

# MINNESOTA DIABETES PLAN 2010

Year 1 Progress Report  
October 2003-December 2004

Facilitated by the Minnesota Diabetes Steering Committee and  
the Minnesota Diabetes Program at the Minnesota Department of Health

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# **Minnesota Diabetes Plan 2010 Progress Report 2005**

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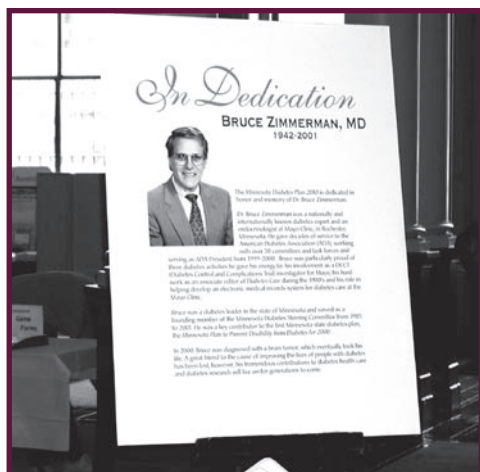
## 1. OVERVIEW OF THE MINNESOTA DIABETES PLAN 2010

### A. Purpose and Vision

The Minnesota Diabetes Plan 2010 (the Plan) is a statewide strategic plan to reduce the burden of diabetes in Minnesota. It consists of a broad set of goals and recommendations for collaborative action. It communicates the vision of “creating a healthier future for all people in Minnesota.” It provides a call to action, urging everyone to play a role.

The Plan goals and recommendations represent areas where action is needed on diabetes in Minnesota, according

to the consensus of a broad range of experts and stakeholders in the state. The Plan is also a tool and a catalyst for motivating coordinated action on diabetes. The Plan is more than a “wish list;” it is a public health initiative with a statewide scope and a broad spectrum of stakeholders.



A poster at the Kickoff Celebration reminds us that the Plan is dedicated to the late Dr. Bruce Zimmerman.

*“Diabetes is a leading cause of death and disability in Minnesota. That’s why the Minnesota Medical Association endorsed the Minnesota Diabetes Plan 2010. It’s a call to action for everyone who has a stake in diabetes care to work together to develop and apply creative solutions, such as finding ways to change policies and behaviors to promote and support healthy living.”*

- Minnesota Medical Association (MMA)

Diabetes is a leading cause of death and disability in Minnesota; the burden in terms of human suffering and cost is very high and growing. There continues to be an epidemic of type 2 diabetes in Minnesota. The number of cases has increased dramatically in the last five years. Major complication, the death rate and costs associated with diabetes are also rising dramatically. There is every indication that these trends will continue throughout the next decade.

Minnesota is the “healthiest state in the nation,” according to a recent United Health Foundation survey (<http://www.unitedhealthfoundation.org/shr.html>). We are a leader in health care and innovative change. This status could be eroded quickly if we don’t take immediate and concerted action to reverse these trends.

It is only through concerted action toward a common vision that we will move ahead in dramatically reducing the impact of diabetes in Minnesota. The Minnesota Diabetes Plan 2010 is a guide for

achieving that vision.

### B. Plan Contents

The Minnesota Diabetes Plan 2010 consists of five broad, overlapping themes. Each theme is defined by a 5-year vision and goals that describe the general course of action for the next 2-3 years. Each goal is supported by specific recommendations for activities. Most recommendations are supplemented with examples. Plan goals are outlined in Table 1. For additional detail on the Plan recommendations and examples, please refer to pages 13-46 in the Minnesota Diabetes Plan 2010 document. Copies of the Plan can be ordered or downloaded from the Diabetes Plan CENTRAL website at: <http://www.health.state.mn.us/diabetesplancentral>

Table 1. Minnesota Diabetes Plan 2010: themes and goals

<b>Theme Area 1: Community Health Promotion</b>
Goal 1: Encourage healthy lifestyle behaviors for youth
Goal 2: Raise public awareness about diabetes
Goal 3: Foster community-based collaboration and communication
Goal 4: Create a healthier environment
<b>Theme Area 2: Health Care Delivery and Professional Issues</b>
Goal 1: Stimulate diabetes awareness and action
Goal 2: Promote professional development and resolve workforce shortages
Goal 3: Make diabetes services fully accessible
Goal 4: Improve diabetes services
<b>Theme Area 3: Diabetes Education and Support Systems</b>
Goal 1: Make diabetes education accessible and culturally appropriate
Goal 2: Inform consumers about financial resources for diabetes health services
Goal 3: Develop support systems for people with diabetes
<b>Theme Area 4: Financial and Resource Issues</b>
Goal 1: Maximize and effectively use diabetes resources
Goal 2: Make the economic case for diabetes prevention and care
Goal 3: Assure health care coverage for all people in Minnesota
Goal 4: Address socioeconomic factors impacting diabetes
Goal 5: Increase legislative support for diabetes
<b>Theme Area 5: Diabetes Data Assessment and Communication</b>
Goal 1: Improve the collection, quality, and scope of Minnesota's population-based diabetes data
Goal 2: Encourage and support routine evaluation of diabetes programs in Minnesota
Goal 3: Generate support and action for collecting diabetes data through advocacy, communication and marketing
Goal 4: Effectively share, communicate, and use diabetes data

Additionally, eight issues were identified as being important to all themes in the Plan. You will find these “crosscutting issues” embedded into goals throughout the Plan. Cross cutting issues are listed below.

- Policy change and advocacy
- Eliminating health disparities
- Prevention
- Access to care
- Coordination and partnership
- Evidence and best practices
- Research and technology

## 2. UPDATE ON THE BURDEN OF DIABETES IN MINNESOTA

Diabetes is not just a common disease; it is an epidemic with devastating human and economic consequences. Diabetes prevalence has increased steadily in Minnesota in recent years. Since 1994, diabetes prevalence has increased 45%, from 3.8% to 5.5% in 2003. In light of increasing trends in diabetes risk factors, it is unlikely that the trend of increasing prevalence of diabetes will be easily reversed.

In 2002, half of all adults in Minnesota had sedentary lifestyles, and 3 out of 5 were overweight or obese. A quarter of a million people in Minnesota (nearly as many as currently have diabetes), are at increased risk of developing diabetes, because they have impaired fasting glucose (IFG). Having IFG, and/or impaired glucose tolerance (IGT), results in the condition, “pre-diabetes.” Pre-diabetes is the state that occurs when a person’s blood glucose levels are higher than normal but not yet high enough for a diagnosis of diabetes. Many Minnesotans diagnosed with pre-diabetes, without proper intervention, will eventually develop diabetes.



The good news is that diabetes can be delayed or even prevented in people with pre-diabetes through lifestyle changes (e.g. changes to diet and increased physical activity) combined with a 5-10% reduction in body weight. Additionally, proper management and care of diabetes can reduce the risk of developing complications including shortened life, heart disease, stroke, blindness, kidney failure, amputations, birth defects, and even infant death.

Pregnancies complicated by diabetes are also a growing problem in Minnesota. Diabetes complicated pregnancies generally fall into two categories. Diabetes that is diagnosed prior to pregnancy, is called “pre-gestational diabetes” (PDM), and can be either type 1 or type 2 diabetes. Gestational diabetes mellitus (GDM) is diabetes that is diagnosed for the first time during pregnancy. Between 1993 and 2002, PDM nearly doubled in Minnesota (from 2.6 to 4.9 per 1,000 live births), and GDM increased 35% (from 25.6 to 34.7). Increases occurred in all demographic groups; additionally, existing racial and ethnic disparities in diabetes complicated pregnancies worsened. The short-term consequences of PDM and GDM are increased risk of complications for both mothers and infants. In the long-term, diabetes during pregnancy increases the risk to the offspring for developing obesity and diabetes later in life. This trend constitutes a vicious cycle, which may contribute to increases in the future burden of diabetes in Minnesota.



Dr. J. Michael Gonzalez-Campoy calling the Minnesota diabetes community to action at the Kickoff Celebration.

Minnesota has made good progress in some diabetes preventive care practices over the last several years (e.g. increases in annual foot check and dilated eye exams). However, almost 80% of Minnesotans with diabetes are overweight or obese, 34% have no leisure time physical activity, over 50% report high blood pressure, 30% have not had an annual cholesterol check, 35% do not self-monitor their blood glucose daily, and 15% are current smokers.

Clearly, there is much work to do to reduce the human and economic burden of current and future diabetes on people in Minnesota.

### 3. PURPOSE OF THIS REPORT

The purpose of this report is to keep Minnesota Diabetes Plan 2010 stakeholders, and other members of the Minnesota diabetes community, up-to-date on the progress being made on the Plan. The Minnesota Diabetes Program (MDP) compiled this report with assistance from the Minnesota Diabetes Steering Committee (MDSC), and with funding from the Centers for Disease Control and Prevention (CDC). As a public health program, one of the roles of the MDP is to monitor and report on progress toward achieving Plan goals. This is the first such progress report, and it documents activities both to promote the Plan and to implement its recommendations.

The MDSC is an advisory group comprised of experts in diabetes, representing professional and voluntary organizations, health care delivery systems, and people with diabetes in Minnesota. Its mandate is to provide expertise to guide the MDP and to diabetes activities at the Minnesota Department of Health

*“CCCH supports the Minnesota Diabetes Plan 2010 because the overall intent of the Plan is to create a healthier future for all people in the state. The Plan also closely aligns with CCCH’s efforts to promote community-wide dialogue and initiatives, reduce health disparities, and improve access to care for all Minnesotans.”*

- The Center for Cross-Cultural Health (CCCH)

(MDH). Additionally, they oversee the implementation and evaluation of the Minnesota Diabetes Plan 2010. The MDSC plays a critical role in the ultimate success of the Plan by providing leadership, facilitating communication, and partnership building among diabetes stakeholders in Minnesota.

This report will be a part of an ongoing series of progress reports intended to inform Minnesota's diabetes community, showcase examples of Plan-related strategies and innovations, and identify gaps where more action is needed. You can help play an important role in monitoring activities and evaluating the impact of the Plan. If you are aware of other key milestones or achievements, please contact us or enter them into the Action Network on Diabetes Plan CENTRAL website (<http://www.health.state.mn.us/diabetesplancentral>). We will highlight these accomplishments on the Plan CENTRAL website and in future publications.

*"Stratis enthusiastically endorses the Minnesota Diabetes Plan 2010 because it is important to the health of seniors in Minnesota. Also, the goals of the Plan are consistent with the goals and mission of Stratis Health. As Minnesota's Medicare Quality Improvement Organization, Stratis Health provides resources at no cost to health care organizations to support care improvement efforts on priority topics, which includes diabetes."*

-Stratis Health

## 4. YEAR 1 HIGHLIGHTS & ACCOMPLISHMENTS

The Minnesota Diabetes Plan 2010 was officially released at the end of October 2003. Since then, much progress has been made in promoting and implementing the Plan. Among the Plan's early accomplishments are:

- Numerous examples of outreach and Plan promotion statewide;
- Development of tools and resources to help facilitate Plan implementation;
- A strong and growing alliance of "Plan Champions";
- Extensive media coverage and recognition throughout Minnesota.

### A. Outreach & Promotion

A key strategy for building awareness of the Plan and motivating individuals and organizations to take action on the Plan is an active campaign of promotion and outreach. Plan partners have promoted the Plan to their colleagues and communities in many different ways, including events and presentations. A few key examples are highlighted here.

#### Events

##### **Kickoff Celebration: Building a Healthier Future**

The Minnesota Diabetes Plan 2010 Kickoff Celebration: Building a Healthier Future was held on Monday, October 27, 2003 at Minnesota's historic Landmark Center in downtown St. Paul. Nearly 200 members of the Minnesota diabetes community attended, despite an early showing of winter weather.

Among those represented were legislators, business people, nonprofit organizations, health care providers, diabetes educators, public health professionals, community-based organizations and people with diabetes. Attendees had the opportunity to network and visit with exhibitors representing over 20 different diabetes-related organizations in Minnesota. In addition, thirteen members of the Minnesota diabetes community stepped forward to endorse the Plan, becoming the first diabetes "Plan Champions."



Storyteller and diabetes advocate, Cathy Feste, sharing a bit of wisdom with diabetes stakeholders at the Kickoff Celebration.

### Join the Journey: Regional Plan Promotion Forums

Several chronic disease programs at the Minnesota Department of Health worked together to create regional forums to share information on important state plans for diabetes, cardiovascular health, cancer, obesity and arthritis. Four daylong forums were hosted around the state in late 2004. The purpose of the forums was to learn about the important work that rural Minnesota organizations are doing in chronic disease. It was also to share information about the various Minnesota chronic disease plans; to share tools and resources for implementing the plans locally; and to continue to strengthen the network of Plan partners.

Two forums were held in mid-October 2004, one in Winona, and one in St. James, Minnesota. Two additional forums were held in Grand Rapids and Fergus Falls, Minnesota in mid-December 2004. Over 110 people attended the forums statewide. Local program examples shared at the forums that addressed Minnesota Diabetes Plan 2010 goals included:

- A faith-based exercise group;
- Worksite health promotion and employee walking programs;
- A county-wide “Kids Walk to School Day”;
- Quality improvement efforts in a rural clinic;
- Community specific diabetes education programs;
- A community gardening and health promotion program;
- A local public health multi-media health promotion program; and
- Vending machine policy changes in elementary schools.



Holly Downing and Laurie Benge describing the “Plant to Plate” program at the Grand Rapids “Join the Journey” forum.

### Presentations

Plan partners, including the MDP, have been invited to give presentations on the Minnesota Diabetes Plan 2010 to a variety of audiences over the past year. Presentations have been given at the national, state, and local levels, each tailored for the specific audience. A downloadable PowerPoint presentation with basic information (described on page 11) has been available on the Plan website, since January 2004. This presentation was downloaded 135 times in 2004. It is likely that this template has been used to develop presentations that are not accounted for in Table 2.

*“Endorsing the Minnesota Diabetes Plan 2010 was important to me because I am a strong proponent of utilizing collaboration of all community members in addressing health care issues and especially diabetes. This Plan helps facilitate ongoing communication and brain storming to address the needs of the people of Minnesota regarding diabetes.”*

- Tara Kaup, RN, MSN, LSN, CDE School Nurse, DiabetesEducator-Saint Paul Public Schools



Table 2. Examples of Plan-related presentations

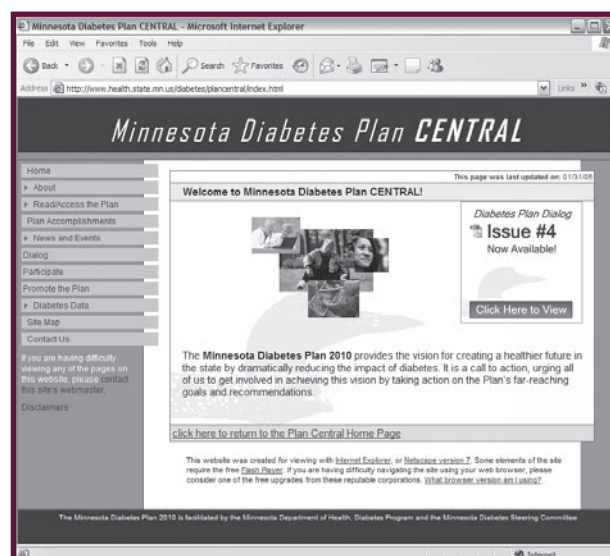
Presentation	Meeting Convener	Date	Audience Reached	Number of Attendees
The State of Diabetes in Minnesota: Successes, Challenges and Opportunities	Novo Nordisk Pharmaceuticals	November 2003	Statewide	30
Diabetes...The Heart of the Matter – MSDE Spring Retreat	Minneapolis-St. Paul Diabetes Educators (MSDE)	May 2004	Statewide	60
“Pediatric Diabetes Education in Schools” (PEDS) Trainings	School Nurse Organization of Minnesota (MSDE)	April, August & October 2004	Statewide	110
Designing the Evaluation of a Statewide Strategic Plan to Address Diabetes	CDC Division of Diabetes Translation	May 2004	National	75
Developing a Database to Evaluate and Coordinate a Statewide Strategic Plan	CDC Division of Diabetes Translation	May 2004	National	75
Changing Face of Diabetes in Minnesota Conference – Culturally Appropriate Change Strategies to Prevent Diabetes	Minnesota Diabetes Program, MDH	September 2004	Statewide	175
Caring For Elders with Diabetes Video Conference	Aging & Adult Services, DHS	September 2004	Statewide	275
“Join the Journey” Regional Plan Forums	Health Promotion and Chronic Disease Division, MDH	October & December 2004	Regional	110

## B. Tools & Resources

Several tools have been developed to help facilitate Plan implementation. Since the Plan is a “road map” or “blue print” for focusing efforts on diabetes statewide, a major focus of the tools has been to promote and coordinate communication.

### Plan CENTRAL

Diabetes Plan CENTRAL (Collaborative Exchange Network To Raise Awareness & Learning) is a web tool designed to serve as an interactive communication hub for the diabetes community to facilitate accomplishing the goals of the Plan. Plan CENTRAL is a regularly updated website and database designed to assist in the sharing of activities, resources, and lessons learned by partners working to implement the Plan. In 2004, the Plan document was downloaded more than 1,200 times. Table 3 describes the various components of the Plan CENTRAL website.



The homepage of the Diabetes Plan CENTRAL website.

Table 3. Plan CENTRAL website components

Web Component	Description of Contents
Home	Stay up-to-date with the “hot topics” box.
About	Learn about the <i>Minnesota Diabetes Plan 2010</i> and Plan CENTRAL.
Read/Access the Plan	Download a PDF of the Plan or order copies using an online form.
Plan Accomplishments	Learn about Plan milestones and Plan evaluation.
News & Events	Access resources for the media and review previous media coverage and events.
Dialog	Read current and back issues of the Diabetes Plan Dialog Newsletter.
Participate	Register to endorse the Plan or view the current list of Plan Champions. Do a free text search of the goals of the Plan, or look for resources to help implement the Plan.
Promote	Download tools and resources to help promote the Plan.
Diabetes Data	Explore the “Diabetes in Minnesota” data report, or find a data fact sheet and links to additional data.
Contact Us	E-mail the webmaster or the Diabetes Plan Coordinator.

## Diabetes Plan Dialog Newsletter



Thumbnail sketch of the Diabetes Plan Dialog newsletter.

The Diabetes Plan Dialog newsletter is a free, online publication developed to facilitate an ongoing conversation about the Minnesota Diabetes Plan 2010. The Dialog newsletter is one component of a set of web-based tools for ongoing exchange about the Minnesota Diabetes Plan 2010, which can be accessed from Diabetes Plan CENTRAL.

The Dialog provides a forum for the Minnesota diabetes community to share stories, celebrate accomplishments and provide ongoing, support, inspiration and motivation for accomplishing the goals of the Plan.

Four issues of the Dialog were published in 2004. The first, titled “Bringing the Plan to Life!” was released in February. The second, released on June, focused on the issues of providing diabetes education and was entitled “Improving Diabetes Education and Support Systems.” The third, released in August was entitled “Keeping Current on Diabetes: The Challenge to Professionals,” and featured innovative examples of professional education being provided to diabetes professionals in Minnesota. The fourth issue, “Health Promotion and Diabetes Education in Diverse Communities,” was released in December.

The first issue of the Dialog was emailed to invitees of the Kickoff Celebration, members of the Minnesota Diabetes Steering Committee, and individuals who had requested copies of the Plan following the Kickoff Celebration. The original subscription list included 200 people. Prior to the release of the second issue a Listserv was established to manage the growing number of subscribers. As of the December 2004 issue, with only word-of-mouth marketing, there were over 300 subscribers to the Diabetes Plan Dialog newsletter. All past issues of the Dialog can be viewed or downloaded from Plan CENTRAL at: <http://www.health.state.mn.us/diabetesplancentral>

## **Plan Resources**

The Plan “Resource List” is one way for the Minnesota diabetes community to share tools, including manuals, journal articles, presentations, maps, reports, survey instruments, software, websites and other resources with the rest of the community. Any individual or organization may add a resource to the listing that they have used, developed or would like to recommend to others working to achieve the goals of the Plan. These resources are listed on Plan CENTRAL under “Participate” and can be browsed or searched by keyword. As of December 2004, over 100 Plan-related resources were listed.

## **Other Promotional Tools & Resources**

In addition to Plan CENTRAL and the Dialog newsletter, a number of other materials have been developed, as needed, to help promote the Minnesota Diabetes Plan 2010. All of these tools are available for download from Plan CENTRAL. These include handouts such as:

- Plan Executive Summary,
- Plan order form,
- Paper endorsement form, and
- A list of the 350 individuals and organizations that helped develop the Plan.

Additionally, three issue briefs have been developed on key aspects of the Plan:

- Why a Diabetes Plan?
- Unified Statewide Action Required to Address Diabetes
- Minnesota Diabetes Program Data Publications

As previously mentioned, a PowerPoint presentation providing a general overview of the Minnesota Diabetes Plan 2010, including speaker’s notes, has been developed. All tools described here are available for download on the Plan CENTRAL website under “Promote the Plan.”

## **C. Partners & Plan Champions**

Endorsing the Plan means indicating public support for the vision and goals of the Minnesota Diabetes Plan 2010. In its first year a total of 58 individuals and organizations registered to endorse the Minnesota Diabetes Plan 2010, thus becoming “Plan Champions.”

Plan Champions are acknowledged on the Diabetes Plan CENTRAL website and in Plan-related promotional materials. Registering as a Plan Champion ensures receiving up-to-date information on Plan-related activities. Plan Champions will also have the opportunity to provide feedback on various aspects of the implementation and evaluation of the Plan. A continuously updated list of registered Plan Champions can be found on Plan CENTRAL under “Participate.”

<http://www.health.state.mn.us/diabetesplancentral>

## **Testimonials from Selected Plan Champions**

Plan Champions represent a cross section of the Minnesota diabetes community. To highlight the diversity of this group of partners, endorsement statements or “testimonials” provided by several Plan Champions can be found in the maroon boxes throughout this document.



Susan Head endorsing the Plan on behalf of the Bemidji Area Indian Health Service.

## D. Media Coverage & Recognition

### Media Coverage

The Minnesota Diabetes Plan 2010 received television, radio and print coverage in its first year. Prior to the Kickoff Celebration in October 2003, a press release describing the Plan was issued to all Minnesota media outlets, resulting in a flurry of Plan coverage in October 2003. The Plan continued to capture the media's attention throughout the first year, due in part to the media's appetite for stories on obesity, diabetes and related health topics. The coverage received by the Plan has been very positive. Table 4 summarizes media coverage of the Plan in the first year.

Table 4. Media coverage of the Plan

Media Venue	Media Type	Date	Approximate Number of People Reached
WCCO News	TV	October 2003	170,000
Minnesota News Network	Radio	October 2003	Taped interview distributed to 75 radio stations statewide. Total reach unknown.
Minnesota Public Radio – Morning Edition Show	Radio	October 2003	44,000
St. Cloud Times	Newspaper	October 2003	28, 210
FOX 9 News	TV	January 2004	146,000
Faribault Daily News	Newspaper	January 2004	6,600
KARE 11 News	TV	March 2004	255,000
Minnesota Public Radio – Mid Morning Show	Radio	June 2004	28,100

Additionally, the Plan has been highlighted in newsletters and professional publications including Minnesota Medicine (8,500 readers), Minnesota Physician (14,000 readers), the Center for Cross Cultural Health's Crosswinds newsletter (500 readers), and the Minneapolis-St. Paul Diabetes Educator's newsletter (200 readers).

### Other Recognition

The Minnesota Diabetes Plan 2010 has received attention, support and recognition from elected officials. Most notably, Governor Tim Pawlenty declared October 27, 2003 "Diabetes Call to Action Day in Minnesota." To read the Governor's Proclamation, please visit <http://www.health.state.mn.us/diabetesplancentral> and click on "Recent Events."

## E. Implementation

There are already numerous examples of partner organizations addressing goals and recommendations of the Plan. The following is not meant to be a comprehensive listing of Plan related activities, but a brief sampling of programs addressing multiple Plan goals. Inclusion in this listing does not imply that these programs were undertaken in direct response to the Plan, but rather that the lead organization acknowledges the fit of their program to the intent of the Plan. For the most up-to-date and comprehensive listing of Plan-related activities and programs please visit the Action Network at Plan CENTRAL under "Participate."

## EXAMPLE 1: Step to it North Side

**Program Purpose:** To create a community walking program in North Minneapolis



Pam Cosby presenting "Step to it North Side" at the Changing Face of Diabetes in Minnesota Conference.

**Lead Organization(s):** NorthPoint Health and Wellness Center and Hennepin County

**Target Audience:** Initially geared toward seniors, but open to all residents of North Minneapolis.

**Activities:** Weekly two-mile group walk on Saturdays at 8:00 am

**Accomplishments To-Date:**

- Group has successfully overcome real and perceived safety concerns. This includes getting the City of Minneapolis to fix sidewalks, and getting local police to accompany the walkers.
- Group has been meeting continuously since 2001.
- Approximately 20 people walk every week.
- Spin-off "Step to it" groups are being planned for other parts of the Twin Cities metro area.

**Plan Goals Addressed:**

- Create a healthier environment
- Foster community-based collaboration & communication

## EXAMPLE 2: International Diabetes Center and Multiple District 5M Lions Diabetes Awareness Committee of Minnesota - On-site Continuing Professional Education

**Program Purpose:** To improve diabetes care and education in all Minnesota communities through education and training initiatives for healthcare professionals.

**Lead Organization(s):** International Diabetes Center (IDC) at Park Nicollet and Multiple District 5M Lions Diabetes Awareness Committee of Minnesota

**Target Audience:** Healthcare systems throughout Minnesota

**Activities:**

- Provide organizational assessment and assistance with infrastructure change to improve diabetes care and education in the community
- Provide on-site training, customization of practice guidelines and follow-up consultation on IDC's Staged Diabetes Management, a systematic approach to prevention, diagnosis, and treatment of diabetes
- Provide training and follow-up consultation on IDC's Type 2 Diabetes BASICS curriculum for patient education
- Offer assistance to organizations as they apply for national recognition from American Diabetes Association Education Program Recognition and National Committee on Quality Assurance/American Diabetes Association Diabetes Physician Recognition
- Conduct blood glucose screenings and community diabetes education programs

**Accomplishments To Date (since 1993):**

- Greater than 50 healthcare organizations statewide have received continuing training and education supported by Lions
- Fourteen community programs were delivered in the past year, potentially affecting over 16,000 people with diabetes
- Enhanced relationships among patients, providers, and educators results in improved patient outcomes (such as reduction in A1c level) and increased staff satisfaction (after implementation of the program, one educator stated that staff are, "all speaking the same language.")



### Plan Goals Addressed:

- Fostering community-based collaboration and communication
- Promoting professional development for the entire clinic staff (nurses, dietitians, front office, medical assistants)
- Improving diabetes services to rural populations
- Improving the collection, quality, and scope of Minnesota's population-based diabetes data (examples: system in place to review data at regular intervals, increased documentation of eye exams and foot exams)

### EXAMPLE 3: Anishinaabe Center – Young Warriors Diabetes Program

**Program Purpose:** To teach American Indian youth to help their people by being a warrior against diabetes.

**Lead Organization(s):** Anishinaabe Center and Office of Minority and Multicultural Health at the Minnesota Department of Health

**Target Audience:** Anishinaabe (Ojibwe) youth aged 8-18 years old, as well as the general community and people with diabetes

### Activities:

- Developed a culturally appropriate animated video for children about diabetes
- Teach the “Young Warriors” how to be presenters and lay health educators
- Young Warriors present the video to other youth and answer questions about diabetes
- Monthly “Defeat Diabetes” community screening and education days

### Accomplishments To-Date:

- Development of an animated video and plans to develop a second video
- 4 Young Warrior presenters trained to-date
- Monthly “Defeat Diabetes Days” ongoing since May 2003
- 375 people screened for diabetes since 2002

### Plan Goals Addressed:

- Encourage healthy lifestyle behaviors for youth.
- Raise public awareness about diabetes
- Foster community-based collaboration and communication
- Stimulate diabetes awareness and action
- Make diabetes education accessible and culturally appropriate



Anishinaabe Center Young Warriors - Mycal Rock, Winnie Lindstrom (front row), and Director Carol Guinn (2nd row)

### EXAMPLE 4: Minnesota Diabetes Collaborative

**Program Purpose:** To reduce duplication, stretch resources, and gain greater impact by providing consistent diabetes messages and promoting best diabetes practices to providers and consumers statewide.

**Lead Organization(s):** American Diabetes Association, Blue Cross and Blue Shield of Minnesota, HealthPartners, Institute for Clinical Systems Improvement, Medica, Metropolitan Health Plan, Minnesota Department of Health, South Country Health Alliance, Stratis Health and UCare Minnesota

**Target Audience:** Adults with diabetes or its risk factors, health professionals, community organizations, public health

**Activities:**

- Sending common messages about diabetes and risk factors to consumers and providers.
- Stimulating and supporting quality improvement and professional development related to diabetes care.
- Networking and sharing diabetes-related resources, data and experiences.

**Accomplishments To-Date:**

This joint effort involving nine of the state's leading health organizations is gaining greater impact by providing consistent diabetes messages and promoting best diabetes practices to providers and consumers statewide.

- Meeting monthly since June 2000.
- Produces key diabetes communications pieces for use by health plans, providers, community organizations, the media and many others (<http://www.mn-dc.org>).
- Created an award winning exam room poster, recently revised in bilingual format (Spanish/English)

**Plan Goals Addressed:**

- Raise public awareness about diabetes
- Foster community-based collaboration
- Stimulate diabetes awareness and action
- Improve diabetes services
- Make diabetes education accessible and culturally appropriate
- Maximize and effectively use diabetes resources



**Minnesota Diabetes Collaborative**

## EXAMPLE 5: Promoting Uniform Indicators for Monitoring the Diabetes Burden and Evaluating Programs

**Program Purpose:** Build capacity to conduct diabetes surveillance and program evaluation and promote consistency in defining and tracking diabetes indicators

**Lead Organization(s):** Centers for Disease Control and Prevention (CDC)'s National Diabetes Prevention and Control Program (NDPCP)

**Target Audience:** Stakeholders interested in monitoring the diabetes burden or evaluating diabetes programs

**Activities:**

- Article published reviewing the status of diabetes surveillance: Desai J, Geiss L, Mukhtar Q, Harwell T, Benjamin S, Bell R, Tierney E. Public health surveillance of diabetes in the United States. *Journal of Public Health Management and Practice*, November 2003; S36-S43
- Interactive web-based tool developed, which provides comprehensive information on commonly used diabetes indicators and their associated data sources

**Accomplishments To-Date:**

- The NDPCP and five state Diabetes Prevention and Control Programs (DPCPs) formed a work group to develop the Diabetes Indicators and Data Sources Internet Tool (DIDIT)
- DIDIT was completed and launched for use by DPCPs; other diabetes stakeholders may access the tool by visiting the following website and completing a short request form: (<http://www.cdc.gov/diabetes/statistics/index.htm>)
- Training on DIDIT was conducted among DPCPs.
- Article on DIDIT submitted to *Preventing Chronic Disease* (<http://www.cdc.gov/pcd/index.htm>).

**Plan Goals Addressed:**

- Improve the collection, quality and scope of Minnesota's population-based diabetes data

### F. Evaluation

From the evidence presented throughout this progress report, it is clear that the Plan requires significant investments of time and resources from the Minnesota diabetes community. The following is a brief overview of the draft Plan Evaluation Design. A final, more detailed, Plan Evaluation Design will be released separately.

#### Purpose

The primary purpose of the Plan's evaluation is to assess the effects of a statewide strategic plan for diabetes. A secondary purpose is to improve the practice of statewide strategic planning for diabetes, including plan implementation and plan evaluation.

#### Stakeholders and Users

An evaluation stakeholder is any individual or organization that has invested resources (including time) in the Plan's development, implementation or evaluation. The primary users of the evaluation are the MDP and MDSC. Other stakeholders include Plan Champions, Action Network members, Dialog newsletter subscribers, the CDC, and other State Diabetes Prevention and Control Programs (DPCPs).

#### How Results Will Be Used

Evaluation of the Plan will yield results related to Plan processes and progress, and also contribute to a small but growing body of knowledge about designing, implementing and evaluating statewide strategic plans.

Evaluation results will be used to:

- Improve Plan marketing and implementation strategies
- Guide the mid-point review of the Plan and make needed additions or improvements
- Guide future strategic planning around diabetes in Minnesota
- Contribute lessons learned to fellow state DPCPs and other chronic disease programs
- Begin developing best practices based on accumulated experiences of state DPCPs and other chronic disease programs
- Document progress on Plan recommendations.
- Demonstrate the value of the Plan to stakeholders

#### Evaluation Questions

The evaluation questions are summarized below. The use of the word "how" is intended to move this evaluation beyond simply counting activities, to achieving an understanding of the types of activities being undertaken, their effectiveness, sustainability, and scope. Evaluation of the Plan will take place at three levels, as summarized in Table 5.

*"CentraCare supports the Minnesota Diabetes Plan 2010 because there is a critical need for the public to be aware of the long-term effects and costs that the diabetes epidemic will present. With decreasing reimbursement and the increasing numbers of people with diabetes it is crucial for health care and government leaders to be made aware of this crisis."*

- CentraCare Diabetes Center



Colleagues networking at the Kickoff Celebration (left: Joe Nelson, right: Dr. Richard Berganstal).

Table 5: Levels of Plan evaluation, and relevant questions at each level.

<b>Level 1: Evaluation questions related to <u>marketing &amp; promotion</u> of the Plan</b>	
1.	What is being done to market and disseminate the Plan?
2.	Are stakeholders aware of the Plan?
3.	How do stakeholders understand their role in the Plan?
4.	Are stakeholders taking action on the Plan? If not, why not?
<b>Level 2: Evaluation questions related to <u>use &amp; action</u> on Plan recommendations</b>	
5.	How is the Plan being used and implemented?
6.	How is the Plan helping to coordinate action on diabetes?
7.	How does the Plan promote partnership among diabetes stakeholders?
8.	Do stakeholders feel the Plan promoted communication, action, coordination and partnership?
<b>Level 3: Evaluation questions related to <u>statewide progress</u> on Plan recommendations &amp; Public Health goals</b>	
9.	How has progress been made on the Minnesota Diabetes Plan for 2010? <ul style="list-style-type: none"> <li>• How has progress been made in each of the five 'Theme' areas?</li> <li>• How has progress been made in each of the 'Goals' within each 'Theme' area?</li> <li>• How has progress been made for each 'Recommendation' in the Plan?</li> </ul>
10.	How has progress been made in areas not directly covered within the Plan ?
11.	What progress is directly attributable to Plan activities?
12.	What progress is indirectly attributable to Plan activities?
13.	How has progress in Plan areas impacted diabetes public health objectives?
14.	How has progress in non-Plan areas impacted diabetes public health objectives?

## **Methods**

Evaluation methods will be observational, and measurement will occur at multiple levels. The MDP will lead the effort of collecting data to track indicators and will answer these evaluation questions through a variety of methods.

## **Evaluation Roles and Responsibilities**

Organizations undertaking activities to address the Plan will be responsible to evaluate those activities. The MDP will invite these organizations to share success stories and evaluation results via Plan CENTRAL. The MDP is responsible for accomplishing the work of coordinating Plan's overall evaluation, including planning, implementation and analysis, but they will rely on two other groups for feedback: the Evaluation Advisory Group (EAG) and the Minnesota Diabetes Steering Committee (MDSC).

The role of the EAG is to provide expert advice and feedback on evaluation planning, implementation, evaluation, interpretation and reporting. The role of the MDSC is to make judgments and recommendations based on the results. Members of MDSC will be integral in promoting and sharing the results with the Minnesota diabetes community at large.

## **Progress on Plan Evaluation**

In the first year of Plan implementation, significant progress was made in developing a comprehensive, statewide Plan evaluation. Accomplishments include:

- Convening the Evaluation Advisory Group (EAG) to review and improve the Plan Evaluation Design, and assist with the resulting evaluation.
- Presenting to a national audience on Minnesota's groundbreaking efforts to evaluate a statewide strategic plan at the 2004 CDC Diabetes Translation Conference.
- Developing a draft Plan Evaluation Design (to be released).
- Developing and testing the Action Network, an online database to collect and share Plan-related activities (to be released).

The Plan Evaluation Design will be posted on Plan CENTRAL for review and comment beginning in 2005. All Plan partners will be asked to consider their role and what unique perspectives and contributions they can bring to the evaluation process.

## **5. PRIORITIES FOR THE FUTURE**

Implementation of the Minnesota Diabetes Plan 2010 is guided by the philosophy that it is the responsibility of each individual or organization within the Minnesota diabetes community to determine how they can best contribute to the success of the Plan. It is up to each of us to select the goals, recommendations, and activities we have the capacity to address. It is through this voluntary, but coordinated and collaborative effort we will, "dramatically reduce the impact of diabetes in Minnesota."

The first year has been very successful, but there is still much that can be done to raise awareness of the Plan and bring new and diverse partners to the table. A thoughtful, coordinated and statewide approach to evaluation will be needed to demonstrate the Plan's impact. Therefore, through the guidance of the Minnesota Diabetes Steering Committee, continued Plan promotion and initiation of evaluation have been selected as key priorities for Year 2.

A few specific, measurable objectives for making progress on these priorities are listed below.

1. A minimum of 15 presentations given on the Plan, at events, trainings, and meetings, by December 2005.
2. A minimum of 800 potential stakeholders, or Plan partners, reached through presentations by December 2005.
3. Increase the number of registered Plan Champions by 50%, or to a total of 75 by December 2005.
4. Increase the number of Dialog Newsletter subscribers by 50%, to a total of at least 420, by December 2005.
5. Collect data on Plan-related initiatives through the Action Network. Increase the number of Action Network program examples from 0 to 100 by December 2005.

### **A. What You Can Do**

To help accomplish these objectives, there are simple and important things we can each do to help make progress on this important initiative (See Table 6).





Table 6. Suggestions and tips for accomplishing Year 2 objectives

Outreach & Promotion	
<ul style="list-style-type: none"><li>Give a brief presentation on the Plan to your organization or partners at your next steering committee meeting, annual conference, staff retreat or other event. Describe how the Plan relates to the mission, vision or expertise of your organization.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Download and customize the “Introduction to the Plan” PowerPoint presentation. It can be found on Plan CENTRAL under “Promote.”</li></ul>
<ul style="list-style-type: none"><li>Share at least one of your organization’s programs or activities that address one or more Plan goal using the online Action Network.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Enter your Minnesota specific program information on Plan CENTRAL, under “Participate” or contact the MDP for assistance.</li></ul>
Tools & Resources	
<ul style="list-style-type: none"><li>Develop a fact sheet or issue brief that highlights important programs and activities occurring in your organization and describe which goals or recommendations of the Plan your activities are helping to address.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Download the Fact Sheet Template, or use the Issue Briefs as models. Both can be found on Plan CENTRAL under “Promote.”</li></ul>
<ul style="list-style-type: none"><li>Create a link to Diabetes Plan CENTRAL on your organization’s website.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> If you need help making the link, contact the MDP for assistance.</li></ul>
<ul style="list-style-type: none"><li>Share your useful diabetes tools or resources through Diabetes Plan CENTRAL, or browse the existing resources</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Submit your tools and resources using the entry form, or search the current “Resource List” found in Plan CENTRAL under “Participate.”</li></ul>
Partners & Plan Champions	
<ul style="list-style-type: none"><li>Endorse the Plan become a registered Plan Champion!</li><li>Encourage your partner organizations to become a registered Plan Champions.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Endorse the Plan confidentially and electronically on Plan CENTRAL under “Participate.”</li></ul>
Media Coverage & Recognition	
<ul style="list-style-type: none"><li>Include a story on the Plan in your organization’s newsletter. Describe your efforts in addressing a particular goal or recommendation or share why you’ve decided to endorse the Plan.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Download the “Media Talking Points.” It can be found on Plan CENTRAL under “Promote.”</li></ul>
<ul style="list-style-type: none"><li>Subscribe to the <i>Diabetes Plan Dialog Newsletter!</i></li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Subscribe electronically on Plan CENTRAL; go to “Dialog.”</li></ul>
<ul style="list-style-type: none"><li>Submit a story idea or upcoming Plan-related event to Plan CENTRAL.</li></ul>	<ul style="list-style-type: none"><li><i>Tip:</i> Enter your ideas electronically through Plan CENTRAL, go to “Events” or email the MDP.</li></ul>

Visit Plan CENTRAL at: <http://www.health.state.mn.us/diabetesplancentral> to share information about your tools, resources, products, activities, and success stories. If you don’t find a way to share on Plan CENTRAL that works for you, please contact the MDP directly at [diabetesplan@health.state.mn.us](mailto:diabetesplan@health.state.mn.us) or (651) 281-9849.

## B. Give Us Feedback on this Report

The MDP will strive to keep the Minnesota diabetes community informed of the Plan’s progress through regular reports. Please let us know how this report can be improved to better meet your needs. In addition, we seek your assistance in monitoring activities and evaluating the impact of the Plan. Whenever you become aware of key diabetes-related milestones or achievements, please enter them into the Diabetes Plan CENTRAL Action Network or contact us, so we can include them in future reports.



Minnesota Diabetes Plan 2010 Kickoff Celebration set-up at the Landmark Center in St. Paul, Minnesota.

