

# CORNERSTONE

A NEWSLETTER FROM THE TEXAS DIABETES COUNCIL/TEXAS DEPARTMENT OF HEALTH

## Diabetes Council Completes Strategic Plan for 2002 and 2003

The Texas Diabetes Council has completed its strategic plan for fiscal years 2002 and 2003 and submitted it to the Texas Legislature. The following priorities are included in the plan booklet, titled *A plan to prevent and control diabetes: The promise of a healthier Texas*. The booklet also updates the reader on the Council's activities and accomplishments and statistics related to diabetes in Texas.

For more information, or to order a copy, call the Diabetes Program at 512-458-7490.

### A Plan to Prevent and Control Diabetes in Texas

#### Priority 1: Quality of life

Quality of life issues encompass many facets: patients, healthcare professionals, industry, and government. In order to improve the care of diabetes patients, the Council must identify and address cultural beliefs, financial status, emotional state (acceptance of disease), and educational level. There must be an adequate number of healthcare professionals who are keenly interested in providing the most current and valid therapy for this disease process, and resources must be available for all patients, regardless of their ability to pay.

#### Priority 2: Provider awareness

The Diabetes Council members agree that a significant number of primary healthcare providers have limited or insufficient knowledge of the standards of diabetes care. They also note that healthcare providers, especially physicians, face many barriers to continuing their professional education in diabetes through seminars and other forums. Not the least of these is the difficulty of finding time in their busy schedules for continuing educa-

tion. Considering the potential costs of diabetes, which are compounded by lack of preventive care, the Council has identified provider awareness as a priority.

#### Priority 3: Prevention

The ways to prevent or delay diabetes and its complications are well known: regular check-ups, exercise, blood sugar control, and healthy eating. The risk factors for diabetes also are well known: African American, Hispanic, Native American, or Asian American background; family history of diabetes; high or low blood sugar; overweight (20 percent over ideal weight); limited physical activity; age 45 or older; and previous diabetes with pregnancy or giving birth to a baby weighing more than 9 pounds at birth. In order to improve preventive efforts, healthcare providers and communities must disseminate this knowledge and encourage healthy lifestyle choices.

#### Priority 4: Statewide and legislative advocacy

A number of private and public institutions are working to improve the quality of life for people with diabetes. The Texas Diabetes Council envisions itself as a gathering place for these institutions, where information is shared and powerful alliances are forged. Through these activities, the Council can better fulfill its legal obligation to advise the Texas Legislature and propose laws related to diabetes.

#### Priority 5: Increased funding

Underlying each of the Diabetes Council's priorities is the need for adequate commitment of public funds. The Council maintains that investments in research, prevention and control, and education for both healthcare professionals and the public ultimately will yield high returns in workforce productivity and treatment cost savings.

## Workgroup Issues Recommendations for Addressing Type 2 Diabetes in Children and Adolescents

(Editor's note: Following is a summary of the findings and recommendations of the Type 2 Diabetes in Youth Workgroup. For more information on the report, call the Diabetes Program at 512-458-7490.)

Type 2 diabetes is one of the major public health challenges of the 21st century. Projections indicate that the number of people with the disease worldwide will double by 2010<sup>1</sup>—and a troubling aspect of this disturbing trend is that diabetes is increasingly attacking children.

Type 2 diabetes usually occurs in overweight adults over the age of 45, but the age of onset of type 2 diabetes is occurring in earlier years. Considered uncommon in recent decades, type 2 diabetes in adolescents now represents one of the most rapidly growing forms of diabetes in the United States.<sup>2</sup>

It is estimated that from 1993 to 1998, the number of youth under 18 years of age with type 2 diabetes tripled.<sup>3</sup> Its recent appearance in young people has been called "alarming," and medical experts caution that the devastating complications of diabetes—heart attacks, blindness, strokes, kidney failure, and amputations—may occur at earlier ages if children with type 2 diabetes are not properly diagnosed and treated.<sup>4</sup>

The Texas Department of Health joined with the Juvenile Diabetes Research Foundation International in May 1999 to host an international conference focused on the rising incidence of type 2 diabetes in youth in Texas. Following the conference, TDH convened the Type 2 Diabetes in Youth Workgroup in September 1999 to develop recommendations aimed at prevention and treatment

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How can we prevent and control diabetes? The Texas Diabetes Council outlines the steps in its state plan for 2002 and 2003... The Council, the Texas Department of Health, and public health partners take on the disturbing trend of type 2 diabetes in children and adolescents

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For a snapshot of diabetes in Texas, read the Diabetes Program's 2001 Fact Sheet

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It's not too late for Medicaid managed care patients in Bexar County to participate in a pilot program that provides comprehensive education and access to specialists, equipment, and supplies... Managed Care Work Group enters the new millennium with a new name and bigger goals... The Texas Legislature is in session, and the Diabetes Council is close at hand... JAMA warns that afternoon blood test may miss diabetes

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Help your patients control diabetes one day at a time with this free guide from the Diabetes Program... Texas Diabetes Council members

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# Texas Diabetes Fact Sheet 2001

(Editor's Note: Unless otherwise referenced, the following information is based on statistics and studies from the Texas Behavioral Risk Factor Surveillance System, Bureau of Disease, Injury, and Tobacco Prevention, Texas Department of Health, and the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.)

## TYPE 1 DIABETES IN CHILDREN

It is estimated that in 1999 there were 9,497 Texans under 18 who had Type 1 diabetes. (Based on prevalence studies of insulin-dependent diabetes mellitus in the United States, 1995)<sup>1</sup>

## PREVALENCE OF DIAGNOSED DIABETES IN ADULTS 18 YEARS OR OLDER

Total Diagnosed:<sup>2</sup> 893,331 people (6% of the adult population, 18 years or older)

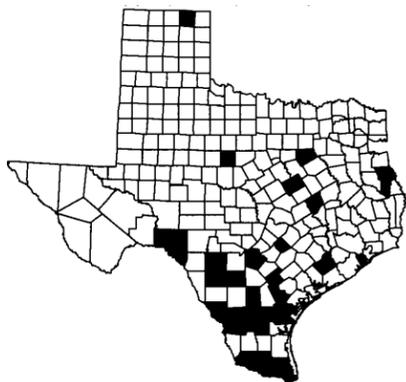
## PREVALENCE OF UNDIAGNOSED DIABETES IN ADULTS 20 YEARS OR OLDER

Total Undiagnosed:<sup>3</sup> 440,512 people (3% of the adult population, 20 years or older)

## DEATHS AMONG PERSONS WITH DIABETES

- Based on Texas death certificate data, diabetes contributed to 13,553 deaths in 1998, and it was the sixth leading cause of death listed on Texas death certificates. Diabetes is believed to be under-reported on death certificates, both as a condition and as a cause of death. A total of 27 Texas counties have mortality rates that are statistically significantly higher than the state's mortality rate during 1990 through 1998. (See Figure 1.)
- The average mortality rate per county was 23.0 per 100,000 during the same period.

## Texas Counties with Significantly Higher Mortality Rates than State Average, 1990-1998



## PREVALENCE OF DIAGNOSED DIABETES BY AGE

Number of people who have been diagnosed /percentage of all Texans in each age group:

- Age 18-44: 241,575 /5.20%
- Age 45-64: 500,395 /22.6%
- Age 65+: 151,361 /13.70%

## PREVALENCE OF DIAGNOSED DIABETES BY GENDER IN PEOPLE 18 YEARS OR OLDER

Number of men or women who have been diagnosed /percentage of all men or women in Texas

- Men: 439,161 /6.26%
- Women: 454,170 /6.20%

## PREVALENCE OF DIAGNOSED DIABETES BY RACE/ETHNICITY IN PEOPLE 18 YEARS OR OLDER

Number of people who have been diagnosed /percentage of the group

- Non-Hispanic White: 470,608/5.60%
- Non-Hispanic African Americans: 120,288/7.80%
- Hispanics: 277,368/7.10%
- Other: 25,067/5.60%

## PATIENTS WITH DIAGNOSED DIABETES 18 YEARS OR OLDER IN TEXAS WHO DID NOT HAVE INSURANCE IN 1999

Number of patients with diagnosed diabetes who did not have insurance/percentage of all patients with diagnosed diabetes who did not have insurance

- Non-Hispanic Whites: 47,195/9.88%
- African Americans: 17,867/19.77%
- Hispanics: 69,479/23.29%
- Others: 2,656/9.92%

## THE FOUR TYPES OF DIABETES

**Type 1 diabetes** was previously called insulin-dependent diabetes mellitus (IDDM) or juvenile-onset diabetes. Type 1 diabetes may account for 5% to 10% of all diagnosed cases of diabetes. Risk factors are less well defined for type 1 diabetes than for type 2 diabetes, but autoimmune, genetic, and environmental factors are involved in the development of this type of diabetes.

**Type 2 diabetes** previously was called non-insulin-dependent diabetes mellitus (NIDDM) or adult-onset diabetes. Type 2 diabetes may account for about 90% to 95% of all diagnosed cases of diabetes. Risk factors for type 2 diabetes include older age, obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose tolerance, minimal or no physical activity, and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Pacific Islanders are at particularly high risk for type 2 diabetes.

**Gestational diabetes** develops in up to 5% of all pregnancies but disappears when a pregnancy is over. Gestational diabetes occurs more frequently in African Americans, Hispanic/Latino Americans, American Indians, and persons with a family history of diabetes. Obesity also is associated with higher risk. Women who have had gestational diabetes are at increased risk for later developing type 2 diabetes. In some studies, nearly 40% of women with a history of gestational diabetes developed diabetes later in life.

"**Other specific types**" of diabetes result from specific genetic syndromes, surgery, drugs, malnutrition, infections, and other illnesses. Such types of diabetes may account for 1% to 2% of all diagnosed cases of diabetes.

## COMPLICATIONS OF DIABETES (NATIONAL STATISTICS)

**Heart disease.** Heart disease is the leading cause of diabetes-related deaths. Adults with diabetes have heart disease death rates about 2 to 4 times as high as that of adults without diabetes.

**Stroke.** The risk of stroke is 2 to 4 times higher in people with diabetes.

**High blood pressure.** An estimated 60% to 65% of people with diabetes have high blood pressure.

**Blindness.** Diabetes is the leading cause of new cases of blindness in adults 20 to 74 years old. Diabetic retinopathy causes from 12,000 to 24,000 new cases of blindness each year.

**Kidney disease.** Diabetes is the leading cause of end-stage renal disease, accounting for about 40% of new cases. 27,851 people with diabetes developed end-stage renal disease in 1995. In the same year, 98,872 people with diabetes underwent dialysis or kidney transplantation.

**Nervous system disease.** About 60% to 70% of people with diabetes have mild to severe forms of nervous system damage (which often includes impaired sensation or pain in the feet or hands, slowed digestion of food in the stomach, carpal tunnel syndrome, and other nerve problems). 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 people with diabetes. From 1993 to 1995, about 67,000 amputations were performed each year among people with diabetes.

**Dental disease.** Periodontal disease (a type of gum disease that can lead to tooth loss) occurs with greater frequency and severity among people with diabetes.

Periodontal disease has been reported to occur among 30% of people aged 19 years or older with type 1 diabetes.

**Complications of pregnancy.** The rate of major congenital malformations in babies born to women with pre-existing diabetes varies from 0% to 5% among women who receive preconception care to 10% among women who do not receive preconception care. Up to 5% of pregnancies among women with diabetes result in death of the newborn; the rate for women who do not have diabetes is 1.5%.

**Other complications.** Diabetes can directly cause acute life-threatening events, such as diabetic ketoacidosis and hyperosmolar nonketotic coma. People with diabetes are more susceptible to many other illnesses. For example, they are more likely to die of pneumonia or influenza than people who do not have diabetes.

## COSTS

**Total (direct and indirect):** \$98 billion (United States, 1997)

**Direct medical costs:** \$44 billion

**Indirect costs:** \$54 billion (disability, work loss, premature mortality)

*This estimate, provided by the American Diabetes Association, is in contrast to higher estimates cited elsewhere that are based on all healthcare costs incurred by people with diabetes, including costs not resulting from diabetes.*

**(The estimated direct and indirect cost of diabetes in Texas in 1997 was \$9.2 billion.)**

## NEW DIAGNOSTIC CRITERIA FOR DIABETES \*

The new diagnostic criteria for diabetes include the following changes:

The routine diagnostic test for diabetes is now a fasting plasma glucose test rather than the previously preferred oral glucose tolerance test. (However, in certain clinical circumstances, e.g., to identify gestational diabetes, physicians may still choose to perform the more difficult and costly oral glucose tolerance test.) A confirmed\*\* fasting plasma glucose value of greater than or equal to 126 milligrams/deciliter (mg/dL) indicates a diagnosis of diabetes. Previously, a value of greater than or equal to 140 mg/dL had been required for diagnosis.

In the presence of signs and symptoms of diabetes, a confirmed\*\* nonfasting plasma glucose value of greater than or equal to 200 mg/dL indicates a diagnosis of diabetes.

When a doctor chooses to perform an oral glucose tolerance test (by administering 75 grams of anhydrous glucose dissolved in water, in accordance with World Health Organization standards, and then measuring the plasma glucose concentration 2 hours later), a confirmed\*\* glucose value of greater than or equal to 200 mg/dL indicates a diagnosis of diabetes. In pregnant women, different requirements are used to identify the presence of gestational diabetes.

## TREATMENT OF DIABETES

Diabetes knowledge, treatment, and prevention strategies advance daily. Treatment is aimed at keeping blood glucose near normal levels at all times. Training in self-management is integral to the treatment of diabetes. Treatment must be individualized and must address medical, psychosocial, and lifestyle issues.

**Treatment of type 1 diabetes:** Lack of insulin production by the pancreas makes type 1 diabetes particularly difficult to control. Treatment requires a strict regimen that typically includes a carefully calculated diet, planned physical activity, home blood glucose testing several times a day, and multiple daily insulin injections.

**Treatment of type 2 diabetes:** Treatment typically includes diet control, exercise, home blood glucose testing, and in many cases, oral medication and/or insulin. Approximately 40% of people with type 2 diabetes require insulin injections.

## IMPAIRED FASTING GLUCOSE

Impaired fasting glucose is a diagnostic category in which persons have fasting plasma glucose values of 110-125 mg/dL. These glucose values are greater than the level considered normal but less than the level that is diagnostic of diabetes. In the United States, it is estimated that 13.4 million persons, 7.0% of the population, have impaired fasting glucose. Scientists are trying to learn how to determine which of these cases will go on to develop diabetes and how to prevent such progression.

## INTERNET RESOURCES

The following web sites provide more information about diabetes, as well as statistics for Texas and the United States.

American Association of Diabetes Educators  
<http://www.diabetesnet.com/aade.html>

American Diabetes Association  
<http://www.diabetes.org>

Centers for Disease Control and Prevention  
<http://www.cdc.gov/diabetes>

Department of Veterans Affairs  
<http://www.va.gov/health/diabetes/>

Health Resources and Services Administration  
<http://www.hrsa.dhhs.gov>

Juvenile Diabetes Foundation International  
<http://www.jdrf.org>

National Institute of Diabetes and Digestive and Kidney Diseases of the National Institute of Health  
<http://www.niddk.nih.gov>

U.S. Department of Health and Human Services Office of Minority Health  
<http://www.omhrc.gov>

Texas Diabetes Council/Program  
<http://www.tdh.state.tx.us/diabetes/tdc.htm>

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- LaPorte RE, Matsushima M, Chang Y-F. Prevalence and incidence of insulin-dependent diabetes, in Diabetes in America, ed. 2. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Disease, 37-45.
  - Estimates based on 1999 prevalence of diagnosed diabetes in Texas for adults, 18 years or older. Texas Behavioral Risk Factor Surveillance System, Bureau of Disease, Injury, and Tobacco Prevention, Texas Department of Health.
  - Harris MI, Flegal KM, Cowie CC, and Eberhardt MS. Prevalence of diabetes, impaired fasting glucose, and impaired glucose tolerance in US adults. The National Health and Nutrition Examination Survey, 1988-1994. Diabetes Care. Vol 21, No 4, 518-524.
- \* For more information about the new diagnostic criteria for diabetes, please refer to Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Diabetes Care 1997 July; 20(7):1183-97.
- \*\* Except in certain specified circumstances, abnormal tests must be confirmed by repeat testing on another day.

of type 2 diabetes and coexisting conditions in children and adolescents.

Workgroup participants included TDH health experts, medical professionals, health educators, and members of the public who contributed their unique experiences and expertise toward the development of this plan. This Type 2 Diabetes in Children and Adolescents Statewide Action Plan proposes a comprehensive approach to combat this emerging problem in Texas.

The report addresses four important areas:

**Why is Type 2 Diabetes in Children on the Rise?** The most likely explanation is the increase in overweight children and corresponding decrease in physical activity.

**Current Diabetes State Programs.** The Texas Diabetes Council promotes the use of Minimum Standards of Care for patients who have diabetes and offers a variety of patient education materials in both English and Spanish. The Council also supports local interventions and school-based programs that target high-risk populations. The Texas Department of Health develops epidemiological profiles that guide the development of programs that reach the areas and populations that have the greatest needs.

**Type 2 Diabetes in Children—An Emerging Epidemic?** The number of children affected by type 2 diabetes (the prevalence) is very small in relation to the number of adults who have or will develop diabetes. More research is needed to assess the extent of the problem. If type 2 diabetes in children is increasing, as appears to be the case, the costs to society could be enormous, as we may begin to see

the complications of diabetes in 30-year-olds.

**Who Is At Risk?** More than three fourths of children diagnosed with type 2 diabetes have a first- or second-degree relative with type 2 diabetes. Children who have type 2 diabetes also tend to be obese or overweight; of African, Hispanic, Asian, or Native American descent; over 10 years of age; and in middle to late puberty. They typically have low levels of physical activity.

**Recommendations:**

- Implement the Coordinated Approach to Child Health (CATCH) program in 8 to 10 schools in each education service center region
- Fund a full-time CATCH coordinator in each of the state's 20 education service centers.
- Establish a pilot program to demonstrate the effectiveness of comprehensive community-based initiatives focusing on obesity and type 2 diabetes in children and adolescents
- Increase public and health professional awareness of type 2 diabetes in children and adolescents
- Support data collection related to the incidence and prevalence of type 2 diabetes in children and youth

**References:**

1. Zimmet P. Diabetes and obesity worldwide — epidemics in full flight. Presented at the 60th Scientific Sessions of the American Diabetes Association; June 10, 2000; San Antonio, Texas.
2. Ponder SW, Sullivan S, McBath G. Diabetes Spectrum, Type 2 Diabetes Mellitus in Teens. Vol 13, No 2, 2000.
3. The New York Times. Childhood Obesity Produces "Adult" Diabetes in Kids. Dec 29, 1998.
4. Goland, RS, as quoted in, "Adult Type of Diabetes Rising Dramatically in Kids and Teens." American Diabetes Association press release, June 19, 1999.

## Managed Care Work Group reorganizes, expands membership

The Managed Care Work Group and Industry Advisory Committee, advisory committees to the Texas Diabetes Council, have combined and expanded their membership to improve productivity and participation.

Charles A. Reasner II, MD, San Antonio, will serve as chair of the new workgroup, which is called the Texas Diabetes Health Care Professionals Committee. Dr. Reasner is chief of clinical endocrinology and associate professor of medicine at the University of Texas Health Science Center at San Antonio and medical director of the Texas Diabetes Institute.

The workgroup has three charges, each of which will be addressed by a subcommittee:

- develop and update standards of care, including algorithms;
- disseminate and distribute materials; and
- ensure compliance with standards and evaluate outcomes.

Among those invited to participate in the Texas Diabetes Health Care Professionals Committee are representatives of the Texas Medical Association, American Diabetes Association, Juvenile Diabetes Research Foundation, American Association of Diabetes Educators, Texas Academy of Family Physicians, Texas Nurses Association, and other health-related professional organizations. Medical directors of managed care organizations in Texas and representatives of pharmaceutical companies and the Texas Medical Foundation also have been invited.

The Managed Care Work Group and Industry Advisory Council began their work in 1995. They developed and published the Minimum Standards for Diabetes Care Under Managed Care in Texas to promote quality health services and education for diabetes patients within the managed care environment.

The Texas Diabetes Health Care Professionals Committee will meet in conjunction with the quarterly meetings of the Texas Diabetes Council in Austin.

## Diabetes Pilot Program to accept Bexar County enrollees through June 2001

The Diabetes Pilot Program will continue to enroll physicians and patients from Bexar County through June 2001. All enrolled patients must complete their education by August 31.

The pilot offers Medicaid managed care patients comprehensive education and access to medical specialists, durable medical equipment, and associated medical supplies. All of these patients who have diabetes, including women with gestational diabetes and children with Type 2, are eligible to participate.

Participating physicians attend continuing medical education programs in diabetes and adhere to the recommendations published in the Minimum Standards for Diabetes Care in Texas developed by the Texas Health Care Professionals and the Texas Diabetes Council. A representative of each managed care plan participating in the pilot coordinates service delivery between the physician, certified diabetes educator, and the patient.

In Senate Bill 162, passed in 1997, the 75th Texas Legislature instructed the Health and Human Services Commission to develop a pilot program to determine the effectiveness of comprehensive diabetes management in the state's Medicaid population. Bexar County was selected for the demonstration project, which officially began on July 1, 1999. More than 100,000 people in Bexar County have been diagnosed with diabetes, with even more at risk of developing the disease.

The pilot program is expected to show that enhanced patient involvement improves therapeutic outcomes, decreases hospital admissions and emergency room visits, and reduces the complications of diabetes, including amputations, blindness, and kidney disease.

*Editor's note: For more information on the Medicaid Pilot Program, contact Bob Johnson, RN, Bureau of Medicaid Managed Care at (512) 794-6853.*

## Afternoon Blood Test May Miss Diabetes

Doctors who give their afternoon patients the fasting plasma glucose test are likely to miss half of the diabetes cases in this group, according to research published in *The Journal of the American Medical Association*. The test is diagnostic for diabetes if a person has a blood glucose level of 126 milligrams per deciliter (mg/dl) or higher, and a second test on another day confirms the same high level of blood glucose.

The recommendation to use the test is based on studies of plasma glucose measured in the morning after an 8-hour fast. However, many patients are seen in the afternoon after variable periods of fasting. In the JAMA study, researchers compared the plasma glucose levels of 6,483 people tested in the morning after a median fasting time of 13.5 hours to the glucose levels of 6,399 people tested

in the afternoon after a median fasting time of 7 hours. Participants in both groups were otherwise similar in age, sex, race, weight, physical activity, waist-to-hip ratio, family history of diabetes, and other factors that may affect blood glucose levels.

The researchers found that fasting plasma glucose levels were consistently higher in the morning group compared to the afternoon, with an overall mean difference of 5 mg/dl. Moreover, the afternoon patients had blood glucose levels suggestive of diabetes at half the rate of the morning group.

To accurately detect diabetes in afternoon patients, the researchers suggest that the diagnostic standard of glucose levels for this group should be lower—114 mg/dl or greater instead of the current standard of 126 mg/dl or greater. In any case, the researchers advise physicians to confirm the diagnosis by repeat testing on a different day, preferably in the morning.

## Diabetes Council Supports Legislative Initiatives

The 77th Texas Legislature convened on Tuesday, January 9, 2001, but lawmakers' work began months before that date. In the time between legislative sessions, special committees studied a variety of issues. Additionally, lawmakers have been submitting proposed legislation since November 13, 2000.

As this work has progressed, the Texas Diabetes Council has been on hand to assist legislators and advocate for better care for Texans who have diabetes as well as measures to help prevent diabetes and its devastating complications. Chair Maria C. Alen, MD, provided information on issues related to diabetes during public hearings in the spring and early fall of the Special Senate

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**You Have The Power To Control Diabetes One Day At A Time**

... That's the message aimed at patients with diabetes in a colorful, easy-to-understand booklet from the Texas Diabetes Council. This popular educational piece—"Controlling Diabetes One Day at a Time"—is back in stock and available free of charge to healthcare providers.

The booklet holds handouts on kidney disease, family support, eye care, foot care, heart health, low blood sugar, medicines, and risk factors associated with diabetes. It includes tips on diet and physical activity and a form where patients can note goals related to food, weight, exercise, medicines, and blood sugar tests. There also is a form that serves as a diary of meals, medicines, and tests.

To order your supply of "Controlling Diabetes One Day at a Time," call 512-458-7490.

**Medicare Expands Coverage of Self-management Training**

At press time the final rule for expanded Medicare coverage of diabetes self-management training was pending. The rule, which outlines benefits and eligibility requirements for patients and education providers, is published in the December 29, 2000, edition of the *Federal Register*, Volume 65, Number 251, pages 83129-83154.

*(Legislative Initiatives, continued from page 3)*

Committee on Border Affairs and the Blue Ribbon Task Force on the Uninsured.

The Council also participates in an inter-agency workgroup that includes representatives of a number of statewide organizations interested in diabetes. This group meets throughout the year to review proposed legislation and advise the Legislature on how to improve the lives of Texans who have diabetes. Diabetes Council members Judith Haley and Mike Thompson serve as the group's co-chairs.

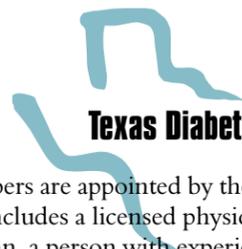
Following are upcoming dates of interest during the session:

Friday, March 9, 2001: Deadline for filing bills and joint resolutions that are not local or have not been declared an emergency by the governor

Monday, May 28, 2001: Last day of the 77th Regular Session

Sunday, June 17, 2001: Last day governor can sign or veto bills passed during 77th Regular Session

Monday, August 27, 2001: Date that bills without specific effective dates (that could not be effective immediately) become law.



**Texas Diabetes Council Members**

Council members are appointed by the Governor and confirmed by the Senate. Membership includes a licensed physician, a registered nurse, a registered and licensed dietitian, a person with experience in public health policy, four consumer members, four members from the general public with expertise or commitment to diabetes issues, and five state agency members.

<b>Maria C. Alen, MD, Chair</b> McAllen	<b>Thomas (Ray) McCann</b> Mount Pleasant
<b>Gene Bell, RN, CFNP, CDE</b> Lubbock	<b>Mike Thompson, Jr.</b> Austin
<b>Victor Hugo Gonzalez, MD</b> McAllen	<b>Jeri Badgett</b> Texas Rehabilitation Commission
<b>Judith L. Haley</b> Houston	<b>Tommy Fleming</b> Texas Education Agency
<b>Jan B. Hamilton, PhD, RD/LD</b> Plainview	<b>Philip Huang, MD, MPH</b> Texas Department of Health
<b>Lawrence B. Harkless, DPM</b> San Antonio	<b>Joanne Molina</b> Texas Department of Human Services
<b>Richard (Rick) S. Hayley</b> Corpus Christi	<b>Linda G. Robinson</b> Texas Commission for the Blind
<b>Belinda Bazan-Lara, MA, RD/LD</b> San Antonio	

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