DIABETES CANADA

SUSTAINING MOMENTUM TO IMPLEMENT THE DIABETES FRAMEWORK (SMIDF):

NOVA SCOTIA ROUNDTABLE 2023

Summary

This grey paper provides key findings about the Sustaining Momentum to Implement the Diabetes Framework: Nova Scotia Roundtable 2023.

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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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framework@diabetes.ca with inquiries about this Diabetes Canada report.

Title: Sustaining Momentum to Implement the Diabetes Framework: Nova Scotia Roundtable 2023

Project Overview: Through the Framework for Diabetes in Canada (the Framework) project, supported by PHAC, the Canadian Diabetes Association (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 in order to identify and share best practices for addressing diabetes, including the identification of barriers in health-equity-seeking communities.

Nova Scotia Roundtable

The First roundtable of this project was held in Nova Scotia, Canada, in November of 2023. Participants were invited from all over the province to share, listen, and brainstorm regarding the Framework. The 4-hour meeting was a combination of presentations, group discussion, and breakout work.

Location and Date: The Prince George Hotel, Halifax, NS, hosted the event on November 6, 2023, from 12 pm to 4 pm AST.

Meeting Objectives:

- Broadly align Nova Scotia's Action for Health & the Framework for Diabetes in Canada.
- Enhance collaboration, efficiencies in care, and data surveillance within diabetes care.
- Develop recommendations to harmonize efforts among strategic partners to operationalize the Framework for Diabetes in Canada through a Nova Scotia lens.

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 (Framework for Diabetes in Canada Infographic, 2022)

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).

Roundtable Description: The half day event featured various sessions covering topics such as digital health, research, surveillance and data collection, illness burdens, primary care challenges and opportunities, perspectives from allied healthcare, patient journeys with diabetes, and practical experiences in implementing the Framework, drawing insights from different regions in Nova Scotia.

Speakers:

- Dr. Mindrum (roundtable Chair and speaker) - Diabetes researcher, and frontline physician
- Dr. Craig White – Primary Care Specialist, addressing challenges and opportunities
- Stacey Smith – Pharmacist and Certified Diabetes Educator (CDE)
- Suzie Currie, PhD – Full professor and Head of the Department of Biology - Sharing the personal journey of living with diabetes
- Natalie Washington – Sharing experiences with diabetes management
- Dr. Fred Melindy, eDOCSNL – Presenting insights from the Newfoundland and Labrador digital health experience

Themes: Themes discussed in the sessions covered aspects such as team communication, data management, the role of nurses and allied health professionals, integrated care, social prescribing, administrative challenges, technology support, financial assistance, and fostering provincial collaborations.

Diabetes in Canada

- Diabetes complications are associated with premature death (Public Health Agency of Canada, 2011).
- Diabetes can reduce lifespan by five to 15 years (Public Health Agency of Canada, 2011).
- The all-cause mortality rate among Canadians living with diabetes is twice as high as the all-cause mortality rate for those without diabetes (Government of Canada, 2023).
- Individuals with diabetes are over three times more likely to be hospitalized with cardiovascular disease, 12 times more likely to be hospitalized with end-stage renal disease, and almost 20 times more likely to be hospitalized for a nontraumatic lower limb amputation (Public Health Agency of Canada, 2011).

Diabetes in Nova Scotia, 2023

An overview was shared of the current stats of diabetes in Nova Scotia, highlighting the rates of people living with diabetes, as well as financial costs.

Estimate Prevalence and Cost of Diabetes – Nova Scotia

(Diabetes in Nova Scotia: Backgrounder, 2023)

Prevalence (1)	2023	2033
Diabetes (type 1 + type 2 diagnosed + type 2 undiagnosed)	177,000 / 17%	204,000 / 21%
Diabetes (type 1 and type 2 diagnosed)	124,000 / 12%	143,000 / 14%
Diabetes (type 1)	5-10% of diabetes prevalence	
Increase in diabetes (type 1 and type 2 diagnosed), 2023-2033	15%	
Direct cost to the health care system	$116 Million	$131 Million
Out-of-pocket cost per year (2)		
Type 1 diabetes costs, % of family income	$223-$14,007 / 1%-9%	
Type 2 diabetes costs, % of family income	$232-$5,010 / 1%-7%	

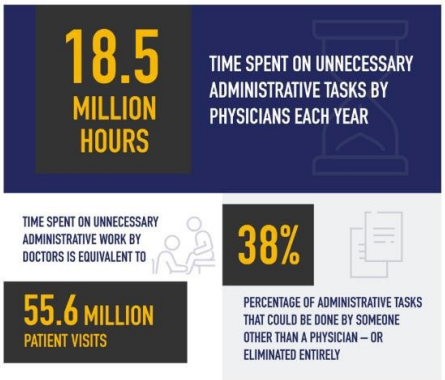
Alignment of Health Objectives

Action for Health, Nova Scotia	Framework for Diabetes in Canada
Innovative primary healthcare models	Promote collaborative efforts among healthcare professionals
Increase the number of care teams working together to maximize resources and provide safe, quality care	Explore the need for additional supports to alleviate barriers
Implement digital solutions to improve processes	Expand technologies and digital solutions
Enhance data collection	Explore options to enhance national diabetes surveillance
Encourage research and discovery through the Health Innovation Hub	Enhance investments for innovative diabetes research
Innovative primary healthcare models	Promote collaborative efforts among healthcare professionals
Source: Action for Health a Strategic Plan 2022–2026, Nova Scotia	Source: Framework For Diabetes in Canada, Public Health Agency of Canada

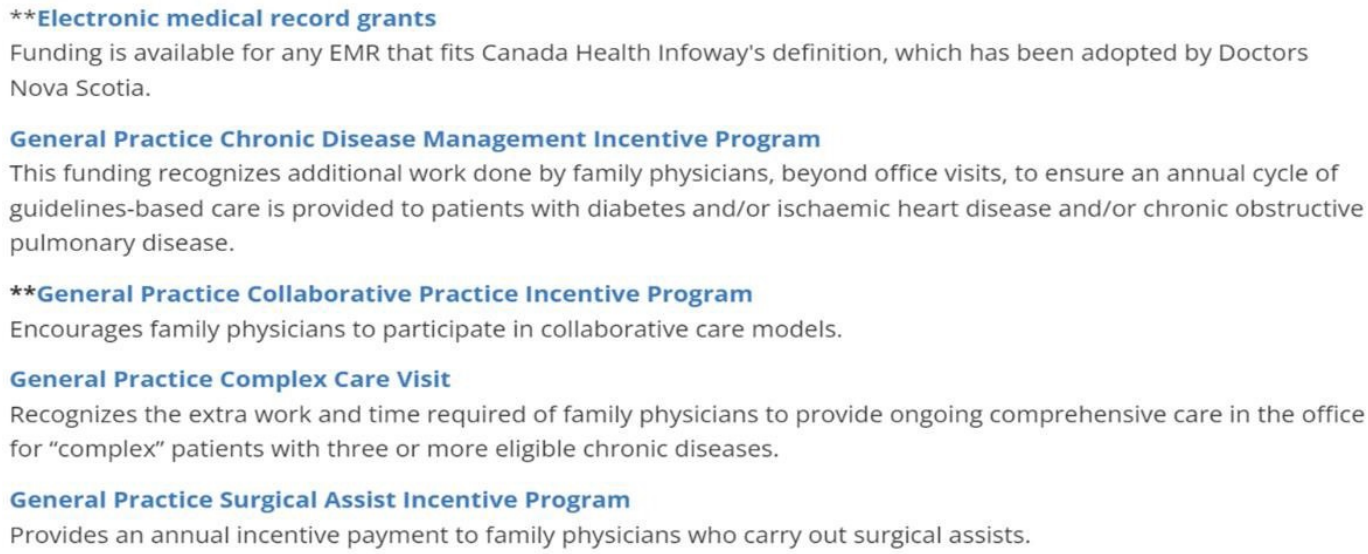
The Framework components identified at the event encompassed various crucial aspects of diabetes care, including prevention, the social environment influencing choices, and the management, treatment, and care provided. Dr. Craig White's presentation emphasized the challenges faced by healthcare providers (HCPs), highlighting the importance of Electronic Medical Records (EMRs) for seamless data sharing across clinics and the need for integrated Chronic Disease Systems which may lead to better integrated care for people living with diabetes. In his presentation, he spoke of the opportunities and motivations to improve current administration systems.

Administrative Use of Time

(Canadian Medical Association, 2023)



The slide below drew attention to the good work that Nova Scotia is doing for the doctors and by extension its diabetes patients.



The New Funding Model

Available to both current APP family doctors and fee-for-service family doctor, the new Longitudinal Family Medicine payment model aims to provide stable, equitable funding for physicians who provide longitudinal family medicine, with a particular focus on access and attachment. The model offers competitive compensation and enhanced accountability, through a payment based on hours worked, services delivered and panel size. The Chronic disease management incentive program recognizes the additional work you do, beyond office visits, when providing guidelines-based care to patients with specific chronic diseases.

The Nova Scotia program is patient-centred rather than disease-centred and recognizes that many patients have more than one chronic disease, which may have common risk factors.

The qualifying chronic diseases are:

- Type 1 and Type 2 diabetes
- Ischaemic heart disease (IHD)
- Chronic obstructive pulmonary disease (COPD)

Allied Health Profession Perspective

Stacey Smith, a Clinical Pharmacy Specialist and Certified Diabetes Educator, committed to patient care, stressed the necessity for educating health care professionals (HCPs) and ongoing training initiatives. Pharmacists and other HCPs are often more accessible to patients than physicians, thus there is an increased opportunity for these professionals to provide check-ins and care to people living with diabetes. The NS roundtable breakout session deliberated on supporting standardized uptake of Diabetes Canada guidelines, emphasizing patient-centered care and shared priorities. The sharing of pharmacists' experiences in Nova Scotia helps gain insight to implementation feedback.

- Keeping up to date on guidelines, new medications
- Not feeling confident in suggesting medications "after metformin"
- Avoiding certain medications altogether if they require special authorization
- Coverage not in line with guideline recommendations
- Failing to "meet them where they are" and empowering them to want to change their behaviors
- Avoiding or delaying initiation of insulin as there is a lack of confidence in educating and training on this

Post-roundtable, Ms. Smith also elaborated more on the pharmacist experience:

I have been visiting pharmacies across the province who are participating in the pharmacy led walk-in clinic pilot and spending time with pharmacists /sitting in on diabetes visits and mentoring on the care plan process and other topics related to diabetes education. The feedback has been really positive. Many have expressed feeling more confident in diabetes management after these mentoring sessions.

Currently, pharmacists are able to assess and prescribe for diabetes and make changes to therapy/add/discontinue medications in the context of a diabetes visit. The stipulation is that the patient has to have a previous diagnosis (i.e. we cannot diagnose diabetes). They do a thorough CDM visit and review relevant labs, go over diet, blood glucose control, etc. One question I've advocated to have on the template being used across the province (and this change has been made) is asking the patient how living with diabetes has impacted their life and what their health goals are. This has been an eye-opening experience for patients and pharmacists. Patients feel really heard and it allows pharmacists to sometimes change their plan or the timeline of their plan to align with their patients' values.

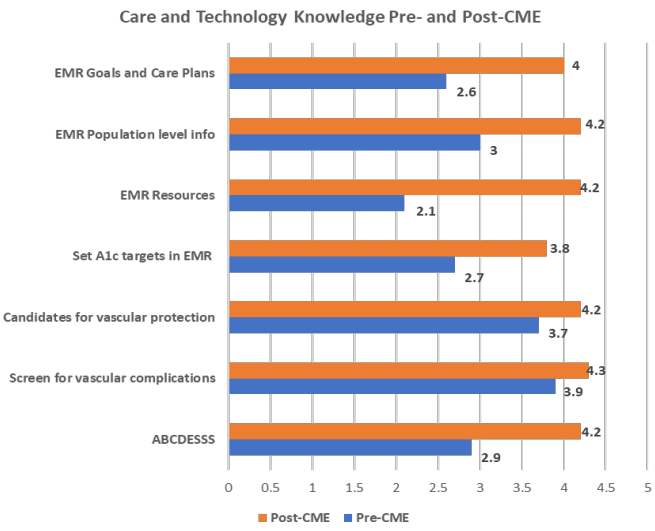
Digital Health: Newfoundland and Labrador Diabetes Pilot

Dr. Fred Melindy from eDOCSNL advocated for the expansion of the use of digital tools', integration of patient data, and knowledge sharing for improved diabetes management. Dr. Melindy spoke to the successes, which have included increased physician engagement, of the Newfoundland and Labrador pilot titled the Newfoundland Project: Diabetes Canada, in partnership with eDOCSNL. The provincial electronic medical records (EMR) program launched a pilot project integrating Diabetes Canada's Clinical Practice Guidelines with the EMRs being used by health-care providers. (evaluation highlights to the right)

Naturally, there were lessons learned from the pilot implementation – summarized by Dr. Melindy below. We have learned that due to the success of the NL pilot, it is being rolled out across Newfoundland and Labrador.

Enablers	Barriers
Pilot group – frequent check-ins	Challenging time in medicine – constant change and **capacity** issues
CMEs	**Turnover** in clinics
One-on-one with providers – going into clinics	Unified toolset does not address individual **workflow** needs
Sharing educational materials	**Awareness** remains a challenge
Social media presence	Implicit assumption of simplistic patient encounters
Good existing support for basic EMR functionality	"No **time** to explore/ experiment"
	No **compensation** for increased time involved in using the tools

Continuing Medical Education (CME) Evaluation Highlights



Patient Perspectives

Presentations by Natalie Washington and Suzie Currie, PhD, underscored the critical importance of equitable access to essential diabetes devices, treatments, and healthcare professionals. Their shared experiences emphasized that the patient centered approach and repeated engagement is key to supporting the frequent adjustments of lifestyles initiated when diagnosed with diabetes. Their presentations brought further voice to the lived experience of barriers on individuals diagnosed with T1D and T2D, respectively, advocating for improved access to healthcare, education, and support systems in Nova Scotia to enhance diabetes management and overall well-being.

Likewise, the group discussions also focused attention on patient mental health. Recognizing that a diagnosis of diabetes often presented both an ask to change one's lifestyle, and a large volume of information can contribute to people feeling overwhelmed and at times 'freezing' and becoming non-active. Elements such as following up with patients, were mentioned as a contributor to increase engagement in positive lifestyle changes. Current studies provide complimentary evidence emphasizing this positive relationship with the following statements:

1. Frequent follow up with health care providers, diabetes coaches, peer support, or community health workers has resulted in improved glycemic control, self-efficacy, and self-care behaviours regarding diabetes – Self- Management Education and Support (Diabetes Canada, 2023)

2. "Supportive interactions, and facilitated patient engagement resulted in patients expressing enhanced motivation to improve self-care." (Grohmann et al., 2017).

3. "Diabetes prevention has been found to be impacted by a patient's desire to modify their current lifestyle, perceptions, and knowledge of the impacts of diabetes. Patients were also influenced by contact with a trusted professional who can help motivate them towards making healthier lifestyle changes that could ultimately lead to a reduction in diabetes risk" (Messina et al., 2017).

Aligning with the Framework's cross-cutting principle of patient centeredness, these statements also connect back to the importance of what Dr. Melindy had spoken to, of the need to engage with patients living with diabetes at every time they meet with their primary care provider.

Further discussed during the meeting was additional approaches that may be taken to improve interactions with primary care providers. Suggestions included the use of automated appointments and check-ins to ensure patients are interacting with their primary care provider in intervals that meet their needs. Additionally, in doing so, the value of these meetings can be increased. Each meeting can be used to break down information, providing further insight regarding diabetes management. By re-visiting and introducing relevant information, patients can be better informed and receive patient-oriented care without being overwhelmed.

During the roundtable, structured breakout groups occurred, plus group discussion was engaged where people with lived experiences spoke openly of the need for more information about living socially with diabetes - such as alcohol consumption, recreational drugs, etc. There would be value in more focused knowledge translation and dissemination of these topics for people living with diabetes.

A Summary of Diabetes NS Roundtable Discussions and Possibilities

Current Experience	Responses	Possibilities
EMR not centralized	There are grants to access EMRs	Have uniform diabetes questions in all EMR programs, look to centralization in the future Centralized location for development of templates and tools
Pharmacy support for those living with diabetes encouraged	Some drugs they can prescribe, however education is a barrier	Expand pharmacist education in diabetes Allow allied HCPs access to the information
Family physician access is limited	Clinics	Expand diabetes care further into allied health Use patient data to inform the provider
Patients living with diabetes having mental barriers (ex. being overwhelmed)	Looking for more support and encouragement	Increase patient-centered physician education, gradually educate (re- educate) patients as to diabetes lifestyle options
Patients living with diabetes experiencing administrative barriers	Looking for more support and encouragement	Automated appointments and check-ins to ensure patients are interacting with their primary care provider in intervals that meet their needs Patient direct link to their records, highlighting what is more important to them
Patients want to know more about socially living with diabetes	CPGs are not patient focused language	Adjust knowledge translation towards the diversity of patient lifestyles

The Nova Scotia roundtable presentations and discussions reinforce the Framework's and the objectives of the SMIDF Project: aiming to provide a comprehensive understanding of the framework and its implementation potential in Nova Scotia. Attendees brought attention to the need to catalyze actionable steps for a more efficient, integrated, and equitable approach to diabetes care in the region.

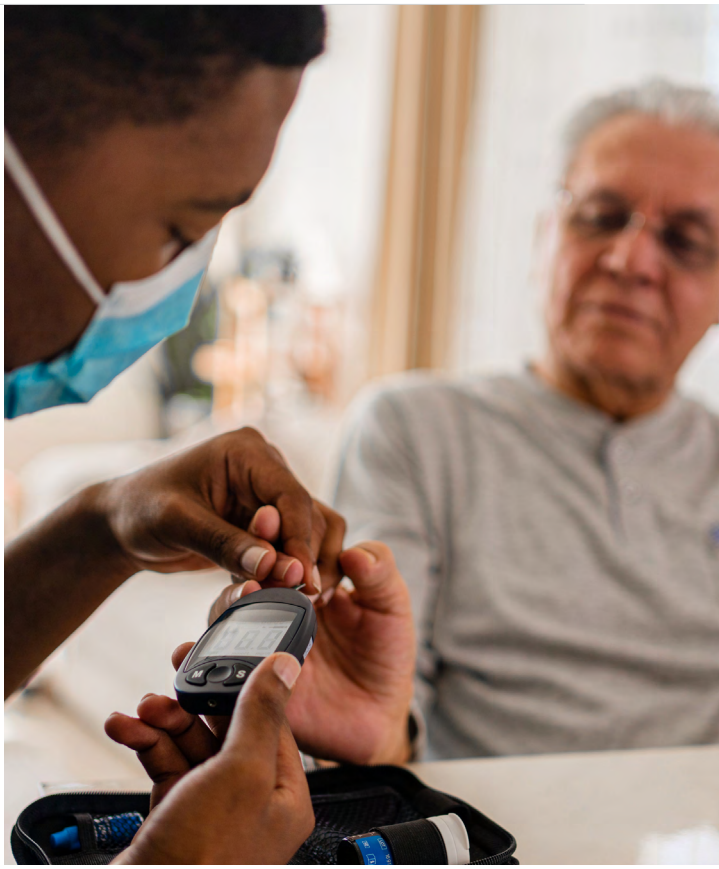
Framework (National)	Actions for Health (NS)	Possible Next Steps for NS
Promote collaborative efforts among healthcare professionals	Innovative primary healthcare models	Create a provincial diabetes committee
Explore the need for additional supports to alleviate barriers	Increase the number of care teams working together to maximize resources and provide safe, quality care	Further expand diabetes support through HCPs Continue supporting pharmacy mentorship
Expand surveillance and data collection	Implement digital solutions to improve processes	Promote the existence of the EMR grant; followed by long-term goals of: unifying diabetes EMR questions, data sharing, and perhaps centralization
Explore options to enhance national diabetes surveillance	Enhance data collection	Expand data collection and sharing in small steps
Enhance investments for innovative diabetes research	Encourage research and discovery through the Health Innovation Hub	Continue supporting the Health Innovation Hub
Facilitate regular updating of clinical practice guidelines to ensure that the most recent research evidence to improve care for people living with all types of diabetes is being integrated.	Accessing continuing care as people age as informed by evidence	

Conclusion

The SMIDF Project is an instrumental initiative by Diabetes Canada and PHAC. The Nova Scotia roundtable in 2023 aimed to encourage further attention and engagement of Diabetes in Nova Scotia. As the initial round table 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:

- Broadly align Nova Scotia's Action for Health & the Framework for Diabetes in Canada.
- Enhance awareness, collaboration, and data surveillance within diabetes care.
- Develop recommendations to harmonize efforts among strategic partners to operationalize the Framework for Diabetes in Canada through a Nova Scotia lens.



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