

Diabetes

Alaska

The Alaska Diabetes Prevention and Control Program (DPCP) partners with the Arthritis Program to expand access to chronic disease self-management education through Living Well Alaska.

As a result of the aging Alaskan population, increases in the prevalence, risk factors and comorbidities of chronic disease are rising at an alarming rate.

Alaska Behavioral Risk Factor Surveillance data show a 10% increase in the number of people diagnosed with diabetes from 2002 to 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 community that has a hospital. Air travel in the state is very expensive, and many rural residents have low 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.

Funding to address this problem was provided to the Alaska DPCP by DDT to support dissemination of a proven chronic disease self-management program. Additional arthritis funding was provided to expand the reach of the initiative, and the Living Well Alaska program was created. 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 conducted with participants.

Since 2006, the program has been conducted in nine different community health centers and two senior citizen centers across the state with promising results. 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 alike are increasing their competencies related to self-management of chronic diseases.

As Living Well Alaska reaches out to various 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.

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North Dakota

The North Dakota Diabetes Prevention and Control Program (DPCP) partners with Blue Cross Blue Shield (BCBS) to develop a Diabetes Management and Quality Improvement Initiative.

Diabetes is a significant public health burden for North Dakota. 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 DPCP contracted with BCBS of North Dakota to develop a Diabetes Management and Quality Improvement Initiative. As part of this initiative, quarterly Provider Reports were sent to almost 600 physicians detailing their adherence to diabetes standards 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 has increased from 13% to 45%.

As a result of the success of the Diabetes Management and Quality Improvement Initiative, BCBS expanded the program to include other chronic diseases, conducting a chronic disease management pilot at one of the largest clinics in the state.

Significant findings included the following:

- A 24% decrease in emergency department 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/patient.

In 2009, the DPCP will partner with BCBS to expand this program statewide, including 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 BCBS. 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 with partners to achieve statewide impact on the care provided for people with diabetes and other chronic diseases.

Diabetes

Texas

The Texas Diabetes Prevention and Control Program (DPCP) mobilizes 17 community-based diabetes prevention and control programs targeting populations with and at highest risk for diabetes.

An estimated 1.8 million Texans, or 10.30% of those aged 18 years and older, have been diagnosed with diabetes. Rates are highest among black non-Hispanic (10.3%) and Hispanic populations (8.0%), and diabetes is the fourth leading cause of death among African Americans and Hispanics. Further, an estimated 460,000 persons aged 18 and older are believed to have undiagnosed diabetes. It is estimated that in 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 2035.

DDT'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. (Three hundred forty-four key partners were recruited and maintained by community programs throughout all regions of the state.)

Since September 1, 2007, these efforts have reached over 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.

Diabetes

Washington

Washington State Department of Health (DOH) partners with the Department of Social and Health Services, Aetna, and the University of Washington Child Health Institute on a health care quality improvement initiative targeting diabetes and other chronic diseases.

Chronic conditions are the leading cause of illness, disability, and death in the United States and account for 75 percent of total health care costs, according to CDC. In Washington State, estimated hospitalization costs for cardiovascular and diabetes-related care amounted to \$6.5 billion and \$1.8 billion, respectively, in 2005. In order to improve the quality of care provided and to impact the long-term cost of chronic conditions, the Washington State DOH (Diabetes Prevention and Control, Heart Disease and Stroke Prevention, Children and Youth with Special Health Care Needs, Asthma Prevention and Control, and Tobacco Prevention and Control Programs; and the Department of Social and Health Services) along with various external partners (Qualis Health, Aetna, and Premera Blue Cross) launched the Washington State Collaborative To Improve Health.

This quality improvement initiative has been a proven strategy for redesigning the health care delivery system for better prevention and management of chronic illnesses. The collaborative has brought together primary care providers, patients with chronic disease, and health insurance plans in an evidence-based intervention designed to improve care. More than 150 health care facilities across Washington have participated in one or more of the Washington State Collaborative initiatives between 1999 and 2007. All have experienced improved care, healthier patients, and increased provider satisfaction. The initial focus was on federally qualified health centers, but the work was quickly expanded to include private practices as well. More recently, emphasis was placed on recruiting providers from rural practices/clinics serving a Medicaid population and having fewer than six providers on staff. Staff from the Washington State DPCP provided technical assistance to the collaborative, incorporating evidence-based approaches and tools designed to improve care for people with diabetes. In 2004, records from 17,349 adult patients with diabetes from clinics using the Chronic Disease Electronic Management System (CDEMS) were analyzed, and the results compared to national surveillance data sets. In some cases, health outcomes were more favorable in Washington State while in others, specific care measures were targeted for improvement. (See table below.)

Intermediate Diabetes-related Health Outcomes	WA CDEMS %	Comparison Data	Source
Last A1c test <7.0%	51.6%	37.0	NHANES
Eye exam in past year	35.4	48.8	HEDIS (commercial)
Foot exam in the past year	52.8%	74.1	WA BRFSS
Last LDL test <100mg/dL	56.5%	34.8	HEDIS (commercial)

Intermediate Diabetes-related health Outcomes compared to National Surveillance data sets

To date, the Washington State Collaborative To Improve Health has reached out to practices delivering care to over 72,000 patients with chronic disease, tracking and improving care measures such as A1c, blood pressure, and lipid control; documented self-management goals for each patient; provided annual eye and foot exams; and delivered tobacco cessation counseling. In the 2008 session, the Washington State Legislature passed a bill to fund a Medical Home Collaborative to improve patient-centered care. This will institutionalize the Washington State Collaborative Program at the DOH.