

Diabetes Surveillance in Arkansas

The Natural State

2007

Diabetes

The Burden of Diabetes in the Natural State*
2007

Arkansas Diabetes Prevention
&
Control Program

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Executive Summary

The Arkansas Diabetes Prevention and Control Program is funded by the Centers for Disease Control and Prevention to reduce and prevent the burden of diabetes in Arkansas. Information on the burden of diabetes in Arkansas is compiled and published every two years. This report is intended to describe the impact of diabetes in Arkansas for program managers, Diabetes Advisory Council members, policy makers, researchers, and other interested parties. The purpose of this information is to provide assistance in determining where interventions are needed.

Key findings of this report

- * The prevalence of diabetes in Arkansas has been at or above the national average for the years surveyed in this report. Diabetes prevalence in Arkansas rose from 6.2 percent in 2000 to 8.1 percent in 2005, a 29 percent increase.
- * An estimated 233,255 adult Arkansans had diabetes in 2005. Of those, 165,611 were diagnosed, but it remained undetected and untreated in the rest.
- * The prevalence of diabetes increases with age. The prevalence among persons over the age of 45 is more than five times greater than the prevalence found among younger persons.
- * The diabetes prevalence among Blacks (10.1%) is higher than among Whites (8.0%).
- * In 2005, 5,481 hospital discharges were reported among people with diabetes in Arkansas at an estimated cost of \$87 million.
- * In 2005, 651 lower extremity amputations and 1,565 hospitalizations for ketoacidosis were attributed to diabetes.
- * In 2005, 387 new cases of chronic end-stage renal disease and 314 deaths among persons receiving dialysis were attributed to diabetes.

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Diabetes Mellitus & Prevalence

Diabetes is a disease in which the body does not produce or properly use insulin. Insulin is a hormone that is needed to convert sugar, starches, and other food into energy needed for daily life. Diabetes can cause serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations. The cause of diabetes continues to be a mystery although both genetics and environmental factors such as obesity and lack of exercise appear to play roles.¹

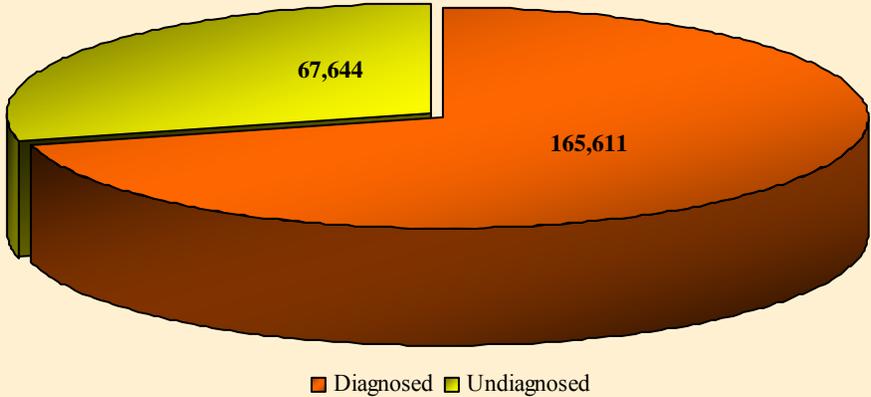
Types of Diabetes:

- ◆ **Type 1** – is due to failure of the body to produce insulin. Type 1 diabetes accounts for 5 to 10 percent of all diagnosed cases.
- ◆ **Type 2** – is due to insulin resistance combined with relative insulin deficiency. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases.
- ◆ **Gestational diabetes** – is the failure of the body to make and use all the insulin it needs for pregnancy. It occurs in 2 to 5 percent of all pregnant women.

An estimated 20.8 million Americans, or 7.0 percent of the U.S population, have diabetes. About two-thirds of these individuals, or 14.6 million, have been diagnosed with diabetes. The remaining 6.2 million people are unaware that they have diabetes.¹

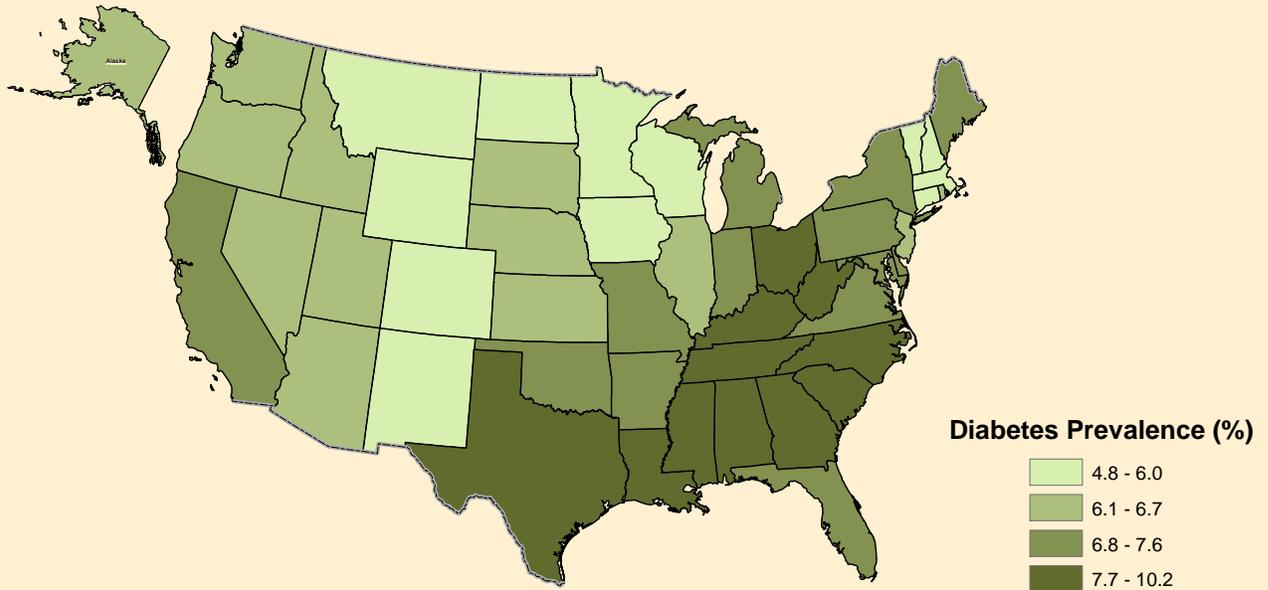
In 2005, diagnosed and undiagnosed diabetes directly affected 233,255 adults in our state (Figure 1). The number of adult (18 and older) Arkansans diagnosed with diabetes totaled 165,611. The number of adults that were living with diabetes but were undiagnosed accounted for one-third or 67,644 people.²

Figure 1. Estimated number of adult (18 and older) Arkansans that have diabetes, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

Figure 2. Diabetes Among Adults in the United States, 2004

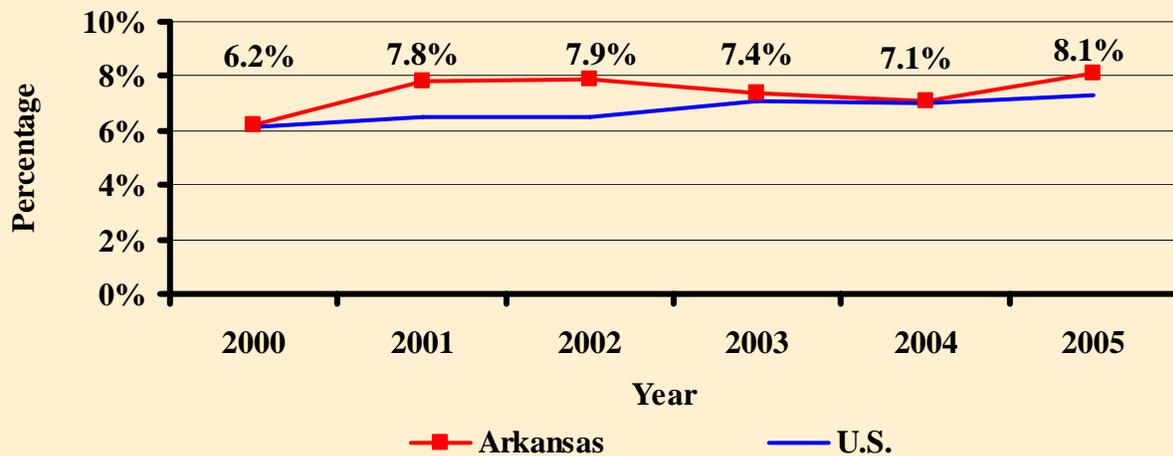


Source: Centers for Disease Control and Prevention, 2004
 *No data were available for Hawaii for 2004

According to the Centers for Disease Control and Prevention (CDC), in 2004 Arkansas had the 22nd highest prevalence of diabetes among adults in the U.S. (Figure 2).

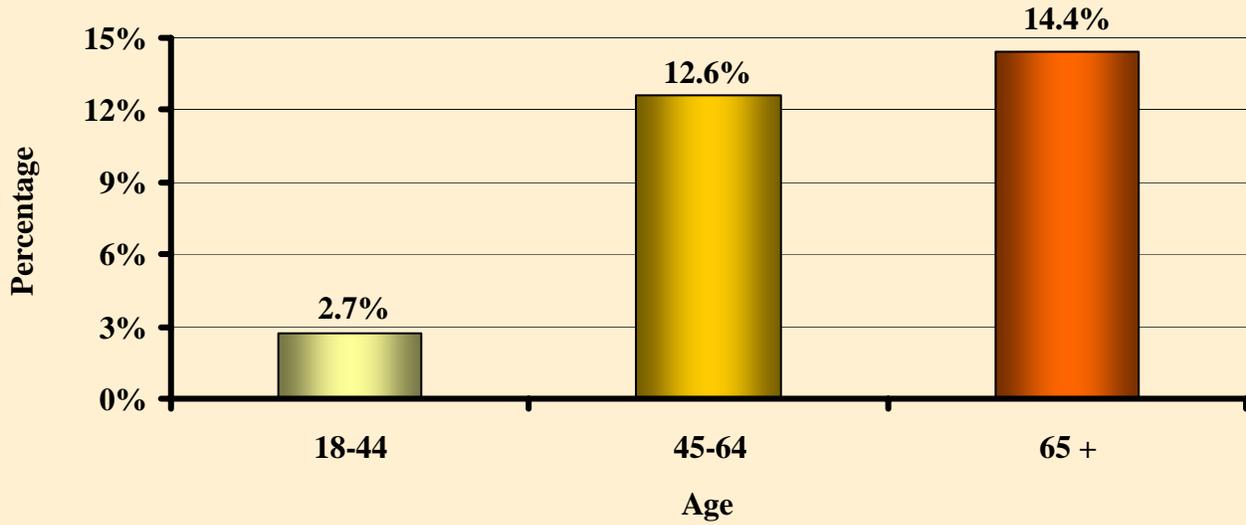
Diabetes prevalence in Arkansas rose from 6.2 percent in 2000 to 8.1 percent in 2005, a 29 percent increase. Diabetes prevalence in Arkansas has been at or above the national mean throughout this period (Figure 3).

Figure 3. Trends in self-reported diabetes prevalence in Arkansas and the United States, 2000-2005



Source: Behavior Risk Factor Surveillance Survey 2000-2005

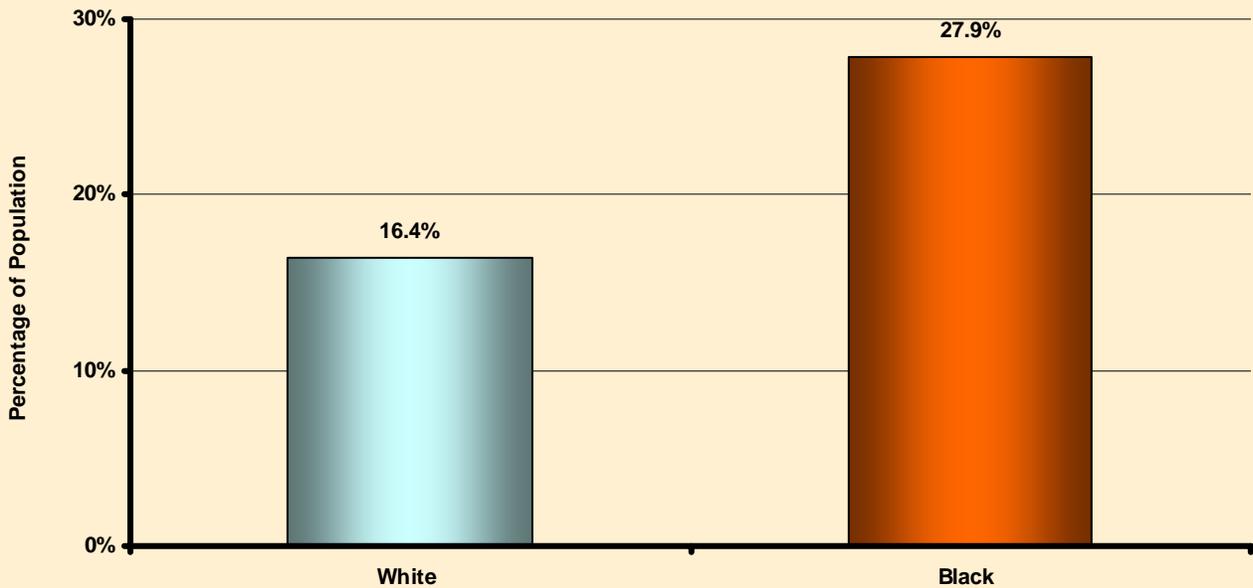
Figure 4. Percent of Arkansans with diabetes by specific age group, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

Like many other chronic diseases, diabetes can remain undetected for a long time before it is clinically diagnosed. Diabetes prevalence increases with age. The percentage of Arkansans in the 45-years and older age group that reported being diagnosed with diabetes was over 5-times greater than the 18-44 age group diagnosed with the disease (Figure 4).

Figure 5. Self-reported diabetes prevalence by race in Arkansas, 2005



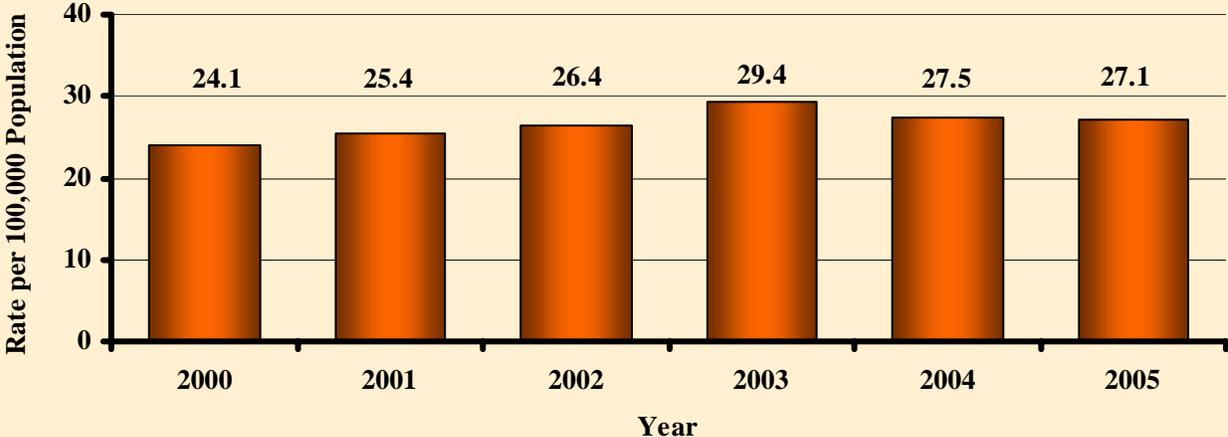
Source: Behavior Risk Factor Surveillance Survey 2005

Diabetes disproportionately affects minorities, primarily Blacks. The prevalence of diabetes among Blacks is 26 percent higher than the prevalence among Whites (Figure 5).

Mortality

Nationally, 224,092 deaths during 2002 were attributed to diabetes. The CDC reported that diabetes, in the same year, was the sixth leading cause of death listed on death certificates.¹ The age-adjusted diabetes mortality rate in Arkansas rose from 24.1 per 100,000 in 2000 to 27.1 per 100,000 in 2005 (Figure 6).

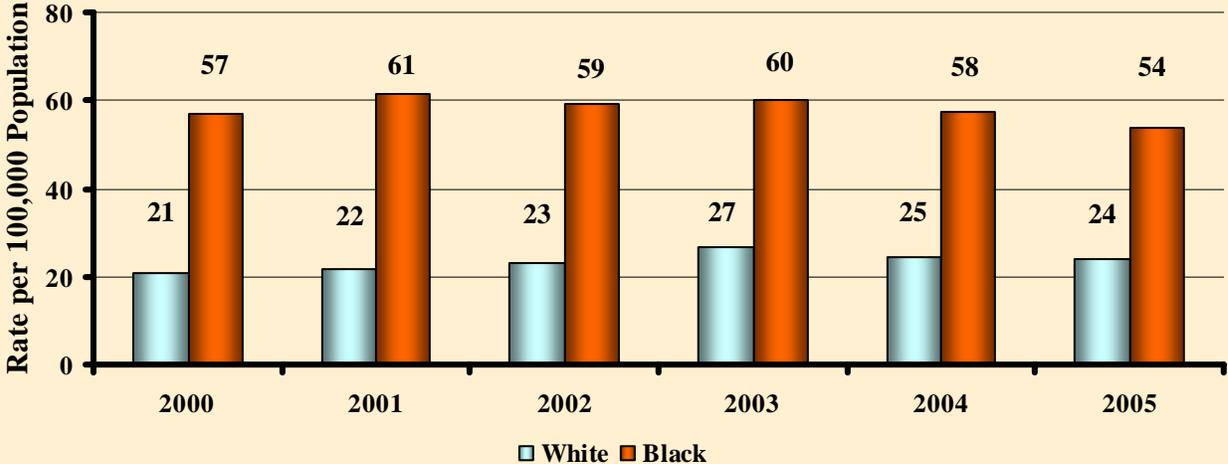
Figure 6. Age-adjusted diabetes mortality rate per 100,000 Arkansans, 2000-2005



Source: Arkansas Center for Health Statistics 2000-2005

Overall, people with diabetes are at twice the risk of dying than people of similar age that do not have diabetes.³ The diabetes mortality rate for Blacks is approximately two times higher than that for Whites (Figure 7).

Figure 7. Age-adjusted diabetes mortality rate per 100,000 Arkansans by race, 2000-2005

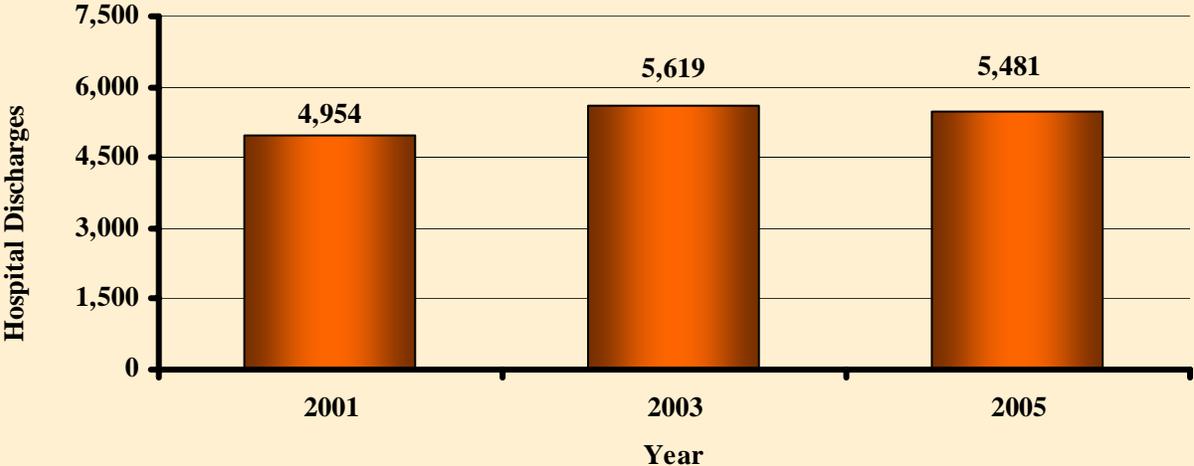


Source: Arkansas Center for Health Statistics 2000-2005

Hospitalizations

The Arkansas Hospital Discharge data system collects in-patient discharge information from all Arkansas hospitals. More than 5,400 hospital discharges with a primary diagnosis of diabetes were reported in 2005. For the years 2001 through 2005 the number of hospital discharges for Arkansans with the primary diagnosis of diabetes increased 11 percent (Figure 8).

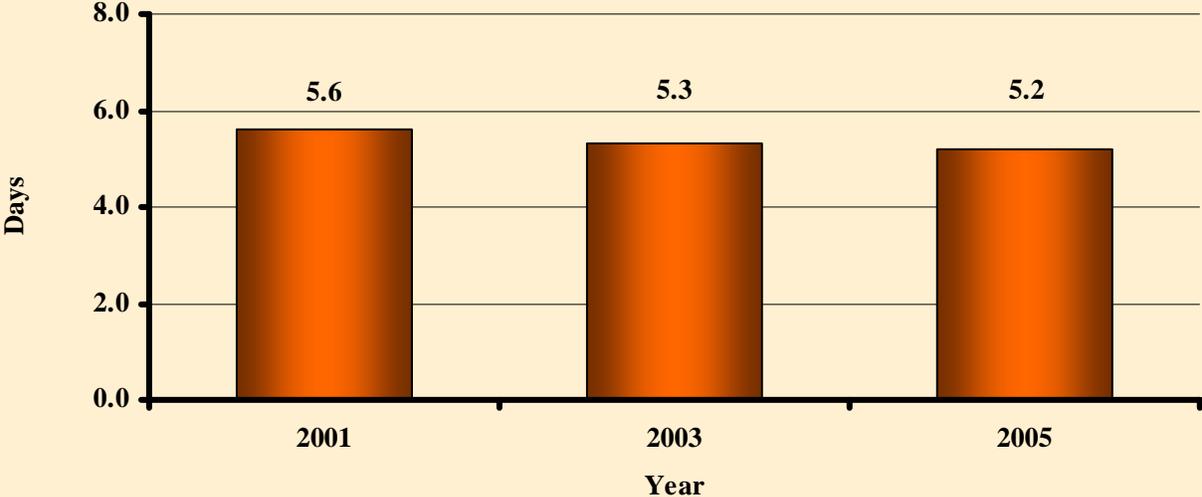
Figure 8. Number of hospital discharges for Arkansans with the primary diagnosis of diabetes, 2001-2005



Source: Arkansas Center for Health Statistics 2001-2005

The length of diabetes related hospital stays remained relatively stable at an average of 5.4 days during the period between 2001-2005 (Figure 9).

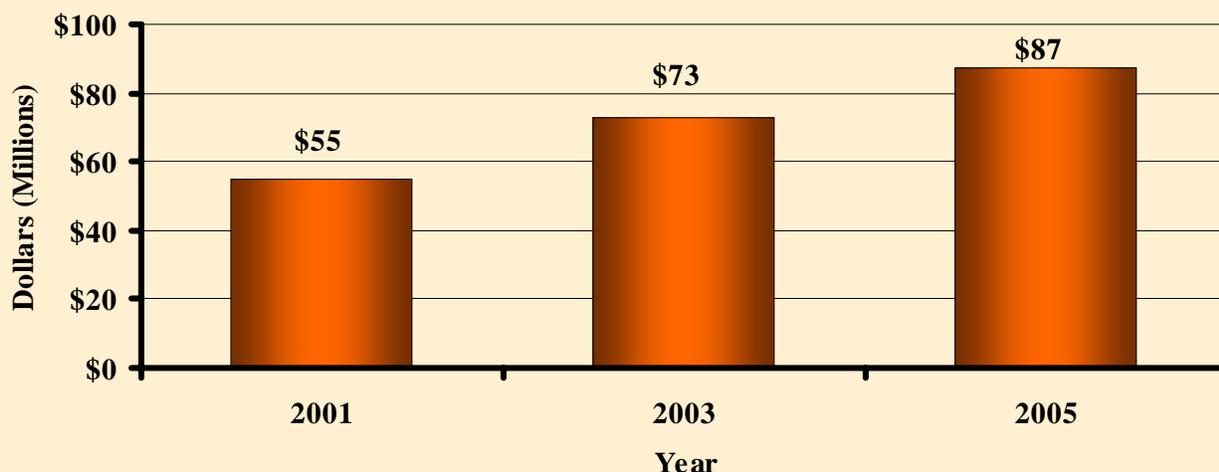
Figure 9. Average length of a hospital stay due to diabetes in Arkansas, 2001-2005



Source: Arkansas Center for Health Statistics 2001-2005

There has been a significant increase in total hospitalization charges due to diabetes in Arkansas. These charges increased from \$55 million in 2001 to \$87 million in 2005, a 58 percent increase (Figure 10). The costs due to diabetes include direct medical costs such as physician visits, hospitalizations, and pharmacy charges, as well as indirect costs, such as lost days of work, disability, and premature deaths. Data are not available to estimate the indirect costs. The direct medical costs due to hospitalizations are estimated from the Arkansas Hospital Discharge data system, although these estimates do not include outpatient costs.

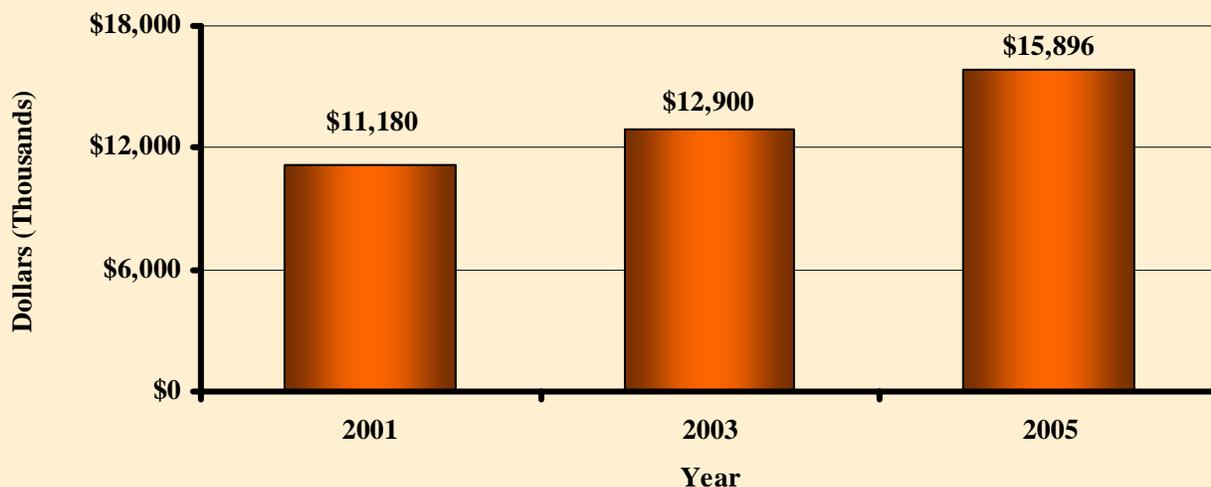
Figure 10. Total hospitalization charges in Arkansas due to diabetes, 2001-2005



Source: Arkansas Center for Health Statistics 2001-2005

Although the average length of stay for hospitalizations due to diabetes has remained relatively the same (5.4 days) that doesn't hold true for costs. Average hospitalization charge due to diabetes increased 42 percent from 2001 to 2005 (Figure 11).

Figure 11. Average charge for a hospitalization due to diabetes in Arkansas, 2001-2005

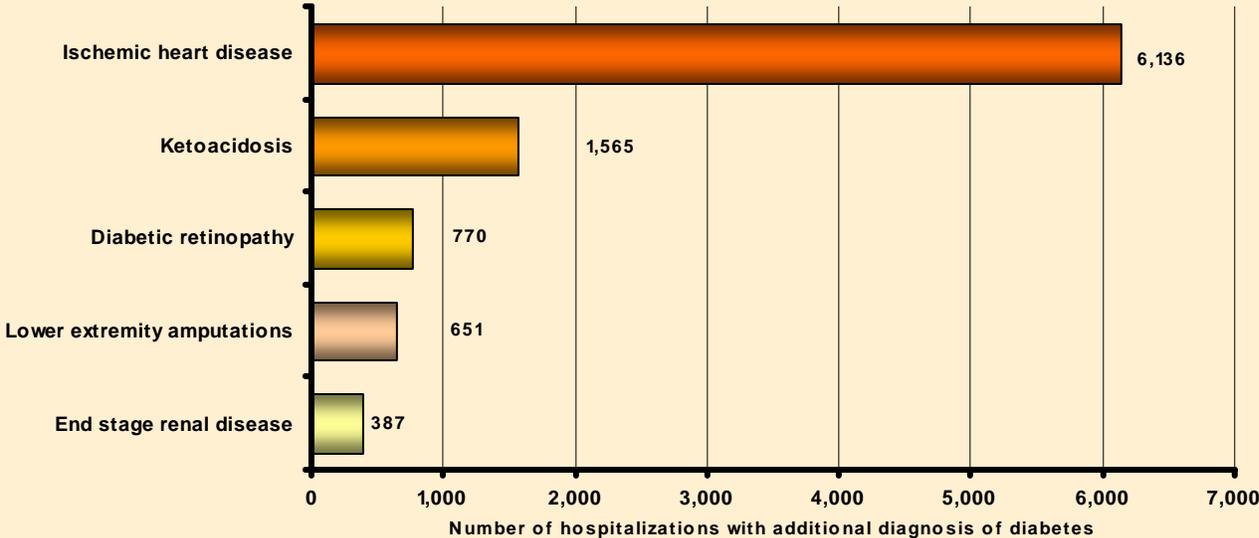


Source: Arkansas Center for Health Statistics 2001-2005

Complications

Diabetes can cause serious complications like heart disease, kidney disease, eye disease, foot problems, dental disease, pregnancy related complications and diabetic ketoacidosis.

Figure 12. Number of hospital discharges with additional diagnosis of diabetes in Arkansas, 2005



Source: Arkansas Center for Health Statistics 2005 & End Stage Renal Disease Network 13, Inc. 2005 Annual Report.

Ischemic Heart Disease (IHD) is a disease of the heart characterized by local and temporary deficiency of blood supply due to obstruction of circulation. In 2005, there were over 6,100 hospital discharges of people diagnosed with diabetes whose primary diagnoses was IHD.

Diabetic ketoacidosis is a condition in which high blood sugar levels along with a low level of insulin result in a dangerous accumulation of ketones, substances produced when the body breaks down fat for energy, in the blood and urine.¹ In 2005, there were 1,565 hospital discharges of people diagnosed with diabetes whose primary diagnoses was diabetic ketoacidosis.

Diabetic Retinopathy is a progressive damage to the blood vessels of the retina caused by long-term diabetes. A total of 770 hospital discharges listing diabetic retinopathy as any diagnosis were reported in Arkansas during 2005.

There were 651 **lower extremity amputations** reported in Arkansas during 2005 among people with diabetes.

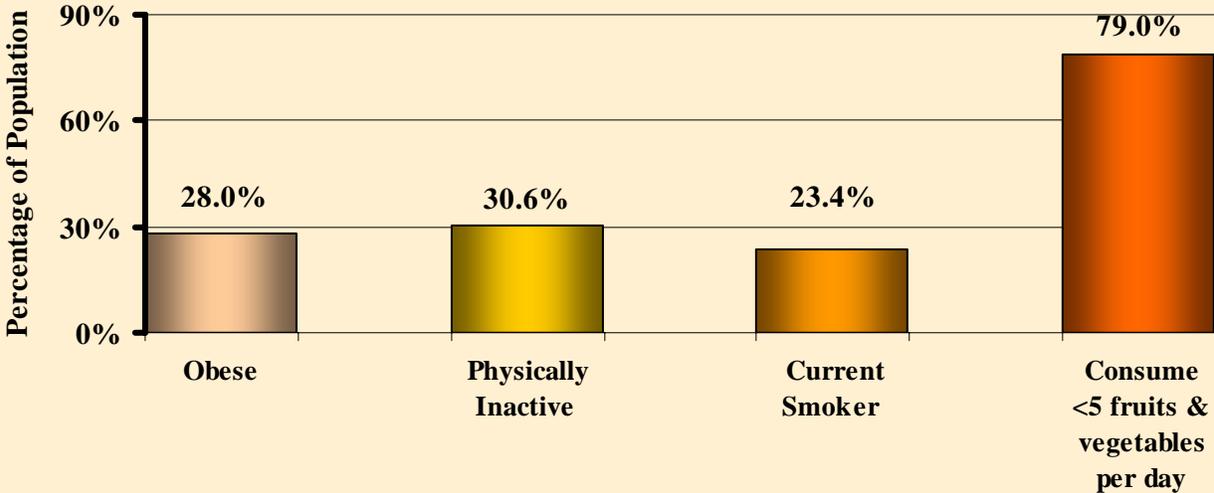
End-stage renal disease is kidney failure requiring dialysis or a transplant to survive.^{1,4} In 2005, among people with diabetes there were 387 new cases of chronic end-stage renal disease and 314 dialysis-related deaths.

Good glucose control has been shown to prevent many of these complications.⁵

Risk Factors

The risk factors associated with a person developing diabetes can be classified as either modifiable risk factors such as obesity and physical inactivity or non-modifiable risk factors such as age, race, and family history of diabetes.⁶ The Diabetes Prevention Program, a large prevention study of people at high risk for diabetes, showed that the risk of developing diabetes could be reduced by 58 percent over 3-years by following recommended lifestyle modifications.⁷

Figure 13. Prevalence of self-reported diabetes risk factors in adult Arkansans, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

Obesity is a label for a weight category that is greater than what is generally considered healthy for a given height. A screening tool often used to assess ones weight category is the Body Mass Index (BMI). A BMI equal to or greater than 30 is considered obese. Obesity increases the risk for many diseases including diabetes. Approximately one fourth of adults in Arkansas are classified as obese based on self-reported height and weight (Figure 13).

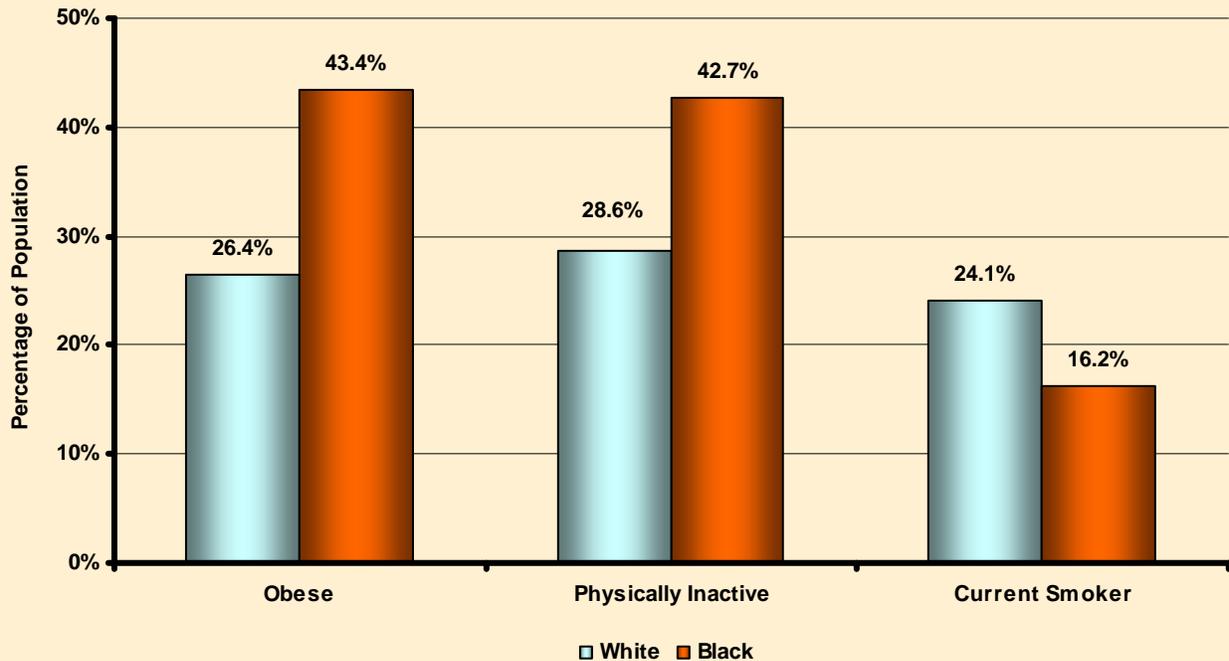
Regular physical activity lowers the risk of developing diabetes.⁵ Nearly 1 in 3 Arkansans report they are physically inactive (Figure 13). According to the 2005 Behavior Risk Factor Surveillance Survey, 43 percent of adults with diabetes report they are inactive.

People with diabetes need to be particularly concerned about the effects smoking has on their health. Smoking elevates one’s blood pressure, increasing risk of heart disease and complications associated with diabetes. Approximately 3 out of 4 adults with diabetes in the U.S. have high blood pressure or use prescription medications to reduce high blood pressure.³ Approximately a quarter of the adult population in Arkansas are current smokers (Figure 13).

Only 21 percent of adult Arkansans report consuming the recommended five servings of fruits and vegetables a day (Figure 13). Healthy eating helps keep blood glucose in the target range.

Major differences exist in the prevalence of risk factors for type 2 diabetes between race/ethnic groups as illustrated in Figure 14.

Figure 14. Prevalence of self-reported risk factors in adult Arkansans by race, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

Obesity (BMI ≥ 30) is a risk factor for many diseases including diabetes. Self-reported obesity among Blacks is 39 percent higher than among Whites and 35 percent higher than obesity among the Hispanic adult population (Figure 14).

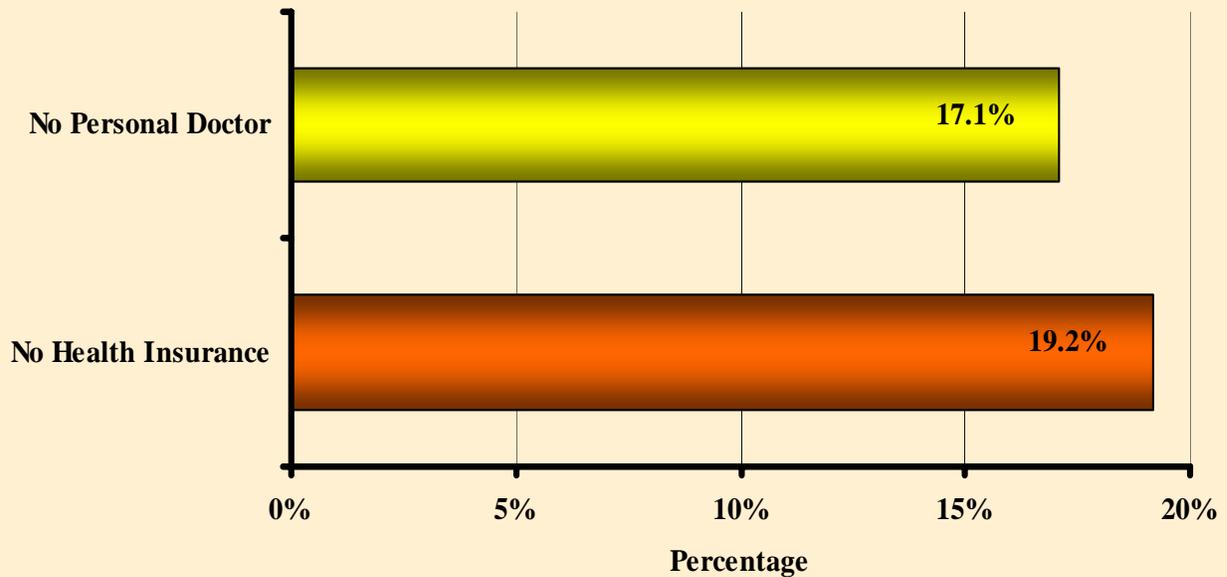
CDC states that millions of Americans suffer from illnesses, such as diabetes, that can be prevented or improved through moderate physical activity (30 minutes a day, 5 days a week).⁸ A higher percentage (42.7%) of adult Blacks report they are physically inactive (Figure 14).

Smoking increases risk of heart disease and complications associated with diabetes. The self-reported proportion of current smokers is higher for Whites (24.1%) than Blacks (16.2%).

Access to Health Care

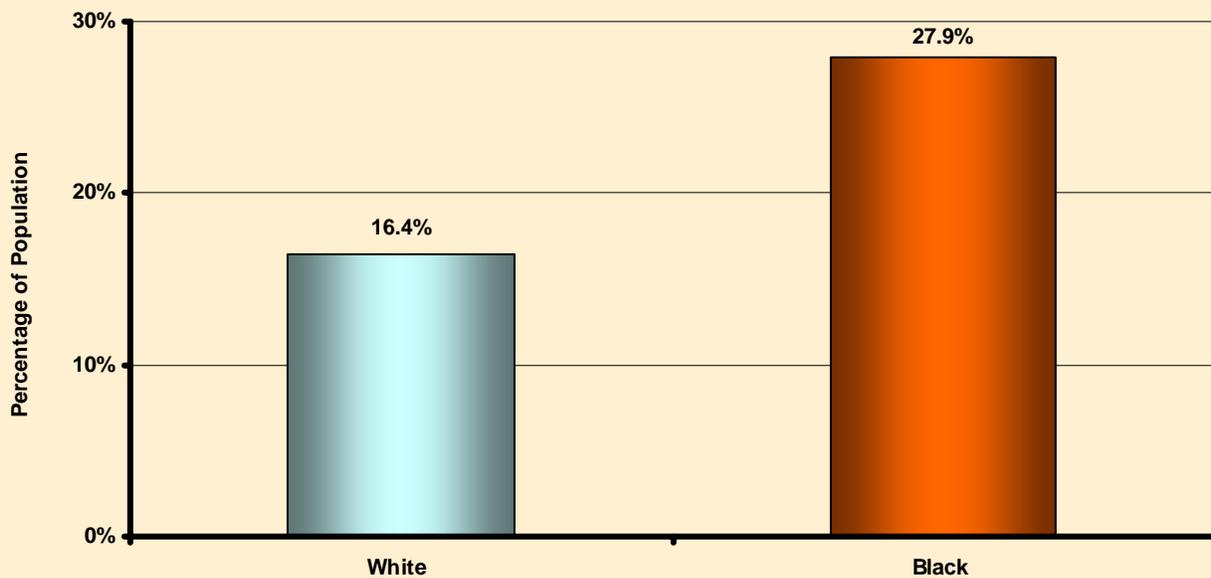
Lack of health care access is a problem faced by many Arkansans with diabetes. Uninsured and under insured adults with diabetes are less likely to receive needed care and preventive health services.⁹ Approximately 1 in 5 Arkansans are without health care coverage (Figure 15). Lack of health care coverage is greater among minority populations in the state (Figure 16).

Figure 15. Percent of Arkansans that reported not having health coverage and/or a personal doctor, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

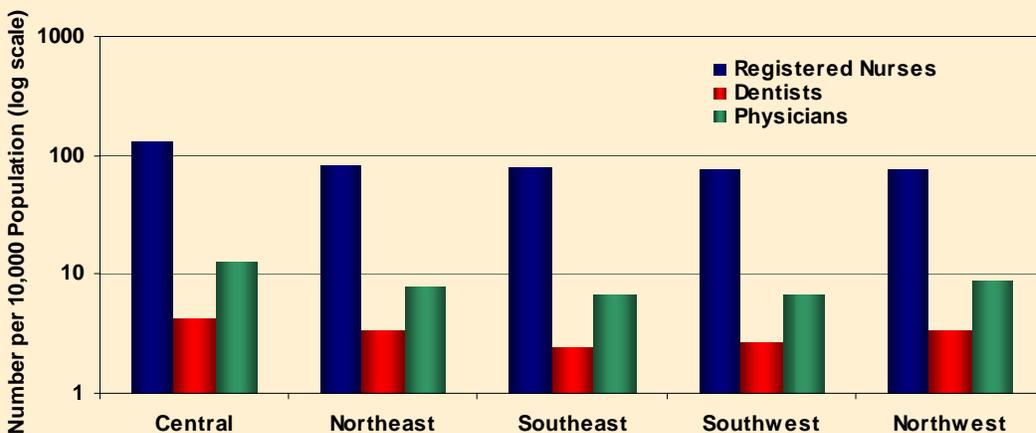
Figure 16. Percent of Arkansans, by race, that reported not having health insurance, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

More than half of the state's population live in areas designated as Medically Underserved Areas (MUAs). The number of health care professionals by the state's Public Health Regions can be seen in Figure 17.

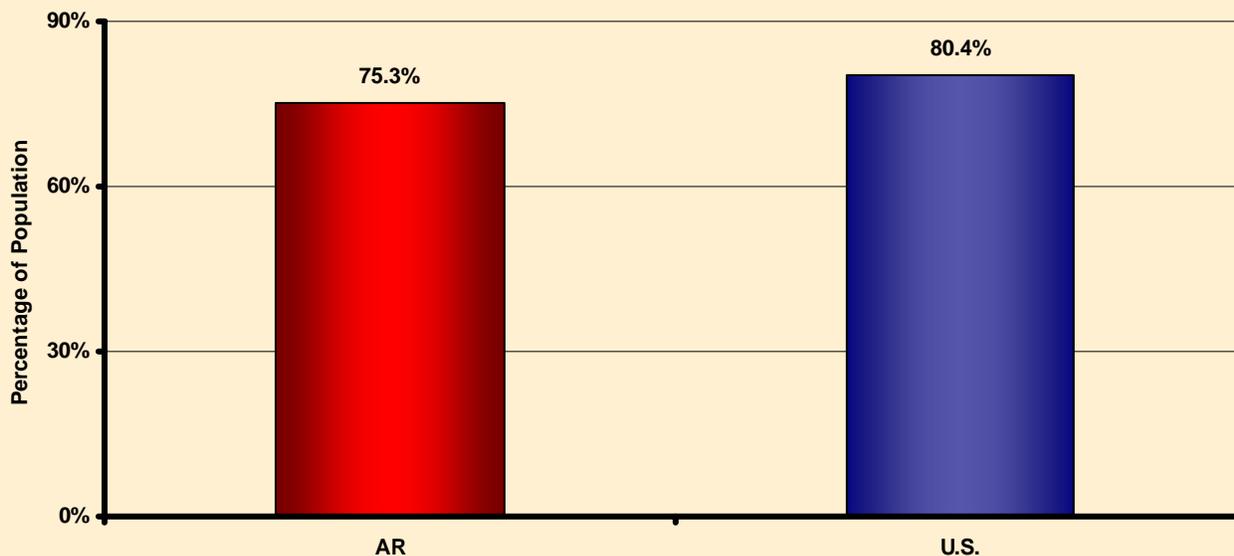
Figure 17. Number of health care professionals per 10,000 population by Arkansas Public Health Region, 2004



Source: Arkansas Center for Health Statistics 2004

Financial barriers can limit access to health care.⁵ Socioeconomic status is determined to a large extent by income and educational level. Income is closely linked to educational level. As the education level increases earning potential increases. Arkansas (75.3) is below the National level (80.4%) for high school graduates and G.E.D. recipients (Figure 18).

Figure 18. Educational attainment for population 25 years and over, 2000

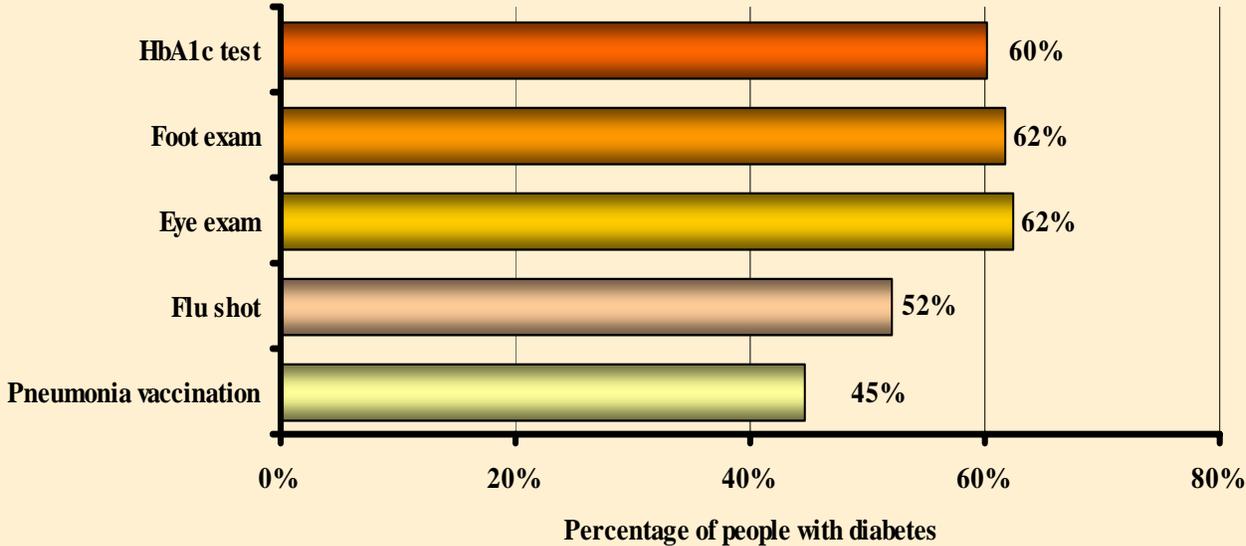


Source: U.S. Census Bureau, 2000

Preventive Care Practices

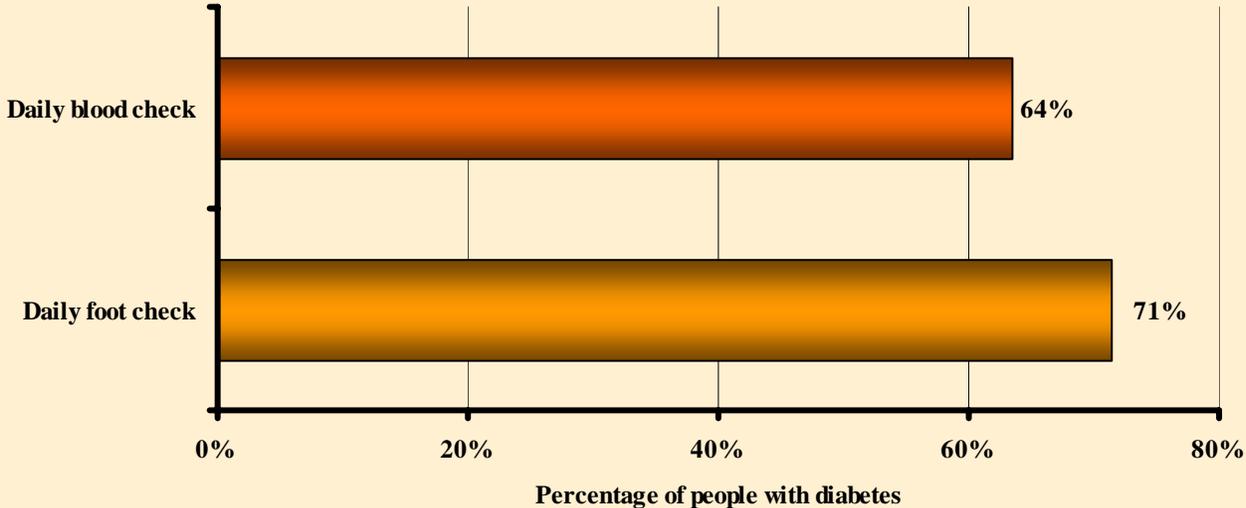
The Centers for Disease Control and Prevention and the American Diabetes Association have set national objectives for preventive care practices among people with diabetes. Following the recommended guidelines, which address receiving annual eye exams, foot exams, HbA1c checks, and flu and pneumonia vaccinations, has been shown to reduce the costs associated with complications of diabetes and also improves the quality of life among people with diabetes.¹

Figure 19. Percentage of adult Arkansans with self-reported diabetes that also report having received preventive care services from a Physician, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

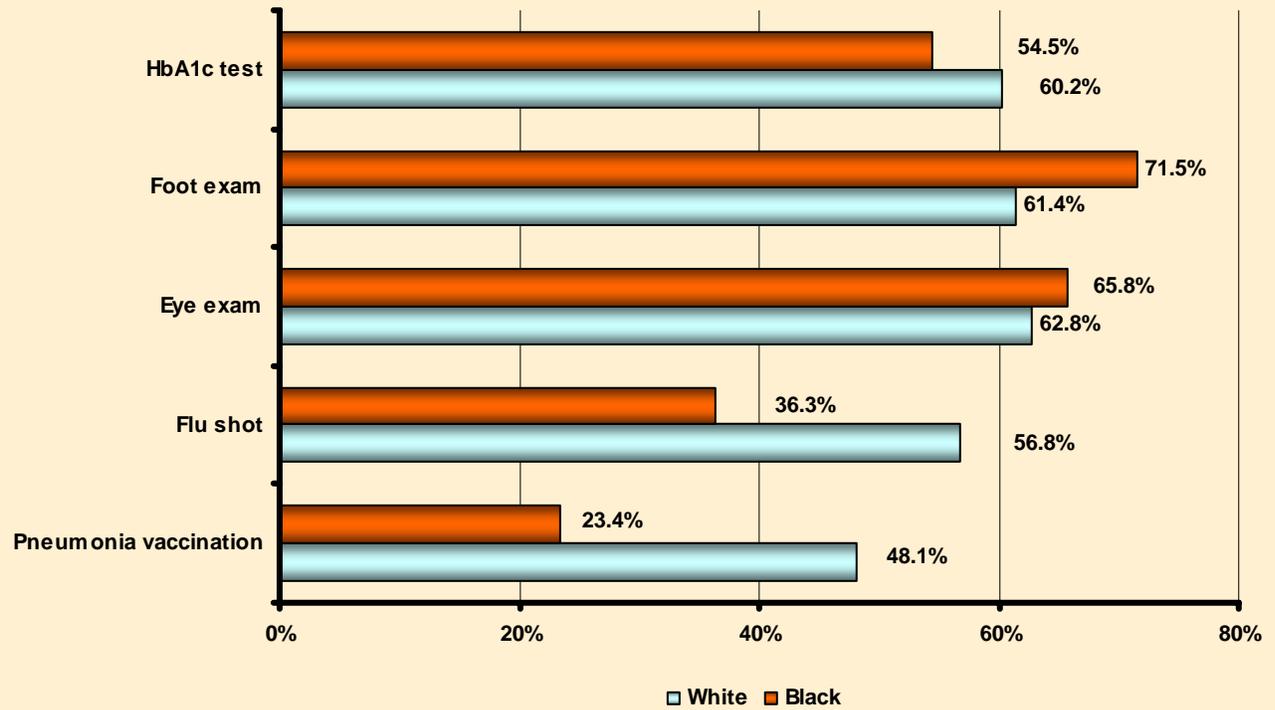
Figure 20. Percentage of adult Arkansans with self-reported diabetes that also report performing self-care activities, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

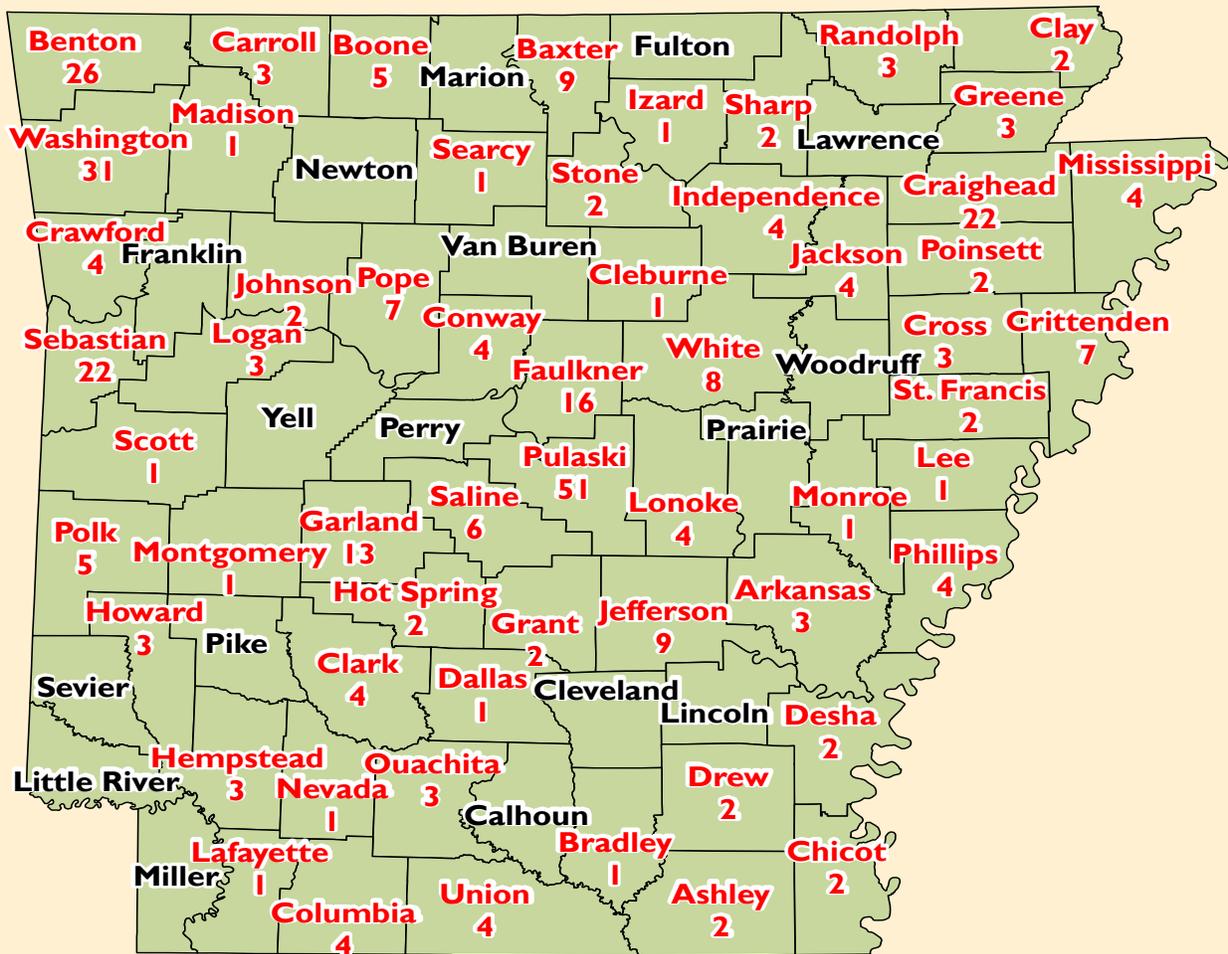
The 2005 Behavioral Risk Factor Surveillance reflected racial differences in preventive care practices among people with diabetes (Figure 21).

Figure 21. Percentage of adult Arkansans with diabetes, by race, that reported having received preventive and self-care activities, 2005



Source: Behavior Risk Factor Surveillance Survey 2005

Map 2. Distribution of Optometrists in Arkansas, 2006



Source: Arkansas Center for Health Statistics 2006

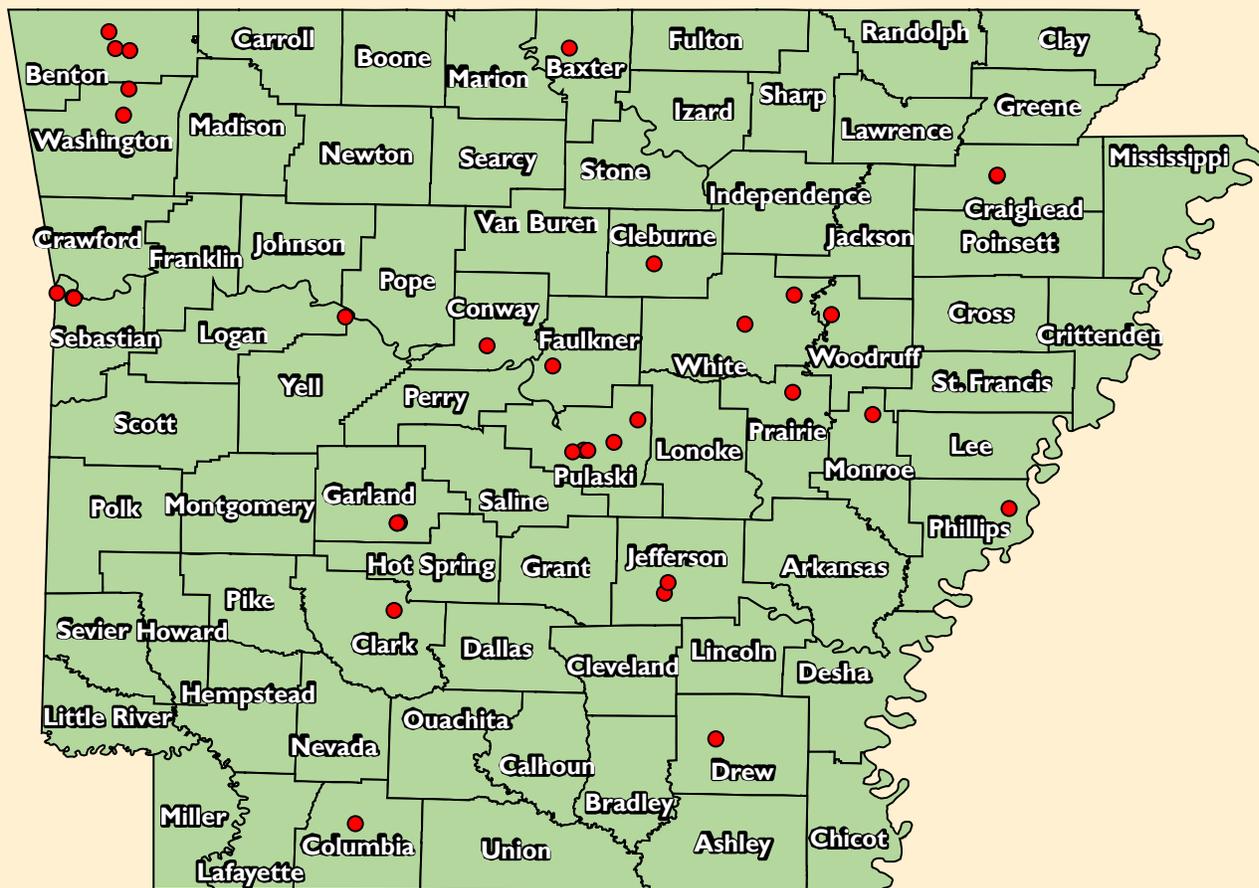
In 2006, Arkansas had a reported 341 Optometrists across 58 counties (in red).

Optometrists:

- * Examine people's eyes to diagnose vision problems and eye diseases and develop treatment plans,
- * Prescribe eyeglasses and contact lenses and provide vision therapy and low-vision rehabilitation,
- * Administer drugs to patients to aid in the diagnosis of vision problems and prescribe drugs to treat some eye diseases, and
- * Diagnose conditions caused by systemic diseases such as diabetes and high blood pressure.¹²

The American Diabetes Association recommends that people with diabetes see an eye care professional at least once a year for a dilated eye exam.¹¹

Map 3. American Diabetes Association (ADA) – Recognized Education Program Sites In Arkansas, 2007



Source: American Diabetes Association 2006

The ADA’s Education Recognition Program certifies diabetes self-management education (DSME) programs that meet National Standards. The National Standards for DSME identifies the essential qualities in diabetes education to facilitate improvement in health care outcomes among people with diabetes. For a list of ADA certified locations see page 23 of this document.

The Arkansas Diabetes Prevention and Control Program along with its advisory council members are working together to establish ADA - recognized programs in all Arkansas counties. Currently, there are 33 recognized DSME programs across 20 counties of the state.

American Diabetes Association – Recognized Education Programs Sites In Arkansas, 2006

Program Name	Address	City
Diabetes Self-Management Education Program	3002 West Pine St.	Arkadelphia
White River Rural Health Center Diabetes Self-Management Center	623 North 9 th	Augusta
White River Rural Health Center Diabetes Self-Management Center	2802 Highway 367 N.	Bald Knob
Hidden Springs Diagnostic Clinic	3000 N.W. "A"	Bentonville
Northwest Medical Center of Benton County	2900 Medical Center Pkwy	Bentonville
White River Rural Health Center Diabetes Self-Management Center	615 North Main	Brinkley
Diabetes Self-Management Education Program	2302 College Ave.	Conway
White River Rural Health Center Diabetes Self-Management Center	405 Highway 11 N.	Des Arc
Diabetes Education Program	1125 North College Ave.	Fayetteville
Cooper Clinic Diabetes Education Program	6801 Rogers Ave.	Fort Smith
Sparks Diabetes Self-Management Program	1311 South I St.	Fort Smith
Diabetes Education Program	7301 Rogers Ave.	Fort Smith
Diabetes Self-Management Education Program	2319 Highway 110 W.	Heber Springs
Delta AHEC Diabetes Education Clinic	1393 Highway 242 S.	Helena-West Helena
Diabetes Self-Management Education Program	300 Werner St.	Hot Springs
Hot Springs Diabetes Education Program	1636 Higdon Ferry Rd.	Hot Springs
Rebsamen Diabetes Self-Management Program	1400 Braden St	Jacksonville
St. Bernard's Outpatient Diabetes Self-Management Training Program	225 East Jackson Ave.	Jonesboro
Clopton Clinic Diabetes Education Center	300 Carson St.	Jonesboro
St. Vincent Diabetes Self-Management Education Program	#1 St. Vincent Circle	Little Rock
AR Diabetes Self-Management Education Program	4301 W. Markham	Little Rock
Diabetes Self-Management Program	9601 Interstate 630, Exit 7	Little Rock
Diabetes Self-Management Education Program	101 Hospital Dr.	Magnolia
Diabetes Self-Management Education Program	778 Scogin Dr.	Monticello
St. Anthony's DSME Program	#4 Hospital Dr.	Morrilton
The Keppell Diabetes Learning Center	624 Hospital Dr.	Mountain Home
Diabetes Health Management Center	3333 Springhill Dr.	North Little Rock
Life Check	1515 West 42nd Ave	Pine Bluff
Diabetes Self-Management Education Program	201 S. Main St	Pine Bluff
Diabetes Self-Management Program	1200 West Walnut	Rogers
Diabetes Self-Management Education Program	809 West Main St.	Russellville
Diabetes Self-Management Center	3214 East Race	Searcy
Northwest Medical Center of Washington County	601 W. Maple Ave.	Springdale

Source: American Diabetes Association 2007

Arkansas Demographics

Arkansas, the Natural State, is home to 2.8 million citizens. Arkansas is blessed with an abundance of clean air, clean water, and a great outdoors.

Some general information about Arkansas:

The following facts were obtained from the U.S. Census Bureau: State and County QuickFacts,¹³ 2005 population estimates:

◆ Total population	2,779,154
Females	51.0%
Males	49.0%
◆ Age distribution	
Persons under 18 years	24.3%
Persons 18-64 years	61.9%
Persons 65 years and over	13.8%
◆ Racial/Ethnic distribution*	
White non-Hispanic	81.3%
Black non-Hispanic	15.7%
Hispanic	4.7%
Asian	1.0%
American Indian and Alaskan native	0.7%
Native Hawaiian and Pacific Islander	0.1%
◆ Median household income (2003)	\$33,445
◆ Persons below poverty (2003)	16.0%

* Values may exceed 100 percent because Hispanics may be of any race, so also are included in applicable race categories.

Healthy People 2010 Objectives

1. Increase the proportion of persons with diabetes who receive formal diabetes education from 45 percent to 60 percent.
2. Prevent Diabetes. Decrease new cases of diabetes from 3.5 cases per 1,000 population to 2.5 cases per 1,000 population.
3. Reduce the overall rate of diabetes that is clinically diagnosed from 40 cases per 1,000 population to 25 cases per 1,000 population.
4. Increase the proportion of adults with diabetes whose condition has been diagnosed from 68 percent to 80 percent.
5. Reduce the diabetes death rate from 75 deaths per 100,000 population to 45 deaths per 100,000 population.
6. Reduce diabetes-related deaths among persons with diabetes from 8.8 deaths per 1,000 people with diabetes to 7.8 deaths per 1,000 people with diabetes.
7. Reduce deaths from cardiovascular disease in persons with diabetes from 343 deaths from cardiovascular disease per 100,000 persons with diabetes to 309 deaths per 100,000 persons with diabetes.
8. (Developmental) Decrease the proportion of pregnant women with gestational diabetes.
9. (Developmental) Reduce the frequency of foot ulcers in persons with diabetes.
10. Reduce the rate of lower extremity amputations in persons with diabetes from 4.1 lower extremity amputations per 1,000 persons with diabetes to 1.8 lower extremity amputations per 1,000 persons with diabetes per year.
11. (Developmental) Increase the proportion of persons with diabetes who obtain an annual urinary microalbumin measurement.
12. Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year from 24 percent to 50 percent.
13. Increase the proportion of adults with diabetes who have an annual dilated eye examination from 47 percent to 75 percent.
14. Increase the proportion of adults with diabetes who have at least an annual foot examination from 55 percent to 75 percent.
15. Increase the proportion of persons with diabetes who have at least an annual dental examination from 58 percent to 75 percent.
16. Increase the proportion of adults with diabetes who take aspirin at least 15 times per month from 20 percent to 30 percent.
17. Increase the proportion of adults with diabetes who perform self-blood-glucose-monitoring at least once daily from 42 percent to 60 percent.

Diabetes Management Schedule*

People with diabetes should receive medical care from a physician-coordinated team of health care professionals. Referrals to these team members should be made as appropriate.

At each regular diabetes visit:

- Measure weight and blood pressure.
- Inspect feet.
- Review self-monitoring glucose record.
- Review/adjust medications to control glucose, lipids, and blood pressure — include regular use of aspirin for CVD prevention.
- Review self-management skills, dietary needs, and physical activity.
- Assess for depression or other mood disorder.
- Counsel on smoking cessation and alcohol use.

Quarterly:

- Obtain A1C in patients whose therapy has changed or who are not meeting glycemic goals (twice a year if at goal with stable glycemia).

Annually:

- Obtain fasting lipid profile (every 2 years if at goal).
- Obtain serum creatinine and estimate glomerular filtration rate.
- Perform urine test for albumin-to-creatinine ratio in patients with type 1 diabetes ≥ 5 years and in all patients with type 2 diabetes.
- Refer for dilated eye exam (if normal, an eye care specialist may advise an exam every 2-3 years).
- Perform comprehensive foot exam.
- Refer for dental/oral exam at least once a year.
- Administer influenza vaccination.
- Review need for other preventive care or treatment.

Lifetime:

- Administer pneumococcal vaccination (repeat if over 64 or immunocompromised and last vaccination was more than 5 years ago).

*Source: National Diabetes Education Program.¹⁴ NIH Publication No. NDEP-12. Revised February 2003. Retrieved March 5, 2007 from http://www.ndep.nih.gov/diabetes/pubs/NumAtGlance_Eng.pdf

Glossary

Age-adjusted rate: A rate calculated in a manner that allows for the comparison of populations with different age structures.

Insufficient physical activity: Not participating in at least 20 minutes of vigorous physical activity on three or more of the past seven days and did not do at least 30 minutes of moderate physical activity on five or more of the past seven days.

Ischemic Heart Disease: Disease of the heart characterized by local and temporary deficiency of blood supply due to obstruction of circulation.

Prevalence: The percent (proportion) of a population that has a disease or a risk factor at a given point in time.

Risk factor: A characteristic or behavior that is consistently associated with increased probability of disease or event.

BMI: A surrogate measure of body fatness expressed as weight (measured in kilograms) divided by height (measured in meters) squared.

Normal weight: Neither overweight nor obese (BMI < 25.0 but more than 18.5).

Overweight: BMI greater than or equal to 25.0 but less than 30.0.

Obese: BMI greater than or equal to 30.0.

Mortality rate: Death rate.

No physical activity: People who reported not being involved in any kind of physical activity or exercise in the past 30 days besides their regular job.

Limitations of the data presented in the report

Findings based on the Behavior Risk Factor Surveillance System (BRFSS) survey are subject to limitations. The BRFSS does not sample persons less than 18 years old, thus the findings might underestimate the true prevalence in Arkansas. The BRFSS relies on information reported directly by the respondent. As such, this self-reported data may be subject to errors. Hospital discharge data used in this report does not include out-of-state hospitalizations.

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Appendix: Summary Tables

Table 1. Arkansas self-reported diabetes prevalence estimates by age group, 2005

Age Group	18-44	45-64	65+
Weighted Frequency	26,981	81,858	56,772
Unweighted Frequency	54	270	203
Percent Population	2.7	12.6	14.4
95% Confidence Interval	1.8-3.5	11.0-14.2	12.4-16.5

Table 2. Arkansas self-reported diabetes prevalence estimates by race, 2005

Race	White	Black
Weighted Frequency	137,039	17,091
Unweighted Frequency	433	61
Percent Population	8.0	10.1
95% Confidence Interval	7.1-8.8	7.2-13.0

Table 3. Prevalence of self-reported obese adult Arkansans by race, 2005

Race	White	Black
Weighted Frequency	438,441	69,114
Unweighted Frequency	1,135	200
Percent Population	26.4	43.4
95% Confidence Interval	24.8-28.0	37.4-49.4

Table 4. Prevalence of self-reported physically inactive adult Arkansans by race, 2005

Race	White	Black
Weighted Frequency	492,234	72,115
Unweighted Frequency	1,385	194
Percent Population	28.6	42.7
95% Confidence Interval	27.0-30.2	36.8-48.7

Table 5. Arkansans, by race, that reported not having health insurance, 2005

Race	White	Black
Weighted Frequency	281,686	46,978
Unweighted Frequency	596	106
Percent Population	16.4	27.9
95% Confidence Interval	15.0-17.9	22.4-33.4

Table 6. Adult Arkansans with diabetes, by race, that reported having received preventive and self-care activities, 2005

HbA1c test	White	Black
Weighted Frequency	75,546	8,919
Unweighted Frequency	242	34
Percent Population	60.2	54.5
95% Confidence Interval	54.5-65.9	39.3-69.8
Foot Exam	White	Black
Weighted Frequency	82,865	11,829
Unweighted Frequency	262	42
Percent Population	61.4	71.5
95% Confidence Interval	56.1-66.8	58.1-85.0
Eye exam	White	Black
Weighted Frequency	84,217	11,101
Unweighted Frequency	276	39
Percent Population	62.8	65.8
95% Confidence Interval	57.5-68.1	51.9-79.6
Flu shot	White	Black
Weighted Frequency	77,882	6,202
Unweighted Frequency	245	24
Percent Population	56.8	36.3
95% Confidence Interval	51.4-62.2	22.1-50.5
Pneumonia vaccination	White	Black
Weighted Frequency	62,562	3,630
Unweighted Frequency	210	16
Percent Population	48.1	23.4
95% Confidence Interval	42.6-53.6	12.0-34.7