2022-2027

South Dakota Diabetes State Strategic Plan

SOUTH DAKOTA DEPARTMENT OF HEALTH

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INTRODUCTION

About this Plan

The South Dakota Diabetes State Strategic Plan 2022 - 2027 is a collaborative effort of state and local partners working on diabetes prevention and management in South Dakota. The involvement of a broad range of partner organizations helped to ensure that the plan reflects a shared purpose and will be a useful and relevant tool for all audiences in South Dakota dedicated to diabetes prevention and management. For a full list of those involved in developing the plan, see Appendix B: Acknowledgements.

This five-year strategic plan was developed over the course of several months. The plan serves as a guide to partners across the state to work together to reduce the burden of diabetes in South Dakota. It will be used as a "blueprint" – providing direction, focus and accountability over the next five years.

The South Dakota Diabetes State Strategic Plan should be considered a living document. Diabetes partners will work together to address strategies, review progress, gather lessons learned, identify success stories, and determine if modification or mid-course corrections to the Plan are needed.

Vision and Mission

Vision

- South Dakotans living free from the burden of diabetes

Mission

- Collaborating to prevent diabetes and improve the quality of life for all South Dakotans affected by diabetes

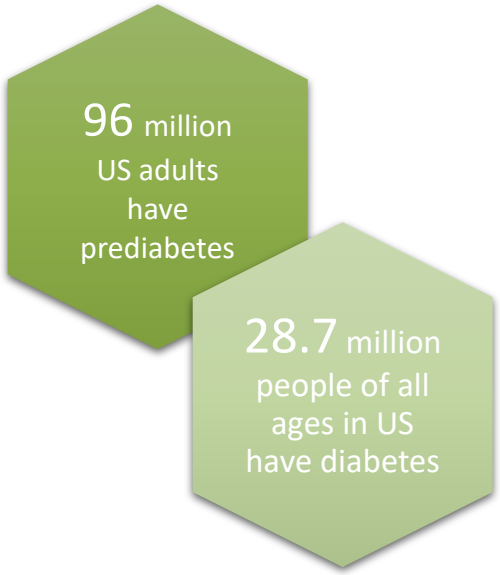
THE BURDEN OF DIABETES

Diabetes and Prediabetes Nationally

Diabetes is growing at a rapid rate within the United States, with nearly 30 million people having the disease, which is more than 10% of the U.S. population. Diabetes is the 7th leading cause of death in the United States.

Prediabetes

- 96 million (38%) US adults have prediabetes [20]
- 26.4 million (48.8%) people aged 65 years or older have prediabetes
- 84% of those with prediabetes do not know they have it
- A higher number of men (52.3 million) than women (43.7 million) have prediabetes [22]
- Prevalence of prediabetes varies slightly among racial/ethnic groups:
    - White 62.4 million
    - Hispanic 14.3 million
    - Black 12.4 million
    - Asian 6 million



Diabetes (2019 estimates) [23]

- 28.7 million (8.7%) people of all ages in US diagnosed with diabetes
- 283,000 children and adolescents younger than age 20 years had diagnosed diabetes.
    - Including 244,000 with type 1 diabetes.
- 1.6 million adults (5.7%) aged 20 years or older reported both having type 1 diabetes and using insulin.
- Prevalence of diabetes varies slightly among racial/ethnic groups:
    - American Indians and Alaska Natives (14.5%)
    - Blacks (12.1%)
    - Hispanic (11.8%)
    - Asians (9.5%)
    - Whites (7.4%)
- Prevalence varied significantly by education level, which is an indicator of socioeconomic status:
    - 13.4% of adults with less than a high school education
    - 9.2% of those with a high school education
    - 7.1% of those with more than a high school education
- Adults with family income below the federal poverty level had the highest prevalence for both men (13.7%) and women (14.4%)

Diabetes and Prediabetes in South Dakota

South Dakota is a primarily rural state which covers over 75,000 square miles. Of South Dakota's 66 counties, 30 (45%) are designated as rural and 34 (52%) are considered frontier (less than 6 people per sq. mile). South Dakota's rural geography impacts access to health care services. Approximately two-thirds of South Dakota is designated by the federal government as a Health Professional Shortage Area due to geographic and low-income disparities. [24, 25] There are approximately 71,000 (11%) people in South Dakota with diabetes, about 21,000 have diabetes but do not know. Additionally, an estimated 218,000 [26]people have prediabetes, meaning that they have abnormally high blood glucose levels.[19]

Prediabetes

Approximately 218,000 (35.5%) people in South Dakota have prediabetes. Diabetes and prediabetes cost an estimated $751 million in South Dakota each year. The serious complications include heart disease, stroke, amputation, end-stage kidney disease, blindness, and death.

More than 1 in 3 people in South Dakota have prediabetes

Risk factors:

- 90% not consuming recommended fruit and vegetable servings
- 64% are overweight or obese
- 46% not meeting physical activity recommendations

Diabetes

- People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes. [19]
  - Total direct medical expenses for diagnosed and undiagnosed diabetes, prediabetes and gestational diabetes in South Dakota was estimated at $588 million in 2012.
  - In addition, another $163 million was spent on indirect costs from lost productivity due to diabetes.
  - The Division of Diabetes Translation at the CDC spent $1,270,508 on diabetes prevention and educational programs in South Dakota in 2016. 10.6% of South Dakotans ever told by a doctor that they have diabetes

  - Gender: [27]
    - 11.8% male
    - 9.4% female
  - Income: [27]
    - Less than 25k: 22.1%
    - $25,000-$49,999: 12.4%
    - $50,000-$74,999: 7.5%
    - Greater than 75k: 6.5%
  - Race/Ethnicity: [27]
    - 9% of non-Hispanic whites
    - 9% of Hispanics
    - 17% of American Indians/Alaskan Natives
  - 11th leading cause of death [27]

Risk Factors for Diabetes and Prediabetes

Prediabetes Risk Factors [28]

- Are overweight
- Are 45 years or older
- Have a parent, brother, or sister with type 2 diabetes
- Are physically active less than 3 times a week
- Have ever had gestational diabetes or given birth to a baby who weighed more than 9 pounds
- Are African American, Hispanic/Latino American, American Indian, or Alaska Native (some Pacific Islanders and Asian Americans are also at higher risk)

Gestational Diabetes Risk Factors

- Had gestational diabetes during a previous pregnancy
- Have given birth to a baby who weighed more than 9 pounds
- Are overweight
- Are more than 25 years old
- Have a family history of type 2 diabetes
- Have a hormone disorder called polycystic ovary syndrome (PCOS)
- Are African American, Hispanic/Latino American, American Indian, Alaska Native, Native Hawaiian, or Pacific Islander

Type 1 Diabetes Risk Factors

- Family history: Having a parent, brother, or sister with type 1 diabetes.
- Age: Type 1 diabetes can occur at any age, but it's more likely to develop as a child, teen, or young adult.
- In the United States, whites are more likely to develop type 1 diabetes than African Americans and Hispanic/Latino Americans.

Type 2 Diabetes Risk Factors

- Have prediabetes
- Are overweight
- Are 45 years or older
- Have a parent, brother, or sister with type 2 diabetes
- Are physically active less than 3 times a week
- Have ever had gestational diabetes or given birth to a baby who weighed more than 9 pounds
- Are African American, Hispanic/Latino American, American Indian, or Alaska Native (some Pacific Islanders and Asian Americans are also at higher risk)

The Financial Toll of Diabetes and Prediabetes

Each year South Dakota spends roughly $751 million on diabetes and prediabetes cost. People with type 2 diabetes have medical expenses that are approximately 2.3 times higher than those without diabetes. In South Dakota, about $588 million was spent on direct medical expenses towards prediabetes and gestational diabetes in 2012. [19, 29]

- People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes.
- Total direct medical expenses for diagnosed diabetes in South Dakota were estimated at $510 million in 2017.
- In addition, another $180 million was spent on indirect costs from lost productivity due to diabetes.
- Prediabetes costs about $751 million annually.

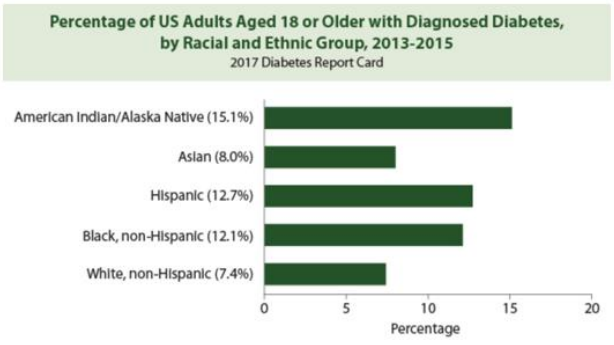
HEALTH EQUITY & HEALTH DISPARITIES

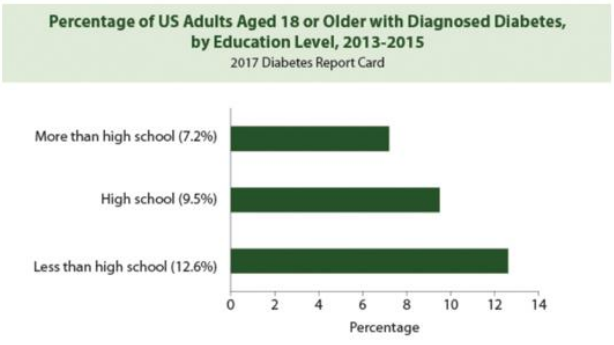
Health Equity Statement

Health equity is when everyone has the opportunity to be as healthy as possible. As defined by the U.S. Department of Health and Human Services, health equity is the attainment of the highest level of health for all people. Population-level factors, such as the physical, built, social, and policy environments, can have a greater impact on health outcomes than individual-level factors. The root causes of health inequity can be directly linked to a failure to address these population-level factors. In addition, linkages between science, policy, and practice are critical to achieving health equity. [27]

Over the past decade, momentum to address social determinants of health (SDOH) and health equity increased. Landmark reports and national initiatives argue for the implementation of research, policies, and programs that address SDOH to reduce health disparities, which are differences in health outcomes and their causes among groups of people.

Some groups of people are affected by prediabetes and diabetes more than other groups. Differences in health status or access to health care among racial, ethnic, geographic, and socioeconomic groups are referred to as health disparities.





The Social Determinants of Health

- **Economic Stability**: Many people in the U.S. have trouble finding and keeping jobs that pay well enough to afford things like healthy food, health care, and housing. [27]
- **Education Access and Quality:** People who are able to attain higher levels of education are more likely to be healthier, but not all children have access to good educational opportunities. [27]
- **Health Care Access and Quality:** Many people in the U.S. do not get the health care services that they need because they cannot afford or easily access it. [27]
- **Neighborhood and Built Environment:** Where people live, work, learn, and play impacts their exposure to health and safety risks. [27]
- **Social and Community Context:** Social support and relationships can have a big impact on people's health and well-being. [27]

Social Determinants of Health & Health Services

Access

- Having health insurance is the strongest predictor of whether adults with diabetes have access to diabetes screenings and care.
- Geographic access to adult and pediatric endocrinologists.

Affordability

- Costs for people with diabetes are 2.3 times those of people without diabetes.
- Approximately 14% to 20% of adults with diabetes report reducing or delaying medications due to cost.
- Cost-related or cost-reducing nonadherence (CRN) is associated with income, insured status, and type of insurance.

Quality

- Having insurance is the strongest single predictor of whether adults with diabetes are likely to meet individual quality measures of diabetes care.
- Sociodemographic disparities in care quality are well documented in national reports and recommendations and appear to remain consistent over time.

South Dakota Diabetes Prevention & Management Activities

- **South Dakota Diabetes Coalition**: The mission of the South Dakota Diabetes Coalition (SDDC) is to collaboratively improve the quality of life for all South Dakotans at risk for, or affected by, diabetes [32]
- **South Dakota Diabetes State Engagement Meeting (StEM) Workgroups**: Two workgroups made up of community organizations, hospital systems, and insurers focused on scaling and sustaining the National Diabetes Prevention Program through four pillars of Awareness, Availability, Screening/Testing/Referrals, and Coverage.

- **Undo the Risk campaign**: Resources, information, and media resources for prediabetes and diabetes
- **LiveYourBest SD**: State-based platform for virtual CDC lifestyle change program delivery
- **Better Choices, Better Health® SD**: Chronic disease self-management resources
- **Good & Healthy SD**: Success stories, model policies, evidence-based programs like the DPP

The Strategic Planning Process

Planning Process

The strategic plan presented in this document is a roadmap for South Dakota to improve quality of life for all through prevention and management of diabetes and associated risk factors. The plan is the result of the planning process described below.

Landscape Analysis

Key background documents, including past plans and assessments and other pertinent data were reviewed. Twelve (12) key informant interviews were held with opinion leaders to discuss what they would like to see accomplished short-term and long-term, assets and opportunities, and challenges and barriers. These results were synthesized to summarize key findings.

Virtual Strategic Planning Sessions

Forty-two (42) individuals, including South Dakota Diabetes Coalition members, South Dakota Department of Health staff, and representatives of key partner organizations, attended virtual strategic planning sessions from August 31 – September 2, 2021. Participants were provided with an orientation that reviewed: state data and community initiatives; a summary of prediabetes task group activities, Community Health Worker efforts, and the development of telehealth; and key informant interview results. The group reviewed the vision and mission statements adapted by a small core planning team of partners from the *2018-2020 Diabetes State Plan*. Participants then discussed, identified, and prioritized goal-specific objectives and strategies. The result of this meeting was a plan outline that provided a clear direction toward achieving diabetes prevention and management goals, leveraging available resources and opportunities.

Iterative Revisions

Using the plan outline developed during the strategic planning meetings, a small Core Team of partners further refined the plan outline and narrative. For each strategy, the group identified key activities needed to implement the strategy. The plan was iteratively reviewed by the Core Team to create the final strategic plan.

Plan Components

- **Goals to focus on** that will contribute to realizing the mission and vision.
    1. Public Awareness and Prevention
    2. Health Professional Screening and Referral
    3. Availability and Access to Services
    4. Reimbursement and Sustainability
- **Objectives to be achieved** by 2027 that represent progress toward accomplishing each goal.
- **Strategies to work on** to achieve the objectives.
- **Activities necessary to implement** the priority strategies.

THE DIABETES STATE STRATEGIC PLAN 2022-2027

Goal I: Public Awareness and Prevention

Enhance public awareness and promote diabetes prevention and management services and resources

Objectives

1. Increase the number of new visitor sessions to the SD Diabetes Awareness website www.undotherisk.com from 10,342 to 12,930.
2. Increase the number of individuals with prediabetes participating in evidence-based lifestyle change programs (e.g. National DPP, BCBH, SD, etc.) from 1,230 to 1,981.
3. Increase the yearly number of individuals with diabetes participating in evidence-based diabetes self-management programs (e.g. BCBH SD, ADA &ADCES DSMES programs) from 3,931 to 5,018.
4. Increase the number of individuals who complete the Undo the Risk self-risk test from 5,828 to 12,000.
5. Decrease the percentage of adults who are obese from 33% to 29%.

Strategies & Activities

A. Develop and promote educational resources, evidence-based programs, and awareness tools.

- Encourage individuals to call the 1-888 number for programing.
- Promote services through webinar presentations, community boosts, and speaking events.
- Develop and promote awareness resources.
- Increase screening opportunities and the community level (including health care systems, CHWs, pharmacies, etc.)
- Promote and support Move Your Way SD implementation in communities to increase physical activity.

B. Tailor diabetes prevention and management messaging and resources for specific cultures and languages.

- Identify specific communities/populations (e.g. Spanish, Karen, American Indian, etc.).
- Develop culturally tailored messaging.
- Promote enrollment into evidence-based physical activity programs for priority populations.

C. Promote the Undotherisk.com and Good and Healthy websites.

- Promote resources and model policies to increase healthy eating and physical activity.
- Promote resources and model policies to reduce obesity.
- Promote resources and model policies to reduce tobacco use (see Tobacco Strategic Plan).
- Promote resources and model policies to reduce risk for cardiovascular disease (see Heart Disease and Stroke Strategic Plan).

D. Promote school, worksite, community, and healthcare policies and environmental changes that support healthy, active lifestyles.

- Promote workplace model policies.
- Promote workplace and community success stories.
- Share resources with schools, worksites, communities and healthcare systems.
- Promote activities that encourage physical activity and healthy eating within communities
- Encourage referrals from community-based organizations for evidence-based diabetes prevention and management programs/services (e.g. non-profits, medical societies, YMCAs, smaller facilitates without their own DPP, etc.).
- Implement evidence-based policy, system, and environmental approaches that increase equitable access to healthy and affordable foods and beverages.
- Promote adoption of healthy community design principles and equitable access to safe places and spaces to be physically active.
- Support healthy eating and physical activity opportunities among early childhood education and school-aged youth.

Goal II: Health Professional Screening & Referral

Improve and expand screening and diabetes prevention and management service referral

Objectives

1. Increase the percentage of individuals who have been told by their health care provider that they have prediabetes from 7% to 8%.
2. Increase the number of referring entities who refer individuals to diabetes prevention programs from 20 to 50.
3. Increase the percentage of individuals with prediabetes who are referred by a health care professional to prediabetes education to prevent diabetes from 40% to 45%.
4. Increase the percentage of individuals with diabetes who have ever taken a course or class in how to manage diabetes from 63% to 66%.

Strategies & Activities

A. Promote provider diagnosis of individuals with prediabetes.

- Reinforce diagnostics for diabetes (glucose ranges for diabetes vs prediabetes).
- Encourage providers to diagnose prediabetes.
- Update and promote prediabetes screening resources.

B. Promote provider referrals to evidence-based diabetes prevention and management programs/services.

- Engage and support healthcare professionals in counseling and referral of patients on healthy eating and physical activity.

C. Strengthen processes for referring patients to diabetes prevention and management services/programs.

- Utilize data to identify opportunities to advance referrals.
- Support and strengthen referrals through a community information exchange for evidence-based programs and social determinants of health resources.
- Expand continuing education opportunities for healthcare workers/CHWs on diabetes prevention and management programs - emphasizing the referral process.

D. Improve and expand infrastructure for care coordination for those at risk of or diagnosed with diabetes.

- Increase awareness around team-based care and the role each health professional plays in diabetes prevention and management
- Embed referrals & measurement into the workflow for new Community Health Workers.

E. Identify a system for bi-directional and cross-system communication, referrals, billing and evidence-based program directory

- Support enabling services provided by CHWs that directly impact diabetes prevention and management.

F. Work with healthcare partners to improve quality of care for patients with, and at risk for, diabetes around screening, testing, and referrals.

- Encourage referrals for individuals with diabetes to ancillary services including foot care, eye care, and dental care.
- Encourage referrals for individuals with diabetes to Diabetes Self-Management Education and Support programs.

Goal III: Availability & Access to Services

Expand availability and access to diabetes prevention and management services

Objectives

1. Increase the number of evidence-based diabetes management programs available in high need areas of South Dakota from 23 to 25.
2. Increase the number of evidence-based lifestyle change programs available in high need areas of South Dakota from 20 to 40.
3. Increase the number of tailored evidence-based lifestyle change programs for populations disproportionately affected by diabetes from 0 to 5.

Strategies & Activities

A. Expand the Community Health Worker (CHW) workforce. (see Community Health Worker Strategic Plan)

- Promote integration of CHWs into healthcare and community-based organizations.
- Train CHWs to provide evidence-based health/behavior change programs.

B. Create or adapt existing evidence-based programs/curriculums (including virtual) to better reach priority populations (e.g. Tribal, Karen, Hutterite, Spanish-speaking) and ensure health equity.

- Identify gaps/needs for tailoring evidence-based lifestyle change programs for populations disproportionately affected by diabetes.
- Explore innovative and inclusive evidenced based programs and approaches to increase physical activity in priority populations. (i.e. Move Your Way).
- Design/deliver tailored programs for men (especially farmers/ranchers).

C. Improve access and use of digital devices in rural communities

- »Support the expansion of broadband within South Dakota by educating providers with the services available in their patient care areas.
- Assist organizations in obtaining funds to support the use of loaner-type electronic devices for patient use.
- Provide patient education materials to programs that educate on the use of telehealth resources.
- Educate CHWs to provide education on technology services to patients.

D. Expand availability of telehealth and virtual programs and services

- Increase the number of recognized DSMES telehealth programs.
- Increase the number of online and distance learning DPP programs.

Goal IV: Reimbursement & Sustainability

Maximize coverage and utilization of diabetes prevention and management services to create sustainability

Objectives

1. Increase the number of private payers that cover the cost of the National DPP from 1 to 4.
2. Increase the number of workplaces that promote diabetes prevention and management within the workplace from 13 to 25.
3. Increase the number of Medicare DPP from 0 to 2.

Strategies & Activities

A. Work with private payers to cover the National DPP.

- Raise awareness about evidence-based diabetes prevention and management programs/services among private payers.

B. Encourage employers to offer evidence-based programs and worksite wellness benefits for employees.

- Raise awareness about evidence-based diabetes prevention and management programs/services among employers.
- Add question to workplace wellness survey about promotion of diabetes prevention and management at the workplace.
- Add intervention(s) to the *Workwell Grant* to implement activities around diabetes prevention and management.

C. Increase the number of providers/programs submitting reimbursement for diabetes prevention and management services to Medicaid, Medicare, and private payers.

- »Gather data on utilization of services from Medicare and Medicaid.
- Educate providers about how to bill Medicare & Medicaid for diabetes prevention & management services (e.g. CPT codes, etc.).
- Increase the number of entities who are eligible to submit for reimbursement through Medicare and Medicaid.
- Update and disseminate billing and coding resources for diabetes prevention and management programs/services.
- Support development of state-wide electronic referral systems.
- Update DSMES reimbursement guide.

D. Expand patient understanding of reimbursable services related to diabetes prevention and management.

- Enhance *Know Your Plan* website & resources, including adding more information for providers.
- Encourage employers to promote *Know Your Plan* at open enrollment.
- Send a mass mailing to providers about *Know Your Plan*.
- Educate CHWs on the *Know Your Plan* project and how to help individuals contact their insurance provider to learn about their coverage.

Appendix A: Strategic Plan (one page)

South Dakota Diabetes State Strategic Plan, 2022-2027

VISION: South Dakotans living free from the burden of diabetes
MISSION: Collaborating to prevent diabetes and improve the quality of life for all South Dakotans affected by diabetes

LAST UPDATE 3/24/22
Note: » Indicates a focus on health equity

Goals Focus on	I. Public Awareness & Promotion Enhance public awareness and promote diabetes prevention and management services and resources	II. Health Professional Screening & Referral Improve and expand screening and diabetes prevention and management service referral
Objectives Measure	1. Increase the number of new visitor sessions to the SD Diabetes Awareness website www.undotherisk.com from 10,342 to 12,930. 2. Increase the number of individuals with prediabetes who have participated in evidence-based lifestyle change programs (e.g. National DPP, BCBH SD, etc.) from 1,230 to 1,981. 3. Increase the yearly number of individuals with diabetes who have participated in evidence-based diabetes self-management programs (e.g. BCBH SD, ADA & ADCES DSMES programs) from 3,931 to 5,018. 4. Increase the number of individuals who complete the Undo the Risk self-risk test each year from 5,828 to 12,000. 5. Decrease the percentage of adults who are obese from 33% to 29%.	1. Increase the percentage of individuals who have been told by their health care provider that they have prediabetes from 7% to 8%. 2. Increase the number of referring entities who refer individuals to diabetes prevention programs from 20 to 50. 3. Increase the percentage of individuals with prediabetes who are referred by a health care professional to prediabetes education to prevent diabetes from 40% to 45%. 4. Increase the percentage of individuals with diabetes who have ever taken a course or class in how to manage diabetes from 63% to 66%.
Strategies Work On	**A. Develop and promote educational resources, evidence-based programs, and awareness tools.** **B. »Tailor diabetes prevention and management messaging and resources for specific cultures and languages.** **C. Promote the Undotherisk.com, Good and Healthy, and HealthySD websites.** **D. Promote school, worksite, community, and healthcare policies and environmental changes that support healthy, active lifestyles.**	**A. Promote provider diagnosis of individuals with prediabetes.** **B. Promote provider referrals to evidence-based diabetes prevention and management programs/services.** **C. Strengthen processes for referring patients to diabetes prevention and management services/programs.** **D. Improve and expand infrastructure for care coordination for those at risk for or diagnosed with diabetes.** **E. Identify a system for bi-directional and cross-system communication, referrals, billing and evidence-based program directory.** **F. Work with healthcare partners to improve quality of care for patients with, and at risk for, diabetes around screening, testing, and referrals.**
Goals Focus on	III. Availability & Access to Services Expand availability and access to diabetes prevention and management services	IV. Reimbursement & Sustainability Maximize coverage and utilization of diabetes prevention and management services to create sustainability
Objectives Measure	1. »Increase the number of evidence-based diabetes management programs available in high need areas of South Dakota from 23 to 25. 2. »Increase the number of evidence-based lifestyle change programs available in high need areas of South Dakota from 20 to 40. 3. »Increase the number of tailored evidence-based lifestyle change programs for populations disproportionately affected by diabetes from 0 to 5.	1. Increase the number of private payers that cover the costs of the National DPP from 1 to 4. 2. Increase the number of workplaces that promote diabetes prevention and management within the workplace from 13 to 25. 3. Increase the number of Medicare DPP in South Dakota from 0 to 2.
Strategies Work On	**A. »Expand the CHW workforce (see Community Health Worker Strategic Plan).** **B. »Create or adapt existing evidence-based programs/curriculums (including virtual) to better reach priority populations (e.g. Tribal, Karen, Hutterite, Spanish-speaking) and ensure health equity.** **C. »Improve access and use of digital devices in rural communities.** **D. »Expand availability of telehealth and virtual programs and services.**	**A. Work with private payers to cover the National DPP.** **B. Encourage employers to offer evidence-based programs and worksite wellness benefits for employees.** **C. Increase the number of providers/programs submitting reimbursement for diabetes prevention & management services to Medicaid, Medicare, and private payers.** **D. Expand patient understanding of reimbursable services related to diabetes prevention & management.**

CORE PRINCIPLES
Emphasize health equity | Engage partners and communities | Collaborate across sectors and chronic disease programs | Use evidenced-based strategies

Appendix B: Acknowledgements

This plan was created in collaboration with several key partners. The following individuals contributed by providing key informant interviews, participating in the Strategic Planning Workshop, and/or serving on the Core Team:

Jodie Barnett: SDDC/Avera
Beth Davis: SD DOH Contractor
Staci Fredenburg: Great Plains Quality Innovation Network
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Samantha Hynes: SD Medicaid
Rhonda Jensen: Sanford Health
Sue Johannsen: Avera
Denise Kolba: Great Plains Quality Innovation Network
Angela Landeen: USD-IHEC (School of Health Sciences)
Kayla Magee: SD Department of Health
Liz Marso: SD Department of Health
Josh Ohrtmann: The Medicine Shoppe
Vicki Palmreuter: South Dakota Foundation for Medical Care
Sharrel Pinto: SDSU-College of Pharmacy
Cheryl Pitzl: Avera Corporate Health
Stephanie Powers: South Dakota Foundation for Medical Care
Nikki Prosch: SD Department of Health
Donna Riley: Monument Health
Stephan Schroeder: SD Foundation of Medicine
Rachel Sehr: SD Department of Health
Larissa Skjonsberg: SD Department of Health
Lindsay Stern: Sanford Health Plans
Ben Tiensvold: Sage Consultants
Shannon Udy: Great Plains Tribal Leaders Health Board
Enid Weiss: SD Department of Health
Len Wonnenberg: Horizon Healthcare

Appendix C: Glossary of Key Terms

- **Diabetes:** The short name for the disease called diabetes mellitus. Diabetes results when the body cannot use blood glucose as energy because of having too little insulin or being unable to use insulin properly.
- **Type 2:** A form of diabetes characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin efficiently. Type 2 diabetes develops most often in middle-aged and older adults but can appear in children, teens, and young people.[1]
- **Type 1:** A form of diabetes characterized by high blood glucose levels caused by a lack of available insulin. This occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. [1]
- **Gestational Diabetes:** A form of glucose intolerance that is diagnosed in some women during pregnancy, even though they have had no known prior history of diabetes. In most cases, the woman's blood glucose levels return to normal after pregnancy. A woman who has had gestational diabetes during pregnancy is at an increased risk for developing type 2 diabetes across her lifespan. [2]
- **Prediabetes:** A condition in which individuals have blood glucose levels higher than normal but not high enough to be classified as diabetes. People with prediabetes have an increased risk of developing Type 2 Diabetes, heart disease, and stroke. Progression to diabetes among those with prediabetes is not inevitable. The Diabetes Prevention Program and Diabetes Prevention Program Outcomes Study have shown that people with prediabetes who lose weight can prevent or delay diabetes. [2]
- **Diabetes Complications:** Conditions that can result from diabetes that is not controlled. Complications can also be considered secondary health problems or comorbidities. The most common are nerve damage, lower extremity amputations, kidney failure, blindness, premature death, stroke, heart disease, congenital malformations, perinatal death, and long- and short-term disability. [2]
- **Diabetes Prevention:** Efforts to prevent or delay the onset of type 2 diabetes in individuals who have prediabetes or who are at high risk for developing type 2 diabetes.
- **Diabetes Management:** Efforts to encourage and reduce barriers to individuals with diabetes practicing self-care behaviors and adherence to clinical treatment to prevent adverse outcomes and complications from diabetes. Note: Diabetes management can also mean the clinical management of diabetes, but for the context of strategic planning we are referring to any efforts to prevent adverse outcomes and complications.
- **Health Equity:** The attainment of the highest level of health for all people. Population-level factors, such as the physical, built, social, and policy environments, can have a greater impact on health outcomes than individual-level factors. The root causes of health inequity can be directly linked to a failure to address these population-level factors. [3]
- **Social Determinants of Health (SDoH):** Are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. [4]

- **National Diabetes Prevention Program (National DPP):** A partnership of public and private organizations working to prevent or delay type 2 diabetes. [5]
- **National DPP Lifestyle Change Program:** An evidence-based solution that can reduce a person's risk of developing type 2 diabetes by 58% (71% in individuals age 65+). CDC-recognized lifestyle change programs are a key component of the National DPP and have proven to be more effective than certain medications at preventing type 2 diabetes. [6]
- **Medicare Diabetes Prevention Program (MDPP):** Is a structured behavior change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. [7]
- **Lifestyle Coach:** An individual who has received formal training to lead the lifestyle change program sessions and supports and encourages participants. [8]
- **Program Coordinator:** Oversees daily operations of the lifestyle change program, supports and guides lifestyle coaches, and ensures that the program meets quality performance outcomes. [8]
- **CDC National DPP Customer Service Center:** Provides organizations easy access to information and resources about prediabetes and the National DPP. Organizations can access training materials, toolkits, and videos; ask questions; and receive technical assistance related to all aspects of the program. [9]
- **CDC Diabetes Prevention Recognition Program (DPRP):** The quality assurance arm of the National DPP. The DPRP identifies organizations that have demonstrated their ability to deliver a proven lifestyle change program to prevent type 2 diabetes. Participation in the DPRP program is required in order to be a part of the MDPP program and is important for other types of reimbursement. [10]
- **Diabetes Self-Management Education and Support (DSMES):** Instruction about nutrition, exercise, medications, blood glucose monitoring, and emotional adjustment to help people with diabetes control their diabetes and make healthy lifestyle choices. There are two accrediting bodies for DSMES (ADA and ADCES) and accreditation is tied to reimbursement for this service. [2]
- **Medical Nutrition Therapy (MNT):** A nutrition-based treatment provided by a registered dietitian nutritionist. It includes an assessment of individual nutrition needs as well as therapeutic and counseling services. Often used to help individuals manage diabetes. [11]
- **Stanford Chronic Disease Self-Management Program (CDSMP):** A suite of self-management education programs for people with chronic health problems. It specifically addresses arthritis, diabetes, and lung and heart disease, but teaches skills useful for managing a variety of chronic diseases.[12]
- **American Diabetes Association (ADA):** Aims to prevent and cure diabetes and to improve the lives of all people affected by diabetes. Accomplishes this mission by funding research, delivering services, providing information, and giving a voice to those denied rights because of diabetes. [13]
- **Association of Diabetes Care and Education Specialists (ADCES):** An interprofessional membership organization dedicated to improving prediabetes, diabetes and cardiometabolic care through innovative education, management and support. [14]

- **Certified Diabetes Care and Education Specialist (CDCES; formerly known as CDE):** A health professional who has comprehensive knowledge of and experience in diabetes prevention, prediabetes, and diabetes management. They partner with people with diabetes to educate, support and help them achieve their goals in managing diabetes. [15]
- **National Standards for Diabetes Self-Management Education:** Provide guidelines for operating a DSMES program, define quality diabetes self-management education, and assist diabetes educators in a variety of settings to provide evidence-based education. [16]
- **Private Payers:** Any health insurance plan that is not run by the federal or state government. [17]
- **Public Insurers:** A program run by U.S. federal, state, or local governments in which people have some or all of their healthcare costs paid for by the government. The two main types of public insurance are Medicare and Medicaid. [18]

Appendix D: References

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Appendix E: Program Funding Statement

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