

Washington State Diabetes Network Leadership Team:

2017 Evaluation Update

Washington State Department of Health

Chronic Disease Unit

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SUMMARY: Similar to previous evaluations of the Washington State Diabetes Network Leadership Team (DNLT), the current evaluation of the team provides ample evidence of a voluntary organization being well-managed. Observations of team meetings and interviews with team members reveal an organization where there is goodwill between members and relatively little indication of strife, where members are highly motivated, intelligent, well-trained and experienced in dealing with the daunting challenges of containing diabetes within the state.

Nevertheless, in spite of many positive characteristics and overall high functioning, the group still faces many challenges, some new, others endemic. New challenges include dealing with the growth of DNLT membership over the past two years. Endemic challenges, which are somewhat ironic given the steady growth of the group, include increasing the diversity of viewpoints within the group such as those from Latinos, American Indians, African Americans, East Asians, Samoans and other Pacific Islanders, and especially receiving the input from those dealing directly with diabetes. The following evaluation is meant to provide the DNLT with observations and points of discussion which may be used, if found useful and relevant by team members, to further improve a highly functioning organization.

BACKGROUND TO THE EVALUATION

Beginning in 2015, this is the fourth process evaluation of the DNLT completed by the author. The author treats the process evaluation information he has collected about the DNLT over the years to be cumulative, with each year's data providing additional perspective, frequently showing aspects of the organization that remains static or give evidence of change.

In September 2015, the first process evaluation began with a focus group of five team members that was facilitated by DOH staff members Teresa Vollan and the author. The original evaluation report of February 2016, also included a total of five in-depth interviews that were conducted by the author, four with then current team members, a fifth interview with a former, but recently active member of the DNLT. All of these interviews were done over the last several months of 2015.

The findings and recommendations of the February 2016 evaluation report were presented by the author to a full meeting of the DNLT during the Spring of 2016. At that time suggestions for corrections, revisions and additional information were provided by ten team members, and were incorporated into a second draft of the report.

Discussion of changes in the DNLT since the original evaluation report of February 2016 and the Spring draft of 2016, came from an in-person interview with Dr. Cheryl Farmer, DOH manager of the team, recorded on August 16, 2016, and from two additional telephone discussions with Dr. Farmer on September 9 and September 20, 2016. The third draft report was completed on September 23, 2016.

For the current report, the fourth in this series, an additional seven people with ties to the DNLT were interviewed from thirty minutes to an hour and ten minutes. All these later interviews were completed during the months of May, June, and July 2017. The interviews were recorded with an Olympus digital voice recorder, and transcribed by the author.

BACKGROUND TO THE DNLT

According to the team's website, *"The Leadership Team of the Washington State Diabetes Network operates as a voluntary collaboration of public, private, tribal, community and academic stakeholders in carrying out the network's mission to reduce morbidity and mortality from diabetes and prevent type 2 diabetes."*

On March 18, 2015, the DNLT membership list included 20 voting members, 15 non-voting or potential members, and 6 DOH staff members. The DNLT membership list of July 2017 listed 32 voting members, 33 non-voting or potential members, and 10 DOH staff members involved in various capacities with the diabetes network.

The mission of the DNLT is, *"To guide and support the individuals and organizations who work to improve the lives of people with diabetes and those who are at risk of developing the disease...Reducing the impact of diabetes among Washington residents."*

EVALUATION FINDINGS

The following evaluation findings are derived from statements by focus group participants, comments from participants during past and recent in-depth interviews, observations of team meetings by the author, statements from the team website, and DNLT documents. The recommendations in the current draft come from team members who participated in the recent interviews and from the author.

1. Developing and Sharing Goals

Findings

1. Earlier evaluations mentioned that the DNLT needed to develop "...goals that are widely understood and supported among the leadership team" and that, "Specific goals and action items are not well communicated to all members, especially new members." Currently, however, shared understanding of the goals of the DNLT seems to be stronger than before.

a. With a history of direct involvement of some team members in the Prevention, Type 2 Diabetes Mellitus Clinical Trial of the Diabetes Prevention Program Research Group, and the adoption of the Diabetes Prevention Program (DPP) by the DNLTL; and the continuing the commitment of the DNLTL to serve those involved with direct management of diabetes, and assist those who help clients self-manage diabetes, there does not appear much conflict within the DNLTL over the goals of the group.

- The New Member Packet and increased communication by DOH staff members with new members are having positive results with the integration of new members into the team, especially when compared to the team in years past.
- New members seem to have a clearer understanding of specific goals and action items of the DNLTL than in the past.
- Recently, much focus in the group has been on prevention, but other areas of diabetes have not been neglected. As one member noted,

“Prevention completely lines up with my interests—but I respect the perspectives of the people across the table who want to do other things, such as managing diabetes. Managing diabetes, self-care, prevention, and hypertension; we’re trying to figure out how to deal with all of these aspects of diabetes, but you can’t manage everything at once. So we’re building trust in the room, so that everyone knows that we will be working on all these aspects of diabetes collectively, but not all at the same time. We’re taking the long view.”

Another team member’s comments do suggest, however, that there is potential for continuing the low-key conflict in

that has existed for a number of years in the DNLTL between care and prevention:

“The number one goal now is to prevent instead of to cure; for 3-5 years there will be probably more focus on prevention; the culture is moving us towards that...the social determinants of health; what we can do to promote walking and physical activity, healthy eating, hypertension and the like.”

- Points previously noted in earlier evaluations in regards to the DNLTL developing goals still apply:
 1. DOH generally has been in the lead role in developing goals, but has been open to ideas from the leadership team.
 2. Development of goals has generally gone better in the workgroups, because they're smaller. Annually, workgroups line out goals that are recorded on paper and established as those for discussion with the larger group.
 3. Within workgroups usually one or two people take the lead, and propose some ideas. Sometimes the DOH staff member in the workgroup will take the lead, but not always. Generally, *“...some ideas bubble up and ends up being identified as that's what we want to do, and how we think we'll measure it.”*
 4. The workgroups come up with goals and then share them out. The leadership teams asks, *“OK what should this team be focusing on?”*
 5. The team as a whole votes on which goals should be adopted.

Recommendations

- Continue using the workgroups to come up with goals, sharing out findings, and team-wide voting for the goals that are ultimately adopted. This process seems effective.
- Continue being open about possible conflicts that may exist between those who have differing goals for the DNLTL, and encourage the group to serve as a big tent for the various aspects of diabetes.

2. Orientation of new members

Finding

- In the past the DNLTL did not have a formal orientation process for new members. As a consequence, many new members were lost when they first began to participate with the team. The new DNLTL orientation process has been an improvement. New members seem to have clearer idea of what their roles are, and what they can learn and accomplish within the team. As mentioned above in the first finding, both the New Member Packet and increased communication by standing DNLTL members and DOH staff members with new members is having a positive effect with the integration of newcomers into the team. (Jenée Carr’s excellent work in this regard was highlighted in the latest interviews.)
- Earlier evaluations suggested that team members had difficulty remembering who their DNLTL colleagues were, where they worked and what they did.

“Badges or name tags would be useful or if we have a member list readily available at the beginning of meetings, and then we see, ‘Oh, that’s where they work.’ Because I usually can’t remember names very well, I need three or four times before I can.”

Currently, team members and people who indicate that they will be attending a DNLN meeting have badges with their names and institutional connection waiting for them at the meeting sign-in table. For those who have not pre-arranged to attend the meeting, blank badges are available for them to fill out.

Recommendations

- Continue with the greatly improved on-boarding process.
- Continue preparing name badges in the current manner.
- Periodically pass out hard copies of definitions of government and public health acronyms for those who may be unfamiliar with these terms. Have a permanent listing of these terms on the DNLN website.

3. Activities the team has taken to respond to the needs and problems of the diabetes community

Findings

- In the past three years the team has been more action oriented.
- Workgroups within the DNLN have had specific tasks and objectives, and produced materials which have been useful for the team.
- Sharing information continues to be extremely important function of the DNLN. Below are just a few of the topics mentioned in the recent interviews that have been shared at meetings:
 1. The presentation and discussion of the ***Diabetes Epidemic Action Reports (DEAR)***
 2. Sharing of information and discussion about the appropriateness of the **Hb A1 c** finger prick test
 3. The presentations and sharing of information by a variety of healthcare professionals. For example, the

presentation of Patricia Lambro, PharmD, Pharmacy Director, Peninsula Community Health Services, about the innovative work she's doing in low-income communities, among other presentations

- The purpose of the DNLT has been to collect all the people who work in diabetes under one umbrella.

Recommendation:

- **Do more of the same.** Given the limitations of financial support the group has received, the Diabetes Network Leadership Team has been effectively responding to needs and problems of the diabetes community.

4. Comprehensive activities planned by the team that connect multiple services, programs, or systems

Findings

- The DNLT provides opportunities for networking and connections and relationships that otherwise would have had to be formed ad hoc.
- The DNLT provides information on diabetes management, diabetes self-management, diabetes prevention (especially with the current emphasis on the DPP).
- In terms of providers, historically the team was dominated by healthcare nurses and dietitians. Professionals in these two professions are valued, and the current interviews also indicate that DNLT members have also valued the increased participation of doctoral-level healthcare professionals, such as medical doctors, pharmacists, university faculty members and researchers.
- The Diabetes Network Leadership Team's emphasis on promoting both diabetes care management and diabetes prevention helps to connect multiple services and programs.

Recommendation:

- Continue present course

5. Ways that members of the team have inspired, motivated, or empowered people involved in the partnership

- Findings

- Similar to past evaluations, members of the DNLTL continue to be hungry for information. Everybody wants to get and share information.

“It’s been great to see and learn from each other what they’re doing in different areas. It’s always been inspiring when you feel like, I’m not making momentum where I’m at, and it’s good to hear what other places are doing. To get new ideas, to get energized.”

- The longevity of the DNLTL relates to the fact that the meetings themselves are energizing.

“Because if you work for a large health system, you might be the only person who focuses on diabetes. So being able to come together with a group of people who focus on diabetes is really empowering, and motivating, and hearing about what other people are doing sparks ideas. I think that can be inspiring or inspirational. I just see people leave that meeting feeling like they really got something out of it. Like they connected with people who are doing similar work, but in other parts of the state. That they otherwise wouldn’t have been in the same room with. I think just hearing about what other health systems are doing, it’s almost like a little competition that gets sparked. I think people usually walk away with some ideas about what they might want to do. And hearing about the newer, kind of

exciting things that are happening in parts of the state, or long-term things that have just been going on for a long time.”

- As in past evaluations, the current evaluation again indicates that participants feel that the DNLT has excellent leadership.

“The meetings are always dynamic, they provide state of the art information. The Department of Health is extremely active. For example, they developed a PSA, and they wanted our comment; they take our input seriously. They’re always active; wanting the participation of members, and are always well prepared. I’ve never before been in a group like that, where all the meetings are consistently well-prepared.”

- There is buy-in from the organizations involved with the DNLT.
- The information the DOH staff sends out to DNLT team members, including the flyers and other hard copies, are valued:

“The DOH diabetes team sends out information about the population I’m working with; they discuss the interventions that others have done, and this helps because of the of literacy of level and poor understanding of the health system of some of the clients I work with. DOH sends flyers to me on heart health, blood pressure, nutrition, diabetes. I get a lot of these from the Department of Health, and they’re extremely well done, as they explain, for example, what it means to have high cholesterol, or what is normal or under control blood pressure.”

“I feel like the DOH is my librarian. I really appreciate that. It’s nice to have someone that understands your needs, and to help you tailor your program to the specific needs of your community. I really love that. It’s a huge help.”

- DOH staff members sometime struggle at *“...what to feed this group that is so hungry for information.”*

Recommendations

- ✓ One interview participant suggested that the DNLTL might want to offer continuing education courses related to diabetes:

“I would like to have continuing education from DOH. It would be priceless. It’s already great to have our transportation paid for, our food, and I would like to receive Continuing Education, as far as cultural sensitivity, how to work with Native Americans, working together with Latino interventions, with examples of African American interventions, and receive training from an institution, for example, more training like we had before, with an organization that is already working with the homeless. Continuing education at different levels from DOH and the DNLTL, from organizations that have experience in working with various populations, would be priceless.”

6. Conflict among team members

Findings

- Historically, there has been relatively little conflict between DNLTL team members.

- Past conflict between team members has been successfully resolved through discussion.

“Originally, with pre-diabetes, some of us were in the camp like, ‘Oh this distracts from pushing for really quality diabetes care.’ And when, say, we were discussing adding on hypertension to the team, this came to a head, and a worry that our messages will get muddied. But we came to the conclusion that hypertension is so important to diabetes care that we need to work on this too.”

- In spite of successful conflict resolution of the same issue in the past, it is still possible to, *“... feel the tension between those who are most concerned about diabetes management, and those who are working on prevention.”*
- Team members tend to be pretty similar in terms of their values about diabetes, although there are some differences of opinion about how to do things. Conflict within the DNLTL does not become too serious, as team members work for different organizations. They do not have to rely on fellow team members to get the work done they do for the organizations that employ them.

“I think it’s a group of generally nice people who don’t like to engage in conflict... We’re not fighting over resources, so it’s not that we would have all that much to fight over.”

“So it’s not so co-woven together that you can’t have just a difference of opinion and be OK with it.”

- A potential source of conflict could be that certain members feel that some of their DNLT colleagues are not active enough within the group. They would like to replace people in the DNLT who do not participate enough in the committees they signed up for with other, more active members.

“Another thing I’ll mention is that we need to have the right people in the right groups. We have all these people who are supposed to be on these phone calls, and they’re not on the phone call. They don’t respond, they don’t call back; you can’t have a good group if the members are not motivated. We should contact those people, ask what the difficulty is, and if they can’t commit themselves to the work, maybe they could help us find someone who can...we have these people, we call them, we invite them and they don’t respond. Who are these people? Let’s do some housecleaning, to make sure we have the right people, on the right groups, doing the right things.”

Recommendation

- The DNLT could discuss whether there is a consensus on the perception that some members are not fulfilling their responsibilities to the team, and if it is determined to be a problem, there should be a discussion on how to resolve it.
- This could be a divisive issue and one would hope that the DNLT would continue to tread as lightly as it has in the past, treating all involved with respect, sensitivity, and understanding.

7. Recruiting diverse people and organizations into the team

Findings

- During the four evaluations done of the group since 2015, it is clear that the DNLT has a history of consistently discussing and attempting to add additional members to increase diversity and representation. For example, during the first evaluation, a DNLT member who was interviewed stated:

“We discuss who is missing from certain geographical areas. So we do have a practice of doing that on a regular basis, if not every meeting, then at least a couple of times a year.”

Two others who were interviewed made the following comments:

“Like in a meeting, we always ask like if there is anybody else who needs to be at the table.”

“I think that we always have an informal discussion about that at the beginning of each meeting, and everybody around the table says there is someone who would be good, and if someone knows that person, they could reach out. I don’t think it’s a formal process.”

Generally, team members agree that they would like to have additional representation within the group, and have mentioned a number of potential additions to the group, especially people with diabetes, and people going through lifestyle classes.

“Because look at it: We’re doing all these things to try and help people out, but it’s not really from people who are saying, ‘This is what it’s really like. This is what we’ve

actually gone through. Here's how you guys can improve your process.'"

"I think the having someone who is a user of the programs has come up every year that I've been on the group and has never come to fruition. In part because how we meet, and how we're structured. And in part because I'm not sure we've put enough effort into finding that person.

During this year's evaluation concerns about increasing the diversity of the group continued to be a major theme of the interviews. Interview participants suggested new team members should be added from the following groups of people including Latinos, American Indians, African Americans, East Asians, Samoans and other Pacific Islanders, and especially people with diabetes.

Recommendations

- In many of the evaluations that I have done for Washington State government since 1999, frequently the people being served by programs are not sitting at the table helping to design programs that will affect them; or if they have been included, it is only after the major decisions and planning have taken place. This seems to be true not only for Washington State, but for many public health and social service programs across the country.

It's also true that often people served by programs do not have the ability, because of job and family responsibilities, or transportation issues, to participate in organizations which provide public health and social service programs.

Rather than simply trying to make the DNLTL membership list more diverse, one interview participant suggested the

following idea as a way of getting more voices involved in program planning:

“It would be useful to do focus groups, separate focus groups for each of these groups, as a way to get them involved in planning. Therefore, if they couldn’t make a commitment to the DNLТ they wouldn’t need to go to the meetings, but could still get their voice heard. A focus group with a particular group could say, ‘Here’s what we’re talking about, here are the services we are talking about for you. What is your opinion? How does that land on you? Is it relevant, what are your needs?’ Go out into the community and say, ‘Here’s our fancy idea; what do you think?’ Sometimes they say; ‘That’s nothing to do with it, with our needs.’”

8. DNLТ efforts to support member participation

Findings

- The DNLТ supports and pays for the travel of those members who need to travel longer distances to meetings, and encourages the organizations they work for to pay the members’ salaries while they attend meetings.
- Although the majority of participants come from western Washington, the eastern part of Washington State is not underrepresented in the DNLТ.
- Although not underrepresented, members from the central and eastern parts of the state do need to spend a day traveling to and from team meetings when they are held in the western part of the state. The DNLТ has responded this situation by more frequently holding meetings in eastern and central Washington State.

Recommendations

- Continue the excellent practice of more frequently holding DNLТ meetings in the central and eastern parts of the state.
- Continue the practice of offering members a teleconferencing option

9. Whose responsibility is it? DOH or the other members of the team?

Findings

- Past evaluations indicated that there was a contradictory dynamic at play within the DNLТ concerning responsibility for work. Members were grateful that DOH organized and ran meetings, took meeting notes, and communicated information.
- At the same time, members were unclear who had responsibility for work and certain projects, and more frequently than not, DNLТ members let DOH staff members take the lead on projects.
- The current executive leadership group seems to be more assertive, and are taking more responsibilities for projects and the direction of the DNLТ.

Recommendation

- A symbiotic relationship between the DNLТ executive leadership group and DOH staff members is a desirable outcome. Having the executive leadership group take more initiative for the team's direction is a positive development, while the DOH staff members still provides valuable services in program administration. The executive leadership group should be encouraged to continue enlarging their leadership role.

10. Membership of the DNLTL has grown from 20 active members to 32 active members. Many of the new members are funded by the 1422 grant. What happens when 1422 funding stops?

Findings

- During the DNLTL meeting of April 19, 2017, one member observed that much of the growth of the membership of the DNLTL was due to 1422 funding.

“1422 funds bring a lot of people into this room. 1422 is coming to an end. The evaluation should focus on a piece of sustainability... What does the end of 1422 mean for the work of this group and the relationships built?”

- Not all of those interviewed for the current evaluation believe that the end of 1422 funding will greatly affect the DNLTL. One interview participant felt that the DNLTL need not plan for the cessation of 1422 funding, and the possible loss of members.

“The core of the group doesn’t rely on 1422 funding, especially the executive leadership group. My position...is funded by taxes. If the national leadership doesn’t continue fund these programs, you don’t know what you don’t know. Will we lose some core people; I think that’s a possibility, but I don’t think it will stop overall progress; it may slow it down a bit. Maybe allocate resources more efficiently...but it won’t hinder the good work that we’re already doing.

We don’t need to plan that the DNLTL may lose members because of the ending of 1422 funds. We can still do the core functions. There are other people that receive their funding from organizations and not 1422, that can still do this work. It may be a little bit harder for us to do when 1422 funds are cut. Timelines, all that stuff. But if 1422 goes away, I see us still

being able to stay there. Perhaps, at a slightly different capacity, but still being able to do what we need to do.”

Another team member interviewed for the current evaluation had a different view:

Interview Participant: *“I think that the energy of the group has been largely related to 1422 work, and I’d hate to see it diminish after 1422 money is no longer with us. So I’d like to challenge the group on what is going to come after that...I think we can continue, but I’d like some collective ownership of what that is going to look like.”*

Author: *“I’ve seen groups collapse after they lost funding. I don’t see that happening with this group; but I can see efforts diminishing.”*

Interview Participant: *“It will be a challenge to leverage some of our public-private funding to work on this. I’d like the work to continue going and having it meaningful.”*

Recommendation

- **One of the priority agenda items of the next DNLT membership meeting should be to discuss the significance of 1422 grant funding to the team, and whether it is necessarily to begin planning for the forthcoming cessation of this funding source.**

SUMMARY CONCLUSION

As was true in past evaluations, the qualitative data collected from DNLТ team members for this year's evaluation have proved to be extremely rich, and I have covered only a fraction of what I have gathered. The observations contained in the current evaluation are not meant to be critical of the Diabetes Network Leadership Team. This group continues to earn high marks in my eyes as an effectively functioning organization that is dealing with a vitally important public health issue. However, even the highest functioning groups have challenges to deal with. If some of the problems of the DNLТ recorded in this evaluation are accurate, the team can act upon them and respond in an effective manner, as they have responded to other challenges in the past.

Thanks are due to the DNLТ interview participants for their help with evaluation, and to my DOH colleagues who have encouraged and supported me in this work.

Currently, I am a visiting professor at the Hong Kong University of Science and Technology, working on a public health research project under a Fulbright scholar research grant. I will be in Hong Kong from August 2, 2017 until July 2018. For comments and suggestions for improving the current DNLТ evaluation please contact me at the addresses below:

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