AADE Position Statement

Diabetes Education and Public Health

Diabetes educators are long-standing advocates for people at risk for and with diabetes, striving to create environments in health care systems, homes, schools, and communities that support diabetes care and prevention. Well positioned in their own communities, diabetes educators promote access to quality diabetes care and diabetes self-management education, ensure healthy nutrition and physical activity choices, and provide social support to help individuals and families initiate and sustain lifestyle adaptations. Diabetes educators in all settings are critical members of the public health workforce. Public health has been defined by the Institute of Medicine as "what we, as a society, do collectively to assure the conditions in which people can be healthy."[1] The word *all*—all people, all populations—is implicit, reflecting the principles of social justice and prevention, on which public health is built.[2,3]

Background

Modern societal forces (eg, an abundance of inexpensive high-calorie foods and high rates of sedentary activities, such as television watching) and constraining social determinants of health (eg, education, economic status, history, and physical environments) have collided with behavioral and biological factors of obesity (eg, overweight, physical inactivity) and little-understood innate traits of individuals (eg, genetics, intrauterine environment) to usher in an 8-fold increase in diagnosed diabetes since 1958. High rates of diabetes (20.8 million in 2005) largely reflect growing rates of type 2 diabetes (90% to 95% of diagnosed cases).[4] Rates of prediabetes have been estimated to be as high as 73 million.[5] This escalation of diabetes and prediabetes affects the social and economic conditions of communities, states, and the nation as a whole and requires the attention of the

This is an official position statement of the American Association of Diabetes Educators (AADE). AADE is a multidisciplinary professional membership organization of health care professionals dedicated to integrating successful self-management as a key outcome in care of people with diabetes and related conditions.

Position Statement Coordinator

Dawn Satterfield, RN, PhD

Task Force Members

Dawn Satterfield, RN, PhD

Carolyn Jenkins, DrPH, APRN-BC-ADM, RD, CDE

Barbara Bodnar, MA, RD, CDE

Ann Constance, RD, CDE

Evan Sisson, PharmD, MHA, CDE

AADE Board approval: May 2007

DOI: 10.1177/0145721707312403

public health community at all levels—local, tribal, state, and national.[6]

Communities and Health

Community is the heart of public health. The word *community* can refer not only to localities but also to groups that share a common interest or cause, although they may not live in the same location. Diabetes educators form local (chapter) and national communities in this sense. Community is the foundation for relationships built between and among organizations and individuals.[7] *Common* and *unity* in the word *community* suggest the common ground and solidarity needed to accomplish shared goals.

Health was defined by the World Health Organization in 1948 as a "state of complete physical, mental, and social well-being, not confined to the absence of disease."[8] The broad dimensions of health, interrelated among physical, mental, and social aspects, help to explain the powerful role of communities in health-related choices. Indeed, the health of individuals is almost inseparable from the health of the larger community.[9] Community self-determination is the responsibility and right of all people of a community. Principles of community engagement (www.cdc.gov/phppo/pce)[10] guide public health advocates to focus on a community's strengths and assets rather than deficits and problems.[11]

Prevention

Prevention is a foundational principle of public health, and it has been recognized by the American Association of Diabetes Educators (AADE) as part of the scope of practice of diabetes educators. Diabetes prevention now stands on a firm foundation of science for all levels of prevention: primary (preventing or delaying the onset of diabetes, as was the goal for intensive lifestyle interventions of several recent trials, including the Diabetes Prevention Program [DPP] in the United States), secondary (preventing or delaying the progression of microvascular complications such as retinopathy with interventions such as intensive glycemic control with near normalization of the A1C value), and tertiary (preventing disability from diabetes complications, such as with interventions that promote the timely detection of proliferative retinopathy and early laser treatment to prevent vision loss).[6] The value of secondary and tertiary prevention interventions to promote preventive care practices such as eye and foot examinations[12] and glucose control[13] has long been established. The recent release of the DPP, confirming the feasibility of preventing or delaying the onset of type 2 diabetes,[14] has shored the science base for primary prevention with exciting implications that are yet unfolding.

Building Partnerships

The health of individuals is integrally connected to the health of their communities. Successful self-management incorporating the AADE 7™ Self-care Behaviors is possible only through access to timely, affordable, and appropriate care and education, social support, and health-supporting environmental conditions that help both people with diabetes and other citizens, including those at risk for diabetes. The broad, ecological perspective of public health, expanding from the central focus on individuals to families, communities, society, and policy, makes clear the need to include partners at various levels of influence.[15] At community levels, for example, church groups, grassroots advocacy groups, schools, zoning boards, businesses, employers, work groups, and libraries can be partners in promoting health and preventing diabetes. Diabetes community health workers, able to link people in communities to health care systems, are often valuable partners in communities dedicated to addressing diabetes prevention and treatment.[16,17] Policies that promote access to quality diabetes care and self-management education; safe and healthy environments for living, working, and learning; and issues of social justice including educational opportunities are vital to the mission of public health. Diabetes educators have been steadfast advocates who have contributed to major policy changes for the benefit of people with diabetes. Continued advocacy efforts will likely include expanding efforts to further promote healthy environments for people with and at risk for diabetes.

Building a Public Health Infrastructure

Creating healthy conditions involves establishing effective systems for health care and information, with the help of committed partners. The core functions of public health are assessment, policy development, and

assurance. To communicate more meaningfully about the key functions of public health in assessment, policy development, and assurance, the 10 essential public health services for building public health infrastructure have been identified[18]:

1. monitor health status to identify and solve community problems;
2. diagnose and investigate health problems and hazards in the community;
3. inform, educate, and empower people about health issues;
4. mobilize community partnerships and action to identify and solve health problems;
5. develop policies and plans that support individual and community health efforts;
6. enforce laws and regulations that protect health and ensure safety;
7. link people to needed personal services to ensure the provision of health care when otherwise unavailable;
8. ensure a competent public and personal health care workforce;
9. evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
10. research for new insights and innovative solutions to health problems.

Conclusion

Seeking to improve the health of populations—public health—is a language of interconnectedness, describing the work across systems for the common good of the people.[2] Recognizing the many interconnections involved in health promotion and diabetes prevention can open doors to partnerships at all levels: local, tribal, state, and national. Policies and practices may need to be changed at various levels to support the delivery of quality care and environments that promote health. Communities are best positioned to determine the interventions that are most meaningful and workable for them, facilitated by participation with diabetes educators and other partners.

Recommendations

1. Identify Community Needs

Consider the need for a community assessment. Consult with your county health department or hospital or clinic administrator to determine if such an assessment has already been conducted. Tools for conducting community assessments related to diabetes prevention and control are available from a number of sources including the Community Toolbox (http://ctb.ku.edu) and the Robert Wood Johnson Foundation (http://www.rwjf.org).

2. Make Connections

Get involved in advocacy efforts to ensure that people with diabetes have access to appropriate, timely, and affordable care. This may include calling, writing, and visiting with legislators and other policy makers or serving on local boards of health. These efforts may also be directed toward environmental changes to help ensure that desirable and affordable food choices are available, as well as safe and accessible places to walk and be active. These efforts are crucial to help support the AADE 7™ Self-care Behaviors.

Expand the reach of diabetes education efforts by engaging new partners, both traditional and nontraditional, who share similar goals. Guidance on establishing and maintaining partnerships can be found in free resources, including the Principles of Community Engagement (www.cdc.gov/phppo.pce),[9] the Community Toolbox (http://ctb.ku.edu), and the Guide for Community Preventive Services (http://www.thecommunityguide.org). You may want to consider using the ecologic model[15] and the chronic care model[19] to help stakeholders envision the far-reaching impact of shared efforts to promote health for people with and at risk for diabetes.[17]

Link with state and national programs with shared goals. Network with other local, state, and national resources to promote health for people with and at risk for diabetes[17] and support the AADE 7™ Self-care Behaviors. Make connections with your state-based Diabetes Prevention and Control Programs (http://www.cdc.gov/diabetes/states/index.htm). These programs seek to establish and maintain strong partnerships to use a systems approach to address diabetes-related health disparities and to promote health and prevent diabetes.

Share resources of the National Diabetes Education Program (NDEP; http://ndep.nih.gov/). A joint initiative led by the Centers for Disease Control and Prevention and National Institutes of Health, NDEP engages more than 200 partners, including AADE. The purpose of the NDEP is to educate people with diabetes and their families, the general public, health care providers, and payers, purchasers, and policy makers that diabetes is

serious, common, costly, and controllable and includes a newer campaign, "small steps, big rewards," to promote awareness about diabetes prevention.

References

1. Institute of Medicine. The Future of Public Health. Washington, DC: National Academy Press; 1988.
2. Wallack L, Lawrence R. Talking about pubic health: developing America's "second language." Am J Public Health. 2005;95(4): 567-570.
3. Wang C. The future of health promotion: talking technology blues. Health Promot Pract. 2000;1(1):77-80.
4. Centers for Disease Control and Prevention. Diabetes at a Glance, 2005. Atlanta, GA: Centers for Disease Control and Prevention; 2005.
5. Cowie CC, Rust KF, Byrd-Holt DD, et al. Prevalence of diabetes and impaired fasting glucose in adults in the U.S. population: National Health and Nutrition Examination Survey 1999-2002. Diabetes Care. 2006;19(6):1263-1268.
6. Engelgau MM, Murphy D, Narayan KMV, Vinicor F. Diabetes and the pubic health perspective. In: Mensing C, ed. The Art and Science of Diabetes Self-management Education: A Core Knowledge Publication of the American Association of Diabetes Educators. Chicago, IL: American Association of Diabetes Educators; 2006:7-19.
7. Green L, Daniel M, Novick L. Partnership and coalitions for community-based research. Public Health Rep. 2001;116(suppl 1): 20-31.
8. World Health Organization. Constitution of the World Health Organization. Geneva, Switzerland: World Health Organization; 1948.
9. US Department of Health and Human Services. Healthy People 2010. Washington, DC: Government Printing Office; 2000. www .health.gov/healthypeople
10. Centers for Disease Control and Prevention. Public Health Practice Program Office. Principles of community engagement: CDC/ASTDR Committee on Community Engagement 1997. Atlanta, GA: Centers for Disease Control and Prevention. www.cdc.gov/phppo.pce. Order no, 19980722-4178.
11. Kretzmann JP, McKnight JL. Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. Chicago, IL: ACTA Publications; 1993.
12. Saaddine JB, Engelgau MM, Beckles GL, Gregg EW, Thompson TJ, Narayan KM. A diabetes report card for the United States: quality of care in the 1990s. Ann Intern Med. 2002;136:565-574.
13. Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Eng J Med. 1993;329:977-986.
14. The Diabetes Prevention Program Research Group. The Diabetes Prevention Program (DPP) description of lifestyle intervention. Diabetes Care. 2002;25:2165-2171.
15. Walker EA. Understanding the individual's health behaviors and choices. In: Mensing C, ed. The Art and Science of Diabetes Self-management Education: A Core Knowledge Publication of the American Association of Diabetes Educators. Chicago, IL: American Association of Diabetes Educators; 2006:1-5.
16. Albright A, Satterfield D, Broussard B, et al. Position of the American Association of Diabetes Educators: diabetes community health workers. Diabetes Educ. 2003;29(5):818, 821-824.
17. Norris SL, Chowdhury FM, Van Le K, et al. Effectiveness of community health workers in the care of adults with diabetes: a systematic review. Diabet Med. 2006;23:544-566.
18. Satterfield DW, Murphy D, Essien JDK, et al. Using the essential public health services as strategic leverage to strengthen the public health response to diabetes. Public Health Rep. 2004;119(3): 311-321.
19. Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? Eff Clin Pract. 1998;1:2-4.