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

Early Spring, 2007

Gestational Diabetes: Betty Jung, RN, MPH, CHES, CT DPH

Gestational diabetes (GDM) has been a legislative topic of interest ever since Senators Clinton, Collins and Lincoln introduced a bill (S. 3914. GEDI Act) to establish an Advisory Committee on Gestational Diabetes. GDM has risen 50% in the past ten years, and this increase has been attributed to the increase in obesity in the United States. Currently, four to eight percent of pregnant women in the United States are affected. Although there is disagreement about how to treat GDM, there is agreement that a strategy to educate health providers and patients about how to prevent GDM is key to addressing the problem.

In the Connecticut Diabetes Prevention and Control January, 2007 Diabetes Data and Surveillance Work Group teleconference, speakers from the national Centers for Disease Control and Prevention (CDC) Diabetes Program and the National Association of Chronic Disease Directors spoke about the epidemiology of GDM and current national efforts to identify the best methods to monitor the prevalence of gestational diabetes in the population. Validation projects are underway to look at how the diagnosis of GDM is being recorded in birth records, hospital discharge records and the Pregnancy Risk Assessment Monitoring System (PRAMS), CDC surveillance project . If you are interested in obtaining a copy of this presentation, please contact Betty C. Jung, at betty.jung@po.state.ct.us, or 860-509-7711.

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

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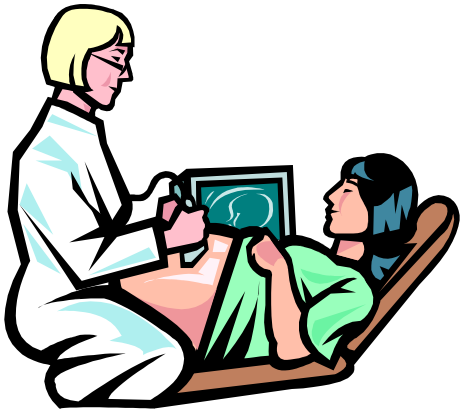
J. Robert Galvin, MD, MPH, Commissioner



Cardiac Rehabilitation Programs Address Diabetes:

Cindy Kozak, RD, MPH, CDE, CT DPH

The Connecticut Society for Cardiac Rehabilitation and the Diabetes Prevention and Control Program (DPCP) have partnered to promote diabetes education. Many patients participating in cardiac rehabilitation have underlying diabetes, however, many have not enrolled in a diabetes education program. The CT DPCP has distributed the Centers for Disease Control and Prevention publication "Take Charge of Your Diabetes" to several of the cardiac rehabilitation programs across the state. This 135 page book is written at a fourth grade reading level. It has chapters on a variety of topics including complications, emotions, sick days and dental disease. It is available in both English and Spanish. For a copy of the book please contact Cindy Kozak at (860)509-7737 or cindy.kozak@po.state.ct.us

The Chronic Care Model: Healthcare in the 21st Century:

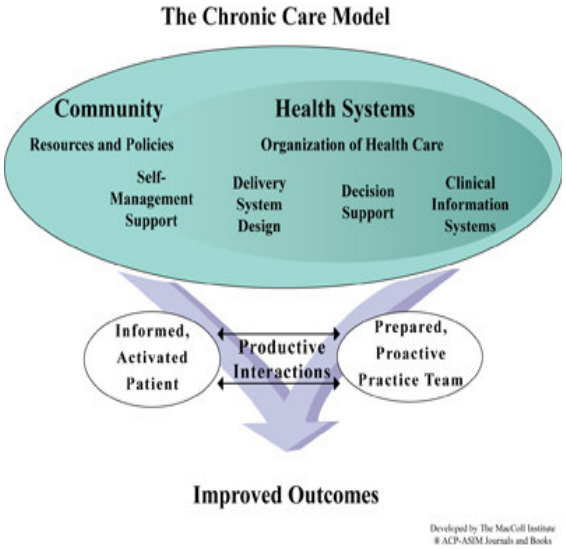
Christine Pinette, APRN, BC-ADM, Diabetes & Endocrinology of Northwestern CT

As we live longer, medical providers will need to deal with more chronic conditions. Over one 1 million Americans now have one of more "chronic conditions" – and that number is expected to grow exponentially as the "baby boomers" age.

The current system and methods of payment are structured around "episodes" of care such as acute illnesses, emergency department visits or hospital admissions. Ninety percent of federal healthcare dollars are now spent on the 10% of Medicare beneficiaries who need "rescue care"- high intensity services for crises and complications related to diabetes, heart failure and other chronic diseases. The recent PBS series "Remaking American Medicine" reports that the growth of healthcare costs keeps exceeding the growth of the gross domestic product and threatens our national economy.

The 2001 Institute of Medicine report "Crossing the Quality Chasm" concluded that the current system cannot meet the demands of chronic illnesses; that "trying harder" will not work; and that a "coordinated system" is needed to address chronic care needs of our population. The Chronic Care Model developed by Dr. Ed Wagner and the Institute for Healthcare Improvement provides a research-based framework to improve chronic care. Applying elements of "reliability science" to healthcare, this model emphasizes delivery systems that provide "the right care" (evidence based), for every patient (equal), every time (consistent). Patient self-management support, community resources, and clinical case management have the potential to prevent complications or crises. In such a system, well informed, "activated" patients work together with providers and multidisciplinary care teams to achieve the patient's goals. Clinical information systems are used to generate data enabling providers to improve care. In the next few years, payment will increasingly depend on the ability to report on quality. Providers who can see their own patient data will be in the best position to improve care in their practices.

To learn more about the chronic care model, go to www.improvingchroniccare.org.



Diabetes Collaborative Improves Patient Care in Connecticut's Health Centers: Susan McGuire, CT Primary Care Association

Drs. Jean Lange and Philip Greiner from Fairfield University presented an analysis of six years of aggregated data collected from seven community health centers participating in the Health Disparities Collaborative via a webcast on Dec. 19, 2006.

The collaborative is based on the Chronic Care Model. It features a redesign of health care delivery, utilizing a cross disciplined team of providers, computerized disease registry, evidence-based health interventions, patient self management and community collaborations. Baseline data showed steady increases in registry enrollment and number of patients receiving A1C tests. The average A1c dropped from 8.4% at baseline to 7.8%, slightly short of the national goal of 7%.

As the initiative progressed, more patients aged 55 or older received an Angiotension Converting Enzyme Inhibitor or an Angiotension Receptor Blocker (two medications for blood pressure control in people with diabetes), a blood pressure reading within the past 12 months and a lipid screen. The number of patients with a blood pressure within the recommended range of <130/80 mm Hg increased each year, as did the number of patients with a LDL level below 100 mg/dl. Other measures that showed improvement from those sites that collected the data were number of patients receiving an eye exam, foot exam or dental exam.

The data from correlational analyses indicate that the longer patients are in the collaborative, the more likely it is that they are reaching lipid and A1C goals and that if providers collect information on key variables, they are more likely to collect information on other variables.

According to the analysts, one possible interpretation of these findings is that as providers become accustomed to the process and data requirements, they are more likely to address and document those measures and outcome improvement.

One of the challenges that collaborative teams face is "spread," or replicating the clinical protocols with other providers and sites. Also, financial support for hiring a data entry staff is a challenge for many health centers. Finally, the health centers' patient population faces daily hardships in addition to managing their disease. Transportation, child care and lack of insurance all affect patient compliance and ultimately, patient outcome.