. Even small modifications can have a significant impact and possibly delay or eliminate the prospect of diabetes.**

The NIH-funded Diabetes Prevention Program (DPP) research study examined whether losing modest amounts of weight through improving diet and increasing physical activity could prevent or delay T2D in people at high risk for developing the disease. With more than 3,000 participants enrolled, the study demonstrated that weight loss was the most important factor in lowering the risk for T2D.<sup>46</sup> The effect of weight loss on the risk for T2D was the same across the board—regardless of sex, socioeconomic status, race, or ethnicity; however, the effect was the greatest among individuals ages 65 and older. The research demonstrated that ultimately, millions of people with prediabetes can prevent or delay T2D through modest

weight loss. Several DPP follow-up studies have shown results similar to the original research.

The DPP research study was so successful that Congress commissioned the CDC to develop and implement a program intervention, making it accessible to the millions of individuals at risk for T2D, especially those who have been diagnosed with prediabetes. A CDC-recognized evidence-based lifestyle change program can significantly reduce a person's risk of developing T2D. Participation in the programs increases knowledge and changes behaviors, attitudes, and beliefs people have toward their health care, empowering them with skills needed to reach and maintain a healthy lifestyle.

These interventions can also be effective in women with a history of gestational diabetes, because lifestyle change programs provide an avenue to build healthy behaviors and set up long-term changes that improve long-term outcomes. Women who participated in a CDC-recognized lifestyle change program were one-third less likely to develop T2D than individuals who did not join a program.<sup>47</sup> The program can also help lower the risk of having a heart attack or stroke, improve participants' health, and help participants feel more energetic.

CDC's evidence-based lifestyle change program resulted in the 2011 launch of the National Diabetes Prevention Program (National DPP),<sup>48</sup> with BWHI as one of its original national partners. The National DPP has been effective in decreasing the risk of T2D by up to half through promotion of lifestyle changes that include losing at least 5% of body weight and maintaining physical activity of 150 minutes or greater weekly.



**While prediabetes can be managed with medication to prevent progression to T2D, lifestyle changes and relevant activities offered through the National DPP have been shown to be more effective than medication alone in decreasing diabetes incidence.**

Health care providers play a key role in identifying at-risk patients and guiding follow-up toward effective interventions, including the National DPP. One study showed that patients are more likely to enroll in a diabetes prevention program if referred by their provider, so educating providers about the importance of increasing screenings for prediabetes and referring patients to the program is an important aspect of diabetes prevention.<sup>49</sup> Some participants report to BWHI that their health care providers have never mentioned prediabetes to them, so they are surprised when their CDC prediabetes risk test score indicates they are at risk for or may already have prediabetes.

**CYL<sup>2</sup> Participant Jacquelyn, Detroit**

Jacquelyn took the Prediabetes Risk Test and also shared it with her sister. Based on their scores indicating they might have prediabetes, they both asked their doctors for A1c tests. Jacquelyn was surprised that her doctor had never tested her, because she had always been faithful about her screenings. Her doctor said he just hadn't thought about testing her for prediabetes since she had no symptoms. The tests confirmed that they both had prediabetes.

In some cases, patients are referred to the National DPP without being told they have prediabetes, so they are surprised to learn this from the program coordinator who sees it on the physician referral. Program partners have also indicated that many of the health care providers they encounter are simply focused on treatment and not prevention, which leads the participants to believe they are destined to get T2D.

**CYL<sup>2</sup> Participant Deana, Los Angeles**

Dee came to the program upon the referral of a previous group member, who told her that she was living proof that a high A1c result did not automatically put her on a waiting list for diabetes. Dee explained that her doctor had recently told her she had prediabetes and that she'd see her in a few months—after which time she would have type 2 diabetes and then the doctor could prescribe treatment for her at that point.

BWHI and other national organizations have continued to work with the CDC on increasing screening for prediabetes and referral to the National DPP. Informing individuals of their prediabetes status can serve as an effective way to increase patient awareness and can serve as a strong motivator for the lifestyle and behavioral changes that empower them to break the cycle of T2D in their families. Broader outreach and education initiatives would inform communities on the preventable nature of T2D, the importance of detecting T2D risk factors, including prediabetes, and the resources available to help individuals implement lifestyle changes to prevent T2D and enhance life quality.

| POLICY/FINDING  | RECOMMENDATIONS   |
|---|---|
| Diabetes prevention should be a focus for all prediabetes patients. | Increase referral of adults with prediabetes to CDC-recognized evidence-based diabetes prevention lifestyle change programs.                        |
|   | Refer all women with a history of gestational diabetes to the CDC-recognized lifestyle change program.  |
|   | Increase funding for awareness programming and public education initiatives about the prevalence of prediabetes and how to prevent type 2 diabetes. |



## DPP programs need sufficient reimbursement and incorporation of all available tools/ flexibilities to reach patients where they are.

At the policy level, BWHI envisions the National Diabetes Prevention Program being available as a health care benefit through employers and public and private health insurance; increased clinical screening and detection as a covered health benefit; more health care provider referrals to the program; and community-trusted organizations delivering the program to people of color, who are most at risk for T2D. The CDC maintains a national program provider registry on its website as an important resource for both patients and providers.<sup>50</sup> There are almost 1,900 CDC-recognized organizations offering the National DPP lifestyle change program across all 50 states and the District of Columbia.<sup>51</sup> Yet, more programs are needed to adequately reach underserved areas of the country and address the gap in the national infrastructure related to program delivery to priority populations who are underrepresented relative to their disease burden and risk factors.

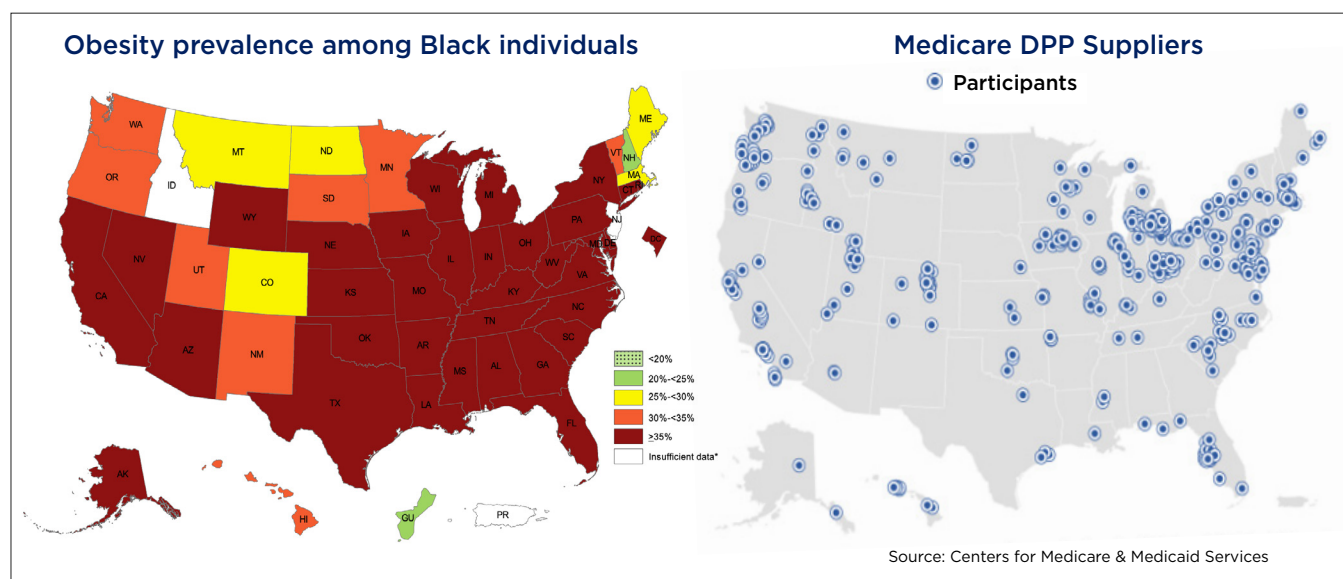
Findings from a study examining the National DPP among diverse and underserved patients within a safety-net health care system showed a large gap between service costs and projected reimbursement.<sup>52</sup> Safety-net system per-patient costs for DPP were estimated at \$800 for the first year, with only 4.7% of participants achieving all DPP program goals. This resulted in a net per-patient financial loss of nearly \$300.<sup>53</sup> Health disparities are likely widened when DPP suppliers find that the program is not financially sustainable in underserved communities. Failing to

accommodate the costs and resources required to address social determinants of health disincentivizes provider participation in high-need, high-risk populations and can all but foreclose access in these communities.

The figures below illustrate the disconnect between geographic areas with highest prevalence (darkest shading) of obesity in Black individuals with availability of the Medicare DPP (blue circles).

The limited set of Medicare DPP suppliers in areas of greatest need is not surprising; the Medicare pay-for-performance mechanism for DPP suppliers was widely criticized as likely to discourage broad program dissemination and widen health disparities related to T2D.<sup>54</sup> These concerns appear to have been well founded. A recent analysis showed that 9 of the 10 states with the largest population of Black and Latinx individuals have severe shortages of Medicare DPP providers.<sup>55</sup> Stakeholders have repeatedly suggested that Medicare reduce the extent to which payments are based on achieving weight-loss goals, and the Centers for Medicare & Medicaid Services (CMS) has responded to supplier concerns by shifting incentives toward participation rather than weight loss and eliminating the second year of DPP services.<sup>56</sup>

BWHI fully supports reimbursement refinements that encourage broader availability of the National DPP for all patients, including Medicare beneficiaries. Adequate reimbursement is essential to, but not sufficient for, meaningful access to the National DPP among Black women.



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## CYL<sup>2</sup> participants have made the important commitment to positive behavior changes that have saved their lives and prevented type 2 diabetes.

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The NIH convened a workshop in 2017 to examine challenges to effectively scaling up successful T2D prevention interventions, including the National DPP, to reach at-risk populations. The goal of the workshop was to better understand how to (1) address socioeconomic and other environmental conditions that perpetuate disparities in obesity and T2D; (2) design effective prevention and treatment strategies that are accessible, feasible, culturally relevant, and acceptable to diverse population groups; and (3) achieve sustainable health improvement approaches in communities with the greatest disease burden.<sup>57</sup> The resulting report noted that:

Interventions in healthcare settings to address obesity and type 2 diabetes-related disparities involve complex considerations at the patient, provider, healthcare system and policy levels. Novel implementation approaches that take account of individuals' social contexts are

necessary for full and sustained achievement of healthy lifestyle behaviors. Although a clinical perspective is considered foundational for diabetes treatment, the traditional clinical context is too narrow to accommodate broader influences on health disparities.

Community-based organizations (CBOs) are often in the best position to understand the unique needs and challenges within their communities, yet they are not clinical entities with sufficient understanding of reimbursement and other elements of starting and operating a DPP. CBOs need and should have targeted assistance to incentivize them to deliver the largely nonclinical DPP, including identification of entities with billing capability, funding to mitigate up-front service delivery costs of recruitment, enrollment, materials, coaches, and marketing by front-end loading more of the payment (e.g., 50% upon enrollment, 25% at Class 4) and targeted grants.







### CYL² Participant, Indianapolis

"I have tried several diet programs and lost weight on all of them. But then the weight always comes back. I now know why. I was always required to work their plan. But this program helps me create and work my own plan. The plan that will work for me. I think I can maintain this!"

### ***Change Your Lifestyle. Change Your Life. (CYL²)***

CYL² is a yearlong group-based program in which trained lifestyle coaches teach participants how to make healthier food choices, increase physical activity, and manage stress. It helps participants deal with those elements in their environments that may create barriers to making the desired changes. These positive lifestyle changes help participants avoid hypertension, heart disease, high cholesterol, and numerous other chronic conditions.

In October 2021, BWHI began its 10th year as a CDC-sponsored National Diabetes Prevention Program (DPP) grantee recipient, working with program affiliates to deliver the program in various cities and states. For the first eight years, our program affiliates offered the program in person, with BWHI providing technical assistance, marketing and communications support, and program oversight and monitoring. In 2020, BWHI became a National DPP distance learning provider, and the CDC approved both our new lifestyle change curriculum culturally tailored for Black women and our application to deliver the program virtually. All of our program partners can now deliver the program virtually to the general population. While we are excited to return to in-person classes, adding this virtual capacity to our provider network makes the program more accessible to those who prefer to participate from home or cannot attend the program in person. Of course, a challenge for many potential participants is the lack of access to the internet or an appropriate mobile device with an affordable data plan, along with skills needed to use the technology.

CYL² is open to all adults ages 18 and older, regardless of race, ethnicity, or gender, with a BMI of 25 or more (23 for Asians), and one of the following:

- Diagnosed with prediabetes
- A history of gestational diabetes
- A score of 5 or higher on the CDC prediabetes risk test ([www.bwhi.org/cyl2](http://www.bwhi.org/cyl2)).

Organizations serving Black women and Latinas, and organizations serving individuals 65 and older are a priority for us, as well as engaging individuals in rural communities who may not have easy access to the in-person program. BWHI is also working with Black men to create a community of support and a tailored virtual lifestyle change program for them.



In partnership with the CDC, we and our program affiliates are working to increase awareness of prediabetes and enrollment in the lifestyle change program, screening for prediabetes and program referral, retention rates for participants, benefit coverage for participation, and CDC-recognized program availability in underserved areas.

As a CDC-designated National DPP training entity, BWHI offers training for new lifestyle coaches and advanced skills training for seasoned coaches. We train master trainers for CDC-recognized providers. We also train seasoned lifestyle coaches in our signature High-Touch Coaching™ model and offer technical assistance to new program providers delivering the program to underserved communities.

Learn more about the virtual program on [our YouTube channel](#).

No matter where individuals are in their weight loss journey, BWHI's lifestyle change program helps participants adopt positive behavior changes that include making healthier food choices, increasing physical activity, and losing weight. Participants also get both individual and group support for the following:

- Emotional wellness and self-care, within the context of lived experience, intersectionality, and participant's reality
- Understanding the relationship between chronic stress, cortisol, and weight
- Dealing with elements in the environment that create challenges to losing weight and trigger unhealthy eating
- Aging and the hormonal impact on weight
- Financial wellness and learning affordable ways to maintain healthy lifestyles

The National DPP is better positioned to reduce the significant health disparities and inequities in prediabetes and T2D by ensuring that DPP suppliers find the program financially sustainable in underserved communities. Solutions include:

- Giving DPP the tools needed to address obesity according to clinical guidelines
- Acknowledging that program "failures" remain at high risk and enabling continued participation with appropriate medical interventions (anti-obesity medications, bariatric surgery) to augment lifestyle modifications
- Expanding coverage and reimbursement for virtual program access to accommodate patient needs for flexible scheduling. These programs should follow a CDC-approved curriculum and be held to the same standards as in-person programs

Sustaining diabetes prevention lifestyle change programs requires the commitment and involvement of all stakeholders. Public and private payers (employers and insurers) can support sustainability by covering the program as a health benefit for their employees and members. All payers should cover DPP services that meet CDC's requirements, including those that incorporate tools such as remote care delivery through distance learning and other interactive models to attract a wider audience such as participants who want group interaction but live in remote areas and cannot attend an in-person program. The CDC's Healthy Communities Program offers this working definition of sustainability:

A community's ongoing capacity and resolve to work together to establish, advance, and maintain effective strategies that continuously improve health and quality of life for all. Sustainability is not just about achieving public health goals; it also relates to concepts such as social justice and socioeconomics.<sup>58</sup>

The CDC also maintains resources to assist organizations in working with payers.<sup>59</sup>

- The *Diabetes Prevention Impact Toolkit* (<https://nccd.cdc.gov/toolkit/diabetesimpact>) is an online, user-friendly, interactive resource for employers, insurers, and states to assess the likely cost effectiveness or cost savings of the program based on the characteristics and risk levels of their employees or members.
- The *National DPP Coverage Toolkit* (<https://coveragetoolkit.org/>) provides information for payers segmented by payer type, including commercial plans, Medicare Advantage plans, and Medicaid agencies and managed care organizations (MCOs).

| POLICY/FINDING  | RECOMMENDATIONS   |
|---|---|
| <p><b>DPP programs need sufficient reimbursement and incorporation of all available tools/flexibilities to reach patients where they are.</b></p> | <p>Create a reimbursement model that more adequately covers the cost for community-based organizations to deliver CDC-recognized lifestyle change programs to people who are most at risk for getting type 2 diabetes. [See additional recommendations specific to community-based organizations (CBOs) in Appendix B.]</p> |
|   | <p>Expand Medicare reimbursement for CDC-recognized evidence-based lifestyle change programs. Increase funding for awareness programming and public education initiatives about the prevalence of prediabetes and how to prevent type 2 diabetes.</p>   |
|   | <p>Expand Medicare reimbursement to include distance learning delivery of CDC-recognized lifestyle change programs.</p>   |





**Health care providers should be better prepared to identify and address T2D risk factors and sufficiently reimbursed to address patient health needs.**

The American Medical Association has identified challenges with managing the prediabetes population, starting with the impracticality of physicians alone being able to address a health problem that affects so many patients, the time pressures that inhibit physicians from effectively delivering the recommended intensive interventions, the inability to address the many social determinants influencing the health of patients outside of the office setting, and the lack of adequate information about community-based resources for T2D prevention.<sup>60</sup> For these reasons, BWHI supports education of health care providers on the available evidence-based lifestyle change programs, along with increased clinical screening, detection, and referral of adults with prediabetes to the program.

A national survey of primary care physicians found that recognition of prediabetes risk factors—and even knowledge of the numeric values that qualify

for prediabetes—was lacking.<sup>61</sup> Less than half of respondents correctly answered questions about A1c tests and fasting glucose levels that would indicate prediabetes. A toolkit offered by the National Diabetes Prevention Program<sup>62 63</sup> includes best practices for reaching physicians with messages about prediabetes and referral to evidence-based lifestyle change programs.<sup>64</sup> The toolkit also recommends processes for connecting patients to the community-based programs.

Primary care providers should be sufficiently reimbursed for the time required for follow-up appointments to help patients prevent or manage T2D. Lack of adherence to diabetes self-management regimens is associated with a high risk of diabetes complications. Research has shown that the quality of the patient-provider relationship is associated with adherence to diabetes treatment.<sup>65</sup> Higher perceived quality of provider-patient communication in patients with T2D has been associated with improved self-management, adherence to diabetes care and greater well-being, perceived personal control, self-efficacy, and less diabetes distress.<sup>66</sup>

| POLICY/FINDING   | RECOMMENDATIONS  |
|--|--|
| <b>Health care providers should be better prepared to identify and address T2D risk factors and sufficiently reimbursed to address patient health needs.</b> | Increase education of health care providers to better prepare them to prevent type 2 diabetes and refer patients with prediabetes to diabetes prevention programs. |
|  | Primary care providers should be reimbursed sufficiently to enable increased time with prediabetes or diabetes patients during follow-up visits.                   |

## High-quality T2D care must be affordable and accessible.

The health implications of a T2D diagnosis can be overwhelming for patients. Disease management is, however, crucial to enable patients to avoid significant complications. Risks can be severe.

**Damage to the kidneys.**<sup>67</sup> Diabetes is the leading reason for kidney failure in the United States.<sup>68</sup> Though kidney disease usually progresses over time, it can seem sudden when it is detected at an advanced stage.

**Cardiovascular disease (CVD).** While many Black women are aware of breast cancer as a health threat, heart disease is the number one cause of death for Black women. T2D is one of the major risk factors for heart disease. Other risk factors include smoking, elevated blood pressure, high blood cholesterol, physical inactivity, high body weight, and a family history of heart disease.

**Stroke.** The damage to blood vessels and nerves due to elevated blood sugar levels can lead to a blockage or a rupture in a blood vessel in the brain—a stroke. People with diabetes are at a 50% increased risk of stroke compared to people who do not have diabetes, and they are much more likely to die after suffering a stroke.<sup>69</sup> Treating diabetes and associated risk factors is helpful in preventing strokes.<sup>70</sup>

**High blood pressure.** Diabetes damages blood vessels, causing blood vessel walls to stiffen and increasing the pressure inside—high blood pressure. High blood pressure, also called hypertension, directly increases the risk of heart attack and stroke.

Rising health care costs in the United States continue to be a challenge to individuals with chronic medical conditions, including diabetes. Health care costs have been on the rise for at least 30 years, and drug prices are a major driver of these costs. For people with diabetes, costs for self-management have remained a near-fatal challenge. Many people diagnosed with diabetes find that they must ration the use of their supplies and prescribed medications. Insulin prices have reached record highs—at least double the prices they were in 2013 (for unclear reasons). Up to 25% of patients prescribed insulin report cost-related underuse.<sup>71</sup> As the price of insulin continues to rise, individuals with diabetes are often forced to choose between purchasing their medications or paying for other necessities, exposing them to serious short- and

long-term health consequences. Capping the price of insulin and related supplies would help patients manage their diabetes and avoid the costs associated with T2D complications.

Nearly three-fifths (57%) of individuals diagnosed with diabetes are insured through a public program, such as Medicare, Medicaid, or the Children's Health Insurance Program, and these programs cover a disproportionate share (66%) of the costs of diabetes. The American Diabetes Association's Insulin Access and Affordability Working Group recommends approaches to this issue from a systems level. These recommendations focus on concepts such as standardized cost-sharing, list price for insulins that closely reflect net price, and health plans that ensure that people with diabetes can access insulin without undue administrative burden or excessive costs.<sup>72</sup>

Diabetes self-management educational programs teach participants who have been diagnosed with diabetes how to cope with and manage their diabetes. These interventions have demonstrated cost-effectiveness by reducing hospital admissions and readmissions related to diabetes. The national standards for diabetes self-management education and training are as follows:

- Self-management education or training is an ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care.
- This process incorporates the needs, goals, and life experiences of the person with diabetes or prediabetes and is guided by evidence-based research.
- The overall objectives of diabetes self-management education and training are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team to improve clinical outcomes, health status, and quality of life.<sup>73</sup>

Diabetes self-management training has been a covered benefit under Medicare for more than 20 years. However, despite the undisputed benefits of diabetes self-management training for people with diabetes—lower hemoglobin A1c, weight loss, improved quality of life, healthy coping skills, and reduced health care costs—only an estimated 5% of Medicare beneficiaries with newly diagnosed diabetes use self-management training services. BWHI supports Medicare changes that will help offset the diabetes self-management training program's delivery costs and enable expanded patient access.

Medicare beneficiaries are covered for a total of 10 hours of initial training within a continuous 12-month period and two hours of follow-up training each year after that, as needed. Currently, to qualify for reimbursement, these diabetes self-management training services must be part of a plan of care prepared by a physician or qualified non-physician practitioner, and the program must be accredited by the Association of Diabetes Care & Education Specialists or the American Diabetes Association.

In addition to self-management training, patients require reliable access to the tools they need to effectively manage their T2D, including test strips. Payers, including Medicaid agencies, have pursued a variety of strategies for providing patients with test strips while reducing overall patient care costs. These strategies have included rebates and competitive bidding mechanisms.

| POLICY/FINDING  | RECOMMENDATIONS   |
|---|---|
| <b>High-quality T2D care must be affordable and accessible.</b> | Expand insurance coverage of diabetes-related programs, resources, and tools to support patients in self-managing their diabetes. |
|   | Cap consumer costs of insulin and supplies in both federal and private insurance programs.  |
|   | Encourage coverage of diabetes test strips by all state Medicaid programs.  |

### **Black women are underrepresented in the clinical trials driving the evidence base for their care.**

Ethical and scientifically sound research requires that any sample population represent the population as a whole. African Americans are often underrepresented in clinical research for numerous historic, societal, educational, and economic reasons.<sup>74</sup> Increased clinical trial diversity helps researchers improve treatments for diseases that disproportionately affect Black women. One of the key reasons we need Black women in clinical trials is to ensure that the discoveries, treatments, interventions, and prevention strategies will be applicable. To create the most effective treatments, it is critical to understand the diseases that affect Black women and how certain drugs metabolize in Black women. Increased clinical trial participation among Black women will help illuminate any differences between subpopulations with respect

to disease trajectory, complications, disease burden, and response to available treatment options.

The barriers to clinical trial participation are complex and likely multifactorial, and include perceptions of and attitudes toward research studies. Black people have historically been taken advantage of, with high-profile examples including the experiments of J. Marion Sims on enslaved women; the exploitation of Henrietta Lacks, whose cells were produced in her name and without her knowledge or consent to develop a series of groundbreaking treatments for polio and in vitro fertilization; and the Tuskegee study, which followed how syphilis progressed in Black men and continued for decades after effective treatments had been identified. These are but a few well-known examples. However, research now is required to be more transparent. We need the participation of Black women to know how well potential treatments work.

| POLICY/FINDING   | RECOMMENDATIONS  |
|--|--|
| <b>Black women are underrepresented in the clinical trials driving the evidence base for their care.</b> | Create and support policies that ensure adequate representation of Black women in clinical trials.                       |
|  | Fund research to learn more about preventive services needed for reproductive-aged women at risk of developing diabetes. |



### Access to healthy food choices is essential to effective prevention and management of T2D.

Healthy diets are important both for primary prevention of diabetes and for managing diabetes. One barrier to a healthy diet filled with fresh fruits, vegetables, and whole grains for some people with diabetes is food insecurity. Food insecurity occurs when a person or family lacks access to adequate nutritious food.<sup>75</sup> This happens due to the lack of financial means to purchase healthy food or by living in impoverished geographic areas devoid of grocery stores with whole, fresh foods.

Neighborhoods that lack access to nutritious foods are also referred to as food deserts.<sup>76</sup> Living in a food desert or in a food insecure household can make managing diabetes difficult. The 10 US counties with the highest food insecurity rates are all at least 60% Black.<sup>77</sup> African Americans experience hunger at twice the rate of white Americans, including one in four African American children.<sup>78</sup> The intersection of food insecurity with Black communities may contribute to high rates of diabetes in Black women. Moreover, food insecurity can compound risk and management of chronic disease. Food insecurity and hunger can also lead to chronic illness and has been associated with mental distress, cancer, pregnancy complications, and having low birthweight babies.<sup>79</sup>

For the most part, food deserts are identified as low-income areas in which a substantial proportion of the population has low access to large grocery stores.<sup>80</sup> A poverty rate equal to or greater than 20% or a median family income of 80% or less of the metropolitan area's median family income (or the statewide median family income) is considered low income. Low-access zones are areas in which the distance to a supermarket or large grocery store for at least 33% of the population is more than a mile in urban areas or more than 10 miles in rural areas.<sup>81</sup>

The range of food policies and initiatives aimed at addressing the issue of food deserts is wide and complex. The bottom line is people need access to healthy food in order to take care of themselves, and health interventions focused on behavioral changes toward healthy choices cannot work without a meaningful opportunity for participants to make those choices.

Sugary beverages contribute to diabetes risk and diabetes management problems. Sugars are digested quickly in the body, leading to spikes in blood sugar. Legislative initiatives targeting sugary beverages reduce unhealthy diet choices.

| POLICY/FINDING   | RECOMMENDATIONS   |
|--|---|
| Access to healthy food choices is essential to effective prevention and management of T2D. | Support bills that increase funding for the creation and support of programs that target food deserts and increase affordability of fresh food. |
|  | Support bills to increase taxation on sugary beverages.   |



## Appendix A: EDGE

### EDGE: Educate, Demonstrate, Guide, Empower BWHI Program Provider Network

In 2016, BWHI established a national program provider network to facilitate the expansion of our lifestyle change program and build capacity for community-based program providers to deliver the program, especially to communities of color.

#### Guiding Principles

- Establish and sustain trust and credibility among network members and others served.
- Always consider lived experiences and realities when delivering the program.
- Work collaboratively and build on existing strengths of membership.
- Develop partnerships and integrate resources partners bring to the network.
- Encourage open and consistent communication among members.
- Build consensus among members and model adaptive leadership.
- Utilize effective adult learning strategies when providing technical assistance and training.
- Offer multiple technical assistance strategies and levels of support.
- Incorporate both evidence-based science and practice-based evidence in technical assistance.
- Offer ongoing evaluation of strategies, technical assistance, and training.

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#### Membership

*\*Founding Members*

##### **Black Women for Wellness\***

Los Angeles, CA

<https://www.bwwla.org>

##### **Perfect Lifestyle**

Houston, TX

<https://mylifestylemed.org>

##### **Fundamental Health Solutions\***

Jackson, TN

<https://www.1healthyplan.com>

##### **Rural Health Medical Program, Inc.**

Selma, AL

<https://rhmpi.com>

##### **Grambling State University**

Grambling, LA

<https://www.gram.edu>

##### **The Wellness Coalition**

Montgomery, AL

<https://www.thewellnesscoalition.org>

##### **Indiana Minority Health Coalition\***

Indianapolis, IN

<https://www.imhc.org>

##### **Urban Health Resource\***

Detroit, MI

<http://www.uhr-uho.org/>

##### **Jackson-Hinds Comprehensive Health Center**

Vicksburg, MS

<https://www.jackson-hinds.com>

##### **Whatley Health Services, Inc.**

Tuscaloosa, AL

<https://whatleyhealth.org>

## Appendix B: Community-based Organizations

Dear Reader,

As the Chair of the BWHI Program Provider Network, I offer a perspective regarding the capacity of community-based organizations (CBOs), like several of our network providers, to successfully carryout the National Diabetes Prevention Program at the current reimbursement level.

It is important to note that the nation should provide an economically sustainable path for CBOs to help deliver this vital preventive health program to people at risk of type 2 diabetes. This is especially true for CBOs that serve populations of color since these populations are not only most underserved but also most at-risk of getting and experiencing the adverse health consequences of diabetes.



Consequently, the BWHI Program Provider Network strongly believes that there must be a reimbursement model that more adequately covers the true cost of delivering the CDC-recognized lifestyle change program while at same time providing incentives and risk-mitigation measures to safeguards the capacity of CBOs to deliver this program.

Specifically, we recommend as to CBOs that the federal government:

- Help mitigate upfront service delivery cost (e.g., recruitment, enrollment, materials, coaches, marketing, etc.) by front-loading more of the payment (e.g., 50% upon enrollment, 25% at Class 4, 15% at Class 9, 5% for 5% weight loss and the last 5% for 7% or more weight loss).
- Recognize that many CBOs that are best positioned to reach, recruit, and serve underserved populations, are not clinical entities. So, care and targeted assistance must be deployed to incentivize these organizations to deliver this non-clinical program in an environment requiring them to acquire or create billing capability. This requirement imposes an enormous risk for CBOs. For example, if Medicare billing is not done properly or if the entity lacks the capacity and experience to successfully meet and carry out all Medicare provider requirements, the entity could be sanctioned, put out of business, or left less well-positioned to carry out its core CBO business.
- Put in place a regulatory or statutory “safe harbor” (or some sort of legal carve out) to protect the ability of CBOs to receive donations and sponsorships from, for example, large health systems that also may simultaneously be delivering DPP, and thus would be a competitor of the CBO if both are NDPP providers. Moreover, clarify that antitrust laws do not preclude a small CBO from competing with, collaborating with, and/or simultaneously receiving sponsor, vendor, and grant support from other entities carrying out NDPP within its market area.
- Require large health systems to partner with CBOs in their market as a condition of CDC full recognition and Medicare Diabetes Prevention Program (MDPP) provider participation. Partnerships among large entities and CBOs to jointly deliver the program provide the best and most practical means to align and marry the benefit of the high capacity of large health systems with the community-centered grassroots reach of CBOs. Such partnerships would create a “win-win” for the community.

In further support of these recommendations, we note that:

- Current pricing models and payment systems do not provide adequate revenue to mitigate the financial cost and risk for “stand alone” CBOs to deliver the National DPP.
- CBOs have the greatest capacity to engage and serve the hardest-to-reach populations but must add considerable new overhead to support the delivery of the program.
- Pay-for-performance models impose additional and substantial incremental “risk burden” on CBOs that is much greater than for their competitors, e.g., hospitals, health systems, and national service organizations.
- Pay-for-performance models require an upfront investment of human and financial capital to deliver the program with no assurance that a provider’s cost will be covered.
- Hospitals, health systems, and national population health companies have a substantial competitive advantage in delivering National DPP services due to their scale, existing infrastructure, and financial resources.
- Their risk burden is minimized as they are in the position to use existing staff to carry out National DPP services on a part-time basis while continuing to provide other fee-based services.
- Small community-based providers have little incentive and marginal ability to compete with large providers.
- If a small community-based provider adds medical billing capability, it, in effect, makes the CBO a clinical organization required to meet a variety of related federal and state requirements.
- If the CBO contracts for MDPP billing through a partner (say a physician practice), it must legally determine whether it or the partner is the MDPP provider. This can potentially affect the CDC recognition status of the CBO.
- Thus, there is a clear and undeniable risk that the current effort to build a “sustainable model” for the program may well leave many CBOs and underserved communities behind unless the reimbursement model and the concomitant policy changes called for above are adopted.

Please know that we would welcome the opportunity to further discuss this national challenge.

Sincerely,

**Carl Ellison**

*President*

Indiana Minority Health Coalition



## Appendix C: Reclaim Your Wellness

In early 2021, Black Women's Health Imperative and HealthyWomen, both leading women's health experts, announced a partnership to raise awareness of obesity as a disease and national health crisis, in a manner that is free of stigma, judgment, and bias.

The multifaceted campaign, [Reclaim Your Wellness](#) is focused on:

- Educating women about the Obesity Continuum of Care
- Ensuring women have access to science-based comprehensive care that ensures patient access for all
- Convening renowned experts to elevate the conversation around underlying causes of obesity and treatments
- Bringing leaders together from across industry to make health, policy, and environmental changes to help reinforce active and healthy living
- Delivering tailored educational and lifestyle content
- Empowering women across diverse communities by providing a platform to share their stories

Obesity affects every system of the body. In addition to diabetes, living with obesity is the root of other diseases, such as cardiovascular disease, some cancers, liver disease, lung disease, heart disease, high cholesterol, high blood pressure, stroke, gallbladder disease, and psychological depression, just to name a few. Obesity has also been named as an underlying health condition which leads to less successful outcomes when contracting COVID-19. This phenomenon is exacerbated by the results of a [2021 survey](#), published by the American Psychological Association, which showed 42% of US adults have experienced undesired weight gain during the pandemic, with an average gain of 29 pounds.

Black women, in particular, are vulnerable to obesity. Studies have shown that Black women, on average, have heightened levels of the stress hormone, [cortisol](#), in their blood stream at any point in time. This changes both the inflammatory and metabolic responses which raises the risk of developing the disease of obesity and obesity-related syndromes.

The partnership and Reclaim Your Wellness campaign provide both organizations with a platform to engage all women, health care providers, and policymakers to understand and address the fundamental relationship between socially and racially mediated stress, the disease of obesity, and other diseases related to obesity.

The program is funded by Novo Nordisk.



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