

# Diabetes Care in Nova Scotia

*a newsletter of the Diabetes Care Program of Nova Scotia*

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## State of the Art

### Improving Outcomes with Population Level Strategies

In recent issues of this newsletter, we have focused on the chronic care model (CCM) as first proposed by Wagner.<sup>1,2</sup> Understanding how chronic care differs from that of acute, episodic care is of paramount importance if we truly want to improve health and health-related outcomes of those living with chronic conditions. The CCM provides us with a quality framework to identify gaps in current approaches and to investigate/develop strategies to address each of these gaps. A variety of efforts and specific initiatives are required to promote and sustain patient, provider, and health system change.<sup>3</sup> In essence, enhanced chronic disease management can be boiled down to finding out and adopting what is needed to ensure productive interactions between informed, activated **patients** and **providers**.

Earlier this spring, the joint Diabetes Care Program of Nova Scotia (DCPNS) and Cardiovascular Health Nova Scotia Workshop, "**Chronic Care: Maximizing the Concept of Self-Management**," introduced in greater detail the self-management component of CCM. Patrick McGowan shared insights and experience on the need for and value of self-management strategies. He introduced us to the Stanford model of peer-to-peer counseling and its use across chronic conditions. He then demonstrated, and had workshop participants try, the approaches that providers should take to engage persons with chronic illness in decision-making and in establishing realistic, attainable treatment goals.

## CONTENTS

State of the Art	
Improving Outcomes with Population Level Strategies .....	1
News From the Care Program .....	3
New Resources .....	5
Pregnancy Focus	
Hungry or Harried? Why Do We Eat the Way That We Do? .....	5
Research to Practice	
Salba .....	7
Celiac Disease and Type 1 Diabetes .....	8
Soy Foods and Cardiovascular Disease: What's New? .....	10
Educator Sharing	
Developing a Healthy Living Program for Seniors: Part 1 .....	11
Community Pharmacists Join Yarmouth Diabetes Centre (DC) Team. Collaboration is Cool! .....	13
Nova Scotia DAP Update .....	14
News From Around the Province .....	14
News From Industry .....	15

#### Newsletter Publication Dates:

The first week of January, April, July, and October. Questions or contributions should be submitted at least 3 to 4 weeks prior to the publication date.

This article introduces and allows us to focus on yet another CCM component—provider organizational supports, also known as practice innovations, or more broadly as “care management processes.” These include disease registries, practice guidelines, reminder systems, performance feedback, and case management.<sup>4</sup> All of these act to ensure that we have prepared proactive practice teams (the provider end of things). Organizational processes such as these have been found to be more likely used in areas that have greater clinical information technology (registries and electronic health records) and external quality incentives (organizational or public recognition or financial or resource reward for better performance).<sup>4</sup>

Renders, et al, in their retrospective comparative study of three different quality improvement programmes, found that service delivery that combined organizational intervention (registries and central recall) with individual therapy advice and patient education by allied health care professionals (nurse, dietitian, and podiatrist) demonstrated improved outcomes (recommended ordering of tests and A1C).<sup>5</sup>

Population level strategies (a new term for many of us) have been shown to improve primary care for diabetes. Population-based diabetes management means taking a broad, high-level look at a whole population to help monitor and deliver patient care. “This approach allows the provider to assess specific elements of care for a large panel of patients independent of individual clinic visits and to select patients for further intervention on the basis of specific care

parameters relative to the rest of the population.”<sup>6</sup> It means using software that has the ability to rank patients within an established registry according to various criteria. This criteria could include clinical indicators such as the most recent A1C, BP, or LDL-cholesterol, or process indicators (test frequency or time since last test). It could also include indicators of self-care (as collected in the DCPNS Registry)—patients without an eye exam in the past 12 months, patients who smoke and have not yet quit, patients who self-blood glucose monitor but are not yet using the results to modify treatment, or patients with a moderate- to high-risk foot assessment rating. Knowing this type of information for a whole population, or a segment of the population (type 1 or type 2 diabetes or for those < age 40 years, etc.), can help Diabetes Centres and individual providers determine the need for targeted interventions. These interventions do not necessarily need to lead to more one-on-one care, but could mean the development and delivery of lifestyle classes to modify risk factors for high blood pressure, to focus emphasis on smoking cessation initiatives, and to form partnerships to address the high-risk foot. This population approach helps to identify and react to outliers within a defined population.

Taking the population approach one step further, it may help to identify barriers to effective clinical management and, in doing so, lead to changes in approach. Earlier work using the population approach was able to uncover physician barriers to adopting effective treatment recommendations; this included mental health problems (depression or anxiety), prior history of poor adherence to care plans, ongoing substance abuse, and serious comorbidity limiting effectiveness of diabetes care.<sup>6</sup> The identification of these types of barriers will also lead to innovations or additional support structures for patients with similarly identified need.

“Population approaches have been shown to reduce clinical inertia and increase patient engagement with the medical system.”<sup>6</sup> In contrast to case management which focuses on individual patients, population management seeks to more effectively harness existing resources to improve the overall level of care for a given patient population.<sup>6</sup>

The biggest challenge will be the translation of the information from population approaches into action.<sup>3</sup> We will be challenged in our present system, where resources are constrained, to balance more intensive intervention in fewer patients with less intensive intervention for more patients.<sup>3</sup>

As users of the DCPNS Registry come to recognize its full potential through the use of provider and indicator reports (for use in quality improvement), we will be able to move forward on local, district, and provincial initiatives. This is an exciting time to be able to look at population needs, discuss and develop interventions, and measure change overtime. For each identified problem area, we will need to ask the following:

- What will the change look like for each of the three areas?
- What can be offered and how do we refocus on self-management **for the patient population?**
- What do we need to do differently **for the provider?**
- What additional resources, linkages, partnerships are required **for the system?**

Exploring possible interventions will lead to creativity and innovation. It could mean more frequent or focused follow-up; the development of an interactive group session or tool to promote self-learning; or focused goal setting, mentoring, modeling, and/or directed mailing; or expansion of your core team members. There are endless possibilities once the creative juices start to flow.\*

Peggy Dunbar  
Coordinator, DCPNS

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**News from the Care Program**

As we prepare this newsletter, we wish you all a restful, rejuvenating summer. Although a long time in coming, the fine weather is finally here—Enjoy!



This issue of the newsletter provides an array of submissions reflecting the work of students, DCPNS staff, and dedicated diabetes educators from across Nova Scotia. We thank you all for your continued contributions. As you scan this issue, you will note a number of projects that are about to be unveiled - the new dyslipidemia guidelines accompanied by a patient education module and new Registry reports. As well, a number of projects will start us in a few new directions—foot care action items, seniors healthy living module, physical activity roundtable, newer ways of reporting and displaying data, etc. These projects demonstrate the ongoing value of the work we all do as we strive to improve the quality of care and services provided to those living with or at risk of developing diabetes in Nova Scotia. Keep up the good work!

**DCPNS Staff**

Our congratulations and best wishes to Zlatko Karlovic and his wife, Val, on the newest addition to their family (daughter Misa). Zlatko is now on paternity leave until January 2007.



We are very pleased to welcome Robin Read to the position of DCPNS Data Analyst. Robin and Igor Grahovac will continue to

enhance the Registry and provide support to DCPNS Registry users.

We are also pleased to announce that we have filled the position of DCPNS Nurse Consultant effective August 14, 2006. Bev Harpell, RN BScN CDE, comes to us from Sutherland Harris Memorial & Aberdeen Hospitals' Diabetes Centres (DCs). Bev brings many years of direct diabetes education experience to the DCPNS in addition to roles that have focused on staff development, infection control, etc.

**Subcommittees**

**Best Practice Committee**

The Dyslipidemia Guidelines were approved by the DCPNS Board of Directors in June. They will be released in the near future.

The *Dyslipidemia Management Module* was piloted in June at the Cobequid Health Centre by a diabetes team (Shawna Boudreau, RN and Susanne Dewolfe, PDT) from the QEII Diabetes Management Centre. Revisions to the module are being made based on the feedback from the pilot. The module will be reviewed by Wanda Firth (Heart Health Clinic, Halifax, and by the diabetes educators at the Sacred Heart Community Health Centre DC in Cheticamp). Once comments are in and final changes made, this module will be available to all DCs in Nova Scotia.

The first draft of physical activity guidelines was developed and presented to the Best Practice Committee (June 16<sup>th</sup>). The Committee agreed that the development of these guidelines required the inclusion of many experts. The DCPNS will be hosting a "Physical Activity and Diabetes Roundtable" in the near future. This will be used as a springboard for focused discussion and targeted initiatives to move these guidelines forward in Nova Scotia. In the meantime, the Committee will continue its work on developing a physical activity assessment tool and guidelines for "getting started" in non-high risk individuals with diabetes.



DCPNS will be conducting a phone survey this summer to evaluate the uptake of each of the recommendations from the *Guidelines for Blood Pressure Monitoring and Education through Nova Scotia Diabetes Centres* and to determine the status of the *Triage Guidelines* (guidelines for initial and follow-up appointments). The findings from the survey will assist the DCPNS in determining which specific DCs require assistance in moving forward.

**Care of the Elderly with Diabetes Residing in Long-Term Care Facilities**

The draft guidelines were reviewed by three external reviewers and the feedback has been mixed—some preferred a shorter version of the guidelines while others preferred a longer version. The needs assessment from 2003 will be reviewed to ensure the final product meets the needs of the intended target audience. A meeting will be held with Continuing Care personnel at DoH to discuss how we should proceed.

**Pregnancy and Diabetes Subcommittee**

The three revised sections (from the 2000 version of the *DCPNS Pregnancy and Diabetes Management Guidelines Manual*) are now available on the website. Hard copies of these sections have been provided to

DCs in Nova Scotia. All other manual owners are directed to the website to access a pdf version for downloading purposes.

### **CIHR Grant Submissions**

Since February, a number of individuals under the leadership of Beth Cummings, DCPNS Medical Advisor, have worked diligently to put together a letter of registration (May 1, 2006) and then the final submission to the CIHR on June 1, 2006. If we are successful, Nova Scotia will be able to play a significant contributing role to the National Diabetes Surveillance System (NDSS). In doing so, we will improve Nova Scotia's understanding and potential use of the NDSS in Nova Scotia. The proposed project focuses on validating the case definitions for two specific populations (< age 20 years and pregnant women with pre-existing diabetes). In addition, clinical applications as part of the proposal will look at outcomes in these populations as well as health services' utilization. Both of these applications will help inform DCPNS/DoH policy and program directions for these more vulnerable populations.

### **Using and Displaying Diabetes Data in a Meaningful Way**

Under the direction of Jennifer Payne, DCPNS Contract Epidemiologist, we have been working with the Public Health Agency of Canada, GIS Infrastructure Office of Public Health Practices, to create a series of maps depicting some of the NDSS and DCPNS Registry data. The potential for this work in providing visuals to the Districts is huge. We will continue to look at mapping additional data such as prediabetes cases and specific clinical indicators.

### **Transition of DCPNS to DoH Provincial Program Model**

The DCPNS is in the process of transitioning from its existing provincial program structure to that of the provincial program model as developed by the DoH. The changes that are taking place will have little effect on the activities of the program. More noticeable changes will include an enhanced/expanded DCPNS Advisory Council (to replace our current Board governance structure).

### **Nova Scotia Diabetes Assistance Program (DAP) for Uninsured Nova Scotians with Diabetes**

Please see the update by Lisa Tay, Project Manager, on page 14.

### **Delegated Medical Function (Insulin Dose Adjustment)**

All nine District Health Authorities have approved the manual and its policies. Exam revisions are also complete. A copy of the revised document has been provided to all DCs and their Medical Advisors.

### **Diabetes Foot Care Issues Paper**

The final version of this report is currently being prepared and will be widely distributed later this summer. This document provides the DCPNS, as well as individuals/organizations with an interest in diabetes foot care, with a number of new and innovative suggestions for continued progress in this area. Keep your ears to the ground for focused activities in the months ahead.

### **DCPNS Registry Enhancements**

Phase I of the interface with Meditech is complete and up and running. This interface will further enhance the DCPNS Registry as it also captures Meditech-registered DC clients for DCs not yet computerized. We are now moving to Phase II of the interface with Meditech (lab data linkage). Other enhancements include:

- Completion of the DC "Indicator Report." This report allows DCs to choose an indicator for a specific period of time and to then run population reports. This will help to guide quality improvement interventions.
- Production of the second annual indicator (outcome) reports for users of the on-site DCPNS Registry. This year these reports will be accompanied by power point slides to highlight some of the changes in key indicators. With two-years of data, comparisons are now possible!
- Completion of the Report by Physician—Lipid Values. This report complements the existing report by physician devoted to A1C and blood pressure values.

### **NDSS District/Provincial Reports**

The NDSS Provincial report with select slides has been posted on the DCPNS website as of May 2006. This is intended to provide consistent data for use by students, policy planners, Districts, etc.

### **Diabetes Centre Grants**

All 8 projects have reached the first milestone and have either submitted or are in the process of submitting their July 1<sup>st</sup> status report. We look

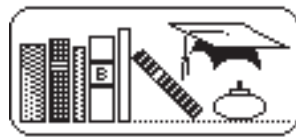
forward to the work of these projects and sharing with other DCs and decision makers what has worked well.

**DCPNS Standardized Diabetes Centre Forms**

All revised documentation forms (adult, pediatric, and pregnancy) are now available on the DCPNS website in pdf for downloading purposes. Anyone using or adapting these forms is encouraged to cite the source.\*

Peggy Dunbar  
Coordinator, DCPNS

**New Resources**



These resources are available from the DCPNS for loan across Nova Scotia. Please call (902) 473-3219 for borrowing information.

**BOOKS**

- **Diabetes and Foot Care: Time to Act** (2005).
- **The How To of Patient Education** (2003).
- **Clinical Epidemiology: How to do Clinical Practice Research** (2006).
- **Diabetes Education Standards Recognition Program: A Quality Assessment Tool for Diabetes Education Centres** (2005).
- **The Art and Science of Diabetes Self-Management Education** (2006).



**VIDEOS**



- **Depression, Diabetes and Stress** (2005).
- **Obesity and Type 2 Diabetes** (2006).\*

**Pregnancy Focus**

**HUNGRY OR HARRIED?  
WHY DO WE EAT THE WAY THAT WE DO?**

With all the alarm bells ringing over obesity today, one can't help but think that something is being overlooked. A recent review of the research on weight loss programs and diets shows that overall dieting (a prescribed regime) is not an effective solution for maintaining long-term weight loss.<sup>1</sup> Is it that we are too focused on what and how much to eat? Could it be that we are forgetting other aspects of life that impact on the foods we choose and the quantities we eat?<sup>2</sup>

Emotional eating is best defined as eating for reasons other than hunger—physical hunger that is. Food itself is very powerful and one of its greatest powers is to provide comfort. Many of us learned the comfort of food at an early age.<sup>4</sup> Food is often associated with happy times in our lives (i.e., family dinners). For some, it can be a negative memory (food being forced on us or restricted), but even though a negative memory, it still wields power that can result in less than healthy perceptions of food.

In addition to the comfort we find in food, we (as a society) have also been provided with ready access to a vast variety of foods (though not always nutritious foods) around the clock. We also don't have to look too far to find it. We are living in "a climate of drive." We work hard to be successful and this leaves little time for taking proper care of our greatest gift—our body. Looking good is a huge part of our culture. There is nothing wrong with looking good, but most people would agree that our culture has established unattainable standards of what it means to "look good." Isn't it odd that media can feed us two completely different messages at the same time? Look over here for the newest way to lose weight, and look over here for this new scrumptious high-fat recipe or new processed food product. Both will change your life!

In essence, we take great comfort in food. We have an abundance of food. We have limited time and more stresses as we move through life. We are bombarded with confusing messages that distract us from paying attention to what is really important – caring for ourselves.

A recent publication by Scherwitz and Kesten, provides a look at seven eating styles that have been linked to overeating, overweight, and obesity.<sup>2</sup> These include:

1. Emotional Eating (eating to manage feelings).
2. Fresh Food, Fast Food (eating mostly processed, high calorie food; less fresh food).
3. Food Fretting (judgmental thoughts and over-concern about food).
4. Task-Snacking (eating while doing other activities).
5. Sensory, Spiritual Nourishment (flavoring food with meaning).
6. Eating Atmosphere (dining aesthetics and surroundings).
7. Social Fare (eating alone vs. with others).

Each of these seven styles has been analyzed on a continuum from "integrative eating" to "non-integrative eating." Integrative eating, also known as "eating for multidimensional nourishment," includes six nutrition themes that are consistent in both Eastern and Western food systems. The six themes are:<sup>2</sup>

1. Eat fresh, whole food in its natural state as often as possible.
2. Be aware of feelings before, during, and after eating
3. Bring moment-to-moment nonjudgmental awareness to each aspect of the meal.
4. Appreciate food and its origins from the heart.
5. Create union with the Divine by "flavoring" food with love.
6. Unite with others through food.<sup>2</sup>

Using the continuum, people who reported eating more fresh food would be considered as having a more integrative eating style with a higher score than those consuming more fast food (less integrative).<sup>2</sup> Comparing the seven eating styles by weight category reveals that people in the normal weight group have the highest integrative eating score. This score is somewhat lower for the overweight group and much lower for the obese group. The obese group is most likely to overeat prompted by negative feelings ("Emotional Eating"); consume more processed, fast, sweet, and fried foods and less likely to eat fresh whole grains, fruit, and vegetables ("Fresh Food, Fast Food"); pay the least attention to the sensory and spiritual aspects of eating ("Sensory, Spiritual Nourishment"); more likely to focus on self-judgment and feeling bad about overeating ("Food Fretting"); more likely to eat in a hectic, tense atmosphere ("Eating Atmosphere"); more likely to eat while doing other things ("Task-Snacking"); and more likely to eat alone ("Social Fare").<sup>2</sup>

The authors of this paper recognize that all seven eating styles are independently related to overeating; thus expanding the scope of factors that appear to underlie overeating. These seven eating styles span the biological, psychological, spiritual, social, and cultural facets of food and eating. This supports the need to shift

from the singular focus of what and how much we eat, to addressing why, how, and with whom we eat.<sup>2</sup>

Our approach to food and eating has evolved into one of convenience and saving time—cutting as many steps as possible in thinking about, choosing, and eating foods. We have lost much of the integrative, sensual, and pleasurable "ingredients" in food preparation and dining. Is it any wonder that as we move away from the dining table and further away from eating with family and friends to eating alone while working, driving, or watching television, we enjoy our food less as we eat more and gain more weight?<sup>2</sup>

Addressing the overeating epidemic effectively calls for us to reassess what optimal eating is all about. It also means paying attention both to measurable nutrients as well as feelings, mindfulness, gratitude, regard, friendship, and non-judgment.<sup>2</sup>

Developing a more positive relationship with food requires us to pay closer attention to our life. If boredom equals the bulge, then how do we address boredom? Maybe when we are bored with a certain diet regime we think we want more food, but what we really want is more variety in the foods we choose. This would also apply to life. Being stuck in a rut can result in a range of feelings (frustration, helplessness). Variety in life is very important for our spirit.<sup>3</sup>

It is okay for all of us to step back and look closely at our lives and the way we choose to think about eating. The author of one book on emotional eating outlines five steps to conquering the problem. Ask the following questions when reaching for food:<sup>4</sup>

1. What is going on? Is this true hunger or is it head or heart hunger?
2. What am I feeling?
3. What is needed? Where is the gap in my life?
4. What is it that is in the way? What are the excuses, and/or feelings?
5. What is it that needs to be done? Identify specific intentions. What solution fits for now? What is one step that can get one closer to the goal?<sup>4</sup>

Another author covers emotional eating well by saying that being overweight is not just a physical problem. Therefore, it needs to be addressed in a broader context.<sup>5</sup> When people address their emotional and spiritual needs, they are more likely to make and to maintain lifestyle choices that are life-enhancing rather than self-destructive. We give food the power to make us happy or sad and, in some cases, even to control our lives. But food has no power other than what we give to it. We often tag foods as good or bad. We empower

food when we believe it can bring us peace and wholeness we are missing. We don't need more willpower; we need more understanding.<sup>5</sup>

Taking time from our busy schedules to shop for, prepare, and eat our foods; to connect with others; and to seek ways toward a more fulfilling life seems like so much work. One dietitian who has written about emotional eating says, "...truly caring for ourselves tends to get put on the back burner for sources of immediate gratification like money, fame, possessions, or a double quarter pounder with cheese."<sup>6</sup> The good news is that overcoming emotional eating is central to attaining better health, a normal weight, and improved energy. The bad news is that it takes some hard work, but the payoffs are huge.<sup>6</sup>

Remember when Bridget Jones (Bridget Jones Diary) sat in front of her TV eating a tub of ice cream singing "All By Myself?" Recall that, in the end, she started to like herself for who she was and that, in itself, is a good start.\*

Cathie Walsh-Yeadon, PDt  
Maternal and Newborn Health Dietitian  
IWK Health Centre

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2. Scherwitz L, Kesten D. Seven eating styles linked to overeating, overweight and obesity. *Explore*. 2005;1(5):342-359.
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5. Ornish D. *Eat More, Weigh Less*. Harper Collins Publishers; 2001.
6. Goodwin K. *Emotional Eating*. Accessed from The Diet Channel (Nutrition Section) at [www.thedietchannel.com](http://www.thedietchannel.com) on May 11, 2006.

Other references on healthy relationships with food include:

- Fletcher A. *Thin for Life. 10 Keys to Success from People Who Have Lost Weight and Kept it Off*. Houghton Mifflin Company; 2003.
- Omichinski L. *Staying Off the Diet Roller Coaster*. HUGS International Inc.; 2000.

**Research to Practice**

**SALBA**

The National Nutrition Committee of the Canadian Diabetes Association recently distributed a draft patient education handout titled "Lipids and Diabetes."<sup>1</sup> In this document, Salba is listed as a food choice to include in a heart healthy diet. After speaking with other dietitians, we found that no one was familiar with Salba. Laura Grayney, St. Francis Xavier University, Dietetic Intern, who recently completed a rotation at Cumberland Regional Health Care Centre, researched Salba for us.

**What is Salba?**

Salba is a grain product. It is a variety of plant species belonging to the mint family called chia. This variety of chia was bred in 1991 when a few white grains produced by the original chia species were separated from the black grains and replanted producing a new species of chia.<sup>2</sup> Salba can be sprinkled on foods such as oatmeal, cereal, yogurt, and soups, or it can be ground and used in baking or shakes. Grinding is not necessary to receive all the health benefits.<sup>3</sup>

**Why is Salba good for you?**

Salba contains omega-3 fatty acids, fibre, protein, calcium, and iron, as well as other vitamins, minerals, and antioxidants. It is considered a functional food.<sup>3</sup> Salba and flax are quite similar. See Table 1 for a comparison between Salba and Flax per two tbsp (15 g) serving.

**Table 1: Comparison 2 tbsp (15 g) Serving**

	Salba	Flax
Omega3/ serving	3.05 g	3.1 g
Fibre/ serving	5.18 g	4.1 g
Flavour	Neutral	Strong
Texture	Smooth	Rough
Water absorbency	20 - 25 x weight	6 x weight
Calories/ serving	57.5	70.0
Gluten free?	Yes	Yes
FDA approved	No	Yes

For both products, a 2 tbsp serving is enough to see health benefits.<sup>2,4</sup> For most people, there is little difference between the 2 choices as each would provide similar health benefits.

#### How would Salba help?

Salba has been investigated by Dr. Vladimir Vuksan at the Risk Factor Modification Centre, St. Michaels's Hospital, University of Toronto. Dr. Vuksan is in the process of publishing data from both randomized acute and long-term studies. In the acute study, Salba was found to reduce after-meal blood glucose and plasma insulin levels as compared to control. In a long-term trial (12 weeks), Salba reduced blood pressure. In the same long-term study, it proved effective with respect to reduction in inflammation and coagulation factors.<sup>5</sup>

#### Where can you buy Salba?

Salba is exclusively distributed by El Peto Products Ltd. in Ontario.<sup>2</sup> At present, we could not locate any stores carrying it in the Maritimes.

#### How much does Salba cost?

The Specialty Food Shop at the Hospital for Sick Children in Toronto carries Salba and retails it for \$15.99/400 gram container.<sup>3</sup> Valley Flax Flour sells flax for \$13.75/400 gram container (plus a booklet).<sup>4\*</sup>

Laura Grayney, Dietetic Intern  
St FX University

Darlene Durant, PDt CDE  
Cumberland Regional Health Care Centre DC

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2. <http://www.salba.info/.php> (accessed June 23, 2006).
3. [www.sickkids.on.ca](http://www.sickkids.on.ca) (accessed June 13, 2006).
4. [www.flaxflour.com](http://www.flaxflour.com) (accessed June 23, 2006).
5. [www.store.newadventures.com/sanamopos.html](http://www.store.newadventures.com/sanamopos.html) (accessed June 23, 2006).



## CELIAC DISEASE AND TYPE 1 DIABETES MELLITUS

As a first-year pharmacy student at Dalhousie University, I decided to volunteer at the Diabetes Care Program of Nova Scotia (DCPNS) as part of my Community Experience Program. I was interested in learning about the association between Celiac disease and type 1 diabetes and the role a pharmacist may have in helping people live with this diagnosis. My goal upon completion of this project was to better understand both diseases, the resources available to help in disease management, and to write an article for the DCPNS newsletter relating the two diseases. I had the opportunity to attend the diabetes education program at the QEII Health Sciences Centre, observe a diabetes clinic day at the IWK Diabetes in Children and Adolescents program, search for pertinent literature and websites, meet with resource personnel at the Celiac Association, and seek out special gluten-free products available at local stores. I learned a great deal from this project. One of the major points learned was that the pharmacist can play a big role in helping patients cope with any disease. The pharmacist can direct consumers to certain clinics and community resources, inform customers re: types of foods to look for, and provide a better understanding of just how the disease works.

Celiac disease is a hereditary, autoimmune disease that has become more common in children in the last 4 or 5 years; however, it can occur at any age. It is unknown what is causing the increased prevalence in children, but the prevalence is approximately 1:300 to 1:80 children.<sup>1</sup> It is caused by a permanent sensitivity to a protein called gluten, which is found in barley, wheat, oats, and rye. When ingested, the body's immune system thinks it is a foreign molecule and launches an attack to get rid of the so-called "toxin." The attack damages fingerlike projections in the small intestine called villi that are used for absorption. This causes a decrease in the surface area of the small intestine that makes it more difficult for absorption to occur. It also causes the destruction of digestive enzymes that are located on the villi, so food will pass through the gut unabsorbed. Symptoms of Celiac disease include diarrhea, abdominal cramping, bloating, and distention.<sup>2</sup>

Type 1 diabetes mellitus (DM) is another autoimmune disorder in which the beta cells of the pancreas are seen as foreign molecules by the body's immune system. The pancreas does not have the ability to produce any insulin because of the absence

or destruction of these beta cells. Insulin is essential to transport glucose from the blood into fat and muscle cells. Glucose is the main energy source for these cells.

Celiac disease and type 1 DM are increasingly becoming associated with each other in many patients. A person can be diagnosed with Celiac disease and then type 1 DM, but it is much more common to be diagnosed with type 1 DM first. It is unknown why most patients are diagnosed with diabetes first, but the reason why some individuals develop two autoimmune diseases is simply that having one autoimmune disease makes it easier to acquire another.<sup>3</sup> It is believed that 0.5-1% of people in Nova Scotia have Celiac disease and that 6 or 7 of 100 type 1 diabetes patients are diagnosed with Celiac disease.<sup>3</sup>

Several serologic tests have been developed to help doctors screen patients who are at risk for Celiac disease. Recently, there has been a test developed to detect the antibody to tissue transglutaminase that is thought to be involved in Celiac disease. It is a highly sensitive test and is believed to be accurate about 95% of the time.<sup>4</sup> There are also blood tests to detect iodine and calcium in the blood. If these values are low, this means that these nutrients are not being absorbed properly. This is an indication for Celiac disease. The serologic tests only give clues to suspect Celiac disease. The highest standard for determining if a patient has Celiac disease is an intestinal biopsy.<sup>3</sup> The biopsy is usually done when the serologic tests are positive. An intestinal biopsy is done by guiding an endoscope down the mouth through the stomach to the small intestine where it pinches off a piece of the proximal small intestine for examination.

First and second-degree family members of a patient with Celiac disease are at risk.<sup>4</sup> It is believed that women are more susceptible to the disease as they are about twice as likely to have the disease than men.<sup>4</sup> People who have the disease but have not been tested are at risk for anemia, fractured bones, and cancer in the long run.

The only treatment for Celiac disease is a lifelong abstinence from the protein gluten.<sup>3</sup> When using this treatment, nutrients are better absorbed. An individual may only need to adjust their insulin levels to cope with both diseases.

There are a variety of tasty gluten-free foods available today. The selection is greater than ever before. These foods are made from ground flaxseed, arrowroot flour, cornstarch, rice flour, brown and

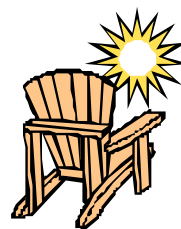
white rice, and even potato flour. There are also many more ingredients used to make gluten-free foods. At the Planet Organic Store located on Quinpool Road in Halifax, there is an entire section devoted to gluten-free foods such as tea biscuits, cinnamon rolls, cookies, different kinds of breads, and cereals, like puffed rice cereal.

People can get lots of great information about gluten-free products and information on Celiac disease by going to the Canadian Celiac Association website at <http://www.celiac.ca/> or by contacting them by phone at (905) 507-6208 or toll free at 1 (800) 363-7296.\*

Rankin MacDonald  
First-Year Pharmacy Student

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### SOY FOODS AND CARDIOVASCULAR DISEASE: WHAT'S NEW?

At the beginning of 2006, a news release indicated that the American Heart Association (AHA) has revised its statement on the beneficial effects of soy protein in reducing cardiovascular risk factors. This article reviews the revised AHA statement and its implications for consumer education.

Over the past 30 years, soy has received much attention about its cardioprotective properties; especially, the LDL-cholesterol lowering effect. In this context, in 1999, the U.S. Food and Drug Administration approved labeling for soy foods that contain at least 6.25 g of soy protein/serving as cardioprotective. This health claim assumed that these soy foods would be consumed at least four times a day to equal a total daily amount of 25 g soy protein. This was the amount believed to be necessary to lower total and LDL-cholesterol. In 2000, the AHA followed with a recommendation to include soy protein foods in a diet that was low in saturated fat and cholesterol for people with dyslipidemia.<sup>1</sup> Health Canada did not follow with similar label approval for soy protein foods sold in Canada.

Many of the earlier studies (1975-1995) on the cholesterol-lowering effects of soy protein, upon which the health claim/recommendation was made, were done on rodents. These studies resulted in a 12.9% decrease in LDL-cholesterol concentration in the animal model. These studies were not specific to the soy protein and soy isoflavones content of the study diets.<sup>2</sup> In recent years, there has been heightened interest in a component of soy protein known as the phytoestrogen called isoflavones. Isoflavones were considered to be the bioactive component in soy protein. Between 1995 and 2002, two meta-analyses of studies were conducted investigating the cholesterol-lowering effects of soy protein and soy isoflavones in humans. The results showed many differences in study participants (gender, pre- and post-menopausal women); in degree of hypercholesterolemia in the participants; in the type and amount of soy protein and soy isoflavones in the study diets; and in the LDL-cholesterol lowering effect. In most of the studies, a cholesterol-lowering effect from soy isoflavones, with or without soy protein, was much lower at 3% to 5%<sup>3,4</sup>, compared to a 12.9% reduction reported in an earlier meta-analysis.<sup>2</sup> Also, there were no beneficial effects shown on other cardiovascular risk factors such as hypertension, HDL-cholesterol, and triglycerides.<sup>3,4</sup>

The AHA revised its statement on the potential role of soy protein and soy isoflavones in cardiovascular

disease (CVD) risk reduction. "Earlier research indicating that soy protein, as compared with other proteins, has clinically important favorable effects on LDL-cholesterol and other CVD risk factors has not been confirmed by many studies reported during the past 10 years."<sup>1</sup>

What impact does this revised AHA statement have on consumer education for CVD risk reduction management? The revised AHA statement indicates that soy foods should be recognized for their content of many bioactive ingredients, which contribute to cardiovascular and overall health. These components include a high content of polyunsaturated fats (including omega-3 fatty acids), fiber (soluble and insoluble), vitamins and minerals, and its low saturated fat content. Soy protein foods could be used to replace foods that are high in saturated fat and cholesterol. However, caution is necessary when choosing soy foods because food processing may alter one or more of the active ingredients found in natural soy.<sup>1,4</sup> Soy foods with the least amount of processing are recommended. These soy foods include mature soy beans, which after cooking, can be added to soup, stew, and chili; roasted soy beans, which can be eaten as a snack; soy flour, which is roasted soybeans ground into a flour; and textured soy protein, which is made from soy flour, is rich in protein, is an excellent source of fiber, and can be used to replace meat in many recipes.<sup>1,4,5</sup> Soy protein and soy isoflavones supplements are not recommended.<sup>1</sup>

However, soy foods should not be considered the main dietary means to lower LDL-cholesterol. Jenkins, et al,<sup>6</sup> compared 3 cholesterol-lowering approaches in the same 34 subjects: very low saturated fat/vegetarian diet, the same diet plus 20 mg lovastatin, and a "portfolio diet," which was vegetarian, high in plant sterols, soy protein foods, viscous fibers, and almonds. Each diet was followed for one month. Although the statin group achieved a significantly lower LDL-cholesterol concentration after one month, the statin group and the portfolio diet group did not differ significantly in their ability to lower LDL-cholesterol below 3.4 mmol/L. The authors concluded that the mechanisms of action of food components found in the portfolio diet approach are complementary and, in combination with each other, maximize the LDL-cholesterol lowering effects of diet.

More research is required to determine the active LDL-cholesterol lowering compound(s) of soy, the mechanism(s) of action, and a dietary reference intake for soy protein or soy isoflavones.\*

Brenda Cook, MAEd PDt CDE  
Diabetes Consultant, DCPNS

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## Educator Sharing

### DEVELOPING A HEALTHY LIVING PROGRAM FOR SENIORS: PART I.

As a component of my community-focused dietetic internship with the DCPNS this summer, I am developing and facilitating a healthy living program for the public. The increased rates of chronic disease that are seen with our rapidly aging population, combined with the lack of provincial health promotion strategies targeted *specifically* to seniors, has prompted me to select seniors as my target audience. As in any program development process, a thorough needs assessment is essential foundational work. Through this needs assessment I wanted to:

- explore among local seniors their perceptions of what “healthy living” entails,
- identify any health-related learning interests or knowledge gaps among seniors that could be addressed in this program, and
- discover what might encourage seniors to participate in a healthy living program and how their learning experience could be enhanced.

### First Steps: Needs Assessment Process

I am currently in the needs assessment phase of this project and have spoken with local seniors individually and during 3 focus group discussions. The first group discussion (n=8) was with residents of a seniors’ apartment complex in a more rural area of the HRM. The participants of the second (n=5) and third (n=5) groups were recruited through a seniors’ lunch program and a seniors’ centre, both of which operate within a city setting. With these settings, I have been able to compare and contrast the perceptions of healthy living among seniors residing in an urban area with those who live outside of the city. The seniors that I spoke with individually were recruited from another seniors’ centres located within the city, for a total of 24 participants.

Each focus group discussion began with a very brief summary of the results of the Diabetes Prevention Program<sup>1</sup> and the Finnish Diabetes Prevention Study<sup>2</sup>; namely, that healthy living plays a major role in the prevention of type 2 diabetes in high risk groups, particularly among those age 60 years and over. This led into a discussion that was guided by the following questions:

- What are your impressions of these research studies that show that seniors can be successful in preventing a chronic disease like diabetes through healthy living?
- What does the term “healthy living” mean to you?
- Are there any health-related topics that you feel you would like to learn more about?
- What would encourage you to participate in a program that addressed some of those topics?
- How do you feel you learn best?

### Participant Description:

All participants were living independently within their communities, with the vast majority (~90%) being women. The age range of the participants varied widely from those in their late 50s to participants in their mid-90s. While the “Strategy for Positive Aging in Nova Scotia” defines a senior as a person over the age of 65<sup>3</sup>, those participants who were below that age self-identified as a senior (they frequented a seniors’ centre or lived in a seniors’ apartment complex) and were thus included in the needs assessment.

### What I’ve Learned So Far

#### 1. What “Healthy Living” Means to Seniors:

The majority of the seniors that I spoke with stated that they were not surprised by the results of the

mentioned studies. They strongly believed that healthy living plays an important role in seniors' health and well-being. The participants overwhelmingly identified the following four areas as being integral components of healthy living:

- **Healthy eating:**  
When questioned further, many participants indicated that to them healthy eating meant following Canada's Food Guide, eating lots of vegetables and fruit, practicing moderation, avoiding fried foods, and drinking lots of water.
- **Physical activity:**  
Walking was by far the form of physical activity that was practiced most regularly by participants. Other forms of activity that participants engaged in include swimming, riding a stationary bike, bowling, playing darts, stretching, and practicing yoga and tai chi.
- **Social activity:**  
The majority of participants highlighted the importance of maintaining strong social ties with family, peers, and their communities for the promotion of good health.
- **Mental activity:**  
Many of the participants expressed that having a positive outlook on life is an important part of being healthy as a senior. Many participants also said that it is important for them to engage in activities that stimulate and challenge their minds.

## 2. Topics of Interest/Knowledge Gaps:

The majority of health-related learning interests among participants were related to the healthy eating component of healthy living. For example, many of the seniors expressed concern over not knowing what foods to select while grocery shopping. This is largely the result of their inability to interpret/utilize the information presented on Nutrition Facts tables. For instance, some seniors said that while they can easily read the amount of a particular nutrient that is in the food that they are selecting, they have no idea how much of that nutrient they should be consuming daily. Thus, these seniors were interested in learning more about recommendations for intake of certain key nutrients such as fat, sodium, iron, calcium, and some vitamins. Similarly, some participants expressed concern over unfamiliar ingredients listed in many convenience foods (i.e., ready-cooked roasts), asking

"Are those things safe for me to eat on a regular basis?"

## 3. Promoters & Barriers to Healthy Living:

Many of the participants expressed that there is currently an abundance of information and services relating to healthy eating and physical activity in their communities. However, they also stated that there are concomitant barriers that are often preventing them from accessing those very services. These include:

- The costs associated with many community-based nutrition and physical activity programs.
- Frustration over the lack of government funding that is put into seniors' programs, resulting in the seniors themselves having to "foot the bill."
- The lack of transportation to available programs. This would also have a detrimental effect on seniors' ability to engage in activities that would provide opportunity for socializing and mental stimulation. Many participants said that they feel that transportation should be provided, free of charge or for a minimal fee, to seniors to permit them to access healthy living programs.

## Next Steps: Program Development

Once the needs assessment is complete, the development phase of my project will begin! While I have yet to commit to specific program topics or modes of delivery, I believe that a major focus will be on the concerns that were brought up surrounding healthy eating. Similarly, the program will likely rely heavily on resources that are already available within the community as there is little need to "reinvent the wheel" or duplicate services. Adult Learning Theory will provide a framework from which I will design and facilitate the program. Major assumptions of Adult Learning Theory are that the adult is a partner with the instructor in the learning process, adults learn through reflection on their own experiences, and adults learn what they perceive to be useful to their personal situation and which has immediate application.<sup>4</sup> Information will be delivered in a way that favors partnering with participants in two-way communication as opposed to didactic information giving. It will also be important to draw on the knowledge that participants' already have by encouraging them to share personal experiences relating to the topic at hand. Opportunities for participants to immediately apply what they have

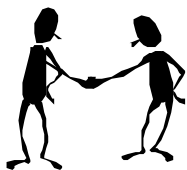
learned will also be provided. In relation to label reading and nutrient recommendations, participants could be asked to select among an assortment of food those items (based on food labels) which would most quickly allow them to meet their requirement for a particular nutrient.

Look for the October issue of *Diabetes Care in Nova Scotia* for an up-date on my completed project along with participant feedback!\*

Fran Martin  
Dietetic Intern, DCPNS

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**COMMUNITY PHARMACISTS  
JOIN YARMOUTH  
DIABETES CENTRE (DC) TEAM**

**"COLLABORATION IS COOL!"**

The Yarmouth Diabetes Centre (DC) has offered group sessions for both new and follow-up patients for a number of years. However, the DC staff continues to explore new ways to deliver services and foster partnerships within the community to better serve its prediabetes and diabetes population. The DC motto is "If you always do what you've always done, then you will always get what you've always gotten!"

In the spring of 2006, the DC decided to seek the advice of its prediabetes and diabetes patients

regarding ways to improve its group sessions. To do so, the DC staff organized a series of focus groups to acquire this valuable feedback from the "experts."

The focus group participants identified the community pharmacist as a valuable, committed health care professional and felt strongly that these individuals should participate in the DC group sessions. The staff began to investigate the possibility. The DC Manager supported the concept and encouraged the staff to "seize the moment."

Some of the local pharmacies were contacted to explore the idea. The DC staff followed the phone call with a standard, short letter describing the DC goals and needs. This letter along with the 2006 group session dates were faxed to each pharmacy and voluntary participation requested.

A meeting date with interested pharmacists was arranged for May 18, 2006 at the DC to discuss the DC services, to learn more about the services provided by pharmacists to people with diabetes in the community, and to move the partnership forward. This was an excellent collaborative opportunity as 12 pharmacists attended.

The first group session to include the participation of a pharmacist was held on May 25, 2006. To date, the local pharmacists have committed to participate in 11 of the planned 15 group sessions in 2006. These pharmacists have agreed to volunteer their time; therefore, the DC is able to offer this service without any financial implications.

The results of this partnership have been very valuable for both the DC staff and the prediabetes and diabetes patients attending the group sessions. This type of collaboration provides a unique opportunity to raise awareness and promote consistent advice re: diabetes management as well as encourage self-management to those living with diabetes.

Many times the pharmacist is the first health care professional people with diabetes consult for advice. DCs are encouraged to consider the benefits of this collaboration and the value it could add to the services provided at the DC.\*

Shonda Jeffery, RN  
Yarmouth Regional Hospital DC

## NOVA SCOTIA DIABETES ASSISTANCE PROGRAM UPDATE

### Overview:

The Nova Scotia Diabetes Assistance Program (NSDAP) has been operational for six months. As of early June, approximately 1300 Nova Scotians with diabetes were enrolled in the program.

### Automation:

Automation took place in early May; much sooner than the Department of Health (DoH) had expected. This required a software upgrade at Pharmicare and every pharmacy in the province. Each registrant received a letter from Pharmicare describing the changes to the program, as well as a new NSDAP registration card to present at the pharmacy.

Automation is excellent news! Registrants no longer have to pay up front and submit receipts for reimbursement. Now there are three simple steps to access the program's financial benefits.

- Step 1: Registrants must get prescriptions for both medications and supplies from their physician.
- Step 2: Registrants must present their NSDAP registration card along with the prescriptions to the pharmacy/CDA supply centre.
- Step 3: Registrants must pay the amount specified at the pharmacy. The pharmacy software electronically calculates the co-pay and tracks the registrant's balance on the deductible.

The system operates in real time. Payments toward the deductible in one location (e.g., a pharmacy) will be instantly visible on the registrant's balance in another location (e.g., the CDA supply centre).

If registrants have not received their NSDAP registration card, or if they have any difficulty with the NSDAP, they should call the Pharmicare customer service line and inquire. The numbers are (902) 429-6565 in Metro Halifax and toll free 1-800-305-5026 if registrants are calling from anywhere else in the province.

### Registration Form Revision:

The NSDAP registration form has been revised. The form has been edited by the DoH plain language editor and reviewed by NSDAP Advisory Board members and a few diabetes educators. The form will be available on the Pharmicare website and will be distributed to pharmacies, physicians' offices, and Diabetes Centres along with its updated companion booklet this summer.

### Evaluation and Self-care Materials:

Materials for data collection have been developed and Research Assistant (RA) orientation and training is now complete. Currently, four RAs are actively collecting data. Of the 350 willing NSDAP registrants that have been contacted to obtain informed consent, close to two-thirds have agreed to take part in the study!

DCPNS Data Managers have developed two separate databases for the study. One database organizes and analyzes the study data. The other database monitors RA work flow and tracks the progress of the study over time.

The self-care materials are embargoed until the first interview has been conducted on all study participants. The materials will likely be distributed to all NSDAP registrants in the fall. To this point in time, the study is about two months behind the original planned schedule; however, we are pleased with the progress of enrollment.\*

Lisa Tay, Project Manager  
Nova Scotia Diabetes  
Assistance Program

## News From Around the Province



### NEW FACES

Welcome to:

- **Jennfier MacNeil, PDt.** Jennifer joins Nancy Price RN, at the Diabetes Centre (DC) in Annapolis Community Health Centre. Our very best wishes to Lynn Barteaux on her retirement. Enjoy!
- **Susan LeBlond, PDt.** Susan joins the staff of the Aberdeen Hospital DC.
- **Shan MacLeod, RN.** Shan takes over from Bev Harpell, RN at the Sutherland Harris Memorial Hospital DC.
- **Cathy Splane, RN.** Cathy joins the staff of the Dartmouth General Hospital and Community Health Centre DC.
- **Sonya Matheson, PDt.** Sonya joins the staff of the North Preston Community Centre DC. Our best wishes to **Tara MacKinnon, PDt**, in her new position as Diabetes Community Consultant for the Confederacy of Mainland Mi'kmaq.

Please remember if you have a chance 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 Canadian Diabetes Association

See the next issue of the newsletter for an update from the Canadian Diabetes Association.



News From  
Industry\*\*

**Trudy Murphy of Sanofi-Aventis** is pleased to announce that Paul Burke has joined the Diabetes Unit with Sanofi-Aventis. He will be promoting Lantus®, in Dartmouth/Cape Breton area. Paul comes with a wealth of experience including promotion of oral diabetes agents. Paul is looking forward to meeting and supporting the Diabetes Educators. Paul can be reached at 1-800-589-3383, Ext. 6375.

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

### REVIEW

#### Helping People with Diabetes Change: A Self-Learning Manual for Professionals

I reviewed the revised (2006) "Helping People With Diabetes Change: A Self-Learning Manual for Professionals" by Helen Jones, Anne Belton, and Lynn Edwards. The manual is the fourth in a series designed to increase the utilization of the Transtheoretical Model of Change (TTM) among Canadian diabetes educators. The manual's clear and straightforward organization permits the valuable content to shine through.

The TTM, also known as the Stages of Change Model, integrates numerous psychological theories of behaviour and change. Its main strength appears to be that it accommodates the complexity of human behaviour more fully than some other approaches which may be rigid and formulaic. I can only imagine the appeal of a model that allows the educator to tailor her/his approach to each patient with flexibility for the approach to change over time as the patient changes.

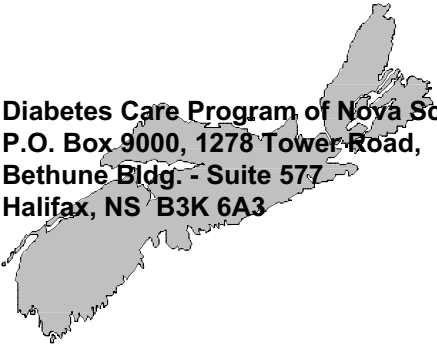
The authors begin with a description of why the TTM is relevant for diabetes educators and how it addresses the theoretical gaps in the mainstream approach to diabetes management. The manual progresses with a deeper explanation of the details of the model and how it can be used by diabetes educators.

Each chapter in the manual is prefaced with a concise outline and list of objectives. The outline helps readers chart their progress and work their way through the document in manageable sections. Busy health care professionals can make use of the outlines to skim the whole manual quickly and get a good sense of the information contained within.

Another useful feature of the manual is the practice exercises. Readers can use them to review the material during reading or later as a refresher. The authors use a combination of factual information and personal experiences in the practice exercises to facilitate the reader's learning and engagement in the process. In addition to the practice exercises, worksheets and templates are provided for educators to develop their own programs for their current practice environment.

Overall, I found "Helping People With Diabetes Change: A Self-Learning Manual for Professionals" to be a well-organized and fascinating manual. The content is timely; self-management is a topic of intense interest among forward-looking health services decision makers. This manual will be very useful for those educators who wish to stay on the cutting edge.✱

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