FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

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Date: 4/04/97

To:	From:
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REMARKS:

Hi Sarah! -- Peter Hickman said that you had asked for some information comparing H.R. 15 (the Thomas prevention bill) to the prevention provisions in the Administration's bill -- see attached summary and side-by-side. These documents are currently in clearance in the Department so these copies should be considered "draft".

As noted in my phone message, we should have something for you on Monday re: some proposed diabetes activities.

-- JOAN

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

MEMORANDUM

April 1, 1997

TO: Chris Jennings and Nancy-Ann Min

FR: Sarah Bianchi

RE: Background for Diabetes Meeting

Background

Sixteen million Americans have diabetes, but only 8 million are aware of their condition. One million Americans develop diabetes each year. In 1996 alone, diabetes will have this impact:

- *The leading cause of new blindness in adults over the age of 30:* Up to 24,000 Americans are blinded each year from diabetes.
- *The leading cause of kidney failure,* causing 20,000 Americans to develop end-stage renal disease from diabetes each year.
- *The leading cause of non-traumatic amputations:* 54,000 amputations are performed on diabetics each year.
- *Seventh leading cause of death:* 400,000 Americans with diabetes die each year.

Costs: An estimated $92 billion in direct and indirect costs were spent on diabetes in 1994. Contributing substantially to these costs are the complications from diabetes (see above).

Type I diabetes (juvenile diabetes) or insulin-dependent diabetes accounts for about 5% of all diabetes cases. In Type I diabetes, insulin-secreting cells are completely destroyed by the body's own immune system and insulin replacement is required to live.

Type II diabetes (adult onset) is characterized by both deficient tissue response to insulin and inability to produce enough insulin. Type II usually strikes individuals over the age of 40 and usually develops over a period of years. Because of this, many people with type II diabetes are never diagnosed until they develop complications. Their elevated blood sugar levels cause substantial long-term damage to the body.

Medicare and Diabetes

- Of the 8 million diagnosed with diabetes, 3.2 million are adults aged 65 or older. In fact, nearly 20% of the elderly population has diabetes.

- One-third of new patients with diabetes are age 65 or older and covered by Medicare.

- Medicare also covers people less than 65 with end-stage renal disease and thus is a major payor for diabetic care.

  -- 20,000 Americans develop end-stage renal disease from diabetes each year.

  -- Medicare expenditures per person with diabetes on kidney dialysis averages $38,700 annually.

- Twenty-seven percent of Medicare expenditures are spent on people with diabetes.

The President's 1998 budget expands Medicare benefits for diabetes outpatient self-management training and blood glucose monitoring

- **Diabetes outpatient self-management training services:** Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs.

  The President's budget will expand coverage to include outpatient training furnished by physicians and other certified providers.

- **Blood glucose monitors and testing strips:** Under current law, Medicare covers blood glucose monitors (including testing strips) only for insulin-dependent diabetics.

  The President's budget will expand coverage to pay for monitors and testing strips for all diabetics.

The President will invest $1.4 billion between 1998 and 2002 in improved care for Medicare beneficiaries with diabetes (CBO scored this policy at $2.4 billion)

There are claims that this benefit will save Medicare money due to reduced incidence of severe complications for beneficiaries with diabetes. While the Health Care Financing Administration's Actuaries do not believe that this will occur, the President believes that these are important policies to improving the quality of beneficiaries' lives.

Evidence suggests that diabetes-related blindness, amputations, and other complications could be substantially reduced with early intervention and disease management.

- Currently screening and treatment for eye disease among persons with diabetes is saving the Federal government around $248 million per year.

- The Diabetes Control and Complications Trial, a ten-year national study confirmed that good control of blood sugar prevented the onset or delayed progression of eye, kidney, and nerve damage by at least 50 percent.

Diabetes Prevention and Outreach (CDC)
CDC strives to increase awareness and education about diabetes, support early detection and treatment of complications, and improve the quality of and access to diabetes care. They have developed a number of innovative community-based, state, and national programs to identify high-risk groups, monitor health outcomes and indicators of quality of health, and provide sound data for sound public health policy decisions. The FY 1998 budget for diabetes is $36 million.

NIH -- NIDDK Research
Many of the therapies developed for diabetes -- insulin pumps, various forms of insulin -- comes from research funded by the NIDDK. Even with these therapies, diabetes remains an exceeding difficult disease to control. Thus, preventing diabetes and its complications are major goals of research.

The recently completed Diabetes Control and Complications Trial (DCCT) demonstrated conclusively that intensive management of diabetes delays the onset and slows the progression of complications of diabetes. These standards were subsequently adopted by a number of medical and health organizations. Additional clinical trials include:

- **Diabetes Prevention Trial-Type 1** will determine whether insulin-dependent insulin-dependent diabetes can be delayed or prevented in people who are at risk for developing this disease. At risk individuals will be treated with low doses of insulin to "immunize" them against this disease. Patients will be followed for four years to determine whether insulin therapy can in fact reduce the risk of developing diabetes.

- **Diabetes Prevention Program (DPP)** is testing intervention strategies to prevent or delay the onset of Type 2 diabetes for individuals with glucose intolerance who are at high risk for developing the disease. Since Type 2 diabetes affects primarily minorities, the DPP will include 50% minority enrollment.

The NIH is also looking at issues of determining genetic links to diabetes, treatments to prevent complications, and causes of insulin resistance. Diabetes funding has grown far more slowly than some other areas of NIH. For example, while breast cancer research grew 200% between 1991-1994, diabetes funding grew by only 15%.

Participants

NIH
Dr. Varmus -- Director
Dr. Gordon -- Director of National Institute of Diabetes and Digestive and Kidney Diseases

CDC
Dr. Vinicor -- Director, Division of Diabetes Translation
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HCFA
Kathy King -- Administrators office
Nancy DeLew -- Deputy Director, OLIGA
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ASPE
Gary Claxton

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

"The Nation's Prevention Agency"

CENTERS FOR DISEASE CONTROL
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DATE 3-31-97 **PAGES** 16 + Cover

TO Sarah Branch

Phone:

Fax:

FROM Don Shriber

Phone:

COMMENTS/NOTES

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

TO: Sarah Bianchi
Domestic Policy Council - White House

FROM: Frank Vinicor, MD, MPH
Director, Division of Diabetes Translation
Centers for Disease Control and Prevention

SUBJECT: Diabetes Mellitus in the United States

DATE: 31 March 1997

Dear Sarah:

Enclosed is a 2 page summary of "Diabetes in the United States," along with a Fact Sheet, and two explanatory figures. I have tried to provide a broad view of this common and serious health condition, indicating where possible interventions could be applied to reduce the burden of diabetes.

I hope it provides a beginning "big picture." Clearly, there are many issues that I did not address, and many possible questions or points that would need clarification and amplification. I would look forward to discussing this information with you and/or your colleagues in order to insure a clear and accurate picture of diabetes mellitus.

Respectfully,

Frank Vinicor, M.D., M.P.H.
Director, Division of Diabetes Translation
Centers for Disease Control and Prevention

As indicated in the accompanying Fact Sheet, approximately 16 million persons have diabetes in the United States. Only ½, or about 8 million people, know that they have diabetes, i.e. it has not been diagnosed in 50% of persons, even though the disease is present. Diabetes is thus a common, but also a catastrophic and costly disease. The data in the Fact Sheet provide some specific information. To provide a more "visceral" sense of the scope and magnitude of the problem, two particular facts are noteworthy: 1) diabetes mellitus is the leading cause of blindness among working aged adults, and the leading cause of all end stage kidney failure cases as well as non-traumatic lower extremity amputations in the U.S.; and 2) in any 24 hour period, e.g. between when one wakes up this morning and will wake up tomorrow, 1700 persons will be diagnosed with diabetes; 150 amputations will occur; 55 persons will go blind; and 55 people with diabetes will experience kidney failure. Unfortunately, because of a growing population which is aging, less active and more overweight, esp. in those very communities at risk for diabetes, e.g. ethnic and racial minorities, the burden of diabetes is likely to increase during the next 5-10 years before it is begun to be brought under control.

To understand where interventions could be directed to reduce this burden, consider Figure 1. The natural history of diabetes is such that 4 "Transition Points" characterize the life cycle of a person with diabetes. As discussed below, conceptually, interventions at any 1 or more of the Transition Points could reduce the devastating burden of diabetes:

Transition Point #1: Presumably, people without clinical diabetes go through a transition where diabetes is now present. Because 1) there may be few signs or symptoms; or 2) symptoms are non-specific, often people do not know that diabetes is present. In fact, studies indicate that Type II diabetes ("adult onset diabetes") is present for between 8-12 years before diagnosis.

Transition Point #2: Because of symptoms, or as part of routine blood tests, diabetes is diagnosed by a health care provider. While it would seem logical that immediate care would be provided, in fact, for any one of several reasons - denial; absent or inadequate health insurance; suggestions from the provider that diabetes is "mild" and nothing to worry about - evaluation and care is not automatically quickly directed to persons with a new diagnosis of diabetes.

Transition Point #3: Eventually, individuals with diabetes do come in contact with the health care system, and persons transition from No Care to Initial Care. However, diabetes is a complex and demanding disease, and education/ time is needed to accomplish many preventative and treatment goals.

Transition Point #4: Over time, persons with diabetes will (hopefully) experience this 4th. transition, and receive quality care, with decreased development/progression of diabetes complications.

Each of these Transition Points can serve as a potential target for intervention with the following programs (see Figure 2): #1 - Primary Prevention; #2 - Screening and Early Diagnosis; #3 - Access; and #4 - Quality of Care (Secondary and Tertiary Prevention). Decisions about where it place resources depends upon the level of resources; the nature of the existing infrastructure; and the strength of the science.

Working in reverse (Transition Point #4 - Quality of Care), reliable and strong science indicates that both glucose control ("secondary prevention") and complication detection and early treatment ("tertiary prevention") are both effective in reducing the development and extent of devastating diabetes complications. These interventions are also cost-effective. Unfortunately, studies also indicate that the standards of diabetes care presently utilized are not satisfactory, no matter what the nature of the health care system, e.g. fee for service, managed care organizations, Veterans Administration Health System; Medicare; etc. While several reasons may account for the lack of quality care, efforts directed to improvements in type, patterns and effectiveness of the patterns of secondary and tertiary preventive diabetes care can substantially control the burden of diabetes. Behavioral and health services research would also be beneficial at this point in conjunction with translation programs at Transition Point #4.

Transition Point #3 - "Access" represents another "site" at which improvements in the diabetes burden would be noted, if properly implemented. Given the changing health care systems, esp. managed care programs; and given 1) the substantial number of diabetic individuals without health insurance; and 2) correcting the perception among health providers that diabetes is not a serious disease, earlier contact with diabetes care programs would likely decrease the development and extent of diabetes complications.

Because 8-12 years elapse between onset and diagnosis of Type II diabetes; and given that accurate and simple diagnostic tests for diabetes exist, Screening or Earlier Diagnoses (Transition Point #2) would seem both logical and clinically beneficial to persons with diabetes. This question is actually complex, and is now being systematically studied by the CDC. At least it is known that certain characteristics, e.g. overweight; underactive; over 45 years of age; an ethnic/racial minority; diabetes in the family; etc.; increase the likelihood that diabetes could be present and not yet diagnosed. In general, then, should diabetes symptoms - excessive thirst, urination or hunger, etc. - be present; or if one is in the "high-risk" category as described above, screening is probably both reasonable and appropriate.

If the onset of diabetes could be stopped before it development of the disease, i.e. Primary Prevention (Transition Point #1), than there would be no burden associated with the condition. At present, 2 primary prevention trials - Diabetes Prevention Trial I (DPT I) for IDDM; and Diabetes Prevention Program II (DPP II) for NIDDM, have been initiated. The primary sponsor of these trials is the National Institutes of Health. Each investigation, however, is co-sponsored by other federal agencies such as the CDC, as well as voluntary health associations and the private sector. It is likely that within 3-5 years, more information will be available to determine IF primary prevention is efficacious; what are the most powerful interventions; and the amount of benefit that would be expected by these programs

In summary, during the last decade, we have learned a great deal about diabetes, both regarding basic and clinical research perspectives, but also in terms of the size of the diabetes problems and what programs could be effective in controlling this disease. Diabetes remains a common, catastrophic and costly disease, i.e. both a clinical AND a public health challenge. Continued research is needed, while improved efforts in "translation," i.e. programs to effectively convert science into daily clinical and public health practice, are needed.

National Diabetes Fact Sheet

Prevalence of Diabetes in the United States

Total (diagnosed and undiagnosed):

16 million (1995 estimate)

- **Diagnosed:** 8 million
- **Undiagnosed:** 8 million
- **Insulin-dependent diabetes (IDDM):** Estimates range up to 800,000 *(No national registry for diabetes exists. These estimates are extrapolated from several regional registries.)*
- **Non-insulin-dependent diabetes (NIDDM):** About 7 to 7.5 million diagnosed cases *(1993 estimate)*

Cost

Total (direct and indirect):

$92 billion (United States, 1992)

- **Direct medical costs:** $45 billion (The figure for direct medical costs includes only those cost directly attributable to diabetes. This is in contrast to figures cited elsewhere that estimate all health care costs incurred by people with diabetes, including costs not related to diabetes.)
- **Indirect costs:** $47 billion (disability, work loss, premature mortality)

Deaths

- In 1993, about 400,000 deaths from all causes are estimated to have occurred among persons aged 25 years and older who have diabetes. This figure represents 5 percent of all persons known to have diabetes and 18 percent of all deaths in the United States in persons aged 25 years and older.
- Based on death certificate data, diabetes contributed to the deaths of more than 169,000 persons in 1992. It is well known that death certificate data underrepresent diabetes deaths.
- Diabetes was the seventh leading cause of death listed on U.S. death certificates in 1993, according to the National Center for Health Statistics. It is the sixth leading cause of death by disease.

Incidence

Total new cases diagnosed every day:

About 1,700 (1990-1992 averaged)

Total new cases diagnosed every year:

625,000 (1990-1992 averaged)

- **NIDDM:** About 595,000 new cases per year
- **IDDM:** About 30,000 new cases per year

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

CDC

Prevalence by Population Groups

Number of people diagnosed with diabetes
(1993 estimates)

- **Women:** 4.2 million
- **Men:** 3.6 million
- **Children age 19 years or younger:** About 100,000
- **Adults age 65 years or older:** 3.2 million

Percentage of Adults with Diabetes by Race and Ethnicity
(estimates of the prevalence of diagnosed and undiagnosed diabetes from various national surveys and special studies)

- **African Americans:** 9.6 percent
- **Mexican Americans:** 9.6 percent
- **Cuban Americans:** 9.1 percent
- **Puerto Rican Americans:** 10.9 percent
- **White Americans:** 6.2 percent
- **American Indians:** Ranges from 5 to 50 percent
- **Japanese Americans:** Among second-generation Japanese Americans 45 to 74 years of age residing in King County, WA, 20 percent of the men and 16 percent of the women had diabetes.

Treatment for Diabetes

Treatment emphasizes control of blood glucose through blood glucose monitoring, regular physical activity, meal planning, and attention to relevant medical and psychosocial factors. In many patients, oral medications and/or insulin injections are also required for appropriate glucose control. Treatment of diabetes is an ongoing process that is planned and regularly reassessed by the health care team, the person with diabetes, and his/her family. Patient and family education are important parts of the process.

Long-Term Complications

Heart Disease

- Cardiovascular disease is 2 to 4 times more common in people with diabetes.
- Cardiovascular disease is present in 75 percent of diabetes-related deaths.
- Middle-aged people with diabetes have death rates twice as high and heart disease death rates about 2 to 4 times as high as middle-aged people without diabetes.

Stroke

- The risk of stroke is 2 to 4 times higher among persons with diabetes.

High blood pressure

- An estimated 60 to 65 percent of persons with diabetes have high blood pressure.

Blindness

- Diabetes is the leading cause of new cases of blindness among adults 20 to 74 years of age.
- Diabetic Retinopathy causes from 12,000 to 24,000 new cases of blindness per year.

Kidney disease

(Treatment by dialysis or transplantation)

- Diabetes is the leading cause of end-stage renal disease, accounting for 36 percent of new cases.
- 19,790 new cases occurred in 1992 among persons with diabetes.
- 56,059 people with diabetes were undergoing dialysis or transplantation treatment in 1992.

Nerve disease

- About 60 to 70 percent of people with diabetes have mild to severe forms of diabetic nerve damage (with such manifestations as impaired sensation in the feet or hands, delayed stomach emptying, carpal tunnel syndrome, peripheral neuropathy).
- Severe forms of diabetic nerve disease are a major contributing cause of lower extremity amputations.

Amputations

- More than half of lower limb amputations in the United States occur among persons with diabetes; from 1989 to 1992, the average number of amputations performed each year among persons with diabetes was 54,000.

Dental disease

- Studies show that periodontal disease, which can lead to tooth loss, occurs with greater frequency and severity among persons with diabetes. In one study, 30 percent of IDDM patients age 19 years and older had periodontal disease.
- The rate of tooth loss is 15 times higher, and the incidence of periodontal disease is 2.6 times higher among Pima Indians with NIDDM.

Pregnancy

- The rate of major congenital malformations in babies born to women with preexisting diabetes varies from 0 to 5 percent among women who receive preconception care to 10 percent amongwomen who do not receive preconception care.
- Three to 5 percent of pregnancies among women with diabetes result in death of the newborn; this compares to a rate of 1.5 percent for women who do not have diabetes.

Gestational Diabetes

- Gestational diabetes develops in some pregnant women; the condition disappears when the pregnancy is over. A history of gestational diabetes, however, is a risk factor for eventual development of NIDDM.
- Gestational diabetes occurs in 2 to 5 percent of pregnancies, and at higher rates among African Americans, Hispanics/Latino Americans, and American Indians *(rates in American Indians range from 1 to 14 percent).*

Impaired Glucose Tolerance

Impaired Glucose Tolerance (IGT) refers to a condition in which blood sugar levels are higher than normal but not high enough to be classified as diabetes (between 140 to 199 mg/dl in a 2-hour oral glucose tolerance test). IGT is a major risk factor NIDDM

- This condition is present in about 11 percent of adults.
- About 40 to 45 percent of persons aged 65 years or older have either NIDDM or IGT.

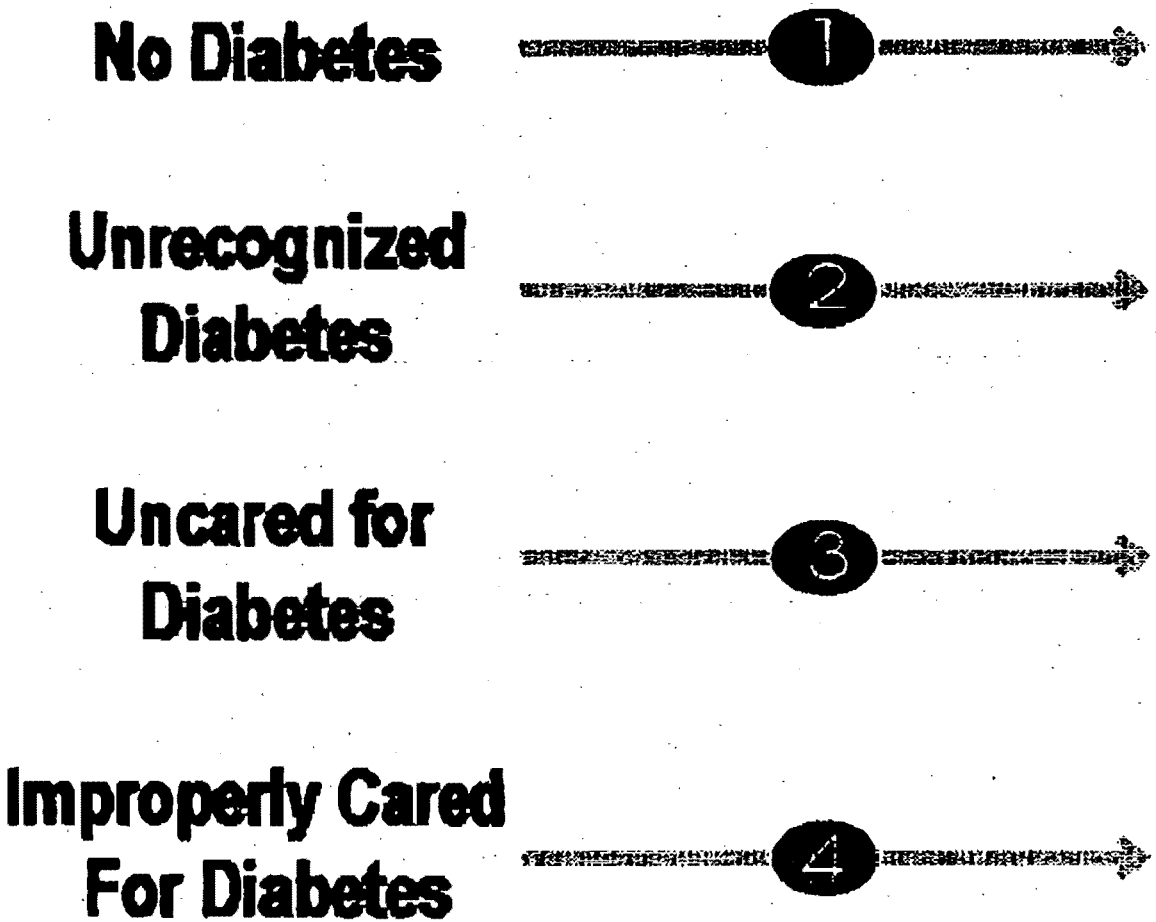
Acknowledgments

The following organizations collaborated in compiling the information upon which this Fact Sheet is based:

- American Association of Diabetes Educators
- American Diabetes Association
- Centers for Disease Control and Prevention
- Department of Veterans Affairs
- Health Resource and Services Administration
- Indian Health Service
- Juvenile Diabetes Foundation International
- National Institute of Diabetes and Digestive and Kidney Disease of the National Institutes of Health

A MODEL OF DIABETES

Figure 1

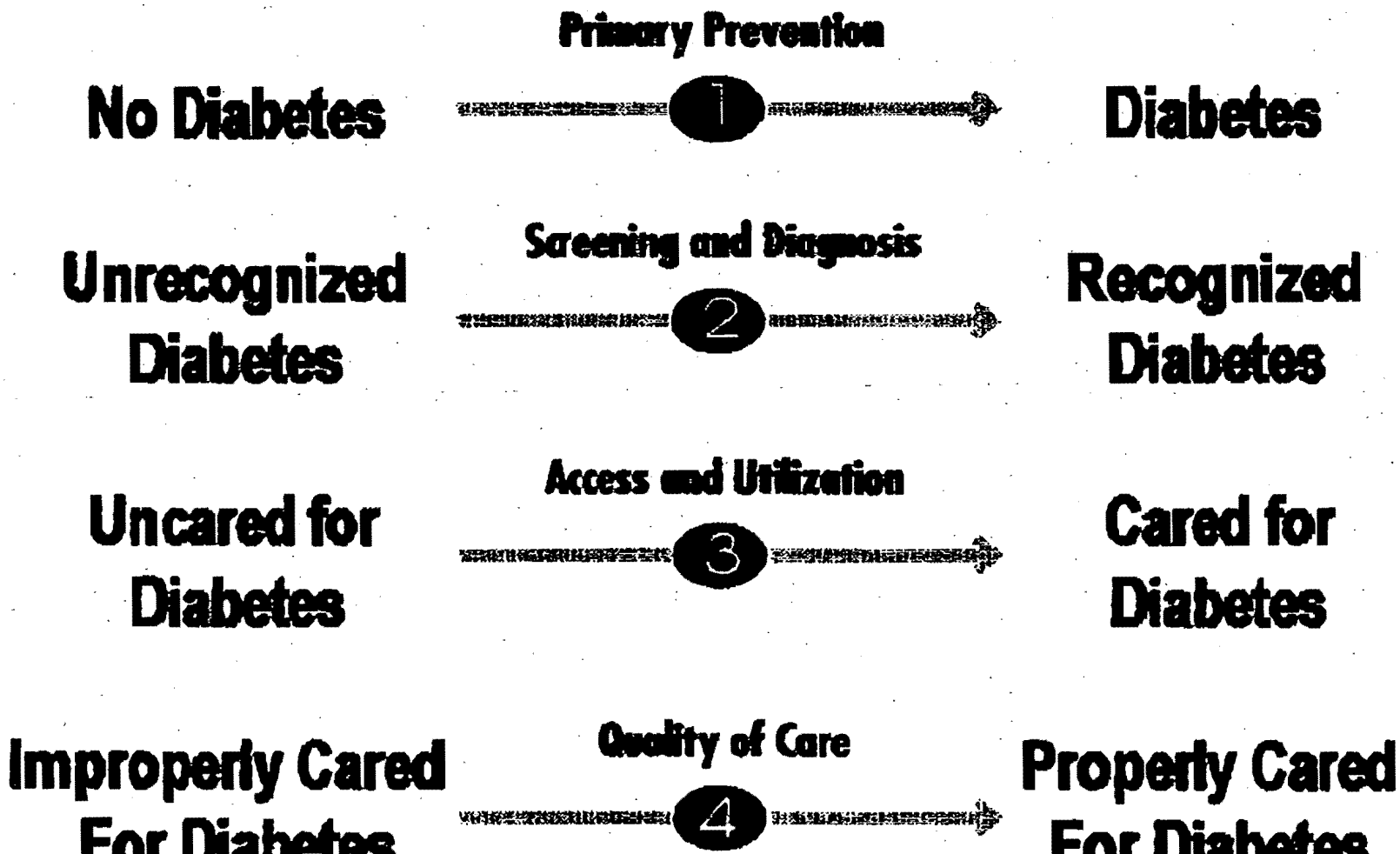


Diabetes Mellitus
A PUBLIC HEALTH PERSPECTIVE

CDC

A MODEL OF DIABETES

Figure 2

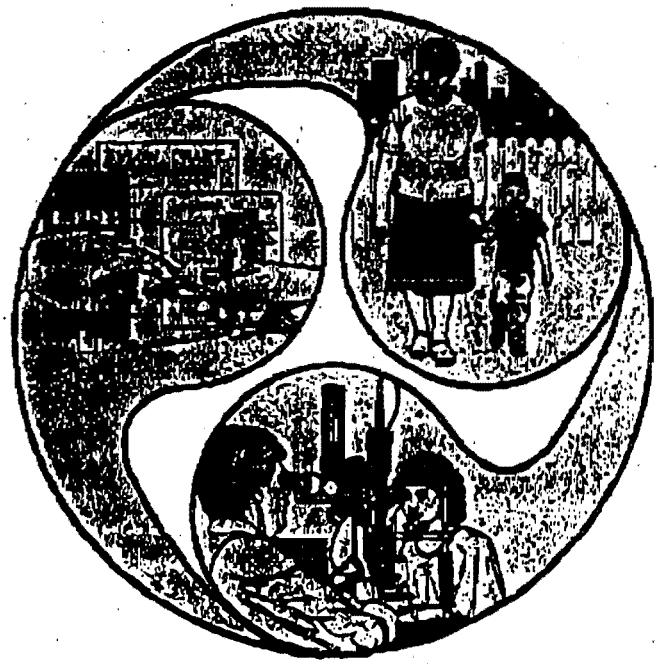


Diabetes

A Serious Public Health Problem

AT-A-GLANCE

1996



Translating Science Into Care

Those who suffer losses due to diabetes are not just statistics on a chart.
They are people whose talents and wisdom are needed and whose problems deserve our unified efforts.
Together we can join to make life more just and more joyful for generations to come.

David Satcher, MD, PhD, Director, Centers for Disease Control and Prevention

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention

CDC

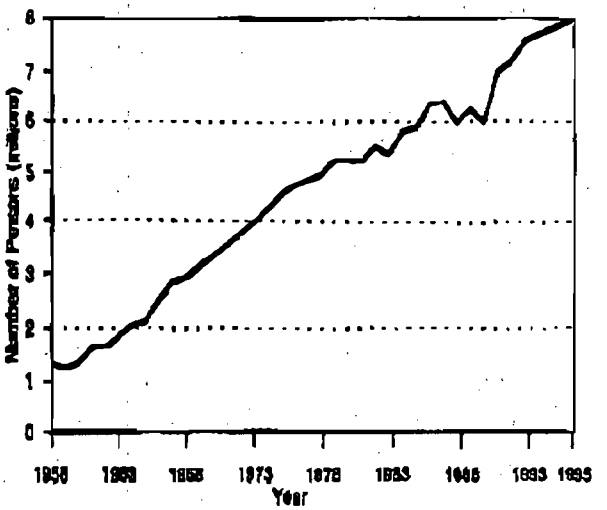
Is Diabetes a Serious Public Health Problem?

In 1995, about 16 million people in the United States had diabetes, but only 8 million had been diagnosed with the condition. The number of persons with diagnosed diabetes has increased from 1.6 million in 1958 to 8 million in 1995—a fivefold increase. Diabetes is the seventh leading cause of death in the United States, and it contributes to thousands of deaths each year. Individuals with diabetes are at increased risk for

- heart disease
- blindness
- kidney failure
- lower extremity amputations not related to injury

Diabetes and its complications occur among Americans of all ages and racial and ethnic groups. The burden of this disease is heavier among elderly Americans and certain racial and ethnic populations, including African Americans, Hispanics/Latinos, and American Indians. For example, more than 10% of elderly adults have been diagnosed with diabetes, and the prevalence of diabetes among various American Indian tribes ranges from 5% to 50%. A number of studies have also shown increased rates of the disease among certain Asian and Pacific Islander populations.

Number of Persons With Diagnosed Diabetes



Source: National Institutes of Health, 1995

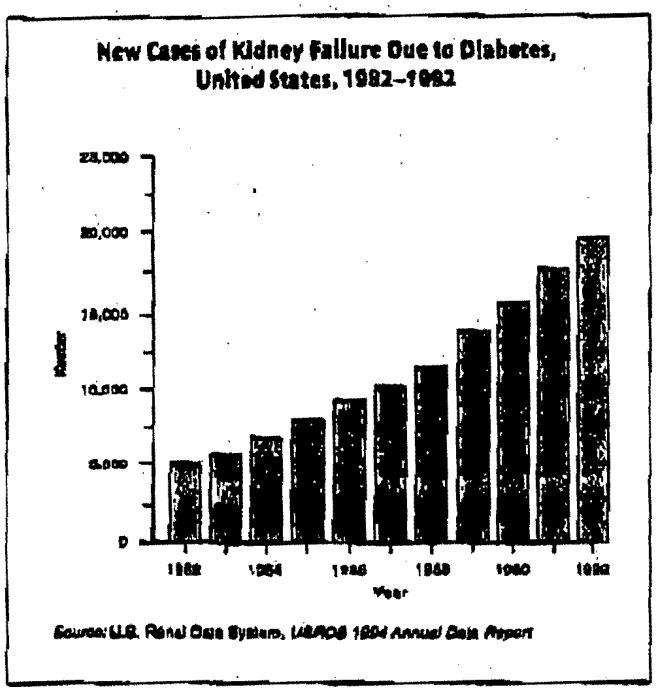
What Is Diabetes?

The term *diabetes* describes either a deficiency of insulin or a decreased ability of the body to use insulin, which is a hormone secreted by the pancreas. Insulin allows glucose (sugar) to enter body cells and be converted to energy. Insulin is also needed to synthesize protein and store fats. In uncontrolled diabetes, glucose and lipids (fats) remain in the bloodstream and, with time, damage the body's vital organs and contribute to heart disease.

Diabetes is classified into two main types: non-insulin-dependent diabetes mellitus (NIDDM) and insulin-dependent diabetes mellitus (IDDM). The most common type is NIDDM. It affects 90% of those with diabetes and usually appears after the age of 40. The other type—IDDM—affects less than 10% of those with diabetes. Although this type of diabetes can occur at any age, it most often appears in childhood or the teen years. The primary focus of the Centers for Disease Control and Prevention (CDC) is to translate scientific information about diabetes into strategic plans that help people prevent the complications of diabetes.

What Are the Economic Costs of Diabetes?

Diabetes imposes a heavy economic burden upon the nation each year. In 1992, an estimated $92 billion in direct and indirect costs were spent on diabetes. Contributing substantially to these costs are the complications of diabetes. For example, in 1992, the cost of treating kidney failure for 56,000 Americans with diabetes exceeded $2.1 billion. This figure did not include the costs associated with disabilities and premature death. In this same year, Medicare expenditures per person with diabetes on kidney dialysis averaged $38,700. Because kidney failure is increasing at an alarming rate, these costs are expected to rise.



More than 60% of lower extremity amputations that are not related to injury occur among persons with diabetes. Approximately 57,000 diabetes-related amputations were performed in 1993. The direct costs of diabetes-related amputations are about $600 million annually.

The full burden of diabetes in terms of death, complications, and costs is not easy to measure. In fact, many hidden costs are associated with diabetes. These costs include a failure to recognize the role of diabetes in premature deaths and the unknown costs related to undiagnosed diabetes. Furthermore, for families and communities, the loss of human lives and abilities transcends numerical measures.

What Are the Benefits of Prevention?

The increasing burden of diabetes is alarming, but the good news is that much of the burden of this major public health problem can be prevented with early detection, improved delivery of care, and diabetes self-management education. For example,

- Currently, screening and treatment for eye disease among persons with diabetes is saving the federal government about $248 million annually. If *all* persons with diabetes received recommended screening and treatment, the annual savings to the federal budget could exceed $470 million.
- Women with preexisting diabetes deliver more than 18,000 babies each year. For every $1.00 invested in preconception care for these mothers, $1.86 can be saved by preventing birth defects.
- The Diabetes Control and Complications Trial, a national 10-year study that involved 1,441 volunteers with insulin-dependent diabetes, confirmed that good control of blood sugar prevented the onset or delayed the progression of eye, kidney, and nerve damage by at least 50%.

What Does CDC Do To Reduce the Burden?

CDC strives to increase awareness and education about diabetes, support early detection and treatment of complications, improve the quality of diabetes care, and enhance access to diabetes care by improving and expanding services.

To advance a common mission to reduce the burden of diabetes, CDC joins with state and territorial health departments in establishing partnerships for populations at increased risk for diabetes and its complications. CDC and its partners use the following approaches:

They define the burden and develop surveillance systems to—

- identify high-risk groups
- monitor health outcomes and indicators of the quality of health care recommended for persons with diabetes
- provide data that can be used to formulate health care policy
- evaluate progress in disease prevention and control

They develop new approaches such as innovative community-based programs—

Project DIRECT—CDC is collaborating with the state of North Carolina to evaluate the effectiveness of community-based public health approaches in reducing the burden of diabetes.

Diabetes Today—This program provides health professionals and community leaders with the skills to mobilize communities and to develop appropriate interventions. One of the outcomes of this course is a strategic plan that is community owned and culturally relevant to the local population.

Latino Diabetes Initiative for Action (Latino DIA)— In 1995, CDC launched this initiative to develop culturally relevant diabetes prevention strategies for Latino communities. CDC enlisted the National Latino Expert Workgroup to collaborate in planning, prioritizing, implementing, promoting, and evaluating strategic Latino DIA activities to narrow the disparity of diabetes in the Latino community.

They implement effective programs—

CDC works with state- and territorial-based diabetes control programs to reduce the complications associated with diabetes. The following are just a few examples of such activities:

The Maine Diabetes Control Program implemented a diabetes outpatient education program in more than 30 hospitals and health centers throughout the state. In a 3-year period, this state education program resulted in a 32% reduction in hospital admissions—a savings of $293 per participant.

The Michigan Diabetes Control Program's Upper Peninsula Diabetes Outreach Network (UPDON) established a program with hospitals, health departments, and home care agencies that improved the quality of diabetes care and education. The participants in the program experienced a 45% lower rate of hospitalizations, a 31% drop in lower extremity amputations, and a 27% lower death rate than did nonparticipants. This program has been replicated in five new outreach networks throughout the state.

The Texas Diabetes Control Program recently formed the Managed Care Work Group to establish minimum standards of care and outcome measures for Texans with diabetes. A cost-benefit analysis by one of the collaborating partners determined a break-even point in 2 years with savings to result thereafter. Other partners are joining as they consider the quality of care issues and realize the cost benefit.

National Partnerships

CDC joins with government agencies, voluntary and professional organizations, academic institutions, and community groups to

- provide data for sound public health decisions
- inform the public about the burden of diabetes
- ensure that current research findings are translated into effective clinical and public health strategies to reduce the burden of diabetes
- promote assurance of optimal diabetes care and education for all persons living with diabetes in the United States

Diabetes presents both a challenge to and an opportunity for public policymakers, health care providers, community leaders, and individuals with diabetes to apply prevention strategies known to make a significant impact. Recent studies in diabetes have confirmed that prevention of complications of diabetes is a strategy that works. Such strategies benefit individuals, families, communities, health organizations, and all those who are financially and economically concerned about the impact of diabetes and its complications.

For more information, please contact the Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
4770 Buford Highway, NE, Mail Stop K-10, Atlanta, GA 30341-3724, (770) 488-5000
E-mail to cdcinfo@cdcnet.em.cdc.gov
World Wide Web at http://www.cdc.gov/nccdphp/ddt/ddthome.htm

FY 1998 - President's Budget
$10 Million Increase

These additional funds will be used for the following major programs:

Establishment of Comprehensive Diabetes Control Program in 7-9 additional States ($4 million)
In FY 1997, all 50 states will have established minimum, core-capacity level diabetes control programs; and 5 states will have received additional funds to expand their core programs into comprehensive programs. Core programs focus on building expertise, assessing the burden of diabetes, and planning diabetes control activities. Comprehensive programs emphasize implementation of public health strategies and interventions throughout the entire state, with an expected improvement in access to, and availability and affordability of quality diabetes services and care. Priority and emphasis is placed on targeting high risk and disadvantaged populations, establishing linkages with managed care organizations, and building partnerships to influence the existing health care system.

National Diabetes Education Program ($2 million)
CDC and NIH joined forces in 1995 to provide leadership to develop and launch a major new program, the National Diabetes Education Program (NDEP). The NDEP is a colloborative effort to improve the outcome of persons with diabetes, promote early diagnosis, and ultimately, prevent the onset of this disease. A Strategic Plan will bring together existing and new prevention strategies as well as early detection and diabetes control efforts to achieve improved intervention quality, continuity, and effectiveness. It will initially address priority target audiences and the needs of minority and other special populations. CDC will have responsibility for coordinating the implementation of the **public health components** of the NDEP.

Strengthening Public Health Surveillance for Diabetes ($2 million)
In order to identify the diabetes burden, monitor trends, and evaluate program outcomes, basic infrastructure, especially existing public health surveillance systems for diabetes, needs to be strengthened, especially at the state level, in order to provide ongoing data on this growing public health problem.

Conducting Applied Research ($2 million)
It is vitally important for CDC to understand how to effectively apply clincial diabetes research findings in today's health care system. Applied research focuses on identifying and understanding the public health implications of the results from clinical trials and scientific studies. Applied research for diabetes prevention and control is needed in the following areas: (1) access to and quality of care of diabetes, with an emphasis on managed care organizations, (2) early detection of undiagnosed diabetes, (3) primary prevention of Type 2 diabetes, and (4) standards of care for diabetes.

FOOT CARE AND DIABETES

Juvenile Diabetes Foundation International
The Diabetes Research Foundation

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Does someone in your family have... TYPE 1 DIABETES?

If so, you may be able to take part in a clinical study to prevent Type 1 Diabetes.

For more information... ☛

Diabetes Prevention Trial – Type 1

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Could you get diabetes?

- ❑ Does someone in your family have diabetes?
- ❑ Are you overweight?
- ❑ Did you get diabetes when you were pregnant?

If you answered "yes" to any of these questions, you could get diabetes.

Join the Diabetes Prevention Program and help find out if diabetes can be prevented.

National Institute of Diabetes and Digestive and Kidney Diseases

NATIONAL INSTITUTES OF HEALTH

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PART OF A SERIES / NO. 3

WHAT YOU SHOULD KNOW ABOUT DIABETES

JDF

Juvenile Diabetes Foundation International
The Diabetes Research Foundation

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PART OF A SERIES / NO. 6

A CHILD WITH DIABETES IS IN YOUR CARE

JDF

Juvenile Diabetes Foundation International
The Diabetes Research Foundation

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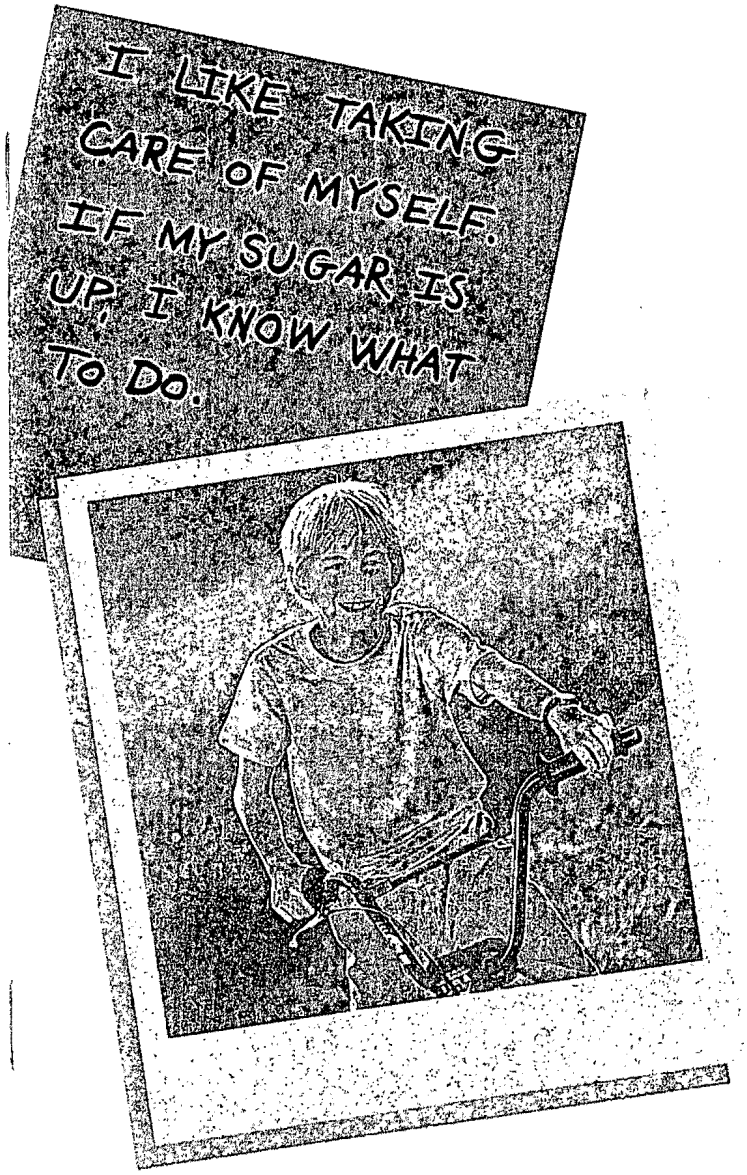
PART OF A SERIES / NO. 7

MONITORING YOUR BLOOD SUGAR



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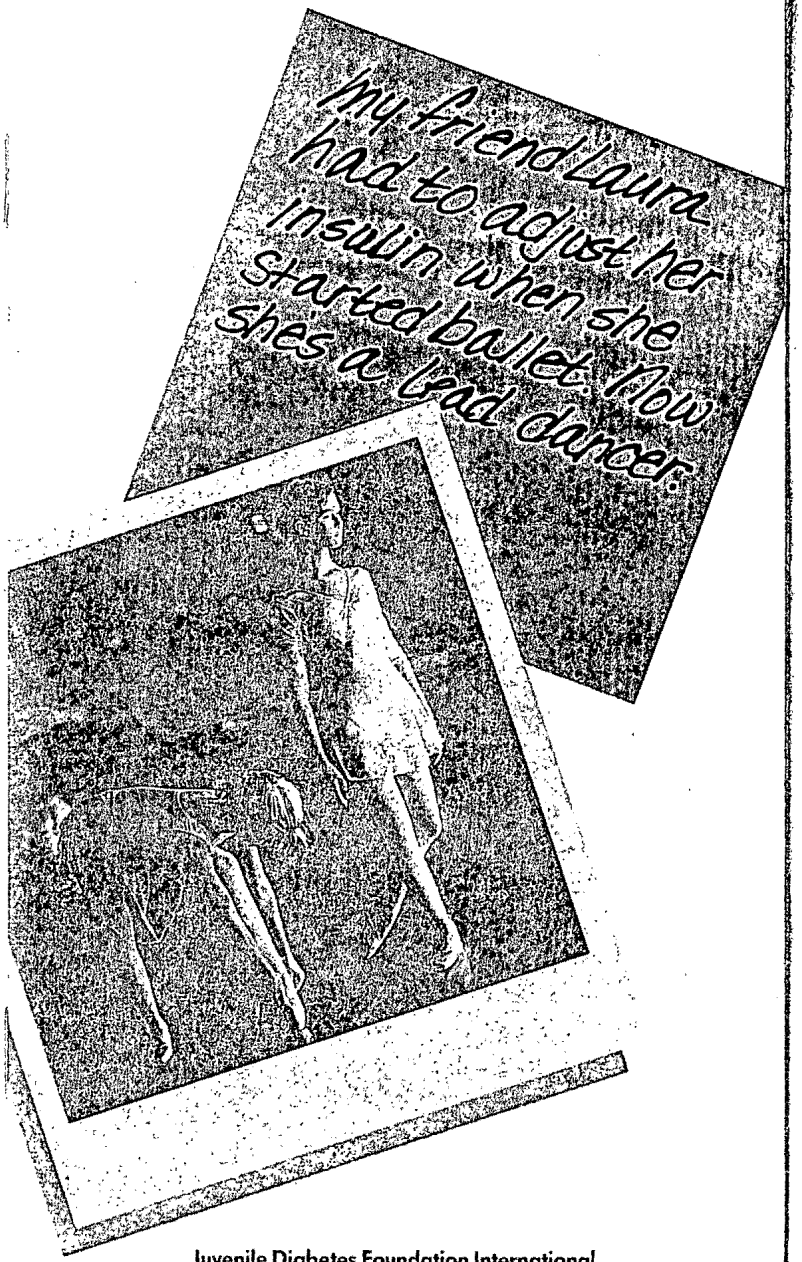
PART OF A SERIES / NO. 4

INFORMATION ABOUT INSULIN



Juvenile Diabetes Foundation International
The Diabetes Research Foundation

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PART OF A SERIES / NO. 13

DIABETES AND YOUR HEART

Juvenile Diabetes Foundation International
The Diabetes Research Foundation

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PART OF A SERIES / NO. 15

DIABETES AND KIDNEY DISEASE

Juvenile Diabetes Foundation International
The Diabetes Research Foundation

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Diabetes Overview

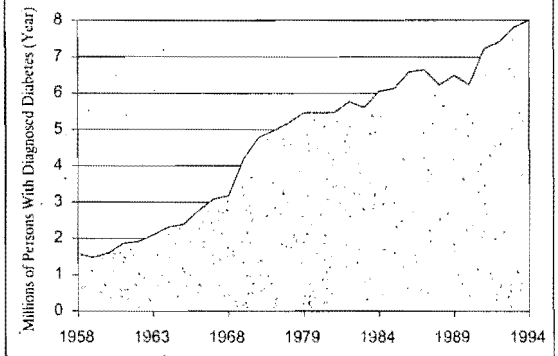
National Institute of Diabetes and Digestive and Kidney Diseases

NATIONAL INSTITUTES OF HEALTH

Almost every one of us knows someone who has diabetes. An estimated 16 million people in the United States have diabetes mellitus—a serious, lifelong condition. About half of these people do not know they have diabetes and are not under care for the disorder. Each year, about 650,000 people are diagnosed with diabetes.

Although diabetes occurs most often in older adults, it is one of the most common chronic disorders in children in the United States. About 127,000 children and teenagers age 19 and younger have diabetes.

Prevalence of Diagnosed Diabetes



Source: The data for this chart comes from *Diabetes in America. 2nd Edition* (p. 63) by National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 1995.

What Is Diabetes?

Diabetes is a disorder of metabolism—the way our bodies use digested food for growth and energy. Most of the food we eat is broken down by the digestive juices into a simple sugar called glucose. Glucose is the main source of fuel for the body.

After digestion, the glucose passes into our bloodstream where it is available for body cells to use for growth and energy. For the glucose to get into the cells, insulin must be present. Insulin is a hormone produced by the pancreas, a large gland behind the stomach.

When we eat, the pancreas is supposed to automatically produce the right amount of insulin to move the glucose from our blood into our cells. In people with diabetes, however, the pancreas either produces little or no insulin, or the body cells do not respond to the insulin that is produced. As a result, glucose builds up in the blood, overflows into the urine, and passes out of the body. Thus, the body loses its main source of fuel even though the blood contains large amounts of glucose.

What Are the Different Types of Diabetes?

The three main types of diabetes are:

- Insulin-dependent diabetes mellitus (IDDM) or Type I diabetes
- Noninsulin-dependent diabetes mellitus (NIDDM) or Type II diabetes
- Gestational diabetes.

Insulin-Dependent Diabetes

Insulin-dependent diabetes is considered an autoimmune disease. An autoimmune disease results when the body's system for fighting infection (the immune system) turns against a part of the body. In diabetes, the

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FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 2 + cover page Date: 4/07/97

To:	From:
Sarah Bianchi	JOAN STIEBER Medicare Part B Analysis Division
Fax: (202) 456-5557 Phone: (202) 456-5585	Fax: (202) 690-8168 Phone: (202) 690-6884

REMARKS:

Sarah -- Here are several options, as requested, for public relations activities related to HCFA's diabetes initiatives.

→ Are there any new demos coming up?
Are we any to take the results of these plans that we are ready to move on?
what could we announce.
how long have they been going

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

OPTIONS FOR PUBLIC RELATIONS ACTIVITIES RELATED TO HCFA'S INITIATIVES TO IMPROVE DIABETES CARE FOR MEDICARE BENEFICIARIES IN MANAGED CARE PLANS

Demonstrated improvement in diabetes care in Arizona HMOs

- As part of a diabetes initiative guided by the Arizona Peer Review Organization (PRO), that state's 7 HMOs have implemented a variety of intervention strategies to improve the quality of their diabetes care for Medicare beneficiaries. A recent review by the PRO of care furnished in 1996 showed significant improvement in all 7 HMOs over care furnished in 1994-95, when many of the services recommended by the American Diabetes Association (ADA) for Type II diabetics were provided much less frequently than necessary. The PRO continues to work with the plans to maintain these initial gains, and to make further improvements in patient care. HCFA's new requirement that Medicare HMOs report their provision of services included in HEDIS 3.0 (standardized measures developed by the National Committee for Quality Assurance, allowing comparison between plans) will provide further incentive for plans to improve their diabetes care.

- A site visit from the Secretary (or other official) could celebrate this model of improved patient care, which was accomplished through collaboration by HCFA, the PRO, and all of the HMOs in a state with a highly competitive managed care market. The visitor could participate in the PRO's monthly meeting with the HMOs to discuss their joint projects (including diabetes care); visit one or more of the clinics where diabetes patients are seen; and meet with patients who have reaped the benefits of Arizona's quality improvement efforts.

Medicare Managed Care Quality Improvement Project (MMCQIP)

- HCFA (with the PROs) is conducting a major pilot project to assess and improve diabetes care in 23 managed care plans in 5 states (CA, FL, MN, NY, and PA), serving roughly 200,000 Medicare beneficiaries with diabetes. An assessment of the plans by the PROs in these states, in conjunction with HCFA, revealed that improvements were needed in numerous areas of diabetes care. Each participating plan has implemented at least one intervention to improve diabetes care, the results of which will be measured by HCFA in early 1998.

- Of the 5 states, New York would be a good model to highlight at this point, as each of its plans has developed its own strategy for improving diabetes care targeted to its particular patient population. One innovative strategy includes a patient education tool developed by NYLCare Health Plans of New York, in which patients are mailed a card showing 8 clinical services with a "prize" offered to those who obtain all 8 services by a designated date. The initial results of a pilot sample suggest that this strategy, in combination with other interventions, has helped to increase utilization of diabetes services.

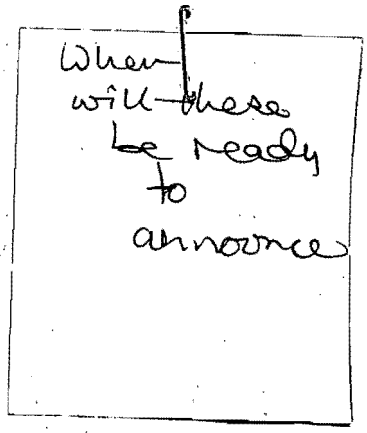
- Each of the MMCQIP interventions underway will be featured in an upcoming newsletter issued by the participating PROs. While the newsletter will be directed at HMO physicians and staff, it could also be distributed to the public and/or used as the basis for a media event.

Consumer information on managed care plan performance

- Several efforts are underway to develop performance measures, which will be critically important in enabling consumers to make informed choices in selecting a provider or managed care plan. These measures will allow consumers to compare the type and frequency of services furnished by different providers, including both diabetes-specific services (e.g. annual eye exam) and other general services that are particularly important for diabetics (e.g. flu shots).

- The ADA, NCQA (developer of HEDIS 3.0), and the Foundation for Accountability (FACCT) (a public-private partnership in which HCFA participates) recently agreed to issue a common set of diabetes-related performance measures within the next 3-4 months. This collaboration represents a major step toward enabling providers, plans, practitioners, researchers, HCFA, and other purchasers to give consumers standardized information -- rather than 3 conflicting sets of guidelines -- regarding performance in the provision of diabetes care. This effort will also reduce the burden on providers of having to meet several different standards in reporting their provision of care.

- This important agreement could be featured in a press conference or other public event, with representatives of each of the participating organizations (including several major employers, and the Federal Employee Health Benefits Program, which are participants in FACCT).



Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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To:	Sarah Bianchi	*Date:*	4/7/97
Telephone:		*From:*	Frank VINICOR, MD, MPH
FAX #:	202- 456-5557	*Telephone:*	(770) 488-5000
Subject:			**FAX: 770-488-5966**
Total		*(including this cover sheet)*	

Transmittal Message

Note to Sarah Bianchi:

I am faxing you the following:

- Budget History for the Divison of Diabetes Translation (1992-1997)
- Description of plans for FY98 $10 million increase in President's Budget
- Description of what it will take to fully fund the Diabetes Control Program ($40M increase)
- Description of the National Diabetes Education Program (NDEP)

By C.O.B. on Monday, we will have a description of what we're doing with state medicaid programs (for Gary Claxton).

Hope this is useful. Please call if you need anything else at all!

Frank Vinicor

Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Budget Appropriations History (FY92-97)
(In Millions)

FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
$ 7.156	$ 9.50	$17.910	$19.765	$22.991	$26.247

FY 1998 - President's Budget
$10 Million Increase

These additional funds will be used for the following major programs:

Establishment of Comprehensive Diabetes Control Program in 7-9 additional States ($4 million)
In FY 1997, all 50 states will have established minimum, core-capacity level diabetes control programs; and 5 states will have received additional funds to expand their core programs into comprehensive programs. Core programs focus on building expertise, assessing the burden of diabetes, and planning diabetes control activities. Comprehensive programs emphasize implementation of public health strategies and interventions throughout the entire state, with an expected improvement in access to, and availability and affordability of quality diabetes services and care. Priority and emphasis is placed on targeting high risk and disadvantaged populations, establishing linkages with managed care organizations, and building partnerships to influence the existing health care system.

National Diabetes Education Program ($2 million)
CDC and NIH joined forces in 1995 to provide leadership to develop and launch a major new program, the National Diabetes Education Program (NDEP). The NDEP is a collaborative effort to improve the outcome of persons with diabetes, promote early diagnosis, and ultimately, prevent the onset of this disease. A Strategic Plan will bring together existing and new prevention strategies as well as early detection and diabetes control efforts to achieve improved intervention quality, continuity, and effectiveness. It will initially address priority target audiences and the needs of minority and other special populations. CDC will have responsibility for coordinating the implementation of the **public health components** of the NDEP.

Strengthening Public Health Surveillance for Diabetes ($2 million)
In order to identify the diabetes burden, monitor trends, and evaluate program outcomes, basic infrastructure, especially existing public health surveillance systems for diabetes, needs to be strengthened, especially at the state level, in order to provide ongoing data on this growing public health problem.

Conducting Applied Research ($2 million)
It is vitally important for CDC to understand how to effectively apply clinical diabetes research findings in today's health care system. Applied research focuses on identifying and understanding the public health implications of the results from clinical trials and scientific studies. Applied research for diabetes prevention and control is needed in the following areas: (1) access to and quality of care of diabetes, with an emphasis on managed care organizations, (2) early detection of undiagnosed diabetes, (3) primary prevention of Type 2 diabetes, and (4) standards of care for diabetes.

Resources Needed for National Diabetes Prevention and Control Program

($40 million)

In order to fully fund a diabetes prevention and control program, an additional $40 million is needed. These resources would enable CDC to:

- Establish **comprehensive diabetes prevention and control programs** in all 50 states, with an emphasis on improving access to, and availability and affordability of quality diabetes care throughout the nation. ($25 million)

- Implement the **public health components of the National Diabetes Education Program**, which is a CDC-NIH collaborative effort, to improve the treatment and outcomes for persons with diabetes, promote early diagnosis, and ultimately, to prevent the onset of this disease. ($5 million in year 1; an additional $5 million would be needed in year 2)

- Develop and implement **public health surveillance systems,** nationally and at the state level, for identifying the diabetes burden and for monitoring trends. ($5 million)

- Conduct **applied research** in order to understand how to more effectively apply scientific findings in today's health care system. ($5 million)

THE NATIONAL DIABETES EDUCATION PROGRAM (NDEP)
A VISION FOR THE FUTURE
(April 4, 1997 Update)

Strong scientific evidence exists today to support aggressive intervention to reduce the medical, social and economic burden of diabetes among all populations especially minority groups who are at higher risk for this debilitating disease. Results of the National Institutes of Health's (NIH) Diabetes Control and Complications Trial (DCCT) clearly showed that persons with insulin dependent diabetes who maintain good control of their blood glucose levels can dramatically reduce their risk for long term medical complications. Other studies suggest that good blood glucose control has similar benefits for persons with non-insulin dependent diabetes and reduces the risk for heart attacks, strokes and peripheral vascular diseases. With so much scientific evidence to support intensified intervention efforts, the question becomes, "What could and should be done to improve the prognosis for all people with diabetes?"

A task force appointed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) made recommendations in 1994 for translating the DCCT results into widespread practice. These recommendations are contained in the document "Metabolic Control Matters." Based on recommendations of the task force and the National Diabetes Advisory Board, the Centers for Disease Control and Prevention (CDC) and the NIH joined forces in 1995 to provide national leadership to develop and launch a major new initiative, the National Diabetes Education Program (NDEP). Substantial progress was made in planning this program in 1996.

A Steering Committee composed of leading clinical researchers, representatives of national diabetes organizations and federal agencies guides the planning and development of the NDEP. The NDEP provides a framework for the development of effective partnerships at the national, state and community levels to reduce the burden of diabetes as a public health problem especially among those at disproportionate risk including the elderly and minority populations. This program will involve collaboration with other Federal agencies; state health departments; multiple professional, voluntary health, minority, national, academic, and other public sector organizations; as well as the private sector (e.g., managed care organizations, corporations and small businesses, pharmaceutical companies, food and sports industries, national and local media including minority media, and others). The NDEP will be an "umbrella program" to coordinate national efforts to reduce the burden of diabetes.

During 1996, planning meetings with four key constituency groups elicited input on the existing barriers to good diabetes care (including diabetes education) and what a national program such as the NDEP should do. The four groups included:

- primary care providers (e.g., physicians, certified diabetes educators, and dietitians).
- payers and purchasers of health care (e.g., insurance industry, managed care organizations,

employer purchasers, and government health programs.).

- consumers and patient-advocates (e.g., organizations representing and that provide health or social services to target populations such as Latinos African Americans, Native Americans, Asians, and the elderly).

- public health providers (e.g., state and territorial diabetes control programs, public health educators, and public health nutritionists).

Using input from these planning meetings with constituents, a mission statement, goal and objectives for the NDEP have been developed by the Steering Committee. The mission states that, "the NDEP is a collaborative effort to improve the treatment and outcome of people with diabetes, promote early diagnosis, and ultimately, prevent the onset of this disease." Based on existing scientific evidence, the NDEP will focus on the implementation of secondary and tertiary prevention strategies proven effective in preventing or delaying progression of the debilitating and costly medical complications related to diabetes.

Broad target audiences identified for the NDEP include the general public, patients and their families, health professionals, and, policymakers and payers. The goal of the NDEP is, "to reduce the morbidity and mortality of diabetes and its complications." Four objectives for this goal are:

- "To increase public awareness of the seriousness of diabetes, its risk factors, and potential strategies for preventing diabetes and its complications."

- "To improve understanding of diabetes and its control among people with this disease, and promote effective self-management."

- "To improve understanding of diabetes and its control among health professionals, and promote an integrated approach to care."

- "To promote health care policies that improve quality and access to diabetes care."

Presently, a strategic plan is being drafted under the leadership of CDC and NIH with guidance from a formal NDEP planning committee and input from the four planning meetings with constituents. Six guiding principles for design of the NDEP were recommended to the Steering Committee. These principles are that the NDEP should: 1) be a comprehensive, ongoing program directed to multiple audiences; 2) be inclusive and establish broad based partnerships; 3) be flexible to meet diverse population and community needs; 4) identify and promote effective interventions; 5) build on the success of other national programs; and 6) set priorities and target intervention efforts for maximum impact.

The NDEP strategic plan will bring together existing and new prevention, early detection and diabetes control efforts to achieve improved intervention quality, continuity and effectiveness. It

will address priority target audiences and the needs of minority and other special populations; a broad array of prevention and public health strategies, and multi-discipline approaches; targeted educational messages and delivery channels; and suggestions for the full participation of public and private sector partners. The following are examples of intervention strategies that may be included in the NDEP strategic plan:

- conduct of targeted media and community-based diabetes awareness campaigns and education programs;
- dissemination of diabetes research on the efficacy of secondary and tertiary prevention, and information on the benefits of investing in prevention;
- promotion of the use of diabetes care guidelines by physicians and other health care providers;
- involvement of community organizations, lay health workers and family members in diabetes prevention and control programs;
- promotion of public/private sector partnerships at the national, state and community levels;
- promotion of the replication of effective diabetes intervention approaches or programs;
- improvement of the health service delivery system including the financing of diabetes care;
- and, the conduct of behavioral and other intervention research/demonstration projects.

Full implementation of the NDEP strategic plan will be contingent upon the resources available from Federal agencies and participating partners in this nationwide endeavor to reduce the burden of diabetes. The initial overall priority will be to focus on increasing awareness among the four target audiences that diabetes is serious, common and costly. Representatives of minority organizations and communities are actively involved in all phases of the development, implementation and evaluation of the NDEP to ensure their unique needs are addressed.

CDC will be responsible for coordinating implementation of the public health component of the NDEP. For example, CDC is proposing to develop a special emphasis program called "Business Responds to Diabetes," modeled after the highly successful "Business Responds to AIDS" and "Labor Responds to AIDS" programs. Additionally, CDC will have lead responsibility for addressing the needs of minority populations using a community-based and other effective approaches.

CDCdoc: ndepdesc.44

Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

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