Time Well Spent:
Treating Obesity and Diabetes

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Activity Overview

Target Audience

This activity is intended for physicians, physician associates, nurse practitioners, and nurses, involved in the care of patients with both T2D and obesity.

Educational Objectives

After completing this activity, the participant should be better able to:

- Utilize three evidence-based screening metrics beyond HbA1C (OGTT, GV, TIR) to assess whether to initiate or intensify T2D therapy, with consideration of obesity as a comorbidity.
- Determine the chronicity of obesity as a comorbidity and the importance of its timely management to mitigate risk of long-term complications in T2D.
- Select the most appropriate therapy for an individual patient with T2D and obesity with consideration of the latest safety and efficacy data of GLP-1 RAs and dual GLP-1/GIP RAs and ADA/EASD Consensus Statements.
- Identify patient- and disease- appropriate goals for the long-term management of weight loss and T2D related complications utilizing shared decision-making approaches and patient-reported outcomes

Reframing How We Approach T2D Management in Primary Care:

Making Time to Address Obesity in Your Busy Practice

T2D Disease Staging

Staging exists in many diseases:

- T1D
- Heart Failure
- Hypertension
- Dyslipidemia
- Chronic kidney disease
- Cancer

Potential staging for type 2 diabetes based on the scientific evidence

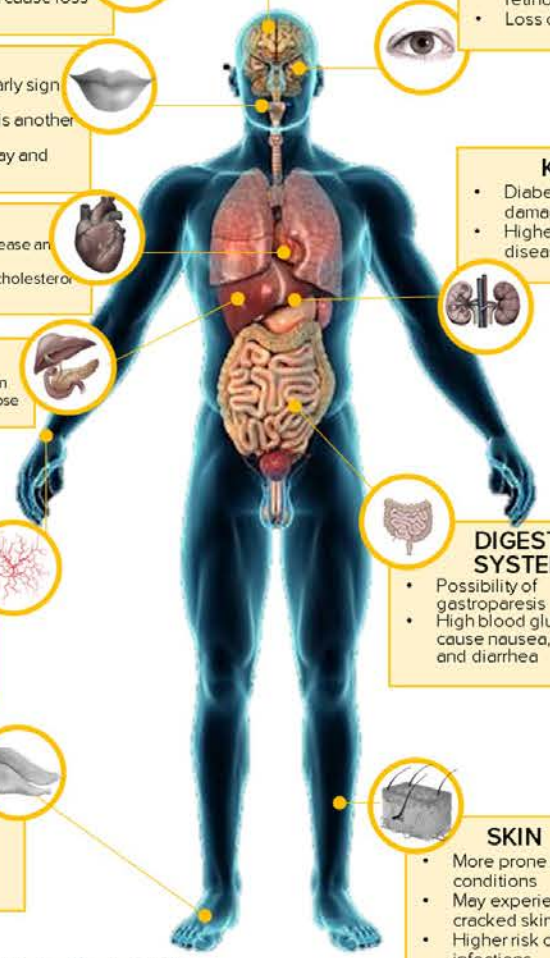
Stage	Fasting glucose	HbA1c
Stage 1 (Prediabetes)	100-109 mg/dl	5.7-5.9%
Stage 2 (Early diabetes)	110-125 mg/dl	6.0-6.4%
Stage 3	≥126 mg/dl	≥6.5%

Redefining fasting glucose of 100-125 mg/dl AND HbA1c of 6.0-6.4% as early diabetes allows for:

1. Appropriate access to resources for these individuals who are at greater risk for complications related to hyperglycemia
2. Timely intervention on the part of patients and providers to avoid progression

1. 83rd Annual American Diabetes Association Scientific Session, presented by Kevin Miller. DO
2. Miller E, Polonsky WH, Miller K. What Role Might There Be for Continuous Glucose Monitoring in the Assessment of Diabetes Risk? *Diabetes Technol Ther.* 2023 Jun;25(S3):S14-S20

Comorbidities Among Patients with T2D



BRAIN
- Increased risk of dementia and stroke
- May experience mental health challenges
- Untreated diabetes can cause loss of consciousness

EYES
- May experience cataracts, glaucoma or retinopathy
- Loss of vision common

MOUTH
- Excessive thirst is an early sign of diabetes
- Sweet-smelling breath is another common symptom
- Possibility of tooth decay and gum infections

KIDNEYS
- Diabetes can cause damage to kidneys
- Higher risk of kidney disease

HEART
- Increased risk of heart disease and heart attacks
- High blood pressure and cholesterol

PANCREAS
- Produced little-to-no insulin
- Causes rise in blood glucose

BLOOD VESSELS
- Increase in plaque in large blood vessels
- High blood glucose can damage small blood vessels

DIGESTIVE SYSTEM
- Possibility of gastroparesis
- High blood glucose can cause nausea, vomiting and diarrhea

FEET
- Neuropathy caused by high blood glucose
- Loss of feeling in feet is common
- Feet at highest risk of serious infection and amputation

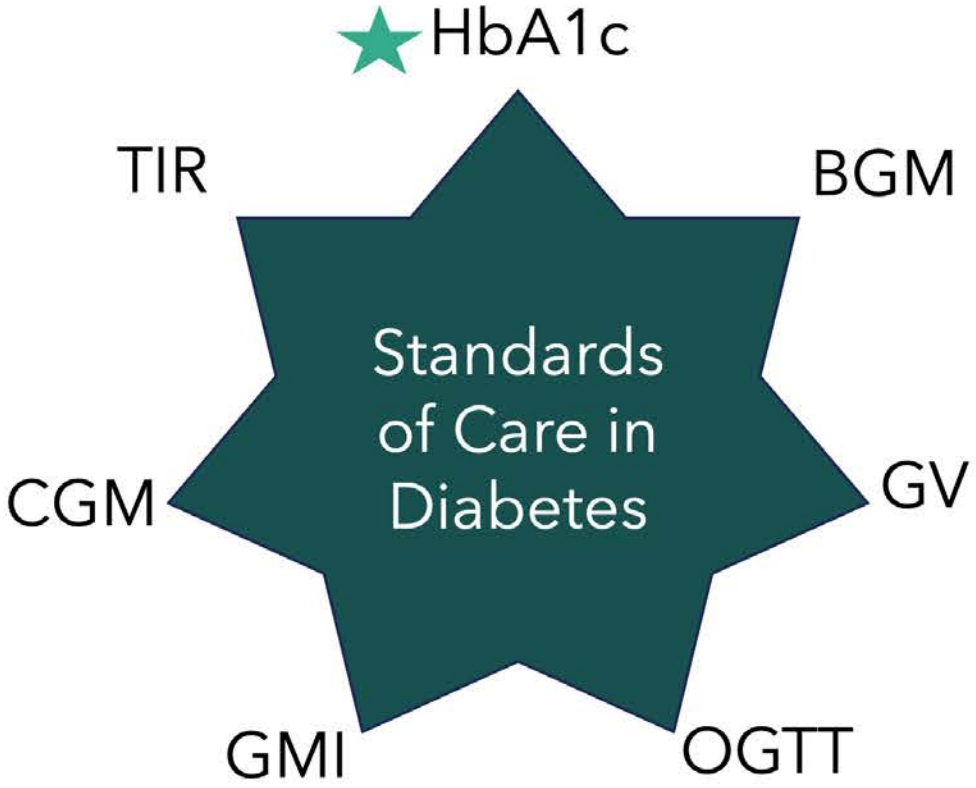
SKIN
- More prone to skin conditions
- May experience dry, cracked skin
- Higher risk of skin infections

....80-90% have overweight or obesity

Image adapted from Tri-City Medical Center 2018.

1. Nowakowska M et al. *BMC Med* **17**, 145 (2019).
2. Fang M et al. *Ann Intern Med*. Published online February 14, 2023. doi:10.7326/M22-3078.

Evidence-Based Glucose Control Screening Metrics



HbA1c Limitations

- Measurement variability
- Discrepancies between true mean blood glucose levels in certain racial/ethnic groups and conditions that alter erythrocyte turnover
- Does not account for hemoglobin variants
- Does not measure glycemic variability or hypoglycemia

BGM, blood glucose monitoring; CGM, continuous glucose monitoring; GMI, glucose management indicator; GV, glycemic variability; OGTT, oral glucose tolerance test; TIR, time in range.

1. ElSayed NA et al. *Diabetes Care* 2023;46(Supplement_1):S111-S127. 2. Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278. 3. Suh S & Kim JH. *Diabetes Metab J*. 2015;39(4):273-282. 4. ADA 2023. https://diabetes.org/diabetes/a1c/diagnosis. 5. Bergenstal RM et al. *Diabetes Care* 2018;41(11):2275-2280.

Addition of CGM as a Risk Assessment & Risk Reduction Tool

- Accurate risk assessment tools determine who is at greatest risk to progress from prediabetes to diabetes
- Addresses inaccuracies of HbA1c that vary between minorities and some disease states
- Allows real-time glucose monitoring through fluctuations for the presence and severity of dysglycemia
- Provides individualized lifestyle data allowing for patients to participate in their own health improvement

Rodbard D. Continuous Glucose Monitoring: A Review of Recent Studies Demonstrating Improved Glycemic Outcomes. *Diabetes Technol Ther*. 2017 Jun;19(S3):S25-S37.

T2D Control and Mitigation of Long-Term Complications

Macrovascular Complications

- Coronary artery disease
- Peripheral arterial disease
- Stroke

Microvascular Complications

- Diabetic nephropathy
- Neuropathy
- Retinopathy

- Individuals with T2D have 2- to 3-fold greater risk of CV events compared to those without diabetes
- CVD is responsible for ~80% of mortality associated with T2D

- Improvement in glycemic, blood pressure, and lipid control
- Novel anti-diabetes therapies in earlier stages

1. Fowler MJ. *Clin Diabetes* 2008;26(2):77-82. 2. Abdul-Ghani M, DeFronzo RA et al. *Diabetes Care* 2017;40(7):813–820. 3. Fan W & Wong ND. 2021. https://www.acc.org/latest-in-cardiology/articles/2021/10/28/12/49/micro-and-macrovascular-complications-management-for-newly-diagnosed-t2dm

Management of Hyperglycemia in Type 2 Diabetes, 2022. A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD)

Diabetes Care 2022;45:2753–2786 | https://doi.org/10.2337/dci22-0034

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The American Diabetes Association and the European Association for the Study of Diabetes convened a panel to update the previous consensus statements on the management of hyperglycemia in type 2 diabetes in adults, published since 2006 and last updated in 2019. The target audience is the full spectrum of the professional health care team providing diabetes care in the U.S. and Europe. A systematic examination of publications since 2018 informed new recommendations. These include additional focus on social determinants of health, the health care system, and physical activity behaviors, including sleep. There is a greater emphasis on weight management as part of the holistic approach to diabetes management. The results of cardiovascular and kidney outcomes trials involving sodium–glucose cotransporter 2 inhibitors and glucagon-like peptide 1 receptor agonists, including assessment of subgroups, inform broader recommendations for cardiorenal protection in people with diabetes at high risk of cardiorenal disease. After a summary listing of consensus recommendations, practical tips for implementation are provided.

ADA/EASD T2D Treatment Initiation and Intensification Recommendations

Treatment Initiation

The use of a GLP-1 RA should be considered prior to the initiation of insulin

The most common side effects tend to occur during initiation and diminish over time

Treatment Intensification

Most patients will require intensification of glucose-lowering medications, some require medication reduction or discontinuation if treatment is ineffective or associated with side effects

Timely re-assessment of individual glycemic targets and their achievement at regular intervals is imperative

Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.

ADA/EASD T2D Treatment Initiation and Intensification Recommendations

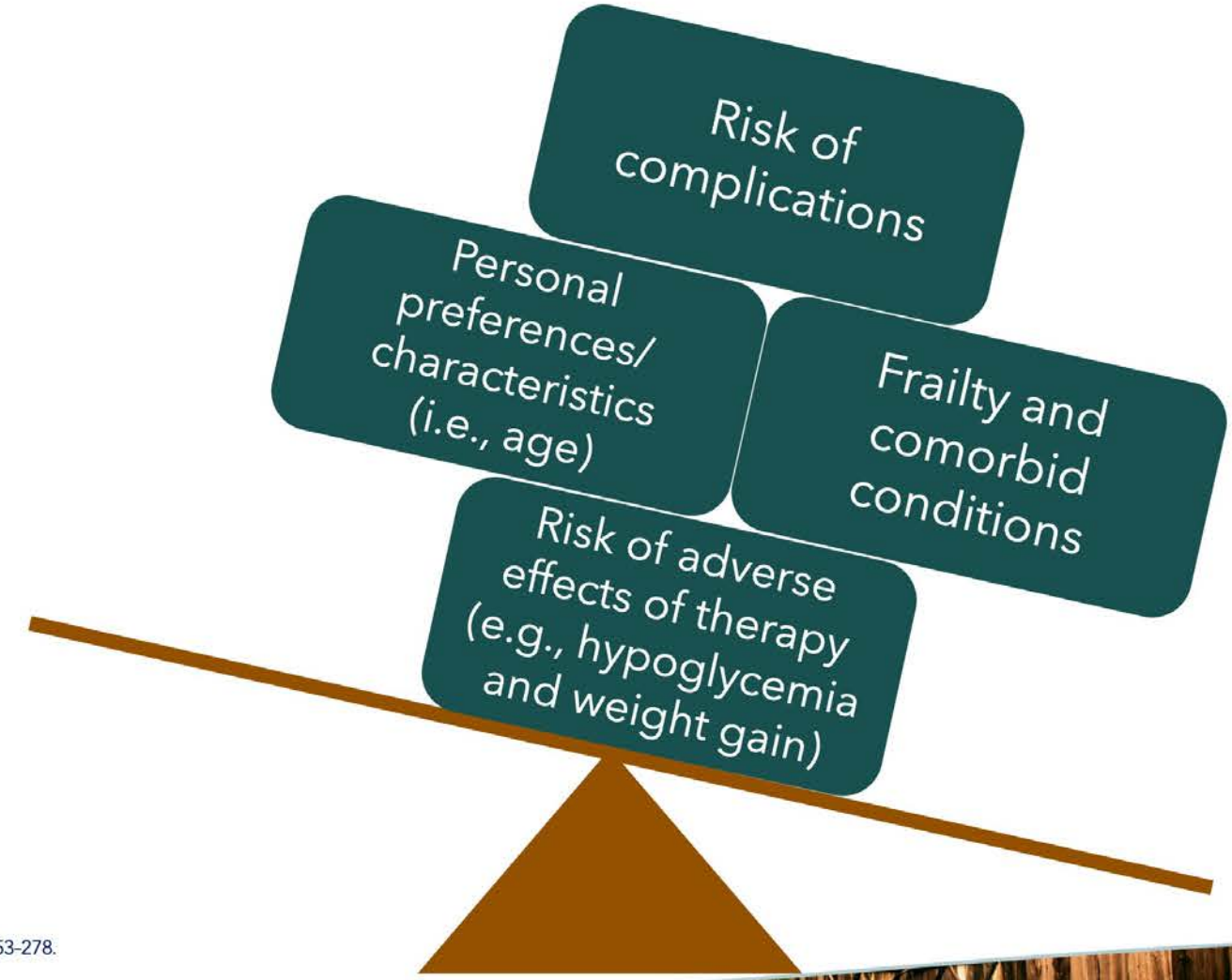
Beware of clinical inertia when managing T2D:
Failure to initiate or intensify therapy

Strategies to avoid clinical inertia

- Create a patient management plan
- Agree and implement changes in a timely manner
- Re-evaluate management plan every 6 to 12 months
- Involve interdisciplinary team members in care

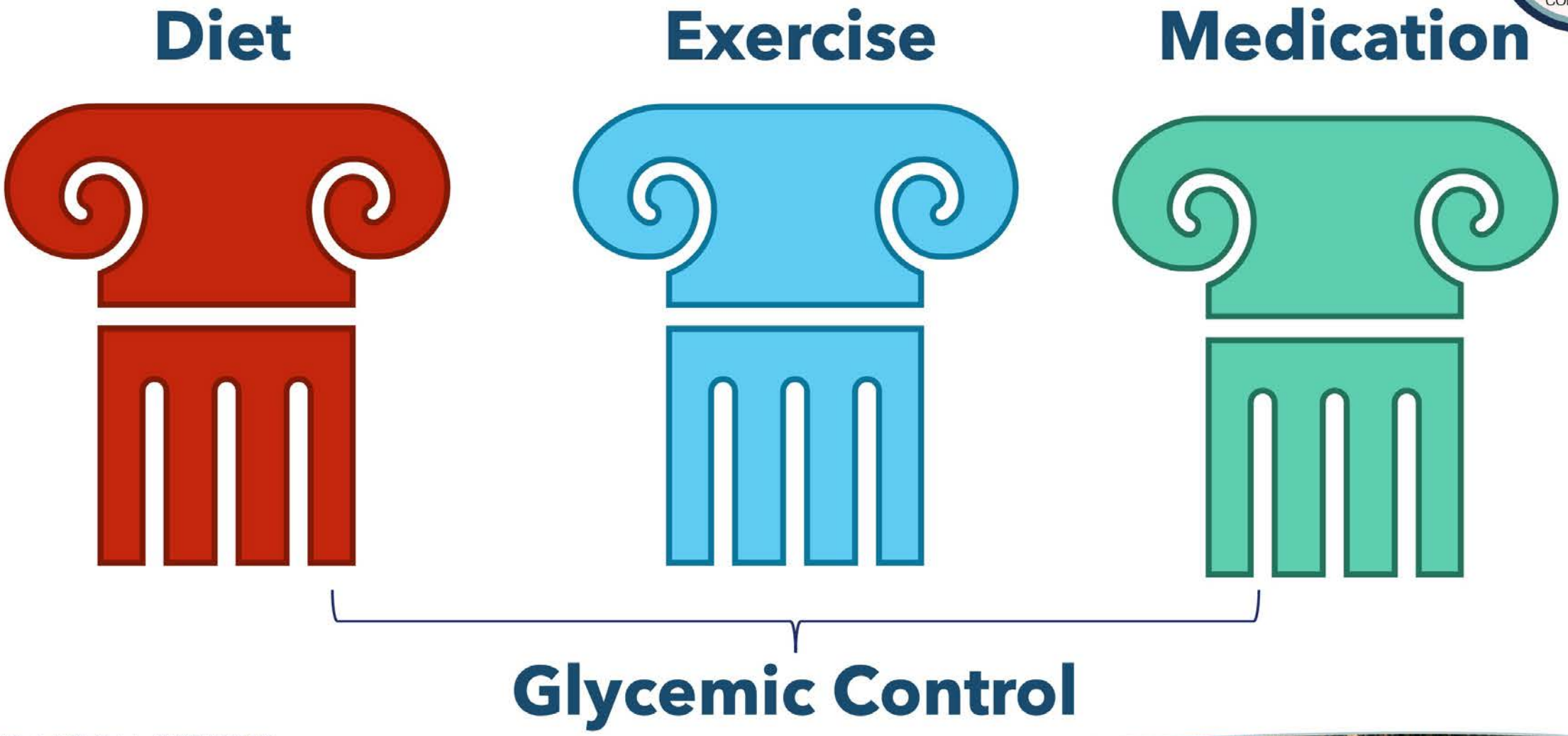
Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.

Glycemic Treatment Targets



Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.

Pillars of Diabetes Management



Ehrhardt N & Al Zaghal E. Clin Diabetes 2020;38(2):126-131.

T2D and the Complication of Obesity are a Dual Public Health Crisis

National Diabetes Statistics Report 2022

- 37.3 million people (11.3% of the U.S. population) with diabetes
- 28.7 million people (28.5 million adults) with diagnosed diabetes
- 8.5 million people (25.0% of adults) are undiagnosed

- 27.7% were overweight (BMI of 25.0 to 29.9 kg/m^2)
- 45.8% had obesity (BMI of 30.0 to 39.9 kg/m^2)
- 16.2% had extreme obesity (BMI of 40.0 kg/m^2 or higher)

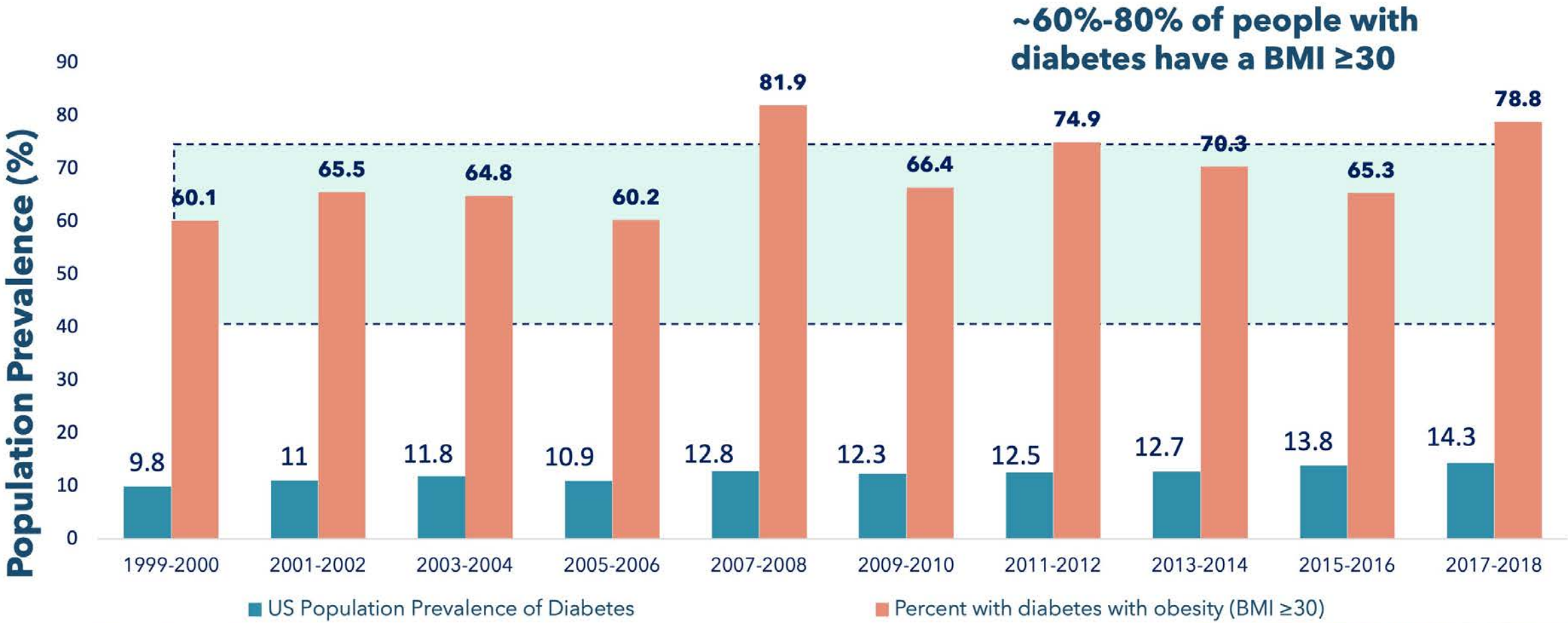
49.4% had an A1C value of 7.0% or higher

34.3% were physically inactive, getting less than 10 minutes a week of moderate or vigorous activity

Centers for Disease Control and Prevention. National Diabetes Statistics Report. June 2022. https://www.cdc.gov/diabetes/data/statistics-report/index.html.

Percentage of People with Diabetes who have Coexisting Obesity

National Health and Nutrition Examination Survey 1999-2018



Wang L, et al. *JAMA*. 2021. Hales CM, et al. *NCHS Data Brief*. 2020.

Impact of Physical Behaviors on Cardiometabolic Health in People with T2D

	Glucose/insulin	Blood pressure	HbA_{1c}	Lipids	Physical function	Depression	Quality of life
SITTING/BREAKING UP PROLONGED SITTING	↓	↓	↓	↓	↑	↓	↑
STEPPING	↓	↓	↓	↓	↑	↓	↑
SWEATING (MODERATE-TO-VIGOROUS ACTIVITY)	↓	↓	↓	↓	↑	↓	↑
STRENGTHENING	↓	↓	↓	↓	↑	↓	↑
ADEQUATE SLEEP DURATION	↓	↓	↓	↓	?	↓	↑
GOOD SLEEP QUALITY	↓	↓	↓	↓	?	↓	↑
CHRONOTYPE/CONSISTENT TIMING	↓	?	↓	?	?	↓	?

↑ Higher levels/improvement (physical function, quality of life); ↓ Lower levels/improvement (glucose/insulin, blood pressure, HbA_{1c}, lipids, depression); ? no data available;
↑ Green arrows = strong evidence; ↑ Yellow arrows = medium strength evidence; ↑ Red arrows = limited evidence.

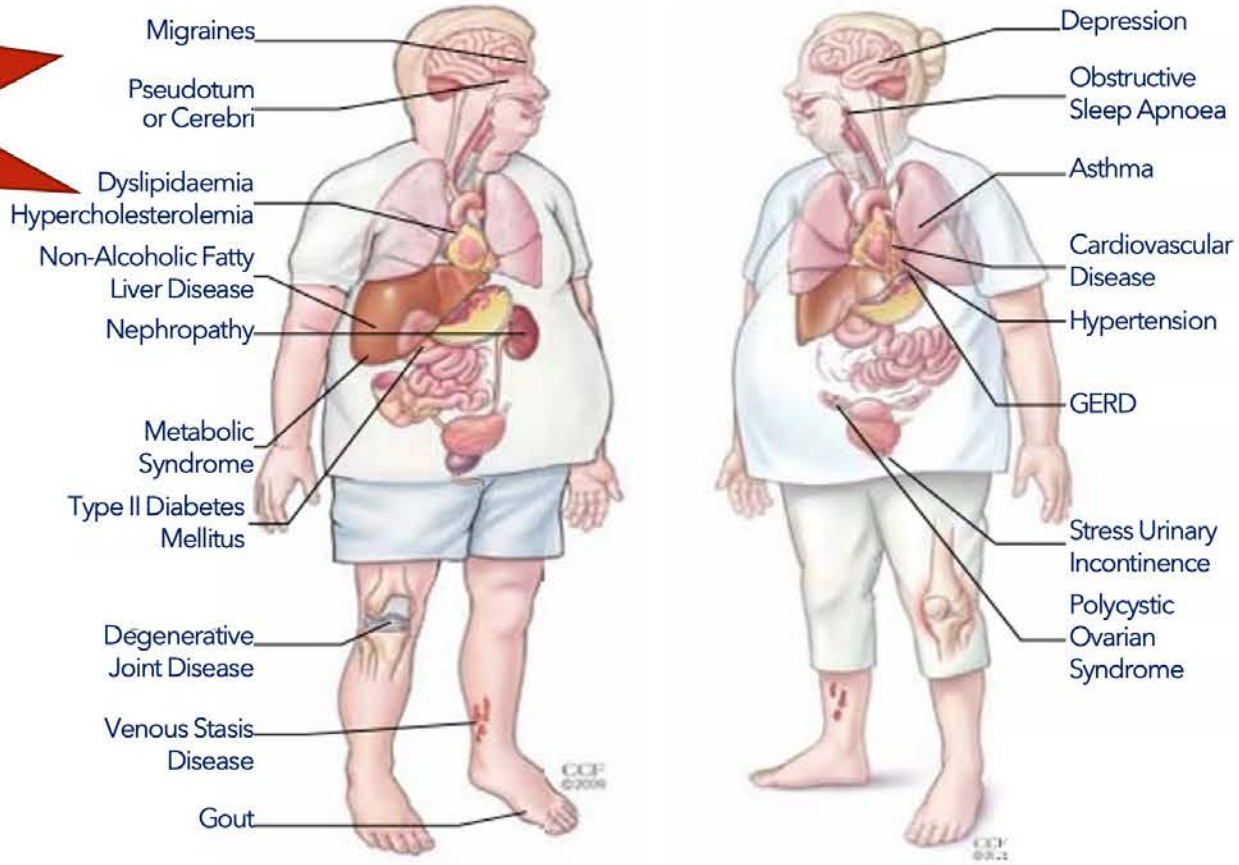
Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.

Burden and Undertreatment of Obesity

55% of adults with obesity reported receiving a diagnosis of obesity

24% of adults with obesity had further contact with a clinician for weight-related conversation

- Prevalence of obesity has tripled since 1975
- Significant negative impact on quality of life
- Substantial increase in national medical expenditures
- Obesity-related comorbidities addressed in primary care, but obesity itself is frequently undertreated



Adapted from Cleveland Clinic Center for Medical Art & Photography

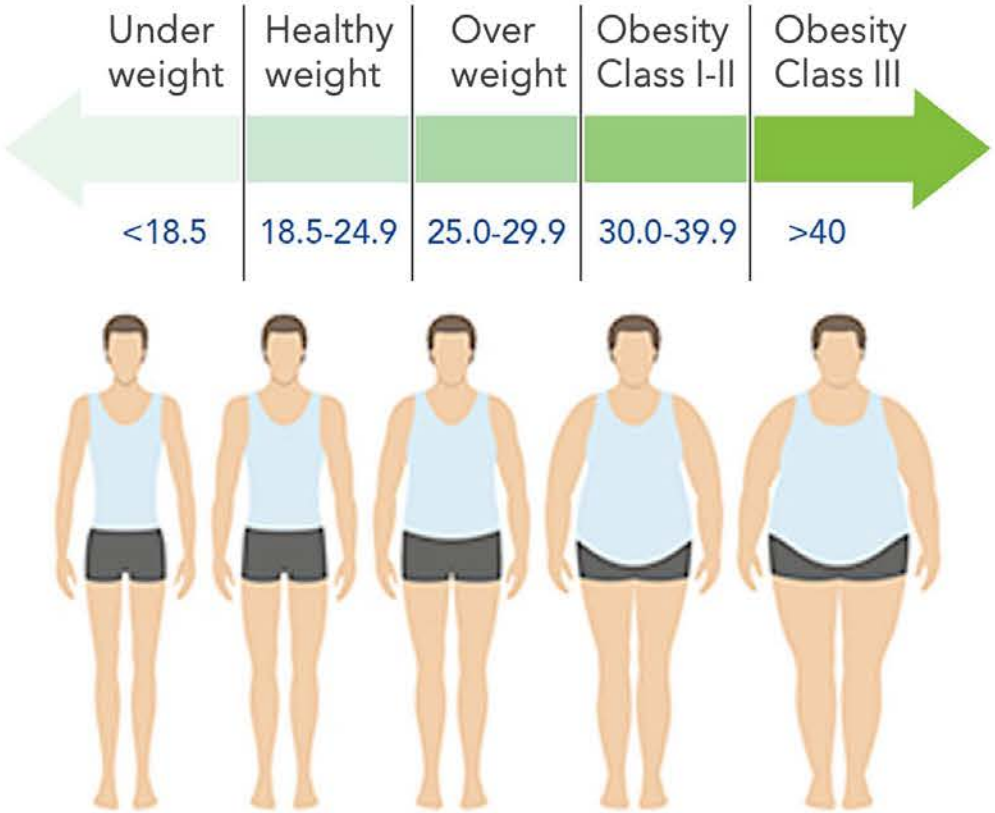
1. Tucker S, et al. Curr Obes Rep. 2021;10(3):396-408. 2. Afshin A, et al. N Engl J Med. 2017;377(1):13-27. 3. Biener A, et al. Clin Chem. 2018;64(1):108-117. 4. Tucker S, et al. Curr Obes Rep. 2021;10(3):396-408. 5. Kaplan L, et al. Obesity (Silver Spring). 2018;26(1):61-69.

Body Mass Index (BMI)

BMI is generally accepted as the first step to determine the degree of overweight and obesity.

It is a practical and useful determinant for increased risk of morbidity and mortality on the population level but less so on the individual level.

Weight Categories Based on BMI



The BMI Global Mortality Collaboration. Lancet. 2016.

Classification of Overweight/Obesity by BMI

Waist Circumference and Associated Disease Risks

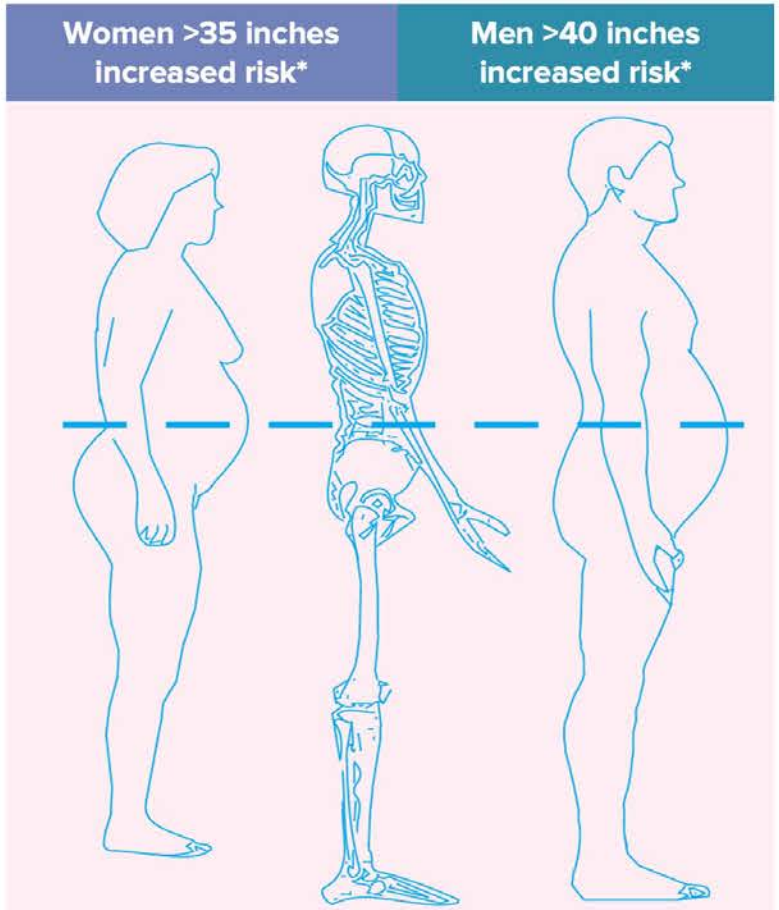
Disease Risk Relative to Normal Weight and Waist Circumference

	BMI (kg/m²)	Men (≤102 cm) ≤40 in Women (≤88 cm) ≤35 in	Men (>102 cm) >40 in Women (>88 cm) >35 in
Underweight	<18.5		
Normal	18.5-24.9		
Overweight	25.0-29.9	Increased	High
Obesity Class I	30.0-34.9	High	Very High
Obesity Class II	35.0-39.9	Very High	Very High
Obesity Class III	≥40	Extremely High	Extremely High

Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults--The Evidence Report. *Obes Res* 1998;6(suppl 2).

How to Measure Waist Circumference

- Locate upper hip bone and top of right iliac crest
- Place measuring tape in horizontal plane around abdomen at iliac crest
- Ensure tape is snug, but does not compress the skin
- Tape should be parallel to the floor
- Record measurement at the end of a normal expiration



Measuring-Tape Position for Waist (Abdominal) Circumference in Adults

*Ethnic/age-related differences affect predictive validity of WC as surrogate for abdominal fat

NHLBI Obesity Education Initiative. NIH. 2000. .

Diagnosing T2D and Overweight/Obesity in the Rural Practice Setting

Compared to urban areas, rural areas experience ~17% higher diabetes prevalence rate

The prevalence of obesity is ~23% in rural settings versus 20.5% in urban settings

Strategies to Improve Care in Rural Settings

- Telemedicine
- Community health workers
- In home education sessions
- Group classes

1. Massey CN et al. *Clin Diabetes 2010;28(1):20-27.* 2. Lepard MG et al. *Curr Diab Rep*. 2015 Jun; 15(6): 608.

ADA/EASD Recommendations for Weight Reduction Among Patients with T2D

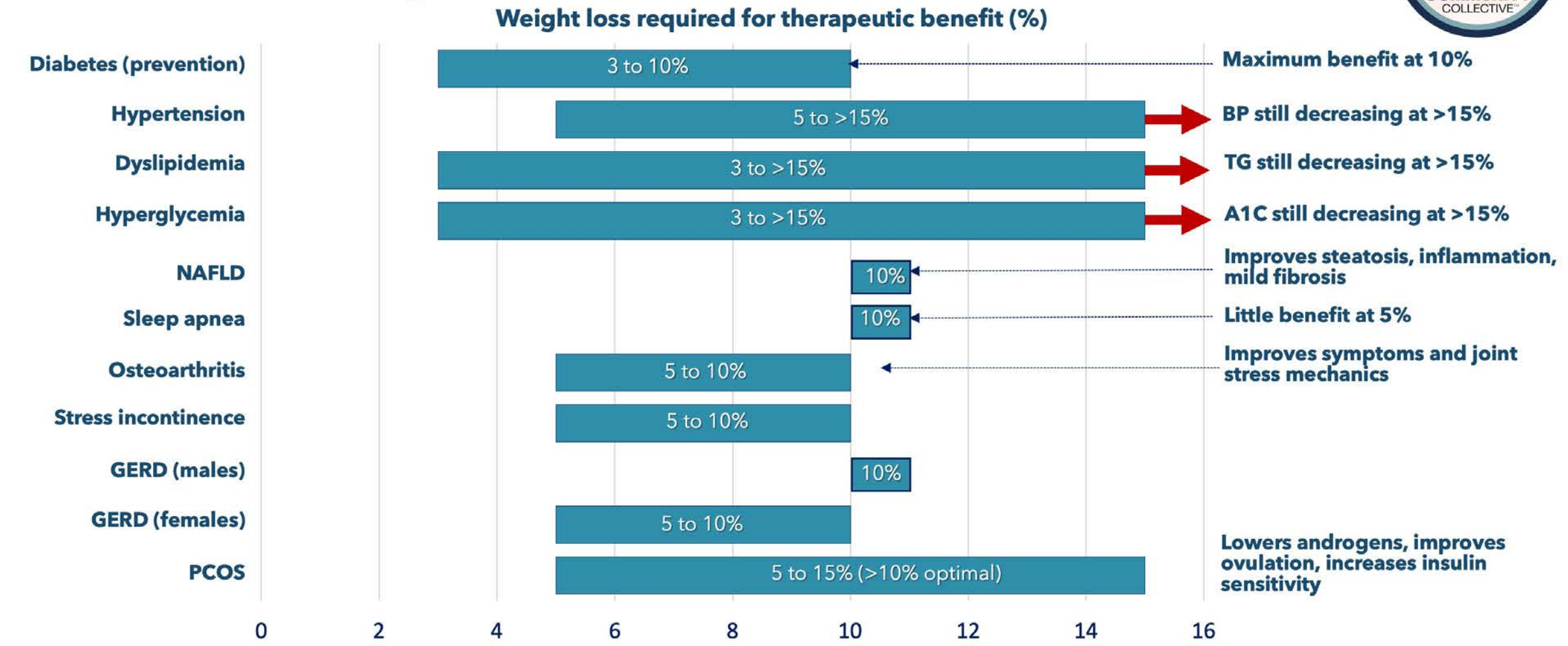
Weight loss of 5-15% should be a primary target in management for many people living with T2D

Weight loss may exert benefits that extend beyond glycemic management to improve risk factors for cardiometabolic disease and QOL

- Greater weight loss results in better outcomes
- 5-10% loss leads to metabolic improvement
- ≥10-15% loss of body weight can have a disease-modifying effect, leading to diabetes remission

Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.

Treating the Obesity: Therapeutic Weight Loss Reduces Complications



GERD, gastroesophageal reflux disease; NAFLD, nonalcoholic fatty liver disease; PCOS, polycystic ovary syndrome.

Cefalu WT, et al. Diabetes Care. 2015.

Case Study: Ms. Gonzales

35-year-old woman is at your office for follow-up of T2D diagnosis

On Exam	Recent Labs	Medications
Weight: 175 lbs **Height:** 66″ **WC:** 33.3″ **BMI:** 28 **BP:** 124/80 mmHg **HR:** 77/min **Cardiac exam:** normal	**Glucose:** 180 mg/dL **A1C:** 7.5% **TC:** 200 mg/dL **LDL-C:** 112 mg/dL **HDL-C:** 50 mg/dL **TG:** 148 mg/dL **eGFR:** >60 mL/min/1.73m^2	Metformin Clonazepam

Previous conversation regarding T2D and overweight to be discussed further at today's visit

A1C, glycated hemoglobin; BMI, body mass index; BP, blood pressure; eGFR, estimated glomerular filtration rate; HDL-C, high-density lipoprotein cholesterol; HR = heart rate; LDL-C, low-density lipoprotein cholesterol; TG, triglycerides; WC, waist circumference.

Using Person-first Language

DO

- Neutral, free of stigma, and based on facts
- Strength-based, encourage what is working
- Respectful and inclusive
- Collaborative
- Person-centered

DO NOT

- Refer to patients as "diabetics"
- Describe patients as "noncompliant"
- Blame patients for their health condition

"Patient living with T2D"

Person ***before*** the disease

1. Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.
2. Dickinson JK et al. *Diabetes Care* 2017;40:1790-1799.

Preferred Terms to Discussing Obesity

Certain words to describe body weight may be perceived by patients to be stigmatizing and blaming, whereas other terminology may be viewed as motivating and encouraging:

Least Motivating ← → *Most Motivating*

Least Motivating	Most Motivating
Fat Chubby Extremely obese	Unhealthy weight Overweight Weight problem

Most Blaming/Stigmatizing ← → *Least Blaming/Stigmatizing*

Most Blaming/Stigmatizing	Least Blaming/Stigmatizing
Fat Morbidly obese Extremely obese Obese	Weight High BMI Unhealthy weight Weight problem

Be Aware of Unconscious Bias

Strategies and considerations when speaking to patients with T2D and obesity

Focus on health, rather than weight

Provide continuous, **non-judgmental feedback** on progress

Recognize that T2D and obesity has many factors; many are **outside of the person's control**

Discuss and identify achievable, **sustainable goals** for your patient

Explore **all causes** of the patient's presenting problems

Recognize that many patients have **tried to lose weight repeatedly**

Consider that patients may have previously **experienced T2D/weight bias from providers**

The 5 A's Approach for Obesity

- Increases initiation and engagement of obesity intervention
- Patients report higher motivation to lose weight

Ask permission to address weight

↓

Assess the patient's desired weight loss goal and reasons for wanting to lose weight

↓

Advise about treatments that match the patient's goals and are likely to produce desired results

↓

Agree on weight loss, lifestyle, and behavioral goals

↓

Assist the patient by creating a plan

1. Schlair S, et al. JCOM. 2012;19(5):221-229. 2. Jay M, et al. BMC Health Serv Res. 2010;10:159.

Assisting Patients Who Have BMI ≥25 kg/m² with Lifestyle Modifications

- Modifications in lifestyle should be encouraged for all patients for whom weight loss is recommended who are also motivated to lose weight
- Modifications should combine health eating, physical activity, and behavioral therapy
- Lifestyle modifications are meant to foster behaviors that can be maintained for life

- Lifestyle modifications are meant to foster behaviors that can be maintained for life
- Consider the modifications more than a diet and that nutrition counseling is imperative to success
- Intensive behavioral therapy, such as smoking cessation, may require multiple attempts

Obesity interventions typically result in early rapid weight loss followed by a weight plateau and progressive regain

Hall KD & Kahan S . *Med Clin North Am* 2018;102(1):183-197.

Health Equity in T2D Care

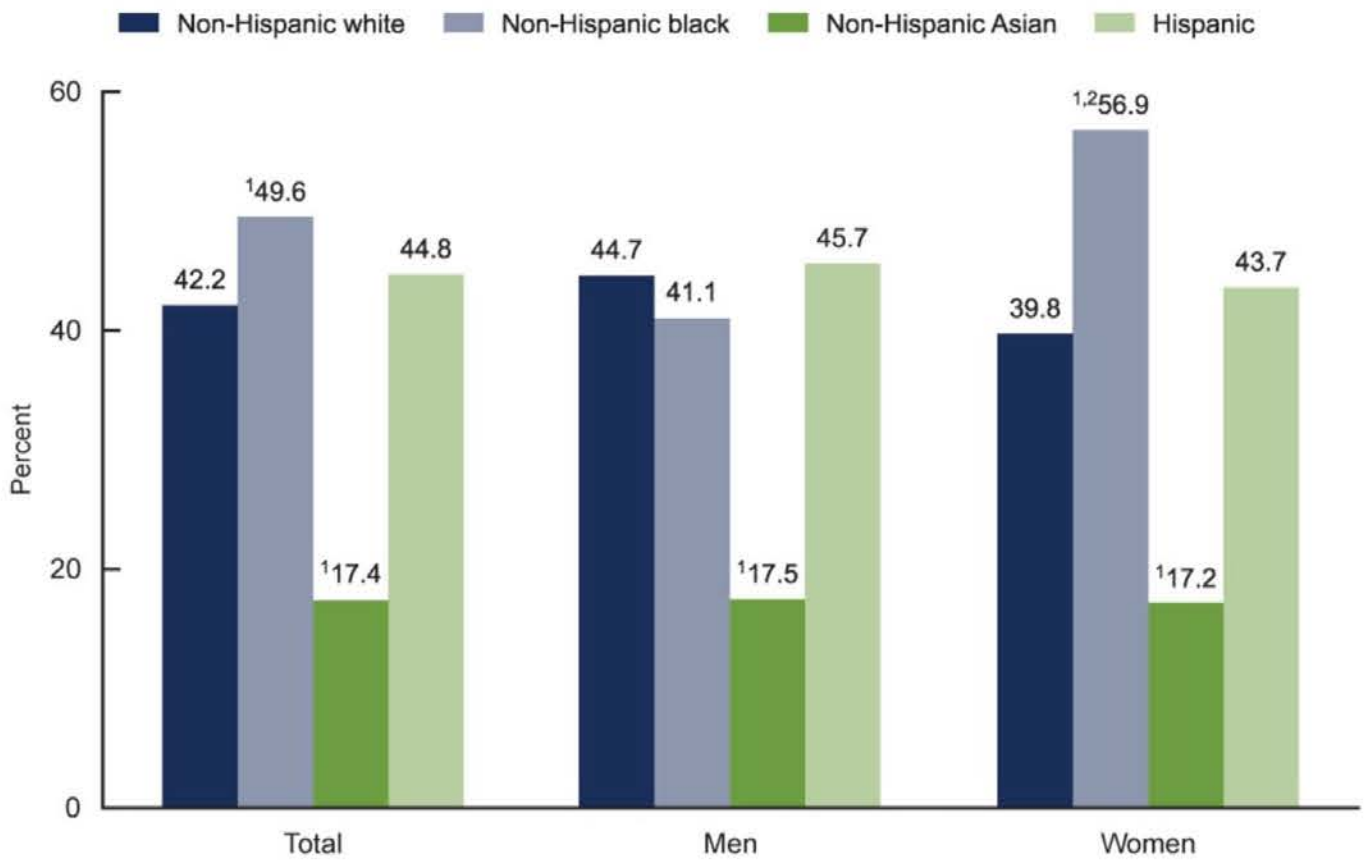
Health Disparities
Characteristics historically linked to discrimination or exclusion

- Geographic location
- Religion
- Socioeconomic status
- Sex
- Age
- Mental health
- Racial or ethnic group
- Sexual orientation or gender
- Cognitive, sensory, or physical disability

- T2D affects racial/ethnic minority and low-income adult populations in the U.S. disproportionately
- Social and environmental factors (SDOH) account for 50-60% of health outcomes
- SDOH should be used as intervention targets in achieving health equity

Hill-Briggs F et al. *Diabetes Care* 2021;44:258-279.

Burden of Obesity and SDOH



- In individuals with incomes just above the FPL, the adult obesity rate was 42.6%, vs 29.7% in people with income levels ≥400% of the FPL
- Adult obesity rate was 35.6% in adults who had less than a high school education, but only 22.7% in college graduates
- YRBS data indicated that obesity rates were highest in American Indian/Alaska Native, Black and Latino students, and in students who identified as gay, lesbian or bisexual

FPL, federal poverty level; SDOH, social determinants of health; YRBS, Youth Risk Behavior Surveillance System.
National Center for Health Statistics, National Health and Nutrition Examination Survey, 2017–2018. https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity#:~:text=More%20than%202%20in%205%20non-Hispanic%20white%20adults,1%20in%202%20Hispanic%20adults%20%2844.8%25%29%20have%20obesity..

Attitudes of Obesity by PCPs and Patients

PCP Attitudes

- More than 50% of physicians viewed patients with obesity as awkward, unattractive, ugly, and noncompliant
- The treatment of obesity was rated as significantly less effective than therapies for 9 of 10 chronic conditions
- Most respondents agreed in the benefit in 10% reduction of body weight
- More than one-half (54%) would spend more time working on weight management issues if their time was reimbursed appropriately

PCP Attitudes

Physicians are common sources of stigma. In a study that surveyed more than 2,400 adult women about their experiences of weight bias, 69 percent of respondents reported that physicians were a source of weight bias, and 52 percent reported they had been stigmatized by a doctor on multiple occasions

Doctors were the second most frequent source of bias reported, out of a list of more than 20 possible sources of weight stigma

1. Foster GD, Wadden TA, Makris AP, et al. Primary care physicians' attitudes about obesity and its treatment. Obes Res. 2003;11(10):1168-1177. 2 Obesity Action Coalition. Understanding Obesity Stigma Brochure. https://www.obesityaction.org/get-educated/public-resources/brochures-guides/understanding-obesity-stigma-brochure/.

Social Determinants of Health

Socioeconomic status
- Education
- Income
- Occupation

Living and working conditions

Addressing SDOH improves health outcomes

Sociopolitical context
- Shared cultural values
- Practices
- Experiences

Multisector domains
- Housing
- Education
- Criminal justice system

Sociocultural context
- Shared cultural values
- Practices
- Experiences

Psychosocial factors
- Environmental
- Social
- Behavioral
- Emotional

Davies MJ et al. Diabetes Care 2022;45(11):2753-278.

Healthy People 2030 and Diabetes

Increase the proportion of people with diabetes who get formal diabetes education – D-06

Status: Little or no detectable change

Learn more about our data release schedule

Most Recent Data:
55.1 percent
(2019) *

Target:
55.2 percent *

Desired Direction:
Increase desired

Baseline:
51.7 percent of adults aged 18 years and over with diagnosed diabetes ever had received formal diabetes self-management education and support (DSME) in 2017 *

* Age adjusted to the year 2000 standard population.

Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes/increase-proportion-people-diabetes-who-get-formal-diabetes-education-d-06

Healthy People 2030 and Diabetes

Increase the proportion of adults whose health care provider checked their understanding – HC/HIT-01

Status: Little or no detectable change

Learn more about our data release schedule

Most Recent Data:
25.6 percent (2019)

Target:
32.2 percent

Desired Direction:
Increase desired

Baseline:
26.6 percent of adults aged 18 years and over reported that a health care provider asked them to describe how they will follow instructions in 2017

Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-communication/increase-proportion-adults-whose-health-care-provider-checked-their-understanding-hchit-01

Considerations for Shared Decision-making

Gather Information

- Ask leading questions
- Clarify information by repeating back what patient said
- Do not interrupt patient
- Assess motivation confidence

Establish Relationship

- Communicate intention to help
- Acknowledge emotions/ feelings
- Use layman's terms to explain
- Collaborate to identify the next step
- Use weight neutral terms
- Instill confidence

Education and Counseling

- Ask questions to make sure patient understood
- Discuss specific diet, exercise, and monitoring goals
- Elicit and address barriers to change
- Explain the nature of T2D

US Preventative Task Force. *JAMA*. 2022; Politi MC, et al. *BMJ*. 2013.

Shared Decision Making in T2D and Obesity

Benefits of SDM

- Considers patient's preferences and values to create a personalized management plan
- Improves decision quality
- Informs patient regarding treatment risks, safety, and benefits

Supports individual autonomy by empowering patients to make decisions about the treatment and care that is right for them at that time

SDM, shared decision-making

Davies MJ et al. *Diabetes Care* 2022;45(11):2753-278.

Value of Interdisciplinary Teams in T2D Management

Pharmacist

Medical Assistant

Person with Obesity/Diabetes

Family / Caregiver

CDCES

Registered Dietitian

Clinician

Countless others!

Community health workers

Behavioural Health Specialist

Case manager

Social Worker

Exercise specialist/Health Coach

Schneider D & Taddei-Allen P. *Am J Manag Care*.2020;26:S356-S367.

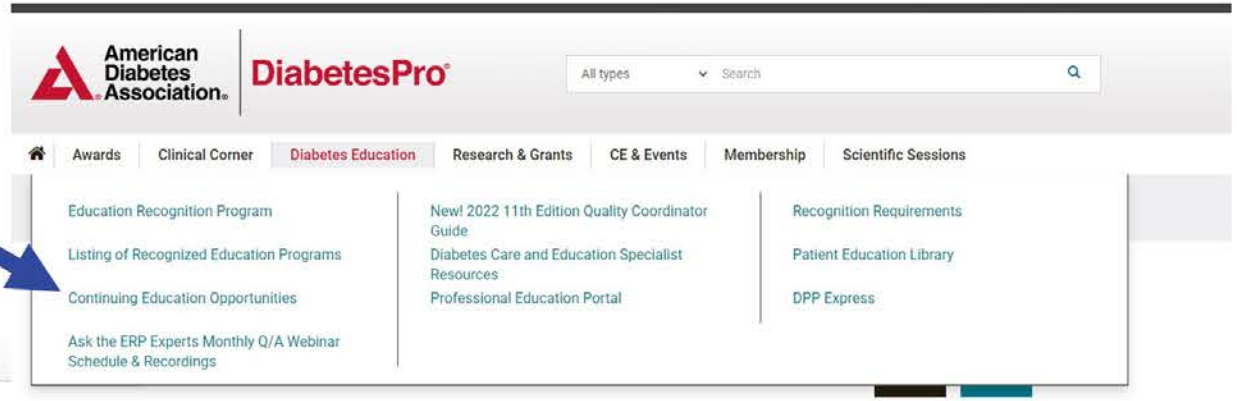
How to Build and Locate Your Team Members

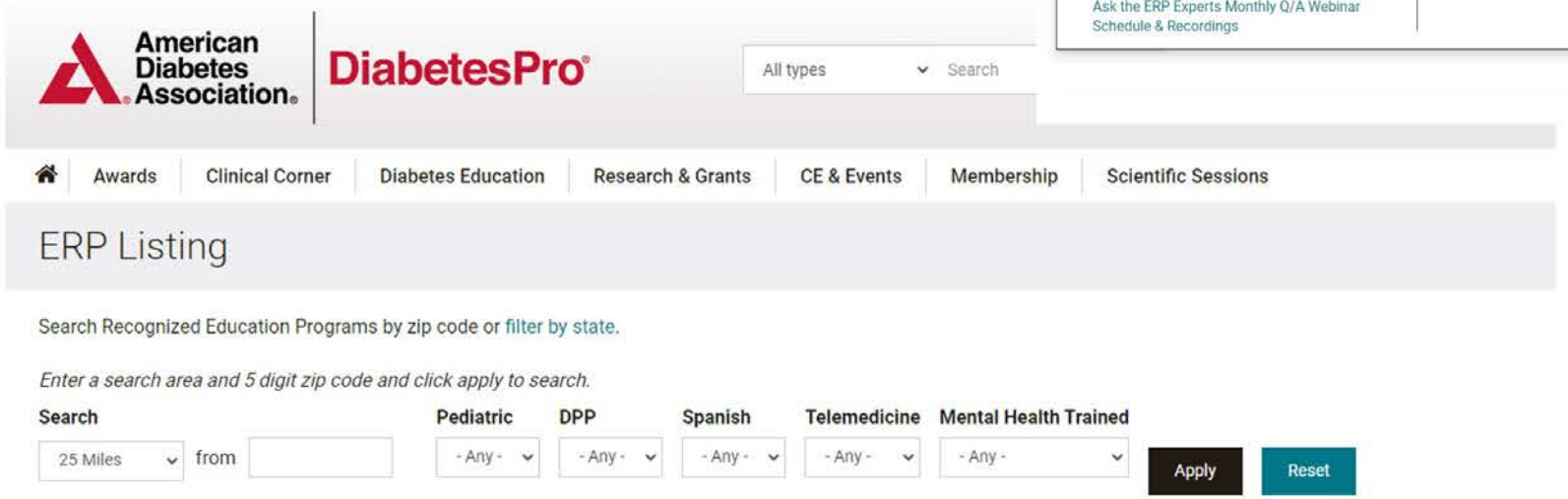
- Google maps to locate service providers geographically close to you
- Drop off business cards and be receptive to receiving them from others near you for referrals
- Be familiar with community events, make sure to attend, and participate in advertising their activities
- Look for opportunities to identify those in your area that provide diabetes education through ADA or ADCES websites
- Visit the local hospital's diabetes education department and introduce yourself
- Identify a diabetes champion in your practice setting

Importance of Collaborative Care

Finding ADA DSMES

Find a DSMES program near you





Professional.Diabetes.org/erp_list_zip.

Additional Resources

- SDOH resources
- SDOH overview, related research and tools
  - cdc.gov/socialdeterminants
- Food assistance, help paying bills, and other free or reduced cost programs, including COVID-19 programs
  - findhelp.org
- American Academy of Family Physicians (AAFP) Toolkit
  - www.aafp.org/everyone:
- Prescription savings resources
- American Association of Clinical Endocrinology (AACE)
  - prescriptionhelp.aace.com
- Association of Diabetes Care and Education Specialists (ADCES)
  - www.diabeteseducator.org/affordability
- Mental health resources
- American Diabetes Association (ADA) provider directory
  - professional.diabetes.org/mhp_listing
- ADCES
  - www.diabeteseducator.org/mentalhealth

Additional Resources

- Local Level community and County
  - Health Care Provider Colleagues
  - Public Health Departments
  - Community Centers and Religious Organizations
- State Level
  - Rural Health Organizations
  - Governmental Health Committees and Legislation Support
  - Insurance Payor Boards
- National
  - Health Governing Bodies: ADA, ADCES, ABOM, ACD
  - Non-profit Organizations: DPP, Diabetes Leadership Council