

Final Report Attitude Makes A Difference Project

Prepared by The Atlantic Seniors Health Promotion Network

Funded by Canadian Diabetes Strategy Community-Based
Program, Public Health Agency of Canada

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Attitude Makes a Difference Project

Final Report
February 28, 2008

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Final Report: Attitude Makes a Difference Project

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1.0 Executive Summary

The Atlantic Seniors Health Promotion Network conducted a project in 2007-8 to document the impact of diabetes on seniors, particularly on older single women in rural areas with lower incomes. The attitudes held by these women related to their diagnosis and subsequent experience with the disease and what they thought was needed to help manage its effects were of central concern.

This Report includes a number of parts that come together to give an impression of the situation. It is not meant to be a scientific study as it included only 116 participants in 14 focus groups across the four Provinces that make up Atlantic Canada. The study is instead a method of putting the stories of these seniors into a context of publicly available information. This is done in order to arrive at some conclusions that are based on the experience of a group of people whose problems in dealing with this disease are little recognized, but whose numbers constitute a large and growing proportion of diabetics, both as seniors and as women.

There are 4 major parts of this report:

- A. A literature review
- B. Some interviews with key experts;
- C. Findings from the Focus Groups; and
- D. Some implications for 'Best Practices' in meeting the needs of these people

Dealing with a chronic condition like diabetes, which requires considerable effort to follow a demanding regimen to manage the disease, to cope with increasing expenditures on drugs and equipment, as well as a stringent requirement to 'eat healthy' (read: expensively) constitutes a real challenge to rural women with low incomes. Attitudes, we found, do make a difference between living a good life and living one that is not.

2.0 Introduction

ASHPN submitted a proposal to the Canadian Diabetes Strategy in 2007 to investigate the impact of diabetes on seniors, particularly on older single women in rural areas with lower incomes. The primary focus was on the attitudes held by these women related to their experience with the disease and what they thought was needed to help manage its effects. The Project began in March, 2007 and finished in February, 2008. It was originally managed from PEI, but was moved in the summer of 2007 to Nova Scotia, after the departure of the original Project Manager. Over this period, the Project Team which included the Project Steering Committee with representatives from each of the Atlantic Provinces, a Project Manager and four Provincial Coordinators, worked to address the issues and concerns of older persons with diabetes in our region. The underlying purpose of this project was to include older persons in as active participants in finding ways to address the diabetic epidemic in Canada.

2.1 Project Partners and Acknowledgements

About the Atlantic Seniors Health Promotion Network

The Attitude Makes a Difference Project is sponsored by the Atlantic Seniors Health Promotion Network (ASHPN), which is an Atlantic-wide, network of organizations and individuals who are working together to enhance the quality of life of seniors. The aim of ASHPN is to connect people, organizations and government agencies throughout the Atlantic Provinces who work for and with older adults. ASHPN is devoted to working with all generations and encouraging communication between age groups. As an agent of support and change, ASHPN uses strategies of community development, research, education and advocacy to further programs, services and policies on behalf of older persons.

About Community Links Nova Scotia

The Attitude Makes a Difference Project is administered by Community Links Nova Scotia which is a provincial voluntary organization with a membership of 190 mainly senior and senior serving organizations. It works to promote healthy communities and to improve the quality of life for seniors and others in rural Nova Scotia through community development and volunteer action.

About the ASHPN Steering Committee

The ASHPN Project Steering Committee is made up of representatives from each of the Atlantic Provinces and is chaired by Sandra Murphy, Executive Director of Community Links. The responsibilities of this committee included providing

overall direction and support to the Attitude Makes a Difference Project, reviewing work plans, project activities and materials and overseeing the project finances.

Acknowledgements

ASHPN would like to thank the Public Health Agency of Canada (PHAC) who funded the project through the Canadian Diabetes Strategy: Community-Based Program Funding and with special thanks to Dawn Shepherd, Program Consultant with PHAC, who supported us in this project.

ASHPN is extremely grateful for the support we received from seniors and service providers throughout Atlantic Canada. Whether it was as a member of a Provincial Advisory Committee or as a member of a community group that helped with one of the many diabetes focus groups, as a professional providing expertise or as one of the many seniors who participated in the focus groups and acted as evaluators and editors of our activities and materials, we truly needed you! It was a team effort that reflects the approach that we take in our region to getting things done.

2.2.0 Rationale for Target Group Selection

Atlantic Canada has largest percentage of persons over 65

According to the 2006 Census, Atlantic Canada continues to have the largest proportion of population over 65 in Canada. In Canada, persons over 65 made up 13.7% of the total population and the population of persons under 15 fell to 17.7%, the lowest level ever. Nova Scotia had the largest number of seniors, 138,196 over 65, (15.1%). Newfoundland and Labrador has 78,235 over 65 (13.9%), Prince Edward Island has 20,165 (14.5%) and New Brunswick has 107,655 over 65 (14.7%). There is a total of 344,340 persons over 65 in Atlantic Canada.

Atlantic Canada has the largest percentage of persons with diabetes

Seniors in Atlantic Canada are particularly vulnerable concerning risk factors for pre-diabetes. Statistics Canada figures indicate the percentage of persons with diabetes is greater in the Atlantic provinces than in any other area of Canada, 6.8% in NL, 6.3% in PEI, 6.7% in NS and 6.0% in NB (the Canadian average is 4.9%). These percentages include the entire population. The percentages are much higher for persons over 65; for example 19.7% of persons in NL over 65 have diabetes¹. There are 129,000 persons over 65 who have been diagnosed as diabetics in the Atlantic Region and there may be as many as one in three more persons over 65 who have diabetes and who do not know it.

Atlantic Canada has the highest percentage of persons with low income

Older persons in the region are also more likely to have low incomes, and live alone, with the majority of these being female. More seniors in Atlantic Canada receive the Guaranteed Income Supplement (GIS) than in any of the other Canadian Provinces (66% in Newfoundland and Labrador, 50% in PEI, 45% in Nova Scotia and 51% in New Brunswick). Most of the persons receiving the GIS are female. It is estimated that over half of the unattached females in the Atlantic Canada live in poverty.² With an aging population growing faster than any other part of Canada, these statistics will continue to grow.³

Many older single women in Atlantic Canada living below the poverty line

Although poverty rates for seniors have improved over the last decade, many older single women in Canada remain poor. Forty-one per cent in 2003 lived below the poverty line⁴ Older single women in the Atlantic area who live in rural communities may be a population at highest risk. Therefore we chose to focus our project on this group.

Generally research and policy uses the GIS as an indication of poverty and eligibility for many government programs cite receiving the GIS. Yet, only including persons who receive all or partial GIS as an indication of low income is misleading, because many others live on near poverty level incomes. They are what Katherine Newman calls the 'near poor' in her [The Missing Class: Portraits of the Poor in America](#).⁵ They earn just enough so they do not qualify for the GIS, but not enough to make ends meet, especially if they are on a fixed income, live in isolated communities and have a chronic disease like diabetes, which is costly to treat effectively.

In summary, statistics and research can give us the general risk factors for diabetes, but many older persons are at risk simply because they are aging. According to research, "The prevalence of diabetes increases dramatically with age and peaks in the 65-75 age groups".⁶ Being old puts seniors in a unique group because many of the determinants that increase the risk for this disease, such as low income, chronic disease, low literacy rates, social and geographical isolation, and physical or mental disability, have an impact on them. When these factors are combined, as they are with many older adults, the risk increases significantly.

There are also factors in the older population that affect their access to information and to programs concerning the prevention and treatment of this disease, such as cultural and ethnic differences and low levels of literacy. Interesting new research indicates that older women may be at greater risk for death from diabetes than older men.⁷

2.3 Objectives

The objectives for this project were:

- 1) To understand how those with pre-diabetes and type 2 diabetes feel about their disease
- 2) To identify the best practices in diabetes prevention and treatment among seniors, including practices which focus on attitudes towards the disease; and
- 3) To identify key actions needed to enhance prevention, treatment and support.

3.0 Literature Review

The literature review focuses on:

- 1) The research on the general impact of diabetes on the lives of older persons
- 2) Attitudes towards diabetes by those who have the disease,
- 3) Information and Education program,
- 4) Support programs for seniors, and
- 5) Best practices research on seniors and diabetes.

3.1 The Impact of Diabetes on Older Persons

Although the primary focus of the project was not on the impact of diabetes on older persons, it was important to scan the literature to get an overall impression of how this disease permeates every part of an older person's life. Statistics indicate that most of those with diabetes are over 40 and that "the prevalence of diabetes increases dramatically with age and peaks in the 65-75 age groups".⁸ The main reason it peaks at this time is that after the age of 75, there are many diabetic-related deaths in this age cohort. There are hundreds of studies describing the devastating affect of diabetes on older persons, but, for the purposes of this project, this research indicates that diabetes puts older persons at great risk for losing their independence. Independence is the one quality that seniors value most highly. Conversely, becoming dependent is their greatest fear. This often means isolation, depending on family or others or having to move into nursing homes. Therefore, losing independence affects not only the seniors but also their families, caregivers and the health care system as a whole.

As a part of the Canadian Diabetes Strategy, a report was presented describing the recommendations for diabetes prevention, care, education research and surveillance in Canada.⁹ Four strategies are presented (p.19) which address the needs of older diabetics: seniors' prevention programs; accessible, affordable transportation; informal and formal care home care for seniors with diabetes, and affordable, safe good-quality, supportive housing.

There is also considerable research on the relationship between the determinants of health and the incidence and management of diabetes. Two studies are selected among the many reviewed. The first study states that low income women may experience a 'disproportionate burden' as diabetics. Many of these women live alone, in isolation and experience stress which may lead to a greater incidence of diabetes and diabetes mortality. Although evidence supports this assumption, "virtually nothing is known about the causes of such increases."¹⁰ The second study proposes that the diabetes management regimen is considered "**among the most demanding regimens of any chronic illness**" and coping with this regimen would be especially difficult for vulnerable populations, such as low-income, older women.¹¹

A major impact on lower-income seniors is a financial one. Diabetes care involves purchasing a variety of drugs and pieces of equipment and other supplies. Recent changes to pharmacare and senior drug subsidy programs in the region mean that seniors on GIS or with low incomes are now covered for some expenses. What is covered is constantly evolving, but what is covered at this writing (early February 2008) is, as best can be made out, as follows:

- In the **Nova Scotia** Seniors Pharmacare Program, seniors on GIS do not have to pay the \$424 annual premium. Seniors who are single and have incomes less than \$24,000 or married and have combined incomes less than \$28,000 pay a restricted premium. All seniors have to pay the dispensing fee and the co-payment of no more than 33% of the total cost of each prescription up to a maximum co-payment of \$382 a year. Seniors can choose between the Seniors Pharmacare Plan and the Family Pharmacare (for which there is no premium, but it covers less drug costs and what it covers is based on income).
- In **Newfoundland and Labrador**, seniors on GIS, single seniors with incomes under \$19,000 or married seniors with combined incomes under \$21,000 have to pay only the dispensing fee. In addition, there is the Assurance Plan for other not covered by these plans. The Assurance Plan puts a cap on the maximum amount that a person would be required to spend on prescription drug costs.
- The **New Brunswick** Prescription Drug Program – Seniors (Plan A) seniors on GIS and single persons with an income of \$17,198 or

married seniors with combined incomes of \$26,955. Those on GIS required to pay only a co-payment of \$9.05 per prescription up to a maximum of \$250 in one year. Those who qualify based on income are required to pay a co-payment of \$15.00 with no yearly maximum.

- The **PEI** Seniors' Drug Cost Assistance Program includes all persons eligible for PEI Medicare over 65 and the fee for each senior, regardless of income is the first \$11.00 of any prescription and the dispensing fee with no maximum.

Research on the future of pharmacare programs for seniors is quite unsettling. Most of it questions whether the provincial pharmacare programs for seniors are sustainable, especially as the baby boomers begin to turn 65 in 2011. These studies came out before the recent pharmacare programs for families and diabetics in NS and the seniors' subsidies came into place in NL and NB. The choices, the studies seem to say, are either increasing the premiums or co-pays, restricting equity of access or abandonment of pharmacare plans altogether.¹² This project did not allow time to cover every issue related to factors affecting the impact of diabetes on seniors, but all indications are that the cost of managing an accessible pharmacare/subsidy plan for seniors in our provinces will continue to be a huge challenge. The eventual outcomes will have enormous implications for older diabetics.

3.2 Attitudes Toward Diabetes

Research on 'attitudes' indicates this is a difficult subject to 'quantify', but several studies attempt to do so. Many studies are focused on the attitude of health professionals dealing with diabetics. Two examples of studies that focused on 'patients' include one from the University of Michigan and one from Uppsala University in Sweden. A study of 1202 persons with diabetes in Michigan measured diabetes related attitudes of both health care professionals and patients¹³.

An editorial in Diabetes Care¹⁴ by the authors of the University of Michigan survey describe the limitations of a questionnaire in which the patients can only answer 'agree' or 'disagree' or put an 'x' on a scale of 1 to 5. They found out, through feedback from their patient respondents and from data analysis, that the information provided in the survey was inadequate or could be misleading. They wrote, "We realize that what we gained in terms of data reduction, analysis and generalizations for our quantitative studies, we paid for in the loss of understanding". They go on to say they are now using focus group studies to find out what the patients experience living with diabetes, in their own words.

They also state that this experience has taught them that the development of programs and interventions to enhance diabetes care will have to depend more on collaboration between care providers, diabetes experts and patients themselves.

In Sweden, fifty diabetic patients completed an attitude questionnaire. The findings indicated that male patients had a more positive attitude towards diabetes than females. Those who had diabetes less than 10 years were more positive than those who had it for longer. Those with higher education levels and who did frequent blood testing and achieved a good metabolic control surprisingly were all associated with a more negative attitude towards diabetes. A group of nurses who also completed the test had a more negative attitude toward diabetes than did the patient group.¹⁵

A Canadian study on healthy aging found positive attitudes were directly related to 'finding life meaningful, manageable and comprehensible'.¹⁶

3.3 Information and Education for Seniors with Diabetes

At a "**Seniors and Diabetes: Healthy Aging Workshop**" held in Ottawa in 2001, seniors and professionals developed strategies for senior specific education, enabling environments, best practices and research.¹⁷ Some of the suggestions for education included;

- 1) Human-interest stories on living with diabetes" by and for seniors,
- 2) Tailor "early warning signs" and make them more visible to seniors and
- 3) Develop a training manual for seniors and diabetes education.

The strategies for best practices included:

- 1) Establish support/self-help groups for seniors with diabetes and caregivers and
- 2) Set up a referral program for physicians to use (for the support groups in their areas).

There is significant amount of research on the effectiveness of diabetes education, most of which presents evidence that "The diabetes education provided by Certified Diabetes Educators helped patients adopt the healthier lifestyle behaviors needed to control their diabetes and to reduce their A1C levels¹⁸.

There are many studies describing the importance of addressing diabetics' concerns and fears and providing them with emotional support¹⁹. Most of these articles are for physicians and suggest how important it is to find out about the

patient's emotional state. Asking questions, such as "How do you feel" and the importance of listening empathetically, are seen as being as critical to outcomes as bloods tests and medications. Patient education cannot be left to the physician alone because physicians are not adequately reimbursed for their time in this regard and they may not have adequate knowledge of how to treat the disease.

Research also cautions that providing education, whether it is by the physician or diabetes educator, cannot assure that diabetics will have accurate knowledge or recall of their medications and that 'self-reported' understanding of diabetes management is not helpful in 'predicting the likelihood of making a medication-recall error. Therefore, on-going education from many different sources is essential, including education and electronic monitoring through the internet.²⁰

Journals and newsletters in Atlantic Canada provide information for professionals, but are also useful in discovering the work that is done for older diabetics in our provinces. In Diabetes Care in Nova Scotia, a newsletter of the Diabetes Care Program of Nova Scotia, there are several articles on programs for seniors, such as a project for 'Developing a Healthy Living Program for Seniors' which includes exploring the perceptions of what 'healthy eating' means to seniors and discovering ways to encourage seniors to participate in a healthy living program.²¹

Many studies suggested the key to success for a healthy life for diabetics is information and education. An internet search came up with thousands of articles and websites devoted to educating and informing diabetics. The Canadian Diabetic Association Website, with links to Atlantic Provinces websites, provides up to date information and resources for Canadians. It has links to reports, recipes, events and research. The CDA also has programs for delivering diabetes education, such as the 'Signature Program, which trains volunteers to make presentations on diabetes to community groups.

In addition to websites by professionals, there are many websites authors who are laypersons and diabetics. For example the www.diabetespeersupport.com site is the responsibility of a Nova Scotian senior who provides information and promotes peer support. The most famous lay person to develop a website for diabetics is David Mendosa, www.mendosa.com which contains up to date information, is supported by the American Diabetes Association, and also 'blogs' and chat rooms. These sites are examples of the power of one person to make a difference.

There are several websites devoted to helping improve the psychosocial support for persons with diabetes, such as “DAWN”, which was designed by Novo Nordisk, a pharmaceutical company, to help diabetics around the world “increase the understanding of how people perceived their diabetes in order to develop better outcomes for treatment. www.dawnstudy.com

One of the fastest growing educational strategies is the chronic disease self-management model such as the ‘Stanford Self-Management Program’ recently implemented in several of Atlantic Provinces or the Model developed by Dr. Ed Wagner²² and implemented in the NB Department of Health Chronic Disease Management Program The Arthritis Self-Management Program has successfully used these models and it has been suggested that it can also be effective for other chronic diseases such as diabetes. The Stanford Self-Management Program involves small group workshops, given for two hours once a week, over a six-week period. Although research on this model was reviewed and key experts discussed this model’s advantages and disadvantages, this report does not have the time and space to examine this as an educational strategy for diabetics. These models were not identified by the participants in the focus groups, but were described by some of the diabetes professionals as a strategy that was being used or considered in their provinces.

Research comparing the effectiveness of self-management (individual) education to group education suggests it is difficult to evaluate which approach achieves the most positive outcome in the long run²³. Information provided by the participants in the focus groups and interviews with key experts suggest it is important to incorporate as many learning opportunities as possible over the longest period of time possible.

3.4 Research on Diabetes Support Groups

There are many studies in academic and popular literature which describe the importance of support groups for persons who are trying to make changes in their lives so that they can manage chronic diseases or conditions. Many studies describe the positive impact of peer support in Alcoholics Anonymous²⁴ and the success of Weight Watchers for those trying to lose weight and eat healthy. Studies of older persons with diabetes and with depression suggest that peer support can be helpful for both²⁵.

Researchers in Dublin conducting a pilot study of the effectiveness of peer support groups and the protocol needed to study these groups was presented in a recent article that was published on-line. The study compared diabetes self

management with a support group approach and proposes that the latter would be more effective in changing behavior and improving metabolic control. The “potential advantage of peer support is that it focuses on the impact of the illness on daily life rather than on medical information about illness”. The authors suggest that “Peer support is a complex intervention and evaluating such an intervention presents challenges to researchers.”²⁶

Many articles in magazines and self-help books describe how those who share similar life experiences can work together to affect positive change. For example in ‘The Willpower Myth’²⁷ the author describes how relationships, either on a one to one basis or in a group, are the only successful way for persons to effect changes in their attitudes. That is, the “only way to get unstuck [in trying to change a negative attitude] is not through will power, but through a relationship with a person or a group who shows them the way. ‘If she can do it, I can do it too.’ This article and several others indicate that support groups are very helpful for persons trying to have a more positive attitude towards a condition. She gives the example of Dr. Ornish’s Program for heart attack survivors. His program had far more success than any other programs studied in changing behaviours and attitudes because it was based on a combination of support groups and education sessions.

Recent research on the impact of ‘internet support groups’ has looked at internet discussion groups can be used as a ‘useful strategy for engaging patients with chronic disease for emotional and information exchange’²⁸

An internet search found hundreds of sites describing diabetes support groups throughout Canada, including support groups for seniors and their families. Research indicates that support groups do indeed help diabetics. The Self-Help Resource Association of BC presents ‘stories of change’ that were made possible through the power of peer support.²⁹ Canadian Pensioners Concerned conducted a national project in 2004 to develop a tool kit to use in preparing for a seniors diabetes support group.

Finally, lengthy interviews were carried out for this project with ‘facilitators’ of diabetes support groups in Nova Scotia and Newfoundland and Labrador.³⁰ There were differences in each of the groups. One was facilitated by a Certified Diabetes Educator, a pharmacist who is diabetic and senior with diabetes who provides countless hours making the calls and using her home for the meetings. Others were facilitated by lay persons who were diabetic but had the support of diabetes educators. The reasons why some groups thrived and others were not able to sustain their membership were very interesting. This is a complicated topic and should be investigated in future projects on seniors and diabetes.

3.5 Research on Best Practices

The Canadian Diabetes Association's three existing 'Report Cards' on diabetes in Canada present 'best practices' in each province and also the challenges the provinces and the Federal government face in the prevention, treatment and care of diabetes.³¹ In 2001, 2003 and 2005, NS received high marks for diabetes prevention, care, education and surveillance through its Diabetes Care Program, which is the only standardized diabetes program in Canada. New Brunswick received a 'best practice' notice for its active partnership in the Canadian Diabetes Strategy Initiatives and the National Surveillance system, but had no formal diabetes policy or strategy, no promotion of diabetes standards and guidelines, no diabetes specific policies or initiatives created by the Ministry. All four Atlantic Provinces received CDA notations for their involvement in self-management strategies.

Although 'best practice' has been a concept used in medical research, it is difficult to use it with any consistency in other areas of research where many factors come together to affect outcomes. It has been suggested that such examples should be called 'best processes'.

4.0 Interviews with Key Experts

Interviews with professionals involved in diabetes care and education in the Atlantic Provinces provided answers to many questions concerning programs and services for seniors in our region. The information is multi-dimensional and reflects the diversity of approaches taken and emphases placed on dealing with this complicated topic. Interviewees are not identified.

Nova Scotia has the first and, as of this writing, still the only coordinated diabetes care programs in Canada. The Diabetes Care Program (DCPNS) implemented in 1991, provides a coordinated approach to diabetes education, care and on-going support to persons with diabetes. "This program promotes improved standards of care for people with diabetes, improved continuing education access for diabetes staff and the collection and analysis of information related to diabetes and diabetes education in Nova Scotia". Through its 39 sites, diabetes education is provided by (mostly) Certified Diabetes Educators, such as nurses, dietitians and pharmacists. It also continues to develop guidelines and patient education modules, as well as working on programs such as 'Pre-diabetes Management and Education Centres' and exercise programs in Diabetes Centres.

The Diabetes Program of Prince Edward Island, with dedicated provincial staff, provides educational programs for diabetics and those at risk for developing diabetes. 'At Risk Classes' are designed to promote healthy living and reduce risk factors for developing diabetes. 'Getting Started' are classes of three hours for those who are newly-diagnosed 'Living Well with Diabetes' offers a series of 12 modules on a variety of topics delivered over five mornings for those living with diabetes. 'Drop-in Glucose Testing' is available to the general public one afternoon a month in Charlottetown, www.peidiabetics.pe.ca.

In NL, there are diabetes educators through out the province, though it is difficult to ascertain the exact numbers. The Central Regional Integrated Authority has a diabetes referral website which provides information on diabetes and how to contact diabetes educators.³² Diabetes educators are also listed in the Western Health Region.

Initiatives that promote healthy living in NL were announced in Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador: Phase I (2005-2006). These initiatives include a Provincial Diabetes Strategy. Discussions with key experts in NL emphasized the cost of diabetes, since, at the time NL had the highest personal costs for diabetics and they were heartened to see that, under new changes, more low income seniors will be eligible for coverage (The 65 Plus Plan) and they are also hopeful that NL will increase access to diabetes medications. As with the other Atlantic Provinces, NL seems to becoming involved in the 'Chronic Disease Self-Management Strategy' and diabetes would be one of the diseases included in this strategy.³³

Some publications by the Government of NL are, Healthy Aging for All in the 21st Century (2006) by the Department of Health and Community Services, which presents demographic data giving a portrait of a province with a rapidly aging society and "Provincial Healthy Aging: Policy Framework" (2007), which presents the policies and programs that the province will implement over five years. Although no program focuses specifically on diabetes, it is identified as the third most common chronic condition in the population, but no policies or programs focus specifically on this disease, although many of the other aging related policies and programs will have an impact on diabetes management.

In New Brunswick, there are currently 120 members of the Diabetes Educator sector of the Canadian Diabetes Association. At least 25 diabetes educators are in each of the 7 Health Regions in the Province with 40-45 in the northern regions. The first conference of diabetes educators is planned for April, 2008 where they will work to organize a diabetes education and care program for the province.

Dr. Angela Mc Gibbon's study on diabetes care in New Brunswick is available in a webcast designed for health care professionals' continuing medical education.³⁴ In four 15-minute webcasts, Dr. McGibbon describes the strengths and weaknesses of the diabetes care program in NB. One of the strengths is the new Joslin Diabetes Centre in Bathurst, the first Canadian affiliate of the famous Joslin Diabetes Centre in Massachusetts, is that patients they serve will be 'in touch with the latest clinical trends and research breakthroughs'. Dr. McGibbon said that the NB diabetes care program was not organized to allow an overall understanding of how the system worked and that the province needs a 'Diabetes Strategy' to promote a standardized system of diabetes care. Dr. McGibbon, with the assistance of the CDA, launched a NB website "Diabetes Care Map of New Brunswick" in 2008. It is a multi-media database which provides information on diabetic resources in the province (www.caremapnb.ca) Provincial contacts in NB also suggested accessing the "Diabetes in New Brunswick" study (New Brunswick Health and Wellness, 2005) which presents data on the prevalence of diabetes in NB.

Discussions with persons working for the CDA in the region confirm the public perception that the key mandate of the CDA is to provide education and information for diabetics. Printed and electronic materials in the CDA office and the wealth of information on the CDA National and Provincial Websites (www.diabetes.ca) reflect this mandate. One of the main problems that results from being so successful in providing information and education is that a great deal of demand is put on CDA diabetes educators. Volunteers are trained, through the CDA Signature Program, to deliver educational sessions, but even with the help of volunteers, it is difficult for the CDA to provide the community education that is needed or requested. It appears, from talking with CDA contacts throughout the region, that many of their programs continue to be popular, particularly the Diabetes Expos. In 2008 there will be 'Live Smart with Diabetes' Expos in St. John's (April 26), Charlottetown (May 2) and Cornwallis, NS (May 24).

The CDA has also been involved in diabetes support groups, as witnessed by the many support groups described on various CDA sites across the country. In 2003, the CDA came out with Peer Support Group Guidelines which provide the directions that must be followed if a support group wishes to have the backing of the CDA.³⁵ The guidelines include the fact that "the peer facilitator must take the Association's facilitator training program and sign a letter of understanding. The facilitator will not be paid and will be subject ongoing evaluation, among other requirements. There are also guidelines for the content and structure of the support group and various forms that must be used as resources, such as a code of conduct policy, a standard of care policy, a participant letter of understanding and evaluation tools.

Communication with various CDA branches across Canada indicated that in some cases the guidelines are used, in some cases they are used with flexibility and in others they are not used. The guidelines reflect the complexity involved in starting and sustaining support groups for diabetics. Diabetics constitute a group that requires accurate, up to date information and would be greatly helped by persons with diabetes expertise. Reliable, accurate information is a concern, but there is a question whether this concern should take such precedence that it results in discouraging the formation of support groups. Managing diabetes is enough of a challenge without putting up well-intentioned barriers between those who are trying to inform diabetics and those who can provide local support for those with the disease.

5.0 ‘Attitude Makes a Difference’ Focus Groups

In each Atlantic province, a Coordinator was engaged to work with the Project Manager, the Project Steering Committee and their Provincial Advisory Committee to organize a representative number of focus groups in French and English. The Project Manager developed a guide (*Attitude Makes a Difference Focus Group Guide*, French and English versions) to be used by the Provincial Coordinators in the focus groups. A total of 14 sessions were held, including 3 in French and one in Labrador.

The intent was to recruit participants from a specific target group, that is older women with diabetes, living alone in rural areas and who had low incomes.³⁶ For the most part we were successful in reaching this population. Fourteen focus groups that included 116 participants were held in the fall of 2007. The focus groups were moderated by the Provincial Coordinators. Each session was recorded and topics were prepared following the questions in the Focus Group Guide as a framework. The Project Steering Committee and the four Provincial Advisory Committees, along with the Provincial Coordinators, worked with community and provincial groups to gather information, plan for the recruitment and facilitation of the focus groups, review the project materials and maintain an exchange of information and ideas between the project team and those working with us in the provinces and rural communities.

5.1 Portrait of the Target Group

The rationale for selecting a target group of older, unattached women with diabetes/pre-diabetes who in rural areas in Atlantic Canada and had low incomes was presented in Section 2.1 above.

Over a period of two months 116 participants were recruited across the region, most of these participants were over 65 (84), female (105), diabetic (104) and came from rural areas (104). The majority had low incomes (63 received the GIS and 12 had incomes below \$15,000).³⁷ More of the participants shared their homes with others, usually spouses or children (74), than lived alone (42).

5.2 Findings of Focus Groups

The following sections provide a summary of the answers given by participants to questions in the Attitude Makes a Difference Focus Group Guide.³⁸

5.2.1 When and How Diagnosed

Most of the seniors in the focus groups were diagnosed by a test that their family doctor ordered. Some were diagnosed after a visit to the hospital because they were very ill, as a result of medications given after dialysis, or after taking a 'blood sugar test' in a store. Others received 'informal diagnoses' by pharmacists, optometrists and in foot clinics. One senior went to breakfast at Zellers and decided to get her blood tested first, her reading was 28. [a blood glucose reading of 7 or greater, with fasting for eight hours, indicates diabetes. A test done at any time, regardless of when you ate, of 11 or greater indicates diabetes].

Most had been diabetics for over 5 years and several over 15 years. Most had symptoms when diagnosed, such as significant weight loss, feeling very tired, thirsty and having to urinate frequently. Several had no symptoms at all.

5.2.2 Reaction to Diagnosis

The question concerning their reactions to diagnosis focused on the 'feelings' the participants had when they were diagnosed. This reflects the overall purpose of this project to understand the feelings that seniors themselves had about diabetes. We defined the word 'attitude' used in the title of the project as, "**an outlook, personal view, an opinion or a general feeling about something**". Participants talked a lot about their feelings in the focus groups.

Most said they were ‘**scared**’ but not surprised. They were aware of diabetes and they knew about the symptoms because other family members had had the disease. Some said they lived with a fear that they would get diabetes. One who was five when her mother had died of diabetes said she was aware of the ‘threat’ of diabetes all her life.

In those who were surprised or did not expect the diagnosis, reaction ranged from relief and acceptance to shock, fear, anger and denial.

Relief and acceptance: Those who were relieved said it was because the diagnosis was not cancer or another disease. “Well, there could be worse things; you know you can live with it.” Some said they now knew why they had not felt that well and knew they had to accept it. One senior was relieved because she knew all along her doctor was not giving her a ‘true’ diagnosis. The doctor told her to ‘start watching what you eat’ but offered no details. When she switched doctors and was ordered to go to blood tests, the doctor called her back saying she was, and had been, diabetic. She was given a diet plan and began to walk for exercise. Many of those who said they ‘accepted’ the diagnosis from the start said it was because they were ‘used to’ the disease because they had been around a husband, mother, father or other relative who had it.

For some the diagnosis did not bother them that much, usually because they were expecting it because of family members that had it. Some felt that it was a part of growing older, accepting diseases as they came along and said ‘You do the best you can.’”

While those having family members with diabetes might not have been surprised when they received their diagnoses, their reactions (positive or negative) depended on the experience with diabetes they had had first hand with family members. Those whose family members were able to cope with the disease and ‘went on with their lives’ seemed to be more accepting of their diagnoses. For those whose family members had had difficulties, there was more fear and anxiety. “I wasn’t surprised because my mother and father had it. I had to give mother a needle. I had a fear of following in her footsteps [going on insulin] and have a massive heart attack like she had.”

For those who were not surprised by the diagnosis, there was also a range in their reactions from resignation and inevitability to depression, fear and feelings of failure. Most expected the diagnosis, either because they were having symptoms or because they had close family members, especially fathers or mothers, who were diabetic and so they both knew the symptoms and also in many ways expected to have it sooner or later. They also knew that the symptoms they were having, especially thirst and going to the bathroom could mean they were diabetic, but many did not realize that rapid weight loss was a

symptom or did they recognize symptoms such as problems with their eyes, feet or nerves in legs and arms.

Surprise, shock, anger, fear and denial: For those who were shocked, it was mainly because they were not expecting the diagnosis. The diagnosis came as a result of what they thought was routine blood work. Most of these seniors either had no symptoms or had symptoms, but did not realize they indicated diabetes. One did not know that 'thirst' was a sign and kept drinking orange juice. "I wasn't really expecting it. "I was just shocked", "I had no warning."

Denial was a common reaction from most participants, whether they were surprised by the diagnosis or expected it. Even if they expected the 'worst' they tried not to think about it. "I was in denial when I found out. I was stressed. I was afraid of the unknown. I was in denial for quite some time [after]." Several acknowledge they had been in denial from the time they were diagnosed, "I was diagnosed in 1999 and have been in denial ever since."

Fear was another common reaction. "I was scared, but there was nothing I could do about it." "I didn't know if I was going to die or not". "I nearly fainted. It was so far from my mind.", "When he [doctor] told me, I could have screamed...because it really hits you." and "I cried for a week." were common reactions of those who were told they were diabetic. The diagnosis was especially difficult for those who had seen the impact of diabetes on close friends or family members. "I had a fear for it, a real fear for it because of my brother." "It was traumatic for me. I had known of only one person with diabetes and he had died from it."

Anger and disbelief was expressed by several participants as their first reaction. They thought they had been well and living a healthy lifestyle, "It has to be a mistake. I eat well, a heart healthy diet." "I could not believe it. I did not tell anyone for a while." Similar to reaction to other diseases, these seniors said "Why Me?" "I cried for a week. It was very devastating – my whole life changed." "I had to deal with needles. It was nearly as bad as cancer (I had that too)."

The majority of seniors were put on medication at first and a few were put on insulin. There was a definite fear of 'getting on the needle'; although many who were on insulin said they felt much better once they were on it.

5.2.3 Getting Help and Information

We asked the participants if they were provided help and information and who had provided it. Most responded that they had received information when they were diagnosed. Three main sources were the family physician, a diabetes

educator and/or their pharmacist. Most had received the diagnosis from the family physician and he/she then referred them to diabetes educators (nurses, dietitians, nutritionists, certified diabetes educators). Each province has a different system, but all have diabetes educators.

Physician: There was a mixed response concerning of the role of the family physician in providing information and support. Some felt their family physician was ‘an absolute wonderful doctor who has tried hard and never given up on me, tries to make me listen and [helps her] to manage my diabetes’. Seniors described ways in which the family doctor would encourage and even ‘kept after me’ until they went to the diabetic clinic. Others felt their doctor was of little help, either because he/she did not have enough knowledge of the disease, especially when combined with the other diseases of the older person, or did not have the time for discussion and education. Most felt their doctors would do more if they could, but as ‘gatekeepers’ for this disease, a lot is expected of them. In addition, Atlantic Canada is experiencing the effect of doctor shortages and high turn over rates, especially in rural areas.

Diabetes Educator: Almost all the participants described the help and information provided by the ‘diabetes educator’ (dietitian, nurse, public health nurse). Some had to go on waiting lists and had to wait ‘a long, long time’.³⁹ In Labrador, participants had to go to St. Anthony on the Island of Newfoundland to see the doctor and to go to the diabetic clinic. Some had to wait up to three months for an appointment before making this trip. In most in rural areas, newly-diagnosed diabetics were able to see a diabetes educator within a few weeks of diagnosis. For those who had to wait, most received information from their physicians, pharmacists, others with diabetes, or from the internet and books and articles on diabetes. In Halifax, at the time this report was prepared, the waiting time to see a diabetes educator is almost a whole year.

Information and help from diabetes educators varied from province to province (described in ‘Best Practices’ below), but all provinces have some program for delivering diabetes education through dietitians and/or nurses in hospitals/diabetic clinics in hospitals or in health centres. Participants were extremely positive about the help and support provided by the diabetes educators once they were able to see them. Besides waiting lists, there were other problems accessing this service. In some areas access requires a long drive or, in the case of Labrador, a ferry ride to the Island. This is expensive unless there is an affordable bus service from rural areas to cities where a hospital’s diabetic clinic might be located.

In some communities, mostly in NS where the ‘Diabetes Care Program’ with its 37 locations throughout the province, diabetes educators can provide information and support to seniors in their communities or in nearby communities.

Diabetes Support Groups: In NL and NS, several seniors belonged or had belonged to Diabetes Support Groups and found the information and support provided by these groups very helpful. Most groups were facilitated by either a lay person or by a health care professional with expertise in diabetes. In all cases, information was provided by health care professionals. In all but one focus group, if they were not members of one already, participants said that they would like to have a support group in their community.

Others: Pharmacists: Pharmacists were described as being very helpful by several seniors. **Information Sessions in Grocery Stores:** A few seniors described the information sessions in the local grocery store as being helpful, especially the tour of the store showing how to choose healthy foods and read labels. **Hospital social worker:** A few seniors who were in hospital either as a result of diabetes or for other medical reasons, were provided information by the hospital social worker which helped them while they waited to see the diabetes educator/dietitian. **Training:** It was interesting to see that in NB, seniors described the information and help they received from diabetes educators as 'training', a term which seems to be a very appropriate word for this type of education experience related to a chronic disease. **Language:** The issue of language was discussed in the French focus groups and most seniors said it was helpful to have information provided in French, but "even if they spoke my language, sometimes I did not understand" and "the brochures were not very useful. It is written too small and is too complicated. We do not understand half of what is written". It was suggested that some words do not translate well, e.g., medical or technical words, and that they should be kept in English. The ability to access information in the language of one's choice is part of a much larger issue, both for francophones and for immigrant communities.

In one focus group, seniors did not seem to be conscious of the consequences of not making changes in their lifestyles. They did not seem to be aware of complications such as blindness and the fact that not testing as required would put their lives in jeopardy.

5.2.4 Changes in Attitude Since Diagnosis

While some participants said their attitude had not changed since they were diagnosed, most had experienced changes, both positive and negative.

Negative changes: Some felt it was still a 'pain' and never gets easier to deal with' and many had days when they 'felt like giving up'. The hardest part is that they are trying to cope with a chronic disease, it is always there lurking and waiting for you to 'do something wrong'. Most accepted the fact that 'living with

diabetes is a constant struggle' and many had times when they wanted to give up "Sometimes I feel like I don't care anymore. I took it seriously at first, now I feel defeated". Because many had other health problems for which they took medication, taking one more pill and having to follow a diet and exercise program was an added burden. Yet even if "it never gets any easier" and "it's very tiring" most felt they were able to cope with diabetes.

Positive changes: They took it more seriously and were less worried and more comfortable with it than in the beginning. Many said they were or were trying to accept it and deal with the 'whole new lifestyle.' Others said were not as afraid as they were at first because they now knew what they could do and what they could not do. Their main problem was that they were also more aware of what could go wrong.

Several even said that living a diabetes lifestyle was good for you and can help you to feel better as you get older. Changing attitudes towards small things in daily life was described, such as learning to see the importance of treating yourself right, choosing the best food you can afford, setting the table for yourself even if you live alone, taking yourself for a walk.

Negative changes: Balancing a positive attitude (I know what I can do and what I can do is to have a healthy way to live) with negative feelings was a daily challenge. Negative feelings were 'caused' by knowing all the things that could go wrong. Experiences of witnessing family members affected by diabetes (amputations, blindness, death) and messages in the media and in doctors offices created fear and anxiety.

In one focus group all the participants said their attitude had not changed at all. "It's just another disease I have to deal with". Nothing really changed. It hasn't stopped me from doing what I want. The moderator observed, "there was a consensus that they are dealing with the disease the best way they know how without letting it control their lives (not necessarily in a positive way). I worried if it has not changed their attitude, are they making the necessary lifestyle changes that are required."

For those who said their attitude had not changed, some said it was because they were already living a 'diabetes lifestyle' e.g. healthy eating and exercise, so they did not change. Others who said they had not changed seemed to be in denial, "Me, I didn't change anything. In my head I don't believe I have diabetes."

5.2.5 Changes in day to day life

Although some seniors said they had experienced no changes in their day to day life, most described ways in which their lives had changed significantly.

Lifestyle (weight management, nutrition, exercise meal planning: With few exceptions all had made changes in what they ate and how they exercised. The perceived (or experienced) progressive nature of diabetes, that it usually gets worse and results in complications, was the most difficult part to deal with. “I feel like I have been dieting for 33 years and I am fed up. It’s really hard living with diabetes. I’ve had so many health problems because of it. It’s not easy coping with the diet and the complications and the financial stress, because it’s expensive living with diabetes.” Constantly keeping track of sugars and the other ways in which diabetics need to monitor their lives resulted in depression for many.

Social life (meals with family friends, parties, etc)

Many described ways in which their attitude towards food had changed. Whether it was the challenge of finding healthy foods, reading labels, eating out in restaurants, eating with family and friends or other social situations, food was central to their lives and had to be seen in new ways which was difficult for many.

Change in cost of living (cost of medication, supplies, food, transportation:

In addition to the cost of supplies, such as testing strips, and the cost of drug plans or cost of drugs if you had no drug plan, there are also additional costs for a diabetic, such as the additional cost of fresh foods and healthy grains, where available, transportation, eye glasses, dental care and heating your home in order to stay warm.

5.2.6 Reasons for Changes in Attitude

Fear or awareness of complications: Fear of losing limbs, eyesight, falling into a coma while asleep or driving the car, heart attacks, strokes, and many other complications from diabetes was a motivating factor in change in lifestyle (diet, exercise, dealing with stress).

Awareness of complications: As one focus group moderator put it, “It seemed that it was only after the damage was done that they really became aware of the consequences of not taking the proper dosage of medication. Often the cost of

the strips was cited as the reason for this.” Once they experienced these consequences, they began to take their diabetes more seriously.

Fear of going on insulin: In several focus groups, those on medication said their biggest fear was ‘going on the needle’. Many of these seniors had experience either giving a needle to a parent or seeing others given needles and were very anxious each time they had their blood check by their doctor that they would be told they had to go on insulin.

Education: Many participants said that the education provided by dietitians and nurses was a great motivator for change. Education helped them ‘accept’ their diabetes and taught them how to cope with their feelings and to manage the many aspects of their lives as diabetics, when and what to eat and in what combination, what kinds of exercise options are appropriate for them, taking medications, knowing how and when to test their blood levels, understanding the blood levels, accessing information on pharmacare or other seniors subsidy programs for medications, etc.

Support of Others: The support of family and friends, especially those who were diabetics, was very helpful, especially in social situations. When families and friends understood their ‘diets’ in social gatherings, it made it easier to enjoy themselves and continue to live a ‘normal’ social life. Those who were members of ***Diabetic Peer Support Groups*** said that these groups were the main reason they were able to make necessary changes and have a more positive attitude towards their condition. Exchanging ideas and sharing experiences made the ‘feel better’, ‘not alone’, ‘less depressed’ and in general led to a greater sense of well being.

5.2.7 Concerns

Impact on physical health-fear of complications: Over and over again, seniors said they were worried ‘it will get worse’. They were worried about losing their eyesight, having limbs amputated, having a heart attack, having to go on kidney dialysis or going into a coma. Many were worried about having to go onto insulin or that both drugs and insulin would not be enough.

Impact on mental health: Several seniors said either in the focus group or in discussion with the moderator, they were worried about being depressed or about the depression of a spouse or child who also might have diabetes.

Impact on social life: Complications from diabetes could affect independence and ability to have a social life. Since food is an integral part of many social

activities, seniors worried how they were going to handle the 'food situation' at these times. Some said they no longer went to parties or to homes where they knew there would be food they could not eat.

Getting information needed to cope with disease: In addition to accessing information or answers to questions, participants were also concerned about how to deal with new information on diabetes medications, ones taken off the market and ones that were now being studied as possibly 'dangerous'. They did not know what to believe or where to find out the facts. Many knew they could ask questions of their doctors (if he/she knew the answer) or at the next meeting with the diabetes educator (if there was going to be a diabetes education meeting in the near future).

Ability to continue coping with diabetes: Many spoke of being tired of trying to cope with life as an older diabetic. There was fear of loss of independence, of being dependent on family. It takes a lot of work, they said, to follow a 'diabetic lifestyle' and its implications and discipline overwhelmed many participants. It takes work choosing the right foods, reading and understanding labels, preparing the right meals, exercising 30 minutes a day and coping with worries and stress. Several spoke of 'giving up.'

Guilt: In five of the focus groups, seniors said they were more worried about their son, daughter or husband who also had diabetes than they were worried about themselves. They also felt guilty that their family members had diabetes. Maybe it was something they did or did not do right. The mother is supposed to make sure her children and spouse eats right and stays well. Several seniors expressed the fear that they would pass diabetes on to their children, especially those who had lived with a mother or father who had the disease and had serious complications. They felt it would be their 'fault' if their children became diabetic.

Fear of dying and leaving family behind; Women who were married worried about leaving husband behind and those with husbands or children with diabetes or other health problems, were worried about how they would be able to cope without them.

5.2.8 Additional Help in Understanding and Managing Diabetes

When asked what helps them now to understand and manage their diabetes, the seniors said the same persons or groups which provided information and support when they were diagnosed continued to help them understand and manage their diabetes, to the extent they could do so. Participants provided many suggestions as to what was needed to enhance prevention (in this case prevention of

complications, prevention of going on more medication or on insulin), treatment and support. They are presented below in order of their 'perceived' importance.

Diabetes educator should come to my community:

When asked what additional help or support they needed, most described the need for more information and support. Those in areas where they had to travel to see a diabetes educator/clinic, wanted the diabetes educator to come to their communities.

Follow-up or refresher courses for diabetics:

Most of the participants wanted 'follow up' or 'refresher diabetes education sessions' in their communities. They said it was hard to take in all the information the first time you visit the diabetes educator/clinic and that you need time to let it sink in so you can ask questions. Also new information seemed to be coming out all the time and people with diabetes need that up to date information.

Financial assistance with diabetes medication and supplies, especially for those who are just above the low income cut eligibility requirements for subsidies. Seniors, especially those with low incomes expressed a great need for financial help for those with diabetes. They said they needed financial help to cover the cost of supplies such as testing strips, for glasses, dental work, foot care and all the other services that are needed by diabetics in order to live a healthy long life.

Diabetes support groups: With the exception of one focus group, all participants described the need for support groups in their communities, both for those with diabetes and for their families.

Diabetes drop-in clinic: Many said they needed a special clinic for diabetics, a place where seniors could drop in and have a blood check or have questions answered.

Place where you can get affordable fruit, vegetables, grains and other staples for a diabetic diet: Buying healthy food out-of-season in rural and remote areas may be impossible, difficult and, in any case, more expensive than the alternatives. It is a difficult choice, sometimes, between eating well and eating at all.

5.2.9 Hopes and Dreams for Future

When we asked them about their hopes and dreams for the future, most said they hoped for a cure for diabetes or at least for medications that would be more

effective, be taken less frequently and with fewer side effects. Many said they wanted to be able to control the disease themselves, that they wanted to feel more in control and to be able to live a 'normal life'.

5.2.10 Twenty Pieces of Advice to New Diabetics

The participants gave several pieces of advice for seniors who are newly diagnosed with diabetes. The following are all quotes from the focus groups:

- 1) Go to the diabetes clinic and pay attention to what they tell you.
- 2) Watch what you eat and exercise every day, it is as simple or as hard as that.
- 3) If you're scared, know you can live a good life.
- 4) Absolutely not a death sentence, it can be managed, really when you stop to think about it, it is just basic good eating.
- 5) It is more difficult for some than for others, so don't get discouraged. New things are coming down the tube all the time. From the time my father died in '76' until now there is no comparison.
- 6) Diabetes in itself is not a terminal illness: it is a condition that you can do something about.
- 7) Strips are expensive, but you need them, so buy them.
- 8) Get to know your pharmacist.
- 9) Eating right is important, but it is the exercise that keeps the blood sugars down. Always carry the right food with you in case you need it.
- 10) It's not a death sentence. Lots of people live long lives. Try to live a fairly normal life.
- 11) [It is] encouraging to tell people, we know so much more.
- 12) It is a disease you can do something about. We are fortunate if we follow a diet, do exercise, we can control it, but someone else can be a lot worse off than we are [have a disease over which they have no control].
- 13) Join a support group and talk to somebody, the best way to get rid of fear is to talk to someone else about it, someone who has diabetes so you will feel you are not alone.
- 14) Get a medic alert bracelet so, if you cannot speak for yourself, it can.
- 15) Seek assistance, ask for help. If they are always scared to seek help, they will feel isolated and enter a cocoon.
- 16) Do not be afraid of needles. Know at the beginning you may be, but soon it will not bother you.
- 17) Take care of yourself - have self-concern!

- 18) Take care of your feet. If you cannot walk because of bad feet, everything will go.
- 19) Be thankful for the years you never had diabetes.
- 20) Be positive!

6.0 Implications for Best Practices

The stories told by participants in the focus groups made it clear that diabetes is a disease that can be managed, something that one can do something about and is not a 'death sentence'. Nevertheless, it is a very difficult chronic disease to manage. To paraphrase one moderator, these were resilient seniors, they had endured a lot and diabetes was just one more challenge. There is an often repeated expression, 'old age is not for sissies': well neither is being a diabetic. A common reaction of a newly-diagnosed diabetic to participating in the first diabetes education session, no matter what format it takes, is that of being 'completely overwhelmed, often scared and wondering if it is possible to manage this disease'. As time goes on, as most of the participants said, they did manage. They described how they felt about the disease when diagnosed and how they were feeling on the day of the focus group meeting. They told us what helped them manage the physical, emotional and financial impact of diabetes in their lives and what they needed to continue to keep up this hard work. Analysis of the reports indicates there are three strategies which helped them manage their disease and they also suggested ways in which to enhance the program manifestations of these strategies.

1. Diabetes Education and Support.
2. Diabetes Support Groups.
3. Financial assistance for diabetics over 65.

Following is a description of these strategies, the ones that seniors defined as valuable and as needed by them and the thousands of others sharing their condition. For each of these, a 'best practice' is cited (See Section 3.5 above.). Although 'best practice' has been a concept used in medical research, it is difficult to apply it with any consistency to other areas of research where many factors come together to affect outcomes. It has been suggested that it should be called 'best processes' or 'best guesses'. Since it is the concept used in our proposal for this project, we will use it here, but with caution.

6.1 Diabetes Education and Support

With only a couple of exceptions, all the participants were referred to a 'diabetes educator' upon being diagnosed.⁴⁰ This meeting/counseling was followed up with either group sessions or other meetings with the diabetes educator (or both). Everyone said they learned a lot from these sessions, but it was hard at first because there was so much to learn. Clearly, there needs to be a 'refresher' course for those who have been diabetic for some time. It is not just 'lifelong learning: it is learning to stay alive long.

Best Practice #1. Nova Scotia Diabetes Care Program

Based on interviews with persons working in diabetes programs in the region described in Section 4.0 and in considering the provincial reports, it appears that the diabetes education program in Nova Scotia could be a 'best practice for diabetes education". Nova Scotia was the first province in Canada to have a Diabetes Strategy in place and the first province to establish an 'arm's length' centralized agency, the Diabetes Care Program of NS (DCPNS). It is funded by the Department of Health and is endorsed by other organizations and agencies providing health care to diabetics. A report prepared by DCPNS⁴¹ describes the success of their Diabetes Education Centres in delivering information to many newly diagnosed diabetics in 'outpatient' settings. In a ten-year period there was an increase of 70% in the number of newly diagnosed referrals. There are now courses for 'at risk patients' in development and many of the Diabetes Education Centres offer on-going education for diabetics in their areas. Like NS, the PEI Provincial Diabetes Program, which has been in place for 5 years, offers diabetes education and similar courses to those in NS.

Best Practice #2. Canadian Diabetes Association Diabetes Expo

In addition to the provincial diabetes education programs, participants also described the information they received and the questions they had answered at the Provincial Diabetes Expos and the community information sessions put on by the CDA. These Expos resemble other consumer trade shows and fairs, such as home or boat shows, that offer a central site for people to come and see products, gain information and hear about services. The Diabetes Expos have workshops and seminars as well. The CDA website describes these shows.

Best Practice #3: Superstore and Sobeys Healthy Eating, Healthy Living Presentations

Several participants described the valuable information they received at the Atlantic Superstore's presentations on healthy eating for diabetics and their reading labels tour of the store, including a discussion on reading labels for sugar, carbohydrates and other ingredients.

Best Practice #4: Pharmacists as Diabetes Educators

Participants in each region gave anecdotal evidence of the positive influence of pharmacists as sources of information and support. In Bridgetown, the Diabetes Support Group is facilitated by a pharmacist, who is a Certified Diabetes Educator and also a diabetic. Ontario has been 'experimenting' with a program in which pharmacists with expertise in diabetes act as diabetes educators and are covered by the provincial health plan. It is too soon to know whether this program is effective.

6.2 Diabetes Support Groups

It was evident in the reports on the focus groups that support groups not only provided seniors with information, but they also provided motivation to persevere. They encouraged and helped to maintain a 'positive attitude' on the part of diabetics. Many seniors said they would like to have a support group in their community or seniors centre and those who already belonged to a support group 'sang its praises'. The challenge is to find ways to develop and sustain support groups that meet the ongoing needs of older diabetics and their families.

Based on the input of participants in the focus groups and interviews with facilitators of diabetes support groups across the region, there appear to be several components that make up a successful support group.

- 1) First and foremost there needs to be a dedicated person or persons to take on leadership responsibilities.
- 2) Ideally, one of the persons 'in charge' should have training as a diabetes educator or have easy access to trained diabetes educators.
- 3) One of the 'leaders' should have the ability to recruit or encourage seniors to join the group and also facilitate the meeting.
- 4) Obtaining community support is important. One of the reasons cited for the success of support groups is that they are located in areas with a 'strong sense of community'.

- 5) The place where the meeting takes place should be accessible, comfortable and if possible, free.
- 6) The meetings should be once a month or less in certain months. Some suggest that is even better to say 'come when you wish to come' so that it does not feel like an obligation.
- 7) There was a general agreement that while the social aspect of the support group is critically important to everyone, the education/information component is equally important. If the support group does not have a diabetes expert providing information, it is important to have a 'disclaimer' saying that facilitators do not deliver care and information is not intended to replace visits with physicians or diabetes educators.

There is so much to learn with this disease, so many questions and so much confusion about information in the minds of older people. Having a person who is qualified to provide education and answer questions is of great value, and is one of the main reasons persons say they belong to support groups. As time goes by, it is important to change the content of the meetings so that they answer the needs of both old and new members. The ability to recruit new members and to encourage older members to rejoin is a talent that is necessary for volunteers to have (they do not have to be the leaders, just have the talent to know how to recruit and encourage). Finally, those involved in support groups said that financial support is really important. Although there is not usually a charge for such meetings, in cases where financial support is available, the group can fund refreshments, pamphlets and other promotional materials, copy educational materials and pay for transportation if needed. The following 'Best Practice' example has most of the above components. Note: We only used examples of support groups that were identified by participants in the regional focus groups.

Best Practice #5: Berwick NS Diabetes Peer Support Group

This support group began almost 8 years ago by a lay person with diabetes and the assistance of both a representative from the CDA and a Diabetes Educator. It meets once monthly in an accessible site in downtown Berwick (no rental charge) with about 12-15 members attending. The meetings alternate between information/education sessions where a diabetes expert makes a presentation and helps with discussion and social events where diabetic meals are shared. The sustainability of this group is reflected in the fact that when the original facilitator left for another province, a new facilitator quickly took her place and now the original facilitator is back and is part of the group. All the participants in the Berwick focus group were members of this support group and their 'testimonies' to the power and influence of support groups for diabetics was the basis for choosing this as a best practice.

Best Practice #6: Trepassey NL Diabetes Support Group

This support group began in 2004 after the facilitator read a book on starting a diabetes support group⁴². Using the information in the book, she spoke with some friends who expressed interest in the idea of starting a “Diabetes Self-Help Support Group.” Once they started the group, it met once a month. A physician who specialized in diabetes acted as a resource person and others with expertise in diabetes spoke to the group. About 8 persons, usually all women, attended and the group disbands for the winter, but begins again in the spring. The main disadvantage, they have found, is the difficulty of finding someone who will take on the responsibility for starting and sustaining the group.

The main value of support groups like the one in Trepassey, as well as the one in Berwick, is the “great comfort for each other – coming together and seeing that you are not alone and learning from each other how to cope with this health problems – just to listen to each other talk about their ways and their lifestyles and most especially to receive the expertise of the professionals. Support groups help to keep you motivated.”

6.3 Financial Assistance for Diabetics

As one key expert put it, “I believe that diabetes is not only a health threat but also a threat to financial health as well.” Seniors in the focus groups and the research both provide evidence that being a diabetic is costly. Medications, not only for diabetes but also for the other diseases many older persons have, sometimes as a result of being a diabetic or from other diseases involved with aging, add up to a lot of money to persons on a fixed income. There is also the cost of eye and dental care, healthy foods and transportation.

As described earlier in section 3.1, all the Atlantic Provinces have introduced some form of financial assistance to help with drugs. Some medications and supplies, such as test strips, may not be covered by these plans/subsidies. Many of the participants said that the cost of being a diabetic is going up while their income stays the same or goes down. For example, the cost of strips at \$1 each can add up if you have to test several times a day.

Unfortunately, we could find no examples of best practices for meeting the financial needs of seniors with diabetes in the Atlantic Provinces, unless we include the new prescription subsidies implemented in NB and NL. Therefore we put these as examples below as a beginning attempt to address the financial burden of diabetes for older persons in Atlantic Canada.

Best Practice #7: New Drug Subsidy Programs for Income Seniors in NB

A Prescription Drug Program for persons over 65 with low incomes. Seniors in NB who receive the GIS or whose income is above the GIS limit but below \$17,198 for a single senior in NB or \$26,955 for a married seniors in NB will be eligible for the Prescription Drug Program – Seniors (Plan A). They will pay a co-payment of \$9.05 per prescription up to a maximum of \$250 a year. Of course, some supplies and related equipment and drugs are not prescribed or not pharmaceuticals.

Best Practice #8: Newfoundland and Labrador Prescription Drug Programs

There are three programs for which persons over 65 may be eligible. **The 65Plus Plan:** Residents in NL over 65 who receive the OAS and GIS are covered for eligible prescription drugs, but not the dispensing fee. **The Access Plan** was instituted to cover low-income individuals or who are single with net annual incomes of \$19,000 or less, or couples without children with net annual incomes of \$21,000 or less. They have to pay the co-pay for drugs, the amount depends on income. In October of 2007, a third program was announced, **The Assurance Plan**, which puts a cap on the maximum amount that a person would be required to spend on prescription drug costs. Depending on their income level, individuals and families will be assured that their annual out of pocket eligible drug costs will be capped at 5.0, 7.5 or 10 per cent of their net family income. This Plan benefits those couples where one spouse is over 65 and the other under 65. Again, of course, some supplies and related equipment and drugs for diabetics are not prescribed or not in the formulary or not pharmaceuticals.⁴³

6.4 Additional Best Practices

Best Practice #9: Drop in Clinic for Diabetics

Many seniors suggested that there should be a drop-in clinic where they could get their blood tested and get answers. Although the PEI 'Drop-in Glucose Testing' does not fit this description fully, it does answer the need, at least for those in Charlottetown, of being able to drop in to get their blood tested (at a specified time). It is a start on a good idea.

Best Practice #10: Innovative Ways to Provide Diabetes Education:

Although the participants did not specify an 'innovative practice' in diabetes education, many said they wanted ways to have diabetes education available in their communities, in as many different ways as possible. One example of an innovative way to provide health education and support can be seen in the volunteer-run program, "Health Connections" Program in Antigonish, NS. This

program works to “maintain a community health resource centre in an accessible location that will facilitate the coordination and delivery of health promotion and prevention programs to the general public throughout Antigonish town and county”. Through its ‘Navigation Services’, it enables improved community access to health information and resources. In its ‘community capacity building’ role, it offers the delivery of facilitator training modules for peer-led and professionally-led support groups, support for the delivery of resource modules and information for the organization of support groups. While Health Connections is not focused on diabetes, it could be an umbrella program to help diabetics to access health information and develop support groups. The “Health Connections Programs” will be offered in the new libraries. Libraries or CAP sites (Computer Access Sites) could also be used to internet access to information on diabetes programs and services.

Best Practice #11: A Network of Diabetes Support Groups in Atlantic Canada

Leaders of support groups, both existing and those that no longer meet, suggested that it would be very helpful to have a way to communicate with other support groups in the Atlantic region in order to find out ways to develop and sustain community support groups.

Best (Potential) Practice #12: A collaborative approach to preventing and managing diabetes among older adults in Atlantic Canada: Steps to take to build a collaborative approach based on experience and findings of project.

This is an idea based on the experience of those involved administering, managing and coordinating the ‘Attitude Makes a Difference Project’. Obtaining information on various aspects of the disease and the support and income programs in existence was not an easy task, even with the help of everyone on the ASPHN Project Team and other project partners. A recommendation based on our experience would be to establish a ‘Core Stakeholders Group’ to act as a council of reference for issues and concerns related to the prevention and care of diabetes among older persons and to build the capacity of older persons to formulate, promote and support initiatives in Atlantic Canada.

7.0 Conclusion and Recommendations

The activities and findings described above reflect what was stated in the objectives for this proposal: 1) we have presented what the literature, key experts and seniors themselves consider best practices; 2) we have asked those with diabetes how they feel about the disease; and 3) asked seniors who have been living with diabetes to identify key actions that are needed to enhance prevention, treatment and support for them and for their families.

In terms of recommendations or key actions, ASHPN thinks these should come from the narratives of the seniors themselves. Here is what they said:

- 1) They said they want accessible, understandable and reliable information and support. This includes diabetes education in their communities, diabetes education that is available right after diagnosis and 'refresher courses' for those who have been living with diabetes for some time.
- 2) They also suggested having clinics where diabetics could drop in and have their blood checked or ask questions. They suggested specific clinics for diabetics, perhaps staffed by nurse practitioners, pharmacists and/or dietitians that would be open 7 days a week.
- 3) They want some type of support groups, places where they can go to discuss diabetes with others who share the same experiences or situation.
- 4) They also need financial help to manage diabetes and prevent complications, including the cost of eyeglasses, dental care, foot care, transportation and healthy foods.

Some of these recommendations or key actions have already started as indicated in 'best practices' above, others wait for policy makers, political leaders, diabetes practitioners and seniors advocates to make them happen.

Reading over the reports from the focus groups reminds us that the best part of any project is the 'stories' that are told by those with experience. We often discount stories or try to fit them into research where they disappear into 'facts' or 'numbers'. Jay Parini, reviewing Garrison Keillor's book, Pontoon, in "The Guardian Weekly" puts it best when he describes the importance of stories, like the ones Keillor writes about in his book or the ones we heard in the focus groups: "You get old and you realize there are no answers, just stories. And how we love them."⁴⁴

Appendix A: Endnotes

¹ Government of Newfoundland and Labrador, *Provincial Healthy Aging*. p.37, 2007.

² The National Council of Welfare describes 'poverty' as qualifying for the 'low-income cut-off' which is \$20,000 for unattached persons. The combined Old Age Security and Guaranteed Income supplement is slightly more than half of this amount.

³ Atlantic Canada and Saskatchewan have the lowest life expectancy rates in Canada: 79.8 in NB and PEI, 79.3 in NS and 78.2 in NL.

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⁶ Diabetes Care Program of Nova Scotia, *Diabetes in Nova Scotia: A Ten Year Perspective*, p. 5, 2003.

⁷ "Death Rate for Women with Diabetes Higher Than That of Men," *Canadian Online Pharmacy* (www.news-medical.net) June 19, 2007.

⁸ Diabetes Care Program of Nova Scotia, *Diabetes in Nova Scotia: A Ten Year Perspective*, p. 2, 2003.

⁹ Stewart, Paula, MD, and Douglas Consulting in consultation with the Coordinating Committee for the National Diabetes Strategy, *Building a National Diabetes Strategy: Synthesis of Research and Collaborations* Public Health Agency of Canada, 2005.

¹⁰ Rapheal, Dennis et al, "The Social Determinants of the Incidence and Management of Type 2 Diabetes Mellitus: Are we Prepared to Rethink Our Questions and Redirect Our Research Activities", *International Journal of Health Care Quality Assurance incorporating Leadership Health Services*, Vol. 16:3, pp 10-20, 2003.

¹¹ Callaghan, D and Williams, A, "Living with Diabetes: Issues for Nursing Practice, *Journal of Advanced Nursing*, Vol. 20, pp. 132-9, 1994.

¹² Morgan, Steven G., et al, "Wither Senior's Pharmacare: Less From (And For) Canada", *Health Affairs*, Vol. 22:3, pp 49-59, 2003.

¹³ Anderson, R.M., Donnelly M.B., and Cedrick R.F., "Measuring the Attitude of Patients Towards Diabetes and Its Treatment" *Patient Education Counseling Journal*, Vol.16, pp.:231-45, 1990.

¹⁴ Anderson, Robert M. and Lynne S. Robins, "How Do We Know: Reflections on Qualitative Research in Diabetes", *Diabetes Care*, Vol. 21:9, pp 1387-8, 1998.

¹⁵ Wikblad, Karin F., et al, "The Patient's Experience of Diabetes and Its Treatment" *Journal of Advanced Nursing*, Vol.15:9, 1990.

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- ¹⁷ Report on “Workshop on Healthy Aging, Part II: Seniors and Diabetes” held on November 28-30, 2001, was provided by the Division of Aging and Seniors, Health Canada.
- ¹⁸ Kiblinger, R.N. and Robert L. Braza, “The Impact of Diabetes Education On Improving Patient Outcomes”, *Insulin*, Vol. 2, pp 24-30, 2007.
- ¹⁹ Rakel, Robert E. MD and Michael A. Weiss, JD, “Diabetes Care: Are We Asking the Right Questions” *Consultant Live*, Vol.47, No. 6, 2007.
- ²⁰ Villanyi, Diane, et al, “Self-Reported Understanding of Diabetes and Its Treatment Among Elderly Ambulatory Subjects in British Columbia”, *The American Journal of Geriatric Pharmacotherapy*, Vol. 5, No. 1., pp. 18-30, 2007.
- ²¹ Martin, Fran, “Developing a Healthy Living Program for Seniors”, *Diabetes Care In Nova Scotia* Newsletter, Vol. 16: No. 4, July 2006: p 11-13 and Vol. 16. No. 4, pp. 7-8 October 2006.
- ²² Wagner, E.H., “Chronic Care Management: What Will it Take to Improve Care for Chronic Illness? *Effective Clinical Practice: Stanford Chronic Care Self-Management Program*, Vol. 1, pp. 2-4, 1998. (Stanford Self-Management Programs are available on-line at www.patienteducation.stanford.edu/programs.)
- ²³ Cook, Brenda, “Group Education in Diabetes Care”, *Diabetes Care in Nova Scotia*, Vol 16. pp.8-9, January 2006.
- ²⁴ Health Canada, *Best Practices: Treatment and Rehabilitation for Seniors with Substance Use Problems*, 2002.
- ²⁵ Bird, Susan, *The Hamilton Diabetes and Depression Peer Support Project*, Hamilton Family Health Team, Hamilton, Ontario, 2007.
- ²⁶ Paul, Gillian, et al, Peer Support in Type 2 Diabetes: A Randomized Controlled Trial in Primary Care with Parallel Economic and Qualitative Analyses; Pilot Study and Protocol, published on-line July 312, 2007 at www.pubmedcentral.nih.gov.
- ²⁷ (Stephanie Losee, *Oprah*, January 2008: 71-73)
- ²⁸ Zrebiec, J.F. and A.M. Jacobson, “What Attracts Patients with Diabetes to an Internet Support Group”, *Journal of Diabetic Medicine*, Vol. 18:2, pp 154-58, 2001.
- ²⁹ SHRA E-Newsletter, May, 2007 (www.selfhelpresource.bc.ca)
- ³⁰ We were unable to identify focus groups in PEI and we were not able to connect with the one in NB which included seniors.
- ³¹ Canadian Diabetes Association, *Diabetes Report Card 2001: Do Provincial, Territorial and Federal Governments Make the Grade?; Diabetes Report Card 2003: Why does it still matter where you live in Canada if you have diabetes?; Diabetes Report 2005: The Serious Face of Diabetes in Canada*)
- ³² www.cwhc.nl.ca
- ³³ For information on the Stanford Model of Chronic Disease Self-Management, see www.patienteducation.stanford.edu/programs. For information on the

Wagner Chronic Care, Model see

www.cacr.ca/en/toolkit/best_possible_care/chronic_disease

³⁴ A webcast of Dr. Gibbon's presentation on diabetes care in New Brunswick is available at: www.grandroundsnow.com/Diabetes/McGibbon.htm

³⁵ Canadian Diabetes Association, *Peer Support Group Guidelines*, Template written August, 2003.

³⁶ Recruiting persons receiving the GIS or who had low incomes was difficult, either because of the methods used to recruit the participants or because of the 'stigma' associated with admitting to having a 'low income'.

³⁷ Of the 11 participants who stated their incomes were between \$36,000 - \$60,000 all were married and/or employed. Nine said they did not receive the GIS, but did not give their income and 16 gave 'no answer' to the income questions.

³⁸ *The Seniors and Diabetes Focus Group Guide* is available with this report as a separate document.

³⁹ According to the Diabetes Care Program in NS, as of February 2008 the wait times have been reduced to less than one month throughout the Province.

⁴⁰ See Appendix B for the definition of a *diabetes educator*.

⁴¹ Diabetes Care Program of Nova Scotia, *Diabetes in Nova Scotia: A Ten Year Perspective*, 2003.

⁴² Canadian Pensioners Concerned, *Dealing with Diabetes*, 2004.

⁴³ Health and Community Services, *The Newfoundland and Labrador Prescription Drug Program*, Government of Newfoundland and Labrador, 2007.

⁴⁴ Parini, Jay, Review of "Pontoon" by Garrison Keillor, *The Guardian Weekly*, p. 38, January 18, 2008.

Appendix B: Definitions

Attitude: An outlook, a personal view, an opinion or a general feeling about something.

Best Practices: Activity, practice, experience know-how or knowledge that has proven to be valuable or effective in a specific situation that may have applicability in another situation.

Chronic Disease: A disease that can be controlled but not cured or a disease that lasts for over a year or indefinitely.

Diabetes: Type 1 diabetes occurs when the pancreas is unable to produce insulin. It usually, but not always is diagnosed in children. Type 2 diabetes is a condition in which the pancreas does not produce enough insulin to meet the body's needs or the insulin is not metabolize effectively. It is usually diagnosed in adults, but increasingly children are being diagnosed. *Pre-diabetes* is defined as having a fasting blood glucose (sugar) level that is near but not quite at the level to be defined as having type 2 diabetes. Not everyone with pre-diabetes will develop type 2 diabetes, but many will. Therefore identifying persons with pre-diabetes is very important. (Canadian Diabetes Association, [Diabetes Dictionary](#), 2007:7)

Diabetes Educator: A diabetes educator is a health care professional (nurse, dietitian, physician, pharmacist, social worker) who has expertise in diabetes management. A Certified Diabetes Educator (CDE) is a health care professional with an expertise in diabetes who meets eligibility requirements and successfully completes a certification exam.

Diabetes Support Groups: According to the CDA, "Diabetes Peer Support Groups are gatherings of people who have been diagnosed with diabetes, or who have someone close to them who has diabetes. The Peer Support Groups are informal networks facilitated by the CDA trained volunteers offering group members the opportunity to meet others with similar challenges. Diabetes Peer Support Groups provide a way for people with diabetes to get together to talk, share concerns, provide encouragement and get practical diabetes information. (www.diabetes.ca) With the exception of the qualification that the facilitator must be trained by the CDA, this definition seems to suit the support groups described by seniors as helpful or needed in the provincial focus groups.

Guaranteed Income Supplement (GIS): A monthly non-taxable benefit to low income Old Age recipients.

Appendix C: Resources

Organizations

Aîné-e-s en Marche – Go Ahead Seniors: 523 chemin Leblanc, St-Leblanc, NB, E4P 6B2, Telephone: 506.577.2271

Atlantic Seniors Health Promotion Network: For information contact Marie Corinne Bourque, Chair, at 523 chemin Leblanc, St-Leblanc, NB E4P 6B2

Canadian Diabetes Association: Call Toll-free 1.800.226.8464, E-mail: info@diabetes.ca, Website: www.diabetes.ca

Community Links: P.O. Box 29103, Halifax, NS, B3L 4T8, Telephone: 902.422.0914, e-mail: communitylinks@hfx.eastlink.ca, website: www.nscommunitylinks.ca

Seniors Resource Centre of Newfoundland and Labrador: 280 Torbay Road, suite W 100, St. John's, NL, A1A 3W8, E-mail: Website: www.seniorsresource.ca

Seniors United Network, 40 Enman Crescent, Charlottetown, PE, C1E 1E6, Telephone: 902.892.3331, E-mail: sun@pei.aibn.com

Additional Websites

www.caremapnb.ca Information on diabetes care and programs in New Brunswick is available on this website.

www.cdc.gov/dhdsp/cdcyergy/contest/resources/diabetes An example of a focus group guide designed for use for Native Americans with diabetes.

www.nscommunitylinks.ca Community Links website has the 'Attitude Makes a Difference Report' and other projects and services for seniors in Nova Scotia.

www.diabetes.ca The Canadian Diabetes Association website has links to all the Canadian Provincial CDA websites. It includes a wealth of information on diabetes.

www.diabetescareprogram.ns.ca Nova Scotia Diabetes Care Program Website.

www.gdiworld.com/tips.htm A brief introduction to focus group topics.

www.gohealthy.ca The “Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador: 2006-2007” presents the Wellness Plan for seniors in the Province, including the development of a Provincial Diabetes Strategy.

www.gov.nl.ca The Newfoundland and Labrador Provincial website includes links to programs and services for seniors in the Province.

www.gov.ns.ca The Nova Scotia Provincial website includes information on programs and services for seniors.

www.gov.pe.ca The PEI Government website has links to services and programs for seniors in the Province.

www.peidiabetes.pe.ca The Diabetes Program of PEI website.

www.peoplewithdiabetes.ca This website posts information on diabetes forums activities and concerns in Canada, including information on diabetes peer support groups.

www.mnav.com/qualitative_research A Manual on how to do focus groups.

www.unu.edu/unupress A manual on the use of focus groups.

www.cdc.gov/diabetes/pubs/index.htm A handbook for diabetes focus groups.

www.seniorsresource.ca The Seniors Resource Centre of Newfoundland and Labrador provides information on programs and services for seniors in the Province including information on the on seniors and diabetes, “Building On Our Strengths: Knowing What’s Good For Me”.