



State of Illinois
Illinois Department of Public Health

GENERAL ASSEMBLY REPORT

Illinois State Diabetes Commission
Illinois Diabetes Prevention and Control Program

As required by PA 098-0097

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Public Act 098-0977 was enacted with a goal of decreasing the incidence of diabetes in Illinois. The law states that by January 10, 2015 and January 10 of each odd-numbered year thereafter, the Illinois State Diabetes Commission shall submit a report to the General Assembly containing the following:

- (1) The financial impact and reach that diabetes of all types is having on the state and the Illinois Department of Public Health (IDPH). This assessment shall include the number of people in Illinois with diabetes or who are covered by the state Medicaid program, the number of people with diabetes and family members impacted by prevention and diabetes control programs implemented by IDPH, the financial toll or impact diabetes and its complications places on IDPH's diabetes program, and the financial toll or impact diabetes and its complications places on the diabetes program in comparison to other chronic diseases and conditions.
- (2) An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment shall also document the amount and source for any funding directed to IDPH from the General Assembly for programs and activities aimed at reaching those with diabetes.
- (3) A description of the level of coordination that exists between IDPH and other entities on activities, programs, and messaging on managing, treating, or preventing all forms of diabetes and its complications.
- (4) The development or revision of a detailed action plan for battling diabetes with a range of actionable items for consideration by the General Assembly and the plan of diabetes, pre-diabetes, and related diabetes complications. The plan also shall identify expected outcomes of the action steps proposed for the two years following the submission of the report, while also establishing benchmarks for controlling and preventing relevant forms of diabetes.
- (5) The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in item (4) of this subsection. This blueprint shall include a budget range for options presented in the plan identified in item (4) of this subsection for consideration by the General Assembly.

The Illinois Department of Healthcare and Family Services shall provide cooperation to IDPH to facilitate the implementation of this subsection. (Source: P.A. 98-97, effective 01/01/2014.)

As required, this document is presented to the General Assembly in compliance with Public Act 098-0097. This document reports the effects and financial impact of diabetes in Illinois, and includes a plan of action to address the impact of prediabetes, diabetes, and related diabetes complications. This document, as well as previous reports from 2011, 2012, 2013, and 2015 is available on the IDPH website at: <http://www.idph.state.il.us/diabetes/about.htm> The Illinois Diabetes State Plan is also available on the IDPH website at: <http://www.idph.state.il.us/diabetes/pdf/IllinoisDiabetesStatePlan2013-2018.pdf>

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The Illinois State Diabetes Commission was established in 2006 through Public Act 094-0788 to:

- Hold public hearings to gather information from the general public on issues pertaining to the prevention, treatment, and control of diabetes.
- Develop a strategy for the prevention, treatment, and control of diabetes.
- Examine the needs of adults, children, racial and ethnic minorities, and medically underserved populations who have diabetes.

IDPH has managed oversight and support of the 15-member commission since July 2010 when the duties and responsibilities for the state's diabetes prevention and control program were transferred from the Illinois Department of Human Services by Executive Order 10-06 and legislation. Over the past six years, the priorities of the commission have been to restructure objectives and goals to help reduce the burden of diabetes among Illinois residents.

The commission consists of physicians who are board certified in endocrinology and have expertise and experience in the treatment of childhood diabetes and adult onset diabetes; health care professionals with expertise and experience in the prevention, treatment, and control of diabetes; representatives of organizations or groups that advocate on behalf of persons suffering from diabetes; legislators; and members of the public who have been diagnosed with diabetes.

The commission met three times in fiscal year 2015 and twice in fiscal year 2016. Attendance at commission meetings has been identified as a barrier in previous reports. After surveying members regarding their continued service, IDPH has closed out memberships of inactive members. The Illinois State Diabetes Commission Bylaws were changed to allow commission voting members to appoint a delegate to attend on their behalf when they are unable to participate in a meeting. IDPH will revisit the current commission membership and make recommendations to enhance participation. The commission completed the Annual Progress Report in June 2016. The report can be found on the IDPH website at: www.dph.illinois.gov/sites/default/files/publications/publicationsohpmmdiabetes-general-assembly-annual-report-2016_0.pdf.

In July 2013, IDPH entered into a five-year competitive agreement with U.S. Centers for Disease Control and Prevention (CDC) for the *State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health – FOA – DP13-1305* approach to preventing and reducing the risk factors associated with childhood and adult obesity, diabetes, heart disease, and stroke; and addressing the management of chronic diseases. IDPH's program, entitled Chronic Disease and School Health (CDASH), addresses the CDC's four chronic disease and health promotion domains: 1) epidemiology and surveillance, 2) environmental approaches that promote health, and support and reinforce healthful behaviors, 3) health system interventions to improve the effective delivery and use of clinical and other preventive services, and 4) community-clinical linkages to support cardiovascular disease and diabetes prevention and control efforts and the management of chronic diseases.

The two grant strategies specific to diabetes include: 1) promoting awareness of prediabetes among people at high risk for type 2 diabetes and 2) promoting participation in American Diabetes Association-recognized, American Association of Diabetes Educators-accredited, state-accredited/certified, and/or Stanford University-licensed Diabetes Self-Management Education (DSME) programs.

In strengthening community-clinical linkages for the management of diabetes, IDPH is referring partners to CDC evidence-based, on-line resources and guidelines. These health communication resources will raise awareness among people at high risk of the following:

- prediabetes risk factors, and
- the location of sites offering the CDC-recognized National Diabetes Prevention (DPP) lifestyle change program, and
- how to enroll in the program.

Evidence-based resources will be used in training, and technical assistance will be available statewide for health care systems, local health departments (LHDs), health educators, parish nurses, and others. These resources will include guidelines for discussing impaired glucose tolerance and hemoglobin A1C measurements, risk factors and lifestyle modifications to reduce the risk of diabetes and to promote the use of materials from the National Diabetes Education Program, and the American Diabetes Association for *American Diabetes Association Alert Day*, *American Diabetes Month* and *World Diabetes Day*.

To improve access to DSME, IDPH is exploring ways to work with health insurance carriers (Medicaid and private health insurance plans) to include DSME as part of the standards of care for patients with diabetes. IDPH is currently participating in efforts to expand Medicaid coverage for diabetes prevention programs (DPP) and is educating partners and providers regarding reimbursement strategies for diabetes education activities. In April and October 2016, IDPH participated in meetings that identified an initial framework which would allow Medicaid managed care organizations (MCOs) to offer chronic disease prevention and management programs to enrollees, specifically community-based programs that address prediabetes and diabetes. The programs offered would be evidence-based, proven to be effective, and include models such as the CDC's-recognized DPP, and the Stanford-developed Diabetes Self-Management Program (DSMP) for adults, modified from Stanford's Chronic Disease Management Program.

Illinois Tobacco Quitline

The Illinois Tobacco Quitline (ITQL), which is operated by the American Lung Association through an IDPH grant, regularly refers people with diabetes who call the ITQL to quitline services and community smoking cessation programs. The ITQL tracks the number of people with diabetes who smoke and who were referred to the quitline, who called the quitline, who initiated a smoking cessation program, and who quit and remained tobacco free for at least seven months. National Diabetes Education program materials are provided to diabetic smokers. Local health departments (LHDs) share information about community-based and local resources, such as smoking cessation programs, chronic disease self-management, and DSME programs with the ITQL so they can provide callers with local and relevant programming information. In fiscal year (FY) 2012, persons with diabetes accounted for 990 callers to the ITQL. Since then, the number of callers who indicate a diabetes diagnosis has decreased; 2,825 and 2,127 in FY2015 and FY2016 respectively (about 11.5 percent of total callers). The decrease is due, in part, to the efforts of the LHDs as well as coordinated efforts of community-based diabetes prevention and control programs. These organizations actively refer persons with diabetes to the ITQL from their DSMP/Chronic Disease Self-Management Program (CDSMP) classes, health events, community events, outreach programs, and patient clinics. These organizations also heavily promote the ITQL via websites and social media.

Public Awareness and Education

The CDASH program and the Illinois State Diabetes Commission were active in promoting the diabetes education to partnering agencies through distribution of National Diabetes Education Program (NDEP) material during American Diabetes Month (November). Through partnership with the Illinois Hospital Association (IHA), a Diabetes Symposium was held in three locations throughout the state in June 2016. More than 80 health care professionals participated in this full-day training on current issues in diabetes education and management. To improve access to DSMP, IDPH partnered with Age Options, a community service provider, to increase the number of DSMP classes offered throughout Illinois, by providing training and technical assistance in underserved areas. IDPH recognizes that prevention of the onset of type 2 diabetes is important to ensuring the long-term health of the residents of Illinois. For this reason, IDPH has worked diligently to increase the number of CDC DPP throughout the state. IDPH continues to partner with organizations such as the Young Men's Christian Association (YMCA) and the American Association of Diabetes Educators (AADE) to work towards increased access to training and support for agencies interested in starting DPP.

A *Diabetes Burden Brief* was published in 2016 and is available on the IDPH website at: <http://www.dph.illinois.gov/sites/default/files/publications/publicationsohpmvol-5-issue-4-diabetes.pdf>. The report contains updates on state data regarding the prevalence of diabetes, prediabetes, weight status, tobacco use, economic cost, and health care access among adults with and without diabetes. As part of the planning process, the burden brief was used to select goals and strategies to include in the Diabetes State Plan.

FINANCIAL IMPACT AND REACH OF DIABETES

I. Financial impact and reach that diabetes of all types is having on the state and the Department

A. Number of people in Illinois with diabetes or covered by the state Medicaid program

According to the Illinois Behavioral Risk Factor Surveillance System, approximately 983,000 Illinois adults (9.9%) have been diagnosed with diabetes and another 6.9 percent have been diagnosed with prediabetes*. In the Medicaid population, 245,000 people have diabetes, which is 7.7 percent of all enrollees (see table 1).

*Prediabetes percent is from 2014 as this question was not included in the 2015 BRFSS survey.

Table 1. Number and Percent of Medicaid Population with Diabetes and Other Chronic Conditions, Illinois, 2013

Condition	# of Medicaid Population with Condition	% of Medicaid Population with Condition
Diabetes	244,700	7.73%
Hypertension	458,503	14.49%
Asthma	247,226	7.81%
Depression / Mental disorder	194,067	6.13%
Cancer	163,742	5.17%
Arthritis	89,542	2.83%
CHF	73,118	2.31%
CHD	47,883	1.51%
Stroke	34,911	1.10%

***Mid-year 2013 Medicaid enrollment = 3,164,371**

Note: This report for the Illinois Diabetes Commission and IDPH, is an examination of the financial toll of various chronic diseases on the state Medicaid program. This data is for CY2015 only. Only individuals who received services directly linked to a specific diagnosis for the chronic diseases being examined were included in this data. Please note that due to the Affordable Care Act (ACA) and Medicaid expansion, along with the transition from ICD9 to ICD10, the results from this report may vary from previous reports.

Source: Illinois Department of Health and Family Services, Medicaid Program

B. Number of people with diabetes and family members impacted by prevention and diabetes control programs implemented by IDPH

IDPH promotes and supports evidence-based DSME programs. Programs are either accredited by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE), or are licensed through the Stanford DSME program. As of July 2016, there were 141 ADA and AADE programs, and nearly half (47) of the counties in Illinois had ADA, AADE, or DSME programs. According to the CDC Diabetes Prevention Recognition Program, 45,941 people with diabetes in Illinois had at least one encounter with an ADA, AADE, or Stanford program in 2014.

C. Financial toll or impact of diabetes and its complications

The CDC Diabetes Cost Calculator estimates the costs of diabetes at the national and state levels. According to CDC, in 2012, medical expenses attributable to diabetes in Illinois totaled \$8.98 billion and indirect expenses, such as lost productivity and premature mortality, totaled more than \$2.39 billion. People with diagnosed diabetes, on average, have medical expenditures that total approximately 2.3 times higher than expenditures would be in the absence of diabetes. Direct costs pertain to the medical expenditures incurred with treating and controlling the symptoms and the complications of diabetes. Indirect costs include factors such as increased absenteeism, reduced productivity, and lost productive capacity due to early mortality.

Hospitalizations due to diabetes place a large toll on the Illinois health care system. The average length of stay for a diabetes hospitalization is 4.4 days and the median cost is \$23,707. Length of time and expense is greater for males who are hospitalized than females and for adults aged 35 years and older compared to those younger than age 35 (table 2).

The financial toll of diabetes on the Medicaid system results in an average cost of \$5,726 per person covered and a total of \$62 million dollars in pharmacy payments. Total payments reached \$1.4 billion. (table 4).

Table 2. Financial Toll of Diabetes Hospitalizations by Sex and Age, Illinois, 2015

Diabetes	Average length of stay	Total hospitalization charges	Median charge per hospitalization
Sex			
Female	4.18	\$ 338,653,203	\$22,780
Male	4.63	\$ 460,889,967	\$24,598
Age			
<5 Years	2.78	\$ 2,285,939	\$18,979
5-14 Years	2.16	\$ 17,857,989	\$14,522
15-34 Years	2.78	\$ 128,572,314	\$17,677
35-64 Years	4.72	\$ 376,219,832	\$25,453
65 and Older	5.30	\$ 582,036,425	\$28,381
Total	4.42	\$799,543,170	\$23,707

Source: Illinois Department of Public Health, Hospital Discharge Database

- D. Financial toll or impact diabetes and its complications places on the diabetes program in comparison to other chronic diseases and conditions

Diabetes hospitalizations result in longer hospital stays and greater charges than hypertension, asthma, and arthritis, but shorter stays than hospitalizations due to other cardiovascular and stroke-related hospitalizations (table 3).

Table 3. Financial Toll of Chronic Disease Hospitalizations, Illinois, 2015

Condition	Average length of stay (days)	Total hospitalization charges	Median charge per hospitalization
Diabetes	4.43	\$799,543,170	\$23,707
Cerebrovascular disease	5.17	\$2,025,685,518	\$35,827
Congestive Heart Failure (CHF)	4.88	\$1,722,295,074	\$27,253
Other Heart Disease	4.88	\$1,369,959,934	\$47,026
Major cardiovascular disease	4.72	\$11,443,254,946	\$37,005
Ischemic Heart Disease	4.38	\$3,312,148,498	\$66,389
Arthritis	3.78	\$21,140,871	\$35,412
Asthma	3.07	\$371,582,151	\$18,746
Hypertension	2.49	\$78,535,053	\$19,769

Source: Illinois Department of Public Health, Hospital Discharge Database

ICD9 Codes Used: Diabetes (250 series); Arthritis (714 series); Asthma (493 series); Congestive Heart Failure (428 series); Major Cardiovascular Disease (390-398, 401-438, 440-448); Hypertension (401 series); Ischemic Heart Disease (410-414); Cerebrovascular Disease (430-438); Other Heart Disease (440-448).

Source: Illinois Department of Public Health, Hospital Discharge Database

The Medicaid system spends more money on diabetes enrollees than enrollees with congestive heart failure, asthma, coronary heart disease, depression, stroke, cancer, and arthritis, but less than enrollees with hypertension. Pharmacy payments for enrollees for diabetes medications are the highest out of the reported conditions (table 4).

Table 4. Financial Toll Diabetes and Other Chronic Conditions Place on Medicaid System, Illinois, 2015

Condition	# of Medicaid Population with Service for Condition	Service Payments	Pharmacy Payments	Capitation Payments	# of Medicaid Population with Service for Condition enrolled in Managed Care as of 12/31/2015	Total Payments	Costs per Person
Diabetes	244,700	\$283,209,237	\$62,241,722	\$1,055,808,693	153,733	\$1,401,259,651	\$5,726.44
Hypertension	458,503	\$398,389,629	\$8,667,004	\$1,896,286,652	300,273	\$2,303,343,285	\$5,023.62
Asthma	247,226	\$172,807,635	\$40,634,002	\$605,040,598	201,696	\$818,482,235	\$3,310.66
Depression/ mental disorder	194,067	\$185,147,927	\$8,044,346	\$791,379,535	135,477	\$984,571,807	\$5,073.36
Cancer	163,742	\$328,208,101	\$28,403,880	\$517,685,002	112,932	\$874,296,983	\$5,339.48
Arthritis	89,542	\$28,436,904	\$16,653,079	\$352,825,151	53,968	\$397,915,134	\$4,443.89
Chronic Heart Failure	73,118	\$205,586,802	\$22,033,727	\$306,633,593	32,469	\$534,254,122	\$7,306.74
Chronic Heart Disease	47,883	\$75,451,516	\$4,741,223	\$196,460,406	22,909	\$276,653,145	\$5,777.69
Stroke	34,911	\$97,022,159	\$11,522,940	\$199,365,424	17,143	\$307,910,522	\$8,819.87

This report for the Illinois Diabetes Commission and IDPH, is an examination of the financial toll of various chronic diseases on the state Medicaid program for CY2015. Only individuals who received services directly linked to a specific diagnosis for the chronic diseases being examined were included in this data. Please note that due to the Affordable Care Act (ACA) and Medicaid expansion, along with move from ICD9 to ICD10, the results from this report may vary from previous reports.

* A Medicaid population of 3,164,371 based on a midyear population on 6/30/2015 was used for this data.

*** A single individual may receive services for several chronic diseases in a given year (i.e. diabetes and CHD), so they be would identified twice in the disease counts and also have any capitation payments made for them listed twice (once for each disease).

II. Assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease.

This assessment also shall document the amount and source for any funding directed to IDPH from the General Assembly for programs and activities aimed at reaching those with diabetes. The CDASH Program is a result of the coordinated chronic disease efforts by the CDC and state health departments across the United States. The purpose of IDPH's CDASH program, which includes statewide diabetes prevention and control activities, is to reduce the burden of chronic disease in Illinois through primary and secondary prevention strategies that focus on the implementation of standards for healthy nutrition and physical activity in early care and education centers, schools, and hospitals. The goals also are to improve the quality of care through statewide reporting and technical assistance to health care providers on the management of hypertension and diabetes; and raise awareness of hypertension and prediabetes, promoting hypertension self-monitoring and medication therapy management, and expanding diabetes self-management education.

Outcomes – IDPH and its partners are addressing seven primary outcomes during the CDASH five-year project period:

- Increased consumption of nutritious food and beverages, and increased physical activity across the life span.
- Improved medication adherence for adults with high blood pressure and adults with diabetes.
- Increased self-monitoring of high blood pressure tied to clinical support.
- Increased use of diabetes self-management programs.
- Improved prevention and control of hypertension.
- Improved prevention and control of diabetes.
- Improved prevention and control of overweight and obesity.

IDPH's diabetes prevention and control activities are supported by core public health activities, such as partnership engagement, workforce development, guidance and support for programmatic efforts, strategic communication, surveillance and epidemiology, and evaluation. The CDASH Program is striving to increase state, community, worksite, school, early care, and education environments that promote and reinforce healthful behaviors and practices across the life span related to diabetes, cardiovascular health, physical activity, healthful food and beverages, and obesity. The Program is planning to improve the quality,

effective delivery, and use of clinical and other preventive services to address prevention and management of hypertension and diabetes. The CDASH Program is striving to increase community clinical linkages to support prevention, self-management, and control of diabetes, hypertension, and obesity during the project period.

CDASH bases program activities on the Expanded Chronic Care Model, which provides a framework that re-orientes public health and health care services to better address the needs of individuals with chronic disease(s). CDASH places greater emphasis on prevention, population health promotion, and the creation of supportive community environments linked to the health care system. Seven areas of focus are emphasized in the model, including:

1. Self-management support that fosters development of personal skills needed to manage chronic disease.
2. Decision support that assists health care providers and community-based programs in gathering and using data to improve quality of care and promote strategies for maintaining good health.
3. Delivery system redesign that encourages the health care system to expand beyond clinical, treatment-oriented services to support individuals and communities in a more holistic way.
4. Expanded use of information systems to improve quality of clinical care, as well as support prevention and community-based efforts.
5. Development and implementation of policies to improve population health.
6. Creation of supportive environments to promote optimal health in social and community settings.
7. Involvement of community groups in establishing priorities and taking action to identify and to remove barriers in healthy living.

Collectively, the work conducted during the CDASH project period will result in a healthier Illinois that delivers healthier students to schools, early care, and education centers; healthier workers to businesses and employers; and a healthier population to the health care system. The CDASH Program activities will make it easier for Illinoisans to take charge of their health.

Until December 2016, efforts provided by IDPH to address diabetes in Illinois were solely funded by the CDC. In December 2016, IDPH was awarded one of two grants from the Association of State and Territorial Health Officials (ASTHO) to develop and implement a comprehensive Diabetes Strategic Plan for Illinois.

There are no sources of state funding appropriated to IDPH for diabetes programs and activities.

PARTNERSHIPS AND COLLABORATIONS TO PREVENT AND CONTROL DIABETES

III. Description of the level of coordination that exists between IDPH and other entities on activities, programs, and messaging on managing, treating, or preventing all forms of diabetes and its complications.

IDPH is leveraging the activities of several federal grant programs for CDASH and diabetes prevention and control. These programs include WISEWOMAN, Maternal and Child Health Services Block Grant, Preventive Health and Health Services Block Grant, Child Care and Development Block Grant, Medicaid, and Safe Routes to Schools, and collaborating with the Million Hearts and the Healthier U.S. Schools Challenge campaigns.

To implement CDASH, IDPH has built upon existing collaborations with many partners, including the Illinois Network of Child Care Resource and Referral Agencies (INCCRRA), the Illinois Primary Health Care Association (IPHCA), the Illinois State Board of Education (ISBE), Illinois Public Health Institute (IPHI), the Illinois Hospital Association (IHA), the University of Illinois Extension, Illinois Action for Healthy Children, the Active Transportation Alliance, the Illinois Head Start Association, the Illinois Department of Human Services (DHS), the Illinois Department of Health Care and Family Services (HFS), the American Diabetes Association, the American Association of Diabetes Educators, the Stanford University Patient Education Center, the Illinois Pharmacists Association (IPhA), and local health departments in DuPage, Kane, Lake, Kankakee, Sangamon, and Will counties. Recent activities have included a symposium and webinars for health care professionals on the referral process, retention of participants, and the sustainability of diabetes education programs.

The heart of Illinois' public health system includes IDPH and 97 certified local health departments. Local health departments cover 100 of Illinois' 102 counties and approximately 99 percent of the state's population. Part of the strategy in the use of CDASH funds is to strengthen the capacity of local health departments to serve as the community's first resource for training, technical assistance, and consultation on strategies to prevent and control chronic diseases.

PARTNERSHIPS AND COLLABORATIONS TO PREVENT AND CONTROL DIABETES (continued)

Illinois has 879 school districts. The ISBE's Learning Standards and Early Learning and Development Standards provide a policy framework for improving education, including health promotion and health education, in Illinois' schools. IDPH will work in partnership with ISBE and local schools to target communities to improve health education, healthy environments, and worksite wellness by using the Coordinated School Health (CSH) model.

Illinois has nearly 200 hospitals. IDPH will expand its existing partnership with the Illinois Hospital Association to examine nutrition standards in Illinois hospitals, sodium reduction in community settings, and collaborate on the development of certified DSME in hospital settings.

IDPH is working in collaboration with IPHI and HFS in support of expanded Medicaid MCO coverage and reimbursement for diabetes and prediabetes self-management education programs. Two demonstration projects will be implemented in 2017.

IDPH is responsible for Illinois' Maternal and Child Health Services Block Grant and several related programs, including the School Health Program. The School Health Program includes continuing education for school nurses, grants to implement the Comprehensive School Health model, and a network of school-based or school-linked health centers.

IDPH uses CDASH funds to target a six-county area in Illinois to concentrate school health, hospital, worksite, and self-management education efforts. These six counties represent 41 percent of the state's population. The local health departments in the CDASH target area will participate in training and work in local communities to implement evidence-based strategies in diabetes education.

IDPH is conducting health system interventions for CDASH using a two-pronged approach. First, at the state level, IDPH is advocating for reporting of national quality measures by eligible professionals who have met Stage 2 Meaningful Use reporting requirements; National Quality Forum (NQF) measure 018 (hypertension management) and measure 059 (diabetes management). Monitoring of NQF 018 and 059 (and related measures) will be used to assess the performance of Medicaid and private managed care plans.

Second, IDPH will facilitate analysis and reporting of these performance measures through the "Public Health Node," which IDPH developed to support reporting of public health meaningful use data. The node provides a structured way to receive, standardize, analyze, and report Stage

1 Meaningful Use indicators. The node uses the open-source *PopHealth* software (approved by the Office of the National Coordinator) for public health surveillance, data analysis, and to develop performance dashboards for interested providers.

Responsibility for development and use of the node rests with the IDPH Division of Patient Safety and Quality (DPSQ).

The DPSQ is working with the CDASH Program on the *Healthy Hearts* campaign. DPSQ staff use data from the *PopHealth* software to assist federally qualified health centers (FQHCs), within specific target areas, analyze data regarding hypertension management. DPSQ staff then work with these FQHCs and their LHDs to develop clinical and community strategies to address health behaviors and to reduce the incidence of uncontrolled hypertension. Through the CDASH Program, IDPH will expand this support and technical assistance to include diabetes and team-based care.

IDPH will continue working at the state and community levels to increase access to DSME. At the state level, IDPH will work with health insurance carriers to include DSME as part of the standards of care for patients with diabetes and to monitor the quality of care.

IDPH has utilized strategies at the community level, including the funding of six LHDs to assess diabetes self-management programs in targeted counties. The LHDs will assess the availability, services provided, geographic locations, capacity, utilization by patients, reimbursement and coverage policies, referring practices, and facilitators and barriers in diabetes education and care. In addition, IDPH will leverage its partnership with IHA and LHDs to provide support and technical assistance to hospitals, FQHCs, and clinics to assist them in establishing DSME programs.

IDPH is working with IPhA to broaden the reach of DSME programs by working with large corporations to engage in their Employer Team-Based Care Pilot Program, which includes diabetes education, medication optimization (MTM), patient-pharmacists goal setting, disease history review, medication adherence, and transmitting information to the patient care team. IPhA will also deploy a survey instrument in late 2016 to gauge the level of pharmacists involvement in MTM services and diabetes self-management programs. The survey results will be shared with IDPH.

IV. Development or revision of a detailed action plan for battling diabetes with a range of actionable items for consideration by the General Assembly. The plan shall identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan shall also identify expected outcomes of the action steps proposed for the two years following the submission of the report while also establishing benchmarks for controlling and preventing relevant forms of diabetes.

The Illinois State Diabetes Commission was an essential partner in developing the Illinois State Diabetes Plan. As required by statute, the commission scheduled and held public hearings to gather information on issues pertaining to the prevention, treatment, and control of diabetes. In addition, the commission collaborated with IDPH's CDASH Program to ensure maximum reach and to promote education related to the nature and extent, underlying causes, and prevention and control of diabetes.

In June 2016, the Illinois Diabetes State Plan was disseminated to the Illinois State Diabetes Commission and partners involved in the plan's development. The distribution list included a broad range of state and local chronic disease professionals representing academic, government, public health, non-profit, business, and advocacy organizations that represent people affected by diabetes and related risk factors. An online survey was developed by IDPH's epidemiology and surveillance team and will be sent to state and local partners to assess the use and effectiveness of the plan. IDPH's CDASH Program staff will collect and analyze results and provide feedback to partners. Findings, including barriers and lessons learned, will be used to adjust program efforts and to ensure continuous quality improvement. Accomplishments will be shared through IDPH communications, state and local success stories, and will be reported during regularly scheduled diabetes commission meetings.

The finalized goals, strategies, and action steps will be evaluated based on identified criteria to assess the level of accomplishment and impact. The epidemiology and surveillance team will conduct data analysis and report findings to IDPH's CDASH Program, diabetes commission, and partners.

The Illinois Diabetes State Plan can be found on IDPH's website at:

<http://www.idph.state.il.us/diabetes/pdf/IllinoisDiabetesStatePlan2013-2018.pdf>

In December 2016, IDPH was one of two states to receive a grant from the Association of State and Territorial Health Officials (ASTHO) to participate in a demonstration project for the development of a comprehensive statewide diabetes plan. IDPH will engage multiple sectors including clinical, community, and public health partners to align state diabetes plans and address gaps to improve diabetes management and associated outcomes. The plan will be completed in 2017.

V. Development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in the Illinois Diabetes State Plan. The blueprint shall include a budget range for all options presented in the plan for consideration by the General Assembly.

According to the CDC, chronic disease public health practitioners must make measurable contributions to the prevention and control of chronic disease and, by doing so, improve quality of life, increase life expectancy, improve the health of future generations, increase productivity, and help control health care spending.

It is increasingly recognized that individual health depends on societal health and healthy communities. In addition to having strong medical care systems, healthy communities promote and protect health across the lifespan, across a variety of sectors, and through a range of policies, systems, and environmental supports that put health in the people's hands and give Illinoisans even greater opportunity to take charge of their health.

Additional funding for diabetes prevention, education, and control would be used to implement and enhance the following activities in diabetes high-burden areas in the state:

- A. Improve and expand diabetes surveillance and monitoring throughout the state to assess the burden of diabetes and guide policy development and evaluation activities to inform, to prioritize, to deliver, and to monitor diabetes interventions at state and community levels.

Strategy 1: Enhance the capacity of statewide surveillance to improve the collection, quality, and scope of population-based diabetes-related data.

Strategy 2: Expand surveillance to enhance collection and analysis of data across the life span for those at higher risk for diabetes.

Strategy 3: Develop and distribute diabetes surveillance, epidemiology, and evaluation reports on a consistent basis.

Strategy 4: Develop data collection activities for analyzing new data sources to monitor prediabetes.

- B. Collaborate with communities to increase the number of evidence-based policies, systems, and environmental change strategies to promote healthy lifestyles, and to improve diabetes management in schools, worksites, and communities.

This will address needed improvements in social and physical environments that make healthy behaviors easier and more convenient. A healthy society delivers healthier students to schools, healthier workers to businesses and employers, and a healthier population to the health care system. These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for people to manage their health. They have broad reach, sustained health impacts, and are the best public health approaches. This recommendation would fund LHDs in high diabetes prevalence counties to collaborate with communities, schools, and early childcare education centers to facilitate and support educational opportunities, resources, and provide awareness materials on prediabetes and diabetes prevention and control. The LHDs can provide resources and support to communities, to schools, and to early childcare providers for joint use agreements, safe routes, complete streets, and active transportation that will help establish healthy environments. The LHDs may promote the establishment, improvement, and accessibility and use of outdoor spaces, including streets, parks, recreation areas, trails, and other public places that are safe, tobacco-free, appropriate, and available for physical activity and play, and have healthy food policies. In addition, the LHDs should promote the availability, accessibility, and affordability of healthful eating by promoting the use of community gardens and farmers' markets, increasing the availability of fresh produce at convenience stores, and locating grocery stores and markets that offer fruits and vegetables in underserved communities.

Strategy 1: Collaborate with partners to assess local needs and implement interventions (e.g., public education efforts, active transportation and environmental change policies) that are culturally appropriate and support healthy lifestyles and diabetes self-management skills.

Strategy 2: Increase the number of environmental approaches for addressing diabetes, promoting healthy lifestyles, and reinforcing healthful behaviors in Illinois worksites.

Strategy 3: Collaborate with communities, schools, early childcare providers, and food service institutions to implement and evaluate policies and interventions to help prevent type 2 diabetes and to ensure safe and quality diabetes care across the life span.

C. Ensure health systems and providers promote and provide accessible preventive services so persons at risk of diabetes will receive appropriate screening to promote early detection of disease and complications, self-management education, and ongoing management to reduce risk of disease and complications.

Health systems interventions improve the clinical environment to more effectively deliver quality preventive services and help people more effectively use and benefit from those services. As a result, some chronic diseases and conditions will be avoided completely and others will be detected early, or managed better, to avert complications and progression and improve health outcomes. Health system and quality improvement changes, such as electronic health records with features to prompt clinicians and deliver feedback on performance, can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is the key, as coverage alone will not ensure use of preventive services.

Funding will allow access to supportive educational messaging for diabetes prevention and control, healthy lifestyle behaviors, and self-management programs. Additionally, identifying and utilizing communication strategies to inform partners of initiatives to increase diabetes prevention and control activities, and share progress and outcome data, will efficiently advance strategic goals.

Strategy 1: Improve the delivery of comprehensive diabetes prevention and control through the IDPH's Diabetes Prevention and Control Program resources, and other culturally-appropriate and evidence-based tools to health systems, payers, health professionals, and community partners.

Strategy 2: Promote health professional education opportunities to enhance lifestyle modification and risk reduction, behavior change, and disease management.

Strategy 3: Enhance partnerships and communication with providers, health and community organizations, payers, and other relevant partners to support standards of care of diabetes.

D. Ensure those with or at high risk for diabetes have access to quality community resources to best manage their conditions, or to reduce disease risk.

This objective will ensure that communities provide support and that clinics provide referrals of patients to programs that improve management of chronic conditions. Community-clinical linkages help ensure people with or at high risk of chronic diseases have access to community resources and support to prevent, delay, or manage chronic conditions once they occur. These supports include interventions such as clinical referral, community delivery, and third-party payment for effective programs that increase the likelihood that people with heart disease, diabetes, prediabetes, or arthritis will be able to "follow the doctor's orders" and take charge of their health. This includes improving their quality of life, averting or delaying onset or progression of disease, avoiding complications (including during pregnancy), and reducing the

need for additional health care, including readmissions to hospitals and emergency department visits.

Strategy 1: Enhance the clinical-community awareness of availability of evidence-based interventions and the process of referring patients to self-management education classes.

Strategy 2: Ensure reliable clinical-community access to accurate and culturally relevant patient education resources and information.

Strategy 3: Increase the number of evidence-based interventions offered to at-risk populations in high diabetes prevalence areas.

Strategy 4: Enhance the ability of state and local providers to establish a reimbursement mechanism for implementation of evidence-based interventions.

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