

# 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 DIABETES COALITION EFFORTS PROFILED AT APPALACHIAN CONFERENCE

*Submitted by Reita Jones RN, BSN, KY Diabetes  
Prevention and Control Program, KY Department for  
Public Health, Frankfort, KY, KDN and KADE Member*

The Diabetes Division at the Centers for Disease Control and Prevention (CDC) has had a partnership with the Appalachian Regional Commission since 2001 to address the high prevalence of diabetes in the 13 Appalachian states particularly targeting areas designated as “distressed counties”. The project is directed and managed by Marshall University and makes \$10,000 grants periodically available to eligible communities for forming or strengthening community partnerships or coalitions to address diabetes needs. **This project has awarded a total of 67 grants over the last 8 years with 20 of them going to Kentucky communities.**

Recently these Appalachian project grantees were invited to attend a conference in

Nashville, Tennessee called *Diabetes Coalitions Celebrating Success 2009*. Kentucky had representation at the conference from five local diabetes coalitions, faculty at Morehead State University and the state Diabetes Prevention and Control Program.

Three of Kentucky’s diabetes coalitions were on the conference agenda to profile one of their coalition’s projects. **Kentucky presenters included Ken Simon with the Powell County Diabetes Coalition, Gwenda Adkins & Ann Thornberry with the Elliott County Coalition, and Rita Rogers & Candace Middleton of the Wolfe County Diabetes Coalition.**

It was exciting and encouraging to learn of all the good work these coalitions are doing to address diabetes-related needs in our Kentucky communities.

### Great Work — Representing Kentucky at the Appalachian Conference!



*Standing from top left: Ken Simon, Powell County Diabetes Coalition, Reita Jones, Kentucky Diabetes Prevention and Control Program, Candace Middleton, Wolfe County Diabetes Coalition, Ann Thornberry & Gwenda Adkins, Elliott County Coalition, Leslie Coffey, Get Healthy McCreary County & Wayne County - Growing Healthy Kids Coalition. Sitting from left: Judy Caldwell, Wolfe County Diabetes Coalition, Ann Rathbun, Morehead State University, Mary Billings & Rita Rogers, Wolfe County Diabetes Coalition*

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# DR. POHL'S COLUMN:

## HEMOGLOBIN A1C REVISITED



*Submitted by Stephen Pohl, MD, Endocrinologist, Lexington, KY, KDN, ADA, and ACE member*

Hemoglobin A1c interpretation presents several issues for the clinician. Some of these issues are merely annoying; others represent significant limitations on the

usefulness of this venerable laboratory test. Fortunately, a lot is going on in A1c-ology including a policy to use something called the **ADAG** (A1c-Derived Average Glucose) and a recommendation to use hemoglobin A1c as a test for diagnosis of diabetes. In the following paragraphs, I discuss these issues in order from annoying through complex.

### ***“Hemoglobin A1c” is a mouthful...***

Over the years my patients referred to hemoglobin A1c as “my what?”, “my three month test”, “that number”, and other expressions that clued me in to a communication problem. The American Diabetes Association recognized this issue a few years ago and recommended simply calling the test “A1c”. I found limited patient acceptance of the name A1c. There seemed to be no alternative to investing the time required to ensure that each patient understood the test and its interpretation. A1c is, however, a useful written abbreviation; so, I will use it from this point on.

### ***Chronic renal failure and certain anemias and hemoglobinopathies render A1c uninterpretable...***

These comorbidities as a rule cause the A1c to be lower than predicted from patients' blood sugars. A technical explanation of why this is so is beyond the scope of this article. Fortunately, several A1c measurement techniques automatically detect hemoglobinopathies, and renal status is usually known. Anemias are more subtle, particularly since Medicare stopped paying for routine blood counts. It is good practice to look for comorbid conditions when a patient's A1c differs widely from the rest of the clinical picture.

### ***A1c results produced by the many available measurement techniques are generally not comparable...***

Inter and intra patient comparisons may be misleading if the tests were performed in different laboratories. The history of this problem is quite complex, and it still is not fully resolved. For now, it is unwise to use A1c results for clinical purposes unless the laboratory reporting the results uses a method that has certification by the National Glycohemoglobin Standardization Program (NGSP). Certified assay methods have an upper limit of normal of about 6.0%. Any laboratory report that lists a higher upper limit of normal is suspect.

### ***A1c numbers have no inherent meaning to patients...***

Values for A1c tests range from about 4 to 20 and do not relate to anything else familiar to persons with diabetes. Furthermore, the unit of measure, percent, is confusing and can be ambiguous. For example, a decrease of 1% in an A1c value of 8% could result in a value of either 7.00% or 7.92%. It has been known for many years that the amount of hemoglobin A1c in blood is directly proportional to the average blood glucose concentration for a period of about three months. Therefore, the possibility has existed that A1c values could be expressed in terms of average glucose instead of percent of total hemoglobin.

In 1993, data from the Diabetes Complications and Control Trial (DCCT) showed that the average blood glucose could be calculated by subtracting 2 from the A1c value and multiplying the difference by 30. Since then many clinicians have used this simple relationship to inform patients regarding their average blood sugar levels in familiar units. It is important to note, however, that the raw A1c value expressed in percent estimates risk of diabetes complications. The only reason to calculate an average glucose is for patient education and comfort. The accuracy of the calculated average glucose is not nearly as important as the accuracy of the underlying A1c level expressed in percent.

Unable to let well enough alone, an international consortium of prominent diabetes professional societies a few years ago established the A1c Derived Average Glucose (ADAG) Study Group. Last summer the Study Group reported that more accurate average blood glucose

# DR. POHL'S COLUMN: HEMOGLOBIN A1C REVISITED (CONTINUED)

estimates could be obtained from the following formula:  
Average Glucose = 28.7 X A1c – 46.7. Before committing this formula to memory, however, let's look at what happens when we apply it. The following table is from the ADAG Study Group publication. To it I have added the values obtained by using the old DCCT formula. While it is reassuring to have rigorous scientific confirmation of what we have been doing for over fifteen years, I prefer “subtract 2 and multiply by 30” to a method that requires either a calculator or a conversion table.

A1c %	Average Glucose ADAG mg/dl	Average Glucose DCCT mg/dl
5	97	90
6	126	120
7	154	150
8	183	180
9	212	210
10	240	240
11	269	270
12	298	300

*ADAG Study Group Publication Chart Adapted by Dr. Pohl Who Added the Old DCCT Formula as Comparison*

***Calculated average glucose values are generally higher than the average glucose on glucose meters...***

This news is about as welcome as finding that the doctor's scale shows your weight to be 10 lbs higher than your home scales. The correct procedure is to explain to the patient that it doesn't matter because the raw A1c number is the risk predictor. However, I can promise that this explanation will draw a blank look from most patients. Risk reduction is a difficult concept to get patients to understand and use. Instead I explain that they are not seeing many of the high blood sugars that normally occur after meals and that to get an A1c below 7.0 it is necessary to keep the meter average close to 100 mg/dl.

***Hemoglobin A1c should be used to diagnose diabetes...***

This year's ADA Annual Meeting received the Expert Committee Report on the Role of the Glycohemoglobin Assay in the Diagnosis of Diabetes. In summary, the committee recommends diabetes should be diagnosed when A1c is  $\geq 6.5\%$ . I find this recommendation compelling largely because, to me, risk reduction, i.e. maintaining a good A1c level, is a more important issue than diagnosis. It is important to note that for now this is only a recommendation and is not yet ADA policy. Furthermore, there are many glucocentric diabetologists in the world. Getting them to give up their cherished fasting blood sugar or even more cherished oral glucose tolerance test will be a battle.

### ***In conclusion...***

Hemoglobin A1c is arguably the most valuable test we have for managing diabetes. There are, however, several limitations and nuances that clinicians must understand in order to use the test properly. Nevertheless, explaining the A1c to patients and helping them do everything possible to keep the number low was the most rewarding aspect of my career.

Results of the A1C-Derived Average Glucose study affirmed the existence of a linear relationship between A1C and average blood glucose levels. As a result, the ADA is promoting use of estimated average glucose or eAG. Patients will be able to receive A1C% and/or eAG values that relate to blood glucose values in mg/dl.

Formula  $28.7 \times A1C - 46.7 = eAG$ .

CONVERSION TABLE		
A1C	eAG	
%	mg/dl	mmol/l
6	126	7.0
6.5	140	7.8
7	154	8.6
7.5	169	9.4
8	183	10.1
8.5	197	10.9
9	212	11.8
9.5	226	12.6
10	240	13.4

*A1C-Derived Average Glucose Chart taken from National Diabetes Education Publication "Guiding Principles for Diabetes Care: For Health Care Professionals", p. 12, NDEP-16 Revised April 2009*

# NEW REPORT SHOWS RECORD NUMBER OF MEDICINES BEING DEVELOPED TO TREAT DIABETES

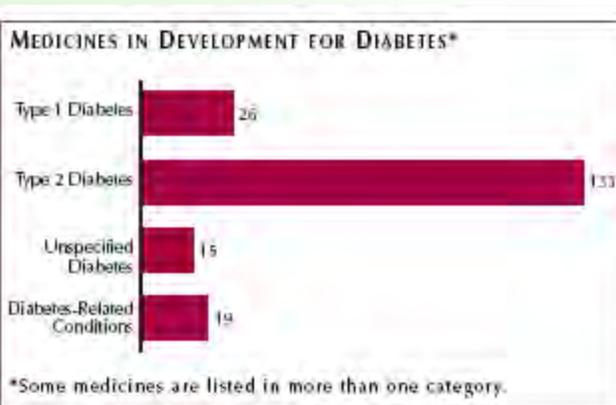
*Taken in Part From May, 2009, News Release, Pharmaceutical Research and Manufacturers of America*

The Pharmaceutical Research and Manufacturers of America (PhRMA) unveiled a new report in May, 2009, on medicines in the research pipeline for diabetes. The report shows that America's pharmaceutical research and biotechnology companies are testing a record 183 new diabetes medicines. The medicines listed in the report are being tested in human clinical trials or are awaiting approval by the U.S. Food and Drug Administration. The complete report and list of medications may be viewed at <http://www.phrma.org/files/Diabetes%202009.pdf>.

The new report was released at a press conference in North Carolina featuring actor Jerry Mathers, who suffers from diabetes and works to raise awareness of this devastating chronic disease. An American icon, Mathers is best known for his portrayal of "Beaver" in the television classic, "Leave It To Beaver".

## **New medicines in the development stage include the following:**

- A first-in-class medicine that significantly improves long-term blood sugar control and targets the dysfunction of pancreas cells, a dysfunction that causes high sugar level in type 2 diabetes.
- A medicine that addresses the underlying cause of type 2 diabetes by modulating genes responsible for insulin sensitization.
- A medicine that stimulates the release of insulin only when glucose levels become too high and by suppressing appetite in patients with type 2 diabetes.



"We released this report in North Carolina because of the alarming rise in the number of new cases of diabetes in the state. Unfortunately, these rising numbers reflect what is occurring nationwide," said PhRMA Senior Vice President Ken Johnson, who discussed the findings of the report at the SAS Institute located in the Research Triangle Park Corridor.

Nationwide, diabetes affects more than 30 million Americans, or about 8 percent of the U.S. population. New cases of it have risen more than 90 percent among adults over the last 10 years, and since 1987 the number of deaths from the disease has risen by 45 percent, according to the U.S. Centers for Disease Control and Prevention and the American Diabetes Association.

## **View full report at:**

<http://www.phrma.org/files/Diabetes%202009.pdf>

"The diabetes medicines now in the research pipeline are contributing substantially to the incredible progress made in the last five years by biopharmaceutical companies in developing new and more effective diabetes treatments," says Billy Tauzin, PhRMA President and CEO. "The nation must continue its strong commitment to the cutting-edge pharmaceutical research that enables today's diabetes patients to manage their disease and lead productive lives."

"The work being done by the pharmaceutical industry to develop new treatments for diabetes and other chronic diseases is extremely important because chronic disease is responsible for seven of ten American deaths and 75 percent of the nation's \$2.2 trillion health care bill," said APhA Foundation CEO William M. Ellis. "The American Pharmacists Association Foundation is committed to helping patients gain the full benefit of their treatments, while reducing overall health care costs as we did during The Diabetes Ten City Challenge <http://www.diabetestencitychallenge.com/>".

Tauzin noted that while researchers are making exciting progress in the search for new cures and treatments for diabetes, these efforts are wasted if the medicines developed aren't accessible to patients who need them.

**Help is available to patients in need of medications through the Partnership for Prescription Assistance ([www.pparx.org](http://www.pparx.org) or 1-888-4PPA-NOW), which is sponsored by America's pharmaceutical research companies. PPA has helped more than 5.7 million patients nationwide.**

# KENTUCKY PRESENTATIONS AT NATIONAL CENTERS FOR DISEASE CONTROL (CDC) DIABETES TRANSLATION CONFERENCE 2009



*Teri Wood, PhD with the KY Diabetes Prevention and Control Program (KDPCP) presented "Public Health Meets Medicaid and Primary Care: Improving Outcomes for KY Medicaid Diabetes Patients" at the Diabetes Conference in Long Beach, CA*



*Janey Wendschlag RN, BSN with the KY Diabetes Prevention and Control Program, Lexington Fayette County Health Department, presented "TRANE Commercial Systems Wellness Program — A Public Private Partnership" at the CDC Conference*



*Janice Haile RN, CDE with the KY Diabetes Prevention and Control Program presented "Kentucky Death Certificate Update 2009" at the 2009 CDC Diabetes Translation Conference*



*In addition, other KDPCP staff Teresia Huddleston (Barren River District) and Jamie Lee (Lake Cumberland District) served as session moderators while Jamie Lee, Donna Jones (Lake Cumberland), Jan Lazarus (Northern KY District), Janey Wendschlag, and Janice Haile volunteered to work the American Association of Diabetes Educators (AADE) Public Health Specialty Practice Group Exhibit.*



## ***Schoolwalk for Diabetes***

**This new program by the American Diabetes Association (ADA) provides lesson plans and activities so schools can educate children regarding diabetes, while promoting physical activity and supporting a great cause! The program allows the school an opportunity to earn free PE equipment based upon money the school raises. For information, go to [diabetes.org/schoolwalk](http://diabetes.org/schoolwalk).**

**Get in on the fun!**

This is an event to benefit the American Diabetes Association and its mission to prevent and cure diabetes and to improve the lives of all those affected by diabetes.

**American Diabetes Association**  
**SCHOOLWALK**  
Educate youth on diabetes, promote physical activity and support a great cause!  
[diabetes.org/schoolwalk](http://diabetes.org/schoolwalk) **1-888-DIABETES (342-2383)**



# DIABETES LEGISLATIVE NOTES

Submitted by: *Gina Wood, West Virginia Diabetes Prevention and Control Program*

If you work in diabetes, there are several pieces of legislation which have been newly introduced on both federal and state levels which may have implications for your particular program or practice.

## ***H.R. 2425 Medicare Diabetes Self-Management Training Act of 2009***

On the federal level, ***H.R. 2425 Medicare Diabetes Self-Management Training Act of 2009*** was introduced on May 14 and is referred to the Committee on Energy and Commerce as well as the Committee on Ways and Means. This bill seeks to amend title XVIII of the Social Security Act to improve access to diabetes self-management training by designating certain certified diabetes educators as certified providers for purposes of outpatient diabetes self-management training services under Part B of the Medicare Program.

The American Association of Diabetes Educators (AADE) encourages diabetes educators and advocates to participate in an e-petition regarding this bill. James Specker, Advocacy Specialist with AADE writes “The purpose of this e-petition is to get as many people as possible to tell Congress to pass the Medicare DSMT Act as part of national health reform. The petition is open to the public and AADE is asking that you spread the word and get your peers, patients, friends, families, etc... to sign and support this effort”.

The petition can be viewed by clicking (or copy and pasting) the following URL: [www.diabeteseducator.org/supportCDElegislation](http://www.diabeteseducator.org/supportCDElegislation).

### **Ways To Spread the Word:**

- Have the e-petition, where possible, available in your office for patients to sign
- Send the link with a quick note to your family and friends encouraging them to support this effort and ask them to forward along as well
- Add the URL to your signature line on emails
- Make it a priority at your chapter meetings

## ***H.R. 1402 Catalyst to Better Diabetes Care Act of 2009***

Secondly, also on the federal level, ***H.R. 1402 Catalyst to Better Diabetes Care Act of 2009*** was introduced on March 9, and is referred to the House Committee on Energy and Commerce.

The purpose of this bill is to catalyze change in the care and treatment of diabetes in the U.S. The bill calls for consideration of the following:

- 1) Establishment of a diabetes screening, collaboration and outreach program for the purposes of reducing the number of undiagnosed seniors with diabetes or pre-diabetes.
- 2) Establishment of an advisory group regarding employee wellness and disease-management best-practices.
- 3) Production of a national diabetes report card.
- 4) Improvement of vital statistics collection and
- 5) A study on the appropriate level of diabetes medical education.

## ***Diabetes Coordinator Legislation***

There is also a new bill that is being introduced into individual state legislatures for which the generic name is ***Diabetes Coordinator Legislation***.

Denise Cyzman, Consultant with the National Association of Chronic Disease Directors writes, “The legislation would establish a State Diabetes Coordinator position within the state’s lead public health official’s office. The Coordinator would be appointed by the lead official in consultation with the governor or governor’s designee. The Coordinator would report directly to the commissioner.

Generally, the Coordinator would:

- Serve as the principle advisor to the lead public health official (e.g., health officer, health director, Secretary of health, or health commissioner) on ways to save lives, improve the quality of life and save money for taxpayers and patients by reducing the rates of diabetes and its complications;
- Develop a way to measure the incidence of diabetes;
- Develop and coordinate implementation of statewide strategy to reduce the incidence, progression and impact of diabetes and its complications;
- Provide leadership and coordination between government agencies across the public and private health sectors to ensure that diabetes-related programs and policies of the Department of Health are coordinated internally and with those of relevant Federal, State and local agencies with the goal of avoiding duplication of effort, maximizing impact and marshaling all governmental resources; and
- Coordinate public and private resources to develop and lead a public awareness campaign regarding the prevention and control of diabetes and its complications

***Watch this Newsletter For More Diabetes Legislative Updates***

# RECENT CHANGES MADE BY THE NATIONAL CERTIFICATION BOARD FOR DIABETES EDUCATORS (NCBDE)

Taken in part from the National Certification Board for Diabetes Educators (NCBDE) June, 2009 Website

## Initial Diabetes Educator Certification Eligibility Requirements to Change in 2010

After meeting the Discipline requirement **AND** before applying for the Examination, all (A through C) of the following requirements must be met:

- A. Minimum of 2 years (to the day) of professional practice experience in the discipline under which the individual is applying for certification (examples: if an individual applies for certification as a registered nurse, 2 years experience working as a registered nurse is required; if an individual applies as a registered dietitian, 2 years experience working as a registered dietitian is required).

**AND**

- B. Minimum of 1,000 hours of professional practice experience in diabetes self-management education **with a minimum of 40% (400 hours) accrued in the most recent year preceding application.**

*In meeting the hourly requirement, professional practice experience is defined as employment for compensation as a diabetes educator in the United States or its territories within the **past four years**. Employment for compensation means to hold a job in which one is actively engaged in diabetes self-management education and for which paid income is comparable to other diabetes educators in the same area or region of the country.*

**AND**

- C. **Minimum of 15 clock hours of continuing education activities applicable to diabetes within the 2 years prior to applying for certification.**

This requirement will follow the same overall guidelines as renewal of certification by continuing education.

**NOTE: The requirement identifying the need for current employment in a defined diabetes educator role providing diabetes self-management education a minimum of four hours per week, or its equivalent, at the time of application will no longer apply.**

## CDE PRACTICE EXAMINATION NOW AVAILABLE

In March, 2009 NCBDE announced that a CDE practice examination is now available for the Certification Examination for Diabetes Educators.

- ✦ The CDE® Practice Exam (PE) contains 50 multiple-choice questions and is illustrative of the type and format of questions used in the actual exams and allows an individual to practice taking an abbreviated version of the exam.
- ✦ The fee to take the PE is \$50. Individuals can take the PE on-line within a 60 day window after purchase.

For more information about the PE and how to purchase one, please go to the NCBDE's testing agency's web site at [www.goamp.com](http://www.goamp.com).

## Renewal Practice Requirement Begins in 2010

The NCBDE Board of Directors has approved a practice requirement for renewal of certification. Beginning with CDEs whose credentials will expire 12/31/2010 (formerly 12/31/2009), individuals will need to document a minimum of 1000 hours of professional practice experience during the five-year certification cycle, in addition to either taking the Certification Examination or renewing by continuing education. The professional practice requirement for renewal of certification, however, is not the same as that required for initial certification.

## Definition of Professional Practice

### What is Included in this Definition

This definition is intended to be as inclusive as possible of positions currently held by CDEs, including program development, program management, public health / community surveillance, diabetes related research, clinical roles in diabetes industry, case management, professional education, consultant roles to industry or other providers, or others.

### What is NOT Included in this Definition

Employment in the manufacture, direct sales, or distribution of diabetes-related products or services in pharmaceutical or other diabetes-related industries, public health screenings, jobs unrelated to diabetes, and participation in diabetes camp will not meet the practice requirement, nor will preceptorship/mentor or other volunteer hours of any kind.

**For more information:** [www.ncbde.org/](http://www.ncbde.org/)

## AADE'S NEW DIABETES EDUCATION ACCREDITATION PROGRAM

### IMPORTANT INFORMATION FOR DIABETES EDUCATORS

*Submitted by: Lois Moss-Barnwell, MS, RD, LDN, CDE, Director,  
Diabetes Education Accreditation Program, American Association of  
Diabetes Educators*

AADE urges you to learn more about the Diabetes Education Accreditation Program (DEAP). Diabetes educators around the country have heralded DEAP as a promising program that can expand access to quality programs for people with diabetes.

AADE is now one of three organizations to receive approval from the Centers for Medicare and Medicaid Services to accredit organizations for diabetes self-management training. The other two are the American Diabetes Association and the Indian Health Service. AADE's approval was posted in the Federal Register on February 27, 2009, effective March 30, 2009.

AADE has accredited thirteen programs with 70 sites thus far, including a church-based program at St. Luke's Episcopal Church in Germantown, Penn. Nadine Uplinger, MS, RD, CDE, BC-ADM, Albert Einstein Health Care Network in Philadelphia runs the program. She notes that, community-based clinics that don't receive accreditation have a difficult time surviving because only programs that are accredited will be allowed to bill Medicare and other insurance programs. With AADE accreditation, these types of programs are eligible for reimbursement and therefore become more viable. Like any accreditation program, there are a number of requirements, but Ms. Uplinger said that the application and site visit were straightforward.

AADE-accredited programs benefit from the availability of the AADE7 System tracking tools for patients' self-management goals. These tools, which are available free to AADE members, allow diabetes education programs to track and report their patients' behavior change and clinical indicators. The cost for AADE's accreditation is based on the number of sites a program has. For programs with up to 10 sites the fee is \$800; for programs with 11-20 sites the fee is \$1,200.

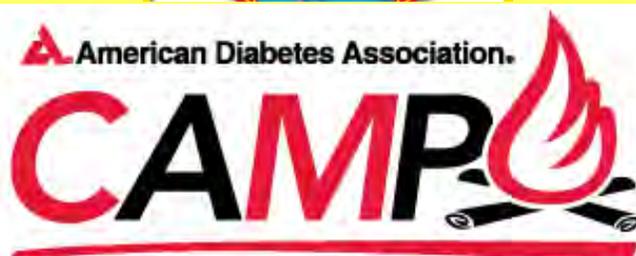
Find out more at: <http://www.diabeteseducator.org/accreditation> which includes all you need to know to become an AADE accredited program. Of particular note, are the podcast (Questions and Answers), the webcast (What To Expect & Getting Started) as well as the Federal Register CMS approval under Official Notices.

If you have any additional questions, please send them to [DEAP@aadenet.org](mailto:DEAP@aadenet.org) or call 800-338-3633.

## KENTUCKY DIABETES CAMP DATES SET

### 20<sup>th</sup> Annual Fun Camp for Children with Diabetes

- For Children with Diabetes grades K-8
- July 17, 2009
- 8:00 am—4:00 pm
- Masterson Station Park, Lexington, KY
- For information, call Melissa Combs-Wright, MS, RD, CDE, UK Pediatric Endocrine (859) 323-5404 X 274
- Sponsors: Kentucky Association of Diabetes Educators (KADE) and the Lexington Lion's Club



**Camp Hendon • Carrollton, KY**

**July 26 - August 1, 2009  
Held at Camp KYSOC**

- Camp Hendon at Kysoc, 1902 Easterday Road, Carrollton, KY
- July 26 — August 1, 2009
- For children with diabetes 9-15 years
- \$350 (ADA Member); \$375 (Non ADA Member)
- Apply online at [www.diabetes.org/adaCampHendon](http://www.diabetes.org/adaCampHendon) and click on Register for Camp
- Staffed 24 hours by medical staff
- Questions: Contact Erin Crosby, ADA, [ecrosby@diabetes.org](mailto:ecrosby@diabetes.org) or 888-DIABETES X 6662 or 513-759-9330
- [www.diabetes.org/adacamphendon](http://www.diabetes.org/adacamphendon)

# PREVENTING MEDICAL ERRORS IN DIABETES

A MESSAGE FROM FDA PATIENT SAFETY NEWS



U.S. Food and Drug Administration



*FDA Patient Safety News articles were submitted by Eva Stone, ARNP, School Health Coordinator, Lincoln County, Kentucky, School Health Services*

## Remove Insulin from Cartons

The Institute for Safe Medication Practices (ISMP) warns that facilities storing insulin vials inside their cardboard cartons after the packages have been opened can be a medical emergency waiting to happen. If the vial is accidentally returned to the wrong carton after being used, that sets the stage for a serious insulin mix-up. That is because the next person looking for a particular insulin product could read the label on the carton, assume that it accurately reflects what is inside, and end up administering the wrong product.

So ISMP recommends that the cartons be discarded, either in the pharmacy before the insulin is dispensed, or when it is received at the nursing station. The bottom line? Do not dispense or store insulin vials in their cartons on patient care units.

### Additional Information:

ISMP Medication Safety Alert! Remove Vials from Cartons. Volume 13, Issue 9. May 8, 2008. <http://www.ismp.org/newsletters/acutecare/articles/20080508-1.asp>

## Don't Share Insulin Pens Between Patients

The FDA is reminding health care professionals not to use a single insulin pen and cartridge on more than one patient. Even if needles are changed between patients, reusing these products on multiple patients may transmit blood-borne pathogens such as hepatitis or HIV between patients.

More than 2,000 patients with diabetes in two hospitals may have recently been put at risk of infection when insulin pens were used for more than one patient. Although staff changed the pen's disposable needle between patients, the pen itself was reused. Patients

who were exposed to the shared insulin pens are being contacted and offered testing for hepatitis and HIV. Some of the patients have reportedly tested positive for hepatitis C, although it is not known whether the pens were responsible for transmitting the virus.

The Institute for Safe Medication Practices points out that air bubbles and pathogenic contaminants can enter the cartridge after injection while the needle is still attached to the pen. ISMP cites studies showing that up to half of all insulin pen cartridges are contaminated after being re-used, and warns that facilities shouldn't assume that everyone understands the importance of following the "one pen, one patient" practice.

### FDA's Recommendations - Safe Use of Insulin Pens:

- Remember that insulin pens containing multiple doses are meant for only one patient, and should not be shared between patients.
- Label the insulin pen with the patient's name and other identifiers, but be sure that this doesn't obstruct the dosing window or other product information.
- Eject and discard the needle after each use and attach a new needle for each new injection.
- Tell patients to never share their insulin pens with another person, because this could result in transmission of hepatitis or other blood-borne diseases.
- Remember that the same risk may exist with any multiple-dose injector device, not just insulin pens.

### Additional Information:

- FDA MedWatch Safety Alert. Insulin Pens: Risk of Transmission of Blood-borne Pathogens from Shared Use. March 19, 2009. <http://www.fda.gov/medwatch/safety/2009/safety09.htm#Insulin>
- FDA Consumer Update. Insulin Pens are Not for Sharing. March 25, 2009. [http://www.fda.gov/consumer/updates/insulin\\_pens032509.html](http://www.fda.gov/consumer/updates/insulin_pens032509.html)
- ISMP Medication Safety Alert! Reuse of Insulin Pen for Multiple Patients Risks Transmission of Bloodborne Disease. Volume 14, Issue 3. February 12, 2009. <http://www.ismp.org/newsletters/acutecare/articles/20090212-2.asp>

## **KENTUCKY DEPARTMENT FOR PUBLIC HEALTH RELEASES**

### **NEW SURVEY FINDINGS**

*Submitted by as Gwenda Bond and Beth Fisher, Cabinet For Health and Family Services, Office of Communications, Frankfort, KY*

In May, 2009, the Kentucky Department for Public Health (DPH) released the state's 2008 Behavioral Risk Factor Surveillance Systems (BRFSS) data, a national survey conducted in all states now considered the world's largest, ongoing telephone health survey system.

Among other things, the survey found that in 2008 vast numbers of Kentuckians continue to categorize themselves as unhealthy and leading unhealthy lifestyles. The BRFSS, which is conducted by the Division of Prevention and Quality Improvement in DPH, looks at numerous health indicators, such as diet and physical activity, to determine the health and lifestyle habits of Kentuckians.

"The BRFSS is a wonderful tool that allows us to paint a portrait of our state's health status," said William Hacker, MD, DPH Commissioner. "Each year, we use information from this survey to learn more about health risk behaviors, shape recommendations for preventive health practices, and determine to what extent Kentuckians have access to care, particularly for chronic diseases like diabetes and heart disease."

The BRFSS program tracks health conditions and risk behaviors of adults 18 and older in the U.S. The Centers for Disease Control and Prevention (CDC) established the survey in 1984.

The Kentucky BRFSS is the main source of non-reportable disease data in Kentucky broken down by demographics like gender, race, age group, income levels, education status and geographic areas like Area Development Districts.

In 2008, Kentucky adults 18 years and older reported a 20.3 percent prevalence of fair or poor general health. In general, residents of Kentucky's Appalachian counties reported higher rates of poor health and chronic diseases than those in non-Appalachian counties. In addition, Kentuckians with a high school degree or less and those with lower income levels reported higher rates of poor health and chronic diseases. In terms of health care access, the BRFSS data found that 14.4 percent of Kentuckians 18 years and older reported lack of health care coverage in 2008. Lack of health care access is highest among residents of Appalachia with 20 percent

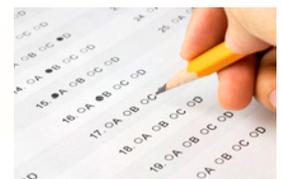
prevalence, men with 15.3 percent prevalence, and those ages 18-24 with 29.8 percent prevalence. Furthermore, those with less than a high school education and those earning less than \$15,000 per year reported 25.6 percent and 30.8 percent prevalence of lack of health care coverage respectively.

Here's a look at some other findings from the survey:

- 30.4 percent of Kentucky adults reported that they did not participate in any physical activities or exercise such as running, golf, gardening or walking for exercise other than their regular jobs.
- 9.6 percent of Kentuckians reported that they had been told by a doctor that they currently had asthma.
- 66.8 percent of Kentuckians are overweight or obese (have a Body Mass Index of 25 or greater).
- 30.2 percent of Kentuckians are obese (have a Body Mass Index of 30.0 or greater).
- Kentucky adults reported some of the highest prevalence of chronic diseases in the nation, such as diabetes, stroke and heart disease.
- 9.8 percent of Kentucky adults reported being told by a doctor that they had diabetes (not including women who were told they had diabetes when they were pregnant).
- 5.8 percent of Kentuckians reported that they had been told by a doctor that they had coronary heart disease.
- 5.4 percent of Kentuckians reported that they had been told by a doctor that they had suffered a heart attack.
- 3.5 percent of Kentuckians reported being told by a doctor that they had suffered a stroke.
- 25.2 percent of Kentuckians reported having smoked at least 100 cigarettes in their entire lifetime and now smoke some days or every day.

The BRFSS data contains more health indicators in addition to those listed in this report. To make an inquiry or request data or datasets, please send a request to either Tracey Sparks, program coordinator, at [tracey.sparks@ky.gov](mailto:tracey.sparks@ky.gov), or Yvonne Konnor, epidemiologist, at [yvonne.konnor@ky.gov](mailto:yvonne.konnor@ky.gov), or call (502) 564-0068.

**Public Information Officer**  
**Cabinet for Health and Family Services**  
**275 E. Main St.**  
**Frankfort, KY 40370**  
**(502) 564-6786 ext. 4012**  
**Fax: (502) 564-0274**



# Check This Out...

## “Guiding Principles for Diabetes Care for Health Care Professionals” !

Newly Revised April 2009

This wonderful newly updated tool , *Guiding Principles for Diabetes Care for Health Care Professionals*, was developed by the National Diabetes Education Program to help the health care team manage diabetes effectively. The principles included in this publication outline seven essential components of quality diabetes care and have quick and easy reference charts within each principle. Below are samples of the quick reference charts for Guiding Principle # 1.

**TABLE 1. Definitions of Pre-diabetes and Diabetes [1]**

Pre-diabetes	
IFG	Fasting plasma glucose (FPG) 100–125 mg/dl after an overnight fast
IGT	2-hr post 75g glucose challenge 140–199 mg/dl
Diabetes	
	Random plasma glucose $\geq$ 200 mg/dl with symptoms (polyuria, polydipsia, and unexplained weight loss) and/or FPG $\geq$ 126 mg/dl* and/or 2-hr plasma glucose $\geq$ 200 mg/dl* post 75g glucose challenge *Repeat to confirm on a subsequent day unless symptoms are present.

**TABLE 3. Case Finding Recommendations for Women with History of Gestational Diabetes [6]**

TIME	TEST
Post-delivery (1–3 days)	Fasting or random plasma glucose (PG)
6 to 12 weeks postpartum	2-hr PG post 75g glucose challenge
1 year postpartum	2-hr PG post 75g glucose challenge
Annually	Fasting PG
Every three years and before another pregnancy	2-hr PG post 75g glucose challenge

**Principle 1: Identify People with Undiagnosed Diabetes**

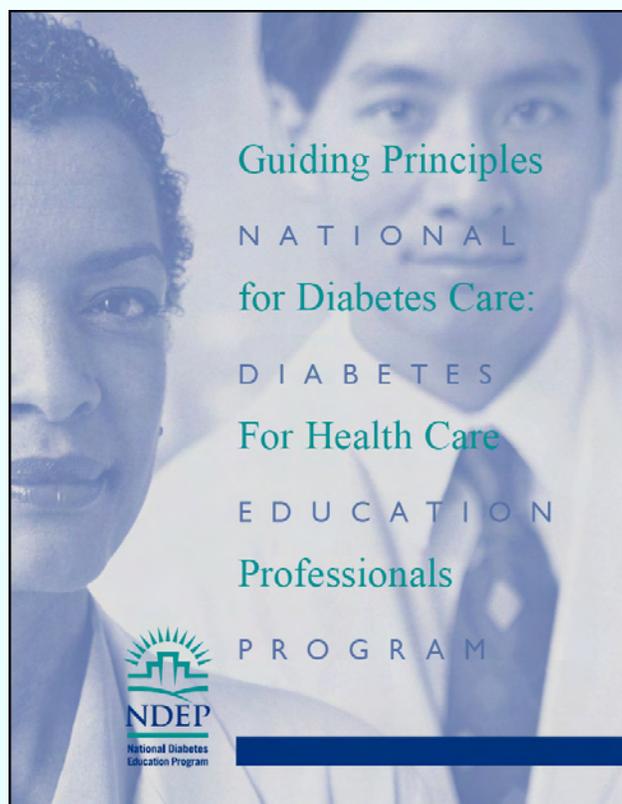
**Principle 2: Manage Pre-Diabetes to Prevent or Delay the Onset of Type 2 Diabetes and Its Complications**

**Principle 3: Provide Ongoing Self-Management Education and Support for People with Diabetes**

**Principle 4: Provide Comprehensive Patient-Centered Care to Prevent or Delay the Onset of Diabetes Complications and to Treat Diabetes and Existing Complications**

**Principle 5: Consider the Needs of Special Populations — Children, Women of Childbearing Age, Older Adults, and High-Risk Racial and Ethnic Groups**

**Principle 6: Provide Regular Assessments to Monitor Treatment Effectiveness and to Detect Diabetes Complications Early**



[www.YourDiabetesInfo.org](http://www.YourDiabetesInfo.org) 1-888-693-NDEP (6337)

**NDEP-16**  
**Revised April 2009**



# National Diabetes Information Clearinghouse (NDIC)

A service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), NIH



## THE NIDDK OFFERS HEALTH RESOURCES FOR MINORITIES

April marked National Minority Health Month, and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Clearinghouses offering publications and research that focus on many health issues affecting minority populations in the United States.

Each year, the NIDDK honors National Minority Health Month by informing the public about health issues prevalent among African Americans, Hispanics/Latinos, American Indians, Alaska Natives, Asian Americans, and Pacific Islander Americans. National Minority Health Month also provides a perfect opportunity for the public and health care professionals to discover the many health resources available to minorities from the NIDDK, part of the National Institutes of Health at the U.S. Department of Health and Human Services.

The NIDDK Clearinghouses publish fact sheets and easy-to-read booklets about diseases and disorders that affect minorities in greater numbers than the general population. These conditions include diabetes, hepatitis C, gallbladder disease, H. pylori infection, sickle cell disease, and kidney diseases. The NIDDK Clearinghouses also offer an array of publications in Spanish; resources from the NIDDK's national diabetes and kidney disease education programs, including several publications focusing on kidney disease in African Americans; and diabetes information in a variety of languages.

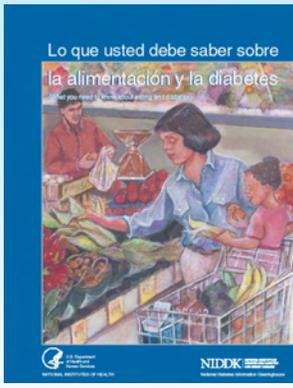
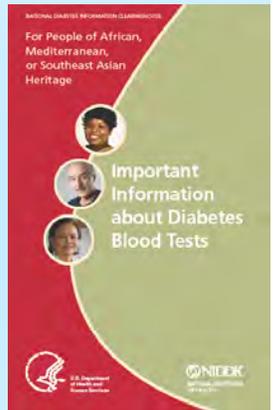
To access information about a wide variety of health conditions affecting minorities, visit the NIDDK Clearinghouse websites:

- National Diabetes Information Clearinghouse
- National Digestive Diseases Information Clearinghouse
- National Kidney and Urologic Diseases Information Clearinghouse

All NIDDK materials are reviewed by both NIDDK scientists and outside experts.

**Diabetes Dateline is a service of the National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health and may be viewed at:**

<http://diabetes.niddk.nih.gov/about/dateline/win09/1.htm>





*Did you get to attend the National American Diabetes Association (ADA) meeting in New Orleans?*

If not, the program is NOW available to purchase WEBCASTS (including contact hours)  
[http://www.diabetesconnect.org/storetemplate/08CE\\_Lectures.aspx](http://www.diabetesconnect.org/storetemplate/08CE_Lectures.aspx)

**FREE PROGRAMS INCLUDE:**

**Incretin Hormones and Whole Body Physiology**

- GLP-1/GIP Secretion—What’s Up? What’s Down?
- Incretins and the Brain
- Incretins and the Islet Cell Function

**New Incretin Mimetic Agents**

- New Incretin Mimetic Agents—Liraglutide and Others
- Dipeptidyl Peptidases—Physiological Functions and Overlapping Activities
- The Clinical Experience with Incretin-Based Therapies

**G-Protein Coupled Receptors in the Beta-Cell—Some Orphans Find a Home**

- Agonists for the GLP-1 Receptor — Once Daily Human GLP-1 Analogs and Small Molecule Ago—Allosteric Modulators

**Measuring Glycemic Control**

- Measuring Glycemic Control: Translating HbA1c into Estimated Average Glucose (eAG)

**PROFESSIONAL DEVELOPMENT  
RESOURCES FOR DIABETES EDUCATION  
2009**

***AADE Core Concepts Course***

**Program Description:** An intensive 3-day seminar on diabetes and diabetes self-management education. Course facilitators will help participants explore the core scientific basis for diabetes education and care and apply concepts to patient situations. Earn up to 22 CE credits.

**Where:** 9/23-25 – Chicago, IL  
 10/14-16 – Dallas, TX  
 10/21-23 – Orlando, FL

**Registration Information:** Online registration at: <https://www.diabeteseducator.org/ProfessionalResources/products/> and look under Educational Conferences. For questions, call 800-338-3633, ext 4817.

**Cost:** Before cut-off date: \$505 (AADE member), \$660 (non-member)

**After cut-off date:** \$585 (member), \$740 (non-member)

**KY Statewide Diabetes  
Symposium 2009**

**\*November 19, 2009\***  
 At the Newport Syndicate,  
 18 East 5th Street, Newport, Kentucky  
 (2 blocks south of Newport on the Levee)

**Brochures Available in July**

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

This symposium is being organized by   
**Kentucky Chapters of the  
American Association of Diabetes Educator's (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:  
 Jan Lazarus, RD LD (859) 363-2116 (janifer.lazarus@ky.gov)  
 Or  
 Janice Haile, RN CDE (270) 686-7747 Ext. 3031 (janice.haile@ky.gov)

## NATIONAL DIABETES MEETINGS SCHEDULED

**2009 American Association of Diabetes Educators  
36th Annual Meeting and Exhibition**  
Atlanta, GA  
August 5-8, 2009

**2010 American Association of Diabetes Educators  
37th Annual Meeting and Exhibition**  
San Antonio, TX  
August 4-7, 2010

## 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 [roszel@fuse.net](mailto:roszel@fuse.net) or Jana McElroy at [jmcelroy@stelizabeth.com](mailto:jmcelroy@stelizabeth.com) or call 859-344-2496. Meetings are held in Cincinnati.

**Date:** September 21, 2009  
**Time:** 5:30 pm Registration  
Business Meeting  
6-7 pm Education Offering  
**Location:** Good Samaritan Hospital  
Conference Center  
**Topic:** TBA\*

**Date:** October 19, 2009  
**Time:** 5:30 pm Registration  
Business Meeting  
6-7 pm Education Offering  
**Location:** Good Samaritan Hospital  
Conference Center  
**Topic:** TBA\*

**Date:** November 2, 2009  
**Time:** 5:30 pm Registration  
Business Meeting  
6-7 pm Education Offering  
**Location:** Good Samaritan Hospital  
Conference Center  
**Topic:** TBA\*



**Kentucky is one of the nation's leading states in the number of people with diabetes who smoke!**

**Special tobacco continuing education programs designed specifically for Kentucky's diabetes educators are being planned.**

### Dates for these programs include:

**DECA Date / Place To Be Determined**

**GLADE Date / Place To Be Determined**

**KADE Date / Place To Be Determined**

**KDN September 11, 2009 Elizabethtown, KY**

**TRADE July 16, 2009 Owensboro, KY**  
**For Information, Contact [Linda.Leber@ky.gov](mailto:Linda.Leber@ky.gov)**

## 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: Dr. Vasti Broadstone, Phone: 812-949-5700 E-mail: [joslin@FMHHS.com](mailto:joslin@FMHHS.com).

## GLADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Greater Louisville Association of Diabetes Educators (GLADE), which covers Louisville and the surrounding area, meets the 2<sup>nd</sup> Tuesday every other month. Registration required. For meeting schedule or to register, please contact Stacy Koch at [stacy.koch@nortonhealthcare.org](mailto:stacy.koch@nortonhealthcare.org).

### **2009 Meeting Dates**

**July 14, 2009 5:30 — 8:00 pm**

- Creative Coaching: Strategies that Inspire by Vanessa Paddy RN, MSN, APRN-BC and Betty Bryan RNC, BSN, CDE
- Norton Medical Building Community Room 301, Louisville, KY
- RSVP by 7-10-09 to Beth Schofield [beth.schofield@roche.com](mailto:beth.schofield@roche.com) (502-523-8338)

**September 8, 2009 Details TBA\***

**November 10, 2009 Details TBA\***



## 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:

Dana Graves  
 Phone: 859- 313-1282  
 E-mail: [gravesdb@sjhlex.org](mailto:gravesdb@sjhlex.org)  
 Or Diane Ballard [DianeBallard@alltel.net](mailto:DianeBallard@alltel.net)

## 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](http://www.kentuckydiabetes.net) or by calling 502-564-7996 (ask for diabetes program).

### 2009 KDN Meeting Dates:

**September 11, 2009 — ELIZABETHTOWN**  
**November 6, 2009 — LOUISVILLE**

Meeting times are 10:00 am—3:00 pm EST  
 “First-timers” should arrive by 9:30 am

## TRADE DIABETES EDUCATOR MEETINGS SCHEDULED

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

**Date:** July 16, 2009  
**Time:** 10 am Registration  
 10:30 am—1pm Program  
 11:30-12 pm Lunch Break  
 1-2 pm Business Meeting  
**Location:** Owensboro Medical Health System  
 HealthPark, 1006 Ford Avenue  
 Owensboro, KY  
**Topic:** *Using the Right Tools to Help Your  
 Diabetes Patient Quit Smoking*  
**Speakers:** Celeste T. Worth, CHES  
 Tobacco Treatment Specialist  
 Kentucky Cancer Program  
 University of Louisville

**Date:** October 15, 2009  
**Time:** 10 am Registration  
 10:30 am—1pm Program  
 11:30-12 pm Lunch Break  
 1-2 pm Business Meeting  
**Location:** Trover Health System  
 Madisonville, KY  
**Topic:** To Be Announced

## The Annual Fall TRADE Workshop is being moved to May 6, 2010

### SAVE THE DATE

**Tri-State Association of Diabetes Educators (TRADE)  
 Annual Workshop**

**May 6, 2010**

**Southern Indiana Career and Technical Center  
 1901 Lynch Road  
 Evansville, IN 47711**

*Diabetes in Children, Teens, and Young Adults*

**Will Provide 6-7 hours of Continuing Education for  
 RD's, RN's, RPh's, and CDE's**

**For information, please contact Mary Tim Griffin RD,  
 LD at 270-852-5454 or [mary.griffin@ky.gov](mailto:mary.griffin@ky.gov)**



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**Mark Your Calendars ★ KY Statewide Diabetes Symposium 2009 ★ 11-19-09**

# Contact Information



**American Diabetes Association**  
 Cure • Care • Commitment®

[www.diabetes.org](http://www.diabetes.org)  
 1-888-DIABETES



**TRADE**  
 Tri-State Association  
 of Diabetes Educators

[www.aadenet.org/  
 AboutAADE/Chapters.html](http://www.aadenet.org/AboutAADE/Chapters.html)



**KDN**  
 KENTUCKY DIABETES NETWORK, INC.

[www.kentuckydiabetes.net](http://www.kentuckydiabetes.net)

KENTUCKY ASSOCIATION  
 of DIABETES EDUCATORS



Bluegrass / Eastern Chapter  
 A Chapter of AADE

[www.kadenet.org](http://www.kadenet.org)



[www.louisvillediabesity.org](http://www.louisvillediabesity.org)



**Kentucky**  
 UNBRIDLED SPIRIT

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



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 KY/Kentuckiana](http://www.jdrf.org/chapters/KY/Kentuckiana)  
 1-866-485-9397



Diabetes Educators Cincinnati Area

[www.aadenet.org/  
 AboutAADE/Chapters.html](http://www.aadenet.org/AboutAADE/Chapters.html)



**American Association of Clinical Endocrinologists**  
 Ohio River Regional Chapter

[www.aace.com](http://www.aace.com)

**Kentuckiana Endocrine Club**  
[joslin@fmhhs.com](mailto:joslin@fmhhs.com)

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