



# News and Notes



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## THE FIRST RESOURCE IN THE CARE OF PEOPLE WITH DIABETES: POSITIVE THINKING

By Louis F. Amorosa, MD



If you have ever done clinical research, you know the power of the placebo effect. My simple interpretation of the efficacy of placebo is that a person who has the willingness to participate in a clinical trial, has more motivation than the man on the street to address a specific medical issue. Thus the volunteer who invests her time and energy in a clinical study is committed to do well. She alters her behavior diet and stress levels are positively affected. The volunteer experiences an efficacious effect of the placebo secondary to these unintended effects. Neurophysiologists are now demonstrating that this "wanting to do well-attitude" actually causes MRI and PET scan detectable brain signals in response to placebo administration in some volunteers.

Most of my patients are not as motivated as clinical study participants, but I always consider the patient with me to be more committed to their health than the man on the street. He hears the message to stop smoking over and over and doesn't listen. I have often been astonished that when I tell the man with me to stop smoking, many times he listens and he will either cut back significantly and stop all together! He has invested his time and money to be with me and is more receptive to the message than the man on the street. The patient with diabetes is just as ready for the right advice.

Conversely I often find that many patients expect an easy way out. They want a pill which will solve everything, one that will make their diabetes go away. The drugs we have available now, including insulin and metformin, have had zero to modest effects on limiting the transition of prediabetes to diabetes or the progression of the disorder. The therapeutic life style including 7 percent weight loss and 50 minutes of exercise 3 times a week was shown to be twice as effective as metformin in preventing progression into type 2 diabetes over 2.8 years (N. Engl. J. Med. 2002; 346:393). New data involving the glitazones are expected to be published soon. But the real challenge in the clinical encounter with a poorly motivated patient with diabetes is not simply to prescribe more medications, but to push a motivational button which will activate the neurochemistry which can turn even a placebo into an effective drug.

I wrote in the first diabetic newsletter, that I devote a lot of my clinical encounter to winning the respect of the patient with my interest and caring. I hope to excite the patient with the thought that unlike most disorders, the patient with diabetes, given the know-how, can think their way out of a potentially very troubled life. I want to stimulate a desire for diabetic education which can do this. For the details I refer to specialists who will teach daily diabetic management. I reemphasize the simple principles of the therapeutic lifestyle in my revisits. The more I work with patients with diabetes, the more I realize that empowering the patient with the tools for their own welfare, from the knowledge of self managing an insulin pump to the knowledge of juggling their time to provide sufficient exercise; all this might fire up that deep seated brain center governing motivation which will make their efforts efficacious.

# NEW JERSEY'S FIRST ANNUAL DIABETES SUMMIT

By Patty Esch, MS, RD, CDE

**A**The New Jersey Hospital Association (NJHA) in Princeton, New Jersey was the setting for the First Annual New Jersey Diabetes Summit, held on March 13, 2007. The New Jersey Department of Health and Senior Services (NJDHSS), the New Jersey Diabetes Advisory Council (NJDAC), and the New Jersey Hospital Association co-sponsored the event, which drew healthcare providers, community health workers, health educators, physicians, nurses, dietitian/nutritionists and social workers, as well as representatives from community and faith-based organizations, health planners, and those in public relations or private industry. Over 230 individuals attended the full-day event, which far exceeded the initial estimate of 130 attendees. The strong attendance reflects the interest the healthcare community has in managing the escalating problem of diabetes.

The focus of the Summit was on improving the quality of diabetes care. To set the stage, Dr. Eddy A. Bresnitz, Deputy Commissioner/State Epidemiologist at the New Jersey Department of Health and Senior Services, presented an overview of the problem of diabetes in the state, including a discussion of who is affected, how we compare to the rest of the country, and the extent of diabetic complications experienced by New Jersey residents.



**I**n his presentation on defining the challenge to improve the quality of diabetes care, the Department's Commissioner Fred M. Jacobs, M.D., J.D., announced the expansion of the New Jersey Diabetes Collaboratives aimed at reducing the disparities, prevalence, and impact of diabetes in the state. Diabetes disproportionately affects Black, Native American, Asian/Pacific Islander, and Hispanic New Jerseyans. The Federally Qualified Health Centers (FQHCs) participating in the Diabetes Collaboratives will work to promote diabetes health care to underserved populations. The Collaborative model includes sharing of best practices across health care providers, tracking patient results electronically, using measurable benchmarks to determine success, and encouraging patients to participate actively in their disease management.



**K**eynote speaker Dr. Frank Vinicor, Associate Director, Public Health Practice, of the Centers for Disease Control and Prevention (CDC) in Atlanta, GA, brought a national perspective in discussing what "quality care" actually means in treating people with diabetes. The audience enjoyed his unique brand of humor and the memorable slides he used to illustrate his main points.

NJDAC members were key contributors in the Summit presentations. NJDAC Chairman Louis Amorosa, M.D., welcomed Summit participants and gave an overview of the day's program. Leonard Pogach, M.D., Chair of the NJDAC Quality Improvement Task Force, gave an informative presentation on how to negotiate ideal versus "real world" goals in caring for people with diabetes.



**N**JDAC Member Patricia Barta, R.N., M.P.H., Vice Chair of the Quality Improvement Task Force, moderated a panel discussion of best practices for achieving improved quality of diabetes care. This session provided the opportunity to compare models of improved quality of care in different treatment settings. Members Walter Miller, M.D., of the Southern Ocean Primary Care Association,

represented a small practice setting, and Philip M. Bonaparte, M.D., the Chief Medical Officer of Horizon Blue Cross Blue Shield of New Jersey, represented a New Jersey health plan. Roger M. Thompson, M.D., of FAAFP Integrated Medicine Alliance, illustrated a large practice setting, and Sharon Buttress, M.D., spoke about best practices at an FQHC, CAMcare Health Corporation.

**N**JDAC member Linda Whitfield-Spinner, L.C.S.W., from the New Jersey Primary Care Association (NJPCA), Inc., moderated the afternoon panel discussion on how the electronic health record can be used to improve diabetes care. Speakers included pediatrician Puthenmadam Radhakrishnan, M.D., M.P.H., F.A.A.P., who gave practical tips on implementing the electronic medical record (EMR) based on experience in his own practice; Thomas Gage, of the NJPCA, Inc., gave an overview of the adoption of a uniform EMR in New Jersey FQHCs and the implementation of a statewide quality analysis system; and, Richard Stark, M.D., highlighted the use of EMRs by the Department of Veterans Affairs, with particular attention to diabetes management.

Based on the evaluation forms, the reaction to the Summit was overwhelmingly positive, with over 98 percent of respondents rating the overall experience as "excellent" or "good." Survey respondents made many suggestions on diabetes-related topics for future Summits. Based on the enthusiastic response and the unfortunate reality of the increasing magnitude of the problem, planning will soon begin for the Second Annual New Jersey Diabetes Summit.



# LEARNING TO EAT RIGHT WITH DIABETES

By Barbara Ertel, MS, RD, CDE

Whether you are being treated with insulin or pills, understanding how to eat properly is important keeping your blood glucose in good control.

## Helpful Clues to Eating Right

- Try to find healthy foods that you enjoy eating. You are an individual and your meal plan should fit your lifestyle.
- Eat your meals at about the same time every day-do not skip meals.
- Eating about the same amount of food at the same meal and at snack-times can help you to avoid short-term problems such as a low blood sugar (hypoglycemia) or high blood sugar (hyperglycemia).
- Your meal choices should not be very different from those eaten by other family members. Everyone should be concerned about eating a healthy diet that includes a greater variety of fresh fruits and vegetables, foods high in fiber, less animal type fats (saturated fats) and limiting foods with added sugar.
- Achieving and maintaining a healthy weight should be a primary goal. Even a 7% weight loss in overweight patients has been shown to make a big difference in controlling blood glucose levels.

## What should be stressed:

- There is no single diabetic diet for improving glucose control for all patients with diabetes.
- Eating properly may also delay or prevent complications associated with diabetes such as kidney disease, high blood pressure and heart disease.

## Question #1: Do patients with type 1 diabetes have special food needs?

If you have type 1 diabetes, your meal plan should help you keep your blood glucose as close to normal as is safely possible. Eat your meals when your insulin is working the hardest. Test your blood glucose levels and write them down so you can match the dose of insulin you are taking with your carbohydrate intake and physical activity. Your health care provider will provide you with instructions on how to adjust your insulin.

## Guide to good control:

- Know how to adjust your food intake (meals and snacks) and your insulin dose when you exercise.
- You should know how to treat and avoid a low blood sugar.
- Know what may be causing a high blood sugar.
- Understand how to eat when you're ill, can't eat normally ("sick-days") and when you should contact your doctor.

Children and teens with type 1 diabetes need a special meal plan that provides them with enough calories and other nutrients for normal growth and development. The increasing number of children and teens who have obesity-related type 2 diabetes should be on a weight-reducing diet, but this diet needs to be adequate in calories, protein, vitamins, and minerals for their special needs.

If you are planning to get pregnant, it is vital that you speak with your doctor prior to becoming pregnant to develop a meal plan that will keep your blood sugar under stricter control during the critical and early period of the pregnancy.

## Question #2: Does the patient with type 2 diabetes have special concerns?

If you have been told that you have type 2 diabetes, your health goals should be:

- Normal levels of blood cholesterol, HDL (good cholesterol), LDL (bad cholesterol), and triglycerides (fats)
- A normal blood pressure
- Weight loss and exercise

- Exercise such as walking 30 minutes per day for a minimum of 4 days per week can make a major difference in controlling type 2 diabetes. Eating right and exercising will help make your medications work better.
- Focus on reducing the fats in your diet. Limit or avoid fried foods. If you are having difficulty in losing weight, it may not be what you are eating. Eat less! Losing 10 -20 pounds can improve both your blood glucose and blood pressure.

### Question #3: What is a nutritious diet for someone with diabetes?

**NUTRITION** refers to getting **NUTRIENTS** such as protein, carbohydrates, fats, vitamins and minerals-from your food to keep you healthy. Carbohydrates, protein and fats provide your body with energy needed for your basic needs. The amount of each that you need varies, but in general a diabetic diet will include:

- **10- 20 % of total calories from protein.** Sources of protein include: fish, lean meats, poultry, eggs, low fat dairy products, beans, grains, and vegetables.
- **Less than 30% fat.** Americans eat too much and the wrong type of fat. Patients with diabetes are at an increased risk for heart disease - more reason to change the amount and types of fat eaten. Less than 10% of the fat should come from SATURATED FATS found in whole milk, butter, high fat meats, high fat cheese, etc. This type of fat has been associated with raising cholesterol and increased risk for heart disease. The primary sources of fat in your diet should come from monounsaturated fats such as plant oils like olive or canola oil, and polyunsaturated fats found in fish and other seafood.
- **Most of the calories should come from COMPLEX CARBOHYDRATES.** Carbohydrates are found in fruits, vegetables, dairy products, and starchy foods such as breads, beans, rice, and pasta. Try to limit foods with added sugars such as candies, cakes, pastries, and sugar sweetened beverages. They can lead to rapid increases in blood sugar levels.
- **Fiber.** Foods containing fiber include: vegetables, fresh fruits, whole grains, and brown rice. Fiber may help to regulate your blood glucose levels.
- **Sodium.** Limit your foods high in sodium. It has been shown that even if you do not have high blood pressure, people who have diabetes tend to be more sensitive to a high salt diet. Foods high in sodium include: processed foods, hot dogs, bologna, salami, frozen prepared meals, regular canned foods, soy sauce, and seasoning salts.
- **Supplements, herbs, vitamins.** Keep your doctor informed about any vitamins, herbs or supplements you may be taking without your doctor's knowledge. Make certain that what you are taking does not interfere with your prescribed medications.

### Question #4: Can people who have diabetes eat sugar?

Sugar is one type of **CARBOHYDRATE**. For about 100 years, people with diabetes were told to avoid sugar. It was thought that table sugar would raise your blood glucose levels more rapidly than any other carbohydrate. The American Diabetes Association (ADA) provides us with basic nutrition guidelines. In 1994, ADA lifted the ban on sugar from its dietary guidelines. This change was based on scientific studies showing that carbohydrate in the form of sugar does not raise blood glucose levels more rapidly than other types of carbohydrate containing foods.

However, there are still good reasons why sugar is not considered to be a smart food choice. Sugary foods are often considered to be "EMPTY" calories. They provide few vitamins and minerals. Your dietitian can help you work sugar into your diet, but these foods should not be used to replace the healthier food choices. There is no reason to avoid foods that contain sugar. What is more important is the amount that you are taking and knowing how it may affect your blood glucose. Testing your blood glucose before and after eating will help you to determine this information. The glucose value two hours after the first bite of food is called a "post-prandial glucose" and is helpful in evaluating your treatment plan.

If you feel you need assistance in learning how to eat properly speak with your doctor or health care provider. You should look for a person who is properly trained and who has specialized knowledge of diabetes. She or he will usually be a Registered Dietitian, preferably one who is a Certified Diabetes Educator. A Certified Diabetes Educator (CDE) must pass a national credentialing examination and can be identified by the initials following their names (RD, CDE). If you wish to find a Certified Diabetes Educator in your area, you can contact the American Association of Diabetes Educators (AADE) at: 1-800- 338-3633 or [www.aadenet.org](http://www.aadenet.org).

# DIABETES SELF-MANAGEMENT EDUCATION: ESSENTIAL TO IMPROVED DIABETES OUTCOMES

**By - Nancy L. Rhodes, RN, MA, CDE**

Co-Chair, Clinical Services Task Force, NJ Diabetes Advisory Council  
and President, Garden State Association of Diabetes Educators

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Those of us in healthcare are all too familiar with the staggering numbers associated with diabetes. According to the American Diabetes Association (ADA), there are 20.8 million adults and children in the United States, or 7% of the population, who have diabetes. While an estimated 14.6 million are currently diagnosed with diabetes, 6.2 million people, nearly one-third, are unaware they are afflicted with the disease. For the last decade, there has been a sharp rise in the incidence of type 2 diabetes among the pediatric population, dispelling the belief this is an adult disease. 45-85% of these children have at least one parent with type 2 diabetes, and a family history of 74-100% having either a first or second-degree relative with diabetes over several generations. Total annual economic cost of diabetes in 2002 was estimated to be \$132 billion, rising currently to \$136 billion. Direct medical expenditures totaled \$92 billion, comprising \$23.2 billion for diabetes care, \$24.6 billion for chronic diabetes-related complications, and \$44.1 billion for excess prevalence of general medical conditions. This estimated \$92 billion in 2002 rose dramatically from \$44 billion in 1997. Cardiovascular disease, the most costly diabetes complication, accounted for more than \$17.6 billion of the \$92 billion in 2002 medical costs for diabetes. Indirect costs resulting from lost workdays, restricted activity days, mortality, and permanent disability due to diabetes totaled \$40.8 billion (88 million disability days). One out of every 10 US healthcare dollars is spent on diabetes and its related complications, and represents 11% of the US healthcare expenditure, 2.4 times higher than those without diabetes. Inpatient hospital care in 2002 totaled \$40.3 billion (16.9 million days) and \$13.8 billion for nursing home care. 2002 rates of diabetes-related outpatient physician office visits totaled 62.6 million. Gestational diabetes, affecting 4% of all US pregnant women (135,000 cases annually) and 54 million Americans with pre-diabetes (beyond the 20.8 million with diabetes), gives rise to even more astonishing concern about what the future holds. (American Diabetes Association. Available on the Internet at <http://www.diabetes.org>).

With diabetes being the 5th leading cause of death in the United States and its incidence having tripled in the last three decades, diabetes healthcare professionals are committed to improving overall diabetes outcomes. One proven method is through Diabetes Self-Management Education (DSME) Programs. It is estimated that greater than 90% of diabetes management is the responsibility of the patients themselves. Yet, a vast majority of these patients have no skills, tools, or knowledge needed to successfully manage their diabetes, and fall victim to the ravaging complications of their disease. DSME is integral to the treatment and management of their diabetes. Physicians, who all too often are faced with time constraints, know that visits with diabetes patients require more complex care and very specific needs. Experience and studies show that a well-informed person with diabetes has significantly improved outcomes, reduced risks of long-term complications, and require fewer hospitalizations than those with limited or no knowledge of diabetes self-management. As a short-term collaborative venture, physicians should strongly consider referrals into the many DSME programs offered. Referrals can range from one to several nutrition education sessions with the program's dietician, to more comprehensive, multidiscipline individualized sessions, or group education classes that commonly total 10 hours of multidiscipline education and training. Services can include carbohydrate counting and meal plan instruction, home glucose monitoring with initial start-up kits provided, insulin administration instruction with various delivery systems, including pre-filled pens and pumps, diabetes medications instruction, stress management, exercise instruction, prevention, detection and treatment of acute and chronic complications of hyper/hypoglycemia, retinopathy, nephropathy, neuropathy, gestational/pre-conception management, behavioral lifestyle changes, smoking cessation, weight management, family counseling...the list goes on. Diabetes clinicians/educators have specialized training and expertise in these areas to improve the overall outcomes to patients and families with diabetes, and to assist the physician with specific needs.

Diabetes education plans must be individualized and focus on medical, psychosocial, and lifestyle changes. Sadly, despite the 53 ADA Recognized Diabetes Education Programs throughout the state of New Jersey, many of them are under-utilized, and unfortunately some have closed due to economic constraints from lack of physician referrals into the programs, or failure of the sponsoring organization to acknowledge their respective DSME programs' value beyond

bottom lines. Frequently, their programs' clinicians/educators meet the needs of their diabetes inpatients, as well as outpatients, reducing length of stay and optimizing diabetes care and management through the hospital's multidiscipline team approach. Additionally, the DSME Program clinicians/educators are involved in staff development and community outreach programs, adding further value to the organization.

ADA recognized programs are subject to a rigidly scrutinized evaluation process initially and every three years, thereafter. The curriculum, instructors, populations served, behavioral change goals, and overall outcomes measurements are among those areas that are assessed, and all programs are subject to a random ADA audit during the three year recognition period.

**Ten content areas must be addressed in any ADA Recognized Education Program:**

- (1) understanding the diabetes disease process and treatment options;
- (2) incorporating appropriate nutritional management;
- (3) incorporating physical activity into lifestyle;
- (4) utilizing medication for therapeutic effectiveness (if applicable);
- (5) monitoring blood glucose and using the results to improve control;
- (6+7) preventing, detecting, and treating acute and chronic complications through risk reduction behavior;
- (8) goal setting to promote health and problem solving for daily living;
- (9) integrating psycho-social adjustment to daily life; and,
- (10) promoting pre-conception, management during pregnancy, and gestational diabetes management. (American Diabetes Association. Available on the Internet at <http://www.diabetes.org/for-health-professionals-ascientists/recognition/edrecognition.jsp>). ADA recognition is the gold standard of diabetes self-management education and serves as a model for third party payors. Only those programs recognized by the American Diabetes Association are eligible for insurance reimbursement, though visits may be limited by certain carriers.

ADA recognized self-management education programs are staffed by diabetes healthcare professionals who encompass multiple professional disciplines. Registered nurses, dietitians, social workers, physicians/podiatrists, pharmacists, exercise physiologists, clinical psychologists, occupational therapists, optometrists, and physical therapists are among those who specialize in providing care and education to people with diabetes, pre-diabetes, and gestational diabetes. Most possess the Certified Diabetes Educator (CDE) credential or are CDE-eligible. The National Certification Board for Diabetes Educators (NCBDE), established in 1986, promotes the interests of diabetes educators by granting certification to those healthcare professionals engaged in the education and treatment of people with diabetes. It aspires to promoting excellence in the profession of diabetes education through the development, maintenance, and protection of the Certified Diabetes Educator credential and the certification process. The CDE credential, granted by the NCBDE, requires an initial written examination, and must be maintained every five years by either written examination or 75 hours of CEU's. Only those who meet the strict criteria of a minimum of two years of professional practice experience in diabetes self-management training, a minimum of 1,000 hours of diabetes self-management training experience, and current employment in a defined role as a diabetes educator a minimum of four hours per week may take the initial CDE examination, which demonstrates proficiency and expertise for competent practice in diabetes self-management training and education. (National Certification Board for Diabetes Educators. Available on the Internet at <http://www.ncbde.org/eligibilityreq.html>).

Many CDE's are members of the American Association of Diabetes Educators (AADE), whose mission is to advance the role of the diabetes educator and improve the quality of diabetes education and care. It is a professional membership organization dedicated to providing continuing education programs and to promoting the interests and image of its members. (American Association of Diabetes Educators. Available on the Internet at <http://www.aadenet.org/>). Many of these Masters prepared diabetes healthcare professionals in specific disciplines possess the advanced practice credential of BC-ADM (Board Certified-Advanced Diabetes Management), in addition to their CDE credential.

This BC-ADM credential is jointly sponsored by the American Association of Diabetes Educators and the American Nurses Credentialing Center, in collaboration with the American Dietetic Association, the Diabetes Care and Education Practice Group, the American Pharmaceutical Association, and the American Diabetes Association, in consultation with the National Certification Board for Diabetes Educators. Most states have local chapters of the AADE, New Jersey's being the Garden State Association of Diabetes Educators (GSADE), whose members encompass multiple disciplines in various organizations. Please visit the GSADE website at [www.gsade.org](http://www.gsade.org) to learn more about NJ's local chapter and its site map will link you to areas of interest in diabetes.



## DIABETES RESOURCES

1. New Jersey Department of Health & Senior Services  
Diabetes Prevention and Control Program  
[www.njdiabetes.gov](http://www.njdiabetes.gov)
2. American Diabetes Association  
[www.diabetes.org](http://www.diabetes.org)  
1-800-342-2383
3. Camp Neveda  
[www.childrenwithdiabetes.com/camps](http://www.childrenwithdiabetes.com/camps)  
1-973-383-2611
4. Juvenile Diabetes Foundation International  
[www.jdf.org](http://www.jdf.org)  
1-800-223-1138
5. American Association of Diabetes Educators  
[www.aadenet.org](http://www.aadenet.org)  
1-800-338-3633
6. Centers for Disease Control and Prevention  
[www.cdc.gov/diabetes](http://www.cdc.gov/diabetes)  
1-877-232-3422
7. National Diabetes Educational Program  
<http://ndep.nih.gov>  
1-800-438-5383
8. Garden State Association of Diabetes Educators  
[www.gsade.org](http://www.gsade.org)  
1-973-543-6464
9. National Diabetes Information Clearinghouse  
[www.niddk.nih.gov/health/diabetes/ndic.htm](http://www.niddk.nih.gov/health/diabetes/ndic.htm)  
1-301-654-3327
10. New Jersey Commission for the Blind and Visually Impaired  
[www.state.nj.us/humanservices/cbvi](http://www.state.nj.us/humanservices/cbvi)  
1-973-648-2111
11. Healthcare Quality Strategies, Inc. (formerly PRONJ)  
[www.hqsi.org](http://www.hqsi.org)  
1-800-624-4557
12. National Institute of Diabetes and Digestive and Kidney Diseases  
[www.niddk.nih.gov](http://www.niddk.nih.gov)

# PRIMARY PREVENTION OF DIABETES - IS THIS THE ANSWER TO THE DIABETES PANDEMIC?

By Dorothy Caputo, MA, APRN, BC-ADM, CDE

**F**or the past 20 years, we have seen diabetes grow exponentially, bringing it to pandemic proportions. All the research on how to best manage diabetes has not helped alleviate this burden. However, in 2002, findings from the DPP (Diabetes Prevention Program) was completed that indicated that diabetes can be prevented or minimally delayed through lifestyle interventions as well as through medication. When are we going to translate this into everyday life?

In this day of tremendous technical progress, we drive to the store for groceries, have at least one phone on every floor in our home (if not one in each room), have a remote control for the TV so we don't have to get up to change the channel, and sit at the computer or TV to play games and communicate, instead of running outside playing stickball or riding bikes!

This change of exercise pattern in our daily lives is affecting every age bracket, every generation. The young don't need to go outside to play; they can play with video games, or on their computers. The middle aged American does not need to walk to the bus stop to get to work, most drive their cars from the point of their home to their office, sitting in traffic for at least one hour each way. The older American goes by bus from their senior complex to areas of entertainment where they then sit and play casino games or watch shows. Add to this the "early bird specials" of high caloric, high fat, high carbohydrate foods (because we know that more is better), and you have an algorithm for obesity.

Process does not necessarily equal outcomes except in the world of lack of exercise. We can go to the doctor, measure our blood sugars, have annual eye exams, get our feet checked and take an aspirin everyday, but if we do not increase our exercise and decrease our caloric portions, obesity will occur. Coupled with obesity comes hypertension, dyslipidemia and diabetes which are only the precursors of more complications and other co-morbid conditions.

How are we going to reverse these patterns? Does technical progress need to cease? Absolutely not! But, we do need to make a conscience effort to increase our daily exercise by walking 30-60 minutes per day, either on a treadmill or outside. Eating smaller portions - stop supersizing! Eat fruit, not drink large quantities of juice. Limit soda intake, drink flavored waters or diet soda. Walk to the store when you can or park further away in the parking lot from the entrance, rather than driving around looking for the closest parking spot. And, we need to impose these healthier lifestyle modifications on our children.

Alarmingly, recent data from the SEARCH project funded by CDC identifies that about one in every 523 young people have been diagnosed with diabetes, according to the first comprehensive assessment of the disease in Americans under the age of 20. Are chicken fingers, macaroni and cheese, and french fries contributors to this?

That places diabetes among the more common chronic illnesses of youth, the researchers report, striking 1.82 children per 1,000, compared with 1.24 per 1,000 with cancer and 120 per 1,000 with asthma.

"Type 2 diabetes was unheard of in children 20 years ago," says pediatric endocrinologist Larry Deeb of the American Diabetes Association. "I frequently see a 55-year-old grandmother who developed diabetes last year, a 35-year-old mother who developed diabetes last year and a 14-year-old who developed diabetes today."

"All my colleagues are worried about 25 and 30-year-olds who are at risk for having heart attacks," Deeb says. "The most important thing is that we recognize the enormity of what's happening and document the extent of it, so we can identify it and intervene."

The SEARCH Study, which was paid for by the U.S. Centers for Disease Control and Prevention and the National Institutes of Health, found that the average age of diagnosis was 8.4 years, and 96% of children under 10 with diabetes had type 1. Girls had a higher prevalence, at 1.88 per 1,000, than boys, at 1.77 per thousand.

# OPENING THE DOORS FOR THE DIABETES COLLABORATIVE

**S**outhern Jersey Family Medical Centers (SJFMC), a non-profit community and migrant health center with six locations throughout Southern New Jersey, is one of the State's 19 community health centers. For more than twenty-seven years, the agency has provided comprehensive primary health care services as a federally funded community and migrant health center to the medically uninsured and underserved. At each of our Centers, clinical staff focus on prevention, early intervention and education initiatives that encourage innovative approaches, enabling us to offer our patients the highest standard of care in a primary care environment.

Faced with the tremendous increase in the number of people with type 2 diabetes in Southern New Jersey, SJFMC recognized the need to expand and improve care for its underserved patients with diabetes. In 2001, we applied and were accepted into the National Diabetes Collaborative, a project supported by the US Department of Health and Human Services, the Health Resources Services Administration and the Bureau of Primary Health Care. Committed to providing an evidence based chronic care model for use by community health centers that would assist with quality improvement purposes, the BPHC Diabetes Collaborative worked to help health centers (1) generate and document improved health outcomes for underserved populations (2) transform clinical practice through models of care, improvement and learning (3) develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status and (4) to build strategic partnerships.

Members of the Collaborative were divided into clusters and teams. Over a thirteen-month period, each team was required to participate in learning sessions and to maintain constant contact with the Collaborative Team, each other and faculty members. The time between learning sessions was used by a team to test and implement an organizational approach to caring for people with diabetes. Each team was expected to connect the goals of the Collaborative to a strategic initiative in their organization. Concepts were presented using the Chronic Care Model in addition to an improvement model developed by the Institute for Healthcare Improvement. Using the two models together provided a process to improve the quality of care for people with diabetes at an accelerated pace.

Findings and achievements of the teams were highlighted at a meeting referred to as the National Congress. It is important to point out that acceptance to the Collaborative was based on the commitment and support of the key leadership in each member organization.

Senior leaders were expected to select the organizational team and provide members with the resources needed to support the team including time for team meetings, other activities and time to implement and test changes in the practice. An electronic management software program, now called PECS, was used by each team to collect data monthly on patients with diabetes. Each team was required to gather and report national core measures used by the health center such as A1c levels, lipid profiles, etc.

The registry provided us with the detailed outcome measures needed for quality improvement methods. It not only served as a means of tracking our progress (both provider and patient) but helped us in the scheduling of patient labs, visits and education sessions. Once a team successfully completed all sessions that were part of the first phase, Phase I, they were accepted into Phase II of the Collaborative. During Phase II, focus continues to be directed toward providing health centers with the technical assistance needed to spread the Collaborative model and sustain the improvements made during Phase I. Teams were also encouraged to continue work on three core aims and measures. The measures were to be directed to national outcomes and process measures made available by the Collaborative at the National Congress. SJFMC remains active as a member of Phase II.

Over the last few years, HRSA has expanded the Collaborative to include improvements in other chronic diseases including asthma, cardiovascular disease and depression. Throughout New Jersey many of the Federally Qualified Health Centers who are dedicated to providing a diverse population of racial and ethnic groups better access to quality medical and dental care, have joined the Diabetes Collaborative. These centers, which are located in high density, urban areas and in rural areas with a large, diverse base of ethnic and minority residents, offer comprehensive services tailored to meet the physical, psychosocial, nutritional and health education needs of their communities. In 2006, approximately 800 Federally Qualified Community Health Centers across the nation were participating in a HRSA Health Disparities Collaborative.

State-based leadership for New Jersey HDC teams comes from the New Jersey Primary Care Association. For more information regarding SJFMC's model and Collaborative participation, contact Carol Mallette at 609-567-0434.

# NEW JERSEY DIABETES ADVISORY COUNCIL NEWSLETTER EVALUATION

A selection of materials from the National Diabetes Education Program is available from the Diabetes Prevention and Control Program. If you would like to receive free patient educational materials, please indicate at the bottom of the page the number of brochures needed and whether you need Spanish, English or a combination of the two.

Please rate, on a scale of one to five, your overall impression of newsletter.

	<b>Agree</b>			<b>Disagree</b>	
The articles increased my awareness/understanding of the topic.	1	2	3	4	5
The information will influence how I practice.	1	2	3	4	5
The information presented will help me improve patient care.	1	2	3	4	5

What other topics concerning diabetes would you like to see covered?

What can we do to make this newsletter more informative?

Please let us know how many brochures you would like to receive\_\_\_\_\_

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Diabetes Prevention & Control Program  
NJ Department of Health & Senior Services  
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Trenton, NJ 08625-0364  
**Fax number: (609) 292-9288**

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