

# Leveraging Data to Inform & Evaluate Diabetes Prevention and Management Intervention in the District

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March Diabetes DPM CoP

March 25, 2025

# AGENDA

- ▶ Current State of Diabetes
- ▶ DC Health Diabetes Surveillance Network
- ▶ Diabetes Burden in DC
- ▶ Purpose of DC Health's Diabetes Program
- ▶ State of Diabetes within DC's FQHC Reporting Network
- ▶ Program Strategies
- ▶ LinkU Walkthrough

# DC Health Diabetes Surveillance Network

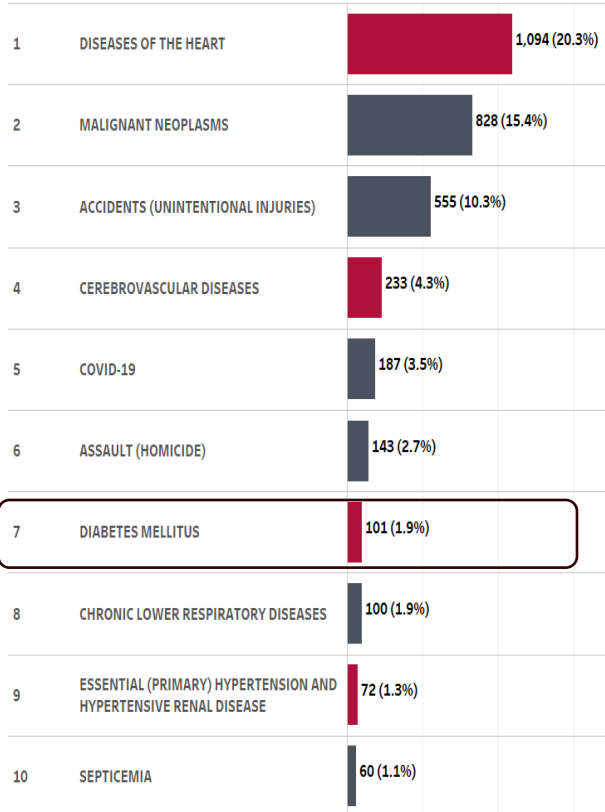


# Current State of Diabetes

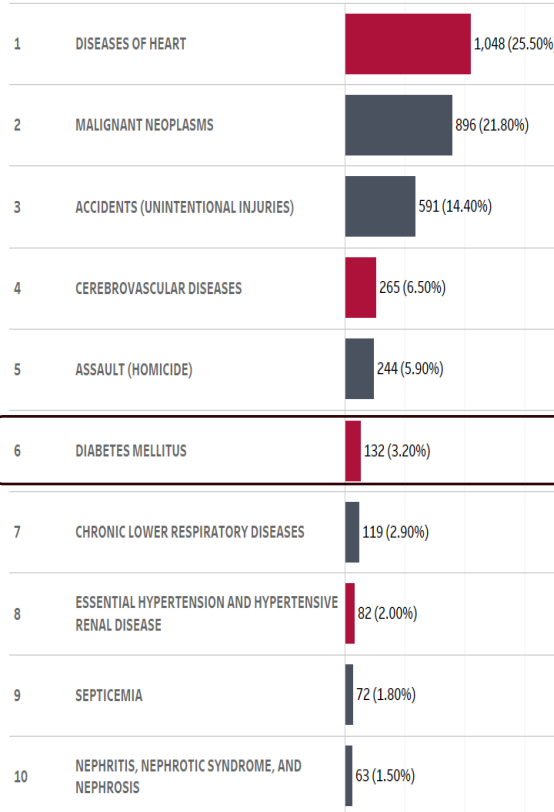
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# Per 2023 BRFSS reports, 10.6% respondents nation-wide and 8.2% District residents were medically diagnosed with diabetes

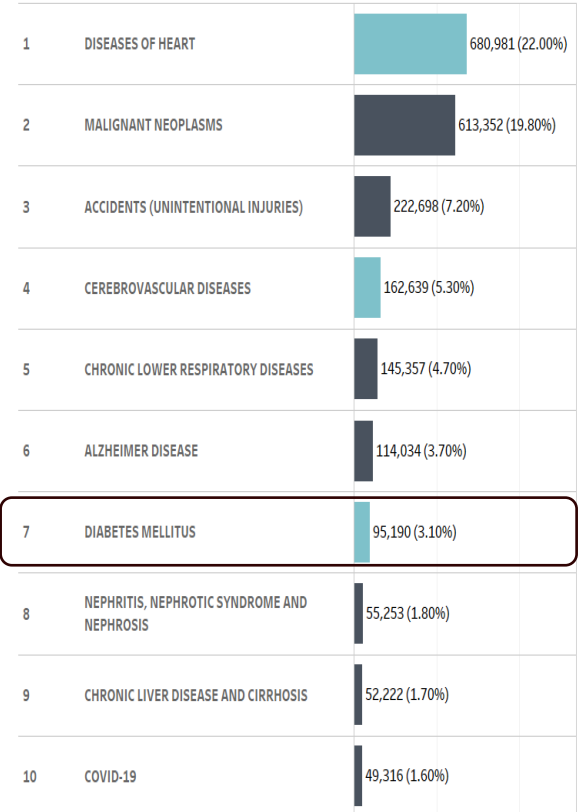
**Top 10 Leading Causes of Death Among District Residents (Deaths Occuring in the District), 2022**



**Top 10 Leading Causes of Death Among District Residents (Deaths Occuring in the District), 2023**



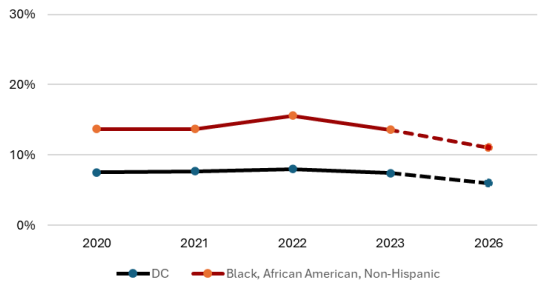
**Top 10 Leading Causes of Death Nationally (Deaths Occuring in the US), 2023**



DC Health Vital Records, 2022- 2023

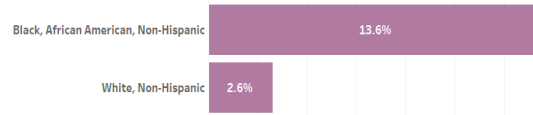
# Burden of Diabetes Among Adult DC Residents, BRFSS 2023

Trends in Diabetes Prevalence with Year 2026 Targets

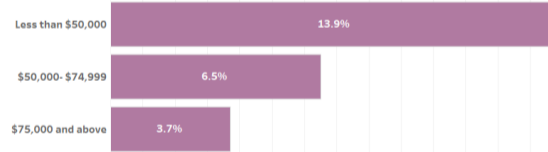


Diabetes Prevalence by Socio-Demographic Characteristics

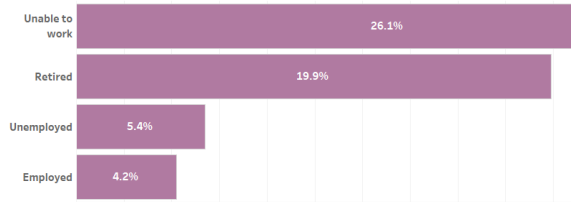
Diabetes Prevalence by Race/Ethnicity



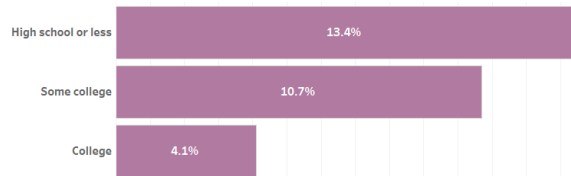
Diabetes Prevalence by Annual Income



Diabetes Prevalence by Employment Status

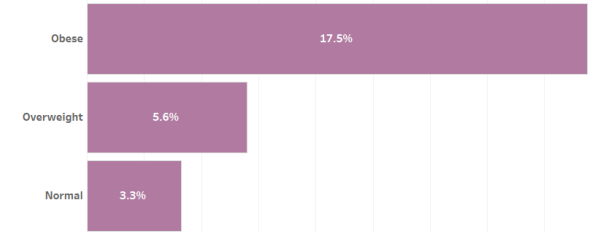


Diabetes Prevalence by Level of Education

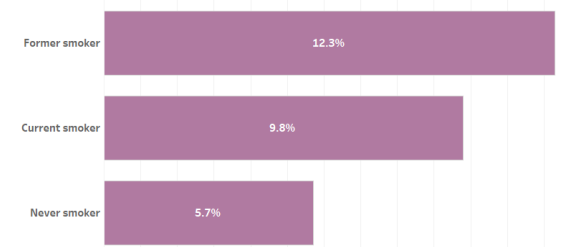


Diabetes Prevalence by High Behavioral Risk Factors

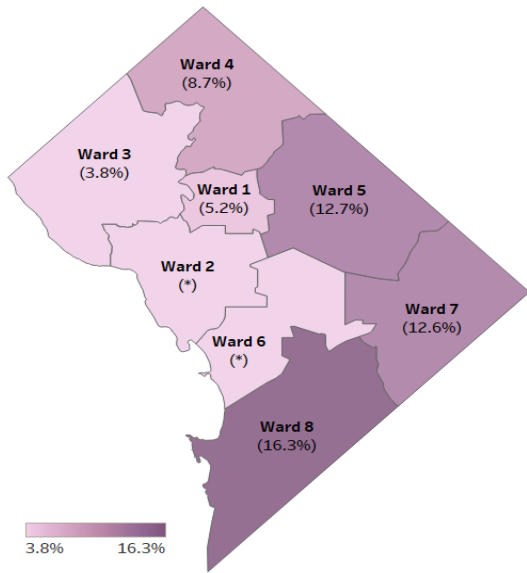
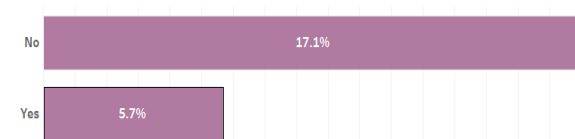
Diabetes Prevalence by BMI



Diabetes Prevalence by Smoking History



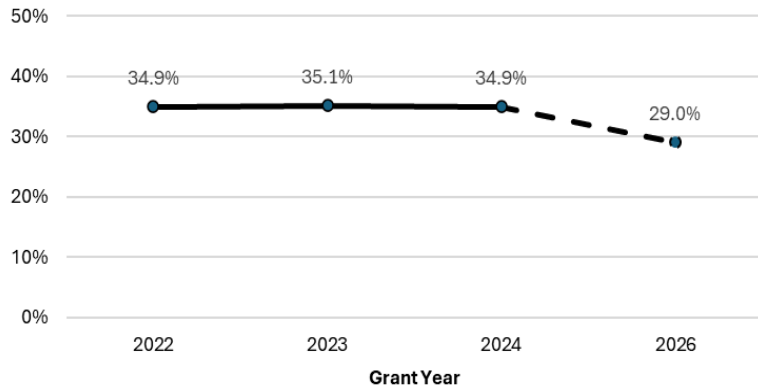
Diabetes Prevalence based on Engagement in Physical Activity



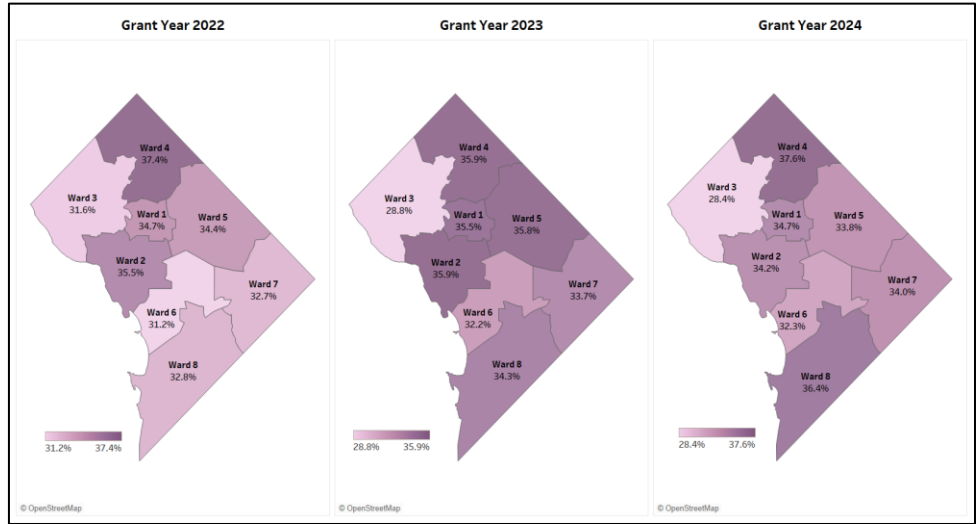
DC Health Behavioral Risk Factor Surveillance System, 2023

# State of Diabetes within FQHC Reporting Network

Trends in Poor Diabetes Control (HbA1c>9) among District residents with Year 2026 Targets

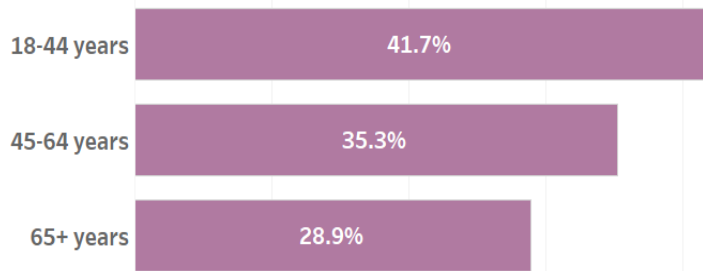


Heart Disease and Stroke Reports, GY 2022-2024  
 Note: GY 2024 data is reflective of only 2 quarters (July 2024-December 2024)



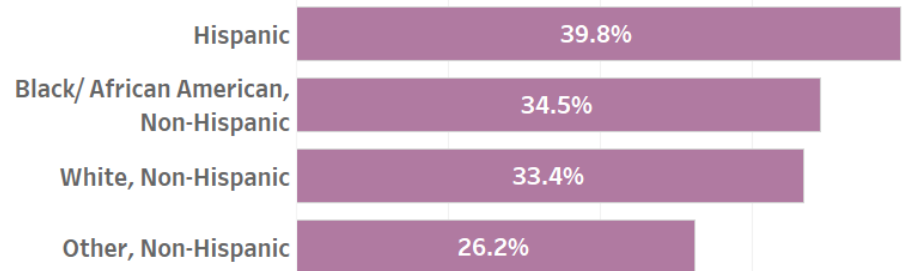
Heart Disease and Stroke Reports, GY 2022-2024  
 Note: GY 2024 data is reflective of only 2 quarters (July 2024-December 2024)

Poor Diabetes Control (HbA1c>9) among District residents by Age Group (GY 2023)



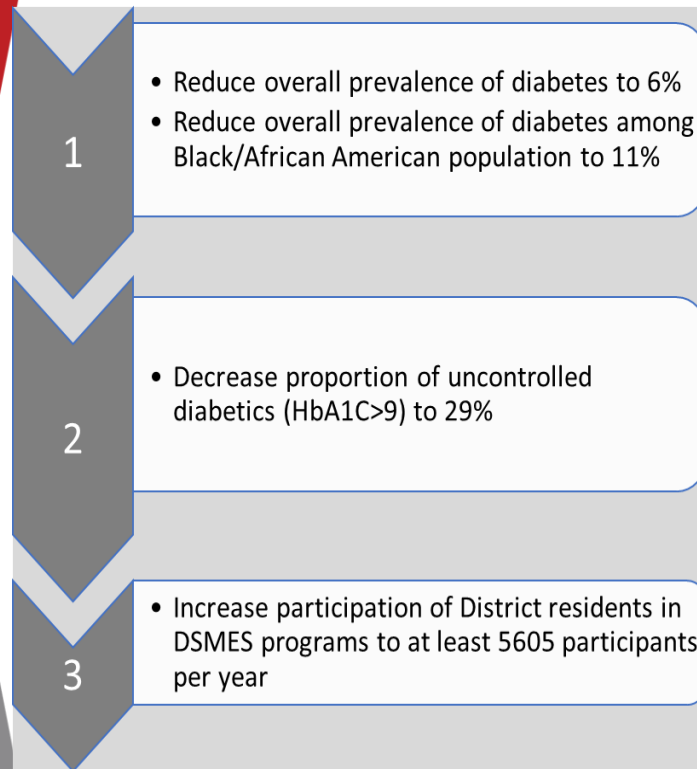
Heart Disease and Stroke Reports, GY 2023

Poor Diabetes Control (HbA1c>9) among District residents by Race/Ethnicity (GY 2023)



Heart Disease and Stroke Reports, GY 2023

# Program Goal

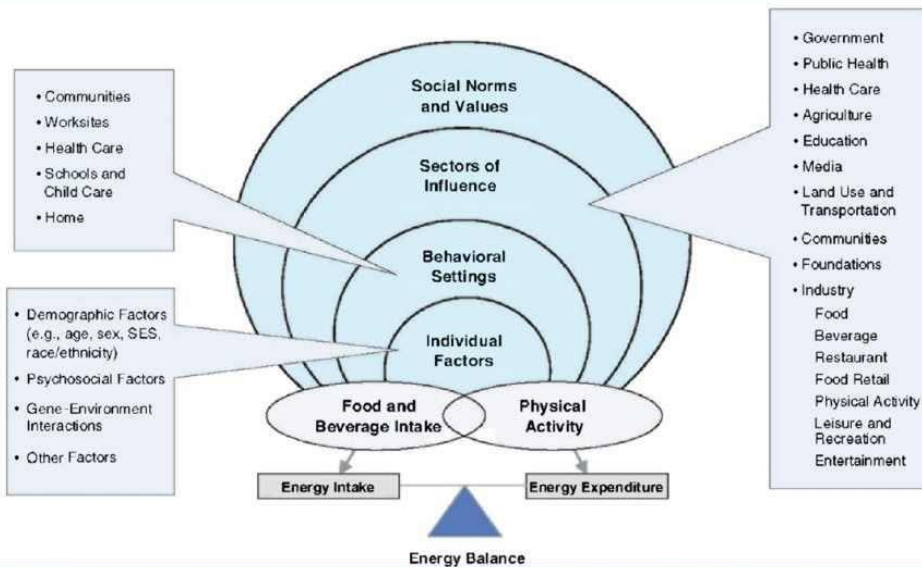


The Chronic Disease Division of the DC Department of Health seeks to reduce the incidence of new diabetes cases and improve diabetes control among existing cases.

Reducing the incidence of new cases and improving the management of existing cases will improve diabetes-related morbidity and mortality District-wide.

**Who? Where? Why? How?**

# Applying Data to Define the Where? Who? and Why? for Program Planning



## Where:

- Diabetes prevalence **2x** higher in Ward 8 (followed by 4, 5, 7)

## Who:

- Black/AA adults **5x** more likely to have diabetes than NH White Adults
- Residents age 40+ over **2x** more likely to have diabetes
- Household income <\$50,000 **3x** more likely to have diabetes

## Why:

- SES challenges
- Lack of preventive care
- Lower health literacy
- Higher stress levels
- Limited access to specialists

## Applying Data to Define the How? of Program Planning

Expand resident access and participation in evidence-based lifestyle change programs	Extend clinical continuums through the pharmacy setting	Strengthen the identification and management of clinical and social needs through multi-directional e-referral systems
<ul style="list-style-type: none"> <li>• Culturally competent care</li> <li>• Intensive and ongoing education, technical and behavioral skill building</li> <li>• Psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>• Place-based, high-touch environment</li> <li>• High perceived acceptability</li> <li>• Opportune engagement</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated care culture</li> <li>• SDOH exacerbate diabetes risk</li> <li>• Cohesive effort to address unmet needs</li> </ul>

*"On average, a person with diabetes spends **less than 1% of their life** with their health care team"*

# Leveraging the Data to Evaluate Our Program

## Process

Did we do what we said we were going to do?

## Outcome

Did our program make a difference?

# Evaluation of Strategy 1

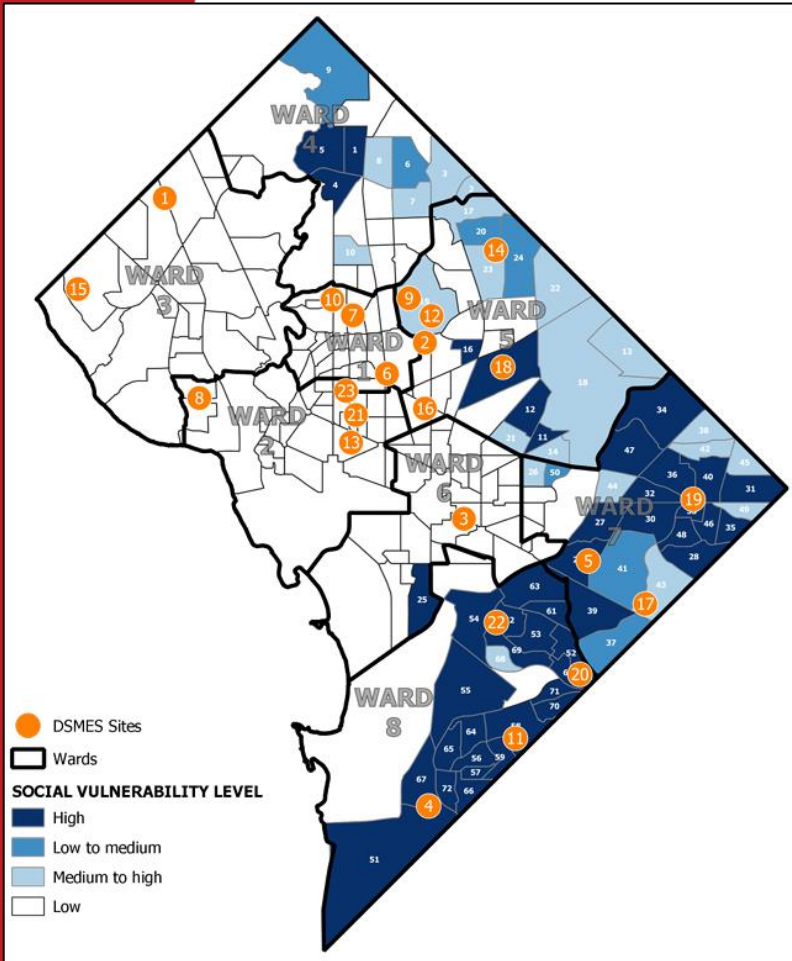
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Assess the impact of strategic placement of DSMES programs in high-burden wards upon resident participation in diabetes care.

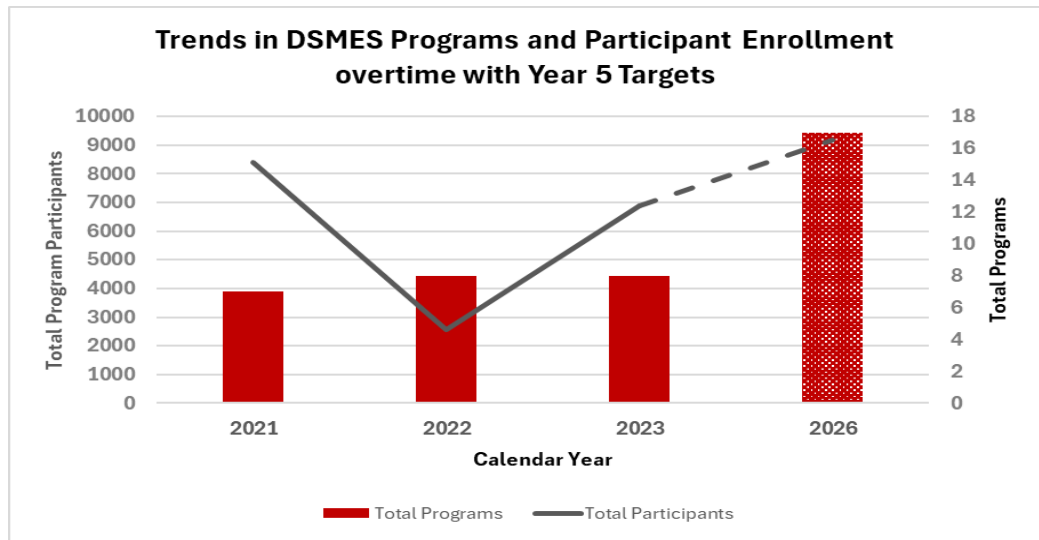
Define organizational best practices and TA needs to establish and scale DSMES programs.

Determine the impact of access and participation in DSMES programs upon diabetes outcomes in high-risk populations

## Active Diabetes Self-Management and Diabetes Support Programs with Social Vulnerability Level



Data Source	Indicators
CDC State Reports, LinkU	# and location of established DSMES, DPP or CDS programs # of residents referred and participating
Quarterly Reports	Description of how programs have been tailored to engage and retain participants
Program Records	<ul style="list-style-type: none"> <li>Program-specific retention</li> <li>Change in participant health outcomes</li> </ul>



CDC DSMES State Reports, CY 2021-2023

# Evaluation of Strategy 2

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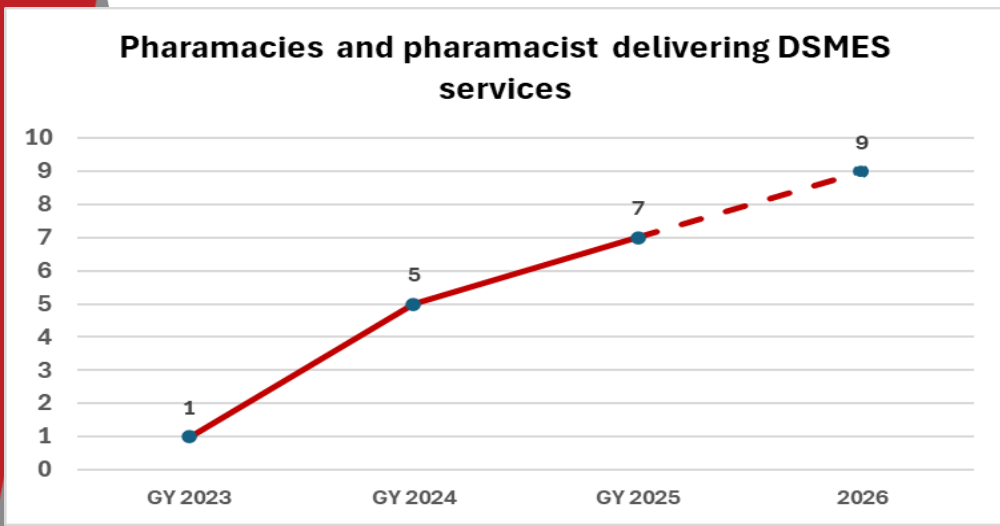
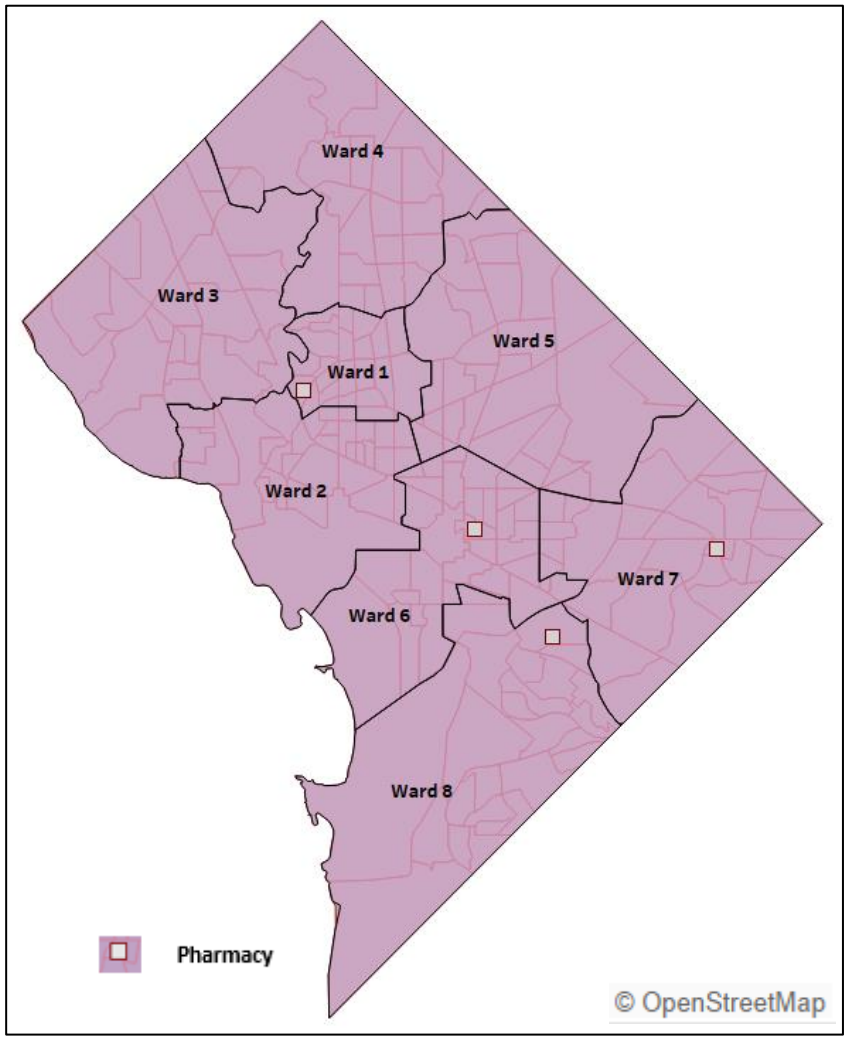
Develop and test models of DSMES and DPP delivery in the pharmacy setting

Define barriers/facilitators to sustaining the pharmacy model

Examine the impact of pharmacy-based program completion upon diabetes outcomes in high-risk populations

Data Source	Indicators
CDC State Reports, LinkU	# and location of established DSMES, DPP or CDS pharmacy programs # residents referred from health systems and CBOs to pharmacy programs
Quarterly Reports	<ul style="list-style-type: none"> <li>• Description of partnerships or resources leveraged to engage and retain participants</li> <li>• Description of processes to sustain DSMES or DPP delivery in the pharmacy setting</li> <li>• Description of communication pathways between pharmacies and health systems</li> </ul>
Program Records	<ul style="list-style-type: none"> <li>• Program-specific retention</li> <li>• Billing outcomes (Medicare, Private)</li> <li>• Change in participant health outcomes</li> </ul>

ADA/ ADCES- Accredited Pharmacies and Pharmacists delivering DSMES programs

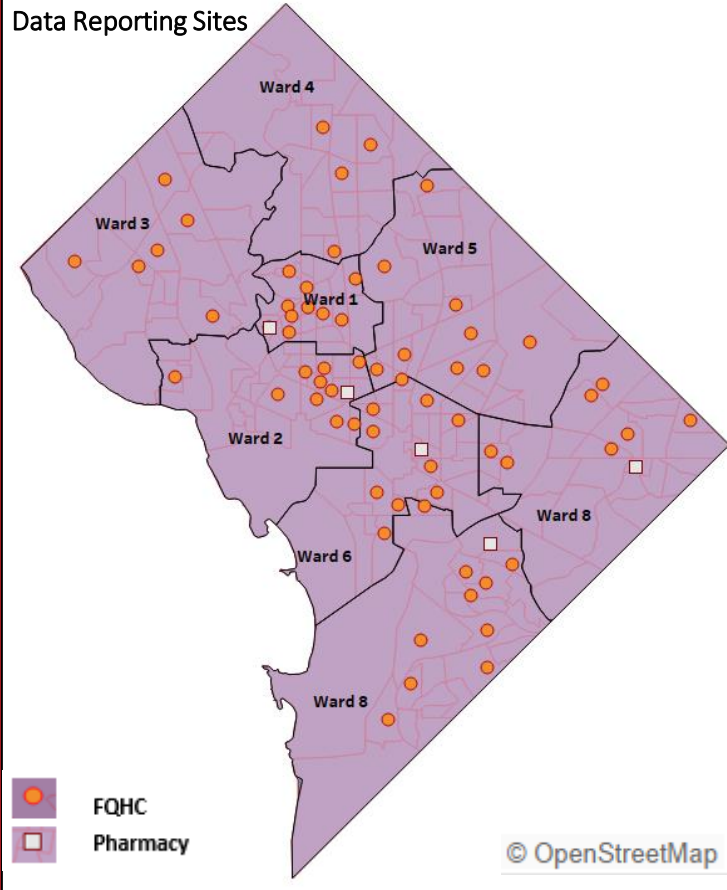


## Strategy 3

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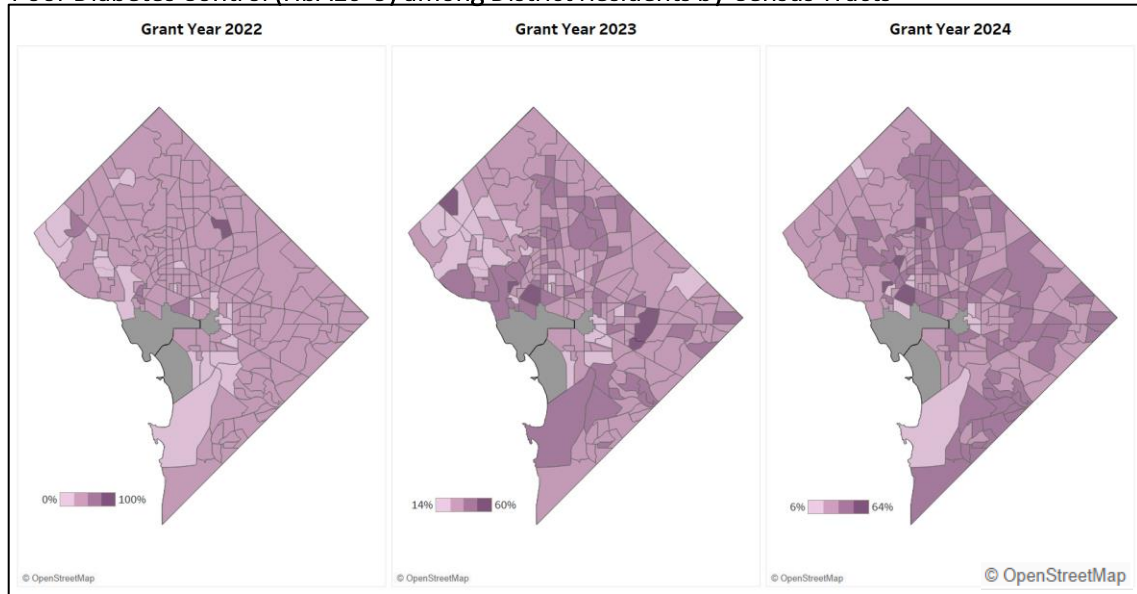
Assess the extent to which use of LinkU decreased the volume of unmet social needs within the priority population

Validate the impact of social service support needs upon health outcomes



Data Source	Indicators
CDC State Reports, LinkU	# residents screened and referred to DSMES or DPP services # residents screened and referred for social needs # residents referred from health systems and CBOs to DSMES, DPP or CDS # of service providers addressing clinical and non-clinical needs # of social needs identified and addressed # of organizations claimed and utilizing LinkU
Quarterly Reports	Social need screening and referral integration into clinical workflows
Program Records	# of residents referred from health systems and CBOs to pharmacy programs # of service providers addressing clinical and non-clinical needs # of social needs identified and addressed Change in participant health outcomes

Poor Diabetes Control (HbA1c>9) among District Residents by Census Tracts



# Thank you

Are their data points that you feel may be helpful to incorporate into the Chronic Disease Division's evaluation?

Are there any data elements that you've seen today that would be helpful to incorporate into your organization's work?

# DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

2201 Shannon Place SE, Washington, DC 20020

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