

# Alaska Diabetes Strategic Plan



20 May 2005

Dear Alaskans:

On behalf of the Alaska Diabetes Advisory Group and the Alaska Diabetes Prevention and Control Program, I am pleased to present the Alaska Diabetes Strategic Plan.

The plan was based on the recommendations of Alaskans from village clinics, universities, community health centers, non-profit organizations, elementary, middle, and high schools, state and municipal agencies, faith-based institutions, public health agencies, hospitals, health professional organizations, public and private health insurance agencies, peer review organizations, and Alaskans with diabetes.

The Alaska Diabetes Strategic Plan establishes a unified course of action to reduce the burden (i.e., premature mortality, morbidity, and economic costs) of this disease among the 18,700 adult Alaskans already diagnosed with diabetes. The plan also addresses the prevention of diabetes in the general population through education, policy and lifestyle modifications.

The rapidly increasing prevalence of this disease in Alaska calls for creative and cost-effective strategies. Implementing these strategies calls for action and cooperation by multiple partners statewide. Putting this plan into action presents a challenging opportunity to influence the health of current and future Alaskans. It is our hope that you will work with the Alaska Diabetes Prevention and Control Program and the Alaska Diabetes Advisory Group to positively impact diabetes in Alaska.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Stillwater". The signature is written in black ink on a light-colored background.

Barbara Stillwater RN, PhD  
Alaska Diabetes Prevention and Control Program

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## Executive Summary

The number of Alaskans with diabetes has increased over the past decade and is expected to increase substantially over the next several decades. This increase will put a significant strain on our healthcare budget that is already at capacity. This increased burden also places greater responsibility on individuals to make healthy lifestyle choices and on health care providers to adhere to clinical guidelines to prevent and/or control this disease.

Preventing and/or controlling diabetes involves health care systems, policy makers, health educators, the primary and secondary school systems, public health officials, businesses, researchers, health care professionals, community groups, and people with diabetes. The fact that any one group cannot manage diabetes presents the opportunity for utilizing a public health approach with multidimensional strategies to meet this challenge.

The Alaska Diabetes Prevention and Control Program (AKDPCP) has engaged diabetes leaders from around the State to respond to this challenge. The *Alaska Diabetes Strategic Plan* has integrated their recommendations into four primary goals: (1) Health promotion is prioritized through statewide planning and coordination; (2) Evidence-based clinical management is provided to Alaskans with diabetes; (3) Diabetes data are collected, analyzed, and reported to understand the burden of diabetes in Alaska and to predict its effect on Alaskans in the future; and (4) Community-based programs are empowered to develop and use evidence-based models of diabetes prevention and health promotion.

The *Alaska Diabetes Strategic Plan* establishes an action plan to reduce the increasing burden of this disease. It proposes strategies based on evidence-based science and incorporates the unique needs of our culturally diverse population.

The *Alaska Diabetes Strategic Plan* recommendations are:

### 1. Prevention and Public Awareness

- Information for making healthy lifestyle choices will be provided to school-age children in Alaska.
- Partners in the Alaska diabetes system will work with the Alaska Chronic Disease & Health Promotion workgroup to design, implement, and evaluate a healthy lifestyle media campaign that will reach the adult population of the state.

### 2. Advocacy and Policy

- The State of Alaska will have statewide policies supporting healthy lifestyle choices.
- School districts in Alaska will have policies that mandate comprehensive physical education K through 12.
- School districts in Alaska will have policies prohibiting/eliminating food with no caloric value (i.e., candy, soda pop, etc.).
- The primary insurance companies in Alaska will support the use of the American Diabetes Association (ADA) Recommended Standards of Diabetes Care.
- The Chronic Disease & Health Promotion workgroup will formulate plans to reduce health disparities related to diabetes.
- Equal access to healthcare for special populations with diabetes will be promoted.
- Diabetes-related policies in Medicaid and Medicare will be reviewed annually.
- Medicaid will reimburse providers for preventive health exams to beneficiaries at risk for diabetes.
- Certified Diabetes Educators will be able to bill, and be reimbursed by, insurers directly.
- Pharmacists will be able to bill, and be reimbursed by, insurers for providing consultation for diabetes care services.

### 3. Data and Research

- Funding to diabetes-related research in the state will increase.
- An information system will be established to facilitate program assessment, implementation and evaluation in Alaskan communities.
- Descriptions of the activities, goals and outcomes of each community-based program that receives funds from the State of Alaska Chronic Disease & Health Promotion programs will be available for dissemination statewide.
- A clearinghouse for statewide diabetes data, regulations, and clinical practice guidelines will be developed and maintained.
- The Alaska Behavioral Risk Factor Surveillance System (AKBRFSS) will include one or more questions on pre-diabetes.
- The following databases will be reviewed annually for data related to diabetes: AKBRFSS, Alaska Vital Statistics, Alaska State Hospital Discharge data, United States Renal Data System, Alaska Medicaid, and Alaska Medicare.
- Diabetes data reports will be prepared and disseminated via the State Diabetes web page and/or as State of Alaska Epidemiology Bulletins.
- The economic burden of diabetes in Alaska will be monitored over time.
- Alaska's progress towards Healthy Alaskans 2010 diabetes objectives will be monitored.

### 4. Training and Programs

- All community-based programs receiving state funds from the Chronic Disease & Health Promotion programs will pilot or implement evidence-based models of intervention with outcome-based evaluation.
- Staff and patients at community health centers in Alaska will be trained in the Chronic Disease Self-Management Program (CDSMP) developed at Stanford University.
- Alaskans with diabetes will have access to a diabetes educator in their community.
- Alaskans with diabetes and their parents, guardians and/or families will have access to educational materials regarding the rights of individuals with diabetes.

## Acknowledgements

### Alaska Diabetes Prevention and Control Program Staff

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## Alaska Diabetes System Assessment Team

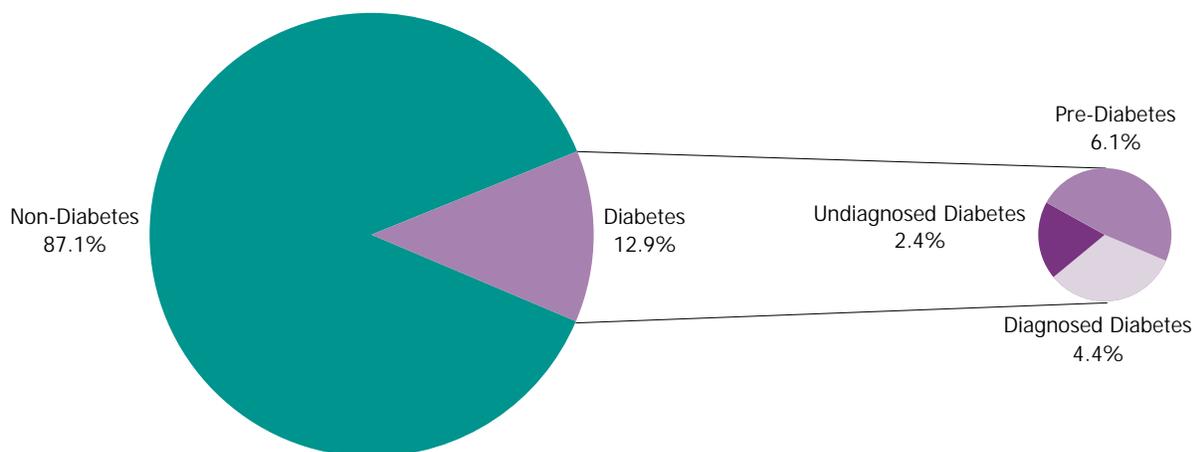
Alaska AARP	KTUU Channel 2
Alaska Academy of Family Physicians	KTVA Channel 11
Alaska Academy of Physicians Assistants	Municipality of Anchorage
Alaska Area Indian Health Service Diabetes Program	National Association for the Advancement of Colored People
Alaska Association of Diabetes Educators	National Parent Teachers Association
Alaska Association of School Nurses	Parrish Nurses Association of Alaska
Alaska Commission on Aging	Premera Blue Cross
Alaska Dept. of Administration Information Technology Services	Providence Diabetes and Nutrition Center
Alaska Health Education Consortium	Providence Wellness Program
Alaska Health Education Library Project	Qualis Health
Alaska House of Representatives	SEARHC Community Wellness Program
Alaska Native Health Board	Southcentral Foundation
Alaska Native Science Commission	State of Alaska Arthritis Program
Alaska Native Tribal Health Consortium	State of Alaska BRFS
Alaska Nurse Practitioner Association	State of Alaska Bureau of Vital Statistics
Alaska Nursing Association	State of Alaska Chronic Disease Unit
Alaska Medicare	State of Alaska Cardiovascular Health Program
Alaska Pharmacist Association	State of Alaska Community Preventive Services Program
Alaska Podiatrist Associates	State of Alaska Department of Education
Alaska Primary Care Association	State of Alaska Diabetes Program
Alaska Parent Teacher Association	State of Alaska Medicaid
Alaska Public Health Association	State of Alaska Division of Public Health
Alaska Regional Health Medical Center	State of Alaska Section of Epidemiology
Alaska School Nurses Association	State of Alaska Health Promotion Program
Alaska Senate	State of Alaska Obesity Control Program
American Diabetes Association	State of Alaska Office of Health Planning and Systems Development
American Heart Association	State of Alaska Public Health Nursing
Anchorage Daily News	State of Alaska School Health Program
Anchorage Neighborhood Health Clinic	State of Alaska Tobacco Control Program
Anchorage School District	Take Heart Alaska
Blue Cross/Blue Shield	University of Alaska Student Nursing Association
BP Health Promotion Coordinator	University of Alaska Dept. of Physical Education
Center for Alaska Native Health Research, University of Alaska, Fairbanks	University of Alaska - Gerontology
CDC - Arctic Investigation Program	University of Alaska - Psychology
Hispanic Women's Health Coalition	University of Alaska School of Nursing
Institute for Circumpolar Health Studies	University of Alaska School of Public Health
KIMO Channel 13	Veterans Administration
Koahnic Broadcast Corporation	Visions Therapy Center
KSKA Public Radio	Young Men's Christian Association (YMCA)

## Diabetes in Alaska at a Glance: Quick Facts

### It is common.

There are approximately 18,700 Alaskans 18 years of age and older who have been diagnosed with diabetes. There are 10,900 Alaskan adults who have diabetes and do not know it. There are another 27,800 Alaskan adults with pre-diabetes. This represents a total of 57,400 Alaskans or 13% of the adult population.

**Figure 1: Diabetes prevalence among Alaska adults (18 years+)**

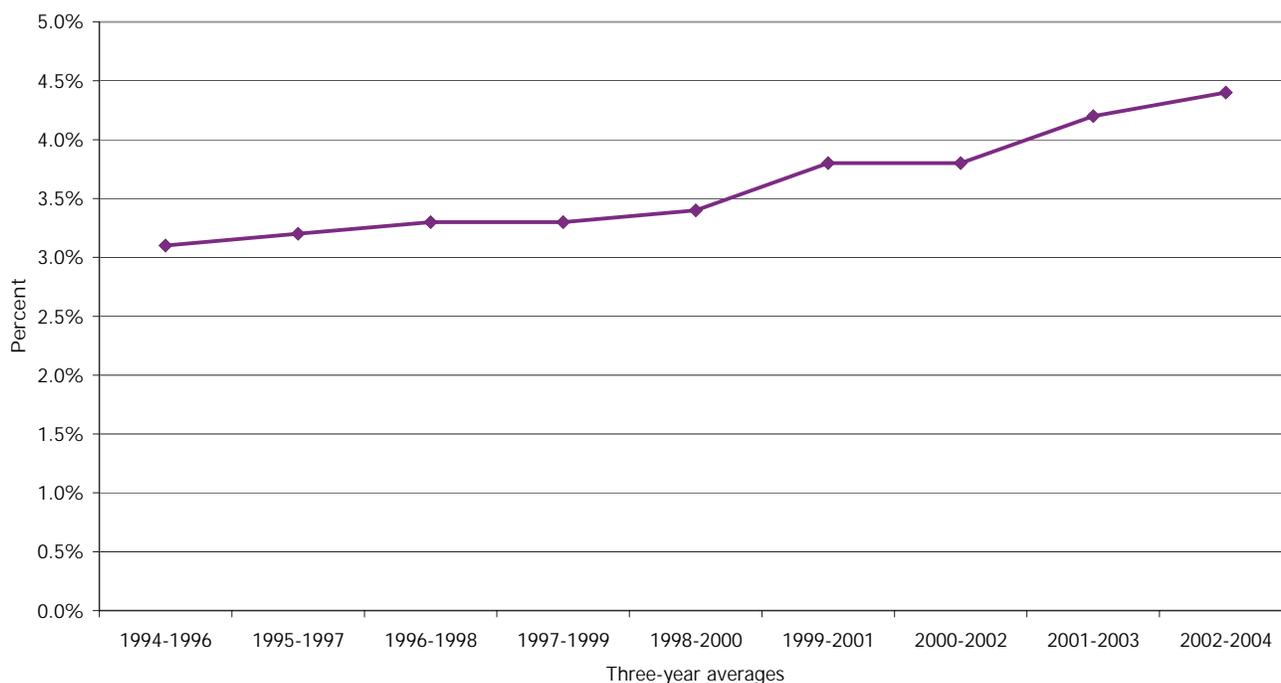


The 2002-2004 AK BRFSS prevalence rate of diagnosed diabetes is 4.4% (CI=3.9%-5.0%). Prevalence rates of undiagnosed diabetes and pre-diabetes are based on NHANES III estimates.

### It is increasing.

The prevalence of diabetes in Alaskan adults has been gradually increasing over the past 10 years. Rates are expected to continue to rise based on the increasing rates of obesity and physical inactivity and the general aging of the Alaskan population.

**Figure 2: Self-reported diabetes prevalence, adults (18 years+), Alaska BRFSS, 1994-2004**

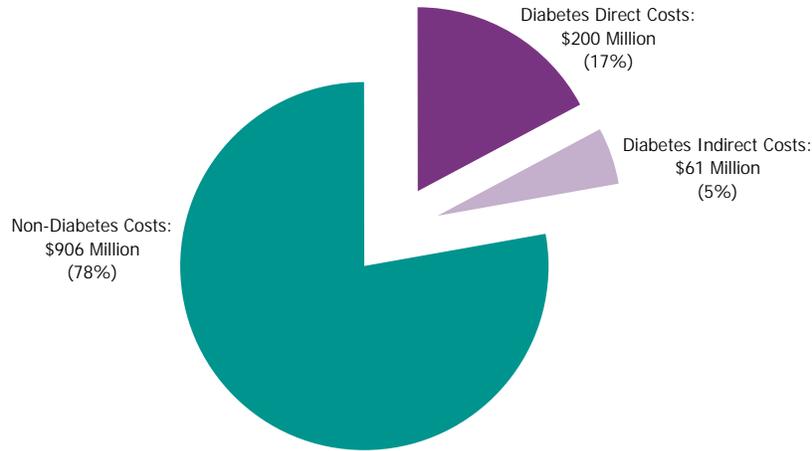


## It is costly.

In 2003, the estimated direct and indirect costs of diabetes in Alaska exceeded \$261,000,000.

Although adults with diabetes account for only 4% of the Alaskan population, treating persons with diabetes accounts for 22% of Alaska's health care costs.

**Figure 3: Distribution of Alaska health care costs in 2003: \$1.2 billion estimate**



Direct costs are associated with the treatment of diabetes and its complications. The total annual per capita cost for a person with diabetes is \$13,243 and the per capita cost for a person without diabetes is \$2,560.

Indirect costs are national per capita dollar estimates associated with decreased productivity, disability, and premature death due to diabetes. Source: Hogan P, Dall T, Nikolov P (2003). Economic costs of diabetes in the U.S. Diabetes Care, 26(3): 917-32.

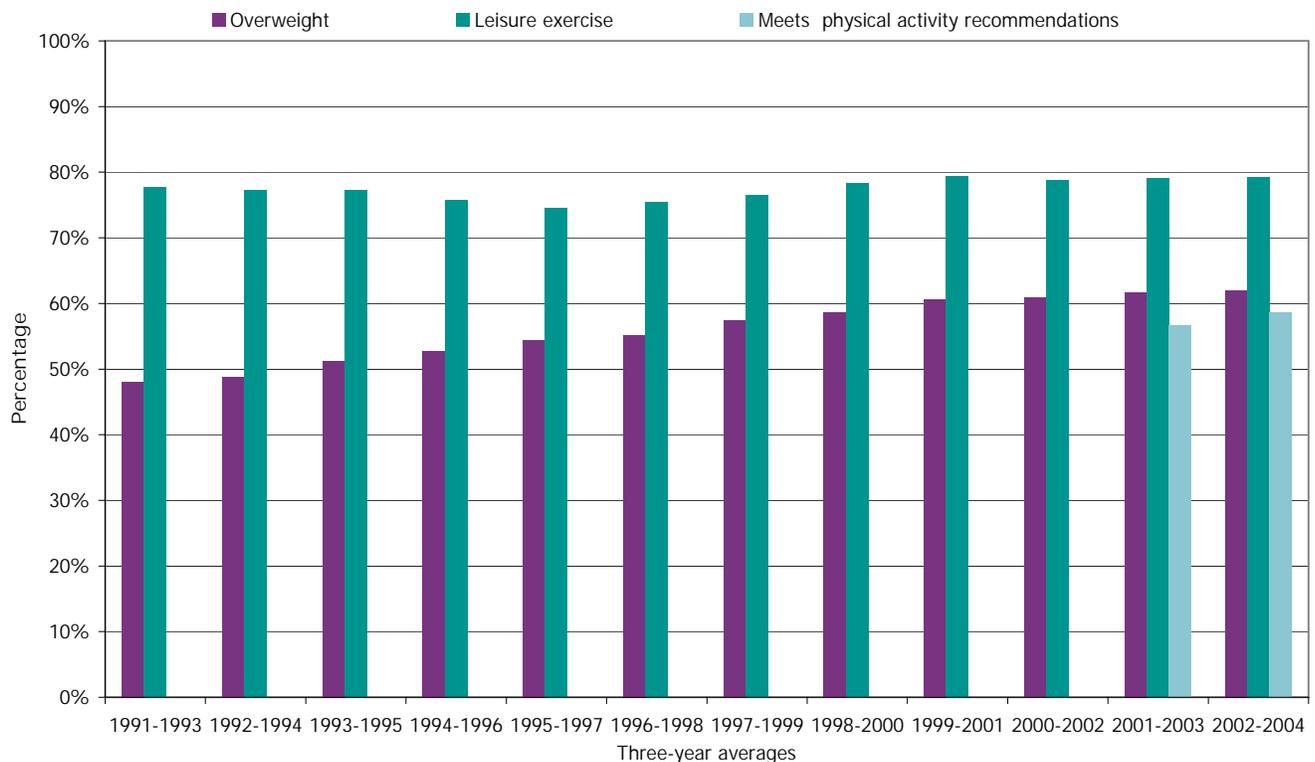
## It is preventable.

Lifestyle changes can reduce the risk of diabetes by 58%.

An estimated 50% of all type 2 diabetes cases would be eliminated if weight gain were prevented.

Even a minimal weight loss of 5% can decrease the risk of developing type 2 diabetes and its complications.

**Figure 4: Overweight and leisure exercise, adults (18+), Alaska BRFSS, 1991-2004**



## It is controllable.

Improved glycemic control reduces the risk of developing complications from diabetes. For every 1% reduction in the HbA1C (e.g., from 8% to 7%), there is a 40% reduction in the risk of developing microvascular complications. For every 10 millimeters of mercury (mm Hg) reduction in systolic blood pressure, there is a 12% risk reduction for any diabetes-related complication.

Comprehensive foot care programs can reduce lower limb amputations by up to 85%.

## Diabetes – Problem Statement

### Prevalence

Diabetes has reached epidemic proportions. The World Health Organization reports that at least 171 million people have diabetes worldwide and this figure is expected to more than double by 2030 (Wild et al, 2004). There are approximately 18.2 million Americans with diabetes and each year more than one million new cases of diabetes are diagnosed in the U.S. (CDC, 2004).

The prevalence of diabetes by state is related to the age and racial/ethnic composition of the state's population. The prevalence of diabetes tends to be lower in states, like Alaska, with younger populations. Although the prevalence of diabetes in Alaska is lower than the general U.S. population, it is likely that the rate will increase substantially as our population ages.

### Risk for Diabetes

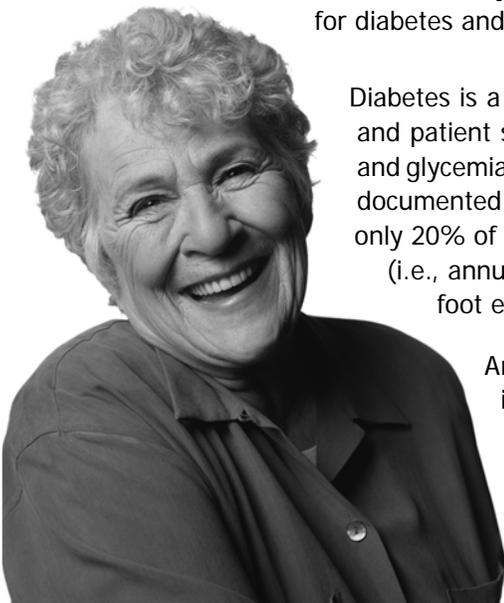
The majority of type 2 diabetes is associated with obesity, physical inactivity, and older age. Except for age, these risks are related to individual lifestyle choices. Obesity is the leading modifiable risk for diabetes, and yet obesity has increased substantially over the past decade in both adults and children. Recent studies [e.g., Diabetes Prevention Program (Knowler et al., 2002) and Multiple Risk Factor Intervention Trial (Smith et al, 2005)] have provided scientific evidence that losing weight and increasing physical activity can reduce the risk of developing diabetes among those at greatest risk by 60%.

### Quality of Care

The prevalence of diabetes is disproportionately borne by persons with low incomes and there are significant diabetes disparities in both health care services and patient outcomes by socioeconomic status. Persons with less education and low income are less likely to receive the recommended diabetic services and more likely to be hospitalized for diabetes and its complications.

Diabetes is a chronic disease that can be effectively controlled through primary care, referrals, and patient self-management (ADA, 2005). The benefits of controlling lipids, blood pressure, and glycemia and of screening for retinopathy, nephropathy, and lower extremity disease are well documented (ADA, 2005). However, according to the 2003 National Health Disparities Report, only 20% of persons diagnosed with diabetes receive all five services commonly recommended (i.e., annual retinal eye exams, annual influenza vaccinations, annual HbA1c checks, annual foot exams, and biannual lipid profiles (NHDR, 2003)).

Among those persons diagnosed with diabetes within the general U.S. population, it is estimated that less than 12% meet the recommended goals for blood glucose, blood pressure, and cholesterol despite evidence that controlling these conditions delays or prevents diabetes complications. While greater numbers of persons with diabetes are taking medication to control blood pressure and cholesterol, fewer are making the necessary lifestyle changes to reduce risk factors for diabetes complications (Saydah et al, 2004).



A survey of primary care providers in six urban Alaskan communities was conducted between 1999 and 2000 to determine their adherence to the American Diabetes Association (ADA) standards of care in their management of their adult patients with diabetes. The providers were queried as to the frequency of which they performed, recommended or referred their patients for diabetes screening and education.

To quantify patient adherence to the recommended standards of care, Alaskans with diabetes are queried via the Alaska Behavioral Risk Factor Surveillance System (AKBRFSS), an annual random digit telephone survey that is used to evaluate health behaviors and to determine the prevalence of multiple diseases and their risk factors in the adult Alaskan population statewide. A comparison of the results of the health care provider and BRFSS surveys is presented below. As you can see, there is a significant discrepancy between what health care providers state that they recommend and what persons with diabetes state they receive.

<b>Comparison between Diabetes Quality Indicators Recommended or Performed by Alaska Health Care Providers and Prevalence of Screening and Testing among Patients Diagnosed with Diabetes 1999-2000</b>		
	<b>1999-2000 HCP Survey</b>	<b>1999-2000 BRFSS</b>
<b>Screening</b>		
HbA1c at least twice a year	92%	65%
Annual foot exam	93%	83%
Annual dilated eye exam	88%	77%
Annual microalbuminuria	87%	DNC
Annual proteinuria	93%	DNC
Annual lipid profile	93%	DNC
Annual dental exam	DNC	71%
Daily self-monitor blood glucose	83%	63%
<b>Education</b>		
Diabetes classes	76%	52%
Referral to dietician	81%	DNC

DNC = Data Not Collected

Healthcare Provider Survey: Between November 1999 and March 2000, 300 physicians, PA's, and NP's were queried regarding their recommended standards of care for their patients with diabetes

## Summary

Diabetes is often characterized as a silent disease.

- It is silent because many people find out they have diabetes after detection of a high blood sugar during a routine health exam. Because diagnosis is commonly delayed, serious complications are often already occurring by the time diabetes is discovered.
- It is silent because persons at risk for diabetes are often unaware of the lifestyle changes they could make to prevent or delay diabetes.
- It is silent because many persons with diabetes minimize its importance and do not adhere to the recommended standards of self-management.
- It is silent because health care providers tend to place a greater emphasis on the treatment of diabetes rather than on its prevention.
- It is silent because public education efforts have not been directed at making environmental and community-level changes.

It is the goal of this plan to break the silence.

## References

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# Alaska Diabetes Strategic Plan

## Background

The Alaska health care system is as diverse as the geography. Itinerant public health nurses and community health aides/practitioners provide most of the health care in rural areas. There are no managed care organizations. Twenty percent of Alaska's population has access to health care through tribally operated facilities. There one municipal health department is located in Anchorage, where 50% of the population resides. There are 24 hospitals, including 4 tertiary care facilities, 24 public health clinics managed by public health nurses, 24 Community Health Centers, and 12 regional tribal health clinics.

The statewide diabetes system that has evolved in Alaska has many strengths; however, it is fractionated and relatively uncoordinated. The 2004 Diabetes Statewide Assessment was the first attempt to identify the multiple and diverse components and to begin to establish mechanisms to achieve cohesiveness.

In March 2004, the Alaska Diabetes Prevention and Control Program initiated process of a statewide diabetes system assessment. Given the tremendous diversity in Alaska related to geography, cultures, and health care delivery systems, it was important to create an assessment process that was both efficient and cost-effective. Under the direction of the Alaska Diabetes Advisory Group, the assessment was conducted via electronic surveys and phone and face-to-face interviews to gather the initial data. Teleconferences and meetings were convened to prioritize recommendations and strategies. The assessment process involved over 100 diabetes partners from every region of the State.

Survey participants were selected according to the following criteria: their level of experience and expertise in the areas addressed by each of the ten national public health performance standards<sup>1</sup>; the region of the State they represented; the cultural and/or racial or ethnic community they represented; their reputation and level of credibility in the community; and their potential for commitment to the implementation of a long-term plan to control diabetes.

Because of the overlap and duplication among the hundreds of recommendations, the Alaska Diabetes Advisory Group collapsed them into four major categories:

(1) prevention and public awareness, (2) advocacy and policy, (3) data, information and research, and (4) training and programs. The Alaska Diabetes Advisory Group met to review each category of recommendations. The members were tasked with prioritizing the recommendations and strategies and identifying the partners necessary for their implementation. The criteria by which they made their recommendations are as follows: degree of public health impact; ability to improve access to quality care; ability to address primary prevention of diabetes in vulnerable and/or high-risk populations; ability to contribute to sustainable changes; and availability of resources to implement recommendations. The Alaska Diabetes Strategic Plan is the results of these efforts.



## Goals of the Alaska Diabetes Strategic Plan

1. Health promotion is prioritized through statewide planning and coordination
2. Statewide and community-wide policies are developed and implemented to promote the primary, secondary, and tertiary prevention of diabetes.
3. In order to understand the burden of diabetes in Alaska and to predict its effect on Alaskans in the future, diabetes data are collected, analyzed, and reported.
4. Community-based programs are empowered to develop and use evidence-based models of diabetes prevention and health promotion, and to educate individuals with diabetes about their rights.

<sup>1</sup> <http://www.apha.org/ppp/hipmain/govfinal.pdf>

The Alaska Diabetes Strategic Plan is divided into four sections corresponding with the four primary goals: within each of these sections are the recommendations and strategies, which were selected and prioritized by the Alaska Diabetes Advisory Group. Many of the recommendations are designed to reduce the long-term impact of diabetes (premature mortality, morbidity, and economic costs) among the 18,700 adult Alaskans already diagnosed with diabetes. Other recommendations address the benefits of secondary prevention efforts among those at greatest risk of diabetes because of their age, ethnicity, and lifestyle. The plan also includes recommendations to prevent diabetes by improving the overall health of the general population. Finally, it is the intention of this plan to provide both the impetus for action and guidance to communities, schools, healthcare providers, worksites, and public health leaders towards the goals of preventing and controlling diabetes in Alaska.

## 1. Prevention and Public Awareness

**Goal: Health promotion is prioritized through statewide planning and coordination.**

### Impact Statement

There is compelling evidence that type 2 diabetes and its complications can be prevented or delayed through lifestyle choices. To prevent and/or control diabetes requires the coordination of multiple partners. Although there is interest in diabetes prevention and control, many activities are done in isolation.

**Recommendation 1:** Provide relevant information on making healthy lifestyle choices to school age children in Alaska.

#### Strategies:

- Review existing healthy lifestyle education material targeting school-aged children.
- Develop new or adapt existing healthy lifestyle education materials to target school-aged children in Alaska.
- Disseminate healthy lifestyle education materials targeting school-aged children in Alaska to school districts statewide.

**Recommendation 2:** Partners in the Alaska diabetes system will work with the State of Alaska Chronic Disease & Health Promotion Section to design, implement, and evaluate a healthy lifestyle media campaign that will reach the adult population of Alaska.

#### Strategies:

- Build partnerships with worksites, non-profit organizations, local health departments, professional healthcare provider organizations, institutions of higher education, community health centers, faith institutions, State of Alaska agencies and programs, tribal organizations, and advocacy groups.

## 2. Advocacy and Policy

**Goal: Statewide and community-wide policies are developed and implemented to promote the primary, secondary, and tertiary prevention of diabetes.**

### Impact Statement

To optimize the general health of Alaska requires the development and implementation of policies at the community and state levels. The effectiveness of the direct involvement of the consumer in public health initiatives cannot be underestimated.

**Recommendation 1:** The State of Alaska will have statewide policies supporting healthy lifestyle choices.

#### Strategies:

- Ensure that all new road construction funded by the State of Alaska includes planning for walkways/pathways and/or bike paths.
- Ensure that state-maintained roads and sidewalks are plowed and maintained regularly.
- Ensure that the Municipality of Anchorage prioritize developing and maintaining sidewalks and walkways.

**Recommendation 2:** School district policies that mandate comprehensive physical education in K through 12 will exist in the school districts in Alaska.

**Strategies:**

- Support resolutions for comprehensive physical education in Alaska schools.
- Partner with existing groups targeting this issue, e.g., Take Heart Alaska, American Heart Association, and Alaska Parent Teacher Association.

**Recommendation 3:** School district policies prohibiting/eliminating food with no caloric value (i.e., candy, soda pop, etc.) in schools will exist in the school districts in Alaska.

**Strategies:**

- Support resolutions in school districts prohibiting or eliminating food with no caloric value.
- Partner with organizations working on nutritional policy in schools, e.g., Alaska Parent Teacher Association, Alaskans for Healthy Kids, and Eat Smart Alaska.

**Recommendation 4:** The primary insurance companies in Alaska will support the use of the ADA Recommended Standards of Diabetes Care.

**Strategies:**

- All health insurance organizations that have clients in Alaska will receive the *2004 Alaska Guidelines for Type 2 Diabetes Management*.
- Representatives of both diabetes healthcare providers and health insurance organizations in Alaska will meet to discuss current standards of care, and efforts they can collaborate on to improve management of diabetes cases.
- Assure use of the Alaska Parent Teacher Association.
- Recommendations for the Clinical Care of Adults with Type 2 Diabetes by including them as continuing medical education (CME) requirements for physicians, pharmacists, nurse practitioners, physician assistants, and registered nurses.
- State and private payer organizations will regularly disseminate information on best clinical practices related to diabetes practices.

**Recommendation 5:** The State of Alaska Chronic Disease & Health Promotion programs will formulate plans to reduce health disparities.

**Strategies:**

- Create a subcommittee to assess access to diabetes healthcare services.
- Conduct an ongoing assessment of issues relating to access to care.
- Provide technical support to community health centers to address health disparities.

**Recommendation 6:** Promote equal access to healthcare for special populations with diabetes.

**Strategies:**

- Distribute a resource list of partners who advocate for the rights of seniors and school-age children with diabetes.
- Support school district policies that assure the medical and safety needs of children with diabetes are met while they are in school.

**Recommendation 7:** Diabetes-related policy in Alaska Medicaid and Alaska Medicare will be reviewed annually and the results will be reported to the Alaska Diabetes Advisory Group.

**Strategies:**

- Present study results to the Commissioner of Department of Health and Social Services (DHSS) and the Director of Public Health.
- Represent diabetes issues in the newly formed Alaska Public Health Policy Forum.

**Recommendation 8:** Alaska Medicaid will reimburse providers for preventive health exams to beneficiaries at risk for diabetes.

**Strategies:**

- Develop a task force with representatives from Alaska Medicaid and the health care provider community.
- Complete a cost analysis study of Alaska Medicaid funds spent on complications versus Alaska Medicaid funds spent on prevention.
- Disseminate results to health insurance organizations in Alaska.

**Recommendation 9:** Certified Diabetes Educators (CDE) will be able to bill, and be reimbursed by, insurers directly.

**Strategies:**

- Provide technical support in an effort to pass legislation giving CDEs the ability to be independent contractors of Alaska Medicaid.

**Recommendation 10:** Pharmacists will be able to bill, and be reimbursed by, insurers for providing consultation for diabetes case management.

**Strategies:**

- Provide technical support in an effort to pass legislation giving pharmacists the ability to be reimbursed by Alaska Medicaid for case management consultation with persons with diabetes.

### 3. Data, Information and Research

**Goal:** In order to understand the burden of diabetes in Alaska and to predict its effect on Alaskans in the future, diabetes data are collected, analyzed, and reported.

#### Impact Statement

Reliable data on prevalence, morbidity and mortality, health behaviors and preventive practices related to diabetes are essential for assessing the impact of diabetes on the health of Alaskans and for determining health policies and practices.

**Recommendation 1:** The State of Alaska will increase funding to diabetes-related research in the state.

**Strategies:**

- Organize a conference highlighting current diabetes-related research in Alaska.
- Translate diabetes research results into reports and disseminate via the State of Alaska Diabetes Clearinghouse.

**Recommendation 2:** An information system will be established to facilitate program assessment, implementation and evaluation in Alaska communities.

**Strategies:**

- Establish a web page within the Alaska Health Library Project, on which information on program assessment, implementation and evaluation efforts in Alaska is posted.
- Establish a diabetes list to provide information on diabetes information, activities, grants and data to community-based program coordinators and planners.
- Community-based programs that receive funding from the state of Alaska Chronic Disease & Health Promotion programs will attend a web-based workshop on program evaluation.
- Community-based health promotion programs from around Alaska will attend a workshop on community assessment and coalition building.
- Provide on-site technical assistance on program assessment, implementation, evaluation, and cultural appropriateness to community-based health promotion programs.

**Recommendation 3:** Descriptions of the activities, goals and outcomes of each community-based program that receives state funds from the Chronic Disease & Health Promotion programs will be available for dissemination statewide.

**Strategies:**

- Current grantees projects will be entered in the Alaska Health Education Library Project database.
- Provide technical assistance to community-based, or worksite, projects to write-up the results of their intervention for review, and have them disseminated to community-based programs statewide.

**Recommendation 4:** A clearinghouse for statewide diabetes data, regulations, and clinical practice guidelines will be developed and maintained.

**Strategies:**

- Provide technical assistance on diabetes data analysis to at least 15 community-based programs or non-profit organizations.
- Produce a diabetes data source fact sheet, which will describe the various diabetes data sources, and disseminate it to its partners in the Alaska diabetes system.
- Design a training program for interpreting and using health data to enhance communication between those doing diabetes surveillance and those providing direct care to persons with diabetes.
- Implement and evaluate a data-use training program for 50% of health care providers in the community care centers.

**Recommendation 5:** The Alaska BRFSS will include one or more questions on pre-diabetes.

**Strategies:**

- Prepare a justification “white paper” to advocate for the inclusion of at least one pre-diabetes question on the Alaska BRFSS.

**Recommendation 6:** The following databases will be reviewed annually for data related to diabetes: Alaska BRFSS, Vital Statistics, Alaska State Hospital Discharge data, United States Renal Data System, Alaska Medicaid, and Alaska Medicare.

**Strategies:**

- Create a data workgroup to establish and maintain a health data list with statewide data related to diabetes.
- Monitor and report statewide diabetes trends.

**Recommendation 7:** Diabetes data reports will be prepared and disseminated via the State Diabetes web page and/or as Section of Epidemiology Bulletins.

**Strategies:**

- Release a series of papers on diabetes prevalence, mortality, cost, and risk factors.
- Complete the *Burden of Diabetes Alaska* monograph, which will describe diabetes statewide, and will be disseminated to all partners in the Alaska diabetes system.

**Recommendation 8:** The economic burden of diabetes in Alaska will be calculated and monitored over time.

**Strategies:**

- Identify data sources to be evaluated for an estimate of diabetes cost in Alaska.
- Publish and disseminate a monograph on the economic burden of diabetes in Alaska.

**Recommendation 9:** Alaska's progress towards Healthy Alaskans 2010 diabetes objectives will be monitored and assessed.

**Strategies:**

- Review the progress towards the Healthy Alaskans 2010 goals every two years.
- Report progress towards the 2010 goals in the form of an Epidemiology Bulletin.

## 4. Training and Programs

**Goal:** Community-based programs are empowered to develop and use evidence-based models of diabetes prevention and health promotion, and to educate individuals with diabetes about their rights.

### Impact Statement

Evidence-based health care is informed by research and uses the best current knowledge for decision-making. Evidence-based community programs recognize the interrelationship between behaviors and the environment and utilize multiple interventions directed at multiple levels.

**Recommendation 1:** All community-based programs receiving state funds from the Chronic Disease & Health Promotion programs will pilot or implement evidence-based models of intervention with outcome-based evaluation.

#### Strategies:

- Provide funding to worksites to determine the feasibility of implementing worksite health promotion programs to target obesity, diabetes and cardiovascular health.
- Partner with other State of Alaska programs and agencies to pilot evidence-based models of intervention.

**Recommendation 2:** Staff and patients at community health centers in Alaska will be trained in the Chronic Disease Self-Management Program (CDSMP).

#### Strategies:

- Sponsor a CDSMP training.
- Provide support for community health centers (CHC) to attend the training.
- Develop a core group of master trainers to teach CDSMP leaders at CHCs.

**Recommendation 3:** Alaskans with diabetes will have access to a diabetes educator in their community.

#### Strategies:

- Assess the potential of non-certified diabetes educators as a part of the statewide diabetes system in Alaska.
- Engage the support of the Alaska Medical Association, Alaska Nurse Practitioners Association, Alaska Academy of Physician Assistants, Alaska Nurses Association, Alaska Dental Association and the Alaska Pharmacists Association in regard to diabetes education in Alaska.
- Develop programs for training all levels of health care providers as diabetes educators in Alaska.

**Recommendation 4:** Alaskans with diabetes will be educated on their rights in school and workplace settings.

#### Strategies:

- Students with diabetes may face discrimination based upon the “silent” nature of their disability. In order to meet the requirements of No Child Left Behind and the High School Graduation Qualifying Exam, students with diabetes and their parents will be educated on their legal rights.
- Develop programs to teach adults with diabetes about workplace accommodations to which they are entitled that enable them to perform their jobs while also controlling their diabetes.

## Strategic Planning Partners

Recommendation	Partners
<b>Prevention and Public Awareness</b>	
Provide relevant information on making healthy lifestyle choices to school age children in Alaska.	AK Action for Healthy Kids Coalition, AK Association of Diabetes Educators, AK Association of School Nurses, AK Family Nutrition Programs, AK Obesity Control Program, AK Parent Teacher Association, AK School Health Program, AK School Nutrition Association, American Diabetes Association, Anchorage School District, Community Wellness Advocates, Eat Smart Alaska, Take Heart Alaska
Partners in the Alaska diabetes system will work with the Alaska Chronic Disease & Health Promotion workgroup to design, implement, and evaluate a healthy lifestyle media campaign that will reach the adult population of the state.	AK Arthritis Program, AKBRFSS, AK Cancer Control Program, AK Cardiovascular Health Program, AK Community Preventive Services Program, AK Health Promotion Program, AK Obesity Control Program, AK Tobacco Control Program, AKYRBS
<b>Advocacy and Policy</b>	
Alaska will have statewide policies supporting healthy lifestyle choices.	AK Chronic Disease Policy Academy, AK Director of Public Health, AK Legislature
School district policies that mandate comprehensive physical education in K through 12 will exist in the school districts in Alaska.	Alaskans Promoting Physical Activity, AK Action for Healthy Kids Coalition, AK Association of School Nurses, AK Family Nutrition Programs, AK Obesity Control Program, AK Parent Teacher Association, AK School Health Program, American Diabetes Association, Anchorage School District, Take Heart Alaska
School district policies prohibiting and/or eliminating food with no caloric value (i.e., candy, soda pop, etc.) in schools will exist in the school districts in Alaska.	Action for Healthy Kids, AK Association of Diabetes Educators, AK Association of School Nurses, AK Family Nutrition Programs, AK Obesity Control Program, AK Parent Teacher Association, AK School Health Program, American Diabetes Association, Anchorage School District, Eat Smart Alaska, Take Heart Alaska
The primary insurance companies in Alaska will improve their coverage to meet the ADA Recommended Standards of Diabetes Care.	Aetna, AK Medicaid, American Diabetes Association, Medicare, Qualis Health, Premera Blue Cross
The Chronic Disease & Health Promotion programs will formulate plans to reduce health disparities.	AK Arthritis Program, AK Cardiovascular Health Program, AK Chronic Disease & Health Promotion programs, AK Chronic Disease Policy Academy, AK Obesity Control Program, AK Primary Care Association, AK Tobacco Control Program
Equal access to healthcare for special populations with diabetes will be promoted.	AK Native Tribal Health Consortium, AK Primary Care Association, American Diabetes Association, Anchorage Neighborhood Health Clinic, Federal Asian Pacific American Council, Filipino Community of Anchorage Inc., Hispanic Women's Health Coalition, National Association for the Advancement of Colored People
Diabetes-related policy in Medicaid and Medicare will be reviewed annually and the results will be reported to the Alaska Diabetes Advisory Group.	AK Medicaid, AK Medicare, American Diabetes Association
Medicaid will reimburse providers for preventive health exams to beneficiaries at risk for diabetes.	AK Medicaid, American Diabetes Association
Certified Diabetes Educators (CDE) will be able to bill, and be reimbursed by, insurers directly.	AK Association of Diabetes Educators, AK Medicaid, American Diabetes Association
Pharmacists will be able to bill, and be reimbursed by, insurers for providing consultation for diabetes case management.	AK Association of Diabetes Educators, AK Medicaid, AK Pharmacists Association, American Diabetes Association

## Strategic Planning Partners

Recommendation	Partners
<b>Data, Information and Research</b>	
The State of Alaska will increase funding to diabetes-related research in the state.	AK Chronic Disease & Health Promotion programs, University of Alaska
An information system will be established to facilitate program assessment, implementation and evaluation in Alaska communities.	AK Chronic Disease & Health Promotion programs, AK Dept. of Administration Information Technology Services, AK Health Education Library Project
Descriptions of the activities, goals and outcomes of each community-based program that receives state funds from the Chronic Disease & Health Promotion programs will be available for dissemination statewide.	AK Chronic Disease & Health Promotion programs
A clearinghouse for statewide diabetes data, regulations, and clinical practice guidelines will be developed and maintained.	AK Chronic Disease & Health Promotion programs, AK Technology Services, AK Health Education Library Project, AK Section of Epidemiology
The Alaska BRFSS will include one or more questions on pre-diabetes.	AK BRFSS, AK Chronic Disease & Health Promotion programs, CDC BRFSS
The following databases will be reviewed annually for data related to diabetes: BRFSS, Vital Statistics, AK State Hospital Discharge data, US Renal Data System, AK Medicaid, and AK Medicare.	AK Chronic Disease & Health Promotion programs, AK Dept. of Administration Information Technology Services
Diabetes data reports will be prepared and disseminated them via the State Diabetes web page and/or as Section of Epidemiology Bulletins.	AK Dept. of Administration Information Technology Services, AK Division of Public Health
The economic burden of diabetes in Alaska will be calculated and monitored over time.	AK Medicaid, Medicare, Premera Blue Cross, Qualis Health, Veterans Administration
Alaska's progress towards Healthy Alaskans 2010 diabetes objectives will be monitored and assessed.	AK BRFSS, AK Dept. of Administration Information Technology Services, AK Division of Public Health
<b>Training and Programs</b>	
All community-based programs receiving state funds from the Chronic Disease & Health Promotion programs will pilot or implement evidence-based models of intervention with outcome-based evaluation.	AK Chronic Disease & Health Promotion programs, AK Dept. of Administration Information Technology Services, AK Health Education Library Project, AK Section of Epidemiology
Staff and patients at community health centers in Alaska will be trained in the Stanford Chronic Disease Self-Management Program (CDSMP).	AK Arthritis Program, AK Chronic Disease Policy Academy, AK Director of Public Health, AK Office of Health Planning and Systems Development, AK Primary Care Association
Alaskans with diabetes will have access to a diabetes educator in their community.	AK Association of Diabetes Educators, American Diabetes Association
Alaskans with diabetes will be educated on their rights in school and workplace settings.	AK Association of Diabetes Educators, American Diabetes Association, Disability Law Center of Alaska, University of Alaska's Center for Human Development.

## Timeline for Strategic Plan

### Prevention and Public Awareness

- By June 2005, review existing healthy lifestyle education material targeting school-aged children.
- By June 2005, make a presentation on the performance improvement plan to the Chronic Disease & Health Promotion workgroup.
- By June 2006, develop new or adapt existing healthy lifestyle education materials to target school-aged children in Alaska.
- By July 2007, the Chronic Disease & Health Promotion workgroup will develop a healthy lifestyle campaign.
- By June 2009, disseminate healthy lifestyle education materials targeting school-aged children in Alaska to 50% of school districts statewide.

### Advocacy and Policy

- By March 2006, present a resolution prohibiting or eliminating food with no caloric value to 50% of school districts in the state.
- By March 2006, all health insurance organizations that have clients in Alaska will receive the *2004 Alaska Guidelines for Type 2 Diabetes Management*.
- By March 2006, representatives of both diabetes healthcare providers and health insurance organizations in Alaska will meet regularly to discuss current standards of care, and efforts they can collaborate on to improve management of diabetes cases.
- By March 2006, a subcommittee of the Alaska Diabetes Advisory Group will be created to assess access to diabetes healthcare services among high-risk populations.
- By March 2007, assure use of the *Alaska Guidelines for the Clinical Care of Adults with Type 2 Diabetes* by including them as continuing education (CME/CEU) requirements for physicians, pharmacists, nurse practitioners, physician assistants, and registered nurses.
- By March 2008, the Chronic Disease & Health Promotion workgroup will conduct an assessment of issues relating to access to care.
- By March 2008, a pilot cost-study of Medicaid funds spent on complications versus Medicaid funds spent on prevention will be completed, reviewed and disseminated to health insurance organizations in Alaska.
- By March 2010, the Chronic Disease & Health Promotion workgroup will complete an assessment of access to healthcare in Alaska, and formulate plans to reduce health disparities related to diabetes.
- By March 2010, school district policies that mandate comprehensive physical education in K-12 will exist in 25% of the school districts in Alaska.
- By March 2010, school district policies prohibiting/eliminating food with no caloric value (i.e., candy, soda pop, etc.) in schools will exist in 25% of the school districts in Alaska.
- By March 2010, diabetes-related policy in Medicaid and Medicare will be reviewed annually and the results will be reported to the Alaska Diabetes Advisory Group.
- By March 2010, Medicaid will reimburse providers for wellness exams to beneficiaries at risk for diabetes.
- By March 2010, 50% of the privately insured population in Alaska will have full coverage to meet the ADA Recommended Standards of Diabetes Care.
- By March 2010, Certified Diabetes Educators will be able to bill, and be reimbursed by, insurers directly.
- By March 2010, Pharmacists will be able to bill, and be reimbursed by, insurers directly for diabetes consultation.

## Data, Information, and Research

- By March 2006, a web page will be established within the Alaska Health Library Project, on which information on program assessment, implementation and evaluation efforts in Alaska are posted.
- By March 2006, a diabetes listserv will be established to provide information on diabetes information, activities, grants and data to community-based program coordinators and planners.
- By March 2006, technical assistance on diabetes data analysis will be provided to at least 15 community-based programs or non-profit organizations.
- By March 2006, the *Burden of Diabetes in Alaska* monograph, which will describe diabetes statewide, will be completed and disseminated to all partners in the Alaska diabetes system.
- By March 2006, a diabetes data source fact sheet, which will describe the various diabetes data sources, will be produced and disseminated to its partners in the Alaska diabetes system.
- By March 2006, create a data workgroup to establish, disseminate, and maintain a health data list with national and statewide data related to diabetes.
- By March 2006, a justification “white paper” will be prepared to advocate for the inclusion of at least one pre-diabetes question on the 2007 Alaska BRFSS.
- By March 2007, design a training program for interpreting and using health data to enhance communication between those doing diabetes surveillance and those providing direct care to persons with diabetes.
- By March 2007, implement and evaluate a data-use training program for 50% of health care providers in the community care centers.
- By March 2007, more than 50% of community-based programs that receive funding from the state of Alaska Chronic Disease & Health Promotion programs will attend a web-based workshop on program evaluation.
- By March 2008, the Alaska Diabetes Advisory Group will organize a conference highlighting current diabetes-related research in Alaska.
- By 2008, Alaska’s progress towards Healthy Alaskans 2010 diabetes objectives will be assessed.
- By March 2010, at least 15 community-based health promotion programs from around Alaska will attend a workshop on community assessment and coalition building.
- By March 2010, on-site technical assistance will be provided on program assessment, implementation or evaluation to at least 10 community-based health promotion programs.
- By March 2010, at least 15 community-based programs from around Alaska will receive training on determining cultural appropriateness in program planning from the State of Alaska Chronic Disease & Health Promotion Unit.
- By March 2010, an information system will be established to facilitate program assessment, implementation and evaluation in Alaska communities.
- By March 2010, the State of Alaska will increase funding to diabetes-related research in the state by 10%.
- By March 2010, a clearinghouse for statewide diabetes data, regulations, and clinical practice guidelines will be developed and maintained.

## Training and Programs

- By March 2006, technical assistance will be provided to two community-based, or worksite, projects to write-up the results of their intervention for review, and have them disseminated to community-based programs statewide.
- By March 2006, the Chronic Disease & Health Promotion workgroup will update current grantees projects in the Alaska Health Education Library Project database.
- By March 2006, the Alaska Diabetes Program, the Alaska Obesity Program and the Alaska Cardiovascular Health Program will fund at least 2 worksite wellness demonstration projects to target obesity, diabetes and cardiovascular health.

- By March 2007, progress towards the diabetes-related Healthy Alaskans 2010 goals will be reported and disseminated statewide.
- By March 2007, the Alaska Diabetes Advisory Group will assess the potential of non-certified diabetes educators as a part of the statewide diabetes system in Alaska.
- By March 2008, the Alaska Diabetes Advisory Group will engage the support of the Alaska Medical Association, Alaska Nurse Practitioners Association, Alaska Academy of Physician Assistants, Alaska Nurses Association, Alaska Dental Association and the Alaska Pharmacists Association in regard to diabetes education in Alaska.
- By March 2007, develop programs and materials for students and their parents regarding their legal rights within the educational system.
- By March 2008, develop programs and materials to educate workers regarding their legal rights in the workplace.
- By March 2010, 75% of federally qualified community healthcare centers in Alaska will be trained in the Chronic Disease Self-Management Program (CDSMP).
- By March 2010, the Alaska Diabetes Advisory Group and its partners in the community will develop programs for training all levels of health care providers as diabetes educators in Alaska.
- By March 2010, 50% of Alaskans with diabetes will have access to a diabetes educator in their community.
- By March 2010, all community-based programs receiving state funds from the Chronic Disease & Health Promotion programs will pilot or implement evidence-based models of intervention with outcome-based evaluation.
- By March 2010, a description of the activities, goals and outcomes of each community-based program that receives state funds from the Chronic Disease & Health Promotion programs will be available for dissemination statewide.

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# 2004 Recommendations for the Management of Diabetes Type 2 in Adults

Criteria for the Diagnosis of Diabetes Type 2 in Adults
1. Symptoms of diabetes (polyuria, polydipsia, unexplained weight loss) plus casual* plasma glucose concentration $\geq 200$ mg/dl * Casual is defined as any time of day without regard to time of last meal.
or
2. FPG $\geq 126$ mg/dl
or
3. 2-hour postload glucose $\geq 200$ mg/dl during an OGTT (using a glucose load equivalent to 75 g anhydrous glucose dissolved in H <sub>2</sub> O).
Note: In the absence of unequivocal hyperglycemia, these criteria should be confirmed by repeat testing on a different day.

Criteria for Screening Asymptomatic Adults
1. Testing should be considered for all adults $\geq 45$ years of age, particularly in those with BMI $\geq 25$ kg/m <sup>2</sup> . If testing is normal, it should be repeated in 3-year intervals.
2. Testing should be considered at a younger age or be done more frequently in individuals with BMI $\geq 25$ kg/m <sup>2</sup> and who have additional risk factors: is physically inactive; has a first degree relative with diabetes; is a member of a high-risk ethnic population (e.g., African American, Asian American, Hispanic/Latino, Native American, Pacific Islander); has delivered a baby $> 9$ lb; has been diagnosed with GDM; is hypertensive; has an HDL-C level $\leq 35$ and/or a triglyceride level $\geq 250$ ; has polycystic ovary syndrome; has been diagnosed with IGT or IFG on previous testing; has a history of vascular disease; or has other clinical conditions associated with insulin resistance (e.g., dyslipidemia, PCOS or acanthosis nigricans).

Criteria for the Diagnosis of Pre-diabetes		
Definitions	Values	Comments
IFG Impaired Fasting Glucose	100-125 mg/dl	Fasting is defined as no caloric intake for at least 8 hours.
or		
IGT Impaired Glucose Tolerance	140-199 mg/dl (2-hour postload)	Test uses a glucose load equivalent to 75 g anhydrous glucose dissolved in H <sub>2</sub> O.

Therapeutic Goals for (non-pregnant) Adults with Diabetes Type 2	
Test	Goal Values
A1C	$< 7\%$ *
BP	$\leq 120/80$ **
Lipids:	
LDL-C	$< 100$ mg/dl
HDL-C	$> 45$ mg/dl (men) $> 55$ mg/dl (women)
Triglycerides	$< 150$ mg/dl
Total Cholesterol	$< 200$ mg/dl***
SBGM:	
FBS	80-120 mg/dl
2-hr. post prandial	$< 160$ mg/dl

Antiplatelet Therapy	ASA 75-162 mg/day
Note: Goals should account for individual patient circumstances.	
* A more stringent goal, i.e., $< 6\%$ , can be considered for some patients.	
** The 2004 ADA recommendation for BP is $< 130/80$ , except for patients with renal dysfunction, in which the goal is 120/75. The goal reflected above is based on the recommendation of JNC7.	
*** In patients over 40 years of age with a TC $\geq 135$ mg/dl, statin therapy to achieve an LDL reduction of 30%, regardless of baseline LDL levels, may be appropriate.	

Components of the Initial Comprehensive Evaluation of Adults with Diabetes Type 2	
History	Medical and family history; assessment of lifestyle, risk factors, activity level, cultural/psychosocial issues.
Physical Exam	Height, weight, BMI, fundoscopic, oral, thyroid palpation, cardiac, abdominal, pulses, extremities, skin, neurological; check sensation with 10 g microfilament
Labs/Tests	A1C, fasting lipid profile, ALT, AST, lytes, BUN, creatinine, TSH (if indicated), UA, microalbuminuria, ECG
Referrals	Ophthalmologist for eye exam, dietician/nutritionist, diabetes educator, foot specialist

Components of Each Clinic Visit for Adults with Diabetes Type 2	
Test	Comments
BP	Monitor and adjust therapy to keep BP $\leq 120/80$ .
Weight	Compare with previous weights to monitor trends.
Blood Glucose	Check random SBGM. Review log of patient's SBGM results. Adjust therapy to attain glycemic goals.
Foot Check	Inspect feet for lesions, ingrown nails, infection, pressure points, calluses, and etc.
Education	Make referrals as indicated.

Patient Education for Adults with Diabetes Type 2		
Topic	Content/Goals	Frequency
General Diabetes Education	Patients and their families should receive diabetes self-management information. This forms the basis for the plan of care and promotes mutually set goals and strategies.	Every visit
Smoking Cessation	Advise all patients not to smoke or use tobacco products. Refer to tobacco cessation program as indicated. Nicotine replacement therapy recommended.	Initial visit; ongoing as indicated
Exercise	Regular physical activity program should be adjusted to the presence of complications. Instruction should address recreational and leisure activities as well as patient's ability to adjust therapy and nutrition to facilitate safe participation. Before beginning a physical activity program, patient should be screened for macro-and micro-vascular complications that may be worsened with physical activity. Consider graded exercise tolerance test in patients with known or suspected CHD.	Every visit
Nutrition	Plan should include assessment of patient's intake, lifestyle, cultural preferences, metabolic states, readiness to make changes, goal setting, dietary instruction, & evaluation.	Every visit; q 6-12 mos. w/RD or nutritionist
SMBG	Instruct patients in self-monitoring of blood glucose (SMBG); routinely review patient's technique and ability to use data to adjust therapy as indicated.	Every visit

Yearly Exams and Tests for Adults with Diabetes Type 2	
Test	Comments
A1C	Twice yearly in patients who are meeting tx goals; quarterly in patients whose therapy has changed or who are not meeting tx goals
Fasting Lipid Panel	Consider pharmacological ix if lifestyle and dietary modifications are ineffective in lowering LDL-C. Re-evaluate lipid profiles 6-12 weeks after new therapies are initiated.
Serum Creatinine	Screen for renal insufficiency.
UA/ Microalbuminuria	Test for protein in urine. Presence of cells, with proteinuria, may indicate alternate diagnosis.
Dilated Eye Exam	Retinal exam either through dilated pupils or stereofundus photos. Consider less frequent exams of low-risk patients based on the advice of a eye care professional.
Dental Exam	Screen for periodontal disease and examine gums and oral cavity for lesions.
Foot Exam	Neurovascular foot exam w/ pulse check, ROM, and 10 g monofilament sensation in 7-9 areas per foot. Also check for ingrown nails, lesions, and any deformities.
Flu Vaccine	Vaccinate yearly.
Pneumovac	Immunize at time of diagnosis if needed. Re-immunize q 6 years.

Routine Health Maintenance for Adults with Diabetes Type 2	
Test/Exam	Frequency
Physical Exam	Yearly.
Pap Smear/Pelvic Exam	Yearly or as per guidelines.
Breast Exam	Yearly.
Mammogram	In women 40-49, q 1-2 years; yearly for women $\geq 50$ .
Rectal Exam & PSA	In men $\geq 50$ for prostate evaluation.
CRC Screening	For average risk pt., flexible sigmoidoscopy should begin at age 50 and then q 5 yrs. If pt. at risk for earlier onset CRC, screening should begin earlier with colonoscopy and be done more frequently.

# STATE OF ALASKA



## ***Executive Proclamation*** ***by*** ***Frank H. Murkowski, Governor***

Diabetes is currently at epidemic proportions. In the United States, 18.2 million adults have diabetes and this number is predicted to reach 30 million by 2030. Every year, 1.3 million new cases are diagnosed in people 20 years and older.

The prevalence of diabetes in Alaska has doubled in the past ten years. Currently five percent of Alaskans over 18 years old (22,589 individuals) have been told by a doctor that they have diabetes.

It is estimated that another 7,000 Alaskans have diabetes but have not had it diagnosed by a doctor, which puts them at increased risk for complications, including heart disease, stroke, blindness, kidney failure, and lower extremity amputation.

Diabetes is the fourth leading cause of death in Alaska. Sixty-five percent of people with diabetes die from heart disease and stroke. Diabetes is also the leading cause of blindness.

Although Americans with diabetes comprise six percent of the population, they consume ten percent of U.S. health care dollars or \$140 billion per year. In the Medicare population, diabetes accounts for one in four health care dollars.

There is an alarming trend in the increasing number of children and adolescents who are being diagnosed with Type 2 diabetes, directly attributed to being overweight and physical inactivity. It is estimated that one in three children born in the year 2000 will develop diabetes as a consequence of obesity. In Alaska, 25 percent of high school students are above normal weight.

Diabetes can be prevented or managed through a healthy diet, weight control, and exercise. Partnering with their health care provider, Alaskans with diabetes can live normal and productive lives.

Those at greatest risk for diabetes include Alaskans who have one or more of the following characteristics: greater than 44 years of age, physically inactive, overweight, and family history of diabetes.

NOW, THEREFORE, I, Frank H. Murkowski, Governor of the State of Alaska, do hereby proclaim November 2004 as:

### ***Diabetes Awareness Month***

in Alaska, and ask all Alaskans to engage in healthy and active lifestyles; to delay and/or prevent diabetes through a healthy diet, weight control, and physical activity; to become aware of the risk factors for diabetes and to seek early diagnosis if at risk; and for those diagnosed with diabetes, to manage it through physical activity, smoking cessation, and control of their weight, blood glucose, blood pressure, and cholesterol to live longer and healthier lives.

DATED: October 25, 2004



A handwritten signature of Frank H. Murkowski in black ink.

*Frank H. Murkowski, Governor*  
*who has also authorized the*  
*seal of the State of Alaska to*  
*be affixed to this proclamation.*

## Alaska Diabetes Prevention and Control Program (AKDPCP)

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