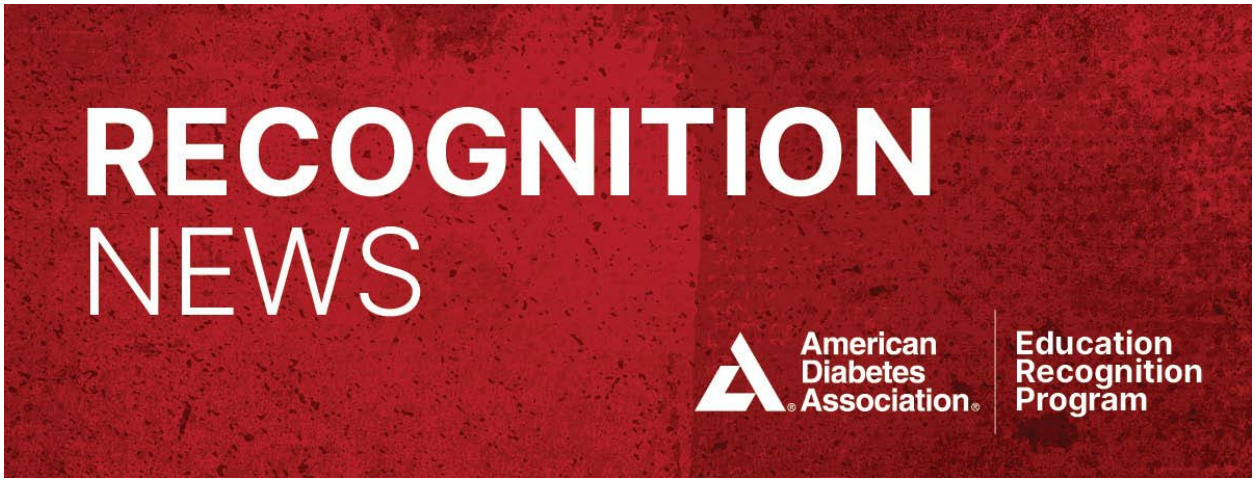
Explore Kidney Month resources, our ERP service spotlight, and more!

Summer 2025



Greetings from the Education Recognition Program (ERP) team!

This summer, we are excited to provide you with updates on diabetes prevention efforts at the American Diabetes Association® (ADA), as well as spotlight one of our ERP programs, the Chillicothe VAMC Diabetes Self-Management Education Program.

We would like to thank each and every one of you for all that you do for people with diabetes.

What's New

ERP Updates

ERP Diabetes Self-Management Education and Support (DSMES) Symposium: Available on Demand

The ERP DSMES virtual symposium is an accredited continuing education program that will award 4.75 CEUs to physicians, physician assistants, nurses, dietitians, pharmacists, and certified diabetes

care and education specialists (CDCESs) who attend 4.75 CEUs. The program's goal is to increase participant access to quality, evidence-based, and sustainable DSMES services.

This program will guide attendees through establishing and maintaining a DSMES service that adheres to the 2022 National Standards for Diabetes Self-Management Education and Support. It will provide updates on the ADA's *Standards of Care in Diabetes—2025*, which is a new requirement for CDCES renewal starting in 2025. Additionally, it will cover the requirement for one CEU in ethics for the Commission on Dietetic Registration recertification with a presentation on diabetes and driving, including an overview of guidelines, rules, and ethics. The program is designed for adult learners, is task oriented, and interactive.

CEUs: 4.75
Where: On demand
Cost: $150

This symposium will be available until December 31.

Register Now

ERP Spotlight: Chillicothe VAMC Diabetes Self-Management Education Program

The Chillicothe VA Medical Center (VAMC) is a specialized rehabilitation and mental health facility providing health care services to approximately 23,000 veterans across 17 counties. The medical center operates six community-based outpatient clinics (CBOCs) strategically located in Athens, Cambridge, Lancaster, Marietta, Portsmouth, and Wilmington, Ohio, ensuring that comprehensive and continuous care is accessible to veterans residing on the outskirts of the primary service area.

Given the vast geographic coverage, educators utilize technology to connect with veterans. Educational services are delivered through video visits to veterans' homes, video sessions at

their local CBOCs, in-person appointments, or phone consultations. Referrals to the program are made by primary care teams within the VA system and the inpatient treatment center on the main campus.

Our diabetes self-management education (DSME) program has a 21-year history of serving veterans and has been a recognized program for over 17 years. Currently, the program is staffed by two educators who hold CDCES credentials. These educators collaborate with pharmacy services for medication adjustments, home telehealth for daily monitoring of blood glucose and other metrics, and mental health specialists for behavioral support. Veterans also have direct access to their primary care team for supplies and consultations. In addition, many veterans participate in a 16-week weight-loss program, which supports lifestyle changes and reinforces diabetes management skills.

Over the past year, 300 veterans have enrolled in the comprehensive diabetes program. Of those, 75% completed all four classes, which cover the full range of diabetes self-management education. The average A1C level before starting the program was 8.3%, and three to six months after completion, the average dropped to 6.8%.

A unique feature of our program is the ongoing support provided after the ADA-recognized portion is completed. Our staff continues to engage with veterans through follow-up visits every six months, reviewing self-care behaviors, lab results, and updating personalized SMART goals. This sustained support reinforces education and ensures individual needs are addressed. Some veterans have remained in follow-up care for over 15 years, and among them, approximately 75% maintain an A1C of 7.5% or lower.

Diabetes Prevention Efforts at the ADA

National Diabetes Prevention Program

The ADA is committed to preventing or delaying diabetes through the National Diabetes Prevention Program (National DPP). The National DPP is a public-private partnership led by the Centers for Disease Control and Prevention (CDC) that is proven to prevent or delay type 2 diabetes in adults who are at high risk. The National DPP is a nationwide program offered by different organizations across the U.S. Refer your patients to the National DPP or begin a program by visiting our National DPP website.

Start Referring

Diabetes Prevention Efforts in Southern States

The ADA's Diabetes Prevention Alliance (DPA) is looking for health care partners, delivery organizations, and payers in the high-risk states of AL, FL, LA, MS, NC, and TX to expand the National DPP. Together, health care organizations, community groups, and employers can enhance health outcomes, lower health care costs, and expand access to diabetes prevention. Interested in reducing or delaying diabetes in your community? Learn more and join today.

Learn and Join

National DPP Lifestyle Coach Training

Coaches are needed to facilitate the National DPP lifestyle change program, and individuals interested in fulfilling this role should complete the appropriate training. The ADA provides on-demand DPP Group Lifestyle Balance™ Lifestyle Coach Training completely online in a convenient self-paced format that is supported by master trainers.

Who can become a lifestyle coach?

- Health care professionals
- Community health workers
- Wellness coaches
- Anyone passionate about health and prevention!

Contact us to learn more.

Contact Us

DPP Express

DPP *Express* is an easy-to-use online platform designed to help organizations and providers manage and track National DPP participants.

Key features:

- Seamless data collection and reporting
- Participant progress tracking
- Compliance with Diabetes Prevention Recognition Program standards
- Improved program efficiency
- Integrated medical claims billing

Learn More

Nutrition and Wellness

Virtual Cooking Classes for People with Diabetes and Caregivers

Our free virtual cooking classes are a great resource for your patients and their caregivers! These cooking classes highlight the fabulous recipes from our Diabetes Food Hub® taught by a professional chef alongside our ADA registered dietitian nutritionist and CDCES. Your patients will have the opportunity to ask questions in the chat throughout the class. Our next class is scheduled for **Thursday, June 26 at 7:00 p.m. ET**.

Can't make it? No worries. Each one is recorded and available on demand if they register prior to the class. Encourage your patients to register and join these fun and engaging sessions.

Encourage Registration

We have more resources to help your patients with their nutrition and wellness journey, including our free monthly Diabetes Food Hub e-newsletter which offers diabetes-friendly management tips and recipes every month.

AID Workshop

Gain valuable insights on automated insulin delivery (AID) devices at your convenience. Tune in to our latest on-demand workshop at your leisure to learn from experienced health care professionals as they share practical tips and strategies for integrating AID devices into your clinical practice.

Watch the Workshop

DaVita's Kidney Educational Toolkit

Understand the connection between diabetes and kidney disease with our new toolkit full of educational materials. Recognizing this link is crucial for preventing kidney issues. Share this resource to educate the people you see on diabetes and kidney health and how to lower their risk with the new toolkit available in both English and Spanish.

Download Now

Xeris Webinar

Gain critical insights on managing hypoglycemia. Severe hypoglycemia can be life-threatening, but with the right strategies, it's manageable. Join our upcoming webinar to hear from top experts in the field, including Scott Pilla, MD; Medha Munshi, MD; and Diana Isaacs, PharmD. Get practical tips on medication adjustments, glucagon use, and patient education. **Don't miss out**—join us on August 7 and enhance your knowledge in diabetes care.

Register Now

Diabetes and Eye Health

Join a free CE course on diabetes and eye health for primary care clinicians. This course focuses on the current epidemiology of diabetes-related eye disease, recognizing how to foster collaborative care with other health care professionals involved in the care of patients with diabetes, as well as identifying the clinical stages and features of diabetes-related retinopathy.

Join the Course

This article was supported through a sponsorship by Corcept Therapeutics

Presence of Hypercortisolism in Difficult-to-Manage Type 2 Diabetes

There are over 38 million people living with type 2 diabetes in the U.S. Despite various treatment options, it remains difficult to manage for many. Excess cortisol production complicates type 2 diabetes management. When individuals produce excess cortisol, it is commonly called hypercortisolism (or Cushing's syndrome) and may be a contributing factor when diabetes is difficult to manage.

People living with hypercortisolism may present with a range of physical characteristics. Classically described discriminate features of the disease include skin thinning, easy bruising, purple striae, and a fatty lump between the shoulders (buffalo hump). Although not all people will have this clinical presentation, they may often present with overlapping features of the disease which include diabetes, hypertension, weight gain, or other cardiovascular complications. Based on emerging literature, the prevalence of hypercortisolism may be more common than previously thought.

Why is screening and diagnosis of hypercortisolism important?

Research indicates that any excess of cortisol may be harmful, as it increases risk for cardiovascular disease, type 2 diabetes, hypertension, and osteoporosis. There are three different tests available to measure cortisol:

1. The Dexamethasone Suppression Test (DST) measures free serum cortisol. This is the most sensitive test for detecting autonomous cortisol secretion outside of the cortisol feedback loop.
2. The Late-Night Salivary Cortisol (LNSC) Test measures cortisol in the saliva that is in equilibrium with active free cortisol in the blood. This is the most sensitive test to detect recurrence of Cushing disease (pituitary source) and is a measure of diurnal rhythm.
3. The Urine Free Cortisol (UFC) Test provides an integrated assessment of cortisol secretion over a 24-hour period. It is the most insensitive test because it measures free cortisol in the urine when it crosses a threshold that exceeds the binding capacity of cortisol binding globin in the plasma.

The DST test is simple and the most sensitive screening method for hypercortisolism, yet we are not adequately utilizing it for screening in the type 2 diabetes population. Clinicians should consider the DST application in the appropriate clinical context.

DST screening for hypercortisolism:

- Administer 1 mg of dexamethasone orally at 11:00 p.m. (bedtime)
- Blood draw for cortisol at 8:00 a.m.
- Draw simultaneous dexamethasone levels to ensure the patient has achieved adequate levels to suppress normal cortisol production
- Use a cortisol cutoff value of greater than 1.8 ug/dL (50 nmol/L)
- Common reasons for false positives should be excluded

DHEA-S and ACTH levels are used to determine if hypercortisolism is ACTH dependent (pituitary or ectopic hypercortisolism) or independent (adrenal hypercortisolism).

Cortisol Levels and Glucose Intolerance

People with diabetes may inherit genes which increase the likelihood of insulin resistance. At night, liver insulin resistance results in fasting hyperglycemia. During the day, due to muscle insulin resistance, postprandial hyperglycemia occurs. Additionally, inherited beta cell failure leads to a decline in insulin secretion, worsening glucose tolerance when combined with insulin resistance.

The presence of cortisol affects multiple physiological processes. Persistently elevated cortisol levels inhibit the insulin signaling and transduction pathway. Blocking this pathway impairs the transport of glucose into cells. Cortisol also directly affects the translocation system, reducing insulin's ability to transport glucose into cells. Additionally, cortisol independently inhibits glycogen synthase.

Glucocorticoids affect the muscle, pancreas, gut, and fat cells:

- Muscle: Decreased glucose uptake/oxidation, decreased glycogen synthesis, and increased protein degradation.
- Pancreas: Decreased insulin secretion, increased GLP-1 resistance, and increased glycogen secretion.
- Gut: Decreased GLP-1GIP.
- Adipocyte (fat cell): When consuming a meal, most of the glucose is absorbed by muscle tissue. A small portion is taken up by adipocytes. However, fat cells also exhibit insulin resistance. This defect in the glucose transport system is present within the fat cells as well. Additionally, stimulating lipolysis releases free fatty acids (FFA) into the bloodstream. Elevated levels of FFA contribute to insulin resistance in both muscle and liver tissues and impair insulin secretion. These documented mechanisms explain how cortisol induces insulin resistance.

Given these interconnected factors, it is unsurprising that cortisol is linked to glucose intolerance and diabetes. Individuals with hypercortisolism experience increased rates of cardiometabolic comorbidities. Pharmacological treatments aimed at these comorbidities, without addressing the underlying hypercortisolism, are ineffective in enhancing long-term cardiovascular health.

Research on Hypercortisolism and the T2D-CATALYST Study

A meta-analysis indicated that individuals with type 2 diabetes who do not achieve glycemic management through multiple medications have poor metabolic management, more comorbidities, and are more likely to present with hypercortisolism. People with type 2 diabetes that has advanced to the point of experiencing complications are approximately 3.5 times more likely to be diagnosed with hypercortisolism.

The CATALYST Study

The study was designed for people living with difficult-to-manage type 2 diabetes despite receiving standard-of-care therapies. CATALYST is the largest prospective study on hypercortisolism prevalence in hard-to-manage type 2 diabetes using post-DST cortisol in appropriate patients with an A1C of 7.5–11.5% despite multiple antihyperglycemic medications. The trial included over 1,000 participants across 36 centers in the U.S., ensuring a diverse population sample.

Part 1: Screening Phase

The first part of the study evaluated the prevalence of hypercortisolism. Those individuals with a cortisol level over 1.8 μg/dL (50 nmol/L) and a dexamethasone level of ≥ 140 ng/dL after a 1 mg DST were then referred to have an adrenal CT scan.

Key inclusion criteria:

- Selecting a well-defined population with difficult-to-manage type 2 diabetes, 18–80 years of age
- A1C of 7.5–11%

and

- Three or more antihyperglycemic agents

or

- Taking insulin and any other anti-hyperglycemic drugs

or

- Taking two or more anti-hyperglycemic drugs and the presence of micro or macrovascular complications

and/or

- Taking two or more anti-hyperglycemic and two or more antihypertensive drugs

Key criteria for excluding patients with recognized causes of falsely elevated DST:

- Use of oral contraceptive pills
- Excessive alcohol consumption
- Severe untreated sleep apnea
- Severe psychiatric, medical, or surgical illness

- Night shift work (awake from 11:00 p.m.–7:00 a.m.)
- Hemodialysis or end-stage renal disease
- Type 1 diabetes
- Diabetes onset less than one year
- Systemic glucocorticoid exposure (excluding inhalers/topical)
- Hypersensitivity or severe reaction to dexamethasone
- Pregnant or lactating
- Cushing's syndrome diagnosis with any pharmacological treatments (current/planned)

Part 2: Treatment Phase

Evaluate the safety and efficacy of medical treatment of hypercortisolism in patients with difficult-to-manage type 2 diabetes identified in Part 1. Patients were randomized to either:

- Mifepristone (300 mg/day titrated up to 600 mg/day, option to increase to 900 mg/day) for 24 weeks

or

- Placebo 24 weeks

Strengths of the CATALYST study:

- Largest and most rigorous U.S. study of its kind to date
- Included participants with poorly managed diabetes despite best therapies
- Excluded individuals with potential false-positive hypercortisolism tests
- Conducted tests viable in a diabetes practice
- Mild renal impairment did not significantly impact results, but requires more research
- Recruited a diverse population from various clinical settings

Limitations of the CATALYST study:

- The findings may not apply to all people with diabetes. CATALYST recruited a highly selected, though common, phenotype.
- Imaging studies were community standard abdominal CTs, not dedicated adrenal CTs. Central reading is now underway.
- Although the DST proved easy to perform, it would be beneficial to have even easier static screening tests.
- The treatment phase is designed to demonstrate whether hypercortisolism is treatable in this population.

Summary Results CATALYST Trial: Part 1

The following results were gleaned from the first part of the study:

- Patients with type 2 diabetes who were unresponsive to advanced medications may have hypercortisolism.
- Cortisol affects insulin action, insulin secretion, GLP-1 action, and metabolism. The treatment of hypercortisolism has been linked to significant metabolic and cardiovascular benefits.
- Among over 1,000 individuals with poorly managed type 2 diabetes on multiple standard therapies, 24% had hypercortisolism. Of these, 35% had an adrenal nodule or abnormal imaging. In CATALYST, 37% of patients needing three or more antihypertensives had hypercortisolism.

Key Takeaways

- Screen for hypercortisolism in difficult type 2 diabetes cases
- DST is a simple and readily available test
- Identifying causes of post DST falsely elevated cortisol levels

- Further research and refinement will be needed to treat hypercortisolism, including determining optimal medical or surgical methods

This article is based on emerging science regarding the relationship of hypercortisolism and diabetes and that understanding continues to evolve.

DSE-N-00035 APR 2025 ENDO

askada@diabetes.org | 1-800-342-2383

Learn more at diabetes.org