This product was developed by the Full Circle Diabetes Program of the Minneapolis American Indian Center and Native American Community Clinic in Minneapolis, MN. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.
Full Circle Diabetes Program

Building Community Supports for Diabetes Care

AADE Annual Meeting
Los Angeles, August 2006
Connie Norman
Full Circle Diabetes Program

- A collaboration between the Minneapolis American Indian Center, Native American Community Clinic and Diabetes Community Council

- Our mission is to build community supports for Native Americans ages 16 to 85 years living in the Twin Cities metro area of Minnesota who have type 2 diabetes
Full Circle Diabetes Program

- On-going Follow-up and Support
  - Framework
    - The Circle Model has promoted effective partnerships between the community center, clinic and council of Elders
    - Strengths of our framework promote OFUS
  - Specific Strategies
    - Clinic-initiated case management
    - Community-initiated talking circles
Strengths of Framework

• Expands program capacity for OFUS
  – Promotes a common mission across several agencies
  – Promotes holistic programming
    • Ensures that services are culturally appropriate
    • Increases variety of services addressing physical, mental, emotional and spiritual aspects of health
    • Patients are empowered to stay connected to programming through a variety of outlets
  – Increases total number of services
    • Increases opportunities for follow-up and support
Strengths of Framework

• Ensures community investment for OFUS
  – Leadership of the Chronic Disease Self-Management Program
  – Talking Circle Facilitation
  – Coordination of Intergenerational Events
  – Active Testimonial Outreach to patients
Strengths of Framework

• Builds trust and accessibility
  – Community-based education opportunities
    • Increases availability of providers
    • Keeps patients / participants connected
    • Encourages patients to seek clinical care when they are ready
    • Multiple entry points into the program
Clinic-Initiated Case Management

• Individualized care
  – Identification of patient specific needs
    • Physical
    • Behavioral
    • Emotional
    • Environmental
  – Development of action plans
    • Builds trust
    • On-going follow-up that promotes patient accountability
Clinic-Initiated Case Management

- Case Management Meetings
  - Engages diverse disciplines
    - Providers
    - Case Manager
    - Dietitian
    - Patient Advocate / Social Worker
  - Provides opportunities to triage patients
  - Fosters proactive care
  - Promotes delivery of consistent messages
Clinic-Initiated Case Management

• Active Outreach
  – Quarterly reminder letters promote timely clinic appointments
  – Referrals support patient specific needs
  – Advocacy ensures patient access to resources
Community-Initiated Talking Circles

- Led by community members living with diabetes
- Culturally appropriate resource
  - Honors the importance of spirituality
  - Builds strength by sharing personal testimonies
    - Provides opportunities to learn from the life stories of each other
    - Reduces barriers to understanding “because we speak the same language and share the same values”
Community-Initiated Talking Circles

• Impact of Chronic Disease Self-Management Program
  – OFUS for participants that have completed the Chronic Disease Self-Management Program
  – Facilitators of talking circles have completed the leaders training for the Chronic Disease Self-Management Program
    • Encourages on-going action planning
Key Lessons

- The Circle Model as an organizational framework promotes both clinic and community-initiated OFUS
- OFUS should be promoted through multiple strategies at the organizational, community and individual levels to best meet diverse patient needs.