Diabetes Partners in Prevention: A Publication of the Connecticut Department of Public Health Fall 2010

MANAGING THE SPACE BETWEEN VISITS: TELEPHONIC DISEASE MANAGEMENT FOR UNDERSERVED PATIENTS WITH DIABETES

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Telephonic disease management has been used to improve chronic disease outcomes and reduce healthcare costs for many different chronic illnesses, including diabetes. However, published reviews on such programs for diabetes have been mixed. Diabetes affects the poor and members of ethnic/ racial minorities at a higher rate than other groups. Disease management, with its emphasis on self management, adherence, screening, and frequent contact outside the medical setting would seem to be ideally suited to improve outcomes for such patients. To test this hypothesis we designed a nurse-led telephonic diabetes disease management intervention in a Community Health Center.

In order to more critically assess the impact of this project, we designed it as a randomized, controlled trial. All patients had type 2 diabetes and most were Hispanic or African American, urban-dwelling, with low socio-economic status. Nearly all had Medicaid or were uninsured. Patients were randomized to receive calls from specially trained, bilingual nurses between once per week and once per month, depending on severity of illness, or to usual care. Calls focused on self management goal setting and problem solving. Telephone contacts were documented in the electronic health record and communicated to front line staff.

A total of 146 patients were randomized to the intervention and 149 to the control group. Depressive symptoms were highly prevalent in both groups. Patient surveys and focus group interviews showed a high degree of satisfaction with the intervention. However, we were unable to demonstrate significant differences between the intervention and control group for any of the clinical or behavioral outcome measures including HbA1C, BMI, systolic or diastolic blood pressure, LDL cholesterol, smoking, or intake of fruits and vegetables, or physical activity.

Despite a rigorous design and a high risk population, this project did not improve clinical or behavioral outcomes at one year as compared to usual care. Challenges included high rates of depression, difficulty reaching patients, and excellent "usual care" at the Community Health Center. While self management has been shown to improve outcomes for diabetes, most healthcare providers are ill equipped to provide self management training, and many patients with diabetes fail to engage with such programs. Often the most poorly controlled patients lead the most chaotic, unstructured lives, limiting their ability to participate in highly structured interventions. Telephonic interventions provide a higher degree of convenience and acceptability to patients as well as being more scalable than the face to face programs. However this intervention did not produce demonstrable improvements in outcomes, adding to recent literature questioning the benefits of telephonic disease management. Further research is needed to develop new strategies to assist underserved patients with diabetes self management.




Influenza Vaccination and Diabetes

By Stephanie M. Poulin, MPH, MT(ASCP), Epidemiologist, Connecticut Department of Public Health

In the years 2007 to 2009, 20,154 Connecticut adults responded to the Behavioral Risk Factor Surveillance System (BRFSS) telephone surveys. Based on the BRFSS data, an estimated 6.9% of Connecticut adults have been diagnosed with diabetes. According to the Centers for Disease Control and Prevention (CDC), individuals with diabetes are more likely to develop severe complications from influenza that result in hospitalizations. Compared with persons without diabetes, mortality from pneumonia and influenza is estimated to be at least seven times higher among persons with diabetes diagnosed before age 30 years. Annual vaccination is the most effective means of preventing influenza and its complications.

In Connecticut, approximately 68.3% of adults diagnosed with diabetes reported receiving the influenza vaccine in the past year. Among CT adults with diabetes, those who were 65 years old and older were more likely to have received an influenza vaccine than adults 18-64 years old (79.8% compared to 59.4%). Approximately 70.0% of CT adult males with diabetes and 66.5% of CT adult females with diabetes received the influenza vaccine.

The national Healthy People 2010 goal for influenza vaccine coverage for non-institutionalized adults 65 years old and older is 90%. The goal for high-risk adults 18 to 64 years old is 60%. These goals have not yet been met despite the CDC's recommendation that persons at higher risk for influenza complications receive the influenza vaccination.

The CDC recommends that the influenza vaccination be administered to all persons aged ≥6 months. The vaccination may be administered as soon as the 2010- 2011 vaccine becomes available. More information on influenza can be found at www.cdc.gov/flu.

Diabetes Accomplishments at CHCs

By Leila Bruno, RD, CDE, Community Health Services and Anne Camp, MD, Fair Haven Community

Two Connecticut Community Health Centers have recently received important distinctions. Both of them serve an ethnically diverse population with a high percentage of patients who are uninsured or under-insured.

The Diabetes Education team at Community Health Services (CHS) in Hartford has achieved recognition status by the American Diabetes Association for the diabetes education services provided, CHS is the only Community Health Center in Connecticut to receive this designation.

Fair Haven Community Health Center in New Haven has had four of its physicians receive National Committee for Quality Assurance / American Diabetes Association Recognition. This voluntary program evaluates 10 measures covering such areas as HbAlc control, blood pressure control, and nephropathy assessment, recognizing clinicians who use evidence-based measures and provide excellent care to their patients with diabetes. They join an elite group of only 77 physicians in the state of Connecticut who currently have this certification.

Health information technology and exchange (HITE) in Connecticut and the nation is undergoing a major overhaul, By Lynn Townshend

Under the 2009 American Recovery and Reinvestment Act (ARRA), billions of dollars are being invested to build a secure and cohesive health information system. Among the goals of the project are to improve health care quality and access for all, to reduce the delivery of duplicative and unnecessary tests, medications and services.

As the state-designated lead agency for HITE, the Connecticut Department of Public Health (DPH) recently received $720,000 of these ARRA funds from the federal Office of the National Coordinator (ONC) for Health Information Technology. DPH is using this funding to develop a strategic and operational plan for interstate and intrastate health information exchange (HIE). Upon approval of the plan by ONC, DPH will receive an additional $6.6 million to create a sustained and secure HIE, leveraging the state's current health information landscape, which includes partnerships with eHealthConnecticut, and the Connecticut Departments of Social Services and Information Technology.

DPH expects to complete the HIE planning process in late 2010, at which time a new quasi-public state agency will take over statewide HITE oversight and implement the operational phase of Connecticut's HIE plan. Known as the Health Information Technology Exchange of Connecticut (HITE-CT), it is governed by a 20-member volunteer Board of Directors. By statute, HITE-CT Board members come from across the spectrum of consumers, state agencies, hospitals, providers, and other stakeholders.

For the latest on Health Information Technology & Exchange, visit www.ct.gov/dph.

Chronic Disease Program funded
By ARRA, Sarah Gaugher, MPH, Dept of Social Services

The CT Department of Social Services, Aging Services Division in partnership with the CT Department of Public Health and the CT Area Agencies on Aging in the Western, Southwestern and Eastern regions is currently part of an exciting grant. Funded by the U.S. Administration on Aging the objective is to bring evidence-based health promotion programs to senior centers, senior housing and community based health organizations. The goal of this 2 year American Recovery and Reinvestment Act initiative is to build a core of group leaders/facilitators for the Chronic Disease Self-Management Program (CDSMP) or, as we call it, the "Live Well" Program.

The CDSMP is a nationwide, cost effective program researched and developed by Stanford University that provides workshop participants with techniques to manage their chronic diseases and enhance their quality of life. It helps participants with ongoing health conditions such as arthritis, diabetes, high blood pressure, anxiety, heart disease and others to find better ways of dealing with pain and fatigue, discover easy exercises to help improve or maintain strength and energy, learn the appropriate use of medications, improve nutrition, talk effectively with family, friends and health professionals.

Taught by specially trained leaders, it provides opportunities for interaction and group problem solving. For more information about Live Well contact Cindy Kozak at (860) 509 –7737 or cindy.kozak@ct.gov

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