

Kentucky Diabetes Connection



The Communication Tool for Kentucky Diabetes News

A Message from Kentucky Diabetes Partners

IN TRIBUTE TO CARLOS HERNANDEZ

*FORMER COMMISSIONER OF HEALTH AND
GREAT DIABETES ADVOCATE*

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 tireless and devout diabetes leader and advocate, Dr. Calixto "Carlos" Hernandez, 84, died at his home in Frankfort on July 13, 2013.

In 1978, Dr. Hernandez, then Director of Preventive Services for the KY Bureau for Health Services in Frankfort, served as chair of the **Kentucky Diabetes Commission** founded by the legislature under Governor Julian Carroll.

The **Diabetes Commission**, established by a Joint House-Senate Resolution of the Kentucky General Assembly, was charged with the tasks of examining the impact of diabetes in Kentucky and assessing the adequacy of resources available for diabetes care. The Commission, working in partnership with the University of Kentucky, estimated the prevalence, mortality, morbidity, and economic loss due to diabetes.

Under Dr. Hernandez's visionary leadership



Dr. Carlos Hernandez

as chair of the Commission, a statewide diabetes study was completed. Based upon this study, plans were established and funding secured for what would eventually become what is known today as the **Kentucky Diabetes Prevention and Control Program (KDPCP)**.

At the time, this innovative new diabetes initiative, which other states have since used as a model, occurred even before national guidance or funding from the Centers for Disease Control and Prevention.

Never wanting to retire, Dr. Hernandez was until his death a leader and persuasive advocate for diabetes. His ongoing passion, influence, and support on behalf of the person with diabetes will never be forgotten. And neither will his contagious smile. Dr. Hernandez, a great Kentucky leader and compassionate friend will be sorely missed, however, his tremendous diabetes legacy will always be remembered!

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CREDIT WHERE CREDIT IS DUE

NO GRIDLOCK IN WHITFIELD'S EFFORTS TO PASS DIABETES LEGISLATION

Submitted by: R. Stewart Perry and Bob Babbage, American Diabetes Association for KY

It is nice to have the opportunity to give credit where credit is due.

We had the honor on September 4th to be in attendance at the Marion County Chamber of Commerce meeting where 1st District Congressman Ed Whitfield received the *American Diabetes Association's Congressional Leadership Award*.



From left: Larry Smith, ADA Volunteer, Ed Whitfield, 1st District Congressman, Stewart Perry, ADA Volunteer, Bob Babbage, ADA Volunteer

This well-deserved tribute was presented in recognition of Congressman Whitfield's efforts on behalf of Americans battling diabetes. Congressman Whitfield has worked tirelessly to develop and promote legislative initiatives in diabetes prevention and care. He is an outspoken advocate for diabetes sufferers and most importantly, he has earned a reputation as a bi-partisan coalition builder in Congress on issues relating to diabetes.

As co-chair of the Congressional Diabetes Caucus, Congressman Whitfield is credited with building the bi-partisan membership of the Caucus and making it one of the most effective caucuses in Washington.

Formed in 1996, the Congressional Diabetes Caucus is the largest in Congress with close to 350 members. The mission of the Caucus is to educate members of Congress and their staff about diabetes and to support legislative activities and initiatives that would improve diabetes research, education, and treatment.

The achievements of the Caucus under Congressman Whitfield and co-chair Diana DeGette, Democrat of Colorado, are impressive. The Caucus was successful in creating the Special Diabetes Program that funds juvenile diabetes research and Native American treatment and prevention programs.

The Caucus helped enact legislation to provide Medicare coverage for blood testing strips, glucose monitors and diabetes self-management education and successfully urged the Centers for Medicare and Medicaid Services to provide coverage for insulin infusion pumps.

A current Caucus initiative is the *Preventing Diabetes in Medicare Act of 2013* which would extend Medicare coverage to medical nutrition therapy services for people with prediabetes and other risk factors for developing type 2 diabetes. Making medical nutrition therapy services available to people diagnosed with prediabetes can be a major factor in preventing the onset of diabetes and the cost of more expensive treatment.

Congressman Whitfield's efforts are showing positive results. New research shows a dramatic improvement in control of blood

glucose, blood pressure and "bad" cholesterol in U.S. adults with diabetes. Other studies indicate that community-based intervention for weight loss in people with prediabetes can induce improvements in multiple type 2 diabetes risk factors.

Over 500,000 Kentuckians, at least 10 percent of the state's population, are living with diabetes. Kentucky has the fifth-highest incidence of diabetes among the states according to the American

Diabetes Association. Estimates of the medical and non-medical costs of diabetes in Kentucky range as high as \$4.8 billion a year.

Congressman Whitfield stands out among a long list of Kentuckians working to address issues relating to diabetes. In 2011, the Kentucky General Assembly passed legislation that made the Commonwealth the first state to mandate a statewide, comprehensive action plan for addressing the diabetes epidemic.

The Kentucky Diabetes Action Plan facilitates and coordinates the efforts of state and local governments, health care providers, diabetes educators, and private citizens to make care and prevention strategies more accessible and effective.

As co-chair of the Congressional Diabetes Caucus, Congressman Whitfield is in a unique and powerful position to provide leadership in diabetes care and prevention and to inspire the efforts of others.

Whatever impact gridlock may have had in other areas of Congress, it has not been a factor in the workings of the Congressional Diabetes Caucus. Thanks in large measure to Congressman Whitfield's leadership, the Caucus is setting an example for how to build powerful coalitions and avoid the distractions of partisanship.

We are delighted to have the opportunity to congratulate Congressman Whitfield as the recipient of the *American Diabetes Association's Congressional Diabetes Leadership Award*. He has earned the respect and admiration of all Kentuckians for taking smart steps to help blunt the growth of this costly epidemic.

Mr. Perry heads Perry and Perry Insurance and is a former chair of the American Diabetes Association's national Board of Directors. Mr. Babbage heads Babbage Cofounder and is former Kentucky State Auditor and Secretary of State. They are advocates for diabetes education and prevention in Kentucky. Bob Babbage may be reached at 859-492-5869 and Stewart Perry at 859-277-7195.

COMMUNITY CHALLENGE: KENTUCKY A LEADER IN DIABETES FIGHT

Submitted by: R. Stewart Perry and Larry Smith, American Diabetes Association for KY

Change is coming in Kentucky's fight against diabetes.

Diabetes is destroying lives in Kentucky. It is destroying families. And it is costing billions of dollars every year in direct and indirect costs to the state's economy.

The impact of diabetes on Kentucky and Kentuckians cannot be understated. There are few things that present a greater challenge to our future prosperity and quality of life. How we confront the growing diabetes epidemic today, could be the most important legacy we leave for future generations.

Estimates of the medical and non-medical costs of diabetes in Kentucky range as high as \$4.8 billion a year. Over 500,000 Kentuckians, at least 10 percent of the state's population, are living with diabetes. According to the American Diabetes Association, Kentucky has the fifth-highest incidence of diabetes among the states.

Despite the daunting statistics, or perhaps because of them, the commonwealth is blessed with thousands of health care professionals, educators, volunteers and others enlisted in the fight. Leaders in state government have been responsive and generous in their support of diabetes initiatives.

Kentucky is considered a hotbed of leadership, innovation and activism among diabetes advocates across the country. And yet, we are still the underdog in the fight.

Fortunately, for future generations Kentucky is stepping up its game even more. In 2011, the General Assembly passed legislation (KRS 211.752) sponsored by Sen. Tom Buford and Rep. Ruth Ann Palumbo, directing the Cabinet for Health and Family Services to report every two years on the impact of diabetes on the commonwealth, the scope of the epidemic, the costs and complications of the disease and what is being done by state government to address the problem.

This was an important step. The legislation specifically requires that the Department for Medicaid Services, the Department for Public Health, the Office of Health Policy and the Personnel Cabinet "collaborate to identify goals and benchmarks while also developing individual entity plans to reduce the incidence of diabetes in Kentucky, improve diabetes care, and control complications associated with diabetes."

When the legislation passed and Gov. Steve Beshear signed it in to



R. Stewart Perry



Larry Smith

law, Kentucky became the first state ever to mandate a statewide, comprehensive action plan for addressing the diabetes epidemic.

As former national chairs of the American Diabetes Association's volunteer board of directors, we talk regularly with legislators, health care professionals and diabetes advocates in other states, and there is no question that they see Kentucky taking a lead in the fight against the disease. Many are using Kentucky's

plan as a model for legislation in their own states.

Observers of Kentucky's ongoing struggle to deal with diabetes and other chronic diseases will reasonably ask, "What makes this effort different from anything that has been done in the past?"

To begin with, KRS 211.752 requires a comprehensive and coordinated effort at an unprecedented level. Requiring state agencies to collaborate in the preparation of the State Diabetes Report assures that everyone has access to all of the important information necessary to develop innovative strategies and keeps the lines of communication open, even when the names and faces of agency heads and key staff change over time.

It requires that the impact and financial toll of diabetes be viewed in relationship to other chronic diseases so that care and prevention strategies can be more effective and efficient.

The legislation further acknowledges the tangible role that health care providers, diabetes educators and others play in the sponsorship and expansion of prevention strategies and seeks to more effectively assimilate the energies of the thousands of groups and individuals already at work in diabetes education, prevention and care.

KRS 211.752 further requires that the biannual report include "detailed action plans for battling diabetes with a range of actionable items." That is bureaucratic language for "what specific programs and activities are we going to conduct to effect change?"

We applaud Gov. Beshear, Sen. Buford, Rep. Palumbo, Cabinet for Health and Family Services Secretary Audrey Haynes, other members of the General Assembly and leaders in state government for their determined effort to fight diabetes and improve the lives of Kentuckians.

We call on every Kentuckian to enlist in the effort to step up the fight against diabetes.

Businessmen R. Stewart Perry and Larry Smith have both served as chair of the American Diabetes Association National Board of Directors.

UPDATE ON REGULATION PERMITTING THE DELEGATION OF INSULIN ADMINISTRATION IN SCHOOL SETTINGS



Pam Hagan
Kentucky Board of Nursing



Submitted by: Pamela Hagan, MSN, RN, KY Board of Nursing, Practice Consultant, Louisville, KY

The Kentucky Board of Nursing's (KBN) regulation 201 KAR 20:400 **Delegation of Nursing Tasks** was amended at the July 9, 2013

meeting of the Administrative Regulations Review Subcommittee which would allow, following training, the delegation of the administration of insulin or glucagon in the school setting within specified parameters.

Following discussion at the Kentucky Board of Nursing meeting held on August 21, 2013, the Board communicated to the Interim Joint Health and Welfare Committee a request to withdraw 201 KAR 20: 400 from consideration on the Committee's agenda. **The Board felt the regulation could be implemented more effectively with the development of the training program as part of the regulation.**

The Board voted to *"convene a workgroup of experts and interested parties to develop the [insulin administration in school settings] curriculum. This workgroup shall report its findings and recommendations to the KBN Practice Committee."*

The Insulin Administration Content Writing Expert Workgroup comprised of nurses and certified diabetes educators has begun its work. In addition to KBN members, invited participants include representatives from the Department of Education (DOE), Department of Public Health (DPH), KY Diabetes Prevention and Control Program, American Diabetes Association (ADA), Kentucky Association of School Nurses (KASN), Kentucky School Boards Association (KSBA), Kentucky Nurses Association (KNA), Parent Teachers Association (PTA), a local Health District, Kentucky Association of Elementary School Principals (KAESP), Kentucky Education Association (KEA), Kentucky Education Support Personnel Association (KESPA), and physicians specializing in pediatrics and endocrinology have agreed to serve on an advisory group to review the curriculum. The curriculum will be sent to the KBN Practice Committee in November for approval and then to the full Board at its December meeting.

The Board's intent is to incorporate by reference the training curriculum and re-file the regulation by the end of the year. For more information contact Pam Hagan, 502-429-7181 or pamelac.hagan@ky.gov.

NEW ADA CONTACT FOR KENTUCKY *DIABETES CARE IN KY SCHOOLS*



Gary Dougherty
ADA



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

Thank you for the opportunity to introduce myself as the new State Advocacy Director for the American Diabetes Association (ADA) in Kentucky. I succeeded Jim McGowan who is now the Executive Director of the Minnesota Alliance of YMCAs.

My background includes nearly 28 years of experience working in and with state government in Ohio, first as a legislative staffer in both the Senate and House of Representatives and then as an advocate and lobbyist for statewide non-profit organizations. I am looking forward to representing the ADA in Kentucky and working to improve the lives of all people affected by diabetes.

As you know, we have been working for some time to change state policy to allow unlicensed school personnel to administer insulin to children in the school setting. After the Board of Nursing adopted the necessary regulation at its June 13 meeting and the Administrative Regulation Review Subcommittee approved it on July 9, families of children with diabetes had every reason to be optimistic. All that remained was approval by the Interim Joint Committee on Health and Welfare on August 21.

Unfortunately, the Board of Nursing withdrew the regulation *"due to issues and questions that were raised by the Board."* Specifically, there was an interest to review more closely the course content of the training program for unlicensed personnel.

At a special called meeting of the Board of Nursing on August 23, the board voted to separate the school delegation issue into its own distinct regulation and incorporate ADA training curriculum language into the revised draft regulation. The first draft is expected by the September 13 meeting of the Board's Practice Committee with the goal of being ready for formal approval at the next meeting of the full Board in October or in December at the latest.

Whereas we have been assured by Board leadership that their recent actions will only delay, not kill, the regulation, we will naturally be pushing for expedited treatment of the revised regulation.

LOUISVILLE DIABETES & OBESITY CENTER WINS SECOND MULTI-MILLION DOLLAR NIH GRANT

*Submitted by: Jill Scoggins, HSC
Communications and Marketing, August
2013*

The University of Louisville's (U of L) Diabetes and Obesity Center has received a five-year \$11.25 million Center of Biomedical Research Excellence (COBRE) grant from the National Institute of General Medical Sciences, part of the National Institutes of Health (NIH).

A five-year COBRE grant funded establishment of the center in 2008.

"This second COBRE grant to continue the center's work is a demonstration of U of L's continued emergence as a research university," said U of L President James R. Ramsey.

"The University of Louisville set out more than a decade ago to become Kentucky's premier metropolitan research university. Getting there is arduous, requiring an unwavering commitment to excellence, innovative thinking and just plain old hard work," Ramsey said. "But I think sustaining it may be even harder. That is why this grant is so significant."

"The Diabetes and Obesity Center is part of the Division of Cardiovascular Medicine in U of L's Department of Medicine. Its purpose is to provide a way to address the profound effect that diabetes and obesity have had on people's health in the United States and their general quality of life," said center Director Aruni Bhatnagar.

"We approach diabetes and obesity not only as individual disease states, but as pieces of a larger, more comprehensive puzzle," Bhatnagar said. "Thus, our researchers are working to develop a better understanding of diabetes and obesity not simply as individual disease states, but as the outcomes of a more comprehensive dysfunction—a dysfunction that profoundly affects all major organs and increases our risk of developing heart disease and cancer."

Since 2008, Diabetes and Obesity Center scientists have "made significant gains in our understanding of diabetes and obesity," said David L. Dunn, Executive Vice President for Health Affairs. "They have revealed an



U of L President James Ramsey announces the COBRE grant receipt. David Dunn, Executive Vice President for Health Affairs, and Aruni Bhatnagar, Director of the Diabetes & Obesity Center, look on.

entirely new mechanism to regulate glucose sensitivity and a new avenue for preventing obesity. They also have increased understanding of the enzymes that regulate glucose metabolism and how this contributes to secondary diabetes complications such as heart failure and restenosis, the narrowing of blood vessels that restricts blood flow."

"A key component of the new grant is its continued support of junior investigators. Within the past four years, seven junior investigators within the center have acquired independent federal funding, making it one of the most successful COBRE programs in the nation," Bhatnagar said.

"This grant not only supports our work in discovering new knowledge that will enable people to live healthier, more productive lives, it also helps us nurture the next generation of research scientists," Ramsey said.

"The center's ultimate goal," Bhatnagar said, "is to discover new and effective means for preventing and treating diabetes and obesity."

"The need for new prevention methods and treatments grows with more intensity every day," he said.

Diabetes and obesity are the two most significant health threats of our age. Over 90 million adults and children in the United States are obese, while 18 million adults are living with type 2 diabetes. These epidemics are spreading at an alarming rate and they are rapidly eroding recent gains in longevity by contributing to the burden of chronic diseases.

"Diabetes doubles the risk of cardiovascular disease. In fact, an astonishing 60 – 70 percent of diabetic patients die of heart disease," Bhatnagar said. "Our team is making new discoveries every day — discoveries that will provide better understanding of the link between cardiovascular disease and the epidemics of diabetes and obesity. The more comprehensive our understanding of these conditions, the closer we come to developing a more effective strategy for their treatment and prevention."

KENTUCKIANS PROVIDE LEADERSHIP AT NATIONAL MEETING

Submitted by: *Becki Thompson, RN, BSN, CDE, KDPCP, Frankfort, KY*

Kentuckians played numerous roles to help lead the American Association of Diabetes Educators (AADE) 2013 national conference held in Philadelphia, PA on August 7-10, 2013 (*see photos with descriptions as part of this article*).

General Session topics included:

- *Leading the Charge* by Phil Southerland;
- *The 5A's of Obesity Management* by Arya Sharma, MD, PHD, FRCPC;
- *Guided Imagery and the New Mind - Body Breakthroughs in Diabetes Care* by Belleruth Naparstek; and
- *How to Change Human Behavior* by BJ Fogg, PhD

There were also a diverse selection of breakout sessions to educate, inform, and energize attendees. As always, the exhibit hall was a huge hit as a place to learn about new products, services, and resources.

At the conclusion of this conference, the passion of all the attendees to address the needs of people with diabetes as well as those with prediabetes was evident!

If you did not get to attend the annual AADE meeting, you can still attend virtually!

Go to: <http://www.myaadenetwork.org/p/cm/ld/fid=1359>



Kentuckians provided leadership at the national AADE Conference - pictured from left - Patti Geil, Program Chair for the national AADE Conference, Tami Ross, 2013 AADE President and moderator for the conference and Debbie Fillman, AADE Education and Research Foundation Chair. Kim DeCoste and Laura Hieronymus, not pictured above, also served on the 2013 AADE Conference program committee.



Janey Wendschlag prepares for her poster session entitled, "Teaching for All Ages, Diabetes, From the Cradle to the Elderly" at the national AADE meeting. The poster and handout were developed by members of the KDPCP curriculum committee and addressed how different generations learn best.



Kentuckians Kim DeCoste (left) and Paula Hollon (right) presented a breakout session at the national meeting entitled, "Small Steps Big Rewards, An Innovative Workplace Diabetes Partnership".



Dana Graves (left) and Maggie Beville (right) both members of the Kentucky Coordinating Body of AADE represented KADE and GLADE respectively at the national meeting.

NDEP SURVEY: MORE PEOPLE KNOWLEDGEABLE ABOUT DIABETES, DESPITE UNDERAPPRECIATION OF ITS SERIOUSNESS



Linda Siminerio

Submitted by: *Samantha Costa, from the AADE National Meeting, August, 2013*

Much to the surprise of diabetes educators, the number of people who consider diabetes a serious disease has declined slightly. Many people are still unaware of its deleterious nature or that it could be delayed or prevented, according to survey results presented at the American Association of Diabetes Educators Annual Meeting and Exhibition held in August.

According to **Linda Siminerio, PhD, BSN, RN, CDE, FAAN**, of the University of Pittsburgh, the National Diabetes Education Program was established in 1997 to improve diabetes management and reduce the morbidity and mortality from diabetes and its complications.

“These survey results provide information that helps the NDEP take the next steps in developing tools, web information and future applications; to develop strategic plans for diabetes educators to use in the primary prevention of diabetes,” Siminerio said during her presentation at the AADE conference.

NDEP Survey Results

The national probability sample included non-institutionalized adults (*aged 45 years and older in 2006; 35 years and older in 2008 and 2011*) via households with landline telephones only, according to Siminerio. Participants were categorized as: people with diabetes, people with prediabetes, people at risk and all others.

According to data presented here, people in the >45 years-of-age group self-reported they have heard about HbA1c and prediabetes, and that diabetes could be prevented. However, when asked, many people did not consider diabetes as a serious disease.

“It’s a little disappointing that the number of people who consider diabetes a serious disease is starting to go down a bit. We need to emphasize the importance of diabetes as a serious disease in all populations. The fact that the number is going down is certainly something we have to pay attention to,” **Joanne Gallivan, MS, RD**, from the National Institutes of Health, said during the presentation.

People were also asked to weigh-in on what they considered to be serious adverse health outcomes due to diabetes. Blindness was ranked as the most serious, followed by: amputation, kidney disease, heart conditions, death, heart attack, foot ulcers, cardiovascular disease, stroke and hypertension.

“We were surprised people at high risk don’t understand they’re at high risk for developing type 2 diabetes. The important message we need to get across is that you can delay or prevent type 2 diabetes,” Gallivan said.

Hispanic and Black Populations

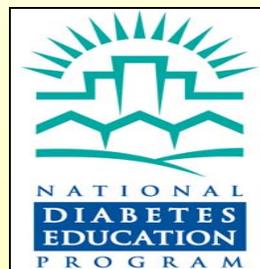
Data indicate that 61% of Hispanics surveyed in 2008 said they were aware diabetes could be prevented with that number increasing to 76% by 2011. Moreover, this population was familiar with the term “*prediabetes*” (*31% in 2008 vs. 50% in 2011*), had heard of a blood test for diabetes (*89% in 2008 vs. 94% in 2011*) or HbA1c (*34% in 2008 vs. 42% in 2011*), and had their HbA1c checked at least once in the prior 12 months (*42% in 2008 vs. 56% in 2011*), according to data.

Data also indicate 70% of blacks surveyed in 2008 said they were aware diabetes could be prevented vs. 86% of blacks in 2011. Only 32% of this population was familiar with the term “*prediabetes*” in 2008 vs. 39% in 2011. However, there was no change in the number of black people who considered diabetes a serious disease (*93% in 2008 and 2011*), Siminerio said.

“That is really abysmal. We have a lot of work to do to communicate prediabetes to this population,” she said.

The majority of people who were surveyed said advice they most frequently followed from a health professional was to: reduce fat intake, take aspirin and lose weight. Plans for a revised survey are underway, according to the presenters.

Disclosure: *Siminerio reports participation in the Sanofi Research Study. Gallivan reports no relevant financial disclosures.*



HOW THE HEALTH CARE LAW IS MAKING A DIFFERENCE FOR THE PEOPLE OF KENTUCKY

Information from www.hhs.gov/healthcare

Because of the Affordable Care Act, the 83% of Kentuckians who have insurance have more choices and stronger coverage than ever before. And for the 17% of Kentuckians who don't have insurance, or Kentucky families and small businesses who buy their coverage but aren't happy with it, a new day is just around the corner.

The new online Health Insurance Marketplace will provide families and small businesses who currently don't have insurance, or are looking for a better deal, a new way to find health coverage that fits their needs and their budgets.

Open enrollment in the Marketplace started October 1st, with coverage starting as soon as January 1, 2014. Kentucky families and small business can visit Healthcare.gov to find the information they need to prepare for open enrollment.

The health care law is already providing better options, better value, better health and a stronger Medicare program to the people of Kentucky by:

Better Options

The Health Insurance Marketplace

Beginning October 1, the Health Insurance Marketplace will make it easy for Kentuckians to compare qualified health plans, get answers to questions, find out if they are eligible for lower costs for private insurance or health programs like Medicaid and the Children's Health Insurance Program (CHIP), and enroll in health coverage.

By the Numbers: Uninsured Kentuckians who are eligible for coverage through the Marketplace.

- 622,054 (17%) are uninsured and eligible
- 435,918 (70%) have a full-time worker in the family
- 264,159 (42%) are 18-35 years old
- 513,688 (83%) are White
- 77,280 (12%) are African American
- 18,272 (3%) are Latino/Hispanic
- 4,158 (1%) are Asian American or Pacific Islander
- 333,912 (54%) are male

588,778 (95%) of Kentucky's uninsured and eligible population may qualify for either tax credits to purchase coverage in the Marketplace or for Medicaid if Kentucky takes advantage of the new opportunity to expand Medicaid coverage under the Affordable Care Act.

Kentucky has received \$253,698,351 in grants for research,

planning, information technology development, and implementation of its Health Insurance Marketplace.

New coverage options for young adults

Under the health care law, if your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old. Thanks to this provision, over 3 million young people who would otherwise have been uninsured have gained coverage nationwide, including 48,000 young adults in Kentucky.

Ending discrimination for pre-existing conditions

As many as 1,894,874 non-elderly Kentuckians have some type of pre-existing health condition, including 241,403 children. Today, insurers can no longer deny coverage to children because of a pre-existing condition, like asthma or diabetes, under the health care law. And beginning in 2014, health insurers will no longer be able to charge more or deny coverage to anyone because of a pre-existing condition. The health care law also established a temporary health insurance program for individuals who were denied health insurance coverage because of a pre-existing condition. 1,441 Kentuckians with pre-existing conditions have gained coverage through the Pre-Existing Condition Insurance Plan since the program began.

Better Value

Providing better value for your premium dollar through the 80/20 Rule

Health insurance companies now have to spend at least 80 cents of your premium dollar on health care or improvements to care, or provide you a refund. This means that 206,771 Kentucky residents with private insurance coverage will benefit from \$14,405,533 in refunds from insurance companies this year, for an average refund of \$100 per family covered by a policy.

Scrutinizing unreasonable premium increases

In every State and for the first time under Federal law, insurance companies are required to publicly justify their actions if they want to raise rates by 10 percent or more. Kentucky has received \$4,225,170 under the new law to help fight unreasonable premium increases.

Removing lifetime limits on health benefits

The law bans insurance companies from imposing lifetime dollar limits on health benefits – freeing cancer patients and individuals suffering from other chronic diseases from having

LAW IS MAKING A DIFFERENCE (CONTINUED)

to worry about going without treatment because of their lifetime limits. Already, 1,414,000 people in Kentucky, including 528,000 women and 362,000 children, are free from worrying about lifetime limits on coverage. The law also restricts the use of annual limits and bans them completely in 2014.

Better Health

Covering preventive services with no deductible or co-pay

The health care law requires many insurance plans to provide coverage without cost sharing to enrollees for a variety of preventive health services, such as colonoscopy screening for colon cancer, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults.

In 2011 and 2012, 71 million Americans with private health insurance gained preventive service coverage with no cost-sharing, including 975,000 in Kentucky. And for policies renewing on or after August 1, 2012, women can now get coverage without cost-sharing of even more preventive services they need. Approximately 47 million women, including 650,425 in Kentucky will now have guaranteed access to additional preventive services without cost-sharing.

Increasing support for community health centers

The health care law increases the funding available to community health centers nationwide. In Kentucky, 21 health centers operate 132 sites, providing preventive and primary health care services to 278,242 people. Health Center grantees in Kentucky have received \$75,822,132 under the health care law to support ongoing health center operations and to establish new health center sites, expand services, and/or support major capital improvement projects.

Community Health Centers in all 50 states have also received a total of \$150 million in federal grants to help enroll uninsured Americans in the Health Insurance Marketplace, including \$2,383,522 awarded to Kentucky health centers. With these funds, Kentucky health centers expect to hire 52 additional workers, who will assist 61,539 Kentuckians with enrollment into affordable health insurance coverage.

Investing in the primary care workforce

As a result of historic investments through the health care law and the Recovery Act, the numbers of clinicians in the National Health Service Corps are at all-time highs with nearly 10,000 Corps clinicians providing care to more than 10.4 million people who live in rural, urban, and frontier communities. The National Health Service Corps repays educational loans and provides scholarships to primary care physicians, dentists, nurse practitioners, physician assistants,

behavioral health providers, and other primary care providers who practice in areas of the country that have too few health care professionals to serve the people who live there. As of September 30, 2012, there were 132 Corps clinicians providing primary care services in Kentucky, compared to 52 in 2008.

Preventing illness and promoting health

As of March 2012, Kentucky had received \$5,000,000 in grants from the Prevention and Public Health Fund created by the health care law. This new fund was created to support effective policies in Kentucky, its communities, and nationwide so that all Americans can lead longer, more productive lives.

A Stronger Medicare Program

Making prescription drugs affordable for seniors

In Kentucky, people with Medicare saved nearly \$141 million on prescription drugs because of the Affordable Care Act. In 2012 alone, 72,391 individuals in Kentucky saved over \$51 million, or an average of \$703 per beneficiary. In 2012, people with Medicare in the “donut hole” received a 50 percent discount on covered brand name drugs and 14 percent discount on generic drugs. And thanks to the health care law, coverage for both brand name and generic drugs will continue to increase over time until the coverage gap is closed. Nationally, over 6.6 million people with Medicare have saved over \$7 billion on drugs since the law’s enactment.

Covering preventive services with no deductible or co-pay

With no deductibles or co-pays, cost is no longer a barrier for seniors and people with disabilities who want to stay healthy by detecting and treating health problems early. In 2012 alone, an estimated 34.1 million people benefited from Medicare’s coverage of preventive services with no cost-sharing. In Kentucky, 485,843 individuals with traditional Medicare used one or more free preventive service in 2012.

Protecting Medicare’s solvency

The health care law extends the life of the Medicare Trust Fund by ten years. From 2010 to 2012, Medicare spending per beneficiary grew at 1.7 percent annually, substantially more slowly than the per capita rate of growth in the economy. And the health care law helps stop fraud with tougher screening procedures, stronger penalties, and new technology. Over the last four years, the administration’s fraud enforcement efforts have recovered \$14.9 billion from fraudsters. For every dollar spent on health care-related fraud and abuse activities in the last three years the administration has returned \$7.90.

Diabetes Discrimination and Barriers to Blood Glucose Testing — A Case in Kentucky



Benjamin Eisenberg



Submitted by: Benjamin Eisenberg, Legal Advocate, Senior Manager, American Diabetes Association (ADA) with input from R. Stewart Perry, Kentucky State Advocacy Chair

Blood glucose testing is undoubtedly an important part of a diabetes self-management regime. Yet there may be significant barriers to implementing this effective management tool. **The scenario below illustrates one such barrier and is based upon a true story that occurred in Kentucky:**

Gloria decides to head out with her friend to a local small town restaurant which they have been going to for twenty years, although the restaurant has new management now. As they sit down and get ready to order, Gloria starts feeling a little low. She decides to check her blood glucose. As a waitress walks by, she sees the lancet, and makes a face filled with disgust. “You can’t do that here,” she snaps. Gloria is shocked — as she never had a problem before.

Gloria explains that she has diabetes, and needs to test her blood glucose before eating to stay healthy. She explains she can be very clean and safe while checking her blood sugar. The waitress shakes her head. “No, it’s dirty, and it will make the other customers feel sick.” Gloria protests as she has already sat down to eat and knows a bathroom is unclean. Plus, she doesn’t want to feel embarrassed for something which is completely normal and safe.

The waitress talks to the manager. The manager tells Gloria that she can either “test” outside, or leave and tells her, “You can’t have blood all over the place in a restaurant.” Gloria refuses. The manager starts yelling, “I can refuse service to whomever I want! And right now I’m refusing you!” He follows through on the threat. In fact, she is barred from ever going back to that restaurant again. Gloria has lost her favorite hometown eating place, and now feels afraid to ever test her blood glucose in public again.

The American Diabetes Association receives hundreds of calls asking for help with diabetes discrimination. In fact, it is not unusual to hear stories about people being told not to test blood glucose in a wide range of circumstances including restaurants, office spaces, workplaces, school classrooms, and a whole range of public places.

As medical professionals, this is important information for your practice. Barriers to blood glucose testing can lead people to avoid testing altogether, or to ration the times they test. Without an effective testing regime, the consequences for effective diabetes management should be clear: increased fluctuations in blood

glucose levels, less awareness of hyperglycemia, dangerous episodes of hypoglycemia, and a whole range of related complications.

Medical professionals, and anyone connected with the diabetes community in Kentucky, should know that people with diabetes have rights. The Americans with Disabilities Act is a federal law that protects people with diabetes, whether they have type 1, type 2, or gestational diabetes. Places of public accommodation, such as restaurants and movie theaters, have to provide reasonable accommodations to people with diabetes (this includes most public and private schools). Public places may have to adapt or change policies for people with diabetes. Since blood glucose testing is a vital part of diabetes care, public places must allow people to do that care, so long as it is safe for themselves and others.

Blood glucose testing is safe. The American Diabetes Association standards, created by prominent endocrinologists and experienced advocates, recommend allowing blood glucose testing anytime, anywhere. The Centers for Disease Control and Prevention found that blood glucose testing was safe, and even preferable, for most children to test blood glucose, including in a classroom setting. Adults, presumably, should be even more capable of safely testing blood glucose. OSHA’s Bloodborne Pathogen Standard permits blood glucose testing by employers at the workplace.

The discomfort of others is not a reason to prevent a person with diabetes from engaging in medical care which is safe, healthy, and necessary for their health. Fears and disgust are not legal reasons to deny a reasonable accommodation under the Americans with Disabilities Act. In a similar way, a restaurant could not prevent a disabled child with a feeding tube from eating, even if seeing the food move through a tube caused discomfort to others. Seeing a person test blood glucose may make some people uncomfortable. But it is necessary for diabetes care. The fears and prejudices of others will have to take a back seat to a person’s medical needs.

Blood glucose testing can be discreet, quick, and easy and should be allowed in all public places. And it should not be a barrier to effective diabetes management and care.

Diabetes educators and other health care professionals can do their part by becoming part of the ADA Health Care Professional Legal Advocacy Network. We help health care professionals advocate for their patients by providing access to trainings, materials, and opportunities. If you are interested in joining, visit diabetes.org/PatientRights or call 703-299-5512.

If any of your patients experience discrimination based on diabetes, have them call 1-800-DIABETES for free legal information and assistance. ADA has extensive experience helping clients advocate for themselves.

Benjamin Eisenberg, 1701 N. Beauregard St., Alexandria, VA 22311, 1-800-676-4065 Ext 2102, BEisenberg@diabetes.org



KY COORDINATING BODY (CB) REPORT



Betty Bryan

Submitted by: *Betty Bryan, RN, CDE
Volunteer Leader of the Kentucky
Coordinating Body (CB) of the American
Association of Diabetes Educators (AADE)*

Members of the Kentucky Coordinating Body (CB) met in Philadelphia, Pennsylvania, Tuesday August 6, 2013, at the Annual American Association of Diabetes Educator's (AADE) meeting. Representatives from the Kentucky

Local Networking Groups (LNG's) GLADE, TRADE, KADE and DECA were present at this meeting. At this meeting, the KY CB:

- Formed a sub-committee to develop policies and procedures in relationship to CB monies. The sub-committee is made up of one representative from each of the KY LNG's, the KY CB Volunteer Leader and Treasurer.
- Decided that for 2013-14, the KY CB members will conduct at least one face-to-face meeting per year and an every other month conference call.
- Discussed ways that the Coordinating Body may partner with the KY Diabetes Prevention and Control Program (KDPCP) to collect diabetes self-management numbers being completed in Kentucky (to improve KY diabetes surveillance).

KY Licensure of Diabetes Educators Follow-up

The KY CB continues to closely monitor current activities related to state licensure for diabetes educators. The following regulations related to KY licensure were reviewed at the September Administrative Regulation Review Subcommittee (ARRS) meeting.

- 201 KAR 45:001. Definitions. *(Amended After Comments)*
- 201 KAR 45:070. Application procedures for current practitioners. *(Amended After Comments)*
- 201 KAR 45:100. Fees. *(Amended After Comments)*
- 201 KAR 45:110. Supervision and work experience. *(Amended After Comments)*
- 201 KAR 45:120. Renewal, reinstatement, and inactive status. *(Amended After Comments)*
- 201 KAR 45:130. Continuing education. *(Amended*



After Comments)

- 201 KAR 45:140. Code of ethics. *(Amended After Comments)*
- 201 KAR 45:150. Complaint procedures. *(Amended After Comments)*
- 201 KAR 45:160. Scope of practice. *(Amended After Comments)*

At the ARRS meeting, there was not a lot of discussion regarding the regulations except for 201 KAR 45:001. In response to a question by co-chair, Senator Ernie Harris, Mr. Larry Smith, a Diabetes Educator Licensure Board member, stated that the administrative regulations established a new diabetes educator licensure program, provided for different types of diabetes educators, and established a fee structure for the program.

For 201 KAR 45:130, in response to a question by Co-Chair Harris, Mr. Smith stated that Kentucky was the first state to establish this program, therefore, comparison with other states' requirements was not possible. Some national associations required more continuing education hours than those established in this administrative regulation.

Motions were made to approve amendments for each of the administrative regulations except for 201 KAR 45:100 and 201 KAR 45:140. Amendments were made to comply with the drafting and formatting requirements of KRS Chapter 13A, correct a statutory citation, and to establish a definitions section in 201 KAR 45:150 for clarity.

The administrative regulations will be referred to a subject matter committee by the Legislative Research Commission at its next regularly scheduled meeting on Wednesday, October 2. The second committee will have a thirty (30) day period in which to review the administrative regulations.

**The KY Diabetes Licensure 2013
Amended Regulations are posted on the LRC
state website [http://www.lrc.ky.gov/KAR/
frntpage.htm](http://www.lrc.ky.gov/KAR/frntpage.htm), click on "searchable by key
word" then enter the word "Diabetes" and
click search to see the newest version of the
amended KY diabetes educator
licensure regulations.**

NEW TAKE ON HOW GASTRIC BYPASS CURES DIABETES

Article posted on nih.gov by Dr. Francis Collins on July 30, 2013

Research by many teams has suggested that reengineering the stomach and intestine changes the balance of hormones and alters gut-mind communication, which then reboots blood sugar control. But now an NIH-funded team at Boston Children's Hospital has a completely new spin on this phenomenon [1].

A dramatic, lasting, weight loss treatment for morbidly obese patients is gastric bypass surgery. Although there are many variations of this surgery, each with its signature metabolic pros and cons, the Roux-en-Y bypass is the most popular. The operation involves reducing the stomach size by 90% (which restricts food intake) and reconnecting the remaining stomach pouch to a latter section of the small intestine called the jejunum. Food thus "bypasses" digestion in the stomach and the upper portion of the small intestine. The result of this gastrointestinal re-engineering is that less food is eaten and fewer calories are absorbed in the gut.

Many morbidly obese individuals also have type 2 diabetes. One of the most intriguing consequences of the surgery is that patients' blood sugar levels normalize within days—long before any weight loss has occurred. Patients can often stop taking their diabetes medication even before leaving the hospital. Traditionally, doctors recommend weight loss through dieting and exercise to improve blood sugar levels—but this surgery lowers blood sugar levels almost immediately. Why this is, is a mystery—and if we understood the mechanism that might help treat diabetes more effectively in individuals who have not had bypass surgery.

After performing the Roux-en-Y bypass in obese, diabetic rats researchers found that the tissue forming the "Roux" limb (the new passage linking the stomach pouch to the lower gut) seems to grow and expand—an energy intensive process that requires a lot of sugar. The researchers suggest that as the intestinal tissue grows—in girth and absorptive capacity—it harvests glucose from the blood, dropping the sugar level in the blood and essentially curing the diabetes. Once the growth stops the intestine is a larger, energy hungry organ that has to work harder to sustain the increased mass; thus it continuously uses more sugar, which might explain how the effects of the surgery are sustained.

What triggers the growth of this Roux limb? It seems that it's exposure to the undigested food, which exits the stomach pouch undigested before continuing through the GI tract.

Exactly how the Roux-en-Y bypass causes the human intestine to grow in this way still needs much more work to be understood.

Obesity is a major problem in the US and globally. More than two thirds of Americans are overweight or obese. Type 2 diabetes, which affects 26 million Americans, goes hand in hand with obesity [2]. Type 2 diabetes raises the risk of stroke, heart attack, blindness, amputations, kidney failure, nerve damage and a long list of other health problems.

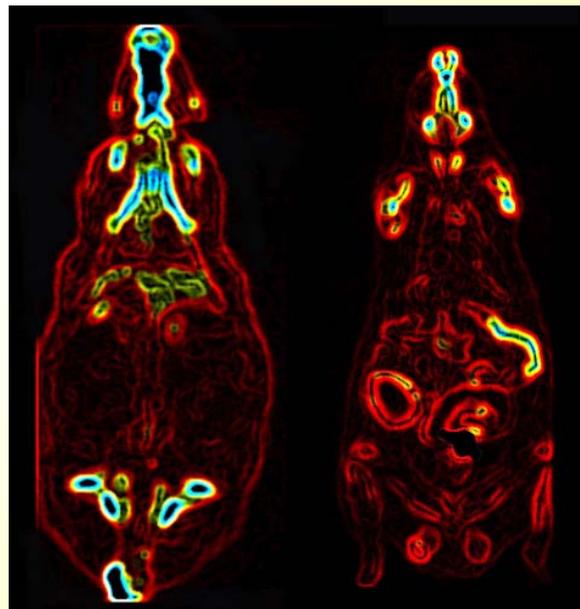
This new research raises the tantalizing possibility of using drugs rather than surgery to reprogram the intestine's metabolism to remove glucose from the blood and lower sugar levels. Could we learn how to bypass the bypass?

References:

[1] [*Reprogramming of intestinal glucose metabolism and glycemic control in rats after gastric bypass*](#). Saeidi N, Meoli L, Nestoridi E, Gupta NK, Kvas S, Kucharczyk J, Bonab AA, Fischman AJ, Yarmush ML, Stylopoulos N. *Science*. 2013 Jul 26;341(6144):406-10.

[2] [*Overweight and Obesity Statistics*](#)

Additional information: [*Bariatric Surgery for Severe Obesity*](#), National Institute of Diabetes and Digestive and Kidney Diseases, NIH
NIH Funding: National Institute of Diabetes and Digestive and Kidney Diseases



Caption: This is a PET/CT scan of a rat before (left) and after (right) gastric bypass surgery. This kind of a PET scan shows that after surgery the intestine (the looping structures) are using more glucose, which appear yellow and orange. By comparison the before surgery snapshot (left) reveals that there is very little glucose uptake in the intestines, which are barely visible.

Credit: Courtesy of the [*Stylopoulos Laboratory*](#)

TRANSFORMING DIABETES PRACTICES

TOOLS TO HELP YOU

The National Diabetes Education Program's (NDEP) refreshed "Practice Transformation for Physicians and Health Care Teams" (formerly known as "Better Diabetes Care") is designed for health care professionals and administrators who want to change systems of health care delivery around diabetes.

Practice change is essential to provide evidence-based care recommended by the Patient-Centered Medical Home (PCMH) model and to manage issues related to diabetes and its complications. This free online resource provides models, links, and tools to help physicians and health care teams initiate and maintain quality improvements in their health care practice. Content featured on this site is based on current, peer-reviewed literature and evidence-based clinical practice recommendations.

"Practice Transformation for Physicians and Health Care Teams" is organized by the following key sections:

Engage Leadership & Assess Your Practice: Helps users to review the tasks that effective leaders can undertake to ensure the successful transformation of a practice into a PCMH.

Provide Evidence-Based Care: Provides an overview of ways an evidence base can guide clinical decision-making. Includes principles and limitations of evidence-based decision-making, differences in numeric presentation of results, and ways to integrate an evidence base into daily practice.

Use Information Systems: Focuses on fundamental technological advances with known effectiveness in clinical systems for improving the process of care delivery and providing better clinical outcomes.

Improve Practice Quality: Addresses how to go about transforming a practice into a PCMH. It provides practical information about the use in clinical settings of rapid cycle improvements that involve small-scale local tests of change in physician offices or health care organizations.

Use Clinical Decision Support: Provides a wide selection of resources and tools that support diabetes prevention and management.

Practice Team-Based Care: Discusses the benefits of team care and useful resources for effective team building.

Enhance Patient-Centered Interactions: Presents seven dimensions of patient-centered care as they relate to people with diabetes, numerous resources to help transform a practice into a PCMH, effective ways to provide patient education and support, and suggestions to address health literacy and build cultural competency.

Improve Patient Care Coordination: Addresses ways to improve coordination of care and to enhance community partnerships. Numerous resources are included.

Visit [www.YourDiabetesInfo.org/Practice Transformation](http://www.YourDiabetesInfo.org/PracticeTransformation) to learn more.



Engage Leadership and Assess Your Practice



Provide Evidence-Based Care



Use Information Systems



Improve Practice Quality



Use Clinical Decision Support



Practice Team-Based Care



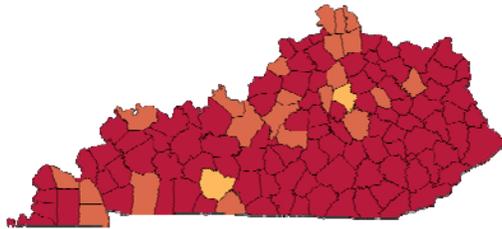
Enhance Patient-Centered Interactions



Improve Patient Care Coordination

Help Kentucky Reverse Diabetes Trends

2010 Diagnosed Diabetes Percentages in Kentucky
(Retrieved August 20, 2013 - CDC Diabetes Atlas)



- In 2010, 96 of Kentucky's 120 counties had rates of diagnosed diabetes at 11.2% or above (*see state map*). This ranks these counties in the top 20% of the nation.
- The Diabetes Prevention Program (DPP), the largest efficacy trial in diabetes prevention, proved that lifestyle interventions for high risk individuals reduced one's chance of developing type 2 diabetes by 58% and results were even greater for adults age 60 and older at 71%.
- The Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) is a key component of the [National Diabetes Prevention Program](#). The purpose of the DPRP is to recognize organizations that have shown that they can effectively deliver a lifestyle change intervention program to prevent type 2 diabetes.
- The Kentucky sites listed here meet this CDC Diabetes Prevention Recognition Program (DPRP) status.

REFER TO:
Kentucky's CDC Recognized Diabetes Prevention Program (DPP) Sites

Boyd	Fayette	Jefferson	Warren	Hamilton (OH)
King's Daughters Medical Center <i>(serves Boyd, Carter, Elliott, Greenup, and Lawrence counties)</i> 2201 Lexington Avenue Ashland, KY 41101 Kim Bayes kim.bayes@kdmc.kdhs.us (606) 408-1560	Baptist Health Lexington <i>(may also serve other counties)</i> 1740 Nicholasville Road Lexington, KY 40503 Kathleen Stanley kstanley@bhsi.com (859) 260-6674 or (859) 260-5122	Baptist Health Louisville <i>(may also serve other counties)</i> 4000 Kresge Way Louisville, KY 40207 Ronda Merryman-Valiyi ronda.merryman-valiyi@bhsi.com (502) 897-8831	Barren River District Health Department <i>(may also serve other counties)</i> 1109 State Street Bowling Green, KY 42101 Megan Givan megan.givan@barrenriverhealth.org (270) 781-8039	YMCA of Greater Cincinnati <i>(serves Northern KY)</i> 1105 Elm Street Cincinnati, OH 45202 Kiana Trabue ktrabue@cincinnatiymca.org (513) 362-2015 or (513) 362-YMCA
	Saint Joseph Hospital <i>(may also serve other counties)</i> Diabetes and Nutrition Center One Saint Joseph Drive Lexington, KY 40504 Dana Graves gravesdb@sjhlex.org (859) 313-2393 or (859) 313-1282 or (859) 313-1504	International Center for Advanced Pharmacy Services (INCAPS) <i>(may also serve other counties — program to begin in 2014)</i> 2100 Gardiner Lane Louisville, KY 40205 Dr. Josh Montney jmontney@sullivan.edu (502) 413-8644		
	YMCA of Central Kentucky <i>(may also serve other counties)</i> 239 East High Street Lexington, KY 40507 Debbie Dean ddean@ymcaofcentralky.org (859) 367-7332 or (859) 254-9622	YMCA of Greater Louisville <i>(may also serve other counties)</i> 545 South 2nd Street Louisville, KY 40202 Rebecca (Becca) Farmer rfarmer@ymcalouisville.org (502) 523-0283 or (502) 314-1613		

This information retrieved 9-4-13, for updates:

<http://www.cdc.gov/diabetes/prevention/recognition/states/Kentucky.htm>

Learn How to Become a CDC Diabetes Prevention Recognized Program (DPRP):

www.cdc.gov/diabetes/prevention/recognition/index.htm

A KENTUCKY SUCCESS STORY GROWTH IN PHYSICAL ACTIVITY

Printed in part from press release July 2013 www.kentucky.com

Positive news about the health of Kentuckians is rare, with the state ranking consistently near the bottom of most measures of good health. But a recent study showed Kentucky scoring well for the number of people who are getting enough physically activity.

"We were surprised," said Dr. Chris Murray, Director of The Institute for Health Metrics and Evaluation, which conducted the study. "Kentucky is a success story."

The findings from the independent health research center based at the University of Washington were collected over several years and broke out results by gender and county for the United States. Kentucky excelled in the percent of change in people getting sufficient physical activity or 150 minutes of moderate activity or 75 minutes of vigorous activity a week.

Seven of the top 10 counties for women were in Kentucky (Morgan, McCreary, Owen, Pulaski, Edmonson, Elliott and Knox). Six of the top 10 counties for men were also in Kentucky (Pike, Elliot, Muhlenberg, Martin, Ohio and McCreary).

Women getting sufficient physical exercise in Morgan County went up by 18 percent, the highest increase in the country! Morgan County Judge Executive Tim Conley said his community has been working to make exercise more of a priority. For example, people have created clubs and get together to walk or run. There has been an effort to educate people about how exercise is connected to good health.

One of the reasons Kentucky had such a high percentage change was that so few people were getting sufficient exercise when the research began, said Murray. But, he said, Kentucky has made greater strides than other states which had similarly challenging beginnings.

He said the research showed three factors that seem to have a positive impact.

- Community programs that promote physical activity.
- A physical environment that promotes physical activity such as parks or walking trails.
- Leadership at the state and local level invested in change.

"The changes reflected in the research are a reflection of an on-going effort in Kentucky," said Elaine Russell, obesity program manager for the state department of public health. State health officials created a plan for improving nutrition and physical activity in 2005, she said.

Murray said it's hard to pinpoint what has made a difference in Kentucky. Other states have similar programs without as much success. So, he said, the research will continue. *"What's interesting is trying to figure the formula that has worked there,"* he said.

MEDICATION COLUMN CREATOR PASSES ON THE TORCH



Sarah M. Lawrence
PharmD, MA

Sarah Lawrence, PharmD, MA and the creator of this newsletter's quarterly medication column is passing on the oversight for development of that column to Carrie Isaacs, PharmD, CDE, with the University of Kentucky and the Kentucky Pharmacy Coalition.



Carrie Isaacs
PharmD, CDE

Sarah was quoted as saying, *"I am proud to have been part of the development of this column, and have had the opportunity to work with many great pharmacists and pharmacy students in the editorial process. I look forward to reading future columns and to continuing to serve in an advisory capacity."*

We would like to sincerely thank Sarah for her creative ideas and all of her past work in developing the medication column.

If you have ideas for Carrie for what you would like to see in future medication columns, email carrie.isaacs@uky.edu.



Virginia Fields
PharmD

Medication Column Update From the Second Quarter 2013

Dr. Fields, who wrote the Medication Column in the last issue of this newsletter, wanted to send readers the source for the answer to the "first myth" regarding how many times a person with diabetes on oral medications (only) needed to test their blood glucose. See her note to readers.

There are several articles that discuss the lack of benefit in blood glucose monitoring in patients only on oral medications. The recommendation of 2-3 times weekly monitoring is from the National Pharmacy Benefit Management for the Veterans Health Administration based on efficacy, safety and cost analysis. It is VA policy that veterans may receive 50 strips per 90 days if only on oral meds, and this extrapolates out to 2-3 times weekly testing. Several private prescription insurance companies also limit the number of test strips a patient can have if only on oral medications.

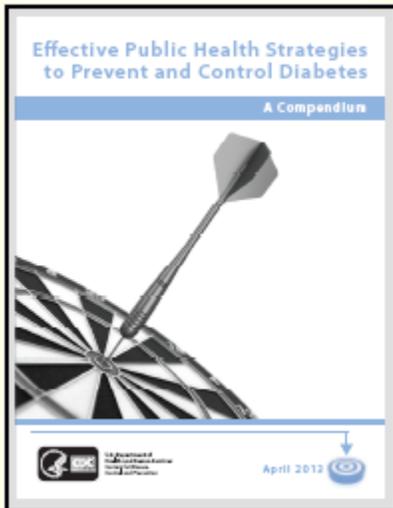


References: *Diabetes Care* January 2009 vol. 32 no. Supplement 1 S13-61.
Lee J, Dang D; *Diabetes mellitus: Pathophysiology, diagnosis, screening, and risk factors. Drug Topics.* September 2012;44-50.
Cameron C, Coyle D, Ur E, Klarenbach S. *Cost-effectiveness of self-monitoring of blood glucose in patients with type 2 diabetes mellitus managed without insulin. CMAJ.* 2010;182:28-34.
Simon J, Gray A, Clarke P, et al; *Diabetes Glycaemic Education and Monitoring Trial Group. Cost effectiveness of self monitoring of blood glucose in patients with non-insulin treated type 2 diabetes: Economic evaluation of data from the DiGEM trial. BMJ.* 2008;336:1177-1180.

HAVE YOU HEARD?

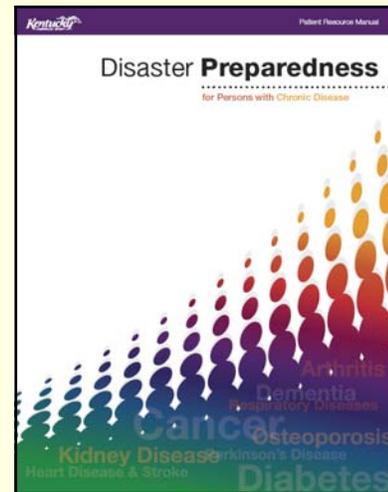
KENTUCKY WORK FEATURED IN CDC COMPENDIUM

Two pieces of Kentucky's work, the Diabetes Centers of Excellence (DCOE) and state/local diabetes coalitions are featured in a CDC published document entitled, *Effective Public Health Strategies for Diabetes Prevention and Control*. To review the document, you can access the document at: <http://www.cdc.gov/diabetes/pubs/pdf/PublicHealthCompendium.pdf>



KY DISASTER PREPAREDNESS BOOK INCLUDES DIABETES

A Disaster Preparedness for Persons with Chronic Disease Patient Resource Manual has been printed and is available through the Department for Public Health, Chronic Disease Branch. The manual includes a section on diabetes. To download a copy go to: <http://chfs.ky.gov/dph/info/dpqi/ed/default.htm> or call 502-564-7996.



world diabetes day
14 November

A campaign led by the International Diabetes Federation

arabic - español - français - português



DIABETES: PROTECT OUR FUTURE

SAVE THE DATE JDRF EVENT

ENJOY AN EVENING IN OZ AND
SUPPORT JDRF AT THE 17TH
ANNUAL PROMISE GALA

**SATURDAY
FEBRUARY 15, 2014**

AT HENRY CLAY
LOUISVILLE, KY

**HONORARY GALA CHAIR
TOM PARTRIDGE
PRESIDENT AND CEO FIFTH
THIRD BANK, KENTUCKY**

SILENT & LIVE AUCTIONS
LIVE MUSIC FEATURING **HAPPY HOUR**
FOR INFORMATION CONTACT:
MEREDITH GAULT MGault@JRRE.org



Free Diabetes Materials and Videos Offered

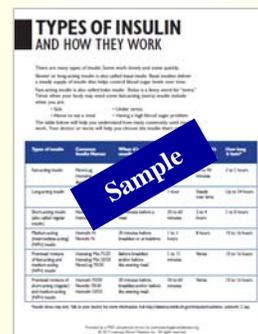
LEARNING ABOUT DIABETES

Learning about Diabetes, Inc. is pleased to announce that a new handout, **TYPES OF INSULIN**, has been posted on www.learningaboutdiabetes.org.

The handout provides a brief summary of the more commonly used types of insulin and information about:

- When insulin is usually taken
- How soon insulin starts working
- When insulin is working the most
- And how long insulin lasts

Visit learnaboutdiabetes.org to download the handouts.

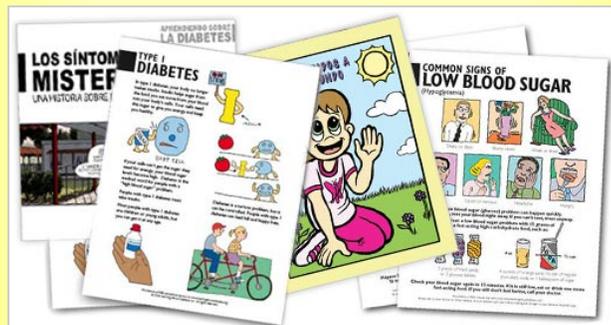


FREE Diabetes Videos

In response to a number of requests from diabetes educators, in addition to being on YouTube you will now find free diabetes education videos

- *What is Diabetes?*
- *Type 2 Diabetes*
- *Walking Works*

www.learningaboutdiabetes.org/videos.html



Congratulations to TRADE's
CDE Scholarship Winner



Janet Meyer

The Tri State Association of Diabetes Educators (TRADE) Local Networking Group (LNG) of AADE would like to congratulate Janet Meyer, the recipient of the TRADE Certified Diabetes Educator (CDE) Scholarship (given annually to a diabetes educator active in TRADE to take or renew their CDE credential). During the TRADE Workshop in April, Janet was presented the award. Janet, who is a former TRADE President and currently works as a nursing instructor at Henderson Community College, plans to renew her CDE this year by CEUs.

The TRADE CDE scholarship drawing application needs to be submitted prior to the January TRADE LNG meeting of the year the applicant is applying.

For more information about the *TRADE CDE Scholarship* contact:
Nancy Wilson 270-686-7747 ext. 3022 or nancy.wilson@grdhd.org.



2013 Webinars

An AADE live webinar is a knowledge based activity offering 1.5 hours CE credit. All webinars are from 1:00 - 2:30 pm EST, unless otherwise noted. Call 800-338-3633 x 100 for information.

FREE Webinar available to AADE members
Comparing Effectiveness of Medications for Adults with Type 2 Diabetes Management

go to <https://www.diabeteseducator.org/ProfessionalResources/products/webcasts.html>

- 11-6-13 Dental Care and Diabetes
- 11-20-13 GDM— After the Birth
- 12-4-13 The Workplace and Diabetes
- 12-11-13 Diabetes Co-Morbidities

For a complete listing of Webinars visit:
<https://www.diabeteseducator.org/ProfessionalResources/products/webinars.html>



Visit the American Diabetes Association's professional education website!
PROFESSIONAL.DIABETES.ORG/CE

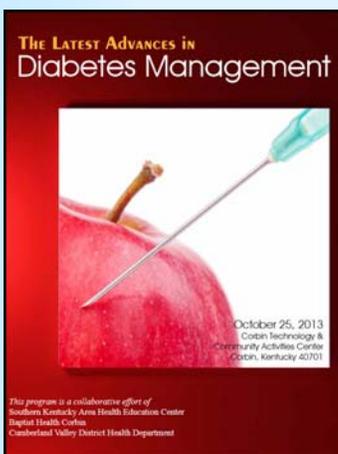
Free Continuing Education Credits

for health care professionals who treat patients with diabetes.



DIABETES EDUCATION OFFERINGS

Corbin Diabetes Symposium October 25, 2013



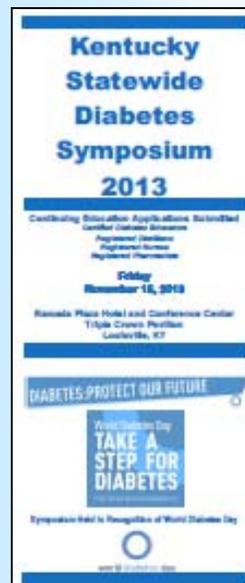
The Latest Advances in Diabetes

**Corbin Technology & Community Activities Center
 Corbin, KY 40701**

For More Information:
 Southern KY Area Health Education Center
<http://www.soahec.org/cecme.html>

Kentucky Statewide Diabetes Symposium 2013

Friday, November 15, 2013



**Ramada Plaza and Conference Center
 Louisville, KY**

Contact Hours for Nurses, Dietitians, Pharmacists have been approved

Brochures now available.
 Online registration:
<http://tinyurl.com/KYDiabetes2013>

For additional information, contact:

Julie Shapero, RD, LD (859) 363-2116
julie.shapero@nkyhealth.org
 Or
Janice Haile, RD, CDE
 (270) 686-7747 Ext. 3031
janice.haile@ky.gov

KADE DIABETES EDUCATOR MEETINGS SCHEDULED

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

December 13, 2013 11:30 am

(*Malone's Tate Creek Road Annual Christmas Gathering*)

March 14, 2014 ALL DAY CONFERENCE 8-4 pm

(*Central Christian Church, Lexington, KY*)

April 19, 2014 *Other details pending

KENTUCKY DIABETES NETWORK (KDN) MEETINGS SCHEDULED

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

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

2013 KDN Meeting Dates (10 am—3 pm EST)

December 6, 2013 — KY History Center, Frankfort

GLADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Greater Louisville Association of Diabetes Educators (GLADE), (*covers Louisville and the surrounding area*), meets the second Tuesday every other month.

Registration required. For a meeting schedule or to register, contact Vanessa Paddy at 270-706-5071

Vpaddy@hnh.net or Anne Ries at 502-852-0253
anne.ries@louisville.edu

November 12, 2013

Baptist Hospital East

Speaker and Topic: To Be Announced



Photos on this page are from the TRADE Workshop 2013, registration volunteers (shown left) and conference attendees (shown in right column).

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 Pam Doyle at pdoyle5@its.jnj.com or call 877-937-7867 X 3408. Meetings are held in Cincinnati four times per year at the Good Samaritan Conference Center unless otherwise noted.

Registration 5:30 PM — Speaker 6 PM

1 Contact Hour

Fee for attendees who are not members of National AADE

TRADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Tri-State Association of Diabetes Educators (TRADE), (*covers Western KY/Southern IN/Southeastern IL*) meets quarterly from 10 am – 2:15 pm CST with complimentary lunch and continuing education. To register, call Nancy Wilson at 270-686-7747 extension 3022 or email Nancy at nancy.wilson@grdhd.org.

Date: Thursday, October 17, 2013

Title: Diabetes Update 2013

Speakers: Joseph Loftus, MD, MS

Bradley Ward, PharmD

Location: Baptist Health Medical Associates

(formerly Trover Clinic)

Building B - 8th Floor

Loman C. Trover & Faull Trover Conference Rm.

200 Clinic Drive

Madisonville, KY 42431

Hostess: Debra Brothers, RN, CDE

2.0 Contact Hours



ENDOCRINOLOGISTS MEETINGS SCHEDULED

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

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Contact Information

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www.diabetes.org
1-888-DIABETES

TRADE
Tri-State Association of Diabetes Educators

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

KDN
KENTUCKY DIABETES NETWORK, INC.

www.kentuckydiabetes.net

KENTUCKY ASSOCIATION OF DIABETES EDUCATORS

KADE
Local Networking Group of AADE
A LOCAL NETWORKING GROUP of the
AADE American Association of Diabetes Educators

www.kadenet.org

GREATER LOUISVILLE ASSOCIATION OF DIABETES EDUCATORS

GLADE
A LOCAL NETWORKING GROUP of the
AADE American Association of Diabetes Educators

www.louisvillediabesity.org

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AACE American Association of Clinical Endocrinologists

Ohio River Regional Chapter

www.aace.com

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joslin@fmhhs.com

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