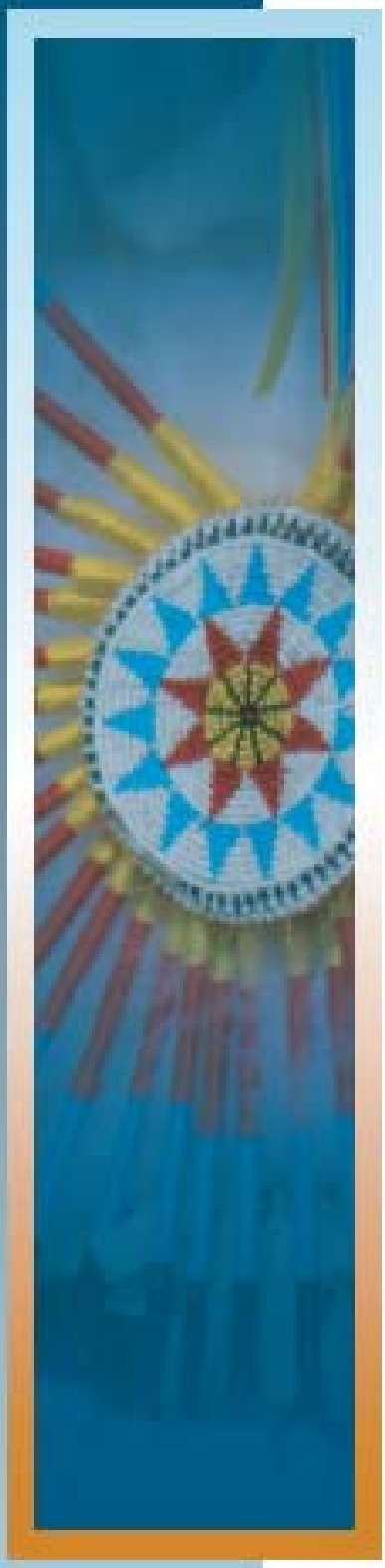

INDIAN HEALTH DIABETES BEST PRACTICE

Community Advocacy for Diabetes Prevention and Control

Revised April 2011

Note! Please review the Best Practice Addendum, which provides the most current information on the Required Key Measures along with examples of ways to obtain the measures. The Best Practice Addendum can be found here: http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Tools/BestPractices/BP_2011_Table_RKM_508c.pdf

Indian Health Service
Division of Diabetes Treatment and Prevention
5300 Homestead Road NE
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http://www.ihs.gov/MedicalPrograms/Diabetes/

Table of Contents

Instructions for Using This Best Practice

The Best Practices are organized into topics on how to plan for and successfully implement a Best Practice in your community.

- **Part 1** provides background information on planning for your program and evaluation, Key Recommendations, and Key Measures.
- **Part 2** provides details on implementation of the Key Recommendations.
- **Part 3** includes appendices, tools, and resources.
- **Part 4** provides a list of references.

As you prepare to select, implement, and evaluate a Best Practice, consider these planning guidelines:

- Meet with your diabetes team to discuss which Best Practice(s) is best suited for your situation and resources.
- Use data from your *Diabetes Care Outcomes and Audit* and/or from a community needs assessment to guide your selection of the Best Practice(s).
- Determine your program goal(s) as a team. For example, your team may decide to work toward increasing the number of people who receive eye exams.
- Print out at least Part 1 of the Best Practice(s) your team feels is most appropriate to implement.
- Work with your diabetes team to review and discuss the Best Practice(s). You may choose to read it together as a team.
- Choose at least one Best Practice after carefully considering your goals and resources (funding, staff, and time).
- **Review the entire Best Practice(s) you have selected with your diabetes team:**
  - Confirm that you have selected a Best Practice(s) appropriate for your community needs and resources and that you are confident that your team can successfully implement, evaluate (measure), and document progress and outcomes.
  - Target the population your team wants to improve outcomes for with the Best Practice(s). Remember, you probably do not have resources to do everything for everyone.
  - Carefully consider the Key Recommendations. The recommendations are based on evidence and have been proven to be effective. You may already be doing some of the recommendations and can easily fit these into your plan, or you may want to consider some new recommendations to enhance and strengthen your program. Identify those your team can implement.
  - Carefully review the Key Measures. Choose those that best fit with your goals and the Key Recommendations you have chosen to implement.
  - If one Best Practice does not fit, then review another Best Practice until you find one that fits.

Throughout the document you will find links that draw your attention to important items within the Best Practice pdf. Here is a list of the items:

- **Action!** Indicates a **link**. Please use the link to access more detailed descriptions.
- **Note!** Indicates an **important** item. Pay special attention to this **important** item.

Summary of Key Recommendations and Key Measures

Key Recommendations for Community Advocacy. These are evidence-based actions that will lead to improved outcomes in the community.

Action! See Part 2 for details on the implementation of each key recommendation.

1. Conduct community needs assessments to determine resources, interests, and requirements for diabetes efforts in the community.

2. Develop partnerships and community advocacy groups where people can work together to improve their community and effectively address diabetes prevention and care.

3. Provide community education to increase awareness of the risk factors for diabetes and inform the community that diabetes and its complications can be prevented or delayed through sustained lifestyle changes that result in modest weight loss.

4. Develop a strategic plan.

5. Involve community partners in participatory evaluation.

Key Measures for Community Advocacy, that can be used to document changes in outcomes related to implementing the Best Practice.

Note! All SDPI grant programs that choose this Best Practice must report as required in the terms and conditions attached to the notice of award on the indicated Measures. Programs may report on other measures as well.

*The following are of primary importance to track progress:

1. *Does the local Community Diabetes Advocacy Group include, at minimum, a community member who has diabetes, the family member of a person with diabetes, and representatives from three community entities and/or health care facilities?

2. *Number of health-related policies that are impacted or implemented as a result of action by the Community Diabetes Advocacy Group.

3. Changes in the community that occurred as a result of policies implemented.

PART 1 Essential Elements of Implementing This Best Practice

Purpose and Target Population

This best practice provides recommendations for developing public policy, raising awareness, and building support for individuals and families at risk for, or living with, diabetes.

Action! See Part 3 – Appendix A. for the importance of Community Advocacy.

Intended Users of this Best Practice

Realizing the vision of healthy people in healthy communities *is possible only if the community, in its full cultural, social, and economic diversity, is an authentic partner in changing the conditions for health.* (IOM, 2002)

- Community members with an interest in diabetes prevention and care
- Health care staff who provide diabetes education and/or services
- Leaders of health care and community organizations, and
- Tribal leaders and Indian community leaders.

Action! See Part 3 – Appendix A. Supplemental Information for discussion of the benefits and risks of implementing this Best Practice.

Definition of Community Advocacy

The work of building healthier communities takes time: our time, that of our children, and that of our children's children. Decisions and actions taken today "must consider the impact on the seventh generation." (Great Law of the Iroquois)

Community advocacy for diabetes is any combination of individual and social actions that are directed at developing a positive policy environment for diabetes, raising awareness of diabetes, and building support to address diabetes. A critical principle of advocacy is that advocacy efforts should be based on evidence (Stimson et al., 2003; Roubideaux et al., 2001).

- Advocacy is *active* promotion of a cause or principle.
- Advocacy involves *actions* that lead to a selected goal.
- Advocacy is one of many possible *strategies*, or ways to approach a problem.
- Advocacy can be used as *part of a community initiative*, nested in with other components.
- Advocacy is *not* direct service. (Work Group on Health Promotion and Community Development, 2009).

Goals of this Best Practice

- Implement best practice approaches in community advocacy for diabetes.
- Provide effective strategies for increasing community awareness of and advocacy for diabetes prevention and treatment opportunities. Such opportunities are intended to reduce the burden of diabetes in American Indian and Alaska Native (AI/AN) communities, regardless of where they are located.

Community advocacy can help to:

- Offer the community an opportunity to take action to improve health for individuals, their families, and their community.
- Encourage dialogue, negotiation, and consensus among all community members.
- Raise awareness about hopeful diabetes treatment and prevention news and reduce the stigma associated with diabetes.
- Engage Tribal leaders in the community and other key partners in awareness and advocacy efforts.
- Mobilize and coordinate resources for community-based diabetes initiatives.

Key Recommendations

These are evidence-based actions that can lead to improved outcomes for individuals and families at risk for, or living with, diabetes.

Key Recommendations for Community Advocacy. **These are evidence-based actions that will lead to improved outcomes in the**
1. Conduct community needs assessments to determine resources, interests, and requirements for diabetes efforts in the community. 2. Develop partnerships and community advocacy groups where people can work together to improve their community and effectively address diabetes prevention and care. 3. Provide community education to increase awareness of the risk factors for diabetes and inform the community that diabetes and its complications can be prevented or delayed through sustained lifestyle changes that result in modest weight loss. 4. Develop a strategic plan. 5. Involve community partners in participatory evaluation.

Action! See Part 2 for details on the implementation of each key recommendation.

Planning For Your Program and Evaluation

Key Action Steps:

1. **Identify your program's goal(s).** There are many program goals consistent with the Key Recommendations of this practice. Examples of Program Goals include:

    - Increase the number of people in the community who are aware of the risk factors for diabetes.

    - Increase the number of people representing different community interests who are working together in partnerships or groups on diabetes-related issues.

2. **Define program objectives** that will be met to reach the program goal(s) in the **SMART format** (specific, measurable, action-oriented, realistic, and time-bound).

Examples of SMART objectives for this Best Practice:

- At least one health-related policy will be revised/developed and implemented to address findings regarding physical activity in the community needs assessment.

- Increase the number of community interests represented on the community advocacy group from five to seven by the end of the fiscal year.

3. **Use Key Measures**. The following Key Measures can be used to monitor progress and the effectiveness of implementing this Best Practice. Results of measures will indicate the degree of success in implementing the **Key Recommendations** and meeting program goals.

Measures of progress need to occur before the intervention (baseline) and at designated times thereafter. Measurement needs to be frequent enough to provide meaningful information for planning and evaluation.

Key Measures

Key Measures for Community Advocacy. These are specific measures that can be used to document changes in outcomes related to implementing the Best Practice.

Note! All SDPI grant programs that choose this Best Practice must report as required in the terms and conditions attached to the notice of award on the indicated Measures. Programs may report on other measures as well.

*The following are of primary importance to track progress:

1. *Does the local Community Diabetes Advocacy Group include, at minimum, a community member who has diabetes, the family member of a person with diabetes, and representatives from three community entities and/or health care facilities?

2. *Number of health-related policies that are impacted or implemented as a result of action by the Community Diabetes Advocacy Group.

3. Changes in the community that occurred as a result of policies implemented.

4. Collect, record, and analyze data on an ongoing basis; share with the team and the organization leadership.

5. Use creative ways to display data and measure outcomes, such as graphs or charts. This helps the team understand the data and know whether there are improvements.

6. Think about what the data are telling you. What changes are you seeing? Are they improvements? Use data for planning next steps.

Action! See the following resources to help your program improve.

See Part 3 – Appendix B. *Key Measures Example* to assist you with identifying ways to choose SMART Objectives and Key Measures that incorporate your community data.

See Part 3 – Appendix C. *Improving Community Advocacy Programs Example* to assist you with applying Key Recommendations and Key Measures to a program plan.

Action! See an online training and a workbook to get more ideas about setting goals and objectives and developing a program plan. Available from: (see pages 23-28.) http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/Basics/Creating/Workbook.pdf

Team Notes:

PART 2 Key Recommendations

Note! Part 2 provides important detail on the 'Why?' and 'How?' of implementation of each Key Recommendation.

Key Recommendations

Note! Building healthier communities involves local people working together to transform the conditions and outcomes that matter to them. That civic work demands an array of core competencies, such as community assessment, planning, community mobilization, intervention, advocacy, evaluation, and marketing successful efforts. Supporting this local and global work requires widespread and easy access to these community-building skills. However, these skills are not always learned, nor are they commonly taught either in formal or informal education.

Key Recommendation 1. Conduct community needs assessments to determine resources, interests, and requirements for diabetes efforts in the community.

Note! The following section is summarized from the Internet-based support system for building healthier communities; [Work Group on Health Promotion and Community Development at University of Kansas. 2009.]

Why?

A community needs assessment may help determine resources, interests, and requirements of diabetes efforts in the community (Work Group on Health Promotion and Community Development, 2009).

How to Implement the Key Recommendation

A. **Develop a plan to identify local needs and resources**. This includes the need to identify your community. Do you want your community to include just your patient/client base, their families or others that are not yet a part of your patient/client population? Addressing this question will help identify the community.

B. **Conduct public forums, listening sessions, focus groups, surveys, and interviews t**o identify community assets, resources, opportunities, and challenges.

C. **Create a report** on the needs to build a healthy community.

D. **Present findings** to the community in a forum-style meeting.

E. **Use feedback** from assessments and community members to develop and track the progress of effective and culturally appropriate, community-directed diabetes programs that complement and support the clinical diabetes program.

Team Notes:

Key Recommendation 2. Develop partnerships and community advocacy groups where people can work together to improve their community and effectively address diabetes prevention and care.

Why?

Successful prevention and treatment of diabetes requires the involvement of policymakers, health care organizations, people with diabetes and their families, and communities (Garfield et al., 2003; Goodman et al., 2006). Community partnership and participation is particularly important to the success and effectiveness of diabetes programs. Sustained positive change cannot be achieved without the support, commitment, and involvement of the community. The underlying principle of community participation is to promote change by offering the community ways to take greater control of health (Stimson et al., 2003).

Community advocacy groups should be established to mobilize communities, build local capacity, help disseminate diabetes information, strengthen strategic partnerships, combine expertise, and leverage resources. Community advocacy groups can carry out the key functions of advocacy, which include understanding community perceptions and opinions, addressing misinformation, and working with community leaders, media, and decision makers to build support for resources and policies to address diabetes.

How to Implement the Key Recommendation

Identify new partnerships and foster existing ones with:

- Tribal leaders and Indian community leaders
- decision makers and policymakers
- community leaders and groups most affected by diabetes
- community activists and advocacy groups
- business leaders
- media
- health care providers
- non-profit organizations and other federal agencies
- leaders of the faith community
- parks and recreation directors
- community members, and
- school principals or school board members.

Team Notes:

Key Recommendation 3. Provide community education to increase awareness of the risk factors for diabetes and to inform the community that diabetes and its complications can be prevented or delayed through sustained lifestyle changes that result in modest weight loss.

Why?

According to the Task Force on Community Preventive Services, there is sufficient evidence that diabetes self-management education is effective in community gathering places for adults with type 2 diabetes with a broad range of ages and ethnic backgrounds (Briss et al., 2000).

How to Implement the Key Recommendation

A. **Use evidence-based community guidelines** to develop and implement community education and health promotion programs, such as programs that promote healthful eating behaviors and increased physical activity.

   Use talking circles to provide an opportunity for people to talk freely about diabetes with truth and openness. Talking circles can help people understand diabetes, find support for managing diabetes, and help prevent onset of the disease in family members who are at increased risk. This technique has been shown to be particularly effective at providing information on type 2 diabetes (Struthers, Hodge, De Cora, et al., 2003; Struthers, Hodge, et al., 2003; Struthers, Kaas et al., 2003; Hodge, et al., 1999; Hodge et al., 2002).

B. **In addition, talking circles can help health care providers understand what activities the community will accept.**

   Provide training to health care providers on community advocacy, so they can understand that working together with the community is essential for successful diabetes program planning, development, implementation, and evaluation (IOM, 2002; Ramsden, et al 2010).

C. **Diabetes educators and other health care professionals should support the role of community health workers** in serving as bridges between the health care system and people with, and at risk for, diabetes (AADE 2009; Norris, et al., 2006; Satterfield, et al., 2002).

D. **Orient people with diabetes, their families, and the community to the health care system and providers**.

E. **Encourage the health care system and providers to offer patients health-related information that is culturally appropriate and at the appropriate literacy level**.

F. **Establish programs to help community members become 'expert users' of the Indian health system**.

G. **Conduct public information campaigns** about diabetes and prediabetes.

H. **Participate in governing boards and task forces** to educate community leaders about diabetes.

I. **Refer to the *Indian Health Diabetes Best Practices* documents**, including those on physical activity, nutrition, adult weight management, youth and diabetes, diabetes and pregnancy, breastfeeding and diabetes, school health, diabetes self-management education, and community diabetes screening, to develop informational education messages.

Action! See IHS Division of Diabetes Best Practices documents, Revised 2011.

Team Notes:

Key Recommendation 4. Develop a strategic plan.

Why?

A strategic plan brings focus to your ideas and activities by creating a 'roadmap' for making a difference in diabetes prevention and care. A strategic plan grounds your dreams. It makes good ideas possible by laying out what needs to happen in order to achieve your vision.

The strategic planning process should be a group effort, taking care to involve both people affected by diabetes and those with capacities to change it. This process enables your program to build consensus around your vision and the necessary steps the program should take to achieve it.

How to Implement the Key Recommendation

One way to make that journey is through strategic planning, the process by which a group defines its own "VMOSA," its Vision, Mission, Objectives, Strategies, and Action Plans.

VMOSA is a practical planning process that can be used by any community organization or initiative. This comprehensive planning tool can help your organization by providing a blueprint for moving from dreams into actions and positive outcomes for your community (Work Group on Health Promotion and Community Development at University of Kansas, 2009).

Vision (The Dream)
Your vision communicates what your organization believes are the ideal conditions for your community: how things would look if the issues important to you were perfectly addressed.

Mission (The What and Why)
An organization's mission statement describes *what* the group is going to do, and *why* it is going to do that. Mission statements are similar to vision statements, but they are more concrete, and they are definitely more 'action-oriented' than vision statements.

Objectives (How much of what will be accomplished by when?)
Once an organization has developed its mission statement, its next step is to develop the specific objectives that are focused on achieving that mission. Objectives refer to specific measurable results for the initiative's broad goals. An organization's objectives generally lay out *how much* of *what* will be accomplished by *when.*

Strategies (The How)
The next step in the process of VMOSA is developing your strategies. Strategies explain *how* the initiative will reach its objectives. Generally, organizations will have a wide variety of strategies that include people from all of the different sectors of the community. These strategies range from broad ones that encompass people and resources from many different parts of the community, to very specific strategies that take place on a much smaller level.

Action Plan (What change will happen? Who will do what by when to make it happen?)

Finally, an organization's action plan describes in great detail exactly *how strategies will be implemented* to accomplish the objectives developed earlier in this process. The action plan contains: 1) specific (community and systems) changes to be sought, and 2) specific action steps necessary to bring about changes in all relevant sectors of the community.

The action plan outlines key aspects of the changes to be implemented. Action steps are developed for each component of the intervention. These include:

- Action steps: *What will happen?*
- Person(s) responsible: *Who will do what?*
- Dates completed: When *will each step be completed?*
- Resources required: *What resources and support are needed (both in terms of what is needed and what is available)?*
- Barriers or resistance and a plan to overcome them: *What problems are we likely to encounter? How will we address these problems?*
- Collaborators: *Who else should know about this action?*

Team Notes:

Key Recommendation 5. Involve community partners in participatory evaluation.

Why?

Participatory evaluation involves community stakeholders in setting evaluation criteria for a project, collecting and analyzing data, and using information gained to adjust and improve the project. Participatory evaluation is not simply a matter of asking stakeholders to take part. Involving everyone affected changes the whole nature of a project from something done *for* a group of people or a community, to a partnership *between* beneficiaries and project implementers. Rather than powerless people who are acted on, beneficiaries become the co-pilots of a project, making sure that their real needs and those of the community are recognized and addressed. Professional evaluators, project staff, project beneficiaries or participants, and other community members all become colleagues in an effort to improve the community's quality of life.

How to Implement the Key Recommendation

Participatory evaluation involves all of the stakeholders in a project – those directly affected by it or affected by carrying it out. Evaluation of the project helps you find out what happened and how to use the information to improve the project to meet community stakeholder needs.

Evaluation should look at two areas: process and outcomes.

Action! See Part 1 – Planning for Your Program and Evaluation.

Team Notes:

Additional Recommendations

Working Together with your Community and Organization

In addition to implementing the **Key Recommendations**, programs need to work on broader community and organizational support of the goals they are trying to achieve.

Organization Recommendations

A health care organization that wants to improve community advocacy efforts must be motivated and prepared for change to occur throughout the organization. Organizational leadership must identify community advocacy as important work. Leaders must develop clear improvement goals and policies, and effective strategies to achieve them.

Adopt system and programmatic changes.

Why?

System and programmatic changes that help support people in their efforts to prevent and control diabetes have been associated with increased delivery of appropriate diabetes care. Community advocacy may help bring people together to raise awareness and initiate action on diabetes prevention and care (Stimson et al., 2003).

The **Social-Ecological Model,** currently used by the public health community, provides a framework for addressing and influencing a person's physical, social, and cultural surroundings in order to support long-term, healthy lifestyle choices. The model encompasses all of the key sectors of society—individual, interpersonal, organizational, community, and broader society—and is consistent with the value of connectedness of self, community, and place that is intrinsic in American Indian and Alaska Native communities (Caprio et al., 2008).

Another tool is the CHANGE tool put together by the Centers for Disease Control's (CDC) "Healthy Communities Program". CHANGE addresses each of the five bulleted sectors noted below. For each sector, the tool includes specific questions to be answered in the areas of physical activity, nutrition, tobacco, chronic disease management, and leadership (plus school district and after-school in the school sector):

- Community-At-Large Sector: Includes communitywide efforts that impact the social and built environments, such as improving food access, walkability or bikeability, secondhand smoke exposure, or personal safety.
- Community Institution/Organization Sector: Includes entities within the community that provide a broad range of human services and access to facilities (e.g., childcare settings, faith-based organizations, senior centers, boys and girls clubs, colleges/universities).
- Health Care Sector: Includes places where people go to receive preventive care or treatment, or emergency health care services (e.g., hospitals, private doctors' offices, community clinics).
- School Sector: Includes all primary and secondary learning institutions (e.g., elementary, middle, and high schools, whether private, public, or parochial).
- Work Site Sector: Includes places of employment (e.g., private offices, restaurants, retail establishments, government offices).

http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm, Last updated May 10, 2010.

How to Implement the Recommendation

A. **Create a supportive policy environment** at the Tribal, clinical, local, and national levels to engage community members in planning, advocating, and implementing diabetes programs.

B. **Support and provide** needed resources, services, and policy changes.

C. **Provide education** to increase awareness of diabetes among community members.

D. **Educate health care providers** on community advocacy.

E. **Strengthen cooperation** between clinical programs and community programs.

Action! See Part 3 – Appendix D. for Community Advocacy: 'Take-Away Lessons'

Team Notes:

PART 3 Appendices, Tools, and Resources

Appendix A. Supplemental Information

1. Importance of a Community Advocacy Program

People with diabetes are not alone. Diabetes affects families and whole communities. In addition to family support, *community* support and advocacy can make a big difference in the outcomes for people with diabetes and in promoting diabetes prevention.

Furthermore, the community is the heart of public health. Public health is the fulfillment of society's interest in ensuring that people live in healthy conditions (Institute of Medicine [IOM], 2002). All community members have a role in public health. Everyone is needed to work together on diabetes prevention and treatment efforts to help make life better for individuals, families and communities affected by diabetes.

Public health is also personal—the family member or friend who died from a preventable cause, the human story that underlies the statistics we cite. Public health takes place in boardrooms, on street corners, in our homes, and in the legislature. So, too, does public health advocacy. (Am J Public Health. 2003 August; 93(8): 1204)

2. Benefits and Risks of implementing This Best Practice

The health benefits for community advocacy cannot be understated—it will raise awareness of the need for policy around diabetes treatment and prevention.

There may be risks to community advocacy in diabetes care in that it opens up discussion about intergenerational trauma, feelings of neglect and abuse, feelings of being marginalized and even racism. But working through these feelings as a community can be healing and helpful. The community can break the cycle of intergenerational trauma and can address the depression and grief that often leads to further health problems. Discussions as a community can help heal the individual, families, and communities.

3. Sustaining a Community Advocacy Program for Diabetes

The following elements are needed to enhance the sustainability of this best practice:

- strong leadership and organizational support that includes funding for staff, training, and resources
- establishing policies that support effective diabetes programs
- recognition of the people working on community advocacy efforts
- use of community advisory groups to keep your community mobilized
- ongoing community assessments to determine what is needed for improvements to meet the community's needs and desires, and
- a flexible and dynamic strategic plan.

Appendix B. Key Measures Example

Remember—this is an example! Apply this process to your community using your data.

Diabetes increasing in the community. Our community is concerned about the increasing number of people who have type 2 diabetes.

Diabetes team takes action. Our diabetes team talked about the role of the community in addressing this problem and how they could be more involved. We read the Community Advocacy Best Practice and talked about the Key Recommendations.

Identified sources of data. Local data included:

- A recent community assessment indicated interest in increasing physical activity opportunities in the community but lack of resources for this.
- Audit data showed 40% of diabetes patients received exercise related education in the past year.
- There is no community wide advocacy group currently meeting.

Selected suitable Best Practice. After thinking carefully about our goals and resources, and reviewing data, we decided the Community Advocacy Best Practice was a good fit for us. We chose to work on one of the Key Recommendations: develop a community advocacy group.

Identified target population. We decided to start implementing this Best Practice for all individuals in the community at risk for, or with, diabetes.

Identified SMART objectives based on our resources and data:

- A community advocacy group, that includes representation of a community member with diabetes, a family member of a person with diabetes, a school representative, a health care representative, and a Tribal representative at minimum, will meet quarterly over the next twelve months.
- At least one new community physical activity policy that increases opportunities for physical activity for the target population will be implemented in the next twelve months.

Selected Key Measures. We chose the corresponding Key Measures for these Objectives and these Key Recommendations. Data will be collected and reviewed at baseline and mid-year.

Table 1. Selected Key Measures.

A. Measure	B. Baseline or beginning value and date (collected prior to starting activities)	C. Most recent value and date (if applicable)	D. Data source (where did these numbers come from)
1. * Number of community members to join a local community advocacy group	0 as of 1/1/2011	5 as of 4/1/2011	Meeting minutes – so far have minimum required membership per objective
2. Changes in the community as a result of policies implemented by the community advocacy group	0 as of 1/1/2011	2 as of 4/1/2011	Meeting minutes/tracking logs/success stories – Result of physical activity policies implemented—elementary school now provides a minimum 30 minutes physical activity time for all students; high school now provides access to its facilities for all community members to use for physical activity
3. * Number of wellness policies implemented by the community advocacy group	0 as of 1/1/2011	2 as of 4/1/2011	Meeting notes—group is currently working on two healthful eating policies
4. Number of resolutions implemented by the community advocacy group	0 as of 1/1/2011	0 as of 4/1/2011	Meeting notes – group is currently working on two Tribal resolutions, should be implemented by next report.

* Required Key Measure

Appendix C. Improving Community Advocacy for Diabetes

Remember—this is an example! Ask these questions in your community, thinking about your local needs, resources and tracking systems.

There are four fundamental questions to ask as you plan and implement your best practice. These questions (and sample answers) are:

1. Who is the target population?

- Individuals and families at risk for, or living with, diabetes.

2. What are you trying to do?

- Increase advocacy for diabetes care and education services in the local community by actively involving all stakeholders.

3. How will you know if what you do makes things better?

- Over one year, a partnership of at least six community groups has joined the Tribal diabetes care and prevention task force.
- A new physical activity policy has been implemented in schools as a result of the community advocacy group's actions.
- Within one year, community advocates working with Tribal leaders, school administrators, the diabetes program team, and other partners will develop and implement a new, joint policy that fundraising activities at school will not involve food. The school district and Tribal leaders will make available a list of ideas for acceptable fundraising activities to all parents and students in the district.
- Within six months, the partnership will develop relationships with local farmers to make fresh fruits and vegetables more readily available and affordable through weekly markets.

4. What can we do to make things better?

- Through a listening session, ask how the community feels about an issue related to diabetes prevention and care, and hear what members think needs to be done about it, before developing the project.
- Establish partnerships with organizations who share a common vision about diabetes prevention and care.
- Ensure that the diabetes clinical and community health care team will provide community organizations and coalitions with technical assistance and support in identifying and securing resources as needed, and at all phases of the project.

Appendix D. Community Advocacy: 'Take-Away Lessons'

Remember that whatever your objectives in undertaking community advocacy, there is success in having tried it. Here are some 'take-away lessons':

1. We cannot do it without each other. Your public health expertise is needed.

2. **The winning equation: Education + Action = Advocacy.** The number one job of an advocate is to educate policymakers and the public.

3. Go together like peanut butter and jelly. Remember, advocacy is about building long-term relationships.

4. Proof is in the pudding. …Use data and the public health human interest stories that you encounter…to further your advocacy efforts.

5. Many roads, one goal. There are many different avenues for effective advocacy.

6. 'Public Health is watching you.' Remember to thank policy makers for the great work they did.

7. ***'Friends – gotta have 'em.'*** It takes partnerships at the community, state, and federal level in the fight to protect, promote, and advance the nation's health.

8. Public Health advocacy is not only rewarding, it is fun.

9. Timing is everything. …The earlier in the process you involve yourself, the better chance of influencing outcome(s).

10. Put the public in public health. Include the public in your public health advocacy efforts.

Tools and Resources

Web-based Resources

A workbook (with online training course) on effective program planning and evaluation. IHS Division of Diabetes Treatment and Prevention [Internet]. [July 2009] **Creating Strong Diabetes Programs: Plan a Trip to Success.**
http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/Basics/Creating/Workbook.pdf

An online training course on effective program planning and evaluation. IHS Division of Diabetes Treatment and Prevention [Internet]. [July 2009] **Creating Strong Diabetes Programs: Plan a Trip to Success.**
http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating_pt_1

Difference between goals and objectives
http://assessment.uconn.edu/docs/HowToWriteObjectivesOutcomes.pdf

Association of American Indian Physicians (AAIP) Diabetes Program. The AAIP Diabetes Program is a member of the National Diabetes Education Program (NDEP) American Indian Alaska Native Workgroup. This workgroup develops culturally sensitive and relevant campaigns and materials to target diabetes education in Native American populations. The program has a list of AI/AN materials and campaigns. http://www.aaip.org/?DIABETESINFORMATION

American Diabetes Association Native American Program: **Awakening the Spirit**
800-342-2383 http://www.diabetes.org/

The **American Diabetes Association** funds research; publishes scientific findings; provides information and other services to people with diabetes, their families, health care professionals, and the public; and advocates for scientific research, SDPI funding, and the rights of people with diabetes. American Diabetes Association's Native American Program: Awakening the Spirit, developed a Diabetes Advocacy Kit in 2008 with tips specific to Native American diabetes programs. The Awakening the Spirit team sponsors the annual SDPI "Voices for Change" Award to recognize excellence in advocacy, innovation, and outcomes in diabetes prevention and treatment services in Native American communities. View "Voices for Change" for ideas from award winning programs. http://www.diabetes.org/communityprograms-and-localevents/nativeamericans/awakening.jsp.

American Public Health Association http://www.apha.org

APHA provides advocacy on health issues for the nation. Select "Advocacy & Policy" for tips and resources on community advocacy. http://www.apha.org/NR/rdonlyres/256C8E98-AC70-4CD0-87BA-6EDC048DB0E8/0/RulesandGuidelinesPHAdvocates.pdf

Active Living by Design http://www.activelivingbydesign.org/index.php?id=293

This website provides information on the Community Action Model by clicking on “Approach” and then “Community Action Model”.

This website provides information on evidence-based recommendations and lists intervention for programs and policies to promote community health.
http://www.thecommunityguide.org/index.html

CDC's Healthy Communities Program

This program is engaging communities and mobilizing national networks to focus on chronic disease prevention. Communities are working to change the places and organizations that touch people’s lives every day—schools, work sites, health care sites, and other community settings—to turn the tide on the national epidemic of chronic diseases. Has the “CHANGE” tool and provides a list of questions for developing a CHANGE program. Interactive website to help develop a program.
http://www.cdc.gov/healthycommunitiesprogram/index.htm

Work Group on Health Promotion and Community Development, University of Kansas. The Community Toolbox: Part 1, Organizing for Effective Advocacy. Assessing Community Needs and Resources Toolkit. 2009. This online tool kit is the ‘gold standard’ for community-based skill-building information. Created and maintained by the Kansas Work Group on Health Promotion and Community Development, the core of the site is the ‘how-to tools’, including information on principles of advocacy (e.g., recognizing allies and opponents), conducting advocacy research, providing encouragement and education, conducting a direct action campaign (e.g., personal testimony letters), media advocacy, and responding to opposition. Available online at: http://ctb.ku.edu/en/tablecontents/ Click on Part 1: Organizing for Effective Advocacy.

Diabetes Prevention Program (DPP)

This site contains study documents regarding the research aspects of the DPP and curricula for planning diabetes prevention information and education campaigns.
http://www.bsc.gwu.edu/dpp/

IHS Division of Diabetes Treatment and Prevention (IHS Division of Diabetes). IHS Division of Diabetes is responsible for developing, documenting, and sustaining clinical and public health efforts to treat and prevent diabetes in American Indians and Alaska. The website includes a staff directory and information on the SDPI programs, IDERP, training opportunities and resources and tools.
http://www.ihs.gov/MedicalPrograms/Diabetes/

Intergenerational trauma
http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/Podcasts/Duran_transcript_508c.pdf

National Diabetes Education Program (NDEP)

The NDEP is a federally funded program including over 200 partners at the federal, state, and local levels. NDEP translates the latest science and spreads the word that diabetes is serious, common, and costly, yet controllable, and for type 2, preventable.

NDEP has a number of American Indian/Alaska Native-specific resources on diabetes prevention and control, including patient education materials, PowerPoint slides, fact sheets, and PSAs for print, television, and radio. These messages and materials are ideal for community advocacy campaigns and have been developed in partnership with the NDEP's American Indian/Alaska Native Work Group. They may be downloaded at: http://www.ndep.nih.gov/

National Indian Health Board (NIHB)

The NIHB provides advocacy and policy formation and analysis to Tribes, Area Health Boards, Tribal organizations, federal agencies, and private foundations. The Area Health Boards serve as the communication link between the NIHB and the Tribes. Area Health Boards advise in the development of positions on health policy, planning, and program design. They gather information and review public opinion and proposals. http://www.nihb.org/

Examples of Current Best Practice Programs

Diabetes Talking Circles
Lorelei De Cora, RN, BSN
(402) 878-2392 ldecora@seva.gov

Seva Foundation
Native American Diabetes Project's Diabetes Talking Circles
PO Box 225
Winnebago, NE 68071
http://www.seva.org/site/PageServer?pagename=Diabetes_Tutorial_Materials

Diabetes Talking Circles is a research-based, culturally appropriate, and well-accepted diabetes education program for American Indians living with diabetes or at-risk for diabetes. The goal of the program is to prevent, treat, and control diabetes. The program consists of a twelve-session curriculum, facilitator's manual, toolkit, and materials for each session. Diabetes Talking Circles uses traditional circles and food, along with group support in a spiritual setting, to create an acceptable way for participants to express their feelings about living with diabetes, receive support, absorb information, and strengthen traditional ties.

Eastern Band of Cherokee Indians
Sally Sneed, RN, Diabetes Program Manager
Eastern Band of Cherokee Indians Health and Medical Division
43 John Crowe Hill Rd.
PO Box 666
Cherokee, NC 28719
(828) 497-1996 sallsnee@nc-cherokee.com

This program offers a comprehensive diabetes care and education program with active community advocacy.

Hualapai Healthy Heart Program
Peach Springs, Arizona.

This program is an SDPI funded demonstration site designed to reduce cardiovascular disease who have engage their greater community in a variety of successful advocacy efforts with a local, regional and national impact.

Winner of the 2010 John Pipe voices For Change Award in 2010.

Action! See
http://forecast.diabetes.org/magazine/your-ada/diabetes-programs-benefit-native-americans

Seneca Nation of Indians Health Department
Carmen Repicci, RN, BSN,
Diabetes Prevention Program (DPP) Coordinator
Special Diabetes Program for Indians (SDPI) Competitive Grant
and
Luane Spruce, RN, BSN,
Diabetes Core Program
Special Diabetes Program for Indians (SDPI) Non-competitive Grant
Seneca Nation of Indians Diabetes Programs
Medical Clinic on Cattaraugus Territory
1510 Route 438
Irving, NY 14081
(716) 532-5582

Seneca Nation offers a full-range of DSME services to community members through the comprehensive diabetes program. There are multiple venues for engaging community advocates.

Additional Contacts

Persons or programs that sites might contact for further ideas and assistance.

Area Diabetes Consultants. Contact information for Area Diabetes Consultants can be viewed at:
http://www.ihs.gov/MedicalPrograms/diabetes/index.cfm?module=peopleADCDirectory

PART 4 References

References

American Association of Diabetes Educators (AADE). Community Health Workers in Diabetes Management and Prevention (AADE Position Statement.). The Diabetes Educator, 2009. In press.
http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/CommunityHealthWorkerPositionStatement2009.pdf

Bassett, Mary T, MD, MPH; Public Health Advocacy, Am J Public Health. 2003 August; 93(8):1204.

Briss PA, Zaza S, Pappaioanou M, et al. Developing an evidence-based Guide to Community Preventive Services—methods. The Task Force on Community Preventive Services. Am J Prev Med 2000;18(suppl 1):35–43.

Caprio, S. et al. Influence of Race, Ethnicity, and Culture on Childhood Obesity: Implications for Prevention and Treatment. A Consensus Statement of Shaping America's Health and the Obesity Society. Diabetes Care, 2008;31(11):2217.

Gallivan J, Greenberg R, Brown C. The National Diabetes Education Program evaluation framework: how to design an evaluation of a multifaceted public health education program. Preventing Chronic Disease. 2008;5(4):A134. Published online 2008 Sept. 15. Accessed July 10, 2009.

Garfield SA, Malozowski S, Chin MH, Venkat Narayan KM, Glasgow RE, Green LW, Hiss RG, and Krumholz HM. Diabetes Mellitus Interagency Coordinating Committee (DMICC) Translation Conference Working Group. Considerations for diabetes translation research in real-world settings. Diabetes Care. 2003;26:2670–74.

Hodge FS, Pasqua A, Marquez CA, and Geishirt-Cantrell B. Utilizing traditional storytelling to promote wellness in American Indian communities. Journal of Transcultural Nursing. 2002;13(1):6–11.

Hodge FS and Stubbs H. Talking Circles: Increasing cancer knowledge among American Indian Women. Cancer Therapy and Research. 1999;8:103–11.

Institute of Medicine. Stoto, MA, Abel CA, and Dielver A, eds. Healthy Communities: New Partnerships for the Future of Public Health. Washington, DC: National Academies Press. 1996.

Institute of Medicine. The Future of the Public's Health in the 21st Century. The National Academies Press, 2002. Entire book available online free.
http://www.nap.edu/openbook.php?record_id=10548&page=19 Accessed July 9, 2009.

Norris SL, Chowdhury FM, Van Let K, et al. Effectiveness of community health workers in the care of persons with diabetes. Diabet Med. 2006;23(5):544–556

Ramsden VR, McKay S, Crowe J. The pursuit of excellence: engaging the community in participatory health research Global Health Promotion December 2010 17: 32-42, doi:10.1177/1757975910383929.

Roubideaux YR, Dixon M. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. American Public Health Association. 2001, Washington, D.C.

Satterfield D, Burd C, Valdez L, Hosey G, Eagle Shield J. The “in-between people”: participation of community health representatives in diabetes prevention and care in American Indian and Alaska Native communities. Health Promot Pract. 2002;3(2):166–175.

Stimson GV, Donoghoe MC, Fitch C, Rhodes TJ with Ball A and Weiler G. Social mobilization, advocacy, and community participation (Chapter 6). In: Rapid Assessment and Response Guide, Version 1.0. Geneva: World Health Organization, 2003. Available online at: http://www.who.int/docstore/hiv/Core/Chapter_6.html
[Accessed July 9, 2009.]

Struthers R, Hodge FS, DeCora L, and Geishirt-Cantrell B. (2003). The experience of Native peer facilitators in the campaign against type 2 diabetes. Journal of Rural Health. 2003;19(2)174–80.

Struthers R, Hodge FM, Geishirt-Cantrell B, DeCora L. Participant experiences of talking circles in chronic management in type 2 diabetes. Qualitative Health Research. 2003;13(8):1094–115.

Struthers R, Kaas M, Hill DL, Hodge F, DeCora L, Geishirt-Cantrell B. Providing culturally appropriate education on type 2 diabetes to rural American Indians: Emotions and racial consciousness. Rural Community Psychology. 2003;E6(1).

Work Group on Health Promotion and Community Development, University of Kansas. The Community Toolbox: Part 1, Organizing for Effective Advocacy. Assessing Community Needs and Resources Toolkit. 2009. Available online at: http://ctb.ku.edu/en/tablecontents/ [Accessed July 9, 2009].