State of the Art


It is important that we contribute to finding a sustainable, realistic solution to SMBG in Nova Scotia, considering the needs of the populations we are trying to serve and the fiscal realities we all face.

Should all people with diabetes (DM) self-monitor their blood glucose? This question has received increasing attention in more recent years as individuals and the health care system struggle with testing-related costs, the limited/unavailable evidence in support of testing for some populations, and the realities of testing and using test results for persons with DM and their health care providers. It is fair to say this is not a new topic. In 2006, both the American and Canadian Diabetes Association (ADA and CDA, respectively) hosted debate style presentations on this topic during their national conferences. In November 2006, Alberta, through the Institute of Health Economics (IHE), hosted the first Canadian Consensus Conference on SMBG. Here speakers from the UK, the US, and Canada presented available clinical evidence, economics (cost), policy, and consumer perspectives. An expert panel (a broad-based, non-government, non-advocacy group) assimilated the information and formulated responses to predetermined questions into a consensus document for distribution across Canada.1 This document was intended for use by all sectors in future decision-making around SMBG. In January 2007, this newsletter was also home to an article titled “To Test or Not to Test…Where is the Middle Ground?”2 - an offshoot of attending and presenting at the IHI consensus conference.

This earlier consensus work has been followed by local, national, and international work. This included, among others, Nova Scotia’s qualitative study on health professional views and practices related to SMBG,3 the recently published Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) recommendations and reports,4 published costing reports from Ontario (ICES),5 more analysis of the scientific evidence,6 continued workshop presentations (International Diabetes Federation [IDF] in Montreal, October 2009, where CDA hosted a preconference panel presentation on SMBG7 and the IDF released Self Monitoring of Blood Glucose Guidelines in Non-insulin Treated Type 2 Diabetes8), etc. It is important that we contribute to finding a sustainable, realistic solution to SMBG in Nova Scotia, considering the needs of the populations we are trying to serve and the fiscal realities we all face.
It is time to act on all of this work—to help inform and guide policy directions in Nova Scotia; to agree on consistent approaches and messages for persons with DM; and to provide the necessary information, supports, and tools to providers and patients to reduce the burden of unnecessary and, sometimes, wasteful testing. It is important that we contribute to finding a sustainable, realistic solution to SMBG in Nova Scotia, considering the needs of the populations we are trying to serve and the fiscal realities we all face.

It is important that we participate in thoughtful dialogue, constructive in its purpose, as this is the beginning of a journey that will take persons with diabetes and their providers to a better level of understanding and more intentional approach to SMBG.

Do all people with non-insulin using type 2 DM need to test?

No. On January 22, 2010, the DCPNS invited Diabetes Centre (DC) representatives (diabetes educators—nurses and dietitians) from each of the DHAs, pharmacists, physicians (generalist and specialist), and nurse practitioners to review and discuss the COMPUS recommendation with regards to SMBG in this specific DM subpopulation (non-insulin using type 2 DM). A number of observers also attended to gain insight from the discussions to help inform future work in the province: Canadian Agency for Drugs and Technologies in Health (CADTH); the Nova Scotia Division of the CDA; Pharmaceutical Services, DoH; the Drug Evaluation Unit and Behavior Change Institute, Capital Health; College of Pharmacy and Academic Detailing, Dalhousie University; and First Nations and Inuit Health (A/Region Pharmacist).

The purpose of the meeting was “to engage a multidisciplinary group of diabetes health care professionals in preliminary discussions/decisions related to the use, frequency, and application of self-monitoring of blood glucose (SMBG) in the non-insulin using type 2 diabetes population in Nova Scotia.” Participants were tasked with:

- Helping to formulate preliminary consensus recommendations, with the help of case-based discussions, on strip usage for individuals with non-insulin using type 2 DM.
- Identifying potential criteria (outliers) for “exception status” in SMBG strip requirements for non-insulin using type 2 DM.
- Recommending next steps with regards to patient and provider tools, supports, and communications.

Prior to the case-based discussions, four plenary presentations, with a focus on the Nova Scotia context, contributed to understanding the following COMPUS recommendation:

For most adults with type 2 diabetes using oral antidiabetes drugs (without insulin) or no antidiabetes drugs, the routine use of blood glucose test strips for SMBG is not recommended by CERC (COMPUS Expert Review Committee).

Plenary Sessions included:

1. Self-Monitoring of Blood Glucose (SMBG): Highlights from CADTH’s Recommendations; presented by Denis Bélanger, Acting Senior Director, CADTH. The first plenary presenter shared insights into the COMPUS recommendation—the approach used to adopt optimal practice of SMBG. This included an overview of available evidence (clinical effectiveness of SMBG), cost effectiveness, potential opportunity costs, and the key issues that were addressed in the recommendation deliberations.

2. Self-Monitoring of Blood Glucose: The Health Care Professional Perspective; presented by Wayne Putnam, MD. This session provided preliminary information and findings from a qualitative study conducted in Nova Scotia. The purpose of this study was “to gain insight into health professionals’ recommendations for, and perceived value of, SMBG in adults with type 2 DM who are not using insulin and are in good control (A1C ≤ 7%). (A qualitative inquiry.)” Interviews conducted with DM educators, community-based pharmacists, and practicing clinicians, demonstrated variations between and within practice disciplines with regards to the frequency of recommended monitoring, reasons for monitoring, use of results, and in the trusted sources of information related to SMBG.

3. Patient and Provider Perspectives on Self-Monitoring of Blood Glucose: Highlights from CADTH’s Focus Groups; presented by Denis Bélanger. This session provided an overview of the patient and health professional perspectives as derived from the CADTH focus groups held in Halifax and Ottawa. These focus groups were held to provide reaction to CADTH’s key messages on the practice of self-monitoring. Shared observations highlighted variations between patients, physicians/nurse practitioners, DM educators, and pharmacists around why they test, value of testing, and use of results. Persons with diabetes provided additional perspectives on the advantages and disadvantages of SMBG.
4. Utilization of Blood Glucose Monitoring Strips: Nova Scotia Pharmacare Programs; presented by Natalie Borden, B.Sc. (Pharm), Manager, Drug Utilization Review, DoH. The final presentation showed the current NS costs for DM medications and the costs associated with test strips, the numbers of test strips (and range) being used by the different DM treatment types (insulin, oral agents, insulin and oral agents, diet only). It also highlighted the most recent studies that have been presented related to this topic (CMAJ). German Institute for Quality and Efficiency in Health Care, and Institute for Clinical Evaluative Sciences (ICES), including proposed scenarios for reducing costs of test strips. This presentation highlighted the challenges faced by Pharmacare and the realities of the decisions that must be made in the current fiscal climate.

These plenary sessions were followed by a reflection exercise where all participants were asked:

- What did you hear. . . . what hit home with you?
- What were the main take away messages for you?

Grouping of these key messages resulted in six theme areas:

**Costs/Wastage**: Awareness of escalating costs and the need for fiscal responsibility in response to wastage and inappropriate use and a recognition that “the potential savings are huge.” “Will the savings go back to DM?”

**Research**: An acknowledgment and better understanding of the lack of evidence in support of SMBG and improved outcomes (A1C and other) with a realization that there is need for more research to better answer the question, “Who benefits from SMBG and in what ways?” “Has patient satisfaction been considered and does SMBG help to motivate and encourage self-care?”

**Variations in practice**: An appreciation of variations in practice among and between DM practitioners. The need for education and programming on how to use, interpret, and act on SMBG results.

**Messaging**: There are many messages that need to be relayed to persons with diabetes and care providers about the impact of SMBG on outcomes as well as current “perceptions and practices.” There is need to refocus patient monitoring on those things that will make a difference in day-to-day management and patient outcomes—food intake, activity/exercise, weight, medication persistence, etc. We will all need to be on the same page (recommendations with regards to frequency of testing and in whom).

**Changes in practice**: “We need to rethink SMBG for those that really need it and will benefit. This rethinking will result in a huge shift in practice and how we interact with patients.” There is no evidence in support of the belief that SMBG is a motivator and results in better outcomes in this population. Should we focus on how to better use SMBG for those that do test (education for physicians and others)?

**Opportunity**: There is a need to change present SMBG guidelines. We need to better understand how SMBG fits within the concept of self-care.

continued on page 8
News from the Care Program

Examining our practices and adjusting to change can sometimes be difficult tasks. Often just creating an opportunity pays big benefits. This issue of the newsletter highlights examples of how thinking and acting “outside the box” can help address an identified need. To cite but a few examples, in the article on self-management (page 12), we see how the concept of self-management support (through the use of a developed tool and short class) has found its way into Diabetes Centre (DC) programming in a more tangible, systematic way. The examples shared in the “Diabetic Foot” article (page 10) shows how creating opportunities with new partners has improved understanding of each others roles and resulted in a consistent, collegial approach to foot assessment across foot care providers in one DHA; and in the case of another, focused attention through a “foot care blitz” has resulted in improved foot assessment rates and a new way of doing business. And, our State of the Art article may pose the greatest challenge to both our beliefs as educators and our routine interactions with clients. However, there are huge opportunities in all of the examples shared to really make a real difference in the lives of people with diabetes and to find those tools and approaches that pay the biggest benefits for all. Keep up the great work!

Advisory Council, Subcommittees, and Working Groups

The DCPNS is pleased to welcome Kevin MacDonald, CEO, GASHA (DHA 7), as Advisory Council Chair effective September 18, 2010. A special thanks to John Malcom, CEO CDHA (DHA 8), who served 2 years as Council Chair. John was instrumental in leading us through our strategic planning process and formalizing a plan that will take us into 2012.

The Council is also pleased to welcome Darla MacPherson, VP Community Health, GHA (DHA 5) as well as Shonda Jeffrey, SWNH (DHA 2), and Wendy Christoff, CBDHA (DHA 8), diabetes nurse educator representatives. These positions take effect with the next Council Meeting scheduled for April 23, 2010.

The Diabetic Foot in Nova Scotia: Challenges and Opportunities—Working Group Activities

October 19, 2009, marked the official launching of the DCPNS patient and provider foot care resources. Copies of the eight (8) different tools were mailed to all Nova Scotia DGs and posted on the DCPNS website.

Dissemination strategies are ongoing and will ensure these forms are readily available to foot care providers across a variety of health care settings.

Care of the Elderly with Diabetes Residing in Long-Term Care (LTC) Facilities

Discussions are underway with Dr. Laurie Mallery, in conjunction with Dalhousie University, to deliver a webinar on the guidelines as soon as we can find a date and available venue. It is our intent that health care providers will be able to watch the presentation by logging online at their computers and participate through two-way communication. This presentation will officially launch the Diabetes Guidelines for the Elderly in LTC Facilities with related power point and other materials to assist with local uptake and implementation. Watch for information on the date and time for the planned presentation.

Special Initiatives

International Diabetes Federation (IDF), World Diabetes Congress, Montreal, PQ, October 2009

Nova Scotia was well represented at the IDF. The DCPNS submitted four posters—foot care resources, long-term care guidelines, development of the Nova Scotia Diabetes Repository, and the DCPNS Model as a means to improving care. Jonathon Fowles and Chris Shields (Acadia University) presented to an international audience on the Physical Activity and Exercise Toolkit, and Dr. Beth Cummings et al, used a poster presentation/discussion to share preliminary results of work being done in Nova Scotia around surveillance of diabetes in children and youth.

DCPNS Provincial Workshop

Mark your calendars for Thursday, April 15th (all day) and the morning of April 16, 2010. Pier 21, Halifax, will be our workshop site. The program will be finalized very soon taking into consideration the feedback from our educators on the needs assessment. At this point in time, Dr. Heather Dean, Professor Department of Pediatrics Section of Endocrinology and Metabolism, University of Manitoba, is confirmed and will speak to type 2 diabetes in youth; and Michael Vallis, PhD, will address self-management support and what we can do as providers translating theory into practice.
SMBG Working Group/Workshop

See State of the Art article, pages 1-3 & 8.

National Diabetic Foot Project

The DCPNS has accepted an invitation from the Canadian Association of Wound Care (CAWC) to participate in a national Expert Advisory Group (EAG). The mandate of this EAG is to develop a bilingual patient brochure (English and French) and an interactive web-based tool that focuses on the prevention and management of diabetes foot ulcers. The CAWC received funding for this project under the Canadian Diabetes Strategy, Public Health Agency of Canada. The project deadline is Mar. 31, 2010. Bev Harpell is capably representing the Program on this Advisory Group.

DCPNS Forms Revision

We are keeping the printer very busy! Just about all forms have been printed (soon to be distributed) and work has started on the flow sheet. Again, thanks to CoraLee Joudrey for her leadership throughout the revision process and to all of the educators who provided direct feedback on draft versions.

DCPNS Insulin Dose Adjustment Policies & Guidelines Manual

Work continues on the review and revision of this manual. Changes are currently being made to the final draft. Our Medical Advisory Group will then be asked to provide their feedback on the revised manual and associated exams. Expected completion date is early to mid April.

Educators planning to write the Insulin Dose Adjustment exam(s) are now required to wait for the revised edition of the guidelines manual/exams.

DCPNS DC Grants

With H1N1 in the fall and the possibility of a labour dispute in mid-January, we decided to delay the call for 2010/11 proposals until later this spring. This will give existing projects time to finish up, and those interested in a grant to gather their thoughts and develop potential partnership projects. These grants continue to be a big success and have helped many DCs to work on interest areas, new approaches, and foster community/primary care partnerships.

Registry & Web-site Enhancements

The DCPNS is offering on-site refresher courses on use of the DCPNS Registry and its reports. Please contact the DCPNS office to obtain an overview of the training session and to arrange a session for your DHA.

We are in the process of revising the report to physician/nurse practitioner following a DC visit. This revised report will include smoking status, date of last eye examination, date of last annual flu shot, and a check box to flag kidney function as an “area of concern.” This report will be able to be used by physicians “in support of the chronic disease management incentive program.”

A new “guidelines” tab has been added to the DCPNS website. This section contains pdf versions of the most current DCPNS guidelines and will be updated as revised or new guidelines become available.

Diabetes Statistics

Through February and early March, the DCPNS will be consulting with diabetes educators, DC Managers, and diabetes specialists (endocrinologists and internists) to help us better define diabetes severity in the populations we see—what elements are considered in determining if an individual is low, moderate, or high severity. We will also be inviting input into the information and indicators collected and reported to the DCs and the DHAs. Is what we are currently reporting helpful, what else would you like to have, etc.? This will help to inform our day-to-day work, plan for the future (to better meet diabetes provider/planner needs) and to support a project that we are working on related to survival analysis and severity of diabetes. If you would like to offer your opinions, please contact the DCPNS office for information on the planned consultations.

Partnership Projects

Provincial Programs Hypertension Initiative

The three provincial programs (Cardiovascular, Diabetes, and Renal), along with Primary Health Care, Health Promotion and Protection and our partner health charities (the Canadian Diabetes Association, the Heart and Stoke Foundation of Nova Scotia, and the Kidney Foundation of Nova Scotia), will be co-hosting a Hypertension Stakeholder Forum at Pier 21 in Halifax on March 29, 2010. As this is a topic that crosses sectors and is of interest to many, we will be extending invitations to an array of stakeholders representative of health, education, recreation, agriculture, food industry, academia, etc. Stay tuned for activities related to, and resulting from, this Forum.

Self-Monitoring of Blood Glucose: The Health Care Professional Perspective

A manuscript being developed under the leadership of Dr. Wayne Putnam with assistance of the partners - DoH (DCPNS
Pediatric Focus

Camps for Kids

Camp Morton and Lion Maxwell are summer weeklong camps held for children with type 1 diabetes. These camps offer a great experience for not only the kids who attend, but for the staff as well. Whether you have been involved in diabetes education for many years or are new to working in the field of diabetes management, camp creates a learning experience for all. Welcoming nurses, dietitians, physicians, or students of any of these professions, camp creates an inside look at life with type 1 diabetes.

Quantifying the Burden of Diabetes: Time to Comorbidity and Time to Death

We are pleased to report that this project is nearing completion. It has proven to be a great learning opportunity for all involved. Currently, we are completing the analytic work using data from the DCPNS Registry, administrative health records (hospital and physician billings), and the National Diabetes Surveillance System. We are also starting to draft the final report that is due to be completed at the end of March 2010. We look forward to sharing the findings of this work in a future issue of the newsletter.

The Diabetes Physical Activity and Exercise Tool-Kit

In this issue of the newsletter you will find a brief update on what’s new with this project in a section titled “Physical Activity Corner” on page 14. Jonathon has also highlighted the most recent findings related to physical activity as derived from the Canadian Health Measures Survey (CHMS).

Diabetes Assistance Program (DAP) for Uninsured Nova Scotians with Diabetes

Under the primary authorship of Michael Vallis, PhD, a manuscript is being prepared for submission on the evaluation of the self-care component of the DAP.

Peggy Dunbar
Program Manager, DCPNS

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Besides the bulk of knowledge that a person obtains from attending camp, it is a great opportunity to escape the daily pressures of life and get back in touch with your inner child. In other words, it is a great week of fun and games. Both camps offer traditional campfire sing-a-longs, night games, and an opportunity to see 3 a.m.! However, each camp has its own unique experience to offer.

Camp Morton is for children aged 13-14 and is great for those interested in camping in a literal sense. Held at the beautiful Kejimkujik National Park, you will find yourself sleeping in tents, eating at picnic tables outdoors, hiking through the scenic trails, canoeing in the clear waters, and learning about nature and the Mi’kmaq culture from expert park interpreters.
**Camp Lion Maxwell** is a completely different experience than Camp Morton. Directed for kids aged 7-12, it is a more traditional summer camp experience. At this camp, instead of sleeping in a tent with a sleeping bag, you will be bunked up in a cabin. Meals are held in a traditional mess hall with differently themed meals each day. Although, you still encounter Mother Nature here through swimming, canoeing, plenty of outdoor games, as well as a chance for an over-night experience at a “remote” location. Also unique to Lion Maxwell, craft time, an end of week dance party, and plenty more surprises!

As nursing students, camp has been able to teach us about type 1 diabetes in a way the lectures at university never could. Even though camp is exhausting, and by the end of the week your bed never felt so comfortable, it is a magical experience that leaves you wanting to come back for more. We recommend camp for anyone who is up to the challenge and is ready to have fun! We both plan to return, and we can’t wait to see you there!

Jaklynn Peck & Ellen MacGregor  
Dalhousie University  
3rd year nursing students

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**CAMP DATES FOR 2010**

- Camp Morton at Keji - July 10-16
- Camp Maxwell at Camp Kadimah - Aug 22-28 (May change by a day; will keep you posted.)

People can apply through the CDA website, Janice Knapp (902-679-2657, Ext. 1367), or Sheilagh Crowley (902-470-8340).

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**Research to Practice**

**Cultural Competence**

The vision for Primary Health Care in Nova Scotia is “communities can improve their health in a system that meets needs... ensuring adequate access to those populations who have traditionally faced barriers.” In 2003, the Department of Health (DOH), Primary Health Care, started a three year Diversity and Social Inclusion Initiative to raise awareness and address the needs of culturally diverse populations. Beliefs, values, and behaviors require unique strategies and policies in order to provide quality health care services. A series of workshops were held throughout the province to determine the needs and concerns of cultural competence among stakeholders. The result of these consultations included the release of “A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia.” In 2006, “Cultural Competency Guidelines for the Delivery of Primary Health Care in Nova Scotia” was released. These guidelines were the first provincial guidelines for cultural competence in Primary Health Care in Canada. This article reviews the meaning and importance of cultural competence as well as training for cultural competence.

**What is Cultural Competence?**

Culture is a composite of influences experienced over a lifetime and evolved over generations. Influences such as language; literacy; symbols (dress and music); beliefs; values; family structures; social and economic factors; and patterns of learned behavior at home, work, and recreation shape an individual's culture. Cultural competence is a “set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations.” Cultural competence includes sensitivity, awareness, knowledge, and skills. In health care, it is important not to think of cultural competence only as communication between health care provider and patient. It is important to consider a broader perspective, including cultural competence among health disciplines. In a health care team, each discipline must be sensitive and aware of respective professional backgrounds, training, experiences, and unique and diverse needs that influence decision-making in practices and patient care. Health care professions and patients have cultural filters that skew interpretation of health and disease, the illness experience, and response and adherence to treatment plans/care guidelines. Interpretations of health and disease are influenced by level of education, cultural background, and experience of the individual. Furthermore, it is important to bring into this broader perspective of cultural competence, the health-related beliefs and values of, and the ways in which rights and protections are exercised in, the health care organization where much of patient care and interdisciplinary interactions occur.

**Why is Cultural Competence Important?**

Many elements have brought cultural competence forward in primary health care - transition to patient-centered care and change in demographics in communities at home, workplace, and recreation. Cultural competence is a central theme in patient-centered care. Attention to reduction of disparities in health services, including...
inequitable access to primary health care and poor health outcomes and health status of culturally diverse populations, are driving forces. In Nova Scotia, Acadian, Francophones, African Canadians, First Nations, Asian, and Arabic peoples are the dominant diverse groups. As well, nonethnic differences exist in communities related to age; language; religion; sexual orientation; abilities and disabilities; and levels of education, skills, and experiences. All health districts in Nova Scotia have experienced integration of ethnic and nonethnic cultures and the enrichment such integration provides.  

**Cultural Competence Training**

Cultural competence training increases awareness and provides skills to facilitate interactions among coworkers and patients. Eight elements of cultural competence for Primary Health Care providers, adapted from DOH, are:  

1. Examine your values, behaviors, beliefs, and assumptions.  
2. Recognize racism.  
3. Listen and understand other worldviews and perspectives.  
4. Learn core cultural elements of the communities you serve.  
5. Engage people to share how their reality is similar to, or different from, your knowledge of their core cultural elements.  
6. Engage people to share their definition and understanding of health and illness.  
7. Develop with others a relationship of trust, respect, dignity, and willingness to hear different perceptions.  
8. Create a welcoming environment that reflects the diverse communities you serve.

The development of cultural competence within communities helps to meet the needs of diverse populations and works towards improved health outcomes. Diabetes educators can use elements of cultural competence in daily interactions and in interpreting annual DC stats. Cultural competence, in its many forms, helps to assess, problem-solve, and develop plans of action to improve diabetes outcomes in the community.  

**Brenda Cook**  
Diabetes Consultant, DCPNS

**References:**


**SMBG: Promoting Meaningful Dialogue and Action continued from page 3**

The second half of the workshop focused on case-based discussions and small group work. These discussions were introduced and facilitated by clinical experts, Drs. Lynne Harrigan and Dale Clayton. Time was taken to introduce participants to a draft decision tool (developed by the DCPNS) intended to guide participants as they worked through seven cases prepared for this SMBG session. Cases moved from simple to more complex and explored considerations related to diagnosis (newly diagnosed or follow-up); degree of hyperglycemia; type of DM treatment (oral agent or lifestyle only); risk of hypoglycemia; and the influences of age, occupation, interest, cognition, and motivation. According to the participants, “the tool allowed for a more objective look at each individual case and removed emotion and subjectivity from the equation.” It allowed for a focus on patient safety, available evidence, an individual’s interest and capability, and the health care team members use of results. The tool also helped the participant to determine, if in the case of testing, if low-intensity (time-limited) or more focused/high intensity testing was required. This tool, with the help of the workshop participants, is in revision and will be made available to diabetes care providers later this spring.

Following the case-based discussions, the group discussed the COMPUS recommendation (issues and realities) and was tasked with providing more detailed responses (via email) to an additional set of questions as a follow-up.
to the meeting. These questions, as well as completion of a “Needs and Wants” exercise, will provide the DCPNS with information related to next steps.

In our “Needs and Wants” exercise, participants were asked, “What do we need to help make the changes as discussed today a reality in your practice setting?”

The question was to be considered for each of the three categories (noted below). Participants were prompted to consider any and all supports, inclusive of educational materials, educational opportunities, common messaging, etc.

1. The person with DM (those new to DM and those who may have had DM for years).
2. Health care providers (physicians, nurses, nurse practitioners, DM educators, pharmacists, etc.).
3. Other (could be specific organizations/agencies; e.g., CDA, DoH, Medavie BlueCross, etc.).

The consensus questions that require reflection and ongoing dialogue included those listed below. Participants were encouraged to try to answer with a yes or no and then clarify this response with comments.

1. Do all people with non-insulin using type 2 DM need to test?
2. Should testing frequency be reduced in non-insulin using type 2 DM?
3. For education (self-management purposes), should all people test at diagnosis?
4. Is a maximum allowance for strips in the type 2 DM non-insulin using population feasible?
5. Should initial self-management education, if appropriate, focus on staggered, limited SMBG for a specified period of time? Please provide your views (what would this look like—how many, for how long…).

As you can see, the DCPNS is still in the information gathering stages, so necessary to inform next steps. With the help of our workshop/working group participants (Champions for Change), we will better refine our responses to the posed questions, and determine the next questions that need answering. We will refine our support tools and work with our partners and other stakeholders to reach across provider and consumer groups to attain consistency in approach and messaging to SMBG in the non-insulin managed type 2 DM population.

Peggy Dunbar
Program Manager, DCPNS

References:
2. Dunbar P. To test or not to test…where is the middle ground? Diabetes Care in Nova Scotia. 2007;17(1):7-8.

Educator Sharing

The Diabetic Foot in Nova Scotia: Creating Opportunities to Meet the Challenges

On October 19, 2009, the Diabetes Care Program of Nova Scotia (DCPNS) officially launched a series of patient and provider diabetic foot care resources. Copies of the tools were mailed out to all Nova Scotia Diabetes Centres (DCs) and also posted on the DCPNS website. Future dissemination strategies, utilizing a variety of media, will ensure the DCPNS foot care resources are readily available to every healthcare provider, stakeholder, and interest group and are implemented across a variety of healthcare settings.

It was also exciting to be able to share these Diabetic foot resources with the world during a poster discussion/presentation at the International Diabetes Federation (IDF) Congress held in Montreal in October 2009.

These patient and provider foot care tools will lead to increased awareness of the diabetic foot, early detection of foot problems, a more standardized approach to the identification of the high/moderate-risk foot, and more streamlined referral to the appropriate foot care provider, along with consistent messaging to individuals with diabetes and among health care providers.

There is still more work to be done, however, to address the growing burden of foot problems and related lower extremity amputations (LEAs) in individuals with diabetes in Nova Scotia.

To promote the early detection of diabetic foot problems, DCPNS has set a target to ensure that a minimum of 80% of all individuals attending a DC in the province will have at least one documented foot assessment each year.

Utilizing the DCPNS Registry Indicator Report and the newly developed diabetic foot care resources, two provincial DCs have accepted the challenge to improve the number of documented foot assessments in their districts. Their creative approaches are worth sharing and serve to motivate and inspire us all to do our part to reduce the burden of the diabetic foot in Nova Scotia.

DHA 3 (Annapolis Valley Health): Foot Day Blitz!

Diabetes educators at the Valley Regional Hospital (VRH) accessed the DCPNS Registry data to look at the numbers of documented foot assessments in their DC. They discovered that the numbers were below the provincially recommended target of 80% and decided to act on the evidence.

Plans were made to hold a “Foot Day Blitz” dedicated solely (no pun intended) to the Diabetic Foot. Invitations were sent to individuals currently attending the DC (excluding those under the age of 18, pregnant, or with prediabetes) who did not have a foot assessment documented within the last 15 months. Subsequently, 600 letters were mailed out. The letters included an invitation to attend the Foot Day Blitz, a description of the event, and a schedule of educational classes that are routinely presented at the DC.

Four diabetes educators (RNs) - two from VRH, one from Soldiers Memorial, and one from Annapolis Community Health Centre - performed the foot assessments, while two diabetes educators (PDts) kept things moving on schedule. Classes (up to 12 participants) were held every hour throughout the day. Each session was 10-15 minutes long and focused on the care and self-management of the diabetic foot. To add an element of fun, draws for prizes were held throughout the day; and free samples of a variety of foot care products were made available. A video on foot care was also shown while participants waited for their foot assessments.

The new DCPNS foot care resources were implemented, and all foot assessments performed were documented and entered into the DCPNS Registry. Foot Day Blitzes were held in November and December 2009 and another is planned for February 2010.

DHA 4 (Colchester East Hants Health Authority): Partnering in Foot Care

Diabetes educators from the Colchester East Hants Health Authority (CEHHA) reviewed the DCPNS 2008 Statistics Report and discovered that their district fell short of meeting the provincially set target for documented foot assessments. They also acknowledged their district’s high rate of LEAs. These numbers were just the catalyst they needed to spark their foot care initiative. The approach - partnering with community foot care nurses to get the job done!

A meeting was planned for October 2, 2009, and invitations were extended to VON, We Care, and other (entrepreneurial) community foot care nurses. The District’s foot statistics were presented, DCPNS foot care resources (to standardize the foot care) were shared, and strategies developed to improve foot care outcomes in DHA 4.
Two client tools were developed for this initiative:

1. **A List of Foot Care Clinics in CEHHA.** Information provided on this form includes: the foot care provider/service (name of organization and phone number), date and time of the foot care clinic, location, cost to attend, and credentials of staff providing the foot care service.

2. **A Release of Information/Foot Care Assessment Confirmation Form.** Completed by the client, this form serves both as a consent for release of information and a confirmation that a foot assessment has been performed on the client. The signed form is faxed to the attended CEHHA DC. The foot assessment is then documented and entered in the DCPNS Registry.

The anticipated outcome of this initiative is to improve diabetic foot outcomes in DHA 4 by:

- Building and strengthening partnerships with community foot care nurses.
- Improving communication between clients, community foot care providers, and diabetes educators.
- Increasing client and provider awareness of the diabetic foot.

**Your Way to Wellness Program Update**

"This program not only changed how I manage my chronic condition, but how I live my life."

This is a testimonial from one of the Your Way to Wellness (YW2W) participants in Nova Scotia. Since 2008, this free, province-wide program has had over 540 participants complete the program. Momentum continues to build as awareness increases and the District Health Authorities (DHAs) gain experience delivering the program.

If you are not already familiar, YW2W is the Chronic Disease Self-Management Program developed by Stanford University in the United States. This evidence-based, licensed program is offered across Canada, the U.S. and in over 20 countries world-wide to empower individuals living with chronic disease(s)/condition(s) to live a healthier life. This program recognizes that even though different chronic health conditions may have different physical impacts on a person's body, they often cause similar problems related to activities of daily living, interactions with the health care system, communication with family and friends, and dealing with negative emotions such as fear, anxiety, and depression.

In randomized studies, results have shown that people who took the program, when compared to people who did not take the program, had improved healthful behaviors (exercise, cognitive symptom management, coping, and communications with physicians), improved health status (self-reported health, fatigue, disability, social/role activities, and health distress), and decreased days in hospital.

The program involves a series of workshops that last 2.5 hours, once a week, for six consecutive weeks. Workshops are highly interactive, with emphasis on strategies to help individuals manage their conditions more effectively. Participants are encouraged to bring along a support person of their choice. Content includes mastery of self-management skills (accomplished through weekly action planning and feedback), modeling (accomplished by lay leaders with chronic conditions), and the frequent use of group problem-solving strategies. The repetitive use of action plans on a weekly basis and group and individual problem-solving assist the participant in learning to apply these tools to an array of situations that may arise as part of living with a chronic condition.

The self-management program does not replace traditional patient education with the doctor or health professional; it is complementary to and reinforces disease-specific education. Participants give and receive support from others who are experiencing similar health conditions. As
Diabetes Care in Nova Scotia

Coordinator, learning about the program, by connecting with the local Y2W in strengthening the Y2W program. Health care professionals can play a role in community workshops.

Management. I was able to learn more about self-management support in the management of their condition. I have since been able to apply the ideas of action planning to my marathon goal. Breaking things into smaller, “doable” steps helped me achieve my goal and feel in control along the way.

I am currently taking what I have learned during the September workshop, along with my experience, and transferring it to individuals attending our DCs. During the first visit, our DCs will be offering some education on goal setting and writing action plans. We have developed a form that outlines the benefits of being a self-manager and the important parts of an action plan; space is also included for individual action plans. In a group setting, examples will be provided of goals and action plans that can be critiqued for patient learning. For many of the people attending our program, this may seem like a foreign idea; so like they say, practice makes perfect, and we will learn and modify as we go. I am committed to sharing what we learn and how we can improve our approach to, and engagement of, our clients in their ongoing care.

Since this is new for us, I welcome any suggestions from others. I am also willing to share any of our work electronically if anyone is interested. Please contact me at coralee.joudrey@cdha.nshealth.ca.

Cora Lee Joudrey
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Self-Management Support: The Tri-Facilities Trial

It is easy to get caught up in telling patients all they need to know about managing their diabetes. In recent years, I have struggled with how much information is enough or too much. Am I providing the education for their benefit or so that I feel that I have done my job? Do individuals feel totally overwhelmed when they try to implement what may seem like a thousand changes to their lifestyle?

I recently ran a full marathon with team diabetes and can relate to the overwhelming feeling of having a lot to accomplish. Fundraising, a training schedule, a plan for fueling during the run... and the list goes on. This would not be easy on an ongoing basis, so I can only imagine how difficult the daily juggling is for our clients.

I was fortunate to attend a workshop hosted by DCPNS on September 22, 2009, around self-management support. This session was presented by Dr. Patrick McGowan, a self-management guru from the University of Victoria, BC. The workshop was offered in small, mixed groups of individuals from each DHA with an interest in Chronic Disease Management. I was able to learn more about self-management support approaches and tools that can be used to actively engage individuals in the management of their condition. I have since been able to apply the ideas to action planning to my marathon goal. Breaking things into smaller, “doable” steps helped me achieve my goal and feel in control along the way.

I am currently taking what I have learned during the September workshop, along with my experience, and transferring it to individuals attending our DCs. During the first visit, our DCs will be offering some education on goal setting and writing action plans. We have developed a form that outlines the benefits of being a self-manager and the important parts of an action plan; space is also included for individual action plans. In a group setting, examples will be provided of goals and action plans that can be critiqued for patient learning. For many of the people attending our program, this may seem like a foreign idea; so like they say, practice makes perfect, and we will learn and modify as we go. I am committed to sharing what we learn and how we can improve our approach to, and engagement of, our clients in their ongoing care.

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DCPNS Grant Funding (2008/09)

Project Summary

**Group Follow-Up Module**

Tina Witheralll and Heather Hopkins, South Shore Health DCs - (902) 354-3175

With the support of a DCPNS Diabetes Centre (DC) Grant 2008/09, the South Shore Health DC staff developed, implemented, and evaluated a group follow-up module. Focus groups held within the District in 2006/07 indicated clients wanted 6-month follow-up appointments at the DCs as well as more group interactive teaching programs. The new group follow-up modules allow the DC staff to make contact with clients on a 6-month basis, without increasing wait time or resources to meet the needs of DC clients.

The key topics for the group follow-up modules were decided by surveying clients and DC staff. The topics within this module include nutrition guidelines - Just the Basics, healthy eating tips for diabetes - weight loss and management, taking care of your feet, and blood glucose monitoring tips. The completed module was reviewed by external reviewers - Lora Lee Sibley and Gora Lee Joudrey, Twin Oaks/Birch Continuing Care Centre DC, and Rita Fitzgerald, Yarmouth Regional Hospital DC. During the time of the grant, the DCs offered 5 group modules (3 at QGH and 2 at FMH), with 20 clients attending these sessions.

**Clients’ Feedback**

At each module, a written evaluation was completed. Comments included:

- The information presented was helpful.
- The session increased my understanding of the management of my disease.
- I liked talking about the problems of diabetics to know you are not alone.
- I like to listen to other peoples concerns and problems. I also got a lot out of this discussion group.
- Information prepared and delivered in relaxed manner and willingness to hear scenarios, questions, etc.

Clients indicated that the following topics would be of interest in the future: weight loss, meal planning, food ideas, snacks/recipes, diet, food management, and eating properly. Clients were also asked what the DC could do to continue to support and assist them. Responses included: continue being concerned, helpful, and supportive; more frequent follow up; yearly visits; and continuing to offer updates.

Feedback and evaluation of this module has been very positive and clients really seem to enjoy this session. As well, the DC educators’ feedback has been very positive – “We are having fun with this session and enjoying the time to interact in a group setting.”

**Where are we now?**

We plan to continue to offer the group follow-up module within our district on a regular basis. South Shore Health DCs have made time available once to twice per month to offer this session. DC clients will continue to attend their one-on-one appointments, followed by a 6-month group session. Our clients now have the opportunity to attend an appointment at the DC twice a year, as compared to once a year previously.

We would like to thank all the South Shore Health DC staff, DCPNS, and our manager for the opportunity to continue to move forward with these projects in our district. For more information on this project, please contact us.
As we are all well aware, the increasing epidemic of obesity and type 2 diabetes has been the source of growing concern in our society. The recent publication of the results of the Canadian Health Measures Survey (CHMS), by Dr. Marc Tremblay and his research group, has confirmed some of our worst fears in this regard, showing on a national scale that the physical health of Canadians has declined over the last two decades. The CHMS was an objective fitness, lifestyle, and health evaluation of over 5000 Canadians aged 6-79, completed between 2007-2009. The results of this study were compared to the last CHMS completed on a national scale in 1981, and represent some alarming (yet not entirely surprising) data that has important implications to diabetes management in the future.

Firstly, this research confirms that the rise in BMI, often identified by self-report in population studies, is in fact a real measured effect – with approximately 2/3 of Canadians classified as overweight or obese. What is important to note is that this rise in BMI is almost entirely due to increased fatness; in particular, abdominal obesity, which correlates strongly with diabetes-associated health risks. When compared to a national cohort of Canadians almost 20 years ago, the prevalence of high-risk abdominal obesity has increased 4-5 fold across most age groups in both men and women. What is also striking (but not entirely surprising) is that these results were coincident with similar declines in musculo-skeletal fitness.

This study is yet one more example of the ever-increasing levels of obesity being established in our society that have important implications for diabetes management in the future. Again, very crucial to addressing this problem is asking about and promoting physical activity and exercise at every visit with your clients. Recent studies confirm that regularly planned physical activity and exercise are primary strategies to maintain weight loss and improve fitness for the best management of diabetes outcomes.

**Toolkit Updates:**

We are now nearing completion of the Lawson Foundation-sponsored research on the *Physical Activity and Exercise Toolkit*. We recently finished data collection on the client portion of the study to determine the effectiveness of the *Toolkit* methods in promoting and establishing physical activity for those with or at risk for diabetes. We are currently analyzing this data and will be presenting some interesting findings this spring at the DCPNS provincial workshop. A big thank you to the individuals who contributed to this work by completing questionnaires or assisting with the data collection with clients – we could not have done this project without you. Your commitment to understanding how to implement physical activity and exercise in practice has been demonstrated. I am confident in saying that Nova Scotia is leading the way in Canada by promoting active lifestyles with persons with diabetes through Diabetes Centres in the province.

Jonathon Fowles, PhD
Associate Professor, Acadia University

**References:**


**NS PROVINCIAL PROGRAMS’ GUIDELINES INVENTORY**

The provincial programs of the Nova Scotia Department of Health have developed a website that provides access to an inventory of practice guidelines that they have developed or endorsed. The inventory includes guidelines for prevention and screening and management of cancer, diabetes, renal, and cardiovascular diseases, as well as guidelines for reproductive care. The guidelines do not represent a complete set for each disease. They have been tailored to the Nova Scotia context by addressing the specific needs of the population and considering the specific services available within the province. The website is expected to be live by March 1, 2010 (http://www.gov.ns.ca/healthguidelines).
News From Around the Province

New Faces

Welcome to:

- **Lisa Cook, RN.** Lisa joins the staff of the Aberdeen Hospital DC (New Glasgow).
- **Florence Gillis, PDt.** Florence joins the staff of the New Waterford Consolidated Hospital DC.
- **Heather Hill, PDt.** Heather joins the staff of the Cumberland Regional Health Centre DC (Amherst).
- **Shelley LeBlanc, PDt.** Shelley joins the staff of the Eastern Memorial Hospital DC (Canso).
- **Kim Munroe, RN.** Kim joins the staff of the Pregnancy and Diabetes Program at the IWK (Halifax).
- **Mary (Lila) Rankin, RN.** Mary joins the staff of the Inverness Consolidated Memorial Hospital DC.
- **Nancy Wells, PDt.** Nancy joins the North Preston-Community Health and Wellness Centre DC.

Please remember if you have a change in any staff (professional or clerical) to let the DCPNS office know ASAP to ensure our contact list remains current. Thanks!

What’s New at the CDA?

**Taking Hold of Our Health: Youth Diabetes Prevention Project**

Last November, the Health Association of African Canadians (HAAC) launched a project that involved youth groups in a unique and interactive opportunity. *Taking Hold of our Health* is a short video featuring local Nova Scotia youth who show-cased their talent regarding education about diabetes prevention through physical activity, healthy living, cultural awareness, and good nutrition.

Through funding from Public Health Agency of Canada and in partnership with Southeastern Community Health & Wellness Centre, Canadian Diabetes Association, and the Black Cultural Centre, the program also featured Spoken Word artist Israel Jones, who provided his take on diabetes prevention.

Learn more about this video by contacting HAAC at (902) 405-4222 or info@haac.ca.

**Team Diabetes and the Blue Nose Marathon**

You’re invited to join Team Diabetes at the annual Blue Nose Marathon, May 21-23, 2010. Help raise funds and awareness for diabetes research and education. Participants raise a minimum of $500 and train to walk or run a 5km, 10km, or half or full marathon.

NEW this year! Win a chance to be part of Team Diabetes in Honolulu this December. To learn more about this exciting opportunity, phone Tom at 453-4232, Ext. 3241 or e-mail tom.sullivan@diabetes.ca or visit teamdiabetes.ca.

Getting to the Heart of Healthy Eating – Free Education Session

The public is invited to join Laurie Barker Jackman, dietitian, for an interactive session that focuses on healthy eating to help keep your heart healthy and live well with diabetes. This session will be held Wednesday, March 24, 2010, 9:30 to 10:30 a.m., CDA, 137 Chain Lake Drive, Bayers Lake.

For more information or to register, please call 453-4232, Ext. 1 or e-mail nsinfo@diabetes.ca.

News from the Company Representatives**

**Medtronic of Canada Ltd.** would like to announce its most recent organizational change. **Catrina Dunham** (902-229-6560) and **Gail Spurrell** (709-690-9088) are the Diabetes Clinical Specialists for Nova Scotia. Catrina covers Yarmouth to New Glasgow/Amherst and Gail covers Antigonish to Cape Breton. **Sarah McVicar** (902-220-0354) is now the Territory Manager for Nova Scotia. The Medtronic team is available to individuals as they transition to insulin pump therapy as well as supporting those currently on the insulin pump. Catrina, Gail and Sarah look forward to hearing from you.

**This information has been brought to our attention to share with educators around the province. Endorsement is not implied by appearance in the newsletter.**
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