

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

The meeting was called to order by Sen. Neil H. Arasmith at
Chairperson

9:00 a.m. ~~pm~~ on March 5, 1985 in room 529-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research
Bruce Kinzie, Revisor of Statutes

Conferees appearing before the committee:

Senator James Francisco
Dr. Joe Hume
Dr. Diana Guthrie, University of Kansas School of Medicine, Wichita
Deborah Hinnen, University of Kansas School of Medicine, Wichita
Dr. Lillian Harstine
Rene Herman
Darlene Hilliard, St. John Diabetes Clinic
Julia Francisco
Bill Horn, Bankers Life Nebraska

The hearing on SB 274 dealing with insurance coverage of diabetic equipment began with a statement from Sen. Francisco who had the bill introduced at the request of the Diabetic Association. He briefly stated that not only does he support the bill but also many others do.

Dr. Joe Hume of Wichita followed with his testimony in support of the bill. (See Attachment I.)

Dr. Diana Guthrie, University of Kansas School of Medicine at Wichita, testified in support of the bill and on behalf of her husband, Dr. Richard Guthrie. (See Attachments II and III.)

Upon conclusion of her testimony, the chairman announced that since there were several others yet to testify and time was running short, another time would be set for those testifying in opposition to SB 274.

Deborah Hinnen of the University of Kansas School of Medicine at Wichita gave testimony in support of the bill. (See Attachment IV.)

Dr. Lillian Harstine testified in support of those who had already given testimony in support of the bill. She said that in her practice she has been frustrated in obtaining supplies and education for diabetic patients due to a lack of financing and asked the committee for support of the bill because she feels there is a real need for it.

Rene Herman followed with her testimony. (See Attachment V.)

Darlene Hilliard of St. John Diabetes Clinic testified next in support of the bill. (See Attachment VI.)

Last to testify in support of the bill was Julia Francisco, the wife of Sen. Francisco. (See Attachment VII.) Upon the conclusion of her testimony, Sen. Francisco explained the glucometer's function to the committee. He also said that if his wife has her infusion pump with her when she is admitted to the hospital, the hospital does not have to do blood work which has resulted in their saving \$1000 to insurers during her last three hospital stays. The pump costs approximately \$100 but saves much more by making home monitoring possible. He feels this will help keep premiums down. He stated that if the committee does not pass the bill, it should be considered in an interim study.

Sen. Reilly said he was not familiar with the infusion pump and asked for information on it. Ms. Hinnen had her pump with her and used it in explaining its function.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,
room 529-S, Statehouse, at 9:00 a.m./~~p.m.~~ on March 5, 1985.

Sen. Werts asked if there is a provision for the two weeks education in the bill. Sen. Francisco and others said there was. Sen. Francisco added that he feels that it would be a good idea if the insurance companies would require the education program before insuring diabetics.

There being some time remaining, the chairman called on Bill Horn of Bankers Life Nebraska to give first testimony in opposition to SB 274 since he had come a long distance to testify. Mr. Horn also distributed copies of testimony from Don Snyder of Beech Aircraft Corporation who was unable to attend. (See Attachments VIII and IX.)

The chairman called the committee's attention to the minutes of the last meeting. It was noted that they should be corrected on page two by removing the second by Sen. Kerr on the first motion made by Sen. Werts to recommend SB 123 favorably and by including the repeat of Sen. Werts' motion and the second by Sen. Kerr after the vote on Sen. Karr's motion. With this correction, the minutes were approved.

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
3/5	DENNIS DEHN	TOPEKA	SEN. WERTS' INTERN
	CHARLES BELT	WICHITA	CHAMBER OF COMMERCE
	Deborah Hinnen	Wichita	American Diabetes Assoc - Ks.
	Thomas Johnson	Topeka	Blue Cross & Blue Shield of Ks
	Charlote J. Evans	St. Marys	" " " " " "
	JACK ROBERTS	TOPEKA	" " " " " "
	Bill Horn	WICHITA	BANKERS LIFE NEBR.
	Marty Topus	Topeka	American Diab Assoc
	Reni Herman	Wichita	consumer
	Belinda Chiedo	Wichita	Kansas Regional Diabetes Center
	Diana Guthrie	Wichita	AADE / and KRDC / USSM - W
	Julia Francisco Mulvaney		Diabetic
	Mary Biedel	WICHITA	CONSUMER
	Katharine Clark	Wichita	Consumer
	Tom M. Hibban	El Dorado	Consumer
	Dick Brock	Topeka	Ins Dept.
	Darlene Hallicard	St John	St John Diabetic Clinic
	M.C. Amboloz	Topeka	KCUL
	Lillian Hardene MD	Wichita, Ks.	practicing physician Wichita & St John Diabetic Clinic

march 4, 1984

I am a practicing Obstetrician-Gynecologist in Wichita, Ks. I have a special interest in high risk obstetrics, especially diabetes in pregnancy. I have been a diabetic for over 30 years.

When I was diagnosed a diabetic the treatment was very simple. You simply eliminated certain foods from your diet, took one shot a day, got a blood sugar every two months or so, checked your urine once a day and prayed that you never had to go to the hospital. I was given a medical excuse not to participate in physical education. My cousin died from complications of diabetes when I was in high school. His parents did not believe that they could have had a child who suffered from such a disease. My father took me to Mineral Wells, Texas, to drink sulphur water for a cure. Having diabetes has been somewhat beneficial though, at KU while in graduate school I was given a car pass so that I wouldn't have to walk so far to my classes.

It was not until I was in medical school and had a better understanding of the physiology of insulin that I changed my regimen. It was also at this time that endocrinologists were beginning to suggest that multiple injections and tight control could prolong the life of a diabetic and reduce their complication factors.

Diabetes mellitus is the major underlying disease in blindness, kidney failure, heart disease and may be important factor in adult obesity.

As with any chronic disease there is a certain stigma associated with a person identified as being a diabetic. The general public thinks of them as somewhat less. Until the recent past a diabetic was discriminated against in many employment situations. The employers were uneducated as to the limitations, if any, on a diabetic's working environment.

Patient education is a very important aspect of a diabetics health. The more a patient learns about their disease, the better they are able to manage their disease. When they can manage their disease, they are able to maintain a good work record and become a productive member of society. Patient education should also reduce or prolong the onset of complications of the disease. To achieve the goal of better glucose control, the patient needs education about diabetes mellitus and how to live with it. They must understand the physiological requirements of their body and how diet, exercise, stress, blood sugar testing and insulin all fit together to give them a better quality of life. Diabetics should not be thought of or referred to as "poor Joe, he's a diabetic". With proper understanding and treatment he can do anything a non diabetic can.

Patient education can be done in an out-patient or an ambulatory in-patient setting. The setting should be such that family members can attend and that there are other diabetic patients present. It is important that dialogue and interpersonal relationships take place with others dealing with

3/5/85
Attachment I

the same problems. At the time of the education session not all patients will be at the same level of comprehension of their disease, but at some time in the future they will remember a certain thing being discussed.

An important aspect of patient education is the stressing of regular home glucose monitoring. We, humans, all need a certain amount of goal setting. The regular (a minimum of 4 times per day) home glucose monitoring gives the diabetic patient a goal and is also a practical method of his checking on his control. The blood sugar level is a readily available physiological measurement of good (or bad) control. Patient home glucose monitoring gives a value at the time taken and this can then be immediately coordinated with the appropriate insulin or diet therapy in order to keep the patient in a normal blood sugar range. The old method of checking blood sugars in the laboratory once a month only proved that the day before the patient had adhered to the proper diet and insulin regimen. It was not possible to adjust diet and insulin dosage to the requirements of his body and activities several times a day.

Until the last few years, insulin therapy has not been close to normal physiology. A non-diabetic patient has a certain amount of insulin available to his body at all times with a reserve available for meals and stress occasions. The introduction of the insulin infusion pump has allowed insulin therapy treatment to become more physiological. I personally am able to better function in my professional capacity and maintain good control of my diabetes since I have had a infusion pump. Now when I get called out in the middle of the night for a delivery I am able to handle the stress without affecting my control. Anytime you can administer a small amount of hormone continuously, rather than a large amount all at one time, the body is able to utilize it better.

At our center the infusion pump has helped an insulin dependent diabetic with severe retinopathy stabilize the disease. The pump has also been very helpful in pregnancies. The data indicates there are fewer anomalies in the babies of diabetic mothers on the pump than those not on the pump. The data also indicates that these same mothers on the pumps are having normal size babies. The very brittle diabetics when placed on a pump have had a decreased need for hospitalization.

In summary the long term cost of diabetes mellitus care can be reduced by:

1. better patient understanding and education about the disease
2. patient home glucose monitoring
3. the use of insulin infusion pumps to give more physiological control of insulin administration

Sincerely yours,

Joseph W. Hume, M.D.

Good morning, Ladies and Gentlemen. Thank you for the opportunity to appear before you today to talk to you about a most important subject. I am sure that all speakers who address you feel that their particular interest and area is the most important. Certainly, I feel the same way.

Let me quote to you in the beginning some statistics to impress upon you the importance of the particular area with which we are dealing today, that is the area of diabetes mellitus. Diabetes mellitus has been called the #1 epidemic chronic disease in our society today by no less an authority than The Center for Disease Control in Atlanta, Georgia, a division of the federal government. There are some 12 million people in the United States with diabetes. Most importantly, the incidents of the disease is going up at the rate of 6% a year, which means that the number of people with diabetes will double every 15 years, so that by the year 2000, there will be 24 million people with diabetes, and by the year 2015, there will be nearly 50 million people in this country with diabetes unless a cure can be found for this important disease.

These numbers make diabetes one of the most important disease with which we have to deal in our society because of the severe complications that occur with the disease. Of the chronic diseases, the numbers of people with the disease are exceeded only by arthritis and hypertension. I might point out that, in order to exceed the numbers for arthritis, one has to include a whole host of diverse and different diseases in the arthritis category, some of which are of not much consequence, some of which simply represent the chronic wear-and-tear degeneration that occurs with the aging process. I might also point out, in regard to hypertension, that nearly half of the individuals with hypertension also have diabetes; that these 2 diseases often occur concurrently and the diabetes often is the cause of the hypertension as it is also the cause of the heart disease that frequently occurs in our society. Diabetes is a common cause of premature heart attack and stroke.

Let me talk for a moment about serious complications of this disease. Diabetes is now the leading cause of new cases of blindness in this country. It is also the leading cause of amputations; and is a major cause of kidney failure as well as causing premature heart attacks and strokes and a variety of problems resulting from damage to the nerves of the body. Diabetes can be an extremely devastating disease, resulting in complete disability by late teenage years or early adulthood in individuals who develop the disease in childhood. The economic loss from diabetes each year is devastating. The direct out-of-pocket cost for medical care, that is hospitalization, re-hospitalization, laser therapy for eye disease, treatments of heart attack, stroke, hypertension, amputation, as well as the cost of medical supplies and medical supervision for the individuals results in a direct medical care cost each year of some 9-12 billion dollars in economic losses. This economic loss does not count the economic loss or costs that occurs as a result of the rehabilitation of individuals losing their sight by such agencies as The Division of the Blind; nor does it account for the cost of rehabilitating individuals with amputations by Vocational Rehabilitation; nor does it count the cost of disability pensions to those who are blind or amputated; and certainly it does not in any way count the economic loss from loss of productivity for individuals with the chronic, disabling problems of diabetes. The tragedy of this, of course, is that often diabetes

3/5/85
Attachment II

affects the young, so that they become disabled at the prime time of their productivity; and society must then support these individuals throughout the remainder of their lives, rather than having them be productive citizens who are contributing to society. It has been estimated that the total economic loss to this country from direct medical care costs, rehabilitation costs, loss of income, and premature death in persons with diabetes is somewhere between 20-30 billion dollars per year.

The tragedy of all of these figures is that they are preventable. Diabetes is not preventable, at least by present-day methodology. However, the complications of diabetes which cause the economic loss from diabetes are preventable. The blood vessel damage in diabetes, which results in the blindness, the kidney failure, the premature heart disease, strokes, amputations, etc, are all related to elevated blood sugar. If the person with diabetes is receiving appropriate medical care and is appropriately educated into the techniques of self management of their disease, it is possible to attain and maintain control of their blood sugar in such a way as to prevent the devastating complications of the disease and to reduce the tremendous medical care costs occurring from the complications of this disease.

Recent estimates from The Center for Disease Control in Atlanta, based upon data obtained in their 20-state diabetes control projects, would indicate that certain of the complications can be severely decreased and their costs severely decreased with proper care and proper education of the person with diabetes. For example, data from the Kentucky Control Project, which is sponsored by the Center for Disease Control and controlled by a committee appointed as a diabetes state-wide task force by the governor of the state by mandate of the state legislature, indicates that it is possible to reduce amputations by 80% of the patients are properly controlled, receive the proper medical care, and have been appropriately educated in the proper foot care for people with diabetes. Data from the main CDC control project on diabetes education indicates that it is possible to reduce re-hospitalization of persons with diabetes by 30% by the simple matter of instituting an out-patient diabetes education class which educates these individuals to the principles of self-management.

Let us extrapolate for a moment the main data to the state of Kansas. Since the state of Kansas constitutes 1% of the total population of the United States, and if we take a figure of \$9 billion in economic losses for diabetes, we can then calculate that the losses in the state of Kansas are some \$90 million per year in medical care costs. Some of these medical care costs are unavoidable, since they are doctor visits and the cost of insulin and supplies. If we were to take a figure of half of the costs as being due to factors which can not be appropriately changed, we still end up with a loss of some \$45 million that is spent on hospitalization and re-hospitalization of persons with diabetes. If that figure can be reduced by 30%, as the main data indicates, it would be possible to save \$15 million per year in medical care costs in the state of Kansas. It is my belief that this is, in fact, a conservative figure and that, if one added the savings from rehabilitation, the savings in the cost of, for example, laser treatments to the eyes which cost \$1000. per treatment and may take from 15-30 treatments per patient; if we were to count the economic losses from disabilities and work loss and premature disability with lack of productivity, the losses would be tremendously greater.

Since much of this can be saved through appropriate medical care and education of the patient, the savings in the state of Kansas will far exceed the very conservative estimate of \$15 million. None-the-less, a saving of \$15 million is a significant savings to the insurers of this state, as well as to the Medicare and Medicaid systems, particularly since these savings can be brought about by a simple mechanism of providing education for individuals with diabetes at a relatively inexpensive cost.

There are multiple studies now, which have been published in the literature, which confirm these findings. The original studies were done in Los Angeles, at the Los Angeles County Hospital, where it was estimated that, for educational costs of some \$300,000 per year, they were able to save the County of Los Angeles \$5 million in rehospitalization costs in the indigent population served by the County Hospital.

Ladies and Gentlemen, I do not know about you, but if I could make a profit of \$5 million on an investment of \$300,000., I would do everything within my power to secure that \$300,000 in order to make the investment with that kind of a return.

Similar studies have been carried out in Atlanta, Georgia, at Emory University and the Grady Memorial Hospital, with very similar results. More recently, studies have been carried out in Memphis, Tennessee, in an indigent, black population, where the savings were also found to be similar to those of the Los Angeles and the Grady Memorial studies.

In the CDC programs in the 20 states, similar figures have been found to those of the main study, with significant reductions in many of the complications of the disease and in rehospitalizations in states such as Kentucky, Illinois, Missouri, Nebraska, Colorado, Washington, and others. Probably the most recent study has been carried out in North Dakota in which the American Diabetes Association, in conjunction with the insurance carriers of the state of South Dakota, set up 2 pilot projects in 2 communities on the state for education of the persons with diabetes, and then tracked those individuals to determine the rehospitalization rate as compared with persons who did not receive the education course. The conclusion of this study was that savings in rehospitalization amount to between 30 and 50% reduction in rehospitalization rate and thus that the programs were cost effective. Based upon that, the insurance carriers of North Dakota have now mandated the education programs for all of their patients under their insurance coverage for that state, including Blue Cross and Blue Shield. The same is true in the state of Maine, where this study was carried out as a part of the CDC control program, but was carried out in conjunction with Blue Cross/Blue Shield. The conclusion of that program was that out patient education for persons with diabetes was cost effective and should therefore be instituted and mandated for all patients under Blue Cross and Blue Shield coverage. This has now been carried out, and these insurance companies are now paying for this kind of coverage.

4/

Ladies and Gentlemen, let me say to you clearly that great strides have been made in diabetes care in the last 5 years. The rules and regulations that have been set up by the insurance industry for covering devices for diabetics and for covering the cost of diabetes education were based upon old data of many years ago, before the massive changes which have occurred in diabetes care in just the last 2-3 years, and certainly in the last 5 years. The data are now being generated in large numbers that the use of various kinds of devices such as insulin pumps, meters to measure blood sugar in patient's at home, and education in the principles of self-management of diabetes have greatly reduced the incidents of rehospitalization and greatly reduced the incidents of complications with their devastating economic losses in areas where these programs have been carried out. The irony of the situation, of course, is that the savings occur predominantly to the insurers who have given great vocal credence to the principles of preventive medicine and the prevention of hospitalization. The whole, new DRG system has been instituted by the federal government and copied by Blue Cross/Blue Shield of Kansas for the purpose of reducing hospitalization and capping medical care costs.

I am saying to you that the data are very clear today that we can do a better job of capping medical care costs by practicing preventive medicine, by preventing the complications, by preventing the hospitalizations, by appropriate out patient care and appropriate patient education, than we can by trying to institute rules and regulations pertaining only to the hospitals. The whole principle of diabetes management of the past 3 years has been revolutionalized by home blood glucose monitoring and the principles of self management of the diabetes, which requires education of the patient to carry out. These principles are aimed entirely at preventive medicine; that is, of preventing complications, or preventing hospitalization, and thus at reducing medical care costs. It seems, therefore, that the insurance industry that has paid lip service to the principles of preventive medicine would embrace these principles forcibly and would attempt, as soon as possible, to institute the use of the various devices, such as home blood glucose monitoring devices and the principles of education, in order to prevent the hospitalizations as have been proven by multiple data throughout the country. Indeed, on a national level, in the insurance industry has moved in this direction. In October, 1984, I was privileged as a representative of the American Association of Diabetes Educators to attend a national conference on third party reimbursement for diabetes at Arlie House, Virginia. This national meeting which was sponsored by the Center for Disease Control in Atlanta, the National Diabetes Advisory Board in Washington, the American Diabetes Association, the American Association of Diabetes Educators and representatives on industry, labor unions and the insurance industry, was called for the purpose of developing national policy regarding third party reimbursement for devices for diabetics, for supplies for diabetics, and for education. I was an invited speaker at the meeting and an active participant in the proceeding. The results of this conference were the formation of the national task force for the purpose of developing national legislation, which eventually will be introduced into the Congress, to mandate diabetes education and to mandate the payment for various diabetic devices, including pumps, glucose monitoring devices such as meters, or implantable glucose sensors, orthopedic devices such as special orthopedic shoes for diabetics, as well as education for all persons with diabetes.

5

The national legislation will be introduced to cover Medicare and probably Medicaid with the recommendation that these similar laws be passed by the various states to cover the various insurance carriers of those particular states.

The legislation which you have before you is modelled after that which is being prepared by the national task force for introduction into the national Congress to cover Medicare and Medicaid. It is our hope that Kansas can be a model state in carrying forth the legislation to give a similar mandate on a state-wide level.

I might point out to you that the insurance industry was an active participant in the Arlie House conference and are members of the national task force, and are assisting in the development of this legislation, as is HCFA, the agency which controls Medicare and Medicaid. They are supportive of the concept that diabetes education and monitoring of blood glucose at home reduced medical care costs, increased savings for Medicare/Medicaid, and for the insurance industry, and that these principles should be reimbursed and encouraged by the insurance industry.

I might say to you that, in defense of the insurance industries desire not to pay for these devices and for education in particular, this has been brought about by a clear lack of standards by the diabetes provider in controlling the quality of both the instruments and the quality of educational programs. Steps are being taken at the present time to correct these deficiencies. For example, I am now President of a national organization called the Association of Insulin Pump Therapists. This organization was formed by individuals who are concerned about the quality of both devices, as well as education and the training of those who use the devices, both the patient and the professionals, in the use of Insulin Pump Therapy. It is the intent of this organization to establish standards, not only for the devices, but also standards for the physicians and teams who will be utilizing the devices on patients. We are in the process of writing those at the present time, and may well develop a certification exam in the future to certify Pump Therapists. Thus, we will control the quality of the devices. We will control the type of patients on whom the devices are placed. We will set standards for the education of those patients, and we will certify and set standards for the individuals who will be placing the devices on the patients; that is, the professionals.

In addition, there are now national guidelines being developed for general diabetes patient education. The National Diabetes Advisory Board, in association with the American Diabetes Association and Association of Diabetes Educators, have developed guidelines for quality patient education programs. These are currently being pilot tested in 207 centers throughout the United States, including 11 centers here in the state of Kansas. It is expected that the pilot testing will be completed by October of this year, and that sometime in early 1986, the final guidelines will be promulgated, and that we will then have the ability to certify those programs which meet the guidelines and thus are quality patient education programs.

6

Another step which is being taken is the certification of educators. The American Association of Diabetes Educators is currently developing a certification examination. It is hoped that, within the next few months, this examination will become available and that diabetes educators will be required to take the certification examination in order to be certified as quality patient educators.

When these two programs are in place, within the next 6-12 months, this should answer the main objection of the insurance industry that they have no control over the quality of these programs. Indeed, there will be control over the quality of the patient education programs.

We feel that the statistics which are available throughout the United States on the reduction of medical care costs, of the effectiveness of patient education and preventive therapy in persons with diabetes, are sufficiently strong to warrant the institution of these programs in the state of Kansas. It would seem ironic that third party payors would not see fit to reimburse for these programs since, in fact, the savings will accrue to them. The savings will also accrue to the state in the reduction of costs in the Medicaid program. Diabetic devices and patient education are very inexpensive projects. A meter to measure blood glucose at home, for example, costs less than \$150.00. If such a device will prevent one day of hospitalization in the lifetime of the patient, it will have paid for itself. Indeed, data are very, very clear throughout the entire United States, that they will do more than prevent more than one day of hospitalization.

It therefore seems penny-wise and pound-foolish for third party payors not to want to have this piece of legislation. Indeed, it seems superfluous that such legislation would be necessary. If I, for example, were the president of Blue Cross/Blue Shield, rather than giving physicians a hard time about paying for Insulin pumps and paying for meters to monitor blood glucose; and in refusing to pay for education programs, rather, I would mandate that patients have meters and use them. I would mandate that all patients have patient education programs before I would write a policy on that individual.

This legislation is introduced because the insurance companies have not seen fit to make these provisions within their policies. Thus, we are attempting to request, by law, that which they should want to do on their own right because of the savings that will accrue to them thereby.

Ladies and Gentlemen, this has been a quick and superficial review of the data related to the devices and patient education. There are massive amount of data related thereto which I will be happy to provide for you if you so desire in your deliberation. The data presented at the Arlie House conference is over 2 inches thick. I will be happy to provide any and all of that, if you so desire, to support our contention that devices and patient education are cost effective and will save millions of dollars for the state of Kansas and for the third party payors of this state, and should, therefore, be a part of the program of this state.

We ask your support in this legislation to see that this is carried out for the benefit of the some 120,000 people in this state with this terrible disease. Working together, we can improve the life of the people of our state who are unfortunate enough to develop diabetes and save money for them, the state and the third party carriers at the same time. Help us accomplish this task.

Respectfully submitted,

Richard A. Guthrie, MD
Professor and Director
Kansas Regional Diabetes Center of the
University of Kansas School of Medicine at Wichita

Board member of the American Associate Kansas Affiliate

March 5, 1985

I am Diana W. Guthrie, an Associate Professor and Diabetes Nurse Specialist for the University of Kansas School of Medicine at Wichita. As a member and present secretary for the American Association of Diabetes Educators, I have had an interest in the certification or other mechanism for promoting the quality of education for patients and other professions in the field of Diabetes Mellitus. The American Association of Diabetes Educators has been given a mandate by the National Diabetes' Advisory Board (the developers of the Diabetes Standards for Patient Education) to determine credentials of the educators of patients. This responsibility was given to this group so that not only will the programs be accredited but that there be some accounting by the personnel offering the programs throughout the United States.

As a member of the Executive committee and Board of Directors of the AADE, we have been working on two levels:

1. To raise the level of knowledge for all educators through ther development of 12 modules concerning ways to educate as well as background for the content to be included.
2. To appraise the accreditation process and the corresponding testing process in order to determine how diabetes educators might best become credentiailled.

At present, a testing service is being sought and a certification consultant has been employed. During the board meeting, in April, direction will be given as to the next steps to take in this credentiailling process.

The American Diabetes Association and the Association of Diabetes Educators feel that all patients have the right to a basic 10 hours curriculum. The three hours or less shotgun education only covers the survival techniques of medication administration, blood sugar and/or urine testing, recognizing and treating hypoglycemia (low blood sugar), the meal plan and when to call the physician. The minimal 10 hours includes the above but also includes hygiene, exercise and psychosocial adjustment education and the needed emphasis and expansion of information on dietary education (i.e. 5 hours on dietary education and the other five hours on other aspects of care). The more ideal 25-35 hour curriculum allows the participant to become a part of the self care team. This team assists the individual to a higher level of understanding and therefore assures a better quality of self care. The goal is a well rounded individual who is able to prevent or at least delay the potential complications of this disease by keeping his or her blood sugars as normal as possible the majority of the time without the person experiencing any significant hypoglycemia. As you can imagine, all of this time is spent in nutritional education. The other half includes more on interacting with the health professionals on self management of the disease. Since the health professionals are not at their side 24 hours of the day, the person with diabetes needs to make intelligent decisions that will involve fluctuations of blood sugars. This person needs to know what is safe and correct to do and when the limits are reached and the physician or other designated health professional should be contacted. One can easily see the necessity for the health professional to be educated to meet the needs of the person having Diabetes Mellitus.

3/5/85
Attachment III

What about the grass roots educators? Preparation may be grandfathered until a fully functioning certification process is in order. Certainly, continuing education will be available through the ADAK, AADE, and the Kansas Regional Diabetes Center of the UKSM-Wichita, along with the support of the Dept. of Continuing Education of Wichita State University. We do have the resources to educate the educators in this State. The Department of Nursing has a unique Diabetes Tract for those professionals wishing to specialize in Diabetes.

For those people employed in hospitals or clinics, an opportunity for more intensive education is available through the weekly classes of the KRDC and/or through the two, two week sessions of the Diabetes Update held each July and Spetember. 75% of these individuals participating in the program have come from such places as Guam and various states outside of Kansas. These are people who may be teaching other subjects besides diabetes in their hospitals or clinics, but still need to learn specialized information in this field.

The state and national resources are willing and ready to assist in whatever process is determined to be needed to assist the third party people in recognizing that the personnel used in educating the patients are qualified.

Testimony SB 274
re: 3rd Party Reimbursement
diabetes education & suppli.
March 5, 1985
Deborah Hinnen, RN, MN

Diabetes education for people with diabetes and their families is a critical component of overall management of the disease. It is not just a nice extra. People must live with their diabetes on a daily basis and control blood sugars well enough to continue being the productive citizens they were before the diabetes was diagnosed. Various programs are available around the country. Education is something that has been shown to save millions of dollars in health care costs for such things as frequent hospitalizations, for amputations and treatment of kidney and eye disease.

The national tax dollar has helped support diabetes demonstration projects from the Center for Disease Control in twenty states in the U. S. Of those twenty states, six have focused on diabetes patient education. Very positive results have been reported on the cost effectiveness of diabetes education in Illinois, Rhode Island, Washington, Michigan, Pennsylvania, and most recently Maine.

A state the size and population of Maine has effectively implemented 10-hour education programs in hospitals around the state and shown a \$30 million savings in rehospitalizations and other health related costs.

The need is there to have diabetes education programs. The cost effectiveness has been demonstrated.

The initial cost investment will be a small sum to consider if even one rehospitalization is prevented.

The question that arises now is not necessarily related to need for education or cost of that education program, but who will pay and how do we know we have a quality program?

3/5/85
Attachment IV

Quality education for the instructors was addressed by Dr. Diana Guthrie. She spoke to the impact Kansans have had in designing and implementing quality programs to teach the teachers.

I want to address quality concerns for the diabetes-education programs themselves.

National diabetes education standards have been developed by the National Diabetes Advisory Board. This Congressionally appointed group is comprised of representatives of national groups and organizations having an interest in diabetes; American Diabetes Association, American Association of Diabetes Educators, Center for Disease Control, Juvenile Diabetes Foundation and others. The standards were made public just over one year ago.

The standards cover ten areas - content, curriculum, faculty qualifications, documentation, etc.

The review process for the standards is being pilot tested now. Kansas has been given permission to participate in the piloting process.

Five programs in Kansas were selected by the Regional Advisory Committee, established by the American Diabetes Association - Kansas Affiliate, to apply for recognition. The type of programs participating in Kansas range from rural hospital based to community based with education only to self management education programs with medical management included.

The education standards recognition process is targeted to be implemented nationally by January, 1986. At this point in time, we see mechanisms being put in place to assure high quality diabetes education taught by high quality faculty.

With DRG's and other changes in health care, it seems most timely and appropriate to support this legislation that would help subsidize education and supplies necessary to reduce hospitalizations and other medical costs for those people with diabetes mellitus.

Thank you for drafting this bill. On behalf of the American Diabetes Association - Kansas Affiliate I want to share my support of SB 274.

Respectfully Submitted,



Deborah Hinnen, RN, MN

Patient Education Coordinator
Kansas Regional Diabetes Center
University of Kansas School of Medicine - Wichita

President, American Diabetes Association - Kansas Affiliate

Member, National Board of Directors
American Diabetes Association

DH:cw

NATIONAL RECOGNITION PLAN FOR
DIABETES PATIENT EDUCATION PROGRAMS

Concept Outline

Purpose of Concept Outline

This concept outline summarizes a plan to formally recognize diabetes patient education programs that meet quality assurance standards recently established by the diabetes community.

Section I provides the rationale for this plan. Section II outlines those steps in the developmental process that have already been accomplished. Section III discusses the method proposed to implement the remainder of the plan.

Section I: Rationale for Quality Assurance
of Diabetes Patient Education Programs

Major strides in the ability to treat diabetes have been made during the last decade as a result of biomedical research, new technologies, and improved application of currently available knowledge and resources. It is now possible to limit the severity of some long-term effects of the disease through preventive approaches to care.

In chronic diseases, especially diabetes, a major share of the responsibility for preventive care rests with the patient. Only an informed and well-motivated person can carry out this responsibility effectively. Evidence is growing that inadequate patient knowledge results in multiple hospital admissions, excessive use of emergency rooms, unnecessary medication, and a high incidence of long-term complications of diabetes, all of which increase human suffering and escalate the costs of care. Studies testing patient education as the variable component of the treatment regimen have shown consistent reductions in these measures. Education for self care is therefore recognized to be a fundamental component of quality treatment for the individual with diabetes.

Although diabetes is treated directly or indirectly in practically every health care facility in the United States, both the quantity and quality of education offered to people with diabetes vary considerably. Access to this important component of treatment is fragmented. Third party reimbursement for ambulatory diabetes patient education is sporadic and largely unavailable. With the advent of the prospective payment system, hospital inpatient education may be in jeopardy.

A major impediment to education for self care has been the lack of national standards to assure that the education provided to people with diabetes is of an acceptable quality and appropriate for the individual. Experience in other fields has demonstrated the ability of uniform standards to improve the quality,

effectiveness and availability of programs. Furthermore, third party payors require quality assurance through standards as a prerequisite to reimbursement for educational services.

Against this backdrop, the National Diabetes Advisory Board (the body mandated by Congress to oversee the federal diabetes effort) determined that the development of national standards for diabetes patient education programs would serve to (1) upgrade the quality and availability of patient education and (2) provide the basis for third party reimbursement for outpatient education. The Board further determined that merely publishing standards without a plan to foster their widespread adoption would be a wasted effort. And finally, the Board felt that widespread adoption of the standards could be accomplished only with the cooperation of the entire diabetes community.

Section II: Development of National Standards and an Implementation Plan

In April 1982, the National Diabetes Advisory Board began its quality assurance initiative by appointing a steering committee to direct the project. The steering committee convened a series of workgroups comprised of experts relevant to the various aspects of the initiative. Between April 1982 and January 1985, seven workgroups have accomplished the following tasks:

1. Development of national standards for diabetes patient education programs. The diabetes patient education standards consist of ten components to guide an institution in the establishment of a new program or the modification of an existing one. The standards offer the flexibility required to tailor a patient education program to the type of diabetes, its duration, and the life-stage of the diabetic person. Each standard is defined by review criteria that establish specific parameters against which diabetes patient education programs can measure themselves.
2. Endorsement, publication and dissemination of the standards. In May 1983, the National Diabetes Advisory Board unanimously endorsed the standards and authorized their publication and dissemination. They were published in several major national journals, including Diabetes Care, The Diabetes Educator and a monograph of the American Hospital Association. Additionally, more than 20,000 copies have been distributed. Following the Board's endorsement, other key organizations of the diabetes community also endorsed the standards. These standards represent a consensus of the diabetes community.
3. Development of a plan to implement the standards. After reviewing several accreditation programs, the steering committee selected recognition as the preferred method of implementation. Recognition differs from accreditation in two ways: (1) it does not require a site visit and (2) funding considerations are not attached to it. It is, however, a formal process through which programs meeting the standards are identified for a level of performance, integrity and quality entitling them to the confidence of the community they serve. Recognition requires a self-study by the applicant program, review by an authoritative body, and periodic renewal.

4. Expansion of the steering committee. In accordance with the recommendations of the workgroup on implementation of a recognition process, it was decided to expand the steering committee to include formal representation from national organizations that would form the basis for a coalition. In September 1983, the steering committee was expanded to include representatives of the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse.

5. Pilot test. The review criteria and the recognition process are currently being pilot-tested at 197 patient education settings throughout the United States. The pilot study began in April 1984 and is scheduled for completion in October 1985. The pilot test is (1) assessing the applicability of the review criteria to a variety of settings, and (2) testing the recognition application and review process. Results of the pilot test will form the basis for any required adjustments in the recognition process prior to nationwide implementation.

6. Materials development. In addition to the standards themselves, support materials for the recognition process have been developed. These include (1) a handbook for potential applicants on how to initiate a new diabetes patient education program or upgrade an existing program to meet the national standards; and (2) an application for recognition and instructions on the application process. The materials are being pilot-tested by the 197 test sites. It is planned to incorporate them into a recognition manual for the national effort.

7. Response of third party payors. A national conference on financing quality care for people with diabetes was held in October 1984. In the session on financing diabetes patient education, representatives of the insurance community advised that national standards, coupled with a quality assurance process and documentation that quality education is a cost-containment measure, would go a long way toward increasing the availability of third party reimbursement for diabetes patient education services.

The developmental process described above has taken nearly three years and has involved more than 500 people including the steering committee, workgroups, and participants in the pilot study. A number of materials are available to document the process.

Section III: Proposed Structure for Implementing a National Recognition Plan

While the developmental process has been conducted under the auspices of the National Diabetes Advisory Board, implementation of a national recognition plan exceeds the Board's authority. Therefore, the steering committee will form the basis for a coalition of diabetes organizations that will assume the responsibility for implementation. The steering committee agreed upon the concept of a coalition for several reasons. The diabetes community is represented by an unusually large number of organizations and agencies (both public and private), each having somewhat different goals and perspectives. A coalition will represent the diabetes community collectively. It will have no vested interest, either in a specific organization or in a particular education program. It can therefore assure

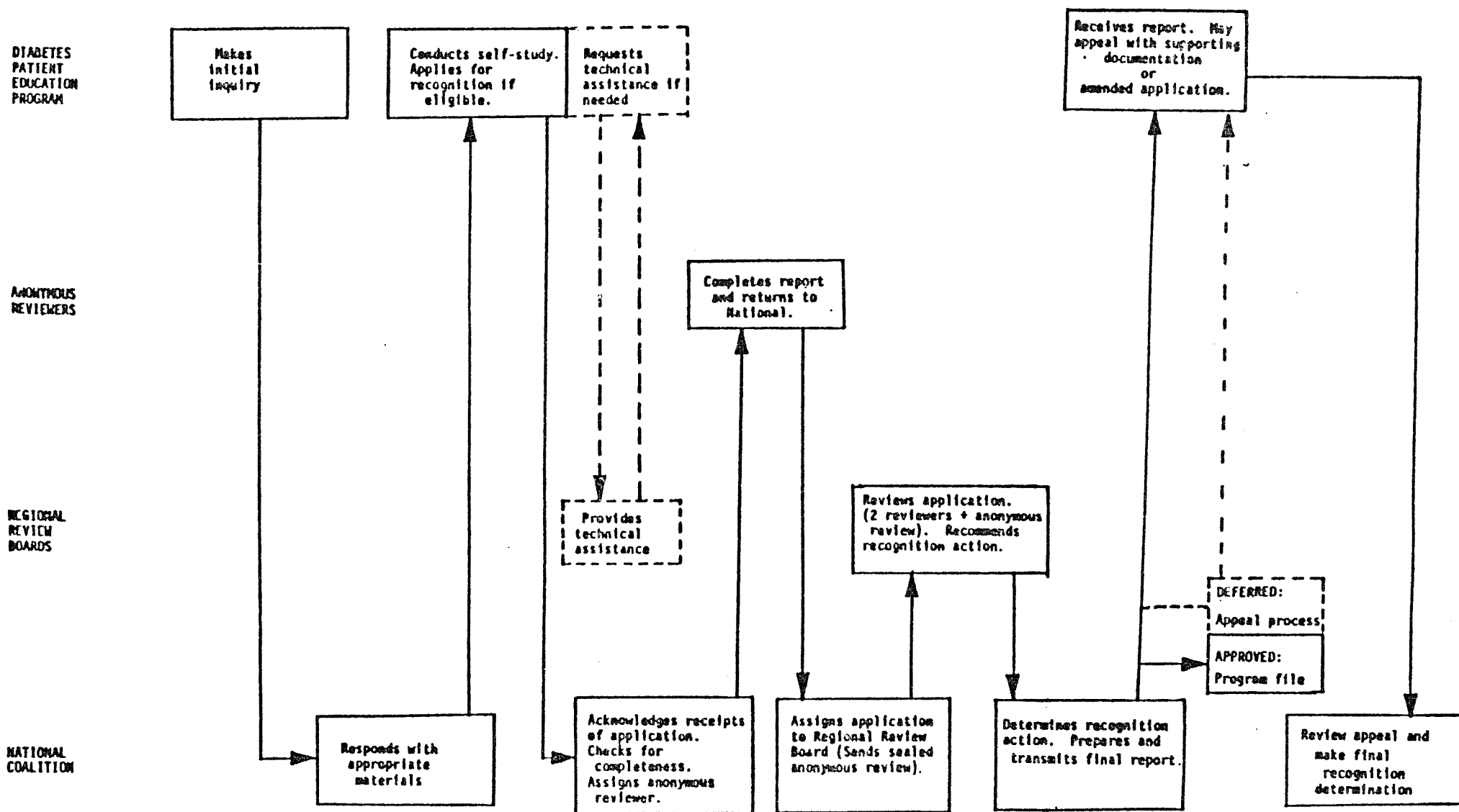
impartial assessment of the quality of all diabetes patient education programs. A coalition within the diabetes community will further the acceptance by those outside the diabetes community of one set of uniform standards for all diabetes patient education programs, thus eliminating the overlapping and sometimes contradictory standards now established by individual programs seeking third party reimbursement. A coalition can assume responsibilities that none of the participating organizations can carry out independently.

The major responsibility of the coalition will be to implement the recognition process. The coalition's tasks will include:

- (a) appointment of regional review bodies to examine applications from within their regions;
- (b) appointment of anonymous reviewers for impartial outside review;
- (c) authorization of site visits in special circumstances;
- (d) final review of applications;
- (e) mediation of appeals;
- (f) conferral of recognition;
- (g) review of support services and materials for the recognition process;
- (h) review and update of standards and recognition process;
- (i) establishment of administrative policy for recognition process.

The attached flow chart illustrates a proposed review process for the national recognition plan.

PROPOSED PROCESS FOR NATIONAL RECOGNITION
OF
DIABETES PATIENT EDUCATION PROGRAMS



Special Announcement

National Standards for Diabetes Patient Education Programs

(National Diabetes Advisory Board, November 1983)

National standards for diabetes patient education programs have been endorsed by the National Diabetes Advisory Board. These standards were developed under the auspices of the Board and in collaboration with the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse.

This statement presents the rationale for the standards and a plan for their implementation. It includes a summary and description of the standards and a tabular presentation for easy reference.

THE NEED FOR NATIONAL STANDARDS

Major strides have been made in the treatment of diabetes during the last decade as a result of biomedical research, technological advances, and improved application of currently available knowledge and resources. Dramatic increases in our knowledge of effective approaches to prevention of some of the complications of diabetes include better methods to assess and control blood glucose. It is now possible to limit the severity of some long-term effects of the disease and thus reduce its medical, social, and economic impact.

Several barriers, however, still preclude the widespread availability of preventive approaches in self-care. These barriers include lack of patient and provider knowledge about diabetes, inadequate reimbursement policies, and lack of coordination among key components of the health care system. One major impediment has been the lack of national standards to assure that the education provided to people with diabetes is of an acceptable quality and appropriate for the individual.

The National Diabetes Advisory Board, in collaboration with experts from within and outside the diabetes community, has developed national standards for diabetes patient education programs. These standards establish specific parameters against which programs can measure themselves. The standards are rigorous enough to be acceptable to the diabetes community, yet flexible enough to be practical for the primary care community. They are applicable in any

health care setting. The Board encourages adoption of these standards by all diabetes patient education programs.

NATIONAL PLAN FOR IMPLEMENTATION OF THE STANDARDS

The National Diabetes Advisory Board (NDAB) is mandated by Congress to oversee the Long Range Plan to Combat Diabetes. In addition to its advisory role, the Board has come to serve as a forum through which the diabetes community can focus on common needs and problems and share in their solutions. Through a series of workgroups, the Board and cooperating organizations determined that the availability of the standards would be enhanced by a process to ensure their widespread application. They are therefore developing a national system of recognition for diabetes patient education programs that meet the standards. Recognition is a voluntary process through which programs meeting the standards are formally identified for a level of performance, integrity, and quality entitling them to the confidence of the community they serve. The process is flexible enough to apply to programs that conform to other standards, provided the other standards adhere to the national consensus standards or are modified to do so.

The standards and the recognition process will be pilot tested during 1984 and 1985. Pilot testing will be conducted under the auspices of a Board-appointed steering committee consisting of representatives of the diabetes-related organizations involved with the Board in the development of both the standards and the recognition process. These organizations include the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse. The results of the pilot testing will form the basis for modifications in the standards and for any required adjustments in the recognition process prior to nationwide implementation. Support materials will be available to provide diabetes patient education programs with additional information on (1) how to meet the standards, (2) how to initiate or upgrade a program to meet them, and (3) how to apply for recognition.

National Standards for Diabetes Patient Education Programs

This table presents the standards in a form for easy reference. Standards applicable to the facility offering the program are designated "institution standards" and are separated from those applicable to the education program itself, which are designated "program standards."

COMPONENTS	STANDARDS	
	Institution	Program
1. Needs Assessment	<ul style="list-style-type: none"> The institution shall assess its diabetic caseload to determine the allocation of personnel and resources to serve the instructional needs of the caseload. There shall be a reasonable match between caseload requirements and resources allocated. 	<ul style="list-style-type: none"> An individualized and documented ongoing assessment of needs shall be developed with the patient's participation. This shall include medical history, present health status, previous diabetes education, health services utilization, associated medical conditions or risk factors, diabetes knowledge, skills, attitudes, self-assessment, identification of support system, barriers to learning, and financial status. The needs assessment shall be the basis for the education program delivered to each patient.
2. Planning	<ul style="list-style-type: none"> The institution shall have a written policy that affirms patient education as an integral component of quality diabetes care. 	<ul style="list-style-type: none"> The participants in planning shall include health professionals involved in the care and education of persons with diabetes and persons with diabetes and their families. The planning process shall define (in order): <ol style="list-style-type: none"> Program goals and objectives Target audience Program setting Patient access mechanisms Instructional methods Resource requirements Patient followup mechanisms Evaluation
3. Program Management	<ul style="list-style-type: none"> A coordinator shall be designated and responsible for all aspects of the program. The organizational relationships, lines of authority, staffing, and operational policies shall be defined. A standing advisory committee with both medical and community/consumer representation shall be established. 	<ul style="list-style-type: none"> Not applicable.
4. Communication/Coordination	<ul style="list-style-type: none"> A physician shall be identified to serve as liaison between the program coordinator and the medical staff. The institution shall regularly inform its staff and the patients (and potential patients) it serves of the availability of its diabetes patient education program. 	<ul style="list-style-type: none"> All information about the patient's educational experience shall be permanently incorporated into the patient's (medical) records maintained by the institution. The role of each education team member shall be clearly defined, and the intercommunication between each shall be documented in the patient's record. There shall be written evidence of coordination between different care settings.
5. Patient Access to Teaching	<ul style="list-style-type: none"> The applicant institution shall have a policy to inform patients routinely about the benefits and availability of patient education. 	<ul style="list-style-type: none"> The program shall be regularly and conveniently available. The program shall be responsive to patient-initiated requests for information and/or participation in the program's activities.

SPECIAL ANNOUNCEMENT

COMPONENTS	STANDARDS	
	Institution	Program
6. Content/Curriculum	<ul style="list-style-type: none"> The institution shall provide space, personnel, budget, and instructional materials adequate for the program. Assessment of available community resources shall be performed periodically. 	<ul style="list-style-type: none"> The program shall be capable of offering information on each of the following content items as needed: <ol style="list-style-type: none"> General facts Psychological adjustment Family involvement Nutrition Exercise Medications Relationship between nutrition/exercise/medication Monitoring Hyperglycemia and hypoglycemia Illness Complications (prevent, treat, rehabilitate) Hygiene Benefits and responsibilities of care Use of health care systems Community resources The institution shall specify the mechanism by which the curriculum shall be reviewed, approved, and updated.
7. Instructor	<ul style="list-style-type: none"> The institution shall identify appropriate instructional personnel and ascertain their competence. The numbers of personnel identified shall be suitable for the diabetic caseload within the institution. Designation of time for identified instructors shall be appropriate to accomplish the necessary educational objectives. 	<ul style="list-style-type: none"> Instructors (health professionals and others) shall be part of a comprehensive care and education program. Instructors shall have recent experience and training in diabetes and knowledge and skills in educational principles and their application.
8. Followup	<ul style="list-style-type: none"> The institution shall transmit the educational record to other appropriate health care settings when a patient transfers his or her care responsibilities. 	<ul style="list-style-type: none"> The program shall provide followup services for those patients who wish to maintain continuity of education within the institution. These services shall include: <ol style="list-style-type: none"> Periodic reassessment of knowledge and skills Timely reeducation based on reassessment Communication with the primary care provider about the need for professional and nonprofessional services.
9. Evaluation	<ul style="list-style-type: none"> The institution shall review periodically the performance of the instructional program and ascertain that it continues to meet national standards. 	<ul style="list-style-type: none"> The program shall conduct and record an individualized assessment of each patient's original needs and progress at regular intervals. The program shall be reviewed in ongoing fashion for both process and outcome, and the results of this review shall be used in subsequent planning and program modification.
10. Documentation	<ul style="list-style-type: none"> All aspects of the evaluation shall be recorded by the sponsoring institution and reviewed periodically to ascertain that national standards are being maintained. 	<ul style="list-style-type: none"> All aspects of the educational program offered to each patient shall be recorded in that patient's medical record as maintained by the institution.

SUMMARY AND DESCRIPTION OF THE STANDARDS

Diabetes is a serious and common disease that is treated directly or indirectly in practically every health care facility in the nation, regardless of size or location.

In chronic diseases, especially diabetes, patients are required to assume a major share of responsibility for their own care. Only an informed and well-motivated person who has the support of the primary health care provider can carry out this responsibility effectively. Evidence is growing that inadequate patient knowledge results in multiple hospital admissions, excessive use of emergency rooms, unnecessary medication, and a high incidence of long-term complications of diabetes, all of which increase human suffering and escalate the costs of care. Studies testing patient education as the variable component of the treatment regimen have shown consistent reductions in these measures. Education for self-care is therefore recognized to be a fundamental component of quality treatment for the individual with diabetes.

At the present time, both the quantity and quality of education offered to people with diabetes vary considerably in the United States. Experience in other fields has demonstrated the ability of uniform standards to improve the quality, effectiveness, and availability of programs. It is hoped that the implementation of national standards will result in increased access to this fundamental component of treatment by stimulating adequate reimbursement for diabetes patient education.

The diabetes patient education standards consist of 10 components that will enable an institution to establish a new program or modify an existing one. Each standard offers the flexibility required to tailor a patient education program to the type of diabetes, its duration, and the life-stage of the diabetic person. Many of the standards are overlapping, reflecting the interdependence among all components of an effective diabetes education program.

1. *Needs assessment.* A successful program is the product of a flexible policy based upon the needs of the community it is intended to serve. Since the diabetes caseload varies from one institution to another, each institution should assess its own needs and match its resources to the needs of its caseload. The needs assessment should be performed initially to guide the management of the program and to form the basis for program planning. It should be a continuing process that will allow the program to adapt to changing service requirements. In addition to the needs of the program, the needs of the individual patient should be assessed to provide the basis for the instructional program offered to each patient. The person with diabetes is recognized to be an equal partner in all aspects of the educational process.

2. *Planning.* Planning is an essential component of a diabetes patient education program. The planning process should describe the program's goals and objectives, target audience, setting (inpatient, outpatient), patient-referral mechanisms, procedures, and evaluation methods. The planning process should be a cooperative effort involving people with diabetes as well as health professionals.

3. *Program management.* Effective management is required to implement a patient education program. A variety of health care professionals is involved in the total care of people with diabetes. Clear lines of authority and efficient systems for communication should be established among everyone involved in the program. The ultimate responsibility for all aspects of program management should rest with one person designated as the program coordinator. In addition, an advisory committee should be established to assist the coordinator and other members of the program staff in setting policy and managing the program.

4. *Communication and coordination.* Several levels of communication are essential to the effective coordination of the program. Physician leadership and participation are necessary to ensure the integration of patient education into the treatment regimen. A physician should be identified to serve as the liaison between the education program coordinator and the medical staff. In addition, the institution should maintain regular channels of communication with its staff and the community it serves to inform diabetes patients and their families about the availability of the program. All information on the patient's educational experience should be incorporated into the medical record.

5. *Patient access to teaching.* It should be the policy of the institution to facilitate access to patient education for the target audience specified in the plan. This is promoted by a commitment to routinely inform both patients and staff about the availability and benefits of patient self-care programs. Diabetes patient education should be regularly and conveniently accessible, and the instructional program should be able to respond to patient-initiated requests for information. The program permits referral by health professionals, health care agencies, or individual patients. The instructional design encourages active patient participation.

6. *Content/curriculum.* The individual patient's needs assessment provides the basis for the instructional program offered to each patient. The assessment should be documented and should include all relevant information regarding the patient's treatment, education, and support systems. Responsibility for various facets of the assessment can be divided among the instructional team members. Curriculum and instructional materials should be appropriate for the specified target audience, taking into consideration the type and duration of diabetes and the age and learning ability of the individual. Both curriculum and available community resources should be reviewed and updated periodically. The institution should provide the program with adequate space, personnel, budget, and materials.

7. *Instructor.* Qualified personnel are essential to the success of a diabetes patient education program. Each institution should be responsible for identifying and evaluating its instructors. Instructors should be skilled professionals with recent experience and training in both diabetes and educational principles. The number of instructors should be proportional to the caseload requirements. Instructors should be allotted sufficient time to complete the instructional program.

8. *Followup.* Followup services are important because diabetes requires a lifetime of proper care. The institution should

provide followup services that include periodic reassessment of the patient's knowledge and skills and should offer supplementary educational services when warranted. Written communication between the program staff and the primary care physician is essential for ongoing identification of the patient's needs. This is especially appropriate in regard to referral for early diagnosis and treatment of the complications of diabetes. Referral to community resources may also provide ongoing support for long-term psychosocial needs and behavioral modification skills. If a patient changes care settings, the institution should request the patient's permission to send his/her records to the new health care setting.

9. *Evaluation.* The institution should review the educational program periodically to ascertain that it continues to meet the national standards. This review should be con-

ducted by the advisory committee. The results of this review should be utilized in subsequent program planning and modification. An assessment of each patient's needs and progress should also be conducted at regular intervals.

10. *Documentation.* Program planning and evaluation should be documented to provide the basis for future program development and modification. All information about the patient's educational experience should be documented in the patient's medical records, as should communication among treatment and education professionals.

For further information contact the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Room 616, Bethesda, Maryland 20205. Tel: (301) 496-6045.

Rene Herman

I am Rene Herman and for 28 years I have had diabetes but only 5 years ago did I learn self management skills and how to live WITH diabetes. Before learning, if I had a problem, it developed gradually enough that it was too late to take care of it as an outpatient. After going through a full week of concentrated diabetes education, I've been able to cut down on office visits and hospital admissions. Diabetes is more than a diet and shots. Other factors like stress, illness, and exercise play a large part in good blood sugar control. Learning how to adjust food and insulin intake in response to these factors and other situations is vital to good, cost effective home management.

My grandmother has been diabetic for about 12 years. A few weeks ago she was hospitalized in Wichita for 8 days to regain control of her diabetes. She had no education during this admission. She was released and she went to her winter home in Texas. With nicer weather she was a lot more active and began having a lot of low blood sugars due to the increased activity. She eventually ended up in the hospital again. Had she had education she would have been able to adjust her own insulin and diet and could have avoided the low blood sugars and rehospitalization.

If diabetes education prevented only 1 hospitalization per patient who has diabetes, it would save the insurance companies many thousands of dollars over just a few months.

In order to really keep on top of diabetes control it is necessary to know what the blood sugar is, at more frequent intervals than once every couple of months at the routine office visit. An example of the benefits of both the education and home glucose monitoring happened to me last spring. I caught a pretty miserable cold. By doing blood sugars at home, I noted that the blood sugars were quite a bit above normal and I adjusted my insulin according to those blood sugars. Prior to the education and home monitoring I would have been unable to adjust the insulin effectively. In my own past that same type of situation has resulted in admission to the Intensive Care Unit in Wichita. Even with the cost of home monitoring equipment (\$250) and education (\$200), all combined is still less expensive for the insurance companies to pay than for a hospital admission with a few days in the Intensive Care Unit not to mention the time loss to my family and job.

Also after acquiring some of the complications of diabetes including eye disease, kidney disease, and nerve damage, it became imperative that I obtain even tighter control of my glucose levels. Kidney function had decreased to the point where it was almost time to consider kidney dialysis. I lost some of the vision in both eyes and had to have laser surgery. After going on the insulin pump and gaining better control of my diabetes as indicated by my hemoglobin A1c levels, my kidney function has returned to near normal and I have lost no more vision. Hospitalizations have also decreased. Prior to pump therapy I was in the hospital causing threatened job loss, loss of income, and loss of family time about once every 2 months. With insulin pump therapy I have now been out of the hospital, no admissions, for over one year.

3/5/85
Attachment II

I believe that even with the expense of education, home glucose monitoring and the insulin pump that I am a good example and not an isolated one that all of these expenses in the long run have and will save the insurance companies thousands of dollars. For cost effective management of diabetes, it is necessary to handle as many of the problems associated with day to day living with diabetes while they are small, before a hospital admission is necessary.

I ask that you support Senate Bill 274 to help those of us in Kansas who have diabetes, LIVE with diabetes.

St. John Diabetes Clinic
Darlene Hilliard, R.N.
Diabetes Educator/Coordinator

The St. John Diabetes Clinic Associated with St. John District Hospital at St. John, Kansas, is a small rural Diabetes outpatient - inpatient education clinic. We evolved out of the need of our diabetic patients for education and follow up. In 1983 our number 5, admitting diagnosis was Diabetes, for a 28 bed hospital this was very high and was primary due to rehospitalization of the same patients. It was determined by asking these patients questions that they had received little or no education.

I attended a intense 2 week program thru the American Diabetes Association Kansas Affiliate, Wichita State University, Kansas Regional Diabetes Center in the summer of 1983 and started an inpatient program. With the implementation of DRG's and short stays, I started seeing outpatients. We moved into our clinic on October 13, 1983. We saw a total of 37 patients in 1983 (see attached report).

In 1984 we added the services of Dr. Lillian Harstine, Endocrinologist one day a month, Dr. Richard Guthrie and Dr. Olga Tatpatti alternate visits every 3 months. This gives the area diabetic patients a chance to see specialists without taking off work to go to Wichita. The patients family physician remains primary provider. We do refer to Wichita frequently.

In 1984 our clinic saw 384 patients and had 105 cancellations due to weather or illness. We saw a total of 197 patients from out of town, 70 patients walked in without an appointment. Dr. Harstine saw an additional 58, Dr. Guthrie made 2 separate trips and saw 17 patients, Dr. Tatpatti made 1 trip and saw 6 patients. We saw patients from Ellinwood, Larned, Stafford, Preston, Great Bend, Plains, Macksville, Kinsley, Rozel, Sawyer and St. John, to name a few.

Diabetes did not appear on the Hospital admission list in 1984. We did admit 6 patients with diabetes but they were admitted for other reasons. We did admit a patient for Diabetes for control and education he had been a diabetic for 17 years and wished to gain control of his disease.

We have had many patients who have not continued education or follow up because insurance won't pay for it and they can't afford it on a fixed income. Diabetes is a very expensive disease and food and insulin comes before education in their priorities. I have done several crash survival sessions so they can survive until they can afford more education. Several patients needs home glucose monitoring which they can't afford.

I teach on a one to one basis and am flexible enough to do crash teaching for survival to extensive teaching depending on individual patient needs. I do teaching I know will never be reimbursed for, and with the tight financial situation of small rural hospitals we watch it but continue even tho

3/5/85
Attachment VI

we loose money.

We feel that that the drop in hospital admissions and readmissions is due to the availability of education and specialist now available in our rural area.

Our clinic is a Pilot Test Site for testing the National Standards of Diabetes Education.

Thank you very much for allowing me to tell you about our diabetes education clinic.

DH/ac

3-4-85

Darlene Hilliard, R.N.
Diabetes Educator/Coordinator
St. John Diabetes Clinic
St. John District Hospital
610 East 1st.
St. John, Kansas
67576
316-549-6330

St. John Diabetic Clinic

Year End Report

for 1984

NUMBER OF PATIENTS SEEN FOR '84 - 384 CANCELLATIONS - 105

DIABETIC - 253 DIET - 80 HYPOGLYCEMIC - 22

SPECIALIST	# OF PATIENTS SEEN	DIABETIC	THYROID	OTHER
Dr. L. Harstine	58	32	9	17
Dr. R. Guthrie	17	17		
Dr. O. Tatpatti	6	6		

NUMBER OF INSERVICES : ATTENDED - 16 GIVEN - 12

NUMBER OF GLUCOMETER STICKS - 72

NUMBER OF DOCTOR REFERRALS - 74 NUMBER OF WALK - INS - 70

NEW PATIENTS - 115 OUT OF TOWN PATIENTS - 197

SPECIAL PROJECTS :

Every Month a new flyer to be developed and sent to various papers - about care or recipes. Stafford County ADA Chapter was developed in February. 3 specialists brought in from Wichita to see patients in our area. Diabetes Clinic at the Stafford County Health Fair was success- 176 people passed through. The Clinic is one of the Satelite Clinic's that is in the National Standards for developing guidelines for other clinics. The liquid diet has been field tested. Weight Control Program being developed. Several cookbooks have been ordered and several sold. Have a Dietician in the house. Walk Path has been granted to be set up in April of '85. Have changed rooms around for Doctor and Specialist - as we all grow.

Tuesday - March 5, 1985

Re: Senate Bill No. 274- By Committee on Public Health and Welfare.
Relating to insurance; concerning coverage for certain
diabetic equipment and education programs.

Mr. Chairman - Members of the Senate Financial Institution and
Insurance Committee.

I'm Julia Francisco. I feel that I know most of you very well.
I am not a doctor, a nurse, or an insurance person. I am, however,
a diabetic. Having lived over half my lifetime with this disease,
I do feel a certain expertise, although not clinical. Also, I am
a taxpayer, and an insured, experiencing premium increases just as
you.

Senate Bill 274 speaks to two issues which are very close to
me. The first being diabetic management training; the second,
Insulin Pump therapy and supplies.

I was diagnosed to be a diabetic 22 years ago. At the age of
16 I was told I would have to take insulin injections daily and
stay on a strict diet. I was sent on my way, visiting the doctor
twice yearly for adjustments.

As I grew older and wiser, I began to realize I had a "Tiger
by the Tail". I stumbled through flus, colds, infections, eye
problems and the birth of my daughter with numerous, and expensive
hospital stays. I felt fortunate to have insurance coverage con-
tinuously, which paid these expenses with no questions asked.

On several occasions, I heard of diabetic management classes

3/5/85
Attachment VII

and seminars which were being conducted by Dr. Guthrie in Wichita. When I was told they cost \$150 (at that time) and that my insurance would not help with the expense, I always put it off. "After all, it couldn't be necessary if the insurance company felt it wasn't!" I was paying premiums and when I was ill they paid, so why pay extra?

The unfortunate fact about diabetes is that the devastating results of poor management usually do not appear right away. Most of you know of my recent health problems: A heart attack in March of 84 resulting in by-pass surgery in April. The expenses which resulted would have devastated us if not for excellent insurance coverage.

Needless to say, I became involved in the Diabetic Management Training early last summer. No one can say for a fact that better training, or even perfect diabetic control, would have averted the problems. However, the evidence is very strong in its favor. Poorly managed diabetes has been shown as a leading cause of heart attacks, kidney failure, amputations, and blindness among others. I can say that at least once in the previous year I have avoided a hospital stay for an intestinal flu because of the self-management techniques I learned at the Diabetic Care Unit. Insurance did not pay for the \$200 course. Blue Cross-Blue Shield would have, however, paid in excess of \$500 for a minimum hospital stay. This does not sound like a good use of our premium dollar.

Concerning the 2nd issue the inclusion of the insulin pump and supplies, I am now using the insulin pump, a device which delivers a

supply of insulin to my system around the clock. Since my introduction to the CPI 9300 in June of 84, I have developed a control level I never dreamed possible.

Blue Cross-Blue Shield covered partial cost of the insulin pump. At a cost of \$2500 initially, with supplies of \$100/month, I would not be using it, if it didn't. Some companies will not cover pumps at all. Perhaps, they feel it is unnecessary treatment. I only know I have been through colds, flu, and infections without a hospital stay due to the good control of the insulin pump has made possible.

One more comment to the cost issue needs to be stated. Several years ago, there was a new device on the market for diabetics. The Glucometer, or Dextrometer, was used to test blood sugars at home, a factor basic to good management. I had heard about this device, and thought it would be handy, but at a cost of \$400-\$500 it was expensive. Insurance, at that time, did not cover this expense. Again, I thought if insurance will not cover this, it must be some fad gadget and not necessary, nor worth the money.

Glucometers and Dextrometers are now a covered expense and proved to be a real aid to good control. Since insurance companies have been covering this expense, more diabetics are owning them and the cost has really come down (about 50%). I would speculate that should the use of the insulin pump be encouraged, the cost,

as with the glucometer, would eventually decrease. More production should result in less cost per unit.

I am insured. Probably by the same company, and in the same group, as many of you. If, next year I should develop kidney disease, the majority of my expenses will be paid by you, the policy holders. If, however, the use of this insulin pump should delay or completely avoid that occurring, it's worth many times its cost to you, needless to say its value to me.

In this time of concern for rising costs, it does not make sense to send the message that good home management is just "not worth it".

Life is full of "what ifs" and "if onlys". I don't choose to dwell on those. I only hope you will do everything you possibly can to assure newly diagnosed diabetics to seek and use all the resources and techniques available to them to assist them in living long and healthful lives.

Thank you.



BANKERS LIFE NEBRASKA

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March 3, 1985

For presentation to the Financial Institutions and Insurance Committee
Mr. Chairman, Committee Member and other interested parties:

My name is William E Horn, I am the Group Claim Manager-Wichita for Bankers Life Nebraska, a position held for the last 17 years. I am also a member of the Sedgwick County Roundtable for Medical Cost containment.

This opportunity to express a few words against Senate Bill 274 is sincerely appreciated. These comments can be considered in opposition to mandated coverages for all conditions or providers. We feel strongly an insurance policy should be written for the benefit of the policyholders and not for the benefit of the providers of a service covered by that policy.

Mandated coverages historically have resulted in increased costs and at the same time remove any incentives for cost control or utilization control. A mandate for a specific treatment program, a specific piece of equipment or educational program for any one illness immediately causes the same cry for hundreds of other illnesses or conditions.

A dangerous precedent is being proposed in asking for the purchase of durable equipment which historically has been covered on a rental basis only and based on a true medical necessity. Such a precedent opens the doors to the point where a policyholder would be forced to turn away from insured programs as we know them today.

Educational programs abound for many medical problems today and to support them all is not economically feasible. Costs for most of these is an affordable amount for the patient today but if mandated could become so sophisticated it is no longer affordable by the non insured tomorrow. Further, when coupled with other similar requests for other programs it becomes unaffordable for insured programs.

Many group policyholders today are very sophisticated in the purchase of health benefits and determining the needs of employees through the purchase of services of professionals in the health provider field. Treatment programs are studied and coverage then sought in the most cost effective way. When a medical need is shown they move to fill the gap. Treatment programs for convenience are rejected while accepting new methodology where a medical need is shown.

We are not against the treatment of diabetes or for that matter educational programs. We do not feel a mandate is the answer to the problem, however. We have followed the purchases of glucometers and dextrometers for several years. While some patients continue the use of this equipment others do not. Patient usage of the equipment is necessary but yet a factor not controllable. The cost of an insulin pump today of \$1500 to \$2000 each could well be many times this is a short period of time after a coverage is mandated. Thus the non use or mis-use of the equipment becomes an economic barrier. Cost effectiveness of a program requires an on going study and any mandates only serve to curb the obtaining of the best medical care at a reasonable cost.

Thank you for listening and we trust these comments will be weighed in your final decision.

Respectfully submitted,

William E. Horn, F.L.M.I.

Group Claim Manager-Wichita

Beech Aircraft Corporation

Wichita, Kansas 67201
U. S. G.

STATEMENT BEFORE THE KANSAS SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE MARCH 4, 1985

Mr. Chairman, members of the committee, my name is Don Snyder, Manager of Health Programs for Beech Aircraft Corporation. We have airplane manufacturing plants in Wichita, Liberal, Salina, and Andover. I appreciate the opportunity today to express our reasons for opposing Senate Bill 274.

At the outset I would like to indicate that we recognize the devastating long-term impact of uncontrolled diabetes, and the value for a diabetic to maintain constant, normal blood sugar levels. The Beech Group Insurance Plan provides excellent coverage for the care and treatment of diabetes. However, to mandate coverage for insulin pumps for all diabetics, and to mandate coverage for self-management education goes beyond the intent and scope of our health insurance plan.

In order to control health insurance costs, our group insurance plan only purchases medical equipment which is necessary for the care and treatment of the medical condition, and only when the condition cannot be adequately controlled through less expensive means. An insulin pump cannot be cost justified, nor is it needed, by every diabetic. Furthermore, mandating coverage for the purchase of insulin pumps will result in a dramatic increase in the price of these pumps because of increased pump sophistication or improved automation. This has happened time after time in the medical field where price is no longer a consideration.

Diabetic self-management education should be provided to the patient at an affordable cost without regard to insurance coverage. Most physicians provide this service as a normal and routine part of their care and treatment. Mandating coverage for health education will only result in unnecessary increased health care costs because the health care provider will be directing the purchase of this added service, and price will no longer be of concern to the patient. Currently our insurance plan does not provide specific coverage for any type of health education. Health education is being provided to our employees, but it is done by the physician or health practitioner as a part of their normal service.

At the center of this issue is whether the legislature wishes to mandate the kind of insurance package the purchaser is required to buy. We have no problem with directions given to insurance companies concerning the kind of package offered. However, as the consumer we should be allowed a choice whether we want such coverage or something tailored to our specific needs.

Through the collective bargaining process a specific benefit plan was negotiated. Inactment of this proposed legislation would alter this negotiated package of fringe benefits, increasing costs at a time when we are especially concerned about escalating health care expenditures.

In our judgement the proposed bill is unwarranted in that it will unnecessarily increase health care costs. It forces our company to accept coverage we do not want and for which we do not want to pay.

Thank you.