DIABETES CANADA

# SUSTAINING MOMENTUM TO IMPLEMENT THE DIABETES FRAMEWORK (SMIDF):

# ONTARIO DIABETES ROUNDTABLE

## OCTOBER 2025

## Acknowledgements


**Report Author**

Yucen Liu, MSc, Ho Ching Nika Shiu

**Sustaining Momentum in Implementing the Diabetes Framework (SMIDF) Team**

Adria Cehovin, MSc (Project Manager),

Hiba Syed, BSc (Coordinator), and

Yucen Liu, MSc (Health Equity and Research Coordinator)

We would like to thank all presenters and attendees for their contributions to the Ontario Diabetes Roundtable.


**Note on Indigenous Engagement and a National Diabetes Framework**

In respect to Reconciliation and in recognition of Indigenous autonomy, self-determination, and sovereignty, the Public Health Agency of Canada has provided independent funding to the National Indigenous Diabetes Association (NIDA). NIDA is engaging with various Indigenous peoples, nations and organizations across Canada to develop an Indigenous Diabetes Framework. Through supporting open dialogue, NIDA sits on the Diabetes Canada/SMIDF's Pan-Canadian Action for Diabetes committee to promote mutual knowledge exchange and collaboration. For more information about NIDA, please visit www.nada.ca

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## 1.0 Executive Summary

On October 1, 2025, Diabetes Canada, with support from the Public Health Agency of Canada, held the Ontario Diabetes Roundtable in Hamilton, Ontario. The event brought together 38 participants including Ontario government agencies, policymakers, researchers, healthcare providers, and community partners to share insights and practical solutions for improving diabetes prevention and care. The discussions highlighted the value of collaboration across research, clinical care, and community settings, in addressing the growing impact of diabetes. Speakers emphasized patient-centered and culturally responsive approaches, health coaching to support self-management, and community-based screening programs that reach people who often face barriers to care. Together, these conversations reinforced a shared commitment to creating more connected, equitable, and sustainable systems that help people live healthier lives.

**Meeting objectives:**

- Identify provincial urban and rural programs, interventions and opportunities to optimize patient care efforts (for those living with or working in diabetes)
- Review alignment between the Diabetes Framework in Ontario and build on the collaborative engagement with strategic partners
- Collectively work and distill transferable elements from interventions for possible uptake in regions across Ontario and Canada

## 2.0 Framework Overview

The Government of Canada introduced the Framework for Diabetes in Canada on October 5, 2022. The Framework aims to support prevention and treatment for all types of diabetes and provide a common policy direction to address diabetes in Canada. The Framework seeks to support the identification of gaps in current approaches, avoid duplication of effort, and provide the federal government an opportunity to monitor and report on progress. In doing so, it strongly promotes the foundation for collaboration across sectors to reduce the impact of diabetes.

The Framework is comprised of six interdependent and interconnected components that represent the range of areas where opportunities to advance efforts on diabetes could be beneficial. The principles and the components (below) form a dynamic environment within which to create change in Canada. These were derived from and built on contributions from diverse groups within Canada throughout the multi-year engagement process.

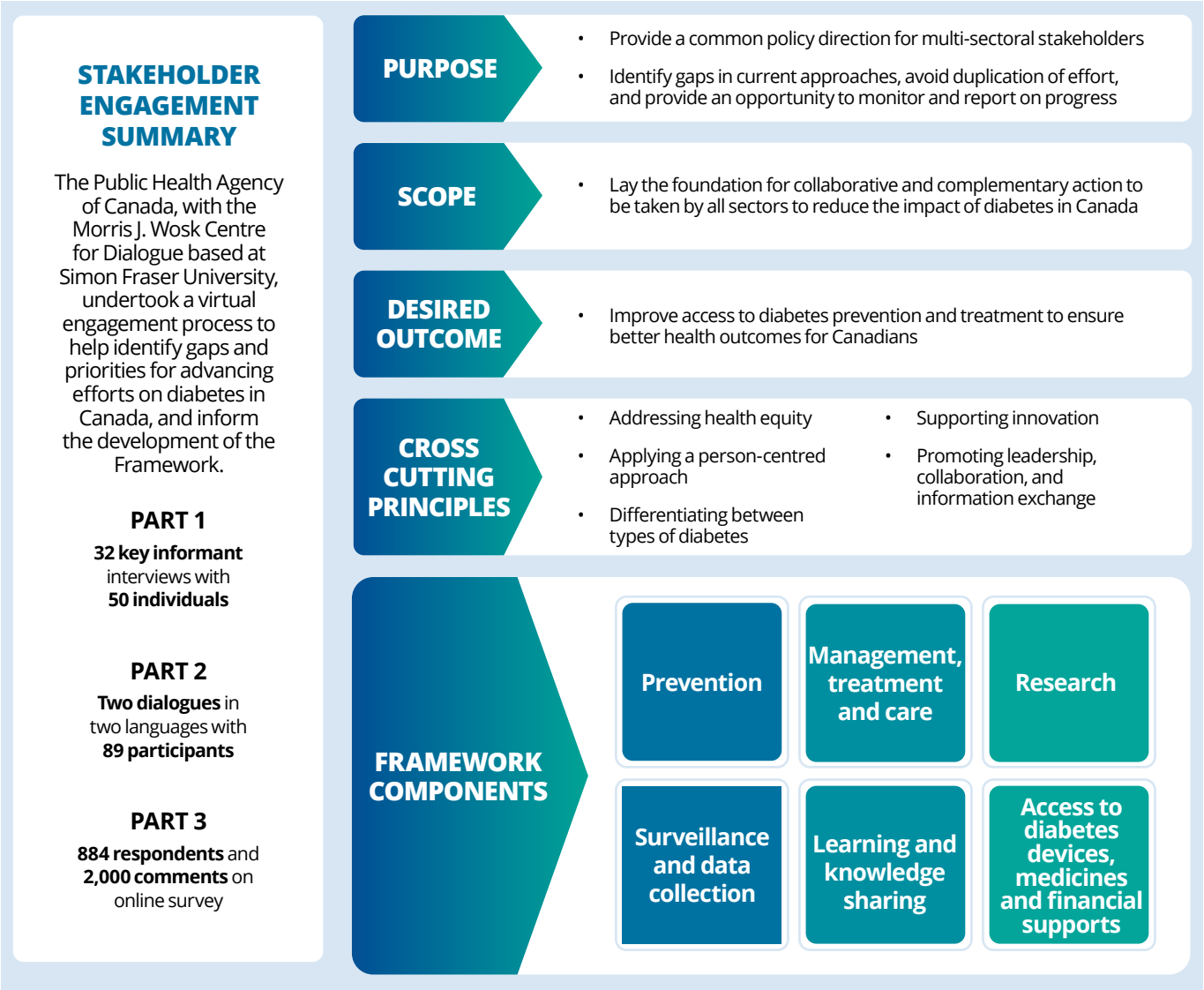
**Cross-cutting principles:**

- Addressing health equity
- Applying a person-centered approach
- Differentiating between types of diabetes
- Supporting innovation
- Promoting leadership, collaboration, and information exchange

**Framework components:**

- Prevention
- Management, treatment, and care
- Research
- Surveillance and data collection
- Learning and knowledge sharing

The Framework summary below outlines the process, purpose, scope, and overall desired outcomes.




Summary of the Framework (Framework for Diabetes in Canada Infographic, 2022)

**Indigenous Engagement and a National Diabetes Framework:** In respect to reconciliation and in recognition of Indigenous autonomy, self-determination, and sovereignty, the Public Health Agency of Canada has provided independent funding to the National Indigenous Diabetes Association (NIDA). NIDA is engaging with various Indigenous peoples, nations and organizations across Canada to develop an Indigenous Diabetes Framework. Through supporting open dialogue, NIDA sits on the Diabetes Canada/SMIDF's Pan-Canadian Action for Diabetes committee to promote mutual knowledge exchange and collaboration. For more information about NIDA, please visit their website (nada.ca).

## 3.0 Roundtable Presentations

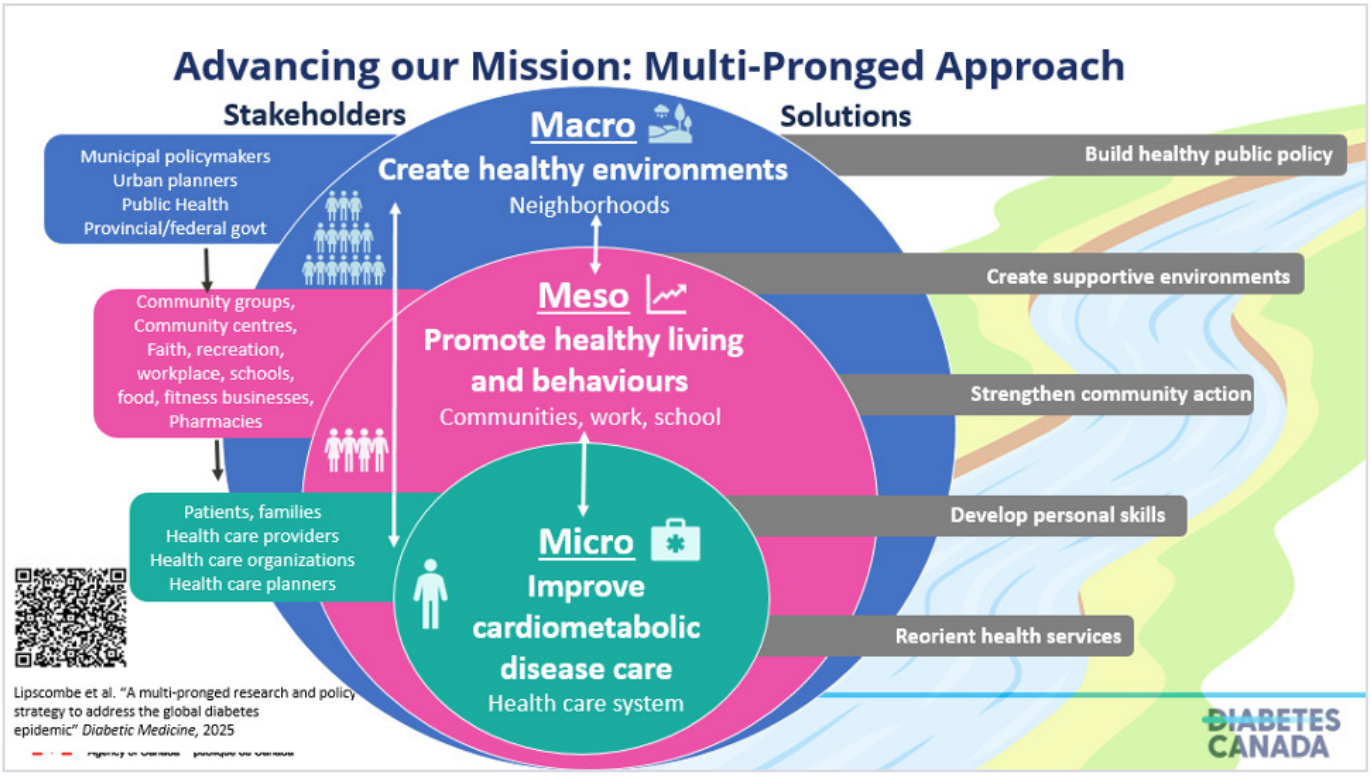
| Presentation Title | Presenter(s) |
|---|---|
| Roundtable Overview and Diabetes Canada: Sustaining Momentum to Implement the Diabetes Framework | Adria Cehovin, Diabetes Canada |
| 3.1 The Network for Healthy Populations (NHP) | Dr. Lorraine Lipscombe, University of Toronto |
| 3.2 Boarding Home Project: Population-specific Strategies in Diabetes Prevention or Management | Jane Rajah, Parkdale Queen West Community Health Center |
| 3.3 A Regional Approach to Diabetes Central Intake | Trina Fitter, Waterloo Wellington Diabetes;<br>Nicole Van Gerwen, Waterloo Wellington Diabetes |
| 3.4 Indigenous Diabetes Health Circle | Dr. Jessica Pace, Indigenous Diabetes Health Circle;<br>Samantha Lascelles, Indigenous Diabetes Health Circle |
| 3.5 Advancing Lower Limb Preservation Care for People with Diabetes Through Collaboration & Partnership | Sandra Fitzpatrick, South Riverdale Community Health Centre |
| 3.6 Community Health Worker Diabetes Program and Diabetes Connections Initiative | Amos Tunji-Ajayi, Sioux Lookout First Nations Health Authority;<br>Madison Pierce, Sioux Lookout First Nations Health Authority |
| 3.7 Promoting Leadership, Collaboration and Information Exchange – The approach of the Scarborough Ontario Health Team's Diabetes Working Group | Ethel Macatangay, Scarborough Health Network |
| 3.8 Health Coaching: Evidence & Impact on Chronic Disease Prevention & Treatment? | Dr. Diana Sherifali, McMaster University |
| 3.9 Community-Based Diabetes Screening Intervention Piloted in Peel Region | Dr. Ghazal Fazli, University of Toronto Mississauga |

## 3.1 Dr. Lorraine Lipscombe – The Network for Healthy Populations (NHP)

Presented by Dr. Lorraine Lipscombe from the University of Toronto, this session introduced The Network for Healthy Populations (NHP), a cross-disciplinary initiative established in 2021 through a partnership between Novo Nordisk Canada and the University of Toronto. NHP works to reduce type 2 diabetes risk and burden through collaborative research and community-driven health solutions. The network concentrates its efforts in Peel Region—encompassing Mississauga, Brampton, and Caledon—where approximately 70% of residents are visible minorities, predominantly South Asian and Black/ Caribbean populations, and where over 15% of adults live with diabetes. The region's challenges include high rates of obesity, socioeconomic disadvantages, and environmental factors such as limited walkability and green space.

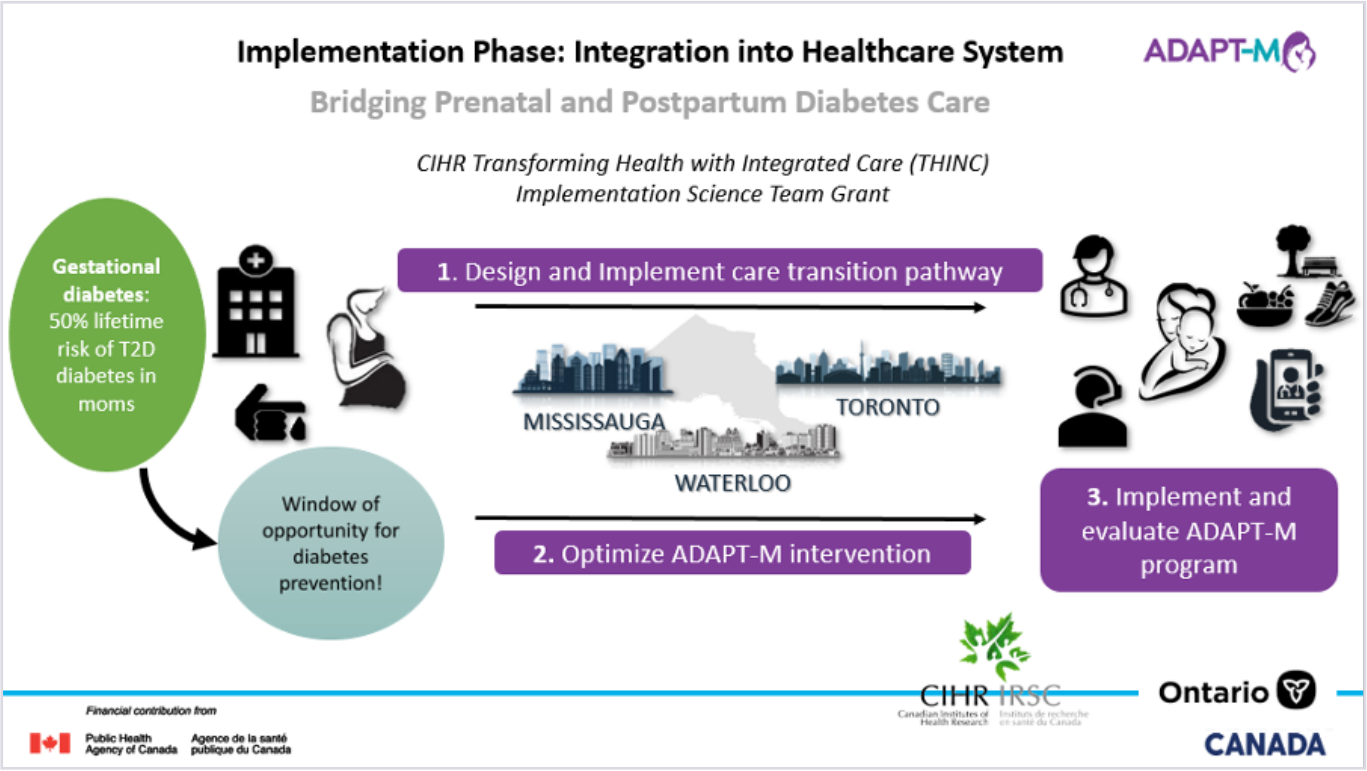
Operating under the principle "learn locally, share globally," Dr. Lorraine Lipscombe introduced that NHP employs a multi-tiered strategy that addresses diabetes care within healthcare systems, partners with community organizations to promote wellness, and collaborates with policymakers to improve public health infrastructure. With over 50 partners across academic, community, and government sectors, the network has catalyzed diverse initiatives ranging from culturally tailored diabetes education and school nutrition programs to urban planning for green spaces, generating approximately $11 million in research funding. The initiative operates at a multi-pronged approach:

- Micro-level: Improve diabetes care within healthcare systems.
- Meso-level: Collaborate with community organizations to promote healthy living.
- Macro-level: Work with policymakers and municipalities to improve public health environments.



A flagship initiative, the ADAPT-TM program provides six-month virtual coaching to women with gestational diabetes history—who face up to a 50% risk of developing type 2 diabetes within a decade—offering personalized nutrition and activity guidance designed around the realities of postpartum life. Launched across three Ontario Health Team regions in August 2025, the program exemplifies NHP's commitment to rigorous evaluation, utilizing partnerships with organizations like ICES and Peel Public Health to integrate geospatial and social determinant data for targeted interventions and consistent monitoring.

Dr. Lorraine's presentation underscored the urgent need to address the rising diabetes burden through collaborative, equity-focused, and evidence-based approaches. NHP exemplifies how academic institutions, communities, and health systems can unite to tackle chronic disease prevention at multiple levels. By combining rigorous research with local engagement and scalable interventions, such as the ADAPT-TM program, the initiative aims not only to improve health outcomes in Peel Region but also to serve as a model for diabetes prevention and care innovation across Canada and globally.



## 3.2 Jane Rajah – Boarding Home Project: Population-specific Strategies in Diabetes Prevention or Management

Presented by Jane Rajah, a Certified Diabetes Nurse Educator at Parkdale Queen West Community Health Centre in Toronto. With 34 years of nursing experience and 18 years as a community diabetes educator, Rajah is a strong advocate for individuals living with diabetes who face multiple social and mental health challenges. She received the 2015 Diabetes Educator of the Year Award from the Banting & Best Diabetes Centre at the University of Toronto. Drawing on her extensive experience, Rajah focuses on reducing barriers to healthcare and improving access to healthy living options for vulnerable populations in the Parkdale community.

Rajah introduced the Boarding Home Project, initiated 18 years ago to address the health needs of individuals with severe mental illness living in boarding homes and precarious housing in Parkdale. The project aims to bridge the gap between diabetes care, mental health, and housing supports by bringing healthcare directly into the community, partnering with COTA Health and Habitat Services – organizations providing oversight and support for boarding homes in Toronto.

The project operates through two main arms: the Bailey House Model, which transformed one boarding home into a diabetes-friendly residence with on-site health supports, regular diabetes check-ins, medication reviews, and health education; and the Rotational Outreach Model, which involves regular visits to seven boarding homes for diabetes screening, foot care, and group education sessions using conversational maps on topics like nutrition, physical activity, insulin, and self-care. Residents are connected to primary care, chiropody, eye screening, and community supports, with trust-building central to the approach as progress depends on long-term, respectful relationships with clients who often fear or distrust healthcare systems.

Rajah highlighted that the common challenges include carb-heavy, low-protein meals and early dinner times leading to overnight hypoglycemia. Interventions include adding evening protein snacks, introducing garden-based food programs, and holding interactive cooking and nutrition sessions. The team trains cooks and support staff twice a year on diabetes-friendly menu planning, crisis management, and practical food substitutions.

The project has implemented medication safety protocols and sick day plans for home staff, while Habitat Services updated standards to include healthier snack and fruit options in boarding homes. Educational tools such as portion control for meals and sample menus support sustained behaviour change at the staff level. The project has resulted in improved screening, earlier detection, and stronger continuity of care for residents with diabetes, along with enhanced collaboration between community partners, housing providers, and healthcare professionals through small, consistent steps and relationship-centered care.

Rajah concluded by reflecting on the resilience of her clients and the cost of inaction in this high-risk population, preventable blindness, amputations, and hospitalizations. Her 18-year commitment to the Boarding Home Project demonstrates how sustained outreach, trust-building, and system collaboration can transform diabetes care for people living with severe mental illness and precarious housing.

## 3.3 Trina Fitter and Nicole Van Gerwen – A Regional Approach to Diabetes Central Intake

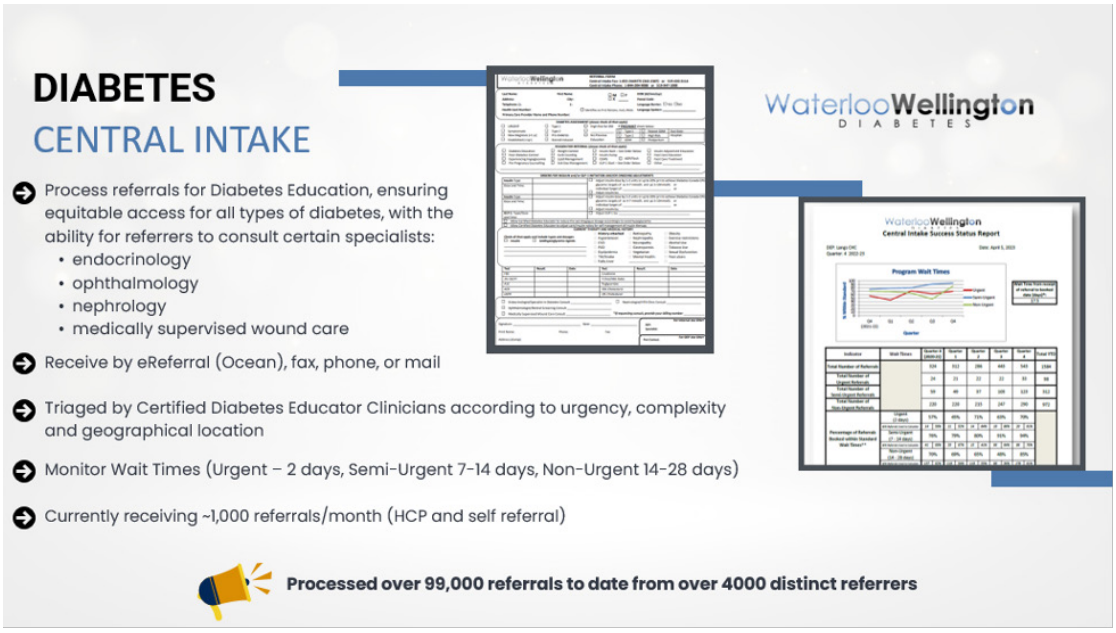
Presented by Trina Fitter and Nicole Van Gerwen from Waterloo Wellington Diabetes. Fitter is a Registered Dietitian and Certified Diabetes Educator with over 25 years of experience in diabetes management, leading numerous quality improvement initiatives across clinical settings. Van Gerwen is the Director of the Waterloo Wellington Regional Coordination Centre (RCC), with over 15 years of experience developing and implementing centralized intake systems across Ontario. Together, they presented a regional model for improving diabetes care coordination through the Diabetes Central Intake (DCI) program.

The Diabetes Central Intake (DCI) launched in 2011 as one of Ontario's first centralized diabetes referral systems for all diabetes types, accepting both provider and self-referrals. Between 2012 and 2014, it expanded to include endocrinology, ophthalmology, nephrology, and a regional diabetes-in-pregnancy clinical pathway. In 2017, e-referral was introduced through the Ocean platform, improving efficiency and tracking. In 2024–2025, streamlined urgent care referral pathways, wound-care consults, and renal-risk screening were added, with funding received to enhance triage capacity and develop an evidence-based guide for managing steroid-induced hyperglycemia.

Fitter and Van Gerwen noted that referrals are accepted via e-referral, fax, phone, or mail, including self-referrals supported by staff assistance. All referrals are triaged by certified diabetes educators based on urgency, complexity, and location, with urgent cases seen within two days, semi-urgent within 7–14 days, and non-urgent within 14–28 days. Clients are directed to the nearest diabetes education program, and referrers receive confirmation and wait-time updates. Over 99,000 referrals from more than 4,000 distinct referrers have been processed to date, averaging approximately 1,000 per month.

Wait-time and referral-volume reports are shared quarterly with all regional diabetes education programs for quality improvement and planning. Regular collaborative meetings, mentoring, and two regional diabetes networks facilitate shared learning and system alignment, with initiatives including prevention programs, Indigenous care education, and region-wide clinical pathway updates. The RCC aligns with the Framework through prevention screening and education, streamlined referral pathways, robust regional data collection, and ongoing regional networks and public-provider education events offered through the regional self-management program.

Fitter and Van Gerwen emphasized how a centralized, data-driven, and collaborative approach improves access, reduces wait times, and enhances care coordination across the diabetes system. The Waterloo Wellington Diabetes Central Intake model demonstrates how consistent triage, shared data, and strong regional partnerships can deliver timely, equitable diabetes care, aligning with Ontario Health's vision for connected, patient-centered service delivery.

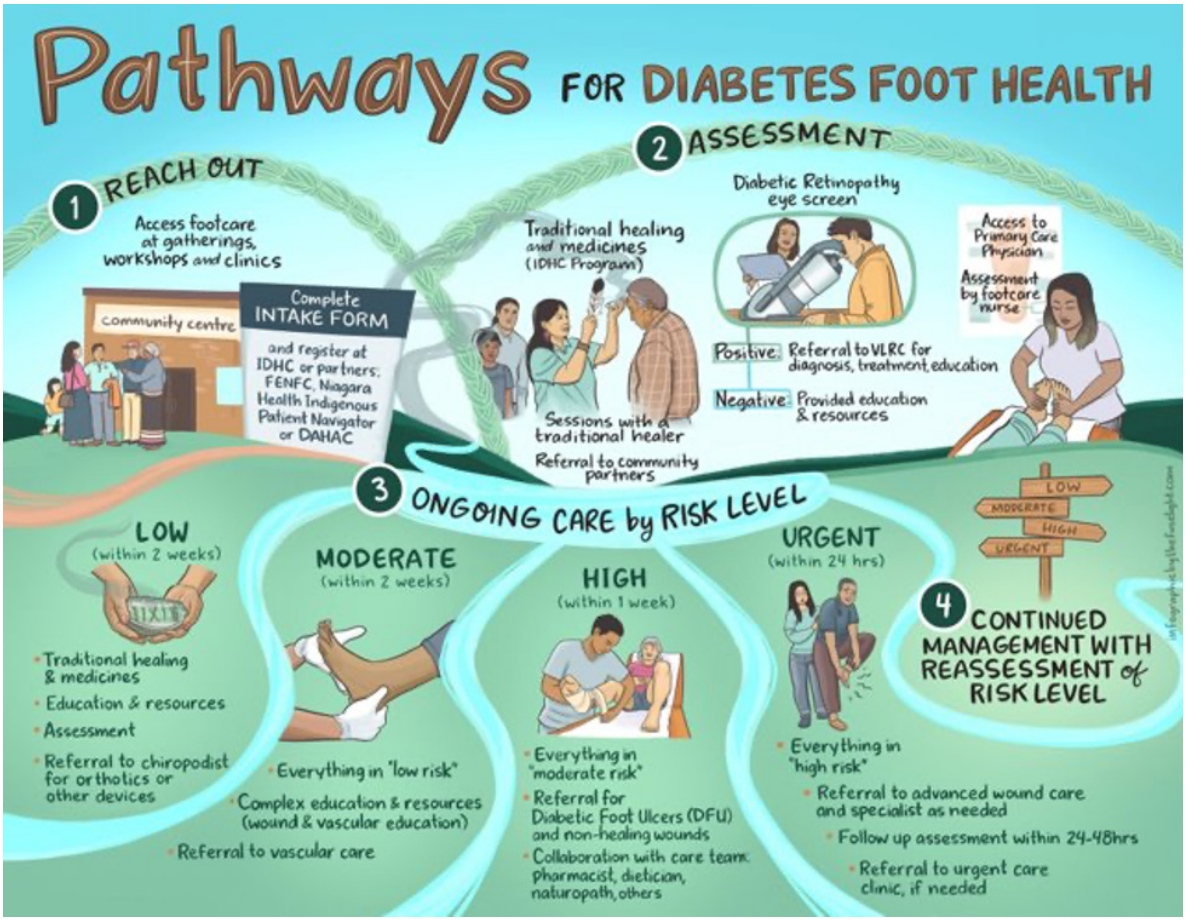


## 3.4 Dr. Jessica Pace and Samantha Lascelles – Indigenous Diabetes Health Circle

Presented by Dr. Jessica Pace and Samantha Lascelles from the Indigenous Diabetes Health Circle (IDHC). The presentation highlighted IDHC's mission to empower Indigenous peoples to live free of diabetes by supporting wholistic wellness rooted in traditional knowledge and community capacity building. Now in its 29th year, IDHC has expanded from Southern Ontario to serve Indigenous communities across the province. Through partnerships, culturally grounded care, and trauma-informed approaches, IDHC continues to reduce diabetes risk and improve wellness outcomes for Indigenous individuals, families, and communities.

Lascelles described several client services programs. The Foot Care Program offers self-care and prevention kits, build-your-own foot care tools, and subsidies for individuals not covered under federal programs, while providing sustainable community-based foot care services and training to build local capacity. The Eye Health Screening Initiative, delivered in partnership with the Vision Loss Rehabilitation Canada, supports mobile eye screening and diabetes retinopathy prevention, achieving strong outreach results and identifying undiagnosed diabetes through community screenings. The Traditional Wellness Program offers province-wide access to one-on-one sessions with traditional healers and practitioners, promoting wholistic approaches to physical, emotional, and spiritual wellness.

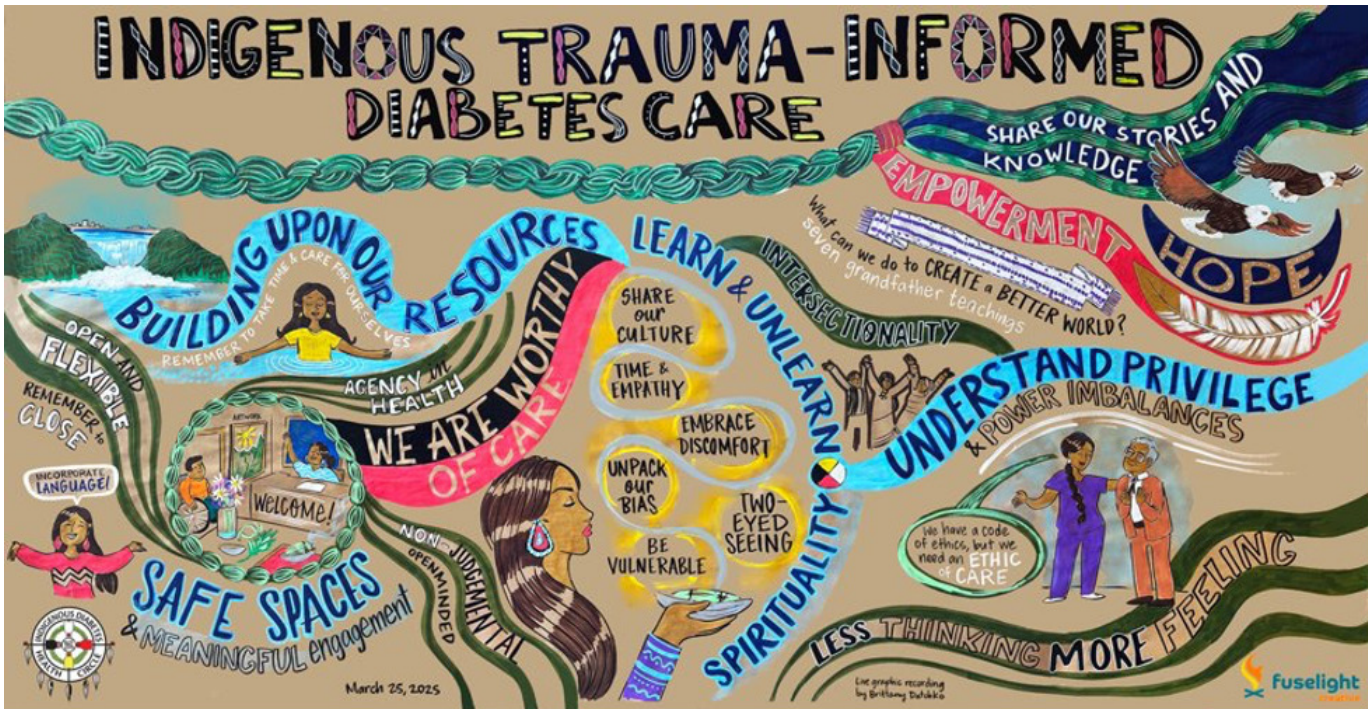
Lascelles highlighted the Lower Limb Preservation Initiative, developed in partnership with Ontario Health, Fort Erie Native Friendship Centre (FENFC), De dwa da dehs nye>s Aboriginal Health Centre (DAHAC), and other community organizations to address the growing rate of lower-limb amputations in the Niagara Region. The initiative aims to improve access to culturally safe, community-based services for foot, eye, and vascular health, introducing a care pathway that integrates cultural safety training for providers and trauma-informed approaches to rebuild trust in care systems. Community-friendly educational materials, such as infographic postcards outlining prevention and referral pathways, were also created.



Dr. Pace noted that the Knowledge Department delivers education, training, and resources through a capacity-building model that trains frontline health workers who support Indigenous communities, providing ISO-accredited, culturally grounded diabetes education both in-person and online. Core multi-day trainings include Diabetes Wellness Training, Foot Care Level 1 Training, and Gestational Diabetes Prevention Training, with monthly webinars, customized community sessions, and distribution of over 10,000 culturally relevant resources annually.

The organization partners on national and provincial grants through CIHR, SSHRC, and Ontario Health, according to the presentation. Key initiatives include Waasnooden/Wawatay, which is creating three graphic novels to raise diabetes awareness among Indigenous youth; Aki Gimiinigonaa Mshkooziiwin (The Land Gives Us Strength), an Indigenous Food Sovereignty initiative, strengthening community connection to land and traditional food systems; the Making Indigenous Men Visible Project, promoting healthy relationships and diabetes prevention among men; and the Trauma-Informed Diabetes Care Project, developing training to improve cultural and emotional safety in clinical encounters with a launch planned for 2026.

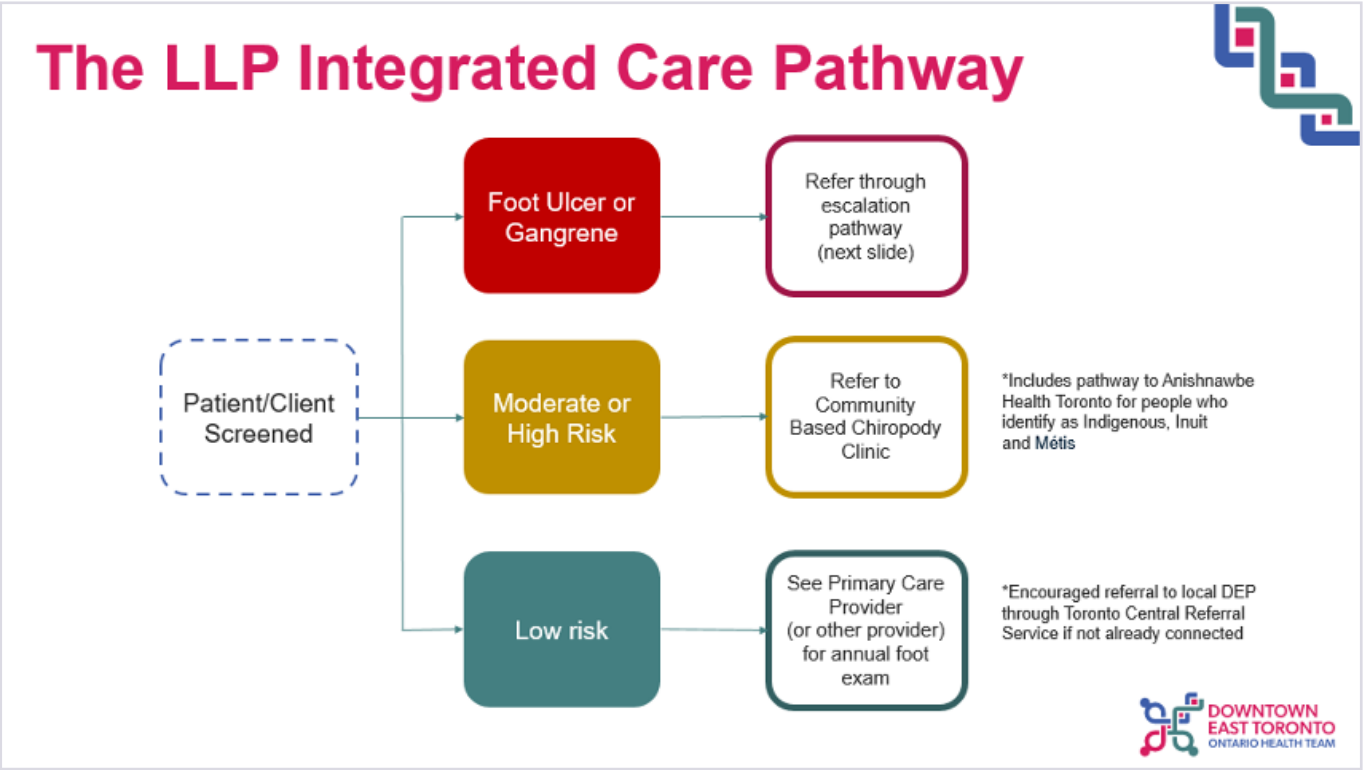
Dr. Pace and Lascelles concluded by reaffirming IDHC's commitment to culturally grounded, community-led diabetes prevention and care. By combining traditional healing with evidence-based practice, IDHC builds Indigenous capacity, restores trust in healthcare systems, and ensures that wellness approaches respect cultural identity and lived experience. Their work stands as a model for sustainable, trauma-informed, and self-determined Indigenous health promotion across Ontario.



## 3.5 Sandra Fitzpatrick – Advancing Lower Limb Preservation Care for People with Diabetes Through Collaboration & Partnership

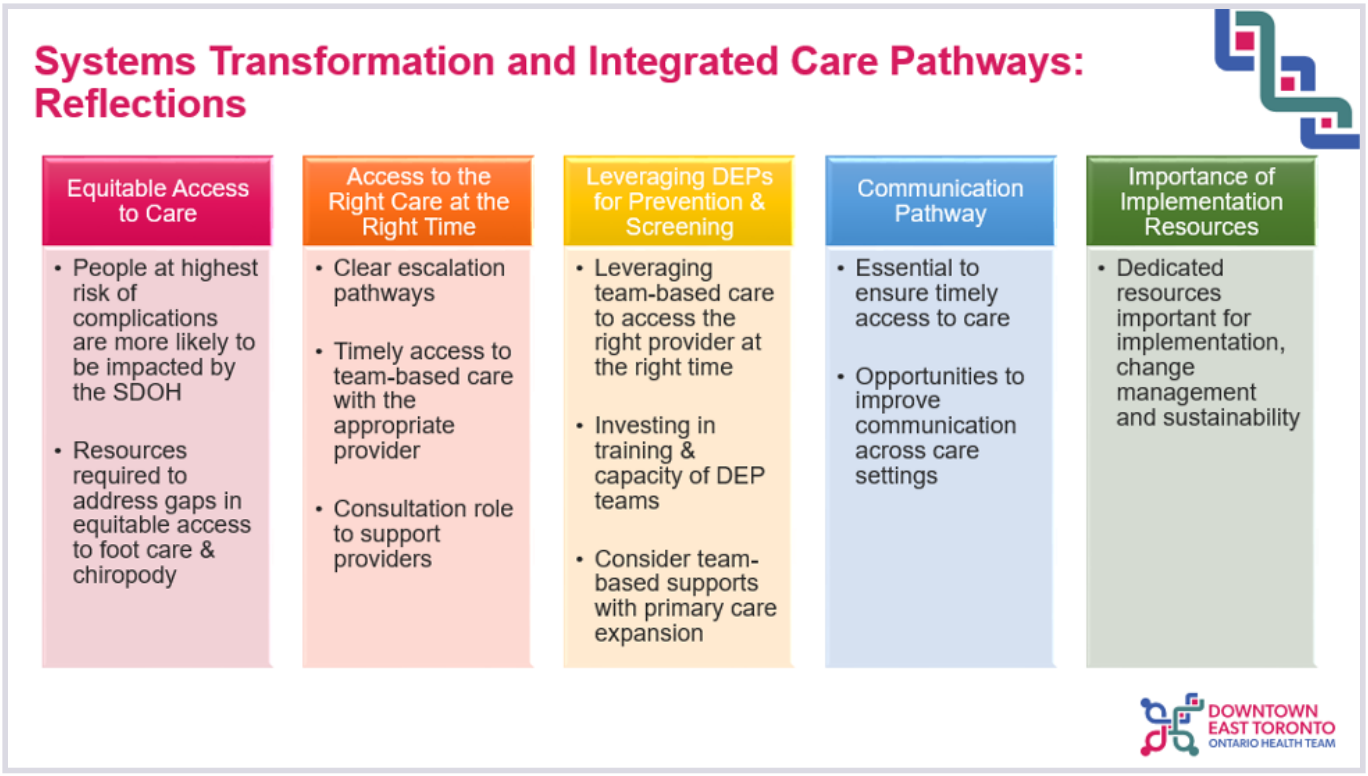
Presented by Sandra Fitzpatrick, Regional Facilitator for the Diabetes Care Connect program at South Riverdale Community Health Centre, this presentation outlined a collaborative initiative to prevent diabetes-related lower limb complications within the downtown east Toronto region. The project was funded by Ontario Health and developed under the Downtown East Toronto Ontario Health Team to improve screening, coordination, and equitable access to foot and vascular care through an integrated care pathway model.

Fitzpatrick introduced the initiative was designed to address high rates of preventable lower-limb amputations linked to social and health inequities, focusing on early detection, prevention, and seamless referral for individuals with diabetes or neuropathy. It was co-designed with hospitals, primary care, community organizations, and people with lived experience. A simplified "Look, Touch & Ask" foot screening tool was developed and embedded into EMRs to streamline screening and data collection, with clear escalation pathways created for patients identified at moderate, high, or urgent risk levels.



According to the presentation, over 960 patients were screened across six partner sites, with 278 referred for chiropody or wound care. The program prioritized outreach to low-income, racialized, and marginalized communities disproportionately affected by diabetes, and leveraged project funds to expand access to publicly funded chiropody care and reduce wait times.

Fitzpatrick noted strong cross-sector collaboration among hospitals, diabetes educators, community health centres, family health teams, primary care providers, chiropodists, diabetes educators and vascular specialists at St. Michael's Hospital, which enabled shared referral tools, data tracking, and consistent screening practices across care settings. She emphasized that the success of this initiative depended on partnership, equity, and sustainability. By embedding screening tools within primary care systems, establishing standardized referral pathways, and building community-based chiropody capacity, the program demonstrated a practical model for improving diabetes care and preventing amputations. The project continues to expand with a focus on strengthening communication, data integration, and long-term equitable access to lower limb preservation services.



## 3.6 Amos Tunji-Ajayi and Madison Pierce – Community Health Worker Diabetes Program and Diabetes Connections Initiative

Presented by Amos Tunji-Ajayi and Madison Pierce from the Sioux Lookout First Nations Health Authority (SLFNHA), this presentation introduced two complementary initiatives, the Community Health Worker (CHW) Diabetes Program and the Diabetes Connections Initiative. Both programs aim to strengthen diabetes prevention and care in 33 remote and fly-in First Nations communities across Northwestern Ontario. It was emphasized that community-driven design, cultural safety, and capacity building are keys to improving access to diabetes care in regions with limited health infrastructure.

Tunji-Ajayi and Pierce explained that diabetes affects 13–14% of people in SLFNHA communities, compared to 9.7% in the rest of Ontario, with barriers including lack of road access, transient healthcare staff, and limited community-based diabetes programs. Hospitalizations and lower-limb amputation rates were noted to be twice as high as the provincial average.

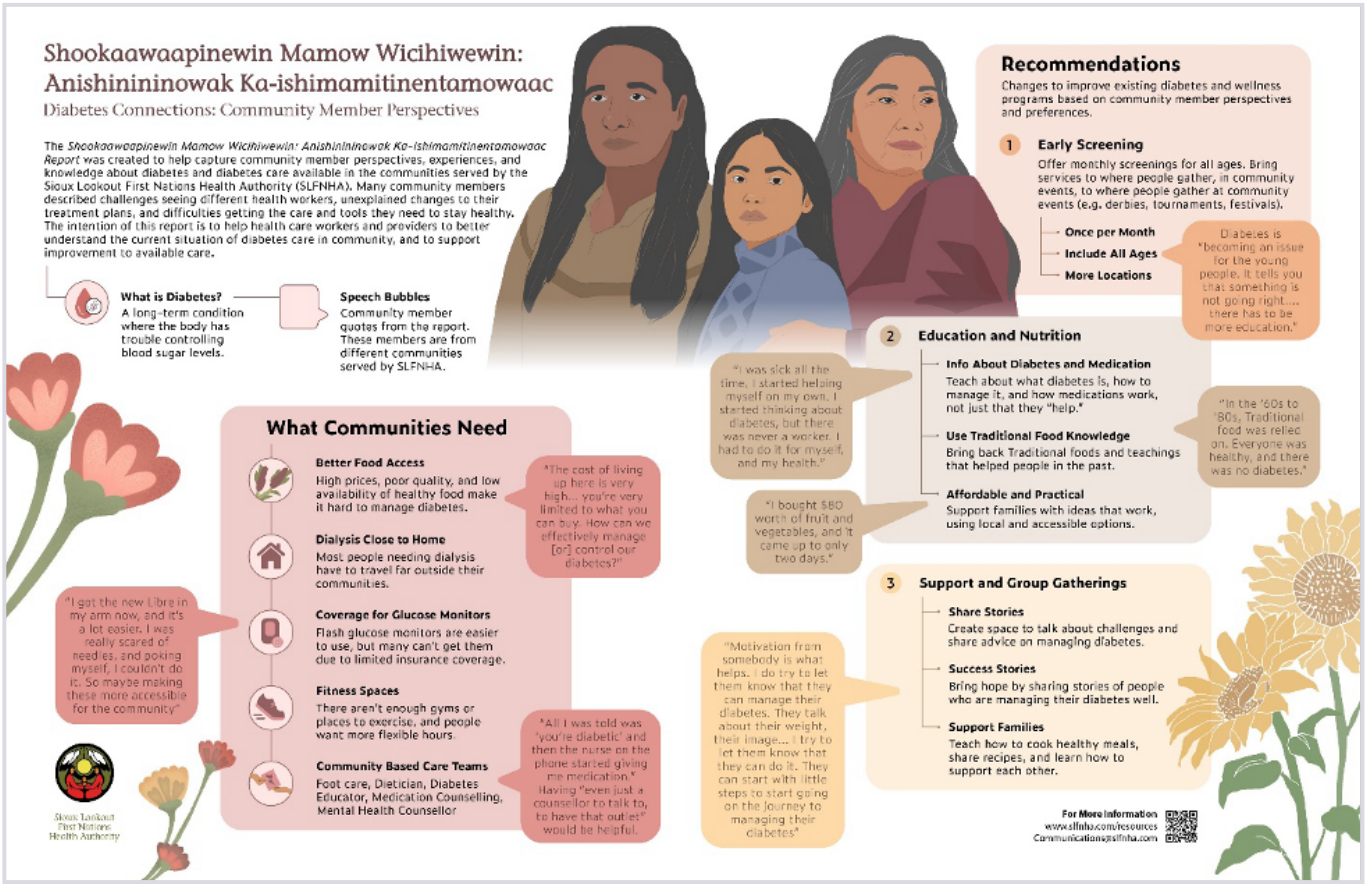
The Community Health Worker (CHW) Diabetes Program was described as aiming to build local diabetes care capacity by training unregulated community health workers. The presentation noted that the program provides ongoing mentorship, skills training, and certification in diabetes education, foot care, and phlebotomy.

Partnerships with Oshki-wenjack educational institutions and colleges support the creation of micro-credentials and phlebotomy training to enhance workforce recognition and retention. The program integrates traditional knowledge and cultural teachings through collaboration with Elders and knowledge keepers, with current initiatives including vision and retinal screening programs, community networking forums, and advocacy for continuous glucose monitor coverage for all with type 2 diabetes.

The Diabetes Connections Initiative was presented as a community-led research project co-designed with SLFNHA and the University of Toronto Department of Family and Community Medicine (DFCM). According to the presentation, the initiative uses interviews, sharing circles, and surveys to document current models of diabetes care and community priorities, providing funding to enrolled communities to support local diabetes care improvements. The project maps existing diabetes services to identify gaps, strengths, and opportunities for coordination and advocacy, focusing on improving care delivery, supporting policy advocacy, and enhancing community engagement in health system planning.

Tunji-Ajayi and Pierce shared insights from interviews capturing the lived experiences and perspectives of community members in SLFNHA communities, that residents called for more preventive care, diabetes education in schools, and affordable, healthy food options. They emphasized the need for culturally relevant, relationship-based care and genuine co-design where community voices drive decision-making.

It was underscored that sustainable diabetes care in northern and remote regions depends on local empowerment, relationship building, and equitable partnerships. By training trusted community members, integrating traditional knowledge, and co-developing care models with First Nations communities, these initiatives represent a shift toward culturally safe and community-led healthcare. Tunji-Ajayi and Pierce highlighted that effective co-design requires humility, listening, and ensuring community participation translates into real influence, not symbolic involvement.



## 3.7 Ethel Macatangay – Promoting Leadership, Collaboration and Information Exchange – The approach of the Scarborough Ontario Health Team's Diabetes Working Group

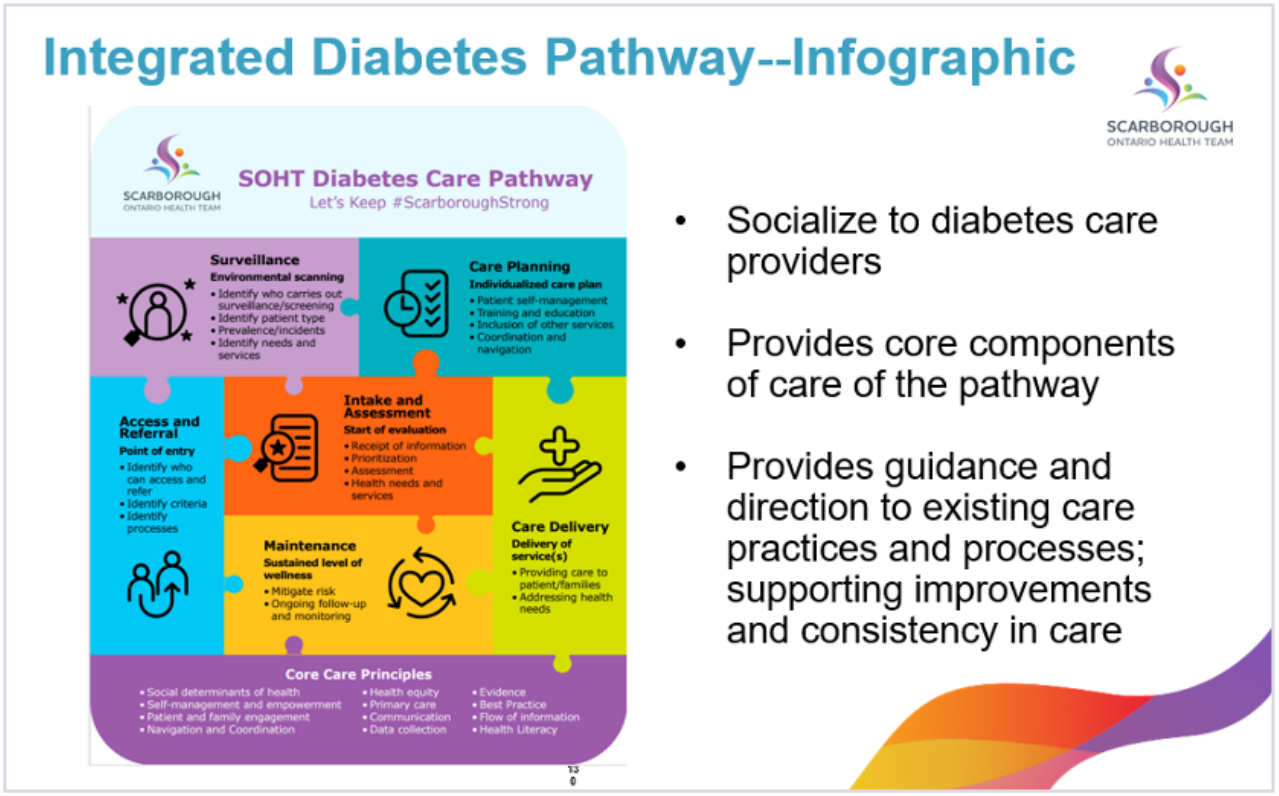
Presented by Ethel Macatangay, Patient Care Director of Nephrology and Chronic Disease Management at Scarborough Health Network, this presentation showcased how the Scarborough Ontario Health Team (SOHT) is advancing diabetes care through collaborative leadership, shared learning, and system integration. Macatangay emphasized that Scarborough has one of Ontario's highest diabetes prevalence rates. Local determinants of health, such as low income, food insecurity, and physical inactivity, were noted to contribute significantly to disease burden.

Macatangay described how the SOHT Diabetes Working Group brings together hospitals, community health centres, primary care, and organizations like Toronto Diabetes Care Connect and Ontario Health atHome, with Diabetes Education Centers (DECs) to provide care and service to people with diabetes in Scarborough. She emphasized equal partnerships and recognition of each organization's area of excellence, avoiding a top-down hospital-led approach.

According to the presentation, each partner uses their existing care pathways, with best practices combined into a unified collaboratively created pathway. A key principle described was "any door is the right door," meaning patients can enter the diabetes care system through any provider or setting. The pathway was characterized as modular and adaptable, representing interlocking puzzle pieces rather than a linear sequence.

Macatangay highlighted several core principles and lessons learned: using local prevalence and outcome data to create shared urgency and alignment; mapping all available community and clinical resources to identify overlaps and service gaps; encouraging open dialogue about limitations and population-specific needs through transparency and trust; and co-leading facilitation by hospital and community representatives to balance perspectives and reduce hierarchy.

Macatangay concluded that Scarborough's success lies in leveraging existing resources, eliminating silos, and building consensus through shared evidence and trust. The collaboratively designed pathway not only strengthens diabetes care delivery across sectors but also serves as a model for chronic disease management more broadly. By prioritizing equity, transparency, and joint leadership, the SOHT is creating a replicable framework for integrated, community-driven health system transformation.



## 3.8 Dr. Diana Sherifali – Health Coaching: Evidence & Impact on Chronic Disease Prevention & Treatment?

Presented by Dr. Diana Sherifali from McMaster University, this presentation explored health coaching as an innovation in diabetes care and chronic disease management. Drawing from over 25 years of research and clinical practice, Dr. Sherifali framed health coaching as an evidence-based intervention that bridges the gap between medical advice and daily self-management, emphasizing support, empathy, and relationship-centered care rather than directive education.

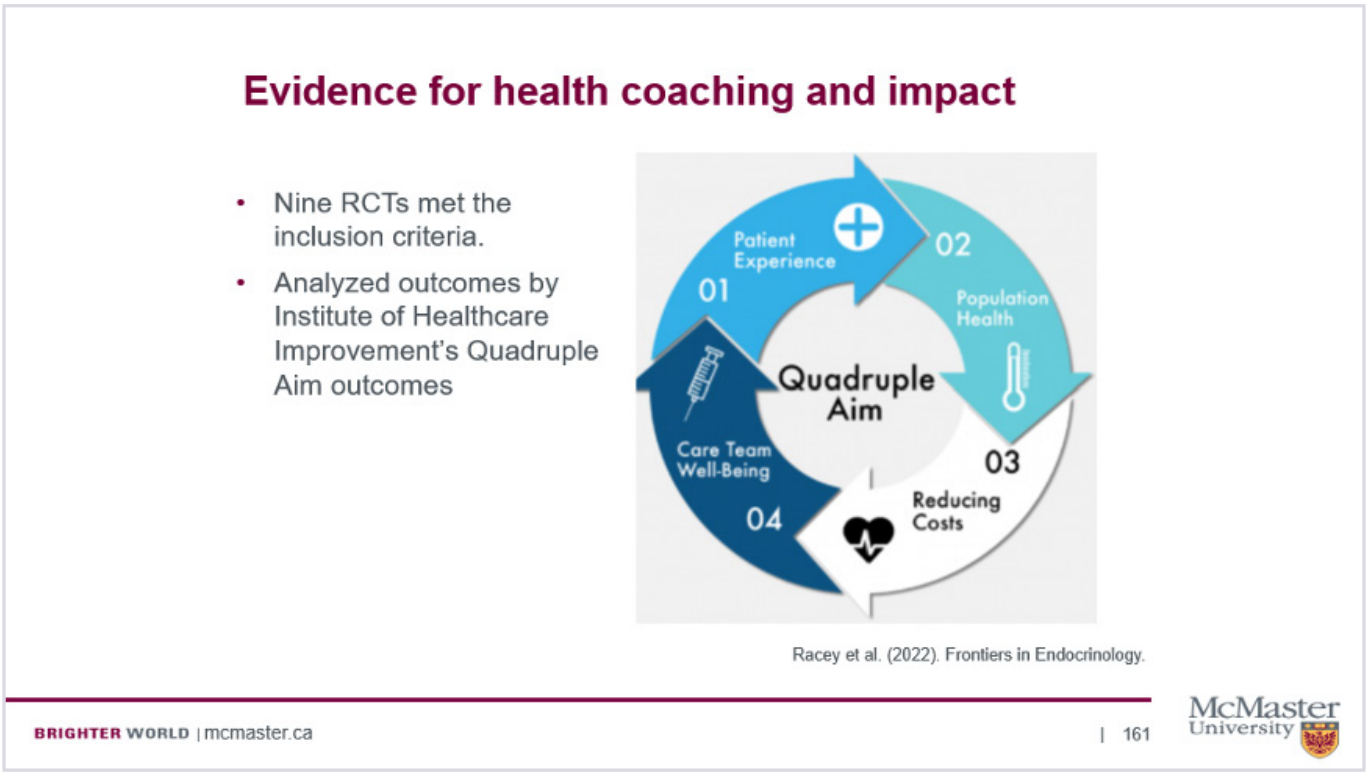
Dr. Sherifali explained that health coaching is a strength-based self-management support intervention that complements diabetes education by focusing on "what's strong with you" rather than "what's wrong with you." She noted it was designed to fill the care gap between clinic visits, where patients manage 90% of their diabetes tasks independently, encouraging goal setting, problem-solving, and self-efficacy through frequent, supportive interactions. Health coaching can be delivered flexibly – in person, by phone, or virtually – making it adaptable across settings.

According to the presentation, a meta-review of 53 systematic reviews covering 232 trials across chronic diseases found that multifaceted health coaching significantly improved clinical outcomes. In type 2 diabetes, health coaching was associated with an average A1C reduction of 0.3%, increasing with longer engagement up to 12 months. Dr. Sherifali described their own randomized controlled trial with 365 participants, which showed that one year of health coaching led to a 0.5% greater A1C reduction compared to usual care, comparable to the effect of adding a new diabetes medication. Participants receiving coaching reported statistically significant improvements in quality of life, particularly in physical functioning and relationships with others.

The intervention was described as including 30 touchpoints over one year, with short, personalized 10–15-minute sessions. Health coaches initiated open-ended conversations led by the participant's own goals. Dr. Sherifali noted the use of the Tiny Habits framework, emphasizing small, frequent behaviour habits over traditional SMART goals, and that the intervention was found to be cost-effective with no adverse events or increased hypoglycemia risk.

Dr. Sherifali noted that health coaching training is now part of McMaster University's Continuing Professional Development Program. Ongoing co-design initiatives with community partners, such as Manitoba's "Minoayawin Coach" (meaning Good Life Coach), were described as reflecting Indigenous perspectives and cultural adaptation. Current research continues to explore AI and data integration and analytics to optimize delivery and assess fidelity across health settings, with health coaching being applied in new contexts including gestational diabetes prevention, type 1 diabetes support, and combined diabetes-mental health interventions.

Dr. Sherifali concluded that health coaching represents a scalable, relationship-based innovation in diabetes and chronic disease management. Grounded in empathy, collaboration, and evidence, it bridges clinical care and daily living by fostering ongoing support and behaviour change. The model's adaptability, from technology-enabled delivery to cultural co-design, positions it as a practical, sustainable strategy for improving health outcomes, reducing system burden, and enhancing both patient and provider experience.



## 3.9 Dr. Ghazal Fazli – Community-Based Diabetes Screening Intervention Piloted in Peel Region

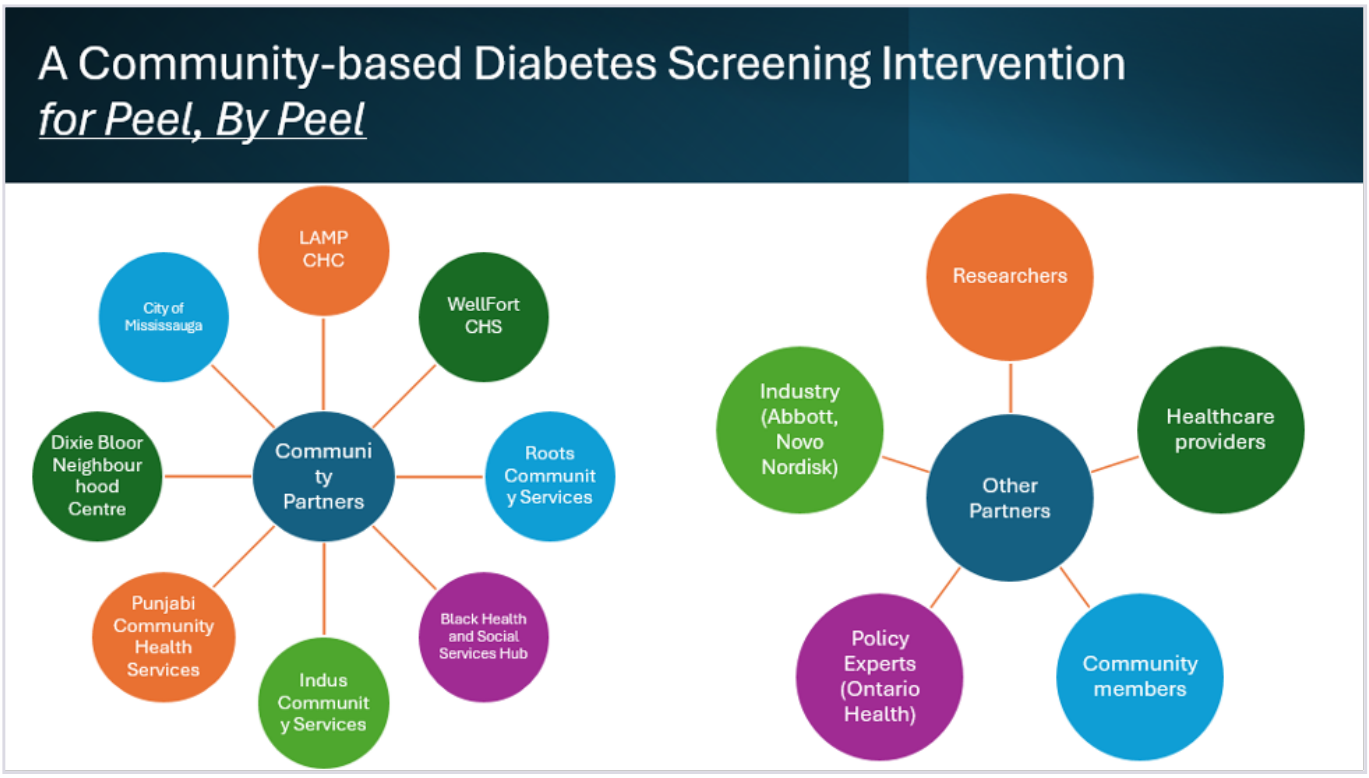
Presented by Dr. Ghazal Fazli, Assistant Professor at the University of Toronto Mississauga and Research Chair in Social and Environmental Determinants of Health with the Network for Healthy Populations, this presentation highlighted a community-based diabetes screening pilot co-designed with local partners in the Peel Region. The project aimed to enhance early detection of prediabetes and diabetes among high-priority populations facing limited access to primary care, using a bottom-up, community-led, and culturally sensitive approach.

Dr. Fazli described a project that addressed barriers to primary care attachment, a key gap contributing to delayed diabetes diagnosis and management, by testing the feasibility and value of community-based screening as an entry point to prevention, education, and care linkage. She emphasized co-design with community organizations to ensure cultural relevance and reduce stigma around testing and screening. The project involved collaboration with multiple community partners, including LAMP Community Health Centre, WellFort, Black Health and Social Services Hub, Indus Community Services, Dixie Bloor Neighbourhood Centre, and the City of Mississauga, with a multidisciplinary team of researchers, healthcare providers, policymakers, and local volunteers using Abbott Afinion A1C analyzers for point-of-care testing.

According to the presentation, the screening model combined a culturally-tailored risk assessment questionnaire adapted from the CANRISK tool with point-of-care A1C testing and questions on social determinants of health. Participants were categorized as normoglycemia (receiving education only), prediabetes (referred to primary care within 1–3 months), or probable diabetes (urgent referral and connection to care provider), with educational materials, support pathways, and guided referrals provided based on postal code and risk category. For unattached individuals, consent-based referrals were facilitated to local primary care providers.

Dr. Fazli described two large-scale wellness fairs held in Brampton and Mississauga in June 2025, which integrated screening with holistic, stigma-free health promotion activities including culinary workshops, Soca and Zumba sessions, children's activities, and local organization booths. She noted that the project demonstrated feasibility and strong community engagement, helped identify individuals unaware of their elevated risk, facilitated new connections to care, and reinforced the importance of cultural tailoring, partnerships, and community trust, while also highlighting implementation challenges including resource limitations and the need for follow-up capacity.

Dr. Fazli emphasized that community-based diabetes screening can play a critical role in advancing health equity, early detection, and system navigation for high-risk and underserved groups. The pilot's success underscored the power of collaboration between researchers, community organizations, and health providers. Moving forward, the team plans to refine the model, expand scaling to other regions, and link participant data to health system outcomes to evaluate long-term impact. Dr. Fazli concluded by noting that effective community health interventions require patience, adaptation, and sustained partnership to achieve meaningful change.



## 4.0 Group Discussions

Following the summit presentations, participants were organized into smaller groups and discussed priority areas to enhance successful diabetes care and opportunities and challenges related to the successful provision of care. There were two sets of discussions, in the morning and afternoon respectively, guided by different topics and followed by share backs with one representative from each group. The discussion process and their findings are described below.

## 4.1 Morning Group Discussion

Participants were organized into six groups where group composition represented a range of perspectives. Each group was given a topic (Prevention and Screening, Data and Technology, Diabetes Care), and was asked to reflect and answer the following questions through the lens of diabetes:

**Question 1 Define:**
What is the current state of your topic in Canada? (i.e. trends, what's working or not working?);

**Question 2 Discover:**
What initiatives, policies, programs, and/or interventions are you aware of that currently support your topic? (please be specific);

**Question 3 Dream:**
What should your topic look like in the next five years in Canada? Consider key outcomes;

**Question 4 Design:**
What policies, initiatives, programs and/or interventions are needed to realize that vision?;

**Question 5 Deliver:**
How can we deliver on this vision? Consider:

- Who will or needs to champion this work?
- What conversations need to be had? What groups need to form, or be further supported? What organizations need to collaborate, and how?

### 4.1.1 Prevention and Screening

| Health Topic: Prevention and Screening | |
|---|---|
| **Define** | • Un-sustained funding and fragmented coordination across regions.<br>• No consistent screening guidelines, especially for pre-diabetes.<br>• Show promise but limited by pilot status and short-term funding. |
| **Discover** | • Programs: ADAPT M, YMCA/YWCA, Small Steps Big Changes, LMC Diabetes Prevention Program.<br>• Public health focuses on healthy behaviours to prevent diabetes and related diseases. |
| **Dream** | • Sustainable, equitable access to prevention programs.<br>• Centralized intake and standardized referrals.<br>• Integration with comorbidity care (renal, foot, eye).<br>• Culturally tailored, community-led approaches. |
| **Design** | • Data-driven planning and upstream funding.<br>• Stronger provincial and regional collaboration. |
| **Deliver** | • Who to champion: Healthcare providers, public health, community organizations, paramedics, pharmacists, and Indigenous partners.<br>• Coordination across micro, meso, and macro levels. |

The two discussion groups of Prevention and Screening noted that Ontario's diabetes prevention efforts show promise but remain fragmented and underfunded. They emphasized the need for consistent screening standards, equitable access, and better integration of data and services. Key barriers include provider capacity, regional inequities, and cultural gaps. Both groups called for sustainable funding, centralized referrals, and stronger partnerships, especially with Indigenous and high-risk communities, to build a more coordinated and inclusive prevention system.

### 4.1.2 Data and Technology

| Health Topic: Data and Technology | |
|---|---|
| **Define** | • Ontario's data systems are fragmented and disconnected.<br>• Privacy laws (PHIPA) limit sharing between research and clinical care.<br>• Organizations are risk-averse to data sharing and innovation.<br>• Data silos at provider, institutional, and provincial levels.<br>• Poor EMR interoperability (Epic, Cerner, etc.).<br>• Short-term funding prevents long-term planning.<br>• Digital divide in rural and Indigenous areas.<br>• Unclear data ownership and Indigenous data sovereignty issues. |
| **Discover** | • Existing Initiatives: Chronic Disease Registry and Primary Care Research Network in development.<br>• Other provinces (e.g., Nova Scotia, Newfoundland & Labrador) show models for integrated systems. |
| **Dream** | • Build a provincial EMR/registry linking all care levels.<br>• Apply AI tools for risk prediction and care optimization.<br>• Involve patients in decisions on data use. |
| **Design** | • Modernize PHIPA to support safe, practical sharing.<br>• Tie data collection to funding for accountability.<br>• Ensure multi-year, stable funding.<br>• Use public-private partnerships to expand access and infrastructure. |
| **Deliver** | • Key Stakeholders: Ontario Health, care providers, patients, governments, and private sector partners.<br>• Collaboration must occur from policy to community level. |

Based on the share-backs from the two groups who discussed the topic Data and Technology, Ontario's data and technology systems are siloed and outdated, hindered by privacy barriers and inconsistent funding. The group called for PHIPA modernization, a unified provincial EMR, and sustainable funding to enable data sharing and integration. Equity, patient involvement, and Indigenous data sovereignty were key priorities. With coordinated efforts and use of AI and partnerships, data could become a driver for improved diabetes prevention and care across Ontario.

### 4.1.3 Diabetes Care

| Health Topic: Diabetes Care | |
|---|---|
| **Define** | • Misalignment between Diabetes Education Centres (DECs) and primary care.<br>• Limited education for patients, families, and practitioners.<br>• Care silos across hospitals, community, and allied health.<br>• Regional disparities in services (foot care, CHCs).<br>• Staffing challenges and burnout.<br>• Policy limits on expanded scopes of practice.<br>• Short, fragmented appointments hinder holistic care. |
| **Discover** | • Diabetes Education Centres (DECs) provide knowledgeable, patient-focused care.<br>• Risk stratification improves care for complex patients.<br>• Some team-based integrated care models exist. |
| **Dream** | • Patient-centered, integrated care with aligned messaging.<br>• Equitable access across regions and ages.<br>• Team-based, coordinated appointments. |
| **Design** | • Expand scope of nurses, dietitians, pharmacists.<br>• Standardized best practices and standing orders.<br>• Use data to support funding and planning. |
| **Deliver** | • Sustained funding and policy support.<br>• Leverage allied care and community resources.<br>• Focus on patient outcomes over system limitations. |

From the two groups who discussed about Diabetes Care, Ontario's diabetes care is strong in education and emerging integrated models but limited by silos, inconsistent messaging, regional disparities, and staffing shortages. The vision is patient-centered, team-based, and equitable care, with expanded scopes, standardized guidelines, coordinated appointments, and data-driven planning, supported by sustained funding and policy reform.

## 4.2 Afternoon Group Discussion

Participants were organized into six groups where group composition differed from the morning session, though still with a range of perspectives represented in each group. Each group was given a new topic (Interventions and Programs, Health Equity, Collaboration and Integration) and was asked to reflect and answer the same questions as in the morning session.

### 4.2.1 Interventions and Programs

| Health Topic: Interventions and Programs | |
|---|---|
| **Define** | • Need for consistent diabetes education standards across care settings.<br>• Greater cultural and linguistic tailoring of materials.<br>• Address gaps in staffing, turnover, and training, especially around technology and complex care.<br>• Expand clinical placements and mentorship to train new diabetes educators.<br>• Integrate trauma-informed, mental health, addiction, and literacy supports into care. |
| **Discover** | • IDC/IHC models, community ambassador programs, and virtual care models show promise.<br>• Community-led initiatives (e.g., CHW programs, workshops, peer leaders) improve engagement.<br>• Upstream programs promoting healthy living, walkability, gardening, food security, are effective at prevention.<br>• Prevention specialists and health coaches in chronic disease management show cross-sector benefits. |
| **Dream** | • Increasing use of virtual platforms and team-based approaches.<br>• Movement toward blending roles (e.g., CDE + health coach + prevention specialist). |
| **Design** | • Sustainable funding models are needed (e.g., funding following the patient).<br>• Upstream investments reduce downstream complications and hospitalizations. |
| **Deliver** | • Shift toward holistic, community-embedded and patient-centered models.<br>• Scaling requires cross-sector buy-in and workforce development. |

Both groups for Interventions and Programs highlighted that diabetes programs are most effective when grounded in community, culturally responsive, and prevention-focused approaches. Sustainable funding, workforce training, and integration of mental health and literacy supports are essential to scale and sustain successful interventions.

### 4.2.2 Health Equity

| Health Topic: Health Equity | |
|---|---|
| **Define** | • Persistent geographic and socioeconomic inequalities in access to care, data, and services.<br>• Lack of culturally relevant and language-appropriate education materials.<br>• Cost barriers for food, medication, and devices, many patients earn “too much” to qualify for assistance but still struggle financially.<br>• Gaps in data for uninsured individuals and limited measurement of social determinants of health.<br>• Fragmented care pathways that fail to meet individual or community needs. |
| **Discover** | • Indigenous Diabetes Health Circle and regional community programs recognized as strong models. |
| **Dream** | • Emphasis on culturally grounded, community-led approaches and inclusion of traditional knowledge. |
| **Design** | • Call for expanded mobile screening, extended hours, and virtual options to improve accessibility.<br>• Need to simplify navigation of services and link patients to nearby supports through regional directories or service portals. |
| **Deliver** | • Champion a multi-sector coalition led by community voices.<br>• Secure dedicated funding and policy champions at government levels. |

Health Equity discussions centered on addressing social, financial, and geographic barriers that limit access to diabetes care. Participants emphasized the difference between equality and equity – ensuring those with greater need receive proportionate support. Indigenous-led, culturally grounded models, improved data systems, and targeted outreach were seen as essential to achieving equitable diabetes outcomes.

## 4.2.3 Collaboration and Integration

| Health Topic: Collaboration and Integration | |
|---|---|
| **Define** | • Need for better communication and data sharing to avoid duplication of services.<br>• Short-term or pilot funding limits sustainability and integration.<br>• Lack of awareness of existing partners and programs across sectors.<br>• Need for true collaboration, not token involvement, with patient partners. |
| **Discover** | • Cross-sector collaboration through OHTs and local partnerships showing early success.<br>• Forums and integrated clinical pathways strengthen communication and awareness across sectors.<br>• Community engagement and patient partners bring valuable lived experience. |
| **Dream** | • Build trust and long-term partnerships beyond traditional healthcare silos.<br>• Share data, resources, and innovations to improve efficiency and reduce fragmentation. |
| **Design** | • Align goals across organizations to maximize collective impact and funding use.<br>• Promote continuous evaluation, learning, and knowledge exchange. |
| **Deliver** | • Who to champion/partners: Government (Ontario Health, OHTs), NGOs (Diabetes Canada, IDC), public health, community organizations, academia, private sector, and non-traditional partners (libraries, local groups, caregivers). |

Both groups for Collaboration and Integration emphasized that effective diabetes care relies on authentic, sustained collaboration across sectors. Integration must include diverse voices, patients, families, community leaders, and non-health partners, to ensure programs are relevant and scalable. Long-term funding, transparent communication, and shared accountability were identified as keys to meaningful, system-wide collaboration.

## 5.0 Conclusions

The SMIDF Project represents a significant collaborative initiative between Diabetes Canada and the Public Health Agency of Canada (PHAC). The Ontario Diabetes Roundtable aimed to encourage further attention and engagement with diabetes in Ontario. It serves as a beacon for fostering collaboration, identifying barriers, and promoting a more equitable approach to diabetes care, thereby positively impacting public health outcomes in the region.
The roundtable met the mentioned meeting objectives and beyond through:

- Identify provincial urban and rural programs, interventions and opportunities to optimize patient care efforts (for those living with or working in diabetes)
- Review alignment between the Diabetes Framework in Ontario and build on the collaborative engagement with strategic partners
- To collectively work and distill transferable elements from interventions for possible uptake in regions across Ontario and Canada

Key Insights generated from the Ontario Diabetes Roundtable:

- Effective diabetes care is grounded in community partnership and cultural relevance. Successful interventions consistently prioritized local knowledge, traditional practices, and community trust over one-size-fits-all solutions.
- Collaboration requires more than coordination; it demands structural change. True collaboration means modernizing privacy legislation like PHIPA, establishing sustainable funding models where resources follow patients, and building integrated EMR systems that enable seamless information sharing across providers.
- Prevention should move upstream with sustained investment. Effective prevention requires investment in social determinants, not just clinical screening. Upstream investments reduce downstream complications and hospitalizations, yet lack of long-term funding prevents scaling.
- Health equity means ensuring those with greater barriers receive proportionate healthcare support. Achieving equity requires mobile screening, extended hours, traditional knowledge integration, and community-led decision-making. Health equity demands intentional design, not equal distribution.
- Data integration is both an opportunity and a barrier. Coupled with stable funding and multi-sector commitment, a provincial EMR, chronic disease registry, and clear frameworks for Indigenous data sovereignty could transform diabetes surveillance, planning, and evaluation.

The Ontario Diabetes Roundtable successfully brought together diverse stakeholders from government, healthcare, research, and community sectors to advance collaborative action on diabetes prevention and care across the province. Throughout the event, participants demonstrated a shared commitment to moving beyond silos, emphasizing culturally responsive care, health equity, and sustainable system integration. The innovative programs and partnership models presented—from community-based screening and health coaching to Indigenous-led wellness initiatives and regional centralized intake systems—offer replicable frameworks for strengthening diabetes care delivery. As Ontario continues to align with the national Framework for Diabetes in Canada, the insights, relationships, and collaborative momentum established at this roundtable will inform policy development, guide resource allocation, and support ongoing efforts to build a more connected, equitable, and patient-centered diabetes care system that serves all Ontarians, particularly those facing the greatest barriers to health.

## References


1. Public Health Agency of Canada. (2022). *Framework for diabetes in Canada.* https://www.canada.ca/en/public-health/services/publications/diseasesconditions/framework-diabetes-canada.html

2. The Network for Healthy Populations. https://healthypopulationsnetwork.utoronto.ca/

3. Eye Health Screening Initiative. https://visionlossrehab.ca/en

4. Sioux Lookout First Nations Health Authority. (2022). *Shookaawaapinewini Maawantoonikewin – Diabetes Report.* https://www.slfnha.com/wp-content/uploads/2023/03/Diabetes-Report-Final-September-2022.pdf

5. Sioux Lookout First Nations Health Authority. (2023). *Shookaawaapinewin Mamow Wicihiwewin: Anishinininowak Ka-ishimamitinentamowaac – Diabetes Connections: Community Member Perspectives Report.* https://www.slfnha.com/wp-content/uploads/2025/09/Diabetes-Report-2023.pdf Sioux Lookout, ON.


DIABETES CANADA

diabetes.ca


**National Office**
1000-170 University Ave
Toronto, ON M5H 3B3
416-363-3373

**Adria Cehovin**
Project Manager,
Convening Project with PHAC
Diabetes Canada
Adria.Cehovin@diabetes.ca

**Hiba Syed**
Coordinator,
Convening Project with PHAC
Diabetes Canada
Hiba.Syed@diabetes.ca



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