



# Diabetes Care in 2020: Following and Leading the Stories of Diabetes

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With the simple turning of a calendar page, 2020 is upon us, as is the time for the annual New Year message from the editorial committee of *Diabetes Care*. Each year we highlight the past year's activities and offer a preview of what lies ahead. An important event in 2019 was the announcement of impact factors for scientific journals. The yearly statement of current impact factors revealed another clear increase for *Diabetes Care*, from 13.4 to 15.3, placing us among the elite journals in any specialty. We are proud of this ranking and hope for a further increase next year.

Last year's editorial outlined some goals, policies, and procedures that contribute to the journal's character (1). Today we offer a wider perspective. *Diabetes Care* is the translational journal of the American Diabetes Association (ADA), linking basic science to clinical science and care. Providing a broad range of expertise, the editorial committee is composed of scientists, clinicians, epidemiologists, and experts in writing, editing, and medical publication. While we all started with deep experience in one or more of these fields, together we are called upon to extend our roles to become journalists. This means more than picking the best scientific studies as they are submitted. It involves actively soliciting, improving, and discussing articles that, collectively, form the stories that matter most to our community. Stories—this is a term not usually

used in scientific discourse, but it is central to all forms of journalism—are important. They explore unmet needs, controversies, or barriers to attaining our goals. In connecting various aspects of a complex issue, they can reveal its broader relevance. They concern shared experiences and common problems and can motivate change.

To illustrate this point, consider the story of the costs of diabetes. People with diabetes and medical providers who care for them are very aware of the rising costs of the drugs and devices needed to manage diabetes. Insulin in particular has risen in price, especially in the U.S. In low-income nations the cost and availability of insulin can be profound concerns. However, reliable information about the causes of this increase, as well as about differences in costs and access to care between regions and health plans, has been limited. The cost-effectiveness of various therapies and ways to organize the delivery of care are major concerns.

The ADA and *Diabetes Care* have made efforts to obtain and report accurate information on this complex and emotionally charged story. In May and June of 2018, four important articles appeared in *Diabetes Care*. The May issue included an ADA Statement on the costs of diabetes in the U.S. in 2017 (2), and nine reports of cost-related studies were summarized in a Commentary (3). The June issue presented a Perspective on access to insulin in the U.S. and globally (4) and

an ADA Statement on insulin access and affordability (5). The flow of information on costs related to diabetes has continued: at last count, 29 articles directly addressing this topic have been published in *Diabetes Care* in 2018 and 2019. In addition, working groups in the ADA are preparing two scientific reviews on the cost-effectiveness of therapies for diabetes, soon to appear in *Diabetes Care*.

The evolving cost story is of interest to the whole diabetes community. It affects nearly all of us directly or indirectly. Cost remains a leading barrier to effective treatment for many people. It is potentially a remediable problem, and the way toward a solution likely depends on high-quality descriptive data, epidemiologic analyses, and interventional studies. One feature article of particular interest, published in the November 2019 issue of *Diabetes Care*, summarized more than two decades of work by a group in Hong Kong leading to an integrated diabetes care system (6). Their population-based approach was able to reduce hospitalizations and mortality in a type 2 diabetes population by ~50% while significantly reducing overall costs as well. Whether this kind of success can be reproduced elsewhere is another part of the story. We expect to publish many more cost-related studies in 2020.

Of course, this is not the only important story relevant to the care of diabetes

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today. Another example is the story of the relationship between diabetes and heart disease. Is diabetes a common but separate disorder that is often associated with heart disease, or is diabetes itself a cause of many cardiac events? Emerging evidence, some of it derived from recent studies of the sodium–glucose cotransporter (SGLT) inhibitor drugs, favors the latter interpretation. In any case, management of diabetes is intertwined with that of heart disease. Recent feature articles in *Diabetes Care* on this story have considered the future of cardiovascular outcome trials involving drugs for diabetes (7), the emergence of heart failure as a complication of diabetes (8), and the evidence from the Diabetes Control and Complications Trial (DCCT) and its follow-up study linking hyperglycemia over time to long-term cardiac outcomes (9).

Yet another active story concerns the use of devices for continuous glucose monitoring (CGM) to refine management of diabetes. Two years ago, *Diabetes Care* published a group of commentaries and consensus statements on the use of CGM (10–13). Further reports have added to the story (14), and the expected harvest of scientific and clinical information based on this new technology is starting to come in. This month's issue contains a collection of articles and a Commentary on the application of CGM to research and care for type 1 diabetes (15). This story, too, will continue to grow.

So, *Diabetes Care* is trying to go beyond the numbers to the meaning of the articles we publish, to develop stories that matter to the community. At the

same time, we will continue to look for the entirely new physiologic insights, drugs, or treatment approaches that will become the big stories of the future. Please help us by continuing to send us your best research studies and brilliant new insights. We will keep working to give the diabetes community the reliable new information it must have to improve care.

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## References

- Riddle MC. *Diabetes Care* in 2019—who, why, what, and how? *Diabetes Care* 2019;42:181–182
- American Diabetes Association. Economic costs of diabetes in the U.S. in 2017. *Diabetes Care* 2018;41:917–928
- Riddle MC, Herman WH. The cost of diabetes care—an elephant in the room. *Diabetes Care* 2018;41:929–932
- Beran D, Hirsch IB, Yudkin JS. Why are we failing to address the issue of access to insulin? A national and global perspective. *Diabetes Care* 2018;41:1125–1131
- Cefalu WT, Dawes DE, Gavlak G, et al.; Insulin Access and Affordability Working Group. Insulin Access and Affordability Working Group: conclusions and recommendations [published correction appears in *Diabetes Care* 2018;41:1831]. *Diabetes Care* 2018;41:1299–1311
- Chan JCN, Lim L-L, Luk AOY, et al. From Hong Kong Diabetes Register to JADE Program to RAMP-DM for data-driven actions. *Diabetes Care* 2019;42:2022–2031
- Cefalu WT, Kaul S, Gerstein HC, et al. Cardiovascular outcome trials in type 2 diabetes: where do we go from here? Reflections from a *Diabetes Care* Editors' Expert Forum. *Diabetes Care* 2018;41:14–31
- Packer M. Heart failure: the most important, preventable, and treatable cardiovascular complication of type 2 diabetes. *Diabetes Care* 2018;41:11–13
- Riddle MC, Gerstein HC. The cardiovascular legacy of good glycemic control: clues about mediators from the DCCT/EDIC Study. *Diabetes Care* 2019;42:1159–1161
- Riddle MC, Gerstein HC, Cefalu WT. Maturation of CGM and glycemic measurements beyond HbA<sub>1c</sub>—a turning point in research and clinical decisions. *Diabetes Care* 2017;40:1611–1613
- Petrie JR, Peters AL, Bergenstal RM, Holl RW, Fleming GA, Heinemann L. Improving the clinical value and utility of CGM systems: issues and recommendations. A joint statement of the European Association for the Study of Diabetes and the American Diabetes Association Diabetes Technology Working Group. *Diabetes Care* 2017;40:1614–1621
- Agiostrotidou G, Anhalt H, Ball D, et al. Standardizing clinically meaningful outcome measures beyond HbA<sub>1c</sub> for type 1 diabetes: a consensus report of the American Association of Clinical Endocrinologists, the American Association of Diabetes Educators, the American Diabetes Association, the Endocrine Society, JDRF International, The Leona M. and Harry B. Helmsley Charitable Trust, the Pediatric Endocrine Society, and the T1D Exchange. *Diabetes Care* 2017;40:1622–1630
- Danne T, Nimri R, Battelino T, et al. International consensus on use of continuous glucose monitoring. *Diabetes Care* 2017;40:1631–1640
- Hirsch IB, Sherr JL, Hood KK. Connecting the dots: validation of time in range metrics with microvascular outcomes. *Diabetes Care* 2019;42:345–348
- Hood KK, DiMeglio LA, Riddle MC. Putting continuous glucose monitoring to work for people with type 1 diabetes. *Diabetes Care* 2020;43:19–21