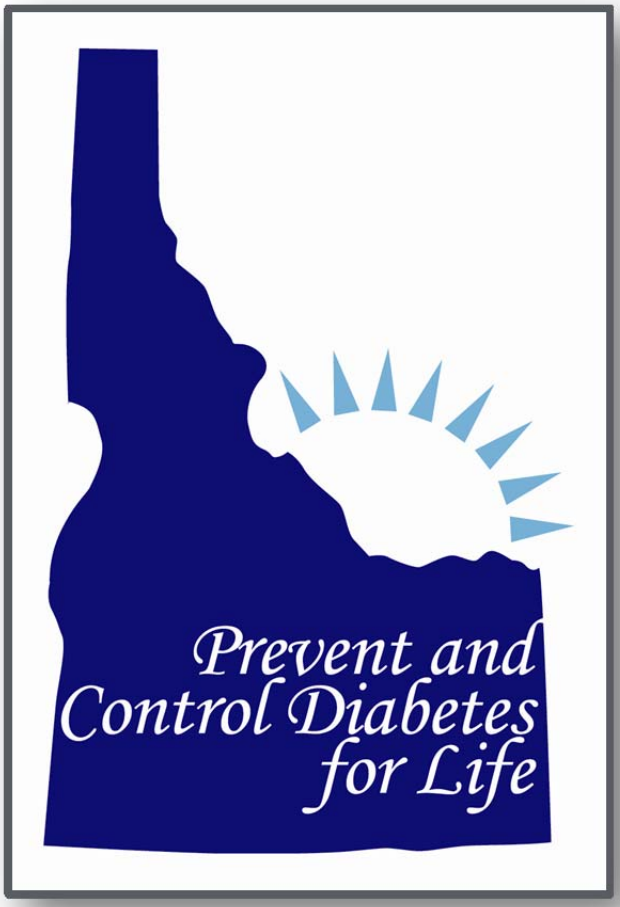
Idaho Health District Diabetes Success Stories

2011-2012

Idaho Diabetes Prevention & Control Program

Idaho's seven (7) Public Health Districts received funding during the fiscal year 2011 – 2012 from the Diabetes Prevention and Control Program (DPCP), to develop partnership networks that work on special projects within the DPCP focus areas and the Idaho Diabetes 5-Year State Plan 2008-2013.



Idaho Diabetes Prevention & Control Program
Public Health District
Success Stories
2011-2012

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Public Health
Prevent. Promote. Protect.
Panhandle Health District

Pandhandle Health District (1):

North Idaho Residents Discover the methods of a Healthier Lifestyle through the "Healthy Eating with Diabetes" Workshop – *Written by: Whitney Fehringer, RD*

Public Health Problem

According to the National Diabetes Fact Sheet of 2011 from the CDC, 25.8 million people of the U.S. population have diabetes. Almost 11 million of those with diabetes are of age 65 and older. Diabetes can be a heavy burden on many levels. Not only is diabetes the leading cause of kidney failure, non-traumatic lower limb amputations, and new cases of blindness, but it also takes a heavy toll financially. The total estimated cost of diabetes in 2007 was $174 billion.

Idaho follows closely to the national trend with 8% total adults with diabetes. In the Panhandle Health District, 7.3% of adults live with diabetes.

Program/Project

In an effort to combat the rate of diabetes and increase knowledge on self-management among Northern Idaho residents, the Panhandle Health District (PHD) in partnership with Shelly Johnson, M.S., Associate Professor at University of Idaho Extension, provided a free 4-part Healthy Eating with Diabetes (HEWD) workshop to 70 individuals during the past year. The workshops were held in three different counties at senior center sites. The primary audience was individuals over 65 years of age but the workshop was open to all ages. The free workshops target disparate populations including elderly, low income and individuals in rural communities with limited medical, educational and economic resources. The curriculum was developed to educate individuals with diabetes, at risk for diabetes, and caregivers of individuals with diabetes. These workshops provide education on the Idaho Plate method for carbohydrate-balanced eating, label reading and physical activity, as well as education on the importance of foot care, eye care, oral care, immunizations, proper blood glucose control, blood pressure and cholesterol. The Area Agency on Aging provides funding for the program.

The collaborative effort incorporates a Registered Dietitian from the Panhandle Health District Diabetes Prevention and Control Program (DPCP). During the last class of the 4-class workshop, presentations are provided on the importance of foot care, eye care, oral care and immunizations. There is also a "clinic" component to the last class in which participants are offered measurements of blood pressure, height, weight, body mass index calculations and foot examinations. Each participant is provided printed resources, including health messages from the National Diabetes Education Program and Clinical Practice Guidelines which encourage the tracking of physician visits and lab test results.

During the last year, health care providers and colleges have joined the effort to educate class participants. Several nursing students from North Idaho College performed foot examinations, height and weight checks and blood pressure measurements during the "clinic" component of the HEWD class. Based on past survey results, the class proves to increase understanding of diabetes. Participants report gaining knowledge on the diabetic diet, what to expect from the physician, and tips for glucose monitoring. More than half of the participants report that fruit and vegetable consumption increased after attending the workshop.

Impact

The success of these workshops, in addition to collaborative efforts, has grown throughout the past year. The continuation of the clinic component and the volunteer efforts of local college nursing programs enhanced the already successful program. Panhandle Health District, in collaboration with the University of Idaho Extension, plans to continue this project and outreach to the disparate senior population of North Idaho to decrease diabetes related health disparities. Plans for growth develop as additional classes including a cooking class are in the works.

Conclusion

Overall, the HEWD workshops continue to be a successful method of educating North Idaho residents how to control, manage and prevent type 2 diabetes. With the addition of a cooking class and continued workshops through various counties of North Idaho, the Panhandle Health District and University of Idaho Extension intend to reach as many disparate groups as possible.

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Public Health – Idaho North Central Health District (2):

Uninsured Patients with Diabetes Receive Dilated Eye Exams

– *Written by: Deb Merica, RN, BSN*

Public Health Problem

- When asked among those with diabetes age 18 and older in Health District 2, 37.2% reported having a dilated eye exam within the past two years. (2010 Behavioral Risk Factor Surveillance System, BRFSS data)
- Uninsured clients are less likely to have annual eye exams than those with private insurance.
- Access to affordable eye exams is a challenge and nearly impossible for adults who are low income and are uninsured.

Program / Project

- In 2009, a free clinic for the uninsured, a coalition of health care professionals, and a group of eye care providers identified the need for a health system project that would improve access to affordable eye exams for uninsured patients at risk for or diagnosed with Type 2 Diabetes. The group of health care professionals, eye care providers and a free clinic represent the following affiliations: Diabetes Advisory Group, Clear View Eye Clinic, Eye Care Specialists Laser & Surgery Center, The Eye Doctor, and the Snake River Community Clinic (SRCC).
- For the purpose of this story, the combined affiliations will be referred to as a partnership network whose focus is to improve access to free eye exams for uninsured patients who qualify for services at the SRCC.
- The partnership network developed an eye exam referral project that utilizes a form developed by the Diabetes Initiative Work Group representing health plans and providers. The form is titled Idaho Diabetes Eye Examination Referral Form and Report.
- The eye exam referral project follows these steps: SRCC initiates the referral process by identifying a patient with diabetes and needing a dilated eye exam. The clinic selects a participating eye care provider's office, gives the patient the contact information of the eye care provider and instructs the patient to make an appointment. The eye care provider performs the dilated eye exam, completes and returns the referral form to the SRCC.
- In December 2011, Lewis and Clark Health Center, a clinic that serves insured patients and uninsured patients, joined the partnership network, and participates in referring eligible patients to project participating eye care providers.
- Currently, seven eye care providers participate in the health system project. They accept patient referrals from SRCC and Lewis and Clark Health Center. Eye care providers' offices include Camas Prairie Clinic in Grangeville, Clear View Eye Clinic in Lewiston and Moscow, Eye Care Specialists Laser and Surgery Center in Clarkston Washington, Looking Glass Eye Clinic in Orofino and Kamiah, and The Eye Doctor in Lewiston.
- Eye campaign materials, including brochures and posters from Idaho Diabetes Prevention and Control Program, are used in concert with the eye exam referral project. The eye campaign materials relay messages that annual dilated exam saves lives, and diabetic eye disease can take away your independence. The materials are distributed

to uninsured patients receiving services at Snake River Community Clinic, and Lewis and Clark Health Center. Materials are also distributed to participating eye care providers' offices, regional hospitals including Clearwater Valley Hospital and Clinics, Gritman Medical Center, St. Joseph Regional Medical Center, St. Mary's Hospital and Clinics, and Syringa General Hospital.

Impact

- From April 2011 to March 2012, the SRCC served 2847 unduplicated patients between the ages of 9 months and 78. Of the patients served, 7.87% or 224 patients were diagnosed with Type 2 Diabetes. Patients from 24 communities received care at SRCC.
- During that time, SRCC reported 64 patients with Type 2 Diabetes were identified as not having received a dilated eye exam in the last two years.
- SRCC referred 48 patients with Type 2 Diabetes to receive affordable dilated eye exams from participating eye care providers; 24 received eye exams from project participating eye care providers. Twelve patients went to eye care providers of their own choosing (locally or out of town).
- SRCC referred 34 patients who are at risk for diabetes to project participating eye care providers for routine eye exams. Of those patients referred, 26 had specialty referrals for specialty treatment.

Conclusion

- The partnership network shares common goals to reach a disparate population of uninsured patients and provide access to affordable dilated eye exams. Currently, seven eye care providers participate from their established locations in Asotin, Idaho, Latah, Lewis and Nez Perce Counties.
- Although the partnership network views the eye exam referral project as valuable and effective, they agree there is a need to reach a greater number of uninsured patients at risk for or diagnosed with Type 2 Diabetes. Currently, the partnership network is formulating ways to improve the referral process and increase access to affordable dilated eye exams for uninsured, medically-needy patients.

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Southwest District Health (3):

Diabetes 101 Education Classes

– *Written by: Juanita Aguilar, RD, LD, CDE*

Public Health Problem

In Idaho, 8% of the adult population has been diagnosed with diabetes. This translates to approximately 90,000 people. Almost 1 in 12 Idahoans have diabetes and 1 in 5 adults age 65 or over have diabetes. In Health District 3, the 2009 average age-adjusted estimates of the percentage of adults with diagnosed diabetes is 8.0%. Gem County has the lowest percentage rate of 7.1% and Washington County has the highest rate of 8.7%. What these rural towns have in common is the limited access to diabetes education classes.

In the United States 8.3% of the U.S population is affected by diabetes. According to the CDC diabetes is the seventh leading cause of death in the United States. About 1.9 million people aged 20 years or older were newly diagnosed with diabetes in 2010 in the United States.

Diabetes is the sixth leading cause of death among Hispanics/Latinos in the United States and the fourth leading cause of death among Hispanic women and elderly. More than 2 million of the Hispanic/Latino living in the US who are over 20 years of age has diabetes and many more remain undiagnosed. Ninety to ninety-five percent of all diagnosed cases of diabetes have type 2 diabetes. Hispanic/Latinos are at higher risk of developing and dying from diabetes and twice as likely as other populations to experience complications such as heart disease, high blood pressure, blindness, kidney disease, amputations and nerve damage.

Diabetes Self-management education (DSME) is often referred to as the cornerstone of diabetes care. Diabetes is largely managed by the person who is affected. It has been estimated that more than 99% of diabetes care and 98% of diabetes outcomes can be attributed to people with the condition. The goal of DSME is to help people with diabetes to take charge. The purpose is not to make people compliant, but to help them incorporate diabetes into their life in a way that works best for them.

Program / Project

Utilizing a bilingual RD, LD, CDE and community partners, a diabetes self-management class and education classes were provided for people who have diabetes or who are at risk for diabetes. Target populations included uninsured, underinsured and Hispanics. A minimum of six classes were offered with a target of at least 80 people. Three classes in English and three classes in Spanish were to be offered by March 30, 2012.

Contributing Partners

- Caldwell YMCA
- Walter Knox Memorial Hospital
- CCS Medical
- Idaho Partnership on Hispanic Health
- Mexican Consulate
- Hispanic Cultural Center
- Sacred Heart Catholic Church
- Canyon County Office on Aging
- Latino Health Coalition
- BSU Nursing Students
- Merck Pharmaceutical

Impact

During FY 2011-2012, South West District Health was able to offer a total of 13 Diabetes Self-management classes with a total of 128 participants! Eight classes were in English with a total of 76 participants. Five classes were in Spanish with a total of 52 participants. Classes were 2 hours long, and included information on blood glucose monitoring, diabetes meal planning, and prevention of diabetes related complications. Basic information was provided on each topic. Classes were held in Emmett, Weiser, Caldwell and Nampa. Feedback from most participants was positive, but some individuals did ask about more advanced classes, and follow up classes. Even though classes were scheduled to be only 1 hour, the usual end time would be at 2 ½ to 3 hours. Participants would stay after class to ask additional questions. An effort was made to refer participants to Diabetes Education Programs in the area. Brochures from three different Diabetes Education programs were provided, and participants were able to review services provided from each program. Partners assisted with marketing classes, providing a location for a class, and distributing flyers for classes.

Conclusion

Diabetes self-management classes for those at risk for diabetes or who have diabetes is an essential part of diabetes care. In this current economy, with the loss of jobs and insurance, people may not be able to cover the costs of diabetes education classes. In our health district there are limited diabetes education programs. Those two factors can make it difficult for some individuals to access care. We have been fortunate to have great community support to help make these classes successful. Although a reach of 128 participants may not seem so great to some, evaluations show that classes did have a positive impact for each participant. We hope that with consistency of having the classes in our health district that we will get an increased number of referrals from health care professionals and by those that attended in the past. We will be able to continue to grow our program and help more individuals make positive changes for a healthier life.

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Central District Health Department
IDAHO HEALTH DISTRICT 4

Central District Health Department (4): Helping Hands for Coping with the Medicare Part D Doughnut Hole

– *Written by: Marjorie Rich, MS, RD, CDE*

Public Health Problem

Medication cost and insurance coverage for those individuals with diabetes is a significant barrier to medication compliance. Subsequently, health parameters including blood glucose, blood pressure, and cholesterol management may not be adequately controlled. Medication costs can be of particular concern at the point when the Medicare coverage gap starts, also known as the "Doughnut Hole". The medication gap occurs when the cost of an individual's medications reaches a certain level ($2,840 in 2011), at which time the individual must pay for the entire cost of their medications, rather than just a small co-payment. More than 3.4 million people fall into the doughnut hole each year. The gap in coverage does not end until medication expenses reach another cut-off value ($4,550 in 2011), after which time most medication costs are again paid for by Medicare. Many older Americans are faced with choosing between the medications they need and eating or having a roof over their head.

Program / Project

The goal of the Doughnut Hole Project was to connect as many people as possible with information and services related to the prevention, treatment, and care of those with or at risk for diabetes. Central District Health Department (CDHD) staff and the Diabetes Prevention and Control Program (DPCP) Coordinator evaluated existing resources. As a result, the CDHD website was revised to be a portal for accessing online information on diabetes prevention and treatment as well as resources for identifying and managing the Medicare Medication Part D Coverage Gap. The website revision was made to educate the public on ways to avoid or minimize the financial effect of the "Doughnut Hole". A handout was developed to market the availability of new information on the CDHD website regarding strategies for the prevention and treatment of diabetes. The cost associated with the research and development of website revisions and handout materials came to $1,596. In addition, information on the gap in Medicare coverage was provided at the CDHD monthly cholesterol clinics. CDHD staff and volunteers assisted clients at five consecutive clinics from June through October 2011, in accessing online resources to help manage the high cost of diabetes medications and treatment supplies with the use of multiple computers and internet access within the CDHD Training Lab (cost: $1,368). Surveys were conducted during months 2, 5 and 6 to determine how many clients, family members, and close friends have diabetes and Medicare, if they could identify when the Gap would happen, and how many would utilize their own computers for information versus needing assistance. During months 5 and 6, participants completed surveys to determine if they had received information about diabetes at the cholesterol clinic, if they had passed it on to someone else, and if they found the information useful.

Impact

There were 600 participants in the cholesterol clinic over the six months. Of those, 23% or 140 had face-to-face contact and personalized messaging to promote the CDHD Website resources and prevention materials. Participation rates were the highest at 33% for the first three months, dropping to 15% the last three months. This is most likely related to the number of clients who return to the clinic every 2-3 months for services and were not interested in stopping a second time.

Incentives (a serving of fresh fruit) helped to increase traffic to computer lab to promote the website.

Conclusion

Survey completion rate was quite high at 45%. The survey was provided along with other clinic paperwork. Data may be skewed by self-selection in which clients who do not know anyone with diabetes or Medicare declined to complete the survey. Self-reported rates of diabetes 9% are consistent with those of our previous survey 10% and BRFSS 8%. Only four clients 1% completing the survey indicated that they had both Medicare and diabetes, but 17% of their family members and 10% of their close friends had both diabetes and Medicare. 45% of our survey participants had a family member with diabetes and 15% have a close friend with diabetes. This indicates that 69% of clients have potential use for information related to diabetes. When this information is combined with last year's observations that 40% of cholesterol clinic participants either had diabetes or were at high risk for developing diabetes, we can see a large potential audience for diabetes prevention messages. 16% of the clients attending the clinic in September and October indicated that they had received diabetes information at our clinic in the past six months. Of those, half had also shared that information with someone else.

With the aging of America, our difficult economic climate, and the rate of new type 2 diabetes diagnoses on the rise, the future of this project needs to encompass a greater population of Medicare recipients. A call for further action should focus on moving the project into additional organizations and venues where a greater number of Medicare recipients can be reached such as AARP, low-income community health clinics, and pharmacies.

South Central Public Health District
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South Central Public Health District (5):

Free diabetes "Head to Toe" clinics

– *Written by: Susie Beem, CHES*

Public Health Problem

Almost six years ago, the coalition started providing free diabetes "Head to Toe clinics". These clinics are available to people with a diagnosis of diabetes who are either a) newly diagnosed, b) uninsured, or c) insured with a high deductible. Head to Toe services include foot exams, eye screenings, dental screenings, hemoglobin a1c tests, blood pressure readings, nutrition education, and occasionally, hearing screenings.

These screenings are important since only about 58.2% of people with diabetes in this district report receiving a yearly dilated eye exam and 73% have received a foot exam.

Nutrition education is provided at most Head to Toe clinics. This is an important piece of the puzzle since about 85% of people with diabetes in this district are overweight. Only 55.6% of people with diabetes in District 5 report getting regular A1C tests. Only 48.5% of people with diabetes report seeing a dentist on a yearly basis.

Program / Project

Funding for this project comes from the Idaho Diabetes Prevention and Control Program (coordinator time), Lions Club (donation of mobile screening unit, fuel, and volunteers), and various agencies that the coalition members represent. St. Luke's Jerome provides carbon-copy eye and dental screening forms, while St. Luke's Magic Valley provides the A1C kits.

This past contract year, the coalition provided 10 Head to Toe clinics. 86 people received eye screenings, while 108 people received a foot exam and 64 received the dental screening. University of Idaho Cooperative Extension and dieticians from the coalition provided nutrition education to 109 people.

A1C tests were available to patients who had not received a test in the last three months (107 people). 93 people had their blood pressure tested. All services are free.

The physicians involved in this project volunteer their time and other coalition members who participate are sponsored by their agencies or volunteer their time. Advertising, scheduling, record keeping, data collection, and follow-up is done by South Central Public Health.

Impact

Out of 86 people receiving an eye screening, nine were identified as having retinopathy, but none of those were urgent needs. Most of the time, one of the volunteer eye physicians took the referral. As stated above, 108 people received a foot exam, and one required follow-up care. Out of the 93 blood pressure readings, 52 had blood pressure higher than the recommended level of 130/80, and 71 out of the 107 A1C tests had an A1C test higher than recommended. Many of the people seen have no insurance and have never had an eye or foot exam before. By going to the people, the coalition saves them several medical appointments. Certified diabetes educators are able to use the A1C number and blood pressure reading as a tool to provide education about blood sugar, proper diet, etc.

Conclusion

The Magic Valley Diabetes Coalition's priority is the Head to Toe clinics. The coalition still uses patient evaluation surveys at the end of each clinic. In the 73 surveys completed this year, 86% stated had it not been for a Head to Toe clinic, they would not have received the recommended services. Overall, the services have been rated at very high numbers and people are very appreciative.

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Southeastern District Health Department (6):

Foot Exam Trainings and Screenings

- Written by: Cherie Nelson, MPH

Public Health Problem

Over the last decade, prevalence of diabetes in Idaho has increased from 4.9% in 2000 to 8% in 2009, according to the 2010 Idaho Behavioral Risk Factor Surveillance System (BRFSS). In Southeastern Idaho however, 10.2% of adults have been diagnosed with diabetes, the highest rate in the state. Further, BRFSS reported that 1-in-5 people over age 65 have been diagnosed with diabetes.

Foot problems, including neuropathy, foot ulcers and amputations, are well-known complications associated with diabetes. Foot ulcers form because of decreased nerve sensitivity to the foot, decreased blood flow to the legs and feet, foot deformities, friction and pressure caused by shoes, or trauma. Far too frequently, foot ulcers are not found in a timely manner or ignored and become infected which can result in an amputation. It is estimated that 15% of people with diabetes will develop ulceration and between 14% and 24% of people with ulcers will undergo amputation. Additionally, 51% of those with one amputation will have a second amputation within five years. 60% of all non-traumatic lower-limb amputations occur in people with diabetes and people over age 65 account for half of the diabetes-related non-traumatic amputations.

The key to preventing serious foot problems and amputations is early detection. Infections and amputations could be decreased by as much as 85% with proper assessment, observation and care by a medical provider. Daily foot checks and foot care performed by the individual help as well. However, many people, especially those living in rural area, do not have access to preventative foot care nor do they understand the importance of checking their own feet daily.

The Healthy People 2010 goal is that 75% of people with diabetes receive an annual comprehensive foot exam. According to the 2006 Idaho BRFSS, only 66.4% of people with diabetes had a comprehensive foot examination performed by their health care provider. In the Southeastern District Health area, only 63.2% of people with diabetes reported receiving a comprehensive foot exam. Lack of access to a podiatrist for a foot exam is most significant in the rural counties of Southeast Idaho.

Program / Project

In an effort to bridge the gap to appropriate foot care in the rural counties of Southeastern Idaho, Southeastern Idaho Public Health (SIPH) and the Southeastern Idaho Diabetes Partnership has partnered with Idaho State University's (ISU) Nursing program and Dr. Jeff Bray, DPM, to provide foot exam training to senior nursing students, and to provide foot screening clinics at health district offices or other community based locations in rural counties using the trained nursing students. Additionally, members of the Southeastern Idaho Diabetes Partnership provided other diabetes education at the foot exam clinics as they are available.

Jeff Bray, DPM trains ISU senior nursing students three times a year. Dr. Bray provides a lecture and demonstration for the students on the Diabetic Foot where he defines the problem and relationship between diabetes, neuropathy, foot ulcers, and amputation; talks about risk factors for neuropathy, ulceration, and amputation; describes the casual chain to amputation; discusses prevention; demonstrates the two-minutes foot exam; shows many of the foot problems seen in patients with diabetes; and shows the consequences of not

examining and caring for the feet. He also emphasizes the importance of patients checking their own feet daily and shows the nurses what to teach patients about checking their own feet. An additional training opportunity is provided at Dr. Bray's office where students are able to work with Dr. Bray on patients who have volunteered to let the students practice on their feet. On the occasions when Dr. Bray is not able to do the training because of time constraints, Dr. Bray has provided a DVD he made on foot exams and foot care for people with diabetes. In addition to foot exams and foot care training, students are required to participate in organized foot exam clinics and provide foot care.

Southeastern Idaho Public Health (SIPH) is committed to providing diabetes services based within the 10 Essential Public Health Services identified by the CDC. The foot exam clinic project specifically subscribes to Goal Three to provide people with information they need to make healthy choices and Goal Seven to help people receive health services. The objective of Goal Three is to conduct health promotion activities to address public health issues by providing targeted, culturally appropriate information to help individuals understand what decisions they can make to be healthy. The objective of Goal Seven is to provide personal health services to individuals who encounter barriers to services by first identifying gaps in service then by supporting and implementing strategies to increase access to care and establish systems of personal health services, including preventative health promotion services in partnership with the community.

SIPH diabetes contract coordinator organizes foot exam clinics in rural communities within the public health jurisdiction. SIPH diabetes contract coordinator works closely with county public health office staff and community partners to organize, advertise, and implement the clinics. Appointments are required for the clinics to distribute chaos evenly throughout the day. SIPH Desk Top Publisher professional, Dana Solomon, creates all advertising and promotional materials including flyers and postcards. SIPH county staff and local partners help advertise the clinic by distributing flyers and contacting potential participants known to participate in other diabetes activities. An article about diabetes foot care and the local clinic is also submitted and published in each local newspaper. Clinic office staff makes appointments for the foot exams and also make follow-up reminder calls to those who made an appointment.

Four students, the nursing instructor, and the diabetes contract coordinator drive together to the clinic. Additional training and education is provided during the ride to each clinic. The nursing instructor reviews the foot-check form, reviews terminology, and provides additional reading for each student to discuss during the ride.

Impact

During the 2012 contract year the SIPH and the Southeastern Idaho Diabetes Partnership organized three foot exam trainings and trained 48 nursing students. Trainings were held on June 1, 2011, August 30, 2011, and March 16, 2012. SIPH and the partnership planned and implemented 19 foot exam clinics in 12 different locations in the eight counties of the health district, including Lava Community Center, St. Anthony Place retirement complex, Lost Rivers Senior Center, Oneida County Senior Center, Power County Senior Center, Bear Lake County Public Health Office, Marsh Valley Senior Center, Caribou County Public Health Office, Curlew Valley Community Center, Oneida County Public Health Office, Franklin County Public Health Office, and Idaho State University. The nursing students checked the feet of 403 patients and referred 81 people to a podiatrist or other health care provider for further evaluation. In addition to the foot exams, organizations from the diabetes partnership provided additional diabetes education. The ISU College of Pharmacy provided glucose checks, blood pressure checks, and medication reviews at four events including Curlew Valley Community Center, Lava Community

Center, Franklin County Public Health Office, and St. Anthony Place Retirement Complex. They also provided education on heartburn, A_1C testing, cholesterol, and heart disease. The State Health Insurance Benefits Associate (SHIBA) attended all clinics and provided information about Medicare and Medicaid. ISU Department of Physical Therapy provided balance testing at Bear Lake County and Lava Community Center. Health West, Inc., medical clinic, participated in clinics at Marsh Valley Senior Center, Lava Community Center, and Power County Senior Center.

The foot exam project not only benefits people with diabetes who receive the foot exam and foot care but the project benefits the nursing students, as well. The students receive the training which will help them in the future as they get into their chosen specialty, but more than that, they are working in a community setting and helping people who aren't sick. The patients at the foot check clinics are happy to be there. They recognize they are receiving a service that they don't always have available to them and are grateful for the service. They have stories to tell. One student noted that taking an interest in a patient's story can help establish a good rapport and helps the patient open up about their foot care or other medical habits. Another student related that the touching relaxed the patient which helped during the exchange of medical information. One student acknowledged they were concerned about touching people's feet, but was brought to the realization as they were talking to their patient, that a real person was attached to those feet. Overall, the students were very grateful for the opportunity to participate in the foot exam clinic. They may have been nervous about working on feet, but having the time to talk to, care for, and educate patients was something they said they enjoyed doing.

Conclusion

People in the rural counties in southeastern Idaho face many barriers to receiving health care, especially foot exams. Barriers include lack of providers, lack of time with patients for available providers, no podiatrist in the area or the visiting podiatrist is only available one or two times each month, insurance requirements, Medicare / Medicaid restrictions, patients don't know to ask physician or the staff for help, or patients cannot pay for the service. The foot exams and the other services provided at the clinics have helped many individuals receive help otherwise unavailable to them. The participants appreciate the attention they receive from the students.

Even though clinics are open to the community many of the participants are older adults and the students benefit from being exposed to, ambulatory older adults. Frequently, students see older adults in long term care facilities or with chronic conditions that keep them bed ridden. This opportunity allows students to see older adults as functioning members of a society. The patients have experiences to share, tales to tell, and the students have enjoyed working with older adults.

An additional benefit from providing the foot exam clinics is other contacts that are made in the community. These new contacts are willing to become partners on diabetes partnership, partner on future foot exam clinics, with other diabetes projects, and many have become involved in other health district programs like Fit & Fall Proof and Living Well in Idaho.

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Eastern Idaho Public Health District (7):

Idaho National Laboratory Engage in Diabetes at Work Education

– *Written by: Timalee Geisler, MHE*

Public Health Problem

Diabetes is currently one of the ten leading causes of death in Idaho. According to the Idaho 2008 BRFSS report, 8% of people living in Eastern Idaho Public Health District boundaries have been diagnosed with Diabetes. The average age of onset is 51. Adults with diabetes experience high blood pressure, cholesterol, weight, heart disease and heart attack, and stroke. They are less likely to visit the dentist and engage in physical activity. Not only does diabetes cause detriment to the well-being of Idaho's citizens, but it also puts tremendous financial burden on the state. The Juvenile Diabetes Research Foundation reports that the total cost of diabetes in Idaho exceeds $873 million per year. The American Diabetes Association estimates that a third of this cost stems from indirect costs such as lost work productivity, and that two-thirds of the cost is a direct result of medical bills.

Program/Project

In an effort to decrease lost work productivity and to increase well-being, Eastern Idaho Public Health District partnered with Idaho National Laboratory (INL) and Gwen Hoffmann, a local Certified Diabetes Educator to implement the National Diabetes Education Program's *Diabetes at Work*.

The Diabetes at Work Program was implemented in five different site locations on the Idaho National Lab campuses over the past year. The Diabetes at Work Program was offered free of charge to employees and family members during the regular lunch hour. The program consisted of six sessions, with one hour-long session per week. The sessions included topics of Understanding Diabetes and Pre-Diabetes, Working with Your Health Care Team, Preventing and Managing Complications of Diabetes, Taking Care of Your Diabetes Every Day, Eating Well and Physical Activity, Caring for a Family Member with Diabetes and Emotional Well Being.

Contributing Partners

- Brad Snedden, INL Health and Wellness Coordinator
- Gwen Hoffmann, RD, LD, CDE
- Eastern Idaho Public Health District, Diabetes Prevention and Control Program
- National Diabetes Education Program

Impact

A total of 86 employees and family members participated in the Diabetes at Work classes. The target audience was INL employees and family members. Having the INL allow employees to attend the classes on their lunch hour and provide a classroom provided an ideal situation for employees to learn. The employees of the INL work 9-10 hour shifts and with travel to some of the campuses do not have time to come into "town" for self-management classes. Bringing the classes to them helped with the attendance.

One of the lessons learned from this project is to catch the attention of the attendees soon. We also need to clarify the audience whether they are engineers, office staff, laborers, etc. The engineers wanted little to no "fluff", only the necessary information of the program.

Barriers include illness or other work obligations that conflicted with the sessions.

- Most of the attendees of the Diabetes at Work program had either been diagnosed with Diabetes or Insulin Resistance.
- If they did not have diabetes, they attended mainly because of a family member with diabetes.
- Only half of those that attended receive regular medical care for diabetes.
- 63% of attendees have had a Hemoglobin A1c test in the past six months.
- 68% of attendees had never received diabetes management education prior to this opportunity.
- 54% of attendees had not checked their blood sugar in the past week.
- 50% of the attendees consume the recommended 3-5 servings of fruit and vegetables each week.
- 50% of attendees engage in 30-60 minutes of continuous physical activity some of the time, 32% most of the time.
- 48% of the attendees have lost 6-20 plus pounds in the last year.
- 76% of attendees agree they have gained better control and management of their diabetes in the past year.

Conclusion

To increase the management of diabetes among INL employees and thus increase productivity, providing the Diabetes at Work classes created an ideal situation. The employees have reported either that this was the only management class they had taken or they learned more from this class than previous education opportunities.

We plan to continue this effort in partnership with the INL and to find additional partners within the health district to bring the program to additional worksites.

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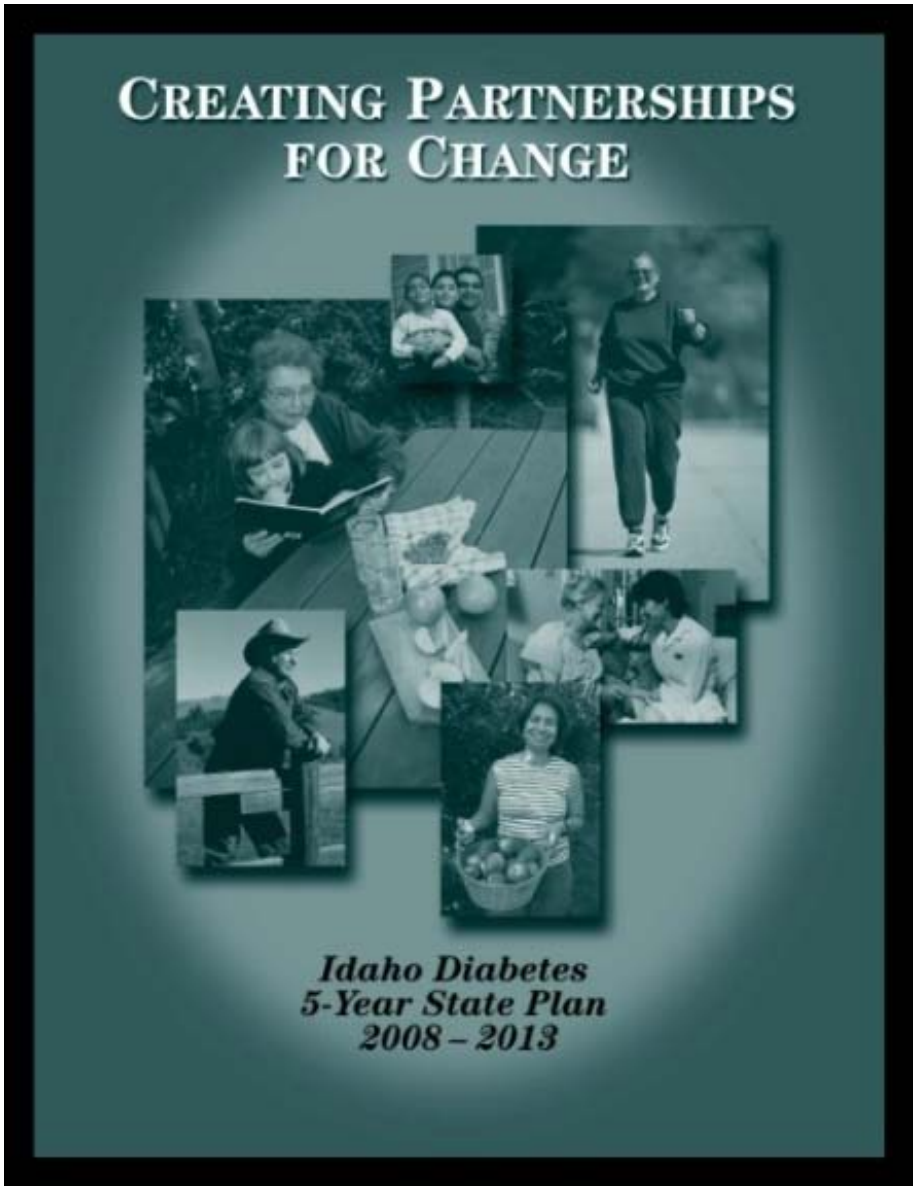
Idaho Diabetes 5-Year State Plan, 2008 - 2013



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