The DIABETES INITIATIVE COLLABORATIVE LEARNING NETWORK: An Approach to Maximizing Program Effectiveness

A Report from the National Program Office

DIABETES INITIATIVE
A National Program of the Robert Wood Johnson Foundation

The *Diabetes Initiative* Collaborative Learning Network:

An Approach to Maximizing Program Effectiveness

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EXECUTIVE SUMMARY

To maximize desired outcomes in target populations, philanthropic organizations are challenged to provide relevant and useful technical assistance to help funded programs incorporate state-of-the-art processes and tools, increase project effectiveness, and enhance sustainability and dissemination of lessons learned. This report describes an approach to providing technical assistance to grantees of the Robert Wood Johnson Foundation® (RWJF) *Diabetes Initiative* emphasizing collaboration and synergy among grantees, program staff, and advisors that led to program evolution and improvement. This report discusses both grantee perceptions of this type of technical assistance and implications for quality improvement programs.

The Diabetes Initiative

The *Diabetes Initiative*, a national program of RWJF, was intended to demonstrate feasible and successful models of self management in primary care and community sites around the country and to promote such programs. The 14 sites of the *Initiative* included urban, rural, frontier, and Indian Country settings; Latino, African-American, American Indian, and White populations – all representing groups experiencing substantial health disparities. The *Diabetes Initiative* National Program Office (NPO) oversaw and provided technical assistance to the grantee organizations.

The NPO provided an approach to technical assistance that would build upon the activities grantees already had in place and provide them flexibility to adapt general models to their own settings and populations. To provide a general structure for this, Resources and Supports for Self Management (RSSM)[1,2] outlined broad categories of key components of self management. What was important was not specifically how grantees provided each of the Resources and Supports, but that they worked to enhance the availability of them all.

A Collaborative Learning Network (CLN) was implemented by the NPO to guide and cultivate the 14 unique, real-world programs by using the RSSM framework and building on the experience and energy of grantees. The CLN provided opportunities for the grantees to learn about improved practices, share experiences, set goals for quality improvement, share accomplishments and barriers to improvement efforts, and work in groups on issues critical to diabetes self management. With this strong emphasis on peer-to-peer learning, many CLN components were guided by the evolving needs of the grantees. For example, a workgroup on depression in diabetes emerged from grantees' recognition of the need for it. The CLN shows promise as a model for both advancing diabetes self management and for providing technical assistance to improve quality in chronic illness programs.

CLN Activities

Multiple formats were used for CLN activities, including face-to-face meetings, workgroup meetings related to specific topics and challenges, teleconferences, learning intensives, site visits, use of a website, and e-mail and phone contacts. Participants in CLN activities included the NPO staff, grantees, National Advisory Committee members, RWJF staff, and outside experts who contributed through presentations and participation in workgroups as well as panel and roundtable sessions.

Central to the CLN approach were 10 meetings over the course of the 45 months of funding. Meetings included presentations on new material, facilitated discussion sessions, thematic workgroup sessions to address key issues, and quality improvement sessions for program improvement on a number of topics. Other features of the face-to-face meetings included oral and poster presentations by grantees to share successful strategies that could be helpful to other sites.

Topic-focused workgroups made up of a subset of interested grantees, NPO staff, and experts in the field met during face-to-face meetings and through regularly scheduled conference calls between meetings for additional collaborative learning and work related to the development of products or strategies for addressing key themes. The focus of each workgroup evolved, and new areas emerged, as the project matured. Depression, organizational capacity, and clinic-community partnerships were some of the topics addressed in workgroups.

A number of other methods were also used to provide technical assistance between formal meetings. These included conference calls on special topics, learning intensives and trainings, site visits by NPO staff, as well as routine e-mail and phone calls.

Grantees brought a wealth of expertise and experience to the CLN, allowing the CLN to be a dynamic process that included ongoing interaction between material presented and grantee experience and reactions. The CLN process also enabled discovery of new themes from grantee experiences in their programs and in response to presentations and group discussions.

Grantee Perceptions of CLN Benefits

The *Diabetes Initiative* contracted with Fleishman-Hillard, Inc. (St. Louis, MO) to assess grantee perceptions of benefits associated with the CLN process for implementing and improving their individual diabetes self management projects. The survey contained both open-ended and structured questions about specific aspects of the CLN as well as questions about the respondent's organization and role in the project. All 14 grantee sites participated; of the 101 representatives contacted, 49 completed the survey.

When asked in an open-ended question to identify the *most important* benefit of participation in the CLN, more than half gave more than one response, an indication that they perceived multiple important benefits from their involvement in the CLN. The responses demonstrated the breadth of content areas that can be addressed by using a CLN format and suggest that some of the content areas are best addressed by presentations; others by initiating planned improvement cycles; others by having information readily available on the Internet; others by grantee-to-grantee interaction at meetings, in workgroups, or on conference calls; and still others by a combination of approaches.

Survey respondents had a favorable impression of how the CLN structure facilitated quality improvement of program services and features at their sites. Of note is that 76% of the respondents said the CLN was useful in helping them create or improve strategies for collaborative goal setting. This is particularly important because collaborative goal setting is a mainstay of self management. In addition, a high percentage of respondents cited the CLN as being helpful in creating or improving organizational capacity for program delivery (74%) and strategies for teaching self-management skills (74%), both of which are essential for program sustainability.

Impact and Lessons Learned

The survey results and the comments clearly showed that individual grantee programs were enriched by the CLN activities and processes. They reported benefitting from sharing among the grantees, learning from experts, and developing new skills. They developed new tools and shared existing ones with each other. Importantly, these improvements led to significant clinical and behavioral improvements among the people they served.[3-7]

The CLN model has much to offer funding agencies that are interested in more than providing funds to implement innovative programs. The interactive and high-touch approach of the *Diabetes Initiative* CLN built a learning community that supported excellence at the individual program level, resulted in sustainable models that have been shared as exemplars, and developed tools for public use that can accelerate the work of similar programs. Philanthropies and other funders may find these lessons learned instructive as they plan and support new programs.

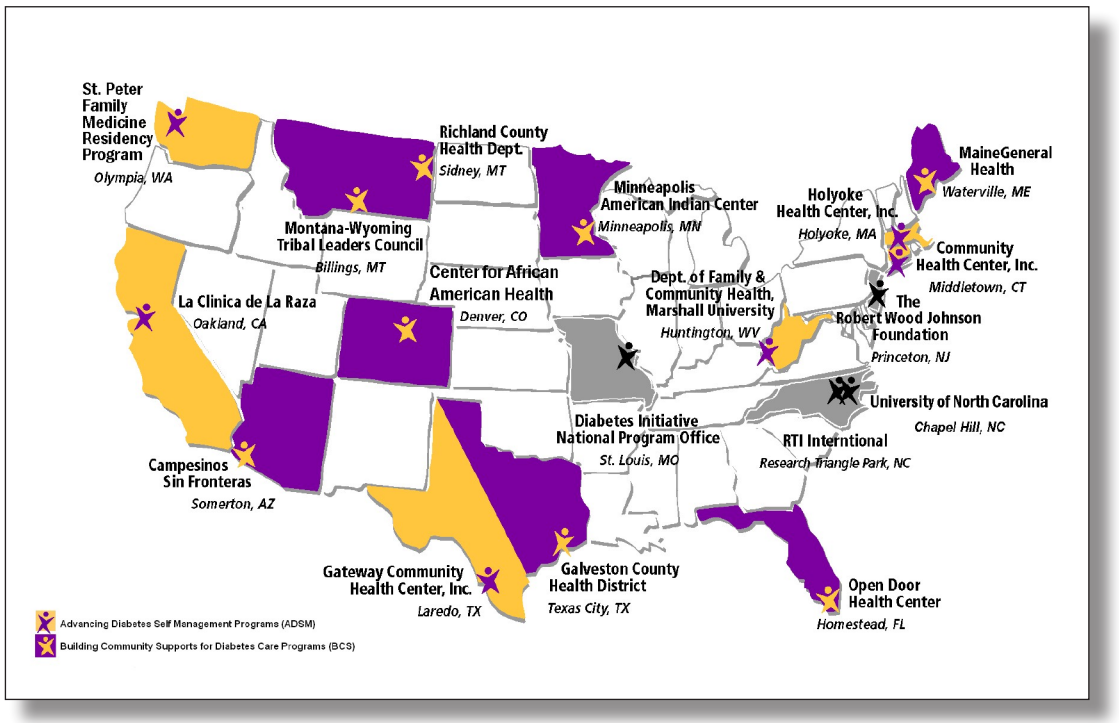
INTRODUCTION

The impact of health philanthropy is indisputable. Philanthropic efforts have played a vital role in a number of areas: helping change the course of health disparities in America, filling health care gaps where federal funding is not adequate, and building networks to support social programs in schools and communities. To maximize desired outcomes in target populations, philanthropic organizations are challenged to provide relevant and useful technical assistance to help funded programs incorporate state-of-the-art processes and tools, increase project effectiveness, and enhance sustainability and dissemination of lessons learned. This report describes an approach to providing technical assistance to grantees of the Robert Wood Johnson Foundation® (RWJF) *Diabetes Initiative* emphasizing collaboration and synergy among grantees, program staff, and advisors that led to program evolution and improvement. This report discusses both grantee perceptions of this type of technical assistance and implications for quality improvement programs.

The Diabetes Initiative

The *Diabetes Initiative*, a national program of RWJF, was developed based on extensive research showing the importance of self management in diabetes and other chronic illness care. The purpose of the *Initiative* was to demonstrate and promote feasible and successful models of self management support in real-world settings, especially among groups who experience a disproportionate burden of diabetes. Projects were to demonstrate that (1) comprehensive models for diabetes self management that improve patient outcomes can be delivered in primary care settings, and (2) support for diabetes management can be extended beyond the clinical setting into communities through partnerships among community organizations and clinics. Overall, 14 grantee sites around the United States were funded (see Figure 1), including six in primary care settings through the Advancing Diabetes Self Management program and eight in community settings through the Building Community Supports for Diabetes Care program. Projects included urban, frontier, and Indian Country settings and Latino, African-American, American Indian, and White populations with varied cultural and linguistic traditions. All sites serve groups that are medically underserved and disproportionately affected by diabetes.

Figure 1. Grantee sites of the Diabetes Initiative



In February 2003, 14 sites began a 15-month planning phase followed by a 30-month implementation phase (May 1, 2004, to October 31, 2006).[1,2] The *Diabetes Initiative* National Program Office (NPO) housed at Washington University in St. Louis and the National Program Director at the University of North Carolina at Chapel Hill oversaw and provided technical assistance to the 14 grantee organizations, with input from a National Advisory Committee (NAC) and RWJF staff.

The NPO provided an approach to technical assistance that would build upon the activities grantees already had in place and provide them flexibility to adapt general models to their own settings and populations. To provide a general structure for this, Resources and Supports for Self Management (RSSM)[1,2] outlined broad categories of key components of self management. These include key components of self management programs – continuity of quality clinical care, individualized assessment, collaborative goal setting, key skills both for disease management and healthy behaviors, ongoing follow-up and support, and community resources. RSSM articulates these key components in broad terms that comprise comprehensive support for self management while providing flexibility for individual programs to tailor their program approaches. What was important was not exactly how grantees provided each of the Resources and Supports within their programs, but that they worked to enhance the availability of them all.

A Collaborative Learning Network (CLN) was implemented by the NPO to guide and cultivate the 14 unique, real-world programs by using the RSSM framework and building on the experience and energy of grantees. Emphasis on exchange among grantees recognized that they came to the CLN with strong programs already in operation, a requirement to receive funding from among the over 300 applications received for the *Diabetes Initiative*. Combining this strong emphasis on peer-to-peer learning with input from "expert" presentations on selected topics and model programs and approaches, the CLN provided opportunities for the grantees to learn about improved practices, share experiences, set goals for quality improvement, share accomplishments and barriers to improvement efforts, and work in groups on issues critical to diabetes self management. Reflecting the active role of grantees in the CLN, many of its components were guided by their perception of their programs' evolving needs. For example, a workgroup on depression in diabetes emerged from grantees' recognition of the need for it. This unique approach shows promise as a model for both advancing diabetes self management and for the provision of technical assistance for quality improvement in chronic illness programs.

In the *CLN Activities* section below, we describe the various formats, strategies and delivery channels that were used to promote grantee learning and improve individual programs. The section on *Grantee Perception of CLN Benefits* provides and discusses results of a survey used by the NPO to evaluate the effectiveness of the CLN approach. The *Impact and Lessons Learned* section examines the enrichment of individual grantee programs resulting from CLN activities and processes and suggests how this information may be used in the future by other philanthropic organizations.

CLN Activities

Multiple formats were used for CLN activities, including face-to-face meetings, workgroup meetings related to specific topics and challenges, teleconferences, learning intensives, site visits, use of a website, as well as email and phone contacts. Participants in CLN activities included the NPO staff, grantees, NAC members, RWJF staff, and outside experts who contributed through presentations and participation in workgroups as well as panel and roundtable sessions.

Face-to-Face Meetings

Central to the CLN approach were 10 meetings over the course of the 45 months of funding. These meetings had two main purposes: (1) to explore key issues and challenges facing providers and communities committed to improving self management care, services, and outcomes; and (2) to facilitate learning, creative problem solving, and product development to improve self management care, services, and outcomes.

A typical meeting lasted one and a half to two days and included:

- presentations on material critical to diabetes clinical management and behavior change as well as other topics relevant to quality improvement of self management programs and services. For planning purposes, these were grouped into four areas: Program Development and Sustainability, Resources and Supports for Self Management, Diabetes Specific Topics, and Special Topics. Table 1 details the sequence of formal meetings of the *Diabetes Initiative* CLN and the processes used during the meetings related to specific areas of focus.
- facilitated discussion sessions. These took place in a number of ways. After a formal presentation, facilitated discussions often included questions aimed at the audience to encourage participation and group interaction. At other times, a roundtable format was used to give more focused attention to an issue in a smaller group setting.
- thematic workgroup sessions to address key issues. Four key areas emerged early in the program: organizational capacity for self management in primary care; approaches to depression and emotional health as an integral component of diabetes self management and care; community health worker/*promotora*/coach interventions; and application of behavior change models (e.g., the Transtheoretical Model[10]) in diabetes self management. Some were initiated by the NPO, and others (e.g., depression) came from the experiences and concerns of grantee staff. Although the intial purpose of these workgroups was to promote improvement in the individual programs, many also led to products (reports, manuscripts, tools, etc.) that were disseminated, thereby contributing to improved practices in self management support, chronic illness care, and quality improvement. (see *http://www.diabetesinitiative.org*)
- quality improvement sessions for sites to begin planning program improvements related to a featured topic. The NPO used an adaptation of the "plan-do-study-act" process called a Planned Improvement Cycle (PIC). Forms and instructions were provided. After presentations on key topics, grantees were given15 to 20 minutes to work with their teams to plan project improvements related to the topic. These plans were then shared and discussed with the entire group, a process that often led to plan revisions. The PIC allowed grantees to set clear objectives, make concrete plans for initiating change, gain feedback and ideas from their peers for extending their plans—and then, between meetings—implement, evaluate, and revise their plans accordingly.

Other features of the face-to-face meetings included oral and poster presentations by grantees to share successful strategies that could be helpful to other sites. The NPO provided a focus and guidelines for those presentations and scheduled them so that each grantee would have the opportunity to be "in the spotlight" at least twice. This was done to promote cross-site learning as well as build capacity for future dissemination and spread of lessons learned by providing grantees opportunities to gain experience and skills giving national presentations.

Table 1. Diabetes Initiative CLN Formal Meetings: Technical Assistance and Topic Areas

	Meetings (Date)									
Topics and Identified Needs	1 (4/03)	2 (7/03)	3 (12/03)	4 (3/04)	5 (7/04)	6 (11/04)	7 (4/05)	8 (10/05)	9 (4/06)	10 (10/06)
Program Development and Sustainability Strategies										
Planned Improvement Cycles			P, PIC							
Sustainability		RT			P			P	P, PIC	PD
Organizational Capacity and Implementation Factors	WG	WG	WG	WG	WG	WG				PD
Evaluation	P									
Dissemination and Spread		RT								PD
Communication				PIC	P, PIC		P	P	PD, PIC	
Grantees Sharing Programs and Findings		POS		POS	GP, POS	GP, POS	GP	GP, POS	GP	GP
Resources and Supports for Self Management										
Overview	P		P, PIC							p
Individual Assessment and Goal Setting	P		P		P, PIC					
Skills and Problem Solving	P		P							
Ongoing Follow-up and Support	P, WG	P, WG			WG	P	P		WG	PD
Community Resources and Linkage	P				P, PIC				WG	PD
Continuity of Quality Clinical Care	P									
Chronic Care Model	P							PIC		
Diabetes-Specific Topics										
General Clinical Management		P								P
Healthy Eating and Diabetes		P								
Physical Activity and Diabetes		P					P, PIC			
Smoking Cessation								P, PIC		
Weight Management						P, PIC				
Special Topics										
Healthy Coping and Diabetes	WG		WG	P, PIC, WG	WG	WG	P, WG		P, WG	P
Community Health Workers (Coaches, Health Workers, etc.)	WG	RT, PD	WG	WG	P, WG	WG	WG		WG	PD
Behavior Change Models	WG	RT	WG	WG	WG	WG				PD

GP = Presentations by grantees of projects and findings; P = Presentation and discussion; PD = Panel discussion; PIC = As described in the text, during the PIC grantees planned quality improvement activities related to key topics presented to their own projects; POS = Posters of grantee projects; RT = Roundtable discussion; WG = Workgroup discussion.

Workgroups

Topic-focused workgroups made up of a subset of interested grantees, NPO staff, and experts in the field met during face-to-face meetings and through regularly scheduled conference calls between meetings for additional collaborative learning and work related to the development of products or strategies for addressing key themes. The focus of each workgroup evolved, and new areas emerged, as the project matured. The depression workgroup, for example, started from grantee reports that depression appeared to be a barrier to self management. After sharing experiences and exploring improvement strategies, the group agreed to use the same screening and assessment tool, shared intervention approaches, and ended up developing a manuscript that was published in Diabetes Spectrum.[11] In another example, the workgroup on organizational capacity for self management support originally met to discuss ways to build internal capacity to support self management. That led to the recognition of a need for indicators of capacity and ways to benchmark progress. Their work culminated in the development of a quality improvement self-assessment tool for use in primary care settings,[12] an article published in *The Joint Commission Journal on Quality and Patient Safety,*[13] and the conversion of the tool to an on-line format to promote dissemination and access (in development).

A group that emerged later was composed of the grantees in Building Community Supports for Diabetes Care program who met to discuss their experiences with clinic-community partnerships to improve diabetes self management. To help answer the question of "added value" of the partnership approach, they participated in developing a logic model or framework for these unique partnerships that included both clinic and community outcomes.[14] The model

led to the development of a corresponding checklist for partnerships to use as a self-assessment tool (see *http://www.diabetesinitiative.org*). In these cases, the intensity of the work necessitated special face-to-face workgroup sessions between regular grantee meetings to move the projects forward.

Other Modes of Technical Assistance

A number of other methods were also used to provide technical assistance between formal meetings (see Table 2). Conference calls were hosted on special topics of interest to grantees. For example, developers of the Texas Community Health Worker credentialing program were invited to present by teleconference to grantees interested in peer support programs.

Learning intensives and trainings enhanced skills related to program implementation. Some were provided by NPO staff and others by expert consultants or contractors. Training focused both on general capacity building (e.g., strategic communications) and specific self management skills (e.g., Chronic Disease Self Management Program leader training for project staff).

NPO staff also conducted site visits (at least two per grantee site) to review progress, provide information and tools pertinent to the phase of the project and specific to each site's needs for improvement, and respond to specific requests for technical assistance. Routine e-mail and phone calls between the NPO and grantee sites provided ongoing support. E-mail was also used to share resources among grantees. The NPO used a web-based survey tool to solicit general feedback and responses from grantees for universal issues and to gather responses from grantees from questions posed by another grantee.

Finally, a special fund was created by RWJF to encourage grantee dissemination of lessons learned. The fund paid registration and travel expenses for approved presentations at national conferences. Over the project period, 47 grantee presentations were supported from that fund.

Table 2. Types of Technical Assistance Included in the Diabetes Initiative CLN Approach

Type	Purpose	Content	Format		Documentation/Follow-up
			Mode	Frequency	
Formal meetings	- Networking and grantee sharing and collaboration - Skill building and updates in the field - Workgroup time - Quality improvement and Development of PICs - Expert consultation	(see Table 1)	- Face to face	- Regular, periodic - (see Table 1)	- PIC review - E-mail/phone feedback - Threading of topics from one meeting to next
Workgroups	- Exchange of knowledge, resources, perceptions, strategies, etc., to improves interventions - Dynamic problem solving - Cooperative planning - Co-creation of products	- Organizational capacity - Depression/negative emotion - Lay health workers - Behavior change models - Clinic-community partnership	- Face to face - Conference call - E-mail and Web	- Ongoing - Ad hoc (see Table 1)	- Meeting minutes - Products
Teleconferences	- Special topics/ innovations - Expert consultation	- Partnership mapping	- Tele-conference	- Ad hoc	- Group debriefing - Summary notes
Learning intensives (workshops, targeted trainings, seminars, etc.)	- Skill enhancement	- Communications training - Self management skills training	- Face to face	- Ad hoc	- Observation - Return demonstration - Follow-up questionnaires - Review grantee plans - Reinforcement at formal CLN meetings
Site visits	- Grantee selection - Needs identification - Consultation - Monitoring and support	- Site-specific	- Face to face	- Ad hoc	- Observation - Summary notes - follow-up as needed
Web	- Share resources, updates, and announcements	- *Diabetes Initiative* - Web links	- Web	- Ongoing	- Track Web statistics
E-mail and phone	- Ongoing routine support - Resources and support - Site-specific needs	- Site-specific	- E-mail and phone	- Daily - Ongoing	- Follow-up as needed

GRANTEE PERCEPTIONS OF CLN BENEFITS

The Diabetes Initiative contracted with Fleishman-Hillard, Inc. (St. Louis, MO) to assess grantee perceptions of benefits associated with the CLN process for implementing and improving their individual diabetes self management projects. As CLN activities were nearing completion, representatives from all 14 grantee sites received an e-mail inviting them to participate in an on-line, self-administered survey (see Appendix). Instructions for completion of the survey were included in the e-mail. The survey was sent to project staff as well as managers and executives who may not have been directly involved in day-to-day operations of the project but were familiar with CLN's impact on their organization as a whole.

The survey contained both open-ended and structured questions about specific aspects of the CLN as well as questions about the respondent's organization and role in the project. Of the 101 representatives contacted, 49 completed the survey and all 14 grantee sites participated. The following sections summarize key findings. We reviewed and compared survey responses from participants based on organization type, audience served, and level of involvement; no obvious or significant differences were present among these subgroups.

- *A total of 29% of the survey respondents identified their job title as a project coordinator or lead planner. Not surprisingly, 29% described their role in the diabetes self management program as "planning and development."*
- *"Involved"[15] participants were more likely to describe their role as either "planning and development" (37%) or "support/ administrative staff" (26%).*

Overarching Benefits

When asked in an open-ended question to identify the *most important* benefit of participation in the CLN, more than half gave more than one response, indicating that they perceived multiple important benefits from their involvement in the CLN (see Table 3).

Table 3

In your opinion, what is the most important benefit that you associate with working or being affiliated with the Diabetes Initiative's Collaborative Learning Network (CLN)? (VOLUNTEERED)

	Total (n = 49)
Sharing information and best practices among grantees	53%
CLN meetings/training sessions/general educational presentations	39%
NPO staff support	16%
Development of materials, brochures, handouts, etc.	14%
Availability of new opportunities	10%
Centralized resource location	6%
Expert presentations	4%
Greater grant focus	4%
Other	4%

Adds to more than 100% due to multiple responses.

Sharing of information among grantees (53%) and learning from meeting presentations and training sessions (39%) were most often mentioned. The CLN structure facilitated grantee learning and sharing by creating opportunities for interaction among grantees and with experts in a number of different venues. Grantee information sharing was also facilitated by providing access to other grantees' contact information and program materials on the *Diabetes Initiative* website. In this context, the information learned and shared included that related to program development as well as program content. Respondents noted:

- *"…the opportunity to meet and network with other grantees, get ideas, do problem solving, etc.…"*
- *"The CLN helped ensure that everyone is truly sharing and learning about best practices."*
- *"Opportunity to learn from other sites and from the national consultants; technical support from the NPO."*

In a second general question, survey respondents were shown a list of nine potential benefits of CLN participation and asked to rank the benefits from high to low (Table 4). Benefits most often ranked in the top three were learning from experts (59%), finding out about and sharing resources for improving their programs (49%), learning from other grantees (45%), and learning about different program approaches (45%).

The responses to this question demonstrate the breadth of content areas that can be addressed with a CLN format. Different content areas are best addressed by presentations; initiating PICs; having information readily available on the Web; grantee-to-grantee interaction at meetings, in workgroups, or on conference calls; or a combination of approaches. For example, experts in diabetes provided grantees state-of-the-art information about topics such as general clinical management, nutrition, weight management, and physical activity. Other experts participated in workgroups to educate grantees on issues such as depression/negative emotion, community health workers, behavior change models, and ongoing follow-up and support. PICs were initiated at formal meetings,

Table 4

Please look at the following benefits that could be affiliated with the CLN. Please rank the benefits from high to low (1 = high; 9 = low) in terms of how important each one is to your project.

	Ranked First (n = 49)	Top Three (n = 49)
Resources for improving your program (e.g. materials, PDSA/PICs, program models, training, etc.)	25%	49%
Learning (in general): from other grantees/sharing ideas	22%	45%
Learning from experts in diabetes and special topic areas (depression, weight management, working with media, etc.)	18%	59%
Building relationships/networking with other grantees and the NPO staff	16%	41%
Learning how to better communicate with patients and families about self management	12%	22%
Learning about different program approaches, models, and theoretical frameworks	4%	45%
Learning how to build networks that enhance aspects of your program (partnership, community health worker networking, patient care teams, etc.)	2%	12%
Learning how to develop, measure, and evaluate program outcomes	—	12%
Learning about ways to get participants involved in your program	—	14%

workgroup meetings, and learning intensives but then implemented at individual grantee sites. Follow-up by teleconferences provided feedback from NPO staff, experts, and fellow grantees. Examples of typical comments include:

- *"We have greatly appreciated and have learned so much from the several trainings we have attended."*
- *"This grant has given us a world-class education on improving care for patients with chronic diseases. It has allowed us to become cutting edge providers developing new approaches…"*

High ranking was also given to sharing resources for improving the program. Shared resources included recruitment and training strategies, educational materials, videos, tools, protocols, articles, and reports. The CLN facilitated this sharing through the formats mentioned above as well as from targeted technical assistance provided by the NPO during site visits and during individual site e-mail and phone calls. Website postings were also used to share resources. Also highly ranked were the opportunities to learn in general. In particular, learning about other program models and theoretical frameworks were cited as being beneficial, as was the opportunity to simply share ideas. One site commented:

- *"Multiple [implementation] models and materials were shared ... Videos and other materials came from national organizations and other grantees. They inspired us to create our own."*

Benefits Related to Program Development and Content

Survey respondents also had a favorable impression of how the CLN structure facilitated quality improvement of program services and features at their sites. Table 5 describes the types of strategies and program materials made available and used by the sites to improve their programs. Of note is that 76% of the respondents said the CLN was useful in helping them create or improve strategies for collaborative goal setting.

Table 5 (n = 49)

Has the CLN helped your organization create new services, features, or program components listed below, and/or improve existing ones?

	Yes to Either	Yes, Create New	Yes, Improve Existing	No to Both	Don't Know
Strategies for collaborative goal setting	76%	31%	55%	8%	16%
Strategies for teaching skills for self management (blood glucose monitoring, healthy eating, physical activity, problem solving, healthy coping, etc.)	74%	27%	55%	14%	12%
Strategies for improving organizational capacity for program delivery	74%	25%	53%	8%	18%
Strategies for providing ongoing follow-up and support	71%	27%	53%	12%	16%
Strategies for addressing depression	69%	33%	45%	18%	12%
Strategies for individualized assessment	65%	20%	49%	14%	20%
Program materials (e.g. videos, curricula, etc.)	63%	29%	43%	12%	25%
Patient education materials	63%	29%	43%	16%	20%
Strategic communications plan	63%	31%	37%	10%	27%
Assessment tools	63%	27%	47%	14%	22%
Strategies for improving community resources for diabetes management	57%	25%	41%	25%	18%
Strategies for enhancing linkage among program components	57%	12%	51%	22%	20%
Program models, flow charts, logic models	57%	20%	45%	22%	20%
Training sessions for staff	57%	22%	39%	22%	22%
Community health worker component	55%	27%	41%	20%	25%
Strategies for enhancing clinical care	53%	12%	43%	25%	25%
Outreach materials	51%	14%	41%	20%	29%

This is particularly important because collaborative goal setting is a mainstay of self management. Additionally, a high percentage of respondents cited the CLN as being helpful in creating or improving organizational capacity for program delivery (74%) and strategies for teaching self-management skills (74%), both of which are essential for program sustainability. Also interesting is that of the list of 17 potential services or features, all the items were cited by more than 50% of respondents.

- *"[We developed a] better understanding of how to set goals."*
- *"[The NPO] assisted with data and tools to improve the existing goal setting to a more systematic and collaborative way."*
- *"[As a result of the CLN, we] created a depression group for diabetic patients and training promotoras in mental health issues."*
- *"Helped us to be more aware of its [ongoing follow up and support] importance and develop systems to implement it."*
- *"Assisted in creating a CHW model in a clinical setting. Before that, CHWs worked outside the clinic setting."*
- *"…helped us to better assess our assessment of the people that take our classes. They helped us to find questions that were more relevant to what we wanted to find out from our participants."*

Benefits Related to Development of Skills to Promote Diabetes Self Management

When asked which skills the CLN helped develop to promote diabetes self management, almost three-fourths (74%) chose presenting at conferences (Table 6). (The NPO provided guidance, support, and opportunities for grantees to develop presentations and presentation skills that would facilitate program dissemination and spread.) Approximately half also chose getting help with disseminating program materials and developing strategic communications plans, as reflected in the comments below:

- *"[We were helped] via communications training and a special session in one of our Learning Network meetings"*
- *"Even though we did not follow the [communication plan] specifically, it [the CLN] made us understand that communications need to be strategic and planned."*
- *"[CLN supported the development of] a manual for other programs to use and a video for potential clients."*

Table 6 (n = 49)

Has the CLN helped your organization develop the skills and/or capacity to better promote diabetes self-management within your provider network and/or your community (dissemination and spread) through any of the following?

Skills or capacity to…	Yes	No	Don't Know
Present at conferences	74%	16%	10%
Spread and disseminate program materials (videos, curricula, manuals etc.)	59%	20%	20%
Develop a strategic communications plan	53%	14%	33%
Develop marketing products (fliers, posters, etc.)	41%	29%	31%
Develop outreach materials	41%	31%	29%
Interact with the media	37%	33%	31%
Plan community events	27%	45%	29%

Benefits Related to Development of Skills to Measure Program Impact

When asked about benefits related to skills for measuring program impact (Table 7), two out of three respondents (67%) said that the CLN helped them develop or implement tools and methods for goal setting. A total of 57% credited the CLN with helping them set up databases to capture information. More than half (55%) of the grantees indicated that CLN provided them tools and methods to evaluate their programs. Developing methods for evaluating behavior change also were perceived as beneficial to more than half the respondents.

Typical comments included:

- *"We finally changed our goal setting sheet to include written action plans."*
- *"[CLN] helped us to set up a database to track the pre- and post-test that we use to track our participants."*
- *"Although it seemed pretty ambitious at times, at the end we saw the value of …continuous emphasis on more evaluations."*
- *"…assisting us in the clinical evaluation of our program. And getting qualitative information through interviews."*
- *"We now use clinic wide the PHQ-9 and that is then incorporated into treatment protocols such as medicine/counseling/groups, etc."*
- *"Facilitated the creation of tools to improve and also measure collaboration with other groups."*

The CLN approach was well accepted and embraced by grantees. All survey respondents identified multiple benefits for their programs. The most frequently reported overall benefit was the opportunity to interact with and learn from peers. This finding confirms the NPO's observation that grantee-to-grantee interaction continually increased over the course of the Initiative. Over time, individual grantees came to rely as much on each other as on the NPO for technical assistance. This, of course, has important implications for sustainability of programs when the funding (and NPO) ends.

Another important finding was that grantees had a favorable impression of how the CLN structure facilitated quality improvement. They identified the opportunity to learn from peers and outside experts about strategies for creating new services or improving existing ones as extremely important. Many also valued the opportunity the CLN provided to improve their communication skills through practice presentations to peers and encouragement to present at national meetings. In summary, no respondent had an overall negative perception of CLN processes or activities.

Table 7 (n = 49)

Has the CLN helped your organization develop the skills and/or capacity to measure your program's impact through any of the following?

Skills or capacity to…	Yes	No	Don't Know
Develop or implement methods/tools for goal setting	67%	16%	16%
Set up databases to capture information	57%	29%	14%
Develop or implement methods/tools for program evaluation	55%	31%	14%
Develop or implement methods/tools for evaluating behavior change	55%	22%	22%

Impact and Lessons Learned

Impact

The survey results and the comments clearly show that individual grantee programs were enriched by the CLN activities and processes. They reported benefitting from sharing among the grantees, learning from experts, and developing new skills, for example. These resulted in projects with greater organizational and programmatic capacity for quality diabetes care and self management support. Grantees expanded the types of intervention strategies based on new learning (e.g., incorporation of mental health components into programs and services) and the channels for delivery based on exposure to new program models and support afforded by the CLN (e.g., creating a community health worker model in the clinic). They developed new tools and shared existing ones with each other. Importantly, these improvements led to significant clinical and behavioral improvements among the people they served.[1-5]

Grantees' discoveries were not kept within the14 sites, but were shared as lessons learned through numerous venues. The expectations and support for dissemination and spread led to the development of a special supplement to the *Diabetes Educator* journal (2007, *33*, Supplement 6) that featured articles from nine of the projects and five from the perspective of the Initiative as a whole. Several sites also shared program models through manuals or curricula that they made available for distribution. Over the course of the Initiative, all the sites shared innovative aspects of their work through presentations and posters at relevant national conferences.

Contributions to the field that reflect the collective work of the teams include the products of the workgroups that were discussed. The collective work of the *Diabetes Initiative* is also evident in the materials developed and disseminated by the *Diabetes Initiative* NPO through its website,[21] publications,[8,9,11,13,22-28] and presentations.[24]

Lessons Learned

The process of the CLN created synergy that accelerated quality improvement. Projects developed beyond their original goals or expectations, and grantees were able to contribute to products that transcended individual project interests. This report covered the benefits of the CLN as reported by grantees of the *Diabetes Initiative.* Based on these results, the NPO identified a number of factors believed to have contributed to the successful implementation and sustainability of projects funded through the Initiative:

- *Adequate resources (program leadership, staffing, dedicated time)*
- *Processes and a framework that support improvement and change*
- *Commitment to long-term goals of dissemination, spread and sustainability, and multiyear funding to achieve them*

Resources

Technical assistance in the CLN was very hands on. The resources to provide this level of support included the core staff of the NPO (four full-time project staff in addition to a project director and part-time evaluation coordinator); support from key program personnel at RWJF; a National Advisory Committee; and various expert consultants. (The evaluation of the overall *Diabetes Initiative* was conducted by an external evaluator by contract with RWJF.) NPO staff were responsible for planning and facilitating technical assistance to ensure program success. The collaborative nature of the work built strong relationships among NPO and grantee project staff, without which the development of joint products and publications would have been impossible.

Another significant resource was the dedicated time of grantee project staff for face-to-face meetings as well as salary support and project funds for local staff to implement, evaluate, and improve new programs and services.

Processes that Support Improvement and Change

The *Diabetes Initiative* was a demonstration project. As such, grantees brought a wealth of expertise and experience to the CLN—from both clinic and community agency perspectives. To take advantage of the unique contributions each could make and create an opportunity for rich cross-site learning, the *Diabetes Initiative* hosted meetings that included grantees of both clinical and community programs. The CLN used a dynamic and fluid process that included ongoing interaction between material presented and grantee experience and reactions. For example, the

content of each formal meeting built upon or was influenced by previous meetings and interactions with grantees. Similarly, workgroups were formed in response to specific grantee needs. In this way, the general framework of Resources and Supports for Self Management and attention to disease-specific diabetes topics (e.g., physical activity or medication management) guided the content for the CLN but allowed flexibility to provide technical assistance to grantees that responded to their own experiences, needs, and programs. As noted, the CLN process also enabled discovery of new themes from grantee experiences in their programs and in response to presentations and group discussions.

Commitment to Long-Term Goals and Time

The program went through stages of development. As previously mentioned, grantee funding began with a 15-month planning phase. During that time, grantees laid the groundwork for their projects by hiring staff and testing their initial work plans, making changes as appropriate. The focus was internal; that is, at the individual program level.

By the time the program transitioned to the intervention phase, grantees had participated in three face-to-face grantee meetings, began deeper exploration of issues in the workgroups, and (most) had had a site visit by NPO staff. These group, face-to-face experiences provided opportunities for grantees to share and learn from leaders and from each other, a facet of the CLN that they reported to be especially rewarding and that escalated program development and improvement. In addition to a focus on improving their own projects, they developed a group identity and a team spirit that led to rich collaborations across sites. Grantees even began contacting each other outside the meetings to exchange resources, materials, and ideas.

As the Initiative matured and the sites began to have experiences that were proving effective, the work of the CLN trended increasingly toward moving the field forward—tapping into grantee experiences and expertise to look for themes, lessons learned, and results that could be shared with others working in clinical or community-based diabetes control, chronic illness care, or quality improvement. At the same time, individual projects began shifting their attention to sustaining and/or spreading their projects locally.

Although sustainability, spread, and dissemination were topics that ran through discussions from the *Initiative's* beginning, projects needed time to evolve—to implement and test quality improvement strategies—and to evaluate results of their program strategies. Developing a credible rationale for what should be sustained and identifying an audience that could benefit from their lessons learned were steps that could only be taken by mature programs. This work clearly follows a developmental path that requires sufficient time to move through the appropriate and critical phases from initial planning to having experience and results of sufficient import to warrant sustaining the programs and sharing their models with others.

This is a model that has much to offer funding agencies interested in more than providing funds to implement innovative programs. The interactive and high-touch approach of the *Diabetes Initiative* CLN built a learning community that supported excellence at the individual program level, resulted in sustainable models that have been shared as exemplars, and developed tools for public use that can accelerate the work of similar programs. Philanthropies and other funders may find these lessons learned instructive as they plan and support new programs.

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APPENDIX

This section includes:

- A cover note to grantees inviting participation in the survey
- The survey questionnaire

Cover Note To Grantees Inviting Participation

Hello!

As you may recall, the NPO is sponsoring an independent survey about the Collaborative Learning Network (CLN). The purpose of this survey is to determine the ways in which the CLN has been of value to you in implementing and improving your diabetes self-management program.

Below is the link to this survey. Please click on the link and complete the survey. At the end of survey, you will be asked to provide general comments and feedback about the survey itself. Please answer candidly as this information will be used to improve the survey.

Thank you in advance for participating in the survey. We appreciate your time and support.

If you have any questions about this survey, please contact Victoria Anwuri at the NPO (vanwuri@im.wustl.edu).

Thank you.

Survey Questionnaire

August 24, 2006

INTRODUCTION:

Thank you for taking time to participate in a brief survey regarding the *Diabetes Initiative's* Collaborative Learning Network (CLN). The purpose of this survey, sponsored by the National Program Office (NPO), is to determine the ways in which the CLN has been of value to you in implementing and improving your diabetes self-management program. This survey is being conducted by an independent third party, Fleishman-Hillard, Inc., and is completely confidential.

The term CLN as used in this survey includes the CLN meetings, annual meetings, ad hoc special topic meetings, workgroup meetings and conference calls, site visits, and sharing of resources by the NPO staff via email and phone. **In this survey, we are not asking about the scope of all the work you do, but about what the CLN has done to help you in your work.**

Please note that if you cannot complete the entire survey, you may save your work by clicking the Save Button below and closing your browser. When you return to the survey, you will be able to start where you left off.

1. In your opinion, what is the most important benefit that you associate with working or being affiliated with the *Diabetes Initiative's* Collaborative Learning Network (CLN)? *Please type your answer in the space below.*

2. Please look at the following benefits that could be affiliated with the CLN. Please **rank** the benefits from high to low (1 = high, 9 = low) in terms of how important each one is to your project. *Please rank all of the benefits. If you change your mind or make a mistake, simply click on the item again and it will remove the rating.*

_____ Learning (in general): from other grantees/sharing ideas

_____ Building relationships/networking with other grantees and the NPO staff

_____ Learning from experts in diabetes and special topic areas (depression, weight management, work with media, etc.)

_____ Resources for improving your program (materials, PDSA/PICS, program models, training, etc.)

_____ Learning about different program approaches, models, and theoretical frameworks

_____ Learning how to develop, measure, and evaluate program outcomes

_____ Learning about ways to get participants involved in your program

_____ Learning how to better communicate with patients and families about self-management

_____ Learning how to build networks that enhance aspects of your program (partnership, CHW networking, patient care teams, etc.)

3. To what extent has the CLN helped your diabetes program accomplish the following:

	Helped a lot	Helped Some	Helped a Little	Has Not Helped at All
Create any new features, services, or program components	**4**	**3**	**2**	**1**
Improve existing services or program components	**4**	**3**	**2**	**1**
Develop the skills and/or capacity to better promote diabetes self-management within your provider network and/or your community	**4**	**3**	**2**	**1**
Develop the skills and/or capacity to measure or monitor your program's impact	**4**	**3**	**2**	**1**

4. Has the CLN helped your organization **create new** services, features, or program components listed below, and/or **improve existing ones?** Select the appropriate answer(s) for each item. If yes to either, please explain how in the space provided.

	Yes		No to Both	Don't Know	If YES, how?
	Yes, Create New	Yes, Improve Existing			
Strategies for individualized assessment	1	2	3	4	
Strategies for collaborative goal setting	1	2	3	4	
Strategies for teaching skills for self-management (blood glucose monitoring, healthy eating, physical activity, problem solving, healthy coping, etc.)	1	2	3	4	
Strategies for addressing depression	1	2	3	4	
Strategies for improving community resources for diabetes management	1	2	3	4	
Strategies for providing ongoing follow up and support	1	2	3	4	
Strategies for enhancing clinical care	1	2	3	4	
Strategies for enhancing linkage among program components	1	2	3	4	
Strategies for improving organizational capacity for program delivery	1	2	3	4	
Program models, flow charts, logic models	1	2	3	4	
Community health worker component	1	2	3	4	
Training sessions for staff	1	2	3	4	
Program materials (videos, curricula, etc.)	1	2	3	4	
Patient education materials	1	2	3	4	
Strategic communications plan	1	2	3	4	
Outreach materials	1	2	3	4	
Assessment tools	1	2	3	4	

5. Has the CLN helped your organization *develop the skills and/or capacity* to better promote diabetes self-management within your provider network and/or your community (dissemination and spread) through any of the following? *(Please select one answer for each item.)* If yes, please explain how in the space provided.

	Yes	No	Don't Know	If YES, how?
Spread and disseminate program materials (videos, curricula, manuals etc.)	1	2	3	
Develop a strategic communications plan	1	2	3	
Develop marketing products (fliers, posters, etc.)	1	2	3	
Plan community events	1	2	3	
Develop outreach materials	1	2	3	
Present at conferences	1	2	3	
Interact with the media	1	2	3	

6. Has the CLN helped your organization *develop the skills and/or capacity* to measure your program's impact through any of the following? *(Please select one answer for each item below.)* If yes, please explain how in the space provided.

	Yes	No	Don't Know	If YES, how?
Develop or implement methods/tools for program evaluation	1	2	3	
Set up databases to capture information	1	2	3	
Develop or implement methods/tools for evaluating behavior change	1	2	3	
Develop or implement methods/tools for goal setting	1	2	3	

7. Have you participated in any quality improvement program(s) other than the RWJF *Diabetes Initiative*? *(Please select one answer.)*

1 ☐ Yes

2 ☐ No

8. Does your organization receive diabetes funding from any organization(s) other than the RWJF? *(Please select one answer.)*

   1 ☐ Yes

   2 ☐ No

   If yes to Q7 or Q8, continue to Q9.
   If no to both Q7 and Q8, skip to Q10.

9. In your opinion, how does your learning experience with the CLN component of the *Diabetes Initiative* differ from support you've received from other quality improvement programs or diabetes funders? *(Please type your answer in the space below.)*

EVERYONE:

10. In your opinion, what could the NPO do or have done to help improve its services to better meet the needs of grantees?

11. What is your job title?
    (Please type your answer in the space below.)

12. How would you describe your role in your diabetes self-management program?
    (Please type your answer in the space below.)

The next questions describe the setting in which your RWJF-sponsored diabetes project has been developed.

13. From which of the following programs did you receive funding? *(Please select one.)*

    1 ☐ ADSM (Advancing Diabetes Self-Management)

    2 ☐ BCS (Building Community Supports for Diabetes Care)

14. What type of audience do you serve? *(Please select all that apply.)*

    1 ☐ Urban

    2 ☐ Rural/Reservation/Frontier

15. Which of the following best describes the setting in which your diabetes project program has been developed?

    1 ☐ Free-standing organization

    2 ☐ Site, clinic, or division that is part of a larger organization

    If you selected 1, Continue to Q16.
    If you selected 2, Continue to Q18.

16. How many professional, administrative, and program delivery staff are in your organization? *(Please select one.)*

    1 ☐ Less than 25

    2 ☐ 26-50

    3 ☐ 51-100

    4 ☐ 101-250

    5 ☐ 251-500

    6 ☐ More than 500

17. How many patients or clients does your organization serve in one year?

    1 ☐ Less than 100

    2 ☐ 100-499

    3 ☐ 500-1000

    4 ☐ More than 1000

    Continue to Q21.

18. How many professional, administrative, and program delivery staff are in your site/clinic/division? *(Please select one.)*

    1 ☐ Less than 10

    2 ☐ 10-25

    3 ☐ 26-50

    4 ☐ 51-100

    5 ☐ 101-250

    6 ☐ 251-500

    7 ☐ More than 500

19. How many patients or clients does your diabetes program serve in one year?

    1 ☐ Less than 100

    2 ☐ 100-499

    3 ☐ 500-1000

    4 ☐ More than 1000

20. Do your diabetes project staff have the authority to make changes or improvements without obtaining approval from your parent organization?

    1 ☐ Yes, my staff has the authority to make changes without obtaining approval from our parent organization.

    2 ☐ No, my staff must receive approval from our parent organization before implementing any changes.

    3 ☐ Yes and no, it depends on the change. Please explain _____

    _____

    _____

EVERYONE:

21. Thinking of your role in your organization's diabetes program, to what extent have you been **directly** involved with the CLN?

    1 ☐ Highly involved (attended most or all meetings, workgroup sessions, and conference calls, actively shared resources and information with other staff in my program, and utilized new information to improve current program)

    2 ☐ Involved (attended many meetings, workgroup sessions, and conference calls, and used and shared resources and information with other staff in my program)

    3 ☐ Moderately involved (attended in some meetings, workgroup sessions, and conference calls, and used resources and information provided through the CLN)

    4 ☐ Not very involved (attended few meetings, workgroup sessions, and conference calls, and had limited use or awareness of information from the CLN)

    5 ☐ Not involved at all (attended no meetings, workgroup sessions, and conferences, did not share or use any new information)

22. To what extent has the CLN impacted your own professional development?

    1 ☐ A lot

    2 ☐ Some

    3 ☐ A little

    4 ☐ Not at all

23. Is there anything else you would like to share about your experience with the CLN? *(Please type your answer in the space provided.)*

24. What is the name of your organization? Optional *(Please type your answer in the space below. We will provide the NPO with a list of the organizations who participated in the survey. If you do not want this information released, please do not answer the question.)*

25. If you are willing to be contacted for follow-up, please provide appropriate contact information.

Name _____

Phone *(Please enter your 10-digit telephone number without the dashes)* _____

E-mail _____

Please click on the FINISH button to submit your answers to Fleishman-Hillard Research. Thank you!

Take advantage of additional resources offered by the Robert Wood Johnson Foundation *Diabetes Initiative*. Please visit ***www.diabetesinitiative.org*** to learn more about the *Diabetes Initiative* and find out about our customizable tools and models for self-management programs that are available to download.