Diabetes
University of Colorado Hospital
COMMUNITY HEALTH NEEDS ASSESSMENT
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DIABETES

OVERVIEW

Diabetes Mellitus (DM) occurs when the body cannot produce or respond to insulin appropriately. Insulin is a hormone needed by the body to absorb and use glucose as a fuel for the body’s cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur.

The three most common types of DM are:

- **Type 1 diabetes**, which results when the body loses its ability to produce insulin. Type 1 diabetes is an autoimmune disease and, at this time, is not preventable. Type 1 diabetes is typically diagnosed in people younger than 30 years of age and accounts for fewer than 10 percent of all diagnosed cases of diabetes.²

- **Type 2 diabetes**, which results from a combination of resistance to the action of insulin and insufficient insulin production. Type 2 accounts for about 90 to 95 percent of all diagnosed cases of diabetes.³ Until recently, type 2 diabetes typically occurred in people older than 30 years of age. With increases in overweight children, youth and adolescents, the rate of type 2 diabetes in children and adolescents has increased to 0.2 percent.

- **Gestational diabetes** is a common complication of pregnancy. Gestational diabetes can lead to perinatal complications in mother and child and substantially increases the likelihood of cesarean section. Gestational diabetes is also a risk factor for subsequent development of type 2 diabetes after pregnancy.⁴

DM affects an estimated 23.6 million people in the United States and is the 7th leading cause of death.⁵ The estimated total financial cost of DM in the United States in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death. The rate of DM continues to rise in the United States, and throughout the world.

Diabetes can lead to serious complications and premature death. Complications include:

- Heart disease and stroke
- Hypertension
- Blindness and eye problems
- Kidney disease
- Nervous system disease

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² Ibid
⁵ Ibid.
- Amputations
- Dental disease
- Complications of pregnancy

Effective therapy can prevent or delay diabetic complications. Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals. Based on this, new public health approaches are emerging that may deserve monitoring at the national level. For example, the Diabetes Prevention Program demonstrated that lifestyle intervention had its greatest impact in older adults and was effective in all racial and ethnic groups.

Four “transition points” in the natural history of diabetes health care provide opportunities to reduce the health and economic burden of DM:
- Primary prevention: movement from no diabetes to diabetes
- Testing and early diagnosis: movement from unrecognized to recognized diabetes
- Access to care for all persons with diabetes: movement from no diabetes care to access to appropriate diabetes care
- Improved quality of care: movement from inadequate to adequate care

There are social determinants that affect diabetes:
- People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25 percent of all adult patients with diabetes in the United States and represent the majority of children and adolescents with type 2 diabetes.
- African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians and other Pacific Islanders are at particularly high risk for the development of type 2 diabetes.
- Diabetes prevalence rates among American Indians are 2 to 5 times those of whites. On average, African American adults are 1.7 times as likely and Mexican Americans and Puerto Ricans are twice as likely to have the disease as non-Hispanic whites of similar age.

Diabetes was not selected as one of the ten Winnable Battles by the Colorado Department of Public Health and Environment. According to CDPHE, “obesity increases a person’s risk for several serious illnesses: heart disease, type 2 diabetes, high blood pressure, high cholesterol, stroke and some types of cancer.” Therefore, by naming obesity as a top ten winnable battle, rates of type 2 diabetes will be impacted by strategies to reduce obesity. CDPHE’s Diabetes Prevention and Control Program has identified the reduction of complications resulting from diabetes as an important outcome for the state. Goals for 2013 have been identified for diabetes preventive care practices and will be discussed in this report.

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The overall incidence rate for type 1 diabetes in Colorado children and youth ages 0-17 was 23.9 per 100,000 people during 2002-2004. The incidence rates were higher in White/Non-Hispanics compared to White/Hispanics, while there are no strong differences in the incidence rates between females and males. The incidence of type 1 diabetes is on the rise in Colorado as well as across the nation. County-level data is not available.

GESTATIONAL DIABETES

**PRAMS:** During your most recent pregnancy, were you told by a doctor, nurse or other health care worker that you had gestational diabetes (diabetes that started during this pregnancy)?

![Gestational Diabetes](image)

In Colorado, the percentage of women who had diabetes during pregnancy fluctuated between 5% and 10% during 2000-2006. From 2004 forward the PRAMS question related to diabetes during pregnancy was changed to differentiate between pre-existing and gestational diabetes. The highest percentage was 8.9% of mothers who gave birth in 2006 and reported having gestational diabetes during pregnancy. This estimate for 2006 and subsequent years did not include women with pre-existing diabetes. It is difficult to determine an overall trend from this data.

The following are social determinants of diabetes as indicated by data from 2004-2006:

- More than 11% of the Hispanic women have gestational diabetes
- Almost 11% of women 35 and older have gestational diabetes
- 10.8% of women with fewer than 12 years of education have gestational diabetes
- 10.2% of women who were at or below 185% of federal poverty level have gestational diabetes

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11 Ibid.
ADULTS WITH DIABETES

BRFSS Survey Question: Have you ever been told by a doctor that you have diabetes? (excludes gestational diabetes)

The prevalence rate of Diabetes in Colorado is lower than the Nation.

Adams, Denver and Arapahoe Counties have diabetes prevalence rates in adults that are higher than the State.

Douglas County has diabetes prevalence rates in adults that are below the State.

There is not a Healthy People 2020 goal that is comparable to this measure.

Figure 3 Told by Doctor Have Diabetes

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The prevalence of diabetes increases with age. Beginning with the age group 35-44, each older age group has a significantly higher prevalence rate.

Black and Hispanic adults have significantly higher prevalence rates of diabetes than White/Non-Hispanic adults.

Prevalence of diabetes increases as income decreases. Each income group has a statistically different rate.

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14 Ibid.
15 Ibid.
Adults with some college or more had significantly lower prevalence rates of diabetes than adults with a high school education or less.

**DIABETES TRENDS**

When comparing the trends in diabetes prevalence overall, Colorado has lower prevalence rates than the nation, but rates are increasing at a similar pace.

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All people with diabetes need education to manage the disease. The Colorado Diabetes Prevention and Control Program has identified 2013 goals for preventive practices including self-monitoring of blood glucose (SMBG), Hemoglobin A1C testing, foot exams, eye exams, Diabetes Self-management Education (DSME), and cholesterol checks.

Figure 9: Preventive care practices performed by adults with diabetes

Figure 10: Baseline and Target BRFSS Measures for Diabetes

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19 Ibid.
In 2009, in an effort to address the increased need for better education and access among individuals with diabetes to quality diabetes self-management education, the Colorado Diabetes Prevention and Control program undertook a comprehensive statewide needs assessment for Diabetes Self-Management Education (DSME). DSME improves clinical outcomes through encouraging preventive care and self-management of diabetes.²⁰

Diabetes self-management is extremely important in reducing the risk for complications associated with diabetes. These techniques first need to be learned through diabetes self-management education, which is an integral part of the treatment plan. People with diabetes and their physicians are responsible for maintaining these preventive health practices to ensure the best health possible.

Health Statistic Regions 6, 7, 8, 14 and 20 were identified as having the greatest need for DSME based on secondary and tertiary prevention indicators, including prevalence of diabetes among adults, estimated counts of adults with diabetes, diabetes mortality rates, prevalence of diabetes self-management education and prevalence of preventive care practices for persons with diabetes. The prevalence of diabetes was considered the most important factor, followed by the prevalence of persons with diabetes who had received DSME.

Regions 7, 8, 14, and 20 are Centura Health Primary Service Areas.

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Diabetes Prevalence (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1 – Northeast</td>
<td>Morgan, Logan, Sedgwick, Phillips, Yuma, Washington</td>
<td>7.5</td>
</tr>
<tr>
<td>Region 6 – Southeast</td>
<td>Crowley, Kiowa, Otero, Bent, Prowers, Huerfano, Las Animas, Baca</td>
<td>10.2*</td>
</tr>
<tr>
<td>Region 7 – Pueblo</td>
<td>Pueblo</td>
<td>8.7*</td>
</tr>
<tr>
<td>Region 8 – San Luis Valley</td>
<td>Saguache, Mineral, Rio Grande, Alamosa, Conejos, Costilla</td>
<td>6.4</td>
</tr>
<tr>
<td>Region 14 – Adams County</td>
<td>Adams</td>
<td>7.5*</td>
</tr>
<tr>
<td>Region 20 – Denver County</td>
<td>Denver</td>
<td>5.4*</td>
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</table>

* Denotes regional diabetes prevalence significantly higher than statewide prevalence of 5.1 percent (2005-2007)

Figure 11: Colorado Counties in Diabetes Focus Regions²¹


DIABETES MORTALITY RATES

Survey: Death Certificates with Diabetes as Underlying Cause of Death

Diabetes causes a variety of serious health complications that can cause or contribute to death. Diabetes is underreported on death certificates; therefore, the number and rate of diabetes related deaths presented are lower than the true number and rate.

Adams and Denver County deaths due to diabetes are higher than the State. Additionally, the Adams County rate is above national levels.

Arapahoe and Douglas Counties have diabetes death rates below the State.

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22 Chart Source: Certificate of Death, Colorado Department of Public Health and Environment. Light blue bars indicate weak data. Rates are per 100,000 population and are adjusted using the direct method applied to 10-year age groups. Population figures are 2007-based estimates from the Demography Section, Colorado Department of Local Affairs. County-specific data are for deaths reported as occurring for residents of those counties.
COLORADO DIABETES PREVENTION AND CONTROL STRATEGIC PLAN

GOAL: Prevent, detect and delay diabetes in Coloradans through effective health systems and community interventions.

Strategy 1: Identify people at risk of developing type 2 diabetes.

Action steps

- Based upon known risk factors for type 2 diabetes, identify priority populations who are at high risk for developing type 2 diabetes.
- Promote early identification of people with diabetes.
- Conduct risk assessments for type 2 diabetes and ensure appropriate diagnostic testing is ordered.
- Reduce incidence of gestational and type 2 diabetes by promoting healthy weight and active lifestyles in women of childbearing age.
- Educate health-care providers about the high conversion rate of women with gestational diabetes mellitus to type 2 diabetes, and refer to the Colorado Clinical Guidelines Collaborative Gestational Diabetes Mellitus clinical guidelines for actions to reduce risk.
- Convey message to women on the importance of achieving prepregnancy weight within 6 to 12 months after delivery.

Strategy 2: Communicate diabetes risk factors and prevention using model public health programs directed to all population segments, with priority given to disparately affected groups.

Action steps

- Use assessment tools to raise the public’s awareness of the risk of developing type 2 diabetes.
- Partner with communication specialists, stakeholders and other state and national organizations in conducting diabetes prevention campaigns utilizing already developed materials.
- Promote programs such as the National Diabetes Education Program’s Small Steps, Big Rewards: Prevent Type 2 Diabetes Healthcare Provider Toolkit by distributing materials to diabetes partners and stakeholders.

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Empower the general public, including children, youth and adults, through education on how to reduce their risk for developing type 2 diabetes.

Work with community organizations including faith-based organizations, schools, senior centers, community health centers, professional organizations and fraternal societies to raise risk awareness, especially in diverse, at-risk populations such as older adults, African-Americans, Hispanic/Latino, Native Americans and the uninsured. **Strategy 3: Implement effective interventions that support healthy lifestyles and early detection of diabetes.**

**Action steps**

- Identify and encourage the implementation of evidence-based programs to increase physical activity, improve nutrition and promote weight loss.

- Partner with the Colorado Physical Activity and Nutrition Program and Coordinated School Health in promoting healthy communities and schools, increasing public awareness of healthy weight, good nutrition and physical activity.

- Partner with the Colorado Physical Activity and Nutrition Program to encourage Colorado employers to implement diabetes-prevention programs such as CDC’s *Diabetes at Work.*

- Train health-care providers to follow the Colorado Clinical Guidelines Collaborative clinical guidelines for obesity.

- Ensure diabetes prevention programs are available and accessible to high-risk populations in all areas of Colorado.

- Partner with all payers to reimburse for diabetes prevention and detection services.

- Build capacity of communities throughout Colorado to offer evidence-based diabetes primary prevention programs for persons with prediabetes.

**GOAL:** Reduce the impact of diabetes on Coloradans by decreasing diabetes-related complications and deaths.

**Strategy 1: Promote quality and consistent management of diabetes.**

**Action steps**

- Promote the use of the Colorado Clinical Guidelines Collaborative evidence-based diabetes guidelines to health-care professionals throughout Colorado.

- Form a Medical Expert Advisory Group to communicate issues of concern that impact the diabetes community, such as diabetes drug recalls, new technologies, changes in lab values, etc.

- Partner with professional associations and health benefit plans to promote the use of the Colorado Clinical Guidelines Collaborative diabetes and gestational diabetes guidelines and to ensure providers have the appropriate tools and resources to implement the guidelines.
Improve professional education (such as nursing and dental schools, medical education) related to the care of people with diabetes and prediabetes by including diabetes-specific content and expanding the required clinical competencies.

Promote awareness and distribution of the Colorado Guiding Principles for the Management of Students with Diabetes for the safe and appropriate care of children with diabetes in schools.

Design strategies and incentives to help more bilingual/bicultural health-care professionals pursue Certified Diabetes Educator credentials and other provider recognitions (e.g., National Committee for Quality Assurance Provider Recognition), especially in underserved areas serving diverse populations.

Partner with academic institutions (colleges of medicine, nursing, podiatry, optometry, dentistry, nutrition, social work and public health), medical professional associations, and peer review groups to promote improved care and services for people with diabetes.

Partner with health system projects (e.g. Improving Performance in Practice) that promote data collection and analysis, practice redesign and quality improvement in caring for people with diabetes (and other chronic diseases).

**Strategy 2: Promote a team-based approach to diabetes management.**

**Action steps**

- Promote the use of the Improving Chronic Illness Care’s Chronic Care Model (see Appendix C) as a quality improvement tool for health-care practices.
- Support and promote evidence-based self-management education programs
- Promote and train the use of community health workers and promotoras to reinforce and support diabetes education.
- Facilitate the creation of diabetes care teams that include diabetes educators, navigators, promotoras and community health workers.
- Include academic institutions and research institutions such as the Rocky Mountain Prevention Research Center in the development and evaluation of community programs.

**Strategy 3: Identify and address gaps in diabetes care.**

**Action steps**

- Identify diabetes care needs and work with the diabetes network to develop statewide efforts to address those needs.
- Raise awareness of the strong link between diabetes and stress and depression for both men and women with diabetes.
- Support the use of Electronic Health Records or diabetes registries by the provider community.
- Support community health centers in their efforts to improve diabetes care through participation in the Bureau of Primary Health Care’s Health Disparities Collaborative.
Collaborate with managed care plans, Medicaid, and Medicare to measure and improve diabetes care for their constituents.

Provide training and educational opportunities for healthcare professionals that promote diabetes standards of care.

**Strategy 4: Improve health outcomes for those with diabetes.**

**Action steps**

- Promote the measurement of quality indicators for diabetes care.
- Support providing feedback to health-care providers on performance.
- Promote diabetes self-management skills including self-monitoring of blood glucose; regular dilated eye, foot and oral health exams; stress management plans; and the use of a diabetes self-management contract.

**Strategy 5: Improve access to diabetes services and education for those who are underserved.**

**Action steps**

- Ensure diabetes educational messages are culturally relevant and appropriate for different literacy levels.
- Support the provision of diabetes services in community settings rather than in just clinical settings.
- Foster sensitivity to the differing needs and appropriate interventions for specific populations including men, women, children, diverse populations and rural communities.

**GOAL: Develop and integrate a surveillance and evaluation system that informs and supports: local level decision-making; state resource allocation; practice-based research; and local, state and national policy development.**

**Strategy 1: Improve diabetes-related surveillance efforts**

**Action Steps**

- Based on existing diabetes surveillance resources as outlined by CDC and prior work of the Colorado DPCP, determine indicators of diabetes prevention and control that are sufficiently valid and sensitive to change. Present these indicators annually in a brief statewide report available through the DPCP website and linked to the CDPHE health statistics portal.
- Collaborate with SEARCH for Diabetes in Youth, a research project of UCD, Preventive Medicine and Biometrics to make county and state level incidence data on diabetes in children available through the DPCP website and linked to the CDPHE health statistics portal.
- Partner with other CDPHE programs and state agencies to develop a long term plan for coordinated and integrated local level surveillance that can be used a) for local planning and evaluation, as well as b) state level planning and resource allocation. Assure that key measures, related to diabetes prevention and control, are valid and useful for planning and evaluation.

- Develop a mechanism to populate CDC’s map of local programs in order to promote access to programs and services. Develop reports that describe local and state program capacity in order to inform diabetes prevention and control priorities.

**Strategy 2. Enhance evaluation of diabetes-related initiatives**

**Action Steps**

- Work with partners at the CDPHE, PHAC, RMPRC and CSPHI to provide training and technical assistance on program planning and evaluation for state and local partners, as needed.

- Partner with the Interagency Prevention Leadership Council, RMPRC and CSPHI to promote the development of practice-based evidence through stronger evaluations of diabetes prevention programs. Link with the service to science program to build capacity and support dissemination of effective community programs.
  

**Strategy 3. Support translation of diabetes research into practice**

**Action Steps**

- Work with Colorado’s academic and research centers to disseminate the results of their diabetes research to health care professionals and other community stakeholders.

- Partner with UCD SOM Department of Family Medicine to support and promote Primary Care Practice Based Research and continuous quality improvement in diabetes prevention and control.

- As part of the long term surveillance plan (referenced in strategy 1 above), work with the RMPRC along with academic and practice partners to establish surveillance measures that are population-based, and that are used to for practice-based public health research and continuous quality improvement studies in public health.

**Abbreviations:**

- CDC—Centers for Disease Control
- CDPHE—Colorado Department of Public Health and Environment
- CSPHI — Colorado School of Public Health Initiative
- DPCP—Diabetes Prevention and Control Program
- PHAC – Public Health Alliance of Colorado
- RMPRC – Rocky Mountain Prevention Research Center
- UCD SOM—University of California Davis School of Medicine
GOAL: Identify opportunities for change through network activities that support diabetes prevention and control.

Strategy 1: Build and mobilize a statewide diabetes network to coordinate and conduct activities that support diabetes prevention and control.

Action Steps:

☐ Identify local and state diabetes partners to build a diabetes network.

☐ Conduct training for members on effective networking utilizing the Health Policy Guide from the Center for Health Improvement.

☐ Through the statewide diabetes network raise public awareness about issues related to diabetes prevention and control.

☐ Develop fact sheets highlighting the human and economic costs of diabetes in Colorado, including the costs and benefits of good diabetes management.

☐ Coordinate with other diabetes-related public policy initiatives.

☐ Engage health professionals and organizations to publicly support diabetes care issues.

Strategy 2: Educate policy makers, community leaders, and funding sources about the importance of public policies and programs that support diabetes prevention and control.

Action Steps:

☐ Use the Colorado Diabetes Strategic Plan as a communication tool.

☐ Ensure health care providers have access to the tools they need to treat diabetes to best evidence standards or guidelines.

☐ Identify diabetes experts to conduct policy analysis and assessment.

☐ Tailor “talking points” to the specific audience.

☐ Develop an agenda annually with identified opportunities for change.

Strategy 3: Develop and sustain diabetes community coalitions throughout Colorado.

Action Steps

☐ Work with community organizations and programs to improve health promotion activities as part of their efforts to achieve Healthy People 2010 objectives.

☐ Partner with community-based diabetes programs, diabetes centers, community groups, faith-based organizations, senior centers, schools and providers, especially those serving diverse, at-risk populations.

☐ Engage underserved populations to become diabetes system partners.
**Evaluation Plan**

The intent of evaluation is to support the state plan as it evolves and to allow for the flexibility to respond to emerging issues and contextual circumstances. All activities outlined in this plan will be evaluated to identify areas that require modification and to assess program impact.

**Process Evaluation**

This component of evaluation focuses on the ongoing tracking of progress made toward completing activities designed to bring about changes directly linked to the program’s goals.

The process evaluation will determine
- the extent to which the plan is being implemented as intended;
- the degree to which goals and strategies are progressing towards completion over the course of the four-year plan, including assessing the strengths, weaknesses and lessons learned during the implementation of the plan;
- how the program appropriately focuses diabetes health efforts, especially toward priority populations.

**Outcome Evaluation**

The outcome evaluation determines whether or not changes are occurring and the impact of the changes in the state. Outcomes include changes in diabetes risk factors such as hypertension, physical inactivity and excess body weight.

The outcome evaluation will
- determine changes in behavior, services and policies that have occurred as a result of the plan;
- assess the inroads in addressing health disparities;
- determine if educational intervention increases public awareness of diabetes;
- track the changes occurring in the state population’s diabetes burden and risk factors over time (as measured primarily through vital statistics, hospital discharge data and the Behavioral Risk Factor Surveillance System).

**Surveillance**

Using existing data systems, such as the Behavioral Risk Factor Surveillance Survey, Child Health Survey, Pregnancy Risk Assessment Monitoring System, HEDIS® data, vital statistics and hospital discharge data, the Diabetes Prevention and Control Program has the capacity to track changes. The program will continue to use the existing data systems to continue its surveillance of diabetes and related risk factors.

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**US PREVENTIVE SERVICES TASK FORCE CLINICAL RECOMMENDATIONS**

**SCREENING FOR LIPID DISORDERS IN ADULTS**

The U.S. Preventive Services Task Force (USPSTF) recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The U.S. Preventive Services Task Force (USPSTF) recommends screening women aged 20

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to 45 for lipid disorders if they are at increased risk for coronary heart disease. The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders. The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.

**CDC RECOMMENDATIONS**

**COMMUNITY INTERVENTIONS**

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC).

**BEHAVIORAL AND SOCIAL APPROACHES TO INCREASE PHYSICAL ACTIVITY: INDIVIDUALLY-ADAPTED HEALTH BEHAVIOR CHANGE PROGRAMS**

Individually-adapted health behavior change programs to increase physical activity teach behavioral skills to help participants incorporate physical activity into their daily routines.

**BEHAVIORAL AND SOCIAL APPROACHES TO INCREASE PHYSICAL ACTIVITY: SOCIAL SUPPORT INTERVENTIONS IN COMMUNITY SETTINGS**

Social support interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support).

**CAMPAIGNS AND INFORMATIONAL APPROACHES TO INCREASE PHYSICAL ACTIVITY: COMMUNITY-WIDE CAMPAIGNS**

Community-wide campaigns to increase physical activity involve many community sectors; include highly visible, broad-based, component strategies; and may also address other cardiovascular disease risk factors.

**DIABETES PREVENTION AND CONTROL: CASE MANAGEMENT INTERVENTIONS TO IMPROVE GLYCEMIC CONTROL**

Case management involves planning, coordinating, and providing health care for all people affected by a disease, such as diabetes.

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DIABETES PREVENTION AND CONTROL: DISEASE MANAGEMENT PROGRAMS

Disease management is an organized, proactive, multicomponent approach to healthcare delivery for people with a specific disease, such as diabetes.

DIABETES PREVENTION AND CONTROL: SELF-MANAGEMENT EDUCATION

Diabetes self-management education (DSME) is the process of teaching people to manage their diabetes. It can be provided in a variety of community settings.

ENVIRONMENTAL AND POLICY APPROACHES TO INCREASE PHYSICAL ACTIVITY: STREET-SCALE URBAN DESIGN AND LAND USE POLICIES

Street-scale urban design and land use policies involve the efforts of urban planners, architects, engineers, developers, and public health professionals to change the physical environment of small geographic areas, generally limited to a few blocks, in ways that support physical activity.

HEALTH COMMUNICATION & SOCIAL MARKETING: HEALTH COMMUNICATION CAMPAIGNS THAT INCLUDE MASS MEDIA & HEALTH-RELATED PRODUCT DISTRIBUTION

Health communication campaigns can increase the use of health-related products when they use mass media messaging and distribute the products at free or reduced prices.

OBESITY PREVENTION AND CONTROL, INTERVENTIONS IN COMMUNITY SETTINGS: WORKSITE PROGRAMS

Worksite nutrition and physical activity programs are designed to improve health-related behaviors and health outcomes.
## LOCAL RESOURCES

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<thead>
<tr>
<th>County or State-wide</th>
<th>City</th>
<th>Provider</th>
<th>Contact Person</th>
<th>Phone Number/ Email</th>
<th>Website</th>
<th>Address</th>
<th>Programs</th>
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</thead>
<tbody>
<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>American Diabetes Association, Colorado</td>
<td>Sue Glass, Executive Director</td>
<td>720.855.1102</td>
<td><a href="http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html#Colorado">http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html#Colorado</a></td>
<td>2480 W 26th Avenue, Suite 120B Denver, CO 80211</td>
<td>This link provides a comprehensive list of clinics that provide AADE accredited diabetes programming.</td>
</tr>
<tr>
<td>Colorado, State-wide</td>
<td>Denver</td>
<td>CDPH: Colorado Diabetes Prevention and Control</td>
<td>*</td>
<td>303-692-2577</td>
<td><a href="http://www.cdphe.state.co.us/pp/Farmtoschool/diabetes/contact.html">http://www.cdphe.state.co.us/pp/Farmtoschool/diabetes/contact.html</a></td>
<td>Prevention Services Division PSD-DPCP-A5 4300 Cherry Creek Drive South Denver, CO 80246-1530</td>
<td>A program by the Colorado Department of Public Health that has resources for prevention and control of diabetes.</td>
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<tr>
<td>County or State-wide</td>
<td>City or County</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Phone Number/Email</td>
<td>Website</td>
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<tr>
<td>Colorado, State-wide</td>
<td>Rocky Mountain area</td>
<td>Juvenile Diabetes Research Foundation, Rocky Mountain Chapter</td>
<td>James Buckles Executive Director</td>
<td>303.770.2873 <a href="mailto:rockymountain@jdrf.org">rockymountain@jdrf.org</a></td>
<td><a href="http://www.jdrfrockymountain.org">http://www.jdrfrockymountain.org</a></td>
<td>8055 East Tufts Ave. Ste.770 Denver, CO 80237</td>
<td>Research, education, community programs focused on juvenile diabetes</td>
</tr>
<tr>
<td>Colorado, State-wide</td>
<td></td>
<td>Defeat Diabetes</td>
<td>* *</td>
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<td><a href="http://www.defeatdiabetes.org">www.defeatdiabetes.org</a></td>
<td>*</td>
<td>Referral and education website to assist people in findings Self Management Programs in the US.</td>
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<td>County or State-wide</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
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<td>Diabetes group visits are provider visits in a group format with support and education components from the diabetes and health educators.</td>
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<td>Gestational Diabetes – Education is provided by Health Corps members to women having pregnancy related diabetes.</td>
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<td>Retinal Screening Program for patients with diabetes to detect early diabetic eye disease (retinopathy).</td>
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<td></td>
<td>Aurora</td>
<td>Diabetes Care at University of</td>
<td>*</td>
<td>720-848-2300</td>
<td><a href="http://www.uch.edu/conditions/diabetes-endocrine/diabetes/">http://www.uch.edu/conditions/diabetes-endocrine/diabetes/</a></td>
<td>1635 Aurora Court Aurora, CO 80045</td>
<td>The American Diabetes Association (ADA)-recognized Diabetes Self-Management Education Program provides patients the tools and resources they need to successfully manage their diabetes.</td>
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<td></td>
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<td>Colorado Hospital</td>
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<td></td>
<td>Aurora</td>
<td>The Medical Center of Aurora</td>
<td>John G. Hill, President and CEO</td>
<td>303-695-2600</td>
<td><a href="http://auroramed.com/conditions_we_treat/diabetes_endocrinology/">http://auroramed.com/conditions_we_treat/diabetes_endocrinology/</a></td>
<td>1501 South Potomac Street Aurora, CO 80012</td>
<td>Diabetes treatment &amp; management services, education and prevention.</td>
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<tr>
<td>County or State-wide</td>
<td>City</td>
<td>Provider</td>
<td>Contact Person</td>
<td>Phone Number/ Email</td>
<td>Website</td>
<td>Address</td>
<td>Programs</td>
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<tr>
<td>Arapahoe County</td>
<td>Aurora</td>
<td>UC Denver: Barbara Davis Center for Childhood Diabetes</td>
<td>George Eisenbarth, MD, PhD, Executive Director</td>
<td>303-724-2323</td>
<td><a href="http://www.barbaradaviscenter.org/">http://www.barbaradaviscenter.org/</a></td>
<td>13001 E 17th Place Aurora, Colorado 80045</td>
<td>The Barbara Davis Center for Childhood Diabetes is one of the largest diabetes programs specializing in type 1 diabetes research and care (both children and adults) in the world.</td>
</tr>
<tr>
<td>Denver</td>
<td>Denver</td>
<td>Denver Health, Sam Sandos Westside Family Health Center</td>
<td>Andrew Steele, MD</td>
<td>303-436-4200</td>
<td><a href="http://denverhealth.org/Services/CommunityHealth/OurClinicsandServices/PrimaryCareServices/WestsideHealthCenter.aspx">http://denverhealth.org/Services/CommunityHealth/OurClinicsandServices/PrimaryCareServices/WestsideHealthCenter.aspx</a></td>
<td>1100 Federal Blvd Denver, CO 80217</td>
<td>Health services for low income and medically uninsured populations in Denver County</td>
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<tr>
<td>Denver</td>
<td>Denver</td>
<td>Clinica Tepeyac: Diabetes Control Program</td>
<td>Tracy Pineda, Health Promotions Director</td>
<td>303.458.5302</td>
<td><a href="http://clinicatepeyac.org/clinic_services.html">http://clinicatepeyac.org/clinic_services.html</a></td>
<td>5075 Lincoln Street Denver, CO 80216</td>
<td>Diabetic Care and Monitoring including Digital Retinal Camera</td>
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<td>County or State-wide</td>
<td>City</td>
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| Denver               | Wheat Ridge| Exempla Lutheran Medical Center: Diabetes & Endocrine Center | Michelle Cassara, MD Medical Director of the Exempla Diabetes Center | 303-403-7933        | [http://www.exempla.org/body.cfm?id=65](http://www.exempla.org/body.cfm?id=65) | Diabetes and Endocrine Practice
3555 Lutheran Parkway, Suite 180
Wheat Ridge, CO 80033 | Support group, education, referral |
| Denver County        | Denver     | Denver Health, Montbello Health Clinic      | Louise Ortiz, MD                                    | 303-602-4000        | [http://denverhealth.org/Services/CommunityHealth/OurClinicsandServices/PrimaryCareServices/MontbelloFamilyHealthCenter.aspx](http://denverhealth.org/Services/CommunityHealth/OurClinicsandServices/PrimaryCareServices/MontbelloFamilyHealthCenter.aspx) | 12600 E. Albrook Drive
Denver, CO 80239 | Primary care services at a low cost to all individuals, including diabetes. |
| Denver County        | Denver     | Clinica Family Health Services, Pecos Medical Clinic | N/A                                                 | (303) 650-4460      | [http://www.clinica.org/index.php](http://www.clinica.org/index.php) | 1701 W. 72 Ave, 3rd Floor, Denver, CO 80221 | Diabetes management, education, prevention and treatment |