



HEALTHY ARIZONA WORKSITES PROGRAM
(HAWP) PRESENTS:

JOURNEY FROM PREDIABETES TO DIABETES- PREVENTION AND TREATMENT



Presented by:

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HEALTHYAZWORKSITES.ORG



WEBINAR HOUSEKEEPING

WELCOME

All lines have been muted.

Please type any questions into the chat or Questions panel and we will do our best to answer them all at the end.

All handouts and a copy of the presentation slides are available in the Handouts panel.

Please complete the survey that will be emailed out after the presentation

A recording will be added to the library of HAWP webinars on our website within 48 hours.

Special thanks to our supporting partner the Dignity Health for their generous support in making this webinar possible.

Participants will learn about

- ❑ Prevalence of diabetes
- ❑ Types of Diabetes
- ❑ Screening and prevention opportunities
- ❑ New paradigms: Lifestyle and behavioral change, Pharmacotherapy, diabetes technology and surgical treatment options
- ❑ Tips for educating your staff about risk factors, diagnosis and treatment

Fast Facts on Diabetes

Diabetes

Total: 37.3 million people have diabetes (11.3% of the US population)

Diagnosed: 28.7 million people, including 28.5 million adults

Undiagnosed: 8.5 million people (23.0% of adults are undiagnosed)

Prediabetes

One in three U.S. adults has prediabetes—96 million people!

More than 8 in 10 don't even know they have it

CLASSIFICATION

- **Type 1 diabetes**
- **Type 2 diabetes**
- **Gestational diabetes mellitus (GDM)**
- **Specific types of Diabetes due to other cause:**
 - **Diseases of the Exocrine pancreas**
 - **Monogenic diabetes**
 - **Drug- or chemical-induced**

Prediabetes

FPG 100–125 mg/dL

OR

2-h plasma glucose 140–199 mg/dL : IGT

OR

A1C 5.7–6.4%

Prediabetes/Diabetes Screening

- ❑ Screening at age 35 for all
- ❑ Any adult who is overweight or obesity and/or who has one or more additional risk factor for diabetes
- ❑ If tests are normal, repeat at a minimum of 3-year intervals.



ARE YOU AT RISK FOR

TYPE 2 DIABETES?



Diabetes Risk Test

- 1 How old are you?**
 Less than 40 years (0 points)
 40—49 years (1 point)
 50—59 years (2 points)
 60 years or older (3 points)
- 2 Are you a man or a woman?**
 Man (1 point) Woman (0 points)
- 3 If you are a woman, have you ever been diagnosed with gestational diabetes?**
 Yes (1 point) No (0 points)
- 4 Do you have a mother, father, sister, or brother with diabetes?**
 Yes (1 point) No (0 points)
- 5 Have you ever been diagnosed with high blood pressure?**
 Yes (1 point) No (0 points)
- 6 Are you physically active?**
 Yes (0 points) No (1 point)
- 7 What is your weight status? (see chart at right)**

Write your score in the box.



Add up your score.



Height	Weight (lbs.)		
4' 10"	119-142	143-190	191+
4' 11"	124-147	148-197	198+
5' 0"	128-152	153-203	204+
5' 1"	132-157	158-210	211+
5' 2"	136-163	164-217	218+
5' 3"	141-168	169-224	225+
5' 4"	145-173	174-231	232+
5' 5"	150-179	180-239	240+
5' 6"	155-185	186-246	247+
5' 7"	159-190	191-254	255+
5' 8"	164-196	197-261	262+
5' 9"	169-202	203-269	270+
5' 10"	174-208	209-277	278+
5' 11"	179-214	215-285	286+
6' 0"	184-220	221-293	294+
6' 1"	189-226	227-301	302+
6' 2"	194-232	233-310	311+
6' 3"	200-239	240-318	319+
6' 4"	205-245	246-327	328+

(1 Point) (2 Points) (3 Points)

You weigh less than the amount in the left column (0 points)

If you scored 5 or higher:

You are at increased risk for having type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanics/Latinos, American Indians, and Asian Americans and Pacific Islanders.

Higher body weights increase diabetes risk for everyone.

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009. Original algorithm was validated without gestational diabetes as part of the model.

Lower Your Risk

The good news is that you can manage your risk for type 2 diabetes. Small steps make a big difference and can help you...

Prediabetes/Diabetes Screening

1. Testing should be considered in overweight or obese (BMI ≥ 25 kg/m² or ≥ 23 kg/m² in Asian Americans) adults who have one or more of the following risk factors:
 - First-degree relative with diabetes
 - High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
 - History of CVD
 - Hypertension ($\geq 140/90$ mmHg or on therapy for hypertension)
 - HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and/or a triglyceride level > 250 mg/dL (2.82 mmol/L)
 - Women with polycystic ovary syndrome
 - Physical inactivity
 - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)

Prevention or Delay of Type 2 Diabetes

- ❑ At least annual monitoring for the development of diabetes in those with prediabetes is suggested
- ❑ Lifestyle Interventions:
 - ❖ Target 7% weight loss
 - ❖ Increase physical to at least 150 min/week
 - ❖ Behavioral strategies

Intensive lifestyle intervention could reduce the risk of incident type 2 diabetes by 58% over 3 years.

Evidence suggests that there is not an ideal percentage of calories from carbohydrate, protein, and fat to prevent diabetes.

Weight loss

- ❑ The recommended pace of **weight loss was 1–2 lb/week**.
- ❑ Calorie goals were calculated by estimating the daily calories needed to maintain the participant's initial weight **and subtracting 500–700 calories/day** (depending on initial body weight).
- ❑ The goal for physical activity was selected to approximate at least **700 kcal/week expenditure from physical activity**. For ease of translation, this goal was described as at least 150 min

Physical Activity

- ❑ Aerobic
- ❑ Resistant
- ❑ Muscle flexibility and balance training

Pharmacotherapy to prevent Diabetes

- ❑ Metformin
- ❑ α -glucosidase inhibitors,
- ❑ **Liraglutide**
- ❑ Thiazolidinedione
- ❑ several weight loss medications like

❖ **Orlistat**

❖ **Phentermine - topiramate**

Obesity Management for the Treatment of Type 2 Diabetes

Table 8.1—Treatment options for overweight and obesity in type 2 diabetes

Treatment	BMI category (kg/m ²)		
	25.0–26.9 (or 23.0–24.9*)	27.0–29.9 (or 25.0–27.4*)	≥30.0 (or ≥27.5*)
Diet, physical activity, and behavioral therapy	†	†	†
Pharmacotherapy		†	†
Metabolic surgery			†

PREVENTION OF VASCULAR DISEASE AND MORTALITY

Prediabetes is associated with heightened cardiovascular risk; therefore, screening for and treatment of modifiable risk factors for cardiovascular disease are suggested

- HLD
- Tobacco use
- HTN

Diabetes

FPG \geq 126 mg/dL. (no caloric intake for at least 8 h). OR

2-h PG \geq 200 mg/dL during an OGTT. OR

A1C \geq 6.5%. OR

Classic symptoms + a random plasma glucose \geq 200 mg/dl

Assessment

Assessing risk of diabetes complications

ASCVD and heart failure history

ASCVD risk factors and 10-year ASCVD risk assessment

chronic kidney disease Hypoglycemia risk

Assessment for retinopathy

Assessment for neuropathy

Goal setting :

- ❑ Set A1C/blood glucose/time in range target
- ❑ If hypertension is present: establish blood pressure target
- ❑ Diabetes self-management goals

A1c Goal

- ❑ A reasonable A1C goal for many nonpregnant adults is <7%
- ❑ Consider more stringent goals (e.g. <6.5%) for select patients if achievable without significant hypos or other adverse effects.
- ❑ Consider less stringent goals (e.g. <8%) for patients with a history of severe hypoglycemia, limited life expectancy, or other conditions that make <7% difficult to attain.

Approach to the Management of Hyperglycemia

Patient / Disease Features

More stringent



Less stringent

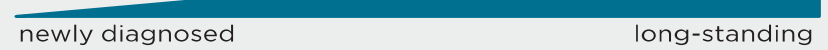
Risks potentially associated with hypoglycemia and other drug adverse effects



low

high

Disease duration



newly diagnosed

long-standing

Life expectancy



long

short

Relevant comorbidities



absent

few / mild

severe

Established vascular complications



absent

few / mild

severe

Usually not modifiable

Patient attitude and expected treatment efforts



highly motivated, adherent, excellent self-care capabilities

less motivated, nonadherent, poor self-care capabilities

Resources and support system



readily available

limited

Potentially modifiable

Treatment plan

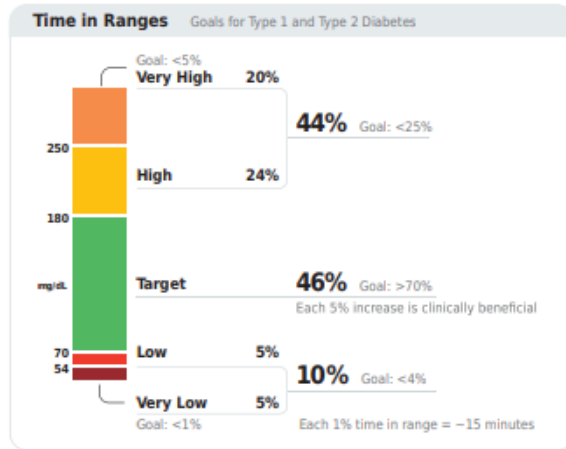
- ✓ Lifestyle management
- ✓ Pharmacologic therapy: glucose lowering
- ✓ Pharmacologic therapy: cardiovascular and renal disease risk factors
- ✓ Use of glucose monitoring and insulin delivery devices
- ✓ Referral to diabetes education and medical specialists

DIABETES TECHNOLOGY

This includes insulin delivery and glucose monitoring technology

- ❑ **Insulin pumps**
- ❑ **Connected insulin pens**
- ❑ **CGM system**
- ❑ **Hybrid devices that both monitor glucose and deliver
Insulin**

AGP Report: Continuous Glucose Monitoring



Test Patient DOB: Jan 1, 1970

14 Days: August 8-August 21, 2021

Time CGM Active: 100%

Glucose Metrics

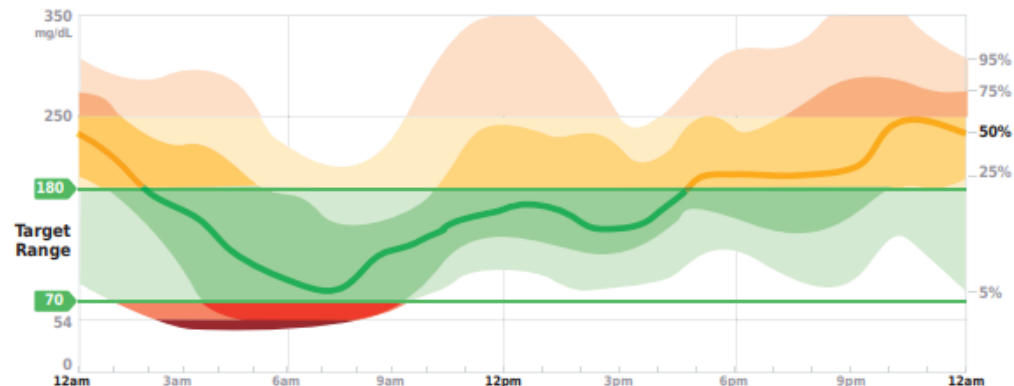
Average Glucose **175 mg/dL**
Goal: <154 mg/dL

Glucose Management Indicator (GMI) **7.5%**
Goal: <7%

Glucose Variability **45.5%**
Defined as percent coefficient of variation
Goal: ≤36%

Ambulatory Glucose Profile (AGP)

AGP is a summary of glucose values from the report period, with median (50%) and other percentiles shown as if they occurred in a single day.



FIRST-LINE Therapy is Metformin and Comprehensive Lifestyle (including weight management and physical activity)



INDICATORS OF HIGH-RISK OR ESTABLISHED ASCVD, CKD, OR HF¹

NO

CONSIDER INDEPENDENTLY OF BASELINE A1C OR INDIVIDUALIZED A1C TARGET

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

ASCVD PREDOMINATES

- Established ASCVD
- Indicators of high ASCVD risk (age ≥ 55 years with coronary, carotid or lower extremity artery stenosis $>50\%$, or LVH⁴)

PREFERABLY

- GLP-1 RA with proven CVD benefit¹
- OR
- SGLT2i with proven CVD benefit¹ if eGFR adequate²

If A1C above target

If further intensification is required or patient is now unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit¹
- DPP-4i if not on GLP-1 RA
- Basal insulin⁴
- TZD⁵
- SU⁶

HF OR CKD PREDOMINATES

- Particularly HF_{rEF} (LVEF $<45\%$)
- CKD: Specifically eGFR 30-60 mL/min/1.73 m² or UACR >30 mg/g, particularly UACR >300 mg/g

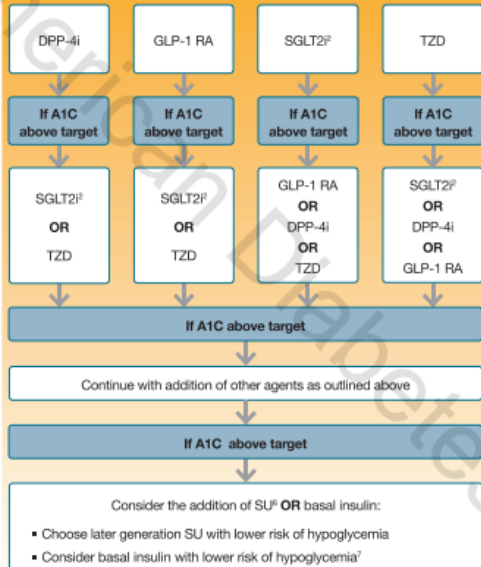
PREFERABLY

- SGLT2i with evidence of reducing HF and/or CKD progression in CVOts if eGFR adequate³
- OR
- If SGLT2i not tolerated or contraindicated or if eGFR less than adequate² add GLP-1 RA with proven CVD benefit¹

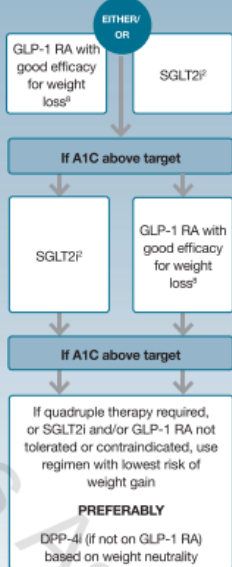
If A1C above target

- Avoid TZD in the setting of HF
- Choose agents demonstrating CV safety:
- For patients on a SGLT2i, consider adding GLP-1 RA with proven CVD benefit¹
- DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
- Basal insulin⁴
- SU⁶

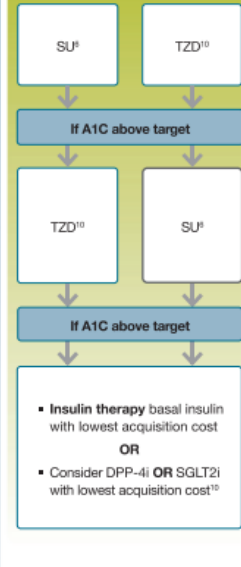
COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA



COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS



COST IS A MAJOR ISSUE⁹⁻¹⁰



- Proven CVD benefit means it has label indication of reducing CVD events
- Be aware that SGLT2i labelling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use
- Empagliflozin, canagliflozin and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVOts. Canagliflozin has primary renal outcome data from CREDESCENCE. Dapagliflozin has primary heart failure outcome data from DAPA-HF
- Degludec or U100 glargine have demonstrated CVD safety
- Low dose may be better tolerated though less well studied for CVD effects

- Choose later generation SU to lower risk of hypoglycemia, Glimepiride has shown similar CV safety to DPP-4i
- Degludec / glargine U300 < glargine U100 / detemir < NPH insulin
- Semaglutide > liraglutide > dulaglutide > exenatide < lixisenatide
- If no specific comorbidities (i.e. no established CVD, low risk of hypoglycemia and lower priority to avoid weight gain or no weight-related comorbidities)
- Consider country- and region-specific cost of drugs. In some countries TZDs relatively more expensive and DPP-4i relatively cheaper

LVH = Left Ventricular Hypertrophy; HF_{rEF} = Heart Failure reduced Ejection Fraction

Table 9.3—Median monthly (30-day) AWP and NADAC of maximum approved daily dose of noninsulin glucose-lowering agents in the U.S.

Class	Compound(s)	Dosage strength/ product (if applicable)	Median AWP (min, max)†	Median NADAC (min, max)†	Maximum approved daily dose*
Biguanides	• Metformin	850 mg (IR)	\$108 (\$5, \$109)	\$3	2,550 mg
		1,000 mg (IR)	\$87 (\$5, \$88)	\$2	2,000 mg
		1,000 mg (ER)	\$242 (\$242, \$7,214)	\$102 (\$102, \$430)	2,000 mg
Sulfonylureas (2nd generation)	• Glimepiride	4 mg	\$74 (\$71, \$198)	\$3	8 mg
		10 mg (IR)	\$68 (\$67, \$70)	\$3	40 mg
	• Glyburide	10 mg (XL/ER)	\$48	\$12	20 mg
		6 mg (micronized) 5 mg	\$52 (\$48, \$71) \$82 (\$63, \$93)	\$11 \$12	12 mg 20 mg
Thiazolidinediones	• Pioglitazone	45 mg	\$348 (\$7, \$349)	\$5	45 mg
	• Rosiglitazone	4 mg	N/A	\$324	8 mg
α-Glucosidase inhibitors	• Acarbose	100 mg	\$106 (\$104, \$106)	\$26	300 mg
	• Miglitol	100 mg	\$284 (\$241, \$346)	N/A	300 mg
Meglitinides (glinides)	• Nateglinide	120 mg	\$155	\$28	360 mg
	• Repaglinide	2 mg	\$878 (\$58, \$897)	\$34	16 mg
DPP-4 inhibitors	• Alogliptin	25 mg	\$234	\$166	25 mg
	• Saxagliptin	5 mg	\$549	\$438	5 mg
	• Linagliptin	5 mg	\$583	\$466	5 mg
	• Sitagliptin	100 mg	\$596	\$477	100 mg

SGLT2 inhibitors	• Ertugliflozin	15 mg	\$372	\$297	15 mg
	• Dapagliflozin	10 mg	\$639	\$511	10 mg
	• Canagliflozin	300 mg	\$652	\$521	300 mg
	• Empagliflozin	25 mg	\$658	\$526	25 mg
GLP-1 RAs	• Exenatide (extended release)	2 mg powder for suspension or pen	\$909	\$727	2 mg**
	• Exenatide	10 µg pen	\$933	\$746	20 µg
	• Dulaglutide	4.5 mg mL pen	\$1,013	\$811	4.5 mg**
	• Semaglutide	1 mg pen	\$1,022	\$822	1 mg**
		14 mg (tablet)	\$1,022	\$819	14 mg
	• Liraglutide	1.8 mg pen	\$1,220	\$975	1.8 mg
• Lixisenatide	20 µg pen	\$814	N/A	20 µg	
Bile acid sequestrant	• Colesevelam	625 mg tabs	\$710 (\$674, \$712)	\$75	3.75 g
		3.75 g suspension		\$674	\$222
Dopamine-2 agonist	• Bromocriptine	0.8 mg	\$1,036	\$833	4.8 mg
Amylin mimetic	• Pramlintide	120 µg pen	\$2,702	N/A	120 µg/injection††

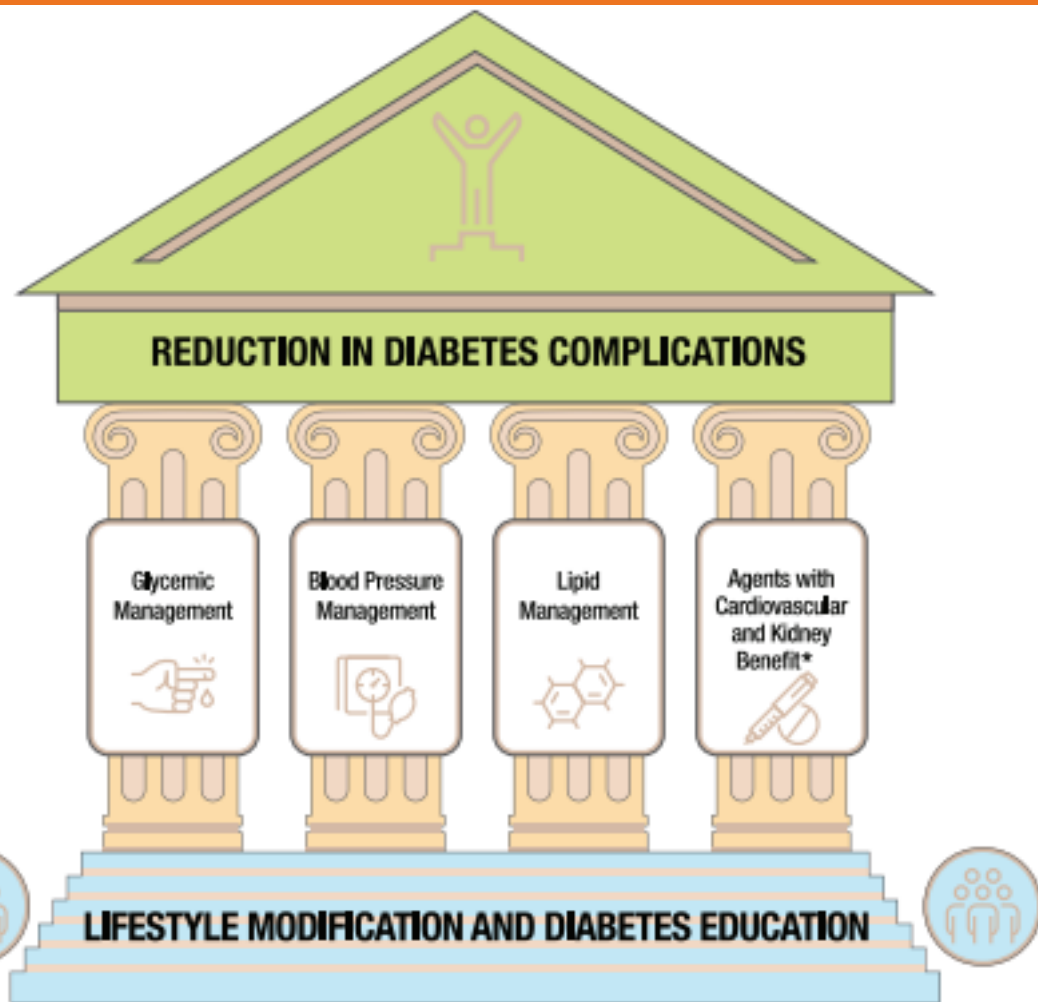
Insulin Therapy in T2DM

- ❑ The progressive nature of T2DM should be regularly & objectively explained to patients.
- ❑ Avoid using insulin as a threat, describing it as a failure or punishment.
- ❑ Give patients a self-titration algorithm

Table 9.4—Median cost of insulin products in the U.S. calculated as AWP (70) and NADAC (71) per 1,000 units of specified dosage form/product

Insulins	Compounds	Dosage form/product	Median AWP (min, max)*	Median NADAC*
Rapid-acting	• Lispro follow-on product	U-100 vial	\$157	\$125
		U-100 prefilled pen	\$202	\$161
	• Lispro	U-100 vial	\$165†	\$132†
		U-100 cartridge	\$408	\$325
		U-100 prefilled pen	\$212†	\$170†
		U-200 prefilled pen	\$424	\$339
	• Lispro-aabc	U-100 vial	\$330	N/A
		U-100 prefilled pen	\$424	N/A
		U-200 prefilled pen	\$424	N/A
	• Glulisine	U-100 vial	\$341	\$272
		U-100 prefilled pen	\$439	\$352
	• Aspart	U-100 vial	\$174†	\$139†
		U-100 cartridge	\$215	\$172
		U-100 prefilled pen	\$223†	\$179†
	• Aspart (“faster acting product”)	U-100 vial	\$347	\$278
U-100 cartridge		\$430	N/A	
U-100 prefilled pen		\$447	\$356	
• Inhaled insulin	Inhalation cartridges	\$1,325	\$606	
Short-acting	• human regular	U-100 vial	\$165††	\$132††
		U-100 prefilled pen	\$208	\$167
Intermediate-acting	• human NPH	U-100 vial	\$165††	\$132††
		U-100 prefilled pen	\$208	\$167
Concentrated human regular insulin	• U-500 human regular insulin	U-500 vial	\$178	\$143
		U-500 prefilled pen	\$230	\$184
Long-acting	• Glargine follow-on products	U-100 prefilled pen	\$118	\$96
		U-100 vial	\$190 (118, 261)	\$95
	• Glargine	U-100 vial; U-100 prefilled pen	\$340	\$277
		U-300 prefilled pen	\$340	\$272
	• Detemir	U-100 vial; U-100 prefilled pen	\$370	\$296
		• Degludec	U-100 vial; U-100 prefilled pen; U-200 prefilled pen	\$407
Premixed insulin products	• NPH/regular 70/30	U-100 vial	\$165††	\$133††
		U-100 prefilled pen	\$208	\$167
	• Lispro 50/50	U-100 vial	\$342	\$274
		U-100 prefilled pen	\$424	\$338
	• Lispro 75/25	U-100 vial	\$152	\$273
		U-100 prefilled pen	\$212	\$170
	• Aspart 70/30	U-100 vial	\$180	\$144
		U-100 prefilled pen	\$224	\$179

Complications of Diabetes



Hypertension

- ❑ Individual with diabetes + HTN + 10 yrs ASCVD risk is low : Goal BP < 140/90 mm/hg
- ❑ Dm + HTN + high ASCVD risk : < 130/80 mm/hg
- ❑ Pregnant patients with diabetes and chronic hypertension was changed to suggest a blood pressure target of < 135/85 mmHg.

Cholesterol management

In adults not taking statins, a screening lipid profile is reasonable :

- ❖ At diabetes diagnosis**
- ❖ At the initial medical evaluation**
- ❖ And every 5 years, or more frequently if indicated**

Obtain a lipid profile at initiation of statin therapy, and periodically thereafter

All Adults age > 40 yrs with type 2 Diabetes should be treated with moderate intensity statin unless contraindicated to prevent ASCVD

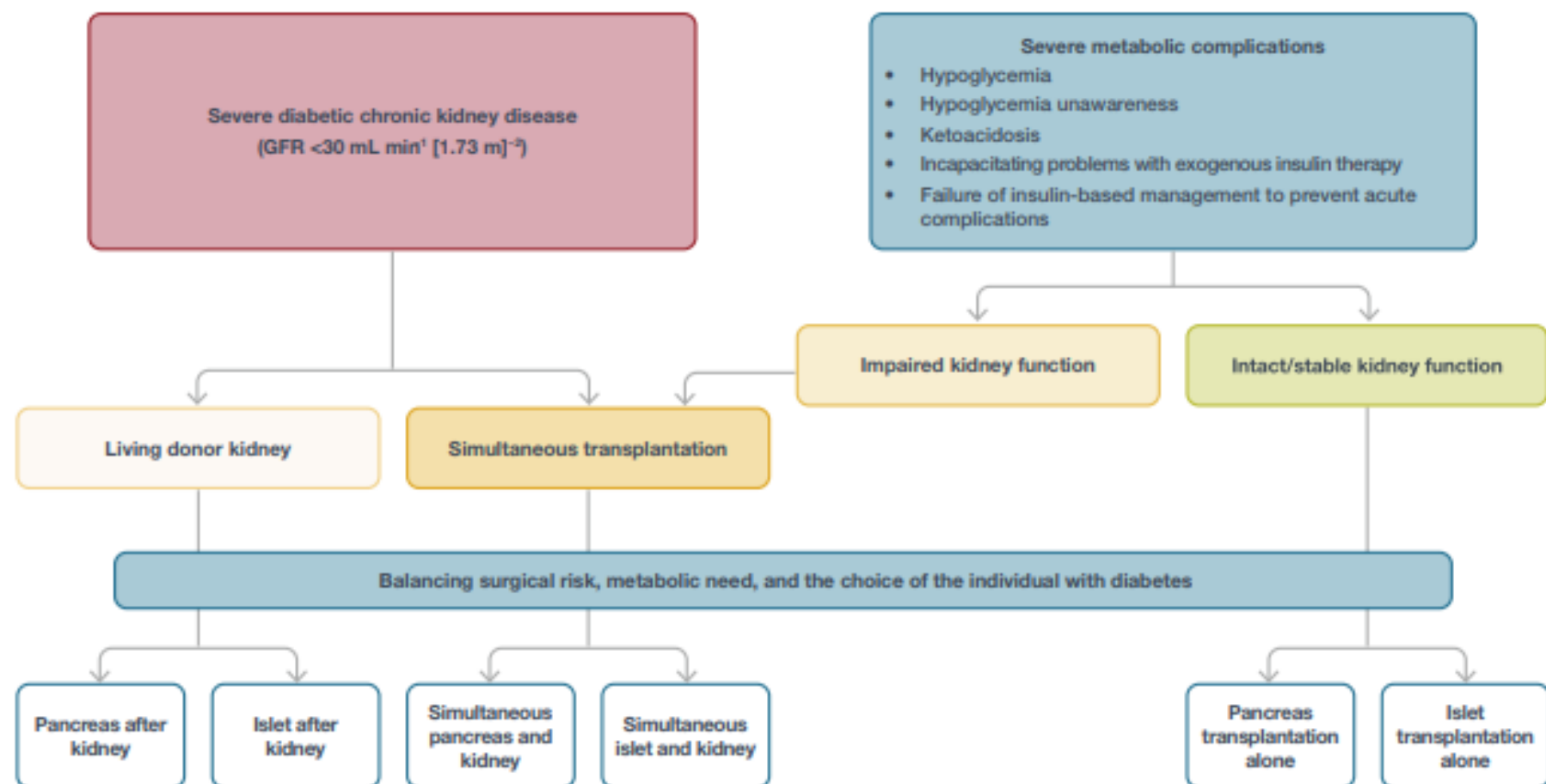
Screening for microvascular complications

Patients with type **1 diabetes, within 5 years** of diabetes onset.

Patients with type **2 diabetes at the time of diabetes diagnosis**

- ❑ Once a year, assess urinary albumin and kidney function
- ❑ Initial dilated and comprehensive eye examination by an ophthalmologist
- ❑ 10-g monofilament testing and at least one of the following tests: pinprick, temperature, or vibration sensation.

Simplified overview of indications for β -cell replacement therapy in people with type 1 diabetes



Diabetes and Employment :

Any person with diabetes, whether insulin treated or non-insulin treated, should be eligible for any employment for which he or she is otherwise qualified

American Diabetes Association. Diabetes and employment. Diabetes Care 2014;37(Suppl. 1):S112–S117; <https://doi.org/10.2337/dc14-S112> (first publication 1984; latest revision 2009)

How Type 2 Diabetes Affects Your Workforce

One in three U.S. adults has prediabetes—96 million people!

More than 8 in 10 don't even know they have it.

Prediabetes puts a person at increased risk for type 2 diabetes, heart attack, and stroke.

COST



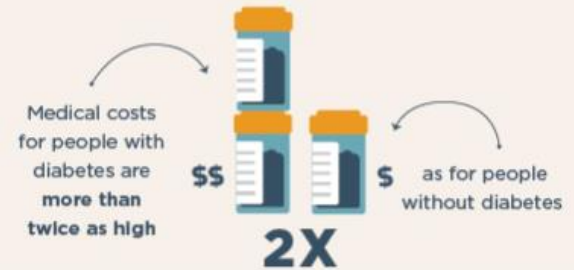
\$327
BILLION

Total medical costs and lost work and wages for people with diagnosed diabetes

Risk of early death for adults with diabetes is

60%
HIGHER

than for adults without diabetes



People who have diabetes are at higher risk of serious health complications:



BLINDNESS



KIDNEY FAILURE



HEART DISEASE



STROKE



LOSS OF TOES, FEET, OR LEGS

Delivery and Dissemination of Lifestyle Behavior Change for Diabetes Prevention

CDC developed the **National DPP**: a resource designed to bring evidence-based lifestyle change programs for preventing type 2 diabetes to communities, including eligible Medicare patients.

An online resource includes locations of CDC-recognized diabetes prevention lifestyle change programs (cdc.gov/diabetes/prevention/find-a-program.html)

Thank you...

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Body copy is set in 14pt Montserrat. No dot points are needed when content is narrative and not in list form.

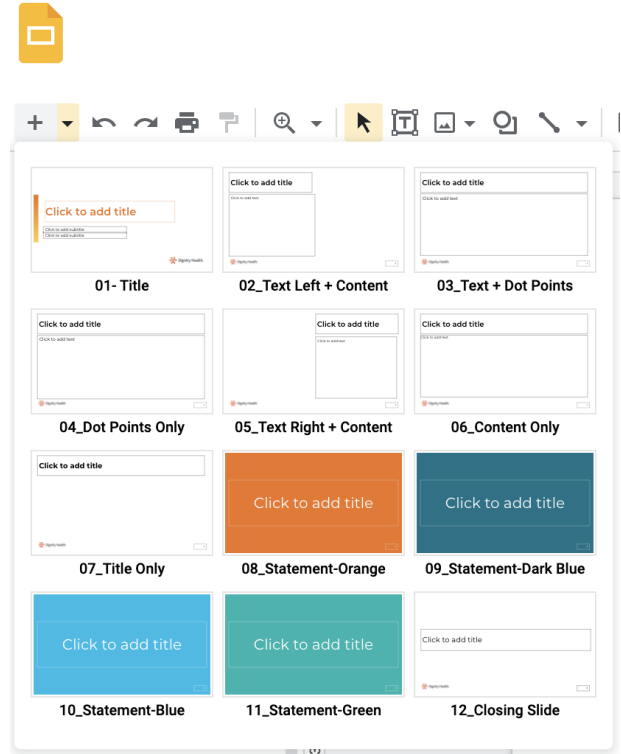
Photography and plenty of white space make your slides more audience-friendly.



Another statement
slide.

Slide Layouts & Images

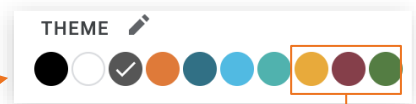
Use the dropdown next to the “+” button to view layout options and add a new slide



Color

Our color palette is bright and vivid. When working with our palette, it's best to keep it simple. Use these tips to help guide the process. Build from white. The use of white space within a design is just as important as the colors being used. Don't overuse color to fill space. It's important to maintain a sense of airiness in the design.

Do not use Google's default palette, **our colors are listed under theme.**

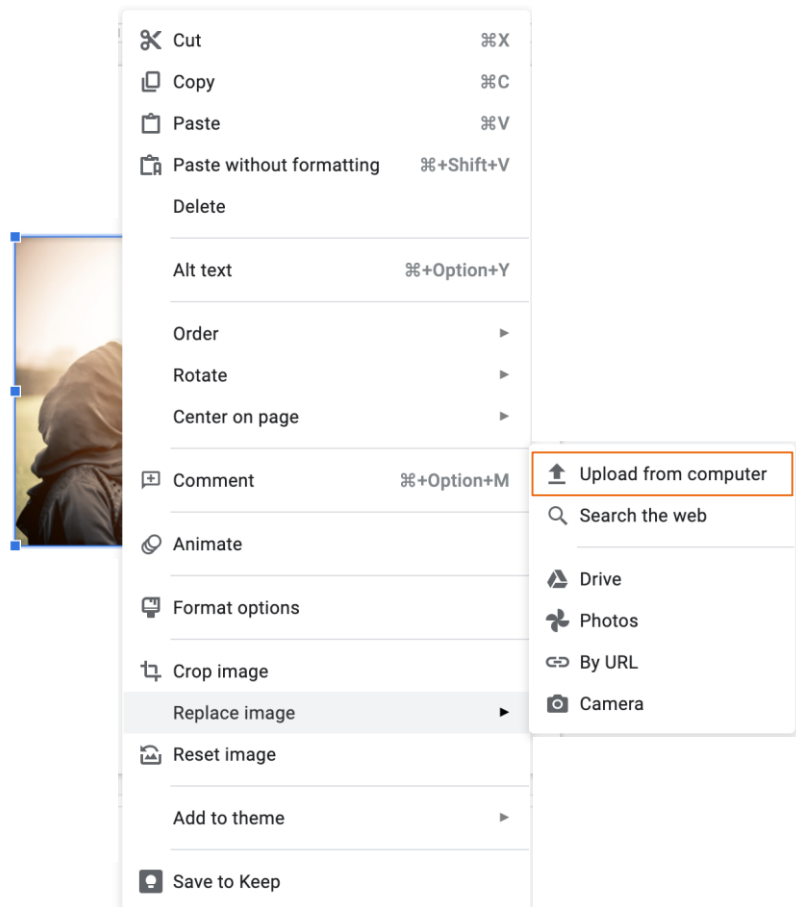


Utility colors have been provided in the Theme row.

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- Use Insert>Image, drag & drop, or copy & paste to place an image into Slides. Images should never overlap text.
- To replace an existing image, right click on the image, Replace Image >

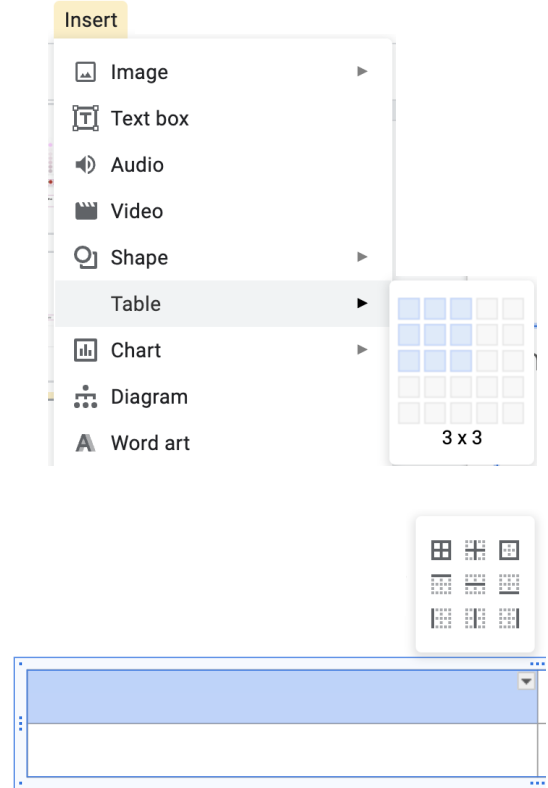
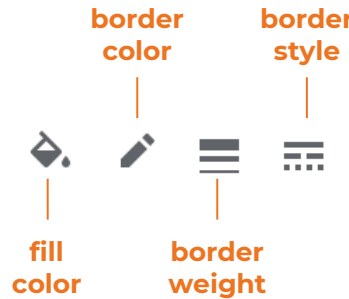


Tables

Insert>Table to create a table.

Styling tables:

- Click the small dropdown inside the cell to access all borders. You can also click directly on a border to adjust individual borders.
- Click inside of a cell and use the toolbar to add more color
- Use Shift+click to style multiple, individual elements in the table



Keep tables as uncluttered as possible.

Title	Title	Title	Title	Title	Title	Title	Title
Text	1200	1200	1200	1200	1200	1200	1200
Text	2000	2000	2000	2000	2000	2000	2000
Text	18000	18000	18000	18000	18000	18000	18000
Text	3400	3400	3400	3400	3400	3400	3400

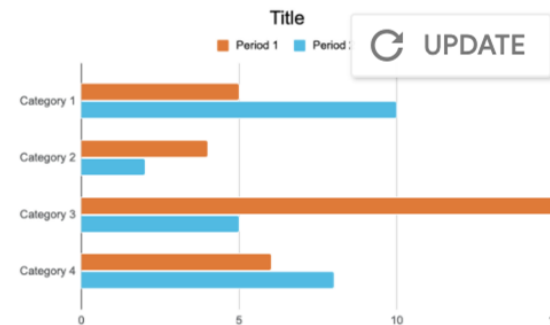
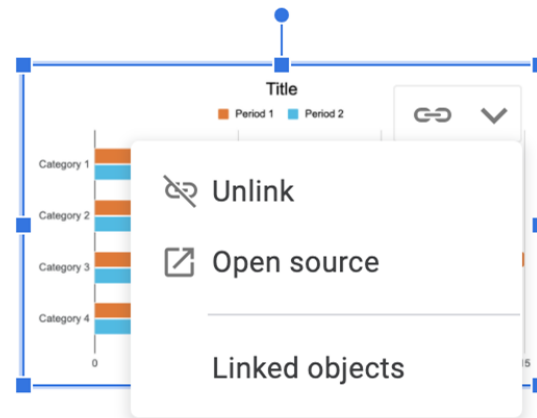
Charts at a Glance

Charts must be created outside of Slides and placed in.

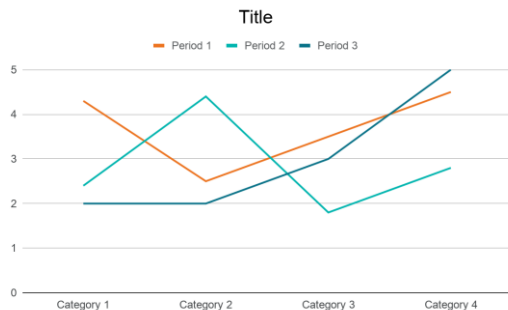
- Insert>Image to insert your own chart

OR

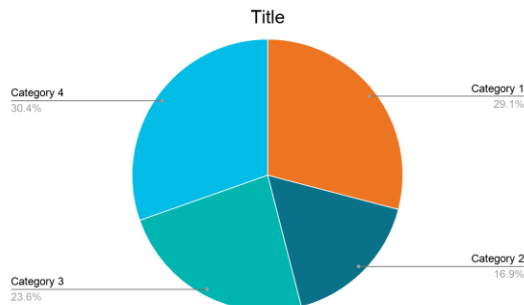
- [Follow these instructions](#) to create dynamic charts in Google Sheets.
 - Charts created in Sheets can link to your presentation. After editing your dataset in Sheets, update your chart by clicking the “Update” button



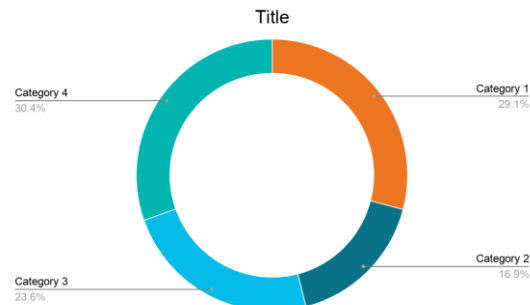
Charts at a Glance



A line graph displays a series of data points.

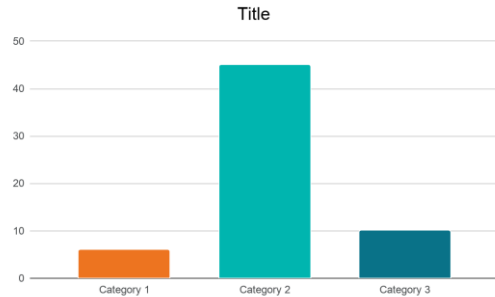


A pie chart displays proportions.

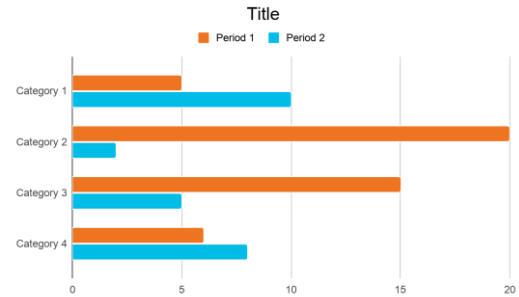


A doughnut chart is another type of pie chart. It displays the same kind of data as a traditional pie chart. Doughnut charts are stylistically more contemporary than pie charts.

Charts at a Glance

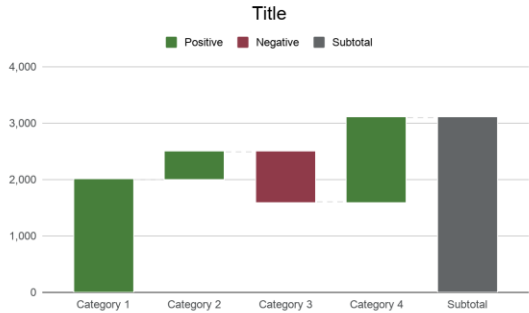


Vertical column charts display quantities by category.

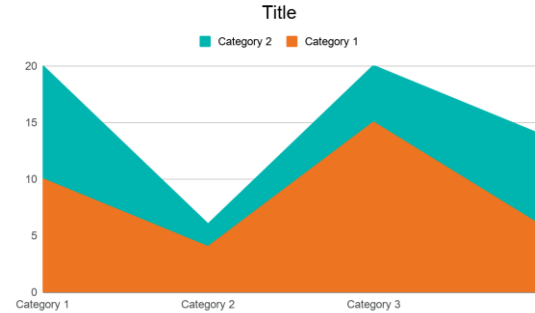


Horizontal bar charts compare quantities. Although bar charts and column charts can be used to display the same data, each is best suited for communicating a different type of information. Horizontal bar charts like this make it easy for the audience to compare quantities.

Charts at a Glance



A waterfall chart shows a running total as values are added or subtracted. It's useful for understanding how an initial value is affected by a series of positive and negative values.



An area chart compares two or more quantities over a period of time.



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