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FOURTH QUARTER 2007

CHF SEEKS SYSTEMS CHANGES TO COMBAT DIABETES DISPARITIES

When the Connecticut Health Foundation commissioned a statistical analysis of the health and well-being of Connecticut residents, the results shed light on glaring disparities in a growing, expensive and widespread health problem.

The *Community Health Data Scan of Connecticut*, a statistical report on the health and well-being of Connecticut residents, shows stark racial and ethnic disparities in the risk, incidence and severity of metabolic disease, particularly diabetes, one of the most serious health threats Connecticut residents face.

According to the data, nearly one-third of the state's population is at risk for diabetes, which cost Connecticut an estimated $1.7 billion in direct and indirect costs in 2002.

Even more remarkable, are data on the disproportionately greater risk borne by Connecticut's racial and ethnic minorities. In fact, age-adjusted statistics for death before age 75 put the rate of diabetes-related deaths among Connecticut African-Americans at 23 per 100,000, compared to 7.4 for whites and 14.3 for Hispanics.

"The current disparities and projected trends are alarming and the board of directors was concerned," said CHF Program Officer Elizabeth Krause. "There was a sense that this was an area of clear racial and ethnic health disparities as well as a major health care and public health challenge."

(continued on page 3)

Experts discuss impact of and approaches to diabetes prevention and care

Chronic Care Model advocates for systems-based improvements in diabetes care

Innovative grantee programs engage patients

Connecticut Health Foundation

Ask the Experts

John B. Buse, M.D., Ph.D., is president, Medicine & Science, for the American Diabetes Association (ADA). In addition to serving as a principal officer, spokesperson and advocate for ADA, Buse is chief of the Endocrinology Division of the Department of Medicine at the University of North Carolina (UNC) School of Medicine in Chapel Hill.

Cindy Kozak, M.P.H., is a health program associate and coordinator of the Diabetes Prevention and Control Program for the Connecticut Department of Public Health. She is a registered dietician and a certified diabetes educator.

What is type 2 diabetes and why is it a concern for people of color?

Buse: Type 2 diabetes is defined by elevations in blood sugar, but is important because of the increased risk of heart attack, stroke, early death and disability. It is more common in ethnic minorities in the U.S. and in those populations more often associated with complications.

What is the difference between type 1 and type 2 diabetes?

Buse: Type 1 diabetes is caused by destruction of the cells that produce and secrete insulin; basically, it is caused by a lack of insulin. Type 2 diabetes results from poor tissue responses to insulin combined with poor insulin production.

Kozak: Type 1 diabetes, which usually develops early in life and used to be called "juvenile diabetes," generally accounts for 5 to 10 percent of all cases. About 90 to 95 percent of all diabetes diagnoses are type 2 diabetes, which used to be known as "adult onset" diabetes but is now being diagnosed in children and young adults.

What are some key barriers to addressing diabetes prevention and diabetes management for people of color?

Buse: I think the fundamental issue is access to care. Beyond that, patient education is absolutely key. Community-based approaches to improve diabetes awareness, engage prevention strategies and enlist patients in control programs show great promise as effective strategies.

Kozak: The populations that Federally Qualified Health Centers serve are less likely to have an adequate diet, sufficient physical activity and access to medical care, factors known to affect progression of the disease.

What are some effective evidence-based practices or strategies for addressing diabetes and diabetes disparities?

Kozak: Education on diabetes prevention and management, increased physical activity, a healthy diet and community-based initiatives all have been shown to be effective. Health disparities are a major focus of the Connecticut Diabetes Prevention and Control Plan that included input from more than 70 partners, who established five workgroups: diabetes prevention, access/policy, education/awareness, disease management and surveillance.

Diabetes Disparities *(continued from front page)*

CHF commissioned the *Data Scan* to help guide the development of CHF's second 10-year strategic plan.

"We wanted to know, 'Is there an emerging trend our foundation should be aware of?'" said CHF President and CEO Patricia Baker. "The statistics indicate it is metabolic syndrome, of which diabetes is a key component."

Lorenz Finison, a principal with the consulting firm Sigma Works, conducted the analysis for CHF. Finison also teaches public health at Boston University.

"Connecticut is very similar to the rest of the country," he said. "There are disparities in these indicators across the country."

Compelled by the arresting numbers, the CHF board developed a $1.3 million, two-year initiative challenging grantees to change systems around diabetes care, risk, prevention and outcomes to reduce racial and ethnic health disparities.

"I am really proud of the fact that while the numbers may have shocked us initially, we were able to take action right away," Baker said.

CHF's 2006 initiative challenges grantees to affect the types of systems changes suggested by the Chronic Care Model, a set of integrated, multi-disciplinary and proactive strategies to improve the way America prevents chronic illnesses and cares for the people affected by them.

CHF's objectives, developed in consultation with Yale-Griffin Prevention Research Center, target innovative systems change on multiple fronts:

- Improved quality of care;
- Improved access to prevention and treatment services;
- A greater understanding of diabetes disparities and effective intervention; and
- Improved data collection to monitor and evaluate efforts to reduce racial and ethnic disparities in diabetes.

CHF invited Connecticut's Federally Qualified Health Centers (FQHCs) to apply. These centers already serve disproportionately minority populations and belong to existing collaboratives for federally targeted improvements in diabetes and other chronic illness care, Krause explained.

CHF awarded grants from $199,940 to $400,000 to four organizations: Community Health Centers, Inc., based in Middletown; Community Health Services in Hartford; Fair Haven Community Health Center in New Haven; and StayWell Health Care, Inc., in Waterbury. *(See page 4)*.

The goal is to demonstrate sustainable systems change on several tiers: from culturally responsive self-management and prevention strategies to small changes in everyday protocols, such as adding screening alert flags to at-risk patients' charts.

"We are expecting small but important systems changes that will improve direct care," Krause said. "Systems changes often occur slowly and incrementally over time."

"We are really proud to partner with these four centers on this initiative and we are very eager to see the outcomes," Baker said.

DIABETES BY THE NUMBER IN CONNECTICUT

6 percent of adults over 18 (157,580 individuals) reported having been diagnosed with diabetes in 2004	
1.25 million adults are at increased risk of developing diabetes because of obesity, sedentary lifestyles or a history of gestational diabetes	
Compared to whites, African-American residents experience **3.8** times increased risk for hospitalizations directly attributable to diabetes **2.4** times increased risk for diabetes-related hospitalizations **4.1** times increased risk for hospitalizations for lower extremity amputations.	Compared to whites, Hispanic residents experience **2.2** times increased risk for hospitalizations directly attributable to diabetes **2.2** times increased risk for diabetes-related hospitalizations **2.3** times increased risk for hospitalizations for lower extremity amputations.

Source: CT Department of Public Health and CHF Community Health Data Scan

CHRONIC CARE MODEL: AN INTEGRATED AND PROACTIVE APPROACH TO CARE

The Chronic Care Model, a set of interactive strategies, identifies six key areas of focus:

1. **Health System** – Create a culture, organization and mechanisms to promote safe, high quality care.
2. **Delivery System Design** – Assure the delivery of effective, efficient clinical care and self-management support.
3. **Decision Support** – Promote clinical care that is consistent with scientific evidence and patient preferences.
4. **Clinical Information Systems** – Organize patient and population data to facilitate efficient and effective care.
5. **Self-Management Support** – Empower and prepare patients to manage their health and health care.
6. **The Community** – Mobilize community resources to meet the needs of patients.

CHF GRANTS $1.3 MILLION TO FIGHT DISPARITIES IN DIABETES CARE

Under a two-year initiative launched in 2006, CHF awarded a total of $1.3 million to four Federally Qualified Health Centers (FQHCs) to reduce racial and ethnic disparities in diabetes in Connecticut through a systems-wide approach.

FAIR HAVEN PUTS FOCUS ON LATINO WOMEN WITH PRE-DIABETES

"Fair Haven Takes Action Against Diabetes" attempts to reduce diabetes disparities among Latinas by educating and motivating women to take command of their health at the earliest warning signs of the disease.

Using an electronic health registry, practitioners at every service point at Fair Haven employ new protocols to identify women at risk for diabetes and screen them for pre-diabetes, or slightly elevated blood glucose.

"Pre-diabetes is a stage when people can still turn it around, explains Ann Camp, M.D., an endocrinologist at Fair Haven Health Center in New Haven, which received a $399,806 grant. "With help they can avoid diabetes."

Interventions and education to prevent diabetes begin immediately at the point of screening and continue through an intensive, 12-week lifestyle program for the women and a parallel program for their children.

"It's a systems change for all of us," said Camp, who is pleased with the program's early outcomes.

Forty-four percent of the Fair Haven women screened in the first phase of the program tested positive for pre-diabetes. Eight percent had full-blown diabetes.

"While it is astonishing to confirm our suspicions that almost 50 percent of the people we test have abnormal results, it is also thrilling to be able to offer these patients research-based interventions that transform their lives and the lives of their families," Camp said.

CHC, INC., TARGETS GAPS BETWEEN VISITS BY PHONE

Taking a page from private insurance — where telephone-based disease management is producing documented clinical success, as well as positive economic returns — Community Health Centers (CHC), Inc., set out to create its own telephone-based nursing intervention for improved diabetes care.

Between their visits to CHC centers in New Britain and Meriden, participating diabetics receive calls from nurses specially trained to screen for symptoms and support self-management. Patients receive calls weekly, biweekly or monthly depending on disease severity.

CHC, Inc., Chief Medical Officer Daren Anderson, M.D., says "managing the space between visits improves on private industry because the center's electronic medical records facilitate the flow of information seamlessly and the program's protocols allow for immediate response by the primary care team."

Eager to affect systems change through research-based practices, CHC, Inc., which received a $400,000 grant, designed and implemented "Between Visits" as a randomized, controlled study.

CREATING A STRONGER BOND TO A MEDICAL HOME IN HARTFORD

New staff, new protocols and new collaborations are driving an effort to help Hartford's low-income residents receive the care they deserve.

"Many do not recognize the need to maintain a patient-provider relationship," said Darren Martin, M.D., director of the diabetes program at Community Health Services, which received a $199,940 grant.

The Diabetes Access Project includes a new bilingual diabetes care coordinator who is responsible for greeting patients, informing them of the center's services, facilitating prescription refills, stressing the importance of follow up care, and getting questions answered by providers.

Community Health Services also partners with the Hispanic Health Council to train "promotoras," peer counselors who will visit patients to reinforce goals and regimens prescribed by practitioners.

"We're trying to make a personal connection with the patients so that they understand the importance of maintaining a relationship and not 'doctor shopping,'" Martin said.

The program also provides expanded education reflecting American Diabetes Association standards, a certified diabetes educator, screenings for all patients and improved data entry for tracking patient progress.

STAYWELL ZEROES IN ON SOCIOECONOMIC OBSTACLES

At community health centers such as StayWell Health, Inc. in Waterbury, socioeconomic difficulties often overshadow and exacerbate health issues.

"Not everyone who comes here has insurance or identification," said Sunil D'Cunha, medical director. "Not everyone speaks English, and not everyone is literate. Because of this, the challenges are often more socioeconomic than they are medical or physical."

StayWell, which received a $307,333 grant, recently launched a program aimed at reducing diabetes disparities by targeting multiple strategies in the Chronic Care Model, particularly patient self-management, education and community resources.

The program includes pre-diabetes screenings at soup kitchens and homeless shelters, and family-based diabetes prevention education in English, Spanish and Albanian at local churches and a newly dedicated chronic care suite.

For patients with diabetes, the program includes counseling in simplified self-management techniques based on easy-to-understand concepts, such as the red-yellow-green traffic signal.

The program also includes enhanced data entry for tracking patient progress; self-management incentives such as free coupons for shoes, grocery stores or trial YMCA memberships, and increased outreach to re-engage patients who may have strayed from the center's care.

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