

West Virginia

Diabetes Strategic Plan

2002-2007



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Executive Summary

Diabetes is a serious chronic disease characterized by elevated blood glucose levels. In West Virginia it is estimated that 106,852 people (7.6% of the adult population) have been told they have diabetes. It is estimated that an additional 53,000 West Virginians have diabetes but are unaware of it. West Virginia ranked fifth in obesity and sixth in physical inactivity prevalence in 2000. These lifestyle measures combined with the fact that West Virginia has the oldest median age in the nation leads to an expected continued rise in both prevalence and incidence of diabetes.

The West Virginia Diabetes Strategic Plan was developed by a variety of health care professionals and community members interested in improving diabetes care. The rationale for developing the Diabetes Strategic Plan was to identify priority areas and select specific goals/objectives to decrease the burden of diabetes in West Virginia. The plan will provide guidance for diabetes prevention and control from 2002 to 2007.

The plan describes priority areas for systems change to significantly impact the current health care system. Goals, rationales, objectives and evaluation measures are proposed for each priority area. The five priority areas are:

1. Surveillance /Data Systems
2. Access
3. Education
4. Health Promotion, Wellness, and Prevention
5. Partnership/Collaboration.

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Introduction

Developmental Process

The purpose of West Virginia's Strategic Plan is to provide a framework to guide statewide diabetes prevention and control efforts from 2002 thru 2007. It is designed to serve as a blueprint for achieving goals determined by focus groups, Diabetes Advisory Committee members, West Virginia Diabetes Control Program staff and the Centers for Disease Control, Division of Diabetes Translation.

Planning for the West Virginia Strategic Plan began in April of 2002 with the Diabetes Advisory Committee (DAC) identifying members for a steering committee, the steering committee subsequently identified focus groups. The focus groups voiced concerns regarding diabetes care and access in West Virginia. These concerns were incorporated into the West Virginia Strategic Plan.

Because West Virginia has the highest median age in the nation, the initial focus group was held with community members interested in senior issues. The West Virginia diabetes educators were contacted by e-mail for suggestions, recommendations, concerns and issues. Pediatric issues were identified with this population's health care providers. Endocrinologists reviewed the document. Telehealth communications experts discussed addressing the issue of lack of healthcare and healthcare information that stems from geographical and cultural barriers.

Additional information used to determine the distal outcome objectives for diabetes management and care included: the West Virginia Healthy People 2010, the 10 Essential Public Health Services, Behavioral Risk Factor Surveillance Survey data, the CDC's national diabetes objectives and data from the "West Virginia Burden of Diabetes."

A draft of the plan was reviewed by DAC members.

The Diabetes Control Program

The West Virginia Bureau for Public Health's (WVBPH) Diabetes Control Program (WVDCP) received comprehensive funding from the CDC in 1998. The WVDCP promoted the guidelines for diabetes care by increasing resources for comprehensive population-based diabetes management and care. The WVDCP collaborated with partners as a means to promote the guidelines for diabetes management and care concepts to health care providers. This process enabled health care providers to meet more of the unmet needs of West Virginia's population with diabetes.

During the five-year period, the WVDCP's funded partnerships have included: West Virginia University Primary Care, West Virginia Association of Diabetes Educators, Marshall University School of Medicine, West Virginia University's Office of Health Services Research, West Virginia University Extension Service, West Virginia Medical Institute (West Virginia's Peer Review Organization), West Virginia Health Initiative Project (WVHIP), Ebenezer Medical Outreach and Charleston Area Medical Center, Education and Research Institute. The WVDCP has engaged in the process of improving diabetes management and care in rural clinics, and through community outreach, professional and public presentations and public service announcements.

The West Virginia Diabetes Advisory Committee was formed in 1991 to provide direction for the WVDCP. It is comprised of community and professional members. The membership is geographically distributed throughout the state. Their goals and objectives are listed in the appendix. One of their continued objectives has been to increase awareness of diabetes on a statewide basis. The Diabetes Advisory Committee collaborated with the West Virginia Library Commission and developed diabetes libraries within the public library system.

Diabetes in West Virginia

Defining the Scope of the Problem

The geography of West Virginia presents problems with access to quality health care. The surface elevation of West Virginia ranges from a low of 240 feet in the Valley of the Potomac to a high of 4,862 feet at Spruce Knob in Pendleton County. There is very little flat land in the state. Non-interstate travel through West Virginia can be treacherous, with numerous mountains to climb over narrow and winding secondary roads.

West Virginia is the second most rural state in the nation, with 64% of its population living in communities of fewer than 2,500. Forty-five of West Virginia's 55 counties are designated as rural, that is, "non-metropolitan" as defined by the Bureau of the Census. Almost 16% of West Virginia's population is aged 65 or older. If, as anticipated, the trend of an aging population continues, West Virginia can look forward to an older population presenting growing demands on the state's health care systems. This is an even greater burden in a state where transportation (access) problems continue to exist.

Rural Appalachian culture influences health in several important ways. Appalachians inhabit a particular mountain environment that separates them physically from other cultural groups and the resources of those groups. Thus, rural Appalachian culture has developed in a historical context of isolation and exploitation, which has assured major differences between Appalachian culture and the dominant urban culture. Many Appalachians are reluctant to enter the mainstream medical system except for emergencies. Health care interventions that are developed with consideration for Appalachian culture, values, language, and behaviors have been most successful in altering the health status of mountain dwellers.

Statistics show that Appalachian residents were found to be at significantly higher risk of injury and illness from seatbelt nonuse, obesity, overweight, and current smoking.

As with most rural areas, physician shortages are prevalent. The federal Division of Shortage Designation (DSD), Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services, designates an area as a Health Professional Shortage Area (HPSA). The designation is usually a geographic area consisting of a county or a sub-county region and is based on the ratio of primary care physician providers to the population. The state's Division of Recruitment (DOR) compiles the information and forwards it to the DSD. Currently in West Virginia there are 50 HPSA service areas that include all or part of 40 counties.

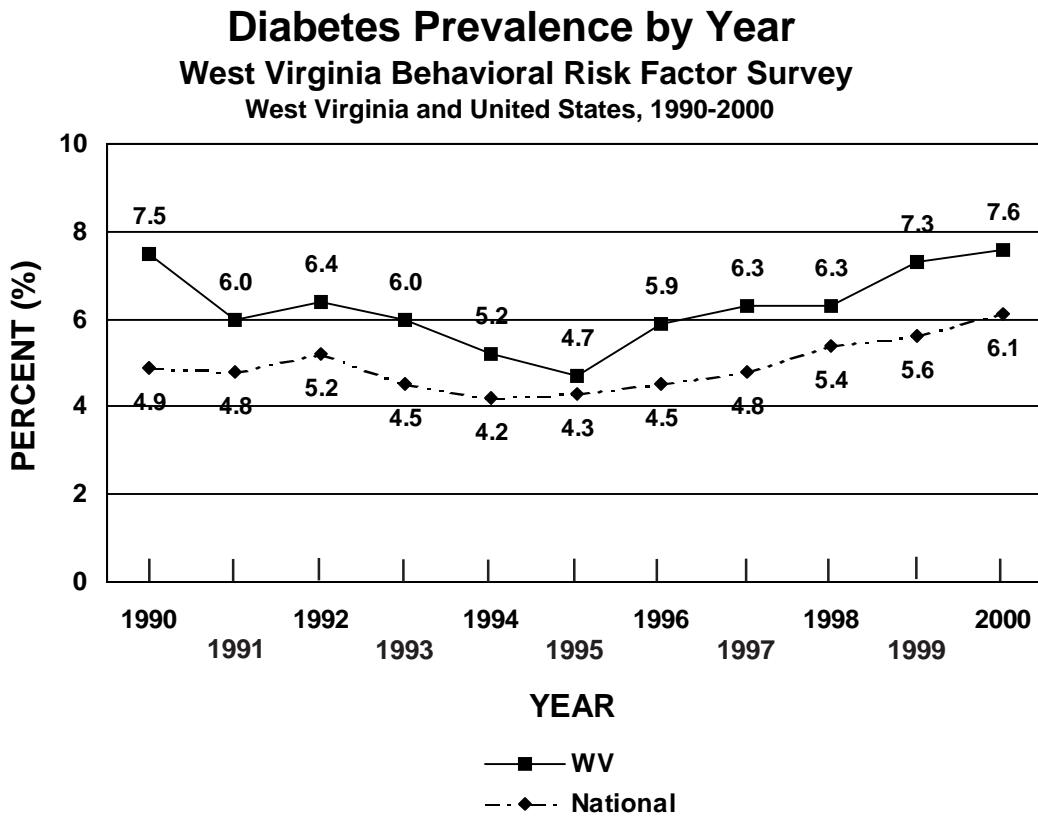
Prevalence and Demographic Distribution

The 2000 Behavioral Risk Factor Surveillance System (BRFSS) revealed an estimated diabetes prevalence of 7.6% among West Virginia adults (Figure 1). This equals approximately 106,852 West Virginian adults having been diagnosed with diabetes. An estimated 53,000 have diabetes but have not been diagnosed. This ranks West Virginia second in prevalence among the 52 states and territories.

BRFSS respondents who reported having diabetes from 1994-1999 were more likely to be older, female, and have less education and lower incomes than those without diabetes (Table 1). Sixty-nine percent (69.1%) of persons with diabetes were over the age of 55 years, compared to 31.0% of the persons without diabetes, and a slightly higher proportion were female (55.3% vs. 52.8%). Forty percent (40.1%) of persons with diabetes had less than a high school education, compared to 20.3% of those without diabetes. Approximately one-third (32.2%) of individuals with diabetes had incomes of less than \$15,000, compared to about one-fifth (19.9%) of respondents without diabetes.

Information on African-Americans was not included in Table 1 due to the small sample size. African-Americans made up only 3.2% of the state's population during the years of 1994-1999, however 10.7% of the African-American population had diabetes during that time period.

Figure 1



Source: West Virginia Health Statistics Center, 2001

Table 1

**DEMOGRAPHIC DISTRIBUTION BY DIABETES STATUS
1994-1999 West Virginia Behavioral Risk Factor Surveys**

CHARACTERISTIC	WITH DIABETES			WITHOUT DIABETES		
	Men	Women	Total	Men	Women	Total
	%	%	%	%	%	%
	44.7	55.3	100	47.2	52.8	100
AGE						
18-54	34.5	28.0	30.9	71.8	65.9	68.7
55-64	26.6	23.9	25.1	11.7	11.9	11.8
65+	39.0	48.0	44.0	16.3	21.8	19.2
EDUCATION						
<12 Years	36.8	42.8	40.1	19.8	20.8	20.3
12 Years	30.6	37.7	34.6	42.0	41.4	41.7
13-15 Years	19.8	13.4	16.3	20.4	22.6	21.6
16+ Years	12.7	5.5	8.7	17.6	15.0	16.3
Unknown	0	0.6	0.3	0.2	0.1	0.2
INCOME						
<\$15,000	25.1	38.0	32.2	16.5	23.0	19.9
\$15,000-\$24,999	27.6	26.5	27.0	23.5	22.8	23.1
\$25,000-\$49,999	28.9	13.6	20.4	32.5	27.5	29.9
\$50,000+	10.2	6.2	8.0	16.0	12.5	14.2
Unknown	8.1	15.8	12.4	11.5	14.2	12.9

Source: West Virginia Health Statistics Center, 2001

Morbidity

Hospitalization data provide additional insight into the burden imposed upon a population with diabetes and are the only measure available of the morbidity associated with the disease.

In 1998, there were a total of 242,723 inpatient hospital discharges of West Virginia residents in West Virginia. Of these, 40,571 (16.7%) records listed diabetes as any listed diagnosis, (i.e., any one of the first nine hospital diagnoses) while 3,685 (1.5%) listed diabetes as the primary discharge diagnosis.

In 1998, diabetes hospitalization discharge rates increased dramatically with age. Women had a higher rate of diabetes-related hospitalizations than men. Substantial variations in hospitalization rates were noted by county with higher concentrations in the southern portion of the state. Another significant finding in 1998 was that 35.6% of all diabetes-related hospital discharges in West Virginia had cardiovascular disease as the primary discharge diagnosis; this compared to 36.0% at the national level in 1996. Diabetes with circulatory disorders resulted in the longest average stay (15.7 days) for women, while diabetes with renal complications was the longest average stay among men (13.7 days).

The average length of stay (ALOS) has decreased both nationally and statewide. The ALOS for West Virginians having a primary diagnosis of diabetes was 7.0 days in 1998, which compared to the national average of 6.3 days in 1996. The ALOS for West Virginians with diabetes as any listed diagnosis was 6.6 days, compared to 6.5 days for the national average in 1996.

Diabetes-related hospital stays continue to cost more than the average hospital stay. The average charge per diabetes-related hospital stay was \$9,665, compared to an overall average charge of \$7,794. The most expensive diabetes diagnosis was diabetes with coma, with an average cost of \$17,446. The next most expensive in hospital costs were hyperosmolar coma at \$14,265 and peripheral circulatory disorders at \$13,073.

West Virginia ranked fifth in obesity and sixth in physical inactivity in 2000. The above lifestyle measures combined with the fact that West Virginia has the oldest median age in the nation leads to an expectation of continued rise in both prevalence and incidence of diabetes.

A summary of the 2000 BRFSS revealed that, of the persons interviewed who had been told that they have diabetes, 54% had at least two (2) HbA1c tests; 71.1% reported that their feet were examined by a health care provider at least once during the year; 65.6% reported that they received a dilated eye examination within the past year, and in 1999 the immunization rate was 59.3%.

The prevalence of end stage renal disease in West Virginia was 72.1 per 100,000 population in 1999. In 1999, 1,303 persons received kidney dialysis, of which 570 (44.0%) had a primary diagnosis of diabetes.

Mortality

In 2000 diabetes was the sixth leading cause of death in both the United States and West Virginia. There were 755 deaths in West Virginia due to diabetes as the primary cause in 2000. The age-adjusted rate per 100,000 population rose from 30.7 in 1995 to 35.7 in 2000. Mortality statistics seriously understate the burden of diabetes, because people often die from the complications of diabetes, which are then coded as the underlying, or primary, cause of death.

In 1995, West Virginia's age-adjusted diabetes mortality rate of 30.7 deaths per 100,000 population was 27.4% higher than the national rate of 24.1 per 100,000. A study of national and state trends in diabetes mortality from 1970 through 1995 revealed that prior to 1975 West Virginia had lower rates of diabetes mortality than the nation as a whole. Since then, West Virginia has reported higher rates of death due to diabetes than the national average. Table 2 illustrates the substantial rise in the mortality of both men and women in West Virginia.

Comparing race-specific death rates, little difference was noted between the white population in West Virginia and the United States until 1990-1995 (Table 2). In 1995, the WV white mortality rate was 29.6 per 100,000 population, compared with the U.S. white rate of 21.9. Nationally, the rates of diabetes mortality in blacks were consistently higher than whites over the 25-year period. This finding is even more dramatic in West Virginia; West Virginia's black mortality rate in 1995 was recorded at 71.6 deaths per 100,000, while the United States death rate was 49.0 deaths per 100,000.

Table 2

**RATES* OF DIABETES MORTALITY, BY GENDER, RACE, AND AGE
West Virginia and United States, 1970-1995**

		1970	1975	1980	1985	1990	1995
Total	W.V.	19.6	19.0	19.7	18.8	25.0	30.7
	U.S.	24.3	20.2	18.1	17.4	20.5	24.1
GENDER							
Male	W.V.	16.7	16.5	17.6	19.6	24.1	28.8
	U.S.	23.0	19.7	18.1	17.6	21.5	26.4
Female	W.V.	22.0	20.7	21.3	17.7	25.4	31.5
	U.S.	25.1	20.4	18.0	17.1	19.7	22.4
RACE							
White	W.V.	18.6	18.3	18.8	18.2	24.6	29.6
	U.S.	22.9	18.9	16.9	16.1	18.9	21.9
Black	W.V.	43.0	34.7	44.0	37.0	41.0	71.6
	U.S.	38.4	34.9	32.8	33.2	40.4	49.0
AGE							
0-44	W.V.	1.1	1.4	0.8	1.2	1.9	1.6
	U.S.	1.4	1.1	1.0	1.1	1.3	1.4
45-64	W.V.	23.7	20.6	20.4	22.8	33.5	34.5
	U.S.	25.3	21.1	20.3	20.0	25.2	29.4
65+	W.V.	115.4	108.9	114.1	94.7	109.7	146.4
	U.S.	168.2	132.1	110.6	101.7	114.4	134.3

*Rates are per 100,000 population adjusted by age to the 2000 U.S. standard million
Source: West Virginia Health Statistics Center, 2001

Target Populations of the West Virginia Diabetes Program

Citizens of WV

All citizens of WV are affected by diabetes. Some people are directly affected such as those with diabetes and their family members. Diabetes also affects the health care community, employers and third party payers.

Decision and Policy Makers

Recognition and understanding of a community health problem is the first action step. Support by those in decision or policymaking positions within the community requires their knowledge and understanding of community needs, medical and financial impacts, program benefits and implementation strategies. Success of health promotion efforts depend on the ongoing involvement and proactive commitment of community and organizational leaders.

Health Care Community

The health care community includes health care providers (physicians, nurse practitioners and physician assistants), certified and/or licensed health care professionals and ancillary staff. They are directly linked to the person with or at risk for diabetes. Interventions directed at this community provide opportunities to promote clinical care guidelines and best practices for treating those with diabetes and working with those at risk. Health professionals need to emphasize the essence of diabetes self-management and care to individuals with diabetes and their family members.

People with Diabetes

Interventions can and should be directed to people with diabetes at all stages of the disease. Effective measures taken by the person with diabetes and health care provider can improve current health status and may reduce risk of complications. Persons with diabetes need to understand the importance of personal responsibility for daily diabetes self-care and need to feel empowered to manage their chronic health condition. The elderly, Medicaid/Medicare recipients, uninsured/underinsured, low income and indigent, African-Americans and youth populations in WV have been selected as the focus for intervention activities.

Priority Areas for Systems Change

Surveillance/Data Systems

Goal: To maintain and improve measurement of the diabetes health care system in West Virginia.

Rationale: Surveillance is the ongoing systematic collection, analysis and interpretation of health data. Surveillance produces information used for program planning and monitoring progress of health objectives.

Process Objectives

- Maintain the current status of diabetes module in BRFSS
- Design linkages among various governmental/private sectors claim data
- Collect patient diabetes related data
- Assess the demographic distribution of diabetes related to WV's health care providers.

Process Evaluation Measures

- Continuation of BRFSS with diabetes module
- Number of governmental/private sources linked
- Number of data sources/systems identified
- Number of data sources/systems integrated for diabetes analysis (data base)
- Discrepancy analysis data needed/data available.

Impact Objectives

- Show prevalence and co-morbidities of diabetes
- Measure progress towards the national diabetes objectives and the WV Healthy People 2010
- Show the sociodemographics of WV
- Identify gaps in diabetes medical care
- Identify gaps in diabetes care awareness.

Impact Evaluation Measures

- Diabetes trends analyzed
- Create change to correct identified discrepancies, improve program outcomes and improve the surveillance system
- Statistical briefs
- Evaluation of WV Diabetes Control Program success in achieving national objectives.

Access

Goal: To improve health and reduce cost by increasing access and availability of quality diabetes services and care.

Rationale: Access to care was identified by the focus groups as a major barrier. Access to care issues relate not only to geographical distribution of quality providers and lack of transportation but also to financial resources to obtain medical care.

Process Objectives

- Promote utilization of clinical guidelines throughout the WV Primary Care System
- Promote and improve medical practice of Primary Care Physicians
- Establish self-management programs in the Free Clinics
- Persuade third-party payers of the advantages of quality diabetes care
- Develop community based resources/education/support groups
- Assess transportation availability within the state.

Process Evaluation Measures

- Number of primary care settings that have adopted or modified clinical guidelines
- Numbers of self-management programs established in Free Clinics
- Number of third-party payers that changed policies to improve quality diabetes care
- Completed transportation assessment.

Impact Objectives

- Increase availability of quality diabetes care and services
- Increase providers' adherence to diabetes protocols
- Promote development of diabetes registry
- Decrease disparities in diabetes care
- Increase access to and demand for services and supplies for the underinsured and uninsured.

Impact Evaluation Measures

- Improvement in the National Diabetes Objectives
- Percentage of increased access to services and supplies for the underinsured and uninsured
- Numbers of persons with diabetes participating in services and care.

Education

Goal: To increase awareness of current diabetes guidelines (standards of care, evidence based-practices and new technology) for prevention and control of diabetes and associated complications.

Rationale: Education is the foundation for achieving quality health care. The target population for education includes health care providers, health care professionals (Certified Diabetes Educators), persons with diabetes and the general public.

Process Objectives

- Identify the educational needs of the health care providers, health care professionals and ancillary personnel
- Assure access to quality health education for health care providers, health care professionals and ancillary personnel
- Identify, develop, implement and promote traditional/nontraditional innovative education strategies for health care providers, health care professionals, ancillary personnel and community members.

Process Evaluation Measures

- Delineation of educational needs of the medical professionals' health care providers, health care professionals and ancillary personnel
- Number and types of programs held and number and types of participants
- Number of innovative education strategies developed.

Impact Objectives

- Improve community awareness of the National Diabetes Objectives
- Improve diabetes management by medical professionals, health care professionals and ancillary personnel.

Impact Evaluation Measure

- Improve the status of the National Diabetes Objectives as measured by the BRFSS 2006.

Health Promotion, Wellness and Prevention

Goal: To establish linkages with existing programs and assist with developing new programs that promote positive health behaviors related to diabetes.

Rationale: Programs are needed to assist people to learn effective ways to take control of lifestyle factors that are associated with the onset of “prediabetes” and its complications. A review of the literature reveals that weight loss and physical activity may delay the onset of type 2 diabetes and does diminish associated complications.

Process Objectives

- Identify health systems/wellness programs addressing risk factors of diabetes
- Create and expand resources promoting healthy lifestyle changes
- Provide technical assistance to maintain/enhance programs.

Process Evaluation Measures

- Delineation of health systems/wellness programs
- Numbers of persons participating in health system/wellness programs.

Impact Objectives

- Increase availability of resources for healthy lifestyle changes
- Increase access to and demand for wellness programs and facilities
- Increase positive health behaviors.

Impact Evaluation Measure

- Improve the status of the preventable risk factors as measured by the BRFSS 2006.

Partnership/Collaboration

Goal: To promote improved diabetes health and reduce morbidity and mortality due to diabetes complications by utilizing statewide partnerships.

Rationale: Partnerships allow diverse individuals to work toward common goals. Collaborations with multiple systems, including community level “grass-roots,” key change agents, other chronic disease programs, health care systems and policymakers facilitate the pooling of resources for planning and promoting effective diabetes care.

Process Objectives

- Identify stakeholders
- Provide education and technical assistance for partners and associates
- Update the Diabetes Resource Manual
- Produce media campaign in collaboration with partners
- Promote the DCP as a community resource.

Process Evaluation Measures

- List of stakeholders and potential areas of contribution
- Updated and distributed Diabetes Resource Manual
- Numbers and type of media products
- Numbers of informational requests.

Impact Objectives

- Improve diabetes awareness in WV
- Expand geographical representation.

Impact Evaluation Measure

- Number and type of statewide collaborations.



Future Direction

While the purpose of this plan is to give direction and guidance to the stakeholders of diabetes, this document has not addressed all issues of diabetes management and care. Additional areas of concern include kidney disease, pregnancy counseling (GDM, type 1 and type 2) and type 1 diabetes and its complications. We are cognizant of the need for additional funding to facilitate and sustain changes identified in this document.



Appendix

CENTER FOR DISEASE CONTROL AND PREVENTION, DIVISION OF DIABETES TRANSLATION

National Diabetes Objectives

IMPACT OBJECTIVE #1—Establish measurement procedures to track progress

By the end of 2003, enhance measurement procedures and establish additional procedures to track program success in reaching the seven national objectives.

IMPACT OBJECTIVE #2—Rate of foot exams

By 2003, demonstrate success in achieving an increase in the percentage of persons with diabetes in West Virginia who receive the recommended foot exams from 1999 BRFSS baseline data of 74.2 percent to 80.0 percent.

IMPACT OBJECTIVE #3—Rate of dilated eye exams

By 2003, demonstrate success in achieving an increase in the percentage of persons with diabetes in West Virginia who receive the recommended eye exams from 1999 BRFSS baseline data of 59.3% to 70.0%.

IMPACT OBJECTIVE #4—Rate of immunizations

By June 30, 2003, demonstrate an increase in the percentage of persons with diabetes in West Virginia who receives the recommended influenza and pneumococcal immunizations from the 1999 BRFSS baseline data 59.3% to 61.8%.

IMPACT OBJECTIVE #5—Rate of HbA1c tests

By 2003, demonstrate an increase in the percentage of persons with diabetes in West Virginia who receive the recommended HgA1c tests from 1999 BRFSS baseline date from 17.9% to 30.0%.

IMPACT OBJECTIVE #6—Identify and reduce health disparities

By June 30, 2003, demonstrate success in reducing health disparities for high-risk populations with respect to diabetes prevention and control.

IMPACT OBJECTIVE #7—Establish linkages to promote wellness and physical activity

By June 30, 2003, demonstrate the establishment of useful programs for health promotion, physical activity, weight and blood pressure control and smoking cessation for persons with diabetes.

Ten Essential Public Health Services

1. Monitor health status to identify health problems.
2. Diagnose and investigate health problems and health hazards.
3. Inform, educate, and empower people about health issues.
4. Mobilize partnerships to identify and solve health problems.
5. Develop policies and plans that support individuals and statewide health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

The parameters of the 10 essential public health services will be revised to incorporate specific diabetes services.

A Healthier Future for West Virginia—Healthy People 2010 Diabetes Objectives

Objective 1:

Reduce perinatal mortality in infants of mothers with diabetes to no more than 12 per 1,000 births. (Baseline: 14.6 per 1,000 births from 1990-1999)

Objective 2:

Reduce the frequency of major congenital malformations in infants of mothers with diabetes to no more than 15 per 1,000 births. (Baseline: 26.5 in 1997)

Objective 3:

Reduce the frequency of lower extremity amputations to 15 per 1,000 persons with diabetes. (Baseline: 20 per 1,000 persons with diabetes in 1992-95)

Objective 4:

Decrease the incidence of end-stage renal disease (ESRD) requiring dialysis or transplantation to no more than 253 per 1,000,000 population. (Baseline: 337 per 1,000,000 population in 1998)

Objective 5:

Increase to at least 90% the proportion of patients with diabetes who annually obtain lipid assessment (total cholesterol, LDL cholesterol, HDL cholesterol, triglyceride). (Baseline: 87.1% in 1997)

FLAGSHIP OBJECTIVE

Objective 6:

Increase to 85% the proportion of persons with diabetes who have a glycosylated hemoglobin measurement at least once a year. (Baseline: 15.9% in 1998)

Objective 7:

Increase to 73% the proportion of persons with diabetes who have an annual dilated eye exam. (Baseline: 65.5% in 1998)

Objective 8:

Increase to 55% the proportion of persons with diabetes who perform self-blood-glucose monitoring (SBGM) at least daily. (Baseline: 50.3% in 1998)

Objective 9:

Increase to 52% the proportion of persons with diabetes who have received diabetes education in the past year from someone other than their physician, such as a registered dietician or certified diabetes educator. (Baseline: 29.5% in 1997)

The successful implementation of the strategic plan will not only address the West Virginia Healthy People 2010 Diabetes Objectives but will also impact the 2010 objectives regarding chronic kidney disease, heart disease and stroke, immunizations and infectious diseases, nutrition and overweight, oral health, physical activity and fitness, tobacco use and vision.

West Virginia Diabetes Advisory Committee Goals and Objectives

- Goal #1** Increase the demand for better diabetes care through public awareness

- Goal #2** Increase early detection of Type 2 diabetes

- Goal #3** Improve management of diabetes care in West Virginia

- Goal #4** Collection of statewide data including BFSS, prevalence, mortality, causes of mortality pregnancy and diabetes, renal disease, and hospital charge data.

- Goal #5** Monitor and evaluate

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