The Fight Against Diabetes: We've Got to DM AACE it!

Paul Aoun, DO, PhD • Member, AACE Key Contact Program • Member, AACE Political Action Committee • Member, AACE Legislative & Regulatory Committee

During one of my clinical preceptorships in medical school, I asked the supervising attending where he foresaw the status of diabetes by the time I anticipated completing my fellowship. He replied, “Paul, as long as people continue to eat, there will be diabetes.” Almost 15 years since the time that conversation took place, the association between diabetes and poor dietary choices, excessive caloric intake, and resultant weight gain remains as strong as ever. In June 2014, the Centers for Disease Control and Prevention (CDC) released the updated National Diabetes Statistic Report which shows an increase of 9% in prediabetes and 13% in diabetes relative to the last CDC report in 2011. In addition, total costs associated with diagnosed diabetes in 2012 have risen to $245 billion; an increase by 41% relative to 2007.

Why is diabetes on the rise? The cause is certainly multifactorial. As most of the cost for diabetes care is provided by government- and insurance programs, some argue that the federal government is not effectively leveraging its investments, programs, and policies to prevent the development of diabetes and reduce the burden of the disease and its dreaded complications. From an epidemiological standpoint, the rise in diabetes appears to parallel that of obesity. Thus, one cannot tackle the epidemics of obesity, prediabetes, or diabetes without channeling financial resources in the right direction and re-examining the eating and lifestyle habits that got the nation on the wrong “metabolic path.”

What is AACE doing? AACE has taken the initiative to develop and seek support in both the U.S. Senate and House for the National Clinical Care Commission Act (S. 539/H.R. 1074), which establishes a commission that will focus on improving diabetes care delivery and patient outcomes. The legislation has the support of the entire diabetes community.

Why support the S. 539/H.R. 1074 bill? Without adding more bureaucracy, the commission will operate with existing funds, at no additional cost to the government, to establish a body of health care professionals to review federal activities, eliminate ineffective programs, make evidence-proven, educational, preventative, and therapeutic recommendations, and thus garner a bigger return on the federal investment in diabetes. In a nutshell, it is an opportunity for endocrinologists to be at the forefront of federal legislative decisions pertaining to our profession and patients.

So what motivated me to get involved? According to Maya Angelou, “If you don’t like something, change it; if you can’t change it, change your attitude towards it.” If curbing the epidemic of diabetes has been challenging, could changing patients and lawmakers’ views on diabetes hold promise for better results?

To many patients I see in new consultations, the attitude towards type II diabetes is that of a “life sentence” that they inherited and feel so helpless about. Albeit aware that eating better and reaching their weight loss goals are beneficial to their health, most look perplexed when educated that if adherent with these strategies they could, as a result, reduce the number of, and in some cases discontinue their anti-hyperglycemic agents, including insulin. The reasons they had failed to appreciate the efficacy of healthier lifestyle choices as a powerful prescription that could potentially lead to a remission of their diabetes are not clear-cut but likely multifaceted. At the core of their reasoning is a possible toning down of their interests and perceived abilities to achieve their goals along with a skewed perception of diabetes evidenced in them opting for the irremediable hypothesis of the disease. As such, dissecting out the obstacles to initiating and sustaining a positive change and altering their perceptions of selves and diabetes could drive a change in behavior.

To further win this battle, some have suggested the medical community revisit its marketing strategies for gaps that might have impacted the effective delivery of the intended messages. People, in general, embrace the idea of change when the perceived outcomes are anchored to something meaningful to them and their set of values. For instance, for someone trying to minimize polypharmacy, a motivator such as “you are 10 lbs away from coming off glimepiride” as opposed to “it is important for you to lose weight” could get that individual on the right path to introduce lifestyle changes for that celebratory endpoint on which he or she could build for continued progress. It would be interesting to also assess if insurance incentives such as gym memberships and/or government-funded health clubs in economically-privileged communities and/or government-funded health clubs in economically-privileged communities fuel patients’ motivation further and improve clinical outcomes. Furthermore, as the debate over what constitutes a “healthy diet” continues to evolve, re-investigating the scientific evidence behind some of the dietary guidelines is warranted. Had previous recommendations for a “low fat”-based diet led to nondiscriminatory intake of refined carbohydrates that fueled the obesity epidemics? Do...
genetically-engineered crops and mass food production compromise the nutritional content and quality of the consumed meals, and if so, to what extent?

Through this Commission, endocrinologists will be at the forefront to voice expert opinions on these issues, share research and clinical outcomes, and discuss motivational tactics that resonated best among their patients and yielded positive results. As such, these contributions will form the basis for the Commission’s recommendations that will be submitted to Congress and to the Secretary of the Department of Health & Human Services for potential implementation.

In our efforts to curb diabetes, it is imperative to also heighten lawmakers’ perception of the many factors leading to pre-diabetes and diabetes. I recently held two very informative meetings with representatives from the offices of the Florida Senators. The meetings helped shed light on the efforts of our profession to bring forth the bill and ensure it does not get diluted in the crossfire of major policy issues such as immigration, budget, and tax reforms. Furthermore, because some offices are hesitant to support “single disease” initiatives out of concern that it could open the floodgates to all disease-specific groups, it was crucial to highlight awareness of diabetes, not as a “single disease” entity per se, but rather an epidemic and a gateway to multiple co-morbidities and as such, worthy of greater attention on Capitol Hill.

Why and how can YOU get involved? Getting involved is simple and becoming an AACE Key Contact is easier than you may think. Key contacts cultivate relationships with their Members of Congress, allowing the Member and their office staff to rely on the liaison as a trusted and valued source of information.

- Register online to become an AACE Key Contact - https://www.aace.com/advocacy/key-contact
- Review the District Meeting Tool Kit and other materials available on the Resources for District Meetings webpage https://www.aace.com/advocacy/leg/resources/district-meetings
- Contact Sara Milo (smilo@aace.com) or Alysia Tampkin (atampkin@aace.com) to help schedule a district meeting with your federal representative(s)

Stride forward on behalf of our specialty - your support today could accelerate progress through Congress.