

# DIABETES

## Targeted Environmental Scan: Working Document

### Prepared for the Governor's Interagency Council on Health Disparities

Updated August 2008

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This document describes known programs that aim to address diabetes disparities in Washington State. Programs that focus on disparities in diabetes risk factors or co-morbidities (e.g., obesity prevention or hypertension screening programs) are beyond the scope of this document.

#### REACH 2010 Coalition

The REACH 2010 Coalition, which is coordinated by Public Health-Seattle & King County, relies on partnerships with community-based organizations to eliminate diabetes-related health disparities among African American, Asian and Pacific Islander American, and Hispanic/Latino communities in King County. Through its first round of CDC funding, the REACH 2010 Coalition funded community partners to provide support groups, peer education, self-management classes and case management services that were relevant to the cultures and languages of the targeted populations. Services were provided by the Center for MultiCultural Health, International Community Health Services, and Sea Mar Community Health Centers. Evaluation of classes and support groups demonstrated increases in physical activity, improvements in dietary behaviors and increased knowledge about diabetes. In addition, participants had increased self efficacy and social support in managing their diabetes. Through its second round of CDC funding (REACH US), which began in November 2007 and will continue through 2012, REACH partners will develop and implement a train-the-trainer program for community-based organizations, faith-based organizations and small businesses. In an effort to expand the number of individuals receiving services, organizations' representatives will receive training on how to provide diabetes education and self-management training to the various communities that they serve in a culturally competent manner.

#### Department of Health Diabetes Prevention and Control Program

The Diabetes Prevention and Control Program of the Washington State Department of Health coordinates efforts of the Washington State Diabetes Network in implementing the Washington State Diabetes State Plan. Goal 6 of the state plan is to support "evidence-based, culturally and linguistically appropriate, and sustainable strategies that affect social determinants of health and reduce disparities in health outcomes". Program staff has recently completed a Diabetes Disparities Report, which provides information and data on disparities in diabetes prevalence, health behaviors, health status, access to medical services, and rates of complications and deaths. The program also sponsors the Washington State Collaborative to Improve Health, in which primary care practices test and measure practice innovations which improve outcomes and move the healthcare delivery system from the acute care model to the chronic care model. Health care providers participating in the Collaborative use the Chronic Disease Electronic Management System (CDEMS) software to track the progress and monitor the health care needs of diabetes patients. Currently, the Collaborative's focus is to enroll small, rural practices with 5 providers or less who see a Medicaid population. The Diabetes Program also provides grants of up to \$10,000 each to help build local diabetes coalitions and implement community diabetes prevention and control activities (local coalition activities are described later in this document). The program formerly funded media awareness campaigns that utilized messages and materials from the National Diabetes Education Program – an example of a program funded through the

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NDEP is the Liberation Theatre for Diabetes Education and ACTION, which will be discussed later in this document.

In addition, the Diabetes Prevention and Control Program in partnership with the Department of Social and Health Services' Aging and Disability Services Administration, local Area Agencies on Aging, the Nooksack Tribe, the Shoalwater Bay Tribe and the Yakima Valley Farm Workers Clinic is working to expand the Chronic Disease Self Management Program (CDSMP) to racially diverse aging populations. This is a 2-year program (January 2008 through December 2009) funded by the Atlantic Philanthropies through the National Council on Aging's Center for Healthy Aging. Through this project, the Nooksack and Shoalwater Bay Tribes will develop expertise in the CDSMP and recruit and enroll tribal members and others in their service area into the program. Similarly, the Yakima Valley Farm Workers Clinic will expand their CDSMP expertise by training additional lay leaders to reach Hispanic seniors with the CDSMP program, including the Spanish-language version, Tomando Control de su Salud. To jump start the work of the partners and communities and to ensure sustainability for the CDSMP in Washington, the Department of Health's Heart Disease and Stroke Prevention unit will support training for 28 additional master trainers in May 2008.

### Sea Mar Community Health Centers

As a community partner in the REACH 2010 Coalition, Sea Mar Community Health Centers developed the capacity and the infrastructure to deliver culturally competent diabetes education and self-management classes to the Hispanic/Latino population. Though funding from the REACH program to continue those services has ended, the Diabetes Program at SeaMar has absorbed those costs and continues to offer one-on-one patient education and 6-week self-management classes through its South Park and Burien clinics. In addition, through a grant from the Department of Health, the Sea Mar Diabetes Program developed an 8-week diabetes prevention curriculum for patients at risk for diabetes, which it will also continue to offer through its South Park and Burien clinics. In addition, Sea Mar received a grant from the Department of Health to produce and show a play called "Tres historias de la vida" (Three Life Stories) to discuss the impact of diabetes in the Hispanic/Latino community. The play used Liberation Theater (also known as Theater of the Oppressed) techniques to engage viewers to find ways to use the information they learned in their own lives. The plays were performed in Spanish-speaking communities in Skagit County and the Yakima Valley. The overall program also provided train-the-trainer workshops to teach community health workers how to use Liberation Theater techniques in their local diabetes awareness efforts. SeaMar is continuing its partnership with Public Health – Seattle & King County as it transitions into the REACH US grant to develop and implement its train-the-trainer curriculum for community groups, faith-based organizations and small employers. Through the new grant, it will also develop community capacity for advocacy and policy work.

### International Community Health Services (ICHS)

Like the SeaMar Diabetes Program mentioned above, the ICHS Diabetes Education Program will absorb the costs and continue to provide diabetes education and self management classes since those services will no longer be supported through REACH funding. ICHS provides 6-week diabetes education classes and support groups in Cantonese, Mandarin, Samoan, Tagalog,

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and Vietnamese and six-week self management classes are conducted in Cantonese and Mandarin. Clinic services also include one-on-one diabetes education and nutrition counseling, as well as Diabetes Days for uninsured diabetic patients to come and receive specialty care (such as eye and foot exams). It has also partnered with Uwajimaya market to provide in-store diabetes workshops and has worked with a peer-educator from Harborview to provide grocery store tours, i.e., shop arounds, in Vietnamese markets. ICHS will continue its partnership with the REACH US program to develop and package curriculum for train-the-trainer programs. In addition, the program has developed and offers a series of cookbooks titled Healthy Asian Recipes, which feature traditional Asian recipes that have been modified to reduce fat, sugar, and salt content, making them healthier and more suitable for people living with diabetes. The cookbooks are available in Chinese, Khmer, Korean, Tagalog and Vietnamese, and include an English translation as well.

### Center for Multicultural Health (CMCH)

CMCH has been a member of the REACH Coalition since 1999. During Phase I of REACH, CMCH organized and hosted two summits with African American men and women living with diabetes and conducted three focus groups that informed the development of the REACH Community Action Plan in the African American community. And for the last seven years, CMCH has developed, implemented and evaluated diabetes education classes, support groups and self-management classes. As a member of the REACH coalition, CMCH also participates in the Washington State Diabetes Network. Through REACH US, CMCH will continue its partnership with the coalition to develop and implement the train-the-trainer program, as mentioned above, but unlike Sea Mar or ICHS, CMCH does not have the resources to continue the diabetes education and self-management classes for the African American community. CMCH's diabetes prevention and control-related work has also included working with the Urban League of Metropolitan Seattle to conduct glucose screenings and provide diabetes education to African Americans in King County, and with the federal Office of Minority Health to develop a plan for preventing and controlling diabetes among African Americans in King County. In addition, CMCH works in partnership with PHSKC through its STEPS to a HealthierUS grant to implement community-based initiatives to promote cardiovascular health and prevent and control diabetes among African Americans in Seattle-King County.

### Local Diabetes Coalitions

There are two well-established and active local diabetes coalitions: the Eastern Washington Diabetes Network and Community Partners for Diabetes Health in Pierce County. In addition, there are two coalitions which are just getting started: the Wenatchee Area Network for Diabetes and the Upper Skagit Diabetes Coalition. Finally, the Tri-Cities Diabetes Coalition is in a transition and is not currently active. All have received funding, in part, through the Department of Health's Diabetes Prevention and Control Program.

The **Upper Skagit Diabetes Coalition** is organized by the Upper Skagit Indian Health Clinic and facilitates communication and coordination with the Nooksack, Lummi, Samish, and Swinomish Tribes' diabetes activities. The Upper Skagit Indian Health Clinic provides diabetes clinics for diabetic patients as well as outreach and educational prevention programs for individuals who do not have diabetes or for those with pre-diabetes. One focus of the Upper

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Skagit Diabetes Coalition is on disparities in the age-of-onset of diabetes diagnosis between male and female patients – while women are typically diagnosed in their 50's, male patients are being diagnosed in their 30's.

The **Eastern Washington Diabetes Network, Community Partners for Diabetes Health in Pierce County and Wenatchee Area Network for Diabetes** do not have an explicit focus on reducing diabetes disparities for racial/ethnic groups, yet some local coalition activities may have that affect. For instance, the coalition in Pierce County works in partnership with food banks to provide diabetes risk assessment and education to their clients, many of whom are from the Hispanic/Latino and Russian immigrant communities. They are also partnering with another community task force to provide various health screening at local food banks. Likewise, while the Wenatchee Network does not specifically target activities toward any racial/ethnic group, a large percentage of diabetes patients in the Wenatchee area are Latino, many of whom are monolingual Spanish-speaking; therefore, the Network strives to provide culturally and linguistically appropriate outreach, services and education. Diabetes education and self-management classes and support groups are conducted in Spanish and Promotoras are utilized for outreach and education. The Eastern Washington Diabetes Network's current focus is to improve diabetes screening and resource dissemination in rural areas. The Network recently provided free diabetes screenings to about 100 individuals from the Chewelah/Addy area and is in the planning stage of a media campaign in partnership with the Colville Tribe. Other population-based local coalition activities that have been conducted and/or are planned include media awareness campaigns, dissemination of community resource guides, diabetes screenings and education at health fairs and diabetes expos.

In addition, the **Okanogan County Diabetes Network** is a new coalition of diabetes educators that is just getting started. The Coalition is funded through the Department of Health's STEPS to a Healthier Washington program through a mini-grant from the Chelan, Douglas, and Okanogan Counties program. Through this grant, local diabetes educators piloted a three week educational class called Dining with Diabetes, to provide basic nutrition education for individuals with diabetes and their caregivers. Forty-five participants took part in the class from the Omak/Okanogan area. A second Dining with Diabetes class is being planned to target the Native American population in the Nespelem area. The coalition hopes to develop a class targeted for the Hispanic/Latino population in the future.

### Washington State University Extension Diabetes Awareness Education

The Washington State University Diabetes Awareness and Education program works with national, state and community partners to promote diabetes awareness and education. It was originally funded for five years through a congressional appropriation and the program has recently been refunded for one year. *On the Road to Living Well with Diabetes* is a single session secondary prevention program targeted for low-income individuals with diabetes to engage them in their own care and diabetes management. *Living Well with Diabetes* is a follow-up four-session nutrition and lifestyle education program for individuals who already completed the *On the Road to Living Well with Diabetes* program. The program is currently offering services in Pierce, Clark, King, Spokane, Grant and Adams counties. Program materials are provided in English, Spanish, Russian, and Chinese.

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### Northwest Indian College Diabetes Prevention through Traditional Plants Program

The Diabetes Prevention through Traditional Plants Program is a two-year train-the-trainer program to learn about the healthful benefits of traditional plants. The goal of the program is to train a couple of people from multiple tribes and then have them return to their communities to serve as a knowledgeable resource. The program aims to improve the health of tribal communities overall, reduce the incidence of diabetes, increase exercise through harvesting and gardening and increase a sense of cultural pride and connection to place. Other potential benefits include a revitalization of plant communities and traditional food sites and more sovereign tribal communities as members become less dependent on subsidized foods.

### Indian Health Service, Special Diabetes Program for Indians

Funded through Congressional appropriation, IHS provides \$150 million annually (through 2008) to fund the Special Diabetes Program for Indians. The program has three components: non-competitive community directed grants, competitive demonstration diabetes prevention projects, and support to develop and implement electronic patient and data management systems. There are 33 community-directed grant programs and 3 demonstration projects in Washington. As an example, the Seattle Indian Health Board's diabetes program is funded through the IHS to provide diabetes self-management education, health care and group education, as well as specialty care once a month for high-risk individuals. The Seattle Indian Health Board also receives funds from IHS to administer the Healthy Heart program for their patients with diabetes (see the targeted environmental scan document on Heart Disease and Stroke for additional information).

### *Discussion of Statewide Gaps and Sustainability*

The following concerns and possible solutions were brought up by contacts working on diabetes programs in Washington State. Please note that some stakeholders indicated that their comments apply to the other chronic diseases being considered by the Council and are therefore included in multiple briefing documents.

- Many stakeholders working at the local level commented that diabetes self-management classes are effective, but participants sometimes struggle to follow guidelines when they can't afford the equipment and supplies needed to monitor and manage their diabetes appropriately. Reimbursement for equipment and supplies needs to align with self-management recommendations.
- There is a need for an inventory of supplies, such as lancets and test strips to give participants who can't afford to test more than once a day. Such supplies could also be used as incentives for participation. Perhaps this can be done through partnerships with pharmaceutical companies.
- Many commented that at a statewide level, diabetes disparities need to be viewed and addressed through policies around the social determinants of health. For example, ensuring high quality education for all and ensuring access to opportunities for physical education and access to affordable fruits and vegetables.

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- Disparities in diabetes rates and outcomes could be addressed by ensuring all people have health insurance and access to affordable health care.
- Local-level community coalitions needed to be strengthened and sustained.
- Sustainable funding for diabetes education and self-management classes are needed – these are programs that have been demonstrated to be effective.
- Mandates for the state to address chronic disease in its biennial budget, similar to King County’s mandate to address communicable diseases.
- Health equity impact assessments should be supported at a statewide level (similar to the King County model).
- A statewide educational campaign could help to promote healthier eating and physical activity among kids, in an effort to prevent chronic conditions such as diabetes.
- The lack of healthy foods available to low-income communities needs to be addressed. Vouchers for farmers markets could be used as incentives for participation in diabetes education classes if there were resources or a sponsor for the vouchers.
- The sustainability of diabetes education programs is difficult in rural areas with limited resources because the process for becoming a “recognized diabetes education program” is difficult. Recognition is necessary in order to receive reimbursement for diabetes education.
- Ensure sustainable funding for the Diabetes Prevention and Control Program to continue to provide grants to local communities for coalition development and diabetes prevention and control activities.
- The Governor needs to hold agencies accountable for addressing the social determinants of health. There should be a mandate for agencies to assess how their work contributes to or works to redress health disparities, such as through using health impact assessment or other tools. And there should be reporting back, similar to what is done through the GMAP process.
- The Council can play a role in translating knowledge and disseminating best practices to local health jurisdictions to help improve the ability of the public health workforce to address health disparities.
- A more collaborative effort is needed to work with Tribes on chronic disease prevention programs, rather than a compartmentalized approach based on disparate funding sources.
- The integration of health services needs to be encouraged as much as possible so that communities are not receiving services based only on funding silos.

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- More support is needed for the services that community groups provide. Community-based organizations (outside of clinical settings), play an important role in the continuum of health care and services for communities of color. These organizations know their communities, know how to reach their communities, and know how to provide services in a culturally and linguistically appropriate way. Often mainstream health organizations don't have the knowledge or ability to provide effective services to communities of color, but these resources and capabilities exist in the communities themselves. Mainstream health organizations need to be encouraged to partner with community organizations and receive incentives to do so.
- Capacity-building and resource support is needed for community-based organizations around policy and advocacy work.

**Diabetes Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Diabetes** is a disease in which glucose builds up in the blood and the body has trouble turning food into energy. Normally, our bodies break down food into glucose, and the hormone insulin helps glucose enter cells so our body can use it for energy. Diabetes prevents the body from making enough insulin or from using it properly. In Type 1 diabetes, the immune system destroys the cells in the pancreas that make insulin. In Type 2, the body's cells are not receptive enough to insulin or the pancreas doesn't make enough insulin, or both. Type 2 diabetes accounts for 90-95% of all cases and is caused, in part, by obesity and lack of physical activity.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- Diabetes prevalence has increased from 4.1% in 1994 to 6.3% in 2005, an increase of 54%.
- In 2005, over 300,000 Washington residents had diabetes.

**CRITERION #2: SEVERITY**

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- Diabetes is the seventh leading cause of death in Washington. In 2005, 1,549 Washington residents died from diabetes and 3,317 more deaths listed diabetes as contributory.
- Washington adults with diabetes are 3.2 times more likely to have high blood pressure and 3.7 times more likely to have heart disease than adults without diabetes.
- One in five adults with diabetes has poor vision; some eventually go blind.
- Diabetes is the leading cause of end-stage kidney disease.
- In 2003, almost 1,000 Washington residents had a lower extremity amputation as a result of poor circulation and nervous-system damage caused by their diabetes.
- In 2004, there were 76,732 hospitalizations resulting from diabetes-related complications, totaling more than \$1.5 billion.

**CRITERION #3: DISPARITY**

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- From 2003-2005, diabetes prevalence was significantly higher for non-Hispanic blacks (13.7%), non-Hispanic American Indians and Alaska Natives (12.0%), Hispanics (8.8%), and Asian/Pacific Islanders (8.7%) than for non-Hispanic whites (6.1%).
- The Index of Disparity for diabetes prevalence was 77%.
- Diabetes mortality rates (per 100,000) for 2003-2005 combined were significantly higher for non-Hispanic blacks (176), non-Hispanic American Indians and Alaska Natives (142), Hispanics (118), and Asians and Pacific Islanders (85) than for non-Hispanic whites (75).
- The Index of Disparity for diabetes mortality was 74%.
- Diabetes mortality rates for non-Hispanic Asians and Pacific Islanders increased by about 10% per year between 1994 and 2002, higher than for any other group.
- Data from King County showed that the prevalence of diabetes among Pacific Islanders was 13.3%, higher than any other racial or ethnic group.
- For 2003-2005, diabetes prevalence was higher among men (6.9%) than women (6.1%).
- From 2002-2004, women were more likely to be hospitalized for diabetes than males at younger ages (5-44), while at ages 45 and older, hospitalization rates were higher for men.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*