The Special Diabetes Program for Indians (SDPI) provides locally-driven, culturally-informed, and evidenced-based diabetes treatment and prevention programs in over 300 Tribal communities. It is one of our nation’s most effective federal efforts in combating diabetes and results in significant positive health outcomes as well as short and long term federal health care savings. This year at the 8th Annual SDPI Poster Session, twenty-five SDPI grantees have been selected to display their approaches towards diminishing diabetes throughout Indian Country. Native Americans and Alaska Natives are known to have a greater chance of developing diabetes than any other racial group. Thanks to the dedication of these Tribal Public Health programs, families across Indian Country are getting the treatment they need, becoming more aware, and taking action to prevent this harmful disease. We are proud to acknowledge their work and care in creating a healthier environment.

Bemidji Area Office
“Diabetes Medication Management” (Bemidji)

The purpose of the project was to: 1) Decrease the patients’ hyperglycemia and 2) Increase the knowledge and skills of RNs and RDs in medication management.

Two SDPI programs volunteered for the project. The International Diabetes Center provided the advanced diabetes training. The project began in October 2014. The staff followed the IDC protocols. After six months, the patients’ blood sugars were amazing! Clinic A’s patients’ A1Cs had dropped 1.0% and Clinic B’s had dropped 2.0%! The American Diabetes Association reports a drop of 1% in elevated A1Cs can reduce the rate of any complication by 21%! In 2017, Clinic A’s patients average a 0.9% decrease in their A1Cs and Clinic B’s patients average a 2.2% decrease in A1Cs. The average decrease for both clinics is 1.5%. An evaluation of the project is underway. This successful project is expanding in Bemidji Area and could be replicated in other areas.

Chinle Service Unit
“CSU Diabetes Program ” (Navajo)

The Chinle Service Unit Diabetes Program has developed multiple resources to educate and care for our diabetic patients. We have begun to refine the way we integrate the service unit’s resources into care of patients. Increasingly, we are making intentional efforts to target patients most likely to benefit from health coaching (based upon elevated A1C level, starting or adjusting insulin, or hospitalized patients). The focus of our activities are on Glycemic Control for new onset uncontrolled diabetes. These activities have broadened our efforts to intentionally work with a high-risk special needs population of diabetes patients and to integrate a larger multi-disciplinary team into the care of patients. Our interventions are emphasized on identification, engagement, retention, education, and medication adherence for new diabetic patients, drawing upon the skills of Chinle’s multi-disciplinary “community of support”. Our program has put together several patient success stories included with past poster sessions.
CSKT Tribal Health
"Flathead Diabetes Program " (Billings)

In January 2017, the Flathead Diabetes Program launched what is now known as the Kidney Keepers Wellness Club. The Flathead Diabetes Program challenged the reservation to increase physical activity by training and participating in the Missoula, MT half marathon. Out of the 78 initial registrants 38 participated in the half-marathon. Since then, the club has evolved into a multi-activity club that meets on a monthly basis with plan activities surrounding healthy lifestyle and the CSKT community strong prevention principals.

Karen I. Fryberg Tulalip Health Systems
"Diabetes Care and Prevention Program " (Portland)

The Tulalip Tribes Diabetes Care and Prevention Program’s diabetes team has been designed to include an integrated team as part of a multi-disciplinary health care system which utilizes a community-specific best practice standards to combat diabetes together with our people to create a sustainable diabetes-free community for our future generations. These services provided by: PharmD, Behavioral health specialists, dentistry, RD, CDE, ARNP, optometry, podiatry services and community outreach workers such as our 76 year old Tulalip Tribal Member and Elder Advocate who works tirelessly on behalf of our people. We offer alternative medicine services, organic gardening experts, chef services, traditional medicine and support our local farmers. This is being achieved through our well-rounded diabetes educational program, cultural activities, healthy foods, diabetes awareness and oral traditions as taught by our elders, conventional treatment and outreach efforts that encourage a return to traditional lifestyle while respecting individual needs and preferences.

Leech Lake Band of Ojibwe
"Leech Lake Diabetes Program " (Bemidji)

The mission of the Leech Lake Diabetes Program and Clinic is to empower our communities to ultimately defeat diabetes and to improve the quality of life for those living with diabetes. The Leech Lake Diabetes Clinic and Program’s staff includes a Certified Nurse Practitioner, two Certified Diabetes Educators, Registered Nurse, Licensed Practical Nurse, Diabetes Wellness Education Coordinator, Clinic Receptionist and Administrative Assistant. Together we specialize in the treatment and medical management of people living with Diabetes and its co-morbidities, as well as educate the Leech Lake community on Diabetes Prevention Programs that have been recently implemented are: Healing Touch Therapy, Broom, Alpha Stim Therapy, Certified Health and Wellness Coaching, and The National Diabetes Prevention Program. The Leech Lake Diabetes Clinic has achieved accreditation with the American Diabetes Association (ADA), which demonstrates that education is being done according to the National Standards, and all plans are individualized using an approved curriculum.

Mohegan Tribe
“Mohegan Tribe Diabetes Program” (Nashville)

Diabetes education in healthy behaviors and nutrition identified unmet needs in Mohegan Tribe Special Diabetes Program for Indians (SDPI) for ages 10-13. A Community Health Worker (CHW) position created new outreach for youth and young adults. Outreach to new and at risk youth include mentoring, cooking classes, and education. A CHW role description was created based on identified youth need. A review of existing program data, best practices, and activities, led to entry in Special Diabetes Outcomes System (SDOS) for evaluation. A collaborative approach linked partners, and new tracking tools were developed. Diabetes Coordinator role included regular planning meetings and supervision. Results of CHW outreach was 46 youth, 52% of 10-13 ages, including new activities. Peer mentoring engaged four young adults as role models. CHW Role improved outreach and engagement. SOS evaluation in 2018 targets ages 10-12. CHW role development requires additional planning and supervision time for SDPI coordinator.
Muscogee (Creek) Nation
“Diabetes Specialty Clinic Saving Sticks” (Oklahoma City)

The Muscogee (Creek) Nation SDPI program established a specialty clinic headed by an APRN-Clinical Nurse Specialist designed to advance the Nation’s diabetes practice. The clinic piloted the Libre-Pro Continuous Glucose Monitor (CGM) with remarkable results. In one particular case, an 81-year-old patient with Type 2 diabetes experienced 10 episodes of hypoglycemia during the night with average duration of 41 minutes. In another instance, a 28-year-old patient provided with a personal CGM reduced finger sticks by 1,344 sticks a year. Utilization of this treatment modality demonstrated positive outcomes in tracking trends and identifying nocturnal hypoglycemia as well as developing a new process to eliminate prescription medications that no longer provide early stage benefits.

Native American Rehabilitation Association of the North West
“NARA Diabetes Treatment & Prevention Program” (Portland)

The focus of the NARA Diabetes Treatment & Prevention Program is diabetes screening, prevention, early diagnosis and reducing the burden of diabetes complications in AI/AN living in the greater Portland, Oregon metropolitan area. The NARA diabetes team is a stable, cohesive, multi-disciplinary clinical group with more than 70 years of combined experience working on SDPI grants. The team manages the care of over 500 people with diabetes and 1000 people with prediabetes. Diabetes Prevention Classes began in 2005, and since then NARA has seen a significant reduction of conversion rates to diabetes in the at-risk Native population. The program strives to use clinical data to drive quality improvement efforts, and has met all GPRA diabetes targets for FY 2012-2017. The team has been recognized nationally for their work in Indian Country and has won numerous awards for innovation in services, improving patient outcomes and advocacy over the last ten years.

Navajo Health Foundation-Sage Memorial Hospital
“Diabetes Management Program” (Navajo)

Sage Memorial Hospital’s Diabetes Management Program consist of Patient Care Coordinators, Diabetes Educator, Diabetes Coordinator, Dietitian, Community Health Nurses and Wellness Center Personal Trainers to help reach our primary goal of reducing the population of patients with diabetes whose Hemoglobin A1c of 8+ in the diabetes registry. We provide services through our wellness center, community garden, diabetes education, community events, case management and home visits. With the purchase of two vehicles we are able to conduct at home visits to the patients who lack transportation. The DMP has successfully reached its goal with numerous patients over the years. A patient with an A1c of 14 has lowered to 7 and has successfully maintained the level with medication management and teamwork with the provider and diabetes educator. Our services provided through the SDPI grant has helped our community with resources and compliance which will help lead to better glycemic control.

Navajo Nation
“Navajo Special Diabetes Project” (Navajo)

In 2016, the Navajo Nation Special Diabetes Project (NNSDP) has reached 79% of the target population (Ages 5-44) who achieved the Required Key Measures of Best Practice: Diabetes-related Education. NNSDP utilized Best Practice methods to address the quality gaps in diabetes prevention services that fostered healthy decision-making skills and identifying potential health risks before it reached a significant disease state. The diabetes prevention program utilized screening through health risk appraisals, one-on-one counseling, and education for behavior modification.

In addition, NNSDP collected personal testimonies on the impact of the wellness program, and demonstrated wellness leadership at the communities, schools and work sites. SDPI funding allowed continuation efforts to expand diabetes prevention services throughout the Navajo Nation.
Oglala Sioux Tribe
“Oyate Bli Helya Diabetes Program” (Great Plains)

The Oglala Bli Helya Diabetes Program staff completed Presidential Fitness tests with students in five schools during the fall and spring of school year 2017-2018 in the following areas: 1) sit and reach, 2) walk/run one mile, 3) push-ups, 4) sit-ups and 5) pull-ups. The results will show the number of students that had comparison data and improved in their fitness levels.

Based on data for the school year 2017-18, 1,333 students enrolled in school and 1,029 (95%) were screened for overweight and obesity. Of the students screened, 52% (n=515/1029) had a BMI percentile >=85. Of the students screened in school year 2017-18, 47% (n=527/1129) had a healthy weight, 19% (215/1129) had overweight, 22% (n=249/1129) had obesity, 9% (n=105/1129) had severe obesity and 2% (n=26/1129) had a BMI percentile that exceeded the range of expected values.

Oklahoma City Indian Clinic
“DSME Retinopathy” (Oklahoma City)

The purpose of the “See the Future of Your Diabetes” program was to increase the number of Oklahoma City Indian Clinic (OCIC) patients with diabetes who receive a Retinopathy Screening. Due to the large number of active patients with diabetes, it is difficult to meet the Government Performance and Results Act (GFOA) measure: Diabetes Retinopathy Assessment.

In 2015, OCIC received a new Optos Retinal Imaging (RI) camera from Indian Health Service (IHS). A member of the diabetes team received training at IHS Joslin Vision Network (JVN). OCIC made changes including: 1) RI is located in the Medical department for better access, 2) ‘Care identified patients with diabetes needing RI, 3) Patients needing RI were sent reminder cards, 4) EHR reminders notified medical staff if RI was due, 5) RI offered during OCIC evening events, and 6) Walk-ins welcomed. OCIC exceeded the internal goal of 79.0% for the GFOA year 2016. This project demonstrates how teamwork and innovative changes can help programs meet goals.

Pascua Yaqui Tribe Health Department
“Pascua Yaqui Diabetes Prevention and Treatment Program” (Tucson)

The mission of the Pascua Yaqui Diabetes Prevention & Treatment Program (PYDPTP) is to nurture and sustain the cultural longevity of the Tribe through offering outreach, physical, mental, and emotional support to empower all community members to strive for a healthier lifestyle through diabetes education, management, and prevention.

The PYDPTP, which has been funded since 1998, aims to reduce the prevalence of diabetes and reduce complications of uncontrolled diabetes among community members.

The program provides a broad range of preventative services including health education, health promotion, care coordination, nutrition counseling, community screening and outreach activities. The focus of the program is to provide community based, diabetes-related education including nutrition, physical activity, and fitness to enable individuals to prevent, or better manage diabetes. Our programs are delivered through the PYT Wellness Center and the Outreach team who work closely with other Tribal program partners to engage community members.

Pueblo of Zuni
“Zuni Healthy Lifestyles” (Albuquerque)

Zuni Healthy Lifestyle Program (ZHLP) has a staff of nine and a program director. The best practice is diabetes-related education which helps to reduce the risk of the development of DM and its complications, and has been scientifically proven to work effectively within the Zuni Community. ZHLP continue to provide creative interventions through diabetes education, physical fitness, and group challenges to change the community’s lifestyle such as: Little Chefs Cooking Classes, Get Fit Together Walking Club, Biggest Loser Challenge, Traditional Harvest Dance with Pueblo throw, Snack Smart, Mobile Monday with Healthy Heart, Battle Buddy and Red Warrior fitness challenges, and slam-dunk diabetes basketball and softball leagues. We’ve also had WIC collaboration with the healthy mom initiative to help eliminate gestational diabetes. Community Gardens for sustainability of life with Zuni carried Cultural practices. Provide Educational sessions: stress management sessions, alcohol and diabetes, basic diabetes education, A1C and cholesterol sessions.
Rosebud Sioux Tribe
“Diabetes Prevention Program” (Great Plains)

Our program focuses on education of all topics regarding diabetes/prediabetes. The RN teaches an evidence-based curriculum for our AADE accredited Diabetes Self-Management Education program. This is currently the only accredited DSME program in southwestern South Dakota. A condensed version of the Native Lifestyle Balance Curriculum is used for individuals at-risk or with diagnosed prediabetes. Due to the high number of women in our area with Type 2 diabetes and high HgbA1c, we now offer women-only nights for one hour, twice a week in the fitness center. Women receive basic diabetes education and physical activity education with one of our three fitness techs and the Lifestyle Coach. We have seen results in weight loss, decreased BMI, and lower HgbA1c in those who combine the education with regular physical activity. We also provide education and information in all our communities, schools, and other venues upon request.

Salt River Pima-Maricopa Indian Community
“Diabetes Prevention Services” (Phoenix)

We have successes to share with updating our program name, outreach to our SDPI target list (101% reached), collaboration with existing partners, and Diabetes Prevention Pilot success quotes (e.g. “Through this program the accountability and support helped me get out of pre-diabetes range and doctor took me off cholesterol meds. Getting off meds was my goal in the beginning of this program and I've met that”). We also held a Health Summit with a kick off by our community manager and information on nutrient rich traditional foods.

San Carlos Apache Healthcare Corporation
“Diabetes Program” (Phoenix)

The San Carlos Apache Healthcare Corporation (SCAHC) is a Tribally-operated facility located in southeastern Arizona that serves the San Carlos Apache community. The SCAHC Special Diabetes Program for Indians (SDPI) grant program has selected good glycemic control (A1C <8%) as its best practice, and has over 600 patients in the target population. Program staff work with patients and community members to help achieve good glycemic control through three components: diabetes clinic, community outreach, and fitness. The diabetes clinic truly functions as a multidisciplinary team, allowing for quality care with a focus on education and prevention of diabetes complications. The outreach program has implemented several unique and collaborative approaches to prevent diabetes in the community. One of the highlights has been the Door2Door Diabetes campaign, which provides in-home diabetes prevention education throughout the entire community.

Southern Indian Health Council, Inc.
“Native Own Wellness” (California)

Patient Centered Medical Home- Our goal is to work with patients to optimize healthcare delivery, while supporting patients in making informed decisions on their diabetes management. Clinical goals are to ensure screening measures are met throughout each visit while working together as a team. Southern Indian Health Co. offers on-site specialist appointments to help meet screening measures. Our data has improved by making sure that all screening measures are reviewed with patients at every scheduled appointment.

Monthly and weekly activities in the community are scheduled to make sure diabetic education and nutrition are also provided outside of the clinic. We work as a team to ensure that we are building awareness in our communities by providing appropriate educational materials and resources that patients can understand and utilize. Providing incentives and using our unique puzzle piece theme helps patients understand that we are a piece to their diabetic puzzle.
Sault Tribe Health Center
“Sault Tribe Diabetes Program” (Bemidji)

The Sault Tribe Diabetes Program’s mission is to provide high quality patient-centered health care that is responsive, courteous, and sensitive to individual, family, community and cultural needs with an emphasis on disease prevention and health promotion. The Sault Tribe Health Division has seven health clinics providing various levels of medical services throughout our seven-county service area. Our services are offered to all Native Americans, ages infant to adult. The diabetes program is a recipient of SDPI Community Directed Grant since 1998.

The Sault Tribe Diabetes program has guided the Tribe’s Health Division’s program planning and driven outcomes to reach optimal diabetes standards of care. Our program strives to improve the health of our Native people with diabetes and advance the health of our Native children and communities. It encompasses the circle of life and is integrated into all of the Sault Tribe’s health programs. We continuously look for ways to inform, educate and support our Native community and extended community to help prevent and manage diabetes in a positive way. We treat the family as a whole, not just the person with diabetes. We encourage self-acceptance and educate patients and families on how to develop healthy strategies to live in harmony with diabetes.

Sault Tribe’s SDPI program offers a team approach that focuses on physical, emotional, mental and spiritual health. We treat patients as a whole and identify tools to help manage all areas of health and wellness in relation to diabetes. With the patient in the center of the team, the SDPI program staff guide the patient in living in balance with diabetes.

Spirit Lake Tribe
“SDPI: A Sacred Life Center” (Great Plains)

We had a dream for a facility for our patients with diabetes to be able to go and learn more about healthier eating, physical activity and a place where they could socialize to provide encouragement for one another. We started the renovation, but our dream got even bigger. We wanted a place for ALL people to get healthier so we can prevent diabetes, and hopefully decrease the new diagnoses of it.

Our facility is almost 100 years old. It is a former school, boy’s dorm, power house, and mechanic shop. We had our grand opening in March 2017, and we currently have almost 600 members! We are definitely on our way to decreasing diabetes. Our staff consists of two registered nurses, three fitness specialists, one data coordinator, and one janitor. We offer diabetes self-management education (DSME), diabetes prevention, and physical activity education. Over all, we do our best to provide holistic care.

Tohono O’odham Health & Human Services
“Healthy O’odham Promotion Program” (Tucson)

The Healthy O’odham Promotion Program (HOPP) has been in existence since 1997 and has continued to develop and implement innovative programs specific to the Tohono O’odham culture. This has sparked positive outcomes which in turn have demonstrated that Tribal members are empowering themselves to make changes which will improve health and the health of their families. HOPP is unique in that we have 11 HOPP Wellness Centers (modular units) in each of the 11 Districts located on the Tohono O’odham Nation. HOPP’s 11 Health Education Specialists, through these HOPP Wellness Centers, engage the residents of these districts by conducting and implementing diabetes-related activities and events in order to promote the message that diabetes can be prevented and can be managed.
Towaoc Indian Health Service
“Sleeping Ute Diabetes Program” (Albuquerque)

The SDPI program for the Ute Mountain Ute Tribe has had a very successful 2017. Our Mission is to educate and motivate people to lower their risk of developing Type 2 diabetes. We believe through education, motivation, and support people can learn to make positive lifestyle changes and prevent Type 2 diabetes from developing. The Goals of our program include: reduce the impact of diabetes in our communities of Towaoc and White Mesa by reducing diabetes related deaths and diseases, educate and motivate people in each department on Diabetes prevention and wellness, make positive lifestyle changes, and meet and educate all ages in our communities. The SDPI funding has made it possible to focus on the areas that need improvement.

We worked with the local IHS clinic in the areas of: community outreach, home visits, case management, and diabetic patient specific appointments and follow ups. In collaboration with the IHS, public health, state health department, and Tribal programs, we were able to reach and engage our diabetic population. Our successful activities include but are not limited to: the development of a Wellness Committee, nutritional education and diabetes education provided by the Registered Dietician and Registered Nurse, community screenings, Health Fair health promotion and education, youth clubs, youth bike club, summer and winter family fitness challenges, walking events, chair exercise, Lipid Management Collaboration, Flu Clinics, tobacco education, and cultural community events. We are delighted to have reached and even pass our target goal numbers with a total of 1,803 participants included in our patient focused programs, activities and events.

Urban Inter-Tribal Center of Texas
“UITCT Diabetes Program” (Oklahoma City)

In 2017 our diabetes program began a weekly cooking class to increase participant’s abilities to cook healthy foods at home. We have six clients in each class and all are involved in preparing and eating the meal. Each class includes items that participants may have little exposure to such as squashes, rutabagas or quinoa. Education is included on nutrition and other ways to prepare and use these items. Participants have shown enthusiasm about many of the recipes and state that they go home and prepare the meals for family members and friends. Many clients also have stated that being able to do healthy cooking in a controlled environment has inspired them to try new and healthier dishes at home. Our participants return monthly to try out new recipes and are getting involved with our diabetes support group and gardening activities, which we also offer.

Winslow Indian Health Care Center
“Hozhoogo Iina Wellness Program” (Navajo)

The Hozhoogo Iina Wellness Program at Winslow Indian Health Care Center (WHGCC) implemented the Systems of Care best practice to increase access to diabetes care and treatment for patients and families living with diabetes residing within the WHCC service area for grant year 2017. In collaboration with interdepartmental supportive services, the program provides preventive services to promote early detection of complications and early intervention to maintain the quality of life of the patient which include: a weekly multidisciplinary clinic, diabetes foot care, home glucose monitor and supplies services, case management of high risk patients by the DM Community Health Nurse, nutrition education provided by the RD and two Nutrition Technicians, fitness coaching services provided by Fitness Specialist and 2 Fitness Technicians, DM youth prevention and management provided by Youth Wellness Nurse, Diabetes in Pregnancy case management and education services, and breast-feeding program to promote primary diabetes prevention for the next generation.

Yukon-Kuskokwim Health Corporation
“Diabetes Prevention and Control” (Alaska)

YKHC’s Diabetes Prevention and Control Program is comprised of a multi-disciplinary team of Diabetes Educators and Outreach Specialists. We are able to offer a multitude of services to patients and families living with diabetes residing within the YKHC service area. Our program offers many services including education and evaluation on a one-on-one basis. This range of services is provided by a medical provider in a primary care setting. This range of services patient and provider satisfaction that enhances patient learning. Outreach Specialists provide several community events annually and coordinate a Wellness Essay that introduces the sport of dog mushing to local youth. Musher’s serve as role models and inspire kids to live healthy lives.
NIHB would like to thank all SDPI participants across Indian Country for your help in ensuring a healthier future for our Tribal communities. We look forward to displaying your ongoing work in the future.

National Indian Health Board

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