

# Diabetes Network News



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Dear Readers,

Welcome to the August edition of Diabetes Network News. Since the last edition the Country Diabetes Network have met in Adelaide as part of a 2 day workshop. Diabetes Outreach hosted the meeting and it was a great opportunity for networking and reflection on the future direction of this network. Each Country Health cluster has representation on this network and so important information from the workshop will be disseminated through each of the clusters. A full report will be included in Edition 64.

Diabetes Outreach has updated the 'What is diabetes' factsheet so that there is now one called 'What is type 1 diabetes' and another called 'What is type 2 diabetes'. The Diabetes Outreach South Australian Rural Directory has also been updated and can be accessed via [www.diabetesoutreach.org.au/directory/default.asp](http://www.diabetesoutreach.org.au/directory/default.asp).

Some educators and CHSA services will now be aware of the changes to the blood glucose meter contract and ordering system. Abbott has the contract until 2012 to provide Xceed meters to SA Health. Please see page 10 for more details.

Jane Giles, Manager - Education

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## Diabetes Outreach

Diabetes Outreach is a program of Country Health SA co-located with The Queen Elizabeth Hospital Diabetes Centre. The service provides continuing education and support programs for health care providers and assistance with service planning.

### Diabetes Outreach

- > Provides training and support for rural and remote health professionals.
- > Contributes to local and regional networks.
- > Promotes evidence based standards of care.
- > Facilitates access to information about quality assurance and documentation.
- > Facilitates access to information about population health needs.

### We offer:

- > Education resources for health professionals and people with diabetes.
- > Education programs conducted in rural and remote areas
- > Distance education programs.
- > Peer support.

### The vision of Diabetes Outreach is:

**Better health for rural and remote South Australians by supporting health service providers towards best practice in diabetes care.**

The Diabetes Outreach team is located at 8 Woodville Rd, Woodville SA 5001. Visit our website [www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au) for access to and information about education programs and free resources for both people with diabetes and health professionals.



L-R: Dr. Pat Phillips, Jane Giles, Kate Visentin, Sharee Westlake

Cover pict: L to R Robyn Paparella and Cindy Whittlesea.

### Feature Article

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## Community groups with specific needs

The following excerpt comes from the 2009 edition of the Diabetes Manual Section 7, which is available online at [www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au). The section was written as a way of supporting health professionals who work with diverse community groups such as rural and remote, Indigenous, culturally and linguistically diverse, children and adolescents and people with mental health issues.

### Rural and remote communities

In Australia 34% of the population live in either a rural or remote area.<sup>1</sup> The disadvantages for rural and remote South Australia (SA) occur in two areas.

1. People living outside the metropolitan areas have higher rates of mortality and morbidity than people living in metropolitan areas.<sup>2</sup>
2. Recruitment and retention are problematic for those health professionals with specialist skills.<sup>3</sup>

In addition, South Australian data also highlights that;

- > In 2007, SA had 82,500 adults (age 16 years and over) living with diabetes in country areas.<sup>4</sup>
- > Comparisons done between metropolitan Adelaide and country SA in 2005 found the prevalence of diabetes to be significantly higher in country areas – 10.2% compared to 7.8%, a 2.4% difference.<sup>5</sup>
- > There are 191 children living in country areas who have type 1 diabetes, 29 of these are on insulin pump therapy.<sup>6</sup>
- > There are 127 young adults between the age of 18 and 25 with type 1 diabetes living in country SA, with 64 of these on insulin pump therapy.<sup>6</sup>
- > 44% of people with diabetes in SA have high cholesterol levels.<sup>7</sup>
- > Persons living in rural and remote regions generally have worse health, in terms of mortality, hospitalisation rates and risk factors compared to those living in metropolitan areas.<sup>8</sup>

Caring for people in a rural or remote setting brings with it all the challenges of distance, isolation and limited access to specialist support services. Strategies such as developing networks at a local, regional and state-wide level can help to overcome some of the barriers.

Major rural centres generally have a core range of health professionals eg diabetes educators, dietitian, podiatrist, physiotherapist, optometrist or ophthalmologist. For health professionals working in smaller health services within a larger cluster of health services, virtual teams can be set up to facilitate access to specialist support and information/education for people with diabetes in their communities.

Rural and remote areas are home to people with all types of diabetes. It is important that diabetes services in rural and remote areas are cognisant of the fact that they play an important role in providing and facilitating best practice in diabetes education.

For example, in a rural area there may be people with type 1 diabetes, children and adolescents with type 1 diabetes and at times some with type 2 diabetes. The geographical area may also have women with gestational diabetes and women with pre-existing type 1 or type 2 diabetes who are pregnant. It is important that education services do not ignore the education and support needs of these groups. If education services do not have the expertise to provide education in these areas it is essential that the service facilitate access in some way (eg distance technologies) to ensure access to education and support for all people living with diabetes in rural and remote areas.

### Indigenous communities

Diabetes is a significant cause of excess morbidity and mortality among Aboriginal and Torres Strait Islander people.<sup>9</sup> Type 2 diabetes occurs at a higher rate and at a younger age than that of non-Indigenous people.<sup>11</sup>

- > South Australia has the most geographically isolated Aboriginal communities in Australia.<sup>11</sup>
- > 45% of Aboriginal communities live more than 250kms away from a health service.<sup>11</sup>
- > Diabetes shows up some 10 years earlier in Indigenous people than non-Indigenous.<sup>12</sup>
- > Diagnosis of diabetes in Indigenous people in 2004-05 were double that of the non-Indigenous population.<sup>12</sup>
- > In 2006/07 the crude hospitalisation rate for diabetes was 3.3 times higher for Aboriginal people compared to non-Aboriginal people.<sup>11</sup>
- > In 2006/07 the crude hospitalisation rate for renal disease was 8 times higher for Aboriginal people as compared with non-Aboriginal people.<sup>11</sup>
- > Ischemic heart disease and type 2 diabetes are leading causes of premature mortality in Aboriginal people.<sup>11</sup>

Many of the complications from diabetes can be prevented with the appropriate community based primary health care interventions.<sup>13</sup> Structured approaches are needed if outcomes of Indigenous Australians are to be improved. A structured approach consists of a shift from reactive care to proactive care. Aboriginal health services require systems of care which ensure early detection and care planning with clients. Registers and recall systems which are linked to appropriate action are integral to this process.<sup>13</sup>

The Strategy for Aboriginal & Torres Strait Islander people;<sup>14</sup>

- > To implement regionally coordinated knowledge management processes.
- > To develop collaborative diabetes implementation plans.
- > To provide coordinated ongoing workforce development programs.
- > To develop and implement effective organisational capacity building initiatives.

In Australia, State funded health services provide services to the whole community. In some areas the Aboriginal Community Controlled Health Services (ACCHS) are also providing primary health care services specific to Indigenous communities. Which ever service is available, it is essential that regional and ACCHS work together to ensure access and equity of service.

The roles of Aboriginal Health Workers (AHW's) within the community health teams of both state funded services and Aboriginal Community Controlled Health services is integral when working with Aboriginal people with diabetes. Some AHW's are also trained as diabetes educators and should provide the majority of education and support. AHW's assist with providing culturally appropriate care.

There are many resources available which are specific to Indigenous communities.

- > Diabetes Australia – Northern Territory  
[www.healthylivingnt.org.au](http://www.healthylivingnt.org.au)
- > Diabetes Australia – Victoria  
[www.diabetesvic.org.au](http://www.diabetesvic.org.au)
- > Diabetes Australia – New South Wales  
[www.diabetesnsw.com.au/about\\_diabetes/indigenous\\_introduction.asp](http://www.diabetesnsw.com.au/about_diabetes/indigenous_introduction.asp)
- > Australian Indigenous Health Information Net  
[www.healthinonet.ecu.edu.au/chronic-conditions/diabetes](http://www.healthinonet.ecu.edu.au/chronic-conditions/diabetes)

## Culturally and linguistically diverse communities

Many culturally and linguistically diverse (CALD) community groups have a high prevalence of type 2 diabetes compared with the non-Indigenous Australian-born population. A combination of genetic, biological, behavioural and environmental risk factors are thought to be related to this higher incidence.

As people migrate to a country like Australia (western culture) they may start to adopt some of the lifestyle behaviours eg eating a greater proportion of high-energy dense foods or reducing exercise levels. Such changes can lead to excess weight gain, thus increasing their risk for type 2 diabetes.<sup>15</sup> Furthermore research highlights that migrants are at a high risk of diabetes complications due to the many barriers that they face when accessing health services. Barriers include:<sup>16</sup>

- > language
- > literacy (in English and native language)
- > stigmatisation
- > lack of access to culturally specific care
- > religious beliefs and cultural practices.

It is important to recognise that religious beliefs and/or cultural practices can affect the person's ability or desire to self manage. There may be different perceptions of what actions will have a positive effect on health across various cultures.

Diabetes health care should be:<sup>16</sup>

- > culturally specific
- > incorporate the diet, beliefs and attitudes of the cultural group
- > foster increased understanding, interest and participation.

Health professionals need to be aware of special circumstances that could be a risk for the client eg Muslims wishing to fast during Ramadan. Health professionals will need to work with clients to ensure that safety is maintained during this period.<sup>17, 18</sup>

Culturally specific resources can help with these situations and Diabetes Australia does provide a national Multilingual

Internet Resource for consumers and health professionals.<sup>19</sup>

In Australia organisations such as the Migrant Resource Centre can be invaluable when working with people from CALD backgrounds.

## Children and adolescents

Type 1 diabetes is one of the most common diseases of childhood and adolescence. Results for the period 2000–2006 on the incidence of type 1 diabetes show the rate is increasing in Australia at almost 3% per year.<sup>20</sup> Type 1 diabetes in children and adolescents is a serious, life-long disease that causes a major health, social and economic burden for individuals with the disease, their families and the community.<sup>20, 21</sup> There is also an increasing prevalence of type 2 diabetes in children<sup>21</sup> but at present there are considerably less children with type 2 than type 1 diabetes.

Current guidelines recommend that children and adolescents should have access to care by a multidisciplinary team trained in childhood and adolescent diabetes.<sup>21</sup> In rural and remote areas the local team should work in a shared care arrangement with the appropriate tertiary level diabetes service.

### Children

Children with type 1 diabetes require insulin from diagnosis and insulin requirements will change as they grow into adulthood. It is becoming more common for children to be on an insulin pump or on multiple dose injections (MDI) from a very young age.

In children with type 2 diabetes, lifestyle education remains the foundation of management. All education should be done as a whole of family approach.

### Adolescence

The management of diabetes during adolescence can be difficult for a myriad of reasons. Firstly, puberty is associated with insulin resistance and so many young people require more insulin than what is usually needed for their weight. Other issues such as alcohol and illicit drug use, dating, sex, contraception, driving, employment, study and sport must be discussed in a non judgmental way.

All children and adolescents in school or child care must have a care plan that has been developed in consultation with the paediatric service, parents and school staff. For more information, visit [www.decs.sa.gov.au](http://www.decs.sa.gov.au) (Department of Education and Children's Services).

### Transition to adult services

Young adults with diabetes pose a challenge because they fall outside the focus of the paediatric and the adult clinics. Many of these young adults are at risk of 'falling through the gaps' which puts them at high risk of acute and long term complications.<sup>22</sup>

Young people with diabetes need support to stay connected to their diabetes health professionals. Resources such as [www.realitycheck.org.au](http://www.realitycheck.org.au) can be invaluable for young people as the website is written by young adults who have type 1 diabetes. The website has many stories and real life accounts of what it is like to live with type 1 diabetes 24/7.

## People with mental health/illness issues

Individuals who live with psychotic disorders and other mental illness have a higher prevalence of type 2 diabetes as compared with the rest of the population.<sup>23</sup> This higher prevalence relates to the illness itself, poor dietary habits, lack of exercise and the direct or indirect effects of antipsychotic and other psychotropic medications.<sup>23, 24</sup> A diagnosis of diabetes has also been shown to double the odds of depression.<sup>25</sup> Conversely a diagnosis of depression can double the risk of developing type 2 diabetes. Depression can also increase the chance of developing complications. It is important to provide people with the appropriate supports and resources. BeyondBlue has a fact sheet called 'Depression and diabetes' at [www.beyondblue.org.au](http://www.beyondblue.org.au) and SANE Australia has also produced a resource called 'The SANE guide to good mental health'. For more information, visit the website at [www.sane.org](http://www.sane.org).

### Medications used in mental illness

Second generation antipsychotic (SGA) medications are widely used in conditions such as schizophrenia, bipolar disorder, dementia and psychotic depression. The use of SGA medications have been associated with reports of dramatic weight gain, type 2 diabetes and changes in lipid profiles.<sup>26</sup> It is for this reason that all people taking antipsychotic medication should be regularly screened for diabetes and its associated risk factors.<sup>23</sup>

There is also a possibility of diabetic ketoacidosis in clients taking SGA medication and clients need to be assessed for and aware of the signs and symptoms of hyperglycaemia.<sup>26</sup>

### Education and support

People who live with a mental illness need ongoing support and education. Diabetes knowledge has been demonstrated to be lower in populations with mental illness as compared to the general population.<sup>27</sup> Frequent repetition of important information is beneficial for all people with diabetes but it is critical for clients with a psychotic illness.

Health professionals who care for clients with mental illness should encourage healthy nutrition and activity as these can improve metabolic parameters even when there is no weight loss.<sup>23</sup>

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## Introducing Naomi Zakarias

Kate Visentin, RN CDE

Noami Zakarias was recently appointed the Country Health SA Chronic Conditions Lead Podiatrist and is based at Gawler Health Service. Noami grew up in Adelaide and lived there until she finished university, after which she moved to the country to live and work for the majority of the last 5½



years. She completed her undergraduate podiatry degree at the University of South Australia, and later also completed a Master of Health Science in Podiatry. Her first rural placement was in the Riverland and this gave her 'a taste of living and working in the country'. Noami has worked at Port Augusta Hospital and Regional Health Service, Port Pirie Regional Health Service and most recently at Flinders Medical Centre.

Noami feels that her mix of rural and metropolitan work has held her 'in good stead for looking at the patient journey from country to metro and back again'. In terms of her rural work she has 'enjoyed the partnerships that you make with the community and being able to see the results of the work because you are working with a smaller community'.

Noami's new position as Chronic Conditions Lead Podiatrist commenced in early March and it is funded through the GP Plus strategy to reduce patient journey and with specific actions contributing to The Chronic Disease Action Plan. Noami explains 'this role brings together podiatry, chronic conditions and patient journey by looking at reasons why country people are travelling to the city for services, if some services could be provided locally, and addressing barriers related to this'.

The main chronic condition that podiatry work with is diabetes, so a large part of the role is working with health professionals that contribute to the care of people with diabetes. Noami explains that the role is 'holistic in that I am not only considering podiatry but also anyone who works with people with diabetes, which is why working with diabetes educators and dietitians and visiting specialists is a key part of my role'.

Noami is really passionate about being an advocate for country clients that are accessing services that are not close to home and investigating strategies to reduce this. Noami is also keen on developing systems for better coordination between metropolitan and country services and with other health professionals that are working with people in the area of diabetes. Noami says 'I think that there are some good examples that are working well already but they are happening in some pockets in the state and we need to look at sharing that information so that we can look at what models could work well for everyone across country'.

Noami has enjoyed 'being able to meet with the country podiatrists and hear about what is working well and ideas on what could be improved upon, with the goal of working towards a more consistent service. It is an exciting time for Country Health SA in that we are starting to see the creation of roles to support allied health clinical networks such as the lead dietitian role, this role and specialist allied health clinician roles.'

For Noami the most challenging aspect of the role has been that the role hasn't existed before so 'there has had to be scoping and collecting data for continuing the role but I have liked that the role can be flexible to address what the current patient journey and chronic conditions priorities are'. Now that the funding for the role has been extended for 12 months, Noami would like to work with the country podiatry network to develop priority areas for the role. For the future Noami would like to 'work with the podiatry network to develop common forms, processes and education materials, as well as forming links also with metropolitan services to develop adequate referral pathways and discharge planning for country clients'.

## Annual weekend conference Diabetes: Getting to the point

Kate Visentin, RN CDE

The Australian Diabetes Educators Association annual weekend conference was held on the 22 and 23rd May at the Adelaide Meridian Hotel. It was another good turn out with lots of participants coming from country South Australia.

It was a varied program which not only met the needs of new diabetes educators but also educators with many years of experience were challenged by speakers such as Dr Paul Drew from Flinders University. Dr Drew presented findings from the latest research on the role of genes in the development of diabetes and the development of diabetes complications.

Professor Jenny Couper gave an interesting overview of the latest research findings in type 1 diabetes. We know that the incidence of type 1 diabetes is increasing, for example, the incidence has doubled in the last 20 years and this cannot be explained by genes. Professor Couper explained that the increase has to be related to the environment and researchers are investigating whether it is occurring in pregnancy or in the first few years of life. The 'accelerator hypothesis' states that weight gain is the link between type 1 and type 2 diabetes. Weight gain and insulin resistance accelerate the loss of insulin producing cells. The overweight epidemic has happened at the same time and heavier children are on average getting type 1 diabetes earlier. Interestingly, studies have demonstrated that there has been a decrease in the gene influence as shown by a falling incidence of the highest risk HLA gene. The question

that researchers are asking is, 'Is the increased weight of the population driving increases in type 1 diabetes and type 2 diabetes'. Researchers are also looking at whether dietary influences could be playing a part, such as, vitamin D and omega 3 fatty acids.

Pauline Hill gave a practical session aimed at getting educators to reflect on how they teach and how they learn. Teaching is instruction for learning. People can provide information to you but you do the learning. Pauline explained that instruction is designed to help the learner construct knowledge (for self care). Knowledge construct occurs through use and repetition, questioning and clarification, linking existing knowledge and doing it. Pauline suggested that one way we can gain insight into how people learn is to ask them to think about something they like doing and then ask them how they learnt to do it. You can also ask 'What do you expect to get from this session?'

Professor Toby Coates spoke about diabetes and the kidney. Diabetic nephropathy now accounts for 31% of patients on dialysis. People are now going onto dialysis very late in life with some patients being started in their 90s. The risk factors for nephropathy include hereditary, race, age and duration of diabetes. Genetics also play a part. Professor Coates discussed the importance of targeting BP to delay the progression of nephropathy.

There was lots of networking at the weekend and delegates had an opportunity to gather resources from the various stalls such as Diabetes Counselling, Pharmaceutical representatives and Diabetes SA. A big thank you to the education committee for organising another interesting weekend.

## The Flinders Program of Chronic Condition Management

Kate Visentin, RN CDE

In April 2010 Jane Giles and I attended the two day workshop to learn about the Flinders Program for managing chronic conditions. The Flinders Program refers to a set of generic tools and processes which have been designed to assist health care providers to assess self management behaviours and in collaboration with clients identify problems and set goals as part of an individualised care plan. The course is designed to equip health professionals with knowledge and skills to use the program in their work place.

The concept of self management refers to not just a persons ability to self care but also their attitude, behaviours and skills. Self management can incorporate;

1. Knowing about the condition
2. Working with an agreed care plan
3. Actively sharing decision making with health professionals and significant others
4. Monitoring and managing signs and symptoms

5. Managing the impact of the condition on physical, emotional, occupational and social functioning
6. Adopting lifestyle behaviours that address risk factors
7. Have the ability to confidently access and use support services as needed (Flinders Program 2010).

The above behaviours underpin the Flinders Program and highlight the complexity of self management for the person with chronic conditions. The Flinders Program has been trialled in a number of sites and in various populations. For information about these studies go to <http://som.flinders.edu.au/FUSA/CCTU/publications.htm#Flindersmodel>.

### The workshop

There were approximately 25 participants enrolled in the 2 day workshop and they came from a number of different disciplines including nursing, social work, physiotherapy, dietetics and occupational therapy. The program has been designed so that it can be used by any health care provider and it is not disease specific.

The first day of the workshop was focused on the theory of the program and the second day allowed us to work through the program with a volunteer. At the time it was very overwhelming because there seemed like an enormous amount of paperwork to wade through. However as we worked through it we could see how the program could be effective.

## Step 1

### Partners in health scale

The scale measures self management capacity and should be completed by the client independently and usually takes 5- 10 minutes.

## Step 2

### Cue and Response Interview

The interview is a tool for the health professional to explore issues around self management. The questions are based on the *Partners in Health questionnaire* but include open ended cue questions. All answers are scored by the health professional and these scores are then compared with the client's scores from the *Partners in Health questionnaire*. When you do the interview it is important that you use open ended questions, affirmations and reflective listening. Notes should be taken in the clients own words. At this point we are not supposed to give solutions, rather the aim is to flag important issues that can be followed up later. I found this particularly difficult to adhere to as this is something as nurses we are not used to doing. In summary the cue and response is about 'finding out' not 'teaching'.

## Step 3

### Cue and response discussion

The discussion about the cue and response is critical because it underpins the development of the care plan. In this discussion the client and the health professional compare and discuss their scores and negotiate which of the issues should form part of the care plan. For example if the health professional scores a 5 and the client scores a 1 then it means that the client does not see this area as a problem but the health professional does. In the discussion the client and the health professional both explain why they do or do not see this issue as a problem. The care plan is then negotiated based on the client priorities and health professional concerns.

## Step 4

### Problem and goals assessment

At this point you ask the client what they see as their main problem. This problem is based on 3 open-ended questions which then lead the client into writing '*the problem statement*'. The problem statement needs to include the problem, impact and feeling eg "because my blood glucose levels are always high I get tired easily and I feel worried and angry when I cant get all of my jobs finished". The person then rates how much this is a problem for them. From the problem statement the goal can be developed. The goal should be written by the client and one off short term goals should be avoided. Goals should be medium to long term and should be written in a positive way. There may be sub goals which support the person to attain the medium to long term goal.

## Step 5

### Care planning

The care plan identifies the health care needs and management aims. Any issues from the *Cue and Response Discussion* should be included in the care plan along with the *Problem and Goal Statements*. The care plan is collaboratively written with the client and should be person centred and non judgemental.

### Strengths of the process

Due to the design of the *Cue and Response Discussion* clients feel listened to. They get to tell their story in a non threatening way whereby strengths and barriers to self management can be identified. Sometimes something that the health professional was concerned about turns out to not be an issue or the health professional brings to light an issue that the client has not considered. Alternatively clients may be concerned about something which the health professional did not identify. What I liked about this process was that it felt transparent and more importantly the collaborative nature of the tools meant that the assessment process was much more fool proof. By fool proof I mean that the process is less likely to let me down because every area is comprehensively assessed not just by me but also by the client. I also liked that all chronic conditions and issues were given equal weight. That is, I was not just focusing in on one condition but instead trusted the process to highlight which condition was an issue for this person.

### Difficulties with the process

One of the difficulties with the program is the time needed to do the process properly. Whilst I appreciate that as you gain confidence you would become more efficient it still requires more time than the more traditional approaches. However, I suspect that the intense time that is put in the beginning probably pays off in the end because you have established rapport, trust and communication. Clients are more engaged and actively involved so I would argue that for those people with complex needs the Flinders Program could be highly effective. I think that it is important within your service to identify strategies which will allow for appropriate and stratified referral to the Flinders program. For example if you are a diabetes educator it may be prudent to assess which of your clients would most benefit from this program. In my own experience I think the program is best suited for people who have had diabetes for some time and have already received diabetes information rather than the person who is newly diagnosed and requires specific information pertaining to their condition such as healthy eating principles and testing blood glucose levels.

In summary, I would highly recommend this workshop to anyone who wants to expand the tools they have available to work with people who have chronic conditions. For information about upcoming workshops you can go to the Flinders Human Behaviour website [http://som.flinders.edu.au/FUSA/CCTU/self\\_management.htm](http://som.flinders.edu.au/FUSA/CCTU/self_management.htm).

# The Person Centred Approach to Healthy Weight Management: helping people achieve and maintain a healthy weight

Connie Stanton, Dietitian, TQEH Diabetes Centre

I was lucky enough to attend a two day training program in Melbourne recently by Dr Rick Kausman who is the author of "If Not Dieting, Then What?"

Dr Kausman is a medical doctor who is recognised as the Australian pioneer of "the person-centred approach to healthy weight management". The aim of the two day training program was to assist health professionals to help patients achieve a healthy weight. I have been a dietitian for almost fifteen years and healthy weight management is still an area I find challenging.

Dr Kausman discussed data showing increasing levels of people in Australia who are above their most healthy weight. He also indicated that there was an increased probability of health risk for people who were a long way above their most healthy weight (body mass index >30) as compared to individuals with a body mass index (BMI) below 30.

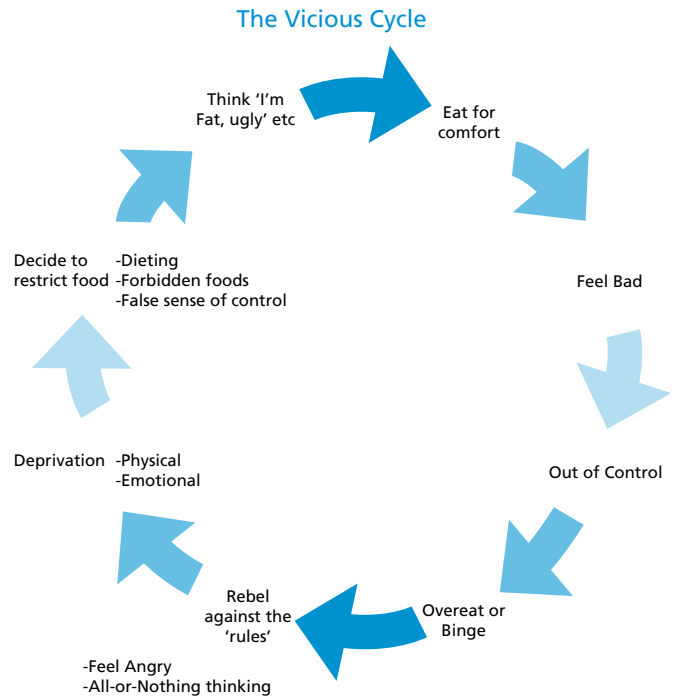
He talked about the abundant availability of good tasting food in our culture and showed a number of examples of clever food marketing. Not only do we have access to lovely food but we are doing less activity which also contributes to increased weight in the population.

There was a lot of discussion on the way the media and our culture believe that rising fuel prices and global warming is partly the result of people being above their healthy weight and how we blame individuals for their weight gain. Dr Kausman showed many examples of the negative way in which the media portray people who are above their most healthy weight and in contrast good looking thin people are considered to be role models. This in turn has made people feel bad about their appearance and weight and has thrown them into the dieting cycle.

Dieting is defined as, anything that tells us what, when and /or how much to eat for the purpose of weight control. Australian statistics indicate that 92% of young women and 44% of middle aged women have dieted at least once.

He described a number of studies indicating that diets don't work. Results of popular diets show that 42% drop out in the first year. Ninety five percent of those who lose weight will regain the weight within a few years, and many will gain more than they originally lost.

Dr Kausman discussed the reasons behind why diets don't work with the diagram on right:



There was discussion around why self-changing dieting attempts fail.

Firstly, people set themselves unrealistic expectations about changing themselves. Secondly, the power the weight loss industry has on people. The big promises attract the customers in the first place, and the magnitude of the promises virtually guarantees that they cannot be fulfilled.

Research also indicates that dieting can have long term effects on immune function, bone mass and increase the risk in developing gallstones. There is also evidence to indicate that adolescent girls that diet are eighteen times more likely to develop an eating disorder than those who do not diet. There seems to be general consensus in the literature that dieting contributes to binge eating. Diets can also create significant emotional distress for people as a result of feeling out of control in their relationship with food, eating, their weight and their body image.

Dr Kausman also discussed why it was important for health professionals to change the way they define, think and talk about weight. Firstly the language that is used, e.g. overweight and obese. Clients often feel offended by these words. He suggests we use much more supportive language like "above a person's most healthy weight or a long way above a person's most healthy weight".

Research indicates there are significant side effects with patients not feeling supported from health professionals. These include, delayed screening for important health issues for women and avoidance of medical care. Some patients report avoiding medical care because of fears of being weighed and their concerns about negative comments. When focussing on a person's weight we may think we are measuring health and wellbeing when really we are not. It puts the focus on the weight, not on the person or on the reasons why weight gain has occurred, and definitely not

on any useful solutions. As we know body mass index (BMI) charts are far from accurate when assessing a patient's health. There is now considerable evidence that there are individuals who are 'obese' and who nevertheless are metabolically normal. Studies indicate that from a population perspective being 'overweight' is not associated with excess mortality. What we should be asking patients is 'what size/weight does that person feel most comfortable at, that they can maintain as a result of a process that can be sustained over the long term (without being preoccupied by thoughts of fat, food, size and shape).

Dr Kausman encourages a person centred approach to healthy weight management rather than a one-size-fits-all, diet-centred approach. It is important that we guide people to make sustainable changes that are right for that particular person. For example, encouraging people to be in control from within rather than handing over the control to a diet, to rules, to numbers or calories. Helping people with strategies to decrease their non-hungry eating and helping people to achieve and maintain a healthy weight without feeling deprived of food or quality of life.

The health professional should be focusing on the process and allowing the weight change to come as a result of that. Well developed listening skills are essential. Reflecting content and emotion allows the patient to know that they have been heard and understood. Generally, patients are not ready to listen until they know with certainty that they have been listened to.

Research indicates that eating without awareness increases chances of non-hungry eating. In other words lots of people are doing lots of eating without awareness which contributes to weight gain. Physiologically it is important to help people to decrease the amount of non-hungry eating and allow them to regularly feel physically hungry (but not starving) before they eat. Helping people become clearer on what being physically hungry and feeling full means is important in decreasing non-hungry eating. Encouraging clients to self monitor with an 'Eating Awareness Diary' and encouraging them to learn about why non-hungry eating might be happening along with looking for opportunities to decrease non-hungry eating. Many people are doing a significant amount of non-hungry eating-and even up to 100%, and a lot of this is usually non-mindful, non-aware non-hungry eating. It is normal to do some non-hungry eating. It is important for us to do our best to help people become more aware of hunger/fullness, what they really feel like (food or otherwise), and look for opportunities to decrease the amount of non-hungry eating they might be doing. On any one particular occasion, non-hungry eating might start with some awareness (often it doesn't, but it can) but often/usually can evolve into non-mindful, non-aware, non-hungry eating.

The Eating Awareness diary can enhance consciousness about the level of hunger and satiety at each meal which can develop intuitive eating. Intuitive eating has been significantly correlated with lower BMI and improved cardiovascular risk. It has also been associated higher levels of pleasure associated with food and eating, fewer dieting behaviours and food anxieties.

Encouraging a positive attitude to food and avoiding labelling foods as forbidden or unhealthy is an important message for people to understand. Dr Kausman encourages terms like 'every day foods' and 'sometimes foods' to eliminate the guilt about food eaten. Making people feel guilty about eating certain 'forbidden food' can increase their desire for the very foods they are trying to avoid.

There has also been a direct positive correlation between the rate of eating and BMI. Eating fast can result in reduced awareness of the quantity eaten and ingesting amounts that exceed the amount necessary for satiety. If we feel guilty about eating, we usually eat more quickly, enjoy the food less and end up eating more. If we know it's ok to have it, it's much easier to eat more slowly, we usually enjoy the food more and we end up eating less.

As health professionals we should be working with people to decrease non-mindful non-hungry eating. This is the eating that people are unaware of, where they often feel out of control and feel physically sick and guilty after they have eaten the food. The mindful non-hungry eating is the conscious eating people do where they enjoy and savour the food feeling in control (at least initially). We are aiming to minimise the guilt and maximise the benefits of mindful non-hungry eating.

Encouraging physical activity is also important when working with people to reach their most healthy weight. Discussing with them that small amounts of physical activity are beneficial and that there are many benefits of being active. Working with the person to work out what are the benefits for that person, and, what might be holding them back.

Finally understanding that there is no way of eating that is right for everyone all the time and that occasionally eating more, or less, than your body actually feels like is normal. It is also normal to eat certain types of food some of the time just for the taste of it. Stretching your thinking so that no single day really means very much on its own and trying to eat a large variety of different types of food on as many days as you can.

Overall I found the two days very rewarding in developing my skills on healthy weight management, I would strongly recommend the workshop to those health professionals working in this area.

Dr Kausman's web site: [www.ifnotdieting.com.au](http://www.ifnotdieting.com.au)

## Activity report : Eye Health Day

Helen McNichol, RN CDE and Diana Pluker RN DE,  
Pt Lincoln Health Service

Eye health is an important part of diabetes management. In 2010 the diabetes educators from Pt Lincoln Health Service identified that in recent times not much has been done in terms of establishing links with eye health service providers. To address this gap we met with the staff of Port Lincoln Optometry service to discuss how we could provide a better service to our clients.

As a result of this initial meeting a workshop was arranged collaboratively with local optometrists. A client handout and referral letter was developed as part of this workshop. The handout is now given to clients when they see the diabetes educator. As a result of the workshop and this newly forged partnership the diabetes educators are now receiving a copy of the clients' results and these are filed in the patients hospital case notes. This is an excellent outcome for clients as it means that the visiting endocrinologist and diabetes educators are now fully informed as to any issues with their eye health.

At the workshop day a local optometrist provided information to staff about:

- > basic eye anatomy,
- > eye assessment and
- > complication damage from diabetes.

The optometrist was asked to explain ways for rural diabetes educators to identify eye health issues and act on them if their town did not have access to a resident optometrist. For example – how to recognise if there was a retinal bleed which needed immediate action. This information (including the client handouts) was provided to the local network and it has been decided to follow up with a formal evaluation after 12 months.

Verbal feedback from clients and the optometrist demonstrate that the clients are more prepared for their appointments now, for example, they are more likely to have made arrangements for someone to pick them up after their pupils have been dilated with eye drops. This is an excellent outcome in terms of improved safety for the clients and the community.

Overall the outcomes of the day were:

- > an information sheet for clients to receive about how eye assessments are carried out and how to prepare for an appointment
- > a referral letter from the diabetes nurse educators to the eye health team.
- > Feedback from the eye health team to the diabetes educators
- > Information on basic eye assessment if there are no optometry services available in your area.
- > Increased understanding of work practises from both professions.

## Barbie Sawyer Nurse Practitioner in Diabetes Education



Barbie is the first registered nurse to become endorsed as Nurse Practitioner (NP) in the South East of South Australia and the first Nurse Practitioner Diabetes Educator in South Australia. Barbie has been employed by the South East Regional Community Health Service (SERCHS)

since 2005 as a Credentialed Diabetes Educator and has been encouraged and supported by SERCHS in her career goal to achieve NP endorsement. She has completed significant study and professional development in preparation for this new role including Master of Nursing Practice Nurse Practitioner and Pharmacology for Advanced Practice. She currently has 10 years experience as a diabetes educator. She successfully applied for a Nurse Practitioner Candidacy through Country Health SA in June 2009 and has been preparing her portfolio of evidence for endorsement over the last 12 months. Barbie has a special interest in type 1 diabetes and has been instrumental in improving many aspects of service delivery

for both children and adults with type 1 and type 2 diabetes. Barbie, in collaboration with other SERCHS colleagues, has been a keen promoter and facilitator of the Dose Adjustment for Normal Eating (DAFNE) program for adults with type 1 diabetes, this program has been running in the South East for the last 4 years and more than 50 people with type 1 diabetes have benefited from the program. Barbie has also been instrumental in facilitating local access for initiation of insulin pump therapy in collaboration with the Mount Gambier Private Hospital and local GP Dr Ronan Mackle. Barbie has undertaken extensive professional development to gain the necessary knowledge and skills to offer this service locally. Barbie has also taken a leadership role in the establishment of a local multidisciplinary children's diabetes clinic in collaboration with local paediatricians and the Women's and Children's Hospital, this clinic is in addition to the Paediatric Endocrine Clinic which is run twice yearly at SERCHS Diabetes Education Service. Barbie's role encompasses advanced clinical assessment, initiating interpreting and responding to diagnostic tests, initiating and monitoring therapeutic regimens, initiating and receiving referrals and prescribing medications for people with type 1, type 2 and gestational diabetes. NP's are quite new in Australia and it is important to understand that it is not a Medical substitute role, but an expansion of the nursing role with a strong collaborative model of care with other health professionals including doctors. Barbie will be showcasing the success of the local DAFNE program at the International Nurse Practitioner conference in Brisbane in September 2010.

## Beyondblue website

Beyondblue is a national, independent, not-for-profit organisation working to address issues related to depression, anxiety and substance misuse disorders in Australia. This is done by working in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression, to bring together their expertise around psychological related illnesses. The key goal of Beyondblue is to raise community awareness about depression and reduce the shame that can be connected with the illness.

Beyond Blues website [www.beyondblue.org.au/](http://www.beyondblue.org.au/) offers a wide range of information for families and friends who know someone who is suffering from one of these issues and also information for health professionals and individuals themselves who have may have a psychological illness.

There is a range of depression, anxiety and related disorder resources available to print and / or download. They include beyondblue fact sheets; cards and booklets on getting diagnosed; getting treatment; and recovery. Other topics covered include:

- > Related disorders
- > Postnatal depression
- > Depression and chronic physical illness
- > Depression in different life stages
- > Depression in different population groups
- > Indigenous mental health guidelines
- > Youthbeyondblue fact sheets - information for young people

In addition to this the website also has a directory of mental health services and therapy contact details.

Another tool the website offers is the 'symptom checklist'.



Whilst this is not a diagnosis the checklist does give an indication on whether the help of a health professional should be sought. This tool allows people who suspect themselves or others of a psychological related illness the opportunity to answer some questions and identify the level of risk the person may be at.

There is also a Bulletin Board which can be used for people to exchange their stories, experiences and views on a range of issues related to their disorders in a confidential, moderated and secure forum.

Beyondblue also offers an e-network. This is an email database which enables beyondblue to provide information to members throughout Australia and the world via the internet. Many members use the service to communicate directly with the organisation, share information and their stories and raise awareness about depression, anxiety and related disorders. Members include people with a mental health condition and other interested people including health professionals. The bulletin board includes up-to-date information and developments in the areas of depression and beyondblue related too; research, programs, resources and events.

## Blood glucose meters for CHSA hospitals and health services

The Minister of Health has awarded Abbott Australasia as the sole supplier for the provision of blood glucose meters and associated consumables to SA Health effective from 1 April 2010 to March 2012.

A buyers guide is available online at <http://in.health.sa.gov.au/sp/Default.aspx?tabid=180>

This guide will advise on how to obtain new Xceed meters and other accessories or consumables. All replacement meters, workstations, batteries etc must be ordered through the SA Health Distribution Centre (SAHDC) via your internal supply/purchasing departments. All the relevant information to order these goods are in the buyers guide.

For any of the following support services please contact Philip Wilson at Abbott Diabetic Care Division on 0400 120 197 or email Philip on [philip.wilson@abbott.com](mailto:philip.wilson@abbott.com)

A full range of education/training services are included within this contract and will include:

- > training at mutually convenient times to metropolitan and regional sites;
- > demonstration of the Optium Xceed monitor and its features;
- > hands on familiarisation with the Optium Xceed monitor;
- > face to face training, including classroom sessions and practical sessions within clinical areas;
- > education support for nursing staff;
- > user guide instruction booklet education;
- > advanced training material and support as required by the customer.

Training material may include:

- > brochures, booklets, CD roms, videos, website, research papers and sampling.

## Diabetes Outreach resources

Diabetes Outreach has updated the 'What is diabetes' factsheet so that there is now one called 'What is type 1 diabetes' and another called 'What is type 2 diabetes'. We hope that having separate factsheets for type 1 and type 2 diabetes will assist you to better tailor your education to the needs of your clients. You can go to [www.diabetesoutreach.org.au/consumer](http://www.diabetesoutreach.org.au/consumer) to download the new factsheets. Feedback about the new factsheets is always welcomed by emailing [diabetesoutreach@health.sa.gov.au](mailto:diabetesoutreach@health.sa.gov.au).



Another updated resource is the Rural directory which was initially designed to assist metropolitan services and specialists to communicate with diabetes education services in rural and remote South Australia.

This communication assists in a smoother patient journey as people are referred back and forth between rural / remote and metropolitan services.

The updated resource is now available on the website <http://www.diabetesoutreach.org.au/directory/default.asp>



## EXT1D website

Exercising with type 1 diabetes isn't simple. This website [ext1d.com.au](http://ext1d.com.au) is providing practical direction on 'how to' exercise successfully and with confidence to people with type 1 diabetes.

The author suggests that there are literally thousands of websites, books and assorted publications telling people with type 1 diabetes about the 'health benefits' and why they 'should' exercise but few on 'how to'. Much of the information available on 'how to exercise' is either too academic to be understood or, it simply scratches the surface avoiding the meaningful issues that can help make exercise and participation in sport part of everyday life.

This difficulty in understanding may be the reason many avoid physical activity through sheer frustration and negative experiences, not a lack of willingness. Although individual responses to exercise can differ among people with type 1 diabetes our goal is to provide a platform for people to find a starting point, to build confidence and a gain deeper understanding so they can maximise the mental and physical benefits of participation in sport and exercise.



Some of the topics discussed on the website include the following:

- > Want to exercise but don't know how
- > Parents who want to encourage and support physical activity for their kids
- > Like to optimise weight loss
- > Recreational athletes looking for improvement
- > Hard core athlete looking for ways to fine tune
- > Information for diabetes educators

Other tools include the type 1 diabetes dashboard: an interactive tool that uses the insulin to carbohydrate factor to convert insulin reductions to carbohydrate savings. The person enters their weight, selects the activity that they are about to participate in and enters the duration they will be exercising for and there you have it.

Membership includes:

- > e-learning programs
- > Presentations include video, review quizzes, learning games and downloadable worksheets to make your learning fun and effective
- > Access to EXT1D's diabetes dashboard to help calculate exercise-carbohydrate-insulin needs
- > Answers to member submitted questions via individual member page and newsletter
- > A member only archive of answers to frequently asked questions
- > A regular Tips N Tricks email newsletter related to exercise and fitness for people with Type 1 diabetes.
- > There is also a community forum dedicated to members sharing their exercise experience and strategies.

People can access info for a free trial, but there is a cost for ongoing use. Best to check it out and see if it is useful before spending any money.

<http://www.ext1d.com.au/diabetes/index.html>

The following recipes come from the Pt Lincoln Diabetes Support group cookbook that was developed as a fundraiser to raise money to assist a local child who has an insulin pump.

## Hearty Vegetable Soup

- > 2 cups sliced carrot
- > 2 cups diced celery
- > 1 cup small broccoli florets
- > 6 cups raw pumpkin diced
- > 12 cups water
- > Pepper to taste
- > 1 cup onion diced
- > 2tsp crushed garlic
- > 1 cup dried soup mix (barley split peas etc)
- > 4 tsp salt reduced vegetable stock powder
- > Cooking spray

Chop all vegetables into a pot that has been sprayed with cooking spray. Sauté garlic and onion for 1 min. add all ingredients and simmer for 1 1/4 hours. Using a potato masher, or hand held blender, mash /blend ingredients in pot until a thick consistency is achieved. Add pepper to taste.

**Serves 6**

**Nutrition info (approx) = Energy/100g 822 KJ, Protein 12.5g, Fat (total) 1.6g, Saturated fat 0.5g, Carbohydrate 29.3g**

## Tuna Rolls

- > 1 large tin tuna drained (425g)
- > 8 slices of Wholemeal bread
- > Curry powder to taste
- > 1 cup low fat mayonnaise
- > 1 cup low fat grated cheese
- > Margarine

Mix all ingredients. Cut crusts off bread and roll slice out with a rolling pin. Lightly butter both sides then spread tuna mixture, roll up and hold together with toothpicks. Place on a wire rack on oven tray. Cook until golden brown. Can be frozen then baked or served fresh not toasted. Great for parties

**Serves 16**

**Nutrition info (approx) Energy/100g 612 KJ, Protein 10.4g, Fat (total) 7.4g, Saturated fat 2.6g, Carbohydrate 9g**

## Adelaide Hills Diabetes Service Providers network

**Anne Mole, Dietitian and contact person for the Hills Area Diabetes Network**

### How it started.

In mid 2008 an open forum was held in the evening at Mt. Barker to gauge interest from service providers in establishing a Diabetes Network in the local area for local workers.

Twenty people attended to air their views and written comments were also received from those who were interested but unable to attend the forum. It was decided that a Network would be established and a small working group was formed to progress its development.

The first meeting of the Hills Area Diabetes Network for Service Providers and Support Staff who worked in the local area, was held at Mt. Barker in September 2008. Its terms of reference were finalised, including meeting frequency, venues and agenda format etc. Network members include health

workers and support staff from both the public and private sectors:- diabetes educators, dietitians, practice nurses, project staff from the Adelaide Hills Division of General Practice (AHDGP), podiatrists, pharmacists and exercise physiologists.

The initial broad aim of the Network was to provide a mechanism for communication and dissemination of information and a regular forum for discussion, support and professional development for health workers who provide diabetes services locally.

Meetings are held three times each year, are shared between morning and evening time slots and alternate between Stirling and Mt. Barker. Around fifteen people attend these two different time slots (although not always the same people due to work or other commitments).

The last evening meeting was a joint professional development dinner meeting with the AHDGP with an attendance of over fifty people. Sponsorship was secured to cover costs for both Network and Division members.

The Network is a developing entity and how it changes will depend on the needs of its members. Network members

are linked electronically as well as having the opportunity to meet face to face three times per year. The daytime meetings are 2 hours in duration, half of which is general business and information-sharing and the other half professional development with up to three guest speakers. Some of the presenters may be from within the Network with members given the opportunity to discuss their role in the area of diabetes care or on a specific contemporary topic.

Network members have also found it useful to put faces to names at meetings and to bring together a variety of local public and private sector workers. In turn this can enhance across- and within-sector referrals. For example, knowing that there is a private dietitian or podiatrist who works on a Saturday morning or early evening to cater for clients who want to be seen out of work hours.

## Investigating collaborative care arrangements for the provision of optimal diabetes care in the Whyalla community

Jo Melville-Smith, RN CDE

### Introduction

The delivery of diabetes services in Australia has undergone changes in recent years possibly in response to the recognition of the increasing burden that diabetes presents. Diabetes is now considered a major health problem globally with rapidly increasing prevalence rates, and high mortality and morbidity.<sup>1</sup> The prevalence of diabetes in Australia is one of the highest for a western nation.<sup>2</sup> The number of adult Australians with type 2 diabetes (T2DM) has doubled in the last 20 years.<sup>3</sup> The incidence of (type 1 diabetes) T1DM in Australia is also on the increase. Between 2000 and 2006, the age-adjusted rate of new cases of T1DM in children aged 0-14 years increased significantly from 19 to 23 per 100,000, an average annual increase of 2.7 per cent per year.<sup>4</sup>

The Federal Government through the Medicare Benefits Scheme, has instigated a number of initiatives aimed at the reorientation of the health care system to improve management of chronic disease conditions such as diabetes. This is because effective diabetes management and education needs to be delivered precisely and appropriately whilst at the same time addressing the individual needs of the client. Education and support models need to be based on empowerment in order to promote self-awareness, personal responsibility, informed choice and quality of life.<sup>5</sup> The general practitioner (GP) is now no longer the sole diabetes care provider, rather he/she is encouraged to collaborate with a group of allied health professionals who have expertise in the management of diabetes, including diabetes educators (DEs). This collaborative or team approach to diabetes management involves all members of the diabetes care team sharing their specialist knowledge and understanding and working collaboratively together with the client. In the team management of diabetes the client is the central member, with input from the GPs, DE, dietitian, podiatrist, ophthalmologist/optometrist, oral health professional, exercise professional and endocrinologist/diabetologist/paediatrician.<sup>6</sup>

A number of studies have demonstrated that collaboration between health care providers has a favourable impact on diabetes management.<sup>7,8,9,10,11,12</sup>

The above implications to diabetes care delivery raises an important question: How to successfully develop and maintain a sound working relationship with GPs around the facilitation of optimal diabetes care? This area has not been well researched and there is a gap in knowledge regarding the establishment of collaborative relationships between DEs and GPs for the purpose of facilitating optimal diabetes care in the community. To address this disparity a study in Whyalla, a regional town on the eastern shore of the Eyre Peninsula, was conducted by the author to ascertain knowledge and information about the facilitation of optimal diabetes care within the community through partnership between the DE and the GP.

### Objectives and method

The specific objective was to determine if current relationships are sound and sustainable and whether any disparities existed which could be examined and ameliorated appropriately so as to afford optimal diabetes care within the Whyalla community in rural South Australia.

A simple survey methodology was used to investigate the referral patterns of GPs to DEs working in a Community Health setting in Whyalla and reasons for referral and non-referral were ascertained in order to distinguish factors that contribute to a sound and sustainable collaborative relationship. GPs (n=16, 84% of those eligible) responded to a short survey including closed and open-ended questions about their experience as a GP in Whyalla, their use of the DE service provided by the local health service, their considerations of the service, and their suggestions for improvement.

### Results

The open-ended questions resulted in rich data being generated and post hoc analysis has resulted in several major themes emerging from the analysis. These include: the degree of awareness of public sector diabetes education services in Whyalla; the referral patterns of Whyalla GPs to the Whyalla Hospital diabetes education services, including reasons for and against referral; and ideas to further enhance service delivery.

### Conclusion

The findings of the project demonstrated that the majority of research participants do value the opportunity to engage with the DE at the Whyalla Community Health service. GPs in Whyalla do acknowledge the role and relevance of the DE as being a member of the diabetes management team. The findings have also demonstrated that predominately Whyalla GPs recognise that the education given by the DEs at the Whyalla Community Health Service is suitable and that they rely on the service as an integral part of ensuring optimal

diabetes care for their clients. The project findings have identified several ways to further develop and strengthen collaboration between DEs and GPs. The comments generated by the research participants were interpreted as useful feedback as part of enhanced communication, rather than negative criticism. Professional collaboration is all about open and honest communication with information being delivered in a positive and supportive manner. The areas of focus include; developing ways for service providers to communicate more expeditiously between themselves, widening avenues to diminish waiting times for client consultations, ensuring information resources are consistent and appropriate; and cultivating opportunities towards sharing primary care facilities.

The project has also demonstrated that public funded diabetes education service provision can continue to be relevant and appropriate and has provided solid evidence that collaborative diabetes care arrangements are occurring between the Whyalla Hospital based DEs and GPs within the Whyalla community. Project findings have also highlighted focus areas to consider and address to further develop and strengthen collaboration between diabetes service providers. Attending to these concerns accordingly will gear the diabetes services at the Whyalla Hospital towards reinforcing multidisciplinary collaboration and will ultimately assist in contributing to improved service delivery for diabetes clients within the Whyalla community.

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## Painful neuropathy

Kate Visentin RN CDE

**Q:** I recently saw a lady who is suffering from neuropathic pain. What type of treatments are available to her?

**A:** Managing neuropathic pain is difficult and it is important that health professionals are familiar with the various options available to people. Neuropathic pain is a disabling condition causing people to suffer moderate or severe pain. Painful neuropathy has numerous psychosocial implications as people try and cope with the physical and psychological impact of their condition. The damage to the nerves means that

conventional analgesics do not work and people will usually require medications like antidepressants or anticonvulsants. Management needs to involve multiple strategies that consider the persons other co-morbidities, concomitant medicines and cost.

### How is it treated?

#### Medication

Most people with chronic neuropathic pain will not respond to simple analgesics although a short trial of paracetamol, aspirin or non steroidal anti-inflammatory (NSAID) drugs can be tried. The National Prescribing Service (Edition 60) review identifies that there is limited evidence for the efficacy of the drugs

which can be used in neuropathic pain. Current guidelines recommend starting drug therapy with either a tricyclic antidepressant or antiepileptic. Anticonvulsant drugs can be useful for chronic neuropathic pain particularly when the pain is stabbing or burning. There is a limited role for opioids and this is usually when the person has not been able to tolerate or respond to other drugs.<sup>1</sup>

It is important that only one medication is started at any given time. The person can be advised to keep a written record of the pain intensity, functioning levels and any adverse effects from the medication. It is important to make sure there is an adequate trial period in which a response can be assessed. You could consider confirming the effectiveness of the medication by a trial discontinuation whereby the person records the same outcome data after they have stopped the medicine. This can be useful when deciding on long term options. Combination therapy with drugs from more than one class is an option<sup>1</sup>.

It is imperative that health professionals discuss realistic treatment goals with their patients. People need to be aware that it is unlikely that pain will be completely eliminated however symptoms can be reduced to a tolerable level. Treatment goals can include improvements in pain related disability as well as a reduction in the actual pain itself. Tools such as the Brief Pain Inventory can be used to assess the pain over time [http://www.hnehealth.nsw.gov.au/pain/health\\_professionals/assessment\\_tools](http://www.hnehealth.nsw.gov.au/pain/health_professionals/assessment_tools).

Most of the medications are given orally but local anaesthetics such as lignocaine and ketamine are sometimes given intravenously.

## Topical preparations

### Capsaicin

Topical capsaicin may be useful for diabetic neuropathy. When it is first applied it can cause burning pain and increased sensitivity but over time it can relieve pain.

### Lignocaine

Topical lignocaine may provide short term relief for some people

### Non-Drug therapies

There is limited information and evidence about non-drug therapies for painful neuropathy. The NPS Newsletter provides the following suggestions:<sup>2</sup>

- > Stress reduction
- > Sleep hygiene
- > Physiotherapy
- > Psychological support such as cognitive behavioural therapy

Some podiatrists are also using other strategies such as;

- > Opsite wraps
- > Support stockings
- > Electrical nerve stimulation (TENS)

The person will need a thorough examination to ascertain what type of neuropathy they have as the type of treatment will depend on the type of neuropathic pain. It is important that people receive appropriate referrals to specialist health professionals such as podiatrists and if required, pain clinics. For more information go to [www.nps.org.au](http://www.nps.org.au).

### Reference

National Prescribing Services, 'Navigating the maze of drug therapy for neuropathic pain', October 2008, Edition 60

## Diabetes Outreach

### Video conferencing program

The topics and dates for the videoconferencing series in 2010 will be:

8th September	Food for thought	Marc Campbell
13th October	DAFNE in a rural setting	Barbie Sawyer and Di Vine
10th November	Meeting the needs of adolescence with diabetes	Diana Sonnack

Go to [www.diabetesoutreach.org](http://www.diabetesoutreach.org) to download a registration form.

### Regional Education Series

Sept / Oct Mt Gambier (30th Sept – 1st Oct)

Contact Jane Giles for more information at [jane.giles@health.sa.gov.au](mailto:jane.giles@health.sa.gov.au)

## Conferences and Workshops

### 29th Diabetes Refresher Day: Paediatrics and Pregnancy in Practice

Presented by the Women's and Children's Hospital

Presentations include:

- > Research – vascular health in children and adolescents with type 1 diabetes
- > Medications in pregnancy
- > Type 1 diabetes in pregnancy
- > Teen issues
- > Managing illness in children and adolescents
- > Children with type 2
- > Dietary management
- > Living with a child with diabetes – a family's perspective

**When:** Friday December 10, 2010 at the Education Development Centre

**Where:** Milner street, Hindmarsh

For more information please email [Marianne.lambert@health.sa.gov.au](mailto:Marianne.lambert@health.sa.gov.au)

### Diabetes Buzz Day 17 September

Buzz Day 'help take the sting out of diabetes' is a fundraising/awareness raising activity coordinated through Diabetes Australia. Information can be found by accessing the Diabetes Australia-VIC website at <http://www.diabetesvic.org.au/Getinvolved/Fundraisingevents/BuzzDay/tabid/280/Default.aspx>

Buzz Day merchandise can be purchased from participants Priceline or Best & Less pharmacies.

### Beyondblue Anxiety and Depression Awareness (ADA) Month October

Beyondblue Anxiety and Depression Awareness (ADA) Month during October provides an opportunity for workplaces, community groups and individuals to take part in activities to raise awareness of anxiety and depression and help reduce the associated stigma.

For ADA Month enquiries or if you require assistance with ADA Month information resources please call the Beyondblue ADA Month Hotline on 1800 226 718 or for more information please visit [http://www.beyondblue.org.au/index.aspx?link\\_id=59.1188](http://www.beyondblue.org.au/index.aspx?link_id=59.1188)

### National Nutrition week 10 - 16 October

Nutrition Week is a National campaign conducted by Nutrition Australia every year to coincide with World Food Day on October 16. The aim of National Nutrition Week is to raise the awareness of the importance of healthy eating for optimal health in the community. This year Nutrition Australia will be promoting Nude Food Day. It's all about encouraging kids and their families to pack their lunches and snacks without the use of wrapping. Each Australian household produces an average 1.14 tonnes of waste per year. Nude food is also about encouraging healthy eating habits and an understanding of 'everyday foods' and 'sometimes foods'. Register your interest at <http://www.nudefoodday.com.au/>

### World Diabetes Day 14 November

World Diabetes Day is celebrated every year on 14 November. The World Diabetes Day campaign is led by the International Diabetes Federation (IDF) and its member associations.

Each year, World Diabetes Day features a new theme chosen by the International Diabetes Federation to address issues facing the global diabetes community. While the themed campaigns last the whole year, the day itself is celebrated on 14 November, the birthday of Frederick Banting who, along with Charles Best, first conceived the idea which led to the discovery of insulin in 1922.

'Diabetes Education and Prevention' is the 2009–2013 theme. Diabetes imposes life-long demands on the 250 million people now living with the disease, and their families. People with diabetes must deliver 95% of their own care, so it is of paramount importance that they receive ongoing, high-quality diabetes education that is tailored to their needs and delivered by skilled health professionals. In addition, IDF estimates that over 300 million people worldwide are at risk of type 2 diabetes.

For more information visit <http://www.worlddiabetesday.org>



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## For more information

**Diabetes Outreach**  
**8 Woodville road, Woodville SA 5011**  
**Telephone: (08) 8222 6775**  
**Fax: (08) 8222 6768**  
**[www.diabetesoutreach.org.au](http://www.diabetesoutreach.org.au)**

Non-English speaking: for information in languages other than English, call the Interpreting and Translating Centre and ask them to call the Department of Health. This service is available at no cost to you, contact (08) 8226 1990.



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