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Diabetes Canada

October 10, 2019

Irfan Dhalla
Vice President, Evidence Development and Standards
Health Quality Ontario (HQO)
130 Bloor Street West
Toronto, ON M5S 1N5

Re: Diabetes Canada Feedback on Quality Standards for Type 1 Diabetes

Dear Dr. Dhalla,

Thank you for the opportunity to provide feedback on the draft report from Health Quality Ontario: *Quality Standard: Type 1 Diabetes*. Diabetes Canada supports the development of quality standards type 1 diabetes.

People living with type 1 diabetes account for approximately 10% of the population living with diabetes. Type 1 diabetes care is complex and requires numerous factors to be addressed. Diabetes care should be patient-centered, and account for comorbidities and other patient factors that may require modification of goals and targets to meet the needs of people living with diabetes.

Quality standards, that are based on evidence-based clinical practice guidelines (CPGs), inform patients, health care providers, and organizations about high-quality care looks for health conditions or processes deemed a priority for quality improvement. HQO's proposed quality standards align with and are strongly based on Diabetes Canada's CPGs. The CPGs are intended to guide practice; inform general patterns of care; enhance diabetes prevention efforts in Canada; and reduce the burden of diabetes complications. Unfortunately, we know that much evidence exists to support better diabetes outcomes, but this evidence is not implemented in full or equitably for all Canadians. While we have seen improvements in outcomes such as myocardial infarction and life expectancy, there continues to be a large care gap. Definition and implementation of diabetes quality standards can improve care.

We ask that you consider integrating the following feedback into the type 1 diabetes quality standards:

1. *Indigenous peoples living with type 1 diabetes:* We applaud HQO for acknowledging the historical context of diabetes in Indigenous populations in Canada. The impacts of our historic and continued colonial policies, including residential schools, Indian hospitals, and the 60's scoop, have created lasting physical, mental, emotional, and social harms for these communities. However, the quality standards should better align with a strengths-based approach to which Indigenous Peoples ascribe. A strengths-based approach offers language and solutions for overcoming issues and draws on the strengths of communities to produce these solutions.[i] Strengths-based approaches move away from deficit discourse, which frame and represent Indigenous Peoples identity in a narrative of negativity, deficiency, and failure, and contributes to stereotyping and stigma of these communities.

   To shift away from a traditional problem-based paradigm, Institutions need to acknowledge that Canada's Indigenous populations continuously demonstrate great strength and resilience. Survivors of colonialism and residential schools have endured oppression, cultural erosion, forced relocation, forced assimilation, and institutionalized racism. When considering the number of challenges these communities have endured, Indigenous groups' current status as well-functioning cultural and political entities demonstrate remarkable strength and resilience. Second, the context in which the health care system and health outcomes exist is rooted in Canada's historic and continued colonial policies.

   The quality standards should mention cultural safety and humility and provide guidance on the delivery of culturally responsive health care. Indigenous Peoples' interactions and engagement with diabetes care can expose individuals to culturally unsafe conditions. Feeling unsafe or stigmatized leads many to avoiding accessing care or disclosing symptoms during health care interactions. Health care relationships provide an opportunity to amend the ongoing colonial dynamics often present in Indigenous health care.[ii] We recommend exploring avenues to ensure that health care services are provided in ways that are culturally safe for Indigenous Peoples. We recommend that all health care professionals and organizations working with Indigenous groups receive cultural safety and humility training. Further, Indigenous learners in the health professions must be supported by creating safe and respectful clinical learning environments that are free of racism and discrimination.

   It is important to hold in mind that strategies, guidelines, and interventions created for the general population may or may not be appropriate for Indigenous Peoples, or worse, could adversely affect them. Quality standards need to support the development of strategies, guidelines, and interventions that are trauma-informed and Indigenous developed, led, and

implemented. These should not only respond directly to the Truth and Reconciliation Commission (TRC) of Canada's 94 Calls to Action, but also acknowledge the impact of continued colonial policies and programs today.

Implementation of standards of care for Indigenous Peoples without system change will be incremental and insufficient to address the magnitude of the burden.

2. *Other high-risk groups:* Diabetes is a disease that brings with it many serious health challenges that disproportionately affects certain groups of Canadians including African, Arab, Asian, Hispanic, and South Asian. While the quality standards include high-risk groups as a risk factor for diabetes, they do not provide guidance on how the quality standards can be implemented differently among high-risk groups, based on their unique priorities and needs. Improvements in diabetes management and care means that everyone has access to culturally relevant care when and where they need it. Culturally appropriate tools need to be developed in collaboration with high-risk groups to support them in preventing diabetes and its complications. For instance, healthy behavioural interventions, such as healthy eating interventions need to be inclusive of all cultural dietary patterns to make it easier for people to adopt a healthy and culturally appropriate diet.

3. *Patient-centered care:* Diabetes Canada supports quality statement 1, which supports self-management education and support: "People with type 1 diabetes and their family and caregivers are offered an individualized, structured self-management education and support program at diagnosis and on an ongoing basis." However, it should be highlighted that the structured self-management education and support programs will be patient-centered. Patient-centered care ensures that the care provided to people living with diabetes is respectful and responsive to individual patient preferences, needs, and values, while ensuring that patient values guide all clinical decisions.

4. *Type 1 diabetes complications:* The quality indicators section, "Indicators That Can Be Measured Using Provincial Data," lists pancreatitis as a complication of type 1 diabetes. Pancreatitis is not a type 1 diabetes complication and should therefore be removed from the quality indicators section.

5. *Access to medications, devices, and supplies:* People living with diabetes should have appropriate and equitable access to the medications, devices, and supplies that best suits their clinical needs and personal context, including insulins, medications to reduce risk of complications, devices to deliver the medication, a continuous glucose monitor (CGM), Flash Glucose Monitor, or SMBG strips. Access to the right medications, devices, supplies, and services with appropriate education and support, helps people living with diabetes achieve optimal health

outcomes.

6. *Education and support programs:* The quality statement 1 section, Diabetes Self-Management Education and Support, lists components that should be included in education and support programs. The glucose monitoring component should be amended to: "Glucose monitoring, including targets for glucose control (self-monitoring of blood glucose and glycated hemoglobin [hemoglobin A1C] levels, *time-in-range if using continuous glucose monitoring*, available monitoring devices, and interpreting and using results for decision-making)."

7. *Cardiovascular protection therapies:* The role of cardiovascular protection in people living with diabetes is critical to optimal care. We suggest a specific quality statement about the use of cardiovascular protection therapies. Diabetes significantly accelerates the development of cardiovascular disease compared to individuals without diabetes. Cardiovascular protection therapies have been shown to significantly reduce the morbidity and mortality associated with cardiovascular disease and are an important cornerstone of the management of diabetes.[iii] These protective therapies (when appropriate) include: statin, angiotensin-converting enzyme inhibitor or aldosterone receptor blocker, anti-platelet therapies, glucagon-like-peptide-1 receptor agonists, and sodium-glucose-cotransporter-2 inhibitors.

8. *Type 1 and type 2 diabetes case differentiation:* The ability to distinguish between type 1 and type diabetes is important for clinical quality improvements in care, since management strategies vary between the two types of diabetes. Unfortunately, the majority of administrative databases (e.g. Ontario Diabetes Database, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Canadian Chronic Disease Surveillance System) do not differentiate between type 1 and type 2 diabetes. Therefore, for the quality indicators, "*Indicators That Can Be Measured Using Provincial Data*," the methodology (including the algorithms) that will be used to compute the denominator, total number of people with type 1 diabetes, should be provided as it intends to differentiate between type 1 and type 2 diabetes.

Diabetes Canada is an organization that produces world-renowned, evidence-based clinical practice guidelines and represents health care providers who practice evidence-based medicine. Treatment standards should be based on currently available evidence and widely adopted by health care providers, organizations, and people living with diabetes. We look forward to people living with diabetes, health care providers, and organizations in Ontario having access to the quality standards for type 1 diabetes.

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DIABETES CANADA

Sincerely,

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[i] Foley, W. & Schubert, L. Applying strengths-based approaches to nutrition research and interventions in Australian Indigenous communities. J Crit Dietetics. 2013; 1(3):15–25.

[ii] Jacklin KM, Henderson RI, Green ME, Walker LM et al. Healthcare experiences of Indigenous people living with type 2 diabetes in Canada. CMAJ 2017: 189(3): E106-E112.

[iii] Diabetes Canada Clinical Practice Guidelines Expert Committee, Stone JA, Houlden RL, Lin P, Udell JA, Verma S. Cardiovascular Protection in People With Diabetes. Can J Diabetes. 2018;42 Suppl 1:S162–9.