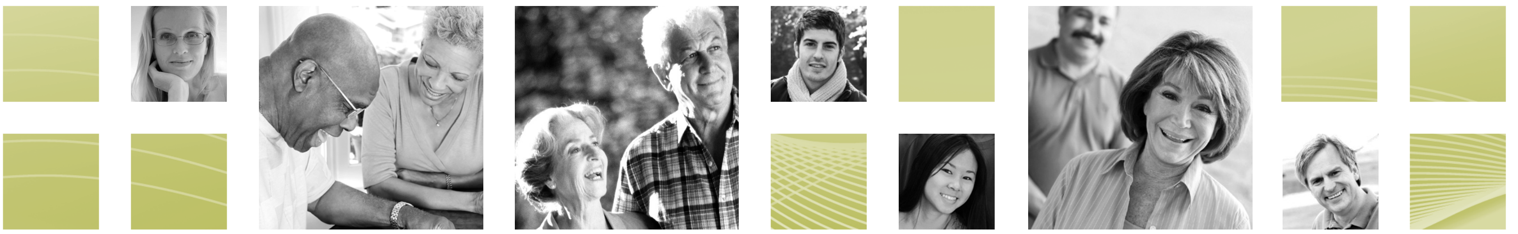


DIABETES

SUCCESSES AND OPPORTUNITIES FOR POPULATION-BASED PREVENTION AND CONTROL

2009

Alaska: Expanding Access to Chronic Disease Self-Management Education Through "Living Well Alaska"

As the Alaskan population ages, chronic disease prevalence, risk factors, and comorbidities are increasing at an alarming rate. Alaska Behavioral Risk Factor Surveillance data show a 10% increase in the number of people diagnosed with diabetes during 2002–2006. If this trend continues, the number of Alaskans diagnosed with diabetes (currently 24,500) will increase significantly. The geography and climate of Alaska restrict access to care and increase the cost of health care. About one-fourth of all Alaskans and nearly half (46%) of Alaska Natives live in communities of less than 1,000 people. Seventy-five percent of Alaskan communities are not connected by road to a hospital. Air travel in the state is very expensive, and many rural residents have little income. Severe weather further limits air travel, causing delays in obtaining care. As a result, many Alaskans with diabetes have limited access to self-management education and support.

To address this problem, funding was provided to the Alaska Diabetes Prevention and Control Program (AK DPCP) by CDC's Division of Diabetes Translation to support dissemination of a proven chronic disease self-management program (CDSMP). Arthritis funding was added, expanding the reach of the initiative and ultimately creating the "Living Well Alaska" program. In 2006, program staff collaborated with Stanford University to train 37 master trainers in 2006. Twenty of these trainers facilitated participant workshops in Anchorage, Juneau, Soldotna, and Talkeetna, reaching 114 participants. The AK DPCP coordinated the initial master trainer workshop and continues to evaluate the effectiveness of workshops.

Since 2006, the program has been conducted with promising results in nine different community health centers and two senior citizen centers across the state. An additional master trainer program will be conducted in 2008–2009, which is expected to generate 50 new course leaders. Through participation in these trainings, health care providers and patients are increasing their competencies related to self-management of chronic diseases.

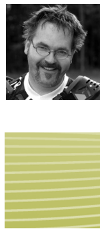
As "Living Well Alaska" extends its reach to more sectors and regions of the state, the program has the potential for large-scale impact, increasing access to self-management education for people with diabetes and other chronic diseases.

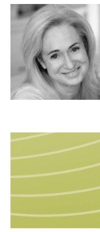
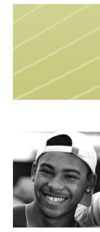
North Dakota: Partnership Develops a Diabetes Management and Quality Improvement Initiative

Diabetes is a significant public health burden for North Dakota residents. More than 29,000 people in North Dakota have diabetes, resulting in more than 9,400 hospitalizations and 665 deaths each year. In 1999, the North Dakota Diabetes Prevention and Control Program (DPCP) contracted with Blue Cross/Blue Shield (BC/BS) of North Dakota to develop the Diabetes Management and Quality Improvement Initiative.

As part of this initiative, quarterly provider reports were sent to approximately 600 physicians in which they provided details of care for each of their patients. Since the initiation of the Diabetes Care Provider Report, the percentage of providers who documented that their patients received all five preventive care measures increased from 13% to 45%.

As a result of the Diabetes Management and Quality Improvement Initiative, BC/BS expanded the program to include other chronic diseases and initiated a chronic disease management pilot at one of the largest clinics in North Dakota.



Significant findings included the following:

- A 24% decrease in emergency room visits.
- Up to a 15% improvement on ambulatory care measures including A1C, lipid and microalbumin tests, and eye exams.
- A cost savings of about $530 per patient.

In 2009, the DPCP will be partnering with BC/BS as they expand this program statewide to include all primary care physicians who are able to provide a similar "Medical Home" system of care. The project will be called MediQhome, and will include all patients cared for by the participating providers—not just those insured by BC/BS. The expanded project is projected to cover up to 80% of all patients in the state. This is an excellent example of a DPCP working through the Model of Influence with partners to achieve statewide impact on the care provided for people with diabetes and other chronic diseases.

Texas: Targeting Populations With—and at Highest Risk For—Diabetes

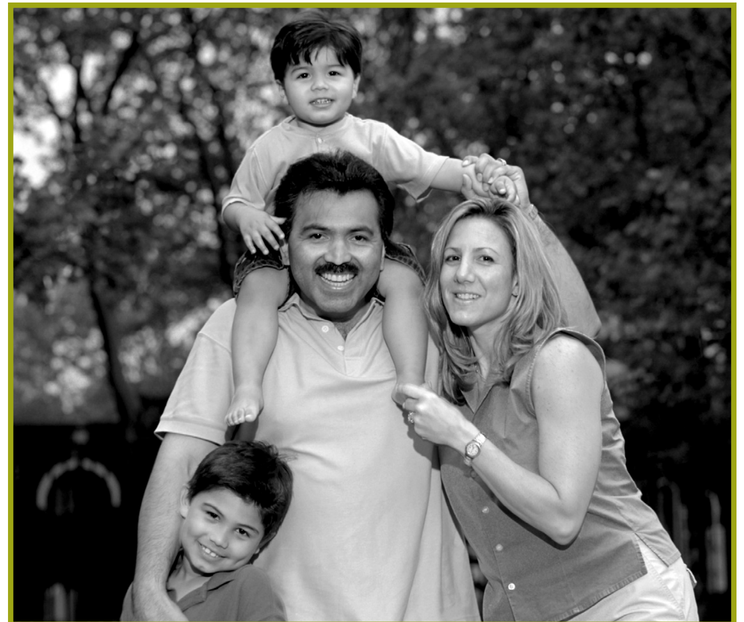
An estimated 1.8 million, or 10.30% of Texans aged 18 years and older have been diagnosed with diabetes. Diabetes is the fourth leading cause of death among African Americans and Hispanics; rates are highest among black non-Hispanic (10.3 %) and Hispanic populations (8.0%). Further, an estimated 460,040 persons aged 18 and older are believed to have undiagnosed diabetes. It is estimated that during the next 30 years, the total number of diabetes cases in Texas will increase by 77%, from 1.3 million in 2005 to almost 2.3 million in 2040.

CDC's funding assisted the Texas DPCP's development of 17 community-based diabetes prevention and control programs. These programs bring culturally appropriate diabetes education and prevention messages to those at greatest risk for diabetes and its complications. Target populations include racial and ethnic minorities with previously noted disproportionate rates of diabetes and diabetes complications and limited access to health care services.

The following changes occurred as a result of the community-based programs:

- Increased opportunities for physical activity and better nutrition with the implementation of 81 ongoing physical activity groups and 81 sustained nutrition programs.
- Increased access to self-management education, with a total of 249 classes.
- Improved capacity of coalition–based community programs to design and implement diabetes interventions (344 key partners were recruited and maintained by community programs throughout all regions of the state).
- Since September 1, 2007, these efforts have reached more than 62,000 Texans (19% African American and 48% Hispanic) across multiple sectors including health systems, senior citizen centers, businesses, faith-based organizations, nonprofit organizations, and schools.

On the front line of health promotion, community-based diabetes programs expand the reach of all elements of the comprehensive state diabetes program supported by the CDC. Recognized for their local efforts, these programs are becoming sought-after resources for translating statewide and national initiatives to the geographic areas they serve.



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