



# OCDPCP

## Ohio Community Diabetes Control Program

*"Let's make Ohio the place where people with diabetes live better lives!"*

## CDC Issues New Format For Diabetes Grants

In February 2000 Centers for Disease Control issued a new evaluation strategy for the Diabetes Control Programs (DCPs) to follow in their grant application process. The key changes in the expectations of program evaluation included:

- Addressing evaluation from a public health perspective
- Assuring that efforts are directed toward specific National Objectives
- Assuring that an evaluation plan reports progress on measurable impact and outcome objectives
- Assuring that measurable process objectives relate to the impact and outcome objectives

Earlier phases of the National Diabetes Control Program focused on development of infrastructure such as partnerships, coalition building, data collection strategies, and advisory committees. While these activities continue to be essential, they are expected to assist the programs in achieving their objectives which must also address all 7 of the National Objectives.

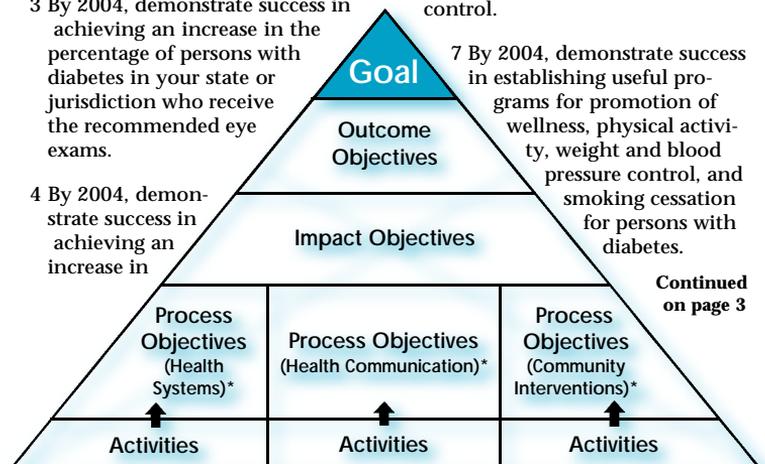
### National Objectives

- 1 By the end of 1999, establish measurement procedures to track program success in reaching the following objectives. (Grantees that have not completed this requirement are expected to have completed it by July 1, 2000).
- 2 By 2004, demonstrate success in achieving an increase in the percentage of persons with diabetes in your state or jurisdiction who receive the recommended foot exams.
- 3 By 2004, demonstrate success in achieving an increase in the percentage of persons with diabetes in your state or jurisdiction who receive the recommended eye exams.
- 4 By 2004, demonstrate success in achieving an increase in

the percentage of persons with diabetes in your state or jurisdiction who receive the recommended influenza and pneumococcal vaccines.

- 5 By 2004, demonstrate success in achieving an increase in the percentage of persons with diabetes in your state or jurisdiction who receive the recommended HbA1C tests.
- 6 By 2004, demonstrate success in reducing health disparities for high-risk populations with respect to diabetes prevention and control.

- 7 By 2004, demonstrate success in establishing useful programs for promotion of wellness, physical activity, weight and blood pressure control, and smoking cessation for persons with diabetes.



\* Basic methods or strategies promoted by the Diabetes Translation Program, Centers for Disease Control and Prevention.

# Work Plan for the Ohio Community Diabetes Control Program

July 1, 2000 starts the third year of funding for the OCDPCP Comprehensive Cooperative Agreement with the Centers for Disease Control and Prevention. The application for 2000-2001 follows the new format issued by CDC and includes an overall goal, outcome, impact and process objectives, activities and evaluation to meet the seven National Objectives (see CDC Issues page 1).

Based on the findings of the chart audits at the rural Community Health Centers (CHCs), forty-seven percent of all HbA1cs were > 8. The outcome objective for the program is to decrease HbA1cs > 8 to no more than 30% by June 30, 2005. By doing chart audits and using computer generated analyses, OCDPCP and the CHCs will be able to track data for improved patient care outcomes. Activities will focus on helping the professional staff increase the percentage of visual and sensory foot exams, routine

HbA1c tests, flu and pneumonia vaccines and referrals for dilated eye exams.

A second area of focus for the OCDPCP is to expand programs and services for the African American and Hispanic population. This will be accomplished through collaborative linkages and coordination with community and interdepartmental partners. The messages and materials from NDEP will be promoted and distributed.

A new area of activity for OCDPCP will be to plan, develop or expand and evaluate diabetes prevention and control interventions in local communities, using the "Diabetes Today" Model. This train the trainer approach will integrate diabetes management into existing physical activity, weight/lipid/blood pressure control and/or smoking cessation programs. Linkages will be made with the Cardiovascular Disease projects, local hospitals, health departments and extension services.

## WebSites

American Diabetes Association  
<http://www.diabetes.org>  
 American Association of Diabetes Educators  
<http://www.aadenet.org>  
 American Dietetic Association  
<http://www.eatright.org>  
 CDC: Division of Diabetes Translation  
 Centers for Disease Control  
 "Take Charge of Your Diabetes"  
<http://www.cdc.gov/nccdphp/ddt>  
 Diabetes Today National Training Center Newsletter  
<http://www.diabetestodayntc.org/newsletter/Dec1999.pdf>  
 Juvenile Diabetes Foundation International  
<http://www.jdfcure.org>  
 National Diabetes Education Program  
<http://www.ndep.nih.gov>  
 National Eye Health Education Program  
<http://www.nei.nih.gov>  
 National Institutes of Diabetes & Kidney Disease  
<http://www.niddk.nih.gov>  
 National Center for Chronic Disease Prevention & Health Promotion, Division of Diabetes Translation  
<http://www.cdc.gov/diabetes>  
 State Diabetes Control Programs  
<http://www.cdc.gov/diabetes/states/states.htm>  
 [yes, states are listed twice]

The source of the dates and the websites are from the Public Health specialty group of AADE.

## Ohio WebSites

Central Ohio Diabetes Association  
[www.diabetesohio.org](http://www.diabetesohio.org)  
 Diabetes Association Greater Cleveland  
[www.dagc.org](http://www.dagc.org)  
 Ohio Department of Health  
[www.odh.state.oh.us](http://www.odh.state.oh.us)

## Diabetes Program for Cleveland Hispanics

Neighborhood Family Practice (NFP) is a Federally Qualified Health Care Center located on the near west side of Cleveland. The Pfizer Foundation has awarded the health care center a three year grant to support diabetes education for the growing Hispanic population in urban Cleveland. Bilingual classes and culturally sensitive disease management counseling is made available for diabetics and their families at no cost to the individual. The goals of the program are to reduce cultural barriers to health care and education and to establish continuing support systems for Hispanic diabetics. For more details, call Neighborhood Family Practice at (216) 281-8945 to speak to Phyllis Marzan, Hispanic Advocate.

# Chart Audit Findings

During 1999 and early 2000, audits were conducted on 200 random charts of patients with diabetes at 20 Federally Qualified Health Centers in 12 rural counties. The initial audits were done prior to interactive educational offerings for clerical and professional staff and assessed patient demographics and provision of care based on the National Standards of Care. Follow-up audits were conducted six to eight months after the educational programs to compare diabetes-related outcomes.

Based on the information collected from the chart reviews, two-thirds of the physicians serving the FQHCs are family practitioners and only one-fourth of the centers have a RD on staff. Half of the patients are over age 60, 91% have type 2 diabetes, and 64% are female. Eighty-four percent of the charts currently include a flow sheet as part of the medical record.

Thirty-six percent of the patients had their HbA1c level tested twice per year and 30% were tested four times per year. Forty-seven percent of the 510 HbA1c values were 8% and higher.

*Additional findings are summarized below.*

<u>Indicators</u>	<u>Initial Audits</u>	<u>Follow-up Audit</u>
Lipid profile	76%	83%
Visual foot exam	69%	93%
Sensory foot exam	31%	53%
Test for microalbuminuria	63%	63%
Influenza Vaccine	35%	37%
Pneumococcal vaccine	17%	23%
Diabetes education by MD and/or RN during office visit	72%	81%

**The following referrals were made:**

Diabetes education	45%
Registered Dietitian	53%
Social Worker	7.5%
Exercise Program	13%
Smoking Cessation (yet 30% of the patients are smokers)	9%
Cardiologist	17%
Dentist	16%
Endocrinologist	10%
Ophthalmologist	58%
Podiatrist	15%
Peripheral Vascular	13%
Renal	3%

*The findings of the chart audits were presented as a poster session at the CDC-Division of Diabetes Translation Conference April 24-26 in New Orleans.*

## CDC Issues *continued from front page*

**Definition of terminology**

Goals - general statements of what is hoped to be accomplished to reflect positive changes such as reduced morbidity and mortality.

Objectives - Measurable and time phased statements indicating who will do what by when.

- Outcome Objectives describe long-term expectations from the program and relate to the attainment of a goal.
- Impact Objectives reflect changes in risk factors or preventive care services associated with health status and contribute directly to achieving outcome objectives.

- Process Objectives indicate what is to be implemented or completed in order to meet the impact objectives.
- Activities - Tasks or "to do" lists that need to be completed to accomplish an objective.
- EVALUATION PLAN describes how impact and process objectives will be monitored, measured and reported.



## UPDATE: Task Force

The Task Force meeting on March 1 was well attended and generated much interest and discussion. Dr. Larry Dolan, Pediatric Endocrinology at University of Cincinnati presented a very informative overview of Type 2 Diabetes in Children. Billy Ruben, Central Ohio Diabetes Association, shared the findings from the Columbus Community Needs Assessment on Diabetes in Central Ohio.

Summary of the three Workgroups:

- Physician Patient Information - Dr. Paul Rosman, Chair. Since November 1999 four of six short articles on diabetes management have been written and published in the state medical journals. Topics included Overview and Diagnostic Criteria, HEDIS Guidelines, Constraints and Problems in Caring for Persons with Diabetes and Syndrome X.
- Resource Guide - Cathy Patton, Chair. A diabetes directory service guide was developed for, and pilot tested in Lima. The committee is making suggestions on ways to modify the resource guide so it can be replicated in other counties.
- Surveillance - Al Pheley, Chair. This workgroup is establishing a diabetes surveillance system that will help to identify, track and monitor diabetes in Ohio. Future surveillance activities will reflect CDC's expectations of state program development in the area of evaluation.

## UPDATE: Federally Qualified Health Centers

The O.C.D.C.P. continues to provide educational programs to the clerical and professional staff in the FQHCs throughout Ohio. In 1999, 19 of the 65 centers were included in the trainings with sites in Fremont, Cleveland, Youngstown, Columbiana Co, Greenville, New Lexington, McArthur, Chillicothe, Pike, Scioto and Lawrence counties.

Thus far in 2000, 64 clerical staff have attended the 5 sessions that were presented to the 9 C.H.C.s in Columbus, Mansfield, and Dayton. Additional trainings are scheduled in June for the centers in Toledo, and Akron. The focus of the one-hour clerical training is to increase awareness and sensitivity about diabetes, the risk factors, and complications and to help the support staff recognize their role as team members.

The interactive professional program utilizes case studies describing

LADA and Syndrome X and a team approach to discuss the diagnostic criteria, medical management, dietary interventions and self care strategies. The cases and slides were developed by Dr. Samuel Cataland, OSU.

The 22 centers targeted this year for the professional update are in Cincinnati, Dayton, Toledo, Columbus, Mansfield and Akron with sessions scheduled in May, June, September and October. A special thanks is extended to the teams who are the presenters:

### **Columbus and Chillicothe**

\*Dr. Cataland - OSU  
Trudy Gaillard, RN, MS, CDE - OSU  
Brenda Fix, RD, LD, Ph.D. - Ross  
Products Division of  
Abbott Laboratories  
Pam Brown, RN - Ohio Primary  
Care Association

### **Cincinnati**

Dr. Robert Cohen - University of Cincinnati

### **Cincinnati continued**

\*Jan Kellogg, RN, CDE  
Betty Claydon, RD, LD, CDE

### **Mansfield**

Dr. Cynthia Dorsey  
Cindy Welch, RN, CDE  
Linda Sirianni, RD, LD

### **Toledo**

Irene Brooks, RN, CDE  
Savita Jindal, RD, LD

### **Akron**

\*Dr. Chuck Curtiss  
\*Kathy Karas, RPH

*\*Task Force Members.*

Again, charts are audited prior to the educational offering to determine the provision of medical care and education for the patients with diabetes in the urban clinics. A partner in this endeavor is KePRO who reviews the Medicare charts, analyzes the aggregate data and shares the findings and recommended interventions with the FQHCs and OCDPC.

# Meet the OCDCP Staff



From left to right Christine Goodall, Thomas Joyce, Martha Yost and Rebecca Goins, not pictured Nancy Patton.

**Thomas (Eddie) Joyce, MA**  
 Program Director/Coordinator with the Ohio Community Diabetes Control Program (OCDCP) since 1998 and consultant to the program since 1986. He earned his Masters of Arts degree in Criminal Law/Sociology. Eddie joined the Ohio Department of Health in 1983 and has previous experience with the Ohio Department of Youth Services.

**Christine Goodall, RD, LD**  
 Nutrition Consultant with the OCDCP since July 1998. She earned her Bachelor of Science degree in Nutrition in 1975 from Kent State University and has been with the Ohio Department of Health since 1976. Chris has served as Nutrition Consultant in the NW and SE District Offices and as consultant with the Pediatric and Adolescent Health Services Unit, and the Bureau of Health Promotion and Risk Reduction.

**Martha Yost, RN**  
 Nurse Consultant with the OCDCP since April 2000. She obtained her nursing degree at Hocking College and has previous experience at the Bureau of Workers Compensation, at ODH as a Health Facilities Surveyor, as a Director of Nursing at two skilled care facilities, a medical-surgical staff nurse and an occupational nurse.

**Nancy Patton, MS, RN**  
 Nurse Consultant with the OCDCP, starting June 26, 2000. She holds a diploma in nursing from Massillon City Hospital School of Nursing and a B.S.N. and M.S. in Nursing from the Ohio State University. Nancy is also a certified school nurse. She has worked in hospital, clinic and school settings developing and implementing diabetes education programs.

**Rebecca Goins**  
 Secretary with OCDCP since 1994. She joined the Ohio Department of Health in 1988 and has been a secretary with the C.O.R.E. program and the AIDS Unit.

## Diabetes Projects Target Medicare Beneficiaries

*By Sheri Knapp, RN, MSN, MBA*

Diabetes is one of the national health projects being administered by KePRO, Inc., the Medicare Peer Review Organization (PRO) for Ohio. The goal of the project - the Ohio Ambulatory Diabetes Project - is to improve the health and quality of care delivered to Medicare beneficiaries with diabetes throughout the state.

Participants, known as collaborators, include physicians, physician practices, or clinics that care for Medicare patients with diabetes. Collaborators represent all regions of the state. The Ohio Ambulatory Diabetes Project measures compliance with the following 10 indicators:

- 1 Biennial eye exam
- 2 Annual HbA1c test
- 3 Biennial lipid profile
- 4 Nephropathy assessed with microalbuminuria
- 5 Foot exam
- 6 Lipid control
- 7 Hypertension control
- 8 Diabetes education
- 9 Glycemic control
- 10 Follow-up intervention for HbA1c level >8%.

The first step of the study determines a random sample size. The sample size is calculated using information provided by collaborators. KePRO, Inc. then abstracts the information from patients' charts on site.

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# Diabetes Projects

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Aggregate data for the entire state and for individual collaborators will then be analyzed. Collaborators, working with KePRO, Inc., will then develop and implement appropriate quality improvement plans. One year later, KePRO, Inc. will re-measure the 10 indicators for each collaborator. In this manner a collaborator can ascertain the progress it has made in delivering quality care to Medicare beneficiaries with diabetes.

KePRO, Inc. is simultaneously conducting a Disadvantaged Diabetes Project in Ohio. This is a local project that is specific to the African American Medicare population with diabetes. The Project will deter-

mine the degree of disparity between the lipid levels of African American Medicare beneficiaries with diabetes and their Caucasian counterparts. Appropriate interventions, directed at collaborators and beneficiaries, will be put in place to close the disparity. As with the national project, a re-measurement will be taken to determine the effectiveness of the interventions.

KePRO, Inc. anticipates completing baseline data collection for both diabetes projects in December 2000 and releasing aggregate state results shortly thereafter. KePRO, Inc. is currently recruiting collaborators for both diabetes projects. There are many benefits to collaborating with KePRO, Inc. on these projects. KePRO, Inc.'s highly trained staff of physicians, nurses, bio-statisticians, analysts, data collectors, and an epi-

demologist assist collaborators throughout the project. By participating in a project a collaborator can expect to improve the quality of care delivered to Medicare patients with diabetes and market this accomplishment to potential patients. KePRO, Inc. offers its services free of charge and all information remains in strict confidentiality.

For more information about KePRO, Inc. and the diabetes projects, please contact:  
 Sheri Knapp, RN, MSN, MBA  
 Diabetes Project Leader  
 Rock Run Center, Suite 100  
 5700 Lombardo Center Dr.  
 Seven Hills, Oh. 44131  
 E-mail: [ohpro.skknapp@sdp.org](mailto:ohpro.skknapp@sdp.org)  
 Phone: (216) 447-9604, ext. 2142  
 Fax: (216) 447-7925



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If you would like to contribute an article for the next newsletter or if you are aware of other upcoming educational opportunities and internet resources, please send us your ideas.

**\*\*DEADLINE - for the Fall Newsletter is September 1, 2000**

**Return to:**

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## LOOKING AHEAD

**August 9 - 13, 2000**  
 American Association of  
 Diabetes Educators (AADE)  
 27th Annual Meeting &  
 Education Program  
 San Diego, California  
 For information:  
<http://www.aadenet.org>

**November 10 - 11, 2000**  
 Central Ohio Diabetes  
 Association Annual Symposium  
 Fawcett Center,  
 Columbus, OH.  
 (614) 486-7124  
[www.diabetesohio.org](http://www.diabetesohio.org)

**November 29 -  
 December 1, 2000**  
 15th National Conference on  
 Chronic Disease Prevention and  
 Control  
 Washington, DC  
 For information:  
 (301) 588-6000  
<http://www.cdc.gov/nccdphp>