DIABETES CANADA

SUSTAINING MOMENTUM TO IMPLEMENT THE DIABETES FRAMEWORK (SMIDF):

NORTHERN DIABETES MEETING

AUGUST 2025

Summary

This grey paper provides key findings about the Sustaining Momentum to Implement the Diabetes Framework (SMIDF): Northern Diabetes Meeting 2025.

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About Diabetes Canada

Diabetes Canada is a national health charity representing more than 4 million people in Canada diagnosed with Diabetes. Diabetes Canada leads the fight against diabetes by helping those affected by diabetes live healthy lives, preventing the onset and consequences of diabetes, and discovering a cure. It has a heritage of excellence and leadership, and its co-founder, Dr. Charles Best, along with Dr. Frederick Banting, is credited with the co-discovery of insulin. Diabetes Canada is supported in its efforts by a community-based network of volunteers, employees, health care professionals, researchers, and partners. By providing education and services, advocating on behalf of people living with diabetes, supporting research, and translating research into practical applications, Diabetes Canada is delivering on its mission. Diabetes Canada will continue to change the world for those affected by diabetes through healthier communities, exceptional care, and high-impact research.

For more information, please visit: www.diabetes.ca.

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Hiba Syed (Coordinator), and
Yucen Liu, M.Sc. (Health Equity and Research Coordinator)

We would like to thank all presenters and attendees for their contributions to the Northern Diabetes Meeting. The insightful presentations and discussions allowed for knowledge sharing, enabling a deeper understanding of diabetes in the Territories.

Title: Sustaining Momentum to Implement the Diabetes Framework (SMIDF): Northern Diabetes Meeting, August 2025

Project Overview: Through the Framework for Diabetes in Canada (the Framework) project, supported by the Public Health Agency of Canada (PHAC), Diabetes Canada continues to bring together key stakeholders to help identify and share best practices. This project began in 2023, and the result of this 3-year project will be an inventory of successful diabetes programs/interventions/projects and the dissemination of findings for adoption and scaling to identify and share best practices for addressing diabetes, including the identification of barriers in health equity-deserving communities.

1.0 Northern Diabetes Meeting

The fifth roundtable of this project was held in Yukon, Canada, in August of 2025. Participants were invited from all Yukon, Northwest Territories and Nunavut to share, listen, and brainstorm. The meeting was a combination of presentations and open discussion sessions. Presentation topics focused primarily on interventions and the current state of diabetes in each of the Territories.

Location and Date: Whitehorse, YK, on August 20, 2025, from 9:00 am to 4:00 pm PST.

Meeting Objectives:

- Bring together participants from across the Territories (and who work with the Territories), including public health professionals, community partners, NGOs, and others to highlight and discuss programs/projects/interventions that address diabetes
- Gain a deeper understanding of how these regions engage with populations impacted by diabetes and identify opportunities for improvement in these systems while expanding networks
- Collectively highlight challenges, innovations, and gaps; creating space for the group to share lessons learned and brainstorm opportunities for the future

2.0 Framework Overciew

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.

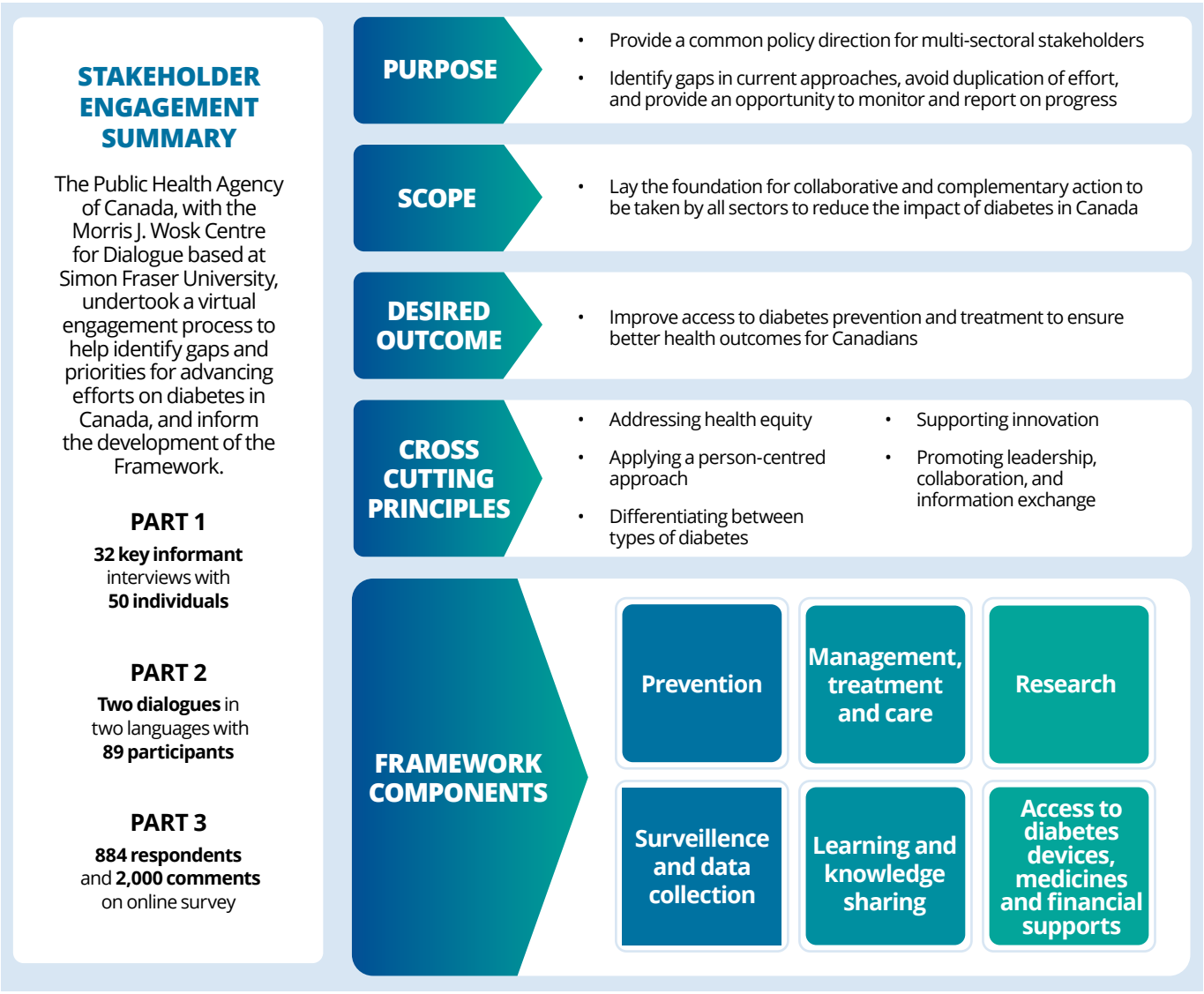
Cross-cutting principles:

- 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
- Access to diabetes devices, medicines, and financial supports

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



Summary of the Framework[1] (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 Meeting Presentations

Presentation Topic	Presenter(s)
Diabetes Canada: Sustaining Momentum to Implement the Diabetes Framework Overview	Adria Cehovin, MSc.
3.1 Yukon Healthy Living Program	Melissa Laluk, CSEP-CEP Annie Worth, CSEP-CEP Brayden Kulych, RN CDE
3.2 Leveraging Virtual Care to Promote Care Closer to Home: The Government of Nunavut's Virtual Nurse Practitioner Program	Gabriela Goodman, MSc RD CHE Robert McMurdy, PHC-NP Kathleen Cleary, PHC-NP
3.3 Yukon Experiences in the Management of Type 1 Diabetes: Patient and Provider Perspectives	Dr. Marney Paradis, PhD Dr. Liris Smith, PhD
3.4 Diabetes in the Northwest Territories	Tanya Earle, RD Erin Currie, NP Rebecca Pumphrey, RD Mabel Wong RD Cameron Thomson, RD Chelsea Foster, RN
3.5 National Indigenous Diabetes Association (NIDA): Indigenous Diabetes Framework	Céleste Thériault, MBA

3.1 Melissa Laluk, Annie Worth, Brayden Kulych- Yukon Healthy Living Program

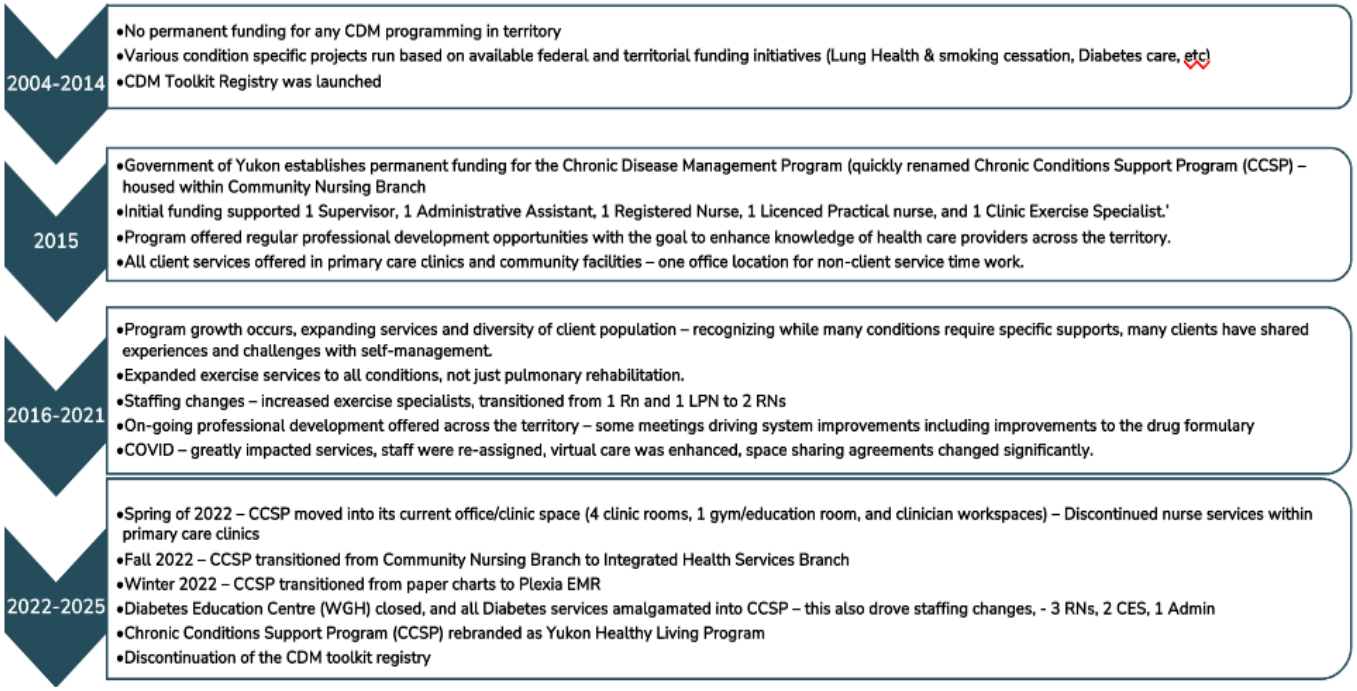
Melissa Laluk, Program Manager at the Yukon Healthy Living Program (YHLP), began by sharing the background of the program and how it developed into its current form. It is important to note that the YHLP is not exclusively focused on diabetes, rather, it is a chronic condition support program, with diabetes included as one component.

The vision of the program is:
"To provide education and support to Yukoners living with chronic conditions, as they work towards establishing self-management strategies and improved health outcomes."

This vision is achieved through collaboration and by keeping a client-centered approach at the forefront of all support efforts.

The program team is composed of a manager, a supervisor, a dietitian, nurses, exercise specialists and assistants, an administrative assistant, and contractors such as pharmacist teams. Since the program operates within the Integrated Health Services branch, which also houses other medical clinics, it can easily leverage additional healthcare providers to strengthen its support.

A brief summary of the program's history is provided below.



Annie Worth, Supervisor for the YHLP, explained that the program is composed of four main pillars of services: nursing, exercise, dietitian, and clinical programs/support. Together, these services provide comprehensive care for clients living with chronic conditions, including diabetes.

Nursing Services

RNs with support from LPNs, perform point-of-care procedures. One-on-one appointments to help clients follow guideline-based care are provided, with one-hour sessions available, giving time to explore behavior changes, identify barriers, and work with patients in whatever capacity they need to better self-manage their diabetes. Clients can access routine checks and procedures such as:

- Foot care assessments
- Blood draws
- ECG (Electrocardiogram) testing (to be introduced in the future)

Exercise Services

Exercise specialists provide supervised one-on-one support as well as structured programs. These programs run for eight weeks, twice a week, and are designed for people with diabetes to help them learn how to use exercise to manage blood sugar levels. Sessions can be delivered virtually, at home, or in clinic, depending on client needs.

Dietitian Services

Dietitians provide individual counseling, follow-up appointments, and food intake reviews with tailored recommendations. While not all clients have access to one-on-one appointments, dietitians remain available to support dietary changes and healthy eating strategies.

Clinical Programs

The program also offers cardiac and pulmonary rehabilitation, along with workshops for diabetes management. Although there is no formal diabetes rehabilitation program, the **Diabetes Wellness Series** provides a two-part introduction to overall diabetes care. Each part is adapted to meet client needs, and information about available services is shared through posters distributed two to four times annually. Attendance is offered both in person and virtually.

In addition to core services, the YHLP has developed diabetes-specific partnerships in recent years with:

- **Department of Education**: A new type 1 diabetes care coordinator role within the department helps support school training, education, and ongoing assistance.
- **Lynx Pediatric Clinic**: Provides resources and support for youth transitioning from pediatric to adult care.
- **Solstice Maternity**: Works with physicians, nurses, and dietitians to support clients with gestational diabetes.
- **Yukon Midwifery Program**: Assists clients with gestational diabetes who are not medically managed but still require support.
- **Community Partners**: Offer education, resources, and ongoing support for client questions.

To manage high demand and prioritize urgent needs, the program has established 2 distinct pathways. Clients with high needs, such as uncontrolled diabetes (A1C > 9%), new insulin starts or titrations, pump support, or gestational diabetes are provided immediate one-on-one support. For others, including those with type 2 diabetes (A1C < 9%), prediabetes, or those undergoing screening, the first step is often group education. If ongoing or more complex needs arise, these clients can then transition to individualized support. This system ensures that urgent cases are addressed quickly while still offering comprehensive care to all clients. The program has already seen significant benefits from this approach.

3.2 Gabriela Goodman, Robert McMurdy, Kathleen Cleary- Leveraging Virtual Care to Promote Care Closer to Home: The Government of Nunavut's Virtual Nurse Practitioner Program

Gabriela Goodman, Territorial Director of Population Health at the Government of Nunavut, explained that Nunavut is a relatively young territory and does not yet have robust territory-wide chronic disease/diabetes health programs. It was mentioned that in the past, there was a brief diabetes pilot project, and now there is the Virtual Nurse Practitioner (NP) Program. This initiative marks the beginning of how Nunavut intends to incorporate diabetes and chronic disease management into its health system.

Robert McMurdy, Nurse Practitioner Consultant with the Government of Nunavut, emphasized the importance of virtual care as a way to reduce geographic barriers and improve access. Data from Statistics Canada indicates that 17.8% of people across the country live in rural areas. In addition, a disproportionate number of First Nations, Inuit, and Métis people, compared to non-Indigenous populations, have less consistent access to healthcare providers.

Nunavut itself covers one-fifth of Canada's land mass and is made up of 25 communities. All of these communities are fly-in/fly-out, which creates major challenges for healthcare delivery and is one of the reasons why the territory is investing more in virtual care.

With Virtual Nurse Practitioner (NP) Program set in place, it aims to demonstrate how virtual care can offer an innovative approach to improving both access to care and health outcomes.

Nunavut faces several barriers to effective healthcare delivery:

- **Geography**: The remoteness of Northern communities make healthcare delivery difficult, with lower recruitment and retention of healthcare professionals compared to southern jurisdictional counterparts, leading to inconsistent continuity of care.
- **Community health nurses (CHNs)**: Care at the community level is primarily delivered by CHNs, who are registered nurses working in an expanded scope. Although supported by MDs and NPs, CHNs often manage clients with complex health conditions complex patients without extensive training that Nurse Practitioners have, which limits their ability to follow evolving up to date evidence-based guidelines, and formulate diabetes care plans in real time (e.g., altering prescriptions or ordering diagnostics).
- **Staffing shortages**: During periods of critical staffing shortages, such as in summer, services are reallocated to priority patients, and diabetes management is often deferred until staffing improves.

Kathleen Cleary, Virtual Nurse Practitioner, shared the barriers patients face, including:

- Limited access to resources such as affordable nutritional food
- Competing comorbidities can limit the time and attention available to focus on diabetes management. Time constraints, as managing diabetes adds to full-time commitments
- Language barriers or communication in the patient's preferred language requires longer appointment times to facilitate quality care.

Challenges in navigating health information can be heightened when general resources and materials are not readily available in the patient's preferred language. Given the highlighted challenges and barriers, The Virtual NP Program was created. It was launched in 2021 and now covers all three regions of Nunavut, serving 13 communities. Nine virtual nurse practitioners provide care across these communities on both a full-time and part-time basis to ensure consistency. Patients are rostered to the program, with the intention that all will be seen at least once every three months. Physical assessments are guided by the NP and completed by licensed practical nurses (LPNs) or paramedics. For complex patients requiring advanced assessments, care is provided collaboratively by in-community physicians, nurse practitioners, or CHNs.

The program's objectives are to:

- Improve timely access to primary and secondary care (via e-consult/referrals) for diabetes and other chronic diseases
- Optimize and improve the health outcomes for individuals with diabetes and other chronic conditions
- Maintain a positive patient experience with every virtual Nurse Practitioner visit

Since its launch in 2021, the program has achieved several outcomes, including:

- Improved access to primary and secondary care
- Bettered chronic disease biomarkers
- Positive patient experiences and improved patient-reported outcome measures

The program itself has also focused on tackling barriers that patients face in managing diabetes. Key strategies include:

- Allowing time to discuss individual difficulties, with full interpretation and communication at the client's preferred pace and language
- Tailoring education in a client-centered manner
- Addressing comorbidities during the same appointment
- Modifying care plans to address what is important to the patient
- Building ongoing therapeutic relationships that foster adherence to therapy

The program has undergone evaluation, with the evaluation plan including indicators such as diabetes biometrics (A1C, weight loss, LDL), patient-reported experience measures, patient-reported outcome measures, and health promotion.

As of July 14, 2025:

- 746 patients were rostered into the program
- 231 patients were being treated for diabetes
- 1,946 virtual clinic days had been completed

Some results shared included the patient experience surveys composed of 12 questions, with results compared between 2022 and 2025.

Patient Report Experience Measure Survey						
Question	**Evaluation Year**	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
I am satisfied with my overall experience today with the virtual NP.	2022	42% (81)	54% (103)	5% (3)	1% (1)	0%
	2025	72% (34)	26% (12)	2% (1)	0%	0%
I received the same quality of care with my virtual nurse practitioner visit as I would have with an in person visit.	2022	37% (71)	56% (107)	5% (9)	3% (5)	0%
	2025	57% (27)	43% (20)	0%	0%	0%
I felt confident that my health issues will actively be followed by the virtual nurse practitioner program.	2022	50% (94)	48% (90)	3% (5)	0%	0%
	2025	74% (35)	26% (12)	0%	0%	0%

Findings showed that patients did not view virtual care as inferior, and positive results were reported across all indicators.

Patient reported outcome measures had a total of 5 questions, also indicating positive results.

Patient Reported Outcome Measures Survey						
Question	**Evaluation Year**	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
There has been a positive change to my quality of life since seeing the virtual nurse practitioner.	2022	42% (26)	55% (34)	3% (2)	0%	0%
	2025	54% (25)	33% (15)	13% (6)	0%	0%
Since I started seeing the virtual nurse practitioner, my health has improved, and I am more able to enjoy my favourite hobbies and past times	2022	32% (20)	56% (35)	13% (8)	0%	0%
	2025	55% (26)	23% (11)	21% (10)	0%	0%
Since seeing the virtual nurse practitioner, I am more aware of how my lifestyle impacts my health	2022	43% (27)	52% (33)	5% (3)	0%	0%
	2025	64% (30)	32% (15)	4% (2)	0%	0%
My chronic disease has been managed better since seeing the virtual nurse practitioner.	2022	37% (23)	57% (36)	6% (4)	0%	0%
	2025	64% (30)	30% (14)	4% (2)	4% (2)	0%

Quantitative diabetes biomarkers were also compared prior to and after the intervention.

Pre-Post Intervention Diabetes Biomarker Comparison					
A1c comparison for all Diabetics	A1c comparison for uncontrolled Diabetics	Wt comparison for all Diabetics	Wt comparison for all Diabetics with a higher Wt risk	LDL comparison for all Diabetics	LDL Comparison for all diabetics at a higher risk
A1c reduction of 0.56%	A1c reduction of 2.89%	Wt reduction of 3.76kg	Wt reduction of 8.52kg	LDL reduction of 0.73mmol/L	LDL reduction of 1.72 mmol/L
Statistical significance was met (P value <0.0148)	Statistical significance was met (P value <0.0005)	Statistical significance was met (P value < 0.0061)	Statistical significance was met (P value <0.0128)	Statistical significance was met (P value <0.0001)	Statistical significance was met (P value <0.0002)

Program Definitions:

- Uncontrolled Diabetes was defined as an A1C >9.0%
- Diabetics defined as a higher weight risk was set at >100 kgs
- Diabetics defined as a higher dyslipidemia risk was set at an LDL > 3.5

Amongst the diabetes biomarkers tested for, a reduction was seen across all.

The following quote was also shared from a lived experience perspective on the impact the program has on their diabetes management care.

"In our community there's not always a nurse practitioner. We were very lucky to meet Kristie. She has been very helpful over the telehealth and with phone calls as well. Since seeing her, I've lost a lot of weight, more than 50 lbs. I'm more active. I am seeing the right doctors and my medication is sent up to me on time"

Health promotion is also a major part of this program. A follow-up evaluation in 2025 found that 20–30% of appointment time was dedicated to health promotion. Clinicians reported incorporating:

- Diet and exercise counseling in 81% of appointments
- Physical activity counseling in 48% of appointments
- Smoking cessation in 76% of appointments
- Alcohol use counseling in 15% of appointments
- Immunization discussions in 31% of appointments

Some challenges highlighted by the group were with LPNs, who support virtual care but also have their own workloads and competing priorities. To address this, a policy was created to formally include virtual care in their workplans. High no-show rates were another challenge. To mitigate this, phone call follow-ups were introduced, which received positive feedback from patients who often lacked time to attend in-clinic appointments.

Parallels were also drawn between the alignment of the program with the Framework for Diabetes in Canada, focusing on prevention, management, and knowledge sharing. Devices and technology are increasingly incorporated, including continuous glucose monitoring and cellphone-based tools. The program also integrates Inuit Qaujimajatuqangit (IQ) values, emphasizing respect, inclusion, and consensus decision-making.

3.3 Dr. Marney Paradis, Dr. Liris Smith- Yukon Experiences in the Management of Type 1 Diabetes: Patient and Provider Perspectives

Dr. Marney Paradis, Founder of the Yukon T1D Support Network, shared that the organization was born from her son's diagnosis with type 1 diabetes at 17, and the family's struggle to access affordable, consistent care. After being denied support by government officials, she leveraged her expertise in policy to establish the non profit, advocate for drug coverage, and influence national health policy. The non-profit successfully petitioned for continuous glucose monitor (CGM) coverage—initially through private sponsorships that quickly expanded to broader access—ultimately prompting government adoption. Most recently, the organization confirmed it will co develop a Type 1 Diabetes Strategy with the Government of Yukon, with an action plan set for release on November 3.

Dr. Liris Smith, Yukon University Health Research Chair, leads the work, focusing on developing local research and partnerships with people with lived experience, communities, and organizations. The project team itself includes advisors, healthcare providers, and researchers.

The goals of the project are to:

- Hear the perspectives of people living with type 1 diabetes and healthcare providers
- Understand both the challenges and benefits of managing the condition in the region

This is achieved by using semi-structured, guided conversations with people with lived experience, while providers complete surveys. Guided conversations were had with anyone that is 12 years or older, living with T1D or caring for someone with T1D, and considering the Yukon "home", including Yukon citizens who have moved for education or other reasons.

Knowledge mobilization is a key part of this project. Two key parts to this are to prepare actionable recommendations and interventions for decision makers and healthcare providers, to support better T1D care and services in the Yukon and to bring decision-makers, healthcare providers, and people living with T1D together to discuss how recommendations can be implemented within existing systems.

While the study is still in progress, the team has reflected on interviews with 12 families (18 people). Thus far, the following themes have emerged:

- Administrative burden: Patients must repeatedly provide documentation every three months to funders to access medications, despite having a lifelong condition.
- Lack of adult endocrinologists: Transition from pediatric to adult care is a major concern.
- Family stresses: Parents worry about their child's health and strive to provide a healthy childhood while managing the burden of education for family, schools, and the public.
- Misunderstanding of T1D: Even healthcare providers sometimes lack knowledge. One example involved a nurse who appeared frightened upon learning a patient had T1D and began providing inaccurate education.
- Lack of formal support at the point of diagnosis: many families felt isolated until they were eventually linked to appropriate care.

Despite these challenges, several strengths stand out. Patients demonstrate a high level of maturity in managing their diabetes, and there is strong community support, with individuals providing one-on-one assistance at hospitals. Exceptional pediatric care is available at BC Children's Hospital, and families benefit from drug and equipment funding.

The project is closely aligned with the Framework for Diabetes in Canada as highlighted by Liris. It highlights health equity issues, applies a person-centered approach by involving people with lived experience from the ground up, and clearly differentiates T1D from other forms. It also supports innovation and promotes leadership, collaboration, and information exchange as there is a large, diverse team working together to inform the project.

3.4 Tanya Earle, Erin Currie, Mable Wong, Rebecca Pumphry, Cameron Thomson, Chelsea Foster- Diabetes in the Northwest Territories

Tanya Earle, Territorial Nutritionist, shared that the Northwest Territories (NWT) is organized into 7 health authorities as shown below.

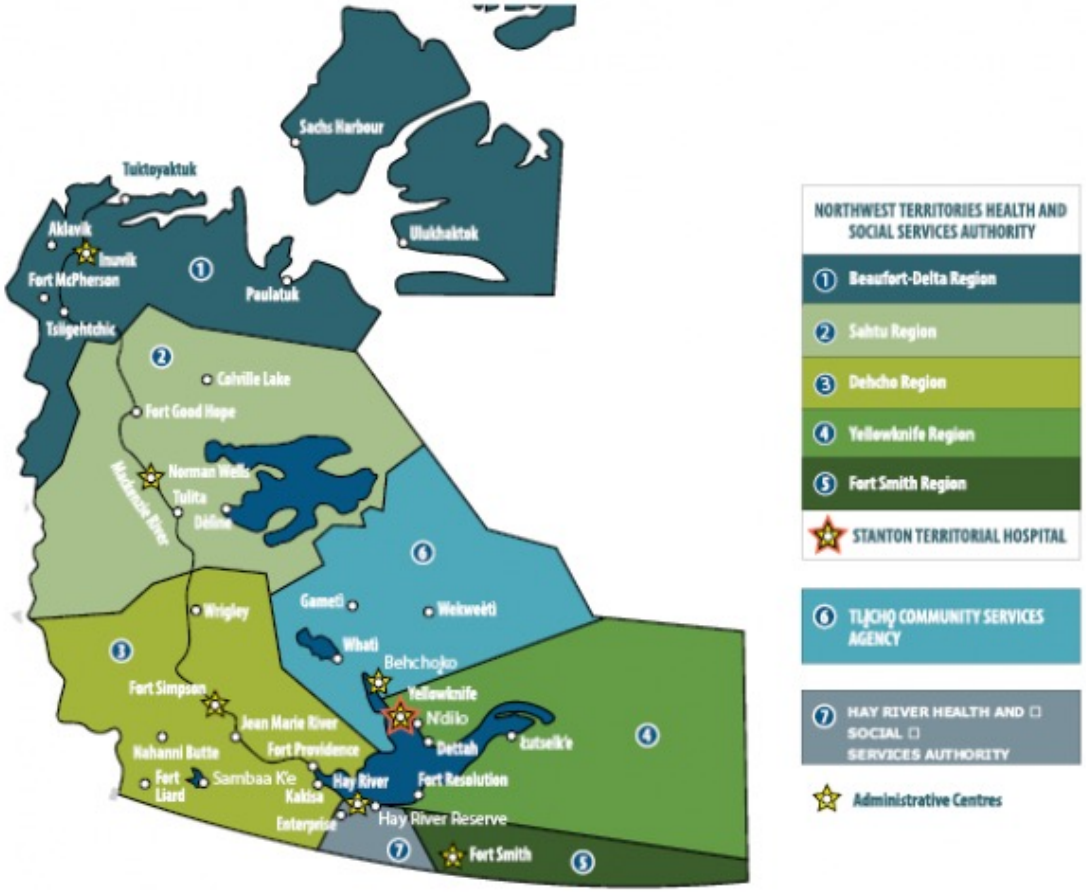
In total, three health authorities serve seven of the eight regions. The Northwest Territories Health and Social Services Authority serves all the regions except for 6 and 7.

The NWT adopted the new 2024 Diabetes Canada Clinical Practice Guidelines. Previously, they had developed their own guidelines in 2013, which included screening for glucose intolerance. These earlier guidelines were created because the standards at the time did not reflect the realities of the NWT. With the updated Diabetes Canada guidelines now more reflective of local realities, the territory has transitioned to using them.

In the Yellowknife Region, monthly interdisciplinary meetings bring together nurses, dietitians, and the regional diabetes team to coordinate care for pregnant patients with diabetes, including those referred from other regions. Patients are monitored every 1–2 weeks until late pregnancy, with care encompassing glucose monitoring, lifestyle management, and pharmacotherapy as needed. Six weeks postpartum, diabetes screening is conducted using a standard 75g glucose tolerance test.

Regional diabetes teams operate in medium to large communities, including Fort Smith, Hay River, Yellowknife, and Inuvik regions.

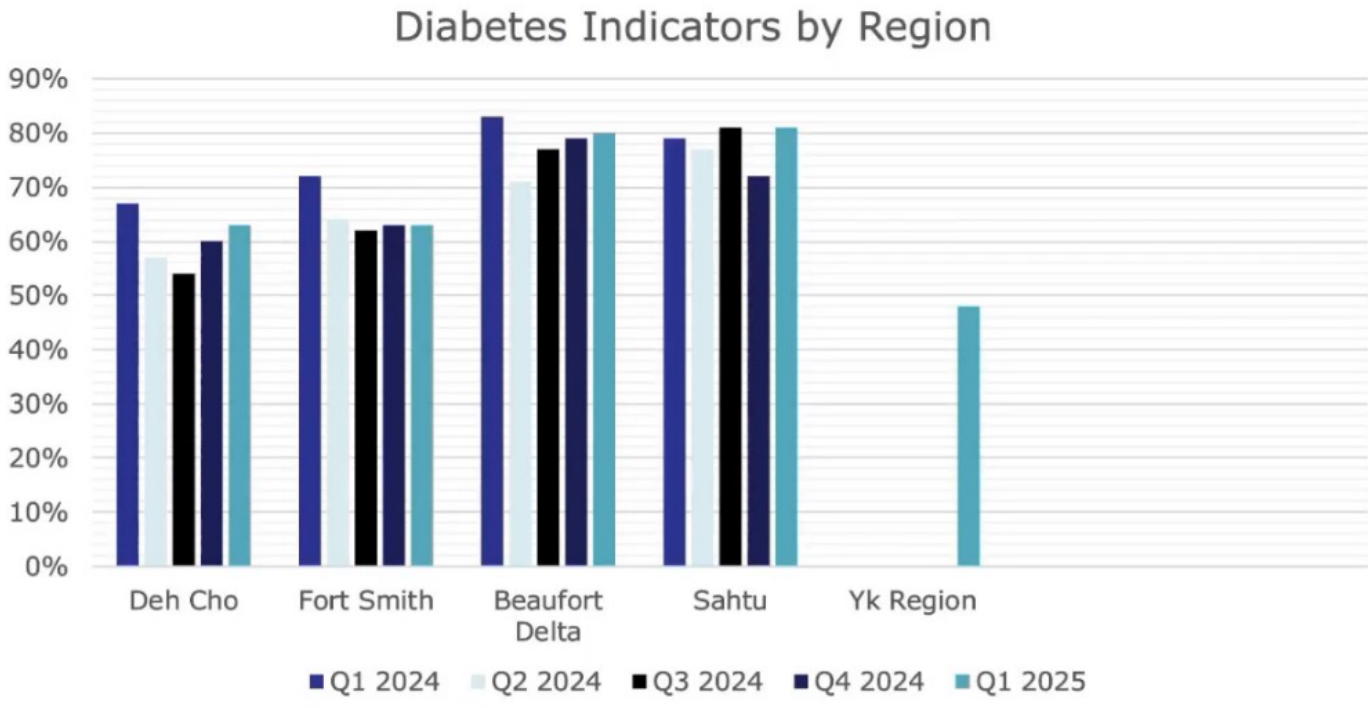
- **Yellowknife Region**: Staff include a registered dietitian, a licensed practical nurse (LPN), Certified Diabetes Educator (CDE) who provides foot care two days a week, a half-time NP CDE, and a community health nurse (CHN). They see patients with type 1 diabetes, type 2 diabetes, and gestational diabetes. Pediatric patients are referred to other provinces. The team also runs prediabetes group sessions.



- **Fort Smith Region**: Does not have a standalone diabetes program but offers group programming for diabetes support. Over the past year, more group sessions have been planned, open to all individuals with diabetes (most of whom have type 2 diabetes). Sessions are held monthly and include vitals (height, weight, blood pressure) completed with the community health representative, along with lab reviews, medication checks, and foot exams. Education is provided by the dietician on topics such as nutrition and glucose monitoring. Sessions also encourage open discussion, peer support, and connection in a welcoming environment. Individual sessions are available for those who prefer one-on-one care. These group sessions have been well received, particularly for the sense of connectedness they foster.
- **Inuvik Region**: Hosted a one-day education session called *On the Land Diabetes Education*, facilitated by a local elder. The session focused on traditional medicines and land-based activities to promote healthy living and cultural practices. Ten participants with type 2 diabetes management attended. The session was held at Jàk Territorial Park, NT and included demonstrations on foraging, preparing traditional medicines, and using natural resources such as spruce gum. A debrief followed, with open dialogue that participants described as eye-opening and positive. Further sessions are planned for Fall 2025.

The NWT uses Telus EMR, with all facilities except for hospitals on the system. Patients with diabetes are flagged if their A1C is not checked every six months or if their albumin-to-creatinine ratio (ACR) is not checked every 12 months. This monitoring system was introduced to reduce complications. Quarterly, the percentage of adults with diabetes who are followed according to these recommendations is calculated. The target is for 75 percent of patients to have their A1C checked every six months and their ACR checked annually. Below highlights a regional breakdown.

Based on the chart, smaller communities have generally performed better in meeting these monitoring goals compared to larger centres, such as the Yellowknife region.



3.5 Céleste Thériault- National Indigenous Diabetes Association (NIDA): Indigenous Diabetes Framework

Céleste Thériault, Executive Director of NIDA, has been leading the development of a Diabetes Framework that applies an Indigenous lens, building on the Framework for Diabetes in Canada. The organization has secured funding to engage Indigenous people and gather their experiences with diabetes, as well as their broader expectations for care. The organization works to raise awareness of diabetes and collaborates with multiple levels of government, Indigenous leaders, Indigenous governments, and people with lived experience to mobilize a broader conversation. As a charitable health organization, it is mandated by a volunteer board of directors. Its vision is to build healthy communities, while its mission is to support environments where people live and work by partnering with organizations and individuals at the level they choose. The organization's values emphasize respect for and connection to the lands they inhabit. Importantly, both the staff and board of directors are 100% Indigenous.

This members-led health charity was founded in 1995 by First Nations women in Winnipeg who recognized the devastating impact of diabetes on their loved ones. With support from the Assembly of First Nations (AFN), they mobilized into a formal organization and secured funding in the late 1990s. Over time, the organization expanded to include First Nations, Inuit, and Métis communities, based on identified needs. 1995 was also the year the AFN declared diabetes a critical issue requiring urgent attention. Out of this declaration came National Indigenous Diabetes Awareness Day, observed annually on the first Friday of May.

This project stems from Bill C-237, the Act to Establish a Diabetes Framework, which was posted online in 2022. The legislation prompted the organization to explore distinction-based pathways, an approach that recognizes the unique rights, cultures, and needs of First Nations, Inuit, and Métis peoples.

The initiative is structured into three phases:

Phase 1: Engagement Activities

a. Conducted virtual engagement and surveys, hearing from 330 people across Canada. This phase ran until December 2023.

Phase 2: Key Areas

a. Currently underway, not yet published, but will inform the final report
b. Three parts:
    i. Strategy and Literature Review
    ii. Engagements (Currently here)
    iii. Final deliverable action-oriented pathways with budget requirements and key outcomes

Phase 3: Implementation

Three project teams are used currently in Phase 2 of this project:

- **Narratives Inc.**: Responsible for knowledge gathering with First Nations and Métis communities through one-on-one interviews. Participants are honored with tobacco and honoraria, following cultural protocols. The team has traveled across the nation to learn and listen. To date, 221 interviews have been collected, with First Nations interviews completed and Métis interviews underway. Below is a map highlighting where the 221 interviews have been completed.
- **Nvision Insight Group Inc.**: Leads Inuit engagement. They have conducted 60 interviews in Northern Communities of the 221, using one-on-one and small group interviews, workshops, and conferences.
- **Waapihk Research**: Provides technical guidance, conducts interviews, and performs background research and analysis of both quantitative and qualitative data. An online survey resulting in 710 respondents was completed. These data so far confirm that a distinctions-based approach may be appropriate for Canadian Indigenous peoples. More details on this will be shared in Spring 2026.

Looking ahead, the project team is focused on ensuring that the work translates into meaningful, actionable change. One priority is to make sure that important distinctions in ideal care are not only observed but also implemented in practice. This means recognizing the unique cultural, social, and health needs of First Nations, Inuit, and Métis communities, and embedding those distinctions into every stage of diabetes care planning and delivery. Another priority is to guarantee that Indigenous patients consistently receive the baseline care they both need and are entitled to. This involves strengthening access to essential services such as regular screenings, timely diagnostics, and culturally appropriate education, while also addressing systemic barriers that have historically limited access.

4.0 Open Discussion Sessions

In addition to presentations, open discussions sessions were held to address any questions related to presentations or discuss emerging topics related to diabetes care, management and treatment in the Territories. Below is a summary of the topics discussed during both the morning and afternoon open discussion sessions.

4.1 Morning Discussion Session Summary

1. Access to Care and Coverage Discrepancies

- Continuous Glucose Monitor (CGM) Coverage:
  - NIHB (Non-Insured Health Benefits) sometimes covers CGMs for people with type 2 diabetes (T2D), particularly if insulin-dependent, but coverage is inconsistent and often requires exemptions.
  - Private insurance like Canada Life has better coverage, but Alberta Blue Cross excludes T2D patients on insulin unless on pump therapy.
  - Yukon and NWT echo similar frustrations with inconsistent coverage and lack of rationale for approvals/denials.
  - Newfoundland & Labrador uniquely covers CGMs for gestational diabetes—a model others are watching.

2. Technology Integration in Remote Monitoring

- Remote monitoring tools like Freestyle Libre, Dexcom, Guardian are being used, with clinic accounts set up for healthcare teams to access readings.
- Glucose apps and connectivity (e.g., Gluco) are used sporadically due to technical barriers, EMR disconnection, or infrastructure gaps.
- Digital communication platforms, such as Time Right and Teams channels, are beginning to be leveraged for peer support and case discussion.

3. Workforce Development: CDE Training and Support

- Many diabetes educators did not start out as Certified Diabetes Educators (CDEs) but earned certification on the job, often supported by territorial or federal funding.
- LPNs can become CDEs, though it's rare—less than 1% of CDE exam writers are LPNs, and tracking hours remains a challenge.
- Most territories follow a model where CDE is preferred, not required, with staff supported to earn the designation within a couple of years.
- There's variation in pathways and standards for who can manage diabetes clients if they are not CDE-certified, and some territories are building tiered models of care (e.g., RN vs NP vs RD).

4. Mentorship, Peer Support & System Navigation

- Lack of mentorship and peer consultation pathways was a major concern.
  - Many CDEs and clinicians in remote or small communities feel isolated.
  - Most rely on informal consultations (e.g., asking a nurse practitioner down the hall or EMR messages), which is not sustainable or equitable.
  - eConsult is a useful tool where available, but it's limited to physicians and NPs.
- Suggested solutions:
  - More regular CDE peer rounds or case debriefs.
  - Creation of territory-wide or pan-Canadian mentorship networks.
  - Use of platforms like Time Right, CNRC, and professional forums for real-time advice and resource sharing.

5. Physician Engagement & Medication Management Gaps

- Consistent concern over variable physician competency and confidence in diabetes medication management.
  - Some physicians defer completely to CDEs, which can overburden educators.
  - Others make inappropriate changes, demonstrating a lack of training or adherence to guidelines.
- Rural and remote communities face rotating locum physicians, leading to disrupted continuity and shifting treatment plans.
- CDEs noted that internists are often inappropriately referred to for basic diabetes management due to a lack of local physician capacity.
- In Yukon, there was a particular concern around lack of physician education and the need for better training or collaboration.

6. Interprofessional Collaboration Models

- Some regions are more integrated (e.g., Northwest Territories' EMR allows inter-team messaging), allowing for better team-based care.
- Multidisciplinary teams (including dietitians, physiotherapists, and social workers) were highlighted as ideal but not universally implemented due to staffing or structural limitations.
- Paramedicine programs were cited in some communities as innovative ways to extend basic diabetes support, especially where staffing is sparse.

7. Provincial-Level Innovations: Alberta as a Model

- Alberta is piloting several initiatives that may serve as inspiration:
  - A Teams-based Diabetes Knowledge Network for real-time collaboration and Q&A.
  - Monthly educator meetings, with recorded sessions for training.
  - 24/7 Diabetes Info Line for providers and patients.
  - Provider- and patient-facing support lines staffed by RNs and RDs.
  - Use of volunteer endocrinologists and internists to offer complex case guidance.

Recommendations and Opportunities

- Develop formal mentorship and peer support networks for CDEs—territory-wide or cross-jurisdictional.
- Advocate for national standards in CGM coverage, particularly for Type 2 diabetes and gestational diabetes.
- Increase access to virtual and hybrid training pathways for CDE certification.
- Build interdisciplinary regional hubs that can support isolated practitioners and patients.
- Expand use of remote monitoring technologies and EMR-based communication tools.
- Consider piloting a shared caseload model with rotation of complex case reviews among educators.
- Encourage joint physician-educator training sessions to align care plans and build physician competency.

Conclusion

The discussion reflected a rich, honest, and solution-oriented dialogue between territories that often face unique and significant challenges in chronic disease management. Despite the limitations, collaboration, creativity, and commitment to quality care were evident across all participants. There is strong momentum to improve equity of access, support CDE development, and build systems that enable smarter, more connected diabetes care in Canada's North.

4.2 Afternoon Discussion Session Summary

1. Models of Care and Program Differences

- **Prenatal Screening & Referral**: In most jurisdictions discussed, screening for gestational diabetes is initiated by primary care providers (GPs or NPs). Once diagnosed, patients are referred to specialized diabetes programs or local dietitians. However, preconception care is largely ad hoc, with no formalized pathway to support patients with pre-existing diabetes in preparing for pregnancy.
- **Follow-up & Management**: Patients with both gestational and pre-existing diabetes are followed closely during pregnancy, often every 1–2 weeks. Management includes blood sugar monitoring, lifestyle guidance, medication adjustments (e.g., switching to insulin or metformin), and patient education about pregnancy-specific glucose targets. Medication choice is individualized based on prior treatment and safety during pregnancy.
- **Timing of Referrals**: Many patients with type 2 diabetes find out about their pregnancies late, often due to lack of routine care or awareness. This delay increases the risk of complications, as some may continue medications like Jardiance that are contraindicated in pregnancy. One striking example shared involved a patient discovering her pregnancy at 34 weeks after unknowingly continuing medication not safe in pregnancy.

2. Barriers and Challenges

- **Lack of Preconception Care**: Providers emphasized the difficulty in identifying or supporting patients planning pregnancies. Most patients do not proactively seek care prior to conception, and there's no systematic identification of those at risk or in reproductive age with diabetes.
- **Technology and Data Use**: Some participants described successful use of electronic health record (EHR) systems to flag at-risk patients early. In the Northwest Territories, for example, patient lists were generated based on high-risk factors, allowing earlier intervention.
- **No-Show Rates and Engagement**: Chronic disease management programs face high no-show rates. Participants acknowledged that patients often don't want to engage in conversations about diet, exercise, or smoking cessation. Providing point-of-care services (e.g., lab work, glucose tests) in-house was seen as a way to improve attendance and integrate education more naturally into visits.

3. Community Innovations & Partnerships

- **Midwifery Integration**: The Fort Smith midwifery team was highlighted as a key resource in gestational diabetes care. Midwives offer in-house glucose tolerance testing, ongoing monitoring, and even follow-up postpartum testing. They provide home visits, flexible communication (texts/calls), and close collaboration with local physicians and specialists when needed.

- **Team-Based Collaboration**: While midwives in Fort Smith do not prescribe medications, they work closely with local physicians or external NPs and OBs to coordinate care. This model contrasts with Yukon, where midwives must transfer care if medical management is needed. This difference sparked a valuable comparison of care protocols and midwifery scope between jurisdictions.
- **Hospital & Acute Care Involvement**: Some teams reported attempting to intervene when patients are hospitalized for other reasons, recognizing these as opportunities to engage them in chronic disease or pregnancy-related care.
- **Education Tools**: A resource was mentioned — a video by Dr. John Campbell titled "Low" — as an educational tool to raise awareness of diabetes symptoms and emergencies in shelter systems. It offers perspectives from staff and people living with diabetes and is being used for staff training in some programs.

Recommendations and Opportunities

- There's an ongoing need to formalize preconception care pathways, especially for patients with pre-existing diabetes, to reduce risk during pregnancy.
- Technology can be better leveraged to identify at-risk individuals earlier and streamline care.
- Programs should continue exploring flexible, integrated care models, such as in-house testing or mobile midwifery, to reduce barriers and improve outcomes.
- More cross-jurisdictional learning is valuable, particularly around midwifery practices, prescribing authority, and interprofessional collaboration.
- Health teams are looking to build relationships and trust, recognizing that engagement in care often starts with addressing urgent or practical needs, not health goals.

5.0 Conclusion

The SMIDF Project is an instrumental initiative by Diabetes Canada and PHAC. The Northern Diabetes Meeting was the first of its kind and aimed to encourage further attention and engagement with diabetes in the Territories. This meeting 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.

References

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