

Kentucky Diabetes Connection



The Communication Tool for Kentucky Diabetes News

AACE

American Association of
Clinical Endocrinologists
Ohio Valley 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

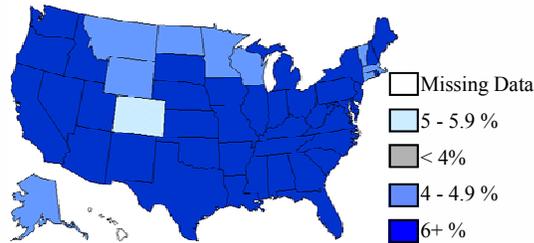
Kentucky Diabetes Prevention
and Control Program

TRADE

Tri-State Association of
Diabetes Educators

A Message from Kentucky Diabetes Partners

THE NATIONAL DIABETES SURVEILLANCE SYSTEM — IS KENTUCKY ON THE RIGHT TRACK?



State-specific Estimates of Diagnosed Diabetes Among Adults

The Centers for Disease Control and Prevention (CDC) offers a national diabetes surveillance system available through <http://www.cdc.gov/diabetes/statistics/index.htm>. This website offers national and state data with detailed charts and maps and even allows KY to track diabetes care trends and practices over the last four to ten years. This surveillance system also allows KY to compare diabetes outcomes with other states. The information contained within this article was taken from the CDC website.

Although Kentucky's prevalence of diabetes continues to climb, Kentucky has made many improvements in increasing diabetes care practices! Kentucky's diabetes prevalence (existing cases) of diagnosed diabetes among the adult population was at least 50% higher in 2004 than in 1994. Specifically, the prevalence of diagnosed diabetes per 100 adult population was 3.9 in 1994 and 7.8 in 2004. Numbers of Kentuckians (in thousands) with diagnosed diabetes was 109 in 1994 and 254 in 2004.

In most states, the number of adults with diabetes who receive "diabetes preventive care practices" increased. Even though the data included within this article show that the rate of all but one of Kentucky's diabetes preventive care practices increased, there is still a need for

additional improvement in the current levels to achieve national health goals.

Kentucky trends in various "diabetes care practices" are outlined below (all data is based upon age adjusted rates per 100 KY adults with diabetes):

- Rates of Dilated Eye Exams in the Last Year were 55.6 in 1995 and 65.5 in 2004
- Rates of Daily Self-Monitoring of Blood Glucose were 32.2 in 1995 and 64.9 in 2004
- Rates of Foot Exam (by Professional) in the Last Year were 49.2 in 1995 and 62.9 in 2004
- Rates of Seeing a Health Professional for Diabetes in the Last Year were 90.9 in 1995 and 93.7 in 2004
- Rates of Daily Self-Exam of Feet were 78.5 in 2000 and 81.4 in 2004
- Rates of Two or More A1c Tests in the Last Year were 71.1 in 2000 and 72.4 in 2004
- Rates of Ever Attending a Diabetes Self-Management Class were 48.1 in 2000 and 47.2 in 2004
- Rates of Influenza Vaccination in the Last Year were 30.2 in 1993 and 50.5 in 2004
- Rates of Ever Receiving a Pneumococcal Vaccination were 21.1 in 1993 and 41.1 in 2004.

For complete information go to: <http://www.cdc.gov/diabetes/statistics/index.htm>.

DIABETES COALITIONS MAKING A DIFFERENCE THROUGH THE SUPPORT OF THE APPALACHIAN DIABETES CONTROL AND TRANSLATION PROJECT (ADCTP)

Submitted by: *Shelia Plogger, ADCTP Project Coordinator, Marshall University School of Medicine, Huntington, West Virginia*

Diabetes coalitions across the Appalachian region are making a difference in their communities by reducing the impact of diabetes on people living in Appalachia. The coalitions are supported through small grants by the unique partnership of the Appalachian Regional Commission (ARC) and the Centers for Disease Control and Prevention (CDC) with the collaboration of the thirteen Appalachian states. The grants are managed by the Robert C. Byrd Center for Rural Health at Marshall University located in Huntington, West Virginia. The research team at Marshall University provides technical assistance that helps community partnerships organize around the problem of diabetes including planning, implementing, and evaluating their projects, in addition to creative training opportunities for coalition sustainability.

The Appalachian Diabetes Control and Translation Project (ADCTP) began in 2000-2001 and has since funded 44 coalitions including nine from the state of Kentucky! The nine Kentucky counties receiving ADCTP funding for their coalitions are located in **Morgan, Elliott, Harlan, Carter, Magoffin, Wayne, Perry, Pike and Lawrence** counties. Approximately 40 coalitions continue to stay active in their communities long after the funding is gone. The sustainability of the coalitions are credited to the technical assistance provided by the Marshall University team and the dedication and commitment of people in the community who are working to combat one of the leading causes of death among people living in the Appalachian Region.

After an ADCTP Diabetes Coalition receives their mini-grant, they begin a series of aggressive activities in their communities to address the problems surrounding diabetes. This is done primarily through promoting healthy behavior change among children and adults in the community. Some of the activities involving children include: the development of calendars with drawings of diabetes messages (completed by students); the implementation of an after-school "healthy" program; and a partnership with a local food restaurant to promote a "Healthy Meal" box for kids (including action figures). The "Healthy Meal" box was quite successful and nearly 500 meals were ordered in the fourth week of the promotion! The coalition reported that the restaurant had many adults that wanted to take advantage of the kids' meal as well.

Other examples of activities have included: a partnership with local businesses to develop walking/activity clubs for employees; partnership with a high school Spanish class to

translate diabetes self-management materials into Spanish for immigrants and migrant workers; and much more!

For more information on the Appalachian Diabetes Control and Translation Project (ADCTP), contact Shelia Plogger at 304-245-6018 email splogger@marshall.edu, Richard Crespo at 304-691-1193 email crespo@marshall.edu, or one of the other team members at Marshall University.

APIDRA - A NEW CHOICE IN INSULIN THERAPY

Submitted by: *Deborah Ballard, MD, Internal Medicine, Louisville Endocrinology, Louisville, KY*

Apidra (insulin glulisine) is a rapid acting insulin analogue developed by Sanofi-Aventis Pharmaceuticals. Because of Apidra's rapid onset of action, it can be administered any time between 15 minutes before a meal or 20 minutes after a meal. Its peak effect occurs in 1 hour and its duration of action is 4 hours.

One unit of glulisine equals one unit of regular human insulin. An open bottle of Apidra can be stored at room temperature (<77 degrees) for 28 days.

Insulin glulisine can be used in insulin pumps. The infusion set and insulin need to be changed every 48 hours, just as with other rapid acting insulin analogues.

In a study of obese non-diabetic patients, insulin glulisine was found to have a more rapid onset of action than insulin lispro.

Insulin glulisine was found to be well tolerated and safe in children. Post prandial glucose excursions were lower after insulin glulisine than after regular human insulin. Currently, Apidra is not FDA approved for use in children.

Use of premeal glulisine has been shown to result in better A1c reductions than premeal regular insulin. Postmeal glulisine was as safe and effective as premeal glulisine or regular human insulin in combination with insulin glargine and was not associated with weight gain.

For patients with Type 1 or 2 diabetes mellitus, Apidra, when added to a basal insulin such as glargine, can help improve glycemic control by allowing greater flexibility in the dosing schedule, better compliance, and less hypoglycemia.

References available upon request.



A DIABETES FOCUS THROUGH THE KY DEPARTMENT FOR MEDICAID SERVICES — DIABETES CARE CHOICES

Submitted by: Department for Medicaid Services, Division of Medical Management and Quality Assurance

The face and shape of Kentucky Medicaid is changing. The KY Department for Medicaid Services (DMS) has launched Diabetes Care Choices, a disease management initiative. The goal of the initiative is to empower Medicaid members to be more informed about and actively engaged in the management and control of their diabetes. The purpose of this program is to provide Medicaid members with diabetes education about the care they should be receiving and guiding them to appropriate professional and community resources. Promoting healthy choices will help prevent or delay diabetes complications.

The Division of Medical Management and Quality Assurance (MMQA) for the Department for Medicaid Services, is planning efforts around diabetes and future initiatives. Partnering with the KY Department for Public Health and other health care providers, the hope is to provide seamless, coordinated efforts for increasing the awareness of the seriousness of the disease, and for providing the resources available for its control. This Division would also like to see an increase in the number of Medicaid members with diabetes receiving at least annual dilated eye exams, foot exams, hemoglobin A1C measurements, lipid profiles, and urinalysis for protein.

DMS launched the “diabetes initiative” in July 2005 in Floyd and Bell counties. The initial phase of this initiative consisted of mailing introductory packets to “identified members” within these counties. The health care providers and Medicaid members in these two counties were also forwarded introductory letters. DMS MMQA “Regional Nurses” visited health care provider offices to provide information and education about the initiative and to deliver diabetes resource packets.

“Regional Nurses” also had appointments with the health care providers to review the Medicaid members’ records. Information was collected on 10% of the patient population to assess compliance with clinical recommendations. This data will be used to measure the degree of improvement over several months. As of September 2005, this data was in the process of being analyzed and aggregated. The initial member and health care provider feedback about the diabetes initiative has been positive.

The provider/member resource packets included:

- Diabetes Care Tool, 01-2005, developed by Kentucky Diabetes Network, Inc. (KDN)

- Kentucky Diabetes Prevention and Control Program pamphlet.
- Diabetes Numbers At-a-Glance/Diabetes Management Schedule, National Diabetes Education Program (NDEP), National Institutes of Health (NIH).
- Kentucky Diabetes Connection, Spring 2005 edition.
- Getting the Very Best Care for Your Diabetes, American Diabetes Association, Inc. (ADA).
- My Personal Diabetes Health Card (KDN).
- Kentucky Medicaid Information newsletter/brochure (DMS, April 2005).
- Guide to Diabetes Educational Materials (KDN, August 2003).
- DMS MMQA Regional Nurse Grid (02/10/05).
- Diabetes Care, 2005 with the Clinical Practice Guidelines (ADA), web address resource information.
- If You Have Diabetes: Protect Your Eyesight (KDN brochure)- added to provider packet only.

During December, 2005, a second mailing was sent to Medicaid members in Bell and Floyd Counties (included members previously identified in the first mailing). This mailing consisted of a newsletter that contained the following information:

- Definition of diabetes
- Helpful tips
- Foot care
- Healthy eating
- Alcohol - know your limits.

Through providing quarterly mailings to the targeted population, DMS staff look forward to educating members regarding diabetes and the devastating complications that can arise from this disease.



KENTUCKY SCHOOL HEALTH AND NUTRITION LAW- IMPLEMENTATION UPDATE

Submitted By: Paul McElwain, School and Community Nutrition,
Kentucky Department of Education (KDE)

Note: This article is an update to the School Nutrition and Physical Activity law passed in the 2005 Kentucky legislative session and serves as an update to the article written in the Spring issue of this newsletter.

Senate Bill 172 was passed in the 2005 session and requires districts and schools to focus additional attention on the nutrition and physical activity environments available to students.

Specifically, school districts are in the process of issuing reports on their evaluations of the nutrition and physical activity environments. These required reports contain recommendations to improve the environments as well as recommendations that local school boards will use to present a plan to improve nutrition and physical activity in the schools. By law, those plans are to be presented on or before January 31 of each year, including 2006. These requirements are in the Kentucky Revised Statutes (KRS) 158.856.

Because many school districts have been analyzing menus for some years now, they are in a position to report that students “do” have daily access to “lower fat” lunch menus, should the student decide to choose those items. Many districts are already in the process of improving the nutrient density of the food and beverage items available through vending machines, school stores, as fund raising activities, as reward items for classroom behavior (a particularly disreputable practice) and as extra items on the cafeteria lines. The new regulation recently adopted by the Kentucky Board of Education will accelerate that improvement as schools will be required, at a minimum, to meet the standards therein. These requirements are in KRS 158.854 (<http://www.lrc.ky.gov/record/05rs/SB172/bill.doc>). The standards are in the Kentucky Administrative Regulation, 702 KAR 6:090 (not yet final). The beverage standards address volume, size, and sugar content while allowing the sale of water, milk, 100% fruit juice and diet soft drinks. The food standards limit fat and saturated fat to 30% and 10% of calories, respectively, while restricting sugar, sodium and addressing portion and pack size. Hopefully, the regulation will be final as of the reading of this Newsletter.

Finally, schools containing grades K-5 are required to develop and implement a policy that provides for daily, moderate to vigorous physical activity for students. The legislation does not contain a mandated minimum amount of time. K-5 schools are assessing the amount and quality of time currently set aside for physical education / physical activity and making decisions about the sufficiency of that time. This requirement is outlined in KRS 160.345(11). Schools are integrating more physical activity into the school

day with morning/afternoon walking clubs and programs like *Take 10* in the classroom. Teachers are finding that students, as well as the teachers and aides themselves, quickly become accustomed to a regular regimen of activity and look forward to that part of the day. It is possible to engage in physical activity and review core content at the same time. The KDE can direct readers of this Newsletter to teachers who can show other teachers how to do this.



2006 CDC DIABETES AND OBESITY CONFERENCE — MARK YOUR CALENDAR!

The Center’s for Disease Control and Prevention (CDC)’s, Division of Diabetes Translation, will convene its annual diabetes conference May 16–19, 2006, at the Adams Mark Hotel, 1550 Court Place, Denver, Colorado. This first time conference collaboration between CDC’s Division of Diabetes Translation and CDC’s Division of Nutrition and Physical Activity will discuss issues concerning both diabetes and obesity. The conference will bring together approximately 800 participants from a wide range of local, state, federal, and territorial governmental agencies as well as private-sector diabetes and obesity partners.

Conference Goals

- Explore science, policy, education, program planning, implementation, and evaluation to enhance public health approaches and strategies to prevent and control diabetes and obesity.
- Increase knowledge and awareness of successful, cost-effective, public and private diabetes and obesity programs.
- Present innovative strategies to increase awareness of diabetes and obesity and how to prevent their complications.
- Provide opportunities for skill-building, information-sharing, and networking.

Mark your calendars to attend the CDC Diabetes and Obesity Conference, May 16–19, 2006, at the Adams Mark Hotel, 1550 Court Place, Denver, CO. Registration information available through CDC at: <http://www.cdc.gov/diabetes/conferences/index.htm#2006> or contact Norma Loner at 1-770-488-5376 to receive registration information. Telephone for the Adams Mark is 303-893-3333 or 800-444-ADAM.

THE INCRETINS: A NEW CLASS OF DRUGS

*Commentary by: Zouhair Bibi, MD, Endocrinologist, Medical Director,
Joslin Diabetes Center, Evansville, IN, ACE Member,
Honorary TRADE Member*

In 1940, the existence of incretins was first considered and between 1960 and 1970 the incretin-concept has been revived. The “incretin effect” is a phenomenon in which oral glucose administration provokes greater insulin secretion than intravenous glucose administration. This means, that when glucose is taken orally, insulin secretion is stimulated much more than it is when glucose is infused intravenously. This effect, the incretin effect, is caused by two hormones, glucose-dependent insulinotropic peptide (GIP) and glucagon-like peptide-1 (GLP-1). Both of these hormones are secreted from endocrine cells located in the intestinal mucosa. This “incretin effect” is estimated to be responsible for 50 to 70% of the insulin response to glucose. Unfortunately this “incretin effect” is greatly impaired or absent in individuals who have diabetes.

In studies of the mechanism of the impaired “incretin effect” in patients with type 2 diabetes, it has been found that the secretion of GIP is generally normal, whereas the secretion of GLP-1 is reduced but its effect is preserved. The preserved effect of GLP-1 has inspired attempts to treat type 2 diabetes with GLP-1 or analogues.

Recently, the FDA approved Exenatide, the first incretin mimetic, as adjunctive therapy to improve glycemic control in patients with type 2 diabetes who are not well controlled with oral hypoglycemic agents (metformin and/or sulfonylurea). Exenatide is the first drug in the new class of incretin mimetics.

Exenatide is an incretin mimetic which has multiple antihyperglycemic actions similar to natural incretin hormones. Basically it mimics several glucoregulatory actions of the incretin GLP-1. Mechanisms by which Exenatide improves glycemic control include enhancing glucose-dependent pancreatic insulin secretion in response to nutrient intake, inhibiting glucagon secretion, delaying gastric emptying, and promoting early satiety. The fact that the enhancement of insulin production is glucose dependant means that Exenatide helps the body produce the right amount of insulin at the right time, thus decreasing the risk of hypoglycemia. Exenatide is resistant to the enzymatic degradation by dipeptidyl peptidase IV (DPP IV), thus extending its presence in plasma following a SC injection (the half-life of GLP-1 is 60 to 90 seconds).

Clinical trials have shown that the use of Exenatide lowered HbA1c and reduced both fasting and postprandial glucose concentrations. Also patients on Exenatide lost weight. Data from clinical trails in patients with type 2 diabetes demonstrated that the significant reductions in A1C and weight were durable through 82 weeks. Animal studies have

shown that Exenatide might promote islet differentiation and inhibit beta-cell apoptosis. **If this turns out to also be the case in humans --- this could potentially reverse the course of the disease!**

In conclusion, Incretin mimetics are a unique class of drugs which will transform our thinking on how to treat diabetes when one or more oral agents fail.

JILL'S EYESIGHT IS SAVED!

Submitted by: Ruth (Rosie) Woolum, Hazard Perry County Community Ministries, Hazard, KY

Note: The following letter was written by Jill, a diabetes patient of the Little Flower Clinic, which is part of the Hazard Perry County Community Ministries and serves as one of Kentucky's federally funded diabetes collaborative sites.

Sitting here, looking out my bay window, watching humming birds come up and drink, I recall that a few days ago the clarity of my distant vision was so poor that I couldn't distinguish the shape of the little birds or that they were even there.



I am a 42 year old diabetic whose vision had become so impaired that I was afraid to drive and I feared my ability to keep my job. I had no insurance that would pay for an eye exam, or cover the cost of glasses, nor could I afford to pay for the exam. Thanks to Community Ministries-Little Flowers Free Clinic and the doctors on their Rotary program, I was able to get an eye exam at no cost to myself.

The girls at the clinic made my appointment with a doctor at the Kentucky Vision Center. When the doctor did my exam, he realized that glasses would not correct my vision. I had a lot of bleeding behind my eyes and he feared some retinal damage. This doctor treated me like I was his highest paying customer and referred me immediately to a retinal specialist. I went to the specialist the very next day.

My vision in my left eye was 20/100 and the vision in my right eye was 20/80. I was considered legally blind. Now, after three laser treatments, my vision has improved to 20/60 in my left eye and 20/40 in my right eye. I am able to drive now and should be able to be fitted for glasses in just a few weeks. I now have hope for my eyesight in the future.

Had this condition not been checked, the retinal damage would have been irreversible. Had it not been for Community Ministries and the eye doctors donating their time, I don't know how long I would have put off having this exam.

Thank God for the doctors in the Rotary Program.

DIABETES HEALTH DISPARITIES COLLABORATIVES: ONE APPROACH TO DISEASE MANAGEMENT

Submitted by: Andrea Adams, KY Primary Care Association

Disease management is a hot topic in Kentucky. The Fletcher administration has made Medicaid reform a priority and lists disease management among its top initiatives. Medicaid providers await finalization of the Administrative Service Organization (“ASO”) award and wonder what form disease management will take under the ASO contract. For a hint at what might come, this article explores an existing program initiated by the federal government to manage the most common chronic diseases among the nation’s most vulnerable populations: Health Disparities Collaboratives (HDCs).

In 1998, the federal Bureau of Primary Health Care (BPHC) began the first HDC, which focused on diabetes, and have since added HDCs for asthma, hypertension, depression, cardiovascular disease, and cancer. Reductions in health disparities are sought through improvements in clinical care delivery and patient self-management. Both process and outcome measures are closely monitored.

Clinical Care Delivery

Many experts agree an evidence-based change in the health care delivery system is needed and long overdue. “Very little has changed in the last 50 years regarding how the health care system cares for patients” notes Dr. Julia Richerson, Medical Director of Family Health Centers in Louisville. “We have new medicines and new treatments, but how we approach the patient has remained essentially unchanged. The old system does not work. If we want our patients to be healthier, we must transform what we do every day.”

The HDCs use three models to change the health care delivery system. The “Learning Model” distills best practices from a national panel of experts, then disperses knowledge to individual health center HDC teams. A “Care Model” is then employed at the health center to identify patients and target both clinical and educational services to them both from within the health center and the community at large. Feedback is given to the HDC teams that engage in a continuous “Improvement Model”, which calls for evaluating, implementing, and testing changes. HDCs provide information on best practice standards and a process for achieving effective implementation in the real world.

How the Health Disparities Collaboratives (HDC) Work

Here’s how the HDCs work. A clinic, predominantly federally funded health centers, applies for admission into one of six HDCs. Patients being seen at the health center for that chronic condition are entered into a registry. Baseline measures are taken on key indicators of health status and quality of care. Those measures are tracked over time and

benchmarked against data from other participating health centers.

Take, for instance, the diabetes HDC. One indicator of the health status of diabetic patients is HbA1c levels. The HDC uses the average HbA1c level of diabetic patients registered at the health center to gauge how that center’s patients are doing over time with respect to the health center’s targets and other health centers in the HDC. Target levels are set. Progress is monitored.

A second use of the HbA1c data is to assess process rather than outcomes. Here, data for registry patients are checked for frequency of testing. Specifically, how many registered diabetic patients have received 2 HbA1c’s spaced at least 91 days apart within the last year?

In short, standard treatment protocols for chronic diseases have been developed and are fairly well accepted. The questions then become: How closely are those protocols being followed? How effective has the standard treatment been? What needs to happen at the patient and provider levels to increase the effectiveness of or adherence to recommended treatment protocols? The HDCs drive quality improvement by providing quantitative feedback to help answer those questions.

Working Together: The Case Management Team

Effectively implementing treatment protocols requires extensive coordination of care. “Historically, organizations have selected a ‘case manager’ to facilitate and coordinate care recommendations. Considering that health care organizations treat thousands of patients each year, coordination and monitoring of care by one individual can be a tremendous task,” according to Pat Willis, RN, MSN, Director of Patient Services for Big Sandy Health Care, which is headquartered in Prestonsburg, KY.

HDCs emphasize the use of evidence-based guidelines and electronic registries to provide a framework for a “team approach” that allows information input from several sources and can be used for multiple purposes. “Registries have become a pivotal tool in case management,” says Ms. Willis. “The team can easily identify patients needing follow-up exams or referrals and provide an array of preventive care reminders for the health team. Simply stated, case management is “planned care” with documented follow-up.” In HDCs, the planning process is aided by treatment protocols. The documentation and follow-up processes are aided by the electronic registry.

Community Partners

HDCs further broaden the care of chronic disease to encompass a team approach that taps into community resources outside the health center. One HDC community partner is the Kentucky Diabetes Prevention and Control Program (KDPCP) of the Kentucky Department for Public Health. “The KDPCP is proud to be a supporting partner for the HDC teams in the Commonwealth. This innovative quality

improvement approach is a very comprehensive effort that seeks to redesign the system for more effective chronic disease management. Through the HDC, medical staff are given the training, tools, and support to become a more prepared and proactive healthcare team in the provision of medical care for challenging chronic conditions such as diabetes or heart disease. The focus of this approach also seeks to motivate and actively involve the patient. KDPCP is excited about the tremendous potential of the HDC for improving diabetes treatment and outcomes in some of our most vulnerable Kentucky population,” says Retia Jones, BSN, RN, of the Kentucky Diabetes Prevention and Control Program, KY Department for Public Health.

Patient Self-Management

But the HDCs are more than protocols and do not rely solely on health care providers. Patients are educated and empowered to play a more proactive role in managing their health. The doctor’s role becomes more advisory, less authoritarian. The treatment plans become more collaborative, less prescriptive. Patients become more proactive and are asked to set self-management goals based on what they believe they can accomplish in conjunction with health center and community resources. As a result, patients become part of the team and learn to manage their symptoms in a way that better fits into their lives.

Not long ago, Milt Stanfield, who is the District 1 Magistrate for Lewis County, became part of another family, one that he did not join by relationship or choice. He joined this particular family due to a medical condition. Milt is a part of the Lewis County Primary Care Center’s Cardiovascular Collaborative. He is a patient of a family physician at the Tolles-

boro Family Health Center. Milt has strong feelings about the care that he receives. He states, “The doctor is one of the best doctors that we have ever had around here. She cares a lot for the folks she sees here in Tollesboro. In addition, she includes me in setting goals for my health care.” He went on to say that, “My blood pressure was always tough to control, and I also suffer from some gout. My goals were to have my blood pressure controlled better, and to reduce my gout symptoms.” Milt proudly states that, “Through the combined partnership of his physician, I have fewer problems with my gout, and my blood pressure is better now than it has been in many years.”

Motivating patients and providers is part of the HDC process that includes community partners and patients in establishing self-management goals. The overall goal is to improve the health status of patients under the care of the provider using an evidence-based approach.

HDCs in Kentucky

Twelve Kentucky organizations participate in at least one HDC (see Table 1). The HDC teams in Kentucky and Tennessee are managed through the Kentucky Primary Care Association. Brenda Wheatley, the HDC Cluster Coordinator, says that “HDC teams support and network with each other through listserves and national disease-specific conference calls. The sharing process is great. Participants are encouraged to share experiences and work with one another and to answer questions for each other. The collaborative has helped not only the patient experience in the center but has helped develop teamwork among health center staff.”

Table 1: Kentucky Clinic Participating in HDCs. Service areas are included.

KY DIABETES COLLABORATIVE NAMES		Counties Served
	Big Sandy Health Care	Floyd, Johnson, Magoffin, Martin, Pike counties
	Bowling Green-Warren County Primary Care Center	Warren, Butler and Edmonson counties
	Community Health Centers of Western Kentucky	Muhlenberg and surrounding counties
	Dayspring Family Health Center	Whitley County, and nearby areas in Tennessee
	Family Health Centers	Jefferson County
	Harlan-Perry Healthcare for the Homeless	Perry and Harlan counties
	HealthPoint Family Care	Campbell, Kenton, Bracken, Robertson counties
	Morgan County ARH	Morgan County
	Park DuValle Community Health Center	Jefferson
	White House Clinic	Jackson and Madison counties.
CARDIOVASCULAR DISEASE COLLABORATIVE		
	Big Sandy Health Care	Floyd, Johnson, Magoffin, Martin, Pike
	Bluegrass Farmworker Health Center	Madison, Fayette, Woodford
	Lewis County Primary Care Center	Lewis, Mason, Fleming, Rowan, Greenup and Boyd counties in Kentucky and three counties in Ohio

**THE FOUNDATION FOR A
HEALTHY KENTUCKY OFFERS
GRANT OPPORTUNITY**

*Submitted by: Mary Jo Dike, Program Manager,
Foundation for a Healthy Kentucky*

The *Foundation for a Healthy Kentucky* is offering the following grant opportunity:

Community Grants: This competitive small grants program seeks projects from community based organizations who want to engage consumers, families and other residents in the policy process through activities that raise awareness of issues as related to the health of Kentuckians or who want to undertake a small project or complement a larger project, outside of normal operations, to enhance access to healthcare for underserved populations. Awards will be \$5,000 or less. **Deadline for receipt of proposals is March 24, 2006.** The RFP is posted on the Foundation's website: www.healthyky.org

If further information is needed, please contact Mary Jo Dike, Program Manager, Foundation for a Healthy Kentucky, 9300 Shelbyville Road, Suite 1305, Louisville, KY 40222, Tel 502-326-2583 Fax 502-326-5748, mdike@healthyky.org, www.healthyky.org .



**Foundation for a
Healthy Kentucky**

**Diabetes Day
At The Capitol
February 7, 2006**

For more information contact:
Deborah Fillman
KDN Advocacy Workgroup

Phone: 270-852-5581
Fax: 270-926-9862

Email: Deborah.Fillman@grdhd.org

**CALL TO CONGRESS:
CONQUER DIABETES!**

**(AN EVENT BRINGING DIABETES ADVOCATES &
ELECTED OFFICIALS TOGETHER IN WASHINGTON, DC)**

*Submitted by: R. Stewart Perry, Lexington, KY, National Vice Chair of
The American Diabetes Association Board Elect*

Every two years, the American Diabetes Association hosts the "Call to Congress", the Association's premier lobbying day, during which Diabetes Advocates meet with their elected officials in Washington, DC to discuss diabetes issues. The upcoming Call to Congress (C2C) will be held from June 7 - 9, 2006 in our nation's capital.

The 2006 C2C is unique because it will take place in conjunction with ADA's National Leadership Meeting and the 66th Annual Scientific Sessions. Combined, these three events will provide unprecedented visibility for ADA and its Advocates in Washington, allowing us to maximize our impact with Congress and the media.

People with all levels of experience in advocacy have attended in the past, and we expect that trend to continue this year. If you have been looking for a way to do more in the fight against diabetes, join us and be heard by those who make the decisions about public policy as it relates to diabetes. Whatever your experience level, the C2C is the opportunity to raise your voice in concert with hundreds of other Diabetes Advocates just like you! Here's a brief preview of the event:

- **Day One:** Receive training from experts on diabetes and public policy. Meet other Diabetes Advocates from around the country.
- **Day Two:** Hit the Hill and meet with your elected officials (ADA will schedule your meetings)! Return to the hotel and discuss your experiences.
- **Day Three:** Additional training on what you can do back at home. Attend ADA's Recognition Luncheon.

Space is limited and slots for the C2C have filled up quickly in the past. If you have questions, email ADA at makingnoise@diabetes.org.

Important Notes:

- Application process closes April 7, 2006.
- Minimum age of attendees is nine years old.
- Daycare will not be provided.
- Members of ADA's National Leadership Council will be invited separately and do not need to pre-register for the event.

**BECOME A
DIABETES ADVOCATE!!**

**THE FOUNDATION FOR A
HEALTHY KENTUCKY OFFERS
REPORTS REGARDING THE KY
MEDICAID WAIVER PROPOSAL
DEALING WITH CHILDREN AND LONG
TERM CARE**

*Submitted by: Mary Jo Dike, Program Manager,
Foundation for a Healthy Kentucky*

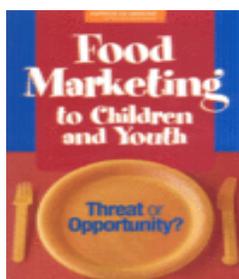
The Foundation for a Healthy Kentucky has engaged the services of Health Management Associates, who recently completed a review of the Kentucky Medicaid Waiver submitted to the federal Centers for Medicare and Medicaid Services (CMS). Health Management Associates prepared two reviews that focus specifically on Kentucky's services for children and long-term care.

All three reports are now available on the Foundation's website at www.healthyky.org:

- KY Health Choices - A Look at the Issues: *Medicaid Waiver Proposal Submitted to CMS in November 2005* - <http://www.healthyky.org/PDFs/KY%20Health%20-%20Major%20Issues.pdf>
- KY Health Choices - A Look at the Issues: *Coverage for Children* - <http://www.healthyky.org/PDFs/KY%20Health%20-%20Children.pdf>
- KY Health Choices - A Look at the Issues: *Long-Term Care Redesign* - <http://www.healthyky.org/PDFs/KY%20Health%20-%20Long%20Term%20Care.pdf>

**“FOOD MARKETING TO CHILDREN AND
YOUTH: THREAT OR OPPORTUNITY?”
NEW REPORT RELEASED**

A new report is now available concerning food and beverage marketing practices to children and youth. This study was requested by Congress, sponsored by the Centers for Disease Control and Prevention (CDC), and completed by the Institute of Medicine (IOM). The report, “*Food Marketing to Children and Youth: Threat or Opportunity?*”, found that food and beverage industries which “target children” are putting children’s long-term health at risk. A high portion of the products marketed to American youths are high-calorie, low-nutrient snacks, fast foods, and sweetened drinks. Turning around the current trends will require broad public and private leadership — including the full participation of the food, beverage, and restaurant industries, food retailers, trade associations, advertising and marketing industry, entertainment industry and the media — in cooperation with parents, schools, and government agencies. The entire report may be downloaded through the IOM website www.iom.edu.



**“PUBLIC HEALTH REPORTING”
OF DIABETES THROUGH
LABORATORIES BEGINS IN NEW YORK!**

New York adopted a health code regulation in December, 2005, that will make it one of the first American cities to keep track of people with diabetes. This policy breaks new ground because it involves the “actual” collection of information about people with diabetes and their blood glucose control.

Under a revised city code passed by New York’s Board of Health, medical laboratories in New York will be required to electronically forward the results of A1C blood tests to the Health Department. The Health Department will then analyze the data to improve diabetes surveillance and monitoring of trends of blood sugar control in people with diabetes. Evaluation of these trends are expected to be used to plan programs for the Diabetes Prevention and Control Program and measure outcomes of diabetes care thereby directing more efficient interventions to health care institutions, health care providers, and people with diabetes. New York’s Health Commissioner, Thomas R. Frieden, MD, MPH, has been quoted as saying that “Diabetes” Status as a leading killer makes it just as important to watch as any contagious disease.”

For more information about diabetes and this new health code, see <http://www.nyc.gov/html/doh/downloads/pdf/diabetes/diabetes-presentation-a1c-registry.pdf> or <http://www.nyc.gov/html/doh/downloads/pdf/public/notice-adoption-a1c.pdf> or contact the New York City Health Department: <http://www.nyc.gov/html/doh/home.html>

**DIABETES: A NATIONAL PLAN
FOR ACTION**

A National Diabetes Action Plan, an initiative sponsored by the U.S. Department of Health and Human Services to address diabetes prevention, detection, and treatment, is available on line. Together with efforts of individuals and organizations — including the American Diabetes Association, the Juvenile Diabetes Research Foundation International, the American Association of Diabetes Educators, and other professional associations — the national action plan utilizes a comprehensive action-oriented approach to identify activities among relevant stakeholders to improve diabetes prevention, detection, and care.

To download a copy of this report or to learn more about this national diabetes action plan visit: <http://aspe.hhs.gov/health/NDAP/NDAP04.pdf>



PATIENT PRESS RELEASE

BE SMART ABOUT YOUR HEART

Submitted by: Linda Leber RN, BSN, CDE, KDPCP State Staff,
KDN member, KADE member

Note: The following article, “*Be Smart About Your Heart: Control the ABCs of Diabetes*”, was adapted from NDEP by KDPCP state staff for use within local diabetes newsletters (for patients) or coalitions during American Heart Month, February 2006.

The Kentucky Diabetes Prevention and Control Program (KDPCP) and the National Diabetes Education Program (NDEP) are teaming up to let the nearly 21 million Americans with diabetes know they are at high risk for heart attack and stroke.

Heart disease is more likely to strike people with diabetes — and at an earlier age— than it is to strike those without diabetes. In fact, heart disease and stroke account for about 65 percent of deaths in people with diabetes. An estimated 8.5 percent of the adult population, or 267,000 people, in Kentucky have been diagnosed with diabetes, and an additional 109,000 Kentuckians may be living with undiagnosed diabetes. That’s a total of 376,000, or 12 percent, of adult Kentuckians who are at high risk of heart attack or stroke because of diabetes.

It is possible to fight back. Heart attack and stroke can be prevented by controlling the **ABCs** of diabetes.

- **A** is for **A1C**. The A1C test measures your average blood glucose (sugar) over the last 3 months.
- **B** is for **blood pressure**. High blood pressure makes your heart work too hard.
- **C** is for **cholesterol**. Bad cholesterol, or LDL, builds up and clogs your arteries.

The Kentucky Diabetes Prevention and Control Program and NDEP advise people with diabetes to work with their health care provider to better manage their health and prevent heart disease. It’s important to check A1C levels twice a year; blood pressure should be checked at each visit and cholesterol should be tested at least once a year.

Specifically, a person’s A1C level should be below 7, blood pressure below 130/80 and LDL cholesterol below 100. To reach these targets, patients should work closely with their health care provider to put together an action plan of lifestyle changes and medications, if needed, to help reach and maintain goals for the ABCs of diabetes.

Getting started.

Here are some general guidelines to help people with diabetes reduce their risk of heart disease and improve their quality of life.

- Get at least 60 minutes of physical activity, such as brisk walking, most days of the week.
- Eat less fat and salt.
- Eat more fiber — choose whole grains, fruits, vegetables and beans.

- Maintain a healthy weight.
- Stop smoking — ask your health care provider for help.
- Take medicines as prescribed.
- Ask your health care provider about taking aspirin.
- Ask others to help you manage your diabetes.

For more information about diabetes, go to the Kentucky Diabetes Prevention and Control Program website at www.chfs.ky.gov/dph/ach/diabetes or contact NDEP at 1-800-438-5383 or www.ndep.nih.gov.

NEW KDN “PREDIABETES” SCREENING AND TRACKING TOOL NOW AVAILABLE

Submitted by: Dee Deakins RN, MS, CDE, Chair,
KDN Primary Prevention and Risk Reduction Workgroup

A new tool for screening and tracking “Prediabetes” has been developed by the Kentucky Diabetes Network (KDN) Primary Prevention and Risk Reduction Workgroup (see page 11 & 12 of this Newsletter).

Prediabetes often precedes the development of type 2 diabetes whereby blood glucose levels are higher than normal but not high enough to be diagnosed with type 2 diabetes. Approximately 40.1% of the US adult population, ages 40 to 74, have prediabetes. Besides being at increased risk for type 2 diabetes, individuals with prediabetes have a 1.5-fold greater risk of cardiovascular disease.

Excess body fat (abdominal obesity) and physical inactivity promote insulin resistance, which contributes to the progression from prediabetes to diabetes. In Kentucky, 63% of adults are obese or overweight with an estimated 611,000 Kentuckians with or at very high risk for developing prediabetes.

This new “*Prediabetes Risk Screening and Tracking Tool*” was developed by the Kentucky Diabetes Network’s (KDN) Primary Prevention & Risk Reduction Workgroup, which is a collaborative network of partners who strive to improve diabetes outcomes and implement preventive strategies.

The tool, targeted for use by primary care providers, is two-sided with one side designated for risk screening (includes a list of risk factors, whom to test, and recommended labs) with the other side designated for tracking purposes, once Prediabetes has been identified.

Use of this tool and earlier identification of those at risk for type 2 diabetes will allow for earlier intervention with preventive lifestyle changes.

This new KDN “Prediabetes Tool” will soon be printed and may be obtained by contacting KDN through the Kentucky Diabetes Prevention and Control Program at 502-564-7996 or may be downloaded from the KDN website at www.kentuckydiabetes.net or the KDPCP website at www.chfs.ky.gov/dph/ach/diabetes.

PREDIABETES RISK SCREENING TOOL

Patient Name: _____ DOB: _____

ID #: _____ Smoker: Yes No (circle one)

This tool is intended for use with ages 18 and older to encourage early detection, intervention, and treatment for all patients at-risk for diabetes. Use it as a reminder for exams or important tests and to simplify record keeping. It should not replace or preclude clinical judgment.

DATE OF VISIT							
Enter result checkmark, or date, as you deem appropriate.							
WHO TO TEST	Check blood glucose in all people ≥ 45 yrs. •IF result is normal AND pt. does not have any of the risk factors (listed below); <u>Repeat test every 3 years</u> •IF result is abnormal, obtain 2 nd test on a different day to verify diagnosis. <u>Repeat test every 1-2 years*</u> ADA						
	Check blood glucose at < 45 yrs. •IF BMI ≥ 25 or >23 if Asian American or >26 if Pacific Islander AND pt. has any risk factors (listed below); <u>Repeat test every 1-2 years*</u> ADA						
RISK FACTORS	Member of a high-risk ethnic population e.g, African American, Hispanic/Latino, Native American, Asian American, Pacific Islander						
	Habitually physically inactive						
	First degree relative with diabetes						
	Hypertensive $\geq 130/85^*$ ATP III, AACE						
	HDL cholesterol level <40 mg/dl (men) or < 50 mg/dl (women) and/or triglyceride level ≥ 150 mg/dl						
	Hx gestational diabetes or delivered a baby weighing >9 pounds						
	Waist Measurement (inches)* *Am J Clin Nutr, Mar2005. Women >35 inches; Men >40 inches						
	Hx polycystic ovary syndrome						
	Hx of cardiovascular disease						
	Presence of acanthosis nigricans or other conditions related to insulin resistance						
PRE DM LAB TEST	Impaired Fasting Blood Glucose (100-125 mg/dl on 2 different dates)						
	Impaired Random Blood Glucose (140-199 mg/dl on 2 different dates)						
	2 hour Oral Glucose Tolerance Test FPG 100–125 mg/dl = IFG (impaired fasting glucose); OR 2 hr. post load glucose 140–199 mg/dl = IGT (impaired glucose tolerance)						

ONCE DIAGNOSIS OF PRE DIABETES IS MADE, USE FORM ON OTHER SIDE FOR TRACKING PRE DIABETES

Kentucky Diabetes Network is a statewide partnership striving to improve the treatment and outcomes for Kentuckians with or at risk for diabetes. This tool may be obtained from www.kentuckydiabetes.net and reprinted in its entirety without permission. Revisions in content may not be endorsed by the Kentucky Diabetes Network, Inc. Jan, 2006.

PREDIABETES TRACKING TOOL



Patient Name: _____ DOB: _____

ID #: _____ Smoker: **Yes** **No** (circle one)

This tool is intended for use with ages 18 and older to encourage early detection, intervention, and treatment for all patients at-risk for diabetes. Use it as a reminder for exams or important tests and to simplify record keeping. It should not replace or preclude clinical judgment.

DATE OF VISIT							
Enter result, checkmark, or date, as you deem appropriate.							
EACH VISIT	Weight (lbs) / Height _____ Inches						
	BMI _____ Target BMI _____ (Goal <25, <23 if Asian American, <26 if Pacific Islander)						
	BP (Goal <130/85)* (Prehypertension 120/80 to 130/89) *JNC 7, AACE						
ANNUAL LABS	Fasting Plasma Glucose (FPG) (Goal <100 mg/dl)						
	Random Glucose (Goal <140 mg/dl)						
	Fasting Lipid Profile:						
	• LDL (Goal <100; desirable <75)						
	• HDL (Goal Men >40, Women >50)						
	• Triglycerides (Goal <150)						
LIFESTYLE COUNSELING	Risk Factor/Lifestyle Education						
	Weight Loss Target wt. _____ (Goal 5% 7% 10%)						
	Exercise/Physical Activity (Goal: At least 30 min, 5 times/week)						
	Medical Nutrition Therapy Referral						
	Tobacco Cessation						
OTHER	Flu/Pneumonia Vaccine (age/health related)						
	Check A1C (Normal 4 to 6%)						
	Assess for Sleep Apnea						
	Assess for Metabolic Syndrome						
	Assess Need for Anti-platelet Therapy						

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NEW CHANGE TO DIABETES QUESTION ON KENTUCKY'S BIRTH CERTIFICATE

Submitted by: Tracey Jewell, KY Department for Public Health,
Adult and Child Health, Frankfort, KY

Kentucky recently adopted a new standard certificate of live birth for use on all infants born in the state. The U.S. standard certificate of live birth was revised in 2003 to allow for expansion of specific data items collected and to include new items that had previously not been collected with the expectation that all states would eventually adopt and use the new format by 2010. These revisions would help aid in the improvement of reporting and monitoring of trends in birth outcomes. Following changes to the U.S. certificate, Kentucky incorporated the new revisions to its certificate and began using the new format on all live births beginning January 1, 2004. Kentucky was one of nine states to incorporate the new certificate in 2004.

Improved and new data elements are now collected on a variety of maternal and infant health care utilization, behavioral, and outcome measures. With these changes, however, modified items and new variables cannot be compared to previous years data, therefore, trend data must start over with year 2004 serving as the baseline year for comparison to future years data.

Data items that have been modified include either changes to the wording of the question or changes to the response categories. For example, the education of mother field has been changed from the highest grade completed on the old certificate to the highest degree attained on the new certificate. This change is minimal when compared to the change in the smoking question. On the old certificate, the smoking question only asked information regarding smoking anytime during pregnancy whereas the new certificate breaks out the smoking information by each trimester of pregnancy.

Diabetes, as a medical risk factor of pregnancy, is among several medical conditions that were modified on the new certificate. On the previous certificate, diabetes appeared as a check box under medical risk factors for that pregnancy with no distinction between gestational diabetes or pre-existing type 1 or type 2 diabetes. With the revised certificate, diabetes now appears as a separate question under the section "risk factors in this pregnancy". A check box for pre-pregnancy diabetes, defined as diagnosis prior to this pregnancy and gestational diabetes, defined as diagnosis in this pregnancy, is now included. This change will allow for separate analysis and comparison of birth outcomes among women with pre-existing diabetes, women with gestational diabetes, and women without diabetes.

As new trend data becomes available, specific and targeted interventions can be implemented towards the pregnant population to help improve birth outcomes and the overall health of the mother.

For more information on the revision of the standard certificate of live birth, please visit the National Center for Health Statistics website at <http://www.cdc.gov/nchs/nvss.htm>

Source: National Center for Health Statistics; National Transition to the 2003 Revised Birth Certificate.



FREE DIABETES PROGRAM FOCUSES ON FOOT CARE

A free diabetes program, "*Proactive Steps For Healthy Foot Care*", is being held by satellite Conference and Live Web cast, Tuesday, March 7, 2006, 2:00-4:00 p.m. (Central Time) • 3:00-5:00 p.m. (Eastern Time) • 1:00-3:00 p.m. (Mountain Time) • 12:00-2:00 p.m. (Pacific Time)

Program Objectives:

1. To review appropriate foot care for people with diabetes.
2. To provide the latest information for treatment of foot wounds of people with diabetes.
3. To determine medical nutrition therapy for people with diabetes and foot problems.

Conference Details:

Target Audience: Physicians, Nurse Practitioners, Nurses, Physician Assistants, Pharmacists, Dietitians and Social Workers.

Registration: www.adph.org/alphtn

Cost: There is no cost to view.

CMEs: Will be provided, Category 1.

CEUs: Nurses, Pharmacists, Dietitians and Social Workers (pending).

Satellite Technical Information: This program will be a live satellite broadcast on both Ku & C bands.

Webcast Information: Please register at www.adph.org/alphtn. To view this live webcast, you will need RealPlayer or Windows Media Player. This program will also be available as an on-demand webcast approximately 5 days after the live broadcast.

Conference Materials: Posted on our website approximately one week before the program.

Questions For Faculty: If you have questions that you want addressed during the conference, you may fax or email those questions and a response will be given during the program.

Email: alphtnquestions@adph.state.al.us or Fax: 888-737-1972.

General Questions: For questions about any of these conference details call: 334-206-5618 or email: alphtn@adph.state.al.us

2006 CLINICAL PRACTICE RECOMMENDATIONS NOW AVAILABLE!

NOTE: *The American Diabetes Association's 2006 Diabetes Clinical Practice Recommendations are now available! The following is a summary of the changes that were made for this year.*

Beginning last year with the 2005 Supplement, the Clinical Practice Recommendations contained only the "Standards of Medical Care in Diabetes" and selected other position statements. This change was made to emphasize the importance of the "Standards" as the best source to determine ADA recommendations. The position statements in the Supplement are updated yearly. Position statements NOT included in the Supplement will be updated as necessary and republished when completed. A list of the position statements not included in the Supplement appears in the January 2006 Diabetes Care Journal, Volume 29, Supplement 1, p. S75.

Format changes

Page numbers now appear in the "Contents Section" for ease in locating particular sections. Recommendations are now listed at the beginning of each section

Additions to the Standards of Medical Care in Diabetes

- Medical nutrition therapy (MNT)—extensively enhanced
- Diabetes self-management education (DSME)
- Physical Activity Neuropathy

Summary of Revisions to Standards of Medical Care for Diabetes

- Assessment of glycemic control
 - * Use of point-of-care testing for HbA_{1c} (A1C) allows for timely decisions on therapy changes, when needed
 - * Glycemic goals
 - * The A1C goal *for patients in general* is <7%
 - * The A1C goal *for the individual patient* is an A1C as close to normal (<6%) as possible without significant hypoglycemia
 - * Nephropathy
 - * To reduce the risk of nephropathy, protein intake should be limited to the Recommended Dietary Allowance (RDA) (0.8 g/kg) in those with any degree of chronic [kidney disease](#) (CKD)
 - * Serum creatinine should be measured at least annually for the estimation of glomerular filtration rate (GFR) in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine alone should not be used as a measure of kidney function but rather used to estimate GFR and stage the level of CKD

CAMP HENDON - KENTUCKY'S DIABETES CAMP FOR CHILDREN SCHEDULED FOR JULY 23—29, 2006

Submitted by : Missy Jardine, ADA Market Director of Youth Programs & Community Outreach, Camps for Children with Diabetes

Camp Hendon, Kentucky's Diabetes Camp for Children, sponsored by the American Diabetes Association, offers a traditional residential camping experience to children ages 8-17 with both type 1 and type 2 diabetes. Camp is located at Camp Crooked Creek in Shepherdsville, Kentucky. Each year Camp Hendon provides a safe, medically managed camp for children and teens with diabetes.

Children who attend camp learn diabetes management skills through "teachable moments". For example, a child may see another child injecting insulin, and more than likely, this encourages them to do the same. Most parents say that Camp Hendon is quite possibly one of the very best things that they can provide for their child with diabetes — from socializing with others that have diabetes to just being a kid and having fun in the outdoors. A week of bonding with other children and positive adult role models are exceptional experiences which cannot be paralleled in the life of a child with diabetes.

Childhood diabetes affects children of all races, ages, ethnicities, genders, and socio-economic backgrounds. Financial contributions allow the American Diabetes Association to provide camp for every child who applies despite their financial situation. Over 45% of campers who attended Camp Hendon in 2005 needed financial assistance to attend camp.

For more information, to receive a brochure, or to provide a campership to sponsor a child (\$325.00) contact:

Missy Jardine
The American Diabetes Association
of Southwest Ohio and Kentucky
644 Linn Street, Suite # 304
Cincinnati, OH 45203

Phone: (513) 759-9330 ext. 6662
Cell Phone: (513) 404-8431
Fax: (513) 421-2203

E-mail: mjardine@diabetes.org
camp website www.camphendon.com



Welcome to Camp Hendon

TRADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Tri-State Association of Diabetes Educators (TRADE), which covers Western KY/Southern IN, meets quarterly from 11 – 2 pm CST with complimentary lunch and continuing education units. To register, call (270) 686-7747 ext. 5581.

Date: **April 20, 2006 The Pedorthist's Role in Diabetes Foot Care**

Speaker: **Carl Riecken and Cindy Mattingly, Pedorthists**
 Location: **Lourdes Hospital
 1530 Lone Oak Road, Community Room
 Paducah, KY**

Date: **July 20, 2006 Pregnancy and Diabetes including Gestational Diabetes**

Speaker: **Ana Marie Spence, MD**
 Location: **Methodist Hospital
 1305 N. Elm Street
 Henderson, KY 42420**

**TRADE Workshop September 2006
 Details To Be Announced**

GLADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Greater Louisville Association of Diabetes Educators (GLADE), which covers Louisville and the surrounding area, meets the 2nd Tuesday every other month (*no meeting in August*). Registration required. Please register and direct questions to Dawn Frazee RN, BSN, CDE at 270-769-1601 ext. 129 or dawns.fraze@ky.gov.

Date/time: **Tuesday, March 14th 5:30-7:30pm**
 Location: **Bravo Cucina Italiana, 206 Bullitt Lane,
 Louisville, KY 40222**
 Speaker: **Dr. Jahangir Cyrus, MD, Endocrinologist**
 Title: **A Clinical Overview of Hypogonadism**
 RSVP: **By March 7th to Dawn Frazee, RN, BSN, CDE.**

Date/time: **Tuesday, May 9th 5:30-7:30pm**
Details To Be Announced

ENDOCRINOLOGISTS MEETINGS SCHEDULED

The Ohio Valley 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



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.

Quarterly general meetings are held from 10-3 pm EST. Anyone interested in improving diabetes outcomes in KY may join. A membership form may be obtained at www.kentuckydiabetes.net or by calling 502-564-7996 (ask for diabetes program).

2006 meeting times are 10:00 am—3:00 pm EST

March 10 Kentucky History Center, Frankfort
June 9 Baptist Hospital East, Louisville
September 15 Lexington
November 3 Kentucky History Center, Frankfort

KADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Kentucky Association of Diabetes Educators (KADE), which covers Lexington and Central Kentucky, meets the 3rd Tuesday of most months from 6 - 8pm, except summer (time & location vary). For a schedule or more information, contact:

Dana Graves Phone: 859-313-1282 E-mail: gravesdb@sjhlex.org
 Laura Hieronymus Phone: 859-223-4074 E-mail: laurahieronymus@cs.com

February 21 **Dr. Wayne will present "Metabolic / Insulin Resistance"**
 March 21 **Details To Be Announced**
 April 13 (Thursday) **3 hour CEU offering**
 May 16 **Details To Be Announced**

DECA DIABETES EDUCATOR MEETINGS SCHEDULED

Diabetes Educators of the Cincinnati Area (DECA), which covers Northern KY, meet the third Monday of each month. Anyone interested in diabetes is invited. Please register with Jana McElroy, email jmcelroy@stelizabeth.com or call 859-344-2496

Date/time: **February 9, 2006, 6:30pm**
 Location: **Bethesda Oak, Cincinnati, Ohio**
 Speaker: **John Kelly, MD, Neurologist**
 Title: **Treatment of Neuropathy in Diabetes**

Date/time: **February 20, 2006, 5:30pm**
 Location: **Kingsgate Marriott, Cincinnati, Ohio**
 Speaker: **Amanda Denney, MD, Endocrinologist**
 Title: **Basal and Prandial Insulin Replacement**

Date/time: **March 20, 2006, 5:30**
 Location: **To Be Announced**
 Speaker: **Sue Barlow RD, CDE**
 Title: **New Insights Into Diabetes Management: Symlin and Byetta**

*Kentucky Diabetes
Connection*



Diabetes Day at the Capitol February 7th 2006

Contact Information



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1-888-DIABETES

KENTUCKY ASSOCIATION
of DIABETES EDUCATORS



Bluegrass/Eastern Chapter

www.kadenet.org



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



Tri-State Association
of Diabetes Educators

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



www.louisvillediababetes.org



Diabetes Educators Cincinnati Area

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



KENTUCKY DIABETES NETWORK, INC.

www.kentuckydiabetes.net



www.chfs.ky.gov/dph/ach/diabetes



American
Association
of Clinical
Endocrinologists
Ohio Valley Chapter

www.aace.com

Kentuckiana Endocrine Club
joslin@fmhhs.com