ADA Standards of Care, Insurance, and Diabetes: A Pediatric Perspective

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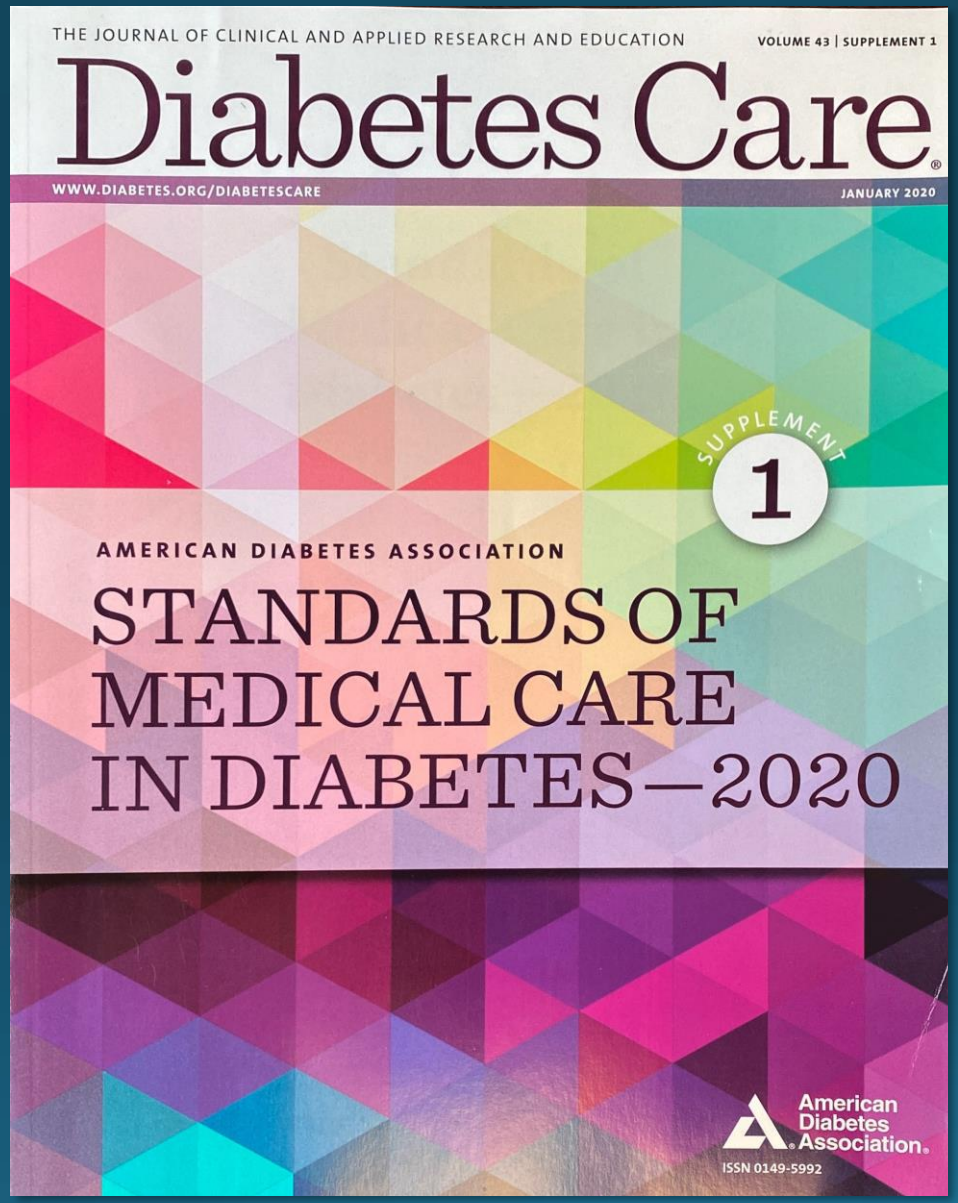
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ADA Standards of Care

Timely

1) Developed yearly, by experts: the Professional Practice Committee
2) Funded solely by the ADA, out of general revenues, i.e. no industry support
3) Living document

Evidence-based

Grading system:

A: RCT

B: cohort studies

C: poorly controlled

E: expert consensus

Individual

1) Health in populations
2) Type 1 DM
3) Type 2 DM
4) Pediatrics
5) Complications
6) Etc.

Recommendation 1.1: Ensure treatment decisions are timely, rely on evidence-based guidelines, and are made **collaboratively with patients based on individual preferences, prognoses, and comorbidities**

Outcomes

- Key to care: continuous care
  - Loss of coverage = change of coverage
  - In adults, an interruption in care leads to a 3.6% relative increase in hemoglobin A1c (marker of average blood sugar)[1]
- Pediatrics: children held captive to parent's insurance
  - Limits choice for children
  - Likely also limits parental employment: "job lock" occurs in adults with diabetes[1]
- The most complex care: diabetes distress

1: Health Aff (Millwood). 2018 Jul;37(7):1024-1032. doi: 10.1377/hlthaff.2018.0204.

Reality: Clinical Care Stories

- The effects on clinic: logistics
- Part Time Job: supplies
- The inverse: patient choice
- Moving to Oklahoma: technology

Therefore…

- Across ALL insurance forms, the BASE of care should be the ADA Standards of Care, with comprehensive coverage of ALL options
  - Minimize disruptions, maximize access
  - Provides for PATIENT and PROVIDER choice within an established framework
  - Allows for new expert opinion to inform PROACTIVE, RAPID changes to plans, to improve care today