August 1, 2022

Sarah Boateng
Chief of Staff
Office of the Assistant Secretary for Health
Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Boateng:

On behalf of the Diabetes Advocacy Alliance (DAA), we are pleased to submit comments in response to the **Request for Information: HHS Initiative to Strengthen Primary Care**, published in the Federal Register on June 27, 2022.

The DAA is diverse in scope, with our 28 member organizations representing patient, professional and trade associations, other non-profit organizations, and corporations, all united to change the way diabetes is viewed and treated in America. The DAA works with the Administration, Congress, and other stakeholders to increase awareness of, and action on, the diabetes epidemic. DAA organizational members share a common goal of elevating diabetes on the national agenda so we may ultimately defeat this potentially deadly, but treatable chronic disease. We also believe that, since most adults with prediabetes and type 2 diabetes are people with overweight or obesity, access to the full continuum of care for obesity is another important tool to reduce new cases of type 2 diabetes and to help adults manage their weight over the longer term.

We applaud your focus on primary care and your search for possible HHS actions that may strengthen ways that primary health care can promote health equity, reduce health disparities, improve health care access, and improve health outcomes. We also very much appreciate your interest in primary care's considerable role in addressing prevention and treatment of chronic diseases and conditions.

Low Rates of Critical Primary Care Practitioner Referrals Must Increase for Adults with Prediabetes, Diabetes and Obesity

There is no doubt that primary care practitioners (PCPs) are important to addressing the prevention and management of diabetes and obesity, as PCPs are the primary source of care for most U.S. adults with prediabetes, diabetes, and obesity and the gateway to appropriate referrals to other health professionals, programs, and services. There is evidence that rates of PCP referrals are very low and could be vastly improved. **The DAA recommends that HHS agencies, including CMS, CDC, and NIH, increase outreach to PCPs to increase awareness of vital programs and treatments and help increase rates of referral for their patients with prediabetes, diabetes, and obesity.** This recommendation is consistent with those made by the National Clinical Care Commission in its Report to Congress, discussed below. The DAA notes, however, that there are some structural issues likely affecting rates of referral that have nothing to do with awareness, as PCPs have little to no time in a typical office visit to address more than acute care.

According to the American Diabetes Association, "Primary care practitioners treat 85–90 percent of the 37.3 million people with diabetes, as well as the 96 million people with prediabetes in the U.S." Estimates range from 85% to 90% for the percentage of adults who develop type 2 diabetes who are overweight or obese. Clearly, if improvements are to come in preventing and treating type 2 diabetes and obesity, PCPs will be critical, not only in delivering advice and care, but also in appropriately referring their patients with prediabetes, diabetes, and obesity to effective programs that can improve their health.

For people with diagnosed diabetes, PCPs can help by increasing referrals to Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) programs.

- One study published in 2021 in the *American Journal of Managed Care* examined electronic health records and a statewide health information exchange database in order to review encounters of adults patients with diabetes with PCPs. A total of 8782 adult patients with diabetes with a total of 356,631 encounters were included. The researchers found that while most patient encounters indicated at least 1 type of need for DSMT, **less than 7% of those encounters** in which there was a documented need for DSMT resulted in a provider referral.
- CMS points out in this year's Medicare Physician Fee Schedule that "despite MNT being endorsed by the American Diabetes Association, American College of Cardiology and the National Kidney Foundation, less than 1 percent of the estimated 14 million eligible Medicare beneficiaries have accessed MNT." (p423). Also, in 2013, the Academy Renal Dietetic Practice Group of the Academy of Nutrition and Dietetics surveyed its members regarding the provision of the Medicare Part B benefit to patients with non-dialysis-dependent CKD and found that only 43.9% of renal RDNs indicated they receive physician referrals for their MNT services.

For their adult patients with prediabetes, PCPs need to greatly increase their rates of referral to community-based or virtual diabetes prevention programs that are recognized by CDC's Diabetes Prevention Recognition Program and delivered as part of the National Diabetes Prevention Program (National DPP) or the Medicare Diabetes Prevention Program (MDPP). In an analysis of data from the 2016 National Health Interview Survey of adults who either

reported being diagnosed with prediabetes or gestational diabetes, or who met BMI criteria for prediabetes, **only 4.2% reported ever being referred to a 12-month diabetes prevention program** and only 2.4% reported attending a program. Age was positively correlated with participation, which shows promise for the MDPP, as was race, with Black and Asian adults more likely to report being referred. Also on the plus side: Of those adults who were never referred or participated, **25% indicated an interest in engaging** in a diabetes prevention program. There is an unmet need and a clear imperative to increase awareness among PCPs of the National DPP and MDPP and increase referrals. Though a referral is not required, a recommendation or referral from a PCP for a diabetes prevention program would boost the likelihood of an adult person with prediabetes signing up for and completing a diabetes prevention program.

As for obesity and PCP recognition and referrals, one research study published in *Obesity* in 2018 showed that only 55% of adults with obesity reported receiving a formal diagnosis of obesity and only 24% had a scheduled follow-up meeting with their PCP to continue discussions of weight and weight loss.

It is especially critical for PCPs with **patients with both obesity and diabetes** to understand how to treat their obesity. Since most adults with prediabetes and type 2 diabetes are people with overweight or obesity, access to the full continuum of care to treat obesity is vital to reduce new cases of type 2 diabetes and to help most adults with type 2 diabetes lose weight or maintain a healthy weight in the long term. According to the National Institute of Diabetes and Digestive and Kidney Diseases, the full continuum consists of discussing and offering the full spectrum of treatments that include providing or referring patients to intensive, multicomponent behavioral interventions (USPSTF "B" recommendation, 2018), weight management programs, weight loss medicines, weight loss devices, or bariatric surgery.

HHS Can Support Optimization of Electronic Medicare Records for the Benefit of Primary Care

The DAA believes that much can done to improve the use and optimization of electronic medical records (EMRs). HHS agencies can help by facilitating the use of registries and reports to identify patients eligible for screening/treatment. EMRs can also be optimized so that PCPs are alerted to integrated treatment options that would generate referrals when criteria are met.

Where HHS Can Look for Evidence-Based Actions that Its Agencies Can Take Now

DAA members have been actively promoting the National Clinical Care Commission's (NCCC) Report to Congress, delivered in January 2022, which contains numerous recommendations that HHS agencies can act upon to improve diabetes prevention, treatment, and care. For example, the following recommendation relates to the need for increased awareness of the National DPP to increase referrals and engagement, discussed above:

- **Rec. 5.1 on p. 61:** NCCC recommends increasing support to CDC for its campaign to raise awareness of prediabetes and promote enrollment in the National DPP lifestyle change program

The DAA, along with the Congressional Diabetes Caucus, recently presented a webinar to increase awareness of the NCCC's recommendations on specific actions that Congress, and federal agencies, can take to improve diabetes prevention, care, and outcomes. This webinar is a useful source of background information.

The DAA highlighted many of the NCCC Report's recommendations in a letter sent on July 15, 2022, to the White House Conference on Hunger, Nutrition, and Health. We have embedded the text of that letter at the end of this document for your convenience and reference. Here are some highlights of actions that HHS agencies can take now:

For CMS:

- Support equitable access to Diabetes Self-Management Training (DSMT) for people with diagnosed diabetes.
- Support equitable access to Medical Nutrition Therapy (MNT) for people with diagnosed diabetes.
- Change the out-of-date statutory language that prohibits coverage of anti-obesity medications so that older adults, particularly those populations disproportionately impacted by obesity, have access to the full range of obesity treatment options.
- Provide coverage for hemoglobin A1c testing when used to screen for prediabetes.
- Implement the 2019 American Medical Association-proposed prediabetes quality measures related to screening for abnormal blood glucose, intervention for prediabetes, and retesting of abnormal blood glucose in patients with prediabetes.
- Expand coverage of the Medicare Diabetes Prevention Program to include virtual delivery, make the program a permanent covered benefit (not only a model expansion service), and remove the "once in a lifetime" limit on participation in the program.
- Test new payment models that allow for greater upfront payments and more equitable risk-sharing between CMS and Medicare Diabetes Prevention Program (MDPP) delivery organizations. In addition, there should be an increase in payment levels to MDPP program delivery organizations to make MDPP programs financially sustainable.
- Provide financial incentives for state Medicaid programs to cover the National DPP lifestyle change program and other evidence-based type 2 diabetes prevention interventions that produce successful participant outcomes that meet or exceed those of the National DPP quality standards. This should include coverage of all proven modes of delivery (that is, in-person, online, and distance learning or telehealth) that produce successful participant outcomes.

For CDC:

- Streamline the National DPP recognition process while maintaining quality, and work with CMS to eliminate differences in National DPP and MDPP program eligibility, delivery modalities, and duration.

For USDA:

- Enhance the **SNAP program to both reduce food insecurity and improve nutrition sufficiency**, both of which will help prevent type 2 diabetes and diabetes complications.
- **Leverage non-SNAP feeding programs to prevent type 2 diabetes in women, children, and adolescents** by:

(1) Enhancing Special Supplemental Nutrition Program for **Women, Infants, and Children (WIC)**.
(2) Further harnessing the **National School Lunch and Breakfast Programs** to improve dietary quality; and
(3) Expanding the **Summer Nutrition Programs and the Fresh Fruit and Vegetable Program**.

From reading your factsheet, we understand that "the Office of the Assistant Secretary for Health will use the responses to this RFI to inform the development of an initial HHS Action Plan to Strengthen Primary Health Care and subsequent steps for the Initiative that identify key strategies and priority actions to build a federal foundation for strong primary health care for all." We support you in your efforts to achieve these outputs.

We thank you and your team for the excellent work you are doing to advance health and wellbeing in the U.S., and please contact either one of us if you need more information.

Sincerely,

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(See appended DAA letter to the White House Conference on Hunger, Nutrition, and Health)

White House Conference
DAA Comments
July 15, 2022

Diabetes Advocacy Alliance (DAA) comments to
The White House Conference on Hunger, Nutrition, and Health

Submitted electronically via WHHungerHealth@hhs.gov

On behalf of the undersigned members of the Diabetes Advocacy Alliance (DAA), we are pleased to submit these comments for consideration and inclusion for the White House Conference on Hunger, Nutrition, and Health. It is our desire for the Biden-Harris Administration to review and include our ideas in its policy recommendations before the September 2022 Conference.

Since 2010, the DAA has worked with legislators and policymakers to increase awareness of, and action on, the diabetes epidemic, and more recently, on the relationship of obesity to prediabetes and type 2 diabetes. The DAA's members represent patient, professional and trade associations, other non-profit organizations, and corporations, all united to change the way diabetes is viewed and treated in America. We share a common goal of elevating diabetes and the obesity-diabetes connection on the national agenda so we may ultimately defeat this treatable, but also potentially deadly chronic disease.

We are committed to advancing person-centered policies, practical models, and legislation that can improve the health and well-being of people with diabetes and prediabetes. An essential component to our goal is combatting health disparities and addressing social determinants of health. Our advocacy to policymakers highlights key strategies to prevent, detect and manage diabetes for those affected by it, and create awareness of how obesity relates to prediabetes and type 2 diabetes and the need for access to the full spectrum of obesity treatments. Our educational outreach also illustrates the health equity implications of existing or new policies, regulations, and legislation, and provides alternatives to address the drivers of these inequities. As it relates to the Conference, we work often on issues of health and nutrition to combat diabetes and obesity.

Obesity is strongly correlated with prediabetes and type 2 diabetes and increasingly is seen in individuals in populations that consistently face food insecurity and lack of access to fresh and healthy foods. According to an article in JAMA Network (August 7, 2020), "Women with greater adiposity had higher odds of food insecurity (25%) compared with those with less adiposity (16%)." The Food Research and Action Center says, "While all segments of the U.S. population can be affected by poor nutrition and obesity, low-income and food insecure people are especially vulnerable due to the additional risk factors associated with inadequate resources and under-resourced communities." That's one of many reasons the DAA is concerned with overweight and obesity and why we mention obesity in our recommendations that follow.

Focus for Our Comments: The DAA is commenting in response to questions #1 and #2.

Question #1: How has hunger or diet-related disease impacted you, your family, or your community?

Michele Tedder, MSN, RN, with Black Women's Health Imperative, a DAA member, wanted to share her story with the White House Conference staff team, about the impact of obesity on her life.

“Speaking both personally and professionally I know first-hand the complexities of obesity. I am one of more than 94 million people living with the disease of obesity. Prior to losing and keeping off almost 80 pounds a little over 4 years ago, I was struggling with Type 2 diabetes, joint issues, severe sleep apnea, high cholesterol, and high blood pressure. Without access to a comprehensive treatment plan that included bariatric surgery, lifestyle change support and weight loss medications for maintenance I was fighting a battle that I wasn’t likely to win on my own. As a Black woman, I am also an example of the unequal burden of obesity on communities of color. Obesity increases the risk for developing over 230 medical conditions including:

- High blood pressure
- Type 2 diabetes
- High Cholesterol
- Certain cancers
- Arthritis
- Lipid disorders
- Sleep apnea

Obesity is a complex and chronic disease that can impact every organ and system of the human body. There is no “one size fits all” solution to obesity. People living with the disease must have access to comprehensive, individualized treatment plans for long-term weight management.
The obesity continuum of care must include access to the following:

- Healthy eating and physical activity
- Behavioral approaches and environmental changes
- Obesity medications
- Surgical procedures
- Managing other health conditions

I am living proof that access to these treatment interventions can significantly improve the health and overall quality of life for people living with the disease of obesity. As a result of an effective individualized treatment plan my type 2 diabetes went into remission, my blood pressure medications were literally reduced by 50%, my cholesterol returned to normal, my sleep apnea has improved significantly, and I am more active now than I have been in more than a decade.

At the Black Women’s Health Imperative (BWHI) -- the first and only national non-profit organization created for and by Black women dedicated to improving the health and wellness of our nation's 21 million Black women and girls -- physically, emotionally, and financially, I work with a team of professionals dedicated to eliminating the barriers to wellness for Black women. One of BWHI’s signature programs, Change Your Lifestyle, Change Your Life Program (CLY2) has helped thousands of people not only shed pounds but also prevent prediabetes, type 2 diabetes, heart disease and many other chronic conditions. BWHI also partnered with HealthyWomen.org in 2021 to launch a multicultural campaign called Reclaim Your Wellness to raise awareness of obesity as a chronic disease, reduce stigma, judgment and bias and elevate the voices and stories of women living with the disease of obesity. As a Senior Program Manager at BWHI I find myself in a unique position to not only tell my story, but also to advocate and support a community that shares my lived experience.

I believe through advocacy, education, and policy changes we can impact obesity outcomes in our communities. Hunger and diet-related disease has impacted my life in many ways. It has changed the direction of my life personally and professionally. But it has also given me a passion to ensure that I work to make health equity a reality. My life, the life of my family, my friends and my community depend on it.”

Michele Tedder, MSN, RN
Black Women’s Health Imperative

Question #2. What **specific** actions should the U.S. Federal government, including the Executive Branch and Congress, take to achieve each pillar?

Specific actions that the Administration and Congress could take to achieve each pillar tie very closely to the final report of the Congressionally-mandated National Clinical Care Commission (NCCC)[1], which was delivered on January 6, 2022. The DAA has synthesized the NCCC report recommendations in the chart below which we believe will advance the White House's goals around hunger, nutrition, and health. The NCCC developed evidence-based, actionable recommendations to address (1) diabetes prevention and control in the general population, (2) diabetes prevention in populations at high risk of developing type 2 diabetes, and (3) treatment of diabetes and its complications.

We also wish to call your attention to and emphasize the third column in the chart. You've asked for specific things that can be done, and there are many items in the chart, recommended by the NCCC, that CMS has the regulatory authority to address but has chosen not to. The DAA has communicated with CMS many times over the past few years and urged action on many of these items.

DAA Chart of Specific Recommendations to the White House Conference on Hunger, Nutrition, and Health

Question #2 What specific actions should the U.S. Federal government, including the Executive Branch and Congress, take to achieve each pillar? What are the opportunities and barriers to achieving the actions? Actions should include specific policy and/or programmatic ideas and changes as well as funding needs.

Conference Pillar	NCCC Report Recommendation	Congressional or Executive Potential Action
1. Improve food access and affordability.	**NCCC Report Rec 4.1 on p. 32:** NCCC recommends that the **USDA SNAP program be enhanced to both reduce food insecurity and improve nutrition sufficiency**, both of which will help prevent type 2 diabetes and diabetes complications. **NCCC Report Rec 4.2 on p.35:** The NCCC recommends that **USDA non-SNAP feeding programs be better leveraged to prevent type 2 diabetes in women, children, and adolescents** by: (4) Enhancing Special Supplemental Nutrition Program for **Women, Infants, and Children (WIC)**. (5) Further harnessing the **National School Lunch and Breakfast Programs** to improve dietary quality; and (6) Expanding the **Summer Nutrition Programs and the Fresh Fruit and Vegetable Program**.	**Congress:** Increase funding for SNAP. **Executive Branch:** USDA should implement the NCCC recommendations for non-SNAP programs.
2. Integrate nutrition and health.	**Support equitable access to Medical Nutrition Therapy (MNT) for people with prediabetes and obesity**. Minority populations have long faced chronic disease health disparities due to socioeconomic inequalities and reduced access to health care, healthy foods, and safe places to be active. These same groups are disproportionately	**Executive Branch:** Support Congressional action to expand coverage of MNT to

[1] The National Clinical Care Commission (NCCC) final report may be accessed at https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf

Conference Pillar	NCCC Report Recommendation	Congressional or Executive Potential Action
	impacted by COVID-19. The compounding impacts of systemic inequalities, food insecurity, reduced access to care and now COVID-19, underscore the need to **provide equitable access to medical nutrition therapy in Medicare**. Currently, Medicare Part B only covers outpatient MNT for diabetes, renal disease, and post-kidney transplant.	prediabetes and obesity.
	Support equitable access to Diabetes Self-Management Training (DSMT) for people with diagnosed diabetes. DSMT is an essential component of diabetes management. CMS needs to make changes to ease administrative burdens on DSMT providers and to increase the current low reimbursement rates. **NCCC recommends the following changes to CMS regulations related to DSMT to improve access and engage more people with diabetes (Rec. 6.1 on p. 79):** • Allow the initial 10 hours of DSMT to remain available beyond the first 12 months from diagnosis until fully utilized. • Allow for six additional hours (instead of two hours) of DSMT, if necessary. • Allow MNT and DSMT to be delivered on the same day. • Eliminate copays and deductibles (cost sharing) for DSMT. • Expand the types of providers who can refer for DSMT (for example, podiatrists, specialists treating diabetes-related complications, and emergency medicine physicians). • Allow community-based sites to provide DSMT. • Standardize the data collection required to simplify the process and ensure consistency across DSMT programs. CMS should ensure that all relevant partners including claims adjudicators follow a consistent approach throughout the audit and oversight processes to ensure better alignment with the purpose and scope of high-quality DSMT programs of all types and sizes.	**Executive Branch:** CMS should change regulations related to DSMT as specified in the column to the left. **Congress:** Support passage of the Expanding Access to Diabetes Self-Management Training Act of 2021 (H.R. 5804/S. 2203) in Congress.
	For adults with prediabetes at risk for type 2 diabetes, support equitable access to evidence-based diabetes prevention programs as recognized by the CDC's Diabetes Prevention Recognition Program, part of CDC's National Diabetes Prevention Program (National DPP), and CMS's Medicare Diabetes Prevention Program (MDPP) for Medicare beneficiaries. There are fixes needed to the National DPP and the MDPP to give access to members of populations that are disproportionately affected by prediabetes and type 2 diabetes.	**Executive Branch and Congress:** Actions for each to take are specified in the NCCC recommendations that follow.
	Before listing these recommendations, we note the **strong correlation of obesity with risk for prediabetes and type 2 diabetes and how obesity is a significant factor in the treatment of both.** While in this chart we are focused on NCCC recommendations for improving the National DPP and the MDPP, we also note that	**Congress:** Urge CMS to provide coverage in Medicare for the full range of obesity treatment options,

Conference Pillar	NCCC Report Recommendation	Congressional or Executive Potential Action
	Medicare beneficiaries still lack access to other proven interventions for the prevention and management of diabetes. Since most adults with prediabetes and type 2 diabetes are people with overweight or obesity, access to the full continuum of care to treat obesity is another essential tool to reduce new cases of type 2 diabetes and to help Medicare beneficiaries manage type 2 diabetes. Even though clinical guidelines recommend treatment of obesity through intensive behavioral therapy (delivered by all modalities: community, online and telephonic), pharmacotherapy, and/or surgery, Medicare does not currently cover the full spectrum of interventions for obesity – interventions that are also important to curbing cases of prediabetes and type 2 diabetes.	including anti-obesity medications, which currently are not covered due to statutory language that does not reflect the current evidence base. **Executive Branch:** CMS should change the out-of-date statutory language that prohibits coverage of anti-obesity medications so that older adults, particularly those populations disproportionately impacted by obesity, have access to the full range of obesity treatment options.
	The following NCCC recommendations, if implemented, would significantly increase access to the National DPP and the MDPP, and reduce inequities.	
	NCCC Rec. 5.1 on p. 61: NCCC recommends increasing support to CDC for its campaign to raise awareness of prediabetes and promote enrollment in the National DPP lifestyle change program. • To reach populations disproportionately affected more effectively by type 2 diabetes risk, CDC should use multiple methods including social media to increase awareness of prediabetes and the opportunity to delay or prevent type 2 diabetes.	**Congress:** Increase funding for CDC for outreach to promote awareness of prediabetes and the National DPP.
	NCCC Rec. 5.2 on p. 63: NCCC recommends that the Centers for Medicare & Medicaid Services provide coverage for hemoglobin A1c testing when used to screen for prediabetes.	**Executive Branch:** CMS should implement the NCCC recommendation.
	NCCC Rec. 5.5 on p. 66: NCCC recommends, consistent with provisions of the Patient Protection and Affordable Care Act, that all insurers be required to provide coverage for participation in and completion of a CDC-recognized diabetes prevention program for those who are eligible.	**Executive Branch:** CMS, VA to ensure coverage for evidence-based

Conference Pillar	NCCC Report Recommendation	Congressional or Executive Potential Action
		prevention programs.
	NCCC Rec. 5.6 on p. 66: NCCC recommends that Congress promote coverage for all proven-effective modes of delivery (for example, in-person, online, and distance learning [telehealth]) for evidence-based interventions that produce successful participant outcomes that meet or exceed those of the National DPP quality standards.	**Congress:** Support passage of the Prevent Diabetes Act (H.R. 2807, S. 2173) in Congress.
	NCCC Rec. 5.7 on p. 67: NCCC recommends that the Medicare Diabetes Prevention Program (MDPP) be approved as a permanent covered benefit (not only a model expansion service) and that coverage of MDPP be expanded to include virtual delivery. Furthermore, the "once in a lifetime" limit on participation in the MDPP should be removed.	**Congress:** Support passage of the Prevent Diabetes Act (H.R. 2807, S. 2173) and **Executive Branch:** CMS should make the MDPP a permanent benefit and eliminate the "once in a lifetime" limit on participation.
	NCCC Rec. 5.8 on p. 68: NCCC recommends that CDC continue its efforts to streamline the National DPP recognition process while maintaining quality, and that CMS streamline its payment process for the MDPP. Differences in program eligibility, delivery modalities, and duration between the National DPP (led by CDC) and the MDPP (led by CMS) should also be eliminated or, at a minimum, reduced.	**Executive Branch:** CDC, CMS should implement the NCCC recommendations.
	NCCC Rec. 5.9 on p. 69: NCCC recommends that funding be provided to support the testing of new payment models that allow for greater upfront payments and more equitable risk-sharing between CMS and Medicare Diabetes Prevention Program (MDPP) delivery organizations. In addition, there should be an increase in payment levels to MDPP program delivery organizations to make MDPP programs financially sustainable.	**Executive Branch:** CMS, CMMI should implement the NCCC recommendations.
	NCCC Rec. 5.10 on p. 70: The National Clinical Care Commission recommends that financial incentives be provided for state Medicaid programs to cover the National DPP lifestyle change program and other evidence-based type 2 diabetes prevention interventions that produce successful participant outcomes that meet or exceed those of the National DPP quality standards. This should include coverage of all proven modes of delivery (that is, in-person, online, and distance learning or telehealth) that produce successful participant outcomes.	**Executive Branch:** CMS should implement the NCCC recommendations.

Conference Pillar	NCCC Report Recommendation	Congressional or Executive Potential Action
	The following two recommendations are also important to the diabetes community. **NCCC Rec. 5.11 on p. 72:** NCCC recommends • Funding for the Special Diabetes Program for Indians (SDPI) in five-year increments so that evidenced-based tribal diabetes prevention programs have the resources to (1) sustain the effort to combat diabetes and its complications; (2) develop additional culturally appropriate, high-impact type 2 diabetes prevention interventions; and (3) evaluate outcomes. • An increase in SDPI funding to address inflation costs, which have consumed more than 34% of the program's resources since 2004, the last year Congress increased funding for the Special Diabetes Program. In the future, annual increases in funding should, at a minimum, address the costs of inflation. • An increase in funding to HRSA's Delta States Network Grant Program to allow the program to include type 2 diabetes prevention as a focus. **NCCC Rec. 5.12 on p. 73:** The National Clinical Care Commission recommends funding type 2 diabetes prevention research to discover how to ensure that all individuals at high risk of developing type 2 diabetes can lower their risk for diabetes and its complications.	**Congress:** Support the Special Diabetes Program for Indians, as specified, and increase funding to HRSA, as specified **Congress:** Should provide adequate funds for NIH and CDC research for diabetes prevention funds, as the NCCC recommends.
3. Empower all consumers to make and have access to healthy choices.	**NCCC Report Rec. 4.4 on p. 40:** NCCC recommends that all relevant federal agencies **promote the consumption of water** and **reduce the consumption of sugar-sweetened beverages** in the U.S. population, and that they employ all necessary tools to achieve these goals, including education, communication, accessibility, water infrastructure, and sugar-sweetened beverage taxation. **NCCC Report Rec. 4.5 on p. 43:** NCCC recommends that the U.S. Food and Drug Administration **(FDA) improve its food and beverage labeling regulations** that influence both food and beverage industry practices and consumer behavior to better prevent and control diabetes. **NCCC Report Rec. 4.6 on p. 45:** NCCC recommends that the Federal Trade Commission (FTC) —in order to prevent children's exposure to, and consumption of, calorie-dense and nutrient-poor foods and beverages that can lead to obesity and type 2 diabetes—be provided the authority, mandate, and requisite resources to (a) create guidelines and rules regarding the **marketing and advertising**	**Executive Branch:** HHS agencies concerned with food, nutrition, and health. **Executive Branch:** FDA should implement the NCCC recommendations. **Executive Branch:** FTC should implement the NCCC recommendations.

Conference Pillar	NCCC Report Recommendation	Congressional or Executive Potential Action
	practices of the food and beverage industry and associated communication networks and platforms targeted to children younger than 13 years old, (b) restrict industry practices based on these rules, (c) fully monitor these practices, and (d) enforce such rules. **(*This recommendation is also included in pillar #2 recommendations.*)** **NCCC Rec. 5.1 on p. 61:** NCCC recommends increasing support to CDC for its campaign to **raise awareness of prediabetes and promote enrollment in the National Diabetes Prevention Program (DPP) lifestyle change program**. • To reach populations disproportionately affected more effectively by type 2 diabetes risk, CDC should use multiple methods including social media to increase awareness of prediabetes and the opportunity to delay or prevent type 2 diabetes.	**Congress:** Increase funding for CDC's "Do I Have Prediabetes?" public awareness program and new programs to publicize the National Diabetes Prevention Program
4. Support physical activity for all.	**Please see pillar #2** for information on the National Diabetes Prevention Program (National DPP) and the Medicare Diabetes Prevention Program (MDPP), both of which include physical activity as integral components of these programs.	

We, the undersigned member organizations of the Diabetes Advocacy Alliance, appreciate this opportunity to share information and our perspectives on what actions can be taken by the Executive Branch and Congress to address hunger, nutrition, and health. If you have any questions, please contact Hannah Martin, DAA co-chair with the Academy of Nutrition and Dietetics (hmartin@eatright.org) or Kate Thomas, DAA co-chair with the Association of Diabetes Care & Education Specialists (kthomas@adces.org.)

Sincerely,

Academy of Nutrition and Dietetics
American Telemedicine Association
Association of Diabetes Care and Education Specialists
Black Women's Health Imperative
Endocrine Society
National Council on Aging
National Kidney Foundation
Noom, Inc.
Omada Health
Teladoc Health, Inc.
Weight Watchers (WW)
YMCA of the USA