

May 6, 2009—DMICC meeting minutes

**Diabetes Mellitus Interagency Coordinating Committee (DMICC)  
DMICC Member Organization National Education Programs**

**NIH Campus, Building 31C, Conference Room 6C  
Bethesda, MD  
12:30pm-4:30pm  
May 6, 2009**

**WELCOME AND GOALS OF THE MEETING**

Dr. Judith Fradkin, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

Dr. Fradkin welcomed participants and reminded attendees that the DMICC is composed of representatives from the federal government and its purpose is to facilitate cooperation, communication, and collaboration on diabetes across the government. The meeting was open to the public and advertised in the Federal Register. No members of the public submitted requests to comment.

To address recent questions about the role of the DMICC and its relation to federal diabetes programs, Dr. Fradkin provided a brief presentation. The DMICC was authorized in 1974 and charged with coordinating diabetes research activities and health programs of federal agencies. The Committee was established to facilitate communication and exchange of information among government entities, and has been very successful with respect to facilitating new partnerships among agencies and helping to reduce overlap and duplication of efforts.

Many of the DMICC's success stories are included in the recent DMICC booklet (for more information, see [http://www2.niddk.nih.gov/AboutNIDDK/CommitteesAndWorkingGroups/DMICC/DMICC\\_Booklet.htm](http://www2.niddk.nih.gov/AboutNIDDK/CommitteesAndWorkingGroups/DMICC/DMICC_Booklet.htm)). One example stems from discussions held at a DMICC meeting that focused on the importance of improving diabetes control, based on the results of the Diabetes Control and Complications Trial (DCCT). Because of these discussions, and at the recommendation of the National Diabetes Advisory Board, the NIDDK and Centers for Disease Control and Prevention (CDC) partnered to create the National Diabetes Education Program (NDEP). This example demonstrates that, by promoting discussion between different agencies, new ideas and partnerships have been born.

Dr. Fradkin explained that the DMICC is a forum for strengthening the NDEP and serves as a venue for information sharing to keep members abreast of NDEP efforts. For example, DMICC member agencies that deliver health care use NDEP materials, so it is important for them to be aware of NDEP activities in order to best utilize the NDEP to help the patients they serve. Information sharing also helps the NIDDK and CDC stay informed about diabetes activities of other organizations, which could impact NDEP efforts. The DMICC is also a venue for facilitating new partnerships around NDEP activities. In some cases, DMICC members, by

virtue of their expertise in diabetes, also participate in NDEP committees and workgroups, which further enhance coordination and partnerships. However, the DMICC does not have authority over the NDEP. The NIDDK and CDC, as co-leaders and funders of this program, have the decision-making responsibility. The two organizations welcome and value input from DMICC members to help inform the NIDDK and CDC in their decision making and look forward to today's discussion on the NDEP.

## **NATIONAL EYE EDUCATION PROGRAM: MAKING VISION A HEALTH PRIORITY**

Ms. Neyal Ammary-Risch, National Eye Institute (NEI)

The NEI established the National Eye Health Education Program (NEHEP) in 1988 through a Congressional directive to increase the federal government's commitment to preventing blindness through public and professional education programs. The goal of the NEHEP is to ensure that vision is a public health priority through the translation of eye and vision research into public and professional education programs. The NEHEP has five main program areas: glaucoma, diabetic eye disease (DED), low vision, special populations (primarily Hispanic/Latino and American Indian/Alaskan Native populations who are at high risk for eye disease), and adults over 50 years of age. Messages of the NEHEP address health literacy, are culturally appropriate and targeted, are collaborative, and are disseminated through as many channels as possible, including community outlets.

Ms. Ammary-Risch noted that the strength of the NEHEP is its partnerships, including approximately 70 national level organizations of the government, professional groups, and voluntary/non-profit organizations that have an interest in eye health or represent the target audiences that are at high risk to develop eye disease. These partnerships aid the NEHEP in identifying strategies, developing resources and materials, and disseminating eye health information to the public.

To assess public knowledge, attitudes, and practices around eye health and disease, the NEI and the Lions Clubs International Foundation conducted a national survey (for more information about the survey and the final report, please see <http://www.nei.nih.gov/kap/>). The findings of the survey are used by NEHEP to inform and guide program efforts and indicated: (1) a continued need to educate the public, especially Hispanics, about DED; (2) a need to increase knowledge that DED has no early warning signs or symptoms; (3) that TV programs and commercials, doctors' offices, newspapers and magazines are the public's top sources for obtaining eye health information; and (4) that primary care physicians, family members, and coworkers have the most influence when recommending an eye exam.

Thus, a goal of the NEHEP is to create awareness about DED among: (1) people with diabetes, their family, and friends; and (2) primary care and other health care providers. Current NEHEP resources include a variety of educational resources available through the [NEI publications catalog](#), a [DED consumer-friendly Web site](#), a [Diabetes & Healthy Eyes Toolkit](#) for use by health promoters, a print public service announcement campaign, and outreach materials to educate and work with health care professionals involved in primary care.

Ms. Ammary-Risch concluded with discussion of the [Health Vision Community Awards Program](#). This program was started in 2003 to provide awards to stimulate the collaborative initiatives of community-based non-profit organizations that support the vision objectives in Healthy People 2010. The Healthy Vision Community Awards are intended to strengthen the capabilities of community-based organizations to develop innovative and sustainable eye health education and promotion projects. There are 72 DED-related programs supported by the program. Information about these programs can be found in the [Healthy Vision Community Programs Database](#).

In response to a question from Dr. Albright, Ms. Ammary-Risch noted that the CDC is a partner in NEHEP, as are many other DMICC member organizations, and that there is collaboration between the CDC's Vision Health Initiative and NEHEP. (A list of NEHEP partners can be found at: <http://www.nei.nih.gov/nehep/about/directory.asp>) Ms. Ammary-Risch also noted, in response to questions, that the results of the media usage study were broken out by ethnic group and could be found in the NEHEP's Five-Year Agenda at [http://www.nei.nih.gov/nehep/docs/nehep\\_5\\_year\\_agenda\\_2006.pdf](http://www.nei.nih.gov/nehep/docs/nehep_5_year_agenda_2006.pdf).

For more information about the NEHEP, please see [www.nei.nih.gov/NEHEP/](http://www.nei.nih.gov/NEHEP/).

## **NATIONAL DIABETES EDUCATION PROGRAM**

Ms. Joanne Gallivan, NIDDK

Dr. Judith McDivitt, CDC

The National Diabetes Education Program (NDEP) was started in 1997 to change the way diabetes was treated, noted Ms. Gallivan. NDEP's original campaign, *Control Your Diabetes. For Life*, was based on the findings of the DCCT. The NDEP has since updated their messages and materials, including addition of cardiovascular disease prevention and in response to recent results from clinical trials on cardiovascular disease and diabetes. Based on the results of those trials, NDEP messages are being updated to emphasize individual goals for diabetes control. The NDEP's second campaign, *Small Steps. Big Rewards. Prevent type 2 diabetes*, focuses on prevention of type 2 diabetes and translates the results of the Diabetes Prevention Program (DPP) clinical trial into materials for health care providers ([Health Care Provider Toolkit](#)) and for patients ([patient toolkit](#)). Prevention messages of the NDEP also evolve: because studies have demonstrated that people connect with family history, risk messages are being adjusted to include family history.

NDEP materials are adapted to promote these messages to children, older adults, and high risk target audiences, and the NDEP has utilized Work Groups to develop culturally-sensitive and culturally-relevant materials. NDEP materials are available in up to 16 different languages, to ensure that these messages reach the target audiences. In addition, in collaboration with its health care professional partners, NDEP has developed materials for diabetes educators, physicians, pharmacists, optometrists, podiatrists, dieticians, and other health care professionals. NDEP messages are disseminated through the Internet, including the [NDEP main Web site](#), [Better Diabetes Care](#) for health care professionals and managed care organizations, and [Diabetes at Work](#) for employers; the [National Diabetes Information Clearinghouse](#); print media; and radio.

Dr. McDivitt discussed the organization of the NDEP—highlighting the importance of partnerships to the NDEP. The NDEP is a unique federal partnership between the NIH and CDC. The two organizations share leadership and management of the NDEP, and bring different assets and complementary activities to the collaboration. In addition, the over 200 partner organizations include professional, non-profit, community, private, and government organizations that act as the major dissemination channels for NDEP materials in the community. Partners provide new ways to reach a wide range of audiences and ensure that NDEP materials and messages are developed for their target audiences. The NDEP has 10 Work Groups that help guide the NDEP across diverse communities and groups—including ethnic/minority audiences, people of different age groups, and professional groups. In addition, there is a cross-cutting work group to plan and implement evaluation activities, and several cross-cutting subcommittees. NIH and CDC have developed an overall strategic plan for the NDEP; the work groups use it to develop their own plans and implement initiatives.

The NDEP is working to further promote its messages by examining new ways to reach more people more effectively, exploring and using new technologies and new media avenues, and continuing to work with current partners and to develop new partner relationships. Another priority is evaluation—NDEP is tracking and collecting both process and impact/outcome measures. NDEP conducted public surveys in both 2006 and 2008 to look at knowledge, beliefs, attitudes, and behavior in adults with respect to diabetes and pre-diabetes and to track NDEP progress. Several work groups also have ongoing evaluation plans and activities, including testing and monitoring of messages, products, and activities. Another priority for the NDEP is to address behavior change. This led to the development of a new initiative— “Support Behavior Change.” The goal of this initiative is to provide resources on how to make lifestyle and behavior changes to prevent and control diabetes. NDEP, with the aid of its partners, has collected resources designed to support behavior change and will add them to the NDEP Web site. The NDEP will not endorse or rank these resources; rather the Program is increasing access to these tools. The goal is to create an interactive, cross referenced repository of these resources.

Dr. Roman inquired as to whether NDEP used different messages for different populations. Ms. Gallivan responded that NDEP uses the same message, but tailors the delivery of the message to the different needs of different populations. NDEP looks to its partners to help adapt the delivery of the messages for diverse audiences. Dr. Pogach noted that broad messages may not convey the risks and benefits for different populations. In response, Dr. Fradkin mentioned that NDEP messages continue to evolve with new scientific results, particularly toward individualized health conditions and in relation to cardiovascular disease risk and diabetes.

For more information about the NDEP, please see <http://ndep.nih.gov/>.

## **NATIONAL KIDNEY DISEASE EDUCATION PROGRAM**

Dr. Andrew Narva, National Institute of Diabetes and Digestive and Kidney Diseases

Dr. Narva noted that the prevalence of end stage renal disease (ESRD) has been rising steadily over the last two decades and that there is a tremendous health disparity in ESRD. The increased prevalence is driven by type 2 diabetes—therefore, improvements in prevalence of ESRD are linked to improvements in the care of diabetes. Early treatment of kidney disease can make a

difference; clinical trials have shown that intensive glycemic control of type 1 diabetes, antihypertensive therapy using angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), or achieving good blood pressure control (<130/80mm Hg) can slow progression of chronic kidney disease (CKD).

CKD, however, remains under diagnosed—at-risk patients are inadequately screened and test results are misinterpreted. In addition, the implementation of recommended care is poor: ACE inhibitors and ARBs are underutilized, blood pressure goals are not achieved, and many people are poorly prepared for dialysis. Many clinicians feel inadequately educated: there is the misperception that CKD is a “specialist” disease, uncertainty about how to interpret diagnostic tests, a lack of clarity about clinical recommendations, and low confidence by clinicians in their ability to successfully manage the disease. The challenge with CKD, therefore, is getting appropriate care to people who need it the most, and moving the point of identification and intervention earlier in the progression of the disease.

Dr. Narva explained that the National Kidney Disease Education Program (NKDEP) aims to reduce the morbidity and mortality caused by kidney disease and its complications by: (1) improving early detection of CKD; (2) facilitating identification of patients at greatest risk for progression to kidney failure; (3) promoting evidence-based interventions to slow progression of kidney disease; and (4) supporting the coordination of Federal responses to CKD. NKDEP is built on the paradigm of the chronic care model, an approach involving informed patients and health care providers that work together, in the context of a community. The model offers a systematic way to identify needs and set priorities, making it clear which elements NKDEP needs to address. NKDEP seeks to implement improvements in kidney care through improvements in the diabetes care delivery system, not through a specialty clinic based approach.

NKDEP campaigns target communities, encouraging testing among at-risk populations (e.g., [African American Family Reunion Initiative](#), [Kidney Sundays](#), and various publications) and supporting community level change (e.g., [You Have the Power to Prevent Kidney Disease](#) video pilot). Because primary care professionals can play a significant role in early diagnosis, treatment, and patient education, NKDEP has developed materials to promote discussion of kidney disease between providers and patients. NKDEP materials for health care professionals educate primary care providers about CKD care prior to referral, provide tools and guidance for diabetes educators, support CKD medical nutrition therapy, and support use of glomerular filtration rate. These and additional resources can be found on the NKDEP Health Professionals Web site: <http://www.nkdep.nih.gov/professionals/index.htm>. In addition, NKDEP provides resources and support for laboratory professionals, including [information to promote routine reporting of eGFR](#) and support for changes in serum creatinine and urine albumin standardization and reporting through [NKDEP’s Laboratory Working Group](#).

In a pilot study, NKDEP is helping community health centers improve CKD diagnosis and management. Community health centers serve populations at high risk for development of CKD, many of whom also have diabetes. The goals are to help community centers adopt system changes that allow them to meet more benchmarks for CKD detection and management, as well

as to identify a set of best practices that can be shared with health centers nationwide. The program is informed by the chronic care model and currently includes five participating centers.

NKDEP also supports coordination of Federal responses to CKD through the statutory [Kidney Interagency Coordinating Committee](#) (KICC). Many Federal agencies lead an aspect of the multi-faceted and interconnected response to CKD. To support the KICC, NKDEP has developed the [Federal CKD matrix](#)—an online resource that summarizes Federal CKD-related activities in multiple categories and provides contact information. This tool will be used to improve communication and promote collaboration among Federal agencies.

In response to a question from Dr. Pagán Raggio Ashley about resources to educate health care professionals about nutrition, Dr. Narva noted that NKDEP created a [webinar](#) to educate non-dietitians on diet and CKD. Dr. Pagán Raggio Ashley recommended that resources and materials continue to be developed for entry-level individuals, including medical assistants, in community health care centers.

For more information about the NKDEP, please see <http://nkdep.nih.gov/>.

## **NLM MEDLINE PLUS: HEALTH INFORMATION FOR THE PUBLIC**

Dr. Elliot Siegel, National Library of Medicine (NLM)

Ms. Loren Frant, NLM

Dr. Siegel began by noting that NLM does not create information, but provides a wide range of health information to the public. Dr. Siegel encouraged the NDEP, as future plans are made, to consider NLM's resources and take advantage of the connection between MedlinePlus and NDEP.

Ms. Frant pointed out that while DMICC research organizations are working hard to generate scientific information, NLM is working hard to ensure that such information can be found by the public. MedlinePlus is the consumer health Web site of NLM and is designed for patients, family, and friends, but is used by professionals as well. The site is available in both English and Spanish, and has links to health information in 44 other languages. MedlinePlus receives over 11 million unique visitors each month, with 60 million page views. In addition, MedlinePlus has links to two other NLM-managed sites—[clinicaltrials.gov](#), which details studies on new drugs and treatments, and [NIH Senior Health](#), a resource with health information for older adults.

Ms. Frant walked DMICC members through the features of the [Medline Plus diabetes page](#), including a disease summary; links to the relevant NIH Institute or Center Web sites, links to tutorials, clinical trials, and journal articles; and information on related topics. Ms. Frant also demonstrated the importance of diabetes in the use of MedlinePlus. “Diabetic Diet” as a topic page receives the second highest total number of page views on MedlinePlus and “Diabetes” itself is fifth. Diabetes is consistently a highly searched for topic on MedlinePlus. Ms. Frant encouraged DMICC member organizations to provide feedback on MedlinePlus via the Web site.

Finally, NLM also publishes the [NIH Medline Plus magazine](#) which is available in both English and Spanish versions. The magazine is published quarterly to share NIH research with the public and promote NIH programs and information campaigns. Ms. Frant noted to DMICC members that there may be opportunities to promote their education campaigns in the magazine. For example, several issues have focused on diabetes, including an [interview](#) with former NDEP chair Dr. Francine Kaufman. The online version of the magazine also includes links to direct consumers to NIH Institute and Center Web sites.

For more information about NLM Medline Plus, please see <http://medlineplus.gov/>.

## **NHLBI GUIDELINES FOR CARDIOVASCULAR RISK REDUCTION—RELEVANCE TO DIABETES**

Dr. James Cleeman, National Heart, Lung, and Blood Institute (NHLBI)

The “[NHLBI Strategic Plan: Shaping the Future of Research](#),” introduced Dr. Cleeman, calls for the Institute “to promote the development and implementation of evidence-based guidelines in partnership with individuals, professional and patient communities, and health care systems and to communicate research advances effectively to the public.” The development of guidelines will accelerate the translation of research advances into practice and provide a platform for NHLBI’s education and outreach programs. NHLBI has a long history of involvement in the development of cardiovascular guidelines, including, but not limited to, [Clinical Guidelines on Cholesterol Management in Adults](#) (ATP III), [High Blood Pressure Guidelines](#) (JNC 7), and [Clinical Guidelines on Overweight and Obesity](#). Dr. Cleeman noted that diabetes is specifically mentioned in these guidelines. The guidelines are currently being updated while new guidelines for [Pediatric Cardiovascular Risk Reduction](#) and [Cardiovascular Disease Risk Reduction in Adults](#) are being developed.

Guidelines are developed through NHLBI partnerships. Expert panels, chosen mainly for their scientific and clinical expertise, are appointed by NHLBI to write the clinical practice guidelines. To guide the overall effort, NHLBI has created a Leadership Group with representation from various stakeholder organizations including professional groups, consumer groups, other NIH Institutes and Centers, Federal agencies, and international global organizations. Additionally, there are cross-cutting work groups on risk assessment, lifestyle interventions, and guideline implementation.

NHLBI is embarking on a new effort aimed at developing and updating cardiovascular guidelines, employing a new model and a new approach—garnering input by convening different meetings with guideline users, including primary care providers, specialists, patients, and consumers. These guidelines will include integrated guidelines and individual risk factor updates. The integrated guidelines are intended to address patients with multiple risk factors; users will be able to look across multiple risk factors in one location for recommendations. In addition, the new guidelines will take a lifespan approach.

Guidelines are intended to be user-friendly, concise, clear, and focused. Implementation issues are being considered throughout the development process so that guidelines can be easily used. Innovative informatics approaches and tools are being incorporated to facilitate guideline

updates. Finally, knowledge gap analysis will determine where there is limited or weak evidence-based data; identified gaps will be incorporated into NHLBI's research planning.

DMICC members discussed this approach to guideline development, including issues such as grading of evidence, balance of risk and benefit, and use of non-clinical trial evidence. Dr. Fradkin expressed interest in seeing how the Pediatric Cardiovascular Risk Reduction group incorporates diabetes in the guidelines and suggested that the group present the final guidelines at a future DMICC meeting.

For more information on NHLBI guidelines, please visit [www.nhlbi.nih.gov/guidelines/index.htm](http://www.nhlbi.nih.gov/guidelines/index.htm).

## **TRANSLATING EVIDENCE INTO EDUCATION IN THE VHA**

Dr. Leonard Pogach, Veterans Health Administration (VHA)

Dr. Pogach explained that Veterans Health Education is designed to help veterans: (1) enhance their quality of life through health promotion and disease prevention; (2) actively partner with their providers and health care teams; (3) engage needed family and social support systems; (4) develop self-management and coping skills; and (5) access and appropriately utilize VHA health care resources across the continuum of care. The VHA believes that education is an essential component of Veteran-centered health care, integrated across the VHA continuum of care, and the responsibility of all clinicians caring for Veterans. VHA also believes that health education is more effectively delivered at the patient-clinician level when formally supported at the organizational level. To ensure that Veterans and their family members receive the education services they need, VHA utilizes several different strategies: planning for the education and skills Veterans need to promote health and prevent disease, and cope with and manage acute and chronic conditions; implementing policy at the national and Veterans Affairs Medical Center (VAMC) levels; creating formal organizational structures at all VHA levels to support and facilitate delivery of health education services; spearheading the development of and support for a network of the Veterans Health Education Coordinators at each VAMC; and providing continuing education for clinicians.

[My HealtheVet](#) is the VA's patient Web portal and currently maintains personal health information records, VA prescription history and online pharmacy refills, and information on a wide range of health topics. Future features include preventative care reminders (including diabetes care), secure messaging with a health care team, lab results, and the ability to view appointments. Dr. Pogach noted that there are over 700,000 registered users and that the site receives high ratings from users.

Dr. Pogach also discussed the VA's [MOVE! Weight Management Program for Veterans](#), which combines annual primary care screening with motivational interviewing approaches to help veterans lose weight, keep it off, and improve their health. The program was developed using NIH, United States Preventative Services Task Force, and VA/Department of Defense (DoD) Clinical Practice Guidelines to tailor a program of screening and weight management for veterans. The program is offered to at-risk patients (Body Mass Index >30, or 25-29 with a weight-related disorder) and 10 percent of patients accept care. The main format of care is

supported self-management: setting goals for weight loss and changes in diet, physical activity, and behavior; and patient-centered determination of follow-up. Supplemental care options include weight loss medication, intensive behavioral treatment, and bariatric surgery. Currently, about 150,000 patients have participated in at least one treatment session. A challenge for the program is providing adequate support for self-management; alternatives are needed to telephone and group care. VA is developing regional coaching centers and eMOVE! Web care to meet this challenge. The MOVE! program has several federal partnerships including DoD and Health and Human Services (HHS).

Dr. Pogach noted that the VHA is the leading national organization for American Diabetes Association Patient Education Recognition with about 47 sites. In regard to diabetes education, VHA distributes NDEP messages to all clinicians enrolled in their Diabetes Educator mail group, has developed patient education tool kits with DoD, provides local customization of programs, and evaluates bundled programs. The VA also conducts research on linking patient education and care management. Dr. Pogach closed with the VA's challenges and next steps: (1) remote delivery of patient education linked to remote management using secured messaging; (2) customization of messages; (3) evidence-based education; (4) assessment of linkage of education to outcomes; and (5) primary care systems redesign and guideline implementation.

Dr. Fradkin noted that there are potential opportunities for collaboration with the MOVE! program with regard to research on cost-effective ways to achieve weight loss. In response, Dr. Pogach indicated that members interested in the MOVE! program should contact Dr. Linda Kinsinger, Chief Consultant at the VHA National Center for Health Promotion and Disease Prevention.

## **INDIAN HEALTH SERVICE DIABETES EDUCATION PROGRAM**

Ms. Lorraine Valdez, Indian Health Service (IHS)

Since the start of the [Special Diabetes Program for Indians](#), there has been an increase in organized diabetes education programs available in tribal communities and the availability of culturally-appropriate programs at the local level. Many of these programs target families and whole communities, rather than the patient alone, and include traditional and cultural approaches. To make sure that the relevance and acceptance of diabetes-related information sharing is at its best, IHS collaborates with tribal clinic staff, patients, tribal leaders, and tribal health workers using focus group sessions and community member feedback. Ms. Valdez noted that, in these communities, it is important to have a variety of materials for use in a variety of ways and to have a dissemination process so that the community can access these materials. An [online catalog](#) allows communities to order materials.

She described several example resources for patients with diabetes (*e.g.*, the basic booklets for diabetes care and treatment; “*Using Our Wit and Wisdom to Live Well with Diabetes*,” a true story of a Native American women’s journey with diabetes; and “*A River Runs Through Us*,” which includes a journal for wellness). In addition, IHS produces *Health for Native Life*, a magazine for American Indians/Alaska Natives (AI/AN) to help prevent and manage diabetes. Special editions of the magazine include “*Gen7*,” a magazine for tweens and teens, and an issue on Native American participation in the Diabetes Prevention Program.

IHS has also developed resources for health care professionals including the “*Balancing Your Life and Diabetes*” curriculum to provide health care professionals working in AI/AN communities with a framework for diabetes education. The “*Youth Staying Healthy*” curriculum is currently in development—one version for teens with type 2 diabetes and another for diabetes prevention for children ages 8-12. In addition, IHS has developed [\*Standards of Care for Adults with Type 2 Diabetes\*](#); 18 [\*Diabetes Best Practices\*](#), as part of a mandate for the SDPI; and the [\*Promoting a Healthy Weight in Children and Youth: Clinical Strategies\*](#), a report that outlines recommendations and strategies for health care professionals.

Ms. Valdez also highlighted new projects in development by IHS and its collaborators. For example, with the HHS’s Office of Women’s Health, IHS is adapting the [\*Bodyworks\*](#) toolkit for AI/AN communities, for boys, and for families as a whole. [\*Strengthen the Family Circle\*](#), a series to promote healthy nutrition habits, was developed in collaboration with the Inter-Tribal Council of Arizona. IHS also collaborates with: Head Start on the *ABC Kit* and *My Amazing Body*, CDC on [\*The Eagle Books\*](#), NIH on the [\*We Can! Ways to Enhance Children’s Activity and Nutrition\*](#) program, the NIH and CDC on the NDEP, the American Diabetes Association on the [\*Awakening the Spirit\*](#) campaign, and the NIH and CDC on the [\*Diabetes Education in Tribal Schools Project\*](#).

## **DISCUSSION AND ANNOUNCEMENTS**

Dr. Fradkin noted the complementarity among today’s presented efforts and the many opportunities for cross promotion. DMICC members discussed issues regarding guideline development and dissemination, and the role of the DMICC in this process.

In conclusion, Dr. Fradkin announced two upcoming events that may be of interest to DMICC members: a meeting to evaluate pre-clinical research programs supported by the *Special Statutory Funding Program for Type 1 Diabetes* on June 17-18, 2009, and a meeting of the chairs of the *Diabetes Strategic Plan* on July 7, 2009. She also encouraged members to contact her with suggestions for topics for future meetings.