Diabetes in the District

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District of Columbia Department of Health
Community Health Administration
Bureau of Cancer and Chronic Disease
**U.S. Prevalence Of Obesity Among Adults**
**BRFSS, 1985**

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

By 1985, the National OBESITY rate did not exceed 15% in any State.

Source: Centers for Disease Prevention and Control
By 2010, the National OBESITY rate exceeded 20% in all States.

Source: Centers for Disease Prevention and Control
District of Columbia
Adult Obesity Statistics
Percent of adults (age 18+) who are obese (BMI >30)

% Female 24.9
% Male 20.6

RACE/Ethnicity
% White 9.8
% Black 36.4
% Hispanic 15.3
% Multiracial 16.7

Trend
% 2013* 22.9
% 2012* 21.9
% 2011* 23.8
% 2010 22.4
% 2009 20.1
% 2008 22.3

* Data prior to 2011 is not directly comparable to previous years of BRFSS data because of the changes in weighting methodology and the addition of the cell phone sampling frame.
District of Columbia

Adult Overweight Statistics
Percent of adults (age 18+) who are overweight (BMI 25.0-29.9)

% Female
24.3

% Male
38.0

RACE/Ethnicity

% White
29.9
% Black
31.4
% Hispanic
39.1
% Multiracial
38.4

Trend

% 2013*
30.9
% 2012*
30.0
% 2011*
29.1
% 2010
33.8
% 2009
31.6
% 2008
32.8

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District of Columbia
Adult Diabetes Statistics
Percent of adults (age 18+) ever told by health professional that they have diabetes

2013

Gender

<table>
<thead>
<tr>
<th>2013</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.5%</td>
<td>7.1%</td>
</tr>
<tr>
<td>2013</td>
<td>8.5%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Race/Ethnicity

<table>
<thead>
<tr>
<th>Ward 1</th>
<th>Ward 2</th>
<th>Ward 3</th>
<th>Ward 4</th>
<th>Ward 5</th>
<th>Ward 6</th>
<th>Ward 7</th>
<th>Ward 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>7.8%</td>
<td>9.1%</td>
<td>8.2%</td>
<td>7.8%</td>
<td>9.7%</td>
<td>9.7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>White</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Black</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Other</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Trend DC

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District of Columbia
Adult Diabetes Statistics
Percent of adults (age 18+) ever told by health professional that they have diabetes

2013

Gender

<table>
<thead>
<tr>
<th>Ward</th>
<th>Overall</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 1</td>
<td>8.4%</td>
<td>8.9%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Race/Ethnicity

<table>
<thead>
<tr>
<th>Ward</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 2</td>
<td>2.8%</td>
<td>14.6%</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

Trend DC

<table>
<thead>
<tr>
<th>Year</th>
<th>USA</th>
<th>DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>9.5</td>
<td>9.1</td>
</tr>
<tr>
<td>2012</td>
<td>9.7</td>
<td>8.2</td>
</tr>
<tr>
<td>2013</td>
<td>9.7</td>
<td>7.8</td>
</tr>
<tr>
<td>2014</td>
<td>9.7</td>
<td>8.4</td>
</tr>
</tbody>
</table>

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### District of Columbia

**Adult Diabetes Statistics**

Percent of adults (age 18+) ever told by health professional that they have diabetes

<table>
<thead>
<tr>
<th>Prevalence by Age Distribution</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons 45 - 54 years</td>
<td>11.5%</td>
</tr>
<tr>
<td>Persons 55- 64 years</td>
<td>18.6%</td>
</tr>
<tr>
<td>Persons 65 years +</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

### Prevalence by Income Groups

<table>
<thead>
<tr>
<th>Income Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>-15K</td>
<td>14.0%</td>
</tr>
<tr>
<td>15k-25K</td>
<td>12.4%</td>
</tr>
<tr>
<td>25k-35K</td>
<td>16.2%</td>
</tr>
<tr>
<td>35k-50K</td>
<td>8.5%</td>
</tr>
<tr>
<td>+50K</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

State Level Strategies for Prevention

- Increase the adoption of food service guidelines/nutrition standards, which include sodium
- Increase the adoption of PE/PA in schools
- Increase the adoption of PA in early childcare and worksites
- Increase reporting of A1c measures and initiate clinical innovations and team-based care models in health systems
- Increase identification and diagnosis of pre-diabetes among people at high risk for type 2 diabetes
- Increase availability and use of lifestyle intervention programs in community settings for the primary prevention of type 2 diabetes
State Level Strategies for Diabetes Control

• Increase availability and participation in ADA-recognized, AADE accredited or Stanford licensed diabetes self-management (DSME) programs
• Increase availability and participation in Stanford licensed chronic disease self-management programs (CDSMP)
• Increase implementation of quality improvement processes in health systems
• Increase healthy food access and opportunities for physical activity in worksites and community
National Diabetes Prevention Program (DPP)

- Evidence–based lifestyle change program in the community or online
- 1 year long
  * Trained lifestyle coach
  * 1x/week for the first 6 months
  * 1x/month for the second 6 months
- Achievable lifestyle changes
  - Learn & improve healthy eating skills, increase physical activity

Results of the DPP

- Weight loss + increase physical activity = prevention or delay of pre-diabetes
- Participants who complete the program are able to reduce their risk of developing diabetes by 58%
- Participants 60 years and older can reduce their risk by 71%

DPP’s With CDC Pending Recognition

MedStar Health

the YMCA
DSME Comparison

- ADA-recognized programs
- AADE accredited programs
- Stanford licensed programs
- DEEP (Diabetes Empowerment Education Program)
Objectives

Expand reimbursement models
- Program sustainability
- Increase accessibility among residents at highest risk and prevalence

Increase # of organizations implementing the evidence-based models at multiple sites

Increase participation in DPP and DSME programs
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