Preventing Diabetes and Healing from Within: A Community Perspective

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The Vision

- Realizing the vision of healthy people in healthy communities is possible only if the community, in its full cultural, social, and economic diversity, is an authentic partner in changing the conditions for health.

IOM, 2002
Community Diabetes Action Council

Formed to develop a Two-Year Community Diabetes Action Plan

Members represent Mechoopda Grindstone NVIH

Equal clinic and community partnership
Digital Story
The Two-Year Action Plan is Complete

Includes
Needs Assessment
Vision/Mission
Goals
Objectives
Strategies & Actions
Structure/Implementation
Timeline
Implementation Plan
Evaluation Plan
Year 1 Budget
Since then……

- Northern Valley Indian Health Board approved the Two-Year Community Diabetes Action Plan.
- The plan as been presented to NVIH Management Team.
- Community identified health improvement objectives have been included into the annual NVIH CQI Plan.
Plan Implementation

To ensure the CDAC Vision becomes reality.

- A community/clinic oversight body has been established.
  
The Community Diabetes Action Council-Implementation Committee (CDAC-IC) and three sub-committee work groups
  
  Youth Prevention Activities
  Traditional Food and Medicine
  Diabetes Health Fair
Action Plan Implementation

- Community-based diabetes screening activities held.
- Community Diabetes Standards of Care days held at the clinic.
- The Youth Subcommittee has met and is making plans for a November event.
- Diabetes Standards of Care clinic is scheduled for November 1st
One Community

Diabetes Standards of Care (SOC) Completion Rates

Percentage

1-Nov 1-Dec 1-Jan 1-Feb 1-Mar 1-Apr 1-May 1-Jun 1-Jul 1-Aug 1-Sep

CDAC Goal
SOC completed
% Diabetics w/ all SOC completed
Blood Sugar Control

In Jan 2012- the average most recently documented A1c was 8.06

In August 2012- the average most recently documented A1c was 7.64

Note: These two numbers do not include all of the same people
Blood Sugar Control

A few of those included in the January data have moved, or passed on.

A couple of people have come back to care or moved back to the community.

Of the original diabetics:
The average A1c in
  Jan 2012 was 7.7
  Aug 2012 was 7.5
A1c Changes

53% had a decrease in A1c

1 stayed the same with an ideal A1c

42% had an increase in A1c
Of those with an A1c increase
  50% still have an A1c of 6.5 or less
  16% have an A1c of 7.1-8.0
  33% have an A1c > 8.0
In Loving Memory

Digital Story

Gretchen Faye Murray
October 17, 1953 - October 5, 2012
Challenges

• **Gaining support**
  - From clinical colleagues, administration, Board of Directors, Tribal leadership and the community that this work is valid, effective, relevant and within the scope of practice of the public health nurse and the clinic.

• **Competing demands**
  - for time and resources to address urgent acute clinical issues.

• **Coordinating times** to meet and come together
  - balancing community schedule and clinic schedule

• **The very human factor of politics**
  - on many levels, in both the community and clinic, that come whenever there is work focused on making change.