

Diabetes Assessment

A Systems Approach

Maine Diabetes Health System Final Summary Report

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BACKGROUND

PURPOSE OF ASSESSMENT:

The Maine Center for Public Health was hired to conduct a rigorous systems-based assessment of the statewide diabetes system based on a modified version of the National Public Health Performance Standards assessment tool. The purpose of this assessment was to identify strengths, limitations, gaps, and needs within the system. The intent was to utilize the results of the assessment as the impetus for the development of an improvement plan.

FORMAT OF REPORT:

This “summary” report provides a brief overview of the assessment process and a synopsis of the major findings for each of the 10 Essential Public Health Services (EPHS). The intent of this “summary” report was to convey the overall findings in a condensed format for those who may be unlikely to read the full report.

The complete report detailing the process, participants, scoring mechanism, and findings is available upon request. This comprehensive 85-page report includes both the quantitative and qualitative results in greater detail and may be particularly worthwhile during the priority setting process of the improvement planning phase. In addition, this report includes feedback solicited on the assessment process.

ASSESSMENT PROCESS:

The formal assessment was conducted in the fall of 2003. A broad range of participants from various disciplines and settings were invited to participate. An introductory meeting with approximately 45 participants was held in September to share the plan, timeframe, and rationale for the relatively new process proposed for conducting a systems-based assessment. Opportunities for participating in the assessment or providing feedback, following the completion of the instrument, were presented.

Core Group Participants

The assessment tool was completed with a core group of approximately 25 individuals who committed to participate in a series of meetings over a three month interval. Members of this group represented a broad spectrum of system partners. Representatives included those from state agencies, advocacy organizations, health systems, local community-based programs, the non-profit sector, institutions of higher education, insurers, and others.

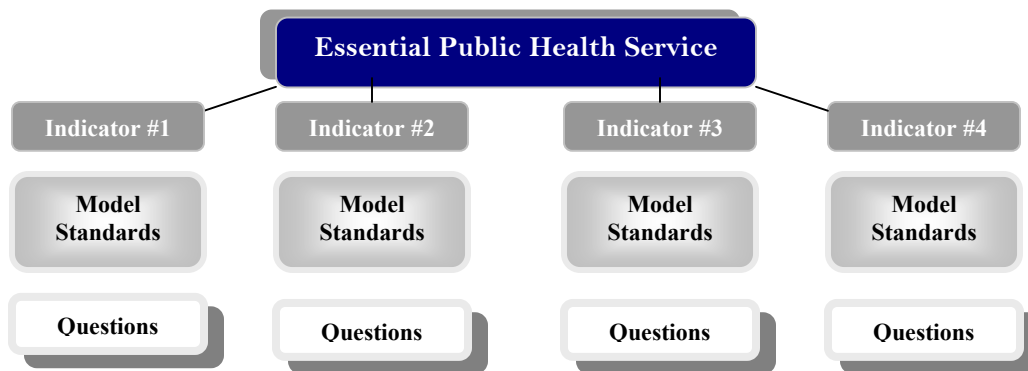
Framework

The 10 EPHS served as the framework for this assessment. The Essential Services were developed by a national taskforce to serve as a further delineation of the three core public health functions identified in 1988 by the Institute of Medicine (IOM). The services provide a mechanism to explain and examine the breadth of public health practice, as well as system performance and capacity. National public health performance standards are based on this framework.

Assessment Instrument

The 98-page assessment tool included a total of 808 questions. The questions were designed to address the extent to which specific diabetes-related models standards were achieved, based on four major indicators. The response options corresponded to a percentage of the activity that was met within the state diabetes public health system. Two summary questions at the end of each section assessed the contribution of the statewide diabetes system and the contribution specific to the state public health agency. Figure 1 depicts the framework for the assessment instrument.

Figure 1. Format of the Assessment Instrument



Scoring and Data Analysis

An algorithm, developed by the Centers for Disease Control and Prevention (CDC), was utilized to develop scores for each essential public health service. The score range included 0 to 100, with higher scores depicting greater performance in a given area.

In addition to the scores that were collectively assigned by the core group, qualitative information was recorded and assessed. Two professional transcribers captured the discussion and comments on laptop computers throughout the meetings. This information was projected onto a screen for all participants to view. Core group members were asked to clarify any comments that were inaccurately transcribed. Two independent reviewers assessed the qualitative data and major themes were devised.

BENEFITS OF ASSESSMENT:

There are many noteworthy benefits of a rigorous review. This assessment was intended to:

- Improve organizational and community communication and collaboration, by bringing partners to the same table.
- Educate participants about public health and the interconnectedness of activities, which can lead to a higher appreciation and awareness of the activities related to improving the public's health.
- Strengthen the diverse network of partners within state and local public health systems, which can lead to more cohesion among partners, better coordination of activities and resources, and less duplication of services.
- Identify strengths and weaknesses that can be addressed in quality improvements through the use of a nationally recognized tool assessing performance standards.
- Provide a benchmark for public health practice improvements, by setting a "gold standard" to which public health systems can aspire.

LIMITATIONS OF ASSESSMENT:

Despite the advantages of an assessment such as this, there are limitations related to the process, tool, data collection, and generalizability of results that warrant attention. They include the following:

Process Limitations

- Although attempts were made to encourage participation from multiple stakeholders, the core group of participants did not reflect a representative sample of partners within the system.
- The assessment format and expected commitment level may have precluded some participants from engaging in process. The group format may have deterred introverted individuals who prefer less interactive approaches and the time commitment may have hindered participation due to lack of employer support or conflicting priorities.

Tool Limitations

- The assessment tool was originally developed to assess an entire public health system. The modifications incorporated into the diabetes tool were not validated and the reliability of this instrument for a specific categorical issue is not fully understood. Furthermore, the lack of a formal definition for a diabetes public health system led to subjectivity during the assessment.
- The lengthy tool was detailed and cumbersome to complete in a consensus-building process. Reaching true consensus on each question was deemed to be unattainable in the given timeframe. Majority vote was used to capture individual item scores when consensus was not achieved.

Data Collection Limitations

- The response options delineated in the tool were awkward. Participants were reminded that a response of “no” did not connote zero activity, but rather reflected limited activity classified as less than 25%.
- The scores were subject to the biases and perspectives of those who participated in the core group and who engaged in the group dialogue.
- Although dissenting statements were recorded, the majority vote may not have adequately reflected the view point of many participants.
- The comments made during the group discussion were often difficult to accurately capture for a variety of reasons including multiple people speaking at once, individuals who could not be heard, comments that were spoken too quickly, or statements that contained too many unfamiliar acronyms. Every attempt was made to capture the qualitative comments, yet gaps exist.

Generalizability of Results

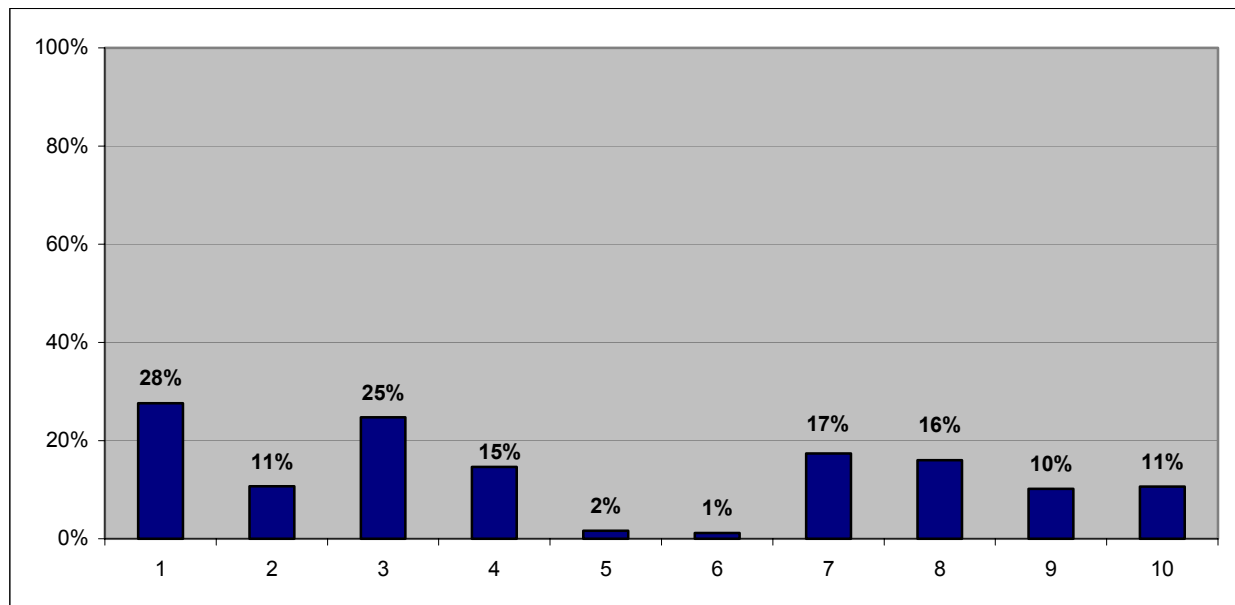
- The results of this assessment were based on a facilitated group process during a specific time period. Changes to the diabetes system at all levels constantly occur. This assessment provides a snapshot approach and the results are unique to the state of Maine.
- The results were intended to provide information in a constructive manner, and not to lay blame or find fault with any one member of the diabetes public health system. Therefore, the findings should be used accordingly.
- The results reflect strengths and deficits throughout the system. While attempts were made to determine local versus statewide activities and needs, this report does not attempt to distinguish between the various components of the diabetes system. If appropriate, generalizations of these findings to specific localities should be done with caution.

ASSESSMENT SCORES

ESSENTIAL SERVICE SCORES:

Each essential service received a score, or percentage, ranging from zero to one hundred. A perfect score of 100% indicates optimal level of performance. Chart 1 depicts the findings. In general, the essential services ranked below 30% suggesting room for improvement in all areas. The two areas with the most activity include essential services one and three; monitoring health status and educating people about health issues.

Chart 1. Overall Scores for Each Essential Service



Legend:

- | | |
|------------------------------------|-----------------------------------|
| 1. Monitor health status | 6. Enforce laws and regulations |
| 2. Diagnose and investigate | 7. Link people to needed services |
| 3. Inform, educate, empower | 8. Assure a competent workforce |
| 4. Mobilize community partnerships | 9. Evaluate health services |
| 5. Develop policies and plans | 10. Research for new insights |

These findings suggest that essential services five and six have minimal activity when compared to the remaining services. Limited activity may be a reflection of a number of issues, including lack of capacity, resources, time, or low priority, to name a few. Efforts should be made during the improvement planning phase to identify priority areas based on predetermined criteria.

INDICATOR SCORES:

The four major indicator scores (range 0 – 100%) across all essential services were: 1) 17% for planning and implementation, 2) 8% for technical assistance, support, and training, 3) 12% for evaluation and quality improvement, and 4) 18% for management of resources. Overall, each indicator score was relatively low and below the 20th percentile, suggesting room for improvement in all areas.

- Assessment of health status statewide
- Attention to vital statistics
- Identification of community assets
- Utilization of technology
- Integration of information systems

	48%
	23%
	16%
	23%

CURRENT STATUS:

- Maine’s biannual Diabetes Surveillance Report utilizes various surveillance efforts and tracks trends
- The Maine Bureau of Health has increased surveillance capacity and technical assistance as a result of new epidemiologists
- MaineCare has a diabetes registry and some local office practice sites have chronic disease registries to help track client data
- Select community programs have invested significant effort into data collection and reporting to community stakeholders
- Claims data, payer data, employer data, and not-for-profit data sources exist

GAPS:

Communication

- Limited data-related communication and sharing exists among data collecting entities
 - Local programs may only collect data provided to a state agency
 - HIPAA regulations may make data sharing more complicated
- Lack of awareness regarding existing data and resources is prevalent

Existing Data

- Data is often not available for key groups and issues
 - Disparities (e.g. Native Americans)
 - Risk Factors (e.g. pre-diabetes)
- Data may not be specific to those with diabetes (e.g. uninsured Mainers who have diabetes)
- Data quality varies
- Consensus on the diagnosis of pre-diabetes does not exist
- Local programs may not integrate data collected with other efforts
- Maine lacks a sub-state public health system to systematically collect and integrate local data

Resources

- Dissemination, coordination, and technical assistance needs exceed current staff resources throughout the system, at all levels
- Technology is underutilized at the state and local level (e.g. geo-coded data, and database software)

OPPORTUNITIES/CONSIDERATIONS:

- Develop an ongoing collaboration with partners on data collection. Create a plan to capture data, fill gaps, report findings, disseminate information, and evaluate efforts.
- Develop mechanisms to support rigorous data collection efforts statewide on key indicators
- Integrate existing surveillance efforts to include pre-diabetes and co-morbidity information

#2: Diagnose and Investigate Problems

SERVICE INCLUDES:

- Epidemiologic investigation of disease patterns of diabetes and other related conditions
- Opportunistic population-based screening, case-finding, investigation and analysis

Planning and Implementation	11%
Technical Assistance	18%
Evaluation and Improvement	0%
Resource Management	14%

CURRENT STATUS:

- Maine Bureau of Health operates a diabetes surveillance system:
 - Includes trend analysis
 - Is informed by science
 - Is integrated with national data
- Epidemiological capacity for chronic disease has recently increased
- The American Diabetes Association and Maine Bureau of Health disseminate research regarding diabetes (specifically for ADEF)
- The Quality Improvement Organization is working in this area

GAPS:

Surveillance System

- Incidence data are not captured
- Laboratory findings and other local data are not integrated
- Reviews of surveillance system are not currently conducted
- GIS capability is limited, although maps are currently included in report
- No system exists for assisting partners in epidemiologic analysis
- Additional data is needed on barriers to seeking care and disparate groups

Development of Plans

- No plan exists for a coordinated statewide response to diabetes risks that includes laboratories and other collaborators
- No formal plan exists for assessing surveillance activities and setting priorities for improvement

Communication

- Surveillance efforts and findings are not widely disseminated
- Policy makers are not systematically provided diabetes related information

Resources

- Limited capacity to meet all local needs to identify, analyze, and respond to diabetes risks
- Current law limits ability for opportunistic population screening
- Limited resources for investigation of priority areas for diabetes

OPPORTUNITIES/CONSIDERATIONS:

- Develop a plan to enhance, integrate, and routinely review the existing surveillance system
- Design a strategic plan that identifies risks and responds to those risks in a coordinated, collaborative way using available research. Develop an accompanying dissemination plan that includes all collaborators and key policy makers.
- Review restrictions on public screening for diabetes
- Use data and science to develop appropriate interventions

- Health education and promotion activities

SCORES (0-100%):

Planning and Implementation	34%
Technical Assistance	
Evaluation and Improvement	30%
Resource Management	17%

CURRENT STATUS:

- When available, research is incorporated into education materials
- Health education programs are implemented throughout
 - ADEF programs attempt to provide services in multiple community settings
 - Nontraditional models also exist (self-management, web learning)
- Training and technical assistance for social marketing, easy-to-read materials, and other health education strategies are available
- Some local programs review the appropriateness of education materials
- Health systems and insurers are beginning to support strategies designed to improve community and diabetes-related health

GAPS:

Coordination and Collaboration

- Limited coordination and consistency exists across the state for health education programs (e.g. ADEF, HMPs, DOE)
- Program participants are often not included in the planning and review of programs

Programs

- Health education programs are available statewide, yet gaps exist (i.e. ADEF reaches one-third of patients)
- Few initiatives focus on at-risk or pre-diabetes populations
- National guidelines on effective health education programs are limited, non-existent, or not widely disseminated
- Many channels for communication are used, yet more could be utilized

Resources/Expertise

- Limited resources are available for evaluating the effectiveness of health education communication efforts
- Maine has limited expertise in health communication

OPPORTUNITIES/CONSIDERATIONS:

- Develop and implement a comprehensive and coordinated health education and health communication strategy for diabetes and pre-diabetes. Link the plan with ADEF, HMPs, ADA, MaineCare, and other strategic partners. Include members of the target audience in planning and evaluation.
- Expand the availability and support of social marketing and easy-to-read training programs
- Conduct a comprehensive literature review to identify best practices
- Evaluate existing interventions in an effort to determine appropriateness and effectiveness
- Explore alternative delivery models (e.g. home visits)

#4: Mobilize Partnerships

SERVICE INCLUDES:

- Organization and leadership to convene and facilitate statewide partners
- Building of a state-wide partnership
- Assistance to partners and communities to organize

SCORES (0-100%):

Planning and Implementation	21%
Technical Assistance	12%
Evaluation and Improvement	
Resource Management	26%

CURRENT STATUS:

- Constituency building around diabetes issues is going on across the state and select areas at the local level have excelled at engaging partners
- Electronic communication has facilitated statewide interaction among some diabetes stakeholders
- The MaineHealth Collaborative has served as a mobilizing force for decision-making and action and has begun to share resources
- Employers are increasingly becoming interested in diabetes due to escalating health care costs
- Technical assistance in community development and team management is available through a variety of sources
- Several entities are collaborating in an effort to leverage system-wide resources for partnership mobilization

GAPS:

Involvement

- There is limited involvement from some sectors of public health
- Existing partnerships often involve “the same people”

Communication

- No process is in place for routinely engaging and briefing policy leaders and other stakeholders
- There is no mechanism in place to communicate with all diabetes stakeholders on routine basis, particularly the non-traditional partners
- Many channels for communication are used, yet more could be utilized

Collaboration

- Limited collaboration exists within state government related to diabetes
- Limited evaluation efforts focus on constituency-building, particularly with regard to diabetes
- Benefits and priorities of collaboration at each level are not delineated or fully understood

OPPORTUNITIES/CONSIDERATIONS:

- Develop a plan to mobilize partnerships (including non-traditional partners) at both the state and local level (e.g. Diabetes Health Council)
- Identify opportunities to engage new partners and share resources for diabetes-related efforts
- Develop strategies to enhance collaboration within state government, specific to diabetes-related issues
- Evaluate existing mobilization and constituency-building activities
- Strengthen Maine’s public health constituency and enhance the sub-state public health infrastructure
- Expand training opportunities on coalition-building and advocacy to include local diabetes programs
- Develop a plan for identifying costs and benefits of partnerships

- Systematic health planning that relies on data

e

SCORES (0-100%):

Planning and Implementation	0%
Technical Assistance	0%
Evaluation and Improvement	0%
Resource Management	7%

CURRENT STATUS:

- Healthy Maine 2010 identifies diabetes objectives and current status
- The diabetes surveillance system is in place and could guide planning and policy development
- Select health systems have provided resources and assistance to communities in an effort to help identify priorities
- Many communities have developed plans to address diabetes related issues
- Many local areas are developing or have developed local policies
- The MaineCare program conducts policy development activities

GAPS:

Planning and Tracking

- A state health plan for diabetes does not exist
- Communities may not have access to local data to set policy priorities
- Progress reports for diabetes health objectives are not available on an annual basis

Resources

- Technical assistance and training is limited, or not available, for local diabetes related health planning and policy development efforts
- Expertise in health policy analysis and development is limited
- Limited financial resources and competing priorities have made policy development difficult
- High needs areas for policy development may not be clearly understood due to a lack of sufficient or reliable data

OPPORTUNITIES/CONSIDERATIONS:

- Develop a comprehensive state diabetes health plan
- Identify a process for developing priorities for policy at the state level
- Develop strategies for setting priorities for policy at the local level
- Support policy development efforts that rely on data
- Work collaboratively to implement key policy priorities
- Identify opportunities for securing policy analysis expertise for diabetes related issues
- Participate in the development of a State Health Plan under Dirigo Health that may provide an opportunity to identify and track diabetes-related health objectives

SERVICE INCLUDES:

- Review, evaluation, and revision of laws and regulations to protect health
- Education of persons and entities obligated to obey or enforce laws and regulations
- Enforcement activities

SCORES (0-100%):

Planning and Implementation	5%
Technical Assistance	0%
Evaluation and Improvement	0%
Resource Management	0%

CURRENT STATUS:

- A review of current laws led to the passage of PL 592 in 1995 which requires insurance coverage for diabetes supplies and self management training (ADEF). This excludes some groups (e.g. self-insured groups)
- MaineCare and large insurers in Maine provide incentives to encourage compliance of PL 592
- Various events include education and training about PL 592
- The Bureau of Insurance enforces laws and reviews benefits
- Laboratories are regulated in how testing can be done
- School nurses are regulated in administering insulin

GAPS:**Planning and Tracking**

- Systematic reviews of enforcement practices do not exist
- Specific enforcement guidelines are not documented
- A central place for complaints to be heard and tracked does not exist
- The impact of current laws on the diabetes population are not fully understood

Resources

- Limited resources exist to effectively enforce laws and regulations and to monitor enforcement procedures
- PL 592 is difficult to enforce with out-of-state insurers
- Technical assistance is virtually nonexistent in this area
- High priority areas for policy development and enforcement have not been identified

OPPORTUNITIES/CONSIDERATIONS:

- Assess current enforcement activities and opportunities and identify areas of improvement based on needs and priorities
- Develop a plan to collaborate with agencies that are best able to enforce laws, review activities, and monitor compliance
- Identify a process for developing priorities for policy enforcement at the state level (e.g. payment of pre-diabetes services)
- Develop strategies for setting priorities for policy enforcement at the local level
- Offer ongoing educational opportunities to persons and entities obligated to obey or enforce laws and regulations
- Build support for new laws that support a comprehensive approach

#7: Link People to Needed Services

SERVICE INCLUDES:

- Assessment of access to and availability of quality services
- Assurances that access is available
- Partnership with public, private, and voluntary sectors
- Development of improvement process

SCORES (0-100%):

Planning and Implementation	18%
Technical Assistance	7%
Evaluation and Improvement	28%
Resource Management	17%

CURRENT STATUS:

- A number of assessments on the availability and utilization of personal health care services have been done at the local and state level
- Local level access projects and Collaboratives have been established
- Projects exist to increase access to MaineCare
- Many programs work with providers to assure care for the underserved
- Maine has begun to coordinate resources for chronic disease
- The Chronic Care Model is being introduced in Maine
- Efforts are underway to address health care provider shortage areas
- Some programs provide education, transportation, and outreach services
- Programs exist to identify those eligible for state medical assistance

GAPS:

Coordination and Data

- Assessment activities are not coordinated statewide
- Information currently collected may not be specific to diabetes
- Limited data is available at the local level and for underserved populations, specifically those with diabetes and those at risk of diabetes

Programs/Services

- Systematic statewide reviews of programs using national guidelines are not done
- Access programs are often not specific to diabetes and only available in select locations
- Barriers to accessing care and gaps in the availability of services may not be well understood
- Mental health is becoming an increasing need among program recipients

Resources

- Limited staff time and expertise available to evaluate and track diabetes related health care availability, access, usage, and quality of care
- Few people in Maine currently conduct rigorous health care analysis specific to diabetes
- Significant resources have been invested in chronic disease in Maine, yet few of the efforts or resources specifically focus on diabetes

OPPORTUNITIES/CONSIDERATIONS:

- Dirigo Health may provide opportunities to increase access
- Evaluate current access projects throughout Maine and share lessons learned
- Identify needs and preferences specific to those with diabetes or at risk for diabetes, particularly for underserved populations
- Develop strategies for responding to needs and identify priority areas for improvement
- Utilize social marketing techniques to encourage action or response

#8: Assure a Competent Workforce

SERVICE INCLUDES:

- Education, training, and assessment of health professionals
- Efficient process for credentialing
- Adoption of improvement programs
- Partnerships with workforce programs
- Continuing education

SCORES (0-100%):

Planning and Implementation	20%
Technical Assistance	0%
Evaluation and Improvement	16%
Resource Management	28%

CURRENT STATUS:

- Bureau of Health trainings are available and grantees can often use grant funds to cover the cost of attending (e.g. HMPs, DPCP)
- Some organizations currently use performance appraisal programs to stimulate individual and organizational quality improvements
- UNE has a public health certificate program and is leading to an MPH
- The Maine Bureau of Health has been able to leverage funds to enhance epidemiologic capacity
- Lifelong learning is supported and training exists for individual professional groups

GAPS:

Development of Plans

- Maine lacks a workforce development plan that coordinates lifelong learning opportunities and strategies to develop competencies
- Maine does not have a process for assessing the diabetes-related workforce
- The chronic care model should be integrated into medical education

Trainings

- Limited opportunities exist to publicize educational opportunities on websites that are routinely maintained
- Training is limited for non-degree individuals (e.g. certified nurse and medical assistants)
- Personnel are often forced to participate in educational programs on their own time
- Lifelong learning may be supported, but few employer incentives exist
- Local data, if available, is often limited

Resources

- Limited resources are available for workforce development
- Many public health professionals are recruited out-of-state
- The system is reactive and no current payment streams exist to support workforce development activities

OPPORTUNITIES/CONSIDERATIONS:

- Increase collaboration across academic institutions, state agencies, local agencies, and hospitals for lifelong learning and the promotion of educational opportunities
- Develop a workforce improvement plan with specific strategies to improve workforce competencies
- Make education and training opportunities more accessible, affordable, and visible
- Work collaboratively with employers, institutions of higher education, and others to develop an incentive plan for workforce development
- Invest resources to recruit and retain qualified health professionals in all areas of the state

#9: Evaluate Health Services

SERVICE INCLUDES:

- Evaluation and critical review of health programs for decision-making and resource allocation
- Assessment of and quality improvement in systemwide performance and capacity

SCORES (0-100%):

Planning and Implementation	8%
Technical Assistance	0%
Evaluation and Improvement	22%
Resource Management	10%

CURRENT STATUS:

- Evaluation efforts are happening at the state and local level and some local efforts are specific to diabetes
- Collaboration exists among state Bureau of Health programs for evaluation of the Healthy Maine Partnership Program
- Some programs (e.g. MaineCare) utilize mid-course reviews to assess programs to assure that the interventions are appropriate
- When available, performance evaluations have been used to help guide strategic planning processes
- Many organizations utilize analytical tools to help monitor performance

GAPS:

Evaluation Efforts

- No systematic statewide evaluation exists specific to diabetes or pre-diabetes
- Evaluation efforts and findings are rarely shared among all stakeholders
- Current data gaps pose challenges for evaluation

Technical Assistance

- Technical assistance in the area of evaluation is not specific to diabetes
- Limited technical assistance opportunities exist on an ongoing basis

Resources

- Limited resources exist to make improvements based on evaluation findings
- Limited capacity exists to review evaluation and quality improvement activities on a predetermined, periodic basis

OPPORTUNITIES/CONSIDERATIONS:

- Develop a statewide evaluation plan specific to diabetes health objectives that is based on consistent indicators and measures of success
- Invest in evaluation capacity building efforts for state and local partners
- Provide training in the area of evaluation, specific to diabetes
- Develop a plan to offer technical assistance to those in need
- Translate research findings into information that is actionable
- Encourage the use of evaluation findings for program-level decision making and resource allocation
- Create mechanisms to routinely disseminate evaluation findings to stakeholders

#10: Research for New Insight

SERVICE INCLUDES:

- Full continuum of research
- Linkage with research institutions and other institutes of higher learning
- Internal capacity to mount timely epidemiologic and economic analyses

SCORES (0-100%):

Planning and Implementation	3%
Technical Assistance	0%
Evaluation and Improvement	5%
Resource Management	35%

CURRENT STATUS:

- Some institutions currently have a research agenda that includes public health issues
- Many opportunities currently exist to share research findings including annual conferences, newsletters, and trainings
- The Bureau of Health and other partners are collaborating to leverage resources and focus research activities
- National research (e.g. chronic care model) is currently being used to drive practice at the local level
- Providers are increasingly interested in helping to provide data for research and many have databases in place

GAPS:

Research Activities

- Maine does not have a research agenda specific to diabetes
- Research dissemination activities are inconsistent and vary considerably
- Existing research efforts are not initiated by the diabetes system
- Translating research to local initiatives and settings can be challenging

Technical Assistance

- Technical assistance in the area of research is limited, particularly for interpreting results and generalizing the findings
- Limited technical assistance exists with regard to applying research findings to population-based interventions

Resources

- Limited workforce resources exist to conduct rigorous research in the area of diabetes
- Maine's skilled researchers are often not available

OPPORTUNITIES/CONSIDERATIONS:

- Develop a Maine diabetes research agenda
- Identify priority areas for research and seek funding opportunities
- Work collaboratively with research institutes and institutions of higher education
- Investigate new data sources (e.g. all claims database) to help identify potential research opportunities
- Develop training and technical assistance opportunities

SUMMARY OF OPPORTUNITIES

The opportunities documented in this report are intended to be used as a springboard for discussion during the improvement planning phase of the Bureau of Health's diabetes grant awarded by the Centers for Disease Control and Prevention. The list is not exhaustive, nor is it intended to be. Furthermore, the potential opportunities are not ranked in order of priority, a process that will likely need to be delineated and undertaken prior to implementation of the state's strategic plan.

Below, several opportunities for consideration are listed:

1. Enhance data and surveillance activities by developing a plan to:
 - Collect information on priority areas (e.g. risk factors, disparities)
 - Link with existing data sources, both traditional and non-traditional
 - Integrate with other surveillance efforts
 - Collaborate with partners on data collection
 - Routinely disseminate information to all collaborators and policy makers
 - Evaluate surveillance activities and data collection efforts on an ongoing basis
2. Enhance communication and collaboration efforts by:
 - Developing a plan to mobilize partnerships at all levels of the system to...
 - Share resources
 - Discuss research findings and best practices
 - Identify and develop educational opportunities that are accessible, affordable, and visible
 - Leverage funds
 - Support policy development and enforcement efforts
 - Evaluating communication activities and collaborative efforts
3. Expand existing policy and advocacy efforts by:
 - Developing a comprehensive state diabetes health plan
 - Using data, research, and evaluation findings to set priorities
4. Enhance diabetes-related services and programs by:
 - Identifying needs specific to those with diabetes or at risk for diabetes, particularly for underserved populations
 - Developing strategies for responding to needs based on best practices
 - Identifying priority areas for improvement
 - Evaluating existing interventions and projects in an effort to determine appropriateness and effectiveness
 - Acting on and modifying existing services and programs (as appropriate) based on evaluation and research findings
5. Enhance and expand workforce diabetes-related and public health educational opportunities by:
 - Creating a workforce improvement plan that is competency-based
 - Collaborating with employers, institutions of higher education, and others to develop incentive programs for workforce development
 - Investing resources to recruit and retain qualified health professionals

Appendix A:

Acronyms

ACRONYMS

ADA:	American Diabetes Association
ADEF:	Ambulatory Diabetes Education and Follow-Up
BOH:	Bureau of Health
CDC:	Centers for Disease Control and Prevention
DPCP:	Diabetes Prevention and Control Program
DHS:	Department of Human Services
EPHS:	Essential Public Health Services
GIS:	Geographical Information System
HIPAA:	Health Insurance Portability and Accountability Act
HMPs:	Healthy Maine Partnerships
IOM:	Institute of Medicine
PL:	Public Law
UNE:	University of New England