The Connecticut Diabetes Prevention and Control State Plan Updates
December, 2011

On October 2, 2007 the Department of Public Health (DPH), Diabetes Prevention and Control Program, released the Connecticut Diabetes Prevention and Control Plan (CTDPCP) for 2007-2012. This plan represents the insight of over seventy partners from around the state representing a variety of expertise. Each participating partner provided input into one or more workgroups that included: Diabetes Prevention, Disease Management, Access and Policy, Education and Awareness, and Surveillance. Each group developed goals, objectives, and strategies to address diabetes in Connecticut.

This is the fourth update designed to inform diabetes stakeholders in Connecticut of the progress made on these goals, objectives, and strategies. The update covers October 1, 2010 through September 30, 2011. Updates are reported from DPH projects and from initiatives of community partners. Partners were asked to report on the progress of meeting the objectives in the CTDPCP through an e-mail survey in November, 2011. This updates document represent the responses from the survey. There are other initiatives taking place across the state.

The DPH and our partners have made significant achievements with the use of limited resources. To enable the implementation of the Plan objectives through enhanced funding, the CTDPCP provided a grant writing technical assistance program on February 24, 2011 for community-based organizations. Evaluations from the program were extremely positive. Attendees were then charged to pursue grant funding. A follow-up survey with attendees indicates at least one organization that attended the session pursued, and was awarded, grant funds.

Within DPH the CTDPCP has been part of two grants during the time from October 1, 2010- September 30, 2011. The Community Transformation Grant (CTG) and the Coordinated Chronic Disease Prevention and Health Promotion Grant.

DPH is proud to provide this update on progress made thus far. The following pages highlight achievements and updates under the appropriate objective for each work group. Please note that only the objectives that had specific achievements or updates are listed below.

Diabetes Prevention

Prevention Objective 1: By 2012, reduce by .5% the prevalence of type-2 diabetes by preventing or delaying the progression of pre-diabetes to diabetes. This is being achieved by:

1. **Increasing the awareness of providers and people with pre-diabetes about the potential to prevent diabetes onset through lifestyle change, and by developing and promoting pre-diabetes screening programs accessible to all at risk Connecticut residents with referrals to health care providers as appropriate.**

Updates:

St Francis Hospital, in collaboration with the Ethel Donahue Tripp Research Center at the University of Connecticut and Mercer College in Macon, GA area plying the Diabetes Prevention Program interventions with participants who have tested positive for pre-diabetes. They are in the third year of this study with African American churches in Hartford and Middletown.

The City of New Haven and the Community Alliance for Research and Engagement has instituted the Healthy Corner Store Initiative. This program encourages grocers to stock more healthy products in a prominent, eye catching fashion. It provides the grocers with free advertising, whole sale pricing and free delivery from local farms. It is couples with the "Health Heroes" programs in New Haven schools which incentivize students and families to eat healthy. As of Nov 2011, four stores are participating.

A grant from the Community Alliance for Research and Engagement brought together Fair Haven Community Health Center (FHCHC), Quinnipiac River Park, City Seed Farmer's Market and the Chatham Square Neighborhood Association on the "Prescription for Produce" program. This initiative enabled ten families participating in the FHCHC Diabetes Prevention Program to use vouchers for fruits, vegetables and whole grain breads at the farmers market. Of the 959 coupons redeemed over the thirteen week program, 233 were used for fruit, 449 for vegetables and 128 for whole grain bread.

The Heart Center of Greater Waterbury conducted a series of presentations called "Sugar Tips-Preventions and Detection of Diabetes" in the greater Waterbury area at senior centers including Prospect, Wolcott and Southbury. The topics covered include what is diabetes; you are what you eat, carbohydrate counting and complications from diabetes.

The DPCP worked with two YMCAs in the state to promote the Diabetes Prevention Program taking place in New Haven and Wilton.

Researchers at the Yale School of Nursing have completed an obesity prevention program in three New Haven area high schools. The program, called Health-e-Teen, was a web-based and highly interactive program focused on increasing healthy eating and physical activity behaviors and self-efficacy in teenagers. Health-e-Teen was highly successful with regards to reach (over 600 students accessed the program), participation, satisfaction. Students enrolled in the study also significantly improved health behaviors. The second version of the program is currently being planned. We have also implemented a diabetes prevention program provided by homecare nurses to residents of subsidized housing. Over 60 adults at risk for type 2 diabetes participated in a group-based interactive class. Preliminary results indicate a significant improvement in health behaviors at 3 months.

Disease Management

Disease Management Objective 1: By 2012, increase by 50% the number of Connecticut physicians and other health care providers who use ADA and other evidence-based guidelines to diagnose and monitor pre-diabetes and diabetes as measured by the number of physicians recognized by the National Council on Quality Assurance (NCQA). This is being achieved by:

1. **Promoting the adoption and integration of ADA and other evidence-based guidelines into clinical practice to support early diabetes diagnosis and use of ABC (A1c, blood pressure, cholesterol) values.**

Dr. Rippel at Quinnipiac Internal Medicine P.C. became the first solo practitioner in Connecticut to be recognized by the National Committee for Quality Assurance (NCQA) as a Level 3 Patient Centered Medical Home.

Saint Francis HealthCare Partners has promoted the NCQA Physician Recognition Program to their 625 community physicians. To date 40 have achieved this designation.

There are currently 119 physicians who have achieved diabetes recognition by NCQA.

Disease Management Objective 2: By 2012, improve patient care by increasing the number of health care providers using electronic medical records or disease registries by 10% to establish a statewide health data exchange, increase outreach, and improve communication among providers. This is being accomplished by:

1. **Developing effective communication vehicles to demonstrate the value of reporting clinical outcomes to providers using evidenced-based literature, peer-to-peer outreach and other means, and showing providers how such clinical outcomes reporting through incentive programs, or other vehicles, can be valuable for their patients, their practices, and others.**

Community Health Center Inc., New Britain used electronic health record generated reports to identify patients with A1c> 9% then recruited fifty patients to participate in ninety minute long shared medical appointments. Twenty four patients completed the intervention by attending group visits with physicians, clinical pharmacists, nurses, psychologists certified diabetes educators and dietitians. Over a four month period patients received education, immunizations, foot exams, retinal and depression screens and medication therapy management. Average baseline A1c was 10.3%. 71% of patients saw an improvement in A1c with the average A1c after 3 months at 8.7%.

Through the Clinical Issues Committee at the Community Health Center Association of CT Patient Centered Medical Home Initiative, clinical leaders from 13 of our state's Federally Qualified Health Centers share best practices in diabetes management.

The DPCP worked with Optimus Community Health Center to improve diabetes outcomes. From July 2010- Dec 2010 the number of patients with an A1c done every four months increased by 20% and the percent of patients with A1c at goal (less than 7%) also improved.

Disease Management Objective 4: By 2012, increase by 5% the percentage of adults, age 18 and older, that are conducting comprehensive self-management to control their disease. This is being achieved by:

1. **Assessing current disparities and creating plans to remove identified disparities through culturally focused diabetes care, and involving community leaders in creating community health initiatives.**

Community Health Center Inc., Meriden provides patients with one-to-one pharmacist appointments to assess drug therapy and recommends modifications as needed to the patient's primary health care provider. Pharmacists also provide medication and disease state education to the patient.

Education and Awareness

Education and Awareness Objective 1: By 2012, increase by 5%, the proportion of people with diabetes participating in diabetes self-management education programs in order to learn about controlling their diabetes. This is being accomplished by:

1. **Making available training curricula options for patient education.**

Updates:

There are twenty eight out-patient diabetes education programs across the state recognized by either the American Diabetes Association or the American Association of Diabetes Educators. Most of these centers also provide in-patient diabetes education and many of these centers accept students in various fields including nursing, dietetics and pharmacy.

The CT DPCP was awarded the "Evaluating Diabetes Group Education" grant from the National Association of Chronic Disease Directors. Working with Norwalk and Windham Hospital as intervention sites and Backus Hospital and the Hospital of Central Connecticut as central sites, data on patient satisfaction with Healthy Interactions Conversation Maps was collected and is currently being analyzed.

The East Hartford Community Health Center provided a diabetes breakfast on October 19 for twenty five patients with diabetes. Healthy foods were offered, education session was conducted and patient set self - management goals while benefiting from the group dynamics and sharing of ideas.

William W. Backus Hospital partnered with Life scan to provide diabetes information and meters to employees at the Mohegan Sun Casino.

Five local health departments provided diabetes self-management education programs as part of their block grant offerings to their communities.

Cardiac Rehabilitation Centers at Johnson Memorial and other Hospitals provide diabetes education materials to all their patients with diabetes.

The CT DPCP worked with the Connecticut Association of Diabetes Educators to design, produce and distribute a poster promoting diabetes education as a Medicare part B benefit.

The CT DPCP Worked with the Department of Social Services/ Aging Services Division to implement the Stanford University Chronic Disease Self-Management Program. From April 2010- July 2011 116 leaders have been trained and 464 people with chronic diseases have participated in the program.

Charter Oak Community Health Center provides weekly classes to patients on basic dietary instruction and medical compliance. This is taught in an open forum format by a Nurse Educator and Registered Dietitian. Attendees are welcome to stop in for 10 minutes or 2 hours. Food demonstrations with use of food models, pictures and hands on tasks are offered. Patients arrive with questions and concerns that need further clarification based on instruction provided by the doctor. This format has been successful because patients do not feel pressured or stressed for time.

CHC Inc. in Meriden conducts diabetes and depression group led by a pharmacist and psychologist to educate patients on medications, lifestyle medication and self -management.

The American Diabetes Association of Connecticut and Western Massachusetts conducted programs for patients/families. 2,700 people with diabetes and their families attended the April 2011 Expo. 1067 of them received free health screenings.

Hartford Hospital Diabetes Life Care participated in a variety of health fair events as Lunch and Learn presentations.

Cornell Scott Hill Health Center reaches out into the community to provide frequent screenings. They also conduct a monthly diabetes support group and twice weekly Zumba classes.

The National Kidney Foundation provides a free screening to individuals at high risk for kidney disease as well as those who do not have insurance or are underinsured. This screening is called KEEP, Kidney Early Evaluation Program. KEEP consists of blood pressure measurement, glucose testing, urinalysis, height and weight measurement, hemoglobin, lipid panel, A1c and estimated Glomerular Filtration Rate. Doctors go over the results from the day of the screening and the blood draw results are sent to the participant from the National office. There is contact with all participants after the screening to see if the participant is following up with their healthcare professional. The National Kidney Foundation serving CT and Western Massachusetts has screened over 6000 people at 131 KEEPs in the past ten years.

Hartford Hospital Diabetes Life Care participated in a variety of health fair events as Lunch and Learn presentations

Optimus Community Health Center/Stamford site was awarded a $125,000 grant from General Electric for diabetes and nutrition education. The grant also supports their dental program.

Education and Awareness Objective 2: By 2012, increase by 10% the number of providers who participate in continuing education programs focused on diabetes. This is being achieved through:

1. **Conducting professional education with a curriculum that incorporates best practices and prevention guidelines (e.g., Grand Rounds, CMEs, etc.) for physicians/providers involved in providing diabetes services.**

Seventy physicians and certified diabetes educators attended the Annual Endocrinology Seminar in September, 2011 and 105 health care professionals attended the Annual Symposium. Both of the professional seminars offered continuing education credits.

Eighty five health care professionals attended the CT DPCP the annual Diabetes Review and Update October 2011.

Thirty-three health care professionals from Community Health Centers across the state attended the May, 2011 Chronic Kidney Disease program sponsored by the CT DPH.

Seventy five health care professionals attended “An Epidemic Among Latinos: How to Improve Outcomes in Patients with Diabetes” sponsored by the University of Texas and promoted by the DPCP.

Sixty eight school nurses attended "What the School Nurse Needs to Know about Diabetes" program presented by staff from the DPCP and the CT Children's Medical Center which was offered as part of the annual nurse supervisor's meeting on September 28, 2011.

Surveillance Objective 1: By 2012, increase by 5% the number of hits to the diabetes surveillance web page as a means of increasing accessibility to the diabetes prevalence, morbidity, and mortality data. This is being achieved by:

1. **Disseminating available diabetes surveillance data to the general public through the CT DPH Website and other appropriate venues.**

Updates:

The *Diabetes Fact Sheet* and *Diabetes Prevalence in Connecticut* fact sheet were updated and posted on the CT Diabetes Surveillance System Website (www.ct.gov/dph/diabetesdata).

The report *The Burden of Diabetes in Connecticut* was updated and posted on the CT Diabetes Surveillance System Website (www.ct.gov/dph/diabetesdata).

At least 13 requests from partners for diabetes data were responded to from October 1, 2010 through September 30, 2011.

Number of diabetes webpages visits/downloads:

March 29, 2011 through Sept 29, 2011:

Web Page/Document	Visits/ Downloads*
Diabetes Surveillance Web Page	859
Diabetes Prevention & Control Program Web Page	645
Diabetes Partners in Prevention Newsletters	371
Diabetes Burden Doc	36
Diabetes Preventive Care Practices	16
Diabetes Surveillance Past Present Future	32
Diabetes Prevalence 2006 - 2008	46
Gestational Diabetes Mellitus Issue Brief	20
Diabetes Prevention & Control Plan 2007-2012	77

Diabetes Burden Doc 2010 (posted 6/2011)	89
Spring 2011 Diabetes Newsletter	14

*Note: These numbers are much lower than past reports because a new web monitoring tool, Google Analytics, is being used. Google Analytics is supposed to be more accurate than the previously used web monitoring tool.