

# Indian Health Service

## Creating Strong Diabetes Programs: Plan A Trip to Success!



A Workbook for Program Planning and Evaluation  
Spring 2010

Indian Health Service  
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## How to Use This Workbook

Welcome to the IHS Division of Diabetes training on Program Planning and Evaluation. This training and corresponding workbook offer an introduction to the concepts and processes of planning and evaluating a diabetes program. We hope that after taking the training and following this workbook, you will be able to use the tools provided for program improvement. You will learn how program planning and evaluation can help make your diabetes program be more effective and you will be able to develop plans to evaluate both the implementation (process) and outcomes (results) of your diabetes program.

### Challenges and Barriers to Program Planning

We know that there are many challenges and road blocks to planning a program. Some of these include:

- Lack of support from administration.
- Lack of resources (space, staff, money, skills, and others).
- Lack of data.
- Fear of change.
- Lack of time.

### Working Collaboratively Can Reduce the Challenges

An effective way to handle the challenges is to work collaboratively. This means working together as a team with shared decisions about the diabetes program and where it is headed.

### Recommended Process for the Training

- Get your diabetes team together and select a group leader (i.e., diabetes coordinator, ADC).
- Ask team members to set aside at least one-half day. You may want to spread this training over a week or two.
- Use this workbook along with the online training.
- In the workbook, read "*How to Use this Workbook*" and "*Introduction*". The online training supports the workbook through the use of short videos.
- The online training that accompanies this workbook has one or two videos for each section that introduce the topic and show a diabetes team working through the section.
- The online training provides Essential Elements, or detailed information, and the Quick Facts provide the key points for each section; all of which is derived from the workbook.
- Use the Action Steps in the workbook or online to fully complete each section.
- When you complete the training and workbook, you will have a completed planning and evaluation project for your diabetes program.

## About this Workbook

- Even though the focus of this workbook and web-based training is geared towards planning a diabetes programs, the information provided in this training can be useful for many types of programs.
- Use this workbook as a stand-alone guide to help create and develop a diabetes program plan with an evaluation component for your diabetes program
- This workbook is also a part of the online diabetes program planning training:  
<http://www.ihs.gov/medicalprograms/diabetes/index.cfm?module=trainingWebBased>
- A planning template and blank forms are located throughout the workbook when you need them. You may want to provide each team member with a workbook and a copy of the road map (or visual planning tool) to guide your diabetes program's development. You may want to make several copies of the blank template and forms to allow for adjustments and updates to your diabetes program plan over time.
- The appendix includes a completed sample that you can use as an example.

**Action!** The word action appears at points in the workbook at which you should take action.

**Tools.** Tools are found in tables throughout the workbook.

**Workbook sections.** Cartoon icons indicate a new section of the workbook.





# Let's Get Started Planning!

## Introduction

Changes are occurring in the IHS *Special Diabetes Program for Indians* (SDPI) grant programs. This is a time of transition and requirements are changing. Many diabetes programs conduct a lot of interesting activities but may not be as productive as possible or may not be able to show their accomplishments and results. The “old” way of doing things focused on reporting activities. Now, however; SDPI grant programs must measure, document, and report on outcomes (results). Often they conduct activities without using a guide (**a plan**) or collecting the right data or information to show that their efforts are successful (**an evaluation**).

SDPI grant programs will need to adapt and learn new skills to be accountable and to show results. They will need more than ever a structure for planning and evaluation, and using proven effective strategies such as the Indian Health Diabetes Best Practices.

It's important to understand why planning and evaluation are needed and why now:

- Funding requirements
- Diabetes program accountability
- Demonstrate results (outcomes)

Planning a diabetes program is an important responsibility. This training offers:

- information and tools for identifying and getting stakeholders involved in the diabetes program
- assessing community needs
- selecting effective activities based on your needs
- showing results
- demonstrating how resources were used

To make the process of planning a little bit more “user friendly” we use an analogy: that planning a diabetes program is like planning a trip. We hope this description helps you understand the concepts of planning and provides a little fun along the way too.

If you are an experienced planner, you may already realize that your diabetes program could be more effective. We encourage you to review what you are doing by following the steps in this training. We feel confident that you will have good results. The web-based, information, and tools are available to you at your convenience.

## Training objectives

Indian Health Services Division of Diabetes Treatment and Prevention  
Program Planning and Evaluation Workbook  
January, 2011

1. Define planning and state why planning a diabetes program is necessary
2. State how to identify and engage stakeholders involved in the diabetes program.
3. Assess the diabetes needs of your community.
4. Select diabetes activities that are shown to be effective.
5. Write a goal and an objective for your diabetes program.
6. State the importance of documenting activities, results and how resources were used.
7. Develop a plan for your diabetes program using a visual planning tool (or road map).



## Where are we headed? Overview of Program Planning

### *Why Plan? Part 1 - Planning a Program is Like Planning a Trip*

This training is called “Creating Strong Diabetes Programs: Plan a Trip to Success!” We often don’t think about it, but we all use planning and evaluation in our daily lives. We plan what we will eat for breakfast, what we will wear, what things we have to do, if we have enough gas in the car, what we will eat for dinner, and so on. Planning is an essential part of our day.

Planning a diabetes program is like planning a trip. We need to determine where we are going, who is going, how we will get there, how much money we have and what we will do and so on.

Planning requires extra time and energy. **But remember, your hard work is going to benefit patients, those at risk of developing diabetes and your community.** So let’s get started planning a diabetes program.

#### **What is program planning?**

Program planning is a process that can help your diabetes program develop, implement, and evaluate interventions using proven activities and strategies. This process includes how to document results and show how resources were used.

#### **What is program evaluation?**

Program evaluation is the systematic examination and assessment of a diabetes program to gather or collect information that can be used to make improvements, demonstrate accountability, and show results. Program planning and evaluation are needed throughout the entire life of a diabetes program – from start to finish. Spending time and effort now to create a diabetes program and evaluation plan will make your work easier in the long term.

## Importance of Planning for Your Community

Diabetes programs need to develop a plan with an evaluation component **before the diabetes program starts** in order to:

- Make rational choices based on relevant information, previous experiences, and community preferences and needs.
- Reach members of the community and give them skills to engage in healthier behaviors.
- Provide proven and effective activities to ensure the best possible results.
- Document how resources were used.
- Document activities that were done.
- Document results achieved
- Determine if a diabetes program is making a difference.
- Revise diabetes programs that are not as strong as they could be.



## ***Who Needs to Plan? Part 2 – Who needs to Plan and How to Get Started***

### **Who needs to do program planning?**

- All those who conduct health and/or diabetes programs, including: nurses, doctors, health educators, dietitians, health specialists, community health representatives, support staff and others.
- All those who make policies for health and/or diabetes programs, including health department administrators, program managers, health directors, and others.

**Everyone plans and everyone should have a role in program planning.**

### **When to get started?**

Program planning and evaluation take place when you start thinking about your diabetes program. When thinking about a trip, you cannot wait until the end of your trip to start the planning or evaluation process. Planning a trip starts the moment you get the idea of taking a trip. The planning and evaluation process must be started when the diabetes program is just an idea.

### **Using the Visual Planning Tool**

We created a visual planning tool (page 14) as a companion to this workbook. A visual planning tool is much like a road map; it can help your diabetes program identify where it wants to go and how to get there.

A visual planning tool (or road map) consists of 5 elements:

1. **Resources** (inputs or what is invested).
2. **Activities** (things a diabetes program does).
3. **Products** (who was served, what was developed).
4. **Results** or outcomes of a diabetes program including learning: awareness, knowledge, skills and actions such as behaviors, practices, decisions, and policies.
5. **Impact** or the long-term consequences (social, economic, environmental) of a diabetes program.

Using the visual planning tool along with the workbook will help your diabetes program keep track of all the elements of the diabetes program and understand how the diabetes program will work. When you have completed the **Visual Planning Tool** (or road map) you will be able to read your diabetes program plan just like a book.

**Action! Go To: Planning and Evaluation Checklist Tool.** Print it out now and check off every tool as you complete them.

**Action! Go To: Tool Tips and Checklist.** Determine what is already available to your diabetes program.

**Action! Go To: Visual Planning Tool (or Road Map)** Print it out now and complete the different sections as you go through the training. Be sure to make copies for all team members.

**Indian Health Division of Diabetes Treatment and Prevention**

**Planning and Evaluation Checklist Tool**

**Diabetes Program Name**

**Prepared By**

**Date**

<b>Tools</b>	<b>Questions</b>	<b>Status (check if done)</b>	<b>Comments and Actions Needed</b>
<b>Tips and Checklist</b>	Did you determine what is already available to your diabetes program?	<input type="checkbox"/>	
<b>Visual Planning Tool</b>	Did you print it out?	<input type="checkbox"/>	
	Did you make copies for all team members?	<input type="checkbox"/>	
<b>Resources</b>	Did you identify stakeholders?	<input type="checkbox"/>	
	Did you determine resources available?	<input type="checkbox"/>	
<b>Assessment</b>	Did you conduct a needs assessment?	<input type="checkbox"/>	
	Did you prioritize needs?	<input type="checkbox"/>	
	Did you come up with potential solutions?	<input type="checkbox"/>	
<b>Activities</b>	Did you learn about best practices?	<input type="checkbox"/>	
<b>Goals and Objectives</b>	Did you identify a goal?	<input type="checkbox"/>	
	Did you write a goal?	<input type="checkbox"/>	
	Did you identify an objective?	<input type="checkbox"/>	
	Did you write a SMART Objective?	<input type="checkbox"/>	
<b>Keeping Track</b>	Did you answer the questions to help you decide what data or information to collect?	<input type="checkbox"/>	
<b>Lessons Learned</b>	Did you complete all the rows of the visual planning tool?	<input type="checkbox"/>	
	Did you read your plan?	<input type="checkbox"/>	
<b>Timeline</b>	Did you create a timeline to make sure that projects are completed on time?	<input type="checkbox"/>	

## Tool Tips and Checklist Tool

Get started with your plan. See what happened before. Learn from previous successes. Learn from previous challenges. Work with your diabetes team and complete this checklist. You will find that this activity may take additional time to track down all the information.

### 1. History checklist

- a) Has planning been done before? Yes or No
- b) If yes and there is an existing report, take the following actions:
  - Locate it.
  - Review it.
  - Talk to the authors.
  - Find out what worked.
  - Find out what did not work.
  - Use it as a starting point.
- c) If no previous report exists find and review the following:
  - Other agencies reports.
  - Related reports online.
- d) Has evaluation been done before? Yes or No
- e) If there is an existing report do the following steps:
  - Locate it.
  - Review it.
  - Talk to the authors.
  - Find out what worked.
  - Find out what did not work.
  - Use it as a starting point.
- f) If no existing report exists, find and review the following:
  - Other agencies reports.
  - Related reports online.
- g) Is there someone who was involved in the diabetes program before and is not involved in the diabetes program now? Yes or No.
- h) If yes, talk to them and find out if they can help the diabetes program and in what ways they are willing to help.
- i) If no, talk to your Area Diabetes Consultant.

## **\_\_2. Constraints**

- \_\_a)** Are there limits on what your diabetes program can plan? Yes or No.
- \_\_b)** If no, hurray! You have the opportunity to plan, implement and evaluate the best diabetes program you can.
- \_\_c)** If yes, you don't need to worry, but you will need to be creative. Start by identifying the constraints. Document all the constraints by writing them down. As a team, discuss and decide what the focus of the diabetes program will be based on the constraints.

## **\_\_3. Recordkeeping**

- \_\_a)** Do you have someone on your team who likes details and is good at keeping track of everything that the diabetes program does? Yes or No.
- \_\_b)** If yes, you are lucky! Recruit them to the team if they are not already members.
- \_\_c)** If no, you need to identify a person who has the training and skills to keep careful records of the diabetes program. You may have to find someone willing to be trained. Even if it is low-tech methods like paper and pencil records, you must carefully document (write down!) everything you do. Find a person or two who has training and skills in organizational planning, numbers and spreadsheets, writing reports and skills in graphical software. Record their names, positions, and contact information by writing it down.

## Visual Planning Tool (or Road Map)

Completing this tool during the training can help you plan where you want to go and how you will get there. Print this blank form out now and complete it as you go through the training. Be sure to print out several copies for each team member.

<b>Resources - What we invest, who we include</b>	Describe your resources.
<b>Activities - What we do</b>	Describe your activities, goal and objectives.
<b>Goal - Broad aim of diabetes program</b>	Describe your goal.
<b>Objectives - Specific, Measurable, Action, Realistic, Time-bound (SMART)</b>	Describe your objectives.
<b>Products - Numbers of things we did</b>	Describe products you will count.
<b>Results - Changes as a result of diabetes program efforts, such as changes in learning, skills behavior, policy</b>	Describe results you will measure.
<b>Impact- Consequences of the diabetes program</b>	Describe impacts you will document.



## Who to bring and what to pack! Resources

Resources are all the things that we invest a diabetes program. Resources can include things like time, staff, funding, equipment, and space. One important resource is the stakeholders. Stakeholders are those people who have a strong interest in the diabetes program. Stakeholders can be those who:

1. receive diabetes program services.
2. make decisions about funding.
3. plan and implement the diabetes program on a daily basis.

It is critical to know what the stakeholders expect from the diabetes program and what they will do to help the. Stakeholders should be active participants in the diabetes program. You can help to ensure this by involving them early on.

You can start the process of involving stakeholders by simply asking them:

- Why are you interested in the diabetes program?
- What do you want the diabetes program to accomplish?
- What resources (time, money, technical assistance) can you contribute?
- How will you help assure that the diabetes program is successful?

Resources also include items like time, staff, funding, equipment and space. Think about each of these and answer the following questions.

**Staff** Who are some people that could or should be involved in your diabetes program? Be specific.

**Time** What time commitment can these people make? Lack of time can be a serious limitation. Make sure people have adequate time to commit to the diabetes program.

### Funding – staff, equipment, and space

- What kind of budget do you have? A common mistake is to want to do too much – more than the budget will allow. Find out and create a realistic operating budget.
- What kind of equipment will you need? How does this fit with your budget?
- Do you have a designated location to conduct your activities? Consider collaborating with a group that already has a location. For example, the Wellness Center, a local gym, the elder center kitchen, and so on.

**Action! Go To: Resources Tool.** Identify stakeholders and determine resources.

**Action! Go To: Visual Planning Tool (or Road Map).** Complete the Resources row.

## Resources Tool

Take a few minutes and work together to determine ways to identify potential partners or stakeholders and determine the resources they may be able to contribute to the diabetes program. When you have completed this section be sure to add it to your visual planning tool.

Diabetes Program Stakeholders	Their expectations	Possible resources they can contribute (time, money, equipment, space, expertise, etc)
<b>Diabetes program recipients or participants</b>	complete this box now.	complete this box now.
<b>Decision makers – funding, staffing, space, etc</b>	complete this box now.	complete this box now.
<b>Diabetes program staff</b>	complete this box now.	complete this box now.



## Picking the Best Route: Assessment

### What is a Needs Assessment?

A needs assessment is a way for health workers in the clinic and community to identify various health issues. Once these health issues are identified, the diabetes team can work together to prioritize and address the community's concerns. A needs assessment will help to strengthen the foundation of your diabetes program. An assessment is a bit like reviewing maps and guidebooks before deciding where to go and what to do on vacation.

You can determine some of the health needs in your community by reviewing your latest **IHS Diabetes Care and Outcomes Audit** data. Available on line at:

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=resourcesAudit>

For example, you can use your IHS Diabetes Care and Outcomes Audit data to find out how many people have diabetes, what their ages are, what kind of treatment they are receiving, how many have received foot exams, eye exams, and laboratory tests. Using the audit data is a good way to identify strengths and weakness of your clinical diabetes program.

Collecting the opinions of key clinic and community members through focus groups, surveys or targeted interviews can help determine specifically what activities your diabetes program needs to address. If you conduct a survey you may want to find out what these people think the focus of the diabetes program should be. Once you know this you can make decisions about priorities and everyone will better understand and embrace the diabetes program

For example, it may be that key people think efforts should be directed at preventing diabetes among youth.

### How does a needs assessment affect your diabetes program's activities?

The simple needs assessment tool provided here will help you collect information to assess the needs of your clinic and community. Remember to use the following:

- Information from prior community assessments.
- Meeting notes, e.g. Tribal Leaders meetings.
- The Diabetes Care and Outcomes Audit Data to help you collect information on numbers of people with diabetes, numbers of people with diabetes that received an A1c in past year, how many people had foot ulcers in past year, etc.
- School records, e.g. number of overweight children by age
- Dental records, e.g. number of people with diabetes who had gum disease.

These are just a few examples of the resources that may be available to your diabetes program.

**Action! Go To: Assessment Tool. Complete it now.**

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Program Planning and Evaluation Workbook  
January, 2011

## Needs Assessment Tool

Assessing and prioritizing your community's diabetes needs will help to strengthen your diabetes program. Information from a simple community needs assessment can help lay the foundation for a strong diabetes program. After completing your assessment your diabetes program will have a better understanding of the most important issues and needs facing your clinic and community. Here are some steps to complete a simple needs assessment.

1) Use your latest IHS Diabetes Care and Outcomes data, GPRA data or school data to describe your diabetes-related needs. Here are some examples:

- How many people have diabetes \_\_\_\_\_
- How many youth are overweight \_\_\_\_\_
- How many \_\_\_\_\_ (what else do you want to know - you fill in the blank)

2) Review records on use of health services and from other health-related sources if available. Find out:

- From the data find out how many people:
  - Have diabetes-related foot issues?
  - Have elevated blood sugar levels?
  - Need weight management?
  - Have diabetes-related eye disease?
- What else can you think of? (you fill in the blank)

\_\_\_\_\_

- From school records find out how many school children are overweight?
- What else can you think of? (you fill in the blank)

\_\_\_\_\_

3) Review the data and make a list of top diabetes-related health issues. List the top diabetes issues:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

4) For each health issue determine:

- How big a health problem is it?
- What are the causes?
- Is it getting better or worse over time?
- If nothing is done, what will be the consequences?

When you complete this tool, return to your visual planning tool and add the additional resources that you identified as available to your diabetes program (audit data, school records).



## Things to do: Activities

In the previous section you learned how to conduct a simple needs assessment and learned how to identify areas that need improvement. Remember the **IHS Diabetes Care and Outcomes Audit** <http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=resourcesAudit> data and other data sources can be used to identify areas in your clinic and community that need strengthening and improving. The Indian Health Diabetes Best Practices identifies certain activities that have been shown to be effective. Implementing these activities can help clinical and community-based diabetes programs improve.

The Indian Health Diabetes Best Practices are evidence-based approaches that address diabetes prevention, treatment, and education practices in American Indian and Alaska Native communities. These Best Practices are:

- Developed by Indian Health systems professionals.
- Based on findings from the latest scientific research and successful experiences of diabetes programs.
- On many topics that may address your program's health issues.
- Created for clinical and community settings.

Implementing a Best Practice results in measurable improvement which can help your program:

- Improve the health status of people in your community.
- Demonstrate program accountability.
- Manage its resources efficiently.
- Improve operations and outcomes.
- Assess what the program is doing.
- Assess the strengths and weaknesses.

**Action!** Review the **Getting Started with the Indian Health Diabetes Best Practices** [http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Tools/BestPractices/2009\\_BP\\_Getting\\_Started.pdf](http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Tools/BestPractices/2009_BP_Getting_Started.pdf)

**Action!** For a quick overview of the Best Practices, take a look at the table in the **Best Practices: Brief Descriptions and Key Measures** [http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Tools/BestPractices/2009\\_Key\\_Measures\\_Table.pdf](http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Tools/BestPractices/2009_Key_Measures_Table.pdf)



## Things to do: Best Practices

**Indian Health Diabetes Best Practices** are available on line at:

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBestPractices>

There are nineteen Best Practices at least one is required for FY 2010 SDPI Community Directed Grant Program Application.

Each Best Practice includes:

- A brief overview.
- A section on monitoring progress and outcomes.
- Clinical, community and organizational recommendations.
- Ideas on evaluating and sustaining a Best Practice.
- Tools and Resources.

Here are 5 tips to help you implement a Best Practice into your program.

Tip #1 - Review the community needs assessment you completed earlier in this training.

Tip # 2 - If you have not already selected the Best Practice that fits your needs, identify one or more now.

Tip #3 - Be sure to get support from Tribal Leaders or reaffirm their commitment to your diabetes program.

Tip #4 - Make sure you use the Best Practice Key Measures and that your program Goal and Objectives are matched-up with the measures.

Tip #5 - Identify how your program will collect and keep track of data on the key measures and other program activities.

**Action!** Review the helpful tips in the [Tips for Using Indian Health Diabetes Best Practices](#).

[http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Programs/SDPI/SDPI2010\\_CommDir\\_Tips\\_%20OBP.pdf](http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Programs/SDPI/SDPI2010_CommDir_Tips_%20OBP.pdf)

**Action!** Take a look at the [Best Practices: Brief Descriptions and Key Measures](#) which provides a brief description and Key Measures for all 19 Best Practices.

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBestPractices>

**Action! Go To: Activities Tool** to learn about the Indian Health Diabetes Best Practices and suggested activities.

**Action!** Record your potential activities in the "Activities" row on the printed **Visual Planning Tool (or Road Map)**

## Activities Tool

Activities and actions require lots of planning. Here are 5 steps to determine which Best Practice and its activities to implement:

1. Once you have reviewed the data and identified areas that need to be improved, sit down with the diabetes team and carefully review just the titles of the 19 best practices. The Indian Health Diabetes Best Practices are evidence-based approaches that address diabetes prevention, treatment, and education practices in American Indian and Alaska Native communities. They are available on line at: <http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBestPractices>
2. After reviewing all 19 titles, list several best practice topics that seem like they are related to the areas that your program needs to improve.

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3. For **clinical diabetes programs**: The diabetes team should identify 1 or 2 Best Practices that fit within the scope of the program's needs and resources.

For example, if your Diabetes Outcome Audit data show that only 60% of people get foot exams, you could choose to increase the percent of people that receive an annual foot exam.

Using the Foot Care Best Practice activities you could choose other actions to do including:

- Hire a podiatrist to provide podiatry care.
- Work with a local shoe store to develop a mechanism for providing appropriate footwear.
- Purchase equipment and medications to manage foot ulcers.
- Provide in-services and support training for health personnel in foot care education.

After determining the best practices that your programs wants to implement, write down the best practice activities that you will include to achieve better outcomes in the areas that are weak. It does not have be all the elements of the best practice – just the ones that fit best with your program and resources):

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4. For **community-based diabetes programs**, the diabetes team may have learned from school data that youth are becoming more overweight. Your team could identify the Youth and Diabetes best practice to prevent diabetes. Some activities from the best practice that you may want to consider doing are to:

- Establish a working relationship with the school board, principal, teachers, and students and invite someone to represent them on your diabetes team.
- Hire a physical activity specialist to provide evidence-based information on physical activity and diabetes.
- Work with the local schools and develop a mechanism for providing equipment for every student so that they can be more physically active during school day.
- Provide in-services and support training for teachers and others interested in increasing physical activity among youth.

Write down the best practice activities that the team decides to implement to achieve better outcomes in the areas that are weak:

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5. For each Best Practice you choose to implement, you must use the **two key measures** within the best practice. You must keep track of this information before; during and after you implement your activities. Write those measures below:

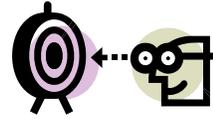
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## Don't Miss This! Goals and Objectives

Once you have identified potential resources and possible activities you are ready to set goals and objectives. Many people are confused about what a goal is and what an objective is. Here are some tips to remember:

### Goals are simple broad ambitions.

- Very concise -usually one sentence.
- Results-oriented and describe overarching aims that a diabetes program wants to achieve.
- Inclusive and do not limit a diabetes program to *specific* activities or people served.

### Objectives are very specific and support the diabetes program's goal.

- Clearly describe milestones necessary to achieve each goal.
- Refer to specific, measurable results.
- Describe *how much* of *what specific activity* will be accomplished by *whom* over *what time period*.
- Each objective should be tied to data and to a result.

## Goals

Let's think about our trip. We could write a goal for it. "The goal of our trip is to have fun with the family." It's a very simple and results-oriented. A goal usually takes just one sentence to write.

Here are 6 examples of goals. Our goal is to:

1. Improve A1c levels among people with diabetes.
2. Increase physical activity levels among youth.
3. Increase awareness of diabetes in our community.
4. Increase healthy eating behaviors such as eating fewer calories.
5. Provide diabetes training to health care givers.
6. Increase number of diabetes foot examinations performed.

## Objectives

Objectives are very specific. If we wrote an objective for our trip, we might write: "To increase the number of minutes the family spends together from 1 hour everyday to 4 hours everyday by the end of our trip."

Before writing an objective, consider writing SMART objectives. The SMART format is often used in interventions. SMART objectives require time to write and a good understanding of what the diabetes program will do, but in the end your diabetes program will have an easier time of demonstrating success.

## SMART objectives

S = Specific (this means “detailed and focused”)

M = Measurable (this means “able to be measured”)

A = Action-oriented (this means “doing a good activity that can be accomplished “)

R = Realistic (this means “reflects reality of the diabetes program and people with diabetes”)

T = Time-bound (this means “include a timeline for completion”)

Here are 6 examples of SMART objectives.

1. To increase the percent of A1c levels that are less than 7.0% from 30% to 50% by the end of the fiscal year.
2. To increase the number of minutes of physical activity among middle school children (grades 7-9) from less than 30 minutes every other day to 60 minutes every other day by the end of the school year.
3. To increase the percent of people that know how to prevent diabetes from less than 20% to 50% by the end of the fiscal year.
4. To decrease the number of sodas that middle school children drink from 6 per day to less than 1 per day by the end of the school year.
5. To increase the number of certified diabetes educators from 0 to 1 by the end of the fiscal year.
6. To increase the percent of foot examinations in our clinic from 70% to 90% by the end of the fiscal year.

You will notice that SMART objectives have time limits. You can use a timetable to break down your objective into small steps and specific tasks. At first you can break the objective into months or weeks, but as the time gets closer to implementing specific tasks you will need to break into smaller tasks and shorter units of time. One of the most challenging things to do is to allot the appropriate amount of time for each task.

The following table is an example of a simple timetable for this objective: To increase the number of qualified health care personnel on our diabetes team from 1 to 2 by the end of the fiscal year

Date	Activity	Specific Tasks	Person Responsible
September	post ad for Certified Diabetes Educator	write ad, post online	JA
October	interview applicants	review applications, schedule interviews	TW
November	hire new person	conduct interviews, select best candidate	BB

**Remember**, resources, needs, activities, the goal, and objectives need to be tied together. Review your Visual Planning Tool and be sure all these elements match.

**Action!** Go To: [Writing Goals and Objectives Tool](#)

**Action!** Go To: [Example of Words to Use in SMART Objectives Tool](#).

**Action!** Go To: [Visual Planning Tool](#) – write a Goal and Objective in the corresponding row.

## Writing Goals and Objectives Tool

After you have reviewed the Indian Health Diabetes Best Practices and have identified 1 or 2 Best Practices that fit within the scope of your resources, you are ready to set a goal and write objectives.

### How to write a goal.

**Goals** are the broad ambitions of your diabetes program. They are not specific. They should not change too much over time. They are usually one sentence. An example of a goal is: "Our goal is to get kids more physically active."

To get started with writing a goal, try writing a trip goal. For example, our goal is to see the spring wildflowers. Write your trip goal here:

A goal may be to prevent diabetes. Write a goal for your diabetes program here:

### How to write a SMART objective.

- S = Specific (detailed and focused)
- M = Measurable (able to be measured)
- A = Action-oriented (tied to a specific activity)
- R = Realistic (reflects reality for the diabetes program and the people with diabetes)
- T = Time-bound (includes a timeline for completion)

Use the 'objective builder' in the next tool to help you write a SMART objective.

Step 1. Write down a verb (like to increase or to decrease) that corresponds to the best practice activity or action you want to do.

Step 2. Write down exactly what it is you will measure. For example, time, calories, percent fat, number of walks, number of sodas per day and so on.

Step 3. Write down the specific population you want to work with. For example, pre-school youth, youth K-6, elders, and so on.

Step 4. Write down what best practice actions and activities your diabetes program has selected to do as an intervention. For example, promote physical activity in preschool through interactive video games that promote physical movement.

Step 5. Write down the baseline information. This information comes from existing data (audit data, survey, interviews, needs assessment).

Step 6. Write down the time frame that you want to accomplish this objective. For example, it may be the end of the school year, or the end of the calendar year, or the end of the fiscal year or at six months or one year.

### Examples of Words to Use in SMART Objectives Tool

This tool can help you create a SMART objective by breaking down the objective into pieces. The following are examples of words you can use to develop a SMART objective. Try using the words from each column to understand how to write a SMART objective.

For example, using the tool, we could write a SMART objective for a diabetes program. The objective is to: increase the number minutes of time spent by youth participating in vigorous physical activity from 10 minutes a day to 30 minutes a day by the end of the school year.

#### Words and phrases to help you write a SMART Objective:

Verb	Measure	Target population	Object (actions)	Baseline measure	Goal measure	Timeframe
To increase	Number of minutes	Youth	Participate in vigorous physical activity	from 10 minutes a day	to 30 minutes a day	By the end of the school year
To decrease	Calories/day	Adults with diabetes	Eat less fat and fewer calories	from 1 piece of fry bread	to ¼ piece of fry bread	By end of 12 week session
To decrease	Snacks/day	Adults with diabetes	Drink fewer sodas	From 2 sodas /day	To diet soda only	By next clinic visit

Verb	Measure	Population	Object	Baseline measure	Goal measure	Timeframe

**Use the tool to help you write a SMART objective.**  
 Write your diabetes program's objective here.



## Have We Arrived? Results

### Importance of Keeping Track

It is essential for diabetes programs to collect good information and keep track of it. Just like when we go on a trip we need to keep track of how much money we have and how much money we spend. We may not think that we are collecting information and keeping track of these things, but that is what we are doing.

Diabetes programs require a similar kind of attention to keep on track and show the results of their efforts. Diabetes programs are responsible for collecting good information, keeping track of it and documenting it. Look at this SMART objective “To decrease the number of sodas that middle school children drink from 6 per day to less than 1 per day by the end of the school year. For this example, it is important to keep track of the number of number of sodas middle school children drink in a day.

It is critical for diabetes programs to collect good information and measure and document it to show what they have accomplished.

There are a series of questions that will help you determine what type of information to collect. Use the *Keeping Track Tool* (page 33) to work through the questions that will help you. Review these questions frequently, at each of your diabetes team meetings and adjust as needed. The *Visual Planning Tool* will also help.

Below are suggestions that a diabetes program might use to keep track of and document:

- How the funds were used. Keep track of and document receipts and payroll expenses and document using budget spreadsheets.
- Activities. Keep track of and document the diabetes program’s activities with attendance logs, clinical measures, curriculum implemented and so on.
- What people have learned. Keep track of what people have learned and document with pre-post surveys.
- How peoples’ behavior changed. Keep track of participation in walking clubs and document time spent walking each day using logs.
- Changes in physical measures. Keep track of A1c levels and document over time.
- Changes in health policies. Keep track of health-related policies and document any changes in policies such as a ban on the sale of sugary drinks in clinics and schools.
- Changes in the environment. Keep track of physical activity locations and document with changes made, such as walking paths established.



## Keeping Track of Data (or Information)

### Importance of Data or Information

Keeping track involves collecting information or data. Data simply means information that is collected in a systematic way. Good data, or data that are carefully and systematically collected, measured and documented, are essential to show that the diabetes program was successful.

### Types of Data to Collect

There are basically two types of data that your diabetes program may want to collect: quantitative and qualitative. Diabetes programs may decide to collect both types of data to strengthen their results.

- 1.) **Quantitative data** usually involves numbers and includes funding and counts of things. This kind of information can be collected through the **IHS Diabetes Care and Outcomes Audit** data and through face-to-face interviews and/or surveys or questionnaires with participants and staff. HIS Diabetes Care and Outcomes Audit can be found at:  
<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=resourcesAudit>

Quantitative data are usually about how many people know or did something. For example, you may want to know how many health care providers attended training on diabetes education. Or you may want to know how many people with diabetes received a foot examination last year or how many had their A1c measured at least once annually.

To collect quantitative data you can:

- Ask questions to find out how much, how many, and to what extent.
- Tally the results as simple frequencies, such as percents and/or the numbers such as attendance. These can be done without special techniques.
- If more sophisticated techniques to analyze the data are needed your diabetes program may need assistance.

2.) **Qualitative data** usually involves words. Questions are about how people feel or think. For example, what did participants think about the classes? Were they too long? Too short? Informative? Boring? What would they like in the future? What do community members think about the grocery stores in the area? If there was a walking group formed offered what would it take to get them to join?

- Qualitative questions are usually asked using one or more of the following methods:
  - Focus groups with participants. Focus groups are small meetings with specified questions to capture people's feelings and thoughts about a special issue.
  - Storytelling approaches such as talking circles or oral history interviews.
  - One-to-one in-depth interviews.

- Basic analyses include recording the data, identifying common themes, and selecting meaningful quotes from participants. More sophisticated data techniques may require assistance to code and enter data into a database and to analyze and interpret the data.
- Logbooks can be used to capture feedback by participants and staff. Using this technique data are recorded in writing. For example, you can ask participants to keep a “activity diary”. You can also ask staff to record observations throughout the process, include what happened and when. This is often better than relying on memory. To analyze the logbooks, the analyst should look for common themes and use quotes from participants without identifying them by name.

## **What data to collect**

Data collection refers to gathering accurate information, and carefully measuring and documenting it. When we refer to data collection we mean collecting, measuring and documenting the data in a careful and systematic way.

## **Products**

Products are the direct yields of what the diabetes program did and are the things that can be counted. Products are numbers of something. To determine what to collect, review your goal and objective. These will determine what needs to be collected. For example, make measurements and document the numbers of:

- Participants who attended the diabetes classes.
- Education classes held.
- Participants satisfied.

## **Results**

Results are the changes that have occurred as a direct result of the diabetes program’s activities. To determine what to collect, review your goal and objective. These will help to determine what needs to be collected. For example, you may want to collect data, make measurements and document the following:

- Change in percent of foot examinations performed.
- Change in school or elder center menu as a result of the diabetes program’s efforts.
- Change in percent of staff that are trained in diabetes care.

## **Impacts**

Impacts are longer-term results and usually affect the community, society or the environment. Many diabetes programs will not see these effects as they can take years to be observed. For example, you may want to keep track of and document:

- The amputation rate over the last 5 years. (audit data)
- The school district’s policy about physical activity in the curriculum. (school)
- Presence of a fitness policy at worksites. (tribal policy)

The table below provides examples of types of data to collect and data sources that can be used.

## Examples of what data to collect.

If your diabetes program wants to know about...	Data sources that can be used
<b>how the money is used</b>	Spreadsheets, receipts for goods and services, payroll
<b>what people learned</b>	Questionnaire, focus group
<b>people's behavior</b>	Pre-survey, survey, observation, pedometer, food log, physical activity log
<b>a physical measure</b>	Audit data, HbA1c level, weight and height, fitness level, waist circumference, blood pressure, smoking
<b>a health policy</b>	Presence of policy that was or was not there before diabetes program's efforts
<b>the environment</b>	Presence of something in environment that was or was not there before the diabetes program's efforts (e.g. walking trail, vending machines)

## When to collect data

It is essential to **collect data before and after your activities and or services**. This is the only way to know that your diabetes program's activities had an impact on whatever you are trying to improve. For example, to show that your diabetes program's efforts had an impact on a participant's knowledge or behavior you must measure participant's knowledge and behavior before and after the diabetes program. The same is true for tracking a change in policy. You have to document that the policy was not in place before you started and as a result of your diabetes program's efforts there is now a policy. Clinical changes must be tracked in the same way: Foot exams before and after efforts to increase foot examinations.



# Data

## Making sense of the data you collect

You may have people with skills to analyze quantitative and/or qualitative data within your organization or you may need to seek external technical assistance. Either way people responsible for data will need to have training and skills on how to code and enter data into a database and analyze and interpret the data. For example, the data person must know how to:

- Create a codebook and code data.
- Enter the data into a spreadsheet or database on the computer.
- 
- Check for data entry errors.
- Calculate the number of participants, percentage of participants meeting recommendations.
- Make comparisons between or find differences using before and after measures.
- Compare results with goal and objective so that you can know if your efforts were successful. For example:
  - What do the numbers say?
  - Are results similar to what was expected? If not, why are they different?
  - Are there alternative explanations for the results?
  - How do the results compare with those of similar diabetes programs?
  - Was the goal met? Why or why not?
  - Were the objectives met? Why or why not?
- Conduct more sophisticated analyses as needed.
- Present data in a clear and uncomplicated format using Excel tables and graphs and prepare power point slides.
- Write reports using the data collected.

**Action! Go To: Keeping Track Tool** and answer the questions to help you decide what data or information to collect.

**Action! Go To: Visual Planning Tool (or Road Map) – Products, Results, Impacts.** Complete the products, results and impacts sections based on what you expect your diabetes program to do.

## Keeping Track Tool

It is critical for diabetes programs to collect good information, measure and document it to show what has been accomplished. Use the following tool to work through these questions. You will need to review these at each of your diabetes team meetings and adjust as needed.

1. Who and how will you keep track of how the money was used? Do you have a person to keep track of how the funds are being used? (For example, accountant, payroll, services provided, purchases made.)

2. Who will be responsible for collecting and keeping track of the data? Who monitors the **IHS Diabetes Care and Outcomes Audit** data?  
<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=resourcesAudit> (For example, you need someone who has good detail or analytical skills.)

3. How and when will you collect data? (For example, you should collect data before and after each activity you do or examine the audit data before and after your activities.)

4. How will you document results? (For example, use before and after measures to track changes in learning, behavior and/or policies.)

5. How will you know the impacts of your efforts? (For example, use GPRA data or diabetes outcomes and audit data to track trends over time.)

6. How will you keep track of things that are working well and those that are not working well? How will you use this information to improve what you are doing? (For example, use your audit data to monitor changes.)

7. How will you keep track of potential outside influences that could enhance or hinder the activities? (For example, a change in hiring or decrease in funding could have a negative impact.)

**Use this area for extra notes:**



## Moving Forward: Lessons Learned

All the planning elements can be put into a visual planning tool. Take a few minutes and look at your Visual Planning Tool. If you have been using this tool as you worked through this training, you will now have a completed plan. As a result you will be able to:

- Know how to identify resources available to you.
- Know how to use existing data sources such as the [IHS Diabetes Care and Outcomes Audit](#) diabetes outcomes and audit data and identify areas that need improving.
- Describe how activities from the Indian Health Best Practices could be implemented to improve your diabetes program.
- Know how to measure numbers of activities and services provided.
- Know how to measure the changes as a result of your diabetes program's efforts.
- Know how to measure long-term impacts.

## Timeline or Schedule of Events

A timeline can help keep all the components of your plan and evaluation on track. A timeline is simply a schedule of events that need to occur at certain times. A timeline can be as simple as an organized list that is broken into steps to provide information about each event and the time the events will take place.

Think about the trip analogy. A trip may be 7 days in length. That means 2 days for travel to and from the destination and 5 days at the destination. That means we have to plan out all the activities we want to do over 5 days. A timeline for your diabetes program is very much the same.

## Reading the Visual Planning Tool (or road map)

When you are finished completing the *Visual Planning* Tool you will be able to “read” your plan. “If we have these **resources**, then we will be able to implement these **activities** and accomplish our goal and objective. And if we implement these activities then we should have these **products**. And if we have these products then we should have these **results**. And if we have these results then we should have these **impacts**.”

**Action! Go To: Lessons Learned Tool.** This is a Quick Guide to the *Visual Planning* tool.

**Action! Go To: Timeline Tool.** This is a simple format for a project timeline.

## Lessons Learned Tool

If you did not complete the visual planning tool as you worked through the online training and the workbook, please complete it now. Go to page 14 for a blank visual planning tool. We encourage you to take time to develop your *Visual Planning Tool*. Creating a visual planning tool is a dynamic process and you will need to return to it frequently to review and update it.

### Quick Guide to the Visual Planning Tool

1. **Resources** are what we invest in the diabetes program. What you need to run a diabetes program.

- How much time is needed?
- How many staff? Who are they? Do you have enough? Do you need to hire new staff or re-train existing staff?
- How much money will be needed? Are there resources available to you that are free?
- Do you have materials available to you? Do you have to develop? Adapt? Adopt? Buy?
- Can you provide the services? What? Who? When? How? Where?

You will need to keep track of and document resources, including:

- time
- staff
- money
- materials
- actions
- services

### Document all resources that are available before and during your activities

2. **Activities** are events or actions or services that your program does or provides – for example, the actual things you do or provide. Remember to use the findings from the **assessment** to help you decide what activities to provide. Write a **goal** and **SMART objectives** to help you clarify your diabetes program and have specific tasks to accomplish in a given **time**.

Here are examples of things to keep track of:

- Training, in-services, workshops and diabetes programs conducted.
- Curriculums used, adapted, adopted.
- Special events held – walks, health fairs.
- Services education and home visits provided.

### Document all activities that are available before and during your activities.,

3. **Products** are direct yields of your diabetes program's efforts and are things that can be counted. Products can usually be counted or measured. Examples include number of:

- DDTP/NDEP Diabetes Fact Sheets given out
- Blood sugar testing meters given at home visits
- People reached, recruited and retained

- Clinical exams, workshops, presentations, classes held

**Document all products that are available before (to provide as a baseline) and during your activities.**

4. **Results** include data or information that is collected in a systematic way. Results are definable and measurable changes that occur as a result of your diabetes program activities such as knowledge, attitudes and skills learned. Documentation, monitoring, and measurement of the results are essential.

For example, you must record changes (before and after) in the following:

- Learning, such as awareness and knowledge.
- Behaviors, such as skills, practices, decisions.
- Policies.

**Document knowledge, skills, behaviors and policies before and during your activities.**

5. **Impacts** or the long-term results are definable and measurable changes that have occurred in the population. These results may take years and may not be easily observed by the diabetes.

For example, you may be able to record changes in the following:

- reduction in number of deaths due to diabetes
- reduction in the number of complications of diabetes
- improved quality of life.
- social change.
- economic change.
- environmental changes.

6. **“Read” your plan.** Your completed road map should allow you to say, “If we have these **resources**, then we will be able to implement these **activities**, with goal and objectives, and if we do these activities then we should have these **products**, and if we have these products then we should have these **results** and if we have these results then we should have this **impact**.”

## Timeline Tool

Creating and using a timeline can help to make sure that projects are completed on time. A timeline is simply a schedule of events that need to occur at certain times. You may find it helpful to keep a timeline. A timeline can be a:

- Simple organized list, with steps and information about all the events and the time it needs to occur.
- More sophisticated lists also exist. These can be found in many computer software programs, such as Excel.

The following is a sample timeline that your diabetes program can adapt.

<b>Month</b>	<b>Action</b>	<b>Expected Completion</b>	<b>Person responsible</b>
1	review current audit data, identify weak areas.	end of month 1	DS
2	access, review best practices with diabetes team, identify best practice that fits with resources and needs.	end of month 2	DS DM team
3	identify best practice elements to implement.	end of month 3	DS DM team

# APPENDIX 1

## Example of Planning

### *Can a diabetes program and a school work together to get youth physically active?*

#### Public Health Problem

The basketball coach began noticing it first. It was becoming harder and harder to recruit youth to the basketball team. To the coach, it appeared that not only were the kids not interested, but when they did play, they lacked the endurance to play a full game. The coach talked to the nurse at the local clinic. The nurse reviewed the health records of youth and found that not only were kids overweight, but several had diabetes. The two adults were very concerned and they decided that something had to be done. Despite the fact that the clinic and school hadn't worked together on a health problem before, they contacted the school board and the service unit director of the clinic. After a series of meetings with the school administrators and the diabetes team, they decided they could work together and were able to identify complimentary resources (space, funding, equipment and staff) to support a physical activity program as a way to improve the overall health of youth in the community.

During the planning of the project, project team members conducted team meetings and identified stakeholders: a) school personnel b) health care providers and community health workers c) parent volunteers and d) students. They contacted potential stakeholders with a letter introducing a potential school-based physical activity program for youth to assess their interest and to ask for their support. They interviewed students to determine what activities they would like to have offered.



## Results of asking the stakeholders about their possible involvement in the project.

Who are the Stakeholders?	What are their expectations?	What will the stakeholders contribute? (time, money, equipment, space, expertise, etc)
<b>recipients or participants</b>	Students said they want to: Have fun Not do boring stuff Want something new Like video games.	participation energy and enthusiasm.
<b>Decision makers</b>	reduce risk of DM accountable for money outcomes creating partnerships.	expertise in teaching money materials space administrative support.
<b>staff</b>	Improve the health of youth by increasing total daily physical activity levels Reduce risk of DM and preventing DM outcomes accountability Recruit basketball players to team.	staff time expertise

### Assessment – Planning the best route.

Next, they identified information on the current level of physical activity for elementary and high school youth. They found that elementary school youth were receiving 30 minutes of physical activity every other day and high school youth who were enrolled in physical education classes (PE) were getting 30 minutes of physical activity every week. They compared their data to Healthy People 2010 and found that the youth were not meeting the current recommendations for physical activity. They asked the school administration about the availability of physical activity program and they learned that the school had an intense testing schedule and had dropped physical education classes. They decided to implement the new class after school. Several schools within the community area were invited and agreed to participate in the new activity. They developed a visual planning tool to outline their plan.

### Activities - Things to do.

They conducted interviews with students and found that the kids were playing lots of video games and that they wanted action-oriented activities. From this the team realized that they had to compete with video-based games, computer games and television viewing. They also used ideas from the Indian Health Youth and Type 2 Diabetes Best Practice.

They were able to have access to an unused building on the school grounds. They recruited volunteers from the community to help staff transform the space into a hybrid health club and video game room. They used funding and held a fund-raiser to purchase stationary bicycles. Each bicycle was wired into big video screens. On the screens were competitive video games. The video games could only be played as long as the users were pedaling. They called their new activity, "We're moving now!"

## Goals and Objectives

Their **goal** was to increase physical activity among school students.

Their **SMART objective** was to increase the number of minutes youth enrolled in the after school activity participate in physical activity during each school day from less than 30 minutes a day to 60 minutes a day by the end of the school year.

## Keeping Track

They used a simple pre-post test to determine if youth increased their physical activity levels over time. They had the kids keep physical activity logs and had them sign in and sign out with beginning and ending time, every time they rode a bicycle .

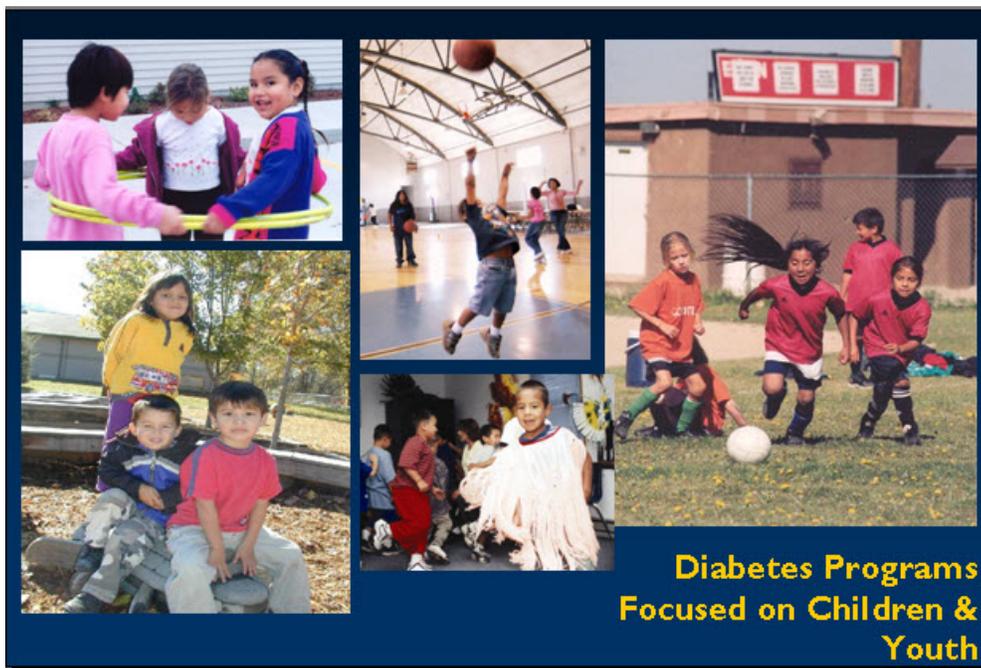
**Products.** They had 10 youth participate in the after school physical activity program. 10 students completed physical activity logs over the time period. The number of minutes increased from less than 30 minutes a day to 60 minutes a day for 7 of the 10 children.

**Results.** 100% of youth involved in the after-school physical activity program were able to ride the bike on each school day by the end of the school year.

**Impacts.** The school board adopted ownership of the very popular after-school physical activity program and is planning on making it a permanent after-school physical activity program.

## Lessons Learned.

The idea was so successful that the kids exceeded their original goal. The visual planning tool helped the team keep track of the resources they used. They were able to use the findings from their assessment to provide activities that kids wanted. They used activities from the best practice. They set a goal and SMART objective and were able to show good results. They used a simple timeline to stay on track. They had a successful after school physical activity program and were able to demonstrate accountability and show good results.



## Visual Planning Tool (or Road Map)

**Title of project: “We’re moving now!”**

**Goal:** Increase physical activity among school students.

**Objective:** Increase the number of minutes youth enrolled in the after school physical activity program participate in physical activity during each school day from less than 30 minutes a day to 60 minutes a day by the end of the school year.

<b>Resources</b>	Stakeholders identified and engaged.	Assess stakeholder needs and wishes.	Identified unused building on school grounds.	Recruited PE teacher to after-school.
<b>Activities</b>	Conducted community-wide campaign to increase awareness and build support for idea.	Recruited dedicated PE teacher who works directly with youth on a daily basis.	Created and promoted a program that required more physical activity.	Created an environmental and policy change to provide safe, fun, challenging place for physical activity.
<b>Products</b>	Numbers of staff trained and the number of activities conducted.	Number of students in after school physical activity program (recruited and retained).	Number of students reported very positive feedback about the physical activity program.	Numbers of kids able to pass physical fitness test.
<b>Results</b>	Change in awareness of being physically active through pre-post test.	Change in kids’ physical activity levels.	Change in skills of staff.	Change in overweight youth’s ability to be active for 60 minutes.
<b>Impact</b>	School and clinic formed new partnerships.	School board adopted new after school physical activity program.	School implemented new policy to ban sugary drinks from school vending machines.	Clinic established activity breaks for employees to get exercise at lunch.

## **APPENDIX 2**

### **Additional Resources on Planning and Evaluation**

#### **1. CDC Practical evaluation of public health programs.**

<http://www.cdc.gov/eval/framework.htm>

Centers for Disease Control and Prevention. Framework for Program Evaluation in Public Health. MMWR 1999;48(No. RR-11).

This guide presents a systematic way to improve and account for public health actions that involves procedures that are useful, feasible, ethical, and accurate. The framework provides guidance to public health professionals. It is a practical, non-prescriptive tool, designed to summarize and organize essential elements of program evaluation.

#### **2. Guide to community preventive services**

<http://www.thecommunityguide.org/default.htm>

This guide presents recommendations on the effectiveness and cost-effectiveness of essential community preventive health services. The guide addresses the most appropriate means to assess evidence from population-based interventions. The Task Force on Community Preventive Services, an independent, non-federal Task Force appointed by the Director of CDC, provides leadership in the evaluation of community, population, and healthcare system strategies to address a variety of public health and health promotion topics such as physical activity, alcohol, cancer, diabetes, mental health, motor vehicle, nutrition, oral health, pregnancy, sexual behavior, social environment, substance abuse, tobacco, vaccines and violence. The Task Force reviews and assesses the quality of available evidence on the effectiveness and cost-effectiveness of essential community preventive health services, and develops recommendations.

#### **3. The Community Tool Box**

<http://ctb.ku.edu/en/>

This website is the world's largest resource for free information on essential skills for building healthy communities. It offers more than 7,000 pages of practical guidance in creating change and improvement, and is growing as a global resource for this work.

#### **4. Innovation Network**

<http://www.innonet.org/>

This website provides useful evaluation information and examples and links to good resources. Innovation Network is a nonprofit organization sharing planning and evaluation tools and know-how. They provide consulting, training, and online tools for nonprofits and funders. They believe that when organizations understand what works and why, they can deliver stronger programs and create lasting change in their communities.

## 5. W.K. Kellogg Foundation

<http://www.wkkf.org/>

This organization seeks to “provide continuous, high-quality support to enhance the mission of the W.K. Kellogg Foundation by developing, capturing, and communicating useful and usable information for key stakeholders and other audiences.” They are a wonderful resource of information including providing practical assistance and principles of "logic modeling" to enhance program planning, implementation, and dissemination activities.

## Appendix 3

### Course Information

#### IHS Division of Diabetes Treatment and Prevention

#### Creating Strong Diabetes Programs: Plan a Trip to Success!

**Release Date:** July 1, 2009

**Expiration Date:** June 30, 2011

**Target Audience:** Health care providers working in Special Diabetes Programs for Indians (SDPI) grant programs.

#### Activity Overview:

This training and corresponding workbook are designed to offer skills and knowledge related to the concepts and processes of planning and evaluating a diabetes program. Following the completion of the training, one can use the tools provided for program improvement and complete a draft program plan and evaluation for their own program.

#### Description: Plan a Trip to Success!

Planning a diabetes program is an important responsibility. This training offers steps and tools on how to identify and get stakeholders involved in the program, how to assess community needs, provides activities in the form of Best Practices that are shown to be effective, and how to document results and how resources were used.

Many diabetes programs conduct a lot of interesting activities, but may not be getting credit for their accomplishments by the participants, community, and health care providers.

Why does this happen? Often programs conduct programs that are focused on doing activities but they do not have data to demonstrate that their activities and efforts are successful. Many times programs are not planning appropriately and are not conducting evaluation.

The IHS DDTP offers a web-based learning program in which participants can learn about the basics of program planning and evaluation. The information in the program will help participants understand what program planning and evaluation are, why they is necessary, how to program plan and conduct an evaluation step by step.

The web-based program is an interactive experience involving activities and videos designed to apply the concepts learned.

## Training objectives

1. Define planning and state why planning a diabetes program is necessary
2. State how to identify and engage stakeholders involved in the diabetes program.
3. Assess the diabetes needs of your community.
4. Select diabetes activities that are shown to be effective.
5. Write a goal and an objective for your diabetes program.
6. State the importance of documenting activities, results and how resources were used.
7. Develop a plan for your diabetes program using a visual planning tool (or road map).

You can start and stop the training, but you will need to note where you stop as the program does not keep track of this for you.

**NOTE:** If you stop once you start the final section with the quiz and practice session, your answers will not be saved. Your computer will not remember your answers, nor will it score your quiz unless you complete the final section in one sitting.

If you have trouble viewing this training on-line, check your system to make sure you have the appropriate hardware and software. If you need help or have any questions, please send an email to [diabetesprogram@ihs.gov](mailto:diabetesprogram@ihs.gov).

## Continuing Professional Education (CE) Credit Information

To receive CE credit, you must view the entire training, successfully pass the quiz (score  $\geq$  80%), and complete an evaluation. You will be able to print a "Certificate of Continuing Education Credits" online following the training.

### ACCREDITATION:



#### **Continuing Medical Education Credit**

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The IHS Clinical Support Center designates this educational activity for a maximum of 2 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

#### **Nurses Continuing Education Credit**

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been designated up to 2.0 contact hours for nurses. (ID No. ANCC-IHS-083/09)





### **Registered Dietitian Continuing Education Credit**

The Indian Health Service (IHS) Nutrition and Dietetics Training Program (NDTP) is accredited by the Commission on Dietetic Registration to sponsor continuing professional education for Registered Dietitians. This activity has been awarded 2 CEUs. Each attendee should only count the number of hours for each activity attended.



**DANB Approval indicates that a continuing education course sponsor is a qualified provider as described in the Dental Registration Guidelines. DANB does not, however, guarantee or warrant any particular continuing education course and is not responsible for the quality of any course content.**

The Indian Health Service (IHS) Division of Oral Health is an ADA CERP Recognized Provider.

The IHS Division of Oral Health designates this continuing dental education course for one (1) credit.

## Sponsors and Partners of Program Planning and Evaluation Training

The planning and development included IHS Division of Diabetes Treatment and Planning and a team of individuals with expertise in relevant professions.

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## Disclosure Statements

All planning committee members and all faculty members for this series of trainings have completed the disclosure process and have indicated they have no significant financial relationships or affiliations with any product or commercial manufacturer that might constitute a conflict of interest. Additionally, each faculty member has indicated that he or she will identify any experimental or “off-label” uses of any medications, and will use generic names or multiple trade names when discussing medications.

## Hardware/Software Requirements:

### Flash Player 8 or higher

Windows	Macintosh
Intel Pentium II 450MHz or faster processor (or equivalent)	PowerPC G3 500MHz or faster processor
128MB of RAM	128MB of RAM

### Operating systems and browsers

**Flash Player 8 is supported on the following operating systems and browsers:**

#### Windows

Platform	Browser
Microsoft Windows 98	Microsoft Internet Explorer 5.5, Firefox 1.x, Mozilla 1.x, Netscape 7.x or later, AOL 9, Opera 7.11 or later
Windows Me	Microsoft Internet Explorer 5.5, Firefox 1.x, Mozilla 1.x, Netscape 7.x or later, AOL 9, Opera 7.11 or later
Windows 2000	Microsoft Internet Explorer 5.x, Firefox 1.x, Mozilla 1.x, Netscape 7.x or later, CompuServe 7, AOL 9, Opera 7.11 or later
Windows XP	Microsoft Internet Explorer 6.0, Firefox 1.x, Mozilla 1.x, Netscape 7.x or later, CompuServe 7, AOL 9, Opera 7.11 or later
Windows Server 2003	Microsoft Internet Explorer 6.0, Firefox 1.x, Mozilla 1.x, Netscape 7.x or later, CompuServe 7, AOL 9, Opera 7.11 or later

#### Macintosh

Platform	Browser
Mac OS X v.10.1.x, 10.2.x, 10.3.x, or 10.4.x	Internet Explorer 5.2, Firefox 1.x, Mozilla 1.x, Netscape 7.x or later, AOL for Mac OS X, Opera 6, Safari 1.x or later

To view video segments - 500kbps (broadband, such as: DSL, cable modem, T1 or faster)

### Methods Used in Development of this Workbook

The concepts provided in this online training course and the workbook are based on the CDC Practical Evaluation of Public Health Programs. We encourage you to seek out this valuable information to enhance your learning process. The materials are available on line <http://www.cdc.gov/eval/framework.htm>

### Updates to Future Program Planning Training Materials

The materials will be updated as needed.