

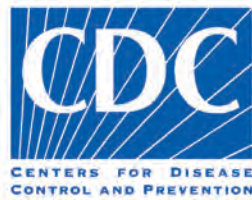
0-6.5
 6.6-8.0
 8.1-9.4
 9.5-11.1
 11.2+
 Map Source: CDC

In 2004, **TWO** out of 120 counties had a rate of diabetes of 11.2% or higher.



MAKING THE CONNECTION:

Engaging community partners to address Type 2 diabetes in vulnerable populations



Healthy Bucks

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Scioto County Health Coalition



ACKNOWLEDGEMENTS

The Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion expresses gratitude and thanks to the University of South Dakota's Chelsea Wesner (Choc-taw), who collected the interviews that inspired this report. Ms. Wesner wrote the report in collaboration with the National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation.

All collaborators would especially like to thank staff and community members from the organizations and community partners featured: Association of American Indian Physicians (AAIP) and Kickapoo Tribe in Kansas' Kickapoo Diabetes Coalition; Association of Asian Pacific Community Health Organizations (AAPCHO); Center for Appalachian Philanthropy (AppaPhil) and Scioto County Health Coalition; Kentuckiana Regional Planning and Development Agency (KIPDA) and KIPDA Diabetes Rural Health Coalition; and National Alliance for Hispanic Health and Salud Para La Gente. This report would not have been possible without the sharing of their stories and diverse experience in reducing health disparities associated with type 2 diabetes.

Suggested citation: Centers for Disease Control and Prevention (2015). Making the connection: Engaging community partners to address Type 2 diabetes in vulnerable populations. A compendium of stories from the CDC's National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations. Atlanta, GA: National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, Centers for Disease Control and Prevention.

TABLE OF CONTENTS

Introduction and Shared Themes	3	Purpose and Background
	4	Methods
	5	Key Findings and Shared Themes
<hr/>		
Featured Grantee Stories	7	Association of American Indian Physicians (AAIP) and Kickapoo Tribe in Kansas-Kickapoo Diabetes Coalition
	12	Association of Asian Pacific Community Health Organizations (AAPCHO)
	15	Center for Appalachian Philanthropy (AppaPhil) and Scioto County Health Coalition
	18	Kentuckiana Regional Planning and Development Agency (KIPDA) and KIPDA Diabetes Rural Health Coalition
	21	National Alliance for Hispanic Health and Salud Para La Gente
<hr/>		
Appendices	25	Contact Information
	26	Appendix A: National Alliance for Hispanic Health – Diabetes Sustainability Plan

PURPOSE AND BACKGROUND

Commissioned by the Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion, this compendium highlights the impact and stories of grantees who were a part of the National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations, a five-year cooperative agreement between 2010 and 2015.

To collect this compendium of stories and interviews, CDC partnered with Chelsea Wesner, an instructor of public health with the School of Health Sciences at the University of South Dakota. Based on interviews with key people in each organization and partnering community, the stories in this compendium demonstrate how grantees, local partners and other stakeholders collaborated to focus on diabetes-related issues through responsive outreach at the individual, family, community, and policy levels. The interviewees discussed strategies used to address risk factors associated with diabetes such as poor nutrition, physical inactivity, lack of diabetes awareness, limited culturally tailored diabetes self-management education and materials and lack of diabetes support in their targeted communities.

Diabetes-Related Health Disparities

- Diabetes affects more than 29 million people, or 9.3 percent of the population, in the United States.¹ Approximately, 1.5 million people aged 20 years or older were newly diagnosed with diabetes in 2012.¹
- It is the seventh leading cause of death in the country and can also cause other serious health complications, including heart disease, blindness, kidney failure, and lower-extremity amputations.
- The highest rates of type 2 diabetes and its complications exist across particular groups of the population, such as adults 60 and older, racial and ethnic minority groups (i.e., African Americans, Hispanic/Latino Americans, American Indians, Native Hawaiians and other Pacific Islanders, and Asian Americans), people with low socioeconomic status and rural populations.
- Non-Hispanic black, Hispanic, and American Indian/Alaska Native adults are about twice as likely to have diagnosed diabetes as non-Hispanic white adults.¹

CDC's Approach to Reducing Diabetes-Related Health Disparities

Variations in type 2 diabetes rates often occur across different communities and populations because of complex individual, social, cultural, economic, and environmental factors. To address these factors, CDC funded and supported six national organizations through the five-year National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations cooperative agreement. The six organizations carried out their work with local partners in 18 communities through:

- establishing multisector partnerships and coalitions
- conducting needs assessments and strategic planning
- identifying and implementing culturally relevant, evidence-based interventions
- building community infrastructure and capacity
- evaluating approaches implemented in the communities
- sharing lessons learned and disseminating findings about effective strategies to reduce diabetes-related disparities

¹ Centers for Disease Control and Prevention (CDC). National Health Interview Survey, 2014. Atlanta, GA: National Center for Health Statistics, Division of Health Interview Statistics, U.S. Department of Health and Human Services.

METHODS

This compendium used ethnographic methods in order to understand the responsive strategies and benefits of these programs in vulnerable communities. These methods guided the collection of stories through informal and structured interviews and helped identify the common themes among them. Following an informal conversation, each interviewee was asked to respond in writing to four or five open-ended questions. This method gave the storyteller time to think about what she or he would like to say, allowing a rich and thoughtful narrative process.

Six national organizations were funded through this cooperative agreement: Association of American Indian Physicians (AAIP); Association of Asian Pacific Community Health Organizations (AAPCHO); Center for Appalachian Philanthropy (AppaPhil); Kentuckiana Regional Planning and Development Agency (KIPDA); National Alliance for Hispanic Health; and National Kidney Foundation of Michigan (NKFM). A map of these organizations and their community partners follows.

National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations (DP10-1001)



Vulnerable Populations Grantees

- | | | |
|--|--|--|
| <p>1 Association of American Indian Physicians</p> <ul style="list-style-type: none"> • Southeast Michigan Tribal Community, Michigan • Kickapoo Tribe, Kansas • United Houma Nation, Louisiana | <p>3 Center for Appalachian Philanthropy</p> <ul style="list-style-type: none"> • Region 1: Ohio and Kentucky • Region 2: Virginia • Region 3: Mississippi | <p>5 National Alliance on Hispanic Health</p> <ul style="list-style-type: none"> • Phoenix, Arizona • Rio Rancho, New Mexico • Watsonville, California |
| <p>2 Association of Asian Pacific Community Health Organizations</p> <ul style="list-style-type: none"> • San Gabriel Valley, California • Waimanalo, Hawaii • Ebeye, the Republic of the Marshall Islands | <p>4 Kentuckiana Regional Planning and Development Agency</p> <ul style="list-style-type: none"> • Bullitt County, Kentucky • Henry County, Kentucky • Shelby County, Kentucky | <p>6 National Kidney Foundation of Michigan</p> <ul style="list-style-type: none"> • Inkster, Michigan • Detroit, Michigan • Flint, Michigan |

All six organizations were invited to participate for this report, and the five that responded are featured in this compendium. To highlight their community-level impact, each national organization identified one of the communities they worked in partnership with to highlight an innovative approach to encouraging health promotion and reducing diabetes-related health disparities.

The interviews and stories for this compendium were collected from the organizations and community partners in Table 1.

Table 1. Organizations and community partners featured in the compendium.

National Organization	Featured Community Partner
Association of American Indian Physicians (AAIP)	Kickapoo Tribe in Kansas' Kickapoo Diabetes Coalition
Association of Asian Pacific Community Health Organizations (AAPCHO)	Kwajalein Diabetes Coalition
Center for Appalachian Philanthropy (AppaPhil)	Scioto County Health Coalition
Kentuckiana Regional Planning and Development Agency (KIPDA)	KIPDA Diabetes Rural Health Coalition
National Alliance for Hispanic Health	Salud Para La Gente Health Clinic

KEY FINDINGS AND SHARED THEMES

In this report, key findings and shared themes reveal that the national organizations and community partners supported through this cooperative agreement hold a number of common beliefs and practices to support the process of reducing diabetes-related health disparities. The significance of community-driven planning and decision-making are highlighted throughout the stories that follow. Derived from the programs featured here, the following themes are listed in order from the most often reported beliefs and practices to those more unique.

1. *Coalition development and community-driven planning:* All programs worked collaboratively with and in the communities they serve through fostering capacity building among new and existing coalitions, conducting community needs assessments and formative research, employing a community-based participatory research approach to guide program development, and engaging stakeholders to help sustain efforts.
2. *Emphasis on diabetes education:* Improving the delivery and increasing the availability of diabetes education were primary objectives of all the programs in this cooperative agreement. While some programs focused on developing culturally responsive methods to engage community members, others focused on expanding evidence-based initiatives such as the Diabetes Prevention Program (DPP), diabetes self-management education (DSME), and medical nutrition therapy.
3. *Increasing access to healthful food:* Nearly half of the programs in this compendium worked to improve access to healthful food options. Utilizing farmers markets, establishing community gardens, and delivering community-based nutrition education, the national organizations and their community partners responded creatively to the need for more access and affordability of healthful and local food.
4. *Increasing access to physical activity:* Only one grantee shared information in the compendium about environmental changes made to make physical activity easier in one community. However, physical activity is often included in discussions related to diabetes prevention and diabetes self-management.

5. *Leveraging a variety of funding sources and community partners:* Several programs secured and combined additional funding—through charitable foundations and complementary diabetes and chronic disease prevention grants—to further strengthen and sustain programming and outreach efforts made possible through the cooperative agreement. Additionally, one program was successful in advocating for the re-designation of state funds to support diabetes education and care in local health departments.

FEATURED GRANTEE STORIES

The following section includes interviews and stories from the five national programs and community partners featured in Table 1. The programs worked collectively to reduce diabetes-related health disparities and used a variety of unique methods. The methods included culturally tailored diabetes education targeting migrant farmworkers in California, above-ground community gardens on the island of Ebeye, leveraging farmers markets to promote nutrition education and economic development in Ohio, building a community walking trail for tribal members of the Kickapoo Tribe of Kansas, and advocating for policy change and the re-designation of state funds for the delivery and coordination of diabetes education in Kentucky.



Dedication of the Kickapoo Walking Trail. Photos in interview courtesy of AAIP; promotional poster retrieved from tribal wellness program website.

ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

Featuring the Kickapoo Diabetes Coalition
Kansas

Through this cooperative agreement, the Association of American Indian Physicians (AAIP) centrally located in Oklahoma City, Oklahoma, partnered to reduce health disparities facing American Indian populations in Louisiana, Michigan, and Kansas. By collaborating with partners to create culturally appropriate and sustainable diabetes-related interventions, AAIP, with its partners, worked to empower communities with limited access to diabetes education and resources. The following is an interview with staff from AAIP, the Kickapoo Tribe of Kansas Diabetes Coalition, and a program officer from the Sunflower Foundation who partnered through this cooperative agreement to establish the Kickapoo Walking Trail.

Q: Describe how the Association of American Indian Physicians (AAIP) supported the Kickapoo Diabetes Coalition through this cooperative agreement.

A: (Jamie McDaniels, acting diabetes program director of AAIP) AAIP worked with the Kickapoo Diabetes Coalition to identify and select a community consultant, who facilitated a needs assessment process to gather feedback from community members related to the status of diabetes impacting the Kickapoo community. AAIP provided technical assistance to the Kickapoo Diabetes Coalition which conducted a strategic planning session utilizing information from the needs assessments and focus groups to decide what kinds of activities would best address the needs identified. Throughout the course of implementation, AAIP continued to support the Kickapoo Diabetes Coalition and on-site coordinator (OSC) or community consultant by being proactive with addressing

challenges and delays with strategic plan activities.

Mini-grants were provided to the Kickapoo Diabetes Coalition for three consecutive years during the implementation phase. This funding was given to supplement strategic planning activities providing incentives, fitness equipment, facility rental costs, and items needed to ensure that activities were successful. AAIP developed a series of questions in order to gather feedback on potential gaps of the Kickapoo Diabetes Coalition to continue its work addressing diabetes and other health-related conditions. The answers to these questions allowed AAIP to work with the OSC to facilitate capacity building trainings that would continue to strengthen the foundation of the Kickapoo Diabetes Coalition.

A: (Elizabeth Stewart Burger, program officer of Sunflower Foundation) The work of AAIP representatives Jamie McDaniel, Heather Levi, and Dr. DeRoin was invaluable for the work around the Kickapoo Walking Trail. AAIP staff often assisted the Kickapoo Diabetes Coalition members with paperwork necessary to execute the grant and build the trail. They also continued to improve the trail after it had been built, because inclement weather damaged the trail. For a busy program officer responsible for managing dozens of complicated grants, having an extra set of eyes, ears, and hands to help with this grant was extremely helpful. AAIP representatives could “push” the coalition to move forward on action steps in ways that I, as an outside program officer, could not, and at times helped to explain cultural differences that enlightened my understanding. The influence of Dr. DeRoin as a respected physician at the tribal health clinic also helped to move things along.

Q: The coordination and connections made through the Kickapoo Diabetes Coalition resulted in a partnership with the Sunflower Foundation to build the Kickapoo Walking Trail. Describe how this partnership evolved and the role of each partner in supporting the establishment of a walking trail.

A: (Jamie McDaniels, acting diabetes program director of AAIP) Dr. Dee Ann DeRoin, who is the lead expert consultant on this project with AAIP, described her prior interactions with the Sunflower Foundation, and how they may be a good partner for the Kickapoo Diabetes Coalition. Because of the prior interaction, discussions began about the various programs that the Foundation offers and walking trails was on the list. Meetings were scheduled between the Sunflower Foundation and the Kickapoo Tribal Council, which led to other meetings with non-tribal organizations that work on natural trails and representatives from the regional Environmental Protection Agency.

The Sunflower Foundation advised the Kickapoo Tribe on an upcoming announcement for funding for walking trails. It was a great opportunity to have this assistance to guide the tribe, so that the project could be established. I believe that this was the first time that the organization worked with a tribal community as a grantor. AAIP’s role in this process was to provide technical assistance and ensure that everything went smoothly. The community consultant guiding the Kickapoo Diabetes Coalition was invited to all of the meetings held, and discussed the progress with AAIP program staff. AAIP suggested that the coalition consider using part of the mini-grant funds to assist with the construction of the trail, and AAIP then paid the contractor directly for the cost of materials used as the surface of the walking trail.

A: (Elizabeth Stewart Burger, program officer of Sunflower Foundation) To my understanding, part of the coalition’s work was to determine the health-related needs and desires of the tribal community, and having a safe, pleasant, and accessible place to walk was one of those needs. A grant writer working for the Kickapoo Tribe of Kansas responded to our Sunflower Trails request for proposal (RFP) and the tribe ultimately received a grant. As part of the grant process, the Sunflower Foundation works with all grant writers to provide recommendations on developing a competitive grant; approving the grant and then spending extra time to explain the administration of said grant; providing technical assistance (free of charge) through other partners; and participating in and supporting events to celebrate the completion of the trail. The role of the coalition was to complete the grant and then oversee the building of the trail with the grant funds. Perhaps more importantly, the coalition spread the word about the trail, organized a ribbon cutting event, received support from tribal leadership, and maintained forward thinking



Kickapoo Tribe in Kansas Health and Wellness Program

1 Mile Walk/Run

July 18, 2015

For all ages

Registration 8:00

Run/Walk Begins 8:15



At the

ki ka poi te to pi mi e e

The Kickapoo Trail

Contact Lucas Holmes for more information lucas.holmes@ktik-nsn.gov



about other health projects that could be achieved, building upon the success of the trail.

Q: The Sunflower Foundation works with communities and schools throughout Kansas to promote health through building walking trails and safe outdoor spaces for physical activity. From the perspective of the Sunflower Foundation, what was special and unique about partnering with the Kickapoo Tribe in Kansas?

A: (Elizabeth Stewart Burger, program officer of Sunflower Foundation) Partnering with a sovereign tribal nation and community was unique in and of itself. I learned that while the tribe was familiar working with federal grants, foundation grants represented new ground. There was learning on both sides. The tribe had to learn that each foundation has different criteria and guidelines for grant administration, and that getting to know more about a foundation and how it works can be helpful up front. Our foundation learned that face-to-face contact is still really valuable for both establishing trust and just “getting stuff done,” even in today’s digital age—or perhaps because of it! We also learned that partnering with a tribe requires immense patience, because sometimes it takes a long time to get decisions from leadership. In this way, seeing monthly emails from the coalition was reassuring about progress still being made.

Q: In terms of sustainability, how does the Kickapoo Diabetes Coalition hope to preserve and utilize the walking trail and play spaces established through this project?

A: (Jamie McDaniels, acting diabetes program director of AAIP) Communication with the Sunflower Foundation continued throughout the rest of project as they organization were viewed as a coalition member. The tribe received other funding called including the Kickapoo Health and Wellness (KHW) grant, which allows them to expand upon and include some of the activities implemented through our partnership and cooperative agreement. As AAIP and the OSC began having continuation conversations with existing partners to gather their feedback on being a part of this new endeavor, we discovered during our meeting with the Sunflower Foundation that there were some outstanding documents needed in order to close out the grant. AAIP and the OSC worked with the new KHW staff to try and get this information to the Sunflower Foundation in regard to needed repairs to the trail. The Sunflower Foundation expressed that it would be possible to increase the amount of the initial grant funding with leadership approval in order to fix the trail, but that the outstanding information would have to be received before that could take place. AAIP also stated that there were additional grant funds from the diabetes project that could assist with this repair.

At this time, several new programs with the tribe are incorporating use of the walking trail into their strategic plans along with the KHW grant to ensure the condition of the walking trail will continue to be safe for those doing physical activity. The OSC did mention that other tribal programs are ensuring that the grass is cut and that the grounds are kept clean.

A: (Elizabeth Stewart Burger, program officer of Sunflower Foundation) As far as I can tell, the coalition is actively involved in making sure the trail gets repaired so it can be used year-round. This has required getting very specific technical assistance from a Sunflower Foundation partner (Kansas Trails Council) and finding a new contractor. The location of the trail is excellent; located next to the wellness center, Boys and Girls Club, and senior living or activity center. I know the coalition has plans in place to use the trail for different projects among those groups. Also, the health professional members of the coalition advise clients/patients to use the trail as part of healthful lifestyle changes.

Q: From this experience, what would you share with community coalitions interested in building a walking trail to promote health and prevent diabetes? What were the most important factors in planning and designing a walking trail for this community?

A: (Jamie McDaniels, acting diabetes program director of AAIP) If communities are interested in developing a

walking trail or similar project, here are our lessons learned:

- Use a contractor with experience constructing walking trails.
- Ensure community coalitions have a long-term plan for maintaining and repairing a walking trail (e.g., cutting the grass, cleaning up any trash, making sure that there is sufficient lighting, having someone patrol it at night, etc.).
- Place distance markers along the way, so that people are aware of how far they are walking or running.
- Be mindful of timing, remain flexible, and expect delays. You don't want to start a project when the weather isn't optimal for construction.
- Encourage shared responsibility and shared accountability, so things don't become the sole duty of one or two people.
- Build trail in a central location where the maximum number of people will have access to it. Select a place that has adequate shading along the trail and benches for people to rest if they need to. Concerning this trail, designing a double loop around the baseball fields was a wise decision because everyone could use the trail based on their own fitness levels.

A: (Elizabeth Stewart Burger, program officer of Sunflower Foundation)

- If seeking a local foundation grant, do your homework on the foundation, their grant cycles, and start the application far in advance. If possible, contact the program officer and get them involved in the early steps.
- Do your own homework on trail-building, and come to the foundation knowledgeable and prepared. There are so many resources on the internet about trail building, and so many ways to find local resources.
- Long before the trail is ever built, start gathering support from as many different partners as possible. One of the best things about a trail is that it can appeal to all ages and abilities, and be used for more than just exercise—it can become a place for native plants, historical signage, or memory benches. Think beyond just a trail as a place to exercise; think of it as a gathering place. Not only do multiple partnerships make stronger grant applications, they ensure sustainability of the finished product, because now you have so many people invested.

Special thanks to AAIP's Jamie McDaniel and Dr. Elizabeth Stewart Burger for sharing their time and stories. To learn more about this project, please find contact information on page 25.



Kwajalein Diabetes Coalition

DIAK PROJECT

ATAKE IN AJMOUR

Then God said, "Let the earth sprout vegetation, plants yielding seed, and fruit trees on the earth bearing fruit after their kind with seed in them"; and it was so. The earth brought forth vegetation, plants yielding seed after their kind, and trees bearing fruit with seed in them, after their kind; and God saw that it was good. Genesis 1:11-12



ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

Republic of the Marshall Islands

The Association of Asian Pacific Community Health Organizations (AAPCHO) works with community health centers in Waimanalo in Hawaii, the island of Ebeye in the Republic of the Marshall Islands (RMI), and San Gabriel Valley, California, to address nutrition, health care management, and physical activity among Asian Americans, Native Hawaiians, and Pacific Islanders. The following is an interview with staff from AAPCHO, the Kwajalein Diabetes Coalition (KDC), and Canvasback Missions highlighting their efforts in establishing EarthBox community gardens at community health centers and schools. This initiative has increased access to fresh fruits and vegetables and healthier nutrition choices for the island's 10,000 residents.

Q: Describe the cultural and geographical diversity of the communities you serve on the island of Ebeye. How do these factors affect healthful eating and access to fresh food on the island?

A: Our island population of roughly 10,000 people is concentrated on Ebeye, an island with a landmass of just .12 square miles. Ebeye is often characterized as one of the most densely populated islands in the world. Limited space and poor soil quality discourages the island population from considering even small-scale family farming. At the same time, the isolated and scattered nature of these islands makes imported fruits and vegetables unaffordable to most islanders. In fact, data gathered from the early stages of our project indicated that the number one reason most islanders with diabetes were not eating fruits and vegetables was because they could not afford them. Imported fruits and vegetables are expensive not only because of freight costs, but also because of their relatively short shelf life by the time they make it to stores in Ebeye. These are factors that contribute to the high cost of importing fruits, vegetables, and other perishable food items.

Q: Despite the rocky sand and soil of Ebeye, you've had success increasing access to fresh fruits and vegetables through developing community gardens that do not require in-ground planting. Share with us the steps that go into creating an EarthBox gardening system.

A: The EarthBoxes that we now use are factory made and come ready with potting soil and fertilizers. We opted to use EarthBoxes for this project because we knew early on that we will have to convince members of our community that even with limited space and poor quality soil, there are still viable ways to do home gardening. Using our established local partnership with the Taiwanese Mission, Canvasback Mission, military community in Kwajalein and RMI government, KDC along with AAPCHO were able to set up a series of training programs in Majuro and Ebeye for a select group of KDC gardeners and members of our community with diabetes. We later expanded our gardening program by linking it with the Ministry of Health's weekly clinic for people with diabetes. In the end, we have a more seamless diabetes program that distributes vegetables at no cost, introduces simple recipes for diabetic patients (previously tested for local palatability), and offers a weekly monitoring program that allows patients to link healthy eating and exercise—or lack thereof—with changes in their health outlook.

KDC also recognizes that EarthBoxes is a costly way of doing family gardening in Ebeye. For this reason, we have built a small in-ground community garden inside our fenced power plant facility in Ebeye. We're now using this garden to experiment on transitioning from EarthBox gardening to in-ground gardening. We have realized some successes in ground gardening by mixing soil collected from our roadside drainage cutters with potting soils. Several harvests have already been collected from this garden and distributed at our weekly diabetes clinics.



This page: From left, KDC First Harvest Event and KDC Community Garden located at a local hospital (right). Page 12: Photo of the island of Ebeye (above) and KDC's Garden of Life poster (below). All photos courtesy of KDC.

Q: In the Marshall Islands, what are some of the most effective ways to get community members involved in community gardens and to begin using the produce at home?

A: Aside from raising awareness and conducting training, it was obvious that one of the vital elements of the KDC program that drew a lot of interest was community-engaged demonstrations illustrated in classroom settings, clinics, as well as through our community gardening activities. At first, even after completing their training sessions on EarthBox gardening, most participants were still reluctant to try it on their own. Some even returned the gardening package—including EarthBoxes, potting soils, seeds, fertilizers, and more—which were provided at no cost. It wasn't until after they saw our community gardens starting to thrive that they began to show interest in experimenting with their own personal gardens.

Most of our older community members have limited formal education and, like others in urban pacific communities, are highly dependent on imported food products. It took a lot of convincing before we started seeing small changes in lifestyles and eating habits, which are now quite evident as the number of people coming to the weekly diabetes clinics was on the rise. This was not the case before the project started.

Q: In terms of sustainability, how does AAPCHO, the Kwajalein Diabetes Coalition, and Canvasback Missions hope to preserve the community gardening system and outreach that were offered through this project?

A: KDC will continue to maintain its relationship with our local, national, and international partners. We believe our established partnerships are one of KDC's greatest assets. Through these partnerships, KDC is ready to start building the long awaited walking pathway. Additionally, a proposal for grant funding has been accepted by the Australian Government to set up an FM radio station in Ebeye, which will be managed by KDC. Through this radio station, our outreach and public awareness programs will continue. One KDC board member reiterates a famous phrase from the movie Field of Dreams: "If you build it, they will come!" We've invested much effort in building our partnerships, and now opportunities for organizational growth continue emerging.

Special thanks to Romeo Alfred of the Kwajalein Diabetes Coalition (KDC), coalition members, and AAPCHO staff for sharing their time and stories.

To learn more about this project, please find contact information on page 25.



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KING'S
DAUGHTERS
MEDICAL CENTER
Ohio



Good at any Main Street Portsmouth
Farmer's Market Vendor,
Saturdays at Roy Rogers Esplanade.
Expires on the last market of the
season.



Healthy Bucks voucher created through the Healthy Bucks Program to purchase fresh produce and healthful foods at a local farmers market. Courtesy of AppaPhil.

CENTER FOR APPALACHIAN PHILANTHROPY

Featuring the Scioto County Health Coalition
Ohio and the Greater Appalachian Region

The Center for Appalachian Philanthropy (AppaPhil) worked to mobilize 11 counties across the Appalachian region through this cooperative agreement to increase opportunities for physical activity, diabetes awareness and education, and access to healthy foods. The following is an interview featuring the Scioto County Health Coalition, a community partner, and its success in partnering with farmers markets to promote access to local whole foods through the Healthy Bucks Program.

Q: Tell us about the Healthy Bucks Program and describe how it complements AppaPhil's other project goals to reduce diabetes risk in the Appalachian region.

A: The Healthy Bucks Program was designed as a community-based intervention to promote the benefits of eating fresh fruits and vegetables. In distressed rural Appalachian communities, access to healthy food is limited. AppaPhil has been engaged in programming through the farmers markets as an opportunity to increase access to healthy food options for individuals with and at-risk for type 2 diabetes. This intervention provides an educational component that also improves diabetes awareness. Children, along with their parents and sometimes grandparents, visit a booth set up at the farmers market and learn about healthy food choices available at the market. Most often, they are provided samples of foods made with vegetables or fruits from the Farmers Market. Once they finish the educational component of the activity, the children are given vouchers, usually in \$1 or \$5 increments, to spend on healthy foods and vegetables available at the market. It has been surprising to see the varieties of vegetables and fruits the children select; data shows more vegetables than fruits are purchased. The parents or grandparents take the items purchased home and prepare meals for the entire family that are typically healthier than their regular diet has been. Often, they return to the farmers markets and share their experiences and purchase additional healthy items.

Q: Empowering community-level coalitions was an important part of the Healthy Bucks Program. Describe your approach to engaging local stakeholders and building capacity among the 10 coalitions involved in this project.

A: The Healthy Bucks Program was conducted entirely by the coalitions. The AppaPhil team provided resources and tools to help the coalitions develop their individual programs, and they have varied from coalition to coalition. Coalition members engaged volunteers and other stakeholders in the educational activities tied to the Healthy Bucks Program. In many cases, the local extension agencies or health centers were the primary partners with the program. In the three Mississippi coalitions, they engaged the churches that were partners in the Faith Based Healthy Ministry Program to help with the Healthy Bucks Program. In Virginia, the activities were coordinated by the cities or towns in which the Healthy Bucks Program took place, with a broad participation of community people.

On a monthly basis, the regional facilitators and coalition members participated in monthly conference calls, hosted by the AppaPhil team, where they shared their stories regarding the program. This provided a peer-to-peer exchange of information and allowed the coalition members to learn from each other the best practices to implement their programs.

Q: Share with us the greater economic impact and health benefits of the Healthy Bucks Program.

A: In this program the greater economic impact went directly to the farmers. They were paid dollar-for-dollar for each Healthy Buck they received from the participants. While the funding was not in large amounts, it did provide an economic opportunity for the farmers to supplement income. It is anticipated the farmers will continue to be partners in future Healthy Bucks Programs. The program also raised awareness for the farmers markets, resulting in increased business overall.



Health promotion activities hosted by the Healthy Bucks Program in a rural Appalachia farmers market. Photos courtesy of AppaPhil.

The health benefits of this program include the opportunities to have whole and fresh fruits, which have an immediate benefit to the overall health of the human body. Long-term health benefits include behavior change through increased consumption of fresh fruits and vegetables. With the continuation of this program as a family- and community-oriented intervention, behavior changes can translate to generational health changes for this distressed Appalachian population.

Q: In terms of sustainability, share some of the key factors that led to the continuation of this program in some of the communities you served through this grant.

A: Each of the communities selected coalition partners to implement the program. These partners and stakeholders helped to promote the program and gain participation. In many cases, they also gained sponsorship for the Healthy Bucks Program, giving the partners an opportunity to participate by providing time and talent, and also to invest dollars and other resources in the program. All of the coalitions have implemented strategic plans that allow for the continuation of the program.

Q: Describe how the Scioto County Health Coalition—one of the ten communities you served through this project—plans to continue this work through a newly formed nonprofit organization.

A: The Scioto County Health Coalition (SCHC) was formed in 2013 through the nurturing of AppaPhil and the existing Scioto County Diabetes Coalition. SCHC became an Internal Revenue Service (IRS) approved 501(c)(3) nonprofit in 2014 and continues to promote health and wellness for the residents of Scioto County. The new coalition has a broad vision to improve the overall health statistics of Scioto County and recognizes programs, like Healthy Bucks, that provide a broad community-based awareness and impact. It plans to continue the Healthy Bucks Program and has elected to partner with Main Street Portsmouth in this endeavor. The SCHC has both a children and an adult component of the Healthy Bucks Program, and anticipates future sponsorship and grants will allow the program to continue. SCHC also recognizes the benefits of the stakeholders and partners in program implementation.

One of the key factors of success for the Scioto County Healthy Bucks Program was the work of the coalition liaison, Katie Williams. As a member of the AppaPhil team, she was instrumental in building relationships, enhancing resources, and connecting the dots in bringing this program into fruition for the community. She has been actively involved in nearly every event, which took place twice each month from May to October in 2015. While she has taken a full-time position with another employer in Scioto County, she still volunteers her time for the coalition and continues to support activities and programs and plans to be involved with the Healthy Bucks Program in 2016 and beyond.

Special thanks to AppaPhil's Mandy Hart, Katie Williams, Sharon Carver, and Regina Tipton for sharing their time and stories. To learn more about this project, please find contact information on page 25.



(Left) Mona Huff, KRDC community organizer, speaks during the American Diabetes Association's biannual Call to Congress in Washington D.C. (Right) Teresa McGeeney, former KIPDA project manager and co-chair of the Kentucky Diabetes Network Advocacy Committee, meets with Kentucky State Representative Mary Lou Marzian during Diabetes Day at the Capitol.

KENTUCKIANA REGIONAL PLANNING AND DEVELOPMENT AGENCY

Featuring the KIPDA Diabetes Rural Health Coalition
Kentucky

The Kentuckiana Regional Planning and Development Agency (KIPDA) established the KIPDA Rural Diabetes Coalition (KRDC) through this cooperative agreement. A tri-county regional group, KRDC was established to improve the health of people with type 2 diabetes in Bullitt, Shelby, and Henry counties through increasing diabetes resources, diabetes awareness and access to DSME, and smoking cessation classes. The following is an interview highlighting the success of KRDC, in partnership with the Kentucky Diabetes Network, to train local community advocates to effectively communicate to their policymakers about the importance of diabetes education. This effort led to the designation of \$2.6 million for the delivery and coordination of diabetes education through local and district health departments.

Q: Describe how the Kentuckiana Regional Planning and Development Agency (KIPDA) established its KIPDA Rural Diabetes Coalition through this cooperative agreement.

A: KIPDA and the University of Louisville both have a long history of working in the community in various capacities. KIPDA's Division of Social Services, the prime recipient of the grant, coordinates many community-based services for older adults and community members of all ages with disabilities. Through this work, KIPDA had established many relationships prior to receiving this grant with community partners and coalitions who work to promote healthy communities. The University of Louisville's Kent School of Social Work also has experience with working in the community in various capacities, including rural communities. Additionally, the University has

partnered with KIPDA Division of Social Services in several projects prior to this grant. The National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations was a natural funding opportunity for KIPDA because of its prior involvement to promote health in the community among vulnerable populations; and the University's Kent School of Social Work was a natural partner. When KIPDA received the grant in September 2010, three community organizers, who lived in the three counties of focus, were hired to engage current and new partners and stakeholders to build a coalition to address diabetes. These community organizers built a coalition of public, private, and community members who were all invested in addressing diabetes in the community. A number of community-based participatory research methods were used to gain feedback from community members, both those who lived with diabetes, as well as stakeholders in the community and professionals who worked in the field, to guide the strategic plan that led the coalition's efforts.

Q: The advocacy efforts of the KIPDA Rural Diabetes Coalition and community partners resulted in securing \$2.6 million to support diabetes services through local and district health departments. How did the coalition work with state-level policy makers to re-designate those funds?

A: One of the important partnerships KRDC formed was with the Kentucky Diabetes Network (KDN), the statewide diabetes coalition. A large focus of KDN is advocacy, and one of the advocacy goals in recent years was to re-designate funds in the Kentucky state budget for diabetes education. There was a line-item designation in the state budget for the local and district health departments to provide diabetes education, but in 2010 the line-item designation was removed. As a result, what we saw in many of the rural counties, including in two of our own, was a loss of diabetes educators at the health departments. There were no specific funds to support diabetes education and within a year of the line-item designation for the funds being cut, the number of health departments offering diabetes education and the number of counties that had diabetes education available were cut by half. Meanwhile, the prevalence of diabetes was continuing to increase steadily.

In February 2012, Teresa McGeeney, former project manager of the Vulnerable Populations diabetes grant at KIPDA and co-chair of the KDN Advocacy Committee, helped to develop a fact sheet and lead an advocacy effort as a part of KDN's annual Diabetes Day at the Capitol. Kentucky State Representative Mary Lou Marzian, Teresa's state representative at the time, had worked as a nurse and dealt with many diabetes patients for several years. As soon as Rep. Marzian saw the fact sheet, she understood the problem and the need for designated funds for diabetes education. Since she also sat on the Appropriations and Revenue Committee in the Kentucky House of Representatives, she helped to add language into the budget that would designate \$2.6 million per year to local diabetes education efforts. Since this designation was in the budget, a community health educator at the health department serving one of the KRDC counties had seven hours of her time each month dedicated to diabetes education and coalition activities. The health department that serves the other two counties hired a dietician who is currently working to become certified as a diabetes educator. This was truly a grassroots advocacy effort which resulted in more Kentuckians with access to diabetes education.

Q: Share with us some of the diabetes services that are important to rural communities in this region.

A: The Diabetes Prevention Program (DPP), diabetes self-management education (DSME), and medical nutrition therapy are invaluable services that the health departments are able to provide at low or no cost to community members. Diabetes support groups have been established in each of the counties of the KRDC as well. Before the coalition existed in our three-county region, the health department's DSME classes were the only ones available in the county. When funding for diabetes education was no longer available, residents would have had to drive to Louisville for these classes. Only Bullitt County, which is an independent health department, was able to continue its diabetes education after the funding change in 2010. The re-designation of diabetes funds helped sustain DSME, establish DPP programs in the counties, and establish support groups in each of the counties.

2004**2011**

In 2004, **TWO** out of 120 counties had a rate of diabetes of 11.2% or higher.

In 2011, **NINETY THREE** out of 120 counties had a rate of diabetes of 11.2% or higher.

Diabetes fact sheet illustrating the growing need for diabetes prevention and care in Kentucky. Map source CDC, courtesy of KIPDA.

Q: In terms of sustainability, how does the KIPDA Rural Diabetes Coalition envision their role in preserving diabetes services in the communities they represent?

A: KRDC exists as a network of partners and community members who are committed to addressing diabetes in the region. The community organizers, who were funded through the CDC cooperative agreement, were instrumental in building these networks and relationships among coalition members. Because of the coalition, partners, such as the local hospital, primary care physicians, pharmacists, and the health departments, all communicate much more effectively. Prior to the coalition, there was difficulty getting enough people to enroll in the few diabetes classes that did exist. After relationships were built between health care professionals and those organizing and facilitating the classes—and methods were established for health care providers to refer patients to DSME or support groups—these resources were much better utilized by the community. Because of the effectiveness of the coalition in making the most of existing resources and funding, one health department has decided to hire one of the KRDC community organizers part-time to continue to serve two of the KRDC counties, and the other health department has agreed to continue facilitating the diabetes coalition through its health educator on staff. The other community partners and community members in the coalition are equally committed to continuing the coalition and its diabetes efforts. Further, KIPDA has provided evidence-based intervention in the region, including the three counties represented in the KRDC counties, for several years through its Health Promotion and Disease Prevention Program. KIPDA was instrumental in facilitating Diabetes Self-Management Program (DSMP) training for all of the community organizers and several lay leaders during the CDC grant implementation. This has helped to build DSME infrastructure in these counties which will continue post grant, including the provision of additional DSMP training. KIPDA will also continue to support the Peer Mentor Program which originated from the CDC grant and has been successful in accessing the Plan4Health grant which will contribute to continued work by the KRDC.

Q: From this experience, what would you share with community coalitions interested in changing health policies and increasing funding for diabetes services and prevention?

A: Know that increasing knowledge about diabetes does have an impact, especially if you connect to the right legislator who understands health issues. Connecting with a statewide network that had an advocacy history and known presence at the state capitol was critical as well. Having data to demonstrate the extent of the diabetes epidemic in Kentucky, as well as the impact of the change in funding in local services delivered, was extremely helpful to our advocacy efforts and to the legislators who supported us.

Special thanks to Teresa McGeeney, formerly of KIPDA, for sharing her time and stories. To learn more about this project, please find contact information on page 25.



Salud Para La Gente staff hosting one of many “charlas” (chats or conversations) to share health information with Hispanic farm workers in the Pájaro Valley of California. Salud’s diabetes charla includes an overview of the disease such as risk factors, symptoms, treatment, management, and the importance of screening. Photo courtesy of NAHH and blurred to protect identities.

NATIONAL ALLIANCE FOR HISPANIC HEALTH

Featuring Salud Para La Gente
California

Through this cooperative agreement, the National Alliance for Hispanic Health focused on raising awareness, increasing diabetes knowledge, and improving access to diabetes self-management education (DSME) among Hispanics in Phoenix, AZ, Rio Ranch, NM, and Watsonville, CA. The following is an interview featuring a partnership in Watsonville, CA, where Salud Para La Gente, a community health center, is helping to increase access to DSME programs in the local Hispanic community and among migrant farmworkers.

Q: Describe how Salud Para La Gente became involved with the National Alliance for Hispanic Health’s CDC cooperative agreement.

A: Salud Para La Gente (Salud) was selected by the National Alliance for Hispanic Health (NAHH) to serve as one of its three lead agencies for this cooperative agreement because of Salud’s history of successfully reaching the Hispanic community in Watsonville and the surrounding Pájaro Valley with chronic disease prevention programs, as well as the disproportionate level of diabetes among Hispanics in that area. The NAHH and Salud’s common goals of improving Hispanic health, coupled with funding for the Mobilizing Communities to Reduce Diabetes (MCRD) program through the CDC cooperative agreement, was a perfect opportunity for partnership.

Q: Your organization had great success providing outreach to Latino immigrants and farmworkers in your area. Share with us your approach to engaging these community members in talking about health and diabetes education.

A: Salud has strong relationships with local agricultural companies that employ hundreds of Hispanic day laborers



Scenes from around the farms in the Pájaro Valley. Courtesy of NAHH.

to pick fruit (strawberries, blackberries, raspberries) during harvest season. Building on these relationships, we reached an agreement with the companies to deliver short “charlas” (chats or conversations) on selected health topics during the workers’ monthly worker safety meetings right before or after lunch breaks. Salud identified topics that were mutually beneficial to the workers and the companies that employ them. Diabetes was one of the important topics identified to review. The diabetes charla included an overview of the disease such as risk factors, symptoms, treatment, management, and the importance of screening. Local DSME workshops available through the MCRD program were promoted and workers were provided with details on how to enroll.

Salud also took these opportunities to create a deeper understanding of chronic health conditions in the Latino community. Within the diabetes context, Salud shared information with farm workers from a sample of Pájaro Valley residents through the 19-year Community Assessment Project survey of health and other quality of life indicators. To create interest about the risk and impact of diabetes among Latinos, the following 2013 data were shared:

- Mexican-Americans are 50 percent more likely to die from diabetes compared to non-Hispanic whites
- 20 percent of Pájaro Valley respondents indicated that they are told by their doctor that they had diabetes or pre-diabetes
- 75 percent of respondents were overweight or obese
- Overweight and obesity was higher (75 percent) in the Pájaro Valley compared to the rest of the county adults (55 percent)

The agricultural companies scheduled a safety meeting for each crew at different dates right before lunch. This allowed employees to ask additional questions during lunch.

Q: How would you describe the migrant seasonal farmworker population that makes up the majority of the berry farm workers where you conducted your visits?

A: Harvest crews average between 25 and 40 workers, depending on labor availability. Because workers rely on their social networks to obtain a job, there is a high concentration of Paisanos (people from the same hometown) working for the same companies. And while there are workers from Central America, the overwhelming majority of workers are from Mexico. Additionally, in interviewing, a small percentage of college students work harvesting berries because they can make more money in the summertime than at other jobs that pay minimum wage.

There is a high percentage of farmworkers who do not have medical coverage. Most are undocumented, and others believe that workers' compensation insurance is medical insurance. There is also a high percentage of farmworker families that have mixed status in this country. Oftentimes, families believe that obtaining coverage and health care services will hinder them from obtaining documents.

The majority of the migrant and seasonal farmworkers in the Pájaro Valley work harvesting berries (strawberries, blackberries, and raspberries). Broadly speaking, non-indigenous workers harvest raspberries and blackberries, while indigenous workers harvest the back-bending strawberries. While there are a handful of indigenous communities that have been identified—Zapotec, Mixtec, Chatino, and Triqui, among others—Mixtec workers make up between 90 and 95 percent of the indigenous workforce.

When the harvest season begins to slow down, people who do not have documents follow the harvest season to other communities. In our case, most workers move to Santa Maria and Oxnard, California, about a four-hour drive south. This makes regular health care a challenge. The more established farmworker populations, usually non-indigenous, stay in the Pájaro Valley during the off-season. This makes it easier for their children to stay in school. They can receive unemployment insurance benefits and other social services, including Medicaid.

The harvest season can run from April to early November. During the peak season, typically from May to October, workers average 10- to 12-hour workdays. Because of the labor shortage the last few seasons (this season employers I spoke with mentioned a 25 percent shortage), workers reported working seven days a week, particularly harvesting raspberries.

Q: Based on your experience of sharing resources and teaching diabetes management information in Hispanic communities, what are some of the most effective techniques you've used while working with Latino immigrants who are new to the region?

A: In the Pájaro Valley, the techniques that are more effective for sharing resources and teaching diabetes management information with Latinos are:

- Checking in with people's understanding of diabetes
- Having visuals and print material
- Focusing on information people are most interested in
- Providing information in the language of preference
- Offering resources that are accessible to community members

MCRD Program staff delivered about 20 diabetes education presentations through August 2015. Staff established working relationships with five farms in the area and were able to reach about 1,000 farmworkers. The National Diabetes Education Program (NDEP) brochure "Prevenamos la diabetes tipo 2 paso a paso" was distributed during each presentation.

Establishing working relationships with farms is time consuming. We researched the farms that were part of the California Strawberry Commission and the local Farm Bureau. We also tried to identify the title or position of the

person within the farming organization who would be able to work with us. Although meetings get postponed because of the challenges that arise with running an organization, we found that it works for us to work with human resources departments. Human resources departments help us understand how what we are offering benefits their organization and identify the meeting space. Working with operations becomes a matter of fitting into their schedule once human resources determines that the information is mutually beneficial.

Q: In terms of sustainability, how does Salud Para La Gente hope to preserve the DSME classes and outreach that were offered through this project?

A: Salud's relationship with agribusiness will continue to be one of the key strategies to reach Hispanics in Watsonville and the Pájaro Valley on diabetes prevention and management and other important health issues. Salud will continue to do outreach to employees at their place of work and offer diabetes information, diabetes-related Salud services and access to insurance. Juntos en Accion Contra la Diabetes (JACD), the diabetes coalition created through the MCRD Program to implement the diabetes work in the Pájaro Valley, is a formal subcommittee of the Regional Diabetes Collaborative (RDC). JACD and RDC will continue exploring ways to preserve the DSME classes for Hispanics. In the immediate future, the United Presbyterian Church is supplying one staff person and meeting space to offer a minimum of one DSME cohort using JACD's selected intervention, Project Dulce. JACD and RDC will continue to explore other types of support that can be offered to maintain opportunities for DSME in the greater Pájaro Valley.

To learn more about our sustainability efforts, please see Appendix A.

Special thanks to Nicholas Sandoval and Paul Baker for sharing their time and stories. To learn more about this project, please find contact information on page 25.

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APPENDIX A

National Alliance for Hispanic Health Juntos en Acción Contra la Diabetes

Diabetes Sustainability Plan

Funding:

The five-year funding for Juntos en Acción Contra la Diabetes' from the National Alliance for Hispanic Health, as a part of the Mobilizing Communities to Reduce Diabetes Program will end on August 31, 2015. While members have agreed to continue looking for funding opportunities to continue our work, JACD has not secured additional funds before the current funding term ends. Through several planning meetings members have decided that work will continue, in a more limited capacity, with identified partners taking a lead in the strategic area that most closely aligns with their work and capability.

Diabetes Coalition Structure:

The Regional Diabetes Collaborative, a collaborative whose mission is to support, promote and coordinate efforts to prevent and manage diabetes in Monterey, San Benito and Santa Cruz Counties, is the space through which diabetes prevention and control efforts take place in the tri-county area. JACD is one of five RDC committees.

Program Accomplishments:

JACD has accomplished in the following areas outlined in the strategic plan: provider education, policy and consumer education. Our provider education efforts have been focused on keeping area providers updated on changes to diabetes standards of care and upcoming diabetes-focused continuing medical education opportunities. Our policy efforts have been focused on implementing the Healthy Eating Options Ordinance with local food outlets, particularly those used regularly by Hispanics. Our consumer education efforts have been focused on supporting Latinos in the Pájaro Valley to better control their diabetes.

Sustainability:

Through individual and group meetings in April and May of 2015, JACD agreed that the committee was a valuable space to collaborate on efforts to reduce and control diabetes in the Pájaro Valley. The RDC has agreed take a leadership role in facilitating and hosting meetings with JACD members. The RDC will provide space at its quarterly meetings so that JACD can continue advancing issues important to its work, reducing JACD's meeting from monthly to a quarterly basis. JACD members agreed to participate in the RDC meetings. Further, JACD members came to consensus that they will carry over the mission and work of JACD efforts in other local collaborative groups such as Go for Health and Health in all Policies.

Further, the committee agreed that the three strategic areas of work- provider education, policy and consumer education- continue to be relevant and are critical to sustain. Jovenes Sanos will continue to implement the Healthy Eating Options Ordinance by working with local food outlets in offering healthier food options. In the provider education area, the RDC will continue organizing the annual Diabetes Forum, where tri-county area providers can learn the latest on diabetes care. Salud Para La Gente will work with the RDC to increase provider participation. Of the three strategic areas, consumer education is the most resource intensive and, with no current funding, seems the least likely to continue. The United Presbyterian Church offered to continue teaching the diabetes management classes without funding, although no diabetes self-management education classes are scheduled. JACD members will continue to look for funding focused on providing community members access to free diabetes management

education and support.

Next Steps and Conclusion:

On September 8, 2015, JACD will be part of the education committee under the RDC. We will voice JACD's work and efforts in the committee reports section of the RDC quarterly Agenda. Jovenes Sanos will continue implementing the Healthy Restaurant Ordinance and other policy efforts. Provider education will continue on an annual basis at the RDC's Diabetes Forum. Options will continue to be explored between RDC, Salud Para La Gente and the United Presbyterian Church in order to provide a limited number of diabetes management classes.

MAKING THE CONNECTION:

Engaging community partners to address
Type 2 diabetes in vulnerable populations

