# Chronic Disease Network and Access Program (CDNAP)



**Prince Albert Grand Council, Saskatchewan** 

**Coordinator Margaret Crellin** 

#### **Partners**

 Collaboration with the partners was definitely a strength and added to our successes



#### **About CDNAP**

- We focused on four chronic diseases that are near epidemic proportions in Northern Saskatchewan
  - Diabetes
  - COPD
  - Hypertension
  - Cardiovascular disease

## Aboriginal Health Transition Fund Adaptation and Integration

- Adaptation Provincial (Network Focus to improve communications)
- Integration Federal (Focus on Access to care, education and capacity building)
- Over a 3 year period original time frame
- Aboriginal people are a Federal Government responsibility
- Provincial Government is responsible for health services for the general population and acute care services

However, these two systems often overlap with

- urban migration from northern communities
- specialist services only available at an urban hospital.

It is the intent of CD NAP to improve the coordination and communication between these two systems

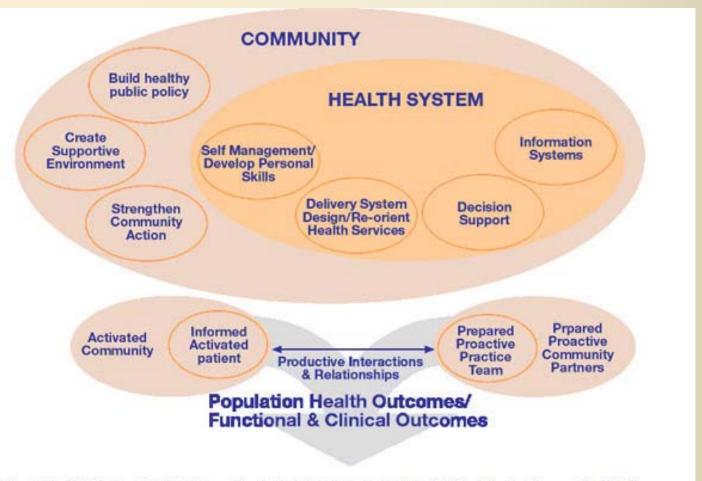
### **CDNAP** Objective

- Facilitate and coordinate communication between care providers to ensure good case management.
- Enhance knowledge and skills of care providers (including health care professionals and paraprofessionals) and clients.
- Coordinate practical research and evaluate the effectiveness of the project

## **Guiding Principals**

- To provide clients living with chronic disease, seamless and equitable access to care in a location in or close to a client's home community
- 2. To maximize positive health outcomes for clients with chronic disease
- 3. To build capacity within communities to support the client and work towards self management and healthy communities
- To incorporate a holistic approach that considers culture and tradition in conjunction with conventional aspects of care
- To utilize technology that provides an innovative approach to education and management of chronic disease

#### **Chronic Care Model**



Created by: Victoria Barr, Sylvia Robinson, Brenda Narin-Link, Lisa Underhill, Antia Dotis & Darlene Revenadale (2002)

Adapted from Glasgow, R. Orleans, C., Wagner, E., Curry, S., Solberg, L (2001). Does the Chronis Care Model also serve as a template for improving prevention? The Milbank Quartarly, 79(4), and World health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion

## Program Outcomes and Successes

- Engaging Excellent People
  - Staff
  - Clinical sub-committee
  - Partnerships



### **Collaboration with ADI**

### Community Diabetes Prevention Worker Training Program

#### Diabetes: An Overview

Lifestyle changes on the health of aboriginal people of Canada. The need for trained community health workers is emphasized.

#### Symptoms of Diabetes

The effects of diabetes on the healthy functioning of the human body is studied and how it relates to traditional aboriginal healing concepts.

#### Types of Diabetes and Their Management

An in-depth look into Type 1, 2 and gestational diabetes and methods of managing these conditions

#### Personal Care Techniques

An emphasis on the practical care of the skin, teeth and feet for the person with diabetes

#### Exercise in Diabetes Management

Information on the impact of exercise on the health of the body as it relates to different types of diabetes. An exercise plan is developed.

#### Impact of Diabetes on Families

Impact of diabetes management on the individual with diabetes and their family support systems.

#### Nutrition in Diabetes Management (2 weeks)

Investigates the importance of good nutrition in the overall health and management of diabetes. Includes recommendations on eating in restaurants, traveling, shopping and menuplanning.

#### Preparing Healthy Meals (2 weeks)

A fun and tasty course in creating new recipes low in cost, fat, sugar, and sodium. Recipes include food choices readily available in most communities.

#### Planning a Community Diabetes Program

Diagnosis in Aboriginal communities is increasing: the health care system within the community need to assess those needs and identify gaps in services.

#### Motivating the Community

This course looks at the analysis and investigation of creative and effective ways to further disbetes education in the community.

Tolkson College many by 1981s, rectifically in college



#### OUR MISSION STATEMENT

Yellowquill College, First Nation remed and operated provides quality education and training. We develop and deliver innovative programs that build abungar commissibles. Gur team is dedicated proceedings expeditors by establishing an environment of dignity and respect. Our students software success in a supportive almosphere.

Anna Dat

## Community Diabetes Prevention Worker Training Program



#### Class of 2010

## **Highest Marks in Canada!**

Eliza Bird and Barb Stonestand received the highest final marks in all of Canada

Great job!!!!



## Home Communities of Diabetes Prevention Worker Training Program

- Sturgeon Lake
- Wahpeton
- Montreal Lake
- James Smith
- Shoal Lake
- Cumberland House
- Little Red
- Hatchet Lake

- Fond du lac
- Southend
- Stanley Mission
- Pelican Narrows
- Agency Chiefs Tribal Council
- Sandy Bay
- Pinehouse

## **Building capacity**



## **Community Grants Projects**

"Creating supportive and healthy environments at the community level though local initiatives"

#### **Prince Albert Grand Council**

Organization	Project Name
Shoal Lake Health Centre	Shoal Lake Cultural Healing Project
Wahpeton Dakota Nation Health	Community Kitchen
Cumberland House Cree Nation Diabetes Wellness Project	Junior Mentors Program
Little Red Health Centre	Promoting Healthy Lifestyles
Hatchet Lake Health	<b>Chronic Disease Prevention</b>
Victoria Laliberte Health Centre	Physical Activity-Sadie's Walk
Fond du Lac Community Health	Healthy Lifestyles
James Smith Clinic	Get Fit for Health
James Smith Clinic	Community Kitchen
William Charles Health Centre	Garden Project

#### **Prince Albert Parkland Health Region**

Organization	Project Name
Addiction Services	Gold Program
PAPHR	Leading the WayCooking for The Future
Carment Court Tenant Association	Keen-Ager's Kitchen

### Northern Health Strategy

Organization	Project Name
Cumberland House Diabetes Care Committee	Healthy Living Mentors Media Campaign
Keewatin Yatthe Regional Health Authority	Chronic Disease Self Management Program

#### James Smith Clinic "Get fit for Health"

#### **Project Description**

 Providing opportunities for physical activity and exercise

## James Smith Clinic "Community Kitchen"

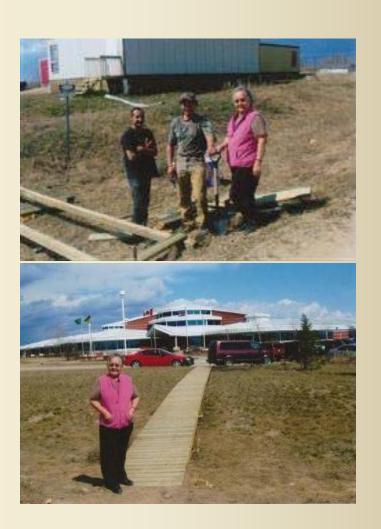
#### **Project Description**

 Educate general public about the benefits and methods of healthy, affordable eating habits

#### Little Red First Nation Health Centre "Eliza's Walk"

#### **Project Description**

- Developed a community walking path, exercise room with equipment.
- Joint endeavour with the school, health centre and community



## Shoal Lake Health Centre "Shoal Lake Cultural Healing Project"

#### **Project Description**

 Develop a cultural healing circle within community that incorporates traditional ceremonies, eating and activities that are healthy and positive



### Fond du lac Community Health "Healthy Lifestyles"

#### **Project Description**

 Host smoking cessation seminars, community kitchen groups, awareness walks and camps for children living with a chronic disease



## Patient Self Management Program

- Live Well with Chronic Conditions
- Keewatin Yatthe Health Region and Northern Health Strategy

## Improving Communications and Breaking Down Jurisdictional Barriers

- The Diabetes Tackle Box was set to be piloted in 4 PAGC Communities; Little Red, Lac La Ronge, Shoal Lake and Hatchet Lake (Wollaston).
- However, due to the increase in interest of the developed materials (diabetes management manual for health professionals, nutrition management manual, nutrition handouts, etc.) the Tackle Box was piloted and distributed to other sites such as the PAPHR Diabetes Education Centre, etc.
- The materials follow the current Canadian Clinical Practice Guidelines and are now available for download on the CD NAP website.

#### **CDNAP** Website



www.ehealth-north.sk.ca

#### **Website Demo**

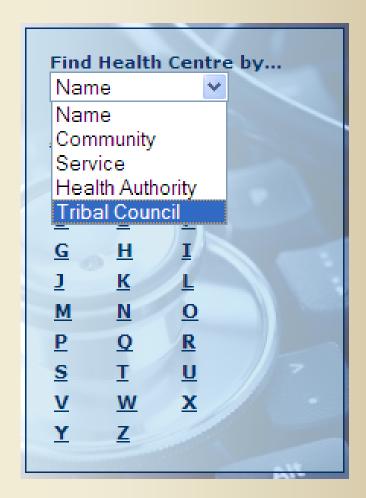
- Directory Demo
- The website will updated and maintained for the next two years

## Website "Directory"



## Website "Directory"

- You may Find Health Centre by:
  - Name
  - Community
  - Service
  - Health Authority
  - Tribal council



#### Website "Tackle Box"



### Tackle Box Demo

- Tackle Box Demo
  - algorithms

### **Type 2 Diabetes in Adults**

#### Risk Factors for Diabetes

- •age≥40 years
- •family history of diabetes
- member of high-risk population
- vascular disease
- dyslipidemia
- obesity
- PCOS
- history of gestational diabetes or delivery of macosomic infant
- other<sup>1</sup>

#### Targets for Glycemic Control

- •A1C ≤ 7%<sup>2</sup>
- •FPG 4.0-7.0 mmol/L
- •PPG 5.0-10.0 mmol/L3

#### Lifestyle Interventions

- Achieve and maintain healthy weight
- Healthy diet⁴
- Regular exercise<sup>5</sup>
- Smoking cessation<sup>6</sup>
- Limit alcohol intake<sup>7</sup>

### **Type 2 Diabetes in Adults**

#### BP test at each diabetes-related visit

- target 130/80
- reinforce lifestlye interventions
- treat with antihypertensives as per guidelines<sup>8</sup>

### Lipid profile at diagnosis and every 1-3 years

- Primary target LDL≤ 2.0 mmol/L
- Secondary target TC/HDL ratio <4.0</li>
- reinforce lifestyle interventions
- treat dyslipidemia as per guidelines<sup>9</sup>

## Screen for microvascular complications

- neuropathy<sup>10</sup> at diagnosis then annually
- nephropathy<sup>11</sup> at diagnosis then annually
- •retinopathy<sup>12</sup> at diagnosis the every 1-2 years

#### **Diabetes Management Cover Page**

THE CHRONIC DISEASE PREVENTION AND MANAGEMENT TACKLE BOX

#### DIABETES MANAGEMENT

CHRONIC DISEASE NETWORK AND ACCESS PROGRAM (CD-NAP)

PREVENTION
RISK ASSESSMENT
NUTRITION MANAGEMENT
ALGORITHMS OF CARE
MEDICATION MANAGEMENT
FNIH DRUG COVERAGE



www.ehealth-north.sk.ca

#### **Diabetes Management Table of Contents Page (1 of 3)**

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These materials were developed by the Clinical Subcommittee of the Chronic	Disease Network and Access Program of the

Prince Albert Grand Council and its partners and funded by the Aboriginal Health Transition Fund.

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#### Diabetes Management Table of Contents Page (3 of 3)

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#### **Nutritional Managements of COPD Page**

Chronic Disease Network and Access Program 2009

# Nutritional Management of COPD

**Guide for Health Professionals** 

Tanya Cockburn RD

Jetta Johnson RD

**Reviewed By:** 

**Rochelle Anthony RD** 

**CDM Dietitian, Saskatoon Health Region** 

# Nutritional Managements of COPD Table of Contest Page

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#### **Unique Features of the Client Handouts**

- We have developed client handouts with the following features
  - Literacy level
  - Colourful pictures
  - Includes traditional foods
- We include client medication handouts and we have handouts for COPD management
  - Nutrition as an example

# CDNAP Public Service Announcements (PSA's)

## PSA – Risk factors of diabetes English version

Here is a sample of an English version of the PSA's currently available on our website



- The following is a list of risk factors for developing diabetes:
  - Are you overweight?
  - Do you have a parent, brother or sister with diabetes?
  - Is it hard for you to get exercise?
  - Have you been told that you might be at risk for developing diabetes?
- If you answered yes to any of these questions, then you might be at risk or you may already have diabetes.
- Remember diabetes is preventable. You are not alone, help is available.
- This message is brought to you by the Chronic Disease Network and Access Program of the Prince Albert Grand Council.



# PSA – Risk factors of diabetes Cree version

- This is the same PSA, but in Cree
- Translation
- The following is a list of risk factors for developing diabetes:
  - Are you overweight?
  - Do you have a parent, brother or sister with diabetes?
  - Is it hard for you to get exercise?
  - Have you been told that you might be at risk for developing diabetes?
- If you answered yes to any of these questions, then you might be at risk or you may already have diabetes.
- Remember diabetes is preventable. You are not alone, help is available.
- This message is brought to you by the Chronic Disease Network and Access Program of the Prince Albert Grand Council.





# Electronic Medical Records Initiative

"Community Engagement on Electronic Medical Records for First Nations-Promise and Challenge"

### Challenges

- Size of the Project
- Timelines
- Arrival of H1N1

### Size of the project

- Scope of the Project is much greater than the original three years
- Systems Change

### **Timelines**

- Constrictive timelines
- Development of the Project left very little time for the implementation and evaluation

### **H1N1**

 Due to the onset of the World Health Organization designation of the H1N1(2009) Influenza Pandemic, many of our staff were redeployed to help in mitigating the risk of this novel virus

### Thank You

Please come visit our display and you are welcome to join us at our sharing circle