



American Public Health Association

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April 17, 1997

Dear Member of Congress:

The American Public Health Association, the American Association of Diabetes Educators, the American Diabetes Association, the Association of State and Territorial Chronic Disease Program Directors, the American Academy of Ophthalmology, the Association of State and Territorial Health Officials, the Association of State and Territorial Directors of Health Promotion and Public Health Education, and the Society for Public Health Education would like to invite you and your health staff to an important briefing on Friday, April 25, 1997, at 8:30 a.m. in Room #325 Russell Senate Office Building. This meeting will provide a discussion of diabetes as a public health issue.

More than 16 million Americans have diabetes, but as many as half will not know it until confronted with one of its serious complications: blindness, heart disease, kidney disease, stroke and leg or foot amputations. Each year diabetes takes the lives of over 150,000 individuals and costs our nation over \$92 billion in health care expenditures and lost productivity. Moreover, diabetes disproportionately affects minorities and the elderly, populations that often have reduced access to health care services.

The following speakers will discuss public health activities in diabetes control:

Belinda Childs, RN, MN, CDE

President
Health Care and Education
American Diabetes Association

Philip Huang, MD, MPH

Chief
Bureau of Chronic Disease Prevention and Control
Texas Department of Health

Frank Vinicor, MD, MPH

Director, Division of Diabetes Translation
Centers for Disease Control and Prevention

Fran C. Wheeler, PhD

Director
Center for Health Promotion
South Carolina Department of Health and Environmental Control

We urge you to join us. Please let me know at (202) 789-5652, if you are planning on attending.

Sincerely,

Mohammad N. Akhter, MD, MPH
Executive Director

125 Years of Leadership in Public Health

MMWRTM

MORBIDITY AND MORTALITY WEEKLY REPORT

- 281 Gamma Hydroxy Butyrate Use —
New York and Texas, 1995–1996
- 283 Pregnancy-Related Behaviors
Among Migrant Farm Workers —
Four States, 1989–1993
- 286 Resources and Priorities
for Chronic Disease Prevention
and Control, 1994
- 288 Hepatitis A Associated with
Consumption of Frozen
Strawberries — Michigan,
March 1997

**Resources and Priorities
for Chronic Disease Prevention and Control, 1994**

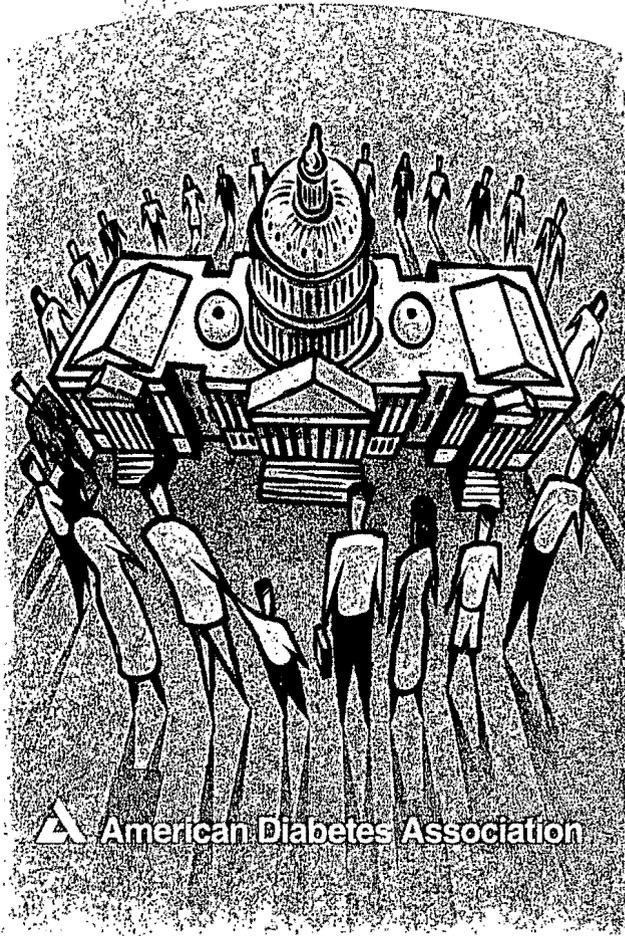
Chronic diseases (e.g., heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, and chronic liver disease) are the major causes of death, disability, and medical expenditures in the United States (1). Although these six diseases accounted for 73% of all U.S. deaths in 1993 (2), characterization of the capacity and priorities of public health agencies to prevent or control these chronic diseases has been limited. To assess the resources, needs, and priorities in chronic disease prevention and control for fiscal year (FY) 1994, the Association of State and Territorial Chronic Disease Program Directors (ASTCDPD) conducted a national survey of state and territorial health agencies; this survey updates a similar survey that collected data for FY 1989 (3,4). This report summarizes the survey findings for 1994, which indicate that, during 1989–1994, expenditures for state-specific chronic disease activities increased modestly but remained disproportionately low in relation to the public health burden of chronic diseases.

In April 1995, ASTCDPD mailed a questionnaire to the ASTCDPD voting member in each state and U.S. territory. The survey addressed four categories: 1) resources; 2) plans and priorities; 3) links with other organizations; and 4) laws, policies, and standards. Responses were received from 41 states and Guam.* Per capita expenditures for the 41 states were calculated using estimates based on the 1990 census.

For FY 1994, the total reported expenditure for chronic disease-control activities in the 41 reporting states was \$287,306,934, and the per capita expenditure was \$1.21 (range: \$0.13–\$3.20). In comparison, for FY 1989, the reported total expenditure for all 50 states, the District of Columbia, Guam, and the Virgin Islands was \$245,371,377, and the per capita expenditure was 99¢ (range: 0–\$3.83) (4); for the same 41 states that responded for 1994, expenditures were \$236,145,920 and

*Data were not provided from Arizona, Delaware, the District of Columbia, Hawaii, Kansas, Massachusetts, New Hampshire, New Mexico, Oregon, West Virginia, and the Virgin Islands.

TAKE ACTION



 American Diabetes Association

THE AMERICAN DIABETES ASSOCIATION

The American Diabetes Association is the country's largest voluntary health organization supporting diabetes research, information and advocacy. The Association is leading the battle to educate Americans about diabetes and its serious implications. Our mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

The Association is made up of a network of one million volunteers, 280,000 diabetes patients and families, and a professional section of more than 12,000 physicians, scientist, nurses, dietitians, pharmacists, social workers, and educators. Together, this network is working to fight diabetes. These volunteers are committed to action because they know:

- More than 16 million Americans have diabetes
- In 1996, over 162,000 Americans died from diabetes
- Diabetes is the fourth-leading cause of death by disease in the U.S.
- Every minute another person is diagnosed with diabetes
- Diabetes is a leading cause of kidney failure, non-traumatic amputations, heart disease, stroke and blindness
- Diabetes costs our nation \$138 billion a year
- There is still no cure!

ADVOCACY GOALS

1

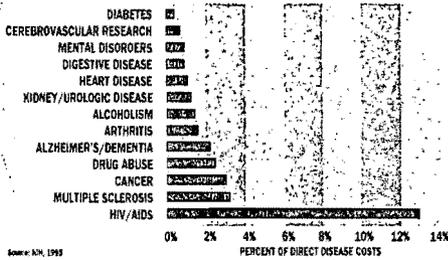
FUNDING FOR DIABETES RESEARCH AND HEALTH CARE PROGRAMS

Diabetes research saves money. For every dollar spent on medical research, \$13 is saved in health care costs, productivity and lost wages. However, of the more than \$13 billion spent by the US Government on medical research, only 3% is used to fund diabetes research, an amount far less than the economic and human effects the disease warrants. The Association supports increased funding for diabetes research particularly at the:

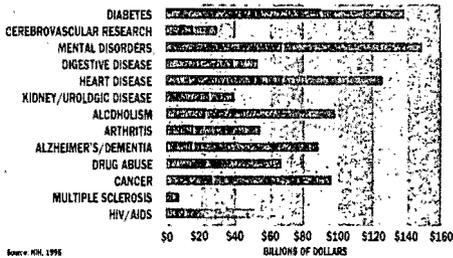
National Institutes of Health (NIH)

NIH supports the majority of diabetes research, most notably at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

NIH RESEARCH SUPPORT



HEALTH CARE COSTS



Centers for Disease Control and Prevention (CDC)

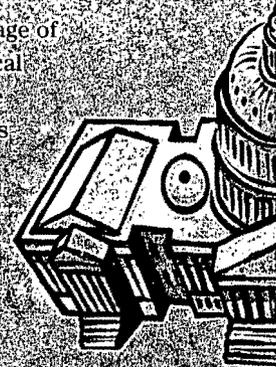
CDC plays an essential role in the surveillance of Americans currently suffering from diabetes (particularly in culturally diverse populations) and in the practical application of research findings through state-based diabetes control programs.

Indian Health Service (IHS)

Native Americans have one of the highest rates of diabetes of any population in the world. With one in three Native Americans developing diabetes, the IHS is the only agency able to serve their needs.

Veterans Affairs (VA)

A substantially higher percentage of veterans cared for at VA Medical Centers have diabetes than the general population. This makes the need for diabetes-related clinical care in the VA system critical. In addition, diabetes research supported by the VA is an important complement to other federal medical research.



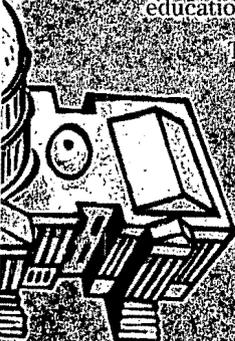
2

**HEALTH
INSURANCE
ISSUES**

Diabetes requires a lifetime of medical care and self-treatment, for which the person with diabetes must have access to supplies and education. With access to supplies and the knowledge to use them, a person with diabetes can greatly reduce the complications that are the primary cause of the expense and suffering associated with the disease.

Overwhelming scientific evidence supports the benefits of supplies and education. Yet, Medicare and Medicaid, the federal government's two largest health care programs, as well as many private health care providers, do not offer comprehensive/affordable coverage of the necessary supplies and education.

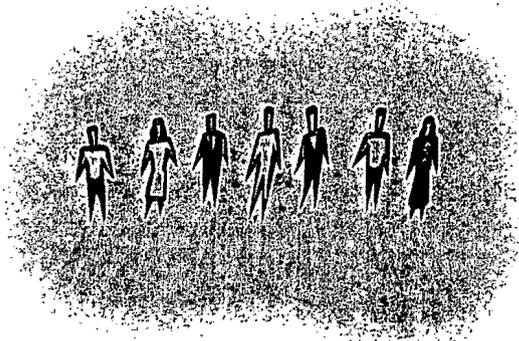
The American Diabetes Association is committed to pursue public policy goals that will ensure greater access to appropriate high-quality health care for people with diabetes, including access to specialty care and reimbursement of diabetes supplies, care and education.



3

**DISCRIMINATION
AGAINST PEOPLE
WITH DIABETES**

Despite the KinderCare agreement and the new FAA policy, people with diabetes continue to face discrimination in many forms. Currently, the American Diabetes Association is engaged in activity to end the Department of Transportation's "blanket ban" on commercial drivers. The Association is also committed to reducing incidents of discrimination in private workplaces, daycare centers and public schools. Diabetes, perse, should not be a cause for discriminating against any person.



**RECENT ACTION —
WE MAKE A
DIFFERENCE!**

Look at what we've done in just one year:

- President Bill Clinton signed the Kassebaum-Kennedy Health Insurance Reform Act of 1996
- The FAA overturned it's 37 year old "blanket ban" on pilots with insulin treated diabetes
- Florida passed diabetes insurance bill
- Increased funding for NIH research
- 85,000 diabetes petitions delivered to Speaker Gingrich & Senator Dole
- New Jersey passed diabetes insurance bill
- 250 congressional sponsors of Medicare reform
- Rhode Island passed diabetes insurance bill
- Plaintiff in Kindercare discrimination lawsuit victory
- West Virginia passed diabetes insurance bill
- Oklahoma passed diabetes insurance bill
- Diabetes '96 campaign.

**BECOME A
DELEGATE FOR
DIABETES**

In 1994 the American Diabetes Association established its Delegates for Diabetes advocacy program. Today, more than 8,000 activists around the country participate in this program by writing, calling and meeting with public policymakers about the needs of people with diabetes. Help educate policymakers about the need for increased funding for diabetes research, better health insurance coverage and an end to discrimination against people with diabetes. Become a delegate for diabetes today!

NAME _____

ADDRESS _____

CITY _____

STATE _____

ZIP _____

Mail to:

DELEGATES FOR DIABETES

1660 Duke Street
Alexandria, VA 22314
fax (703)549-8748
<http://www.diabetes.org>

 American Diabetes Association

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Success for a lifetime with diabetes



*Live life to its fullest. Team up with a
diabetes educator and learn to
self-manage your diabetes.*



SELF-MANAGEMENT MATTERS

Team up with a diabetes educator

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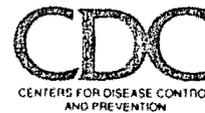
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UNREALIZED PREVENTION OPPORTUNITIES:
REDUCING THE HEALTH AND ECONOMIC BURDEN
OF CHRONIC DISEASE

*A Report of the
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service



March 1997

Diabetes

FY 98 Appropriations Fact Sheet

The American Public Health Association request for the CDC Diabetes Translation Program is \$60 million in FY 98. Funding has not been adequate to support a comprehensive community-based diabetes program in every state and territory. Many opportunities to prevent the costly and life-threatening complications of diabetes are being missed. The president's FY 98 budget includes a \$36.2 million appropriation, 10 million more than the FY 97 appropriation of \$26.2 million.

BASIC FACTS ABOUT DIABETES

Diabetes is the seventh leading cause of death in the U.S.

Almost 16 million Americans have diabetes. An estimated 8 million people are unaware that they have diabetes.

The complications associated with diabetes include heart disease, kidney-disease, blindness, and medical conditions requiring lower-extremity amputations.

Controlling high blood pressure in people with diabetes could reduce strokes by 75 to 90 percent and coronary heart disease by 25 to 50 percent.

Diabetic eye disease is the single greatest cause of blindness in working age Americans.

Diabetic lower extremity disease causes 57,000 leg, foot, and toe amputations each year among adult Americans.

Direct and indirect costs of diabetes total more than \$92 billion each year.

CDC DIABETES TRANSLATION PROGRAM

CDC has provided resources for state-based diabetes control efforts since 1977. These programs have been effective in reducing diabetes complications. The current level of funding, however, only allows for the development of basic diabetes control programs in all 50 states. Three states, Michigan, Minnesota and North Carolina, are presently funded at higher levels which are adequate to develop community-based interventions for populations disproportionately affected by diabetes, improve prevention efforts, increase educational programs, and promote health care policies intended to reduce the number of diabetes complications.

An additional \$10 million would enable the CDC to provide the enhanced level of funding to a total of 14-17 states, and implement a National Diabetes Education Program. In conjunction with the expansion of state-based initiatives, this program would ensure high quality and consistent standards in diabetes care, as well as improve access to care and increase educational programs designed to prevent complications.



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United States General Accounting Office

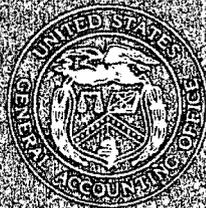
GAO

Report to the Chairman, Subcommittee
on Health and Environment, Committee
on Commerce, House of Representatives

March 1997

MEDICARE

Most Beneficiaries With Diabetes Do Not Receive Recommended Monitoring Services



What would CDC do for the primary prevention of diabetes?

12/19/96

The stages of prevention:

In the context of health, prevention has traditionally been defined as having three stages. Primary prevention refers to stopping a disease from ever occurring. Secondary prevention refers to stopping the development of complications that are the result of having a disease. Tertiary prevention refers to stopping the end-stages of the complications, i.e. minimizing or reducing the damage caused by complications.

In reality some health conditions, such as death, will inevitably occur and cannot be prevented. Death, however, as well as many other health conditions can be *delayed* substantially. Thus primary prevention can also refer to delaying the onset of a health condition ("compression of Morbidity", Friess, et al). For example, interventions or programs that would delay the onset of diabetes by 10 years (say from mean age of onset of 65 to 75) would likely lead to a substantial increase in years of life that are disease free, which in turn would improve quality of life. Such "primary prevention" could also reduce life-time costs of health care (this would only occur, however, if the overall costs of the primary prevention program were lower than the overall costs associated with treating diabetes that occurred earlier).

These stages of prevention can be related to the stages that occur in the natural history of diabetes care. Each of the stages of diabetes care can serve as a focus for public health and clinical intervention.

Natural history stage:

1. No diabetes to diabetes.
diabetes itself.

2. Unrecognized to recognized.
for early detection
to start early glycemc control)

3. Improper care to proper care.
(ACE inhibitors to prevent ESRD.)
stopping the development of end-stage renal disease.

Prevention stage:

1. Primary prevention is stopping or delaying the development of

2. *In a person who has already developed diabetes* (Screening
secondary prevention is stopping or substantially
delaying development of one of the complications
of diabetes such as kidney disease.

3. *In a person with diabetes who has already
developed clinical signs of kidney disease* tertiary prevention is

The science base for primary prevention of diabetes:

Mechanistic studies, as well as observational studies, are consistent and strongly suggestive that low levels of physical activity and a heavy body weight increase the risk for developing diabetes. No convincing experimental evidence has yet demonstrated, however, that by increasing physical activity and/or decreasing body weight the risk of developing diabetes can be reduced. Further, if changes in physical activity and in body weight reduce the risk of developing Type II diabetes, how this can most effectively and efficiently be accomplished is not clear. Other risk factors have been shown to be equally strongly related to the development of diabetes, including age and family history. It is important to note, however, that these latter two risk factors can not be changed, but may serve as markers to improve the targeting of primary prevention activities.

CDC is currently providing financial and technical support for the NIH-sponsored Diabetes Prevention Program (DPP) which promises to be the authoritative primary prevention study for diabetes. The DPP is a 7-year randomized controlled clinical trial begun in 1995 to test the efficacy of three interventions to prevent the development of diabetes in persons at high risk for the disease. (High risk is defined as having impaired glucose

tolerance as well as any of the following: being obese, having a family history of diabetes, and being from an ethnic group with a high prevalence of diabetes.) The three interventions are treatment with metformin (a drug that reduces production of glucose by the liver), treatment with troglitazone (a drug that increases insulin sensitivity), and an intensive lifestyle program that emphasizes increasing physical activity and decreasing body weight. The DPP is scheduled for completion in 2002.

CDC is also currently providing financial and technical support for the NIH-sponsored Pound of Prevention Study (POPS). The POPS began in 1993 and is a community-based 5-year randomized controlled trial to prevent excessive weight gain in adults. This study uses low cost health promotion approaches (newsletter, post-card reminders, group classes) to provide persons with information and guidance on physical activity and dietary control to prevent weight gain. Final results should be available in 1998.

In addition, CDC has just begun a cooperative agreement with San Diego State University to develop a pilot project for weight gain prevention in the managed care setting. This study is still in its developmental stages but it is envisioned as a randomized controlled trial using provider-assisted approaches to changing patients behaviors related to weight gain, specifically physical activity and nutrition. The model will be similar to the Physician Assessment and Counseling for Exercise (PACE) program that has been developed to promote physical activity in the clinical setting.

Primary prevention of diabetes: the future

The scientific and programmatic basis for primary prevention of diabetes is in its infancy. Until very recently the major focus of clinical and public health research and practice has been on the treatment of persons who have already developed diabetes, i.e. secondary and tertiary prevention. Unfortunately there is no current scientific consensus on what interventions, programs, or policies are effective in the primary prevention of diabetes. It is likely, however, that such a consensus will emerge within the next 5-7 years.

In the interim, CDC is actively pursuing a number of applied research and program-policy activities related to weight control and physical activity at the community and health system levels, in collaboration with State and Local health departments and the evolving infrastructure of managed care. In addition, with an active and growing national network of Diabetes Control Programs in every State, the CDC will be in a strong position to implement at the population level the emerging findings from rigorous scientific studies of the primary prevention of diabetes.

Projected Areas of Public Health Surveillance and Applied Research for DDT

Public Health Surveillance \$5.0 million

1. Comprehensive assessment of diabetes and its complications in a representative sample of the US population and in high risk subpopulations (such as minority and aged populations) in the NHANES IV.
2. Comprehensive assessment of preventive care received by persons with diabetes at the state and regional levels using the BRFSS.
3. Studies to estimate the burden of NIDDM in children.
4. Development of models to project the future burden of diabetes.
5. Studies to estimate the burden of chronic disease in the US populations attributable to diabetes.
6. Studies to estimate the risk of diabetes attributable to various risk factors found in the US population.

Applied Research \$5.0 million

A. Health Services Research

1. Studies to accurately estimate the effectiveness of important preventive interventions among persons with diabetes served by large health systems.
2. Evaluation of the cost and cost effectiveness of various interventions in large health systems.
3. Identifying the co-existence of other chronic diseases among people with diabetes, e.g. thyroid disorders, osteoporosis, CVD, and assessing optimal strategies to deliver care to diabetic subjects with co-existing diseases.
4. Development of models to assess optimal allocation of resources across interventions to reduce the burden of diabetes.
5. Identifying factors affecting patient adherence with interventions and strategies to enhance adherence to recommended standards of care for persons with diabetes.
6. Development of valid indicators of quality diabetes care.
7. Studies to better understand to quality of life issues for persons with diabetes.

B. Research to Address the Etiology and Burden of Undiagnosed Diabetes in the US

1. Studies to examine factors related to patient awareness of diabetes in large health care systems.
2. Studies to understand the benefits and liabilities surrounding the early detection of diabetes through active screening.

C. Economics burden of Diabetes

1. Estimate of the cost diabetes in the medicare population.

\$40 M increase

	25 M	Comp. Programs
	5 M	NDEP
✓	5 M	Surveillance
✓	5 M	Applied Research

CORE PLANNING - "5 P's"

- ① PRESENCE - "somebody" in state health dept. or DM.
- ② PROBLEM I.D. - EARLY SURVEILLANCE
- ③ PARTICIPATION - Coord.
- ④ PLAN - State Wide
- ⑤ PROJECT - Local

CDC Funding to States for Diabetes: From Essential Underpinnings to Comprehensive Programs

Essential Underpinnings - Core Programs

With CDC funding for a core diabetes program, a state begins to build the essential underpinnings for a comprehensive program. A core program is limited in scope, but sets the stage for implementation of more comprehensive activities. Key elements of a successful diabetes program, initiated through a core program, include:

- o Establishment of a focal point within the state health agency for targeting diabetes, e.g., at least one person working on a full-time basis, actively focusing his/her time and attention to addressing this one issue, building state-based expertise in state-of-the-art diabetes prevention and control, and identifying other key players for concerted, coordinated action
- o Establishment of a statewide coalition to spearhead diabetes prevention and control efforts comprising state and local health agency staff, professional and voluntary organizations, community leaders, health care providers, managed care organizations, and others with key roles to play in reducing the burden of diabetes.
- o Establishment of a basic surveillance system to determine the burden of diabetes in the state and to begin to assess where gaps exist in patient access to quality diabetes care. Basic surveillance information is essential for the development of a statewide plan.
- o Development of a statewide plan to prevent and control diabetes that outlines expected outcomes, appropriate activities to undertake, and the roles of various players.
- o In some states, implementation of small-scale projects to evaluate interventions e.g., a state might link with a managed care program to institute a patient reminder system. This system, designed to help ensure that patients return at regular intervals for critical eye screenings, might be implemented in only one or two communities under core program funding.

Comprehensive Programs

With CDC funding for a comprehensive program, a state builds on the solid foundation already established through the core program, and moves on to initiate,

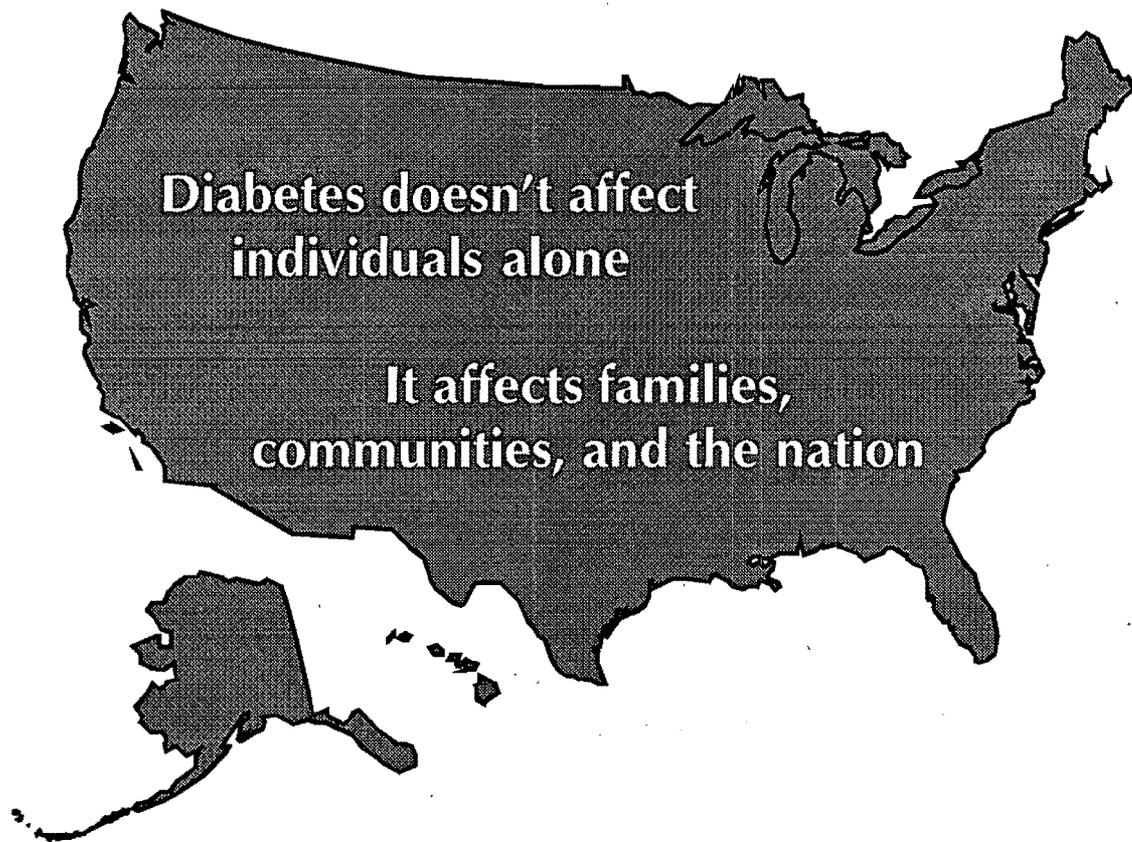
lead, and coordinate comprehensive diabetes prevention and control activities statewide.

States with comprehensive diabetes programs:

- o Coordinate with and influence existing and evolving health care delivery systems to improve the quality, access, and affordability of care for at-risk populations (e.g., by working closely with managed care organizations and others to develop diabetes care guidelines and to ensure that quality, affordable services are in place for people with diabetes; working with state Medicaid and Medicare programs to develop and monitor diabetes care quality outcome measures)
- o Ensure people with diabetes receive the self-care education they need to minimize complications. People with diabetes are key players in reducing their own risk of developing debilitating complications. Working closely with state medical societies, academic institutions, and others, states can ensure that these people receive the education they need to minimize complications.
- o Implement the statewide plan, with the support of the statewide coalition, and participation from a broad base of national, state, and community-level players. States hone and replicate interventions shown to be effective through small-scale projects.
- o Implement and evaluate innovative programs in communities designed to improve access to care, detect previously undiagnosed diabetes, and reduce risk factors related to diabetes
- o Enhance diabetes-related knowledge, attitudes, beliefs and behaviors by implementing statewide health communications campaigns (e.g., media campaign to increase awareness among health care professionals and people with diabetes on the health importance of monitoring blood glucose levels)
- o Conduct ongoing monitoring and evaluation of diabetes control outcomes and activities within the state to identify successful strategies and program components, and adjusting intervention efforts accordingly
- o Enhance surveillance systems to better assess and monitor the burden of diabetes in communities throughout the state, and to appropriately target and tailor prevention efforts.

CDC's National Diabetes Control Program





It's common

Almost 16 million Americans have diabetes

It's serious

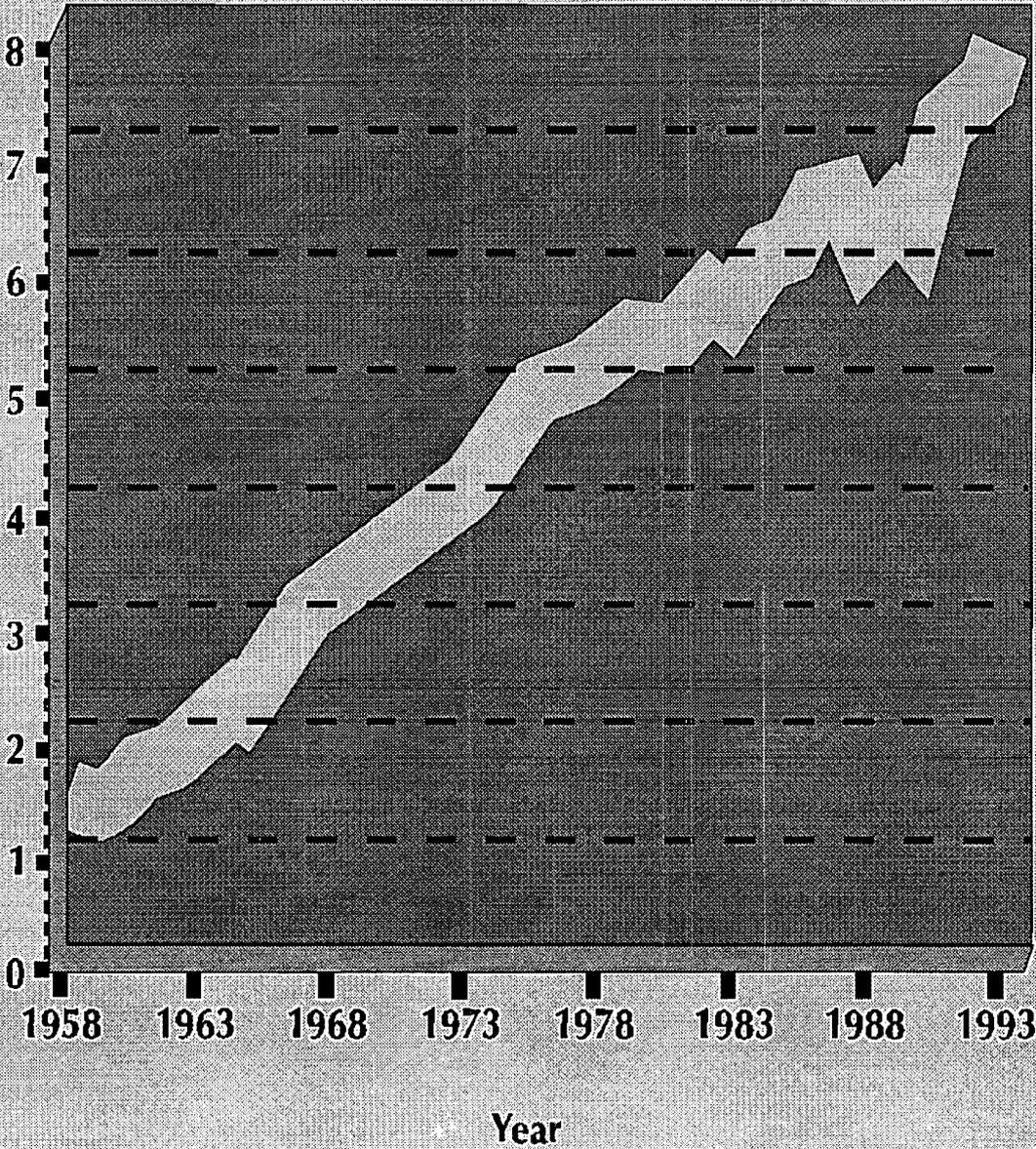
Complications include blindness, amputations, heart disease, kidney failure, nerve damage, and premature death

It's costly

The cost is more than \$92 billion annually *

*** Source: American Diabetes Association**

Number of People with Diabetes (millions)



Opportunities for Prevention

- ◆ Diabetes-related blindness could be prevented in 16,250 people a year – a **65% reduction**
- ◆ 32,400 diabetes-related amputations could be prevented each year – a **60% reduction**
- ◆ Diabetes-related kidney failure could be **reduced by 50%**

Public Health Response to Diabetes

As part of its national strategy, CDC provides resources and technical assistance to state health departments, national organizations, and communities

- ◆ to determine the size and nature of diabetes-related problems and why they exist
- ◆ to develop and evaluate new strategies for diabetes prevention
- ◆ to establish partnerships to prevent diabetes problems
- ◆ to increase awareness of diabetes prevention and control opportunities among the public, the health care and business communities, and people with diabetes
- ◆ to improve access to quality diabetes care in order to prevent, detect, and treat diabetes complications

CDC's National Diabetes Control Program

Core capacity-building diabetes control programs

Develop initial expertise in diabetes control

Provide a focal point for diabetes control

Establish systems to define the scope of the diabetes problem

Identify gaps in diabetes care, for both patient access and quality-of-care issues

Develop and evaluate limited intervention projects

Identify external supporters for diabetes control activities

**Average CDC award
to state health departments**

\$232,000

Comprehensive diabetes control programs

Build on expertise in program, science, and policy areas to control and prevent diabetes

Coordinate statewide diabetes control and prevention

Expand systems to define and analyze the scope of the diabetes problem

Improve access to diabetes care for all people and raise the quality of that care

Use statewide public health projects to reduce diabetes-related problems

Inform, educate, and empower external supporters to control and prevent diabetes

**Average CDC award
to state health departments**

\$800,000

**“Those who suffer losses due to diabetes
are not just statistics on a chart.
They are people whose talents
and wisdom are needed and
whose problems deserve
our unified efforts.”**

***-- David Satcher, MD, PhD, Director
Centers for Disease Control and Prevention, 1994***



Division of Diabetes Translation

Phone 770-488-5000

Internet <http://www.cdc.gov/diabetes>