

# **New Hampshire Action Plan For Diabetes**

**Improving the Health**

**and Quality of Life**

**of New Hampshire**

**Residents Affected**

**by Diabetes**



**2006**

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# Letter to Diabetes Partners from DAG

The Diabetes Advisory Group (DAG) is pleased to offer the first statewide *Action Plan for Diabetes*. This plan is the result of the collaborative efforts of over 120 individuals from 65 organizations involved in diabetes prevention and care in New Hampshire.

This plan is a blueprint for action to guide statewide diabetes prevention and care efforts for the next few years. The goals and recommendations described in this plan reflect the consensus of a broad range of experts and stakeholders. Our success in implementing these recommendations will depend on partners working together toward a common vision.

We would like to thank everyone who contributed to the development of this plan, including the Community Health Institute/JSI staff who facilitated the process. We look forward to collaborating to achieve our shared goal—to improve the health and quality of life for New Hampshire residents who have been diagnosed with or are at risk for diabetes.

If you are interested in participating in the implementation of this plan, please send in the form included with this report or call (603) 271-5173. We look forward to working with you and your community to implement improvements to the diabetes prevention and care system.

Sincerely,  
Members of DAG

The following is a list of organizations who contributed to the development of this action plan for diabetes:

American Cancer Society	Monadnock Community Hospital
Ammonoosuc Community Health Services	Nashua Division of Public Health and Community Services
Androscoggin Valley Home Health & Hospice	NH Association of Diabetes Educators
Anthem BCBS	NH Diabetes Education Program
Berlin Health & Hospice	NH Optometric Association
Berlin Public Schools SAU #3	NH Pharmacy Association
Catholic Medical Center	NH Public Health Networks
Cedar House for Seniors	NH Health Information Center
Cheshire Medical Center	NH Institute for Health Policy and Practice, UNH
Child Health Services	NH Minority Health Coalition
Community Health Access Network	North Country Health Consortium
Community Health Institute/JSI	North Country Senior Meals
Concord Hospital	Northeast Health Care Quality Foundation
Coos County Family Health Services	Office of Medicaid Administration
Cottage Hospital	Optimum Health and Energy
Dartmouth-Hitchcock-Keene	People with Diabetes
Dartmouth-Hitchcock-Manchester	ServiceLink
Department of Health and Human Services	Smiths Medical
Diabetes Self Management Program	Souhegan Home Hospice Care
Doctors Who Care, LLC	Southern New Hampshire Medical Center
Elliot Hospital System	Speare Medical Associates
Frisbie Memorial Hospital	Speare Memorial Hospital
HealthReach Diabetes	St. Joseph Hospital
Home Health and Hospice Care	Strafford Medical Associates
Ideabetes	The Works Health and Fitness
Keene Diabetes Group	Town of Derry Fire Department and Emergency Services
Keene School District	Town of Gorham
Lakes Region General Hospital	University of New Hampshire
Lamprey Health Care	Wentworth-Douglass Hospital
LRG Healthcare	White Mountain Center
Manchester Community Health Center	
Manchester Health Department	
Manchester Visiting Nurse Association	

# Purpose of the Plan

*The New Hampshire Action Plan for Diabetes* summarizes a statewide collaborative effort to improve diabetes prevention and care in our state.

This document is intended for use by all stakeholders to guide planning for their programs, funding, policies, and diabetes-related activities during the next five years.

This plan incorporates the results of a 2004–2005 comprehensive assessment of the strengths and weaknesses in our current system for diabetes prevention and care. The assessment revealed gaps in our ability to respond effectively to the increasing burden of diabetes. The Plan prioritizes the most urgent needs for improvement and outlines strategies to enhance New Hampshire’s system for diabetes prevention and care.

Many people were consulted in the development of this Plan to assure that the objectives for improvement reflect a consensus among individuals, families, communities, schools, work sites, organizations and government.

Given the complexity and the scope of the problem, any effort to improve the diabetes care system requires the coordinated and collaborative efforts of all who work to prevent and manage diabetes.

The recommendations detailed in this report should be embraced and pursued by all partners if we are to achieve our shared goal—to improve the health and quality of life for New Hampshire residents who have been diagnosed with or are at risk for diabetes.

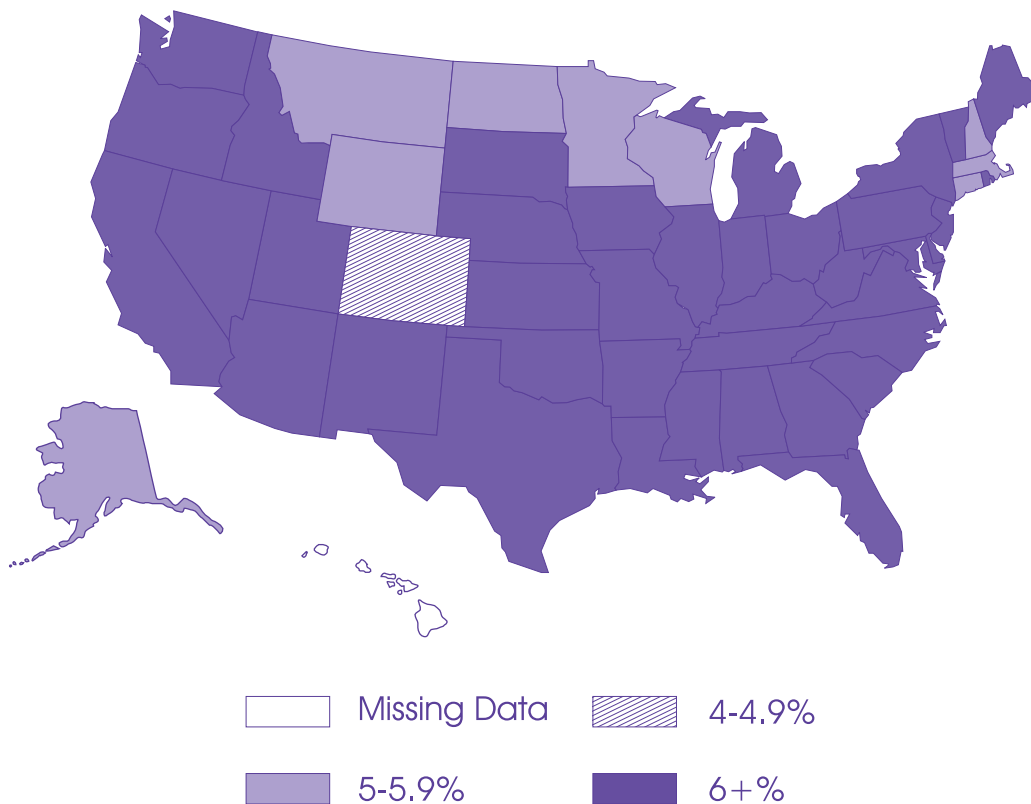
# Diabetes: New Hampshire's Challenge

## Why should we care about diabetes?

### Diabetes is a common disease.

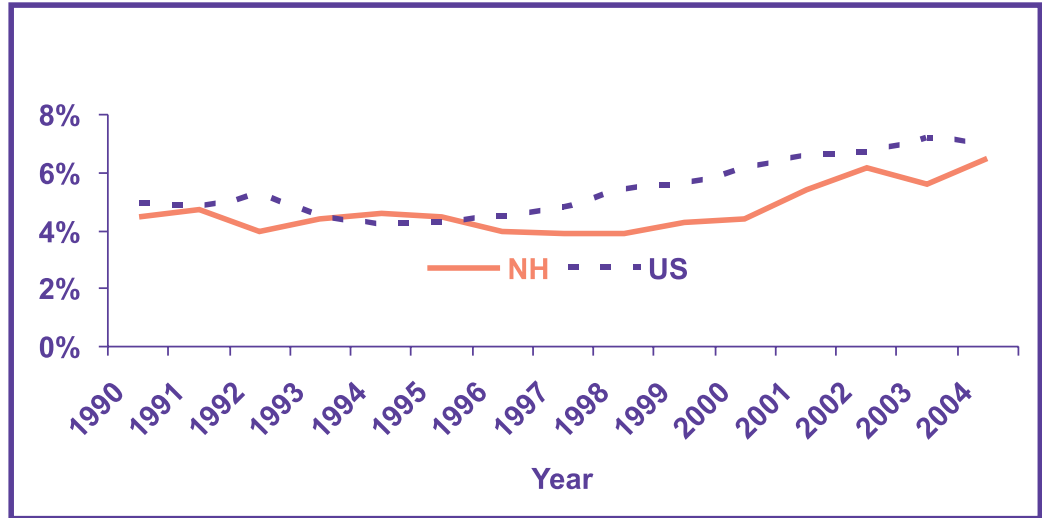
Diabetes is a common disease and the number of people with diabetes is rising. According to the Centers for Disease Control's National Diabetes Surveillance System, the prevalence of diagnosed diabetes has increased in all age groups from 1980 to 2004.

*Figure 1. Age-Adjusted Prevalence of Diagnosed Diabetes per 100 Adult Population, by State, United States, 2004<sup>1</sup>*



Based on the most recent available data, 6% of the adult population in New Hampshire has been diagnosed with diabetes. The prevalence of diagnosed diabetes has increased by 50% over the past five years (4% in 2000 to 6% in 2005).

Figure 2. The Percentage of the Adult Population Diagnosed with Diabetes: New Hampshire and United States, 1990 to 2004.<sup>2</sup>



Without intervention, the prevalence of diabetes is expected to continue to rise due to changes in the age and racial/ethnic composition of the population, overall population growth, and increasing numbers of people who are overweight, obese or less physically active.

The prevalence of diabetes increases with age. In 2004, the prevalence of diagnosed diabetes among people aged 65–74 (16.7%) was approximately 12 times that of people less than 45 years of age (1.4%).<sup>3</sup> As shown in Figure 3, the proportion of New Hampshire residents aged 65 and over has been increasing steadily since 1970 (Figure 3).<sup>4</sup>

Figure 3. The Percentage of the Population over 65 Years of Age: New Hampshire and United States, 1970 to 2000.

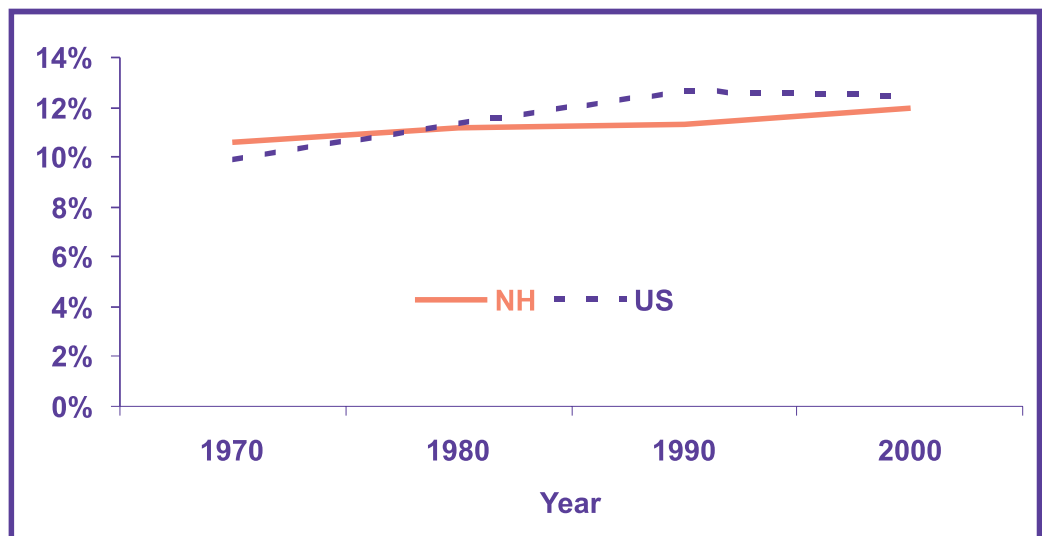
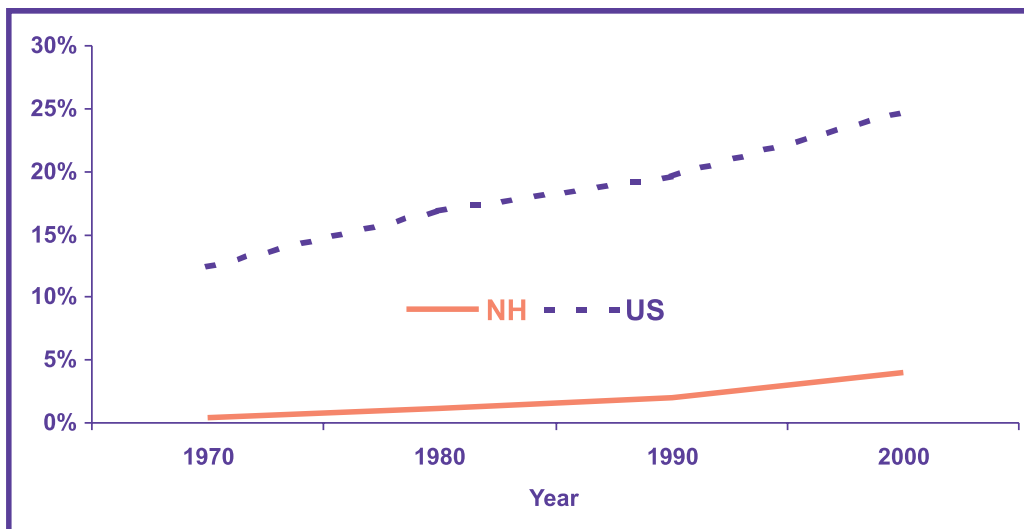


Figure 4 shows that the proportion of the New Hampshire and United States population not designating itself as “white alone” in the US census is growing. Minority populations have an increased risk for diabetes. Research has shown that

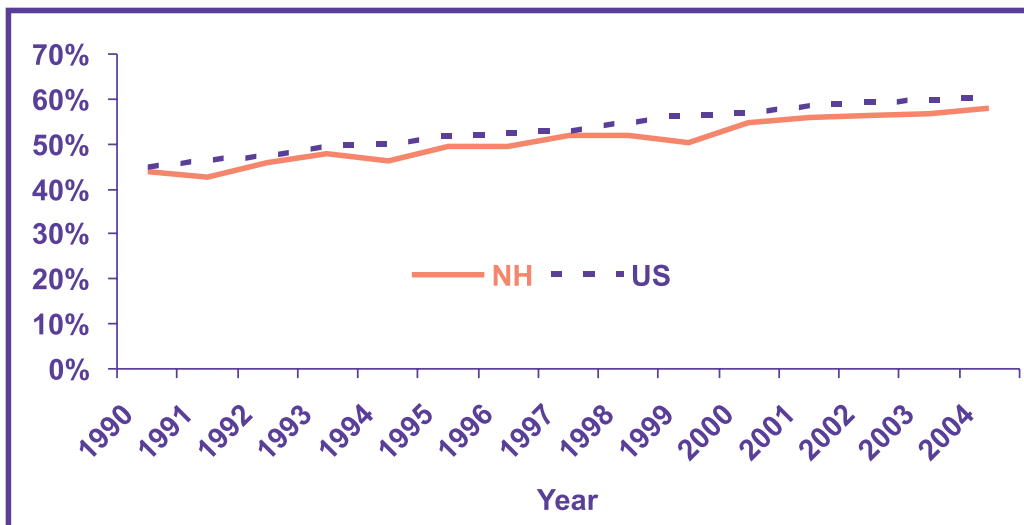
non-Hispanic blacks are 80% more likely to have diabetes than non-Hispanic whites. It has been estimated that Hispanic/Latino Americans are 70% to 80% more likely than non-Hispanic whites to have diabetes.<sup>5</sup> A recent survey of African Descendants and Latino residents of Hillsborough County, New Hampshire, predicts that diabetes prevalence in these groups will exceed that of New Hampshire's overall population, and highlights the need to address disparities in accessing diabetes prevention and screening services.<sup>6</sup>

Figure 4. The Percentage of the Population that is Minority: New Hampshire and United States, 1970 to 2000.



Being overweight is a key modifiable risk factor for diabetes. New Hampshire has reported an increase in the prevalence of overweight adults from 44% in 1990 to 58% in 2004 (Figure 5). It has been estimated that the risk of developing Type 2 diabetes increases by 25% for each additional unit of BMI added above 22 kg/m<sup>2</sup> (approximately 5–7 pounds for an adult of average height).<sup>7</sup>

Figure 5. The Percentage of the Adult Population that is Overweight: New Hampshire and United States, 1990–2004.



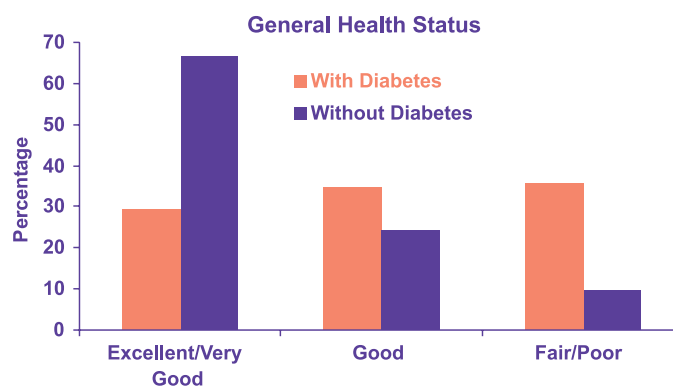


## Diabetes is a devastating disease.

According to the most recent data, diabetes is the 6<sup>th</sup> leading cause of death in New Hampshire and the nation.<sup>8</sup>

The general health status of people with diabetes is worse than that of people without diabetes. People with diabetes are significantly less likely to report excellent or very good health and more likely to report fair or poor health than people without diabetes. People with diabetes are more susceptible to many other illnesses and, once they acquire these illnesses, often have worse prognoses. Complications from diabetes include heart disease and stroke, blindness, kidney disease, nervous system disease, dental disease and complications of pregnancy. The risk for death among people with diabetes is about twice that of people without diabetes of similar age.

Figure 6. General Health Status of Adults With and Without Diabetes; New Hampshire 2003<sup>9</sup>



## Diabetes is costly.

Diabetes is very costly in terms of direct medical costs and lost productivity and premature mortality. Diabetes represents 11% of the U.S. health care expenditures. One out of every 10 health care dollars spent in the United States is spent on diabetes and its complications. People with diabetes have medical expenditures 2.4 times higher than they would if they did not have diabetes.<sup>10</sup> Without effective prevention and control of diabetes, this disease has the potential to overwhelm our health care system.

## Diabetes and its complications are preventable.

Prediabetes is a term used to distinguish people whose blood sugar levels indicate an increased risk of developing diabetes. Progression to diabetes among those with prediabetes is not inevitable. There is evidence that people at high risk for diabetes can delay and possibly prevent the development of Type 2 diabetes by losing 5–7% of total body weight through 30 minutes of physical activity 5 days a week and healthier eating.<sup>11</sup> Recent research has shown that reasonable changes in physical activity and diet reduced the risk of developing diabetes by 58% among men and women in all racial and ethnic groups.<sup>12</sup>

For people who have developed diabetes, effective treatment is available. When diabetes is diagnosed at an early stage, associated morbidity and mortality can be limited through effective control of glucose, blood pressure, and blood lipids. Unfortunately, nearly one-third of all people with diabetes are undiagnosed.<sup>13</sup>

# Evaluating the Prevention and Care System

Early intervention is critical to improve the health and quality of life for New Hampshire residents with diabetes. System-wide planning for diabetes prevention and management to improve our ability to intervene is essential.

For this reason, the Federal Centers for Disease Control and Prevention (CDC), Division of Diabetes Translation, supported a national initiative for coordinated diabetes planning. CDC provided methodology for states to conduct a detailed assessment of the quality and quantity of their diabetes-related services. Many states have used the results of these evaluations to create plans to improve diabetes prevention and care. Many diverse members of the diabetes prevention and care system in New Hampshire met to complete this task.

## Methods

Two strategies were used to identify strengths and weaknesses of the current capacity for diabetes prevention and care in New Hampshire.

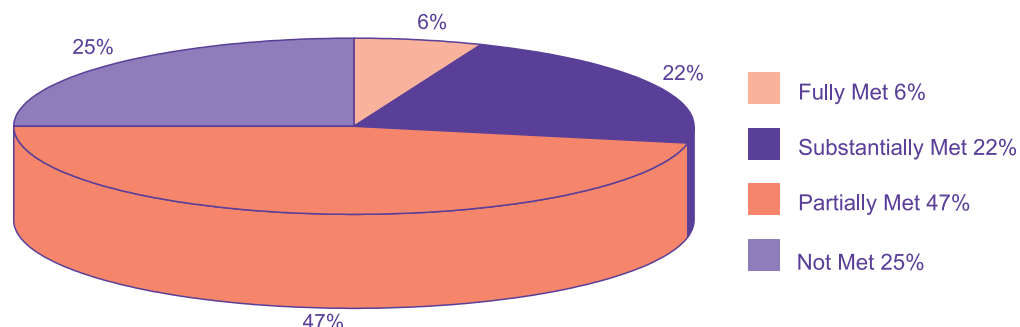
First, seven community focus groups were offered throughout the state. Six of the meetings were co-hosted with the local Public Health Networks including Berlin/Gorham, Keene, Littleton/Lancaster, Manchester, Nashua, and Dover/Rochester. One meeting was co-hosted by the New Hampshire Minority Health Coalition. Seventy-six local participants represented people living with diabetes and their family members, providers of services targeted to people with diabetes, schools, and other community organizations. During the focus groups, participants noted strengths and weaknesses of the diabetes prevention and care system in their communities and made recommendations to improve it.


Second, the *Centers for Disease Control (CDC) State Diabetes Performance Assessment* instrument<sup>14</sup> was completed by participants in four working groups. The instrument is a survey that asks working group participants to rate the effectiveness of our diabetes prevention and care system. A total of 35 people from 19 towns representing health care providers, payors, advocates, educators, researchers and policymakers attended one or more work groups.

## Identification of Strengths and Weaknesses

Analysis of the CDC assessment instrument results created an overall rating of the state diabetes prevention and care system and identified gaps and barriers in the existing system.

Figure 7. Diabetes Prevention and Care System, CDC Ideal Standards Met





The New Hampshire Diabetes Prevention and Care System received an overall rating of 38 out of 100. According to the participants in the assessment process, the CDC ideal standard was “substantially or fully” met in response to 28% of the questions; the CDC standard was “partially or not” met in response to 72% of the questions. Since this was the first time that the instrument had been completed, these results serve as the baseline against which to monitor improvement. Findings of the community meetings were consistent and complementary.

### **Participants in the assessment process identified the following overall strengths of the diabetes prevention and care system:**

1. Good data collection and reporting for the diabetes care system;
2. Extensive development and dissemination of quality health education and health promotion programs for people with diabetes;
3. Strong collaborative partnerships at the local level;
4. Well-trained providers delivering quality diabetes education and care to patients accessing services;
5. Availability of high-quality, accessible diabetes care services; and
6. Good programs designed to educate and support people with diabetes.

### **Weaknesses of the diabetes prevention and care system include:**

1. Lack of a statewide plan for workforce development and assessment of diabetes workforce needs;
2. Barriers to care as a result of poor insurance coverage and high out-of-pocket expenses for needed services and supplies;
3. Need for an information clearinghouse to facilitate access to available resources and services;
4. Lack of awareness of the general public of the causes and consequences of diabetes to support prevention and early intervention;
5. Need for coordination and collaboration across the public health system to promote a diabetes/chronic disease agenda; and
6. Lack of systematic evaluation of the effectiveness of interventions to inform planning and program development.


The New Hampshire Diabetes Education Program convened a day-long meeting to present the results of this assessment in December 2005. Members of the Diabetes

Advisory Group and other stakeholders used the assessment results to agree on priorities to improve the diabetes prevention and care system statewide.

Participants were presented with a list of possible areas for improvement identified through the assessment of the diabetes prevention and care system. Participants were then asked to rank top priority areas for improvement, giving priority to those aspects of the diabetes care system for which improvement was most likely to: 1) positively improve health outcomes; 2) be achievable given reasonable resources; and 3) be supported by the participants' organization in the implementation phase. Results were aggregated and the areas receiving the highest ranking were selected as priorities to be included in the *New Hampshire Action Plan for Diabetes*.

## Priorities for improvement are:

- 1. Workforce Development:** Participants recommend that the state diabetes care system:
  - Conduct a comprehensive assessment of the diabetes workforce and available training opportunities;
  - Develop a statewide plan for workforce development; and
  - Establish a centralized clearinghouse of educational opportunities and dissemination strategy.
- 2. Public Education:** Participants agree that the focus of the diabetes care system has to extend beyond the care and treatment of diabetes to address the prevention of the disease. The state diabetes prevention and care system must educate the broader public—especially people who are at risk for diabetes—about how to remain healthy and how to screen for diabetes to assure early intervention into care, if needed.
- 3. Access to Care:** Participants acknowledge that the diabetes prevention and care system does a good job of linking people to needed services largely through the dedicated efforts of service providers who work to overcome barriers. Of greatest concern are financial barriers that limit access to care (particularly specialty care) and influence the quality of self-care (e.g., high out-of-pocket cost for test strips.) Participants acknowledge that much can be gained by sharing strategies to optimize benefits and access free or reduced-cost services and supplies. Participants recommend that the state diabetes prevention and care system:
  - Establish a central clearinghouse of diabetes-related services and resources to facilitate access by consumers and providers;
  - Convene a task force to identify strategies to subsidize out-of-pocket expenses to reduce financial barriers to care; and
  - Work with insurance and pharmaceutical companies to address financial barriers and promote prevention.

- 
- 4. Collaborative Partnerships:** The diabetes prevention and care system would benefit from stronger collaborations with non-traditional partners to promote an integrated diabetes/chronic disease agenda. Together, partners can advocate common prevention messages of weight loss, exercise and a healthy diet with work sites, schools and communities to improve the health and well-being of individuals.

## Taking Action



**Goals, objectives and strategies for addressing high priority areas for improving the diabetes prevention and care system follow.**

# Workforce Development



## Goal 1:

Develop  
statewide  
plan for  
workforce  
development.

### Problem Statement:

The Diabetes System has not conducted a comprehensive assessment of the diabetes workforce. As a result, there is a lack of objective information about both supply of qualified personnel and gaps in professional education. The N.H. workforce would be strengthened by preparing a statewide plan for workforce development, establishing a centralized list of workforce educational opportunities, and better publicizing these opportunities.

### Objective #1:

Establish Subcommittee on Workforce Development.

### Strategy:

- Identify and recruit members.

### Objective #2:

Assess diabetes workforce supply and demand.

### Strategies:

- Define diabetes workforce {e.g., emergency room clinical staff, clinicians with non-diabetes-related specialties such as Ob/Gyns and general practitioners, providers without access to teaching hospitals, nurses, home health nurses, school nurses, medical assistants, other medical staff, social workers, case managers, food service professionals, Meals on Wheels, human resource staff in large companies, mental health providers, teachers and others}.
- Inventory current workforce.
- Project workforce needs.
- Estimate gaps in workforce.

### Objective #3:

Assess diabetes workforce training needs.

### Strategies:

- Develop training needs assessment methodology and tool(s) targeted to diabetes workforce. Topical areas for training to assess include: knowledge of and adherence to guidelines/diabetes competency, cultural competency, and use of interpersonal communication for behavior change and diabetes prevention.
- Conduct training assessment and analyze findings.

### Objective #4:

Develop statewide plan for diabetes workforce development based on training needs assessment findings.

### Strategies:

Specific strategies will depend on assessment results. Preliminary suggestions to enhance workforce training include:

- Provide more information about diabetes in nursing school curricula; Develop mentoring approaches; Establish listserv and internet-based information on

best practices for providers; Develop and disseminate standardized tickler systems to promote adherence to diabetes care guidelines.



### Objective #1:

Ensure accessibility and availability of needed training.

### Strategies:

- Review assessment findings and current training offerings to ensure that available trainings meet needs identified in the assessment. Where needed, develop new trainings.
- Ensure trainings are accessible. Considerations include: diverse locations, alternative sites to limit travel time (e.g., schools), and alternative formats (e.g., internet-based learning) to provide training.
- Ensure faculty are available.

### Objective #2.

Increase demand for available trainings.

### Strategies:

- Work with insurance companies to create incentives for providers to attend trainings;
- Develop centralized clearinghouse of education opportunities and a dissemination strategy to advertise training opportunities. Key characteristics of this system include: 1) quickly updatable system, 2) on-line access to list, and 3) regular updates via listserv to MDs, RDs, RNs, NPs, CDEs, and school nurses.

**Lead Agency:** DAG Subcommittee on Workforce Development

**Partners:** AHECs, Community Health Centers, nursing and medical schools, hospital human resource departments, insurance companies, the Diabetes Guidelines Committee, NHADE, as well as CDEs, school nurses, endocrinologists, nutritionists, dieticians, and health educators.

### Selected Performance Measures:

- Workforce assessments completed.
- Statewide plan for diabetes workforce development completed.
- Available trainings match training needs identified in assessment.
- Number of providers accessing information from clearinghouse.
- Frequency of updates to educational opportunity clearinghouse.
- Workforce training needs addressed.



### Goal 2:

**Implement statewide plan for diabetes workforce development.**





## Goal:

**Inform, educate and empower people about the causes and consequences of diabetes.**

## Problem Statement:

The Diabetes System needs to provide more information on the causes and consequences of diabetes to the broader public. To effectively respond to the challenges posed by diabetes, the system must educate everyone, especially people who are at risk for diabetes, about how to remain healthy. Key behaviors to encourage include: Eating a healthy diet rich in fruits, vegetables and whole grains; getting 30–60 minutes of physical activity most days of the week; and quitting smoking.

### Objective #1:

Establish Subcommittee on Public Education.

### Strategy:

- Identify and recruit members.

### Objective #2:

Identify partners who can help educate the public about the causes and consequences of diabetes.

### Strategies:

- Identify and collaborate with state-level partners to promote diabetes prevention among constituents including New Hampshire Department of Education, Business and Industry Association, Hospital Association, Medical Society, New Hampshire Child Care Resource and Referral Network, WIC and Home Health Care Association.
- Identify and collaborate with local partners to promote diabetes prevention among constituents including local schools, local employers, service clubs, faith-based institutions, senior centers and senior housing, VNAs and home health agencies.
- Identify public health partners to support statewide and local level educational efforts. Evaluate feasibility of partnering with other chronic disease advocates—heart disease, cancer, arthritis, osteoporosis, and asthma—who share a common prevention agenda. Recruit “friends of diabetes” such as retired nurses to assist in local level implementation.

### Objective #3:

Develop educational messages targeted to the public regarding the causes and consequences of diabetes.

### Strategies:

- Identify and review culturally appropriate materials promoting the prevention message (healthy living reduces the risk of developing diabetes) to key populations. Obtain or create new materials when needed.
- Prepare educational “kits” with messages and materials for key populations.

#### **Objective #4:**

Partner to disseminate educational messages to the public.

#### **Strategies:**

- Collaborate with statewide media and local media outlets to communicate educational messages.
- Implement strategies with partners.

**Lead Agency:** DAG Subcommittee on Public Education

**Partners:** NH Department of Education, Business and Industry Association, Hospital Association, Medical Society, New Hampshire Child Care Resource and Referral Network, WIC, Home Health Care Association, chronic disease advocates, and media.

#### **Selected Performance Measures:**

- Diabetes prevention messages identified.
- Diabetes prevention materials developed.
- Diabetes prevention messages and materials disseminated through multiple channels.
- Policies and behaviors targeted by messages and materials assessed for shifts.



## Goal 1:

**Increase patient and provider access to information about existing health benefits and free or reduced cost services and supplies.**

### Problem Statement:

Financial barriers (e.g., the high out-of-pocket cost for test strips) limit access to appropriate care for diabetes patients, particularly specialty care, and influence the quality of self-care. In the short term, patients and providers need ready access to specific information to address financial barriers. In the long term, insurers, providers and manufacturers must work together to make cost and coverage decisions that emphasize prevention and reduce more costly, avoidable medical care.

### Objective #1:

Establish Subcommittee on Access to Care.

### Strategy:

- Identify and recruit members.

### Objective #2:

Increase provider access to information about “back door benefits”, community resources, benefit features and product decisions affecting cost, and other financial assistance opportunities for patients.

### Strategies:

- Complete an inventory of existing community and supplier/manufacture resources and benefits strategies used by diabetes providers.
- Hold Diabetes Provider Resource and Support Forum for diabetes providers on financial assistance resources and benefit strategies.
- Develop listserv or electronic discussion group for diabetes providers to communicate with peers on patient financial assistance (and other) topics.
- Establish clearinghouse for diabetes-related information and resources for providers (web and paper-based). The clearinghouse could also host the listserv or discussion groups.

### Objective #3:

Increase patient access to information about eligibility/benefit assistance programs and community resources to reduce financial barriers.

### Strategies:

- Work with providers, especially in the inpatient setting, to assist patients to connect with existing patient financial/eligibility assistance programs.
- Develop and maintain a current database of services/supplies covered by each insurer. Make the database available to both patients and their providers.
- Collaborate with pharmacies and durable medical equipment providers to work on patients’ behalf in making cost-effective decisions.
- Offer sessions on effective use of benefits, community resources and financial assistance in diabetes support groups, senior centers, and other local organizations.
- Promote use of patient advocates/lay health workers to help diabetes patients negotiate the health care and health care financing systems.

- Identify and link with regional groups working on medical transportation. Collaborate with these groups to increase transportation access to diabetes services.
- Establish clearinghouse for diabetes-related information and resources for patients (web and paper-based).



### Objective #1:

Create a specific plan to address cost and access issues with respect to blood glucose monitoring supplies.

### Strategies:

- Convene a Diabetes Home Monitoring Task Force to: 1) investigate the potential for expanding or replicating a local foundation/charitable entity to assist diabetes patients with limited income; and 2) work with pharmaceutical companies to increase access to blood glucose monitoring supplies and related products.
- Work with insurers to adopt prevention-oriented coverage decisions/policies (e.g., covering the cost of blood glucose monitoring supplies).

**Lead Agency:** DAG Subcommittee on Access to Care

**Partners:** Diabetes providers, insurers, pharmaceutical companies

### Selected Performance Measures:

- Number of providers and patients accessing information.
- Frequency of updates to clearinghouse.
- User satisfaction with information provided.

### Goal 2:

**Reduce financial barriers to necessary acquisition and use of blood glucose monitoring supplies.**

## Problem Statement:

The New Hampshire Diabetes Advisory Group (DAG) serves as a coordinating body for activities to address the priority areas for improvement detailed in this plan. The DAG is being restructured to include the broad diabetes prevention and care interests in the state. Three subcommittees will be established to oversee and help achieve objectives for improvements outlined in this plan.

The DAG welcomes participation in the implementation of improvement activities. An invitation to participate is included with the plan. Any individual or organization involved in the prevention and care of diabetes is encouraged to join our collaboration by submitting the enclosed form or contacting:

New Hampshire Diabetes Education Program (NHDEP)  
NH DHHS, Division of Public Health Services  
29 Hazen Drive  
Concord, NH 03301  
1-800-852-3345 x5173  
603-271-5173

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13. Centers for Disease Control and Prevention. 2005 National Diabetes Fact Sheet: General Information and National Estimates on Diabetes in the United States, 2005. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005. Available at <http://www.diabetes.org/uedocuments/NationalDiabetesFactSheetRev.pdf>
14. This survey was developed and validated by the Centers for Disease Control; it was originally designed to measure a state's capacity to deliver essential public health services. We adapted the survey to evaluate various kinds of services specifically related to diabetes care and prevention in New Hampshire. A maximum score of 100 on this survey would indicate a comprehensive, integrated, highly effective system for diabetes care. Scores less than 100 illustrate areas within the system that could be improved.

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