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**RUPRI Center for Rural Health Policy Analysis**

**Rural Diabetes Care Management Programs:  
An Inventory of Sample Programs in Six States**

**Roslyn S. Fraser-Maginn, M.A.**

**Anne M. Skinner, B.S., R.H.I.A.**

**Sue Nardie**

**Keith J. Mueller, Ph.D.**

The mission of the RUPRI Center is to provide timely analysis to federal and state health policy makers, based on the best available research. The research of the RUPRI Center focuses on rural health care financing and system reform, rural systems building, and meeting the health care needs of special rural populations. Specific objectives include conducting original research and independent policy analysis that provides policy makers and others with a more complete understanding of the implications of health policy initiatives, and disseminating policy analysis that assures policy makers will consider the needs of rural health care delivery systems in the design and implementation of health policy.

The RUPRI Center is based at the University of Nebraska Medical Center, in the Department of Preventive and Societal Medicine, Section on Health Services Research and Rural Health Policy. For more information about the center and its publications, please contact

RUPRI Center for Rural Health Policy Analysis  
University of Nebraska Medical Center  
984350 Nebraska Medical Center  
Omaha, NE 68198-4350  
Phone: (402) 559-5260  
Fax: (402) 559-7259  
<http://www.rupri.org/healthpolicy>

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## Contents

<b>Introduction.....</b>	<b>1</b>
<b>National-Level Organizations .....</b>	<b>2</b>
Centers for Disease Control and Prevention, Diabetes Prevention and Control Program....	3
Office of Rural Health Policy – Rural Health Outreach Grant Program .....	3
Office of Rural Health Policy – Rural Health Network Development Grant Program .....	4
Health Disparities Collaboratives .....	5
National Association of Rural Health Clinics.....	6
<b>Region/Cluster-Level Organizations .....</b>	<b>7</b>
Health Disparities Collaboratives – Southeast Cluster .....	8
Health Disparities Collaboratives – Northeast Cluster .....	8
<b>State-Level Organizations .....</b>	<b>9</b>
<i><b>Diabetes Prevention and Control Programs</b></i>	
Maine Diabetes Prevention and Control Program .....	10
Nebraska Diabetes Prevention and Control Program .....	10
New Mexico Diabetes Prevention and Control Program.....	11
South Carolina Diabetes Prevention and Control Program .....	11
Washington Diabetes Prevention and Control Program .....	12
Wisconsin Diabetes Prevention and Control Program.....	12
<i><b>Quality Improvement Organizations</b></i>	
Nebraska Quality Improvement Organization .....	13
New Mexico Quality Improvement Organization .....	13
South Carolina Quality Improvement Organization .....	14
<i><b>State Rural Health Clinic Associations/Offices</b></i>	
Maine Rural Health Clinics .....	14
Nebraska Rural Health Clinics.....	15
Wisconsin Rural Health Clinics.....	15
<b>Local-Level Organizations .....</b>	<b>16</b>
<i><b>Maine</b></i>	
Fish River Rural Health .....	17
MaineGeneral Diabetes Care Initiative for Kennebec Valley .....	17
Northern Maine Medical Center .....	18
Sacopec Valley Health Center .....	18
<i><b>Nebraska</b></i>	
Brodstone Memorial Hospital.....	19
Cambridge Medical Clinic .....	19
Great Plains Regional Medical Center.....	19
Kimball Health Services .....	20
Physicians Clinic Valley .....	20

<b><i>New Mexico</i></b>	
Ben Archer Health Center.....	21
<b><i>South Carolina</i></b>	
New Horizons Family Health Services, Inc.....	21
<b><i>Washington</i></b>	
Cascade Family Medical Center .....	22
Klickitat Valley Health Services.....	22
Ocean Beach Hospital and Medical Clinics.....	23
Yakima Valley Farm Worker’s Clinic .....	23
<b><i>Wisconsin</i></b>	
Family Health Center of Marshfield, Inc. ....	24
Family Health/La Clinica.....	24
Menominee Tribal Clinic.....	25
Northern Health Centers, Inc. ....	25
<b>Glossary</b>	
Acronyms .....	26
Clinic Types .....	26
Disease Management Information Systems.....	26

## **Introduction**

The purpose of this inventory is to share key contact and program information with organizations that might be interested in starting a chronic disease management (DM) program in their facility.

This inventory is composed of diabetes management programs that participated in a research study focused on rural implementation of DM programs. We assessed diabetes management programs as a proxy for chronic DM programs found in rural areas. An initial list of federal agencies, private foundations, and professional trade associations involved in chronic diabetes management was compiled through an Internet search and contacts with key informants. We conducted 37 telephone interviews with program administrators at the national, state, and local levels across four major diabetes initiatives: the CDC Diabetes Prevention and Control Program (DPCP), the Health Disparities Collaborative (HDC) composed of Community Health Centers, the Center for Medicare and Medicaid Services (CMS) through Quality Improvement Organizations (QIOs), and the ORHP Outreach and Network Programs. The sample was geographically stratified across six states: Maine, Nebraska, New Mexico, South Carolina, Washington, and Wisconsin.

The first interviews were conducted with national representatives, which led to referrals to state-level participants. Further referrals were collected from state-level contacts to local-level participants at rural clinics whose activities the state-level contacts believed were worth monitoring or replicating by others.

Profile information was obtained from each organization's Web site and supplemented by what we learned during the interviews. Each organization was given the opportunity to review and approve its profile.

## *National-Level Organizations*

### **National-Level Organizations**

National-level organizations support chronic disease management by providing an infrastructure of knowledge, monetary and non-monetary resources, and administration. These organizations can support widespread programs across the country through state and/or regional offices. Providers and organizations looking to implement a disease management program can contact national-level organizations to find out about programs available in their state or region.

National-level organizations included in this inventory:

- Centers for Disease Control and Prevention
  - Diabetes Prevention and Control Program
- Office of Rural Health Policy
  - Rural Health Outreach Grant Program
  - Rural Health Network Development Grant Program
- Health Resources and Services Administration - Bureau of Primary Health Care
  - Health Disparities Collaborative
- National Association of Rural Health Clinics

*National-Level Organizations*

<b>Program Name</b>	<b>Centers for Disease Control and Prevention Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	David Hutchins, Project Officer Centers for Disease Control and Prevention National Center for Chronic Disease Prevention & Health Promotion KOGR Building, Mail Station K10 Atlanta, GA 30333 (770) 488-5405 (phone) (770) 488-5966 (fax) david.hutchins@cdc.hhs.gov <a href="http://www.cdc.gov/diabetes/index.htm">http://www.cdc.gov/diabetes/index.htm</a>
<b>Purpose</b>	The Diabetes Prevention and Control Program, Division of Diabetes Translation (DDT), translates diabetes research into daily practice to (1) understand the impact of the disease, (2) influence health outcomes, and (3) improve access to quality health care. The DDT is a part of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. The division does not support the direct provision of services, but facilitates the efficient, fair, and effective availability of these services to all Americans affected by diabetes. The division does not do laboratory research and does not routinely fund individual investigators. DDT's goal is to reduce the burden of diabetes in the United States. The division works to achieve this goal by combining support for public health-oriented diabetes prevention and control programs and translating diabetes research findings into widespread clinical and public health practice.
<b>Eligibility</b>	Open to all
<b>Program Name</b>	<b>Office of Rural Health Policy – Rural Health Outreach Grant Program</b>
<b>Contact Information</b>	Eileen Holloran, Rural Health Outreach Grant Program Coordinator Health Resources and Services Administration Office of Rural Health Policy 5600 Fishers Lane, Room 9A-55 Rockville, MD 20857 (301) 443-7529 (phone) (301) 443-2803 (fax) eholloran@hrsa.gov <a href="http://ruralhealth.hrsa.gov/funding/outreach.htm">http://ruralhealth.hrsa.gov/funding/outreach.htm</a>
<b>Purpose</b>	The Rural Health Outreach Grant Program is designed to encourage the development of new and innovative health care delivery systems in rural communities that lack essential health care services. The emphasis of this grant program is on service delivery through creative strategies requiring the grantee to form a network with at least two additional partners. Programs

*continued on p. 4*

*National-Level Organizations*

<p><b>Purpose</b> (<i>continued</i>)</p>	<p><b>Office of Rural Health Policy – Rural Health Outreach Grant Program</b> (<i>continued</i>)</p> <p>funded have varied greatly, and have brought care that would not otherwise have been available to at least two million rural citizens across the country. Through consortia of schools, churches, emergency medical service providers, local universities, private practitioners and the like, rural communities have managed to create hospice care, bring health check-ups to children and provide prenatal care to women in remote areas. In 2004, 17 projects out of the 108 funded focused on diabetes. As of July 2005, 9 projects out of the 101 funded focused on diabetes. In addition, ORHP funds many more programs involved with diabetes prevention.</p>
<p><b>Eligibility</b></p>	<p>“To be eligible the grant recipient’s Headquarters must be a public or nonprofit private entity and be located in a designated rural county, or exclusively provide services to migrant and seasonal farmworkers in rural areas, or be a Native American Tribal or quasi-tribal entity.” (Retrieved August 26, 2005, from <a href="http://ruralhealth.hrsa.gov/funding/outreach.htm">http://ruralhealth.hrsa.gov/funding/outreach.htm</a>.) More information on eligibility is available at <a href="http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp">http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp</a></p>
<p><b>Program Name</b></p>	<p><b>Office of Rural Health Policy – Rural Health Network Development Grant Program</b></p>
<p><b>Contact Information</b></p>	<p>Erica Molliver, Network Development Program Coordinator Health Resources and Services Administration Office of Rural Health Policy 5600 Fishers Lane, Room 9A-55 Rockville, MD 20857 (301) 443-1520 (phone) (301) 443-2803 (fax) <a href="mailto:emolliver@hrsa.gov">emolliver@hrsa.gov</a> <a href="http://ruralhealth.hrsa.gov/funding/network.htm">http://ruralhealth.hrsa.gov/funding/network.htm</a></p>
<p><b>Purpose</b></p>	<p>The Rural Health Network Development Grant Program provides funding to help rural communities strengthen their health care systems. Grants support rural providers for up to three years who work together in formal networks, alliances, coalitions, or partnerships to integrate administrative, clinical, financial, and technological functions across their organizations. This integration of functions and services helps to overcome the fragmentation of health care services in rural areas, improves coordination of those services, and achieves economies of scale. This program does not support direct patient care services.</p> <p style="text-align: right;"><i>continued on p. 5</i></p>

*National-Level Organizations*

<p><b>Eligibility</b></p>	<p><b>Office of Rural Health Policy – Rural Health Network Development Grant Program (<i>continued</i>)</b></p> <p>“To be eligible, the applicant organization must be a public or nonprofit entity that is a network or is a member of a network that includes at least three separately owned health care providers or other entities that provide or support the delivery of health care services. Additionally, the applicant's administrative headquarters must be located in a designated rural county or rural zip code of an urban county. Rural located but urban-owned organizations may apply for a network development grant if their parent organization submits a letter assuring the applicant's autonomy in receiving and administering the grant funds.” (Retrieved August 26, 2005, from <a href="http://ruralhealth.hrsa.gov/funding/network.htm">http://ruralhealth.hrsa.gov/funding/network.htm</a>.) More information on eligibility is available at <a href="http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp">http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp</a></p>
<p><b>Program Name</b></p>	<p><b>Health Disparities Collaboratives (HDCs)</b></p>
<p><b>Contact Information</b></p>	<p>Health Resources and Services Administration (HRSA) Bureau of Primary Health Care 5600 Fishers Lane, Room 17C-26 Rockville, MD 20857 <i>please see Web site for specific contacts:</i> <a href="http://www.healthdisparities.net/hdc/html/home.aspx">http://www.healthdisparities.net/hdc/html/home.aspx</a></p>
<p><b>Purpose</b></p>	<p>The HRSA HDCs are a national effort to achieve strategic system change in the delivery of primary health care. Starting with the Chronic Diseases Care Model, the HDC focused on the conditions of highest importance to the health centers in terms of cost, volume of patient visits, and/or complexity of care needed. The HDCs have evolved national health center infrastructure to improve the delivery of prevention services, cancer screening, and acute conditions, such as oral health, that affect the patient flow of the health centers.</p> <p>The mission of the HDCs is to expand access to high quality, culturally and linguistically competent primary and preventive care for underserved, uninsured, and underinsured Americans. To eliminate health disparities and improve functional and clinical outcomes, health care organizations must change the way they deliver care. The HDCs call for such a change—a transformation in the delivery of care. The HDCs strive to achieve excellence in practice through the following goals: (1) generate and document improved health outcomes for underserved populations; (2) transform clinical practice through models of care, improvement, and learning; (3) develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status; and (4) build strategic partnerships.</p> <p style="text-align: right;"><i>continued on p. 6</i></p>

*National-Level Organizations*

<b>Purpose (continued)</b>	<b>Health Disparities Collaboratives (continued)</b>  The HDCs are grouped into five regional clusters. Within each Cluster, a state Primary Care Association (PCA) serves as the lead agency for the region. The PCA then collaborates with a selected state Clinical Network. Within lead PCAs are Cluster Directors and Coordinators. These individuals provide day-to-day “hands on” oversight, management, training, networking, technical assistance, and support to HDC participants in the region.
<b>Eligibility</b>	Federally Qualified Health Center – Community Health Center*
<b>Program Name</b>	<b>National Association of Rural Health Clinics (NARHC)</b>
<b>Contact Information</b>	Bill Finerfrock, Executive Director National Association of Rural Health Clinics 200 10th Street Des Moines, IA 50309 (515) 280-1944 (phone) (515) 243-5941 (fax) info@narhc.org <a href="http://www.narhc.org/">http://www.narhc.org/</a>
<b>Purpose</b>	NARHC is the only national organization dedicated exclusively to improving the delivery of quality, cost-effective health care in rural underserved areas through the Rural Health Clinics (RHC) program. NARHC works with Congress, federal agencies, and rural health allies to promote, expand, and protect the interests of clinics in the RHC program. Through the association, NARHC members become actively engaged in the legislative and regulatory process.
<b>Eligibility</b>	Clinics in the RHC program.

\*Defined in Glossary

## *Region/Cluster-Level Organizations*

### **Region/Cluster-Level Organizations**

Rural Federally Qualified Health Centers that participate in the Health Disparities Collaborative, sponsored by the Health Resources and Services Administration's Bureau of Primary Health Care, are grouped by state into specific geographical regions called Clusters. Cluster directors provide programmatic oversight, structure, and support for collaborative participants in their region. Federally Qualified Health Centers interested in learning about Health Disparities Collaboratives and Disease Management can contact their cluster director for more information.

Region/cluster-level organizations included in this inventory:

- Health Disparities Collaboratives
  - Southeast Cluster
  - Northeast Cluster

*Region/Cluster-Level Organizations*

<b>Program Name</b>	<b>Health Disparities Collaboratives – Southeast Cluster: <i>Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee</i></b>
<b>Contact Information</b>	Sue Veer, Associate Executive Director South Carolina Primary Health Care Association 2211 Alpine Road Extension Columbia, SC 29223 (803) 788-2778 (phone) (800) 438-3895 (toll-free) (803) 788-8233 (fax) suev@scphca.org <a href="http://www.healthdisparities.net/hdc/html/home.aspx">http://www.healthdisparities.net/hdc/html/home.aspx</a>
<b>Purpose</b>	The Southeast Cluster is one of five regional clusters associated with the Health Resources and Services Administration’s Health Disparities Collaboratives. Their goal is to be able to reduce health disparity as it relates to diabetes and to look at making sure that all individuals that suffer from chronic illness or from diabetes have access to health care. In addition, they seek to ensure that providers are providing appropriate care that is evidence-based, comprehensive, and consistent.
<b>Program Name</b>	<b>Health Disparities Collaboratives – Northeast Cluster: <i>Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Puerto Rico, and the Virgin Islands</i></b>
<b>Contact Information</b>	Wanda Montalvo, RN, MSN, ANP, Northeast Cluster Director Connecticut Primary Care Association 18 Rainbow Avenue Staten Island, NY 10302 (718) 556-1007 (phone) (718) 556-1811 (fax) wmontalvo1@aol.com <a href="http://www.ctpca.org/progservices/health.html">http://www.ctpca.org/progservices/health.html</a> <a href="http://www.healthdisparities.net/hdc/html/home.aspx">http://www.healthdisparities.net/hdc/html/home.aspx</a>
<b>Purpose</b>	The Northeast Cluster is one of five regional clusters associated with the Health Resources and Services Administration’s Health Disparities Collaboratives. The goals of the Northeast Cluster Collaborative are to generate and document improved health outcomes for the underserved populations; transfer knowledge about how to promote positive breakthrough changes; and develop infrastructure, expertise, and leadership to support and drive improved health, access, and cost outcomes.

### **State-Level Organizations**

State-level organizations support local disease management programs by providing a more clinic-specific implementation of the program infrastructure handed down from the national level. In most cases, state organizations have the flexibility to customize national programs to fit best the needs of the state. Providers and organizations looking for assistance in implementing a disease management program can contact their state-level organizations to find out about available resources.

State-level organizations included in this inventory:

- Centers for Disease Control and Prevention
  - Diabetes Prevention and Control Program
    - Maine
    - Nebraska
    - New Mexico
    - South Carolina
    - Washington
    - Wisconsin
  
- Centers for Medicare and Medicaid Services
  - Quality Improvement Organizations
    - Nebraska
    - New Mexico
    - South Carolina
  
- State Rural Health Clinic Associations/Offices
  - Maine Rural Health Clinics
  - Nebraska Rural Health Clinics
  - Wisconsin Rural Health Clinics

*State-Level Organizations*

***Diabetes Prevention and Control Programs***

<b>Program Name</b>	<b>Maine Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	<p>Jim Leonard, Program Director                  Maine Department of Health and Human Services                  Bureau of Health                  11 State House Station                  286 Water Street                  Augusta, ME 04333-0011                  (207) 287-2906 (phone)                  (207) 287-4631 (fax)                  james.f.leonard@maine.gov  <a href="http://www.maine.gov/dhhs/bohdcfh/dcp/index2.htm">http://www.maine.gov/dhhs/bohdcfh/dcp/index2.htm</a></p>
<b>Purpose</b>	<p>The Maine Diabetes Prevention and Control Program, funded by the Centers for Disease Control and Prevention, dedicates its resources to promote excellence in diabetes care, increase access to care, and support efforts to enhance a more efficient and effective health care system for the people in Maine.</p>
<b>Program Name</b>	<b>Nebraska Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	<p>Kathy Goddard, RD, CDE, LMNT, Program Manager                  Jan Bahm, RN, BSN                  Nebraska Diabetes Prevention and Control Program                  Nebraska Health and Human Services System                  301 Centennial Mall South                  Lincoln, NE 68509-5044                  (402) 471-0194 (Kathy Goddard)                  (402) 471-0162 (Jan Bahm)                  kathy.goddard@hhss.ne.gov                  jan.bahm@hhss.ne.gov  <a href="http://www.hhs.state.ne.us/dpc/ndcp.htm">http://www.hhs.state.ne.us/dpc/ndcp.htm</a></p>
<b>Purpose</b>	<p>The Nebraska Diabetes Prevention and Control Program strives to develop, implement, and evaluate a systems-based diabetes prevention and control program. An additional purpose of this program is to deliver a broad range of public health activities that will reduce death, disability, and costs related to diabetes and its complications.</p> <p>Program emphasis is on a broad systems-based approach that integrates health systems, health communications, health education and community interventions. The program facilitates outreach and involvement of communities, businesses, school systems, faith communities, and other organizations and agencies in diabetes program activities. This integration will result in efforts that will influence both the traditional and emerging health care delivery system. Other areas of emphasis include program accountability, health disparities, partnerships, and leadership. This program will continue to emphasize primary, secondary, and tertiary prevention, and serve as a partner in the National Diabetes Education Program.</p>

### State-Level Organizations

<b>Program Name</b>	<b>New Mexico Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	Mary Frerichs, RN, MS New Mexico Department of Health Harold Runnels Building RM S1300 1190 St. Francis Drive, PO Box 26110 Santa Fe, NM 87502-6110 (505) 827-2953 (phone) (505) 827-2329 (fax) maryf@doh.state.nm.us <a href="http://www.diabetesnm.org/">http://www.diabetesnm.org/</a>
<b>Purpose</b>	The New Mexico Diabetes Prevention and Control Program's mission is to reduce the burden of diabetes in New Mexico and improve the quality of life for New Mexicans who are affected and/or impaired by diabetes, by preventing and controlling the complications of diabetes and by developing strategies to prevent or delay the onset of type 2 diabetes.
<b>Program Name</b>	<b>South Carolina Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	Dr. Rhonda Hill, Director Division of Diabetes Prevention and Control Bureau of Chronic Disease Prevention and Health Promotion South Carolina Department of Health and Environmental Control Box 101106 Columbia, SC 29211 (803) 898-3432 hillrl@dhec.sc.gov <a href="http://www.scdhec.net/health/chcdp/diabetes/">http://www.scdhec.net/health/chcdp/diabetes/</a>
<b>Purpose</b>	The South Carolina Diabetes Prevention and Control Program has the following objectives: establish and maintain measurement procedures to track program success, i.e., monitoring the burden of diabetes and surveillance; demonstrate success in achieving an increase in the percentage of persons with diabetes in South Carolina who receive the following recommended services: foot and eye exams, influenza and pneumonia vaccinations, and hemoglobin A1c tests (at least twice a year); demonstrate success in reducing health disparities for high-risk populations with respect to diabetes prevention and control; demonstrate success in establishing linkages to useful programs for promotion of wellness, physical activity, weight and blood pressure control, and smoking cessation.

### State-Level Organizations

<b>Program Name</b>	<b>Washington Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	Kathleen Clark, CDE, MS, RD Washington Diabetes Prevention and Control Program PO Box 47855 Olympia, WA 98504 (360) 236-3608 (phone) (360) 236-3708 (fax) kathleen.clark@doh.wa.gov <a href="http://www.doh.wa.gov/cfh/diabetes/default.htm">http://www.doh.wa.gov/cfh/diabetes/default.htm</a>
<b>Purpose</b>	The Washington Diabetes Prevention and Control Program’s purpose is to reduce the complications and mortality from diabetes, and work toward preventing type 2 diabetes. Funded through the Centers for Disease Control and Prevention, the Washington program is required to work toward national objectives around diabetes indicators, and beyond that, is directed to work with populations who are at higher risk for diabetes and its complications. The rural areas in Washington were found to have a higher prevalence of diabetes along with worse complications.
<b>Program Name</b>	<b>Wisconsin Diabetes Prevention and Control Program</b>
<b>Contact Information</b>	Leah Ludlum, RN, BSN, CDE Diabetes Prevention and Control Program Division of Public Health PO Box 2659 Madison, WI 53701-2659 (608) 261-9422 (phone) (608) 266-8925 (fax) ludlule@dhfs.state.wi.us <a href="http://www.dhfs.wisconsin.gov/health/diabetes/index.htm">http://www.dhfs.wisconsin.gov/health/diabetes/index.htm</a>
<b>Purpose</b>	The Wisconsin Diabetes Prevention and Control Program (DPCP) is dedicated to improving the health of people with or at risk of developing diabetes. Forming and maintaining strong, active partnerships with health systems and communities is the key to sharing prevention strategies, promoting early detection of disease, and implementing the Wisconsin Essential Diabetes Care Guidelines to reduce the risk of diabetes complications. The DPCP uses a statewide approach to improve diabetes through working with health systems, designing population-based community interventions, outreach to high risk populations, conducting surveillance and evaluation of the burden of diabetes, and coordinating statewide efforts through the Wisconsin Diabetes Advisory Group.

*State-Level Organizations*

***Quality Improvement Organizations***

<b>Program Name</b>	<b>Nebraska Quality Improvement Organization</b>
<b>Contact Information</b>	Julie Smith, RN, BSN, MHA, Quality Improvement Manager CIMRO of Nebraska 1230 O Street, Suite 120 Lincoln, NE 68508 (402) 476-1399 (phone) (402) 476-1335 (fax) jsmith@neqio.sdps.org <a href="http://www.cimronebraska.org/">http://www.cimronebraska.org/</a>
<b>Purpose</b>	CIMRO of Nebraska (CIMRO-NE) is the Medicare quality improvement organization (QIO) for the state of Nebraska. CIMRO-NE provides services that enhance the quality of health care delivered to Medicare beneficiaries. CIMRO-NE staff assist health care providers in improving the quality of health care delivered to Medicare beneficiaries in Nebraska. As the QIO under contract with the Centers for Medicare & Medicaid Services, CIMRO-NE works to promote quality health services, determine medical necessity of services rendered, and ensure professionally recognized standards of care are met for services rendered. CIMRO-NE staff provide educational tools and resources to Nebraska’s hospitals, physician offices, nursing homes, and homecare agencies to improve quality of care delivered. CIMRO-NE will be focusing on Electronic Clinical Information to assist health care providers and facilities in improved care management and chronic disease management.
<b>Program Name</b>	<b>New Mexico Quality Improvement Organization</b>
<b>Contact Information</b>	Galina Priloutsckaya PhD, MBA, Senior Analyst New Mexico Medical Review PO Box 3200 Albuquerque, NM 87190 (505) 998-9765 (phone) (505) 998-9899 (fax) gpriloutsckaya@nmmra.org <a href="http://www.nmmra.org/index.php">http://www.nmmra.org/index.php</a>
<b>Purpose</b>	The New Mexico Medical Review Association (NMMRA) is an Albuquerque-based, non-profit, physician-sponsored organization. By serving as a resource to the state's health care community and to Medicare beneficiaries, NMMRA seeks to fulfill its mission to improve the quality and protect the integrity of health care in New Mexico. NMMRA has served continuously as the state's only federally contracted Medicare quality improvement organization since 1984.

### *State-Level Organizations*

<b>Program Name</b>	<b>South Carolina Quality Improvement Organization</b>
<b>Contact Information</b>	Anne Lockwood, MPH, CHES, Outpatient Interventions Manager Carolina Medical Review 250 Berryhill Road, Suite 101 Columbia, SC 29210-6469 (803) 731-8225 (phone) (800) 922-3089 (toll-free) (803) 731-8229 (fax) alockwood@scqio.sdps.org <a href="http://www.mrnc.org/mrnc_web/cmr/">http://www.mrnc.org/mrnc_web/cmr/</a>
<b>Purpose</b>	Carolina Medical Review (CMR) is the non-profit, physician-sponsored Medicare quality improvement organization for South Carolina. CMR's staff of physicians, nurses, epidemiologists, biostatisticians, health information management, and administrative personnel supports hospitals, physician offices, nursing homes, home health agencies, and others throughout the state in the pursuit of health care excellence.

### *State Rural Health Clinic Associations/Offices*

<b>Program Name</b>	<b>Maine Rural Health Clinics</b>
<b>Contact Information</b>	Melody Martin, Outreach Coordinator Maine Primary Care Association 73 Winthrop Street Augusta, ME 04330 (207) 621-0677 (phone) (207) 621-0577 (fax) memartin@mepca.org <a href="http://www.mepca.org/">http://www.mepca.org/</a>
<b>Purpose</b>	The mission of the Maine Primary Care Association is to advance the strength and sustainability of its membership of safety-net primary care providers and facilitate access to primary care for the medically underserved or uninsured in Maine.

### *State-Level Organizations*

<b>Program Name</b>	<b>Nebraska Rural Health Clinics</b>
<b>Contact Information</b>	Dennis Berens, Rural Health Coordinator Nebraska Office of Rural Health PO Box 95044 Lincoln, NE 68509-5044 (402) 471-1046 dennis.berens@hss.ne.gov <a href="http://www.hhs.state.ne.us/orh/">http://www.hhs.state.ne.us/orh/</a>
<b>Purpose</b>	The mission of the Nebraska Office of Rural Health is to define and promote the development of a health care system that assures the availability and accessibility of quality health care services to meet the needs of people living in rural Nebraska. Programs and activities are designed to assist rural Nebraskans in obtaining high quality health care through recruitment and retention, hospital maintenance, community planning, health care networks and cooperative ventures, identifying community leaders, developing leadership skills, and having an information clearinghouse. The Office is charged with the development of a state rural health policy in consultation with the Rural Health Advisory Commission.
<b>Program Name</b>	<b>Wisconsin Rural Health Clinics</b>
<b>Contact Information</b>	Stephanie Weier, CHES, Program Specialist Wisconsin Primary Care Association 49 Kessel Court, Suite 210 Madison, WI 53711 (608) 277-7477, ext. 241 (phone) (608) 277-7474 (fax) sweier@wphca.org <a href="http://www.wphca.org/">http://www.wphca.org/</a>
<b>Purpose</b>	The mission of the Wisconsin Primary Health Care Association is to advance geographic, financial, and cultural access to comprehensive, community-oriented primary health care services for all people in Wisconsin. The Wisconsin Primary Health Care Association, founded in 1982 is a private, non-profit member organization comprising a statewide network of Community and Migrant Health Centers, Healthcare for the Homeless Programs, and other organizations that share in the Association's mission.

## *Local-Level Organizations*

### **Local-Level Organizations**

The local-level organizations profiled in this inventory include clinics that have participated in a national or regional disease management program. The programs range from highly structured to non-structured. Providers and organizations looking for examples of disease management programs that have been implemented may contact any of the clinics listed for more information.

*Local-Level Organizations*

*Maine*

<b>Facility Name</b>	<b>Fish River Rural Health</b>
<b>Contact Information</b>	Sue Bouchard, RN, BSN Fish River Rural Health PO Box 309 Eagle Lake, ME 04739 (207) 444-5973 sueb@mail.sjv.net
<b>Purpose of Diabetes Management Program</b>	The program’s purpose is to improve care for diabetic patients through education and self-management. Fish River Rural Health is a member of the Health Disparities Collaboratives, which focus on “changing practice changing lives.” Outcome improvements are measured on the basis of tracking and analyzing patient care through PECS.*
<b>Registry Participation</b>	Patient Electronic Care System (PECS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*
<b>Facility Name</b>	<b>MaineGeneral Diabetes Care Initiative for Kennebec Valley</b>
<b>Contact Information</b>	Natalie Morse, Director, Community Health Improvement MaineGeneral Health 32 College Avenue Waterville, ME 04901 (207) 872-1788 (phone) (207) 877-7379 (fax) natalie.morse@mainegeneral.org <a href="http://www.mainegeneral.org/">http://www.mainegeneral.org/</a>
<b>Purpose of Diabetes Management Program</b>	The program’s purpose is to reduce diabetes incidence, morbidity, and mortality. Goals revolve around improving primary care, improving services within hospitals, and improving support services in the community. High rates of diabetes and the merger of multiple health care facilities warranted a coordinated approach and population health perspective. Multiple organizations joined the initiative and provided several funding streams.
<b>Registry Participation</b>	Custom Access database – created by Physician Hospital Organization
<b>Type of Clinic</b>	Hospital-Based Health Clinic

\*Defined in Glossary

### *Local-Level Organizations*

<b>Facility Name</b>	<b>Northern Maine Medical Center</b>
<b>Contact Information</b>	<p>Roberta Guerrette, RN  Northern Maine Medical Center  194 East Main Street  Fort Kent, ME 04743-1433  (207) 834-3760 (phone)  (207) 834-2202 (fax)  roberta.guerrette@nmmc.org  <a href="http://www.nmmc.org">http://www.nmmc.org</a></p>
<b>Purpose of Diabetes Management Program</b>	<p>The program’s purpose is to provide necessary self-management education that will assist in maintaining optimal quality of life for health care consumers with diabetes. Program assistance is provided by the Maine Diabetes Prevention and Control Program to follow the guidelines developed by the American Diabetes Association.</p>
<b>Registry Participation</b>	Custom In-House System
<b>Type of Clinic</b>	Hospital-Based Clinic
<b>Facility Name</b>	<b>Sacopee Valley Health Center</b>
<b>Contact Information</b>	<p>Donna Burke-Butler, RN  Sacopee Valley Health Center  PO Box 777  Parsonfield, ME 04074  (207) 625-8126  (207) 625-7820  <a href="mailto:burke@svhc.org">burke@svhc.org</a></p>
<b>Purpose of Diabetes Management Program</b>	<p>The program’s purpose is to deliver quality care to patients who have diabetes by participating in the Health Resources and Services Administration’s Health Disparities Collaboratives. The Chronic Care Model and PECS* is used to track patients and improve systems. Additional resources are provided by Maine’s Diabetes Prevention and Control Program.</p>
<b>Registry Participation</b>	Patient Electronic Care System (PECS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*

\*Defined in Glossary

*Local-Level Organizations*

*Nebraska*

<b>Facility Name</b>	<b>Brodstone Memorial Hospital</b>
<b>Contact Information</b>	Lynette Huntsinger Brodstone Memorial Hospital 520 East 10th Street Superior, NE 68978 (402) 879-3281, x452 (phone) (402) 879-3401 (fax) <a href="http://www.brodstonehospital.org/welcome.htm">http://www.brodstonehospital.org/welcome.htm</a>
<b>Purpose of Diabetes Management Program</b>	As part of the Heartland Health Alliance, the program’s purpose is to improve diabetes care in rural areas. The program is affiliated with a hospital diabetes center to meet standards for the American Diabetes Association. The program’s focus is on providing education for diabetes self-management.
<b>Registry Participation</b>	None
<b>Type of Clinic</b>	Hospital-Based Outpatient Education Program
<b>Facility Name</b>	<b>Cambridge Medical Clinic</b>
<b>Contact Information</b>	Barb Langley Cambridge Medical Center 309 Nelson, PO Box 488 Cambridge, NE 69022 (308) 697-3317 (phone) (308) 697-4176 (fax) blangley@trivalleyhealth.com
<b>Purpose of Diabetes Management Program</b>	The program’s purpose is to improve outcomes for diabetic patients by making regular follow-up contacts. Assistance by Nebraska’s quality improvement organization (CIMRO-NE) helped to initiate electronic management and recall system to increase compliance and provide better care for patients.
<b>Registry Participation</b>	SECAT – Provided by Nebraska’s quality improvement organization, CIMRO-NE
<b>Type of Clinic</b>	Rural Health Clinic*
<b>Facility Name</b>	<b>Great Plains Regional Medical Center</b>
<b>Contact Information</b>	Linda Bahe Great Plains Regional Medical Center 601 West Leota North Platte, NE 69101 (308) 696-8000 (309) 696-7473 bahel@mail.gprmc.com <a href="http://www.gprmc.com/">http://www.gprmc.com/</a>

*continued on p. 20*

### *Local-Level Organizations*

<b>Purpose of Diabetes Management Program</b>	<b>Great Plains Regional Medical Center</b> <i>(continued)</i>  The program's purpose is to educate diabetic patients in the area as a means of reducing their complications and effectively self-managing their disease thereby reducing unnecessary medical costs. Rural clinic patients receive referrals to participate in an education program. Curriculum is provided through the American Diabetes Association to meet Medicare guidelines.
<b>Registry Participation</b>	None
<b>Type of Clinic</b>	Hospital-Based Outpatient Education Program
<b>Facility Name</b>	<b>Kimball Health Services</b>
<b>Contact Information</b>	Julie Schnell Kimball Health Services 505 South Burg Street Kimball, NE 69145 (308) 235-1952, ext. 604 (phone) (308) 235-1954 (fax) clinic@kimballhealth.org <a href="http://www.kimballhealth.org/">http://www.kimballhealth.org/</a>
<b>Purpose of Diabetes Management Program</b>	As a hospital-owned physician's clinic with a high diabetic population, Nebraska's quality improvement organization, currently CIMRO-NE, encouraged participation in its diabetes project. The program's purpose is to serve the clinic's diabetic population with the assistance of electronic charting and educational programs through the hospital.
<b>Registry Participation</b>	Diabetic Flow Sheets through electronic charting system (Med Informatics)
<b>Type of Clinic</b>	Rural Health Clinic*
<b>Facility Name</b>	<b>Physicians Clinic Valley</b>
<b>Contact Information</b>	Julie Brosseau Physicians Clinic Valley 625 South Pine Street Valley, NE 68064 (402) 359-2277 (phone) (402) 359-5432 (fax) jbrosse@nmhs.org
<b>Purpose of Diabetes Management Program</b>	The program's purpose is to take better care of diabetic patients by educating them about their disease and changing the indicators that go along with their disease. Patient education is provided through monthly visits by a nurse practitioner from an Urban Hospital-Based Diabetic Institute. Program assistance provided by Nebraska's quality improvement organization, CIMRO-NE.

*continued on p. 21*

### *Local-Level Organizations*

<b>Registry Participation</b>	<b>Physicians Clinic Valley</b> ( <i>continued</i> )  SECAT – Provided by Nebraska’s quality improvement organization, CIMRO-NE
<b>Type of Clinic</b>	Network Affiliated Health Clinic

### *New Mexico*

<b>Facility Name</b>	<b>Ben Archer Health Center</b>
<b>Contact Information</b>	Marie Castillo, RN, CDE Ben Archer Health Center 255 Highway 187 PO Box 370 Hatch, NM 87937 (505) 267-3088 (phone) (505) 267-1747 (fax) healthed@zianet.com <a href="http://www.bahcnm.org/">http://www.bahcnm.org/</a>
<b>Purpose of Diabetes Management Program</b>	The program’s purpose is to prevent complications from diabetes with a strong focus on outreach and community education. The program is a long-time member of the Health Disparities Collaboratives, and monitors its diabetic patients through PECS* to meet the goals of the American Diabetes Association.
<b>Registry Participation</b>	Patient Electronic Care System (PECS)* Previously Diabetes Electronic Management System (DEMS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*

### *South Carolina*

<b>Facility Name</b>	<b>New Horizon Family Health Services, Inc.</b>
<b>Contact Information</b>	Dr. Lori Malvern New Horizon Family Health Services 130 Mallard Street Greenville, SC 29601 (864) 233-1534 (phone) (864) 751-0479 (fax) lmalvern@newhorizonfhs.org

*continued on p. 22*

### *Local-Level Organizations*

<b>Purpose of Diabetes Management Program</b>	<b>New Horizon Family Health Services, Inc. (continued)</b>  The program’s purpose is to address diabetes in its patient population through participation in the Health Resources and Services Administration’s Health Disparities Collaboratives. Cardiovascular disease and diabetes are the top two diagnoses in South Carolina. The lack of a Certified Diabetes Educator prompted New Horizon Family Health Services to join the Diabetes Collaborative to address the issue. The goal of New Horizon’s program is to set up systems so proven guidelines are incorporated into the physician’s practice.
<b>Registry Participation</b>	Patient Electronic Care System (PECS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*

### *Washington*

<b>Facility Name</b>	<b>Cascade Family Medical Group</b>
<b>Contact Information</b>	Kitty Carmichael Cascade Family Medical Group 326 South Stillaguamish Arlington, WA 98223 (360) 435-2144 (360) 435-9601 kitty@cfmg.net <a href="http://www.cascadevalley.org/clinics/affiliates.html">http://www.cascadevalley.org/clinics/affiliates.html</a>
<b>Purpose of Diabetes Management Program</b>	The program provides specialized diabetic care and education to patients in the rural community. A nurse practitioner has grown the patient population through actively marketing their diabetes management services to other primary care physicians. The program maintains a strong focus on community support and awareness.
<b>Registry Participation</b>	Chronic Disease Electronic Management System (CDEMS)*
<b>Type of Clinic</b>	Independent Health Clinic
<b>Facility Name</b>	<b>Klickitat Valley Health Services</b>
<b>Contact Information</b>	Jeff Teal Klickitat Valley Health Services PO Box 5 Goldendale, WA 98620 (509) 773-4017 (509) 773-4543 jteal@kvhs.net <a href="http://kvhs.net/4_1.html">http://kvhs.net/4_1.html</a>

*continued on p. 23*

**Local-Level Organizations**

<b>Purpose of Diabetes Management Program</b>	<b>Klickitat Valley Health Services (<i>continued</i>)</b> The program’s initial goal was to reach people with the diagnosis of diabetes with education to improve their overall health care and self-management. A federally funded grant allowed the program to expand to provide public information and awareness, enhanced self-management skills, and quality improvement in the medical management of diabetes.
<b>Registry Participation</b>	Chronic Disease Electronic Management System (CDEMS)*
<b>Type of Clinic</b>	Publicly Owned Health Clinic
<b>Facility Name</b>	<b>Ocean Beach Hospital and Medical Clinics</b>
<b>Contact Information</b>	Lynne Roy Ocean Beach Hospital and Medical Clinics 174 1st Avenue North Ilwaco, WA 98624 (360) 642-3181 (360) 642-6329 <a href="http://www.oceanbeachhospital.org/">http://www.oceanbeachhospital.org/</a>
<b>Purpose of Diabetes Management Program</b>	The program’s purpose is to educate diabetic patients about their disease and to encourage and support self-management. A large diabetic population and involvement of Washington’s Diabetes Prevention and Control Program initiated the start of the program. Federal grants and other types of funding help to sustain and grow the program.
<b>Registry Participation</b>	Chronic Disease Electronic Management System (CDEMS)*
<b>Type of Clinic</b>	Independent Health Clinic
<b>Facility Name</b>	<b>Yakima Valley Farm Worker’s Clinic</b>
<b>Contact Information</b>	Glen Davis Yakima Valley Farm Worker’s Clinic 518 West 1st Ave., Building 602-A Toppenish, WA 98948 (509) 249-1268 (509) 453-2209 <a href="http://www.yvfwc.com/">http://www.yvfwc.com/</a>
<b>Purpose of Diabetes Management Program</b>	The purpose of program is improving diabetes care through participation in the Washington Diabetes Collaborative and tracking of patient information through CDEMS.*
<b>Registry Participation</b>	Chronic Disease Electronic Management System (CDEMS)* Previously Diabetes Electronic Management System (DEMS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*

\*Defined in Glossary

## *Local-Level Organizations*

### *Wisconsin*

<b>Facility Name</b>	<b>Family Health Center of Marshfield, Inc.</b>
<b>Contact Information</b>	Eva Scheppa Family Health Center of Marshfield, Inc. Marshfield Clinic 1000 North Oak Avenue Marshfield, WI 54449-5777 (715) 389-4958 (phone) (715) 389-4788 (fax) scheppa.eva@marshfieldclinic.org <a href="http://www.wphca.org/marshfield.html">http://www.wphca.org/marshfield.html</a>
<b>Purpose of Diabetes Management Program</b>	The program's purpose is to improve the health and well-being of their diabetes patients and to keep them healthy and living long lives without complications. The program receives assistance and resources from Wisconsin Primary Health Care Association to achieve goals set by the American Diabetes Association.
<b>Registry Participation</b>	Custom Electronic Medical Records
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*
<b>Facility Name</b>	<b>Family Health/La Clinica</b>
<b>Contact Information</b>	Zella Van Natta Family Health/La Clinica 400 South Town Line Road PO Box 1440 Wautoma, WI 54982 (920) 787-5514 (phone) (920) 787-4737 (fax) zella@famhealth.com <a href="http://www.wphca.org/La_Clinica.pdf">http://www.wphca.org/La_Clinica.pdf</a>
<b>Purpose of Diabetes Management Program</b>	The program's purpose is to diagnose, treat, and provide continuity of care to diabetic patients. Chart review initiated by an insurance company showed deficiencies in diabetes care which initiated the implementation of DEMS and the diabetes program. Wisconsin Primary Health Care, along with several other organizations, help to provide resources to maintain the program. The program was recently accepted into the Health Disparities Collaboratives with a focus on depression.
<b>Registry Participation</b>	Diabetes Electronic Management System (DEMS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*

### *Local-Level Organizations*

<b>Facility Name</b>	<b>Menominee Tribal Clinic</b>
<b>Contact Information</b>	Patricia Burr, Diabetes Educator Menominee Tribal Clinic Keshena, WI 54135 (715) 799-5154 (715) 799-3099 patriciab@mtclinic.net <a href="http://www.mtclinic.net/Default.htm">http://www.mtclinic.net/Default.htm</a>
<b>Purpose of Diabetes Management Program</b>	The program's purpose is to educate the community and patients' families to bring about diabetes awareness through activities and complete care in an effort to improve quality of living and prevent complications for diabetes patients. The clinic incorporates multidisciplinary care to treat patients.
<b>Registry Participation</b>	Epi Info (Centers for Disease Control and Prevention product) <a href="http://www.cdc.gov/epiinfo/">http://www.cdc.gov/epiinfo/</a>
<b>Type of Clinic</b>	Tribal Health Clinic
<b>Facility Name</b>	<b>Northern Health Centers, Inc.</b>
<b>Contact Information</b>	Rhonda Kroll Northern Health Centers, Inc. 15937 State Highway 32 Lakewood, WI 54138 (715) 276-6321 (phone) (715) 276-1428 (fax) rhondak@nhcmedden.com <a href="http://www.nhcmedden.com">http://www.nhcmedden.com</a>
<b>Purpose of Diabetes Management Program</b>	The program's purpose is to reduce health disparities and improve patient outcomes. As part of the Health Resources and Services Administration's Health Disparities Collaborative, the Chronic Care Model and PECS* is used to track patients and improve systems. The Wisconsin Primary Health Care Association also plays a vital role in their diabetes' program.
<b>Registry Participation</b>	Patient Electronic Care System (PECS)* Formerly Diabetes Electronic Management System (DEMS)*
<b>Type of Clinic</b>	Federally Qualified Health Center – Community Health Center*

## GLOSSARY

<b>Acronyms</b>	
CDC	Centers for Disease Control and Prevention
DDT	Division of Diabetes Translation
DM	Disease Management
DPCP	Diabetes Prevention and Control Program
FQHC	Federally Qualified Health Center
HDC	Health Disparities Collaboratives
HHS	Health and Human Services
HRSA	Health Resources and Services Administration
NARHC	National Association of Rural Health Clinics
ORHP	Federal Office of Rural Health Policy
PCA	Primary Care Association
<b>Clinic Types</b>	
Federally Qualified Health Center (FQHC) - Community Health Center/Migrant Health Center	FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs benefit from enhanced reimbursement from Medicare and Medicaid under the prospective payment system. <a href="http://www.raconline.org/info_guides/clinics/fqhc.php">http://www.raconline.org/info_guides/clinics/fqhc.php</a>
Federally Qualified Health Center (FQHC) Look-alike	Meets all requirements for federal FQHC grant funding but has not received a grant. Look-alikes share many but not all the benefits of FQHC status. <a href="http://www.raconline.org/info_guides/clinics/fqhc.php">http://www.raconline.org/info_guides/clinics/fqhc.php</a>
Rural Health Clinic - Certified (RHC)	Clinic certified to receive special Medicare and Medicaid reimbursement. RHCs must be located in underserved rural areas and provide primary care services. RHCs use a team approach of physicians, nurse practitioners, physician assistants, and certified nurse midwives to provide services. <a href="http://www.raconline.org/info_guides/clinics/rhc.php">http://www.raconline.org/info_guides/clinics/rhc.php</a>
<b>Disease Management Information Systems</b>	
Chronic Disease Electronic Management System (CDEMS)	A software application developed by the Washington State Diabetes Prevention and Control Program in 2002. CDEMS is a Microsoft Access database application designed to assist medical providers and management in tracking the care of patients with chronic health conditions. CDEMS is pre-coded to track diabetes and adult preventive health but is customizable to change those tracking measures or define measures for monitoring other chronic conditions. Printed progress notes, patient lists, and summary reports generated from the registry database can alter the way services are delivered and measure quality improvement efforts. <a href="http://www.cdems.com/basics.html">http://www.cdems.com/basics.html</a>
Diabetes Electronic Management System (DEMS)	A registry designed to manage diabetes specifically. DEMS was developed by the Washington State Diabetes Prevention and Control Program and released in 1999. The diabetes measures and reports are hard-coded and therefore less flexible in DEMS. CDEMS is an outgrowth of DEMS, extending the patient tracking system to other chronic diseases. CDEMS enables the customization of the diabetes measures and definition of

*continued on p. 27*

	<p><i>Diabetes Electronic Management System (DEMS) (continued)</i></p> <p>measures to monitor other chronic conditions such as asthma, cardiovascular, depression, etc. The CDEMS reports program is more flexible and generates reports based on each user's setup. DEMS and CDEMS both store demographic information, visit dates and vitals, medications, diagnoses, services, labs, and notes. Both also produce a lab history and graph selected labs, and both utilize the electronic lab interface to download lab results into the registry. DEMS users wishing to convert to CDEMS can use the Import program to transfer DEMS data into CDEMS.</p>
<p>Patient Electronic Care System (PECS)</p>	<p>The Patient Electronic Care System (PECS) is a software program specifically aimed at supporting the adoption of the Care Model in the care of patients with diabetes, cardiovascular disease, asthma, depression, cancer, and preventive service needs. In PECS version 2.1 (as well as 1.2.7i), the chronic conditions of asthma, cardiovascular disease, depression, and diabetes are included, as well as cancer screening and follow-up.</p> <p><a href="http://www.healthdisparities.net/hdc/Content/PECS_Info_Packet_061604.pdf">http://www.healthdisparities.net/hdc/Content/PECS_Info_Packet_061604.pdf</a></p>