

Alaska Diabetes Coalition Strategic Plan

2011-2015



Alaska Department of Health and Social Services
Sean Parnell, Governor • William J. Streur, Commissioner



State of Alaska
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Alaska Diabetes Coalition 2011-2015 Strategic Plan

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I. Background (Stakeholder Involvement)

This is the third statewide strategic plan developed to address diabetes in Alaska, following plans issued in 1999 and 2004. The developmental process for this plan started in 2009. This plan is the result of multiple teleconference/webinars, web-based surveys, and face-to-face meetings.

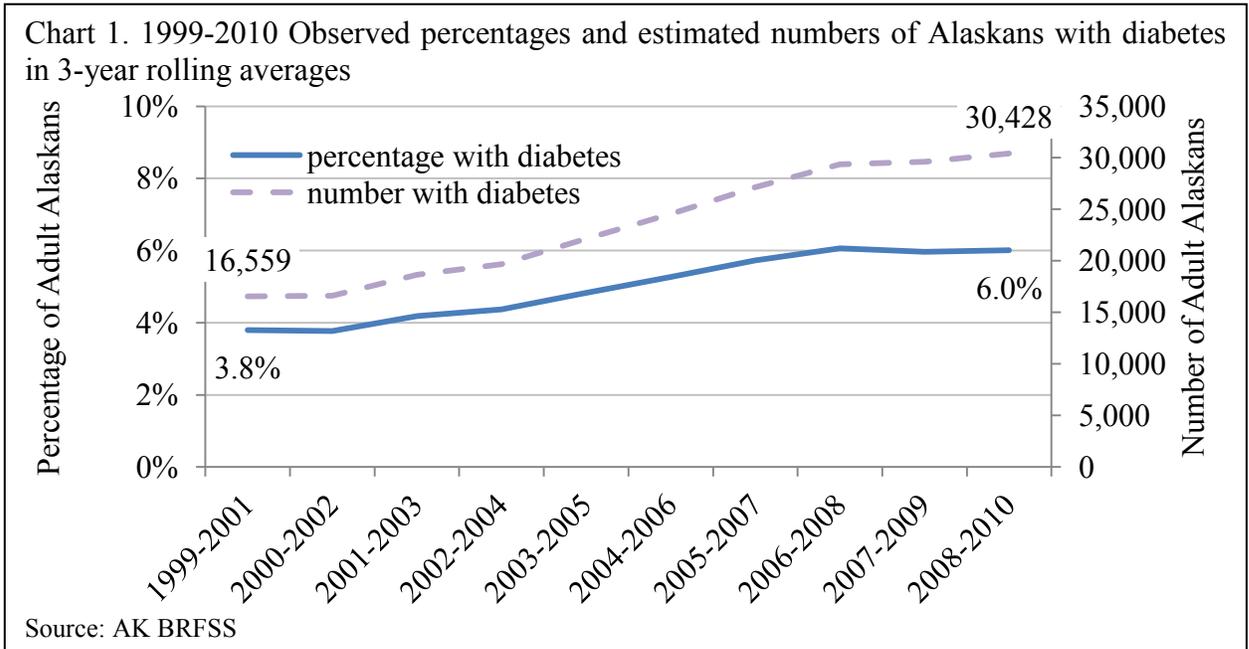
Our grateful thanks to everyone who participated in this extended process.

Alaska Center for the Blind and Visually Impaired (Karla Jutzi)
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Veterans Administration (Pat Lentz)
... And survey respondents from the AKDiabetes listserv, Alaska Native Special Diabetes Programs for Indians (SDPI) and federally qualified community health centers.

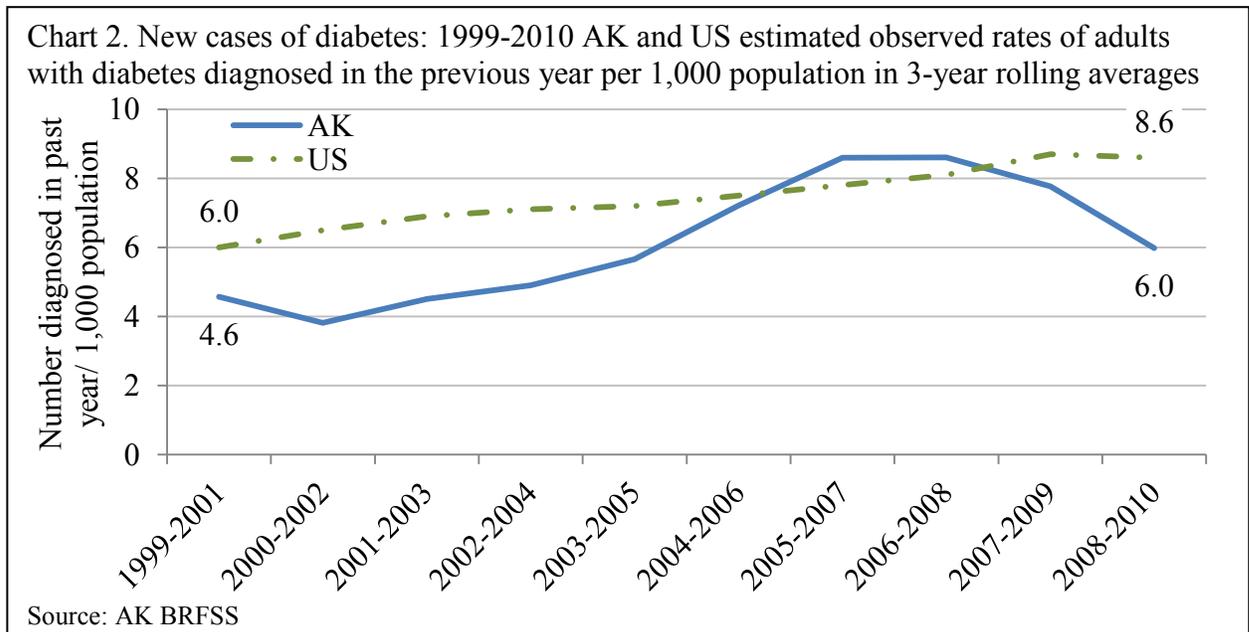
II. Data on Disease Burden and Existing Efforts

A. A Quick Look at Alaska Data on Diabetes

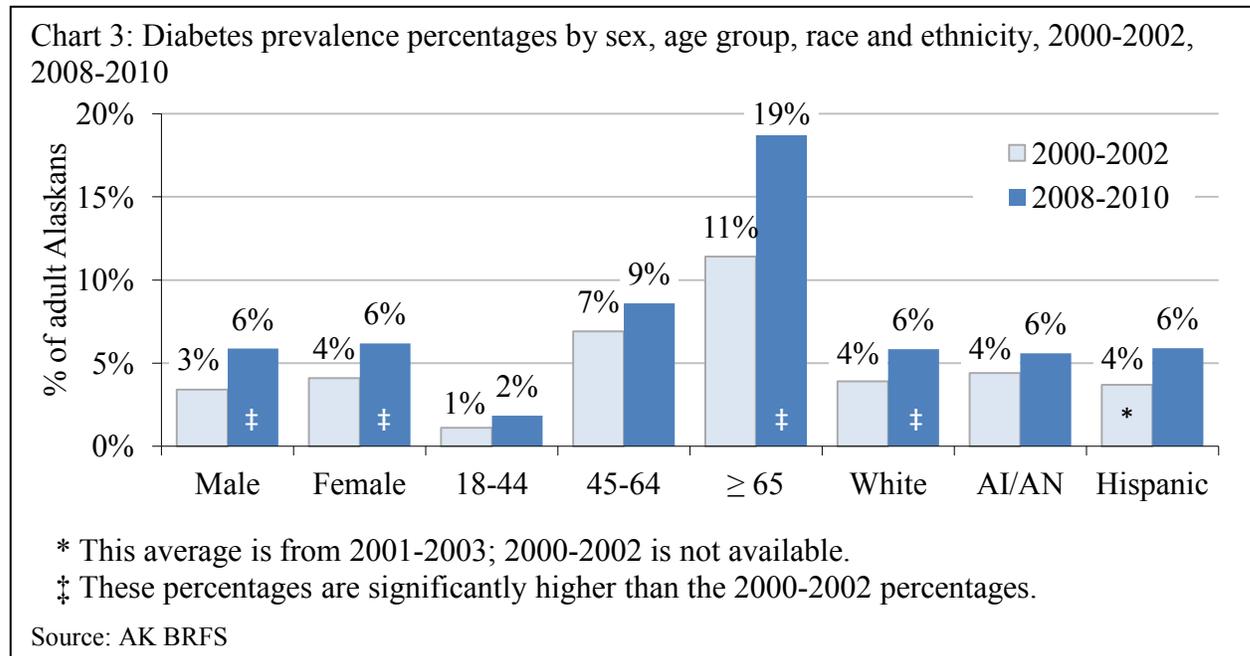
About one in twenty adult Alaskans report that they have diagnosed diabetes. The percentage of Alaskans with diabetes appears to be leveling off starting in 2007. However, the estimated number of Alaskans with diabetes continues to increase as the numbers of middle-aged and older persons increase. (Chart 1)



The rate of newly diagnosed diabetes among Alaskans peaked between 2005 and 2008 and then diminished (Chart 2).



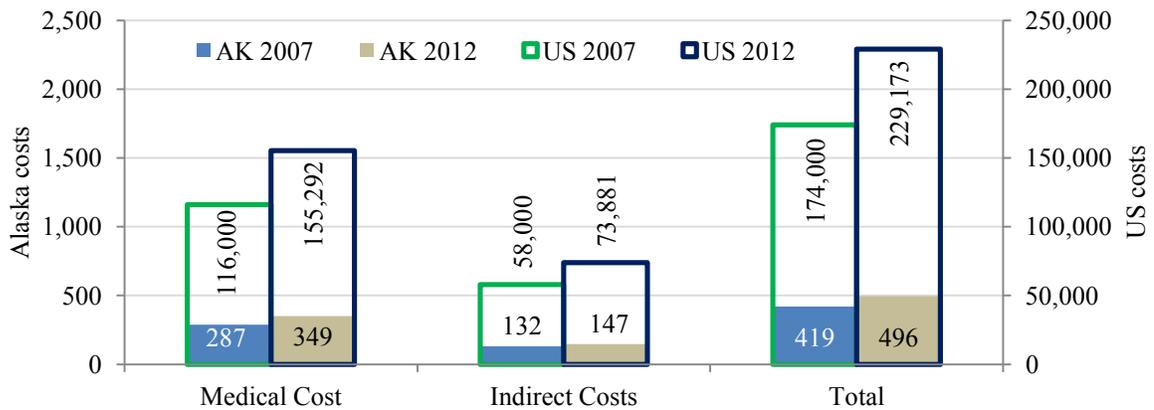
Certain groups of Alaskans have higher percentages with diagnosed diabetes than others. (Chart 3) In particular, the percentage of Alaskans ≥ 65 with diabetes started higher in 2000-2002 and increased more between then and 2007-2009 than the other age groups. This increase, compounded by dramatic growth in the overall number of Alaskans ≥ 65 during this time¹, was one of the drivers in the continuing rise in the estimated number of Alaskans with diabetes.



Diabetes is expensive. The Agency for Healthcare Research and Quality estimates that 23% of all hospital stays in 2008 were for diabetes-related care. Total estimated 2008 US expenditures on hospital stays for patients with diabetes was \$83 billion, with the mean cost per hospitalization being about 25% higher for patients with diabetes than those without. Much of this care was publically financed. Medicare and Medicaid paid for nearly three-fourths of hospital stays by patients with diabetes (60% and 10% respectively) but for about half of the hospital stays for patients without diabetes (32% and 20% respectively).²

An analysis of the economic costs of diabetes in the US found that half of the annual per capita health care spending on diabetes was for inpatient hospital care.³ This report also estimated that 30% of the total burden of diabetes is from indirect costs, such as absenteeism and lost productivity. Based on these estimates, the Alaska economic burden related to diabetes will be nearly \$0.5 billion in 2012. (Chart 4, next page)

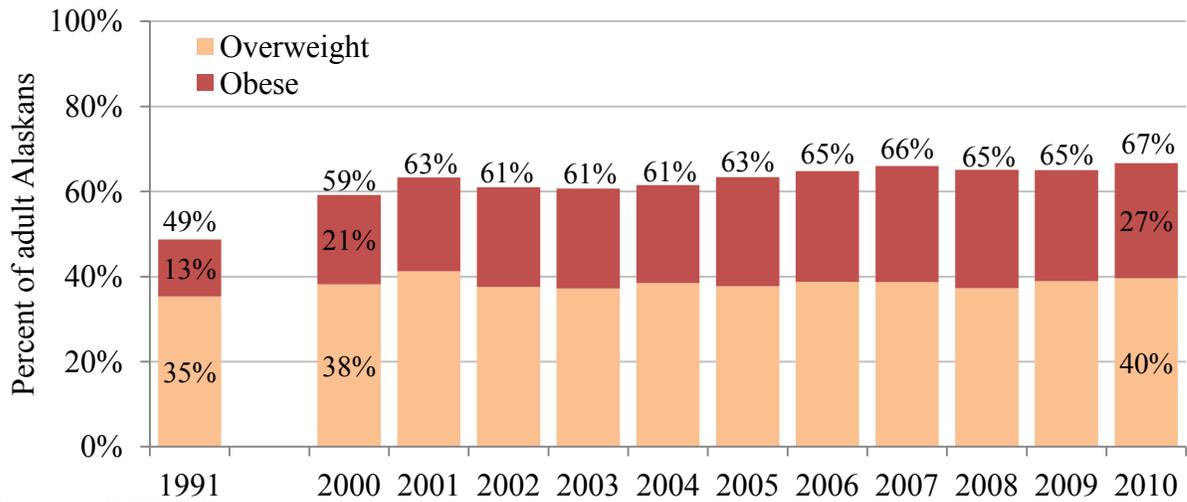
Chart 4. Estimated 2007 and inflation- and population-adjusted 2012 Alaska and US Medical, Indirect and Total Costs associated with diabetes (in millions)



Sources: 2007 - ADA Calculator (<http://www.diabetesarchive.net/advocacy-and-legalresources/cost-of-diabetes-results.jsp?state=Alaska&district=0&DistName=Alaska+%28Entire+State%29>) after adjustment using CPI – 2007 to 2012 inflation adjustments (http://www.bls.gov/cpi/cpi_dr.htm) using Anchorage tables to represent Alaska and estimated growth in the number of Alaskans with diabetes.

Diabetes is preventable. Some diabetes risk factors cannot be controlled, such as age, family history and race or ethnicity. Others may be more malleable, such as physical inactivity and obesity. Between 1991 and 2010, the percentage of adult Alaskans that were obese (body mass index ≥ 30) doubled. (Chart 5)

Chart 5. Percentage of Adult Alaskans Who Are Overweight ($25 \leq \text{BMI} < 30$) or Obese ($\text{BMI} \geq 30$), 1991, 2000-2010.



Source: AK BRFSS

Based on national research,⁴ as many as 140,000 adult Alaskans (26% of the adult population) have pre-diabetes and are at high risk of developing diabetes within five years. The Diabetes Prevention Program demonstrated that diabetes can be substantially delayed or averted with physical activity and moderate weight loss.⁵ The Alaska Diabetes Program has

reported significantly higher percentages of Alaskans with self-reported diagnosed pre-diabetes in the ≥ 45 age groups than among younger adults and among Alaskans in the obese group than among those who were not obese.⁶

Diabetes risk status information can be a strong motivator for adopting healthier behaviors. Adult Alaskans that self-reported a pre-diabetes diagnosis were about 50% more likely to have had a blood glucose test in the previous three years (88% vs. 52%), which suggests that many providers are considering diabetes risk factors in their health assessment. On the other hand, one-third of obese adults reported that they had not received a blood glucose test in the previous three years. Most of the people in this group that is at high risk for diabetes and pre-diabetes were young (60% were 18-44), White (70%), middle income (50% had an annual income \geq \$50,000) and had health insurance (76%).⁶

B. Existing Efforts - Diabetes Scorecard (2010-2012)

Goal 1: Prevent Diabetes

Inputs	Activities	Outputs	Score	Anticipated Outcomes			Score
				Short-term	Intermediate	Long-term	
AK Diabetes Program and partners	Share information and resources	AK-HealthPromotionMaterials catalogue	Area of Need Although many agree that sharing information and materials would be helpful, the website had 23 subscribers as of 5/1/2012. It could have more users, because its content is open.	Increased percentage of diabetes programs that are using evidence-based interventions and proven materials	Alaskans with or at high risk of diabetes have increased access to evidence-based diabetes programs.	<ul style="list-style-type: none"> ▪ Reduced diabetes incidence ▪ Reduced percentages with diabetes complications or co-morbidities of Alaskans with diabetes 	Area of Need Even if this strategy had many many users, it is not a powerful intervention for reducing diabetes incidence.

Considerations:

There is strong interest in preventing diabetes (e.g., reducing the number of adults with diagnosed and undiagnosed diabetes) in Alaska.

- Diabetes prevention is frequently mentioned in the goals and recommendations of the 2005-2010 Diabetes Strategic Plan. The 2010-2015 goal follows the spirit of this 2005-2010 goal: Health Promotion is prioritized through statewide planning and coordination.
- The Indian Health Service has 24 Alaska Special Diabetes Program for Indian (SDPI) grantees, all of which are responsible for working to prevent diabetes.
- Other agencies are also working to prevent diabetes, particularly two community hospitals (Juneau and Fairbanks) and Alaska Health Fairs, Inc.
- To date, most diabetes prevention activity in Alaska has involved physical activity promotion events, community education about diabetes and pre-diabetes, and/or screening promotion.

In the 1990’s, the Diabetes Prevention Program⁷ demonstrated that increased physical activity and a modest weight loss can substantially reduce the risk of developing diabetes among people at highest risk for this disease. This program is difficult to replicate for a number of reasons, including its length (16 weeks) and that education/supportive services were provided one-to-one, making it a very expensive proposition.

- Four SDPI grantees are replicating the Diabetes Prevention Program in Alaska, with varying success.

- In the years since information this intervention was first published, a model involving group-delivery by trained lay providers has also been shown to be effective. The Affordable Care Act specifically mentions this model. The CDC is leading work to scale it up across the country: it is responsible for program certification, and it is supporting a contractor (DTTAC) to lifestyle coaches and master trainers. UnitedHealth is reimbursing some YMCAs for providing the workshops; other insurance companies are considering adding this coverage as well.
- Most Alaska providers do not have the resources to add this program.

Goal 2: Control Diabetes

a. Living Well AK

Inputs	Activities	Outputs	Score	Anticipated Outcomes			Score
				Short-term	Intermediate	Long-term	
AK Diabetes Program; partners	Living Well Alaska: CDSMP, DSMP	2 T-trainers 23 Master Trainers 16 Course leader trainings 157 Course leaders	<p>Making progress</p> <p>2008-2010</p> <p><i>Reach</i></p> <p>78 workshops 17 Communities 561 Participants</p> <p><i>Course Leaders</i></p> <p><u>2008</u> 36 active, including 31 new</p> <p><u>2009</u> 48 active, including 33 new</p> <p><u>2010</u> 51 active, including 33 new</p> <p><i>Referrals</i></p> <p>44 Referrals by providers 340 Self-referrals</p>	Increased effectiveness of all LW AK partners to deliver CDSMP courses based on workshop leader feedback forms	Increased participant self-efficacy as measured on pre/post test	Increased ABC control for participants with diabetes	<p>Making progress</p> <p>66% (280) participants complete the workshop (4 of 6 sessions)</p> <p>31% with diabetes of participants</p> <p><u>A1c improvement</u></p> <p>65% of participants with diabetes and A1c measures available showed improvement. At baseline, 41% had an A1c at goal (≤ 7.0). The percentage at goal increased to 50% at 3-month follow-up and remained at 50% for the 6- and 12- month follow-up.</p>

Considerations:

- One of the recommendations under the fourth goal in the 2005-2010 Diabetes Strategic Plan was to bring the Chronic Disease Self-Management Program to Alaska. That goal was: Community-based programs are empowered to develop and use evidence-based models of diabetes prevention and health promotion, and to educate individuals with diabetes about their rights.

Goal 2: Control Diabetes, cont

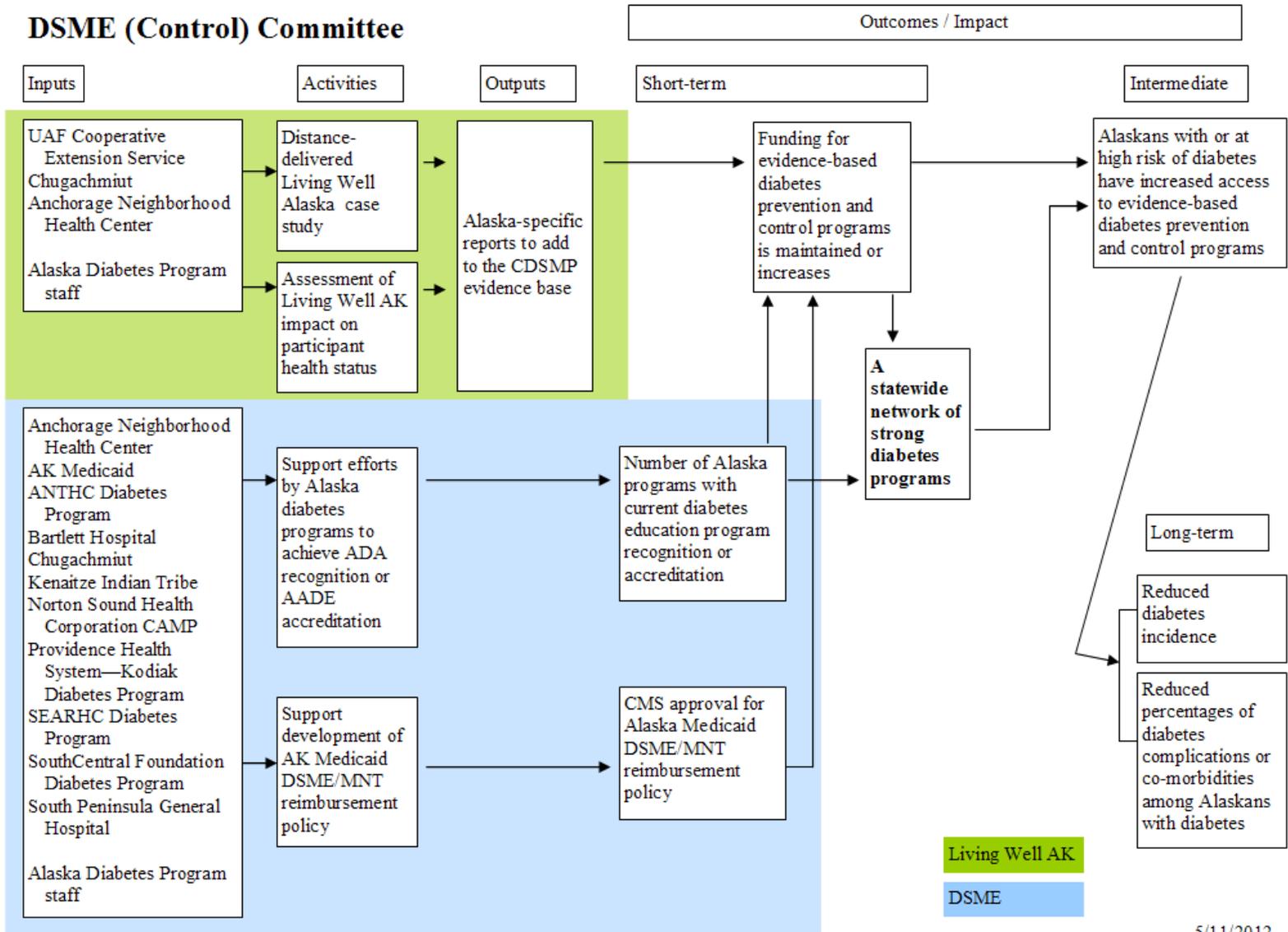
b. DSME Committee

Inputs	Activities	Outputs	Score	Anticipated Outcomes			Score
				Short-term	Intermediate	Long-term	
AK Diabetes Program; partners	Explore and implement diabetes self-management education recognition policy for Alaska	<ul style="list-style-type: none"> ▪ Survey to document current DSM education activity and its reach ▪ Collect DSM recognition policies from other states ▪ Analyze other state’s DSME recognition policies ▪ Collect additional supporting documents ▪ Design delivery alternatives <ul style="list-style-type: none"> ▪ Estimate cost of delivery alternatives ▪ Estimate numbers served and reach of delivery alternatives 	Just Started	Increased access to diabetes self-management education	Increased number of individuals receiving diabetes self-management education	<ul style="list-style-type: none"> ▪ Improved health status for participants ▪ Reduced numbers of hospitalizations, ER visits and Alaskans with diabetes complications ▪ Reduced Medicaid expenditures for diabetes care 	Just Started

Considerations:

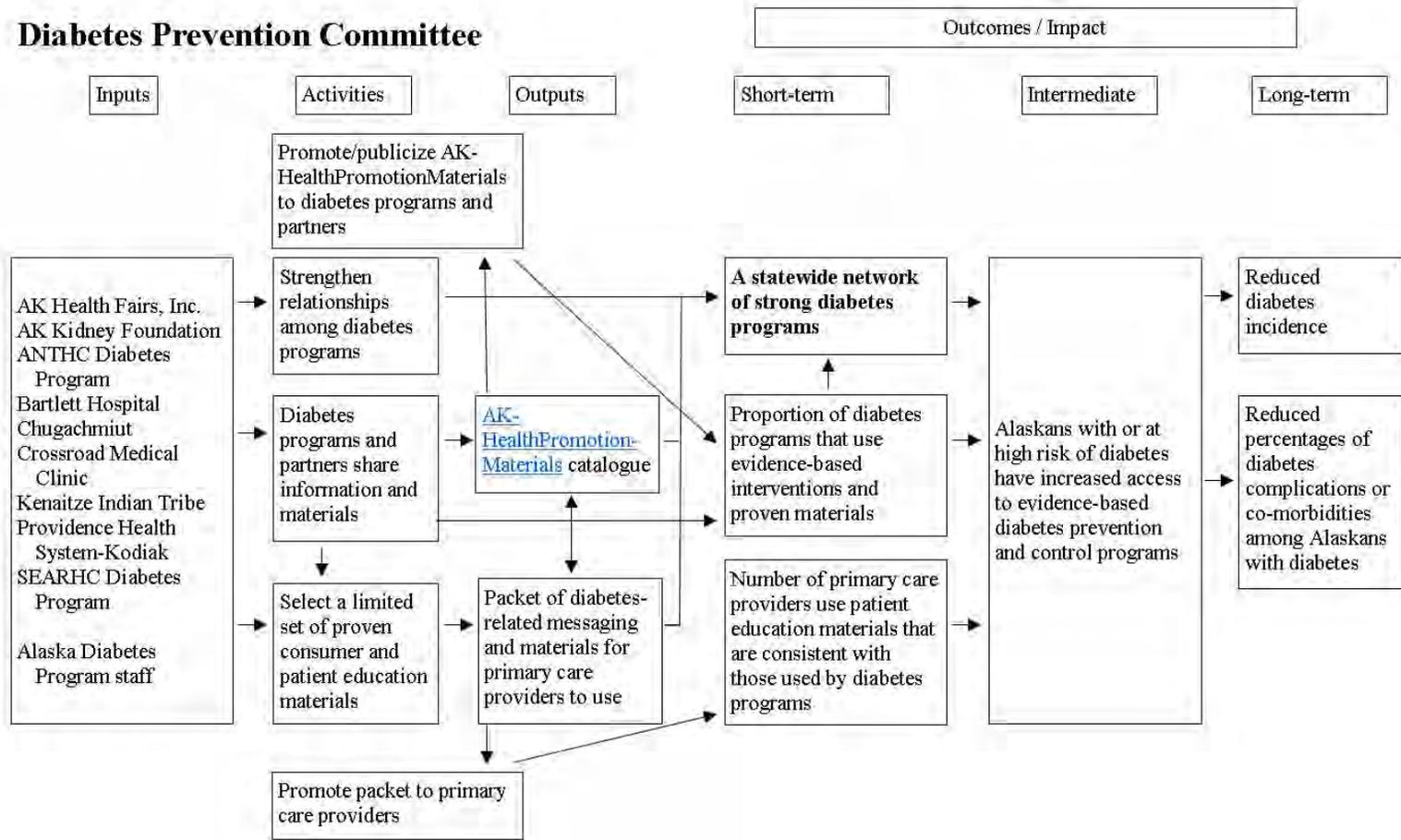
- The second goal in the 2005-2010 Diabetes Strategic Plan was: Statewide and community-wide policies are developed and implemented to promote the primary, secondary, and tertiary prevention of diabetes. Several recommendations under this goal mention Alaska Medicaid policy, particularly in connection with supporting use of ADA Recommended Standards of Care, reimbursing providers for providing preventive health exams for individuals at risk for diabetes, and allowing Certified Diabetes Educators and pharmacists able to be directly reimbursed for diabetes-related care.

B. Control diabetes (reduce the percentages of complications and co-morbidities among Alaskans with diabetes)



III. Goals and Objectives

A. Prevent diabetes (reduce diabetes incidence)



C. SMART Objectives and Timelines

Goal 1 in SMART terms:

By 2015, at least 5 programs will be participating in a network that, they report, has supported their use of evidence-based resources to prevent diabetes.

Timeline

Prevention Committee monthly meetings (4th Thursdays at 9:00 AM)

[AK-HealthPromotionMaterials](#) established in 2010-2011

Provider Packet Project

By 10/15/2012: Packet of diabetes education materials selected

By 1/16/2013: Joint acquisition of selected materials starts

By 3/31/2013: Committee members report that primary care providers are using materials from the packet.

Goal 2

A. Living Well AK in SMART terms:

By 2015, a case study will have been completed that identifies the critical components for successful distance-delivery of Living Well AK/CDSMP workshops.

Timeline:

First [case study report](#) published 4/2012

By 9/30/2012: AK DPCP works with Chugachmiut to design process evaluation and select variables

By 1/31/2013: Chugachmiut provides distance delivered DSMP to member villages

By 3/15/2013: AK DPCP receives process evaluation data from Chugachmiut.

By 5/31/2013: AK DPCP publishes case study report.

B. DSME Committee in SMART terms:

By 2015, at least 4 additional facilities in Alaska will become recognized by ADA to provide DSME.

Timeline:

DSME Committee monthly meetings (4th Thursdays at 1:00 PM)

By 6/30/2012: Collect information about AK DSME/MNT needs and share it with stakeholders

By 10/30/2012: Develop a feasibility plan for a statewide ADA DSME license

By 12/30/2012: Identify diabetes programs in AK that are interested in pursuing ADA recognition

By 6/30/2013: At least 1 program submits application for new ADA recognition

IV. Plan Implementation and Integration of Strategies with Other Programs

The success of this plan depends on the Alaska Diabetes Coalition and its committees. Coalition members are responsible for participating in the committees and providing knowledge, energy, vision and skills to get the work done. The Alaska Diabetes Program is responsible for providing support and technical assistance to the Coalition for work associated with Goal 1 (preventing diabetes) and Goal 2b (DSME). The Diabetes Program also provides leadership for overall implementation of Goal 2a (Living Well Alaska), and holds the statewide license for all related activities.

The Alaska Diabetes Coalition includes representatives of the Alaska Obesity and Alaska Tobacco Programs and has met with the Alaska Comprehensive Cancer Partnership and Take Heart Alaska coalition to share information about agendas and strategies. These representatives and meetings help assure cross-fertilization of ideas and that work toward shared goals is aligned.

The Alaska Diabetes Program is part of the Alaska Section of Chronic Disease Prevention and Health Promotion (SCDPHP), which is currently completing a strategic plan. The Centers for Disease Control and Prevention (CDC) is the primary source of support for both the Section strategic planning effort and the Alaska Diabetes Program. The CDC is striving to reduce administrative barriers that historically have limited the ability of state chronic disease programs to join forces. It wants state agencies, including SCDPHP, to use the strategic planning process to take advantage of the opportunity. Consequently, how the Diabetes Program manages its workload may change as SCDPHP moves to increase efficiency and use of evidence-based practices; the commitment to diabetes prevention and control will not be affected.

V. Resources for Implementing this Plan

A. Alaska Diabetes Program

The Alaska Diabetes Prevention and Control Program (AK DPCP) dates from 1986. Program efforts to reduce the burden of diabetes in Alaska are consistent with national directives and place special emphasis on populations with or at increased risk for diabetes. AK DPCP is the lead program for Living Well Alaska: Better Choices, Better Health, the chronic disease self-management program in Alaska, which was initiated in 2006.

CDC funding and imperatives for diabetes programs

Diabetes was the first categorical chronic disease program funded by Congress. When the AK DPCP was first funded by the Centers for Disease Control and Prevention (CDC) in 1993, this program focused on increasing access to care for Americans with diabetes, particularly care related to amputations. As the research-driven evidence base has evolved, the CDC Division of Diabetes Translation (DDT) has expanded the scope and reach of programmatic activity and stepped back from tertiary prevention to secondary and now, to primary prevention strategies. DDT's support for programmatic activity is clearly evolving to tightly focus on evidence-based strategies that affect health care systems and community-clinical linkages, along with surveillance and evaluation. Appendix A contains a table of evidence-based interventions/strategies for diabetes prevention and control based on recommendations by the US Preventive Services Task Force, DDT, the Indian Health Service Special Diabetes Program for Indians, and the American Diabetes Association.

B. Other Resources

In Alaska, diabetes education programs are affiliated with hospitals, community health centers and Tribal health organizations. The table below lists these provider types by region.

Region (Census areas)	19 Civilian Hospitals	24 Special Diabetes Program for Indians Programs‡	25 Community Health Centers (CHC)‡
Municipality of Anchorage	Providence Anchorage*, AK Regional	Southcentral Foundation (SCF)*	Anchorage Neighborhood Health Center, Village of Eklutna, SCF
Matanuska-Susitna Borough	Mat-Su Regional		Denali Family Services (mental health), Mat-Su Health Services, Sunshine CHC (Talkeetna)
Gulf Coast (Kenai, Kodiak, Prince William Sound)	Central Peninsula (Soldotna)*, Cordova Community, South Peninsula (Homer)*, Providence Kodiak*, Providence Seward, Providence Valdez	Chugachmiut (Seward), Copper River Native Assoc (Copper Center & Gakona), Council of Athabaskan Tribal Governments (CATG - Fort Yukon), Kenaitze, Kodiak Area Native Assoc. (KANA), Ninilchik Traditional Council, Seldovia Village Tribe (SVT – 2 sites; Homer & Seldovia)	Chugachmiut, CATG, Cross Road Medical Center, Kenaitze, KANA, Kodiak CHC, Native Village of Eyak, Peninsula Community Health (Soldotna), SVT
Interior (Fairbanks, SE Fairbanks, Yukon-Koyukuk)	Fairbanks Memorial*	TCC (Fairbanks)*	Interior CHC, TCC
Northern (Nome, Northwest, Arctic Slope)	Samuel Simmonds Memorial (Barrow), Kotzebue, Nome	Arctic Slope Native Assoc (Barrow), Maniilaq (Kotzebue), Norton Sound Health Corporation (NSHC - Nome)	Maniilaq, NSHC
Southeast	Bartlett (Juneau)*, Ketchikan General *, Sitka Community *, Petersburg Medical, Wrangell Medical Center	South East Regional Health Consortium (SEARHC – 5 sites; Haines, Hoonah, Klawock, Juneau, and Sitka), Ketchikan Indian Community, Metlakatla, Yakutat Tlingit Tribe (YTT)	Alaska Island Community Services (Wrangell), Dahl Memorial Clinic (Skagway), SEARHC, YTT

Region (Census areas)	19 Civilian Hospitals	24 Special Diabetes Program for Indians Programs‡	25 Community Health Centers (CHC)‡
South West	Kanakanak (Dillingham)	Aleutian/Pribilof Islands Assoc (A/PIA - King Cove), Bristol Bay Area Health Corporation* (BBAHC - Dillingham), Yukon Kuskokwim Health Corporation (YKHC - Bethel)	A/PIA, Bethel Family Clinic, BBAHC, Camai CHC (Bristol Bay Borough), EAT, Iliuliuk (Unalaska), YKHC
# accredited or recognized	8	3	0
*ADA recognized or AADE accredited ‡Primary site listed; may have multiple sites			

For this plan, the critical questions are if these programs will have continued support going forward and if there are current or likely gaps between diabetes education program service areas and the populations at risk.

1. Civilian/community hospitals

Many hospitals have a diabetes education program to enhance their inpatient care. Some of these programs also provide outpatient care and community outreach. Under a 2012 requirement by the Internal Revenue Service, non-profit hospitals are required to engage the community in conducting an assessment and developing a plan for community health improvement.

2. Special Diabetes Program for Indians

Congress established this program in 1997 and has extended it five times. The most recent extension was in 2010 for three years; funding has not increased since 2007.

This program has been tremendously important to establishing and maintaining a high standard of care by Tribal diabetes programs. SDPI funding has been associated with reduced levels of kidney failure, amputation, heart attack and stroke among program beneficiaries. Supporting these changes are improved health status indicators such as blood glucose, blood pressure and cholesterol. SDPI has also supported tribal initiatives to prevent diabetes, including work in schools and communities to promote physical activity and healthy nutrition and four Tribal replications of the National Diabetes Prevention Program.

3. Community Health Centers

Funding for community health centers has increased dramatically in the past 15 years; both the level of Federal investment and the number of patients served by the Health Center Program have more than doubled nationally. In the early 1990's there were only two community health centers in Alaska: the Anchorage Neighborhood Health Center and the Interior Health Center. Now, there are 25 and they provide care at 142 sites. Presently, the Health Center Program was reauthorized and funded through 2012 by the Health Care Safety Net Act of 2008 (Public Law (P.L.) 110-355).

The Health Services and Resources Agency (HRSA) is the primary federal funding source for these programs. It has established a core set of clinical performance measures that it requires its grantees to report patient care data on a number of measures, including this one:

“Percentage diabetic patients whose HbA1c levels are less than seven percent, less than eight percent, less than or equal to nine percent, or greater than nine percent.”⁸

The objective underlying this measure is to increase the percentage of patients with diabetes whose HbA1c level is below seven percent.

VI. Evaluation

This plan will be evaluated from two perspectives: (a) Accomplishments related to the SMART objectives and (b) how well the Coalition functions in accomplishing these objectives.

A. SMART objective indicators

Prevention Committee	DSME (Control) Committee
<u>Outputs</u> – # AK-HealthPromotionMaterials members – # diabetes programs that adopt materials in the provider packet as their standard – # diabetes programs that are jointly acquiring materials in the provider packet	<u>Outputs</u> Living Well AK – # Living Well AK reports DSME Committee – # Policy-related reports
<u>Short-term outcomes</u> – Proportion of diabetes programs that use evidence-based interventions* and proven materials – Number of primary care providers who use patient education materials that are consistent with those used by diabetes programs	<u>Short-term outcomes</u> DSME Committee – CMS approval of AK Medicaid state plan amendment – AK Medicaid implementation of DSME/MNT reimbursement policy
<u>Short-term Outcome (Prevention and DSME Committee efforts)</u> <i>Network of strong diabetes education programs</i> – # programs with ADA recognition or AADE accreditation – # community health centers or Tribal health organizations that regularly offer Living Well AK workshops (either CDSMP or DSMP) – # community health centers or Tribal health organizations that have adopted decision-support features in their electronic health record to reinforce ADA Recommended Preventive Standards of Diabetes Care	
<u>Intermediate outcome (Prevention and DSME Committee efforts)</u> <i>Alaskans with or at high risk of diabetes have increased access to evidence-based diabetes prevention and control programs</i> – # of Alaska villages, towns or cities with (i) a Living Well AK sponsor that regularly offers workshops (CDSMP or DSMP), (ii) a recognized/certified diabetes education program, and/or (iii) a community health center or Tribal health organization that is using diabetes patient education materials from the provider packet – % of all Alaska adults that live in these places	

<p><u>Long term Prevention Outcome (BRFSS variables)</u> <i>Reduce diabetes incidence</i> <input type="checkbox"/> incidence <input type="checkbox"/> % adults <input type="checkbox"/>45 and/or with BMI <input type="checkbox"/>30 with blood sugar screening in previous 3 years <input type="checkbox"/> % with pre-DM that report changing behavior to reduce risk</p>	<p><u>Long term DSME Outcome (BRFSS variables)</u> <i>Reduce percentages of diabetes complications or co-morbidities among Alaskans with diabetes</i> <input type="checkbox"/> % with diabetes and vision or kidney health problems (new, starting 2011) <input type="checkbox"/> % with an annual dilated eye exam, foot exam & ≥ 2 A1c tests <input type="checkbox"/> % with formal diabetes education <input type="checkbox"/> % that self-monitor blood glucose at least daily</p>
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*Appendix _ has a chart that lists strategies and interventions that have been endorsed by the Community Guide, the US Preventive Health Services Task Force, the CDC Division of Diabetes Translation, the Indian Health Service and/or the American Diabetes Association.

A report using these indicators which is similar to the Diabetes Scorecard in this plan will be prepared annually and presented to the full Coalition in the fall. Key surveillance information produced during the previous year will be presented at the same time.

B. Coalition Assessment

During the fall/winter of 2012-2013, Coalition members will be asked to respond to a short survey. The results of this assessment will be used to improve the support provided by the AK Diabetes Program and identify untapped strengths and resources (within the Coalition or that have not yet joined it) that might be available to expedite progress toward objectives. A similar survey will be conducted in 2015.

Appendix A: Evidence-based interventions/strategies for diabetes prevention and control

A. Preventing Diabetes

	USPSTF/Community Guide	CDC/DDT (intervention) ⁹ , unless otherwise noted	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Screening</i>	<ul style="list-style-type: none"> ▪ For lipid disorders in adults¹² ▪ For diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg^{12,13,14} ▪ For obesity in adults¹⁵ and children¹⁶ 	<ul style="list-style-type: none"> ▪ If overweight and ≥ 45 ▪ If in another high risk group (NDEP) 	Best Practice for Community Diabetes Screening (includes education and follow-up, not just who)	<ul style="list-style-type: none"> ▪ If have BMI ≥ 25 and have ≥ 1 additional risk factor ▪ If ≥ 45 ▪ Every 3 years (S13) ▪ Re-screen people with pre-diabetes at least annually (S16)
<i>National Diabetes Prevention Program</i>		<ul style="list-style-type: none"> ▪ Increase availability of National Diabetes Prevention Program (#3) ▪ Increase provider referrals to National Diabetes Prevention Program services (#3) 	Best Practice for Diabetes Prevention	<ul style="list-style-type: none"> ▪ Patients with pre-diabetes should be referred to an effective ongoing support program targeting weight loss of 7% of body weight and increasing physical activity to ≥ 150 minutes a week. (S16) ▪ Provide follow-up counseling (S16)
<i>Pre-diabetes health care</i>		Small Steps, Big Rewards Toolkit ¹⁷	Best Practice for Diabetes/Pre-Diabetes Case Management (part)	Metformin therapy may be considered, especially if patient has a GDM history, a BMI ≥ 35 and/or age < 60 (S16)

Preventing Diabetes, cont. (related programs)

	USPSTF/Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Promoting physical activity</i>	<ul style="list-style-type: none"> ▪ Campaigns and informational approaches: Community-wide campaigns¹² ▪ Individually-Adapted Health Behavior Change Programs^{12,18} ▪ Social Support Interventions in Community Settings^{12,19} ▪ Creation of, or enhanced access to, places for physical activity combined with informational outreach activities^{12,20} ▪ Community-scale²¹ and street-scale^{12,22} urban design and land-use policies 	Facilitate access to safe, attractive and affordable places for people with pre-diabetes or multiple diabetes risk factors to be physically active (#3)	Best Practice for Physical Activity for Diabetes Prevention and Care (part)	
<i>Obesity Prevention and Control</i>	<p>Interventions in community settings</p> <ul style="list-style-type: none"> ▪ Behavioral interventions to reduce screen time²³ ▪ Technology-supported interventions - multi-component coaching or counseling interventions²⁴: <ul style="list-style-type: none"> – To reduce weight – To maintain weight loss 		Best practice for Adult Weight and Cardiometabolic Risk Management	<ul style="list-style-type: none"> ▪ Weight loss is recommended for all overweight or obese individuals (S21) ▪ Individuals at risk for type 2 diabetes should: <ul style="list-style-type: none"> – Achieve the USDA recommendation for dietary fiber and foods containing whole grains (S21) – Limit their intake of sugar-sweetened beverages. (S22)

Preventing Diabetes, *cont. (settings)*

	USPSTF/Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Cardiovascular disease (CVD) prevention and control</i>	<ul style="list-style-type: none"> ▪ Team-Based Care to Improve Blood Pressure Control²⁵ ▪ Behavioral Counseling in Primary Care to Promote a Healthy Diet in Adults at Increased Risk for CVD²⁶ 			
<i>Community-wide</i>	Health Communication & Social Marketing ^{12,27,28} -use multiple channels (including mass media) to deliver messages that increases health behavior	Health Communications to raise awareness of pre-diabetes among populations at risk and health care providers. (#3)	<ul style="list-style-type: none"> ▪ Best Practice for Community Advocacy for Diabetes Prevention and Control ▪ Best Practice for Diabetes Prevention and Care (part) 	
<i>Worksites</i>	<p>Nutrition and physical activity programs designed to improve health-related behaviors and health outcomes¹²</p> <ul style="list-style-type: none"> ▪ Assessment of Health Risks with Feedback to Change Employees' Health²⁹ ▪ Worksite programs for obesity prevention and control³⁰ ▪ Point-of-decision prompts to encourage use of stairs³¹ ▪ Smoke-free policies to reduce tobacco use among workers³² ▪ Smoking cessation incentives and competition combined with additional information³³ 	Promote National Diabetes Prevention Program coverage by employers and health plans (#3)		

	<ul style="list-style-type: none"> Interventions to promote seasonal influenza vaccinations³⁴ 			
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Preventing Diabetes, *cont. (populations)*

	USPSTF/Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Pregnant and postpartum women</i>			Best Practice for Diabetes in Pregnancy (part)	<ul style="list-style-type: none"> If diabetes risk factors are present, screen for undiagnosed type 2 diabetes at first prenatal visit (S15) If no risk factors, screen at 24-28 weeks gestation (S15) Screen women with GDM at 6-12 weeks post-partum (S15) If a woman has GDM history, screen for diabetes /pre-diabetes every 3 years (S15) If a woman has GDM history and pre-diabetes, refer to lifestyle intervention or metformin (S15)
<i>Children and youth</i>	Enhanced school-based physical education ³⁵		<ul style="list-style-type: none"> Best Practice for Breastfeeding Support Best Practice for School Health: Promoting Healthy Eating and Physical Activity and Managing Diabetes in the School Setting (part) Best Practice for Youth and Type 2 Diabetes Prevention and Treatment 	

B. Controlling Diabetes (preventing complications and co-morbidities)

	USPSTF / Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Care provided by multi-disciplinary team</i>	<ul style="list-style-type: none"> ▪ Case management interventions to improve glycemic control¹²³⁶ 	<ul style="list-style-type: none"> ▪ Support financial sustainability/reimbursement for community health workers (#2) ▪ Promote patient-centered medical homes and the Planned Care Model (#1) ▪ Support health care organization policies that sustain quality of care improvements for people with diabetes/pre-diabetes (#1) 	Best Practice for Systems of Care	<ul style="list-style-type: none"> ▪ People with diabetes should receive medical care from a physician-coordinated team. (S16) ▪ Care should be aligned with components of the Chronic Care Model (S48) <ul style="list-style-type: none"> – Optimize provider and team behavior – Support patient behavior change – Change the system of care
<i>Self-management education</i>	<ul style="list-style-type: none"> ▪ Self-management education¹²³⁷ <ul style="list-style-type: none"> – In community gathering places – Homes of children & adolescents with T1 DM 	<ul style="list-style-type: none"> ▪ Support financial sustainability/reimbursement for DSME/CDSM programs (#2) ▪ Expand reach of DSME/CDSM programs to reach vulnerable populations (#2) 	Best Practice for DSME and support	People with diabetes should receive DSME upon diagnosis and as needed thereafter. (S24)

Controlling Diabetes, *cont.*

	USPSTF / Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Diabetes health care recommendations</i>	<ul style="list-style-type: none"> ▪ Disease management programs^{12,38} <ul style="list-style-type: none"> – Glycemic control – Provider monitoring (GHb) – Neuropathy screening – Lipid monitoring – Nephropathy screening – Diabetic retinopathy screening 		<ul style="list-style-type: none"> ▪ Best Practice for Diabetes/Pre-Diabetes Case Management (part) ▪ Best Practice for Diabetes in Pregnancy (part) ▪ Best Practice for Oral Health Care ▪ Best Practice for Pharmaceutical Care ▪ Best Practice for Cardiovascular Health and Diabetes (part) ▪ Best Practice for Screening for Chronic Kidney Disease ▪ Best Practice for Diabetes Eye Care ▪ Best Practice for Foot Care 	<ul style="list-style-type: none"> ▪ Diabetes Care recommendations (S18) <ul style="list-style-type: none"> – Glycemic Control – Medical Nutrition Therapy Reassess when treatment goals are not met – Intercurrent illness – Hypoglycemia – Bariatric surgery – Immunizations ▪ Prevention and management of diabetes complications (S28) <ul style="list-style-type: none"> – Neuropathy screening and treatment – CVD – Hypertension – Lipid management – Antiplatelet agents – Smoking cessation – CHD screening and treatment – Nephropathy screening and treatment – Retinopathy screening and treatment – Foot care

Controlling Diabetes, *cont.*

	USPSTF / Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Health communications</i>		<ul style="list-style-type: none"> ▪ Support health communication to increase access to sustainable self-management education and support services (#2) ▪ Support health communications to improve quality of care for people with diabetes (#1) 	Best Practice for Diabetes Prevention and Care (part)	
<i>Tobacco cessation</i>		Increase access to smoking cessation services for people with diabetes (#2)	<ul style="list-style-type: none"> ▪ Best Practice for Cardiovascular Health and Diabetes (part) 	
<i>Diabetes in particular settings</i>		Encourage <i>worksites</i> policies/environmental supports that contribute to improved control of ABCS (#2)	Best Practice for School Health: Promoting Healthy Eating and Physical Activity and Managing Diabetes in the School Setting (part)	
<i>Emotional health, social situation</i>			Best Practice for Depression Care	Patients' psychological and social situation should be assessed as an ongoing part of the medical management of diabetes. (S26)

Controlling Diabetes, *cont.*

	USPSTF / Community Guide	CDC/DDT (intervention) ⁹	IHS Diabetes Best Practice ¹⁰	ADA (supplement page) ¹¹
<i>Reimbursement</i>		Support implementation and maintenance of reimbursement policies(#1) <ul style="list-style-type: none"> – to reduce patient costs - copayments, medications & supplies, – employ provider incentives and performance-based payments, – value-based insurance designs, help un- and under-insured people with diabetes. 		MNT should be adequately reimbursed (S21)
<i>Promote physical activity</i>			Best Practice for Physical Activity for Diabetes Prevention and Care (part)	People with diabetes should be advised to perform ≥ 150 minutes/week of physical activity (S25)

References

Part II: Data

¹ AK Dept of Labor and Workforce Development, Research and Analysis Section. Population 2000-2011 by Borough/Census Area. <http://labor.alaska.gov/research/pop/estimates/data/TotalPopulationBCA.xls> (printed 5/14/2012)

² Frazee T, Jiang J and Burgess J. *Hospital Stays for Patients with Diabetes, 2008*. AHRQ H-CUP Statistical Brief #93. 8/2010. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb93.pdf> (printed 6/22/2012)

³ Dall T, Mann ES, et al. Economic Costs of Diabetes in the U.S. 2007. *Diabetes Care* March 2008; 31(3); 596-615. <http://care.diabetesjournals.org/content/31/3/596.full.pdf+html> (printed 6/5/2012)

⁴ Cowie CC et al. Full Accounting of Diabetes and Pre-Diabetes in the U.S. Population in 1988-1994 and 2005-2006. *Diabetes Care*. Feb 2009; 32(2); 287-294,

⁵ This website has a complete description of research associated with the Diabetes Prevention Program and its results: <http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/> (printed 8/15/2012)

⁶ AK Diabetes Program. Pre-Diabetes and Blood Glucose Testing in Alaska, 2008. *Epidemiology Bulletin* 5/10/2010; Alaska Division of Public Health. http://www.epi.hss.state.ak.us/bulletins/docs/b2010_13.pdf

Part III: Goals and Objectives

⁷ Ratner RE, Diabetes Prevention Program Research. An Update on the Diabetes Prevention Program. *Endocr Pract* Jan-Feb 2006; 12 (Suppl 1); 20-4. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1762035/?tool=pubmed> (printed 8/15/2012)

Part IV: Evaluation

⁸ US Health Resources and Services Agency. *Clinical and Financial Performance Measures* <http://bphc.hrsa.gov/policiesregulations/performanceasures/> (printed 6/21/2012)

Appendix A

⁹ CDC/DDT. Core Diabetes Interventions and Strategies, Pilot Performance Indicators, and AAP Objectives (12/5/11) Email attachment to state Diabetes Prevention and Control program managers re: Guidance for Preparing/Submitting Year 3 Annual Progress Reports and FSRs 6/5/2012.

Intervention #1: Improve quality of clinical care for people with and at risk for diabetes to improve control of A1c, Blood pressure and Cholesterol, and to promote tobacco cessation (diabetes ABCS).

- Policy-related strategies:
 - Support implementation of policies within health care organizations that contribute to and help sustain quality care improvements for people with diabetes/pre-diabetes
 - Support implementation or maintenance of evidence-based reimbursement strategies and policies (e.g., reduced patient insurance copayments; public insurance reimbursement of medications and testing supplies; physician reimbursement incentives and performance-based payment; value-based insurance designs; assistance for un- or under-insured patients with diabetes)
- Clinical/health systems related strategies:
 - Promote adoption of models to improve delivery and quality care in clinical settings (e.g., Patient Centered Medical Home, Planned Care Model)
- Communication/Media related strategies:
 - Support health communication efforts or coalition initiatives that reinforce the interventions listed above to improve quality of clinical care for people with diabetes.

Intervention #2: Increase access to sustainable self-management education and support services for people with diabetes to improve control of ABCS.

- Community-related strategies:
 - Expand reach/spread of diabetes self-management education (DSME) and chronic disease self-management (CDSM) programs in community settings to reach vulnerable populations with greatest diabetes burden/risk.
 - Support implementation of policies/environmental supports within worksites that contribute to improved control of A1c, blood pressure and cholesterol and promote tobacco cessation among people with diabetes.
 - Increase access to tobacco cessation services for people with diabetes who smoke (e.g., quitlines, etc.).
- Policy-related strategies:

- Support implementation of policies that promote financial sustainability/reimbursement for DSME/CDSM programs.
- Support implementation of policies that promote financial sustainability/reimbursement for Community Health Workers (CHWs) involved in providing self-management education and support services for people with diabetes.
- Clinical/Health Systems-related Strategies:
 - Expand the role of allied health professionals (e.g., pharmacists, nurses, CHWs in providing diabetes self-management education (e.g., Asheville model)
- Communication/Media-related strategies
 - Support health communication efforts or coalition initiatives that reinforce the interventions listed above to increase access to sustainable self-management education and support services for people with diabetes.

Intervention #3: Increase access to sustainable, evidence-based lifestyle interventions to prevent/delay onset of type 2 diabetes among people at high risk.

- Community-related strategies
 - Increase access/availability and use of the 16-session core and 6-session post-core lifestyle program as an intervention targeting populations with multiple diabetes risk factors including but not limited to women with previously diagnosed gestational diabetes.
 - Facilitate access to safe, attractive, and affordable places for people with prediabetes or multiple diabetes risk factors to engage in physical activity, including but not limited to promotion of workplace policies and programs that increase physical activity.
- Policy-related strategies:
 - Partner with employers and health plans to offer the 16 session core and 6 session post-core lifestyle program as a covered benefit to prevent or delay onset of diabetes.
- Clinical/Health Systems-related strategies:
 - Implement systems to increase provider referrals of people with pre-diabetes or multiple diabetes risk factors to sites providing the 16 session and 6 post-core session lifestyle intervention program.
- Communication/Media-related strategies
 - Promote marketing campaigns or coalition initiatives to raise awareness about pre-diabetes among populations at risk and health care providers.

¹⁰ Indian Health Service. 2011 Revised Indian Diabetes Best Practices (home page)
<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBPList> (printed 8/17/12)

¹¹ ADA: http://care.diabetesjournals.org/content/35/Supplement_1/S11.full

¹² Listed under the *Interventions and Resources* tab of the Healthy People 2020 diabetes page:
<http://www.healthypeople.gov/2020/topicsobjectives2020/ibr.aspx?topicId=8>. (printed 5/1/12).

¹³ <http://www.uspreventiveservicestaskforce.org/uspstf/uspdiab.htm>

¹⁴ <http://www.uspreventiveservicestaskforce.org/uspstf/uspdiab.htm>

¹⁵ <http://www.uspreventiveservicestaskforce.org/uspstf/uspobes.htm>

¹⁶ <http://www.uspreventiveservicestaskforce.org/uspstf/uspchobes.htm>

¹⁷ NDEP Small Steps Big Rewards, Toolkit for providers
<http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=118>. Note: This resource was not specifically mentioned in the PowerPoint slides.

¹⁸ <http://www.thecommunityguide.org/pa/behavioral-social/individuallyadapted.html>

¹⁹ <http://www.thecommunityguide.org/pa/behavioral-social/community.html>

²⁰ <http://www.thecommunityguide.org/pa/environmental-policy/improvingaccess.html>

²¹ <http://www.thecommunityguide.org/pa/environmental-policy/communitypolicies.html>

²² <http://www.thecommunityguide.org/pa/environmental-policy/streetscale.html>

²³ <http://www.thecommunityguide.org/obesity/communitysettings.html>

²⁴ <http://www.thecommunityguide.org/obesity/TechnologicalCoaching.html>

²⁵ <http://www.thecommunityguide.org/worksites/flu-hcw.html>

²⁶ <http://www.uspreventiveservicestaskforce.org/uspstf/uspdiat.htm>

²⁷ <http://www.thecommunityguide.org/pa/campaigns/community.html>

²⁸ <http://www.thecommunityguide.org/healthcommunication/campaigns.html>

²⁹ <http://www.thecommunityguide.org/worksites/ahrf.html>

³⁰ <http://www.thecommunityguide.org/obesity/workprograms.html>

- 31 <http://www.thecommunityguide.org/pa/environmental-policy/podp.html>
- 32 <http://www.thecommunityguide.org/tobacco/worksite/smokefreepolicies.html>
- 33 <http://www.thecommunityguide.org/tobacco/worksite/incentives.html>
- 34 <http://www.thecommunityguide.org/worksite/flunon-hcw.html>, <http://www.thecommunityguide.org/worksite/flu-hcw.html> (healthcare workers)
- 35 <http://www.thecommunityguide.org/pa/behavioral-social/schoolbased-pe.html>
- 36 <http://www.thecommunityguide.org/diabetes/casemgmt.html>
- 37 <http://www.thecommunityguide.org/diabetes/selfmgmteducation.html>
- 38 <http://www.thecommunityguide.org/diabetes/diseasemgmt.html>



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