DIABETES CANADA

URBAN DIABETES SUMMIT

Conference Report

Acknowledgements

Report Author

Lisa Dias

Sustaining Momentum in Implementing the Diabetes Framework (SMIDF) Team

Adria Cehovin, MSc (Project Manager),
Hiba Syed, BSc (Support Coordinator), and
Maleka El Naghi, MPH (Health Equity and Evaluation Officer)

We would like to thank all presenters and attendees for their contributions to the Urban Diabetes Summit.

Note on Indigenous Engagement and a National Diabetes Framework

In respect to Reconciliation and in recognition of Indigenous autonomy, self-determination, and sovereignty, the Public Health Agency of Canada has provided independent funding to the National Indigenous Diabetes Association (NIDA). NIDA is engaging with various Indigenous peoples, nations and organizations across Canada to develop an Indigenous Diabetes Framework. Through supporting open dialogue, NIDA sits on the Diabetes Canada/SMIDF's Pan-Canadian Action for Diabetes committee to promote mutual knowledge exchange and collaboration. For more information about NIDA, please visit www.nada.ca

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1.0 Executive Summary

On March 3, 2025, Diabetes Canada, through support from the Public Health Agency of Canada, hosted an Urban Diabetes Summit in Edmonton, Alberta. The summit brought together approximately 35 participants from across Canada to share knowledge and engage in dialogue about diabetes care in urban contexts. In alignment with the Diabetes Framework in Canada, throughout the meeting, the principle of health equity was discussed and considered during summit proceedings.

Participants from Western and Central Canada were in attendance, including stakeholders from the following sectors:

- healthcare professionals;
- diabetes researchers;
- health equity researchers and advocates;
- non-governmental organizations (NGOs);
- public health and government leaders.

The summit brought together these diverse stakeholders to share knowledge about initiatives, programs, and services in urban settings, followed by a dialogue about successful diabetes care and potential improvements to facilitating more equitable and effective care for Canadians. Centered around diabetes care in urban settings, presentations were delivered by attendees. The presentation topics explored different models of diabetes care delivery, public health approaches to diabetes prevention, lived experience of navigating the healthcare system, and initiatives to support more equitable diabetes prevention and care for equity-deserving groups.

Following the presentations, summit participants engaged in dialogue about diabetes prevention and care in urban regions. Participants were encouraged to identify key health priorities, assess existing efforts including barriers and facilitators, and explore opportunities for improvement. Findings from the discussions identified key health priorities, including strengthening primary care collaboration, improving health communication, supporting capacity-building, ensuring continuity of care, and addressing intra- and inter-provincial variations in care.

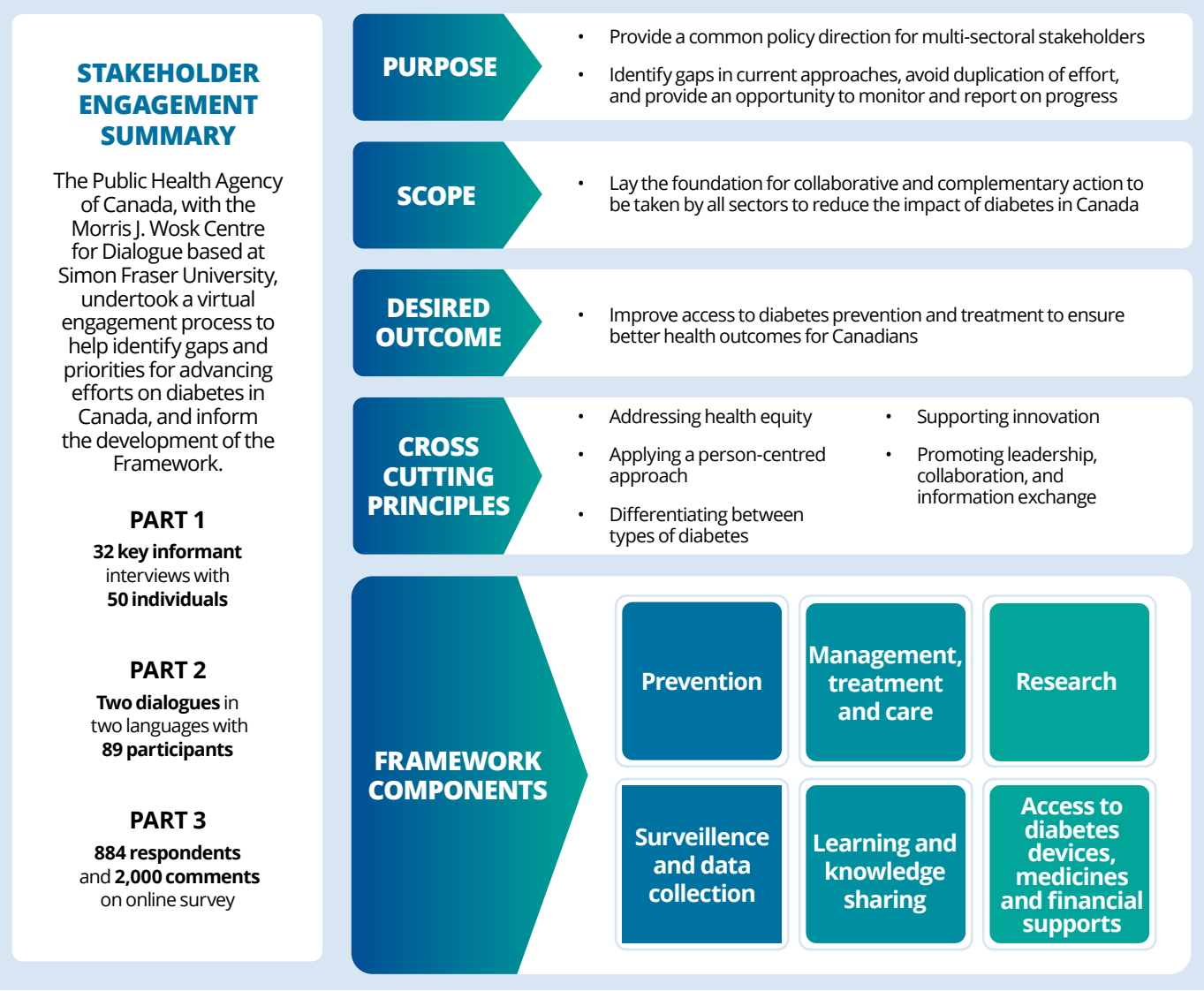
2.0 The Framework for Diabetes in Canada and SMIDF Overview

Diabetes Canada is a national health charity representing more than four million people in Canada diagnosed with diabetes. Diabetes Canada leads the fight by helping those affected by diabetes live healthy lives and addressing the onset and consequences of diabetes. In partnership with the Public Health Agency of Canada (PHAC), Diabetes Canada is engaging in a three-year project, Sustaining Momentum to Implement the Diabetes Framework (SMIDF). The Diabetes Framework, officially referred to as the Framework for Diabetes in Canada, was presented by the Government of Canada in 2022. The Diabetes Framework aims to support prevention and treatment for all types of diabetes and provides a common policy direction to address diabetes in Canada (PHAC, 2022). The Diabetes Framework also supports the identification of gaps in current diabetes care approaches, promotes reducing duplication of effort, and provides the federal government an opportunity to monitor and report on progress (PHAC, 2022). The Diabetes Framework is comprised of six interdependent and interconnected components of diabetes efforts, including:;

- Prevention;
- Management, treatment, and care;
- Research;
- Surveillance and data collection;
- Learning and knowledge sharing; and;
- Access to diabetes devices, medicines, and financial support.

A summary of the Framework for Diabetes in Canada is provided in Figure 1.

Figure 1: Visual of the Framework for Diabetes in Canada (PHAC, 2022)



3.0 About the Urban Diabetes Conference

The Urban Diabetes Summit was held in Edmonton, Alberta, on March 3, 2025, to facilitate cross-sector and provincial engagement, knowledge exchange, and intentional dialogue on diabetes care and prevention in urban settings. The conference drew approximately 35 participants from Western (British Columbia, Alberta, Saskatchewan, and Manitoba) and Central (Ontario) Canada.

Those in attendance represented different sectors, including the following stakeholder groups:

- healthcare professionals;
- diabetes researchers;
- health equity researchers and advocates;
- non-governmental organizations (NGOs);
- public health and government leaders.

Knowledge exchange was facilitated through formal presentations led by conference attendees, followed by guided discussions. The presentations provided context and deeper understanding of some initiatives and experiences in diabetes care and prevention across urban Canadian settings. The presentation topics included different approaches to diabetes care delivery, strategies for diabetes prevention in public health, personal experiences with the healthcare system, and initiatives aimed at promoting equitable diabetes prevention and care for underserved communities.

Following the conference presentations, attendees participated in guided dialogue about successes and challenges in diabetes care. The multi-stakeholder dialogue was informed by the following objectives:

- Identify key health priorities
- Assess existing successes in diabetes care
- Examine current barriers, gaps, and areas for improvement
- Consider short- and long-term changes to support improvement

These objectives and corresponding questions prompted purposeful dialogue to assess current diabetes care efforts, identify barriers or gaps, and develop action steps for both immediate and long-term improvements in diabetes care. Conference presentations are described below in *4.0 Conference Presentations*, and the process and outcomes from the guided dialogue are provided in section *5.0 Group Discussions*.

4.0 Conference Presentations

Presentation Topic	Presenter
Welcome and Land Acknowledgement	Peter Senior, BMedSci, MBBS, PhD, FRCP, FRCP(E) Kathy Dmytruk, BSc, RD
Overview of the Framework for Diabetes in Canada	Adria Cehovin, MSc
4.1 Diabetes Centre Calgary, Adult Specialty Diabetes Clinic, Alberta Health Services	Julie McKeen, MD, FRCPC
4.2 Health Equity and Diabetes in Alberta	Doreen Rabi, MD, MSc, FRCPC
4.3 Peel's Public Health Approach to Chronic Disease Prevention	Philip Cavicchia, PhD
4.4 South Asian Health Institute (SAHI): Program Overview	Shagun Tiwari, BSc Divya Sandhu, MPH
4.5 Unlocking Hope Diabetes Project, IDEA Diabetes	Barbara MacDonald, RN, BSN, MS-DEDM, CDE
4.6 Diabetes Mobile Clinic, Calgary	David Campbell, MD, FRCPC, PhD
4.7 Patient and Family Perspective on Diabetes Care	Renea Marsden

4.1 Julie McKeen— Diabetes Centre Calgary, Adult Specialty Diabetes Clinic, Alberta Health Services

Julie McKeen is the Medical Director of the Diabetes Centre Calgary (DCC) and clinical assistant professor in the Department of Medicine at the Cumming School of Medicine, University of Calgary. She has clinical expertise in endocrinology, including diabetes, diabetes in pregnancy, thyroid disease, reproductive disorders, pituitary disease, and adrenal disease.

McKeen provided an overview of the DCC services, emphasizing its role as part of a larger endocrinology and metabolism program across Calgary. DCC serves a large and diverse patient population with type 1 and type 2 diabetes, including those requiring insulin pump therapy and individuals requiring diabetes care during pregnancy. The centre operates across six outpatient locations, including two community care sites serving those that are more socioeconomically challenged, and offers diabetes in pregnancy and inpatient navigator services across four acute care sites.

DCC consists of an interdisciplinary team, including diabetes educators (nurses, dieticians, pharmacists) and psychosocial support staff, who work collaboratively with referring practitioners to address the varying care needs of patients. Diabetes educators play multiple roles and work to their full scope of practice, providing diabetes self-management education, supporting clinical management, and communication and advocacy, along with providing person-centered care. DCC services are accessed through a centralized endocrinology triage system (Endocrinology Central Access and Triage, ECAT) allowing referrals from primary care providers, specialists and acute care providers across Calgary, southern Alberta, and eastern British Columbia. Currently, self-referrals to DCC are not accepted, as ongoing care from a primary and/or specialty care provider is required. However, DCC does support patients in finding a primary care provider by connecting them to the provincial "Alberta Find a Family Doctor" website (identifies family doctors throughout the province that are taking new patients), and/or connecting patients to walk-in primary care services that have capacity. Access to a DCC diabetes educator is independent of a referral to see an endocrinologist, so endocrinologists are not gatekeepers into the program. To further reduce barriers to access, DCC care is delivered through various modes, including in-person, telephone, virtual, and email consultations.

DCC serves a high-needs patient population that requires frequent visits throughout the year. In 2024 alone, DCC conducted 3,639 new patient appointments and 34,863 follow-up appointments. The challenge that DCC faces is that the prevalence of diabetes is increasing, and diabetes care is becoming much more complex, while funding to support patients remains static. This challenge requires that the program be adaptable to shifting needs and circumstances. One approach to addressing capacity challenges is implementing virtual group classes for diabetes in pregnancy (DIP), and in-person and virtual group classes for insulin pump education and insulin pump starts.

Administrators and support staff are continually assessing needs and making changes to improve access and patient care. System performance is monitored through tools such as a dashboard that provides real-time data. The centre also prioritizes system efficiency through Alberta Health Services (AHS) digital tools like Connect Care (the provincial electronic medical record used by all speciality ambulatory clinics within Alberta Health Services) and Access Owl (a Tableau dashboard that provides patient access analytics). Ensuring efficiency in the system is also achieved by supporting staff. Staff are encouraged to share their perspectives on improving care quality, and they have access to local, national and international comprehensive guidelines and resources to support evidence-based decision-making for any patient care situation. Novel programs layered within clinics also support research and innovation.

McKeen's presentation highlighted DCC's commitment to providing quality diabetes care while remaining adaptable in the face of increasing demands on the healthcare system. The DCC also demonstrates a commitment to capacity building through community partnerships with clinics, primary care networks, pharmacists, and vendors, and by promoting continued education for all clinicians and staff.

For additional information on the services discussed, please visit: www.diabeteseducatorscalgary.ca and www.endometab.ca

4.2 Doreen Rabi—Health Equity and Diabetes in Alberta

Doreen Rabi is a faculty member at the Cumming School of Medicine, University of Calgary and a member of the Libin Cardiovascular Institute. At the Cumming School of Medicine, she is a professor across departments including, Medicine, Community Health Sciences, and Cardiac Sciences.

At the summit, Rabi highlighted the importance of health equity in diabetes care, emphasizing how fostering equity requires addressing the unique context-specific needs of an individual rather than providing the same resources to everyone. She underscored how individuals are shaped by their multiple intersecting social locations and identities, influencing how they experience a diabetes diagnosis and care within an inequitable healthcare system. Diabetes related stigma and shame can exacerbate challenges for people living with diabetes as they navigate self-management of illness, seek care in healthcare settings, and access broader social supports. Rabi shared how in Alberta, there is a dedicated diabetes strategy that is intentionally working to embed health equity in diabetes care. A Diabetes Working Group (DWG) was created in 2022 to review diabetes care across the province and provide recommendations through a health equity lens. The DWG produced a final report in Spring 2024 and has begun sharing initial recommendations.

Since initial recommendations were shared, the province has started implementing changes that impact diabetes management, treatment, and care, and improve access to diabetes devices and medicines. For example, provincial health benefits now cover continuous glucose monitors (CGMs) for adults, whereas previously, only individuals under 18 could access the benefit. Additionally, efforts are underway to broaden access to care for other diabetes technologies, specifically insulin pumps. Since 2013, the province has provided insulin pump coverage for eligible individuals with type-1 diabetes however, inequitable access to the technology persists due to barriers in receiving primary care referral. There is an ongoing effort to improve access to this diabetes technology, especially outside of urban centers, ensuring those living in more rural or remote areas have inclusive and accessible access.

Rabi also described how the organizational landscape for supporting diabetes care in Alberta has evolved with a focus on building partnerships with communities, including involving people with diabetes. One such commitment was the Diabetes, Obesity, and Nutrition Strategic Clinical Network (SCN), overseen by Alberta Health Services (AHS), which previously focused on closing gaps in care quality. This network has dispersed due to restructuring within AHS. However, another promising organizational commitment is the Provincial Diabetes Steering Committee, consisting of clinical experts, operational leaders, and people with diabetes, who focus on identifying priority needs in diabetes care and are accountable for addressing the initial recommendations offered by the DWG. The steering committee also functions as a forum for shared learning, collaboration, and closing communication gaps.

In addition to provincial-level organizational commitments, work is underway to develop key partnerships aimed at promoting trauma-informed and dignity-focused care, particularly for Indigenous communities, newcomer populations, and vulnerable populations, such as those experiencing housing insecurity. A goal of these partnerships is to ensure that those most impacted by diabetes care decision-making are integrated in efforts to improve quality care. Several initiatives were discussed that aim to improve health system navigation and support more equitable access to diabetes care. One such initiative is the Multicultural Health Brokers Cooperative which offers newcomers who are waiting for opportunities to become licensed practitioners to become healthcare navigators and support fellow newcomers in learning about the healthcare system.

These key partnerships are opportunities for communities and patients to be a part of creating change in diabetes care across Alberta. While these opportunities are promising, there are also social and political factors that pose challenges for diabetes care in the province. Rabi outlined ongoing challenges, including a rapidly changing political climate that impacts the integration of care, large percentage of the population without access to a primary care clinician, limited services to support onboarding for increasing newcomer groups coupled with negative public discourse on immigration, and threats to equity, diversity, and inclusion (EDI) programming and policy due to antagonistic sentiments. Additionally, there is a need to address COVID-19 denialism through improved communication and education efforts since COVID-19 remains a concern for people with diabetes who are at risk of worsening health outcomes if they experience infection.

In the face of these challenges, Alberta's diabetes strategy continues to evolve with a focus on closing gaps in access to diabetes care, medical devices, and medicine, fostering partnerships and collaboration among different groups (e.g., clinicians, researchers, and patients) and communities, and incorporating a health equity lens to diabetes strategies and initiatives.

4.3 Philip Cavicchia—Peel's Public Health Approach to Chronic Disease Prevention

Philip Cavicchia, PhD, is the Manager of Healthy Eating, Active Living, Mental Health Promotion Chronic Disease and Injury Prevention Division at Peel Public Health. Cavicchia shared a detailed overview of the Peel region's public health initiatives aimed at chronic disease prevention, including diabetes. The Region of Peel is part of the Greater Toronto Area and is a densely populated area with 1.45 million residents across three municipalities. The population is highly diverse, where 69% of residents identify as a part of a racialized group, as high as 81% in the city of Brampton; South Asian is the most commonly identified racialized group. The region faces a high diabetes burden, with 1 in 6 adults living with the condition and the second-highest 10-year diabetes risk in the province (between 2020 and 2030).

To address the prevalence of diabetes and other chronic health conditions, Peel Public Health takes a population health approach aimed at improving the overall health of the community while working to reduce health inequities experienced by different population groups. The population health approach also uses a life-course perspective that recognizes how health risks and opportunities change throughout different life stages and have a cumulative effect over time. From this approach, Peel Public Health is engaging in health promoting initiatives, targeting the upstream social and environmental factors that influence health, including food insecurity and the built environment.

Examples of key public health prevention strategies in Peel include:

- Assessment and surveillance (e.g., Peel Health Data Zones for tracking diabetes prevalence and incidence)
- Building healthy public policy that supports chronic disease prevention
- Creating supportive environments that make the healthy choice the easy choice
- Strengthening community action through partnerships
- Building awareness to educate and engage residents

Examples of these strategies in action include a faith-based settings initiative that works with faith leaders to encourage greater uptake of healthier food options and physical activity through education and promotion, and making changes within shared community settings, such as installing water refill stations and replacing deep fryers with commercial ovens. Household food insecurity is also being addressed with a nutritious food basket survey and food affordability monitoring. Information and data generated through these tools are used to increase community partners' and decision-makers' understanding of household food insecurity to improve community support for those most impacted by food insecurity.

Peel region is also addressing diabetes and chronic disease prevention through healthy built environment initiatives recognizing that community planning and design plays a crucial role in health promotion. For example, walkable and transit-oriented environments encourage physical activity, which can support physical health and mental well-being. To develop healthier and more complete communities, the Region of Peel implemented the Healthy Development Framework, which requires a health assessment for municipal development applications. The Healthy Development Assessment focuses on six core elements including density, service proximity, land use mix, street connectivity, streetscape characteristics and efficient parking.

Successful prevention efforts require capacity building and ongoing collaboration with partners and the community. Peel Public Health continues to work closely with community groups, social services, municipalities, and healthcare system partners to enhance the impact of public health initiatives with the aim of enhancing diabetes prevention at both individual and system levels.

To learn more about public health initiatives in the Region of Peel, visit:

- Peel Health Data Zone Information Tool - peelregion.ca
- Healthy communities - peelregion.ca
- Peel Walkability Composite Index - Comparison Tool

4.4 Shagun Tiwari and Divya Sandhu—South Asian Health Institute: Program Overview

Shagun Tiwari and Divya Sandhu's presentation highlighted the role of health equity and culturally appropriate health promotion in diabetes prevention. Tiwari and Sandhu support the South Asian Health Institute (SAHI), housed in the Equity, Diversity and Inclusion (EDI) department at Fraser Health, whose work is centered on engaging and empowering South Asian communities in the region to achieve better health and wellbeing. Given that South Asians are one of the fastest growing populations in Canada and are the largest visible minority group in Fraser Health region, SAHI plays an important role in supporting the delivery of equitable and culturally responsive health promotion and care.

SAHI was established in 2013 in response to the high prevalence of chronic health conditions, including diabetes, in South Asian communities in Fraser Health region. The institute aims to understand and address health disparities by focusing on promoting healthy living and wellness, engaging communities, and enhancing collaboration and partnerships. Their upstream approach to prevention includes capacity building while addressing systemic barriers on health access.

Examples of specific actions that SAHI has undertaken include attending cultural events to enhance food literacy, producing accessible educational materials and content and working with children and youth to explore the relationship between food, stigma, and labels. Additionally, South Asian volunteers participate in community outreach and provide services to foster more culturally and linguistically inclusive programming and care. SAHI team members also participate in roundtables and working groups bringing insights back to Fraser Health to inform the health authority's programming and services.

Alongside providing SAHI owned resources in various South Asian languages, SAHI offers informal consultations. The consultations support Fraser Health programs and communities by guiding them in promoting accessibility, including advising on the use of translated materials and ensuring content is culturally relevant to meet the unique needs of South Asian communities. Through community outreach and partnerships, SAHI continues to support equitable and inclusive diabetes prevention, promoting overall wellbeing in South Asian communities.

SAHI's websites: www.fraserhealth.ca/sahi

4.5 Barbara MacDonald—Unlocking Hope Diabetes Project, IDEA Diabetes

Barbara MacDonald is a cofounder of IDEA Diabetes, a collective that aims to improve health and quality of life for people living with diabetes by advancing an empowerment centered approach to diabetes self-management and care.

MacDonald shared how hope, power, and action are core principles guiding the work of IDEA Diabetes. The principle of hope emphasizes that individuals are deserving of the best possibilities in their care and self-management. A focus on hope fosters a sense of possibility and creates supportive, safer spaces for people with diabetes. The principle of power focuses on shifting towards strengths-based care and empowering individuals through inclusive, person-centred language. This includes reframing communications from prescriptive (e.g., "you should") to collaborative (e.g., "let's figure this out together) language and working towards reducing stigma in diabetes discourse. The principle of action highlights the importance of taking purposeful steps to improve diabetes care by assessing the current landscape, envisioning desired outcomes, and implementing strategic actions. IDEA Diabetes applies the principles of hope, power, and action to create meaningful and equitable change in diabetes care.

One innovative initiative that IDEA Diabetes is engaged in is the Unlocking Hope Diabetes Project, a proof-of-concept project designed to identify community-driven solutions in diabetes care for First Nations people. The community engaged project works with First Nations communities across four provinces, British Columbia, Saskatchewan, Ontario, and New Brunswick, to collaboratively identify existing strengths, cultural values, and local expertise and to generate a multi-level plan for diabetes, including the development of clinical protocols and policies. Through cooperative dialogue, mentorship, capacity-building and virtual support, the IDEA Diabetes team will work with 5 to 10 champions living with diabetes to develop solutions. In addition to inspiring hope, relationship building and taking time to build trust is central to the collaborative work undertaken with the champions and communities participating in this project.

To learn more about IDEA Diabetes and their work, visit: www.idea-diabetes.com

4.6 David Campbell—Diabetes Mobile Clinic, Calgary

Mobile clinics are a form of healthcare service delivery increasingly used to address barriers to accessing care in underserved communities. David Campbell, an endocrinologist/diabetes specialist and associate professor at the University of Calgary's Department of Medicine, described the development and deployment of the Diabetes Mobile Clinic (DMC) in Calgary serving inner-city vulnerable populations, particularly individuals experiencing homelessness.

In collaboration with the Calgary Diabetes Advisory Committee (CDAC), the DMC was developed in response to disparities in diabetes care among vulnerable and underserved groups. Using existing research about the target populations and service access data, the team identified communities in Calgary where there was a need for an alternative service delivery model. The team partnered with a local community organization, the *Alex Community Health Centre*, which was already operating a primary care mobile health bus, to deliver comprehensive diabetes care in mobile settings.

The DMC has been operating since June 2024, providing essential diabetes care, including:

- Retinal photography with remote teleophthalmology to provide diagnostics and subsequent expedited referral pathways to local retinal specialists as needed
- Diabetes related monitoring through point-of-care A1C testing and urine protein testing
- Foot assessment and basic foot care provided by a trained nurse
- Diabetes education provided by certified diabetes educators
- Diabetes specialist consultations and follow-up care

The DMC aims to be a one-stop shop for diabetes care where practitioners can work to their full scope of practice, reducing barriers to accessing care. Since it began operating less than one year ago, the DMC has served 125 individuals, delivered 119 nursing appointments, 97 sessions with diabetes educators, and 40 endocrinology consultations. Currently, the team is conducting an implementation study to understand all stakeholder perspectives on the DMC model of service delivery and to assess long-term sustainability. In the future, the team aims to conduct a randomized control trial to rigorously measure if the DMC model improves patient attendance and health outcomes.

The DMC is a promising model for delivering diabetes care to underserved and vulnerable groups; however, Campbell underscored ongoing challenges and opportunities. In the context of DMC service delivery, data and surveillance were highlighted as key issues. While the DMC facilities ease access to point-of-care testing (e.g., A1C testing), tracking long-term outcomes remains difficult due to incompatibility between electronic medical records (EMR). Additionally, to sustain the DMC model, there is a need to encourage public investment (i.e., sustainable funding) to ensure consistent administration and enhanced integration of the service into the healthcare system.

By integrating multiple services into a mobile care delivery model, the DMC is addressing inequities in access to diabetes care and support. This initiative has the potential to improve health outcomes for underserved communities and reduce the burden on the healthcare system.

To learn more about the Calgary Diabetes Advocacy Committee and the DMC, visit: www.calgarydac.ca

4.7 Renea Marsden—Patient and Family Perspective on Diabetes Care

Renea Marsden, both a professional working in the diabetes field and a parent of a child diagnosed with type 1 diabetes, shared her experience navigating the challenges of a diagnosis. Marsden recounted the uncertainty leading up to her daughter's diagnosis, describing how symptoms were initially difficult to interpret. Following a medical appointment and bloodwork, the family received a call from the doctor urging them to attend the hospital immediately, where a type 1 diabetes diagnosis was confirmed.

Marsden highlighted the systemic challenges that followed a diabetes diagnosis, including lack of guidance, unanswered questions in clinical encounters, and dismissive comments, such as "at least it's not cancer" and "is that the "bad" diabetes?". Motivated by these experiences, Marsden became an advocate, working with organizations like the Juvenile Diabetes Research Foundation (JDRF) and the Alberta Diabetes Foundation to support others experiencing similar struggles.

Sharing her experiences as an advocate and family caregiver, Marsden highlighted gaps in the healthcare system noting that there is often a lack of a clear pathway for care and support for those diagnosed with diabetes and the transition from pediatric to adult care can leave patients with inadequate care or no care at all. Other systemic challenges include barriers to important social and economic supports, such as delays in receiving medical tax credits.

Within my position, I take several phone calls a month from patients who are overwhelmed and lost with what to do next after a diagnosis. For most the access in part with affordability of the medications needed is sometimes a barrier too great for those diagnosed. They opt to reduce or eliminate the mediations altogether due to finances or lack of education on the matter. This leads to bigger issues down the road with complications. With my own daughter, our experience with the coverage of certain devices which provide a standard of care as deemed by medical field researchers, Clinicians and professionals are outside of reach due to affordability. We even had a benefits company comment to our claim that it is considered a "luxury" to have a CGM and not medically necessary. An insurance company should not be deciding what is a "luxury" for a person with type one diabetes, which would lead to a clear definition and understanding if what is considered a standard of care and how it improves the lives and longterm health of those with the disease.

She concluded by calling for change, encouraging improvements in models of care and support for all those affected by diabetes.

5.0 Group Discussions

Following the summit presentations, which provided a deeper understanding of diabetes care in urban regions, attendees had the opportunity to organize into smaller groups and discuss priority areas to enhance successful diabetes care and opportunities and challenges related to the successful provision of care. There were two sets of discussions guided by different but interrelated sets of questions, followed by an open forum. The discussion process and their findings are described below.

5.1 First Group Discussion

Attendees were organized into five groups where group composition represented a range of perspectives. Each group was asked to: ***Question 1***: *Reflect on the current state of diabetes in your urban region. What health topics must be prioritized to support successful diabetes care? (Example of Health Topics: Access to Primary Care, Food Insecurity, Health Communication in Primary Care, Housing as a Social Determinant of Health).*

The following health topics were identified in response to *Question 1*:

Range of health topics identified by groups:
• Collaboration across primary care teams • Health communication in primary care • Capacity building in diabetes care and strategic utilization of existing resources, services, and programs • Continuum and implementation of diabetes care throughout the healthcare system • Inter- and intra-provincial variations in diabetes care and potential inequities

After identifying health topics, each group was asked to select one topic to engage in further reflection. The conversation was guided by the following questions:

- ***Question 2a***: *What diabetes interventions/programs/policies exist in your urban region that successfully address the identified topic? Please highlight any common trends across provinces or sectors.*

- ***Question 2b***: *What are the barriers or gaps in addressing the identified topic to support successful diabetes care in your urban region? Please highlight any common trends across provinces or sectors.*

While each group focused on discussing a unique health topic, there were commonalities across the groups when identifying the barriers, gaps, and successful interventions. Notably, when discussing barriers or gaps to successful diabetes care, the following factors were discussed across several of the groups: challenges in navigating care, limitations in data and data systems, fragmentation in the health system, and deficiencies in structural and sustainable investment (e.g., funding). Similarly, when discussing instances of services, programs, or policies that have been successful, some examples that were commonly discussed across some groups included: centralized administration of programs and services (e.g., central triage), improvements in access to diabetes treatment or devices (e.g., expansion of CGM coverage), and community focused service delivery (e.g., mobile clinics).

Complete group deliberations pertaining to questions 2a and 2b are detailed in the tables on the following pages according to the health topic discussed.

Health Topic: Collaboration across primary care teams

Barriers or gaps:

- There is a need for a "North Star" (i.e., a centralized entity) to oversee, connect, and guide within respective jurisdictions.
  - Successful programs or promising initiatives exist but this is coupled with a lack of standards and unified voice directing change.
- Inconsistency in data and, at times, lack of data altogether.
- There is a need for consistent clinical guidelines to support implementation in care.
- Fragmentation exists across sectors that play a role in the delivery of primary care.
  - For example, varying drug and health benefits offered through employers influence the kind of treatment available to patients and shape how primary care providers prescribe and deliver care.
- There is a communication (i.e., branding) problem: the language used in diabetes care can be stigmatizing or judgmental which can hinder communications between primary care providers and patients.

Interventions and opportunities:

- Opportunity to improve data collection processes and existing data systems. Enhance the connections of data systems to ensure they "communicate" with each other.
- Examples of centralized entities that support diabetes care exist outside of primary care, such as inpatient care in Alberta, where there are standard guidelines and access to data. These examples can serve as models for implementing a "North Star" in diabetes primary care.
- Improvements have been made to prevention, diagnosis, and treatment communications for some illnesses (e.g., cancer communications) that can serve as models for improving communications in diabetes care.

Health Topic: Health communication in primary care

Barriers or gaps:

- Diabetes stigma contributes to communication problems in care contexts.
- Access to care is impacted by power dynamics and a lack of trust in healthcare environments.
- There is fragmentation in the healthcare system, impacting patient care experiences. Often patients are presented with "many doors" (i.e., options) with no clear direction or single place to turn to when diagnosed.
- Individuals experience challenges in navigating the system, and there is insufficient support to address gaps.
- Some systems could benefit from considerations of how they can be scaled up.

Interventions and opportunities:

- Fraser Health Diabetes Clinic in British Columbia was acknowledged for its communication practices, which includes follow-up phone calls with care providers. The Wellness Team at the clinic connects with community care specialists to identify populations needs and work towards addressing those needs (e.g., referrals, school visits, forms).
- My Health Teams in Manitoba was discussed for the work they do in supporting care access. These teams aim to improve access to primary care, enhance patient-centered services, and ensure seamless coordination among care providers. Their focus includes promoting quality and safety, supporting system sustainability, and emphasizing prevention and chronic disease management.
- The research of Dr. Sonia Butalia, from Department of Medicine at the Cumming School of Medicine, University of Calgary was discussed. Butalia is engaged in clinical trial research of a diabetes program across Alberta for youth who are transitioning from pediatric to adult care. The program involves a transition coordinator who supports youth in connecting with care. Communication is facilitated by accessible digital technologies, such as texting and emailing.

Health Topic: Capacity building in diabetes care and strategic utilization of existing resources, services, and programs
Barriers or gaps: • Fragmentation and lack of coordination across the health system pose real challenges in diabetes care. • Variation in and across programs contributes to inconsistencies in care. • There is a need for more strategic planning of how to use limited resources. • Virtual care is important, but there are limitations to this kind of care. For example, not everyone has access to the internet. • Out-of-pocket costs that patients incur influence the type of care and treatment they pursue. For example, there is limited coverage for foot care and glucose monitoring sensors.
Interventions and opportunities: • Virtual health can help expand access to care, but there also needs to be awareness of the limitations of this type of care (e.g., access may still be a barrier). • There is an opportunity to improve user design in the development and planning of programs and interventions that view individuals holistically and not just as patients (e.g., access to appropriate translation services, inclusion of family and caregivers at appointments, and accessible parking).   • Additionally, the inclusion of different cultural perspectives is needed. A client and community centered focus in the design and delivery of diabetes care can foster more culturally appropriate care. • Opportunity to map pathways of care, detailing how an individual can move through the system. Including information about the services and resources available in a region.

Health Topic: Continuum and implementation of diabetes care throughout the healthcare system

Barriers or Gaps:
• There are many pilot projects coupled with insufficient financial investment to ensure the sustainability and longevity of successful initiatives.
• Often, there is a focus on stigma, problems, and barriers. A shift in perspective towards a strengths-based and solutions-oriented approach can help foster change.
• The need to strengthen a collective voice among people who are interested in creating change.
  • For example, the need for the public to put pressure on the private sector to do more to support diabetes prevention and care.
  • Collective voice shaped by self-advocacy and community advocacy.
• Navigating the diabetes care system is challenging. There is not a singular avenue (i.e., "one door") for people to access when seeking care.
• Concern was expressed for the level of attention diabetes receives in comparison to other health problems. How is diabetes ranked in terms of the importance of focus?
• Systemic challenges due to the lack of connectivity in services and programs across the health system.
• Lack of attention on preventative strategies.
• Limitations exist in data and diabetes registries.

Interventions and opportunities: • Services delivering screening and diabetes care in communities, such as mobile clinics, were discussed as enhancing access within the health system. • Food prescriptions (i.e., Food Rx) were seen as helpful steps in addressing food insecurity. There is a need to ensure partnerships and programs are in place to support food prescribing practices in healthcare. • The Vancouver Island Region of the First Nations Health Authority (FNHA) Regional Diabetes Strategy was discussed as offering a cooperative model to support decision-makers in enhancing diabetes care. • An important improvement is the expansion of coverage for diabetes technologies and medicine, such as the recent expansion of CGM coverage in Alberta. • Opportunity to create information or education hubs that are publicly accessible and easy to navigate. • Bill C-64, "An Act respecting pharmacare," was described as having the potential to address inequities in access to treatment by filling gaps for those who do not have private health and drug insurance. • Lack of connectivity across the health system might be addressed by establishing an ongoing mechanism to share innovative ideas across the country. • Strategies to address stigma in diabetes care can attend to language use. For example, using the language of "Wellness Centre" rather than "Diabetes Clinic". • Look to other countries, such as Scandinavian countries, to see how they support the prevention of diabetes and chronic illnesses by structuring prevention strategies into everyday life. For example, Scandinavian countries emphasize physical activity through active transportation as a prevention strategy.

Health Topic: Inter- and intra-provincial variations in diabetes care and potential inequities
Barriers or gaps: • Inconsistencies and/or lack of increase in funding continue to be a problem in diabetes care. • Improvement in collaboration across sectors is needed. • Concern was expressed for how private businesses/entities providing care or access to treatments are influenced by capital and how this motive may negatively impact patient care. • Access to care is impacted by the insufficient number of healthcare providers.

Interventions and opportunities:
• Virtual care can reduce barriers to accessing care for some individuals and communities. However, it was emphasized that providers need to be attentive to the harm that can be caused through this mode of care and that it is best to move at the speed of trust.
• Promising new care services were highlighted, such as Nurse practitioner-led clinics and refugee clinics in Ontario, along with pharmacy-led clinics in Alberta. Indicators on the impact of these clinics are pending.
• Ensuring that patients who do not have primary care providers can still access diabetes care was discussed as an important opportunity.
• Examples of encouraging collaborations across organizations or sectors were highlighted, including:
  • The province of Alberta was discussed as an example of having more integrated care
  • Centralized intake for diabetes care in some regions
  • Peer-led programming can support community development.

5.2 Second Group Discussion

Following the first group discussion, summit attendees were reorganized into new groups, with each group representing a specific sector that plays a role in diabetes care (i.e., clinical, research, government, and NGOs). Each group was also assigned one of the health topics identified in the first round of discussions and asked to consider a new set of questions from the perspective of their assigned sector. The groups were organized along the following sectors and health topics:

Group & sector	Assigned Health Topic
Clinical (Group 1)	Collaboration across primary care teams
Clinical (Group 2)	Health communication in primary care
Non-governmental Organizations (NGOs)	Capacity building in diabetes care and strategic utilization of existing resources, services, and programs
Research	Continuum and implementation of diabetes care throughout the healthcare system
Government	Inter- and Intra-provincial variations in diabetes care and potential inequities

The following questions guided the conversation for this second round of discussion:

- ***Question 3a****: How can this sector sustain or advocate for improved diabetes care in relation to the provided health topic in urban regions?*

- ***Question 3b****: What needs to change within the next 6 months for this to happen? What needs to change within the next 5 years? What role does this sector play in both short-term and long-term changes?*

These two questions generated productive discussion on the changes needed within diabetes care and how those changes correspond to the sector represented by each group. Conversations within groups largely focused on the changes needed without ascribing a specific timeline to those changes. There were some notable commonalities in the discussion themes between some sector groups, such as: the need for clear pathways to care and other supports (e.g., financial supports), centralization of information and resources to support both patients and healthcare providers, and enhancing sustainability in diabetes care through improved funding (and funding models), collaborations, and partnerships. Below are summaries of the discussions generated by questions 3a and 3b.

Clinical Sector (Group 1): Collaboration across primary care teams

- A major challenge is fragmentation in care among multiple primary care physicians and other health profession groups, sometimes creating tension between practitioners. To enhance collaboration, improvements in communication are needed to ensure a clear understanding of both patient needs and provider roles. Additionally, some patients are concerned that the complexity of their condition becomes a barrier to accessing care.
- Effective leadership is needed to drive changes, along with adequate support and resources to optimize primary care capacity. Examining funding models for complex care is important and there are recent models that have been successful at attracting more providers (e.g., new model in British Columbia). Also emphasized was the need for strengthened political leadership to ensure appropriate funding and support for improvements in primary care.
- Knowledge of available services and a clearly defined care pathway is necessary to reduce redundancy in services. A "one-stop shop" model was proposed to improve access and coordination in diabetes care.

Clinical Sector (Group 2): Health communication in primary care

- To improve diabetes care, participants emphasized the importance of effective communication between patients and healthcare providers. Patients, especially those who are newly diagnosed, require clear and supportive conversations about their health condition, and those living with diabetes need ongoing education and support.
- Access to patient information was discussed as a key issue. Participants discussed the value of a centralized resource where patients and providers could access information and communications to enhance consistency in care (i.e., a "one-stop shop" for information to enhance communication and coordination).
- One example discussed was how Ontario is exploring, over the next 5 years, the integration of artificial intelligence (AI) in electronic medical records (EMRs) to streamline documentation. This technology would allow healthcare providers to dictate notes while generating patient summaries in real time that patients could later review. The technology might evolve so that links to informational resources could be integrated into the patient summaries. Such technological advancements could transform patient-provider communications.
- Primary care toolkits were also highlighted as a way to improve the integration of best practices and guidelines into routine care. To promote progress, an environmental scan was proposed within the next six months to identify and adopt best practices. Participants acknowledged that some provinces were more advanced than others and that those regions can be modelled rather than reinventing solutions.
- Improvements to how funding models are incorporated into care frameworks were discussed as an important avenue for achieving sustainable changes that could lead to better outcomes for patients.
- Concerning funding, participants also discussed how changes in government often lead to new mandates in healthcare before improvement strategies can be fully implemented. Frequent political changes can be disruptive to supporting healthcare improvements long-term.

NGO Sector: Capacity building in diabetes care and strategic utilization of existing resources, services, and programs

- Participants discussed the need for a centralized organization or mechanism that providers embedded in NGOs can access to find information and direct individuals to appropriate care systems.
- Data collection efforts are underway across many organizations and initiatives. Concerns were raised about the purpose and quality of the collected data. Participants discussed whether the language used, and questions asked to generate data were the most useful and appropriate. While funding is often tied to measurable data, lived experience also plays an important role in improving services and programs.
- Stigma can be associated with accessing care, especially for individuals experiencing a new diabetes diagnosis. Participants emphasized the importance of ensuring that individuals are not discouraged from seeking care, especially if they do not immediately engage in care.
- Advocacy for improved care within the structure outlined by the Framework for Diabetes in Canada remains a priority.
- Concerning financial support, it was noted that philanthropic support allows for more flexibility compared to government funding, but there is potential for NGO-government partnerships to facilitate effective work.

Research Sector: Continuum and implementation of diabetes care throughout the healthcare system

- The disconnect between researchers and the healthcare system was discussed, noting that the research community is, at times, isolated. Participants highlighted how research plays an important role in addressing healthcare problems and supporting the implementation of effective interventions and approaches in diabetes care.
- Participants discussed the need for priority setting and strategic decision-making to ensure that investments in certain areas are followed through to the end.
- Knowledge exists about effective and ineffective approaches to improving diabetes care. There is a need to more purposefully document and communicate these successes and failures to avoid repetition.
- While preserving patient privacy in research is important, concerns were raised about the prevalence of anonymized data. Too much anonymized data can negatively influence data utility and, therefore, the generation of impactful research.
- Timely access to care was discussed along with opportunities for improvement. Participants discussed the example of cancer care where cancer patients are flagged in a system and do not have to wait for an appointment. A similar approach for diabetes could improve timely access to care.

Government Sector: Inter- and Intra-provincial variations in diabetes care and potential inequities

- The importance of promoting communication and shared standards across jurisdictions to build pathways to care and improve coordination across sectors was emphasized. Additionally, integration between care providers and better support for different components of care were identified as key priorities.
- Collaboration with NGOs was discussed as a way to help build political will for diabetes care.
- Identified gaps included the need for better support in schools and improved patient pathways. Clearly defined pathways, especially for those transitioning from acute to primary care, could improve efficiency and accessibility in care.
- Participants also discussed the need for clear financial support pathways for patients, including access to disability credits, CGM and pump coverage, and federal drug coverage for seniors.
- The need for foundational standards in diabetes care was discussed. Establishing minimum benchmarks is necessary, such as time per visit or patient load.
- Ongoing education for healthcare providers and patients was highlighted, with a recommendation for a centralized repository or “one-stop shop” for education and resources.
- A “Best Practice Portal” was proposed as a cost-effective and sustainable solution for implementing and sharing best practices. A centralized platform for clinical practice guidelines, resources, and health system navigation was suggested to reduce redundancy and ensure that individuals know what programs and services to access for specific needs.
- A pan-Canadian diabetes network was proposed to facilitate knowledge-sharing across Canada’s health regions.

5.3 Open Forum Discussion

Following the two rounds of group discussions, attendees engaged in an open forum style conversation. Some key conversation points from the open forum are highlighted here:

- AI translation technology may provide opportunities for improving healthcare access for non-English-speaking patients.
- In Ontario, healthcare remains fragmented as patients transition from acute care to other forms of care. Alberta faces similar challenges, despite funding from Alberta Health (ministry) to AHS, with additional care occurring outside the AHS system.
- The question was raised as to whether jurisdictions have funding tied to the number of assessments or clinical evaluations. Additionally, concern was expressed for the lack of established minimum standards for care, making consistent delivery difficult. While clinical guidelines exist, the data remains disconnected, and standardized care models are lacking.
- With respect to funding models, participants discussed how outcome-based funding has potential benefits but also risks discouraging providers from treating complex patients who may not yield "favourable" results.
- The United Kingdom's (UK) National Health Service (NHS), despite its challenges, has successfully reduced the diabetes life expectancy gap (6 years in the UK vs. 11 in Canada). This achievement has in part been accomplished by NHS implementing quality outcome frameworks and having linked healthcare data. This is an approach Canada has yet to adopt.

Additionally, throughout summit discussions, a participant from the Waterloo Wellington region in Ontario shared examples of diabetes care in their region. The table below highlights some diabetes care initiatives in this region.

Overview of Waterloo Wellington diabetes care and centralized referral intake

The Waterloo Wellington Regional Coordination Centre (WWRCC) is a referral and coordination hub dedicated to streamlining access to care across the Waterloo Wellington region in Ontario. Hosted by Langs Community Health Centre in Cambridge and funded by Ontario Health West, the WWRCC is a provincial leader in central intake development. It currently offers centralized intake services for diabetes, orthopedics, cataracts, and the Ontario Seniors Dental Care Program as part of the System-wide Coordinated Access (SCA) strategy, aimed at improving healthcare access for Ontarians.

Waterloo Wellington Diabetes (WWD)
A program of the WWRCC, Waterloo Wellington Diabetes (WWD) provides centralized intake for diabetes education referrals and specialist referrals, including Endocrinology, Nephrology, Retinal Screening, and Medically Supervised Wound Care. The WWD team consists of:

- Two triage Diabetes Nurse Educators
- Two Referral Clerks
- A Resource Clinician (RC) who is also Project Lead

The RC is a certified diabetes educator who mentors diabetes educators across the region, leads diabetes care improvement initiatives, and chairs regional diabetes networks for both adult and pediatric care.

Waterloo Wellington Diabetes Regional Diabetes Network (WWRDN)
Established in 2013, the Waterloo Wellington Diabetes Regional Diabetes Network (WWRDN) convenes five times a year, bringing together representatives from Adult Diabetes Education Programs, specialists (Endocrinology, Nephrology, Cardiology), primary care, community pharmacy, and health promotion organizations. The network focuses on:

- Enhancing regional diabetes planning and care
- Sharing best practices, experiences, and updates
- Promoting consistency and collaboration in diabetes care
- Identifying gaps and advocating for solutions

As one of Ontario's first Regional Coordination Centres, WWRCC has developed a Framework for the Development and Implementation of a Regional Central Intake. WWRCC has produced a guide that outlines strategies for developing, scaling, and expanding central intake models to improve access for individuals living with or at risk of chronic diseases. The guide can be accessed at the following link: ENGLISH - Resources - Waterloo Wellington Regional Coordination Centre.

Throughout summit discussions, Indigenous food sovereignty programs were also discussed. A specific initiative in Northern Ontario facilitated by the Noojmowin Teg Health Centre was highlighted. These programs are detailed in the table below.

Noojmowin Teg Health Centre, Indigenous Foods Sovereignty Program
Noojmowin Teg Health Centre offers a program supporting Indigenous food sovereignty by promoting access to traditional, locally sourced foods. Key Indigenous Foods Sovereignty Programs include: 1. *Harvest to Share*: Partners with Indigenous butchers and hunters, covering butchering fees in exchange for one-third of the wild meat, which is distributed to community members in need. Food portions are based on household size. 2. *Hospital Food Program*: Traditional meals prepared by an Indigenous caterer, frozen, and delivered to two small hospitals for use as needed. 3. *Jiibaakwedaa* (food bundle program): Quarterly distribution of 20 food bundles, each containing traditional ingredients for two meals (one fish-based, one wild meat-based) with recipes. 4. *Elder Food Program*: Monthly distribution of 20 food bundles, each designed for two one-pot meals using traditional ingredients, tailored for elders. 5. *High School Good Food Locker*: Indigenous caterer prepares traditional wild meat chili, frozen in individual portions and stored at a high school for student access as needed. For more information, visit the Noojmowin Teg Health Centre website: nthc.ca

6.0 Conclusion

The Urban Diabetes Summit provided a valuable forum for clinicians, researchers, public health and government leaders, advocates, and individuals with lived experience to share knowledge and discuss strategies aimed at improving diabetes care in urban settings across Canada. Through a diverse range of presentations and group discussions, attendees shared knowledge and insights on innovative diabetes care models, health equity-focused initiatives, public health prevention strategies, and community-centered approaches to addressing health inequities and disparities in access to care.

Presentations highlighted different diabetes services and programs, such as Calgary's Diabetes Centre and Mobile Clinic, Alberta's health equity-focused diabetes strategy, Peel Region's public health initiatives, and community-centered efforts like the Unlocking Hope Diabetes Project and the South Asian Health Institute's programs. The lived experiences shared during the conference further underscored the systemic challenges in diabetes care, particularly regarding care transitions and barriers to accessing resources.

Through structured and engaging discussions, participants identified critical health priorities and actionable steps to enhance diabetes care in urban settings. Key priorities included strengthening primary care collaboration, improving health communication, supporting capacity-building, ensuring continuity of care, and addressing intra- and inter-provincial variations in care. Additionally, key themes emerged from the discussions, emphasizing the importance of health equity, interdisciplinary cross-sector collaboration, and the importance of patient- and community-centered accessible care.

The tangible solutions for fostering more equitable diabetes care generated at the Urban Diabetes Summit highlight what is possible when key stakeholders with diverse expertise, skills, and experiences come together to share knowledge and engage in deliberate dialogue. Moving forward, the insights gained from this summit will guide continued efforts of promoting equitable diabetes care and supporting the ongoing implementation of the Framework for Diabetes in Canada.

References

Public Health Agency of Canada. (2022). Framework for diabetes in Canada. https://www.canada.ca/en/public-health/services/publications/diseasesconditions/framework-diabetes-canada.html

DIABETES CANADA

diabetes.ca

National Office
1000-170 University Ave
Toronto, ON M5H 3B3
416-363-3373

Adria Cehovin
Project Manager,
Convening Project with PHAC
Diabetes Canada
Adria.Cehovin@diabetes.ca

Hiba Syed
Support Coordinator,
Convening Project with PHAC
Diabetes Canada
Hiba.Syed@diabetes.ca

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