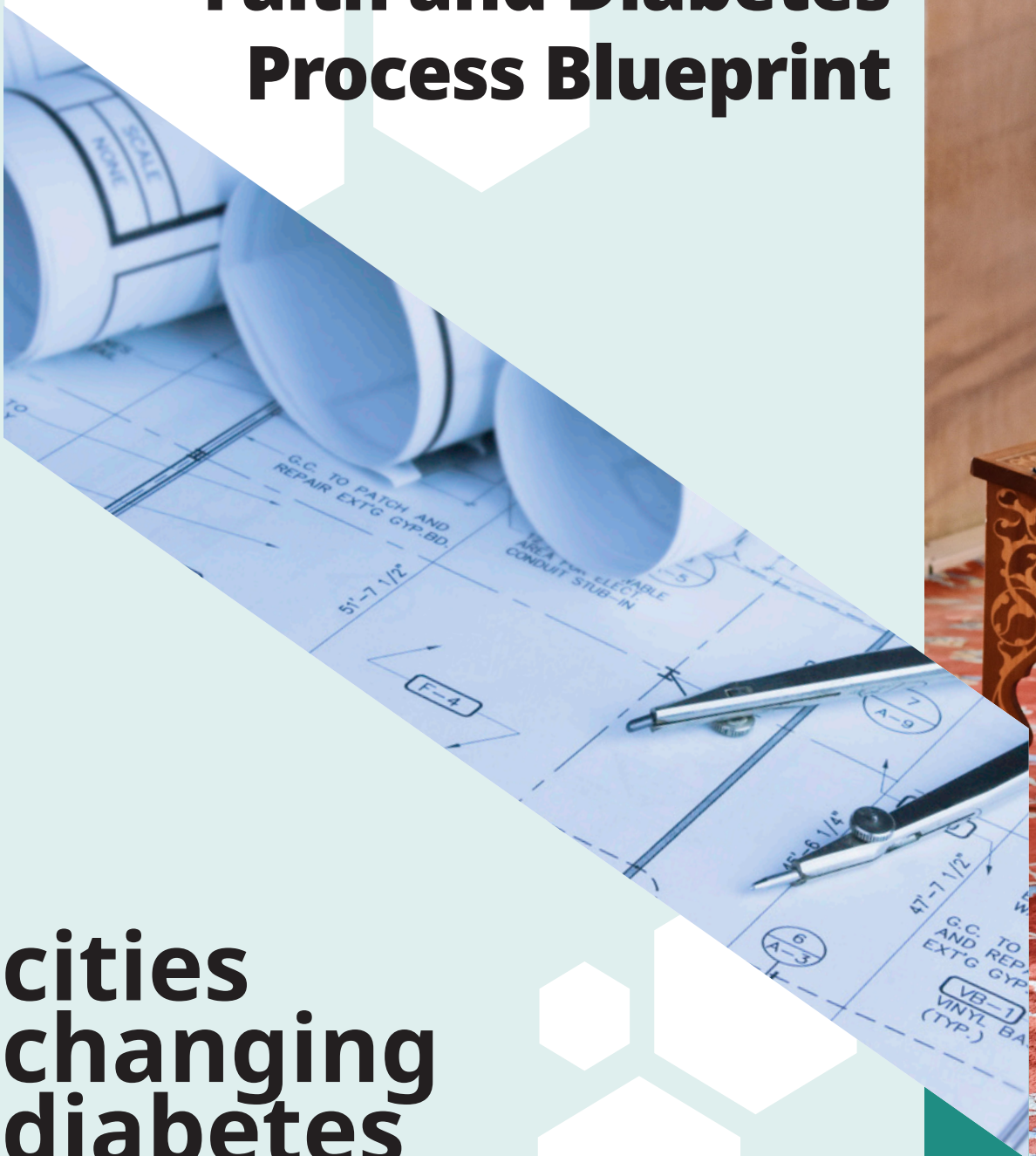
Faith and Diabetes Process Blueprint



cities changing diabetes

Faith and Diabetes Process Blueprint

Preface: How to Use this Blueprint

This Process Blueprint is designed to help your community create your own Faith & Diabetes Initiative. This Process Blueprint serves as a companion to the Houston Case Study, which describes in detail the processes, structures, and decisions that went into designing and implementing the Cities Changing Diabetes - Houston's Faith & Diabetes Initiative. Please start by reading the Houston Case Study.

This Process Blueprint will guide you through questions to consider while you design your own initiative to address the specific needs and wants of your faith community, or group of faith communities. You will find guiding questions in the left column, with lessons we learned in Houston in the right column. We encourage you to use this framework to plan and implement your own initiative – one that reflects your community's beliefs, values, needs, strengths, opportunities, and sense of spirit.

By the time you work through all the sections of this Blueprint, you should have the necessary information to launch your own Faith & Diabetes Initiative, to learn from your experiences, and to continue adapting it for long-term sustainability.

The Houston Faith & Diabetes Initiative has evolved greatly since we first held a Faith & Diabetes Summit in 2016. Through repeated cycles as described in the 2020 published CCD's The Urban Diabetes Action Framework, Faith & Diabetes has become a community-based program that supports Houston faith communities in their efforts to counteract diabetes and obesity.

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The document was developed by individuals with three distinct perspectives on Cities Changing Diabetes: the program lead from a backbone organization for the initiative, the local stakeholder engagement consultant to Cities Changing Diabetes, and a university researcher with a health services research background.

Working with houses of faith and other stakeholders in Houston has been extremely meaningful to us, and we hope that you will experience the same. This work is hard, it requires patience, and it requires heart. We wish you and your community all the success in the world!

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Faith and Diabetes Process Blueprint

Houston Context

This Blueprint came out of work started by Houston stakeholders in Cities Changing Diabetes (CCD), a global health initiative based on a unique public-private-community partnership partnership helps communities understand their unique diabetes challenges, identify areas and populations at greatest risk, and design and implement targeted solutions. The program brings together medical and public health institutions, communities of faith, employers, insurers, and non-profit organizations.. Houston, the 3rd city globally to join Cities Changing Diabetes, launched the first Faith & Diabetes Initiative within the CCD global effort. The stakeholders identified religious affiliation as a leading characteristic of the Houston population, and faith organizations as prominent institutions in the social fabric of the community. As part of Cities Changing Diabetes, the Faith & Diabetes Initiative was funded by Novo Nordisk with significant in-kind support from the Institute for Spirituality and Health at the Texas Medical Center as well as TMF Health Quality Institute. Research performed by UTHealth School of Public Health was sponsored by the Robert Wood Johnson Foundation. The Faith & Diabetes Initiative was designed to dovetail with other high priority action areas in Houston's CCD initiative.

We are grateful for the support from Novo Nordisk, Robert Wood Johnson Foundation, the Cities Changing Diabetes Houston Core Team and numerous clergy and layleaders as well as program participants and their families.

Houston Diabetes Peer Support Program

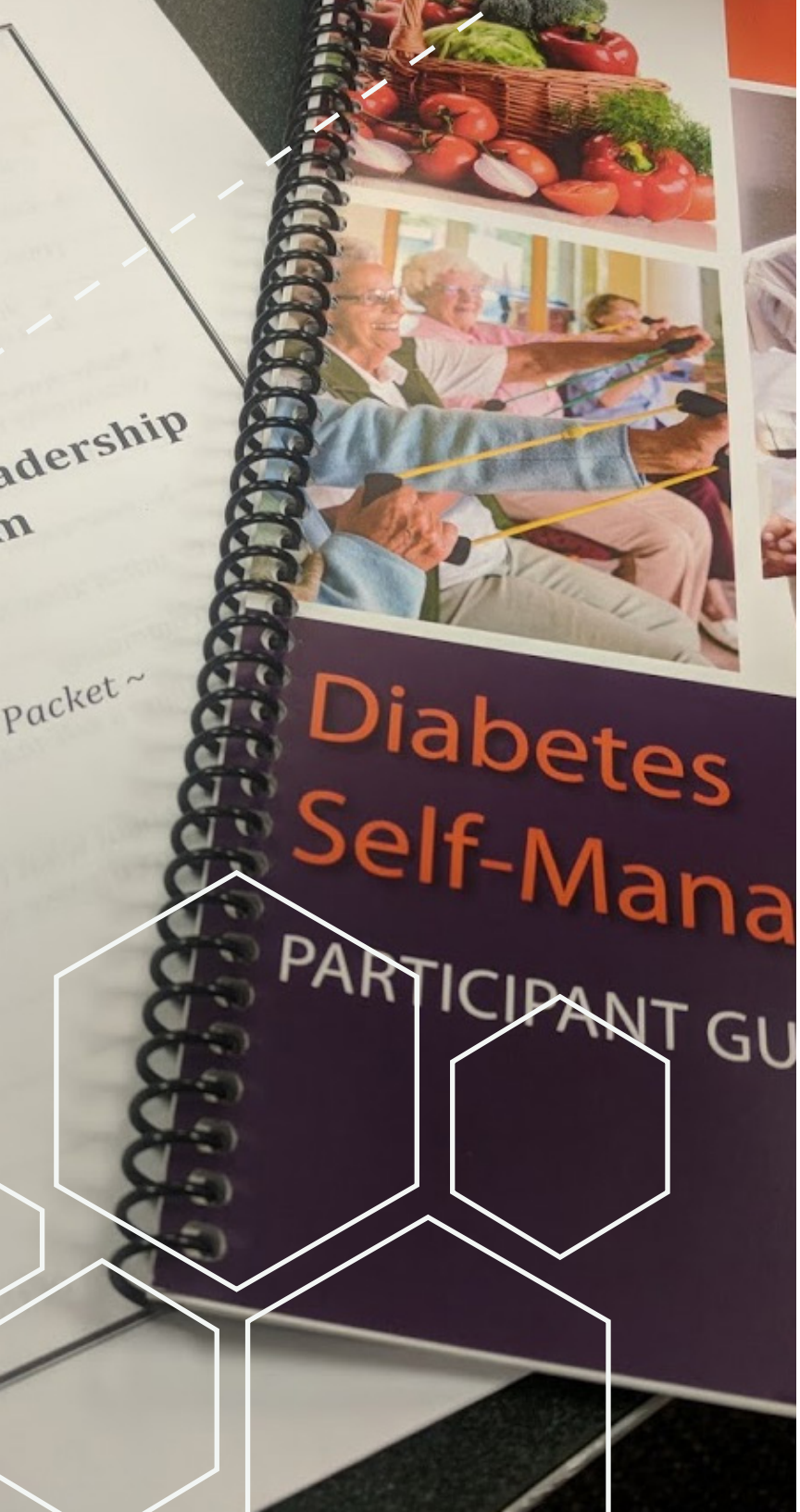
MyDiabetesHQ, an online service platform "Helping people with diabetes thrive, not just survive."

My Diabetes HQ Live!, a weekly talk show simulcast via YouTube and Facebook.

Bite of HOPE, a place-based model to improve local food systems.

A disaster management plan for the local population with diabetes.

A collaborative of employment-based diabetes prevention programs.



Overview of the Guiding Questions for Faith and Diabetes Initiatives:

These overarching questions are designed to help you think through the major aspects of developing your Faith & Diabetes Initiative. They act as the section titles in this document, and they are complemented by the sub-questions in the left column of each page. Additionally, they closely parallel the CCD Urban Diabetes Action Framework for designing and implementing a city-wide diabetes initiative, and you should refer to that resource in addition to these guiding questions.

1. ***What is the context for our work?***
2. ***How will we make this a Faith and Diabetes initiative & not just a diabetes initiative?***
3. ***What are our community's needs & what resources do we have to address those needs?***
4. ***What programs can we adapt to serve our needs?***
5. ***What are our goals & how will we know when we've reached them?***
6. ***How will we use new information to improve our program and share our story with others?***

GUIDING QUESTIONS

A Why do we want to do this work?

B What do we know about diabetes vulnerability and the community context?

C What experiences has our community had with health promotion efforts?

D Who needs our help when it comes to obesity and diabetes?

What is the context for our work?

Cities Changing Diabetes uses a "Map, Share, Act" model. The "mapping" component focuses on understanding the context of the work - What currently exists? What is happening right now? In order to build a narrative around an initiative, it is important to "set the stage." Context is also important when making key decisions about how to move forward.

Community characteristics, culture, and values shape the landscape for creating innovative programs, so it is useful to understand features of your community before you start looking for solutions. The "community" that hosts this initiative may be a city, county, town, neighborhood, single congregation, or any other community with shared interests in addressing the growing diabetes epidemic. The only thing you need to embark on this journey is a determination to enhance the health and well-being of your community and an open mind to thinking creatively about connections between faith and health.

Houston's Lessons Learned

Please read the Houston Case Study for details about how stakeholders in Cities Changing Diabetes assessed the diabetes vulnerability in Houston and chose Faith & Diabetes as a central facet of our efforts to address the needs of particular groups most affected by risk for diabetes.

In working with volunteers from many different faith organizations, we found that:

- Some faith organizations initially thought of Faith & Diabetes as a means for doing outreach in their neighborhoods, and were surprised to discover just how prevalent diabetes was inside their existing community.
- Some communities view diabetes as an inevitable disease because it is so common amongst family and friends, so it seems futile to them to participate in a prevention initiative.

GUIDING QUESTIONS

E What are important characteristics of our faith community? Consider many different factors in addition to size of community and faith affiliation.

F How ready is our community for implementing a change?

G How ready is our community to work with new partners?

Houston's Lessons Learned: The Context for Our Work

- Diabetes is seen in some communities as a shameful secret kept even from family or close friends. The stigma of having diabetes meant that members of faith communities were sometimes reluctant to self-identify as having diabetes, and were reluctant to participate in a group.

- Many faith organizations had organized and offered their own health programs in the past, and were eager to build on those successes. However, when outside groups had brought health promotion projects into the faith communities it had not gone well, and the communities felt exploited by outsiders. Some faith groups were therefore skeptical about the Faith & Diabetes Initiative, suspecting that "outsiders" providing health information might have an ulterior motive, or might be gaining financially from offering the DSMES classes.

- Many participants in the Houston initiative had received diabetes education from trained clinicians, but found that not helpful because they felt like they were being lectured or scolded. They found learning with peer educators from their own communities more effective because peer educators share and understand the personal lives of the DSMES class participants.

- Some volunteers who trained as peer educators encountered resistance from members of their faith community, who disputed the right of peer educators (non-clinicians) to lead diabetes self-management education classes.

- Volunteers from faith organizations were more confident about their community's readiness for change before they launched their initiative than they were after they had organized and taught a diabetes self-management education and supports (DSMES) class. This may indicate that we all underestimated the complexity of the endeavor, the amount of work or time involved, or the degree of support they would receive from their faith community.

GUIDING QUESTIONS

A Are we thinking about faith communities as "just another setting," or are we drawing upon the uniqueness of our faith communities to enrich the initiative?

B How will we keep faith central in all phases of the work?

C What sacred texts, foods, rituals, people, symbols, and places in our faith traditions are relevant to this work?

How will we make this a Faith & Diabetes initiative, not just a diabetes initiative?

"Diabetes" is only half of the equation in a "Faith & Diabetes" Initiative. Because organized responses to chronic diseases are most often managed by health systems, it is easy to forget the value and uniqueness of working with and within communities of faith. By elevating the conversation to include a real focus on what communities of faith bring to the table, an ordinary initiative can be transformed into one filled with the richness of religious traditions.

Houston's Lessons Learned

Read the Houston Case Study to learn how Houston stakeholders engaged diverse faith communities in defining the focus and scope of the initiative and weaving faith into all aspects of the initiative.

- Workgroup members felt it was essential to ensure that the Faith & Diabetes Initiative kept the spiritual component central to the initiative, rather than using faith communities as "just another delivery site" for health promotion programs. We recognized early on that faith communities are special because of their unique ability to bring communities together around shared beliefs, values, practices, cultures, and histories. In other words, the Faith & Diabetes Initiative shouldn't forget the faith part of the equation. To celebrate and lift up faith, its role in the process was considered at every level of planning.

GUIDING QUESTIONS

D How are we engaging our faith leaders (clergy and lay leaders) in all aspects of our planning, recruitment, teaching etc.?

E What does our tradition say about health, healing, and the body?

F How is news spread amongst members of our community? Who can help us use these channels?

Houston's Lessons Learned:
Make this a Faith & Diabetes initiative

- For example, Action Workgroup (AWG) meetings began with moments of prayer and silent reflection, allowing attendees a moment to set an intention in ways that reflected their respective beliefs and practices. Additionally, visits by the team were scheduled with participating houses of faith in order to make sure that the Action Workgroup as a whole was aware of where fellow participants were coming from, and knew what the communities were like "on the ground." This type of visit helped to provide an undercurrent of cultural awareness and mutual respect, and is highly recommended in any Faith & Diabetes Initiative.

- The AWG decided to devote an entire module of the Congregational Health Leadership Training to "religious studies," where the group shared with each other their most important beliefs, practices, texts, rituals, times of year, people, foods, etc. A homework packet was assigned, asking the participants to complete a full inventory of the "elements of faith" present in their traditions. Each participant gave a presentation, allowing them to give a history of their faith community and explain why they felt at home there.

- Another dimension of this section of the training was a unit on types and goals of interfaith dialogue. This helped to "set the stage" and ensure that everyone knew that we weren't simply coming together as people interested in diabetes, but that faith was a shared pillar for participants across traditions. Beyond binding the group together through interfaith understanding, these activities helped participants be creative about how they were going to see faith and health as interconnected.

- Finally, in terms of content delivery, trainees were encouraged to "wrap" their health programming in the language of their particular tradition. Education or peer support sessions, for example, often drew upon scriptures or familiar stories in order to support the messages that were being relayed.

Houston's Lessons Learned:
Make this a Faith & Diabetes initiative

- In working with faith communities, we discovered that bringing people from different traditions together was beneficial as participants discovered that they shared some important beliefs. They felt better understood and supported by people of other faiths than they had before.

- Many forged bonds across faiths and supported each other in their health initiatives. Shared beliefs included:

  - Daily actions are part of spiritual practice, and spiritual beliefs guide all aspects of daily life.
  - One's body should be kept healthy as a spiritual vessel.
  - Fasting at particular times is an important practice in many faiths.
  - One has a spiritual duty to care for others, especially those in need.
  - Specific foods are associated with specific times of year, events, or celebrations.
  - Prayer, meditation, or reading sacred texts were shared strategies for dealing with the stress of illness or coping with the complexities of daily life.

GUIDING QUESTIONS

A Have our faith leaders "bought into" the program? How can they support the program?

B Are there lay leaders or other community members who have special skills that they can contribute?

C How does Faith & Diabetes build on existing health ministry activities (health promotion and education programs such as health fairs, classes, lectures)?

D Are we including the perspectives of people living with diabetes as we plan?

What are our community's needs and what resources do we have to address those needs?

Implementing change in any setting can be very complicated. In planning a health initiative, it helps to think through in advance exactly what strengths already exist in your community (or "communities," if you are working to bring together multiple houses of faith) and what barriers you might encounter while planning and implementing a program. Identifying barriers helps to identify needs.

"Resources" is a broad category that includes tangible things like funds, supplies, and meeting space, as well as intangible things like experience, skill sets, knowledge, and time. A careful inventory of available and needed resources at the outset of an initiative, as well as a consistent reevaluation of how resources are being used will help to ensure sustainability.

Houston's Lessons Learned

Read the Houston Case Study to learn how Houston stakeholders identified diverse resources in the community that could be leveraged for the Houston Cities Changing Diabetes.

In working with faith communities, we learned:

- Stakeholders in Houston thought our abundance of faith organizations could provide physical space for this initiative. We discovered that space in many faith organizations is fully booked a year or two in advance. However, when the physical space was not as available as anticipated, faith communities provided a great community setting even when they had to find other venues for their DSMES classes, such as public schools, public libraries, and community centers.

GUIDING QUESTIONS

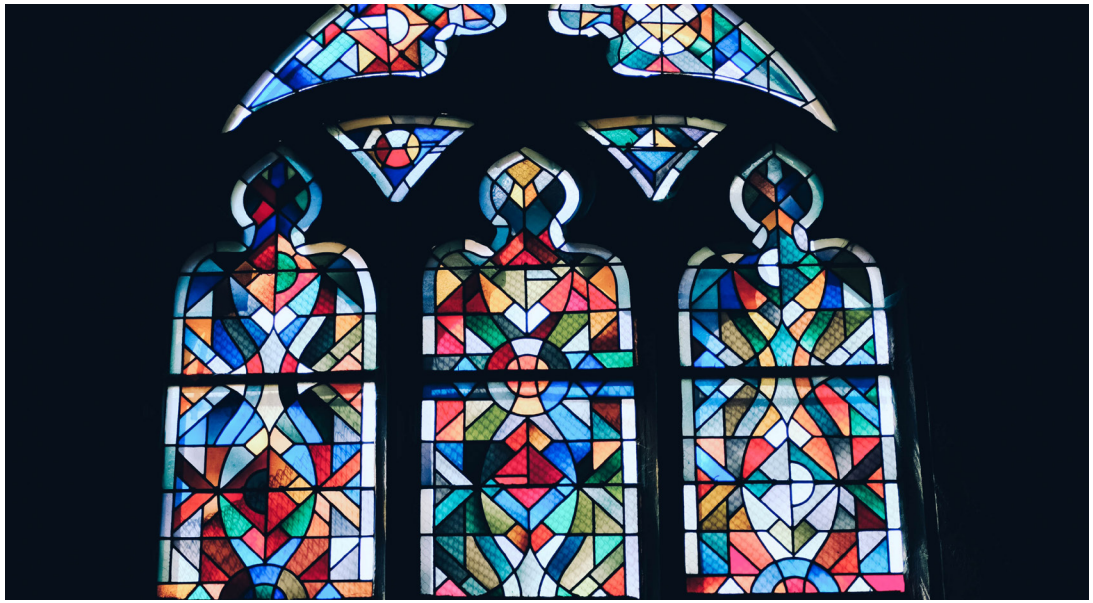
E What time constraints need to be considered?

F Where will activities be held and what space is available (virtual, in person, at faith community, elsewhere)?

G What existing relationships do we have with organizations that might provide information, collaborations, or other resources?

Houston's Lessons Learned:
Needs and Resources

- Large organizations with strong leadership were not the best venue, as people from smaller faith organizations felt their interests and voices were overshadowed by the larger group.
- Finding a neutral, non-affiliated "backbone" organization was essential for everyone to feel comfortable and heard. This role was filled in Houston by the Institute for Spirituality and Health at the Texas Medical Center, a non-denominational, unaffiliated non-profit organization.
- Although volunteers were the mainstay of the Faith & Diabetes Initiative, having at least one salaried coordinator was essential for maintaining coordination, communication, and record keeping.



GUIDING QUESTIONS

H What communication networks are available?

I What gaps exist in funding, knowledge, and time, and how might they be filled?

J Does our Faith & Diabetes Initiative require any additional funding? If so, what is our plan to acquire that funding?

Houston Lessons Learned:
Needs and Resources

- It is critical to recruit people from the community to lead Faith & Diabetes DSMES classes, because they are trusted by their community members, who find peer-led discussions more effective than ones led by clinicians.
- Time is a vital and scarce resources, as demands on time (jobs, family, health issues, and unexpected events) will compete with time people can spend on this initiative. This was the primary reason for trying to get 2 or more volunteers from each organization so they could be each other's backup.
- Trainees brought a valuable depth of knowledge about the unique circumstances that define their traditions and community life. Those who reside outside of their communities do not and cannot have access to this knowledge, which is largely experiential and subjective.

GUIDING QUESTIONS

A

Which aspects of obesity and diabetes risk in our community do we want our program to address?

- Preventing obesity through policy and changes to the built environment?
- Preventing prediabetes from turning into diabetes?
- Boosting diabetes knowledge and self-management skills among people already living with diabetes?

B

Are we most interested in helping certain age groups, people with pre-diabetes, or people currently living with diabetes?

What programs can we adapt to serve our needs?

Now that you have considered the wider context of the work, the role that faith will play in your work, and what needs and resources are involved, it is time to ask yourself – "What exactly are we going to do?"

Importantly, a Faith & Diabetes Initiative should build upon existing, successful evidence-based solutions as much as possible. Using solutions that have already been tested and have shown they can be effective allows a program to build upon others' work while simultaneously making room for creativity and innovation. Evidence-based best practices provide a coherent narrative that participants, stakeholders will trust. Balancing evidence-based processes with community insights, stakeholder engagement, and creative thinking about solutions is a recipe for success.

Houston's Lessons Learned

Read the Houston Case Study to learn how Houston stakeholders selected a program focus and engaged other groups in collaborating in our initiative, often with in-kind contributions to the effort.

In Houston, we learned that:

- We were most successful in engaging stakeholders, volunteers, program participants, and collaborating organizations when we built upon their respective interests, experiences, and expertise, and forged a collective effort in Faith and Diabetes.
- It is best to adapt existing programs rather that building something from scratch. We were able to be creative and meet the unique needs of our participants while also using an existing program as a foundation.

GUIDING QUESTIONS

C What programs have already been developed and used successfully in other places and how strong is their evidence about how and why those programs worked? Can we adapt them for our use?

D Which program providers already exist in our community and have experience partnering to provide the type of obesity or diabetes program we're interested in? Can we call upon them for help?

E Which program can be feasibly adapted to our community needs, taking into account costs, time commitments, appeal to potential participants, likelihood of garnering leadership support, credibility among potential funding sources?

Houston's Lessons Learned:
Programs to Adapt

- Many program providers (public health agencies, healthcare providers, universities and nonprofit organizations) are eager to work with communities of faith on health promotion project. It is important to work with organizations that match your community's interests and needs. For instance, in Houston we wanted to build a community-driven program to address two goals:
  - Train volunteers from houses of faith as peer-educators to facilitate diabetes self-management education and supports (DSMES) in their communities of faith.
  - Provide communities of faith with information about sustainable prevention projects that they could implement in their own communities, such as community gardens, walking trails, healthy cooking classes.
- Many groups had already implemented independent programs to address diabetes in Houston and members of those groups were key members of the CCD Action Work Group. They contributed important input to the initial design phases of Houston Faith & Diabetes. Equally importantly, they contributed their knowledge and existing connections.

Houston's Lessons Learned:
Programs to Adapt

- Many different DSMES programs exist, but most required too much time or were cost prohibitive for faith communities. Through connections provided by the CCD Action Work Group, we established a key partnership with TMF Health Quality Institute, which provided free peer educator training using an condensed Gateway Laredo DSMES curriculum and training materials that they with thousands of people across 5 states in the United States. Because TMF Health Quality Institute could collect data about the DSMES class participants as part of their contract with Medicare (federal public health insurance for people over age 65), TMF Health Quality Institute could offer training and materials to our faith communities at no cost for the first year of our initiative.

- Local public health departments can be important allies. For prevention projects, CCD Action Working Group members from the Houston Health Department and Harris County Public Health Department partnered with us to provide training and free resource materials for faith communities to use in starting their own community-based prevention projects.

GUIDING QUESTIONS

A What are the goals of this initiative? To share knowledge, inspire action, or inform policy? Be as specific as possible.

B Are the project volunteers involved in the goal setting process?

C Are the goals realistic and attainable?

D How might our goals change over time?

What are our goals and how will we know when we've reached them?

Realistic, achievable goals help to drive an initiative forward and provide stakeholders with a common point of reference when considering where to go next. Furthermore, setting a series of goals allows for success to be celebrated along the way, which serves as motivation to keep moving forward. Goals that are too easy to achieve will result in outcomes that do not reflect the collective potential of stakeholders. Goals that are too difficult may not ever be achieved, which frustrates earnest efforts for change. It may be helpful to think of goals as "tiered" - with broad goals serving as a foundation, and more specific goals acting as guideposts along the way.

Documenting your experiences is an important part of implementing a Faith & Diabetes Initiative, just as it is in any health promotion project. Only when you document what you have done and what has changed will you be able to know if your community has achieved its short and long-term goals. That information is also essential for figuring out what you might change in the future to engage more people, obtain even better results, or inspire others to embark on a similar journal.

Houston's Lessons Learned

Read the Houston Case Study to learn how Houston stakeholders identified short and long term goals, and documented progress towards their goals.

- Our primary goal was to equip volunteers from diverse faith communities with knowledge, tools, and a supportive network so that they could advance a culture of health within their faith organizations.
- At the onset, our focus was on helping people living with diabetes and providing them with tools and resources to better manage their disease.

GUIDING QUESTIONS

E Are there some goals that we can achieve in the near term, to provide experience and feedback?

F How do our short term goals fit together with our long term goals?

G What aspects of our program can we count, observe, or converse about? How do we plan to do this for:

- Processes?
- Outcomes?
- Satisfaction?

Houston's Lessons Learned:

Reaching Our Goals

- We quickly found that people were overwhelmed with a "buffet" of project possibilities at the outset. In other words, we started with too many goals! We quickly realized that our goals were too ambitious, and we narrowed our focus after the pilot group so that subsequent training focused trainees' time and effort on simpler shared, tangible goals.

- Counting process measures seems like it should be easy, but how we count depends on what we are trying to find.

- Different groups involved in this project were interested in recording different information. We found that it was very challenging for participants in Faith & Diabetes to record measures of process, outcomes, knowledge, or habits, even though health promotion professionals usually consider those measures as essential to any program.

- Individuals' quotes and anecdotes expressed the value of the program and changes participants had experienced much better than any numerical measures could. For example, one team was dismayed to have only one participant, until she recounted the significant health scare she had the previous month because she had never understood what was happening when her blood sugar was very high, or what she should do about it. They realized what a profound impact they could have on one person's life.

- TMF Health Quality Institute, which provided peer educator training, tracked data about the DSMES class participants as part of their contract with Centers for Medicare and Medicaid (federal public health insurance for people over age 65). It was beneficial to use the evaluation metrics approved by the federal government.

GUIDING QUESTIONS

H

What kinds of evidence are the most convincing? How might we measure changes in:

- Knowledge about diabetes & healthy practices?
- Attitudes about living with diabetes and utility of prevention activities?
- Daily behaviors that can add up to better health, such as walking regularly, asking for help, or incorporating healthy eating habits?
- Physical outcomes, like A1C test results, bad cholesterol and high blood pressure?

I

Does the evidence based program we are using or adapting have existing evaluation methods and metrics we can use?

Houston's Lessons Learned:

Reaching Our Goals

- In our case, TMF Health Quality Institute recorded data only for the participants over age 65. These focused on knowledge about diabetes and healthy practices, attitudes about living with diabetes and utility of prevention services and changes in daily behaviors to improve health.
- By comparison, other partners in the initiative wanted to count the total number of people who participated at all, regardless of age or insurance eligibility, and also wanted to consider the ripple effect of teaching a small group who then shared that knowledge with family members and friends, greatly expanding the "reach" of the program.
- Peer educators and participants felt most comfortable recording their testimonials or photo-journaling to document their experiences and important changes in themselves and their communities. They also felt that it was the most meaningful way to share their experience with others.
- We learned that destigmatizing data collection is an important step in empowering all participants in the initiative to consider evaluation measures and their value to sustaining their projects.
- We underestimated the amount of time and resources needed both to collect and evaluate data about the program processes and outcomes.
- In a project like ours, where volunteer efforts and "in-kind" contributions were heavily relied upon, it was very difficult to get necessary resources (expertise, funding, time) to complete a thorough evaluation of all the information we obtained. We learned that project planning needs to designate resources and expertise that will be devoted specifically to data analysis and full evaluation.

GUIDING QUESTIONS

A **How are we going to use the information about our experiences and outcomes to improve what we are doing?**

B **What purpose will we have in sharing our story?**

- Obtaining feedback?
- Engaging more members of the community?
- Securing funding for continuing our initiative?
- Providing information for other people to use as a model in starting their own initiatives?

C **How can we best tell our story to each audience?**

How will we use new information to share our story and improve our initiative?

Every initiative can be thought of as a cycle - from brainstorming to implementation to evaluation to refinement and back again. A program that does not continuously evolve is at risk of becoming irrelevant and stagnant. Having a system in place to share experiences and collect feedback and improvement suggestions will help an initiative stay current and attuned to the ever-changing landscape of chronic disease prevention.

Houston's Lessons Learned

Read the Houston Case Study to learn how the Houston Faith & Diabetes Initiative recorded important facts about each stage of our initiative, how people shared their narratives, and how we used that information to improve out initiative.

- Many things did not go exactly as we initially planned, even though a lot of thought and work had gone into the planning

Houston's Lessons Learned:
Share Our Story & Improve

- We found it helpful to ask ourselves and all participants to comment regularly on what had worked well for them and their communities, what had not worked well for them, what had surprised them, and what they would like to include in future versions of the program.

- People were most comfortable sharing their stories with each other in person, so we held regular reunions so that people could share their experiences, reconnect with other people, and get ideas about ways to improve their own initiatives.

- It was important to celebrate successes, as well as to take time to share frustrations. The regular meetings, organized as pot luck dinners, provided a good opportunity for people to get re-energized, as well as to provide a forum for collective problem-solving.

- Although we provided a template and technical support for people to write news articles to share with members of their faith communities through their faith organization's Facebook page, printed bulletin, or as a poster, people preferred the social interaction of face-to-face meetings over written materials.

- Participants who completed DSMES classes were eager for an on-going connection with other people living with diabetes. This fed into another one of Houston's CCD projects - peer support groups. The intersection of the Faith & Diabetes Initiative with the other projects in Houston's CCD participation have been key to the sustainability of the Faith & Diabetes Initiative.

Faith & Diabetes Process Blueprint

Congratulations! Now that you have worked through this Blueprint, you are ready to embark upon your Faith & Diabetes journey. We hope this document has provided you with helpful guidance as you and your partners consider ways to help members of your community holistically prevent and manage chronic disease as part of the daily walk through life and faith. As you take on this difficult but rewarding work, please share with us your experiences so they can inform the future of the Faith & Diabetes movement.

To stay updated with Faith & Diabetes, please visit FaithAndDiabetes.org and email info@FaithAndDiabetes.org to get on the mailing list so you don't miss upcoming webinars, tools and publications.

To share and otherwise engage with the authors of the Faith & Diabetes Blueprint, please write to:

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