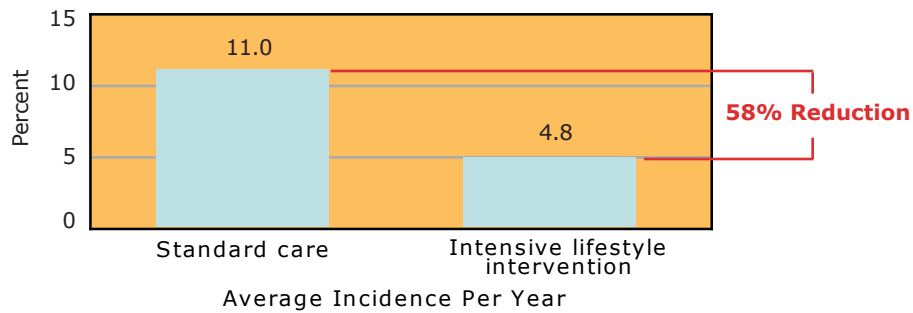


**Preventable** – Before people develop type 2 diabetes, they almost always have prediabetes. The Diabetes Prevention Program, a large national study of over 3,000 people showed that changes in lifestyle, including healthier eating (lowering fat and calories), increased activity (about a half hour per 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**



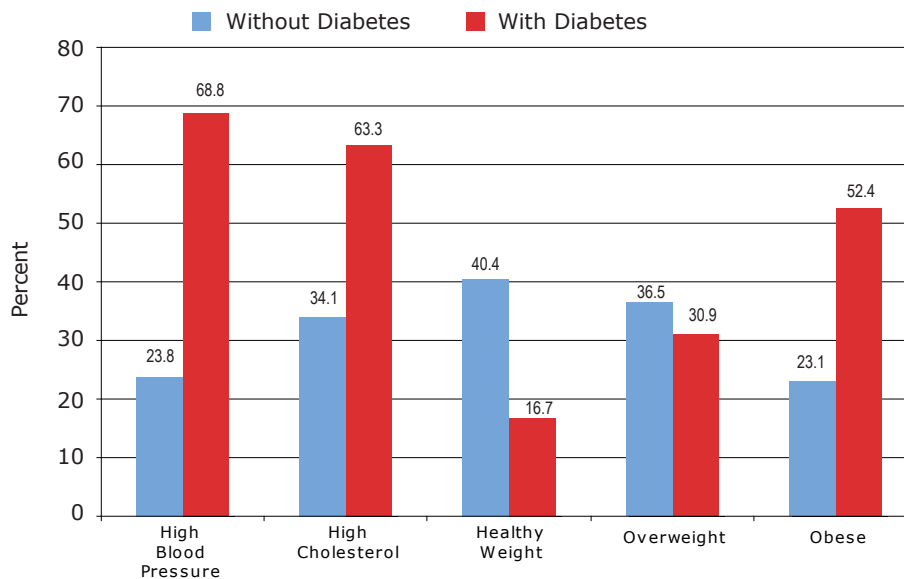
Source: New England Journal of Medicine, Vol. 346, No. 6, February 7, 2002.

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

<b>By 2017:</b>	<b>Virginia Baseline<sup>1</sup> (%)</b>	<b>HP 2010 Target (%)</b>	<b>Virginia 2017 Target (%)</b>
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 <sup>2</sup>	61 <sup>3</sup>	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 <sup>2</sup> (2 times/year)	65 <sup>3</sup> (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 <sup>2</sup>	76 <sup>3</sup>	80
5. Increase the proportion of adult Virginians with diabetes who have an annual foot exam. (HP2010 Obj 5-14)	72.9 <sup>2</sup>	91 <sup>3</sup>	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 <sup>2</sup>  48.6 <sup>2</sup>	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 <sup>3</sup>	75
8. Increase the proportion of adult Virginians with diabetes who obtain an annual urinary microalbumin measurement. (HP 2010 Obj 5-11)	Not available <sup>4</sup>	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 <sup>3</sup>	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 <sup>1</sup> (%)	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 <sup>4</sup>	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 <sup>3</sup>	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 <sup>5</sup>	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 <sup>5</sup>	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 <sup>3</sup>	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.

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# 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

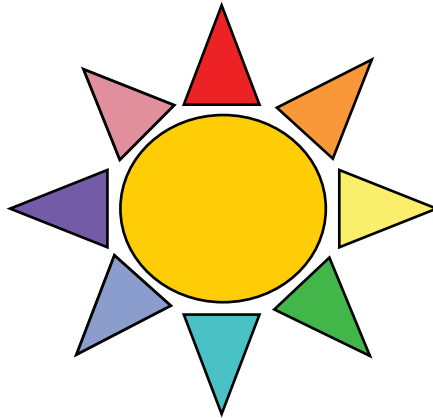
The Plan was facilitated by the Virginia Diabetes Council Executive Committee who engaged consultants to gather broad stakeholder input and assemble a comprehensive list of strategic initiatives to address the needs related to diabetes in Virginia. Seven Diabetes Dialogues were held across the Commonwealth, 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**

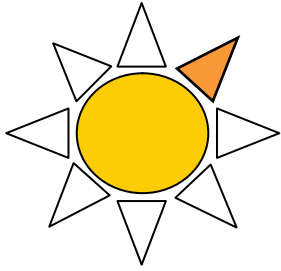
To improve the lives of Virginians affected by diabetes.

## **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.**

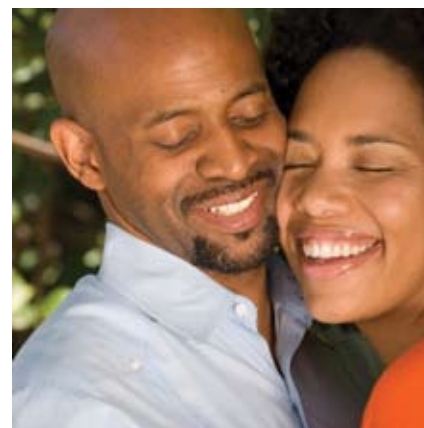
**Goal 1. Strengthen the infrastructure and resource base of the Virginia Diabetes Council to facilitate the Plan's implementation with its partners.**

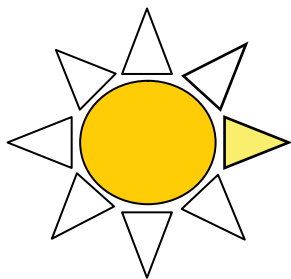
### Objectives

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.**

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**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.

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**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.

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**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.

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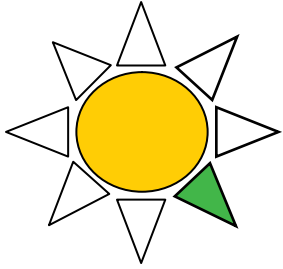
**Goal 4. Annually review and evaluate the Plan.****Objectives**

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.**

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**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.

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**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.

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**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**

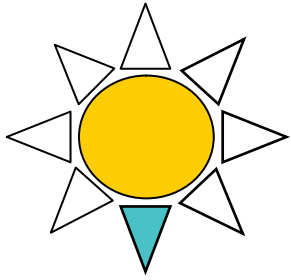
1. By March 2009, enlist faith communities to engage in diabetes awareness activities, for example, identifying lay health outreach “ministers,” and share best practices.
2. By June 2009, encourage and support programs to focus on diabetes prevention by providing community-based curriculum and instruction materials.
3. By March 2010, identify and disseminate information on effective, evidence and community-based programs that reduce risk factors for diabetes.

- 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

**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





## **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 (A1C, 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).

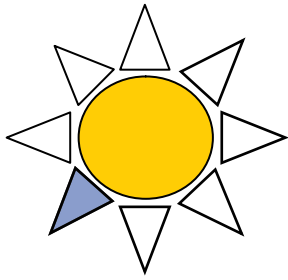
7. By June 2013, review and adapt existing social marketing campaigns. Pre-test, implement, and post-test to track results. Alternate originally created campaigns which also brand VDC, with adapted campaigns to broaden resources.

#### **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 Ophthalmology  
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.**

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**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.

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**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.

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**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.

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**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.**

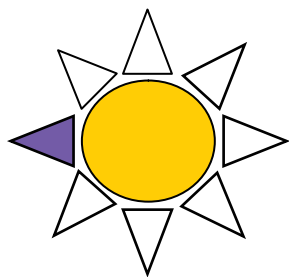
**Objectives**

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 Ophthalmology  
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 Ophthalmology

