# DIABETES TOOL KIT

## A PRACTITIONER'S REFERENCE

*6th Edition*

*(July 2012)*

TEXAS DIABETES
COUNCIL

www.texasdiabetescouncil.org

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# *Acknowledgements*

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# *Health Care Professional Education*


| *Chapter* | *Topic* | *Page* |
|---|---|---|
| **1. Overview** | a. Introduction | 4 |
| | b. What is Diabetes? | 6 |
| | c. Facts about Diabetes | 10 |
| | d. Texas Diabetes Fact Sheet | 11 |
| | e. Pre-diabetes | 15 |
| **2. Standards & Practice Recommendations** | a. Criteria for Diagnosing Diabetes | 17 |
| | b. Diabetes Management Goals of Therapy | 18 |
| | c. Recommended Adult Immunization Schedule | 19 |
| **3. Pregnancy & Diabetes** | a. Gestational Diabetes (GDM) Standards of Care | 21 |
| | b. Treatment of Gestational Diabetes | 25 |
| | c. Pregestational Diabetes Guidelines | 34 |
| **4. Monitoring** | a. Self Monitoring Blood Glucose (SMBG) | 38 |
| **5. Acute Complications of Diabetes** | a. Hypoglycemia | 43 |
| | b. Hyperglycemia | 44 |
| | c. Vibrio vulnificus | 45 |
| **6. Chronic Complications of Diabetes** | a. Chronic Complications of Diabetes | 48 |
| **7. Diabetes Education** | a. Educating the Person with Diabetes | 51 |
| | b. Teaching Strategies for Diverse Populations | 53 |
| | c. National Standards for Diabetes Self- Management Education Programs | 55 |
| **8. Medications** | a. Diabetes Medications Supplement | 63 |
| **9. Resources** | a. Resources for Individuals with Diabetes | 75 |

# *Introduction*

The Texas Diabetes Council's (TDC) Diabetes Tool Kit was prepared by an interdisciplinary team of volunteer certified diabetes educators (CDEs) and professional staff of the Texas Department of State Health Services Diabetes Prevention and Control Program to be of service to Texas practitioners, diabetes educators, and residents who live with diabetes. Many partners contributed to its development, revisions, and distribution.

## The Tool Kit Features:

- Self-management training content based on the National Standards for Diabetes Education;
- Minimum Standards of Care and evidence-based treatment algorithms prepared by volunteer endocrinologists, physicians, nurses, dietitians, pharmacists, and professionals on the Medical Professionals Advisory Subcommittee of the Texas Diabetes Council.

This Tool Kit assists primary care providers, educators, and health plans to deliver quality care and to implement quality improvement efforts. The Tool Kit is a resource that includes professional and patient education materials.

Patient education materials in English and Spanish help primary care providers and educators address basic self-management education with their clients who have diabetes. These tools assist those who conduct diabetes self-management education, case management, or disease management.

## Standards of Care

The Council's Minimum Standards of Care for Diabetes in Texas are accompanied by decision support tools, i.e., a minimum practice recommendations flow sheet, treatment algorithms designed for primary care settings, and information intended for use in professional preparation and continuing education of licensed health care professionals and the medical leadership and case/disease management staff of health plans. The Kit promotes delivery of quality care and quality improvement efforts focused on provider practices and clinic or office systems. Charts and algorithms can be reproduced or integrated into the office's medical record system to remind providers of critical preventive services and therapeutic targets and to set the basis for feedback on treatment strategies.

## Diabetes Management

The Task Force on Community Preventive Services, a non-federal group supported by the Centers for Disease Control and Prevention, reviewed studies and concluded that diabetes disease management and case management can improve glycemic (blood sugar) control and physicians' monitoring rates (A1c testing). Disease management includes identifying clients/members with diagnosed diabetes, implementing care plans that are proven to be effective, and tracking, measuring, and managing health outcomes.

## Diabetes Self-Management Education

The Task Force also recommended self-management education for adults with type 2 diabetes in community settings, e.g., community centers, libraries, and places of worship.

Texas professionals may offer diabetes self-management training and information in clinical or community settings. The Council recognizes that most certified diabetes educators and programs credentialed by the American Diabetes Association (ADA) or Indian Health Services are located in metropolitan areas. Many patients receive information from various members of the diabetes care team: primary care physicians, nurses, pharmacists, dietitians, and specialists such as dentists, podiatrists, endocrinologists, and eye specialists. These health care providers may seek assistance with education and reinforcement from trained community health workers/promotores de salud, lay support group leaders, and county extension agents.

## Updates

Updates to the algorithms in the Tool Kit will be available on the Internet at www.texasdiabetescouncil.org.

## Acknowledgements

The Texas Diabetes Council thanks the volunteers on the Medical Professionals Advisory Subcommittee who developed the first edition of the Diabetes Tool Kit (2001) and oversaw its first significant revision (2003). The effort involved many diabetes professionals across Texas and was supported by organizations that consented to the inclusion of resource information in this reference.

# *What is Diabetes?*

Diabetes is a serious chronic disease. It happens when too much glucose stays in the blood stream because there is either no insulin or not enough insulin that can move the glucose into the body's cells. Most of the food people eat is changed into simpler proteins, fats, or a simple carbohydrate called glucose. Glucose is the form of sugar that cells need to make energy. The pancreas, a gland near the stomach, normally makes insulin to move glucose from the blood stream into the cells. In diabetes, the body cannot make insulin or properly use the insulin it has.

Controlling blood glucose helps to prevent the damage to blood vessels and nerves that lead to complications: blindness, amputations, kidney failure, stroke, heart attack, digestive and nerve problems, gum disease, and even depression (sadness). Good control is achieved by daily attention to nutrition, exercise, weight control, self-checks, and taking medicines as ordered. Regular checkups (including blood tests, dental exams, eye exams, and foot exams) are recommended.

## TYPES OF DIABETES

There are 2 major types of diabetes. Several less common types of diabetes follow:

### TYPE 1 DIABETES

- Characterized by absolute insulin deficiency. This occurs as an auto-immune process destroys the pancreas' ability to produce insulin.
- The person with type 1 diabetes must inject insulin daily.
- Onset occurs most often in childhood or adolescence, but can occur at any age.
- Typical onset may be dramatic with polyuria, polydipsia, and polyphagia. Patients may report rapid weight loss regardless of their oral intake and poor energy/exercise tolerance.
- If untreated, can progress to diabetic ketoacidosis (DKA) and coma.
- Does not usually run in families, but there is a higher risk.
- Usually occurs in normal-weight individuals.
- Accounts for up to 10% of all diagnosed cases of diabetes.
- Was called Insulin Dependent Diabetes (IDDM) or Juvenile Onset until 1997.

### TYPE 2 DIABETES

- Characterized by relative insulin deficiency. Type 2 diabetes is a progressive disease of insulin resistance in combination with insulin deficiency. The body may produce some insulin, but the body is unable to use it properly.

- Lifestyle modification — nutrition and exercise are fundamental to diabetes therapy.
- The person with type 2 diabetes may begin their medical treatment with a variety of oral, inhaled, or injected therapies.
- Onset occurs most often in people over age 30, but is being found more frequently in youth who are overweight.
- Typical onset gradual. Patients may report mild fatigue, blurred vision, frequent yeast infections or no specific symptoms. Months to years of gradually increasing hyperglycemia contributes to approximately 50% of newly diagnosed patients already having a serious diabetes complication at time of diagnosis.
- Risk factors include:
  - Being overweight (≥ 30 pounds overweight or a Body Mass Index (BMI) ≥25)
  - Family history of diabetes
  - Hispanic, African American, Asian American, or Native American origin
  - Older than 30 years of age
  - Sedentary lifestyle
- Increases the risk for heart attack and stroke because many with type 2 also have hypertension and hyperlipidemia.
- Accounts for most (90%) of all diagnosed cases of diabetes.
- Was called Non-insulin Dependent Diabetes (NIDDM) or Adult Onset until 1997.

**Gestational Diabetes Mellitus (GDM[1,2]):**

- Characterized by any degree of glucose intolerance with onset or first recognition during pregnancy.
- Incidence- occurs in approximately 7% of all pregnancies, resulting in more than 135,000 cases in the United States annually. Prevalence may range from 1-14% of all pregnancies, depending on the population studied and diagnostic tests employed.
- Usually diagnosed between the 24th and 28th week of pregnancy.
- Treatment may include insulin and dietary changes. Medications are often discontinued in the post-partum period.
- Risk factors include:
  - Obesity
  - Maternal age

  - History of GDM with previous pregnancy
  - Family history of diabetes
  - Ethnicity — African American, Hispanic American, and American Indian origin
- Maternal hyperglycemia may result in increased maternal and fetal complications, including macrosomia, birth trauma, hypoglycemia, hypocalcemia, and jaundice. Rarely, fetal death may occur.
- Women with GDM have an increased risk of developing type 2 diabetes later in life. Staying physically active and achieving weight loss may help to prevent or delay type 2 diabetes.

**Maturity Onset of Diabetes in Youth (MODY[3]):**

- A subtype of Type 2 diabetes occurring in individuals < 25 yrs of age (age of onset 15-25 yrs). A monogenic form that is inherited in a autosomal-dominant fashion (MODY 1-5).
- Characterized by a pure insulin secretory defect rather than an impairment of insulin sensitivity. Individuals secrete little insulin but require only small doses of exogenous insulin to control their glucose.
- Women with MODY often present with GDM[4]

**Latent Autoimmune Diabetes of Adulthood (LADA[5,6]):**

- Characterized by adult age at onset, the presence of diabetes associated autoantibodies (+ GAD and ICA), and delay from diagnosis in need for insulin therapy to manage hyperglycemia. Patients often have low to normal BMI, poor glycemic control in spite of adequate compliance to diet and oral agents, and decreasing body weight during a constant diet.
- Epidemiology of LADA is influenced by geography (more common in North America and Europe), genetic susceptibility, environmental factors, gender (males predominate), and age at diagnosis (30-60 yrs).
- A slowly progressive autoimmune diabetes, often mistaken for type 2 diabetes mellitus. LADA patients generally have more insulin secretory capacity than children with type 1, require less exogenous insulin for glucose control, and may have residual persistent c-peptide secretion.
- Treatment with oral agents fails relatively quickly. Patients progress to insulin dependence.

**Other types:**

- Steroid Induced Diabetes
- Cystic Fibrosis Related Diabetes
- Diabetes of the Elderly
- Diabetes in the HIV patient
- Other Medical Types of Diabetes- thalassemia, sp whipple procedure, etc.

- Impaired Fasting Glucose* (IFG)
  1. Fasting plasma glucose 100 mg/dL-125 mg/dL.
- Impaired Glucose Tolerance* (IGT)
  1. Two-hour plasma glucose 140 mg/dL-199 mg/dL. May have normal or near normal glycated hemoglobin (A1c) level.
- Insulin Resistance
  1. Condition in which blood glucose levels are held within non-diabetic ranges by rising insulin levels (2-3 times higher than normal).
  2. Can progress to type 2 diabetes and increase cardiovascular risk in overweight people.
  3. Conditions in which insulin resistance occurs:
     a. Type 2 diabetes
     b. Obesity, especially with central (abdominal) fat distribution with waist circumference > 40 inches (male), > 35 inches (female)
     c. Advanced maternal age
     d. Stress (major trauma, surgery, critical illness)
     e. Puberty: transient and developmentally normal reduced insulin sensitivity due to growth hormone
     f. Acanthosis nigricans (a skin marker seen in skin folds that indicates high insulin)
     g. Polycystic ovarian disease (PCOS) with accompanying hyperinsulinemia can occur in obese or non-obese females
     h. Hypertension (blood pressure > 140/90 mm Hg in adults)
     i. Dyslipidemia
  4. Can be improved by weight loss (physical activity and dietary changes).

* Can be reversed in many obese people through weight reduction (at least 5-7%) by daily physical activity (30 minutes a day at least 5 days a week) and reduced-fat/calories nutrition.


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4. Weng J, Skelund M, Lehto M, et al. Screening for MODY mutations, GAD antibodies, and type 1 diabetes- associated HLA genotypes in women with gestational diabetes mellitus. *Diabetes Care* 2002; 25(1):68-71.
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6. Monge L, Brunot G, Pinach S, et al. A clinically oriented approach increases efficiency of screening for latent autoimmune diabetes in adults (LADA) In a large clinic-based cohort of patients with diabetes onset over 50 years. *Diabetic Medicine* 2004; 21:456-459.

# *Facts about Diabetes*

A. Diabetes is a chronic disease. It affects daily life, most body systems, and is a family concern.

B. Diabetes affects 25.8 million adults (8.3%) in the United States, 7.0 million of whom do not yet know it.

C. Diabetes affects approximately 1.8 million Texas adults (9.7%).

D. Complications of diabetes in the United States:

- Diabetes is the leading cause of kidney failure.
- Diabetes is the leading cause of blindness among adults aged 20-74 years.
- Diabetes causes mild to severe forms of nervous system damage in 60-70 percent of persons with diabetes.
- Diabetes causes more than 60% of nontraumatic lower-limb amputations.
- Diabetes increases heart disease death rates among adults (2 to 4 times higher than adults without diabetes.
- Diabetes increases risk for stroke (2 to 4 times higher among people with diabetes)

E. Prevalence of diabetes by age groups:

1. Age 65 or older — 26.9%
2. Age 20 or older — 11.3%

F. Prevalence of diabetes by race/ethnicity in people 20 years or older:

1. Non-Hispanic whites — 7.1%
2. Non-Hispanic blacks — 12.6%
3. Hispanic/Latino — 11.8%
4. American Indians and Alaska Natives — 14.2% (Indian Health Services) varies among regions. Ranges from 5.5% (Alaska Natives) to 33.5% among American Indian adults in southern Arizona.
5. Asian American and Pacific Islanders — 8.4%.

G. Direct and indirect costs of diabetes in the United States (2007) were almost $174 billion, including:

1. $116 billion in direct costs (includes Medicaid and other state programs)
2. $58 billion in indirect costs (lost wages and early death)

*Source:* CDC National Diabetes Fact Sheet, 2011

# *Texas Diabetes Fact Sheet*

Prevalence estimates are based on surveys in which individuals are asked if they have been diagnosed with diabetes. Efforts to increase diabetes screening and awareness lead to more people knowing they have diabetes and, consequently, being able to report that they have been diagnosed. This increase in awareness would also be reflected in the estimated prevalence rate.

## I. 2010 DIABETES PREVALENCE

### Prevalence of Diagnosed[1] Diabetes in Persons 18 and Older

An estimated 1.8 million persons aged eighteen years and older in Texas (9.7% of this age group) have been diagnosed with diabetes. Nationwide, 22 million persons eighteen years of age and older have been diagnosed with diabetes (9.3% of this age group).

### Prevalence of Undiagnosed[2] Diabetes in Persons 18 and Older

Another estimated 460,040 persons aged eighteen years and older in Texas are believed to have undiagnosed diabetes (based on 1999-2000 NHANES age-adjusted prevalence estimate of 2.5% of persons twenty years of age and older). The total for both diagnosed and undiagnosed diabetes is 2.3 million.

### Prevalence of Diagnosed[1] Diabetes by Sex in Persons 18 and Older

Male..... (9.9%)

Female ..... (9.5%)

### Prevalence of Diagnosed[1] Diabetes by Race/Ethnicity in Persons 18 and Older

White, non-Hispanic ..... (8.2%)

Black, non-Hispanic..... (16.5%)

Hispanic ..... (11.0%)

## Prevalence of Diagnosed[1] Diabetes by Race/Ethnicity and Age Group in Persons 18 and Older

| AGE GROUP | WHITE, NON-HISPANIC | BLACK, NON-HISPANIC | HISPANIC | ALL RACES |
|---|---|---|---|---|
| 18-44 | 2.2% | 8.0% | 4.2% | 3.5% |
| 45-64 | 10.1% | 20.8% | 21.5% | 14.5% |
| 65+ | 19.2% | 38.0% | 32.2% | 23.0% |
| Overall | 8.2% | 16.5% | 11.0% | |

**Sample size too small to report a reliable estimate (n<20).

## Prevalence of Diagnosed[1] Diabetes by Age Group in Persons 18 and Older

18-29 Years.....1.5%

30-44 Years.....4.3%

45-64 Years.....14.0%

65+.....23.0%

## Prevalence of Diagnosed[1] Diabetes by Educational Level in Persons 18 and Older

No High School Diploma.....14.4%

High School Graduate.....11.1%

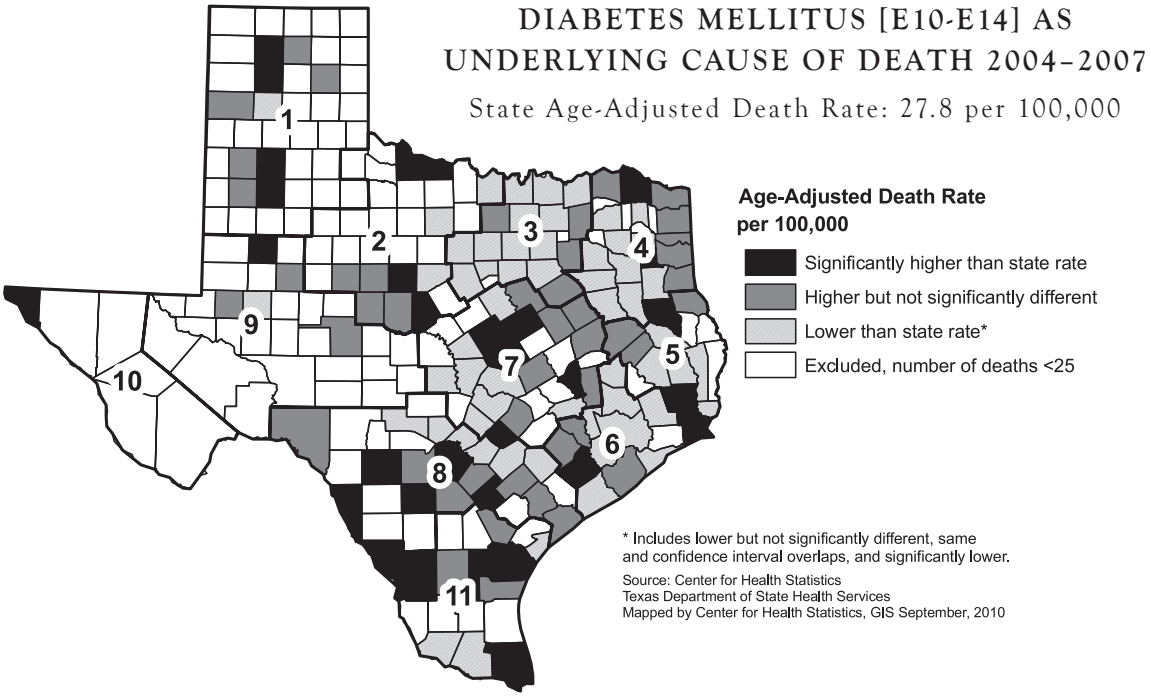
Some College.....9.7%

College+.....7.1%

# II. DIABETES MORTALITY[3]

## Deaths Among Persons with Diabetes

Diabetes was the sixth leading cause of death in Texas 2002 through 2007. In 2007, 5,105 deaths were directly attributed to diabetes. Diabetes was also the sixth leading cause of death nationally in 2002 through 2004 and 2006, and seventh in 2005. Diabetes is believed to be under-reported on death certificates in Texas and the nation, both as a condition and as a cause of death.




The map above shows the age-adjusted mortality rates per 100,000 persons for Texas by county for the years 2004 through 2007, with diabetes as the underlying cause of death. The state rate for the four years is 27.8 per 100,000. More of the counties in Health Service Regions 8 and 11 fall into the "significantly higher than state rate" and "higher than state rate, but not significantly different" categories. Many counties along the eastern part of our state fall into the "higher than state rate, but not significantly different" category.

## Diabetes Mortality[3] Rate (Per 100,000) by Race/Ethnicity, Texas, 2007

The 2007 diabetes mortality rate for Texas was 26 deaths per 100,000 persons. Mortality rates for each race/ethnicity were applied to the 2007 population by race/ethnicity:

**Of persons who have diabetes, in 2007:**

- 19 per 100,000 whites (non-Hispanic)
- 40 per 100,000 Hispanics
- 46 per 100,000 blacks (non-Hispanic)
- 22 per 100,000 persons who fall in the "Other" category

The 2007 mortality rates (per 100,000) for blacks (non-Hispanic) and Hispanics were more than double that of whites (non-Hispanic).

## III. DIABETES PREVALENCE AMONG YOUTH (LESS THAN 18 YEARS OF AGE)

Diabetes among children and adolescents is mainly type 1. The SEARCH for Diabetes in Youth study funded by the Centers for Disease Control and Prevention and the National Institutes of Health indicated that, during 2002–2005, 15,600 youth in the U.S. were newly diagnosed with type 1 diabetes annually, and 3,600 youth were newly diagnosed with type 2 diabetes annually.[4]

Among youth aged <10 years, the rate of new cases was 19.7 per 100,000 each year for type 1 diabetes and 0.4 per 100,000 for type 2 diabetes. Among youth aged 10 years or older, the rate of new cases was 18.6 per 100,000 for type 1 diabetes and 8.5 per 100,000 for type 2 diabetes.[4]

In 2007, the Texas BRFSS survey began including two questions regarding diabetes prevalence among youth. In households that include a child or adolescent, respondents are now asked if the child or adolescent has been diagnosed with diabetes, and if so, what type of diabetes they have (type 1 or type 2). While response to the question regarding type of diabetes has not been adequate to provide a reliable estimate of prevalence by type, the 2009 survey indicates that an estimated **26,000** Texas youth (**0.4%** of this age group) have been diagnosed with diabetes (type 1 and type 2). Diagnosed diabetes prevalence for Texas youth are presented by sex and race/ethnicity below. Differences are not statistically significant.

### Diagnosed Diabetes Prevalence by Sex, Texas Youth, 2009

| | | 95% CI |
|---|---|---|
| Boy: | 0.3% | (0.1-0.9%) |
| Girl: | 0.5% | (0.3-1.0%) |

### Diagnosed Diabetes Prevalence by Race/Ethnicity, Texas Youth, 2009

| | | 95% CI |
|---|---|---|
| White, non-Hispanic: | 0.4% | (0.2-0.9%) |
| Black, non-Hispanic: | 1.0% | (0.3-4.2%) |
| Hispanic: | 0.3% | (0.1-0.7%) |

1 *Source:* 2010 Texas Behavioral Risk Factor Surveillance System, Statewide BRFSS Survey, for persons who are eighteen years of age and older. Data include both type 1 and type 2 diabetes. Persons with diabetes include those who report that they have been told by a doctor that they have diabetes. Women who report diabetes only during pregnancy are not included in prevalence.

2 Persons 20 years of age and older. Centers for Disease Control and Prevention. Prevalence of Diabetes and Impaired Fasting Glucose in Adults, United States, 1999-2000. *MMWR*. September 5, 2003; 52(35);833-837.

3 Texas Department of State Health Services, Texas Vital Statistics. Data include male and female, and all ages. Data are provisional.

4 Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

Revised: 07/01/12

# *Pre-diabetes*

**Definitions:** Impaired glucose tolerance (IGT) and impaired fasting glucose (IFG) have been officially termed "pre-diabetes." The term is used with patients who have higher than normal blood glucose levels (IFG) or insulin resistance (IGT) but not at diagnostic levels. Most people with pre-diabetes are statistically likely to develop type 2 diabetes within 10 years of assessment.

Similarly, women who experience gestational diabetes are also at high risk for developing type 2 diabetes in later years (a 20-50% chance of developing diabetes within 5-10 years). Source: CDC.

**Research findings:** The Diabetes Prevention Program (DPP) reported in *Diabetes Care,* April 2002, established that overweight people with impaired glucose tolerance could delay or prevent the onset of type 2 diabetes over the three-year study course with modest lifestyle changes, namely regular physical activity and dietary changes. Metformin, used in one arm of the study, was found to contribute to reducing the risk of type 2 diabetes among younger (25-40 years old) and heavier (50-80 pounds overweight) subjects.

Screening and making recommendations to manage pre-diabetes should be a priority for all health care providers and considered at any health care visit.

**Co-morbidity:** Pre-diabetes is not just an early warning for type 2 diabetes. Persons with IFG and IGT have a higher risk of cardiovascular disease. This risk is constant even if they do not develop type 2 diabetes, thus, they warrant evaluation and intervention for other cardiovascular risk factors, usually hypertension and dyslipidemia.

**Diagnostic guidelines:** Diagnosis of IGT is preferably done by the 2-hour oral glucose tolerance test (OGTT) using 75-gram glucose solution after an 8- to 12-hour fast. OGTT is more likely to identify insulin resistance while fasting plasma glucose (FPG) can detect limited insulin secretion. Impaired Fasting Glucose: Fasting plasma glucose = 100 mg/dL-125 mg/dL.

**Impaired Glucose Tolerance:** Oral glucose tolerance test value is 140 mg/dL-199 mg/dL. May have normal or near normal A1c level.

**Treatment guidelines:** Type 2 diabetes prevention or delay among persons at high risk (pre-diabetes) involves modest weight loss (5 to 7% of total body weight) through diet changes to reduce calories and moderate exercise (30 minutes a day, at least 5 days a week) to burn calories.

Concomitant risk for CVD and stroke should be addressed. Evaluate and aggressively treat hypertension and/or dyslipidemia and counsel patients who smoke to quit.

- **See Weight Loss Algorithm:**
  Weight Management for Overweight Children and Adolescents
- **See Weight Loss Algorithm:**
  Weight Loss for Overweight and Obese Adults
- **See Exercise Algorithm:**
  Exercise for Type 2 Diabetes Prevention and Therapy
- **See Prevention Algorithm:**
  Prevention and Delay of Type 2 Diabetes in Children and Adults with Impaired Fasting Glucose (IFG) and/or Impaired Glucose Tolerance (IGT)

# *Criteria for Diagnosing Diabetes*

A. Fasting plasma glucose (FPG) ≥ 126 mg/dL

**or**

B. Symptoms of hyperglycemia and a casual plasma glucose ≥ 200 mg/dL

**or**

C. 2-hour plasma glucose ≥ 200 mg/dL during an OGTT.

| TEST | | | |
|---|---|---|---|
| **Stage** | Fasting Plasma Glucose (FPG) (Preferred)* | Casual Plasma Glucose | Oral Glucose Tolerance Test (OGTT) |
| **Diabetes** | FPG ≥ 126 mg/dL (7.0 mmol/1)** | Casual Plasma Glucose ≥ 200 mg/dL (11.1mmo1/1 plus symptoms)*** | Two-hour Plasma Glucose 2hPG ≥ 200 mg/dL**** |
| **Impaired Glucose Homeostasis (Pre-Diabetes)** | Impaired Fasting Glucose (IFG) IFG = FPG 100-125 mg/dL | | Impaired Glucose Tolerance(IGT) = 2hPG 140-199 mg/dL |
| **Normal** | FPG < 100 mg/dL | | 2hPG < 140 mg/dL |

* The FPG is the preferred test for diagnosis in children and nonpregnant adults, but any one of the three listed is acceptable. In the absence of unequivocal hyperglycemia with acute metabolic decompensation, one of these three tests should be used on a different day to confirm diagnosis.

** Fasting is defined as no caloric intake for at least 8 hours.

*** Casual is any time of day without regard to time since last meal. Symptoms are polyuria, polydipsia, and unexplained weight loss.

**** OGTT should be performed using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water. The OGTT is not recommended for routine clinical use.

*Source:* Diabetes Care, Vol. 31, (Suppl 1), Jaunary 2008

# *Diabetes Management Goals of Therapy*

| GOALS FOR NON-PREGNANT DIABETIC PATIENTS | |
|---|---|
| **Blood Sugar Before Meals** | 70-130 mg/dL (normal: < 100 mg/dL)*<br>< 110 mg/dL** |
| **Blood Sugar 2 hrs. After Meals** | < 180 mg/dL* (peak)<br>< 140 mg/dL** |
| **Blood Sugar at Bedtime** | 110-150 mg/dL* (normal < 110 mg/dL) |
| **Blood Sugar at 3:30 a.m.** | goal = 100 mg/dL* |
| **Blood Sugar Before Exercising** | 100 mg/dL*<br>If < 100 mg/dL, snack before exercising (one carb [15 g] for every 30 minutes).<br>If type 1 diabetes with blood sugar > 250 mg/dL, caution against exercise, check ketones, drink water, and notify doctor (may need to increase insulin). |
| **A1c** | ≤ 6.5%**, *** |
| **Ketones** | Negative |
| **Blood Pressure** | ≤ 130/80 mmHg; if ≥ 1 g proteinuria, ≤ 125/75 mmHg |
| **Triglycerides** | < 150 mg/dL |
| **LDL-Cholesterol** | < 100 mg/dL |
| **HDL-Cholesterol** | ≥ 40 mg/dL |
| **Microalbuminuria** | < 30 mg/24 hour |
| **eGFR** | ≥ 60 ** |
| **Body Mass Index (BMI)** | < 25 (Overweight 25-29.9; Obesity ≥ 30) |

* American Diabetes Association: Clinical Practice Recommendations, 2008.

** American Association of Clinical Endocrinologists (AACE), Medical Guidelines for Clinical Practice for the Management of Diabetes Mellitus. Endocrine Practice, Vol. 13 (Suppl 1), May/June 2007

*** AACE (2007) and the Texas Diabetes Council (2009).

## Recommended Adult Immunization Schedule—United States - 2012

**Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.**

**Figure 1. Recommended adult immunization schedule, by vaccine and age group[1]**

| VACCINE ▼ AGE GROUP ► | 19-21 years | 22-26 years | 27-49 years | 50-59 years | 60-64 years | ≥ 65 years |
|---|---|---|---|---|---|---|
| Influenza [2] | 1 dose annually | | | | | |
| Tetanus, diphtheria, pertussis (Td/Tdap) [3,*] | Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs | | | | | Td/Tdap[3] |
| Varicella [4,*] | 2 Doses | | | | | |
| Human papillomavirus (HPV) Female [5,*] | 3 doses | | | | | |
| Human papillomavirus (HPV) Male [5,*] | 3 doses | | | | | |
| Zoster [6] | | | | | 1 dose | |
| Measles, mumps, rubella (MMR) [7,*] | 1 or 2 doses | | | 1 dose | | |
| Pneumococcal (polysaccharide) [8,9] | 1 or 2 doses | | | | | 1 dose |
| Meningococcal [10,*] | 1 or more doses | | | | | |
| Hepatitis A [11,*] | 2 doses | | | | | |
| Hepatitis B [12,*] | 3 doses | | | | | |

*Covered by the Vaccine Injury Compensation Program

- For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- Tdap recommended for ≥65 if contact with <12 month old child. Either Td or Tdap can be used if no infant contact
- No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

**Figure 2. Vaccines that might be indicated for adults based on medical and other indications[1]**

| VACCINE ▼ INDICATION ► | Pregnancy | Immunocompromising conditions (excluding human immunodeficiency virus [HIV])[4,6,7,14] | HIV infection[4,7,13,14] CD4+ T lymphocyte count: < 200 cells/μL | HIV infection[4,7,13,14] CD4+ T lymphocyte count: ≥ 200 cells/μL | Men who have sex with men (MSM) | Heart disease, chronic lung disease, chronic alcoholism | Asplenia[13] (including elective splenectomy and persistent complement component deficiencies) | Chronic liver disease | Diabetes, kidney failure, end-stage renal disease, receipt of hemodialysis | Health-care personnel |
|---|---|---|---|---|---|---|---|---|---|---|
| Influenza [2] | 1 dose TIV annually | | | | 1 dose TIV or LAIV annually | 1 dose TIV annually | | | | 1 dose TIV or LAIV annually |
| Tetanus, diphtheria, pertussis (Td/Tdap) [3,*] | Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs | | | | | | | | | |
| Varicella [4,*] | Contraindicated | | | 2 doses | | | | | | |
| Human papillomavirus (HPV) Female [5,*] | | 3 doses through age 26 yrs | | | | 3 doses through age 26 yrs | | | | |
| Human papillomavirus (HPV) Male [5,*] | | 3 doses through age 26 yrs | | | | 3 doses through age 21 yrs | | | | |
| Zoster [6] | Contraindicated | | | | 1 dose | | | | | |
| Measles, mumps, rubella (MMR) [7,*] | Contraindicated | | | 1 or 2 doses | | | | | | |
| Pneumococcal (polysaccharide) [8,9] | 1 or 2 doses | | | | | | | | | |
| Meningococcal [10,*] | 1 or more doses | | | | | | | | | |
| Hepatitis A [11,*] | 2 doses | | | | | | | | | |
| Hepatitis B [12,*] | 3 doses | | | | | | | | | |

*Covered by the Vaccine Injury Compensation Program

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

- For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- Contraindicated
- No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2012. For all vaccines being recommended on the Adult Immunization Schedule: a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/pubs/acip-list.htm). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

## Footnotes — Recommended Adult Immunization Schedule—United States - 2012

1. **Additional information**
   - Advisory Committee on Immunization Practices (ACIP) vaccine recommendations and additional information are available at: http://www.cdc.gov/vaccines/pubs/acip-list.htm.
   - Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) available at http://wwwnc.cdc.gov/travel/page/vaccinations.htm.
2. **Influenza vaccination**
   - Annual vaccination against influenza is recommended for all persons 6 months of age and older.
   - Persons 6 months of age and older, including pregnant women, can receive the trivalent inactivated vaccine (TIV).
   - Healthy, nonpregnant adults younger than age 50 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or TIV. Health-care personnel who care for severely immunocompromised persons (i.e., those who require care in a protected environment) should receive TIV rather than LAIV. Other persons should receive TIV.
   - The intramuscular or intradermal administered TIV are options for adults aged 18–64 years.
   - Adults aged 65 years and older can receive the standard dose TIV or the high-dose TIV (Fluzone High-Dose).
3. **Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination**
   - Administer a one-time dose of Tdap to adults younger than age 65 years who have not received Tdap previously or for whom vaccine status is unknown to replace one of the 10-year Td boosters.
   - Tdap is specifically recommended for the following persons:
     - pregnant women more than 20 weeks' gestation,
     - adults, regardless of age, who are close contacts of infants younger than age 12 months (e.g., parents, grandparents, or child care providers), and
     - health-care personnel.
   - Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-containing vaccine.
   - Pregnant women not vaccinated during pregnancy should receive Tdap immediately postpartum.
   - Adults 65 years and older may receive Tdap.
   - Adults with unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series. Tdap should be substituted for a single dose of Td in the vaccination series with Tdap preferred as the first dose.
   - For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second.
   - If incompletely vaccinated (i.e., less than 3 doses), administer remaining doses.

   Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (See footnote 1).
4. **Varicella vaccination**
   - All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
   - Special consideration for vaccination should be given to those who
     - have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or
     - are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
   - Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.
   - Evidence of immunity to varicella in adults includes any of the following:
     - documentation of 2 doses of varicella vaccine at least 4 weeks apart;
     - U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity);
     - history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or having an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link to a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease);
     - history of herpes zoster based on diagnosis or verification of herpes zoster by a health-care provider; or
     - laboratory evidence of immunity or laboratory confirmation of disease.
5. **Human papillomavirus (HPV) vaccination**
   - Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4).
   - For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at 11 or 12 years of age, and for those 13 through 26 years of age, if not previously vaccinated.
   - For males, HPV4 is recommended in a 3-dose series for routine vaccination at 11 or 12 years of age, and for those 13 through 21 years of age, if not previously vaccinated. Males 22 through 26 years of age may be vaccinated.
   - HPV vaccines are not live vaccines and can be administered to persons who are immunocompromised as a result of infection (including HIV infection), disease, or medications. Vaccine is recommended for immunocompromised persons through age 26 years who did not get any or all doses when they were younger. The immune response and vaccine efficacy might be less than that in immunocompetent persons.
   - Men who have sex with men (MSM) might especially benefit from vaccination to prevent condyloma and anal cancer. HPV4 is recommended for MSM through age 26 years who did not get any or all doses when they were younger.
   - Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, persons who are sexually active should still be vaccinated consistent with age-based recommendations. HPV vaccine can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test.
   - A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose (at least 24 weeks after the first dose).
   - Although HPV vaccination is not specifically recommended for health-care personnel (HCP) based on their occupation, HCP should receive the HPV vaccine if they are in the recommended age group.
6. **Zoster vaccination**
   - A single dose of zoster vaccine is recommended for adults 60 years of age and older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the Food and Drug Administration (FDA) for use among and can be administered to persons 50 years and older, ACIP recommends that vaccination begins at 60 years of age.
   - Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.
   - Although zoster vaccination is not specifically recommended for health-care personnel (HCP), HCP should receive the vaccine if they are in the recommended age group.
7. **Measles, mumps, rubella (MMR) vaccination**
   - Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, laboratory evidence of immunity to each of the three diseases, or documentation of provider-diagnosed measles or mumps disease. For rubella, documentation of provider-diagnosed disease is not considered acceptable evidence of immunity.

   Measles component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
     - are students in postsecondary educational institutions;
     - work in a health-care facility; or
     - plan to travel internationally.
   - Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type from 1963 to 1967 should be revaccinated with 2 doses of MMR vaccine.

   Mumps component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
     - are students in postsecondary educational institutions;
     - work in a health-care facility; or
     - plan to travel internationally.
   - Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health-care facility) should be considered for revaccination with 2 doses of MMR vaccine.

7. **Measles, mumps, rubella (MMR) vaccination (cont'd)**

   Rubella component:
   - For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

   Health-care personnel born before 1957:
   - For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider routinely vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.
8. **Pneumococcal polysaccharide (PPSV) vaccination**
   - Vaccinate all persons with the following indications:
     - age 65 years and older without a history of PPSV vaccination;
     - adults younger than 65 years with chronic lung disease (including chronic obstructive pulmonary disease, emphysema, and asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver disease (including cirrhosis); alcoholism; cochlear implants; cerebrospinal fluid leaks; immunocompromising conditions; and functional or anatomic asplenia (e.g., sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]);
     - residents of nursing homes or long-term care facilities; and
     - adults who smoke cigarettes.
   - Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after their diagnosis.
   - When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. Vaccination during chemotherapy or radiation therapy should be avoided.
   - Routine use of PPSV is not recommended for American Indians/Alaska Natives or other persons younger than 65 years of age unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives who are living in areas where the risk for invasive pneumococcal disease is increased.
9. **Revaccination with PPSV**
   - One-time revaccination 5 years after the first dose is recommended for persons 19 through 64 years of age with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions.
   - Persons who received PPSV before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose.
   - No further doses are needed for persons vaccinated with PPSV at or after age 65 years.
10. **Meningococcal vaccination**
    - Administer 2 doses of meningococcal conjugate vaccine quadrivalent (MCV4) at least 2 months apart to adults with functional asplenia or persistent complement component deficiencies.
    - HIV-infected persons who are vaccinated should also receive 2 doses.
    - Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of *Neisseria meningitidis*, military recruits, and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
    - First-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday.
    - MCV4 is preferred for adults with any of the preceding indications who are 55 years old and younger; meningococcal polysaccharide vaccine (MPSV4) is preferred for adults 56 years and older.
    - Revaccination with MCV4 every 5 years is recommended for adults previously vaccinated with MCV4 or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia or persistent complement component deficiencies).
11. **Hepatitis A vaccination**
    - Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
      - men who have sex with men and persons who use injection drugs;
      - persons working with HAV-infected primates or with HAV in a research laboratory setting;
      - persons with chronic liver disease and persons who receive clotting factor concentrates;
      - persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A; and
      - unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. (See footnote 1 for more information on travel recommendations). The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
    - Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30 followed by a booster dose at month 12.
12. **Hepatitis B vaccination**
    - Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
      - sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men;
      - health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids;
      - persons with diabetes younger than 60 years as soon as feasible after diagnosis; persons with diabetes who are 60 years or older at the discretion of the treating clinician based on increased need for assisted blood glucose monitoring in long-term care facilities, likelihood of acquiring hepatitis B infection, its complications or chronic sequelae, and likelihood of immune response to vaccination;
      - persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease;
      - household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
      - all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.
    - Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.
    - Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 $\mu$g/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 $\mu$g/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.
13. **Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used**
    - 1 dose of Hib vaccine should be considered for persons who have sickle cell disease, leukemia, or HIV infection, or who have anatomic or functional asplenia if they have not previously received Hib vaccine.
14. **Immunocompromising conditions**
    - Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and influenza [inactivated influenza vaccine]), and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at http://www.cdc.gov/vaccines/pubs/acip-list.htm.

# *Gestational Diabetes (GDM) Standards of Care 2006*

**Gestational Diabetes (GDM) defined** as "glucose intolerance with onset or first recognition during pregnancy."

## I. Who to Screen (Universal screening is suggested)

### 1. Those at High Risk for GDM

The following pregnant women are at high risk for developing GDM:

- Member of an ethnic group with a higher than normal rate of type 2 diabetes
- Glycosuria at the first prenatal visit
- Polycystic ovary syndrome
- A family history of diabetes, especially in first degree relatives
- Prepregnancy weight 110 percent of ideal body weight or significant weight gain in early adulthood
- Age greater than 25 years
- Previous delivery of a baby greater than 9 pounds (4.1 kg)
- Personal history of abnormal glucose tolerance
- Previous unexplained perinatal loss or birth of a malformed child
- Maternal birth weight greater than 9 pounds (4.1 kg) or less than 6 pounds (2.7 kg)
- Current use of glucocorticoids
- Personal birth weight of over 9 lbs

(Jovonovic, 2006, Parretti, et al., 2001, Bevier, et al., 1999, Scholl, et al., 2001, Laird & McFarland, 1996)

### 2. Those at Low Risk for GDM

Although, there is little agreement regarding who should be screened between American College of Obstetricians and Gynecologists (ACOG) and ADA, Jovonovic (2006) suggests universal screening since identifying pregnant women with hyperglycemia has proven to improve outcomes. Jovonovic and ACOG believe that universal screening is more practical and that selective screening is not sensitive enough.

ACOG and ADA suggested that screening may be omitted in low risk women. Such women must have all of the following characteristics:

- Age less than 25 years
- Normal weight before pregnancy

- Member of an ethnic group with a low prevalence of GDM (i.e., patient is NOT Hispanic, African, Native American, South or East Asian, Pacific Islander)
- No first degree relative with diabetes mellitus
- No history of abnormal glucose tolerance
- No history of poor obstetric outcome

(*Diabetes Care*, 2004; ACOG, 1994 & 2001).

## II. Guidelines for Screening

1. Screen pregnant women at first prenatal visit if undiagnosed type 2 diabetes is suspected and/or the following characterize the pregnant woman:
   - Marked obesity
   - Personal history of GDM [33 to 50 percent risk of recurrence, and some of these recurrences may represent unrecognized type 2 diabetes (ACOG, 2001)]
   - Glycosuria
   - Strong family history of diabetes
2. Screening is optimally performed at 24 to 28 weeks of gestation (Jovonovic & Peterson, 1985).
3. Further screening unnecessary in the following scenario that is diagnostic of diabetes if confirmed on a subsequent day:
   - Evaluation of any woman who has a random serum glucose value ≥ 200 (11.1 mmol/L)
   - Fasting serum glucose value ≥ 126 (7.0 mmol/L) is unnecessary, because these findings alone are diagnostic of diabetes, if confirmed on a subsequent day (Diabetes Care Suppl, 2004)

## III. Tests for Screening

Note: 50-g oral glucose challenge test is suggested with ≥ 130 as threshold for abnormal test

50-g oral glucose challenge test for screening (without regard to timing of last meal) is done, followed by serum glucose measurement one hour later:

**Abnormal Finding is as follows:**

- Value 130 to 140 (7.8 mmol/L). Jovonovic (2006) uses 130 as the threshold for outpatients. Avoid the use of capillary blood for testing.

**Sensitivity of values:**

- At the 130 threshold, the test is positive in 20 to 25 percent of pregnant women and detects 90 percent of gestational diabetics.
- At the 140 threshold, 14 to 18 percent of tests will screen positive and 80 percent of gestational diabetics will be detected (Brody, et al., 2003). ACOG and the ADA have stated that either threshold may be used.

- Women with an abnormal value are then given a 100-g, three hour oral glucose tolerance test (GTT).
- Universal screening using a threshold serum glucose concentration of 130 (7.2 mmol/L) had 100 percent sensitivity, but 25 percent of women screened required a GTT and the cost per case diagnosed was $249 (ACOG, 2004). Raising the serum glucose threshold value to 140 (7.8 mmol/L) dropped the sensitivity to 90 percent with 15 percent of women screened requiring a GTT. In this protocol, the cost per case diagnosed was $222.
- According to Jovonovic (2006) an A1c higher than 6.5 percent suggests diabetes, but A1c below this level should not be taken as evidence against the diagnosis of diabetes.

## IV. Diagnostic Testing for Women that Screen Positive

- A three hour oral GTT for definitive diagnosis is warranted
- In populations/patients at very high risk of GDM, obtaining a GTT without performing a prior screening test (glucose challenge test) may be cost-effective

GDM is present if two or more of the following serum glucose values are met or exceeded:

- Fasting serum glucose concentration ≥95 (5.3 mmol/L)
- One-hour serum glucose concentration ≥180 (10 mmol/L)
- Two-hour serum glucose concentration ≥155 (8.6 mmol/L)
- Three-hour serum glucose concentration ≥140 (7.8 mmol/L)
- Carbohydrate loading for three days has been recommended before the GTT, but is probably not necessary

(Fourth International Workshop-Conference on Gestational Diabetes)

The Fourth International Workshop-Conference on Gestational Diabetes GTT values cited above are based upon the Carpenter and Coustan modification of earlier values (Carpenter and Coustan, 1982).

They are lower than those proposed by the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus and the National Diabetes Data Group (NDDG), (*Diabetes Care*, Suppl, 2000). The values are lower because the thresholds derived from the older Somogyi-Nelson method of glucose analysis were corrected to account for the enzymatic assays currently in use. (See following table.)

| TWO DIAGNOSTIC CRITERIA | | |
|---|---|---|
| **Status** | **Plasma or Serum Glucose Level Carpenter/Coustan Conversion mg/dL/ mmol/L** | **Plasma Level National Diabetes Data Group Conversion/mmol/L** |
| Fasting | 95 mg/dL/ 5.3 mmol/L | 105 mg/dL/ 5.8 mmol/L |
| One Hour | 180 mg/dL/ 10 mmol/L | 190 mg/dL/ 10.6 mmol/L |
| Two Hours | 155 mg/dL/ 8.6 mmol/L | 165 mg/dL/ 9.2 mmol/L |

| | | |
|---|---|---|
| Three Hours | 140 mg/dL/ 7.8 mmol/L | 145 mg/dL/ 8.0 mmol/L |

Thus, application of the more stringent Fourth International Workshop criteria to all women with positive screening test results reduced the prevalence of infants weighing < 4000 grams from 17.1 to 16.9 percent, and the prevalence of infants weighing < 4500 grams from 3.0 to 2.9 percent.

ACOG considers use of either the Fourth International Workshop or the National Diabetes Data Group criteria acceptable for diagnosis of GDM. The ADA recommends use of the Fourth International Workshop-Conference on Gestational Diabetes criteria.

Treating women with one abnormal GTT value decreases the risk of a macrosomic infant and is cost-effective. These women often have insulin resistance along with fasting insulin levels similar to women with GDM.

There is not complete agreement on treatment of women with abnormal GTT.

- Some treat them as GDM would be treated if GDM criteria is met
- Some wait and consider further intervention following repeated oral GTT in four weeks

Jovonovic and others consider use of :

- Two-hour 75-g GTT often more cost-effective than the three-hour test
- The ADA and World Health Organization (WHO) have endorsed use of the two-hour 75-g oral GTT for diagnosis of GDM
- Criteria for diagnosis vary:
  - Some use test as a one step approach for both screening and diagnosis, no benefits drawn

Other tests that should be considered:

- GDM confirmed with abnormal GTT (ADA)
- Serum glucose concentration that is >140 (7.8 mmol/L) after the 50-g glucose challenge is associated with a 25 to 30 percent risk of a macrosomic infant if no treatment is offered (Jovonovic & Peterson, 1985)
- Fasting serum glucose concentration > 90 (5 mmol/L) at 24 to 28 weeks of gestation, and
- A1c value above normal, are highly sensitive and a specific predictor of subsequent infant macrosomia in the general obstetrical population (Schrader, et al., 1995). Hemoglobin values alone were not sufficiently sensitive to predict those women at risk of delivering a macrosomic infant.

The ADA will not re-address the criteria for screening and diagnosis until the results of the National Institutes of Health sponsored Hyperglycemia and Adverse Pregnancy (HAPO) Clinical Trial is complete in 2007.

# *Treatment of Gestational Diabetes*

## I. Medical Nutrition Therapy (MNT)

**MNT Recommended in the following situations:**

- Those who do not meet GDM criteria, but have fasting blood glucose > 90
- Abnormal glucose challenge test
- Or one abnormal value on the oral GTT

Goals are to:

- Contribute to fetal well-being
- Prevent ketosis
- Provide adequate weight gain
- Achieve normoglycemia

**Caloric Requirements Needed Based on Ideal Body Weight**

The suggested caloric intake is approximately:

- 30 kcal per kg current weight per day in pregnant women (BMI 22 to 27)
- 24 kcal per kg current weight per day in overweight pregnant women (BMI 27 to 29)
- 12 to 15 kcal per kg current weight per day for morbidly obese pregnant women (BMI >30)
- 40 kcal per kg current weight per day in pregnant women with a BMI less than 22

1. Carbohydrates
   - Approximately 35 to 40 percent of calories
2. Protein
   - Approximately 20 percent of calories
3. Fat
   - Approximately 40 percent of calories

According to Jovonovic (2006), 75 to 80 percent of women with GDM will achieve normoglycemia with the above suggested caloric distribution. Postprandial blood glucose concentrations are directly dependent upon the carbohydrate content of a meal. The postprandial glucose rise, therefore, can be blunted if the diet is carbohydrate restricted. Complex carbohydrates, such as those in starches and vegetables, are more nutrient dense and raise postprandial blood glucose concentrations less than simple sugars.

### Caloric Distribution

*Breakfast*

- Approximately 10% of total calories
- Carbohydrate limited, due to time of greatest insulin resistance

*Lunch*

- 30% of total calories

*Supper*

- 30% of total calories

*Snacks*

- Approximately 30% of calories are distributed as needed
- Leftover calories

## II. Monitoring

### Glucose Monitoring Guidelines

- Daily monitoring documented on a log:
  - Upon awakening
  - 1-hour post meals
  - The difference between measuring 1-hour versus 2-hours postprandially has not been established
  - Postprandial glucose control leads to improve outcomes (decreases incidence of large-for-gestational age, decreases risk for cesarean delivery)

Degree of fasting does not predict the need for insulin therapy (Jovonovic, 2006)

## III. A1c Measurements

- Utilized as feedback, evaluate merit of glucose monitoring
- A1c is lower in pregnancy (average, 20% lower)
- Rise in red cell mass in 1st trimester and decrease in red blood cell life span

## IV. Exercise

- ADA approves moderate exercise in individuals without medical or obstetrical contradictions to exercise

## V. Medication Regimen

Insulin Therapy is the only recommended medical therapy approved in the United States.

Oral anti-hyperglycemic agents are not endorsed by the ADA or ACOG and have not been approved by the United States Food and Drug Administration.

**A. Initiating Insulin Therapy**

Start insulin therapy when glucose concentrations reach the values below in order to prevent macrosomia, shoulder dystocia, and/or birth trauma, despite MNT:

| JOVONOVIC, 2006 | ACOG | ADA |
|---|---|---|
| Fasting blood glucose concentration ≥ 90 (5 mmol/L) | Fasting glucose concentration ≥ 95 (5.3 mmol/L) or | Fasting plasma glucose concentration > 105 (5.8 mmol/L) or |
| One-hour postprandial blood glucose concentration ≥ 120 (6.7 mmol/L) | One-hour postprandial glucose >130 to 140 (7.2 to 7.8 mmol/L) or | One-hour postprandial plasma glucose > 155 (8.6 mmol/L) or |
| The Texas Diabetes Council suggests following Jovonovic's guidelines;<br>Fasting hyperglycemia higher threshold (>105 [>5.8 mmol/L] versus ≥ 90-95 [ ≥ 5-5.3 mmol/L]) is associated with increased risk of macrosomia, and an increased risk of fetal death in the last trimester at times | Two-hour postprandial blood concentration ≥ 120 (6.7 mmol/L) | Two-hour postprandial plasma glucose > 130 (7.2 mmol/L) |

According to Jovonovic (2006), dosing varies according to degree of obesity, ethnic characteristics, and other demographic criteria. Specific guidelines are as follows:

- 50 to 90 units are typically utilized to achieve glucose control (type of insulin used is calculated based upon blood glucose values)
- If fasting glucose is high, it is recommended to add an intermediate-acting insulin, with an initial dose of 0.2 U/kg body weight (such as NPH insulin) before bedtime
- If postprandial blood glucose concentrations are high, regular insulin or insulin lispro before meals at a dose calculated to be 1.5 U per 10 grams carbohydrate in the breakfast meal and 1 U per 10 grams carbohydrate in the lunch and dinner meals is recommended
- If both preprandial and postprandial blood glucose concentrations are high or postprandial glucose levels can only be blunted if starvation ketosis occurs, then
- Initiate a four injection per day regimen:
    - Consider administering a total dose of 0.7 U/kg up to week 18
    - 0.8 U/kg for weeks 18 to 26
    - 0.9 U/kg for weeks 26 to 36
    - 1.0 U/kg for weeks 36 to term

    - In a morbidly obese woman, the initial doses of insulin may need to be increased to 1.5 to 2.0 units/kg to overcome the combined insulin resistance of pregnancy and obesity
- Insulin is typically divided into the following schedule:
  - 45 percent as NPH insulin (30 percent before breakfast and 15 percent before bedtime) and
  - 55 percent as preprandial regular insulin
    - 22 percent before breakfast
    - 16.5 percent before lunch
    - 16.5 percent before dinner
- Four-times daily regimen improves glycemic control and perinatal outcome better than a twice-daily regimen
- Dosing is based on frequent self monitoring
- Four or more glucose measurements each day are recommended
- Twin gestations have an approximate doubling of the insulin requirements

**Insulin Types**

- Human insulin should be prescribed since it is the least immunogenic of the commercially available insulin preparations
- Insulin analogs like Lispro, Aspart, Glulysine are comparable in immunogenicity to human Regular insulin
- Only Lispro and Aspart have been investigated in pregnancy; studies denote acceptable safety profiles, lower risk for postprandial hypoglycemia, minimal transfer across the placenta, no evidence of teratogenesis
- Long-acting insulin analogs (Glargine, Detemir) have not been studied extensively in pregnancy; therefore, the use of human NPH insulin as part of a multiple injection regimen in pregnant women is recommended
- Lente insulins have too much variability in effect and therefore are not recommended (Jovonovic, 2006)

**B. Treating Hypoglycemia** (Jovonovic, 2006)

Remote from meal or snack time Hypoglycemia should be treated by:

- Administering 10 to 20 g of carbohydrate immediately
- Consider use of correction factor of one unit of rapid-acting insulin lowers blood glucose by 25 mg/dL

| JOVONOVIC'S GUIDELINES | |
|---|---|
| **If glucose <50 mg/dL** | Subtract 2 units of regular insulin from the dose of insulin given before the meal |
| **For glucose 50 to 75 mg/dL** | Subtract one unit from the dose of insulin given before the meal |
| **For glucose 75 to 100 mg/dL** | It is not recommended to change insulin dose |
| **For glucose 100 to 125 mg/dL** | Add one unit regular insulin to the dose of insulin given before the meal |
| **For glucose 100 to 150 mg/dL** | Add two units regular insulin to the dose of insulin given before the meal. |

Jovonovic (2006) does not recommend the use of insulin pumps (expensive and do not clearly provide a benefit in the setting of GDM).

**C. Oral Anti-Hyperglycemic Agents**

- The ADA and ACOG do not endorse the use of oral anti-hyperglycemic agents during pregnancy
- Oral anti-hyperglycemic agents have not approved by the Unites States Food and Drug Administration (ACOG, 2001, ADA, Suppl, 2004)
  - Tolbutamide and chlorpropamide are not to be used for pregnancy; the agents are known to cross the placenta and can cause fetal hyperinsulinemia, which often leads to other complications such as neonatal hypoglycemia and macrosomia (Garcia-Bournissen, et al., 2003; Zucker & Simon, 1968)
  - Glyburide has minimal transplacental passage; some neonatal hypoglycemia (Elliot, Langer, et al., 1991); the Fifth ACOG International Workshop cautioned its use until there is more research
  - Metformin should not be used in GDM; currently, there are no randomized trials evaluating its use in GDM; a trial in Australia may be completed in 2007 and may elucidate the safety and efficacy of Metformin in GDM; its use in GDM is not recommended
  - Acarbose is not recommended for use at this time; some of the drug may be absorbed systemically
  - Thiazolidinediones, glinides, GLP-1 not recommended during pregnancy; they are considered experimental

## VI. Management During the Peripartum Period

- Hold insulin during labor and delivery
- Normal saline often achieves normoglycemia

- Avoid hyperglycemia during labor in order to prevent fetal hyperinsulinemia, neonatal hypoglycemia, hyperbilirubinemia, hypocalcemia, erythremia
- Keep maternal blood glucose concentration between 70 and 90 mg/dL

## VII. Measures After Delivery

- Blood glucose should be measured on the day after delivery to assess for hyperglycemia; use criteria for diabetes diagnosis for nonpregnant individuals
- A regular diet can be considered for the GDM woman postpartum
- Patient should assess blood glucose at home for a few weeks post discharge (especially those that were diagnosed early in their gestation or who necessitated insulin therapy); remind patient to report any high values

## VIII. Risk of Diabetes Postpartum

One third to two-thirds of women with GDM will have GDM in a subsequent pregnancy (Philipson & Super, 1989; Moses, 1996; Catalano, et al., 1991). They tend to be older, more parous, and have a greater increase in weight between their pregnancies than women without a recurrence. Higher infant birth weight in the index pregnancy and higher maternal prepregnancy weight have also been associated with recurrent GDM.

- Parity, habitus, large birth weight, and diabetes in a first-degree relative are less correlated with later diabetes.
- GDM is also a risk factor for the development of type 1 diabetes. Specific HLA alleles (DR3 or DR4) may predispose to the development of type 1 diabetes postpartum, as does the presence of islet-cell autoantibodies (Ferber, et al., 1999).
- Progestin-only (but not combined estrogen-progestin) oral contraceptives (OCs) have been associated with an increased risk of developing type 2 diabetes in women with recent GDM. In a study of Hispanic women with recent GDM who were breast feeding, the use of progestin-only OCs was associated with an increased risk of type 2 diabetes (Kjos, et al, 1998). Generalizability to other women is not yet clear.

## XI. GDM Follow-Up

All women with known diagnosis of GDM should undergo

- An oral glucose tolerance test using a two-hour 75 gram oral glucose tolerance test
  - 6-12 weeks after delivery or after cessation of breast feeding.
  - Women who have an abnormal oral glucose tolerance test are therefore noted as having impaired glucose tolerance or a diagnosis of diabetes mellitus, based on ADA diagnostic criteria.
  - Those with impaired glucose tolerance should be counseled about their subsequent risk for developing overt diabetes. (See algorithm for Prevention and Delay of Type 2 Diabetes in Children and Adults with Impaired Fasting Glucose (IFG) and/or Impaired Glucose Tolerance (IGT).

- Diabetes Education should be ordered to include meal planning to achieve ideal body weight along with other appropriate therapies as indicated on TDC algorithms for diabetes management.
- Education should include advice regarding contraception and future pregnancy plans.
- Education should include the risk towards the development of GDM in subsequent pregnancies as well as their risk for the development of type 2 diabetes in the future.
- Blood glucose measurement should be done at least at three year intervals; with hyperglycemia, more frequent testing is warranted.

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# *Pregestational Diabetes Guidelines*

Pregestational diabetes encompasses a diagnosis of type 1 or type 2 diabetes prior to gestation. It should be noted that undiagnosed pregestational diabetes is suspected in the presence of maternal hyperglycemia and fetal anomalies. The risk of fetal anomalies is therefore increased when fasting hyperglycemia is found at GDM diagnosis (Jovonovic, 2006; Sheffield, et al., 2002).

Suspect type 1 diabetes with the presence of the following (Jovonovic, 2006):

- Serum anti-insulin antibodies and anti-islet cell antibodies may be helpful for identifying type 1 diabetes in pregnant women
- GDM in lean women
- Diabetic ketoacidosis during pregnancy
- Severe hyperglycemia during pregnancy requiring large doses of insulin
- Postpartum hyperglycemia
- Type 2 diabetes and monogenic diabetes (e.g., maturity onset diabetes of the young and permanent neonatal diabetes) is difficult to distinguish from GDM
  - These pregnant women tend to be lean (while obesity is a risk factor for type 2 diabetes)
  - Should be followed for glucose status to evaluate for other disorders

Women should be directed to (Jovonovic, 2006):

- Continue self blood glucose monitoring postpartum to document persistent hyperglycemia
- Consider fasting blood glucose testing every 6 to 12 months for the next 5 to 10 years if their blood glucose is normal during this period

| **Pregestational Diabetes General Guidelines** | Based on American College of Obstetricians & Gynecologists, 2006 | |
|---|---|---|
| **Recommendations Based on Limited or Inconsistent Scientific Evidence** | Level B | |
| **Patient Visits** | Q 1-2 weeks during 1st two trimesters; weekly after 28-30 weeks of gestation | |

| | | |
|---|---|---|
| **Caloric Requirements** | 1. Nutrition consult warranted<br>2. 300 kcal higher than basal in patients with singleton fetus | Carbohydrate counting increase dietary flexibility to avoid excessive weight gain |
| | Normal Weight | 30-35 kcal/kg/d |
| | < 90% desirable body weight | Increase to 30-40 kcal/kg/d |
| | > 120% of desirable body weight | Decrease calories to 24 kcal/kg/d |
| **Caloric Composition** | Complex, high-fiber carbohydrates | 40-55% |
| | Protein | 20% |
| | Unsaturated fats | 30-40% |
| **Caloric Distribution** | 1. 10-20% – Breakfast<br>2. 20-30% – Lunch<br>3. 30-40% – Supper<br>4. 30% – Snacks, prevent nocturnal hypoglycemia | Artificial sweeteners safe; patient log of food intake for several days/week to adjust insulin, exercise and correlate to glucose values |
| **Insulin Therapy Needs** | | |
| | First trimester | 0.7-0.8 u/kg/d |
| | Second trimester | 0.8-1 u/kg/d |
| | Third trimester | 0.9-1.2 u/kg/d |
| **Maintain Glucose at Near Normal Levels** | 1. Fasting < 95 mg/dL or less<br>2. Premeal < 100 mg/dL or less<br>3. 1-hour postprandial < 140 or less<br>4. 2-hour postprandial < 120 mg/dL or less<br>5. HS, not to decrease < 60 mg/dL<br>6. Average maintained @ 100 mg/dL<br>7. A1c no higher than 6% | |
| **Induction of Labor** | Note recommended for suspected fetal macrosomia | Induction does not improve fetal outcomes |

| | | |
|---|---|---|
| **Monitoring** | Antepartum fetal monitoring, nonstress test, biophysical profile, contraction stress test, fetal movement counting | Valuable testing |
| **Maintain Glucose Control Near Physiologic Levels Before, During Pregnancy** | Decreases spontaneous abortion, fetal malformation, fetal macrosomia, intrauterine fetal death, neonatal morbidity | |
| **Counseling** | Teach hypoglycemia & preconceptional counseling to patient and families | Cost effective, beneficial |
| **Cesarean Delivery** | For estimated fetal weight > 4500 g | To prevent traumatic injury |
| **Insulin Therapy During Labor & Delivery** | Prior to active labor | 1. Hold AM Insulin<br>2. Start NS IV<br>3. Usual dose of intermediate-acting insulin at HS |
| | With active labor or blood glucose < 70 mg/dl | 1. IV to D5% @ 100-150 cc/h (2.5 mg/kg/min) to keep glucose at 100 mg/dL<br>2. Check glucose hourly to adjust insulin or infusion rate<br>3. Short acting IV insulin at 1.25 u/h if glucose > 100 mg/dL |
| **DKA during Pregnancy** | Laboratory assessment<br>Document acidosis | ABGs, glucose, ketones, electrolytes at 1-2 hour intervals |

| | | |
|---|---|---|
| | Insulin therapy | Low-dose IV @ 0.2-0.4 u/kg, loading dose;<br>2-10 u/h, maintenance |
| | Fluid therapy | 1. NS, 1 L in 1st hr<br>2. 500-1,000 ml/h for 2-4 hrs<br>3. 250 ml/h until 80% replaced<br>4. 4-6 L, total replacement in 12 hrs |
| | Glucose | Start D5% NS when glucose reaches 250 mg/dL |
| | Potassium | If normal or reduced, start infusion @ 15-20meq/h;<br>If elevated, wait until normal levels, then add in IV in concentration of 20-30 meq/l |
| | Bicarbonate | 44 mEq (one ampule) to L of .45NS if pH < 7.1 |

# *Self Monitoring Blood Glucose (SMBG)*

Since diabetes is primarily a disease controlled by the patient, it is extremely important for the patient to monitor their diabetes on a day-to-day basis. The frequency of self monitoring blood glucose (SMBG) depends on the type of diabetes and the level of blood glucose control desired. One of the main purposes of blood glucose measurements is to assist in making adjustments in treatment, through either dietary intake, medications, activity levels or a combination of all 3 factors.

## FREQUENCY OF TESTING

### Type 1

- Ideally, test before and after meals and at bedtime.
- For those patients on bedtime insulin, checking a 3:00 a.m. blood glucose is necessary at least 1x/week. If the patient is awakened during the night with signs and symptoms of hypoglycemia, if the fasting glucose continues to rise with increasing bedtime insulin or if the patient complains of restless sleep, a glucose check at 3:00 a.m. is required to better determine correct insulin dosage.
- Once stable, patients should alternate times to SMBG throughout the day.
- Test before, during, and after vigorous activity to avoid hypoglycemia.
- Increased testing is indicated if the patient has hypoglycemic or hyperglycemic symptoms and during periods of illness, injury, or stress.

### Type 2

Recommended for those on insulin or oral medications and during periods of stress, such as infection or trauma.

- Depending on degree of control desired, test glucose before breakfast and before supper.
- Some patients may require testing before each meal and at bedtime.
- For those patients on bedtime insulin, checking blood sugar at 3:00 a.m. is necessary at least 1x/week. If the patient is awakened during the night with signs and symptoms of hypoglycemia, if the fasting glucose continues to rise with increasing bedtime insulin, or if the patient complains of restless sleep or awakening with a headache, a glucose check at 3:00 a.m. is required to better determine the correct insulin dosage.
- More frequent blood glucose measurements are indicated when changes are made in medication or insulin.
- If blood glucose levels are stable, test before breakfast and before supper, 2-3x/week.

Use of SMBG for those who are being treated only with a healthy eating plan is controversial. Many patients may benefit by measuring their responses to different foods and activities. The immediate feedback of SMBG can assist patients with making appropriate dietary modifications to improve future glucose results. They will want to SMBG more frequently during periods of stress or illness.

## Glycemic Control Goals (nonpregnant adults)

| TIME OF DAY | NORMAL VALUES NON-DIABETIC | ADA* GOALS | AACE** GOALS | ACTION SUGGESTED IF: |
|---|---|---|---|---|
| **Fasting** | < 100 mg/dL | 90 – 130 mg/dL | < 110 mg/dL | < 80 or > 140 mg/dL |
| **Preprandial (Before meals and snacks)** | < 110 mg/dL | 70 – 130 mg/dL | < 110 mg/dL | < 80 or > 140 mg/dL |
| **After meals** | 70-140 mg/dL | < 180 mg/dL (peak)* | < 140 mg/dL (2 hrs. after meal) | Determined by clinician |
| **Bedtime** | < 110 mg/dL | 110-150 mg/dL | unavailable | < 110 or > 160 mg/dL |
| **A1c (also called glycosylated hemoglobin A1c, HbA1c or glycohemoglobin A1c)** | < 6% | < 7% (a) or as close to normal (<6%) without significant hypoglycemia (b) | ≤ 6.5%*** | > 7% |

* Diabetes Care. Vol. 31, (Suppl 1), January 2008

** American Association of Clinical Endocrinologists (AACE), Medical Guidelines for the Management of Diabetes Mellitus: The AACE System of Intensive Diabetes Self-Management – Vol. 13 (Suppl 1), May/June 2007.

*** AACE (2002) and the Texas Diabetes Council (2009).

a. For patients in general with diabetes b. For the individual with diabetes

• **See Glycemic Control Algorithm:**
Glycemic Control for Type 2 Diabetes Mellitus (adults only)

**A ten-year study showed that patients with type 1 who kept their blood glucose near these levels developed significantly fewer diabetes-related complications. Even if blood glucose levels were not in the desirable range, any lowering of blood glucose reduced the chances of developing complications.**

In the following groups of people, glycemic control goals may be more relaxed

- In the elderly, infants and toddlers;
- In patients with hypoglycemic unawareness;

- In patients with advanced renal or cardiac disease;
- In patients experiencing difficulties with following their treatment plan.

To avoid symptoms of hyperglycemia in these groups, keeping blood glucose under 150 mg/dL is recommended.

## Special considerations in SMBG

1. It is often helpful for patients to document their glucose results in a written log. This activity can assist patients in seeing glucose patterns during certain times of the day. It can also be helpful in making correlations between medications, dietary intake, activity and resulting glucose levels.
2. If available, patients can benefit from utilizing computer-downloading features of the meters. The glucose data can be grouped based on time of day, day of the week, weekends vs. weekdays, as well as providing markers of meals, activity and medication times. These computer programs are available for health care professionals' use in the office as well as being available to the patients to use at home.
3. Assess your patient's level of competence and select a glucose meter that best meets their needs. Not all patients will benefit from added features and the "extras" may just confuse the patient more.
4. Instruct the patient on the proper use of their particular glucose meter. Encourage the patient to read the instruction manual and know how to set the correct date and time, how to recall data, how to change the battery and how to trouble-shoot the meter for problems. Be sure the patient is aware that some meters may read the glucose results in mmol rather than mg/dL.
5. Instruct patients to check the expiration date and the proper means of storage and handling for their glucose monitoring strips
6. Instruct patients on interpreting the glucose results. It is not enough to just monitor the glucose. The patient needs to understand the correlation between the food they eat, the medications they take, their activity level and the resulting glucose level. The patient must be provided with guidelines on adjusting their insulin dosages for optimal glucose control.

## Pregnancy in Preexisting Diabetes — Type 1 and Type 2

- Tight blood glucose control before conception and throughout pregnancy is critical for optimal outcomes.
- Testing before each meal, 1-2 hours after meals and at bedtime every day and 1-2x/week at 3:00 a.m. are optimal.
- Insulin treatment is recommended if the fasting glucose >105 mg/dL and/or 2 hour postprandial levels are >120 mg/dL

## Gestational Diabetes

- A controversy exists regarding the best times to monitor. Fasting and 2-hour post-meal blood glucose testing are most commonly used. Studies have shown that fasting and 1 hour after meal testing resulted in improved glycemic control.
- Insulin treatment is recommended if fasting glucose >105 mg/dL and/or 2-hour postprandial levels are >120 mg/dL

## Monitoring in the hospital setting

Managing hospitalized patients with diabetes should include capillary blood glucose measurements at the bedside. This should be part of the patients' "vital signs." Results can be obtained rapidly, and therapeutic decisions can be made that result in improved management and shortened hospital stays. Using capillary blood glucose tests instead of venipunctures enhances the patients' comfort and provides an opportunity for the patient to learn SMBG. Adequately trained personnel must perform bedside glucose tests. According to the American Diabetes Association in 2003, the "use of bedside blood glucose monitoring requires 1) clear administrative responsibility for the procedure, 2) a well-defined policy/procedure manual, 3) a training program for those personnel doing the testing, 4) quality control procedures, and 5) regularly scheduled equipment maintenance." Frequency of measurement should be individualized based on each patient's condition and health care provider recommendation.

Glucose monitoring systems cannot and should not replace laboratory glucose determinations, but they can greatly reduce their frequency and supplement expensive laboratory data.

## A1c and self-monitoring of blood glucose (SMBG)

Another means of managing diabetes is with a hemoglobin A1c test, or often simply called an A1c. This test reflects the glucose (or blood sugar) control over the past 3 months. Testing the A1c level every 3 months is a good way to understand how well glucose levels are controlled over a long period and can help understand how SMBG frequency, timing, meal plans, and medications may need to be changed or adjusted.

## Reasons to check blood glucose more frequently

- When diabetes medicine changes
- When initiating other kinds of medicines
- When making dietary changes
- When exercise routine or activity level changes
- When level of stress increases
- When the patient is sick. When ill, even without eating, glucose levels may run high, so testing is important!

## Other reasons to check blood glucose

- When symptoms of hypoglycemia occur, which include dizziness, shaking, sweating, chills, and confusion
- When symptoms of hyperglycemia occur, which include sleepiness, blurred vision, frequent urination, and excessive thirst
- To learn how meals, physical activity, and medicine affect blood glucose levels
- To document how well blood glucose is controlled
- When patients have a job in which poor control could cause safety problems
- To help a patient decide if it is safe to drive or perform other tasks that require concentration if taking insulin or have had hypoglycemia in the past

Sacks DB, Bruns DE, Goldstein DE, MacLaren NK, McDonald JM, Parrott M: Guidelines and recommendations for laboratory analysis in the diagnosis and management of diabetes mellitus. *Diabetes Care* 25:750-786, 2002

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# *Hypoglycemia*

## BLOOD GLUCOSE LESS THAN 70 MG/DL

| | | |
|---|---|---|
| **Onset:** | Sudden | |
| **Symptoms:** | Shaky | Hungry |
| | Tired/sleepy | Headache |
| | Grouchy/irritable | Poor concentration |
| | Rapid heart beat | Numbness or tingling around mouth or tongue |
| | Sweaty | |
| **Causes:** | Delayed or missed meal | |
| | Too much exercise | |
| | Too much insulin/diabetes pill | |
| **Treatment:** | Eat a food containing 15 gm fast-acting carbohydrate (sugar) — | |
| | 1/2 c. juice or regular soda | 6-7 hard candies (not sugar free) |
| | 5 sugar cubes | 3 glucose tablets (5 grams glucose each) |
| | 1 small box of raisins | 8 oz. skim milk |

Patients should always carry quick-acting carbohydrate (sugar). If they get symptoms, they should eat one of the foods listed above. They should feel better in 15 minutes. Recheck blood sugar. May repeat if needed. If the next meal is more than one hour away, most can eat one of the following: 1 peanut butter sandwich, cheese and crackers, or drink 1 cup skim milk.

If patient is unable to eat/drink but still conscious, a helper can quickly apply glucose gel or cake frosting to the gums and massage.

**DO NOT GIVE FLUIDS IF UNCONSCIOUS/UNABLE TO SWALLOW.** If unable to swallow, a family member/friend must inject 1 vial of glucagon subcutaneously. Instruct patient to notify their health care provider if they have three episodes of hypoglycemia within a one-week period or if one episode results in loss of consciousness.

**PREVENTION:** Follow meal plan, don't skip
Take medication as prescribed
Monitor blood sugar regularly

# *Hyperglycemia*

## BLOOD GLUCOSE MORE THAN 240 MG/DL

| | | |
|---|---|---|
| **Onset:** | Can develop slowly, getting a little higher each day.<br>Can develop quickly after a big meal or illness. | |
| **Symptoms:** | Thirstier than usual<br>Urinary frequency<br>Blurred vision<br>Cuts/sores that heal slowly | Hungrier than usual<br>More tired/sleepier than usual<br>Dry, itchy skin |
| **Causes:** | Too much food<br>Too little/no exercise | Not enough insulin/diabetes pill<br>Infection/stress/illness |
| **Treatment:** | Take diabetes medication<br>Identify possible causes | Drink more water<br>Walk or mild physical activity unless glucose > 300 mg/dL or as health care provider advised |

If blood sugar suddenly goes over 200 mg/dL, continue with treatment plan. Check sugars frequently to assure they are returning to normal level. Encourage more sugar-free fluids; for example, 8 oz. of water per hour. Notify health care provider if blood sugars are averaging over 200 mg/dL for a week or more.

**PREVENTION:**

- Follow meal plan
- Monitor blood sugar regularly
- Regular exercise as advised by health care provider
- Take medications as prescribed.

# *Vibrio vulnificus*

## What is *Vibrio vulnificus*?

Vibrio vulnificus is a bacterium in the same family as those that cause cholera. It normally lives in warm seawater and is part of a group of vibrios that are called "halophilic" because they require salt.

## What type of illness does *V. vulnificus* cause?

*V. vulnificus* can cause disease in those who eat contaminated seafood or have an open wound that is exposed to seawater. Among healthy people, ingestion of *V. vulnificus* can cause vomiting, diarrhea, and abdominal pain. In immunocompromised persons, particularly those with chronic liver disease, *V. vulnificus* can infect the bloodstream, causing a severe and life-threatening illness characterized by fever and chills, decreased blood pressure (septic shock), and blistering skin lesions. *V. vulnificus* bloodstream infections are fatal about 50% of the time.

*V. vulnificus* can also cause an infection of the skin when open wounds are exposed to warm seawater; these infections may lead to skin breakdown and ulceration. Persons who are immunocompromised are at higher risk for invasion of the organism into the bloodstream and potentially fatal complications.

## How common is *V. vulnificus* infection?

*V. vulnificus* is a rare cause of disease, but it is also underreported. Between 1988 and 1995, CDC received reports of over 300 *V. vulnificus* infections from the Gulf Coast states, where the majority of cases occur. There is no national surveillance system for *V. vulnificus*, but CDC collaborates with the states of Alabama, Florida, Louisiana, Texas, and Mississippi to monitor the number of cases of *V. vulnificus* infection in the Gulf Coast region.

## How do persons get infected with *V. vulnificus*?

Persons who are immunocompromised, especially those with chronic liver disease, are at risk for *V. vulnificus* when they eat raw seafood, particularly oysters. A recent study showed that people with these pre-existing medical conditions were 80 times more likely to develop *V. vulnificus* bloodstream infections than were healthy people. The bacterium is frequently isolated from oysters and other shellfish in warm coastal waters during the summer months. Since it is naturally found in warm marine waters, people with open wounds can be exposed to *V. vulnificus* through direct contact with seawater. There is no evidence for person-to-person transmission of *V. vulnificus*.

## How can *V. vulnificus* infection be diagnosed?

*V. vulnificus* infection is diagnosed by routine stool, wound, or blood cultures; the laboratory should be notified when this infection is suspected by the physician, since a special growth medium can be used to increase the diagnostic yield. Doctors should have a high suspicion for this organism when patients present with gastrointestinal illness, fever, or shock following the ingestion of raw seafood, especially oysters, or with a wound infection after exposure to seawater.

## How is *V. vulnificus* infection treated?

If *V. vulnificus* is suspected, treatment should be initiated immediately because antibiotics improve survival. Aggressive attention should be given to the wound site; amputation of the infected limb is sometimes necessary. Clinical trials for the management of *V. vulnificus* infection have not been conducted. The antibiotic recommendations below come from documents published by infectious disease experts; they are based on case reports and animal models.

- Culture of wound or hemorrhagic bullae is recommended, and all *V. vulnificus* isolates should be forwarded to a public health laboratory
- Blood cultures are recommended if the patient is febrile, has hemorrhagic bullae, or has any signs of sepsis

**Antibiotic therapy:**

- Doxycycline (100 mg p.o./IV twice a day for 7-14 days) and a third-generation cephalosporin (e.g., ceftazidime 1-2 g IV/IM every eight hours) is generally recommended
- A single agent regimen with a fluoroquinolone such as levofloxacin, ciprofloxacin or gatifloxacin, has been reported to be at least as effective in an animal model as combination drug regimens with doxycycline and a cephalosporin
- Children, in whom doxycycline and fluoroquinolones are contraindicated, can be treated with trimethoprim-sulfamethoxazole plus an aminoglycoside
- Necrotic tissue should be debrided; severe cases may require fasciotomy or limb amputation

## Are there long-term consequences of *V. vulnificus* infection?

*V. vulnificus* infection is an acute illness, and those who recover should not expect any long-term consequences.

## What can be done to improve the safety of oysters?

Although oysters can be harvested legally only from waters free from fecal contamination, even legally harvested oysters can be contaminated with *V. vulnificus* because the bacterium is naturally present in marine environments. *V. vulnificus* does not alter the appearance, taste, or odor of oysters. Timely, voluntary reporting of *V. vulnificus* infections to CDC and to regional offices of the Food and Drug Administration (FDA) will help collaborative efforts to improve investigation of these infections. Regional FDA specialists with expert knowledge about shellfish assist state officials with tracebacks of shellfish and, when notified rapidly about cases, are able to sample harvest waters to discover possible sources of infection and to close oyster beds when problems are identified. Ongoing research may help us to predict environmental or other factors that increase the chance that oysters carry pathogens.

## How can I learn more about *V. vulnificus*?

You can discuss your medical concerns with your doctor or other health care provider. Your local city

or county health department can provide information about this and other public health problems that are occurring in your area. Information about the potential dangers of raw oyster consumption is available 24 hours a day from the FDA's Seafood Hotline (telephone 1-800-332-4010); FDA public affairs specialists are available at this number between 12 and 4 p.m. Monday through Friday. Information is also available on the internet at: **http://vm.cfsan.fda.gov.**

Some tips for preventing *V. vulnificus* infections, particularly among immunocompromised patients, including those with underlying liver disease:

- Do not eat raw oysters or other raw shellfish.
- Cook shellfish (oysters, clams, mussels) thoroughly:
  - For shellfish in the shell, either a) boil until the shells open and continue boiling for 5 more minutes, or b) steam until the shells open and then continue cooking for 9 more minutes. Do not eat those shellfish that do not open during cooking. Boil shucked oysters at least 3 minutes, or fry them in oil at least 10 minutes at 375°F.
- Avoid cross-contamination of cooked seafood and other foods with raw seafood and juices from raw seafood.
- Eat shellfish promptly after cooking and refrigerate leftovers.
- Avoid exposure of open wounds or broken skin to warm salt or brackish water, or to raw shellfish harvested from such waters.
- Wear protective clothing (e.g., gloves) when handling raw shellfish.

Date: October 25, 2005
*Content source:* National Center for Infectious Diseases/Division of Bacterial and Mycotic Diseases

# *Chronic Complications of Diabetes*

High levels of sugar (glucose) in the blood vessels over time lead to a variety of medical problems because too much sugar damages the lining of large and tiny blood vessels and other body tissues. Fortunately, early diagnosis and daily blood sugar control are possible with good nutrition, daily physical activity, weight control, taking prescribed medication and self-testing of blood sugar. Daily diabetes care means living a healthy lifestyle, often one that benefits the whole family.

## Heart disease

- Heart disease is the most common reason that adults with diabetes die at an earlier age. Adults with diabetes are two to four times more likely to die from heart disease than people without diabetes.

## Stroke

- The risk for stroke is also 2 to 4 times higher among people with diabetes. Having high blood pressure — higher than 130/80 mm Hg — or high blood fats (lipids) further increases the chances for persons with diabetes to have heart disease and/or stroke.


- **See Cardiovascular Risk Reduction Algorithm:** Hypertension for Diabetes in Adults
- **See Cardiovascular Risk Reduction Algorithm:** Lipid Treatment for Type 1 and Type 2 Diabetes in Adults
- **See Cardiovascular Risk Reduction Algorithm:** Macrovascular Risk Reduction: Antiplatelet Therapy


## Blindness

- Diabetes is the leading cause of blindness among adults because high sugar levels damage tiny blood vessels in the retina at the back of the eye.

## Kidney disease

- Diabetes is the leading cause of end stage renal disease (ESRD) in the United States also because high sugar levels damage tiny blood vessels in the kidneys. Many people then require dialysis or kidney transplantation.

## Neuropahy

- About 60% to 70% of people with diabetes have mild to severe forms of nervous system damage. The results of such damage include loss of usual sensation or feeling pain in the feet

or hands, slowed digestion of food in the stomach, carpal tunnel syndrome, sexual impotence, and other nerve problems.

- Severe forms of diabetic nerve disease increase the risk of lower-limb (toe, foot, or leg) amputations.

## Amputations

- More than half of nontraumatic lower-limb amputations in the United States occur among people with diabetes.
- Preventing amputations takes good blood sugar control, protective footwear (not walking around barefoot), daily inspections at home for cuts that a person might not feel, proper nail trimming, foot checks at every doctor visit, and a foot exam for sensation at least yearly.


- **See Foot Care Recommendations:** Foot Screening Mapping Examples
- **See Foot Care Recommendations:** Diabetic Foot Screen
- **See Foot Care Recommendations:** Diabetic Foot Exam
- **See Foot Care Recommendations:** Diabetic Foot Care/Referral
- **See Foot Care Algorithm:** High Risk Scenario & Ulcer Management
- **See Pain Management Recommendations:** Recommendations for Treatment of Painful Peripheral Diabetic Neuropathy


## Dental disease

- Periodontal or gum diseases are more common among people with diabetes than among people without diabetes.
- Almost one third of people with diabetes have severe gum diseases in which the teeth get too loose.

## Complications of pregnancy

- Poorly controlled diabetes before and during the first trimester of pregnancy can cause major birth defects in 5% to 10% of pregnancies and miscarriage in 15% to 20% of pregnancies.
- Poorly controlled diabetes during the second and third trimesters of pregnancy can result in excessively large babies, posing a risk to the mother and the child.

## Other complications

- Uncontrolled diabetes often leads to imbalances that can threaten life, such as diabetic ketoacidosis and nonketotic coma.

- People with diabetes are more susceptible to infectious illnesses and, if they have these illnesses, are more seriously ill or die than people without diabetes. For example, they are more likely to be seriously ill with pneumonia or influenza than people who do not have diabetes.

## Targets for Preventing Chronic Complications

- Monitor blood glucose.
- Control blood sugar (glucose) to near normal levels: blood sugars usually range from 70 to 100/110 mg/dL.
- Fill prescriptions and take medicines as prescribed; patient should tell doctor, pharmacist, or nurse about any problems related to getting or taking all the medicines.
- Get to and stay at a good body weight for height and build; a health care provider can measure body mass index (BMI) and help set an appropriate goal.
- Control blood pressure: goal is ≤ 130/80 mmHg.
- Control blood fats (lipids/cholesterol and triglycerides).
- Daily physical activity: 30 minutes a day of moderate to vigorous activity.
- Daily balanced eating habits; limit high fat foods.

# *Educating the Person with Diabetes*

## PRINCIPLES OF ADULT EDUCATION

**Adults:**

1. Are motivated to learn when they identify a need to learn or when social or professional pressures require new learning.
2. Are more likely to learn when content is organized in attractive learning packages.
3. Are self-directed and like to determine their specific learning experiences.
4. Enjoy small group interactions.
5. Draw their knowledge from years of experience and do not change readily.
6. Learn from others' experiences as well as from their own.
7. Want practical answers to current problems and enjoy problem solving.
8. Like physical comfort and a relaxing atmosphere.
9. Like tangible rewards.
10. Hate to have their time wasted.

## STEPS TO AID RECALL

1. Present instructions in a clear, simple manner.
2. Make advice detailed and specific.
3. Repeat and stress areas of particular importance.
4. Break instructions down into categories.
5. Check for understanding by asking person to repeat instructions and/or return demonstrations.
6. Utilize a variety of teaching methods such as diagrams, models, videos, etc., to reinforce verbal instructions.
7. Positively reinforce accurate recall of information.

## STRATEGIES TO INCREASE ADHERENCE

1. Involve person in establishing treatment goals.
2. Keep it simple.
3. Tailor treatment to fit the person's lifestyle.
4. Utilize reminders.
5. Seek and encourage family support.
6. Inform individual of desirable and undesirable effects of medications or treatments; let them know what to expect.
7. Monitor adherence.
8. Give feedback.

## THE THREE DOMAINS OF LEARNING

1. **Cognitive** — learning that requires thinking
2. **Affective** — learning that requires a change in beliefs
3. **Psychomotor** — learning of skills and performance

## THE EDUCATIONAL PROCESS

### I. Assess

A. Prior education and health beliefs
B. Current routine and skills
   1. Medication(s)
   2. Monitoring
   3. Meal plan
   4. Exercise/activity level
C. Physical limitations
   1. Altered vision
   2. Hearing loss
   3. Arthritis/tremors
   4. Memory deficits
   5. Concurrent illnesses
D. Literacy and cognitive ability
E. Psychosocial
   1. Support system
   2. Financial and transportation limitations
   3. Emotional status

### II. Develop plan

A. Goals and objectives
B. Topics and content
C. Activities
D. Documentation
E. References

### III. Implement plan

A. Keep in mind strategies that facilitate learning

### IV. Evaluate

A. Continued follow-up
B. Referral to other agencies or health care providers

# *Teaching Strategies for Diverse Populations*

An individualized education plan should be designed for every patient. The education plan should include basic skills and daily self-management practices.

**Basic skills include:**
Safe practices of medication administration
Meal planning
Hypoglycemia management
Self-blood glucose monitoring

**Daily self-management practices include:** Prevention and management of complications

Diabetes education is critical for proper disease management, but barriers to care often pose major obstacles towards achieving the implementation phase of AADE's Standards of Care. Communication barriers, financial/legal problems, and cultural barriers are known to hinder medical care.

Minimizing the language barrier would expedite the teaching-learning process. The following suggestions can be used by health care providers whose cultural background is different from the patient's.

1. Learn a few words, sentences or phrases in your target group's language to start a positive working relationship.
2. Use appropriate terms when addressing or referring to diverse groups (i.e., Hispanic/Latinos, Puerto Ricans, Mexicans, Cubans, instead of minorities).
3. Demonstrate respect, tolerance, and acceptance of different ideas.
4. Judge the merits of behavior rather than letting tone of voice, communication style or accent influence your behavior.
5. Ask questions. "If you don't ask, you won't know."
6. Observe; be aware of body language.
7. Establish relationships with several cultural groups to facilitate better understanding of the groups' values, beliefs, and communication style.
8. Be patient. Don't give up easily.
9. Develop culturally appropriate educational activities.
10. Identify appropriate communication channels for each ethnic group, i.e., church leaders or family.
11. Translate educational material appropriate for the ethnic group or subgroup. Spanish material may not be appropriate for various Hispanic cultures.
12. Identify culturally appropriate communication themes. Identify an adult translator preferably of the same gender.
13. Pamphlets and brochures should be well illustrated, geared to the appropriate reading level and in the preferred language.

14. Visit the patient's home.
15. Recommend US Dept. of Health and Human Services' *Diccionario de la Diabetes*, which is at a lower reading level for explanation of terminology in conjunction with frequently used terms by specific ethnic groups.
16. Recommend patient have an active support person who has an interest in learning and assisting the patient in every aspect of diabetes self-management.

STANDARDS AND REVIEW CRITERIA

# National Standards for Diabetes Self-Management Education

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Diabetes self-management education (DSME) is a critical element of care for all people with diabetes and is necessary in order to improve patient outcomes. The National Standards for DSME are designed to define quality diabetes self-management education and to assist diabetes educators in a variety of settings to provide evidence-based education. Because of the dynamic nature of health care and diabetes-related research, these Standards are reviewed and revised approximately every 5 years by key organizations and federal agencies within the diabetes education community.

A Task Force was jointly convened by the American Association of Diabetes Educators and the American Diabetes Association in the summer of 2006. Additional organizations that were represented included the American Dietetic Association, the Veteran's Health Administration, the Centers for Disease Control and Prevention, the Indian Health Service, and the American Pharmaceutical Association. Members of the Task Force included a person with diabetes; several health services researchers/behaviorists, registered nurses, and registered dietitians; and a pharmacist.

The Task Force was charged with reviewing the current DSME standards for their appropriateness, relevance, and scientific basis. The Standards were then reviewed and revised based on the available evidence and expert consensus. The committee convened on 31 March 2006 and 9 September 2006, and the Standards were approved 25 March 2007.

**DEFINITION AND OBJECTIVES**—Diabetes self-management education (DSME) is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.

**GUIDING PRINCIPLES**—Before the review of the individual Standards, the Task Force identified overriding principles based on existing evidence that would be used to guide the review and revision of the DSME Standards. These are:

1. Diabetes education is effective for improving clinical outcomes and quality of life, at least in the short-term (1–7).
2. DSME has evolved from primarily didactic presentations to more theoretically based empowerment models (3,8).
3. There is no one "best" education program or approach; however, programs incorporating behavioral and psychosocial strategies demonstrate improved outcomes (9–11). Additional studies show that culturally and age-appropriate programs improve outcomes (12–16) and that group education is effective (4,6,7,17,18).
4. Ongoing support is critical to sustain progress made by participants during the DSME program (3,13,19,20).
5. Behavioral goal-setting is an effective strategy to support self-management behaviors (21).

## STANDARDS

### Structure

**Standard 1.** *The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.*

Documentation of the DSME organizational structure, mission statement, and goals can lead to efficient and effective provision of services. In the business literature, case studies and case report investigations on successful management strategies emphasize the importance of clear goals and objectives, defined relationships and roles, and managerial support (22–25). While this concept is relatively new in health care, business and health policy experts and organizations have begun to emphasize written commitments, policies, support, and the importance of outcome variables in quality improvement efforts (22,26–37). The continuous quality improvement literature also stresses the importance of developing policies, procedures, and guidelines (22,26).

Documentation of the organizational structure, mission statement, and goals can lead to efficient and effective provision of DSME. Documentation of an organizational structure that delineates channels

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of communication and represents institutional commitment to the educational entity is critical for success (38–42). According to the Joint Commission on Accreditation of Health Care Organizations (JCAHO) (26), this type of documentation is equally important for small and large health care organizations. Health care and business experts overwhelmingly agree that documentation of the process of providing services is a critical factor in clear communication and provides a solid basis from which to deliver quality diabetes education (22,26,33,35–37). In 2005, JACHO published the *Joint Commission International Standards for Disease or Condition-Specific Care*, which outlines national standards and performance measurements for diabetes and addresses diabetes self-management education as one of seven critical elements (26).

**Standard 2.** *The DSME entity shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.*

Established and new systems (e.g., committees, governing bodies, advisory groups) provide a forum and a mechanism for activities that serve to guide and sustain the DSME entity (30,39–41). Broad participation of organization(s) and community stakeholders, including health professionals, people with diabetes, consumers, and other community interest groups, at the earliest possible moment in the development, ongoing planning, and outcomes evaluation process (22,26,33,35,36,41) can increase knowledge and skills about the local community and enhance collaborations and joint decision-making. The result is a DSME program that is patient-centered, more responsive to consumer-identified needs and the needs to the community, more culturally relevant, and of greater personal interest to consumers (43–50).

**Standard 3.** *The DSME entity will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.*

Clarifying the target population and determining its self-management educational needs serve to focus resources and maximize health benefits (51–53). The assessment process should identify the educational needs of all individuals with diabetes, not just those who frequently attend clinical appointments (51). DSME is a critical component of diabetes treatment (2,54,55), yet the majority of individuals with diabetes do not receive any formal diabetes education (56,57). Thus, identification of access issues is an essential part of the assessment process (58). Demographic variables, such as ethnic background, age, formal educational level, reading ability, and barriers to participation in education, must also be considered to maximize the effectiveness of DSME for the target population (13–19,43–47,59–61).

**Standard 4.** *A coordinator will be designated to oversee the planning, implementation, and evaluation of diabetes self-management education. The coordinator will have academic or experiential preparation in chronic disease care and education and in program management.*

The role of the coordinator is essential to ensure that quality diabetes education is delivered through a coordinated and systematic process. As new and creative methods to deliver education are explored, the coordinator plays a pivotal role in ensuring accountability and continuity of the educational process (23,60–62). The individual serving as the coordinator will be most effective if there is familiarity with the lifelong process of managing a chronic disease (e.g., diabetes) and with program management.

## Process

**Standard 5.** *DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructors' scope of practice and expertise.*

Diabetes education has traditionally been provided by nurses and dietitians. Nurses have been utilized most often as instructors in the delivery of formal DSME (2,3,5,63–67). With the emergence of medical nutrition therapy (66–70), registered dietitians became an integral part of the diabetes education team. In more recent years, the role of the diabetes educator has expanded to other disciplines, particularly pharmacists (73–79). Reviews comparing the effectiveness of different disciplines for education report mixed results (3,5,6). Generally, the literature favors current practice that utilizes the registered nurse, registered dietitian, and the registered pharmacist as the key primary instructors for diabetes education and members of the multidisciplinary team responsible for designing the curriculum and assisting in the delivery of DSME (1–7,77). In addition to registered nurses, registered dietitians, and pharmacists, a number of studies reflect the ever-changing and evolving health care environment and include other health professionals (e.g., a physician, behaviorist, exercise physiologist, ophthalmologist, optometrist, podiatrist) (48,80–84) and, more recently, lay health and community workers (85–91) and peers (92) to provide information, behavioral support, and links with the health care system as part of DSME.

Expert consensus supports the need for specialized diabetes and educational training beyond academic preparation for the primary instructors on the diabetes team (64,93–97). Certification as a diabetes educator by the National Certification Board for Diabetes Educators (NCBDE) is one way a health professional can demonstrate mastery of a specific body of knowledge, and this certification has become an accepted credential in the diabetes community (98). An additional credential that indicates specialized training beyond basic preparation is board certification in advanced Diabetes Management (BC-ADM) offered by the American Nurses Credentialing Center (ANCC), which is available for master's prepared nurses, dietitians, and pharmacists (48,84,99).

DSME has been shown to be most effective when delivered by a multidisciplinary team with a comprehensive plan of care (7,31,52,100–102). Within the multidisciplinary team, team members work interdependently, consult with one another, and have shared objectives (7,103,104). The team should have a collective combination of expertise in the clinical care of diabetes, medical nutrition therapy, educational methodologies, teaching strategies, and the psychosocial and behavioral aspects of diabetes self-management. A referral mechanism should be in place to ensure that the individual with diabetes receives education from those with appropriate training and credentials. It is essential in this collaborative and integrated team approach that individuals with diabetes are viewed as leaders of their team and assume an active role in designing their educational experience (7,20,31,100–102,104).

**Standard 6.** *A written curriculum reflecting current evidence and practice guidelines,*

*with criteria for evaluating outcomes, will serve as the framework for the DSME entity. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas listed below are to be provided*:

- Describing the *diabetes disease process* and *treatment options*
- Incorporating *nutritional management* into lifestyle
- Incorporating *physical activity* into lifestyle
- Using *medication(s)* safely and for maximum therapeutic effectiveness
- *Monitoring blood glucose* and other parameters and interpreting and using the results for self-management decision making
- Preventing, detecting, and treating *acute complications*
- Preventing detecting, and treating *chronic complications*
- Developing personal strategies to address psychosocial issues and concerns
- Developing personal strategies to promote health and behavior change

People with diabetes and their families and caregivers have a great deal to learn in order to become effective self-managers of their diabetes. A core group of topics are commonly part of the curriculum taught in comprehensive programs that have demonstrated successful outcomes (1,2,3,6,105–109). The curriculum, a coordinated set of courses and educational experiences, includes learning outcomes and effective teaching strategies (110–112). The curriculum is dynamic and needs to reflect current evidence and practice guidelines (112–117). Current educational research reflects the importance of emphasizing practical, problem-solving skills, collaborative care, psychosocial issues, behavior change, and strategies to sustain self-management efforts (31,39,42,48,98,118–122).

The content areas delineated above provide instructors with an outline for developing this curriculum. It is important that the content be tailored to match each individual's needs and adapted as necessary for age, type of diabetes (including pre-diabetes and pregnancy), cultural influences, health literacy, and other comorbidities (123,124). The content areas are designed to be applicable in all settings and represent topics that can be developed in basic, intermediate, and advanced levels. Approaches to education that are interactive and patient-centered have been shown to be effective (83,119,121,122,125–127).

These content areas are presented in behavioral terms and thereby exemplify the importance of action-oriented, behavioral goals and objectives (13,21,55,121–123,128,129). Creative, patient-centered experience-based delivery methods are effective for supporting informed decision-making and behavior change and go beyond the acquisition of knowledge.

**Standard 7.** *An individual assessment and education plan will be developed collaboratively by the participant and instructor(s) to direct the selection of appropriate educational interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.*

Multiple studies indicate the importance of individualizing education based on the assessment (1,56,68,131–135). The assessment includes information about the individual's relevant medical history, age, cultural influences, health beliefs and attitudes, diabetes knowledge, self-management skills and behaviors, readiness to learn, health literacy level, physical limitations, family support, and financial status (10–17,19,131,136–138). The majority of these studies support the importance of attitudes and health beliefs in diabetes care outcomes (1,68,134,135,138,139).

In addition, functional health literacy (FHL) level can affect patients' self-management, communication with clinicians, and diabetes outcomes (140,141). Simple tools exist for measuring FHL as part of an overall assessment process (142–144).

Many people with diabetes experience problems due to medication costs, and asking patients about their ability to afford treatment is important (144). Comorbid chronic illness (e.g., depression and chronic pain) as well as more general psychosocial problems can pose significant barriers to diabetes self-management (104,146–151); considering these issues in the assessment may lead to more effective planning (149–151).

Periodic reassessment determines attainment of the educational objectives or the need for additional and creative interventions and future reassessment (7,97,100,152). A variety of assessment modalities, including telephone follow-up and other information technologies (e.g., Web-based, automated phone calls), may augment face-to-face assessments (97,99).

While there is little direct evidence on the impact of documentation on patient outcomes, it is required to receive payment for services. In addition, documentation of patient encounters guides the educational process, provides evidence of communication among instructional staff, may prevent duplication of services, and provides information on adherence to guidelines (37,64,100,131,153). Providing information to other members of the patient's health care team through documentation of educational objectives and personal behavioral goals increases the likelihood that all of the members will address these issues with the patient (37,98,153).

The use of evidence-based performance and outcome measures has been adopted by organizations and initiatives such as the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), the Diabetes Quality Improvement Project (DQIP), the Health Plan Employer Data and Information Set (HEDIS), the Veterans Administration Health System, and JCAHO (26,154).

Research suggests that the development of standardized procedures for documentation, training health professionals to document appropriately, and the use of structured standardized forms based on current practice guidelines can improve documentation and may ultimately improve quality of care (100,153–155).

**Standard 8.** *A personalized follow-up plan for ongoing self management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals and the plan for ongoing self management support will be communicated to the referring provider.*

While DSME is necessary, it is not sufficient for patients to sustain a lifetime of diabetes self-care (55). Initial improvements in metabolic and other outcomes diminish after ~6 months (3). To sustain behavior at the level of self-management needed to effectively manage diabetes, most patients need ongoing diabetes self-management support (DSMS).

DSMS is defined as activities to assist the individual with diabetes to implement and sustain the ongoing behaviors needed to manage their illness. The type of support provided can include behavioral, educational, psychosocial, or clinical (13,121–123).

A variety of strategies are available for providing DSMS both within and

outside the DSME entity. Some patients benefit from working with a nurse case manager (7,20,98,157). Case management for DSMS can include reminders about needed follow-up care and tests, medication management, education, behavioral goal-setting, and psychosocial support/ connection to community resources.

The effectiveness of providing DSMS through disease-management programs, trained peers and health community workers, community-based programs, use of technology, ongoing education and support groups, and medical nutrition therapy has also been established (7,13,89–92,101,121–123,158–159).

While the primary responsibility for diabetes education belongs to the DSME entity, patients benefit by receiving reinforcement of content and behavioral goals from their entire health care team (100). Additionally, many patients receive DSMS through their provider. Thus, communication is essential to ensure that patients receive the support they need.

## Outcomes

**Standard 9.** *The DSME entity will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.*

In addition to program-defined goals and objectives (e.g., learning goals, metabolic, and other health outcomes), the DSME entity needs to assess each patient's personal self-management goals and his/her progress toward those personal goals. The AADE7 self-care behaviors provide a useful framework for assessment and documentation. Diabetes self-management behaviors include physical activity, healthy eating, medication taking, monitoring blood glucose, diabetes self-care related problem solving, reducing risks of acute and chronic complications, and psychosocial aspects of living with diabetes (112,160). Assessments of patient outcomes should occur at appropriate intervals. The interval depends on the outcome itself and the timeframe provided within the selected goals. For some areas, the indicators, measures, and timeframes may be based on guidelines from professional organizations or government agencies. In addition to assessing progress toward personal behavioral goals, a plan needs to be in place to communicate personal goals and progress to other team members.

The AADE Outcome Standards for Diabetes Education specify self-management behavior as the key outcome (112,160). Knowledge is an outcome to the degree that it is actionable (i.e., knowledge that can be translated into self-management behavior). In turn, effective self-management is one (but not the only) contributor to longer-term, higher-order outcomes such as clinical status (e.g., control of glycemia, blood pressure, and cholesterol), health status (e.g., avoidance of complications), and subjective quality of life. Thus, patient self-management behaviors are at the core of the outcomes evaluation.

**Standard 10.** *The DSME entity will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.*

Diabetes education must be responsive to advances in knowledge, treatment strategies, educational strategies, psychosocial interventions, and the changing health care environment. Continuous quality improvement (CQI) is an iterative, planned process (161) that leads to improvement in the delivery of patient education (162). The CQI plan should define quality based on and consistent with the organization's mission, vision, and strategic plan and include identifying and prioritizing improvement opportunities (163). Once improvement projects are identified and selected, the plan should incorporate timelines and important milestones including data collection, analysis, and presentation of results (163). Outcome measures indicate the result of a process (i.e., whether changes are actually leading to improvement), while process measures provide information about what caused those results (163–164). Process measures are often targeted to those processes that typically impact the most important outcomes. Measuring both process and outcomes helps to ensure that change is successful without causing additional problems in the system (164).

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# DIABETES MEDICATIONS SUPPLEMENT

## WORKING TOGETHER TO MANAGE DIABETES

This medication supplement guide is to provide health care professional with at-a-glance information on medications commonly used for people with diabetes. For complete prescribing information, please consult the medications package insert or the Physicians' Desk Reference.

DEPARTMENT OF HEALTH & HUMAN SERVICES - USA

NDEP
National Diabetes Education Program

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# SECTION A Diabetes Medications

## Table 1. Oral Agents to Treat Type 2 Diabetes

| Agent | Class | Primary Action | Typical Dosage |
|---|---|---|---|
| Tolbutamide (Ornase™)<br>Tolazamide (Tolinase™)<br>Chlorpropamide (Diabenese™) | Sulfonylureas<br>(1st generation) | Increases insulin production in the pancreas. | Tolbutamide: 0.25–2.0 g/day in divided doses; maximum, 3 g/day<br>Tolazamide: 100–1,000 mg/day in divided doses; maximum, 1 g/day<br>Chlorpropamide: 100–500 mg/day twice a day; maximum, 750 mg/day |
| Glyburide (Micronase™, Diabeta™, Glynase™)<br>Glipizide (Glucotrol, Glucotrol XL™)<br>Glimepiride (Amaryl™) | Sulfonylureas<br>(2nd generation) | Increases insulin production in the pancreas. | Glyburide: 1.25–5 mg/once or twice a day; maximum, 20 mg/day<br>Glynase: 0.75–12.0 mg/day; maximum 12 mg/day<br>Glipizide: 2.5–20.0 mg/once or twice a day; maximum, 40 mg/day; or XL* 2.5–10.0 mg/once or twice a day; maximum, 20 mg/day<br>Glimepiride: 1–8 mg/day; maximum, 8 mg/day |
| Repaglinide (Prandin™) | Meglitinide | Increases insulin release from pancreas. | New diagnosis or A1C <8%, 0.5 mg;<br>A1C >8%, 1–2 mg, 15–30 min before each meal;<br>increase weekly until results are obtained;<br>maximum, 16 mg/day |
| Nateglinide (Starlix™) | Phenylalanine derivative | Increases insulin release from pancreas. | 60–120 mg before each meal |
| Metformin (Fortamet™, Glumetza™, Glucophage™) | Biguanide | Primarily decreases hepatic glucose production. Minor increase in muscle glucose uptake which may improve insulin resistance. | 500 mg/day twice a day with meals, increase by 500 mg every 1–3 wk, twice or three times a day; usually most effective at 2,000 mg/day; maximum, 2,550 mg/day<br><br>Long acting form Glucophage XR™: 500mg once/day, max dose 2000mg once/day |
| Rosiglitazone (Avandia™) | Thiazolidinedione | Decreases insulin resistance, increasing glucose uptake, fat redistribution; minor decrease in hepatic glucose output; preserves β-cell function; decreases vascular inflammation. | Initially 4 mg/day in single or divided doses.<br>Increase to 8 mg/day in 12 wk, if needed;<br>maximum, 8 mg/day with or without food |
| Pioglitazone (Actos™) | Thiazolidinedione | Decreases insulin resistance, increasing glucose uptake, fat redistribution; minor decrease in hepatic glucose output; preserves β-cell function; decreases vascular inflammation. | Initially 15 or 30 mg/day;<br>maximum with or without food 45 mg for monotherapy,<br>30 mg for combination therapy |
| Acarbose (Precose™)<br>Miglitol (Glyset™) | Alpha-glucosidase inhibitor | Slows absorption of complex carbohydrate from GI tract. | 25 mg/day; increase by 25 mg/day every 4–6 wk;<br>maximum, split dose before meals (with first bite of food)<br>300 mg/day(150 mg/day for weight <60 kg) |
| **Combinations** | | | |
| Glucovance™<br>(Glyburide and Metformin) | Sulfonylureas and Biguanide | Decreases hepatic glucose production and increases insulin secretion. | Ratios of glyburide and metformin (in mg):1.25/250, 2.5/500, 5/500.<br>Initial: 1.25/250 once or twice a day, increased every 2 weeks.<br>2nd line: 2.5–5/500 twice a day, increased every1–2 weeks.<br>Average dose 7.5/1,500.<br>Maximum dose should not exceed 20 mg glyburide/2,000 mg metformin daily. |
| Metaglip™<br>(Glipizide and Metformin) | Sulfonylureas and Biguanide | Decreases hepatic glucose production and increases insulin secretion. | Ratios of glipizide and metformin (in mg): 2.5/250, 2.5/500, 5/500.<br>Initial: 2.5/250 once or twice a day, increased every 2 weeks.<br>2nd line: 2.5–5/500 twice a day, increased every 1– 2 weeks.<br>Maximum doseshould not exceed 20 mg glipizide/2,000 mg metformin daily. |
| Avandamet™<br>(Rosiglitazone and Metformin) | Thiazolidinedione and Biguanide | Decreases hepatic glucose production, increases glucose uptake, decreases insulin resistance, and preserves β-cell function. | Ratios of rosiglitazone and metformin: 1 mg/500 mg, 2 mg/500 mg, 4 mg/500 mg, 2 mg/1,000 mg, 4 mg/1,000 mg twice a day;<br>dosage individualized based on current therapy.<br>Maximum, 8 mg/2,000 mg per day. |
| Actoplus Met™<br>(Pioglitazone and Metformin) | Thiazolidinedione and Biguanide | Decreases hepatic glucose production, increases glucose uptake, decreases insulin. | Ratios of pioglitazone and metformin: 15 mg/500 mg, 15 mg/850 mg |
| Avandaryl™<br>(Rosiglitazone and Glimepiride) | Thiazolidinedione and Sulfonylurea | Decreases insulin resistance and increases insulin secretion. | Ratios of rosiglitazone and glimepiride: 4 mg/1 mg, 4 mg/1 mg |

See Table 1 continuation on next page.

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*A1C = glycated hemoglobin ALT = alanine aminotransferase CHF = congestive heart failure*
*FPG = fasting plasma glucose GI = gastrointestinal XL = TZD= thiozolidinedione, CYP 450= cytochrome P 450*

| Side Effects | Precautions | Critical Tests | Comments |
|---|---|---|---|
| Hypoglycemia, weight gain, hyperinsulinemia<br>Disulfiram reaction with alcohol | Chlorpropamide remains active for up to 60 hours. Use extreme caution with elderly patients or patients with hepatic or renal dysfunction. | All are metabolized in liver. Periodic evaluation of liver function is suggested. | Use of these agents is not recommended unless the patient has a well-established history of taking them. Second-generation sulfonylureas provide more predictable results with fewer side effects and more convenient dosing. |
| Hypoglycemia, weight gain, hyperinsulinemia | Clearance may be diminished in patients with hepatic or renal impairment. | | Glipizide is preferred with renal impairment.<br>Doses >15 mg should be divided.<br>Glimepiride indicated for use with insulin.<br>Shown to have some insulin-sensitizing effect. |
| Hypoglycemia, weight gain, hyperinsulinemia | Use with caution on patient with hepatic or renal impairment. | | Patients should be instructed to take medication no more than 30 minutes prior to a meal. If meals are skipped or added, the medication should be skipped or added as well. Approved for use as monotherapy or in combinatin with TZD or metformin. |
| Minimal risk of hypoglycemia | Currently no contraindications available. Use with caution with moderate to severe hepatic disease. | Periodic evaluation of liver function tests. | Approved as monotherapy or in combination with metformin or TZD. Has only a 2-hour duration of action. If meals are skipped or added, the medication should be skipped or added as well. |
| Nausea, diarrhea, metallic taste, possible lactic acidosis | Due to increased risk of lactic acidosis, should not use if suspect frequent alcohol use, liver or kidney disease, or CHF. | Contraindicated if serum creatinine is: >1.5 mg/dL in men or >1.4 mg/dL women. Do not use if creatinine clearance is abnormal. Monitor hematological and renal function annually. | Especially beneficial in obese patients due to potential for weight loss, improved lipid profile, and lack of potential for hypoglycemia requiring supplemental carbohydrate intake. Discontinue for 48 hr after contrast dye procedures. |
| Minor weight increase of 3–6 lbs., edema | Should not be used in patients with CHF or hepatic disease. Can cause mild-to-moderate edema. | Avoid initiation if ALT >2.5X upper limit of normal. Measure ALT periodically. Discontinue if ALT >3X upper limit of normal. | Approved for use as monotherapy and in combination with metformin, sulfonylureas, or insulin.<br>Less interactions associated with CYP-450. |
| Minor weight increase of 3–6 lbs., edema | Should not be used in patients with CHF or hepatic disease. Can cause mild-to-moderate edema. | Avoid initiation if ALT >2.5X upper limit of normal. Measure ALT periodically. Discontinue if ALT >3X upper limit of normal. | Avoid initiation if ALT >2.5X upper limit of normal. Measure ALT periodically. Discontinue if ALT >3X upper limit of normal. |
| Gas and bloating, sometimes diarrhea for both drugs | Should not be used if GI disorders are concurrent. | Avoid if serum creatinine is >2.0 mg/dL. Monitor serum transaminase every 3 months for 1st year of therapy. | Approved for use as monotherapy and in combination with metformin, sulfonylureas, or insulin. If used with hypoglycemic agents, such as sulfonylureas or insulin, must treat hypoglycemia with glucose not sucrose. |
| Hypoglycemia, weight gain, lactic acidosis | Should not be used if suspect frequent alcohol use, liver or kidney disease, or CHF. | Same caveats as individual components. | Patients may frequently use 2 different dose tablets to attain desired daily dosage and results. Discontinue for 48 hr after procedure using contrast dye. |
| Hypoglycemia, weight gain, lactic acidosis | Should not be used if suspect frequent alcohol use, liver or kidney disease, or CHF. | Same caveats as individual components. | Patients may frequently use 2 different dose tablets to attain desired daily dosage and results. Discontinue for 48 hr after procedure using contrast dye. |
| Edema, possible lactic acidosis | Should not be used if suspect frequent alcohol use, liver or kidney disease, or CHF. | Same caveats as individual components. | Less expensive than using agents separately. Reported decrease in GI upset associated with metformin and weight increase associated with rosiglitazone. Discontinue for 48 hr after procedure using contrast dye. |
| Same caveats as individual components. | Same caveats as individual components. | Same caveats as individual components. | Same caveats as individual components. |
| Same caveats as individual components. | Same caveats as individual components. | Same caveats as individual components. | Same caveats as individual components. |

See Table 1 continuation at right.

** Agents in a class of medicines share mechanisms of action, require similar precautions, and generally have similar side effects. For proper usage, please read label. Agents should not be used in patients with type 1 diabetes.*

**TEXAS DIABETES COUNCIL**
**2009 Update to Diabetes Medications Supplement**

### Table 1 Continuation: Oral Agents to Treat Type 2 Diabetes

| Agent | Class | Primary Action | Typical Dose | Side Effects | Cautions | Critical Tests | Comments |
|---|---|---|---|---|---|---|---|
| Colesevelam (Welchol) | Bile acid sequestrant | Slow complex carbohydrate absorption/lower fat flux through liver | 625mg tablet, 6 tablets daily or 3 tablets BID | Constipation<br>Dyspepsia<br>Nausea | Bowel obstruction<br>Triglyceride >500mg/dL<br>History of Pancreatitis | Lipid profile | May reduce absorption of: Phenytoin, warfarin, levothyroxine<br>Other medicines should be moved 1 hour before colesevelam |
| Sitagliptin/metformin Janumet | DPP-4 inhibitor<br>Biguanide | Reduce hepatic glucose production and lower post-prandial glucagon levels | Sitagliptin/metformin 50mg/500mg or 50mg/1000mg dosed BID<br>Max: see individual components | See individual components | See individual components | See individual components | See individual components (Sitagliptin on table 5) |
| Pioglitazone/ glimepiride Duetact | Thiazolidinedione<br>Sulfonylurea | Improve insulin resistance/increase pancreatic insulin secretion | Pioglitazone/ glimepiride 30mg/2mg or 30mg/4mg Daily<br>Max: 30mg/4mg Daily | See individual components | See individual components | See individual components | See individual components |

June 2009

# Diabetes Medications

### Table 2. Glucose-Lowering Activity—Oral Diabetes Agent

| Medication | Blood Glucose Most Affected | Greatest Risk for Hypoglycemia |
|---|---|---|
| Sulfonylureas | Fasting and postprandial | Nocturnal, fasting, 4–6 hr after meals |
| Meglitinide or phenylalanine derivative | Postprandial | 2–3 hr after meals |
| Biguanide | Fasting and postprandial | After exercise if prolonged and strenuous |
| Alpha-glucosidase inhibitor | Postprandial | None |
| Thiazolidinedione | Fasting and postprandial | None |
| Glucovance™ | Fasting and postprandial | Nocturnal, fasting, 4–6 hr after meals |
| Metaglip™ | Fasting | Nocturnal, fasting 4–6 hr after meals |
| Avandamet™ | Fasting and postprandial | After exercise if prolonged and strenuous |
| Actoplus Met™ | Fasting and postprandial | After exercise if prolonged and strenuous |
| Avandryl™ | Fasting and postprandial | Nocturnal, fasting, 4–6 hr after meals |

**TEXAS DIABETES COUNCIL**
**2009 Additions to Diabetes Medications Supplement**

### Table 2 Continuation: Glucose-Lowering Activity-Oral Diabetes Agent

| Medication | Blood Glucose Most Effected | Greatest Risk of Hypoglycemia |
|---|---|---|
| Sitagliptin | Post-prandial | None |
| Colesevelam | Post-prandial | None |
| Sitagliptin/metformin | Fasting and post-prandial | None |
| Pioglitazone/glimepiride | Fasting and Post-prandial | Nocturnal, fasting, post-prandial |

June 2009

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Testing frequency and times may vary based on individual assessment.

## Table 3. Important Insulin Information*

| Insulin | Onset | Peak | Effective Duration | Maximal Duration | Comments |
|---|---|---|---|---|---|
| Human insulins | | | | | |
| **Rapid Acting** | | | | | |
| Lispro (Humalog™) | < 15 min | 1–2 hr | 2–4 hr | 3–5 hr | Should be taken just prior to or just after eating. |
| Aspart (Novalog™) | < 15 min | 1–3 hr | 3–5 hr | 4–6 hr | Should be taken just prior to or just after eating. |
| Glulisine (Apidra™) | < 15 min | 0.5–1 hr | 3 hr | 3 hr | Should be taken just prior to or just after eating. |
| **Short Acting** | | | | | |
| Regular (Novolin R™, Humulin R™) | 0.5–1 hr | 2–4 hr | 3–5 hr | 8 hr | Best if taken 30 min before a meal. |
| **Intermediate Acting** | | | | | |
| Lente (Novolin™, Humulin L™) | 3–4 hr | 4–12 hr | 12–18 hr | 16–20 hr | Limited supplies. |
| NPH (Novolin N™, Humulin N™) | 2–4 hr | 4–10 hr | 10–16 hr | 14–18 hr | Bedtime dosing minimizes nocturnal hypoglycemia. |
| **Long Acting** | | | | | Characterized by a "flat" or "peakless" concentration profile. |
| Insulin glargine (Lantus™) analog | 4–6 hr | None | 24 hr | 24 hr | Cannot be mixed with any other insulin. Stress site rotation and not to use same syringe used with other insulins. Not recommended for pre-filling syringes. |
| Detemir (Levemir™) | 3–4 hr | 50% in 3–4 hr, lasting up to 14 hr | 5.7–23.2 hr | Dose dependent-5.7–23.2 hr | Cannot be mixed in same syringe with other insulins. Duration of action is dose dependent: 6 hrs (0.1U/kg), 12hrs (0.2U/kg), 20 hrs (0.4U/kg), 23 hrs (0.8U/kg and 1.6U/kg). |
| Pre-mixed Human | | | | | |
| Humalog™ 75/25 Novolog Mix™ 70/30 | <15 min | 1–2 hr | 10–16 hr | 14–18 hr | 75% NPL, 25% Lispro 70% NPH, 30% Aspart Should be taken just prior to or just after eating because of rapid onset. Caution because of name confusion with Humalog and Novolog. |
| Humulin™ 70/30 Novolin™ 70/30 | 0.5–1 hr | 2–10 hr | 10–16 hr | 14–18 hr | Humalin and Novolin are 70% NPH and 30% regular insulin. |

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**2009 Additions to Diabetes Medications Supplement**

### Table 3 Continuation: Important Insulin Information*

| Insulin | Onset | Peak (hours) | Effective Duration | Maximum Duration | Comments |
|---|---|---|---|---|---|
| Humulin Mix 50/50 | <15 minutes | 1 ½ to 2 ½ | 10-16 hours | 16-20 hours | |

Discontinued Insulins: All animal source insulins, Lente insulin, Ultralente insulin, Exubera inhaled

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*Site rotation for injections is necessary for all types of insulin.

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## Table 4. Recommended Insulin Storage

| Insulin Type | Refrigerated (36° F–46° F) | | Room Temperature (59° F– 86° F) | |
|---|---|---|---|---|
| Vial | Opened | Unopened | Opened | Unopened |
| Humalog™, Novolog™, Humulin™, Novolin™, Apidra™ | 28 days | Until expiration date | 28 days | 28 days |
| Lantus™ (10 mL) | 28 days | Until expiration date | 28 days | 28 days |
| Detemir (Levemir™) | 42 days | Until expiration date | 42 days | 42 days |
| Pens/Cartridges | Not in use | | In use | |
| Humalog™ | Until expiration date | | 28 days | |
| Humulin R™ ( available in cartridge only) | Until expiration date | | 28 days | |
| Humulin N™ | Until expiration date | | 14 days | |
| Humulin 70/30™ | Until expiration date | | 10 days | |
| Humalog Mix 75/25™ | Until expiration date | | 10 days | |
| Novolog™ | Until expiration date | | 28 days | |
| Novolog Mix 70/30™ | Until expiration date | | 14 days | |
| Novolin R™ (prefilled and 1.5-mL cartridge) | Until expiration date | | 30 days | |
| Novolin R™ (3-mL cartridge) | Until expiration date | | 28 days | |
| Novolin N™ (prefilled and 1.5-mL cartridge) | Until expiration date | | 7 days | |
| Novolin N™ (3-mL cartridge) | Until expiration date | | 14 days | |
| Novolin 70/30™ (prefilled and 1.5-mL cartridge) | Until expiration date | | 7 days | |
| Novolin 70/30™ (3-mL cartridge) | Until expiration date | | 10 days | |
| Detemir (Levemir™) | Until expiration date | | 42 days | |
| Apidra™ | Until expiration date | | 28 days | |
| Lantus™ | Until expiration date | | 28 days | |
| Self-filled syringes (Note: not recommended for glargine) | 14 days* | | 7 days | |

**TEXAS DIABETES COUNCIL**
**2009 Additions to Diabetes Medications Supplement**

### Table 4 Continuation: Recommended Insulin Storage

| Insulin Type | Refrigerated (36˚F - 46˚F) | | Room Temperature (59˚F - 86˚F) | |
|---|---|---|---|---|
| | Opened | Unopened | Opened | Unopened |
| Humalog Mix 50/50 Vial | 28 days | Until expiration date | 28 days | 28 days |
| Humalog Mix 50/50 Pen device/cartridge | **Do not refrigerate once opened.** | Until expiration date | 10 days **Do not refrigerate once opened.** | 10 days |

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## Table 5. Incretins and Amylins

| Agent | Primary Action | How Supplied/Storage | Typical Dosage | Duration Action | Side Effects | Precautions | Comments |
|---|---|---|---|---|---|---|---|
| Exenatide (Byetta™) | Decreases post-meal glucagon production Delays gastric emptying<br>Increases satiety, leading to decreased caloric intake.<br>Degree of response depends on plasma glucose levels | 250 mcg/ml:<br>- 5 mcg/dose prefilled pen<br>-10 mcg/dose prefilled pen<br>If not in use: refrigerate until expiration date.<br>If in use: stable at room temperature<br>Discard after 30 days. | 5 mcg BID subcutaneous for first 1 month, then 10 mcg BID, injected within 60 minutes before morning and evening meal | Peak effects in approx 2 hours with maximal duration of 10 hours. | Nausea and hypoglycemia most common; occasional vomiting, diarrhea, jitters, dizziness, headache. | Not for use in patients with Type 1 diabetes, severe renal disease or ESRD*, or severe GI disease. | Consider lowering dose of sulfonylurea to avoid hypoglycemia when starting.<br>May reduce the rate of absorption of oral medication.<br>Medications requiring threshold concentrations should be taken 1 hour prior to injection.<br>Approved for use with sulfonylureas and/or metformin or in combination with a TZD* alone or with metformin. |
| Pramlintide (Symlin™) | Decreases post-meal glucagon production<br>Delays gastric emptying,<br>Increases satiety, leading to decreased caloric intake.<br>Degree of response depends on plasma glucose levels | 5 ml vials containing 0.6 mg/ml. Requires U-100 insulin syringe for injection<br>If not in use: refrigerate until expiration date.<br>If in use: room temperature Discard after 28 days. | Type 1 diabetes: 15–60 mcg starting with 15 mcg subcutaneously before meals of 30gm or more carbohydrate. Type 2 diabetes: 60–120 mcg starting with 60 mcg subcutaneous before meals. Titrate as directed by prescriber. | Maximum effect in 20 minutes with rapid elimination. Maximum duration of 4 hours | Nausea and hypoglycemia most common. Doses are adjusted based on presentation of these side effects. Occasional vomiting, stomach pain, dizziness, indigestion. | Indicated for insulin treated type 2 diabetes or for type 1 diabetes. Contraindicated in patients with hypoglycemia unawareness, gastroparesis. Or poor adherence<br>Should never be mixed with insulin and should be injected separately. Reduce insulin dose by 50% when starting. | Requires patient testing of blood sugars before and after meals, frequent physician follow up, and thorough understanding of how to adjust doses of insulin and pramlintide.<br>May reduce the rate of absorption of orally administered medication. Medications requiring threshold concentrations should be taken 1 hour prior to injection. |
| Sitagliptin (Januvia™) | DPP-4 inhibitor* Inhibits the DPP-4 enzyme that degrades GLP-1 and GIP resulting in 2-3 fold increased levels of these incretins. Increases insulin secretion in presence of elevated plasma glucose. Reduces post-meal glucagon secretion . | 25mg, 50mg, 100mg tablets | 100 mg po qD<br>Moderate renal insufficiency (CrCl>30 to <50mL/min): 50mg/day<br>Severe renal insufficiency (CrCl <30mL/min): 25mg/day | Approximately 24 hours | Low incidence of side effects including hypoglycemia or gastrointestinal symptoms<br>Headache, upper respiratory tract infection, nasopharyngitis | Not for use in type 1 diabetes<br>Assessment of renal function is recommended prior to initiation and periodically thereafter. | May be used as monotherapy or in combination with metformin or TZDs.<br>Not associated with weight loss |

Adapted from © 2006 The Diabetes Center, Old Saybrook, CT. Used with permission. *DPP-4-dipeptidyl peptidase -4 GIP- glucose dependent insulinotropic polypeptide GLP-glucose like polypeptide ESRD-End Stage Renal Disease TZD-Thiazolidinedione

## Table 6. Hypoglycemia Treatment

| Agent | Primary Action | How Supplied/Storage | Typical Dosage | Duration Action | Side Effects | Precautions | Comments |
|---|---|---|---|---|---|---|---|
| Glucagon | Converts liver glycogen to glucose | 1 mg vial with diluent; emergency kit, 1 mg vial with prefilled syringe of diluent. Before reconstitution, room temperature until expiration date. After reconstitution, may be stored for up to 48 hours under refrigeration. | 0.5–2 mg subcutaneous | 15 min, should be followed by carbohydrate snack. | Occasional nausea and vomiting | Must be reconstituted prior to injection. Should be followed by carbohydrate snack and blood glucose testing every 15 minutes until glucose level returns to acceptable levels. | Patient should be instructed to teach colleagues, family, etc. how to give injection. Only use if patient isunconscious or unable to eat or drink. All people taking insulin should receive a prescription for glucagon kit for emergency use. |

Adapted from © 2006 The Diabetes Center, Old Saybrook, CT. Used with permission.

## Table 7. Recommended Control Measures

| Biochemical Index | Preprandial | Peak postprandial | A1C (ADA)* | Blood pressure | LDL | TG | HDL |
|---|---|---|---|---|---|---|---|
| Goal | 90–130 mg/dL | <180 mg/dL | <7% | <130/80 | <100 | <150 | >40 |

Adapted from © 2006 The Diabetes Center, Old Saybrook, CT. Used with permission. LDL=low density lipoprotein TG=triclycerides HDL=high density lipoprotein *ADA—American Diabetes Association

WORKING TOGETHER TO MANAGE DIABETES

# SECTION B

## Medications to Lower High Blood Pressure*

| Category | Generic Name | Brand Name™ | Minimum Daily Dose | Maximum Daily Dose | Special Considerations for class of drugs |
|---|---|---|---|---|---|
| Angiotensin-converting enzyme (ACE) inhibitors | benazepril | Lotensin™ | 10 mg QD | 40 mg QD or divided | May cause cough.<br>May increase potassium concentrations.<br>Do not use potassium or salt substitutes without consulting physician.<br>Do not use if pregnant or if trying to conceive.<br>Caution if creatinine >1.5. |
| | captopril | Capoten™ | 25 mg divided dose | 100 mg divided dose | |
| | enalapril | Vasotec™ | 5 mg QD | 40 mg QD or divided | |
| | fosinopril | Monopril™ | 10 mg QD | 40 mg QD or divided | |
| | lisinopril | Prinivil, Zestril™ | 10 mg QD | 40 mg QD | |
| | moexipril | Univasc™ | 7.5 mg QD | 30 mg QD or divided | |
| | perindopril | Aceon™ | 4 mg QD | 8 mg QD | |
| | quinapril | Accupril™ | 10 mg QD | 80 mg QD or divided | |
| | ramipril | Altace™ | 2.5 mg QD | 20 mg QD or divided | |
| Angiotensin II receptor blockers | trandolapril | Mavik™ | 1 mg QD | 4 mg QD | May cause dizziness and upset stomach.<br>Do not use potassium or salt substitutes without consulting physician.<br>Do not use if pregnant or if trying to conceive.<br>Caution if creatinine >1.5. |
| | candesartan | Atacand™ | 8 mg QD | 32 mg QD or divided | |
| | eprosartan | Teveten™ | 400 mg QD | 800 mg QD or divided | |
| | irbesartan | Avapro™ | 150 mg QD | 300 mg QD | |
| | losartan | Cozaar™ | 25 mg QD | 100 mg QD or divided | |
| | olmesartan | Benicar™ | 20 mg QD | 40 mg QD | |
| | telmisartan | Micardis™ | 20 mg QD | 80 mg QD | |
| | valsartan | Diovan™ | 80 mg QD | 320 mg QD | |
| Calcium channel blockers | amlodipine | Norvasc™ | 2.5 mg QD | 10 mg QD | May cause constipation, dizziness, upset stomach, and flushing.<br>Call physician for shortness of breath, unusual heartbeat, or swelling of feet or hands. |
| | diltiazem | Cardizem LA™ | 120 mg QD | 540 mg QD | |
| | diltiazem | Cardizem CD™ | 180 mg QD | 420 mg QD | |
| | diltiazem | Dilacor XR™* | 180 mg QD | 420 mg QD | |
| | diltiazem | Tiazac™ | 180 mg QD | 420 mg QD | |
| | felodipine | Plendil™* | 2.5 mg QD | 20 mg QD | |
| | isradipine | DynaCircCR™* | 2.5 mg QD | 10 mg QD | |
| | nicardipine | Cardene SR™* | 60mg in divided dose | 120 mg divided dose | |
| | nifedipine | Adalat CC™* | 30 mg QD | 60 mg QD | |
| | nifedipine | Procardia XL™* | 30 mg QD | 60 mg QD | |
| | nisoldipine | Sular™* | 10 mg QD | 40 mg QD | |
| | verapamil | Calan™ | 80 mg QD in divided dose | 320 mg divided dose | |
| | verapamil | Calan SR ™ | 120 mg QD | 480 mg divided dose | |
| | verapamil | Covera HS™* | 120 mg QD | 360 mg QD | |
| | verapamil | Isoptin™ | 80 mg QD in divided dose | 320 mg divided dose | |
| | verapamil | Isoptin SR™* | 120 mg QD | 480 mg QD or divided | |
| | verapamil | Verelan™ | 80 mg QD in divided dose | 320 mg divided dose | |
| | verapamil | Verelan PM™ | 120 mg QD | 360 mg QD | |
| Thiazides and related diuretics | bedroflumethiazide | Naturetin™ | 2.5 mg QD | 20 mg QD | May increase blood glucose concentrations.<br>Take in morning to minimize diuretic effect at night.<br>May cause low potassium, need to monitor level. |
| | chlorothiazide | Diuril™ | 125 mg QD | 500 mg QD or divided | |
| | chlorthalidone | Hygroton™ | 12.5 mg QD | 25 mg QD | |
| | hydrochlorothiazide | HydroDIURIL™ | 12.5 mg QD | 50 mg QD or divided | |
| | hydrochlorothiazide | Microzide™ | 12.5 mg QD | 50 mg QD or divided | |
| | indapamide | Lozol™ | 1.25 mg QD | 2.5 mg QD | |
| | methyclothiazide | Enduron™ | 2.5 mg QD | 5 mg QD | |
| | metolazone | Mykrox™ | 0.5 mg QD | 1.0 mg QD | |
| | metolazone | Zaroxolyn™ | 2.5 mg QD | 5 mg QD | |

* *Agents in a class of medicines share mechanisms of action, require similar precautions and generally have similar side effects.*
*CC= extended release XL=extended release SR=sustained release CR=controlled release CD=extended release XR=extended release PM=extended release, controlled onset HS=extended release, controlled onset Dosages based on JNC7 usual dose range.*

# Medications to Lower High Blood Pressure* (continued)

| Category | Generic Name | Brand Name™ | Minimum Daily Dose | Maximum Daily Dose | Special Considerations for class of drugs |
|---|---|---|---|---|---|
| Loop diuretics | bumetanide | Bumex™ | 0.5 mg QD | 2 mg QD or divided | May cause low potassium. Need blood test to monitor level. (Parenteral drug available) May cause photosensitivity:sunscreen recommended. |
| | ethacrynic acid | Edecrin™ | 25 mg QD | 200 mg divided dose | |
| | furosemide | Lasix™ | 20 mg QD | 80 mg QD or divided | |
| | torsemide | Demadex™ | 2.5 mg QD | 10 mg QD | |
| Potassium-sparing diuretics | amiloride | Midamor™ | 5 mg QD | 10 mg QD | Do not use potassium or salt substitutes without consulting physician. Need to monitor potassium level. |
| | triamterene | Dyrenium™ | 50 mg QD or divided | 100 mg divided dose | |
| Aldosterone receptor blockers | eplerenone | Inspra™ | 50 mg QD | 100 mg divided dose | |
| | spironolactone | Aldactone™ | 25 mg QD | 50 mg divided dose | |
| β-blockers | acebutolol | Sectral™ | 200 mg QD | 800 mg divided dose | Intrinsic sympathomimetic activity. May alter blood glucose, may mask signs of low blood. Call physician for slow heart rate (<60), confusion, or swelling of feet or legs. Can cause claudication. Do not discontinue abruptly. |
| | atenolol | Tenormin™ | 25 mg QD | 100 mg QD | |
| | betaxolol | Kerlone™ | 5 mg QD | 20 mg QD | |
| | bisoprolol | Zebeta™ | 2.5 mg QD | 10 mg QD | |
| | carteolol | Cartol™ | 2.5 mg QD | 10 mg QD | |
| | metoprolol | Lopressor™ | 50 mg QD | 100 mg QD or divided | |
| | metoprolol | Toprol XL™* | 50 mg QD | 100 mg QD | |
| | nadolol | Corgard™ | 40 mg QD | 120 mg QD | |
| | penbutolol | Levatol™ | 10 mg QD | 40 mg QD | |
| | pindolol | Visken™ | 10 mg in divided dose | 40 mg divided dose | |
| | propranolol | Inderal™ | 40 mg divided dose | 160 mg divided dose | |
| | propranolol | Inderal LA™* | 60 mg QD | 180 mg QD | |
| | timolol | Blocadren™ | 20 mg divided dose | 40 mg divided dose | |
| α-blockers | doxazosin | Cardura™ | 1 mg QD | 16 mg QD | To prevent dizziness, avoid standing up suddenly, especially with the first few doses. |
| | prazosin | Minipress™ | 2 mg in divided dose | 20 mg divided dose | |
| | terazosin | Hytrin™ | 1 mg QD | 20 mg QD | |
| Combined α- and β-blockers | carvedilol | Coreg™ | 12.5 mg divided dose | 50 mg divided dose | May mask signs of low blood glucose levels. Take with food to avoid stomach upset. |
| | labetalol | Normodyne™ | 200 mg divided dose | 800 mg divided dose | |
| | labetalol | Trandate™ | 200 mg divided dose | 800 mg divided dose | |
| Direct vasodilators | hydralazine | Apresoline™ | 25 mg QD | 100 mg divided dose | May cause headaches, fluid retention, or fast heart rate. |
| | midoxidil | Loniten™ | 2.5 mg QD | 80 mg divided dose | |
| Central α-agonists | clonidine | Catapres™ | 0.1 mg QD | 0.8 mg divided dose | Do not discontinue drug suddenly without consulting physician. |
| | clonidine | Catapres TTS™* (patch) | 0.1 mg Q week | 0.3 mg Q week | |
| | methyldopa | Aldomet™ | 250 mg divided dose | 1,000 mg divided dose | |
| | guanfacine | Tenex™ | 0.5 mg QD | 2 mg QD | |
| Peripheral Anti-adrenergics | guanadrel | Hylorel™ | 10 mg in divided dose | 75 mg divided dose | May cause dizziness, nasal congestion, and depression. |
| | guanethidine | Ismelin™ | 10 mg QD | 50 mg QD | |
| | resperine | | 0.1 mg divided dose | 0.25 mg divided dose | |

* *Agents in a class of medicines share mechanisms of action, require similar precautions and generally have similar side effects.*
*XL = extended release LA = long acting*

*Note: There are many combination medications for the control of blood pressure. The indications and caveats are the same for each individual component.*

For all anti-hypertensives:
- *Ask pharmacist before using OTC products.*
- *Monitor blood pressure regularly.*
- *To prevent dizziness, advise patient to stand up slowly. If dizziness persists, refer to health care provider.*

Information about high blood pressure can be found at the following Web sites:
*Health care professionals: http://www.nhlbi.nih.gov/health/prof/heart/index.htm*
*Information for people with diabetes: http://www.nhlbi.nih.gov/hbp*
*Drugs used to treat high blood pressure: http://www.nhlbi.nih.gov/guidelines/hypertension/express.pdf*

WORKING TOGETHER TO MANAGE DIABETES

# SECTION C

## Medications for the Treatment of Dyslipidemia

| Category | Generic Name | Brand Name | Minimum Daily Dose | Maximum Daily Dose | Special Considerations for class of drugs |
|---|---|---|---|---|---|
| HMG-CoA reductase inhibitors (statins) | atorvastatin | Lipitor™ | 10 mg QD | 80 mg in divided doses | Main action: Lowers LDL ("bad") cholesterol. Also lowers TG and modestly raises HDL.<br>Have blood tests for liver enzyme concentrations.<br>Notify physician if muscle aches or weakness develops.<br>Use caution if combined with fibric acid derivatives due to the increased risk of rhabdomyolysis. |
| | fluvastatin | Lescol™ | 20 mg QD | 80 mg in divided doses | |
| | fluvastatin | Lescol XL™ | 80 mg QD | 80 mg in divided doses | |
| | lovastatin | Mevacor™ | 10 mg QD | 80 mg in divided doses | |
| | lovastatin (extended-release) | Altocor™ | 20 mg QD | 60 mg QD | |
| | pravastatin | Pravachol™ | 10 mg QD | 80 mg QD | |
| | rosuvastatin | Crestor™ | 5 mg QD | 40 mg QD | |
| | simvastatin | Zocor™ | 5 mg QD | 80 mg in divided doses | |
| Cholesterol absorption inhibitors | ezetimibe | Zetia™ | 10 mg QD | 10 mg QD | Main action: Lowers LDL cholesterol; inhibits absorption of cholesterol.<br>If used with a statin, take together.<br>If used with bile acid sequestrant, ezetimibe should be taken 2 hr before or 4 hr after bile acid sequestrant. |
| Nicotinic acid (niacin) | nicotinic acid (extended release) | Niaspan™ | 50–100 mg QD | 2,000 mg QD | Main action: Lowers LDL cholesterol increases HDL ("good") cholesterol, lowers triglycerides.<br>Take with food.<br>May cause flushing.<br>May increase blood glucose levels.<br>Have blood tests for liver enzyme concentrations.<br>Long-acting forms may be more likely to cause liver malfunction. |
| | nicotinic acid | | 250 mg/day QD | Titrated up to 1500mg therapeutic dose in 3 divided doses. Maximum dose= 3000mg | |
| Lipid combinations | lovastatin-niacin | Advicor™ | 20 mg/500 mg QD | 40 mg/2,000 mg QD | Main Action: Reduces LDL, TC , and TG and increases HDL due to the individual actions of niacin and lovastatin. |
| | simvastatin-ezetimibe | Vytorin™ | 10 mg/10 mg QD | 80 mg/10 mg QD | Main Action: Reduces LDL cholesterol. |
| | Amlodipine+atorvastatin | Caduet™ | 2.5mg/10mg QD | 10 mg/80 mg QD | Blood Pressure medication (Calcium channel blocker (see Blood pressure med chart)+lipid (statin) medication. Same comments as individual |
| Fibric acid derivatives | fenofibrate | Tricor™ | 48 mg QD | 145 mg QD | Main action: Lowers triglycerides, increases HDL cholesterol.<br>Perform blood tests for liver enzyme concentrations.<br>Adjust dose based on age and renal impairment.<br>Notify physician if muscle aches or weakness develops. |
| | fenofibrate | Lofibra™ | 67 mg QD | 200 mg QD | |
| | fenofibrate | Triglide™ | 50 mg QD | 160 mg QD | |
| | fenofibrate | Antara™ | 43 mg QD | 130 mg QD | |
| | gemfibrozil | Lopid™ | 1,200 mg BID | 1,200 mg BID | |
| Bile acid sequestrants | cholestyramine | LoCHOLEST™ | 4 g QD | 24 g in divided doses | Main action: Lowers LDL cholesterol.<br>May cause constipation and stomach upset.<br>May need to be taken at a different time than other medications to avoid drug interactions.<br>May increase triglycerides blood concentrations.<br>Can be combined with other agents such as statins. |
| | cholestyramine light | LoCHOLEST light™ | 4 g QD | 24 g in divided doses | |
| | cholestyramine | Questran™ | 4 g QD | 24 g in divided doses | |
| | cholestyramine light | Questran light™ | 4 g QD | 24 g in divided doses | |
| | cholestyramine | Prevalite™ | 4 g QD | 24 g in divided doses | |
| | cholestipol | Colestid™ | 2g QD or BID | 6g QD or BID | |
| | colesevelam | Welchol™ | 1,875 mg (3 tablets) QD | 4,375 mg (7 tabs) QD or BID | |

*HMG-Coa = 3-hydroxy-3-methylglutaryl coenzyme A LDL = low-density lipoprotein HDL = high-density lipoprotein TC = total cholesterol*
*TG = plasma triglycerides generic = generic drug manufacturers*

WORKING TOGETHER TO MANAGE DIABETES

The U. S. Department of Health and Human Services' National Diabetes Education Program (NDEP) is jointly sponsored by the National Institutes of Health and the Centers for Disease Control and Prevention with the support of more than 200 partner organizations.

www.ndep.nih.gov
1-800-438-5383
revised 3/07 NDEP – 54 – S
CS109012

# *Resources for Individuals with Diabetes, July 2012*

**Note:** *Resources for Individuals with Diabetes* is updated routinely. The most recent version can be accessed on the Texas Diabetes Council web site at www.texasdiabetescouncil.org.

## *Statewide Organizations*

### Children's Health Insurance Program in Texas (CHIP)/Children's Medicaid

1-800-647-6558, 1-877-543-7669
fax: 1-877-542-5951
www.chipmedicaid.org

Comprehensive health insurance for children (newborn through age 18) in families that earn too much to quality for Medicaid but likely cannot afford to buy health insurance.

### Medicaid

Texas Department of Human Services
Statewide: 1-800-252-8263
www.hhsc.state.tx.us/medicaid/index.html

Eligibility is based on financial income.

### Children with Special Health Care Needs (CSHCN, formerly CIDC)

Phones: 1-800-252-8023, or 1-800-422-2956 (Family Health Services)
Fax: 512-458-7417
www.dshs.state.tx.us/cshcn

Children with Special Health Care Needs (formerly CIDC) provides state-funded assistance for children with type 1 and type 2 diabetes for services not covered by Medicaid, CHIP, private insurance or third party payors.

### Texas Diabetes Prevention & Control Program/Council

Texas Department of State Health Services
P.O. Box 149347, Mail Code 1965
Austin, Texas 78714-9347
(512) 776-7490, 1-888-963-7111 ext. 7490
www.texasdiabetescouncil.org

The Texas Diabetes Council was established by the Texas Legislature in 1983 and works with private and public organizations to promote diabetes prevention and awareness of quality care. The Council develops, implements and monitors a state plan for diabetes prevention and control. **FREE** educational materials are available to order online.

### Texas Department of State Health Services Audiovisual Library

P.O. Box 149347, Mail Code 1975
Austin, TX 78714-9347
1-888-963-7111 ext. 7260
www.dshs.state.tx.us/avlib/default.shtm

Offers free loan of audiovisual materials to Texas residents on a number of health and safety topics.

### HHSC (Health and Human Services Commission) Office of the Ombudsman

1-877-787-8999
Fax: 512-491-1067
TDD Hotline 888-425-6889 or 512-438-3087 (not toll free)

The Office of the Ombudsman was created to assist the public with health and human services-related complaints or issues.

## *National Organizations*

### American Association of Diabetes Educators

200 W. Madison Street, Suite 800
Chicago, Illinois 60606
1-800-338-3633 (general inquires)
1-800-832-6874 or www.mydiabetespartner.org for diabetes educators in your area
www.diabeteseducator.org
email: aade@aadenet.org

### American Diabetes Association

1660 Duke Street
Alexandria, Virginia 22314
1-800-806-7801 (membership)
1-800-342-2383
1-800-232-6733 to order publications
www.diabetes.org

### American Dietetic Association

120 South Riverside Plaza, Suite 2000
Chicago, Illinois 60606-6995
1-800-877-1600

Consumer Nutrition Hotline:
1-800-366-1655 (Spanish available) for a list of registered dietitians in your area

www.eatright.org

### Joslin Diabetes Center

One Joslin Place
Boston, MA 02215
617-732-2400
www.joslin.org

### Juvenile Diabetes Research Foundation International (JDRF)

120 Wall St., 19th Floor
New York, New York 10005-4001
1-800-533-2873 (JDF-CURE)
www.jdf.org
email: info@jdrf.org

### Medic Alert Foundation International

2323 Colorado Avenue
Turlock, California 95382
1-800-ID-ALERT (432-5378), or 1-888-633-4298
www.medicalert.org

### Diabetes Research and Wellness Foundation

5151 Wisconsin Ave., NW
Suite 420
Washington, D.C. 20016
www.diabeteswellness.net

## *Government Agencies*

### Centers for Disease Control and Prevention Division of Diabetes Translation

4770 Buford Highway, NE, Mailstop K-10
Atlanta, Georgia 30341-3717
1-800-232-4636
1-770-488-5000/Fax: 1-770-488-5966
TTY: 1-888-232-6348
1-877-CDC-DIAB (232-3422)
www.cdc.gov/diabetes

### National Diabetes Education Program

One Diabetes Way
Bethesda, MD 20814-9692
1-800-438-5383
Five web addresses:
www.cdc.gov/diabetes/ndep home page
www.ndep.nih.gov for publications, audiovisual resources & publications
www.diabetesatwork.org for business and managed care organizations
www.betterdiabetescare.nih.gov for changes in health systems
www.cdc.gov/podcasts for podcast viewing

American Diabetes Association, American Dietetic Association, and the other organizations listed above have educational publications and audiovisual materials available, some at no cost. The list of other materials is only a sampling of diabetes education materials. The public library, local health department, local hospital and heart association are also sources for information.

### National Diabetes Information Clearinghouse

1 Information Way
Bethesda, Maryland 20892-3560
(301) 654-3327
1-800-860-8747
ndic@info.niddk.nih.gov
www.niddk.nih.gov

### National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

1 WIN Way
Bethesda, Maryland 20892-3665
1-800-WIN-8098; (301) 984-7378
email: win@info.niddk.nih.gov
www.niddk.nih.gov

### National Institutes of Health

www.nih.gov

### United States Department of Agriculture Food and Nutrition Information Center

http://www.nal.usda.gov/fnic
1-800-687-2258

Food Guide Pyramid – Copyright free materials that can be downloaded from Internet Weight-control Information Network

## *Patient Magazines/Print*

### Diabetes Digest

5 South Myrtle Ave.
Spring Valley, NY 10977
845-426-7612
fax: 845-426-7512

### Diabetes Forecast

www.forecast.diabetes.org

### Diabetes Health

6 School St.
Suite 160
Fairfax, CA 94930
1-800-234-1218
fax: 415-258-2822
www.diabeteshealth.com

### Diabetes Interview (monthly)

P.O. Box 668
Fairfax, CA 94978-0668
1-800-488-8468
Fax 1-800-559-0031

### Diabetes Self-Management

P.O. Box 51125
Boulder, CO 80323-1125

### Diabetes Wellness Letter

DRWF, P.O. 231
Shrub Oak, NY 10588

### Practical Diabetology

150 22nd Street
New York, NY 10011

### Voice of the Diabetic

Free upon Request
811 Cherry Street, Ste. 309
Columbia, MO 65201-4892

## *Patient Magazines/Online*

### Children with Diabetes

www.childrenwithdiabetes.com

Helps kids with diabetes and their families learn about diabetes, meet people with diabetes, and help others with diabetes.

### Diabetic Gourmet

www.diabeticgourmet.com

Online magazine dedicated to healthy eating, diabetes, and diabetes-related health issues, with news, recipes, articles, forums, tools, and more.

### Diabetic Lifestyle Online Magazine

www.diabetic-lifestyle.com and www.dlife.com

Includes recipes, menus, medical updates, and practical information on managing diabetes on a daily basis

## *Online Resources/Chat Rooms*

### Diabetic-Lifestyle Just for Kids

www.diabetic-lifestyle.com/forkids.htm

### Children with DIABETES

www.childrenwithdiabetes.com

### Diabetes Chat

www.diabetesCHAT.net

Must be 18 years old to participate

# *Medical Alert Jewelry*

### Diabetes Research & Wellness Foundation

**FREE** diabetes ID necklaces
www.diabeteswellness.net/

# *Medication Assistance & Information*

### Abbot Diabetes Patient Assistance Program

866-224-8887
www.abbottdiabetescare.com

### Access Diabetic Supply

1901 Green Road, Suite A
Deerfield Beach, FL 33064
1-800-705-5819 (Tel)
www.diabeticsupply.com

### American Diabetes Supply, Inc.

1-877-787-7543
www.diabetessupplies.com

### American Diabetes Wholesale

1121 S Military Trail
Suite 355
Deerfield Beach, FL 33442
Ph. (Toll Free) – (877) 241-9002
Fax (Toll Free) – (866) 995-4820
www.americandiabeteswholesale.com

### BD Medical-Diabetes Care

1-866-818-6906
http://www.bd.com/us/diabetes/page.aspx?cat=7002&id=14199

### Bureau of Prescription Help

573-996-3333
www.freemedicine.com

### B-Scientific Diabetes Centre

800-544-5969
877-505-5545 (fax)
www.bscientific.com
Serves Medicaid, CHIP, CSHCN, & commercial enrollees

### Better Living Now, Inc.

500 Wheeler Road
Hauppauge, New York 11788
1-800-854-5729 – Customer Service
1-800-654-7515 – Customer Service Fax Line
1-800-756-8775 – Sales
www.betterlivingnow.com

### CCS Medical

14255 49th Street North, Suite 301
Clearwater, FL 33762
1-800-726-9811
www.ccsmed.com/english/patient/index.asp

### Care Entrée

1-888-411-3888
www.careentree.com

### Drugstore.com

www.drugstore.com

### Edgepark Medical Supplies Shop

1-800-321-0591
www.edgepark.com/

### Focus Express Mail Pharmacy Inc.

1250 Easton Road
Suite S-101
Horsham, PA 19044
1-866-403-6287
www.focuspharmacy.com

### Free Drug Card

www.freedrugcard.us

### Free Medicine Foundation

573-996-3333
www.freemedicinefoundation.com/index.html

### Free Medicine Program

800-921-0072
www.freemedicineprogram.com

### Free Medicine Revolution

www.freemedicinerevolution.com

### FREEDOMED

1-888-722-7556
www.freedomed.com

### Liberty Medical Supply Pharmacy

10400 S. Federal Hwy., Suite 200
Port St. Lucie, FL 34952
www.libertymedical.com

### Health Warehouse

100 Commerce Blvd.
Cincinnati, OH 45140
1-866-885-0508
Fax: 1-866-821-3784
www.healthwarehouse.com

### Medicare Prescription Drug Plans

800-633-4227
www.medicare.gov/MPDPF/Shared/Static/Resources.asp

### NeedyMeds

www.needymeds.org

### Partnership for Prescription Assistance (PPA)

1-888-477-2669
www.pparx.org

### RxAssist

www.rxassist.org

### RxHope

www.rxhope.com

### Select Care Benefits Network

www.myrxadvocate.com

### State Pharmaceutical Assistance Programs

www.ncsl.org/programs/health/drugaid.htm

### Veterans Prescription Service

877-222-8387
www.va.gov/healtheligibility

### Western Diabetic Supplies

1140 36th St - Suite 140
Ogden, Utah 84403
Ph: 877-937-8342
Fax: 866-808-3418
www.westerndiabeticsupplies.com

## *Pharmaceutical Companies Assistance Programs*

### Amylin Pharmaceuticals, Inc.

Amylin Patient Assistance Program
Phone – 1-800-330-7647

### AztraZeneca Pharmaceuticals, LP

AstraZeneca Foundation Patient Assistance Program
Phone – 1-800-292-6363

### AZ&ME/AstraZeneca Prescription Savings Program for people without insurance

1-800-292-6363
www.astrazeneca-us.com/help-affording-your-medicines/

### Aventis Pharmaceuticals Inc.

Sanofi-Aventis Patient Assistance Program
Phone – 1-800-221-4025

### Bayer Pharmaceuticals Corporation

Bayer Patient Assistance Program
Phone – 1-800-348-8100
www.Bayerdiabetes.com

### Bristol-Myers Squibb Company

Bristol-Myers Squibb Patient Assistance Foundation, Inc.
Phone – 1-800-736-0003

### Eli Lilly and Company

Lilly Cares
Phone – 1-800-545-6962

### GlaxoSmithKline

Bridges to Access
Phone – 1-866-728-4368

### Johnson & Johnson

Health Care Systems Patient Assistance Program
Phone – 1-800-652-6227

### Merck Patient Assistance Program

Phone - 1-800-994-2111

### Merck/Scherling-Plough Pharmaceuticals

Merck/Sherling-Plough Patient Assistance Program
Phone – 1-800-347-7503

### Novartis Pharmaceuticals Corporation

Novartis Pharmaceuticals Corporation Patient Assistance Program
Phone – 1-800-277-2254

### Novo Nordisk Inc.

Novo Nordisk Diabetes Patient Assistance Program
Phone – 1-866-310-7549

### Pfizer

866-776-3700
www.pfizerhelpfulanswers.com

2 programs: Connection to Care, &Pfizer Pfriends — not age-mandated
Note: Cannot have insurance to quality for this program

### Pfizer Pfriends

1-866-706-2400
www.pfizerhelpfulanswers.com

### Roche Laboratories Inc.

Roche Laboratories Patient Assistance Program
Phone – 1-877-757-6243

### Sanofi-Aventis

Sanofi-Aventis Patient Assistance Program
Phone – 1-800-221-4025

### Scherling-Plough Corporation

SP-Cares Patient Assistance Program
Phone – 1-800-656-9485

### Takeda Pharmaceuticals North America, Inc.

Takeda Patient Assistance Program
Phone – 1-800-830-9159 or 1-877-582-5332

# *Supplies for Checking Feet*

### Free Monofilament for Checking Feet

1–888–275–4772
www.hrsa.gov/leap

# *Eye Care Assistance*

### American Foundation for the Blind

11 Penn Plaza, Suite 300
New York, New York 10001
1-800-232-5463
212-502-7600
afbinfor@afb.net
www.afb.org

### Eye Care America

655 Beach St.
San Francisco, CA 94109-1336
1-800-222-3937
www.eyecareamerica.org
Note: Also provides assistance with medications

### Blindness Education, Screening, and Treatment (BEST) Program

Division for Blind Services
Texas Department of Assistive and Rehabilitative Services (DARS)
1-800-628-5115
www.dars.state.tx.us/dbs/best/
DBSinfo@dars.state.tx.us

### InfantSEE

1-888-396-3937
www.infantsee.org

### Knights Templar Eye Foundation

1000 East State Parkway, Suite I
Schaumburg, IL 60173
847-490-3838
www.knightstemplar.org/ktef/ktef-faq.htm#contact

### Lighthouse International

111 East 59th Street
New York, New York 10022-1202
1-800-334-5497
1-800-829-0500
212-821-9200
212-821-9713 (TDD)
info@lighthouse.org
www.lighthouse.org

### Lions Clubs International

www.LionsClubs.org

### Mission Cataract USA

1-800-343-7265
www.missioncataractUSA.org

### National Association for Visually Handicapped (NAVH)

22 West 21st Street, 6th Floor
New York, New York 10010-6493
212-889-3141
www.navh.org

### National Eye Institute

National Institutes of Health
2020 Vision Place
Bethesda, MD 20892-3655
301-496-5248
2020@nei.nih.gov
www.nei.nih.gov

### National Federation of the Blind

1800 Johnson Street
Baltimore, MD 21230
Phones: 1-888-581-4741, 410-659-9314
Fax: 410-685-5653
www.nfb.org

### Prevent Blindness America

500 East Remington Road
Schaumburg, IL 60173-4557
1-800-331-2020
847-843-2020
info@preventblindness.org
www.preventblindness.org

### VISION USA

1-800-766-4466
www.aoa.org/x5607.xml

## *Eyeglasses*

### Sight for Students

1-888-290-4964
www.sightforstudents.org/

### New Eyes for the Needy

548 Millburn Ave.
P. O. Box 332
Short Hills, NJ 07078-0332
973-376-4903
Email: neweyesfortheneedy@verizon.net
www.neweyesfortheneedsy.org

## *Prosthetic Assistance*

The following organizations provide assistance to people who otherwise are unable to afford prosthetic care. Some provide other services as well. Each organization has its own method of providing services and requirements for eligibility. If you do not qualify for one program, you may be eligible for another, so don't give up!

### Angels with Limbs

289 Broadway
Long Branch, NJ 07740
(732) 222-2500
info@angelswithlimbs.com
www.angelswithlimbs.org

(New Jersey only) Angels with Limbs is a charitable, non-profit corporation soliciting unused artificial limbs so as to recycle their usable prosthetic components in fabricating a new prosthesis for needy un-insured or under-insured New Jersey amputees.

### Barr Foundation

136 NE Olive Way
Boca Raton, FL 33432
561/391-7601
foundation@t-barr.com
www.oandp.com/resources/organizations/barr/

This fund pays for materials and fitting of a new prosthesis after the prosthetist has established that there are no other sources of funding available. The Barr Foundation also accepts used prosthetic devices. Please call the Barr Foundation for further information.

## Bowman Siciliano Limb Bank Foundation

100 Spanish Oak RD
Weatherford, Texas 76087
817/597-1826
LimbBank@danabowman.com
www.danabowman.com/danabowman122006_032.htm

The Bowman Siciliano Limb Bank Foundation acts as a ready resource for artificial limbs for those in need. It is a non-profit organization seeking to fulfill the need for artificial limbs in underdeveloped nations and here in the United States where traditional funding is unavailable.

## Challenged Athletes Foundation

11199 Sorrento Valley RD, STE C
San Diego, CA 92121
858/866-0959
caf@challengedathletes.org
www.challengedathletes.org

The Challenged Athletes Foundation raises money to help people with physical disabilities pursue an active lifestyle through physical fitness and competitive athletics.

## Life Without Limbitations Foundation

P.O. Box 96
Lake Bluff, IL 60044
847/946-8306
limbitations@comcast.net
www.lifewithoutlimbitations.org

Life Without Limbitations is a non-profit organization dedicated to providing prosthetic care for individuals, principally children, who cannot otherwise afford it and raising awareness of the challenges facing amputees. Currently assisting people only in the United States.

## Limbs for Life Foundation

5929 N May, STE 511
Oklahoma City, OK 73112
405/843-5174 or 888/235-5462 (toll-free)
admin@limbsforlife.org
www.limbsforlife.org

Each qualified applicant will be provided with partial or complete funding for an advanced prosthesis, fitted by a highly qualified prosthetist.

### Limbs of Hope Foundation

6782 S Dixie DR
West Jordan, Utah 84084
801/548-0553
donate@limbsofhope.org
www.limbsofhope.org

The Limbs of Hope Foundation accepts new and used prosthetics that are to be sent across the globe in hopes of bettering the quality of life for those in need. They also provide recreational opportunities and recreational equipment for underdeveloped countries, as well as remodeling clinics in countries torn by war and/or illness.

### Limbs of Love

1000 S Loop West STE 150
Houston, TX 77054
713/747-7647
www.limbsoflove.com

Limbs of Love utilizes the time, skills and resources of medical professionals and manufacturers who receive no remuneration in an effort to improve the overall quality of life for amputees, primarily in Texas.

### National Amputation Foundation

40 Church ST
Malverne, NY 11565
516/887-3600
amps76@aol.com
www.nationalamputation.org

The National Amputation Foundation (NAF) has for over 80 years been offering valuable assistance to veterans of World War I, II, Korea, the Vietnam Conflict, Desert Storm and Iraqi Freedom. Since then, the Foundation has expanded its facilities to include civilian amputees as well.

## *Advocacy*

### Advocacy, Inc.

7800 Shoal Creek Blvd., #171-E
Austin, TX 78757-1024
1-800-252-9108

### Patient Advocate Foundation

800-532-5274
www.patientadvocate.org

# *Children's Resources*

### Children with Diabetes

www.childrenwithdiabetes.com

### Marathon Kids

www.marathonkids.org

### Shriners Hospitals

800-237-5055

### Texas Children's Hospital

832-822-3670
www.texaschildrenshospital.org/CareCenter/Diabetes

# *Camps*

### ADA Diabetes Camps

www.diabetes.org/communityprograms-and-localevents/diabetescamps.jsp

Each summer, there are day camps and 1- to 3-week camping sessions for children with type 1 diabetes. Tuition assistance is available based on financial need.

### Camp Bluebonnet

Sponsor: Children's Diabetes Camp of Central Texas
Contact: Amy Wallquist
P.O. Box 12885
Austin, TX 78711-2885
Email: camp_bluebonnet@yahoo.com
www.childrensdiabetescamp.org

Day camp for children with diabetes, ages 4-17

### Camp Sweeney

P. O. Box 918
Gainesville, TX 76273
940-665-2011/Fax: 940-665-9467
www.campsweeney.org/

Summer camping sessions from 10 days to 3 weeks for children ages 5-19 with type 1 diabetes. Family weekend camp and winter session offered. Camperships available.

### Texas Lions Camp

P.O. Box 247
Kerrville, Texas 78029-0247
1-830- 896-8500/ Fax: 830-896-3666

www.lionscamp.com/Diabetes.htm

Two **FREE** summer camping sessions exclusively for children ages 8-15 that use insulin. Sponsored by Texas Districts of Lions Clubs International.

## *General Information*

### Maternal and Child Health Library

www.mchlibrary.info/KnowledgePaths/kp_diabetes.html

## *Language Translation*

### CDC's "Take Charge of Your Diabetes" is available in 9 languages.

For translations, access the following link:
http://www.hawaii.gov/health/family-child-health/chronic-disease/diabetes/resourcesandtools.html

## *Pump Training*

### IPump.org, Inc.

program-director@ipump.org
www.ipump.org/

IPump.org provides temporary financial assistance and **FREE** supplies to people of all ages with diabetes in need throughout the U.S.

| | | |
|---|---|---|
| Animas: | Animas Pump Company | 1-877-937-7867 |
| MiniMed: | Medtronics | 1-800-999-9859 |
| Cosmo: | Smiths Medical | 1-800-544-4734 |
| Omnipod: | Insulet Corporation | 1-800-544-4734 |

## *Primary Care Service Sites*

### Texas Association of Community Health Centers

www.tachc.org

### U.S. Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA)

ask.hrsa.gov/pc/

# *Support Services*

### Family Support Network

www.childrenwithdiabetes.com/fsn/

# *Insurance Information*

### Health Insurance Consumer Guides

www.heatlhinsuranceinfo.net

### Insure Kids Now!

877-543-7669
www.insurekidsnow.gov

### Medicaid

1-877-267-2323

### State Children's Health Insurance Program

1-877-543-7669
www.cms.hhs.gov/home/schip.asp

### The Texas Department of Insurance

333 Guadalupe
Austin 78701

or

P.O. Box 149104
Austin 78714-9104
800-578-4677 (in Texas), 512-463-6169

Consumer Helpline
1-800-252-3439, 463-6515 in Austin
www.tdi.state.tx.us