Chinle Comprehensive Health Care Facility

“Bringing Healthcare to the Community”

AIM
The Chinle Diabetes Program is to support the well-being of our community through the introduction of education in self-management care to prevent diabetes, manage the progression of diabetes, and address other chronic diseases. Our goal is to enhance the systems of care for the patient while utilizing a consistent cultural approach.

Mission
To strengthen systems, policies and environments that support positive lifestyle choices and changes.

Goal
Optimize Systems of Care that support healthy, happy generations living in balance and harmony with hope and belief for a better tomorrow.

Patient Story

Grant Benally, (80) learned he had diabetes during a visit to the emergency room. He was participating in a group low impact icebreaker exercise at a training when he collapsed; that’s when he knew something was wrong. Months later Grant was admitted again to the ER and he soon realized that he needed to make a change. “I wanted to do my part by helping myself, so I started walking. I knew it would be hard but I did it!” That was six years ago and Grant is still walking to keep his diabetes in control. He’s very thankful for the doctors, dietitian, and his health coach for educating him about diabetes. Grant says, “I’ve come to understand that it’s a partnership between the patient and Health Coach. The Health Coaches are informative, very knowledgeable, and vital to patients that are newly diagnosed with diabetes. I appreciate the help. I could not have controlled my diabetes without my Health Coach.”

Patient Comments

“I liked where I was the spokesperson, talked about all my issues, the coach and his partner listened.”
“We talked about my diabetes, good job to my diabetes coach.”
“Wish I didn’t have diabetes.”
“The provider is to rush and wasn’t really attending to my med needs”
“I like my providers concern about my diabetes care. It makes me feel important and made me aware of myself (take care of myself better).”
“I was very happy about my visit and how much progress I made with my A1c.”
“Very concerned about my diabetes, so I got help and I’ll try my best.”
“People like me need good education about our diabetes. I had a good teacher today, thank you so much.”

Balancing Community-Centered Activities and Services

PROGRAM ACTIVITIES

Shared Medical Appointments (SMA) and Group Classes
- Diabetes SMA: peer support with patient leader
- Diabetes Podiatry SMA: decreasing risk of amputation in high risk patients and home visits
- Balancing Your Lifestyle & Diabetes Curriculum and Classes
- Sweet Success SMA
- Diabetes Advisory Group
- Prevent Type 2 Diabetes (T2)
- Diabetes Advisory Group

Services:
- Multidisciplinary team care in clinic that includes:
  - Provider, Health Coaches, Registered Nurses, Integrated Behavioral Health, Office of Native Medicine, Dietitians, Pharmacy, Fitness Specialist, Population Health
  - Pharmacy support in Primary Care clinics and CVD clinic
  - Pediatric/Teen clinic and Women’s Health Coach
  - Health Coaching with structured AADE principles
  - Case Management of Newly Diabetes Diagnosed Individuals
  - High risk case management with involvement of the Community Health Representatives and Public Health Nursing
  - Patient Home Visits

Community Awareness

- Girls on the Run
- Fruits & Vegetables Prescription Program
- Healthy Habit Goals
- Food Demonstrations

Population Health Services

- Mobile Health Unit: Healthcare in Motion
  - Ats’ii Shanahego Nahiilta
- ArcGIS mapping for monitoring population and services
- Geographical Information Systems (GIS)
- Services:
  - Support and providing technical assistance
  - Training and performance
  - Data analytics and improvement projects
  - Planning and evaluation

Outcomes

Combined Outcome Measure Comparison:
- Combined CVD mortalities for 2017 Chinle Service Unit
- Combined CVD mortalities for 2017 Navajo Area Indian Health Service

Barriers to Care

- Transportation
- Inability to cook healthy meals
- Medication management
- Fear of needles

Patient Home Visits

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