CULTURALLY GROUNDED DIABETES WELLNESS PROGRAM FOR AMERICAN INDIAN AND ALASKA NATIVE ADULTS(25-40) WITH TYPE 2 DIABETES IN LOS ANGELES COUNTY, CALIFORNIA

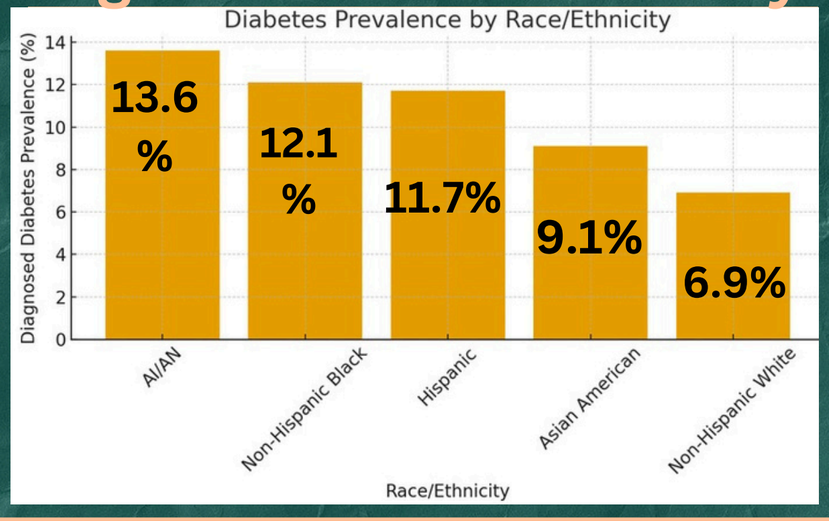
HSC 624 Community Analysis and Program Planning
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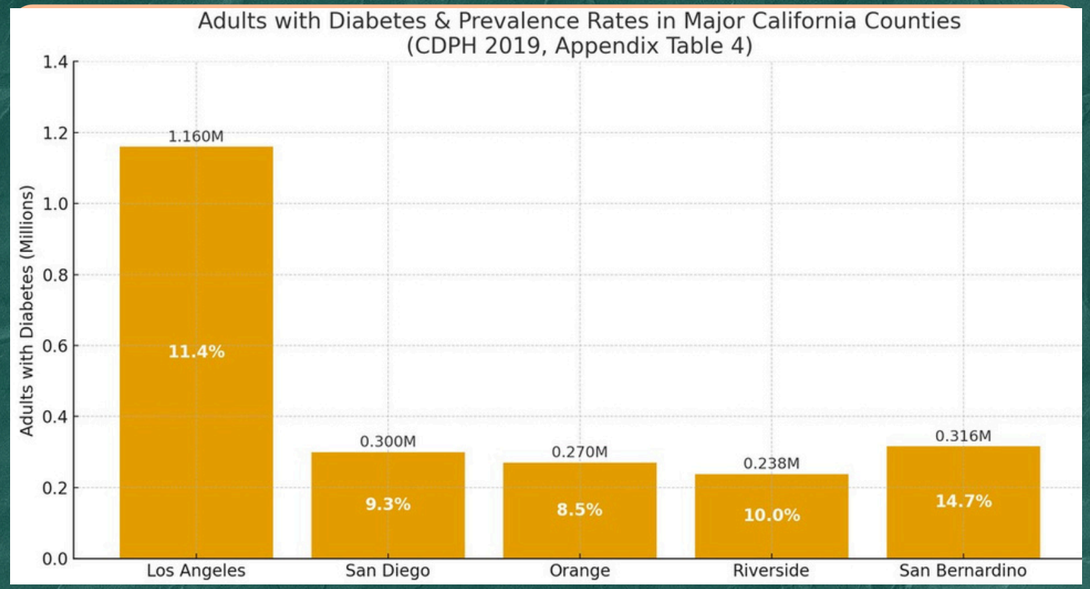
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Statement of the Problem

Type 2 Diabetes among AmericanIndianAndAlakaNativeAged 25- 40 in LA County

- 37 million U.S. adults are diagnosed with diabetes, including nearly 29 million with type 2 diabetes (ADA, 2023).
- American Indian/Alaska Native (AI/AN) adults experience about 13.6% diabetes prevalence
- 1 in 10 adults is diagnosed with diabetes, with AI/AN and other minority groups disproportionately affected (LADPH, 2025).
- Cultural mismatch, limited support, and systemic barriers restrict the ability of urban AI/AN adults to engage in diabetes self-management practices.





Need

To reduce persistent diabetes disparities, the AI/AN community in LA County needs culturally grounded, community-led, and peer-supported approaches that truly support effective diabetes self-management.

Mission,Goals, and Obejectives

MISSION



To provide culturally tailored, holistic education and community-based support that empowers AI/AN adults in Los Angeles County to effectively manage type 2 diabetes.

GOAL



Reduce the burden of type 2 diabetes and its complications among AI/AN adults in Los Angeles County.

PROGRAM OBJECTIVES

PROCESS

- Enroll 50 AI/AN adults aged 25–40 with type 2 diabetes residing in Los Angeles County.
- 3 culturally competent facilitators will be trained to deliver the Culturally Tailored (DSMES) workshops.
- 50 culturally tailored toolkits for all participants
- Schedule the home visits for all participants by the CHW

IMPACT

After 6 months,

- 60% efficacy and self-management (≥25% increase in DSES & DSMQ scores).
- 75% will report fewer barriers and increased use of community resources (CHW surveys/logs).

OUTCOME

- 75% will report a ≥1-point improvement in overall health on a 5-point scale (or maintain “excellent” if already rated).
- 75% will show a ≥1-point improvement in diabetes-related quality of life (DQOL), reflecting better daily functioning and satisfaction with diabetes care.

Population, Setting, and Participants

Population

- Adults aged 25 to 40 years who self-identify as American Indian or Alaska Native.
- Self-reported or have been diagnosed with type 2 diabetes.
- Residency within Los Angeles County.



Setting

United American Indian Involvement, Inc. (UAII).

- Clinical Setting
- Classroom Setting



Participants

There will be five focus groups, each with 10 participants (approximately 50 participants in total). Groups will be stratified by age and gender to capture diverse perspectives and experiences.



Collaborators and Stakeholders

United American Indian Involvement, Inc. (UAII)

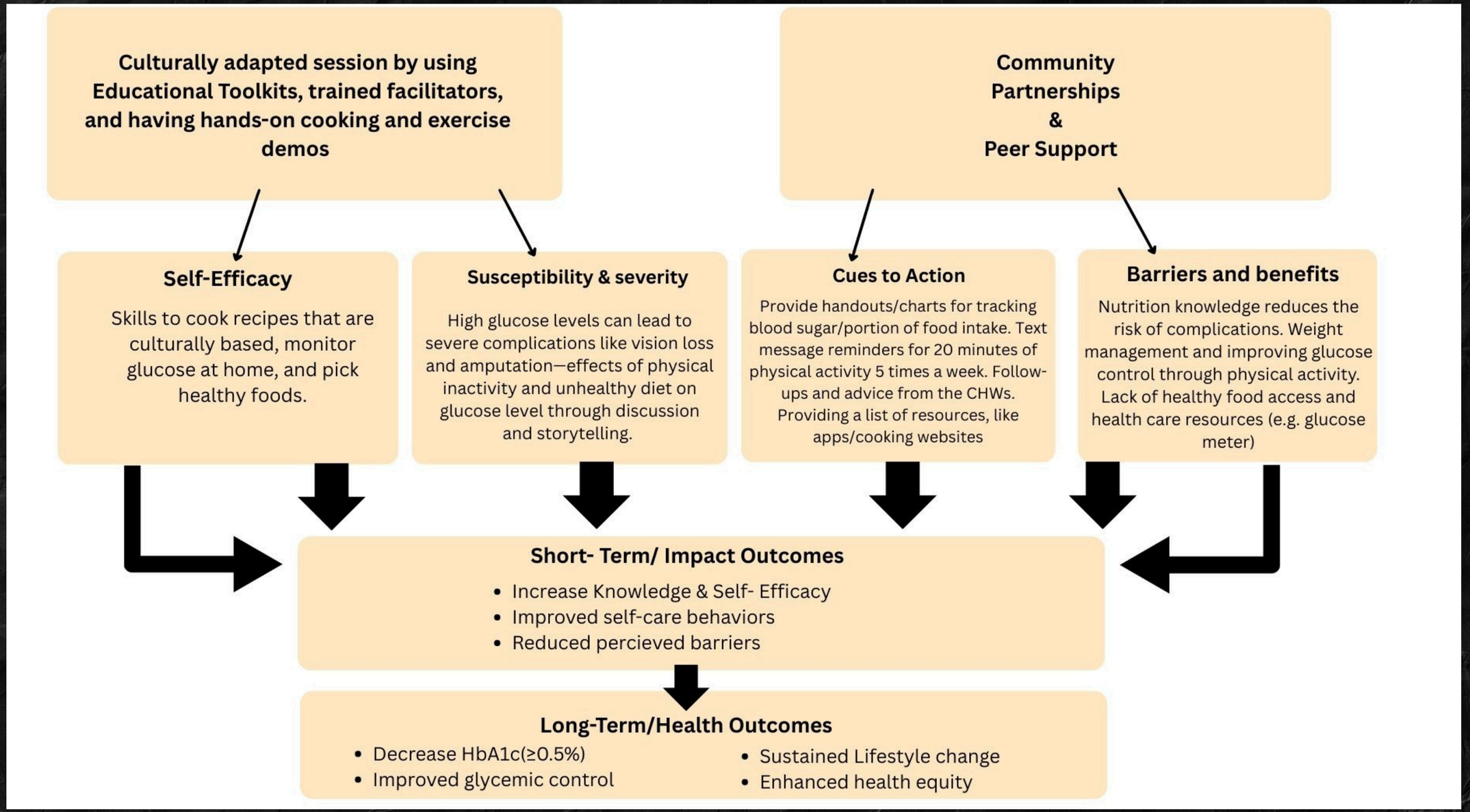
Project Angel Food (with the USC Keck School of Medicine & Other Partners)

Indian Health Service (IHS) – California Area Office

Los Angeles City/County Native American Indian Commission (NAIC)

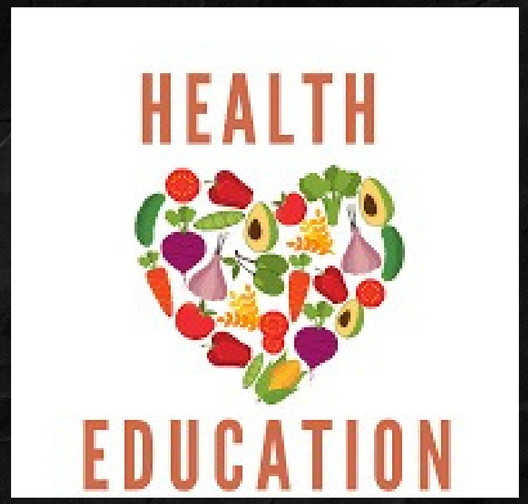
Los Angeles County Department of Public Health (LACDPH) – Division of Chronic Disease and Injury Prevention

Theoretical Framework: Health Behavior Model (HBM)



Main components of the program plan

Strategy 1



Adapted from What Can I Eat? Healthy Choices for American Indian and Alaska Native Adults with Type 2 Diabetes”(Stotz et al., 2025)

Culturally Tailored Diabetes Self-Management Education and Support (DSMES) workshop

Strategy 2



Adapted from the Community Outreach and Patient Empowerment (COPE) model (Trevisi et al., 2019)

Community Health Worker (CHW) Outreach and Peer Support strategy

Description & Anticipated Outcomes

Our key staff

- Principal investigator
- Program Coordinator
- 3 Facilitators: Nurse, Dietitian, Physical Activity Instructor
- 5 Community Health Workers (CHWs)
- AI/AN Elders
- Data Analyst / Evaluation Specialist

Strategy 1:
DSMES Workshops
- Storytelling
- Glucose monitoring
- Cooking demo
- Label reading
- Native-inspired activity



Strategy 2:
CHW Outreach
- Home visit + calls
- Weekly check-ins
- Support hours
- Resource linkage



Short-Term (0–3 months)
↑ Knowledge
↑ Self-efficacy



Mid-Term (3–6 months)
Consistency in self mangment behaviour
↓ Barriers to accessing resources



Long-Term (1–2 years)
↑ Over all Health Status
↑ QOL
↑ Community connection



Evaluation Plan

Quasi-experimental One-Group pretest-posttest

$O_1 \rightarrow \quad X \rightarrow \quad O_2 \rightarrow \quad O_3 \rightarrow \quad O_4 \quad \rightarrow \quad O_5 \quad \rightarrow \quad O_6$



Diabetes-related nutrition knowledge



Self-management behaviors



Self-efficacy



Barriers and difficulties to access diabetes care



Clinical indicators



Quality of life

Time point

O_1: Baseline
O_2: 3 months (midpoint)
O_3: 6 months (posttest)
O_4: 12-month follow-up
O_5: 18-month follow-up
O_6: 24-month final follow-up

Measurement Tools (Validated Instruments)

- **DRNK: Nutrition knowledge**
- **DSES: Diabetes self-efficacy**
- **DSMQ: Self-management behaviors**
- **PDDT: Barriers to care**
- **DQOL: Quality of life**
- **Clinical: A1C, BP, weight (via partner IHS/UAII clinics electronic health record)**

Data Collection Approachs

- **Surveys administered at UAII, IHS clinics & CHW home visits**
- **Clinical data pulled from partner clinic EHRs (with consent)**
- **A1C analyzed with CLIA-certified labs**
- **BP & weight recorded using standardized clinic equipment**
- **All data stored in HIPAA-compliant REDCap**

How We Know the Program Works?

Process Evaluation

- Tracking administrative data
- Using fidelity checklists

Ensures the program is implemented as planned and reaches the intended population.

Impact Evaluation

- Measures: knowledge, self-efficacy, self-management, barriers
- Expected improvement: 25% for 75 % of participants

Indicates whether DSMES + CHW support improved skills and behaviors

Outcome Evaluation

- ≥0.5% decrease in A1C
- Improved QOL
- self-rated overall health status

Shows whether behavior changes led to real health improvements

Statistical Analysis



- Descriptive statistics
- Paired t-tests
- Repeated Measures ANOVA
- Regression analysis

These tests evaluate changes across time and reveal which factors are linked to improved diabetes outcomes.

Qualitative Analysis

Thematic analysis of CHW logs and participant feedback

To understand cultural relevance, engagement, and barriers.

Dissemination plans

The Principal Investigator and Program Coordinator will prepare the report

Report Components & Key Findings

- **Behavioral results: ↑ knowledge, ↑ self-efficacy, ↑ self-management**
- **Clinical results: ↓ A1C, ↓ BP, stable/reduced weight**
- **Participant feedback: cultural relevance, satisfaction, experiences**
- **Process results: recruitment, attendance, CHW follow-ups, fidelity**
- **Barriers reduced & resource use increased**
- **Recommendations for program sustainability**

Share with

Funding Partners & Research Foundation (SDPI & CSULB) Final + quarterly reports



Collaborators and Community Partners UAII, IHS, and LACDPH through summaries and presentations.



Participants through Talking Circles and simple Handouts



Broader Community through

- Community health fairs
- Social media updates

Professionals through

University seminars + public health forums.



Conclusion

By honoring culture and strengthening self-management, this program offers a powerful, evidence-based pathway to reducing diabetes disparities and supporting healthier futures for AI/AN families in Los Angeles County.



Thank You

Any Questions?