

**An Evaluation of the  
Mobile Diabetes Screening Initiative**

**Conducted by  
BIM Larsson & Associates  
and  
Allen Consulting & Training**

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## Acknowledgements

Many individuals contributed their time, knowledge and information to this evaluation. We would like to recognize the following communities who participated in the evaluation:

- Fishing Lake Métis Settlement
- Elizabeth Métis Settlement
- Kikino Métis Settlement
- Buffalo Lake Settlement
- Conklin community
- Town of Grande Cache
- La Crete community

From each of these communities we would like to thank the following people who made this evaluation possible:

- Bookers
- Participants in focus groups and individual face-to-face interviews
- Key Contacts
- Local Service Providers, e.g., Registered Nurses
- Elected and Non-Elected Officials

This work would not have been possible without the assistance and support of:

- Members of the Mobile Diabetes Screening initiative (MDSi) team
- Members of the staff of MDSi at the University of Alberta
- Members of the Alberta Health and Wellness, Government of Alberta

## ***An Evaluation of the Mobile Diabetes Screening Initiative***

Response to Larsson and Allen

The main goal of the MDSi program is to screen for diabetes and its related complications in off-reserve Aboriginal population and Metis settlements in Northern Alberta. The current evaluation focused on how to increase community participation in MDSi and to provide specific recommendations for program modifications and enhancements. The evaluators made a concentrated effort to collect data from 6 communities during the fall of 2008. The evaluators reported many positives about the MDSi screening program.

In addition, the evaluators made a number of suggestions for improvement of the program, however, MDSi are doing many of them already or have tried them in the past:

### ***Develop services based on an Aboriginal Healing Model***

This suggestion appears to be a good one, however, the evaluators admit that it would be a major commitment which would require an increase in resources.

### ***Logistical Changes***

MDSi does work closely with the communities to determine the clinic schedule - arrangements are made 2 to 6 months in advance of the visit. Regional health staff are made aware of visits. Team travel schedules are sent to regional health staff in the health areas. Bookers are hired through the contact person in each community - by the community and from the community. "Recall" lists for each community are generated from the MDSi electronic database and provided to the community booker.

### ***Strengthen the Community Connection***

Currently MDSi relies on the community contact to make the community aware of the MDSi visit. Each community is asked to provide transportation for clients needing a ride, however not all communities have this capability. Client counseling is on an individual basis and as culturally appropriate as possible. Currently MDSi sends a copy of each client's screening results (with Client permission) to the client's physician and community nurse.

### ***Enhanced Communication***

To date, MDSi has produced and distributed a newsletter to all the communities, health regions and other stakeholders. MDSi has developed a website and will soon have a feature where communities can access their own data online.

### ***What can MDSi do***

- MDSi will continue to work with communities and health area staff to book community screening clinics at times suitable for the communities. MDSi will revisit the idea of holding a "bookers training" session
- MDSi will explore the idea of meeting with elders, traditional healers and key community members prior to holding the screening clinic

- MDSi will update and share a list of community partners (currently kept in the field staff binder) with the communities
- MDSi will continue to have the “lunch and learn” sessions for community members in each community
- MDSi will continue to explore working in the schools (MDSi has seen clients from Kikino school, has worked in Grande Cache school and contacts have been made in Fishing Lake, Peerless Lake and Trout Lake schools).
- MDSi will continue efforts to liaise with area health people and physicians clinics in the areas
- MDSi will endeavor to meet with community leaders and members and health area staff to disseminate MDSi results and findings
- MDSi will continue to become more culturally aware through various educational resources
- MDSi will explore the Aboriginal Healing model and holistic approach, although to implement this would require a major commitment, change of focus and require considerable additional resources

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## 1.0 Introduction

The Mobile Diabetes Screening initiative (MDSi) was implemented in 2003 as part of the Alberta Diabetes Strategy and funded by Alberta Health and Wellness. MDSi is a partnership between Alberta Health and Wellness and the University of Alberta. Since then, MDSi has traveled to 23 communities (Métis Settlements and other rural, remote or off-reserve Aboriginal communities) in Alberta providing increasing awareness of diabetes risk and providing diabetes screening services.

### 1.1 Evaluation Background

Since its implementation two evaluations of MDSi have been conducted. The first evaluation, completed in February 2005, examined the implementation of the program. Next, a formative evaluation was completed in January 2007, which provided evidence that MDSi met the expectations of the program. Both evaluations showed evidence of the value and success of the MDSi based on intended goals.

A third evaluation conducted by BIM Larsson & Associates and Allen Consulting & Training was completed in the fall of 2008. This evaluation used an improvement-oriented approach gathering qualitative and quantitative data related to outputs, outcomes and strengths and weaknesses found in MDSi. This evaluation focused specifically on how to increase community participation in MDSi and therefore would provide specific recommendations for program modifications and enhancements.

### 1.2 Evaluation Areas of Inquiry

The evaluation conducted in 2004-2006, noted a concern that some high risk individuals did not appear to visit the MDSi clinic. There were also concerns about follow up once a client had been referred to a physician. Finally, other research has shown there is strong relationship between lifestyle and diabetes. Based on the above, the evaluation had three major areas of inquiry:

1. Do some high risk target sub-populations not attend MDSi clinic screening? If so, why not?
2. Do clients act on MDSi recommendations and follow up with appropriate health services. If not, why not?
3. What, if any, are the indications that behavioural change is occurring as a result of the screening?

## 2.0 Methodology

Multiple methods, sources, and types of data were used in the evaluation. The following provides a brief overview.

Primary data were collected from:

- Fishing Lake Métis Settlement

- Elizabeth Métis Settlement
- Kikino Métis Settlement
- Buffalo Lake Settlement
- Conklin community
- Town of Grande Cache
- La Crete community

Primary data consisted of:

- Qualitative data
  - Focus groups (n=3)
  - In person interviews (n=22 )
  - Key stakeholder telephone interviews (n=7 )
  - Observation (n=6)
  - MDSi team member interviews (n=4)
  
- Quantitative data
  - Client survey (n=61)

Secondary data consisted of:

- MDSi data base
- MDSi summer survey (draft analysis)

For further details on methodology and data analysis please refer to Appendix B: Methodology and Analysis.

## 3.0 Findings

The key findings presented below are presented in relation to each area of inquiry. The findings are based on qualitative data from interviews and focus groups with participants and quantitative data from surveys completed by those attending clinics (respondents). These findings are compared with secondary data from MDSi database as well as MDSi Summer Survey data. For more in-depth information related to each area of findings please refer to Appendix C: Data Findings.

### ***3.1 Do some high risk target sub-populations not attend MDSi clinic screening? If so, why not?***

#### **3.1.1 MDSi Clinic Reaching Community Members**

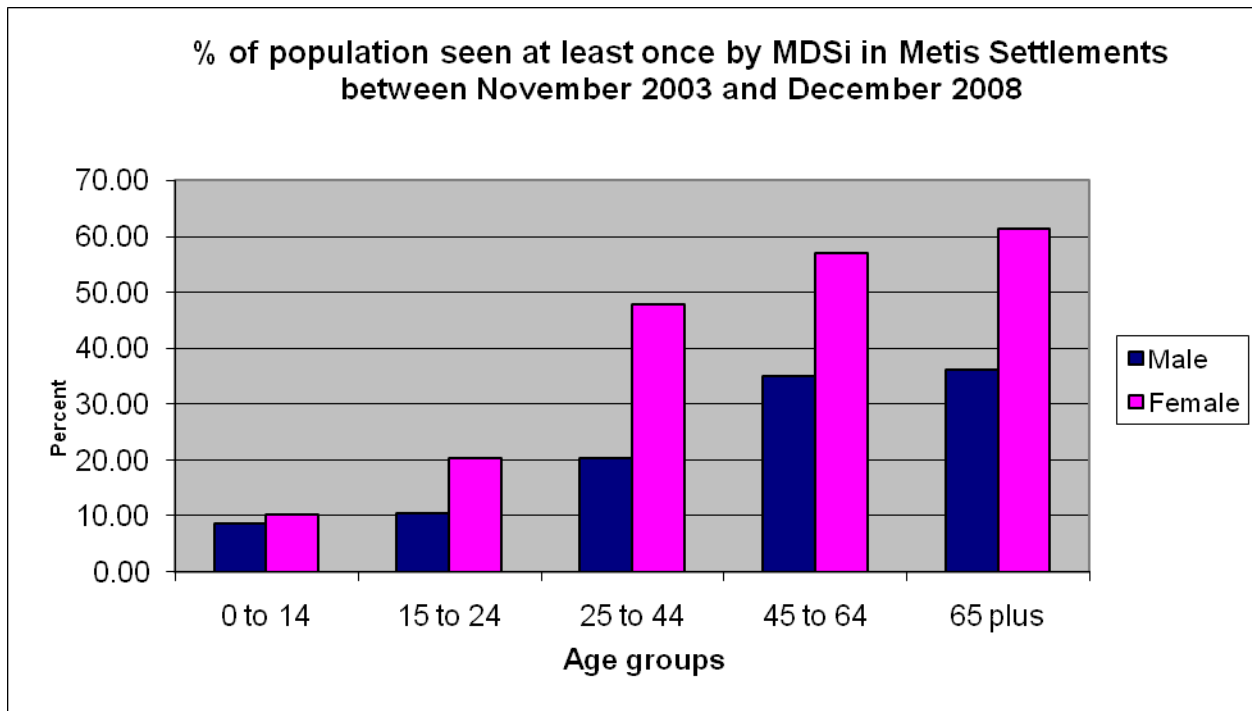
The prevalence rate of diabetes in the Aboriginal population is significantly higher than the general population<sup>1</sup>. Diabetes rates within the Métis population rose by 66% between 1998 and

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<sup>1</sup> Diabetes among Aboriginal (First nations, Inuit and Métis) People in Canada: the Evidence. Available from [http://www.hc-sc.gc.ca/fnih-spnia/alt\\_formats/fnihb-dgspni/pdf/pubs/diabete/2001\\_evidence\\_faits-eng.pdf](http://www.hc-sc.gc.ca/fnih-spnia/alt_formats/fnihb-dgspni/pdf/pubs/diabete/2001_evidence_faits-eng.pdf) - accessed march 17th, 2009.

2006<sup>2</sup>. There is also a greater rate of hospitalization for diabetes related issues compared to the general population<sup>3</sup>. In light of this, early detection and prevention is important. According to participants, prior to MDSi clinics coming to the communities, very few people were aware of the risks of diabetes and therefore did not access diabetes screening.

MDSi visits to the communities have been successful in raising awareness among community members of the importance of participating in diabetes screening. This awareness has resulted in community members accessing diabetes screening through MDSi clinics. The data from communities visited by MDSi to date indicate that females attend MDSi clinics at approximately twice the rate of males.



### 3.1.2 Community Members View Screening as Important

The Canadian Diabetes Associations’ 2003 Clinical Practice Guidelines recommend community-based screening programs for Aboriginal communities. Community members interviewed

<sup>2</sup> Diabetes among Aboriginal (First nations, Inuit and Métis) People in Canada: the Evidence. Available from [http://www.hc-sc.gc.ca/fnihah-spnia/alt\\_formats/fnihb-dgspni/pdf/pubs/diabete/2001\\_evidence\\_faits-eng.pdf](http://www.hc-sc.gc.ca/fnihah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/diabete/2001_evidence_faits-eng.pdf) - accessed march 17th, 2009.

<sup>3</sup> Cardinal, J., Schopflocher, D., Svenson, L., Morrison, K., & Laing, L. (2004). First Nations in Alberta: a focus on health service use. Edmonton, Alberta: Alberta Health and Wellness.

concluded that screening is important. Most survey respondents (95%) felt all community members should visit the MDSi clinic at least once a year.

Most participants also recognized that Aboriginal people are at a higher risk for diabetes but in some communities respondents did not know that Aboriginal descent constituted a risk factor.

### **3.1.3 Awareness of MDSi Visit**

Local bookers are the key to raising awareness of the MDSi visits. The majority of respondents (69%) interviewed while attending the clinic were made aware of the MDSi clinic through the local booker. It is therefore important, according to the participants, that the booker is well connected with all sectors of the community and is flexible when booking appointments.

### **3.1.4 Why Are Some Community Members Less Likely to Attend MDSi**

Fear, according to participants, was the most common reason for people not attending MDSi. The fear was multi-faceted: fear of diagnosis, fear of the disease, fear of having to change lifestyle, etc.

There was a sense in all communities that seniors, in particular, choose not to attend the MDSi clinics. It was felt that many are set in their ways and do not want to make lifestyle changes; they have seen the devastating effects that diabetes can have on a person and they were fearful of getting the same 'sentence'.

There were also practical reasons for not accessing MDSi clinic. These reasons fell into four broad categories:

- Lack of transportation.
- The person was not in the community during the day due to work or other commitments and MDSi was not open in the evening in most communities.
- Lack of awareness that MDSi was in the community.
- Lack of awareness of being at risk for diabetes.
- Conflicts with other major community events.

### **3.1.5 Culturally Relevant**

Participants stated that the MDSi team was always respectful and approachable. They noted that the information provided by the MDSi team was appropriate for the people served in that:

- All information was delivered in clear and easy to understand language;
- Client plans were concrete and straight forward, for example the focus was on changing one mutually agreed upon health factor; and
- Any pictures used in the information brochures were of Aboriginal people.

The fact that community members viewed the MDSi team as accessible and easy to talk to contributed to MDSi's ability to reach a larger population within the communities.

## **3.2 Follow Up on MDSi Recommendations**

MDSi does not diagnose diabetes but recommends that the client go to their physician for final diagnosis. Participants in the evaluation suggested that most people do follow up, even if it is not done immediately following the MDSi visit. There appear to be some differences among the various communities. Some communities were more likely to report that community members do not follow up with a physician. The main reasons that influenced the follow up rate were:

- Access to transportation. It is a major issue both within the community as well as in accessing services outside the community.
- Difficulty getting an appointment with a physician and experiencing difficulty finding a physician who they feel is supportive and accessible.
- Fear of doctors and hospitals in general based on past experiences.
- Services are not culturally appropriate.

Local service providers expressed concern that some community members do not follow up on MDSi recommendations and it is not until a crisis occurs in the person's health status that they seek medical help. At that time there is often an acute admission to a hospital for treatment of diabetes related complications. According to service providers, discharge planning after such admissions is limited since few services are available in most communities. Nurses or dieticians with diabetes expertise are not available in most communities. Therefore, for most community members, MDSi is the only reliable diabetes service that could be accessed.

## **3.3 Behaviour Changes**

### **3.3.1 Individual Impact**

Community members identified the following impact made by MDSi at the individual level:

- Increased awareness of diabetes before, during and after an MDSi community visit;
- A growing understanding among community members of the relationship between lifestyle and health outcomes. Even though many people struggle with changing their behaviour – they know it is important to try.
- Community-school connections are established, i.e. school newsletters advertise upcoming clinics;
- A shift from a disease focus to a wellness focus, i.e. talking about healthy lifestyles versus focus of not getting sick.
- Youth are at an increased risk of diabetes and advised that they may be at risk, which means there is a need for immediate intervention and earlier prevention.

Identifying specific behaviour changes among community members is difficult to do according to participants. However, some examples were provided where significant changes had been made by individuals:

- Individuals stopped drinking pop.

- Many people were trying to lose weight - clubs like the “biggest loser” are organized in some communities.
- More people were seen walking in the community.
- People were trying to eat healthier (more fruits and vegetables).

Service providers in the community noted that:

- The MDSi program was discussed among community members.
- Many community members tried to change behaviours but after a while fell back into earlier patterns.

Several communities commented that MDSi on its own cannot expect to change community knowledge and awareness but other services must become involved as well. According to respondents, partnerships with local services are required to advance MDSi and subsequently effective diabetes prevention. MDSi should be linking and establishing partnerships with local community activities whenever possible.

### **3.3.2 Community Impact**

When asked to provide examples of the impact MDSi has had at the broader community level, participants stated that overall it has created more health awareness and resulted in community members attending annual screening. According to respondents, yearly visits by the MDSi clinic provide the community with a sense that they are valued and it personalizes diabetes and serves as a reminder about health and wellness.

Regional coordinators within health regions commented that MDSi visits have impacted how they plan and implement various chronic disease management initiatives.

Most community members still equate having access to health services as having access to a locally based physician. Most people access health services reactively not proactively. Health prevention and promotion are not well understood. However, the success of MDSi in reaching the community members has resulted in community members accessing the clinic in preventative ways, without calling it health promotion and prevention.

When local service providers are included in planning and scheduling community visits the acceptance of MDSi is improved. This type of coordination and relationship building results in stronger anchoring of MDSi in community life.

## **4.0 Conclusions and Recommendations**

### **4.1 Strengths**

When asked to identify the “best part” of MDSi eleven major areas were identified:

1. The MDSi clinic increases community members' awareness of diabetes, even among community members who do not visit the clinic.
2. MDSi offers a culturally appropriate way of receiving a range of tests that many do not get even if they visit their physician.
3. The use of a local person being responsible for connecting with community members and booking clients contributes to the clinics credibility.
4. MDSi clinics are often located closer than physician clinics making it accessible (even though there may still be a transportation issue locally).
5. The clients are familiar and comfortable with the location of the MDSi clinic in their communities, and therefore more likely to visit the clinic.
6. It is easy to get an appointment with MDSi.
7. Clients receive results immediately from MDSi and do not have to wait.
8. It is a one-stop for all information, i.e. weight, height, blood pressure, cholesterol, and retina exam. This makes it more relevant and understandable.
9. The clinic provides services in a relaxed atmosphere and it is a place where community members get up to 45 minutes with professional health care providers who can advise and assist them in how to improve their health through lifestyle choices.
10. The team is trusted and friendly.
11. Finally, MDSi screening increases the chance of early diagnosis. Without MDSi the majority of the people would not be diagnosed until a later date or not at all. Therefore, MDSi may reduce the number of community members who end up having undiagnosed diabetes resulting in health complications that may lead to an acute care admission.

## **4.2 Areas for Improvement**

When asked how MDSi services could be improved the following suggestions were made:

- Work closer with the communities in determining the schedule and allowing the communities at least one month to prepare for the visit.
- Inform regional health staff of the upcoming visits.
- Include local community partners in the planning such as public health nurses, schools, home care staff, and other services.
- Establish partnerships with the communities by working in close collaboration with key stakeholders, service providers and elected and non-elected official. This partnering can be accomplished through meetings, presentations, joint initiative of special events, school visits etc.

It should be noted that some of the suggestions made by participants are activities MDSi are already engaged in. Since the participants still consider these a concern alternative strategies or approaches should be considered. Also, implementing some of these suggestions will require additional resources such as staff time.

### **4.3 Recommendations**

As noted in the findings, MDSi is bringing information to the communities in culturally sensitive ways, such as:

- Educating the communities that Aboriginal people are at a higher risk for diabetes than non-Aboriginal people.
- Using materials for diabetes information that use simple language, Aboriginal content and show Aboriginal people in pictures.
- Locating the clinic in familiar and comfortable community locations.
- Utilizing local community people as bookers who also provide interpretative services.
- Attempting to encourage behaviour change in small steps, such as asking the person to make one change, i.e. stop drinking pop.
- Giving all persons respect and dignity.

Further findings revealed that some people may not perceive their risk of getting diabetes as high so they do not attend screening clinics. Reasons given were:

- They are unaware about the seriousness of the condition and the consequences.
- They are unaware that they belong to a high risk population.
- They have barriers that prevent them from attending the screening, such as:
  - lack of transportation,
  - lack of availability during the day,
  - fear of diabetes and its consequences,
  - lack of knowledge about diabetes prevention and management,
  - lack of knowledge about diabetes,
  - lack of knowledge of the negative and positive consequences of adopting certain lifestyle behaviours,
  - fearful of the disease, sickness, doctors and hospitals, and
  - an unwillingness or inability to change some of the traditional ideas surrounding a medical model that speaks to disease and illness.

#### **4.3.1 Continue MDSi Services**

MDSi has been successful in reaching Métis and remote communities and has created a setting where persons of Aboriginal descent feel comfortable and have started to engage in preventative measures to address diabetes. Considering this is a high risk population that are unlikely to access other screening services the MDSi visits should be continued.

#### **4.3.2 Develop Services Based on an Aboriginal Healing Model**

The findings have shown there is an increased awareness of diabetes and the relationship between lifestyle and health and some initial evidence is shown of behavioural and/or community change. Community members described the desired Aboriginal concepts inherent in service delivery such as the holistic approach and importance of partnerships and community connection. Therefore, based on this finding it is suggested that MDSi coordinate and integrate their medical model with a more Aboriginal healing model. This model would focus on the life cycle of the individuals being children, youth, adults and the seniors. It would also address a holistic approach to the physical, mental, emotional and spiritual well-being of the individual.

Finally, it would be based on a continuum of care of prevention, screening, management and lifestyle rethinking or retraining.

It is suggested that this approach would facilitate individual and community behaviour change. The approach is based on the assumption that the individual is connected with the community and therefore MDSi must work in conjunction with the communities to facilitate individual change. This community connection is very prevalent in Aboriginal communities but it is also evident in other rural and remote areas.

This model should be developed in conjunction with each of the communities as each community is unique and their response to a healing model will be unique. The initial MDSi presentations made in the communities created an awareness and lasting impact on those who attended which, according to community representatives, created a sense of being valued. This type of connection and working towards the same goal should continue. The model will evolve slowly and be developed by building trust in the communities through participation in community events.

It is recognized that this is a major commitment which will require an increase in resources.

#### **4.3.3 Logistical Changes**

It is suggested that MDSi work with communities in identifying the best time of the year for the visit, when the clinic should be open and consider scheduling the frequency of visits depending on the size of the community. This would alleviate community event conflicts identified by participants.

It may be possible for MDSi to partner with communities in order to provide some transportation alternatives to individuals who want to come to the MDSi clinic but do not have a ride. Liability and insurance concerns would have to be considered.

The booker is a critical component of the program. They are crucial in notifying people about the clinic. They often work from an existing list but most of their solicitation is done through family, friends and word of mouth. It is suggested that the booker be changed periodically to get new family and friends coming to the clinic. Also, an on-going and thorough list should be kept by the bookers of people visiting the clinic so MDSi can build on this list. Another suggestion could be having two bookers.

#### **4.3.4 Strengthen Community Connection**

It is suggested that the MDSi team set aside some time when visiting the communities in order to connect and plan with community members. An invite could be made to elected officials, other community stakeholders and community members.

Elders and traditional healers should be invited to the MDSi clinic at the beginning of the visit. They can provide information on specific community protocols as well as feedback on how to provide information about diabetes depending on the life cycle of the individual. As indicated in

the findings some senior adults have more difficulty changing their ways. Perhaps another approach could be developed for them. Also, these traditional people could assist the MDSi team in presenting a holistic approach to health and wellness for individuals who are coming for screening.

Information and updating sessions by the MDSi team could be arranged at community events. Discussions with these groups should focus on strategies for working together in a partnership to address clinic attendance, follow up, and other creative and collaborative ways to prevent and manage diabetes. Some suggestions may be to partner with the local school and diabetes (health) promoter and to work collaboratively on diabetes awareness presentations and dietary/nutritional awareness. Another option is to engage in local community events such as the “fish fry” or scheduled feasts.

MDSi could be more effective in creating behaviour change by:

- Partnering with local agencies and events to provide culturally appropriate services, such as:
  - Working with the local community around transportation barriers for people wanting to attend the clinic;
  - Providing dietary information and alternatives that are appropriate for the traditional diets; and
  - Working with the schools to provide clinic notification and education and awareness information.

Again, this recommendation would require more staff time and expertise and consequently more resources.

#### **4.3.5 Enhanced Communication**

It is suggested that communication between MDSi, community contacts, community stakeholders, and regional health providers could be improved by:

- MDSi notifying the key contact of their upcoming schedule and encouraging the key contact to notify all community stakeholders. Maybe a list of possible community partners should be developed and included in the preparation package that goes out to communities. In this way the key stakeholders in the community can also encourage their clients to visit the clinic. MDSi can communicate directly with community stakeholders to creatively plan awareness events.
- MDSi can communicate regularly and on-going with the local health regions in order to update them in their statistics and those individuals requiring follow up. They can also participate in discussions of how to improve services and work together to better serve the clients. This communication could include providing advocacy for some individuals to follow up with physicians and other diabetes services.

## **Appendix A: Project Restrictions**

## **Project Restrictions**

There were three major project restrictions to this evaluation.

First, because of the tight timelines data were gathered during the fall schedule only. As a result qualitative data were gathered from six of the 23 communities that MDSi visits during the year. Quantitative data were gathered from seven communities. This was supplemented with secondary quantitative data collected from all communities that MDSi visits.

Second, participants in focus groups and individual interviews were selected by the booker or the project coordinator or key contact. This selection process appeared to target primarily people who were using the services of MDSi. Biases may exist due to this selection process.

Thirdly, evaluations of this kind require time and effort for all involved to establish trust and for relationships to develop which in turn leads to community buy-in into the process. Short time lines limited this and hence, some processes and methodologies to data collection ended up having to be changed during the community visits.

## **Appendix B: Methodology and Analysis**

## Methodology

In order to answer the three evaluation questions a triangulation approach was used. It entailed collecting data from multiple sources, using multiple methods and multiple types of data. The following outlines the key data sources:

### Primary data consisted of:

- **Qualitative Data**
  - Focus groups (n=3)
  - In person interviews (n=22 )
  - Key stakeholder telephone interviews (n=7 )
  - Observation (n=6)
  - MDSi team member interviews (n=4)
  
- **Quantitative Data**
  - Client survey (n=61)

### Secondary data consisting of:

- MDSi data base
- MDSi summer survey (draft analysis)

### Target Population

The target population for the evaluation was persons living in rural and remote areas of the province including but not limited to:

- Métis people on settlements,
- Métis people off settlements,
- First Nations people off-reserve,
- Mennonite people

### Cultural Sensitivity and Approach to Data Collection

The evaluation adhered to the principles of conducting evaluations within Aboriginal communities. Other non-Aboriginal communities were treated with the same respect and cultural sensitivity.

- The communities were notified by the MDSi program of the impending evaluation and expectations.
- Permission was received from the communities for the evaluators to enter the community.
- Key community contacts identified by the MDSi program assisted the evaluators in all aspects of the evaluation regarding the protocols of each community.
- The community was involved in the full process of the evaluation.
- All participants and knowledge received were respected.

### Focus Groups

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Focus groups were requested in all six communities and were held in three of the communities visited by MDSi during the time period of the evaluation. The manager of MDSi introduced the evaluation through an email to each community. The MDSi key contact for each community was contacted by the evaluator and the purpose of the evaluation was explained and they were asked if they were willing to participate in the evaluation. All communities agreed to take part in the evaluation. The community contact was then asked to invite community members to a focus group. The focus group was usually held on the Wednesday of the week when the MDSi clinic was in the community. The purpose of the focus group was to get feedback on how the MDSi had impacted the community, both at the individual level but also at the broader community level including infrastructure, planning and health policies. The target participants were:

- Clients using the services of MDSi,
- Clients NOT accessing the service of MDSi,
- Repeat users of MDSi services,
- One time users of MDSi services,
- Representatives from agencies within the community such as public health nurses, diabetes awareness promoters, home support, youth program, principal, youth educators,

In total 22 people participated in the three focus groups held in the communities. For a copy of the focus group tool please refer to Appendix D.

### **In-Person Interviews**

Individual interviews were also conducted during each of the visits to the community. The purpose was to ensure that all of the target population was represented in the total sample as well as ensuring that all potential community uniqueness was captured. The target interviews included:

- Bookers
- MDSi clinic visitor
- Drivers/transportation coordinators

In total 22 interviews were conducted. For a copy of the interview tool please refer to Appendix D.

### **Key Stakeholder Interviews**

Key stakeholders representing the broader service delivery spectrum were identified by the program. These were individuals who could provide a broader perspective on the impact of MDSi at the regional level and provide feedback as to whether or not the initiative had any impact at the broader community level as well as at the regional level. The interviews included representatives from three health regions representing:

- Health planning
- Service coordination
- Chronic disease management

- Home care services
- Aboriginal liaisons

In total 6 interviews were conducted. For a copy of the interview tool please refer to Appendix D.

### **Client Survey**

A client survey was developed to capture clients' perspective of the purpose of MDSi, the impact at the personal level, and to what degree MDSi had contributed to any lasting change in the community's approach to prevention and reduction of diabetes incidences.

The survey was administered by the MDSi staff prior to the client receiving any service. In total 61 surveys were collected.

For a copy of the survey please refer to Appendix D.

### **MDSi Data Base**

The database maintained by the program provided data related to uptake by population/gender/age.

### **Summer Survey Draft Results**

The preliminary findings from a telephone survey conducted in 2008 by the primary investigator for MDSi was reviewed and compared to the evaluation findings.

## **Analysis**

Triangulation was accomplished by using multiple methods, multiple sources and multiple types of data. The findings from each method were compared and contrasted to identify any irregularities, areas where clarity was required or areas of contrasting findings.

### **Qualitative Analysis**

To ensure data confidence, validity and reliability the following data collection approaches and analysis were used. It should be noted that validity and reliability measures are internal to each community.

**Data Collection:** The evaluators spent 12 days combined in the six communities. This allowed time to establish rapport within the communities, observe the community uniqueness and meet the various stakeholders outside of the focus group setting as they came to the clinic or attended other services being provided in the location where the MDSi clinic was held.

**Validation of Data:** At the end of each segment or topic during the focus groups and the individual interviews with community members, the evaluators paraphrased the information that had been provided. At the end of each focus group the information was reviewed by category.

**Coding:** Data was hand coded by broad categories. A matrix was used to capture themes by population and areas of inquiry. Open analysis was conducted. That is, all qualitative

responses were reviewed without a pre-established template or expected pattern for responses and then coded for general areas or themes.

**Reliability:** Both evaluators took extensive notes during the focus groups (when appropriate). Both sets of notes were used in the analysis. Peer debriefing took place after each focus group and any irregularity was followed up for clarification.

## Appendix C: Data Findings

## **1. Do some high risk target sub-populations not attend MDSi clinic screening? If so, why not?**

The prevalence rate of diabetes in the Aboriginal population is significantly higher than the general population<sup>4</sup>. Furthermore, research has shown that First Nations people are four times as likely to access the emergency departments for diabetes related concerns and have a significantly higher rate of hospitalization for diabetes related issues compared to the general population<sup>5</sup>. Research conducted by Dr. Toth between 1998 to 2006, showed that the diabetes rate within the Métis Settlements population rose from three per cent to five per cent. This is a 66 per cent increase. The rates were highest for women of the Settlements compared to men.

As identified in the previous MDSi evaluation there is a concern among community organizers and MDSi staff that some high risk sub-populations within the communities do not attend the clinics. However, to what degree this is a more common practice within the communities MDSi visits than other Alberta communities is unknown. The most critical factor is that Aboriginal populations in general are more at risk to develop diabetes and therefore a higher proportion of the community population is at risk. Based on these data early detection and prevention of diabetes is important.

MDSi visits to the communities have been successful in raising awareness among community members of the importance of participating in diabetes screening. This has resulted in community members accessing diabetes screening through the MDSi clinic. Data from communities visited by MDSi in the fall of 2008 indicated that females age 25 and up have a higher representation at MDSi clinics as compared to the overall population; whereas males of similar age appear to be underrepresented. However, in some communities there is also a change occurring within the male attendance rates at clinics. The data suggest males over the age of 45 have similar or higher proportional representation at MDSi clinics than the overall population.

### **Community Members View Screening as Important**

The Canadian Diabetes Associations' 2003 Clinical Practice Guidelines recommend community-based screening programs for Aboriginal communities. Community members concurred that screening is important. When asked in focus groups and individual interviews who should come to the MDSi clinic there were three main responses. Some people believe all who live in the community should visit the clinic whereas others suggest that those most at risk should attend the clinic. The categories most commonly used of who should come were:

- Anyone who is Aboriginal.

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<sup>4</sup> Diabetes among Aboriginal (First nations, Inuit and Métis) People in Canada: the Evidence. Available from [http://www.hc-sc.gc.ca/fnihah-spnia/alt\\_formats/fnihb-dgspni/pdf/pubs/diabete/2001\\_evidence\\_faits-eng.pdf](http://www.hc-sc.gc.ca/fnihah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/diabete/2001_evidence_faits-eng.pdf) - accessed march 17th, 2009.

<sup>5</sup> Cardinal, J., Schopflocher, D., Svenson, L., Morrison, K., & Laing, L. (2004). First Nations in Alberta: a focus on health service use. Edmonton, Alberta: Alberta Health and Wellness.

- Those people who have diabetes
- Those people who are related to those people who have diabetes

Most participants did recognize that Aboriginal people are at a higher risk for diabetes but there were still a few participants who did not know that Aboriginal descent constituted a risk factor. Although bookers do schedule non-aboriginal people if they have free appointment times, most of the people attending MDSi in the six communities visited were Aboriginal.

All survey respondents (100%) knew that the MDSi clinic comes to the community to screen for diabetes. Most survey respondents (95%) felt all community members should visit the MDSi clinic at least once a year and almost 85% indicated that community members with diabetes should visit MDSi clinic once a year. The large majority (90%) of people, interviewed while attending the clinics during the evaluation, indicated they came because they were concerned about getting diabetes.

### **Awareness of MDSi Visit**

In order for community members to visit the clinic they must be aware that the clinic is in the community. The majority of respondents (69%) interviewed while attending the clinic found out about it through the local booker. It is therefore important, according to the participants, that the booker is well connected with all sectors of the community and is flexible when booking appointments. Furthermore, the booker must ensure the client has access to transportation to get to the clinic.

Having a close relative receive a diabetes diagnose is often a trigger for personal concern. This raises the person's awareness that they are at risk and therefore they come in for screening.

**Why Are Some Community Members Less Likely to Attend MDSi?** When participants were asked why some at-risk community members do not attend the clinic there were multiple, but consistent responses from all communities. Fear, according to participants was the most common reason for not attending. The fear was multi-faceted: fear of diagnosis, fear of the disease, fear of having to change lifestyle, etc.

There was a sense in all communities that seniors, in particular, choose not to attend the MDSi clinics. It was felt that many are set in their ways and do not want to make lifestyle changes; they have seen the devastating effects that diabetes can have on a person and they were fearful of getting the same 'sentence'.

Some community members are not able to access the clinic since they are away from the community during the day or some major event is taking place in the community the same day which takes priority.

Another reason for not attending was that community members were not aware of the specific diabetes symptoms and therefore did not come because they did not feel sick. Many respondents interviewed, especially those residing outside of the Métis Settlements, were unaware that Aboriginal heritage may place one at risk for diabetes.

In summary, the reason for not attending the clinic fell into five broad categories:

- Lack of transportation (please refer to 3.2 follow-up on referrals).
- The person was not in the community during the day due to work or other commitments and MDSi was not open in the evening in most communities.
- Other community event which takes priority.
- Lack of clinic awareness and notification.
- Lack of education on what places an individual at higher risk for diabetes.
- Resistance to and fear of behaviour and lifestyles changes that might be required.

It should be noted that during the time of the evaluation, close to a third (31%) of the visits were from community members who attended the clinic for the first time. The majority of respondents indicated that they did not have diabetes, and that they came for screening as a preventative factor. Both of these findings suggest that MDSi is reaching further into the communities.

### **Culturally Relevant**

All participants noted that the information provided by the MDSi team was appropriate for the people they served in that:

- All information was delivered in clear and easy to understand language;
- Client plans were concrete and straight forward, for example the focus was on changing one mutually agreed upon health factor; and
- Any pictures used in the information brochures were of Aboriginal people.

Participants further stated that the MDSi team was always respectful and approachable. According to participants the team was non-Aboriginal but they were helpful and nice. As an example participants noted that it was easy to understand the type of lifestyle changes that were being discussed. This statement was also supported in the survey findings where respondents indicated they followed suggestions made by MDSi staff such as eating better, exercising and watching their weight. The fact that community members viewed the MDSi team as accessible and easy to talk to contributed to MDSi's ability to reach a larger population within the communities.

## **2. Follow up on MDSi Recommendations**

MDSi screening was viewed by the participants as a helpful and accessible way to gain information about diabetes and to assess whether or not they appear to have diabetes. MDSi does not diagnose diabetes but refers clients to their physicians for final diagnosis. Previous evaluations found that not all clients referred to physicians followed up on the referral.

The degree to which Aboriginal populations are less likely to follow up on a referral compared to the general population is still unclear. There is a sense among some communities that this is a concern, however, participants in the evaluation suggested that most people do follow up, even if it is not done immediately following the MDSi visit. There appear to be some differences among the various communities. Some communities were more likely to report that community members do not follow up. The main reasons that influenced the follow up rate were:

- Transportation barriers
- Difficulty getting an appointment with a physician
- Fear of doctors/hospitals
- Lack of physician who they feel is supportive
- Services not culturally appropriate

The evaluation findings are supported by initial findings from the MDSi *Summer Survey Results*<sup>6</sup>, which identified that 89 of the 175 individuals surveyed (51%) visited a doctor after being screened by MDSi and most went within a week. Of those who waited longer to see the doctor they “*did not think it was that important*”. Most respondents had further blood tests done and most tests agreed with the MDSi results. However, of those being screened by MDSi, there were few individuals who followed up with a nurse or dietician about their risk of diabetes, their weight, cholesterol or blood pressure.

Service providers also expressed concern that some community members do not follow up on MDSi recommendations and it is not until a crisis occurs in the person’s health status which then prompts them to seek medical help. At that time there is often an acute admission to a hospital for treatment of diabetes related complications. As noted earlier, this has also been identified in research conducted by Alberta Health and Wellness<sup>7</sup> which showed that First Nations people are four times as likely to access the emergency departments for diabetes related concerns and have a significantly higher rate of hospitalization for diabetes related issues compared to the general population. According to service providers, discharge planning after such admissions is limited since few services are available in most communities. Nurses or dieticians with diabetes expertise are simply not available in most communities. When a person qualifies for home care and it is available in the community it does not always appear that a referral from acute care discharge planning to local home care service is made. Therefore, for most community members, MDSi is the only reliable diabetes service that can be accessed.

### **Physicians Perceived as Not Supportive**

Many community members also expressed hesitation in accessing physicians. They described that a supportive physician has the capacity to take on new clients, allow for walk in appointments, describe the diseases, allow for questions to be answered, and understand that if

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<sup>6</sup> Summer Survey Results – DRAFT – Accessed December 2008.

<sup>7</sup> Cardinal, J., Schopflocher, D., Svenson, L., Morrison, K., & Laing, L. (2004). First Nations in Alberta: a focus on health service use. Edmonton, Alberta: Alberta Health and Wellness.

a patient cannot make appointments they will not be labeled as noncompliant. Most community members indicated they have difficulty finding a physician who is supportive and accessible.

### **Transportation**

Access to transportation is a major issue both within the community as well as in accessing services outside the community. There appears to be inconsistency in transportation support to those who want to access the MDSi clinic. In most communities the MDSi booker reported that they will provide transportation to anyone who is interested in attending but cannot get there. In other communities it is the role of the diabetes education coordinator (a project position) to ensure that transportation is provided. In a couple of communities there was no transportation provided for accessing the MDSi clinic.

There are many unique challenges for rural and remote Albertans accessing services. For Aboriginal populations the issues are many, including financial (cost of operating), access to vehicles, and having a driver's license. Many people do not own a vehicle and have to rely on others to drive them. If they are able to get a ride it is often not at a time when they have an appointment, or it may not even be to the centre where their physician practices. Participants report that transportation barriers are even more challenging among older community members. For example, it was estimated in one community that approximately 95% of women over 65 years of age do not drive.

## **3. Behaviour Changes**

### **Individual Impact**

All communities indicated that young people in their community were becoming more aware of the importance of healthy eating and active lifestyle. It cannot be determined to what degree MDSi has contributed to this change. However, community members identified the following ways MDSi has contributed to healthy changes among the community members:

- Increased awareness of diabetes before, during and after a MDSi community visit;
- Community-school connections established, i.e. school newsletters advertising upcoming clinics;
- A shift from a disease-focus to a wellness focus i.e. talking about healthy lifestyles versus focus of not getting sick.
- Youth are at an increased risk of diabetes and advised that they may be at risk, which means the need for immediate intervention and earlier prevention.

Identifying specific behaviour changes among community members is difficult to do according to participants. However, some examples provided where significant changes had been made by individuals:

- Individuals stopped drinking pop.
- Many people were trying to lose weight - clubs like the "biggest loser" are organized in some communities.

- More people were seen walking in the community.
- People were trying to eat healthier (more fruits and vegetables).

Service providers in the community noted that:

- The MDSi program was discussed among community members.
- Many community members tried to change but after a while fell back into earlier behaviours.

Several communities commented that MDSi on its own cannot expect to change community knowledge and awareness but other services must become involved as well. According to respondents, partnerships with local services are required to advance MDSi and subsequently diabetes prevention. MDSi should be linked with local community activities whenever possible. In one community a fish fry (feast) was held during the MDSi visit. This feast could have been used as an opportunity for MDSi staff to connect with the community and provide information about healthy eating. Another example of a local initiative was one community that had offered Community Kitchen to young moms where they looked at healthy eating and traditional foods. MDSi could have connected with the group to provide suggestions and resources on traditional eating.

When asked about the availability and use of recreational activities within the community, participants recognized that Aboriginal people do not go to the gym and, especially the older people, “*would laugh at the idea of exercise*”. Traditionally, physical activity was part of the Aboriginal lifestyle and for older community members this is how it will remain.

It was reported that younger people were more likely to become involved in organized sports, which many communities identified as having softball, hockey, hiking, and exercise programs such as teen fitness program and teen walking groups.

Diet was recognized as an important component of managing diabetes. The challenge for Aboriginal people was incorporating traditional meats and berries to abide by the Canadian Food Guidelines. Some respondents stated that Aboriginal people are not familiar with vegetables and fruit and find it challenging to include these in meals because they may not be familiar with the tastes and do not know how to prepare it. Some respondents suggested that this barrier was even more pronounced among the older populations where new ways of preparing traditional foods were often rejected. For example, older persons did not like bannock made with whole wheat and baked in the oven instead of bannock made from white flour and fried in grease which is the most common way to prepare it.

There were also concerns that very few culturally relevant opportunities were available for the seniors in the communities as it relates to changing behaviour. As noted before, physical activity is not viewed as an activity in itself but rather a way of life. Changes to the traditional foods must be introduced slowly and by local community champions who understand both the older populations’ hesitation to change but also the need for healthy lifestyle.

## **Community Impact**

When asked to provide examples of the impact on the community of MDSi, participants stated that overall it has created more health awareness and resulted in community members attending annual check-ups. According to respondents, yearly visits by the MDSi clinic provide the community with a sense that they are valued and it personalizes diabetes and serves as a reminder about health and wellness.

Individuals interviewed stated that since MDSi visits began in the community they have noticed that people with diabetes have gained a sense of hope and understanding that it is possible to live in a healthy and relatively normal way with diabetes. It is not necessarily a 'death sentence' anymore. The result is that community members are more likely to show up for an MDSi appointment compared to other appointments.

Regional coordinators within health regions commented that MDSi visits have impacted how they plan and implement various chronic disease management initiatives. In one region they stated that in the fall of 2008 an education component was implemented on nutrition lifestyle, dietary, recreation, chronic disease self-management and they are now working with the community in a standardized approach to a healthy lifestyle.

It was further indicated that local communities are also changing some of their policies because of the work of MDSi in their community. For example one Community Health Council created a policy to have healthy food options, and no "junk-food", at their meetings.

## **4. Strengths**

### **Access**

The easy access to MDSi was noted by all participants as a major strength of MDSi. Specifically, participants stated:

- MDSi clinics are often located closer than physician clinics (even though there may still be a transportation issue locally).
- The clients are familiar and comfortable with the location of the MDSi clinic in their communities.
- It is easy to get an appointment with MDSi.
- Clients receive results immediately from MDSi and do not have to wait.
- It is a one-stop for all information, i.e. weight, height, blood pressure, cholesterol, and retina exam.
- The team is trusted and friendly.

Survey respondents also identified that the "best part" of MDSi was:

- The ease to make an appointment (30%).
- The valuable information they received, i.e. check your blood to know if you have diabetes (26%)
- The information and awareness related to healthy lifestyle (18%) they received.
- The helpfulness of staff (16%).

## **Connection with Community**

The communities in general view the visits by MDSi positively. The frequency of visits appears to meet the need according to most community members interviewed. The staff is trusted and is viewed as being approachable and easy to access. Extend hours of service was a suggestion to improve access for those working outside of the community.

The use of a local person being responsible for the connecting with community members and bookings of clients was a strong component that contributes to the clinics credibility, according to the respondents. The local connection was vital, since most of the MDSi's notification for an upcoming visit was through word of mouth.

When local service providers were included in planning and scheduling community visits the acceptance of MDSi was improved. This type of coordination and relationship building resulted in stronger anchoring of MDSi in the community life. The result is that service providers have an opportunity to inform their clients and encourage them to visit the clinic.

A couple of communities were able to announce the MDSi clinic's visit within their school newsletter. Respondents indicated that this method reached many families. In one community the team was also able to visit a school which was viewed by service providers as a powerful way of reaching young community members and to increase their knowledge and awareness of healthy living.

There is very little evidence that the MDSi clinic in anyway proactively partners with elected leaders. However, in several communities respondents indicated that elected leaders certainly are aware of the high incidence of diabetes and its risk to its population, but for many elected officials the key community issues remain the economic situation, i.e. lack of employment.

## **The “Best Part” of MDSi Services**

Participants were asked to comment on the “best part” of MDSi coming to the community. There were many benefits, according to community members:

- The MDSi clinic increases community members' awareness of diabetes, even if they do not visit the clinic.
- For many visitors to the clinic the most beneficial information was information on overall health issues that were tested for and discussed, i.e. body mass index, diet, active living, blood pressure, etc.
- The clinic provided services in a relaxed atmosphere that was relatively easy to access. Respondents commented that MDSi was the only place where they get up to 45 minutes with professional health care providers who can advise and assist them in how to improve their health through lifestyle choices.
- It was a culturally appropriate way of receiving a range of tests that many do not get even if they visit their doctor. In particular many people would never travel to Edmonton for Retinal Photography, and many people with diabetes indicated their own physician had not suggested they complete this test as part of their disease management.
- Having community people involved in coordinating the visits encouraged attendance.
- Finally, MDSi increased the chance of people obtaining a diagnosis that would most likely not be diagnosed until a later date or not at all. Moreover, MDSi may support diabetes crises resulting in acute care services.

## **Awareness**

MDSi has raised the diabetes awareness in the communities it visits. Participants all agreed that MDSi has brought attention to individuals about the disease. Seventy two percent of survey respondents indicated they were more aware of diabetes since MDSi started coming to the community. This was also supported by the MDSi Summer Survey where 70% felt that they knew more about diabetes after being screened by MDSi.

Slowly, communities are becoming more aware that Aboriginal populations are at higher risk for diabetes. When survey respondents were asked if they felt they were in a higher risk population for developing diabetes 41% indicated they were however over a third (36%) did not know that Aboriginals are a high risk population. Furthermore, in some communities service providers indicated they did not know this was a fact. In particular, this was noted in communities where no community health council or other formal connection to the local health region existed and where no official presentation had been made by the MDSi research team.

In the MDSi *Summer Survey* follow up of clients 76% of respondents indicated they were aware of being at a higher risk. This higher rate of awareness may be due to the fact that the evaluation survey was completed as the client came to the clinic. They had not received any specific information about diabetes when they completed the survey, whereas the *Summer Survey* was completed on clients who had previously attended the clinic.

The more important aspect noted was that community members are beginning to understand that there is a direct relationship between lifestyle and health outcomes. Even though many people might be struggling with changing their behaviour – they know it is important to try. Seventy-nine percent indicated there are things that they can do to prevent getting diabetes. The most common behaviour changes mentioned were exercise (41%) and healthy eating (37%).

This finding is similar in the MDSi Summer Survey that showed after being screened by MDSi, 74% thought that it was necessary to improve their eating habits, 61% felt they needed to improve their exercise levels, and 33% thought it necessary to reduce their stress levels.

The knowledge of disease management is also increasing. People know that being diabetic does not mean a fast decline and tragic loss of limbs and function as long as long as they take care of themselves. Of those people who came to the clinic with a prior diagnosis of diabetes, 20% said they had followed the suggestions provide by MDSi such as changing their diet or starting to be more active.

There were consistent comments made by community members that the most powerful way to impact the community was to reach school aged children. Participants refer to the impact of smoking cessation campaigns that target younger children and how these children bring the

messages into the home. In one community the diabetes educator had introduced new foods and focused on increasing children's knowledge of healthy food. According to parents, these messages were brought home by the children.

## **Services**

When asked if there are services available in the community for persons with diabetes, less than a third (29%) of the respondents indicated this as being true. Even though most communities did not feel they had any local health services, there are some services in most communities such as public health, home care, diabetes educators, Aboriginal health liaison workers, recreational staff and various school staff. However, considering the high health needs in the communities, many are most likely underserved. A complicating factor is that the service sector is project based, which challenges sustainable programming and continuity in service delivery. Long term commitments by funders and elected officials help support large health behaviour changes and healthier outcomes for populations.

Most community members still equate having access to health services as the same as having access to a locally based physician. Most people access health services reactively not proactively. Health prevention and promotion does not have a high profile and when discussed in general terms, it is not considered as critical to health as immediate access to physician services. However, the success of MDSi in reaching the community members has resulted in community members accessing the clinic for prevention and health promotion reasons, without calling it by name.

## **5. Areas for Improvement**

### **Communication**

Key contact people within the communities are contracted to schedule the MDSi clinic. They require one month's notice in order to make the arrangements for the clinic. It is assumed by MDSi that the key contact notifies all community stakeholders. It was found that often the key contact would arrange for the booker and the booker would then contact friends/relatives/people from previous lists who attended MDSi and schedule appointments for them. However, often the key contact did not notify other stakeholders, such as the regional health providers, the local public nurse, the diabetes promoter or homecare personnel. There is an opportunity for MDSi to expand its scope by ensuring these stakeholders are involved in MDSi.

Some communities advertised the clinic in the local newspapers, local newsletters and community poster boards; however, word of mouth and booker solicitation are the most common forms of advertisement. It was suggested that advertisement should also be done on the radio, through the school newsletters or on Facebook, a web-based application.

It was suggested by some participants that more extensive and inclusive notification be provided to the communities and stakeholders. The regional health service providers also suggested that it would be helpful if MDSi would communicate with them on an ongoing, regular basis providing community breakdowns of screening data. Together they could identify needs

and the regions might be able to provide more support to the clinic and clients. MDSi strives to do this, however the continuous staff changes and reorganization of reporting structures makes this a challenge that MDSi continuously has to work on to keep up to date records of contacts.

### **Cost Impacts Lifestyle Choices**

One of the greatest challenges to preventing and managing diabetes, according to participants is the perceived cost involved. It was acknowledged in all communities that many people did not have a lot of money and vegetables and fruits were seen as more expensive than wieners and Kraft dinner. Also, when participants spoke about recreational activities these were equated with a cost, such as how much it costs to play hockey. Another cost identified by participants was the strips needed to check their blood sugar. These strips are expensive and are not covered by health care. Many people may decide not to check their blood sugar as frequently because of the expense.

### **Isolation**

Some participants lamented that MDSi was a team and a clinic that came into the community, did the screening and left. They were not seen as part of the community or working with the community members in preventing or managing diabetes. They were seen strictly as a screening mechanism.

## **Appendix D: Tools**

## **Community Members Focus Group**

*Introduction of project, use of data and report back.*

### **Community View of MDSi**

- How did you become aware of MDSi? (How do people in general become aware of the clinic?)
- Who is the MDSi for? (Who should come, why, age, gender, when or how often should they come?)
- What is the purpose of the MDSi? (How was it described to you?)

### **Resistance to Accessing the Service**

- Are there some groups of people who should attend the MDSi who choose not to? If so, why don't they come?
- What could/would make it easier for people to attend MDSi?
- What was or would be the one thing (or more) stopping you from using MDSi?

### **Client Behaviour and Use of Service**

- If someone has been identified as having (pre) diabetes or being of high risk for diabetes – what should they do next? (What guidance is given to them of where to access resources?)
- What types of services are important for those at risk for diabetes?
- What can individual people who are at risk do to reduce the impact and future health risks from diabetes?
- Do you have services in the community for people who have diabetes? (Where do they go for services?)
- What could/would make it easier for people to use diabetes services?

### **Individual Behaviour Changes**

- Have you noticed any changes in community members' behavior as it relates to diabetes over the last few years? If so what changes?

### **Community Impact of MDSi**

- Does the MDSi make any difference in the health of your community? If so, how and what –please explain. Give examples.
- How is the MDSi clinic viewed by the community? (Culturally appropriate, frequency, staffing patterns, connection with community services)

## Individual Interviews

### Community View of MDSi

- What is MDSi?
- What is your connection to it/role in promoting the clinic?
- Why did MDSi start coming to the community? (Invited or uninvited?)
- How is MDSi viewed in the community?
- Who comes to the clinic? Why do you think they come? How do they find out about it?

### Resistance to Accessing the Service

- Who do you think does not access the clinic that should be going? (Barriers, perception, fear,)
- Why do you think they don't come?
- What would make it easier for people to come to MDSi?

### Client Behaviour and Use of Service

- Those who have been to the clinic and have been diagnosed as having diabetes – do they act on the referral? Why or why not? How do you know?
- Why do people keep returning to MDSi?
- What services exist to support community members dealing with diabetes?

### Community Impact of MDSi

- What is the most important aspect of having the MDSi come to the community?
- Has the clinic made any difference in the community? (Awareness, knowledge, less travel, earlier detection, service coordination) How do you know – examples?
- How can MDSi services be improved?

### Individual Behaviour Changes

- How has someone you know/or yourself changed since being diagnosed with diabetes?

## MDSi Outcome Survey

(review this with clients at the start of their visit)

|   |                                      |
|---|--------------------------------------|
| Community: _____  | Day of visit in the community: _____ |
| Gender:        M        F   | Age: _____ # times visited: _____    |
| Diagnosed with diabetes since (year) _____  |                                      |
| How did you find out the clinic was in the community today? (circle all that apply) |                                      |
| Coordinator   | Friend Add/poster                    |
|   | Last appointment                     |

### A. About the MDSi.....

| Statement  | True | False | D/K |
|--|------|-------|-----|
| MDSi comes to the community to screen for diabetes                                     |      |       |     |
| MDSi comes to the community to screen for pre-diabetes                                 |      |       |     |
| The MDSi clinic provides help only to those who are already diagnosed with diabetes    |      |       |     |
| All community members should visit the clinic at least once                            |      |       |     |
| Community members with diabetes should visit MDSi each time they come to the community |      |       |     |
| There are services in the community for persons with diabetes. If yes, which ones?     |      |       |     |

### B. About you.....

| Statement   | True | False | D/K |
|---|------|-------|-----|
| I am in a high risk group for developing diabetes   |      |       |     |
| I came today because I am concerned about getting diabetes                                |      |       |     |
| Since MDSi started coming to the community I am more aware of diabetes.                   |      |       |     |
| Since MDSi started coming to the community I have changed my lifestyle. If yes, how ..... |      |       |     |

**C. About you (those living with diabetes).....**

| Statement   | True | False | D/K |
|---|------|-------|-----|
| Since being diagnosed I have followed all suggestions made by MDSi      |      |       |     |
| I know where to go in the community for help with diabetes.             |      |       |     |
| I can get the help I need from community services for my diabetes       |      |       |     |
| I know the things to do to stay healthy with diabetes. If yes, explain. |      |       |     |

**Open Questions:**

What is the best part of the MDSi clinics?

How can MDSi improve its services to the community?

What is the biggest change you made in your life as a result of being screened by MDSi?

I know there are things I can do to reduce the risk of getting diabetes, such a