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No more flying under the radar

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Collaboration as the means to the end

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The famous American baseball player, Babe Ruth, once said about collaborating and teamwork: “The way a team plays as a whole determines its success. You may have the greatest bunch of individual stars in the world, but if they don’t play together, the club won’t be worth a dime.”

As a leader in the fight against diabetes, these words have special meaning to us. No one has a lock on what will slow down or even stop the diabetes epidemic in the US, now affecting 29 million Americans and counting. The epidemic is changing the health of this nation so quickly – one-third of all money spent in Medicare, the US government insurance programme for retirees, is spent on diabetes. 86 million Americans have prediabetes. These numbers show that the problem is going to get worse before it gets better. It’s going to take many different ‘team players’ to put a dent in this public health problem.

When Novo Nordisk started operations in the US 25 years ago, it was with a handful of employees wanting to change the lives of patients with diabetes through our medicines. We knew there was a tremendous market in the US, but something else was concerning. Diabetes was not viewed as a serious disease, treatment options were limited by the science and reimbursement, and healthcare professionals wanted to know more about this disease that was growing in prevalence.

Jesper Høiland in conversation with Mary Baumann from the American Diabetes Association at the launch of Cities Changing Diabetes in Houston, November 2014
We’ve been trying to keep pace with the epidemic in the US ever since. Today, the Novo Nordisk workforce in the US accounts for 16% of our global company’s employees. Our production site in Clayton, North Carolina, our research and development centre in Seattle, our field employees spread across the nation and our home office in Plainsboro, New Jersey are all working in their own way to bring value to the communities we serve.

Collaborating with our communities, with our teams, and with those who have a stake in how this nation confronts diabetes is the only way we will make a difference for patients.

**Taking on the epidemic through partnership**

In this issue of TBL Quarterly, we’ll explore some of our company’s efforts in the fight against diabetes and chronic disease. Now leading in the US region for nearly two years, I see how we must maintain leadership – but not in the same, traditional ‘big pharma’ way.

We’ll start by mapping the problem in the US and how it has grown. Treating patients who know they have the disease is one challenge, but how do you find the undiagnosed when the criteria for screening has been out of sync with the scientific evidence? You’ll read about how our long-standing commitment – and through the strength of a unified diabetes policy community – is bringing change that could help identify millions more patients earlier in the course of type 2 diabetes.

Making change in the US federal government takes extraordinary patience, passion and resilience. You’ll get a glimpse into what one of our lobbyists, Lauren Semeniuk, calls ‘a good week’ when working with federal legislators on behalf patients and Novo Nordisk.

Then we head west to Houston, Texas, one of the communities participating in our Cities Changing Diabetes initiative. This is a unique journey for Novo Nordisk and our local coalition partners who are mapping the diabetes challenge, looking to bring together a large number of stakeholders to learn what’s working and what’s not, and then creating an action plan for the fourth largest city in the US. It is a story about building trust and creating a shared goal that could change policy and practice in this diverse city.

You’ll read about how our Triple Bottom Line business principle fits very well with the concept of Creating Shared Value. It’s an idea in which companies can increase profits, enhance competitiveness, and solve societal issues all at once. Steve Noyes, vice president, Public Affairs, Novo Nordisk US, and Kyle Peterson, managing director at a firm called FSG discuss how this approach has worked for us.

We have a fantastic and committed workforce at our Clayton, North Carolina production site. They really bring their passion for patients to their work and their community, and a lot of work has been done to bring the patient experience closer to everyone there.

"Collaborating with our communities, with our teams, and with those who have a stake in how this nation confronts diabetes is the only way we will make a difference for patients."

And finally, partnership is key to everything we do. In the US, we build those partnerships with organisations and programmes who share some of our priorities, but make a positive impact in communities and patients. Read how our Corporate Giving and Social Impact team uniquely connects Novo Nordisk and local and national communities.

Through this issue, you’ll see that the fight against diabetes is bigger than our company. No single organisation or individual has the answer, and finding solutions doesn’t always mean someone is right and someone else is wrong. Learning from our stakeholders, collaborating with them, and taking a patient first approach will be critical to our business and the patients we serve.

JESPER HØILAND
Executive Vice President
Novo Nordisk US
## Diabetes in the US – how it all adds up

Diabetes affects millions of people in the US and puts a significant economic burden on society – here is a snapshot.

### Today

- **29 million people** have diabetes.
- **234,051 annual deaths** from diabetes are expected today.

### 2025

- **53 million people** are expected to have diabetes.
- **419,100 annual deaths** from diabetes are expected in 2025.

### The Cost

Total cost of diabetes has increased 48% from 2007-2012.

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>2007</th>
<th>2012</th>
<th>Increase</th>
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<tr>
<td>Medical Expenditures</td>
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</tr>
<tr>
<td>Undiagnosed diabetes</td>
<td>$33</td>
<td>$33</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Five states represent 37% of the national cost of diabetes.**

![Chart showing the national cost of diabetes by state](chart.png)

- **California** has the highest cost at $37 billion, followed by Florida ($24 billion), Texas ($24 billion), New York ($22 billion), and Pennsylvania ($13 billion).

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5. Gestational diabetes is a form of glucose intolerance diagnosed during the second or third trimester of pregnancy.
6. Prediabetes is a condition where blood glucose levels are elevated but remain below the diabetic threshold.
No more flying under the radar

A new draft screening guideline for diabetes has the potential to change the diabetes trajectory in the US. Through a diabetes coalition, Karin Gillespie and her team have been part of this journey from the beginning.

On 6 October, 2014, the discovery of cells that form a positioning system in the human brain – the brain’s GPS system so to speak – won the Nobel Prize for Medicine.

It was also the same day Karin Gillespie, Associate Director in Novo Nordisk’s Changing Diabetes Policy team, received the news that the US Preventive Services Task Force (USPSTF) had published a new draft guideline for screening of type 2 diabetes.

Although this piece of news can hardly be compared to a Nobel Prize award, it was according to Karin, “a significant milestone for all of us who have spent several years advocating for policy change to address the growing diabetes challenge.”

The new guideline – when finalised – will change what US healthcare providers look for when deciding who needs to be screened for diabetes. This is great news for millions of people who will benefit from the new approach to diabetes screening and healthcare professionals will have a better chance of steering their patients at risk, or in early stages, of developing diabetes towards appropriate counselling and care. Like a new and improved GPS system navigating the course for diabetes screening.

On the wrong track
In the US, the diabetes epidemic continues to grow in scope and urgency. More than 29 million people have diabetes – equivalent to about 9% of the population – and over 8 million of them don’t know that they have it. The number is even bigger when looking at the population at risk of developing the disease, also known as prediabetes, 86 million. Research shows that less than 12% of them know that their health needs attention.

According to Karin, the situation has been on the wrong track in the past years. “We could see that millions of at-risk Americans weren’t getting screened – and thus not getting the information, intervention and care they need to either prevent diabetes or prevent the dangerous and costly complications of the disease,” she says.

The burden of diabetes is first and foremost felt by people and their families whose quality of life is affected by the disease and who may face serious health complications. But it also puts pressure on society since diabetes and particularly its associated complications are costly to treat.

1 CNN, 6 October 2014, Medicine Nobel prize goes for work on cells that form brain’s GPS system. Available at: http://edition.cnn.com/2014/10/06/health/nobel-prize-medicine-physiology/


3 Prediabetes is a condition where blood glucose levels are elevated but remain below the diabetic threshold.

In 2012, diabetes cost the nation more than USD 322 billion in medical expenses and lost productivity. The large economic burden includes costs associated with diagnosed diabetes (all ages) and undiagnosed diabetes, gestational diabetes, as well as prediabetes (adults). This annual burden exceeds USD 1,000 for each person in the US.6

On top of this, the prevalence of diabetes is projected to grow substantially in the coming decades due to population growth, aging, and increasing racial and ethnic diversity, which will lead to large increases in the associated economic burden.6

Karin knew that it didn’t have to be this way. “Type 2 diabetes is a chronic disease that we know largely how to prevent and manage and screening is the entry point to prevention. But if you can’t find people, you can’t provide care,” she points out.

What was needed was a new approach to screening.

Speaking with evidence…

Multiple factors, including older age, obesity, family history of diabetes, are well recognised as increasing a person’s risk for developing type 2 diabetes. However, the current diabetes screening guideline, published back in 2008, recommends screening only people with high blood pressure. The American Diabetes Association (ADA) guideline recommend screening for adults who are age 45+ and younger adults who are overweight or obese and have at least one other risk factor.

Since these screening guidelines are not aligned, it can be difficult for both patients and healthcare providers to know who and when to screen for diabetes. This results in many people at risk ‘flying under the radar’. Another barrier to comprehensive screening is the Affordable Care Act tying reimbursement for preventive services like diabetes screening to the USPSTF guideline. For example, under the current guideline, less than half of people with undiagnosed diabetes would be eligible for and fully covered for screening.7

In 2011, Novo Nordisk initiated a multi-pronged advocacy effort with the goal to change the federal guideline to align with guidelines from the American Diabetes Association and others that recommend screening based on multiple risk factors.

“A key element of our work was to commission research to build the evidence base for broader screening because the USPSTF’s recommendations are evidence-based,” says Karin. This included working with many colleagues across Novo Nordisk as well as external experts to present the needed research. As an example, research was published in Health Affairs in January 2012, advising the task force to conduct a re-review of the evidence for diabetes screening and consider a broader range of evidence.8

…and with one voice

Another cornerstone of the effort was that Novo Nordisk did not embark on this journey by themselves. Instead, they mobilised the diabetes community, working through a coalition – the Diabetes Advocacy Alliance (DAA) – which is a group of 20 members representing patient, professional and trade associations, other non-profit organisations, and corporations.

Activities of the DAA included attending several meetings with the Agency for Healthcare Research and Quality which oversees the USPSTF, participation in the stakeholder workgroup on diabetes screening, hosting a policy roundtable, writing comment letters and building the evidence base for broader screening.

Their combined efforts culminated in the October 2014 release of the new draft screening guideline. Although Karin admits that it was sometimes challenging to get alignment across so many organisations, the payoff was far greater. Working in unison, they managed to engage the diabetes community and speak with one credible voice about the need to change the screening guideline.

A monumental shift

With the new draft guideline, diabetes screening will be recommended for adults with any one of the following risk factors: above the age of 45, obesity/overweight, family history of diabetes, history of gestational diabetes or polycystic ovarian syndrome (PCOS), or member of an ethnic or racial minority. It is also the first time that the USPSTF recommends screening for prediabetes.

“This represents a monumental shift,” says Karin. “Analysis shows that with broad uptake of the new guideline, nearly three times more are eligible for screening and nearly twice as many adults with undiagnosed diabetes and prediabetes could get detected.”10

It means that tens of millions more people with diabetes and prediabetes could get screened and that health plans will ultimately be required to cover the cost of screening tests with no co-pay. And it means less confusion at the practice level since the new draft guideline is closely aligned with ADA and other guidelines available.

From a societal perspective, the new screening guideline could help change the human and cost trajectory of diabetes. With the new guideline, people with prediabetes...
can benefit from lifestyle intervention to improve their health and people with undiagnosed diabetes receive the information and treatment they need to manage the disease and prevent complications.

“With the new screening guideline, more people with diabetes will know they have the disease and could benefit from our life-changing and lifesaving products and services,” says Karin.

Still work to be done
The final screening guideline is expected to be released and put into effect within the next couple of months and reimbursement is expected to kick in by the beginning of 2017. Although this may mark the end of Karin’s work from a policy perspective, she emphasises that the job is not done yet for Novo Nordisk.

“We now have a company-wide team in place to help not only educate employees about this important policy change and its impact, but also to inform our key stakeholders, such as payers and healthcare providers,” says Karin. “We would like to use our resources to help increase awareness and adoption of the guideline, so that ultimately more people get screened for diabetes, detected, and receive the care they need.”

There is still work to be done to change the course of diabetes, but with the new draft screening guideline, the US is moving along the right track.

GETTING AHEAD OF DIABETES COMPLICATIONS
A new draft diabetes screening guideline will allow for more people at risk – or who have diabetes but don’t know it – to be screened, detected or possibly diagnosed. In this way, they can take steps to improve their health so that they may avoid developing diabetes-related complications.

WHAT’S THE PROBLEM?

29 MILLION PEOPLE HAVE DIABETES BUT 1 OUT OF 4 DON’T KNOW THEY HAVE IT1

86 MILLION PEOPLE HAVE PRE-DIABETES BUT 9 OUT OF 10 DON’T KNOW THEY HAVE IT1

Undiagnosed diabetes may lead to serious health complications like blindness, kidney failure, heart disease, stroke and loss of toes, feet or legs.

WHAT’S THE DIFFERENCE IN SCREENING GUIDELINES?

CRITERIA (2008 SCREENING GUIDELINE)
• HIGH BLOOD PRESSURE

CRITERIA (NEW DRAFT SCREENING GUIDELINE)
• 45+
• OVERWEIGHT/OBESE
• FAMILY HISTORY
• GESTATIONAL DIABETES2 OR PCOS3
• ETHNIC/RACIAL MINORITY

WHAT’S THE POTENTIAL IMPACT OF THE NEW DRAFT SCREENING GUIDELINE?4

<table>
<thead>
<tr>
<th>(Mio. people)</th>
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<tbody>
<tr>
<td>NUMBER SCREENED</td>
</tr>
<tr>
<td>DIABETES DETECTED</td>
</tr>
<tr>
<td>PRE-DIABETES DETECTED</td>
</tr>
</tbody>
</table>

3 Gestational diabetes is a form of glucose intolerance diagnosed during the second or third trimester of pregnancy.
4 Polycystic ovarian syndrome.
4 Analysis by IHS Global insights for Novo Nordisk, November 2014.
On the job in Washington, DC

As a lobbyist, Lauren Semeniuk works at the intersection where patient and corporate interests meet. No day is the same when you work on ‘The Hill’ in Washington, DC, but here is a glimpse into what Lauren calls ‘a good week’.

Thursday, 19 March 2015, 07:00 – The ‘doc fix’
I woke up to a meeting invitation for myself and my colleagues. The topic: Discussion on the ‘Sustainable Growth Rate’ (SGR), to which I immediately rolled my eyes “This again?!”

SGR is a system for reimbursement of physicians and other health care providers, such as nurse practitioners, for treating patients under the nation’s Medicare programme. This is our federal health programme that targets seniors, i.e. 65 years and older. The SGR system is put in place to control spending on physicians. However, with the repeated recommended cuts, many physicians face difficult decisions about continuing to participate in the Medicare system, which would cause a large gap in patient care.

Since 2003, physicians have been battling these reimbursement plummets and consequently warned that they may have to discontinue treating seniors. In 2010, the American Medical Association surveyed 9,000 physicians who care for Medicare patients. About one in five (17%) physicians overall, and nearly one-third (31%) of primary care physicians, responded they currently restricted the number of Medicare patients in their practice. The top two reasons they gave: 1) Medicare payment rates too low and 2) the ongoing threat of future payment cuts makes Medicare an unreliable payer.

To avoid this situation, Congress has had to pass 17 legislative patches since 2003, also known as temporary ‘doc fixes’, to avert sizable cuts – often 20% or even higher – to Medicare provider reimbursement rates. Can you imagine if you were told that next month your paycheck is going to drop by 20%? All this has woven great instability through the Medicare programme – primarily by impacting patients’ choices of healthcare providers, but also just by contributing a long-running, undercurrent of uncertainty to other sector providers in Medicare, from pharmaceuticals to hospitals, as to its overall financial sustainability. Not good at all for those patients who need certainty in access to a physician.

So, here we are with another deadline looming. The current ‘doc fix’ patch is due to expire on March 31.

Thursday, 19 March 2015, 14:00 – A new beginning
But this time the legislative solution was different! Negotiating very delicate compromises, both political parties in Congress were writing House Resolution (H.R.) 2: the Medicare Access and CHIP Reauthorization Act of 2015.

Though not the catchiest title, this legislation would not only stop, but replace the SGR with a new formula – and extend coverage of a health safety net programme for vulnerable children (the Children’s Health Insurance Program, known as CHIP) important to our young human growth hormone, haemophilia, and type 1 diabetes patients, and address some other priorities. I was getting pretty excited - if Congress passed this we would solve several problems in one swoop!

Participating in the US’ democratic process, laws, and culture, I have directly lobbied Members of Congress for eight years. My co-workers and I always make the patient-centric case that Medicare seniors need access to physicians, and also to medicines to treat their diabetes. In fact, strong access and adherence to diabetes treatment ultimately saves money in the Medicare system because diabetes and

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1. The vast majority of Americans and their families of working age receive health insurance through their employer or other arrangements. This SGR formula is not applicable there, only in Medicare.
3. Grassroots is a rather uniquely American advocacy tool. It is entirely voluntary and private if employees participate or not. For more information, see: http://www.actfordiabetes.com/
prediabetes kept in control avoids more costly complications – costly financially and to quality of life.

So, this time at the meeting March 19, my colleagues and I were considering two approaches. First, would we be willing to really elevate our visibility, and tell the Congressional leadership they could count Novo Nordisk publically amongst endorsers of H.R. 2? The crucial questions were how ‘in front’ did we want to be, and would people misinterpret our intentions? Secondly, would we want to activate our ‘grassroots’ system, ACT for Novo Nordisk, and ask employees to send an email to their Representative and Senators asking them to “Vote Yes” on H.R. 2? Amongst ourselves, we thought we had the winning argument that this vote was about stability for patients and health care providers. We proposed the two-pronged strategy to our Executive Team and received sign off to go ahead.

Tuesday, March 24 2015, 09:00
– Working both top-down and bottom-up
The most challenging aspect of this campaign for me was 1:1 lobbying of some budget-conscious Members of Congress to vote for it. Because H.R. 2 was not fully funded, more than a few I talked to were apprehensive about adding to the federal deficit. Not one US Representative to whom I talked to personally – three on this day alone - disagreed that the SGR formula was flawed and needed to be replaced by something more rational and predictable, but they had fiscal qualms. Final passage was not at all a sure thing.

Meanwhile, to me the most rewarding aspect of this campaign was the activism of our employees which our grassroots team, led by my colleagues Sarah Nordstrom, and Amy Thienel, were in charge of. What this means is that messages were crafted and sent from relevant members of our Executive Team to employees to “click and send” those emails. We witnessed the highest ever participation rate amongst our employees: 751 employee alerts were sent to US Representatives and 1,320 employee alerts to US Senators which equals 2,071 distinct emails to “Vote Yes for H.R. 2”.

Thursday, March 26 2015, 16:00 – Final vote in the House; then Senate; then off to White House!
And what was the overall vote? Well, the House passed H.R. 2 by a vote of 392 to 37. Later, the Senate passed it on April 14 by a vote of 92-8. President Obama signed it into law April 16 and is now Public Law 114-10.

I just cannot stress enough how extraordinary this legislative opportunity was and we showed our endorsement early. Though we will continue to rise to challenges with our US Congress on many issues, ranging from intellectual property protections to advancing the diabetes agenda, we will never again have to fight the ‘doc fix’!

### WHY IS LOBBYING FOR H.R. 2 GOOD FOR PATIENTS?

- A permanent fix to Medicare physician payments (SGR) ensuring that Medicare patients have continued access to providers of their choice
- $300m two-year extension of Special Diabetes Program for Native Americans and type 1 research
- Two-year extension of the Children’s Health Insurance Program (CHIP) which is especially critical for young growth hormone and haemophilia patients
- Extension of Childhood Obesity Program which extends a $10 million program, including an important childhood obesity longitudinal study

Lauren Semeniuk first became acquainted with Novo Nordisk when her niece was diagnosed with type 1 diabetes and Lauren wanted to learn more about the disease. In 2007, she joined Novo Nordisk’s Government Affairs team based in the nation’s capital, a short commute from her home in Maryland, where she lives with her husband and their six cats.
We can send a man to the moon, but can we change diabetes?

Houston is home to managing complexity. Since 1961, the city has been the command center for the US space programme, including the historic moon landing in 1969. Sending three men to the moon, and safely getting them back to earth, has earned Houston the nickname, Space City. But solving the problems of space travel is one thing, managing the complexity of the city itself is another.

Houston is the ninth largest city in the US by area.\(^1\) It is four times the size of New York City but with only a quarter of the population. With so much distance between residential and commercial areas, challenges such as auto-dependency, food deserts and a lack of outdoor recreational opportunities, has led to both worsening air pollution and health. As Rice University’s Kinder Institute for Urban Research puts it, Houston has been viewed as “the most sprawling, least dense, most automobile-dependent major city in America.”\(^2\)

In 2012, Houston Mayor, Annise D. Parker, set up mission control to begin doing what Houston does best, solving complex problems.

The state of health in Houston
The high-level health challenges are clear – one in 10 Houstonians has diabetes and one in three adults is obese.\(^3\)

Like many major cities around the world, Houston is not alone in the need to improve urban health. But Houston’s sprawling urban landscape adds a layer of complexity other cities might not face.

According to Dr. Stephen Linder from the University of Texas Health Science Center’s School of Public Health, the overall diabetes prevalence in Houston is 11% but variation across the city is quite large. In some areas the diabetes prevalence is as high as 20% and in others as low as 5%.

In Houston, one in three adults is obese and one in ten has diabetes

In 2012, Houston Mayor, Annise D. Parker, set up mission control to begin doing what Houston does best, solving complex problems.

When Mayor Parker launched the Healthy Houston initiative in 2012, she created a task force to bring to the table innovative ideas and thinking to address the city’s food deserts – where a lack of affordable healthy food contributed to unhealthy alternatives for many residents – and to encourage physical activity in schools, work settings and communities.

Since the launch of Healthy Houston, the Mayor’s office has initiated plans to make the city’s transportation infrastructure more conducive to biking and walking and easier to use public transportation to connect the city’s many suburban areas with the downtown.

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Partnerships and collaborations with like-minded organisations have led to a host of activities, including city wide walking campaigns to networks between store owners to invest in healthy corner stores. One organisation, Children and Neighbors Defeat Obesity (CAN DO) Houston, has been providing education and training to boost the number of urban gardening enthusiasts.

With all boosters in full thrust, the timing was perfect for a rendezvous with a new programme designed specifically to better understand the complexity of urban diabetes.

**Getting a better understanding of urban health**

In the US, an estimated 81.3% of people with diabetes live in cities. Urbanisation is associated with sedentary lifestyles and a changing diet and therefore an increased risk of developing type 2 diabetes. In response, three global organisations with a joint ambition to better understand and take action to reverse the growing prevalence of urban diabetes joined force to launch Cities Changing Diabetes in 2014.

The global programme is a partnership between University College London (UCL), one of London’s leading universities, Steno Diabetes Center, a world leading institution in diabetes care and prevention, and Novo Nordisk, a global healthcare company with more than 90 years of innovation and leadership in diabetes care. Mexico City was the first city that was inaugurated in March 2014, followed by Copenhagen, Houston, Tianjin and Shanghai.

No one organisation and no one company can solve the urban diabetes challenge alone, so Cities Changing Diabetes is built on public-private partnerships between businesses, city leaders and planners, healthcare professionals, academics, community leaders and others with a stake in the outcome.

Cities Changing Diabetes aims to support cities with prevention, care and control of diabetes through three concrete steps. First, the programme partners, city officials and community stakeholders will map the city’s burden of diabetes with a combination of quantitative and qualitative evidence. The body of evidence will provide insights into what’s working today and where are the challenges and the priorities for the future.

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**In the US, an estimated 81.3% of people with diabetes live in cities**
Once mapped, the programme will share the results from the first wave of cities to drive and inform wider action in other cities around the world. New knowledge will be shared continuously so that everyone involved can gain from the experience of others – and create solutions for their own local needs. In November 2015, the Cities Changing Diabetes programme will share findings at the first Cities Changing Diabetes Summit in Copenhagen.

As successful actions are identified, Cities Changing Diabetes will work with city officials and community stakeholders to scale up solutions to tackle diabetes in cities. The hope is a catalyst affect that equips a wide range of partners in taking concerted and focused action on the ground in cities through health promotion and care, as well as urban design.

With Healthy Houston already bringing about change to improve urban health, it was a natural fit for Cities Changing Diabetes to join the efforts and begin mapping the problems and potential intervention points to accelerate better health outcomes.

Cities Changing Diabetes in Houston
On November 3, 2014, Houston became the first US city to join the Cities Changing Diabetes programme. A local partnership was formed with Mayor Parker, Houston’s Department of Health and Human Services, Harris County Healthcare Alliance, the University of Texas School of Public Health, the American Diabetes Association in Houston, Houston Business Coalition on health and Clinton Health Matters Initiative.

The research for Cities Changing Diabetes in Houston will be led by Professor Stephen H. Linder from the University of Texas School of Public Health with support from David Napier from University College London. At the global level, the programme will be supported by UCL, Steno Diabetes Center and Novo Nordisk.

In October 2015, initial data will be available and begin informing strategies that can have the greatest impact on both the prevention and management of diabetes in Houston.

Director of Houston’s Department of Health and Human Services, Stephen Williams, is hopeful that the data collected through Cities Changing Diabetes could be used to create individualised diabetes prevention plans that are tailored to each neighborhood’s unique needs.

“Hopefully the Cities Changing Diabetes programme could lead to concrete actions to help increase healthy eating and exercise, and support Healthy Houston’s ongoing work designed to reduce food deserts and promote the availability of locally-grown foods.”

One thing is sure, if urban living trends continue, the number of people living in cities will continue to grow and so will the challenge of urban health. It’s essential to find solutions now. But the city of Houston, its local leadership, business and organisations are a strong team to begin unravelling the complexity of creating healthy lifestyles for its residents. After all, Space City helped send the first man to the moon.

Watch a video about Cities Changing Diabetes to learn more about what has happened since the programme was launched: http://citieschangingdiabetes.com/2015/03/25/cities-changing-diabetes-turns-1/
Creating Shared Value (CSV) is based on the idea that companies can increase profits and enhance competitiveness by solving societal problems. It was coined by Michael Porter and Mark Kramer in Harvard Business Review¹ and is gaining ground both in business schools and boardrooms, but is CSV more than just an idea? Steve Noyes, Vice President of Public Affairs in Novo Nordisk US, and Kyle Peterson, Managing Director of FSG, think so. Read why as they discuss conceptual implications and concrete examples from the real world.

Seen from your perspective, what is unique about the Creating Shared Value approach? How does it differ from traditional business and CSR?

Steve: I think the shared value approach brings it all together. Traditional business and CSR tend to be more focused on one or the other – separately. However shared value defines the synergies as it combines both objectives into one.

Kyle: I believe shared value builds upon the great thinking and practice of CSR but there is a difference. Shared value is addressing social problems at scale while actually making a profit, so it is a business proposition. Traditional business does not always seek to address an unmet social need, which is not necessarily wrong, but then it is not shared value. CSR has a lot of interpretations but one I refer to most often is when companies are mitigating their negative impacts on society or complying with business ethics standards – of course this is important, but it’s not necessarily creating shared value.

Can the approach transform companies? And do you think it can be applied to companies across different industries and geographical locations?

Steve: Yes, but I think it may be easier for a healthcare company. By the nature of our business, we are doing things that address unmet needs for patients while being profitable. However, since it is the nature of the way we do business we should challenge ourselves to take it one step further. Shared value can transform a company’s thinking and planning to intertwine the social impact and the business opportunity to maximise the impact in both areas.

I think shared value is a very important principle regardless of geography. It can be customised to the local level because it is about understanding the needs of communities and how you can link business opportunities into that. This is very consistent with our company’s Customer Focus Model.

Kyle: Absolutely, I have seen shared value applied in almost every sector, including banking, extractives and certainly pharma and medical device companies. For pharma, it is about moving beyond conventional market share and address new unmet needs. That can be done through development of new products, by making existing products available to populations that have not before had access to them or by making changes in the value chain or the enabling environment. It is about creating new opportunities to address health outcomes.

How is shared value linked to Novo Nordisk’s way of doing business according to the Triple Bottom Line (TBL)2 principle?

Steve: I see shared value as the execution of TBL, which allows for its components not to be seen in silos. Here in the US, I believe that we have not yet realised the full potential of TBL and I think that shared value becomes the bridge between any two of the components. It brings them together in terms of how we execute and implement TBL in our daily lives. Shared value creates clarity, and that is important for setting direction.

Kyle: I agree that shared value and TBL are complementary. What is interesting about Novo Nordisk is that the company has a set of values that intrinsically links business goals to its interactions in society. Not every company thinks this way and making the linkage is one of the toughest obstacles for many. For Novo Nordisk, I think that shared value is about translating TBL to a practice level that brings the principle to life, for example around products or changes in the value chain – it is all about application.

Ideally, in the long run a shared value effort should be led from within the business – how do you suggest to create the necessary foundation for this?

Kyle: I think Novo Nordisk is already doing it to some extent. First of all, by engaging in deep dialogue about what shared value means to the company, how it affects its programmes and how you can move programmes further by taking more of a shared value lens.

Steve: However, it will not be meaningful for us to try and advance shared value as a new concept in itself. We build our business on TBL and the Novo Nordisk Way3 and we can use the shared value thinking as a way to better execute on these to enhance our outcomes.

“Shared value can transform a company’s thinking and planning to intertwine the social impact and the business opportunity to maximise the impact in both areas.”

In which areas do you see potential for Novo Nordisk to generate even greater health and business impact?

Steve: As mentioned, I think we are at an advantage compared to other industries because the commitment to patients is inherent in our business and with that the social value. Working in Public Affairs, we have a great opportunity to embrace this.

As an example, we have been working for 4-5 years to establish a new federal guideline for diabetes screening that is broader in scope and will allow for more patients at risk for diabetes, or who have diabetes but don’t know it, to be screened and detected or possibly diagnosed. This is a perfect example of a shared value initiative – patients at risk can get the information they need to take steps to benefit from lifesaving products and services like those we offer.

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2 Novo Nordisk manages its business in accordance with the Triple Bottom Line (TBL) business principle which is anchored in the company’s Articles of Association. It means that the company strives to conduct its activities in a financially, environmentally and socially responsible way.

3 Novo Nordisk Way is the company’s value-based management system. The Triple Bottom Line business principle is integrated in the Novo Nordisk Way.
Kyle: Novo Nordisk has made great advances in emerging markets like China and Indonesia. Here, I believe there are opportunities to go even deeper and to use some of the insights to tackle new unmet needs, for example when it comes to adherence to improve health outcomes. Another example is the new initiative, Cities Changing Diabetes, which is going very deep and very local to explore barriers in places like Mexico City and Houston. It has the potential to create new shared value.

How is Novo Nordisk collaborating with external partners to generate even greater health and business impact?

Kyle: I think that Novo Nordisk does stand out in terms of being open towards working with partners. For example, I don’t think it would have had success in a place like China without its relationship with the World Diabetes Foundation, the Ministry of Health, the Academy of Sciences and other partners. I also think that Cities Changing Diabetes is going to push Novo Nordisk into new ways of working with partners, where you are not necessarily able to direct, but one among many working together to drive positive change.

Steve: Working with associations, coalitions, and other organisations at both the national and state level simply expand the voice advocating for change. When we collaborate with external stakeholders like the Health and Human Services Department and the federal government, we are able to advance opportunities for improved patient care, which has tremendous impact for our business as well. Specifically, these types of collaborations have had an impact on the diabetes screening guideline and quality metrics work. We believe involving external partners is critical to advancing shared value.

Have you experienced areas where stakeholders in society have opposite interests? Will there not always be areas where companies make decisions that benefit one stakeholder over another?

Steve: Yes, for example our pricing approaches are often being questioned, but what I have learned over the years is that we must always start with the patient. If you approach your day to day work with a patient focus, it will allow you to engage in richer, truer and more meaningful dialogue with your stakeholders who will also help you reach your business objectives.

Kyle: This could be a controversial thought but I think governments can wonder if there is a hidden agenda behind companies, and may not embrace what companies want to do although they have genuine intentions. I don’t think that it is necessarily about opposite interests, but more a kind of scepticism.

Also, I don’t think a company – no matter who it is – can solve all unmet needs at once. It’s incremental and it’s tough because you are always going to be met with new expectations, but that is also what keeps you on your toes.

Steve: I think the devil is in the detail. When you execute and live by a shared value approach you have to balance both the social and the business component. My personal experience is that you can almost always find an overlap if you approach things with an open mind. But it requires negotiations and trade-offs and we need to constantly ask ourselves “are we doing the best we can?”

“For pharma, it is about moving beyond conventional market share and address new unmet needs. That can be done through development of new products, by making existing products available to populations that have not before had access to them or by making changes in the value chain or the enabling environment.”
Health on two wheels

A bike can be a powerful vehicle for change. Novo Nordisk is using its pedal power to raise funds for a cure to type 1 diabetes, inspire people affected by diabetes through an all-diabetes professional cycling team and to promote the health benefits of biking.

BIKING IS GOOD FOR YOUR HEALTH

States with higher rates of bicycling and walking to work also have lower rates of obesity, high blood pressure, and diabetes.¹

People exercise for longer when they are outside compared to at home, work, or a gym.²

The health benefits of cycling outweigh the safety risks by a factor of twenty to one.³

DID YOU KNOW?

In 2013, 16.2 million bicycles were sold in the US (all wheel sizes).⁴

Annual miles bicycled in the US (2009):

8,956,000,000⁵

This is almost the same as the distance from Earth to Pluto and back.

Only 1.0% of all trips taken in the US are made by bicycle whereas 83.2% are made by car (2009).⁶

⁴ Apparent market consumption based on U.S. Department of Commerce import statistics, and estimates of domestic market production by National Bicycle Dealers Association and Gluskin Townley Group, LLC. Available at: http://nhts.ornl.gov/introduction.shtml
⁵ 2009 National Household Travel Survey (NHTS). Available at: http://nhts.ornl.gov/introduction.shtml
⁶ 2009 National Household Travel Survey (NHTS). Available at: http://nhts.ornl.gov/introduction.shtml
RACING TO CHANGE DIABETES

Team Novo Nordisk is a global all-diabetes sports team of cyclists, triathletes and runners, spearheaded by the world’s first all-diabetes professional cycling team. The cycling team competes in major professional races around the world.

IN 2014, ACHIEVEMENTS FOR THE PROFESSIONAL CYCLING TEAM INCLUDED:

8 PODIUM APPEARANCES  151 RACE DAYS

MILLIONS OF PEOPLE AFFECTED BY DIABETES REACHED AT RACES AND COMMUNITY ENGAGEMENT EVENTS

1 MILLION+ FACEBOOK FOLLOWERS – MORE THAN ANY OTHER PRO CYCLING TEAM

RAISING FUNDS FOR A CURE

Every year Novo Nordisk employees hop on their bikes across the US to raise funds for type 1 diabetes research.

ADA TOUR DE CURE 2014
300 NOVO NORDISK EMPLOYEE RIDERS
$72,000 RAISED

JDRF RIDE TO CURE 2014
39 NOVO NORDISK EMPLOYEE RIDERS
$56,415 RAISED

"Why I ride... Because I can! Type 1 diabetes is a lifestyle and not a disease. This is the mind-set I want to share"

Boris Kaushansky, Associate Director, has type 1 diabetes

“Riding for a cause we believe in is a perfect opportunity to show the community we walk the talk at Novo Nordisk.”

Ryan Guite, District Business Manager

NOVO NORDISK’S CEO LARS REBIEN SØRENSEN HAS PARTICIPATED IN THE JDRF DEATH VALLEY RACE FOR 8 YEARS
Closing the gap between production and patient

When you work at a production facility, the end user of the product sometimes seems far away. Employees at Novo Nordisk’s manufacturing site in Clayton are working together to change this.

Located in Clayton, North Carolina lies a building where every day insulin crystals are mixed with chemical stabilisers and ultra-pure water to form different kinds of treatment options for people living with diabetes in North America, Europe, Brazil, Egypt and China.

The building is also workplace for more than 700 people. According to Amy Bryson, communications partner at Novo Nordisk’s manufacturing site in Clayton, they know all there is to know about the production process – quality assurance of the raw materials, aseptic filling of glass vials and cartridges and correct packaging of the finished products – you name it.

“People know all about the engineering process but they did not get an opportunity to understand the patient’s experience with the product and what it is like to live with diabetes,” says Amy. She recalls an event when a colleague from the US headquarters came to Clayton to do a presentation on the diabetes market, and where one reaction from the technical support staff said it all: “You know more about our products than we do, and we make the stuff!”

And then the ball started rolling.

Getting closer to the patient

Amy gathered a group of colleagues and began brainstorming ways that they could increase knowledge among employees about the different products made at the site, and how they impact patients differently. She then drafted a communication plan to increase patient focus and product education throughout the year.

“We wanted to show tangible examples of what it is like to have diabetes from the narrative of a patient and give employees a clearer understanding of how Novo Nordisk’s products benefit people living with diabetes,” she explains.

Amy’s plan called for six patient focus and product education sessions covering topics such as basics about the disease, patient stories and videos, and a presentation of the entire product portfolio. So far, the sessions have had 440 attendees.

Amy highlights that the activities not only help to close the gap between production and patient, but also strengthen the site’s quality mindset and the importance of adhering to standards and codes of conduct to ensure product quality and patient safety. After viewing the patient video, one of Amy’s colleagues responded that “it must simply be impossible not to behave in the right way after watching this video.”

But the work does not stop there. For team Clayton, patient focus is literally about walking the talk.

A walk with one goal

As part of the efforts, Amy and her colleague Sharon Pastirik, who is the chairman of the site’s Social Responsibility Committee and Sean Neally, Director and JDRF One Walk Champion, organised for JDRF to come and talk about their work. JDRF is the leading global organisation funding type 1 diabetes research. This was also an opportunity to encourage employees to fundraise and participate in the local JDRF One Walk, which Novo Nordisk’s manufacturing site in Clayton has participated in since 1996.

Each year, JDRF One Walks bring together more than 900,000 people and raises more than USD 68 million for type 1 diabetes research. The overriding goal is to create a world without type 1 diabetes.

“We had a kickoff event where children of employees who have type 1 diabetes came and talked about what it is like living with diabetes. Their fathers talked about how meaningful it is to work at the site that makes their child’s life-saving medicine. It was very moving to hear their testimony,” Amy recalls.

At the local JDRF One Walk hosted on 25 October, over 240 Novo Nordisk employees and family members turned up, a site record and more than doubling last year’s attendance. In total, more than 6,000 people from the area participated in the walk. And the manufacturing site was able to raise USD 13,400 – making Novo Nordisk one of the top five fundraisers for the area and smashing the USD 10,000 goal set by the site’s Social Responsibility Committee.

1 Formerly known as the Juvenile Diabetes Research Foundation.
2 For more information, see http://www2.jdrf.org/site/PageServer?pagename=about_walk
When competition is thrown out the window

Novo Nordisk chemist, Jienna Pope, was one of the 240 taking part in the October walk. She singlehandedly raised USD 1,000 to support type 1 diabetes research.

“My uncle has type 1 diabetes but found out at a late age and struggled to get control of it until recently,” says Jienna. “I also have a very good friend who has a 4-year-old son with the disease, and it rocked her world. Supporting an event that could change his life and my uncle’s life is very rewarding.”

Jienna has so far participated in three JDRF walks. She also believes that the walks help her become more patient centred because it gives her an opportunity to hear first-hand how diabetes affects patients’ lives and to see how the support gives them hope for a better future. And each year she is positively surprised by the large turnout.

“Some of my best memories from the JDRF One Walks are the unity. Competition is thrown out the window, and we all come together to support a great cause. I remember my 3-year-old son asking me why so many people were there. I told him what JDRF was and what everyone was doing and he said ‘mama, that’s cool’. All I could do was smile and say ‘yeah that’s cool’."

Novo Nordisk employees at the local JDRF One Walk, October 2014
This Q&A features Diana Blankman who is Senior Director of Novo Nordisk’s US Corporate Giving and Social Impact (GSI) team where she and her colleagues work with strategic social investments and partnerships. But how is this related to Novo Nordisk’s business and how do they select which projects to support?

Could you tell a bit about your role and what your team does?
My team works to create partnerships and programmes that align with our company’s business priorities, while at the same time have a positive impact on the lives of our patients and the communities in which we operate. One way we do this is by creating and funding activities around awareness, education and prevention in our key therapeutic areas. These initiatives include advocacy programmes, camps, patient and research conferences and fundraising events at both the local and national level.

We also provide support to community-based initiatives, particularly near our US offices in New Jersey, that focus on the challenges of urban health and wellness. While the programmes we support under this umbrella may not be directly tied to our disease states, they align with the core competencies of our organisation and our commitment to the importance of living and maintaining a healthy lifestyle.

Another key aspect of the work we do is centered on using our resources beyond the dollars we give, to provide an even greater impact. This is in the development of engagement programmes that utilise the hands-on time, talents and skills of our employees.

Why do you engage in these activities?
Novo Nordisk is a leader dedicated to making a difference in the lives of patients. We also want to be seen as an active participant in addressing some of society’s critical issues. This helps to create a more favourable business environment and helps to demonstrate ‘authentic commitment’ whereby we truly ‘walk the talk.’ In GSI, we do this through strategic corporate giving and investing in partnerships that add value to both society and our company.

The GSI team has evolved a great deal over the past four years. We’ve gone from being a somewhat insular check-writing function, to one that is much more strategic, aligned with business priorities and actively engaged with both our internal and external stakeholders. This ultimately allows us to use our expertise and strengths as an organisation to partner with those that share similar objectives and goals. In the context of health and overall welfare of society, our contribution becomes much more than the dollars and enables us to make the biggest difference.
What do your external stakeholders say about this approach?
Expectations from society towards companies are not declining – they continue to rise – but I think our external stakeholders share the understanding that moving from a traditional philanthropy-based approach to one that is more focused on shared value creation is much more meaningful.

I am a firm believer that using our resources in a way that benefits society AND ties directly to our business, is where we can see true innovation and value creation.

What are the challenges with this approach?
At Novo Nordisk, we operate according to the Triple Bottom Line (TBL) principle which means that we take into account the financial, social, and environmental impact of our decision-making. When you look at TBL and the overall concept of shared value, it is about thinking long-term. Ensuring the sustainability of our business is key but we are also concerned with short-term business results in the US market. So it’s a matter of striking the right balance between long and short term. Shared value can be one way to prioritise the work that we do.

What kind of initiatives do you support?
We recently launched our Community Health Collaborative™, a new grants programme designed to support community-based initiatives that address urban health and wellness in Trenton, New Jersey and surrounding communities.

The programme’s launch comes off the findings of an in-depth community-needs assessment in which Novo Nordisk identified two priority areas – Healthy Lifestyle + Built Environment and Access to Healthy Foods – to best align some of our corporate giving with genuine community-identified needs.

Chronic diseases, including obesity and diabetes, are a persistent problem in urban areas and cities. What we saw was that diabetes levels in Mercer and Middlesex counties in New Jersey are higher than the state and US averages, while Trenton’s adult diabetes prevalence is more than twice as high as the US average. Trenton is also a ‘food desert’ and only about one in three Trenton children get the recommended amount of exercise. A healthy diet, an active lifestyle, and access to healthy food options can impact these diseases in a positive way, and we would like to support that.

How do you select projects for the Community Health Collaborative™ grants?
The grants are open to local 501c3 organisations. Priority areas are those with initiatives to promote wellness, such as education programmes around healthy choices and the benefits of active lifestyles, and to improve or enhance the built environment and recreational infrastructure. We are also looking at programmes that help to address the ‘food desert’ phenomenon, increasing access to healthier food options, and encouraging continued growth of urban agriculture activities.

To be considered, organisations must fill out a detailed application form that describes the project, what needs it is addressing, anticipated outcomes, milestones, potential for the project to be scaled and how progress will be measured.

What is the ultimate goal of this programme?
We’d like to be able to move the needle in addressing the challenges that urban communities have around healthy living. In addition to funding eight programmes this year through the Collaborative, we are bringing the organisations together to learn from one another, and develop ways of leveraging the work they are doing individually with the group as a whole. These organisations all have one thing in common – the shared objective of making their communities a better and healthier place to live. Imagine what they could accomplish working with others with the same goal? Our hope is that if this programme is successful, we would roll it out to other key markets throughout the US.

Most pharmaceutical companies have a grants programme – what makes Novo Nordisk different?
I often say that every pharmaceutical company I know has a grants programme and has a volunteer programme. So why Novo Nordisk? Why should we be the company of choice? For me, it is clearly our commitment to the TBL and to doing what’s right. More importantly, it’s our people and their hands-on engagement – sharing of skills, resources, expertise and passion – that brings the TBL to life.
About Novo Nordisk and the Triple Bottom Line

Headquartered in Denmark, Novo Nordisk is a global healthcare company with more than 90 years of innovation and leadership in diabetes care. This heritage has given us experience and capabilities that also enable us to help people defeat other serious chronic conditions: haemophilia, growth disorders and obesity.

We believe that a healthy economy, environment and society are fundamental to long-term value creation. This is why we manage our business in accordance with the Triple Bottom Line business principle and consider the financial, environmental and social impact of our business decisions.

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For a deeper look at how Novo Nordisk works with sustainability visit our website at: novonordisk.com/sustainability

The next issue of Novo Nordisk’s TBL Quarterly will be available in September 2015