DIABETES
CARE PROGRAM
OF NOVA SCOTIA

The Diabetes Care Program of Nova Scotia

Strategic Plan

2008-2012

Approved in principle by the DCPNS Advisory Council

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NOVA SCOTIA
Department of Health

Background

The Diabetes Care Program of Nova Scotia (DCPNS) is one of eight provincial programs funded by the Nova Scotia Department of Health (DoH). Implemented in 1991, the Program was initially mandated to standardize and improve the quality of care provided through Nova Scotia Diabetes Centres (DCs). Using an Advisory Council and a number of committees/working groups, the DCPNS advises the Ministry on service delivery models; establishes, promotes, and monitors adherence to diabetes care guidelines; provides support, services, and resources to diabetes healthcare providers; and collects, analyzes, and distributes diabetes-related data for Nova Scotia.

The Program is currently involved in/or supporting research and partnering with others to improve our understanding of diabetes and diabetes care and prevention issues in Nova Scotia.

The DCPNS manages the provinces diabetes databases including the National Diabetes Surveillance System (NDSS) Nova Scotia dataset as well as the DCPNS Registry. The DCPNS Registry allows for the collection of a number of data elements that allow us to both describe the diabetes population and track trends in clinical and self-care practices. Recent analysis (2007) of Registry data indicated significant improvement (p value < 0.001) in a number of key indicators for individuals attending Nova Scotia's DCs including blood pressure and blood lipids as well as a reduction in the proportion of individuals with poorly controlled diabetes.

The data from both the NDSS and the DCPNS Registry is used in support of provincial initiatives and for program planning at the District level and to assess the merit of targeted interventions or quality improvement programs.

In Nova Scotia, the approach to care and education in DCs has been standardized with the assistance of the DCPNS. The DCPNS ensures that these programs promote self-care, survey for and monitor the development/progression of diabetes complications, and follow national and provincial guidelines for optimal care. The DCPNS supports all DCs with activities focused on knowledge transfer/translation, networking in support of best/promising practice, and standardization aimed at quality/equitable care.

The DCPNS provides:

- Diabetes expertise including program planning and evaluation
- Standardized documentation, statistics keeping, and referral forms (no cost)
- Guidelines for special populations (pregnancy and pediatrics) and specific complications/co morbidities (hypertension, dyslipidemia, renal impairment, and foot problems)
- Access to new knowledge and knowledge translation—quarterly newsletters and annotated bibliographies; annual provincial and/or regional workshops; facility or district diabetes surveys.
- Access to local and regional data as well as data analysis support and reporting
- Provincial policy and procedures (including exams) for insulin dose adjustment
- Diabetes Centre grants for quality improvement initiatives

In summary, there are a number of supports in place to help prevent and manage diabetes in Nova Scotia; however, we face a growing number of challenges. In the past five years, the prevalence of diabetes has increased approximately 20% and the number of people at-risk of diabetes is also increasing. High rates of obesity and inactivity will further influence these numbers well into the future. As individuals with diabetes are now living longer with their condition this increases the number of people with multiple comorbidities and those requiring complex care regimens. Diabetes care providers are challenged to stay current in the newer medications and treatment technologies and to keep abreast of the best practice approaches. The DCPNS has a valuable role to play in supporting Nova Scotia's health care system and in planning for the most effective and efficient use of resources in the years to come.

Introduction

In Fall 2007, the Diabetes Care Program of Nova Scotia (DCPNS) began a strategic planning process to set the direction for the program for the next five years. After reviewing evidence about current trends in diabetes care and management, conducting as environmental scan, hearing from other Provincial Programs, and listening to what stakeholders across Nova Scotia had to say about future directions for diabetes care, we put our plan to paper. Twenty-four of 100 surveys were returned representing responses from over 53 people in total. Efforts to inform the strategic plan culminated with a DCPNS strategic planning meeting on March 27th and 28th 2008. This strategic plan represents the combined input of many people, and will guide the Program's work for the next five years.

The full report generated from the strategic planning process can be found on the DCPNS website in a pdf version (www.diabetescareprogram.ns.ca) under the section *Annual Report*.

Our Vision

The Diabetes Care Program of Nova Scotia (DCPNS) is a trusted and respected program that values partnerships and supports integrated approaches to the prevention and management of diabetes. We envision a Nova Scotia where there are fewer cases of diabetes, complication rates for those with diabetes are reduced, and where all Nova Scotians with diabetes have access to the resources they need to live well.

Our Mission

To improve, through leadership and partnerships, the health of Nova Scotians living with, affected by, or at risk of developing diabetes.

Our Core Values

The following values guide the decisions and actions of the DCPNS.

We believe in:

Excellence

Collaboration

Responsiveness

Evidence

Inclusiveness

Accountability

Integrity

Strategic Direction 1

To forge new and strengthen existing partnerships in the development of an integrated system of chronic disease prevention and management aimed at reducing the development and progression of diabetes complications.

Key Activity Areas

- Form a collaborative network across Provincial Programs to explore integrated chronic disease care models for Nova Scotia.
- Develop criteria for diabetes/prediabetes risk stratification including referral algorithms indicating the most appropriate program and/or provider team.
- Partner to develop and pilot community interventions for individuals at-risk of developing diabetes.
- Develop and pilot a disease management system that uses a refined case management approach, including automated referral to the appropriate care provider, for people with diabetes at high-risk and/or with multiple comorbid conditions.
- Partner to develop a communication strategy to inform individuals with diabetes and health care providers about integrated chronic disease management.
- Implement training opportunities for health care providers to acquire and enhance their knowledge and skills around diabetes, including motivational approaches to support chronic disease management.
- Explore web-based applications and tools to support integrated care.

Measuring Success

- A collaborative network including Provincial Program partners has been formed and meets regularly.
- Risk-stratification referral algorithms have been developed and implemented for prediabetes and diabetes.
- Collaborative community-based interventions have been developed and piloted for individuals at risk of developing diabetes.
- A refined case management system for high-risk individuals attending Nova Scotia Diabetes Centres has been developed, piloted, and implemented.
- Individuals and health care providers clearly understand and support new integrated chronic disease prevention and management programs, as evidenced by referral and overall utilization.
- Train-the-trainer programs including core diabetes education have been developed for and delivered to health care providers working in a variety of settings (primary care, continuing care, etc.).
- New web-based applications have been identified and promoted in support of integrated care.

Strategic Direction 2

Create and share knowledge through collaboration in the development, implementation, and evaluation of comprehensive standards and guidelines for diabetes care, education, and service delivery across the many settings in which care is provided.

Key Activity Areas

- Maintain active surveillance of new advances and best practices in diabetes care, education, and service delivery and facilitate knowledge transfer to key stakeholders.
- Identify priorities for disease management, including guideline revision and development.
- Promote accessible, high quality diabetes care through the identification of gaps in service delivery and programming.
- Establish new and strengthen existing partnerships in multiple settings.
- Refine the framework and process of diabetes service review including the reporting of targets..

Measuring Success

- The DCPNS is a recognized leader in knowledge translation related to high quality diabetes care as evidenced by requests for resource materials, DCPNS surveys, presentations; the number of publications and partnerships; and the measureable uptake of standards/guidelines and tools used to inform and guide provider practices and decision making.
- A schedule for regular review and revision of the DCPNS guidelines, to reflect current recommended practice, has been enacted.
- Priorities for guideline revision/development have been established.
- The DCPNS has created new partnerships in a variety of care delivery areas, as evidenced in committee memberships, partnership projects, and increased use of guidelines by all care providers.
- Performance indicators for accreditation/evaluation purposes have been reviewed and revised, where necessary, and a baseline of new measures have been collected.
- A schedule for the routine review of DHA diabetes services using established performance indicators has been established and implemented.

Strategic Direction 3

Use complete, accurate, and accessible local and provincial data, to set targets, make informed decisions, and take action to improve diabetes outcomes in Nova Scotia.

Key Activity Areas

- Enhance the current performance measurement framework (clinical and self-care), including process and outcome indicators for diabetes surveillance.
- Encourage the use of the DCPNS data holdings by policy and decision makers; health system planners; Department of Health (including other provincial programs); DHAs and the IWK Health Sciences Centre; Diabetes Centres; researchers; and others.
- Expand the DCPNS Registry and its other data holdings to increase the completeness and accuracy of diabetes related data in Nova Scotia.
- Enhance internal Program and DHA/IWK capacity to use available DCPNS data holdings for innovative research, sharing, and publication.
- Identify health decision maker and provider priorities for diabetes data collection and reporting.
- Identify opportunities and address barriers to integrating information in the DCPNS Registry with other data sources.
- Seek funding opportunities to optimize use of the DCPNS diabetes data sources.

Measuring Success

- All Diabetes Centers are participating in data collection through on-site use of the DCPNS Registry and are using the data to guide practice.
- A performance measurement framework describing indicators and benchmarks to track progress has been developed for general and special diabetes populations.
- Provincial targets have been set for key performance indicators and a quality cycle for improvement implemented.
- Through partnership, new data fields have been identified by data source and processes for retrieval/collection determined.
- The DCPNS has established new partnerships and is engaged in research and surveillance with variety of partners employing information held by the DCPNS holdings.
- A position paper to identify barriers to, and opportunities for, integrating, sharing, and moving data between the Registry and other data holdings/data sources has been developed.
- DHAs, IWK Health Sciences Centre, and others are requesting, using, and citing DCPNS data sources in reports and business plan submissions.

- The DCPNS has secured grant funding to optimize use and/or reporting of diabetes data for use in system planning and care delivery.
- Reports are routinely produced for special and vulnerable diabetes populations.
- A diabetes flow sheet supported by decision-tools is available including through the electronic medical record.

Strategic Direction 4

Promote self-management in individuals living with, affected by, or at risk of developing diabetes. Develop and promote related supports and tools, along with targeted interventions aimed at encouraging health care provider engagement in self-management support.

Key Activity Areas

- Identify and develop strategies to address existing barriers to self-management at both the individual and provider levels.
- Document and develop tools and programming to promote diabetes self-management in collaboration with CDM partners.
- In partnership with Provincial Programs and others, develop curricula that address self-management support for providers.
- Partner with academic institutions and professional organizations to include self-management support in both foundational curricula and continuing education programming for health care providers.
- Explore and promote access to a complete listing of community resources and services that support self-management.

Measuring Success

- A gap analysis (including a synthesis of the literature) has been completed that identifies the barriers and solutions to supporting self-management.
- A self-management support component has been developed and included as part of the academic core curriculum in a variety of health professions.
- Continuing education opportunities for health care providers, including sessions on self-management support, are being offered.
- A system of peer-to-peer support (chronic disease self-management program) has been developed, implemented, and promoted.
- Listings of community resources are available and accessible in a variety of mediums.
- Chronic disease self-management programs are promoted by diabetes health care providers and routinely accessed by individuals with diabetes.

Strategic Direction 5

Reduce the incidence of diabetes through strategic, collaborative partnerships aimed at health promotion and prevention.

Key Activity Areas

- Work with partners to identify the various audiences, the information to be shared, and actions required to reduce the incidence of diabetes, diabetes complications and other chronic diseases.
- Improve case detection of diabetes and prediabetes in Nova Scotia.
- Identify and form partnerships to help meet the health needs of vulnerable, at-risk populations.
- In partnership, help to support and influence the Province's strategic directions related to chronic disease prevention.
- Develop a communication strategy with the guidance of the provincial programs collaborative network and other stakeholders to disseminate risk reduction and chronic disease prevention messages.

Measuring Success

- A communication strategy aimed at chronic disease prevention, including consistent messaging, has been developed and implemented in partnership with others.
- Identify and implement effective programs designed to improve the direction of diabetes in Nova Scotia.
- Vulnerable, at-risk populations have been identified and health promotion and prevention strategies have been developed with partners.
- A common prevention theme has been determined and strategies to promote it have been implemented.

Strategic Planning Participants

DCPNS Advisory Council Members

John Malcom, CEO Cape Breton District Health Authority (Council Chair)
Renata Bennett, Nurse Practitioner, Caledonia
Brendan Carr, VP Medicine, Capital District Health Authority
Beth Cummings, Pediatric Endocrinologist, IWK Health Centre
Vic Gouthro, Canadian Diabetes Association (Patient Advocate), Bras d'Or, Cape Breton
Lynne Harrigan, Internist, Annapolis Valley Health Authority
Ali Imran, Endocrinologist, Capital District Health Authority
Cheryl Northcott, VP Patient Care Services, Cumberland Health Authority
Murdock Smith, General Practitioner, Sydney
Maureen Topley, Diabetes Nurse Educator, Colchester East Hants Health Authority
Tina Witherall, Diabetes Dietitian Educator, South Shore Health Authority

Advisory Members—Ex-Officio

Peggy Dunbar, Program Manager, Diabetes Care Program of Nova Scotia
Lynn Edwards, Director, Acute & Tertiary Care, Department of Health

Other Participants (DCPNS staff)

Brenda Cook, Diabetes Consultant
Kim Dionne, former DCPNS Coordinator Administrative Services
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Igor Grahovac, former DCPNS Diabetes Data/Surveillance Consultant
Zlatko Karlovic, Director Diabetes Surveillance
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Jennifer Payne, former DCPNS Epidemiologist
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