Diabetes Training and Technical Assistance Center

GLOSSARY OF KEY TERMS

A

Accessible — Easy to approach, reach or enter. In health, normally refers to the degree to which a product, health service, or environment is accessible to people.

Action Plan — A step-by-step timeline of action taken to achieve a particular goal, including details on "who, what, where, when, and how much."

Actions — Specific steps to be taken, by whom and by when, to implement a strategy.

Advocacy — To speak or write in favor of a person, issue or cause.

Affordable — Care that does not have economic or financial barriers; including those related to the cost of seeking and obtaining health care, in relation to a patient's or household's income.

Assets — Resources needed for accomplishing coalition objectives and carrying out related strategies. Examples include skills, influence, connections, and funding.

At-Risk Populations — The populations that have a higher than average risk for a disease or condition. For example, population at risk for type 2 diabetes include adults who are overweight or obese (BMI ≥ 25 kg/m^2) and who have one or more additional risk factors for diabetes (e.g., physical inactivity, first-degree relative with diabetes).

B

Best Practice

A technique, method, process, activity, incentive, or reward that is believed to be more effective at delivering a particular outcome than any other technique, method, process etc. when applied to a particular condition or circumstance. Best practices can also be defined as the most efficient and effective way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people. A best practice can evolve to become better as improvements are discovered.

http://ww.businessdictionary.comdefinition/best-practice.html

Benchmark

A measurement that indicates when a goal or objective has been met or a strategy has been successfully implemented.

C

Capacity

The ability of a community to access and implement its resources to affect the lives and health of its constituent population.

Capacity Building

The coalition formation and planning stages of activities that improve a community or organization's ability to achieve its mission more effectively.

Chronic Disease

A disease that is long-lasting or recurrent, including cancer, heart disease, stroke, asthma, and arthritis.

Chronic Disease Burden	A general term used in public health and epidemiology to identify the cumulative effect of a broad range of harmful chronic disease consequences on a community including the health, social and economic costs to the individual and to society.
Coalition	An entity composed of several diverse organizations or constituencies that have agreed to work together to achieve a common goal.
Coalition Coordinator	A staff member (paid or unpaid) who works to ensure that coalition organizational practices are maintained — e.g., that appropriate people are involved and engaged; meetings occur as planned; internal and external communications are effective; and action steps are implemented.
Collaboration	Collaboration results from people working together and sharing resources to achieve a common goal. It is a well-defined relationship entered into by two or more organizations to achieve common goals, and includes a jointly developed structure and shared responsibility, authority, accountability, resources, and rewards.
Communication	Activities designed to keep coalition members and key stakeholders up-to-date, involved, and supportive of Healthy Communities activities. Also includes social marketing tasks for engaging the media in order to reach coalition objectives.
Communication Strategies	A series of steps taken to update and inform coalition members and external leaders about the importance of a specific strategy and a coalition's overall progress.

Community	A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.
Community-Based Interventions	An intervention conducted within and by members of a particular community (e.g., grassroots efforts, efforts by a local civic group). Can be done in conjunction with an outside group (e.g., nonprofit organization, research group).
Community Capacity	The resources or assets available to a coalition or community for accomplishing their goals. Characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems and include citizen participation and leadership, skills, resources, social and organizational networks, sense of community, community power, and understanding of community history.
Community Champions	Members of the community who help promote the importance of policy strategies or the Healthy Communities movement.
Community Coalition	Community coalitions form in response to an opportunity such as new funding, a new threat to the health of community members, or other defined problems/issues. Coalitions also form when local organizations come together to augment limited resources, staff, time, talent, equipment, supplies, influence, etc. to solve a problem. Through this sharing of resources, coalitions provide a multifocal approach to a defined community issue and can benefit from shared resources. (Butterfoss DF, 2007)
Community Competence	The skillful application of community capacity that includes commitment, participation, conflict management, decision-making, and communication.

Community Home	A long-term base of operations in a community that enables stakeholders to maximize resources for identifying and addressing public health challenges.
Community Network	Cross relationships and other connections that help to foster the purpose and goals of a coalition or Healthy Communities movement.
Community Participation	The creation of opportunities to enable all members of a community to actively contribute to and influence the development process and to share equitably in the fruits of development.
Cooperative Agreement	A close collaboration between a funding agent and one or more recipients, in which the recipients agree to accomplish a set of goals and objectives.
Core Group	A dependable sub-group of coalition members who are focused and dedicated to the achievement of the coalition's goals and mission. They accept responsibility for the work of the coalition and accountability to the community the coalition represents.
County Estimates (Diabetes)	Estimates of diagnosed diabetes for all counties in the United States, derived from CDC's Behavioral Risk Factor Surveillance Survey (BRFSS) and census data. The estimates provide a clearer picture of areas within a state that have higher or lower diabetes rates.

Cultural Competency

The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes that are used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications actions, customs beliefs values and institutions of racial, ethnic, religious or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors and needs presented by consumers and their communities (Cross, 1989), also http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=11.

D

Demonstration Project

An organized implementation and evaluation of a novel or small-scale approach aimed at assessing the merits of its widespread use.

Determinants of Health

The range of personal, social, economic and environmental factors that determine the health status of individuals or populations (WHO, Health Promotion Glossary, 1998). The determinants of health can be grouped into seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services.

Diabetes Mellitus	A serious chronic disorder characterized by hyperglycemia (high blood sugar) and abnormalities in the metabolism of carbohydrates, protein, and fats.
Diabetes Prevention and Control Program (DPCP)	DPCPs (Funded by the Division of Diabetes Translation) are a population-based, public health programs that serve as the hub of the overall state diabetes system. This system includes public, private and voluntary organizations that contribute to the health and well-being of communities and the delivery of diabetes-related public health services within a state.
Disadvantaged Populations	Populations that share a characteristic associated with high risk of adverse health outcomes (e.g. Aboriginal peoples, single mothers in poverty, women, homeless people, refugees). An approach to disadvantaged populations is the use of specific strategies targeted at that particular population. This is distinct from and over and above that of strategies aimed at reducing the gradient or range of underlying determinants of health that affect health on a gradient (e.g. income, education).

E

Earned Media	Favorable publicity for no cost through promotional efforts or events other than advertising (i.e., paid media).
Empowerment	The community's capacity to identify problems and solutions or to achieve equity. Or "the process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environments to improve equity and the quality of life (Minkler and Wallerstein, 2005, p.34). Refers to increasing the spiritual, political, social, or economic strength of individuals and communities. For coalitions, it means ensuring that members know their roles and have the skills, resources, confidence, and authority to carry out their responsibilities.

Environmental Change (Environment)	Physical, social, or economic factors designed to influence people's practices and behaviors. Examples of alterations or changes to the environment include: ▪ *Physical*: Structural changes or the presence of programs or services, including the presence of healthy food choices in restaurants or cafeterias, improvements in the built environment to promote walking (e.g., walking paths), the availability of smoking cessation services to patients or workers, and the presence of comprehensive school health education curricula in schools. ▪ *Social*: A positive change in attitudes or behavior about policies that promote health or an increase in supportive attitudes regarding a health practice, including an increase in favorable attitudes of community decision makers about the importance of nonsmoking policies or an increase in nonacceptance of exposure to second-hand smoke from the general public. ▪ *Economic*: The presence of financial disincentives or incentives to encourage a desired behavior, including charging higher prices for tobacco products to decrease their use or the provision of nonsmoker health insurance discounts.
Epidemiology	The study of the factors affecting the distribution of risks or illness in a population.
Executive Committee (Steering Committee)	A group of individuals responsible for general operating policy, procedures, and related matters affecting coalition activity as a whole. In some cases, steering committees work with community decision-makers to set or obtain policy priorities and to identify task groups to achieve specific objectives.

F

Facilitator

A discussion leader who enables a process to happen, or enables and encourages people to find their own solutions to problems or tasks. It also can refer to a discussion leader who is skilled at group problem-solving techniques and in building consensus toward an action or decision.

Four Ps of Marketing

As aspect of social marketing, this refers to Product, Placement, Price, Promotion — a strategy to make the perceived benefits of a behavior more important than its cost.

G

Goals

Broad, long-term aims that define accomplishment of the mission

Guide to Community Preventive Services ("The Community Guide")

Provides systematic review of published studies addressing the effectiveness and cost effectiveness of population-based diabetes interventions in health care systems and community settings.

H

Health Disparities

Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States which rise as a consequence of health inequities which are systemic, avoidable, unfair and unjust.

Health Equity

Achieved when everyone has the opportunity to attain their full health potential, regardless of social position or other socially determined circumstance.

Health Inequality	"…is the generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups…that need not imply moral judgment…[and may result from] a personal choice that would not necessarily evoke moral concern".[3] Some inequalities reflect random variations (i.e. unexplained causes), while others result from individual biological endowment, the consequences of personal choices, social organization, economic opportunity or access to health care. Public policy is concerned with health inequalities attributable to modifiable factors, especially those that are perceived as inequitable.
Health Inequity	Differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – thus inherently unjust and unfair.
Healthy Communities Movement	A community-based participatory process to improve community life, primarily through policies that creates positive, lasting changes to local systems and environments.
Healthy People 2010	A national activity that sets ten-year targets for what individuals, families, health care providers, and communities can do to eliminate health disparities and improve the quality of life by the year 2010. Healthy People 2020 is now in development. See http://www.healthypeople.gov/.

I

Incidence

Describes the rate of new cases of a disease in a group over a period of time.

Infrastructure

In context of Healthy Communities work, infrastructure can refer to four areas: 1) Structuring an organization, coalition, or other community planning group to optimally achieve community health objectives; 2) Creating a network of key stakeholders to accomplish stated goals; 3) Changing the built environment to encourage healthful behaviors; and 4) Changing systems within organizations to improve health.

Institutionalization

The process of establishing a policy as a permanent or ongoing fixture in a community or making it part of a structured and usually well-established system.

J

Jurisdiction

A geographical area over which a court or government body — on the municipal, county, state, or national level — has the power and right to exercise authority.

M

Memorandum of Understanding (MOU)

A document that identifies the mutual roles, responsibilities, and resource commitments between two or more parties involved in a particular effort.

Mentors

Individuals with expertise or experience with a specific strategy to guide the efforts of individuals or, in the case of healthy communities work, the efforts of communities.

Milestones	Short-term accomplishments leading to an eventual longer-term outcome, such as the achievement of a coalition objective.
Mission	A statement of the overall purpose of a coalition or organization.
Multi-Level	Refers to multiple levels of the Socioecological Model (Individual, interpersonal, organizational, community, society).

N

National Diabetes Education Program	Founded in 1979, the US Department of Health and Human Services, NDEP is a federally sponsored joint CDC/NIH Initiative that involves public and private partners in efforts to improve the management of and outcomes for diabetes. Their goal is to promote early diagnosis and prevent or delay the onset of diabetes. http://www.ndep.nih.gov/

O

Objectives	Specific, quantifiable, realistic targets that measure the accomplishment of a goal over a specified period of time.
Outcome Evaluation	A method of evaluation which uses techniques that will provide evidence as to whether or not the program or intervention accomplished the intended efforts.

P

Partnership

A group of entities or individuals with common interests who intentionally come together for a common purpose. Partners are committed to the integrity of the partnership, agree on specific goals, develop a plan of action, and share responsibility to accomplish those goals.

Policies

Laws, regulations, rules, protocols, and procedures, designed to guide or influence behavior. Policies can be either legislative or organizational in nature. Policies often mandate environmental changes and increase the likelihood that they will become institutionalized or sustainable. Examples of legislative policies include taxes on tobacco products, provision of county or city public land for green spaces or farmers' markets, regulations governing the National School Lunch Program, and clean indoor air laws. Examples of organizational policies include schools requiring healthy food options for all students, a district ban on the sale of less than healthy foods throughout the school day, menu labeling in restaurants, required quality assurance protocols or practices (e.g., clinical care processes), or a human resources policy that requires healthy foods to be served at meetings.

Population Health

Both a description and a concept that underlies the discussion of health disparities. "Population health strategy focuses on factors that enhance the health and well-being of the overall population. It is concerned with the living and working environments that affect people's health, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health."[5] It is concerned with aggregate rather than individual health status and risk factors, and policies and strategies that address non-medical determinants affecting health throughout the life course.

PSE

Policy, **S**ystem and **E**nvironmental Changes. In the context of sustainability, this can refer to **P**olicies that help create sustainable changes in **S**ystems and **E**nvironments.

Practice Based Evidence	Interventions that have not been proven to be efficient, but are considered promising practices and are based on local and/or clinical experience.(i.e., non-experimental data, experience of practitioners)
Prediabetes	A condition in which individuals have blood glucose levels higher than normal, but not high enough to be classified as diabetes. People with prediabetes have an increased risk of developing type 2 diabetes, heart disease and stroke.
Prevalence	Describes the number of people in a given group who are reported to have a disease at a certain point in time.
Primary Health Care	The World Health Organization defines primary health care as "the principal vehicle for the delivery of health care at the most local level of a country's health system. It is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Beside an appropriate treatment of common diseases and injuries, provision of essential drugs, material and child provision of essential drugs, maternal and child health, and prevention and control of locally endemic diseases and immunization, it should also include at least education of the community on prevalent health problems and methods of preventing them, promotion of proper nutrition, safe water and sanitation."
Primary Prevention	Strives to reduce risk factors for a particular disease.

Process Evaluation

A method of evaluation often used to assess the manner in which the program was conducted and to identify problems encountered in the planning organization, implementation or monitoring phases of the program, project or services provided.

Public health

"Public health is the combination of science, practical skills, and values directed to the maintenance and improvement of the health of all the people. It is a set of efforts organized by society to protect, promote, and restore the people's health through collective and social action. …Public health activities change with changing technology and values, but the goal remains the same - to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the populations."[6] This broad definition aligns more closely to "population health" and should be distinguished from the definition of the five core "public health" programs and services that are aimed at primary prevention and are provided by health departments, regional health authorities and local units: population health assessment, surveillance, disease prevention, health protection and health promotion.

R

Rate

Measure of the frequency of a phenomenon. In epidemiology, a rate is an expression of the frequency with which an event occurs in a given time frame in a defined population. Rates, rather than numbers, are used to compare populations at different times, at different places, or from different socioeconomic and racial groups.

Resources

Assets such as funding, in-kind contributions, human talents, and connections.

Risk Factor

A factor that, if present, increases the probability of some event seen as harmful. A risk factor may be an aspect of personal behavior or lifestyle, an environmental exposure, or an inborn or inherited characteristic that epidemiologic evidence suggests is associated with health-related conditions. We can use epidemiologic data to identify populations with abnormally high rates of a disease or a health condition. Once these people are identified, epidemiologists can determine what characteristics these people have in common or do not have in common with the entire population. Identifying risk factors is a complex process. For diabetes and its complications, epidemiologists have identified significant risk factors—age, race, obesity, and family history.

S

Secondary Prevention

Programs focus on preventing complications once a person has been diagnosed with a disease. For diabetes, this includes screening for diabetes, the use of preventive care services such as control of A1C, hypertension, and cholesterol and treatment of diabetes related complications. Complications of diabetes include cardiovascular disease, hypoglycemia, hyperglycemia, periodontal disease, psychosocial problems, retinopathy and peripheral neuropathy.

Sector

A segment of the community — e.g., business, schools, community institutions, workplace, health care.

SMART Objectives

Objectives that are Specific, Measurable, Achievable, and Time-bound. For example: “The number of schools that offer nutritious breakfast and lunch food options in cafeterias will increase from 20% (current level) to 40 percent by October of (year).”

Social Capital	Features that enhance coordination and cooperation within and among organizations. *Social capital* involves "the relationships and structures within a community, such as networks, civic participation, reciprocity, and trust, which promote cooperation for mutual benefit" (Putnam, 1995, p. 66); it is a bonding relationship between community members and results from their participation (Putnam, 1995; Minkler & Wallerstein, 2005).
Social Determinants of Health	Social determinants of health can be understood as the social conditions in which people live and work.[1] Dennis Raphael defines, " the social determinants of health are the economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. The resources include but are not limited to conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and income distribution; social exclusion; the social safety net; and unemployment and job security.[2]
Social Justice	Absence of systematic disparities between groups with different levels of underlying social advantage/disadvantage – that is, wealth, power, or prestige.
Social Marketing	The application and adaptation of commercial marketing concepts and techniques to the analysis, planning, implementation, and evaluation of programs designed to bring about behavior change of target audiences to improve the welfare of individuals or their society. Social marketing emphasizes thorough market research to identify and understand the intended audience and what is preventing them from adopting a certain health behavior and to then develop, monitor, and constantly adjust a program to stimulate appropriate behavior change. Social marketing programs can address any or all of the traditional marketing mix variables—product, price, place, or promotion.

Social Media	Primarily Internet- and mobile-based tools for sharing and discussing information online.
Socio-Ecological Model	The Socio-Ecological Model shows how effective strategies for community change occur across individual, interpersonal, organizational, community, and public policy levels. While individual approaches to behavioral change are broadly used and valued in health promotion efforts, these changes are best achieved if reinforced, rewarded, and supported by social norms and networks found within communities and environments that support positive health decisions (Green, Richard, and Potvin, 1996; Stokols, 1996). Policies, laws, regulations, rules, protocols, and procedures established at the municipal level or within organizations can impact the larger population and promote sustainability when threaded through social and environmental infrastructures.
Socioeconomic	Describes the financial and cultural characteristics of a population.
Socio-Economic Status or SES	A term that describes the position of an individual group in a population or society, reflecting the overall hierarchy. The most frequently used indicators of SES are income, education and occupational categories. Its conceptual cousin is class, which originated in social theories that explain rather than simply describe the structure and functioning of society. To be consistent with previous national documents on health status and their determinants, SES is used and is intended to be interpreted in the broader sense of the term.
Stakeholder	A person or organization with direct interest, involvement, or investment in a coalition or its efforts.
Strategies	Broad activities required to achieve an objective. Means by which policy, programs, and practices are put into effect as population-based approaches (e.g., offering healthy food and beverage options in vending machines at schools, implementing activity breaks for meetings longer than one hour) versus individual-based approaches (e.g., organizing health fairs, implementing cooking classes, disseminating brochures).

Strategic Member Recruitment	Process of selecting coalition members and external partners based on how their availability, skills, interests, and resources to support planned objectives.
Surveillance	The ongoing and systematic collection, analysis, and distribution of information. Surveillance methods detect changes in a trend or distribution in order to initiate investigative or control measures.
Sustainable	Public health collaborations, efforts, and activities that have an adequate, consistent financial base along with sufficient staff, resources and commitment to support ongoing operation.
Sustainability	A community's ongoing capacity and resolve to work together to establish, advance, and maintain effective strategies that continuously improve health and quality of life for all.
Sustainability Plan	A written, community-based plan to achieve sustainability. The plan should include goals, objectives, strategies, community-home structures, resources, and roles of community decision-makers. http://www.civicpartnerships.org/docs/tools_resources/sustainability.htm
Sustainability Planning Team	A group of individuals and organizations that takes responsibility for developing sustainability plan.

Sustainable Communities

People and local organizations and agencies should be empowered to create attractive and economically thriving communities and neighborhoods. They need support to overcome challenging economic, social, and cultural barriers, such as community conflict, power inequalities, economic burden, and disparities. Sustainable communities should be:

- *Active, cohesive, and safe* with a strong local culture and shared community activities.
- *Well run* with effective and inclusive participation, representation, and leadership from a variety of community sectors.
- *Environmentally sensitive* in providing places for people to live.
- *Well designed,* featuring environments that provide opportunities for physical activity.
- *Well connected* via transportation and communication resources that link people to jobs, schools, healthcare, and other services. *Thriving* with a flourishing and diverse local economy.
- *Well served* with public, private, community, and voluntary services that are appropriate to people's needs and accessible to all.
- *Fair for everyone,* including those in other communities, now and in the future.

Systems Change

Change that impacts all elements, including social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change. Examples are implementing the National School Lunch Program across the state school system or ensuring a hospital system goes tobacco free.

T

Transformational Leaders

Change agents who are good role models and who can create and articulate a clear vision, empower followers to achieve at higher standards, lead as peer problem-solvers, build broad-based involvement and participation, and act in ways that make others want to trust them.

Type 1 Diabetes

A chronic condition in which the pancreas fails to secrete insulin and the body is unable to use insulin to promote carbohydrate (sugar, starch, and fat) metabolism in cells. Type 1, insulin-dependent diabetes mellitus (IDDM), occurs among children and adults under 30 years old. People with this form of diabetes require frequent injections of insulin to maintain a normal level of glucose in the blood.

Type 2 Diabetes

Type 2, non–insulin-dependent diabetes mellitus (NIDDM), is the most common form of diabetes. People who get type 2 diabetes are usually older than those who get type 1, and obesity is a very common disease factor. In this form of diabetes, the pancreas secretes insufficient amounts of insulin and tissues resist the effect of insulin. Treatment measures include controlling diet, weight reduction, and, if necessary, insulin injections or pills.

V

Vulnerable Populations

Vulnerable populations are groups of people who are commonly exposed to social and economic contexts or environments that may result in high levels of risk factors for adverse health outcomes.

Vision Statement (Inward or Outward)

An inward vision statement is a vivid description of the organization as it effectively carries out its operations. An outward vision statement describes the ideal state of a population that the organization is addressing. In the case of tobacco policies, for example, an outward vision statement could be "a tobacco-free society."

Sources:

- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, Healthy Communities Program (2011). A sustainability planning guide for communities. Available at http://www.cdc.gov/healthycommunitiesprogram/pdf/sustainability_guide.pdf. Accessed on August 22, 2011.

- Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion, Division of Diabetes Translation (2010). Diabetes Today: A course on how to build skills to plan and implement community-based programs for persons with or at risk for diabetes.

- Public Health Agency of Canada (2011). Social Determinants of Health Definitions: Canada's Response to WHO Commission on Social Determinants of Health. Available at http://www.phac-aspc.gc.ca/sdh-dss/glos-eng.php. Accessed on August 22, 2011.