State of the Art

Thrive!

In Nova Scotia, one in three children and youth are overweight or obese. One in three!

Today's generation of children, join an adult population already at very high risk of developing preventable chronic conditions such as type 2 diabetes, cardiovascular disease, obesity, and some cancers. As Nova Scotians, we have among the highest rates of chronic disease in the country; and we’re seeing diseases such as type 2 diabetes in more and more children and young adults.

Change is clearly required. Yet, there are no simple solutions to prevent childhood obesity and chronic disease. It will take a multi-faceted approach and a collaborative effort to improve our collective health.

Thrive! is a first step towards making Nova Scotia a healthier province.

Thrive! is a $2.4 million government-wide effort that outlines ¾ key action areas providing a framework for future success. It is focused on healthy eating and physical activity. The directions and actions are based on scientific evidence, expert advice, and public input. The actions build on existing success, while setting out realistic and achievable next steps.

Four Key Directions

Support a Healthy Start for Children and Families

The road to health begins long before we are born. Early experiences influence how our brain develops, our ability to learn, and our long-term health. These experiences include the well being of our parents, conditions during pregnancy, and the ways we live, eat, move, and play as infants and young children. Thrive! focuses on greater use of best practice and guidelines for prevention in public health and primary care such as consistent growth monitoring, information and resources for parents, and more support for breastfeeding.
Equip People with Skills and Knowledge for Lifelong Health

As we work to change our environment and surroundings, we will also support individuals to be more “health literate.” This means equipping people, starting as young as possible, with the skills and knowledge to make the healthiest choices possible in their circumstances. The ability to move with confidence (physical literacy) and an understanding of food and nutrition, and basic food skills (food literacy) are needed to adopt healthier behaviours for life. The plan includes actions to encourage free play and activity in child care, increase physical education and activity in schools, and teach food skills and knowledge in schools through community programming.

Create More Opportunities to Eat Well and Be Active

Even when people have skills and knowledge, they face barriers including a lack of time, money, and access to opportunities for healthy eating and physical activity. When affordable and appealing options are available in the places we live, learn, commute, work, and play, we can build healthy eating and physical activity into our daily routines. Thrive! includes actions ranging from supporting healthy eating policies in child-care, schools, sport and recreation settings, and other public institutions, to providing more affordable programming in the critical after-school time period.

Plan and Build Healthier Communities

The way our cities, towns, and communities are designed affects our health. Things like good public transit, well-maintained parks, community gardens, farmers markets, and safe, efficient walking and cycling networks make it easier for people of all ages to be healthier. Thrive! includes actions to develop a provincial active transportation policy and plan, work with municipalities on land use policy to support physical activity and healthy eating, expand physical activity leadership programs into all municipalities and Mi’kmaq communities, and increase access to facilities and places to be active.

These four strategic directions require a foundation of strong social policy to support families, increase equity, and ensure that the health of Nova Scotians is considered in all major government policies.

We know that change won’t be easy. We first need to develop a shared understanding of the problems and the solutions. Organizations like the Diabetes Care Program of Nova Scotia as well as individual Diabetes Centres and diabetes care providers can help. We encourage you to visit thrive.novascotia.ca and take the Thrive! pledge.

Physicians and other health care providers can encourage their patients to go online, learn about Thrive!, and take the pledge. Raising awareness around the issue and our proposed solutions is an important first step.

As a strategic body, we would also like to hear from you. We welcome and encourage the input and ideas from diabetes care and other chronic disease providers on how we can join forces to make Nova Scotia a healthier province and on how you can help us achieve success in our four key areas.

We can reshape the future together.

For more information on Thrive!, or to offer suggestions/solutions, please contact me directly. We will be playing a role in connecting initiatives and like-minded people, sharing best and promising practices, and looking for innovations and small measures of success. Remember to keep us top of mind as you look for ways to influence the future health of Nova Scotians.

Michele McKinnon
Department of Health and Wellness
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Vision without action is a daydream.
Action without vision is a nightmare.

Japanese Proverb
News from the Care Program

Summer is upon us, and what a summer it is!

While we may be wilting in the office, we are all finding many ways to truly enjoy the summer weather.

We are pleased to profile the Thrive! initiative as the State of the Art feature article for this issue of the newsletter. We can all agree that efforts focused on our children and youth will have huge payback in the diabetes and chronic disease world. As Michele McKinnon notes, there are many opportunities for collaboration and innovation in targeted work, both in and outside the workplace. As health care providers, we can use our voice to advocate for change and to support community-based and health system efforts, we can use our many skills and expertise to help inform and keep the momentum moving forward, and we can work specifically with high-risk individuals and families—women with gestational diabetes and their offspring—to improve outcomes and reduce future risks. We look forward to other ideas you may have and your help in the realization of these.

We are also pleased to see the DCPNS Grant submission summary from the Cape Breton District Health Authority on the interesting work with adults who have persistently high A1C values. There are some great learnings here including an improved understanding of the challenges and opportunities as well as useful tools that can help us all work better for and with this important population.

DCPNS Advisory Council, Subcommittees, and Working Groups

DCPNS Advisory Council

The Council meets again late August. We have a number of updates planned as well as discussion on the formation of a Joint Advisory Council. The formation of a Joint Advisory Council is a recommendation from the Department of Health and Wellness Provincial Programs’ Review that was conducted in 2011. This Joint Council will provide support and direction to all three provincial programs—DCPNS, Cardiovascular Health Nova Scotia, and the Nova Scotia Renal Program.

Pregnancy and Diabetes Working Group

We are really in countdown mode. All 13 sections of the resource document are complete, with a few still in the external review phase. We are hoping for a review of the full document by key opinion leaders outside the province; then we will be ready to go to print. We will launch this resource this fall (date to be confirmed) and plan to use Telehealth and a few on-site presentations, where possible.

Diabetes in Long-Term Care Facilities Working Group

The Long-Term Care Working Group draft guidelines on the frequency of A1C and bedside blood glucose monitoring for elderly residents in long-term care facilities have been finalized following feedback from the external reviewers. We are building supporting documents—case studies and an FAQ document. Distribution is planned for November/December 2012.

We have recently completed a survey of LTC facilities to determine the uptake of the guidelines released in 2010 (targets for glycemic control and assessment and treatment of hypoglycemia) to gain an understanding of the impact on residents and staff and to inform the best processes for the next phase of guidelines. The results from the survey will be shared in an upcoming issue of the newsletter.

Transition from Pediatric to Adult Care

In April 2012, the “Moving On with Diabetes…” Adolescent Transition Resource Binder was launched. Since this time, meetings, teleconferences, and follow-up calls have been made to assist with dissemination, implementation, and uptake. On pages 6 and 7, Maureen Topley, DCPNS Transition Project Consultant, provides answers to some common questions that have been posed during the meetings and follow-up calls. We hope that these will help in the adoption of the tools, as we get serious in our attempts to improve the transition experience for adolescents/young adults and their families. Learning from other programs as they start and continue down this road will be invaluable.

Insulin Pump Therapy Working Group

While we were a bit over zealous in planning a June launch for the materials developed by this working group, we have now landed on a launch date of
DCPNS Website Enhancements

We are scheduled to go live with the new website in August 2012. Take a look and let us know what you think (http://diabetescare.nshealth.ca).

Special Initiatives

Self-Monitoring of Blood Glucose (SMBG) Decision Tool and Supporting Videos

Interprofessional sessions (physicians, diabetes educators, pharmacists, and other health care providers with an interest in diabetes management) have been offered across the province over the past year. Other sessions are being planned for the fall. If you haven’t yet visited our website to view the videos and the decision tool, you may want to do so. Video 1 provides the context and reasoning behind the development of the tool; the 2nd video provides added insight into the key components of the tool and how to use the tool in practice. Check it out at http://diabetescare.nshealth.ca.

Partnership Projects

Provincial Programs Hypertension Initiative (DCPNS, CVHNS & NSRP)

My Blood Pressure Card Initiative… Come on Nova Scotia…Check it!

We are very pleased to launch and make available new materials as noted below. These have been developed to better meet the needs of specific Nova Scotia populations and reflect the feedback from information gathered earlier during focused work with these specific groups.

French: Wallet cards and brochures have been translated into French.

African Nova Scotian: A poster, for display/promotional purposes, profiles Honorable Percy Paris (Economic and Rural Development and Tourism Minister) having his blood pressure measured.

New Immigrant: A poster, for display/promotional purposes, is the same as that developed for the African Nova Scotian community with the inclusion of the key message (Check your blood pressure) in six different languages. These languages include Russian, Spanish, Simplified Chinese, Arabic, Tagalog, and Farsi (also called Persian).

Mi’kmaq: The brochure and poster have been re-designed to reflect the culture of the First Nation population. The language used is English, with the addition of a few specific websites of interest to Aboriginal peoples.
**Practice Point**

**Q:** We are now recognizing the increasing use of injectible non-insulin therapies in our Diabetes Centre (DC). How do we capture this treatment category in the DCPNS Registry?

**A:** Because we do not currently have a category under “Treatment” to capture this new classification (non-insulin injectable therapy), we are continuing to recommend Registry users enter individuals starting on Victoza as T2 OA. However, Victoza has been added to the OA drug list in the IOC section of the Registry, so we are asking that Victoza be selected from the drug list (do not type it in) to allow the tracking of this information. The DCPNS will run the data internally and provide to each DC as a separate report with the annual statistics (starting with the 2012/2013 statistics). If you are able, please enter anyone who has started on Victoza as of April 1, 2012, so this data can be available for the 2012/13 statistics reports. STARTING ON VICTOZA DOES NOT CONSTITUTE AN INSULIN START, SO PLEASE DO NOT TRY TO ENTER THIS AS AN SI in the Registry.

**Q:** How can DCs use the DCPNS Newly Diagnosed Population Report to its full potential in the future?

**A:** The report provides an important look at the processes (completion of foot assessment, documented eye examinations, SMBG testing, etc.) as well as changes in key measures (A1C, BP, Lipids, etc.) during the first 8-12 months attending your DC. This will help to show your program where added focus should be placed during these early months of education/intervention. For example, in the first 2 years of producing this report (and we are still improving the report based on your feedback), improvement in AIGs was noted for all treatment categories; however, the trend was not the same for blood pressure. Using this information, DCs should look to addressing blood pressure issues through focused education, specific recommendations to primary care providers, etc. As an added insight, this report provides information on the dropout rates following the first visit and in the first three-month period. Some DCs have already taken this information and are looking to survey early dropouts to better understand and address barriers and challenges as raised by these individuals. In summary, this new report provides valuable insight into the newly diagnosed population (descriptive, process, and short-term clinical measure) and acts as the basis for quality improvement to better meet the needs of this population.

**Department of Health and Wellness Announcement**

Effective Aug. 1, Lantus, a long-acting insulin analogue, will be added as a benefit on Pharmacare for eligible patients who need an alternative to NPH or other pre-mix insulin.

The Nova Scotia Pharmacare Program has decided to add Lantus® to the Nova Scotia Formulary under special authorization with specific criteria required for coverage. The criteria are:

- For the treatment of patients who have been diagnosed with type 1 or type 2 diabetes requiring insulin and are currently taking NPH and/or premix insulin daily at optimal dosing for at least three months. **AND**
- Have experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management. **OR**
- Have documented severe or continuing systemic or local allergic reaction to existing insulin.
Educator Sharing

Moving Forward with “Moving On with Diabetes…” Pediatric to Adult Transition Care in Nova Scotia

In April 2012, the “Moving On with Diabetes…” Adolescent Transition Resource binder was provided to Nova Scotia Diabetes Centres (DC) who provide pediatric diabetes care. The Adolescent Transition Resource binder contains patient and provider tools to facilitate the successful preparation and transition of adolescents to adult diabetes care. Following the release of these materials, meetings and teleconferences were scheduled with the DC teams to review the content, answer questions, and discuss implementation. Response to the meetings was very positive, with a total of 45 participants - pediatric and adult diabetes educators as well as DC administrative staff, pediatricians, adult endocrinologists/internists, and DCPNS Transition Working Group members - taking part. DC teams were encouraged to begin to use the patient and provider tools as soon as possible.

Issues and questions arising from the meetings and teleconferences as well as some initial DC implementation plans are outlined in the following question and answer format.

1. How do we put transition care and the Adolescent Transition Resource binder resources into practice?

Included in the binder is a Purpose & Intended Use sheet that outlines how to use the various forms and patient handouts. Teams were encouraged to review the handout along with the tools in the binder and plan the best way to incorporate these into their specific DC program. One DC may use the tools slightly different from another (e.g., one DC may mail the Adolescent Knowledge & Skills Self-Assessments prior to an appointment, while another may have the adolescent complete the Self-Assessments at the appointment). Most pediatric teams are planning to meet to discuss and decide what will work best in their local situation.

2. What does the term “designate” mean, and how do we pick or assign that person?

The literature and various models on transition care have demonstrated that one of the key components for effective transition is the use of a transition coordinator/liaison between the pediatric and adult diabetes services. In our Nova Scotia model, we have identified this role as the “pediatric designate” and “adult designate.” A designate is a “member of the diabetes care team who has been assigned to be most responsible for the coordination and completion of transition education/care of a particular adolescent(s).”

How this person is chosen will depend on the specific DC and circumstances (e.g., workload). We also know that some adolescents “connect” better with a particular DC team member and this may be a factor in the decision. Having one team member take on a clear “designate” role in both the pediatric and adult program settings will help ensure there is a more seamless transfer of care. It provides a contact person from one team to another if there are questions, if clarification is needed, or if there is a loss to follow-up situation that needs to be addressed.

3. Often, adolescents stay in the same DC and simply transition to the adult program. Does that make a difference in how we use the transition materials?

Regardless of where they are followed for adult diabetes care, adolescents need the same preparation for the transition to adult care. Transition care is about building skills and self-efficacy to prepare them to manage their diabetes independently and confidently as adults. The Adolescent Knowledge & Skills Checklist and Transition Handbook (to follow), which intended to be used during the last pediatric year, can be useful to indentify specific education/skill areas that need reinforcement through the young adult years. The Transition Summary Report will still need to be completed and forwarded to their adult diabetes specialist and family physician and can provide the starting point for the adult DC chart.

4. Is there anything in the transition resource material for parents? They also need information and assistance to guide them through the process of “letting go.”

A specific handout for parents - “Moving On with Diabetes…” Advice for Parents - is in development. Once finalized, it will be distributed to become part of the Adolescent Transition Resource binder. The goal of a
transition program is to facilitate the gradual transfer of information and skills from the parents/guardians to the adolescent. Involving both in the process and preparation will help everyone understand the importance of preparing for adult diabetes care.

5. **It is very difficult to know who to refer the adolescent to for adult diabetes care.** A list of adult diabetes specialists in the province would be helpful.

A directory of endocrinologists and internists in Nova Scotia with a special interest in diabetes will be provided to all DCs once finalized.

6. **There are a number of issues that affect diabetes management during adolescence, specifically mental health and behavioral issues.** Access to mental health and psychological services is very limited, and it is difficult to navigate the system. What can be done to address this?

The DCPNS has representation on a few provincial working groups/committees such as the Depression Strategy Working Group and the Chronic Disease Prevention and Management Advisory Committee. It is well recognized that mental health issues are a major concern for people with chronic conditions and work is currently underway to help in the early identification and treatment of stress and anxiety as well as depressive disorders. This will all be interwoven with the recently released Mental Health and Addictions Strategy—Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians.

7. **Who has responsibility for care between the last pediatric appointment and first adult appointment? How do we ensure the adolescent is not lost to follow-up if they do not keep their first appointment?**

Most pediatric DC programs presently inform the adolescent to continue to contact them if they have any problems before their first adult appointment. This is included in the expanded Transition Pathway and is encouraged as standard of care.

Several of the transition resources help support the seamless transfer of care and reduce chances of loss to follow-up. Having a pediatric and adult designate is also key component to successful transition.

8. **Have some DCs/teams already started to implement the Transition Resource tools?**

Five of 12 pediatric DC teams have already begun to use the worksheets, checklists, and other Resource tools. While some teams are still reviewing the materials, most have plans to discuss implementation at upcoming pediatric team meetings. Those who have started are identifying adolescent charts (flagging by colour) and placing age appropriate self-assessments and educational checklists on the charts. Most DCs have started with the older adolescents (transitioning this year) and plan to implement the other worksheets/self-assessments more fully with the younger adolescents in the fall of 2012.

The response is positive. The DC teams can already see how the self-assessments identify areas that need work and how the diabetes educator checklist is especially useful if the adolescent does not see the same educator at each visit. Participation and feedback from all involved in this process will be necessary to ensure the success of this provincial initiative.

9. **Will the “Moving On with Diabetes…” Adolescent Transition Resources be available electronically or online for both healthcare providers and adolescents/young adults to access?**

We anticipate that all of the “Moving On with Diabetes…” Adolescent Transition handouts will be available through the DCPNS website. DCs with a pediatric program will also receive copies of materials as needed.

Maureen Topley, RN BN CDE
DCPNS Transition Project Consultant

References:
DCPNS Grant Funding (2009/10)

Project Summary

Pilot Project Looks at Case Management Approach for Diabetes Patients

Lynn Gilbert, Public Affairs Assistant, and Phillip Morehouse, Director, Health Transformation, Quality Management, Education & Risk, Cape Breton District Health Authority

In June 2012, the Cape Breton District Health Authority (CBDHA) finalized its evaluation report on a pilot project designed to improve diabetes care in individuals (adults) with persistently high A1C (> 9%).

Work on the pilot project, “Case Management Model Evaluation for the Care of Patients with Diabetes,” began in 2009. This followed a successful submission to the Diabetes Care Program of Nova Scotia (DCPNS) in response to a call for proposals to develop a programmatic approach for a specific population (those with A1C > 9%). The program’s purpose was to develop, implement, and evaluate a refined case management approach for people with diabetes using a multidisciplinary team and a client-centered approach.

In total, 16 patients were recruited, 8 patients through selected physician offices and another 8 through the Northside Diabetes Centre (DC). Inclusion criteria included individuals who were a patient of a North Sydney doctor and were between 25-75 years of age, had type 1 or 2 diabetes, and A1C values persistently above 9%. The Case Management Team engaged the participants in self-assessment, assessed and reviewed each case, and made recommendations that were shared with the patient. This team consisted of the Project Manager, the Case Managers (DC Nurse and Dietitian Educators), the patient’s family physician, a pharmacist, community Occupational Therapist (OT)/Physiotherapist (PT), and a Social Worker. Involvement of the extended team members varied depending on participant need.

In February 2010, the first patient assessments were completed on all 16 participants. Eight (8) patients completed the project in March 2011.

Following an evaluation of the project, four key findings were evident:

- Three tools implemented in the project provided the team with a more in-depth understanding of individual issues and considerations. These included provider (physician, Diabetes Centre, and pharmacist) assessment and patient self-assessment tools as well as the Diabetes Quality of Life Scale, the Diabetes Distress Scale, and the Hospital Anxiety and Depression Scale (HADS). These forms are available and can be used by other programs to get similar in-depth information.

- On average, patients saw a 1.4% absolute reduction in their A1C; a decrease of 9.1% in their Low-Density Lipoprotein (LDL) and generally improved on the Quality of Life Scale and the Diabetes Distress Scale.

- Of the project’s initial 15 patients, 11 scored positive on the HADS assessment. Of the seven patients who withdrew from the project, four had anxiety or depression.

- Patients who completed the project were satisfied with the program, rating the quality of service as good to excellent.

Overall, project organizers say it was successful.

“We learned that patients with diabetes whose A1C is consistently over 9% have a complex set of needs which we are not fully equipped to meet currently through the DC and our community,” says Phillip Morehouse, Director of Health Transformation, Quality Management, Education and Risk for CBDHA. “This group of patients generally has mental health needs which need to be addressed in order for them to have the energy and affect to make improvements in their daily life. These patients also need more frequent contact to assist them in developing the skills of self-management. As well, the physician/DC relationship for these patients needs to be strengthened. The pilot taught us that the present scheduling process in the DC does not work with a refined case management process for those patients that need more and different types of access/support. DCs need to move to a more proactive approach for specific patient populations.”

The final evaluation report, including process documents and forms, offers 13 recommendations including the need for DCs to adopt a case management approach, physicians to be more involved in the process, improved mental health access for people with chronic disease, improved scheduling for the DCs, clarity around roles and responsibilities, and more.

This report will be available for viewing on the DCPNS Website by late summer/early fall 2012. The pilot was funded in part by the DCPNS.
Physical Activity Corner

Sustaining Physical Activity and Exercise at Diabetes Centres

The Physical Activity and Exercise Toolkit project has been in full swing this past year in numerous centres in Nova Scotia and nationally with the adoption of the resource by The Canadian Diabetes Association (CDA). “Physical Activity and Exercise” is now the third volume in the set of “Building Competency in Diabetes Education” resource manuals provided by the CDA for diabetes educators to use in their practice. A copy of the resource will be provided to each Diabetes Centre in Nova Scotia early in the fall compliments of the DCPNS. If you are interested in obtaining another resource manual, extra brochures, or a DVD, these are now to be purchased through the CDA. Acadia will no longer be providing this resource. The link to order form can be found online at https://orders.diabetes.ca/cda/find.asp?find_category=PD.

To complement the national rollout of the Physical Activity and Exercise resources by the CDA, the Lawson Foundation has also supported a series of workshops across the country to deliver the Physical Activity and Exercise resource manual, much like what was done in Atlantic Canada. Dr. Jonathon Fowles and Dr. Chris Shields have delivered workshops in Moncton, Toronto, Barrie, Regina, Kelowna, Vancouver, Prince George, and Whitehorse and are scheduled to give workshops in Ottawa, Milton, Winnipeg, and Montreal in the fall. To build further capacity for promoting physical activity and exercise in Diabetes Centres (DCs), there will be ‘Train-the-Trainer’ workshops for diabetes educators, kinesiologists with a background in exercise in diabetes, and those who have attended the basic workshop, to help peer educators lead other professionals through the basic workshop to use the manual and tools in their practice. ‘Train-the-Trainer’ workshops are being delivered in the fall, and a session will be available as a pre-conference workshop at the annual CDA conference (Wednesday, Oct. 10 from 7:30-10:30am; pre-registration required). This workshop would be good for those of you who would also like to refresh your knowledge and skills on physical activity counseling and exercise prescription.

As a follow-up and conclusion to our Lawson Foundation supported initiative to enhance physical activity and exercise resources in Nova Scotia, we have been finishing our client data collection at DCs where exercise professionals have been providing services. We also did a short survey at three sites where exercise professionals have been leading exercise classes regularly for more than a year. We thought we would provide a snapshot of this feedback, specifically as an overview of what was going on throughout the year, as it also may be helpful for creating, organizing, and maintaining exercise classes for individuals with diabetes at DCs in the future.

Interestingly, we found that everyone who filled out the questionnaire (n=11) had attended either a walking class or a resistance band class regularly for nine months or longer, starting in the summer of 2011. These individuals were taught many skills on how to exercise and be more physically active. In addition to resistance band exercises, some had learned chair yoga, Nordic Pole walking, and how to use pedometers and heart rate monitors. The surveys revealed that the participants’ confidence in performing aerobic exercise increased - on a scale of 1 to 10, from 4.8 before taking the class to 6.9 after taking the class. Their confidence in completing resistance exercise greatly improved as well from 4.0 before the classes to 6.8 after. They found it very helpful having an instructor and reported enjoying the classes very much.

When asked why they continued to attend the class, most reported that it was enjoyable, motivating, and energizing to be with a group of people who had diabetes like themselves. The camaraderie among the members really kept the group together. Also, many people reported that the decrease in blood glucose seen after class was a great motivator to continue. Many reported increased mobility and independence for activities of daily living as positive outcomes.

The exercise group in Annapolis Royal (one of the three sites) also underwent exercise testing to see how they improved since beginning the class. All seven of these participants decreased their waist circumference by a minimum of 3 cm. This group has been using the Steps Count Pedometers. Eight members of the group started logging their steps on the logyoursteps.com website in May. They have just reached 5 million steps, which has taken them from Halifax to Winnipeg. Their goal is to walk across the country. They said that this program has helped them increase their walking and given them a new perspective on walking.
All of the survey participants said that since taking the class they have increased their daily physical activity. Their confidence in their abilities to continue being physically active after the classes is high, but they will need continuous support from the diabetes educators. In Annapolis Royal, the participants are so motivated they are continuing to attend the class regularly on their own. Some DCs have taken it upon themselves to teach the resistance band class regularly once a week for individuals who are interested. We strongly encourage each diabetes educator to look at creative ways to support physical activity and exercise at their Centre, as it appears that there are great rewards to those who participate regularly.

Stephanie McQuaid, B Kin
Physical Activity and Exercise Toolkit Project and Research Coordinator

Three Provincial Programs Offer Blood Pressure Grants in 2012/13

In an effort to address and reduce common risk factors associated with chronic disease through collaborative partnerships and programs, the three Provincial Programs - Diabetes Care Program of Nova Scotia (DCPNS), Cardiovascular Health Nova Scotia (CVHNS), and the Nova Scotia Renal Program (NSRP) - are offering joint grants in 2012/13 to support projects focused on blood pressure. The Provincial Programs will fund two projects (DHA Projects) to a maximum of $10,000 each as well as 4 to 5 smaller grants (Site-specific/Community Projects). These smaller projects will be funded to a maximum of $3,000 each. These grants will help to better support the Nova Scotia population either at risk for or living with high blood pressure.

Grant information has been sent to the CEO of each District Health Authority (DHA) for circulation to those staff interested/inolved in chronic disease prevention and/or management, including Directors/Managers of Primary Care; Chronic Disease Management; Diabetes, Cardiac, or Renal Programs; and others. We are interested in collaborative efforts across programs. We would also encourage a joint submission if two or more DHAs would like to come together to apply for one of the $10,000 grants.

The purpose of the projects is to develop, in partnership, a blood pressure/hypertension program aimed at awareness, prevention, early detection, and/or management. These projects should be:

- Developed, evaluated, and refined over a 9-12 month period in keeping with quality improvement initiatives.
- Designed for sharing with/application across the DHAs.

**Letters of intent (LOI) are required by September 14, 2012.** (See process for application submission/approval available through the three Provincial Programs.) Following review of the LOIs, select applicants will be invited to submit a full three-page application by October 26, 2012. Successful applicants will be provided with funding starting early November for completion of project within 9 months.

Examples of potential projects can be found in the Grant Projects Overview document (also available from any one of the three Provincial Programs).

Please contact the DCPNS office for more information (info@dcpns.nshealth.ca or 473-3219).
News From Around the Province

**New Faces**

**Congratulations to:**

Marilyn Crooks, RN, on her recent retirement from Soldier’s Memorial Hospital Diabetes Centre (DC). Please join us in wishing Marilyn the best that retirement has to offer!

**Welcome to:**

Ciara Lamoreau, RN. Ciara joins the Soldier’s Memorial Hospital DC in August 2012.

*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 happening at the Canadian Diabetes Association?**

**We want YOU to join us for the Walk or Run for Diabetes!**

The Nova Scotia Region is asking educators in the Halifax Regional Municipality to join us for some physical activity and help support the local Walk or Run for Diabetes. Bring your friends and family and walk in support of Nova Scotians living with type 1 and type 2 diabetes. Make it a friendly competition and challenge your fellow educators to get involved!

- **Date:** Sunday, September 23rd
- **Location:** Studley Gymnasium, Dalhousie Campus, Halifax
- **Start Time:** 10:00 a.m. 5km, 3km, and kid’s run!

For more information, contact lauren.wilkie@diabetes.ca or phone 453-3241 for details and registration information.

**Plans for a Healthier Nova Scotia – Thrive!**

The Canadian Diabetes Association applauds the province of Nova Scotia for the development of a strategy that focuses on healthy eating and physical activity – as it relates to children and families. This focus is instrumental in helping to lessen the burden of diabetes - it is estimated that over 50% of type 2 diabetes could be prevented or delayed with healthier eating and increased physical activity.

The Association supports the approach of emphasizing health and supportive environments as opposed to addressing weight.

Partnerships and community engagement plans have also been referenced as part of the strategy and the Association welcomes this opportunity to work with all levels of government as well as all departments to support the implementation.

**New! Canadian Journal of Diabetes**

The Association recently combined three previous health professional publications into one: *Canadian Journal of Diabetes*. This is a peer-reviewed journal that spans in content from diabetes education to research.

If you have an article you’d like to consider published, please submit online via the Association’s website (http://www.diabetes.ca/publications/cjd/).

Stay tuned for the launch of the new DCPNS website in August 2012!