Clinic-Community Partnerships: A Strategy for Building Community Supports for Diabetes Care

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People living with diabetes make most of their self management choices during daily life. Community resources and supports for diabetes care and management are therefore an essential component of quality diabetes care. A promising strategy for building community supports for diabetes care is the creation of partnerships among clinics and community organizations. Working together extends the range, variety, and coordination of services available and builds the capacity of the partnership to respond to the needs of their population.

PARTNERING TO BUILD COMMUNITY SUPPORTS

The Building Community Supports for Diabetes Care (BCS) projects of the Robert Wood Johnson Foundation Diabetes Initiative demonstrate how clinic-community partnerships can strengthen the community environment and improve the continuum of services and supports individuals need to manage their diabetes. These projects illustrate various levels of partnerships, which can range in scope from one clinic working with one community organization to broad networks of agencies working together. Examples of BCS partners include:

- public health departments
- faith-based organizations
- local businesses
- fitness and wellness centers
- pharmaceutical companies
- universities and university extension agencies
- Area Health Education Centers (AHEC)
- parks and recreation departments
- social service organizations

SUCCESSFUL COLLABORATION

The BCS grants gave communities the opportunity to rally around a health issue that is challenging the entire population. Although the approaches varied across sites, a number of themes emerged. Factors contributing to successful clinic-community partnerships include:

- time to build trust
- attention to the process of collaboration
- a shared understanding of the goals of the partnership
- involvement of the population to be served
- a broader vision
- recognition of and respect for all partners' contributions
- acknowledgment/celebration of successes

Some partners contributed materially by offering programs, services, supplies, space, funds, staff time, volunteers, etc. Others contributed in intangible ways, e.g., providing access to populations and services, expertise, opportunity, and credibility.

BCS projects included, and went beyond, reciprocal referrals for services. Partners worked together to create or improve community resources and supports for self management using the contributions of all the partners.

The **Diabetes Initiative of the Robert Wood Johnson Foundation** includes 14 projects around the United States, all demonstrating that self management of diabetes is feasible and effective in diverse, real-world settings. Specific lessons learned from the Initiative include:

- The importance of Community Health Workers in diabetes self management
- Approaches to depression, negative emotions and healthy coping in diabetes self management
- Approaches to providing ongoing follow up and support for self management, since diabetes is "for the rest of your life"
- How to develop effective partnerships between clinical and community organizations
- System and organizational factors to support self management programs in primary care settings

For more information, protocols, publications, and other materials, visit: ***www.diabetesinitiative.org***

DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

PARTNERSHIP MODELS THAT BUILD COMMUNITY SUPPORTS FOR DIABETES

A Circle Paradigm

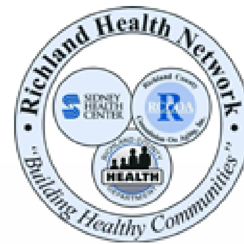
The Minneapolis American Indian Center (MAIC) chose a Circle Paradigm to organize their partnership because of its close relationship to Native American culture and its emphasis on holism. The circle symbolizes inclusion of all partners and recognizes their equal contributions to the survival and vitality of a community. Four key partners participated in the creation of the Full Circle Diabetes Program: MAIC, the Native American Community Clinic, the Diabetes Community Council (community members), and Wilder Research. The Full Circle program provides resources and supports for diabetes self management to promote wellness in the four key dimensions of health: physical, mental, emotional, and spiritual. The participatory approach ensures these resources and supports for self management meet the needs of all the partners. Contact: Minneapolis American Indian Center at 612-879-1708.

Community-Clinic-Academic Partnerships

The Montana-Wyoming Tribal Leaders Council, the Billings Area Indian Health Service, Black Hills State University, and Tribal health leaders collaborated to build community supports for people with diabetes who live on large land-based federal Indian reservations in Montana and Wyoming. The vast distances between partners, providers and community members required the diabetes project to focus on building capacity at the Tribal level. All Tribal health staff, diabetes staff, and Community Health Representatives (CHRs) received training on diabetes, the diabetes self management education (DSME) curriculum, motivational interviewing, and follow up support. Tribal-specific DSME programs are offered with monthly follow up by CHRs. Interventions are documented and evaluated by the university partner to ensure tools and methodologies developed can be adapted and replicated by other tribes. Contact: MT-WY Tribal Leaders Council at 406-252-2550.

An Ecological Approach

The mission of the Richland County Community Diabetes Project in Sidney, Montana is: To develop partnerships dedicated to building a community environment that supports diabetes self management. The partnership goals are to:



- Join clinical and community care models to develop a coordinated system of care;
- Broaden the definition of continuum of care;
- Develop community ownership of the project;
- Change community norms; and
- Improve community health status.

Framing their work in an ecological model, the project has developed services and activities across all levels. To support self management in the clinical setting, they developed an ADA-recognized Diabetes Education Center. To bring diabetes self management into the everyday lives of this frontier community, they organized activities such as a walking club, a weight-loss program, worksite wellness activities, and a restaurant competition. The key to success has been involvement of the community in the project and the common vision of bettering residents' health. Contact: Richland County Health Department at 406-433-6946.

Community-clinic-academic Partnerships

Campesinos Sin Fronteras is a community-based organization that has built strong partnerships with the Sunset Community Health Center, the University of Arizona Cooperative Extension, and the Arizona College of Public Health. They serve and provide access to the farm worker population, from whom they recruit, hire, and train promotoras, or community health workers. Promotoras are the foundation of this diabetes program. They conduct community education, lead support groups, and follow up with patients in their homes. Their first-hand knowledge of the needs of the population helps build bridges between the community and its health and social service systems. Other partners contribute to the broad network of clinical and support services, and the College provides technical assistance and program evaluation. Contact: Campesinos Sin Fronteras at 928-627-1060.