

Preventing Diabetes and Healing from Within: A Community Perspective



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Northern Valley Indian Health-Community Health Director

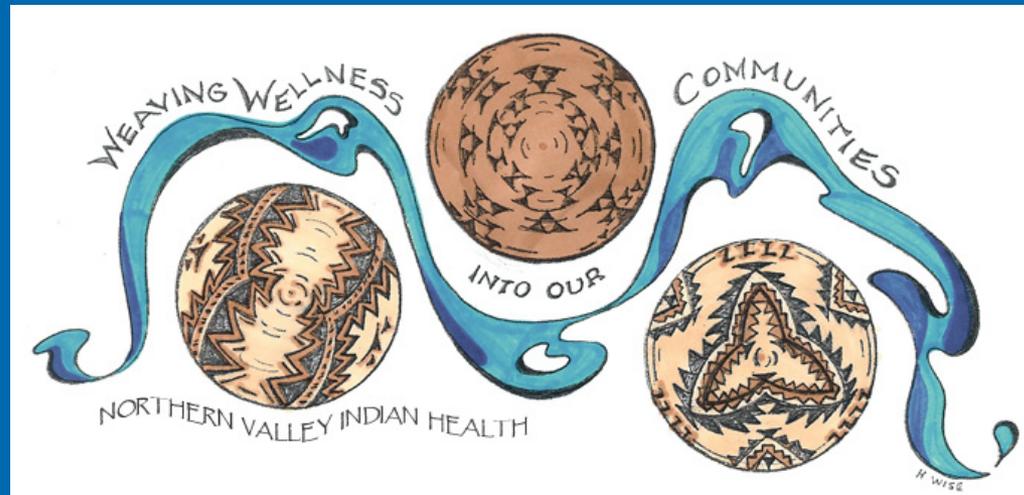
Julia Fred- Grindstone
Northern Valley Indian Health Board Member

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Community Health Management Assistant

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.*



Community Diabetes Action Council

Formed to develop a
Two-Year Community
Diabetes Action Plan

Members represent
Mechoopda
Grindstone
NVIH

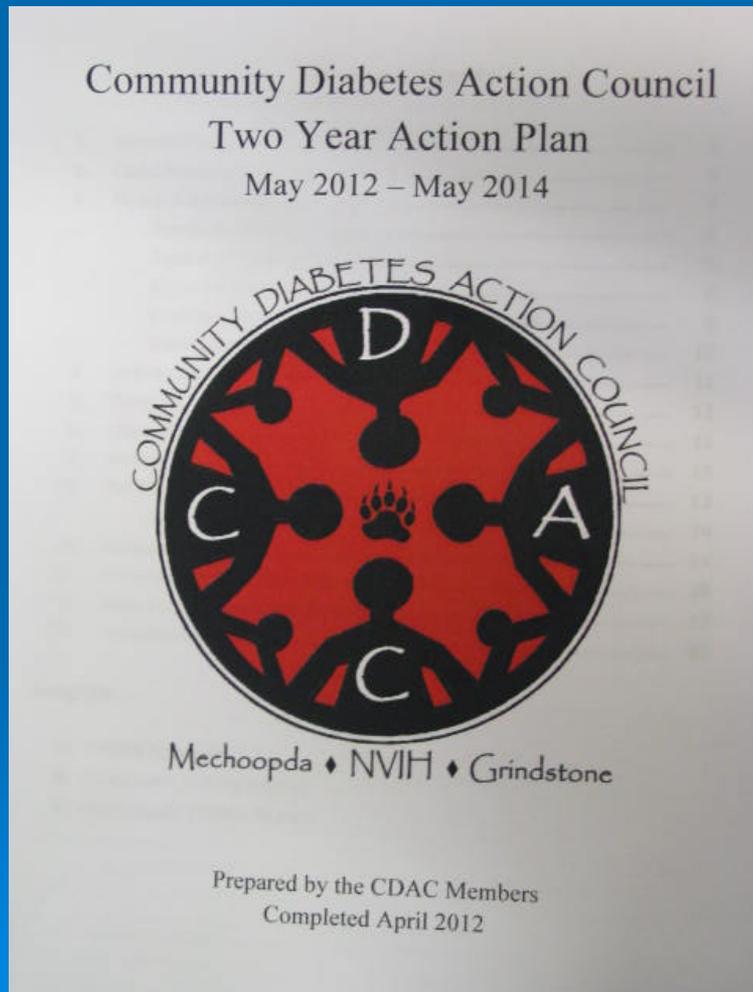


Equal clinic and community partnership

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
- 
- A decorative graphic consisting of several sets of concentric circles, resembling ripples in water, is located in the bottom right corner of the slide. The circles are light blue and vary in size and opacity, creating a subtle background element.

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

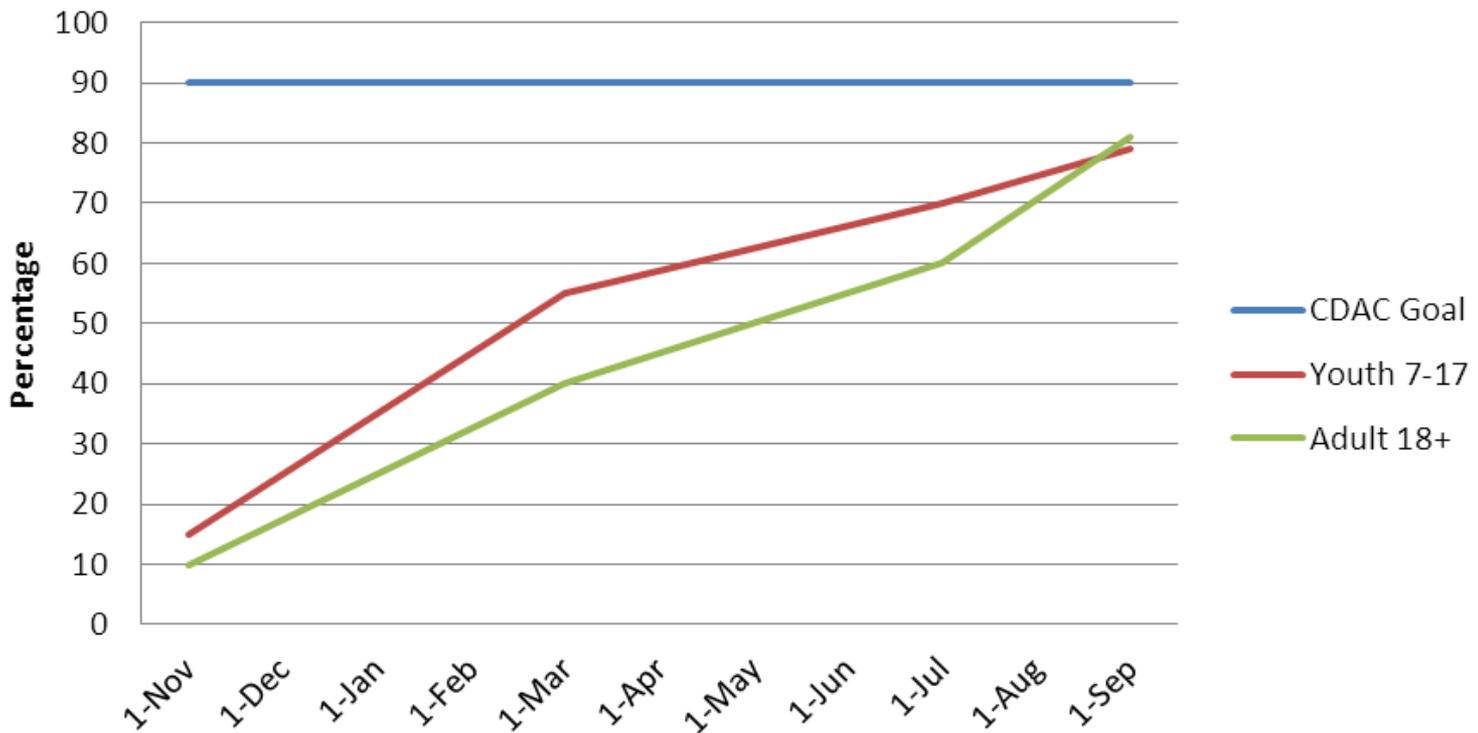
Action Plan Implementation



- 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

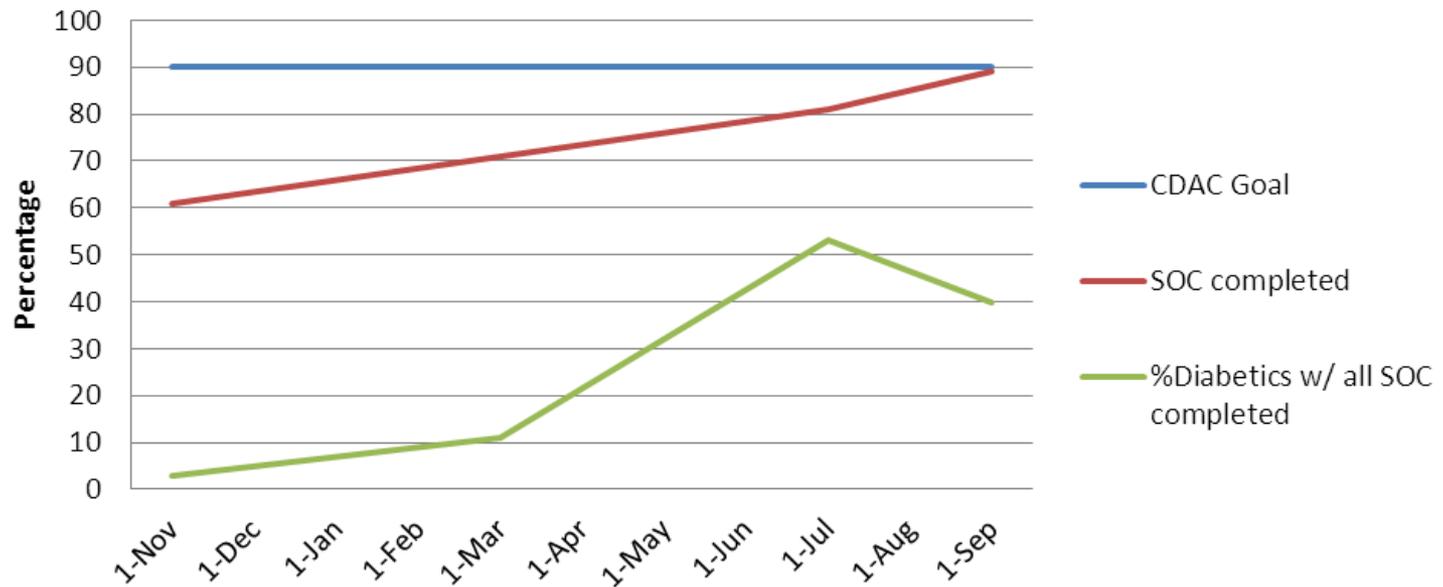
One Community

Community Diabetes Screening Rates



One Community

Diabetes Standards of Care (SOC) Completion Rates



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

Fred - Mota





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.

