Welcome!

Thank you for joining the webinar:

**Teaching Self-Management of Diabetes**
Colin Reeve, BSP, CDE

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Teaching Self-Management of Diabetes

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Taché Pharmacy at Seven Oaks Hospital
Winnipeg, Manitoba
Disclosures:

- Lifescan Canada
- Sanofi
- Bayer
- Abbott Labs
- Pfizer
- Canadian Pharmacists Association
Objectives

Discuss diabetes self-management education with patients in a community pharmacy setting.

Patient assessment
- Identify patient's perceived goals of therapy/identify perceived barriers to behaviour change
- Collaboration and referral to key healthcare providers
- Importance of periodic reassessment

Guideline based treatment options for patients with diabetes (CDA CPG '13 guidelines)
- Nutrition and diet recommendations
- Safe and proper use of medication therapy
- SMBG recommendations

Acute and Chronic complication management and self care
- Hypoglycemia management and prevention
- Chronic complication prevention and management (microvascular/macrovascular)

Postscript: Marketing a diabetes education service in a community pharmacy setting
Preface - How are patients with diabetes receiving care in the community? (...and are they at target?)

**DICE study:**
- Nearly half (49%) of patients were not at target blood sugar levels (A1C ≤ 7%)
- Intensive treatment plans were considered for only half (56%) of people not at target
- More than 50% of the total group was either managed by lifestyle alone or by taking no or only one oral anti-diabetes medication
- When asked about their treatment plans for patients not at target, physicians identify lifestyle intervention as their plan for 79% of patients
  - Patient non-compliance with diet (72%) and exercise (71%) were the principle barriers to achieving optimal control identified by family physicians

Harris SB, Ekoé JM, Zdanowicz Y, Webster-Bogaert S, Glycemic control and morbidity in the Canadian primary care setting (results of the diabetes in Canada evaluation study), *Diabetes Research and Clinical Practice*, 2005;70:90-97
Preface - How are patients with diabetes receiving care in the community? (...and are they at target?)

Monitoring:

A 2009 study conducted by the Canadian Institute of Health Information found that in the previous year:

- 81% of all Canadians with diabetes received an HbA1c test
- 74% received a urine protein test to measure kidney function and
- 51% had their feet checked for sores or irritations.
- 66% received a dilated eye exam in the last 2 years

Patient-centred Diabetes Self-Management Education and Support

- Diabetes is a chronic, progressive disease (UKPDS)
- The chronic and multifactorial nature of the disease requires team-based management of care (collaboration is key!)
- Focus on prevention of sequelae
- Patient-centric disease management (Chronic Care Model)
Patient: MN

- 47 years old
- Type 2 diabetes for 5 years
- New client to your pharmacy
- Recently accepted as a patient at a local primary care clinic in your area
- Would like to speak with a pharmacist about his diabetes - feels he needs a “refresher” on his self-management skills
- His daughter was just diagnosed with gestational diabetes and he is worried she will have diabetes in the future
- Your pharmacy offers diabetes education services by appointment
Patient Assessment

- Where do we start with this patient?
- Need to assess:
  - Patient’s current health status (A1C, blood lipids, etc.)
  - Medication review
  - Lifestyle (diet, exercise)
  - Psychosocial issues/support systems
  - Patient goals and perceived barriers to change
# Patient Assessment

## Sample Diabetes Patient Care Flow Sheet for Adults

### Part A:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Type of diabetes: Type 1 □ Type 2 □ Other □</th>
<th>Date of birth:</th>
<th>Date of diagnosis:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Risk factors, co-morbidities</th>
<th>Self-Management (discuss w/ patient; add date and location in chart)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Patient Goals:</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Possible Barriers to Self-Management:</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>Diabetes Self-Management Education:</td>
</tr>
<tr>
<td>Peripheral Artery Disease</td>
<td>□ Weight Management:</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Ht:</td>
</tr>
<tr>
<td>Mental health diagnosis</td>
<td>Target Wt:</td>
</tr>
<tr>
<td>Polycystic Ovary Syndrome</td>
<td>Target BMI:</td>
</tr>
<tr>
<td>Foot disease</td>
<td>□ Physical Activity (aerobic 150 min/week; resistance 2-3 times/week)</td>
</tr>
<tr>
<td>Erectile Dysfunction</td>
<td>□ Glucose Meter/lab comparison</td>
</tr>
<tr>
<td>Smoking</td>
<td>□ Patient Care Plan (Pregnancy Planning/Driving License):</td>
</tr>
<tr>
<td>(Date stopped)</td>
<td>Date discussed</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td>(Assess/discussed)</td>
<td></td>
</tr>
</tbody>
</table>

| Vaccinations                  |                                                                      |
|-------------------------------|                                                                      |
| Flu (annual)                  | Date: ______________________ | Date: ______________________ |
| Pneumocococcus                | Date: ______________________ |                             |

<p>| Visits (Every 3 to 6 months)  |                                                                      |
|-------------------------------|                                                                      |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>BP</th>
<th>Weight</th>
<th>A1C Target 5.7% or</th>
<th>Notes (Goals, clinical status)</th>
<th>Hypoglycemia</th>
<th>Antihyperglycemic Agents / CV protection</th>
</tr>
</thead>
</table>

---

**Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada**
Patient: MN

- A1C 7.6% (PCP provided)
- BMI 31.3 (calculated)
- Tests blood glucose once daily but does not have log book with him.
- Comorbid diseases: hypertension, peripheral neuropathy (feet)
- MN has attended group diabetes education classes including dietetic counselling (5 years ago).
- Sedentary lifestyle
  - Walks 1-2 times a week (20 min). Would exercise more if he had someone to exercise with.
  - Admits to drinking a bottle of pop everyday. Knows he needs to eat healthier. Does not want to follow a strict “diet”.
<table>
<thead>
<tr>
<th>Date Dispensed (DD/MM/YY)</th>
<th>Quantity dispensed</th>
<th>Purpose for Use</th>
<th>Medication, Dosage &amp; Form (Brand or generic / manufacturer as known by the patient)</th>
<th>Direction of Use</th>
<th>Pharmacist comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5x3 ml</td>
<td>T2DM</td>
<td>Humulin 30/70</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>T2DM</td>
<td>Metformin 500 mg</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension</td>
<td>Ramipril 5 mg</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peripheral Neuropathy</td>
<td>Gabapentin 100mg</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insomnia</td>
<td>Mirtazapine 15 mg</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTC/Herbal</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prescriptions (including nasal sprays and eye drops)**

Pharmacist recommendations & comments for patient:
To be determined...
Patient: MN
Where to start?

**Lifestyle factors:**

- Large cohort studies\(^1,2\) have demonstrated regular physical activity are associated with reductions in cardiovascular and overall mortality of 39% to 70% over 15 to 20 years of follow-up.

- Nutrition therapy \(^3\) has demonstrated an A1C lowering effect of 1-2% as evidenced in multiple studies\(^3\).

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At diagnosis of type 2 diabetes
Start lifestyle intervention (nutrition therapy and physical activity) +/- Metformin

- A1C < 8.5%
  - If not at target (2-3 mos)
    - Start metformin immediately
  - Consider initial combination with another antihyperglycemic agent
  - Initiate insulin +/- metformin

- A1C ≥ 8.5%
  - If not at glycemic target
    - Start/Increase metformin

Add an agent best suited to the individual:

**Patient Characteristics**
- Degree of hyperglycemia
- Risk of hypoglycemia
- Overweight or obese
- Comorbidities (renal, cardiac, hepatic)
- Preferences and access to treatment
- Other

**Agent Characteristics**
- BG lowering efficacy and durability
- Risk of inducing hypoglycemia
- Effect on weight
- Contraindications and side effects
- Cost and coverage
- Other

Add another agent from a different class
- Add Intensify insulin regimen

Make timely adjustments to attain target A1C within 3 to 6 months
Lifestyle factors
Assess readiness to change

Ask MN what he feels he could do to change his lifestyle/What would motivate him to change?

- Positive influence on his daughter
- Healthier/longer life (more time with grandchildren)
- Feeling/looking better
- Diabetes in better control

What are his perceived barriers to change?

- Does not want to follow a “strict” diet
- No one to exercise with
- States that he is nervous about exercising more often: voices concerns about low blood sugars, increased chances of a cardiac event and foot problems (autonomic neuropathy)
2013 CPG Recommendations

Physical activity:
- 150 minutes of moderate- to vigorous-intensity aerobic exercise each week, spread over at least 3 days of the week, with no more than 2 consecutive days without exercise
- resistance exercise at least twice a week and preferably 3 times per week in addition to aerobic exercise

Nutrition:
- People with diabetes should receive nutrition counselling by a registered dietitian to lower A1C levels
- Individuals with diabetes should be encouraged to follow Eating Well with Canada's Food Guide in order to meet their nutritional needs
- In overweight or obese people with diabetes, a nutritionally balanced, calorie-reduced diet should be followed to achieve and maintain a lower, healthier body weight

Physical Activity Risks: the Facts!

- Risks of inactivity far outweigh risks associated with physical activity
- Risk of a cardiac event during exercise is 6 events per 100,000 persons¹ (middle aged males) vs. risk of obesity/inactivity for CV disease (even with comorbid CV disease present)
- Autonomic neuropathy is not a contraindication for aerobic or resistance exercise; exercise (resistance) may help to prevent foot ulcerations in persons with peripheral diabetic neuropathy²

MN’s goals:

- Attend an 8-week Diabetes exercise program offered at the local YMCA (offered in 1 month)
- Exchange his daily bottle of pop for water immediately
- Attend group dietetic counselling at a DEC (Diabetes Education Center) in the next 3 months
- Incorporate the plate technique and handy portion guide principles into his daily meal choices (CDA, Just the basics)
Just the Basics

Plan for healthy eating

Handy portion guide

Your hands can be very useful in estimating appropriate portions. When planning a meal, use the following portion sizes as a guide:

- **FRUITS/GRAINS & STARCHES**: Choose an amount the size of your fist for each of Grains and Starches, and Fruit.
- **VEGETABLES**: Choose as much as you can hold in both hands.
- **MEAT & ALTERNATIVES**: Choose an amount up to the size of the palm of your hand and the thickness of your little finger.
- **FATS**: Limit fat to an amount the size of the tip of your thumb.

MILK & ALTERNATIVES: Drink up to 250 mL (8 oz) of low-fat milk with a meal.

Canadian Diabetes Association,
www.diabetes.ca/files/JTB17x_11_CPGO3_1103.pdf
Self-Monitoring of Blood Glucose (SMBG)

- MN testing blood sugars once daily
- Takes mixed insulin twice daily with breakfast and supper
- Admits to treating a low blood sugar at least once a week usually before lunch or bedtime (keeps a chocolate bar with him at all times to treat a reaction)
- Admits to testing only “to show his doctor the readings”; doesn’t see how testing can help him manage his diabetes on a day to day basis
2013 CPG Recommendations: SMBG

If using insulin > once a day (Type 1 or Type 2 Diabetes):
- Test ≥ 3 times daily, including pre and post-meal tests

If using once-daily insulin in addition to oral antihyperglycemic agents:
- Test ≥ once a day

If not receiving insulin therapy:
- SMBG individualized depending on type of antihyperglycemic agents, level of glycemic control and risk of hypoglycemia
- When glycemic control is not being achieved, SMBG should be instituted and should include periodic pre- and postprandial measurements and training of healthcare providers and patients on methods to modify lifestyle and medications in response to SMBG values
- If achieving glycemic targets or receiving medications not associated with hypoglycemia, infrequent SMBG is appropriate
SMBG goals for MN

- Test 3 times daily alternating before/after meals, fasting, bed and occasional 3 am readings (nocturnal hypoglycemia) immediately
- Test before any planned physical activity starting immediately
- Identify the impact of exercise/meals/meal timing on blood sugar readings in 3 months (scheduled follow-up)
2013 CPG Recommendations: Self-Treatment of Hypoglycemia

Hypoglycemia definition:
1) The development of autonomic or neuroglycopenic symptoms
2) A low plasma glucose level (<4.0 mmol/L)
3) Symptoms responding to the administration of carbohydrate

Treatment:
- Severe hypoglycemia:
  - 20 g carbohydrate, preferably as glucose tablets or equivalent. BG should be retested in 15 minutes and then re-treated with another 15 g glucose if the BG level remains <4.0 mmol/L
- Mild to moderate hypoglycemia:
  - 15 g carbohydrate, preferably as glucose or sucrose tablets or solution.
  - Retest BG in 15 minutes and re-treat with another 15 g carbohydrate if the BG level remains <4.0 mmol/L
Recommendations for MN:

- Take insulin ½ hour before meals, not with meals
  - May consider recommending PCP switch insulin regimen to MDI insulin to increase meal flexibility
- Test blood glucose before driving (until resolution)
- Stop treating hypoglycemia with a chocolate bar!
  - Sugar + fat lowers glycemic index
  - Overcompensation of treating hypoglycemia can cause rebound hyperglycemia
- Test blood glucose more frequently when starting exercise classes
  - Hypoglycemic response to exercise can last up to 24 hours
Avoiding complications

- Before leaving MN asks about using a pair of insoles in his dress shoes; his feet are sore from breaking in a new pair of shoes.

- After questioning further, you discover that MN is soaking his feet daily in epsom salts each day after work.
**Diabetes and Foot Care: A Patient's Checklist**

<table>
<thead>
<tr>
<th>DO...</th>
<th>DON'T...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• check your feet every day for cuts, cracks, bruises, blisters, sores, infections or unusual markings.</td>
<td>• cut your own corns or calluses.</td>
</tr>
<tr>
<td>• use a mirror to see the bottom of your feet if you can't lift them up.</td>
<td>• treat your own in-growing toenails or slivers with a razor or scissors. See your doctor or foot care specialist.</td>
</tr>
<tr>
<td>• check the colour of your legs and feet. If there is swelling, warmth or redness or if you have pain, see your doctor or foot specialist right away.</td>
<td>• use over-the-counter medications to treat corns and warts. They are dangerous for people with diabetes.</td>
</tr>
<tr>
<td>• clean a cut or scratch with a mild soap and water and cover with a dry dressing for sensitive skin.</td>
<td>• apply heat to your feet with a hot water bottle or electric blanket. You could burn your feet without realizing it.</td>
</tr>
<tr>
<td>• trim your nails straight across.</td>
<td>• soak your feet.</td>
</tr>
<tr>
<td>• wash and dry your feet every day, especially between the toes.</td>
<td>• take very hot baths.</td>
</tr>
<tr>
<td>• apply a good skin lotion every day on your heels and soles. Wipe off any excess lotion.</td>
<td>• use lotion between your toes.</td>
</tr>
<tr>
<td>• change your socks every day.</td>
<td>• walk barefoot inside or outside.</td>
</tr>
<tr>
<td>• always wear a good supportive shoe.</td>
<td>• wear tight socks, garters or elastics, or knee highs.</td>
</tr>
<tr>
<td>• always wear professionally fitted shoes from a reputable store. Professionally fitted orthotics may help.</td>
<td>• wear over-the-counter insoles — they can cause blisters if they are not right for your feet.</td>
</tr>
<tr>
<td>• choose shoes with low heels (under 5 cm high)</td>
<td>• sit for long periods of time.</td>
</tr>
<tr>
<td>• buy shoes in the late afternoon (since your feet swell slightly by then).</td>
<td>• smoke.</td>
</tr>
<tr>
<td>• avoid extreme cold and heat (including the sun).</td>
<td></td>
</tr>
<tr>
<td>• exercise regularly.</td>
<td></td>
</tr>
<tr>
<td>• see a foot care specialist if you need advice or treatment.</td>
<td></td>
</tr>
</tbody>
</table>

**Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada**

[http://guidelines.diabetes.ca/Browse/Appendices/Appendix9](http://guidelines.diabetes.ca/Browse/Appendices/Appendix9)
# Modifiable risk factors

<table>
<thead>
<tr>
<th>Complications</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>↑ BG</td>
</tr>
<tr>
<td><strong>Microvascular Complications</strong></td>
<td></td>
</tr>
<tr>
<td>Neuropathy</td>
<td>✓</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>✓</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Macrovascular Complications (CVD, PAD)</strong></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease, Peripheral arterial disease</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Avoiding Complications Checklist

### Part B:

<table>
<thead>
<tr>
<th>Care Description</th>
<th>Objective</th>
<th>Target</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-monitoring of Blood Glucose</strong></td>
<td>Ensure patient can use glucose meter; interpret results and modify treatment as needed. Develop a blood glucose monitoring schedule with patient and review records</td>
<td>Peak meal (mmol/L) = 4.0-7.0 mmol/L for most patients; Peak meal (mmol/L) = 5.0-10.0 mmol/L for most patients 5.0-8.0 mmol/L if not achieving A1C target</td>
<td>Early detection and treatment. If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise</td>
</tr>
<tr>
<td><strong>Blood Glucose Control</strong></td>
<td>Measure A1C every three months for most adults. Consider testing at least every 6 months in adults during periods of treatment and lifestyle stability when glycemic targets have been consistently achieved.</td>
<td>A1C ≤ 7.0% for most patients individualized based on life expectancy, functional dependency, extensive coronary artery disease at high risk of ischemia, multiple comorbidities, recurrent severe hypoglycemia, hypoglycemia unawareness, long-standing diabetes unable to achieve A1C &lt;7% despite best efforts (including intensified insulin).</td>
<td>Early detection and treatment. If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise</td>
</tr>
<tr>
<td><strong>Hypoglycemia</strong></td>
<td>Enquire about hypoglycemia at each visit. Discuss recognition and treatment of hypoglycemia and risk benefit of hypoglycemia and pharmacologic management.</td>
<td>Avoidance of hypoglycemia especially in the elderly, those with hypoglycemia unawareness, and those with criteria for less stringent control.</td>
<td>Early detection and treatment. If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise</td>
</tr>
<tr>
<td><strong>Blood glucose meter accuracy</strong></td>
<td>Meter results should be compared with laboratory measurements at least annually, and when indicators of glycemic control do not match meter.</td>
<td>Simultaneous fasting glucose/meter lab comparison within 20%.</td>
<td>Early detection and treatment. If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise</td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>Measure BP at diagnosis and at every diabetes clinic visit.</td>
<td>BP &lt;130/80</td>
<td>Early detection and treatment. If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise</td>
</tr>
<tr>
<td><strong>Waist Circumference</strong></td>
<td>Measure as an indicator of abdominal fat.</td>
<td>WC 210cm (North America); WC 220 cm (Europe); WC 230cm (South and Central Americans)</td>
<td>Early detection and treatment. If neuropathy present: require foot care education, specialized footwear, smoking cessation. If ulcer present: manage by multidisciplinary team with expertise</td>
</tr>
</tbody>
</table>

### Body Mass Index
- Calculate BMI (mass in kilograms/height in metres)<sup>2</sup>
- Healthy body weight target: BMI <18.5-24.9

### Nutrition
- Encourage nutritional therapy (by a registered dietitian) as an integral part of treatment and self-management
- Meet nutritional needs by following Eating Well with Canada's Food Guide
- Aerobic: ≥150 minutes/week
- Resistance: 3 sessions/week
- Smoking cessation

### Physical Activity
- Discuss and encourage aerobic and resistance exercise. Evaluate those with possible CAD or microvascular complications undertaking exercise substantially more vigorous than brisk walking.

### Smoking
- Encourage patient to stop at each visit, provide support as needed.

### Chronic Kidney Disease (CKD)
- Identification of CKD requires screening for proteinuria using random urine ACR (2 out of 3 samples over 3 months) and assessment of renal function using a serum creatinine converted to eGFR. Type 1 diabetes: Screen at 5 years duration and then annually if no CKD. Type 2 diabetes: Screen at diagnosis and then yearly if no CKD.

### Retinopathy
- Type 1 diabetes: Screen 5 years after diagnosis, then rescreen annually. Type 2 diabetes: Screen at diagnosis and 1-2 years after initial screening if no retinopathy is present. The intensity for follow-up assessment should be tailored to the severity of the retinopathy. Screening should be conducted by an experienced eye care professional.

### Coronal Artery Disease (CAD)
- Conduct CAD risk assessment periodically: CV history, lifestyle, duration of DM, sexual function, abdominal obesity, lipid profile, BP, reduced pulses, bruits, glycerinic control, retinopathy, eGFR, ACR, Baseline ECG and every 2 years if >40 years and duration >15 years, and end organ damage, cardiac risk factors.

### Vascular Protection
- First priority in prevention of diabetes complications is reduction of cardiovascular risk by vascular protection through a comprehensive multifaceted approach. All people with DM: optimize BP, glycerinic control and lifestyle (Statin if age ≥40 years OR macrovascular disease OR microvascular disease OR long duration of DM ≥15 years and age ≥30 years). ACEI or ARB if age ≥55 years OR macrovascular disease OR microvascular disease

### Dyslipidemia
- Fasting lipid levels (TC, HDL, TG and calculated LDL) at diagnosis, then yearly if treatment not initiated. More frequent testing if treatment initiated.
- Lipid targets for those on statin therapy: Primary target: LDL ≤2.0 mmol/L or 250 mg/dL reduction. Alternate Primary target: apo B <1.0 g/L or non-HDL-C ≤2.6 mmol/L

### Care Objectives
- People with diabetes will have better outcomes if primary care providers: 1) identify patients with diabetes in their practices 2) encourage self-management and use interdisciplinary team approach to attainment care objectives 3) schedule diabetes-focused visits 4) use diabetes patient care flow sheets and systematic recall.

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*Adapted from the Canadian Diabetes Association 2013 Clinical Practice Guidelines for the prevention and management of diabetes in Canada*
Marketing a diabetes education service in a community pharmacy setting
If you build it...will they come?
If you build it...will they come?

NO!

- You must make sure they know about it
- You must show them the value
- You must help them see the benefits they can get out of it

... and then they will come!
The 4 C’s and 7 P’s of Service Marketing

- Client Value
- Convenience
- Product
- Process
- People
- Place
- Price
- Promotion
- Physical evidence
- Cost
- Communication

The 4 C’s and 7 P’s of Service Marketing

- Raise awareness of the existence of the service
  - Consider who you are marketing to: PCP? Patient?
  - Health Fairs/Speaking Engagements
  - Visit local clinics/DEC’s
  - Network!

- Promotional materials and advertising
  - Pamphlets, print media

- Physical evidence
  - Let people know there is something different happening in your pharmacy

- Personal selling
  - How you “sell” your service to clients (show them the value)
  - Network!
Promotion

Caring for others as we would want to be cared for...

All patient education services are provided by Colin Rains, BPharm, CDE. Colin has been providing Diabetes Education Services as a Pharmacist since 1996. He is currently the Manitoba representative for the Canadian Pharmacists Association Diabetes Strategic Advisory Committee, a computer-aided diabetes patient group as well as other professional groups.

All Diabetes Services are offered by appointment only.

Taché PHARMACY

Diabetes Education Services

2301 McPhillips St.
Winnipeg, Manitoba
Phone: 204-619-3220
Fax: 204-183-2544

Our Diabetes Service Offerings Include:

Diabetes Services

Our diabetes management program is designed to help patients with diabetes to live better lives. We provide education, support, and resources to help patients manage their diabetes effectively.

Diabetes Products & Services

We carry a wide range of diabetes products, including insulin, injectables, glucose meters, and other supplies. We also offer personalized recommendations to help patients choose the best products for their specific needs.

Diabetes Strategy for Pharmacists

The Canadian Pharmacists Association Diabetes Strategy for Pharmacists is a comprehensive guide that provides pharmacists with the knowledge and tools they need to effectively manage diabetes in their practice.

Inside Staff/Partner Management Skills

Staff members are responsible for providing diabetes education and support to patients. They must have the knowledge and skills to help patients manage their diabetes effectively.

Healthcare providers should ensure that staff members are trained to deliver high-quality care to patients with diabetes. This includes knowledge of best practices, current guidelines, and relevant medication information.

Healthy Living Skills

Encouraging healthy living is an essential aspect of diabetes management. Staff members should work with patients to develop healthy lifestyle habits that can help improve blood glucose levels, reduce risk factors, and improve overall health.

Our Diabetes Service Offerings Include:

- Diabetes Services
- Diabetes Products & Services
- Diabetes Strategy for Pharmacists
- Inside Staff/Partner Management Skills
- Healthy Living Skills
The 4 C’s and 7 P’s of Service Marketing

- Estimate demand
  - Economy of scale
- Calculate costs
  - Promotion costs, material costs
- Determine net desired income and set an initial price
  - What is an acceptable ROI for your service?
- Adjust price if needed
- Test your price with potential patients
  - May consider a pilot testing of your service
- Launch your service (adjusted price)
The 4 C’s and 7 P’s of Service Marketing

- Free is not a price!
- Subjective price is a reflection of value
- $0 = 0 value
Conclusion

- Diabetes is a multifaceted disease requiring a teamwork, patient-centric approach to care.
- Pharmacists play an integral role as part of a diabetes care team.
- Guideline-based management and coordinated (communicated) care is essential for effective diabetic care management.
- Lifestyle changes are fundamental to controlling blood glucose, reducing complications and quality of life measures for persons with diabetes.
- As we shift from a product-based to a consultative-based delivery of service, it is essential that we market our services in kind.
Questions?
Thanks for joining us!

- Please direct questions, feedback and suggestions to diabetes@pharmacists.ca
- Join the CPhA Continuing Professional Development Mailing List to be informed of future webinars and educational programs delivered by CPhA.
- Join MyCPhA and become a member of the Diabetes Community.