An Academic-Community Engagement: A Roadmap for Developing a Culturally Relevant Diabetes Self-Management Program among Vietnamese Americans

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ABSTRACT

Recognizing and addressing culture-specific differences concerning diabetes self-management education and support (DSMES) programs can potentially increase participation among Vietnamese Americans with type 2 diabetes and improve health outcomes. This paper describes the academic-community engagement process used to seek input from the Vietnamese community of Oklahoma to tailor a DSMES program. The Community Engagement Continuum (CEC) (CDC, 2011) was utilized as a conceptual framework to engage with the Vietnamese community. The academic team assembled a community advisory board (CAB) of stakeholders, who were selected to advise the team on intervention development; elicited community feedback; and integrated recommendations to tailor the DSMES program. Twenty-three CAB members participated in a minimum of three community engagement meetings over six months. Meetings were structured to elicit feedback and suggestions to ensure that the tailored program was embedded in Vietnamese cultural practices and accounted for community resources and needs. CAB members identified that education and resources must be provided in the Vietnamese language with special attention to culturally relevant adaptations concerning healthy eating and medication adherence. Application of the CEC framework facilitated the inclusion of Vietnamese community perspectives and beliefs, the identification of potential collaborators, the establishment of trust and relationships, and the development of a culturally relevant DSMES program. This engagement process may serve as a model for other underserved minority populations to develop culturally appropriate health promotion and disease prevention interventions.

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The prevalence of type 2 diabetes (T2D) has been continuously on the rise among Vietnamese adults in the U.S. and in Vietnam (De Souza et al., 2022; Pham & Eggleston, 2016). Type 2 diabetes is a chronic disease that requires lifestyle management to maintain adequate glycemic levels and to prevent or delay the onset of complications. Uncontrolled diabetes is a risk factor for the increasing disability rate and decreasing health-related quality of life among Vietnamese patients with diabetic complications (Pham et al., 2020). Evidence indicated that diabetes self-management education and support (DSMES) programs lower hemoglobin A1c level, prevent diabetes complications, and decrease healthcare costs (Powers et al., 2020). Clinics and hospitals offer DSMES programs, but they remain inaccessible and inappropriate for Vietnamese Americans (VietAmericans), largely due to language barriers and cultural differences.

Community-based processes have been demonstrated to be a critical step in developing sustainable and successful DSMES program among African American and Latino adults (Two Feathers et al., 2005). Other studies have used the community-based participatory approach and engaged with the community to develop promising culturally targeted diabetes management interventions among Native Americans and Alaska Natives (Jernigan & Lorig, 2011), the Marshallese community (Yeary et al., 2017), and the combination of African American, Filipino, and Vietnamese communities (Gilmer et al., 2005). Diabetes self-management education has been shown to improve knowledge, self-efficacy, and self-management behaviors among Spanish-speaking individuals (Smith-Miller et al., 2016). Attention to linguistic and cultural factors may render interventions that better optimize glycemic control and self-management in VietAmerican communities. Evidence shows that VietAmericans value traditional health practices as they prefer to maintain practices with which they are most familiar (Nguyen, 2014) and desire for a DSMES program to be offered in the Vietnamese language (Truong et al., 2011). Many VietAmericans living with T2D receive informal education from family, friends, and others diagnosed with diabetes for knowledge and decision-making around self-care. Without formal DSMES available in the Vietnamese language, knowledge gained from informal education may negatively influence self-care behaviors. Thus, developing a culturally and linguistically relevant intervention with community input would better facilitate adoption and participation and improve diabetes self-management behaviors.

To gain valuable insight from the VietAmerican community of Oklahoma, community engagement is critical in fostering relationships between academia and the community. Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, a particular special interest, or similar situations to address issues affecting the well-being of those people (CDC, 2011). Furthermore, community engagement with immigrant populations requires regular interactions with these populations to seek input and interpret information, and involves them at the forefront in dissemination of activities (Turin et al., 2020). Despite widespread application of the community engagement framework in culturally diverse and disadvantaged communities to improve health outcomes (Cyril et al., 2015), there is no literature on academic-community partnerships with the VietAmerican community with the effort to develop diabetes self-management education and support for this specific population.

Academic-community partnerships enhance the acknowledgment and development of respect for differences in behavior practices, preferences, and opinions (Williamson et al., 2016). Academic-community engagement with the VietAmerican community allows the academic team to become part of the community and the community representatives to become part of the academic team, creating a unique working environment for partnered research. This paper describes the community engagement processes and procedures used to seek alignment and collaboration with Vietnamese community partners throughout Oklahoma and the resulting adaptations of a DSMES program.

In fulfilling the purpose of this academic-community engagement project, the academic team established a formal community research partnership with the Vietnamese community, using community-based participatory approaches to engage Vietnamese health care providers, community leaders, adults diagnosed with T2D, and their caregiver partners to achieve the following objectives:

1. Create a community advisory board of key stakeholders within the Vietnamese community of Oklahoma, selected to advise the academic team on program development.
2. Tailor the DSMES program to best address the cultural needs of the community and translate resources/materials into the Vietnamese language.
3. Develop the infrastructure for program implementation and plan for a pilot test to evaluate the acceptability and feasibility.

METHODS

APPROACH

The academic team comprised three faculty members and a doctoral student from the University of Oklahoma Health Sciences Center College of Nursing and College of Pharmacy. Among these faculty members, two have been serving as members of the Asian Health Coalition for more than a decade and one of these is a Vietnamese woman who speaks Vietnamese fluently. In addition,

one faculty member on the team has been conducting community-based participatory research in partnership with marginalized communities for more than a decade. To situate our positionality and power in this project, our team identified our own degrees of power through factors of race (one faculty member was Vietnamese; two faculty members were white; the doctoral student was African), class (all were upper middle), education attainment (all had earned doctoral degrees or were in the process of doing so), gender (all were female), and citizenship (one had immigrated to the United States as an adult). Taking a reflexive approach was central to our goal to create an environment in which authentic bidirectional learning could occur in sessions with VietAmerican community partners. Hereafter, "we" will refer to the academic team. We aimed to elicit input to help us shape a Vietnamese DSMES program and ensure that this intervention responded to the community's needs. Recognizing the importance of inclusivity, we incorporated a process to extend engagement opportunities for community members with different areas of expertise, various cultural experiences, and community roles and responsibilities. The ultimate goal in partnering with the Vietnamese community of Oklahoma is to develop a culturally and situationally tailored intervention embedded in the cultural practices, community resources, and relevant supportive needs among VietAmericans living with T2D. This project was reviewed by the academic institution's Institutional Review Board who determined that it did not constitute research.

RECRUITMENT AND ESTABLISHMENT OF A COMMUNITY ADVISORY BOARD

In order to assemble a comprehensive CAB who could contribute cultural knowledge, expertise, and lived experiences, the academic team initially collaborated with the president of the Vietnamese-American Community in Oklahoma City and the Metropolitan Areas and the Oklahoma Asian Health Coalition, who assisted in forming a 23-member CAB. Purposive approaches were used to identify participants as community representatives from each organization to participate. Eleven organizations were invited to co-influence program development. These organizations include the Asian District Cultural Association, Vietnamese-American Community in Oklahoma City and Metropolitan Areas Association, Asian Health Coalition, Vietnamese Catholic churches, Vietnamese Baptist churches, Vietnamese Buddhist temples, healthcare practice clinicians, and Vietnamese Immigration Services. One to four community representatives from each organization who either volunteered in their roles, worked in the target organizations, or have experiences in diabetes education and health literacy were invited to serve on the CAB. These representatives were then assigned to one of the four working groups based on the individual's role or profession to create a forum for discussions with a clear focus on program effectiveness. Engaging all possible organizations and stakeholders as equal partners was essential to ensure that program adaptations were community-driven and sustainable.

Representation on the CAB included a wide range of stakeholders and health providers with a variety of interests and expertise, such as community leaders, healthcare professionals, faith-based community members, and VietAmericans with T2D and their care partners. The purposes of the CAB were to (1) identify community priorities, needs, and interests of a Vietnamese DSMES program; (2) provide input on a translated program to ensure content relevance; (3) review the diabetes education curriculum and offer feedback to address culture-specific needs; and (4) discuss and outline the pilot study proposal and the approach to outcome measurements. CAB members were encouraged to share their knowledge, expertise, and resources within the community. Interactions among members presented the opportunity to leverage network connections to implement the tailored program.

APPLICATION OF THE COMMUNITY ENGAGEMENT CONTINUUM (CEC)

Community engagement can take many styles and can include partnerships with organized groups, agencies, institutions, or individuals. The CEC is a modified diagram drawn by the International Association for Public Participation and was conceptualized to ensure meaningful engagement and to promote community health (CDC, 2011). Unlike some community engagement efforts to achieve a time-limited project, moving along this CEC, our academic-community engagement could evolve into long-term partnership to address social, economic, cultural, and environmental factors. Utilizing the CEC as a conceptual framework, which ranges from community outreach activities to shared leadership, we applied various levels of engagement to improve communication and build trust with community partners to enhance collaboration efforts and to optimize the likelihood that the tailored DSMES program would have its intended effect (Table 1). This collaboration promoted equitable sharing of decision-making power and responsibilities among four workgroups: (1) Healthcare professionals (n = 6), (2) Community leaders (n = 7), (3) Faith-based community (n = 5), and (4) Patient representatives (n = 5), each with a different charge (Table 2).

ACADEMIC-COMMUNITY TEAM MEETINGS

To ensure compliance with the COVID-19 pandemic restrictions and to accommodate the community representatives' schedules, all meetings were held via Zoom in the evenings. Holding community meetings

in the evening and via Zoom has been a sustainable approach to overcome participation barriers for busy and geographically dispersed representatives. Additionally, holding separate small workgroup meetings allowed ideas to be shared among those with similar backgrounds and in a less intimidating environment.

The academic team facilitated the meetings and remained neutral to the discussions. Ground rules were agreed upon at the first meeting to ensure a safe space to foster open communication and to ensure that every voice had equal value. The community meetings were recorded on Zoom with participants' permission. Meeting notes were collected by the graduate student assistant. CAB meetings were conducted in both English and Vietnamese; participants were provided with a $75 gift card as reimbursement for their time.

A total of six meetings were held over six months. Each representative was met with three times – initial, individual workgroup, and final meeting. All representatives attended the first meeting and the final meeting. The first meeting focused on orienting the CAB members to the study by sharing our previous research findings (Nguyen & Edwards, 2014) and lessons learned regarding health beliefs and diabetes self-management practices among Vietnamese adults (Nguyen & Jones, 2021). Sharing the findings allowed CAB members to have adequate information about the project to permit judgement on the need for community support and participation. Then, we introduced the goal of adapting the Association of Diabetes Care and Education Specialist (ADCES) DSMES content and eliciting essential feedback to achieve cultural and linguistic relevance. Group discussions during the first meeting included identifying barriers to self-management and identifying community resources that could be leveraged to promote healthy behaviors. The second through fifth meetings were held with each specific workgroup separately to gain relevant context-specific knowledge. During this meeting, the discussion topic included identifying and prioritizing culturally appropriate intervention approaches for a DSMES program development. Each specified workgroup reviewed the DSMES content focusing on the ADCES seven self-care behaviors–healthy eating; being active; taking medications; monitoring; problem solving; healthy coping; reducing risk–and integrating content to include Vietnamese cultural health practices. The workgroups discussed the most effective instructional format and delivery modes to reach various age groups and economic statuses within the Vietnamese community. At the final meeting, with all CAB members reconvened, we shared members' ideas and feedback obtained from individual group meetings, and sought further clarification on the tailored program. The feedback received from CAB members guided the final revision of the DSMES content and program delivery.

To engage the community members in all phases of program development and incorporate their feedback, the academic team also sought input on developing the infrastructure to deliver the intervention and discuss a plan for a pilot test to evaluate the acceptability and feasibility of the program. Ongoing community involvement for the collaboration project can benefit from quality improvement and evaluation efforts (Williamson et al., 2016). Additionally, engaging stakeholders enhances study design, processes and outcomes selection, and helps keep the focus on patient-centeredness (Forsythe et al., 2018). A comprehensive strategy was developed to engage the Vietnamese community in all aspects of the program tailoring process, from proposal development through program delivery.

RESULTS

COMMUNITY INPUT ON THE CULTURALLY RELEVANT DSMES PROGRAM

The academic team introduced the ADCES diabetes education curriculum to CAB members and asked for their input on tailoring the content to best address the Vietnamese cultural needs. The discussion topics for each working group were similar; therefore, community input was clustered by themes. The common themes included healthy eating, taking medication, and monitoring. These themes were from the ADCES seven self-care behaviors that CAB members thought were most relevant (ADCES, 2021). Through this interaction, it is clear that health beliefs and cultural practices are closely connected for this VietAmerican community.

Vietnamese food consumption and utilization of complementary and alternative herbal products were identified as high priorities across all workgroup meeting discussions. The CAB members verbalized concerns about the cultural misperception of carbohydrate intake and the inability to read food labels and to measure food portions. One CAB member from the faith-based community workgroup stated, "My mother eats rice three meals a day for 65 years; I am not going to tell her to cut that out. If she doesn't eat rice, she will eat vermicelli or some other type of noodles." One patient representative member shared, "I am an engineer and I can read, but reading food labels is difficult for me. I can imagine that would be nearly impossible for people who don't read English." Another member from the patient representative workgroup stated, "They tell me to eat so many grams of carbohydrates at each meal; the problem is I don't know how much a gram is, we do not measure our food in grams, we use bowls to measure food." To mitigate high intake of carbohydrates, the CAB recommended using Vietnamese food models, replicas, and Vietnamese utensils to teach people about healthy eating and emphasized education on food labels, carbohydrate consumption,

and Vietnamese food preparation (i.e., portion sizes). CAB members also advised that the program should provide relevant education about commonly used herbal products and food commonly used as herbs.

The use of complementary and alternative products to manage diabetes was raised during every meeting. According to a member from the community leader workgroup, "These products have fewer side effects than the Western medicine, and they are good to control hyperglycemic symptoms." The CAB members realized that many VietAmericans utilized herbal products and suggested that the adapted DSMES program acknowledge and respect the use of traditional herbs, while educating individuals about the appropriate use of Western medicine. It was recommended that education program revisions incorporate these herbal products. The CAB members emphasized that the community needs to have a clear understanding about medication safety and interactions with Western medicines, while they recommended only minor modifications for cultural relevancy on being active, healthy coping, and reducing risks.

A member from the healthcare professional workgroup pointed out that nutrition is often the main focus of self-management among Vietnamese adults with diabetes, and there is relatively little focus on prescribed medication, blood glucose monitoring, risk reduction behaviors, or personal strategies for health promotion, which is consistent with our previous research findings (Nguyen, 2014; Nguyen & Edwards, 2014). CAB members also suggested that the community would benefit from emphasizing the importance of and reason for regularly self-monitoring blood glucose levels, a clear explanation of differences between blood sugars and HbA1c levels, and incorporating family members in this education.

Factors such as health literacy and cultural beliefs influence diabetes self-management and can sometimes be barriers to health behavior change. To overcome these barriers and facilitate health behavior change, we plan to incorporate relevant Eastern health practices to best address socio-cultural needs based on the community members' input on the program development. Additionally, our program will embed the health belief model to enhance self-efficacy and reinforce healthy behaviors (Rosenstock et al., 1988). Because an individual's health behavior is impacted by his or her perception within four areas—severity of condition, susceptibility to problems, barriers to action, and self-efficacy—our intervention will also aim to address these areas.

COMMUNITY INPUT ON LINGUISTICALLY RELEVANT DSMES PROGRAM

The CAB members recognized that differences in language are likely a significant issue in the adoption and delivery of effective DSMES for the Vietnamese population. While there are many DSMES materials available, few materials have been translated into the Vietnamese language. Those materials that have been translated are often a direct translation of the information with inadequate attention to differences in cultural needs, such as differences in health beliefs and food consumption. CAB members acknowledged that the terms used in these translated materials frequently reflect a straight dictionary translation and recommended that the terms need to be customary speaking words to ensure easy and accurate comprehension.

A native Vietnamese independent contractor was hired to translate education materials to the Vietnamese language. A member of the academic team (A.N.) revised content to target towards lower literacy levels, aimed at improving glycemic control and overall health status for this community. Because the translation and revision of education content took longer than the timeline of this project, there was no opportunity for CAB members to review the translated materials and provide input. However, we anticipate pilot testing the materials with users prior to implementation and program delivery. In Spanish-speaking populations, diabetes education offered in the Spanish language improved physical activity and diabetes control (Smith-Miller et al., 2016; Wheeler et al., 2012). At the time of this writing, ADCES resources for people with diabetes are available in Spanish, Chinese, French, and Tagalog. Furthermore, the CAB suggested the use of technology apps, which were preferred over written resources, to deliver education and communication. Our academic team felt it was essential to translate the DSMES curriculum and resources into the Vietnamese language for linguistic relevancy and then revise the content to ensure appropriateness. We also felt that leveraging technology to provide education and support is necessary to overcome the barrier of transportation.

COMMUNITY INPUT ON PROGRAM IMPLEMENTATION AND FUTURE STUDY DESIGN

Community advisory members were empowered to share their knowledge and insights to shape program delivery and future study design. The Vietnamese free clinic and the primary care clinics where most Vietnamese patients seek health services were suggested as primary settings for program implementation to optimize adoption. The CAB members also suggested strategies to include adding the DSMES program to the existing Vietnamese clinics and holding education sessions at the Asian Health and Wellness events for in-person education. Moreover, CAB members recognized that transportation is a barrier and suggested that the education program be delivered via a secured YouTube channel or Vietnamese radio station to accommodate those individuals.

Incorporating community input on the intervention program development was essential to ensure that the representatives not only provided initial feedback, but also verified that community recommendations and interpretations resonated. Starting with the proposal development, the members' input was instrumental in designing the program outcome measures to be meaningful and socio-culturally relevant. In addition to eliciting outcome measures, we asked for input on the type of study, sampling, and recruitment strategies, as we aimed to encourage empowerment and to enhance study decisions. Although CAB members did not share their opinions on type of study or sampling, they suggested using the Vietnamese radio station and social media as a recruitment strategy and educational platform. The CAB also mentioned that including the caregiver partners was essential to foster support and promote optimal self-management behaviors, particularly among patients with limited English proficiency or those who relied on others for transportation.

DISCUSSION

Focusing on a culturally relevant DSMES program as a model for implementation to prevent diabetes complications and improve health, we engaged with the Vietnamese community representatives who have first-hand knowledge of this community to ensure sensitivity and applicability. We believe that our project presented here offers a model for culturally situated and contextually relevant program development. This academic-community collaboration provided an opportunity to increase the breadth and depth of identifying culturally appropriate programmatic needs through listening to the community's voice and promoting partnership building throughout the process. Involving members of all levels with various backgrounds and community responsibilities helped us to create equitable academic-community research partnerships and strategies to overcome potential implementation challenges. Furthermore, our project demonstrated clarity about the engagement with the Vietnamese community in Oklahoma, about norms and experiences with engagement efforts, and about trust and relationship building to foster community commitment. Because VietAmericans are underrepresented in diabetes and biomedical literature, this paper provides to a wider scientific audience the application of the CEC with this understudied population. The information presented can guide future health promotion and disease prevention programs and research, and can serve as a model for regionally diverse VietAmerican communities.

Among the strengths of this project, we believe that trusting relationships among members of this academic-community team were at the forefront. We have been guided by community leaders in the evolution of this community's cultural and social environment and they have led discussions regarding the community's health priorities. As a member of the Asian Health Coalition of Oklahoma and a Vietnamese woman, a member of the academic team (A.N.) has been working with the Vietnamese community of health promotion efforts for over 15 years and has built a strong relationship. Therefore, engaging with this underserved community to seek advice on health program development was a natural extension and it helps us to recognize and respect the various health beliefs and practices of this community. It also allowed the CAB members to recognize our passion and commitment to translate knowledge to improve health among this community. These traits were strengths and served to overcome differences between academic and community partners.

Common to other community engagement partnerships, challenges arose during the process. Given the various backgrounds and experiences of the CAB members, ensuring that all members felt their input was valuable at the meetings was a challenge. Based on our observations, the members who had healthcare experiences were more likely to speak during the workgroup meetings. Those without healthcare experiences felt more comfortable sharing and speaking individually with the Vietnamese-speaking academic team member (A.N.). We made every effort to empower all community representative members to take ownership of the project development and provided opportunities for the members to continue sharing input individually, as they felt comfortable.

Another challenge was ensuring the representation of persons with type 2 diabetes (T2D) diagnoses and their caregivers. Only three people who have T2D and two family members were actively involved in this project; this may not be representative of this community. To overcome this challenge, every effort was made to establish community views by encouraging the CAB to contact us if they had additional feedback they wanted to share outside of the community workgroup meetings. These informal contacts allowed us to understand the collective views of the Vietnamese community members as emergent opinions or as ideas developed throughout the project.

Furthermore, our academic team had to adapt to scheduled community meeting days when not all invited members attended and when attending individuals were not originally invited. To ensure that all representatives had an opportunity to provide input, an academic team member (A.N.) made telephone calls on the weekend after the meetings to each CAB member who missed the scheduled meeting. All representatives were reminded that participation in this project was limited to individuals selected by the academic team; therefore, referring others to participate was discouraged, as the ideal number of CAB members is 10–16 members (Kubicek & Robles, 2016).

The community-based approach provides guidance for developing, maintaining, sustaining, and evaluating partnerships, which is an ongoing process to build the community's capacity and apply cultural context to promote health and prevent diseases (Israel et al., 2012). Drawing on local knowledge from the VietAmerican community to develop interventions has the potential to increase acceptability and sustainability of multilevel interventions, since beliefs and culture are already well-integrated into the behaviors and practices that resulted in positive health outcomes. Through community partnerships, cultural accommodation is ensured, leading to the strengthening of study design and implementation to address the multiple determinants of health and disease (Wallerstein et al., 2017). Additionally, the community representatives expressed gratitude for the opportunity to discuss diabetes prevalence, the threat of its complications, and the need to have a culturally appropriate intervention in their community, and they were eager to provide input for program development. Finally, the members expressed and assumed community responsibilities and recognized the importance of all levels of the community working together to address diabetes and its related health concerns.

CONCLUSION

Our project was the first to partner with a VietAmerican community and apply the CEC framework with the integration of cultural practices to develop a DSMES program among VietAmericans in the Midwest region. Applying the CEC (CDC, 2011) was effective in identifying potential collaborators and establishing trust and relationships with VietAmerican community partners. Our team demonstrated that following a multi-step process and utilizing the Zoom platform is a feasible method for collaborating with the VietAmerican community to seek input on the development of the culturally tailored DSMES program. Incorporation of the VietAmerican community's values and facilitators to health-seeking behaviors into a decision-making process allowed the establishment of an ongoing partnership with the community to ensure that its cultural values continue to shape health service programs. Furthermore, this process can be utilized to develop other culturally resonant health education and chronic disease management programs. Future research is needed to evaluate the impact of academic-community engagement on the acceptability, feasibility, and outcomes of a culturally adapted DSMES program among VietAmerican individuals with T2D.

Clinical Resources

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- Community-Engaged Research: A Quick-Start Guide for Researchers. https://consult.ucsf.edu/sites/g/files/tkssra436/f/guide_for_researchers.pdf
- Association of Diabetes Care and Education Specialists (ADCES). Tools and Resources. www.diabeteseducator.org/home.

APPENDIX

	GOAL AND OBJECTIVES	PROCEDURES
OUTREACH	Create a community advisory board (CAB). To identify potential collaborators, we sought advice on how to: 1. Approach and enter partnerships with the Vietnamese community. 2. Identify community organizations that best aligned with project goals. 3. Seek guidance on aligning the program with existing community resources.	We selected members to serve as community representatives from various organizational roles to have diverse representation and to ensure they had the capacity to be active participants.
CONSULT	Identify and meet with CAB members. To learn about existing community resources that may relate to or may support the DSMES program, we: 1. Gain insight into local views concerning diabetes self-management. 2. Initiate the process of developing shared vision in diabetes care. 3. Seek guidance on how to best approach and work with specific organizations.	We sought feedback from CAB members who have prominent roles in promoting health in the community.
INVOLVE	Conduct community meetings with each workgroup separately. We held small working group meetings to: 1. Allow all members' input to incorporate cultural practices with the educational content. 2. Ensure adequate opportunities and respect for expressing ideas/opinions.	We reviewed the existing Association of Diabetes Care & Education Specialist (ADCES) diabetes education 2016 guidelines and tailored the content to address culture-specific needs, focusing on the seven self-care behaviors and prioritizing possible intervention strategies.

(Contd.)

	GOAL AND OBJECTIVES	PROCEDURES
COLLABORATE	Enhance community partnerships to: 1. Strengthen relationships. 2. Determine the point of contact for questions that may arise during program development. 3. Gain further information on community resources and DSMES program alignment.	We followed up with the working groups to summarize input and strategies, and respond to CAB members' questions and recommendations. In addition to aligning education content, we collaborated with CAB members to ensure community perception and attitudes were incorporated, rather than assuming relevance to this community and taking community acceptance for granted.
LEADERSHIP	Conduct follow-up meetings with CAB members to: 1. Present summarized strategies and intervention design for the DSMES program. 2. Encourage CAB members to discuss the pilot study proposal, the approach to outcomes measurement, and the outline process for sustaining partnership with the community.	We shared feedback we received from different workgroups, agreed to be open to each other's ideas in program refinement, and reassured members that future decision-making will be a team effort.

Table 1 Academic-Community engagement goals and procedures.

CAB WORKGROUP MEMBERS	RATIONALE FOR INCLUSION
Healthcare professionals (n = 6) MD; DNP; PA-C; PharmD; CDCES with BC-ADM; former director of an ADA accredited diabetes education program	To help the academic team understand barriers and facilitators in diabetes education at their practices and help translate study findings at the practice level.
Community leaders (n = 7) Asian District Cultural Association; Vietnamese-American Community in OKC and Metropolitan Areas Association; Asian Health Coalition	To help the academic team reach and connect with VietAmericans with T2D in the community and to offer important insights into developing the program, and assistance in program promotion/delivery within the cultural community.
Faith-based community (n = 5) Vietnamese Catholic Church of OKC; Vietnamese Baptist Church of OKC; Vietnamese Buddhist Temples	To help the academic team reach and connect with Vietnamese individuals with T2D in the faith-based community and to offer important insights into developing the program, and assistance in program promotion/delivery within the religious community.
Patient representatives (n = 5) Vietnamese adults with T2D and/or care partners (family members or caregivers)	To provide exemplars of lived experiences with challenges and successes in diabetes self-management and/or overcoming barriers associated with glycemic control. Patient representatives provide input in study design, outcome measures, and delivery of culturally relevant intervention.

Table 2 Community Advisory Board Members.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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