

Kentucky Diabetes Connection



The Communication Tool for Kentucky Diabetes News

A Message from Kentucky Diabetes Partners

KENTUCKY PASSES TWO DIABETES BILLS!

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

Submitted by: Bob Babbage, Babbage Cofounder, Bob@BabbageCofounder.com

Two important diabetes proposals, now approved and signed into Kentucky law, are getting national attention!

Licensure for Diabetes Educators (Senate Bill 71) won House and Senate approval and was signed by Governor Steve Beshear. The concept was strongly supported a year ago, but two women led the way for its passage this year — Senator Alice Forgy Kerr (a Republican) and Representative Ruth Ann Palumbo (a Democrat).

Senator Alice Forgy Kerr was the sponsor of SB 71, which received overwhelming Senate and House votes. Leading diabetes advocates in a rousing rendition of "My Old Kentucky Home" on Diabetes Day was typical of the enthusiasm Senator Kerr gave to this effort.



Senator Alice Forgy Kerr, above left, talks with Carolyn Dennis, above right, at the 2011 Diabetes Day at the Capitol held February 10th



Representative Ruth Ann Palumbo, above left, and Senator Tom Buford, above right, sponsored recently passed diabetes legislation (SB 71's companion house bill and SB 63 respectively)

Often Senator Kerr spoke of her late mother's health struggle in her last years of life. Diabetes led to an amputation, meaning many difficult days, with Senator Kerr being the primary caregiver. "I am deeply, personally committed to action with so many wonderful, devoted professionals, for Kentuckians facing diabetes and its consequences. Diabetes is a growing threat to our families as well as our economic future. Diabetes educators are at the center of the fight," Senator Kerr said.

The longest serving woman in the legislature, Rep. Ruth Ann Palumbo, is a stalwart in the work for diabetes action. She steered the diabetes licensure bill through the House. "We have to work together, find new steps to take, and support professionals like our diabetes educators," Rep. Palumbo said.

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AND MORE!

KENTUCKY PASSES TWO DIABETES BILLS!

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Kentuckians in prominent roles with the American Association of Diabetes Educators (AADE), including the immediate past president, Deborah Fillman, previous AADE board member, Kim DeCoste, and current AADE board member, Tami Ross, gave generously of their time and expertise in support of SB 71.

Nicole Johnson, Miss America 1999, now a university administrator and doctoral candidate, made a special appearance on the KY House and Senate floors calling attention to numerous diabetes-related bills, but especially licensure for diabetes educators.

Another Senate Republican led Senate Bill 63 which calls for Medicaid, Public Health and the State Employee Health Plan to produce a *Blueprint for Action* on diabetes in the state.

It was proposed and backed by Senator Tom Buford, the prominent chairman of the Senate Banking and Insurance Committee.

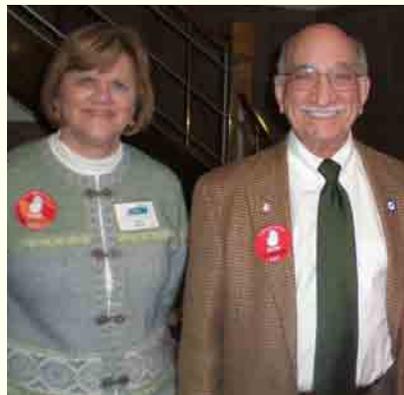
Joining Senator Buford in winning House support, again, was Rep. Palumbo.

"Obviously, the Senate and House have different majorities, but a united stance for decisive action on diabetes," Senator Buford said.

"The Senate as well as the House want to know exactly what's being done for diabetes, what works best, and what we need for greater success," Senator Buford added. "Programs claim action. We want to be sure we're doing everything possible."



Stewart Perry, left, National and State Diabetes Advocate, introduces Logan Gregory, right, who spoke to nearly 150 diabetes advocates who attended the 2011 Diabetes Day at the Capitol



Nancy Walker, left, Chair of the KY Diabetes Network (KDN) Advocacy Workgroup with Dr. Carlos Hernandez, right, former KY Commissioner of Health, as they prepare to visit legislators at Diabetes Day at the Capitol

Five other states are now considering bills almost identical to Senator Buford's, including California, Texas and Washington.

Legislators concerned that diabetes patients may not get the support they need are considering licensure for diabetes educators in the South and Midwest.

"We've had key leaders on the national front from Kentucky," Rep. Palumbo said, "like Deb Fillman, Stewart Perry and Larry Smith. Now we are leading by example with laws to help, family to family, here and across the nation."

Also approved by the 2011 legislature is a new task force on childhood obesity (HCR 13) <http://www.lrc.ky.gov/record/11RS/HC13/bill.doc>. Additionally in another resolution, the House asked for a review of practices for school students with chronic illness by the State, the Kentucky Department for Education, the Kentucky Board of Nursing, and national associations for diabetes, asthma and epilepsy (HR 187) <http://www.lrc.ky.gov/record/11RS/HR187/bill.doc>



Photo Above: Representative Susan Westrom talks with nearly 150 diabetes advocates who attended the 2011 Diabetes Day at the Capitol



Photo Left: Morehead State instructor, Ann Rathbun, center in black, surrounded by diabetes advocates as they prepare to visit legislators at the 2011 Diabetes Day at the Capitol

DIABETES DAY AT THE CAPITOL HELD FEBRUARY 10, 2011

**NEARLY 150 ADVOCATES ATTEND
55 VISITS WITH LEGISLATORS CONDUCTED**

Submitted by: Nancy Walker, KY Diabetes Network (KDN) Advocacy Workgroup Chair, TRADE member

On February 10 and February 17, 2011, advocates with the Kentucky Diabetes Network (KDN) and the American Diabetes Association (ADA) went to our Kentucky Capitol to let our voices be heard in support of Diabetes! In these two days, there were nearly 150 advocates in attendance, over 55 legislators visited, and diabetes packets left for each and every KY legislator!

The event began with training the participants, which included several inspirational speakers. Logan Gregory, a young person with diabetes, discussed living with diabetes, fighting for more recognition / money, and the need for protective laws for people with diabetes.

Wilma Hoskins, a diabetes educator who works for Dr. Leera Patel, an endocrinologist, motivated attendees by asking, ***“How Dare We NOT Take Action NOW To Fight Diabetes!”***

Senator Kerr talked with advocates about her commitment to diabetes and funding, then led the group in a stirring rendition of “My Old Kentucky Home”! Bob Babbage presented information regarding the diabetes related bills in session.

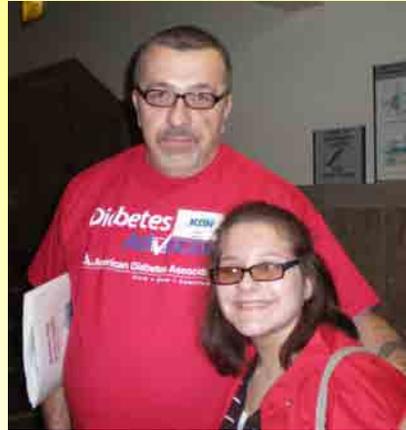
Advocates then headed to the legislators offices to meet with legislators and express concern for the growing problem of diabetes and the need for continued funding, physical activity in the schools, safety in the school system for children with diabetes, licensure for diabetes educators, collaboration / reporting of existing diabetes state programs, and more.

Bill Outcomes:

To date, diabetes funding has been preserved – no increases are expected, but no decreases are expected either. Two diabetes related bills were signed into law this year – both history makers!

- **Senate Bill 71** — The ***Diabetes Educator Licensure Bill*** was signed into law by Governor Beshear on March 16, 2011. Kentucky is the first state in the United States to have this licensure and will set the pace for other states to pass diabetes educator licensure across the country.
- **Senate Bill 63** — “An Act relating to Diabetes...” was also signed into law by Governor Beshear on March 16th. This bill provides for collaboration between Medicaid and other state entities in order to report to the legislature how state monies are spent in diabetes including the outcomes related to diabetes care and prevention.

All in all, this year was a great year for diabetes advocates! We still have a lot of work to do, but every year brings more recognition and attention to the needs of people with diabetes and the prevention efforts needed to impact this devastating disease.



Madison County Diabetes Coalition advocates, John Elliott and his daughter Kori, told their diabetes story to their legislators at the 2011 Diabetes Day at the Capitol

Daviess County Diabetes Coalition President, David Vowels, left, and diabetes educator Wilma Hoskins, right, prepare for visits with their legislators



Senator Alice Forgy Kerr, left, talks with ADA Midwest State Advocacy Director Jim McGowan, right, regarding diabetes legislation in Kentucky

Former KDN President and Advocacy Workgroup Chair, Greg Lawther, turns in legislator visitor forms following several visits with key legislators



DR. POHL'S COLUMN

THE EYES HAVE IT



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

Two journal articles on diabetic retinopathy recently caught my attention. Their titles: *“Are Individuals With Diabetes Seeing Better? A Long-Term Epidemiological*

Perspective” and *“Prevalence of Diabetic Retinopathy in the United States, 2005-2008.”* Both were published in August, 2010, the former in *DIABETES*, the latter in the *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*. One of the authors of these articles is Dr. Ronald Klein, Professor of Ophthalmology at the University of Wisconsin. Dr. Klein was famous in the early 1980's for outfitting a bus with ophthalmologic equipment and driving around Wisconsin doing eye exams and metabolic studies on everyone with type 1 diabetes he could find as well as a sample of persons with type 2. His studies provided unequivocal evidence that blood sugar control determines the risk for development and progression of diabetic retinopathy. These findings antedated the Diabetes Control and Complications Trial by ten years and were very encouraging to those of us who believed in the value of trying to control diabetes. Naturally, I was very curious to find out if individuals with diabetes are seeing better and if the prevalence of diabetic retinopathy has decreased in the thirty years since Dr. Klein bought his bus.

The good news is that both prevention and treatment of diabetic retinopathy have proven to be very effective among patients with good access to care.

Individuals with diabetes who are engaged in good self-management practices are seeing better. The bad news is that the prevalence of retinopathy is still high.

The second article estimates the prevalence of diabetic retinopathy and vision threatening diabetic retinopathy at 28.5% and 4.4% respectively among US adults with diabetes. These numbers are about 50% higher than

prevalence rates obtained by similar methods twenty years ago. There are methodological problems that limit the validity of comparing recent and older data. Nevertheless, these data show nothing to indicate that the prevalence of diabetic retinopathy is decreasing. If anything, the situation is worsening. Remember, too, that prevalence is a rate, i.e. percent of persons with diabetes.

Since diabetes is much more common now, the total number of people with retinopathy is much greater. Interestingly, the epidemiologists are now writing in terms of prevalence of vision threatening diabetic retinopathy in the entire population rather than just the population of persons with diabetes.

The implication of the prevalence data, I think, is that we can expect a wave of blindness from diabetic retinopathy to follow the current worldwide epidemic of diabetes with a lag of about twenty years.

The epidemiology articles cited above suggest that poor access to care is responsible for the fact that prevalence of diabetic retinopathy remains high despite availability of proven effective prevention and treatment measures. The authors do not define “poor access to care”; so, I take poor access to describe persons with diabetes who either can't or don't avail themselves of health care resources. The “can't” column includes maldistribution of health care resources and financial barriers and is in the domain of major social issues. The “don't” column includes ignorance, indifference, and denial, the barriers that diabetes care practitioners and persons with diabetes face every day. Eventually, our health care system must address both columns in order to end blindness caused by diabetes.

There are some unique and interesting things about retinopathy that all of us need to understand. Diabetic retinopathy begins with damage to small blood vessels in the retina. These vessels dilate and leak forming micro aneurysms, hemorrhages, and exudates, lesions that are easy to see with an ophthalmoscope. These lesions usually don't interfere with vision but are harbingers of more serious problems. As the damage to the small vessels progresses the retina becomes

DR. POHL'S COLUMN (CONTINUED)

ischemic and sends hormonal signals that stimulate growth of new blood vessels, a process called neovascularization. This would seem to be a good way to restore blood supply to the retina. Unfortunately, neovascularization occurs in an abnormal location between the retina and the vitreous. The new vessels are fragile and bleed. When rupture of a vessel occurs, blood displaces the vitreous and blocks passage of light to the retina with immediate loss of vision in the affected eye. Fortunately, this blood gets reabsorbed and vision returns within a few weeks. However, the process of bleeding and reabsorption causes scarring and traction on the retina leading to retinal detachment and eventually to permanent loss of vision.

The mainstay of treatment of advanced retinopathy is laser photocoagulation. In some cases it is possible to use a laser to destroy individual abnormal blood vessels. However, use of a procedure called panretinal photocoagulation (PRP) is more common. PRP involves placement of 1,000 or more small laser burns in the retina. The goal is to destroy as much of the retina as possible in order to reduce the mass of tissue sending the signal for neovascularization in response to ischemia. PRP is uncomfortable and does not restore vision already lost from retinopathy, but it does prevent blindness.

The brief explanation of retinopathy and its treatment in the last two paragraphs is grossly simplified. Even so, it is complex and difficult to understand.

Trying to explain retinopathy to a patient amounts to saying, "In order to keep you from going blind we may have to destroy your retinas."

This is not the sort of news that inspires patients to run to the nearest eye doctor for an exam. Furthermore, there are no happy customers singing the praises of laser photocoagulation and encouraging their friends and family to have it done. In my experience laser treated patients tend to be disappointed and frustrated because their diabetes has reached a very serious stage and they notice no improvement from the treatment.

An even more basic problem is simple ignorance. John Bunton, chair of the KY Diabetes Network (KDN) Health Plan Partners group, tells me that some patients don't get eye exams because Medicaid doesn't pay for glasses. After all, there is no point in getting an exam if one can't

afford glasses. We used to have an eye doctor come to our office once a week so that our patients could get eye exams while they were in for diabetes follow up. This idea fizzled because the patients felt they weren't getting a proper eye exam. After all, we didn't have a phoropter, that big gizmo with all the lenses and dials, or a technician who asks that vexatious question, "Which is better, number one or (click) number two?" Detection and treatment of diabetic retinopathy have nothing to do with refraction, but our patients didn't want to see the eye doctor if they couldn't get a prescription for new glasses. In an even more graphic example of ignorance, I had at least two patients who underwent vitrectomy and later told me that the eye doctor popped their eyeballs out, cleaned 'em up real good, and popped 'em back in.

For many years KDN and other organizations have attacked the retinopathy problem by encouraging primary care physicians to be more aggressive in getting their patients to eye doctors for annual exams. This effort has met with considerable success and should be continued. Unfortunately, it is not enough. Procrastination in getting eye exams is a specific example of a general problem in diabetes care. People with diabetes, or without for that matter, tend not to take preventive measures or seek care until symptoms develop. Even when confronted with the dire consequences of ignoring diabetes and self-management, a sizable number of people with diabetes just don't do what their providers advise them to do. Add in the "can't" factor and it is easy to see why vision threatening retinopathy remains a serious and common problem with no easy solution.

For now the best we can do is continue to slog away at educating the politicians, the general population, persons with diabetes, and ourselves about the nature of diabetic retinopathy and what we can do about it.



For a copy of the report, *Improving the Nation's Vision Health: A Coordinated Public Health Approach*, go to http://www.cdc.gov/visionhealth/publications/vhi_report.htm

DIABETIC PERIPHERAL NEUROPATHY

A GUIDE FOR MEDICAL PROFESSIONALS



Dr. Benjamin M. Schaffer is a podiatrist in Louisville, Kentucky who has been in private practice since 1982. He is board certified in foot surgery by the American Board of Podiatric Surgery, and is experienced in the treatment of wounds and conditions associated with diabetes.

Dr. Benjamin Schaffer

The widespread nature of diabetes in the USA is well known by health professionals, with as many as 23 percent of Americans over the age of 60 years old diagnosed. Within this group, as many as 60 to 70 percent are affected in some way by diabetic peripheral neuropathy (DPN).

The term diabetic peripheral neuropathy refers to the gradual injurious effect of prolonged hyperglycemia on the terminal portions of nerve fibers to the hands and/or feet.

A common misconception among patients is that the condition is related to peripheral vascular disease, but neuropathy may occur with or without PVD.

Diabetic peripheral neuropathy may have the following effects based on the types of nerve affected:

Sensory nerves: Patients may experience pain, numbness, or both at the same time. The term “glove and stocking” is often used to describe the distribution of altered sensation with *polyneuropathy*, but in some patients *mononeuropathy* can be observed. Compression neuropathies including carpal tunnel syndrome, tarsal tunnel syndrome, Morton's neuroma, and spinal compression disorders are common among diabetics. Electrodiagnostic testing or diagnostic nerve blocks may be helpful in establishing a diagnosis for these patients.

Painful neuropathy is usually experienced as a tingling, burning, shooting sensation, or hypersensitivity. The pain is usually worse when shoes and socks are off, especially at night (a key contrast from most orthopedic conditions), but for some patients the pain is unremitting - day and night. Sometimes even the bed sheets cause discomfort. Pain associated with walking should be screened for peripheral arterial disease.

Loss of sensation: The ability to feel pain from blisters, foreign bodies, fractures, and infections can lead to neglect of serious conditions and devastating consequences. The proprioceptive nature of motor nerves is vital to balance, and sensory neuropathy often forces patients to require a walker or cane to

function without falling. Permanent changes in the shape of the foot with acute non-traumatic fractures (Charcot Osteoarthritis) can accompany the loss of feeling. The changes can predispose the foot to ulceration. The health care provider needs to have a high index of suspicion for any edema, especially with warmth in a neuropathic patient.

Motor nerves: Muscle wasting can be observed on physical exam, especially in the intrinsic muscles of the forefoot that stabilize the digits. The result is a progression of bunion and hammertoe deformities. The changes in foot shape can cause pressure changes in shoe fit and weight bearing that can lead to ulceration. In some cases, the anterior muscle group of the lower leg is affected, and can lead to a drop foot gait.

Autonomic nerves: In the extremities this is manifest by impaired sweat gland function, dry, and potentially cracked skin which no longer is an efficient barrier to infection. Keeping the feet covered with a sock and use of moisturizers on a regular basis is critical to help maintain an effective skin barrier for many diabetics.

Management of diabetic peripheral neuropathy is based on symptoms, but in all cases, good patient education is critical to minimize secondary contributing problems. The role of good glycemic control in the progression of the condition needs to be clear to the patient. The individual's responsibility related to diet, exercise, and avoidance of smoking needs to be clear. The role of additional medical conditions such as thyroid dysfunction, vitamin deficiency, side effects of medications, connective tissue disorders, alcohol abuse compression neuropathy, and excessive alcohol use needs to be considered and addressed. In some cases the patient will relate worsening pain when blood sugar is poorly controlled, facilitating a correlation to the diabetes.

Non-pharmaceutical, topical, and alternative medicine approaches may be attempted alone, or to supplement medicinal treatments, but in my experience they have a much smaller role than medications. TENS can be helpful, especially in difficult to manage patients. The Rebuilder is a newer device that performs electrical stimulation, while Anodyne employs topical infrared therapy. Hypnotism, biofeedback, and acupuncture are additional well known pain management techniques. Topical capsaicin is touted by many as effective, but in the clinical setting patient compliance is difficult, especially considering the dosing schedule, burning side effects, and difficulty handling the compound.

DR. SCHAFFER'S ARTICLE (CONTINUED)

Alpha-lipoic acid is an antioxidant found naturally in the body, and as a supplement is believed to be helpful in controlling neuropathic pain. It can help to reduce glycemic levels, but may also lower levels of thyroid hormone levels. Liniments such as Biofreeze may give some relief in mild cases. Lidocaine patches and topical lidocaine can be helpful, especially if the pain is focal. While the patches are expensive, using a segment over the posterior tibial nerve at the ankle, and another segment anterior to the ankle can be helpful in blocking some of the pain impulses.

Oral Medications: Even though there are only two prescription medications with FDA approval for painful neuropathy (Lyrica and Cymbalta), there are many medications used to help with the symptoms of neuropathy. Most of the medications fall into the categories of anticonvulsants and antidepressants, with analgesics also prescribed regularly for the neuropathic pain.

Over-the-counter acetaminophen and NSAID's may have a place on a limited basis, but may be less effective than other choices for the nighttime problems with sleep, and may be of concern for long term side effects, especially if used with regularity.

Opioids are still used by many practitioners, particularly if pain is periodic and needs to be addressed on a PRN basis. They are useful as a supplement to other modalities. The analgesic tramadol is also an effective choice, and is considered by most to have no abuse potential.

Tricyclic antidepressants (TCA's), serotonin-specific re-uptake inhibitors (SSRI's), and serotonin-norepinephrine re-uptake inhibitors (SNRI's) are the commonly used classes of antidepressant classes. TCA's, including amitriptyline, desipramine, clomipramine, and imipramine, have a long track record for treating DPN. They can be effective at times in low dose for nocturnal pain. The bedtime dosing can also help avert some of the many side effects, including dry mouth, somnolence, urinary retention, orthostatic hypotension, and tachycardia. Amitriptyline or nortriptyline 25 mg at bedtime is often effective as a starting therapy, and may be reduced to 10 mg for elderly patients.

SSRI's and SNRI's are newer antidepressants. They may have the same efficacy as TCA's with less side effects. The SNRI's fluoxetine and paroxetine may be less effective than TCA's, but SSRI's such as venlafaxine may possess similar efficacy compared to the TCA's.

Cymbalta (duloxetine) is an SNRI with FDA approval for DPN. The once daily dosage can be started at 30 mg, but is usually dosed at 60 mg once daily. Side effects can include nausea, dry mouth, constipation, and insomnia. Its cost may be justified over TCA's in patients with whom cardiovascular and anti-cholinergic side effects are of concern.

Anticonvulsants that have been used with success for DPN include carbamazepine, phenytoin, lamotrigine, although for the last 10 or more years gabapentin (Neurontin) has become popular for its safety and effectiveness in treating nerve pain. Unlike other anticonvulsants, there is no need for lab monitoring. The wide range of dosing can accommodate many patients. Doses may range from 100 mg at bedtime for extremely sensitive patients, and can be given as high as 3600 mg in divided doses. The drug is usually started at 300 mg doses one to three times daily, and can be titrated upwards. The most common side effects of sedation and dizziness generally dissipate over a period of a couple of weeks, and can often be avoided by starting with a low dosing schedule and gradually increasing. Phenytoin and carbamazepine present the practitioner with long term responsibilities of monitoring the patient for toxicities.

Lyrica is touted by Pfizer as having a more linear patient response rate to dosing compared to gabapentin, and is particularly useful for patients who can't seem to benefit from increasing doses of gabapentin. The potential side effects are similar to those of gabapentin, with the addition of peripheral edema. Dosing is generally started at 150 mg per day in divided doses of two or three times daily. Pain relief can be rapid with this medication, and after one week the dosing can be increased to 300 mg per day. The capsules range from 25 mg to 300 mg, and generally cost the same regardless of dose.

Diabetic peripheral neuropathy can cause pain that has profound effect on patients while sometimes simultaneously can cause impaired loss of protective sensation that can lead to balance issues, foot ulcers, and amputations. The need for regular evaluation and education of patients as well as accommodation of foot deformities should be taken seriously by all medical providers.





2011 CAMP HENDON JULY 26 - JULY 31 CENTER FOR COURAGEOUS KIDS SCOTTSVILLE, KY

Submitted by: Bryan Fallon, President, Kentucky Diabetes Camp for Children, Inc., 1613 Forest Hill Drive, Louisville, KY 40205, 501(c) 3 Tax ID: 27-3619275

There are a lot of things in life that are just hard, complicated and seem unfair. Diabetes is on that list. It is really easy for a child with diabetes to get frustrated with everything that they need to learn, understand, and do. The feeling of being alone and abandoned is almost always on their mind. At Camp Hendon, things are different, really different!

On September 2, 2010, the American Diabetes Association informed the Camp Hendon Board that they had discontinued their support of Camp Hendon. Following that decision, the Camp Hendon Board decided to form our own 501(c) 3 tax exempt corporation to continue the important work for kids with diabetes in Kentucky and southern Indiana. Camp Hendon receives no funding from national organizations or other diabetes nonprofits. Camp Hendon is NOT part of JDRF or ADA. **Camp Hendon has a big heart, a big mission and limited resources; we need your help!**

Our Purpose & Mission

Camp Hendon gives children, ages 8-17, with diabetes in Kentucky and Southern Indiana a chance to have a fun, safe, medically supervised camping experience while realizing they are not alone in their fight for a cure. The Kentucky Diabetes Camp for Children, Inc. "Camp Hendon" is established to assist children and teens with diabetes in gaining the skills and knowledge needed to transition to independent diabetes management. This new corporation is founded to fill a void in Kentucky and the surrounding region to aid children and teens who have diabetes. The corporation is made up of unpaid volunteers.

At Camp Hendon kids with diabetes find a chance to get to know others who face the same challenges. One of the greatest benefits both children and their parents express about camp is the ability to feel part of a group where everyone has diabetes and the feelings of isolation are eliminated. At Camp Hendon, children with diabetes are surrounded by people just like them – both children and adults — who share their day to day ordeals and triumphs managing their diabetes. The campers are provided with 24-hour medical care from wonderful all volunteer doctors, nurses, dietitians and adult counselors. Camp Hendon is a continuing project that began in 1965. It was named for the late Dr. J. Robert Hendon who was the first endocrinologist in Kentucky.

About Costs

Camp Hendon has adopted the credo from our host facility, The Center for Courageous Kids. The Credo states that "every child who is accepted to camp will attend at —**No Cost To Them.**" We do not charge for a child to attend camp.

That said, it costs approximately \$2,000 per child for the camp program. Donations are accepted from anyone in any amount to help defray the costs of the camp. We are perpetually raising money so that camp can exist. We genuinely appreciate any help and donations.

For more information on signing up for camp, volunteering, or making donations, please visit: www.camphendon.com or call 502-817-6286.

Recently GLADE made a very generous \$2,000 donation to our new camp. I am challenging the other Kentucky AADE groups (TRADE, KADE, DECA) to match this bighearted donation and help us in our quest to help the children of Kentucky and Southern Indiana.

KENTUCKY MOVES AHEAD TO ADOPT ELECTRONIC HEALTH RECORDS

Frankfort Press Release 3-8-11 Beth Fisher or Gwenda Bond (502) 564-6786 ext. 3101 or ext. 3100

Governor Steve Beshear announced that Kentucky continues to forge ahead with efforts to adopt electronic health records (EHRs), with more hospitals and providers receiving monetary incentives for EHRs and linking to the Kentucky Health Information Exchange (KHIE).

The recent developments are part of ongoing work to install viable EHR systems in hospitals, medical practices, pharmacies, labs and other medical facilities, and linking those systems to an exchange where data can be transmitted to and from facilities. The effort is being closely monitored by the federal government, which provides monetary incentives for EHRs and is setting guidelines and specific criteria for the health information exchanges.

“This is an exciting time for the American health care industry as we work to improve health care through technology,” said Gov. Beshear. “Kentucky is leading the way in the effort to adopt electronic health records nationwide and this puts us that much closer to fully achieving our vision. We know that health information technology can help improve patient care by creating greater efficiency and reducing errors.”

The Office of National Coordinator (ONC) in the federal Department for Health and Human Services also recently approved the strategic and operational plan submitted by the Cabinet for Health and Family Services (CHFS), which details the state’s strategy for deploying KHIE. The ONC’s approval makes available \$9.75 million in previously announced federal funds awarded to CHFS under the 2009 American Recovery and Reinvestment Act (ARRA) for the implementation of a statewide electronic health network.

Meanwhile, numerous Kentucky hospitals and medical providers have already received federal incentive dollars from the Centers for Medicare and Medicaid Services (CMS) for adopting electronic health records. Medicaid incentive payments began in January 2011 to assist with the purchase or upgrade of information technology systems for health care records. In February, payments exceeded \$12 million, reaching the state’s urban areas, as well as rural communities.

In January, CHFS awarded the first two incentive payments to University of Kentucky Healthcare and Central Baptist Hospital. In the first round of incentive payments, UK received \$2.8 million and Central Baptist received \$1.3 million. Since then, several hospitals and health care practices have received incentive payments, with more expected.

Below is a list of other incentive payments distributed by CHFS in January and February 2011:

January 28, 2011

- Cynthiana-Harrison Memorial Hospital, \$556,740
- Corbin-Baptist Healthcare System Inc (Baptist RMC), \$1,244,697
- Fordsville-Local provider, \$21,250
- Newport-Health Point Family Care (various providers), \$63,750
- Pineville-Two local providers, \$42,500
- Campbellsville-Variou local providers, \$63,750

February 3, 2011

- Newport-Health Point Family Care, Inc. (various providers), \$255,000
- Mount Sterling-Family Care Clinic (two providers), \$42,500
- Hartford Doctor’s Clinic (two providers), \$42,500
- Flatlick-PCH Medical Clinic (one provider), \$21,250
- Pineville Community Hospital, \$593,677
- Albany-Clinton County Hospital, \$588,079.13
- Paducah -Baptist Healthcare System (Western Baptist Hospital) \$772,169
- Burkesville-Cumberland County Hospital Association (various providers), \$63,750
- Harlan-Local provider, \$21,250
- Bardstown-Center for Women’s Health (one provider), \$21,250
- Hazard-Mountain After Hours Clinic (various providers), \$85,000

February 16, 2011

- Newport-Health Point Family Care, Inc. (various providers), \$63,750
- Hazard-Mountain After Hours Clinic (one provider), \$21,250
- Ashland Hospital Corporation (King’s Daughters Medical Center), \$1,200,771
- Lexington Fayette County Health Department (various providers), \$ 318,750
- Morgantown-Local provider, \$21,250
- Murray-Primary Care Center (various providers), \$85,000
- Gray-Grace Community Health Center, Inc. (various providers), \$106,250
- Burkesville-Cumberland County Hospital Association (Cumberland County Hospital), \$355,379
- Henderson-Community United Methodist Hospital (Methodist Hospital), \$842,202
- Burkesville-Cumberland Family Medical Center (various providers), \$233,750
- Pikeville-Local provider, \$21,250

NATIONAL 2011 DIABETES FACT SHEET NOW AVAILABLE

NATIONAL CERTIFICATION BOARD FOR DIABETES EDUCATORS EXPANDS PRACTICE REQUIREMENT FOR RENEWAL



The National Certification Board for Diabetes Educators (NCBDE) recently expanded the practice requirement for renewal of the certified diabetes educator (CDE) credential allowing the inclusion of volunteer activities related to diabetes care and self-management education. This new rule is effective beginning with those CDEs renewing in 2011.

For Complete Information:
[http://www.ncbde.org/
practice_require.cfm](http://www.ncbde.org/practice_require.cfm)

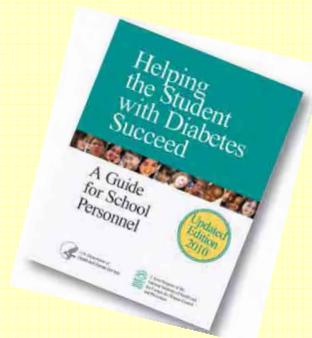


Download at: [http://www.cdc.gov/
diabetes/pubs/pdf/ndfs_2011.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf)

FREE DIABETES GUIDE FOR SCHOOL PERSONNEL NOW AVAILABLE!

Helping the Student with Diabetes Succeed, the updated 2010 version, is now available to order! Includes new sections on training school personnel, meal planning, carbohydrate counting, insulin administration, appropriate developmental stages for students to perform diabetes care tasks, sample forms and more!

For a FREE copy, visit
<http://ndep.nih.gov/>
or call 1-888-693-6337
NDEP publication # 61



CMS CLARIFIES STANDARDS FOR THE DELIVERY OF DSMT

Recently the American Association of Diabetes Educators (AADE) along with other national diabetes entities led a joint effort to contact the Centers for Medicare and Medicaid Services (CMS) to notify them of the need for greater clarity and consistency regarding Medicare coverage and reimbursement policies related to Diabetes Self-Management Training (DSMT). The following is an excerpt shared by AADE to its members.

Clarification of National Standards Permitting Qualified RDs, RNs, or Pharmacists to Individually Furnish Diabetes Self-Management Training Services

The Centers for Medicare and Medicaid Services recently clarified payment policy regarding the quality standards applicable to Diabetes Self-Management Training (DSMT) providers. In particular, CMS instructed contractors about the differences between the quality standards for entities following the CMS quality standards and those following the National Standards for Diabetes Self-Management Training Program (National Standards).

CMS Quality Standards – DSMT providers following CMS quality standards generally require a multidisciplinary team approach to the provision of DSMT services (although there is an exception to this requirement which permits a Registered Dietitian who is also a Certified Diabetes Educator to individually furnish DSMT services in a rural area). In addition, CMS has noted that a dietitian may not be the sole provider of the DSMT service. CMS has instructed contractors that this exception and special note are applicable only to those entities following the CMS quality standards.

National Standards – National Standards no longer require a multidisciplinary team approach, although these quality standards note that DSMT services are most effective when delivered by multidisciplinary teams consisting of a Registered Dietitian (RD), Registered Nurse (RN), and pharmacist as the key primary instructors for diabetes educators assisting in the delivery of services. Current National Standards require that at least one member of the team (or, if no

team, the individual furnishing the training) must be an RD, an RN, or a pharmacist. The National Standards continue to call for all of the instructor(s) on the diabetes team to be certified as diabetes educator(s) or have recent educational and experiential preparation in education and diabetes management. However, the review and approval of credentials of DSMT program instructors is solely the role of the accrediting organization (listed below).

Until the Medicare Benefit Policy Manual is revised, contractors have been instructed to recognize that DSMT services may be furnished by an individual RD, RN, or pharmacist when those services are billed by, or on behalf of, a DSMT entity accredited as meeting the National Standards by the American Diabetes Association, Indian Health Service, or the American Association of Diabetes Educators, which are all CMS-approved accrediting organizations that use the National Standards for DSMT programs. This clarification does not affect who can qualify as “certified providers” to bill for DSMT services and, as such, payment for DSMT services may only be made to a physician, individual, or other provider that bills Medicare for other services for which direct Medicare payment may be made by CMS.

When following the National Standards, RDs may submit claims and be paid directly for DSMT services, as appropriate, because RDs are permitted to bill and receive payment for other Medicare services. However, since pharmacists and RNs cannot bill and receive payment directly from CMS for these types of services, the DSMT services they furnish to Medicare beneficiaries are billed by other certified providers, as appropriate, on their behalf.



DIABETES BELT HITS KENTUCKY HARD

68 OF KENTUCKY'S 120 COUNTIES IN "DIABETES BELT"

A recent new study by the Centers for Disease Control and Prevention (CDC) has named 68 of Kentucky's 120 counties as lying within a newly identified "DIABETES BELT".

The diabetes belt means that the prevalence of diagnosed diabetes is especially high and people who live in the diabetes belt are more likely to develop type 2 diabetes than people who live in other parts of the United States.

In 2010, data from the 2007 and 2008 Behavioral Risk Factor Surveillance System were combined with county-level diagnosed diabetes prevalence estimates. **Counties in close proximity with an estimated prevalence of diagnosed diabetes $\geq 11.0\%$ were identified as being in the "Diabetes Belt"**. Prevalence of risk factors in the diabetes belt was compared to that in the rest of the U.S. Excess risk associated with living in the diabetes belt with selected risk factors, both modifiable (sedentary lifestyle, obesity) and non-modifiable (age, gender, race/ethnicity, education), was calculated.

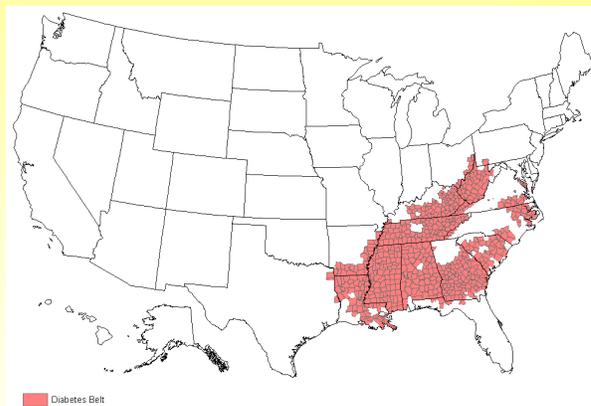
A diabetes belt consisting of 644 counties in 15 mostly southern states was identified.

People in the diabetes belt were more likely to be non-Hispanic African-American, lead a sedentary lifestyle, and be obese than in the rest of the U.S. Thirty percent of the excess risk was associated with modifiable risk factors such as sedentary lifestyle and obesity, and 37% with non-modifiable factors.

The authors of the study concluded that culturally appropriate interventions aimed at decreasing obesity and sedentary lifestyle in counties within the diabetes belt should be considered.

For More Information:

Geographic Distribution of Diagnosed Diabetes in the U. S.A. Diabetes Belt. Barker LE, et al. Am J Prev Med. 2011 Apr;40(4):434-9. (<http://www.ncbi.nlm.nih.gov/pubmed/21406277>)



Kentucky Counties in Diabetes Belt (Diabetes Rates ≥ 11.0)

| | | | |
|------------|------|------------|------|
| Adair | 11.6 | Lawrence | 11.8 |
| Allen | 11.3 | Lee | 11.9 |
| Barren | 11.5 | Leslie | 12.2 |
| Bath | 11.4 | Letcher | 12.5 |
| Bell | 12.1 | Lincoln | 11.4 |
| Bourbon | 11.1 | Logan | 11 |
| Boyd | 11.9 | Magoffin | 12 |
| Boyle | 11.1 | Marion | 11.1 |
| Breathitt | 12.2 | Martin | 12.2 |
| Butler | 11 | Mason | 11 |
| Carter | 11.5 | McCreary | 11.8 |
| Casey | 11.5 | McLean | 11 |
| Clark | 11.1 | Menifee | 11.7 |
| Clay | 11.9 | Mercer | 11 |
| Clinton | 11.6 | Metcalfe | 11.5 |
| Cumberland | 11.6 | Monroe | 11.4 |
| Edmonson | 11.4 | Montgomery | 11.5 |
| Elliott | 11.5 | Morgan | 11.7 |
| Estill | 11.5 | Muhlenberg | 11.1 |
| Floyd | 12.6 | Nicholas | 11.2 |
| Fulton | 11 | Ohio | 11.1 |
| Garrard | 11.2 | Owsley | 11.9 |
| Grayson | 11.2 | Perry | 11.9 |
| Green | 11.4 | Pike | 12.6 |
| Greenup | 11.7 | Powell | 11.7 |
| Harlan | 12.1 | Pulaski | 11.4 |
| Hart | 11.2 | Rockcastle | 11.4 |
| Hickman | 11 | Rowan | 11 |
| Jackson | 11.6 | Russell | 11.4 |
| Johnson | 11.8 | Simpson | 11.1 |
| Knott | 12.4 | Taylor | 11.3 |
| Knox | 11.9 | Wayne | 11.5 |
| Larue | 11.2 | Whitley | 12.1 |
| Laurel | 11.9 | Wolfe | 11.9 |

GESTATIONAL DIABETES DIAGNOSIS CHANGING? *CRITERIA MAY DOUBLE NUMBER OF WOMEN WITH GDM*

Taken in part from ADA press release through Lauren Gleason
lgleason@diabetes.org 703-549-1500 ext. 2622

The American Diabetes Association (ADA) is recommending changes in the way pregnant women are tested for gestational diabetes, which will likely result in a doubling of the number of women diagnosed, but should also reduce the health risks to mother and baby.

The new testing guidelines are published in a special supplement to the January issue of Diabetes Care as part of the Association's revised Standards of Medical Care, which are updated annually to provide the best possible guidance to health care professionals for diagnosing and treating adults and children with all forms of diabetes.

Currently, there are inconsistent standards around the world for how women are tested for gestational diabetes – a type of diabetes that comes on during pregnancy and resolves after delivery – as well as inconsistent cutpoints for diagnosis. Recent evidence from the Hyperglycemia and Adverse Pregnancy Outcomes (HAPO) study, a multinational epidemiologic study, has shown that the risk of adverse maternal, fetal and neonatal outcomes rises in direct relation to the mother's glucose levels. It also found that risks are present at glucose levels previously felt to be normal (below prior cutpoints for diagnosing gestational diabetes). Therefore, the International Association of Diabetes and Pregnancy Study Groups, a consensus group which includes the ADA, developed new recommendations using the HAPO data for the testing and diagnosis of diabetes during pregnancy. The American Diabetes Association has officially adopted these recommendations.

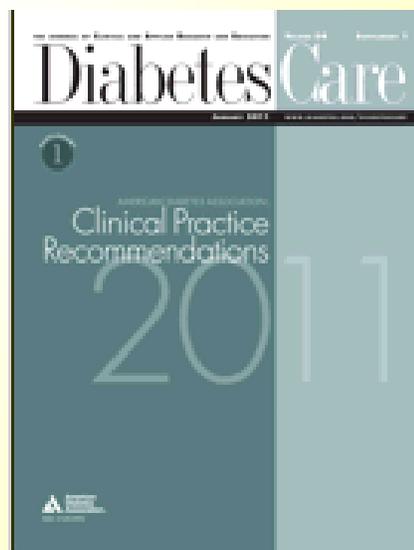
The new recommendations call for testing all women not previously known to have diabetes using the 75-gram oral glucose tolerance test (OGTT) between 24 and 28 weeks of gestation and using diagnostic cutpoints of greater than 92 mg/dl for the fasting glucose test; greater than 180 mg/dl one hour after drinking the 75-gram glucose solution; and greater than 153 mg/dl two hours after drinking the glucose solution.

The new guidelines also call for testing all pregnant women with risk factors for type 2 diabetes at their first neonatal visit, due to the rising prevalence of undiagnosed type 2 diabetes in women of childbearing age. However, a diagnosis at this stage would be

considered a diagnosis of type 2 diabetes and not gestational diabetes.

“We support a world-wide, uniform definition of gestational diabetes, and this is the best way to get there,” said Dr. Carol Wysham, Chair of the Professional Practice Committee. “However, we also recognize that health systems need time to convert to the new strategy and in the interim, they can continue to use prior methods for diagnosis until they can make the switch. It's important that they do ultimately convert, though, as the new definition will enable us to ward off preventable complications in both mother and child.”

Under the current guidelines, roughly 135,000 women in the United States are diagnosed with gestational diabetes each year, or 4 percent of all pregnant women. This figure is expected to double under the new diagnostic criteria, though the additional diagnoses will be women with mild GDM that can generally be treated with lifestyle change (diet and exercise). More severe cases of GDM, which were generally picked up with the older criteria, may require the mother to take insulin. Left untreated, gestational diabetes can lead to overweight babies, complications during delivery and a higher risk for both mother and child to develop type 2 diabetes later in life.



**For more information go to:
[http://care.diabetesjournals.org/
content/34/Supplement_1](http://care.diabetesjournals.org/content/34/Supplement_1)**

SUMMARY OF REVISIONS TO THE 2011 DIABETES CLINICAL PRACTICE RECOMMENDATIONS

Revisions to the Diagnosis and Classification of Diabetes Mellitus position statement:

The section on diagnosis of gestational diabetes mellitus has been revised to reflect use of the 75-g oral glucose tolerance test and new diagnostic criteria.

Additions to the Standards of Medical Care in Diabetes position statement:

A section titled “Transitions in care for youth with diabetes” has been added.

A section titled “Monogenic forms of diabetes” has been added.

Revisions to the Standards of Medical Care in Diabetes position statement:

In addition to many small changes related to new evidence since the prior version, the following sections have undergone major changes:

III. DETECTION AND DIAGNOSIS OF GESTATIONAL DIABETES MELLITUS has been revised to reflect use of the 75-g oral glucose tolerance test and new diagnostic criteria.

VI.A.1. Hypertension/Blood Pressure Control has been revised to reflect new evidence reinforcing the importance of individualization of blood pressure goals.

VI.B. Nephropathy Screening and Treatment has been revised to include a table of suggested management for complications of more advanced chronic kidney disease.

VII.A. Children and Adolescents has been revised to remove lower limits on A1C targets and to include discussion on appropriate individualization and safety.

IX. STRATEGIES FOR IMPROVING DIABETES CARE has been revised to reflect growing evidence for the effectiveness of restructuring systems of chronic care delivery.

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For more information go to:
[http://care.diabetesjournals.org/
content/34/Supplement_1](http://care.diabetesjournals.org/content/34/Supplement_1)



Order FREE **Stop Diabetes** Community Leader Kits today

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VEY_ID=28002&ACTION_REQUIRED=
URI_ACTION_USER_REQUESTS](http://stopdiabetes.diabetes.org/site/Survey?SURVEY_ID=28002&ACTION_REQUIRED=URI_ACTION_USER_REQUESTS)

DIABETES COOKING CLASSES MENU PERFECT FOR EASTER Too!

Submitted by Donna Heaverin, RN, BSN, Kentucky Diabetes Prevention and Control Program, Lincoln Trail District Health Department, GLADE, KDN member

Lincoln Trail District Health Department and Hardin Memorial Hospital joined together in December to present Holiday Cooking with Diabetes. Two classes were presented for approximately 30 participants.

Not only did participants learn ways to decrease the typical fat, carbohydrate, and calorie intake that comes with a traditional holiday meal, they received recipes they could take home and use.

Mechelle Coble, MS, RD, LD, CDE, Donna Heaverin, RN, BSN, and Roxanne True, MS, RD, LD, all of the Lincoln Trail District Health Department (LTDHD), demonstrated preparation of several recipes including taste testing enjoyed by the attendees. Menu items included pork tenderloin, steamed green beans, cranberry sauce, pumpkin trifle, and more.

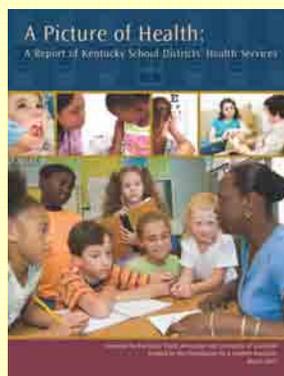
Excellent reports were received from participants about the food, and many stated they now had their menu for their Christmas (or Easter) dinner! Hardin Memorial Hospital and LTDHD plan to collaborate biannually to provide more diabetes and cooking demonstrations. Their next class will be in the spring about healthy cooking on a budget.



The "Cooking for Diabetes Control" team from left to right Donna Heaverin, Roxanne True, and Mechelle Coble

NEW KENTUCKY SCHOOLS HEALTH SERVICES REPORT NOW AVAILABLE!

Kentucky Youth Advocates and the University of Louisville recently released a study on districts' school health services during the 2008-2009 school year. The project, funded by the Foundation for a Healthy Kentucky, included a voluntary survey sent to Kentucky's 174 public school districts and a survey sent to Kentucky health care providers. Results included 137 responding districts which covers more than 80 percent of the student population in Kentucky. *A Picture of Health: A Report of Kentucky School Districts' Health Services*, provides a comprehensive view of KY school health services.



Access the full report at:
http://www.kyyouth.org/docu-ments/11pub_picture_of_health.pdf

NEW KY Needle Disposal Fact Sheet Now Available

Updated January 2011

New version at:

<http://waste.ky.gov/RLA/Pages/Fact-Sheets.aspx>

Sheets.aspx

(under Medical Waste

Disposal / Home Needle Disposal)



TRI-STATE HEALTH MINISTRY LEADERSHIP MEETING

Friday, May 13, 2011
 9:30 a.m. – 2 p.m.
 Mother of God Church
 119 W. 6th Street, Covington, KY 41011

Learn more about an opportunity to participate in the Faith United to End Childhood Obesity initiative from the Campaign for Healthy Kids.

The project is funded by Save the Children and the Robert Wood Johnson Foundation as part of the national effort to reverse the childhood obesity epidemic. “Campaign for Healthy Kids” is working with local partners across the country, with the aim to accelerate state and local policy change to increase children’s access to affordable healthy food and opportunities for physical activity. Campaign materials will be provided.

Registration Deadline: May 6th, 2011

Contact: Sharon Becker, Dayton, OH 937-227-9454 or
 Marlene Feagan, Covington, KY 859-655--6749

SPECIAL CIRCUMSTANCES IN DIABETES

27TH ANNUAL TRADE WORKSHOP
 Applied to Meet Certified Diabetes Educator Requirements for Recertification:

May 20, 2011
 8:30 AM – 4:45 PM

St. Mary’s Medical Center
 Manor Building
 (Evansville, IN)

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



TRADE

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

- Topics include:
- **NEW Techniques for Eating Healthier
 - **Newest Gestational Diabetes Guidelines
 - **Diabetes and Dental Disease
 - **Diabetes Care in a Disaster
 - **Obesity and Type 2 Diabetes Epidemic
 - **CDC’s Diabetes Translation Division – Tools and Resources
 - **And More....

For more information or a brochure contact:
 Nancy Walker at
nancy.walker@grdhd.org
 Or call 270-686-7747 X 3019.

EDUCATIONAL OFFERINGS

SAVE THE DATE
 Friday, September 23, 2011
 KADE sponsored all day symposium



“Illuminating Ideas for Diabetes Education”

This all day symposium will explore various topics that will assist in helping to make your daily diabetes education more invigorating! Check the KADE website for more information and location!



Check the KADE website for more information and Details!
<http://kadenet.org/>

KY Statewide Diabetes Symposium 2011

Save the Date!

| November 2011 | | | | | | |
|---------------|----|----|----|----|----|----|
| SU | MO | TU | WE | TH | FR | SA |
| | | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |



*** Friday, November 18, 2011 ***

Application will be made for CEUs for Nurses, Dietitians, Pharmacists, and other Healthcare Professionals, as well as hours for CDE

Location: Lexington, KY
 Registration forms available in July

This symposium is being organized by
Kentucky Local Networking Groups of the American Association of Diabetes Educators (AADE)



- Diabetes Educators of the Cincinnati Area (DECA)
- Greater Louisville Assn. of Diabetes Educators (GLADE)
- Kentucky Assn. of Diabetes Educators (KADE)
- Tri-State Assn. of Diabetes Educators (TRADE)



**Kentucky Diabetes Network
 Kentucky Diabetes Prevention & Control Program**

For additional information regarding this program, please contact:
 Julie Shapero RD, LD (859) 363-2416 (julie.shapero@nkyhealth.org)

Or

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

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ADA ALERT DAY NOW EXTENDED FOR A MONTH! FREE STOP DIABETES KITS AVAILABLE TO ORDER!

The American Diabetes Association (ADA) Alert Day was held the fourth Tuesday in March, however, it is now being extended through April 22! Diabetes Alert is a “wake-up” call asking the American public to take the Diabetes Risk Test to find out if they are at risk for developing type 2 diabetes. ADA is asking the public to “*Join the Million Challenge*” by rallying one million people to take the Diabetes Risk Test **beginning on Diabetes Alert Day on March 22, 2011 through April 22, 2011**. Participants may log on to stopdiabetes.com and click on “take the test” or call 1-800-DIABETES. The test, available in English or Spanish, determines low, moderate or high risk for type 2 diabetes through a series of questions about weight, age and family history.

**Diabetes educators may order FREE STOP DIABETES KITS
(SEE PAGE 15 OF THIS NEWSLETTER FOR DETAILS).**

**Or contact Helen Overfield at the ADA KY office,
161 St. Matthews Avenue, Suite #3, Louisville, Kentucky 40207
office phone (502) 452-6072 x 3317**

TAKE THE DIABETES RISK TEST

Know your risk for type 2 diabetes.

American Diabetes Association.
ALERT! DAY

JOIN THE MILLION CHALLENGE

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).

**2011 Dates: March 11th; June 3rd;
September 16th; November 4th**

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 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

ENDOCRINOLOGISTS MEETINGS SCHEDULED

The Ohio River Regional Chapter of the American Association of Clinical Endocrinologists (AAACE) 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

71ST ADA SCIENTIFIC SESSIONS

If you are involved in diabetes research or the delivery of diabetes care and services—Don't miss this chance to join your colleagues at the world's largest and most prestigious diabetes meeting. It provides cutting-edge education and information for all members of the health care community.

Date: June 24-28, 2011

**Location: San Diego Convention Center
San Diego, California**

**For information on fees or to register, visit:
https://www2.cmrreg.com/ada_3s/**



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 a meeting schedule or to register, contact Melissa Kleber diabetesed@rocketmail.com.



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 Nancy Walker at nancy.walker@grdhd.org.

All Programs Offer 2 Free Contact Hours

**2011 Dates: May 20th (Workshop);
July 21st; October 20th**



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preventdiabetes@ymcalouisville.org

Central Kentucky:
 Diabetes Prevention Program Coordinator
 Keoka Caulder 859-367-7333
Ddean@ymcaofcentralkentucky.org or kcaulder@ymcaofcentralky.org

Contact Information



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www.diabetes.org
 1-888-DIABETES



TRADE
 Tri-State Association of Diabetes Educators

AN OFFICIAL CHAPTER OF THE
 American Association of Diabetes Educators

AADE



KDN
 KENTUCKY DIABETES NETWORK, INC.

www.kentuckydiabetes.net

KENTUCKY ASSOCIATION
 of DIABETES EDUCATORS



KADE

Bluegrass / Eastern Chapter
 A Chapter of AADE

www.kadenet.org



www.louisvillediabesity.org



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www.jdrf.org/chapters/KY/Kentuckiana
 1-866-485-9397



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AADE



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.