

## **Tips for Using Indian Health Diabetes Best Practices in the Special Diabetes Program for Indians (SDPI) Community-Directed Grant Application for FY 2010**

The Indian Health Diabetes Best Practices are consensus-based approaches, developed by Indian health system professionals that anyone in clinical and community settings can use to implement or improve diabetes treatment and prevention. One of the requirements of the FY 2010 SDPI Community-Directed grant program is to implement at least one of these Best Practices. Here are some tips to help you decide which Best Practice(s) to implement and how to provide the information required in your grant application.

### **Tip 1: To determine which Best Practice(s) to adopt or adapt, conduct a community needs assessment.**

- Use your latest Diabetes Outcomes Audit, GPRA, school or other data to determine the diabetes-related health issues in your clinic or community.
- Use these data to determine what is needed. For example, how many people with diabetes received an annual eye, foot or oral examination? How many have good glucose control? Does the community want a prevention program?
- Identify the areas that need improving and identify the areas that your program will address.
- Be sure to identify a specific group of people, the target population that will be the focus of the program.

Note: Learn more about how to identify what your community needs are and how to improve your diabetes program in the Program Planning and Evaluation web training section "**Picking the Best Route**" [http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating\\_pt\\_5](http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating_pt_5)

**Tip 2: Select at least one Best Practice that addresses the needs identified in your needs assessment and that fits with your program's resources, interests, and expertise and determine what activities you will do and services you will offer.** Each Best Practice provides recommendations for you to review. You don't have to implement all of the recommendations in the Best Practice you select; pick the recommendations that fit best with your needs and resources. Some examples are:

Example 1 (Clinical): We learned from our Diabetes Audit data that our program can improve the examination rate for foot care.

- Conduct comprehensive annual foot exams for people with diabetes and identify risk factors predictive of ulcers and amputations.
- Hire a podiatrist and provide podiatry care.
- Work with a local shoe store and develop a mechanism for providing appropriate footwear.
- Purchase equipment and medications to manage foot ulcers.
- Provide in-services and support training for health personnel in foot care education.

Example 2 (Community-based): We need a diabetes prevention program for youth.

- Establish a working relationship with the school board, principal, teachers, and students and invite someone to represent them on your diabetes team.
- Hire a physical activity specialist to provide evidence-based information on physical activity and diabetes.
- Work with the local schools and develop a mechanism for providing equipment for every student so that they can be more physically active during school day.
- Provide in-services and support training for teachers and others interested in increasing physical activity among youth.

Note: Learn more about selecting the right Best Practice activities for your clinic or community using the resources on this webpage.

<http://www.ihs.gov/medicalprograms/diabetes/index.cfm?module=toolsBestPractices>

**Tip 3: Ask for support from organization and tribal leadership for staff, time, equipment, and space, so that you can effectively implement the selected best practice(s) activities and services.** Support from your leaders is key to the success of your program and activities. Be sure to communicate

your needs to appropriate leaders and to ask for a commitment of their support. Make sure that the resources available to you are sufficient to carry out the activities and services you are planning. Note: Identify your partners and resources by using the Program Planning and Evaluation web training section “Who to bring and What to pack” and the resources tool.

[http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating\\_pt\\_4](http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating_pt_4)

**Tip 4. For each Best Practice you choose, find the two key measures in the document and write a goal and objectives for each.** Your goal should be a “big picture” statement of what you want to happen as a result of implementing the selected Best Practice(s). For example, if your program selects the foot care Best Practice, a goal is “to improve foot care in our facility.” To write your objectives, start by reviewing the two key measures from the Best Practice. Then use the SMART format and the SMART tool to write your objectives.

**Sample SMART Objectives.** Use this format to write your objectives

Verb	Measure	Target population	Object (actions)	Baseline measure	Goal measure	Timeframe
To increase	the percent	of people with diabetes	who receive foot exams	from 60%	to 80%	in one year.
To increase	the number of minutes	youth	who participate in daily physical activity	from 10 minutes	to 30 minutes	by the end of one year

Remember, SMART means:

- S = Specific means “detailed and focused”
- M = Measurable means “able to be measured”
- A = Action-oriented means “doing a good activity that can be accomplished “
- R = Realistic means “reflects program and patient reality”
- T = Time-bound means “include a timeline for completion”

Note: Learn more about how to write a goal and SMART objectives in the Program Planning and Evaluation web training section “Don’t miss this!”.

[http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating\\_pt\\_7](http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating_pt_7)

**Tip 5. Based on the services and activities that your program will do to meet the Best Practice objectives identify how your program will collect and track data on these.** For the services and activities you identified, decide what data you will need to collect both pre and post activity. For example:

- Program activities conducted –use attendance logs and clinical measures.
- What people learned or what behaviors they changed –use pre-post surveys.
- A1c levels – Diabetes Audit reports.
- How the funds were used –use budget spreadsheets.

Note: Learn more about how to collect data and track progress in the Program Planning and Evaluation web training section “Have we arrived? Results: Keeping Track”.

[http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating\\_pt\\_9](http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=creating_pt_9)

**Tip 6. Learn more ways to integrate Best Practices** into your program plans by completing the entire training on Program Planning and Evaluation.

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingBasicsCreating>

For an example of program planning and evaluation go to Appendix 1 in the Program Planning and Evaluation workbook.