



Indian Health Service

Division of Diabetes Treatment and Prevention

Advancements in Diabetes Seminar Innovative Approaches for Nutrition Care

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Kelli Begay:

Our first presenter is Darian Schaubert. Darian is a health coach and supervisory dietitian, at the Standing Rock IHS Hospital and has been there for the past 8 years. He has worked in a variety of roles since 1988, from research to a radio talk show host to a group educator, which he is going to focus on today.

Our second presenter is Abbey McCarthy. Abbey works in Maine at the Penobscot Nation Health Department as a dietitian and diabetes coordinator. She's been there for the past 12 years, running both clinic and community-based programs and she will be sharing a creative way that she and her clinic have addressed food insecurity.

And we'll end today's webinar with Stacy Hammer. Stacy is an enrolled member of the Lower Sioux Indian Community and began her career as a registered dietitian and diabetes coordinator for the Lower Sioux community in May of 2013. Stacy works with tribal members within all life cycles and she's also worked in partnership with organizations like the American Indian Cancer Foundation to help develop the Healthy Native Food Toolkit.

So with that, I welcome Darian to start off with today's presentation. Darian.

Darian Schaubert:

Good morning everybody or good afternoon. It's a pleasure to be here today. I appreciate being asked to talk a little bit about some of the things that we're doing up here at Standing Rock to improve patient care using group education. I've had a long history of doing various group education types of things and when I first got to IHS I was really frustrated, I think by a lot of problems that face us when it comes to education. I think there are a lot of things that we deal with. We have thousands of patients that need our care and things and we're always short on staff to do it.

We're being asked to do a presentation on the multiple, multiple different conditions, diabetes and cancer and high blood pressure and all these different things and it's hard to talk on all these different things when there's not enough time always to pick all these different topics. And so we developed a process of combining some of the risk factors and things that we try to address into one talk so that one talk can be used for 50 different presentations just by basically doing a little bit of changes



to that and we all face problems with lack of referrals for patient care, specially dietitians and things often we don't get the referrals even though people ask us to see those folks. And so we actually came up with some ways of actually overcoming the referral process by asking -- getting patients to actually request to be seen by us and then it's real simple and fast to get the referral at that point if they want to be seen for weight loss or whatever the case might be. But without a better way to deliver what we're doing it's almost impossible to educate everybody that wants to see us and so we don't want to say no to offering education so it's important that we try to look at new innovative ways to be able to reach more people and that's what they asked me to talk about today.

What I found through group education is that it dramatically improves your productivity. I have seen up to 400 patients in one day by doing group educations in a school, we did half-hour sessions one time, four of them, and saw pretty much a hundred patients in each of the groups that we did like that. In the clinics and stuff, we can do up to 25 to 35 patients at a time. If we do it at the morning and the evenings and I'll talk about that more later, you can do up to 70 patients a day, which is more than a lot of providers of us -- will get to see in a month sometimes when it comes to education. And what's really neat about that is by taking different directions of providing group education going to different locations and I'll talk about some of them here shortly, you can provide education to patients that often avoid us. The patient that show up in the clinic every single day, day again, day again, day again because they're not following what they're supposed to do or showing up at the clinic all the time. Well, if we do group education out in lobbies and things like that, we're catching the people that often avoid us. They won't ask to see us and if we try to see them they'll say no. But if they're sitting out there waiting to be seen, there is your opportunity to see somebody that has to listen to you basically. Through that process we've created a lot of self-referrals and paid requests for education and improved our reimbursement, our referral rate. We've used it for equality projects and so forth and all the professions whether you're a dietitian, physician, nurse or physical therapist or whatever can use these same techniques based on developing similar presentations and so forth.

One of the problems with group education, it's hard to get people to come and return to group education programs that we have time and time again. It's hard to relate the education we're providing to everybody. You don't want to bore people to death out there. So, you have to find a way of broadening the scope of what you're presenting so it reaches more people and not everybody wants to be educated but most will listen. Like I have said, if you get their attention.

So what do you do to get their attention? One of the things that I developed is a quick questionnaire thing that I have people sign with their name and birth date on it and I asked them some real general questions that relate to a lot of diseases and things. Do you often get tired and sleepier? Not getting enough sleep that can relate to diabetes and a whole host of other conditions; depression and so forth. Do you ever feel down, depressed, or know somebody in your family who is? That way, they're maybe not listening because they have a problem but because of somebody else in their family may have this problem. A lot of times people would be more interested listening and participating if you're not directing the education directly at them even if it's meant to. If its directed towards them, they have a better chance of listening to it if they could say what if this is for somebody else.

A lot of people that don't have time to cook or skip meals start eating unhealthy snacks and with that you start getting overweight and so forth. So I try to ask questions or pretty much if you each would have asked these five questions right now I would say close to 90% to 100% of you are going to answer yes to one of those questions. Then I ask them, do you ever drink or eat any of these things ever, potato chips, pop, juice and alcohol, milk, different foods and things that can affect your health if you're not getting them?

Again, most everybody answers yes to quite a few of those questions. When I do groups of patients, I'd say about 80% to 90% percent of them answer yes to many of these questions. If they say no to drinking milk and stuff, that might indicate you might want to talk about lactose intolerance because they may not be able to drink milk and they're missing vitamin D and things. So by asking

some general questions like this you just opened up the page to all of what the audience is interested in and if you page through those while you're talking you can actually cover the topics that relate to them whether they're being tired and whether there might be issues related to that and so forth. It really makes it easier to talk to groups and reach them because they're interested because they've already answered yes to one of the risk factor questions that you've asked. They just have to answer yes or no on these questions.

Then I also ask, do you want to lose weight, exercise more, and reduce your risk of diabetes? Almost everybody will answer yes to one of those questions because whether we want to or not we usually feel like we're overweight more than we should be and we always feel like to get exercise more. So once again if you relate the weight issues to health and exercise issues to health, you've caught them already again. Then I also ask them, would like to work with a health coach who is myself or it could be a physician or nurse, whoever to talk about some of these things? Again, you're catching them and getting them interested in talking with you.

By identifying these high-risk behaviors once again if they're smoking or whatever it might be, depending on the group you're reaching, whether it's a pregnancy group, if there are people that are smoking then you can talk about the fact of how smoking can cause the umbilical cord to shrink by three-fourths of its size and the baby won't get any nutrients and things or it can cause high blood pressure or it can cause all kinds of cancer-related issues and things. If they're not exercising, you talk about how that relates to a bunch of other things, diabetes and obesity and so forth. So all the different risk factors that we mentioned, lack of sleep, poor eating, use of alcohol and things, stress and drama, I like to use the word drama instead of stress because a lot of people are more interested in talking with our drama specialists than they are for our mental health folks and so I often use innovative words and things to make things sound more appealing to folks when I'm talking about it.

I also talk about bleeding gums and how that's an inflammatory process that can also affect your risks of heart disease and stroke and things also. It starts there first and those particles in your mouth actually end up in your blood stream shortly later. If they have previously been told they high A1Cs or high BMIs and obesity, high lipid levels, low HDL, things like this, you can key that into how they relate to their health like low HDLs can often mean that they're not getting enough exercise and you can relate to how HDLs are a form of cholesterol that they're burning and so it's important that they do more exercise if those are some of the risk factors that they had. They really key in to your education then.

So the goal is to target education to common risk factors and symptoms as they relate to almost everyone. For instance, exercise is one problem but it relates to a lot of other diseases. Stroke, heart attack, diabetes, everything and so by targeting common things like that, you get everybody's interest right away.

I also educate on the effects of healthy behaviors like how running for instance will prevent cancers and diabetes and obesity and all the related diseases. So again, by focusing on one area you can cover many areas. I try to talk about how even like one pound of weight loss can take 2,500 pounds of pressure off your knees and stuff if you have pain issues and stuff like that and an orthopedic surgeon told to me about that and the days we did orthopedic clinic side to go out and I do group talks on those topics.

But anyhow, I target education -- the diseases with similar risk factors. As I just mentioned cancers could be caused by a lot of the same risk factors as heart disease, prediabetes, depression, anemia and alcohol. So I can go over that more later if people want to call me back about some of those topics. Almost everybody knows somebody who has one of these diseases and so by bringing those topics up, again, you can get everybody asking, "Is it me?"

I relate those triggers and risk factors to the diseases, like I just mentioned, high blood pressure, high body weight, joint pain, how it relates to weight, poor physical fitness and how blurry vision and

things could be caused by high blood sugars and other things. So again you're tweaking their attention to something they may not have but they're concerned that they might and in other words promoting the importance of these healthy behaviors.

I also try to link them back to traditional things that way back when we didn't have corn sugars and things and now we have a lack of fiber and we're not getting sun anymore and less exercise and that combined with alcohol and pop and all these inflammatory agents and things can cause lots of new diseases we didn't have. A hundred years ago we didn't have any diabetes. So the high calorie meals, the extra sugar and fat, processed foods have artificial things and a lot of people really don't like the thought of eating artificial things and so that's a really good one for trying to get people to listen. I talk about how lack of sleep can actually cause us to have -- make poor food choices and things because we're tired, we don't feel like cooking and stuff and how that thinking then make us exercise less and so forth.

I try to link some of the new modern things that aren't good for us to some of these problems. I try to get patients to ask, "What can you do to help me then?" And if he do that, you basically have a self-referral and you can see him, you get paid for the visits and so forth. I do this by partnering with groups I do stuff in waiting rooms. I'll do it at 8 o'clock in the morning and I do it at 12:30 in the afternoon when the biggest groups are out there and I'll talk for sometimes two hours out there until pretty much everybody is gone.

I do senior meal programs because you can catch up 25 people at a crack there. The days that we have diabetes clinic, or footwear care clinics, I do diabetes programs out there on those days. I also go to schools and do parent programs talking about low cost meals and healthy meals and I go talk to kids about preventing obesity and things by being more active and eating less sugary foods. I do the pregnancy clinic dates and the pregnancy centering programs. I work with public health with a lot of cancer group presentations and things. On orthopedic days, I go out and do pain and obesity-related problem areas there and radio shows and various other things like that and that's a good way to expand what you're doing.

I like to start by talking about healthy traditions that we had with dance and the traditional foods and how healthy they were, even simple things like horseback riding, how it's like an elliptical machine and when the Sioux for instance were very good horseback riders and because of it, they're very healthy and didn't have any diabetes and things way back when and so I try to go back to the traditional things in each of my talks to try to relate. If I'm talking about exercise, how dance is important and how walking is important and doing games with family and friends is -- it's all activity, find something you enjoy and do it.

I talk about traditional foods that were high in protein, how they made Wasna which was berries and meat mixed together dried so we didn't get all that food that we get now. It was mixed slowly and we ate it year-round and that's why some of the traditional foods were so healthy like that. I talk about eating foods with the family and stuff to improve the mental health of the family and such too and by doing the traditional motion and traditional foods and then working together with people and eating together and things, it kind of rekindles those healthy behaviors.

By doing so, you get more referrals and reimbursement because when you do group talks like this what we did is we work with the doctors on that and we dramatically -- every time I get a letter from somebody or a survey that says they want to see the doctor, I just show it to the doctor and they throw in the referral for me and I can see them and we get paid for it and that goes for other health professionals whether they are diabetes educators or whatever.

By doing so and doing these group visits, I've seen big changes. We've had one diabetic that lost 260 pounds in just 7 months with some of the group sessions we did. We have several other ones that are completely off all of their medications for diabetes, several of them, some of them that had pre-diabetes and never developed the diabetes, they're obese, and just through these types of group

sessions like this, they basically got rid of their problems and I like to use those examples when I'm talking without using their name so people can see the positive impact of changing these behaviors.

So by identifying areas and places you can do these group talks and developing these talks more generally like this and I have developed several that I can share with people. You can really reach people quickly and I actually have people in the audience share their success stories and what they have done and several of them are off their medications and we'll talk about that, and it really helps the talks quite a bit. So group education really works if you develop your talks more generally like this and then apply them to more specific topics and it changes more behaviors and it improved coverage and referrals and you change their life for good basically. So I've developed a series of talks like that that I'm willing to share with just about anybody, if anybody has any questions on those type of things.

I have developed PowerPoints and questionnaires and education sheets and some of that stuff would be in some of the handouts that we had today. I put later in the talk when everybody else is done, we'll probably do some question and answers on this stuff. If you have questions, you can ask me at that time or this is my email and stuff too if you want to email me directly after the talk on some of those things and that's all I have today.

Kelli Begay:

Great. Thank you, Darian. That was a lot of information in a short amount of time and you did excellent on your timing.

Darian Schaubert:

Thank you. I can talk for hours and you know that for -- I didn't today though.

Kelli Begay:

Thank you so much. Like Darian said, we'll have questions answered at the very end of our presentations today. So right now, we're going to turn it over to Abbey McCarthy. Abbey, are you there?

Abbey McCarthy:

I'm here.

Kelli Begay:

Okay, great. You're on. Thank you.

Abbey McCarthy:

Great, what a great presentation, really energetic, and into a lot of things. Well I'm happy to talk to you today about a program that we started at our tribal clinic. Our program is a community approach to improve nutrition and to decrease food insecurity in the clinical setting. So this is a picture of our program. As you can see it is a food bank, it has dried whole-wheat pasta, whole grain cereals, canned vegetables, soup and dry beans. The food pantry is located just outside the waiting room at our clinic. It is unmanned so people can help themselves and take as much as they need and it costs us absolutely nothing to run this program because we have a partnership with one of our local food pantries and this program has touched the lives of hundreds of people as they come into the clinic to pick up their medicines or go to the doctor.

So today I'm going to talk to you about why we started a food bank at our clinic, how we were able to do it, the successes and barriers that we have had as well as the response from the community.

So the idea for this program, starting a food bank in our clinic was generated from a great presentation that Kelli Begay gave at USET Diabetes Conference, and it was about the hardships with food insecurity. These are the statistics that she presented which are derived from the Food Research and Action Council and they're really heartbreaking.

More than 42.2 million Americans live in households that struggle against hunger and people in rural areas tend to have higher rates of -- they tend to struggle more than people in metropolitan areas. And one in five households has children -- one in five households that have children can't buy enough food to feed their family. And 43.1 million people lived in poverty in 2015. And almost 20% of children under age of 18 lived in poverty in 2015. So as you can see, this is a really -- a really deep problem.

During Kelli's presentation, she presented this tool that is developed by Indian Health Services and this tool is meant to identify food aid in a community and to serve as a comprehensive list and resource guide for people on the community that are struggling with food insecurity. So as you can see, I've filled in this handout where you see the light blue is where I've kind of typed everything in, and the parts of it in white are kind of preset so you can find out the programs that are in your community and use the handout to type them in. When I began filling out this handout I was really surprised to find out how little there was for aid in our community.

And talking with all these people that do this for a living I was really saddened to hear all the personal stories of those people that are living with food insecurity, like kids hiding food under their bed and so forth. So if we look at this handout you might be looking and thinking well, "That's a lot." But if we really go through it, it's really not a lot because some of these are redundant.

So we have a mobile grocery store truck, which I'll show here. We have the mobile grocery store truck which is actually part of the food distribution and commodities which is actually the same thing as the food pantry and the food bank. So it's just kind of redundant but because they were preset and I couldn't edit them, I just kind of had to leave them in there. And then we also do have a children's food pantry at a school and only kids are eligible to receive that food. So it's actually -- there are not a lot of programs even though it might look like there are.

Here's a link to the food insecurity tool. And I would encourage everyone on the call today to check it out and fill it out and really go down this rabbit hole. Not only will it be a great resource for your community but it will be a great learning opportunity for you, I think. I know, I definitely learned a lot when I filled it out.

The food insecurity tool helped me realize the scope of food insecurity in our community and although none of it was really new information to me, I'm a dietitian, so I see folks in the office that struggle. But the tool really allowed me to fully conceptualize the problem and to compare the problem with the resolutions that we offer in the community and to really ascertain that there is -- there's really not -- it's really not a comprehensive solution.

So for us, the community problem is -- our community doesn't have direct access to WIC or food stamps, people actually have to travel to Bangor, our biggest city is Bangor here which is like 12 miles away. So if you don't have a car, I mean, that in itself can be a big burden. And for people that are using the local food pantry, many people don't have cars, so they're biking or walking to the food pantry. They are hauling bags and backpacks so it's really labor intensive. So just transporting the groceries can be difficult and it limits the amount that they can carry out. We live in Maine here so we have six months of winter and the winter season also affects people's ability to get groceries. If they can't dig their way out of their house or you know, it's slippery, there's just really a lot of issues.

And then there's other issues too such as food pantry hours are limited and also you have to qualify. So if you are a working parent that works and doesn't meet the qualification for low income, a lot of these food resources that are out there actually aren't available to you. Now, our food pantry here

actually doesn't turn anybody away but I'm not so sure that the community fully knows that. So some people might just not go there because they don't know.

So I decided to start a food bank at our clinic based on -- just really based on Kelli's presentation and filling out that insecurity resource tool and finding a problem. Now, over the past five years, I've partnered with the local food pantry in the community and I've been conducting nutrition education cooking demos trying to turn commodity foods into food that people actually want to eat. And the commodity foods include tomato soup, whole-wheat pasta, mixed vegetables, beans, carrots, corn, lentils, beans. And over this time, I quickly recognized that there are a cohort of these that they just don't turn over quickly and so there ends up being a surplus of them and they kind of -- they're stocked on the shelves and in the basement and there's kind of a big surplus. So I, knowing this, I asked the food pantry coordinator if she was agreeable to setting up a table here at the clinic where we could kind of act as a little food bank to disburse the commodities and she was really agreeable and eager to see them put to use.

At this point in the presentation, if you're thinking -- well, that doesn't make sense, you have the food pantry, and anybody can get the items, why would you have them on the clinic? And again, that if you go back to just people not being able to carry out enough that we really need to have food wherever. So if you're coming into the clinic that you can just grab some, so there's limited hours for clinics and not everybody that needs the food ends up qualifying.

So anyway for planning purposes -- so the implementation of this table was pretty easy. We just measured the intended space in the waiting room and we ordered a small narrow table that would fit in the space without causing hindrance or distraction.

And this is the picture of our waiting room. So if you can see these green chairs right here, these green chairs form a U here. And then this front, this is the receptionist desk where patients would check in and we originally put our food pantry table right here where the pink sign is. So we set up a table, we arranged the food, we put our food insecurity tool there. I don't know if you can see it, that's a copy of the food insecurity tool. And then we also created a sign.

So some people feel ashamed about needing food help. We really wanted to create a sign that was welcoming, encouraging and all inclusive. We also wanted to -- we also felt like a sign that just read "free food" might incite hoarding and that really wasn't what we were going for. So we came up with the sign to strike a balance and the sign says, "What's in your pantry? This is the season when we could all use a few extra pantry staples. Free food, this food is for you. Take what you would like and make something delicious. Know someone who would like something? Take an item for them too. Don't be afraid to try something new."

So I didn't design the sign. I actually had a nutrition student do it. But I really like the sign because it makes it clear that there are other people who might need food assistance and it makes it clear that the food is free. And it preserves people's dignity by saying, "You can take something for a friend and it also encourages them to try something." So if they think they don't like canned carrots or green beans, you know, we want you to try, go ahead and try.

So we had some immediate feedback from the community as soon as we put the table up, both employees and patients were really happy to see the table. We actually put it up during Christmas time. So it really created a spirit of unity and a caring atmosphere and colleagues donated food to the table, some of our patients brought in food, people brought in bags, it was just a really incredible thing. But some problems came up and somebody suggested that perhaps the table was too public, that there is a spotlight on anyone who uses it because of the way that the waiting room was set up, anybody who gets up to take the food, kind of everybody can see. And we did have -- we had some participations from patrons that people were only taking really a small amount of items, the items weren't turning over quickly.

So we relocated the table. We moved the whole table close to the exit and entrance of the building which is a shared entrance. As soon as you come into the building, if you left go, you've got the senior meal site and if you go right you've got the clinic and it's really increased the utilization of our food bank. And here's the picture here where you can see when people come into the door, the food bank is right there so they can take stuff on their way out or they can take stuff on their way in. It's just really discrete.

So when we moved the table we had a lot of use. We found that I need to restock the table daily. We go through about a two cases of food a day which is about 48 cans. And I did have patients, some of my patients would come and say, you know, I wasn't really sure if I should be taking food because I'm not low income. So I actually ended up moving the food insecurity table off of the food table and I photocopied them and I've put them in our waiting room. But I did think it was important to take away because people are at the doctors and they're just finding out they had diabetes and trying to control blood pressure. And this table, it's all full of really nutrient-rich food and we want them to make a jumpstart with their diet and to try to control their diet, their issue with food. So we did take that away. And the results are just wholly positive. It creates a really caring atmosphere, nothing says that you care like offering nourishment. I had lots of people saying, "Thanks for doing this. No one has ever done this here before." And there's a lot of talk with the elders and people all the time are adding recipes or food.

And I really like this program because in addition to helping people, it gives the clinic a really good appearance and reputation. Our clinic does fantastic things every single day but most of those things happen behind closed doors and are private.

So far too often, the clinic doesn't really get the praise it deserves. And this program shows the community that we care and allows the clinic to shine like a beacon that it is. And that's my presentation today and if you have any questions, I'd be happy to hear them.

Kelli Begay:

Awesome, thank you Abbey. I really love this program and it seems fairly easy as far as getting it started so thank you so much for sharing that with us today. And our next presentation is with Stacy Hammer and Stacy I'm trying to bring up your slides here --

Stacy Hammer:

Hello everyone. I'm Stacy Hammer. I'm a Registered Dietitian here at the Lower Sioux Health Care Center. I'm just going to present some different programs that we've kind of implemented here over the last couple of years just following two amazing presentations. I'm just all excited in coming off of those two presentations I'm a little nervous now to proceed here. But I will start here. I titled this "Wicozani" it's a Dakota word for overall health and wellness or whole health. So we've been utilizing this word a lot over the last year I would say in our community, just because I think whenever -- especially coming out of a dietitian's mouth, healthy is just not -- it kind of turns people off sometimes especially when you use that in relation to food unfortunately. Unfortunately, it has kind of negative connotations. We should be utilizing our Dakota language here and what better way is to use a word like "Wicozani" where we're really talking overall health and wellness and integrating that in all areas of our health.

So some of the topics for discussion that I'll be bringing up is I'd like to talk briefly at the beginning here about the history of our community here. We're located in Morton, Minnesota. So I'll kind of talk about that briefly, I think it's really important for you to understand where we're coming from here in our community and where we're hoping to go in the future with future generations.

I'll be talking about our elders and youth connection through different activities such as our diabetes bingo and our healthy living bingo which is a diabetes prevention bingo that we have here in our community. I'll be talking about the Administration on Aging Title VI Program about the Elder

Nutrition Program, helping in food projects that we've been working on for the last two years with our Lower Sioux Health and Human Services Advisory Committee and also tribal leadership engagements that we've been working with our tribal leaders with, promoting healthy eating and health and wellness here in our community. Lastly, I'll just be talking briefly about some of the areas that are coming up next I think that things that are merging within my work here as well surrounding nutrition.

So this is a very loaded slide but I just kind of wanted to -- if you look at these slides later you can read a little bit more about the history of our community here. I just thought it was important -- again, like I mentioned, we are a relatively small community and a lot of that comes from the history of what happened to our people during the Dakota War of 1862. So I just left that up there just to kind of -- like I said, if you want to get back and read that a little bit later, but I just think it's really important to talk about the history so that we can move forward in our future here as a community and as a people.

And where we are today, so we are located, like I've mentioned in Morton, Minnesota, which is about two hours southwest of the Minneapolis-Saint Paul metropolitan area. So we're on about 2,000 acres in southwest Minnesota. We currently have around 1,100 enrolled community members living within a 10-mile radius here and approximately 50% are under the age of 18. We are also governed by a five-member tribal council as well.

So we look at the history of our health care administration here. The bottom left, or excuse me, it's in your left hand side of the screen here is the picture of our recreation center. So we were originally housed in there, we had a small little office, which is now a computer lab for the kids, but I was placed here for first time as a registered dietitian in the year of 2013. So up until that point, you know, a really small community health office. We've had the SDPI program before I was hired here but it was held by a coordinator that was a registered nurse, so she did a lot of public health nursing, obviously since we didn't have a direct care facility on the reservation at the time. And then, move forward a little bit to 2014 and 2015, I have a picture in the center there that that little building there is where we moved after we moved out of the recreation center.

So we house our benefit coordinator, contract health, myself, and we had our community health nurse and then our director. So here we are today. So we moved into our -- we opened our new clinic here in March of last year. So we just celebrated our one year anniversary. So for the first time ever in our community here we have our own clinic on our reservation. So it's just great to listen to the elders and especially listening to my dad and talk about how that's something that they always wanted here. He remembers growing up here and always wanted to have our own clinic here. We have a little bit of a history here with the town located really close to us about eight miles from town here, is the town of Redwood Falls and up until 1955, community members here, the Native people here were not allowed in that hospital. So my dad for instance, his generation had to be brought to an IHS clinic or IHS facility in South Dakota. So a three-hour drive versus a six-minute drive. So a lot of that still resonates in our community today. So we are bridging that gap and we have a good relationship today with the town of Redwood Falls, but it is nice to have our own services here on our reservation.

So some of my duties here as a SDPI Coordinator are listed here. I do diabetes education for management prevention, medical nutrition therapy and a lot of community health focuses here within my work. Obviously we all know we have a lot of grant writing responsibilities and reporting not just with our SDPI program but as I'll mention, I have other grants that I'm directing as well right now. I also mentioned the Elder Nutrition programming, menu development and nutrition analysis I do for that program. I worked on our website as a website administrator as well, so I try to update that. Community Action Grants, Project Manager currently with the Notah Begay Foundation. We have a Cultivating Healthy Communities "Wicozani" with the children needs. I'm also the Project Director for that and that's funded through the Aetna Foundation. Luckily those two grant opportunities really are merging well and have the same focus. So a lot of that worked intertwined together. And also I work with our Health Human Services, Advisory Committee, as a facilitator and organizer.

So some of the activities and services within our diabetes program here, I do facilitate monthly diabetes bingo as I mentioned and also healthy living bingo with our kids. That is something that we purchased through the curriculum that was developed by the White Earth Diabetes Projects. So if you're interested you can contact White Earth Diabetes Project. They do still sell the diabetes bingo and healthy living bingo and it is culturally relevant as well. Grocery store tours, I implemented those about two years ago. I tried scheduling them monthly and just having them on the schedule. I never had anyone actually call to meet me on that scheduled date and time. So now what I do is I just individualize it. So when I meet this client, I always offer that, you know, bring up for the next visit we can meet up at the grocery store and we can do a grocery store tour. That is something that I am currently doing.

We also collaborate with the Minnesota Department of Health Statewide Health Improvement Program, our tobacco prevention program and a series of races such as we do a yearly pow wow 5k. We do a diabetes awareness trail run in the fall. And with all of those different programs I do incorporate a lot of nutrition education into that as well and then annually we do a diabetes awareness dinner. I typically bring in a speaker and we have a healthy community dinner with that.

This is one of the tools that I worked on last year. I brought in one of our elders, a couple of Dakota language speakers and we talked about what a traditional plate would look like and integrated that into today's world obviously. And hopefully utilize the Dakota language in there as well. So as you can see it's very familiar, I utilized what Indian Health Services did with their *MyPlate* and just kind of integrated our own language and our own foods on the front. And in the back side there are more example plates as well. I just think it is important that within our community, it's obviously we're not -- our traditional foods are very different than Navajo traditional food. So I just think when you get that question, what is traditional food for Native Americans? And then I always try to educate people that it's different wherever you are located. Community members really like that, actually. I utilized that one-on-one with my clients but then, community events, I'm usually hand those out as well.

Lower Sioux Elder Nutrition Program is something that began here in July of 2014. It was a very big change from the norm. Our elders were given daily meal tickets. We have a casino located on our reservation here at Jackpot Junction, that's the name of the casino. And they were allowed a food ticket every day to utilize at any of the food outlets in the casino. Basically they had a choice of buffet, pizza, all the foods that we really don't want to encourage for a lot of our population that have diabetes and heart disease. So there's a huge endeavor on having to be the dietitian that is developing and analyzing recipes and then sending that over to our casino as to create those meals. But it's been a great relationship with our casino and they really adhere to the nutrition that I'm handing to them as far as the recipes and the menus as well, but it has been a challenge. As you'll see here the benefit obviously is really helping our elders have a better understanding of what a healthy plate looks like because that's they're receiving with their meal each day, Monday through Friday.

I do a series of different surveys. I've had some elders express that they were pretty excited that they were experiencing weight loss, they've been trying to lose weight but they haven't been able to. And I had one mention to me that she -- after a month of participation, she lost a few pounds and she was so excited about that. And feeling after a meal, they're feeling full but not too full so that was encouraging. And obviously like I mentioned the challenges of integrating and starting this program was very time consuming initially obviously, developing those menus, locating recipes, a lot of trial and error and acceptability of new recipes as well. And acceptance of change I think with anyone is really hard to -- all of a sudden, here is your meal and you don't really have it, this isn't a choice, this is the meal if you want to have it. But I do follow the DASH diet. I try to keep it lower sodium, smaller portions and a typical meal obviously -- and trying to get our elders in for congregate dining is still kind of a challenge.

So the next thing that I wanted to talk about is the formation of our Lower Sioux Health and Human Services Advisory Committee. So this is an eight-member Advisory Committee that were nominated during a community dinner that we had with the Sioux Chief, Sean Sherman, two years ago. So again here's just some more information about our committee and what our long term goal is. As I mentioned, I'm support staff that help facilitate these meetings in collaboration with the American Indian Cancer Foundation.

So the long-term goal is to increase community engagement to establish a sustainable Lower Sioux Indian community food system that improves the access to healthy food, connects the community to indigenous foods and create healthier families.

And here is just a few -- some of the roles and responsibilities such as providing input towards programming and grant funding use and community needs by staffing each of these areas. So we do meet with our committee monthly to talk about different grant opportunities that are coming across our desk and what are some of the objectives they would like us to focus on. So I think it's really important that we talk to our community members about what they want to see, what does health mean to them.

One of our big success, I guess one of our biggest successes in the last two years has been the adoption of the Honoring Little Crow with the Healthy Indigenous Foods Initiative. So if you'd like any more information on that or you would like to see a copy of that, if that's something that you would like to see happen in your community, please feel free to email me. But we did adopt that resolution, our tribal council did on September 20th. Some of the key areas of that resolution is changing our vending machines so that 75% of those items in our vending machines at our rec center and our community center were healthy or indigenous and healthy meaning that we follow the healthy snack guidelines on the site that the USDA has for schools.

We also are calling for a policy to encourage our Wacipi vendors to provide healthy and indigenous food. I'm giving them 50% discount on that theme. And we had a strategic plan, we just met in January to come up with a strategic plan to present to our tribal council. We just met with them actually this past Monday and pointed out these different focus areas within that strategic plan. And again this is something if you want to read after the presentation here, just to kind to see kind of what that timeline looks like. A lot of power in collaboration and the partnerships, I always encourage anyone that any of your funding partners working together with all your departments within your health, recreation, behavior health, and working together with all the other organizations within your community really helps with this work.

And of course I think it's very important that we engage and garner tribal leadership support. We need to connect, really talk with leadership throughout this entire process, bring the voices of your community to them by survey results, focus groups, et cetera. And again I can't mention enough American Indian Cancer Foundation and their help and assistance with technical support and they do meet with us each month with the committee as well. So again, if you need their resource as well, I can provide that to you.

And what's next? So integrating nutrition education into a recovery program, so I've had participants of outpatients of our drug and alcohol programs expressing interest in nutrition education as part of their recovery. Weight gain seems to be one thing that I hear a lot from those in recovery, so I'll see them one-on-one for nutrition education on weight loss.

But I also see there's been an opportunity to screen for possible malnutrition diagnoses for follow up medical nutrition therapy. And I've also had a lot of participants request to be allowed to participate in our Elder Nutrition Program meal service during outpatient recovery. So my question now is how can we support that model and integrate it into our recovery here, outpatient recovery in our community. So again, engaging and talking with our leadership about how we can make that happen.

I just left this up as our last slide. It was a digital recording that we had that was created from a strategic plan that we had, a strategic planning meeting, I should say last fall with our clinic staff, community health staff and our committee as well. And thank you again for hearing what we're doing here in our community.

Kelli Begay:

Thank you so much Stacy and thank you to all of our presenters. You guys are so inspired in the work that you're doing and I hope that our audience is also inspired to try some of these innovative ideas out in their clinic or communities.