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CHRONIC DISEASES

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You asked four questions related to chronic disease. Your questions and answers appear below.

1. Provide a summary and legislative history of the Illinois diabetes caucus.

In April 2011, Illinois House minority leader Tom Cross and other legislators announced the formation of a bipartisan Legislative Diabetes Caucus. The caucus was not created by legislation, but instead by a group of legislators interested in the topic, led by an eight-member steering committee. The caucus is intended to advance diabetes policy and educate legislators about diabetes issues, among other things.

Currently, 52 legislators are members of the caucus (there are 177 legislators in total in the Illinois General Assembly). In addition to legislative members, there are affiliate members (citizens or groups that are interested in diabetes policy).

The caucus has no set budget. There is one staff person who serves as the caucus executive director, in addition to other duties. The caucus is also planning to have two full-time interns. The caucus website is <http://www.ilgadiabetes.com/>.

Mission. The group's mission is to promote sound diabetes policy development in various ways, such as educating legislators about diabetes issues; establishing a forum to develop political strategies to advance diabetes issues; and providing education about the differences between type I and type II diabetes. The group's full mission statement is available at <http://www.ilgadiabetes.com/mission-statement/>.

Bylaws. The group has adopted bylaws, available online at <http://www.ilgadiabetes.com/bylaws/>. The bylaws provide that a board of directors is responsible for the overall policy and direction of the caucus. The board members are non-legislators. Among other things, the bylaws address the caucus mission, board membership, committee meetings, and other internal board matters. The bylaws specify that the caucus is organized exclusively for charitable and educational purposes.

Activities. Caucus members have advanced legislation concerning various diabetes-related issues. In July 2012, Illinois Governor Pat Quinn signed into law Public Act 97-819, designating November 14 as Diabetes Awareness Day in the state. The caucus website includes summaries of various laws affecting diabetes and bills that have recently been considered on the topic: <http://www.ilgadiabetes.com/legislation/>.

The caucus has also engaged in other activities designed to increase awareness about diabetes and advance the caucus mission. For example, in October 2011, the Diabetes Caucus, along with the Illinois Diabetes Policy Coalition, held a Diabetes Summit to consider ideas for legislation to help residents with diabetes.

2. How many states have legislative caucuses related to chronic diseases?

We contacted several organizations, including the National Conference of State Legislatures, American Diabetes Association, and other chronic disease organizations. According to the American Diabetes Association, there are diabetes-related caucuses in Arizona, Pennsylvania, and Washington. In 2007, an Ohio state senator sponsored an asthma caucus, but it is unclear if the caucus is still active; we are awaiting confirmation on that question.

Many states address chronic diseases by convening bodies such as task forces or working groups. For example, OLR Report [2012-R-0149](#) summarizes studies concerning Lyme Disease prepared by committees or other groups in Maryland, Massachusetts, and Virginia. North Carolina has a [Joint Legislative Task Force](#) on Diabetes Prevention and Awareness. Kentucky convened a Task Force on Childhood Obesity in 2011.

Congressional Caucuses. While few states have caucuses related to chronic disease, there are several Congressional caucuses related to chronic diseases and other health conditions. Some examples are:

- Congressional Diabetes Caucus
(<http://house.gov/degette/diabetes/>)
- Congressional Lupus Caucus
(http://rooney.house.gov/index.php?option=com_content&view=article&id=3346)
- Congressional Lyme Disease Caucus
(<http://wolf.house.gov/index.cfm?sectionid=34&parentid=6§iontree=&itemid=1291>)
- Congressional Pulmonary Obstructive Disease Caucus
(<http://www.uscopd.org/congressionalcaucus/congressionalcaucus.htm>)
- Congressional Cystic Fibrosis Caucus
(<http://www.cff.org/GetInvolved/Advocate/CFCaucus/>)
- Congressional Kidney Caucus
(http://mcdermott.house.gov/index.php?option=com_content&view=article&id=288&Itemid=60)

3. What is the status of any recommendations related to chronic disease from the Sustinet Act (PA 09-148)?

PA 09-148 established a nine-member board to recommend to the legislature, by January 1, 2011, the details of and implementation process for a self-insured health care plan called Sustinet. The recommendations had to address, among other things, the (1) phased-in offering of the Sustinet plan to various groups and (2) governance structure of the entity that would oversee the Sustinet plan.

PA 11-58 repealed the prior Sustinet law established in PA 09-148, and, among things, established the Office of Health Reform and Innovation and Sustinet Health Care Cabinet in the lieutenant governor's office.

PA 09-148 contained certain recommendations specifically related to chronic disease. Many of these recommendations related to the Sustinet plan or the quasi-public entity which would oversee the plan, and therefore are no longer applicable due to PA 11-58's repeal of the prior Sustinet law. For example, one provision in PA 09-148 required the Sustinet board to recommend that the public authority overseeing Sustinet establish action plans with measurable objectives in various areas, such as the effective management of chronic illness.

Another provision of PA 09-148 required the board to establish a medical home advisory committee to develop policy governing the administration of patient-centered medical homes providing health care services to Sustinet Plan members. The act required the committee to make recommendations on various matters, including how to advise members with chronic health conditions on monitoring and managing their conditions.

The Sustinet board's final report to the legislature in January 2011 is available [here](#). The appendix to the report includes the final reports submitted by various advisory committees and task forces to the Sustinet board.

Some of the recommendations in these reports were specifically focused on the chronic disease population, but were tied to Sustinet's enactment and thus have not been implemented. For example, the Preventive Health Care Advisory Committee recommended that the Sustinet plan include an Annual Individual Preventive Care Plan, and that for patients with chronic conditions, providers should have the option of working with the patient to develop a more extensive plan.

Many of the recommendations by the Tobacco and Smoking Cessation and Childhood and Adult Obesity task forces would impact some segments of the chronic disease population. For example, the Tobacco and Smoking Cessation task force recommended that the state require all insurers to provide coverage for comprehensive tobacco usage cessation interventions. The task force also recommended that the state eliminate the (1) small business limited exemption from the workplace smoking prohibition and (2) option for businesses to maintain a smoking room. These recommendations have not been enacted.

4. Have any state agencies conducted recent studies of the chronic disease population and, if so, what were the results?

The Department of Public Health (DPH) conducts data collection and analysis concerning the prevalence and burden of various chronic diseases. As part of this process, DPH publishes health improvement and strategic plans for various conditions. The plans most relevant to chronic disease populations include asthma; cancer; diabetes; genomics; nutrition; obesity prevention and control; oral health; and physical activity. The plans are available [here](#).

DPH publishes abstracts of its most recent plans in each program area in its *Directory of Connecticut Health Plans*. The directory is available at the above link. DPH also maintains individual web pages with statistics and other information about specific diseases. A list is available [here](#).

Below, we briefly summarize a sample of the available documents and information DPH has prepared related to asthma and diabetes. If you would like more information about a particular document or other diseases, please let us know.

Asthma. According to DPH's asthma [webpage](#), the percentage of state adults reported as having asthma increased from 7.8% in 2000 to 9.4% in 2009. In 2009, the cost of acute care due to asthma as a primary diagnosis reached \$112 million, with \$78 million of that total being public funds.

The most recent statewide asthma plan was released in 2009. The plan, *A Collaborative Approach for Addressing Asthma in Connecticut, 2009 - 2014*, includes information on the background of the condition and its burden on the state, as well as seven goals to address asthma. According to the plan, the prevalence of asthma is higher in adult females, male children, and Hispanic and non-Hispanic black people.

DPH's asthma webpage has numerous links to information on specific issues related to asthma. For example, there is a link to a guidance manual for childcare providers in managing asthma. Another link provides information about reporting cases of workplace asthma to DPH's occupational health unit.

The webpage has information about, among other things, asthma and sports; surveillance; environmental factors; and evaluation tools.

Diabetes. DPH's [webpage](#) on diabetes surveillance contains numerous publications, news briefs, presentations, and other statistical and informational documents.

One 2011 [document](#), *The Burden of Diabetes in Connecticut*, contains information on the prevalence, morbidity and mortality, and risk factors of the disease, among other things. According to the report, diabetes was the 8th leading cause of death in Connecticut in 2008. The report also addressed the costs of diabetes-related care. For example, it found that in 2008, approximately \$128 million was billed for hospitalizations in Connecticut due to diabetes as a principal diagnosis, while almost \$46 million was billed for diabetes-related hospitalizations with a lower extremity amputation. The report noted that obesity is the primary modifiable risk factor for diabetes. According to the report, 80% of people with diabetes are obese when diagnosed.

Another [document](#) shows diabetes prevalence by gender, race, ethnicity, age, education, household income, and county, for 2007-2009. The information was gathered through telephone surveys of over 20,000 adults, asking them, "have you ever been told by a doctor that you have diabetes?" According to the survey, an estimated 6.9% of the state adult population has diabetes. The percentage is slightly higher for males (7.5%) than females (6.4%). The percentage is higher among African-American (13.3%) than other racial groups. Rates also decrease with increasing education and household income. Most counties' rates are fairly close to the state average; the counties that varied the most from the average were Tolland (5.4%) and Windham (9.1%).

DPH's most recent diabetes prevention and control [plan](#) covers the years 2007-2012. The plan was the product of the Diabetes Advisory Council and five work groups. The advisory council includes representatives from DPH, health care professionals, legislators, and other stakeholders. The work groups addressed prevention; disease management; education and awareness; access and policy; and surveillance. The plan contained objectives and related strategies in each of these areas.

A recent [news brief](#) on DPH's webpage reported data on hospitalization for diabetes-related nontraumatic lower-extremity amputation from 1999-2009. The data show that the age-adjusted rates for such hospitalizations declined 36.4% among Connecticut adults 40 years and older during that span. There were differences in rates of

decline by age, gender, and race and ethnicity. For example, the decline in hospitalization was greater among those age 75 and older than among younger groups.

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