

The

Michigan Action Plan
for
Diabetes Primary Prevention



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Introduction

In 2002, the Diabetes Prevention Program Research Group * completed a large-scale study to determine if lifestyle interventions or pharmacological therapies prevent or delay the onset of diabetes in individuals with impaired glucose tolerance. A six-year randomized clinical trial was conducted at 27 different sites throughout the United States.¹ Study results indicated that *either* lifestyle changes or pharmacological therapy could prevent or delay type 2 diabetes among individuals with prediabetes, but that of the two, *lifestyle changes were significantly more effective*. Specifically, the study found that changes in eating and exercise habits prevented or delayed the onset of type 2 diabetes among high-risk adults by 58%; these benefits applied to individuals regardless of race, ethnicity, gender, or age.¹

Helpful definitions:

Prediabetes: a condition that distinguishes people at risk for diabetes, indicated by either a higher than normal level of fasting blood glucose (100 mg/dl to 125 mg/dl), or a higher than normal 2-hour glucose tolerance (140-199 mg/dl), but with neither test result high enough to be considered diabetes.²

Diabetes: a chronic condition characterized by high levels of blood glucose (fasting blood glucose \geq 126mg/dl or a 2-hour glucose tolerance of \geq 200mg/dl), resulting from deficiency in insulin production, insulin action, or both.²

With evidence showing that lifestyle changes can be beneficial to people of all ages, genders, and racial/ethnic groups, the task became identifying effective strategies for implementing prevention programs. In 2004, the Chronic Disease Directors (CDD), as part of a nationwide effort to establish effective diabetes prevention programming, funded the Diabetes Primary Prevention Project (DPPP). The Michigan Department of Community Health (MDCH) Diabetes Prevention and Control Program's proposed project (*Preventing Diabetes in Michigan*) outlined steps to identify resources and programmatic prerequisites to implement a diabetes primary prevention program; it was one of six projects nationwide awarded planning grant funding from the CDD.

The Michigan Diabetes Prevention and Control Program (MDPCP/MDCH) in conjunction with the Michigan Public Health Institute (MPHI) convened two workgroups to discuss diabetes prevention and to identify resources essential for a primary prevention program. The internal workgroup, comprised of MDCH staff, and the external workgroup, comprised of stakeholders from throughout the state, drew on their personal expertise, information from the Diabetes Partners in Action Coalition (DPAC), and information from focus groups to develop

recommendations to address diabetes primary prevention. The result is the Michigan Action Plan (MAP) for Diabetes Primary Prevention. (For more information on the planning process, please see Appendix.)

The MAP recommendations are clustered into six categories: resources, policy, community intervention, health systems, health communication, and evaluation. Included in the MAP are public health outcomes and statewide objectives identified through the DPPP process. Continuation of partnerships and collaboration generated by the DPPP will be critical to the successful implementation of the MAP recommendations and progress toward meeting the statewide objectives and public health outcomes.

*The Diabetes Prevention Program Research Group was supported by the National Institutes of Health through the National Institute of Diabetes and Digestive and Kidney Diseases, the Office of Research on Minority Health, the National Institute of Child Health and Human Development, and the National Institute on Aging; the Indian Health Service; the Centers for Disease Control and Prevention; the General Research Center Program, National Center for Research Resources; the American Diabetes Association; Bristol-Myers Squibb; Parke-Davis.

The Michigan Action Plan (MAP) for Diabetes Primary Prevention

Recommendations

The MAP recommendations prescribe specific actions for state and community partners to achieve diabetes primary prevention goals and objectives and to realize the outcomes envisioned by workgroup participants.

Policy

Collaboration. Collaboration within MDCH is essential to the success of the MAP and can only be achieved with a commitment from both administration and staff. Within the Division of Chronic Disease and Injury Control, there is great potential for programs to work together not only to address conditions with similar risk factors and target populations, but also to develop common intervention strategies and messages. Similarly, department-wide, opportunities should be explored to create new partnerships with Epidemiology, Medicaid, Minority Health, Office of the Surgeon General, and Office of Services to the Aging. Opportunities for MDCH programs to communicate, share information, coordinate, plan, and evaluate primary prevention efforts are critical components for successful collaborative programs.

Developing a framework for cross-program collaboration will require additional support from department leadership and executive management.

Such a framework should include:

- visible leadership support and participation at collaborative meetings
- staff who work across disease areas
- incentives for state programs to work together
- model program development
- personnel to enable cross-collaboration
- opportunities for cross-program communication and information sharing, e.g., joint strategic planning sessions
- requirements for funds to be used for collaborative, rather than categorical programs.

Funding. Prevention needs to be a funding priority. DPPP participants overwhelmingly agreed that at both national and state levels, funds allocated for prevention need to equal funds allocated for health care. Furthermore, redirecting federal and state funds from categorical funding (funding by disease domain) to non-categorical primary prevention programs (funding across diseases to develop programs that have common prevention goals) would greatly enhance a collaborative diabetes primary prevention effort. As noted earlier, federal and state governments should also foster collaboration by giving funding priority to programs

Policy Recommendations:

- ▶ Foster collaboration through changes in the administrative framework
- ▶ Change funding priorities
- ▶ Implement policy and environmental changes to foster healthy lifestyles
- ▶ Facilitate reimbursement and insurance coverage

that engage in collaborative activities. Finally, funding needs to be dedicated for the comprehensive evaluation of prevention programs. All funding agencies would like strong outcome data to justify their continued commitment to projects. Without adequate dollars, however, program evaluation is often limited to assessing process objectives rather than outcome objectives. Funding needs to cover costs of health surveillance, assessments of environmental changes, economic analyses of prevention programs, and the development of epidemiologic capacity within programs (see Documenting Progress).

Policy and environmental changes to foster healthy lifestyles. Diabetes primary prevention programs need to operate in a supportive environment. A number of policy changes are necessary to create an environment that encourages the adoption of healthy behaviors.

- Create tax incentives for communities, businesses, and consumers that promote or adopt healthy behaviors; e.g., communities building walking trails or restaurants offering healthy food choices.
- Increase access and the affordability of healthy foods by providing farmers with subsidies to grow fruits and vegetables and expanding Project Fresh, the National Farmer’s Market Nutrition Program in Michigan.
- Promote healthy lifestyles and food choices at schools and organization meetings and events.
- Create areas in every community for increased physical activity by supporting the design and construction of “walkable” communities.

Reimbursement and insurance coverage. For many people, the costs related to diagnosing, managing, and treating a chronic disease are overwhelming. In Michigan, insurers cover costs associated with diabetes treatment and management. There is nothing, however, currently in place to cover costs for the treatment and management of prediabetes, as implemented in the diabetes primary prevention clinical trial. The Michigan’s Diabetes Cost Reduction Act should be modified to cover self-management training, equipment, and pharmaceuticals for prediabetes, as prescribed by patients’ physicians. It is also important for the state to work with insurance companies to allow for the reimbursement of costs for educational classes related to diabetes primary prevention.

In addition, insurance companies could offer discounts on premiums for those who participate in diabetes primary prevention programs, and the state could consider Medicaid reimbursement for diabetes primary prevention activities.

Diabetes facts for Michigan³

- The State of Michigan has the 7th highest diabetes prevalence in the United States.
- Over 590,000 Michigan adults have been diagnosed with diabetes.
- An additional 227,900 Michigan adults have diabetes, but are not aware of it.
- An estimated 1.5 million Michigan adults have prediabetes and are at high risk for developing type 2 diabetes.
- In 2002, the economic cost of diabetes-related care in Michigan was estimated at over 4.7 billion dollars.

Community Intervention

Expand existing infrastructure. The Diabetes Primary Prevention Program must maximize current resources by using the existing infrastructure as the foundation for expansion of all diabetes prevention activities.

Enlist individuals. Resources include not only agencies and organizations engaged in diabetes prevention services and surveillance in Michigan, but also Michigan residents who are diagnosed with diabetes or prediabetes. These individuals are a valuable resource and should be recruited for prevention efforts to serve as advocates within their communities and to share information about diabetes and prediabetes.

Collaboration. The models of collaboration at the state level can be used as an example to develop local collaborations and to provide partners with a structure that is familiar and comfortable. Organizations can partner together by:

- assisting with operations
- serving on boards of directors
- assisting with grant proposals
- participating in strategic planning
- sharing staff and financial resources.

Address racial and ethnic health disparities. Effective programs must be created to address the needs and cultures of racial and ethnic minority populations in Michigan. State and community organizations that serve these populations can partner with local diabetes prevention agencies to develop effective materials and programs. Resource and educational materials should be translated into languages used by the populations served.

Support faith-based initiatives. It is crucial that faith-based organizations be involved in state and local collaborations focused on diabetes primary prevention. Faith-based organizations provide an opportunity to reach target populations that may otherwise be missed by diabetes primary prevention programs. Resources, such as technical assistance, educational materials, seminars, and tool kits, should be developed and made available to faith-based initiatives. Further support could be provided through mini-grants to promote diabetes prevention activities.

Formalize the lay health worker program. Lay health workers provide an excellent opportunity to expand primary prevention education and services in communities. The reach and effectiveness of this program can be enhanced by:

- developing a statewide training and certification program for lay health workers
- creating a statewide association for lay health workers to provide services for members
- providing training for community programs on the best ways to utilize lay health workers for diabetes primary prevention.

Community Intervention Recommendations:

- ▶ Expand existing infrastructure
- ▶ Develop programs serving racial and ethnic minority populations
- ▶ Support faith-based initiatives
- ▶ Formalize lay health worker program
- ▶ Expand venues

Expand venues. Leaders in diabetes primary prevention programs need to implement programs in locations that are accessible and acceptable to the populations (communities) they serve. The table that follows presents a sample of potential venues identified to better penetrate communities.

Possible outreach venues

Community:

Beauty Salons and Barber Shops
College Campuses
Health Clubs/Recreation Centers
Grocery Stores
Restaurants

Health Care:

Nurse Managed Clinics
Community Health Centers

Workplace:

Chambers of Commerce
Workplace Health Fairs
Healthy Options in Cafeterias

Government:

Secretary of State
Park Commissioners
Family Independence Agency
Public Transportation

Health Systems

Provide consumer materials. Health care providers have a clear opportunity to reach and educate people at-risk for or with prediabetes. Materials designed for consumers should be made available to health care providers for distribution to their patients. These materials should include curricula and tools focusing on nutrition, physical activity, and behavior change.

Educate primary care providers. To detect prediabetes, primary care providers must know its risk factors and how to detect and treat it. Guidelines for the diagnosis and treatment of prediabetes must be created and disseminated to health professionals, especially primary care providers. These materials should include information on diagnostic testing, lifestyle counseling, and appropriate referrals. Examples of materials and training include: pharmacological treatments, diagnostic tests, and healthy lifestyle interventions. Training will need to be provided at all levels of the primary health care system.

Disseminate research and best practices. Dissemination of information about effective approaches to the prevention, diagnosis, and treatment of prediabetes is critical for a number of audiences. Research findings related to prediabetes, diagnosis, and treatment should be identified and disseminated

through publications accessible to health care providers and other professionals involved in diabetes prevention efforts. Relevant information must be made available regarding best practices in social marketing, behavior change, communication, epidemiology, evaluation, nutrition, and physical activity since these have a direct relationship with diabetes primary prevention efforts. Experts that can assist programs in their efforts need to be linked to local organizations.

Address psychosocial issues. A successful prevention program must address consumers' psychosocial issues. Denial, lack of motivation, and depression are potential barriers to diabetes prevention. Health systems and diabetes primary prevention programs must work to acknowledge these factors and develop strategies to address them in a manner that will help participants to make and sustain healthy changes in their lifestyles.

Health Systems

Recommendations:

- ▶ Provide consumer materials for health care providers
- ▶ Educate primary care providers
- ▶ Disseminate research and best practices
- ▶ Address psychosocial issues

Health Communication

A cornerstone of any effective prevention effort is the effective use of health communication. Without a clear message that is understood by the target population, a campaign is likely to fail.

Use consistent, unified messages. All partners involved in diabetes primary prevention activities must work together to shape and adopt consistent, clear, and unified messages. These messages should be used in all materials and programs, be framed positively, and offer options for behavior change. Effective messages communicate that healthy lifestyles improve the overall quality of life, and that lifestyle changes can prevent or delay the onset of diabetes.

Develop culturally appropriate messages and materials. In addition to being clear and consistent, prevention messages also need to be culturally and linguistically appropriate for all people. Michigan has a diverse set of sub-populations and a number of organizations that serve these groups. These organizations should be involved in all aspects of message, program, and material development to ensure that the messages and approaches used are appropriate and understandable. Partners should work together to identify the best venues for distribution of these materials.

Examples: message dissemination

Sources:

- ▶ Community leaders, including clergy and politicians
- ▶ Health providers/health care staff
- ▶ Lay health educators
- ▶ Local newscasters/media personalities
- ▶ Fictional characters in the media

Vehicles:

- ▶ Physical activity resource lists
- ▶ Health websites
- ▶ Messages on prescription bags
- ▶ Home host parties
- ▶ Messages on pay stubs

Resources

Successful diabetes prevention requires that state and community partners have access to resources that will support their efforts. Organizations that deliver diabetes prevention programming will need financial and material assistance. These organizations include state agencies, faith- and community-based organizations, professional associations, insurers, health care providers, statewide health promotion organizations, and consumer advocacy groups.

Develop infrastructure. It is essential that the Michigan Department of Community Health build a foundation of resources to promote the development of a comprehensive diabetes primary prevention program across the state:

Health Communications Recommendations:

- ▶ Use consistent, unified messages
- ▶ Develop culturally appropriate messages and materials

Resources Recommendations:

- ▶ Develop infrastructure
- ▶ Develop a centralized network
- ▶ Invest in communities
- ▶ Maximize impact

Funding is needed for diabetes prevention program planning, implementation, and evaluation. This includes support for project staff, meetings, training and education, materials, and incentives for consumer participation.

Program tools and materials must be developed to guide efforts and approach diabetes primary prevention with a unified message:

- guidelines for health professionals for diagnosing, managing/counseling, and referring patients with prediabetes
- primary care protocol for risk assessment, evidence-based diagnostic tests, and healthy lifestyle interventions
- curricula/tools for staff in social marketing/behavior change, nutrition, and physical activity
- curricula/tools for consumers in nutrition, physical activity, and behavior change.

Experts in behavior change strategies, communication, epidemiology, evaluation, and diabetes risk factors must be identified and integrated into program development.

Skills for staff in group facilitation, outreach, program administration, evaluation, and data analysis are essential.

Partnerships will need to be nurtured and sustained, and more partnerships created both with consumers and advocates.

Develop a centralized network. Creating and making accessible a centralized resource network is essential to support efficient statewide diabetes primary prevention activities. The resource network will facilitate collaboration, information exchange among MAP partners, and provide assistance for developing and maintaining collaborative relationships. This network could include:

- websites
- directory of diabetes resources
- clearinghouse of diabetes materials
- toll-free information line
- listserv
- data resources.

Invest in communities. The state will need to provide financial and technical assistance to community programs in a variety of forms. Although funding is needed at all levels, it is critical at the local level where the programs are implemented.

Financial assistance could be provided through:

- mini-grants to support diabetes primary prevention programs through community-based organizations or local health departments
- mileage reimbursement for local partners to attend statewide meetings
- in-kind contributions such as hosting conference calls, meetings, and websites
- funds for joint projects with other partners.

Technical assistance should be provided for:

- grant writing
- program evaluation
- forming and maintaining community partnerships
- accessing training, tools, software.

Maximize impact. Integrate DPP activities into the existing Division of Chronic Disease and Injury Control. For maximum impact, and the most efficient use of resources, diabetes primary prevention activities should be integrated into the Division of Chronic Disease and Injury Control within MDCH. Integration would capitalize on a recommended chronic disease model that calls for a broader view of chronic disease management focusing on sets of related symptoms or risk factors, rather than on a specific disease or part of the body.

Strengthen partnerships. Strong partnerships, founded on principles of resource sharing and collaboration, can lead not only to increased efficiency, but also to better outcomes. Expanding partnerships by identifying new members through consultation with key leaders can strengthen existing partnerships. Likewise, unifying programs and agencies to address mutually agreed on common goals will strengthen existing partnerships.

Develop a plan to address diabetes prevention in youth. Maximizing resources means maximizing impact. Developing strategies that address diabetes prevention among youth are critical to impacting the prevalence of diabetes in Michigan. A growing number of children have or are at-risk for prediabetes and diabetes. Since many health habits are formed early in life, it is important to implement behavior interventions aimed at youth. Recommendations for working with youth include requiring healthy food options as part of school breakfast and lunch programs, as well as using intergenerational mentoring to model healthy behaviors.

Statewide Objectives For Diabetes Primary Prevention

The MAP goals. The overarching goal for diabetes primary prevention is to prevent diabetes among people with prediabetes by helping them to increase their physical activity, improve their eating habits, and reduce their weight. The objectives and outcomes related to diabetes primary prevention are outlined in the diagram that follows.

- **Process objectives.** Process objectives describe infrastructure improvements that are necessary to achieve desired outcomes in diabetes prevention.
- **Impact objectives.** Impact objectives measure the impact of establishing prevention infrastructure.

Process and impact objectives outline a direction toward meeting diabetes prevention goals. These objectives need to be measurable to monitor changes in behavior and health indicators, and ultimately, public health outcomes.

Public Health Outcomes. Public health outcomes directly relate to increased detection and implementation of effective lifestyle interventions. The ultimate result of attaining the MAP goals and objectives will lead to long-term, population-based changes in the prevalence and complications of diabetes.

The emergence of prevention programs will result in the delayed average age of onset of diabetes, decreased prevalence and incidence of diabetes, decreased diabetes-related complications, and reduced health care costs. Diabetes prevention programs may also affect the prevalence of obesity as people with sedentary lifestyles adopt healthy behaviors and improve their eating habits.

In addition, as prediabetes becomes part of preventive care, there may be other incidental benefits to society such as economic development resulting from reduced healthcare costs, increased interest and funding for diabetes prevention, and more breast-feeding women as a measure against the development of diabetes in breast-fed children⁴.

The Michigan Action Plan (MAP) for Diabetes Primary Prevention

The MAP goals. The overarching goal for diabetes primary prevention is to prevent diabetes *among people with prediabetes* by helping them to increase their physical activity, improve their eating habits, and reduce their weight.

Infrastructure Investment Input	Suggested Process Objectives	Suggested Impact Objectives	Public Health Outcomes
<ul style="list-style-type: none"> • Increase funding for prevention activities. • Support the development of prevention programs at a variety of levels and settings. • Foster collaboration across programs. • Help communities become health conscious through increasing public awareness and working with health care providers, and creating physical environments and policies that promote healthy lifestyles. 	<p>Increase the number of:</p> <ul style="list-style-type: none"> • Physicians who monitor fasting blood glucose levels. • People who are identified with prediabetes (to engage them in prevention activities). • Women with a history of gestational diabetes who are monitored for prediabetes. • Programs promoting breast-feeding. • Communities that implement policy and environmental changes to promote healthy behaviors. • Programs that engage in collaborative activities. 	<ul style="list-style-type: none"> • Increase knowledge of risk factors for diabetes. • Increase awareness of prediabetes. • Increase awareness of ways to prevent diabetes. • Increase healthy eating behaviors. • Increase physical activity levels. • Decrease overweight and obesity rates. • Increase proportion of women who initiate breast-feeding. 	<ul style="list-style-type: none"> • Delay the average age at onset of diabetes. • Decrease diabetes prevalence. • Decrease diabetes-related complications. • Reduce health care costs associated with diabetes.

Documenting Progress

Sustainable diabetes primary prevention programs must demonstrate their impact and success in achieving program objectives. Data showing the effective results of these programs could lead to increased funding from state, federal, and private sources. Partners involved in diabetes primary prevention need to carefully consider how to evaluate their activities. It is critical that they establish benchmarks from the outset, identify data collection needs, and adopt standardized measures.

The Michigan Action Plan (MAP) for Diabetes Primary Prevention

Establishing benchmarks. Establishing benchmarks at the national, state and community level will allow partners to measure and present their achievements. Below are some examples of benchmarks that could be used to monitor progress on MAP objectives.

Infrastructure Investment Input	Process Objectives	Documenting Progress:	Impact Objectives	Documenting Progress:
<ul style="list-style-type: none"> ● Increase funding for prevention activities. ● Support the development of prevention programs at a variety of levels and settings. ● Foster collaboration across programs. ● Help communities become health conscious through increasing public awareness, working with health care providers, and creating physical environments and policies that promote healthy lifestyles. 	<p>Increase the number of:</p> <ul style="list-style-type: none"> ● Physicians who monitor fasting blood glucose levels. ● People who are identified with prediabetes (to engage them in prevention activities). ● Women with a history of gestational diabetes who are monitored for prediabetes. ● Programs promoting breast-feeding. ● Communities that implement policy and environmental changes to promote healthy behaviors. ● Programs that engage in collaborative activities. 	<p>Examples of benchmarks for process objectives:</p> <ul style="list-style-type: none"> ● Adoption of clinical guidelines to identify and treat people with prediabetes. ● The number of providers participating in prediabetes-related CME courses. ● The number of fasting blood glucose reports in patients' charts. ● The number of people participating in prevention activities. ● The number of women enrolled in breast-feeding programs. ● The number of schools that have adopted healthy eating programs. ● The number of communities that implement healthy community assessments. 	<ul style="list-style-type: none"> ● Increase knowledge of risk factors for diabetes. ● Increase awareness of prediabetes. ● Increase awareness of ways to prevent diabetes. ● Increase healthy eating behaviors. ● Increase physical activity levels. ● Decrease overweight and obesity rates. ● Increase proportion of women who initiate breast-feeding. 	<p>Examples of benchmarks for impact objectives:</p> <ul style="list-style-type: none"> ● The amount of mass media airtime devoted to prediabetes and diabetes prevention messages. ● The number of people who are able to identify risk factors for prediabetes and diabetes. ● The % of overweight people who are actively trying to lose weight. ● The number of people with prediabetes who are tested for diabetes every one to two years. ● The proportion of people who are eating 5 or more fruits and vegetables a day. ● The number of health plans reimbursing for prediabetes self-management training. ● The proportion of breast-fed infants.

Establish benchmarks. Establishing benchmark measures at the national, state, and community level will allow partners to assess their progress in meeting DPP objectives. Benchmarks selected by state and community partners to document program effectiveness should be:

- tied to DPP objectives
- tailored to the community to ensure they are meaningful
- measured by standard instruments to ensure generalizability of collected data.

The model on the preceding page provides some example benchmarks tied to prevention objectives.

Identify data collection needs and sources. Each benchmark will need to have an identified data source. Data available from existing resources such as the Michigan Behavior Risk Factor Surveillance System (BRFSS), the Michigan Diabetes, Arthritis, and Osteoporosis Survey, Diabetes Outreach Networks, and insurance and medical records offer potential progress measures for some of the DPP process and impact objectives. These sources house information, for example, on knowledge and awareness of prediabetes, self-reported health behaviors, numbers of fasting blood glucose laboratory tests, and diagnoses of prediabetes.

New data sources will need to be identified and/or established for evaluation of other benchmarks such as:

- changes in community policies and environmental practices that encourage healthy behaviors
- greater access to healthy foods
- mass media time devoted to prediabetes and diabetes prevention, and other social marketing markers.

Partners will also need to determine the effectiveness of using a cross-program collaboration model to implement the MAP. Surveys with MDCH leadership and staff as well as other partners to assess satisfaction with and effectiveness of cross-program collaboration will need to be conducted. Measures of effectiveness could include the following:

- proportion of sustained and diverse representation at project meetings
- number of new collaborative meetings, projects, and partnerships
- dissemination of materials that are shared and used by partners
- participation of members on the boards of directors of partner organizations
- amount of increased funding for joint projects.

Next Steps

The recommendations presented here provide direction for state and local programs and agencies to collaboratively provide diabetes primary prevention services throughout Michigan.

The process for using the MAP recommendations began with endorsement from DPAC and the Michigan Diabetes Prevention and Control Program (MDCH)—essential first steps toward converting recommendations into action—and will continue with its dissemination to all potential partners in the State of Michigan. The next critical step will be for Michigan partners to *use* the MAP for diabetes prevention. Each partner organization will need to consider how the recommendations can be integrated into its diabetes prevention efforts, and then define and communicate its role in diabetes primary prevention to fellow partners. Only by working together will the full impact of the recommendations be realized.

A second step and major challenge for state and local agencies will be to work together to secure funding and other resources to initiate the plan. This will include the identification of federal funding available to the state, funding available at the state level for local programs, and research into foundation opportunities. Other non-financial resources include developed curricula, educational materials, and media campaigns that can be adapted for use in Michigan.

Finally, progress on the recommendations at the local and state level must be evaluated annually. This will involve, at a minimum, surveying collaborators, assessing the success of individual programs, and gathering surveillance data. Regular evaluation of the recommendations is essential to monitor progress and to guide the future MAP recommendations.

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Appendix

Diabetes Primary Prevention Project Planning Process

The DPPP was initiated to determine requisites for state health department programs to work collaboratively for prevention of type 2 diabetes. As part of the process, participants were asked to identify interventions and settings for prevention programs and the resources needed to develop them. To guide discussions, the Chronic Disease Directors (CDD) provided questions for project participants to answer (see inset).

Assembling stakeholders. MDCH gathered together two groups of key stakeholders to work on the project goals. The internal workgroup was formed from a number of program areas within MDCH, such as Diabetes, Cancer, and WIC and also involved MPHI staff and consultants. This workgroup met four times during the project and focused on the first six DPPP questions. Many of the internal workgroup members later participated in the external workgroup.

The external workgroup represented a wide range of stakeholders in diabetes prevention, such as health systems, health plans, and diabetes educators. The project staff carefully considered the composition of this group to ensure a broad representation of geographic areas, gender, racial/ethnic groups, work settings, areas of expertise, and professions. This workgroup met for a two-day session that focused on the remaining six questions. Focus group results (see below) and information from the Data and Research and Evaluation (DaRE) workgroup of the Diabetes Partners for Action Coalition (DPAC) were presented to the external workgroup as resource material to help inform their responses.

Focus group input. Prior to the external workgroup meeting, two sets of focus groups were conducted to investigate diabetes primary prevention program options and gather data for the national evaluation of all DPPP grants. First, five focus groups were held with subsets of stakeholders: local health departments, health plans, minority-based organizations, faith-based organizations, and consumers. The findings from these focus groups were presented at the two-day meeting of the external workgroup and used in the formulation of project recommendations.

Four more focus groups were conducted later to collect national evaluation data. The participants for these focus groups included internal workgroup members, external workgroup members, professionals, consumers, and members of DPAC. This information was also used to develop the project's final report and the MAP.

DPPP Questions

1. What internal and external partners are needed for diabetes primary prevention and what are their roles?
2. What strategies or policies are needed to encourage disparate parts of the health department to work together?
3. What public health policy changes are required?
4. What resources are needed to develop diabetes primary prevention interventions?
5. What processes are needed to ensure collaboration?
6. What strategies are needed to build community partnerships?
7. Where are new opportunities to influence persons with impaired glucose tolerance?
8. What are the performance benchmarks that should be used to measure success?
9. What are the objectives related to diabetes primary prevention?
10. What are potential health outcomes?
11. What data is needed related to diabetes primary prevention?
12. How does health department planning around diabetes primary prevention result in new program policies and relationships that appropriately meet changing community and health system needs?

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