

# Diabetes “One Step Ahead” – program

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## Aim

To develop, coordinate and extend diabetes services and programs to ensure a cohesive continuum of care which meets the needs of our culturally diverse community, which may delay or prevent the development of cardiovascular disease and preventable complications from diabetic neuropathy in individuals with diabetes, and delay or prevent the onset of diabetes in individuals at high risk of developing the disease.

## Program objectives and sub-objectives.

### Year One – Prevention and Management Strategy for Diabetic Complications.

#### 1. To develop appropriate community based exercise programs that promote long term lifestyle modification, in order to prevent the complications of cardiovascular disease and diabetic neuropathy.

- To conduct a thorough literature review on the current evidence supporting exercise for diabetes, and to consult with other evidence based programs that are using exercise for diabetes management, to ensure that the “One Step Ahead” program reflects evidence based practice.
- To determine inclusion/exclusion criteria for participants in the exercise groups.
- To develop a referral system that utilises DAV’s “My Diabetes Health Card”.
- To develop an advertising strategy to inform both GP’s and participants about project recruitment processes and the need for ongoing GP support.
- To conduct focus groups with people with diabetes in order to determine exercise preferences.
- To develop a worksheet for the recording of pre and post exercise measures including BGL’s and heart rate.
- To begin with two exercise groups to initially be conducted at BHS. Each group is to consist of a maximum of 8 participants, who shall attend twice a week for 8 weeks. The first 6 weeks shall be conducted in the BHS physiotherapy department, and the final two weeks at Broadmeadows Leisure Centre. Four groups shall therefore be completed in the first four months.
- To develop links with Broadmeadows Leisure Centre’s “Living Longer, Living Stronger” exercise program, for ongoing exercise support following completion of the 8 week program at BHS.
- To develop links with CHC’s in the Hume Moreland region, in order to move the classes into the community after 4 months of classes at BHS. One CHC shall start taking new groups in months 4 to 8, and two more CHC’s shall start taking new groups in months 8 to 12. The number of groups taken by each CHC will depend on capacity and referrals. Please see diagram “Model for exercise classes in Year 1”.
- To develop links with other leisure centres in the Hume Moreland region, in order to move the classes to leisure centres following the 8 week program at the CHC’s. Please see diagram “Flowchart for participants in “One Step Ahead”.

#### 2. To develop appropriate education programs that include education on diabetes, nutrition, foot care and exercise, to encourage long term lifestyle changes that facilitate a reduction in cardiovascular disease and foot complications.

- To develop an introductory session for each participant prior to the commencement of the exercise program. This shall consist of baseline assessment including waist measure, exercise questionnaire, quality of life questionnaire, foot screening, heart rate and BGL.
- To deliver education during the introductory session about adequate hydration, the risk of hypoglycaemia whilst exercising, warning signs of cardiac events, and safety whilst exercising.
- To deliver education sessions immediately before or after the exercise classes, limiting the number of times the participant needs to travel.
- To develop a 5-session education program on nutrition, to be delivered to each group over 5 consecutive weeks of the 8 week exercise program.

- To develop a 4 session education program on diabetes education, to be delivered to each group over 4 consecutive weeks of the 8 week exercise program.
- To allow up to 14 sessions for individual education on nutrition for participants who may require additional support. Preference for these sessions should be given to participants of a different culture who may require an interpreter for more complex information.
- To allow a flexible number of sessions for individual diabetes education for participants who may require additional support. Preference for these sessions should be given to participants of a different culture who may require an interpreter for more complex information.
- To develop an education and risk screening program on foot care, to be delivered to the group post exercise.
- To establish links with other health professionals in the CHC's of the Hume Moreland catchment.
- To deliver modified education sessions on nutrition, diabetes education and foot care to groups being conducted in CHC's where there are limited health professionals to deliver the programs (e.g. Podiatry, diabetes education, dietetics).

**3. To develop a treatment program of minor foot complications, in order to prevent further development of complications arising from diabetic neuropathy.**

- To establish a risk screening program, to be conducted immediately post exercise classes.
- To develop clear inclusion/exclusion criteria for the foot treatment program.
- To provide 3 hours of treatment per week, for the treatment of minor foot complications.
- To establish links with other programs for the referral of more complex foot complications for treatment.

**4. To promote social networks for people with diabetes in the Hume-Moreland catchment through the development of self-help groups for individuals with diabetes.**

- To conduct a literature review on self-help groups for diabetes, and to consult with other evidence based programs, in order to establish a model for delivery of self-help groups.
- To conduct focus groups with people with diabetes to establish a preferred model for self-help groups.
- To identify natural leaders within the groups who would be suitable for a role in organising and coordinating a self-help groups for people with diabetes.
- To establish a location for self-help groups.
- To establish a sustainable system that enables interested individuals to access the self-help groups.

**5. To evaluate the outcomes of the project.**

- To ascertain the need for ethics approval for the collection of information from the participants in the project.
- To establish links with GP's for the collection of information via the "My Diabetes Health Card".
- To collect relevant measures via the "My Diabetes Health Card", including HbA1c, cholesterol sub-fractions, blood pressure and weight, and to collect these measures before the program, and at 4, 8 and 12 months.
- To conduct a literature review on quality of life questionnaires and exercise questionnaires for diabetes in order to find reliable and valid questionnaires for outcome evaluation.
- To collect information on quality of life and exercise using the questionnaires found in 5.4 prior to the commencement of the project and at 4 and 12 months.
- To collect waist measures prior to the commencement of the project and at 4 and 12 months.
- To develop a brief feedback form for completion by the participants on the final session of the 8 week program.

To develop an evaluation plan using the RE-AIM evaluation