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BR: BETSY RODRIGUEZ
CM: CATHERINE MAXWELL

BR: Welcome, everyone, to today's webinar, "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." Today's webinar is hosted by the National Diabetes Education Hispanic/Latino Stakeholder Group. But we are very happy that so many NDEP partners and community health workers join us in today's webinar. We have over 500 registrations, which shows the tremendous interest in this year's standards of medical care.

My name is Betsy Rodríguez. I am the Deputy Director of the National Diabetes Education Program at the Division of Diabetes Translation at the Centers for Disease Control and Prevention. And today, I will serve as your moderator. We are very excited to launch this webinar series in 2016 with this great topic, which promises to be very interesting as this year we're seeing more changes than ever to the diabetes standards of care.

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We are thrilled to have with us Ms. Catherine Maxwell, a pharmacist and a certified diabetes educator, who is part of the Diabetes Field Medical Team at Sanofi Aventis here in Georgia. Catherine received her bachelor's degree in chemistry for Salem College, her primary degree from the University of North Carolina in Chapel Hill, and completed an ambulatory care residency at UNC Health Care. She earned her CDE credentials in 2004 while working at the Grady Health Care System in the Diabetes and Internal Medicine Clinics in Atlanta, Georgia. Catherine is currently a member of the American Diabetes Association, the American Association of Diabetes Educators, and the Atlanta Local Networking Group. She has served as the chair for these groups since 2006.

In her personal life, Catherine enjoys spending quality time with her family, including her husband, daughter, and son, and chocolate Lab in Peachtree Corners, Georgia. She serves on the local elementary PTA board, teaches faith formation classes at her church, and volunteers for various community and

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faith-based activities. And we're so happy to have Catherine with us today as our main speaker. So, Catherine, welcome, and thank you very much for joining us today.

After Catherine's presentation, you will have the opportunity to ask questions, so please submit them using the chat box in the lower box of your screen during the webinar. Today's event will offer continuing education credits and handouts will be provided once we close this webinar with specific instructions on how to obtain CEUs.

So without any further ado, Catherine, please take it away.

CM: Thank you so much, Betsy. It is an honor to be your presenter today. So, welcome.

So since 1989, the American Diabetes Association has provided a Standards of Care supplement based on evidence. This standard of care information is the basis of my presentation today, and I'm going to

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highlight particular sections that are pertinent to the role of community health workers and the like. So on this slide, you'll see a screenshot from the ADA website with an image of the supplement cover from the 2016 publication, along with, in very small print, URL links. This is a screenshot just to give you a flavor of the host of additional resources that you can access free of charge by going to the professional.diabetes.org website.

This slide gives the section layout of the 2016 standards that are published every January. Within their standards of care supplement, there are 14 sections, S1 through S14. And they contain over 235 recommendations. Now I'm not going to cover this material in its entirety this afternoon, but if you have a particular interest in one of these sections that I either don't cover or don't comprehensively cover, I suggest you visit the website for the most comprehensive information.

As we proceed through this presentation, you will see grades next to some of the recommendations. These

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grades are A, B, C, and E. And I won't call them out each time. They're there for your reference.

Basically, over the years that this publication has been in circulation, there's been an increase in the number of recommendations, but also the quality based on evidence. This year in 2016, over half of the recommendations in the Standards of Care received an A grade, which is the highest level. And as you can see, it's based on clear evidence from randomized controlled trials, for example. The lower levels of evidence are minimized, such as C and E.

Most of us on the phone, myself included, are trying to fill unmet educational needs for the diabetes community. And with diabetes being a disease at epidemic proportions, most people with type 2 diabetes in particular see primary care providers to manage their disease. Primary care providers and their staff usually have more of the need to refer to these types of standards and specialists, like endocrinologists and certified diabetes educators. So the ADA has made a concerted effort over the last 5 to 10 years to make diabetes management information

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more streamlined and user-friendly for primary care providers. This slide is simply highlighting for you that there isn't a grid version of the Standards of Care that exists that goes along and is taken from the full supplement.

The abridged version is only 21 pages long, as opposed to the 111 pages of the full supplement. So I think it's one of the best pieces. It's a must-read, and it highlights a lot of the key figures and tables.

This is our first question, or what we'll call a knowledge check. Basically, what I've just presented. So please participate if you can. In 2016, ADA published its *Annual Complete Standards of Medical Care* and a *Standards of Care* abridged for primary care providers. They are both based on—and then the answers follow—either the chronic care model. And now it looks like most people are selecting the correct answer, which is based on strength of evidence and a grading system.

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So, again, these standards of care undergo a strict process that controls for conflicts of interest. And it's without influence from industry. It may seem obvious that with an annual publication that there are revisions every year, and there are. So these revisions that are included in the Standards of Care are based on changes and additions within the literature from January 1st of the previous year. Within the Standards of Care, there's a two-page summary of the revisions that are broken out by the separate sections. I'm going to cover some of the revisions with you today during this webinar that I felt were most pertinent.

This change is definitely worth highlighting. This is a general change, and it's not related to any one section. The [American Diabetes] Association made one point of clarification this year, which they hope clinicians, advocates, journalists, and the general public alike will adopt. So in a line that was their longstanding policy, the Standards of Care will no longer use the term "diabetic" to refer to patients with diabetes. Those with diabetes are individuals

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with diabetes, not "diabetics." And ADA will continue to use the term "diabetic" only as an adjective for complications related to diabetes. For example, diabetic retinopathy.

Moving into the sections now, I'll cover materials within Strategies for Improving Care or Section 1. Within this first section, I'll review key recommendations, diabetes care concepts, care delivery systems with three key objectives, and then two new revisions to this section, including what to do when treatment goals are not met and tailoring treatment to vulnerable populations. And this is where we'll meet Ms. Arias.

So within strategies for improving care, the key recommendations are intended to cover really all sections of the entire supplement of standards. First and foremost, throughout, you'll hear a common theme that we use a patient-centered, communications style approach. This incorporates patient preferences, assesses literacy and numeracy, and addresses cultural barriers to care.

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Next, treatment decisions should be timely and based on evidence-based guidelines that are tailored to patient preferences. And third, care should be aligned with the components of the chronic care model to insure productive interactions between a proactive prepared team and an informed activated patient.

And then, lastly, feasible care systems should support team-based care, community involvement—and that means you, community health workers—along with patient registries and decision-support tools to meet patient needs.

Moving along within diabetes care concept sections, these three key themes are woven throughout the standards of care. Again, patient-centeredness, a one-sized approach does not fit all. And these standards provide guidance for when and how to adapt recommendations to individualized plans, which you can be a part of making with your patients.

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Second, diabetes across the lifespan, meaning as our patients pass through different life stages, such as from pediatric to adult, how can we improve coordination of their care between the clinical teams?

And, finally, advocacy for patients with diabetes. This could be many things. But here, we know that obesity, physical inactivity, and smoking have a tremendous adverse toll on the health of our patients. And efforts by us are needed to address and change these societal determinants at the root of these problems.

Over the last 10 years, we've seen steady improvements in the proportion of patients with diabetes who are treated with lipid-lowering statins and those who are achieving recommended levels of A1C, blood pressure, and LDL. But nevertheless, one-third to one-half, 33 to 49 percent of patients, still do not meet targets for glycemic control, blood pressure control, or cholesterol control. And only 14

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[percent] meet targets for all three measures, including nonsmoking status.

Now, we also know that progression to atherosclerotic cardiovascular disease or ASCVD control is slowing. This is good news. But we still have a lot of room for improvement in all areas. And even after adjusting for patient factors, the persistent variation in quality of diabetes care across providers' practice settings indicate that there's a potential for system level improvements, and we all know this because we've been patients in our own health care system whether it be for diabetes or something else. A major barrier to optimal care is a delivery system that is often fragmented. It lacks clinical information capabilities. It's duplicative and poorly designed for coordinating product care delivery.

Now to our second question. How many patients with diabetes do not meet targets for A1C, blood pressure, or lipids? Great, all of you have been listening. So far, so good. We all know that this is a place where

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we can help as part of the community health care team. Understanding these standards will help us even more.

As I mentioned a few minutes ago, the chronic care model has been shown to be an effective framework for improving quality of diabetes care. And taking a team approach is important for a complex chronic disease like diabetes. The chronic care model includes six core elements for providing optimal care to patients with chronic disease. The first component is the delivery system design. And we definitely want to move from a reactive acute care model to a proactive preventative care system where planned visits are coordinated through team-based approach.

Secondly, a person with diabetes has to live with it all the time. And they really have to become their own primary care provider in the sense that they're self-managing their disease. So self-management and support is a key part of the chronic care model.

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Number three, decision support, basing care on evidence and effective care guidelines, which this statement is.

Number four, clinical information systems using registries that can help us with population-based information and support.

Number five, community resources and policies.

Number six, health systems that create a quality-oriented culture.

Now the National Diabetes Education Program, of which you are all part here today, has a wonderful website that's been put together with gobs of resources that specifically call out how to be proactive in the community support and using that as a key to success.

Within these strategies, what are the objectives in helping health care professionals design and implement more effective delivery systems for

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patients with diabetes is supporting patient behavior change.

These strategies are in direct harmony for those of you who might be familiar with the AADE7 self-care behaviors. So the first one includes healthy lifestyle. That means being physically active, eating healthy, quitting smoking, managing weight, and coping effectively. For disease state self-management, it's usually related to taking and managing medications, self-monitoring blood sugar and blood pressure. And then, thirdly, prevention of diabetes complications. This could also include self-monitoring of foot health, eye screenings, screening for renal complications, and obtaining immunizations appropriately.

I believe that Betsy held a webinar last September on the 2015 Joint Position Statement that was released by not only the ADA but in partnership with the American Association of Diabetes Educators and the Academy of Nutrition and Dietetics. As a nation of community health care providers, we're taking a

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holistic team approach to patient care and a need for comprehensive patient education and ongoing self-management support. But if you know that, based on this position statement and information at sight that patients engaged in ongoing diabetes self-management education, and support can improve their A1Cs by up to as much as one percentage point in people with type 2 diabetes. That's impressive, and not everyone knows that. And I think it's our job to help be our own advocate for what we know we can help patients obtain more effectively. A one percentage point drop in A1C is more than most medications can do.

So below this bullet point is a link to the Joint Positions Statement, which I think marries the standard of care very nicely. In this Section 1, I'm going to summarize for you care delivery systems in saying that the chronic care model is an effective framework for improving quality of care. And, again, the National Diabetes Education Program maintains online resources to help us design and implement more effective health care systems using a team-based approach for those with diabetes.

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Now, I want to introduce you to Ms. Arias. I will give you some details about this simulated case on the next slide. Please use the chat box to give your thoughts and strategies on how a community health worker could help her achieve treatment and behavioral goals more successfully.

Ms. Arias is a 60-year-old grandmother with a 12-year history of type 2 diabetes, complicated by high blood pressure and being overweight. She has a BMI of 36 and has struggled with weight control since young adulthood. At a follow-up visit, she had an A1C of 8.9 percent and a blood pressure of 148 over 88. She's missed her medical appointments for the last year. Also, she's made an appointment today complaining that she's not been feeling good for the last 3 weeks. The nurse checks her blood sugar, and it's 450 milligrams per deciliter. Ms. Arias tells the nurse that she lives alone and that she's having issues getting food, cooking, and picking up her medications. She admitted that she's been missing her insulin shots the last 4 days. A neighbor took her to

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the appointment today. Ms. Arias' doctor recommended that she should not leave the office without making an appointment to be seen in 1 week. The receptionist worked with Ms. Arias to set up an appointment next week.

Now, go ahead and let me give you a chance to prioritize. What might be the first thing you would coordinate with Ms. Arias as a designated community health worker for her? A lot of her problems, including longstanding type 2 diabetes, having a high A1C, and these psychosocial issues are all too common. And I'm sure that you had experienced working with people like her. So I see helping get medications, can neighbors assist? Proper transportation. Transportation assistance. What is her health insurance status? Wonderful. So it looks like you know there's many points where you could start. And in all cases, I think, help her improve the care that she's currently receiving.

The next couple of slides sort of pertains to what we're talking about here with Ms. Arias. So this is a

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new section actually about when treatment goals are not met. And this is from Section 1. So when treatment goals are not met, patient adherence to medications should be addressed as a first priority. We can help her explore the barriers to medication adherence, such as remembering to obtain or take medication, such as her fears, possible depression that often occurs as people age with chronic diseases. And her own health beliefs about the medications that she's been prescribed.

Also, medication factors, such as the complexity of her insulin regimen, multiple daily dosing, the cost, which I know you all are tuned into, and possible side effects that she may be/have experienced. System factors, such as inadequate follow-up and support. And it's our job to take this information and help simplify complex treatment regimens [that] can help patients improve their adherence to the prescriptions.

Another addition—that is I felt timely to this case—another addition to the standards of care this year

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is tailoring treatments to vulnerable populations, and it's included under health disparities. So the American Association—or the ADA calls out two key areas that affect diabetes care. First, lack of health insurance. And while the Affordable Care Act has improved access to health care, many remain without coverage. We don't know with Ms. Arias what her status is. Secondly, food and security. This is the unreliable availability of nutritious food and the inability to consistently obtain food. And about one in every seven people in the U.S. is food insecure.

ADA offers two key recommendations for dealing with food insecurity. First, we should evaluate both high and low blood sugars in the context of food insecurity. And, second, recognize that homelessness, poor literacy, and poor numeracy often occur with food insecurity. And appropriate resources can and should be made available for these patients in particular with diabetes and food insecurity, which we know Ms. Arias suffers.

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In this section on vulnerable populations, community health workers are specifically called out. Here's what they say about it. 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 diabetes self-management education and support services. And there's also growing evidence for the role of community health workers in providing ongoing support. This is encouraging.

So what happened with Ms. Arias? Well, I think that you guys have been chatting back and forth while I've been reviewing some of the slide information. But this is what I had to say about it. A referral should be triggered for diabetes self-management education and support for Ms. Arias because she has new complicating factors that have arisen and they influence her self-management, such as transportation issues and food insecurity. Ms. Arias should work with a community health worker to get assistance with transportation, also help her understand the

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importance of adequate nutrition while on insulin in particular, help her get information on how eating affects her insulin and vice versa, and help her arrange transportation to future scheduled MD appointments and not waiting until the worst case scenario to go to the doctor.

Is there anything else that, Betsy, you'd like to add from the chat information?

BR: Well, I have been receiving tons of great comments like, for instance, everybody's looking to provide to Ms. Arias coordinated transportation, looking on how to coordinate home visit care for her, talking about shopping for food and meds, looking for community linkages that will help her with food insecurity. There is one here that says, "Can a neighbor assist her with part of the care?" And, as you can see, these are not just traditional clinical responses, rather looking to solutions to the social determinants of health that Ms. Arias is facing. So it is amazing to see that most of the comments that we're getting, it's by trying to help Ms. Arias to be

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social determinant of health. For instance, Vicky Carnes, says, "Oh, we need to assess Ms. Arias' health insurance status." Joyce wants a system to get meds and insulin daily. Donna is saying, "Does she have funds to pay for insulin? Medication help? Transportation?"

So it's all about the social determinants of health, which is what's really I am liking a lot about the comments. There is another one here, Sheila says, "Assistance with insulin. Assistance with food and cooking. Access to medications, food, and transportation." Oh, Sammy says, "Social workers to assist with financial resources."

CM: Very nice.

BR: Yes.

CM: And like you said, these are not the types of things that may come up in her clinical plans, but her social plans, her community plans can include and should include and be assessed. And that's what we're

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talking about with the chronic care model and the team-based approach using community support solutions.

BR: Mary is saying, "Establish why she isn't taking her insulin. If it's cost, if it's needing education." Carol says, "I would assist with food planning and preparation."

CM: Very good. Sounds like you have a lot of people who know what they're talking about.

BR: Yes, indeed. And some people have been asking me the website that you just mentioned. And that one is www.betterdiabetescare.nih.gov.

CM: Right, let me try to get back to that. This is the NDEP website that Betsy just described on this post-it note. Betterdiabetescare.nih.gov. Chock full of resources and references.

I'm going to skip to another knowledge check. We're going to take a minute to weigh in on what we've just

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learned. So diabetes management requires individualized, patient-centered, and culturally appropriate strategies. To overcome disparities, who may assist in the delivery of DSME and support services? Very nice. The majority of you have selected A and C, which is lay leaders and community health workers (promotores). Parole officers was not included in the standards of care recommendations.

Okay, now into Section 2, which is called Classification and Diagnosis of Diabetes. Throughout this section, I'm placing an emphasis on type 2 diabetes. We won't spend time on really classification, but we will spend time on some diagnostic criteria. Here, we have four different ways or tests used to screen for and diagnose diabetes and detect people with prediabetes actually. So these include fasting plasma glucose of greater than 126 milligrams per deciliter, or you could use a 2-hour plasma glucose of greater than 200 milligrams per deciliter during an oral glucose tolerance test or OGTT or using the A1C test if it's greater than or equal to 6.5, it meets the criteria. Or in a patient

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with classic symptoms, having a random plasma glucose of greater than or equal to 200 milligrams per deciliter. In the absence of symptoms, the result of the first three tests should be confirmed by repeat testing.

Something new to the Classification and Diagnosis section for diabetes is to clarify the relationship about when to test adults. What age? So to clarify the relationship between age, BMI, and risk for type 2 diabetes and prediabetes, the ADA revised the recommendations for screening, which is now to test all adults beginning at age 45 regardless of weight—that's the change. Testing is also recommended for asymptomatic adults of any age who are overweight or obese and have one or more additional risk factors for diabetes, such as family history, inactivity, race, such as Hispanic/Latino, African American, Native American, and Asian American. And then having had gestational diabetes in women.

So this is the way to screen for type 2 diabetes. And type 2 accounts for the majority of all diabetes,

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which is 90 to 95 percent, characterized by insulin resistance and relative insulin deficiency.

So this slide kind of helps to restate the previous slide and give you some specific parameters about body mass index or BMI for both non-Asian and Asian-Americans who have one or more additional risk factor. Again, for all patients, testing should begin at age 45 years regardless of weight. And if tests are normal, repeat testing should be carried out at a minimum of 3-year intervals.

For this classification and diagnosis continuation slide, the top bullet we've already covered. But the second bullet addresses atherosclerotic cardiovascular disease, which is a common co-diagnosis along with people who have diabetes. So it says in patients with diabetes, we should identify and if appropriate treat other ASCVD risk factors, such as being obese or overweight.

And then, unfortunately, more and more children and adolescents are living life overweight. And the

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diagnosis of type 2 diabetes is emerging in tandem with this at an alarming rate. So we should consider testing for type 2 diabetes in overweight obese children and adolescents with two or more additional diabetes risk factors.

Here are some more specifics on screening for type 2 diabetes in children and adolescents. So these are the lists of risk factors that go along with being overweight that would warrant a screening for type 2 diabetes. Again, having a family history, race or ethnicity, signs of insulin resistance, maternal history of diabetes or gestational diabetes. Age of initiation of screening is 10 years or at the onset of puberty and the same frequency of every 3 years. Screening can be done with an A1C test.

That concludes the Screening and Diagnosis section of our presentation today. And now I'm going to move into the third section of the Standards of Care called Foundations of Care. This section has been now combined with a section that was previously separated

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out, but now are both within this section in the 2016 version.

The Foundations of Care include eight key components. We've seen some of these components and discussed them within our case and throughout other sections, but here we have listed self-management education, nutrition, counseling, physical activity, smoking cessation, immunizations, psychosocial care, and medications. All are important, and we won't discuss all of these in depth today. But I do know that psychosocial care for people with diabetes is certainly something that we could help with as community health workers.

As I said before, people with diabetes, this is a 24/7, 365-day a year problem. We have no cure, and it can lead—chronic diseases such as diabetes can lead to anxiety and depression and eating disorders. These things need to be assessed. And psychosocial care, I think, is one of the most important things and aspects that we can help uncover as sort of

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detectives and advocates for our patient society needs.

Of course, Foundations of Care for Diabetes Self-Management, Education, and Support is a cornerstone of the management and the basis for initial care, and should be part of ongoing care management. All people with diabetes should participate and receive DSME and support in order for behavior change recommendations to be effective. Again, it should be patient-centered and individualized, but also respectful and responsive to individual patients' preferences, needs, and values.

These four points are the critical time points at which time DSME support should be delivered. So this is important and not always done. We feel that this is a service that's underutilized and also not covered well. But, if at all possible, BSME should be offered at diagnosis; also annually for assessments of education, nutrition, and emotional needs; when new complicating factors arrive that influence self-management; and when transitions in care occur. So

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what I feel is that what we need to learn and what habits we need to overcome have to be reinforced regularly. So these are all times at which concepts can be reviewed, reinforced, supported, and repeated continually, so that what we need to know and understand can be learned and retained and acted upon when the patient is at the right place to do so.

This is a knowledge check about what we just discussed and it says the DSME, or Diabetes Self-Management Education and Support algorithm defines critical time points for its delivery. These include, and it looks like everyone is selecting "all of the above," which is what we just discussed. A lot more detailed information on what to do at each of these four critical time points is also available by the ADA. And there's a nice checklist that I haven't included because it wasn't published in the Standards of Care, but it is actually available through the Position Statement, the Joint Position Statement that I think Betsy had featured last year. It's downloadable and printable. And it also offers printable referral forms or examples of referral

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forms. And I'm happy to follow up with you on that if you're not sure where to find those. So good job.

Now we're moving into Glycemic Targets, Section 5. Glycemic target goals have evolved over the years. We're going to spend some time on the latest recommendations from 2016. As you know, I'm sure, glucose control is directly related to the development of future complications, such as blindness, amputation, and diabetic kidney disease. So we definitely have to measure and help our patients understand the importance of measuring their blood sugar.

Shown here are the ADA's recommended glycemic goals for many nonpregnant adults. These recommendations are based on values for A1C with listed blood sugar levels that appear to correlate with the achievement of an A1C of less than 7 percent. So the top line, A1C of less than 7 percent, gives the previous 2 to 3 month average. Again, this might be an appropriate goal for many nonpregnant adults, and it should be measured twice a year for those at goal, but even

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more frequently, such as quarterly, for those who are not at goal.

Preprandial capillary plasma glucose and peak postprandial capillary plasma glucose give daily information related to eating and exercise effects, additionally medication effects if they're taking medications. For the preprandial, our premeal goal right now is 80 to 130 for nonpregnant adults with diabetes and a peak postmeal or postprandial plasma glucose goal is less than 180.

So deciding the A1C goal, again, should be patient specific. This slide shows the approach to management of hyperglycemia, and it depicts elements of decision making that can be used to determine appropriate efforts to achieve and set glycemic targets. You may have seen this before because it's been out for several years, but I'm going to walk you through it briefly. Going down the left side, you'll see a series of patients or disease characteristics that are either modifiable or thought to be nonmodifiable with a corresponding A1C impact scale on the right.

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The small end of the ramp aligns with a more stringent A1C goal, such as less than 6.5 percent, and a wider end of the ramp aligns with a less stringent A1C goal of 8 percent or less.

So, for example, in trying to define an A1C goal for a patient, you may look at several of these about risks associated with hypoglycemia, disease duration, life expectancy, and then down to the modifiable elements, such as patient attitude and resources or support systems. And through that evaluation, come up with an appropriate A1C goal for the patient. And it could change over time, obviously.

All right, that was a lot of information to talk about with respect to A1C goal setting. And I want to make sure I explained it well enough. So please respond to this question: More stringent glycemic goals may be appropriate for individual patients. Which factors below support more stringent A1C goals, such as an A1C of less than 6.5? I think what might be harder about this question is it wasn't spelled out fully, and you might not have understood the

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question. But it looks like most people after I read the question were selecting the correct answer for setting more stringent goals. So it's B, a highly motivated adherent patient with a good support system would be a likely candidate for more stringent A1C goal; whereas, someone with longstanding diabetes duration or a high risk of hypoglycemia might be a less likely candidate and have a less stringent A1C goal of maybe greater than 7, somewhere between 7 and 8. So, very good! It looks like the majority selected the appropriate answer.

So based on your responses and the discussions that we've had, I think we should move along. This is a summary slide about what we just discussed about setting A1C targets. I'm going to continue on here within the section of glycemic target and emphasize the atherosclerotic cardiovascular disease outcomes information.

There's evidence for a cardiovascular benefit of intensive blood sugar control after long-term follow-ups, and we've seen this in studies that have been

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going on for decades—follow-up studies. One in particular is the Diabetes Control and Complications Trial, which was a major clinical study for patients with type 1 diabetes where they found a trend towards lower risk of atherosclerotic cardiovascular disease events in the patients who were randomized to intensive controls—meaning they were trying to achieve a close to normal A1C of 6 percent or less.

Now this started in 1983, and since then we've relaxed our goals for intensive controls. But nevertheless, when the DCCT ended in 1993, research continued studying the participants. And the follow-up study is called the EDIC study or Epidemiology of Diabetes Interventions and Complications. And it assessed the incidents and predictors of cardiovascular disease events such as heart attacks, strokes, need for heart surgery, as well as diabetic complications related to microvascular—eyes, kidneys, and nerve complications.

Well, in the 9-year follow-up for DCCT called EDIC, they showed a 57 percent significant reduction in the

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risk of nonfatal heart attack or MI, stroke, and/or atherosclerotic cardiovascular disease death, compared with the previous on the standard arm. So this benefit in intensive control is what is touted. Now, I don't expect you to recall all these facts after this study or with your patients, but I hope that you've seen here the importance of glycemic control, how it should underscore in your mind as you work with people who have uncontrolled diabetes, the importance of preventing complications, both microvascularly and macrovascularly related to atherosclerotic disease.

Now, another new section with respect to glycemic targets is here around older adults. And that is defined as greater than or equal to 65 years of age. There is a whole separate section on older adults, Section 10, which we're not going to review. But I did include the statement that is somewhat related to glycemic target management for the older adults. That is a new addition this year in the standard of care. And it states: "Because of the growing number of older adults with insulin-dependent diabetes, the ADA

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added the recommendation that people who use continuous glucose monitoring, also called CGM, and insulin pumps should have continued access after they turn 65 years of age." It's a good time to highlight the growing use of technology here with this information across all age groups.

So CGM and pump technology should be continued in those greater than 65, particularly those who are considered young elderly, meaning that their functional and cognitive capacity is high. In characterizing people using functional and cognitive capacity, it's oftentimes more appropriate than using chronological age. But in this case here, they've used chronological age for the patients who may still need to rely on the technology.

Now I see, does Medicare cover pumps? And Gustavo says, "Medicare covers pumps for people older than 65. Does it cover CDMs?" And I'm not sure, but this could vary, and it might be different from area to area or plan to plan.

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So speaking of age, let's revisit Ms. Arias one last time. What happened after her first visit that we previously discussed? It says Ms. Arias returned using a transportation voucher arranged by her community health worker to her 1-week follow-up. She reports feeling better and is relieved that her community health worker is willing to help her coordinate transportation through her social network and for future visits. She has restarted her insulin, and the fingerstick blood glucose before lunch was 175. This is much better than 450 a week ago. She questions though the need for some of her medications. She feels she's having to make a choice between taking her medication and buying food. So, obviously, still outstanding issues with access for food and medication.

During her medical appointment, Ms. Arias is offered the option to receive a discount for a home delivery meal program. Here, I'm thinking something like Meals on Wheels. There are so many healthy food delivery programs that can be subsidized nowadays. But what are some other possible next steps for us as the

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community health workers? Oh, I see already people are sharing through the chat some of their recommendations and thoughts around connecting to food resources, assisting with budget, medication assistance. A medication discount program has been suggested to explore. And then a medication review by a doctor. He or she qualifies for Medicaid. Again, we don't know her insurance status, but these are all wonderful opportunities for us to ask those questions and sort of get involved and share the resources that we have.

So I think we can also discuss the importance with her as keeping blood sugars in the range that her doctor has determined. Let's say it's around 7½ percent. Because we know that keeping blood sugar under good control will prevent more health problems in her future and more expenses. She also has grandchildren, so we need to help leverage that and let her know how important it is for her to reduce her risk by having uncontrolled blood sugar and inconsistent controls of her blood sugar.

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I'm not sure because it's hard for me—everyone is so great in sharing. But as a pharmacist, I think it would be good to arrange a session, the pharmacists or a pharmacist that Ms. Arias has in her community store. Because she probably needs to visit the pharmacy a couple of times a month, and those trips don't necessarily cost a co-pay. So while she's getting her prescriptions, maybe the pharmacist could review her medications and recommend to her and/or make calls to her doctor on how to combine or eliminate some of her medications. Maybe even help her conserve her supplies or get them at a better cost.

I see language barriers to be addressed. Also, the community health worker could listen to Ms. Arias' thoughts around the home delivery meal programs. Maybe even connect her to someone who has benefited from a service like that or the same service so that they can give some feedback on their experience with it. It says in the chat box, "Provide free senior companion service." Betsy, is there anything you'd

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like to share from what you've been reading in the chat box at this point?

BR: Sheila says ongoing follow-up with RD, assistance medication. She's saying also about assistance programs, looking to prescription assistance programs. That's another alternative that has been provided. Community health workers can educate Ms. Arias on health, on medications, programs available in the community. There are low cost or free senior lunches at senior centers. That's pretty much about what I have seen here. It's mostly about looking for medication discount programs, kind of the feedback that we're getting here.

CM: Okay, good. I think she's in good hands if she's connected on this line. And I like that you're still sharing. Continue to do that. So people might be learning things from your posts. I'm getting good ideas for how their community's connections might be improved.

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I'm going to move on to Section 6 on Obesity Management for the Treatment of Type 2 Diabetes. I don't have a lot on this, but, of course, it's a very important component to this chronic disease in particular. This new section has been added on obesity management and incorporates some previous recommendations related to bariatric surgery, also has new recommendations related to comprehensive assessment of weight in diabetes, and the treatment of overweight obesity with behavior modification and pharmacotherapy.

And why? Why is this so important? Well, there is a strong and consistent body of evidence that obesity management can delay progression from both prediabetes to type 2 diabetes, and it can delay progression of the disease itself when someone has been diagnosed. Weight loss improvement not only lowers blood glucose it can also help with blood pressure control and lead or reverse insulin resistance when insulin secretory capacity is still preserved early on in the disease. Many studies also document other benefits of weight loss in patients

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with type 2, including improvements in mobility, both physical functioning and sexual functioning and health-related quality of life.

Now this last bullet point might speak and resound more with the patients themselves because these are the types of things that can motivate them to make behavior changes when they understand what the weight loss can do outside of just losing weight.

When patients ask you, "What should I be doing?" and you ask yourself, "How can I encourage them to take small steps, you know, towards losing weight?" Well, here are some physical activity recommendations from the standards of care. And these, again, are recommendations. And I don't think any one of us on this phone are in a position to say, "This is what you need to do, bottom line." It's really a spectrum and I think starting with small steps, working towards these recommendations is really what we should be encouraging patients with diabetes to do. The top line has to do with children with diabetes and prediabetes. And for someone who's been

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sedentary, working up to at least 60 minutes a day of physical activity. So this doesn't have to be all at one time. It can be broken up and worked towards.

Adults with diabetes, the recommendation is at least 150 minutes per week of moderate-intensity aerobic activity on at least 3 days of the week, with no more than 2 consecutive days without exercise. That's a lot to say, but I think you get the gist of they want it to be, you know, consistent whether it might be 10 minutes every other day, working up to this overall recommendation. All individuals, including those with diabetes, should limit sedentary times, which is exactly what we're not doing this afternoon on this webinar. I hope we can all agree that we will get up after this session and move around a little bit because we need to break up extended amounts of sedentary time, defined as greater than 90 minutes sitting. Adults with type 2 diabetes should perform resistance training at least twice a week in the absence of contraindications. So those are the physical activity recommendations in a nutshell.

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Section 7 is one of our last sections and is near and dear to my heart as a pharmacist because there are many options for managing patients' glycemic control with medications. So this is Approaches to Glycemic Treatment. This is a slide that has a screenshot of kind of a key figure that people can refer to in clinical practice or maybe even as a community health worker to just understand levels of risk, cost issues, and combinations of things just at a overarching level. The foundation of therapy is in the aqua color, sort of like the frame of the recommendations for the anti-hyperglycemic therapy in type 2. And it says, "Healthy eating, weight control, increased physical activity, and diabetes education." So those are obviously the cornerstones.

But the first line pharmacologic therapy recommended is Metformin. And each of these agents or classes of agents that are listed underneath these as dual therapy recommendations and triple therapy options are all delineated by their efficacy, the hypoglycemia risk, the effect of the medication or class on weight, the side effects, and then the

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relative cost for a self-pay patient. And in super tiny fonts, in between the first, second, and third line—I'm actually going to try to use my pointer here—is a statement that says, "If A1C target is not achieved after 3 months of monotherapy with Metformin, proceed to two drug combinations." And there's no specific order and here are the two drug combinations with Metformin. So there are six different classes of agents. Again, can be added in combination with Metformin in no particular order. But once you see that—let's see here, you're going to combine Metformin with sulfonylurea because that patient is looking for a low-cost option that's highly effective. So that's kind of how you read this table or this figure.

And for the sake of time, I think I'm going to move on. So for this individual taking multiple agents over time and their A1C is still not at goal, the ADA Standards of Care includes nice tables again and charts on insulin therapy management, which can be fairly complex at first glance and might seem intimidating to patients who are asked to go on

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insulin. There's very good information and support to show how efficacious insulin is. And this is just an example of an algorithm that physicians and clinicians can refer to and different ways that they can add additional insulin over time in order to control both fasting and postprandial. Again, this is just a nice visual aid that you could be aware of and refer back to try to help understand medication management a bit more.

Now it is still February, and we're in American Heart Month, so, again, atherosclerotic cardiovascular disease is something that we mentioned briefly before, but it is a leading cause of death for those with diabetes. And diabetes actually confers its own independent risk factor for cardiovascular disease. I'm not spending a whole lot of time on this either, but I did want to point your attention to a new term that is replacing CVD, and I've been using it as much as I can throughout the presentation. Atherosclerotic cardiovascular disease or ASCVD has now replaced the former term CVD as the more specific term. And this section is expanded upon in the Standards of Care. It

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includes information on blood pressure control and goals, lipids control and LDL goals, and lipid recommendations. Again, if you have an interest in that, please refer back to Section 8.

Section 9 will move into microvascular complications; whereas, ASCVD is a macrovascular section. This is microvascular complications in Section 9, including foot care. Microvascular complications, if you don't know or use the term frequently, are nephropathy, which is related to the kidney disease, neuropathy or the nerves, and retinopathy or the eyes. So nephropathy, the term here 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. So, again, just a new terminology that you may want to start using or sharing with people who haven't read the Standards of Care this year. Diabetic kidney disease is the term that now we are going to go forward using.

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And since diabetes is the leading cause of kidney failure, here are two brief points related to diabetic kidney disease around treatment recommendations. So the first is to optimize glucose controls to reduce the risk or slow the progression of diabetic kidney disease. And then, secondly, to optimize blood pressure control to reduce risk or slow progression of diabetic kidney disease again. Okay? So, again, we're not going to spend time on the blood pressure recommendations or diabetic kidney disease, but this is the section from which you can find that information.

And, finally, the last section I'll cover today is on diabetes advocacy. People with diabetes should not have to face discrimination and so by advocating for their rights, the ADA helps insure they live long, healthy, and productive lives. One tactic for achieving this goal of diabetes advocacy is to implement the ADA's Standards of Medical Care through advocacy-oriented position statements. So the ADA publishes evidence-based, peer-reviewed statements on the topics such as diabetes and employment, diabetes

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and driving, and diabetes management in certain settings such as schools, childcare programs, and even correctional institutions.

So in addition to the ADA's clinical position statements, these advocacy position statements are important tools in educating schools, employers, licensing agencies, policymakers, and others about the intersection of diabetes medicine and the law. These statements can all be downloaded from the ADA website at professional.diabetes.org/soc.

This concludes my presentation today of the review of the Standards of Care 2016 with a particular emphasis on community health workers and diabetes self-management education and support. In summary, these Standards of Care are an important resource for those who care for people with diabetes. Revisions have been made to this annual publication to include terminology and clinical practice recommendations. Diabetes self-management education and support are integral to the execution of these recommendations and help true professionals and community health

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workers or promotores should empower people with diabetes or those at risk to receive the care they need.

Thank you so much, and I will take questions Ana and Betsy at this point.

BR: Thank you very much, Catherine for yet another great webinar. I invite everybody to please visit our newly designed NDEP website. We're going to be showing that slide there. Thank you, Ana. And now we have a couple of questions. Let's see, Catherine. The first question that we have here is: "Are there any community health workers resource lists for Wisconsin?" So I think that there is an official list of community health workers networks. Usually in the past, it used to be posted in the APHA Community Health Workers section. I cannot recall from the top of my head if precisely Wisconsin—we do have community health workers network association there. But I will look into that information. I'm going to be pulling some of these questions and follow-up with an email after this webinar. So as soon as I found

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the specific one in that state, I will share that information with you all.

And I always recommend people to go to the State Health Department because some of them have been working with community health workers, they certainly will know what networks of community health workers are in the state.

So there is another question here, Catherine. It says, "You mentioned tobacco cessation to minimize diabetes challenges. Is that smoking or all forms of tobacco usage?" What do you have to say about that one, Catherine?

CM: It would be all forms of tobacco use, although there's relative degrees of risk conferred with— depending on which method of tobacco use the patient is using. Now smoking cessation is directly linked with multifactors that can impact adversely health overall, including, I think, like I said, blood pressure, cardiovascular disease, and even insulin resistance can worsen with smoking. But other types

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of tobacco use should be recommended and advised to the patients to not do because of the other problems that can occur. I'm thinking of mouth cancers and things that also can coexist. Cancer and diabetes, although we did not discuss this today, are commonly linked. And oftentimes, someone with diabetes is at a higher risk of developing certain forms of cancers. And so having a risky behavior like tobacco use can compound that risk.

BR: Okay. Thank you, Catherine. There is another question here, and it says, "Mary Jane Christian is asking if fasting still requiring two labs results of more than 126?"

CM: Only if there are no overt symptoms of diabetes. So the polyuria, the polydipsia, and the polyphagia, or maybe like a Candida infection or something. If those types of symptoms are not there, and they're only seeing an elevated fasting, then it is required to be repeated in that instance.

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BR: Okay, thank you. There is another question here. It says, "What rate do you see children with type 2 diabetes?"

CM: Oh, you know, it depends. It's growing, and it depends on the race of the child. I think Hispanic/Latino children are at the highest risk. And if I can just recall from some of my recent readings, about 30 percent for that. Other ethnicities may be lower.

BR: What I recall from the top of my head is that some study has been reported that between 8 percent to 45 percent of children who have been newly diagnosed with diabetes have the form of type 2 diabetes. That's what I recall from the top of my head. I might be wrong. So don't quote me on that one, but as you just said, this is a growing problem right now, primarily in the Hispano/Latino population.

BR: So then, "What immunizations would you look for?"

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CM: Well, again, I'm not an expert. I have not actually read the recommendations on immunizations in a very long time. But I do know that the flu vaccine and the pneumococcal vaccine have specific recommendations for people who have diabetes. I'm not sure, there may be others that I'm missing.

BR: Yes, those are the two preliminary most important ones in people with diabetes is the flu vaccine and the pneumococcal immunization.

There is another common kind of question here, "Weren't these recommendations the same since 2010 or so?" Well, actually, no, the whole purpose of our webinar today was to give you the updates. I think that the one that I like the most, Catherine, is something that we knew for so many years, but now is on an official document as a standard of care. It's referring to people with diabetes as people with diabetes, rather than diabetics. And also, I think that the great emphasis that has been done on looking to social determinants of health as part of the compliancy with diabetes regime. I think that's also

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awesome. Is there any other comments that you may want to make in this aspect, Catherine?

CM: I completely agree with you, Betsy, in that for years I've been trying to use the terminology "person with diabetes" instead of diabetic. But I still hear it frequently even among my peers in the diabetes health care community. So I feel that that is an important general change that we should all share with our friends and colleagues.

BR: Yeah. Another question here says, "How do you request a copy of the Standards of Care? Through the ADA site or NDEP site?"

CM: Yes, let me go back to the very first—and you may have missed it. One of the very first slides.

BR: Yeah, while she's looking, I can say that it is through the ADA website.

CM: Can you see this Slide 11? There's a website on the bottom.

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BR: But if you go to the ADA website, look to Health Care Professional tab, and you click in there, and you will be able to find the Standards of Care in the ADA, American Diabetes Association website.

So there is an interesting question here, Catherine. Someone is asking us, "How can you address those patients who are well-educated, but still not adherent to goals, compliant to goals?"

CM: People who are well-educated, yet not adherent. Well, I think well-educated might be a relative term. They may seem well-educated in one aspect. They could be a corporate executive who is very successful, you know, in managing business, yet there could be a very big disconnecting gap in his knowledge and perceptions about the risks of having diabetes. So I think that's kind of what I feel maybe should be said about that question in that you should never assume that what they do in their—I guess, their professional life,

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might transfer over into their health literacy and health understanding.

BR: I would like to add also, Catherine. I just recall like 2 or 3 years ago, I went to the ADA Health Disparities Forum they used to have, and one of the speakers happened to be one of the Secretaries of Health and he happens to be a person living with diabetes. And he shared with us how the instructions were given to him by the doctor on sick day management. He didn't get it. And, finally, he ended in ER with a ketoacidosis. So he said, "Here I am. I am the perfect example. I am supposed to know everything from A to Z for diabetes, and here I was in the ER with a ketoacidosis event." So never assume that because people are well-educated, they will be able to follow all those things that are required in order to keep diabetes under control.

CM: Right. And, as we all know, saying one thing and recommending something is much different than actually doing it. And people go through so many stages of change and acceptance and what motivates

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one is specific to that person. So I think we can't underestimate the importance of saying things different ways, getting information in a repeated fashion.

BR: There are many things that have been documented in the literature, being one of them, you know, getting training to do motivational interview. That seems to be effective in getting to know what are the different challenges, and things that people may have. There is also a lot of evidence around the use of contracts for people who may be having struggle in some area of diabetes self-management and education. And, of course, a peer-to-peer kind of work seems to be working with many people living with diabetes.

There is another question here: "Medicare covers pumps for people over 60 years old. Does it cover continuous glucose monitoring?"

CM: Unfortunately, I do not know the answer to the coverage questions as well as I should. I'm not actually a pharmacist who dispenses and adjudicates

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claims. I would have to look that up. And, again, from one of my previous comments, it may not be the same from state to state.

BR: Well, one of the things that I can recall from the top of my head that Medicare used to still have struggle in this area for people over 60 because in the past it used to cover only people with type 1 diabetes. And in order to be considered, the patient should complete the comprehensive diabetes education and has been on multiple injections kind of treatment. And then having an A1C more than 7 percent and having a history of hypoglycemia and having a history of fluctuations in the blood glucose readings or even having the dawn phenomenon, which is another issue that happens in people with type 1 diabetes. So to my best knowledge, I think that this still is an area here. So that's why I think that one of the aspects in the Standards of Care is that section when you were talking about diabetes advocacy. I think this is one of the areas that will require more and more advocacy for those that are over 65 and looking

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to be using insulin pumps and continuous monitoring glucose systems.

CM: I'm looking, and it's not specific to continuous glucose monitoring. Although the ADA website does have great resources around all the different technology-related devices. But the position statement from the ADA AADE talk about how CMS reimburses for 10 program hours of initial diabetes education and 2 hours in each subsequent year. And the referrals can be made like you say for specific treatment, specified indicators. And there, again, I think I mentioned before, there are sample referral forms to get reimbursement for education. And through that education, probably there would be things specific to coverage that they could access that would be within their own community through that education and service.

BR: Well, I can talk from my own experience, you know, being a person living with diabetes. When it comes to devices and technology and pumps and continuous monitoring tools and things like that, all health insurances will require a lot of work from the

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patient, from the health care providers. There is this so-called "necessity letter" that has to explain all of the challenges in management that people may be facing, like the one that I just mentioned, a high A1C, history of hypoglycemia, history of fluctuation in the blood glucose patterns, and things like that. And then this whole emphasis of people participating in comprehensive diabetes education classes. It's one of the things that is required for any health insurance to cover insulin pumps. So that's the way our system is.

So there is another question here that says, "Where does an oral health evaluation occur?" And I think, again, this is one of those disconnections that we still need to work with, which is making not only the patients but many health care professionals and allied health professionals that there are other professionals that should be part of the health care team. And those are dental, dentists, ophthalmologists, pharmacists. So in the NDEP lingo, we call them the PPOD providers. So what I'm trying to say here is that we have to make the connection to

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those health care professionals that are so linked to these kinds of issues that people with diabetes may be facing. And oral health is one of the neglected areas. So I think that, again, when it comes to empower our patients is to letting them know the importance of doing those visits to the dentist. Anything else that you may want to add?

CM: I wish I could, but I don't think I have any words of wisdom in this area.

BR: Okay, so there are some other interesting questions, but due to the lack of time that we have, we have to conclude our webinar for today. I have been collecting all these questions. I will do my best to have for you some quick responses on the ones that have been neglected by not answering the questions. We have been doing our best to answer some of those. I would like to thank you again, Catherine, for yet another great webinar. I invite everyone to go and visit our newly redesigned NDEP website at www.cdc.gov/diabetes/ndep and to check the many

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resources that can help you in your diabetes education, prevention, and control classes.

Feel free to email us, and we will be more than happy to answer any specific questions.

So thank you to everyone and thank you, Catherine.

And that's all. Good-bye.