>> TARYN EGELANIAN: Okay. Well, welcome, everybody. We are going to start the program. Thank you for taking the time to attend today's webinar, Patient Advocacy Across the Ages. We are looking forward to an excellent program.

My name is Taryn, and I work in the Legal Advocacy Department here at the American Diabetes Association. And before we start, I am just going to go over a couple brief housekeeping announcements.

First, all phone lines will be muted except for those of the presenters today. The webinar is being recorded, and we will make the recording and the webinar available for access online within about a week or two of today. And if you notice, in the bottom left-hand corner of your webinar screen, there is a Chat box. You are welcome to submit questions or comments at any time during the program. We will answer as many of the questions as possible as we go along today.

And I want to briefly introduce the presenters you will hear from today. Linda Siminerio is Director of the diabetes Institute at the University of Pittsburgh, and Linda is also the Co-Chair of the Association's Safe at School Working Group.
You'll hear from Anastasia Albanese-O'Neill. Anastasia is Assistant Professor at the University of Florida's College of Nursing, and she is also incoming Co-Chair of the Association's Safe at School Working Group.

And Crystal Jackson is Director of the Association's Safe at School campaign, and you will hear from all of them in a few minutes. I want to let you know that today's webinar is supported by an unrestricted educational grant from Novo Nordisk, and we appreciate their support.

And before we actually start, we want to find out who is on today's webinar, so please check off all of the categories that apply to you, and we'll find out who is out there.

Well, there's a great number of you out there today, and we really appreciate it. There are quite a few diabetes educators, a lot of nurses, a fair number of dietitians, and we welcome all of you and everyone else who continues to less you know who you are today.

So now I am going to turn things over to Linda Siminerio.

>> LINDA SIMINERIO: Today we are going to focus upon the fourth bullet, but I just want to first refresh and refer you to the mission of the ADA, and it's to prevent and cure diabetes and improve the lives of all people affected by diabetes. We do many things. One is, of course, increase federal and state funding for diabetes prevention, treatment, and research. We have efforts to prevent diabetes and improve the availability of accessible, adequate, and affordable healthcare. But what the focus today is, is to talk about eliminating discrimination against people with diabetes.

So go to the next one. I am moving it, but -- there it goes. Okay.

Discrimination can impact anyone who has diabetes, and everyone who has diabetes deserves fair treatment throughout their life span, whether it be at work, at school, in daycare, while driving, those who are incarcerated in jail or prison, and in other parts of their life. However, this doesn't always happen, and that's what we are going to be talking about.

What is unfair treatment due to diabetes? Well, the way we define it is the treatment that prevents a person who has diabetes from a normal experience just because he or she has diabetes. If it doesn't seem fair, it may be unlawful discrimination.

There are legal protections for people with diabetes, and we need to recognize that discrimination is often based on fears and misunderstandings and not really facts. Diabetes is considered a disability under federal law.

How big is the problem? The ADA receives an average of 250 calls a month related to diabetes discrimination. In 2014, the Association’s Legal Advocacy Department provided individual guidance and health for over 1,000 of these situations. And those of you who are directly working with patients, I hear a lot of
healthcare professionals on this call, this is really a resource for you.

So Taryn, I am going to go to the next poll. You want to take that on?

>> TARYN EGELANIAN: So we'd like to find out how many of your patients -- or have any of your patients been treated unfairly -- which is called discrimination -- because of having diabetes? And it looks like the predominant answer is yes. And some say I don't know, and we will get to all of this today.

Now back to Linda.

>> LINDA SIMINERIO: So the purpose of legal advocacy is to provide information, training, and resources to prevent or stop discrimination for people with diabetes and their families, for people who help defend folks like lawyers, people like healthcare providers like those of you, many of you on this call, and advocates. And it's for schools, employers, and correctional facilities. And to help people know their rights and to help them promote self-advocacy and to build expert teams. We have a professional volunteer network support with expertise, and we have the Health Care Professional Legal Advocacy Network, which we hope if you are not already a member you will think about joining, and an Advocacy Attorney Network.

One of the things that we work toward is using methods, and as I alluded to before, one of the things that happens is that oftentimes discrimination is often a result of people not understanding and fear. So one of our first steps in resolving problems is to educate. If education doesn't work, then we go to negotiating. If negotiation doesn't work, then we explore litigation. And finally, legislation.

One of the things that I have been proud to be a part of is working on some of our position statements, and for those of you who may not be aware, we just updated our School Position Statement. But you know, these are documents that provide a lot of good evidence and a foundation when things do get to the negotiation or litigation or legislation stage.

So getting involved. Where do you work? Do you work with adults or pediatrics? We certainly can use some support for both populations.

What interests you? Legal or legislative advocacy or both? Is it about diabetes prevention that you are interested in or management?

And during patient encounters, questions to ask, things to listen for, what's your employer's position on discrimination?

And back to you again, Taryn. I think we have another poll coming up. Oh, I guess this slide just represents all of the different audiences across the life span that can be impacted by discrimination.

And now on to the poll with Taryn.
TARYN EGELANIAN: Okay. So please let us know the type of patients you see in your practices. And I see we have quite a few who are adult oriented. A lot of you see adult and pediatric patients. And you will learn about all populations today.

LINDA SIMINERIO: So Taryn, I am going to turn this over to Crystal for this part of the presentation to talk about schools.

CRYSTAL JACKSON: Thanks, Linda and Taryn. Now we are going to turn our focus to the Association's Safe at School campaign and to our advocacy efforts on behalf of children with diabetes.

The Association's Safe at School campaign is based on three principles regarding diabetes management at school. The first is all school staff members need to have a basic knowledge of diabetes and know who to contact for help. At a minimum, everyone who has supervisory responsibility for the child should understand diabetes and know how to recognize a low and know how to get help.

Second, the school nurse is the primary provider of diabetes care, but other school personnel must be trained to perform diabetes care tasks when the school nurse is not present. These tasks include insulin and glucagon administration, blood glucose monitoring, carbohydrate counting, and the recognition and treatment of highs and lows.

Third, students who are capable of doing so should be permitted to provide self-care wherever they are at school or at school-related activities.

And these organizations have endorsed the Safe at School campaign and its goals and principles, and they collaborate with the Association to help foster safe environment for children with diabetes at school.

And next we are going to talk about some real diabetes challenges for students, and soon you will understand why the Association's Safe at School campaign is so essential to the health and well-being of our children with diabetes.

So as Linda mentioned, we do receive a number of phone calls, our Legal Advocacy staff receives a number of phone calls regarding discrimination issues, and many of those calls come from parents of children with diabetes. And unfortunately, they are not calling to tell us everything's going well at school. We do hear about a lot of problems at school, even though we know there are many schools out there doing things very, very well to take care of our kids. But these are just some common themes that we often hear about from parents.

We hear about the failure of schools to have trained staff to assist students with diabetes. We know that today's reality is that most schools do not have a full-time school nurse. So there really is a need to train backup personnel. These backup personnel are just
so essential for the schools, even in those schools fortunate enough to have a full-time school nurse because we know the full-time school nurse cannot be in all places at all times. They usually don't go on field trips, nor do they stay for afterschool school-sponsored activities. Also, quite frankly, the school nurse is very busy, so she might be busy helping another student, or she may be absent.

Regardless, it is the school's responsibility to have a school nurse or another trained staff member available at all times to provide needed care, and it is the school's responsibility to train school staff, not the parents' responsibility, although the parent will need to provide specific information about their child because every child with diabetes is different, as you well know.

Many schools have no one authorized or trained to administer insulin or glucagon. Many schools do not have personnel to cover field trips or extracurricular activities. And as I said earlier, the school nurse is usually not available to accompany students during these activities.

We sometimes hear about the school's refusal to permit blood glucose checks outside of the health clinic or the office. We also hear about some school districts who have attempted to send kids away from their neighborhood schools to another school where there is a full-time school nurse. Many times this requires a long bus ride, and then the concern arises about the lack of trained personnel on the bus to help a student with diabetes.

We've heard of instances where schools have refused to enroll students with diabetes and have actually recommended to parents that they homeschool their child.

So all of these examples of school diabetes management problems constitute discrimination and are in violation of federal laws and many state laws and have an adverse impact upon diabetes medical outcomes.

This is just a list of federal laws that provide protections to children with diabetes in addition to state laws. I am going to provide you with a quick overview of these laws so that you can understand how they work and how you can use them to ensure that your patient's diabetes management needs are met during the school day and at all school-sponsored activities, including field trips and extracurricular activities.

Both the Americans with Disabilities Act, or ADA, and Section 504 are civil rights law. Both prohibit discrimination on the basis of disability. Both also prohibit retaliation for asserting the right not to be discriminated against. These laws are not limited to disabilities that affect learning or academic progression.

But sometimes because the schools are more familiar with the individuals with disabilities Act or IDEA, some school personnel may insist that the child with diabetes is not covered and is not eligible for services under ADA or 504 unless he or she is having academic
difficulties. This simply is not true. A child's learning need not be substantially limited in order for the child to be protected by these laws.

And the Americans with Disabilities Act and Section 504 both share the same definition of disability, which includes three elements: A physical or mental impairment that substantially limits one or more major life activities -- and just so you know, a major life activity does include endocrine function; number two, a record of such impairment; or number three, being regarded as having such an impairment. And this most definitely includes children with diabetes.

The word "disability" is not a label. Rather, it is a legal term to help parents to secure needed health services and academic modifications for their child. So if you have parents of patients who are concerned about that disability label, just let them know that it's a legal term of art that will help them to secure needed services for their child with diabetes.

So here's a list of major life activities substantially limited by diabetes, and even though there's a number of activities, the only one that needs to be demonstrated is a substantial limitation of endocrine function. So of course, that is diabetes, and that is the major life activity that is substantially limited.

Schools cannot take mitigating measures into account when determining eligibility under ADA or 504. In other words, insulin, although it lowers blood glucose levels, cannot be considered to obviate the need to meet the child's diabetes needs, and it does not relieve the school's responsibility to provide services to the child under federal law. So insulin is not a mitigating measure.

Under Section 504, schools must identify children with disabilities, including diabetes. Realistically, schools don't always do a good job of doing this. Usually it is the parent or guardian who initiates this process by contacting the school's 504 coordinator, who might be the school principal, guidance counselor, teacher, or someone else. Schools must provide free and appropriate public education. Schools cannot charge a fee to provide health services to the child. Schools must educate children with disabilities with other students as much as possible. All kids with diabetes or another chronic condition cannot be segregated into a separate classroom or school. Schools must allow parental participation in decisions. Parents should attend all meeting and work with the 504 team to develop the child's 504 plan. Schools must provide equal opportunity to participate in all nonacademic and extracurricular activities. And cost is not a bar to the school's obligation to meet the diabetes management needs of the child.

The Individuals with Disabilities Education Act, IDEA, is a federal law specific to education. It applies to children with specific disabilities. A subsection of these kids with diabetes
will be covered under IDEA. Diabetes is classified as "other health impairment" or "OHI" under IDEA. Those that are covered may have another disability that has demonstrated an adverse impact upon learning. Some of these kids have fluctuated blood glucose levels that impact learning, so they may qualify for services under IDEA.

A child with diabetes is covered if he or she needs special education and related services in order to benefit from an education.

Under this law, an individualized education program, referred to as IEP, sets out what the school is going to do to meet the child's individualized education needs. The IEP is developed by a team that includes parents, special education experts and school staff. And please note that students who are protected and eligible for services under IDEA are also covered under ADA and/or Section 504. These students do not need a separate 504 plan. An individualized education program is written by the school's 504 IEP team for eligible children.

So just a quick recap of the laws. Section 504, under this law, public and private schools, including religious schools receiving federal funds have obligations to provide services to kids with diabetes.

The Americans with Disabilities Act, the same as 504, except it covers day cares and camps. It does not cover religious affiliated schools and programs.

IDEA is a special education law. So an adverse impact upon learning or academic progression must be demonstrated in order for the child to be eligible for services under IDEA.

So with respect to state laws -- we just covered federal laws, and there are also state laws that impact the delivery of diabetes care in the school setting. So this slide shows where specific school diabetes care laws are in place, and you can access the text of these laws and regulations on ADA's website if you go to diabetes.org/kidswin. It's right on the slide. Please note that just because you don't see your state listed doesn't mean your state isn't Safe at School friendly. Some states already have laws in place that allow trained school staff members to provide care and support self-management.

In some states, like Alaska, Nevada, Colorado, Utah, and most recently North Dakota, the Board of Nursing has taken the lead in standardizing and improving diabetes care at school.

So now let's test your knowledge of what we covered in this section on federal and state legal protections.

Rebecca, a first grader, is excited about her first school field trip to the city zoo. Rebecca's parents have been told that one of them needs to accompany Rebecca on her field trip. What is the proper course of action? So we are going to the next slide, and let's read down these, and you can check as many as apply. Let's test your knowledge.
Parents can take a day off to attend. School nurse can attend. Rebecca can't go without a parent. Trained teacher can go with Rebecca. Rebecca goes, no prelunch insulin. Field trips covered in her 504 plan. Or I don't know.

Let's see how we do.

Okay. So certainly parents can take the day off to attend if they choose to do so, but just remember that parental attendance is not a prerequisite for student participation.

Most definitely it would be great if the school nurse could attend.

The school cannot tell Rebecca she cannot go without a parent. A trained teacher could go with Rebecca, absolutely. Rebecca goes and then she just goes without her prelunch insulin, which is not acceptable.

Field trips covered in her 504 plan. Absolutely, we recommend to parents that they do, indeed, include a field trip provision in their child's 504 plan.

So now I am going to turn this back over to Linda, who is going to cover written care plans.

Linda?

>> TARYN EGELOGIAN: Linda, please press * 7 to unmute your line.

>> LINDA SIMINERIO: Can you hear me now? Hello?

>> TARYN EGELOGIAN: Yes, we can.

>> LINDA SIMINERIO: Okay. The Diabetes Medical Management Plan sets out how the child's diabetes needs will be met in the school setting; for example, how to recognize and treat high and low blood glucose. And a template of a diabetes management plan -- so you don't have to work on creating your own, we already have one developed for you -- can be downloaded from the ADA's website at www.diabetes.org/dmmp.

We have other resources for you. This is the Section 504 plan, a written document where the parents and school agree on the services and accommodations that the student needs, and each child with diabetes has individual needs. A Section 504 plan must be individually developed.

We want to make sure that we have other resources and training modules for you, and again, all of these resources for Safe at School, like training modules, websites, manuals, et cetera, are all available to you at diabetes.org/schooltraining.

Care of the younger child in the child care setting. This has given us some pause, and we spent a great deal of time attending to this because it's becoming a very important issue for young children.

Like schools, ADA and Section 504 prohibit discrimination on the basis of disability in the child care setting. Under ADA, child care providers must make reasonable modifications to enable a child with diabetes to fully participate unless the modifications impose an undue hardship or cause a fundamental alteration to the nature
of the program.

Under Section 504, federally funded entities must provide disability-related accommodations in the child care setting.

Under the IDEA, pre-kindergarten programs must identify children with disabilities and provide disability-related accommodations. Many states already have laws and regulations impacting the provision of child care.

Child care providers must accept children about diabetes; provide training to staff with the help of a diabetes professional and the parent or guardian; provide prescribed care and adhere to the care schedule, like routine glucose monitoring, insulin administration, meals, snacks, making sure for the young child they are eating on time; and very important for this age group, recognize and be able to tripe hypoglycemia and hyperglycemia, including glucagon administration; and allow the child to participate in their own care as they are able to do so.

The Safe at School child care planning tools. You can see that there's many resources available to you, including, if you look at the left-hand lower corner, another position statement. But again, an example of a medical management plan and brochures, et cetera, and tips, a handy, useful tool for the families or you, yourself, if you are engaging in providing education or training for the daycare center.

Children moving on to postsecondary education, these institutions must comply with Section 504 and the Americans with Disabilities Act, but unlike primary and secondary schools, postsecondary institutions are not required to provide free and appropriate public education. No free tuition. Institutions have no identification requirements. Students must self-identify. So it's important to educate young students that they need to do this as they are transitioning on. Students can do this by contacting their institution's disability office.

Institutions must provide academic adjustments so that it does not discriminate because of the student's diabetes. For example, a student might arrange to take an exam at an alternate time of his or her blood glucose levels, if they are out of range, for example if they've just had a hypoglycemic event and need some time to get their thoughts together.

Documentation is required. Having a high school 504 plan isn't enough because this is a completely different environment and a change in the student's care and environment. Usually the school will require a written confirmation of diabetes from the child's healthcare provider. A 504 plan can be developed, but more often, the institution's disability office will provide the student with letters of accommodation to provide instructors so they can notify instructors as the student determines who should be notified.

The Association also has this comprehensive resource for
postsecondary students that explains the rights of postsecondary students. It covers the Section 504 and the Americans with Disabilities Act and how it applies to these young people and explains how to navigate the 504 process at the college level. This resource is available also for downloading at the link provided in this slide.

So some of our recent Safe at School developments. The Association celebrated a great victory for our California students that have, really, implications and provide a foundation for all of us in August of 2013, making it clear that school employees can administer insulin to these students.

We've achieved success in the state legislators or working with the state Boards of Nursing so that 30 states now meet ADA 3 ten nets.

We are excited about the new child care statement published last October and the development of child care-specific resources are under way. This October, our Revised School Position Statement was published in Diabetes Care that you can access on our website. And now I am going to turn the program over to Anastasia, who will cover the rights of people with diabetes in employment, driving, and correctional facilities.

So thank you, and Anastasia, it's all yours.

>> ANASTASIA ALBANESE-O'NEILL: Thanks so much, Linda. That was terrific.

I'm going to talk, again, as Linda said, about the legal protections for people with diabetes in the context of employment, driving, and in correctional facilities. And this brings us back, of course, to the Americans with Disabilities Act, which Crystal spoke about at length, again, enacted in 1990 and amended in 2008. This is a law intended to provide comprehensive protection against discrimination against qualified individuals with disabilities. And it recognizes, I think, that the source of discrimination is often not due to an individual's limitations but really about fears and myths and stereotypes that others hold.

I would just remind everybody on the phone or on the webinar that it was once common practice to restrict individuals with diabetes from certain jobs or entire classes of employment solely because of the diagnosis of diabetes or the use of insulin, and this was without regard to the individual's abilities or circumstances. And this is discrimination, and this law helps us move beyond those types of restrictions.

So in terms of the Act's requirements, it prohibits discriminating against a qualified individual with a disability who is an employee or an applicant, and I would just remind you that people with diabetes qualify as a person with a disability because diabetes constitutes a substantial limitation on endocrine function. So that's important for you to keep in mind.

Discrimination can include taking an adverse action because of a disability such as hiring -- or failing to hire someone or firing
them; reducing their pay or their working hours because of diabetes; providing fewer fringe benefits, like access to healthcare possibly; failing to promote the person; and failing to provide reasonable accommodations. And we are going to discuss those reasonable accommodations a little bit more in the next slide. But if it doesn't seem right to you when you are talking with your patients, it might be discrimination.

So let's look at those reasonable accommodations. So these include a number of things. If the employee falls under the ADA, then the employer must make reasonable accommodations. And these can typically be provided at little or no cost. To obtain accommodations, the employee must make a request, and while they can make a verbal request, it's our position that we encourage that that request be made in writing. It's always nice to have documentation.

And if the need for accommodation isn't obvious, the employer might ask for reasonable medical documentation. And I will talk about this a little bit more later, but remember that diabetes is often seen as an invisible chronic disease, and so it may be that the employer looks at that employee, doesn't think that they qualify, and would ask for this documentation.

I want you to assure your patients and remind you that this doesn't mean that the employee has to provide their entire medical record or their mental health history. It's what's pertinent to provide those accommodations with respect to diabetes.

So what are reasonable accommodations? So Up on the screen here, you can see some examples of accommodations employers can reasonably make. These are some of the most common, and they fall into basically three categories. Some are being able to care for your diabetes while you are on the job, which might mean a break to check blood glucose and to treat it by administering insulin or having a snack.

The second category would be leave for treatment or training and diabetes education or illness due to diabetes.

And the third broad category would be accommodations for secondary complications of diabetes. So for example, an employee might need a larger computer screen if they have diabetic retinopathy, or they might need a chair or stool if they have diabetic neuropathy.

So again, look at these examples here, and again, there may be other specific accommodations based on the individual need.

So online here, we have an example of a template letter that the employee could submit to their employer as a request for accommodations. And our goal really is to empower the person with diabetes or the employee to make this request on their own. And if that isn't successful because there is a refusal by the employer or noncompliance, then the healthcare provider would get involved.

Now, some of you out there are thinking, you know, reality is
actually fairly complicated, and that's true, and it may be that the healthcare provider may need to get involved earlier. There may be employees who don't have computer access or who have low literacy, and in that case, we would encourage the healthcare provider to step in earlier to advocate on behalf of that patient. But ideally, we want to empower people with diabetes to make the request on their own initially.

So if the employer asks for reasonable medical documentation after the patient has submitted their own written request, the healthcare provider can provide a letter that describes diabetes to establish coverage under the ADA and can document the needed accommodations, and they can get very specific here.

This letter should also really emphasize that the patient can successfully perform the job and avoid danger words, and this should really counter the safety concerns with an individualized assessment.

And I just -- remember that employment decisions shouldn't be based on generalizations or stereotypes regarding the effects of diabetes, and there are a lot of them out there. The impact of diabetes and its management varies widely among individuals, and so individual assessment by a healthcare provider that's familiar with the patient is really paramount in this case. It should be the treating healthcare provider and not necessarily the employer's in-house medical staff.

There is a sample request available online, and you can see the URL there on your screen.

So we have a case study. This is a time for all of us to participate. We have Mary, who is a 49-year-old female with type 2 diabetes. She works as a customer service representative in a busy call center. And during her appointment with you, you notice that her blood glucose drops below 70 milligrams per deciliter around 11:15 a.m. several times a week. And what Mary tells you when you ask is that her bathroom breaks are limited to 5 minutes and that she's penalized for extra time that she takes or breaks. And she is told she can't check her blood glucose at her desk because that would interfere with helping customers.

Take a minute to digest that. And then, based on that case study, what type of recourse does Mary have? How should she respond to her employer's instructions in terms of not checking at her desk and being penalized for extra time?

And Taryn, can you submit the poll when we are ready?

Well, clearly, you are all experts on -- exactly. So checking blood glucose is certainly a reasonable accommodation, and she should seek accommodations based on the process that we described earlier. Excellent.

All right. Well, we won't linger here. So let's move on to driving.
So as many of you know, a driver's license is essential for work for many people, for taking care of their family, for securing access to getting around to different places, for interacting with friends, for attending classes or school and performing, really, many of the other functions of daily life. So driving is significant. And most people with diabetes do not pose an increased risk of motor vehicle accidents, and the diagnosis of diabetes is not sufficient to make any judgments about an individual's capacity to drive safely.

Once again, people with diabetes are diverse, and they're diverse in terms of the nature of their condition, the symptoms they experience, the measures they take to manage their diabetes, and so it's important that identification and evaluation processes are appropriate, individualized, and not solely based on the diagnosis of diabetes but, rather, on concrete evidence of actual risk.

That said, there are individuals whose diabetes does pose a significantly elevated risk, and so this must be identified and evaluated prior to them getting behind the wheel. This can be done at the time of licensure with a brief questionnaire that can be used to define drivers at increased risk. And it is important once again that the evaluation processes are appropriate and individualized. And it must include an assessment by the treating physician or diabetes specialist, someone who works with the patient.

So what might a healthcare provider be asked to evaluate? Well, they'll be asked to review the recent diabetes history and provide a recommendation as to whether the person -- the driver -- has a condition that impairs his or her ability to safely operate a motor vehicle. And this may include any severe hypoglycemia in the past two years, and they will be asked to provide those dates; the events surrounding the severe hypoglycemia and the specific instances -- were these individualized or is there a trend; is the driver at risk for severe hypoglycemia? Can the driver detect early hypoglycemia and treat it? Do they adequately monitor blood glucose levels? Does the driver have any diabetes-related complications that may interfere with safe driving? Again, this may be retinopathy that has an impact on vision or neuropathy in the lower extremities that impairs the ability to operate the pedals. If the answer here is yes, then the healthcare provider with expertise in evaluating these specific conditions and their relationship to risk should be included. And then does the driver have a good understanding of diabetes and its management, and will they follow the suggested treatment plan?

This, again, comes out of our position statement at the Association, and the focus here is on hypoglycemia. And I will just say that healthcare providers and educators can really take the lead in discussing risk reduction with patients on a routine basis. And again, specifically the risks of driving with low blood glucose. There was a study done, but what it found was 50% of drivers with
type 1 diabetes and fully 70% of drivers with type 2 diabetes had never discussed driving risk reduction with their healthcare providers. This is important.

Blood glucose should be measured before driving. Driving should never begin with a blood glucose 90 and 70 milligrams per deciliter. Never drive when blood glucose is below 70 milligrams per deciliter. During long drives, you need to treat. And if hypoglycemia is detected while driving, immediately pull off the road. Have a fast-acting carbohydrate or source of glucose, and do not resume driving until blood glucose is over 90 milligrams per deciliter. This is outlined nicely in the position statement.

Let's talk a little bit about commercial driving. Until 2003, there was an outright ban on persons treated for diabetes from being commercial drivers. This meant that people with diabetes can never consider becoming most types of drivers, and people with type 2 diabetes lost their livelihoods when it was necessary for them to be on insulin. This put people in a horrible position. You could avoid insulin and keep your job or take insulin and lose your access. This was really a horrible position for people with diabetes.

After 2003, a Diabetes Exemption Program -- and still currently today -- was put into place for interstate commercial drivers. But unfortunately, this exemption program, while it's an improvement on the outright ban, it can take up to six months for the exemption to be -- the application to be reviewed and approved, and that means that individuals may still experience hardship if they start taking insulin. And many employers and occupational health clinics are unaware of this program.

I am not going to get into the specifics here. They are all listed for you on the screen. But here are the criteria that would be reviewed when somebody -- someone interested in being a commercial driver or a current commercial driver who is prescribed insulin would have to fulfill. And you can look at the list here on your screen.

And there is another slide that lists additional criteria, including maintaining a driving and blood glucose log, checking blood glucose every 2 to 4 hours, only driving between a certain blood glucose range, submitting quarterly and annual reports, and reporting all motor vehicle accidents or adverse driving events in a timely way.

And you can see that between those two slides, that was an extraordinary burden, particularly for people who didn't have any incidents at all.

The good news is that there is a new proposed rule that was published in the Federal Register on May 4, 2015, that amends the Federal Motor Carrier Safety Regulations and eliminates the ban against insulin. It gets rid of the cumbersome Diabetes Exemption Program altogether and all certification of insulin-using drivers will be done by certified medical examiners, just like people who
have diabetes and take oral medications and for people with other medical conditions that affect driving, like sleep apnea and others. The treating clinician would assess diabetes and risk.

The new rule is not yet final, but the new rule is very good, and it really is the result of the Association's persistent advocacy over the years. And if you look at our Driving Position Statement, it's quoted extensively in the Notice of Proposed Rulemaking. So stay tuned. We are very hopeful about this change in process.

A little bit about commercial driving. Some common problems that you may talk about with your patients. Employer may fire -- the employer may fire or refuse to hire individuals who use insulin due to a misunderstanding about the exemption program, that it's possible. That's still the law today.

The employer may require Department of Transportation medical certification when it's not applicable. Or they may require a certain A1C level. You may get this question a lot. They may say that the patient's A1C or commercial driver's A1C must be at a particular level. But the Diabetes Exemption Program is silent on A1C levels, and we believe that these cutoffs are illegal. And so the Association is currently working to fight these cutoffs in court. This is complicated, commercial driving, and so if you have questions, our staff is always available and happy to talk through these issues with you. You can call 1-800-DIABETES, or you can write directly to Legal Advocacy, and the email address is there on your screen.

All right. So let's talk -- we are almost done. Let's talk about private driving and licensure in the United States. So this is regulated at the state level by the DMVs, and they collaborate at the national level with the organization seen there, the American Association of Motor Vehicle Administrators and NHTSA.

And this is variable by state. There's -- each state assesses diabetes differently, and each state asks different questions to identify those at-risk drivers that we talked about earlier. So they may assess risk at new and renewal license using questionnaires, when people are getting a new license or renewing them. They may ask if you have a medical condition that may interfere with safe operation of a motor vehicle, or they may include a list of medical conditions that they think interferes with safe operation, and there may be a list where you check the box.

In some states, diagnosis alone will trigger a medical evaluation prior to licensure. Again, our approach here at the ADA -- and it's outlined in the Position Statement -- is to identify actual risk based on the individual's diabetes, and again, the assessment of risk should be done by the treating healthcare provider.

If you want to know what the rules are in your state, I really encourage you to go to the URL at the top of the slide there and look
up the rules specific to your patients. And just a note on that URL. Driverslicenses is all one at the -- behind that backslash there on the URL.

I am going to talk just for 30 seconds on corrections. I just wanted to share that the American Diabetes Association has worked with the Philadelphia Police Department to create policies and procedures to make sure that people with diabetes have access to medication, food, and medical personnel, and that police officers are receiving training about diabetes symptoms and care. And this effort has expanded recently to Florida, where the state-level initiative has resulted in the creation of continuing education modules available to law enforcement officers. And this is -- the information in these modules is based on American Diabetes Association medical standards of care.

I am going to stop there and turn it back over to Crystal.

>> CRYSTAL JACKSON: Okay. Thank you, Anastasia. Can you hear me, Taryn?

>> TARYN EGELANIAN: Yes, we can.

>> CRYSTAL JACKSON: Okay. Excellent. Thank you.

Okay. So you've received a lot of information today about the impact of discrimination upon your patients and the potential impact of discrimination in outcomes for your patients. But these are only some examples of diabetes discrimination. We haven't covered it all today.

I was trying to post links while Taryn, Linda, and Anastasia were talking, just some helpful links for you to go to to get more information. I have been trying to post throughout the webinar. Certainly, give us a call at 1-800-DIABETES if you have more questions because, obviously, we are not going to -- unfortunately -- get to a lot of these questions, but please know that we are here for you and happy to answer your questions any time by calling 1-800-DIABETES.

So we covered some examples of discrimination. When discrimination happens, what should the person do? What should the person do? And I can't stress enough or encourage you enough to tell your patient to give us a call at 1-800-DIABETES, as we have expert attorneys on our staff who will provide information and guidance to your patients when they feel they have been discriminated against.

When your patient says something to you regarding his or her ability to safely manage diabetes at work or at school, again, have your patient give us a call or email us at askADA@diabetes.org.

The Association, we have a wealth of outreach materials, including free tear-offs for medical alert cards to help advise your patients. Our tear-off sheets have instructions on how your patients can get help with discrimination problems. And you can order these by going to shopdiabetes.org, and the product code is listed there if you would like to get some of those. Or just give
your local ADA market office a call, and they will be able to help you get some of these resources.

We have medical alert wallet cards for your patients that may also be ordered. And again, your local ADA office is an excellent resource for these materials. So please give them a call or, again, you can give us a call at 1-800-DIABETES, and we would be happy to help you.

Taryn, I am trying to advance this next slide. Oh, here we go.

As you have heard, we have a wealth of materials available for you to share with your patients, a lot of good information in these materials about the substance of the law, what kinds of accommodations should be requested, where to go for help. We also have many of our materials available in Spanish. I think somebody had asked that question earlier. So yes, we do have some materials available in Spanish.

The Association also has a wealth of training resources available online. This particular page shows links to our discrimination webinars that we've held in the past. We've held them on a variety of topics -- employment, law enforcement, school issues. So this is just another resource for you, a place where you can go to get that information.

So this past February, Dr. Siminerio and I co-presented a Safe at School workshop at the Association's postgraduate course in New York City in February. And if you weren't able to attend, this is another opportunity to get this information, and we also have this set up so you can obtain continuing education credits for listening to this webcast, and this slide shows you some links to where you can go to access this program and also where you can go to access the webcast without credit. So really, anyone can go and listen to this, and I strongly urge you to do so.

So every day brings new issues and challenges that can be addressed and resolved with your help. We hope you'll want to join us. We hope you'll want to join our Legal Advocacy Health Care Professional Network. We really need your help. We need your help to train and educate school personnel and other decision-makers about diabetes and diabetes care tasks. We need your help. You can advocate for your patients facing employment problems by writing letters and making phone calls. We need your help. You can help by advising our attorneys on diabetes management in specific cases. And we need your help. We need your help to distribute educational materials to your patients about diabetes discrimination in the workplace, in school, and in other places of public accommodation.

So again, if you want some more information about how to join the Network, about the Network, the URL is listed in this slide. We hope you'll want to join us if you haven't done so already.

Before you exit the slides or exit this webinar, we hope that you'll spend an extra minute answering some questions. We are going
to conclude the webinar now. Thanks so much for joining us, and if you have any questions, we will do our best to -- we will -- not do our best -- but we will follow up to answer your questions in the next week or so. So thanks so much for attending, and thanks so much to all of the copresenters for being online with us today.

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