



Contents lists available at [ScienceDirect](#)

Canadian Journal of Diabetes

journal homepage:
www.canadianjournalofdiabetes.com

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Review

Diabetes Care Program of Nova Scotia: Celebrating 25 Years of Improving Diabetes Care in Nova Scotia

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ARTICLE INFO

Article history:

Received 25 April 2017

Accepted 14 June 2017

Keywords:

chronic care model

Nova Scotia

organizing diabetes care

Mots clés :

modèle de soins de longue durée

Nouvelle-Écosse

organisation des soins aux diabétiques

ABSTRACT

The Diabetes Care Program of Nova Scotia (DCPNS)'s mission is "to improve, through leadership and partnerships, the health of Nova Scotians living with, affected by, or at risk of developing diabetes." Working together with local, provincial and national partners, the DCPNS has improved and standardized diabetes care in Nova Scotia over the past 25 years by developing and deploying a resourceful and collaborative program model. This article describes the model and highlights its key achievements.

With balanced representation from frontline providers through to senior decision makers in health care, the DCPNS works across the age continuum, supporting the implementation of national clinical practice guidelines and, when necessary, developing provincial guidelines to meet local needs. The development and implementation of standardized documentation and data collection tools in all diabetes centres created a robust opportunity for the development and expansion of the DCPNS registry. This registry provides useful clinical and statistical information to staff, providers within the circle of care, management and senior leadership. Data are used to support individual care, program planning, quality improvement and business planning at both the local and the provincial levels.

The DCPNS supports the sharing of new knowledge and advances through continuous education for providers. The DCPNS's ability to engage diabetes educators and key physician champions has ensured balanced perspectives in the creation of tools and resources that can be effective in real-world practice. The DCPNS has evolved to become an illustrative example of the chronic care model in action.

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R É S U M É

La mission du Programme de soins aux diabétiques de la Nouvelle-Écosse (DCPNS, de l'anglais *Diabetes Care Program of Nova Scotia*) vise à « améliorer, par le leadership et les partenariats, la santé des Néo-Écossais qui vivent avec le diabète, qui sont concernés par cette maladie ou qui risquent d'en être atteints ». Le DCPNS, qui favorise la collaboration avec des partenaires locaux, provinciaux et nationaux, a permis d'améliorer et de normaliser les soins aux diabétiques en Nouvelle-Écosse au cours des 25 dernières années par l'élaboration et l'application d'un modèle de soins créatif et collaboratif. Le présent article décrit le modèle et fait état de ses principales réalisations.

En assurant une représentation équilibrée des prestataires de première ligne aux principaux décideurs des soins de santé, le DCPNS permet d'améliorer et de normaliser les soins aux diabétiques tout au long du continuum d'âge, veille à la mise en œuvre des lignes directrices nationales relatives à la pratique clinique et, lorsque nécessaire, donne lieu à l'élaboration des lignes directrices provinciales pour répondre aux besoins locaux. L'élaboration et la mise en place d'une documentation et d'outils de collecte de données standardisés dans tous les centres du diabète ont offert une occasion certaine de création et d'élargissement du registre du DCPNS. Ce registre fournit des informations cliniques et statistiques utiles au personnel, aux prestataires au sein du cercle de soins, aux gestionnaires et à la haute direction. Les données sont utilisées pour assurer les soins individualisés, la planification de programmes, l'amélioration de la qualité et la planification d'affaires aux niveaux local et provincial.

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<http://dx.doi.org/10.1016/j.cjcd.2017.06.005>

Le DCPNS contribue au partage des nouvelles connaissances et avancées au moyen de la formation continue des prestataires. La capacité du DCPNS à mobiliser les éducateurs en diabète et les principaux défenseurs de la médecine a assuré un équilibre des points de vue dans la création d'outils et de ressources qui peuvent être efficaces dans la pratique réelle. Le DCPNS constitue désormais un exemple concret de modèle de soins de longue durée en action.

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Introduction

In 2016, the Diabetes Care program of Nova Scotia (DCPNS) celebrated its 25th anniversary. This government-initiated program continues to identify, corral and mobilize resources in support of equitable and accessible quality diabetes care across a province facing economic challenges, changing demographics and variable access to care providers and services.

In 1991, the Nova Scotia (NS) Department of Health and Wellness (DHW) established the DCPNS as a provincial program at a time when facilities were looking for funds to establish or expand ambulatory clinics, including diabetes centres (DCs). These DCs supported primary care and specialist physicians in the care of growing numbers of Nova Scotians living with diabetes (1). While there were already DCs in NS, the DHW had determined earlier that little was known about these programs and services, their approaches to care delivery or their successes and challenges.

The DCPNS's mission is "to improve, through leadership and partnerships, the health of Nova Scotians living with, affected by, or at risk of developing diabetes" (2). Working together with local, provincial and national partners, the DCPNS improved and standardized diabetes care in NS by developing and deploying a resourceful, integrated and collaborative approach reflective of key components of the Expanded Chronic Care Model (3,4). This article describes how the DCPNS achieves its mission, and it highlights several key achievements. The Figure 1 provides a quick visual overview of key activity areas and accomplishments.

Accomplishing the DCPNS Mission

Program organization

In 1991, the DCPNS consisted of a medical director/diabetologist (parttime), coordinator (fulltime dietitian), nurse (parttime) and secretary. As the DCPNS's mission evolved over time, so did the composition of the team. The DCPNS now has the equivalent of 7 full-time staff and 2 part-time medical advisors (representing the pediatric and adult speciality areas of diabetes). Approximately half of the staff is devoted to information technology (IT) and information management (IM), which sustain and enhance the DCPNS registry through programming, provision of user support, analytics and reporting. Supported by registry and other diabetes data sources, the remaining staff address guideline development/dissemination, policy, knowledge translation and practice issues. Working groups and committees, consisting of both internal staff and external stakeholders, are established on an ad hoc basis.

In 1991, a board of directors was formed, specifically at arm's-length from the DHW, representing major provincial stakeholders, and it included Dalhousie University (academia), the NS Medical Society, the NS Association of Health Organizations, the NS Dietetic Association, the NS Nurses Association (professional societies) and the NS Division of the Canadian Diabetes Association (now Diabetes Canada). The board was responsible for the DCPNS and accountable to the DHW. This board was replaced in 2007 by the DCPNS advisory council, which retained members from the original organizations and added representatives from senior leadership, from both the DHW and within the health authorities, who had knowledge of the health-care system, operations and service delivery.

In 2016, as part of changes in the organization of health care in NS, the DCPNS transitioned from reporting to Acute Care within the Department of Health and Wellness to reporting to Primary Care and Population Health within the Nova Scotia Health Authority, while continuing to support the interests of diabetes in children/youth and pregnant women in collaboration with the Izaak Walton Killam Health Centre.

Program Operations

In the spirit of collaborative partnership, NS diabetes care stakeholders function as team members of the DCPNS, working toward a common goal. The DCPNS develops and operationalizes guiding principles to accomplish its mission (Table 1).

Program activities

With a focus on diabetes stakeholders' engagement, common priority areas were established. The earliest work addressed the identified need for consistency in the provision of care and services to keep people as close to home as possible. As a place to start, consistency (standardization) was required in the:

- Tracking of patient population/visits (statistics) for comparative purposes overtime
- Approach to initial assessment and follow-up care (documentation)
- Approach to specific areas of DC practice (foundational guidelines)
- Care of specialty populations (pediatrics and pregnancy).

Working groups and committees were populated with content experts reflective of geographic practice variation and were balanced with educators from both urban and more rural practices (5). The DCPNS's ability to engage diabetes educators and key physician champions has ensured balanced perspectives in the creation of tools and resources that can be effective in real-world practice.

Guidelines, Projects and Tools

In 1992, the DCPNS produced 8 guideline documents aimed at standardizing specific diabetes care across NS, including surveillance elements that would enable ongoing monitoring (Table 2) (6). Diabetes practice in DCs has been evaluated using these guidelines in subsequent years by way of practice surveys and chart audits.

Illustrative examples (Table 3) demonstrate the continued focus on these foundational guidelines. These guidelines demonstrate the success of engagement and the ability of a provincial program to translate evidence-based clinical care guidelines (7) into practice by introducing projects, producing valued tools and influencing provincial and national agendas (6,8). These resources are located on the DCPNS website (diabetescare.nshealth.ca) for ease of access and sharing.

The DCPNS Registry and Diabetes Information Management System

Since 1992, DCs across NS have used standardized forms to accept referrals from physicians and nurse practitioners, collect

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