

Kentucky Diabetes Connection



The Communication Tool for Kentucky Diabetes News

A Message from Kentucky Diabetes Partners

KENTUCKIAN NOW PRESIDENT OF AADE



Tami A. Ross
2013 President
American Association
of Diabetes Educators

University of Kentucky and has over 20 years experience providing diabetes and nutrition education in a variety of settings. Tami currently counsels individuals seeking diabetes education and nutrition guidance through her practice with Internal Medicine Associates in Lexington.

Kentuckian Tami Ross is now serving as the 2013 President of the American Association of Diabetes Educators (AADE)! Tami, from Lexington, is a registered dietitian, certified diabetes educator, and a nationally recognized speaker and consultant.

Tami received her Bachelor of Science Degree from the

KENTUCKY DIABETES REPORT 2013 SENT TO LEGISLATURE

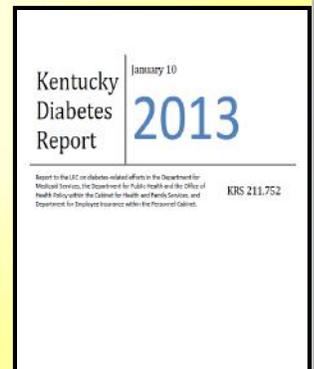
A new Kentucky Diabetes Report, 2013, was sent to Kentucky legislators for review in January. This report is a result of a law enacted by the legislature and signed by Governor Steve Beshear in 2011.

The statute requires that in odd numbered years, state entities including the Department for Public Health, the Department for Medicaid Services, the Office of Health Policy, and the Personnel Cabinet collaborate in developing a report on the impact of diabetes on the Commonwealth. The statute also requires the state entities to propose recommendations for how to address the diabetes epidemic.

Access full report at:

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

Under
"Helpful Information"
"KY Diabetes Report"



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AAACE
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

KENTUCKY DIABETES DAY AT THE CAPITOL HELD FEBRUARY 28, 2013



*KDN Advocacy Workgroup Co-Chairs
Mary Beth Lacy (left) and Maggie Beville (right)*

*Submitted by: Maggie
Beville, RN, BSN, CDE,
KY Diabetes Network
(KDN) Advocacy
Workgroup Co-chair*

Conference calls were a must.
Texting was our friend.
Email was a "BIGGY"!
Social media to the end.

And don't forget that elbow grease
That helped carry the totes
And the wonderful results
That came from well written notes!

It all came together.
Diabetes Day was finally here.
Packets had been stuffed
Each job was made clear.

The team was assembled.
The agenda was in line.
And it was at about this point
We knew that things were fine.

When we walked into room 149
We could see a sea of RED.
What a wonderful feeling —
It was PRIDE instead of DREAD!

And as alluded to
We had learned an ART,
And in the end it proved to be
A beautiful big HEART!

There were young and old.
--A potpourri of Red--
All there for the same cause,
When it was all done and said.

For every person in that room
Had come to play a part,
To help fight diabetes.
Yes sir---they had HEART!

The Grand finale to the plan,
Was yes, our Diabetes Day,
And all in all---it was well worth it.
What more can we say!

The 2013 Diabetes Day at the Capitol was a huge success again this year with 155 advocates attending and distributing 138 legislator packets. There have been 21 advocate reporting forms returned thus far from legislator visits.

As a new co-chair to the KDN Advocacy Workgroup, Maggie Beville wrote the following poem about "Diabetes Day" that sums up her experiences...

The Road to Diabetes Day

I'm here to tell a story,
I don't know where to start,
But we soon found out
That we'd have to learn a new art!

This story had a beginning
Back around September or such,
It sounded so exciting —
We'd give it our special touch!

With butterflies in our stomachs,
Thinking "Oh, what have we done!"
Getting ready for this occasion,
Was anything but fun!

It was like "crossing a river with lots of fog".
We had never been this way ---
Trying to feel which way to go,
We hardly knew what to say!

But we soon learned in time
What to do—to complete this task.
If we really needed help —
All we had to do was ask!

We had a wonderful committee,
The KDN Board and ADA,
The Kentucky Coordinating Body,
Sanofi, Cabot Cheese, and Kind Bars blazed the way!



*Julie Shapero, above, a
member of the KDN Advocacy
Workgroup demonstrates the
use of the "Stop Diabetes Photo
Prop" used at Diabetes Day.*



The 2013 Diabetes Day at the Capitol event included 155 diabetes advocates, pictured above, preparing for visits with legislators.

FOUR KY SITES FUNDED FOR DPP AS AADE GRANTEES

Printed in part from the AADE March 2013 e-newsletter

Four Kentucky sites were recently chosen by the American Association of Diabetes Educators (AADE) to become Diabetes Prevention Program (DPP) sites. These sites are expected to become nationally recognized as Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program (DPP) sites under the CDC DPP Recognition Program.

The Kentucky sites named to receive a grant include:

**Saint Joseph Hospital - Lexington
Baptist Health Louisville - Louisville
Central Baptist Hospital - Lexington
King's Daughters Medical Center - Ashland**

The Centers for Disease Control and Prevention (CDC) estimates that 79 million adults in the U.S. (one in three) have prediabetes. The National Diabetes Prevention Program (National DPP) brings an evidence-based Lifestyle Change Program for preventing type 2 diabetes to local communities.

In 2012, CDC selected AADE as one of 6 partner organizations to assist in expanding the reach of the National DPP. This is an exciting opportunity because it highlights the leadership role that diabetes educators can play in diabetes prevention efforts. An overarching goal of this project is to make the Lifestyle Change Program a covered healthcare benefit for people with prediabetes.

In mapping out AADE's DPP, 12 target states were chosen: Alabama, Florida, Kentucky, Louisiana, Michigan, Mississippi, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, and West Virginia. By December 14, 2012, the funding opportunity announcement for the DPP was posted in MYAADE NETWORK on the 12 target states Coordinating Body (CB) and 10 Community of Interest (COIs) networks. Emails about the funding opportunity were also sent to the AADE Diabetes Education Accreditation Programs (DEAP) coordinators for 184 programs in the 12 target states. Emails also went to eligible subscribers (total 4,730) in all 22 groups from MY AADE NETWORK.

AADE had a tremendous response to our Requests for Proposals and received applications from all over the country. Applicants filled out the Site Readiness Assessment Application and submitted them to AADE by the January 31, 2013 deadline. The applications were evaluated with a focus on current capacity and future prospective as it aligned with the goals of the National DPP.

The 2013 AADE DPP sites are listed below:

UAB Medicine/The Kirklin Clinic - Birmingham, AL
Lakeland Regional Medical Center Foundarion-Lakeland, FL
Martin Health System - Jensen Beach, FL
Winter Haven Hospital - Winter Haven, FL
Saint Joseph Hospital - Lexington, KY
Baptist Health Louisville - Louisville, KY
Central Baptist Hospital - Lexington, KY
King's Daughters Medical Center - Ashland, KY
West Jefferson Medical Center - Marrero, LA
Holland Hospital - Holland, MI
MedNetOne Health Solutions - Rochester, MI
Metropolitan Hospital - Wyoming, MI
Spectrum Health Hospital - Grand Rapids, MI
University Pharmacy - Detroit, MI
Keyhabits Diabetes Management & Supplies- Hazlehurst, MS
UMA Diabetes Endocrine Center - Athens, OH
Choctaw Nation of Oklahoma - Choctaw, OK
Norman Regional Health System - Norman, OK
Northeast Tribal Health System - Miami, OK
Abington Health - Willow Grove, PA
Achieving Better Control, Inc. - Lower Gwynedd, PA
The Chester County Hospital - West Chester, PA
Palmetto Primary Care Physicians - N. Charleston, SC
H.E.R.O. LLC - Antioch, TN
Laughlin Memorial Hospital - Greeneville, TN
Methodist Lebonheur Healthcare Memphis Hospitals -
Germantown, TN
Northcrest Medical Center (NMC) Endocrinology Clinic -
Springfield, TN
Williamson Medical Center - Franklin, TN
Monongalia General Hospital - Morgantown, WV
St. Patrick Hospital Foundarion (Multirate) - Missoula, MT

Staff members from the selected sites will receive Lifestyle Coach training by the Diabetes Training and Technical Assistance Center (DTTAC) and will be recruiting qualified program participants to begin implementation of DPP before June 2013.

AADE plans to grow the DPP by selecting and funding additional AADE DPP Sites and cohorts, pending availability of funds. In addition, we will be working with CDC and their other partners on marketing of the National DPP to employers and third party insurers with the aim of offering it as a reimbursable benefit to employees. Updates will be posted on the AADE website. Stay tuned to learn more and to hear about future opportunities. For questions, contact: dpp@aadenet.org.

More information on the National Diabetes Prevention Program (National DPP) and the evidence-based Lifestyle Change Program curriculum can be found on the CDC website. <http://www.cdc.gov/diabetes/prevention/>



KENTUCKY BOARD OF NURSING

NURSING BOARD REVISING “DELEGATION” REGULATION

PUBLIC HEARING TO BE HELD



*Sharon Mercer
KY Board of Nursing*

*Article adapted from email received from:
Sharon Eli Mercer, MSN, RN NEA, BC,
Nursing Practice Consultant, Kentucky
Board of Nursing*

There will be some revisions to the KY Board of Nursing (KBN) “Delegation” regulation which will be filed by March 15, 2013. The comment period for the regulation will start on April 1st.

If comments are received during that time, then KBN will hold a hearing. Following the hearing, KBN would then determine if “comments received” will become incorporated into the administrative regulation. The regulation would then be ready to go forward to the Administrative Regulation Review subcommittee.

If the regulation is approved by the Administrative Regulation Review Committee, it would then be sent for approval to the Health and Welfare committee. If approved by the Health and Welfare committee, the regulation would become “official” and KBN would then consider changing the Advisory Opinion Statement regarding “delegation to unlicensed persons”.

Thus, it is anticipated that it will be several more months before the “Delegation” Advisory Opinion Statement would be expected to be changed.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

Public Hearing:

A public hearing on this administrative regulation shall be held on **April 23, 2013 at 1:00 p.m. (EST)**

in the office of the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, KY.

Attendance at Public Hearing:

Individuals interested in being heard at this hearing shall notify this agency in writing by **April 16, 2013**, five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled.

This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made.

Written Comments:

If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business **April 30, 2013**.

Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to:

**Nathan Goldman, General Counsel
Kentucky Board of Nursing
312 Whittington Parkway, Suite 300
Louisville, KY 40222
Tel: (502) 429-3309
Fax: (502) 564-4251
Email: nathan.goldman@ky.gov**



DIABETES IN KY SCHOOLS — KENTUCKY BOARD OF NURSING AND AMERICAN DIABETES ASSOCIATION WORK TOGETHER TO RESOLVE ISSUES



Jim McGowan,
American Diabetes
Association



Submitted by: Jim McGowan, Midwest
State Advocacy Director, American Diabetes
Association

In the last issue of this newsletter, I told you about the concerns the American Diabetes Association (ADA) had with the Kentucky Board of Nursing's (KY

BON) advisory opinion statement regarding the delegation of insulin administration to unlicensed personnel. That "opinion statement" was creating some difficulty for school nurses to delegate insulin injection when they are not able to be present in a school when the injection is needed.

I am pleased to report that the KY BON, at its February meeting, revisited that opinion, and passed a proposed regulation which will make it possible for school nurses to safely train and delegate insulin administration tasks to willing, volunteer school staff, when the nurse cannot be present.

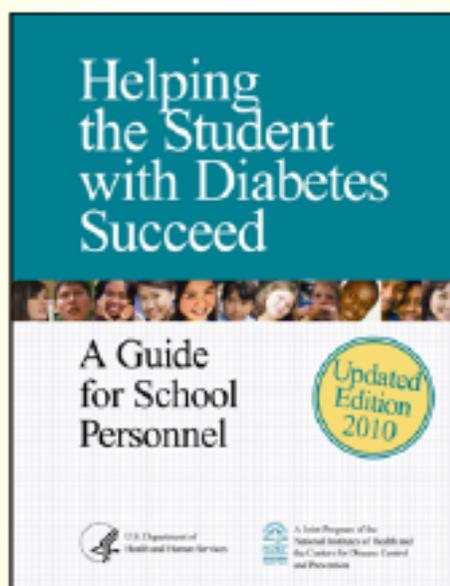
The regulation was developed cooperatively by the KY Board of Nursing and the ADA. We will also work together to develop the training and supervision guidelines, relying heavily on the recommendations of the National Diabetes Education Program's (NDEP) *Helping the Student with Diabetes Succeed: A Guide for School Personnel*. The guide can be found at: <http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=97#main>. This comprehensive resource guide helps students with diabetes, their health care team, school staff, and parents work together to provide optimal diabetes management in the school setting. NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations.

The "proposed regulation" was filed the week of March 11. It will be published in the Register on April 1 and comments will be accepted during the month of April. The regulation will then go before the Regulation Review Committee, followed by the Health and Welfare Committee.

I will be sending out an ADA Advocacy Action Alert during the public comment period, encouraging all diabetes advocates to voice their support for the Board's decision and to support this safe, tested and proven program for keeping our kids safe at school.

If you would like to be added to that alert and voice your support, please sign up as a Diabetes Advocate at: www.diabetes.org/advocate

I'd like to thank many of the KDN members who have been supportive and helpful in getting us to this point. If you have any questions, please don't hesitate to contact me at: jmccgowan@diabetes.org



www.YourDiabetesInfo.org/media/Youth_NDEPSchoolGuide.pdf



National Diabetes Education Program
www.YourDiabetesInfo.org • 1-888-693-NDEP
A joint program of NIH and CDC



CLINICAL PRACTICE GUIDELINES ON THE MANAGEMENT OF NEWLY DIAGNOSED TYPE 2 DIABETES MELLITUS IN CHILDREN AND ADOLESCENTS



Suzanne E. Kingery, MD

Submitted by: Suzanne Kingery, MD and Kupper Wintergerst, MD, Pediatric Endocrinologists, University of Louisville, Louisville, KY

In the past 30 years, the United States has seen an increase in the prevalence of obesity and type 2 diabetes mellitus among children and adolescents in almost epidemic proportions. Once thought to be a disease limited to adults, type 2 diabetes among children and adolescents accounts for nearly one-third of new onset diabetes among children 18 years or younger. Clinical providers are now faced with treating these young people with type 2 diabetes based on diabetes principles geared toward pediatric patients with type 1 diabetes or using adult standards for the treatment of type 2 diabetes.



Kupper Wintergerst, MD

In an effort to improve the treatment of type 2 diabetes in youth, a collaborative effort between the American Diabetes Association, the Pediatric Endocrine Society, the American Academy of Family Physicians, and the Academy of Nutrition and Dietetics established practice guidelines for the management of type 2 diabetes mellitus in children and adolescents. These practice guidelines were published in the February 2013 edition of the *Journal of Pediatrics*. These practice guidelines cover six key areas of management of type 2 diabetes mellitus.

Which patients require insulin?

The first guideline recommends that children and adolescents who are 1) ketotic, 2) in diabetic ketoacidosis at presentation, or 3) in whom the distinction between type 1 and type 2 diabetes mellitus is uncertain, should be initiated on insulin therapy. Insulin should also be initiated for patients who present in poor glycemic control as evidenced by a blood sugar greater than 250 mg/dl or in those patients who have a HbA1c (hemoglobin A1c) greater than 9%.

If insulin therapy is not indicated, what other

treatment and therapies can be initiated?

These guidelines recommend that in all other instances, except for those who require insulin, lifestyle modification including physical activity and dietary changes should be initiated in conjunction with metformin as the first line therapy for treatment of type 2 diabetes in children and adolescents. While lifestyle modification has previously been considered the mainstay of treatment in type 2 diabetes, the committee recognizes the challenge in maintaining these behavioral changes over time. Metformin has long been recognized as a safe and effective medication in the treatment of type 2 diabetes because it improves hepatic insulin sensitivity and has a lower risk of hypoglycemia compared to insulin. Because of the gastrointestinal side effects of metformin, the committee recommends starting metformin at a low dose of 500 mg daily, increasing this medication by 500 mg every 1 to 2 weeks up to a maximum dose of 2000 mg daily in divided doses.

How often should clinicians monitor patients?

Clinicians should monitor children and adolescents with type 2 diabetes every 3 months. The practice guidelines suggest that intensification of treatment should be based on HbA1c and fingerstick blood glucose goals. HbA1c provides a measurement of glycemic control over the previous 2 to 3 months. The committee recommends a target HbA1c of less than 7% for children and adolescents with type 2 diabetes, but comments that this ideal may not be applicable to all patients. When patients are above blood sugar and HbA1c target, treatment should be intensified when possible. Intensification of treatment can include more frequent blood glucose monitoring, adding more anti-diabetic medications, increasing frequency of clinic visits, or meeting with a dietitian or diabetes educator.

Which patients require fingerstick glucose monitoring? How often should patients monitor fingerstick glucose?

Patients who are taking insulin, and/or any other medication with a risk for hypoglycemia, should

CLINICAL PRACTICE GUIDELINES (CONTINUED)

monitor fingerstick glucose. These guidelines also suggest that patients should monitor fingerstick glucose 1) when initiating or changing treatment regimens, 2) in patients who have not met treatment goals, or 3) when patients have an intercurrent illness. The guidelines recommend that all patients with newly diagnosed type 2 diabetes, regardless of treatment therapy, should perform a fingerstick glucose before meals and at bedtime until reasonable control is met. In patients using a single long-acting insulin therapy at bedtime, the committee suggests fasting fingerstick glucose monitoring. If an oral agent is used in conjunction with long-acting insulin, the committee recommends glucose monitoring twice a day (fasting and a 2 hour post-prandial). In patients using the most intensive insulin regimen, basal-bolus regimens or insulin pumps, the committee recommends glucose monitor monitoring prior to every meal.

What diet plan should patients follow?

As part of the nutritional counseling at the time of diagnosis and during on-going management, the guidelines recommend incorporating the Academy of Nutrition and Dietetics' *Pediatric Weight Management Evidence-Based Nutrition Practice Guidelines*. The guidelines stress that regardless of the meal plan recommended, nutrition education should be provided to maximize adherence and results.

How much physical activity is recommended?

Finally, these practice guidelines recommend that children and adolescents with type 2 diabetes participate in at least 60 minutes of moderate-to-vigorous exercise a day. The committee also recommends limiting non-academic screen time to 2 hours a day. This degree of physical activity is intended to reduce BMI (body mass index) and improve glycemic control in children and adolescents with type 2 diabetes.

These practice guidelines are not intended to replace clinical judgment, but are based on systematic grading of the quality of evidence and strength of the recommendation. These guidelines will likely evolve over the next several years as more evidence-based and randomized control trials in children and adolescents with type 2 diabetes mellitus are concluded and new treatment therapies become available.

A YEAR OF MEETING DIABETES EDUCATORS ACROSS THE COUNTRY

ANN CONSTANCE SHARES HER EXPERIENCE



Ann Constance

*Submitted by Ann Constance, MA, RD, CDE,
2012 AADE Diabetes Educator of the Year*

It has been my privilege to represent the American Association of Diabetes Educators (AADE) at meetings across the country this past year!! One thing for sure is that diabetes educators are passionate about their work and ready for fun wherever you go!

Some of the things I learned are:

1. There are educators concerned about their profession. In one area, people were being hired to work in provider offices and were providing 'diabetes education' at a lower rate of pay. While we know lay health workers cannot replace the expertise of diabetes educators — do we realize how both groups can work together to better serve people with diabetes?
2. Some educators are working as case managers in provider offices. One educator I met was even hired by a University to help their employees better manage their chronic health conditions. As patient centered medical homes spread, the role of case managers in provider offices will continue to expand. Diabetes educators already know how to manage one of the most serious and costly chronic conditions, so we can take on other chronic conditions too!!
3. Some educators are working in health systems that are part of Accountable Care Organizations (ACOs). Once again, educators are needed as ACOs look at ways to save Medicare dollars, improve safety and reduce waste. The more time people with diabetes spend with diabetes educators, the better their glucose control becomes.
4. Educators are using (and getting paid for) telephonic, Skype and Telehealth visits. I particularly liked the program that Maine instituted with employers. The educators met with the employed person one time and then follow-up via phone about once per month for the next year. The co-pays on diabetes medications are waived as an incentive to participate. Positive outcomes are being seen. Plus the research shows more frequent contact over time yields better outcomes!
5. It was exciting to see that some of the AADE groups are very involved with advocacy and policy change. It is critical that we be involved politically if we are going to influence how future health care is delivered. Get advocacy updates by emailing advocacy@aadenet.org.

KY BOARD OF LICENSED DIABETES EDUCATORS



KY CB REPORT CONTINUED

hours required to gain licensure (*this only applies to individuals applying for licensure without a current CDE or BC-ADM*).

An amendment to the statute was formulated — Senate Bill 201 — by the KBLDE and taken to the legislature for vote.

The KY CB became involved in this process when it was noted that the proposed amendment used the language of “person” rather than “healthcare professional” for potential licensure applicants. In discussions with the KBLDE, the KY CB asked that the amendment be modified to use of the term “healthcare professional” and to specify types of healthcare professionals who would be eligible for licensure (i.e. nurses, dietitians, pharmacist, physicians...). The KBLDE agreed to this modification. However, the final document submitted for vote DID include the term “healthcare professional” rather than “person” but did NOT include the specifications as to the type of healthcare professional that could become licensed (due to LRC recommendations to the KBLDE that this was unnecessary).

Additionally, in discussions with the KBLDE, the CB requested language be added to the amendment that would require a basic diabetes knowledge exam for those applying for licensure who did not already have a CDE or BC-ADM certification. Because of financial concerns regarding the cost of administration of an exam, the CB agreed to remove this request, stipulating that we would like it reconsidered for future legislation.

Through a long course of legislative activity, the original Senate Bill 201 passed the Senate then became attached to HB 366, which then passed through the House and has now been delivered to the Governor for signature.

It is now left to the KBLDE to re-write regulations related to several elements of the licensure law. The CB will review these regulations as they are made available and will share these with local networking groups as quickly as possible. Opportunities for public comment will be available to anyone with questions or concerns regarding the regulations.

Diabetes educators are encouraged to review information as it becomes available and to voice their comments/concerns directly with the KBLDE; at the public hearing; or by sending your concerns in writing to members of the CB.

You may contact the KBLDE via their website at bde.ky.gov.

If you would like to submit comments to the CB, email Betty Bryan at bbryan@hmb.net.

Kentucky Board of Licensed Diabetes Educators



Submitted by: Kim Coy DeCoste, MSN, RN, CDE, Chair of the Kentucky Board of Licensed Diabetes Educators (KBLDE)

Suggestions have been received by the KY Board of Licensed Diabetes Educators (KBLDE) to improve our website to enhance communication. Work on the website will be occurring.

Kim Coy DeCoste

In the meantime, diabetes educators may submit any questions or comments to the KBLDE regarding KY diabetes educator licensure to <http://bde.ky.gov>.

UPDATES TO THE KBLDE WEBSITE:

“**About the Board**” posted March 20, 2013 — includes a power point presentation regarding the functions of the Board presented by Angela Evans, from the Attorney General office, to KBLDE members at their March 2013 meeting.

“**Board Mission**” posted on March 20, 2013 — describes the newly developed mission statement of the Board, which says, *The mission and purpose of the Kentucky Board of Licensed Diabetes Educators is to regulate the practice of diabetes education in Kentucky and to ensure safe and competent diabetes education to all people in the Commonwealth.*

KBLDE 2013 Meeting Dates: April 16; May 21; June 18; July 16; August 20; September 17; October 15; November 19; December 17



KY COORDINATING BODY (CB) REPORT



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

Much of the recent activities of the AADE KY Coordinating Body (CB) have been centered on Diabetes Educator Licensure. The Kentucky Board of Licensed Diabetes Educators (KBLDE)

was advised by the Legislative Research Commission (LRC) that the existing statute regarding diabetes educator licensure required an amendment to allow applicants to practice at an “apprentice” level while obtaining the necessary supervised

DIABETES MEDICATION UPDATE: NEW AGENTS ENTER THE MARKET IN 2013



Sarah M. Lawrence
PharmD, MA

Submitted by Sarah M. Lawrence, Pharm D, MA, Lawrence Pharmacy Services, Louisville, KY

The early months of 2013 have seen the approval of several new agents to treat Type 2 Diabetes. In addition to agents that have been approved, an additional drug has cleared the last regulatory hurdle before FDA approval. This article will discuss new agents that are poised to enter the market and agents that seem to be positioned for approval later this year.

Alogliptin (Nesina) is a new dipeptidyl peptidase-IV (DPP-IV) inhibitor being marketed by Takeda pharmaceuticals of Japan. Alogliptin is the fourth agent approved in this class to be approved for use in the United States and joins **sitagliptin (Januvia)**, **saxagliptin (Onglyza)** and **linagliptin (Tradjenta)**. Although Takeda's marketing materials have promoted alogliptin as a novel medication for Type 2 diabetes, its mechanism of action is the same as the other agents in this class, and its adverse effect profile seems similar as well.

All DPP-IV inhibitors block the actions of dipeptidyl peptidase-IV, an enzyme that degrades endogenous incretin hormones such as glucagon-like peptide 1 (GLP-1). GLP-1 increases glucose dependent insulin secretion and decreases glucagon production in order to help lower blood glucose levels. Endogenous GLP-1 is quickly inactivated by DPP-IV under normal conditions, so DPP-IV inhibitors are designed to prevent the breakdown of GLP-1 and facilitate GLP-1's beneficial effects on blood glucose levels. Because DPP-IV inhibitors increase insulin release in response to meals, they primarily affect post-prandial glucose levels and have lower rates of hypoglycemia than other agents that increase insulin secretion, such as the sulfonylureas.

The ADA/EASD position statement on the management of Type 2 diabetes classifies all DPP-IV inhibitors as second line agents, after first line agent metformin. DPP-IV inhibitors are appropriate for use in combination with metformin, and in three drug combination regimens with metformin and another agent. **At this time, clinicians should avoid combining DPP-IV inhibitors with GLP-1 agonists (exenatide and liraglutide) because they affect the same biological pathway.**

Alogliptin will be marketed as single ingredient **Nesina** and in a combination dosage form with metformin. This product will be marketed under brand name **Kazano**. The three other

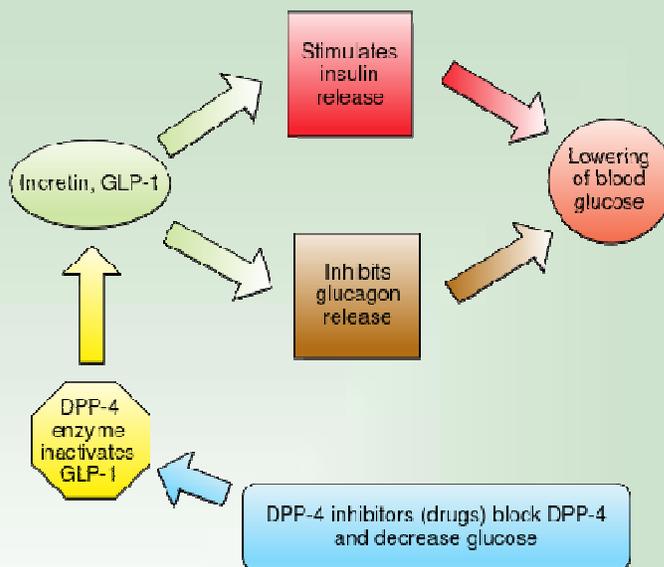


Image source: Wikimedia Commons

DPP-IV inhibitors are also available in combination products with metformin. Alogliptin is also available in combination with pioglitazone (Actos), which represents the first time a DPP-IV inhibitor has been marketed in conjunction with a thiazolidinedione. This product will be marketed as brand name **Oseni**. All three products are projected to be available by summer 2013.

Canagliflozin (Invokana) is part of a new class of diabetes medications. These agents, known as SGLT2 inhibitors, do not affect insulin in any way. In January, an FDA advisory panel voted 10 to 5 to recommend approval of canagliflozin. This represents the last step before formal approval by the FDA and paves the way for canagliflozin to become the first SGLT2 inhibitor on the US market. Another agent, dapagliflozin was rejected last year over concerns of breast and bladder cancer risks. These risks do not appear to be a problem for canagliflozin based on available data.

SGLT2 is part of a family of sodium-glucose linked transporters that help regulate renal glucose reabsorption. Canagliflozin inhibits these transporters, causing glucose to be excreted in the urine. Although the panel voted to recommend approval of canagliflozin, several members expressed concerns that the drug may increase the risk of genitourinary infections, and would probably not be appropriate for patients with diabetes and existing renal impairment. The panel also noted the need for longer term data on the drug's impact on cardiovascular risk, which has become a concern for diabetes medications in general in recent years. More information should be available about this new class of medication as canagliflozin progresses through the approval process.

JDRF KY LICENSE PLATES HIT THE ROAD

MEDICAID AFFORDABLE CARE ACT FAQs



- The first Juvenile Diabetes Research Foundation (JDRF) Kentucky license plate has become reality in 2013!
- If you registered for a JDRF plate, look for a notice that will be mailed to you alerting you that your JDRF plate is ready to be picked up at your local Division of Motor Vehicle Licensing.
- If you did not register for a JDRF plate but would like to receive one, please notify your local licensing office.
- Registration fees are \$25 and will need to be paid directly to the state.

The Centers for Medicare & Medicaid Services (CMS) recently posted a set of “frequently asked questions” to the [Medicaid.gov](http://www.medicaid.gov) website. To view the FAQs, go to: <http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html>

Please direct questions to HHSIEA@hhs.gov.



NEW DIABETES RESOURCES AVAILABLE

PRINTABLE FACT SHEETS

Submitted by: *Patricia Herrmann, National Association of Chronic Disease Directors (NACDD)*

Copies available at: www.diabetesleadershipinitiative.com under the heading “Where Are We Working?”

The National Association of Chronic Disease Directors (NACDD) Diabetes Leadership Initiative (DLI) is pleased to announce the publication of a new white paper on diabetes and a series of fact sheets related to systems change for better diabetes care, as follows:

- **The High Cost of Diabetes and Diabetes Complications**, the second in a series of white papers on diabetes, the white paper highlights the substantial cost burden of diabetes and its major complications in both human and financial terms.
- **Reducing Diabetes Complications - Cardiovascular Disease** (fact sheet)
- **Reducing Diabetes Complications – Neuropathy** (fact sheet)
- **Reducing Diabetes Complications – Retinopathy** (fact sheet)

The Diabetes Leadership Initiative (DLI) is a three-year NACDD effort to improve the health of people with diabetes by building awareness of the need to detect, delay, and manage the important but often under-recognized major diabetes complications.

For more information about the DLI or these new resources, please contact:

Miriam Patanian, MPH
Project Director, DLI
patanian@chronicdisease.org

OR

Amy Greene, MSW, MPH
Project Coordinator, DLI
greene@chronicdisease.org



2013 CLINICAL PRACTICE GUIDELINES

NOW AVAILABLE

Below is a Summary of the Revisions to the Standards of Medical Care in Diabetes 2013 — Full Content May Be Viewed Online at:

http://care.diabetesjournals.org/content/36/Supplement_1/S11.full



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

- Section II.C. Screening for Type 1 Diabetes has been revised to include more specific recommendations.
 - Section IV. Prevention/Delay of Type 2 Diabetes has been revised to reflect the importance of screening for and treating other cardiovascular risk factors.
 - Section V.C.a. Glucose Monitoring has been revised to highlight the need for patients on intensive insulin regimens to do frequent self-monitoring of blood glucose.
 - Section V.D. Pharmacological and Overall Approaches to Treatment has been revised to add a section with more specific recommendations for insulin therapy in type 1 diabetes.
 - Section V.F. Diabetes Self-Management Education and Support has been revised to be consistent with the newly revised National Standards for Diabetes Self-Management Education and Support.
 - Section V.K. Hypoglycemia has been revised to emphasize the need to assess hypoglycemia and cognitive function when indicated.
 - Section V.M. Immunization has been updated to include the new Centers for Disease Control and Prevention (CDC) recommendations for hepatitis B vaccination for people with diabetes.
- Section VI.A.1. Hypertension/Blood Pressure Control has been revised to suggest that the systolic blood pressure goal for many people with diabetes and hypertension should be <140 mmHg, but that lower systolic targets (such as <130 mmHg) may be appropriate for certain individuals, such as younger patients, if it can be achieved without undue treatment burden.
 - Section VI.A.2. Dyslipidemia/Lipid Management and Table 10 have been revised to emphasize the importance of statin therapy over particular LDL cholesterol goals in high-risk patients.
 - Section VI.B. Nephropathy Screening and Treatment and Table 11 have been revised to highlight increased urinary albumin excretion over the terms micro- and macroalbuminuria, other than when discussion of past studies requires the distinction.
 - Section VI.C. Retinopathy Screening and Treatment has been revised to include anti-vascular endothelial growth factor therapy for diabetic macular edema.
 - Section IX.A. Diabetes Care in the Hospital has been revised to include a recommendation to consider obtaining an A1C in patients with risk factors for undiagnosed diabetes who exhibit hyperglycemia in the hospital.

Revised Position Statement

- The position statement “Diagnosis and Classification of Diabetes Mellitus” has been revised slightly to add newer information about monogenic forms of diabetes.

Revisions to the National Standards for Diabetes Self-Management Education and Support

- The task force report “National Standards for Diabetes Self-Management Education and Support” represents

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CMS CHRONIC CONDITIONS DASHBOARD AVAILABLE

The Centers for Medicare and Medicaid Services (CMS) recently released a new interactive tool that allows users to examine chronic conditions among Medicare beneficiaries. The *CMS Chronic Conditions Dashboard* presents statistical views of information on the prevalence, utilization, and Medicare spending for Medicare beneficiaries with chronic conditions. The Dashboard displays information on a set of predefined chronic conditions available in the Chronic Condition Warehouse (CCW) at both the national and state level for 2011. This set of chronic conditions is consistent with the list of conditions included in the currently available 2012 edition of the CMS chartbook, “Chronic Conditions among Medicare Beneficiaries”.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CCChartBook.html>

The statistics in the Dashboard include:

- (1) the prevalence of Medicare beneficiaries with the specific 15 chronic conditions,
- (2) the prevalence and per capita Medicare spending for beneficiaries with multiple chronic conditions, based upon counting the number of conditions from the set of 15 conditions, and
- (3) utilization metrics for 30-day hospital readmissions and emergency department visits by the number of chronic conditions.

In addition to the information being available at the state and national levels, the Dashboard also allows the user to select information for specific beneficiary sub-groups defined by gender, age group or dual eligibility status. This effort is aligned with Goal 4 in the HHS Strategic Framework on Multiple Chronic Conditions that addressed the need for research to fill knowledge gaps about the interventions and systems to benefit individuals with multiple chronic conditions. The chronic conditions dashboard is accessible at: www.cdwdata.org under “CMS Interactive Data” OR <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html>

TWO KENTUCKY SITES RECEIVE AADE “BETTER HEALTH” GRANT

Printed in part from AADE January, 2013 E Newsletter

The American Association of Diabetes Educators (AADE) Research and Education Foundation recently announced recipients of the *Reaching Out for Better Health* grant which supports new and expanded outreach and education activities of accredited diabetes programs that target underserved populations. The AADE Research and Education Foundation received over 40 applications and has selected 10 accredited education programs to participate. The Foundation will provide over \$190,000 in grants.

Congratulations to the recipients!

- Bay Clinic, Hilo, HI
- St. Patrick Hospital Diabetes Care and Prevention Center, Missoula, MT
- St. Luke’s Regional Medical Center, Sioux City, IA
- Genesys Diabetes Nutrition and Learning Center,

- **Diabetes Resource Center of Hopkinsville, Hopkinsville, KY**
- Diabetes and Nutrition Center - East Alabama Medical Center, Opelika, AL
- Family Health Care Diabetes Education Center, Statesboro, GA
- **Jewish Diabetes Care, Louisville, KY**
- North Shore Long Island Jewish Hospital System, New Hyde Park, NY
- Columbus Regional Hospital Diabetes Self-Management Training Program, Columbus, IN

The Foundation is grateful for the substantial support from the following corporate donors: Abbott, Bayer Diabetes Care, Pepsico, and Lilly.



NIH / CDC REPORT: BIG IMPROVEMENT IN DIABETES CONTROL

Printed in part from National Institutes of Health News Release, February 2013, Contact: Amy Reiter 301-496-3583

Findings demonstrate need for improved care, especially among youth, some minorities

More people are meeting recommended goals in the three key markers of diabetes control, according to a study conducted and funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC).

The report, published online February 15 in *Diabetes Care*, shows that, from 1988 to 2010, the number of people with diabetes able to meet or exceed all three of the measures that demonstrate good diabetes management rose from about 2 percent to about 19 percent. Each measure also showed substantial improvement, with over half of people meeting each individual goal in 2010.

The measures are A1C — which assesses blood sugar (glucose) over the previous three months — blood pressure and cholesterol. They are often called the ABCs of diabetes. When these measures fall outside healthy ranges, people are more likely to be burdened by complications of diabetes, including heart disease, stroke, kidney disease, blindness, and amputation.

Despite improvement, the results show continued need for better diabetes control. In particular, young people and some minority groups were below average in meeting the goals.

To gauge diabetes management, researchers analyzed data from the National Health and Nutrition Examination Surveys from 1988-1994 and 1999-2010.

“The most impressive finding was the significant improvement in diabetes management over time across all groups,” said Catherine Cowie, PhD, the study’s senior author and director of the Diabetes Epidemiology Program at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), which conducted and funded the study. “However, we see a lot of room for improvement, for everyone, but particularly for younger people and some minority groups.”

According to 2007-2010 data on Americans with diabetes:

- 53 percent met A1C goals, compared to 43 percent in 1988-1994 data
- 51 percent met blood pressure goals, compared to 33 percent in 1988-1994 data
- 56 percent met cholesterol goals, compared to 10 percent in 1988-1994 data

Improved cholesterol control was likely due to the increase in the use of statins, a type of cholesterol-lowering drug, from

about 4 percent of people with diabetes during 1988-1994 to 51 percent during 2007-2010. Glucose control was worse in Mexican-Americans and in younger adults. Only 44 percent of Mexican-Americans met A1C goals, versus 53 percent of whites and blacks in 2007-2010 data. People between 20-49 years old were less likely to meet A1C goals than older people.

“It is particularly disturbing that good control was seen less frequently in young people,” said Judith Fradkin, MD, director of the NIDDK Division of Diabetes, Endocrinology, and Metabolic Diseases. “Research has shown that good diabetes control early in the course of disease has long-lasting benefits reducing the risk of complications. For people with long life expectancy after diagnosis of diabetes, it’s especially important to focus on meeting diabetes management goals as early as possible, because with that longer life comes a greater chance of developing complications if they do not control their diabetes.”

“Not only do Mexican-Americans and non-Hispanic blacks have higher rates of diabetes, members of these groups who develop diabetes also have poorer health outcomes,” said the paper’s first author, Sarah Stark Casagrande, PhD, an epidemiologist from Social & Scientific Systems Inc., Silver Spring, Md., whose work is supported by NIDDK. “While diabetes control has improved in these populations, some disparities remain, demonstrating the need for improved management of the disease to prevent its devastating complications.”

Goals for A1C, blood pressure, and cholesterol must be individualized for people with diabetes, as effects of diabetes can differ depending on a person’s age, type of diabetes, diabetes medications, complications from diabetes, and other factors.

For A1C, a goal for many people is below 7 percent. It is particularly important for people with long life expectancies to control A1C to protect against eye, nerve, and kidney disease in the future. Goals can be less stringent for people with limited life expectancy, since complications develop over time. For blood pressure, the goal for most people is 130/80. Moderate or high dose statin therapy is recommended for people over 40 with diabetes, with a goal of keeping the low-density lipoprotein (LDL) — sometimes called bad cholesterol — less than 100 milligrams per deciliter. Control of blood pressure and cholesterol are particularly important for lowering cardiovascular risk.

About 26 million Americans have diabetes, and another 79 million have prediabetes, a condition that places them at increased risk for developing type 2 diabetes and heart disease. Between 1988 and 2012, the prevalence of diagnosed diabetes has more than doubled, from nearly 4 percent of the U.S. population to nearly 9 percent, according to data from the Centers for Disease Control and Prevention.

DIABETES ALERT DAY

ACTIVITIES IN COVINGTON

Submitted by: Julie Shapero, RD, LD and Joan Geohegan, RN, BSN, CDE, Northern KY Health Department, KDN and DECA members

Julie Shapero and Joan Geohegan, diabetes educators with the Northern KY Health Department, arranged with Cynthia Rorer, Walmart Pharmacy Manager, to host a **Diabetes Alert Day** display at the Fort Wright store on Tuesday, March 26th. Julie and Joan met with 37 Walmart shoppers to discuss the diabetes risk test and provide information on classes and support groups. About half of the people that stopped by the display mentioned that they had previously been diagnosed with diabetes.

The **Diabetes Alert** display was situated near the Easter candy aisle. To gain attention, a box of regular and sugar-free chocolate candy was displayed. Shoppers were then asked which was the “better choice” for someone with diabetes. Participants were surprised to learn that the sugar-free candy had the same calories and more carbohydrates than the regular candy.

The Walmart Pharmacy plans to keep the **Diabetes Alert Day** poster and diabetes risk tests on display for another week. The pharmacist requested more diabetes displays in the future and also has agreed to speak at an upcoming Diabetes Support Group program. The Northern KY Diabetes Coalition also arranged for a **Diabetes Alert Day** message on the electronic billboard at the St. Elizabeth Regional Diabetes Center. According to the transportation planning council, the traffic count for the electronic sign is over 200,000 cars daily.



Pictured left to right: Julie Shapero, Joan Geohegan, and Cynthia Rorer work at a display for “Diabetes Alert Day” March 26, 2013 at Walmart in Fort Wright.

The Northern KY Diabetes Coalition arranged for a “Diabetes Alert Day” message on the electronic billboard at St. Elizabeth Regional Diabetes Center. Daily traffic count was over 200,000 cars.



The Immunization Action Coalition recently released a tool that can be used by health professionals in educating people with diabetes about needed vaccines.

The tool can be downloaded for free at: <http://www.immunize.org/catg.d/p4043.pdf>

Vaccinations for Adults with Diabetes

The table below shows which vaccinations you should have to protect your health if you have diabetes. Make sure you and your healthcare provider keep your vaccinations up to date.

Vaccine	Do you need it?
Hepatitis A (HAV)	Maybe. You need this vaccine if you have a specific risk factor for hepatitis A virus infection* or simply want to be protected from this disease. The vaccine is usually given in 2 doses, 6 months apart.
Hepatitis B (HBV)	Yes! If you are younger than 60 and have never received or completed a series of 3-dose vaccine, you need to be vaccinated now. If you are 60 or older, discuss your need for HepB vaccine with your healthcare provider.
Human papillomavirus (HPV)	Maybe. You need this vaccine if you are a woman age 26 or younger or a man age 21 or younger. Men age 22 through 26 with a risk condition** also need vaccination. Any other man age 22 through 26 who wants to be protected from HPV may need it, too. The vaccine is given in 3 doses over 6 months.
Influenza	Yes! You need a flu shot every fall (or more often) around you. Yes! and for the protection of others around you.
Meningitis, pneumococcal (MMN)	Maybe. You need at least 1 dose. Yes! or later. You may also need a second dose.*
Meningococcal (MCV, MPSV)	Maybe. You need the first-year college-vaccinated individual. Yes! if you have certain health conditions, or if you are 19-21 and a student, or if you either have never been vaccinated or were not vaccinated before.
Pneumococcal (PCV13, PPV23)	Yes! People with diabetes (PCV13). If you are young, you will need to get another dose when you are 65 or older, as long as it's been at least 2 yrs. since your previous dose. Adults with certain high-risk conditions also need vaccination with PCV13. Talk to your healthcare provider to find out if you need this vaccine.**
Tetanus, diphtheria, and whooping cough (pertussis, Tdap, Td)	Yes! All adults need to get a 1-time dose of Tdap vaccine (the adult whooping cough vaccine). After that, you need a Td booster dose every 10 years. Consult your healthcare provider if you haven't had at least 3 tetanus and diphtheria-containing shots sometime in your life or you have a deep or dirty wound.
Varicella (Chickenpox)	Maybe. If you are an adult born in the U.S. in 1980 or later, and have never had chickenpox or the vaccine, you should be vaccinated with the 2-dose series.
Zoster (shingles)	Maybe. If you are 60 or older, you should get a 1-time dose of this vaccine now.

*Consult your healthcare provider to determine your level of risk for infection and your need for this vaccine. If you will be traveling outside the United States, you may need additional vaccines. For information, consult your healthcare provider, a travel clinic, or the Centers for Disease Control and Prevention at www.cdc.gov/travel.



KIPDA Rural Diabetes Coalition
Diabetes has no boundaries

In collaboration with the University of Louisville
 Funding provided by the Centers for Disease Control and Prevention

KIPDA RURAL DIABETES COALITION ~ HENRY COUNTY CHAPTER ~ OUR STORY

*Submitted by: Mona Huff, Henry County Community Organizer
 Mona.huff.henrykipda@gmail.com*

The KIPDA Rural Diabetes Coalition (KRDC) is a coalition of community members in Henry, Shelby, and Bullitt Counties whose mission is to improve the lives of people with type 2 diabetes and create healthier communities. KRDC does this by promoting the following:

- ~ **Diabetes awareness and education**
- ~ **Motivating self-care**
- ~ **Creating healthy living resources**
- ~ **Increasing involvement in the recommended care measures**
- ~ **Increasing awareness of the long-term complications of diabetes**

KIPDA and the Kent School of Social Work at the University of Louisville received a grant from the CDC to fund this project. The county groups are to be an arm of KIPDA Rural Diabetes Coalition and assist the KRDC to understand the needs and personality of each county. The Henry County Chapter of the KIPDA Rural Diabetes Coalition had its first meeting in June of 2011 with several professional people from our county and citizens living with diabetes.

Discussion indicated that education and support are the two immediate needs in Henry County. Therefore, an educational piece with varying speakers is a part of each meeting. We have sponsored two educational events on a Saturday providing expert speakers and resources, as well. We have completed a photo voice project, a community assessment and a needs assessment with close to 150 participants. That information has been analyzed by the University of Louisville Team. As a result, we are offering free Diabetes Support Group meetings led by a retired Certified Diabetes Educator, Stanford's Diabetes Self-Management Program, and ADA's "Live Empowered Program" in a local African American Church, and we have started a walking club for all of Henry County. We have sponsored three A1C speakers through our coalition member, Jared Zirkle who works with Sanofi. Additionally, Diane Davidson, RN, CDE from Novo Nordisk has been one of our lead speakers at our two educational events, serves as medical advisor for the "Live Empowered Program", and is teaching a series to our coalition members on diabetes and how to become better advocates for diabetes. We write a quarterly newsletter that is given to the members of our local county group, doctors' offices, the Health Department, restaurants, HC Extension Office, churches, as well as being distributed through several collaborators' email lists. Our local pharmacy also places the newsletter into prescription bags of diabetes medications. We have been fortunate to have great partners in the community and to reach many individuals through our initiatives.

Another important project is our effort to help the physicians reach out to their patients. Henry County Medical Center agreed to give out physician packets last spring as a trial run to see how it would work. A packet was put together with general information on diabetes and simple self-management tools. The doctors felt that the packets were helpful, so we expanded our reach. We are using one of the Seven Steps from AADE as a theme each time (changing packets out every 6 months) with general information on diabetes and county dates for events added to the packet. We are thrilled and encouraged that every medical office in Henry County has agreed to do this!

Henry County has had great success working toward the KRDC's goals of providing resources for people with diabetes, helping communities to encourage healthy lifestyle choices, and engaging local medical professionals. Our desire is to help our folks understand that diabetes is not a life-ender, but the complications of diabetes can affect the quality of life and perhaps cause premature death. Education and encouragement is what we offer to empower and help our communities understand diabetes management. We have experienced great success, but we are just beginning to ROAR!

The Henry County mantra is: Diabetes is:

A personal diagnosis.

A family diagnosis.

A community diagnosis.

TOGETHER we can win the battle!



Pictured above: Members of the Henry County Chapter of the KRDC / KIPDA Rural Diabetes Coalition

This article was supported by the Cooperative Agreement Number IU58DP002815-01 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

HAVE YOU HEARD?

DIABETES EDUCATORS — EDUCATE STAFF AND COMMUNITY ABOUT SAFE INJECTION PRACTICES

Seems there is still confusion about safe injection practices and some nurses (and others) have used insulin pen devices, fingerstick devices, etc. for multiple patients thinking that changing the needle each time between patients safeguarded the patient... read on....

Injection safety is part of the minimum expectation for safe care anywhere healthcare is delivered; yet, CDC has had to investigate numerous outbreaks of life-threatening infections caused by injection errors. Since 2001, at least 150,000 U.S. patients have been negatively impacted by unsafe medical injections. For the report go to: <http://www.cdc.gov/HAI/settings/outpatient/outbreaks-patient-notifications.html>

When healthcare providers fail to follow basic infection control practices during injection preparation and administration, patients can be exposed to life-threatening illnesses such as hepatitis and/or bacterial infections. To assist diabetes educators and others in covering this important topic, CDC is releasing a digital press kit about the impact of unsafe injection practices in U.S. healthcare settings.

The digital press kit includes fact sheets, an infographic, videos and podcasts, and quotes from CDC experts. See the digital press kit at: <http://www.cdc.gov/media/releases/2012/dpk-unsafe-injections.html>.

In addition, to further educate healthcare providers about safe injection practices, CDC is releasing several new educational pieces. See more at <http://www.oneandonlycampaign.org/news/new-tools-help-clinicians-ensure-every-injection-safe>.

PREGNANCY WEIGHT GAIN RECOMMENDED WHEN OVERWEIGHT OR OBESE...

As more and more people are overweight or obese, there have recently been questions from diabetes educators regarding appropriate weight gain for these individuals in pregnancy. The Institute of Medicine (IOM) has published guidelines and resources that may be helpful.

The Committee on Dissemination of the IOM Pregnancy Weight Guidelines held a one-day workshop on March 1, 2013 at the National Academy of Sciences in Washington, D.C. to dialogue about communicating and implementing recommended guidelines for pregnancy weight gain. The intent is to present outreach products that have been designed to help women plan for healthy weight gain during pregnancy and to give providers tools to help pregnant women achieve their weight gain goals.

Visit the website below to view the pregnancy weight guidelines and to obtain related resources for use in your teaching and outreach with women before, during and after pregnancy.

<http://www.iom.edu/About-IOM/Making-a-Difference/Kellogg/HealthyPregnancy.aspx>

If Before Pregnancy...

During Pregnancy Gain...

Underweight BMI less than 18.5	28-40 lbs.
Normal Weight BMI 18.5-24.9	25-35 lbs.
Overweight BMI 25.0-29.9	15-25 lbs.
Obese (includes all classes) BMI greater than or equal to 30.0	11-20 lbs.

DIABETES COSTS NEW HELPFUL DATA

Source: Printed in part from *Diabetes Care* April, 2013

New Diabetes Cost Data Was Recently Released in the American Diabetes Association (ADA) *Diabetes Care* Journal, April, 2013.

- Care for people with diagnosed diabetes accounts for more than 1 in 5 health care dollars in the U.S., and more than half of that expenditure is directly attributable to diabetes.
- Total cost of diabetes in the United States jumped from \$174 billion in 2007 to \$245 billion in 2012 (\$176 billion in direct medical costs and \$69 billion in reduced productivity).
- The per-person cost of medical care attributed to diabetes was \$6,649 in 2007 versus \$7,900 in 2012, a 19 percent increase.
- Most (62 percent) of the cost for diabetes care in the United States is provided by government insurance (including Medicare, Medicaid and the military). The rest is paid for by private insurance (34 percent) or by the uninsured (3 percent).
- Diabetes costs / medical expenditures include: hospital inpatient care (43% of the total medical cost), prescription medications to treat the complications of diabetes (18%), antidiabetic agents and diabetes supplies (12%), physician office visits (9%), and nursing/residential facility stays (8%).
- People with diagnosed diabetes incur average medical expenditures of about \$13,700 per year, of which about \$7,900 is attributed to diabetes.
- People with diagnosed diabetes, on average, have medical expenditures approximately 2.3 times higher than what expenditures would be in the absence of diabetes.

KENTUCKY RECEIVES NEW FUNDING TO FIGHT PREDIABETES EPIDEMIC

Source: Printed in part from *CHFS Press Release 3-20-13*

The Kentucky Department for Public Health (DPH) has been awarded a federal grant to help curb rates of prediabetes and type 2 diabetes among residents of the Commonwealth. The award, worth \$134,380 comes from the National Association of Chronic Disease Directors (NACDD) and the Centers for Disease Control and Prevention (CDC). Similar awards will also go to seven other states.

“Diabetes is a tremendous public health concern that is both horrific for the individual, if unmanaged, and costly in terms of medications, various complications and long-term hospitalizations that are so often associated with the disease,” said Health and Family Services Cabinet Secretary Audrey Tayse Haynes. “We must act now to begin reversing the devastating impact of diabetes on our state. We are excited to continue our work with the Diabetes Prevention Program to help more Kentuckians start making healthier lifestyle choices so they can avoid developing diabetes and lead longer, healthier lives.”

“Prediabetes has become an absolute epidemic in America,” said John Robitscher, CEO of the National Association of Chronic Disease Directors. “We appreciate the opportunity that CDC has provided us to identify well-positioned states that can make a difference in slowing the incidence of this alarming trend.”

The DPH Kentucky Diabetes Prevention and Control Program is coordinating the diabetes prevention grant project in the Commonwealth. The program has been collaborating with a steering committee to develop a work plan for the grant.

The committee includes sites that currently offer the National Diabetes Prevention Program - the YMCA of Greater Louisville, the YMCA of Central Kentucky, and the YMCA of Greater Cincinnati. In addition, the Louisville Metro Department of Health and Wellness, the Lexington-Fayette County Health Department, the Northern Kentucky Independent District Health Department and the Department for Public Health’s Worksite Wellness Program are also participating.

Kentucky will focus on three diabetes prevention strategies – raising awareness among healthcare providers to improve the recognition and treatment of prediabetes; encouraging state and local government to add CDC-recognized lifestyle change programs to its list of covered services under employee health plans; and partnering with businesses to increase support for coverage of CDC-recognized lifestyle change programs as a covered benefit.

Kentucky will have until Dec. 31, 2013 to complete its project.



2013 Webinars

An AADE live webinar is a knowledge based activity offering 1.5 hours CE credit.

- April 24** Elder Care: Setting Targets, Treating Safely
- May 8** Elder Care: Diabetes and Cognitive Decline
- May 22** Management of Type 2 Diabetes in Children / Adolescents: New Guidelines
- June 12** Develop Your Inner Entrepreneur
- July 10** Medication Management: Case Study

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



2nd Annual Diabetes Education Conference Sunday, May 19, 2013

Muhammad Ali Center / Louisville, KY / 11:30 am – 5:00 pm
FREE Half-Day Conference for Families, Individuals and Caregivers Affiliated With Type 1 Diabetes

RSVP: www.jdrfkyconference.eventzilla.net

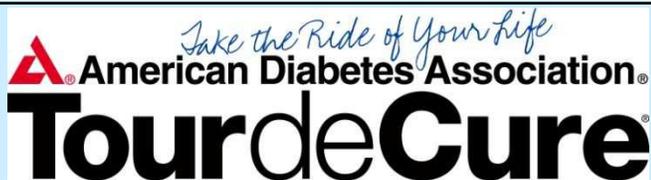
JDRF Golf Scramble Monday, May 20, 2013 at Valhalla Golf Club, Louisville

Walk to Cure Diabetes Schedule

- August 24** Greater Louisville Walk, Churchill Downs
- September 14** Four Rivers Walk, Noble Park, Paducah
Big Sandy North Walk, Central Park, Ashland
- September 21** Bluegrass Walk, Lexington Legends
- September 28** Cruisin' for a Cure, Bowling Green Ballpark
Big Sandy South Walk, Prestonsburg
Community & Technical College

For information contact: mgault@jdrf.org
502-485-9397 or 866-485-9397

DIABETES RELATED OFFERINGS



**CYCLING EVENT IN LOUISVILLE, KY
TO RAISE FUNDS FOR DIABETES RESEARCH**

WHEN: SATURDAY, MAY 18, 2013

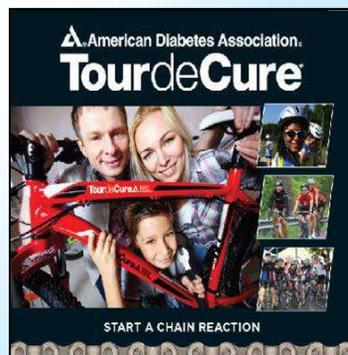
**WHERE: NORTON COMMONS
10712 MEETING STREET, PROSPECT, KENTUCKY**

REGISTER TODAY!

**DIABETES.ORG/
LOUISVILLETOURDECURE
(502) 452-6072 EXT. 3318
OR 3307**

REGISTRATION FEE: \$25

**NOTE: EACH RIDER MUST RAISE A
MINIMUM OF \$200 TO HELP FUND
LOCAL DIABETES RESEARCH,
EDUCATION AND ADVOCACY BY
THE EVENT DATE.**



Training News



Diabetes Prevention Program Training 2013 Dates

**DTTAC's Lifestyle Coach Trainings
Emory University in Atlanta, Georgia
May 14-15, 2013**

These interactive 2-day trainings, led by an experienced DTTAC Master Trainer, will train Lifestyle Coaches with the skills, knowledge and experience to successfully facilitate the Diabetes Prevention Program (DPP).

Training is open to organizations that have received pending recognition status from the CDC. Cost of training is \$1,500 per participant (which includes breakfast, lunch and snacks during the training, all instruction and printed materials).

For more information email: dttac@emory.edu

KADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Kentucky Association of Diabetes Educators (KADE), (*covers Lexington and Central Kentucky*), meets the 3rd Tuesday of every month except summer (*time & location vary*). For a schedule or more information, go to <http://kadenet.org/> or contact: Dee Deakins dee.deakins@uky.edu or Diane Ballard dianeballard@windstream.net.

KADE's 2013 Symposium, *Exploring Diabetes: Gestational to Geriatric* Electronic Handouts Available at:

<http://kadenet.org/>

KENTUCKY DIABETES NETWORK (KDN) MEETINGS SCHEDULED

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

Anyone interested in improving diabetes outcomes in Kentucky may join. 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)

June 14, 2013 — Central Baptist Hospital, Lexington

September 13, 2013 — Shelby Campus, Louisville

December 6, 2013 — KY History Center, Frankfort



Connie White, MD, Deputy Commissioner of Clinical Affairs with the KY Department for Public Health, left, with KDN President Mechelle Coble, right, following Dr. White's presentation at the March 8, 2013 KDN program.

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*

GLADE DIABETES EDUCATOR MEETINGS SCHEDULED

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

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

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.

2013 TRADE Workshop April 26, 2013

**July 18, 2013 — Owensboro, KY
October 17, 2013 — Madisonville, KY**

ENDOCRINOLOGISTS MEETINGS SCHEDULED

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

Kentucky Diabetes Connection



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YOU CAN TAKE CONTROL
YMCA Diabetes Prevention Program

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

**For more information, please contact one of the following
Diabetes Prevention Program Coordinators in your area:**

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Contact Information



American Diabetes Association
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www.diabetes.org
1-888-DIABETES



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



KENTUCKY DIABETES NETWORK, INC.
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www.kadenet.org

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A LOCAL NETWORKING GROUP of the
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