

for detecting peripheral artery disease and the procedures for charging for screening for it. In addition, the group would be tasked with looking at the costs and benefits of such educational programs and of increased screening for peripheral artery disease in diabetic patients.

Result of the studies conducted by the task force would be transmitted to the governor, the secretaries of health and of human services, and the chair of the legislative health and human services committee.

FISCAL IMPLICATIONS

HSD estimates its costs as follows: “HSD will require additional staff to perform the study as required in the bill. The estimated additional budget impact shown in the table above is for 0.33 FTE of 4 different types of HSD staff (an Economist-Advanced, a physician, a coder and a Native American liaison) for a total of approximately \$459 thousand.”

DOH estimates that its personnel cost for convening and participating in the task force would be approximately \$10 thousand.

SIGNIFICANT ISSUES

According to a 2013 Centers for Disease Control study, 10.7 percent of New Mexicans 18 years of age or older were diagnosed as having diabetes, with 170 thousand New Mexicans carrying that diagnosis at that time. By 2018, according to the Department of Health, that number was 250 thousand. The prevalence of diabetes is increasing throughout the U.S., undoubtedly related to the increasing rate of obesity in the U. S. population as a whole, but the 2017 prevalence in New Mexico was higher than the national prevalence, 10.7 percent compared with 9.4 percent. DOH estimates the annual costs for New Mexico adults with diabetes exceeds \$2 billion annually.

Because of the deposit of fatty material in the peripheral arteries of diabetic patients, they are prone to the development of nerve damage, especially in the feet and lower extremities. According to CDC data, as much as 89 percent of diabetes-related amputation could be prevented both through screening of diabetics for peripheral nerve damage and through treatment alternatives to amputation. Amputation results in a considerably decreased quality of life for those for whom it is necessary. Probably due to greater awareness on the part of both the public and of medical care providers and better care, the national rate of lower extremity amputations decreased from 11.2 per 1,000 persons with diagnosed diabetes in 1996 to 3.9 (a decrease of 65 percent) in 2008. (https://www.cdc.gov/media/releases/2012/p0124_lower_limb.html). The rate likely could be decreased further with screening for peripheral artery disease and frequent foot examination of diabetic patients. As noted by DOH with respect to related SB 16, “An ADA task force created the Comprehensive Foot Examination and Risk Assessment. In addition, the ADA’s *Standards of Medical Care in Diabetes-2016* recommend an annual comprehensive foot examination to identify risk factors predictive of foot abnormalities, ulcerations, and amputations to decrease morbidity and mortality (<https://clinical.diabetesjournals.org/content/35/1/55>).”

DOH continues:

In a recent study on diabetes-related non-traumatic lower-extremity amputation by the Centers for Disease Control and Prevention (CDC) (<https://doi.org/10.2337/dc18-1380>), the authors recommend improving preventive foot care, optimally managing glycemic

control and cardiovascular risk factors, and diabetes self-management education. In regards to the latter, in addition to the clinical management of diabetes (including foot exams), diabetes can be self-managed and complications prevented or delayed through evidence-based programs such as diabetes self-management education (DSME). DSME programs are formally recognized or accredited by the American Diabetes Association and American Association of Diabetes Educators. In addition, the community-based Diabetes Self-Management Education Programs (DSMEP) have been proven to improve quality of life and help adults better manage their health. These programs are effective in improving health outcomes and reducing the costs of diabetes (State FY20 Diabetes Prevention and Control Legislative Fact Sheet)...

It is recommended that contracts for high risk populations be considered to adequately address the significant disparities affecting the American Indian populations regarding extremity amputations.

However, in accordance with the State-Tribal Collaboration Act section 11-18-3 Collaboration with Indian nations, tribes or pueblos (C), additional consideration must be given to the procurement process for developing, monitoring, evaluating contracts within the high priority areas, which may include our tribal communities.

DOH also comments on disparities in prevalence of peripheral artery disease, which is higher among African Americans than among non-Hispanic whites and Hispanics. Native Americans have higher rates of peripheral artery disease and amputation compared with other groups.

The Medical Board comments regarding the related bill, “SB16 is requesting funding for an unspecified program of education in the area of medical education. To make sense, the request should specify at least an outline of the course material, who is going to teach the material to patients and practitioners (not just physicians), and how is the result to be measured. This is as much a research project as it is a medical subject for a seminar or a course.” Establishment of a task force, as envisioned under SJM 1, that could specify carefully the program of education on diabetes complications according to the best available medical and educational evidence.

RELATIONSHIP

Senate Bill 16, which appropriates \$250 thousand to DOH to conduct educational programs for communities and for health care providers on diabetes-related peripheral artery disease and the avoidance of amputation.

LAC/sb/al/rl