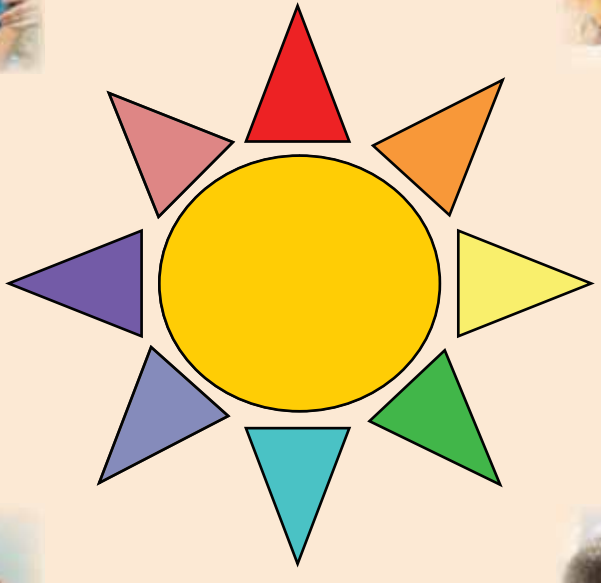
Virginia Diabetes Plan 2008–2017



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The Value of the Virginia Diabetes Plan

**According to Virginia Diabetes Council members,
a state plan . . .**

- Creates a starting point from which action can flow,
- Allows prioritization, target setting, and marshalling of resources,
- Provides data about effective programs that leads to evidence-based practice,
- Enables progress to be tracked and measured and compare ourselves to other states,
- Grants us a voice and resources for change,
- Identifies gaps in services,
- Promotes supportive policies and legislation,
- Locates and links resources for persons with multiple health problems,
- Encourages community physicians to be more involved and use best practices,
- Facilitates regional involvement that eliminates redundancy.

**The Virginia Diabetes Plan was facilitated by the
Executive Committee of the Virginia Diabetes Council**

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If you have questions, please contact the Virginia Diabetes Council at adm@virginiadiabetes.org An electronic version of the Virginia Diabetes Plan is available at www.virginiadiabetes.org.

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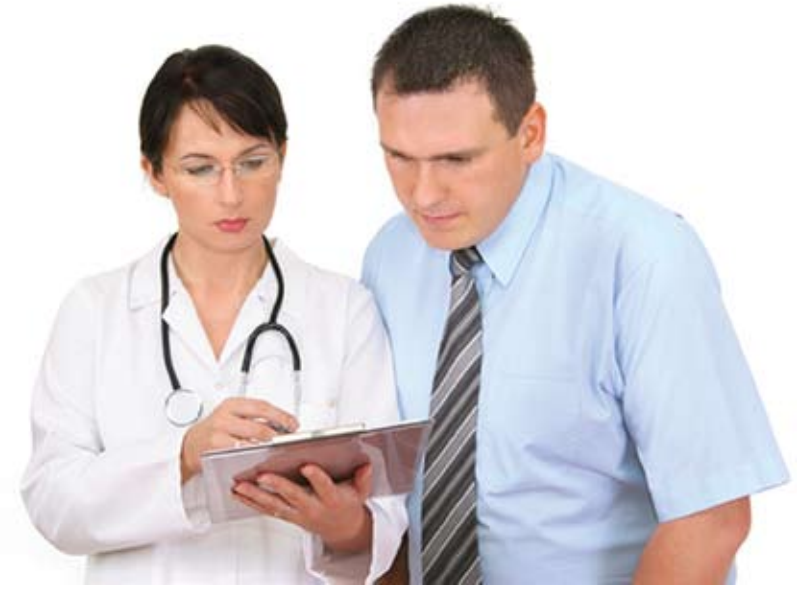

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The Virginia Diabetes Council

As a diabetes epidemic sweeps the state, the Virginia Diabetes Council (VDC), a 501(c)3 non-profit organization, provides a forum for communication, collaboration and action among diabetes stakeholders in the Commonwealth of Virginia. The VDC vision, to improve the lives of Virginians affected by diabetes, is a formidable effort since the 2005 estimated prevalence of all types of diabetes and prediabetes in Virginia was nearly 2 million people. Diabetes remains the sixth leading cause of death in Virginia claiming 3,381 lives in 2004 either as a primary or contributing cause.

VDC accomplishments are numerous and are detailed on its website (www.virginiadiabetes.org). Highlights include:

- Passage of legislation in 1998 and 1999 requiring insurance reimbursement for diabetes education and supplies.
- Publication of "Improved Coverage for Diabetes Education and Supplies".
- Developed the Diabetes Toolkit to increase awareness and use of American Diabetes Association (ADA) Clinical Practice recommendations among providers and patients.
- Partnered with the Virginia Podiatric Medical Association and Richey and Co. shoe store to provide properly fitted active footwear for needy individuals with diabetes.
- Launched "Operation Diabetes" with Virginia Commonwealth University School of Pharmacy to identify persons at high risk for developing type 2 diabetes and encouraged them to track their steps for six weeks—a model presented at the 2007 Virginia Pharmacist Association mid-year meeting.
- Awarded mini grants to support innovative diabetes prevention community-based programs.
- Exhibited and presented at professional meetings for health care providers.
- Offered a one-day continuing educational program "Gestational Diabetes and Beyond: Management of Gestational Diabetes and Prevention of Type 2 Diabetes" for health care professionals.

The VDC approaches the primary prevention, detection, and treatment of diabetes in a strategic and systematic manner. The Virginia Diabetes Plan 2008-2017 (Plan) updates Diabetes in Virginia, A State Plan, 1998 and identifies key priorities and implementation strategies. Accomplishing the work outlined in this Plan requires participation of diverse individuals, stakeholder organizations and coalitions. VDC leadership continuously recruits new members and partners to carry out its strategic efforts.

If you are reading this Plan, most likely you also have a stake in diabetes. The VDC encourages your participation in this critical effort by joining the VDC to donate your time, expertise and financial resources to make a difference in the lives of those affected by diabetes.

Virginia Diabetes Plan Executive Summary

According to the Centers for Disease Control and Prevention (CDC), one in three US children born in 2000 could develop diabetes during their lifetime. In Virginia, the prevalence of diagnosed diabetes among adults (> 18 years of age) has increased 90 percent during the past 11 years. In 2005, an estimated 396,260 adult Virginians had been diagnosed with diabetes, yet an additional 198,130 adult Virginians are estimated to have undiagnosed diabetes. Currently, there are no state-level data sources available to estimate the prevalence of diabetes in youth under age 18.

Although the increasing burden of diabetes and related complications is alarming, recent studies have found that lifestyle changes that include moderate weight loss and exercise can delay or prevent the onset of type 2 diabetes among adults with prediabetes. For people living with diabetes, many of the complications can be delayed or prevented with early detection, improved delivery of care, and better education about diabetes self-management.

Now, we must work together and maximize our resources to lessen the burden of diabetes. The Virginia Diabetes Plan 2008-2017 was developed by the VDC and many diverse partners, such as health care providers, advocacy groups, government agencies, persons with diabetes and concerned family members. The plan covers a 10-year time frame and is organized around 8 strategic initiatives:

1. **Capacity Building.** Strengthen the capacity of the Virginia Diabetes Council to achieve the strategic initiatives of the Plan by working collaboratively with partners throughout the Commonwealth.
2. **Surveillance and Evaluation.** Support a surveillance and evaluation system that reduces gaps in diabetes data and provides clear and easily accessible information about diabetes for decision-making and evaluation.
3. **Prevention.** Improve public competency to reduce personal risk factors for type 2 diabetes by increasing awareness about prediabetes, risk factors for type 2 diabetes, and the consequences of diabetes.
4. **Education and Empowerment.** Identify or create and disseminate educational methods, curricula, and instruction for diabetes management and control.
5. **Access to Care.** Evaluate and eliminate barriers to diabetes care. Encourage and enhance creative alternatives to extend the health care system's ability to detect, treat, educate and manage the care of persons with diabetes.
6. **Quality of Care.** Engage Virginians in a partnership of care for diabetes detection and treatment, education and self-management that are of the highest quality.
7. **Research.** Raise awareness of diabetes research that is conducted in the Commonwealth to facilitate collaboration among diabetes researchers and create a comprehensive agenda that addresses all aspects of diabetes research.
8. **Advocacy.** Engage legislators and key institutional leaders to support policies and laws that focus on prevention of diabetes and support for those with diabetes, including access to and quality of care and education.

The Healthy People 2010 objectives (and the Healthy People 2020 objectives when published) are the long-term benchmarks for this plan. The intent is that the committed partners in this effort will lead the way to put these recommendations into action for the health of all Virginians. This Plan is a call to action, urging individuals, communities and organizations to get involved to achieve this vision.

The success of this plan depends upon ALL OF US taking action NOW!

What is Diabetes?

Diabetes is a disease that makes it hard for your body to turn food into energy. Most of the food we eat is broken down into glucose, a sugar that is the main source of fuel for the body. Insulin must be present for glucose to move out of your blood and into your cells, which uses the glucose to give your body energy.

In people with diabetes, the pancreas either produces little or no insulin, or the cells do not respond appropriately to the insulin that is produced. Over the years, high blood glucose damages nerves and blood vessels, which can lead to complications such as heart disease and stroke, kidney disease, blindness, nerve problems, gum infections, and amputation.

The Major Types of Diabetes

Type 1 Diabetes

- Type 1 diabetes accounts for 5-10% of diabetes in the United States.
- It is an autoimmune disease which attacks and destroys the insulin-producing cells in the pancreas.
- Individuals with type 1 diabetes require insulin injections and are usually diagnosed during childhood or young adulthood.

Type 2 Diabetes

- Type 2 diabetes accounts for 90 – 95% of diabetes in the United States.
- It is a condition in which the body does not use insulin efficiently (insulin resistance) and the pancreas is unable to produce enough insulin to compensate for the inefficiency.
- Individuals who are overweight and inactive have an increased risk of developing type 2 diabetes.
- It usually occurs in adults but due to the increase in obesity and inactivity it is now being diagnosed in children.

Risk Factors for Type 2 Diabetes

- Age 45 and older
- A family history of diabetes
- Being of African American, American Indian, Asian American, Hispanic/Latino or Pacific Islander descent
- Overweight (Body Mass Index (BMI) $\geq$25)
- Sedentary lifestyle
- Polycystic ovary syndrome (PCOS)
- History of heart disease
- History of gestational diabetes or delivered a baby weighing > 9 lbs
- Blood pressure is 140/90 or higher
- Elevated cholesterol or triglycerides levels
- Having prediabetes

Gestational Diabetes

- Gestational diabetes mellitus (GDM) occurs during pregnancy.
- Women over 25 years of age and have risk factors for diabetes should have a blood glucose level tested at the first prenatal visit and then a glucose tolerance test between the 24 -28th weeks of the pregnancy.
- Blood glucose levels usually return to normal after the birth of the baby.
- Women should be screened 6 -12 weeks postpartum and then routinely every 1-3 years.
- Women who develop gestational diabetes are at significant risk of developing type 2 diabetes.

Prediabetes

- Blood glucose levels are higher than normal blood glucose levels (100 – 125 mg/dl) but not high enough for a diagnosis of diabetes.
- Sixty percent of people with prediabetes can prevent or delay diabetes by losing 5 to 7 percent of their body weight through increased physical activity (30 minutes most days of the week) and eating healthy foods.
- Forty percent of adult Virginians ages 40 -74 years old are estimated to have prediabetes and are at increased risk of development type 2 diabetes unless they make lifestyle changes.

How is Diabetes Diagnosed?

A diagnosis of diabetes can be made based on any of the following test results, confirmed by retesting on a different day, unless symptoms of diabetes are present.

Symptoms:

- Blurred vision
- Frequent urination
- Increased thirst
- Increased fatigue
- Increased hunger
- Slow healing sores
- Unusual weight loss

- **Fasting blood glucose test:** A blood glucose level after an 8-hour fast. This is the preferred test for diagnosing diabetes in children and non-pregnant adults.

- **Oral glucose tolerance test (OGTT):** Blood test is done 2 hours after drinking a beverage containing 75 or 100 grams of glucose dissolved in water.

- **Random** (taken at any time of day).

Blood glucose levels for the diagnosis of prediabetes and diabetes

	Fasting	2 hour oral glucose	Random blood glucose
Normal	99 mg/dl and below	139 mg/dl and below	139 mg/dl and below
Prediabetes	100-125 mg/dl	140-199 mg/dl	140-199 mg/dl
Diabetes	126 mg/dl and above	200 mg/dl and above	200 mg/dl and above

Gestational diabetes is diagnosed based on blood glucose levels measured during the OGTT. Glucose levels are normally lower during pregnancy, so the levels for diagnosis of gestational diabetes are lower.

Blood glucose levels for gestational diabetes

	Fasting	At 1 hour	At 2 hours	At 3 hours
Gestational Diabetes	95 or higher	180 or higher	155 or higher	140 or higher

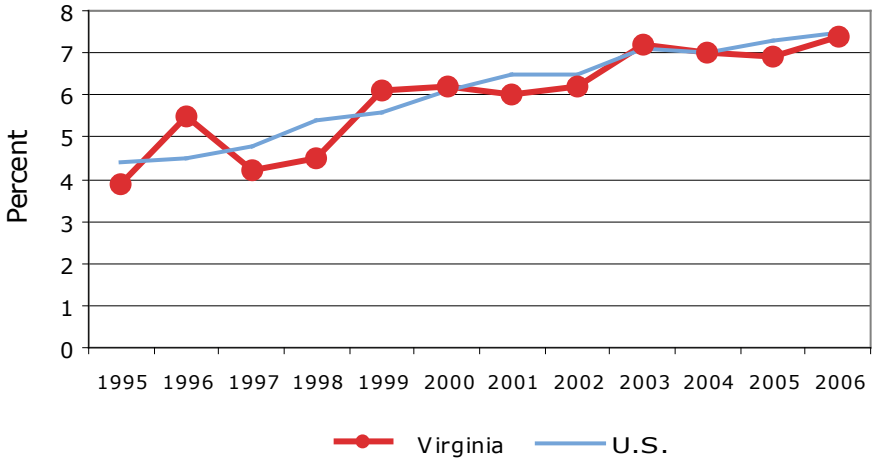
Source: http://diabetes.niddk.nih.gov/dm/pubs/overview/index.htm#types\ NIH Publication No. 06–3873, September 2006, National Diabetes Information Clearinghouse

Diabetes in Virginia

Common, Serious, Costly, Controllable, and Preventable.

Common - The prevalence of diagnosed diabetes among adults (> 18 years of age) in Virginia has increased 90 percent from 3.9 percent in 1995 to 7.4 percent in 2006. Virginia's rising prevalence has remained close to the national prevalence during the past 11 years and for 2006 they are virtually identical, 7.4 percent and 7.5 percent, respectively.

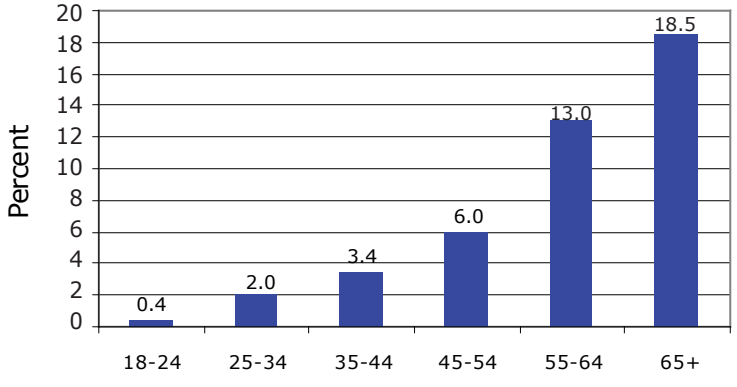
Prevalence of Diabetes Among Adults in Virginia and in U.S., 1995-2005



Source: Virginia Behavioral Risk Factor Surveillance System, 1995-2006; CDC, 1995-2006

Age is a major risk factor for diabetes. The prevalence of diabetes accelerates with age, emphasizing the importance of addressing other modifiable risk factors for type 2 diabetes early and throughout the lifespan.

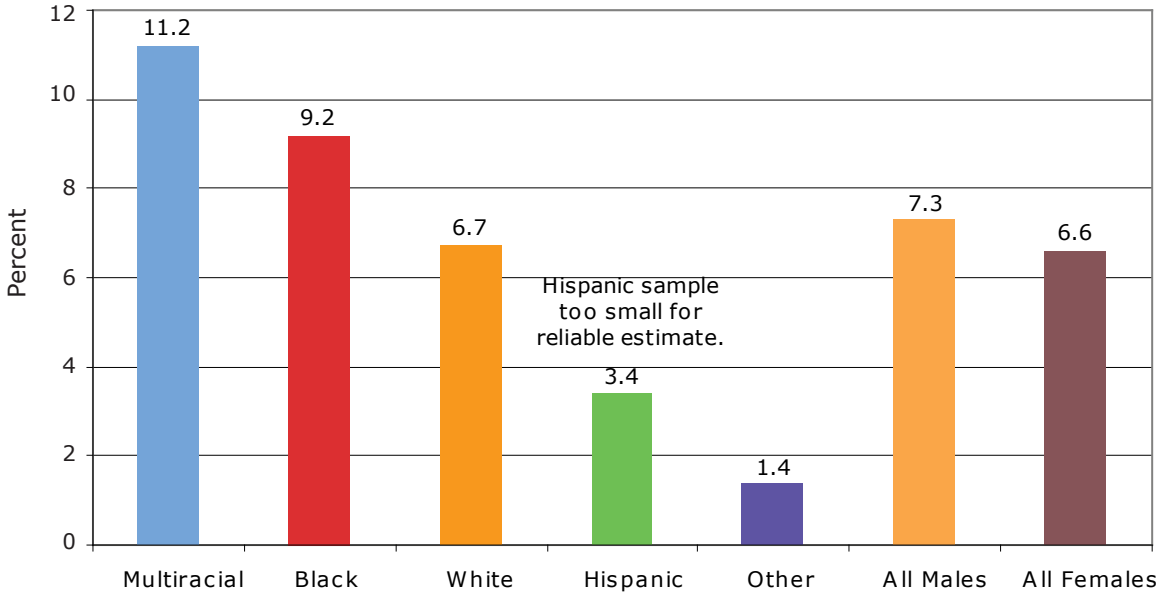
Prevalence of Diabetes in Virginia by Age Group, 2005



Source: Virginia Behavioral Risk Factor Surveillance System, 2005

Race, ethnicity, and gender are also important risk factors for diabetes. The prevalence of diabetes is highest among multiracial and black Virginians and is higher among males than females. Note that the Hispanic sample is small and almost certainly underestimates the higher prevalence of diabetes usually found in this group nationally.

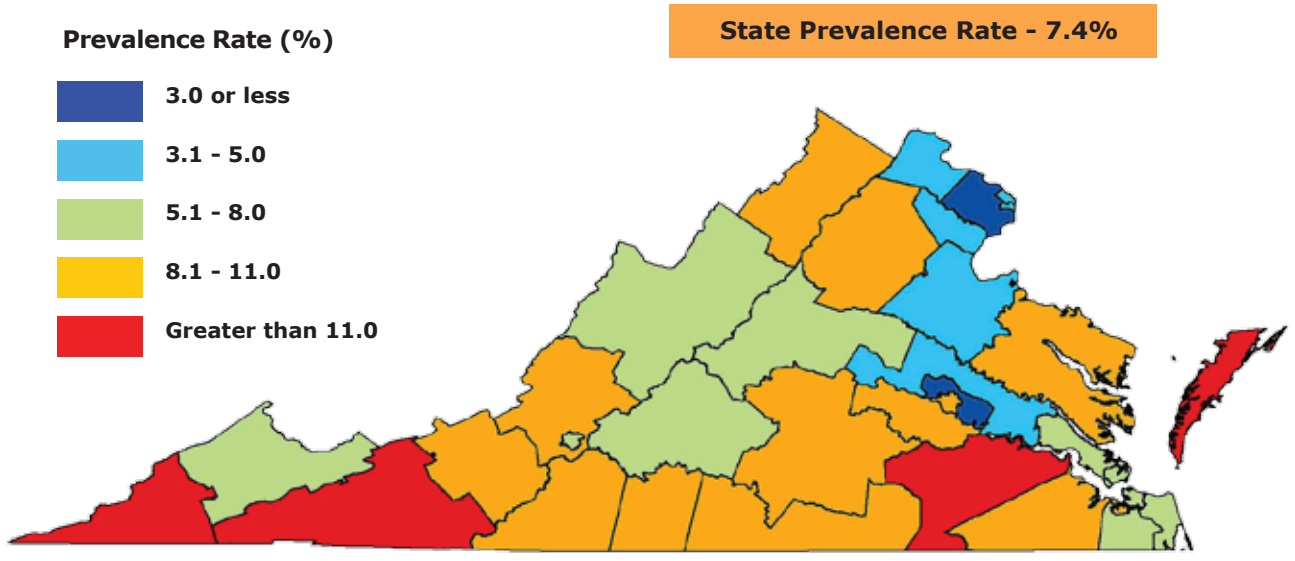
Prevalence of Diabetes in Virginia by Race, Ethnicity and Gender, 2005



Source: Virginia Behavioral Risk Factor Surveillance System, 2005

Certain geographic regions of the state have a higher prevalence of diabetes. A striking example is the Appalachian counties of far southwest Virginia, where diabetes is 63 percent more prevalent than in non-Appalachian counties. In 2005, the four health districts with the highest prevalence rates are the Eastern Shore (15.4%), Lenowisco (14.2%), Crater (12.6%), and Mount Rogers (12.3%).

Prevalence of Diabetes in Virginia by Health District

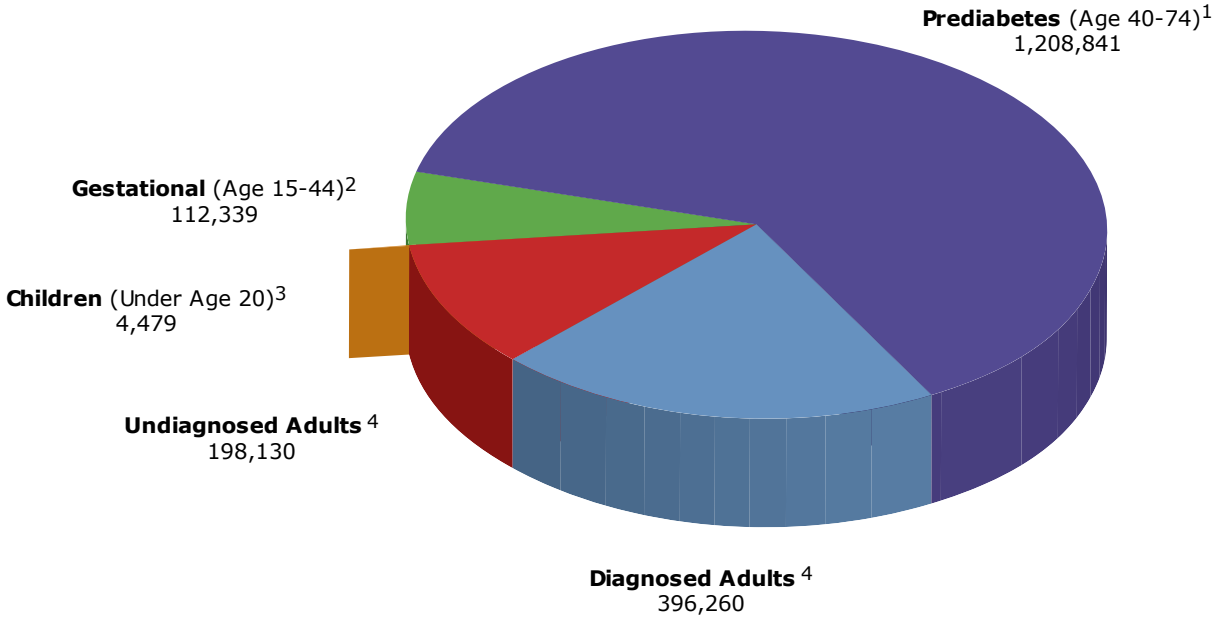


Source: Virginia Behavioral Risk Factor Surveillance System, 2005

To determine the extent of diabetes and potential diabetes in Virginia, it is important to consider several sources in addition to the 396,260 diagnosed adults (6.9 percent).

- In 2005, an additional 198,130 adult Virginians were estimated to have undiagnosed diabetes.
- Approximately 112,339 women have been diagnosed with gestational diabetes (diabetes during pregnancy), which increases their risk of developing diabetes by 20 to 50 percent in the next 5 to 10 years following pregnancy.
- The CDC estimates the prevalence of diabetes among youth under age 20 is 0.22 percent. Type 2 diabetes, although still rare, is being diagnosed more frequently in children and adolescents, particularly in American Indians, African Americans, and Hispanic/Latino Americans.
- By far the largest group at risk for diabetes are people who have somewhat elevated blood glucose levels. This condition is now termed prediabetes in order to signal its seriousness.
- The CDC estimates that 40 percent of adults between the ages of 40-74 years have prediabetes. There are an estimated 1,208,841 adult Virginians with prediabetes in the 40-74 age range.

Estimated Number of Virginians with All Types of Diabetes and Prediabetes in Virginia, 2005



Sources:

1 National Center for Health Statistics, Centers for Disease Control and Prevention. Third National Health and Nutrition Examination Survey (NHANES III) 1988–1994

2 National Diabetes Education Program (NDEP), Type 2 Diabetes Risk After Gestational Diabetes Fact Sheet, April 2006

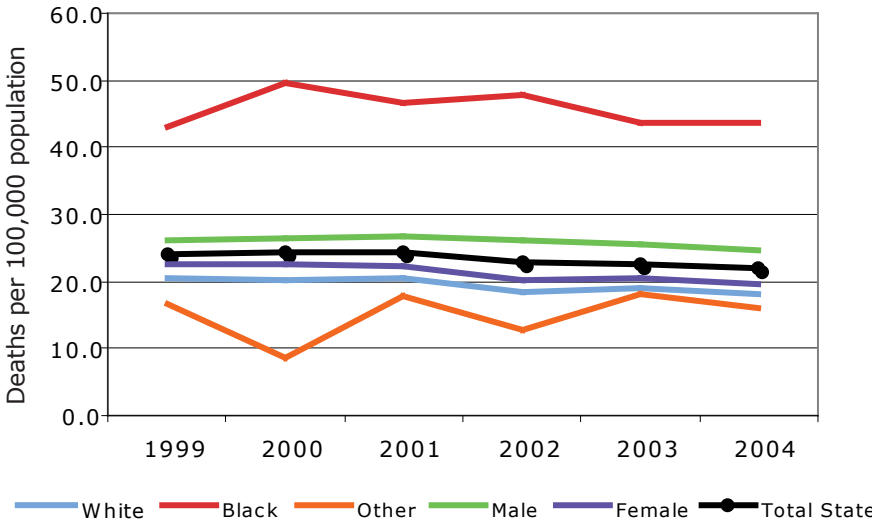
3 CDC, National Diabetes Fact Sheet, 2005

4 Virginia Behavioral Risk Factor Surveillance System, 2005

Serious - Diabetes was the 6th leading cause of death in Virginia in 2005. Diabetes can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, amputations of the leg, foot and toe, as well as, deaths related to flu and pneumonia.

Overall, Virginia's mortality rate due to diabetes has decreased slightly from 1999 (24.0 per 100,000) to 2004 (22.0 per 100,000). Blacks consistently have more than double the mortality rates due to diabetes than whites: 43.7 per 100,000 vs. 18.0 per 100,000, respectively in 2004. The rates for males are also consistently higher than those for females.

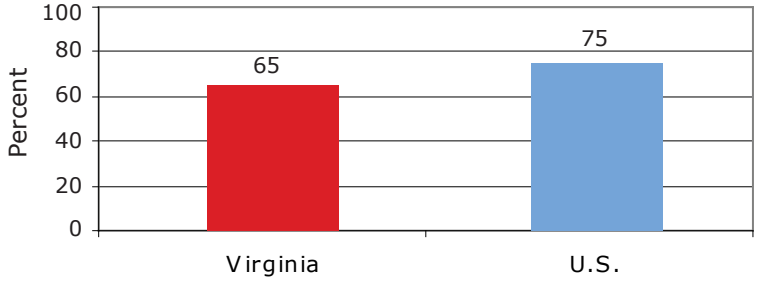
Mortality Rates for Diabetes as the Primary Cause of Death by Race and Gender, Virginia 1999-2004



Source: Virginia Department of Health, Division of Health Statistics, 1999-2004

The leading cause of death for persons with diabetes is cardiovascular disease. Nationally, three quarters of deaths to persons with diabetes are due to cardiovascular disease. In Virginia, the figure is slightly less, but still very high at 65%.

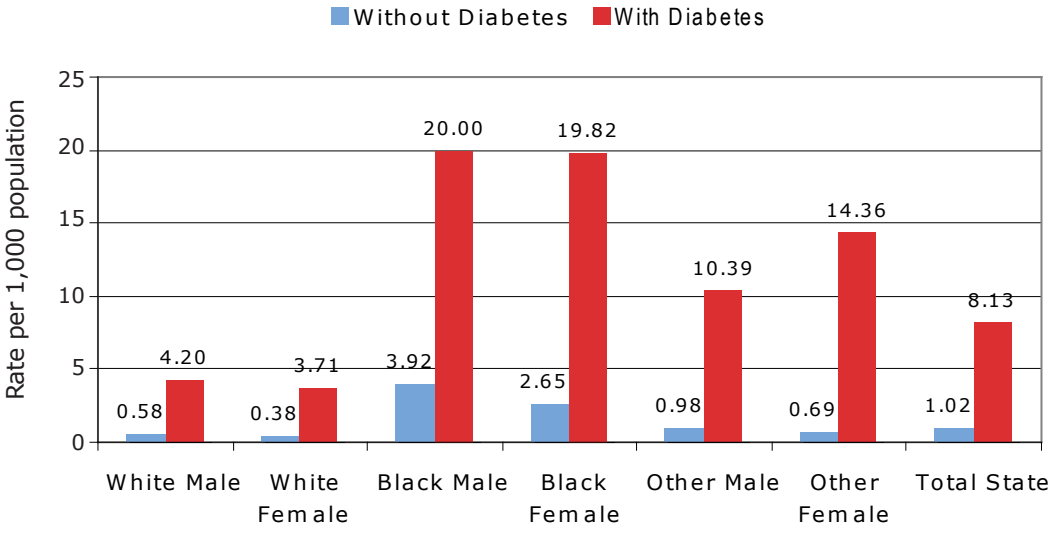
Percent of Deaths Due to Cardiovascular Disease Among Persons with Diabetes in Virginia and U.S., 2004



Source: Virginia Department of Health, Division of Health Statistics, 2004

Regardless of gender or race, persons with diabetes are much more likely to have end-stage renal disease (ESRD) than persons without diabetes. However, the disparity and overall rate of ESRD is much higher among blacks than whites. Blacks with diabetes in Virginia have 5 to 6 times the rate of ESRD found among whites with diabetes.

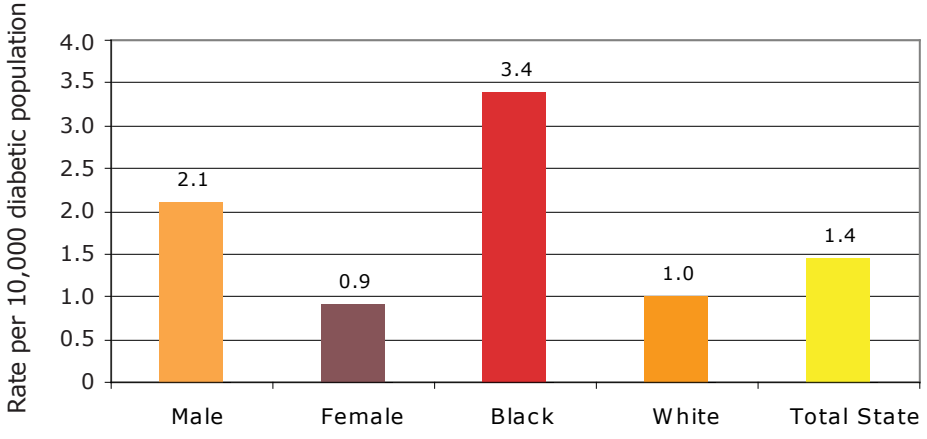
Prevalence of End-Stage Renal Disease Among Persons With Diabetes by Race and Gender, Virginia 2003



Source: Mid-Atlantic Renal Coalition, 2003

There are both gender and racial disparities in the rates of non-traumatic lower extremity amputations. Males have twice the rate of females and rates for blacks are about 3.5 times higher than rates for whites.

Hospital Discharge Rates for Non-Traumatic Lower Extremity Amputation, Virginia, 2005



Source: Virginia Health Information, 2005

Costly - Persons with diabetes are at greater risk of hospitalization due to complications such as diabetic ketoacidosis, end-stage renal disease, lower extremity amputation, and cardiovascular disease. In 2005, the number and cost of these diabetes-related hospitalizations in Virginia are shown in the table below.

Total number of diabetes related hospital discharges:	11,704
Total cost:	$203,850,130.00
Average cost per discharge:	$17,417.13
Average length of stay:	5 days

Source: Virginia Health Information, 2005

Controllable – Many of the complications from diabetes can be prevented or delayed by taking steps to control or manage diabetes. Since 1999, the statewide percent of people with diabetes who check their blood glucose daily, who had their A1c, feet and eyes checked, and who received pneumonia vaccines have all increased.

Management Practice:	1999	2000	2001	2002	2003	2004	2005
Daily blood glucose checks HP2010 Goal: 61%	42.5%	46.4%	50.1%	54.4%	55.5%	58.6%	**62.1%**
Hemoglobin A1c check twice per year HP2010 Goal: 65% (1/yr.)*	N/A	**73.4%**	**71.5%**	**70.3%**	**71.7%**	**74.1%**	**76.2%**
Annual foot exam HP2010 Goal: 91%	59%	61.6%	62.5%	69.8%	72.2%	72.9%	76.2%
Annual eye exam HP2010 Goal: 76%	64.4%	64.2%	62.2%	63.3%	63%	64.7%	65.5%
Annual influenza vaccine HP2010 Goal: 60%	53.5%	No Data Available	52.2%	51.1%	49.5%	48.7%	48.3%
Ever had pneumococcal vaccine HP2010 Goal: 60%	30.1%	No Data Available	39.2%	39.7%	43.8%	45.7%	48.6%

= Goal Met

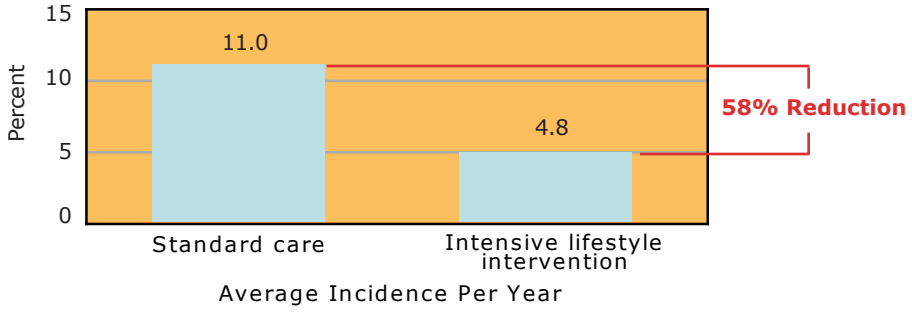
Data notes: Three-year averages were used to improve the precision of the annual estimates. Two-year averages were used when three years of data were not available; vaccination questions were asked every other year prior to 2001; rates are age-adjusted.

Sources: Centers for Disease Control and Prevention- http://apps.nccd.cdc.gov/DDTSTRS/statePage.aspx?state=Virginia#PCP

Healthy People 2010- www.healthypeople.gov *Virginia reports twice per year, as this is the ADA and CDC recommendation. The HP2010 goal of 65% is for one A1c check per year. The HP2010 goals reflect those that have been newly established during the Healthy People 2010 Midcourse Review in 2005.

Preventable – Before people develop type 2 diabetes, they almost always have prediabetes. The Diabetes Prevention Program, a large national study of over 3,000 people showed that changes in lifestyle, including healthier eating (lowering fat and calories), increased activity (about a half hour per day of moderate walking), and modest weight loss (5 to 7 percent of body weight), can substantially reduce the progression from prediabetes to type 2 diabetes by 58 percent.

Reduction in Incidence of Diabetes Due to Lifestyle Interventions, Diabetes Prevention Program Study 2001



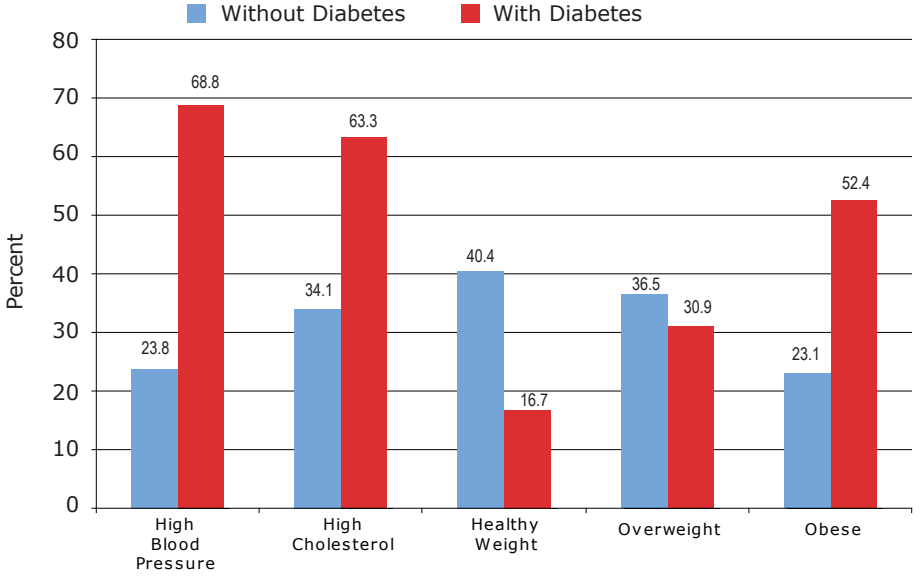
Source: New England Journal of Medicine, Vol. 346, No. 6, February 7, 2002.

High blood pressure, obesity, and high blood cholesterol are three of the major modifiable risk factors for type 2 diabetes. Adult Virginians with diabetes report having these risk factors more often than adult Virginians without diabetes.

Persons with diabetes are

- 2.9 times more likely to have high blood pressure than those without diabetes,
- 2.3 times more likely to be obese,
- 2 times more likely to have high cholesterol.

Percent of Adults without and with Diabetes Who Have Modifiable Risk Factors for Type 2 Diabetes, Virginia, 2005



Notes:
High Cholesterol = LDL Cholesterol over 100 or total cholesterol over 200
Healthy Weight = Body Mass Index (BMI) from 18.5 to 24.9
Overweight = BMI from 25 to 29.9 Obese = BMI of 30 or greater

Source: Virginia Behavioral Risk Factor Surveillance System, 2005

Long-term Diabetes Management Objectives

By 2017:	Virginia Baseline[1] (%)	HP 2010 Target (%)	Virginia 2017 Target (%)
1. Increase the proportion of adult Virginians with diabetes who have ever received formal diabetes education. (HP2010 Obj 5-1)	53	60	65
2. Increase the proportion of adult Virginians with diabetes who perform self-blood glucose monitoring at least once a day. (HP2010 Obj 5-17)	62.1[2]	61[3]	75
3. Increase the proportion of adult Virginians with diabetes who have a glycosylated hemoglobin measurement at least twice a year. (HP2010 Obj 5-12)	76.2[2] (2 times/year)	65[3] (1time/year)	85
4. Increase the proportion of adult Virginians with diabetes who have an annual dilated eye exam. (HP2010 Obj 5-13)	65.5[2]	76[3]	80
5. Increase the proportion of adult Virginians with diabetes who have an annual foot exam. (HP2010 Obj 5-14)	72.9[2]	91[3]	91
6. Increase the proportion of adult Virginians with diabetes who are: • vaccinated annually against influenza (HP2010 Obj 14-29 c) and • ever vaccinated against pneumococcal disease. (HP2010 Obj 14-29 d)	48.3[2] 48.6[2]	60 60	70 70
7. Increase the proportion of adult Virginians with diabetes who have at least an annual dental examination. (HP2010 Obj 5-15)	61.2	71[3]	75
8. Increase the proportion of adult Virginians with diabetes who obtain an annual urinary microalbumin measurement. (HP 2010 Obj 5-11)	Not available[4]	No target available	TBD
9. Reduce the proportion of adult Virginians with diabetes who have high blood cholesterol levels. (HP 2010 Obj 12-14)	63.3	No target available	57
10. Reduce the proportion of adult Virginians with diabetes who have high blood pressure. (HP 2010 Obj 12-9)	68.8	No target available	61
11. Reduce cigarette smoking among adult Virginians with diabetes. (HP 2010 Obj 27-1a)	14.8	No target available	10
12. Reduce the proportion of adult Virginians with diabetes identified as obese. (BMI of 30 or more) (HP 2010 Obj 19-2)	52.4	No target available	47
13. Increase the proportion of adult Virginians with diabetes who consume five or more servings of fruits and vegetables per day. (HP 2010 Obj 19-5 and 19-6)	32.7	No target available	50
14. Increase the proportion of adult Virginias with diabetes who engage in moderate physical activity for at least 30 minutes per day 5 or more days per week or vigorous physical activity for at least 20 minutes per day 3 or more days per week. (HP 2010 Obj 22-2)	36.5	50[3]	55

1 Virginia Baseline Data Source: Virginia Behavioral Risk Factor Surveillance System, 2005.
2 Three-year averages were used to improve the precision of the annual estimates. Two-year averages were used when three years of data were not available; vaccination questions were asked every other year prior to 2001; rates are age-adjusted.
3 This HP2010 target reflects the new target established during the Healthy People 2010 Midcourse Review in 2005.
4 No data source currently available with a representative statewide sample.
5 No data source currently available with a representative statewide sample. Therefore, a recommendation to implement the Youth Risk Behavior Survey (YRBS) in Virginia is included in the Virginia Diabetes Plan.
6 Children are not reflected in these objectives at this time because no data source is currently available with a representative statewide sample to measure progress in people less than 18 years of age.

Long-term Diabetes Prevention Objectives

By 2017:	Virginia Baseline[1] (%)	HP 2010 Target (%)	Virginia 2017 Target (%)
1. Increase the proportion of adult Virginians with prediabetes and gestational diabetes who have ever received formal diabetes education. (HP 2010 Obj 5-1)	Not available[4]	No target available	TBD
2. Increase the proportion of adult Virginians who engage in moderate physical activity for at least 30 minutes per day 5 or more days per week or vigorous physical activity for at least 20 minutes per day 3 or more days per week. (HP 2010 Obj 22-2)	47.4	50[3]	60
3. Increase the proportion of child and adolescent Virginians who engage in moderate physical activity for at least 30 minutes per day 5 or more days per week or vigorous physical activity for at least 20 minutes per day 3 or more days per week. (HP 2010 Obj 22-2)	Not available[5]	No target available	TBD
4. Reduce the proportion of adult Virginians identified as obese (BMI of 30 or more). (HP 2010 Obj 19-2)	24.1	15	15
5. Reduce the proportion of child and adolescent Virginians identified as obese (BMI of 30 or more). (HP 2010 Obj 19-3 c)	Not available[5]	5	TBD
6. Increase the proportion of adult Virginians who consume five or more servings of fruits and vegetables per day. (HP 2010 Obj 19-5 and 19-6)	27.2	75 (2 fruits) 50 (3 vegetables)	50
7. Reduce the proportion of adult Virginians with high blood cholesterol levels. (HP 2010 Obj 12-14)	37.1	17	17
8. Reduce the proportion of adult Virginians with high blood pressure. (HP 2010 Obj 12-9)	28.6	14[3]	14
9. Reduce cigarette smoking among adult Virginians. (HP 2010 Obj 27-1a)	20.6	12	12
10. Increase the proportion of adult Virginians being tested for high blood glucose or diabetes within the past three years. (No HP 2010 Obj)	Data to be available in 2009	N/A	TBD

1 Virginia Baseline Data Source: Virginia Behavioral Risk Factor Surveillance System, 2005.
2 Three-year averages were used to improve the precision of the annual estimates. Two-year averages were used when three years of data were not available; vaccination questions were asked every other year prior to 2001; rates are age-adjusted.
3 This HP2010 target reflects the new target established during the Healthy People 2010 Midcourse Review in 2005.
4 No data source currently available with a representative statewide sample.
5 No data source currently available with a representative statewide sample. Therefore, a recommendation to implement the Youth Risk Behavior Survey (YRBS) in Virginia is included in the Virginia Diabetes Plan.

Priority Populations

To impact the goals and objectives developed by the VDC, people from many population groups in multiple settings must be engaged in the work. Priority populations for this Plan include high-risk segments of the public at large, health care providers, persons with diabetes, and policy makers.

High-risk groups

Early diagnosis and aggressive treatment of diabetes improves health outcomes. The public must be made aware of the risk factors, symptoms and potential complications of diabetes. Those at highest risk for developing diabetes must be informed, motivated and empowered to seek information, education and treatment. The population groups below will be the focus of this Plan due to their increased risk for developing diabetes and related complications:

- Black/African Americans
- Hispanics/Latinos
- Asian/Pacific Islanders
- Persons from medically underserved areas
- Women with a history of gestational diabetes
- Persons with low incomes
- Under or uninsured
- Newcomers/immigrants
- Older adults
- Persons with cardio-metabolic risk
- Persons with disabilities
- Persons with prediabetes
- Overweight or obese children and adults

Health care providers

Health care providers are those who provide medical treatment and education for persons with diabetes. Interventions directed toward health care providers provide the opportunity to promote clinical standards of care and best practices for treating those with diabetes and working with those at risk. Health professionals are responsible for ensuring that persons with diabetes:

- Understand how to care for themselves at home.
- Receive regular, timely tests to detect complications of diabetes.
- Provide treatment as needed.
- Impart to individuals with diabetes the importance of diabetes self-management and care.

Persons with diabetes

Interventions can be directed to people with diabetes at all stages of the disease. Measures taken by the patient and health care providers can improve current health status and reduce risk for further problems. Persons with diabetes need to fully understand their treatment plan and how to incorporate it into their lives. They also need to understand the importance of personal responsibility for daily diabetes self-care and to feel empowered to manage their chronic condition at home, school, and other settings.

Policy Makers

Recognition and understanding of a community health problem is the first step in taking action to deal with the problem. Support by those in decision or policy-making positions within the community requires their knowledge and understanding of the needs of the community, medical and financial impact, and the benefits of programs and implementation strategies. The success of public health efforts depends on the ongoing involvement and proactive commitment of these community and organizational leaders at the local and state levels.

Settings

The settings in which health interventions take place are not limited to hospitals, medical offices, or public health clinics. To make an impact on the diabetes problem in Virginia, we must consider additional settings where people live and work, and where decisions are made that affect the quality of and access to care and diabetes education. These settings may include communities, schools, worksites, and health systems.

Communities

The term community can be used to describe a geographic region or a group of people linked by age, gender, race, or ethnicity. For a group to be defined as a community, however, community identity with shared values and norms should be present. Unlike interventions that focus on the individual and take place in a health care professional's office or clinic, community-based programs can reach an entire population group. Venues included in the community setting are public facilities; schools and child care sites; local government and agencies; and faith and civic organizations that provide an entrée to where people live, work and play. These organizations can be strong advocates for educational, policy, and environmental changes throughout the community. When used in concert with prioritized approaches, community-based interventions increase the likelihood of improving personal and community health.

Schools

Children spend one-third of their day in school. School systems should promote healthy eating and physical activity to engage children in healthy behaviors at a young age. For those children with diabetes, school personnel must have an understanding of diabetes and its management to facilitate the appropriate care of the child with diabetes.

Worksites

Employees spend about a third of their day at the worksite and are a captive audience for educational activities. A variety of interventions may be offered at worksites:

- support groups
- awareness activities focused on high-risk employees
- educational opportunities for employees affected by diabetes
- policy development related to employer-sponsored health insurance policies

Health systems

Health systems include the facilities, providers, third-party payors, and other systems that deliver diabetes care and education. Facilities include all settings where health care is provided such as clinics, hospitals, physicians' and diabetes educators' offices. Providers include physicians, nurses, dietitians, diabetes educators, exercise physiologists, psychologists, social workers, pharmacists, and others who provide care directly to the patient. Goals of health systems interventions may be increasing reimbursement for diabetes care and education, improving the workflow of a physician's office, or implementing appointment reminder systems to ensure timely patient follow up.

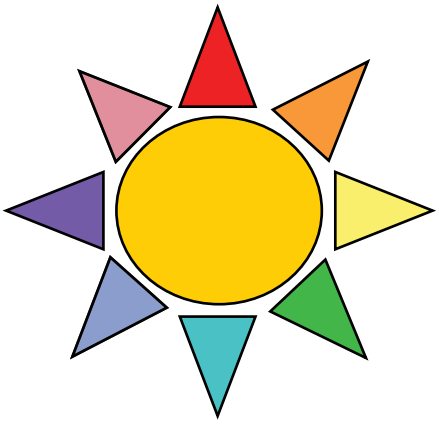
Virginia Diabetes Plan Development, Implementation & Evaluation

The Plan was facilitated by the Virginia Diabetes Council Executive Committee who engaged consultants to gather broad stakeholder input and assemble a comprehensive list of strategic initiatives to address the needs related to diabetes in Virginia. Seven Diabetes Dialogues were held across the Commonwealth, offering the opportunity for a cross-section of individuals with interests in diabetes to present issues of regional and general concern. VDC members responded to an on-line survey, giving each member organization the opportunity to provide input and present new ideas for the Plan. Key informant interviews were conducted to round out stakeholder input, ensuring diverse and comprehensive key opinion leader input into the Plan.

Plan implementation will rely heavily on the VDC's leadership capacity to gain wide stakeholder collaboration in the Plan's 8 key strategic initiatives. The VDC's chief priority is to create and sustain these collaborations to insure progress in preventing diabetes and proper care for those Virginians who have diabetes.

The VDC will review the Plan annually to evaluate progress on strategic initiatives, make necessary adjustments, and re-affirm the current year's key objectives. They will communicate progress on the Plan through a broad network of stakeholder organizations and individuals. Diabetes prevention and control are the responsibility of all Virginians. For each strategic initiative the VDC has identified those organizations with relevant interests, expertise and resources that are current or potential key partners to make this Plan successful. The list of key partners is not exhaustive and the partnership of other organizations is encouraged. Membership and affiliation with the VDC is always welcome. For information, interested individuals should contact:

Virginia Diabetes Council
adm@virginiadiabetes.org
http://www.virginiadiabetes.org



Virginia Diabetes Plan

Vision

To improve the lives of Virginians affected by diabetes.

Mission

To bring partners together to identify and promote best practices for diabetes prevention, control, and treatment in Virginia.

Initiatives, Goals and Objectives

Initiative 1: Capacity Building

Initiative 2: Surveillance and Evaluation

Initiative 3: Prevention

Initiative 4: Education and Empowerment

Initiative 5: Access to Care

Initiative 6: Quality of Care

Initiative 7: Research

Initiative 8: Advocacy

Initiative 1
Capacity Building

Strengthen the capacity of the Virginia Diabetes Council to achieve the strategic initiatives of the Virginia Diabetes Plan by working collaboratively with partners throughout the Commonwealth.

Goal 1. Strengthen the infrastructure and resource base of the Virginia Diabetes Council to facilitate the Plan's implementation with its partners.

Objectives

1. By March 2008, designate a Steering Committee and seven (7) VDC Work Groups that will provide leadership for achieving strategic initiatives in the Plan: Surveillance and Evaluation, Prevention, Education and Empowerment, Access to Care, Quality of Care, Research, and Advocacy.

2. By March 2008, revise the VDC website with appropriate links to diabetes resources and partners. Update annually.

3. By March 2008, develop and initiate a marketing plan that continually recruits and engages a statewide, diverse membership representing individuals, coalitions, and organizations concerned about diabetes. Members will be sought with the skills and resources needed for the Plan's implementation and ensuring that the underserved regions with a high impact of diabetes are represented. Evaluate recruitment efforts annually.

4. By March 2008, ensure that local, regional and state diabetes partners have multiple options for participating in VDC meetings and activities (e.g. quarterly meetings in sites other than Richmond, a quarterly newsletter, teleconferencing, etc.).

5. By June 2008, engage in strategic planning for VDC that focuses on its vision, mission, structure, and annual work plan.

6. By June 2008, develop a business plan and annual budget process for VDC that is updated annually.

7. By June 2008, form a resource development team to develop and initiate a funding campaign to support VDC's infrastructure, permanent staffing requirements and implementation of strategic initiatives.

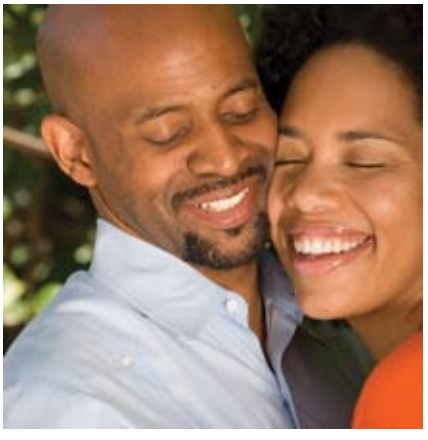
8. By September 2008, develop a communication plan which promotes and links the VDC members, key partners, local coalitions, and the public with information about the Plan and diabetes resources (e.g., clearinghouse website, email list serve, E-newsletter, and teleconferencing capabilities).

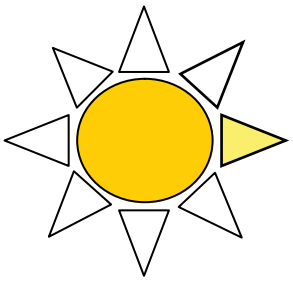
9. By January 2009, recruit and hire a full time Executive Director and part time assistant for the VDC.

10. By December 2009, develop and execute a plan to biennially evaluate the VDC's effectiveness and its responsiveness to members.

Key Partners

Virginia Diabetes Council





Initiative 2
Surveillance and Evaluation

Support a surveillance and evaluation system that reduces gaps in diabetes data and provides clear and easily accessible information about diabetes for decision-making and evaluation.

Goal 1. Improve access to diabetes data for decision-making, policy development and evaluation at the state and local levels.

Objectives

1. By March 2008, convene a Data and Surveillance Work Group to provide leadership for an integrated surveillance system that incorporates all relevant and available data.

2. By March 2008, create a summary of diabetes data that is maintained on the Virginia Department of Health website and linked to the VDC website and other appropriate websites.

3. By September 2008, create and disseminate a diabetes data presentation that shows trends, impact and cost of diabetes in Virginia. Post to VDC and partner websites, revise annually.

4. By September 2009, improve accessibility of Virginia diabetes data by planning and initiating a diabetes data awareness campaign that highlights data availability by health district, city and county (where available), including frequency and source, and how to access it (organization, contact person, website). Evaluate biennially.

5. As they become available, incorporate new and emerging data systems, such as Pregnancy Risk Assessment and Monitoring System (PRAMS), Virginia Hospital Information (VHI), and updated electronic birth certificate data to estimate the prevalence and incidence of pre-existing diabetes and gestational diabetes in pregnant women.

Goal 2. Develop additional systems to obtain and access high quality diabetes data that are not currently available, including: local prevalence of diabetes by city and county, prevalence of prediabetes, and prevalence of diabetes in children.

Objectives

1. By September 2010, obtain funding to expand the surveillance system and to secure additional staff and resources for collecting, analyzing and disseminating new diabetes data.

2. By December 2010, encourage sharing agreements to improve access and use of electronic data and work with partners in public and private health care (e.g., emergency department discharge data).

3. By September 2011, examine clinical data from all partners to identify health disparities, information gaps, and promote use of these data by local coalitions (e.g., prevalence data on diabetes in children, types 1 and 2).

4. By March 2012, identify strategies to obtain and make diabetes in children and emergency department discharge data accessible.

5. By December 2012, develop long-term diabetes management and prevention objectives that can be tracked annually for children less than 18 years of age.

6. By March 2013, assess the feasibility and environment for electronic submission of diabetes information from providers in Virginia via electronic medical records or registries.

Goal 3. Support evaluation of diabetes prevention and control interventions and monitoring of health outcomes.

Objectives

1. By March 2009, develop an Evaluation Work Group of health professionals, insurers and employers who measure outcomes of programs and interventions for the prevention, detection, treatment and management of diabetes in Virginia. Determine best practices to collect outcomes data that provides evidence, cost effectiveness, and a business case for expanding successful programs and care.

2. By March 2010, Evaluation Workgroup will offer training and technical assistance to community-based programs to measure outcomes of programs for the detection, treatment, and management of individuals with diabetes in Virginia.

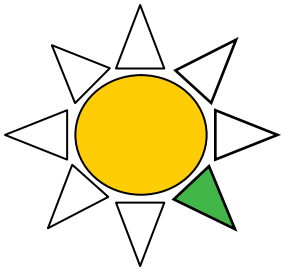
Goal 4. Annually review and evaluate the Plan.

Objectives

1. By January 2009, develop a process and system for tracking progress made by VDC members and stakeholders on the Plan goals and objectives.

Key Partners

American Diabetes Association
Businesses
Centers for Disease Control and Prevention
Clinics, Hospitals
Department of Medical Assistance Services
Juvenile Diabetes Research Foundation
Medical Schools
Outpatient Facilities
Private Physician Practices
Virginia Association of Health Plans
Virginia Diabetes Council
Virginia Department of Education
Virginia Department of Health
Virginia Health Quality Center
Virginia Office of Emergency Medical Services
Virginia Pharmacy Association
Virginia School Nurses Association



Initiative 3
Prevention

Improve public competency to reduce personal risk factors for type 2 diabetes by increasing awareness about prediabetes, risk factors for type 2 diabetes, and the consequences of diabetes.

Goal 1. Convene a Virginia Diabetes Council Prevention Work Group to develop a plan that encourages Virginians to engage in healthy lifestyles, know the risk factors for diabetes, and to be regularly screened for diabetes and prediabetes.

Objectives

1. By March 2008, convene a Virginia Diabetes Council Prevention Work Group to begin developing a comprehensive statewide approach to diabetes prevention.

2. By December 2008, initiate planning to develop and execute a 5-year social marketing campaign on preventing risk factors for diabetes that includes pre- and post-testing for each segment of the campaign.

Goal 2. Ensure that prevention resources and program ideas are easily accessible to all Virginians and stakeholder organizations through multiple channels.

Objectives

1. By June 2008, explore opportunities (e.g. Operation Diabetes) to partner with pharmacists and pharmacy students to identify and educate persons at high-risk of developing type 2 diabetes and persons with undiagnosed diabetes.

2. By December 2008, obtain funding to continue and expand the diabetes primary prevention mini grant program to increase access to prevention resources and program ideas for high-risk populations.

3. By September 2009, collect and develop prevention resources, best practices and unique prevention program ideas, and offer them through web-based means (website, email, web-blasts, and webinars), conferences and other channels of communication.

Goal 3. Support and assist Virginia employers to implement healthy worksite lifestyle practices.

Objectives

1. By September 2008, work with the Virginia Business Coalition on Health and other partners to convene employers that actively promote healthy lifestyles for their employees to share experiences, best practices, and innovative ideas. Communicate results through all VDC and business channels.

2. By June 2009, partner with organizations to strengthen VDC's ability to support employer efforts that promote healthy lifestyles for their employees.

3. By June 2010, develop a plan to use an existing chronic disease prevention worksite model, market it statewide to key employers, measure and publish outcomes.

Goal 4. Support the Virginia Department of Education and local school boards to raise diabetes awareness and institute healthy lifestyle practices for faculty, staff and students, and support healthy lifestyle practices for families.

Objectives

1. By March 2008, collaborate with partners to promote the Governor's Nutrition and Physical Activity Program that rewards schools for promoting health and wellness and to promote other resources that improve nutrition and physical activity in the school setting.

2. By September 2008, work with partners to develop and disseminate a "diabetes alert" for school staff that highlights the prevalence of diabetes in Virginia.

3. By September 2008, encourage schools as employers to initiate workforce practices and policies that educate personnel to know the symptoms of diabetes, have regular check-ups, practice healthy lifestyles, and serve as role models for students.

Goal 5. Encourage and support lay health volunteers and community-based programs to provide evidence-based diabetes primary prevention efforts.

Objectives

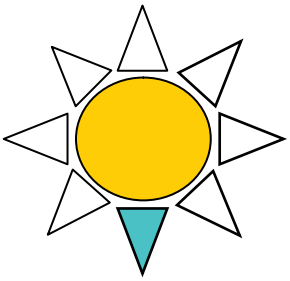
1. By March 2009, enlist faith communities to engage in diabetes awareness activities, for example, identifying lay health outreach "ministers," and share best practices.

2. By June 2009, encourage and support programs to focus on diabetes prevention by providing community-based curriculum and instruction materials.

3. By March 2010, identify and disseminate information on effective, evidence and community-based programs that reduce risk factors for diabetes.

Key Partners

American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association
Faith Communities
Health Insurers and Health Plans
Health Systems
Juvenile Diabetes Research Foundation
National Diabetes Education Program
National Kidney Foundation of the Virginias
Persons with Diabetes
School Boards
School Food Service Managers
School Health Advisory Boards
Virginia Business Coalition on Health
Virginia Center for Diabetes Professional Education
Virginia Chapters of the American Association of Diabetes Educators
Virginia Tech/Virginia Cooperative Extension Programs
Virginia Department of Education
Virginia Department of Health
Virginia Diabetes Council
Virginia Health Quality Center
Virginia Pharmacists Association
Virginia School Nurses Association



Initiative 4
Education and Empowerment

Identify or create and disseminate educational methods, curricula, and instruction for diabetes management and control.

Goal 1. Increase access to high quality, evidence-based educational curricula and resources to those engaged in teaching persons with diabetes (health care providers, lay health workers, schools and businesses).

Objectives

1. By March 2008, appoint a Virginia Diabetes Council Education Work Group to develop a comprehensive statewide approach to diabetes education and support groups for persons with diabetes.

2. By March 2008, partner with the Department of Education to review and update the existing diabetes training manual for school personnel, promote the role of the school nurse in diabetes management, and support training programs for school staff.

3. By December 2009, conduct an initial and thorough search to identify effective and replicable curricula and programs for persons with diabetes and post on the VDC website and other accessible places, revise annually (e.g. National Diabetes Education Program).

4. By March 2010, identify successful employee diabetes management programs and disseminate to employers and insurance companies annually.

5. By September 2010, develop key messages for educating persons with diabetes about how to manage their disease to prevent complications. Distribute key messages via e-mail and other means to "health care agencies and organizations". Post key messages on the VDC website. Evaluate and update annually.

6. By January 2012, define a standard for training and certifying diabetes professionals and lay health workers.

Goal 2. Promote professional educational opportunities for health care providers that focus on evidence-based practice, recommendations for treating children and adults with diabetes, and self-management of chronic disease.

Objectives

1. By March 2008, obtain at least one commitment/sponsorship from a partner organization to offer the "Gestational Diabetes Mellitus and Beyond" conference in Virginia.

2. March 2008, investigate and increase use of teleconferencing and telemedicine technology for providing diabetes professional education, especially in rural and underserved areas of the state.

3. By June 2009, partner with other organizations with similar interests to initiate and promote a speakers' bureau that offers training at local physician journal and study clubs and grand rounds. Evaluate and update speakers/topics biennially.

4. By September 2009, assure that a prediabetes and/or diabetes presentation is offered at each major professional conference in Virginia.

5. By December 2009, identify and promote the use of patient standards for treating type 1, type 2 and gestational diabetes.

6. By December 2011, develop, pilot test and offer standardized educational programs for diabetes health care providers that are modeled after programs for other chronic diseases (e.g.,

Physician Asthma Community Education (PACE) & Nurse Asthma Community Education (NACE) programs for pediatric asthma) that can be offered in 2 evening sessions or online.

7. By September 2012, partner with pharmaceutical companies to develop an academic detailing program or "Lunch & Learn" sessions on the care of prediabetes and diabetes patients in pediatric and generalist physician practice sites throughout the state.

8. By March 2013, identify or develop, pilot test and offer an educational program to certify diabetes lay health workers, parish nurses and volunteers in health districts, churches, industry and services clubs that can be offered in evening sessions or online.

9. By September 2015, expand the "Lunch & Learn" sessions to related specialists (i.e. cardiologists, podiatrists, dentists, etc.).

Goal 3. Promote self-awareness and personal action in self-management of diabetes.

Objectives

1. By March 2008, investigate and increase use of teleconferencing and telemedicine technology for providing diabetes patient education in identified areas of need.

2. By June 2008, develop a one-page standardized Diabetes Action Plan for emergency diabetes management, to be signed by physician, parent and responsible school nurse/personnel, that is consistent with National Diabetes Education Program's Helping the Student with Diabetes Succeed, to be filed for each student with diabetes in his/her school.

3. By June 2008, partner with Virginia Pharmacists and other partners to replicate community-wide pharmacy-based interventions focusing on prevention and education, such as the Ashville Project.

4. By June 2009, identify and disseminate National Diabetes Education Program materials to promote self-awareness, self-responsibility and personal action to manage diabetes (web-based, printable flyers, brochures). Evaluate biennially and update as needed.

5. By June 2009, increase access of culturally appropriate educational materials to groups across the state that has been identified as exhibiting health disparities by surveillance data.

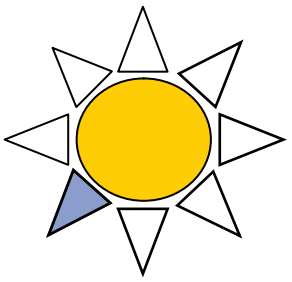
6. By December 2010, plan, fund, and implement a 3-year social marketing campaign that encourages persons with diabetes to take one simple "doable" action to manage their diabetes (e.g., Know your ABCs (AIC, Blood Pressure and Cholesterol); Know Your BMI; Know Your GFR; Know What to Ask Your Doctor about Diabetes, Ask Your Doctor About Regular Foot and Eye Exams).

7. By June 2013, review and adapt existing social marketing campaigns. Pre-test, implement, and post-test to track results. Alternate originally created campaigns which also brand VDC, with adapted campaigns to broaden resources.

Key Partners

Area Agencies on Aging
American Association of Retired Persons
American Diabetes Association
Diabetes Education Programs
Health Insurers and Health Plans
James Madison University, Center for Health Outreach
Juvenile Diabetes Research Foundation
Local Cable Stations
Medical Schools
Medical Society of Virginia
National Diabetes Education Program
National Kidney Foundation of the Virginias
Persons with Diabetes
Pharmaceutical Companies of the Virginias
Schools of Nursing
Schools of Public Health
Stanford University's Chronic Disease Self-Management Program
United Mine Workers
Virginia Association of School Nurses
Virginia Business Coalition on Health
Virginia Center for Diabetes Professional Education
Virginia Chapter of the American Academy of Family Physicians
Virginia Chapter of the American Academy of Pediatrics
Virginia Chapter of the American College of Physicians

Virginia Chapters of the American Association of Diabetes Educators
Virginia Commonwealth University Health Systems Speakers Bureau
Virginia Department of Health
Virginia Diabetes Council
Virginia Dietetic Association
Virginia Health Quality Center
Virginia Nurses Association
Virginia Pharmacist Association
Virginia Society of Opthalmology
Virginia Tech/Virginia Cooperative Extension Program



Initiative 5
Access to Care

Evaluate and eliminate barriers to diabetes care. Encourage and enhance creative alternatives to extend the health care system's ability to detect, treat, educate and manage the care of persons with diabetes.

Goal 1. Convene a Virginia Diabetes Council Access to Care Work Group to identify unique regional issues and develop ideas to improve access to care for persons with diabetes in medically underserved areas of Virginia.

Objectives

1. By March 2008, convene diverse representatives from medically underserved regions, through electronic or telephonic means to serve as an Access to Care Work Group to regularly discuss their activities, innovations, and challenges. Include reports from these communications in VDC internal and external communications (website, internal news letters, external communications, brochures, etc.). Assess progress, value of forum, and telehealth components.

2. By September 2009, partner with the Virginia Telehealth Network to facilitate the adoption and mainstream integration of routine health information systems (HIS), electronic medical records, and other distributive technologies, to improve access and quality of care for persons with diabetes, especially in underserved and rural areas.

Goal 2. Identify, recommend, and promote action to increase the number of health care providers who are well trained in diabetes care and alternative health programs that enhance and extend the work of physicians.

Objectives

1. By June 2009, convene a task force of generalist physicians, and specialists in pediatrics, endocrinology, nephrology, and faculty from Virginia medical schools to assess the needs of specially identified audiences (see Priority Populations, p. 20). Make recommendations for residency curricula and educational programs at statewide conferences and meetings to address these needs.

2. By June 2010, convene the first in a series of dialogues to discuss best medical/community practices, alternative care models, and self-management practices for diagnosing, treating and managing diabetes and prediabetes. Summarize and disseminate results in white papers: "Virginia Dialogue on Best Practices" and "Personal Initiative in the Diagnosis, Treatment, and Management of Diabetes Mellitus." Repeat dialogues and white papers every five years.

3. By 2011, enlist endocrinology chairs in Virginia's medical schools to engage in a dialogue on the statewide scarcity of endocrinologists and develop a white paper on issues such as:

- Number of endocrinologists and those in training
- Desired ratio of endocrinologists to population
- Access to endocrinology services in rural/remote areas
- Incentives for physicians to enter specialty training and remain in state to practice
- Measures VDC and its partners can take to increase access to endocrinology services

4. By 2012, take action on recommended measures resulting from the dialogue/white paper.

Goal 3. Increase access to resources to support health care providers and lay health workers in their efforts to care for persons with diabetes, especially educating patients about diabetes self-management.

Objectives

1. By March 2008, convene a task force of diabetes educators to develop a mentorship program for health care providers in areas of the state that lack diabetes education programs. Set and achieve realistic targets for number of education programs in these areas.

2. By March 2009, convene a task force of key stakeholders to determine how to assist the pharmaceutical companies in Virginia to provide donations and product samples to clinics/organizations serving indigent individuals and underserved regions. Continue dialogue to explore ongoing opportunities for mutual support.

3. By March 2009, develop an electronic Diabetes Resources Directory in the Commonwealth and a process for systematic updating of the resources. Biennially, update, promote and distribute the Directory to physician offices and the VDC stakeholder network.

4. By June 2010, include in funding campaign, monies to support and train health professionals and other lay health workers' to provide evidence-based chronic disease self-management education (e.g. Stanford's Program) outreach efforts.

Goal 4. Facilitate the adoption and mainstream integration of routine health information systems (HIS), electronic medical records, and other distributive technologies, to improve access and quality of care for diabetes patients.

Objectives

1. By March 2009, convene organizations that are currently using HIS, the electronic medical records and other distributive technologies, compile list of their lessons learned, develop recommendations for best practice and ongoing support.

2. By March 2010, investigate and identify successful health information systems that have improved access and quality of care for diabetes patients.

Key Partners

American Diabetes Association
Community Care Network of Virginia
Endocrinologists
Health Insurers and Health Plans
Hospitals and Health Care Organizations
James Madison University, Center for Health Outreach
Medical Society of Virginia
National Kidney Foundation of the Virginias
Nephrologists
Parish Nurses
Partnerships for Prescription Assistance
Persons with Diabetes
Pharmaceutical Companies
Virginia Academy of Family Physicians
Virginia Action for Healthy Kids
Virginia Association of Free Clinics
Virginia Chapter of American Academy of Pediatrics
Virginia Chapter of the American College of Physicians
Virginia Chapters of the American Association of Diabetes Educators
Virginia Community Healthcare Association
Virginia Department of Health
Virginia Diabetes Council
Virginia Dietetic Association
Virginia Health Quality Center
Virginia School Nurses Association
Virginia Society of Opthalmology
Virginia Telehealth Network

Initiative 6
Quality of Care

Engage Virginians in a partnership of care for diabetes detection and treatment, education and self-management that are of the highest quality.

Goal 1. Improve the generalist physician's competency in the knowledge of and compliance with national standards for diabetes care.

Objectives

1. By March 2008, convene a Virginia Diabetes Council Quality of Care Work Group and include generalist physicians and specialists from Virginia's medical schools and adult, family practice and pediatric residency programs.

2. By September 2010 the Work Group will develop recommendations for how to expand the diabetes-related content in medical schools and residency program curriculum.

3. Beginning in January 2011, the Work Group will engage other specialty training programs (dentistry, ophthalmology, cardiology, podiatry, pharmacy, nursing and nutrition) to identify and evaluate other national model diabetes curricula that have been developed and evaluate for adoption in Virginia.

4. In 2011, add diabetes professional and interest organizations (e.g. Virginia Chapters of the American Association of Diabetes Educators, Virginia Dietetic Association, American Heart Association) to the Work Group to collaborate on resources and telemedicine strategies needed to support physicians in detecting and treating diabetes and educating patients on disease self-management and lifestyle behavior changes.

Goal 2. Expand knowledge about and use of the Chronic Care Model within Virginia.

Objectives

1. By December 2008, convene organizations that are currently using the Chronic Care Model in Virginia, compile list of their lessons learned, develop recommendations for best practice and ongoing support.

2. By March 2010, engage Virginia health insurance companies and health plans to support and implement the Chronic Care Model.

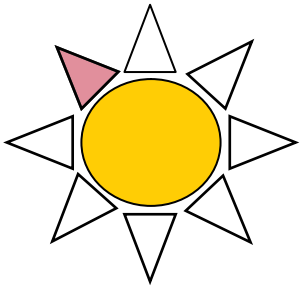
3. By March 2011, identify regions and provider group(s) willing to adopt the model in their sites and train them, using materials and resources from the Bureau of Primary Health Care (Diabetes Collaborative Model).

4. Publish quality improvement outcomes made by organizations and providers implementing the Chronic Care Model.

Key Partners

American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association
Community Care Network of Virginia
Health Insurers and Health Plans
Medical Schools
Medical Society of Virginia
National Kidney Foundation of the Virginias
Persons with Diabetes
Virginia Association of Community Service Boards, Inc
Virginia Association of Health Plans
Virginia Chapter of American Academy of Pediatrics
Virginia Chapter of the American Academy of Family Physicians
Virginia Chapter of the American Academy of Internal Medicine Physicians

Virginia Chapter of the American College of Cardiology
Virginia Chapter of the American Society of Exercise Physiologists
Virginia Dental Association
Virginia Chapters of the American Association of Diabetes Educators
Virginia Community Healthcare Association
Virginia Department of Health
Virginia Diabetes Council
Virginia Dietetic Association
Virginia Health Quality Center
Virginia Podiatric Medical Society
Virginia Society of Opthalmology



Initiative 7
Research

Raise awareness of diabetes research that is conducted in the Commonwealth to facilitate collaboration among diabetes researchers and create a comprehensive agenda that addresses all aspects of diabetes research.

Goal 1. Develop a Virginia Diabetes Council Work Group on Research to set a collaborative research agenda for the state.

Objectives

1. By March 2009, identify a broad base of those who conduct diabetes research in the Commonwealth (basic, clinical, behavioral, community, economic, etc.) and recruit them into a Virginia Diabetes Council Work Group on Diabetes Research.

2. By March 2010, create a diabetes research agenda for the Commonwealth with proposed funding levels and possibilities for grant funding for the research.

3. By September 2011, develop a plan to solicit potential funding to support the unified Commonwealth of Virginia diabetes research agenda.

Goal 2. Activate a clearinghouse and communication plan that updates diabetes stakeholders about research efforts within the Commonwealth.

Objectives

1. By September 2009, develop, implement and maintain an electronic clearinghouse of all diabetes research and results in Virginia, with links to appropriate national research sites.

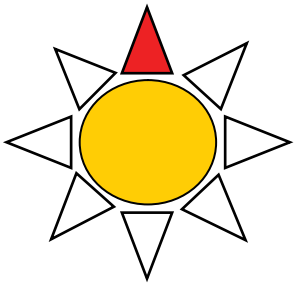
2. By March 2010, disseminate information on research projects and results through multiple channels to all appropriate partners.

3. By June 2013, implement pilot research projects relevant to the research agenda by partnering with funding sources and researchers in academic and clinical institutions in local communities.

4. By June 2015, create ways to translate results from research projects to community-based prevention and clinical programs.

Key Partners

American Diabetes Association
Colleges and Universities
Diabetes Research Institutions
Health Systems and Hospitals
Juvenile Diabetes Research Foundation
Medical Schools
Pharmaceutical Companies
Research America
Schools of Nursing
Schools of Public Health
Virginia Association of Health Plans
Virginia Department of Health
Virginia Diabetes Council
Virginia Pharmacists Association



Initiative 8
Advocacy

Engage legislators and key institutional leaders to support policies and laws that focus on prevention of diabetes and support for those with diabetes, including access to and quality of care and education.

Goal 1. Convene a VDC Advocacy Work Group to examine diabetes-related issues that should be addressed by state legislation or organizational policy.

Objectives

1. By March 2008, recruit VDC members to establish a Advocacy Work Group to focus on legislation and policy concerning diabetes.

2. By September 2008, Advocacy Work Group will develop a long- and short-term policy agenda that will be disseminated to VDC membership and its partners and updated annually.

3. By September 2008, Advocacy Work Group will familiarize themselves with and develop a working relationship with the General Assembly health and insurance committee membership, staff and allied commissions (i.e. Joint Commission on Health Care (JCHC) and Joint Legislative Audit and Review Committee (JLARC)) and national resources - National Association of Chronic Disease Directors (NACDD) and the American Diabetes Association (ADA).

4. By December 2008, create an advocacy link on the VDC web page as a means to gather support and educate the public on diabetes issues in Virginia.

Goal 2. Respond to stakeholder requests for specific public policy initiatives.

Objectives

1. By March 2009, develop an initial set of diabetes funding priorities for consideration by the Virginia General Assembly, supporting existing and new initiatives such as the diabetes prevention and control efforts of the Virginia Department of Health.

2. By March 2010, strengthen school wellness policy by including access to healthy foods and 30 minutes of exercise in grades K-10 so that healthy eating and exercise habits are more likely to follow students throughout their lives.

3. By March 2010, advocate for school nurse coverage in all schools.

4. By 2011, initiate promotion of adopting the Youth Risk Behavior Factor Surveillance Survey (YRBSS) in Virginia by preparing comparative study of other states' ability to obtain federal grant funding based availability of YRBSS data.

5. By 2012, pursue legislative support to recruit additional pediatric and adult endocrinologists to practice in Virginia.

6. By 2013, determine the feasibility of making diabetes a reportable disease in Virginia.

Goal 3. Promote a grassroots health initiative (non-legislative) for cities and towns to prioritize walking and biking friendliness when designing public housing, schools, libraries and parks.

Objectives

1. By June 2010, convene a symposium of statewide coalitions that focus on health promotion and chronic disease prevention to develop or enhance a long-term plan to improve the built environment to support access to physical activity for all Virginians.

Key Partners

American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association
General Assembly Legislators and Staff
Health Insurers and Health Plans
Joint Commission on Health Care
Joint Legislative and Audit Committee
Kids Count
Medical Society of Virginia
National Kidney Foundation of the Virginias
Other Statewide Coalitions with a focus on Health Promotion and Chronic Disease Prevention
Persons with Diabetes
School Health Advisory Boards
Virginia Association of Health Plans
Virginia Chapter of American Academy of Family Physicians
Virginia Chapter of American Academy of Pediatrics
Virginia Chapter of American College of Physicians
Virginia Chapters of the American Association of Diabetes Educators
Virginia Department of Education
Virginia Department of Health
Virginia Diabetes Council
Virginia Dietetic Association
Virginia Nurses Association
Virginia Poverty Law Center
Virginia Public Schools Government Affairs Coordinators
Virginia School Food Services Managers
Virginia School Nurses Association
Voices for Virginia's Children
Voluntary Agency Lobbyists

Call to Action

The *Virginia Diabetes Plan 2008-2017* is a framework to help Virginians organize around a set of common goals to address diabetes, its prevention and its complications. The active involvement of all individuals, organizations and communities is essential to accomplish this plan. Here are some ways you can help:

1. **Join the Virginia Diabetes Council as a partner to address diabetes initiatives.**

2. **Use the Virginia Diabetes Plan to guide actions in your organization or local community.**

3. **Communicate your programs and your successes with the Virginia Diabetes Council members so that we may benefit from your progress and collaborate on initiatives.**

4. **Share data to enhance information about the burden of diabetes and diabetes prevention efforts in Virginia and our progress in reducing the burden.**

5. **Make a tax-deductible donation to the Virginia Diabetes Council to support implementation of the Virginia Diabetes Plan.**

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