

Kentucky Diabetes Connection



The Communication Tool for Kentucky Diabetes News

A Message from Kentucky Diabetes Partners

KENTUCKY DIABETES STATE PLAN DEVELOPMENT

EVENT HELD IN FRANKFORT TO BEGIN PROCESS

AACE

American Association of Clinical Endocrinologists
Ohio River Regional Chapter

ADA

American Diabetes Association

DECA

Diabetes Educators Cincinnati Area

GLADE

Greater Louisville Association of Diabetes Educators

JDRF

Juvenile Diabetes Research Foundation International

KADE

Kentucky Association of Diabetes Educators

KEC

Kentuckiana Endocrine Club

KDN

Kentucky Diabetes Network, Inc.

KDPCP

Kentucky Diabetes Prevention and Control Program

TRADE

Tri-State Association of Diabetes Educators

From endocrinologists to consumers with diabetes... from private health plans to Medicaid... from legislators to business leaders... over 100 key diabetes stakeholders met in Frankfort at the Kentucky History Center on September 21, 2010, to begin the process of developing a **Kentucky Diabetes State Plan**. Dr. Steve Davis, Deputy Commissioner of Health, welcomed participants and thanked them for their commitment to work on one of the state's costliest issues.

Since attendees had a wide range of backgrounds — some who were more familiar with diabetes and some who were not — Pamela Allweiss, endocrinologist with the Centers for Disease Control and Prevention (CDC), began the day with a **Diabetes 101 presentation and a Call To Action**.

New data recently released (*see Kentucky Diabetes Fact Sheet, updated September 2010 p.16 of this newsletter*) noted that Kentucky has the fourth highest prevalence of adults diagnosed with diabetes in the nation at 11.4% compared with the national median of 8.3%. However, Denise Glover, MSW, also with CDC, pointed out that reasons for Kentucky's increase in diabetes prevalence could be twofold. She noted that on one hand the increase could mean that more people are actually developing diabetes, while on the other hand, it could mean that KY providers are doing a good job of diagnosing and caring for diabetes (if

more people are being diagnosed earlier and people with diabetes are living longer once the diabetes is diagnosed — the prevalence increases).



Over 100 diabetes stakeholders attended the Kentucky Diabetes State Plan Event held September 21 in Frankfort

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KENTUCKY DIABETES STATE PLAN DEVELOPMENT (CONTINUED)

Morning presentations by Denise Cyzman and Patty Ferry, contractors for the project, included results of two surveys that were recently conducted in KY (a consumer survey and a stakeholder survey completed in July / August 2010). Recent trends in KY diabetes data was presented by Teri Wood, PhD, an epidemiologist with the KY Department for Public Health.

After lunch, which was provided compliments of the American Association of Diabetes Educators (AADE), participants divided themselves into action teams to begin to develop specific plans in one of four areas: ***Primary Prevention for People with Pre-Diabetes or at High Risk for Diabetes; People with Diabetes; People with Diabetes Complications; or Health Disparities.***

Plans are to conduct conference calls with each of the action teams over the next 3 months to continue the planning process. A final ***Kentucky Diabetes State Plan*** is expected to be released in March of 2011. With the assistance of the state diabetes plan steering committee, once the state plan is drafted, implementation is expected to begin statewide by diabetes stakeholders.

KY Diabetes State Plan Steering Committee Organizations: the American Association of Diabetes Educators, KY Chapters (Diabetes Educators Cincinnati Area, the Greater Louisville Association of Diabetes Educators, the Kentucky Association of Diabetes Educators, the Tri State Association of Diabetes Educators), the American Diabetes Association (Kentucky Area), the Barnstable Brown Diabetes and Obesity Center at the University of Kentucky, Juvenile Diabetes Research Foundation (Kentuckiana Chapter), the Kentuckiana Endocrine Club, the Kentucky Diabetes Network, the University of Kentucky Division of Endocrinology and the University of Louisville Pediatric Endocrinology and the University of Louisville School of Medicine.



Patty Ferry (left) and Denise Cyzman (middle) presented results of the Kentucky consumer and stakeholder surveys while Denise Glover (right) presented information regarding the system of diabetes in Kentucky explaining where interventions could occur that would impact Kentuckians along the diabetes continuum.



Joan Geohegan (left) and Jan Lazarus (right) work on the table centerpieces made out of "exercise stretch bands" for the diabetes state plan event.



Reita Jones (left), Dr. Pam Allweiss (center), and Theresa Renn (right) set up for the first presentation at the diabetes state plan event.



Diabetes state plan attendees Marlene Feagan (left) and Nancy Walker (right) work to develop vision / mission statements.



Action Team (above) discuss strengths and opportunities around chronic complications for people with diabetes.



Action Team (above) works to develop possibility statements around primary prevention for people with pre diabetes or at high risk for developing diabetes.

DEBORAH FILLMAN, AMERICAN ASSOCIATION OF DIABETES EDUCATORS (AADE) PRESIDENT LEADS THE 2010 NATIONAL CONFERENCE IN SAN ANTONIO

As President of the national organization, Kentuckian Deborah Fillman, RD, LD, CDE, led over 3,000 diabetes educators who attended the annual meeting of the American Association of Diabetes Educators (AADE) held in San Antonio the first week of August. Attendees included RN's 52%, RD's 30%, RPh's 4%, and all others 14%.



Debbie Fillman (left), 2010 AADE President, presides during the opening session of the national conference held in San Antonio.

Debbie Fillman (right), welcomes AADE members to the Novo Nordisk annual walk / run event.



Debbie Fillman (left), introduces the presenter at the closing session of the annual AADE National meeting.



Photos by Lagniappe Photography, courtesy AADE

AADE TO REINTRODUCE “DIABETES EDUCATOR LICENSURE BILL” IN KENTUCKY

Submitted by: James Specker, American Association of Diabetes Educators (advocacy@aadenet.org) with input from Bob Babbage, Babbage Cofounder, Government Relations, Frankfort, KY

As management of diabetes becomes increasingly complex, it is imperative that diabetes health care professionals be well educated and appropriately credentialed. **The American Association of Diabetes Educators (AADE) announced September 22, 2010, that legislation to require licensure for those practicing diabetes education or using the title “diabetes educator” will be reintroduced in 2011 in Kentucky, the pilot state for this initiative. This legislation will also be introduced for the first time in Indiana during the 2011 legislative session.**

Working closely with key legislative leaders during the 2010 session of the Kentucky General Assembly, diabetes educators worked to explain the fundamental role of diabetes educators in the health care system. Led by Deborah Fillman of Owensboro and Kim DeCoste of Richmond, KY AADE members helped the legislature understand what’s at stake as they address diabetes issues.

Representative Ruth Ann Palumbo of Lexington sponsored the 2010 *Diabetes Educator Licensure* legislation that passed the House health committee, and then received overwhelming support by the full House. She was supported by a bipartisan group of House members, who reminded lawmakers of the growing crisis of diabetes throughout the state, the South and the nation. The two health committee chairs, Representative Tom Burch and Senator Julie Denton, both of Louisville, showed great concern and connection to the facts, the needs and the work of state and local health officials and practitioners. The Senate committee on health also passed the *Diabetes Educator Licensure* legislation. However, the 2010 legislative session ended before a final Senate vote could be taken.

KY legislators have a strong, growing awareness of the toll diabetes takes on individuals and families. During these past months, legislators have carefully reviewed the care of students with chronic illnesses in our public schools. Also, legislators listened to a review of diabetes services and the resources needed to meet the growing demand. Representative Dennis Horlander from Louisville recently took the entire day to attend a working session to develop a Kentucky Diabetes State Plan.

Diabetes educator licensure is intended for the healthcare professional that has a defined role as a diabetes educator, not for those who may perform some diabetes-related functions as part of, or in the course of, other routine occupational duties. Without this “legal” definition, diabetes educators will continue to be a self-defined entity. While payors may reimburse for the diabetes education service (DSMT), they may not recognize or reimburse the provider of these services — the qualified diabetes educator. Licensure of the diabetes educator will also provide for consumer safety and provide minimum standards for recognition of the professional. **Please ask your colleagues, professional group or association to support the *Diabetes Educator Licensure* legislation when it is reconsidered in Frankfort, starting January 4, 2011.**



LIGHT BULB IDEAS TO MAKE YOUR EDUCATION PROGRAM SHINE – AUGUST 5, 2010 – AADE



**KDPCP Curriculum Team
(left to right)**

**Kim Jackson, RN, CDE
Mechelle Coble, RD, CDE
Janey Wendschlag, RN
Marisa McLin, RD
Judith Watson, RN, CDE, CN
Donna Heaverin, RN (kneeling)**

Submitted by Judith Watson, RN, CDE, CN, Kentucky Diabetes Prevention and Control Program, Purchase District Health Department, TRADE, KDN member

The Curriculum work group representing the Kentucky Diabetes Prevention and Control Program (KDPCP) provided a presentation titled, **Light Bulb Ideas to Make Your Presentations Shine!**, on August 5, 2010 at the American Association of Diabetes Educators (AADE) annual conference. Mechelle Coble, RD, CDE, and Janey Wendschlag, RN, offered the crowd of over 400 diabetes educators illustrative examples of how to provide education using various tools to teach the AADE 7 Self-Care Behaviors.



Over 400 diabetes educators wait for the presentation to begin.

The idea for this presentation began with a simple question to staff of KDPCP – “How can we make our classes more interesting?”. The tools that were presented included story telling, props that were off-the-shelf and do-it-yourself, games and written materials. These tools were categorized according to the AADE 7 self-care behaviors.



Mechelle Coble illustrates how story telling can be used for all ages.



Display table with various teaching props was located inside the door of the conference room.

Diabetes educators were challenged to add new tools to their teaching box. Each attendee was given a CD with the tool box materials that included how to make and/or where to find the tools, electronic versions of materials produced by KDPCP and other information to help grow each educators’ tool box.



Presenters Janey Wendschlag (left) and Mechelle Coble (right) going over last minute preparations.

The group received a standing ovation and have been invited to Washington State to present to a diabetes educator program there.



**CONGRATULATIONS —
WELL DONE!**



Each attendee was given a CD with resource materials.



Janey Wendschlag engages the audience to show how games make learning more fun.

KENTUCKY MEDICAID MAKING CHANGES

WHICH DIABETES SUPPLIES WILL BE PROVIDED

HOW DIABETES SUPPLIES WILL BE PROVIDED

The following is an excerpt from a letter the Kentucky Medicaid Administration, Kasie Purvis, Provider Relations Manager, sent to Kentucky Medicaid Providers on September 17, 2010, regarding diabetes supplies and their coverage by Medicaid

Dear Kentucky Medicaid Provider:

Please be advised that the Department for Medicaid Services is making changes to the Kentucky Medicaid Durable Medical Equipment (DME) Program and the Pharmacy Program. **Beginning October 5, 2010, the diabetic supplies listed below will be processed through the pharmacy point-of-sale (POS) system**. Claims submitted for members who are Medicare primary, will continue to be processed through your DME provider number and not through the Pharmacy Program.

Diabetic supplies that will be billable through pharmacy POS are blood glucose meters, blood glucose test strips, urine test or reagent strips, blood ketone test or reagent strips, insulin syringes, pen needles, lancets, lancing devices and calibration solutions. The preferred Blood Glucose Meters are listed below. There will be no grandfathering of blood glucose testing supplies.

The products listed below are the preferred products for diabetic supplies

- Abbott (Freestyle Lite, Freestyle Freedom Lite, Precision Xtra)
- Lifescan (One Touch Ultra, One Touch Ultra Mini (various codes approved), One Touch Ultra2, One Touch Ultrasmart)
- Roche Diagnostics (Accu-Chek Compact Plus, Accu-Chek Advantage, Accu-Chek Active, Accu-Chek Aviva)

Reimbursement: The payment algorithms for reimbursement will be the same as those currently applied to pharmacy claims.

Quantity Limits: The following quantity limits (QL) will be applied:

- Lancing Devices - Maximum quantity limit of 1 per every 6 months
- Lancets - Maximum quantity limit of 200 per month
- Syringe w/needle - Maximum quantity limit of 125 per month
- Pen Needles - Maximum quantity of 125 per month
- Blood-Glucose Meter - Maximum quantity limit of one meter per year
- Blood Sugar Diagnostics - Maximum quantity limit of 200 per month
- Urine Glucose Test, Strip - Maximum quantity limit of 200 per month
- Urine Actone Test, Tablet/Strip - Maximum quantity limit of 200 per month
- Urine Gluc-Acet Combination Test Strip - Maximum quantity limit of 200 per month

Copays: Copays for diabetic supplies will be calculated and applied to the annual \$225.00 out-of-pocket cap through the pharmacy program. There will be no copays applied to the meters. Remaining diabetic supplies will have a 3% copay with a maximum out of pocket of \$15.00 per month. Current exemptions from copays are still in effect.

Claim Adjudication: For assistance, contact the Technical Call Center (800) 432-7005

Prior Authorization: Requests can be made by contacting the Managed Access Program (MAP)/Prior Authorization department at (800) 477-3071 OR by completing a prior authorization request form located at <https://kentucky.fhsc.com>. Please fax all requests to Magellan Medicaid Administration at the following numbers: Non-Urgent: (800) 365-8835; Urgent: (800) 421-9064; Mental Health Providers: (800) 453-2273; Long Term Care: (800) 453-2273.

Diabetic Supply Information: For the posted list of preferred products and information relating to diabetic supplies, visit the pharmacy website at <https://kentucky.fhsc.com> refer to the *Diabetic Supplies* tab.

DR. POHL'S COLUMN

CONTINUOUS GLUCOSE MONITORING (CGM)



Stephen L. Pohl, MD
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Submitted by: Stephen Pohl, MD, Endocrinologist, Lexington, KY, KDN, ADA and ACE member

At age 55, the height of my midlife crisis, I started taking flying lessons. I quickly learned that there are many parallels between aviation and medicine. One is the similarity between the autopilot and the human pancreas. An autopilot is a device that senses the position and motion of the airplane in space, compares the information to the desired course, and sends commands to the control surfaces in the wings and tail to keep the plane on course. The pancreas senses the blood glucose concentration and releases insulin into the blood in just the right amount to keep the blood sugar normal. Not surprisingly, the idea has been around for at least 50 years that it should be possible to develop an autopilot-like device, an artificial pancreas, to take over for the defective pancreas in diabetes.

The conceptual basis for the artificial pancreas is the positive feedback loop.

The components required to create such a loop are a blood glucose sensing device, an insulin delivery device, and a computer that uses the blood glucose information to control insulin delivery. Such a system should produce better control of blood glucose. In addition, from the patient's perspective, there is the enormous appeal that an artificial pancreas might be a set-it and forget-it device.

A machine that could provide respite from the constant vigilance required to manage unstable type 1 diabetes remains something of a dream. Nevertheless, some of the technology and concepts related to the artificial pancreas, e.g. the insulin pump, have already found their way into routine clinical care. **The device that is currently nearing the tipping point is the continuous glucose monitor (CGM).**

Early artificial pancreas developers envisioned a noninvasive glucose sensing device analogous to the pulse oximeter, the thing with the red light placed on a

fingertip during surgery. Unfortunately, noninvasive sensing of glucose has proved much more difficult than sensing of oxygen saturation of hemoglobin. As an interim measure, glucose sensors with a small part placed just under the skin have been available for several years.

Despite the obvious appeal of CGM, adoption has been slow.

This year, however, CGM got a big boost due to the presentation of the STAR 3 trial at the annual meeting of the American Diabetes Association. STAR 3 (Sensor-Augmented Therapy for A1c Reduction) was a large clinical trial comparing treatment with a continuous glucose monitor and an insulin pump to multiple daily insulin injections (MDI) with conventional home glucose monitoring. There were 30 study sites and 485 people aged 7 to 70 with type 1 diabetes in the year-long trial. The CGM group used the Medtronic MiniMed Paradigm REAL-Time system. This system consists of a subcutaneous probe that monitors extracellular glucose continuously and sends the information to an insulin pump equipped with software to assist in adjusting the pump settings. It is important to note that this is an "open-loop" system, i.e. the patient, not the computer, decides how to run the pump. The study was sponsored by Medtronic, Inc., with support from Novo Nordisk, Lifescan, Bayer, and Becton Dickinson.

The results of STAR 3 are impressive and convincing.

Baseline A1c for both study groups was 8.3% and decreased to 7.5% for the CGM/Pump group compared to 8.1% for the MDI group. Furthermore, adult CGM/Pump users experienced a full 1.0% decrease in A1c to 7.3%. Consistent users, i.e. those who used the system at least 81% of the time, reduced average A1c to 7.1%. Of the 156 pediatric patients, 44% achieved age specific goals for A1c. Most impressively, CGM/Pump treated patients achieved these large improvements in diabetes control without an increase in severe hypoglycemia. Fear of hypoglycemia has plagued intensive treatment of diabetes for decades and has been a major impediment to controlling diabetes.

In order to get the inside scoop on STAR 3, I called on

DR. POHL'S COLUMN

(CONTINUED)

my former colleagues at the Kentucky Diabetes Endocrinology Center (KDEC), one of the STAR 3 study sites. Drs. Lyle Myers was the Principle Investigator and Dr. Wendell Miers was co-investigator at the KDEC site. Diane Ballard, RN, was the study coordinator. Diane is also an independent contractor and has agreements with most of the CGM and pump suppliers to provide training in the use of their products.

At present, most patients using CGM have type 1 diabetes and also use an insulin pump.

Use of the artificial pancreas and its components in type 2 diabetes is controversial at present. Inability to achieve treatment goals or hypoglycemia motivates patients to start using CGM. Accuracy of CGM is still an issue. It is interesting that patients tend to believe their meters when the two methods disagree even though there is a large amount of literature regarding inaccuracy of home glucose monitoring. The lag between the time of sampling and the appearance of the blood glucose result is also a problem. Some diabetes treatment centers are doing three day “diagnostic” CGM to guide treatment. However, there are as yet no widely accepted methods for interpreting such data.

Medtronic dominates the market with its integrated system consisting of an insulin pump, CGM device, and management software. DexCom sells a CGM device that is not yet integrated with a pump. A third CGM device, manufactured by Abbott Laboratories, is currently unavailable in the United States. The CGM device costs approximately \$2,000. Supplies may cost up to \$10 per day. Insurance coverage is inconsistent. Patients who are interested in CGM must work with the device manufacturer to arrange insurance reimbursement in advance. For now, it is best for patients starting CGM to work with diabetes care professionals who are experienced in the use of this technology. Go to the manufacturers' web sites, www.medtronicdiabetes.com and www.dexcom.com, for help in getting started.

The most interesting thing about my visit to KDEC was their description of the ways that patients find to use CGM.

For example, many patients discover proactive strategies to prevent the sensor alarm from sounding. The CGM

device contains a system to alert the wearer when the blood glucose is either above or below a user-defined target range. Users quickly discover that the alarms go off at inopportune times and find ways to prevent this from happening. In addition to watching their blood sugars with the CGM, they anticipate other factors like food and exercise and adjust insulin delivery to keep glucose in the target range.

For years I tried to teach my patients the differences between proactivity and reactivity with only limited success. It seems to be human nature to wait until things are out of whack and then give insulin or glucose to try to fix a high or low blood sugar. Unfortunately, this reactive approach results in bouncing blood sugars. Fixing a high blood sugar with extra insulin often causes low blood sugar which must then be fixed with sugar causing high blood sugar and on and on. I used to call this “chasing your own tail”. Perhaps the unpleasant stimulus of the sensor alarm will prove to be a more effective teacher.

It turns out that “proactive” describes human fuel homeostasis more broadly. The mere anticipation of eating stimulates insulin secretion. There is also the well known incretin effect. For equal increases in blood glucose, orally administered glucose stimulates insulin secretion several fold more than intravenous glucose. Both of these mechanisms anticipate changes in blood glucose and modify the hormonal milieu to blunt the magnitude of these changes. The glucose-insulin feedback loop, the basis of the artificial pancreas, is just one part of a complex and elegant system that allows us to switch rapidly between modes of storing fuel and releasing fuel from stores.

The flow of fuel into and out of stores is what blood glucose control is all about. An autopilot is a device that reduces a pilot's workload by keeping the airplane straight and level and on course so that the pilot has more time to attend to a myriad of other tasks involved in flying such as safety, navigation, and communication. An autopilot is not a set-it-and-forget-it device; it is simply a tool that enables a pilot to be more proficient. The continuous glucose monitor is here. The artificial pancreas is coming soon. I think that these devices will turn out to be tools that enable patients to be more proficient in managing diabetes. In any case, it will be fascinating to see what happens as this technology sees widespread clinical use.

I think we may be in for some surprises!

IMPROVING THE RATE OF RETINAL EXAMINATION IN PRIMARY CARE OF DIABETES MELLITUS : *A GOAL FOR EFFICIENCY AND EXCELLENCE IN PRACTICE*



*Submitted by: A. O'tayo LaLude, MD,
Coalition Grace Project, Primary Care
Physician, Louisville, KY*

INTRODUCTION

Dilated eye examination is a standard of care in the management of patients with diabetes mellitus (DM)¹. Since type 2 DM (T2DM) constitutes the preponderant number of DM patients cared for by primary care providers (PCP), it is imperative that caregivers understand the pathobiological complications of DM in the eyes of their patients. Though better understood today than by the peoples living on the banks of river Nile about 4,000 years ago², T2DM is an indolent disease that requires urgent and aggressive management upon diagnosis. At the rate that the disease is manifesting in every continent of the world, it is, therefore, a global epidemic³.

A. O'tayo LaLude, MD

EPIDEMIOLOGY - USA ± Kentucky

In the USA, according to the American Diabetes Association and the Center for Disease Control (ADA/CDC), about 24 million or 8% of Americans are diagnosed with DM and yet about 6 million are not aware that they have the disease; another 55-60 million others live with pre-DM status.^{4,5} Kentucky ranks high in the number of citizens afflicted with DM at 9.9% of our population in 2008 data⁶. Since then, probably between 10.5% to 12% of Kentuckians have the disease.

WHY EYE EXAMINATION?

Blindness from DM is a terminal diagnosis and this catastrophic complication could be remedied by early diagnosis and treatment of the patient. The often cited Diabetes Control and Complications Trial (DCCT) followed 1441 people with type 1 diabetes mellitus

(T1DM) for a mean 6.5 years⁷. Early diagnosis and intensive treatment with insulin delayed the onset and slowed the progression of diabetic retinopathy by an average of 76% and 54% respectively. Another study of T2DM patients treated with insulin, the Kumamoto University study⁸, demonstrated an average reduction of 69% worsening in retinopathy.

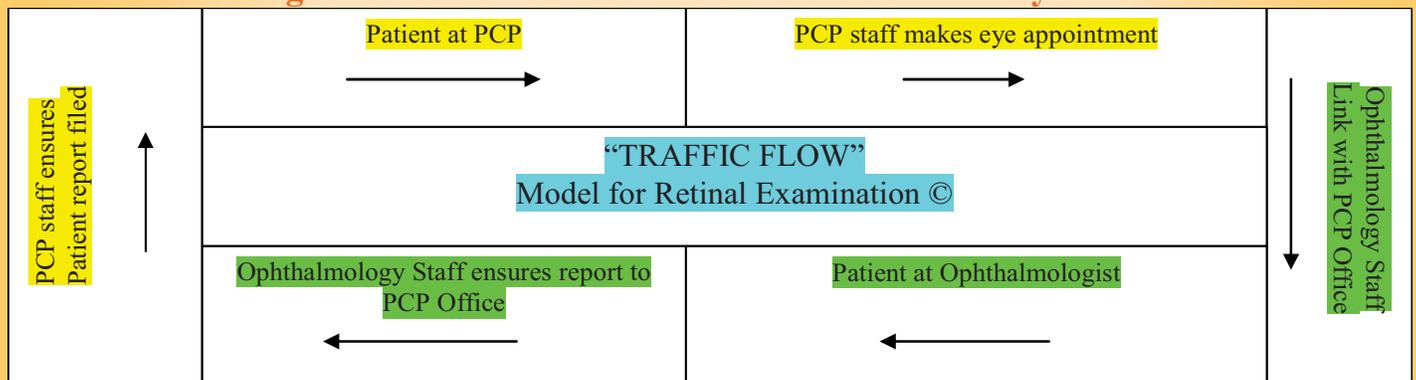
In their paper, Laufgraben and Meattey emphasized the need for baseline eye examinations because of the progressive nature of retinopathy — sight threatening incidence of retinopathy could be as low as 0.3% in the early years of DM and up to 3.9% in a five-year period⁹. The authors reminded us that "over 60% of T2DM have some degree of retinopathy". The important message was that people with diabetes had a 25-fold increased risk of developing blindness that could be prevented by astute clinicians.

EFFICIENCY IN CONSULTANCY

In the U.S., adults 40 years and older, have a 40% prevalence rate of retinopathy with 8% of them bearing sight-threatening retinopathy⁹. To avoid delay in your practice for scheduling an ophthalmologic examination or for the patient missing an eye examination, an efficient protocol must be agreed to by the offices of the attending primary care physician (PCP) and the consulting ophthalmologist (Ophth), **See Figure 1**

The essence of referral to the ophthalmologist is communication — a secure and confirmed "traffic" flow of personnel-to-personnel contacts between both offices. A patient is referred by the PCP; the patient was seen by the Ophth (or did not show up for the appointment) and the visit or non-visit was confirmed by the personnel in the Ophth office who conveyed the transaction to the personnel in the PCP office. In the PCP office, a

Figure 1: A "Traffic Flow" Model for Diabetes Eye Care



DR. LALUDE'S ARTICLE (CONTINUED)

designated person logged in the consultancy report in the patient's record (or called the non adherent/no show patient to emphasize the importance of the DM dilated eye examination).

EXCELLENCE IN RETINAL CARE

Choose ONE ophthalmology practice, as the main consultancy unit to see 70 - 80% of all your patients that require retinal examinations, and probably 2 other offices to "service" your patients, in case of variable health insurance coverage. Why?

1. You need "communication" sharpness between your practice and the consultancy practice,
2. Quality of care provided by the specialist must be confirmed by your practice,
3. Efficiency in service delivery by the consultant,
4. Excellence in evidence-based medicine (EBM) to confirm your DM knowledge,
5. Contribute significant quality-of-life (QOL) outcome to the patient.

CONCLUSION

Efficiency and excellence in retinal eye examination are essential in the 21st Century practice of DM. About 50% or more of newly blind people became so as a major result of DM complications. PCP's must increase their knowledge capacities of EBM to translate their practices into centers of excellence in DM. Intensive insulin treatment should be the choice to lower hemoglobin A_{1c} to below 7% for prevention of progressive retinopathy. DM and other specialty guidelines are pushing clinical measures and the outcome of any standard-of-care by a clinician should be the yardstick¹⁰ of his/her competence or the knowledge deficits for preventive care of diabetic retinopathy.

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SCHOOL NURSE DIABETES TRAININGS HELD ACROSS KENTUCKY

Submitted by: *Teresia Huddleston MS, RD, LD, CDE, KY Diabetes Prevention and Control Program, Barren River District Health Department, TRADE and KDN member*

Caring for the child with diabetes poses a special challenge upon schools and their staff. Several regional diabetes staff with the Kentucky Diabetes Prevention and Control Program (KDPCP) provided free continuing education programs for school nurses in July. KDPCP of the Lexington Fayette County Health Department, the KY River District Health Department, the Cumberland Valley District Health Department, and the Barren River District Health Department (BRDHD), presented their **2010 School Nurse Diabetes Updates** on February 19th, July 19th, July 21st, and July 27th respectively. Some of the programs were made available on ITV to allow for school nurses across the state to view them without having to travel — which made the programs available from Paducah to Pikeville. Attendance included: February 19th — 30 on site; July 19th — 32 on site; July 21st — 48 on site with 20 joining via ITV; July 27th — 34 on site with 42 joining via ITV (for a total of 206 participants in all).

Examples of content provided at the BRDHD training included: Kentucky Board of Nursing regulations regarding medication administration by licensed versus unlicensed personnel and the school nurses' role in diabetes management (presented by *Eva Stone, ARNP for Boyle County Schools*); a personal view of parenting a child with diabetes and working with the schools (presented by *Marissa Hesson RN, CDE*); using insulin pumps at school (presented by *Ann Freyberger, RD, CDE*) and diabetes meal planning and food allergies including an explanation of food vendors and how to obtain nutrient information (presented by *Kelly Holt, School Food Service Supervisor for Warren County Schools*).

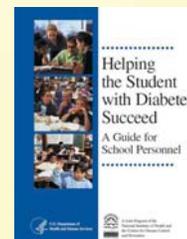
Diabetes education programs for school nurses are a growing need because of the diabetes epidemic and the shortage of school nurses. Diabetes educators and school nurses can be a great resource for each other when dealing with issues regarding children with diabetes. By working together, diabetes educators and school nurses can assure that the child with diabetes has a successful school year.

For more information: American Diabetes Association "Safe at School Campaign" and KY Board of Nursing at: <http://kbn.ky.gov/practice/>.



Ann Freyberger discusses insulin pumps during the July school nurse training held in Bowling Green

COMING SOON!!
UPDATED NDEP SCHOOL GUIDE
(Expected in Late Fall 2010)



TREATMENT OPTIONS FOR KIDNEY DISEASE

Submitted by: Greg Donaldson and Joanne Engelland, Treatment Options Program Specialists, Fresenius Medical Care, 502-452-2041 ext 13 (for Greg) or 270-443-0217 (for Joanne)

Having kidney disease today is much easier to deal with than in any other time in history. Kidney patients are able to choose more kinds of treatment options than ever, thus giving the patient the ability to choose a treatment option to match their lifestyle.

When chronic kidney disease (CKD) develops into End Stage Renal Disease (ESRD), decisions about treatment will need to be made. These important decisions deserve a specialized education that not everyone is capable of giving. For that reason and because so many patients start dialysis without full knowledge of their options, Fresenius Medical Care, one of the largest providers of kidney disease management services, provides this education free to all kidney disease patients and their families.

Throughout areas of Kentucky, Fresenius has kidney educators, called Treatment Options Program Specialist, (TOPS). These specialists, in cooperation with the local nephrology physicians, provide education to patients and their families who are in stage 3 and 4 kidney failure. Their goal is to educate patients about various forms of kidney treatment as well as to give information that may slow the progression of their disease. This new and exciting program will provide sufficient information so that the patient can actively participate with his/her physician to select the appropriate renal replacement therapy. Renal replacement therapy is chosen when the kidneys no longer work (stage 5). A person may choose between: hemodialysis (outpatient, in-home, and nocturnal), peritoneal dialysis (usually called home therapy), transplant, or no therapy.

Kidney Education

It is important to note that this free education is provided in an "unbiased" class or individual setting. This critical information is presented in such a way that the participants are not influenced in regards to their choices. It is felt that educated patients will become more empowered to not only become active in their care but to also feel more in control of their disease.

The topics presented in these classes are basic and beneficial in understanding CKD. Patients and families will begin to learn more about the kidneys, what they do and what happens when they fail. Guidance will be given in slowing the progression of the disease such as taking control of their diabetes or high blood pressure, the number one reasons for kidney failure. Also discussed are the differences between acute and chronic kidney disease, glomerular filtration rate (GFR) and symptoms of CKD, such as swelling in the feet and hands, poor appetite, fatigue, itching and difficulty in breathing.

For every form of dialysis, there needs to be an appropriate access or way to do the dialysis. The class will discuss the importance of being prepared for dialysis and having the right access placement before it is needed. Unfortunately, 82% of new dialysis patients start with an emergency temporary catheter. These catheters have a high risk of infection and are not preferred by the renal community. The preferred access for hemodialysis is a fistula with a graft being the second choice. A fistula will surgically tie a vein and artery together, usually in the non-dominant arm, to insure the best possible dialysis treatment. The only access available for peritoneal dialysis is the peritoneal cavity catheter, which must be placed a few weeks before treatment can begin.

Treatment Options

There are two types of Peritoneal Dialysis and Hemodialysis. The first type of **Peritoneal Dialysis (PD)** is **Continuous Ambulatory PD or CAPD**. This is a home therapy completed by the patient usually during the day. The patient does the treatments usually four times a day where he/she places a cleansing fluid (dialysate) into their peritoneal cavity and then drains the cleansed kidney fluids. This generally takes approximately 30 minutes for each treatment. The second type of **PD is called Continuous Cycling PD or CCPD**. This style of PD uses a nightly machine that does the dialysis while the patient sleeps. These methods take only a few days to learn and can be done without a partner in the home. Travel is also easier with both forms of PD and the diet can be more liberal as the patients will dialyze daily, thus acting more like a person's own kidneys.

Hemodialysis, a process of using a person's own blood to remove excess fluid and waste from the body, has several options available. Remember a fistula will need to be in place to receive the best treatment possible for all the forms of hemodialysis. Traditionally, one thinks of coming to an outpatient center for three days a week as the preferred method of dialysis. Many continue to do this type of dialysis and are very pleased with this choice. Additionally, some dialysis centers also provide **dialysis at night (nocturnal)**, or offer those same hemodialysis treatments at home. This form of hemodialysis, at home, takes extensive training and a partner to be present during the treatments. It is portable and patients find it easier to travel.

As you can see, dialysis options are as individual as the patients. No longer does one have to choose an option and then work their lives around dialysis. The patients can now have dialysis work for them! At Fresenius Medical Care, we want the patient to be in charge of their dialysis and to have the freedom to live their lives to the fullest!

REMEMBER

**An educated patient is an involved patient,
An involved patient is an empowered patient,
And an empowered patient is a healthy patient.**

CDC Urgent Reminder

Reuse of Fingerstick Devices Transmit Bloodborne Disease

Use of Fingerstick Devices on More than One Person Poses Risk for Transmitting Bloodborne Pathogens

The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B (HBV) and other bloodborne pathogens to persons undergoing fingerstick procedures for blood sampling — for instance, persons with diabetes who require assistance monitoring their blood glucose levels. Reports of HBV infection outbreaks linked to diabetes care have been increasing.

Fingerstick devices are used to prick the skin and obtain drops of blood for testing. There are two main types of fingerstick devices: those that are designed to reuse on a single person and those that are disposable and for single-use.

Reusable Devices often resemble a pen and have the means to remove and replace the lancet after each use, allowing the device to be used more than once (see **Figure 1**). Due to difficulties with cleaning and disinfection after use and their link to numerous outbreaks, CDC recommends that these devices never be used for more than one person. If these devices are used, it should only be by individual persons using these devices for self-monitoring of blood glucose.



Figure 1

Single-use, auto-disabling fingerstick devices: These are devices that are disposable and prevent reuse through an auto-disabling feature (see **Figure 2**). In settings where assisted monitoring of blood glucose is performed, single-use, auto-disabling fingerstick devices should be used.



Figure 2

The shared use of fingerstick devices is one of the common root causes of exposure and infection in settings such as long-term care (LTC) facilities, where multiple persons require assistance with blood glucose monitoring. Risk for transmission of bloodborne pathogens is not limited to LTC settings but can exist anywhere multiple persons are undergoing fingerstick procedures for blood sampling. For example, at a health fair in New Mexico earlier this year, dozens of attendees were potentially exposed to bloodborne pathogens when fingerstick devices were reused to conduct diabetes screening.

Recommendations

Anyone performing fingerstick procedures should review the following recommendations to ensure that they are not placing persons in their care at risk for infection.

- Fingerstick devices should **never** be used for more than one person.
- Auto-disabling **single-use** fingerstick devices should be used for assisted monitoring of blood glucose.

These recommendations apply not only to licensed healthcare facilities but also to any setting where fingerstick procedures are performed, including assisted living or residential care facilities, skilled nursing facilities, clinics, health fairs, shelters, detention facilities, senior centers, schools, and camps. Protection from infections, including bloodborne pathogens, is a basic requirement and expectation anywhere health care is provided.

**For Additional Information
visit: www.cdc.gov**

New Resources Available from the Patient Education Workgroup of KDN

Some new items, listed below, have been created by the Patient Education Workgroup of the Kentucky Diabetes Network (KDN).

- **Sugar Substitutes Guide for Professionals** - Table sugar substitutes including ingredients and uses
- **KDN Diabetes Publication Listing** - Listing of diabetes educational materials by topic and language available from a variety of sources
- **KDN Patient Assistance Resource Library** - listing of assistance resources for diabetes patients including medication and supplies

To access these items, visit the KDN website:

http://www.kentuckydiabetes.net/professional_resources.html

2010 Patient Assistance Resource Listing Compiled by the Kentucky Diabetes Network (KDN)					
Name	Program	Availability	Web Site Address	Phone	
Coverage	Charles Ray III, Diabetes Association, Inc.	National	http://www.crd.org/faq/faq.html		
Coverage	Foundation for Health Care				
Coverage	Healthy Kentucky				
Coverage	Healthy Kentucky & Kentucky Program				
Coverage	Insulin Pump and Supplies				

2010 Sugar Substitutes Guide for Health Professionals									
Brand Name	Form	Weight (g)	Weight (oz)	Acceptable Daily Intake	Maximum Component of Sugar	Component of Sugar	Caution	Website	Brand.com
Aspartame	Tablet	200 mg	0.705 oz	200 mg	100 mg	100 mg	Persons with PKU should avoid		
Saccharin	Tablet	350 mg	1.235 oz	350 mg	350 mg	350 mg			
Sucralose	Tablet	100 mg	3.527 oz	100 mg	100 mg	100 mg			
Sorbitol	Tablet	100 mg	3.527 oz	100 mg	100 mg	100 mg			
Stevia	Tablet	100 mg	3.527 oz	100 mg	100 mg	100 mg			

2010 Publications Listing Compiled by the Kentucky Diabetes Network (KDN)			
Title	Author	Year	Web Site Address
Are You at Risk for Type 2 Diabetes? Things Every Person Should Know	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
Diabetes: Assessment and Prevention Strategy	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
Diabetes: Prevention for Health Care Professionals	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
Can You Tell Your Child's Blood Sugar is Too High?	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
Is My Type 2 Diabetes (Pre-diabetes) Getting Worse?	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
Is My Type 2 Diabetes (Pre-diabetes) Getting Worse? A Guide for Health Care Professionals	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
Health Care Professionals' Role in Diabetes Prevention	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html
What You Don't Know About Diabetes Prevention	Wendy L. Mendenhall, MD, PhD	2010	http://www.kentuckydiabetes.net/professional_resources.html

YMCA OF GREATER LOUISVILLE JOINS WITH CDC TO OFFER DIABETES PREVENTION PROGRAM IN LOUISVILLE, KY



Lauren Ewalt
Exercise Physiologist

In 2009, the YMCA of Greater Louisville was awarded a grant from the YMCA of the USA, as part of piloting the Centers for Disease Control and Prevention's National Diabetes Prevention Program. This grant was to help expand the YMCA's Diabetes Prevention program and to help reduce the impact of chronic disease in communities across the nation.

2,687 YMCAs, is working with CDC and other organizations to expand the program to as many communities as possible nationwide as part of CDC's National Diabetes Prevention Program.

The YMCA's Diabetes Prevention Program is based on the landmark Diabetes Prevention Program (DPP) led by the National Institutes of Health (NIH) and supported by CDC. The DPP showed that with lifestyle changes and modest weight reduction, a person with pre-diabetes can prevent or delay the onset of type 2 diabetes by 58 percent. Researchers at Indiana University School of Medicine were able to replicate the successful results of the national DPP in a group setting and by training YMCA professionals with the YMCA of Greater Indianapolis. Unlike the national DPP research study, which was conducted with several health care professionals one-on-one, the YMCA's program is conducted in a group setting. The research by the Indiana University researchers also demonstrated that the YMCA could effectively deliver a group-based lifestyle intervention for about 75 percent less than the cost of the original Diabetes Prevention Program. This research also highlighted the ability of the YMCA to take the program to scale nationally.

It's been estimated that 235,000 Kentuckians have been diagnosed with pre-diabetes, which isn't too surprising since 30 percent of Kentuckians are obese and another 30 percent report no physical activity. These 235,000 individuals will most likely develop type 2 diabetes within 10 years unless they make a lifestyle change. Since Kentucky's rate for diagnosed diabetes is now 4th highest in the nation, it becomes critical that we try to help those at risk to either slow or halt the progression of the disease. Here is where the YMCA can help.

The YMCA's Diabetes Prevention Program is a group-based lifestyle intervention designed especially for people at high risk of developing type 2 diabetes, and has been proven to cut their risk of developing the disease by more than half. The YMCA of Greater Louisville is one of eleven YMCAs nationally who received start-up funds to launch or expand the program in their community. YMCA of the USA, the national resource office for the nation's

The goals of the YMCA's Diabetes Prevention Program are to reduce and maintain individual weight loss by at least 7 percent and to increase physical activity to 150 minutes per week. In a group setting, a trained lifestyle coach helps participants learn skills for healthier lifestyles by teaching about healthy eating, increasing physical activity and other behavior modifications over the course of 16 core sessions. After the initial core sessions, participants meet monthly for

YMCA's Diabetes Prevention Program Results

Total Weight Loss (lbs)	666.5
Average Weight Loss per person (lbs)	10
Average Percentage of weight Loss (%)	4
Average Number of Sessions Attended (out of the 16 core sessions)	12

Test and Lab Value Indicating Pre-diabetes

Test	Lab Value
Fasting Plasma Glucose	100 -125 mg/dL
2-hour (75 gm glucola) plasma glucose	140 - 199 mg/dL
Non-Fasting glucose	140-199 mg/dL
A1C	5.7% - 6.4%

Continued...

up to a year for added support in maintaining their lifestyle changes.

Since launching the program in July 2009, the YMCA of Greater Louisville has enrolled 176 high risk individuals. A total of 77 individuals have completed the 16 core sessions and another 76 are in their first four months and still attending weekly sessions. Out of those 77 individuals, 88 percent have lost weight. The Diabetes Prevention Program Results table, shown within this article, displays the program results for those 77 individuals. Almost half of the participants have lost 5 percent of their body weight by 16 weeks. Moreover, over 80 percent of our participants have reported increased physical activity, decreased portion sizes, and have noticed improvements in their overall health, self-esteem, energy level, relationships, and their effectiveness at work. Debbie, a past participant, comments "I have learned to change my lifestyle....the way I balance my food consumption with physical activity." Debbie sums the program up very nicely. The YMCA's Diabetes Prevention Program helps people reduce their risk of developing type 2 diabetes by helping them make small lifestyle changes that will lead to a longer, healthier life.

The YMCA of Greater Louisville has been fortunate to receive funding for at least another year. We are currently enrolling individuals with pre-diabetes in the greater Louisville area (Jefferson County, Bullitt County, and Oldham County). Eligible participants include adults who are overweight and have a high risk of developing diabetes. An individual's risk can be determined through taking the American Diabetes Association Diabetes Risk Test and/or viewing recent blood work. The table labeled "Test and Lab Value" shows lab values that indicate an individual has pre-diabetes.

Note: Eligible participants for the YMCA's Diabetes Prevention Program must be overweight/obese (BMI \geq 25 kg/m²) AND have one of the lab values listed above OR be at risk for developing type 2 diabetes as indicated through the American Diabetes Association Diabetes Risk Test.

We continue to look forward to offering the support and tools to those individuals who are at high risk of developing type 2 diabetes in the greater Louisville community. Together, with our various community partners, we are working hard to prevent and delay the onset of type 2 diabetes in the state of Kentucky.

If you are interested in hearing more about the YMCA's Diabetes Prevention Program or want to know how you can start referring high risk individuals, please contact Lauren Ewalt at 314-1613 or at lewalt@ymcalouisville.org.

**KY ADA DIABETES CAMP
CLOSED PERMANENTLY
KY CHILDREN TO ATTEND OHIO CAMP**

The following was submitted by Vasti Broadstone, MD, Endocrinologist and Medical Director of Camp Hendon at Kysoc, the ADA Diabetes Camp in Kentucky. This is an excerpt from an email which Dr. Broadstone received from Erin Crosby, with the American Diabetes Association concerning the future of Camp Hendon.

A new regional Diabetes Camp Program for the Kentucky, Southern Ohio, and West Virginia area will begin in 2011. The camp will be located in Camp Korelitz at Camp Joy in Clarksville, Ohio.

Please know that this decision was not made lightly, nor was the decision made quickly. As you know, Camp Hendon was cancelled in 2010 after the closure of our host facility, Camp KYSOC. In order to provide a camp program for children living with diabetes in Kentucky, we opened the doors of Camp Korelitz in Ohio. As a result, over 40 children from Kentucky were able to participate in the camp program. We had an incredible week of camp, and feedback from both parents and campers was exceptionally positive.

The experience of the regional program in 2010 showed that not only was a regional camp possible, but it was very successful. The facility at Camp Joy offers modern cabins, a top-notch medical facility, a spacious dining hall, and a wide variety of activities for campers of all ages and abilities to enjoy. Additionally, Camp Korelitz has a relationship with Cincinnati's Children's Hospital, which allows for incredible medical coverage, offering one of the most medically safe programs in the country.

While this is a difficult decision, we feel that a regional camp offers the best opportunity for the children of Kentucky, Ohio, and West Virginia to experience summer camp.

We would like to offer the opportunity for Camp Hendon camp committee members to participate in the Camp Korelitz regional camp committee. All meetings will have a conference call option, allowing for participation without travel.

I know this is difficult news, but know that the decision was made with the best interest of our campers in the forefront. Camp is a magical place for our campers, and we hope to continue the experience for generations to come. Please contact me at any time with questions.

**Erin Crosby, American Diabetes Association
Tel: (513) 759-9330 ext. 6662**

ONLY HALF OF KENTUCKIANS WITH DIABETES GET ANNUAL FLU SHOT *URGE YOUR PATIENTS TO GET VACCINE*

Submitted by: Janie Cambron RS, BS, MPH, Regional Epidemiologist, Health Information Officer, Green River District Health Department

Influenza, or flu, is a very contagious disease caused by the flu virus, which spreads from infected persons to the nose and throat of others. Flu can lead to pneumonia and can be especially dangerous for the elderly, young children, those with heart or breathing conditions, and **those with diabetes**.

Approximately 23,000 deaths due to seasonal flu and its complications occur on average each year in the U.S., according to recently updated estimates from the CDC. **During flu epidemics, death rates among people with diabetes increase by 5% to 15%. Although people with diabetes are more likely to die with the flu, research indicates that about 50% of them did not get a flu shot and that includes people with diabetes in Kentucky.**

Getting an annual flu shot helps the human body develop antibodies to protect against flu virus infection. This year's flu vaccine includes the 2009 H1N1 (swine flu) strain as part of the regular seasonal vaccine. All residents age 6 months and older are now recommended to receive annual flu vaccination.

Flu vaccinations are now available through health care providers and your local health department. Special efforts may be needed to ensure your patients with diabetes obtain their flu and pneumonia vaccine.

Besides getting an annual flu vaccine, here are some other tips to stay healthy this flu season:

- Wash your hands often with soap and water for 15-20 seconds or by using alcohol-based disposable hand wipes or gel sanitizers.
- Cough and sneeze into your elbow
- Avoid touching your eyes, nose or mouth. Germs are often spread when a person touches an object that is contaminated with germs and then touches his or her eyes, nose, or mouth.
- Avoid close contact with people who are sick.
- Stay home from work, school, and errands, if possible, when you are sick. This will help prevent others from catching your illness.
- Remind children to also practice healthy habits because germs spread easily at school and in child care settings, resulting in high rates of absenteeism among students and staff.

CDC DIVISION OF DIABETES TRANSLATION URGES PROVIDERS TO BE READY FOR FLU SEASON

Taken from CDC Division of Diabetes Translation, News To Use, August, 2010

New influenza vaccination recommendations state that EVERY person aged 6 months or older should receive a flu shot. (Some children aged 6 months — 8 years may need 2 doses.) People with diabetes should receive the flu shot, NOT the nasal spray.

Additional highlights of the 2010 influenza vaccination recommendations include:

- 1) a recommendation that children aged 6 months–8 years whose vaccination status is unknown or who have never received a seasonal influenza vaccine before (or who received a seasonal vaccine for the first time in 2009–10 but received only 1 dose in their first year of vaccination), as well as children who did not receive at least 1 dose of an influenza A (H1N1) 2009 monovalent vaccine regardless of previous influenza vaccine history should receive 2 doses of a 2010–11 seasonal influenza vaccine (minimum interval: 4 weeks);
- 2) information about Fluzone High-Dose, a newly approved vaccine for persons aged ≥ 65 years; and
- 3) information about other standard-dose, newly approved influenza vaccines and previously approved vaccines with expanded age indications.

Vaccination efforts should begin as soon as the 2010–11 seasonal influenza vaccine is available and continue through the influenza season. These recommendations and other information are available on the CDC's Influenza Website (<http://www.cdc.gov/flu>); any updates or supplements that might be required during the 2010–11 influenza season will also be available on this Website.

Have
Diabetes?
A Flu Shot
Could
Save Your
Life!



Free Diabetes Alert Necklaces

Diabetes educators know the importance of people with diabetes wearing medical identification, yet purchasing medical identification can be expensive. Now there is a solution!

The Diabetes Research and Wellness Foundation (DRWF) offers the *Bulk ID Program* which is more reliable and less expensive than individual orders. Simply complete the Free Bulk Identification Program form (below) and have the patient complete the Free Necklace Coupon Sheet and fax them to 202-244-4999. Or you may also mail your requests to:

DRWF – Necklace Program
5151 Wisconsin Avenue, NW
Suite 420
Washington, DC 20016

The necklaces will be mailed to the diabetes educator's facility in approximately 2 weeks!

FREE BULK IDENTIFICATION PROGRAM

I, _____, from _____ will send the necklace request forms to DRWF in order to receive (in bulk) FREE Diabetes ID's for my patients. DRWF will be sending the packages to the given contact name and mailing address. Once you have compiled your patient's requests, please send the request forms to our address in order to receive your id's. Please note due to HIPPA regulations: patients are requested to complete the necklaces coupon. You can mail, fax or email your requests. Please allow 2 weeks for DRWF to process your order. Your facility will only receive the amount of names that you have given. If you should fail to send in the full names and addresses, those names will not receive a necklace due to insufficient address.

Contact Information
 DRWF

Attn: Free Bulk Id Program
 5151 Wisconsin Avenue NW, 4th Floor, Washington, DC 20016-4124
 Main Line: 202-298-9211 Fax to Valerie: 202-244-4999
 Email to Valerie: rjjeremiah@diabeteswellness.net

Please fill out the following:

Name:	Title:	
Organization Name:		
Street Address (No PO Box):		
City:	State:	Zip:
Phone Number:	EXT.	Fax Number:
Email Address:		

I understand all of the conditions of the Free Bulk Identification Program.

Signature _____

Date _____

For Office Use Only

Staff: _____ Date Rec'd: _____ Qty Rec'd: _____ Date Sent: _____

Comments: _____

FREE	DIABETES EMERGENCY NECKLACE
	In case of Emergency, the attending physician or paramedic needs to know you have diabetes.
Name _____	
Address _____	
City _____	State _____ Zip _____
<small>Send a Self-Addressed, Stamped Envelope To: Free Diabetes Necklace Diabetes Research and Wellness Foundation™ • P.O. Box 96046, Washington, DC 20099-6046</small>	

FREE	DIABETES EMERGENCY NECKLACE
	In case of Emergency, the attending physician or paramedic needs to know you have diabetes.
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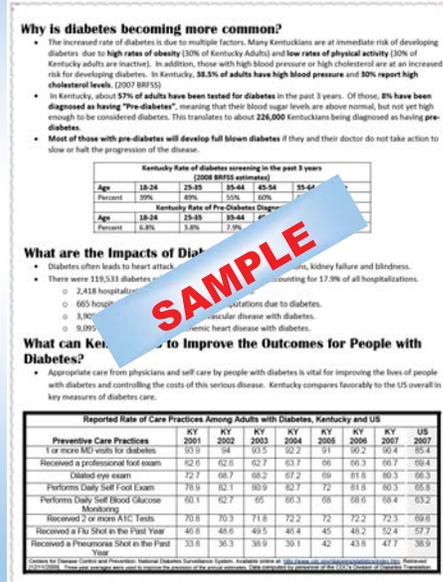
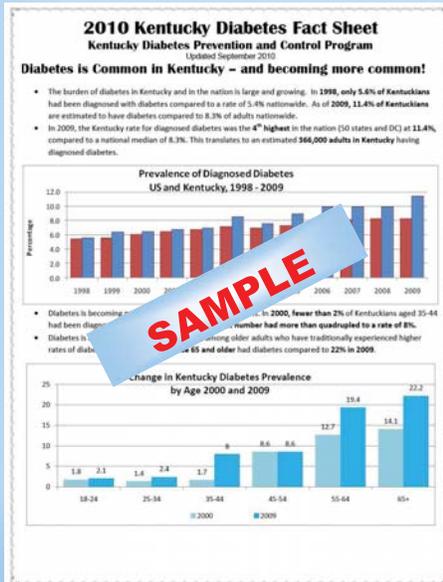
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City _____	State _____ Zip _____
<small>Send a Self-Addressed, Stamped Envelope To: Free Diabetes Necklace Diabetes Research and Wellness Foundation™ • P.O. Box 96046, Washington, DC 20099-6046</small>	

2010 KENTUCKY DIABETES FACT SHEET

UPDATED VERSION (SEPTEMBER 2010) NOW AVAILABLE

For copies of the newest Fact Sheets go to the state diabetes website at
www.chfs.ky.gov/dph/info/dpqi/cd/diabetes.htm
 or call 502-564-7996 (ask for the diabetes program).



Sign Up to Receive Your Kentucky JDRF License Plate



Submitted by: The Kentuckiana Chapter, JDRF

In the coming months, as you sit at a traffic light in a Kentucky town, you may notice a new license plate on the vehicle in front of you.

The Kentuckiana Chapter of the Juvenile Diabetes Research Foundation (JDRF) was recently approved by the state for a Kentucky JDRF license plate! This initiative will help us spread awareness about JDRF to those individuals in the Commonwealth who may have an affiliation with diabetes but are not currently aware of our organization or how we can support them. Funds from the sale of the license plates will help us in our quest to find a cure for diabetes and its complications!

If you are interested in getting a JDRF license plate, please send \$25 payable to JDRF for the license plate registration fee along with your name, address, phone number and e-mail address to JDRF, 133 Evergreen Road, Louisville, KY 40243 by November 1st. You should receive notice from the Kentucky Division of Motor Vehicle Licensing by the first of the new year that your JDRF license plate(s) is / are ready to be picked up at your local county clerk's office.

Thank you for your support in raising awareness to help us find a cure!





Above is a date saver for a program being offered regionally in Kentucky by the UK Cooperative Extension Services. Family and Consumer Science Agents (extension agents) across KY will have the option to attend this training and implement the program in their community with a local health professional (diabetes educator) partner. *The local partner is also invited to attend the training.*

If you are interested in this partnering/training opportunity, please contact your local extension agent to express your interest and to see if they have plans to attend the training and implement the program in your area. For more information, contact Ingrid Adams at ikadam2@email.uky.edu.

2010 State Health Disparities Profiles Available

The 2010 Health Disparities Profiles examine key health indicators at the state level for different racial and ethnic populations in each of the **50 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands.**

Twenty-one health indicators are presented, which highlight some of the key areas related to health disparities among different populations. This resource can be used as a reference for policymakers and program managers to identify areas where major health disparities exist in each state. For Kentucky data, go to:

http://www.healthstatus2010.com/owh/disparities/ChartBookData_search.asp

Purchase Area Diabetes Connection Offered Type 2 Diabetes Prevention Program

Submitted by DeAnna Leonard RN, BSN, Kentucky Diabetes Prevention and Control Program, Purchase District Health Department, TRADE and KDN member

The Purchase Area Diabetes Connection (PADC) held its first Type 2 Diabetes Prevention Conference in April at the West Kentucky Community and Technical College (WKCTC) campus in Paducah, KY. Approximately 80 people attended including student volunteers from the Nursing Department. Zonya Foco, RD, a nationally known speaker, started the conference off with a boom and energized the audience with her presentation “Power of One Good Habit”. Her simple steps for making small changes proved to be very inspirational and helpful. During breaks, Zonya talked with participants at her booth and offered some great specials on her resources.

Chef Patrick Fletcher and his team of culinary students prepared a delicious lunch with carefully planned amounts of carbohydrates to challenge attendees’ pancreases for the 2 hour postprandial blood glucose testing. During the lunch break, participants visited exhibits to learn about stroke risk reduction, stop smoking tips, ways to increase physical activity, and information about preventing diabetes and cancer. “Master Food Volunteers” from the McCracken County Extension Service demonstrated healthy cooking.

During the afternoon session Tish Mavigliano, RD, LD, CDE cleverly engaged participants into making a healthy meal in a specified time. She definitely got some ooh’s and aah’s when they realized how quickly and fast a healthy meal could be assembled. At the end of the day, blood glucose screenings (2 hour postprandial), body mass index, body fat analysis and blood pressure screenings were available. Counselors were on hand to talk with participants regarding their results. The partnership of the PADC and the various departments of WKCTC along with our great sponsors – Roche and local businesses – made this day possible. It certainly opened the door for planning diabetes prevention activities in the future.



NATIONAL DIABETES MEETINGS SCHEDULED



2010 American Association of Diabetes Educators

2010 WEBINAR Schedule (1-2:30 pm EST)
To Register: www.diabeteseducator.org

- October 13 Depression and Stress: A Distressing Duo
- November 3 Exploring the Real Reasons for Overeating
- December 1 Being Active Having Diabetes: Keeping Your Patients Moving

October 26, 2010

Registration
Deadline October 15,
2010

Cost \$45

Deaconess Hospital
Johnson Hall
Evansville, Indiana

For More
Information Contact:

Karen Fleck
Pager: 467-3200
Cell: 450-3581

Deaconess Hospital &
Deaconess Diabetes Center

For Health Care Professionals
& Healthcare Students

Present...

GEM:
Glucose
Elevations
Matter

Lifestyle Changes
for A Lifetime

Tuesday
October 26, 2010

8:00 a.m. - 4:30 p.m.

Johnson Hall
Health Sciences Building
Deaconess Hospital
Evansville, IN

Registration limited to
150 participants

Parking available in the
adjacent parking lots &
the Harriet Street garage

EDUCATIONAL OFFERINGS

Kentucky Statewide Diabetes Symposium 2010

Applied to Meet
Certified Diabetes Educator (CDE)
Renewal Requirements

November 19, 2010

Marriott Louisville Downtown
280 West Jefferson Street
Louisville, KY



world diabetes day

November 19, 2010

Registration Deadline
November 11, 2010

Contact Hours Provided 5-6

Cost \$50

Marriott Louisville Downtown

For 2010 Symposium Brochure
Contact

janifer.lazarus@nkyhealth.org
janice.haile@ky.gov

October 29, 2010

Registration
Deadline
October 8, 2010

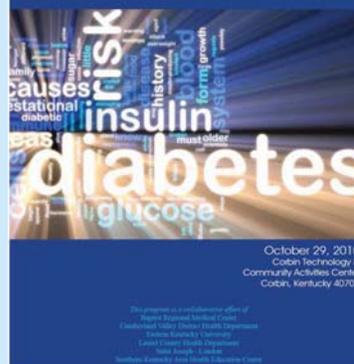
Cost FREE

Corbin Technology &
Community
Activities Center in
Corbin, KY

For More Information
Contact:

Cindi Farmer
606-526-8319
Wilma Hoskins
606-864-5187 ext 233
Carolyn Hacker
606-598-5564 ext 115
[www.soahec.org/
ccmeschedule.htm](http://www.soahec.org/ccmeschedule.htm)

THE LATEST ADVANCES IN Diabetes Management



October 29, 2010
Corbin Technology &
Community Activities Center
Corbin, Kentucky 42701

This program is a collaborative effort of:
Regional Diabetes Center
Louisville University Health Department
Louisville University (University)
Louisville University Health Department
Kent State University
Southwest Kentucky State University
Southwest Kentucky State University

KADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Kentucky Association of Diabetes Educators (KADE), which covers Lexington and Central Kentucky, meets the 3rd Tuesday of every month except summer (time & location vary). For a schedule or more information, go to <http://kadenet.org/> or contact:

Dee Deakins deeski@insightbb.com

Or Diane Ballard dianeballard@windstream.net

Details: go to <http://kadenet.org/>

KENTUCKY DIABETES NETWORK (KDN) MEETINGS SCHEDULED

The Kentucky Diabetes Network (KDN) is a network of public and private providers striving to improve the treatment and outcomes for Kentuckians with diabetes, to promote early diagnosis, and ultimately to prevent the onset of diabetes.

Anyone interested in improving diabetes outcomes in Kentucky may join. A membership form may be obtained at www.kentuckydiabetes.net or by calling 502-564-7996 (ask for diabetes program).

2010 KDN Meeting Dates:

Meeting times are 10:00 am—3:00 pm EST

“First-timers” should arrive by 9:30 am

Date: November 5, 2010

Location: Clinical & Translational Research Building –
Louisville, KY

DECA DIABETES EDUCATOR MEETINGS SCHEDULED

Diabetes Educators of the Cincinnati Area (DECA) (covers Northern Kentucky) invites anyone interested in diabetes to our programs. Please contact Susan Roszel, corresponding secretary at sroszel@fuse.net or Jana McElroy at jmcelroy@stelizabeth.com or call 859-344-2496. Meetings are held in Cincinnati at Good Samaritan Conference Center unless otherwise noted.

Registration 5:30 PM — Speaker 6 PM
1 Contact Hour —Fee for attendees who are not members of National AADE

October 18, 2010
November 15, 2010

TRADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Tri-State Association of Diabetes Educators (TRADE), which covers Western KY/Southern IN/Southeastern IL, meets quarterly from 10–2 pm CST with complimentary lunch and continuing education. To register, call (270) 686-7747 ext. 3019 or email Mary Tim Griffin at mary.griffin@ky.gov.

All Programs Offer 2 Free Contact Hours

Date: October 21, 2010

Time: 10am — 2pm

Location: Methodist Hospital, Henderson, KY

Topics: What’s New in Diabetes Drugs

Speakers: Justin Greubel, PharmD

GLADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Greater Louisville Association of Diabetes Educators (GLADE), which covers Louisville and the surrounding area, meets the second Tuesday every other month. Registration required. For meeting schedule or to register, please contact Melissa Kleber diabetesed@rocketmail.com.

**2010 Meeting Dates (meetings at 5:30 pm
and program at 6:30 pm)**

November 9, 2010

ENDOCRINOLOGISTS MEETINGS SCHEDULED

The Ohio River Regional Chapter of the American Association of Clinical Endocrinologists (AACE) and the Kentuckiana Endocrine Club (KEC) meet on a regular basis. For a schedule of meetings, contact Vasti Broadstone, MD, phone 812-949-5700 email joslin@FMHHS.com



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 Tri-State Association of Diabetes Educators

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KDN
 KENTUCKY DIABETES NETWORK, INC.

www.kentuckydiabetes.net

KENTUCKY ASSOCIATION of DIABETES EDUCATORS



Bluegrass / Eastern Chapter
 A Chapter of AADE

www.kadenet.org



www.louisvillediabete.org



KENTUCKY DIABETES PREVENTION AND CONTROL PROGRAM



<http://chfs.ky.gov/dph/info/dpqi/cd/diabetes.htm>



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Diabetes Educators Cincinnati Area

AN OFFICIAL CHAPTER OF THE
 American Association of Diabetes Educators




American Association of Clinical Endocrinologists
 Ohio River Regional Chapter

www.aace.com

Kentuckiana Endocrine Club
joslin@fmhhs.com

NOTE: Editor reserves the right to edit for space, clarity, and accuracy.