Moving Toward a System of Diabetes Prevention and Care in Kentucky: A Proposal for Community Action against Chronic Disease, Lexington, Kentucky, May, 2012.

Executive Summary

Summary

In 2009, Kentucky ranked 4th in the nation in diabetes prevalence. (Kentucky Diabetes Network) As one of the unhealthiest states in the U.S., the Commonwealth consistently ranks high on physical inactivity, poor nutrition, and weight or obesity measures – all of which contribute to the development of adult onset or Type 2 diabetes that accounts for 90-95% of all cases of diabetes. No single healthcare purchaser, plan or provider can improve the outcome of chronic diseases like diabetes on its own. To improve care throughout a community, key health care partners--including local citizens--must define and coordinate strategies that are measurable and achievable. For purposes of this report, "community" refers to the population in a geographical area as a "community" which in Kentucky is usually a county or city.

Prevalence

"In the past 15 years, the percentage of Kentuckians who reported that they had been told they have diabetes has increased nearly three-fold, from 3.5% in 1995 to 10% in 2010… Like many chronic diseases, the prevalence of diabetes is strongly linked to… characteristics such as race, age, economic status and geographic location. In addition, poor nutritional choices, lack of physical activity, and rising rates of obesity combine with these factors to produce a particularly favorable climate for an increase in diabetes prevalence in Kentucky over the next decade and beyond". (Wood T, Pohl SL, 2011)

Creating a Statewide Framework

The implementation of a state-wide health system that is geared to the prevention, detection and management of diabetes requires help from not only the health care sector but business leaders, community support groups, and lay men and women. Creating a system that is both accessible and practical for all members of the community would result in the achievement of four goals:

1) All people with diabetes would have a proper diagnosis.
2) All people with diabetes would be taking action to eliminate or monitor for diabetes-related complications.
3) All people at risk for diabetes would be educated about healthy lifestyle choices and diabetes prevention, and be given the tools to make such choices.
4) All communities throughout Kentucky would know how to support and help education, screening and management efforts.

The Problem

The largest gap in primary, secondary, and tertiary prevention of Type 2 diabetes is the failure of health providers and communities to recognize that diabetes is a societal, and not just a medical problem; and has become an increasingly serious community health problem for its citizens and economy. For far too long we have viewed diabetes as something to be dealt with by individuals and their families as a private and not a community concern, and in many cases without a system of coordinated, comprehensive clinical management. Although the approach to diabetes prevention and care is often exemplary in many organizations or locations, it is still seen by some health professionals in the field as "working in our own silos".

Additionally, many communities fail to have clearly stated and measurable goals for optimal nutrition and exercise, and to have a plan for assessing outcomes.
Nationwide, 25% of people with diabetes do not know they have the disease and up to 90% of people with pre-diabetes do not recognize it.

Moving Ahead: Solutions for Community Success

Each community, organization or employer must find a way to take responsibility for the health of its population. Many successful programs have been implemented around the state and across the nation. What can groups without successful programs in place do to improve the health of their citizens both at risk for and who have developed diabetes?

1) Create a system of accountability- Identify a community agency or existing coalition or health department to take a leadership role in community activities and take responsibility for the diabetes health of the population.
2) Define what constitutes success for diabetes prevention, detection and treatment. One possible starting point for measurement would be a) to have all programs measure patients' values for A1c over time, the frequency of patients' blood glucose self-monitoring, performance of annual foot exams, performance of annual dilated eye exams, and annual assessment of kidney function b) to use quality indicators such as hospital and emergency room admissions, incidence of diabetes complications (diabetic retinopathy, amputations, etc.) and death rates due to diabetes.
3) Document community personnel resources for dealing with diabetes, including diabetes educators, primary care providers, endocrinologists, nurse practitioners, physician assistants, dentists, pharmacists, podiatrists, school nurses, and others; and community organizational resources, including medical centers, hospitals, managed care organizations and other health plans, medical clinics, boards of health, boards of education, mental health professionals, cooperative extension services, churches and the religious community (including parish nurses), the YMCA and fitness centers, and community colleges and universities training health professionals, businesses looking to increase employee health and productivity, and branches of diabetes support groups and voluntary health organizations.
4) Engage in an action planning process that involves all community partners, including the community resources noted above.

Conclusion

Conquering the mountain of diabetes in the Commonwealth cannot be accomplished by one person, one business, or health provider working alone. Taking a community-oriented approach, as exemplified above, with informed and empowered citizens, will reduce the burden of diabetes and help Kentucky become a healthier state. It is no small task; but the recognition that each community and each person plays a role in the health of our state is essential. Whether it is through on-the-job wellness programs, cooperative community activities, or at the hospital bedside, effectively dealing with diabetes can remove Kentucky from the top of the state's chronic disease hierarchy--and you can be a part of the change.

Wood, T., Pohl, S.L., (2011). Kentucky Diabetes Epidemic: Challenges for the Kentucky Health Care System, Journal of the Kentucky Medical Association, 109, 31-324.