

DIABETES MEDICAL EMERGENCY RESPONSE TASK FORCE

Minutes of the 2nd Meeting of the 2018 Interim

October 8, 2018

Call to Order and Roll Call

The 2nd meeting of the Diabetes Medical Emergency Response Task Force was held on Monday, October 8, 2018, at 3:00 PM, in Room 171 of the Capitol Annex. Senator Ralph Alvarado, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Ralph Alvarado, Co-Chair; Representative Danny Bentley, Co-Chair; Senator Reginald Thomas, Representatives Mary Lou Marzian and Addia Wuchner; Chris Bartley, Gregg Bayer, Chad Burkhart, Robert Couch, and Troy Walker.

Guests: Randy Lawson, Professional Firefighters Association; Dr. Ryan Stanton, Medical Director, Lexington Fire and Emergency Medical Services; Dr. Cathy Hanna, President, Kentucky Board of Pharmacy; Brian Diamond, Student, College of Pharmacy, University of Kentucky; Samantha Klein; Angela Lautner, Founder, Group Leader, and Sarah Ferguson, Advocate, KOI#insulin4all (Kentucky, Ohio, and Indiana).

LRC Staff: Chris Joffrion, Lead Staff, and Becky Lancaster.

Approval of Minutes

A motion to approve the minutes from the September 20, 2018 meeting was made by Representative Marzian, seconded by Chris Bartley, and approved by voice vote.

First Responders' Perspective on Diabetes

Dr. Ryan Stanton, Medical Director, Lexington Fire and Emergency Medical Services, stated that roughly 15 percent of the United States population is diagnosed as diabetic and another approximate 5 percent has diabetes but are undiagnosed. Approximately one-third of the United States population lives with prediabetes. There are two types of diabetes, Type 1 and Type 2. If a patient has Type 1 diabetes, the body does not make insulin that can be used for energy and activity. If there is no insulin, the body will think there is no glucose and start to break down other fuel sources. Glucose is the only fuel source of the brain. The brain does not have the ability to break down or make another fuel source. Type 1 diabetic patients must have insulin to survive. The only route of administering insulin is by an injection or by an insulin pump that gives insulin directly and constantly in varying doses to the patient.

If a patient has Type 2 diabetes, the body does not make insulin but there is an imbalance in the amount of glucose and insulin and the body is not able to process it properly. Hypoglycemia is the most common diabetic emergency encountered in the field. Hypoglycemia occurs when the amount of glucose in the blood falls below the normal lower limit. The most common sign of hypoglycemia is an altered mental status. Hyperglycemia is the term for a high blood glucose level. Extremely hyperglycemic patients may suffer from diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar nonketotic syndrome (HHNS). DKA is more common in the Type 1 diabetic, whereas HHNS is more common in the Type 2 diabetic. In both conditions, the blood glucose level increases drastically. The signs and symptoms of DKA are produced primarily by dehydration and acid build-up. Treatment is not necessarily insulin, with hyperglycemic episodes the initial treatment is fluids.

Gregg Bayer, President, Kentucky Association of Fire Chiefs, stated that the entry level emergency medical technician (EMT) will complete 160 hours total course instruction. An EMT can ride in an ambulance and provide basic life support. The next level is an advanced EMT. The advanced EMT will complete 250 hours total course instruction and can administer intravenous (IV) fluids and certain cardiac medications. The third level is a paramedic. A paramedic must complete 1200 hours total course instruction. Paramedics can administer drugs such as diuretics, narcotics, or benzodiazepine. Each level of EMT must also complete a 1 hour continuing education unit (CEU) every two years that is specific to diabetic emergencies.

A typical diabetic run is to someone who is a known diabetic, usually hypoglycemic, with a decreased level of blood sugar. The paramedic will assess the patient and their history, establish an airway, and if the blood sugar is below 60 mg/dl administer glucose through an IV injection. After administering glucose the patient typically wakes up and is conscious. Many times patients will refuse to be transported to the hospital. If the patient suffers from DKA, the blood sugar level is elevated, the patients are semi-conscious or lethargic and cannot consent or refuse treatment. DKA patients are typically transported to the hospital.

Troy Walker, President, Kentucky Ambulance Providers Association, stated that Muhlenberg County has approximately 6,000 emergency medical service (EMS) runs a year. Approximately two percent of EMS runs are diabetes related with 90 percent of the EMS runs being hypoglycemic in nature. Most of those patients do not go to the hospital. During a typical diabetic EMS run patients receive IV fluids and medication. If a patient is not transported to the hospital the ambulance service does not get reimbursed for any of the supplies used or equipment costs.

Mr. Bayer stated that the community paramedicine program identifies, in a prehospital setting, groups of people that are at risk for a medical emergencies, including diabetes. Community paramedicine workers will proactively seek them out, ask questions,

help them with supplies and doctors' visits, or be an advocate for the patient. The community paramedicine programs decrease emergency calls and costs to the patient and insurance company. Dr. Stanton stated that two men in Lexington operate a similar program. The Lexington program has decreased EMS runs by 5,000 over the last five years.

In response to questions from Representative Wuchner, Dr. Stanton stated that approximately one out of every 50 EMS runs are diabetes related. In most pediatric EMS cases that involve Type 1 diabetes, the patient has not been previously diagnosed. Pediatric symptoms originally present similar to flu or virus symptoms. Mr. Bayer stated that the premise of the community paramedicine program is to identify a group of super users, people that have 50 to 60 diabetic EMS runs in a two month period. Dr. Stanton stated the idea of community paramedicine is giving a person who is vulnerable a personal advocate.

In response to questions from Senator Thomas, Dr. Stanton stated that access to care is multifactorial. A patient may need gas for their car, a ride to an appointment, medications can be cost prohibitive, or the patient may need help understanding prescription instructions. Community paramedicine workers try to understand the patient's barriers and work to tear down the barriers to improve the patient's health. Mr. Bayer stated that the majority of the people seen want access to healthcare but escalating healthcare and prescription costs make access difficult. Mr. Walker also sees problems with access to healthcare and affordability.

In response to questions from Senator Alvarado, Dr. Stanton recommended that the legislature not mandate management of the people that work on the front lines. He advocated that the front line workers have access to the tools necessary to help patients. Mr. Bayer recommended that legislation be passed to address EMS systems cost recovery when a patient is not transported to the hospital.

In response to questions from Dr. Couch, Mr. Bayer stated that the initial partnership with the community paramedicine program was to be established with a hospital but that has not happened at this time. The premise was to reduce the amount of emergency room visits and overload of patients. The community paramedicine program does not bill patients. Dr. Stanton stated that the Lexington community paramedicine program is funded by a grant scheduled to end in December 2018. Mr. Walker stated that EMS services follow Medicare guidelines and that Medicare does not reimburse for a non-transport EMS runs. He stated that there are five beta test sites for community paramedicine programs in Kentucky. Medicare is studying those test sites to see how the program is working and how much money will be being saved.

Emergency Prescription Refills

Dr. Cathy Hanna, President, Kentucky Board of Pharmacy, stated that pharmacists are highly trained health care providers who play key roles in helping patients with diabetes manage their conditions. The Board of Pharmacy has approved protocols that allow

pharmacists to ensure patients with diabetes have access to diabetes testing supplies. Many pharmacists across Kentucky are certified diabetes educators with numerous Medicare certified diabetes self-management education programs in community pharmacies. Pharmacists are authorized by law to dispense a 72 hour emergency supply of non-controlled medications for conditions that are chronic and where interruption of therapy might be harmful to the patient. The law works well for tablets and capsules but is problematic for chronic medications such as insulin where a 30 day unit package cannot be divided. She recommended changing the law to allow pharmacists to dispense the smallest unit package for non-oral medications such as insulin.

In response to questions from Senator Thomas, Dr. Hanna stated that she does not know if the pharmacy benefit managers (PBM) are making pharmacists sell a higher cost insulin because of a relationship with a pharmaceutical company. She stated there are incidents when the cash price of insulin could be cheaper than the insurance copayment depending on the insurance company's prescription formulary list. Brian Diamond, student, College of Pharmacy, University of Kentucky, stated that many longer acting insulins cash prices tend to more expensive than insurance copayments. He has seen that shorter acting insulins could possibly have a cheaper cash price. Dr. Hanna stated that pharmacists have to research to find the cheapest product for the patient.

In response to questions from Senator Alvarado, Dr. Hanna recommended that the smallest available unit, typically one 30 day vial of insulin, be able to be dispensed as an emergency prescription.

Insulin Drug Price Transparency and Emergency Prescription Refills

Angela Lautner, Founder, Group Leader, KOI#insulin4all (Kentucky, Ohio, and Indiana), stated that KOI#insulinforall is a grassroots group of volunteers across Kentucky, Ohio, and Indiana with a goal to promote public awareness of the rising costs of insulin. KOI#insulinforall encourages citizens to meet with legislators to discuss ways to help reduce the costs of insulin. Since her Type 1 diabetes diagnosis, she has seen the price of insulin climb without restriction or transparency. In 2017, all long lasting insulins, except one, was removed from her insurance plan's formulary due to cost by the PBM. She is now on an insulin pump that delivers Humalog to her body all day. In 18 years, the list price of a vial of Humalog has increased from approximately \$30 to \$274 with no changes to the insulin. There are only two quick acting insulins, Humalog made by Eli Lilly and Novolog made by Novo Nordisk. A study from BMJ Global Health stated that the production cost of a single vial analog insulin may cost no more than \$6.16. List prices are set by Novo Nordisk, Eli Lilly, and Sanofi, who control 96 percent of the world's market for insulin.

Some states are looking to see what can be done to get drug price transparency and answers to why the price of insulin keeps changing with no changes to the insulin. In March, people in Kentucky, Ohio, and Indiana gathered in Cincinnati to organize an action plan to bring the issue of increasing costs of insulin directly to the legislators in the tristate

area. One hundred seventy three Kentuckians have signed a petition to raise awareness about the rising price of insulin. Each signature on the petition is someone either purchasing insulin with Type 1 diabetes or has insulin dependent Type 2 diabetes. The American Diabetes Association has started a petition directed to the federal legislators to begin the discussion about the price of insulin.

Samantha Klein testified that she is a Type 1 diabetic and wears an insulin pump. She puts insulin into her pump once every three days, one vial of insulin is approximately one and a half weeks supply. She had an incident where she received her sealed insulin vial from the pharmacy and opened it at home to find it shattered. She could not use the insulin. She was due for a refill and checkup with her endocrinologist but not until the next week. She could not immediately reach her endocrinologist because it was after office hours. She called her mother for assistance. Her mother, Sarah Ferguson, Advocate, KOI#insulin4all (Kentucky, Ohio, and Indiana), stated that she researched different ways she could get the insulin without a prescription. She recommended passing a law similar to one in Ohio called Kevin's Law, named in honor of Kevin Houdeshell who died from a lack of insulin. Pharmacists could then dispense a 30 day vial of insulin as an emergency prescription. Ms. Ferguson did receive insulin for her daughter from someone in her diabetes support community.

In response to questions from Representative Marzian, Ms. Klein stated that the cash price of a vial of Novolog insulin is \$300 per vial, with insurance she pays \$50 a month. Ms. Ferguson stated that if she broke a vial or needed more insulin she would have to pay the \$300 cash price ahead of time. Ms. Ferguson does not know if there is a replacement policy for broken vials at her pharmacy. Ms. Klein stated that her insulin comes in a sealed box that is specially delivered to the pharmacy, her prescribed insulin is not kept in stock at the pharmacy.

Adjournment

There being no further business, the meeting was adjourned at 4:38 PM.