10-Year Strategic Plan

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Chair, Board of Directors
Diabetes Initiative of South Carolina

2017 - 2027
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as partners of the DSC
INTRODUCTION

The Diabetes Initiative of South Carolina (DSC) was established by legislative action in July 1994. A governing Board was created, and an administrative structure which included three Councils: Diabetes Center, Outreach, and Surveillance was established.

In 2012 a report, The Burden of Diabetes in South Carolina, was released by DHEC which reflected the scope, impact, and costs of diabetes and its complications in South Carolina, using the most recently available data. The report was the result of close cooperation between the Diabetes Initiative Board, the Surveillance Council, and the DHEC Office of Chronic Disease Epidemiology and Evaluation. The major findings in the report serve as the basis for the Strategic Plan of the Diabetes Initiative of South Carolina. Major issues are identified by the Board, and long range diabetes health status goals and aims are highlighted. Each Council is charged with developing programs that will directly address these issues. Broadly speaking, professional education issues are the responsibility of the Diabetes Center Council, patient and public awareness and information are the province of the Outreach Council, and database establishment, maintenance, and follow-up are conducted by the Surveillance Council. Close integration with activities of the DHEC Division of Diabetes, Heart Disease, Obesity, and School Health has been fundamental to this plan.

This document is therefore prepared to: (a) define the major health-related issues about diabetes in SC; (b) describe a 10-year plan (2017 – 2027) that will address those issues; (c) create an ongoing evaluation process; (d) define specific responsibilities for addressing defined goals and aims; and (e) indicate constraints/assumptions that are inherent in the Strategic Plan.

The Strategic Plan was initiated by a committee, appointed by the DSC Board Chairperson. The Plan was circulated widely to all Board and Council members and was revised and updated on many occasions. Board approval was granted on September 29, 2017.
MISSION STATEMENT

The Diabetes Initiative of South Carolina will maintain a leadership position in providing education about diabetes and its complications to the general public, individuals with diabetes, health professionals, and health care systems. The Diabetes Initiative will develop and sustain educational programs in medicine, nursing, pharmacy, and other health-related professions and will promote the highest standards of health care for people with diabetes and the complications.

The Diabetes Initiative of South Carolina will:

- develop methods to promote the recognition (certification) of optimal numbers of health professionals,
- develop programs to increase knowledge and care for diabetes and its complications,
- advocate for community-based diabetes programs to promote life-style changes that have the potential to prevent or delay the onset of diabetes and its complications,
- support programs that will provide ongoing epidemiological information and surveillance of health care costs, scope and impact of diabetes and its complications in South Carolina,
- work closely with other organized groups that are active in improving outcomes for diabetes and its complications,
- encourage and support research on selected clinical issues in diabetes, as defined and approved by peer reviewed research protocols.
RATIONALE

Society is holding U.S. health care providers and health care organizations accountable for the cost-effectiveness and quality of care provided to people with diabetes. In 2017, 30.3 million people in the United States have diabetes mellitus—or about 9.4 percent of the population, and of those, ninety to ninety-five percent of people have type 2 diabetes mellitus. Furthermore, 23.8% of people with diabetes in the U.S. are undiagnosed. Finally, approximately 5% of people with diabetes are estimated to have type 1 diabetes or 132,000 children and adolescents younger than age 18 years. People with diabetes consume a large share of the health care costs, due to the increased morbidity and mortality associated with diabetes. Many of the complications of diabetes are preventable. Early treatment of the complications of diabetes, such as retinopathy, neuropathy, and nephropathy, may slow the rate of progression of these complications. People with diabetes depend on their primary health care provider (PCP) or endocrinologist to manage their diabetes and health care reform stresses the need for PCP’s in managing overall health for people with diabetes. Yet, the care of the person with diabetes should include a team of individuals who focus on diabetes care such as nurse practitioners, physician assistants, nurses, diabetes educators, dietitians, pharmacists, mental health professionals, in addition to the PCP. A comprehensive care plan developed by a diabetes team, including input from the patient and the family, will encompass the patient’s medical history, behaviors, risk factors, environmental factors, and cultural background. Therefore, it is very important that the team provides the diabetes care which meets the current diabetes guidelines as outlined by the American Diabetes Association.
OVERVIEW

We define five major focus areas:

Focus Area 1: Preventing Progression to and the Complications of Diabetes.

Focus Area 2: Educating Patients and Providers.

Focus Area 3: Ensuring Access to Care and Increasing Public Awareness.

Focus Area 4: Advancing Public Policy and Building the Capacity of the Diabetes Initiative of South Carolina (DSC) and to effect change.

Focus Area 5: Surveillance and Evaluation of the Impact of Diabetes in South Carolina.

For each focus area, we have defined the major issues that are presently recognized, and have indicated major quantifiable objectives (goals). Specific charges and programs are defined, and integration of the programs with other organizations is promoted. Oversight is provided by the Diabetes Initiative of South Carolina Board.
**Diabetes Initiative of South Carolina**

**DIABETES IN SOUTH CAROLINA**

Diabetes mellitus is a major public health issue. Diabetes is the 7th leading cause of mortality in South Carolina. In 2015 the number of diabetes deaths/100,000 population were 25.4% white and 49.5% black.

One in six African-Americans has diabetes, whereas one in nine white adults has diabetes. Approximately 1 in 4 adults over the age of 65 in South Carolina has diabetes. Uncontrolled diabetes is associated with many complications including blindness, renal failures, myocardial infarctions, cerebrovascular accidents and lower extremity amputations. In 2014, the total amount of hospital charges related to a diagnosis of diabetes in South Carolina was more than $404 million. The cost of care for diabetes in South Carolina is projected to exceed four billion dollars by 2020.

In South Carolina one in six adults over the age of 65 years old has prediabetes. Standards of care are changing rapidly as new knowledge about prevention and treatment emerges. There has been an explosion of new agents for the prevention and treatment of diabetes and its complications, and improved medical devices for insulin delivery and self-glucose monitoring are appearing at a rapid rate. A consensus is emerging in the medical scientific community that intensive management of glucose, blood pressure, and blood lipids will forestall or prevent many of the complications of diabetes. Further, careful observation by trained health professionals will detect early, treatable problems related to the eyes and feet, and laboratory testing at intervals will clearly indicate which patients need aggressive therapy for elevated blood glucose, kidney damage, or altered blood lipids.

This Strategic Plan of the Diabetes Initiative of South Carolina is an attempt to deal with these issues. A 10-year plan, comprehensive in nature, is developed to focus on specific issues, define strategies to deal with these issues, and assign responsibilities to achieve our aims by Year 2027. Addressing the barriers to adequate care for people with diabetes, monitoring care implemented in the health care delivery system, and implementing cost-effective measures to reduce the complications of diabetes will aide to lessen the burden of diabetes for South Carolinians.
The overarching theme of caring for people with diabetes is to endorse a good quality of life, promote a reasonable body weight, and outline an overall management plan which is suitable for the patient as integrated into the patient’s health care team. South Carolina ranked 6th in the nation for prevalence of adults with diabetes in 2016. Four out of five adults with diabetes in South Carolina are overweight or obese. Seven of ten people with diabetes have hypertension. Two of three people with diabetes have high cholesterol. Cases of end stage renal disease due to diabetes has increased by 50 percent in the past ten years. Two out of five people with diabetes have not taken a Diabetes Self-Management Education and Support (DSMS) class.

To improve the outcomes of people with diabetes in South Carolina, the Diabetes Initiative of South Carolina annually publishes the evidence-based South Carolina Adult Guidelines for Diabetes Care. These guidelines are based on the Standards of Medical Care for Diabetes from the American Diabetes Association. These guidelines are promoted at the continuing education programs sponsored by the Diabetes Initiative of South Carolina and the DHEC Division of Diabetes, Heart Disease, Obesity and School Health, and are distributed in the community sites by the South Carolina Hospital Association.

The South Carolina Adult Guidelines for Diabetes Care provide evidence based therapy and monitoring to minimize complications from diabetes and promote a higher quality of life for those with diabetes.
### South Carolina Adult Guidelines for Diabetes Care – 2017

#### Key concepts: goals should be individualized; certain populations (children, pregnant women, and elderly) require special considerations; less intensive glycemic goals may be indicated in patients with severe or frequent hypoglycemia; more intensive glycemic goals may further reduce microvascular complications at the cost of increasing hypoglycemia; postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals.

<table>
<thead>
<tr>
<th>Screening for Diagnosis of Diabetes</th>
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<tbody>
<tr>
<td>At age 45, all adults should be screened regardless of weight. To test for diabetes or to assess risk of future diabetes, either A1C, Fasting Plasma Glucose (FPG), or 2 h 75 g Oral Glucose Tolerance Test ( OGTT) are appropriate. An A1C level of 5.7% to 6.4% indicates increased risk for diabetes. The presence of diabetes is indicated by: A1C level of 6.5% or higher; FPG level of ≥126 mg/dL; OGTT level ≥200 mg/dL.</td>
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</table>

#### Prevention/Delay of type 2 diabetes: refer to support program targeting weight loss of 7% of body weight and physical activity to at least 150 min/week (i.e. National Diabetes Prevention Program). In those identified with prediabetes, identify and if appropriate, treat other CVD risk factors. *Reference: International Diabetes Federation (IDF) Consensus Worldwide Definition of the Metabolic Syndrome*

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### A1C
**Goal: A1C < 7.0%**

Quarterly, then 2x/year if meeting goal; more stringent goals (< 6.5%) may reduce complications at the cost of increased risk of hypoglycemia and may be considered in individuals patients. In older adults with hypoglycemia, goal may be 7.5-8% to avoid hypoglycemia episodes, if history of severe hypoglycemia, advanced complications or limited life expectancy.

#### Blood pressure
**Systolic < 140 mmHg, Diastolic < 90 mmHg**

Prescribe medications for BP > 140/90 mmHg along with lifestyle change. Recommended treatment: ACE inhibitors, ARB, thiazide-like diuretic, or dihydropyridine calcium channel blocker. If using combination therapy to achieve goal, then examine risks vs benefits of goal of < 140/90 and monitor for side effects. With increased cardiovascular risk, the BP target should be < 130/80 mmHg.

#### Lipid profile
**Screening at diabetes diagnosis; initial medical evaluation, and/or at age 40.** Thereafter every 5 years if not on a statin or if on a statin or indicated.

**In addition to lifestyle therapy, ASCVD risk factors include LDL > 100 mg/dL, high blood pressure, smoking, overweight, and obesity, and family history of premature ASCVD.**

#### Diagnosis of Diabetes/Screening for A1C

<table>
<thead>
<tr>
<th>Age</th>
<th>Risk Factors</th>
<th>Recommended Statin Intensity**</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>none</td>
<td>Moderate or high</td>
<td>As needed to check adherence</td>
</tr>
<tr>
<td>40-75</td>
<td>ASCVD risk factors</td>
<td>Moderate or high</td>
<td>As needed to check adherence</td>
</tr>
<tr>
<td>&gt;75</td>
<td>ASCVD risk factors</td>
<td>Moderate or high</td>
<td>As needed to check adherence</td>
</tr>
</tbody>
</table>

#### Management of CVD with calculated eGFR

Yearly measurement of UACR, serum Cr, potassium; more frequent monitoring depending on the eGFR at the time.

#### Diabetic Kidney disease

A1C or 2 h IPG recommended for treatment of microalbuminuria when 2 of 3 tests are elevated within a 6-month period. Should begin after 5 years duration then annually. At diagnosis and annually.

#### Aspirin therapy

*75-162 mg/day*

All patients with type 1 or type 2 (unless contraindicated) with increased CV risk for primary prevention, including most men and women ≥ age 50 with at least one additional CV risk factor. As secondary prevention for all with history of CVD. For patients with atherosclerotic cardiovascular disease and documented aspirin allergy, clopidogrel (Plavix) should be used.

### Diabetic retinopathy

By an ophthalmologist or an experienced ophthalmologist in diabetic retinopathy.

In all patients with coronary hypertension: if UACR < 30 mg/dL G to refer to nephrologist. ACE or ARB recommended for treatment of microalbuminuria when 2 of 3 tests are elevated within a 6-month period. Should begin after 5 years duration then annually. At diagnosis and annually.

#### Diabetic foot examination

Visual inspection at each visit. Comprehensive exam annually should include inspection of skin, neurological assessment (10-g monofilament testing with at least one other assessment: proprioception, temperature, vibration, or ankle reflexes); and vascular assessment including pulse in the legs and feet, assessment of foot deformities (focal lesions, interdigital callosities, maceration, nail) musculoskeletal (ROM, foot type, digit, bony prominence). Specialized therapeutic footwear is recommended for high-risk patients with diabetes including those with severe neuropathy, foot deformities, or history of amputation. 5 years after diagnosis and at least annually thereafter. At diagnosis and at least annually thereafter.

#### Self-monitored blood glucose (SMBG)

**Goals:**
Preprandial glucose 80-130 mg/dL
Post-prandial glucose <180 mg/dL
Prior to driving >90 mg/dL

Three or more times daily for patients using multiple insulin injections or insulin pump therapy, including before meals or snacks, and occasionally postprandial, at bedtime, and prior to exercise, if suspicion is low BS and critical tasks such as driving. CGM is more useful for lower A1C in type 1 DM > 25 yrs.

May be helpful to guide treatment/self-management for patients using less frequent insulin injections or non-insulin therapies.

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Continued on next page
**Diabetes Initiative of South Carolina**

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**Reference unless otherwise noted:**

*Physical activity recommendations:*
http://journals.lww.com/acsm-nsmase/Focus%282010%29/200Exercise_and_Type___2_DiabetesAmerica_n_College_st18.aspx

**Dietary approaches to Stop Hypertension Eating Plan (DASH):**

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**Page 2: South Carolina Adult Guidelines for Diabetes Care – 2017**

Key concepts: goals should be individualized; certain populations (children, pregnant women, and elderly) require special considerations; less intensive glycemic goals may be indicated in patients with severe or frequent hypoglycemia; more intensive glycemic goals may further reduce microvascular complications at the cost of increasing hypoglycemia. Postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals.

<table>
<thead>
<tr>
<th>Exam/Test</th>
<th>Care of the Person with Type 1 Diabetes</th>
<th>Care of the Person with Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glycemia</td>
<td>The preferred treatment is glucose (15-20 grams) for a conscious individual; any glucose containing carbohydrate is appropriate. Repeat treatment if SMBG is &lt;180 mg/dL or if contraindications exist. Ensure patient is awake and alert. Continue treatment every 1-2 hours as needed.</td>
<td>The preferred treatment is oral glucose or intravenous dextrose. Repeat treatment if SMBG is &lt;180 mg/dL or if contraindications exist. Continue treatment every 1-2 hours as needed.</td>
</tr>
</tbody>
</table>

**Review self-management goals**

- Each visit emphasizes dietary therapy and physical activity. Metformin may be prescribed to control glucose levels.
- Medication: oral antidiabetic agents (e.g., metformin) and insulin may be prescribed.
- Exercise: at least 150 minutes per week of moderate-intensity aerobic physical activity.
- Nutrition: a diet rich in whole grains and lean protein sources, limiting saturated and trans fats.
- Education: patient education classes offered by diabetes educators.

**Diabetes self-management education and support (DSMES)**

- DSMES focuses on the education and the importance of support which is ongoing for people with diabetes.
- Education should be individualized, based on the National Standards for DSMS and include the AADET™.
- Being Active: regular physical activity is an essential component of diabetes management.
- Nutrition: a diet rich in whole grains and lean protein sources, limiting saturated and trans fats.
- Pharmacologic therapy: use of oral antidiabetic agents (e.g., metformin) and insulin.
- Exercise: at least 150 minutes per week of moderate-intensity aerobic physical activity.
- Education: patient education classes offered by diabetes educators.

**Assessment of patient’s psychological & social situation**

- Initial and ongoing part of medical management of diabetes.
<table>
<thead>
<tr>
<th><strong>Timing</strong></th>
<th><strong>Diabetes Diagnosis</strong></th>
<th><strong>Hemoglobin A1C</strong></th>
<th><strong>Whole Blood Glucose</strong></th>
<th><strong>Dextrose</strong></th>
<th><strong>Insulin Therapy</strong></th>
<th><strong>Hypoglycemia</strong></th>
<th><strong>Treatment of Hyperglycemia (Diabetic Ketoacidosis [DKA] and Hyperosmolar Hyperglycemic Syndrome [HHHS])</strong></th>
<th><strong>Data Collection</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis should be clearly identified on the medical record (MR) by the physician using current classification.</td>
<td>Order AIC on all patients with diabetes or hyperglycemia if not able to document level in MR within 30 days of admission (excluding gestational) and/or prior to elective surgery to assess glycemic control.</td>
<td>Written protocols or orders for WBG POC testing to include frequency and individual plan for subsequent monitoring. WBG POC testing policy should be limited to patients strictly defined by the institution (e.g., post-op, ICU, etc.).</td>
<td>Written policy/protocol for the coordination of WBG POC testing, insulin administration, and meal tray delivery</td>
<td>As ordered.</td>
<td>Insulin therapy should be initiated per written orders sets. Insulin therapy is the preferred method during hospitalization. In critical care units, validated protocols for IV infusion is the preferred route of insulin administration with goals (for blood glucose levels of 140-180mg/dL). More stringent goals such as 130-140mg/dL may be appropriate in select patients.</td>
<td></td>
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</tr>
<tr>
<td>The criteria for the diagnosis of diabetes (indicated by one of the following):</td>
<td>1. A1C level of 6.5% or higher</td>
<td>2. FPG level of 2.126 mg/dL</td>
<td>3. Two-hour OGT level of 200 mg/dL</td>
<td>a. Basal insulin to cover carbohydrate load from meals or enteral nutrition. b. Prandial/nutritional insulin to cover carbohydrate load from meals or enteral nutrition. c. Correction insulin given as rapid acting insulin analog in patients with meals (e.g., lispro, glulisine)</td>
<td>a. Basal insulin.</td>
<td>a. Glucose monitoring b. Correct electrolyte c. Low dose insulin therapy d. Hourly insulin testing when patient is receiving IV insulin infusion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention/delay of type 2 diabetes: refer to support program targeting weight loss of 7% of body weight and physical activity to at least 150 min/week (i.e., Diabetes Prevention Program).</td>
<td>Insulin therapy should be initiated per written orders sets. Insulin therapy is the preferred method during hospitalization. In critical care units, validated protocols for IV infusion is the preferred route of insulin administration with goals (for blood glucose levels of 140-180mg/dL). More stringent goals such as 130-140mg/dL may be appropriate in select patients.</td>
<td>Written policy/protocol for the coordination of WBG POC testing, insulin administration, and meal tray delivery</td>
<td>Written protocols and order sets to include:</td>
<td>a. Treatment for hyperglycemia and a plan for prevention of hypoglycemia for each patient. b. Basal and prandial insulin. c. Insulin therapy. d. Hourly insulin testing when patient is receiving IV insulin infusion. e. IV insulin infusion; transition from IV insulin infusion to subcutaneous insulin regimen (i.e., basal insulin given 2 hours prior to discontinuing IV insulin infusion).</td>
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<tr>
<td>In those identified with prediabetes, identify, and if appropriate, treat other CVD risks.</td>
<td>Written policy/protocol for the coordination of WBG POC testing, insulin administration, and meal tray delivery.</td>
<td>Written protocols and order sets to include:</td>
<td>Written protocols and order sets to include:</td>
<td>a. Basal insulin. b. Correct electrolyte c. Low dose insulin therapy. d. Hourly insulin testing when patient is receiving IV insulin infusion.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Standardized written protocols and order sets:</strong></td>
<td>Staff Education: The following groups have education specific to policies, protocols, order sets and conditions related to diabetes: dietitians and others involved in medical nutrition therapy, staff involved in WBG POC testing, medical staff, nursing staff including advanced practice, pharmacists, physicians assistants and interdisciplinary teams.</td>
<td>Transitioning for Discharge:</td>
<td>Written protocols and order sets are recommended for the following patients with diabetes:</td>
<td>a. Pancreatectomy b. Gestational</td>
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</tbody>
</table>
Focus 1: Preventing Progression to and the Complications of Diabetes

In 2015 more than 330,000 South Carolinians over age 18 had prediabetes, constituting approximately ten percent of the population, ninety percent of whom were unaware. The prevalence of prediabetes among blacks is significantly higher than whites. In people with prediabetes, progression to diabetes can be slowed or prevented. Once a person has diabetes, poor blood sugar and risk factor control can lead to kidney failure, blindness, heart attacks, strokes, amputations, and death. In 2014, 1234 South Carolinians died from diabetes, or three deaths every day. Progression to diabetes may be slowed or prevented and complications may be reduced or avoided with a healthier diet, weight loss, tobacco cessation, exercise, and adequate blood sugar, blood pressure and cholesterol control. By addressing the social and physical environments that contribute to these behaviors and risk factors, ideal conditions for lifestyle and behavioral changes may occur.

GOALS:
3. Increase access to evidence-informed lifestyle interventions to prevent or delay onset of type 2 diabetes.
4. Aid the maintenance and development of safe environments such as parks and walking trails that facilitate physical activity.
5. Assist public health efforts that promote the link between known risk factors and diabetes onset.
6. Raise awareness of the link between obesity and diabetes, and the association between vascular conditions and diabetes.
7. Support and promote the number of diabetes focused health promotion campaigns to raise awareness about prediabetes, including diabetes awareness events across the state.

8. Increase awareness to evidence-based tobacco cessation services for people with diabetes who smoke (i.e. 1-800-QUIT-NOW).

9. Evaluate literature related to efficacy and effectiveness of diabetes screenings and complications.
Focus 2: Educating Patients and Providers

The rapid development of new medications, new technologies, new regimens, and new guidelines for diabetes make creating and following up-to-date, optimal treatment plans difficult for providers and patients. For providers, best practices have often changed since completion of their training, and it can be challenging to stay current. For patients, diabetes requires self-management including weight control, exercise, blood glucose monitoring, and medication administration. If patients do not receive education on self-management or do not internalize this information, care of their diabetes is hindered. The American Diabetes Association (ADA) and the American Association of Diabetes Educators (AADE) formed a task force in 2011 and renamed the National Standards for Diabetes Self-Management Education (DSME) to the National Standards for Diabetes Self-Management Education and Support (DSMES). Diabetes education for practitioners and patients is necessary to optimize diabetes care and management in South Carolina.

Goals:
1. Increase access to evidence-based educational curricula and resources for people living with diabetes.
3. Promote professional educational opportunities for healthcare providers that focus on evidence-based practice and recommendations for managing people living with diabetes.
4. Annually update the SC Guidelines for Diabetes Care and the SC Guidelines for Diabetes Care in the Hospital and disseminate to healthcare providers across the state.
5. Provide professional education opportunities annually on evidence-based programs, resources in the management of diabetes, and current clinical practice guidelines, including the SC Guidelines for Diabetes Care.
6. Advocate for the expansion of diabetes-related content in medical schools and residency program curriculum.
Focus 3:
Ensuring Access to Care and Increasing Public Awareness

In South Carolina one out of every eight adults have diabetes, one in six African-Americans have diabetes, one in four adults above the age of 65 have diabetes, and one in five adults with less than $15,000 in annual income have diabetes. Barriers to care that lead to suboptimal outcomes among different demographic groups include language barriers, unsafe or inadequate areas for exercise, lack of social support, limited access to medical services, and limited budgets to afford healthy foods and medical supplies. Increasing public awareness and ensuring access to care will expand the number of South Carolinians with positive outcomes and help to diminish discrepancies in care.

Goals:
1. Identify the number of diabetes focused health promotion programs and resources in faith-based institutions, cultural organizations and communities.
2. Identify “free or low cost” health care services for people with diabetes.
3. Support and promote the role of allied health professionals (e.g., pharmacists, nurses, community health workers [CHW], social workers [SW], etc.) in providing diabetes care management.
4. Identify barriers, and disparities to accessing health care services for people with diabetes.
5. Identify resources for those with disparities and barriers to healthcare. Encourage provider groups to pursue specialized certifications and accreditations for quality care in the specialties of diabetes and/or hypertension.
6. Foster existing and form new working relationships with community organizations, including cultural and faith-based communities.
7. Promote culturally appropriate models of diabetes education and care.
Focus 4:
Advancing Public Policy and Building the Capacity of the Diabetes Initiative of South Carolina (DSC) and to Affect Change

The cost of care for all South Carolinians with diabetes was estimated to exceed three billion dollars in 2015.\(^7\) In 2020 this cost is expected to top four billion dollars, with less than a quarter covered by private insurance.\(^7\) Given these figures and the overall prevalence of diabetes in the state, diabetes care is an issue of monumental importance to South Carolina. Advocating for health policy and legislative changes as well as influencing government and community leaders on a state and local level are necessary to reduce the burden of diabetes for South Carolina and its people. DSC can strengthen their capacity to affect positive change to diabetes prevention, education and care in South Carolina.

**Goals:**
1. Ensure that DSC members have multiple options for participating in meetings and activities.
2. Conduct a periodic review of the DSC Strategic Plan to evaluate effectiveness and progress of objectives.
3. Recruit a diverse population to include community leaders to serve on the DSC Board & Councils.
4. Promote diabetes awareness and education to stakeholders.
5. Work with the South Carolina Department of Health and Environmental Control to ensure inclusion of the prediabetes and diabetes data in the annual reports as needed.
6. Increase utilization of diabetes data for decision-making, policy development and evaluation at the state and local levels.
7. Track progress on objectives of the DSC strategic plan.
8. Advocate for coverage and reimbursement of Diabetes Self-Management Education and Support (DSMS) services by private health insurers, and disseminate information on the cost benefits associated with good blood glucose management to insurers, payers and recipients.
9. Foster collaborative relationships with the General Assembly Health and Insurance Committee membership, staff and allied commissions (i.e. AACE Carolinas Chapter, Joint
Commission on Health Care, National Association of Chronic Disease Directors and the American Diabetes Association).

10. Create a set of diabetes funding priorities for consideration by the SC General Assembly, supporting existing and new initiatives such as the diabetes prevention and control efforts of the SC Department of Health and Environmental Control, The Diabetes Advisory Council, and the Diabetes Initiative of SC.
As of 2016 South Carolina had the sixth highest prevalence of diabetes in the country.\textsuperscript{1} In 2014, one out of every eight South Carolinians had diabetes and another one in ten had prediabetes.\textsuperscript{7} Approximately 1 in 6 African-Americans in South Carolina has diabetes.\textsuperscript{4} South Carolina had the 17\textsuperscript{th} highest rate of diabetes among African-Americans in the nation.\textsuperscript{4} The diabetes epidemic is a major public health concern that needs a carefully planned strategy for assessment and intervention. In order to plan and implement programs to effectively combat a problem of this magnitude; current, reliable data are needed to clarify the scope of diabetes in this state and to develop methods to conduct surveillance on prediabetes. Accurate surveillance data can be used to assess the needs of different demographic groups and regions, inform decision makers as well as the public, guide the allocation of resources and focus of interventions, and provide information necessary to evaluate the success of prevention and management programs.

**GOALS:**
1. Partner with the DHEC other relevant organizations to develop and maintain systems to obtain and access high quality diabetes data on prevalence, mortality, hospital utilization, and prediabetes incidence and prevalence.
2. Regularly produce and update data products such as fact sheets, journal articles, presentations and website communications.
3. Develop and annually update the DSC website with culturally and linguistically appropriate links to partner websites and a variety of diabetes resources including evidence-based information and programs.
4. Incorporate the use of electronic health records for surveillance and evaluation purposes for prediabetes and diabetes.
5. Provide access to various data trends, risk factors, impact, and cost data, and post to the DSC website.
6. Develop and/or utilize best practices to collect and monitor outcome data related to management of diabetes.

7. Evaluate the literature relating to efficacy/effectiveness of DM screenings in the community and develop policy recommendations relating to screenings for prediabetes, diabetes and its complications.

8. Provide a directory of grant resources, and include currently funded diabetes research in the state of SC.
CONCLUSION

Diabetes is a huge problem in South Carolina. The Diabetes Initiative of South Carolina (DSC) is charged by the SC General Assembly to provide an ongoing strategy to address issues on a statewide basis. DSC works to achieve positive accomplishments such as coordination between statewide public health programs and facilitates, academic institutions, patients, health professionals, and insurance organizations. DSC promotes growth of health professionals dealing with diabetes, conducts major professional education symposia, and proposes long-range plans as guidance for health professionals and organizations. The overarching goal of the DSC is the continuation of current programs and the development of new targeted initiatives, which will lead to continuous improvements in the care of people at risk and with diabetes, along with a decrease in morbidity, mortality, and costs of diabetes and its complications in South Carolina.
References


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