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

Diabetes-related Lower Extremity Amputations, Betty Jung, RN, MPH, CHES, CT DPH

In the United States, diabetes is the leading cause of lower extremity amputations (LEAs). In 1997, 67% of LEAs were related to diabetes. National age-adjusted rates of diabetes-related LEA hospital discharges were 28 times those not related to diabetes.

Approximately two-thirds (66.7%) of diabetes-related LEA hospitalizations were paid by Medicare and an additional 8.1% were paid by Medicaid. LEA rates increased with age in both populations. For people with diabetes, peripheral neuropathy and peripheral vascular disease are major predisposing factors for LEAs. Other factors include the lack of adequate foot care and infection.

In Connecticut, for 2003, there was a total of 1,054 Connecticut hospital discharges for diabetes-related lower extremity amputations. The median length of hospital stay was 8 days. The median charge was $24,790, for a total of $40,469,946 in 2003.

Looking at selected subgroups, Connecticut males have 2.3 times the rate of LEA compared to females. Black residents have 3.5 times the rate of lower extremity amputations compared to white residents and 1.5 times the rate for Hispanic residents. Comparing Hispanics with Caucasians we see Hispanics with 2.2 times the rate of LEAs compared with white residents.

In summary, males and ethnic minorities are high risk groups for LEAs in Connecticut. Good medical management and consistent practice of preventive measures by people with diabetes can reduce the need for LEAs. For references or more information contact Betty Jung, RN, MPH, CHES at (860)509-7711 or betty.jung@po.state.ct.us

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Keeping Connecticut Healthy

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J. Robert Galvin, MD, MPH, Commissioner

Profiling Variation in Outpatient Care for Medicare Beneficiaries, Michelle Kelvey-Albert, Qualidigm

The Centers for Medicare & Medicaid Services (CMS) contracts with Quality Improvement Organizations (QIOs) in the United States to work on targeted health-care quality initiatives. These initiatives are focused on settings of care in physicians' offices, hospitals, nursing homes, and home health agencies. In the outpatient physician office setting, targeted services include improving the rates of: annual mammography screening and annual A1c, biennial eye exam, and biennial lipid profile for chronic disease management of diabetes.

Qualidigm, the Medicare QIO for Connecticut, is reporting the rates of these outpatient services for Medicare beneficiaries on its website (www.qualidigm.org). Maps of Connecticut illustrate the rates for whites and non-whites by Health Service Area. The maps highlight variation across small local areas and between whites and non-whites. Qualidigm is currently working with health care providers to improve the rates of these services. By reporting these rates publicly, Qualidigm hopes to facilitate ongoing efforts to make improvements in care, especially for the underserved. By working with existing resources and helping to mobilize the community, our goal is to increase outreach to the underserved, thus increasing the rate of preventive services. To join these initiatives with Qualidigm contact Michelle Kelvey Albert, Health Educator at 860-632-6367 or at malbert@ctqio.sdps.org

Two Connecticut Educators Are in the News, Cindy Kozak, RD, MPH, CDE, CT Department of Public Health

Gerralyn Spollett, MSN, C-ANP,CDE received this year's Outstanding Educator in Diabetes from the American Diabetes Association. Gerralyn is the Associate Director of the Yale Diabetes Center where she is involved in diabetes education, research and clinical work as a nurse practitioner. As an educator, she specializes in developing programs for African Americans, Hispanics and Native Americans. She sees herself as a partner in diabetes care and is able to interface her education efforts with clinical disease management. She is also a frequent contributor to diabetes journals, is on the editorial board of Diabetes Spectrum and is the author and associate editor of *The Complete Nurses Guide to Diabetes.*

Carolé Mensing, RN, MA, CDE of the University of Connecticut Health Center recently completed her role as Editor in Chief for a book entitled *The Art and Science of Diabetes Self Management Education: A Desk Reference for Healthcare Professional*. This comprehensive resource features more than 800 pages of essential information written for educators by educators. There are three compelling sections including understanding the individual's health behavior and choices, translating science into art and facilitating successful self management. Each chapter concludes with pearls for the educator including teaching tips, demonstration ideas, and resources, as well as learning pearls for the person with diabetes.

Gerralyn Spollett

Carolé Mensing

Diabetes Care in an Urban Health Center, Anne Somsel, RN, Fair Haven Community Health Center

Patients with diabetes at Fair Haven Community Health Center in New Haven receive special care. By participating in the Health Disparities Collaboratives sponsored by Health Resources and Services Administration (HRSA) we are better able to assess, make changes and improve patient care following the Chronic Care Model. The six elements of the Chronic Care Model allow us to look at all aspects of patient care. The clinical information system data registry provides many reports for the individual patient, the clinicians and the center as a way to gauge where we are and what quality improvement we can undertake. This information helps to redesign the visit so that patients receive the full benefit of care including an eye appointment that is due or a needed mammogram. The reports can also tells us the average A1c and the percentage of patients with preventive screening tests in the last year. Patient education and self management goals can also be recorded.

Since 2000, the diabetes team at the center has made some positive changes to improve patient care and patient's involvement in the care. The health educator has offered diabetes education classes and one-on-one education/ adherence sessions. We have worked closely with the Social Services Department to obtain prescription assistance programs for those who cannot afford the medications and we have engaged an optometrist to provide free eye exams for our uninsured patients.

Being part of a larger network of community health centers is inspiring and valuable as we work to decrease the disparities our patients with diabetes face.

Yale–New Haven Health System Diabetes Collaboration, Jean Zimkus, RN, Yale New Haven Health System

Yale New Haven Health System, through its delivery networks, Yale - New Haven Hospital, Bridgeport Hospital and Greenwich Hospital , has formed a collaborative, interdisciplinary diabetes self-management education initiative. Diabetes educators and physicians from the Yale New Haven Health System have come together to provide innovative care and services to optimize the health and well-being of those affected by diabetes. Comprehensive diabetes self-management education classes are offered at each member hospital. The program incorporates a multidisciplinary team of healthcare professionals in collaboration with the individual and their support person(s) to promote sustainable lifestyle changes necessary for day-to-day management of diabetes as well as reduction of risk of chronic complications of diabetes.

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