# Diabetes Improvement Plan

2021-2025

# Executive Summary

The Diabetes Prevention and Control Program (DPCP) at the Michigan Department of Health and Human Services has created this five-year Diabetes Improvement Plan in collaboration with partners who represent many facets of diabetes experience, care, and advocacy. It reflects the priorities expressed by these partners, and our commitment to Michigan residents with diabetes.

In the plan that follows, the DPCP outlines the following three priority areas and their goals:

## State Leadership

- **Enhance network partnerships.**
- **Engage leaders.**
- **Drive innovation and expand cross-program collaboration.**
- **Provide support and educational opportunities for diabetes professionals.**

## Diabetes Prevention

- **Reduce barriers to Diabetes Prevention Program (DPP) participant engagement and success.**
- **Enhance policy and coverage for prediabetes and the DPP.**
- **Build systems to support 'Screen, Test, Refer' for prediabetes.**

## Diabetes Management

- **Enhance medical coverage of Diabetes Self-Management Education and Support (DSMES).**
- **Increase utilization of technology.**
- **Increase incentives for health care providers.**
- **Advance care for people living with diabetes.**

Many of the strategies we will use to address these goals highlight health equity. The impact of diabetes varies greatly between communities, and ensuring that increased resources are directed to those with greatest needs can reduce diabetes disparities and improve population health for Michigan residents.

This plan is not meant to represent all the work being done by the Diabetes Prevention and Control Program or our partners. We are funded through multiple sources, including the Centers for Disease Control and Prevention, and our work is far-reaching and complex. The goals in the Diabetes Improvement Plan represent our commitment to improve access to diabetes prevention and management resources in communities that need them most, and to advance in the areas that are most relevant to our partners.

# Contents

# Introduction

**Diabetes has a significant impact on Michigan residents.**

**1 in 3**
people are at risk of developing **type 2 diabetes**

Diabetes is a complex health condition affecting 9.8% of the Michigan population[1]. Diabetes puts people at risk for additional health problems, such as heart disease, kidney disease, vision loss, and amputation. It requires significant time and resources to manage diabetes in a way that prevents these complications. In addition, it is estimated that nearly one in three Michiganders has diagnosed or undiagnosed prediabetes[2] – blood glucose levels that are higher than normal, but not yet high enough for a diagnosis of diabetes. People with prediabetes are at very high risk for developing type 2 diabetes. Without intervention, 15-30% of people with prediabetes will develop type 2 diabetes within five years.[3]

The ability to prevent type 2 diabetes, and to manage diabetes in all its forms, varies greatly from person to person – often due to factors beyond an individual's control. Inequities in access to resources cause disparities between groups in the prevalence of diabetes, and in health outcomes for people who have the disease.

The Diabetes Prevention and Control Program at the Michigan Department of Health and Human Services (MDHHS) represents our state's coordinated public health approach to the challenge of diabetes and the disparities in diabetes prevalence and outcomes. Our mission is to:

- **increase access to resources** to help people prevent or delay the onset of type 2 diabetes;
- **address disparities in diabetes prevalence and health outcomes**, and in access to prevention and management resources;
- **improve health outcomes and the quality of care** for people with diabetes; and
- **reduce diabetes related complications and deaths**.

Through our partnerships, we support and evaluate evidence-based programs and strategies that improve diabetes care, address the risk of type 2 diabetes, and engage healthcare partners and community organizations in this work.

This five-year Diabetes Improvement Plan (2021-2025) was developed in response to 31 key informant interviews with partners in diabetes care and prevention around the state, including healthcare systems, healthcare providers, diabetes professionals, community organizations, and people with diabetes and their families. The themes that resulted from these interviews were then prioritized by a broader audience of partners. The goals and strategies outlined here reflect these priorities.

# Health Equity

# Health Equity

The creation of an equity-focused approach to diabetes prevention and management is a foundational value of the MDHHS Diabetes Prevention and Control Program.

As stated in our mission above, we aim to increase access to resources and services within communities experiencing the greatest health disparities. To do this, we must be *data driven*, using data to identify priority populations, focus our efforts, and direct resources to these communities. Concentrating resources in communities with the greatest need will decrease disparities and improve population health over time.

Rather than create separate health equity related goals, we intend to expand our ability to view all our work through a *health equity lens*. This is critical, because inequities become part of the structure of organizations over time. They are hard to recognize, and even good ideas can be implemented in ways that unintentionally harm communities experiencing inequities.

*The ability to obtain healthcare information in accessible formats, such as American Sign Language (pictured) or large print materials, is critical to addressing disparities among people with disabilities.*

# Health Equity

## Applying a Health Equity Lens

The heart of applying a health equity lens means reflecting on questions like these, and being willing to change our actions as a result of the answers:

- *Who is impacted?*
- *Have those affected helped to shape this work?*
- *Who is included/excluded?*
- *Who benefits, and who is harmed?*
- *What do the data tell us? What data are missing?*
- *Who is, and who is not, making the decisions?*
- *What can we do differently?*

Source: Minnesota Department of Health, Health Partnerships Division.[4]

Strategies such as working with nontraditional partners, enhancing outreach to communities experiencing inequities, and improving the cultural relevance of diabetes-related services are an integral part of the plan that follows. These and other equity related strategies in this report are indicated with a magnifying glass symbol.

*Participants in diabetes prevention and management programs can be more successful in meeting their goals when there are safe, affordable opportunities for physical activity.*

Health Equity

# Definitions

Terms such as health equity, health disparities, and the social determinants of health are widely used, but not always well defined. The definitions below are from www.healthypeople.gov, an inter-agency federal workgroup that sets science-based national objectives for improving the health of all Americans. They serve as the working definitions of these concepts used by the Diabetes Prevention and Control Program (DPCP).

**Health equity** is "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

**Equity vs. Equality**

*Equity* is not the same as *equality*. To truly level the playing field, groups with poorer health outcomes and fewer resources require additional effort and resources.

**Health disparity** refers to "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

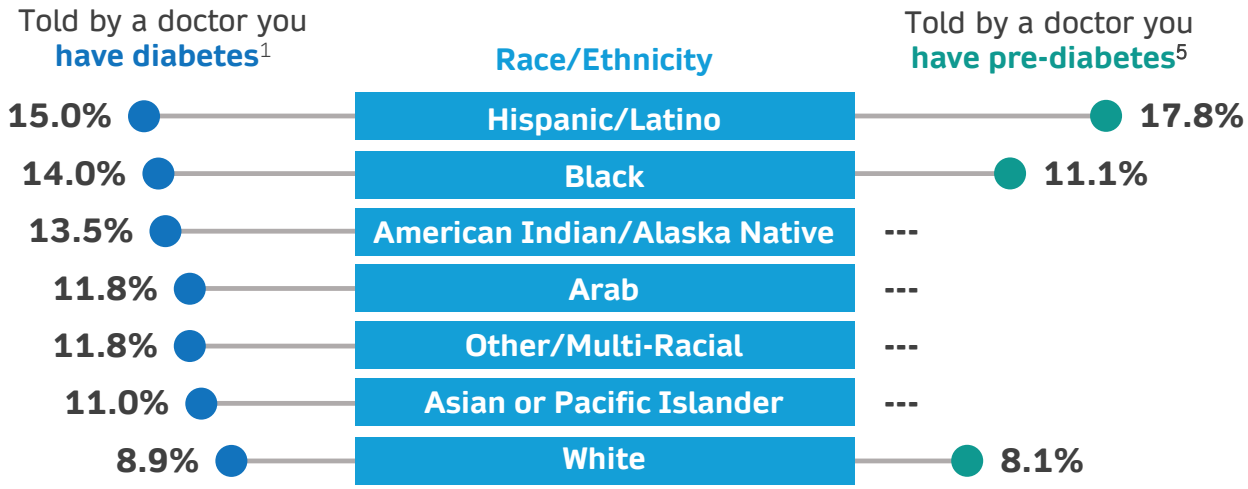
The **social determinants of health** are "conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality of life outcomes and risks." Examples of social determinants include access to educational, economic, and job opportunities; public safety; access to fresh food; social support; transportation options; residential segregation, and others.

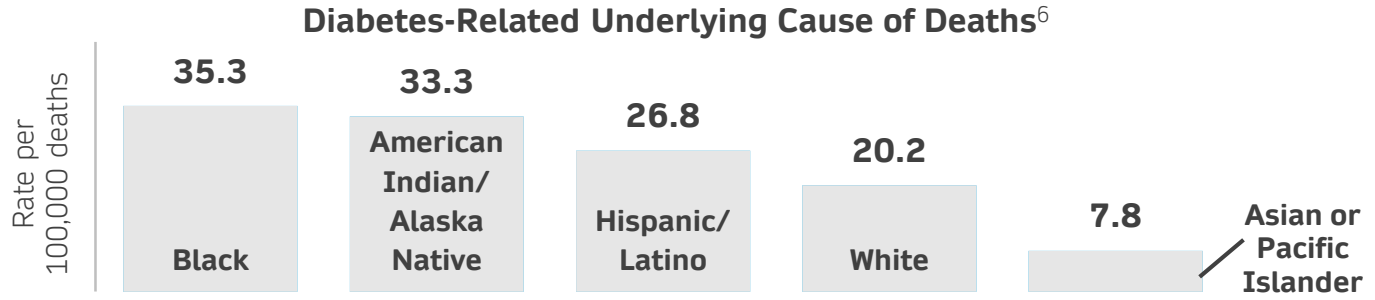
Diabetes prevention and management are evolving in response to increased understanding and application of these concepts. Behavior change is the tip of the iceberg; advice to eat well and get prescribed amounts of physical activity isn't effective in communities without a grocery store, where members struggle to afford and obtain fresh food, and where safe and accessible physical activity options are limited. Increasing access to these and other social determinants of health can increase participation and success in diabetes prevention and management programs and have a positive impact on population health.

Health Equity

# Health Disparities

Since access to diabetes prevention and management resources is not distributed equitably, it should not be surprising that communities are disproportionately impacted by diabetes. Black and Hispanic/Latino Michigan residents are significantly more likely to have diabetes, and to have diabetes as an underlying cause of death, than White Michigan residents.




The reasons for these disparities have many layers and are in large part due to the social determinants of health. The greatest predictor of life expectancy in the United States is the zip code in which we live[7]. Communities of color have been impacted by a long history of racism, systemic oppression, and chronic under-resourcing. As a result, members of these communities do not have equal access to health insurance, health care, medication, nutritious food, and physical activity – the building blocks of diabetes prevention and management. Other populations, too, are often overlooked and under-resourced, such as rural communities, people with low incomes, individuals who are LGBTQ+, and people with disabilities. Particularly, 22.5% of Michigan residents with disabilities have been diagnosed with diabetes, compared to 7.1% among people without disabilities[8].

Diabetes prevention and management programming could have the greatest impact in the communities that need it most, but a 'one size fits all' approach is not effective. We are committed to addressing the barriers within systems and programs that keep people from being as healthy as they can be.

# Diabetes Improvement Plan Goals

The Diabetes Improvement Plan outlines strategies to improve the reach and effectiveness of our work across three areas of action: state leadership, diabetes prevention and diabetes management. Each area of action contains broad goals, followed by the strategies we will use to meet these goals, and actions partners may take to amplify our efforts.

Diabetes Improvement Plan Goals

# State Leadership

The Diabetes Prevention and Control Program at MDHHS is uniquely positioned as the convener of the state's public health approach to diabetes prevention and management. In this role, we support providers of evidence-based diabetes prevention and management programs, drive innovation in program delivery, and continually challenge ourselves and our partners to do this work with a health equity lens.

## State Leadership Goals

### Enhance network partnerships.

While our work depends heavily on public health and healthcare, building a more diverse and inclusive network will stretch our dollars, increase our reach, and make us more effective.

### Engage leaders.

A critical element of our role as state facilitator is to highlight the efforts of our partners, and advocate with funders and decision makers to effectively communicate the needs of Michigan's residents with diabetes.

### Drive innovation and expand cross-program collaboration.

The urgent need to reach overlooked or under-resourced populations of people with diabetes requires creativity and collaboration with other programs and services that serve these populations.

### Provide support and educational opportunities for diabetes professionals.

Diabetes professionals are the cornerstone of diabetes prevention and management, and one of the best ways to support local capacity is to support all levels of that workforce, including obtaining much-needed professional education.

Diabetes Improvement Plan Goals

# State Leadership

## We will employ the following strategies to address these goals:

- Increase the capacity and reach of Diabetes Partners in Action Coalition (DPAC) and the Diabetes Prevention Network.
- Engage new partners, with priority to communities experiencing inequities, and to non-traditional community partners such as food banks, faith-based organizations and businesses. 
- Work with federal funders and policy makers to prioritize the needs of communities experiencing inequities (as defined by the data) in funding allocation. 
- Provide relevant, up to date information for healthcare providers and community members on the MDHHS diabetes website.
- In partnership with the MDHHS HIV section, develop and maintain interventions that address diabetes and increase screening for chronic kidney disease in people with HIV (Human Immunodeficiency Virus). 
- Collaborate with other MDHHS chronic disease programs (such as Tobacco Control and Cardiovascular Health) to cross-promote programs that support similar populations.
- Support departmental efforts to enhance infrastructure for a chronic disease registry and for data-related projects.
- Provide tailored continuing education opportunities, including those focused on health equity, for diabetes management and prevention professionals, including nurses, dieticians, certified diabetes care and education specialists, community health workers and lifestyle coaches. 
- Collaborate with the Michigan Community Health Worker Association to increase knowledge related to diabetes prevention and management among Community Health Workers. 
- Develop surveillance briefs and data products highlighting communities experiencing the greatest inequities. 

*Strategies such as working with nontraditional partners, enhancing outreach to communities experiencing inequities, and improving the cultural relevance of diabetes-related services are identified with a magnifying glass.*

# State Leadership

## Partners may:

- Understand the impact of social determinants of health on participant experience and success and use tailored approaches to program development and implementation.
- Advocate for enhancement of policy by:
    - Mobilizing regional networks to help ensure that policymakers understand the needs of people with diabetes.
    - Educating policymakers about diabetes and its complications and risk factors.
- Create patient education materials that are culturally relevant and appropriate for a variety of literacy levels, in collaboration with DSMES and community partners.
- Develop and enhance regional diabetes networks to include individuals with diabetes, with priority to communities of highest diabetes prevalence.

### Focus on innovation

The DPCP supports diabetes prevention and management programming that has a strong evidence base, meaning research has shown these programs to be effective. However, many of the studies supporting the programs' effectiveness could benefit from increased representation from groups experiencing the highest diabetes prevalence. We recognize this limitation, and our work includes helping participants overcome barriers to participation and engagement, and helping affected communities develop relevant interventions with quality principles.

Diabetes Improvement Plan Goals

# Diabetes Prevention

The goal of diabetes prevention efforts is to prevent or delay the development of type 2 diabetes. Much of the primary prevention of type 2 diabetes is carried out on an individual level, ideally as a collaboration between the patient and the healthcare provider. However, addressing prevention should be broader, as individuals and communities do not have equitable access to the support and resources necessary for optimal health. We are committed to removing barriers and increasing access to quality programming and coordinated care.

## Diabetes Prevention Goals

### Reduce barriers to DPP participant engagement and success.

Reducing the psychological, cultural, and social determinants of health barriers to participation in prevention programs can increase participants' confidence in the program and in themselves – and ultimately increase success.

### Enhance policy and coverage for prediabetes and the DPP.

Insurance coverage of the Diabetes Prevention Program addresses one of the biggest barriers to participation: program cost. Medicaid coverage is an essential link to reaching communities experiencing inequities.

### Build systems to support 'Screen, Test, Refer' for prediabetes.

Engaged patients and providers, combined with improved access to screening, can provide an important boost to prevention efforts that ultimately improves population health and reduces healthcare expenditures.

Diabetes Improvement Plan Goals

# Diabetes Prevention

## We will employ the following strategies to address these goals:

- Advocate for policy change to include Medicaid coverage of the DPP, including: 
    - Allocate funding for DPP implementation for populations at greatest risk for type 2 diabetes.
    - Enhance relationship with Medicaid Managed Care Organizations to build the case for coverage.
    - Address the social determinants of health through tailored implementation of the DPP.
    - Connect with national experts to share best practices.
- Collaborate with payers and employers to expand availability of the DPP as a covered benefit.
- Promote the adoption of prediabetes clinical quality measures.
- Educate healthcare providers and care team members on strategies to screen for and address prediabetes.
- Encourage utilization of Health Information Exchanges to receive referrals and provide feedback to health care teams.
- Using Geographic Information System data, compare data maps of populations with prediabetes to available DPP programming and work with DPP providers to address gaps. 
- Increase awareness and utilization of alternate delivery modes for the DPP among DPP providers, health care providers, and community members, especially in rural communities and those with transportation barriers. 
- Deliver diabetes prevention messaging in communities experiencing inequities in collaboration with trusted local organizations. 
- Encourage individuals to request information from their provider on their diabetes risk, and support programs such as the DPP.
- Support the development and implementation of national certification for DPP Lifestyle Coaches.

# Diabetes Prevention

## Partners may:

- Use data to identify communities experiencing the greatest inequities for participation in the DPP. 
- Ensure the cultural relevance and linguistic competency of DPP materials, including supplemental documents, curriculum, and promotional items. 
- Pair DPP delivery with other programs (e.g., Cooking Matters or EnhanceFitness) that address access to food and physical activity to enhance participant outcomes.
- Advocate for adequate coverage of adequate lifestyle coach time to support participants by Medicaid and other payers.
- Provide the DPP as a covered benefit to staff in your organization.

Diabetes Improvement Plan Goals

# Diabetes Management

The goal of diabetes management is to effectively treat and control diabetes to prevent or delay related complications. Management of diabetes is a lifelong commitment and requires the full participation of the patient and their healthcare team to prevent complications that can shorten a life- and health-span and increase healthcare expenditures. Health plan coverage, engaged providers and equitably available resources are critical supports that help people with diabetes manage this complex condition.

## Diabetes Management Goals

### Enhance medical coverage of DSMES.

Medicaid recipients are among the populations who can benefit most from quality support for their diabetes management, yet the issues surrounding Medicaid coverage of DSMES are complex, and policy changes are required to increase access to care.

### Increase utilization of technology.

Technology intersects with program delivery at every level. Demand for telehealth and online programming increased dramatically as a result of the COVID-19 pandemic, and providers rose to the challenge. Our vision includes sustained capacity for telehealth, increased online program delivery, and streamlined electronic referrals for DSMES.

**Increase incentives for health care providers.** Payers are moving away from a "sick care system" to a model where reimbursement is based on the quality of care and the outcomes achieved. Health systems require support to make this shift.

### Advance care for people living with diabetes.

There are many separate elements necessary for diabetes management. A layered approach with providers, educators, various health sectors, and people living with diabetes is required in order to address gaps, increase resources, and improve outcomes.

Diabetes Improvement Plan Goals

# Diabetes Management

## We will employ the following strategies to address these goals:

- Collaborate with Medicaid to address the social determinants of health and DSMES utilization. 
- Continue support of Association of Diabetes Care and Education Specialists (ADCES)-accredited/American Diabetes Association (ADA)-recognized/State-certified DSMES programs with training, technical assistance, and networking opportunities.
- Enhance understanding of DSMES and the Standards of Medical Care in diabetes among health care providers and hospital administrators.
- Engage Medicaid and health systems to show impact of diabetes education on clinical outcomes, and support value-based reimbursement, especially in rural communities and those with transportation barriers. 
- Increase awareness and utilization of alternate delivery modes, such as telehealth and online programs, among DSMES providers, health care providers and community members. 
- Promote the establishment of DSMES services in local health departments, with priority to rural areas lacking hospital-based programs. 
- Enhance care coordination for people with diabetes and other chronic conditions.
- Increase engagement of pharmacists in providing medication therapy management for people with diabetes, including addressing barriers to serving Medicaid beneficiaries. 
- Use data to increase the identification and improve the care of patients with diabetes in Federally Qualified Health Centers.
- Conduct a demonstration project using community paramedicine professionals as resource connectors for diabetes education.
- Raise awareness about the impact of diabetes management on other chronic health conditions (such as chronic kidney disease, hearing loss, and dementia).

Diabetes Improvement Plan Goals

# Diabetes Management

## Partners may:

- Engage legislators on policy changes that will enhance health plan coverage of diabetes, including medication and supplies. 
- Enhance diabetes care management in Patient Centered Medical Homes (PCMH). 
- Assess DSMES utilization data to identify and address barriers to participation and share successes with DSMES providers statewide. 
- Advocate with the Centers for Medicare and Medicaid Services for policy changes that make DSMES more flexible, available, and accessible to Medicare and Medicaid beneficiaries. 
- Develop materials to educate providers on the benefits of DSMES.

# Indicators of Success

# Indicators of Success

An evaluation plan was created to assess the process and outcomes of state leadership, diabetes prevention, and diabetes management goals and strategies. Health equity is woven throughout the evaluation plan to prioritize communities experiencing inequities, and to ensure program decisions are based on data. Short to mid-term evaluation questions and indicators are designed to document progression of activities, successes, and challenges. Sample process evaluation questions to assess implementation of activities are provided below.

## Sample Process Evaluation Questions

- To what extent did we engage new partners representing communities experiencing inequities, priority populations as defined by the data, or organizations addressing social determinants of health?
- What specific actions did we take to increase resources for communities experiencing the greatest inequities? What were the outcomes?
- How did we tailor media/communication material? To what extent did we translate to non-English languages, consider accessibility, reading level, and other needs? What was the percentage of communication funding focused on priority populations?
- How many Michigan DPPs/DMSES programs are offering virtual, distance learning, and other alternate modes of delivery?
- How has Medicaid coverage of DSMES changed to increase access? What specific barriers did we overcome/address?
- In what ways has the partnership between DSMES and PCMH/Federally Qualified Health Centers (FQHCs) become more integrated or coordinated?
- How many people did we enroll in the national DPP/DSMES? Do these people represent communities experiencing the greatest inequities?

# Indicators of Success

In addition to process outcomes, long-term outcomes were selected to monitor progress of health conditions. Sample outcome evaluation questions are provided below.

## Sample Outcome Evaluation Questions

- To what extent has prediabetes and diabetes prevalence changed over time?
- To what extent have health outcomes associated with diabetes changed over time?
- To what extent have racial and ethnic disparities associated with prediabetes/diabetes changed over time? Do populations experiencing inequities have the greatest rate of prediabetes/diabetes improvement?

By monitoring the progress of process activities and their corresponding outputs and longer-term outcomes, we hold ourselves accountable to the goals and intentionality of addressing health disparities described in this Diabetes Improvement Plan. Evaluation reports outlining our progress and achievements will be disseminated regularly throughout the five years.

The evaluation plan is available upon request.

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# Diabetes Improvement Plan

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MDHHS
Michigan Department of Health & Human Services

For more information, visit www.michigan.gov/diabetes



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