

CREATING PARTNERSHIPS FOR CHANGE



*Idaho Diabetes
5-Year State Plan
2008 – 2013*

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*“Diabetes is the
quintessential
chronic disease
and you need to look at the
entire system of care.
Simply telling providers to
work harder and better
will not work if the
system is not structured to
support them in
quality improvement.”*

*Dr. Ann Albright, Director,
Division of Diabetes Translation,
Centers for Disease Control*

INTRODUCTION

PLAN: A METHOD FOR MAKING, DOING OR ACCOMPLISHING SOMETHING.

Idaho's 5-Year Diabetes State Plan is intended to be all of those. A diverse group of people, from all areas of Idaho, came together to make this plan one that will help health systems, organizations, communities and individuals address the serious impact of diabetes in Idaho.

For 12 years, the members who make up the Diabetes Alliance of Idaho (DAI) have focused on improving the care and management of people with diabetes. They've made a commitment to educate Idahoans with diabetes and to reduce diabetes-related complications.

All of us, though, will be involved in the doing part of this plan. As health systems and organizations, we'll do all we can to identify people at risk for developing diabetes and diabetes complications. We'll need to address the disparate burden faced by racial and ethnic minorities, by the elderly and by people living in rural areas. We'll do all we can to make sure that each person affected by diabetes, without regard to race or ethnic group, to socio-economic status, to age or location, receives optimal, timely care. As communities, we'll do all we can to work together in a comprehensive, collaborative and coordinated way to help our citizens learn how to manage diabetes and to enjoy life to its fullest. As individuals, we must do all we can to take responsibility

for our own and our family's health: to seek more nutritious foods, to get regular physical activity and to work with our health care professionals to ensure that we stay healthy.

The Diabetes Alliance of Idaho believes that this 5-year plan is realistic and achievable. The DAI believes that with commitment and passion, we can accomplish the goals set forth in the plan. As health systems and organizations working together, we can succeed in improving the quality of diabetes care and management. As communities, we can accomplish bringing improved health to our neighbors, which in turn will help strengthen those communities. And as individuals, we can achieve personal health goals that will help us avoid the complications of diabetes and, more important, help us to stem the tide of the diabetes epidemic.

DIABETES IS A GROWING THREAT

Diabetes has been described as the greatest threat to public health ever faced by this country. Looking at the numbers, that's no exaggeration. As many as 20.8 million Americans have diabetes. More than one third of these people — 6.2 million — are unaware that they have the disease.

Add to those numbers another 54 million Americans who suffer from elevated blood sugar, a condition considered a precursor to diabetes, and you start to see why some health care professionals are already calling this an epidemic.

Understanding diabetes

There are two kinds of diabetes — type 1 and type 2. While both have to do with the body's inability to regulate blood sugar, they differ dramatically in terms of treatment and prevention.

Type 1, formerly referred to as juvenile diabetes, appears in childhood or early adolescence and is the result of a physical malfunction that causes the body's own immune system to attack and destroy insulin-producing cells. Type 2, what we used to call adult-onset diabetes, is associated with lifestyle and is generally believed to be triggered by inactivity and significant weight gain.

Left uncontrolled, diabetes can damage major organs. Complications can lead to nerve damage, blindness, kidney failure and amputation. Diabetes is also considered a key risk factor for heart disease.

Change is possible

Recent studies indicate that changes in lifestyle — reducing weight by 5 to 7 percent coupled with moderate, regular exercise and a low-fat, low-calorie diet — can cut a person's risk of developing type 2 diabetes almost in half.

There's also good news for people already living with diabetes. Informed self-management in addition to regular monitoring by a knowledgeable health care professional can significantly reduce the frequency and severity of complications arising from type 1 and type 2 diabetes.

Self-Management Works:

- Controlling blood pressure can reduce the risk of heart disease and stroke by 40 percent.
- Controlling blood glucose can reduce the risk of eye, kidney and nerve disease by 40 percent.
- Controlling blood cholesterol can reduce cardiovascular complications by as much as 50 percent.
- Thorough, regular foot examinations can reduce amputations by 45 to 85 percent.
- Laser therapy can reduce the risk for loss of eyesight by 50 to 60 percent.

WHAT ABOUT THE
FISCAL TOLL EXACTED
BY DIABETES?

\$174

billion in direct and indirect costs (U.S. 2007)

\$116

billion in medial costs alone (U.S. 2007)

\$1^{out of every} \$5

spent on health care in this country goes toward caring for someone diagnosed with diabetes

Idaho is headed for a public health crisis of its own

Unfortunately, when it comes to diabetes, Idaho is right in line with national trends. In just 10 years — from 1994 to 2004 — diabetes among adults increased by a staggering 48 percent. And like the national picture, almost a third of the 72,000 Idaho adults who have diabetes don't realize they have the disease.

When you consider factors such as the rising number of uninsured, a rapidly aging population and a significant increase in the number of overweight and obese children and adults, it's apparent that Idaho faces a daunting challenge. Limiting our ability to respond to that challenge is the reality of a health care delivery system that is fragmented, underfunded and already overburdened. Clearly what's needed to deal effectively with the looming diabetes "epidemic" is a new plan of action.

**IDAHO HAS
WORK TO DO**

70k

adults have diabetes

80k

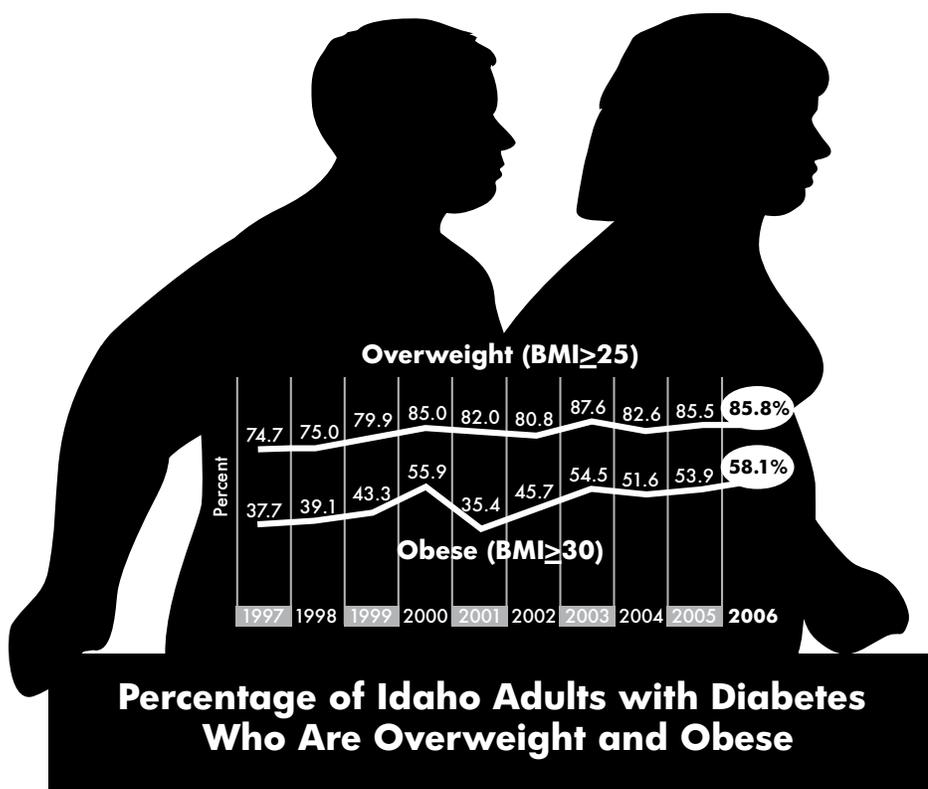
Idaho adults have pre-diabetes

2 in 5

adults aged 65 and over have diabetes

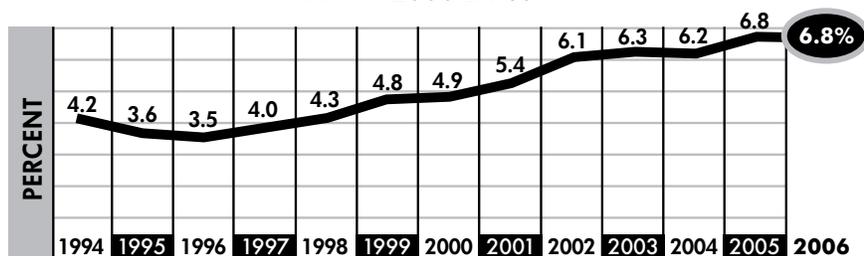
58%

of the population is overweight or obese – a major risk factor for diabetes



Percentage of Idaho Adults with Diabetes

1994 – 2006 BRFSS



IDAHO DIABETES STATE PLAN 2008-2013:

Creating Partnerships for Change

Improving the prevention, diagnosis and treatment of diabetes in Idaho is an enormous undertaking. The human and financial demands alone will far exceed the capacity of any single group, community or government entity, regardless of the level of commitment. Real success — something that is achievable and sustainable — can only be realized through a coordinated effort that brings together both traditional and non-traditional participants in a working partnership that is aligned with and guided by a central plan.

That guidance is exactly what the Idaho Diabetes State Plan 2008-2013 provides.

THE IDAHO DIABETES STATE PLAN IDENTIFIES FOUR GOALS:

- Quality of Care*** — Emphasizes the importance of following clinical guidelines that reflect the most current understanding of diabetes care and treatment. Recommends the use of technology to educate key populations and improve the efficiency of health care delivery systems.
- Access to Care*** — Identifies the most common barriers to care in Idaho and recommends solutions that will help to ensure effective medical care and self-management education for all who need it regardless of race, ethnicity, socio-economic status, native language or physical location.
- Diabetes Prevention and Prevention of Diabetes Complications*** — Offers ways to identify individuals and populations that are at high risk for diabetes as well as those who have diabetes, either diagnosed or undiagnosed, so they can be introduced to the system of care and receive appropriate treatment.
- Guide Public Policy*** — Recognizes the importance of educating policy makers and community leaders so they are better able to make informed decisions regarding quality of care, access to care and prevention.

DIABETES POSES AN EVEN GREATER THREAT TO SOME RACIAL AND ETHNIC GROUPS

- Native American teens have the highest rates of type 2 diabetes.
- African American, Hispanic and Native American adults are twice as likely as Caucasian adults to have diabetes.

LIFESTYLE MAKES A BIG DIFFERENCE

Inactivity and obesity are contributing factors in 90-95% of the cases of type 2 diabetes among people 40 years of age and older.

Encouraging collaboration, coordination and integration

As conceived, the Idaho Diabetes State Plan is a dynamic document that encourages participation by offering a range of intervention options so that organizations — large and small, urban and rural — can identify the opportunities within each goal that are best suited to their mission and resources.

Participation is only the first step. The plan also encourages the creation of communication channels to aid collaboration and the sharing of ideas. Whether supported by online technology or regularly scheduled face-to-face meetings, learning about successes and then finding the means to replicate those successes is central to the strategy driving the plan.

Another critical issue is data collection. Everything from gaining financial support to shaping public perception to evaluating the success of this plan depends on ready access to accurate data. For this reason, the plan encourages the development of processes and systems for collecting and communicating data gathered from programs and projects arising out of this plan’s interventions.

Finally, to bring about substantive change the Idaho Diabetes State Plan must remain relevant; a great deal can happen over a five-year period. To ensure its longevity, the Diabetes Prevention and Control Program, working with the Diabetes Alliance of Idaho, will be responsible for conducting regular reviews of the content to make certain that the plan always reflects the most current thinking on the subjects of diabetes diagnosis, management and treatment.



BE INSPIRED



Partnerships in Northern Idaho help point the way to healthy eating.

Shelly Johnson, University of Idaho Kootenai County extension educator, partners with senior centers in North Idaho to bring the Idaho Plate Method to people with diabetes. Healthy Eating with Diabetes (HEWD) offers free classes through funding from the local Area Agency on Aging. Since the HEWD program started in

2000, more than 600 people have learned how to make better food choices and to reduce their heart disease risk. Its partnership with Panhandle Health District and the Diabetes Prevention and Control Program helps northern Idahoans with diabetes develop better self-management skills.



Partnerships in Southeast Idaho help Hispanics with diabetes manage their disease.

Dr. Elizabeth Cartwright, Assoc. Professor in Idaho State University's Anthropology Department and Director of Hispanic Health Projects (HHP), partners with a tireless group of Hispanic community members, researchers and ISU students to address

diabetes among Hispanic people in the American Falls and Aberdeen areas of Southeast Idaho. Support from partners like the Southeastern District Health Department and Health West, Inc. helps bridge the gap between access and disparity.

Excellent work relating to diabetes prevention and treatment is already under way in most regions of our state, thanks to the commitment and talents of health care providers, educators, community leaders and service providers.



Partnerships in Boise and the Treasure Valley help economically disadvantaged Idahoans with diabetes manage their disease.

Lorrie Apel, Clinic Manager of the Garden City Community Clinic (GCCC), partners with Central District Health Department's Marjorie Rich, a registered dietitian and the diabetes program coordinator, to bring diabetes education and self-management

to patients in GCCC's Diabetes Care Program. The GCCC is a free clinic located in the heart of Ada County's medically underserved area. The clinic offers medical and dental services and donates supplies and medications to its patients.



Partnerships in South Central Idaho help rural Idahoans with diabetes manage their disease.

Susie Beem, Diabetes Program Coordinator of the South Central District Health Department, partners with the Magic Valley Diabetes Coalition to offer comprehensive screening and education in the Head-to-Toe Program. Supported by health care professionals, including eye specialists, podiatrists and certified diabetes educators, the Lion's Club

Mobile Screening Unit, the University of Idaho Cooperative Extension, and the Idaho Diabetes Prevention and Control Program, this program brings free eye screening, foot examinations and nutrition education to rural residents of Jerome, Richfield, Twin Falls, Bellevue, Fairfield, Shoshone, Hagerman and Buhl.

PLAN GOALS

GOAL 1 QUALITY OF CARE

Every patient deserves planned, patient-centered medical care on an ongoing basis by a team of skilled health professionals. Quality care follows recommended clinical guidelines that reflect the most current



understanding of diabetes care and treatment. Because diabetes is a complex disease, it is difficult for providers and patients to be aware of the most current treatments that result in quality diabetes care. At the same time, it is often difficult to deliver care that is culturally appropriate and sensitive to patient needs. The future of quality diabetes care should include

the use of technology to inform and educate the health care professional and the patient as well as creating efficient and effective health care systems that support quality improvement and team care.



PRIORITY 1

Evidence-Based Medical Care: Ensure that evidence-based medical care is practiced in medical settings by a prepared health care team and that patients are informed and actively engaged in their own care.

RECOMMENDED INTERVENTIONS

Clinical Practice Guidelines (CPG): Define, establish and promote CPGs for diabetes prevention and treatment based on science and evidence-based research.

Partnership Network: Develop and maintain a network of partners, such as the Diabetes Alliance of Idaho (DAI), that will promote and review progress toward achieving the clinical practice guidelines.

ABC's of Diabetes: Treat diabetes comprehensively so that A1c levels, blood pressure and cholesterol are kept as near to normal as is safely possible.

Patient Self-Management Goals: Implement programs that encourage and empower patients to set self-management goals and foster a responsibility for their own health.

Quality Measures: Identify national quality measures that are adopted by health systems, including health plans, to measure guideline outcomes.

Pre-diabetes and Undiagnosed Diabetes: Identify people with pre-diabetes as well as those who have undiagnosed diabetes and provide appropriate treatment and education.

Professional Education: Promote and provide ongoing professional education for health care providers about clinical practice guidelines, diabetes care and cultural competency, which includes cultural awareness and sensitivity.

Culturally Sensitive Health Care: Develop programs and processes to ensure that people of underserved racial and ethnic populations receive culturally effective, quality diabetes care, including culturally and linguistically relevant patient self-management tools. As often as possible, medical information should be provided in the patient's or the family's primary language.

*I consider
type 2 diabetes as
a disease of 'choice.'
The choices I made
got me there.
The choices I am
making got me through it.
The choices I will
make will determine my
disease in the future.*

Deb Filler

EXPECTED OUTCOMES

- ▶ Recognized uniform set of clinical practice guidelines are adopted by health care organizations, health plans and health care professionals that result in improved medical outcomes for people with diabetes.
- ▶ Increased number of providers trained and using clinical practice guidelines and informed about diabetes care.
- ▶ Increased number of people with diabetes reaching recommended or optimal A1c, blood pressure and cholesterol levels and receiving recommended foot exams, eye exams and vaccinations.
- ▶ Increased number of high-risk individuals assessed for pre-diabetes and diabetes.
- ▶ Increased number of people with diabetes setting self-management goals.
- ▶ Increased number of programs and tools that are culturally and linguistically specific for underserved racial and ethnic populations, including medical interpretation resources.
- ▶ A reduction in the burden that diabetes places on underserved populations as reflected in diabetes clinical measures and prevalence.



PRIORITY 2

Multidisciplinary Team Care: The function of a multidisciplinary team is to provide continuous and supportive care for people with diabetes throughout the course of their disease. Patients must be included as a member of the health care team and must be empowered to help direct their own care. Good team care is cost-effective and should be continuous, proactive, planned, patient-centered and population-based. Team care should occur in acute care settings as well as in chronic care clinical settings. Although team care is ideally addressed in one clinical setting, a team approach to care can be delivered through disease management programs, in diabetes self-management education programs, and in some cases, community settings. When possible, teams should include individuals who are linguistically and culturally diverse. Key to quality team care is the attention that is paid to behavioral and mental health issues.

RECOMMENDED INTERVENTIONS

Acute Care: Hospitals should have coordinated, formalized protocols for the management of patients with diabetes that include documentation of plans for:

- General recommendations for diabetes care including nutrition management.
- Blood glucose targets.
- Treatment of hypoglycemia and hyperglycemia.
- A team of care providers educated in the specific management of diabetes.
- Patient diabetes self-management education.

Communication: Information about patient health status should flow between the hospital setting and out-patient clinical setting and be complete and timely to provide optimal care. The patient and/or patient’s family should be adequately informed of care requirements in their preferred language when possible.

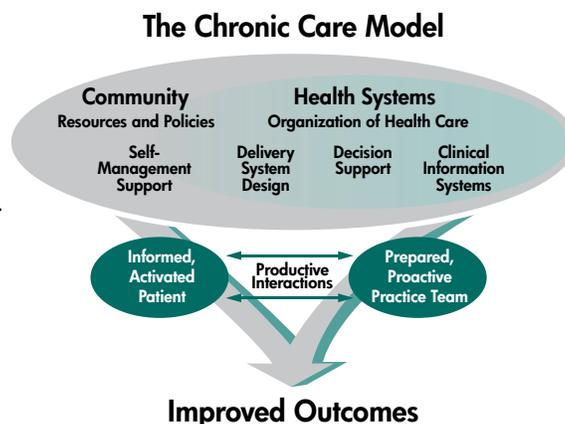
Disease Management: Implement programs that promote preventive care, teach evidence-based care and result in improved patient outcomes, especially for high-risk patients.

Diabetes Self-Management Education Programs (DSME):

Promote patient referrals to American Diabetes Association or Indian Health Service – recognized DSME programs.

Team Care: Promote the concept of team care by involving podiatrists, eye specialists, pharmacists, nurses, dietitians, dental professionals, mental health counselors and others as members of the diabetes care team. Ensure that teams are linguistically and culturally diverse, when possible.

Mental and Behavior Health: Provide mental and behavioral health assessment and counseling to patients as part of comprehensive care. Include mental health counselors as members of the diabetes care team.



EXPECTED OUTCOMES

- ▶ Increased number of hospitals reporting formalized protocols for the management of people with diabetes in a hospital setting.
- ▶ Increased number of hospitals reporting a communication system that includes informing the primary care physician and the patient about health outcomes.
- ▶ Increased number of patients in disease management programs that experience better health outcomes.
- ▶ Increased number of people receiving diabetes self-management education.
- ▶ Increased number of people who are able to set self-management goals.
- ▶ Increased number of podiatrists, eye specialists, pharmacists, dietitians, dental professionals and other health providers who are accessible to people with diabetes.
- ▶ Increased number of people receiving a mental health assessment.



Developing Cultural Competency

(Cultural Appropriateness)

Ensuring the implementation of interventions that are specifically designed to meet the needs of identified disparate populations. Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enables this system, agency or those professionals to work effectively in cross-cultural situations.

PRIORITY 3

Health Information Technology: Information technology, including the Internet, is demonstrating enormous potential to transform the health care delivery system where patient and health system information can provide secure, seamless, time-sensitive care and actively involve patients in their own self-care. Expand the use of electronic medical records and registries to promote quality diabetes care, Internet communication between patients and the health care team, and preventive care reminders that ensure care at appropriate intervals.

RECOMMENDED INTERVENTIONS

Electronic Medical Records and Registries (EMR): Expand and support the use of EMRs to prompt preventive care, promote comprehensive care, communicate and track care, and monitor the quality of care.

Communication Technologies: Use Internet-based and other technologies to provide patient education and disease management in multiple languages with the goal to monitor diabetes care and blood glucose control.

Telemedicine: Promote distance technologies that encourage and assist patients to receive regular, recommended exams, such as tele-retinal exams and blood glucose checks.

Tele-Education: Promote and support the use of information and communication technologies to provide continuing medical education (CME) for all health care professionals and to enable distance education of patients.

EXPECTED OUTCOMES

- ▶ Increased number of patients whose A1c, blood pressure, cholesterol and other measures reach target values.
- ▶ Increased number of clinics establishing clinical information systems through electronic medical records and registries that demonstrate improved care and report improved quality of diabetes care.
- ▶ Increased number of federally qualified community health clinics (Idaho Primary Care Association) using electronic medical records and registries.
- ▶ Increased number of providers and physician practices that can demonstrate improved diabetes care because of established quality measures.
- ▶ Increased number of patients who can report satisfaction and benefit in receiving personal medical information via the Internet such as appointment scheduling, health information, lab reports, blood glucose monitoring and dialogue with a provider.
- ▶ Increased number of patients participating in disease management programs resulting in better diabetes care.
- ▶ Increased number of telemedicine systems that deliver medical care, especially in rural areas, which can enable patients to receive medical care such as retinal eye exams.

PRIORITY 4

Professional Education: Diabetes is one of many chronic diseases, and perhaps the most complicated, that providers treat in the course of medical practice. Translation of medical research is resulting in new treatment options including medication, medical equipment and supplies, and increased knowledge about the disease itself. A knowledgeable, culturally diverse and informed health care workforce is necessary to ensure quality diabetes care.

RECOMMENDED INTERVENTIONS

Continuing Medical Education (CME): Plan for and provide a range of CME opportunities for health care professionals, including regional workshops, conferences, seminars and grand rounds focused on diabetes care.

Health Care Student Education: Encourage state university programs to provide diabetes education in their medical and health curricula in programs such as nursing, dietetics, physician assistant, residency programs, dental, pharmacy, public health and health promotion.

Professional Education Availability: Develop a centralized clearinghouse of education opportunities and a dissemination strategy to advertise education opportunities. Key characteristics of the system include:

- A regularly updated electronic system.
- On-line access to the list.
- A system that is easily accessed throughout the state.

EXPECTED OUTCOMES

- ▶ Increased number of continuing education programs that focus on diabetes translation research, best practices and standards of care resulting in informed health professionals and students in health care professions.
- ▶ Improved patient outcomes as a result of a better-informed health care workforce.



PRIORITY 5

High-Risk Populations and Disparate Communities: People at high risk for developing diabetes are those who have a low socio-economic status and a lower level of education, live in a rural area, may be elderly and/or may be part of a high-risk racial or ethnic group. None of these factors should reduce the quality of diabetes care that is made available to these people. It is important for health care professionals to be sensitive to the needs of all patients, but it is especially important to be sensitive to those facing diabetes without resources and to be respectful of their cultural beliefs. Information and care should be delivered where people live, work, worship and play and be provided in multiple languages.

RECOMMENDED INTERVENTIONS

Culturally Sensitive Health Care System: Ensure an informed, culturally sensitive provider delivery system by promoting cultural competency training and education programs for health care professionals, which will help to improve diabetes care and to create culturally sensitive health systems for disparate populations.

Patient Education Materials: Provide health information using an array of different media and in other languages.

Health Information Programs: Provide opportunities for people to receive basic diabetes care and information in non-medical settings such as worksites, faith communities, senior centers, cultural centers, community centers and through trained community/lay health workers such as promotoras and community health representatives.

EXPECTED OUTCOMES

- ▶ Increased number of health professionals who have received cultural competency training and who can demonstrate improved competency.
- ▶ Increased number of bilingual or multilingual health care professionals.
- ▶ Increased number of materials and information made available in other languages.
- ▶ Increased number of non-medical settings providing diabetes information.

My thoughts are for you to be concerned about, and involved in, more public awareness activities regarding this silent killer. Discuss ways and methods to bring a strong resounding message that will appeal to Hispanics.

Loretta Nicol
 Medicare Specialist
 Canyon County
 Organization on Aging

GOAL 2 ACCESS TO CARE

Some people with diabetes are less likely to receive medical care and diabetes self-management education because of socioeconomic status, age or race and ethnicity. People living in rural areas of Idaho may be less likely to access care because of

distance from a primary care provider or specialist. Being uninsured or underinsured may prevent people from accessing continuous, planned care that results in better diabetes management. People who are of a racial or ethnic community may be less likely to access or receive care because of language, ability to pay or cultural beliefs about health and illness.



PRIORITY 1

Linking People to Health Resources and Care: Challenges to accessing care include an uneven distribution of health care services, especially in rural areas, and lack of awareness by people about diabetes resources outside of the clinical setting, such as diabetes education programs, community programs and support groups. Knowledge of where the gaps in care and information exist will enable the diabetes health system to identify and implement solutions to improve access to care for more people. Conducting a comprehensive needs-assessment process should result in greater access for more people to diabetes resources and the development of resources where they are lacking.



RECOMMENDED INTERVENTIONS

Needs Assessment: From 2009 to 2010, conduct a comprehensive needs assessment of diabetes resources involving individuals and organizations who are involved in diabetes prevention and care, including but not limited to:

- Diabetes self-management education programs.
- Specialist care such as podiatry, ophthalmology/optometry, medical nutrition therapy, dental, behavioral health and others.
- Medicare and Medicaid coverage.
- Community health worker or promotoras programs.
- Federally qualified community health clinics, free clinics and rural health clinics.
- Community partners such as non-profits, philanthropic organizations, State of Idaho commissions (Aging, Blind, Hispanic), retail pharmacies, worksites.
- Diabetes support groups.
- Organizations that provide patient education printed materials, available in multiple languages, including those from the National Diabetes Education Program, the American Diabetes Association and other national organizations.
- Community wellness programs.
- Telemedicine capacity.

- University programs and projects.
- District health departments representing local public health.
- Regional Idaho Department of Health and Welfare offices.
- Transportation resources.
- Pandemic and disaster health planning groups.

Idaho Diabetes Resource Guide:

Compile and distribute a comprehensive list of resources in multiple languages, including links to medical care, diabetes self-management education, patient information and health programs such as smoking cessation, nutrition and physical activity.

Internet Linking: Develop an Internet-based link to diabetes resources.

“Medical Homes”: Assess the potential of and participate in the development of a health system to provide services to people who are uninsured or underinsured and who lack a medical home in areas such as:

- Free clinics.
- Federally qualified community health clinics.
- Free and reduced prescription drug programs.
- Volunteerism by medical professionals.

EXPECTED OUTCOMES

- ▶ A Needs Assessment Report based on the outcomes of the needs assessment process.
- ▶ A multilingual Idaho Diabetes Resource Guide supported by the Diabetes Alliance of Idaho and made electronically available to people with diabetes and health professionals.
- ▶ Increased number of people with diabetes and their families who receive the services they need, including diabetes self-management education, medical care, links to Medicare and Medicaid and federal programs such as Food Stamps and WIC (Women, Infants and Children).
- ▶ Increased number of people who access the resource guide via the Internet.
- ▶ Increased number of community programs that give people the opportunity to learn diabetes self-management skills outside of a medical setting and in a culturally and linguistically appropriate manner.
- ▶ Increased number of clinics providing free and affordable services.

PRIORITY 2

Telemedicine/Telehealth: Rural areas often have limited access to care while experiencing the greatest need for a specialist to manage and treat patients with chronic diseases, such as diabetes. Telemedicine uses technology to help close this disparity gap. For example, home-based telemedicine utilizing an interactive television connection permits not only observation and communication but tests for indicators like blood pressure, blood sugar and heart sounds.

Telemedicine consultations using videoconferencing technology allow increased access to medical services at urban or rural area hospitals and ambulatory care settings. Telemedicine saves money and time spent traveling to large urban areas or major medical centers and encourages the participation of the primary care provider in the direct care of the patient.

RECOMMENDED INTERVENTIONS

Telemedicine/Telehealth Systems: Explore and expand the use of telemedicine systems such as videoconferencing, interactive television connections and home telephone monitoring that uses low-cost televideo equipment running over regular phone lines.

Personal Health Records: Empower patients to use technology as part of their health care and diabetes self-management, including computer links to their personal health record.

Electronic Medical Records and Registries: Increase the number of electronic medical records and registries that are linked among health systems such as provider to provider, patient to provider/clinic and patient to provider to ensure continuity of care.

EXPECTED OUTCOMES

- ▶ Increased ability to provide expert-based health care to understaffed rural areas and to provide advanced emergency care.
- ▶ Increased number of programs that allow patients to see their personal health record.
- ▶ Increased number of health systems that are linked electronically.



PRIORITY 3

Community Partnerships: Partnerships outside of the health care setting provide resources and opportunities to help people prevent and control diabetes and chronic disease. Bringing programs, health messages and health professionals to where people live, work and play provides more opportunity to help people live healthy lives and encourages personal responsibility for managing disease and health. Community partnerships increase the potential to reach high-risk groups of people in rural communities who are of low socioeconomic status and/or members of a racial or ethnic minority.



RECOMMENDED INTERVENTIONS

Nontraditional Health Care Delivery Sites: Develop partnerships that expand the use of mobile screening and exam units in rural communities that are one-stop venues for delivery of basic diabetes screening and exams by a variety of health care professionals. Examples of nontraditional sites include:

- Mobile screening vans provided by universities or philanthropic organizations such as Idaho State University or the Lions Club and local public health districts.
- Churches or faith communities.
- Community centers at such places where migrant seasonal farm workers can access basic care and information.

Worksite Wellness: Develop employer-based programs that provide diabetes disease management and information, and health care coverage for education, medication, supplies and nutrition and physical activity information to help employees better manage their diabetes.

Transportation: Develop transportation programs through grants and partnerships that provide transportation to medical care by public transportation or through use of gas vouchers.

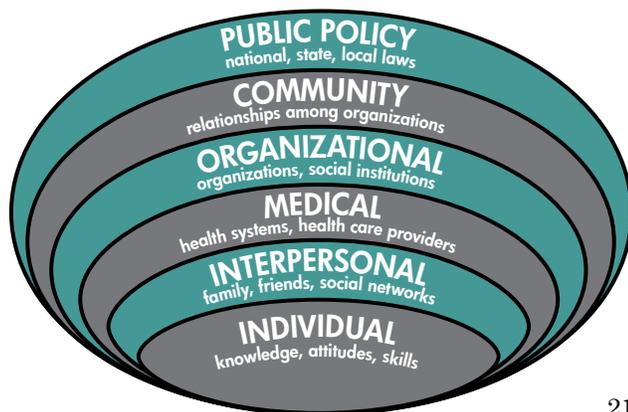
Promotoras and Community Health Worker Programs: Implement the promotoras or community health worker model in communities where culturally relevant health care and health information promote improved health outcomes.

Chronic Disease Self-Management Programs: Implement evidence-based, culturally and linguistically appropriate programs that empower people to improve diabetes self-management skills.

EXPECTED OUTCOMES

- ▶ Increased number of communities where basic diabetes screenings and self-management information are provided.
- ▶ Increased number of diabetes programs in faith communities and community centers.
- ▶ Increased number of diabetes programs available for seasonal farm workers.
- ▶ Increased number of employers who have wellness programs with diabetes management and prevention as a priority.
- ▶ Reduced number of sick days reported by employers.
- ▶ Increased funding for transportation programs.
- ▶ Increased number of promotoras or community health workers trained to provide basic diabetes information in their community.
- ▶ Increased number of chronic disease self-management programs.

Socio-Ecological Model



GOAL 3 DIABETES PREVENTION AND PREVENTION OF DIABETES COMPLICATIONS

The rate of diabetes in Idaho and the United States continues to increase as does the rate of pre-diabetes. Since 1994 in Idaho, the rate of diabetes has gone from 4.2 percent to 6.8 percent in 2006 — a 61 percent increase. In a landmark study, the Diabetes Prevention

Research Group found that a weight loss of 5 to 7 percent was linked to a 58 percent reduction in diabetes. As of 2006, 8 percent of Idaho adults had been told by a doctor that they have pre-diabetes — when a person's blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. To improve health outcomes and to prevent the complication of diabetes, it is essential to identify people who are at high risk for diabetes as well as those who have diabetes, either undiagnosed or diagnosed, and treat them appropriately.



PRIORITY 1

Public Awareness and Responsiveness: People may be unaware that they are at risk for developing diabetes or that they have diabetes. These individuals may not seek preventive medical care such as having regular blood glucose checks, monitoring blood pressure and checking cholesterol.

RECOMMENDED INTERVENTIONS

Health Messages:

- Develop and promote core messages about diabetes prevention that are consistently and accurately communicated where people live, work and play and seek medical care.
- Promote the use of information technologies that educate patients about how to prevent and self-manage type 2 diabetes.
- *National Diabetes Education Program (NDEP):* Promote nationally recognized diabetes prevention and control messages such as “Small Steps = Big Rewards” (see <http://cdc.gov/diabetes/ndep>).

Lifestyle:

- Implement programs that educate and motivate people to improve their nutrition and their physical activity levels to reach and maintain a healthy weight.
- Partner with statewide and local health promotion programs such as the Idaho Physical Activity and Nutrition Program (IPAN) to promote healthy lifestyles to the public.
- Encourage primary care physicians and other health professionals to counsel patients to develop a healthy lifestyle.

Diabetes Risk Assessment:

- *Medical Settings:* Promote risk assessment of diabetes through paper screening tests, family history assessment and medical evaluation including checking blood glucose levels, cholesterol and blood pressure.
- *Community Settings:* Ensure that whenever diabetes risk assessments are conducted in public settings, people have the opportunity to seek medical treatment if indicated.

Medication Adherence: Encourage patients to take medications as prescribed to manage blood pressure, cholesterol and other health conditions.

Smoking Cessation Counseling: Ensure that patients who are ready to quit smoking receive smoking cessation counseling and are directed to local resources such as Health District smoking cessation programs and QuitNet and QuitLine.

Self-Management: Encourage people with diabetes to actively engage in self-management of their disease by helping patients to set goals with their health professional and linking them to diabetes self-management education programs.

Community Partnerships: Develop community partnerships and programs that promote healthy communities where people live, work and play such as:

- *Media:* Engage the media to promote diabetes prevention messages.
- *Faith Communities:* Partner with places of worship to provide health messages to members.



- *Worksites and Employers:* Collaborate with employers to provide wellness programs to employees such as www.diabetesatwork.org.
 - *Philanthropic and Professional Organizations:* Engage these organizations in increasing awareness about diabetes and funding programs that promote prevention of diabetes and control of complications.
 - *Schools:* Advocate for required physical activity classes, healthy food choices and health education to students and school staff. Link diabetes prevention to school health through Idaho Department of Education through the Coordinated School Health Program.
 - *Parks and Recreation:* Develop programs and health messages that engage the public in using community parks and facilities to prevent diabetes and other chronic diseases.
 - *Planning and Zoning:* Actively participate in designing healthy communities that promote healthy lifestyles.
- ▶ Increased numbers of patients who report taking diabetes self-management classes or who engage in self-management practices.
 - ▶ Increased number of physician practices or clinic systems that report having a quality measure related to assessing patients for pre-diabetes.
 - ▶ Increased number of people at high-risk for diabetes who can identify a “medical home.”
 - ▶ Improved management of diabetes and other chronic conditions because of medication adherence, specifically improved blood glucose, cholesterol and blood pressure control.
 - ▶ Increased number of media partners providing public service announcements, feature stories and health information reporting.
 - ▶ Increased number of faith communities promoting health messages and activities related to diabetes prevention and control of complications.
 - ▶ Increased number of employers working with health plans, public health or a medical organization to provide wellness programs to employees.
 - ▶ Increased participation of philanthropic and professional organizations engaged in programs and funding to prevent diabetes complications.
 - ▶ Increased number of schools implementing effective policies, environmental change and education around physical activity, nutrition and tobacco prevention.
 - ▶ Increased number of people with pre-diabetes or diabetes who stop smoking.
 - ▶ Increased number of partnerships with communities who report working with parks and recreation and planning and zoning to promote healthy living options that could result in the decrease in diabetes and other chronic diseases.

EXPECTED OUTCOMES

- ▶ Increased distribution of diabetes prevention messages in community settings and promoted by partners.
- ▶ Increased use of NDEP materials promoting the prevention of diabetes and prevention of diabetes complications.
- ▶ Increased use of information technologies that educate patients about how to prevent and self-manage type 2 diabetes.
- ▶ Decrease in the number of people developing diabetes.
- ▶ Increased number of programs that help people improve their nutrition and physical activity.
- ▶ Increased number of physicians who report counseling and goal setting with patients on lifestyle changes, including medication adherence.

PRIORITY 2

Evidence-Based Medicine and Standards: Sound, evidence-based strategies must be taken to delay or prevent the onset of diabetes. Health care providers and other individuals working with at-risk populations should be encouraged to use interventions that are most likely to benefit their patients. Using evidence-based medicine and standards enables providers to achieve outcomes earlier that last longer, are cost-effective and ethical.

RECOMMENDED INTERVENTIONS

Diagnostic Criteria: Promote the clinical practice guidelines for diagnosis and care of pre-diabetes and diabetes.

Primary Care: Ensure that the pre-diabetes diagnosis is a high priority of primary health care and is paired with patient counseling to reach and maintain a healthy weight through healthy eating and physical activity as well as smoking cessation.

Ensure that people with diabetes engage in regular, routine self-management practices such foot exams, eye exams, vaccinations, A1c tests and medication adherence.

Health Plans: Promote coverage for pre-diabetes self-management, including allowing employers to purchase plans that cover pre-diabetes and other wellness and prevention options.

EXPECTED OUTCOMES

- ▶ Improved quality of care including early diagnosis of pre-diabetes and diabetes.
- ▶ Increased number of health professionals in primary care settings who report counseling patients to improve lifestyle behaviors such as weight loss and smoking cessation.
- ▶ In the long term, a decreased rate of diabetes complications such as blindness and impaired vision, nerve damage, high blood pressure and cardiovascular disease.
- ▶ Increased number of people able to access pre-diabetes self-management education that is a covered health plan benefit.

The key function of a multidisciplinary team is to provide continuous, comprehensive and aggressive lifetime management for people with diabetes.

Kris Ernst, RN, CDE
American Association of Diabetes Educators

PRIORITY 3

Populations and Communities at High Risk for Diabetes: People who are uninsured, underinsured, of low socio-economic status or of a racial or ethnic group are at higher risk for developing diabetes and often have fewer opportunities or experience barriers in seeking medical care or preventive services.

RECOMMENDED INTERVENTIONS

Barriers to Diagnosis and Care: Identify barriers to screening for pre-diabetes and diabetes for high-risk, hard-to-reach populations and disparate communities. Focus on strategies to reduce barriers.

Culturally Appropriate Health Messages: Distribute culturally and linguistically appropriate diabetes prevention messages.

Food and Nutrition:

- Support the pricing and distribution of affordable fruits and vegetables.
- Educate people about affordable, healthy, nutrient-rich foods while respecting cultural preferences for food choices.
- Link people to food and nutrition assistance programs that ensure a quality diet such as Food Stamps and the Women, Infants and Children (WIC) Program.

EXPECTED OUTCOMES

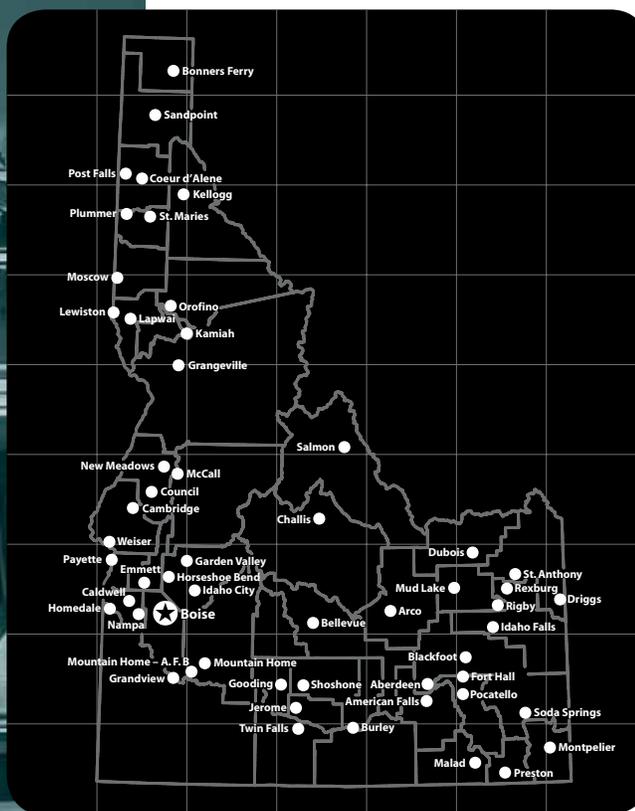
- ▶ Increased number of people at high risk for developing diabetes that are screened and provided necessary medical services.
- ▶ Increased number of people who are aware of the risk for developing diabetes.
- ▶ Increased number of programs and messages that promote good nutrition.
- ▶ Increased number of people who are enrolled in Food Stamp and WIC Programs.



GOAL 4 GUIDE PUBLIC POLICY

To achieve quality of care, access to care, diabetes prevention and prevention of complications, policy and decision makers must be informed about the problem of diabetes and make diabetes a high priority. Good policy decisions from a legislative or organizational

level can produce positive and powerful effects on health systems, enable people to access health care and help communities influence healthy behaviors.



PRIORITY 1

Policy Development: The goal of diabetes policy and advocacy is to ensure that policies improve access, quality of care and the environment for people with diabetes. Policies can range from coverage for diabetes education to policies in workplaces or in schools that support healthy food options for employees and students, respectively. Advocacy is the tool that increases awareness about the need for, and use of, these policies.

Gathering and reporting compelling data that not only measure the problem of diabetes but also the positive outcomes from well-structured programs are critical activities that can shape policies. Data sources must come from a wide selection of Idaho’s citizens, including racial and ethnic minorities, from rural areas and the under- and uninsured members of our communities.

RECOMMENDED INTERVENTIONS

Policy Gap Analysis: Conduct a diabetes-related policy gap analysis to identify high-priority community and health system issues. The analysis should include policies directed at groups that are at high risk for diabetes, including communities of color and the uninsured and underinsured. The analysis should also include identification of cultural competence curricula in clinical training programs and continuing professional education.

Burden of Diabetes and Other Chronic Diseases: Maintain an ongoing system of data collection and reporting that describes the impact of diabetes and co-morbid chronic diseases. Advocate and plan for new sources of data that measure health outcomes.

Economic Impact: Report the economic impact of diabetes. Monitoring and reporting the economic impact, including direct and indirect medical costs, opens opportunities to develop cost-saving approaches to preventing and treating diabetes.

Success Stories: Elicit testimonials, patient stories and case studies that demonstrate the success in preventing or treating diabetes. Share information with policymakers and legislators.

Diabetes State Plan: Conduct ongoing evaluation of the plan’s interventions to measure and communicate the state’s efforts to prevent and treat diabetes effectively.

EXPECTED OUTCOMES

- ▶ A policy report defining the gaps in policy and solutions to address the gaps.
- ▶ Data and economic reports disseminated to policymakers, health professionals and the public.
- ▶ Increased contact with policymakers and legislators.
- ▶ Increased level of legislation and policies implemented that have the potential to prevent diabetes or assist people with diabetes to experience better health.
- ▶ Increased number of success stories reported.
- ▶ Improved diabetes outcomes across State Plan Priorities.

PRIORITY 2

Diabetes Alliance of Idaho (DAI): Strengthen the DAI to enable it to fulfill its mission. DAI is the statewide diabetes partnership network focused on improving access to quality health care, increasing awareness and support through diabetes education, preventing diabetes and reducing diabetes-related complications for those challenged with diabetes in Idaho.

RECOMMENDED INTERVENTIONS

State Plan: The DAI will address State Plan Priorities, report and evaluate outcomes.

Advocacy: Use DAI members and their organizations to build bridges to the Legislature, Governor’s office, business community and other advocates.

Diabetes Media Messages: Develop a “media kit” or diabetes informational packet that includes fact sheets, talking points, data, best practices, contact information and more. Disseminate to statewide media, legislators, advocates, hospitals, universities and others.

Advocacy Training: Provide training to DAI organizations and individuals about effective advocacy methods.

EXPECTED OUTCOMES

- ▶ Increased recognition of the DAI as the lead organization in promoting quality diabetes care, improved access to care and diabetes prevention.
- ▶ Increased number of DAI members trained in advocacy and engaging advocacy activities to improve policy.
- ▶ Diabetes media messages.

PRIORITY 3

Data Sources: Data measures the impact of diabetes on the people of Idaho. It describes the quality of care in medical settings and is essential for defining programs to prevent and treat diabetes. Data gathered must include racial and ethnic minorities and disparate populations.

RECOMMENDED INTERVENTIONS

New Data Sources: Advocate for compelling data sources such as hospital discharge data that measures quality of care.

Data Dissemination: Translate data into actionable, clear and persuasive messages to provide a credible and convincing story for policy change and development. Distribute data to health care providers, policy and decision makers, and the public.

Annual Report: Produce an annual report dedicated to diabetes prevention and treatment among Idahoans and distribute to a wide audience of partners including the regional health districts, legislators, hospitals, physicians and other partners that use all these data sources.

EXPECTED OUTCOMES

- ▶ Increased number of data sources available.
- ▶ Increased use of data that supports convincing and credible messages, which can then influence policy change and development.
- ▶ Increased number of diabetes programs or initiatives directed by data.

PRIORITY 4

Funding: Seek additional and adequate funding sources to enable diabetes prevention and care at the community, organizational, medical and individual level.

RECOMMENDED INTERVENTIONS

EXPECTED OUTCOMES

Grants: Seek funding for diabetes prevention and treatment programs to reach people at high risk for developing diabetes or who have diabetes, which also includes culturally and linguistically underserved communities.

► Increased funding overall.

Governmental Funding: Advocate for increased funding from government sources.



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RESOURCES

American Association of Clinical Endocrinologists (AACE)
www.aace.com/

American Association of Diabetes Educators (AADE)
www.aadenet.org

American Diabetes Association
www.diabetes.org

American Dietetic Association
www.eatright.org

American Heart Association—The Heart of Diabetes
www.s2mw.com/heartofdiabetes/index.html

Centers for Disease Control and Prevention
www.cdc.gov/health/diabetes.htm

Chronic Care Model
[www.ihl.org/IHI/Topics/ChronicConditions/Diabetes and at](http://www.ihl.org/IHI/Topics/ChronicConditions/Diabetes_and_at)
www.improvingchroniccare.org/

Diabetes Alliance of Idaho
www.diabetesidaho.org

Health Disparities Collaborative
www.healthdisparities.net

Improving Chronic Illness Care Program
www.improvingchroniccare.org

National Committee for Quality Assurance
www.ncqa.org

National Diabetes Education Program
www.ndep.nih.gov

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
www.niddk.nih.gov/health/diabetes/diabetes.htm

Stanford Self-Management Programs
<http://patienteducation.stanford.edu/programs/>

GLOSSARY

Access: A person's ability to obtain appropriate health care services. Barriers to access can be financial, geographic, organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing or improving health coverage.

Alternative and complementary care:

A group of diverse medical and health care systems, practices and products that are not presently considered to be part of conventional medical care as practiced in the U.S. Examples include dietary supplements, acupuncture, chiropractic manipulation, massage, meditation and prayer, therapeutic touch, electromagnetic fields and aromatherapy. More information can be found at: <http://nccam.nih.gov>.

Best practices: Best practices in health promotion are those sets of processes and activities that are consistent with health promotion values, goals, ethics, theories, beliefs, evidence and understanding of the environment and that are most likely to achieve health promotion goals in a given situation.

Blood glucose meter: A machine used to measure blood glucose from a drop of blood placed on a specially coated strip; can be used outside of a physician's office or lab.

Behavioral Risk Factor Surveillance System (BRFSS): BRFSS is the largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the U.S. annually since 1984. Conducted by the 50 states, it provides state-specific information about health issues such as diabetes, asthma, cancer screening, obesity, tobacco use and more.

Blood glucose: The main sugar that the body makes from food we eat. Glucose is carried through the bloodstream to provide energy to all of the body's living cells. The cells cannot use glucose without the help of insulin.

Body mass index (BMI): A formula that assesses both height and weight to classify overweight and obesity and to estimate the relative risk of disease. BMI numbers define overweight as a BMI >25 and obese as a BMI >30 (<http://www.nhlbhsupport.com/bmi/bmicalc.htm> (<http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm>).

Built environment: Settings for which policies, social factors and physical space can be manipulated at some level. Built environments that impact diabetes include walking paths and recreational areas; healthy food choices in grocery stores, restaurants and schools; non-smoking policies; community-based educational programs; transportation to care settings; etc.

Case management: A process used by a doctor, nurse or other health professional to manage a person's health care. Case management ensures that people can access health services and resources.

Centers for Disease Control and Prevention (CDC), Division of Diabetes Translation (DDT): The DDT is part of the National Center for Chronic Disease Prevention and Health Promotion at CDC under the U.S. Department of Health and Human Services (DHHS). The mission of DDT is to eliminate the preventable burden of diabetes through leadership, research, programs and policies that translate science into practice.

Chronic Care Model: A model for health care improvement that identifies the essential elements of a health care system in order to encourage high-quality chronic disease care. The elements that are targeted are: community, health system, self-management support, delivery system design, decision support and clinic information systems. The expectation is that patients are healthier and providers more satisfied, resulting in health care cost savings. (www.improvingchroniccare.org)

Community-based organization: A private non-profit organization that is representative of a community or significant segments of a community and provides educational or related services to individuals in the community.

Complications: Conditions that can result from poorly controlled diabetes. Complications can also be considered secondary health problems. Some examples include eye and dental disease, foot problems, and heart and kidney disease.

Covered services/coverage: Health care services that are paid for, completely or partially, by an insurance plan. Coverage for diabetes-related services may vary between insurers and insurance products.

Diabetes:

Type 1 diabetes: A condition in which the pancreas makes so little insulin that the body cannot use blood glucose as energy. Type 1 diabetes most often occurs in people younger than age 30 and must be controlled with daily insulin injections.

Type 2 diabetes: A condition in which the body either makes too little insulin or cannot use the insulin it makes in order to turn blood glucose into energy. Type 2 diabetes can often be controlled through meal plans and physical activity. Some people with type 2 diabetes have to take diabetes pills or insulin.

Gestational Diabetes: Gestational diabetes mellitus (GDM) is defined as any degree of glucose intolerance with onset or first recognition during pregnancy. The definition applies whether insulin or only diet modification is used for treatment and whether or not the condition persists after pregnancy. It does not exclude the possibility that unrecognized glucose intolerance may have antedated or begun concomitantly with the pregnancy.

Diabetes Educator: Diabetes educators are health care professionals who focus on helping people with and at risk for diabetes and related conditions achieve behavior change goals which, in turn, lead to better clinical outcomes and improved health status. Diabetes educators apply in-depth knowledge and skills in the biological and social sciences, communication, counseling and education to provide self-management education/self-management training.

Diabetes self-management education

(DSME): Diabetes education, also known as diabetes self-management training (DSMT) or diabetes self-management education (DSME), is defined as a collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions. DSMT/DSME is an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and the diabetes educator(s). The intervention aims to achieve optimal health status, improve quality of life and reduce the need for costly health care.

Dilated eye exam: An eye exam in which eye drops are put in the eyes before the exam. The drops enlarge the pupils so that the doctor can clearly see the retina, or back of the eye.

Diabetes disease burden: Disease burden is the impact of a health problem in an area measured by financial cost, mortality, morbidity or other indicators. It is often quantified in terms of quality-adjusted life years or disability-adjusted life years, which combine the burden due to both death and morbidity into one index. This allows for the comparison of the disease burden due to various risk factors or diseases. It also makes it possible to predict the possible impact of health interventions.

Diversity/diverse or disparate populations:

Groups of people distinguished by social or demographic elements such as race/ethnicity, socioeconomic status, age and gender as well as culture, history, beliefs, attitudes, experiences, practices and health issues.

Electronic medical records (EMRs):

Computer-based patient medical records, which provide a comprehensive, easily accessible medical history for every person.

End-stage renal disease (ESRD):

End-stage renal disease (ESRD) is that stage of kidney impairment which is irreversible, cannot be controlled by conservative management alone and requires dialysis or kidney transplantation to maintain life.

Glycosylated hemoglobin (HBA1c or A1c): Glucose attaches to the hemoglobin component of the red blood cell and increases in proportion to the blood glucose level over the preceding three to four months in people with diabetes. It is an accurate measure of chronic glycemia in diabetes. The nondiabetic reference range is an A1c percentage of 4.0-6.0. Regular A1C testing is essential to monitor the effectiveness of diabetes treatment plans.

Guidelines: Clinical practice recommendations for managing or preventing diseases. Guidelines are usually based on scientific evidence or expert opinion. Guidelines covering various elements of diabetes prevention and care are produced by a number of organizations for a variety of caregivers (including people with diabetes). See <http://www.guidelines.gov/> for an extensive listing.

Health disparities: Refers to specific populations and communities experiencing unequal (higher) incidence, prevalence, mortality and burden of diseases and other adverse health conditions as compared to the health status of a general population. Efforts to identify and address health disparities will pay particular attention to populations that have historically been disadvantaged in some way, including by race, ethnicity, socioeconomic status, education level, disability, gender, age, occupation, sexual orientation and/or geographic location.

Health literacy: The capacity of an individual to obtain, interpret and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing. This includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems.

Healthy People 2010: A statement of the national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

Hyperglycemia: Also called high blood glucose. A condition in people with diabetes where blood glucose levels are too high. Symptoms include frequent urination, unusual thirst and weight loss.

Hypoglycemia: Also called low blood glucose. A condition that results when blood glucose levels are too low. Symptoms include feeling nervous or anxious, feeling numb in the arms and hands, shakiness or dizziness.

Impaired fasting glucose (IFG): A condition in which a blood glucose test, taken after an 8- to 12-hour fast, shows a level of glucose higher than normal but not high enough for a diagnosis of diabetes. IFG, also called pre-diabetes, is a level of 110 mg/dl to 125 mg/dl. Most people with pre-diabetes are at increased risk for developing type 2 diabetes.

Impaired glucose tolerance (IGT): A condition in which blood glucose levels are higher than normal but are not high enough for a diagnosis of diabetes. IGT, also called pre-diabetes, is a level of 140 mg/dl to 199 mg/dl 2 hours after the start of an oral glucose tolerance test. Most people with pre-diabetes are at increased risk for developing type 2 diabetes.

Incidence: The number of new cases of a disease among a certain group of people over a specific period of time (for example, one year).

Insulin resistance: A condition that occurs when the body cannot use the insulin it makes effectively and as a result, glucose levels rise.

Insulin: An essential hormone that converts sugar, starches and other carbohydrates into energy needed for daily life. Without insulin, sugars build up in the blood, causing serious, life-threatening complications and eventually death. Diabetes is characterized by the inability to produce or properly use insulin.

Lay health workers: Individuals without formal medical training who serve as a bridge between community members and medical or social services. Related terms and roles are community health advocates, lay health educators, community health representatives, peer health promoters, community health outreach workers, peer counselors and promotoras de salud.

Literacy: An individual's ability to read, write and speak in their primary language, compute, and solve problems at levels of proficiency necessary to function on the job, in the family of the individual and in society.

Medical nutrition therapy (MNT):

Treatment based on nutrition. It includes checking a person’s nutrition status and giving the right foods or nutrients to treat conditions such as those caused by diabetes, heart disease and cancer. It may involve simple changes in a person’s diet or intravenous or tube feeding. Medical nutrition therapy may help patients recover more quickly and spend less time in the hospital. Also called nutrition therapy.

Mortality: Related to death. Diabetes mortality is often referred to in describing the number of people that have died with diabetes as immediate or contributing cause of their death.

Metabolic syndrome: People have the metabolic syndrome when they have several disorders of the body’s metabolism at the same time, such as obesity, high blood pressure and high cholesterol. This syndrome affects at least one out of every five overweight people. Reduction or elimination of some of the components of the syndrome is possible through positive lifestyle changes.

Pancreas: An organ that makes insulin and enzymes for digestion. The pancreas is located behind the lower part of the stomach and is about the size of a hand.

Pancreatic beta cells: Cells that make insulin.

Podiatrist: A doctor who treats people who have problems with their feet. Podiatrists help people with diabetes keep their feet healthy by providing regular foot examinations and treatment if necessary.

Population-based (health): The interrelated aspects of health and illness for specific groups of people. Populations may be defined by social or demographic factors, geography, health practices, risks and outcomes or other elements. Aspects of health and illness include disease prevalence and incidence, related morbidities, mortality, risk factors and health behaviors.

Populations at risk: People with shared characteristics (the population) who are at higher risk for developing diabetes (e.g., people who are older, have a family history of diabetes, belong to certain racial/ethnic groups, are overweight or obese, are physically inactive or have a poor diet) or are at higher

risk of developing complications of diabetes (e.g., those who lack access to preventive care, have uncontrolled blood sugar, blood lipid or blood pressure levels or who practice unhealthy lifestyles).

Pre-diabetes: A condition where blood glucose levels are higher than normal but are not yet high enough to be diagnosed as having type 2 diabetes. Most people with pre-diabetes develop type 2 diabetes within 10 years. Currently, pre-diabetes is defined as impaired glucose tolerance (IGT) or impaired fasting glucose (IFG).

Prevalence: The number of people in a given group or population who are reported to have a specific disease at any one point in time.

Preventive care/prevention: Health care that stresses behavior, regular testing and screening, and other services to prevent diabetes and its complications. Preventive care for diabetes includes healthy exercise and diet, regular testing and early detection of complications, smoking cessation, frequent self-monitoring of blood glucose, etc. Prevention of type 2 diabetes includes screening for pre-diabetes, regular exercise and weight management.

Promotoras(es): Promotoras are community members who serve as liaisons between their community and health, human and social service organizations. They work with organizations and institutions — formally and informally, as employees or volunteers — to bring information to their communities. As liaisons they often play the roles of advocate, educator, mentor, outreach worker, role model, translator and more. The promotora model of community outreach is based on a Latin American program-type that reaches underserved populations through peer education. They take the community health worker model one step further because they speak the same language, come from the same neighborhood and (commonly) share some life experiences with the community members they serve. Promotoras use a variety of methods to make contact with the community. From intimate group gatherings in individuals’ homes to large community meetings, promotoras make direct contact with target audiences, conveying crucial information to provide community support (www.proyectovision.net/english/news/13/promotoras.html)

Quality improvement (QI): An organized approach to improving work processes to meet or exceed standards or expectations. Applied to diabetes care, QI can be used to improve processes such as treatment, education, follow-up and support to meet diabetes patient needs and guideline recommendations.

Registry: A tool that allows health professionals to access information that is pertinent to an individual patient’s care and to make queries against information for the entire patient population.

Risk behaviors: An individual’s lifestyle choices (such as poor nutrition, physical inactivity, inaction to control blood glucose, blood lipid and blood pressure levels) that increase their risk of diabetes or its complications.

Risk factors: Characteristics of individuals that increase the probability that they will experience disease or death compared to the rest of the population. Risk factors for developing diabetes include genetics, environmental exposures and socio-cultural living.

Self-care/self-management: Activities undertaken by an individual to control and monitor their diabetes outside of the clinical setting. More than 90 percent of diabetes care is self-care. Self-care can include monitoring blood glucose levels, following a treatment plan, eating healthfully, exercising, losing weight, checking for foot ulcers, attending classes and support groups, and scheduling regular clinical examinations and testing.

Self-monitoring of blood glucose (SMBG): A method for testing the level of glucose in the blood using a blood glucose meter that can be done by the person with diabetes; also called home blood glucose monitoring.

Surveillance: The ongoing and systematic collection, analysis and distribution of information. Surveillance methods detect changes in trends or distribution to initiate investigative or control measures.

Telemedicine: Refers to the use of various telecommunications by physicians and medical systems that provide health care to their patients through electronic or digital means. Telemedicine employs technology that makes it possible for health care providers to care for their patients in the patients’ homes or in other remote areas. Telemedicine can enable caregivers to collect and transfer medical data, still images, and live audio and video transmissions.

PARTICIPANTS

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- Benewah Medical Center
- Bingham Memorial Hospital
- Blue Cross of Idaho
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- Canyon County Organization on Aging
- Central District Health Department
- Centro De Comunidad Y Justicia
- Diabetes Resource Center
- Director's Office, Idaho Department of Health and Welfare
- Dr. Richard Christensen & Associates
- Eastern Idaho Public Health District
- Eastern Idaho Regional Medical Center – Wellness Center Health Promotion and Diabetes Education
- Family Health Services
- Genesis World Mission and Garden City Community Clinic
- Glaxo Smith-Kline
- Gooding County Memorial Hospital Diabetes Education Program
- Holy Rosary Medical Center
- Humphreys Diabetes Center
- Idaho Commission for the Blind and Visually Impaired
- Idaho Commission on Hispanic Affairs
- Idaho Dairy Council
- Idaho Department of Health and Welfare: Bureau of Vital Records and Health Statistics, Worker Health and Safety Program
- Idaho Department of Medicaid
- Idaho Partnership for Hispanic Health
- Idaho Primary Care Association
- Idaho State School and Hospital
- Idaho State University: Department of Anthropology, Department of Dental Hygiene, College of Pharmacy
- Liberty Dialysis
- Lions Club of Idaho
- Madison Memorial Hospital
- Magic Valley Foot Clinic
- Meridian School District – Eagle Middle School
- Mountain States Group
- Nimiipuu Health Center
- Nimiipuu Health Nutrition Program
- North Central District Health Department
- Novartis
- Novo Nordisk
- Oneida County Hospital
- Panhandle District Health Department
- PBZ Marketing Communications
- Podiatry Center of Idaho
- Portneuf Medical Center, Diabetes Education
- Quality Programs, Regence Blue Shield
- Roche Diagnostics/Boehringer Mannheim
- Rocky Mountain Diabetes & Osteoporosis Center
- Rosendahl Foot & Shoe Center
- Saint Alphonsus Regional Medical Center
- Shoshone Bannock Tribe
- Snake River Community Clinic
- South Central Public Health District
- Southeastern District Health Department
- Southwest District Health Department
- St. Benedicts Family Medical Center Diabetes Management Center
- St. Mary's Hospital & Clinics
- Syringa General Hospital
- Terry Reilly Health Services
- University of Idaho Cooperative Extension
- University of Idaho Kootenai County Extension Office
- Wellness Center Diabetes Education
- West Valley Medical Center Diabetes Resource Center

For more information about this plan
visit the Diabetes Alliance of Idaho website at:
www.diabetesidaho.org



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