DIABETES CANADA

SUSTAINING MOMENTUM TO IMPLEMENT THE DIABETES FRAMEWORK (SMIDF):

BRITISH COLUMBIA ROUNDTABLE

FEBRUARY 2024

Summary

This grey paper provides key findings about the Sustaining Momentum to Implement the Diabetes Framework: British Columbia Roundtable 2024.

Publication Date

October 2024

Report Length

13 pages

Cite As

Sustaining Momentum to Implement the Diabetes Framework: British Columbia Roundtable. Diabetes Canada. 2024.

About Diabetes Canada

Diabetes Canada is a national health charity representing more than 4 million people in Canada living with Diabetes. Diabetes Canada leads the fight against diabetes by helping those affected by diabetes live healthy lives, preventing the onset and consequences of diabetes, and discovering a cure. It has a heritage of excellence and leadership, and its co-founder, Dr. Charles Best, along with Dr. Frederick Banting, is credited with the co-discovery of insulin. Diabetes Canada is supported in its efforts by a community-based network of volunteers, employees, health care professionals, researchers, and partners. By providing education and services, advocating on behalf of people living with diabetes, supporting research, and translating research into practical applications, Diabetes Canada is delivering on its mission. Diabetes Canada will continue to change the world for those affected by diabetes through healthier communities, exceptional care, and high-impact research.

For more information, please visit: www.diabetes.ca.

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Maleka El Naghi (Health Equity and Evaluation Officer)

We would like to thank all presenters for their contributions at the British Columbia Roundtable. The insightful presentations allowed for knowledge sharing, enabling a deeper understanding of diabetes in British Columbia.

Title: Sustaining Momentum to Implement the Diabetes Framework (SMIDF): British Columbia Roundtable 2024

Project Overview: Through the Framework for Diabetes in Canada (the Framework) project, supported by the Public Health Agency of Canada (PHAC), Diabetes Canada continues to bring together key stakeholders to help identify and share best practices. This project began in 2023, and the result of this 3-year project will be an inventory of successful diabetes programs/interventions/projects and the dissemination of findings for adoption and scaling to identify and share best practices for addressing diabetes, including the identification of barriers in health equity-deserving communities.

British Columbia (BC) Roundtable

The third roundtable of this project was held in British Columbia, Canada, in February of 2024. Participants were invited from all over the province to share, listen, and brainstorm regarding the Framework. The meeting was a combination of presentations, group discussion, and breakout work. Presentation topics included digital health and innovation, research, government and NGO initiatives, mental health and diabetes, South Asians and diabetes, primary care challenges and opportunities, and perspectives from allied healthcare.

Location and Date: Vancouver Marriott Pinnacle Downtown Hotel in Vancouver, BC, on February 27, 2024, from 11:30am to 4 pm PDT.

Meeting Objectives:

- Engage with the Framework for Diabetes in Canada
- Identify provincial programs, interventions, and opportunities to optimize prevention and patient care efforts
- Energize the National Diabetes Framework in British Columbia and build on the collaborative work done with strategic partners
- Determine diabetes access and resource pathways in British Columbia

Framework Overview: The Government of Canada introduced the Framework for Diabetes in Canada on October 5, 2022. The Framework aims to support prevention and treatment for all types of diabetes and provide a common policy direction to address diabetes in Canada. The Framework seeks to support the identification of gaps in current approaches, avoid duplication of effort, and provide the federal government an opportunity to monitor and report on progress. In doing so, it strongly promotes the foundation for collaboration across sectors to reduce the impact of diabetes.

The Framework is comprised of six interdependent and interconnected components that represent the range of areas where opportunities to advance efforts on diabetes could be beneficial. The principles and the components (below) form a dynamic environment within which to create change in Canada. These were derived

from and built on contributions from diverse groups within Canada throughout the multi-year engagement process.

Cross-cutting principles:

- Addressing health equity
- Applying a person-centered approach
- Differentiating between types of diabetes
- Supporting innovation
- Promoting leadership, collaboration, and information exchange

Framework components:

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

The Framework summary below outlines the process, purpose, scope, and overall desired outcomes.

Summary of the Framework[1]

STAKEHOLDER ENGAGEMENT SUMMARY

The Public Health Agency of Canada, with the Morris J. Wosk Centre for Dialogue based at Simon Fraser University, undertook a virtual engagement process to help identify gaps and priorities for advancing efforts on diabetes in Canada, and inform the development of the Framework.

PART 1

32 key informant interviews with **50 individuals**

PART 2

Two dialogues in two languages with **89 participants**

PART 3

884 respondents and **2,000 comments** on online survey

PURPOSE

- Provide a common policy direction for multi-sectoral stakeholders
- Identify gaps in current approaches, avoid duplication of effort, and provide an opportunity to monitor and report on progress

SCOPE

- Lay the foundation for collaborative and complementary action to be taken by all sectors to reduce the impact of diabetes in Canada

DESIRED OUTCOME

- Improve access to diabetes prevention and treatment to ensure better health outcomes for Canadians

CROSS CUTTING PRINCIPLES

- Addressing health equity
- Applying a person-centred approach
- Differentiating between types of diabetes
- Supporting innovation
- Promoting leadership, collaboration, and information exchange

FRAMEWORK COMPONENTS

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

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 their website (nada.ca).

Speakers:

- Adria Cehovin - Framework for Diabetes in Canada
- Andrea Godfreyson - British Columbia Ministry of Health Programs
- Dr. Parmjit Sohal - South Asians and Diabetes
- Kathleen Chouinor - The Type 2 Diabetes Network
- Kim Lucas - JDRF- Type 1 Diabetes
- Leena Mazhar - JDRF and Diabetes Canada: Mental Health + Diabetes Directory
- Colleen Fuller - Diabetes Research- Prediabetes and Mild diabetes
- Dr. Shazhan Amed - CAPACITY project overview
- Dr. Alan Low - Pharmacist perspective on diabetes in British Columbia
- Dr. Fred Melindy - Project 360 in Newfoundland and Labrador

Diabetes in British Columbia, 2024

Below are Diabetes Canada's estimates of diabetes prevalence and costs, in British Columbia:

Estimate Prevalence and Cost of Diabetes - British Columbia

Prevalence (1)	2024	2034
Diabetes (type 1 + type 2 diagnosed + type 2 undiagnosed)	818,090 / 15%	1,042,370 / 17%
Diabetes (type 1 and type 2 diagnosed)	568,310 / 10%	760,890 / 12%
Diabetes (type 1)	5-10% of diabetes prevalence	
Diabetes (type 1 + type 2 diagnosed + type 2 undiagnosed) and prediabetes (includes undiagnosed)	1,667,520 / 30%	2,000,810 / 32%
Increase in diabetes (type 1 and type 2 diagnosed), 2024-2034	34%	
Direct cost to the health care system in 2024	$642 Million	
Out-of-pocket cost per year (2)		
Type 1 diabetes costs, % of family income	$945-$6,487 / 3%-4%	
Type 2 diabetes costs, % of family income	$388-$6,098 / 1%-4%	

Presentations

The HCP Perspective

Healthcare providers (HCPs) are the backbone of patient care, providing medical support throughout a patient's journey through the healthcare system. Their support continues beyond medical care; they also advocate for patients' rights in receiving care and support. Dr. Parmjit Sohal and Dr. Alan Low highlighted their experiences providing care to individuals living with diabetes.

Dr. Parmjit Sohal, family physician, provided context about diabetes amongst South Asians, a diverse ethnic group with an elevated risk of developing diabetes, living in British Columbia. Throughout his career, he has seen the challenges and barriers his patients face while navigating their diabetes journey. Some of these include a limited understanding of diabetes, language barriers, and being unaware of diabetes complications. As such, recommendations were made to improve primary and secondary prevention in the South Asian community:

- Increasing awareness and knowledge sharing
- Introducing lifestyle changes at an earlier age
- Accessible and affordable interventions
    - Specific to cultures and ethnicities
- Earlier and frequent screening

Dr. Alan Low, pharmacist, shared his patient experiences as an allied health professional. Key patient care themes from his experiences include:

- Minimal education being provided by healthcare professionals to patients
    - Patients lacking education and guidance for glucose control
- Low accessibility
    - Diabetes education programs
        - Patient requiring physician referral to access Diabetes Education Programs
    - HCPs primary care
        - Delay increases severity in symptoms
        - *"Lack of referral physicians accepting new patients with diabetes"*
        - *"care not universally covered"*
        - Shortage of pharmacists
    - Treatment
        - Some treatments and medications with restricted access include *"Gliclazide, empagliflozin, insulins, and number of strips, supplies, and CGM"* and often have:
            - *"Special authorization criteria*
            - *Requirement for prior treatment failure*
            - *Requirement for insulin usage"*
- High costs for treatment
    - Limited public coverage for medicine
    - Risk assessment and screening is not covered
    - *"Over the counter therapies, wound care, and other necessities of treatment are not covered"*
- Patient health challenges/management
    - *"Glucose control is not taken seriously until there are complications of organ damage"*

Dr. Low shared the importance of enabling pharmacists and other allied care health professionals to assist in the diabetes journey for patients. However, the lack of funding and support acts as a barrier for pharmacists in providing the help that patients need. It was stated that when CGM was approved, pharmacies were 27 weeks behind in providing the care technology.

Government Initiatives

Government and NGOs have an essential role in molding our healthcare systems and increasing access to services. Their collective efforts support communities through education and the creation of diabetes care, treatment, and management programs. Below includes the initiatives and overall work discussed by government and NGOs present at the BC roundtable.

Andrea Godfreyson, Director, Injury & Clinical Prevention, from the BC Ministry of Health, shared resources that are available from the BC government for chronic disease prevention and management, including Diabetes. Some examples of initiatives that were reviewed are listed below:

Physical Activity Strategy (primary): Stimulates coordinated action across the province from a physical activity perspective and includes targeted actions for children and youth, Indigenous peoples, older adults, and communities.

Lifetime Prevention Schedule (primary, secondary): A provincial program identifying the clinical prevention services that should be offered to the general asymptomatic population of people in B.C. based on age and sex.

interCultural Online Health Network (primary, secondary, tertiary): A University of British Columbia initiative that provides culturally relevant multilingual resources and self-management opportunities for patients.

Initiatives specific to diabetes include:

Chronic disease self-management program: Provides patient education over a 6-week period in multiple languages. selfmanagementbc.ca

HealthLinkBC: Provides reliable non-emergency health information and advice in British Columbia. Information and advice is available by telephone, website, a mobile app and a collection of print resources. Users may connect with a nurse, dietitian, pharmacist or qualified exercise professional, and translation services are available in more than 130 languages. healthlinkbc.ca

For supporting childhood healthy weights:

Live5-2-1-0: Tools, resources and supports for community partners to make environmental changes that support children to eat well and be active every day. The Live 5-2-1-0 message supports four guidelines to follow everyday: Enjoy 5 or more vegetables and fruits, no more than 2 hours of recreational screen time, play actively for at least 1 hour, and zero sugary drinks. live5210.ca/pages/home

Generation Health Community: Facilitated group program for families with children ages 8-12 that focuses on healthy living activities to make lasting lifestyle changes. generationhealth.ca/community/

Generation Health Clinic: Family-centered healthy living program for children and teens ages 6-17 living with overweight or obesity and specific health concerns. generationhealth.ca/clinic/

NGO Initiatives

JDRF, Diabetes Canada, and Mental Health

Kim Lucas, Juvenile Diabetes Research Foundation (JDRF) and Leena Mazhar, University of British Columbia, spoke on the topic of mental health and diabetes. Lucas shared the gaps in mental health care for people living with diabetes (Figure 1). Lucas highlighted that physicians are often not equipped to address the mental health needs of patients with lived experience. This is a crucial component to diabetes care that requires greater attention, due to the high prevalence of mental health disorders amongst people living with diabetes. For example, individuals diagnosed with diabetes are twice as likely to develop depression.[2]

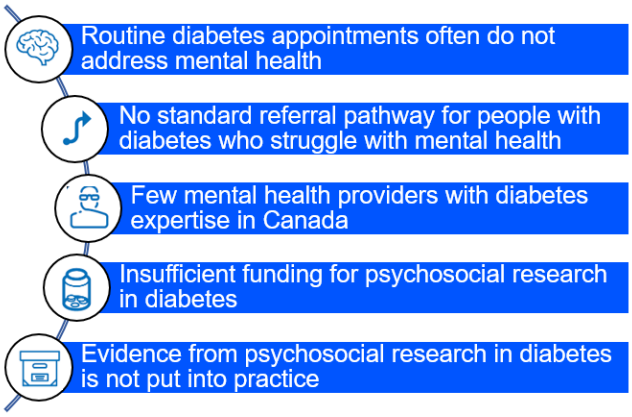
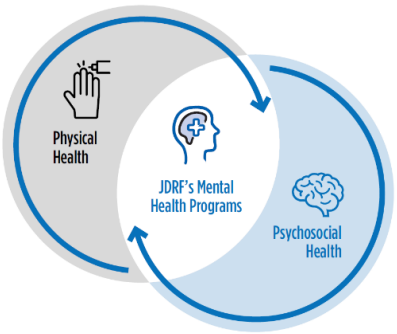


Figure 1. Gaps in mental health care for people with lived experience.

In light of this information, JDRF, with Diabetes Canada, has created a 3-part project including a training program, directory, and an evaluation study. Mazhar provided greater details of this program, sharing that it is a virtual, bilingual training program created to gain a better understanding of the needs of people with lived experience (type 1 and type 2) and ways to support them. The content provided in the program is created by subject matter experts, people living with type 1 and type 2 diabetes.

Once the training program is complete, providers are to apply to the mental health and diabetes directory on the JDRF website. JDRF approves all providers on the list. The directory includes:

- Names
- Professional profiles
- Virtual appointment availability
- Contact information
- Type of population cared for



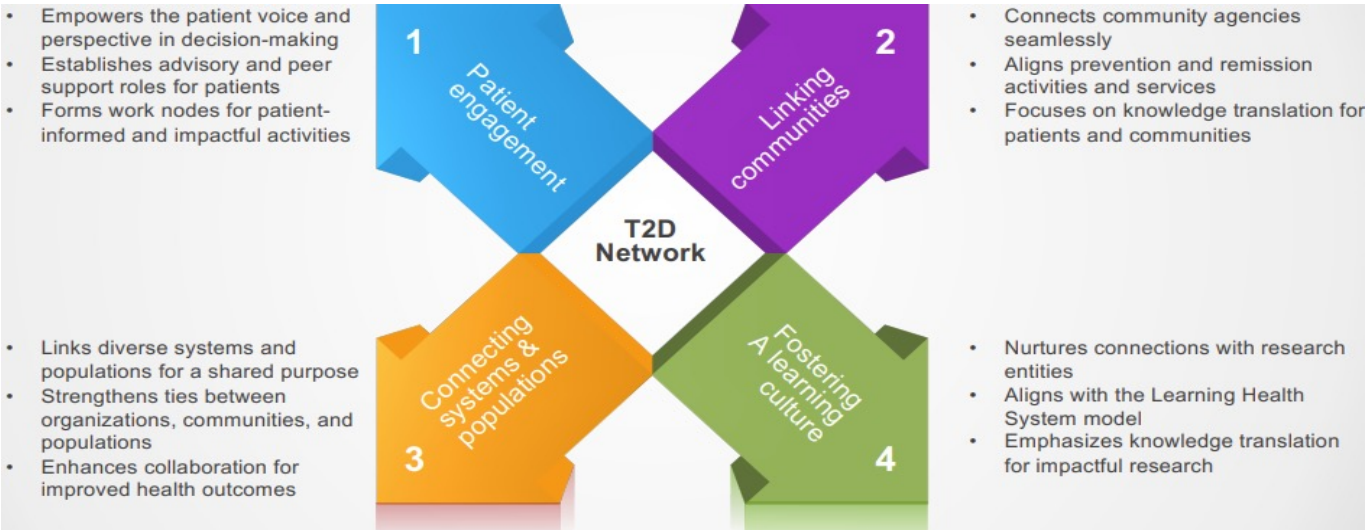
The third part of this project is an evaluation study where perspectives of individuals with lived experience is the central focus. **The overall goal is to determine if individuals living with diabetes are able to connect with providers who understand diabetes and if they experience any tangible benefit in their mental health as a result.** This initiative highlights a mental-health focus which aligns with the Framework's cross-cutting principle of "supporting innovation" along with a component of the Framework under "Management, treatment, and care". To access the Mental Health + Diabetes Directory, visit directory.jdrf.ca.

The Type 2 Diabetes Network

The Type 2 Diabetes Network was introduced to the group by the CEO of the Institute for Health System Transformation and Sustainability (IHSTS), Kathleen Chouinor. The NGO leads the Type 2 Diabetes Network. The NGO focuses on bringing patients and community building to the center of diabetes care and conversations, aligning with the cross-cutting principle of "applying a person-centred approach" from the Framework for Diabetes in Canada. As an organization that is currently working in the type 2 diabetes space, they are looking to create a tighter, more coordinated network of community – based initiatives within British Columbia, by answering the following:

- What are the gaps in diabetes care?
- What are the perspectives we need to gather to address these gaps?
- How can we develop a network of care in the community that can augment the official government services for diabetes care?
- How can we create a mechanism that can organize and coordinate community-based Type 2 diabetes care services, including other NGO's, municipalities, patient partners, advocacy groups, etc., across BC?

Below are the pillars that make up the T2D network.



CAPACITY

Shazhan Amed, Principal Investigator of CAPACITY (CAnadian PediAtric diabetes Consortlum) registry presented on behalf of the project. The project is the first Canadian national childhood diabetes registry, marking a significant achievement in pediatric diabetes care. The registry aims to *"inform the implementation and evaluation of interventions that will improve the health and well-being of children and youth with diabetes and to provide more equitable and high-quality diabetes care across Canada"*.[3] This project is currently in the second phase of the three-phase initiative.

Digital Health

Digital health innovations are revolutionizing modern healthcare delivery, leveraging technology to enhance patient outcomes and improve efficiency in the medical field. Dr. Fred Melindy shared the value of adopting technology to enhance clinical practice through the "Practice 360" project. This project is currently implemented in Newfoundland and Labrador and focuses on integrating the diabetes clinical practice guidelines in an EMR system. Figure 2 showcases the significant achievements attained through the use of the EMR system, thus far. Aside from the usage metrics, initial indications for using EMR tools highlights a positive change in provider behaviour towards more guidelines-directed care and monitoring.

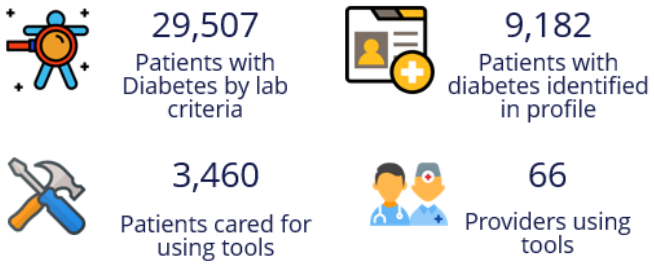
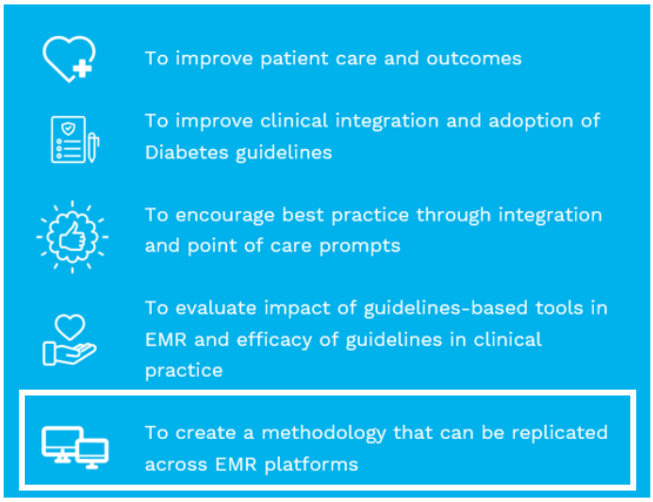


Figure 2. Use Metrics for Practice 360: Diabetes Tools in EMR in NL

HCPs across BC have found the logistics of obtaining patient information from current systems to be rather challenging. Dr. Alan Low states that on average, he has to log into **11 different platforms** to access patient information and sometimes is unable to access certain information if this information is provided by a hospital system. Considering that Dr. Melindy's platform is implemented on a provincial level and has provided promising results to those who have used it in Newfoundland and Labrador, its EMR system has transferable elements which could be adjusted to fit other healthcare systems in places like British Columbia.

Practice 360 Objectives



Diabetes Research

Research plays an important role in the advancement of knowledge and strategies. Colleen Fuller, Canadian Institute of Health Research (CIHR) researcher, shared with roundtable attendees a new study underway which focuses on:

- Prediabetes and mild diabetes characteristics
- Management strategies and practices including downstream testing and therapeutic views
- Patient outcomes such as adverse cardiovascular events and all-cause mortality.

The aim of this study is to *"inform future policy, research, and quality improvement initiatives to optimize diabetes care in this context, with the aim of improving patient outcomes and using healthcare resources wisely."*

Breakout Discussions

In addition to the presentations, structured breakout group sessions were implemented. Below highlights the breakout session questions and responses from the attendees.

Summary of First Breakout Session Group Work

QUESTION: What interventions and programs exist or should exist, that could support or address issues discussed?		
Participant Response Themes	**Challenges**	**Opportunities**
Not enough educational resources for patients	• Minimal resources that are patient centered and reflect diversity • Minimal resources that exist for cultural communities	• Expand diabetes education centres (ex. Surrey is densely populated, yet only has one diabetes education centre) • Expand translated materials to cater to diverse populations within BC • Support patient advocacy groups
Looking for greater government support and involvement	• Need for a provincial strategy with measurements and targets	• Expand government programs that have low-income individuals in mind, advocates for CGM, and includes dental coverage • Use the Diabetes Framework to guide government • Conduct a province-wide assessment and determine the kind of help patients are looking for • Expand funding for diabetes prevention
Access to resources needed to upkeep lifestyle (medical, food, help etc.)	• Those that can afford it can buy it, but not all can • Hard to find and access resources (including who to reach out to for guidance)	• Creation of a program similar to the mammogram program, which can be done at the pharma level • Promote existing BC programs – both to medical frontline workers and patients (ex. Calling 811 for health information and advice*) ***8-1-1 was a service unknown to some at the BC Roundtable, which many seemed interested in.***
Lack of coordination across industries	• Important to create a coordinated, comprehensive approach for diabetes • Currently have a fragmented system • Not enough communication on the good things being done in the province • Duplication of work, waste of effort	• Improve communication across all industries by working together (government, private sector, NGOs etc.) to adjust the system • Dialogue and learn from other provinces and regions
Limited access to HCP's	• Almost 27% of the population does not have a primary care provider[4]	• The 2024/25 – 2026/27 service plan highlights the goal to allow greater access for BC residents to a family physician through recruitment of more, new family physicians and retaining those currently in practice • Incorporate community screenings as this allows for conversation in the moment and limits the need to visit an HCP

QUESTION: Of the 6 Framework components, which do you think is/are most actionable in BC over the next year, how and why?	
Responses	**Recommendations**
Access to diabetes devices, medicines and financial supports	• Improving access to technologies, drugs, coaching and prevention centres
Learning and knowledge sharing	• Having a personalized approach to patient education
Management, treatment, and care	• Expanding patient engagement • Having a greater focus on lifestyle • Less fearmongering, shift to food-first messaging where its moving away from putting cultural food in negative light • Giving greater thought on target demographic in terms of interventions
Prevention	• Creating patient journey maps that highlight all stops and points patients to resources • Provide more screening opportunities
Surveillance and data collection	• Ensure that data that is collected is accessible and collecting from the beginning of interventions

British Columbia 2024/25- 2026/27 Service Plan and the Framework

From a provincial level perspective, below is a comparison of the BC Service Plan from the Ministry of Health and the Framework for Diabetes.

The Framework	British Columbia 2024/25- 2026/27 Service Plan
Promoting leadership, collaboration and information exchange	**Timely access to team-based, culturally safe, and comprehensive primary care services:** Continue to work with the Parliamentary Secretary for Rural Health, FNHA, Métis Nation BC and other key partners to improve access to culturally safe primary care services for people living in rural, remote, and Indigenous communities throughout our province, including innovative use of virtual technologies linked to in-person services.
Management, treatment, and care	**Timely access to team-based, culturally safe, and comprehensive primary care services:** Continue to expand team-based primary care, providing people access to additional care through nurse practitioners, registered nurses and licensed practical nurses, and other allied health professionals such as pharmacists, mental health and substance use workers, registered midwives, dietitians, and more.
Addressing health equity **Applying a person-centered approach**	**Enable sustainable health sector innovation for quality population and patient health care:** Continuing to support and promote the application of an equity lens for the design and delivery of health care services and programs, to embed cultural safety, anti-racism, and equity for Indigenous Peoples, immigrants, racialized groups, persons with disabilities, the LGBTQIA2S+ community, and other populations facing systemic inequities.
Prevention	**Timely access to hospital, surgical and diagnostic services throughout the province:** Continue to improve patient flow across hospitals through effective system planning, hospital capacity management, and accountability to system performance targets.
Supporting innovation	**Modernize digital care services and tools to provide a connected, safe, and trusted system:** Continue support for HealthLinkBC and primary care network implementation and digital health solutions for the Provincial Attachment System, to increase access for British Columbians to family physicians and nurse practitioners.
Source: Framework For Diabetes in Canada, Public Health Agency of Canada	Source: British Columbia Ministry of Health. (2024). 2024/25-2026/27 Service Plan. https://www.bcbudget.gov.bc.ca/2024/sp/pdf/ministry/hlth.pdf

Event Feedback

Overall, quality conversation and great engagement from the attendees and the event supported knowledge sharing and collaboration. Government representatives engaged enthusiastically in discussions and eager to hear more about the group's insights. Many individuals felt they had gained value from this event, with one attendee sharing the following:

"I was particularly interested in and focused on discussions relating to engagement of people with diabetes and pre-diabetes in the medical system. Because my role is to enhance surveillance in BC, it is important for me to know how people with diabetes interact with the healthcare system so that I can determine who is missing in our provincial assessment of diabetes cases. I was interested to learn the role that pharmacists are playing in supporting appropriate treatment of diabetes, and how physicians may be the only point of contact some patients have for learning about their conditions, but that family physicians may not have the resources or time required to connect patients to non-medical care such as nutrition advice. I was encouraged by discussions providing suggestions to enhance patient follow-up and learning through pharmacists or 811."

Conclusion

The SMIDF Project is an instrumental initiative by Diabetes Canada and PHAC. The British Columbia Roundtable 2024 aimed to encourage further attention and engagement with diabetes in British Columbia. As the third roundtable of this project, it serves as a beacon for fostering collaboration, identifying barriers, and promoting a more equitable approach to diabetes care, thereby positively impacting public health outcomes in the region.

The roundtable met the mentioned meeting objectives and beyond through:

- Engaging with the Framework for Diabetes in Canada
- Identifying provincial programs, interventions, and opportunities to optimize prevention and patient care efforts (for those living with or working in diabetes)
- Energizing the National Diabetes Framework in British Columbia and build on the collaborative work done with strategic partners
- Determining diabetes access and resource pathways in British Columbia and the roundtable's feedback

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