First Quarter 2014

Kentucky Diabetes Connection

The Communication Tool for Kentucky Diabetes News

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

A Message from Kentucky Diabetes Partners

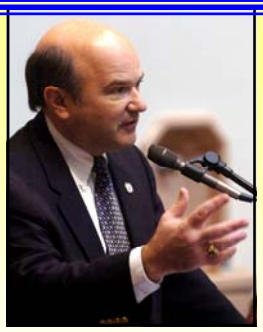
KENTUCKY HOUSE BILL 98 PASSES

AFFECTS CHILDREN WITH DIABETES AT SCHOOL

Submitted by: Lisa Edwards, ADA Staff, Lexington, KY

The American Diabetes Association (ADA) is pleased to announce the passage of Kentucky House Bill 98, a key piece of legislation in the fight to keep children with diabetes medically safe at school. This bill, signed in to law by Governor Beshear, allows school staff to volunteer to be trained to assist children who have diabetes with insulin administration and, in an emergency situation, to administer glucagon. In addition, the bill allows children, if they are capable to do so, to self-manage their diabetes while at school.

The bill was sponsored by Kentucky State Representative Robert R. Damron (District 39), who is now serving his 11th term in office. A similar bill was introduced in the state senate by Kentucky Senator Julie Denton (District 36). Denton has served in the state senate since 1995 and has been a champion in the fight to keep children with diabetes safe at school along with Representative Damron.



Representative Robert Damron, above, sponsor of HB 98, speaking from the House Floor

Senator Julie Denton, above, sponsored the Senate version of House Bill 98 (Senate Bill 30)

"The Association is grateful for the tireless commitment of our diabetes advocates and Representative Damron and Senator Denton to ensure the passage of this vital legislation" said Stewart Perry, Kentucky State Advocacy Chair, American Diabetes Association. "The new legislation will provide peace of mind to children living with diabetes and

(Continued on p. 2)

If you would like to be added to the mailing list to receive this magazine, please contact: Kentucky Diabetes Connection, P.O. Box 309, Owensboro, KY 42302-0309 or Phone: 270-686-7747 ext: 3031 or Email: janice.haile@ky.gov

KY House Bill 98 Passes (Continued)

their parents, ensuring that access to diabetes care may be made available even when a school nurse is not."

For several years, volunteer diabetes advocates from the American Diabetes Association, Kentucky Voices for Health, Protection and Advocacy, the Kentucky Diabetes Network and many others have helped to raise awareness and build critical support to ensure the successful passage of this legislation.

An estimated 215,000 children are living with diabetes in the United States. These children have a disease that must be managed 24/7, including the many hours spent at school, on field trips and in extra-curricular activities. Every day, children with diabetes are put at serious risk if no one, including a school nurse, is present at school to help with daily and emergency diabetes care. House Bill 98 will remove that risk by allowing volunteers to be trained in every school in Kentucky to provide the diabetes care these children need and deserve to learn and be healthy.

To address barriers to diabetes care at school, the Association created its ***Safe At School*** campaign. Through this campaign, the Association is dedicated to making sure that all children with diabetes are medically safe at school and have the same educational opportunity as their peers.

For more information, call the American Diabetes Association at 1-800-DIABETES (1-800-342-2383) or visit www.diabetes.org.

Highlights of House Bill (HB) 98:

- Written permission from a child's parent or guardian and instructions from the child's health care provider would be required before any of the medications could be administered, according to HB 98.
- The legislation states that schools would have to implement the training requirements in the bill beginning July 15.
- The legislation would also allow children to perform their own blood glucose checks and self-administer insulin at school upon written request of their parents or guardians and authorization by a child's health provider.
- HB 98 includes an emergency clause that would make the bill effective upon being signed into law.

Diabetes Care in Kentucky Schools

Gary Dougherty

Submitted by: Gary Dougherty, Associate Director, State Government Affairs for the American Diabetes Association (ADA)

The effort to allow unlicensed school personnel to administer insulin to children with diabetes in the school setting has taken a long and sometimes circuitous path. The American Diabetes Association (ADA) has been a steady partner throughout this process, always advocating on behalf of these children and their families to ensure there is as little disruption in their lives as possible.

Earlier this year, when a consensus could not be reached on the proposed administrative regulation 201 KAR 20:405, the ADA supported legislative remedies that were proposed by Rep. Bob Damron (HB 98) and Sen. Julie Denton (SB 30). These bills sought to allow unlicensed school personnel to volunteer to be trained to provide basic diabetes care, including administering insulin and glucagon, to children with diabetes in Kentucky schools. The bill also allowed children, if they are capable, to self-manage their diabetes while at school.

Within weeks of its introduction in January, HB 98 was unanimously passed out of the House Health and Welfare Committee and brought to the floor of the Kentucky House of Representatives for a vote. As a result of working closely with and achieving the support of the Kentucky School Boards Association, HB 98 was passed 91-0 by the House.

Conversations continued as the legislative process turned to the Senate.

Prior to another unanimous vote in the Senate Health and Welfare Committee, the Kentucky Diabetes Network offered its critical support of this legislation.

Having the support of such a respected statewide partnership of over 200 organizations, associations, and individuals with a professional or personal connection to diabetes was invaluable as HB 98 was brought to the floor of the Kentucky Senate for a vote. With support from many in the education and medical communities as well as from diabetes advocates throughout the Commonwealth, the legislation was overwhelmingly passed by the Senate by a 37-1 vote.

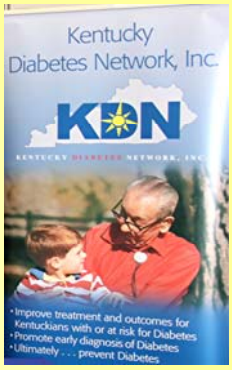
Within a week, the House considered the modest changes made in the Senate and, once again, approved the bill – this time by a 96-2 vote. At this writing, HB 98 has been delivered to Governor Beshear for his signature. The enactment of HB 98 into law will make school a safe and fair place for all Kentucky schoolchildren living with diabetes.

Working in partnership with so many other diabetes advocates, we are humbled by the swift and overwhelming approval given to HB 98 by the Kentucky General Assembly and look forward to working with all interested parties to ensure the timely and comprehensive implementation of the new law.

American Diabetes Association

DIABETES DAY AT THE CAPITOL HELD FEBRUARY 6, 2014

The Kentucky Diabetes Network, the American Diabetes Association, and the Juvenile Diabetes Research Foundation conducted Diabetes Day at the Capitol on February 6, 2014, in Frankfort, KY. Despite snowy weather conditions, 88 people had registered for the event, 50 brave souls were able to attend and visited with 22 Senators and 28 Representatives to discuss diabetes needs in KY. Individual diabetes packets were also left for all KY legislators.



Pictured left to right in photo above: Helen Overfield, Melanie Leininger Walton, Stewart Perry, Susan McDonald, John Bunton, Mary Beth Lacy, Gary Dougherty and Lisa Edwards.

Senator David Givens, pictured fifth from left, visited with (left to right) Beth Thomas, RN, LaCosta Carver, RN, Peggy Tiller, RN, Destiny Greer, RN, and Kristen Branham, RN, from the Lake Cumberland District Health Department.

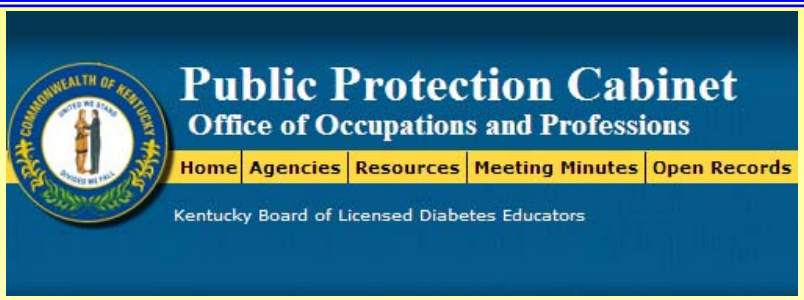
Senator Sara Beth Gregory, pictured third from left, met with (left to right) Beth Thomas, RN, Kristen Branham, RN, Destiny Greer, RN, LaCosta Carver, RN, and Peggy Tiller, RN, from the Lake Cumberland District Health Department's Diabetes and School Nurse Programs at Diabetes Day at the Capitol held February 6, 2014.

Senator John Schickel, second from left, and Representative Sal Santoro, far right, met with (left to right) Tracie Pabst, Dietetic Intern, Joan Geohegan, RN, and Julie Shapero, RD, from the Northern KY District Health Department during Diabetes Day at the Capitol.

Representative Kelly Flood, third from left, met with Fayette County Diabetes Coalition members (left to right) Christina Busse, EKU Dietetic Student, Janey Wendschlag, RN, and Dustin Knight, Health Educator, to discuss diabetes needs in Kentucky.

New *Frequently Asked Questions* Document Posted On Kentucky Board Of Licensed Diabetes Educators (KBLDE) Website

A new *Frequently Asked Questions* document was recently posted on the Kentucky Board of Licensed Diabetes Educators (KBLDE) Website at www.bde.ky.gov (see questions and answers listed below).



www.bde.ky.gov

The Licensure Board also reported that as of the first of March, KY had 38 MLDEs (Master Licensed Diabetes Educators) and 12 LDEs (Licensed Diabetes Educators) for a total of 50.

Who is eligible for diabetes educator licensure under the grandfathering law and what is required?

The Board strongly encourages licensed physicians, dietitians/ nutritionists, pharmacists and nurses practicing in diabetes education to apply for licensed diabetes educator under the grandfathering law. For these individuals to apply, they should do the following:

- Complete page 1 of the application;
- Sign the affidavit at the bottom of page 3 of the application;
- Provide payment of $50 (check payable to Ky State Treasurer) for the licensure fee;
- Enclosed with the application prior to July 1st, 2014, submit a letter from your employer verifying that your scope of practice is within the scope of practice as defined in 201 KAR 45:160 (or if you are self-employed, a letter from yourself reflecting this);

OR

Enclosed with the application prior to May 1st, 2014, document on page 2 of the application that you have practiced diabetes education for a minimum of 1,000 hours *each year* for the past three years (3000 hours total), AND submit ≥1 letter(s) from a supervisor(s) who attests to this practice requirement

Who is not eligible for diabetes educator licensure under the core body of knowledge grandfathering law?

The KBLDE has determined that licensure in some professions is not by itself sufficient for a core body of knowledge in diabetes education without significant additional experience or qualifications in comprehensive diabetes self-management education. The following list identifies some of those professions, but is not an all-inclusive list:

- Licensed Practical Nurse
- Certified Health Education Specialist
- Certified Medical Assistant
- Chiropractor
- Certified Pharmacy Technician
- Dietetic Technician
- Occupational Therapy Assistant
- Physical Therapy Assistant
- Licensed Pedorthist

I am a student currently enrolled in a health professions program. Am I eligible to receive diabetes educator licensure before the end of the grandfathering date of July 1, 2014?

The KBLDE does not consider students who are not currently licensed health professionals to have the core body of knowledge necessary to be a licensed diabetes educator in order to apply for licensure before July 1, 2014 based on the core body of knowledge and experience stipulation.

If my professional license does not require me to become licensed as a diabetes educator why would I want to?

Though it is not a requirement of the law (KRS 309:327), it is still important that those health professionals (e.g. RNs, RDs, Pharmacists) currently practicing as diabetes educators become licensed. Professional licensure has numerous purposes: consumer protection, professional recognition and setting quality guidelines for the profession. Currently, payers may reimburse for the diabetes education service (DSMT) but they are not reimbursing the diabetes educator. Licensure may help to strengthen the profession and lead to reimbursement for the qualified diabetes educator. Without this "legal" definition tied with licensure, diabetes educators will continue to be self-defined.

Additionally, those wanting to serve as supervisors for an Apprentice Diabetes Educator are required to have an active license as a Licensed Diabetes Educator.

Why do I need a license?

As a licensed diabetes educator, you will have a defined scope of practice. Legal scope of practice and licensure established through the state provides consumer protection and sets quality guidelines for the practice of diabetes education. In addition, licensure offers professional recognition and protection for the

diabetes educator. As stated above, licensure may lead to more widespread reimbursement for diabetes education.

If I already have my CDE/BC-ADM, why do I need a license?

Both the CDE and BC-ADM are voluntary credentials. There is no legal scope of practice set forth by either of these credentials. A license defines the profession and legal scope of practice for the respective discipline.

I lead a diabetes support group or coordinate a diabetes coalition and I am not a health care professional. Do I need a diabetes educator license to continue my duties?

It is the opinion of the KBLDE that Community Coalitions or Support Groups are not considered diabetes self-management education and can continue to provide support and information. The scope of practice of Diabetes Education as defined in 201 KAR 45:160 is what a Diabetes Educator does. If the majority of what you are doing is included in this scope of practice, you may need to be licensed to do it. If what you are doing is not, then you may not need to be licensed.

What is a Licensed Diabetes Educator (LDE)?

A LDE is a health professional who has a defined role as a diabetes educator. The LDE provides comprehensive diabetes education within the scope and practice of diabetes education as defined by the statutes and regulations set forth by KRS Chapter 309 and 201 KAR Chapter 45. This license is a minimum requirement to practice as a diabetes educator in the Commonwealth of Kentucky, although an LDE may also supervise certain individuals (http://www.lrc.ky.gov/KRS/309-00/325.PDF) who provide limited diabetes information. A Licensed Diabetes Educator may or may not be credentialed as a Certified Diabetes Educator (CDE) or Board Certified-Advanced Diabetes Management (BC-ADM). Once licensed, you may call yourself a LDE. You will continue to gain knowledge and skills and may advance to the next level of a diabetes educator (CDE or BC-ADM).

What is a Master Licensed Diabetes Educator (MLDE)?

The creation of the Master Licensed Diabetes Educator acknowledges individuals' completion of an intense credentialing program and that passed the examination of the American Association of Diabetes Educators or the National Certification Board for Diabetes Educators. These credentials are limited to specific healthcare providers and graduate degreed individuals. Although the Licensed Diabetes Educator will be able to perform all the duties the Master Licensed Diabetes Educator can perform, the title of Master Licensed Diabetes Educator acknowledges the additional preparation and expertise required for these credentials. Once licensed, you may call yourself a MLDE.

Who should apply for an Apprentice Diabetes Educator permit and why is a permit important?

Having the Apprentice Diabetes Educator permit is required to pursue a diabetes educator license to legally practice diabetes education while obtaining the work experience required for licensure as a diabetes educator. Without the category of Apprentice Diabetes Educator, the person would be practicing diabetes education without a license, thus violating the statutes. Therefore, while obtaining work experience you will be required to file an application and pay a fee.

Is there a fee for licensure or a permit?

The initial licensing and renewal fees for the all license/permit types are $50.00 per year.

If I am an independent practitioner/self-employed, who can write my letter stating that I practice Diabetes Education?

If you are an independent practitioner, you can write your own letter stating that you are self-employed and to what extent Diabetes Education is a part of your practice.

What is a certified copy of my credential (CDE or BC-ADM) in good standing?

A copy of your certificate or wallet card or a letter from the credentialing body stating that you have passed is acceptable.

Why is an examination not required for licensure?

The KBLDE requested an opinion on this issue from our legal counsel with the Office of the Attorney General and the legal opinion follows:

"The statute as written does not give the Board authority to require an examination as a requirement for licensure. Pursuant to KRS 309.331, the Board has the general duty to carry out and enforce the statutes governing the practice of diabetes education. However, the General Assembly did not give the Board the authority to create or adopt an examination for licensure. In the absence of clear authority to act, it is interpreted that the authority was not intended to be given. In addition to lacking specific authority to create or adopt an examination, KRS 309.335 does not list an examination as a requirement for licensure."

It is of the opinion of the KBLDE that the regulations submitted related to the supervised practice experience and a board approved course will be sufficient to assure that the licensed diabetes educator will have the minimum competency required to practice. The supervised practice experience and the course will be further defined in the regulatory process.

Important Message from the Licensure Board:

**** When completing the licensure application, please be sure to sign the applicant affidavit on page 3, after part 3. ****

KENTUCKY COORDINATNG BODY (CB) REPORT

Vanessa Paddy

Submitted by: Vanessa Paddy, MSN, APRN, 2014 Volunteer Leader for the Kentucky Coordinating Body (CB) of the American Association of Diabetes Educators (AADE)

Current 2014 CB Volunteer Leader, Vanessa Paddy (GLADE) and 2015 Volunteer Leader, Kelly Dawes (TRADE) attended the ***AADE's annual Leadership Forum*** in Chicago on January 10th and 11th. Many topics were discussed including diabetes educator licensure, ways to improve communication via social media, and measures to increase participation in Local Networking Group (LNG) activities. The program was well attended by LNG and CB members from all over the United States. This AADE training program provided a unique networking opportunity with diabetes educators with very diverse backgrounds and experience.

CB members Vanessa Paddy and Betty Bryan recently attended a meeting of the **Kentucky Board of Licensed Diabetes Educators.** Vanessa and Betty attended the meeting to stay in touch with the licensure process and to stay abreast of any changes or updates. The primary focus of this Board meeting was to review and approve applications. **For more information about the licensure process, see their website at bde.ky.gov.**

Other activities of the CB include:

- The CB members have **designed and purchased banners/display boards to be used for events hosted by LNGs.** Each LNG will receive a banner that displays the state Coordinating Body logo and the three LNGs within the state along with our DECA partner.
- CB members, Maggie Beville and Betty Bryan will be attending the AADE's annual **Public Policy Forum** in Washington D.C. in May. This event allows our state representatives to have a voice with members of Congress to address issues concerning diabetes.
- The CB voted to approve **scholarships for each KY LNG** to send one Volunteer Leader to ensure representation at the annual AADE conference to be held in Orlando, FL this year (covering the early bird registration).

For more information or questions regarding the activities of the Coordinating Body, contact Vanessa Paddy at vpaddy@hmh.net.

KENTUCKIAN CHOSEN TO ATTEND MEETING IN WASHINGTON, D.C.

Submitted by: Jamie Lee, RN, CDE, MLDE, Lake Cumberland District Health Department, Somerset, KY

The Lake Cumberland District Health Department (LCDHD) is excited to announce that Destiny Greer, RN, CDE with the Diabetes Education Program has been chosen to attend the Appalachian Regional Commission Consultation Meeting in Washington, D.C. on April 10th. The purpose of this important, invitation-only meeting will be to inform key stakeholders about Type 2 diabetes and the impact of the diabetes epidemic in our state. Destiny will be serving as a voice of the frontline health departments working with underserved communities in Kentucky.

Destiny was invited to this meeting because of her extensive work with diabetes coalitions in the district. She is the co-chair of the Adair W.A.T.C.H. and Russell County Community Health Coalitions, plus is a member of the Green County Health Wellness and Casey Health Empowerment Coalitions. She has helped write several successful grants for health activities in her counties.

Destiny has been with the Diabetes Education Program at LCDHD since 2006 and covers Adair, Casey, Green, Russell, and Taylor Counties. She is a member of the Kentucky Diabetes Network and the Kentucky Diabetes Prevention and Control Program. She became a Certified Diabetes Educator (CDE) in December 2012 and a Lifestyle Coach for the CDC's Diabetes Prevention Program in 2014. Destiny resides in Adair County with her husband, Greg, and two sons, Camden and Zane.

Congratulations Destiny!

We are so proud of you!

Destiny Greer, pictured above, will be representing underserved KY communities at a meeting in Washington D.C.

GOVERNOR BESHEAR'S KYHEALTHNOW!

FRANKFORT, KY.
(printed in part from state press release)
Kentucky's dismal health rankings are well-known and span generations. The state has long had the dubious distinction of being among the national leaders in cancer diagnoses, smoking rates, diabetes, heart disease and a host of other maladies.

Governor Beshear, above, announces kyhealthnow initiative
http://kyhealthnow.ky.gov.

Governor Steve Beshear declared recently that Kentucky will significantly reduce incidence and deaths from these diseases and habits through a new, aggressive and wide-ranging initiative, called **"kyhealthnow,"** that builds on Kentucky's successful implementation of health care reform. **kyhealthnow** will use multiple strategies over the next several years to improve the state's collective health.

By setting specific, five-year goals, Kentucky holds state health agencies accountable for measurable success, but also challenges local governments, businesses, schools, nonprofits and individuals to take meaningful steps toward improving health in their communities.

"Many individuals and groups in Kentucky are working on ways to make Kentuckians healthier, whether through improving access to trails, providing smoking cessation tools, or expanding availability of cancer screenings," Governor Beshear said. "Through **kyhealthnow**, we will finally monitor and measure all those efforts against seven major health goals, and every Kentuckian can help. Better collective health for Kentuckians means better-prepared students and a more reliable workforce, both of which are critical for a successful future."

About kyhealthnow

kyhealthnow targets seven major health goals to be met within five years, by 2019:

- **Health insurance** - Reduce Kentucky's rate of uninsured individuals to less than 5 percent
- **Smoking** - Reduce Kentucky's smoking rate by 10 percent
- **Obesity** - Reduce the rate of obesity among Kentuckians by 10 percent
- **Cancer** - Reduce Kentucky cancer deaths by 10 percent
- **Cardiovascular Disease** - Reduce cardiovascular deaths by 10 percent
- **Dental Decay** - Reduce the percentage of children with untreated dental decay by 25 percent, and increase adult dental visits by 10 percent
- **Drug Addiction** – Reduce deaths from drug overdose by 25 percent, and reduce the average number of poor mental health days of Kentuckians by 25 percent.

Each of the goals includes multiple strategies to meet it, which will be implemented through a combination of executive actions, legislative actions, public-private partnerships and enrolling more Kentuckians in health care coverage.

A complete list of the goals and strategies can be found at http://kyhealthnow.ky.gov.

Current Kentucky Health Statistics

Kentucky consistently ranks among the worst states in most national health rankings, including:

- 50th in smoking
- 42nd in obesity
- 46th in physical inactivity
- 38th in diabetes
- 49th in poor mental health days
- 50th in poor physical health days
- 50th in cancer deaths
- 47th in heart disease
- 46th in high blood pressure
- 41st in annual dental visits
- 48th in heart attacks

"For years, Kentuckians have lacked access to the preventive treatment and early diagnosis that are essential to good health. Thanks to the Governor's leadership, we now have over 244,000 more Kentuckians with health care coverage than we did last fall. And that number continues to grow daily," said Cabinet for Health and Family Services Secretary Audrey Tayse Haynes. "Over time, as these newly insured Kentuckians find a health home and become accustomed to seeing their doctor for annual physicals and routine screenings, our health outcomes will gradually improve. This focus on wellness is truly a culture change for many of our citizens, some of whom have never before been insured. But as our kynect enrollment numbers demonstrate, it is a change they are embracing."

DIABETES MEDICATION UPDATE
FDA APPROVES NEW DRUG FOR TYPE 2 DIABETES

Carrie Isaacs PharmD, CDE

Submitted by Carrie Isaacs, Pharm D, University of Kentucky, Lexington, KY

The Food and Drug Administration on January 8th approved U.S. marketing of the drug dapagliflozin, the second of a new class of medications that aim to improve glycemic control in patients with Type 2 diabetes. Dapagliflozin's approval follows that of canagliflozin (Invokana™). Dapagliflozin will be marketed under the name Farxiga™ and is being co-marketed by the drug manufacturers, AstraZeneca and Bristol-Myers Squibb. It has also been approved in 38 other countries.

The drug dapagliflozin, supplied as a tablet, is a sodium glucose co-transporter 2 (SGLT2) inhibitor. This drug class works by blocking the reabsorption of glucose by the kidney, thus increasing excretion of glucose in urine and lowering glucose levels in the blood.

According to the FDA, 16 clinical trials involving more than 9,400 patients with type 2 diabetes assessed the safety and effectiveness of dapagliflozin. It has been studied as both a monotherapy and for use in combination with metformin, pioglitazone, glimepiride, sitagliptin and insulin. After 12 and 24 weeks of therapy, A1c was decreased by -0.72% and -0.77% with dapagliflozin 5 mg and by -0.85% and -0.89% with dapagliflozin 10mg, in type 2 diabetes patients inadequately controlled by lifestyle modifications compared to placebo (-0.18% and -0.23%, $P < 0.001$). Fasting blood glucose reductions were apparent at week 1 and continued to significantly decrease with dapaglifozin 5 mg and 10 mg at week 12 compared to placebo and at week 24 compared to placebo (-24 to -29 mg/dL versus -4 mg/dL; $P = 0.0005$ and <0.0001, respectively).

In addition to lowering blood glucose, SGLT2 inhibitors exhibit effects that could be of benefit for patients with metabolic syndrome, such as body weight reduction and decreases in blood pressure (more systolic compared to diastolic). Furthermore, significant decreases in serum uric acid have been reported which can possibly indicate a decrease in risk for cardiovascular events. Body weight loss of -2.4 to -11.1 lbs has been reported across all studies with SGLT2 inhibitors and has been sustained with dapagliflozin for up to at least 2 years. Greater weight reductions have been seen among late-stage type 2 diabetics (patients on high doses of insulin plus oral sensitizers) (-9.5 to -11.1 lbs) compared to early-stage type 2 diabetes patients (-4.4 to -5.5 lbs). Systolic blood pressure (SBP) reductions of -1.66 to -6.9 mmHg and diastolic blood pressure reductions of -0.88 to -3.5 mmHg have been reported with the SGLT2 inhibitors. The BP effects were not dose-dependent and were not accompanied by any notable changes in heart rate or increases in hypotension and/or syncope. The SBP reductions were not correlated with change in body weight or glycemic control, suggesting SGLT2 inhibitors' antihypertensive effects are independent of A1c or body weight reduction.

Labeling for dapagliflozin states that the drug is not intended for the treatment of type 1 diabetes. The use of the drug is contraindicated in patients with diabetic ketoacidosis, moderate or severe kidney impairment (eGFR <60mL/min/1.73 m^2), or end-stage renal disease.

According to the labeling, patients with active bladder cancer should not use dapagliflozin and dapagliflozin should be used with caution in patients with a prior history of bladder cancer because bladder cancer was diagnosed more than the expected number in clinical trial participants who received the drug. In clinical trials, the majority of patients who experienced bladder cancer had hematuria at baseline, indicating that some cancers were likely preexistent.

Dapagliflozin has been associated with hypotension and dehydration, particularly among older patients, those with impaired renal function, and those taking diuretics. The labeling states that patients who use the drug should be counseled to have adequate fluid intake.

The most frequently reported adverse events in clinical trial participants treated with dapagliflozin included genital fungal infections and urinary tract infections (UTIs), with a higher proportion of the genital fungal infections occurring in females than males (7.4-25.0% and 2.5-8.3%, respectively). These genital mycotic infections were mild to moderate in severity, generally treated with antifungal therapies prescribed by healthcare professionals or by self-treatment, and <1% led to discontinuation of therapy. Both genital infection and UTI cases occurred within the first year of therapy and had low recurrence rates of <3%. Additional information about these and other potential adverse events is provided in an FDA-required Medication Guide.

With these factors in mind, the FDA has asked for six post-marketing studies to be performed. These include a cardiovascular outcomes trial in order to analyze how Farxiga affects patients with high risk of heart disease, and a double-blind randomized and controlled analysis of the risk of bladder cancer for patients who are a part of the cardiovascular outcomes trial.

The recommended starting dosage of dapagliflozin is 5 mg taken once daily in the morning with or without food. The dosage may be increased to 10 mg/day if the lower does not provide adequate glycemic control. Dapagliflozin is supplied as 5- and 10-mg tablets.

References:
Rosenwasser RF, Sultan S, et al. SGLT-2 inhibitors and their potential in the treatment of diabetes. *Diabetes Metab Syndr Obes.* 2013; 6:453-67.
Zhang M, Zhang L, et al. Dapagliflozin treatment for type 2 diabetes: a systematic review and meta-analysis of randomized controlled trials. *Diabetes Metab Res Rev.* 2013 Oct 2 [Epub ahead of print].
Goring S, Hawkins N, et al. Dapagliflozin compared with other oral anti-diabetes treatments when added to metformin monotherapy: a systematic review and network meta-analysis. *Diabetes Obes Metab.* 2013 Nov 14 [Epub ahead of print].
Idris I, Donnelly R. Sodium-glucose co-transporter-2 inhibitors: an emerging new class of oral antidiabetic drug. *Diabetes Obes Metab.* 2009;11:79-88.

KADE Conducts Successful Symposium

Submitted by: Dana Graves, RN, MSN, CDE, CPT, Diabetes Clinical Nurse Specialist, St Joseph Hospital, Lexington, KY

The Annual **Kentucky Association of Diabetes Educators (KADE), Local Networking Group (LNG)** symposium "Navigating The Maze of Diabetes Care" was a wonderful success, and attended by 72 participants. The day long symposium was held on March 14th at Central Christian Church in Lexington, KY.

Topics included a diabetes research update by Dr. Dennis Karounos, mental health and diabetes challenges by Dr. Amanda Merchant and new drug therapy developments by Dr. Condit Steil. The symposium concluded with a panel discussion of *Electronic Medical Records (EMR)* and included panel members: Dr. Wendell Miers, Margaret Pisacano, JD, and Diane Ballard, RN.

A number of vendors were also available and provided helpful information regarding their diabetes products.

Pictured above: Attendees of the 2014 KADE Symposium held March 14th in Lexington, KY

Indiana Second State To Pass Licensure For Diabetes Educators

James Specker
AADE
Advocacy Director

Submitted by: James E. Specker, MBA , MIS, Director, Federal and State Advocacy, American Association of Diabetes Educators, jspecker@aadenet.org

"On March 24, 2014 Indiana Governor Mike Pence signed SEA 233 Licensure of Diabetes Educators into law. The licensing of diabetes educators in Indiana will professionalize this health field by creating minimum standards for licensed diabetes educators, ensuring that those who train individuals on how to manage their diabetes have the core competencies to do so and offer an element of patient protection.

The next step in this process is to work with the medical licensing board in the state of Indiana to ensure that the requirements adequately meet the standard of care that diabetes educators hold themselves to.

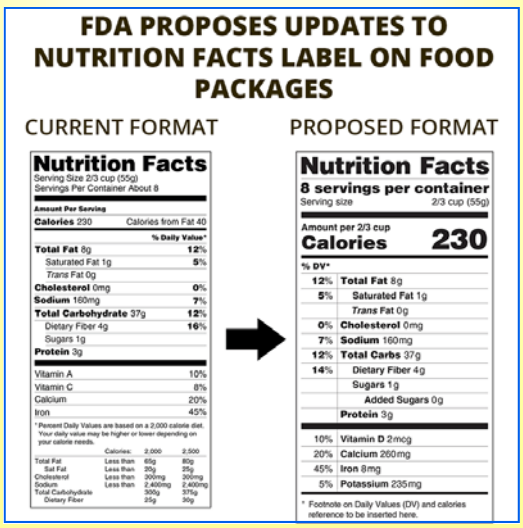
Our involvement in the regulatory process will be a first for AADE as Kentucky wrote their regulations without our input. We are optimistic that this involvement will carry over into other states as they move forward with licensure to help ensure a consistent standard across the country."

Proposed Update To Nutrition Facts Label

The U.S. Food and Drug Administration recently proposed to update the Nutrition Facts label for packaged foods to reflect the latest scientific information, including the link between diet and chronic diseases such as obesity and heart disease.

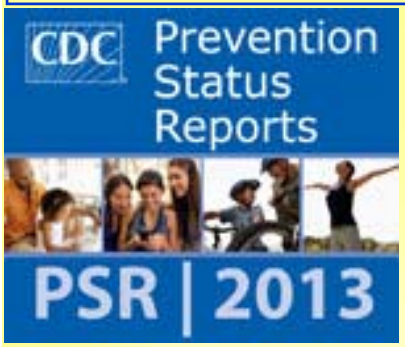
The proposed label also would replace out-of-date serving sizes to better align with how much people really eat and would feature a fresh design to highlight key parts of the label such as calories and serving sizes.

Read more about this announcement by visiting:
http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm387418.htm



Prevention Status Reports Are Here

Nutrition, Physical Activity, and Obesity among selected topics



CDC's newly released 2013 Prevention Status Reports (PSRs) highlight the status of state-level policies and practices designed to prevent 10 important public health problems.

The PSRs are a set of individual reports that focus on 10 health topics for all 50 states including the District of Columbia. The reports provide information for decision makers and state health officials to review their states' health status and identify areas of improvement.

Among the 10 health topics are the Nutrition, Physical Activity and Obesity reports with emphasis on 5 public health policies and practices:

- **Nutrition standards for foods and beverages in schools**
- **Nutrition standards for foods and beverages in government facilities**
- **Inclusion of nutrition and physical activity standards for licensed childcare facilities**
- **State physical education time requirement for high school students**
- **Breastfeeding in hospitals and birth centers**

Each report describes the public health problem, identifies potential solutions to the problem drawn from research and expert recommendations, and reports the status of those solutions for each state and the District of Columbia, using a simple, three-level rating scale—green, yellow, or red.

To help state health officials and other public health leaders use the PSRs, CDC also created the PSR Quick Start Guide. The guide provides users with tips and tools for using the PSRs to increase the use of evidence-based public health practices and improve health outcomes in their state.

To view the report visit: http://www.cdc.gov/stltpublichealth/psr/

New School Health Policy Matrix Released

New State School Health Policy Matrix

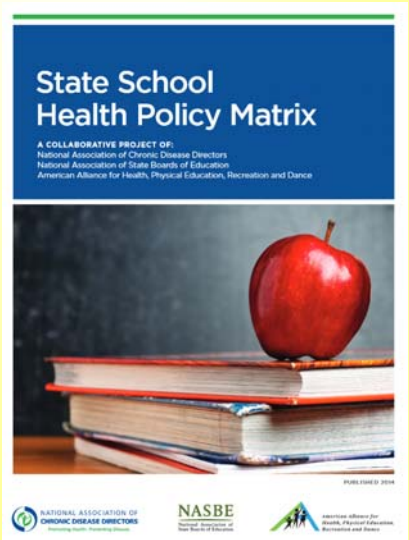
A new ***State School Health Policy Matrix***, developed by the National Association of Chronic Disease Directors (NACDD) and partners has recently been released. One section of the Matrix addresses administration of medication in the school environment, including administration of diabetes medication.

As leaders across the country seek to improve student health, there is a growing need for tools to help navigate the complex world of school health policy. The **National Association of Chronic Disease Directors (NACDD)**, along with the **National Association of State Boards of Education (NASBE)** and **American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD)** have worked together to develop this guide of state-level school health policies with the following topics: competitive foods and beverages, physical education and physical activity, and administration of medication in the school environment.

The State School Health Policy Matrix outlines relevant state-level policies for each of these areas, including a direct link to the policy. It also it indicates which political entity or agency adopted the policy or issued guidance, helping to answer the question – Who has historically had the authority to make policy changes in the areas of competitive foods and beverages, physical education and physical activity, and administration of medication in each state.

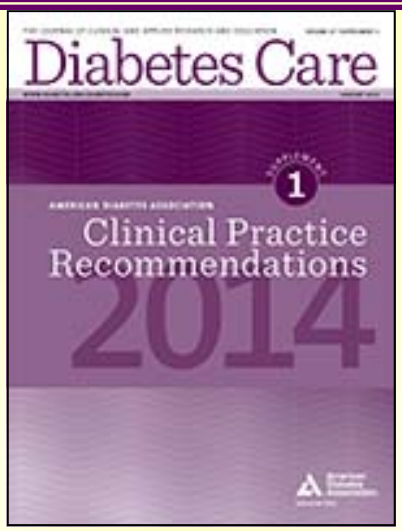
The publication can be viewed on NACDD's School Health Publications page:

https://chronicdisease.site-ym.com/?SchoolHealth-Pubs .



Summary of Revisions to the ADA 2014 Clinical Practice Recommendations

Printed in part from press release



The American Diabetes Association recently released their annually revised Standards of Medical Care in Diabetes for 2014, with an emphasis on individualized treatment of diabetes.

"It is clear that optimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of dedicated health care professionals working in an environment where patient-centered high-quality care is a priority," the authors wrote.

The position statement, published in the January issue of *Diabetes Care*, includes current criteria for the diagnosis of diabetes; testing for diabetes in asymptomatic patients, screening for type 2 diabetes in children, screening for type 1 diabetes, prevention/delay of type 2 diabetes and glucose monitoring.

Of note, the recommendations encourage clinicians to seek various options when prescribing medication to treat neuropathy and uphold one-step screening for gestational diabetes. They also suggest that patients with diabetes see a nutritionist or dietitian to implement a healthy eating pattern individualized to their needs.

"Individualized care is becoming more important in the treatment of diabetes," **Richard Grant, MD, MPH,** chair of the Professional Practice Committee and research scientist with the Kaiser Permanente Division of Research, said in a press release. "As the evidence base evolves, we are learning more about how to apply this data to our patients, and we're finding that the evidence often supports looking at the individual patient needs rather than a one-size-fits-all approach."

Previously, the recommendations called for a one-step screening method to identify gestational diabetes endorsed by the International Association of the Diabetes and Pregnancy Study Groups. In 2013, the National Institutes of Health recommended a two-step approach. However, Grant said that there is insufficient evidence that would warrant a change to the recommendation by the ADA at this time, according to the press release.

SUMMARY OF REVISIONS

In addition to many minor changes related to new evidence since the prior year, and to clarify recommendations, the following sections have undergone more substantive changes:

- **Section I.B. Diagnosis of Diabetes** was clarified to note that A1C is one of three available methods to diagnose diabetes.
- **Section II.C. Screening for Type 1 Diabetes** was revised to include more specific recommendations, specifically screening for relatives at a clinical research center.
- **Section III. Detection and Diagnosis of Gestational Diabetes Mellitus** was revised to reflect the recent National Institutes of Health (NIH) Consensus Guidelines and to provide two methods for screening and diagnosing (versus the prior Standards that recommended the International Association of the Diabetes and Pregnancy Study Groups [IADPSG] method).
- **Section V.C.a. Glucose Monitoring** was revised to add additional continuous glucose monitoring language, reflecting the recent approval of a sensor-augmented low glucose suspend threshold pump for those with frequent nocturnal hypoglycemia and/or hypoglycemia unawareness.
- **Section V.D.2. Pharmacological Therapy for Hyperglycemia in Type 2 Diabetes** was changed from 3–6 months to 3 months for a trial with noninsulin monotherapy.
- **Section V.E. Medical Nutrition Therapy** was revised to reflect the updated position statement on nutrition therapy for adults with diabetes.
- **Section VI.A.3. Antiplatelet Agents** was revised to recommend more general therapy (i.e., dual antiplatelet therapy versus combination therapy with aspirin and clopidogrel).
- **Section VI.B. Nephropathy** was revised to remove terms "microalbuminuria" and "macroalbuminuria," which were replaced with albuminuria 30–299 mg/24 h (previously microalbuminuria) and albuminuria ≥300 mg/24 h (previously macroalbuminuria).
- **Section VI.C. Retinopathy** was revised to recommend exams every 2 years versus 2–3 years, if no retinopathy is present.
- **Section VI.D. Neuropathy** was revised to provide more descriptive treatment options for neuropathic pain.
- **Section VIII. Diabetes Care in Specific Populations** was updated to reflect current standards for thyroid and celiac screening. Additionally, new incidence and prevalence data from SEARCH were incorporated.
- **Section IX.A. Diabetes Care in the Hospital** was updated to discourage the sole use of sliding scale insulin in the inpatient hospital setting.

ADA 2014 Legislative and Regulatory Priorities

Printed in part from press release

The American Diabetes Association (ADA) is pleased to announce its legislative and regulatory priorities for 2014, including both the federal and state efforts the Association executes across targeted issue areas. Each year, the Association identifies the leading federal and state legislative and regulatory priorities that will guide our ongoing efforts to Stop Diabetes®.

The diabetes epidemic is taking a devastating physical, emotional and financial toll on millions of people across the nation. Currently, in the U.S. there are nearly 26 million people living with diabetes and another 79 million with prediabetes. The national annual cost of diagnosed diabetes is an estimated $245 billion, representing a 41 percent increase over a five year period.

"The American Diabetes Association is dedicated to giving a voice to the millions of Americans affected by diabetes," said Gina Gavlak, RN, BSN, Chair, National Advocacy Committee, American Diabetes Association. "Our legislative and regulatory priorities are instrumental in guiding our work with Congress and state legislators, and help drive our efforts to make diabetes research, prevention programs and access to health care a top priority on Capitol Hill and in every statehouse across the nation."

The American Diabetes Association's Federal Priorities for 2014 include:

- **Federal Funding for Diabetes Research and Programs**: Increase funding for the National Institutes of Health's National Institute of Diabetes and Digestive and Kidney Diseases and the Centers for Disease Control and Prevention's Division of Diabetes Translation; reauthorization of the Special Diabetes Program; funding for the National Diabetes Prevention Program and increasing overall federal funding for diabetes research and prevention.
- **Health Insurance**: Ensure public and private health insurance options, including those under the Affordable Care Act, Medicare and Medicaid; provide access to the services, tools and education necessary to meet the needs of people with diabetes and prediabetes.
- **Prevention**: Focus on primary prevention efforts of type 1, type 2 and gestational diabetes.
- **Discrimination**: Oppose laws and policies resulting in unfair treatment of people with diabetes, with a focus on employment issues.
- **Health Disparities**: Support laws and policies specifically focused on reducing the disparate impact of diabetes on minority communities.
- **Research and Surveillance**: Focus on expansion of screening, diagnosis, data collection and treatment of women with gestational diabetes and their children.
- Bills advancing Federal Coordination on Diabetes
- Bills related to Complications and Comorbidities of Diabetes

The American Diabetes Association's State Priorities for 2014 include:

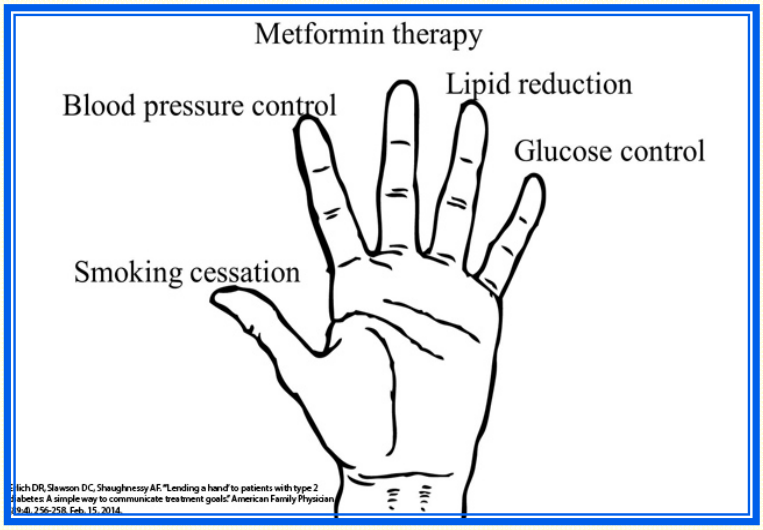
- **Health Insurance**: Ensure public and private health insurance options, including those under the Affordable Care Act and Medicaid, provide access to the services, tools and education necessary to meet the needs of people with diabetes and prediabetes; oppose efforts to repeal or create loopholes in the states and the District of Columbia with Diabetes Cost Reduction Acts
- **Discrimination**: Continue to advance the Safe at School campaign to ensure students with diabetes are medically safe and have access to the same educational opportunities as their peers that do not have diabetes; oppose laws and policies regarding driving licenses which result in the unfair treatment of people with diabetes.
- **Prevention**: Focus on primary prevention of type 2 diabetes.
- **Diabetes Programs and Surveillance**: Support funding for Diabetes Prevention and Control Programs and other diabetes public health programs.
- Bills Advancing State Coordination on Diabetes
- Bills Related to Complications of Diabetes

Handy Tool Ranks Diabetes Interventions by Effectiveness

Useful For Teaching

Taken in part from Tufts University press release

An editorial in a February issue of *American Family Physician* proposes a simple way for physicians ***(and diabetes educators)*** to communicate with patients about the best treatments for diabetes. **The "lending a hand" illustration reprioritizes treatment goals, based on research on mortality reduction, to convey that glycemic control is no longer the primary intervention. In order of benefit, to improve length and quality of life, patients with type 2 diabetes benefit most from these interventions, starting with smoking cessation (#1 thumb), blood pressure control (#2), metformin therapy (#3), lipid reduction (#4), and lastly glucose control (#5 pinky).**



Hand symbol, above, is a useful tool to convey most important diabetes treatment with the thumb being #1 and the pinky being #5

"Glycemic control is stuck in people's minds as the primary goal of treatment, but evidence has existed since the 1970s that other interventions are of greater benefit," said senior author Allen Shaughnessy, PharmD, M.Med.Ed., professor of family medicine at Tufts University School of Medicine and fellowship director of the Tufts University Family Medicine Residency Program at Cambridge Health Alliance.

Shaughnessy and colleagues wrote the editorial on their "lending a hand" illustration to demonstrate the paradigm shift in treatment priorities. "Lending a hand" emphasizes interventions that improve length and quality of life for those living with type 2 diabetes, in line with new guidelines from the American Diabetes Association and the European Association for the Study of Diabetes.

The "lending a hand" illustration uses the fingers of an open hand to depict diabetes interventions from thumb to pinky in descending order of benefit, relative to complications and mortality. Smoking cessation is considered the most important intervention (the thumb). Blood pressure control, metformin drug therapy, and lipid reduction follow along the pointer to ring finger. Glycemic control, considered the least important intervention, is relegated to the pinky.

"Some degree of glycemic control is necessary to prevent symptoms," Shaughnessy said. "It's just that the return on investment is low when we try to push patients with diabetes to get their blood glucose as close as possible to normal."

According to the National Diabetes Information Clearinghouse, approximately 25.8 million Americans have diabetes, and seven million of those may not be diagnosed. The NDIC further estimates that type 2 diabetes accounts for 90-95 percent of all cases of diabetes. Diabetes is a major cause of heart disease and stroke and the leading cause of new cases of blindness among adults.

"Our aim in proposing "lending a hand" is to communicate the most beneficial interventions patients can make to reduce their symptoms and risk of death from diabetes complications. But this model requires a shift in thinking away from the outdated idea that glucose reduction is most important, which may be a challenge," said first author Deborah Erlich, M.D., M.Med.Ed., assistant professor at TUSM, assistant family medicine clerkship director, and program director of the new Carney Family Medicine Residency, a TUSM affiliate.

"Working to control blood glucose while not addressing the other risk factors first is like rearranging deck chairs on the Titanic. The ship's going down," said author David Slawson, M.D., professor and vice chair of the department of family medicine, director of the Center for Information Mastery, and director of the family medicine fellowship at University of Virginia School of Medicine.

Reference:

Erlich DR, Slawson DC, Shaughnessy AF. "'Lending a hand' to patients with type 2 diabetes: A simple way to communicate treatment goals." American Family Physician (89:4), 256-258. Feb. 15, 2014.

Academy of Certified Diabetes Educators Began in 2014

Taken in part from NCBDE email communication with CDEs

Letter from ACDE President Christine Day

In January, 2014, the Academy of Certified Diabetes Educators (ACDE) officially launched and within a short time nearly ***1,000*** CDEs joined. ACDE is built on a foundation of open dialogue - and your involvement will help to make it a success. **For no financial obligation**, you can see what makes ACDE the right place for you. Activate your membership today at www.academycde.org.

Experience the ACDE Difference...

- ACDE is the only organization serving the unique needs of the Certified Diabetes Educator® (CDE®) through education, networking and advocacy.
- ACDE promotes the value of the certification process to the diabetes educator and, most importantly, the growing number of patients we serve.

ACDE membership is the next step to expand your professional network and enhance your job opportunities. Sign on today to activate your membership in this exciting new organization (*see instructions below*). Together we can create a unified voice for our multi-discipline field, advocating for the value of CDE certification.

Sincerely,

Christine Day

Christine Day RN, MS, CDE®, ACNS-BC
ACDE President

Message from the National Certification Board of Diabetes Educators (NCBDE)

NCBDE sent CDEs an email message back in January regarding the launch of a new organization for CDEs - the Academy of Certified Diabetes Educators (ACDE).

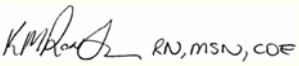
If you chose to pursue membership in ACDE, we hope you'll be active in the organization and spread the word to your fellow CDE colleagues, encouraging their participation. Feel free to pass this message on...

If you have not had a chance to check out the organization, we hope you'll take some time over the next few weeks to learn more about it. ACDE was established to provide increased opportunities for networking, professional resources and educational advancement. For more information on the relationship between ACDE and NCBDE, go to: http://www.ncbde.org/about/orgfaqs/ .

As mentioned in the earlier message: ACDE has several membership categories, but the active category of membership with voting privileges is reserved for current CDEs. Therefore, in order to ensure that current CDEs are identified correctly, NCBDE has provided your certificate number and name to ACDE. However, please know that we value your privacy, so no contact information has been provided to ACDE related to your record. In addition, CDEs who choose not to activate their membership in ACDE by June 30, 2014 will have their records deleted from the ACDE database. (Note: You can register again at a later date with verification of your CDE® credential.)

A message from ACDE President Christine Day, RN, MS, CDE®, ACNS-BC, about the organization is provided below, as well as instructions on how to activate your membership. We hope you will consider being actively involved with your peers!

Sincerely,



Kellie M. Rodriguez, RN, MSN, CDE®
Chair, NCBDE Board of Directors

How Do You Activate Your Membership?

1. You'll want to sign in and, at a minimum, add a valid email address to your profile. Here's how to sign in:
2. Access the sign in screen: There are a number of different ways to sign in: Visit www.academycde.org and use the sign in area on the right-hand side of the home page; use the "Sign In" menu option at the top of the page; or use the following link to go directly to the sign in screen: https://academycde.site-ym.com/login.aspx.
3. For the username: enter your CDE certificate number (full 8 digits, and no dashes). Your certificate number can be found above in the "To: portion" of this email message. (Note: if you've changed your username since the site launched, enter the updated username).
4. For the password, enter your last name as maintained in NCBDE's database which uses upper and lower case letters (e.g., Doe, not DOE or doe). Your last name as maintained in the database can be found above in the "To: portion" of this email message.
5. *****Please read this next step in full before proceeding,*****
   Enter as much profile information as you wish. **However, the email address field is a required field. Without an active email address in your profile, ACDE cannot activate your membership and any additional profile information that you've entered cannot be saved.** Therefore, be sure to enter a valid email address to complete your membership activation and save your profile data.
6. *****IMPORTANT: Do not hit the "SAVE" button until you have entered your desired email address.**

COUNTY HEALTH RANKINGS:

KENTUCKY HIGHLIGHTED NATIONALLY FOR SUCCESSES

Taken in part from national and state press release

Whether you reside in Clallam County, Wash., Miami-Dade County, Fla., or somewhere in between, where you live affects your health. That's the conclusion of the 2014 County Health Rankings report recently released .

The report, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, ranks how U.S. counties compare on 29 factors that impact health such as smoking, unemployment and high school graduation rates. This year's report, the fifth annual, includes seven new measures: housing, transit, access to mental health providers, injury-related deaths, food environment and access to exercise opportunities.

"The County Health Rankings show us how health is influenced by our everyday surroundings — where we live, learn, work and play," said Bridget Catlin, director of the County Health Rankings, in a news release. People living in the least healthy counties are twice as likely to live shorter lives as people living in the healthiest counties, according to the report. The least healthy counties also have twice as many children living in poverty and double the teen births.

WHAT MAKES A COUNTY HEALTHY?

The report reveals key factors that help define health in a county. Residents of the healthiest counties enjoy better access to healthy foods, parks and gyms. More residents have enough food to eat and better access to health providers. They also graduate high school and college at higher rates, and have fewer preventable hospital stays.

Least healthy counties have higher rates of smoking, obesity, physical inactivity, teen births and sexually transmitted infections. They have higher unemployment, more children in poverty, higher violent crime, more deaths due to injuries and more people with too little social support. The least healthy counties also have more overcrowded households, homes that lack adequate facilities to cook, clean or bathe, and too little affordable housing.

Nationally, the report found a number of positive trends including the following:

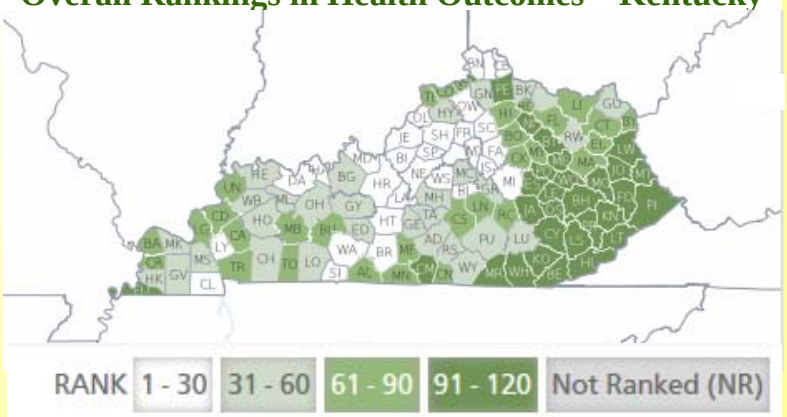
- Teen birth rates have declined about 25 percent since 2007;
- The rate of preventable hospital stays decreased about 20 percent from 2003 to 2011; and
- Smoking rates dropped from 21 percent in 2005 to 18 percent in 2012.

"The County Health Rankings are a starting point for change, helping communities come together, identify priorities and create solutions that will help all in our diverse society live healthier lives, now and for generations to come," said Risa Lavizzo-Mourey, president and CEO of the foundation.

According to the 2014 *Rankings*, the five healthiest counties in Kentucky, starting with most healthy, are Oldham, followed by Boone, Shelby, Calloway and Scott counties. Kentucky was also selected by the Robert Wood Johnson Foundation as one of three states to be highlighted nationally for its success in implementing strategies for improving health at the community level. State officials and health leaders gathered April 2 at the Kentucky History Center in Frankfort to celebrate Kentucky's successes, highlighting promising local health projects and initiatives to improve community health.

To find out how your county measures up, visit **www.countyhealthrankings.org**.

Overall Rankings in Health Outcomes—Kentucky



The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The rankings are based on two types of measures: how long people live and how healthy people feel while alive.

HAVE YOU HEARD?

Kentucky Diabetes Network is now on Facebook®

Like Kentucky Diabetes Network on Facebook.

Find us on: facebook.

Congress Passed Funding Increases For Diabetes!

Taken in part from ADA advocacy email

Congress recently passed an important spending bill funding the government through Fiscal Year 2014. **And it contained some great news for people with diabetes!**

Highlights include:

$76 million dollar increase in FY 2014 funding for the **Division of Diabetes Translation at the Centers for Disease Control and Prevention**, to a total of $137.3 million for the year - a nearly **125% increase** over last year's funding.

$10 million for the National Diabetes Prevention Program, which was completely unfunded in FY2013.

$1.744 billion dollars for the National Institute of Diabetes, Digestive and Kidney Diseases at the National Institutes of Health. This is a **$51 million increase** over last year's funding.

New FREE Low Literacy Resource From *Learning About Diabetes, Inc.*

Learning About Diabetes, Inc., recently announced another free diabetes care aid, ***"Driving With Diabetes"*** which has been added to their collection of free resources offered.

For free low literacy materials, visit www.learningaboutdiabetes.org .

Also thanks to the generous assistance of Northwestern University Feinberg School of Medicine, nine (9) award winning, easy-to-understand English and Spanish language diabetes education videos can now be downloaded from:

www.learningaboutdiabetes.org .

A companion guide for educators to help maximize use of the videos accompanies these diabetes education aids.

LEARNING ABOUT DIABETES

KY Diabetes Camp For Children

Camp Hendon - Kentucky's Diabetes Camp for Children is June 29-July 4, 2014 at Camp Loucon in Leitchfield, Kentucky. Priority application deadline to attend is May 15, 2014. For more information or to volunteer visit www.camphendon.org .

The 8th Annual Southern Obesity Summit is coming to Kentucky October 5-7 at the Louisville Marriott Downtown!

Shaping Kentucky's Future Collaborative, a consortium of foundations & organizations across the state working collaboratively to support healthy, thriving communities, is serving as the host organization. For more information, contact:

Carolyn Dennis
Shaping Kentucky's Future Collaborative
120 Creekside Drive
Georgetown, KY 40324
Carolyn.Dennis@roadrunner.com

Findings From 2014 Surgeon General's Report *Confirm Smoking Causes Type 2 Diabetes!*

Nearly 26 million Americans have diabetes and the number is rising daily. Since 1980, the percentage of people under 45 with diabetes has increased by 167%.

There are many risk factors for type-2 diabetes. Many of these, like family history, can't be changed. One risk factor that can be changed is smoking. Researchers have known for some time that smoking makes diabetes complications worse. But new findings from the 2014 Surgeon General's Report now confirm that smoking causes type-2 diabetes.

HOW DOES SMOKING CAUSE DIABETES, OR MAKE DIABETES WORSE?

- Smokers have more abdominal or "belly" fat. This kind of fat makes the body more resistant to insulin.
- Nicotine in cigarette smoke may make the body more resistant to insulin. This means that smokers with diabetes may need to take more insulin and have worse control of their blood sugar than non-smokers.
- Smokers with diabetes are more likely to have diseases that result from damaged blood vessels than are nonsmokers with diabetes. Chemicals in cigarette smoke cause injury to the cells lining the blood vessels. This interferes with the body's ability to make blood vessels widen and to control blood clotting.

American Association of Diabetes Educators

AADE Webinars:

April 23—Diabetes & Visual Impairment
May 7—Obesity Series, Part III: Pharmacotherapy
May 21—Advanced Topic: SLGT-2 Inhibitors
June 11—Obesity Series, Part IV: Surgical Interventions
July 23—Technology & Youth—Using tech to teach self–management

Reserve your place now, as seating is limited.
Webinars take place from 1-2:30 Eastern and offer 1.5 hours CE credit, unless otherwise noted.

For a full list of offerings and to register visit:
https://www.diabeteseducator.org/ProfessionalResources/products/webinars.html

AADE14
REFRESH. RECHARGE. RENEW.
AUGUST 6-9, 2014 | ORLANDO, FL
HOME REGISTER HOTEL & TRAVEL EDUCATION EXHIBITION & SPONSORSHIP GENERAL INFO AADE NEWS SPEAKER INFO

SAVE THE DATE

Diabetes Symposium:
Inpatient Care of Diabetes

Thursday, April 24, 2014
8:00 a.m. – 4:30 p.m.
St. Mary's Manor Auditorium
Evansville, IN

Cost: St. Mary's Employees $10.00
Outside Participant $40.00
CEU's will be offered

Nurses, Pharmacists, and Dietitians are welcome to attend.
Please call 812.485.1814 for more info
Presented by: Joslin Diabetes Center

ST.MARY'S stmarys.org
everyday victories

DIABETES EDUCATION OFFERINGS

TRADE
Workshop 2014
30TH ANNUAL

Applied to Meet Certified Diabetes Educator Requirements for Recertification

May 16, 2014
7:30 AM – 4:30 PM

Henderson Community College
Fine Arts Center
Henderson, Kentucky

The Kentucky Diabetes Prevention & Control Program, in partnership with TRADE, recognizes this program as a professional diabetes update.

KENTUCKY DIABETES PREVENTION AND CONTROL PROGRAM
KDPCP

TRADE
Tri-State Association of Diabetes Educators
A Local Networking Group (LNG) of the American Association of Diabetes Educators (AADE)

REGISTER NOW!
Topics include:

- KY and IN Health Information Exchanges/ Kynect
- Urgency of Addressing Prediabetes: Become a CDC Recognized Diabetes Prevention Program (DPP)
- Management of High Risk Pregnancies Associated with Diabetes
- Monogenic and Idiopathic Diabetes: Diagnosis and Management
- Stages of Change, Motivational Interviewing, and Empowerment Tips for Behavior Change
- Generational Styles of Learning: Tips for Teaching the AADE 7 Self-Care Behaviors

For brochure: email janice.haile@ky.gov or call 270-686-7747 X 3031

SAVE THE DATE!

Kentucky Statewide Diabetes Symposium 2014

Friday, November 7, 2014

CEU's for Nurses, Dietitians, Pharmacists and other Healthcare Professionals as well as hours for Certified Diabetes Educators (CDE)

Brochures will soon be available.

For additional information, contact:

Julie Shapero, RD, LD (859) 363-2116
julie.shapero@nkyhealth.org

Or

Janice Haile, RN, CDE (270) 686-7747 Ext. 3031
janice.haile@ky.gov

KADE Diabetes Educator Meetings Scheduled

The Kentucky Association of Diabetes Educators (KADE), *(covers Lexington and Central Kentucky)*, meets quarterly *(time & location vary)*. For a schedule or more information, go to http://kadenet.org/ or contact: Dee Deakins dee.deakins@uky.edu or Diane Ballard dianeballard@windstream.net.

April 19, 2014 **Details pending*

Learn How To Become a CDC Recognized Diabetes Prevention Program

http://www.cdc.gov/diabetes/prevention/recognition/standards.htm

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. Membership is free. A membership form may be obtained at www.kentuckydiabetes.net or by calling 502-564-7996 *(ask for diabetes program)*.

2014 KDN Meeting Dates *(10 am—3 pm EST)*
June 13, 2014
September 12, 2014
December 5, 2014

GLADE Diabetes Educator Meetings Scheduled

The Greater Louisville Association of Diabetes Educators (GLADE), *(covers Louisville and the surrounding area)*, meets the second Tuesday every other month. Registration required. For a meeting schedule or to register, contact Vanessa Paddy at 270-706-5071 Vpaddy@hmh.net or Anne Ries at 502-852-0253 anne.ries@louisville.edu

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 at susan_roszel@trihealth.com 513-977-8942. Meetings are held in Cincinnati four times per year at the 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

TRADE Diabetes Educator Meetings Scheduled

The Tri-State Association of Diabetes Educators (TRADE), *(covers Western KY/Southern IN/Southeastern IL)* meets quarterly from 10 am – 2:15 pm CST with complimentary lunch and continuing education. To register, call Janice Haile at 270-686-7747 extension 3031 or email janice.haile@ky.gov .

May 16, 2014—30th Annual TRADE 2014 Workshop
Henderson Community College, Henderson, KY

July 17, 2014—Trade Quarterly Program
Details to be Announced
Murray Calloway County Hospital Center for Health and Wellness
Murray, KY

October 16, 2014—TRADE Quarterly Program
Details To Be Announced
Deaconess Gateway Hospital, Newburgh, IN

January 2015—TRADE Quarterly Program
Details To Be Announced
Owensboro Health, Owensboro, KY

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.

Learn About The CDC National Diabetes Prevention Program

http://www.cdc.gov/diabetes/prevention/about.htm

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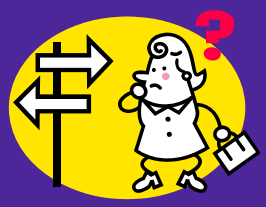

NEED A KY DIABETES RESOURCE?

Kentucky Diabetes Resource Directory
Update your entry information
https://prd.chfs.ky.gov/KYDiabetesResources

Contact Information

American Diabetes Association
Cure • Care • Commitment
www.diabetes.org
1-888-DIABETES

TRADE
Tri-State Association of Diabetes Educators
A LOCAL NETWORKING GROUP of the AADE American Association of Diabetes Educators

KDN
KENTUCKY DIABETES NETWORK, INC.
www.kentuckydiabetes.net

KENTUCKY ASSOCIATION of DIABETES EDUCATORS
KADE
Local Networking Group of AADE
A LOCAL NETWORKING GROUP of the AADE American Association of Diabetes Educators
www.kadenet.org

GREATER LOUISVILLE ASSOCIATION OF DIABETES EDUCATORS
GLADE
A LOCAL NETWORKING GROUP of the AADE American Association of Diabetes Educators
www.louisvillediabetes.org

KENTUCKY DIABETES PREVENTION AND CONTROL PROGRAM
KDPCP
Kentucky UNBRIDLED SPIRIT
http://chfs.ky.gov/dph/info/dpqi/cd/diabetes.htm

JDRF IMPROVING LIVES. CURING TYPE 1 DIABETES.
www.jdrf.org/chapters/KY/Kentuckiana
1-866-485-9397

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Diabetes Educators Cincinnati Area
A LOCAL NETWORKING GROUP of the AADE American Association of Diabetes Educators

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Joslin@EMHHS.com

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