Kentucky

Kentucky Diabetes Network

Public Health Problem
Kentucky ranks seventh in the Nation for the highest percentage of the adult population diagnosed with diabetes. Approximately 8.9 percent of the adult population, or an estimated 274,000 Kentucky adults, have been diagnosed with diabetes. It is estimated that 29 percent of diabetes cases, or an additional 111,900, are undiagnosed. Based on these estimates, approximately 385,900 (about 12.5 percent, or 1 in 8) adult Kentuckians have diagnosed or undiagnosed diabetes (2005 BRFSS). Individual organizations were working to combat Kentucky's diabetes epidemic, but a more coordinated approach was needed to create synergy and prevent duplication of efforts. In response to this need, the Kentucky DPCP convened partners in 1999 to establish a statewide coalition to combine efforts and resources.

Taking Action
The Kentucky Diabetes Network (KDN) is a statewide partnership of organizations, associations, and individuals who have a professional or personal connection with diabetes. KDN secured 501(c3) status and has grown to a membership of more than 300 partners. It strives to improve the treatment and outcomes for Kentuckians with diabetes, to promote early diagnosis, and ultimately to prevent the onset of diabetes.

KDN consists of six workgroups (Public Awareness, Primary Prevention/Risk Reduction, Professional Education, Patient Education, Advocacy, Public Relations) whose work is guided by a diabetes strategic plan. KY DPCP serves as administrative coordinator for KDN and liaison to the board, and KY DPCP staff participates on the various committees. The primary source of funding for comes from pharmaceutical partners and donations from individuals and groups.

Implications and Impact
KDN demonstrated success in leveraging resources to address the burden of diabetes in Kentucky, especially in policy. KDN sponsors an annual "Diabetes Day at the Capitol" to educate legislators about diabetes. This resulted in greater recognition of the burden of diabetes by policymakers and a $2.4 million increase in funding for KY DPCP since 2006. A portion of these funds support six new developing Diabetes Centers of Excellence that provide care coordination and diabetes education targeting Medicaid recipients. It also led to the establishment of a Diabetes Research Board that receives $200,000 per year in State funds.

KDN won the National Association of Chronic Disease Directors' 2006 Public Policy Award for its outstanding work. KDN partners have made strides in patient, professional, and public awareness education. Partners developed and distributed a variety of diabetes materials and tools, a professional newsletter (Kentucky Diabetes Connection), a lending library, and also sponsored continuing education on diabetes management and prevention. KDN collaborated with the Kentucky Obesity and Physical Activity Programs, Partnership for a Fit Kentucky, the Primary Care Association, and the Kentucky Heart Disease and Stroke Program to provide learning sessions to universities and health centers participating in the Chronic Care Collaborative. KDN also hosted a media campaign in support of National Diabetes Month and Diabetes Alert Day including press releases, and billboard displays, and it hosted events promoting the message "Move It, Lose It, Prevent Type 2 Diabetes."

Kentucky (continued)

To complement this work in diabetes education, KDN integrates cultural competency through presentations at KDN meetings to encourage sensitivity, develops materials in both English and Spanish, and offers a Certified Diabetes Educator scholarship for qualifying people who either represent or serve a minority population.

Overall, KDN has played a vital role in strengthening the Kentucky State diabetes health system infrastructure through better coordination and collaboration of resources and efforts to reduce the burden of diabetes. Since 2000, KDN has generated $3,155,946 in cash and in-kind resources for its diabetes prevention and control efforts.

New Mexico

Free Patches and Gum Help New Mexicans with Diabetes Kick the Habit

Public Health Problem
People with diabetes who smoke are at increased risk for developing CVD caused by:

- Decreased amount of oxygen reaching the tissues
- Damaged and constricted blood vessels
- Increased blood pressure
- Decreased levels of high density lipid (good) cholesterol
- Increased risk of blood clots forming in damaged blood vessels
- Increased insulin resistance
- Increased blood sugar levels

People with diabetes who smoke are three times more likely to die from heart disease or stroke as people with diabetes who don't smoke. This is in addition to the already elevated risk of death from CVD for people with diabetes (about two to four times higher than people without diabetes). Smoking also increases the risk of other diabetes complications such as, kidney disease and failure, nerve damage, ulcers and infections that may lead to amputations and possible eye damage.

Taking Action
Because smoking increases the risk of cardiovascular and circulatory complications among people with diabetes, two New Mexico Department of Health Chronic Disease Bureau Programs collaborated on increasing access to tobacco cessation resources for people with diabetes.
The DPCP Manager and the Tobacco Use Prevention and Control Program (TUPAC) Manager, Supervisor, Quitline Specialist, and Media Strategist met with the Medical Officer/ Epidemiologist to discuss possible collaboration around this issue. Based on the serious complications smoking causes in people with diabetes, TUPAC recommended that they prioritize their nicotine replacement resources for people who call the Quitline to people with diabetes. TUPAC worked with the Quitline vendor, Free & Clear Inc. (F&C) to implement a protocol so people with diabetes were eligible to receive free nicotine replacement therapy (NRT) TUPAC and F&C created a special data report to track the number of people with diabetes who received NRT. DPCP arranged for the NM Medical Society to train community health workers/promotores on motivational interviewing for smoking cessation. DPCP distributed information and resources about the Quitline to primary care providers and members of the Diabetes Advisory Council. A TUPAC staff member also provided information at one of the DAC meetings. TUPAC disseminated a press release about the Quitline and free NRT for people with diabetes during Diabetes Month.

Implications and Impact

- Easier access to Quitline for all New Mexico residents, including those with diabetes and to free NRT
- Helped policymakers (legislators and Department of Health leadership) see the benefits of funding something like this. NRT is more tangible than some other prevention efforts.
- From December 2006 to June 2007, 341 people with diabetes registered with the Quitline. Almost 52 percent (176) of them received some for of free NRT (the majority requested the patch).

Utah

The Health Plan Partnership

Public Health Problem
People living with diabetes who are members of health plans are not receiving sufficient rates of annual eye exams. If people do not receive eye exams, people with diabetes may suffer further damage to the eye that could ultimately lead to blindness.

The objectives of this partnership were the following:
- Quality Improvement officers from major Utah health plans to meet monthly
- Quality Improvement officers work collectively to improve quality of care for health plan members with diabetes.

Taking Action
Interventions to increase eye exam rates included:
- Patient education
- Patient incentives
- Programs to increase provider awareness
- System changes
    - Automated phone call reminder system
    - Improved documentation of eye exam.

Involvement/Partners
- Quality improvement officers from major Utah health plans
- Health plan medical directors
- Quality improvement organization

Implications and Impact
The partnership has allowed participating health plans to identify and develop common solutions to overcome barriers related to improved diabetes medical care, including screening eye exams. Funds provided to health plans by the Utah DPCP were used as seed money to implement programs to measure diabetes complication testing, better identify patients with diabetes, and provide people with diabetes with reminders to obtain clinical exams. Since implementing the partnership in 1999, diabetes patient care has improved. Eye exam rates have improved more than the national rates, suggesting the partnership had direct impact. In addition to the eye exam intervention, participating plans, with support from the Utah DPCP, have worked successfully to improve measures related to A1C, lipid, and hypertension in patients with diabetes.

Lessons Learned
- Focus interventions where data are available.
- Identify ways the partnership is useful to its members.
- Obtain buy-in from the biggest players.
- Plan with evaluation in mind.