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The Minnesota Diabetes Collective Impact Initiative

Blueprint for Implementation

Prepared by FSG and the Collective Impact Partners, June, 2013

A message from the Executive Team of the Minnesota Diabetes Collective Impact Initiative

In Spring, 2012 the Minnesota Department of Health's Diabetes Program and the University of Minnesota and Mayo partnership "Decade of Discovery" convened a series of meetings with Minnesota leaders and diabetes stakeholders to discuss a novel approach, "Collective Impact," as a model to increase the scope and impact of promising but disjointed efforts to reduce the impact of diabetes in Minnesota. Based on those meetings, FSG, the consulting firm that developed the Collective Impact model, was hired to facilitate and support the planning process. An Executive Team, Planning Group and four Work Groups developed the Common Agenda and Blueprint for Action contained in this document. This Collective Impact approach brought together committed individuals from across a variety of organizations to develop goals and strategies to address diabetes, using a coordinated, organized Collective Impact process. That process and approach now drives the work of the Minnesota Diabetes Collective Impact Initiative.

Executive Team

This report would not have been possible without the leadership of the Executive Team, who have led this effort from conception to implementation.

David Etzwiler, Executive Director at Decade of Discovery

Sheila Kiscaden, Project Manager at Decade of Discovery

Andrew F. Nelson, Executive Director at HealthPartners Institute for Education and Research

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Gretchen Taylor, Diabetes Program Supervisor at Minnesota Department of Health

Collective Impact Partners

This work is a collaborative of over 25 organizations and over 50 plus individuals from across Minnesota and across the healthcare system. The following organizations were co-creators in this work:

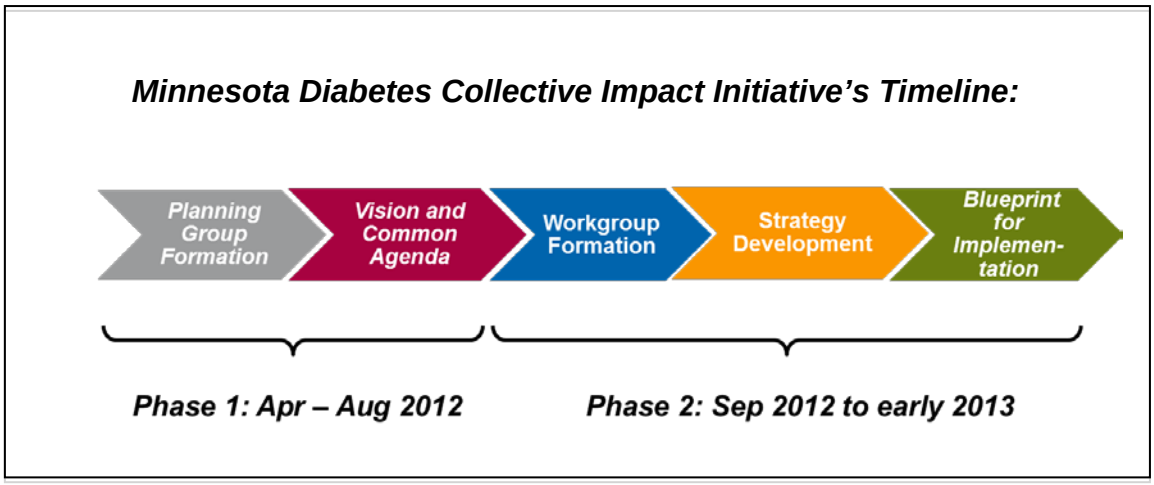
- *American Diabetes Association*
- *Blue Cross Blue Shield of Minnesota*
- *Centers for Disease Control and Prevention*
- *Courage Center*
- *Dave Ellis Consulting*
- *Decade of Discovery*
- *Essentia Health*
- *Essentia Institute of Rural Health*
- *Governor's Task Force on Health Care Reform*
- *Greater Twin Cities United Way*
- *Haberman Inc*
- *Halleland Habicht, LLC*
- *HealthEast*
- *HealthPartners Institute for Education and Research*
- *Himle Rapp*
- *Indian Health Service*
- *Institute for Clinical Systems Improvement*
- *International Diabetes Center*
- *Lifescience Alley*
- *Mayo Clinic Health System*
- *Medica*
- *Minneapolis Urban League*
- *Minnesota Community Measurement*
- *Minnesota Department of Health*
- *Minnesota Health Action Group*
- *Novo Nordisk*
- *Sanford Health System*
- *SEIU Healthcare Minnesota*
- *Southside Community Health Services*
- *Stairstep Foundation*
- *Stratis Health*
- *The Isuroon Project*
- *UCare*
- *UnitedHealth Group*
- *University of Minnesota*
- *University of Minnesota's Extension Center for Family Development*
- *West Side Community Health Services*
- *YMCA of the Greater Twin Cities*

Discovering better ways to solve social problems

- FSG is a nonprofit consulting firm specializing in strategy, evaluation, and research.
- Our international teams work across all sectors by partnering with corporations, foundations, school systems, nonprofits, and governments in every region of the globe. Our goal is to help companies and organizations—individually and collectively—achieve greater social change. In this effort FSG worked with local actors to promote their vision for social change as part of a Collective Impact effort – helping to support an emergent strategy arising from local actors with FSG assisting based on our experience with other Collective Impact efforts.
- Working with many of the world's leading corporations, nonprofit organizations, and charitable foundations, FSG has completed more than 400 consulting engagements around the world, produced dozens of research reports, published influential articles in *Harvard Business Review* and *Stanford Social Innovation Review*, and has been featured in *The New York Times*, *Wall Street Journal*, *Economist*, *Financial Times*, *BusinessWeek*, *Fast Company*, *Forbes*, and on *NPR*, amongst others.
- Learn more about FSG at www.fsg.org.

Purpose of this Document

Minnesota has a unique opportunity to address chronic disease prevention and management and, in particular, diabetes. In the spring of 2012 numerous organizations throughout Minnesota began a collective impact process to respond to the tremendous burden and costs associated with diabetes by aligning efforts, sharing data and engaging the community. The Minnesota Diabetes Collective Impact Initiative's mission is to become the state with the lowest incidence and the healthiest outcomes for diabetes in the nation. In order to achieve this mission, the effort created workgroups bringing together diverse actors across the state to develop strategies around diabetes prevention and care delivery. Now, at the end of Phase 2, the workgroups have been formed and are solidifying those strategies. This document will serve as a blueprint that captures the purpose of this work and the journey these organizations have undertaken. It also includes concrete next steps as the workgroups and the overall effort transitions into implementing the strategies, developing a community engagement plan, identifying indicators to track progress and learn, and establishing a backbone organization to continue to align the work. Please use this document as a reference and guide as the Minnesota Diabetes Collective Impact Initiative moves forward.



Letter from the Planning Group

A bold and unprecedented approach is needed. We must act now.

Chronic diseases, including diabetes, have emerged as the health epidemic of this generation. This reflects our aging population, our adoption of an increasingly sedentary lifestyle, and our struggle with environments that present a challenge to making healthier choices for our lives. Diabetes is responsible for a staggering amount of human suffering and economic, social, and emotional costs for the citizens of Minnesota. Diabetes also dramatically increases our risk for other life-threatening diseases including cardiovascular, cerebrovascular, and end-stage renal disease. This chronic disease that complicates and reduces quality of life for so many in our state needs to be stopped.

While Minnesota fares better than many other states, we cannot ignore the fact that diabetes diminishes our quality of life, disproportionately affects some of Minnesota's populations, and taxes our medical care delivery system significantly. Diabetes is a major health challenge for our state. Every year, more Minnesotans develop diabetes. And yet, we spend the majority of our resources treating those who have the disease, leaving few resources for prevention and rendering us unable to stem the tide of new cases.

We have many extremely talented individuals and tremendous organizations in our state addressing diabetes and yet, given the growing numbers of cases, the sobering conclusion is that we are not fully realizing the potential of these assets. The prevalence of diabetes grows each year having nearly doubled in the last twenty years. More than one in three Minnesotans have either diabetes or prediabetes, a condition associated with higher risk of developing diabetes. The vast majority of those with pre diabetes are undiagnosed and unaware. A bold, unprecedented, and unified approach is needed. We must act now.

Together, we can achieve change statewide.

As members of Minnesota's Diabetes Collective Impact Initiative Planning Group we believe that the only way to address and impact diabetes in Minnesota is with an approach that brings together the health care system, government agencies, lawmakers, the private sector, and community-based organizations to work in concert. Targeting **people at high risk** of developing the disease, this effort seeks to drive major improvements in preventing the onset of diabetes **across all communities in the state**, whether they are defined by geography, race/ethnicity or economic opportunity. In addition, this work seeks to dramatically improve outcomes of **people with diabetes and those with complications** of the disease, many of whom suffer significantly from the human and financial burden of diabetes. Our approach will focus beyond simply looking at the quality of health care delivered and take into account individual factors and environmental barriers that limit positive health outcomes for those at risk of developing diabetes as well as those who live with the disease.

> *"Collective Impact is more about the "how," than the "what" – that's why it's a unique approach"*
> *James Eppel*

A group of organizations, listed below, have come together to adopt a "**Collective Impact**"[1] approach to address diabetes in our state. Jointly, we represent the **Planning Group (PG)** for this effort, the **Minnesota Diabetes Collective Impact Initiative**. Collective impact represents a unique way of working together – rather than trying to find the next "silver bullet" it is about making better use of our existing assets, systems, and the wealth of knowledge and experience that the state boasts. Collective Impact is about moving from models of "isolated impact" to one where **agendas and activities are aligned**, appropriate **data and evidence is shared** to inform strategies, and communities work toward **common goals and a shared vision**.

Our work is ongoing. In this first part of this document, we outline the work we have already completed through our revised Common Agenda. It includes: a common definition of the problem of diabetes in our state, a shared vision around which to drive change, and an explanation of how we have begun to align each partner's activities to our shared goals and vision through the work of four cross-cutting workgroups. In the second part of the document, we look forward at what we have committed ourselves to accomplishing with our Blueprint for Implementation. In this section we outline and show how those workgroups will develop a shared measurement system to keep ourselves accountable; establish a backbone organization to provide dedicated staff, manage and support the implementation of our strategy, and to serve as the coordinating function for this effort; and implement a community engagement plan to bring other necessary stakeholders into the discussion.

We are excited to share this document with you and look forward to your engagement on this bold and ambitious effort. Join us.

Planning Group Members:

- Ann Albright, Centers for Disease Control and Prevention
- Jeanne Ayers, Minnesota Department of Health
- Don Bishop, Minnesota Department of Health
- Dana Boyle, Lifescience Alley
- Jim Chase, Minnesota Community Measurement
- James Deming, Mayo Clinic Health System
- Dave Ellis, Dave Ellis Consulting
- Jim Eppel, formerly of Blue Cross Blue Shield of Minnesota
- David Etzwiler, Decade of Discovery
- Fred Haberman, Haberman Inc.
- Alfred Babington Johnson, Stairstep Foundation
- Clarence Jones, South Side Community Health Services
- Sheila Kiscaden, Decade of Discovery
- Jennifer Lundblad, Stratis Health
- Mike Lynch, UCare
- Jan Malcolm, Courage Center
- Mary Manning, Minnesota Department of Health
- Jim McGowan, American Diabetes Association
- Andrew F. Nelson, HealthPartners Institute for Education and Research
- Gary Oftedahl, Institute for Clinical Systems Improvement
- Carolyn Pare, Minnesota Health Action Group
- Teresa Pearson, Halleland Habicht
- Gregg Simonson, International Diabetes Center
- Steven A. Smith, Mayo Clinic Rochester
- Gretchen Taylor, Minnesota Department of Health
- Ghita Worcester, UCare
- Jon Zurbey, Haberman Inc.

[1] Kramer, Mark, and Kania, John, "Collective Impact," *Stanford Social Innovation Review*, 2011.

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Summary

Our ***vision*** is to make Minnesota the state with the lowest incidence and the healthiest outcomes for diabetes in the nation. The ***goals*** of the Initiative are to: (1) significantly **reduce new cases** of diabetes for those at high risk of developing the disease; and (2) curb the rising **cost of care and human burden** for people with diabetes and complications of the disease. While we are focusing in the shorter term on people at risk and those with diabetes, in the long term we envision engaging all Minnesotans through our work to achieve our vision. Our overarching ***approach*** involves aligning our work around mutually agreed upon goals and creating the conditions needed for success. Specifically, we recognize the critical need to:

- Align the efforts of systems and communities to address diabetes, its risk factors, and barriers to achieving prevention and disease management goals
- Ensure data, including clinical data as well as data on socioeconomic variables and public health surveillance measures, is effectively collected, reported and used to track systemic progress around addressing diabetes and its risk factors
- Ensure that prevention and disease management systems adopt evidence-based or -informed practices
- Support policy makers at the local, city, and state levels to adopt and effectively implement policies and practices that help manage and reduce the risk of diabetes for all Minnesotans.
- Coordinate with public health activities aimed at the broader population (e.g., policies to address tobacco use) that may affect the target populations of this effort.

As a result of our work, we envision a ***future*** in which:

- Organizations addressing diabetes prevention or care in Minnesota align their work towards common, shared goals articulated by the Initiative;
- There is consistent collection, standardization, and use of data and a culture in which findings are widely disseminated;
- Organizations use common goals to advocate for policy changes that create an environment that facilitates adoption of evidence-based solutions;
- We utilize the strengths each organization brings to the table linking community, government, private sector, civil society, and health-care systems to make interventions more effective and appropriately tailored to the communities in which they are delivered; and
- ***Above all***, the human cost of diabetes in Minnesota is greatly diminished: fewer new cases develop each year and the duration and quality of life is improved for those with diabetes.

A new approach to address diabetes has been launched in Minnesota through the Minnesota Diabetes Collective Impact Initiative. Over two dozen organizations representing a wide range of stakeholders have come together to develop and endorse this common agenda for tackling diabetes. Building on this common agenda, we have created a Blueprint for Implementation detailing how Minnesota will take action

in the coming year. Our outcomes not only have potential to transform the picture of diabetes in Minnesota, but to serve as a model for chronic disease prevention and treatment across the country.

Collective Impact (CI) represents a new way of working together to address complex social challenges. CI is the commitment of a group of actors from different sectors to a common agenda for solving a complex social problem. Collective Impact is more rigorous and specific than collaboration among organizations. There are five conditions that, together, lead to meaningful results from Collective Impact: (1) a common agenda, (2) shared measurement, (3) mutually reinforcing activities, (4) continuous communication, and (5) a backbone organization. The Minnesota Diabetes Collective Impact Initiative will take advantage of this powerful and unique approach to create measurable progress on diabetes.

The Problem

- Diabetes **continues to grow** in Minnesota at an alarming rate, with the number of diagnosed cases nearly **doubling** over the last 20 years
- The vast majority of resources are **spent on managing and treating diabetes**, instead of **preventing** new cases from occurring.
- These trends exist within the context of **significant assets** in Minnesota to address the disease and improve health.

Diabetes continues to grow at an alarming rate

The current state of diabetes nationwide is troubling and predictions for the future are even more unsettling. The prevalence of diabetes in America has nearly quadrupled from 1980 to 2010.[2] Disparities are also significant: American Indian adults are more than twice as likely to have diabetes than white adults.[3] If trends continue, one in three Americans born in the year 2000 will develop some form of diabetes during their lifetime. For black and Hispanic children, the picture is more dire. One in two will develop diabetes.[4]

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[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey. Available at: http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm. Accessed July 23, 2012.

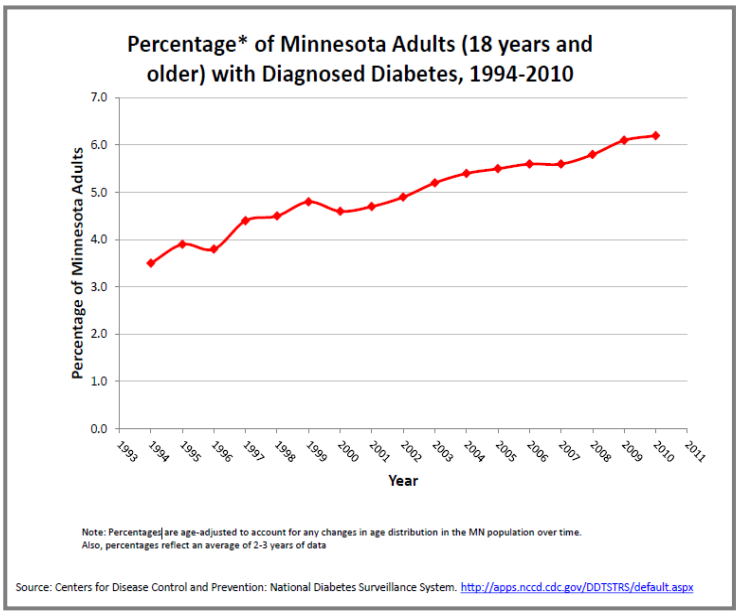
[3] CDC, "National Diabetes Fact Sheet," 2011.

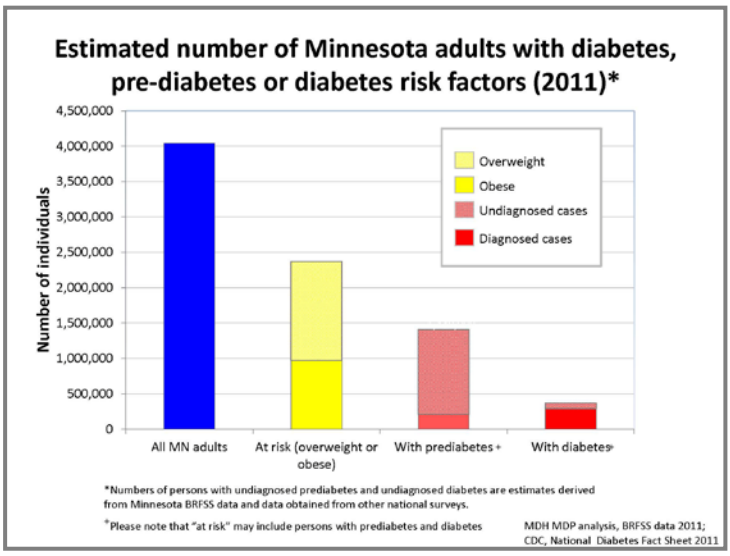
[4] Narayan KM, Boyle JP, Thompson TJ, Sorensen SW, Williamson DF. "Lifetime Risk for Diabetes Mellitus in the United States." *JAMA*. 2003; 290 (14): 1884-90.

Minnesota follows the national diabetes trends and the situation is worsening

For most diabetes-related statistics, Minnesota is considered to be doing better than average in comparison to the rest of the nation. However, Minnesota was one of three states with the lowest diabetes prevalence rate nationwide up until 2008. The state has since lost that position.[5] Presently, 7.3% of adults in Minnesota report that they have been diagnosed with diabetes.[6]

The number of new cases of diabetes continues to grow in Minnesota, doubling in the last twenty years and mirroring national trends [see Figure 1].[7] Rates of overweight and obesity, which are risk factors for diabetes, have markedly risen over the same period suggesting the prevalence of diabetes may continue to climb[8]. As many as 1.8 million adults (more than one in three) in Minnesota have diabetes or prediabetes.[9] In addition, almost two-thirds of the adult population is overweight or obese. These numbers underscore the large proportion of adults in Minnesota who live with diabetes or are at increased risk of developing the disease [see Figure 2][10].





[5] Maps of Trends in Diagnosed Diabetes, November 2011. Available at: http://www.cdc.gov/diabetes/statistics/slides/maps_diabetes_trends.pdf. Accessed August 3, 2012.

[6] http://www.health.state.mn.us/diabetes/pdf/DiabetesPrediabetesMinnesotaFactSheet2012.pdf

[7] Centers for Disease Control and Prevention: National Disease Surveillance System. Available online at: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx

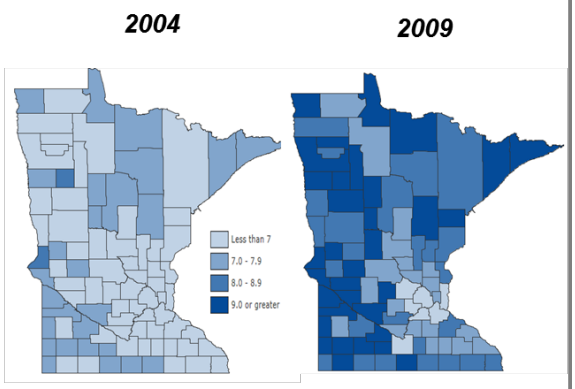
[8] BRFSS data from Minnesota Department of Health.

[9] Minnesota Department of Health estimates, 2007.

[10] MDH, "Diabetes and Prediabetes in Minnesota," 2010. Note: *Adults with prediabetes may also be considered within the high-risk population (overweight or obese)

Diabetes disparities for racial and ethnic minorities, rural areas, and low-income Minnesotans are significant.

Figure 3: Percentage of Adults with Diabetes by Minnesota County



Source: MN Health Atlas

Significant disparities in diabetes prevalence and risk factors exist among people with lower socioeconomic status, older adults, and those living in rural areas[11] [see Figure 3].[12] Although the overall proportion of minorities in Minnesota is small, the state is becoming increasingly diverse.[13] There is a need for additional data for distinct racial and ethnic sub-populations, but available data shows marked disparities. Diabetes-related mortality rates (2006-2010) were 1.3 times higher for Hispanics, 2.1 times higher in African Americans, and 3.8 times higher in American Indians than in whites.[14] African-born groups may now have a higher prevalence of diabetes risk factors as a result of lifestyle changes due to immigration[15]. Gestational diabetes signifies increased risk of developing diabetes for mothers and greater likelihood of impaired glucose tolerance for babies. Higher rates of gestational diabetes among Asian, African American, and Hispanic women suggest disparities and increased risk for future generations[16]. This pattern is mirrored in obesity rates, which are significantly higher for young children (2-5 years of age who live in families participating in WIC) of color as compared to white children[17].

The human and economic burden of diabetes on Minnesotans is astronomical.

Minnesota adults with diabetes are increasingly overweight or obese and have high cholesterol,[18] increasing risk for complications of the disease. Diabetes is the leading cause blindness, kidney failure,

[11] Centers for Disease Control and Prevention, Diabetes Data and Trends. Available at: http://apps.nccd.cdc.gov/ddtstrs. Accessed July 23, 2012.
[12] Minnesota Health Atlas; US Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx
[13] Minnesota non-white and Latino populations have increased by 27% from 2000-2007. http://www.demography.state.mn.us/documents/MinnesotasNonwhiteandLatinoPopulation2007.pdf
[14] "MDH Vital Statistics Interactive Query, https://pqc.health.state.mn.us/mhsq/frontPage.jsp
[15] SHAPE Survey, Hennepin County Human Services and Public Health Department 2006.
[16] Diabetes in Minnesota: Chapter 13, Pregnancy (MDH), available at http://www.health.state.mn.us/diabetes/diabetesinminnesota/pregnancy1009.pdf. Accessed August 3, 2012.
[17] Obesity and Overweight Status In Minnesota WIC Children. Available at: http://www.health.state.mn.us/divs/fh/wic/statistics/wtstatus/index.html. Accessed August 3, 2012.
[18] National Diabetes Surveillance System. Available at: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx. Accessed July 23, 2012.

and lower-extremity amputation[19]. Heart disease deaths and strokes are twice as common among adults with diabetes as compared to those who do not have diabetes.[20] Diabetes takes a significant toll on individuals, their families, and communities. Diabetes is the seventh leading cause of death in Minnesota,[21] and those living with the disease have a lower quality of life.

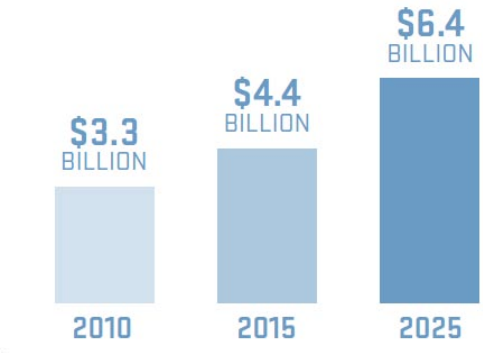
> *"We must effectively leverage the existing resources in the state to make the most impact on people with diabetes and at high risk of the disease"*
> *— Ken Bence, Medica*

Disparities persist in treatment outcomes as well. Levels of optimal care[22] for Minnesotans who have government-sponsored health insurance are significantly lower than those attained for Minnesotans who have insurance, even when these individuals are treated by the same health care providers.[23]

Most resources spent on diabetes are focused on managing and treating the disease, rather than preventing new cases from occurring.

According to the most recent estimates, diabetes costs Minnesota about $3.3 billion dollars annually, with that figure expected to rise to $6.4 billion if current trends continue [see Figure 4].[24] These costs do not reflect the social and emotional costs of the disease. Direct costs continue to rise due to a number of factors, including per unit cost of medical interventions, escalating prices charged by providers, and growing treatment volumes due to the rise of chronic conditions and obesity overall.[25] The economic burden of diabetes is staggering.

Figure 4: The Growing Cost of Diabetes



Source: Minnesota Diabetes 2025 report

In comparison, the relative investment in prevention of diabetes is miniscule. Recent state-level data for this is

[19] National Institute of Health: Fact Sheet National Diabetes Statistic, 2011. Available at: http://diabetes.niddk.nih.gov. Accessed July 23, 2012.
[20] National Diabetes Surveillance System. Available at: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx. Accessed July 23, 2012.
[21] Minnesota Department of Health, "Chronic Disease and their Risk Factors," 2011.
[22] Clinical management of diabetes in Minnesota is tracked by a series of five measures known as the D-5. Currently, only 37% of individuals with diabetes have optimal diabetes care, meaning that all five of the measured clinical objectives are met by 37% of those with diabetes.
[23] Minnesota Community Measurement, "2009 Health Care Disparities Report," 2009. A number of factors could be responsible for this finding, including difficulty navigating the system, institutional barriers, environmental barriers that prevent people from being compliant, etc. See: http://mncm.org/site/upload/files/Book_4.20.12pdf.pdf for updated information.
[24] Minnesota Diabetes 2025.
[25] United Health Group, "Why are Healthcare Costs Rising?" March 2010; Robert Wood Johnson Foundation and Johns Hopkins University, "Chronic Conditions: Making the Case for Ongoing Care," February 2010.

unavailable. If we assume that Minnesota is in line with national data, however, federal spending data shows investment on diabetes *treatment* was 386% more than that for diabetes *prevention*.[26] Stakeholders across the state argue that more needs to be done to prevent those at risk from developing the disease.

This lays the groundwork for a **perverse cycle** to take root. The majority of available resources are dedicated towards treatment, which prevents a stronger focus on addressing the fundamental causes of diabetes, contributing to increasing prevalence of diabetes, which then fuels increases in treatment costs and health care spending.

We have to better utilize the many assets we have in Minnesota to address prevention of diabetes and improve health for those who have diabetes.

The facts above paint a disturbing picture. We need to break the perverse cycle of our resource allocation. We need to stop this pattern by leveraging our many skills, programs, and resources through a new approach, *together*.

There are a number of organizations and efforts mobilizing resources to address diabetes across the state. Stakeholders point to the richness of these assets and Minnesota's key strengths—sound evidence-based models, strong public policy leadership, and leaders in the health care delivery field. However, we believe these assets need to be clearly aligned to common goals. A number of fundamental barriers exist across the system that prevents greater impact around diabetes in Minnesota:

Need for improved system- and community-wide **alignment and coordination**: Overall, there are a number of efforts driving information sharing and collaboration to improve health and address diabetes at multiple levels in Minnesota. However, these efforts are often siloed and uncoordinated. This has limited our ability to drive change. There is need for overarching support to align the agendas of the wide landscape of stakeholders seeking to address this issue: state agencies, health care providers, payers, businesses and employers, policymakers, community-based organizations, and advocates. Competition for resources often limits working together and reinforces artificial divisions between key players. In addition, we may fall prey to inviting the same people we know to the table and miss out on utilizing the creative potential and resources of those outside our typical health care delivery circle, for example.

The Initiative also recognizes the need to make stronger connections between communities and health systems, and the need to create supportive environments to help individuals and families better manage their health. We cannot expect all improvements in health to come from changes in the health care delivery system. In fact, only 10-15% of our health is likely determined by medical care, while behaviors account for 40% and factors including genetics and environment account for the remainder[27]. Therefore, we need to integrate approaches that target behavior and factors that influence behavior. Engaging

[26] Gold, M., Briefel, R., and the MPR Study Team, "An Opportunity for Federal Leadership in Changing Diabetes: a Study of Federal Spending on Diabetes," June 2007.

[27] McGinnis et al, Health Affairs 21:78-93, 2002.

communities will be critical for us to address a greater proportion of the factors that influence health issues, such as diabetes.

Need for greater collection, sharing, and use of **data and knowledge**: To drive ongoing improvement and continuous learning, regular reporting of aggregated, system-wide analyses around Minnesota's progress for addressing diabetes and its risk factors is critical. Stakeholders across the state are calling for improved common measures capable of moving beyond tracking patient outcomes measures to tracking costs, patient experience, disparities data, and a number of critical systems measures, such as community engagement and access to diabetes care. Expanding the context in which these measures is interpreted (i.e., in light of measures of health equality, such as income, education, entry into prenatal care or other preventive services) may offer new interpretations of the data and allow us to better direct resources at factors that have strong influence on health outcomes.

> *"The health system is able to serve the motivated populations very well. However, there is room for much improvement, as a lot of work still needs to be done for people with complications because of the socio-determinants of health"*
> *– Sheila Kiscaden, Decade of Discovery*

Need for strong **policy and advocacy**: The Initiative recognizes the need for improved efforts to drive policy changes, advocacy, and greater awareness around diabetes and its risk factors among individuals and policymakers. As budgets for public programs have been reduced over time, there is need for a unified and aligned voice championing critical policy solutions to promote health and reduce the incidence of diabetes in the state. Many call for a united front to encourage reimbursement and effective financing for the National Diabetes Prevention Program (NDPP), for example. In our efforts we need to involve communities to ensure that the policies advocated are ones that can be adopted, implemented and embraced in practice.

Need for **innovation and to scale** evidence-informed policy and practice: A number of evidence-based or -informed efforts exist across the state, but achieving scale statewide of proven prevention programs has not yet occurred. Whether through funding, capacity, or policy incentives to drive innovation, address risk factors, or reduce costs, stakeholders must identify, prioritize, and implement—in coordination---the best opportunities to improve health and reduce health care expenditures. For example, the Diabetes Prevention Program has well demonstrated its impact among participants. However, the program is not yet widely available and must be disseminated using strategies tailored to the infrastructure and needs of the communities it serves

No single organization can stem the tide of diabetes. It takes a group of highly committed organizations coming together around a common agenda to drive real progress in addressing diabetes statewide. We must make better use of current resources, while also filling critical gaps that exist. Rather than competing for resources or working in silos, we need to align our work and support the use of mutually reinforcing activities to advance progress. We must ensure greater accountability among organizations towards our common goals, ensuring that our plans are implemented. We need **Collective Impact** to dramatically alter the course of diabetes in our state.

The Opportunity and Approach

Minnesota can be a national leader in diabetes prevention and treatment.

A group of organizations, comprising the Planning Group (PG), with significant assets and expertise have come together in Minnesota to launch a Collective Impact effort to address diabetes. We agree that a new approach of working together is needed in order to stem the tide of diabetes in Minnesota. "Collective Impact" is the commitment of a group of diverse or cross-sector organizations to defining a common agenda to solve a complex social problem. We believe that a focused strategy with dedicated resources is needed to make better use of our existing resources and reduce the burden of diabetes in Minnesota. Through the Minnesota Diabetes Collective Impact Initiative, Minnesota now has the unique opportunity to realize the potential of our assets and become a national leader in the prevention and treatment of diabetes. As the first state-wide Collective Impact effort focused on chronic disease, the Initiative will not benefit Minnesotans alone, but stands to provide lessons to other organizations and communities across the country and to ultimately affect millions of lives.

> *"There was a certain reluctance to engage in talking about disparities not so long ago; discussions around health inequities and the need to engage people in the context of their community were avoided in meetings for a long time"*
> *– Alfred Babington Johnson, Stairstep Foundation*

The Minnesota Diabetes Collective Impact Initiative has made **significant progress** since its inception:

- Formed a wide-range of leading organizations into a **Planning Group** to lead this effort, committing **resources** and **time** to oversee the work
- Articulated a simple yet powerful **definition of the problem** of diabetes in Minnesota that highlights both the growing trend and the disproportionate allocation of resources
- Developed **guiding principles** to focus and sequence the work
- Formulated a **"common agenda"** document that captures a shared vision, common understanding of the challenge, and articulates the preliminary theory of change
- Created **four cross-cutting workgroups** and tasked them with developing a full set of strategies to drive towards the theory of change
- Adopted a preliminary strategy of **supporting the National Diabetes Prevention Program (NDPP) as a means of strengthening diabetes prevention statewide while aggressively exploring a broader menu of innovative strategies and partnerships to support prevention**
- Began creating a **"Common Care Model" that articulates the group's position around how to improve diabetes treatment** in Minnesota
- Continued **community engagement conversations** and brought in new members to ensure those most likely affected by this work are engaged in strategy development
- Began **advocacy efforts to support the goals outlined above**, including sending letters to the Governor's office in support of the NDPP

Theory of Change

Our theory of change lays the groundwork for impact.

This Initiative is aimed at driving major improvements in preventing and treating diabetes across communities in Minnesota. This effort is not intended to be just about "new interventions" nor is it an attempt to compete with any of Minnesota's noteworthy diabetes initiatives. No one organization, however innovative or powerful, can address our state's needs alone. Hence the need and support for the Collective Impact effort. This effort will identify programs and innovations already making a positive difference and build on these successes by strengthening and contextualizing them to our diverse communities. The Initiative adds value by building strong public awareness about the urgent need to stem the tide of diabetes.

Systemic Needs

Our theory of change is based on addressing the systemic challenges articulated by the Planning Group in this document: Need for improved system- and community-wide **alignment and coordination**; need for greater collection, sharing, and use of **data and knowledge**; need for strong **policy and advocacy**; and need for **innovation and scaling of** evidence-based or -informed policy and practice.

Sample Strategies

In order to address the systemic needs and achieve our goals, the Initiative will deploy a number of strategies. These strategies will be aligned with one or both of our goals, helping us achieve our long term vision. The strategies may include a variety of different programs targeted to increasing self-efficacy among those with prediabetes or diabetes, improvements in the delivery of medical care or ways to empower communities to change local policies or environments that strongly impact health. For example, the strategies may include identifying people with undiagnosed prediabetes, working on policy change to reimburse prevention activities, disseminating evidence-based programs to address highest burden patients, and developing care solutions that take into account behavior and environmental factors, outside of the health care system..

Target Populations and Goals

The scope of this effort is focused on 1) **people at high risk of developing diabetes** and **2) people with diabetes and those who have complications and/or comorbidities of the disease**. In order to address our target populations, we will focus our work on achieving two goals: (1) Significantly **reduce new cases** of diabetes for those at high-risk of developing the disease; and (2) Curb the rising **cost of care and human burden** for people with diabetes and complications of the disease.

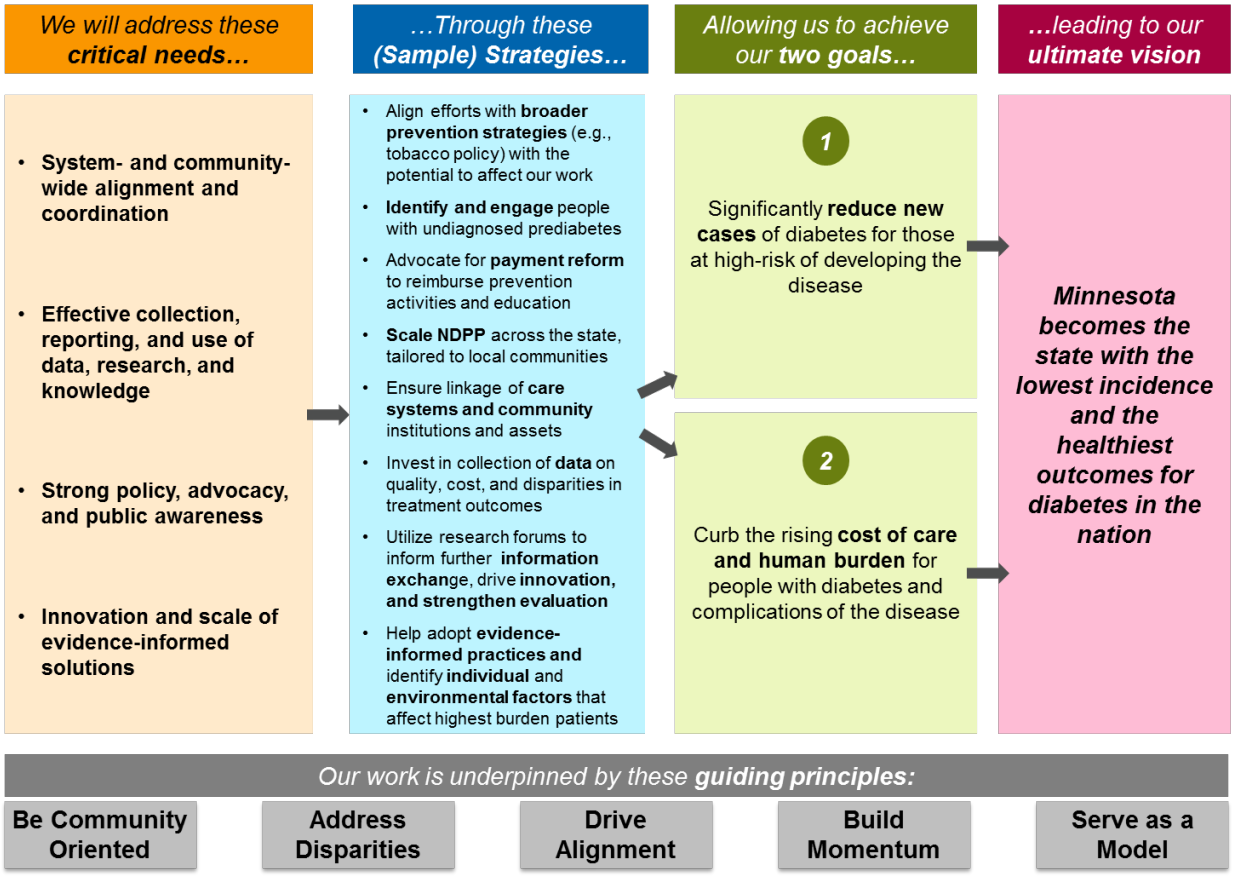
While we have selected two target populations on which to focus our initial effort, our long-term vision is broad and inclusive. Our hope is to eventually affect all Minnesotans through this effort. Even in our early years, as we focus on our target populations, we will need to carefully coordinate with public and diverse

health system efforts aimed at the general and specific populations for chronic disease that may be leveraged and extended to our target populations (for example, Minnesota's Statewide Health Improvement Program (SHIP) or may affect our target populations (for example, policy on discouraging tobacco use).

Vision

Our sample strategies, leading to our two goals, will help us achieve our long term vision. Our ***vision*** is to make ***Minnesota the state with the lowest incidence and the healthiest outcomes for diabetes in the nation***.

The figure below provides a visual depiction of our theory of change.



Underlying our approach to change is a set of **guiding principles** around which to orient our work.

- **Community Oriented**. Keep individuals, families, and communities at the forefront, prioritizing locally-based solutions contextualized to the needs of different communities.
- **Address Disparities**. Be more intentional and accountable in focusing on how certain populations are disproportionately affected.

- **Drive Alignment**. Leverage what already exists and align activities.
- **Build Momentum**. Include strategies that help deliver quick wins and achieve cost savings for the state.
- **Serve as a Model**. Leverage insights to serve as a model for addressing other chronic diseases in Minnesota and beyond.

Support for Collective Impact is broad and growing.

Since releasing the "Common Agenda," significant progress has been made. The Planning Group has expanded, and four workgroups have been established. Those workgroups have led the charge in developing a set of strategies that drive towards the theory of change articulated here. As the next section will show, those workgroups have identified preliminary strategies and created new models for thinking about diabetes in Minnesota. For the most developed of these strategies, activities and advocacy efforts have already begun. Furthermore, conversations around community engagement are ongoing, and new members have been added to the Planning Group (PG) and workgroups to ensure that those who are most likely affected by this work can inform strategy development.

Over the coming months the effort will create shared indicators to measure the effort, establish a backbone organization with dedicated staff, who will track the progress of all the workgroups, manage community engagement and communication for the effort, and coordinate activities and advocacy efforts. These activities will be covered in the second half of the document.

Our goals are ambitious: to both prevent diabetes among those at highest risk and to improve care for those who have diabetes so we can minimize the human suffering and costs. To reach our goals, we will need the collective efforts of all stakeholders, working across systems to address essential needs. Each organization will bring its unique strengths, experiences, abilities, and beliefs to this work, yet share a collective ambition. The common agenda was the first step to translate our goals into action, the following Blueprint for Implementation is the second. We now move into the third phase, turning our strategies into measureable actions that create positive change for all Minnesotans. The time to act is now.

Workgroup Structure

Overview of Workgroup Roles and Responsibilities

The workgroups play an important role in ongoing strategy-setting, community engagement, and implementation. The workgroups are charged with identifying effective strategies to support the two goals articulated by the Common Agenda: to significantly reduce new cases of diabetes among those at high risk of developing the disease and to reduce the human burden and rising cost of care for people with diabetes and its complications. The strategy selection and development process involves the collection of research on effective, evidence-informed strategies, the use of data to inform the identification of key strategies, and identifying funding sources and local agencies and organizations to support the strategies.

Workgroups are also asked to incorporate the input and perspectives of the community to strengthen the strategy development process. Throughout the implementation of the strategies, members of the workgroups help to coordinate activities among workgroup member organizations and others in the community.

The activities conducted by the workgroups represent a new way of working together to address a complex problem.

- Our workgroups require a high level of commitment from members and authority to align activities and commit resources.
- Our workgroups develop clear indicators that hold members accountable for their outcomes and must show the capacity to constantly adapt to new needs and refine strategies to attain expected outcomes.
- We prioritized systematic and regular coordination with other workgroups with support from the backbone organization and Planning Group.

Background of Minnesota Diabetes Collective Impact Workgroups

The Minnesota Diabetes Collective Impact Effort comprises four distinct workgroups that work in concert to achieve the goals articulated by the Common Agenda. The structure of the workgroups emphasizes specific strategies required to reach the defined goals, focusing on the population groups the Planning Group selected. The structure also includes functional groups that will be supporting target populations, while addressing the most critical barriers across the system. The workgroups are as follows:

- Workgroup #1: Diabetes **Prevention**
- Workgroup #2: Diabetes **Care Delivery**
- Workgroup #3: **Data Collection**
- Workgroup #4: **Policy and Awareness**

Workgroup #1: Diabetes Prevention

Goal: The primary goal of Workgroup #1 is to significantly reduce new cases of diabetes among those at high risk of developing the disease. Achieving this goal also achieves the second goal of Minnesota's Diabetes Collective Impact Initiative: "Reducing the human burden and rising cost of care for people with diabetes and its complications."

Strategy: The Strategy of workgroup #1 is **to identify, prioritize and scale solutions for preventing diabetes among populations at high risk.**

Context: During Phase I of the Collective Impact Initiative (i.e. before workgroups had been formed), the Planning Group recognized that multiple prevention models would need to be scaled to meet the Initiative's Vision. For that reason, from its inception the group committed to prioritizing and serially scaling evidence-based prevention programs with the most promising health and financial returns. Tactically, the group identified the National Diabetes Prevention Program (NDPP) as the most promising model to prioritize for its initial scaling in Minnesota.

At present, the Collective Impact Initiative's prevention efforts are singularly focused on making the NDPP available to all Minnesotans for whom it is indicated. In future years the group will continue its work to identify other promising prevention interventions in dialogue with the community. NDPP is the first of a menu of prevention alternatives that will be necessary to achieve our goals.

Singular Focus: The National Diabetes Prevention Program (NDPP) is an evidence-based lifestyle change program for preventing Type 2 diabetes. It is based on the Diabetes Prevention Program research study, which was led by the National Institutes of Health and conducted by research centers throughout America. The DPP study showed that type 2 diabetes was prevented or delayed by 58% over a three year period in people with prediabetes who participated in a structured lifestyle change program focused on healthful eating, increased physical activity, and behavior change strategies to achieve modest weight loss. The goal of the DPP was 7% weight loss, but the mean weight loss among study participants was only 5%.

After the Diabetes Prevention Program was tested in the research study and in several implementation (or real world) studies, CDC along with public and private partners developed the National Diabetes Prevention Program. Participants in the National Diabetes Prevention Program work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (usually 1 per week) and 8 post-core sessions (1 per month). The National Diabetes Prevention Program encourages collaboration among federal agencies, community-based organizations, employers, insurers, health care professionals, academia, and other stakeholders to prevent or delay the onset of type 2 diabetes among people with prediabetes in the United States.

Several lifestyle change sites that provide the National Diabetes Prevention Program are already in operation in Minnesota and the program is gaining traction in the community.

Tactic: The first tactic selected by Workgroup #1 and unanimously approved by the full Planning Group is to scale the CDC's National Diabetes Prevention Program (NDPP) in Minnesota. Workgroup #1 has partnered with Workgroup #4 (due to the large communications and advocacy needs of the NDPP strategy) to develop a set of actions to support NDPP expansion in Minnesota. The group articulated the following vision for the strategy:

NDPP Vision: The CDC's National Diabetes Prevention Program (NDPP) is available to all Minnesotans who have prediabetes, have had gestational diabetes, or are otherwise at high risk.

- **All payers and employers** support the adoption of the NDPP for persons at risk for diabetes though reimbursement and plan design
- **All providers are aware of prediabetes, and are** supported to **test persons at risk** and to **refer** to the NDPP
- A **diverse, trained workforce with organizational and community capacit**y is in place to deliver the NDPP in appropriate ways to all of Minnesota's populations
- A **comprehensive and culturally appropriate marketing campaign** generates awareness about prediabetes that encourages those at risk to be tested and seek referral to the NDPP
- **Budget, infrastructure, and human resources** are in place to **coordinate** the plan for statewide implementation and to **monitor progress**

Toward that end, the workgroup has developed a **workplan** and specific actions to pursue in the following categories:

- Outreach to employers and self-insured businesses
- State engagement for Medicaid coverage and state employee health plan coverage
- Outreach to private plans
- Implementation of a communications plan
- Data support

The workplan's actions are currently focused primarily on supporting the adoption of the NDPP for persons at risk for type 2 diabetes through reimbursement and plan design. Actions to increase provider and public awareness of prediabetes, testing and referral to the NDPP, and availability of NDPP programs to meet the need of Minnesota's diverse populations statewide will be undertaken as next steps.

Members

Ann Albright	Director, Division of Diabetes Translation	Centers for Disease Control and Prevention
Arelene Becker		West Side Community Health Services
Jim Eppel	Former Chief Operating Officer	BCBS of Minnesota
David Etzwiler	Executive Director	Decade of Discovery

Glen Gunderson	CEO	YMCA of the Greater Twin Cities
Fred Haberman	CEO and Co-Founder	Haberman Inc.
Alfred Babington Johnson	President and CEO	Stairstep Foundation
Tim Koehler	President of the Diabetes Prevention and Control Alliance	United Health Group
Rita Mays	Diabetes Prevention Planner	Minnesota Department of Health
Tracey Miller	Chief Operating Officer	West Side Community Health Services
Carolyn Pare	President and CEO	Minnesota Health Action Group
Gregg Simonson	Director, Professional Training and Consulting	International Diabetes Center
Gretchen Taylor	Diabetes Program Supervisor	Minnesota Department of Health
Houa Vue-Her	Program Director for Health and Nutrition Programs	University of Minnesota's Extension Center for Family Development

Workgroup #2: Diabetes Care Delivery

Goal: The goal of Workgroup #2 is to identify and/or scale solutions to improve care to reduce the overall cost and burden of care for people with diabetes and the complications from the disease

Context: In Minnesota improving outcomes, reducing cost, and improving the patient experience for those with diabetes has been and continues to be the focus of many efforts by health care organizations and payers. Across the State of Minnesota, many diabetes and chronic disease care delivery improvement strategies are being developed and tested. Nearly every care system and health insurer has identified and committed resources to test diabetes or chronic disease strategies.

- Minnesota led the way in the development of performance measurement and reporting of diabetes care delivery, the "D 5". This measurement strategy allows comparison of results between practices and care systems, and successfully created incentives quality improvement and care delivery changes.
- The Diabetes and Heart Health Collaborative has worked across systems for many years to produce a variety of diabetes tools and resources.
- The Bridges to Excellence Guiding Coalition made diabetes the focus of its first ever increasing measurement threshold and alignment of financial reimbursements for employers, health plans, and state health programs.
- Efforts have been made to improve quality of diabetes care through using electronic health records (EHR's) to effectively identify chronic disease, including diabetes, through the use of registries, automatically generated prompts and reminders for diabetes care. Recent innovations involve expanding the availability of EHR's to enhance patient involvement in disease management and to actively engage other community providers in supporting care management with shared access to clinical information.
- Pilots for the use of medical homes for high-cost and high-need populations, including the use of telemedicine and integration of clinical services with rehabilitation services, have demonstrated reduced hospitalizations, increased the number of healthy days, and decreased costs. Some pilots have collected data that document longitudinal (4 year) strong return on investment.
- Redesigning primary care models to develop intraprofessional collaboration and care teams is being tested in a number of sites and multiple health systems.
- Pharmacy-based medication monitoring and patient education is another strategy being implemented through both clinical and retail pharmacy sites.
- Patient engagement strategies such as use of Patient and Family Activators are being tested.
- There is a Minnesota pilot underway that focus on reducing utilization by patients with multiple conditions and/or disabilities and another that focuses diabetic patients with depression.

Minnesota is also in the midst of implementation of reforms that are changing the environment for health care services: accountable care organizations, health care homes, expansion of Medical Assistance. Efforts to improve care for diabetes and other chronic diseases in order to achieve the triple aim of

reducing costs, improving outcomes, and improving the patient experience are impacted by the challenges health care providers and payers are facing in addressing the other health system changes that are still evolving and creating uncertainty.

Process:

The group conferred about the Minnesota context for identifying evidence-informed practices and the individual and environmental factors that affect those with diabetes, particularly those with the highest burden of the disease. Next the group reviewed and considered strategies, models and approaches for improving diabetes care that are being implemented across the state and other parts of the country.

Ed Wagner's Chronic Care Model and Kate Lorig's work on patient self-management provided useful frameworks for discussion of what opportunities and gaps exist for improving outcomes for those with diabetes.

Conclusions:

While improvements within the health care systems need to continue, even optimal practices and decision supports within care systems cannot succeed without active patient engagement.

- Clinical services are only a small part of what patients need to successfully manage their disease. Patients and communities are an untapped resource in improving diabetes care.
- Care delivery and management needs to include community resources outside clinical services that enable the patient to successfully manage their chronic disease.
- Simple, inexpensive systems are needed that facilitate electronic information sharing between the patient, the community resources used by the patient and the clinical care providers.
- There is a need for additional data to inform decision making and to help communities identify existing gaps, assess patient needs, set measurement goals and monitor progress.
- A more patient-centered care model is needed that also recognizes the role that the community plays in the patient's ability to manage a chronic disease.

The findings and experience with diabetes care improvements can be readily applied to other chronic diseases. For example:

- Focusing on the barriers to care delivery and patient self-management are critical factors for improving outcomes and reducing costs.
- Measures of the patient experience are needed to identify needs and opportunities for improvements both within the care system and with the broader community.
- While many strategies for care delivery improvement and cost reductions are being implemented, there is a gap in formal evaluation and measurement which limits how Minnesota can determine which are successful solutions that could be scaled to improve care delivery.

- Many innovations are also coming from the field of practice. There is no systematic way to share what is learned in Minnesota which could help disseminate models for replication and/or develop consensus on best practices.

Savings are more likely to be achieved when interventions to address cost drivers focus on those patients with complications and/or complex health status.

- Current risk prediction models are not able to accurately predict the highest cost patients.
- There is evidence that patient engagement and providing community supports for care management can reduce the cost of care, improve outcomes and the patient experience.

There is general agreement that best practices in clinical care delivery include use of:

- Multi-disciplinary care teams that are fully trained and educated on diabetes care, that meet regularly, and whose members function at the top of their licenses.
- Common assessment tools, standardized tools and processes.
- Order and draw labs in advance of patient visits so results may be discussed at the visit
- Decision supports for practitioners such as Diabetes Wizard
- Patient registries to track care, in and out of clinical care sites
- Care plans and care coordination for chronic disease management in order to improve care for the most complex patients

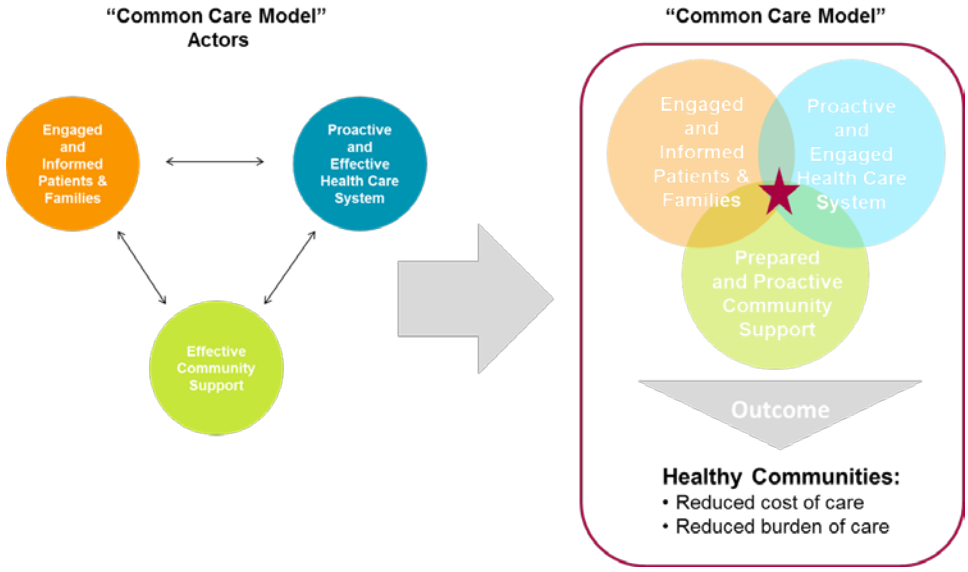
There are many opportunities and interest in collaboration between the health care providers and other community agencies and resources to improve outcomes and health status. Significant benefits can be obtained by fostering local decision making supported with local outcome and health status data and evaluations. Currently data is not readily available that can help local communities assess, plan, and measure outcomes and progress. There is also a recognition that care delivery needs to be attuned and responsive to the patients' cultural and community contexts.

Conceptual Framework for Care Improvement and Strategy Identification:

The work group is actively engaged in developing a new framework for care management that builds on Wagner's Chronic Care Model and incorporates elements of the Kate Lorig's Disease Self-Management model. The emerging framework, currently being called the "PACE Chronic Care Framework" focuses on the role and engagement of both the patient and his community supports in managing a chronic condition, and in the connections and information sharing between the patient, the community, and his health care team.

Group members have identified 3 main spheres in sustainable and responsive care delivery – **Patients**, **Health Care System** and the patient's **Community**. Along with determining what is needed to strengthen effectiveness within each domain, Workgroup #2 has focused on the interactions and exchange of information between the 3 spheres for overall care improvement and better outcomes. The diagrams below show the evolution of the group's thinking. The first graphic adapts the Chronic Care

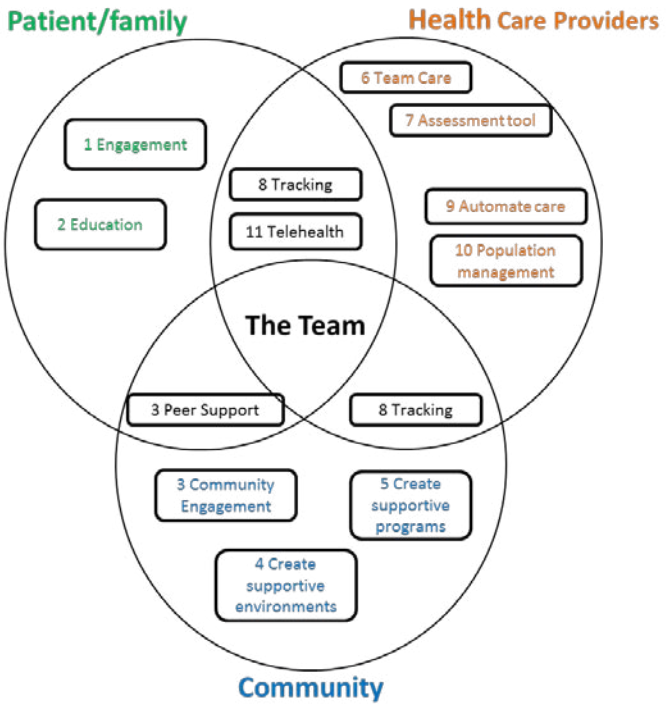
Model to strengthen the role and responsibility of the patient and the community to take action to improve health outcomes. This was referred to as the “Common Care Model”.



As the group examined the role of the patient and the community, there was a recognition that health care system improvements will continue to be necessary but will be insufficient to achieve the overall outcomes sought. The group’s discussion of the role of the patient, the community and the interface with the health care system evolved to the development of the “Patient-Activated, Community-Engaged (PACE) Chronic Care Framework”. This framework, as illustrated in the graphic below, envisions a *Patient, Community, Care system Team* approach to achieving health care cost reduction and reduction in the burden of care for those with diabetes or other chronic conditions.

DRAFT – Common Care Framework - Ultimate Team Care

What Do We Need to Do So That All Patients Thrive?
And What Tools Are Available?



1. Patients need to care and be engaged.
   - Motivational Interviewing
   - Group appointments
   - Supportive networks
   - Shared decision-making
2. Patients need appropriate education
   - Diabetes education
   - Self-management classes
   - Chronic disease self-management system
3. Family and Peer Support
   - Peer Education
   - Community activities

4. The community needs to be engaged
   - Culture, resources, listen
   - Conduct community assessment
   - Build relationships
   - Identify needs
   - Use data
5. The community needs supportive environments. For example:
   - Worksite wellness/incentives
   - Residential design/support

5. The community needs supportive programs. For example:
   - Business initiatives
   - Public programs
   - Built environment

6. **Medical care should be through a highly effective team**
   - **Each member functioning at the highest level of their ability**
   - **Chronic care training**
7. **Need consensus on what good care looks like**
   - **D5 for diabetes**
8. **Tool needed to measure and track patients**
   - **Registry**
   - **Information sharing**
9. **The right things should happen automatically**
   - **Protocols**
   - **Clinical pathways**
   - **Reminders**
10. **Attention should be given to managing the health of the entire population**
11. **Medical care should expand beyond the walls of our buildings**

Strategy Development:

Workgroup #2 is in the process of building a work plan based on reviewing potential activities for each of the 3 domains of the "PACE Chronic Care Framework". From the list of potential activities the group is currently assessing these strategies:

- **Identify diabetes indicators for community-based measurement, assessment and planning.**
  - Reliable and accessible data on diabetes outcomes is needed to inform decision making.
  - Process outcome measures are needed to measure progress in all domains. For example: measurement of self-efficacy for disease management and clinical decision-making, perceived social supports, knowledge of diabetes self-care practices.
- **Share successful practices and chronic care initiatives.**
  - Develop and publish a paper outlining the PACE Chronic Care Framework**:**
    - Field test and refine the framework through community and professional feedback
    - Develop a crowd source template for community contributions to the PACE framework development and for listing successful practices and interventions within each domain.
  - Convene a colloquium/learning collaborative for Minnesota care systems to share and disseminate learning
  - Provide evaluation consultation and resources to improve the reliability of findings and foster learning,
- **Engaged and Informed Patients & Families**
  - Provide point(s) of access and distribution of care management and health care information that patients, their families, and the community supports the patient is using (eg. school nurses, home care, public health able to access Clinical Care Respository.)
  - Identify communication strategies within and between health care providers and community resources
- **Prepared and Proactive Community**
  - Develop and use annual community health report using conventional and unconventional measures of health status and health outcomes
    - Identify measures of community engagement in care management
    - Add chronic disease management measures to the community health assessments required of local public health and of community hospitals. Encourage collaboration/joint efforts in conducting these community health assessment.
  - Identify ways to ensure the linkage of care systems and community institutions and assets

Members:

Joseph Bianco	Division Director	Essentia Health
Don Bishop	Manager, Center for Health Promotion	Minnesota Department of Health
James Deming	M.D. Family Medicine	Mayo Clinic Health System
Tammy Didion	Diabetes Prevention Planner - Clinic Coordinator	Minnesota Department of Health
Julie Hallanger-Johnson	M.D. Endocrinologist	Sanford Health System
Marit Hansen	Health Systems Senior Manager	Novo Nordisk
Marsha Hughes	Diabetes Educator	HealthEast
Nancy Flinn	Director of Research and Outcomes	Courage Center
Sheila Kiscaden	Project Manager	Decade of Discovery
Jennifer Lundblad	President and CEO	Stratis Health
Andrew Nelson	Director, Institute for Research and Education	Health Partners
Patrick O'Connor	Assistant Medical Director and Senior Clinical Research Investigator	HealthPartners Institute for Education and Research
Gary Oftedahl	Chief Knowledge Officer	Institute for Clinical Systems Improvement
Teresa Pearson	Director, Diabetes Services Innovative Health Care Designs	Halleland and Habich
Kevin Peterson	Professor of Family Medicine	University of Minnesota
Sharon Quinlan	Nurse Administrator	Essentia Health
Deb Smith	Bemidji Area Diabetes Consultant	Indian Health Service
Thao Mee Xiong	Health System Representative	Greater Twin Cities United Way

Workgroup #3: Data and Knowledge

Goal: Workgroup #3 members are providing support for the global CI strategy as well as Workgroups #1,2,4 for existing and new data needs to inform the success of our efforts. One example would be the supporting data needs for scaling the NDPP.

Context: The strategies of Workgroup #3 will be designed to develop data collection and reporting that will support efforts to improve the overall data landscape for persons at high risk of developing type 2 and gestational diabetes and for persons living with diabetes. The workgroup will also work in concert with Workgroup #1 and #2 to identify and prioritize data needs that will support strategies developed by these workgroups.

Workgroup #3 developed a landscape map of the data needs associated with identification and referral of persons eligible for the NDPP (see following page).

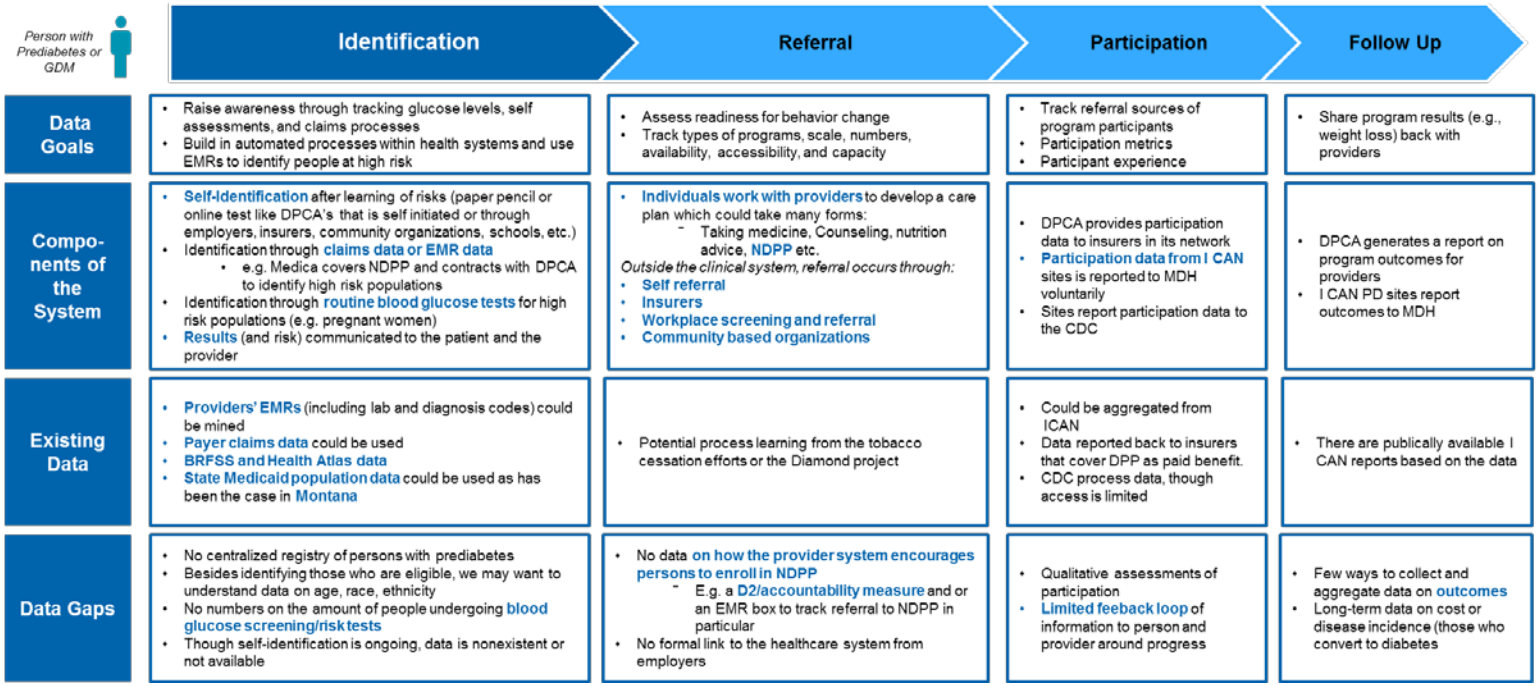
Workgroup #3 members have also launched a dialogue with the Peer Provider Grouping to begin to identify tangible ways that the work of the CI effort can inform the second phase of their analysis.

Strategy Development: In order to better inform decisions and respond to data requests emanating from Workgroup #1 (Prevention) and Workgroup #2 (Care Delivery), members of Workgroup #3 are now embedded in the strategy development process for each group.

Workgroup #3 members are supporting the strategy, scaling the NDPP, by reviewing current literature on translation of the NDPP specifically around cost, evidence and health outcomes and collaborating with the communications team as they develop the materials for select target audiences

Members

Jim Chase	President	Minnesota Community Measurement
Jay Desai	Researcher	HealthPartners Institute for Education and Research
Ryan Johnson	Masters Health Services Analyst Division of Health Care Policy & Research	Mayo Clinic Rochester
Mike Lynch	Payer/Clinician	Ucare
Renee Kidney	Diabetes Program Epidemiologist	Minnesota Department of Health
Darin Smith	Director, Health Mgmt Analytics at Medica	Medica
Steven A. Smith	M.D. Endocrinologist	Mayo Clinic Rochester
Jeanette Ziegenfuss	Manager, Data Collection Center	HealthPartners Institute for Education and Research


Person with Prediabetes or GDM
Identification
Referral
Participation
Follow Up
Data Goals
Raise awareness through tracking glucose levels, self assessments, and claims processes
Build in automated processes within health systems and use EMRs to identify people at high risk
Assess readiness for behavior change
Track types of programs, scale, numbers, availability, accessibility, and capacity
Track referral sources of program participants
Participation metrics
Participant experience
Share program results (e.g., weight loss) back with providers
Compo-nents of the System
Self-Identification after learning of risks (paper pencil or online test like DPCA's that is self initiated or through employers, insurers, community organizations, schools, etc.)
Identification through claims data or EMR data
e.g. Medica covers NDPP and contracts with DPCA to identify high risk populations
Identification through routine blood glucose tests for high risk populations (e.g. pregnant women)
Results (and risk) communicated to the patient and the provider
Individuals work with providers to develop a care plan which could take many forms:
Taking medicine, Counseling, nutrition advice, NDPP etc.
Outside the clinical system, referral occurs through:
Self referral
Insurers
Workplace screening and referral
Community based organizations
DPCA provides participation data to insurers in its network
Participation data from I CAN sites is reported to MDH voluntarily
Sites report participation data to the CDC
DPCA generates a report on program outcomes for providers
I CAN PD sites report outcomes to MDH
Existing Data
Providers' EMRs (including lab and diagnosis codes) could be mined
Payer claims data could be used
BRFSS and Health Atlas data
State Medicaid population data could be used as has been the case in Montana
Potential process learning from the tobacco cessation efforts or the Diamond project
Could be aggregated from ICAN
Data reported back to insurers that cover DPP as paid benefit.
CDC process data, though access is limited
There are publically available I CAN reports based on the data
Data Gaps
No centralized registry of persons with prediabetes
Besides identifying those who are eligible, we may want to understand data on age, race, ethnicity
No numbers on the amount of people undergoing blood glucose screening/risk tests
Though self-identification is ongoing, data is nonexistent or not available
No data on how the provider system encourages persons to enroll in NDPP
E.g. a D2/accountability measure and or an EMR box to track referral to NDPP in particular
No formal link to the healthcare system from employers
Qualitative assessments of participation
Limited feeback loop of information to person and provider around progress
Few ways to collect and aggregate data on outcomes
Long-term data on cost or disease incidence (those who convert to diabetes

Workgroup #4: Policy and Advocacy

Goal: The goal of Workgroup #4 is to support strong policy, advocacy and public awareness for diabetes prevention and care delivery.

Context: The strategies of Workgroup #4 will be designed to support the strategies of Workgroups #1 and #2, as they relate to advocacy and awareness activities. Due to the large advocacy and communications need of the first strategy identified by Workgroup #1, Workgroup #4 has partnered with Workgroup #1 to develop a set of actions to support NDPP expansion in Minnesota. As advocacy and awareness needs of Workgroup #2 are articulated, Workgroup #4 will also assist in those activities.

Strategy: The first strategy selected by Workgroup #1 and approved by the full Planning Group is to scale the CDC's National Diabetes Prevention Program (NDPP) in Minnesota. Workgroup #4 members are leading the following workstreams and contributing a communications/advocacy perspective to the other activities underway to support the NDPP scaling:

- Development of a communications plan to support the scaling of the NDPP
- State engagement for Medicaid coverage and state employee health plan coverage

Members

Jeanne Ayers	Assistant Commissioner	Minnesota Department of Health
Susie Bell	Account Supervisor	Himle Rapp
Dana Boyle	Vice President of Community Engagement	LifeScience Alley
Mike Connelly		Governor's Task Force on Health Care
Mitchell Davis	Intersection Director	Minneapolis Urban League
Dave Ellis	Freelance Guide and President/CEO	Dave Ellis Consulting
David Etzwiler	Executive Director	Decade of Discovery
Fred Haberman	CEO and Co-Founder	Haberman Inc
Clarence Jones		Southside Community Health Services
Mary Manning	Director, Division of Health Promotion and Chronic Disease	Minnesota Department of Health
Tee McClenty	Executive Vice President	SEIU Healthcare Minnesota
Jim McGowan	Executive Director	Midwest Alliance of YMCAs
Kathy Mock	Healthcare advocacy	Ex- Blue Cross Blue Shield
Carolyn Pare	President and CEO	Minnesota Health Action Group
Laurel Reger	Diabetes Planner	Minnesota Department of Health
John Stieger	Retired Director of Communication	Minnesota Department of Health
Fartun Weli	Founder / Executive Director	The Isuroon Project
Ghita Worcester	Sr VP Public Affairs and Marketing	UCare
Donna Zimmerman	Policy Expert	Health Partners Institute for Education and Research

Metrics and Indicators

A Shared Measurement System Will Create Alignment and Accountability for the Initiative

A **shared measurement system** is the use of a common set of measures to monitor performance, track progress toward goals, and to learn what is working and not working. The Minnesota Diabetes Collective Impact Initiative recognizes the benefits of such a system and has committed to establishing a plan to develop the necessary metrics and indicators in the next few years. The goals of this system will be two-fold: 1) to hold us accountable to our partners, the communities we seek to serve, and Minnesota as a whole; and 2) to allow us to gauge the effectiveness of our strategies and tactics in order to alter or change them over time to improve the effectiveness of the effort as the Initiative matures.

The benefits of shared measurement in Collective Impact include:[28]

- Greater alignment among the goals of different organizations
- More collaborative problem solving
- Formation of an ongoing learning community that gradually increases the effectiveness of all participants

Characteristics of Effective Indicators

In order for the shared measurement system to be effective it is vital that we select effective indicators. There are many characteristics of effective indicators. Some include that they are metrics that the end users (residents of Minnesota, policy makers, participants in the Minnesota Collective Impact Initiative) agree are useful and relevant;- they must be well-understood.by persons in and out of the medical field; the measure needs to be linked to the strategies and desired outcome of the initiative; the data must come from a reliable and trustworthy source;; collection must fit within the budget of the Initiative, the data must be relatively recent and available over time so that we can track the progress of our strategies; the data must be useful in the day to day work of the Planning Group, workgroups, or partner organizations/ coalitions also working to prevent and treat diabetes in Minnesota. [29] [30]

Next Steps for Indicator Selection

The Minnesota Diabetes Collective Impact Initiative recognizes that we have already taken the first vital step at establishing an effective shared measurement system: developing a collective effort, with broad engagement by organizations across the field and the state. We are in the process developing a “logic

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[28] Hanleybrown, Fay. FSG blog post: “Shared Measurement in Collective Impact”. Available at: http://www.fsg.org/KnowledgeExchange/Blogs/SocialImpact/PostID/166.aspx. Accessed February 11, 2013.

[29] Kramer, Mark, and Kania, John, “Collective Impact,” *Stanford Social Innovation Review,* 2011.

[30] http://www.cdc.gov/obesity/downloads/CDC-Evaluation-Workbook-508.pdf

model" that provides a more detailed diagram of which how our strategies will be implemented and the desired activities, outputs and outcomes expected for each. This will help to guide conversations about evaluation in an iterative fashion – informing the evaluation, leading to refinements in our logic model, which in turn will allow improved clarity in our evaluation. As we move forward members of the Initiative will need actively participate in these conversations. Additional conversations around confidentiality and transparency when collecting, sharing and distributing data will be needed. Also, members will need to devise a plan to secure appropriate baseline data in order to make comparisons and track progress.

Preliminary Workgroup Indicators

Workgroups will need to begin the process of selecting the indicators for our shared measurement system through in depth conversations around the strategies included in the logic model. These indicators will include process and outcome indicators. Process indicators that track activities stemming from the tactics or interventions chosen by the Initiative and depicted in the logic model that are critical to achieving desired outcomes. Outcome indicators can be used to mark progress against outcomes we hope to see improved as a part of the logic model specific to each strategy and, perhaps, the overall Theory of Change. The combination of these indicators will help us to understand what factors make implementation of our strategies more favorable and what barriers, allowing us to learn, are revise our approaches and keep the initiative moving forward. Population-based indicators will be included because of their importance for state policymakers and broader strategic thinking in Minnesota around diabetes. [31]

Each workgroup will need to review their strategies and with input from workgroup 3, examine a variety of potential indicators and discuss these candidates over the next few months to determine if they meet all characteristics for effective indicators.

Development of the indicators is an iterative process and certain indicators may take time to create. Future indicators may drill down deeper to look at smaller sub-sets of the population, or focus on specific activities the Initiative or workgroup is engaging in. Ultimately, we hope that these indicators will allow us to document Minnesota's progress toward achieving its goals.

[31] http://www.cdc.gov/obesity/downloads/CDC-Evaluation-Workbook-508.pdf

Transition

Establishing a plan to continue to support the Minnesota Diabetes Collective Impact Initiative is critical to maintain the momentum that has been built while the backbone is being formed

Over the last months the Executive Team (ET) has spoken with many organizations throughout Minnesota to gauge their interest in becoming a backbone organization for the Initiative, or offering services or resources to establish a backbone organization. While these conversations have been helpful to better understand the needs of the state as it relates to the overall effort, the ET will need more time to identify who will be involved and determine the necessary structure that can fully support the entire effort. In the meantime, a combination of ET members and workgroup members, specifically those from MDH, will help to provide the necessary support as the effort continues. There are four main foci for the transition: 1) Maintain Strategic Coherence of the Effort, 2) Help Coordinate the ET and Planning Group (PG), 3) Continue Fundraising and Outreach and 4) Support Individual Workgroups.

The following are a list of the activities that FSG has been engaged in as well as future activities needed to support the work of the Minnesota Diabetes Collective Impact Initiative. In the transition period between FSG's departure and the identification of the backbone organization, individuals or organizations will need to be identified to move these activities forward. Effective completion of the transition plan should assure that the Initiative does not lose momentum. These activities will happen in parallel to the efforts to establish a backbone. Once the backbone is in place many of these duties will be transferred to the backbone and its staff.

Activities shared with light blue are Logistical/Tactical Activities: Activities that involve logistical support, internal communication, note-taking and dissemination, and scheduling. All other activities are Strategic Activities: Activities that involve strategic oversight, external communication, research and evaluation, or policy. Finally, those activities that will involve substantive content work are **bolded**.

1. Maintain Strategic Coherence of the Effort

A. Accountability, Evaluation, & Guidance

	Owner
I. Analyze and monitor progress (including workgroup progress) against specific strategies identified by workgroups, and more broadly against goals as outlined in workgroup charters	ET
II. Continue to develop outcome indicators and performance measures to evaluate progress and to inform system improvement	Co-chairs
III. Begin to collect indicators and develop data collection processes	**Co-chairs; WG members**
IV. Monitor outcome indicators and performance measures related to workgroup to evaluate progress and to inform system improvement	Co-chairs; ET

B. Knowledge Sharing, Overall Logistical Support

		Owner
I.	Coordinate research and other activities currently underway by members of the CI Initiative	Co-chairs
II.	Encourage sharing of best practices among the Executive Team, Planning Group members, and the workgroups	ET
III.	Monitor and enable easy dissemination of Implementation Plan	David Etzwiler; Haberman
IV.	Provide overall logistical support (any logistical support not directly related to Executive Team meetings, Planning Group meetings, co-chair calls, or workgroup meetings)	ET, MDH

2. Help Coordinate through ET and PG

A. Management and Facilitation

		Owner
I.	Identify and raise issues / concerns with the Executive Team and Planning Group	David Etzwiler; Gretchen Taylor
II.	Assist development of agendas (may provide draft agenda) for Executive Team meetings, workgroup meetings, and other meetings as necessary	David Etzwiler; Gretchen Taylor
III.	Guide meeting agendas at weekly Executive Team meetings, workgroup calls, co-chair calls	ET
IV.	**Create decks and materials for Executive Team meetings, Workgroup meetings, and other meetings as necessary**	**David Etzwiler; Gretchen Taylor**
V.	Follow-up and manage next steps that come out of Executive Team meetings, workgroup meetings, and other meetings as necessary	David Etzwiler

B. Logistics

	Owner
I. Manage meeting logistics (e.g., dial-in, attendance, cancellations, etc.)	MDH Support
II. Consolidate workgroup updates for Executive Team and Planning Group	ET; MDH
III. Notify Planning Group and / or Executive Team of concerns or issues that might stall advancement	Co-chairs; MDH
IV. Coordinate weekly calls with Executive Team (as well as co-chairs, workgroup meetings, and Planning Group meetings as well)	MDH Support
V. Summarize meeting notes and next steps	MDH

3. Fundraising and Backbone

	Owner
I. Facilitate communication between the Executive Team, Planning Group, co-chairs, and workgroups to understand challenges at the workgroup level and strategic coherence at the Executive Team level	Co-chairs; MDH
II. Develop external communications materials and comprehensive communications plan	David Etzwiler; Haberman
III. Actively campaign for further funding and maintain relationships with existing funders; respond to funder requests for information	David Etzwiler; ET
IV. Continue backbone discussion and finalize backbone	ET

4. Support Individual Workgroups

	Owner
I. Assist development of agendas (i.e. provide draft agenda)	Co-chairs; MDH
II. Develop materials for workgroup meetings	**Co-chairs; MDH**

III. Develop talking points for workgroup co-chairs to guide their facilitation of workgroup meetings *(if needed)*	MDH
IV. Support the co-chairs to facilitate meetings as needed *(if needed)*	MDH
V. Follow-up and manage next steps that come out of workgroup meetings	MDH
VI. Ensure attendee lists are up to date	MDH Support
VII. Assist workgroup co-chairs with completing report back to groups	MDH
VIII. Help workgroup co-chairs incorporate Executive Team feedback	MDH
IX. Manage meeting logistics (e.g., video conferencing, attendance, lunch, cancellations, send final lists to admin staff etc.)	MDH Support
X. Print meeting materials and talking points	MDH Support

Note on Transition Plan: *The above outlines the main activities that FSG has been involved with over the course of Phase III; MDH will develop a method that's most efficient for its staff in getting the work done over the Transition Phase of the project*

Backbone Organization

Backbones provide the infrastructure support necessary for Collective Impact efforts to maintain alignment, be responsive to the community and thus sustainable

From the beginning of the effort, the ET and PG have been committed to the 5 conditions of Collective Impact, including the establishment of a backbone to complement the efforts of the groups providing oversight for the Minnesota Diabetes Collective Impact Initiative. Within this Collective Impact effort, the backbone organization will provide the supporting infrastructure to coordinate work among partners and push forward the overall Initiative. Based on the experience of similar efforts across the country, a robust backbone function is a key success factor to sustaining Collective Impact. As mentioned in the Transition section, throughout Phase II of the effort the ET has consulted with many existing organizations throughout the state to determine interest and capacity to be a backbone. There are 6 core activities of a backbone:

Given prevention and care delivery are at different places with their strategy development, this mix of activities will vary depending on the capacities of the workgroups moving forward. Initially the backbone will need to focus on the same four workstreams that were shared in the Transition section: 1) Maintain Strategic Coherence of the Effort, 2) Help Coordinate the ET and PG, 3) Continue Fundraising and Outreach and 4) Support Individual Workgroups.

As part of that search the ET looked for organizations that exhibited the following characteristics:

- Perceived as a **neutral convener and honest broker**

- Viewed as a **credible organization** with deep relationships and knowledge throughout Minnesota
- Committed to making the Collective Impact effort **one of its top 2-3 priorities**
- **Dedicated staff** experienced in **strategy development, group facilitation, data analysis,** and **public and community advocacy and communication**
- Have **topical expertise** in public health, specifically diabetes prevention and care and chronic care management
- Able to **raise sufficient financial resources ($300K+ annually)** from a **range of sources (i.e., private sector, foundations, government)**

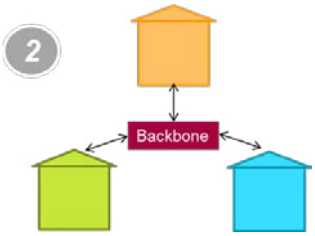
Defining a Backbone Structure

The ET also examined different structures to help determine which one would be responsive to the unique needs of Minnesota around the issue of diabetes. While the backbone role is often played by a single organization, networks of individuals or a shared service model across organizations may also prove effective. The following illustrates the top four models that were considered; with model #1 being the most promising structure to pursue:

Description: A respected and neutral non-profit functions as the administrative home for the backbone with its leadership coming from outside (e.g., Decade of Discovery)

Pros: Share resources; Freedom to manage

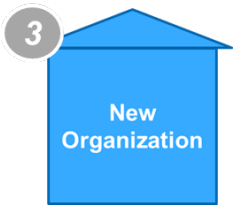
Cons: Decision-making can be confusing



Description: Existing organizations work together to provide resources and staffing for the backbone (e.g., Decade of Discovery working together with another organization, such as a local university)

Pros: Broad buy-in; expertise; May be easier to raise funds

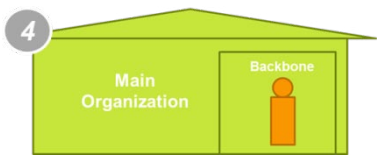
Cons: Difficult to manage, Less accountability; Coordination challenges



Description: Establish a new nonprofit

Pros: Neutrality, no "baggage"; Clarity of focus; Resources devoted to the Initiative

Cons: May be seen as "competitor"; Time intensive to create



Description: The backbone sits within an existing organization (e.g., a local university)

Pros: Credibility and network; Existing infrastructure

Cons: Potential "baggage"; Not seen as neutral; Lack of enthusiasm among existing players

Staffing & Budget Guidance

It is FSG's experience that the following roles will be a necessary part of any backbone as it provides support to the Initiative. These roles can be fulfilled through a combination of full-time and part-time employees. FSG recommends at least two staff members are initially hired full-time to continue to make progress on the workstreams: an Executive Director and Project Coordinator.

Recommended Staff Positions	Required Skills	Description	Hiring Timeline
Executive Director	• Collaborative relationship builder • Respected and influential • Focused but adaptive • Servant leader	• Organizational leadership and development of the entire initiative • Oversees all functions with a focus on strategy and data • Advisor to Workgroups and key stakeholders in the community • Serves as a public ambassador for the initiative	ASAP
Project Coordinator	• Analytical • Plug and play where needed • Ability to skillfully manage multiple logistics at once	• General project management and tracking of key workstreams • Assist in some administrative tasks, including scheduling for the Executive Director, event planning, and office operations • Supporting workgroup co-chairs in analyzing and synthesizing materials before workshops	ASAP
Facilitator	• Collaborative relationship builder • Effective communicator	• Along with ED, facilitates Workgroup and Planning Group meetings • Builds relationships and urgency among existing and new members • Outreach to community members and key partners to learn and strengthen prevention and care delivery strategies	Q3-Q4 of 2013
Community Outreach Manager	• Effective working behind the scenes to facilitate connections • Skilled operator with trusted relationships • Policy development acumen	• Outreach to community members and key partners throughout the state • Develops and executes communications plan for multiple audiences including employers, providers, and plans	End of 2013 – 2014

As the effort grows, the initial backbone staff can look for support in shared measurement and external communication.

Outsourced Support	• **Analytical** • **Effective communicator**	• **Shared Measurement:** Gather, analyze, and use data to inform changes in prevention and care delivery strategies • **External Communication:** Execute on broad-based communication plan for MN once strategies for prevention and care delivery are finalized

Below is a ***sample yearly budget*** for a backbone organization. Note that the actual budget for the backbone for this Initiative may be lower. The budget below assumes the salary for the Executive Director is already paid from another source and that the office is paid for in kind.

Expense Category	Budget	Description
Salaries	--	1 FTE Executive Director; assuming existing salary
	50,000	1 FTE Project Coordinator
	60,000	1 FTE Facilitator
Total Benefits	27,500	(25% of salaries)
Communications	30,000	Website, collaterals, media
Community Outreach	40,000	Events, community outreach, space rental
Data Support & Evaluation	100,000	Data consultants and technology systems
Travel & Meetings	20,000	Workshops, events, retreat
Office	--	Assuming in kind/paid rent, utilities, supplies
Administration	28,000	Back office admin, postage, miscellaneous
Total Expenses	**$355,500**	

Next Steps to Launching the Backbone

Launching a backbone for the MN Diabetes Collective Impact Initiative will involve a continued focus on staffing and fundraising. Dedicated staffing would need to be hired and/or drawn from existing organizations. To support the staff and outreach that is necessary, the backbone will need to put forth its own fundraising effort and contribute to its funding. The ET is working and will continue to work on securing additional funds. Currently, there are 8 funders who have supported Phases I and II. There are multiple conversations going on with organizations to sponsor this work moving forward. The ET has begun a second round of focused conversations with a potential backbone partner organization that will continue into early March. In the meantime, as laid out in the Transition section, various members of the Collective Impact effort will be serving different roles that a backbone would traditionally serve until the official backbone is up and running.

Community Engagement

Community engagement will be critical in ensuring lasting ownership of the Initiative and its results.

From the early days of the Initiative, Planning Group and workgroup members have articulated the need to engage community members – those who will help shape and ultimately be affected by our work. At the same time, the PG has recognized the need to make some preliminary strategic decisions and to set up some initial processes before engaging the community broadly to ensure that those interactions are most productive.

At the end of Phase II, several members from the Initiative have come together to identify the key components of community engagement, to take place over the course of 2013 (Phase III). The different components of community engagement are: (1) goals (the "why"); (2) definition (the "who"); and (3) and community engagement mechanisms (the "how").

The "Why"

Before engaging the community it will important for the Initiative to articulate why this is necessary. The reasons to engage the community may be different depending on the workgroup and the strategies, and may also change over time for a given strategy. There are a range of goals for engaging the community:

- Build **public will** and create a sense of urgency
- Gather the **input** from community members and explain the work
- Get **feedback** on specific strategies and indicators from community members
- **Co-create solutions** through innovative problem-solving rooted in the "lived-experience" of the community
- **Ensure ownership** by empowering others to lead and see themselves as part of the solution
- **Build skills and capacity so community members lead implementation and benefit from the resources devoted to the work in their community.**

The "Who"

For the purposes of this document and the Initiative, community engagement refers to ***individuals*** in the community who potentially stand to benefit from the work of the Initiative. Members from low-income, minority, immigrant, and rural communities will be a particular focus for the community engagement process.

In addition to engaging individuals through community engagement, different workgroups or the Planning Group may identify other *stakeholder groups* to engage and seek feedback from. For example, Workgroup #2 (Care and Treatment) may decide to engage providers to seek feedback on the Common Care Model. Other examples of these potential stakeholder groups include: youth, women with gestational diabetes, diabetes trainers, physicians, nurses, community health workers, insurers, pharmaceutical and medical device companies, and private sector employers in the state.

The "How"

Once the goals of community engagement have been identified, the individual Collective Impact workgroups will develop the methods for conducting the engagement. Wherever possible, we will aim to leverage the lessons and methods of existing efforts, recognizing that a number of community engagement efforts already occur in the state. The workgroups will need to:

- Identify **champions / connectors / representatives** who can help to link us with our targeted constituencies
- Develop **a timeline** – are there players who should be engaged earlier or later due to political factors or a critical path that requires sequencing?
- Determine **key messages or questions** for the groups we plan to engage

A number of mechanisms can be used for community engagement, including:

- Focus groups
- Community meetings
- Town halls
- Conferences
- Surveys
- Media campaigns

Work to Date

A small group of members from the Initiative met in February, 2013 to begin to identify the community engagement approach for Work Group 1's focus on diabetes prevention. Over time, community engagement for Work Group 2 will be undertaken as well. The members of the initial community engagement group are:

- Michael Connelly, The Governor's Task Force on Health Care
- Mitchell Davis, Minneapolis Urban League
- David Ellis, Dave Ellis Consulting
- David Etzwiler, Decade of Discovery
- Alfred Babington Johnson, Stairstep Foundation
- Clarence Jones, Southside Community Health Services
- Jim McGowan, American Diabetes Association
- Carolyn Pare, Minnesota Health Action Group
- Gretchen Taylor, Minnesota Department of Health
- Hua Vue-Her, University of Minnesota's Extension Center for Family Development
- Fartrun Weli, The Isuroon Project
- Thao Mee Xiong, Greater Twin Cities United Way

The key takeaways and next steps articulated at this meeting were:

- Identify and document **community leaders and connectors associated with target communities**:

  - Support overall diabetes/prediabetes awareness and NDPP program availability
  - Specifically engage and partner with communities to aid legislative efforts
- Develop **background materials for introductory outreach** to community leaders and connectors:
  - CI Initiative and NDPP backgrounders, noting differences between other efforts/programs
  - Specific health indicators and benefits available to target communities
  - Details on MDH grants and NDPP program availability to target communities
  - Engage community leaders in conversation about how best to further engage community in dialogue, and as true two-way partners moving forward
- Engage **broader communities in conversation around diabetes and prediabetes awareness and the NDPP and its availability and efficacy**
- Implement **ongoing community engagement action plan based on conversations;** action plan led in part by community leaders and connectors and the communities at-large

Appendix A

Frequently Asked Questions about this work

1. What is Collective Impact?

   FSG (www.fsg.org), a nonprofit strategy consulting and evaluation firm, has been engaged by the Planning Group to facilitate the development of a Collective Impact effort to address diabetes in Minnesota. FSG has written about and led the development of several Collective Impact initiatives, which they define as the commitment of a group of cross-sectoral actors to a common agenda for solving a complex social problem. Collective Impact is **distinct from other collaborations** in that it has five unique features: a common agenda, shared measurement, mutually reinforcing activities, continuous communication between the actors, and a backbone organization that coordinates and manages the effort. FSG has launched Collective Impact efforts in a number of communities across the country, focusing on such issues as youth substance abuse, education, and juvenile justice. FSG has also published two seminal articles in *Stanford Social Innovation Review* on best practices for Collective Action.

2. Why is Collective Impact the right approach for addressing diabetes in Minnesota?

   The innovation of Collective Impact lies in a *new process* for working together. While Minnesota has performed better than several other states and has strong assets to address diabetes, progress needs to be accelerated. More than 1 in 3 adults in the state have diabetes or pre-diabetes and treating diabetes costs the state about $2.7 billion every year. While new practice and tools can help, **systemic challenges** between the different actors also stall progress. These challenges include inadequate sharing of information, working in pockets of "isolated impact," lack of coordination between organizations and their leaders, misaligned incentives, and sub-optimal use of data to make informed decisions. By developing a Common Agenda, bringing multiple actors together, and sustaining momentum through a backbone organization, a Collective Impact effort can help address systemic these challenges in a way that has not been done before.

3. Minnesota has many partnerships focused on diabetes. What is unique about this effort?

   This effort recognizes the significant collaboration that distinguishes Minnesota and will take advantage of those existing partnerships. However, Collective Impact brings several unique factors typically not seen in other collaborations: (1) the **leadership** of a range of organizations represented by those with the **authority to make decisions**; (2) **aligning activities** of organizations, not just sharing of information; (3) **accountability** for making change based on an agreed-upon set of indicators; and (4) a **backbone organization with dedicated staff** moving the effort forward.

4. Who will lead this effort?

   The Collective Impact effort will be overseen by a **Planning Group** comprising of government, business, provider, health system, nonprofit, community representatives, and funders, among others. Over the first four months during the launch of this effort, the Planning Group (PG) has met for a half day session least once a month, providing leadership and guidance to FSG. Eventually, the work will be led and facilitated by a **backbone organization** with dedicated staff and resources. The

PG will make a decision on the selection and establishment of the backbone, and will continue to provide guidance to the backbone. In addition, a number of **workgroups** will be developed with guidance from the PG, which will be responsible for developing indicators, strategies, and carrying out the activities of the effort. The backbone organization will be responsible for bringing together the workgroups as needed to align their work and report to the PG.

5. What are the goals and scope of the Collective Impact effort?

   Collective Impact is an evolving journey, and the full launch of an effort typically takes 12 – 18 months. During the first four months of this effort, the Planning Group has defined the challenges of diabetes in Minnesota, developed a long term vision, and selected the target populations and goals of this effort. These have been summarized in the Common Agenda document.

   The specific strategies for the effort will be developed by the workgroups and with input from communities. Over the next five months, the PG will identify the workgroups and members, identify candidates for the backbone organization, and oversee the workgroups in developing specific strategies and indicators.

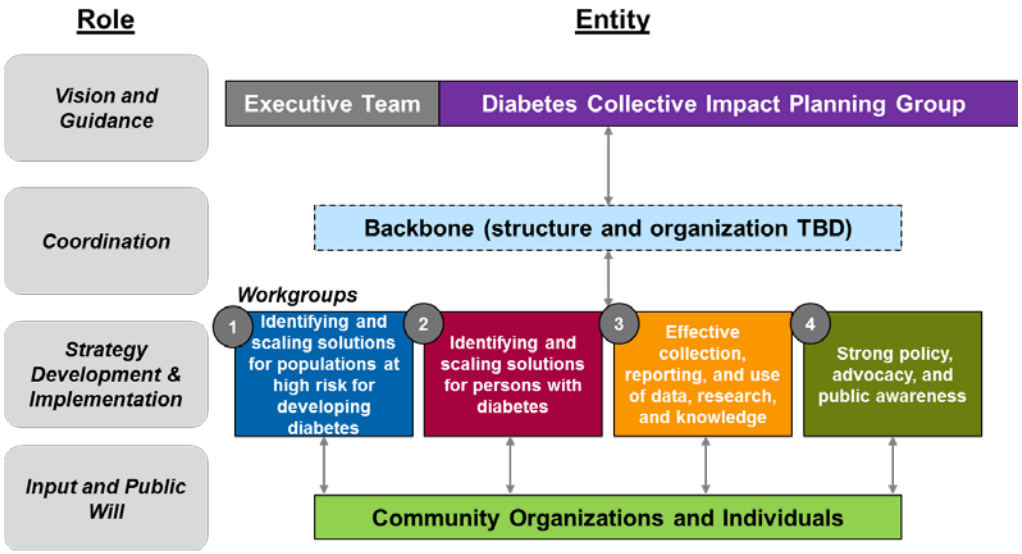
6. How will the Collective Impact effort learn from existing work?

   Collective Impact is about **leveraging the assets and actors that exist, rather than duplicating efforts**. For example, the MDH Steering Committee has laid the ground work for identifying critical challenges and opportunities to address diabetes in the state. Our goal is not to duplicate, but to learn from and build upon the work the Steering Committee and others have done on this issue. To facilitate that learning and coordinate efforts, several MDH Steering Committee members sit on the Collective Impact Planning Group. In addition, we will engage a number of other actors through interviews in the process to make sure we learn from their work. As the CI work progresses, we will continue to work closely with the various organizations working on diabetes to engage them as part of this partnership and learn from their work.

Appendix B

Governance Structure and Decision Making Processes

The Effort Will be Led by the Planning Group, with Close Coordination among Workgroups and Input from the Community



While This Effort Strategy Development Process Happens from the Bottom-Up, the Decisions Are Ultimately Made at the Top

Governance and Decision Making

- **Workgroups** are at the heart of the effort; they identify strategies and activities and **make recommendations to the Planning Group** for approval
- **Planning Group** reviews all **strategy** recommendations from workgroups and **approves for further action**
- For addition of **new members** to workgroups, co-chair(s) propose names to the **Executive Team** (ET) and ET approves
- For any questions or suggestions pertaining to a workgroup, **respective co-chairs to be contacted**

The Planning Group Provides the Overall Guidance and is Responsible for Approving the Strategic Direction of the Effort

Key Responsibilities of Planning Group

- Offer **long term direction and guidance** to the workgroups and overall effort
- Review workgroup recommendations on strategy, refine, and **approve strategies**
- Monitor **progress of activities** against indicators to ensure accountability
- **Champion this effort** to policymakers, funders, and other key stakeholders in the state
- **Oversee backbone selection progress** and provide **guidance to backbone organization**

Workgroups Play an Important Role in Ongoing Strategy Setting, Community Engagement, and Execution of the Effort

Workgroup Structure

- Workgroups are **led by two co-chairs**, each from a different organization, with rotational leadership
- Workgroups will **consist of ~8 representatives** of different organizations and communities, bringing skillsets relevant to the nature of the workgroup goals
- Members should have authority to **represent organizations and make decisions**, though there is no requirement for a specific level of seniority

Key Responsibilities of Workgroups

- **Identify effective strategies to support achievement of goals:**
  - Investigate effective evidence-informed strategies
  - Use data to inform identification of strategies
  - Suggest refinement of impact measures based on strategy development (as needed)
  - Identify funding sources and local agencies to support strategies
- **Community engagement:**
  - Engage communities and varied stakeholder groups for input within workgroups and through relevant stakeholder dialogues
  - Coordinate with other workgroups to ensure effective engagement and communication with varied stakeholders and communities
- **Implementation:**
  - Coordinate activities among workgroup members and others in the community to implement strategies
  - Dedicate time to tactics of planning events, identifying volunteers

The Co-Chairs Will Lead and Facilitate the Workgroups

Co-Chair Roles

- **Prepare for each workgroup meeting** with support from **the Executive Team and FSG** through one or two hour-long calls each month
- **Jointly lead and facilitate** the workgroup meetings or calls
- **Report back to the Planning Group** and coordinate with the co-chairs of the other workgroups as needed

Proposed Membership Processes for Planning Group and Workgroups

Process Step	Planning Group (PG)	Workgroups
Identifying Members	• Members may be suggested by anyone to the ET • Generally, only one member per organization, unless that member fills a critical unmet need on the PG	• Members may be suggested by anyone to the workgroup Co-Chairs
Approving New Members	• Members must be approved by ET	• Members must be approved by both Co-Chairs and ET
Inviting Members	• Any PG/WG member can propose to ET • ET can invite new members	Co-Chair(s) propose names to ET and ET approves
Member Requirement	• Consider MOU	• Consider MOU
Inviting Guests to Attend Meetings	• Meetings are generally closed to non-members • ET may invite a relevant non-member presenter • PG members must get any guests approved by ET	• Meetings are generally closed to non-members • Workgroup Co-Chairs may invite a relevant non-member presenter • Workgroup members must get any guests approved by Co-Chairs

Appendix C

Full List of Workgroup Members

Minnesota Diabetes Collective Impact Planning Group Members

(29 Members)

Ann Albright *Director, Division of Diabetes Translation*	Centers for Disease Control and Prevention	Aga6@cdc.gov
Jeanne Ayers *Assistant Commissioner*	Minnesota Department of Health	Jeanne.ayers@state.mn.us
Don Bishop *Manager, Center for Health Promotion*	Minnesota Department of Health	Don.bishop@state.mn.us
Dana Boyle *Vice President of Community Engagement*	LifeScience Alley	dboyle@lifesciencealley.org
Jim Chase *President*	Minnesota Community Measurement	chase@mncm.org
James Deming *M.D. Family Medicine*	Mayo Clinic Health System	deming.james@mayo.edu
Dave Ellis *President and CEO*	Dave Ellis Consulting	wdellis1951@yahoo.com
Jim Eppel	Formerly, Blue Cross and Blue Shield of MN	Jamesweppel@gmail.com
David Etzwiler *Executive Director*	Decade of Discovery	etzwi004@umn.edu

Fred Haberman *CEO and Co-Founder*	Haberman, Inc	fred@modernstorytellers.com
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Appendix D

MINNESOTA DIABETES COLLECTIVE IMPACT INITIATIVE

Implementing proven solutions statewide.

Momentum is Growing

Stakeholders from across the state have committed to the initiative, including the State of Minnesota and numerous payers, care systems and related health and community organizations. The Minnesota Department of Health, Decade of Discovery, HealthPartners, Blue Cross and Blue Shield of Minnesota and UCare have provided seed funding to implement the initial priorities of the initiative.

During the summer of 2012, Initiative representatives formed a Planning Group and developed a Common Agenda for Tackling Diabetes. The Initiative differs from other collaborations in several important ways, including the development of a common agenda, mutually reinforcing activities, continuous communication, shared measurement and a backbone organization to drive the process over time. (Kramer, Mark, and Kania, John, "Collective Impact," Stanford Social Innovation Review, 2011)

Initial Priorities

The Planning Group has created four workgroups to carry out the Initiative's initial priorities:

1 **Workgroup #1**
Identify and Scale Solutions for Preventing Diabetes among Populations at High Risk.

2 **Workgroup #2**
Identify and/or Scale Solutions to Improve Care for People with Diabetes.

3 **Workgroup #3**
Ensure Effective Collection, Reporting and Use of Data, Research and Knowledge.

4 **Workgroup #4**
Support Strong Policy, Advocacy and Public Awareness.

Initial Prevention Strategy

The Diabetes Prevention Program, a randomized intervention trial conducted by the National Institutes of Health (NIH), showed that Type 2 diabetes was prevented or delayed by 58% over a three-year period in people with prediabetes who ate more healthfully, increased physical activity, and lost a modest amount (7%) of their body weight. (New England Journal of Medicine, 2002:346:393-403)

While the Initiative recognizes other proven interventions will and must play a role in an effective community prevention effort, the Planning Group sought to intervene first where it could demonstrate the greatest health returns for those at risk of Type 2 diabetes and the highest cost savings for public and private payers.

As a result, the Initiative's Prevention Work Group will focus on making the Centers for Disease Control and Prevention's (CDC's) National Diabetes Prevention Program available to all Minnesotans as its initial prevention strategy. This prioritization is consistent with the recommendations of the American Diabetes Association and Minnesota's Governor's Task Force on Health Care Reform. To the extent other prevention models and lifestyle change programs with equivalent health outcomes emerge, they will be considered.

In addition to its focus on prevention, the Initiative is actively identifying proven strategies for improving care and supporting self-management among people with diabetes in Minnesota.

How to Get Involved

If you would like to learn more or get involved, please email the Minnesota Diabetes Collective Impact Initiative co-chairs:

Andy Nelson
Executive Director

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All statements and conclusions, unless specifically attributed to another source, are those of the authors and do not necessarily reflect those of the other organizations or references noted in this report.

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