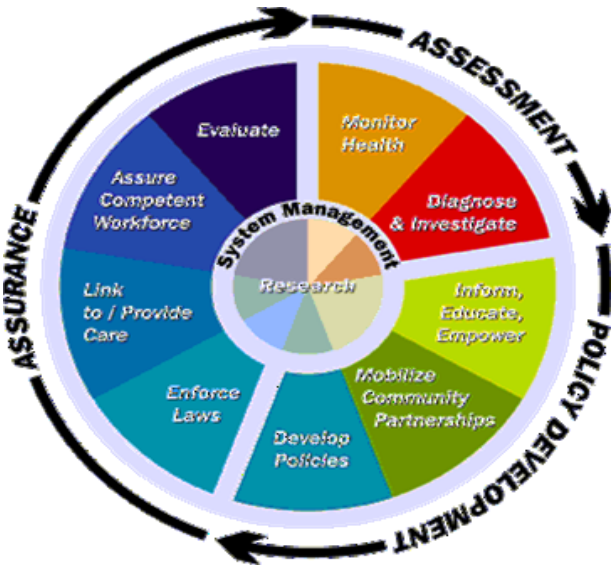
2014-2016 ONEIDA Community Health Improvement Plan (CHIP)

The 2014-2016 Oneida Community Health Improvement Plan (CHIP) was developed by a team of partners from within the organization with the vision to improve the health of the Oneida Community. The plan focused on three primary areas for improvement. These areas were selected after reviewing data from Oneida's Community Health Assessment in 2012 and the Oneida's Quality of Life Survey in 2014. Goals, objectives and strategies were set and tracked over the course of three years. This report serves as the final report on those selected focus areas.



Challenge: One of the greatest challenges in compiling this report was finding the same data sets to compare results from 2014 to present. Over the past few years, improvements were made in how and what data was collected. This was particularly evident after Oneida's 2017 Community Health Assessment survey was developed. Survey questions were changed to collect better, more usable data from the Oneida Community. The changes demonstrate the team's ability to adjust and awareness of current trends and issues. However, this has resulted in losing the ability to directly compare data from 2014 to present. For a couple of the objectives in this report, a notation is made to indicate when data was similar to data from 2014, because no direct comparison could be made.

Strength: One of the greatest strengths of this process was learning to work with data. The team and partners have grown stronger in understanding how data can help programming, finding data when none exists, and using data to drive programming changes. Data also helps the community to visualize and understand the health and wellness concerns in the Oneida Community.

For questions about this report, please call Oneida Community Health Services Department at 920-869-4840.

2014-2016 ONEIDA Community Health Improvement Plan (CHIP)

Focus Area	Decrease Obesity
Goal 1	Reduce Oneida Tribal Members obesity rate.
Objective	By 2017, Oneida Tribal Members age 18 years and older will reduce the obesity rate by 2%. *Measure: percent of community members with BMI over 24.*
Outcome	No change noted.

Some of the **strategies** that have occurred over the past few years include:

- Nutrition counseling through provider referral.
- Farmer Market events coordinated through Oneida Community Integrated Food Systems (OCIF).
- Wellness coaching for overall improvement of health status.
- Distribution of healthy recipes offered through a variety of approaches including the Diabetes Cook Book and programs such as Head Start/ Early Head Start and elder education events.
- The Wellness Council has provided a multidisciplinary approach to develop strategies to impact target populations within the community.

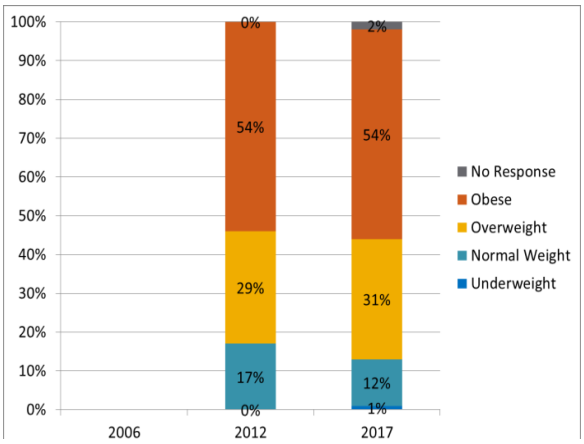
Conclusions:

Although we did not see a decrease in the obesity rate, it also did not increase. Strategies this plan period had been targeted to groups within the community. It's possible that those responding to the Community Health Assessment are not participating in the strategies. Moving forward, efforts may need to be more community wide such as policy change.

Weight Category	Body Mass Index	
	Children	Adults
Underweight	Below 5th percentile*	Below 18.5
Healthy weight	5th percentile to less than 85th percentile	18.5 to 24.9
Overweight	85th percentile to less than 95th percentile	25 to 29.9
Obese	95th percentile or above	30 or above

Body mass index (BMI) is used to determine if you or your child are underweight, healthy, overweight or obese. Children are underweight if their BMI is below the 5th percentile, healthy weight if their BMI is between the 5th to less than the 85th percentile, overweight if their B

Body Mass Index (BMI)

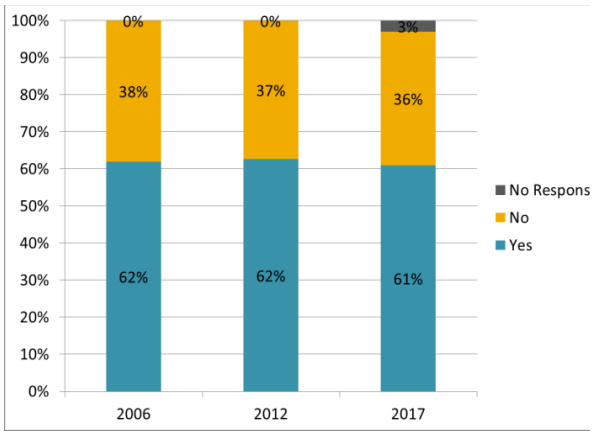


Resource: Oneida Community Health Assessment

2014-2016 ONEIDA Community Health Improvement Plan (CHIP)

Focus Area	Decrease Obesity
Goal 2	Oneida Tribal members will increase their physical activity levels.
Objective	By 2017, Oneida Tribal Members are 18 years and older who regularly exercise will increase by 2%. *Measure: number of respondents and those that responded to regular exercise.*
Outcome	Those that regularly exercise decreased by 1%.

During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening or waling for exercise?



Resource: Oneida Community Health Assessment

Some of the **strategies** that have occurred over the past few years include:

- Providing community wide physical activity opportunities such as the monthly Just Move It Oneida events.
- Tribal support for the Oneida Family Fitness Center to include programs offering free memberships.
- A pilot study conducted by Wellness Council to evaluate the benefit to offer paid work time for employees to exercise at work.

Conclusions:

Although we see documented increase in participation at community wide physical activity events, those that completed the Community Health Assessment may not be participating in the events. In addition this Community Health Assessment saw an increase in respondents 65+ years that may not be as physically active as other age groups.

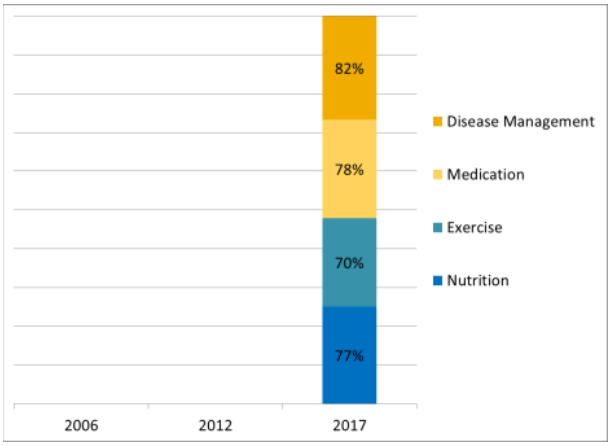
2014-2016 ONEIDA Community Health Improvement Plan (CHIP)

Focus Area	Quality Diabetes Care
Goal 1	Diabetes education is available to Oneida Tribal Members with diabetes.
Objective	By 2017, the percent of Oneida Tribal Members reporting diabetes education is readily available from the Oneida Community Health Center will increase by 4%. *Measure: number of patients with diabetes and those that responded receiving some type of education.*
Outcome	In 2017, we do not have the same data set as used in 2014 for direct comparison. However, we have identified the different types of diabetes education diabetic patients are receiving (see chart below).

Some of the **strategies** that have occurred over the past few years include:

- Provide routine community wide diabetes education events; Family Fun Night every February, Bellin Run team every June, Diabetes Golf event every August, Diabetes Event every August, and Diabetes Walk every September.
- Provide small group education opportunities through the Diabetes Talking Circle. Additional diabetes education presentations have been provided by request for the local Lacrosse team, high school groups, and summer programs.
- Provide one-on-one education opportunities based on patient individual needs.

Which of the following educational materials have you received about diabetes? (Of those with diabetes)



Resource: Oneida Community Health Assessment

Conclusions:

Collaboration between Diabetes Team, Oneida Behavioral Health, Nutrition, Oneida Family Fitness, and Oneida Adventures has increased diabetes education opportunities in the Oneida Community. These collaborations will continue into the future.

2014-2016 ONEIDA Community Health Improvement Plan (CHIP)

Focus Area	Quality Diabetes Care		
Goal 2	Provide an integrated, multidisciplinary approach to diabetes treatment for Oneida Tribal Members.		
Objective 1	Oneida Comprehensive Health Division providers will continue to incorporate the 18 Best Practice Standards of the Special Diabetes Program for Indians (SDPI). *Measure: # of providers that incorporate at least one Best Practice Standards*	**Objective 2**	By 2017, Oneida Comprehensive Health Division Providers will routinely screen patients diagnosed with diabetes for depression. *Measure: # of patients screened verses total number of patients with diabetes diagnosis*
Outcome 1	100% of providers at Oneida Community Health Center incorporated at least one of the standards routinely in patient care. Reports demonstrate100% of these providers routinely incorporated 11 of the standards.	**Outcome 2**	In 2013, only 5% of those charts reviewed in a random diabetes audit were screened for depression. In 2017, the rate increased to 12%.

18 Best Practice Standards Special Diabetes Program for Indians
Aspirin or Other Antiplatelet Therapy in Cardiovascular Disease
Blood Pressure Control
Chronic Kidney Disease screening and monitoring
Dental Exams
Depression screening
Diabetes related education
Eye exam- retinopathy screening
Foot exam
Glycemic control
Immunizations: Hepatitis B
Immunizations: Influenza
Immunizations: Pneumococcal
Immunizations: Tetanus/ Diphtheria
Lipid Management in Cardiovascular disease
Nutrition Education
Physical Activity education
Tobacco Use Screening
Tuberculosis screening

Some of the **strategies** that have occurred over the past few years include:

- Development of a standardized depression screening for patients diagnosed with diabetes. This was successfully integrated into the work flow in the Electronic Medical Records (EMR).
- Development of a referral system to Behavioral Health Services when depression is diagnosed.
- Routine meetings of a multidisciplinary team that works collaboratively with community partners to ensure patients receive the most current care.
- Patients receiving care consistent with the 18 Best Practice Standards of the Special Diabetes Program for Indians (SDPI). The Electronic Medical Record (EMR) workflow addresses all 18 Best Practice Standards for healthcare visits. Annual chart audits are completed to evaluate improvement of individual treatment plans toward meeting the standards.

Conclusions:

Implementation of the Electronic Medical Record (EMR) has assisted all providers in incorporating the 18 Best Practice Standards of the Special Diabetes Program for Indians (SDPI) into routine patient care.
Low screening for depression resulted in better communication with providers on the importance of screening. Improvement in depression screening will be tracked in future audits.

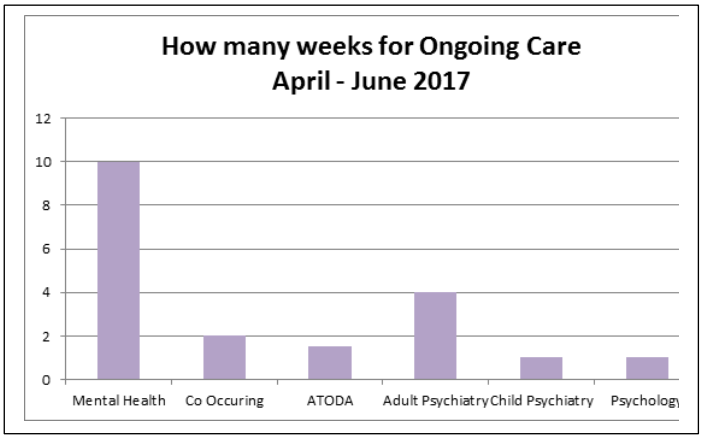
2014-2016 ONEIDA Community Health Improvement Plan (CHIP)

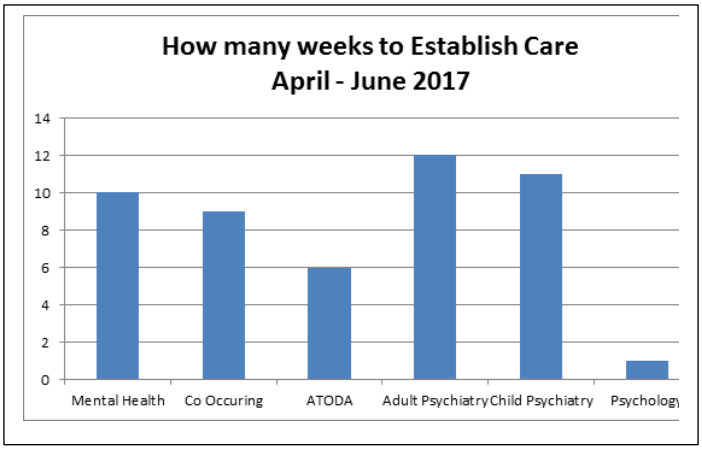
Focus Area	Access to Care- Behavioral Health
Goal 1	Improve access to Behavioral Health Services for Oneida Tribal Members.
Objective	By 2017, the percent of Oneida Tribal Members reporting they needed to see a provider at Oneida Behavioral Health Services but could not due to lack of appointments will decrease by 2%. *Measure: # of patients reporting could not get an appointment verses the total # patients scheduling appointments.*
Outcome	In 2017, we do not have the same data set as used in 2014 for direct comparison. However, we know access to care for Behavioral Health Services has improved over the past few years. Enhanced monitoring of "Access to Care- 3rd available appointment" is now tracked each month.

Some of the **strategies** that have occurred over the past few years include:

- Ongoing recruiting and retention of a qualified workforce. There continues to be a nationwide shortage in behavioral health professionals, so this remains a challenge.
- Provide general education to the community on how broken appointments impact access to care for all areas, including behavioral health professionals. This has been offered in the Kalihwisaks, at Community Meetings, and on the TV monitors at the Oneida Community Health Center, and division quarterly reports.
- Development of broken appointment policies with the desired effects to encourage patients to keep scheduled appointments. Data has periodically been reported out to the community through general education on impact of no show rate to access to care.
- Development of a referral system to Behavioral Health Services when mental health or substance abuse services are needed.
- Promotion of Employee Resource Center (ERC) and Employee Assistance Program (EAP). We know that greater than 50% of the employee base is Oneida Tribal Members.

These reports are a snap shots view. Results are impacted by the number of patients seen during each evaluation period and the behavioral health care professionals available to see patients.





Conclusions:

Access to Behavioral Health Services continues to be an issue. The shortage of behavioral health professionals nationwide contributes to the struggle to find and keep qualified professionals to serve the community. Recruitment and retention activities are ongoing for these valuable professionals.