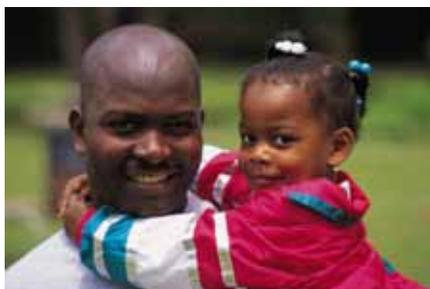


ARKANSAS DIABETES STATE PLAN 2003-2008



Date

Dear XXXXX,

It is with hope and pride that we present the Arkansas State Diabetes Strategic Plan. This plan will address the current scope of diabetes in the state and outline a plan for controlling diabetes and the many threatening complications of this prevalent disease.

Diabetes in Arkansas is a growing health concern. Almost eight percent of the entire population of Arkansas, nearly 235,000, suffers from this chronic disease; however, one third are unaware of this condition. Arkansas has consistently ranked at or above the national average for diagnosed diabetes since 1995. The diabetes frequency in Arkansas increased 15% from 1994 to 2000. It is time for imaginative plans and effective action.

Arkansas consistently ranks near the bottom of national averages in many areas. We are hoping that with a comprehensive plan, Arkansas can reverse the diabetes trend among its citizens. This plan will describe priority areas, goals, and objectives that will enable Arkansas to fight this costly and deadly disease. With education and awareness, early diagnosis, access to treatment and promotion of healthier lifestyles, Arkansans with diabetes will live longer, healthier lives.

The Arkansas Department of Health (or the XXXX) is not alone in this challenge. Partnerships have been formed with many federal, state, and local organizations to combat the growth of diabetes among Arkansans. Working together we can create a healthier Arkansas.

Sincerely,

XXXXXXXXXX

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What is Diabetes?

Diabetes is a disease in which the body does not produce or properly use insulin. Insulin is the hormone that is needed to convert sugar, starches and other food into energy needed for daily life. Insulin unlocks the cells of the body, allowing glucose to enter and fuel them. When a person has diabetes, their body does not produce enough insulin or cannot effectively use the insulin it does produce.

There are three main types of diabetes:

- 1) Type 1 Diabetes – the body does not produce the insulin needed. This was previously called insulin-dependent or juvenile onset diabetes. This type of diabetes requires insulin injections. It is estimated that 5% to 10% of people with diabetes have Type 1.
- 2) Type 2 Diabetes - the body fails to properly use what insulin it has combined with a possible relative insulin deficiency. Approximately 90-95% of Americans with diabetes have Type 2 diabetes.
- 3) Gestational Diabetes - Gestational diabetes starts when a woman's body is not able to make and use all the insulin it needs for pregnancy. There seems to be a link between the tendency to have gestational diabetes and Type 2 diabetes. Gestational diabetes develops in 2% to 5% of all pregnancies.
- 4) Pre-Diabetes-blood glucose levels that are higher than normal but not yet high enough to be diagnosed as diabetes. There are 41 million people in the United States, ages 40 to 74, who have pre-diabetes.

DIABETES IN ARKANSAS

PREVALENCE

Data from the Behavioral Risk Factor Surveillance Survey (BRFSS) states that 7.8% of Arkansas's population suffers from diabetes. Approximately 235,000 Arkansas adults have diabetes, with as many as one-third of those individuals unaware that they have the condition.

According to the 2001 BRFSS, diabetes was reported more often in older age groups of Arkansans, with a substantial increase in prevalence after the age of 45. Further, the prevalence of diabetes among African Americans in Arkansas (11.3%) was 77 percent higher than among whites.

MORTALITY

Diabetes was the 6th leading cause of death in Arkansas in 2001.

One in five diabetes deaths (21%) occurred prematurely – that is, among persons below the age of 65 years.

In recent years, diabetes mortality rates in Arkansas and the US overall have risen approximately 10 percent.

However, the burden of mortality associated with diabetes is not borne equally across all population groups with the state. For example:

The diabetes mortality rate for African American Arkansans is three times the rate seen among whites.

Among whites in Arkansas, one fourth (25%) of all diabetes deaths in 2001 occurred in persons 65 or younger and 4 percent occurred in persons under the age of 45. However, among African American Arkansans, 32% of diabetes deaths occurred in persons under the age of 65 and 7 percent occurred in younger persons 45 or younger.

Mortality figures are skewed by several factors:

Diabetes is highly underreported on death certificates, both as a condition and as a cause of death.

Persons with diabetes are 2 to 4 times more likely to die of heart disease or stroke than are persons without diabetes. CVD (Cardiovascular disease) accounts for 42% of deaths in Arkansas.

Deaths caused by kidney disease are also more common among persons with diabetes.

COST

The total cost of diabetes includes direct medical costs (such as physician fees, home health care, hospital charges, pharmacy charges, supplies, and the like) and indirect costs (that is, the costs associated with disability, lost work time, premature mortality, etc.). Data is not available to estimate these total costs for the state of Arkansas. However, various sources provide information that may be applied to derive some perspective on the costs of diabetes borne by the system and individuals in Arkansas.

In 2001, there were nearly 5000 hospital admissions with a primary discharge diagnosis of diabetes. Since 1999, the average length of stay has increased suggesting that patient conditions are more severe or more complex, requiring additional time in the hospital resulting in higher hospital costs. In addition, average charges for hospitalizations due to diabetes have increased each year since 1998 to a current average of more than \$11,000 per hospitalization. Hospitalizations due to diabetes in Arkansas accounted for a total cost of

more than \$55 million in the year 2001. Among the most serious and costly hospitalizations are those that are caused by serious complications of diabetes, including heart disease, diabetic ketoacidosis, and lower extremity amputations.

COMPLICATIONS¹

Uncontrolled diabetes can lead to a number of serious complications. The following is a list of the most prevalent health conditions associated with diabetes.

Heart disease

Adults with diabetes are 2 to 4 times more likely to die of heart disease than adults without diabetes.

Stroke

Persons with diabetes are 2 to 4 times more likely to have a stroke than persons without diabetes.

High blood pressure

It is estimated that approximately 65 percent of persons with diabetes have high blood pressure.

Blindness

Diabetes is a primary cause of new cases of blindness in adults. Nationally, diabetic retinopathy causes from 12,000 to 24,000 new cases of blindness each year. In the 2001 Arkansas Behavioral Risk Factor Surveillance Survey, 26 % of persons with diabetes reported that they had been told their diabetes had affected their eyes.

Kidney disease

Diabetes is the leading cause of end-stage renal disease (ESRD), responsible for approximately 40 percent of all new cases.

Nervous system disease

As many as 70 percent of people with diabetes have some form of nervous system damage, including impaired sensation or pain in the feet or hands, digestion problems, carpal tunnel syndrome, and other nerve problems.

Amputations

CDD reports that more than half of lower limb amputations in the United States occur in people with diabetes. In Arkansas in 2001, more than 1000 non-traumatic lower extremity amputations were performed in Arkansas hospitals. An overwhelming 63 percent of these amputations were performed on persons with diabetes.

Dental disease

Periodontal disease (a type of gum disease that can lead to tooth loss) is more common and often more severe among persons with diabetes.

Complications of pregnancy

The rate of major congenital malformations (birth defects) in babies born to women with pre-existing diabetes can be as high as 5 percent among women who receive prenatal care and 10 percent among women who do not receive prenatal care.

¹ The Burden of Diabetes in Arkansas

Other complications

Diabetes can directly cause acute life-threatening events, such as diabetic coma. In general, people with diabetes are more susceptible to many other illnesses. For example, they are more likely to die of pneumonia or influenza than people who do not have diabetes.

RISK FACTORS

The prevention of diabetes depends ultimately on the reduction of risk factors. While some of the risk factors for diabetes – such as age, racial origin, and family history– are not modifiable, other risk factors can be modified.

- 1) Weight - The primary risk factor influencing the prevalence of diabetes in Arkansas is obesity. THE BRFSS indicates that 60 % of Arkansas' adults could be categorized as overweight or obese. Persons with diabetes are more likely to be obese or overweight (77% combined categories) than persons without diabetes (58%). There is also an epidemic of childhood obesity in our state and our nation.² In Arkansas, 34% of students in the 9th-12th grades describe themselves as overweight.³
- 2) Physical Activity – BRFSS results indicate that more than half (51%) of Arkansas adults do not engage in sufficient physical activity. Only 37% of high school students attend Physical Education class.
- 3) Nutrition - BRFSS findings indicate that more than three fourths (78%) of Arkansas adults reported not eating enough of the recommended fruits and vegetables to maintain a balanced diet.

ACCESS TO CARE

Healthcare professionals are not evenly distributed across the state. Fifteen (20%) of Arkansas' 75 counties have fewer than 4 primary care physicians per 10,000 population. 22% of the state's total population lives in areas designated as Health Professional Shortage Areas (HPSAs) by the federal government.

12% of persons with diabetes (an estimated 19,000 persons statewide) reported that they were not currently covered by any health plan. This ranks Arkansas 15th in the nation in the percent of uninsured citizens.

Essential Services of Public Health

² "The Prevention Connection:", 2002

³ Pediatric Nutrition Surveillance System, 2000

Before addressing the issues related to diabetes in Arkansas, it is important to put the unique challenges of this disease in the context of general public health services. Regardless of the public health issue, ten primary services are essential:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population based health services.
10. Research for new insights and innovative solutions to health problems.

Application of these ten essential health services serves as the foundation to any comprehensive plan relating to diabetes. This list is the first level of response dealing with the public awareness, patient awareness, and patient treatment for diabetes.

It is also important to recognize and take action on the 17 primary diabetes-related objectives of the Healthy People 2010 report. With efforts led by the Centers for Disease Control and Prevention National Institutes of Health, and the American Diabetes Association, substantial improvement in the health status of Americans can be realized. The objectives of this report outline the fundamental focus of the state's plan to identify, treat, and most importantly, to educate those with and those susceptible to diabetes.

The Arkansas Diabetes State Plan

The Arkansas Diabetes Strategic Plan will present goals, rationale, strategies, specific action steps, and evaluation procedures to implement positive change in four impact areas relevant to diabetes in Arkansas:

Diabetes Education & Self-Management

Health System Re-Design

Healthy Weight

Physical Activity

Diabetes State Plan 2003

On November 20, 2002, the Council and additional partners were convened to develop an Arkansas Diabetes State Plan. Priority topics were chosen based on the Healthy People 2010 objectives and the assessment conducted as part of the strategic plan in 2000. Partners were sent examples of two state plans from other states, the diabetes-related healthy people 2010 objectives, and the existing strategic plan prior to the retreat. Partners attending the retreat were asked to identify the vital few from the important many goals. They were also given the opportunity to suggest other important goals. Through a facilitation process that encouraged input from all partners, priority goals were identified. Partners brainstormed objectives and activities for each area. The cardiovascular disease and diabetes-related objectives were adopted from the existing Arkansas Cardiovascular State Plan. The group then decided that the remaining goals and healthy people 2010 objectives that were deemed important to address fell into four broad areas: System Redesign, Diabetes Education/Self-Management, Healthy Weight, and Physical Activity.

The over-arching themes for these areas were the 5 components of the chronic care model and reducing health disparities, the goal being to address both the Healthy People 2010 objectives as well as the Essential Services of Public Health. Committees were formed and meeting times established for early January to complete objectives, prioritize activities and assign responsible organizations for each activity. Each committee had access to the Surveillance report and the Chronic Disease epidemiologist was available to each committee to enable data driven decision-making.

The State plan will be distributed to Diabetes Council and Diabetes Coalition Members, appropriate Health Department Colleagues, Payers, legislators/policy makers and will be available on the ADPCP website in March 2003.

Goal 1

Diabetes Education/ Self-Management

Improve preventive practices associated with the management and control of diabetes and pre-diabetes.

Rationale:

Less than fifty percent of people with diabetes in Arkansas receive a course or class related to diabetes self management. Diabetes education has been shown to reduce the number of hospitalizations, ER visits, costs and complications associated with diabetes. With the

increasing prevalence of diabetes in Arkansas, education of the people with diabetes and the general public would decrease the burden of the disease in our society. It is essential to increase diabetes educational opportunities for healthcare providers in the form of continuing education. This, in turn, can enable facilities to become ADA recognized. This is particularly important in rural areas of the state where there is little or no access to quality education.

Objectives:

- Increase the proportion of persons with diabetes who receive formal diabetes education.
Target: 60 percent Baseline: 45% of persons with diabetes received formal diabetes education in 1998. (NHIS) (HP 2010 1-1)
- Increase the proportion of adults with diabetes who perform blood glucose monitoring at least once daily. Target: 60 percent. Baseline: 42 percent of adults aged 18 years and older with diabetes-performed self-blood-glucose-monitoring at least once daily. (BRFSS) (HP 2010 1-2)
- Increase the proportion of adults with diabetes who have an annual dilated eye examination. Target: 75 percent Baseline: 47 percent of adults aged 18 years and older with diabetes had an annual dilated eye examination in 1998. (NHIS) (HP 2010 1-3)
- Reduce the frequency of foot ulcers in persons with diabetes. (HP 2010 5-9)
- Reduce the rate of lower extremity amputations in persons with diabetes. Target: 1.8 lower extremity amputations per 1,000 persons with diabetes. Baseline: 4.1 lower extremity amputations per 1,000 persons with diabetes. (NHDS, NHIS) (HP 2010 5-10)
- Increase the proportion of adults with diabetes who have at least an annual foot examination. Target: 75 percent Baseline: 55 percent of adults aged 18 years and older with diabetes had at least an annual foot examination. (BRFSS) (HP 2010 5-14)
- Increase the proportion of persons with diabetes who obtain an annual urinary micro albumin measurement. (HP 2010 5-11)
- Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year. Target: 50 percent. Baseline: 24 percent of adults aged 18 years and older with diabetes had glycosylated hemoglobin at least once a year. (BRFSS) (HP 2010 5-12)

Activities:

Target population: people with diabetes.

- Increase access to quality diabetes education and care in rural and underserved areas in Arkansas (Lead Organization: **Community Health Centers of Arkansas**).
 - Increase the number of CDE's and ADA recognized programs in rural Arkansas.
 - Provide annual continuing education programs to facilitate certification of health professionals.

- Provide technical assistance on: becoming a CDE, becoming a recognized program, sustaining a program, reimbursement, making the case to business administrators.
- Educate about and encourage development and continuation of diabetes self-management education programs.
- Increase preventive care and education for people with pre-diabetes or otherwise at risk for developing diabetes (Lead Organization: **NUPAC**).
 - Develop and implement a plan to identify, refer and follow up those undiagnosed and at risk for developing diabetes.
 - Engage partners across the state to implement screening initiative of those at high risk.

Target population: public

- Increase awareness of the public about factors associated with the prevention, management and control of diabetes and pre-diabetes (Lead Organization: **AFMC**).
 - Identify target audiences including: general public, legislators, and employers.
 - Identify and/or develop and distribute print, radio/TV public service announcements.
 - Recruit media liaisons in all regions.
 - Increase dissemination of NDEP media campaign materials.
 - Provide programs in target communities through schools, faith-based organizations, industry and media liaisons in each region.

Target population: Healthcare Professionals

- Distribute ADA guidelines and tools for implementation (Lead Organization: **Arkansas Wellness Coalition**).
 - Wellness Coalition
 - State AMA Journal and meetings
 - Provide quick-reference list
 - Identify and/or develop tools and forms for provider implementation
 - Provide CEU programs for office staff at clinics and rural hospitals through interactive video
- Increase participation of private and group clinics in the State Chronic Disease Collaborative (Lead Organization: **Community Health Centers of Arkansas**).
 - Streamline office visits by introducing interdisciplinary approach.
 - Market the Chronic Disease Collaborative through mailings, ADPCP website, professional meetings, newsletters, journal and newspaper articles.
 - Conduct the Arkansas Collaborative annually.

Target Population: Policy and Decision Makers

- Identify top 20 employers in Arkansas; educate employers on benefit of self-management education (Lead Organization: **NUPAC**).

Goal 2

Health System Redesign

Establish and implement change in policy, procedures and the healthcare system to improve care for people with diabetes.

Rationale:

Effective management of chronic illness requires more than simply adding interventions to an existing system focused on acute care. Rather, it necessitates basic changes in delivery system design. These changes can be made at various points in the health care and legislative systems to foster improved chronic care for Arkansans. The Chronic Care Model, which was developed nationally, has been shown to improve outcomes for those patients with chronic disease. Implementation of this model on a statewide basis is a major initiative for Arkansas in the years to come. An additional area of focus is the effort to educate and inform legislative bodies of the impact that can be achieved through healthy lifestyle change and behavior modification.

Objectives:

- Improve the way that medical care is provided for patients with diabetes.
- Increase the spread of the chronic care model into rural Arkansas.

Activities:

Target population: people with diabetes

- Utilize Hometown Health to create community diabetes workgroups to implement change and increase awareness (Lead Organization: **HHI**).

Target population: the public

- Focus prevention efforts on at-risk communities as identified by data sources within the various partners (Lead Organization: **NUPAC**).
- Advocate reimbursement for diabetes education (Lead Organization: **ADA**).
- Coordinate efforts with charitable organizations, insurers, and faith-based coalitions to advocate increased access to diabetes education and supplies (glucometers, strips etc.) for underinsured or underserved Arkansans (Lead Organization: **SHARP/DPCP**).

Target population: healthcare professionals

- Continue the spread of the chronic care model throughout the state (Lead Organization: **Community Health Centers of Arkansas**).

Target Population: Policy and Decision Makers

- Support and advocate legislative changes to impact the care of diabetes and chronic care in Arkansas (Lead Organization: **ADA**).
- Advocate reimbursement for diabetes education and supplies from private payers and government health plans (Lead Organization: **ADA**).

Goal 3

Healthy Weight

Increase the percentage of Arkansas Youth and Adults with BMIs in the healthy weight range.

Adults: 40.1% in 2000 to 42.1% in 2010.

Youth: 70.3% in 2001 to 72.3% in 2010.

Children: 75% in 2000 to 77% in 2010.

Rationale:

There are multiple factors related to being overweight including inherited, environmental, cultural, and socioeconomic conditions. Being overweight is associated with diabetes, elevated serum cholesterol, and elevated blood pressure. The proportion of persons classified as being overweight increases with age until about age 50 for men and 70 for women then declines. Being overweight is more prevalent in minority populations, especially among minority women.

There are several measures of body fat. The most commonly used is the Body Mass Index (BMI), which describes relative weight for height and is significantly correlated with the amount of total body fat. BMI is calculated as weight in kilograms/height in meters² (Kg/m²). The National Heart Lung and Blood Institute has recently reclassified the measure of overweight as BMI of 25.0 –29.9 Kg/m² and obesity as ^{BMI} of 30. Kg/m² and greater.

Objectives:

- Implement an awareness campaign emphasizing the association between being overweight and developing type 2 diabetes.
- Implement focused educational campaign to help Arkansans adopt healthy lifestyle habits.
- Improve the ability of Arkansans to make recommended lifestyle changes that will lead to healthy weight.

Activities:

Target population: people with diabetes

- Increase the availability of Registered Dietitians to provide nutrition education in rural communities, thereby facilitating the formation of certified diabetes education programs in these communities. (Lead Organization: **AHEC**).

Target population: public

- Collaborate with faith-based organizations to provide healthy lifestyle education to culturally diverse populations (Lead Organization: **NUPAC/Arkansas Cooperative Extension**).
- Collaborate with childcare providers, schools and other educational organizations to provide healthy lifestyle education to youth (Lead

Organization: **Arkansas Diabetes Prevention and Control Program/ NUPAC**).

- Work with state vending association to provide clients with a list of healthier options for vending machines (Lead Organization: **UAMS College of Public Health**).
- Work with the Arkansas Restaurant Association to encourage restaurants to include healthy choices on their menus (Lead Organization: **UAMS College of Public Health**).
- Encourage gas stations and convenience stores to provide healthy options, including fresh fruit in their stores (Lead Organization: **UAMS College of Public Health**).
- Encourage worksite environments that support healthy employees (Lead Organization: **NUPAC/ Arkansas Cooperative Extension**).
- Collaborate with local agencies, health care facilities and community organizations to provide healthy lifestyle education in communities (Lead Organization: **NUPAC/Arkansas Cooperative Extension**).

Target population: healthcare professionals

- Utilize Small Steps-Big Rewards program from NDEP (Lead Organization: **Arkansas Diabetes Prevention and Control Program**).
 - Health care provider's tool kit
 - Web-based resources for healthcare providers
 - Partner outreach materials to businesses and consumer-based programs
 - Messages and materials for media through local diabetes educators.

Goal 4

Physical Activity

Increase physical activity in Arkansas.

Rationale:

Physical inactivity, along with overweight/obesity is the major modifiable risk factor for the chronic diseases like diabetes, cardiovascular disease and arthritis. According to the CDC, the direct medical cost associated with physical inactivity was \$76 billion in 2000. More than a third (36%) of adults report physical activity patterns that are classified by the CDC as insufficient physical activity and 15 percent can be said to be physically inactive in their daily lives in Arkansas during the year 2001.

CDC recommends 30 minutes a day on 5 or more days a week of physical activity to be healthy. Engaging in regular physical activity reduces the risk of developing diabetes and other chronic diseases.

Objectives:

- Decrease the percentage of elementary school (K-6) students who do not attend physical education class to 50 percent. Baseline: 68.7 percent of Arkansas youth do not attend any physical education class. (YRBS 2001)
- Decrease percentage of people with diabetes who are physically inactive to 40 percent. Baseline: 50 percent of people are physically inactive. (BRFSS 2001)
- Increase worksites with designated physical activity areas to 40 percent. Baseline: 28 percent of organizations have a designated exercise/walking area. Among these almost half have outdoor only facilities. (Survey of Employer Cardiovascular Health Policies and Programs, 2002)
- Decrease physical inactivity in the general public to 12 percent by 2004. Baseline: 15 percent of general population is physically inactive, 36 percent have insufficient activity. (BRFSS 2001)
- Increase education on importance of exercise.

Activities:

Target population: people with diabetes

- Distribute educational materials on physical activity to general practice providers, endocrinologists, pharmacies, collaborative and Medicaid facilities (Lead Organization: **Governor's Council on Fitness**).
- Emphasize the chronic care model for exercise; patients can set realistic goals for physical activity through the Arkansas Collaborative (Lead Organization: **Arkansas Diabetes Prevention and Control Program**).
- Utilize partnerships that already exist with AARP/AAA, Healthy Aging Coalition to stress importance of physical activity to seniors (Lead Organization: **Governor's Council on Fitness**).

Target population: the public

- Wellness coalition to develop physical activity materials to distribute to school nurses and staff (Lead Organization: **Governor's Council on Fitness**).
- Partner with Governor's Council on Fitness in an effort to make legislative changes (Lead Organization: **Governor's Council on Fitness**).
- Increase access to physical activity facilities by partnering with the Governor's Council on Fitness via supporting legislation (Lead Organization: **Governor's Council on Fitness**).
- Arrange "Awareness Walk" on county level with Minority Health Commission, Hometown Health (Lead Organization: **ADA**).
- Distribute educational materials through faith-based organizations (Lead Organization: **ADA/ Governor's Council on Fitness**).
- Utilize public service announcements on physical activity (Lead Organization: **Governor's Council on Fitness**).
- Develop public transit ads promoting physical activity (Lead Organization: **Governor's Council on Fitness**).
- Write articles in Arkansas publications promoting physical activity (Lead Organization: **Governor's Council on Fitness**).

Target Population: Policy and Decision Makers

- Focus on pending legislation that is aimed at reducing employee health insurance premiums
- Promote walking clubs at work with employee incentives (Lead Organization: **Governor's Council on Fitness**).
- Support legislative efforts to make a state mandated requirement for daily P.E. class (Lead Organization: **Governor's Council on Fitness**).
- Implement mandatory physical education classes K-12 grade (Lead Organization: **ADA**).

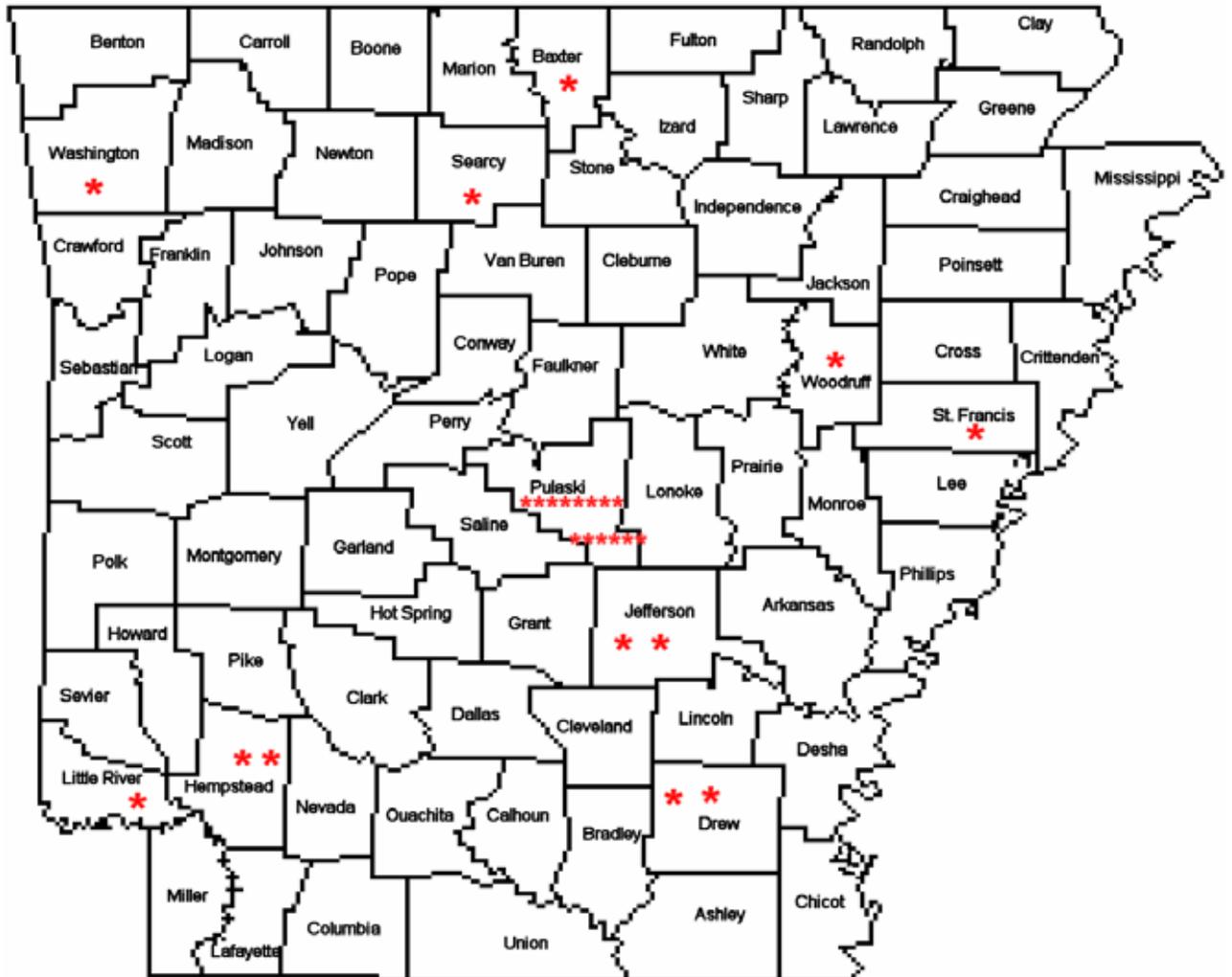
PARTNERSHIPS & LINKAGES for ALL GOALS

The organizations listed below represent the primary partners who participate in providing services related to diabetes in Arkansas. Without the cooperation and leadership of these organizations, the long-term goals with respect to diabetes education, control, and treatment could not be achieved.

American Diabetes Association
Arkansas Department of Health
Arkansas Diabetes Advisory Council
Arkansas Diabetes Prevention and Control Program
Arkansas Foundation for Medical Care
Arkansas Hospitals
Arkansas Wellness Coalition
Blue Cross Blue Shield of Arkansas
BRFSS
Centers for Disease Control
Civic groups
Department of Education
End Stage Renal Disease Registry
Governor's Council on Fitness
Healthy Aging Coalition ADH-CVH
Medicaid
Physician groups
SHARP
U.S. Bureau of Vital Statistics
Youth Risk Behaviors Survey

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1. Phillips, MM & Balamurugan, A (2002) The burden of diabetes in Arkansas. Little Rock, AR Diabetes Control Program, Arkansas Department of Health
2. www.cdc.gov



**This document was prepared by the Arkansas Diabetes Advisory Council
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