DIABETES CANADA

Summary of Diabetes Canada Diabetes 360° New Brunswick Roundtable

October 24, 2019

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CONTEXT

This report presents the highlights from the New Brunswick Diabetes Roundtable organized by Diabetes Canada. It documents the advice provided by participants on the work that New Brunswick needs to engage in to reduce the burden of diabetes, from prevention and screening to management. Priority areas for action on diabetes are identified within a chronic disease framework.

The *New Brunswick Diabetes Roundtable* is the last of a series of facilitated discussions that *Diabetes Canada* held across the country with invited participants (national, ON, NB, BC). The participants are concerned about the burden of diabetes and prepared to offer advice on diabetes prevention, care and management. Fifty-five (55) individuals with varied experience gathered in Fredericton to share their concerns, listen to others and identify actions that could make a meaningful difference for individuals and communities at risk.

Russell Williams (Senior VP Mission) and Jake Reid (National Director, Government Relations) of *Diabetes Canada* welcomed the group and emphasized the shared opportunity to shape future national and provincial diabetes strategy. This initiative is also important to build momentum for *Diabetes 360º*.

Participants introduced themselves, indicating where they live and in what capacity they were attending. The diverse group, from across the province, included individuals with lived experience, advocates, health professionals, agency administrators and government officials. *See Appendix A for List of Participants.*

Special thanks to Nancy McKay for summarizing the meeting discussion and feedback into this final report.

Purpose

To set the stage for the day's discussion, the goals for the *Diabetes Roundtable* were presented as:

1. To learn about *Diabetes 360º* and the call for a national diabetes strategy
2. To learn about the current government and department of health approach to chronic disease and diabetes
3. To share the lived experience of people who have diabetes and learn from a patient perspective the impact of living with a chronic condition
4. To help identify the gaps in diabetes prevention, care and management in the province
5. To advise on a vision for diabetes prevention, care and management in a provincial context, and what that would mean within a federal Diabetes 360º strategy and for communities at risk

To ensure participants had relevant background information, invited presentations and individual diabetes vignettes preceded the Roundtable discussion including:

- **Burden of Diabetes in NB** - Jake Reid, National Director, Government Relations, Diabetes Canada
- **Diabetes 360º** - Kimberley Hanson, Executive Director, Federal Affairs, Diabetes Canada
- **Diabetes Initiatives and Priorities in NB** – Noortje Kunnen, Director, Community Health and Chronic Disease Prevention and Management, N.B. Department of Health
- **Diabetes Vignettes** – Stories from people living with diabetes

The presentations were circulated following the Roundtable.

DIABETES

Diabetes is a chronic disease in which the body has difficulty regulating the amount of glucose (or sugar) in the blood. Elevated blood sugar over time can lead to organ, blood vessel and nerve damage. Diabetes contributes to 30 per cent of stokes, 40 per cent of heart attacks, 50 per cent of kidney failure requiring dialysis, 70 per cent of non-traumatic limb amputations and is the leading cause of vision loss in Canada.

Type 1 diabetes is found in five to 10 per cent of Canadians with diabetes and occurs when the body is unable to produce insulin, a hormone that controls the level of glucose (sugar) in the blood. The cause of type 1 diabetes is unknown, and it is not preventable. It occurs when a person's immune system destroys the cells in the pancreas that make insulin.

Type 2 diabetes is the most common, where the pancreas either cannot effectively use or produce enough insulin. It is found in approximately 90-95 per cent of Canadians living with diabetes. Alarmingly, type 2 diabetes, which used to be a type of diabetes exclusively experienced by adults, is now increasingly developing in children. The causes of type 2 diabetes can be genetic, behavioural and/or environmental. When compared to Caucasians, Indigenous peoples of Canada are at higher risk of type 2 diabetes. In addition, people of South Asian, Hispanic, or African descent are also at higher risk of type 2 diabetes.

Prediabetes occurs when an individual's blood glucose levels are high, but not yet high enough to be diagnosed with type 2 diabetes. Approximately 50 per cent of those with prediabetes go on to develop type 2 diabetes.

Gestational diabetes is a temporary condition that develops during pregnancy. Blood glucose levels usually return to normal following delivery, however both mother and child are at higher risk of developing type 2 diabetes later in life.

DIABETES IN NEW BRUNSWICK

In New Brunswick, calls to *Diabetes Canada* predominantly relate to health care access, barriers to diabetes management and costs. Information was provided about the economic and out-of-pocket costs 2019-2029 in New Brunswick including:

- The direct cost to the health-care system in New Brunswick is estimated to be $100-$127M in a system where almost 50% of government dollars go the health care.
- Annual out-of-pocket costs per year include: i) Type 1 diabetes on multiple daily insulin injections - $30-$3,100, ii) Type 1 diabetes on insulin pump therapy - $100-$6,200, and iii) Type 2 diabetes on oral medication - $1,100-$2,000.

In developing future strategy, it is important to recognize the opportunities and challenges. Participants heard that the *Provincial Comprehensive Diabetes Strategy* has provided a strong foundation with government commitment and engagement from the health care community. Strategy results were promising. However, challenges exist in that the system has moved beyond the focused diabetes strategy to a chronic disease approach including diabetes. There is a significant risk of isolated policies, programs and services and inadequate resources for diabetes going forward. Action is needed.

According to *Diabetes Canada*, the prevalence rates for diabetes are rising. It is predicted that 1 in 3 people will have diabetes/pre-diabetes by 2029. New Brunswick is expected to have the highest rates of diabetes/pre-diabetes of all the Atlantic provinces driven mostly by the Type 2 numbers. The costs and effects on people living with diabetes in the province will be compounded given lower annual income and less robust health supports relative to other jurisdictions.

DIABETES 360˚ STRATEGY FRAMEWORK: A CANADIAN CALL TO ACTION

Kimberley Hanson, *Diabetes Canada,* emphasized that, with the prevalence of diabetes expected to more than double, there is a burning platform for change that should galvanize government around the diabetes issue. She stated that although New Brunswick has had a dedicated Diabetes Strategy, Canada has been without one since 2013. Past national results were not measurable, and the Aboriginal diabetes initiative is all that remains.

In 2017, multi-sectoral stakeholders in Canada came together to develop an approach to "diabetes" inspired by the 90-90-90 Target for HIV/Aids. This highly successful strategic initiative has reduced the burden of that disease worldwide and was identified as a promising model for consideration by the diabetes community. The evidence-based approach and engagement of all countries toward results was fundamental to success against HIV/Aids. *Diabetes 360º* is a strategy focused on patient health outcomes. Four important targets have been identified:

- *Prevention* – 90% of Canadians live in an environment that preserves wellness and prevents the development of diabetes
- *Screening* – 90% of Canadians are aware of their diabetes status
- *Treatment* – 90% of Canadians living with diabetes and prediabetes are engaged in appropriate interventions to prevent complications
- *Outcomes* – 90% of Canadians engaged in interventions are achieving improved health outcomes

Canadians, as evidenced by a 2018 IPSOS poll, showed that 6 in 10 Canadians would be more likely to vote for a party that would implement a diabetes strategy. Recent advocacy efforts yielded support for funding *Diabetes 360º* from the Parliamentary Committees on Finance and Health in 2018-19 and from the NDP and Green parties.

Not only do Canadians support *Diabetes 360º,* it makes economic sense. Based on peer reviewed research, a $150 million investment equals $20 billion in savings in 7 years with an estimated 770,000 fewer cases of type 2 diabetes, 245,000 fewer hospitalizations and 34,000 fewer lower limb amputations not to mention the positive impact on human and financial costs. The *Roundtable* presentation provides details about the target, actions and measurable outcomes in the quadrants of prevention, screening, treatment and improved outcomes. In the strategy, consideration and recommendations are outlined for two subgroups: i) type 1 diabetes and ii) indigenous peoples.

The plan for implementing *Diabetes 360º* counts on securing $150 million in federal funding over 7 years (2020-2026) for a Taskforce to i) act as a central resource/center of expertise for Provinces/Territories, ii) implement a foundation of data and metrics to better quantify the diabetes burden in Canada, iii) facilitate the sharing of best practices, and iv) create efficiencies. Clearly, Provinces can move forward without the federal funding commitment.

The Diabetes Canada plan to March 2020 is to: i) learn from the four roundtables, ii) build momentum from the demonstrated public support and public campaign, iii) engage the new Federal Government to solidify commitment to *Diabetes 360º,* and iv) request funding for *Diabetes 360º* in the 2020 Federal Budget.

Based on questions from participants, the need for leadership from *Diabetes Canada*, in general, and specifically on lifestyle and food insecurity was highlighted.

DIABETES INITIATIVES AND PRIORITIES: NEW BRUNSWICK UPDATE

Noortje Kunnen, New Brunswick Department of Health (DH), provided an update on government priorities and commitments related to chronic disease, including diabetes. She stated that an increase in the prevalence of chronic conditions and diseases is expected given that:

- the province has one of Canada's oldest populations and is aging at a greater rate than other jurisdictions ~ by 2026 it is estimated that 26.3% of residents will be over the age of 65, and
- residents also experience high levels of overweight and obesity' smoking, physical inactivity, unhealthy diets, and excess alcohol use.

The most recent data describing the chronic disease burden in the province is 2015-16. The top 3 conditions causing hospitalisations are COPD, Congestive Heart Failure and Osteoarthritis. Although the diabetes registry is distributed every 2 years, DH is now working on a more comprehensive chronic disease registry. In recognition of access issues that exist, a billing incentive is in place for primary care physicians providing care to people with COPD and diabetes. To date, diabetes management has the greatest uptake.

DH has moved to a comprehensive approach to chronic disease from prevention to management. Staffing in the chronic disease unit has increased from 2 in 2018 to 6 in 2019. The provincial *Chronic Disease Prevention and Management Framework Strategy* is seen to be a good fit with *Diabetes* 360º with areas of focus including prevention, screening, management and monitoring/research. Initiatives related to Chronic Disease are:

- *Establishment of a provincial Chronic Disease Prevention and Management (CDPM) Working Group*
- *CDPM current state and gap analysis*
- *Atlantic Collaborative in Chronic Disease*
- *Live Well/Vivre Bien*
- *COPD: INSPIRED/UPSTREAM*
- *Smoking cessation*
- *Stroke Community Reintegration Working Group*

Initiatives specific to diabetes are:

- *Evaluation of Diabetes Case Managers*
- *Review of the Insulin Pump Program*
- *Foot care initiative: Atlantic Collaborative*
- *Practice Profiles (scheduled for fall)*
- *Continuation of funding for:*
    - *Pump Program (up to 25 years of age)*
    - *Certification in insulin dose adjustment*
    - *Bursaries for diabetes educator certification*
    - *Diabetes Camps*
    - *Diabetes Case Managers*
    - *Diabetes Education Clinics and foot clinics*
    - *Incentive billing codes (Diabetes and COPD)*
    - *Live Well/Vivre Bien*

In response to participant questions, it was learned that:

- The upcoming evaluation of diabetes case managers follows a previous evaluation of diabetes clinics conducted by the NB Health Council. The results of that study were shared with regional health authorities and recommendations were implemented.
- The Diabetes Educator Certification bursary program is under review.
- Funding towards annual eye examinations is on the radar, however it is now, more than ever, necessary to set priorities from the list of potential action areas.
- New Brunswick relies on other provinces when considering innovations on new medications/devices. Currently insulin pumps are under review.
- Department of Health is trying to work more closely with Department of Social Development on the issue of access to drugs and test strips. Access is still a significant issue and will be discussed with the pharmacy services group.

A review/evaluation of the diabetes case managers (and primary care providers they work with) will be undertaken with the goal to improve services for diabetic patients.

DIABETES VIGNETTES

Through the personal stories, the *Diabetes Vignettes* provided the opportunity for participants to share the lived experience of people who have diabetes and reflect on the impact of living with a chronic condition.

A young man living with type 1 diabetes is a volunteer, advocate and fundraiser with Diabetes Canada. Since being diagnosed at an early age, he and his family quickly learned what it meant to live with diabetes. The family embraced healthy lifestyle choices regarding exercise and healthy diet. Family, school and community support was essential to his well-being. Pump therapy was a game-changer…although it was liberating, the eating regime was very strict. Now, as a young adult living on his own, he utilizes the tools he learned growing up. Life is manageable; yet he faces mental fatigue and financial uncertainties in managing the disease. *Diabetes 360º* is seen as important given its impact on individuals, communities and the country.

A young aboriginal man living with diabetes grew up in a family of people with diabetes and learned early on the ups and downs of living with this disease. He was a valued member of the Indigenous Working Group during development of *Diabetes 360º*. He is concerned that children are facing an obesity epidemic and may well be the first generation not to outlive their parents. Life with diabetes is harder that one thinks. After living with diabetes denial and facing obesity and health issues, he changed his lifestyle allowing him to better manage his disease. As a professional addictions' worker, he sees the suffering from addiction issues and unknown diabetes. He now is the co-ordinator of a community youth center that teaches cultural practices and going back to traditional eating habits. He believes that First Nation communities are the fastest growing demographic in Canada with the fastest growing diabetes numbers. Boundaries to "self care" and being healthy are significant. First Nation communities needs services and support to address issues of cultural disconnect, food insecurity, mental health and lack of knowledge to prevent or manage diabetes. He strongly feels that this should be a grass roots movement. All to go back to their work and *consider the individuals*. He cautions that plans are great, but we must not forget the individuals that must face this scary disease alone.

A young woman living with Type 1 diabetes was finally diagnosed at age 22 after two years of challenges. With pump therapy and other requirements to manage her disease, the need to ensure continuation of extended health insurance has dictated choices in her life and work. In her journey, she has experienced a lot of judgement and "shaming" by professionals when making life choices. She advises that "non-compliant", as a term, should never be used as a health care provider. Although this is a painful chronic disease for many people who fear the future, she has benefited from an amazing community and career in the field. She firmly believes that *Diabetes 360º*

will increase understanding of the cause of diabetes, the intergenerational trauma and the reality of living with diabetes. It can help to remove the stigma and judgement related to belief that people cause their diabetes by their lifestyle choices.

TAKING STOCK AND SETTING PRIORITIES

New Brunswick is at a critical juncture with the government shift from a dedicated *Diabetes Strategy* to diabetes becoming part of the *Chronic Disease Prevention and Management Framework*. It is important to not lose momentum in efforts targeted to decease the burden of diabetes in the province.

The second phase of the *Roundtable* was structured to hear and seek advice from invited participants. Six discussion groups were asked to consider and report back to the plenary group on two questions:

- *What work does NB need to engage in to reduce the burden of diabetes, from prevention and screening to management?*
- *What are the priority areas for focused action on diabetes within a chronic disease framework?*

Engagement Work to Reduce Burden of Diabetes and Priority Actions

From the discussion group reports, participant input and advice were organized under five (5) ***Areas of Engagement: System Organization/Integration, Prevention, Screening, Management*****,** and ***Outcomes*****.** Under each theme, ***Priority Areas for Focused Action*** are identified for further consideration within a chronic disease framework. This approach to presenting the information is seen to be consistent with ***Diabetes 360º***.

Area of Engagement: Advocacy for Healthy Public Policy

- Address social determinants of health
    - Address food security issues
    - Increase access to healthier food
    - Strengthen anti-poverty initiatives
- Decrease access to sugary sweetened beverages/fast food
    - Increase taxation
- Introduce and monitor use of "health for all – health impact screen" across government when developing legislation, regulation and policy (regardless of portfolio)
    - Involve community and government stakeholders to adopt healthy public policy (e.g. heart health school programs, food policy in public spaces – schools, arenas)
- Increase access to Disability Tax Credit for people living with Diabetes

- Decrease the "coverage gap" between insurance holders and the working poor (i.e. equal treatment)
- Establish healthy eating habits at daycares through education and standards
    - Educate workers on healthy eating habits (i.e. role models for children)
    - Reduce the use of additives (e.g. ketchup, soya sauce, salt etc.)
- Establish clearer, more specific guidelines for nutrition in schools
    - Need to include healthy tasty options

Area of Engagement: System Organization/Integration

- Increase public and workplace awareness of the burden of diabetes management
- Improve communication about diabetes management between Health and Social Development (i.e. interprofessional level, Departmental level)
- Improve communication with other initiatives
    - Anti-poverty, Addictions & mental health
- Engage primary care providers/clinicians in the framework
    - Need enough primary care for all (e.g. dieticians, nurse educators, social workers)
- Improve collaboration given that services and systems involved with managing complications of diabetes are siloed
- Improve communication related to research, programs, best practices and outcomes
    - Involve Chronic Disease Centers and shared services updates
    - Hold regular communication meetings
- Add more resources to Diabetes within the Chronic Disease portfolio
    - Mandate and funding for routine, regular screening for diabetes
    - Funding for more Diabetes Educators/case managers
        - All EMP units should have Certified Diabetes Educators
    - Expand *Live Well/Vivre Bien*
        - Increase access using coaching, motivation and goal setting
        - Consider educating *"community champions"*

Area of Engagement: Prevention

- Increase investment in public education
    - Launch wellness commercials on TV and social media
    - Develop an awareness campaign on the signs and symptoms of diabetes
- Build a culture of wellness and prevention in early years
    - Develop healthy skills / behaviors (i.e. food/home economics; physical activity/physical education for all grades)
- Increase promotion of healthy lifestyles and behaviors

    - Increase access to prevention programs
    - Change relationship between eating and coping
        - Offer Healthy Lifestyle classes
        - Acknowledge underlying emotional/mental issues that contribute to health difficulties
        - Strengthen earned health behaviors (not eating unhealthy treat as a reward)
    - Partner with industry on wellness initiatives and strategies
    - Promote physical activity (i.e. workplace, children & parents; seniors)
        - Consider support/reward/incentive systems (i.e. fitness credit, trading sick days for vacation)
        - Include kinesiologists in programs
- Increase access to healthy, safe environments in rural and urban areas
    - Allow use community facilities – arenas with walking tracks, malls in early hours etc.)
    - Establish healthy food polices in public facilities
- Enhance Public Health services for education re healthy lifestyle and healthy eating
    - Acknowledge that it is more an action gap than a knowledge gap
    - Focus on youth education for healthier lifestyle (i.e. pre-school, elementary)

Area of Engagement: Screening

- Establish a provincial screening mandate with wider access to screening clinics
- Increase screening and access to screening using innovative screening approaches
    - More free screening for younger populations and adults (i.e. public level, community groups, workplace, university/college)
    - Move screening clinics from only physician offices/health clinics to community sites
        - Clinics at pharmacies where pharmacists/technicians become more accessible
        - After hours clinics
        - Basic screening-mobile screening that are like blood clinics (i.e. can partner with industry)
        - Mailout letter with *CANRISK* screening and resources (e.g. cancer screening mailout) to help individuals or high-risk populations to identify their risk
    - Advocate with drug insurance companies for “screening incentive”
    - Utilize A1C machines

- Work towards aligning Clinical Practice Guidelines with appropriate testing and screening
    - Access to retinopathy screening
- Increase awareness of screening resources available

Area of Engagement: Treatment/Management

- Improve access to diabetes programs and services
- Introduce Case Managers/Health Navigators
    - Help people go to the right spot for the right care and treatment
    - Establish diabetes navigators to support people living with diabetes (e.g. through 811, LINK program)
- Improve access to medications and required supplies/tools
    - Introduce changes for fair and equitable access to technology, devices, medication
        - Manage medications permitted based on "equal access for all"
        - Decrease co-pay
        - Change language in forms which currently limit access to certain medications
        - Develop a comprehensive plan wherein all supplies are included (i.e. now need Health Card to get needles and strips)
        - Eliminate provincial discrepancies in prescription drug program
        - Fund access to insulin pumps for all who need it
- Improve access to diabetes care and treatment
    - Develop virtual support programs
    - Move diabetes management out of hospitals into communities
    - Create different points of access for Diabetes Educators (i.e. pharmacies and other community spaces)
    - Change the name from *"Diabetes Education Session"* to "*Diabetes Support Center or "Diabetes Self-Management"*
    - Consider *"NEW" program* (Nutrition, Exercise, Wellness)
    - Standardize access to education & Diabetes Education Centers
- Introduce changes that encourage self-management
    - Promote autonomy through self-referral and self-booking (NBMD electronic consults)
    - Enhance *Patient Connect*
    - Provide direct access to personal bloodwork
    - Establish accommodating hours for clinics
    - Provide access to help line for individuals with pre-diabetes or living with diabetes (i.e. 811; after hours support)
- Establish *Chronic Disease Support Centers* with team approach
    - Access to multiple health providers

    - Access to education and Healthy Living
    - One Door-One Stop approach to eliminate the silos and disconnect among healthcare professionals
- Effectively use technology for rural access (i.e. virtual clinics and access to physicians)
- Recognize the scope of diabetic distress and improve screening
    - Involve Mental Health
    - Attach social workers to Diabetes Education Centers
        - help navigate system
        - access to mental wellness programs
    - Establish psychological support groups
- Access to preventive footcare services

Area of Engagement: Outcomes

- Evaluate prevention strategies (i.e. post-partum screening)
- Measure and report on outcomes

MOVING FORWARD

Representatives from *Diabetes Canada* thanked individuals for their participation. The ideas and advice from the group, as documented in the *Roundtable* report, will be carefully considered. Although Diabetes Canada will set priorities going forward, there is a need to create provincial action following our report. Individuals were encouraged to each think about action and what role they could play moving forward. It may also be important to meet early in the 2020 to continue this dialogue on priorities.

New Brunswick was congratulated for its good work in the past and, with the energy and creative ideas heard today, that work is expected to continue. *Diabetes Canada* will further consider sending a letter and report to government with signatories demonstrating participant support. By working together, all provinces and territories can exchange best practices and data comparisons. Moving forward, *Diabetes 360°* will provide leadership and support.

APPENDIX A – LIST OF PARTICIPANTS

Blackmer, Susan
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Ward, Rainer
Watson, Brianne
Werner, Tara
Williams, Russell
Woodcock, Patricia

APPENDIX B: NOTES SUBMITTED REFLECTING GROUP DISCUSSION

Group 1

Engagement to Reduce Burden of Diabetes

- **More screening**
  - Younger populations
  - University and college students
  - Workplace
  - Letter with CANRISK screening and resources
  - Incentive with drug insurance plans
- **Promote physical activity**
  - In the workplace
  - Kids & parents
  - Fitness credit
  - Include kinesiologists in our programs
- **Include diabetes patients in programs that cardio patients now access**
- **Psychological support groups**

Priority Areas for Focused Action within a Chronic Disease Framework

1. Cover drugs with evidence of CV and renal protection
2. More coverage for **essential** tools (ex. insulin is covered, but not needles)
3. Promote autonomy: self-booking online

4. Accommodating hours
5. Help line for diabetes patients and pre-diabetes
6. Better communication between healthcare professionals and social development
7. Measure outcomes

Group 2

- **Prevention**
  - Early
    - culture of wellness and prevention
    - skills development (i.e. food/home economics, activity/physical education
  - Support/Reward/Incentive
    - Employees could trade sick days for vacation
  - Enhance Public Health
- **Access**
  - Screening
    - Free
    - Public level/community groups
    - AIC machines
  - Bloodwork
    - Access your own information
- **Management (i.e. decrease workload of self-management)**
  - Public recognition of DM burden in the workplace
  - Mental Health
  - Access medications and supplies
    - Health card to get needles and strips
  - Complications - siloed

Group 3 (Raven Labillois - raven@unb.org)

Engagement to Reduce Burden of Diabetes

1. **Public Policy**

Sugary sweetened beverages/Fast Food– sugar is prevalent everywhere. Must tackle at a policy level to decrease access and increase taxation. Increase access to healthier food

2. **Education at Younger Age**

Impact early childhood behaviours.

- Daycare healthy habits/education/standards
  - Reducing the use of additives (e.g. ketchup, soya sauce, salt)

    - Educating workers as these are the healthy habits children will pick up on
- Healthy tasty options in schools
- Clearer, more specific guidelines for nutrition in schools
- Diabetes Canada campaign

3. **Relationship between eating and coping**

Underlying issues (emotional/mental) that contribute to health difficulties/need to strengthen earned health behaviours

4. **Public advocacy for increased screening**

Move from only doctor offices and health clinics to more access and self-assessment (i.e. pharmacy, mail-outs, CANRISK)

5. **Live Well / Vivre Bien**

Possibility of expansion and more accessibility using coaching, motivation, goal setting is biggest help

6. **Change name from "Diabetes Education Session" to "Diabetes Support Center" or Diabetes Self-Management"**

Conversation/action of health care provider from manager to supporter

7. **Language in forms limits access – cost of medication - decrease co-pay**
    - Changing the language in policy which makes access to technology/devices/medication easier (i.e. Libre not covered due to language)
    - Comprehensive plan (all supplies together)
    - Prescription drug program has provincial discrepancies
    - Disability Tax Credit – more access (saving money for people living with diabetes)

Priority Areas for Focused Action within a Chronic Disease Framework

1. Add more resources to Diabetes within the Chronic Disease Portfolio
    - Routine, regular screening covered
2. Working towards aligning with the Clinical Practice Guidelines with appropriate testing and screening
3. Chronic Disease Support Centers – Team Approach
    - Education
    - Access to multiple health disciplines
    - One door approach-One Stop Shop – stop the silos and disconnect between healthcare professionals

        - Healthy Living access
        - More access between centers (communication and sharing services updates)
    4. Public Education of Signs and Symptoms of Diabetes
        - Awareness campaign (hyperglycemia)
    5. Different points of access for Diabetes Educators (nurses/dieticians)
        - Pharmacies and other community spaces
    6. Funding provided for Diabetes Educators
        - Should have Certified Diabetes Educators in EMP in all units
    7. Diabetes Educators / Case Managers and Live Well / Bien Vivre
        - Can we educate community champions?

8. Increase access to healthy, safe environments

Rural vs. urban – using community facilities such as arenas (walking tracks) and malls (open early for walking)

9. Rural Areas

Moving management out of hospitals into communities; effectively using technology for virtual clinics/physicians

Group 4 (Denise Gray 506-375-2624)

- Concerned about the fast food industry and energy drinks
- Increased access to prevention programs
- Education to parents
- Raise awareness with pictures of effects of Diabetes
- Insulin pump programs for all
- Patients being seen for screening and maintenance in the community rather than in the hospital setting
- Timely access to care
- Awareness of services available in the community
- Self referral
- Standardizing access to education, DEC's etc.
- Enhancement of Patient Connect
- NBMD – electronic consults
- Financial concerns (e.g. strips, eye examinations)
- CanRisk sent in the mail for screening
- Incentive programs to stay healthy
- 811 and care plan
- After hours support
- Importance of socializing and exercise/exercises for seniors (donations as they can)
- Healthy Lifestyle Classes

- Wellness commercials on TV and social media
- Clinics geared to diabetes in Pharmacies or After-Hours clinics
- Universal access to the medications of choice and supplies
- Access to retinopathy screening
- Access to preventive footcare services
- "NEW" Program (nutrition/exercise/wellness)
- LINK program – navigating patients based on priorities (?? through 811)

Group 5 (Michelle Corcoran 506-392-7277)
Engagement to Reduce Burden of Diabetes

Prevention
- **Decrease sugary drinks – introduce tax**
- **Education re healthy eating**
    - Public Health role to educate – education re drinking water, healthier foods/cooking
    - Not a knowledge gap but an action gap
    - Youth education for healthier lifestyle – (i.e. preschool, elementary)
- **Education and communication are key***
    - Healthy choice is just not there
    - Treats should not always be food
    - Need focus groups to identify problems and issues
        - Need buy-in for doing/action – not preachy
        - Emphasize unhealthy choices
    - Shortcomings in dialogue around food not as treat but good for you
    - Exposure to positive healthy food choices are easy choices
    - Policies in all areas should be healthy (i.e. heart health school programs, arenas)
    - Need resources for this:
        - Rural vs. city access
        - Community stakeholders vs. involved stakeholders (i.e. do not need to create new stakeholders; work with those who are already there)
        - Make healthier behaviour "normal"/shift the conversation
- **Case Managers/Health Navigators**
    - to help people go to the right spots for right care & treatment
- **Screening**
    - Community pharmacists and technicians become more accessible (i.e. clinics at pharmacies)
    - Basic screening-mobile screening clinics that are like blood clinics (i.e. can partner with industry)
    - Increase awareness of resources out there

- Provincial screening mandate – are there screening clinics?
  - "it could happen to me" vs. "it could not happen to me"

Priority Areas for Focused Action within a Chronic Disease Framework

1. Increased awareness in schools for healthy behaviours
2. Improved access to diabetes care and treatment (i.e. alternatives to physicians/NPs)
    a. Pharmacists/Technicians, Social Workers, Diabetes educators for non-MD led clinics
    b. Virtual support programs
    c. Too heavily dependent on disease/health clinical models
        i. Need mental wellness (e.g. phone conversations) and access to social workers
        ii. Screen for diabetes distress
3. Need nutrition/food security education
4. Must determine how to engage primary clinicians in the framework
    a. Need enough primary care for all (i.e. dieticians etc.)

Note: Communication meetings regularly to share who is doing what program/outcomes/ NB research (for PWD/HCP

Group 6 (Angela Daley)

- Breast-feeding initiatives
- Evaluate strategies being done for prevention (i.e. post-partum screening)
- Workplace strategies (i.e. partner with industry)
- Improve communication with other initiatives (i.e. anti-poverty, addictions & mental health)
- Decrease the gap between insurance holders and the working poor (i.e. equal treatment)
- Manage medications allowed based on equal access for ALL
- Education – physical activity as part of all grades
- Health in all policies regardless of portfolio
- Focus on anti-poverty and increase access
- Social work attached to DECs to help navigate forms (e.g. mental wellness programs etc.)