Important Updates of the 2016 American Diabetes Association's Standards of Medical Care in Diabetes

Secrets of Success for the Health Care Team and Community Health Workers

Hosted by:
NDEP Hispanic/Latino Stakeholder Group
Today’s Presenters

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Standards of Care

ADA Standards of Care are based on a complete review of the relevant literature by a diverse group of highly trained clinicians and researchers. After weighing the quality of evidence, from rigorous double-blind clinical trials to expert opinion, recommendations are drafted, reviewed, and submitted for approval to the ADA Executive Committee; they are then revised on a regular basis, and subsequently published in Diabetes Care.

Standards of Medical Care in Diabetes

A comprehensive Position Statement covering all components of diabetes care, general treatment goals, and tools to evaluate quality care.

Access the standards.
View the full PDF.
Comment.
Mobile (Coming soon)

Order your print copy of the Diabetes Care supplement containing the full Standards of Care. (Coming soon)

Standards of Medical Care in Diabetes: Abridged for Primary Care Providers

View the abridged standards.

Resources

Summary of Revisions of the Standards of Medical Care in Diabetes

View the 2016 summary of revisions.

Evidence Table

View the 2016 evidence table.

http://professional.diabetes.org/content/clinical-practice-recommendations

Diabetes Association Standards of Medical Care in Diabetes.
Introduction. Diabetes Care 2016; 39 (Suppl. 1): S1-S2
Sections in 2016 Standards of Medical Care

S1 - Strategies for Improving Care
S2 - Classification of Diagnosis of Diabetes
S3 - Foundations of Care and Comprehensive Medical Evaluation
S4 - Prevention or Delay of Type 2 Diabetes
S5 - Glycemic Targets
S6 - Obesity Management for the Treatment of Type 2 Diabetes
S7 - Approaches for Glycemic Treatment
S8 - Cardiovascular Disease and Risk Management
S9 - Microvascular Complications and Foot
S10 - Older Adults
S11 - Children and Adolescents
S12 - Management of Diabetes in Pregnancy
S13 - Diabetes Care in the Hospital
S14 - Diabetes Advocacy
## Evidence Grading System

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Clear evidence from adequately-powered, well-conducted, generalizable RCTs, including evidence from a multicenter trial or meta-analysis that incorporated quality ratings in the analysis; Compelling nonexperimental evidence; Supportive evidence from adequately-powered, well-conducted RCTs.</td>
</tr>
<tr>
<td>B</td>
<td>Supportive evidence from a well-conducted cohort studies Supportive evidence from a well-conducted case-control study</td>
</tr>
<tr>
<td>C</td>
<td>Evidence from case series or case reports Conflicting evidence with the weight of evidence supporting the recommendations</td>
</tr>
<tr>
<td>E</td>
<td>Expert consensus or clinical experience</td>
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</tbody>
</table>
Standards Abridged for Primary Care

Abridged version of the 2016 Standards of Care containing the evidence-based recommendations most pertinent to primary care
Knowledge Check

• In 2016, the American Diabetes Association published its annual (1) Complete Standards of Medical Care and (2) Standards of Care Abridged for the Primary Care Provider. They are both based on:

  a. Chronic Care Model
  b. Strength of evidence grading system (ex. A, B, C & E)
  c. Clinical opinion only
  d. Influence from industry
In 2016, ADA published its annual (1) Complete Standards of Medical Care (2) Standards of Care Abridged for the Primary Care Provider. Based on?

- Chronic Care Model: 18%
- Strength of evidence grading system: 79.5%
- Clinical opinion only: 1.6%
- Influence from industry: 0.8%
Summary of Revisions

• General changes

• Section changes
  – Revisions to all 14
  – Selected section revisions covered in this presentation
    • General, S1, S2, S3, S8, S9
General Change - NEW

• The Standards of Care will no longer use the term “diabetic” as a noun to refer to patients with diabetes.
  – Diabetes does not define people
• Those with diabetes are individuals with diabetes, not “diabetics.”
• ADA will continue to use the term “diabetic” as an adjective for complications related to diabetes (e.g., diabetic retinopathy).
2016 American Diabetes Association's Standards of Medical Care in Diabetes

S1: STRATEGIES FOR IMPROVING CARE
S1: Strategies for Improving Care

• Key recommendations
• Diabetes Care Concepts
• Care Delivery Systems, including three key objectives:
  – Optimize Provider and Team Behavior
  – Support Patient Behavior Change
  – Change the System of Care

• New in 2016:
  – What to do when treatment goals are not met
  – Tailoring treatment to vulnerable populations.
Strategies for Improving Care

Key Recommendations

• Patient-centric approach
• Decisions made in a timely manner and based on evidence-based guidelines
• Aligned with Chronic Care Model
• Team-based with community involvement, patient registries, and decision support tools
Strategies for Improving Care

Diabetes Care Concepts

Three key themes are woven throughout the Standards of Care in Diabetes:

1. Patient-centeredness
2. Diabetes across the lifespan
3. Advocacy for patients with diabetes
Strategies for Improving Care Delivery Systems

- 33-49% of diabetes patients still do not meet targets for A1c, blood pressure, or lipids.
- 86% do not meet the targets for all A1c, BP, lipids, and nonsmoking status.
- Progress in ASCVD control is slowing.
- Substantial system-level improvements are needed.
- Delivery system is fragmented, lacks clinical information capabilities, duplicates services & is poorly designed.
Knowledge Check

• How many patients with diabetes do NOT meet targets for A1c, BP or lipids?
  a. 14-20%
  b. 33-49%
  c. 62-78%
  d. None of the above
How many patients with diabetes do NOT meet targets for A1c, BP or lipids?

- 14-20%: 0.5%
- 33-49%: 83.2%
- 62-78%: 9.8%
- None of the above: 6.5%
Care Delivery Systems

*Chronic Care Model*

**Six Components:**

1. Delivery system design
2. Self-management support
3. Decision support
4. Clinical information systems
5. Community resources & policies
6. Health systems

www.betterdiabetescare.nih.gov
Strategies for Improving Care
Care Delivery Systems

Support Patient Behavior Change

• Implement a systematic approach to support patient behavior change efforts, including:
  
  – Healthy lifestyle: physical activity, healthy eating, tobacco cessation, weight management, effective coping
  
  – Disease self-management: taking and managing medication, self-monitoring of glucose and blood pressure when clinically appropriate
  
  – Prevention of diabetes complications: self-monitoring of foot health, active participation in screening for eye, foot, and renal complications, and immunizations

- American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), and the Academy of Nutrition and Dietetics
- DSME/S improves A1c by as much as 1 percentage point in people with T2DM

Diabetes Care July 2015 vol. 39 no. 7 1372-1383
Care Delivery Systems

**Chronic Care Model (CCM)**

CCM is an effective framework for improving the quality of care and facilitating patients’ self-management.

The National Diabetes Education Program (NDEP) maintains an online resource to help health care professionals design and implement more effective health care delivery systems for those with diabetes.

[www.betterdiabetescare.nih.gov](http://www.betterdiabetescare.nih.gov)
A Case Study in Coordinated Care
Identify the roles that CHWs/Promotores can play using the chronic care model (CCM):

• Ms. Arias is a 60-year old grandmother with a 12-year history of type 2 diabetes, which is complicated by elevated blood pressure and being overweight. Ms. Arias has a BMI of 36 and has struggled with weight control since young adulthood.

• At a follow-up visit, she had an HbA1c of 8.9 percent, and a blood pressure of 148/88. She has missed her medical appointments for the last year. Also, she made an appointment today complaining that she has not been feeling good for the last three weeks.

• The nurse checks her blood sugar and her result was 450 mg/dl. Ms. Arias tells the nurse that she lives alone and that is having issues getting food, cooking and picking up her medications. She admitted that she has been missing her insulin shots in the last four days. A neighbor took her to the appointment today.

• Ms. Arias’ doctor recommended that she should not leave the office without making an appointment to be seen in one week. The receptionist/referral coordinator worked with Ms. Arias to set up an appointment next week.
When treatment goals are not met - NEW

- Patient adherence should be addressed.
- Barriers may include:
  - Patient factors (e.g., remembering to obtain or take medications, fears, depression, and health beliefs),
  - Medication factors (e.g., complexity, multiple daily dosing, cost, and side effects), and
  - System factors (e.g., inadequate follow-up and support)
- Simplifying a complex treatment regimen may improve adherence.
Tailoring Treatment to Vulnerable Populations

Health Disparities - NEW

- Lack of health insurance
- Food insecurity (FI)
  - Carefully evaluate hyperglycemia and hypoglycemia and propose solutions. A
  - Recognize that homelessness, poor literacy, and poor numeracy often occur with food insecurity; appropriate resources should be made available for patients with diabetes. A
Health Disparities

Community Health Workers (CHW):

• Diabetes management requires individualized, patient-centered, and culturally appropriate strategies.
  – To overcome disparities, community health workers, peers, and lay leaders may assist in the delivery of DSME and diabetes self-management support services

• There is growing evidence for the role of community health workers, as well as peer and lay leaders, in providing ongoing support.
A Case Study in Coordinated Care – Cont’d

DSME/S referral should be triggered as Ms. Arias has new complicating factors that have arisen that influence self-management. She has food insecurity and transportation issues.

Possible solutions for CHW/Promotores are to assist with a plan to help her get consistent and adequate nutrition, help her understand how to match insulin to food intake, and help her arrange for transportation to future MD appointments.
www.betterdiabetescare.nih.gov
Knowledge Check

- Diabetes management requires individualized, patient-centered, and culturally appropriate strategies. To overcome disparities, who may assist in the delivery of DSME and diabetes self-management support services?
  a. Lay Leaders
  b. Parole officers
  c. Community health workers
  d. A and C
Diabetes mgmt. requires individualized, patient-centered, and culturally appropriate strategies. To overcome disparities, who may support?

- a. Lay leaders 0.6%
- b. Parole officers
- c. CHWs/Promotores 13.7%
- d. A and C 85.7%
2016 American Diabetes Association's Standards of Medical Care in Diabetes

S2: CLASSIFICATION AND DIAGNOSIS OF DIABETES
Classification and Diagnosis Criteria for the Diagnosis of Diabetes

Fasting plasma glucose (FPG) ≥126 mg/dL (7.0 mmol/L)

OR

2-h plasma glucose ≥200 mg/dL (11.1 mmol/L) during an OGTT

OR

A1c ≥6.5%

OR

Random plasma glucose ≥200 mg/dL (11.1 mmol/L)
Classification and Diagnosis of Diabetes Testing - *NEW*

- To clarify the relationship between age, BMI, and risk for type 2 diabetes and prediabetes, the ADA revised the screening recommendations. The recommendation is now to test all adults beginning at age 45 years, regardless of weight.

- Testing is also recommended for asymptomatic adults of *any age* who are overweight or obese and who have one or more additional risk factors for diabetes.
Classification and Diagnosis Screening for Type 2 Diabetes

• Consider testing in asymptomatic adults of any age with BMI $\geq 25$ kg/m$^2$ or $\geq 23$ kg/m$^2$ in Asian Americans who have 1 or more add’l dm risk factors. B

• For all patients, testing should begin at age 45 years. B

• If tests are normal, repeat testing carried out at a minimum of 3-year intervals is reasonable. C
Classification and Diagnosis Screening for Type 2 Diabetes (Cont’d)

- FPG, 2-h PG after 75-g OGTT, and the A1c are equally appropriate. B
- In patients with diabetes, identify and, if appropriate, treat other ASCVD risk factors. B
- Consider testing for T2DM in overweight/obese children and adolescents with 2 or more add’l diabetes risk factors. E
Classification and Diagnosis Screening for Type 2 Diabetes in Children and Adolescents

Overweight plus any two:
  – Family history of type 2 diabetes in 1st or 2nd degree relative
  – Race/ethnicity
  – Signs of insulin resistance or conditions associated with insulin resistance
  – Maternal history of diabetes or GDM

• Age of initiation 10 years or at onset of puberty
• Frequency: Every 3 years
• Screen with A1c
2016 American Diabetes Association's Standards of Medical Care in Diabetes

S3: FOUNDATIONS OF CARE
S3: Foundations of Care

1. Self Management Education
2. Nutrition
3. Counseling
4. Physical Activity
5. Smoking Cessation
6. Immunizations
7. Psychosocial Care
8. Medications
Foundations of Care and Comprehensive Medical Evaluation

DSME/S is a cornerstone of diabetes management:

• Basis for initial care
• Part of ongoing care management
Foundations of Care and Comprehensive Medical Evaluation

DSME/S algorithm defines four critical time points for DSME/S delivery. These include:

1. at diagnosis;
2. annually for assessment of education, nutrition, and emotional needs;
3. when new complicating factors arise that influence self-management; and
4. when transitions in care occur.
Knowledge Check

• The DSME/S algorithm defines critical time points for DSME/S delivery. These include:
  a. At diagnosis
  b. Annually for assessment of education, nutrition, and emotional needs
  c. When new complicating factors arise that influence self-management
  d. When transitions in care occur
  e. All of the above
The DSME/S algorithm defines critical time points for DSME/S delivery. These include:

- At diagnosis (0.8%)
- Annually: Education/Nutrition/Needs
- When new complicating factors arise
- When transitions in care occur
- All of the above (99.2%)
S5: GLYCEMIC TARGETS
Glycemic Recommendations for Nonpregnant Adults with Diabetes

A1c ≤7.0%* (<53 mmol/mol)

Preprandial capillary plasma glucose 80–130 mg/dL* (4.4–7.2 mmol/L)

Peak postprandial capillary plasma glucose† <180 mg/dL* (<10.0 mmol/L)

* Goals should be individualized.
† Postprandial glucose measurements should be made 1-2 hours after the beginning of the meal.
Patient/Disease Features

Risks associated with hypoglycemia & other drug adverse effects

Disease Duration

Life expectancy

Important comorbidities

Established vascular complications

Patient attitude & expected treatment efforts

Resources & support system

A1c 7%

more stringent

less stringent

Potential modifier

Usually not modifier

- Highly motivated, adherent, excellent self-care capabilities
- Less motivated, nonadherent, poor self-care capabilities
- Readily available
- Limited

- Low
- High
- Newly diagnosed
- Long-standing
- Long
- Short
- Absent
- Few/mild
- Severe
Knowledge Check

• More stringent glycemic goals may be appropriate for individual patients. Which factor(s) support more stringent A1c goals?
  a. Long-standing diabetes duration
  b. Highly motivated, adherent patient with good support system
  c. High risk of hypoglycemia and other drug adverse effects
  d. None of the above
Which factor(s) support more stringent A1c goals?

- Long-standing diabetes duration: 24.6%
- Adherent patient/support system: 59.1%
- Greater risk of hypoglycemia/drug effects: 16.3%
- None of the above: 8.4%
Glycemic Targets
Glycemic Goals for Non-Pregnant Adults

• Lowering A1c to <7% has been shown to reduce microvascular complications and, if implemented soon after the diagnosis of diabetes, is associated with long-term reduction in macrovascular disease. B

• Consider more stringent goals (e.g. <6.5%) for select patients if achievable without significant hypoglycemia or other adverse effects. C

• Consider less stringent goals (e.g. <8%) for patients with a hx of severe hypoglycemia, limited life expectancy, or other conditions that make <7% difficult to attain. B
Glycemic Targets
A1c and ACVD Outcomes

- Diabetes Control and Complications Trial (DCCT): Lower risk of ASCVD events with intensive control
- Epidemiology of Diabetes Interventions and Complications (EDIC): 57% reduction in risk of nonfatal MI, stroke, or ASCVD death
- Benefit of intensive glycemic control persists for decades and is associated with a modest reduction in all-cause mortality.
- ACCORD, ADVANCE, VADT suggested no significant reduction in ASCVD outcomes with intensive glycemic control.

Care.DiabetesJournals.org
Glycemic Targets
Older Adults - NEW

• Because of the growing number of older adults with insulin-dependent diabetes, the ADA added the recommendation that people who use continuous glucose monitoring and insulin pumps should have continued access after they turn 65 years of age.
A Case Study in Coordinated Care
A Case Study in Coordinated Care – Cont’d

• Ms. Arias returns, using a transportation voucher arranged by a CHW, to her one week follow up.
• She reports feeling better and is relieved that her CHW is willing to help her coordinate transportation through her social network to future medical visits.
• She has restarted her insulin and the fingerstick BG before lunch is 175 mg/dl. She questions the need for some of her medications. She feels she is having to make a choice between taking her medications and buying food.
• During her medical appointment, Ms. Arias is offered the option to receive a discount for a home-delivery meal program.
• What are some possible next steps for the CHW?
S6 OBESITY MANAGEMENT FOR THE TREATMENT OF T2DM
S6 Obesity Management for the Treatment of T2DM - NEW

- This new section, which incorporates prior recommendations related to bariatric surgery, has new recommendations related to the comprehensive assessment of weight in diabetes and to the treatment of overweight/obesity with behavior modification and pharmacotherapy.
Obesity Management for the Treatment of T2DM - *Benefits of Weight Loss*

- Delay progression from prediabetes to type 2 diabetes
- Positive impact on treatment of type 2 diabetes
  - Most likely to occur early in disease development
- Improves mobility, physical and sexual functioning & health-related quality of life
Physical Activity Recommendations

- Children with diabetes/prediabetes: at least 60 min/day physical activity B
- Adults with diabetes: at least 150 min/wk of moderate-intensity aerobic activity over at least 3 days/week with no more than 2 consecutive days without exercise A
- All individuals, including those with diabetes, should limit sedentary time, particularly by breaking up extended amounts of time (>90 min) spent sitting. B
- Adults with type 2 diabetes should perform resistance training at least twice weekly A
S7 APPROACHES TO GLYCEMIC TREATMENT
## American Diabetes Association Standards of Medical Care in Diabetes

### Introduction

*Diabetes Care* 2016; 39 (Suppl. 1): S1 – S2

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### Anti-hyperglycemic Therapy

#### Type 2 Diabetes

<table>
<thead>
<tr>
<th>Monotherapy</th>
<th>Dual therapy</th>
<th>Triple therapy</th>
<th>Combination injectable therapy</th>
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</thead>
<tbody>
<tr>
<td>Efficacy</td>
<td>Efficacy</td>
<td>Efficacy</td>
<td>Efficacy</td>
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<tr>
<td>Hypo risk</td>
<td>Hypo risk</td>
<td>Hypo risk</td>
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<tr>
<td>Weight</td>
<td>Weight</td>
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<td>Side effects</td>
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<td>Side effects</td>
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<tr>
<td>Costs</td>
<td>Costs</td>
<td>Costs</td>
<td>Costs</td>
</tr>
</tbody>
</table>

#### Metformin

- High efficacy
- Low risk
- Neutral to low GI
- Low lactic acidosis
- Low costs

**If A1C target not achieved after ~3 months of monotherapy, proceed to 2-drug combination (order not meant to denote any specific preference—choice dependent on a variety of patient- and disease-specific factors):**

1. **Metformin** + Sulfonylurea
   - Efficacy: high
   - Hypo risk: moderate risk
   - Weight: gain
   - Side effects: hypoglycemia
   - Costs: low

2. **Metformin** + Thiazolidinedione
   - Efficacy: high
   - Hypo risk: low risk
   - Weight: gain
   - Side effects: edema, HF, fxS
   - Costs: low

3. **Metformin** + DPP-4 Inhibitor
   - Efficacy: intermediate
   - Hypo risk: low risk
   - Weight: neutral
   - Side effects: rare
   - Costs: high

4. **Metformin** + SGLT2 Inhibitor
   - Efficacy: intermediate
   - Hypo risk: low risk
   - Weight: loss
   - Side effects: GI, dehydration
   - Costs: high

5. **Metformin** + GLP-1 receptor agonist
   - Efficacy: high
   - Hypo risk: high risk
   - Weight: gain
   - Side effects: hypoglycemia
   - Costs: variable

**If A1C target not achieved after ~3 months of dual therapy, proceed to 3-drug combination (order not meant to denote any specific preference—choice dependent on a variety of patient- and disease-specific factors):**

1. **Metformin** + Sulfonylurea + DPP-4-i
   - Efficacy: high
   - Hypo risk: moderate risk
   - Weight: gain
   - Side effects: hypoglycemia
   - Costs: low

2. **Metformin** + Sulfonylurea + TZD
   - Efficacy: high
   - Hypo risk: moderate risk
   - Weight: gain
   - Side effects: hypoglycemia
   - Costs: low

3. **Metformin** + SGLT2-i + GLP-1-RA
   - Efficacy: intermediate
   - Hypo risk: low risk
   - Weight: loss
   - Side effects: GI
   - Costs: high

4. **Metformin** + DPP-4-i + Insulin
   - Efficacy: high
   - Hypo risk: high risk
   - Weight: gain
   - Side effects: hypoglycemia
   - Costs: variable

**If A1C target not achieved after ~3 months of triple therapy and patient (1) on oral combination, move to injectables; (2) on GLP-1-RA, add basal insulin; or (3) on optimally titrated basal insulin, add GLP-1-RA or mealtime insulin. In refractory patients consider adding TZD or SGLT2-i:**

<table>
<thead>
<tr>
<th>Basal insulin + Mealtime insulin or GLP-1-RA</th>
</tr>
</thead>
</table>
Approach To Starting & Adjusting Insulin in T2DM
2016 American Diabetes Association's Standards of Medical Care in Diabetes

S8 CARDIOVASCULAR DISEASE AND RISK MANAGEMENT
S8 Cardiovascular Disease and Risk Management

• “Atherosclerotic cardiovascular disease” (ASCVD) has replaced the former term “cardiovascular disease” (CVD), as ASCVD is a more specific term. - New
2016 American Diabetes Association's Standards of Medical Care in Diabetes

S9 MICROVASCULAR COMPLICATIONS AND FOOT CARE
S9 Microvascular Complications and Foot Care

• “Nephropathy” was changed to “diabetic kidney disease” to emphasize that, while nephropathy may stem from a variety of causes, attention is placed on kidney disease that is directly related to diabetes. - NEW
Recommendations: Diabetic Kidney Disease

Treatment

• Optimize glucose control to reduce risk or slow progression of diabetic kidney disease. A

• Optimize blood pressure control (<140/90 mmHg) to reduce risk or slow progression of diabetic kidney disease. A
2016 American Diabetes Association's Standards of Medical Care in Diabetes

S14 DIABETES ADVOCACY
Advocacy Position Statements

• ADA publishes evidence-based, peer-reviewed statements on topics including:
  – Diabetes and employment
  – Diabetes and driving
  – Diabetes management in schools, child care programs, and correctional institutions.

• These are important tools for educating:
  – Schools
  – Employers
  – Licensing agencies
  – Policy makers

• Professional.diabetes.org/SOC
Summary

• The ADA Standards of Care are an important resource for those who care for people with diabetes.
• Revisions have been made to this annual publication, which include terminology and clinical recommendations.
• Diabetes self-management education and support are integral to the execution of these recommendations.
• Health care professionals and community health workers (CHWs)/promotores should empower people with diabetes, or those at risk, to receive the care they need.
Q&A
Visit CDC NDEP’s New Website
http://www.cdc.gov/diabetes/ndep
Learn more from the National Diabetes Education Program

National Diabetes Education Program
Call 1-800-CDC-INFO (800-232-4636)
TTY 1-(888)-232-6348 or visit www.cdc.gov/info
To order resources, visit https://nccd.cdc.gov/DDT_DPR/

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