

Diabetes & Heart Health Centre Annual Report 2006-2007

Routine Programming:

- 3 main centres
 - Melfort – travels to Naicam and St. Brieux as needed
 - Nipawin – travels to Cumberland House 2x/month, Carrot River regularly 1 - 2 x/month and to Smeaton, Arborfield and Zenon Park as needed
 - Tisdale – travel to Hudson Bay, Kelvington, Porcupine Plain 1 - 2 x/month; to Rose Valley every 2 months
- Offer Discovering Diabetes Self- Management Classes
 - 1 class/wk for 4 consecutive weeks
 - Provided in various communities at varying frequencies
- Individual sessions available in all communities
- Meter Accuracy Clinics available in many communities
- Inservice provided to health region staff upon request
- Classes available according to demand:
 - Lipid Lowering Class
 - Grocery store tours
 - Cardiac classes – Matters of the Heart or Heart to Heart in 3 main centres 1- 3 times/yr according to demand .
 - Exercise therapist – the position has become permanent part time
- All DNE's passed the Provincial Insulin Adjustment Exam in Jan/07 and will be doing Insulin Adjustment as per the new KTHR policy.
- 4 Educators submitted portfolios to renew their CDE status in Feb/07

New Projects:

- Lifestyle Balance Program- completed the program in September 2006 and piloted in Nipawin and Melfort. The program is now offered in Melfort and Nipawin on a regular basis and Tisdale will be coming on in 07-08. The next steps are to recruit more leaders for the program to enable offering in more communities. The program was accepted to the SAHO conference in April/07.
- Type 2 Diabetes Patient Resource (Steps to Success) – completed and printed in March 2007; implementation will take place in 07-08 year.
- Diabetes Days- ½ day forums held for the public with KTHR speakers
 - Nipawin – Nov 2, 2006; 44 attended;
 - Melfort – Nov 16, 2006; 55 attended;
 - Tisdale – Nov 30, 2006 (bad storm/weather) 25 attended
- Conversation Maps implemented In Nipawin, Smeaton and Tisdale. These are interactive tools to use in small group settings for clients with Diabetes.
- National DES conference Abstract on Meter Accuracy Clinics- October 2006
- New Diabetes Food Guide developed and implemented-May 2006; revised March 2007

- Home Care Wellness Clinic – DHHC staff provided inservice to Home Care staff regarding the Care Maps for Blood Sugar Tesing and Blood Pressure Testing for Wellness Clinics.
- Inpatient Diabetes Management- Goal will be better care(consistent, accurate, timely)for inpts in all hospitals in KTHR
- Telehealth Diabetes Clinics – there were a number of diabetes clinics held to improve access to clients. Tisdale to Hudson Bay clinics were held and Pregnancy and Diabetes clinics were held between Nipawin and Saskatoon.

Committee Work:

- Saskatchewan Insulin Adjustment Module – Betty Deschamps & Carlene Schmaltz were on the revision committee
- Saskatchewan Committee on the Development of Clinical Practice Guidelines for the Management of Foot Complications - Bettylou Fagnou was a member
- Health Quality Council: Chronic Disease Management (CDM) Collaborative – Betty Deschamps on the RIT (Regional Improvement Team) for Wave 1; Bettylou, Tracy, Courtney, Carlene and Jessica have joined the RIT for Wave 2 with Drs Hanekom, Van der Ross and Karras.
- Provincial Diabetes Advisory Committee – Carlene Schmaltz completed her term and Bettylou was recommended for KTHR.
- Northern Chronic Care Coalition – this is the new group formed as a result of the Shared Paths project and will continue the work of the CDTAC. Heather sits on this coalition for KTHR.

Melfort Team won the Friends of CDA award for their support of the Northeast Branch of CDA in Melfort.



Diabetes Day in Nipawin November 2006



DHHC Team Indicators
2006-07

Satellite Clinics (#):

TISDALE and AREA:

Hudson Bay 20

Kelvington 11

Porcupine 12

Rose Valley 7

TOTAL 50

NIPAWIN and AREA:

Smeaton 3

Carrot River 11

Arborfield 9

Cumberland House 14

TOTAL 37

Meter Accuracy Clinics:

Regional Total Seen: 216

Regional Out of Range: 14%

Regional Not Calibrated Correctly: 2%

Regional Improper Sharps Disposal: 20%

Lifestyle Balance Program:

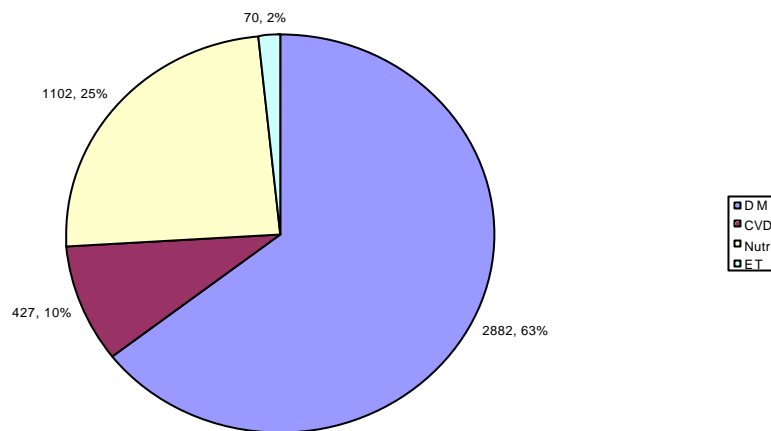
Melfort - 2 sessions with 19 participants

Tisdale - 1 session with 10 participants

Nipawin - 3 sessions with 29 participants

General Utilization: (note ET stats are not complete)

DHHC Team 06-07 Statistics



Specific Statistics:

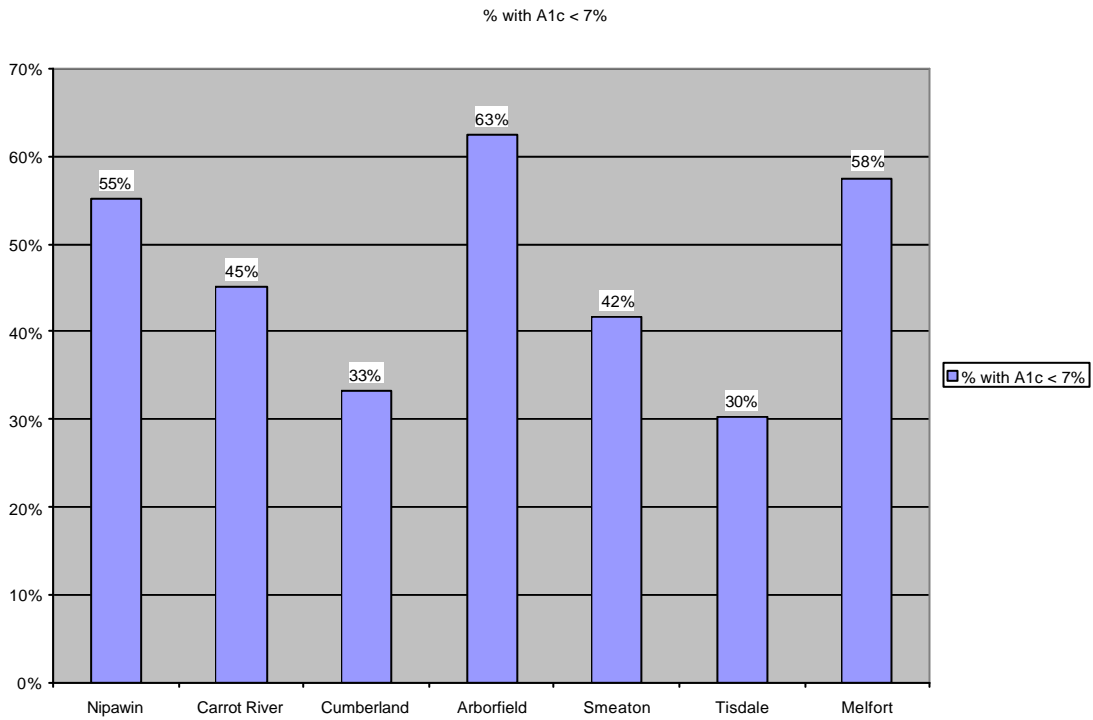
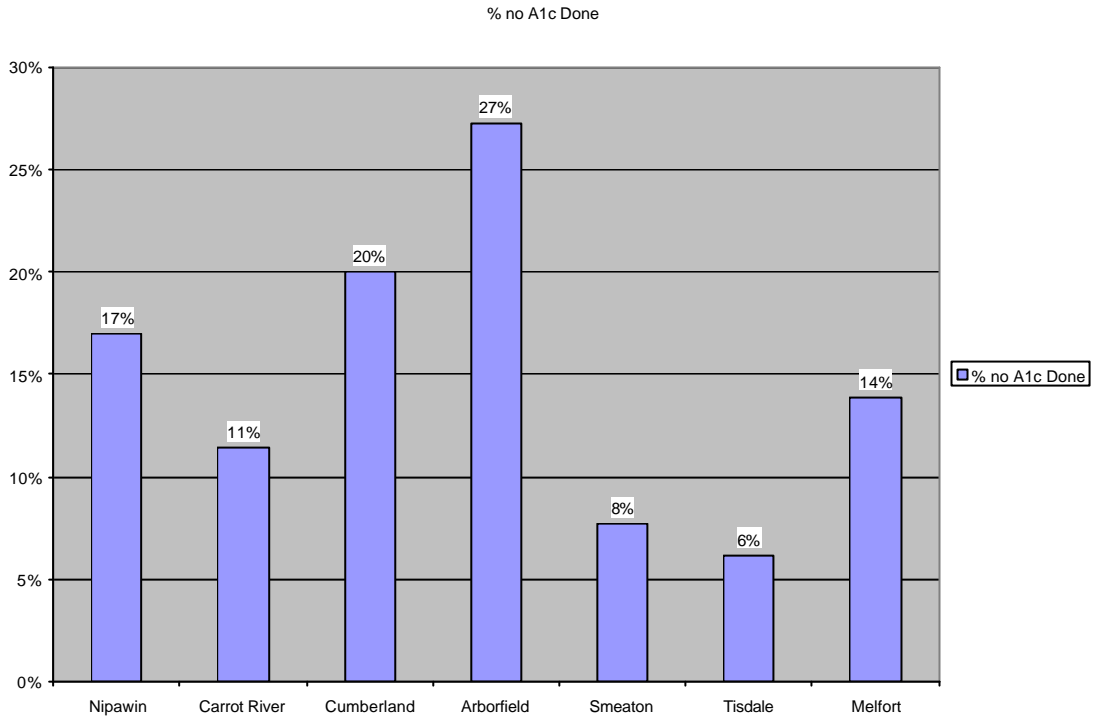
| | Melfort | Tisdale and Area | Nipawin and Area | Regional |
|--|---------|------------------|------------------|----------|
| Total Diabetes Visits | | | | |
| 2006-07 | 981 | 851 | 1020 | 2852 |
| Newly diagnosed(includes PreDM) visits: | | | | |
| 2005-06 | 57 | 104 | 109 | 270 |
| 2006-07 | 56 | 118 | 111 | 285 |
| Initial Visits Not Newly Diagnosed: | | | | |
| 2006-07 | 35 | 67 | 111 | 213 |
| Follow Up Visits: | | | | |
| 2006-07 | 890 | 666 | 798 | 2354 |
| Pre DM Stats | | | | |
| 2006-07 | 27 | 30 | 62 | 119 |
| Insulin Starts | | | | |
| 2006-07 | 27 | 14 | 28 | 69 |
| Outpatient Visits | | | | |
| 2006-07 | 617 | 543 | 524 | 1684 |
| Inpatient Visits | | | | |
| 2006-07 | 45 | 21 | 59 | 125 |

Regional Hemoglobin A1C Data:

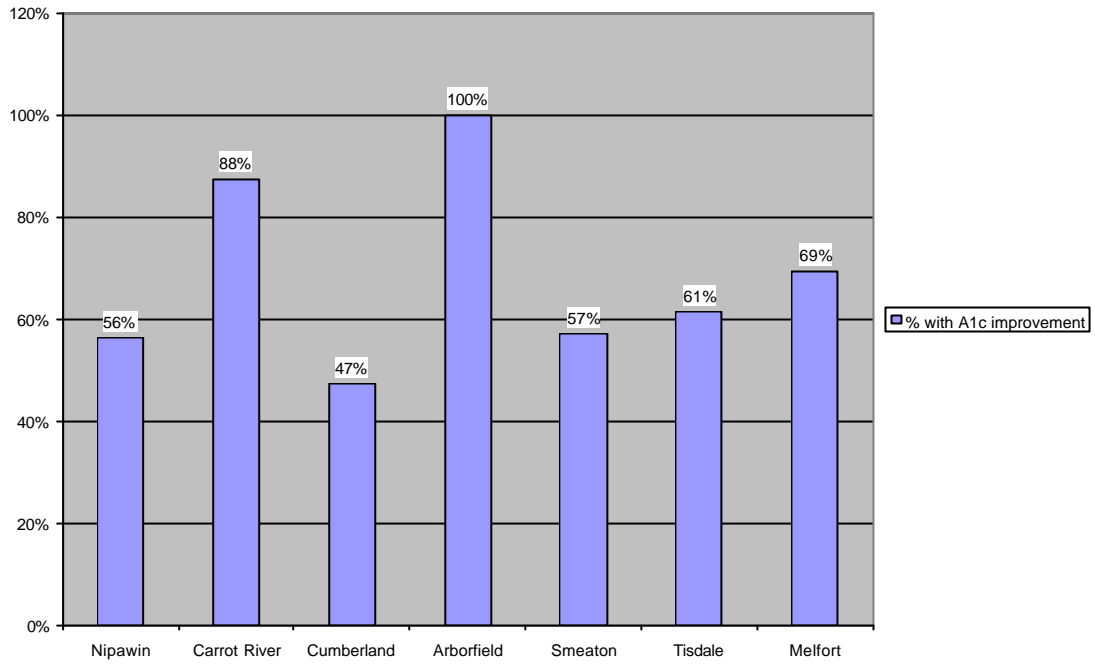
% of clients with improved A1C : 46.5% (Range 47%-100%)

% of clients with no A1C done: 15% (Range 6%-27%)

Total number of individuals seen: 803 (excludes Hudson Bay, Porcupine Plain, Kelvington, Rose Valley)



% with A1c improvement



Individuals Seen 06-07

