Diabetes Policy Summit:
Exploring Policy Options for Better Diabetes Outcomes in Ontario

Summit Report
November 4, 2014
Canadian Diabetes Association
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EXECUTIVE SUMMARY

People with diabetes (PWD) in Ontario are not receiving the care needed to achieve their full health potential. Despite the wealth of information guiding diabetes care, many with diabetes are not experiencing recommended care as per the best evidence, which leads to poor health outcomes. The rationale for the Canadian Diabetes Association’s (CDA) Diabetes Policy Summit: Exploring Policy Solutions for Better Diabetes Outcomes in Ontario on November 4, 2014, was to explore policy and system interventions to bridge these gaps in care and to reduce health inequities. The policy summit brought together health/diabetes leaders from the provincial government, public health, Local Health Integrated Networks (LHINs), non-profit organizations and Aboriginal care networks to identify barriers and propose policy solutions in three critical areas for policy action:

1) Foot care;
2) Optimal monitoring and testing of blood glucose; and,
3) Children and youth with diabetes in school.

Diabetes is a complex chronic disease that requires an active and ongoing partnership between individuals and their clinical care teams for optimal management. Evidence-based care guidelines such as the Canadian Diabetes Association’s 2013 Clinical Practice Guidelines (CPGs) for the Prevention and Management of Diabetes in Canada provide a comprehensive review of all clinical and scientific evidence currently available for effective prevention and management of diabetes in Canada. Despite the wealth of information guiding clinical care in Canada, there is a significant gap between evidence-based diabetes care and what people are experiencing.

Challenges to achieving better outcomes include the accessibility and affordability of needed supports for self-management and gaps in clinical care, screening and prevention of diabetes-related complications. Good public policies are required to bridge the gaps in clinical care and address inequity in health so that the most vulnerable populations can also achieve their health potential.

On November 4, 2014, the Canadian Diabetes Association (CDA) brought together key stakeholders on the forefront of healthy public policy development, clinical change and technological innovation to explore learnings to date and promising approaches that can inform policy development. Over 60 people from across Ontario participated in the one-day dialogue, including policy-makers, researchers, health leaders and primary care providers from provincial government, public health, local health integration networks, health care organizations and Aboriginal care networks as well as stakeholders with personal experience with diabetes (living with or supporting a person with diabetes [PWD]).

The specific objectives of the Summit were to:
1. Raise awareness about the challenges facing people with diabetes, as well as evidence-based best practices in the three critical areas related to diabetes management:
   • Foot care;
   • Optimal monitoring and testing of blood glucose;
   • Children and youth with diabetes in school.
2. Collectively explore strategies and solutions to overcome some of these challenges in Ontario.
In advance of the one-day meeting, participants received a workbook that provided the context for diabetes in Ontario and the three critical areas, and key questions to stimulate discussion. Panel presentations on each of the three critical areas for policy action (foot care; optimal blood glucose monitoring; children and youth in school) outlined key issues, successful approaches and ideas for moving forward on the policy front. Following each panel presentation, all participants worked together at round tables to identify barriers to achieving better outcomes and to identify possible policy solutions for Ontario. In the afternoon, participants selected one of the three areas based on their own interests, experience and expertise, and contributed to an in-depth discussion of barriers and policy solutions for the chosen area. In plenary, each large group reported back highlights of their discussions.

The results of the discussions are included in this summary report, integrating elements of the morning round tables, afternoon large group discussions and plenary dialogue on barriers and policy solutions.

Participants identified the following key barriers identified for each area:

**Foot Care:**
- Disparities in access to preventive foot care still exist depending on income levels and where people live (e.g., rural, isolated areas).
- Key services and supports needed to prevent foot complications for PWDs are not insured by the province.
- PWDs are not receiving screening (foot checks) of the quality and frequency recommended by current best practice guidelines.¹
- Supports are lacking for implementation of recommended delivery of evidence-based prevention and care.
- Care is not well coordinated, and mechanisms for communication among health care providers are inadequate.

**Optimizing Blood Glucose (BG) Monitoring and Testing:**
- PWDs on low or limited income and no health insurance are unable to pay for the costs of insulin and test strips.
- Disparities exist in access to interprofessional primary care teams (as recommended by clinical practice guidelines) and laboratory services for A1C testing and monitoring depending on where people live (e.g., rural, isolated areas) and/or the availability of appropriately-funded practice models (e.g., community health centres, family health teams).
- Goal-setting and targets may not be realistic to enable PWDs to achieve results.
- PWDs may face practical and emotional/psychosocial challenges to self-monitoring of blood glucose (SMBG).
- CDA Clinical Practice Guidelines for A1C and SMBG are not being implemented by all primary care providers caring for PWDs.

¹ A 2009 CIHR report indicates that, in Ontario, only 51% of people with diabetes had their feet checked by health care professionals in the previous year.
- Communication and coordination of care is absent or inconsistent among members of the interprofessional care team, other points of care (e.g., laboratories), and the person with diabetes with respect to BG testing and follow-up actions.

**Children and Youth with Diabetes:**
- Education and training for school staff about diabetes and their expected role in providing support is inconsistent across schools and school boards.
- Standardized, flexible, age-sensitive policies are not in place across school districts to support students with diabetes.
- At the provincial level, there is no policy governing care for students with diabetes in schools.
- Current provincial legislation protecting against potential liability of school staff and school boards is not well understood or up-to-date, resulting in concerns about liability.
- Disparities exist in the availability of supports needed by students in schools, such as educational assistants, nursing support from community care access centres (CCACs) or public health.
In response to the identified barriers, participants propose the following policy and system solutions:

**TABLE 1 SUMMARY OF PROPOSED POLICY AND SYSTEMS SOLUTIONS**

<table>
<thead>
<tr>
<th>CRITICAL AREA FOR POLICY ACTION</th>
<th>SOLUTIONS</th>
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| **Foot Care for People with Diabetes** | 1. Develop a provincial policy framework for the prevention and management of foot complications for PWDs and supporting tools for implementation.  
2. Support improved self-management by PWD to prevent foot complications.  
3. Ensure equitable access to specialty foot care prevention, treatment and devices for every PWD in Ontario, regardless of where they live.  
4. Improve the screening for foot complications by primary care providers.  
5. Strengthen coordination of care and communication between health care professionals. |
| **Optimal Blood Glucose Monitoring and Testing for People with Diabetes** | 1. Introduce policies for A1C and SMBG testing, supplies and other supportive technology to strengthen access, especially for PWDs living in rural, remote areas or with income barriers.  
2. Empower PWDs for optimal SMBG and self-care through access to tailored diabetes education, tools and practical supports for self-efficacy.  
3. Improve primary care practice-level supports and incentives to facilitate the implementation of CPG recommendations for optimal BG monitoring and follow-up. |
| **Children and Youth with Diabetes in Ontario** | 1. Create a provincial policy for care of students with diabetes in schools and ensure consistency and accountability across school districts and schools.  
2. Promote collaboration among key stakeholders to inform and advance the policy development process.  
3. Develop standardized resources to guide the development of an individualized care plan (ICP) for students with diabetes.  
4. Introduce consistent education, training and supportive resources for teachers, other school staff and administrators and school boards.  
5. Require each school to have student self-management supports in place for prevention and treatment hypoglycemia. |
Diabetes Policy Summit:
Exploring Policy Options for Better Diabetes Outcomes in Ontario

1.0 PURPOSE OF THE POLICY SUMMIT
Diabetes is a complex chronic disease that requires an active and ongoing partnership between individuals and their clinical care teams for optimal management. Evidence-based care guidelines such as the Canadian Diabetes Association’s 2013 Clinical Practice Guidelines (CPGs) for the Prevention and Management of Diabetes in Canada provide a comprehensive review of all clinical and scientific evidence currently available for effective prevention and management of diabetes in Canada. Despite the wealth of information guiding clinical care in Canada, there is a significant gap between evidence-based diabetes care and what people are experiencing.

Good public policies can enable the health care system and broader society to close the gap between evidence-based care as recommended by the current guidelines and the care experienced by people with diabetes, thereby supporting better outcomes for those living with the disease, in particular vulnerable populations. Challenges to achieving better outcomes include the accessibility and affordability of needed supports for self-management and gaps in care (clinical care, screening and prevention of diabetes-related complications.) Good public policies are required to bridge the gaps in care and address inequity in health so that the most vulnerable populations can also achieve their health potential.

On November 4, 2014, the Canadian Diabetes Association (CDA) brought together key stakeholders on the forefront of healthy public policy development, clinical change and technological innovation to explore learnings to date and promising approaches that can inform policy development related to diabetes. Over 60 people from across Ontario participated in the one-day dialogue, including policy-makers, researchers, health leaders and primary care providers from provincial government, public health, local health integration networks (LHIN), health organizations and Aboriginal care networks as well as people living with diabetes or supporting a person with diabetes (PWD)).

The Summit aimed to:

A. Raise awareness about the challenges facing people with diabetes, as well as evidence-based best practices in the three critical areas related to diabetes management:
   • Foot care;
   • Optimal monitoring and testing of blood glucose;
   • Children and youth with diabetes in school.

B. Collectively explore strategies and solutions to overcome some of these challenges in Ontario.

2.0 INTRODUCTORY REMARKS
Rick Blickstede, President and CEO, Canadian Diabetes Association (CDA), welcomed participants and provided introductory remarks. He noted the importance of developing better policy options to improve outcomes for people living with diabetes and that the results of the policy summit will help to inform CDA’s strategic planning process.
Chris Jarvis, an Olympic rower who competed in the 2004 Summer Olympics in Athens, shared his experience growing up with type 1 diabetes and his own journey towards better self-management. He emphasized the importance of supporting children and youth at an early age to achieve their full potential and the need for policies that create an environment that supports self-care and inclusiveness.

The Honourable Dipika Damerla, MPP (Mississauga East – Cooksville), Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness), provided a lunchtime address describing the current policy initiatives aimed at supporting Ontarians to achieve healthy weights and a balanced lifestyle. This approach contributes to reducing risk factors for diabetes and other chronic diseases. She noted the importance of building partnerships and supporting community-driven programs to achieve these goals.

**Diabetes Policy Summit**

A Participant Workbook was provided prior to the Summit, to set the context for the state of diabetes in Ontario and the three critical areas for policy action. The agenda and the list of participants are included in the Appendices. The workbook and presentations are available at [http://www.diabetes.ca/publications-newsletters/advocacy-reports/exploring-policy-options-ontario](http://www.diabetes.ca/publications-newsletters/advocacy-reports/exploring-policy-options-ontario).

### 3.0 DIABETES IN ONTARIO

Dr. Jan Hux, Chief Science Officer, CDA, gave an overview of diabetes and key issues in Ontario. Diabetes is a major health issue in Ontario, affecting the quality of life of those who have the disease and their families, and placing a heavy burden on our health care system. The burden of care is large and growing, with actual diabetes rates higher than those self-reported in health surveys. In Ontario, nearly one in ten people (1.46 million) have been diagnosed with diabetes. By 2024, if no action is taken, 13% of Ontarians or 2.2 million people will be diagnosed with diabetes; in addition, another 2.5 million people will be living with prediabetes. Based on the Canadian Diabetes Association’s estimates, Ontario will be one of the provinces with the highest percentage increase in diabetes prevalence between 2000 and 2020.

There is significant room for improvement in enhancing outcomes for people with diabetes and reducing health system costs. Continued collaboration and information sharing among stakeholders help to narrow the gap between recommended evidence-based care and what people with diabetes actually experience.

### 4.0 FOOT CARE FOR PEOPLE WITH DIABETES

Dr. Janine Malcolm, Co-Chair of the Champlain Diabetes Foot Care Expert Committee, presented on the Champlain Diabetes Foot Care Strategy and initiatives that have been implemented based on the strategy.

Ms. Lindsey Cosh, Foot Care Coordinator of the Southern Ontario Aboriginal Diabetes Initiative (SOADI), presented an overview of the program which supports Aboriginal communities working to reduce the high incidence of diabetes and its complications through prevention, intervention and management activities. SOADI includes a four-component holistic foot care model.
4.1 **Barriers to Optimal Foot Outcomes in Ontario**

Participants identified the following barriers to optimal foot outcomes in Ontario:

- **There are inequities in the access to care associated with low income and living in rural or remote areas.**
  - Access to endocrinologists and specialists outside of major centres is limited.
  - While Diabetes Education Programs are distributed throughout the province, access is inconsistent in some regions.
  - Barriers exist in timely access to home care and specialty care.
  - Not all LHINs across the province have community health centres (CHCs) serving their population. CHCs are funded to provide a range of primary care services through a multidisciplinary team model, including foot care and diabetes education.
  - Regional, locally-driven programming is unavailable in some communities, e.g., rural, Aboriginal, cultural communities (as opposed to “one-size fits all”).
  - Because some preventive services are not funded by the Ministry of Health (e.g., chiropody, off-loading devices\(^2\) for diabetes foot ulcers), PWDs on low or limited income and/or without private health insurance do not have the ability to pay for them.
  - People living in Aboriginal communities in remote areas (e.g., with fly-in service only) experience the greatest access barriers, with isolation compounded by poverty and limited access to community-based care.

- **Key preventive services and supports for foot complications are not insured by the province.**
  - Investments have been made for some care, but have been limited to less expensive, less complicated measures that could prevent serious foot complications.
  - Chiropody services\(^3\), off-loading devices and prescription footwear\(^4\) are not broadly covered, although some LHINs have funding for chiropody (e.g., Champlain LHIN).
  - PWDs without private health insurance must pay out-of-pocket and many people do not have the means to do so (e.g., prescription footwear costs between $300 and $500).
  - The Ontario government has not aligned their funding policy with the most efficient and effective practices for delivery of foot care adopted in other jurisdictions.\(^5\)
  - Current funding models do not adequately support family physicians who wish to work in an interprofessional team (provision of full range of prevention and care; having funded time to meet together).\(^6\)

\(^2\) Diabetic foot ulcers frequently occur on weight bearing areas of the foot which are subjected to high pressure. Relieving pressure (offloading) is essential to the prevention of ulceration and/or as part of any management plan that aims to facilitate the healing of diabetic foot ulceration.

\(^3\) Chiropodists cannot bill OHIP for services provided.

\(^4\) The Ontario government may pay for orthotics (custom insoles), but not for prescription footwear.

\(^5\) For examples, see Participant Workbook, p.8.

\(^6\) The Hamilton, Niagara, Haldimand, Brant LHIN funds a foot care program for PWDs with no insurance.
\begin{itemize}
\item PWDs are not receiving sufficient and adequate foot screening recommended by current best practice guidelines.\textsuperscript{7} This may be due to several reasons.
\begin{itemize}
\item PWDs may:
\begin{itemize}
\item Not have a primary health care provider.
\item Lack awareness of the risk of foot complications or the guidelines for self-assessment.
\item Be confused about to whom to go to for help, given the range of foot care specialists and centres for service.
\end{itemize}
\item Preventative foot care programs may not be client-centred or culturally appropriate.
\item Health care professionals may:
\begin{itemize}
\item Be unclear about respective roles and responsibilities for foot screening (diabetes educators, family physicians, nurses, specialists) or concerned about duplication of services.
\item Lack education about the importance of foot screening and risk assessment.
\item Focus on high risk populations because of limited resources, missing opportunities to prevent complications for other PWDs.
\end{itemize}
\item Family physicians may:
\begin{itemize}
\item Not prioritize foot screening in the context of a short appointment or be reluctant to address this issue.
\item Lack knowledge about how to screen for/assess vascular complications and structural foot problems that can lead to foot ulcers as part of overall diabetes care.
\end{itemize}
\item Standards for foot screening and risk assessment are lacking:
\begin{itemize}
\item There is no standardized provincial approach to foot care/screening.
\item Approaches are inconsistent across institutions/organizations.
\item Standardized education is lacking for the range of professionals on a multidisciplinary primary care team.
\end{itemize}
\end{itemize}
\item Supports are lacking for implementation of recommended evidence-based prevention and care.
\begin{itemize}
\item There is no provincial standard care pathway defined for foot care to guide the delivery of collaborative, interprofessional care.
\item Access to outcome data for evaluation and benchmarking is limited.
\item Levels of risk have been established (low, intermediate, high, urgent) to guide screening, assessment and management of foot complications\textsuperscript{8}; however, to date the levels are not widely used in structuring the work of integrated, interprofessional teams.\textsuperscript{9}
\item PWDs may not have the information, financial resources or social supports needed to follow treatment plans.
\item Primary care providers:
\begin{itemize}
\item May not have viable treatment options, given the funding limitations for foot care: a participant succinctly stated: “the problem is not that we don’t know how to screen –
\end{itemize}
\end{itemize}
\end{itemize}

\textsuperscript{7} A 2009 CIHR report indicates that, in Ontario, only 51% of people with diabetes had their feet checked by health care professionals in the previous year.


\textsuperscript{9} Cases tend to be lumped as “the diabetic foot” in foot care policy and practice when in fact there are various levels of risk requiring unique response.
but then what do we do with patients who don’t have the money to pay for treatment?”

- Have to navigate many different clinical practice guidelines and do not have access to a unified guideline for chronic disease management.
- Are not being used to the full scope supporting their practice such as diabetes educators, nurses, e.g., referrals to Ontario Diabetes Education Programs for education of self-assessments and self-care for feet.

- **Care is not well coordinated, and communication between health care providers is inadequate.**
  - There is a general lack of coordination: a) across health professional disciplines; b) across organizations (primary care organizations, medical laboratories, specialty clinics, home care, hospitals); c) across government ministries and jurisdictional levels of government, e.g., provincial, federal (for health care services for on-reserve First Nations).
  - At this time, the only method of supporting the prevention and care of foot complications PWD is through OHIP billing; the funding model does not support collaborative interprofessional care.
  - Public health is a separate silo, administered outside the LHIN structure; this poses a challenge for the coordination of prevention initiatives.
  - Communication across specialties is inadequate, especially during transitions.
  - Electronic medical record (EMR)\(^\text{10}\) systems that support evidence-based care planning and communication are not used to their full potential, and sharing of data is not timely enough (e.g., for sharing of foot screening, assessment and care plans among the care team); provider training and the design of functional EMR technologies are key issues.
  - Electronic health record (EHR)\(^\text{11}\) systems are not fully developed and/or compatible to support timely access to patient data across points of care (e.g., laboratories, pharmacies, primary care organizations, hospitals).

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\(^{10}\) An Electronic Medical Record (EMR) is a computerized medical record of a patient, created in an organization that delivers care such as a hospital or a primary care physician practice.

\(^{11}\) An Electronic Health Record (EHR) is a record of personal health information created and maintained in electronic form by eHealth Ontario to enable health information custodians to use electronic means to disclose personal health information to one another for the purpose of providing or assisting in the provision of health care to the individual whose personal health information is contained in the record.
### 4.2 Successful Approaches

**Table 2. Examples of Successful Approaches to Improving Foot Care Outcomes**

<table>
<thead>
<tr>
<th>Successful Approach</th>
<th>Description</th>
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| Champlain Diabetes Foot Care Strategy | - Identified foot care resources and gaps, consulted with clients and health care practitioners (HCPs), created a webpage of regional resources and the foot screening toolbox, and conducted education and dissemination of the screening toolbox, including:  
  √ Education Resources for clients/patients: client foot ulcer profile; tips for foot care and good foot wear.  
  √ Resources for providers: use of monofilaments, locating/palpating pedal pulses, callus assessment; examples of foot structural/biomechanical abnormalities.  
- Trained 161 health care providers and offers ongoing workshops (since 2013).  
- Improved access to chiropody services in the Champlain LHIN by hiring four full time chiropodists who provide outreach to 16 sites in the Champlain region.\(^\text{12}\)  
- Supported a quality improvement project at the Ottawa Hospital to implement best practices for foot screening and risk stratification.  
  √ Standardized foot ulcer risk assessment increased from a baseline of 48% to a sustained 89% with a result of higher risk patients being identified and supported.  
  √ Providing information and training for use of evidence-based practice tools, implemented new weekly foot clinics, provided audit and feedback and used iterative cycles to revise forms and processes.  
  √ Foot assessment is now a quality indicator with audits occurring quarterly. |
| Southern Ontario Aboriginal Diabetes Initiative (SOADI) | SOADI uses a traditional healing approach that views body, mind, spirit and emotions of the individual as equally important. SOADI’s Holistic Foot Care Model includes four components:  
1. Holistic foot care events focused on screening, education, training and self-management.  
2. Sustainable foot care locations to provide ongoing local services with education, preventative treatment and referrals.  
3. Individual foot care subsidies to improve access for those who do not qualify for other funding sources (home visits, foot care office sites, preventative foot device support).  
4. Self-care and prevention resources, including a DVD, foot care kit, educational handouts with healthy feet checklist, and diabetic socks.  
Other program components aligned with the Aboriginal values and beliefs include:  
- A framework for practicing health promotion in a good way, based on the traditional medicine wheel.  
- Reflexology, a focused pressure technique directed at the feet and used by Aboriginal ancestors as part of their healing. |
| Interprofessional Diabetes Foot Ulcer Team (London, ON) | - This community-based model is well received by patients and has had positive outcomes.  
- The team consisted of a multidisciplinary team of nine different health disciplines: two chiropodists, orthotist, physiotherapist, wound nurse, clinical psychologist, social worker, nurse diabetes educator, two dietician diabetes educators and infectious diseases physician.  
- Evaluation of the team-based care model identified the following key success factors:  
  √ Patients were central members of the team and participated in the decision-making.  
  √ All team members were provided with education on current best practices on managing patients with diabetic foot ulcers.  
  √ Management and resources were under one roof. |

\(^{12}\) In the second quarter, the LHIN chiropodist program served 177 new clients for individual appointments and 148 for group education, provided 976 individual chiropody appointments (33% included treatment of foot ulcer) and 22 group sessions.
4.3 Proposed Policy and System Solutions
Participants identified the following interventions to improve foot outcomes for people with diabetes in Ontario:

- **Develop a provincial policy framework for the prevention and management of foot complications for PWDs and supporting tools for implementation.**
  - Consolidate and expand the evidence base:
    - Demonstrate the cost savings and benefits from investing in preventative foot care.
    - Conduct a gap analysis to identify the most pressing policy issues and areas requiring action in Ontario.
  - Address funding issues to ensure equitable access across the province to foot care education, screening, treatment and devices.
  - Consider a universal access policy for a minimum standard of care for all PWDs.
  - Promote the implementation of best practices (e.g., CDA and other CPGs):
    - Focus on preventative measures.
    - Enhance supports for patient empowerment and self-care, including attention to social determinants of health such as income and social supports.
    - Apply patient-centred care.
    - Use inter-professional teams and a chronic disease management approach.
    - Enhance health care professional education.
  - Integrate foot checks into the Ontario Diabetes Strategy as a fourth mandatory screening for PWDs (in addition to A1C, retinal scan and cholesterol level).
    - Increase accountability by requiring public reporting of quality indicators.
    - Include investments in technology to support evidence-based care.

- **Support improved self-management by PWD to prevent foot complications.**
  - Increase awareness about the risks of foot complications and what PWDs can do to prevent them.
  - Engage PWDs in developing community-based preventative foot care programs.
  - Include self-management as a central component of foot care programs and empower PWDs in all aspects of care.
  - Provide family physicians with a Healthy Feet checklist to guide their assessment and communication with PWDs.
  - Ensure diabetes education includes hands-on support for self-assessment and clear, culturally appropriate information about preventing and managing foot complications.
  - Improve supports for PWDs to understand and navigate the system:
    - Provide accessible information about locally-available foot care services, e.g., via an electronic platform.

- **Ensure equitable access to specialty foot care prevention, treatment and devices for every PWD in Ontario, regardless of where they live.**
  - Provide provincial insurance coverage to all PWDs for visits to chiropodists, prescription footwear and off-loading devices.
  - Integrate foot care into Diabetes Education Programs across the province.
  - Expand primary care models such as CHCs in underserved areas to increase access to foot care specialists (e.g., chiropodists).
  - Invest in expanded preventative foot care services:
Invest in preventative foot care services in communities with highest rates of foot complications, e.g., rural/isolated, Aboriginals, certain ethno-cultural communities.

Develop and coordinate local, community-based preventative foot care programs in partnership with PWDs to ensure access to relevant, culturally-appropriate supports.

**Improve the screening for foot complications by primary care providers.**

- Enhance education and training of health care professionals and promote implementation of Best Practice Guidelines.
- Ensure screening for pressure points is included in risk assessment (not just sensation).
- Promote use of off-loading to prevent foot ulcers and promote healing.
- Conduct educational campaigns for providers and PWDs.
- Provide organizational support through effective delivery system design and decision support (e.g., standardized screening form, diabetes registries with call back reminders, flow sheets, etc.).
- Focus policies on the important role of primary care providers in checking feet, as first point of contact in the care system.
- Introduce physician billing incentives for screening and for referral to Diabetes Education Programs.
- Improve education of front-line workers, e.g., personal support workers.
- Promote data collection of foot care outcomes within organizations for ongoing evaluation and benchmarking.

**Strengthen coordination of care and communication between health care professionals.**

- Clarify health care professional roles and responsibilities, as per scope of practice, for all disciplines that support PWDs to prevent and manage foot complications (e.g., diabetes educators, chiropodists).
- Promote integration of multidisciplinary specialized care, including:
  - Clear mechanisms to support regular communication among care providers.
  - Referral and management care pathways.
  - Use of the right care provider at the right time based on need.
  - Harmonized tools (across disciplines; across organizations), such as CPGs, intake sheets, check lists, etc.
  - Multidisciplinary specialized clinics.
- Develop and promote the use of provincial, standardized care pathways:
  - Define algorithms based on risk (low, intermediate, high, urgent).
  - Identify success criteria (where benefits exceed risk).
  - Provide a decision tree (stepwise approach) to guide care/treatment based on assessment of risk.
- Enhance electronic medical record (EMR) systems and support their use:
  - Promote the use of diabetes registries by physicians to guide care for their patients with diabetes.  
  - Integrate a simple tracking system for screening/foot care into EMRs and pilot with physicians as a practice tool.
  - Increase access to EMR systems to include all members of the care team.

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13 Use of patient registries for diabetes management is a key component of an evidence-based, tested model for chronic disease management, the Chronic Care Model.
5.0 OPTIMAL BLOOD GLUCOSE MONITORING AND TESTING FOR PEOPLE WITH DIABETES
Dr. Gillian Booth, Endocrinologist at St. Michael's Hospital, presented on the prevention of macrovascular (stroke, heart disease, peripheral arterial disease) and microvascular (eye disease, renal, neuropathy) complications. She summarized recommendations from clinical practice guidelines for monitoring of long-term BG control (A1C) and patient self-monitoring. She provided an overview of patient, provider, practice and health system barriers to monitoring and self-care and suggested removing cost barriers to optimal self-monitoring and implementing the Chronic Care Model in clinical practice to improve outcomes and reduce health system costs.

Ms. Susie Jin, pharmacist and Certified Diabetes Educator, presented current approaches to BG control and diabetes self-management, with a focus on monitoring with purpose (frequency; acting on results). She discussed current monitoring practices of providers, gaps in monitoring A1C and supporting patient self-monitoring of BG. She shared provider practice tools developed by the CDA to strengthen current practice to better align with the CPGs.

5.1 Barriers to Optimal Blood Glucose Monitoring and Testing by PWDs
Participants identified the following barriers to optimal blood glucose (BG) monitoring and testing for people with diabetes in Ontario:

- **PWDs on low or limited income and no health insurance are unable to pay for the costs of insulin and test strips.**
  - Public coverage of test strips under the Ontario Drug Benefit (ODB) is linked to CDA’s CPGs regarding evidence for benefits of SMBG; however, PWDs not covered under ODB or private insurance experience financial barriers, having to pay for monitoring supplies and drugs.
  - PWDs may not know what additional supports are available and how to access them, e.g., Trillium, CDA and ODB.
  - Participants also noted the difference between CDA and the Canadian Agency for Drugs Technology and Health (CADTH) recommendations with respect to coverage of drugs and monitoring supplies.

- **Disparities exist in access to recommended inter-professional primary care teams and laboratory services for A1C testing and monitoring** depending on where people live (e.g., rural, isolated areas) and/or the availability of appropriately-funded practice models (e.g., community health centres, family health teams).
  - Some PWDs do not have a primary care provider to facilitate monitoring, diabetes education and self-management support.
  - PWDs in communities without community health centres or family health teams do not have access to recommended inter-professional care.

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14 Blood glucose (glycemia) is monitored mainly through glycated hemoglobin (A1C) tests, self-monitoring of blood glucose (SMBG) and continuous monitoring systems. A1C is a reliable estimate of blood glucose levels over the previous three to four months, and therefore is a valuable indicator of the effectiveness of treatment. SMBG (self-monitoring of blood glucose) refers to home blood glucose testing by the person living with diabetes (or caregiver). Self-testing of blood glucose is done with a portable electronic device called a glucose meter that measures sugar levels in a small drop of blood, usually from the finger, that is placed on a disposable test strip. The key importance of SMBG is that it is the only way to immediately determine hypoglycemia (low blood sugar).
Some communities do not have access to laboratory services; PWDs may need to travel long distances to access A1C testing services and may need to take days off work to attend appointments.

Northern communities become isolated in the winter months due to road closures, preventing travel by car for testing or medical appointments.

- **Goal-setting and targets may not be realistic to enable PWDs to achieve results.**
  - Primary care providers may not be tailoring BG targets to the unique needs of each PWD, e.g., elderly PWDs have unique metabolic issues and therefore it is not helpful to aim for an A1C target of 7.0 or below.
  - PWDs and providers may not share the same goal.
  - A shared care plan with concrete targets and follow-up actions may not be in place and understood by the PWD and all members of the care team.
  - The care plan may not take into account barriers to accessing insulin/other drugs, test strips, healthy food or other supports needed to achieve results (e.g., PWDs on low or limited income and no health insurance may skip medication or glucose testing because of the cost).

- **PWDs may face practical and emotional/psychosocial challenges to SMBG.**
  - PWDs may not have access to diabetes education (not referred by primary care provider; no service available locally; service is at maximum capacity):
    - Community-based, culturally appropriate, flexible diabetes education, materials and supports may be lacking.
    - Government-funded diabetes education programs may not be appropriately allocated to meet need (e.g. under or over-utilization in some communities) resulting in gaps in access to quality self-management supports.
  - PWDs may lack knowledge or skills about:
    - The complexity of diabetes and diabetes self-care.
    - How to carry out recommended SMBG and the tools available for support.
    - Testing according to need and then acting.
  - PWDs face emotional barriers to self-care:
    - SMBG on a daily basis is invasive and can be tiring.
    - PWDs may be reluctant to do a BG test in public places due to stigma.
    - PWDs may not see the value of testing because many benefits of glucose control are in the long term.
    - PWDs may lack motivation if they do not see improvements in BG results or if they do not feel they have the resources to take required action (e.g., to afford drugs, test strips, healthy food, etc.).
    - Some PWDs experience depression and other mental health problems that make self-care more difficult.
CDA Clinical Practice Guidelines for A1C and SMBG are not being fully implemented by all primary care providers caring for PWDs.

- This may be due to:
  - Lack of knowledge or awareness of CPG recommendations for A1C and SMBG
  - Lack of time available during the 7-minute diabetes appointment to provide recommended evidence-based BG monitoring
  - Complexity of care/multiple chronic conditions, each with their own set of CPGs
  - Limited resources and practice infrastructure to support interprofessional care (links to funded models of primary care; may include limited access to diabetes educators)

- CPGs are not typically embedded within the electronic medical record system (e.g., process for triggering recall for A1C tests); without this functionality, it is unlikely that the provider will take the time to log into a separate site to access guidelines and tools.

- Even when A1C is monitored at the frequency suggested in the CPGs, primary care providers may not:
  - Conduct ongoing evaluation of BG testing patterns by PWDs
  - Have the knowledge or skills to recommend appropriate actions
  - Refer to other team members, such as diabetes educators, to support behaviour change and attainment of targets
  - Focus on patient empowerment/self-efficacy so patients understand the clinical numbers that result from BG tests and participate in identifying realistic, individualized, achievable action plans that can motivate change

Communication and coordination of care is absent or inconsistent among members of the interprofessional care team, other points of care (e.g., laboratories), and the PWD with respect to BG testing and follow-up actions.

- Providers may not communicate with other members of the care team or with the PWD about BG targets or recommended course of action; this limits consistent and coordinated care planning.

- Providers may not be clear about respective roles and scope of practice, and therefore, when to refer, when to communicate what information (e.g., A1C and SMBG test results; recommended follow-up) and with whom (e.g., between the primary care provider, the endocrinologist, the diabetes educator).

- Protocols and technology to support sharing of electronic medical records (EMR) among all members of the care team are not in place, such as:
  - Shared care plans to optimize BG
  - A1C laboratory test results
  - Systems that allow diabetes educators to track the work they are doing with PWDs, caregivers, etc. to improve self-management of BG.

- Electronic health record (EHR) systems that enable direct sharing of laboratory results and patient information with other points of care (e.g., primary care providers, specialists, hospitals) are not well developed throughout the province; there are policy barriers preventing access by the full circle of care (e.g., privacy legislation).

- PWDs do not have direct access to their own medical records and BG test results.15

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15 There are some examples of pilot projects in the province where this type of functionality has been implemented.
### 5.2 Successful Approaches

**Table 3 Examples of Successful Approaches to Optimizing Blood Glucose Monitoring and Testing**

<table>
<thead>
<tr>
<th>Successful Approach</th>
<th>Description</th>
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</table>
| Chronic Care Model  | - The Chronic Care Model (CCM) is an evidence-based approach to treating chronic diseases, including diabetes. Research indicates that implementing the CCM can:  
  √ Improve BG levels (A1C), cholesterol (LDL-C) and use of statins.  
  √ Reduce overall mortality and health care costs (drugs and hospital expenditures).  
  - CCM is based on proactive, planned and population-based care that is patient-centred and that supports a productive interactions and relationships between patients and the practice team, within a supportive environment. Elements of CCM include:  
    √ Delivery system design (using an interprofessional team).  
    √ Self-management support for the PWD.  
    √ Decision support for the care team.  
    √ Clinical information systems.  
    √ Community and health system supports.  
- Implementing the CCM means addressing health system supports such as funding policies that lead to poor outcomes:  
  √ Reviewing the evidence about impact of income and lack of private health insurance on adherence to recommended self-management by PWDs.\(^\text{16}\)  
  √ Developing policies that address access to affordable medications, supplies (e.g., BG strips for self-monitoring), and access to healthy foods. |
| CDA Provider Practice Tools | - To support implementation by providers of the CDA Clinical Practice Guidelines, a number of tools have been developed and are available on-line at:  
  √ SMBG Recommendation Tool to Health Care Providers provides situational-specific recommendations to support individual tailoring of SMBG frequency to PWD need.  
  √ Suggested SMBG Patterns for Patients Using Insulin is a chart for tracking use of medication and SMGB results to support monitoring and taking action to optimize BG levels.  
  √ The five Rs of Organized Care into Practice provides guidance to a practice-level approach to optimizing BG monitoring and testing by PWDs (from CDA Guidelines):  
    o **Recognize** diabetes risk factors and screening for diabetes.  
    o **Register** PWDs to be able to track them.  
    o **Recall** PWDs for timely reassessment of targets and risk of complications.  
    o **Resource** PWDs with information and supports through use of interprofessional teams.  
    o **Relay** information among the care team and PWD for coordinated care and timely management. |
| CDA Tools for PWDs | - CDA developed tools for PWDs to help determine individualized frequency and timing for self-testing of BG:  
  √ An interactive tool.  
  √ BG log pages.  
  √ A website dedicated to helping PWDs understand high and low BG and the role SMBG plays in achieving target:  

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\(^{16}\) A 2006 telephone survey by Kwan et al. determined that PWDs with an income of less than $30,000 per year or with no private health insurance were more likely to skip taking medications due to cost, skip glucose testing due to cost or buying unhealthy foods due to cost.
5.3 Proposed Policy and Systems Solutions
Participants identified the following policy solutions to improve BG monitoring for people with diabetes in Ontario:

- **Introduce policies for A1c and SMBG testing, supplies and other supportive technology to strengthen access, especially for PWDs living in rural, remote areas or with income barriers.**
  - Introduce A1C point of care testing for rural and remote communities who do not have access to laboratory services.\(^{17}\)
  - Facilitate use of technology to support BG monitoring, e.g., use of the Ontario Telemedicine network for education.
  - Evaluate the funding of BG test strips, taking into consideration the potential positive impact of:\(^{18}\)
    - Raising the minimum test strip allowance, e.g., examining the policies of other provincial jurisdictions such as Quebec.
    - Creating a process where ODB coverage of test strip expenses is more closely linked to demonstrated need/frequency of testing required by individual PWDs.\(^{19}\)

- **Empower PWDs for optimal SMBG and self-care through access to tailored diabetes education, tools and practical supports for self-efficacy.**
  - Work with primary care provider networks to increase PWD referrals to diabetes educators and nurses for self-management support.
  - Expand use of the Ontario Telemedicine Network to provide diabetes education to PWDs in rural and remote areas.
  - Ensure providers giving diabetes education include clear, culturally-appropriate information about:
    - How and when to test and the tools available to help track results.
    - What the BG test results mean and the follow-up actions required.
    - Strategies for overcoming barriers to appropriate action.
    - ODB policies for coverage of test strips and other information that could mitigate cost impacts of testing.
  - Promote education, care and support aimed at developing incremental, achievable goals and BG targets shared by PWDs.
  - Enable PWD access to their health data, including BG test results and recommendations of diabetes educators so they can coordinate their own care.\(^{20}\)

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\(^{17}\) Participants noted that point of care testing may not provide results as those generated by a laboratory; however, the small margin of error is an acceptable alternative when no other testing options are in place. This approach has been used successfully in some First Nations communities.

\(^{18}\) A 2008 study by Kwan et al indicates that PWDs greater than 65 years of age (who qualify for seniors health benefits) were less likely to have skipped taking medications or glucose testing due to cost. Participants noted that some programs are in place to facilitate the sharing of BG test strips by seniors who have an excess amount with PWDs who do not have adequate coverage to afford their own test strip requirements.

\(^{19}\) There is currently a de facto allowance through the public coverage of strips within the ODB of 15/30 depending on risk of hypoglycemia.

\(^{20}\) Participants noted that not all PWDs would benefit from this approach because they may not have the required health literacy or personal resources.
Address policy barriers that prevent sharing of health data with patients (e.g., privacy legislation, health care provider protocols (professional codes; organizational policies))

Adapt existing mechanisms and/or develop new innovative technologies for sharing health data with PWDs, e.g., ability for PWDs to call in for A1C test results, use of an app for electronic transfer of information.

- **Improve primary care practice-level supports and incentives to facilitate the implementation of CPG recommendations for optimal BG monitoring and follow-up.**
  - Accelerate the implementation of electronic health record (EHR) systems to improve primary care provider access to patient health data from laboratories and other points of care.
  - Ensure all members of the care team have access to patient health data such as lab results and recommendations for diabetes education.  
  - Promote and support the implementation of reminder systems to ensure optimal frequency of A1C testing, such as:
    - Practice-level creation of diabetes patient registries and EMR-embedded reminder systems with practice prompts.
    - Laboratory-based reminder systems.
  - Develop a flow sheet outlining the care pathway for PWDs in the Ontario health system that integrates CPGs into the EMR and delineates recommended protocols and referrals for monitoring and assessment, patient education and self-management support.  
  - Develop practice-level resource groups responsible for administration and data management for the patient registry of PWDs.

- **Facilitate training opportunities for primary care providers to increase knowledge and skills in:**
  - Adopting recommended CPGs and a purposeful testing approach (individualized BG targets, frequency of testing, taking appropriate action to improve BG levels, patient education, supports for SMBG and behaviour change).
  - Working effectively in interprofessional teams to support patient-centred diabetes management (e.g., clarify and maximize scope of practice of members of care team, referral protocols, shared care, communication).
  - Using available tools and EMRs to their full potential to optimize BG monitoring and follow-up.

- **Align primary care funding and delivery models to support implementation of evidence-based, interprofessional team-based diabetes care:**
  - Fund models of delivery that integrate the range of care team members needed to provide evidence-based quality care to PWDs, including psychosocial supports for self-management (e.g., social worker, psychologist, personal coach).
  - Better integrate diabetes education programs into team-based delivery of care.

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21 Participants noted that this may require expanded access to electronic medical records (EMR) and/or developing clear mechanisms for sharing of data and care plans.

22 This type of approach currently exists in Nova Scotia through their diabetes care program. Participants also recommended examining the model developed by the Ontario Stroke Network.
➢ Review primary care funding and remuneration for diabetes-specific appointments, taking into consideration:

- Limitations of short appointments to adequately address complex health issues and effective implementation of CPGs.
- The potential of a shorter chronic disease visit where multiple conditions are monitored by the primary care provider (e.g., blood work), and patients are referred to a diabetes educator for the more time-intensive patient education and follow-up.

### 6.0 CHILDREN AND YOUTH WITH DIABETES IN ONTARIO

Dr. Sarah Lawrence, Pediatric Endocrinologist at the Children’s Hospital of Eastern Ontario, outlined the requirements under the law for schools to reasonably accommodate the special needs of children and youth, including diabetes. She summarized the elements of best practice school policies, including the joint position statement of the Canadian Pediatric Society and Canadian Pediatric Endocrine Group.

Ms. Shana Betz shared her personal experiences advocating for adequate school supports for her daughter, who lives with type 1 diabetes, as well as her experience advocating with a provincial network of parents to improve diabetes policies in schools. She presented examples on the impact of inadequate policies on health outcomes for students and described a very supportive policy developed by the York Region District School Board in Toronto, Ontario.

### 6.1 Barriers to Consistent Care and Support for Children and Youth at School

Participants identified the following barriers to providing consistent care and supports for children and youth in schools in Ontario:

- **Education and training for school staff about diabetes and their expected role in providing support is inconsistent across schools and school boards.**
  ➢ Lack of understanding may result in students with diabetes experiencing:
    - Stigma at school, e.g., being excluded from physical activity, school trips
    - Insufficient support in dealing with low blood sugar (eating in the classroom, having adequate time for lunch).\(^2^3\)
    - Negative health outcomes, e.g., seizure resulting from unrecognized hypoglycemia
  ➢ Teachers may not understand their role, and incorrectly feel overburdened. Policies should call for school personnel to be trained (e.g. teaching assistants).
  ➢ Tools and supports for training and policy implementation may not be available.

- **Standardized, flexible, age-sensitive policies are not in place across school districts to support students with diabetes.**
  ➢ Some schools or school boards have explicit policies in place while others do not.
  ➢ Where already in place, policies may not:
    - Align with current evidence-based guidelines or be comprehensive, e.g., for basic and advanced training of school personnel, emergency protocols, supportive

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\(^{23}\) Designated staff members who can provide advanced support may not be identified (e.g., to administer insulin or glucagon in the event of hypoglycemia).
environments for BG testing, insulin administration and other strategies to deal with high and low BG levels.

- Take into account the varying levels of support of different age groups (e.g., young children require more intensive supports)
- There is limited awareness among schools and school boards of evaluated models/promising practices for care for students with diabetes in schools, i.e., what school board policies are working well and how they can be adapted?
- School boards and school administrators may not place priority on developing a diabetes care policy over competing priorities.

- **At the provincial level, there is no policy governing care for students with diabetes in schools.**
  - There are no provincial guidelines or mandated requirements for school boards to put policies in place for students with diabetes; minimum standards have not been established to ensure consistency across the province.
  - Standardized care policies that describe the roles and responsibilities of school staff are not established.
  - The current policies governing administration of medication to children at schools are outdated (PPM81), not diabetes-specific or reflective of current CDA guidelines.
  - Cross-ministerial coordination is not in place at the provincial level to provide leadership on diabetes policies in schools (Ministries of Health, Education, Labour).
  - There has been no review to date of the respective roles of stakeholders in policy development and care of students with diabetes in schools (e.g., CDA, school boards, Ontario Principals’ Council, public health, community care access centres, etc.).

- **Current provincial legislation protecting against potential liability of school staff and school boards is not well understood or up-to-date, resulting in concerns about liability.**
  - School staff may not:
    - Feel comfortable with student use of testing and insulin delivery devices in classrooms or other school areas where classmates are present for fear of possible needle stick injuries.
    - Intervene to assist with care or respond to a health emergency because they fear being found liable if something goes wrong.
  - There is limited awareness of the protection available under the Good Samaritan Act for school staff that choose to intervene.
  - There has been no clear articulation of potential liability from non-action.

- **Disparities exist in the availability of supports needed by students in schools, such as educational assistants, nursing support from community care access centres (CCACs) or public health.**
  - In some cases, parents are required to visit the school during the lunch period or school events to monitor BG and impact of activities on BG (e.g., levels of physical activity higher than normal), to ensure appropriate food intake or to administer insulin. This may interfere with the parent’s ability to work in order to ensure their child is safe.
- Depending on the policy of the LHIN, CCACs may not provide nursing support to young children to monitor BG and administer insulin, or the frequency of visits may not be sufficient to ensure optimal BG management.
- Lack of transferable services across catchment areas for school boards, LHIN/CCAC, public health, etc. may result in gaps in service; in some cases, children who are most in need are least likely to receive needed supports.
### 6.2 Successful Approaches

#### Table 4 Examples of Successful Approaches to Consistent Care and Support for Children and Youth with Diabetes in Schools

<table>
<thead>
<tr>
<th>Successful Approach</th>
<th>Description</th>
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</table>
| CDA Guidelines for the Care of Students Living with Diabetes at Schools            | - CDA guidelines outline specific roles and responsibilities for parents, guardians, students, school personnel and health care providers in the following areas:  
  - Communication and education.  
  - Daily management.  
  - Physical activity, sports and extracurricular activities.  
  - Emergency situations.  
  - It also outlines in detail what should be included in each child’s Individual Care Plan (ICP). |
| Joint Position Statement CPS/CPEG                                                  | The CPS/CPEG position statement describes key elements of an evidence-based school policy to support children and youth with diabetes:  
  - **An individualized care plan** (ICP) must be developed for each student with diabetes and discussed among parents or guardians and the school principal (or designate) and teacher, with input from a health care provider as needed.  
  - **Basic education and training for all staff:**  
    - Understanding the importance of food, activity, insulin and BG checks.  
    - Recognizing and treating highs and lows.  
    - Dispelling myths.  
  - **Advanced training for a small group of staff (at least 2 school personnel):**  
    - Providing support to a student with diabetes.  
    - Helping check blood sugars or administer insulin, especially for younger children.  
  - **Accommodation for student self-care needs:**  
    - Meals and snacks are supervised to ensure that they are eaten and on time.  
    - Students are able to test their blood sugar anytime, anywhere, and to be able to eat as needed (whether in class, in the gym, or elsewhere).  
    - Students have extra time for exams or tests in the event of an episode of low blood sugar. |
| York Region District School Board (YRDSCB) Policy on Diabetes                     | The YRDSCB has a fairly comprehensive diabetes policy in place with the following elements:  
  - Individual care plan established.  
  - Junior kindergarten/senior kindergarten/Grade 1 students with diabetes receive visits from a CCAC nurse 2 times per day to assist with BG testing and insulin administration.  
  - Junior kindergarten and senior kindergarten have a shared educational assistant to monitor student needs and initiate response if needed.  
  - Diabetes information is in all classrooms.  
  - Collaborative partnerships are in place with school personnel to ensure accommodation of student self-care needs. |
6.3 Proposed Policy and Systems Solutions

- Create a provincial policy for care of students with diabetes in schools and to ensure consistency and accountability across school districts and schools.
  - Ministry of Education should lead collaboration with Ministries of Health and Labour to ensure coordinated policies are in place.
  - Review best practice models to identify what works:
    - Build on/adapt successful approaches from other jurisdictions or leading Ontario school boards.
    - Identify existing policies, tool kits and templates to avoid “reinventing the wheel”.
  - Set clear expectations/responsibilities for duty of care and for education/training:
    - School boards, principals, teachers and other staff members.
    - Health providers (e.g., CCACs, public health, other health professionals).
  - Frame diabetes care in schools as a safety and human rights issue rather than as “special treatment”.
  - Consider a coordinated policy that addresses other chronic health conditions such as asthma and allergies.
  - Address liability concerns for teachers, schools and boards by interpreting and/or revising current legislation, such as the Good Samaritans Act and Sabrina’s Law.
  - Review funding allocations to enhance classroom supports for teachers with students with diabetes in the classrooms, e.g., eligibility for educational assistant hours, CCAC nursing hours.
  - Assess and address any gaps arising from incongruous boundaries for school boards, CCACs and public health units.
  - It was noted that there are unique issues related to Aboriginal students which must be addressed in collaboration with Aboriginal stakeholders:
    - Jurisdictional issues for providing diabetes care to Aboriginal students in schools (on and off-reserve).
    - Culturally-appropriate approaches and supports.

- Promote collaboration among key stakeholders to inform and advance the policy development process:
  - Include the full range of stakeholders:
    - Government ministries (Ministries of Education, Health and Labour)
    - Canadian Diabetes Association and parent advocacy networks
    - Aboriginal diabetes networks and tribal councils.
    - Canadian Pediatric Society and Canadian Pediatric Endocrinology Group
    - Ontario Diabetes Pediatric Programs
    - School Boards
    - Ontario Principals’ Council
    - Ontario Teachers’ Federation
    - Teachers’ unions
    - Association of Local Public Health Agencies and Chief Medical Officers of Health
    - Ontario Association of Community Care Access Centres
    - First Nations, Métis and Inuit representatives

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24 Based on the CDA standard of care, as legislated.
Other organizations, as appropriate.
- Consider creating a province-wide committee to facilitate the development of a collaborative strategy.
- Drive implementation through the government channels, stakeholder organizations/networks (health; education) and parental advocacy networks.

- **Develop standardized resources to guide the development of an individualized care plan (ICP) for students with diabetes:**
  - Create a standardized form for individualized student care plans that outlines roles and responsibilities of school personnel, parents and the student with diabetes.
  - Develop guidelines to ensure input from the health care team and student/parent involvement.
  - Ensure the principal, teacher and trained staff members are aware of the details of the ICP.

- **Introduce consistent education, training and supportive resources for teachers, other school staff and administrators and school boards:**
  - Basic education for all school staff \(^{25}\) in understanding the importance of food, activity, insulin and BG checks, and recognizing and treating BG highs and lows to prevent potentially serious consequences of low blood sugar such as loss of consciousness or seizure.
  - Advanced education for a minimum of two designated school staff to support a student with diabetes (BG monitoring, insulin injections and/or bolus through a pump).
  - Consider a train-the-trainer model and standardized, uniform package of information to make the best use of provincial funding resources.
  - Integrate diabetes education into the curriculum for teachers and students.
  - Increase the support available to teachers when they have a student(s) with diabetes in the classroom who requires support, e.g., access to educational assistant hours.

- **Require each school to have students self-management supports in place prevention and treatment of hypoglycemia, including:**
  - Regularly scheduled meals and snacks and adequate time to consume them, with supervision.
  - Student’s ability to test their blood sugar anytime, anywhere and to be able to eat as needed (whether in class, in the gym or elsewhere).
  - Adjusting either food intake or insulin doses for increase physical activity.
  - Providing extra time for exams or tests in the event of an episode of low blood sugar.
  - Ready access to child’s emergency kit.
  - Ensuring a support staff member is designated (teacher, educational assistant, other) to assist with monitoring and insulin injection and to deliver glucagon if required.

\(^{25}\) A standardized information package could be developed for all teachers, supply teachers, bus drivers and volunteers, and adapted for students.
7.0 SUMMARY OF PROPOSED POLICY AND SYSTEMS SOLUTIONS

### TABLE 5
SUMMARY OF PROPOSED POLICY AND SYSTEMS SOLUTIONS

<table>
<thead>
<tr>
<th>CRITICAL AREA FOR POLICY ACTION</th>
<th>SOLUTIONS</th>
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| **Foot Care for People with Diabetes** | 1. Develop a provincial policy framework for the prevention and management of foot complications for PWDs and supporting tools for implementation.  
2. Support improved self-management by PWD to prevent foot complications.  
3. Ensure equitable access to specialty foot care prevention, treatment and devices for every PWD in Ontario, regardless of where they live.  
4. Improve the screening for foot complications by primary care providers.  
5. Strengthen coordination of care and communication between health care professionals. |
| **Optimal Blood Glucose Monitoring and Testing for People with Diabetes** | 1. Introduce policies for A1C and SMBG testing, supplies and other supportive technology to strengthen access, especially for PWDs living in rural, remote areas or with income barriers.  
2. Empower PWDs for optimal SMBG and self-care through access to tailored diabetes education, tools and practical supports for self-efficacy.  
3. Improve primary care practice-level supports and incentives to facilitate the implementation of CPG recommendations for optimal BG monitoring and follow-up. |
| **Children and Youth with Diabetes in Ontario** | 1. Create a provincial policy for care of students with diabetes in schools and ensure consistency and accountability across school districts and schools.  
2. Promote collaboration among key stakeholders to inform and advance the policy development process.  
3. Develop standardized resources to guide the development of an individualized care plan (ICP) for students with diabetes.  
4. Introduce consistent education, training and supportive resources for teachers, other school staff and administrators and school boards.  
5. Require each school to have student self-management supports in place for prevention and treatment hypoglycemia. |
8.0 CLOSING REFLECTIONS AND NEXT STEPS
Dr. Jan Hux thanked participants and noted the urgency to take action to improve care and support for people with diabetes across the province. The dialogue identified realistic, effective policy alternatives that can be implemented immediately in Ontario.
Over-arching messages from the day included:

- doing the right thing is actually cheaper than paying for complications and poor health outcomes;\(^{26}\)
- there are health gains that can be achieved easily through building structures and collaborations and focusing on what we know works;
- there are clear examples of health care providers and administrators shifting to evidence-based, interprofessional models of care and to develop grassroots, culturally appropriate approaches to diabetes prevention and care.

Participants were thanked for their enthusiasm and willingness to share their experience and expertise.

\(^{26}\) Foot care vs foot amputation; supports for children with diabetes in school vs emergency visit for hypoglycemia; etc.
Diabetes Policy Summit:
Exploring Policy Options for Better Diabetes Outcomes in Ontario

8:30 a.m.-4:30 p.m.
Tuesday, November 4, 2014
Sheraton Centre Toronto, Pine Room
123 Queen Street West, Toronto

Objectives:
- Raise awareness about the challenges facing people with diabetes, as well as evidence-based best practices in three critical areas
- Collectively explore strategies and solutions to overcome some of these challenges in Ontario

Agenda

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<th>TIME</th>
<th>ACTIVITY</th>
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<tbody>
<tr>
<td>8:00 a.m.</td>
<td>Registration and Breakfast</td>
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<tr>
<td>8:30 a.m.</td>
<td><strong>Welcome and Introduction to the Summit</strong></td>
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<td></td>
<td>- Mr. Rick Blickstead, President and CEO, Canadian Diabetes Association</td>
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<td></td>
<td>Review of Agenda: <strong>Jacquie Dale</strong>, Lead Facilitator, One World Inc.</td>
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<tr>
<td>9:00 a.m.</td>
<td><strong>Diabetes in Ontario – An Overview</strong></td>
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<td></td>
<td>- Dr. Jan Hux, Chief Science Officer, Canadian Diabetes Association</td>
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<tr>
<td>9:20 a.m.</td>
<td><strong>Foot Care for People with Diabetes</strong></td>
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<td>- <strong>Ms. Lindsey Cosh</strong>, Foot Care Coordinator, Southern Ontario Aboriginal Diabetes Initiative</td>
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<td>- <strong>Dr. Janine Malcolm</strong>, Co-Chair, Champlain Diabetes Foot Ulcer and Amputation Reduction Strategy</td>
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<td>- Synthesis: <strong>Aileen Leo</strong>, Executive Director, Government Relations and Public Affairs, Canadian Diabetes Association</td>
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<tr>
<td>10:15 a.m.</td>
<td><strong>Round Table Discussion</strong></td>
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<tr>
<td>10:35 a.m.</td>
<td>Break</td>
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<tr>
<td>10:55 a.m.</td>
<td><strong>Children and Youth with Diabetes in Ontario</strong></td>
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<tr>
<td></td>
<td>• <strong>Dr. Sarah Lawrence</strong>, Pediatric Endocrinologist, CHEO</td>
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<td>• <strong>Ms. Shana Betz</strong>, Parent</td>
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<td>Synthesis: Aileen Leo, Executive Director, Government Relations and Public Affairs, Canadian Diabetes Association</td>
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<tr>
<td>11:40 a.m.</td>
<td><strong>Round Table Discussion</strong></td>
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<tr>
<td>12:00 p.m.</td>
<td><strong>Lunch</strong></td>
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<td></td>
<td>• Sign-up for the afternoon small group discussions</td>
</tr>
<tr>
<td>1:00 p.m.</td>
<td><strong>Optimal Blood Glucose Monitoring and Testing by People with Diabetes</strong></td>
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<tr>
<td></td>
<td>• Dr. Gillian Booth, Endocrinologist, St. Michael's Hospital</td>
</tr>
<tr>
<td></td>
<td>• Ms. Susie Jin, Pharmacist and Diabetes Educator</td>
</tr>
<tr>
<td></td>
<td>Synthesis: Aileen Leo, Executive Director, Government Relations and Public Affairs, Canadian Diabetes Association</td>
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<tr>
<td>1:50 p.m.</td>
<td><strong>Round Table Discussion</strong></td>
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<tr>
<td>2:15 p.m.</td>
<td>Break</td>
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<tr>
<td>2:30 p.m.</td>
<td><strong>Small Group Facilitated Discussion</strong></td>
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<tr>
<td></td>
<td>Participants join the discussion group of their choice to further explore one of the three focus areas, using the questions in the workbook</td>
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<tr>
<td>3:45 p.m.</td>
<td><strong>Reporting back</strong></td>
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<tr>
<td>4:10 p.m.</td>
<td><strong>Closing Reflections and Next Steps</strong></td>
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<tr>
<td></td>
<td>• Dr. Jan Hux, Chief Science Officer, Canadian Diabetes Association</td>
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<tr>
<td></td>
<td>• Evaluation</td>
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<tr>
<td>4:30 p.m.</td>
<td><strong>Adjournment</strong></td>
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<tr>
<td>Name</td>
<td>Organization/Position</td>
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</tr>
<tr>
<td>Christine Albee</td>
<td>Canadian Diabetes Association</td>
</tr>
<tr>
<td>Lisa Alphonse</td>
<td>Ministry of Health and Long-Term Care</td>
</tr>
<tr>
<td>Lesia Babiak</td>
<td>Johnson &amp; Johnson Inc.</td>
</tr>
<tr>
<td>Arielle Baltman-Cord</td>
<td>Ministry of Health and Long-Term Care</td>
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<tr>
<td>Krista Banasiak</td>
<td>Canadian Diabetes Association</td>
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<tr>
<td>Leah Bartlett</td>
<td>Champlain LHIN</td>
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<tr>
<td>Lynn Baughan</td>
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<tr>
<td>Shana Betz</td>
<td>Parent</td>
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<tr>
<td>Arlene Bierman</td>
<td>Institute for Clinical Evaluative Sciences</td>
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<tr>
<td>Rick Blickstead</td>
<td>Canadian Diabetes Association</td>
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<tr>
<td>Gillian Booth</td>
<td>St. Michael’s Hospital</td>
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<tr>
<td>Mariam Botros</td>
<td>Canadian Association of Wound Care</td>
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<tr>
<td>Joan Canavan</td>
<td>LifeScan Canada Inc.</td>
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<tr>
<td>Mary Carothers Bell</td>
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<tr>
<td>Glen Chenard</td>
<td>St. Elizabeth's Health Care</td>
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<tr>
<td>Lynn Chiarelli</td>
<td>One World Inc.</td>
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<tr>
<td>David Colby</td>
<td>Chatham-Kent Public Health Unit</td>
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<tr>
<td>Lindsey Cosh</td>
<td>Southern Ontario Aboriginal Diabetes Initiative</td>
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<tr>
<td>Cheryl Cullimore</td>
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<td>Jacquie Dale</td>
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<tr>
<td>The Honourable Dipika Damerla</td>
<td>MPP Mississauga East - Cooksville</td>
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<tr>
<td>Kimberly Davey</td>
<td>Six Nations Health Services</td>
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<tr>
<td>Joanna Dydula</td>
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<tr>
<td>James Elliott</td>
<td>Researcher</td>
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<tr>
<td>Brent Fraser</td>
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<tr>
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<tr>
<td>Carolyn Gall Casey</td>
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<td>Sherry Green</td>
<td>London Diabetes Foot Clinic</td>
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<td>Jan Hux</td>
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<tr>
<td>Chris Jarvis</td>
<td>I Challenge Diabetes</td>
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<td>Susie Jin</td>
<td>Pharmacy 101</td>
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<td>Helena Koa</td>
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<tr>
<td>Jason Lagerquist</td>
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<tr>
<td>Sarah Lawrence</td>
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<td>Cindy Lazenby</td>
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<td>Anne Le-Quang</td>
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<tr>
<td>Margaret Maheandiran</td>
<td>CDA Ontario Advocacy Committee</td>
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<tr>
<td>Janine Malcolm</td>
<td>The Ottawa Hospital</td>
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<tr>
<td>Name</td>
<td>Organization</td>
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<tr>
<td>Noella Mandamin</td>
<td>Grand Council Treaty #3</td>
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<tr>
<td>James Meloche</td>
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<tr>
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<td>Seema Nagpal</td>
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<td>Nicole Nitti</td>
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<td>Natasha O’Farrell</td>
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<td>Nathalie Sava</td>
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<tr>
<td>Catherine Yu</td>
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<tr>
<td>David Zimmer</td>
<td>MPP Willowdale</td>
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