**Sustaining the Diabetes Self-Management Program**

**Report from An Invitational Conference sponsored by**

**Group Health Research Institute**



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**Executive Summary**

The effectiveness of diabetes care hinges on both outstanding medical care and on *diabetes self-management (DSM).* To support DSM, researchers at Stanford University developed the *Diabetes Self-Management Program* (DSMP). 1, 2 With funding from the Washington State Attorney General, researchers at Group Health Research Institute supported the startup of three new DSMP programs in English and Spanish, collaborating with three agencies in eastern Washington – Community Choice in Wenatchee, Inland Northwest Health Services in Spokane, and the Benton-Franklin Health District in Tri-Cities. A persistent challenge with such grant-funded programs is its transitory nature. Great time and effort are spent developing successful programs, which may then be disbanded if funding cannot be maintained. Anticipating this challenge, we organized an invitational sustainability conference, *Sustaining the Diabetes Self-Management Program*, on April 20, 2016*.* The purpose was to*:*

***Bring together a diverse audience of stakeholders to explore strategies for sustainability of diabetes and other self-management programs at the local and statewide levels***

Starting in January 2016, a planning committee guided conference development, set the agenda, and identified attendees. We used *World Café* methods to gather information related to three questions:

1. Why are chronic disease self-management programs important to our communities? What differences do these programs make? What are you seeing? What’s happening?
2. What would be possible if we continue in the next generation of our work?
3. How can we activate our community (local, county, state – leadership and resources) around this need?

Analysis completed in July 2016 found that six broad themes emerged from the presentations and discussions: 1) benefits; 2) challenges; 3) business/employers; 4) state-level issues; 5) community-level issues; and 6) outreach.

1. Three areas of benefits were noted: health benefits, social benefits, and building skills and tools.
* The DSMP complements medical care. By helping people learn how to work with their health care team it may help them overcome their resistance to formal medicine, increasing communication with their doctor or other health care practitioners.
* Social benefits were noted at the personal, family and community levels. On the personal level, from participants to lay leaders there are opportunities for service which are both a responsibility and privilege. The DSMP may promote better communication in families as all become more aware of symptoms and needs. Diabetes profoundly affects the community. In the workshop, participants are with a group of people who won’t judge them – it is a safe place which can break social isolation.
* Skill building is key to the DSMP. The program provides tools for people to manage their own health. It gives them the skills to manage symptoms, teaches them the steps to reach goals that can be beyond health issues, and puts them in control of the outcome of their condition.
1. Challenges include time, costs, and people.
* The DSMP is time intensive with layers of training and recruitment needs. Program activities that take time include startup, outreach, program promotion, supporting lay leaders, and recruiting and training volunteers.
* The DSMP has inherent costs including personnel for program management, training master trainers and lay leaders, marketing, advertising, recruitment, supplies, food for attendees, workshop space rental, child care, fidelity monitoring, and honoraria for lay leaders. Each program must organize and make efforts to decide how to find program funds. Funding is fragmented. State funds for diabetes education are underutilized, in part because the reimbursement process for complicated. Depending on the financial situation of a community, it may be difficult to find people who can be ongoing lay leaders without compensation. Certified diabetes educators (CDEs) are paid, while lay leaders are not, and there is concern about the fairness of this approach.
* A key people challenge is developing trust and buy-in at the community and family levels. This can take time, as community members attend workshops and then spread the word. There are also people issues related to health care providers. There is a history of territoriality on the part of diabetes educators. However, when more formal diabetes education and the DSMP are viewed as complementary the person with diabetes gets the best of both approaches. Primary care providers and endocrinologists have difficulty keeping the program in mind and are usually a poor referral base.
1. Businesses/employers can be strong advocates in supporting the DSMP.
* There are many ways to promote the value of the DSMP to business and employers. State reports can be used to quantify the costs of diabetes, and local areas may be able to quantify how much it costs to NOT support diabetes self-care.
* Businesses may donate space for workshops, provide monetary or in-kind donations (healthy snacks, printing, space), and give employees time to attend workplace workshops. Program managers can benefit from communicating with local business leaders about the program.
* In some communities the DSMP may be the only resource for education and support for people with diabetes, and the workshops can have a large impact on those who attend. The hope is to reduce morbidity and mortality from complications of the disease, and to reduce job-related absenteeism due to uncontrolled diabetes.
* The workshop is an investment in the lives of the employees – part of health promotion. When their employers value them and invest in their long-term health employees feel greater commitment to the employer.
1. State-level issues
* Diabetes costs Washington State $4 billion / year in health care costs, lost work, and diminished productivity.
* One of the biggest challenges in Washington is the need for improved statewide coordination.
* The billing picture is complicated – there was a universal desire to have insurers support the DSMP and other self-management programs as a covered benefit – and while some do this it is not currently required by the state.
* The DSMP is one approach to help meet one of the largest health challenges in the state. State leaders need to communicate with those who are actually doing the work.
1. Community-level issues
* Community engagement with DSMP programs varies. At the county level there may be few resources to offset program costs.
* Communication with community organizations can lead to a structured solid program. Organizations can be the source of both participants to fill classes and structural and fiscal support for programs.
1. Outreach is one of the most important responsibilities of the organization supporting the DSMP.
* Despite the documented program benefits it can be challenging and time-intensive to build and maintain a pool of leaders and master trainers and to maintain program enrollment.
* Over time, and as programs become established, leaders can become a valuable voice for successful outreach.
1. **Overview of the issues**

The National Institutes of Health estimate that diabetes affects 11.3% of all Americans aged 20 years or older and 27% of those over age 653; the majority have type 2 diabetes mellitus (T2DM). In 2012, 81,000 Washington state residents aged 64-75, and 63,000 aged 75+, had diabetes4 . Diabetes doubles medical expenses, and management is complex 5. Controlling blood sugar levels (measured with the HbA1c test), blood pressure, and lowering cholesterol levels are key, and a tailored mix of medications is usually necessary to treat this triad of factors.

The effectiveness of diabetes care hinges on both outstanding medical care and on *diabetes self-management (DSM).* Self-management refers to the decisions and behaviors that patients with T2DM make every day - whether to take and adjust their medications, what to eat, whether to exercise, monitor their blood sugar and blood pressure, and whether to schedule an eye exam. These decisions directly affect the trajectory of the disease and the likelihood of serious complications including heart disease, kidney failure, and blindness. To support DSM, researchers at Stanford University developed the *Diabetes Self-Management Program* (DSMP). 1, 2 The program is a 6-week workshop that empowers people with T2DM to take control of their disease in their everyday lives.

The DSMP effectively promotes positive diabetes outcomes1, 2, 6, 7. The DSMP has been shown to improve self-efficacy, depression, low blood sugar episodes, communication with physicians, healthy eating, and patient empowerment1. Integration of DSM with primary care is important because primary care providers are responsible for individualizing the medications to treat diabetes and co-occurring hypertension and lipid abnormalities. But this can be very difficult to accomplish. Access to community-based DSMPs is limited and training for primary care teams in self-management support sparse.

With funding from the Washington State Attorney General, researchers at Group Health Research Institute supported the startup of three new DSMP programs in English and Spanish by collaborating with three agencies in eastern Washington – Community Choice in Wenatchee, Inland Northwest Health Services (INHS) in Spokane, and the Benton-Franklin Health District in Tri-Cities. A persistent challenge with such programs is that grant funding is temporary. Great time and effort are spent developing successful programs, which may then be disbanded if funding cannot be maintained. Anticipating this challenge, we organized a sustainability conference - *Sustaining the Diabetes Self-Management Program*. The purpose of this 1-day invitational conference was to*:*

***Bring together a diverse audience of stakeholders to explore strategies for sustainability of diabetes and other self-management programs at the local and statewide levels***

1. **Planning**

A planning committee guided conference development, set the conference agenda, and identified speakers and conference attendees. A diverse group of potential stakeholders from across the state was selected to attend the conference. We held the conference in Ellensburg WA - a site that was equidistant from our three funded sites, and was accessible with same-day transportation.

As we discussed the conference, one of the planning committee members, Deb Miller, suggested that we use *World Café* methods to gather information during the conference. The group responded with great enthusiasm and the methods were employed as outlined below.

1. **Methods for organizing the conference, recording, and summarizing findings (see Appendix 1 for an expanded discussion of the methods used)**

World Café uses clusters of small groups (4-5 people) conversing together about issues or work that matters to them. We used the seven design principles underlying this method to structure the conference.

1) Set the Context: We were very clear about the purpose of the sustainability conference. We invited speakers and attendees who would further that purpose and contribute to the sustainability conversation.

2) Create Hospitable Space: We provided parking, drinks, snacks and lunch. We placed butcher paper, multicolored pens, and Play-Doh at every table to encourage recording and interaction and keep the mood light. We had a sufficient number of tables that everyone could sit facing the front.

3) Explore Questions that Matter: We found the information on the World Café web site about asking questions that matter particularly helpful.

 ([https://www.principals.ca/documents/powerful\_questions\_article\_(World\_Cafe\_Website).pdf](https://www.principals.ca/documents/powerful_questions_article_%28World_Cafe_Website%29.pdf) )

Using the powerful question guidelines we came prepared with three questions:

1. Why are chronic disease self-management programs important to our communities? What differences do these programs make? What are you seeing? What’s happening?
2. What would be possible if we continue in the next generation of our work?
3. How can we activate our community (local, county, state – leadership and resources) around this need?

A table “host” was assigned for each table, and tables were limited to 3-5 participants. Others moved on to different tables with each new question. We assigned the participants for each table so that with each change the participants would be among a new group. These rounds of conversation enabled the goal of harvesting what a community thinks or feels about a topic.

4) Encourage Everyone’s Contribution: We used several techniques to encourage all to participate including table orientation and limiting the number at each discussion table.

5) Connect Diverse Perspectives: Meeting attendees brought a wide variety of perspectives to the conversation – business leaders, leaders from the Washington state Department of Health, administrators from health plans and community non-profits, academicians, community health workers and *promotores*, and chronic disease workshop lay leaders and workshop attendees.

6) Listen Together for Patterns and Insights: We invited recorders to think about what they heard during morning presentations and to record their observations from specific perspectives, or story arcs: 1) Taking change to scale; 2) Pivotal points – what did we learn from breakthroughs of others; and 3) Specific Themes – what themes were heard and what do they tell you?

7) Share Collective Discoveries: Each table host shared with the entire group the themes and ideas they heard at their table. This was followed by a period of group discussion and reflection. Recorder notes were shared with those summarizing the findings of the conference.

1. **Findings**

Reviewing all notes from table hosts and recorders identified seven broad themes: benefits; challenges; business/employers; state level issues; community level issues; and outreach. The enthusiasm for the work overall was best captured by two comments: that “We could change the world – healthy lives in a way that works!” and that we could “Eradicate chronic disease in a few generations: teach early on – family accountability”.

**Benefits**

Three areas of benefits were noted – health benefits, social benefits, and the building of skills and tools.

Health benefits – Self management is an investment in health on several levels.

The DSMP is a natural complement to usual medical care. People don’t want to be told what to do. By helping people learn how to work with their health care team it may help them overcome their resistance to formal medicine, increasing communication with their doctor or other health care practitioners. The program is a good complement to the 1:1 education provided by certified diabetes educators (CDEs) and adds a new dimension to care. “It translates information in a way that teaches you how to live with diabetes.”

There are also personal benefits. When people are not in a panicked place of just learning they have diabetes they may realize they have more options and may be more likely to seek out education. The program teaches participants that diabetes isn’t a death sentence; its very title – “Living Well” – gives hope. It generates an enthusiasm to learn and to take control, rather that feeling defeated. A person becomes responsible for their own health and they are thus much more likely to take care of themselves, taking accountability and choosing to live a healthier lifestyle. Setting goals can carry over – it teaches the steps to achieve a goal and tools that carry over to other areas of their lives.

Finally many commented on better quality of life as a major health benefit.

Social benefits – there are also social benefits to the program. Diabetes impacts the individual, the family, and the community, and the DSMP can have effects on all of these areas.

On the personal level, the DSMP approaches people as individuals. From participants to lay leaders there are opportunities for service which are both a responsibility and privilege. People who may not even know they have diabetes hear about it, talk with their doctor, go to workshops – it’s a cycle that can work through social networks. The empowerment found in the personal experiences provided in the workshop improves self-confidence. It can be highly motivating, increasing the amount of social capital that a person can contribute.

Many also commented on the profound impact going to a workshop can have on the family. Diabetes affects the whole family. The DSMP may promote better communication in families as both the people with diabetes and their family members become more aware of symptoms and needs. When caregivers come to the workshop it helps support them to prevent diabetes in other family members. This knowledge can be passed through generations – improving the health of families – children benefit from adults making lifestyle changes. In this way it impacts the next generation in the family and their health. Perhaps we could eradicate chronic disease in a few generations by teaching early and promoting family accountability. Bringing children to the workshop was endorsed as a potentially impactful activity.

Diabetes profoundly affects the community. In the workshop, participants are with a group of people who won’t judge them – it is a safe place. This can break social isolation: “You don’t feel like you’re the only one”; it is a shared struggle and “I’m not in this alone”. The leaders are usually someone participants can identify with. The workshop eliminates the power differential and feelings of being “less than” sometimes present between health care professionals and patients. Lay leaders are also empowered to give back to the community in many ways – for example by helping to recruit participants at health fairs – and this is an additional form of personal development. The program builds community strength through empowerment. A strength of the lay-led model is that members from a community can communicate in their own language – it does not require culturally competent employees. Self-management breaks cultural barriers and enhances cultural community.

Skills/Tools

Skill building is key to the DSMP. The program provides tools for people to manage their own health. It gives them the skills to manage symptoms, teaches them the steps to reach goals that can be beyond health issues, and puts them in control of the outcome of their condition. Participants learn to ask more questions beyond the workshop. The conversations in the workshop matter because “how you live with it is more important than the clinical piece.” The acquired skills can then be shared with the community.

**Challenges**

Time

Time is one of the main challenges with the DSMP. It is time intensive with layers of training and recruitment needs. It takes a lot of effort to start a program and scale up, as does getting the word out about the program. On the broader level there is concern that many efforts are duplicated – that it may waste time and money. It is labor intensive to promote the program and support lay leaders, and it can be hard to recruit and retain volunteers. It can be hard to find the time to build relationships with providers and other community partners for continual referrals, which are critical to the success of the program.

Costs

Running the DSMP has inherent costs – someone must organize the program locally, typically a designated program manager from an agency. Master trainers and lay leaders must be trained. Other costs can include marketing, advertising, recruitment, supplies, food for attendees, workshop space rental, child care, someone to monitor fidelity, and honoraria for lay leaders. Without funds for these activities it is impossible to maintain a program.

Reimbursement for the program can come from a variety of sources, but each program must organize and find program funding. Currently funding is fragmented. Some programs are funded by grants, surviving from grant to grant – but this is a risky way to support a good program long-term. Insurance typically funds a set number of hours to provide everything they (e.g. diabetes educators) need to accomplish. The lay led DSMP is most commonly not included as a reimbursable expense. At the same time, state funds for diabetes education are underutilized, in part because the process for reimbursement is complicated. Greater clarity is needed in this area. Buy-in from insurance companies is needed as well.

Another issue is whether leaders should be paid. The DSMP and other chronic disease programs employ a peer-leader model. Leaders often receive a modest stipend, and sometimes travel costs, but this is not a salary. Depending on the financial situation of a community, it may be difficult to find people who can be ongoing lay leaders without compensation. CDEs are paid, while lay leaders are not, and there are concerns about the fairness of this approach.

People

One of the key people challenges is developing community level trust. This can take time, as community members attend workshops and then spread the word. Leaders must meet participants “where they are at”. Family buy-in can also be a challenge, and having people bring family members, including children, to the workshop may activate whole families, though bringing small children to class may be a distraction. A unique strength of the DSMP is the many languages that are now available – workbooks have been developed for languages around the world.

There are several people issues related to health care providers. There is a history of territoriality on the part of diabetes educators, since diabetes education is an important revenue stream and they have unique training in educating people about their diabetes. However, when more formal diabetes education and the DSMP are viewed as complementary the person with diabetes gets the best of both approaches. And diabetes educators can serve as an important referral base to DSMP workshops.

Primary care providers are also a potential referral base, but most sites find that PCPs and Endocrinologists have difficulty keeping the program in mind. Without a more organized referral approach (for example, having office staff give every patient with diabetes a flyer about the program – or using electronic health records to identify people with diabetes and send them program information) PCPs and specialists have been found to be a poor referral base.

**Business/Employers**

Approach

Business can be strong advocates in supporting the DSMP. They may donate space for workshops, provide monetary or in-kind donations (healthy snacks for workshop participants, free printing of workshop materials, free space for promoting workshops), and give employees time off to attend workplace workshops. Program managers can benefit from communicating with local business leader about the program. One highly successful approach has been promoting the program using stories and celebrity speakers. There can also be a focus on employer benefits (see value below). A healthy workforce is a productive and more stable workforce, and in some communities diabetes is a real threat to business productivity.

Value (monetary)

There are many ways to promote the value of the DSMP to business and employers. State reports can be used to quantify the costs of diabetes, and local areas may be able to quantify how much it costs to NOT support diabetes self-care. For example, in the Latino community the DSMP has been shown to reduce HbA1c, and reduced HbA1c is associated with reduced complications and health care costs. Evidence can create a strong economic argument.

On a broader community level it is important to define how prevention saves money, reduces health care costs, and saves taxpayer dollars. We know how much treatment costs, and this can be a selling point.

In some communities the DSMP may be the only resource for education and support for people with diabetes, and the workshops can have a large impact on those who attend. The hope is to reduce morbidity and mortality from complications of the disease, and to reduce job-related absenteeism due to uncontrolled diabetes.

Benefits (non-monetary)

Because of its impact on families, the DSMP can play an important role in diabetes prevention, and prevention, not just management, matters.

The workshop is an investment in the lives of the employees – part of health promotion. When their employers value them and invest in their long-term health employees feel greater commitment to the employer. Several attendees pointed out that employers offer safety training, so why not offer the DSMP and longer-term health prevention?

**State Level**

Impact – Costs

Diabetes is a big problem for the state and health systems, and state leaders are also concerned about prediabetes. Diabetes costs the state of Washington $4 billion / year in health care costs, lost work, and diminished productivity.

Challenges

One of the biggest challenges in Washington is the need for improved statewide coordination. Washington is a state known to have relatively high penetrance of the DSMP and other chronic disease self-management programs. But lack of coordination across these programs wastes time and money. An important question is “how can we create awareness & make the program better” by coordinating statewide and unifying efforts around the different programs in the state. There are variations in how the program is offered across the Health Care Authority (HCA), fee for service (FFS), and managed care organizations. While variation is expected, coordination might improve programs statewide. Two examples are: 1) alignment and partnerships for PSAs to advance the work; and 2) a map showing where trainers are to avoid duplication of services.

Better understanding/promoting current reimbursement options

There was a universal desire to have insurers support the DSMP and other self-management programs as a covered benefit – and some do. Some states, for example Oregon, require that self-management support be included in all benefit packages. At the same time, those from the state find that programs aren’t taking advantage of state funding that is available. The DOH is working with HCA for reimbursement for DSME, but Medicaid and Medicare payment options are underutilized, in part because the application process is complicated. The fact that different organizations have different ways to bill further complicates this picture. The question was raised whether the HCA can require insurance companies to report how much diabetes education they provide.

Alignment with state goals, communicating with the state

The DSMP is one approach to help meet one of the largest health challenges in the state. State leaders need to communicate with those who are actually doing the work. The Health Care Authority & DHHS are critical partners with managed care organizations as they move away from fee for service – troubleshooting is needed to improve alignment and partnerships. . One way to demonstrate the value of the DSMP to Health Departments is with true stories.

The 2014 Washington State *Diabetes Epidemic & Action Report* (DEAR) outlined team recommendations, which are listed below. Self-management support was included in these goals. <http://www.doh.wa.gov/Portals/1/Documents/Pubs/345-342-DiabetesEpidemicActionReport.pdf>

The following are the ten recommended goals from the DEAR report:

* Ensure all appropriate populations have access to the Diabetes Prevention Program in Washington.
* Increase access to safe and affordable active living where people work, learn, live, play, and worship across their lifespan.
* Increase access to healthy foods and beverages where people work, learn, live, play, and worship.
* Ensure all people with diabetes receive self-management education from a Diabetes Education Program.
* Ensure people with diabetes and gum disease have access to guideline-based oral health treatment.
* Enhance care coordination for people with both diabetes and mental illness.
* Ensure all appropriate populations have access to Chronic Disease Self-Management Education programs in Washington.
* Ensure involvement of Community Health Workers to address diabetes in populations with the greatest needs.
* Increase stakeholder involvement in policymaking that pertains to diabetes.
* Support the Plan for a Healthier Washington’s investment in Analytics, Interoperability & Measurement.

**Community Level**

Current State

Engagement with DSMP programs at the community level varies. At the county level there may be few resources to offset program costs. Yet an activated community can be a crucial support for the program.

Approach

In garnering community support, stories matter. As one speaker said, “Make them cry.” Find leaders that are similar to members of the population (e.g. Spanish, churches, schools), and use them to reach out within their communities. Encourage the whole family approach to prevent disease for generations to come – invite family members for support. Program leaders can make the business case to every segment of communities and it might be possible to scale up the program in regions.

Partnerships

Many types of community partnerships are possible, but in all it is important to listen to the community. Communication with community organizations can lead to a structured solid program. Organizations can be the source of both participants to fill classes and structural and fiscal support for programs. By integrating with community agencies it is possible to take the program to where the people are – rather than expecting them to come to a health clinic or less familiar setting. Examples of organizations that might be helpful include:

* Food banks
* Cultural organizations
* Grassroots organizations with funding/support, led from within and led by people from the community (information is better received from peers)
* Community health workers who want to teach and help people be heathier
* Churches, which can provide classes on site to meet people where they are and where they worship and take other classes
* Senior Centers
* Senior housing
* Health clubs
* Midwives
* Optometrists
* Health clinics
* Schools

**Outreach**

One of the most important responsibilities of the organization that is supporting the DSMP is outreach. Despite the documented benefits of the program, it can be challenging and time-intensive to build and maintain a pool of leaders and master trainers to continue the program, and to maintain program enrollment. Over time, and as programs become more established, the leaders can become a valuable voice needed for successful outreach. But it is also important to remember that the primary responsibility of the lay leaders is to lead. They donate tremendous amounts of time – and this needs to be recognized and respected. Outreach is an organizational responsibility. There are many tools that can be used for outreach including:

* Community health fairs
* Public service announcements on TV and radio
* Announcements in churches
* Posters in clinics and other public spaces
* Announcements at community events (e.g., ball games, bingo, etc.)
* Workshop participants may volunteer to make announcements about the program at community groups to which they belong

**References:**

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**Appendix 1. World Café**

World Café uses clusters of small groups (4-5 people) conversing together around tables about issues or work that matters to them. We used the seven design principles underlying this method to structure the conference.

1) Set the Context: We were very clear about the purpose of the sustainability conference. We invited speakers and attendees who would further that purpose and contribute to the sustainability conversation.

2) Create Hospitable Space: We provided parking, drinks, snacks and lunch. We placed butcher paper, multicolored pens, and Play-Doh at every table to encourage recording and interaction and keep the mood light. We had a sufficient number of tables that everyone could sit facing the front.

3) Explore Questions that Matter: We found the information on the World Café web site about asking questions that matter particularly helpful.

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Questions are developed to guide the conversation. Why, how, and what are found to generate more powerful responses than who, when, where, which, or yes/no questions.

Two quotes and the list of characteristics that make a powerful question guided our work:

Finn Voldtofte (Denmark): The question has to catch people where they are, to meet them where there is the most energy and relevance for them, and then use that energy to go deeper. Action will flow naturally from that energy.

Felipe Herzenborn (Mexico): the question also needs to be simple and clear and penetrating. It’s like a laser beam. A good question invites and challenges you to reflect at a deeper level – to find the knowledge or wisdom that’s already there beneath the surface.

**A powerful question:**

* Generates curiosity in the listener
* Stimulates reflective conversation
* Is thought-provoking
* Surfaces underlying assumptions
* Invites creativity and new possibilities
* Generates energy and forward movement
* Channels attention and focuses inquiry
* Stays with participants
* Touches deep meaning
* Opens the door to change
* Evokes more questions
* Leads us to the future

Using these guidelines we came prepared with three questions:

1. Why are chronic disease self-management programs important to our communities? What differences do these programs make? What are you seeing? What’s happening?
2. What would be possible if we continue in the next generation of our work?
3. How can we activate our community (local, county, state – leadership and resources) around this need?

A table “host” who stayed at the table was assigned for each table, and tables were limited to 3-5 participants. Others moved on to different tables with each new question. We assigned the participants for each table so that with each change the participants would be among a new group. These rounds of conversation enabled the goal of harvesting what a community thinks or feels about a topic. (For more information see <http://www.theworldcafe.com/>, <http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/> , and <http://www.artofhosting.org/what-is-aoh/> )

4) Encourage Everyone’s Contribution: As described above – we used several techniques to encourage all to participate including table orientation and limiting the number at each discussion table.

5) Connect Diverse Perspectives: This was an invitational meeting, and we included people who brought a wide variety of perspectives to the conversation – business leaders, leaders from the Washington state Department of Health, administrators from health plans and community non-profits, academicians, community health workers and *promotores*, and chronic disease workshop lay leaders and workshop attendees.

6) Listen Together for Patterns and Insights: We invited recorders to think about what they heard during the morning lectures and to write down their observations from specific perspectives, or story arcs. The story arcs we chose were: 1) Taking change to scale; 2) Pivotal points – what did we learn from breakthroughs of others?; and 3) Specific Themes – what themes were heard and what do they tell you? The notes from recorders were then shared with those who would be summarizing the findings of the conference.

7) Share Collective Discoveries: Each table host shared with the entire group the themes and ideas they heard at their table. This was followed by a period of group discussion and reflection. Through this report we are sharing our findings in written form with all attendees and others who may be interested.