

# Full Circle Diabetes Program

**BUILDING COMMUNITY SUPPORTS FOR DIABETES CARE**



FUNDING  
SUPPORT  
FROM THE  
ROBERT  
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MIND  
BODY  
SPIRIT  
EMOTION

**YOUR GUIDE  
TO SUCCESSFUL  
PROGRAM  
IMPLEMENTATION**



# FULL CIRCLE DIABETES PROGRAM

## Resource Toolkit

### 2006

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Diabetes Community Council  
Minneapolis American Indian Center  
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**Dedication**

We give a heartfelt thanks to the diabetes community council members who shared their very personal stories and contributed their knowledge and commitment to make the Full Circle Diabetes Program a success. We also thank the Native American Community Clinic staff for 4 years of hard work and dedication to the project.

## WELCOME

The Full Circle Diabetes Program is pleased to present this toolkit. We sincerely hope you will find assistance and inspiration for your own program development as we share our journey of building community supports for diabetes care.

This manual has been written through the support of a grant from the Robert Wood Johnson Foundation® to the Minneapolis American Indian Center, the Native American Community Clinic and Wilder Research.

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## THE FULL CIRCLE DIABETES PROGRAM

### MISSION

TO ADVOCATE FOR  
COMMUNITY SUPPORTS FOR  
DIABETES CARE IN THE  
CONTEXT OF THE TRADITION  
OF HONORING THE FULL  
CIRCLE OF LIFE.

### GOAL

TO CREATE A CULTURALLY  
APPROPRIATE DIABETES  
MANAGEMENT PROGRAM  
BASED ON COMMUNITY  
ISSUES AND PRIORITIES.

The Minneapolis American Indian Center (MAIC) and the Native American Community Clinic (NACC) collaborated to develop the Full Circle Diabetes Program as part of the Building Community Supports for Diabetes Care initiative, funded through the Robert Wood Johnson Foundation (RWJF). The vision was to develop a comprehensive diabetes program to promote self-management that was relevant to the community and culturally appropriate.

MAIC partnered with NACC as the primary health care clinic, and with Wilder Research to manage program evaluation.

Our mission was to advocate for community supports for diabetes care in the context of the tradition of honoring the full circle of life, which addresses body, spirit, mind and emotion. Our project goal was to create a holistic and culturally appropriate diabetes management program based on community issues and priorities. To reach our goal we utilized a Circle Model of program development.

A circle model promotes holistic programming through attention to the full circle of life, recognizing that all aspects of our being require attention, and that all people contribute to the survival and vitality of a community through their unique contributions. Community support is strengthened through the engagement of participants in program planning and through the development of meaningful relationships. Partnerships are enhanced through clearly understanding the direction and objectives of the project, believing in it, and working together to develop a mission that creates buy-in and support.

The first step in pursuing our goal, and implementing a Circle Model, was the formation of the Diabetes Community Council (The Council). Comprised of American Indians, many with type 2 diabetes from the Minneapolis/St Paul area, The Council's role was to serve as an advisory board and to be the voice of the community during program development. Our council functioned through an open and flexible system that fostered the sharing of personal testimonies of living with diabetes, and the development of trusting relationships. Very profound messages came forward through the testimonies, revealing the wisdom of the community and providing programming ideas, focus and priorities.

Together, The Council, MAIC and NACC created the Full Circle Diabetes Program. How the critical roles of the project (administration, funding, coordination, community input, evaluation and clinical services) were fulfilled is outlined in the main body of this toolkit. We believe that these key functions must always be coordinated and implemented no matter how an organization is structured.

We see our project as having three primary successes: promoting healing through holistic programming; building and maintaining community support; and developing and sustaining successful partnerships. Embedded within each of these successes are important lessons learned along the way. It is these lessons, the real underpinnings of the success of the program, which we wish to share with you and that are the purpose for producing this toolkit.

An important goal of our project is to honor the tradition of sharing. We acknowledge your wisdom and experience in program development, and, therefore, gratefully accept your comments and welcome the opportunity to learn about your programming successes. If you have information you would like to share or if you would like to know more about our project, please feel free to contact us. Our contact information can be found in **Appendix A**.



## CHOOSING A PATH...

### A Circle Model of holistic program development

A Circle Model recognizes that all people contribute to the survival and vitality of a community through their unique contributions. Through this participatory model of honoring the wisdom and the talents of many individuals, a sense of community is fostered.

A Circle Model can be looked at in contrast to a typical linear organizational chart. A linear chart implies a hierarchy and a top-down flow of information. Those at the top of the chart are in a leadership position, and they determine, through their personal knowledge and beliefs, what the priorities are and how the organization will function. In order to communicate with the leaders there are prescribed channels one must take, and layers of people to get through to communicate needs and ideas; input from those near the ends of the chart may be lost or not even considered. Organizing from a circle perspective implies interconnectedness; each element or person contained within the circle is connected, and each has a valuable contribution to give. Communications can occur naturally allowing for a more fluid movement of information and sharing of ideas. Tables 1 and 2 illustrate the difference in the flow of information between a linear and circle perspective.

TABLE 1: LINEAR ORGANIZATIONAL CHART

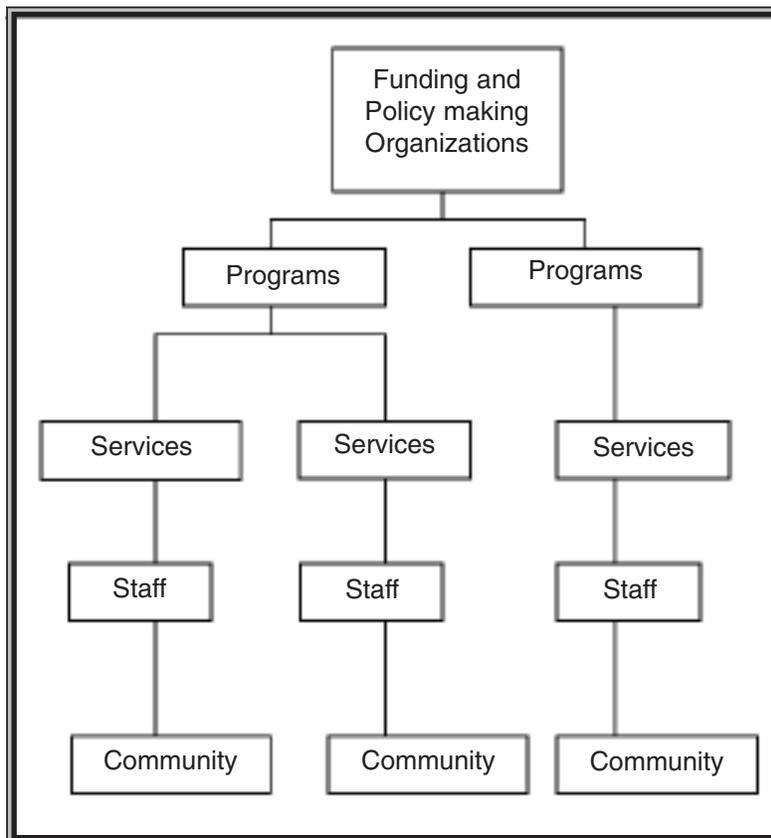


TABLE 2: CIRCLE ORGANIZATIONAL CHART

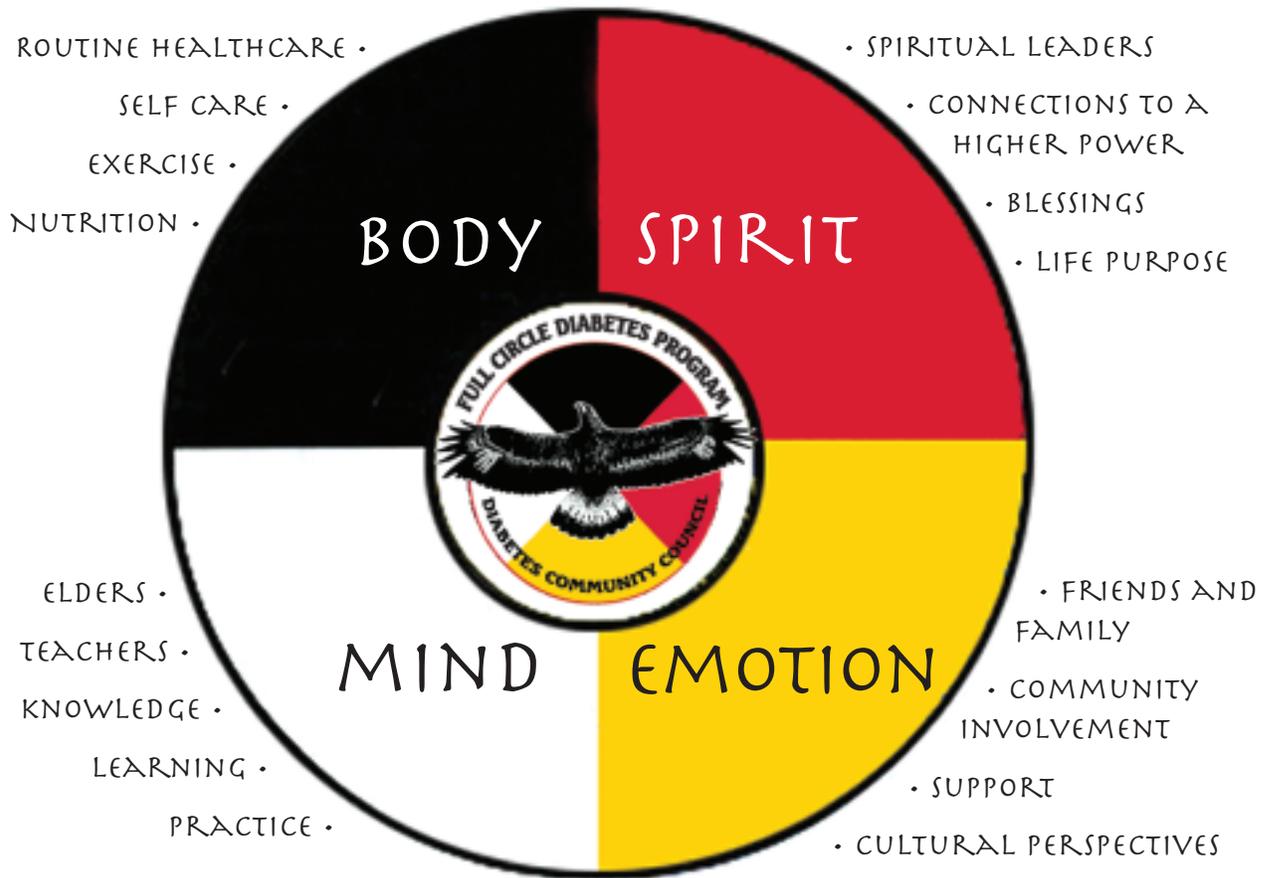


Throughout our organizing and program development, the partners important to the circle - medical professionals, elders, spiritual leaders and community members - were all present and engaged. All voices were heard and all issues considered. Priorities and concerns came directly from their sources and solutions were considered collectively. Leadership was not a role that just one person assumed, rather the one in the leadership role at any given time was the one who had the knowledge to bring benefits to the community.

The circle also guided our program development. In Native cultures the circle is often depicted with lines separating it into four parts. The number four represents many things to Native people; the four quarters of the earth, the four elements of the universe, and the four true colors. Our circle is divided into the four important elements of holistic health: Body, Spirit, Mind, and Emotion. Holistic balance is obtained when we nurture equally these elements of our being. When all elements within the circle are discussed together, it reminds us to honor all parts of our lives and to strive for balance. The following questions were used to design the Full Circle Diabetes Program.

- Body- what are the Physical Needs in relation to diabetes management, and how can we support them?
- Spirit- What are the Spiritual Needs, and how do we recognize and support those needs in diabetes management?
- Mind-What are the Educational Needs, and how do we support these needs in diabetes management?
- Emotion- What are the Emotional Needs, and how do we support these needs in diabetes management?

# A HOLISTIC CIRCLE





## HEALING THROUGH HOLISTIC PROGRAMMING

A benefit of approaching healthcare from a holistic point of view is the focus it places on self-management and comprehensive care. Ultimately, we are personally responsible for our health; it is our job to put into practice the education, advice, and help provided by our healthcare team, and it is our responsibility to be aware of and nurture our total being. By evaluating all aspects of our lives, we can become aware of imbalances and set goals to make improvements aimed at achieving balance and improving our health.

This principle also applies to creating health programs. If they are constructed with the goal of providing services to address all aspects of health—Body, Spirit, Mind and Emotion—they will be more comprehensive and have a greater potential for impact. We can more effectively work with patients on their goal setting and on taking action to assume self-management in ways that are both meaningful to them and reinforce personal responsibility.

We categorized components of our programming into the four life areas of Body, Spirit, Mind and Emotion because we considered these areas to be the most important aspects of our lives regarding health. We recognize that the areas overlap and some of our programming components could fit into more than one area, but they also fit where they were assigned, and that ensures all areas are addressed. We recommend that when creating a holistic program of your own, you look at program components in the context of whether they address all the areas you have chosen to target.

Development of a holistic program emphasizes that healing oneself is more than receiving medicine and treatments at the doctor's office. Inclusion of program components into each category of Body, Spirit, Mind and Emotion, supports and complements healthcare and broadens the number and type of settings that can be involved. Healthcare support in our community included education and physical activity at community gatherings, blessings at events, the sharing of testimonies at council meetings and talking circles, and the promotion of self-management through classes taught by peers.

Our beliefs about using a circle perspective for program development were validated by the results we achieved: holistic programming that focuses on important elements of our being; strengthening of community through equal partnership in program development; and services that are effective, comprehensive and pertinent to the needs of the consumer.

## USING A CIRCLE MODEL FOR PROGRAM DEVELOPMENT

In this section, we aim to describe how we utilized a Circle Model in the creation of the Full Circle Diabetes Program. We hope that this example is useful in your endeavors. We have also included a holistic programming evaluation tool for your reference in **Appendix B**.

### Steps to developing holistic programming

Our first step focused on the gathering of The Council in order to hear the testimonies of community members living with diabetes. Initially, The Council met twice per month for six months. During the meetings the council members shared stories about barriers to diabetes self-management, how they coped through existing resources and visions for a better future. Minutes were kept of all of the meetings and through review of the minutes themes were identified. The themes represented the issues that were discussed most often by the council during the council meetings. A sample of themes we identified is listed in **Appendix C**.

The coordinator presented the themes using circles divided into the four important life elements of Body, Spirit, Mind, and Emotion. Two separate circles, one for barriers and one for visions/solutions, were used. The identified themes were assigned to the appropriate life element of their respective circle. The Council members reviewed the circle summaries to ensure that their input was accurately represented.

By collectively reviewing the information and determining gaps within the circles, focus was maintained on the provision of a diverse array of services, highlighting the importance of treating the person, not just the disease, to gain holistic wellness. Sample circle summaries are located in **Appendix C**. Our step by step process is outlined below.

### 1. Barriers

Identify barriers to providing your particular service through meetings, circle discussions, and sharing of testimonials. Classify each identified barrier into one of the corresponding sections of the circle. Evaluate your circle. What does your circle look like? Are any sections empty? An empty section does not mean that there are no barriers. It may identify a lack of attention or thought. Go back and continue discussions with the thought of the empty section. Complete your circle with any new information gathered.

### 2. Community assessment

Conduct an assessment of community resources. Plan for adequate time and possibly additional staff to complete the assessment. Depending on the availability of staff time this could take 1-3 months. Another option is to enlist the help of a local college class or student intern. Determine which available community resources provide a solution to your identified barriers.

### 3. Solutions and Visions

Identify solutions or visions for the identified barriers and also include the available community resources as solutions where appropriate. Assess if current resources are being fully utilized and identify agencies to approach for possible partnerships, thus, providing an opportunity to expand needed services and reach a greater number of community members. See **Appendix C** for sample circle summaries.

#### **4. Rank your solutions**

Have open discussions about the solutions and resources listed. Clarify, refine, consolidate similar ideas and evaluate placement within the circle. Next, rank the solutions within each section to determine the top priorities.

#### **5. Begin budgeting**

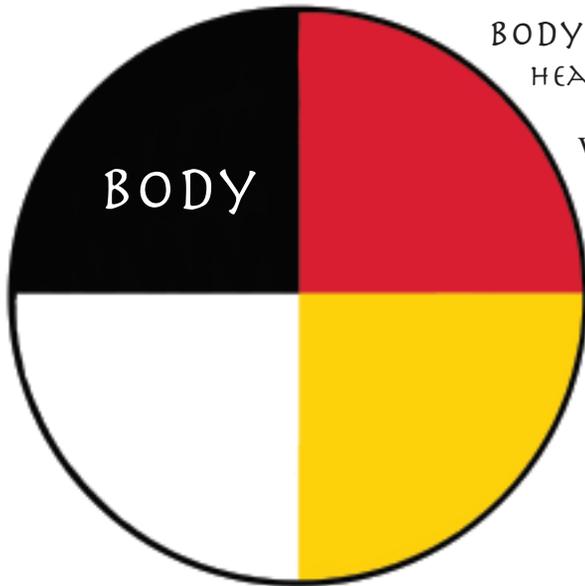
Present participants with a list of all the solutions they had identified in step four above, along with the cost of each solution (include staff time in your calculations) and the total budget. Prioritize and rank the solutions based on the available budget. Choose solutions from each section to provide holistic as well as budgetary balance and choose the solutions that rank highest. Some popular solutions may have to be eliminated if they require too great a portion of the available budget. Repeat the process for the next highest priority until the budget is exhausted. See **Appendix D**.

#### **6. Develop your programming**

You now have your foundation. The next step is to take action. Allocate your funds and design your new programming from the chosen solutions. Develop partnerships to help you offset the cost and to promote existing community resources. Because programming is based on community input, you will have developed a program that is holistic and appropriate to the community you serve. The community group will feel validated for all their work and they will feel a sense of ownership for the program.

**Appendix E** provides an example of our action plan with goals, objectives and action steps. The following pages outline in more detail the components of our programming as they relate to the areas of Body, Spirit, Mind and Emotion.

## HOLISTIC PROGRAMMING COMPONENTS



BODY ... WE HONOR OUR BODIES WITH PHYSICAL HEALTH

We recognized that to gain participation in healthy activities, it was important to “meet people where they are” and to try to reduce or eliminate identified barriers. We sought to provide as many opportunities and variety of options as possible. Physical components of our programming included:

- **Clinical services**

Case management, to promote timely follow-up care and goal setting, was identified as an important component of healthcare services provided by the clinic. Care plan meetings were developed to build on the case management services. Referrals to physical therapy and coaching by a trained personal coach were also implemented. Protocols for diabetes care were developed and implemented.

- **Community collaborations**

To engage people in physical activity we worked with walking clubs and water aerobics classes and helped recruit members for a subsidized fitness center membership. As a result of collaborations with community agencies offering these services, more physical activity options were available at a lower cost to both the program and the participants.

- **Advocacy**

Finances were identified as a barrier to meeting health care goals. Many participants faced financial challenges or had no medical insurance. A patient advocate was hired to assist with referrals to appropriate outside health care services and facilitate access to insurance.

## SUCCESS TIPS



CONDUCT CARE PLAN MEETINGS TO HELP CLIENTS SET GOALS AND TO PROVIDE FEEDBACK AND SUPPORT

IDENTIFY FITNESS FACILITIES AND HELP THEM RECRUIT PARTICIPANTS IN EXCHANGE FOR FREE OR REDUCED-COST EXERCISE OPPORTUNITIES.

PROVIDE PATIENT ADVOCACY RESOURCES TO HELP CLIENTS GAIN ACCESS TO INSURANCE, OUTSIDE RESOURCES AND OTHER COST SAVING SERVICES

ENLIST THE SERVICES OF A CASE MANAGER TO FACILITATE PATIENT EFFORTS TO ACCESS HEALTHCARE SERVICES



## SPIRIT ... NOURISHING THE SOUL BY JOINING TOGETHER

As humans, we long for community and acceptance. Activities and ceremonies that bring us together in love and fellowship nurture our soul's inner need for connections with others.

Spirituality and religion are often confused. Religion is a formal system of beliefs and practices, while spirituality is a common experience (although it can mean different things to different people). Believing in the power of love and kindness can be thought of as spirituality. Spirituality can also be a sense of belonging to something larger than oneself. The spiritual aspects of our programming included:

- **Blessings**

We offer a blessing before a meal. Blessings provide a feeling of protection and unity. A participant is asked to give a blessing in whichever way he or she feels comfortable. Participation is completely voluntary.

- **Connections to traditional healers**

The clinic is respectful of patients' wishes for alternative healthcare treatments and maintains connections to Native traditional healers.

- **Honoring cultural perspectives**

Participants in the program speak to issues from a cultural perspective; they gain strength from connecting to their heritage and spiritual beliefs, and from connecting to something larger than themselves. Many feel a responsibility to preserve their culture. They want culturally appropriate programming to know that they are moving forward in a meaningful way.

- **Thinking of others in times of need**

Participants in the Full Circle Diabetes Program have become a close community and they responded with prayers, cards and visits when others were experiencing personal struggles. Participants know they have the support of people who care for them in a loving and spiritual way.

- **Testimonies**

Sharing personal stories is healing. Through the process of giving and receiving testimony, participants report feeling supported, less alone in their challenges and motivated to make healthful life changes. Program meetings were the first place many had ever spoken to others about their personal struggles with diabetes. It is empowering to hear how others have overcome challenges and doing so gave hope to many.

## SUCCESS TIPS



ALLOW TIME FOR THE GIVING OF HEART-FELT TESTIMONIES. THERE ARE BENEFITS TO BOTH THE GIVER AND THE RECEIVER

DEFINE THE DIFFERENCE BETWEEN SPIRITUALITY AND RELIGION; ENGAGE IN DISCUSSIONS AND HONOR YOUR RELIGIOUS DIFFERENCES

PROMOTE A FEELING OF LOVE, SAFETY AND HOPE THROUGH RESPECTFUL COMMUNICATIONS AND CULTURAL CONNECTIONS



MIND... WE HONOR OUR MINDS BY ACQUIRING NEW KNOWLEDGE AND EDUCATION.

In order for patients to be successful in managing their health and disease, they need information for sound decisions. They need to know and understand the facts of their health. Educational opportunities are important to foster self-management and are most effective when presented in a variety of ways. Facilitating opportunities for participants to learn from each other is also beneficial. Our educational programming includes:

- **Self-management**

Self-management classes with group accountability and support are powerful motivators for self-change. We offered Chronic Disease Self-Management workshops, licensed through Stanford University, which promoted weekly goal setting and sharing of progress with the group. If progress had not been made, the group would brainstorm potential solutions that would help the participant meet their goal the following week. Community representatives were trained to teach the classes, which gave ownership of the program to the community. Reputable self-management curricula are available for purchase and for free. Find one that meets your time and budget. We found that stipends for the teachers' time increased commitment, and incentives for participation and course completion helped increase recruitment and retention.

- **Individual education**

Some individuals are not comfortable in a group setting. Individual educational opportunities help those participants achieve their goals. Also, individual sessions can build on topics and goal setting from group classes.

- **Community education**

Community events and activities are welcoming and comfortable since the only expectation of participants is to be present. They also provide opportunities for people to connect with one another in a familiar location and to learn together and from each other. Keep your events open to a community-wide audience. Community activities may be the first point of contact with your program for many individuals, and, therefore, an important channel for recruitment. You can use expert speakers to address topics of high interest and disseminate educational materials that promote upcoming classes. Serving meals can provide an opportunity to model a healthy diet and draw people to your event.

- **Participation in local mainstream educational events**

Nationally and locally recognized organizations sponsor exciting educational events throughout the year. These events provide a wealth of information and opportunities for community members to become involved in volunteer activities. Organize group participation and increase attendance through offering incentives of pre-event activities and free transportation. Engage passionate program participants to visit local health fairs and to volunteer to promote your program.

## SUCCESS TIPS



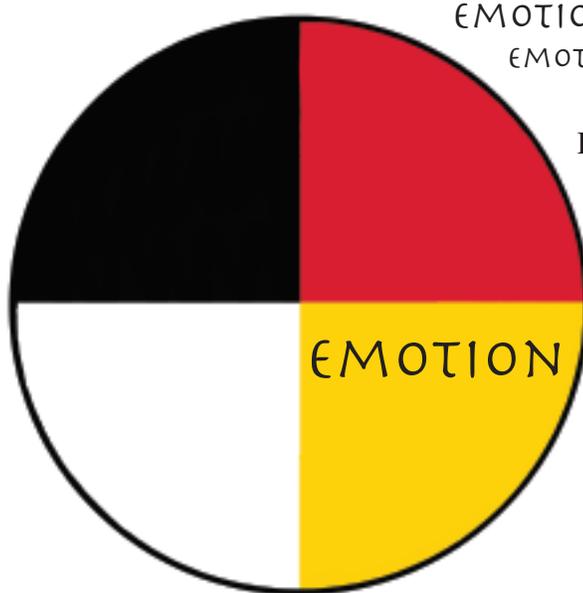
PROVIDE OPPORTUNITIES FOR PARTICIPANTS  
TO SET GOALS AND PRACTICE NEW SKILLS

PROVIDE OPPORTUNITIES FOR  
PARTICIPANTS TO SHARE AND  
LEARN FROM EACH OTHER

MOTIVATE SELF-CHANGE  
THROUGH GROUP ACCOUNTABILITY  
AND SUPPORT

HOLD EVENTS IN FAMILIAR  
LOCATIONS AND KEEP THEM OPEN  
TO A COMMUNITY-WIDE AUDIENCE

DECREASE BARRIERS OF TRANSPORTATION  
COST, AND ISOLATION TO PROMOTE PARTICIPATION  
AT COMMUNITY EVENTS AND EXPOS



## EMOTION ... HONORING OURSELVES BY NURTURING OUR EMOTIONAL WELL-BEING

Depression is significantly linked to chronic disease. Acknowledging this connection and providing support for improving emotional health is crucial in the prevention and treatment of any chronic disease. The program addresses emotional health in the following ways:

- **Opportunities for sharing**

Sharing personal struggles is beneficial to personal health; people unburden themselves and feel understood and supported in their challenge to manage their disease. Sharing is integral to creating community and a sense of safety. Sharing is healing for both the giver and the receiver.

- **Building connections**

We all need fulfilling relationships in our lives for emotional wellbeing. We need to know that we are thought of and cared for. Relationships develop through sharing and working for a common purpose in the classes and at events. Relationships are strengthened when we take time to remember people through thoughtful actions during difficult times. A telephone call, visit, or thoughtful card can substantially lift a person's spirit.

- **Empowerment through outreach**

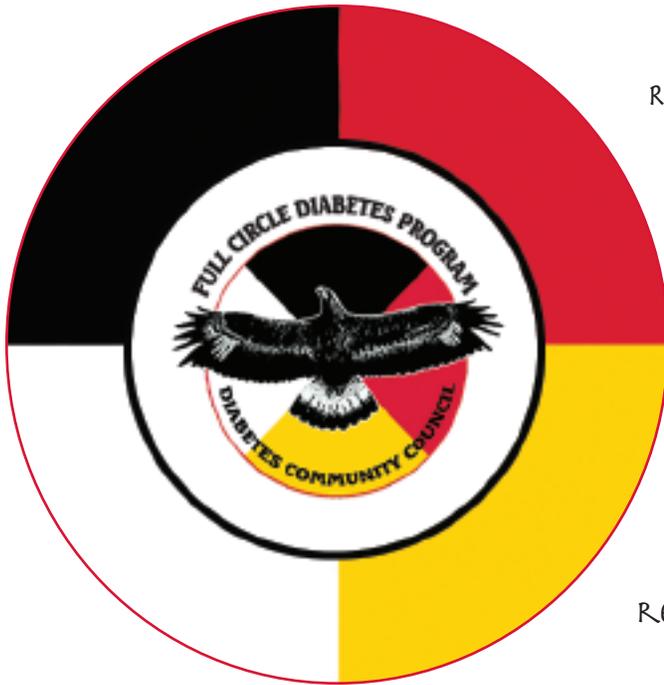
A person's self-esteem is nurtured through successes and positive experiences. Engage individuals to participate in planned outreach activities, as they gain skills and experience positive responses, they become empowered to share their personal stories with family members and others in the community, thus becoming effective advocates.

- **Referrals to counseling services**

Depression is significantly linked to chronic disease. Providing services that address mental health will also help manage a chronic disease. We use and recommend a depression screening for each patient diagnosed with diabetes. The screening provides an opportunity to identify those that may need referrals for counseling, medications or other mental health resources. Our talking circles were another way to provide emotional help for patients. The talking circles provided a safe place for people to ask for and receive help from their peers and to know that others share their same challenges. Lists of mental health resources were made available at the talking circles.

## SUCCESS TIPS

### CREATE SUPPORT THROUGH CARING ACTIONS



RECOGNIZE THE RELATIONSHIP BETWEEN DEPRESSION AND CHRONIC DISEASE. PROVIDE SCREENINGS AND REFERRALS FOR EMOTIONAL HEALTH

ENGAGE WILLING PARTICIPANTS TO PARTICIPATE IN OUTREACH ACTIVITIES

PROVIDE OPPORTUNITIES FOR SHARING AND BUILDING RELATIONSHIPS



## **BUILDING COMMUNITY SUPPORT**

Building and maintaining community investment is achieved one individual at a time. As a person gains trust and learns to control his or her own healthcare, he or she becomes empowered to be a positive role model for others in the community. Leaders are present throughout any community. Creating a forum to highlight and build on individual skills engages natural leaders and motivates them to use their abilities to help others. There is always inherent strength in the community; our role is to nurture it along.

Organizational involvement in the community and a presence at community events demonstrates commitment and builds relationships. The organization can then truly partner with the community and not work alone in efforts to maintain and expand programming. We operated on the premise that the community knows exactly what is needed for support. While this may seem obvious, many programs are developed by professionals using only their own internal wisdom and experience to set priorities. We went to the heart of the community—directly to the people—asked for assistance, and acted on their priorities. Actively listening to and using the knowledge of the community to create programming builds ownership and validates the wisdom of the community. The resulting program makes sense to those using it, and individuals become effective program advocates. The advantages for community members include: increased self-management of their health condition and their healthcare; motivation and support to continue positive changes; enhanced skills; strengthened community connections and an increased awareness of community resources.

### **Identifying Leaders and Building Skills**

It was important to create opportunities for involvement. In our setting, community members living with diabetes served as important role models for behavior change and positive diabetes self-management. Council members were trained to be teachers for a chronic disease self-management class, renamed “Living in Balance”, and they also requested and received training on public speaking and leadership skills. Community members were recognized as A1c champions through a national program. The champions were given opportunities to speak to others about their success in lowering blood sugar levels. Other opportunities for outreach and advocacy included: staffing information tables at health fairs and conferences; speaking to university students at classes and at special informational programs; producing an inspiring testimonial video; participating in local American Diabetes Association events and committees; and organizing and attending intergenerational events. Participants of the Full Circle Diabetes Program have stated that participation in the program has also helped them be more open with their families and others about diabetes.

### **A Community Council**

Healthcare programs are often developed through a committee composed solely of health professionals who may not be a part of the community they serve. Such an arrangement builds on the priorities of the professionals and their perception of community needs. Other programs may use a focus group to gain community input. Often a focus group operates from a set agenda with a deliberate set of questions and a designated group leader. We desired a more fluid and open process, one that would allow adequate time to build trust and understanding. We decided that the development of a community council would be in line with our goals and be the most productive process to gain meaningful community input while also building commitment and community ownership.

The Council met bi-monthly for the first six months and then monthly thereafter. Trust was built using a process that involved the sharing of personal testimonies. Time and patience were required for the

process to work smoothly. The telling of personal stories is often seen as tangential, however, it is essential in order to build a trusting environment and to appreciate personal challenges. The council members frequently comment on the benefits they gain from listening to and giving their own testimonies and how they feel safe and respected within the group. By truly listening to the testimonies, it was possible to pull out the major themes. It was then essential to reaffirm that the messages had been accurately captured. The process was one of listening, reframing and affirming the major messages. Ultimately, the work of The Council made clear the struggles of living with diabetes, how people currently cope, and which resources are most effective in promoting healthy living with diabetes

Finally, we found it essential to budget staff time for a project coordinator to ensure efficient coordination of council activities. Through participation in The Council, staff helped build community support and investment. Council members developed a strong commitment to the project, actively promoting the resources in the community. This helped to break down additional barriers of isolation, denial and anger of being diagnosed and living with diabetes. The following section contains information on the development and management of our community council.

## **Steps to development and management of The Council**

### **1. Recruitment**

Prospective council members were identified through community events and programs, posting flyers, and making calls based on referrals. Our recruitment goal was 15 people, generally considered a workable number for groups. One-on-one meetings were conducted with community members, interested in becoming council members, to establish trust and to gain an appreciation of the personal impact of diabetes on each individual. The meetings helped the coordinator understand the motivations and personal gifts that each council member would bring to the table. Regular meetings were held, twice a month initially, to build relationships and work on the mission and vision.

### **2. Facilitation**

Effective facilitation and relationship building are key to success. The goal of our meeting facilitation was to enhance feelings of security, community and respect. During the meetings, the facilitator was supportive and gently moderated the discussions. The facilitator focused on posing questions to generate ideas, and on having open discussions of issues. Following a routine agenda with general time lines allowed time for sharing of personal stories. Everyone around the circle is given a chance to respond to questions.

### **3. Meeting Set up and feedback**

Each time, the meeting room is set up the same way to develop a feeling of continuity and comfort. Chairs and tables are arranged in a circular configuration to foster communication among participants. A comment card, rating form, agenda and pencil are provided at each place. The comments and ratings provided immediate feedback to the facilitator for quality improvement and provided those who felt less comfortable speaking aloud to a group a way to contribute to the discussion. All comments are included in the meeting minutes.

### **4. Blessing**

A blessing is offered at the start of each council meeting to set a peaceful and grateful tone. We nurture the spiritual part of our lives when we engage in activities that connect us to each other. The blessing brings us together while we acknowledge the greater world and ask for assistance and protection. The multi-tribal and multi-denominational nature of the group is respected and prayers are given in whichever way the prayer-giver feels comfortable.

### **5. Meal**

Sharing a meal is a universal activity that helps to build friendships and community. The meals also provide a way to model healthy food choices. Since our council meetings were in the evening, providing a meal helped relieve the stress of needing to fix a meal and to eat quickly before coming to the meeting.

### **6. Honoring commitments**

We inform potential council members that it is a “working” council and a certain level of commitment is expected. Interested people are encouraged to attend a meeting as a visitor first before making a formal commitment. We offer a stipend of \$20.00 to council members for each meeting attended to honor their time and efforts and to build commitment. Some council members opt not to receive a stipend, while others receive a grocery store gift card in lieu of payment.

## 7. Tangible results and products

We operate from the belief that the program belongs to the community; our role as staff is to help their visions become reality. Individuals feel validated when they see action taken on their ideas. Feeling that they are personally making a difference for all participants with diabetes motivates them with their own self-management and to continue to be role models in the community.

See **Appendix F** for sample community council materials.

## SUCCESS TIPS



HONOR COMMITMENTS OF TIME AND EFFORT

INVEST TIME TO BUILD RELATIONSHIPS AND TRUST BETWEEN COUNCIL MEMBERS AND STAFF AND AMONG COUNCIL MEMBERS

PROVIDE OPPORTUNITIES TO CREATE TANGIBLE PRODUCTS TO VALIDATE COMMUNITY INPUT

ALLOW TIME FOR PERSONAL TESTIMONIES TO BRING FORTH MEANINGFUL MESSAGES

CREATE OPPORTUNITIES FOR PEER EDUCATION AND COMMUNITY OUTREACH



## DEVELOPING AND SUSTAINING SUCCESSFUL PARTNERSHIPS

Our initiative consisted of five partners, the Native American Community Clinic (NACC), Minneapolis American Indian Center (MAIC), the Diabetes Community Council, Wilder Research and the Robert Wood Johnson Foundation (RWJF). Having a common understanding of the goals and objectives of each individual partner makes it possible to appreciate the value of each one's contribution. To achieve that level of understanding, it is necessary to have consistent, clear and frequent communication. Equally important is to make sure that key functions are identified and completed.

Active involvement by each partner creates a strong circle. The five partners in this project were involved every step of the way. This section outlines in more detail how the partners covered the key functions of program development: administration, funding, coordination, community input, clinical services, and evaluation.

### KEY FUNCTIONS

#### Administration and Funding

RWJF facilitated program success through ensuring accountability and providing expert direction and opportunities for learning and networking. They provided a forum for continuing education through a series of collaborative learning sessions, and they were easily accessible and available. The Full Circle Diabetes Program staff was accountable for producing work plans and reports, hosting site visits, and attending regularly scheduled mandatory meetings. All of these activities helped to keep the project on track and developing in a productive and thoughtful way. RWJF invited us to share our program at national meetings and through papers. Their commitment to the program was evident through their contributions of productive advice, timely funding, direction and support.

While your program may not be organized in the same manner as ours, you undoubtedly have an administration and budget. An engaged, supportive and thoughtful administration is critical to ensuring a strong program.

#### Coordination

Devoting specific hours for coordination of your project is crucial. The time needed for coordination must be carefully thought through and specific hours allocated. A full time coordinator was hired for our project and supported through the MAIC, the fiscal agent for the grant. The coordinator's role included:

- Overseeing the project coordination
- Setting up and facilitating meetings between partners
- Creating and facilitating the Diabetes Community Council
- Translating input from The Council into meaningful programming
- Coordinating the day-to-day management of the project and implementing intervention activities
- Making sure the evaluation data transfers were completed
- Forming collaborations with other community programs
- Serving as point person to the RWJF National Program Office
- Completing work plans, reports and managing the program budget

#### Community Input

The Diabetes Community Council shaped the development of the Full Circle Diabetes Program through sharing beliefs about barriers and gaps in healthcare delivery, and providing their visions for

improving diabetes self-management. The discussions built trust and strengthened relationships, promoting the sharing of very personal testimonies. Through these testimonies, very profound messages came forward. The process required time and patience. The sharing of personal stories is often seen as tangential; however, this process was essential in order to appreciate personal challenges. Embedded within these testimonies were everyday struggles, coping strategies, and visions for a healthier future. By truly listening to the testimonies, we were able to pull out the major themes and then reaffirm that the messages had been accurately captured. The Council also helped to design community-based activities to complement and expand existing resources aimed at improving diabetes self-management. Council members became class leaders for the “Living in Balance” chronic disease self-management program, led talking circles, designed intergenerational events, and participated in outreach activities.

### **Clinical Services**

The Native American Community Clinic (NACC), along with the program coordinator, began implementing and promoting the program components. Patients were enrolled and a diabetes registry developed. A case manager was hired to assist with the enrollment process that required: completing a number of forms and assessments for evaluation and tracking purposes; setting up medical appointments; tracking lab tests; making appropriate referrals; and developing a process for ongoing follow up and support. The NACC managed all clinical aspects of the project to include:

- Quarterly clinical visits with monitoring of blood glucose, Hgb A1c, lipids, and foot checks
- Annual clinical exams to include urine protein, retinal eye exam, immunizations, and dental checks
- Routine annual physical exams with pap smear, mammogram, colon cancer screening, and prostate cancer screening (depending on age).
- Depression screening, treatment, and therapy
- Dietitian evaluation and follow-up
- Nicotine and chemical use screening and support and treatment services

The clinic also collected and transmitted data to Wilder Research for evaluation. Together with the project coordinator, the clinic developed and implemented diabetes healthcare protocols and hosted educational community events.

Consistent and active attendance of the NACC staff at the Diabetes Community Council meetings allowed them to hear first-hand the community perceptions of the medical care system including barriers that inhibit diabetes self-management. Through these unique learning experiences, clinicians were empowered to make informed decisions on how to best serve patients. As a result, the program developed through community input, and the clinicians understood and supported the program. See **Appendix G** for examples of helpful clinical forms.

### **Evaluation**

Ongoing evaluation supported our program through highlighting areas for quality improvement. Programs must continually change and grow to continue to be effective, and reliable evaluation data can lead you in the right direction.

Wilder Research brought expertise and commitment to the project that was key to building an effective evaluation plan. Their staff took time to understand the Full Circle Diabetes Program and address the needs of all stakeholders, while building the evaluation skills of program staff. The evaluation plan targeted the program outcomes and questions most important to the partners, ensuring that data collection requirements fit program operations, goals, and the resources available to MAIC and NACC.

Wilder Research provided guidance throughout data collection and was responsible for data entry and analysis as well as writing user-friendly and informative semi-annual reports. Finally, all partners worked together to understand the results of each evaluation, to celebrate the program's successes, and to fine-tune the evaluation process and programming as needed.

## **STEPS TO SUCCESSFUL PARTNERSHIP**

### **Dedicated staff time**

We found that having dedicated staff time was a necessity for coordinating partnership activities, maintaining momentum, and ensuring that the program was successfully implemented. The coordinator facilitated the meetings, interpreted the information that was presented at the meetings, and developed a trusting relationship with The Council and other partners. The program coordinator was also the one who tended to the small details necessary to achieve success.

Equally important was the designation of a person at each partner site who would ensure accountability and implementation of responsibilities. In order to expand our planning into active programming, we subsequently found it necessary to divide the MAIC coordinator's responsibilities between two positions, one at the clinic and one at the MAIC. The evaluation partner, Wilder Research, was under contract through the funding period.

### **A clear mission and vision**

The mission of the Full Circle Diabetes Program calls for the creation of a culturally appropriate diabetes management program based on community issues and priorities. All partners must clearly understand the direction and objectives of the project, believe in it, and work together to develop a mission that creates buy-in and support.

The project must also be structured to help each partner meet its own mission and objectives and identify each other's strengths. Defining the benefits gained from the collaboration enhances a feeling of success and a sense that the program is moving in the right direction. Partners become increasingly invested when treated respectfully and when individual benefits are realized. By recognizing their interdependence and working cooperatively, partners build on their collective strengths to meet individual and group goals and are better able to address any problems honestly and openly. Table 3 lists the partners' responsibilities and benefits.

### **Regular meetings**

Regular attendance at community and organizational meetings enables all partners to move forward together through the planning process, refining and expanding programming as the project moves along. Partners have opportunities to discuss their perspectives on the progress of the program and open communication promotes the sharing of concerns and working together towards solutions.

### **Ideas turned into action**

Most important to program success is converting the ideas and solutions developed by the partners into action. Seeing action that leads to results validates the partners' contributions, builds commitment to the project and generates continued interest and investment. Developing an action plan that outlines your goals, objectives and action steps will help to keep you focused on priorities, and the addition of timelines to meet each objective will keep you on track. Sharing the plan with all partners helps everyone to be accountable and validates your time.

**Table 3 Partnership responsibilities and benefits**

<b>Partner</b>	<b>Roles/Responsibilities</b>	<b>Benefits of Collaboration</b>
Diabetes Community Council	Act as an advisory board and advocate for the Full Circle Diabetes Program through outreach activities. Provide direction for program planning.	Empowerment and personal growth through contribution and participation. Support for living with diabetes. Programming that is responsive to community priorities.
Minneapolis American Indian Center (MAIC)	Host and coordinate work of The Council and other partners to develop the Full Circle Diabetes Program. Oversee program implementation including work plans, reports, accounting and coordination of meetings with partners. Expand resources through developing community partnerships. Participate and facilitate diabetes team meetings with clinic staff.	Service to the community. Enhanced opportunity for continued funding.
Native American Community Clinic (NACC)	Enroll clients into the Full Circle Diabetes Program and provide health services and case management. Provide data for evaluation. Promote diabetes self-management and provide diabetes education. Sponsor and attend community events.	Greater exposure and reach into the community. Improved health for people served.
Robert Wood Johnson Foundation	Provide funding, technical assistance and support throughout the project. Provide opportunities for education, networking and project promotion at national meetings. Provide guidance and direction through all phases of the project. Ensure accountability.	Contribution to organizational mission. Advancement of quality diabetes self-management and care.
Wilder Research	Provide a framework for evaluation procedures. Consolidate data into useful information for quality improvement. Participate in council and organizational meetings to gain an appreciation for the Full Circle Diabetes Program	Exposure as a research organization that is sensitive to the needs of the communities they serve. An opportunity to learn from the community.

## SUCCESS TIPS



DESIGNATE STAFF TIME AT EACH PARTNER SITE

DEVELOP A CLEAR MISSION AND VISION

IDENTIFY AND IMPLEMENT KEY FUNCTIONS

HOLD REGULAR MEETINGS AND KEEP CONVERSATIONS OPEN AND WORKING TOWARD THE GOOD OF ALL

TURN IDEAS INTO REALITY TO VALIDATE AND HONOR CONTRIBUTIONS



## PROGRAM EVALUATION

Program evaluation involves careful and purposeful collecting and analyzing of information about a program or some aspect of it for the purpose of making program improvements. The evaluation should highlight what is working, what can be improved, and ways to reach program goals most efficiently and effectively. Program evaluation is often essential for obtaining and maintaining funding as well. There are many different types of evaluations, ways to collect information, and ways to analyze it. Four important things to consider in designing an evaluation protocol are:

- What information do you want from the evaluation?
- What will you do with the data after you have it?
- Who is the audience for the evaluation?
- What resources do you have for data gathering and analysis?

### **Stakeholder involvement**

Make sure that all service providers/organizations that are involved in program planning and delivery (i.e., stakeholders) are also involved in creating the evaluation plan. Each partner will want certain data tracked to satisfy its organization's goals and to justify continued participation. Have a discussion with each stakeholder at the onset of evaluation planning on the different needs, resources, and limitation of their organization/position, allowing for the creation of an evaluation plan that is viable for everyone. That process also allows stakeholders to understand and take accountability for the information they need to collect, how and when to collect it, and how and when to deliver it to the primary person responsible for the evaluation.

### **Audience**

Determine your audience. Are you gathering information for staff, funders, an advisory board, or to share with the community? What do they want or need to know? If you have multiple audiences, you may need to prioritize.

### **Data content**

Measuring outcomes is most effective if you collect data that corresponds to your program goals and objectives. For example, you may want to measure both short-term changes (such as knowledge and skills) and longer-term changes (such as behavior and clinical indicators), depending on the goals and objectives of your program. Similarly, if your program is designed to affect your clients' social, emotional, and physical well being, your evaluation will be most meaningful if some measure of each is included in it.

Be practical in terms of staff and client time and effort. It is important to separate the "need-to-have" evaluation components from the "nice-to-have"; any data collected should have a well thought-out purpose and use.

## **Resources**

Know your resources. Evaluation takes time, skill, and money. You want an evaluation design that meets your needs and fits your resources and budget. Consider who has time to oversee the evaluation and to collect data. You may also need people with the skills to do interviews, focus groups, data analysis, or other tasks that may be involved in the evaluation. Look at the availability of funds to hire a consultant to assist with all or parts of the evaluation, to fund staff time, to offer incentives to participants for providing data (if appropriate), or to pay for other expenses that might crop up in the process of data gathering and evaluation.

## **DESIGNING THE EVALUATION MODEL**

### **1. Create a logic model**

A logic model is a diagram that delineates the connection between the program's activities ("input"); client involvement; and the anticipated changes in knowledge, skills, and behavior from that involvement. Creating a logic model for your program is the best way to spell out how your program will achieve results and what results are reasonable to expect.

### **2. Prioritize outcomes**

Your logic model will likely contain more outcomes than are feasible to measure. You will need to determine, based on your audience and your goals, which are most important to include in the evaluation.

### **3. Select sources of data and collection strategies**

Given the results you want to measure, your resources, and the characteristics of your patients or program participants, you will need to decide how best to collect the information you need. Collection strategies include, but are not limited to: phone interviews, focus groups, written surveys, and review of files. Sources of information include clients, staff, partnering organizations, community members, and pre-existing data/records

### **4. Keep ethics at the center**

You'll want to make sure that your evaluation plan takes into account your clients' privacy needs, rights, and well being.

### **5. Select tools**

Use existing standardized tools if appropriate. If not, create and pre-test the tools for gathering information. Tools must get at the information you need, be easy for staff and clients to use, and be as impartial as possible. For instance, if you have access to clinical data and permission to use it, don't rely on self-reported data for clinical values such as blood pressure and hemoglobin A1cs. Medical records would be more accurate.

### **6. Implementation**

Implement your evaluation plan and consider timing. If you want to track how participants' perceptions have changed, for example, gather the data starting with their pre-program perceptions. Data should be gathered with a clear idea of how you will summarize or analyze it in a meaningful way.

While data collection may occur every three months or less, staying on top of the evaluation is at least a weekly effort. As you go, make sure data collection tools and strategies are working as you planned; people involved in the evaluation know what to do and when; and that evaluation stays at the forefront of people's minds and to-do lists.

## **7. Share results**

Share what you have learned to build more support for your program, to give extra encouragement to participants, to generate feedback for making program improvements, and to inform others of lessons learned. From reports to one-page handouts, there are many ways to let your stakeholders know what you learned and how you will respond. It is essential that whatever format(s) you choose for disseminating information meet the needs of your particular audience.

## SUCCESS TIPS



IMPROVE EFFICIENCY AND COST THROUGH  
A FOCUSED EVALUATION

COLLECT DATA THAT REFLECT THE  
DIVERSITY OF YOUR PROGRAMMING  
TO GENERATE EFFECTIVELY  
MEASURED OUTCOMES

KEEP ON TOP OF DATA COLLECTION  
PROCESSES AND QUALITY AS YOU GO

PRE-TEST DATA COLLECTION TOOLS FOR  
CLARITY, SIMPLICITY, AND ACCURACY

BE PRACTICAL IN TERMS OF STAFF AND CLIENT  
TIME AND EFFORT. CHOOSE WISELY

INVOLVE ALL PARTNERS IN THE EVALUATION PLAN



## REFLECTIONS ON THE JOURNEY

The Full Circle Diabetes Program sought to strengthen the voice of the community and use its wisdom for program development. Unique successes were realized due to: the use of a holistic and cultural approach; the willingness of the partners to follow the direction offered by The Council; building community investment; and maintaining successful partnerships. The result was a comprehensive diabetes program focused on self-management.

The Council was essential to the success of our model of programming. It was through The Council that the wisdom of the community came forth to produce ideas, focus and priorities. The Council accomplished its goal in the development of a culturally appropriate diabetes program. They maintain their commitment to support each other and actively engage in program activities. Council members continue to teach “Living in Balance” workshops, share their testimonies and seek future opportunities to build community supports for diabetes care. The strengths of the project and benefits of participation in the council as viewed by the council members were captured through personal interviews. **Appendix H** lists the paraphrased comments, which clearly demonstrate the personal growth, commitment and visions for the future that evolved.

The MAIC and the NACC continue to work closely with The Council and other program participants to support the community activities. Team meetings are held regularly at the clinic and staff work cooperatively to make sure the activities run smoothly. The result is a very seamless operation. Internally the partners understand lines of division of work, but for the participants there appears to be no separation. The result is multiple avenues of entry into the program and support from both the clinic and the MAIC.

Enrollment in the Full Circle Diabetes Program through the Native American Community Clinic is growing and the clinic continues to expand and improve services to foster self-management. Future funding opportunities for the Minneapolis American Indian Center are enhanced due to the success of the program. Our overall recommendations for successful program development are:

- Have faith in the wisdom of the community and put their recommendations into action.
- Develop your program from a holistic perspective.
- Gain buy-in from all partners early and maintain communications throughout the project.
- Support the development of relationships through sharing and respect.
- Dedicate staff time to meet key functions and responsibilities.
- Attend community events to develop relationships and gain trust.
- Build self-management supports through ongoing program evaluation and quality improvement.
- Provide opportunities for potential participants to experience community activities and get a feel for the program before becoming officially enrolled.



## APPENDICES

## APPENDIX A: CONTACT INFORMATION

**For more information about our project, please contact:**

Native American Community Clinic  
Full Circle Diabetes Program Coordinator  
1213 East Franklin Avenue  
Minneapolis, MN 55404  
(612) 872-8086  
[www.nacc-healthcare.org](http://www.nacc-healthcare.org)

or

Minneapolis American Indian Center  
Ginew/Golden Eagle Program Director  
Minneapolis American Indian Center  
1530 Franklin Avenue  
Minneapolis, Minnesota 55404  
(612) 879-1708  
[www.maicnet.org/ginew](http://www.maicnet.org/ginew)

### **Contributing partner**

Wilder Research  
1295 Bandana Boulevard North  
Ste 210  
St Paul, Minnesota 55108  
[www.wilder.org](http://www.wilder.org)

## APPENDIX B: HOLISTIC PROGRAMMING EVALUATION TOOL

### PROGRAMMING STEPS

#### 1. Gather community information.

Through meetings, circle discussions, sharing of testimonials: identify barriers to providing your particular service (we identified barriers to diabetes self-management). Classify each identified barrier into one of the corresponding sections of the circle.

#### Barriers

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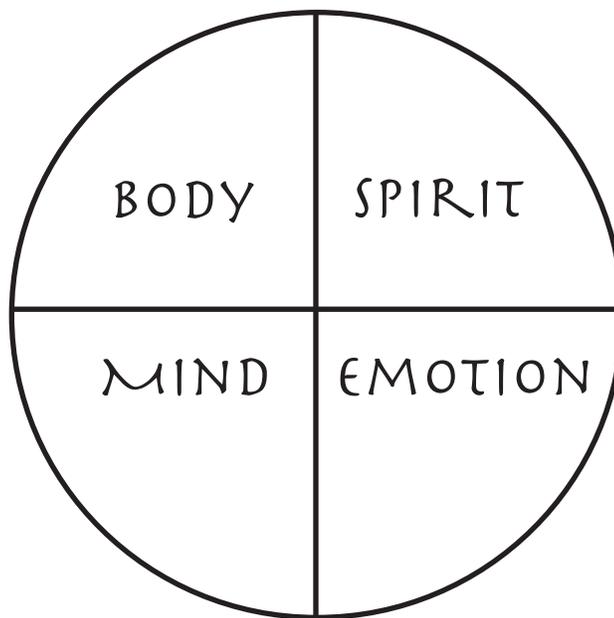
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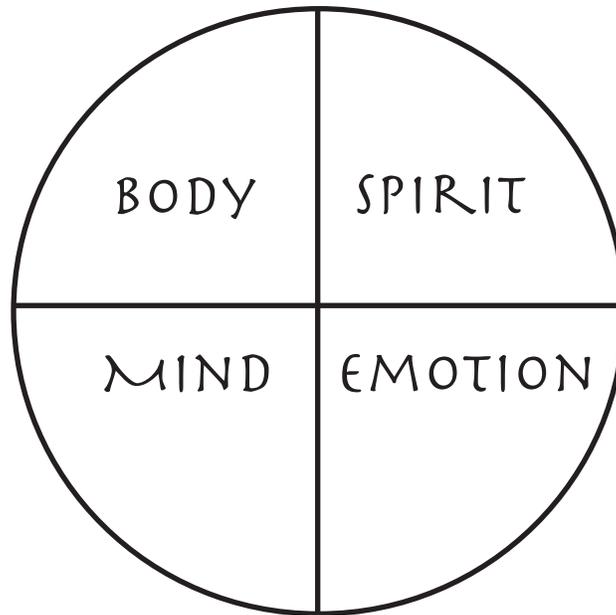
#### 2. Evaluate your Circle

What does your circle look like? Are any sections empty? An empty section does not mean that there are no barriers in that section. It may identify a lack of attention or thought. Go back to step one and continue discussions with the thought of the empty section. Complete your circle with any new information gathered.

#### 3. Identify Visions/Solutions

Have your community group identify solutions for each of the barriers identified in step one. Provide everyone with a circle of the identified barriers and a new circle to identify corresponding solutions. This is a brainstorming session; avoid evaluating the ideas and don't let budget limit your ideas. The goal is to gather all the ideas and consolidate them into the circle.

## PROGRAMMING SOLUTIONS

**4. Conduct a community assessment of resources**

To avoid duplication of efforts, determine what resources are currently available that match your identified solutions. Are these resources being utilized fully? Are there opportunities for partnerships that will promote the greater use of these resources? Include these resources in your circle of solutions.

**5. Rank your Solutions**

Have open discussions about the solutions and resources listed; provide clarification, refine, consolidate similar ideas and evaluate placement within the circle. Next, rank the solutions within each section to determine the top three or four priorities.

**6. Choosing Solutions**

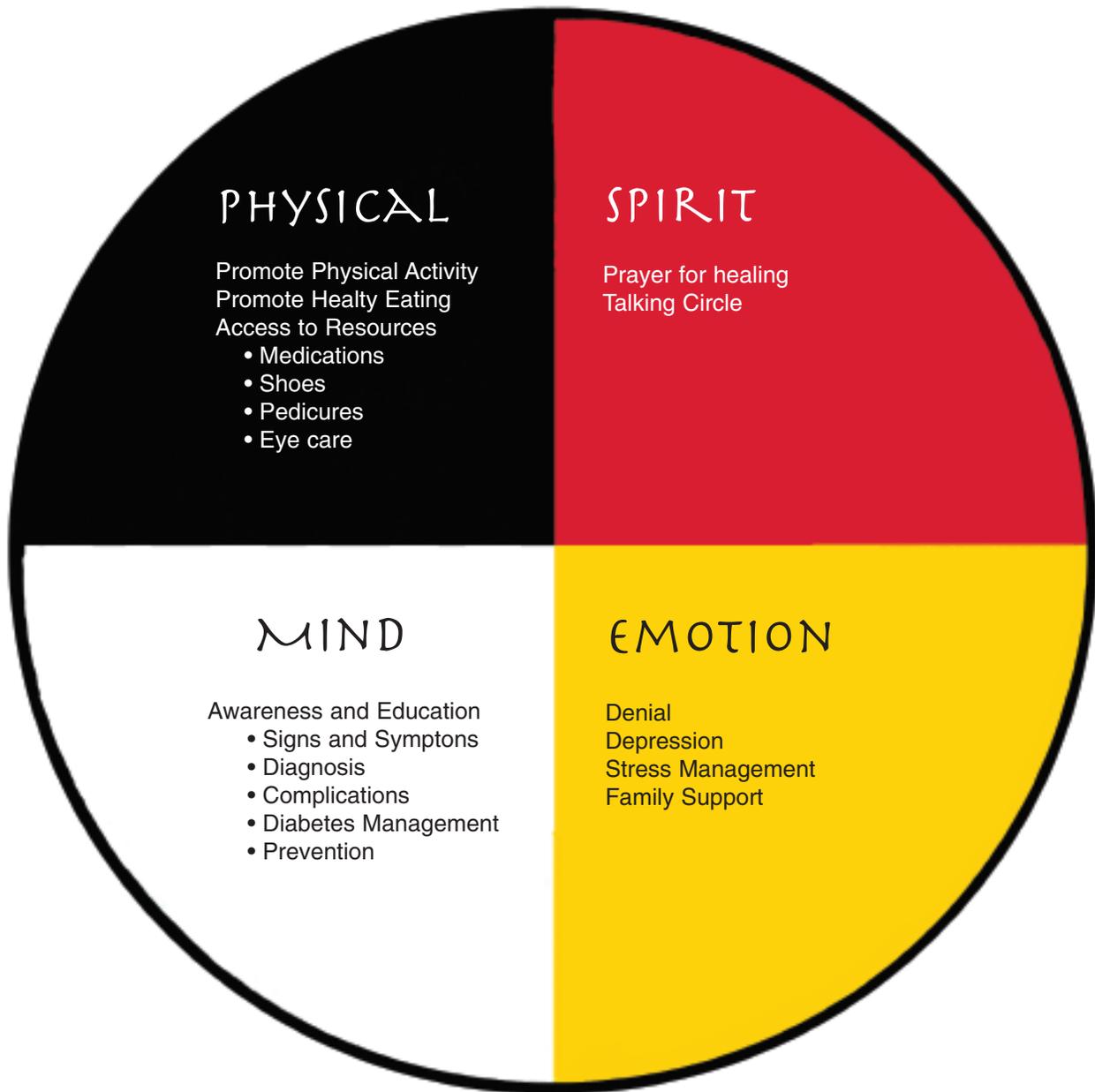
Determine what it would cost (include staff time in your calculations) to develop each solution. Place that information along side the corresponding solution. Also, provide the overall budget amount available for programming. Choose solutions from each section to provide holistic as well as budgetary balance.

**7. Develop your programming from the solutions identified**

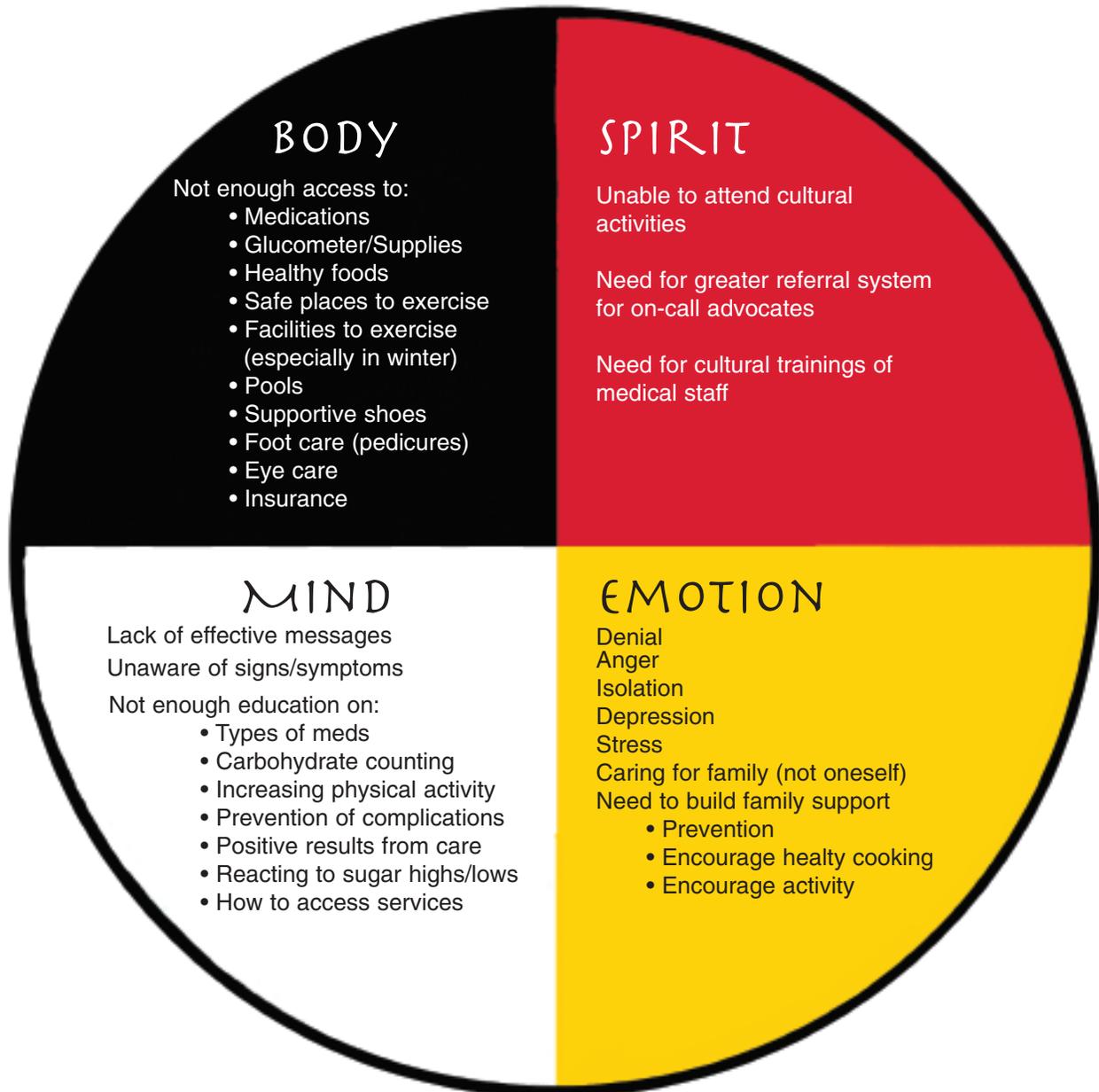
You now have your foundation. The next step is to take action. Allocate your funds and design your new programming. Develop partnerships to help you offset the cost and which promote existing community resources. You will then have developed a program that is holistic and appropriate to the community you serve. The community group will feel validated for all their work and they will feel a sense of ownership for the program.

## APPENDIX C: SAMPLE CIRCLE SUMMARIES

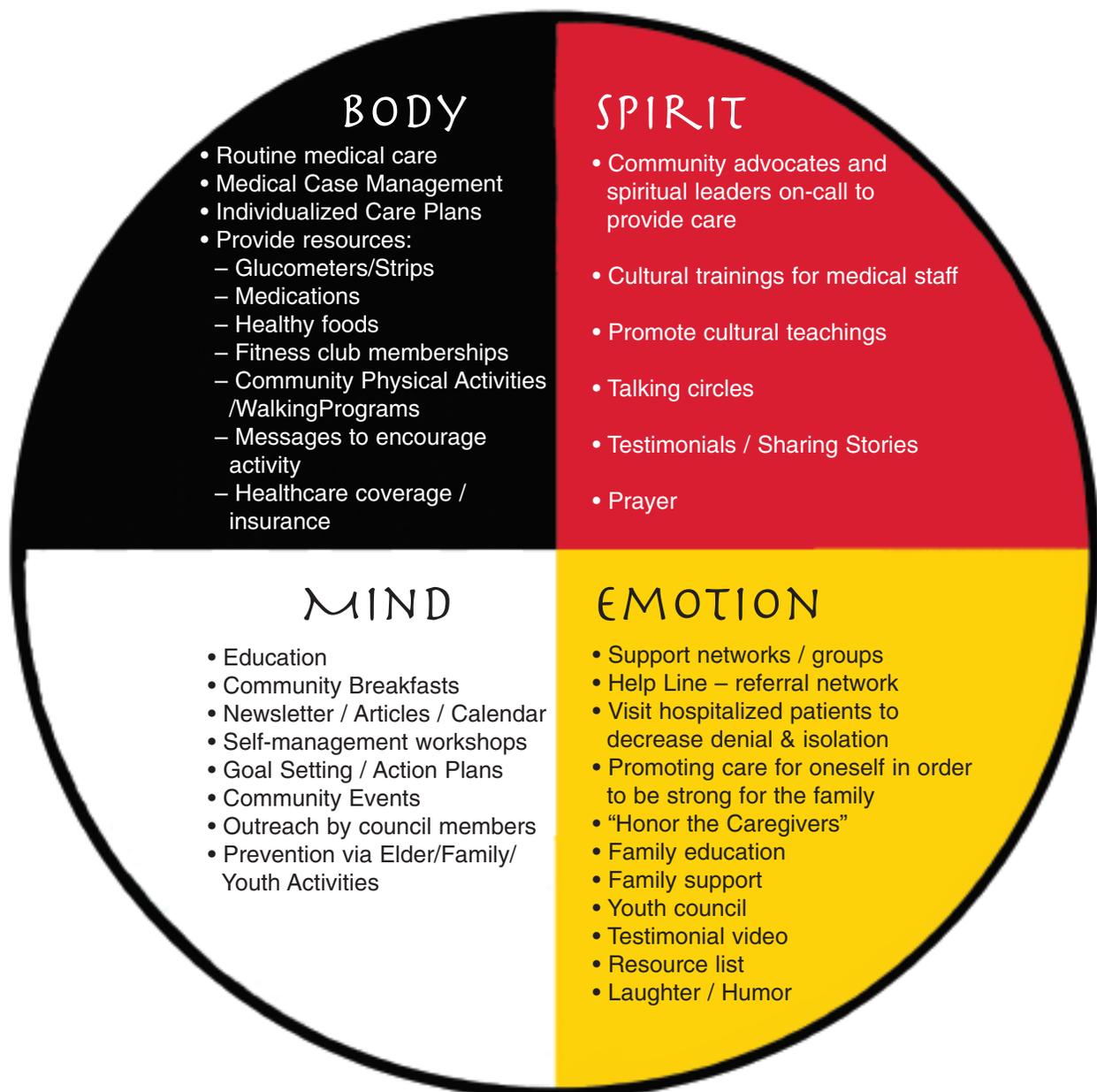
### THEMES



## BARRIERS TO DIABETES SELF-MANAGEMENT



## VISIONS TO BUILD SUPPORTS FOR DIABETES CARE



## APPENDIX D: BUDGET PLAN

### Building Community Supports for or Diabetes Care Initial Budget

Resource	Budget per person	Budget for 50 people	Priority
Shoes		\$80 per person x 50 people =	\$ 4,000
Bands		\$4 per person x 50 people =	\$ 200
YWCA membership for 3 months (or passes)		3 months x 50 people =	\$11,100
Migizi membership for 3 months		\$60/mo. X 3 mo. X 50 families =	\$ 9,000
MAIC activities for 3 months			
- group classes		\$30/hr x 3 hr/week x 12 weeks =	\$ 1,080
- personal trainer session		\$60/hr x 1 hr/person x 50 people =	\$ 3,000
<b>SUBTOTAL</b>			

Resource	Budget per person	Budget for 50 people	Priority
Transportation to Cultural Resources		\$15.00 per hour for driver	

Cultural trainings for medical staff		\$125 x 3 trainings = \$375	
<b>Mental Health</b>			
<b>Resource</b>	<b>Budget per person</b>	<b>Budget for 50 people</b>	<b>Priority</b>
Medical Case Manager/clinical services			
Educational Classes			
- food		\$150 per meeting x 6 meetings = \$900	
- education materials		Curriculum, materials, evaluation = \$550	
- curriculum and evaluation			
Community Calendar		\$60/month for 50 mailings = \$60	
Honorariums for Outreach		\$10/ hour x 30 hrs/month = \$30	
<b>SUBTOTAL</b>			

<b>Emotional Health</b>			
<b>Resource</b>	<b>Budget per person</b>	<b>Budget for 50 people</b>	<b>Priority</b>
Honorarium for Facilitator of support group		\$30 per meeting x 6 meetings = \$180 \$50 for snacks x 6 meetings = \$300	
Honorarium and incentives for leader of self management classes		Class leader \$30/class x 6 classes = \$360 X 2 leaders = \$200 Incentives \$20 gift cards x 10 = \$300 Food	
Family Activities (Intergenerational Gathering)		\$1000/gathering (quarterly) = \$1,000	
Family Activities (Elder / Youth Activities at GGE)		\$175 per activity x 3 activities (1 per month) = \$ 525	
<b>SUBTOTAL</b>			
<b>TOTAL</b>		<b>\$11,600</b>	

## APPENDIX E: ACTION PLAN Building Community Supports for Diabetes Care

**Overall Goal: Build Community Supports for Diabetes Self-management and Quality Diabetes Care**

**Goal 1: A community leadership council will guide the assessment, development and implementation of community supports for diabetes care.**

**Process Objective 1.1:** By the end of month 3, engage 15 community members to actively participate on the Diabetes Community Council.

<b>Activity or strategy</b>	<b>Stakeholders or others to involve</b>	<b>Resources needed</b>	<b>Deadline</b>	<b>Process data/ how we will evaluate</b>	<b>How this activity reaches objective</b>	<b>Comments</b>
Identify potential members for the Diabetes Council	Project coordinator, community staff, clinical partners	Time; Flyers; Presentations; Referrals	End of March 2003	Number and types of community resources available	Creates awareness	
Meet with potential members for the Diabetes Community Council	Project coordinator	Council Interest Form; Goal/Objectives; Contact Information Form	End of April 2003	Verbal commitment to participate on the council	Forms and strengthens relationships; begins to create structure for change	
Convene first meeting of the Diabetes Community Council	Project coordinator, community staff, council members, clinical partners	Space, dinner, and agenda with specific objectives	End of April 2003	Number of attendees as a proportion of those invited	Forms and strengthens relationships; begins to create structure for change	

**Process Objective 1.2:** By the end of month 9, develop a community action plan for improving client access to diabetes information and resources

Activity or strategy	Stakeholders or others to involve	Resources needed	Deadline	Process data/ how we will evaluate	How this activity reaches objective	Comments
Develop working document outlining barriers to diabetes management as specific to physical, spiritual, mental and emotional self	Diabetes council; Project coordinator; community staff; clinical partners	Space; dinner; Agenda with specific objectives; Comment cards; Council rating form; Sign-in sheet; Name cards; Process eval. form	End of July 2003	Process evaluation of meeting minutes; development of document outlining barriers as specific to physical, spiritual, mental and emotional self	Identifies specific needs of Native Americans living with diabetes in South Minneapolis	
Conduct 2 focus groups to determine barriers and resources needed for diabetes care	Project coordinator; Wilder Research Center staff	Recruitment materials, a "neutral" space, refreshments, incentives, consultant fees	End of Aug. 2003 End of Oct. 2003	# groups held # target audience participating	Ensures input of patients of primary partner clinic; begins to create awareness	
Develop community action plan to promote diabetes self-management specific to mind, body, emotion and spirit.	Diabetes council; Project coordinator; community staff; clinical partners	Space; dinner; Agenda with specific objectives; Comment cards; Council rating form; Sign-in sheet; Name cards; Process eval. form	End of Oct 2003	Process evaluation of meeting minutes; development of community action plan as specific to physical, spiritual, mental and emotional self	Community-driven initiative to provide needed messages and services	
Develop marketing	Diabetes council; Project	Space; dinner; Agenda with	End of Dec. 2003	Development of key messages;	Community-driven initiative to build	

materials and signage design	coordinator; community staff; clinical partners	specific objectives; sample materials; marketing expertise and equipment		production of testimonial video; development of brochure	support for diabetes; increases awareness; # participants recruited for pilot
Develop evaluation tools for community action plan	Project coordinator; Wilder Research Center	Community action plan; Evaluation expertise	End of Dec. 2003	Development of evaluation tools specific to community action plan components	Evaluation of effectiveness of community activities and direction for improvement
<b>Goal 2: Local community agencies will have sustainable working partnerships that raise awareness and support people who are managing diabetes and their families.</b>					
<b>Process Objective 2.1: By the end of month 11, build collaborations between area agencies providing diabetes care and create referral system</b>					
<b>Activity or strategy</b>	<b>Stakeholders or others to involve</b>	<b>Resources needed</b>	<b>Deadline</b>	<b>Process data/ how we will evaluate</b>	<b>How this activity reaches objective</b>
Assess the current programs and services offered by community agencies for diabetes care	Project coordinator; Diabetes council	Time; Internet resources; Agency summary forms	End of Oct. 2003	# of agency summaries	Begins to create structure for community-wide referral system
Promote community-wide referral system	Project coordinator	Time; Materials to develop working referrals system	End of Dec. 2003	# referrals provided and received	Builds community supports for diabetes care
<b>Process Objective 2.2: By the end of month 11, increase community awareness of Building Community Support for Diabetes Care Initiative and recruit 50 participants for the pilot phase.</b>					

Provide physical activity equipment such as shoes, bands and weights	Project coordinator; Diabetes council; clinical partners; merchandiser	Community action plan; goal contracts; funds	Jan. – March 2004	# participants receiving resources; amount of physical activity reported	Increases access to resources needed for physical activity
Supplement local memberships at health clubs	Project coordinator; Diabetes council; clinical partners; health clubs	Community action plan; goal contracts; funds	Jan. – March 2004	# supplemented memberships; amount of physical activity reported	Increases access to physical activity and support networks
Offer physical activity at the community center	Project coordinator; Diabetes council; clinical partners; exercise physiologist	Community action plan; goal contracts; planning time; funds	Jan. – March 2004	# participants; amount of physical activity reported	Increases access to physical activity and support networks
<b>Process Objective 3.2</b> By the end of month 11, community members will have greater access to spiritual supports for diabetes care.					
<b>Activity or strategy</b>	<b>Stakeholders or others to involve</b>	<b>Resources needed</b>	<b>Deadline</b>	<b>Process data/ how we will evaluate</b>	<b>How this activity reaches objective</b>
Assess the current spiritual supports	Project coordinator; Diabetes council	Time; resources; Agency summary forms	End of Oct. 2003	Council minutes; focus group results; # of agency summaries	Identifies current and needed supports
Identify and contract to offer agency-specific services	Project coordinator; Diabetes council	Time; contracts; services rendered	End of Dec. 2003	# agencies that contract services to build community supports for diabetes	Expands community resources for diabetes care
<b>Behavioral Objective 3.2</b> By the end of the project, increase the number of our client with diabetes who report greater spiritual supports for diabetes care.					

Healing Talking Circles	Project coordinator; Diabetes council; Clinical partners; Community leaders	Space; food; informational flyers; Honorariums	Jan. – March 2004	# participants; satisfaction survey	Increases spiritual supports	
Increase transportation access to cultural resources	Project coordinator; Diabetes council; Clinical partners	Time; vans; driver; contract fees for driver	Jan. – March 2004	# participants utilizing transportation to attend cultural activities	Increases spiritual supports	
Referral system for community advocates and spiritual leaders	Project coordinator; Diabetes council; Clinical partners; Medical personnel	Time; referral system; commitment from advocates and spiritual leaders	Jan. – March 2004	# referrals from hospitals/clinics to community advocates and spiritual leaders	Increases spiritual supports	
Cultural trainings for medical staff	Project coordinator; Diabetes council; Clinical partners; Medical personnel	Time; trainer; educational materials; Honorariums	Jan. – March 2004	# of trained medical professionals; satisfaction survey	Increases spiritual supports	
<b>Process Objective 3.3</b> By the end of month 11, the Native American community in our area will have greater mental supports for diabetes care.						
<b>Activity or strategy</b>	<b>Stakeholders or others to involve</b>	<b>Resources needed</b>	<b>Deadline</b>	<b>Process data/ how we will evaluate</b>	<b>How this activity reaches objective</b>	
Assess the current mental supports	Project coordinator; Diabetes council	Time; resources; Agency summary forms	End of Oct. 2003	Council minutes; focus group results; # of agency summaries	Identifies current and needed supports	

Identify and contract to offer agency-specific services	Project coordinator; Diabetes council	Time; contracts; services rendered	End of Dec. 2003	# agencies that contract services to build community supports for diabetes	Expands community resources for diabetes care
Behavioral Objective 3.3 By the end of the project, increase the number of our clients who report greater knowledge and skills to manage their diabetes.					
Medical Case Manager	Project coordinator; Diabetes council; Clinic partners; Case manager	Time; funds; contract for services	Jan. – March 2004	# meetings between participants and medical case manager; # goal statements; satisfaction survey	Helps to identify and schedule care programming
Education classes	Project coordinator; Diabetes council; Clinic partners Educators	Time; funds; curriculum; contract and honorariums for educators	Jan. – March 2004	# participants at classes; pre-post survey	Increases knowledge and build skills to manage diabetes
Community newsletter / articles	Project coordinator; Diabetes council; Clinic partners	Time; funds; personal testimonies	Jan. – March 2004	# newsletters / articles published and distributed to participants	Increases knowledge and builds supports for diabetes care.

Process Objective 3.4 By the end of month 11, the Native American community in our area will have greater emotional supports for diabetes care.

Activity or strategy	Stakeholders or others to involve	Resources needed	Deadline	Process data/ how we will evaluate	How this activity reaches objective
Assess the current emotional supports	Project coordinator; Diabetes council	Time; resources; Agency summary forms	End of Oct. 2003	Council minutes; focus group results; # of agency summaries	Identifies current and needed supports
Identify and contract to offer agency-specific services	Project coordinator; Diabetes council	Time; contracts; services rendered	End of Dec. 2003	# agencies that contract services to build community supports for diabetes	Expands community resources for diabetes care
<b>Impact (Behavioral) Objective 3.4</b> By the end of the project, increase the number of our clients who report greater emotional support to manage their diabetes.					
Support Group	Project coordinator; Diabetes council; Facilitator	Time; Contract and honorariums for facilitator	Jan. – March 2004	# participants at support group; satisfaction survey	Increases emotional support for diabetes care
Help Line - referrals	Project coordinator; Diabetes council; Referral network; Help line facilitator	Time; contract with help line personnel; fees for services	Jan. – March 2004	# calls / referrals	Increases access to services/information and builds support
"Honor the Caregivers" family activities	Project coordinator; Diabetes council; Clinical partners	Time; contracts with facilitators; activity supplies	Jan. – March 2004	# participants in activities; satisfaction survey	Increases family support for diabetes care

## **APPENDIX F: SAMPLE COUNCIL MEETING MATERIALS**

Diabetes Community Council Rating Form

Rating

Excellent (5), Good (4), Fair (3), Poor (2), Very Poor (1)

1. Purpose of meeting was clear and specific \_\_\_\_\_
2. Many members were involved in the process and committed to the decisions \_\_\_\_\_
3. Got a lot done, and it was worth our time and effort \_\_\_\_\_

**Additional Comments**

Diabetes Community Council Sign-In Sheet

Date

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

11. \_\_\_\_\_

12. \_\_\_\_\_

13. \_\_\_\_\_

14. \_\_\_\_\_

15. \_\_\_\_\_

16. \_\_\_\_\_

17. \_\_\_\_\_

June 15, 2005

# Diabetes Community Council

## Agenda

- |             |  |
|-------------|--|
| 5:00 – 5:45 | Welcome/Dinner   |
| 5:45 – 6:15 | Evaluation Results <ul style="list-style-type: none"> <li>– Wilder Research Center</li> <li>– Fiscal Year: May 1, 2004 – April 30, 2005</li> </ul>                     |
| 6:15 – 7:00 | Discussion <ul style="list-style-type: none"> <li>– Evaluation Results</li> <li>– Program Improvement</li> <li>– Work Plan for May 1, 2005 – April 30, 2006</li> </ul> |

Next meeting on Wednesday, July 20th

Thank you for your interest and time!

### Special Notes:

- Please sign in
- Please set up name tent
- Feel free to use comment cards to share ideas

## Building Community Supports for Diabetes Care

- Coordinate the Full Circle Diabetes Program to encourage spiritual, physical, emotional and mental support for diabetes care
- Advocate for community supports for diabetes care
  - Refer community members to participate in the Full Circle Diabetes Program activities
  - Create recommendations for environmental and policy changes for diabetes care
- Collaborate with local agencies to raise awareness and support diabetes care
  - Speakers Bureau, Information Booths, Outreach

**APPENDIX G: SAMPLE CLINICAL FORMS****Lifestyle Survey**

FOR OFFICE USE ONLY

Chart #: \_\_\_\_\_

1. Are you currently following a food planning method?  
<sup>1</sup> Yes  
<sup>2</sup> No ← **GO TO QUESTION 4**
  
2. What food planning method(s) are you currently following? **(CHECK ALL THAT APPLY)**  
<sup>1</sup> Calorie counting  
<sup>2</sup> Carbohydrate counting  
<sup>3</sup> Exchange lists  
<sup>4</sup> Fat gram counting  
<sup>5</sup> Food pyramid/health choices  
<sup>6</sup> No added sugar  
<sup>7</sup> Low carbohydrate  
<sup>8</sup> Other (specify: \_\_\_\_\_)
  
3. How often do you follow a diabetes food plan?  
<sup>1</sup> Rarely  
<sup>2</sup> Sometimes  
<sup>3</sup> Most of the time  
<sup>4</sup> Always
  
4. Do you exercise?  
<sup>1</sup> Yes  
<sup>2</sup> No ← **GO TO QUESTION 8**
  
5. What types of exercise do you do?  
**(CHECK ALL THAT APPLY)**  
<sup>1</sup> Walking  
<sup>2</sup> Swimming  
<sup>3</sup> Biking  
<sup>4</sup> Sports  
<sup>5</sup> Active Job  
<sup>6</sup> Aerobic machine  
<sup>7</sup> Exercise class  
<sup>8</sup> Other (type: \_\_\_\_\_)
  
6. How many days per week do you exercise?  
<sup>1</sup> One day per week  
<sup>2</sup> 1 to 2 days per week  
<sup>3</sup> 3 to 4 days per week  
<sup>4</sup> 5 to 6 days per week  
<sup>5</sup> Every day
  
7. Each day you exercise, how many **total** minutes do you exercise?  
<sup>1</sup> 1 to 10 minutes per day

- <sup>2</sup> 11 to 15 minutes per day  
<sup>3</sup> 16 to 20 minutes per day  
<sup>4</sup> 21 to 30 minutes per day  
<sup>5</sup> More than 30 minutes per day
8. Has your weight changed in the past three months?  
<sup>1</sup> Yes, I've gained weight → # pounds gained \_\_\_\_\_  
<sup>2</sup> Yes, I've lost weight → # pounds lost \_\_\_\_\_  
<sup>3</sup> No change  
<sup>4</sup> I don't know
9. Do you test your blood sugar?  
<sup>1</sup> Yes  
<sup>2</sup> No → **GO TO QUESTION 11**
10. How often do you test your blood sugar?  
<sup>1</sup> 3 or more times per day  
<sup>2</sup> 1 to 2 times per day  
<sup>3</sup> A few times per week  
<sup>4</sup> A few times per month
11. How good do you feel about your progress in reaching the goals you set for managing your diabetes?  
<sup>1</sup> Excellent  
<sup>2</sup> Good  
<sup>3</sup> Fair  
<sup>4</sup> Poor  
<sup>5</sup> I have not set a goal yet
12. During the past 30 days, for about how many days have you felt sad, blue, or depressed?  
\_\_\_\_\_ days
13. How well do you know how to access resources to help manage your diabetes?  
<sup>1</sup> Very well  
<sup>2</sup> Well  
<sup>3</sup> Somewhat well  
<sup>4</sup> Not well  
<sup>5</sup> Not well at all
14. In general, how well do you believe that you can cope with diabetes-related stress?  
<sup>1</sup> Very well  
<sup>2</sup> Well  
<sup>3</sup> Somewhat well  
<sup>4</sup> Not well  
<sup>5</sup> Not well at all
15. How often do you take your oral medications/insulin at the scheduled times each day?  
<sup>1</sup> Always

- <sup>2</sup> Most of the time
- <sup>3</sup> Sometimes
- <sup>4</sup> Rarely
- <sup>5</sup> Not at all

16. How often do your family/friends/community support you in living with diabetes?

- <sup>1</sup> Always
- <sup>2</sup> Most of the time
- <sup>3</sup> Sometimes
- <sup>4</sup> Rarely
- <sup>5</sup> Not at all

Thinking about when you visit your doctor:

17A. How often do you ask questions about things you don't understand related to your diabetes?

- <sup>1</sup> Always
- <sup>2</sup> Most of the time
- <sup>3</sup> Sometimes
- <sup>4</sup> Rarely
- <sup>5</sup> Not at all

17B. How often do you prepare a list of questions to ask your doctor?

- <sup>1</sup> Always
- <sup>2</sup> Most of the time
- <sup>3</sup> Sometimes
- <sup>4</sup> Rarely
- <sup>5</sup> Not at all

17C. How often do you discuss any personal problems that may be related to your diabetes?

- <sup>1</sup> Always
- <sup>2</sup> Most of the time
- <sup>3</sup> Sometimes
- <sup>4</sup> Rarely
- <sup>5</sup> Not at all

Thinking about your participation in the Full Circle Diabetes Program activities (diabetes breakfasts and dinners, talking circles, physical activities, intergenerational sharings, medical case management, goal setting, personal training, nutrition counseling and outreach/video by the Diabetes Community Council):

18A. How much have you discussed what you have learned with your family or friends?

- <sup>1</sup> A lot
- <sup>2</sup> Quite a bit
- <sup>3</sup> Some
- <sup>4</sup> Very little
- <sup>5</sup> Not at all

18B. How much has the information helped you better manage your diabetes?

- <sup>1</sup> A lot
- <sup>2</sup> Quite a bit

- <sup>3</sup> Some
- <sup>4</sup> Very little
- <sup>5</sup> Not at all

19. How can the Full Circle Diabetes Program better support you in managing your diabetes?

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*Thank you*

# FULL CIRCLE DIABETES PROGRAM

## Welcome!

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**The Diabetes Community Council of the Minneapolis American Indian Center –Ginew/Golden Eagle Program in collaboration with the Native American Community Clinic hopes that you will enjoy the Full Circle Diabetes Program resources.**

### **Diabetes Education**

Join us for our monthly Diabetes Breakfasts and Dinners. At the breakfast, participants identify topics of interest to learn about in the coming months. At the dinners, we discuss the basics of diabetes. Come to all five BASICS lessons and receive a Full Circle T-Shirt!

### **Supportive Resources**

The Diabetes Community Council offers monthly talking circles – providing a time to share and learn from the life stories of others living with diabetes.

The Diabetes Community Council offers a 6-week “Living in Balance” program. This program focuses on building skills in order to put your knowledge into action! Sign up for an upcoming 6-week series. If you complete this series, you will receive a \$20 gift certificate to Cub Foods!

### **Physical Activity Resources**

As part of the Full Circle Diabetes Program, you will enjoy access to water aerobic classes, local gym scholarships and personal training consultations.

### **Intergenerational Sharing Events**

Join us to celebrate the strengths of our community! The Diabetes Community Council offers fall and spring events to celebrate community wellness.

### **Medical Case Management**

Case management resources include advocacy at the Native American Community Clinic, access to diabetes resources, promotion of timely medical care, and support in goal-setting. A registered dietitian is also available for nutritional counseling.

### **Transportation**

Transportation to Full Circle Diabetes Program activities is available within South Minneapolis. Bus cards may also be available to attend Full Circle Diabetes Program activities.

# FULL CIRCLE DIABETES PROGRAM

## Case Management Services

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**Case management is an essential part of your diabetes self-management plan. We invite you to meet with our case manager to discuss your personal needs for diabetes self-management. Take the first step and schedule an appointment today!**

**During your personalized case management meeting, we may discuss:**

- **Identify barriers to diabetes self-management**
  - Work with the case manager to identify the barriers that prevent you from managing your diabetes
  - Identify the barriers that you want to address right away
- **Develop an action plan**
  - Identify small steps to overcome barriers for diabetes self-management
  - Check in with the case manager for continued support
- **Stress and time management**
  - Identify your specific stressors and time management issues and ways to deal with them in a healthy way
- **Referrals**
  - Apply for scholarships to local gyms
  - Development your own exercise plan
  - Schedule an appointment with a registered dietitian
  - Assistance with referrals to other diabetes related appointments
- **Develop advocacy skills**
  - Identify issues or questions for providers and other professionals
  - Develop a plan to advocate for yourself in a variety of situations
- **Resource Assistance**
  - Insurance Applications
  - Social Security Applications
  - Financial and Transportation resources
  - Community and other health resources



**Full Circle  
Diabetes**

**NATIVE AMERICAN COMMUNITY CLINIC  
CASE MANAGEMENT ACTION PLAN**

Program

Client Sticker: \_\_\_\_\_

Date: \_\_\_\_\_

Physical	Action	Date Completed
A1c		
BP		
Lipids		
Eye		
Foot		
Dental		
Kidney		
Heart / EKG		
Immunizations		

<b>Behavioral</b>	<b>Action</b>	<b>Date Completed</b>
<b>Food Plan</b>		
Exercise Plan		
Smoking		
BG Testing		
CD		
Other:		

<b>Emotional</b>	<b>Action</b>	<b>Date Completed</b>
Mental Health		
Stress / Coping		
MD Relations		
Community Support		
Other:		

<b>Environmental</b>	<b>Action</b>	<b>Date Completed</b>
Health Insurance		
Medication Access		

## EXERCISE PRESCRIPTION

I herewith certify that \_\_\_\_\_ has been evaluated to be physically fit to participate in community exercise classes.

### Pertinent Health Information:

HT: \_\_\_\_\_ WT: \_\_\_\_\_ A1C: \_\_\_\_\_ BP: \_\_\_\_\_

Total CHOL: \_\_\_\_\_ HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ TG: \_\_\_\_\_

### Due to:

- Diabetes
- Peripheral neuropathy
- Retinopathy
- Arthritis
- Cardiovascular Disease
- Peripheral vascular disease
- Kidney disease
- Other: \_\_\_\_\_
- Hypertension
- Autonomic neuropathy
- Asthma/COPD
- Other: \_\_\_\_\_

• Cardiac History \_\_\_\_\_

• Mobility Problems \_\_\_\_\_

• Injuries \_\_\_\_\_

• Meds (beta blockers/diuretics) \_\_\_\_\_

**Recommendations:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Restrictions:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Attending Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## APPENDIX H: COUNCIL MEMBER COMMENTS

Having open discussions is very powerful and healing. It helps to hear the messages people bring to the table. Bringing people together helps to form a community. Healing does not take place alone. The talking provides support when hearing about others with the same challenges and how they approached them. Acknowledging challenges is the first step to dealing with them. There is strength in community, it is holistic and helps to form friendships.

Having programs to attend helps to broaden a person's world. Elders can face the challenge of having their world become smaller by not getting out as much and having less contact with the community and family. They may be dealing with their health challenges alone. Getting out and having a safe, friendly community to be a part of is very helpful.

The program has been flexible and spontaneous, allowing the direction to flow with the needs of the members. It has given people a sense of value and accomplishment.

It is helpful to be as positive as we can be in our speech and actions, to infuse wisdom of culture in daily lives. Look at life not death and maximize the wellness feeling. Children depend on us and need to hear positive messages and see the people around them living a life of positive action.

The people in the programs are doing extraordinary things to survive and it is good to hear from them. It would be interesting to put a tape recorder at a council meeting to use in our replication efforts. A web site is important particularly for young people. That is how they get their information in this new era of communication.

The people bring the power to the council by speaking and asking for what they want. At the council people put their heads together not butting heads. Each individual brings something to the council and all of these individual ideas, stories and needs come together to create something new. The new thing is a direction to take and motivation to take action. One of the best qualities of the council is that everyone listens and then takes action to get things done. The council has helped the council members to reach out to the community.

The breakfasts and dinners help people know what to do at home with nutrition and health. I would like to see cooking demonstrations or something more than just talking or telling me about nutrition. Have different foods to try at the breakfasts and dinners. The breakfasts and dinners help me to get out of the house.

Sharing is so helpful. Sitting in a circle is important; it brings out the best in people. Being able to talk one by one without interruption is good. The council has helped us learn how to share with the community. We have learned a lot.

The breakfasts are very informative. By attending I get hope and courage to know there is knowledge to share about nutrition and other health issues. Attending the breakfasts has changed my outlook on what foods to eat.

The talking circles are a place where people can come and open up to heartfelt thoughts about daily struggles. Starting the meetings with a prayer helps to guide us. People have touched my life through the circles. What is good about the council and the circles is that it is possible to collectively create a vision of what we want and then make it happen.

A strength of the programs is the coordination of writing down our goals, visions and dreams and having caring people to work with. Leadership skills are important.

The way the council was set up from the beginning encouraged people to share. It is a confidential, professional and respectful place. Listening is also communicating and sharing is a gift for all.

Joint management between the Full Circle program and the clinic is key to success. Because of the connection with the clinic, information, suggestions and issues could be communicated easily. The flow of information helped to direct programming and system development and provided more opportunities for support. If there had been not been a connection I may not have participated in the program. The connections with other community programs were also beneficial. I probably would not have participated on my own, but through the Full Circle program I feel a part of it and more motivated to attend the activities.

I want to go to the meetings. The program has been like a splash of cold water.

Important points to share are that all people are welcomed, the video was good and outreach activities feels good. We could not have done the outreach on our own.

Things that work the best are the teaching and the Living in Balance program. The programming at the breakfasts and dinners has been helpful. What has helped me the most is the support of everyone and the sharing of experiences. Participating has helped me see my own denial and inspired me to make changes.

Important points to remember are to appreciate everyone's unique gifts, start the meetings with prayer.

We have reached our goals and that is rewarding. The program has proven to be of value to the community as evidenced by the great attendance and interest in the video. Of great importance is that the council has been able to direct action in program development.

There are many people interested in what our council does. I would like to see more people involved in what we do. My involvement with the council, education, exercise, and living in balance has helped me to make positive changes. The programs are very educational and well attended. Transportation is a plus. Every time I go I learn.

The clinic has been so helpful and friendly. I am glad to have the clinic in the community. They helped me out with meds when I did not have insurance. They have everything right there with case management, exercise, nutrition counseling.

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## NOTES

# NOTES

MIND  
BODY  
SPIRIT  
EMOTION

MIND  
BODY  
SPIRIT  
EMOTION

