# Connecticut Diabetes Prevention and Control Program
# Diabetes Preventive-Care Practices

Diabetes preventive-care practices have been shown to be effective in reducing the incidence and progression of diabetes-related complications. While people with diabetes need to perform these practices to prevent complications, good medical management is also essential in ensuring the quality of daily living.

The Health Resources and Services Administration (HRSA) Diabetes Health Disparities Collaborative (DHDC) [1] has compiled a set of measures and established goals [2] for eliminating health disparities in primary care (Table 1). These evidence-based measures and goals are being used by clinicians in primary care settings to set baselines for improving the delivery of preventive services to people with diabetes. Seven of Connecticut's 10 HRSA-funded community health center corporations participate in this collaborative.

## Table 1: HRSA's National Diabetes Preventive Health Measures

| MEASURES FOR PATIENTS WITH DIABETES | PATIENT POPULATION GOAL |
|---|---|
| 1. Average A1c of <7.0% (plasma glucose concentration) | >48% [3] |
| 2. Patients with 2 A1cs in last year (at least 3 months apart) | >90% |
| 3. Documentation of self-management goal setting | >70% |
| 4. Cardiac Risk Reduction Option 1: Statins (medication to lower cholesterol) | >60% |
| 4. Cardiac Risk Reduction Option 2: ACE inhibitors or ARB medication (to treat high blood pressure and heart failure) | >75% |
| 4. Cardiac Risk Reduction Option 3: Aspirin or other antithrombotic Agent (keep the blood from clotting and causing a heart attack) | >80% |
| 5. Patients with Blood Pressure of <130/80 mm Hg | >40% |
| 6. Patients with Low Density Lipoprotein < 100 mg/dL ("bad cholesterol") | >70% |
| 7. Patients who are current smokers | <12% |
| 8. Dilated eye exam in past year | >70% |
| 9. Comprehensive foot exam in the past year | >90% |
| 10. Microalbuminuria screening in past year (protein in the urine) | >50% |
| 11. Annual Influenza vaccination | >90% |
| 12. One pneumococcal vaccine (for those 65 years and older) | >90% |
| 13. Dental exam in past year | >70% |
| 14. Depression Screening (at least every 12 months) | >50% |
| 15. Exercise (3x/week for at least 20 minutes) | >60% |
| 16. Weight Reduction (for those with a BMI of >25) | >30% |

The National Diabetes Surveillance System (NDSS), maintained by the Centers for Disease Control and Prevention (CDC) Diabetes Prevention and Control Program (DPCP), [4] has chosen 9 of the 16 HRSA's National Diabetes Preventive Health Measures to monitor the preventive-care practices of people with diabetes (Table 2, Col 1). *Healthy People 2010* (HP) has established national goals for 7 of the 9 NDSS

measures (Col 2). There are no national baselines or standards for annual doctor visit and daily self-exam of the feet.

Data (Col 3) show that the nation has surpassed only 1 of the 7 *HP 2010* objectives (2+ A1c tests in past year). Connecticut 2005 Behavioral Risk Factor Surveillance System (BRFSS) data (Col 4) show that Connecticut has surpassed 3 of the 7 HP objectives. When compared to national averages (Cols 3), Connecticut (Col 4) surpassed the nation in 7 of the 9 preventive-care practice measures. The only 2 measures that the nation did better were for annual doctor visits, and attendance at diabetes self-management classes (which did not meet the HP target).

## Table 2: CDC DPCP's Preventive-Care Practices

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| **MEASURES FOR PATIENTS WITH DIABETES** | **GOAL** | **% ACHIEVED** | |
| | **HP 2010** [5] | **US** [6] | **CT** [7] |
| 2+ A1c Tests in Past Year | 65% | 71.9% | 81.8% |
| Annual Dilated Eye Exam | 76% | 68.6% | 82.0% |
| Annual Doctor Visit | -- | 90.1% | 88.4% |
| Annual Foot Exam | 91% | 67.7% | 73.2% |
| Annual Influenza Vaccine | 90% | 56.8% | 59.7% |
| Attended Diabetes Self-Mgmt Classes | 60% | 53.7% | 48.0% |
| Daily Glucose Self-monitoring | 61% | 59.8% | 67.7% |
| Daily Self-exam of Feet | -- | 65.8% | 65.9% |
| Ever Had Pneumococcal Vaccine | 90% | 50.3% | 51.6% |

These data indicate that there is room for improvement, both at the national and state levels. Current efforts are underway in Connecticut to address these measures in the development of a Diabetes State Plan. The state plan involves the collaborative efforts of over 42 organizations to address the burden of diabetes in Connecticut.

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The goals of the CT Diabetes Prevention and Control Program (CTDPCP) are to improve care for people diagnosed with diabetes, initiate health promotion efforts in collaboration with other chronic disease programs, and reduce the burden of diabetes for people in high-risk racial and ethnic populations in Connecticut. For further information, contact the CTDPCP at: 860-509-7801. [8]

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[1] Health Disparities Collaboratives. Background. Retrieved June 6, 2006, from http://www.healthdisparities.net/hdc/html/about.background.aspx
[2] Health Disparities Collaboratives. HDC Topics: Diabetes. Retrieved June 6, 2006, from http://www.healthdisparities.net/hdc/html/collaboratives.topics.diabetes.aspx
[3] Estimate based on 1999-2002 A1c percent of 39.8% as basis for a 2010 long-term target using CDC's DDT/MIS algorithm. Retrieved June 16, 2006, from http://www.ahrq.gov/qual/nhqr05/effectiveness/diabetes/T1-21.htm
[4] National Diabetes Surveillance System. Retrieved June 6, 2006, from http://www.cdc.gov/diabetes/statistics/
[5] CDC Wonder. Retrieved June 6, 2006, from http://wonder.cdc.gov/scripts/broker.exe
[6] National Diabetes Surveillance System. Retrieved June 6, 2006, from http://www.cdc.gov/diabetes/statistics/
[7] CT Department of Public Health. Connecticut Behavioral Risk Factor Surveillance System unpublished 2005 data.
[8] CT Diabetes Prevention and Control Program

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