

DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation



Moderator:

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Presentations:

- Minneapolis American Indian Center
- Richland County Health Department
- Campesinos Sin Fronteras
- Montana-Wyoming Tribal Leaders Council

DIABETES INITIATIVE

Collaboration: Moving beyond the basics

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October 19, 2006

Two key issues

- Shared definition of goals
- Process of collaboration

Shared definition of goals

Types of Engagement: shared definition of goals

- Continuum of rationale of joining collaborative efforts
 - Share information
 - Minimize duplication of services
 - Increase referral
 - Share resources
 - Joint planning
 - Joint implementation

(Alter, C. and J. Hage, *Organizations Working Together: Coordination in Interorganizational Networks.* 1992, Newbury Park: Sage Publications.)

- Be sure everyone has the same understanding of types of engagement
- Come to consensus on type of engagement the group wants
- Remember the importance of self interest everyone needs to see a benefit of engaging in the collaboration

- Where you land is both developmental and dynamic
 - Change over time
 - Change according to specific needs
- Move from zero sum game to expanding resources by acting together

Process of collaboration

- Shared leadership
 - Within collaboration
 - Across organization
 - Change is good but need good transitions
- Decision making structures
 - Enable everyone to take part
 - Remember different organizations have different structures so may need to provide "training"
 - Ensure community voice

- Power dynamics within organizations and within collaboration
 - History
 - Culture
- Trust
- Enhance capacity of all groups to be better able to engage in these processes
 - More strategic partnerships
 - Types of capacities needed change as level of type of engagement changes

A Circle Paradigm promotes holistic community partnerships



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Native American Community Clinic

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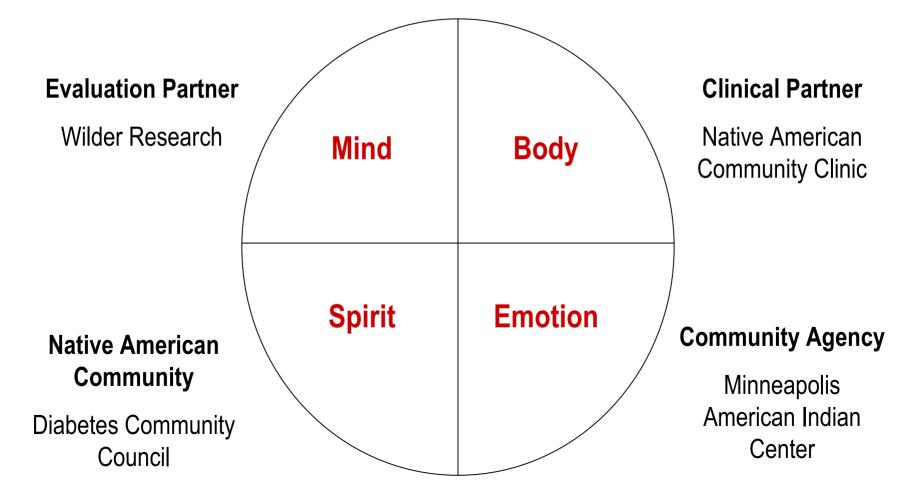


Project Model

- We chose a Circle Paradigm to organize community
 partnerships because of its close relationship to Native American
 culture and emphasis on holism.
- The symbol of the circle encompasses a unique perspective. It recognizes that all partners contribute equally to the survival and vitality of a community.
- The essence of a participatory process is fluid leadership. The
 partner in the leadership role at any given time is the one who
 has the knowledge to be successful and bring benefits to the
 community.



Circle Paradigm





Key Objectives for Building Partnerships

- To ensure that diabetes programming is grounded in community-identified health priorities
- To promote ownership of the initiative amongst diverse partners
- To provide a variety of holistic supports for diabetes care
- To continually evaluate and improve programming



Key Strategies for Building Partnerships

- Creation of Diabetes Community Council
 - Engage community members in partnership
- Circle Discussions
 - Build trust and relationships between partners
 - Foster consistent and open communication
 - Promote a collective vision / mission
- Holistic Focus
 - Increase scope and variety of programming
 - Provide support and resources to enhance the work of each partner



Overcoming Barriers for Building Partnerships

- To ensure that programming is grounded in community-identified health priorities
 - Invest time to build trust
 - Honor the testimonial process
 - Identify, reaffirm and act on themes
- To promote ownership of the initiative amongst diverse partners
 - Appreciate how the initiative helps each partner meet its own mission and objectives
 - Work cooperatively to build upon the strengths of each partner
 - Dedicate resources to ensure partner commitment and accountability

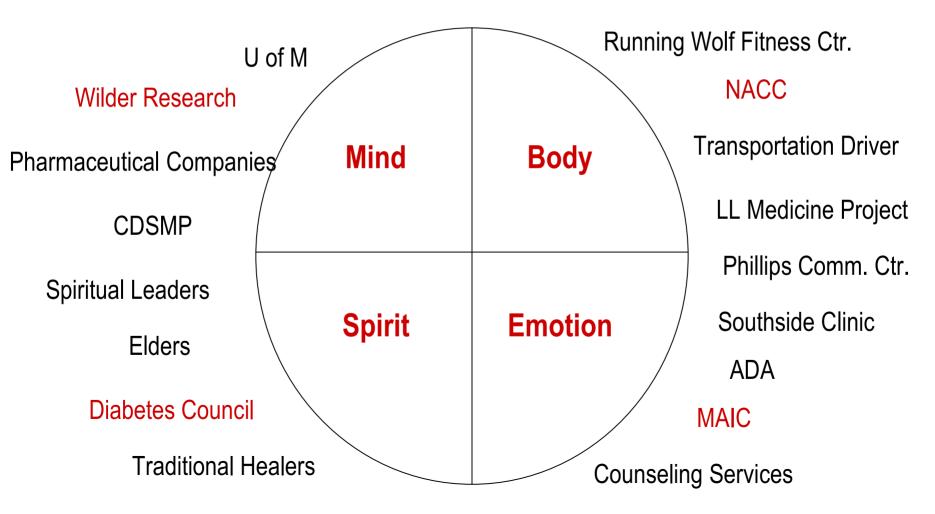


Overcoming Barriers for Building Partnerships

- To provide a variety of holistic supports for diabetes care
 - Consciously assess holism of programming
 - Invite additional partners to the circle to fill gaps in services
- To continually evaluate and improve programming
 - Partner with an evaluation consultant
 - Involve all partners in the creation of the evaluation plan
 - Prioritize evaluation according to audience, goals and resources



Our Successful Partnership Today





Major Accomplishment

- Seamless Partnerships
 - The diverse partners of the Full Circle Diabetes Program recognize and promote their interdependence to accomplish a collective vision of providing holistic supports for diabetes care.



Key Lesson

- A holistic framework enhances community partnerships by:
 - providing opportunities for open and consistent communication between community members, clinicians and agencies
 - focusing the initiative on one collective vision
 - ensuring a variety of supports for diabetes care
 - encouraging cooperative relationships to enhance the work of each partner

"The program complements itself, like family."

"It is the circle of life."

Diabetes Community Council member

An Ecological Approach Provides a Comprehensive Model to Initiate and Sustain Diabetes Self-Management

a.k.a.: Partners in Progress

Richland County Community Diabetes Project

Lisa Aisenbrey, RD Project Director



The Process of Partnership

- Richland Health Network
 - Richland County Health Department
 - Sidney Health Center
 - Richland CountyCommission on Aging
- Partners since 1999
- Mission: Building healthy communities through networking, health promotion, and volunteerism



Richland County Community Diabetes Project

- Not just to avoid duplication of services
- Collaboratively we accomplish more we individually could
- Mission: Partnerships dedicated to building a community environment that supports diabetes self-management

Major Objectives

- Joining clinical and community care models to develop a system to coordinate the overlap
- Broaden the definition of continuum of care
- Develop community ownership of the project
- Change community norms
- Improve community health status

A Journey has Obstacles

- Internal and external identity struggle
 - A collaborative network is both our greatest strength and our weakest point
- Finding our niche
- Resistance to change
- Collaboration means different things to different people

Strengthening Our Links

- Sharing resources
- Try to move each partner forward
 - □ Fit partnership into each agency's mission and promises



- Sustainable clinical/community connections
 - Diabetes Education Center
 - □ Exercise Rx and free indoor walking options
- Increasing the network's collaboration with other community partners

Domino Effect on Community Collaboration

- Communities in Action (VISTA project)
- Sidney Public Library
- Richland County Nutrition Coalition
- Local Restaurants
- Parish Nursing
- RSVP
- Literacy Volunteers of America
- LIONS Club
- American Diabetes Association Montana
- McCone County Senior Center
- Montana Diabetes Project
- Eastern Montana Mental Health
- Local Health Care Providers
- Grocery Stores
- Schools
- Local Worksites
- Media
- And more...



A Highlight of our Successes

- New partnerships develop; become active
 - □ Senior Coalition, Communities in Action
 - □ Health issues included in local growth policies
- Healthier lifestyles for project participants
 - □ 46% self-report weight loss
 - □ 58% self-report increased physical activity
- Decreased primary diagnosis diabetes admits
 - □ ER admits and hospitalizations each decreased 33%
- Increased number of A1c measurements
 - □ ER A1c measures increased 400%
 - □ Outpatient A1c measures increased 7.5%

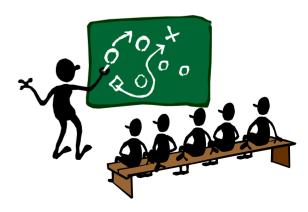
Lessons Learned

- Partnership is hard work! (but worth it)
 - □ Give and take are both required
 - □ Building trust takes time
- Programs vs. Infrastructure
 - □ Programs make the partnership visible
 - Programs are an opportunity to build systems-based infrastructure
- Changing social norms is an immense challenge
 - □ Disease labeling is not necessary
 - □ Active work w/ additional partner agencies
 - Tasty Fork project changing nutrition norms





- The importance of RHN is twofold:
 - □ Assist partners in meeting the expectations of their customers
 - Provides a comprehensive and efficient manner of addressing chronic disease in our service area by engaging these customers
- Continue to use the ecological model as a basis for addressing community health issues
- Commonalities for future collaboration:
 - □ Inform, Educate, and Empower
 - Mobilize Community Partners
 - □ Link People to Needed Services
 - □ Develop Policies and Plans



"Coming together is a beginning.

Keeping together is progress.

Working together is success."

Health

SIDNEY HEALTH CENTER

HEALTH HEALTH PARTIES OF HEALTHY COMMING

-Henry Ford



Campesinos Sin Fronteras Diabetes Management Program (CDMP)

Building Community Support for Diabetes Care in Migrant and Seasonal Farmworker Communities in Yuma County, Arizona

A Model for Partnership Building

Sunset Community Health Center, UofA College of Public Health, UofA Coop. Ext. Special Action Group (SAG), Yuma Regional Medical Center, Yuma County Health Dept. and Campesinos Sin Fronteras

RWJF Building Community Support For Diabetes Care Capstone
Meeting
Tucson, Arizona
October 18, 2006

Campesinos Sin Fronteras A Community Based, 501c3 Non-Profit Organization Serving the Border Communities of Yuma County, AZ



Target Population and Geographic Area



- 10 miles from the US/Mexico border
- Farmworker Population
- Agriculture is the major industry





Key Partner - Sunset Community Health Center



- Designated as a Federally Qualified Health Center (FQHC) receiving section 329 330 federal funding
- Overseen by a local 15-member Board of Directors
- Provider of medical & dental services to low-income, uninsured/underserved population for over 25 years
- Provider of diabetic education
- 20,000 active users
- Services provided to over 4,000 Migrant/Seasonal Workers
- 80,000 patients encounters per year
- 5 clinic sites located in Yuma County

Key Objectives for Building Partnerships

- To build community support for diabetes care
- To improve the level of quality care for migrant and seasonal farmworkers
- To provide comprehensive personalized diabetes care and support to the target group
- To truly meet the specific cultural and linguistic needs of the population

Key Strategies

- Clearly defined goals, objectives, and roles among collaborators
- Using a culturally sensitive approach/Spirituality
- Using the evidence based Promotora model as the main strategy to reach and serve the population
- Opening doors to any group or individual that wanted to support the program. i.e. animadora/es, family members, other local providers, etc.
- Meeting regularly with the local community advisory group
- Holding monthly meetings with Sunset's Medical Director, Executive Director, Promotoras and other collaborators
- Media Coverage (development and distribution of diabetes education newspaper insert)

How Barriers Were Overcome

- With vision, perseverance, patience, and hard work
- By staying focused
- By keeping true to the mission of the program
- By advocating for patients at all levels of medical care
- By celebrating our participants' successes

Most Important Elements for Building a Successful Partnership

- Respect
- Trust
- Appreciation
- Recognition of everyone's contributions
- Honesty
- Sharing monetary and human resources
- Sharing space
- Celebrating together





CAMPESINOS SIN FRONTERASHEALTH • HOUSING • SOCIAL SERVICES

Most Important Accomplishments

- Establishment of Diabetes Care Community Infrastructure
- On-going guidance and support of the Community Advisory Group
- Obtained Obesity Prevention Synergy Grant
- Establishment of a Free Family Diabetes Institute
- Establishment of on-going support groups as a social network for the participants focusing on healthy coping skills, negative emotions and depression
- Program sustainability through other new and current partnerships (Sunset and the Area Agency on Aging)
- Sunset Executive Director and Medical Director's direct involvement in partnership and Promotora meetings

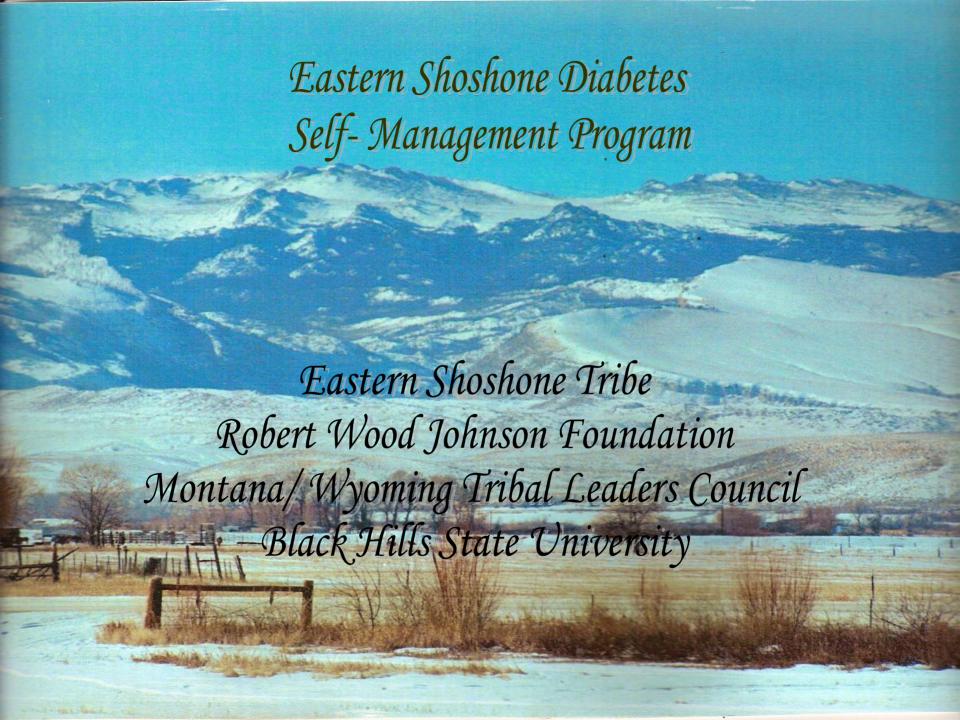
Most Important Outcomes of the Partnership

- Farmworkers' access to diabetes prevention and treatment
- Improvement of health indicators among participants
- Sunset hiring a Promotora to be part of CDMP
- Sharing monetary resources for community outreach and education
- Strong "friendship" relationship between Sunset and Campesinos Sin Fronteras staff

Today's Successful Partnership

- Serving more than 300 participants
- Holding 6 weekly support groups
- Sharing space with Sunset for the Diabetes Family Institute
- Working toward Sustainability
- Development of a Promotora Manual
- Dissemination of CDMP as a model program (articles, websites, news stories)
- High recognition and appreciation from local officials and other community organizations





Interview



Project's Model For Partnership That Built Community Support For Diabetes Care

COLLABORATION!

COLLABORATION!

- Collaboration was with the following programs:
 - Robert Wood Johnson Foundation
 - Montana/ Wyoming Tribal Leaders Council
 - Blacks Hills State University
 - Wind River Service Unit
 - Shoshone Business Council





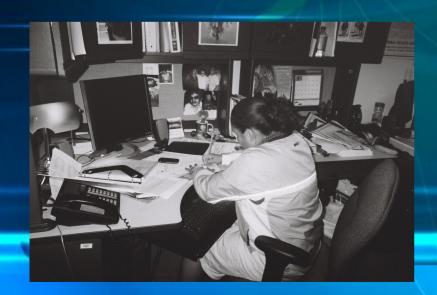






Building Community Support For Diabetes

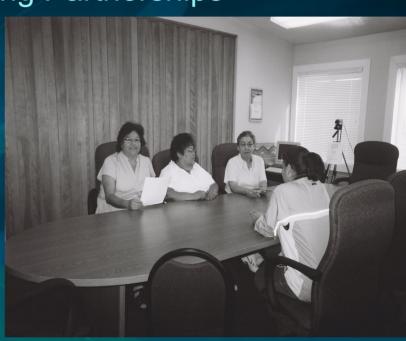
- Program first was involved in their own training and classes.
- Program passed out flyers to the community.
- Program would complete three home visits before the community member would agree to participate.
- The Eastern Shoshone Diabetes Program conducted 7,608 home visits between 2004 and 2006.





Key Objectives For Building Partnerships

- Identifying: What is Diabetes?
- Coping with Stress
- Diet
- Moving to stay Healthy
- Medications
- Monitoring: Knowing your numbers
- Acute Complications
- Long Term Complications Of Diabetes



Strategies Used For Developing These Partnerships

- Communication
- Home Visits
- Post Planning before each activity



Incentives such as T-shirts, Water Bottles, Certificates, Wrist Bands, and Pins.

Barriers

- Times of the Activities
- Denial From Clients
- Work Environment
- Prejudice towards Clients
- Personal Conflicts
- Trust Issues





Our Successful Partnership

- Training and Support from Black Hills State University.
- Feed Back From Clients.
- Noticeable Change in Clients- Physical and Mental.
- Collaboration and Communication between programs that were supporting the classes.

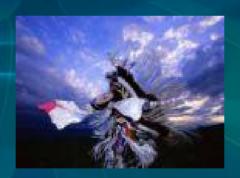




Outcomes and Accomplishments

- Clients Have A Sense Of Change
- Met the Goal Established
- Eastern Shoshone Diabetes Program has become a household name
- Community has gone from Denial to Acceptance
- Program is Progressing to Family Education







Key Lessons

- Program Employees Better Able To Relate To Clients
- Eastern Shoshone Diabetes Program Able to Walk The Walk & Talk The Talk
- Outreach Workers are able to utilizes what is being taught
- Outreach Workers are able to understand the clients hardship and emotional stress



EDUCATION IS LIFE SAVING!



