Journal of Diabetes Science and Technology
Volume 2, Issue 2, March 2008

EDITORIAL

The "Catalyst to Better Diabetes Care Act of 2007"

David C. Klonoff, M.D., FACP

The Catalyst to Better Diabetes Care Act of 2007 was introduced late in 2007 into both the U.S. House of Representatives as HR3544 by Congressman Zachary Space and the U.S. Senate as S2479 by Senator Sherrod Brown. Both legislators are from Ohio. Currently, the House bill is awaiting action from the House Energy and Commerce Committee. The Senate bill is at the Senate Committee on Health, Education, Labor, and Pensions. It is expected that the Senate bill will be marked up there. This means that the bill will be debated and a decision will be made whether the measure should be recommended to the full Senate for a vote or whether it should be amended in any substantive way. If different versions of this bill are passed by these two chambers, then the bill will be sent to the conference committee where the differences will be worked out. A similar bill introduced into the U.S. Senate in 2006 was never voted on.

The Catalyst to Better Diabetes Care Act of 2007 was introduced in light of the following facts about diabetes: (1) one in three Americans born in 2005 will get diabetes; (2) one in two American minorities born in 2005 will get diabetes; (3) 1,500,000 new cases of diabetes were diagnosed in adults in 2005; (4) in 2005, 20,800,000 Americans had diabetes, which is 7% of the population of the United States; (5) 6,200,000 Americans are currently undiagnosed; (6) about 1 in every 500 children and adolescents have type 1 diabetes; (7) African-Americans are nearly twice as likely as whites to have diabetes; (8) nearly 13% of American Indians and Alaska Natives over 20 years old have diagnosed diabetes; and (9) in states with significant Asian populations, Asians were 1.5 to 2 times as likely as whites to have diagnosed diabetes.[1,2]

The Catalyst to Better Diabetes Care Act of 2007 contains five main provisions. First, this bill requires the Secretary of Health and Human Services to (a) review uptake and utilization of the Medicare diabetes screening benefit; (b) establish an outreach program to identify existing efforts to increase awareness of the diabetes screening benefit among Medicare beneficiaries and providers; and (c) maximize economies of scale, cost-effectiveness, and resource allocation in increasing utilization of the Medicare diabetes screening program.

Second, this bill requires the Secretary of Commerce to establish an advisory group to examine and recommend best practices of chronic illness employee wellness incentivization and disease management programs.

Third, this bill directs the Secretary of Health and Human Services to prepare, biennially, a diabetes report card for the nation and for each state that (a) is adaptable by state and local agencies in order to rate or report local diabetes care, costs, and prevalence and (b) includes trend analysis in order to track progress in meeting established national goals and objectives and to inform policy and program development.

Fourth, this bill requires the Secretary of Health and Human Services, acting through the director of the Centers for Disease Control and Prevention (CDC), to

Author Affiliation: Mills-Peninsula Health Services, San Mateo, California

Abbreviation: (CDC) Centers for Disease Control and Prevention

Keywords: act, bill, catalyst, CDC, Congress, diabetes, House, Senate

Corresponding Author: David C. Klonoff, M.D., FACP, Mills-Peninsula Health Services, 100 South San Mateo Drive, Room 3124, San Mateo, CA 94401; email address dklonoff@yahoo.com

J Diabetes Sci Technol 2008;2(2):175-177

conduct, support, and promote the collection, analysis, and publication of data on the prevalence and incidence of type 1 and 2 diabetes and of prediabetes. The bill requires such activities to include an assessment of diabetes as a primary or underlying cause of death. Furthermore, the bill allows the secretary to promote the addition to death certificates of language to improve the collection of diabetes mortality data.

Fifth, this bill requires the Secretary of Health and Human Services to conduct a study of the impact of diabetes on the practice of medicine in the United Sates and the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.

One of the main reasons for introducing this bill is the high cost of diabetes to this nation. Diabetes carries staggering costs, including the estimate in 2007 that the total amount of direct and indirect costs of diabetes was $174,000,000,000 according to the American Diabetes Association.[3] Although 18% of the Medicare population has diabetes, spending on this group of people consumes 32% of the Medicare budget according to the Center for Medicare & Medicaid Services.[4]

A second reason for introducing this bill is the serious significant mortality and morbidity in the United States due to diabetes. According to the CDC, (1) death certificate statistics showed that diabetes contributed to an official number of 224,092 deaths in 2002; (2) diabetes is likely to be seriously underreported, as studies have found that only 35 to 40% of decedents with diabetes had it listed anywhere on the death certificate and only about 10 to 15% had it listed as the underlying cause of death; (3) the risk for stroke is two to four times higher among people with diabetes; (4) diabetes is the leading cause of new blindness in America, causing approximately 18,000 new cases of blindness each year; (5) diabetes is the leading cause of kidney failure in America, accounting for 44% of new cases in 2002; (6) 44,400 Americans with diabetes began treatment in 2002 for end-stage kidney disease and a total of 153,730 were living on chronic dialysis or with a kidney transplant as a result of their diabetes; (7) approximately 82,000 amputations were performed on Americans with diabetes in 2002; and (8) poorly controlled diabetes before conception and during the first trimester of pregnancy can cause major birth defects in 5 to 10% of pregnancies and spontaneous abortions in 15 to 20% of pregnancies.[1,2]

A third reason the bill was introduced is because the complications and tremendous costs can be prevented by currently available medical treatment. According to the Agency for Healthcare Research and Quality, appropriate primary care for diabetes complications could have saved the Medicare and Medicaid programs $2,500,000,000 in hospital costs in 2001 alone. According to the Diabetes Prevention Project sponsored by the National Institutes of Health, lifestyle interventions such as diet and moderate physical activity for those with prediabetes can reduce the development of diabetes by 58%, and among Americans aged 60 and over, such lifestyle interventions can reduce diabetes by 71%.[5] Detecting and treating diabetic eye disease can reduce the development of severe vision loss by 50 to 60%. Comprehensive foot care programs can reduce amputation rates by 45 to 85%. Detecting and treating early diabetic kidney disease by lowering blood pressure can reduce the decline in kidney function by 30 to 70%.[1] Quality improvements in the care of diabetes will surely lead to decreased costs of care for this expensive disease.[6]

The Catalyst to Better Diabetes Care Act of 2007 bill is worthy of support. This current act recognizes the importance of preventing, diagnosing, monitoring, and treating diabetes. The bill will result in increased availability of glucose monitoring technology for recipients of Medicare, and many studies have demonstrated the benefits of glucose monitoring in type 2 patients both using[7] and not using insulin.[8] The bill will facilitate better disease management programs for chronic diseases, such as diabetes. The bill will facilitate the collection of statistics about trends in care, costs, and prevalence of diabetes in order to more effectively drive public policy toward this disease. Such information is scarce in the United States. The bill will clarify the language that will be necessary for diabetes to be listed on death certificates, which will result in a better estimate of the importance of this disease. Currently, physicians report conditions that coexisted or preexisted and contributed to death but did not result in the underlying cause of death. Diabetes is frequently such a contributing cause, but this disease is often not reported as a contributing cause on autopsies.[9] This underreporting to the National Center for Health Statistics at CDC results in an underestimate of the prevalence of diabetes among decedents and the public health impact of diabetes.

I recommend that readers of this Editorial write, phone, or email their U.S. Congress representative or U.S. senator and express their support for these important bills. The Catalyst to Better Diabetes Care Act of 2007 will indeed lead to earlier diagnosis, better treatment, and improved outcomes for diabetes in the United States.

References:

1. National Diabetes Fact Sheet US 2005 [cited 2008 Feb 1]. Available from: http://apps.nccd.cdc.gov/ddtstrs/template/ndfs_2005.pdf.
2. Williamson DF, Vinicor F, Bowman BA; Centers For Disease Control And Prevention Primary Prevention Working Group. Primary prevention of type 2 diabetes mellitus by lifestyle intervention: implications for health policy. Ann Intern Med. 2004:140(11):951-7.
3. Devastating toll of diabetes reaches $174 billion [2008 Feb 1]. Available from: http://www.diabetes.org/for-media/pr-devastating-toll-of-diabetes-reaches-174-billion-012308.jsp.
4. Centers for Medicare and Medicaid [2008 Feb 1]. Medicare fact sheet: Medicare health support to improve care of beneficiaries with chronic illnesses. Public Affairs Office. Available from: http://www.cms.hhs.gov/CCIP.
5. Knowler WC, Barrett-Connor E, Fowler SE, Hamman RF, Lachin JM, Walker EA, Nathan DM; Diabetes Prevention Program Research Group. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med. 2002;346(6):393-403.
6. Brown SE, Chin MH, Huang ES. Estimating costs of quality improvement for outpatient healthcare organisations: a practical methodology. Qual Saf Health Care. 2007;16(4):248-51.
7. Saudek CD, Derr RL, Kalyani RR. Assessing glycemia in diabetes using self-monitoring blood glucose and hemoglobin A1c. JAMA. 2006;295(14):1688-97.
8. Martin S, Schneider B, Heinemann L, Lodwig V, Kurth HJ, Kolb H, Scherbaum WA. Self-monitoring of blood glucose in type 2 diabetes and long-term outcome: an epidemiological cohort study. Diabetologia. 2006;49(2):271-8.
9. Cheng WS, Wingard DL, Kritz-Silverstein D, Barrett-Connor E. Sensitivity and specificity of death certificates for diabetes: as good as it gets? Diabetes Care. 2007;31(2):279-84.