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RATIONALE	Despite prevention efforts which have been initiated in the community, cases of diabetes continue to rise. In addition, diabetes creates significant challenges for individuals, their families, and our health care system.						
GOAL	To reduce the incidence of diabetes and support people who have health impacts associated with diabetes.						
STRATEGY	To educate community members on the impact of diabetes, identify diabetes in the early stages and create programs to ensure access to services efficiently.						
OBJECTIVES	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**
To ensure that all resources and services in Kahnawake continue to promote awareness, prevention, care and support in a holistic manner encompassing Kanienke:ha language and values. (Logic model to be developed, from ADI Sub Committee Strat Plan)	To maintain the ADI sub Committee	Community, individuals with diabetes	ADI subcommittee	Ongoing	Improved access to services	Annual subcommittee reports, Diabetes rates, CHU annual Report	Successful community mobilization, improved overall wellness and reduced complications due to diabetes.
	To audit existing services in prevention, promotion, care and treatment.	Kahnawakehró:non	Diabetes Subcommittee	Ongoing	Frequency of use of data base for existing services.	Annual subcommittee reports, Diabetes rates, CHU annual Report	Successful community mobilization, improved overall wellness and reduced complications due to diabetes.
	Develop strategies to incorporate traditional values, culture and language into services.	Kahnawakehró:non	Diabetes Subcommittee	Ongoing	Organizational Inventory	Annual subcommittee reports, Diabetes rates, CHU annual Report	Successful community mobilization, improved overall wellness and reduced complications due to diabetes.

	Develop a mechanism to guage application of incorporation of traditional values, culture and language in service delivery.	Kahnawakehró:non	Diabetes Subcommittee	Ongoing		Annual subcommittee reports, Diabetes rates, CHU annual Report	Successful community mobilization, improved overall wellness and reduced complications due to diabetes.
To help patients attain target blood glucose levels safely (Diabetes Education)	To provide education for newly diagnosed pateints with diatbetes	Patients newly diagnosed with diabetes	Diabetes Nurse Educator	Ongoing	SBGM logbook filled and brought to MD Appointment	Progress Notes	Increased understanding of how diabetes affects the body
	To provide education about medications used to treat diabetes	Patients living with diabetes	Diabetes Nurse Educator	Ongoing	Improved adherence to medications	Self reported	Improve blood glucose control
	To reduce risks associated with hypoglycemia	Patients living with diabetes & their families/friends	Diabetes Nurse Educator	Ongoing	No reported hypoglycemic episodes	Anecdotal. Glucometer readings printout	Decreased risks of severe hypoglycemia leading to coma or death
	To help patient achieve target blood glucose levels	Patients living with diabetes	Diabetes Nurse Educator Physicians Nutritionist	Ongoing	Decrease in A1C	Test results FNDSS	Decreased number of complications leading to decrease morbidity and mortality
	To reduce stress	Patients living with diabetes	Diabetes Nurse Educator	Ongoing	Improved blood glucose levels	Anecdotal	Decrease in complications and decreased cardiac risk
To ensure early detection of complications of diabetes (Diabetes Education)	To ensure complication screening is performed on patients coming through the clinic	OPD Patients living with diabetes	Diabetes Nurse Educator	Ongoing	Flowsheet	Progress Notes Test Results Consultation form from Ophthalmology Footcare assessment form Chronic disease management form	Early detection of complications

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To educate the community and staff about diabetes and its complications (Diabetes Education)	To educate Kahnawakero:non about diabetes and its complications	Kahnawakero:non	Diabetes Nurse Educator	Quarterly	Progress Notes	Attendance Anecdotal	Decreased incidence & prevalence of DM and complications in Kahnawakero:non
	To educate staff about diabestes and its complications	KMHC Staff	Diabetes Nurse Educator	Every 1-2 months during educational rounds		Attendance records	Increased knowledge to care for Kahnawakero:non
To improve treatment of hypertension (Diabetes Education)	To provide blood pressure testing to ensure early detection	Patients living with diabetes, hypertension or coming for ABPM	Diabetes Nurse Educator Outpatient Nurses	Ongoing	Early detection noted by diagnosis in OPD chart by physician	FNDSS	Decrease sequelae to hypertension
	To educate patients about hypertension	Patients living with diabetes, hypertension or coming for ABPM	Diabetes Nurse Educator	Ongoing	Decreased rate of hypertension. Blood pressure at target	FNDSS	Decrease sequelae to hypertension
	To provide education about medications used to treat hypertension	Patients living with diabetes, hypertension or coming for ABPM	Diabetes Nurse Educator	Ongoing	Improved adherence to medications	Self reported	Decrease sequelae to hypertension
To ensure research done at KMHC on diabetes respects the principles of OCAP and the community is informed of all research completed at KMHC (Diabetes Education)	To help in implementation of research projects as needed	Research assistant	Diabetes Nurse Educator OPD Nurse Manager	Until Jan 2012	Data is completed as needed		Decrease and early detection of complications of diabetes

	To disseminate study data from research study	KMHC KSCS KSDPP Onkwa	Research Assistants	As needed			Increased knowledge of the impact of interventions in Kahnawake
To provide awareness, or educational opportunities for at-risk groups for Diabetes (KMHC Operations)	Diabetes: Blood glucose screening booths Display boards Workshops	Adult population with preventable risk factors.	CHU Nurse	May June November	Increased demand for screening opportunities.	Number of screenings 500+n no new/undetected diabetes found Number of requests for	Decreased number of undetected diabetic/IFG persons in community.

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Goal	TO HELP PATIENTS ATTAIN TARGET BLOOD GLUCOSE LEVELS SAFELY.						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**
To provide education for newly diagnosed patients with diabetes.	Teach regarding: • Disease process of DM and its complications. • SBGM • Self-management with diet and physical activity	Patients newly diagnosed with diabetes	Diabetes Nurse Educator	Ongoing	SBGM logbook filled and brought to MD appointment	Progress notes	Increased understanding of how diabetes affects the body
To provide education about medications used to treat diabetes.	• Teach about medications action	Patients living with diabetes	Diabetes Nurse Educator	Ongoing	Improved adherence to medications	Self-reported	Improve blood glucose control
To reduce risks associated with hypoglycemia.	• Teach about signs and symptoms, causes and treatment of hypoglycemia	Patients living with diabetes& their Families/friends	Diabetes Nurse Educator	Ongoing	No reported hypoglycemic episodes	Anecdotal. Glucometer readings printout	Decreased risks of severe hypoglycemia leading to coma or death
To help patient achieve target blood glucose levels	• Review self-management strategies: nutrition, diet, stress reduction • Adjust medications as per MD orders	Patients living with diabetes	Diabetes Nurse Educator, Physicians, Nutrtionists	Ongoing	Decrease in A1C	Test results FNDSS	Decreased number of complications leading to decrease morbidity and mortality
To reduce stress.	• Teach stress reduction strategies • Counsel patients as needed • Refer to other services as needed	Patients living with diabetes	Diabetes Nurse Educator	Ongoing	Improved Blood glucose levels	Anecdotal	Decrease in complications and decreased cardiac risk

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Goal	TO ENSURE EARLY DETECTION OF COMPLICATIONS OF DIABETES.						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**
To ensure complication screening is performed on patients coming through the clinic	Reviewing patient's chart prior to physician visit to ensure the following are done: - Blood & urine tests - Foot assessment - Ophthalmology visit	OPD Patients living with diabetes	Diabetes Nurse Educator	Ongoing	Flow sheet	- progress notes - test results - consultation form from Ophthalmology - foot care assessment form - Chronic disease management form	Early detection of complications
Goal	TO EDUCATE THE COMMUNITY AND STAFF ABOUT DIABETES AND ITS COMPLICATIONS						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**
To educate Kahnawakero:non about diabetes and its complications.	- Participate/lead in educational rounds - Write articles for Aionkwatakari:teke, Eastern Door - Television - Diabetes screening on the street	Kahnawakero:non	Diabetes Nurse Educator	Quarterly	Progress notes	Attendance Anecdotal	Decreased incidence & prevalence of DM and complications in Kahnawakero:non
To educate staff about diabetes and its complications.	- Facilitate educational rounds - Approach reps to sponsor rounds	KMHC staff	Diabetes Nurse Educator	Every 1-2 month during educational rounds		Attendance records	Increased knowledge to care for Kahnawakeron:non

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Goal	TO IMPROVE TREATMENT OF HYPERTENSION.						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**
To provide Blood Pressure testing to ensure early detection.	- Check blood pressure on all patients coming through the OPD or Diabetes program. - Perform 24-hour ambulatory blood pressure monitoring (ABPM) as ordered by physicians.	Patients living with diabetes, hypertension or coming for ABPM	Diabetes Nurse Educator Out-Patient Nurses	Ongoing	Early detection noted by diagnosis in OPD chart by physician	FNDSS	Decrease sequelae to hypertension
To educate patients about hypertension.	- Teach about hypertension in following ways: - What it is - associated risks - lifestyle changes to help prevent/ treat	Patients living with diabetes, hypertension or coming for ABPM	Diabetes Nurse Educator	Ongoing	Decreased rates of hypertension. Blood pressure at target	FNDSS	Decrease sequelae to hypertension
To provide education about medications used to treat hypertension.	- Teach about medications action and expected side effects and their duration.	Patients living with diabetes, hypertension or coming for ABPM	Diabetes Nurse Educator	Ongoing	Improved adherence to medications	Self-reported	Decrease sequelae to hypertension

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Goal	TO ENSURE RESEARCH DONE AT KMHC ON DIABETES RESPECTS THE PRICIPLES OF OCAP AND THE COMMUNITY IS INFORMED OF ALL REASEARCH COMPLETED AT KMHC.

Objectives	Main Activities	Target Group	Title Responsible	Calendar/ Dates	Indicators	Data	Health Impact
To help in implementation of research projects as needed.	- assist the research assistant in acquiring the data for the First Nations Diabetes Surveillance System	Research assistant	Diabetes Nurse Educator OPD Nurse Manager	until Jan 2012	Data is completed as needed		Decrease and early detection of complications of diabetes.
To disseminate study data from research study.	- Presentations to Kahnawake organizations. - Put data on KMHC website - Publish data in Eastern Door	KMHC KSCS KSDPP Onkwa	Research Assistants	As needed			Increased knowledge of the impact of interventions in Kahnawake