



**Summary of Diabetes Canada  
Diabetes 360°  
Ontario Roundtable**

**September 24, 2019**

# Table of Contents

- CONTEXT .....3
  - DIABETES IN ONTARIO.....3
  - DIABETES 360 ° .....3
- ABOUT THE ROUNDTABLE.....4
  - Objectives:.....4
  - Participants:.....4
- KEY THEMES .....5
- PARTICIPANT PRIORITIES .....6
- DISCUSSION QUESTIONS .....6
- NEXT STEPS.....9
- PARTICIPANTS LIST..... 10

## CONTEXT

On September 24, 2019, Diabetes Canada brought together more than 50 key stakeholders from across Ontario for a high-level discussion aimed at laying the groundwork for a comprehensive provincial diabetes strategy based on the [Diabetes 360°](#) framework.

## DIABETES IN ONTARIO

In Ontario today, more than 4.4 million people, or 29 per cent of the population, live with prediabetes or diabetes – and every six minutes in our province someone new is diagnosed with this progressive, chronic disease. Once thought to be a disease of older individuals, type 2 diabetes is now increasingly being diagnosed in working age or younger people, impacting Ontarians in the prime of their life. Young adults now 20 years old face a 50 per cent chance of developing diabetes in their lifetime; for First Nations, that risk is up to 80 per cent.

The impact on individuals, families and our health care system is crippling. Diabetes reduces quality and length of life, and contributes to 30 per cent of strokes, 40 per cent of heart attacks, 50 per cent of kidney failure requiring dialysis, and 70 per cent of non-traumatic limb amputations. It is a leading cause of vision loss in working age (aged 20-65) Ontarians. People with diabetes also are at greater risk of depression and other mental health challenges, and people living with serious mental illnesses are at greater risk of developing diabetes. Treating the disease will cost our health-care system a staggering \$1.5 billion this year alone.

Simply put, it is a disease that Ontario cannot afford to ignore. Urgent action is needed to stem the tide of diabetes – and the time to act is now. With the health-system transformation currently underway, Ontario has an unprecedented opportunity to take bold action to address this public health crisis, help ease the burden on our hospitals and health-care system and improve health outcomes for Ontarians with diabetes.

## DIABETES 360°

[Diabetes 360°](#) is an adaptable strategic framework developed by Diabetes Canada in partnership with more than 100 stakeholder organizations, to help all levels of government build or enhance strategies to tackle the diabetes epidemic and deliver results. It is modelled on a proven, ambitious approach implemented globally to combat HIV/AIDS and includes specific evidence-based recommendations aimed at enhancing prevention, screening, treatment and outcomes.

It is set up to deliver results in just seven years by focusing on four key targets:

- 90 per cent of Canadians live in an environment that preserves wellness and prevents the development of diabetes
- 90 per cent of Canadians are aware of their diabetes status
- 90 per cent of Canadians living with diabetes are engaged in appropriate interventions to prevent diabetes and its complications
- 90 per cent of Canadians engaged in interventions are achieving improved health outcomes

## **ABOUT THE ROUNDTABLE**

### **Objectives:**

The specific objectives for the Roundtable were to:

- Gauge appetite among stakeholders to shape a diabetes strategy for Ontario
- Explore possible governance and accountability structures
- Identify early wins and next steps for shaping such a strategy

### **Participants:**

The day-long Roundtable brought together more than 50 participants from across the province, representing key stakeholder groups including:

- people living with diabetes
- health care providers and researchers
- diabetes education clinics/programs, family health teams and community health centres
- Indigenous health organizations
- mental health organizations
- public health units, Local Health Integration Networks and Health Quality Ontario
- provincial and national professional associations
- digital health experts
- life sciences partners
- government
- diabetes organizations, other health charities and community-based groups

The session began with a presentation by Diabetes Canada to help frame and inform discussions, followed by roundtable and whole-group discussions throughout the course of the day.

While this report provides a summary of the day's discussions and participants'

recommendations, the main takeaway is the broad consensus shared by Roundtable participants that Ontario needs concerted and coordinated action to stem the diabetes epidemic in our province. We need a comprehensive strategy like [Diabetes 360°](#) that can provide a clear focus for action, help concentrate scarce human and financial resources, improve public health efforts, and set out specific outcomes against which progress can be measured to ensure accountability and monitor effectiveness.

## KEY THEMES

Several key themes emerged over the course of the facilitated discussions and group activities during the day-long session. These key themes drove the conversation and often focused on a central question: how do we address the diabetes epidemic in Ontario?

**Health Equity:** Participants felt strongly that health equity must be at the forefront of any strategy aimed at addressing diabetes in Ontario and included as a foundational principle and priority. A provincial diabetes strategy must strive to achieve better health outcomes for all Ontarians and address the systemic barriers that drive health inequities and lead to higher rates of diabetes and complications among certain sub-populations.

**Patient Engagement in Co-Design:** Participants emphasized the importance of engaging patients in all stages of the design and implementation process to better understand the patient experience; identify barriers that impact on patients' health; ensure services are responsive to their needs, preferences and values; and ensure patients have the right supports to take control of their own health. This is especially true for vulnerable populations that have traditionally been left out of the health services planning process.

**Collaboration:** Participants spoke to the importance of enhancing inter-professional collaboration and building well-coordinated teams (supported by enhanced data sharing and patient tracking systems); breaking down silos and increasing linkages within the health sector and across sectors (e.g. social services, municipal government, private sector); better utilizing existing health care providers, services, and resources; and leveraging existing knowledge, data and best practices to improve care and patient outcomes.

**Need for Better Data:** Participants highlighted the need to harness health and socioeconomic data to address health inequities; improve data collection and sharing to inform policy development, clinical care standards, program planning and resource allocation; and ensure ongoing monitoring and reporting to strengthen accountability and monitor effectiveness.

**Patient-Centered Care:** Participants emphasized the importance of providing holistic care that considers the patient's physical, psychosocial and financial needs; improving

coordination and integration of care; ensuring equitable access to interdisciplinary services; improving patient access to own health information; and creating “one stop shop” health hubs to make it easier for patients to access services. Participants also spoke of the need to take the burden off the patient to navigate the system and simply “go to where the people are” (e.g. pharmacies, grocery stores, recreation centres, etc.) to deliver services.

**Innovation:** Participants spoke of the potential to tailor interventions to the needs of individual patients (or patient groups) and highlighted the need to develop predictive tools to better understand who should be targeted for specific interventions. Participants also would like to see enhanced access to virtual care and use of digital health tools to support prevention and self-management programs and help empower patients to take control of their health.

## **PARTICIPANT PRIORITIES**

At the beginning of the Roundtable, delegates were asked to reflect on “***the most important thing you hope to get out of this meeting.***” Some high-level themes included:

- Alignment on moving forward on a provincial Diabetes 360° strategy
- Actionable next steps towards implementing a strategy
- Understand my role for next steps and how various stakeholders can work together
- Ensure development of an Indigenous diabetes strategy remains in the hands of Indigenous communities
- Ensure patient-centered approach & meaningful engagement of people living with diabetes in the development of a provincial diabetes strategy
- Ensure focus on health equity – strategy must address barriers to wellness and needs of marginalized communities
- Highlight opportunity to better leverage health care providers as part of integrated health care teams and in the development of a provincial diabetes strategy
- Focus on prevention as a key priority
- Opportunity to connect with other stakeholders in the room – learn from each other
- Identify champions for Diabetes 360°

## **DISCUSSION QUESTIONS**

Participants worked in groups to discuss questions outlined by Diabetes Canada. Delegates were tasked with finding commonalities among their responses and reported back to the group at large. The following summary includes key highlights from individual group and whole-group discussions.

### **Roundtable Discussion #1:**

**Question:** *“What would an Ontario Diabetes Strategy mean to me? How would it improve outcomes in my area?”*

**Discussion** (key points)

- Create accountability structure to ensure proper implementation and sustainability
- Provide a common framework for implementation; lots of great work currently going on at local level, but need overarching framework to connect across various initiatives and strategies; break down silos
- Establish common metrics – key to operationalizing across sectors
- Enhance ability to address inequities and target care
  - Focus on marginalized communities
  - Measurement and data collection to better understand the needs of vulnerable populations (and even of sub-groups within these populations) and address inequities that drive disparities in diabetes risk, treatment and health outcomes,
  - Creation of multisector partnerships (e.g. housing, social services, public health) to address inequities
  - Improved care and outcomes for specific subpopulations through targeted interventions
- Address fragmented access to care; clearly define roles and enhance linkages between various parts of health care system and across sectors to provide patients with comprehensive care and support (access to team-based care and mental health supports, diabetes education, self-management tools, social services, financial supports, technology to improve care and system navigation, etc.)
- Allow funds to be used more equitably and efficiently; leverage additional funds
- Create ripple effect across other chronic diseases; preventing and better managing diabetes can reduce incidence of other chronic conditions
- Increase awareness and understanding to “destigmatize” diabetes and shift focus away from “blame and shame” approach to diabetes prevention/management
- Improve system navigation for both patients and health care providers
- Identify best practices; leverage existing knowledge and models of care
- Encourage innovation and development of predictive tools to better understand who we should target for specific interventions / screening
- Enhance linkages between various levels of government – e.g. promote greater awareness of the role of built environment, access to recreation centers, etc. in diabetes prevention/management

**Roundtable Discussion # 2**

**Question:** *What are the top 3-5 priority elements for an Ontario Diabetes Strategy? (What issues must be tackled first? What are our opportunities for early wins?)*

## Discussion (key points):

- Conduct needs assessment and gap analysis -- data, best practices, resources, etc. -- comprehensive environmental scan looking at entire province
- Define what “success” would look like for Ontario (including specific success measures for marginalized communities)
- Leverage existing models of care and best practices
- Optimize role of various health care providers – leverage skills -- e.g. pharmacists
- Enhance collection and use of data to improve patient care, policies, clinical care standards, program planning and resource allocation
- Create data / resource / knowledge hub (portal)
- Apply health equity lens – address barriers -- focus on most vulnerable populations
- Develop tailored and targeted prevention strategies aimed at high-risk populations
- Enhance patient-centered care
  - Deliver care where people are
  - Involve patients in development of care pathways, self-management tools, education programs, support services, etc.
  - Tailor care and services for specific subpopulations
  - Address fragmented access to care and supports – e.g. health hubs
  - Focus on holistic care – create linkages among sectors / services providers to address physical, emotional, social and financial needs of patients
  - Create electronic patient portal
  - Provide training for health care providers to help with self-management
  - Improve patient navigation of services; provide support to patients as they move through system
- Ensure equitable access to interdisciplinary services; embed services together and enhance access; help patients navigate
- Enhance team-based care to improve coordination, efficiency and effectiveness
  - Create well-coordinated teams (even if under separate roof)
  - Enable secure data sharing
  - Improve system navigation and patient tracking
  - Create centralized intake system and promote resource sharing
- Develop a provincial digital health strategy; enhance access to virtual care (without losing access to one-on-one services)
- Leverage Ontario Health Teams; co-design strategy / framework with OHTs
- Ensure secure and stable funding that is equitable across the province
- Address stigma / discrimination – create a public awareness campaign to destigmatize diabetes



## NEXT STEPS

The session concluded with a whole-group discussion aimed at identifying actionable next steps for moving forward on an Ontario [Diabetes 360°](#) Strategy.

### Discussion (key points):

- Identify a task force to begin work on an Ontario Diabetes 360° Strategy
- Develop letter of support to get commitment to a strategy
- Propose a plan or create a survey to solicit input from Roundtable participants and additional stakeholders
- Identify champions – stakeholder groups, key individuals within government, health columnists / media, other key influencers, etc.
- Share information about Diabetes 360° more broadly to build support – e.g. include in webinars aimed at various groups / health care providers
- Engage government on the need for a provincial diabetes strategy; engage politicians at both provincial and municipal level
- Support development of an Indigenous diabetes strategy led by Indigenous groups
- Engage with Ontario Health Teams – OHTs will be key to operationalizing strategy
- Set up a community of practice on Quorum (through Health Quality Ontario) to enhance collaboration and engagement, sharing of best practices, tools and resources
- Advocate for improved integrated data strategy at a provincial level
- Survey landscape of existing programs -- leverage these programs and resources – don't recreate the wheel
- Leverage existing platforms -- don't need different apps for different chronic conditions; bring together partners that serve different populations onto one platform
- Leverage existing skills among health care providers – e.g. strengthen role of pharmacists in diabetes care
- Be creative in identifying cross-sectoral partnerships; create linkages with partners that are not specifically in health care (e.g. retail, transit); bring them into conversations about building healthy sustainable communities; find linkages (e.g. diabetes and climate change – impact of climate on health)
- Create a type 2 diabetes risk prediction tool for Canadians and expand the Diabetes Prevention Program across all diabetes education programs; update existing CanRisk assessment tool for specific populations – customized prediction tool – so that prevention programs can be better customized
- Support development of health coach training; adapt into digital environment
- Bringing key learnings back to respective organizations to effect change and build support

## PARTICIPANTS LIST

- **Abidah Shamji**, National Manager, Government Relations & Advocacy, JDRF
- **Agnes Coutinho**, Vice-President, Board of Directors, Indigenous Diabetes Health Circle
- **Aimee Sulliman**, Lead, Stakeholder Relations (cardiovascular, renal, and metabolic portfolio), AstraZeneca
- **Allison Weinstein**, Implementation Lead, Home & Community Care Branch, Ministry of Health
- **Ananya Banerjee**, Assistant Professor, Social & Behavioural Health Sciences | Epidemiology, Dalla Lana School of Public Health
- **Brian Halladay**, Person living with diabetes | Advocate
- **Catharine Whiteside**, Executive Director, Diabetes Action Canada
- **Charlene Lavergne**, Person living with diabetes | Advocate
- **Dana Whitham**, Clinical Leader Manager, Diabetes & Renal Transplant, St Michael's Hospital
- **Ellen MacLean**, Supervisor (Acting), Diabetes Prevention Strategy, Toronto Public Health
- **Gabriella Simo**, Manager, Advocacy – Ontario, Diabetes Canada
- **Gillian Booth**, Endocrinologist | Scientist, C-UHS, St. Michael's Hospital | Adjunct Scientist, ICES
- **Harpreet Bajaj**, Endocrinologist & Director, Late-Phase Research, LMC | Research Associate, Leadership Sinai Centre for Diabetes
- **Jake Reid**, National Director, Government Relations, Diabetes Canada
- **Jane Harrison**, Manager, WAASH-KESHUU-YAAN Unit, Anishnawbe Health Toronto
- **Jeff Mehlretter**, Director, Pharmacy Economics, Neighbourhood Pharmacy Association of Canada
- **Jen Hanson**, Executive Director, Connected in Motion
- **Jennifer MacKinnon**, Director, Primary Care, NE LHIN
- **Jill Hamilton**, Head, Division of Endocrinology, Sick Kids
- **Joanne Lewis**, Director, Knowledge Management, Diabetes Canada
- **Joseph (Joe) Cafazzo**, Wolfond Chair in Digital Health | Lead, Centre for Global e-Health, UHN
- **Joe-Anne Chaput**, Primary Care Clinic Coordinator, Misiway Milopemahtesewin CHC
- **John Armstrong**, Chair, Ontario Chronic Disease Prevention Alliance (OCDPA)
- **Kasia Luebke**, Director, System & Sub-region Planning & Integration, Central East LHIN
- **Kimberley Hanson**, Executive Director, Federal Affairs, Diabetes Canada
- **Lisa Bitonti-Bengert**, Director, Clinical Improvement & Informatics, Health Quality Ontario
- **Lori MacCallum**, Program Director, Knowledge Translation & Optimizing Care Models, Banting & Best Diabetes Centre

- **Lori Sutton**, Regional Facilitator, Toronto Diabetes Care Connect, South Riverdale CHC
- **Lorraine Lipscombe**, Division Director, Endocrinology & Metabolism, Women's College Hospital
- **Lynn Woods**, Manager, DEP & Chronic Disease Wellness Centre, Mackenzie Health | Central LHIN DEP Leaders Collaborative
- **Margaret (Maggie) Hahn**, Research Director, Mental Health & Metabolism Clinic, CAMH
- **Maria Consuelo Cenizal**, Manager, Chronic Disease & Mental Health, Flemington CHC
- **Mark Palmert**, Associate Chair (Ambulatory Care) Paediatrics, Sick Kids
- **Marko Perovic**, Senior Manager, External Affairs, Novo Nordisk
- **Michael Green**, Head, Department of Family Medicine | Director, Health Services & Policy Research Institute, Queen's University
- **Monica Slovynec D'Angelo**, Director, Health, Conference Board of Canada
- **Noah Wayne**, Director, Clinical Programs | Chief Privacy Officer, NexJ Health
- **Oria James**, Person living with diabetes | Advocate
- **Patrick Tohill**, Director, Government Relations, JDRF
- **Paul Bailey**, President, Black Health Alliance
- **Paul Oh**, Medical Director, Cardiovascular Prevention & Rehabilitation Program, Toronto Rehab
- **Rachel Moon-Kelly**, Manager, Chronic Disease & Injury Prevention Northumberland Public Health
- **Russell Williams**, Senior Vice-President, Mission, Diabetes Canada
- **Sandeep Gill**, Clinical Knowledge Translation & Exchange Specialist, Association of Family Health Teams of Ontario (AFHTO)
- **Sanya Khan**, Project Manager, Healthy Communities Initiative, Central West LHIN
- **Seema Sethi**, Project Implementation & Team Lead, Home & Community Care Branch, Ministry of Health
- **Sohail Gandhi**, President, Ontario Medical Association
- **Stacey Livitski**, Person living with diabetes | Advocate
- **Surkhab Peerzada**, Regional Manager, Chronic Disease | Choose Health Self-Management Program  
South Riverdale CHC
- **Susie Jin**, Pharmacist & Certified Diabetes Educator
- **Trish Topping**, Senior Manager, Self-Management Program, Central East LHIN
- **Wendy Bahn**, Coordinator, Alliance for Healthier Communities